Avera St. Benedict Health Center

Parkston, SD

Community Health Needs Assessment

2019

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2019 Avera St. Benedict Health Center
Community Health Needs Assessment Summary:
An assessment of Hutchinson County conducted by Avera St. Benedict Health Center

Overview

From November 2018-February 2019, Avera St. Benedict Health Center conducted a Community Health Needs Assessment (CHNA) focusing on the needs of their primary and secondary service areas. The process involved a variety of approaches to collect qualitative and quantitative data through research, interviews, focus groups, survey (electronic and paper versions), and electronic medical record data review. This plan will guide Avera St. Benedict's activities as it moves toward its vision of bold leadership in the transformation of health care to enhance the lives of individuals and communities it serves.

Description of Avera St. Benedict Health Center

Avera St. Benedict was started as a twelve bed facility on February 10, 1934, by the Benedictine Sisters of Sacred Heart Convent and Dr. J.L. Waldner. A new hospital wing opened in 1946 with 34 beds and 12 bassinets. Avera St. Benedict continued to grow and expand by building a new 38 bed acute care hospital in 1965. In August of 1988, St. Benedict purchased the Supervised Living homes and attached the Intermediate Long Term Care Facility in 1989. Additions in 1992, 2005, and 2015 have continued to expand Avera St. Benedict Health Center. Today, Avera St. Benedict is a 25 bed Critical Access Hospital with surgical and obstetrics capabilities. Under one roof are the attached Parkston Certified Rural Health Clinic; a 47 bed long term care facility that provides skilled nursing services; a 27 bed assisted living facility; and a physical therapy wing with wellness center. Avera St. Benedict also owns and operates a licensed daycare off site of the main facility. Avera St. Benedict Health Center also operates Certified Rural Health Clinics in Tripp and Lake Andes, S.D. Outreach to area nursing homes, Hutterite colonies, and consultations at other healthcare facilities are also a part of Avera St. Benedict's medical staff duties.

Avera St. Benedict's primary medical staff includes 4 primary care physicians; 2 certified registered nurse anesthetists, 5 advanced practice providers (PA's and CNP's); and 1 mental health counselor. Additional fully staffed services in the health center include a fully digital radiology department, laboratory, physical/occupational/speech therapy, pastoral care, massage therapy, sports medicine, emergency services, and nursing.

Outpatient services provided by outreach and/or specialist physicians include: Oncology, ENT, Surgery, Pulmonology, Cardiology, Dermatology, Urology, Orthopedics, Audiology, Podiatry, Psychiatry, and Nephrology. Telemedicine is the delivery mechanism for psychiatry, infectious disease, and palliative care. As a part of the Avera Health System, the Avera St. Benedict rural providers have access to cutting edge technology through the Avera eCare Services. Avera St. Benedict has a full complement of eServices with eEmergency, eConsultation, eICU, eStroke, ePharmacy, and eTriage.

Evaluation of Impact of Prior Community Health Needs Assessment

Avera St. Benedict Health Center conducted a CHNA in 2016. The priorities from the prior needs assessment were access to care; behavioral health needs; promoting and increasing preventative medicine and overall wellness; promoting a healthy physical environment and safety; and addressing ongoing chronic disease, obesity, and related health concerns. For each of these prioritized areas, two to ten strategic goals were placed to address the overarching priorities. Avera St. Benedict strives to have these programs and goals incorporated into ongoing operations. Below are the goals, results, and impact of the 2016 implementation plan.

Access to Care

1. Goal #1. Educate the public on services available at Avera St. Benedict Health Center.
    1.1.1. *Result:* Continuous updates to Avera St. Benedict's website and social media page.
    1.1.2. *Impact:* Improved access to care by letting the public have additional avenues to learn about services provided locally.

2. Goal #2. Retain 100% of specialty providers/specialty outreach clinics at Avera St. Benedict Health Center.
    2.1.1. *Result:* Continued working with specialists to gauge physician satisfaction.
    2.1.2. *Impact:* Maintain access to care locally. This will save community members time and dollars associated with saved travel. Avera St. Benedict currently maintains 14 onsite specialties.

3. Goal #3. Train all Avera St. Benedict employees on how to access translation services.
    3.1.1. *Result:* All Avera St. Benedict employees were provided with training on how to access translation service and tools to improve communication with individuals that are non-English speaking. One of Avera St. Benedict's physicians is bilingual.
    3.1.2. *Impact:* Provide the same quality care to individuals regardless of languages spoken.

4. Goal #4. Decrease poor access to medical care due to transportation issues by maintaining outreach programs to populations that have transportation barriers. (Hutterite women, Amish, Homebound Elderly/Individuals).
    4.1.1. *Result:* Avera St. Benedict dedicated a Registered Nurse at .8 FTE and an advanced practice provider at .1 FTE to provide primary care services as needed at local Hutterite Colonies and for the Amish. An RN is dedicated on an as needed basis for the Visiting Nurse program to provide in home services to the homebound elderly.
    4.1.2. *Impact:* Increased access to care for individuals with transportation needs.

Behavioral Health

1. Goal #1. Provide clinical access to mental health/substance use counseling services.
    1.1.1. *Result:* Avera St. Benedict staffs a behavioral health specialist 32 hours per week.
    1.1.2. *Impact:* The service area of Avera St. Benedict has access to quality behavioral health services with generally same day appointment availability.

2. Goal #2. Provide no charge telepsychiatry access at the clinic to youth residents of Our Home, Inc.
    2.1.1. *Result:* Avera St. Benedict works with Our Home, Inc. to provide no charge telepsychiatry access for the youth in need of these services. Avera St. Benedict also works with Avera University Psychiatry Associates to use psychiatry residents for telepsychiatry access for adult patients in need of psychiatry services.
    2.1.2. *Impact:* Decrease travel costs for patients and increase access to psychiatry for kids and adults with significant mental health needs.

3. Goal #3. Provide a facilitator or referral for facilitator for critical incident debriefing for first responders in the primary service area.
    3.1.1. *Result:* Avera St. Benedict provides a counselor at no cost, as needed, for first responder critical incident debriefing to be held at the location of choice of the first responders.
    3.1.2. *Impact:* Retention and resiliency of first responders in the community.

4. Goal #4. Provide a minimum of two behavioral health related community education programs yearly.
    4.1.1. *Result:* Avera St. Benedict provided many free community education programs on behavioral health topics, including grief, diabetes management, substance abuse, depression, etc.
    4.1.2. *Impact:* Decreased stigma surrounding behavioral health topics.

Preventative Medicine and Wellness

1. Goal #1. Provide healthy lifestyle classes to local 4th graders.
    1.1.1. *Result:* Provided Healthy Choice curriculum to 4th graders at Parkston and Andes Central School Districts in 2016 and 2017.
    1.1.2. *Impact:* Educated approximately 75 children on lifestyle choices to prevent chronic illness.

