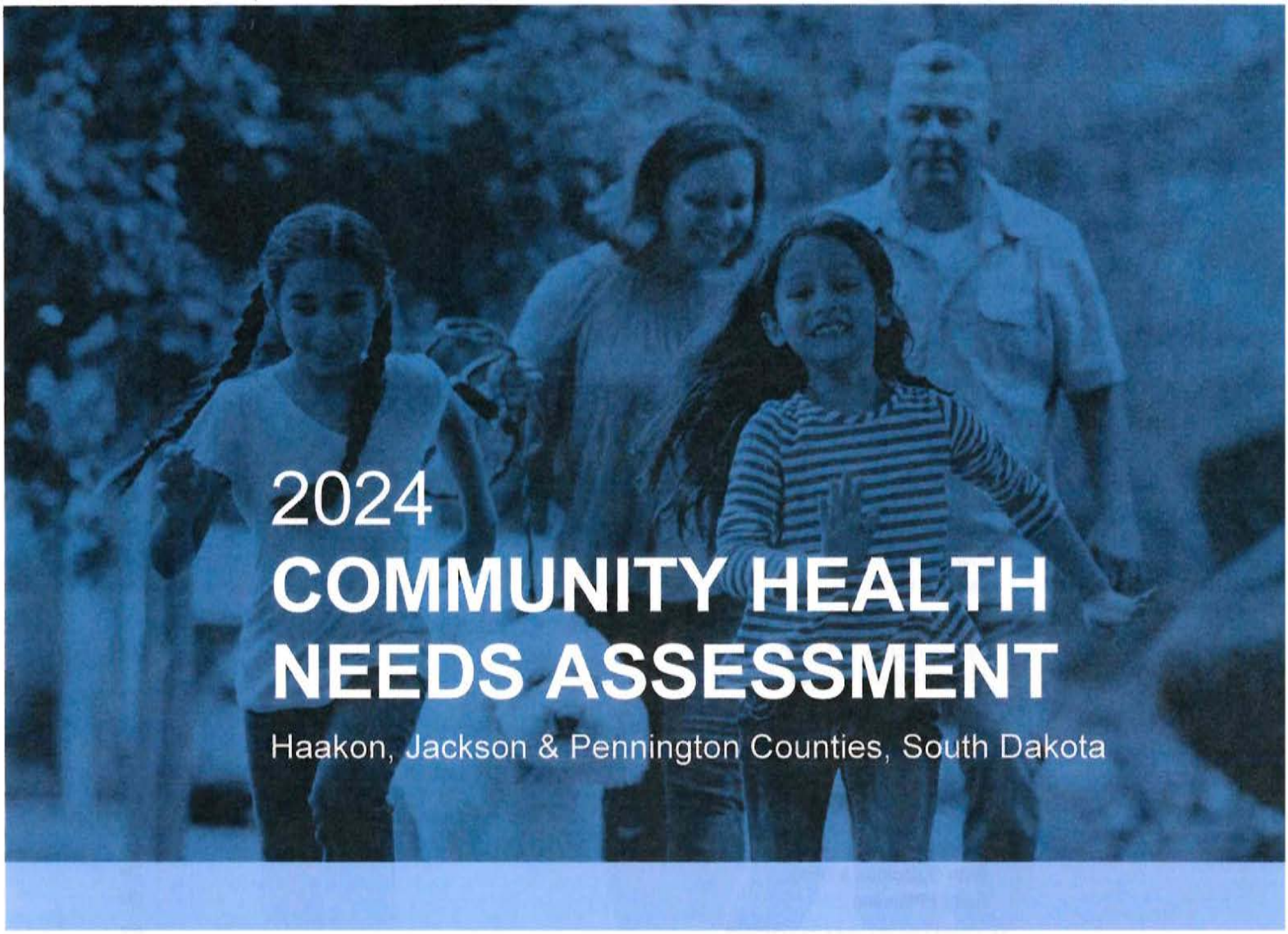


2024 COMMUNITY HEALTH NEEDS ASSESSMENT

Haakon, Jackson & Pennington Counties, South Dakota

Sponsored by

Hans P. Peterson Memorial Hospital

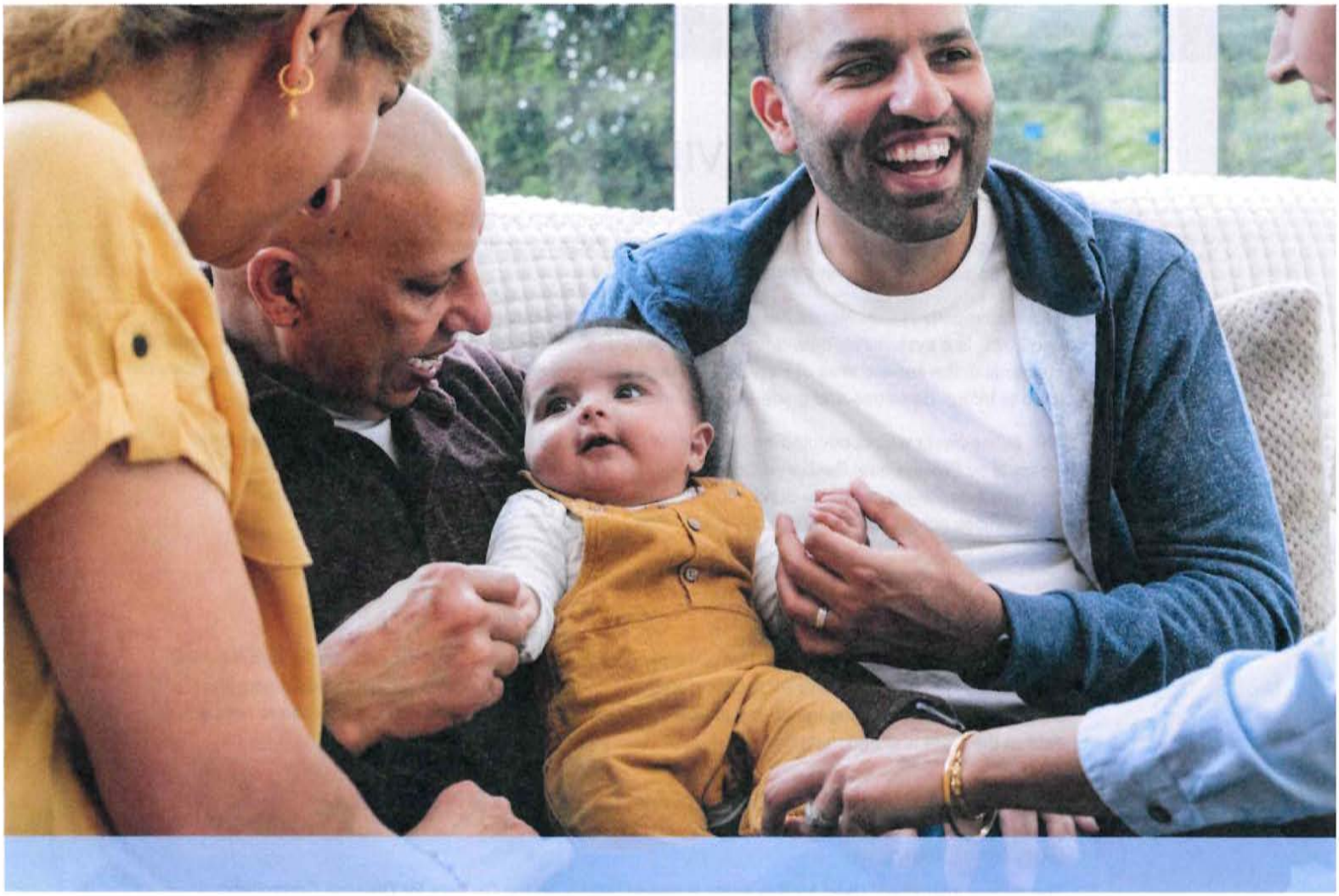
PHILIP HEALTH SERVICES

In collaboration with

Monument Health

2024-0304-02

Prepared by
www.PRCExcellence.com



INTRODUCTION

Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

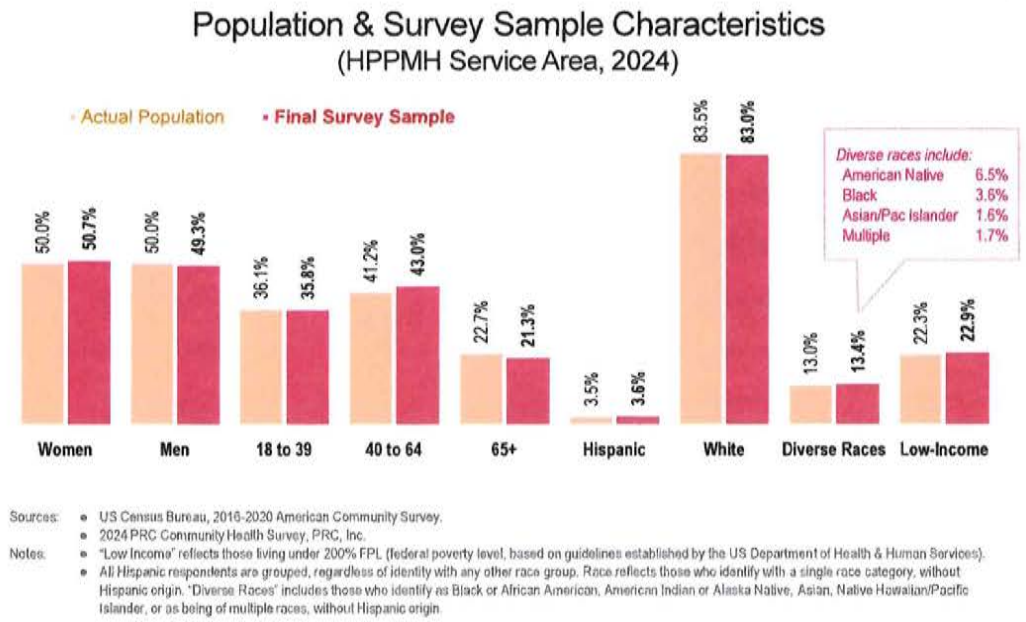
The sample design used for this effort consisted of a random sample of 327 individuals age 18 and older in the HPPMH Service Area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the HPPMH Service Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 327 respondents is ±5.7% at the 95 percent confidence level.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the HPPMH Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's health care needs, and these children are not represented demographically in this chart.]



