2016

COMMUNITY HEALTH NEEDS ASSESSMENT

Anthony Timanus, Administrator

EXECUTIVE SUMMARY

Avera Gregory Hospital is a licensed 25-bed critical access hospital located in the heart of central South Dakota. The Avera Gregory Hospital is owned by Avera McKennan Hospital & University Health Center of Sioux Falls, S.D., part of the greater Avera Health System. Avera Health is a ministry of the Benedictine Sisters and Presentation Sisters. This network serves eastern South Dakota and surrounding states with hospitals, nursing homes, clinics and other health services at more than 300 locations.

The Avera Health community is guided by the Gospel values of compassion, hospitality and stewardship. Our mission is "to make a positive impact in the lives and health of persons and communities by providing quality services guided by Christian values." Our vision is "to provide a quality, cost-effective health ministry, which reflects Gospel values. We shall improve the health care of the people we serve through a regionally integrated network of persons and institutions."

Although conducting a community health needs assessment is an IRS requirement, the awareness of needs, through data collection and collaboration with community members and leaders, fits the Avera mission and vision of improving the health of people in Gregory County and the surrounding areas. This process provides direction for prioritizing our future strategies in developing community health driven goals.

Data collection for the Avera Gregory Hospital Community Health Needs Assessment began in the fall of 2015. Our objectives are:

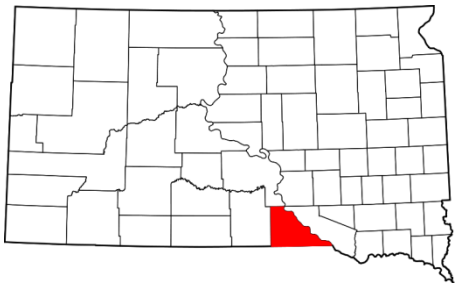
- To recognize health-related concerns of community leaders and members to include medically underserved, low-income or minority populations residing in the areas from which the facility draws its patients
- To increase community wellness, and not continue with the current reactive medical model
- To develop strategic plans that can be undertaken with action from Avera Gregory Hospital and community partners
- To move community benefit programs from what may have been perceived as providing random acts of kindness to strategic targeted programs to meet identified community health needs

Based on the results of this assessment, the 2016 implementation strategy will focus on the following priorities: **community members with disabilities, enrollment and access to health insurance, obesity/diabetes, and tobacco use.**

Description of Community Served by the Hospital

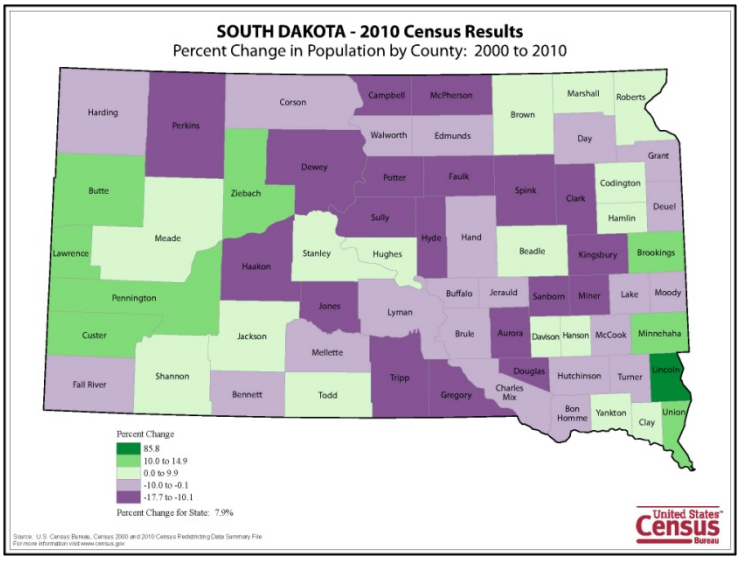
Community Description

The Avera Gregory Hospital serves the residents of Gregory County. According to the South Dakota Association of Healthcare Organizations 2014 Inpatient Origin & Destination Study, nearly 70 percent of the hospital's discharges originate from Gregory County (67.68 percent or 245 of 362 hospital discharges in 2014). Gregory County has a total area of 1,053 square miles and is located on the southern border of South Dakota adjacent to Nebraska.