2. Goal #2. Hold an annual Women's Health Day in the community of Parkston
    2.1.1. *Result:* Avera St. Benedict hosted an annual "Pretty in Pink" (Women's Health Day) to help education females on recommended wellness and cancer prevention screenings.
    2.1.2. *Impact:* Approximately 100 women were educated on wellness/preventative screenings.

3. Goal #3. Hold a monthly diabetes support group at Avera St. Benedict Health Center
    3.1.1. *Result:* Avera St. Benedict hosted a free diabetes support group monthly from 2016-2017. Avera St. Benedict then transitioned to a free "Better Choices, Better Health" curriculum that focused on one of three topic areas: all chronic diseases; diabetes; and opioids. Four staff members are trained in the evidenced based "Better Choices, Better Health" curriculum.
    3.1.2. *Impact:* Improve community member's self-management of chronic disease.

4. Goal #4. Provide health screenings or health services at a minimum of three worksites per year.
    4.1.1. *Result:* Collaboration with local businesses results in Avera St. Benedict doing worksite wellness screenings or providing other wellness services to 7 worksites in total.
    4.1.2. *Impact:* Improved population health by providing screening and prevention at worksites; many health issues were caught early as a result, which allowed individuals to follow up with ambulatory management vs inpatient management of medical issues.

5. Goal#5. Provide a minimum of four community education programs/activities yearly that focus on preventative medicine and/or physical activity.
    5.1.1. *Result:* Avera St. Benedict provided community education programs/activities that focused on preventative medicine and/or physical activity. The Wellness Center director will organize potential physical activities that may include running events, biking events, sports tournaments, etc.
    5.1.2. *Impact:* Promoted a cultural of wellness and physical activity for all ages in the community.

6. Goal#6. Provide Annual Wellness Visits in the clinic for Medicare Beneficiaries.
    6.1.1. *Result:* Implemented Annual Wellness Visits in the clinics for Medicare beneficiaries, resulting in 30% of Medicare ACO beneficiaries per year receiving one of these visits.
    6.1.2. *Impact:* Improved preventative screening rates and immunizations for the Medicare population in the community.

7. Goal #7. Provide free blood pressure checks at all clinics, hospital, and wellness center.
    7.1.1. *Results:* No cost blood pressure checks are available in all Avera St. Benedict Heath Center locations.

7.1.2. *Impact:* Early detection improved hypertension control.

8. Goal#8. Add one new fitness class offering at the Wellness Center.
    8.1.1. *Results:* A community member taught a yoga class for a year and half that was open to the public. The Wellness Center added "Fitness on Demand", which is over 1000 virtual classes available 24/7.
    8.1.2. *Impact:* Both of these new opportunities increased participation and added variety for people that use the wellness center at Avera St. Benedict Health Center.

9. Goal#9. Improve screening rates for colon, cervical, and breast cancer among our patient population by 5 percent utilizing June 30, 2016 clinical data as the baseline.
    9.1.1. *Results:* Improved clinic workflows to keep patients more informed on recommended due dates for cancer screenings.
    9.1.2. *Impact:* Breast cancer screening rates are now at 69.1percent and colon cancer screening rates are now at 65.6 percent.

10. Goal#10. Provide a minimum of one community education session on the importance of immunizations across a lifespan.
    10.1.1. *Results:* Community education lectures on immunizations took place for the following: HPV vaccination, influenza, and shingles. Colony outreach nurse, primary care providers went to 9 colonies and completed a Q & A panel about HPV vaccination and how this helps prevent cancers.
    10.1.2. *Impact:* increased awareness and accurate information on immunization recommendations.

11. Goal#11. Dedicate a minimum of 1 day per month on clinical foot care for prevention of adverse health outcomes due to inappropriate care of feet.
    11.1.1. *Result:* Avera St. Benedict Health Center provided nursing staff once per month to help patients with clinical foot care.
    11.1.2. *Impact:* Prevented foot care issues from worsening.

<u>Environment and Safety</u>

1. Goal #1. Provide CPR training to a minimum of 150 community members/agricultural workers.
    1.1.1. *Result:* Provided CPR certification classes to the public in Parkston and on the Hutterite Colonies.
    1.1.2. *Impact:* Avera St. Benedict certified or educated over 150 community/agricultural workers in CPR , which improves the likelihood of positive health outcomes from a cardiac event or farm accident.

2. Goal #2. Provide basic first aid training to a minimum of 150 youth.
    2.1.1. *Result:* Provided basic first aid teaching to farm youth and youth involved in babysitting.
    2.1.2. *Impact:* Over 150 youth complete basic first aid training to improve the likelihood of positive health outcomes from injury.

<u>Chronic Disease, Obesity, and Related Health Concerns</u>

1. Goal #1. Avera St. Benedict serves as a training site location for students in health care professions.
    1.1.1. *Result:* Avera St. Benedict is an active training site for students in the FARM program, RHEPS Program, medical residents, other medical students, physician assistant students, nurse practitioner

students, nursing students, behavioral health students, medical assistant students, health care administration students, etc.

1.1.2. *Impact:* Avera St. Benedict provided training to students from July 2016-January 2019. This has helped increase the pipeline for health professions to assist with long term health care professional recruitment and retention, including having many of these students come back to Avera St. Benedict for careers.

2. Goal #2. Avera St. Benedict will support the Parkston Health Occupation Student Association (HOSA) Chapter.
    2.1.1. *Result:* Avera St. Benedict supports the Parkston HOSA Chapter by providing healthcare advice, health care career education, and helping with fundraising efforts. ASB provides a physician to sit on the HOSA Advisory Board.
    2.1.2. *Impact:* Students get real life experience and exposure to health professions careers. By being involved in HOSA, it allows rural health to maintain viability and relevance.

3. Goal #3. Avera St. Benedict will allow internal and external chronic diseases self-management support groups to use rooms on the health center campus at no cost for meetings.
    3.1.1. *Result:* Avera St. Benedict hosts weekly Weight Watcher's and Alcoholics Anonymous meetings at no charge.
    3.1.2. *Impact:* Access to self-management groups to improve health outcomes.