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2024 PRC Community Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% FPL (federal poverty level, based on guidelines established by the US Department of Health & Human Services).
- All Hispanic respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. "Diverse Races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

- Hegg Realtors
- Indian Health Service - Kyle Health Center
- John T. Vucurevich Foundation
- Kahler Financial Group
- Lawrence County Planning & Zoning
- LDH Advisory Council
- Little Wound School
- Live Well Black Hills
- Midland Scientific
- Monument Health Behavioral Health Center
- Monument Health Custer Clinic
- Monument Health Hot Springs Clinic
- Monument Health Lead-Deadwood Hospital
- Monument Health Rapid City Clinic, Flormann Street
- Monument Health Rapid City Hospital
- Monument Health Rapid City Hospital Family Medicine Residency Clinic
- Monument Health Spearfish Clinic
- Monument Health Spearfish Hospital
- Monument Health Sturgis Hospital
- Monument Health Sturgis Hospital
- Northern Plains Eye Foundation
- Oglala Sioux Lakota Housing
- One Heart
- Oyate Health Center
- Pennington County Health & Human Services
- Philip Ambulance Service
- Philip Chamber of Commerce
- Philip Health Services
- PHS Home Health
- PHS Providers
- Prairie Hills Transit
- Rapid City Advisory Council
- Rapid City Fire Department
- Red Cross
- Same Day Surgery Center
- South Dakota Community Foundation
- South Dakota Department of Health
- South Dakota Parent Connection
- Spearfish Schools
- SPH-BF Advisory Council
- STH Advisory Council
- Trask Family Dental
- United Capital
- United Way
- Wall Chamber of Commerce
- Western South Dakota Community Action
- Working Against Violence, Inc.
- Youth & Family Services

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, LGBTQ+ residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