As of the 2010 census, there were 4,271 people residing in the county and 1,983 households. The most recent data from the U.S. Census Bureau estimates the population for Gregory County at 4,201 in 2015. The population density is five people per square mile (5/km²). There are 2,405 housing units at an average density of 2 per square mile (2/km²).

The population of Gregory County has been declining about 10 percent per decade for the last 80 years.



Age	Gregory County		South Dakota	
	Number	%	Number	%
Under 5 years	251	5.9%	59,303	7%
5 to 9 years	259	6.1%	57,691	7%
10 to 14 years	283	6.7%	55,424	7%
15 to 19 years	206	4.9%	57,997	7%
20 to 24 years	186	4.4%	59,689	7%
25 to 34 years	376	8.9%	109,504	13%
35 to 44 years	432	10.2%	94,677	11%
45 to 54 years	574	13.6%	111,942	13%
55 to 59 years	286	6.8%	56,790	7%
60 to 64 years	369	8.7%	49,347	6%
65 to 74 years	470	11.1%	62,692	8%
75 to 84 years	367	8.7%	39,912	5%
85 years and over	176	4.2%	19,740	2%
Total	**4235**	**100%**	**834,708**	**100%**

Source: U.S. Census Bureau, 2010 - 2014 American Community Survey 5-Year Estimate

The population is distributed fairly evenly with 23.6 percent under the age of 19 and 24 percent who are 65 years of age or older. 100 percent of our population is considered rural.

Education levels of Those People 25 Years and Older

Gregory County		
Education Level	**Total**	**Percentage**
Less than High School Diploma	409	13.4%
High School Graduates	1,177	38.6%
High School Degree or Higher	**2,638**	**86.5%**
Some College No Degree	686	22.5%
Associate Degree	241	7.9%
Bachelor Degree	433	14.2%
Graduate or Professional Degree	101	3.3%
Total Persons 25 Years and Older	**3,050**	**100.0%**
Source: U.S. Census Bureau 2010-2014 American Community Survey 5-Year Estimate		

Housing

According to the 2010-2014 American Community Survey, there are 2,501 housing units in Gregory County; with 79.5 percent of them being occupied. Some 29 percent of the housing was built in 1939 or earlier. Three bedroom homes are the majority at 38 percent of the total number available. The average family size is 2.1 people per household. 42 percent of these housing units are worth less than 50,000 dollars.

Income

The median income is $37,321. The majority of working adults make roughly $50,000 to $74,999 per year. About 10.5 percent of the population is below the poverty line. 35 percent of Gregory school children qualify for free and reduced lunches.

INCOME AND BENEFIT	Estimate	Margin of Error
Total households	1,989	+/-79
Less than $10,000	195	+/-2.1
$10,000 to $14,999	163	+/-2.2
$15,000 to $24,999	338	+/-3.2
$25,000 to $34,999	239	+/-2.0
$35,000 to $49,999	332	+/-2.6
$50,000 to $74,999	326	+/-2.6
$75,000 to $99,999	175	+/-2.0
$100,000 to $149,999	151	+/-1.7
$150,000 to $199,999	30	+/-.8
$200,000 or more	40	+/-9
Median household income (dollars)	37,321	+/-2,434
Mean household income (dollars)	51,431	+/-3,392
Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates		

Unemployment

Gregory County has traditionally enjoyed a low unemployment rate. Some 25.9 percent of workers in Gregory County are self-employed versus the state average of 9 percent. This is primarily due to the amount of farmers and ranchers in the area. There are also multiple hunting lodges that are self-owned and operated during hunting season. These businesses contribute to the high tourism rate in the County.

Labor Force, Employment and Unemployment for Gregory County				
Labor Force Table				
The table below shows the annual not seasonally adjusted Labor Force, Employment and Unemployment data for Gregory County in All years.				
Time Period	**Labor Force**	**Employed**	**Unemployed**	**Unemployment Rate**
2010	2,181	2,086	95	4.4%
2011	2,159	2,060	99	4.6%
2012	2,133	2,040	93	4.4%
2013	2,104	2,022	82	3.9%
2014	2,086	2,015	71	3.4%

Source: Labor Market Information Center, SD Dept. of Labor & Regulation in cooperation with U.S. Bureau of Labor Statistics