Description of Community Served

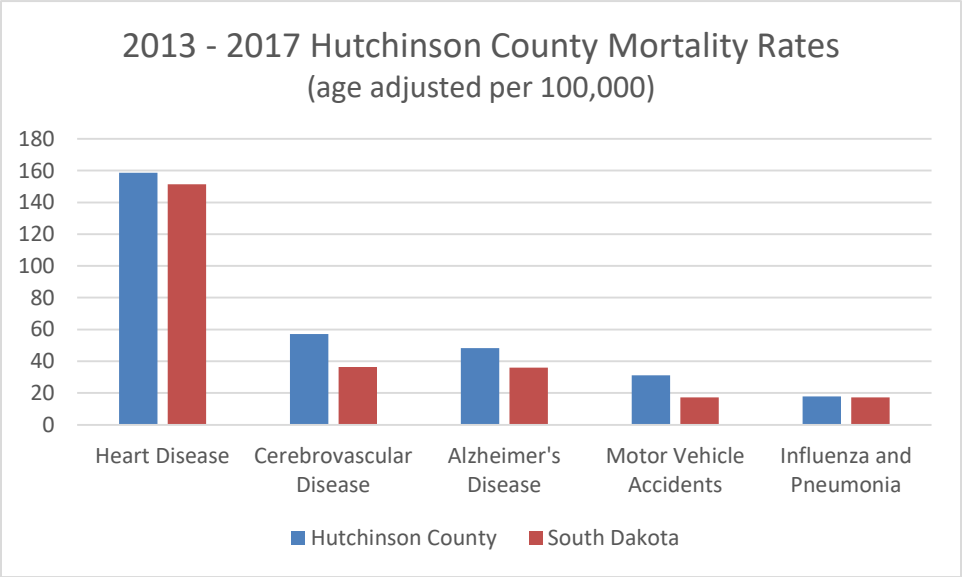
Demographics of Primary and Secondary Service Area

Avera St. Benedict Health Center is located in Parkston, S.D. Parkston is located in Hutchinson County, S.D., in the south central part of the state. Agriculture is the primary economic driver in the county. Avera St. Benedict's primary service area is defined as Hutchinson County. In fiscal year 2018, 60 percent of inpatient discharges and 61 percent of Emergency Room visits were from Hutchinson County. According to the U.S. Census Bureau's 2017 data, the population of Hutchinson County was just over 7,300 people and is predominately White/Caucasian (95%). According to SD Department of Health Statistics in 2016, about 23 percent of the population is over the age of 65. County Health Rankings statistics assesses the unemployment rate of 2.4 percent compared with the state of South Dakota's 2.8 percent unemployment (2016.) County Health Rankings states that the median household income of Hutchinson County is $51,800, which is about $3,100 less than the state's average (2016). The percentage of persons 100 percent below the Federal Poverty Level from 2012-2016 was 13.4 percent, with about ¼ of households being single parent households. County Health Rankings rates high school graduation rates in the county at 87.1 percent and adults over 25 years of age with some post-secondary education at 23.7 percent (2013-2017). The secondary service area, including portions of Douglas, Davison, Bon Homme, Hanson and Charles Mix Counties are demographically similar to Hutchinson County with rural, agricultural lifestyles. In fiscal year 2018, these four counties made up 37 percent of inpatient discharges and 31 percent of Emergency Room visits. According to County Health Rankings and the US Census, Charles Mix County is different from the rest of the service area in that there is a 32 percent Native American population, lower rates of individuals 16 and older in the civilian labor force (58.7%), and more children in poverty (31%). Avera St. Benedict is the primary medical provider for 8 Hutterian Brethren Colonies in the primary and secondary service area, which includes about 550 individuals. Avera St. Benedict Health Center sees about 8,000 patient encounters a year for one or more service at the health center.

Health Status of Hutchinson County

2017 Data from the South Dakota Department of Health () shows mortality in Hutchinson County as compared to the state of South Dakota. The following are mortality indicators where Hutchinson County is either equal to or higher percentage than the State:

- Death due to heart disease
- Death due to motor vehicle accidents
- Death due to cerebrovascular disease
- Death due to influenza and pneumonia
- Death due to Alzheimer's disease



Source: South Dakota Department of Health, Office of Health Statistics

County Health Rankings and US Census identifies the following health indicators as either equal or higher percentage than the State:

- Percentage of adults that report having been diagnosed as having diabetes (2014 County Health Rankings)
- Percentage of adults who are obese based on a BMI of >30 (2019 County Health Rankings)
- Children under 18 years of age in poverty (2019 County Health Rankings)
- Traveling 20 or more minutes to get to work (2010-2014 US Census)

The government website, healthindicators.gov (2016), identifies cancer prevention services. The following three cancer prevention services rank poorer in Hutchinson County than in the State.

- Percent of adult women age 50 and older who report having a mammogram in the past two years
- Percent of adults age 50 and older who have had a sigmoidoscopy/colonoscopy within the past 10 years
- Percent of women age 18 and older who report having a pap smear test in the past three years

The following are additional measures that show access to health care in Hutchinson County:

- According to County Health Rankings (2019), 11 percent of adults under 65 years of age lacked health insurance.
- According to the South Dakota Department of Health (2012-2016), 69.2 percent of expectant mothers receive prenatal care in the first trimester, versus 72 percent in the State
- County Health Rankings (2019) identifies the ratio of population of Hutchinson County to primary care providers at 1230:1. Ratio of population to Advanced Practice Providers (2017) was 670:1.

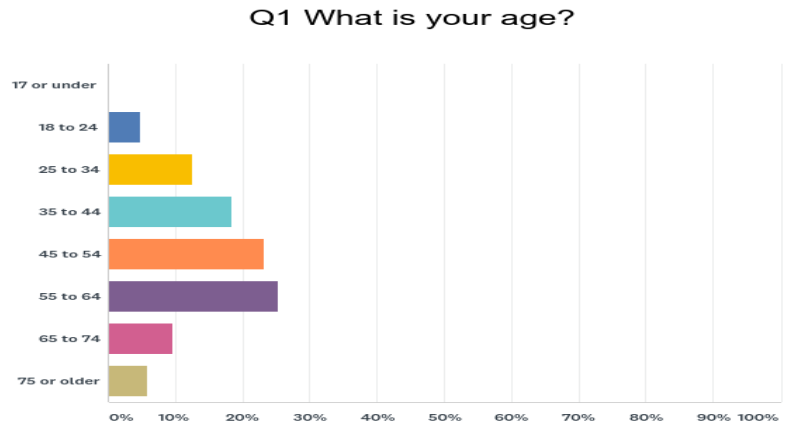
Adolescent health behaviors risks of students in grades 9-12 continue to be high across the state of SD. According to the SD Department of Health Youth Risk Behavior Survey in 2015, 33.3 percent have tried smoking; 37.2 percent have had sexual intercourse, and 60.3 percent have tried alcohol. County wide data was not available for these measures.

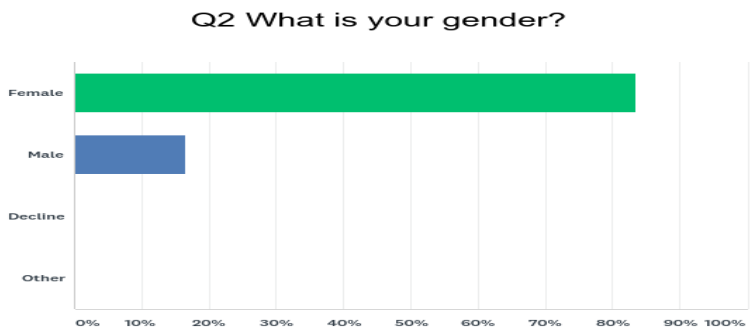
Hutchinson County has multiple health indicators that are better than the State average. Tables of comparable county to state health indicators are in the appendix.