Hans P. Peterson Memorial Hospital made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Hans P. Peterson Memorial Hospital had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Hans P. Peterson Memorial Hospital will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following "Areas of Opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the key informants giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Lack of Health Insurance ▪ Barriers to Access – Cost of Physician Visits – Appointment Availability – Difficulty Finding a Physician – Culture/Language ▪ Skipping/Stretching Prescriptions ▪ Dental Insurance Coverage ▪ Lack of Financial Resilience ▪ Ratings of Local Health Care
CANCER	▪ Leading Cause of Death ▪ Cervical Cancer Screening
DIABETES	▪ Diabetes Deaths ▪ Prevalence of Borderline/Pre-Diabetes ▪ Key Informants: *Diabetes* ranked as a top concern.
DISABLING CONDITIONS	▪ Multiple Chronic Conditions ▪ Activity Limitations ▪ High-Impact Chronic Pain ▪ Osteoporosis [Age 50+] ▪ Sciatica ▪ Alzheimer's Disease Deaths
HEART DISEASE & STROKE	▪ Leading Cause of Death
HOUSING	▪ Housing Insecurity ▪ Housing Conditions ▪ Experience of Homelessness ▪ Key Informants: *Social Determinants of Health (especially Housing)* ranked as a top concern.

— continued on the following page —

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Mental Health
2. Substance Use
3. Social Determinants of Health (especially Housing)
4. Diabetes
5. Tobacco Use
6. Disabling Conditions
7. Nutrition, Physical Activity & Weight
8. Heart Disease & Stroke
9. Infant Health & Family Planning
10. Sexual Health
11. Injury & Violence
12. Cancer
13. Access to Health Care Services

Hospital Implementation Strategy

Hans P. Peterson Memorial Hospital will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

SOCIAL DETERMINANTS	HPPMH	HPPMH vs. BENCHMARKS vs. SD	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	0.4	1.0	3.9		
Population in Poverty (Percent)	12.9	12.3	12.5	8.0	
Children in Poverty (Percent)	18.2	15.5	16.7	8.0	
No High School Diploma (Age 25+, Percent)	6.0	7.3	10.9		
Unemployment Rate (Age 16+, Percent)	1.8	1.9	4.5		3.9
% Unable to Pay Cash for a $400 Emergency Expense	29.8		34.0		19.7
% Worry/Stress Over Rent/Mortgage in Past Year	36.7		45.8		29.4
% Unhealthy/Unsafe Housing Conditions	10.4		16.4		4.1
% Homeless in the Past Two Years	9.2				2.3
Population With Low Food Access (Percent)	33.8	29.1	22.2		
% Food Insecure	29.0		43.3		19.4

better similar worse

OVERALL HEALTH	HPPMH	HPPMH vs. BENCHMARKS vs. SD	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	20.4	15.0	15.7		13.4

better similar worse

ACCESS TO HEALTH CARE SERVICES (continued)	HPPMH	HPPMH vs. BENCHMARKS vs. SD	vs. US	vs. HP2030	TREND
% Outmigration for Care	22.1				25.8
% Rate Local Health Care "Fair/Poor"	19.7		11.5		16.1
		better	similar	worse	

CANCER	HPPMH	HPPMH vs. BENCHMARKS vs. SD	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000 (Age-Adjusted)	149.2	148.9	146.5	122.7	157.6
Lung Cancer Deaths per 100,000 (Age-Adjusted)	31.9	34.5	33.4	25.1	
Female Breast Cancer Deaths per 100,000 (Age-Adjusted)	21.3	19.1	19.4	15.3	
Prostate Cancer Deaths per 100,000 (Age-Adjusted)	21.5	18.7	18.5	16.9	
Colorectal Cancer Deaths per 100,000 (Age-Adjusted)	11.5	14.0	13.1	8.9	
Cancer Incidence per 100,000 (Age-Adjusted)	433.0	457.8	442.3		
Lung Cancer Incidence per 100,000 (Age-Adjusted)	56.3	55.9	54.0		
Female Breast Cancer Incidence per 100,000 (Age-Adjusted)	135.3	123.8	127.0		
Prostate Cancer Incidence per 100,000 (Age-Adjusted)	86.6	123.2	110.5		
Colorectal Cancer Incidence per 100,000 (Age-Adjusted)	33.1	39.8	36.5		
% Cancer	10.6	10.6	7.4		12.6