Gregory County is a federally designated Frontier area that carries a federal Medically Underserved Population designation. Frontier areas are defined as sparsely populated rural areas that are isolated from population centers and services and have "six or fewer people per square mile." Gregory County has 4.2 persons per square mile, which is well under the standard definition. Gregory County also qualifies as a Health Professional Shortage Area (HPSA). Statistically, access to health care in South Dakota is of significant concern and there are numerous barriers to accessing health care. In addition to the barriers already mentioned, health insurance also affects access to health care while the national benchmark for uninsured adults is 13.5 percent. South Dakota is at 11 percent and Gregory County is considerably higher at 17 percent uninsured adults.

Community Health Needs Assessment Process

Avera Gregory Hospital began the community health needs assessment with primary data collection consisting of one-on-one interviews and focus groups with representatives from within our service area. These individuals showed representation from civic and business organizations such as the Gregory Public School systems, the Gregory Chamber of Commerce, the Department of Social Services, the Gregory County Commissioners, the Business Development Group, the South Dakota Department of Labor and Regulation, the City Council to include the mayor, the local food bank, and Gregory/Winner business owners. Questions utilized for data collection were as follows:

- What is healthy about our community?
- What is unhealthy about our community?
- What services do you feel are needed in our communities that do not currently exist?
- Are there specific populations you are aware of in need of services? What type of services do they need?
- Do you see productive collaborations in the community addressing health needs? Examples?
- What do you believe is the most pressing health care related need facing the community?
- In what ways is the hospital serving the community well? In what ways could the hospital serve the community better?

- Based on the goals set in our 2013 CHNA assessment how successful were we in achieving those goals? Do the issues identified continue to be significant problems?

Avera Gregory Hospital also collected secondary data, which included the research of Gregory County demographics and health-related statistics and obtaining reliable data through Internet search. Sources of this data include United States Census Bureau, County Health Rankings & Roadmaps, United States Department of Health and Human Services, South Dakota Hospital Association, Focus on South Dakota by the Helmsley Charitable Trust, and South Dakota Department of Health.

Community Input

Focus groups and a town hall meeting were utilized for primary data collection over the last 12 months using the above questions. Careful consideration was taken when establishing these groups and meetings to ensure that the assessment process was gathering input from persons who represented the broad interests of the community Avera Gregory Hospital serves. One focus group included the Avera Gregory Hospital Advisory Board, made up of community leaders who had been appointed based on their knowledge and involvement in the community and with our organization. The Advisory Board composition consists of the following backgrounds: mortuary services, banking, farming/ranching, law and local business owners. The second focus group was conducted as a town hall style meeting in which 27 community members attended. The town hall meeting format was utilized to generate greater community participation and discussion. The third focus group was conducted with the local school board, the principal of the high school and elementary school and the superintendant of schools for Gregory County. In addition our CHNA team attended local and county government meetings to solicit feedback and ensure that we understood the myriad of issues facing the community, not just in the healthcare arena, but throughout the process of government. The director of the local food bank, thrift clothing store, and senior meals center were also solicited for input to ensure that the needs and wants of the most vulnerable populations were taken into account. This combined with feedback from the local ministerial association, who do extensive charity work in the area, ensured that the hospital center this process on these high risk individuals.

Several statistical factors highlighted the importance of including input from minority groups. The U. S. Census Bureau's race statistics for Gregory County indicate that American Indian and Alaska Native residents make up a significant portion of our population base. Gregory County is located in-between the Rosebud Indian reservation both to the west in Todd County and to the east in Charles Mix County. Gregory County does not have a tribal headquarters in its geographic area and there were no tribal leadership organizations within our service area to reach out to. At our community town hall meeting and the focus groups conducted special effort was made to encourage Native American participation through flyers and advertisements in the local paper. The administration feels that this minority was well represented at these events.

Governmental public health department input was provided by the state public health nurse who is stationed in Burke, SD. All results and focus selection was done with her input and verification that the hospital was focused on public health issues within our County.

Race

The racial makeup of the county is primarily White and American Indian. The other demographics present in this county are African American, Asian, other, and Identified by two or more.