Who was Involved in the Assessment

A variety of individuals and groups of people were involved in the CHNA process from November 2018 through February 2019. Qualitative data was obtained from focus groups with the Parkston Commercial Club and Ministerial Association. The Parkston Commercial Club is a group of businesses in the Parkston area that meet monthly to support the community in a variety of ways, including fundraising for local events and family centered entertainment. Commercial club members are generally involved in many different activities in the community of Parkston, the local school district, and the surrounding area. The Ministerial Association members are clergy from many different congregations, some of which run food and clothing banks for individuals in need. The Ministerial Association meets monthly to work together to address many community and individual needs that are also social determinants of health. Formal individual interviews were conducted with two county health nurses, Andes Central School District Principal; Tripp School District Principal; Parkston School District superintendent; one Hutterite Colony boss; and manager of the only medical clinic in Lake Andes, SD. County health nurses are the only form of public health in Hutchinson County.

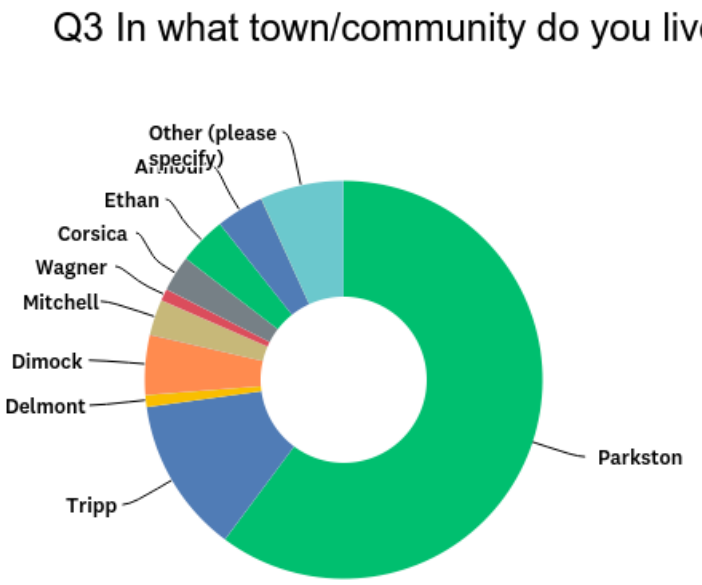
A survey (electronic and paper) was completed by 103 community members. The graphs below depict the community involvement and demographics of the individuals that completed the survey.





Which of the following apply to you or are you involved in?

ANSWER CHOICES	RESPONSES	
Commercial Club	19.00%	19
Ministerial Association	3.00%	3
School District as a parent	34.00%	34
School district as an employee or board member	3.00%	3
Food pantry board or staff	1.00%	1
Food pantry user	0.00%	0
Economic development group	3.00%	3
Sports club or association outside of school	18.00%	18
Community volunteer	32.00%	32
Business owner	19.00%	19
Fire Department or EMS	9.00%	9
User of WIC services	0.00%	0
Other involvement in youth organizations	13.00%	13
Healthcare employee	55.00%	55
None of these apply to me	7.00%	7
Total Respondents: 100		



How the Assessment was Conducted

The assessment process started with a core group of hospital staff and administration discussing the best approach to the CHNA. It was decided to approach the assessment from a multi-factorial data gathering process.

1. Statistical data from reliable data repositories or agencies
2. Formal interviews
3. Information discussions
4. Focus groups
5. Anonymous survey (electronic and paper)
6. Review of clinical/medical services and projects at Avera St. Benedict
7. Assessing needs of the unique Hutterite and Amish populations

Statistical data was gathered in December 2018. After gathering data, it was compiled to be cross referenced with focus group and survey data. Statistical information gathered is in the appendix.

Formal interviews with county health nurse was completed in January 2019. Community health nurses work in the public health realm, provide immunizations and education at schools, work with families to access WIC services, and provide many other community education programs on health issues. Formal interview with a Hutterite Colony boss was conducted in December 2018 to assess the health needs of the Hutterite population that is served by Avera St. Benedict Health Center. Eight colonies are served by Avera St. Benedict. An interview with the Lake Andes clinic manager was completed in November 2018. The clinic manager not only manages the clinic, but also sees patients, is involved in many community organizations in Lake Andes, and has cared for the Native American population in the Lake Andes area for many years. She has a strong understanding of Native American culture and the social determinant of health that correlate to life on an Indian Reservation. School officials at three school districts in Avera St. Benedict primary and secondary service area were also interviewed. These school districts are in the towns of Parkston (November 2018), Tripp (January 2019), and Lake Andes (November 2018). The interviews followed a standardized assessment tool, viewable in the appendix.

An anonymous survey was set up on an electronic platform for people to access. This was a 17 question survey. The survey was sent out electronically through email to a list serve of community members, Rural Office of Community Service, Parkston School District, Tripp School District, and Andes Central School District, Parkston Fire Department and EMS, and accessible through the Avera St. Benedict Facebook page. The same survey was also available via paper copies, which were available at all three of Avera St. Benedict's clinic locations. The survey results are broken down by question in the appendix.

Focus groups were held with the Parkston Commercial Club (December 2018) and Ministerial Association (January 2019). The standardized assessment tool used for the formal interviews was also used in the focus groups. These two focus groups were chosen to make sure that a cross section of the community, including those with limited financial means, where represented.

A review of clinical/medical services and projects was completed by reviewing recently completed grant applications and evaluative reports; reviewing the hospital's health outcome statistics; and using clinical data population health analytics to review preventative care completion rates, cancer screening rates, diabetes health indicator completions rates, delinquent well child follow ups, preventative visits for Medicare beneficiaries, and percentage of patients that receive follow up care after hospitalizations.

After all qualitative and quantitative data was gathered and reviewed this information was used to prioritize health needs. No written comments were received on the prior report, but would have been considered if received.

Health Needs Assessed and Identified

Identified health needs through the data gathering process were stratified into five broad categories to help prioritize areas and realistically choose options for the health center to address.

A community environment that makes exercise easy. The community feels that there are some great resources in Parkston for exercise, but there are gaps. Walking and bike paths, 24/7 indoor exercise access, open gym times at the school, adult sports leagues, and girls running programs were all identified as areas where improvements could be made in the community.

Behavioral health concerns. Behavioral health needs identified during the process included concerns over underage alcohol use, drug use, and vaping in the community. Vaping is an emerging health concern for children, adolescents, and teens. Easier mental health access in school was also identified.

Nutrition deficits. Recurring nutrition related problems were consistent findings. Examples include poor nutrition, unhealthy eating habits, limited fresh foods, food access for the poor, and obesity. Nutritional deficits lead to chronic diseases, increased health care costs, and poor quality of life.

Social determinant of health. Poverty, deterioration of housing, lack of transportation services, lack of appropriate childhood supervision, cost of health care, and limited workforce were consistent themes throughout the data review, groups/interviews, and surveys.

Access to care. Overall access to health care was assessed as being very good in the service area. Some concerns with health care access were reported throughout the assessment process. These included health related services for low income families related to dental and vision care and increased access for urgent health care needs versus emergency department care.