DISABLING CONDITIONS (continued)	HPPMH	HPPMH vs. BENCHMARKS vs. SD	vs. US	vs. HP2030	TREND
% Sciatica/Chronic Back Pain	31.0				24.0
% [50+] Arthritis/Rheumatism	41.0				38.9
% [50+] Osteoporosis	17.8			5.5	10.4
Alzheimer's Disease Deaths per 100,000 (Age-Adjusted)	31.4	38.8	30.9		26.3
% Caregiver to a Friend/Family Member	22.1		22.8		25.3
		better	similar	worse	

HEART DISEASE & STROKE	HPPMH	HPPMH vs. BENCHMARKS vs. SD	vs. US	vs. HP2030	TREND
Heart Disease Deaths per 100,000 (Age-Adjusted)	157.3	156.5	164.4	127.4	148.5
% Heart Disease	9.2	7.2	10.3		6.7
Stroke Deaths per 100,000 (Age-Adjusted)	29.7	33.8	37.6	33.4	31.2
% Stroke	3.0	2.6	5.4		4.6
% High Blood Pressure	44.1	33.5	40.4	42.6	38.5
% High Cholesterol	37.4		32.4		37.5
% 1+ Cardiovascular Risk Factor	89.3		87.8		86.6
		better	similar	worse	

MENTAL HEALTH	HPPMH	HPPMH vs. BENCHMARKS vs. SD	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	27.2		24.4		3.6
% Diagnosed Depression	30.6	17.9	30.8		13.6
% Symptoms of Chronic Depression	42.0		46.7		20.5
% Typical Day Is "Extremely/Very" Stressful	20.3		21.1		5.9
Suicide Deaths per 100,000 (Age-Adjusted)	29.9	20.4	13.9	12.8	16.3
Mental Health Providers per 100,000	333.4	227.0	313.7		
% Receiving Mental Health Treatment	25.0		21.9		12.5
% Unable to Get Mental Health Services in Past Year	9.9		13.2		3.0
		better	similar	worse	

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	HPPMH	HPPMH vs. BENCHMARKS vs. SD	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	27.9		30.0		23.3
% No Leisure-Time Physical Activity	25.2	23.5	30.2	21.8	20.3
% Meet Physical Activity Guidelines	29.0	21.7	30.3	29.7	17.8
% [Child 2-17] Physically Active 1+ Hours per Day	46.9		27.4		49.6
% Overweight (BMI 25+)	72.6	72.2	63.3		74.3
% Obese (BMI 30+)	43.7	36.8	33.9	36.0	30.7

RESPIRATORY DISEASE (continued)	HPPMH	HPPMH vs. BENCHMARKS vs. SD	vs. US	vs. HP2030	TREND
% [Child 0-17] Asthma	8.1		16.7		11.0
% COPD (Lung Disease)	4.9	6.9	11.0		15.1
		better	similar	worse	

SEXUAL HEALTH	HPPMH	HPPMH vs. BENCHMARKS vs. SD	vs. US	vs. HP2030	TREND
Chlamydia Incidence per 100,000	708.6	567.1	495.0		
Gonorrhea Incidence per 100,000	582.7	337.1	194.4		
		better	similar	worse	

SUBSTANCE USE	HPPMH	HPPMH vs. BENCHMARKS vs. SD	vs. US	vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000 (Age-Adjusted)	24.4	20.8	11.9		17.1
Cirrhosis/Liver Disease Deaths per 100,000 (Age-Adjusted)	24.6	13.4	12.5	10.9	
% Excessive Drinking	17.7	20.3	34.3		17.1
Unintentional Drug-Induced Deaths per 100,000 (Age-Adjusted)	7.3	7.6	21.0		7.2
% Used an Illicit Drug in Past Month	7.1		8.4		1.6
% Used a Prescription Opioid in Past Year	14.1		15.1		22.7

Hans P. Peterson Memorial Hospital

2025-2027 Implementation Strategy

For more than 60 years, Hans P. Peterson Memorial Hospital has demonstrated its commitment to meeting the health needs of the Haakon County region.

This summary outlines Hans P. Peterson Memorial Hospital's plan (Implementation Strategy) to address our community's health needs by 1) sustaining efforts operating within a targeted health priority area; 2) developing new programs and initiatives to address identified health needs; and 3) promoting an understanding of these health needs among other community organizations and within the public itself.