Population by Race		
White	3,779	89%
African American	7	< 1%
Asian	9	< 1%
American Indian and Alaska Native	341	8%
Native Hawaiian and Pacific Islander	0	
Other	5	< 1%
Identified by two or more	94	2%

Source: U.S. Census Bureau, 2010-2014 American Community Survey 5 – Year Estimate

The previous CHNA has been available on the web for the previous three years. Avera Gregory Hospital has received no requests for written copies and no written comments about the 2013 CHNA or implementation plan.

Answers for each question were compiled and analyzed.

Q: What is healthy about our community?

All groups that we met with continue to be extremely complimentary of the physicians and the providers at our facility. In the last year our community has had a significant influx of pneumonia and RSV. Community members expressed that it was easy to make an appointment and that their experience in the emergency department was very positive. None of the groups that were surveyed expressed any issues with access to care.

Groups also expressed their satisfaction with the telemedicine services that our facility offers. The eEmergency program in the ED allows providers to link to an emergency department physician at the touch of a button. This has led to a significant improvement in quality outcomes and trauma results in

the last five years. The ePharmacy program and bedside medication verification process has also resulted in a significant decline in medication errors over the last three years.

The hiring of a MSW in the clinic has improved the mental health picture of the community. This combined with the coordinated care program has allowed us to target high needs patients and ensure that a team of care providers meets weekly to identify their needs and ensure the patients have the ability to get to their appointments, that their medications are correct, and that their home life is optimally situated to allow them the best chance for improvement.

The groups identified that the rural agrarian lifestyle of this community requires a subset of the population to work outside in a non-sedentary way that improves health. The farming and ranching community displays less obesity and other co-morbidities. This at risk population becomes less active in retirement creating some challenges around physical activity and overall health and well-being.

Q: What is unhealthy about our community?

Multiple groups have continued to express frustration about the ability to eat a healthy diet in our community. As a small town of only 1300 people the grocery options in this community are very limited with one grocery store and a dollar store. Dollar General only carries non-perishable items and fresh produce, meats, vegetables, and other healthy items cost more than the boxed meals at the local grocery store. This disproportionally affects the lower income level members of our community and those on a fixed income.

The Gregory community also has one of the lowest rates of access to exercise opportunities in the state. There is no exercise equipment available to non-high school members of our community without paying a fee. Our trail system is considerably limited with only one track around the park that is less than a mile long. Even if community members desired to change their lifestyles the ability to do so in such a rural agrarian setting is extremely difficult.

Q: What services do you feel are needed in our communities that do not currently exist?

In regards to hospital services the community has expressed a desire for more mental health provider involvement. They have also requested the services of an ophthalmologist to conduct cataract surgery in the local community. The closest provider is in Mitchell which is 120 miles away.

The community has expressed a desire for a more modern clinical building. The current building was built in the 1940s and used to be the location of the hospital. The foundation of this building has started to crack and the repairs are becoming noticeable. The community has acknowledged that something must be done in the next 5-10 years.

Q: Are there specific populations you are aware of in need of services? What type of services do they need?

Our primary sources confirmed the need to address the disabled population specifically in the realm of health insurance. Since a large portion of the disabled population has either a vision or cognitive

impairment they have difficulty understanding health care bills and discharge instructions. The community expressed appreciation of the care coordination and post acute follow up calls and wishes to see these programs expanded.

According to billing trends over the last five years, our facility has roughly 30 percent of charges go either to bad debt or charity care. This is an indication of the large subsection of our community that still has not received insurance under the Affordable Care Act. While this does not affect this population's ability to receive treatment in the hospital, the community is concerned that these people do not participate in routine health maintenance or preventative medicine. As such when they present their symptoms in the emergency department the condition for which they are receiving treatment may have deteriorated to the point that significant interventions are required. Many times the issue could have been addressed at a much earlier stage resulting in better outcomes and less cost to both the hospital and the governmental system.

Q: Do you see productive collaborations in the community addressing health needs? Examples?

Once a month the community is holding a nutrition counsel to address the diet and exercise needs of the community. We feel that Avera Gregory can become a strong partner with this organization to address the root cause of why community members are becoming unhealthy in the beginning of the process.

The community wishes we would collaborate with the local schools and the governmental bodies to address health issues and take action on them prior to the community members coming to the hospital. The administration has been attending city council meetings to hear firsthand what these issues are and how we can be of assistance as the largest employer in the community.