Community Assets Identified

The Avera St. Benedict Health Center's CHNA committee identified several community resources (Appendix). Utilization and referral to these services, resources, and programs will assist Avera St. Benedict to address the population health of the community.

Summaries: Priorities

For each of the broad categories of identified needs, priorities in each category were chosen, which are identified below. The CHNA committee discussed the health needs identified during the community health needs assessment and prioritized the needs based on the following criteria:

1. Estimated feasibility for the health care center to address the issue with current resources
2. Importance the community placed on the need
3. Burden, scope, severity, or urgency of the health need
4. Health disparities associated with the need

Obesity. Obesity was prioritized as an area to address. Themes throughout interviews, focus groups, survey data, and statistical data show that obesity is a problem in our community which directly correlates with exercise and nutrition. The community placed high need in this area and many health disparities link back to obesity. Obesity is a public health issue, so the burden of obesity also speaks to the need to prioritize this area.

Substance use prevention. Substance use prevention needs were prioritized based on community feedback. Elements of behavioral health care have been a consistent theme during prior CHNA's as well. Avera St. Benedict has the current infrastructure to integrate some elements of substance use prevention at no cost as a community benefit. Evaluation of impact of the community going without these services was discussed and how this would potentially leave a void in the community where feedback and data indicate substance use prevention as a valued service. Partnering with health professions students on special projects focused on substance use prevention will also help with the feasibility to help better address emerging trends in substance use in our service area.

Transportation. Transportation was prioritized secondary in importance. The community ecognizes that if community members do not have transportation, health disparities will increase. This also puts increased stress on volunteer EMS members for increase ambulance calls.

Deterioration of homes. Deterioration of homes in the service area was viewed through a feasibility lens. Although Avera St. Benedict cannot address the issue alone, the CHNA committee feels that this can be addressed through partnerships on a small scale. Deterioration of homes is a social determinant of health that can lead to many health care exacerbations, such as asthma and COPD.

After school activities for kids. The criteria of feasibility was utilized to prioritize this need. The CHNA committee feels that through community partnerships this can be addressed on a small scale. Children in grades K-3 are especially vulnerable, as they are "too old" for daycare and "not old enough" to stay home alone. Creating community partnerships to increase afterschool activities can help prevent psychosocial problems and risky youth behavior.

Access to care. Although access to primary medical care was assessed as being an asset in our service area, there are gaps in access. The burden of poor access to health care does not just mean primary medical care, but also dental and vision care for children and low income adults. Lack of vision and dental care can also lead to increased health disparities over a lifetime. Avera St. Benedict will continue to prioritize access to care through partnerships and innovation.

Walking and bike paths. The community voice states that having an environment where exercising is easier is a priority. The feasibility for the health care center to address the issue with current resources was assessed as not realistic at this point in time.

Next Steps

Avera St. Benedict will set goals for the prioritized areas. The goals will be incorporated into an implementation plan that will be presented to the Avera St. Benedict Board of Directors by October 2019. The implementation plan will provide a framework to address the health needs identified and how these can be incorporated into clinical operations. This assessment can be obtained by contacting the administrative offices at Avera St. Benedict Health Center. This community health needs assessment and implementation plan will be available on Avera St. Benedict's website.

Appendix 1

Community Health Needs Assessment Committee Members

1. Rita Blasius, President/CEO, Avera St. Benedict Health Center
2. Denise Muntefering, Vice President of Patient Services, Avera St. Benedict Health Center
3. Melissa Gale, MBA, Avera St. Benedict Health Center Contracted Project Director
4. Angela Hall, RN, Education Coordinator, Avera St. Benedict Health Center
5. Kerri Lutjens, RN, Hutterite Colony Outreach Nurse, Avera St. Benedict Health Center
6. Hali Hutcheson, LPC-MH, Avera St. Benedict Health Center
7. Julie Semmler, Avera Public Relations/Marketing
8. Ember Dale, Wellness Center Director, Avera St. Benedict Health Center
9. Heather Bowar, Care Specialist, Avera St. Benedict Health Center

Appendix 2

Community Assets/Resources

- Avera St. Benedict Health Center: Critical Access Hospital, Certified Rural Health Clinic, Bormann Manor Skilled Nursing Facility, Assisted Living Facility, Licensed Off-Site Child Daycare Center, Wellness Center
- Avera Home Medical
- Vision Care Associates
- Parkston Dental Center
- Parkston Chiropractic Clinic
- Werning Chiropractic Clinic
- Our Home, Inc.
- Parkston Drug
- Parkston School District
- Parkston Commercial Club: Membership includes 66 local businesses and organizations
- Parkston Ministerial Association
- Weight Watchers
- Alcoholics Anonymous
- Parkston Public Library
- Parkston Area Economic Development Corporation
- City of Parkston: Police, Fire, and Emergency Medical Services
- Parkston Public Pool and Parks
- Several in home child care providers
- Parkston Area Foundation
- Parkston Food Pantry, (Also includes Backpack Program)
- Home Instead Senior Care
- Department of Social Services
- Community Health: Includes WIC (Women, Infants, Children) Services and Public Health Education/Awareness