Hospital-Level Community Benefit Planning

Prioritization Process [IRS Form 990, Schedule H, Part V, Section B, 1g, 6g]

After reviewing the Community Health Needs Assessment findings, the CHNA Steering Committee met December 11th to prioritize health needs and determine how to best utilize health resources in 2025-2027.

Steering committee members went through a process of understanding key local data findings (Areas of Opportunity) and ranking identified health issues against the following established, uniform criteria:

- **Magnitude**. The number of persons affected, also considering variance from benchmark data and Healthy People targets.
- **Impact/Seriousness**. The degree to which the issue affects or exacerbates other quality of life and health-related issues.
- **Feasibility**. The ability to reasonably impact the issue, given available resources.
- **Consequences of Inaction**. The risk of not addressing the problem at the earliest opportunity.

Prioritization Results

From this exercise, the Areas of Opportunity were prioritized as follows:

1. **Mental Health**
2. **Substance Abuse**
3. **Social Determinants of Health (especially Housing)**
4. **Diabetes**
5. **Tobacco Use**
6. **Disabling Conditions**
7. **Nutrition, Physical Activity & Weight**
8. **Heart Disease & Stroke**
9. **Infant Health & Family Planning**
10. **Sexual Health**
11. **Injury & Violence**

1. Mental Health	
Partners	• IHC (Integrative Health Centers) telehealth services integrated into Philip Clinic • Avera Behavioral Health (telehealth services) • Monument Health • Capital Area Counseling
Goal(s)	**Improving access and awareness of mental health**
Timeframe	2025-2027
Scope	This strategy will focus on residents in the service area of HPPMH (Haakon County, the eastern portion of Pennington County, and the northern portion of Jackson County, South Dakota)
Strategies & Objectives	**Strategy #1: Increase Awareness of Available Mental Health Resources in Our Community** • Partner and collaborate closely with our mental health telehealth partner IHC to help spread awareness and availability of mental health services in our community. • Collaborate with Capital Area Counseling on available services in our community. • Increased advertisement of available services in our community **Strategy #2: Improve Mental Health Screening Process within our clinics** • Education and reminders to our facility providers to conduct yearly mental health screenings during patient physicals. • Provide screenings at yearly health fair. • Encourage provider education relating to mental health needs **Strategy #3: Expand Access To Mental Health in Our Communities** • Research other telemedicine options that are available i.e. Talkspace, Brightside, etc. • Work with area schools on other options for mental health and/or counseling. • Utilize Human Services Center for Geriatric Psych needs. • Collaborate with Capital Area Counseling on possible location sites outside of Philip to provide services • Collaborate with IHC on expanding telehealth services outside of Philip Clinic which may include Kadoka Clinic and increasing more remote services for patients.
Anticipated Outcomes	• Increase staff awareness of available resources for patients in need • Improve transportation to services and access to virtual provider visits • Improve basic health care access for people who are forgoing care due to cost, lack of transportation, or lack of information • Reduce emergency care encounters and timeliness of care provided

3. Cancer	
Partners	• HPPMH Medical Staff • HPPMH Registered Dietician • South Dakota Department of Health • Philip Area Foundation
Goal(s)	**To explore, develop and support opportunities that will positively impact the health of our community members related to cancer prevention, treatment and survivorship.**
Timeframe	2025-2027
Scope	This strategy will focus on residents in the service area of HPPMH (Haakon County, the eastern portion of Pennington County, and the northern portion of Jackson County, South Dakota)
Strategies & Objectives	**Strategy #1: Primary Care-Provider Education** • Educate primary care providers on evidence-based practices regarding cancer diagnosis and treatment. • Support medical staff participation in cancer related Continuing Medical Education events **Strategy #2: Community Education** • Coordinate community education with regional healthcare providers • Include education at annual Health Fair and other health events sponsored by HPPMH • Provide community education through newsletters on cancer screenings and other healthy lifestyle choices via Facebook, Website, Newspaper, Radio and Newsletter. **Strategy #3: Early Diagnosis** • Evaluate options to provide mammography locally or partner with a regional provider to promote mammogram services • Sponsor a provider-led cancer education and support group
Anticipated Outcomes	• Increase staff knowledge of early detection and treatment • Community awareness of services available • Early patient diagnosis and treatment