Q: What do you believe is the most pressing health care related need facing the community?

This question prompted the most diverse responses from the different groups that we surveyed. Some groups were concerned about cancer rates, others about heart disease, and others about smoking and alcohol abuse. The administration reviewed the secondary data with the various focus groups. This refined the conversation and came to the following conclusions.

Obesity and diabetes were contributing cause to the majority of the critical emergencies that community members were facing in relation to the health issues. The difficulties described earlier in diet and exercise was contributing factors in the prevalence of these conditions in the community.

Q: In what ways is the hospital serving the community well? In what ways could the hospital serve the community better?

The hospital has done a better job over the last three years in getting involved in community projects to include, business development, land development, school support and involvement, chamber of commerce activities, and community promotional events. The service excellence team has adopted the community theater and provides workers to volunteer during showings that allow this organization to continue. Hospital donations to community fundraisers have been strong throughout the period. The

hospital also sponsors dinners once a month for families in need to provide meals for those without the funds to feed themselves.

Our physician and provider staffs are very caring and provide a personal touch to the practice of medicine that can only be achieved in a small town where everyone knows everyone by name. Access to care is extremely good to the point that all community members reported being able to make an appointment the same day that they call. The overwhelming message is that our hospital provides quality care to the community and that our trauma program is the best in the area of the four hospitals that serve the members of Gregory County.

Criticisms of care were few and far between. The most prevalent being the billing process. Avera Gregory has recently transitioned to a centralized billing office outside of the community. The bills are not being received by the community members as quickly as they have been in the past. This combined with more denials of payment by insurance companies has lead to a decrease in satisfaction amongst the community.

Prioritized Significant Community Health Needs

Our data collection findings centered around three main issues in 2013; obesity, behavioral health, and alcohol abuse. We have found through our primary and secondary data collection that some of these issues have improved and that our focus for the next three year period should, in some cases, be moved to other areas.

Prioritization was done with the assistance of three diverse councils within our organization. The primary and secondary data was presented at our Medical Staff which consisted of 5 physicians, 4 nurse practitioners, the administration, and the director of patient care. It was also presented at the hospitals operations council and the Avera Gregory Advisory Board meeting. Goals and focus efforts were ranked on the severity of the problem, the scope at which it could be addressed, and the possibility that our organization could potentially make an impact on the issue within the next three years. The results of these discussions are as follows.

In 2016 our implementation strategy will focus on the following priorities; **community members with disabilities, enrollment and access to health insurance, obesity/diabetes, and tobacco use.** According to secondary data provided by both the State Department of Health and the Focus on South Dakota report access to behavioral health and diagnosis of mental health issues has fallen well below the state average in our community area. Although alcohol abuse continues to be a concern in Gregory and Tripp Counties, the issue ranks well below the state average and was not identified as a significant need.

The disability rate in the Gregory/Tripp county area continued to rise in the last three years. We define disability as having significant impairment in one of the following categories; hearing, vision, ambulation, or cognition. The state's overall disability rate is 13.1 percent while Gregory and Tripp County are 17.3 percent and 11.8 percent respectively. This is compared to a national rate of 12.6 percent in 2013. Gregory County is one of the top three highest rated counties state wide in this

demographic. Through this assessment process, we want to ensure that we have the necessary resources and equipment to address the needs of disabled persons within our community.

Since the implementation of the Affordable Care Act, the state's uninsured rate continues to decline. The state's overall uninsured rate was 11.4 percent in 2014, down from a recent high of 15.1 percent in 2009. Despite this trend downward, Gregory and Tripp County continue to have a disproportionally higher percentage of uninsured. Residents under the age of 65 in Tripp County in 2013 without health insurance were reported at 18.4 percent, and in Gregory County it was at 17.0 percent. This was raised as a concern during many of our focus groups due to its potential affect for people accessing preventative and community health medicine.

The Gregory county area is located in a region where it is difficult to find indoor exercise facilities and businesses that are focused on health and wellness. While public parks and a school gym are available these are difficult for our elderly population to use, and cost-prohibitive for a large portion of our community. Avera Gregory Hospital feels that one of the most important contributions that we can make in our community is to provide education and wellness facilities so that the community members can make changes in their lifestyles. In most chronic conditions, providers recommend exercise and a change in diet. This need was identified in our last CNHA as well and significant education has been provided to targeted community members. We feel that this education needs to continue in conjunction with other efforts to increase healthy lifestyle choices within the community.