Appendix 3

Needs Discussed During Focus Groups and Interviews

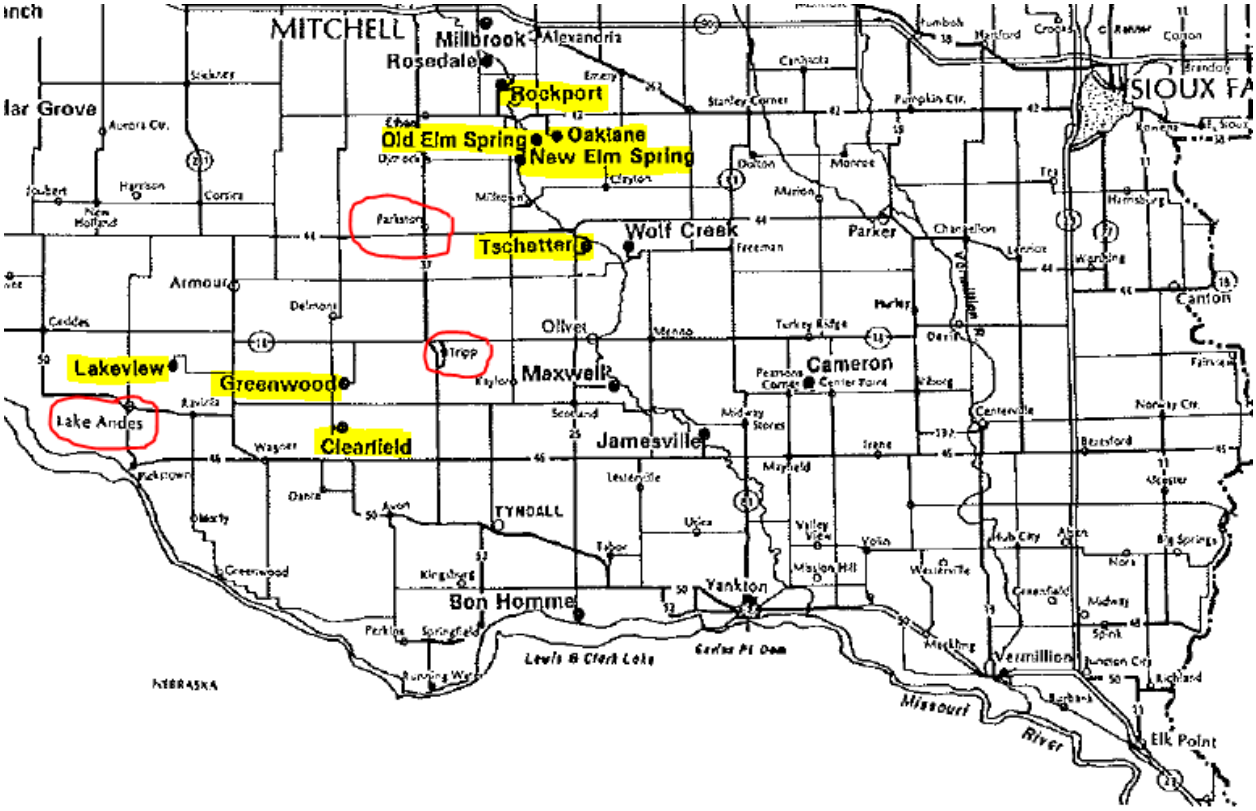
- A community environment that makes exercise easy
  - Walking and bike paths
  - Adult sports leagues year round and accessible 24/7
  - "Girls on the Run" program
  - Open gym time for the public
- Poor nutrition and unhealthy eating habits
- Concerns of obesity
  - Poor nutrition
  - Unhealthy eating habits
  - Limited access to fresh foods, farmer's market, Bountiful Baskets program
  - Support group for weight loss
- Transportation issues/shuttle services
- Cost of health care
  - Inadequate insurance coverage
  - Discounted prices for cost share policies
  - Dental exams for low income families
  - Eye exams for low income families
- Poverty
  - Deterioration of homes
  - Limited workforce
  - High unemployment for Native American population
  - Lack of supervision of children/youth
- Quick Tip health education in schools
- Drug and alcohol use
- Mental health
  - access in schools
  - getting people to use available services
- Lack of after school programs for elementary/middle school children

Appendix 4

Map of South Eastern South Dakota

Hutterite Colonies Highlighted Receive Medical Services at Avera St. Benedict Health Center

Parkston and outreach clinics in Tripp and Lake Andes are circled in red



Appendix 5

Survey Tool used in Focus Groups and Interviews

Avera St. Benedict Health Center is conducting a community health needs assessment in order to better understand the community's health needs. We are thankful for your participation in our assessment and we value your opinion. Please know that your name will not be associated with any comments in the assessment, so please speak candidly.

Interviewer:

Date:

Participant:

Title/Community Relationship:

Questions:

1. What is healthy about our community? What is unhealthy about our community?
2. What services do you feel are needed in our community that do not currently exist?
3. Are there specific populations you are aware of in need of services? What type of services do they need? (For example, a growing Latino population in need of translation services.)
4. Do you see productive collaborations in the community addressing health needs? Examples?
5. What do you believe is the most pressing health care related need facing the community?
6. Do you feel the hospital is addressing this need? How so? Or how do you believe the hospital may begin to address this need?
7. In what ways is the hospital serving the community well? In what ways could the hospital serve the community better?
8. Any other comments you think are important to address in the CHNA?

Appendix 6

2018-2019 ASB Community Health Needs Assessment Survey Results

What is your age?		
Answer Options	**Response Percent**	**Response Count**
18 to 24	4.85%	5
25 to 34	12.62%	13
35 to 44	18.45%	19
45 to 54	23.3%	24
55 to 64	25.24%	26
65 to 74	9.71%	10
75 or older	5.83%	6
answered question		103
skipped question		0

In what town/community do you live?		
Answer Options	**Response Percent**	**Response Count**
Parkston	60.19%	62
Tripp	12.62%	13
Delmont	.97%	1
Lake Andes	0%	0
Dimock	4.85%	5
Kaylor	0.0%	0
Scotland	0.0%	0
Mitchell	2.91%	3
Wagner	0.97%	1
Corsica	2.91%	3
Ethan	3.88%	4
Armour	3.88%	4
Hutterite Colony	0.0%	0
Other (please specify)	6.80%	7
answered question		103
skipped question		0

What is your gender?		
Answer Options	Response Percent	Response Count
Female	83.5%	86
Male	16.5%	17
answered question		103
skipped question		0

Please check any of the following that you think are valuable services for community members		
Answer Options	Response Percent	Response Count
Diabetes Management through support groups, group medical visits, and clinical follow up.	73.53%	75
Planet Heart Screenings	81.37%	83
Specialists that come to Avera St. Benedict either in person or via telemedicine	84.31%	86
The Memory Clinic (diagnoses and follows patient with memory loss, dementia, Alzheimer's, etc.)	70.59%	72
Cancer screening for breast cancer, cervical cancer, lung cancer, prostate cancer, colon cancer	86.27%	88
End of life care options such as home health, visiting nurse, and hospice	78.43%	80
Behavioral health care in the clinic for mental health counseling, substance use, crisis intervention, telepsychiatry	71.57%	73
Critical Incident Debriefing for EMS/First Responders	65.69%	67
Public use of Avera St. Benedict's Wellness Center	81.37%	83
Foot Clinic	70.59%	72
Access to immunizations and flu shots for children and adults	82.35%	84
Worksite wellness programs	59.80%	61
Hospital services provided at worksites	54.90%	56
Alcoholics Anonymous Meetings	67.65%	69

Weight Watchers Meetings	61.76%	63
Health Education in Schools	71.57%	73
Wellness visits at the clinic	71.57%	73
Pre-natal care for pregnant women	72.55%	74
Concussion testing/IMPACT testing	69.61%	71
Tobacco cessation programs	62.75%	64
Teen Pregnancy Prevention	66.67%	68
Agricultural Health and Safety	68.63%	70
Screening for osteoporosis	64.71%	66
Alcohol and Drug prevention groups for kids	67.65%	69
Childhood developmental screening	66.67%	68
Advocates for domestic violence and sexual assault	64.71%	66
Disease Specific Community Education Programs (such as a speaker on heart disease)	61.76%	63
Grief and Loss Groups	70.59%	72
Medical case managers assigned to patients	53.92%	55
Hutterite Colony Nursing Services/Outreach	60.78%	62
Other (please specify)	6.86%	7
	answered question	87
	skipped question	1

Which social determinants of health do you think apply to our community?		
Answer Options	**Response Percent**	**Response Count**
Poverty	11.11%	10
Lack of transportation	8.89%	8
Poor access to healthy and affordable food	2.22%	2
Inability to cook	2.22%	2
Lack of safe exercise availability	3.33%	3
Poor access to walking paths and places to ride bike	16.67%	15
Lack of family and friends as a sense of belonging	5.56%	5
Lack of spiritual connection	2.22%	2
Poor access to health care	0.0%	0
Lack of health insurance	11.11%	10
Lack of child care/daycare	10.0%	9
Drug use, alcohol use, other	26.67%	24
	answered question	90
	skipped question	13