Tobacco use was identified as an issue in our 2013 CHNA, however due to competing priorities and projects and a lack of financial resources the hospitals was not able to address this need in 2013. After reviewing multiple secondary sources it is our belief that tobacco use in our service area continues to increase. The state percentage of tobacco users is 17 percent while Gregory County is at 21 percent. The long term health implications of tobacco use are well documented and directly relate to the overall health and wellness of our community. We feel this is an issue that has escalated. The hospital will work with community partners to address the increase and hopefully reduce the overall use of tobacco in our area.

Potentially Available Resources

There are two acute care facilities in Gregory County, Avera Gregory Hospital and the Burke Community Memorial Hospital. The Burke Community Memorial Hospital operates with one primary care physician with advanced practice provider support. The Avera Gregory Hospital offers inpatient and skilled, swing-bed care, general surgery, endoscopic services, orthopedic surgery, emergency services, rehabilitation therapies (PT, OT, ST), dietary consultation, laboratory, radiology (including general radiologic services, CT scan, MRI, mammography, bone density scan, ultrasound, cardiovascular testing). Several specialty clinics are held at Avera Gregory Hospital including podiatry, obstetrics/gynecology (OB/GYN), orthopedics, cardiology, ENT, nephrology, urology, and surgery.

Avera ***e***Care Services consist of ***e***Emergency, Avera eICU® Care, ***e***Pharmacy and ***e***Consult. ***e***Emergency gives the Gregory Hospital the ability to consult with emergency medicine physicians located at Avera McKennan Hospital & University Health Center, a regional tertiary facility, during a patient encounter. This enhances the ED experience for both our patients and our staff. Board-certified emergency

medicine physicians are only the push of a button away, ready to offer guidance and best practices for our more complex ED patients.

Avera eICU® Care gives us the ability to tap into the skills of intensivists, who help us manage more critical patients. ***e***Pharmacy reviews medication orders, improving outcomes for patients with increased monitoring of drug interactions, allergies and correct dosing. ***e***Consult places Gregory County patients in direct contact by face-to-face video encounters with specialists located through the Avera McKennan network. AveraNow is a recent program that allows patients to see a primary care physician through the use of an internet capable device at a location of their choosing. This service allows expanded access to health care needs throughout the service area. Patients pay a flat fee that is not billed through health insurance which further increases access among the targeted population.

Avera Medical Group Gregory offers comprehensive medical care to adults and children. Eight full-time providers are on staff; five family practice physicians, and three certified nurse practitioners who cover Avera Gregory Hospital Emergency Department call 24/7. Avera Medical Group Gregory also has five outreach clinics in Gregory, Winner, Fairfax and Colome, S.D. and Butte, Neb., which they staff throughout the week. The Gregory clinic is conveniently located one block east of the hospital.

Gregory County has one general dentist in the area that provides coverage five days a week for routine and emergency dental care. The clinic is located in Gregory, S.D.

A public health office is maintained in Burke, S.D., through an alliance contractual agreement between Gregory County and the South Dakota Department of Health. Some of the services include WIC, school health, immunizations and baby care education.

Gregory County has one 52 bed nursing home, Avera Rosebud Country Care Center, which offers skilled, intermediate and home care services. There are three assisted living centers; Silver Threads (34- beds) in Gregory, TLC (10- bed) in Burke, and The Haisch Haus (10 bed) in Bonesteel.

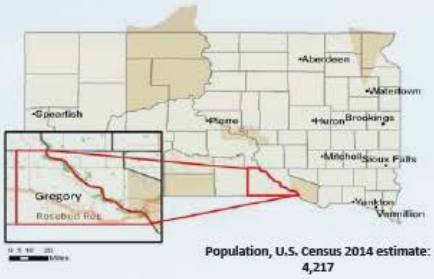
DATA ASSESSMENT ANALYSIS

Avera Gregory began the assessment process by gathering the most recent statistics about public health from county, state and national resources. Collecting both primary and secondary data strengthens the hospital's community health needs assessment and allows the hospital to look for trends and themes throughout the process.