Which of the following apply to your or are you involved in?		
Answer Options	Response Percent	Response Count
Commercial Club	19.00%	19
Ministerial Association	3.0%	3
School District as a parent	34.00%	34
School district as an employee or board member	3.00%	3
Food pantry board or staff	1.0%	1
Food pantry user	0.0%	0
Economic development group	3.0%	0
Sports club or association outside of school	18.0%	18
Community volunteer	32.0%	32
Business owner	19.0%	19
Fire Department or EMS	9.0%	9
User of WIC services	0.0%	0
Other involvement in youth organizations	13.0%	13
Healthcare employee	55.0%	55
None of these apply to me	7.0%	7
Other (please specify) 5%		5
answered question		100
skipped question		3

Please check the ways that you use technology to help with your health.		
Answer Options	Response Percent	Response Count
Using the Avera Patient Portal (Avera Chart)	78.95%	60
Sending emails or electronic messages to your doctor	27.63%	21
Using health apps on your phone or electronic tablet	36.84%	28
Use of wireless devices to send health information to your phone or computer (fit bit, apple watch, etc)	25.0%	19
Using the internet for medical information	61.84%	47
Having a medical visit over your electronic device	3.95%	3
Other (please specify)	2.63%	2
answered question		76
skipped question		27

Which of the following do you think help to promote health professions?		
Answer Options	Response Percent	Response Count
Health Professions Clubs in high school or college	62.37%	58
Scrub Camps or Camp Med in the middle schools	52.69%	49
Job shadowing at the hospital or clinics	83.87%	78
Internships or rotations at medical facilities	81.72%	76
Other (please specify)	3.23%	3
answered question		93
skipped question		10

Do you think there are certain populations of people in our community that are in need of services that they cannot get? (Example-Spanish speaking patients in need of translation services)

Responses were free text, with 29 individuals responding and 74 skipping the question. Themes of the responses are the following:

Number of Responses	Response Theme
14	No/None/NA
4	yes (no/little explanation)
2	transportation for the elderly/ disabled
1	Spanish translation services
6	Cost of health insurance/working poor struggles
2	Native American socioeconomic issues

What Avera St. Benedict Does Well

Responses were free text, with 66 individuals responding. Themes of the responses are the following:

Number of Responses	Response Theme
24	Variety of services; lots of specialists available; access to quality health care
23	Positive patient care experiences
4	Keeping up technology/facility up to date
13	Educating the community/ Community involvement
1	Provides Financial Assistance
1	Other

Something Unhealthy about the Community

Responses were free text, with 46 individuals responding. Themes of the responses are the following:

Number of Responses	Response Theme
16	Alcohol, drug, tobacco/vaping use in teens and adults
6	Lack of access to walking and biking paths or general lack of exercise
8	People choosing unhealthy foods/poor food access/obesity
5	Difficulty fitting in to the community/community morale
11	Other or none

Something Healthy about the Community

Responses were free text, with 50 individuals responding. Themes of the responses are the following:

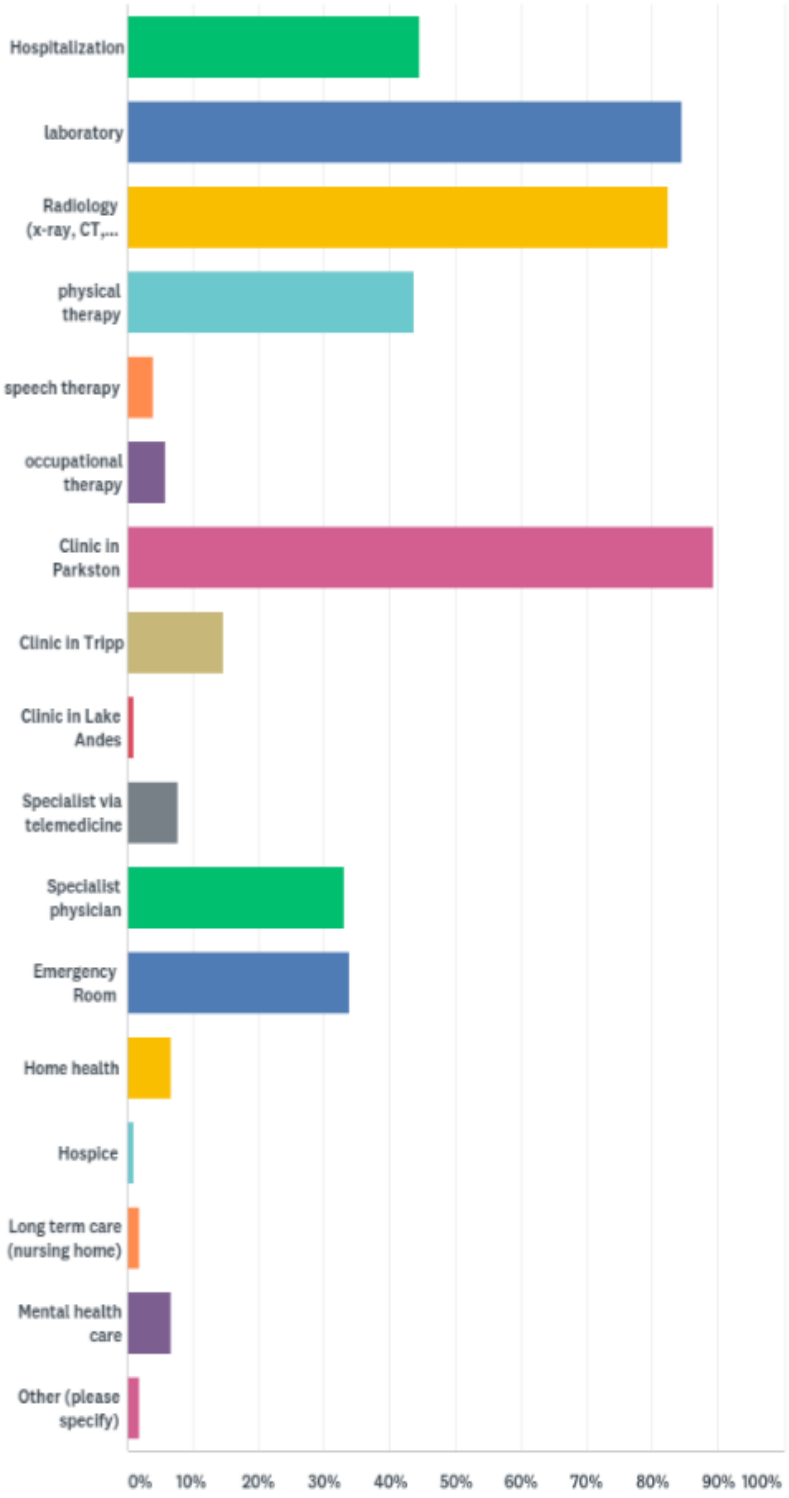
Number of Responses	Response Theme
17	Access to indoor and outdoor exercise opportunities/public parks
7	public health/healthcare access
14	Community helps those in need
9	Cleanliness of community, great school, faith based services
3	Other