One of the major contributing sources to our study was the Focus on South Dakota report commissioned by the Leona and Harry B. Helmsley charitable trust. This guide provided us a very interesting picture of where Gregory County ranked in relation to a myriad of health factors compared to other counties in the state. The summary of their findings are included below.

FOCUS ON SOUTH DAKOTA
A Picture of Health

SOUTH DAKOTA HEALTH STUDY: GREGORY COUNTY RESULTS



Population, U.S. Census 2014 estimate: 4,217

SURVEY RESPONSES

South Dakota Responses: 7,675	Response Rate: 48%
Gregory County Responses: 107	Response Rate: 56%

RESPONDENT PROFILE

SOUTH DAKOTA (n = 7,675)		GREGORY COUNTY (n = 107)
57.4%	Female	36.8%
11.3%	Non-White	13.2%
19.1%	Age 65 and older	27.5%
20.3%	Income ≤ 100% FPL (Federal Poverty Level)	27.4%
19.9%	Three or more ACEs (Adverse Childhood Experiences)	13.4%
8.5%	Five or more ACEs (Adverse Childhood Experiences)	9.1%

NEED FOR CARE

75.0%	Need Medical Care	57.5%
79.5%	Need Prescription Medications	74.8%
9.5%	Need Mental Health Care	5.4%
1.1%	Need Alcohol or Drug Treatment	0.6%

ACCESS TO CARE

94.2%	Have a usual place to go for care	97.2%
77.4%	Have a personal doctor/provider	74.7%
13.0%	Unmet medical needs	6.2%
6.4%	Unmet prescription needs	2.9%
35.8%	Unmet mental health needs	0.0%
45.6%	Unmet alcohol or drug abuse needs	0.0%

HEALTH PROFILE

SOUTH DAKOTA (n = 7,675)	Percent who have been told by a doctor that they have...	GREGORY COUNTY (n = 107)
11.4%	Diabetes	28.0%
10.9%	Asthma	10.5%
33.3%	High Blood Pressure	30.4%
8.9%	Heart Disease	12.3%
28.5%	High Cholesterol	26.9%
3.4%	COPD (Chronic Obstructive Pulmonary Disease)	2.9%
8.9%	Cancer	8.5%
54.7%	At least one of the above	62.3%
17.0%	Depression	11.6%
17.6%	Anxiety	6.7%
3.4%	PTSD (Post-Traumatic Stress Disorder)	1.4%
1.7%	Bipolar Disorder	0.0%
2.6%	Addiction Issues	1.4%
25.5%	At least one of the above	16.6%

HEALTH RESULTS (SCREENINGS)

	Percent who screened positive for...	
83.4%	Overall health status (good, very good, excellent)	87.2%
5.5%	Depression	2.9%
7.5%	Anxiety	2.9%
6.0%	PTSD (Post-Traumatic Stress Disorder)	9.9%
17.0%	Current Smoker	21.0%
42.4%	Alcohol Abuse	21.3%
6.7%	Marijuana Use (past year)	0.9%

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This information allowed us to narrow our search down to some of the most prevalent issues that need to be addressed. From the information we concluded that the community members that we serve are older than the state average by a significant margin. 27.4 percent of our residents are below the federal poverty level. Mental health access, which we focused on in 2013, has become less of an issue with only 5.4 percent of the survey respondents indicating that they need access to mental health care. All major behavioral health diagnosis's are well below the state average to include depression, anxiety, and PTSD. We feel that our 2013 Implementation Strategy to focus on behavioral health needs to include hiring a Masters in Social Work has contributed to this improvement.

Alcohol Abuse has also shown a significant decline since our last assessment. Our County is only at 21.3% percent that report abuse which is roughly half of the state average. While this is still a concern we feel that there are most pressing issues to address in our assessment during this three year period. Past efforts will be continued to further reduce the use and abuse of products containing alcohol.

While access to care is trending in a positive direction, diabetes and other co-morbidities continue to run well below state average for our area. This is one of the justifications for us to renew our focus on obesity and diabetes prevention/treatment.

Secondary data was also gathered from the South Dakota Dashboard located at http://www.southdakotadashboard.org. This website provided insights on disability rates, health insurance coverage rates, obesity, and diabetes rates by County. In reviewing disability rates we found that Gregory County was among the top three Counties in the state for disability in vision, hearing, ambulation, and cognition. Gregory County has a disability rate of 18.4 percent. . We as a system have decided to focus on areas that we can influence a reduction in this rate and what we can do as a system to ensure access to care for these individuals.

The South Dakota Dashboard also gave us some insight into the rate of uninsured in our County. Gregory County reported a 17 percent uninsured rate which is significantly higher than the state average of 11.4 percent. This statistic also greatly affects the poor and most vulnerable in our community. South Dakotans living below poverty had a 26.1 percent rate of being uninsured, compared to a 9 percent rate for those living above poverty.

In addition Gregory County has a 31.9 percent obesity rate and a diabetic rate of 10.6 percent. Obesity is a contributing factor of the diabetic rate, but it is not the only one. Other factors that play a role in the development of diabetes include: age, family history, sedentary lifestyle, ethnicity, and socioeconomic status. Avera Gregory will work with our physician partners to screen for these diseases as well as to develop control plans to address the issue.

According to County Health Rankings at http://www.countyhealthrankings.org/app/south-dakota/2016/rankings/gregory/county/outcomes/overall/snapshot Gregory County is ranked 45 out of 66 Counties in the state. Our premature death rates are significantly higher than the national average. This is in part due to our alcohol-impaired driving deaths rate of 25 percent. Other factors also contributing include a 30 percent physical inactivity rate as well as a very low access to exercise

opportunities at 21% compared to the national average of 91%. Our preventable hospital stay rate is also significantly higher than the state and national average.

Evaluation of Impact

Obesity was an identified problem in the 2013 CHNA. Our facility attempted to build a community use gymnasium and a new physical therapy department to work on this issue. The physical therapy department was completed with our funds and has increased quality in rehabilitation and treatment. The community gymnasium and trail system was not supported by the city or county government. This administration attempted to secure multiple grants, to include a Bush Foundation grant, but was denied in the process. We did work with the local grocery store to promote healthy eating choices and sent providers and nurses to teach classes at the local school. The hospital nutritionist started a healthy choices program that provided free education and healthy eating alternatives to community members, but the program has so far been underutilized by our various partners.

Mental health access was identified as an issue. The hospital invested in a new social worker to assist the physicians in mental health counseling. This program has gone extremely well and we feel is a large contributor to the decline in mental health issues reported in our community. We have also utilized coordinated care programs and discharge management programs in conjunction with home health to monitor patients after they leave the health care center. This ensured proper use of medications, a stable living environment, and an assessment of the patient's ability to pay for prescription drugs after discharge. More extensive use of psychiatry and clinic psychology was also used to increase access to mental health treatment within the community. These programs will continue.

Alcohol abuse was the last identified issue within the community. The 2013 assessment found that the community did not have access to events and leisure activities that did not involve the use of recreational alcohol. The hospital partnered with the school to give dangers of drinking seminars throughout the school year. Through the chamber of commerce and with the support of the city the hospital sponsored alcohol free events throughout the year to include events in the park and holiday shows that gave community members the ability to attend entertainment venues without drinking present. We feel that these events contributed to the reduction of reported drinking excess in the community.

This assessment summary is available on the Avera Gregory Hospital website, http://www.avera.org/gregory-hospital/. A copy may also be obtained by contacting the administrative staff of Avera Gregory Hospital, 400 Park Ave., Gregory, SD 57533.

Appendix 1: CHNA Committee Members

Anthony Timanus, MHA, Administrator, Avera Gregory Hospital
Katie Biggins, RN, Director of Patient Services, Avera Gregory Hospital
Sarah Sperl, RN, DON, Avera Gregory Hospital
Dr. Richard Kafka, Chief Medical Officer, Avera Gregory Hospital
Tammy Graesser, Clinic Manager, Avera Medical Group
Jamie Sachtjen, Clinic Manager, Avera Medical Group

Appendix 2: Focus Group Facilitators

Blane Bartling, Gregory City Council
Jessie Biggins, Gregory County Commissioner
Jeff Determan, Gregory High School Principal

This report was prepared for the 27 June 2016 meeting of the Avera Gregory Hospital Board.

Avera Gregory Hospital Board Approval

By: Name and Title Emmett Kotrba, Chairman of the Board

Date: 28JUN16