A Health Service that you would be OK with if it went away Responses were free text, with 28 individuals responding. Themes of the responses are the following:	
Number of Responses	**Response Theme**
18	None/NA/Keep all services if possible
2	Worksite wellness
4	Specialists/Specialty Services
3	Self-Management (weight watchers/ BCBH/Workshops
1	Other

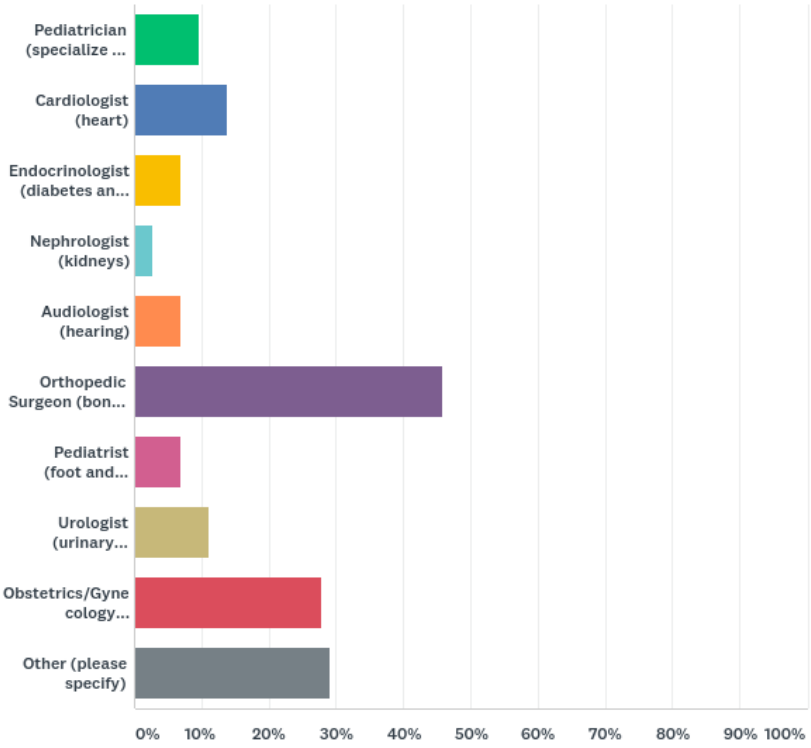
The most important health care issue in our community Responses were free text, with 49 individuals responding. Themes of the responses are the following:	
Number of Responses	**Response Theme**
8	Substance use/mental health care
8	Care for the elderly and children
6	Chronic diseases/Cancer
5	Healthy eating, exercise, preventative services
4	Workforce Needs
6	Obesity
12	Other/unknown

What Avera St. Benedict can do better Responses were free text, with 41 individuals responding. Themes of the responses are the following:	
Number of Responses	**Response Theme**
9	Billing/providing less expensive care
6	Promoting available services
10	Nothing/keep up the good work
2	Healthier/Better meals on site
14	Other

What health care services have you or your immediate family used in the past three years? Please check all that apply:



Q7 What specialists do you use for your health care?



Appendix 7

Health Status Statistics for Hutchinson County, South Dakota

Chronic Health Indicators & Morbidity						
Indicators	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
% of adults that report having been diagnosed as having Diabetes	countyhealthrankings.org	2015		10.00%		9.00%
Age-adjusted cancer incidence rate	sdcancerstats.org	2001-2015	446		464	
% of adults that report fair or poor health	countyhealthrankings.org	2016		11.00%		12.00%
Average number of reported physically unhealthy days per month among adults 18 years of age and over	countyhealthrankings.org	2016		2.9%		3.10%
Average number of reported mentally unhealthy days per month among adults 18 years and over	countyhealthrankings.org	2016		2.6%		2.9%

Preventive Services						
Indicators	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
% of adult women respondents age 50+ who report having mammogram in past 2 years	healthindicators.gov	2016		73.10%		78.70%
%of adults age 50+ who have had a Sigmoidoscopy/Colonoscopy within the past 10 years	healthindicators.gov	2016		48.50%		65.80%
% of women age 18+ who report having a pap smear test in the past 3 years	healthindicators.gov	2016		67.60%		81.30%

Access to Care						
Indicator	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
% of adults under 65 years (18-64) of age without health insurance	census.gov	2015	629	11.00%	82558	12.00%

Diet & Exercise						
Indicators	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
% of adults who are Obese based on BMI of >30	countyhealthrankings.org	2015		31.00%		29.00%

Tobacco Use						
Indicators	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
% of adults 18 years and over that report currently smoking cigarettes	countyhealthrankings.org	2016		14.00%		18.00%

Social Determinants of Health						
Age Group	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
Under 5 years	*doh.sd.gov/statistics*	*2016*	*596*	*8.10%*	61369	*7.10%*
Under age 18	*doh.sd.gov/statistics*	*2016*	*1,807*	*24.50%*	213287	*24.60%*
19-64 years of age	*doh.sd.gov/statistics*	*2016*	3297	45.70%	451993	52.2%
65 years and over	*doh.sd.gov/statistics*	*2016*	*1,668*	*22.60%*	135805	*16.00%*

Sex	Data Source	Year	Hutchinson County		State of SD	
			Number	%	Number	%
Male	*factfinder.census.gov*	2017	3,616		430,587	
Female	*factfinder.census.gov*	2017	3,661		424,857	

Race & Ethnicity						
Age Group	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
White	*doh.sd.gov/statistics*	*2016*	7,103	96.40%	737,070	85.20%

Black or African American	*doh.sd.gov/statistics*	*2016*	78	1.10%	17,302	2.00%
American Indian or Alaska Native	*doh.sd.gov/statistics*	*2016*	98	1.30%	77,711	9.00%
Asian	*doh.sd.gov/statistics*	*2016*	17	0.20%	12,767	1.50%
Native Hawaiian or other Pacific Islander	*doh.sd.gov/statistics*	*2016*	2	0.00%	656	0.10%
Some other race	*factfinder.census.gov*	*2010*	36	0.50%	7477	0.90%
Two or more races	*doh.sd.gov/statistics*	*2016*	70	1.00%	19,948	2.30%
Hispanic or Latino Origin	*factfinder.census.gov*	*2010*	120	1.60%	22,119	2.70%

Unemployment

Indicator	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
Employment – Percent Unemployed (Population age 16 and older that is unemployed)	countyhealthrankings.org	2016		2.40%		2.80%

Economic Security and Financial Resources

Indicators	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
Children under 18 years age in poverty	countyhealthrankings.org	2016		19.00%		17.00%
Median Household Income	countyhealthrankings.org	2016	$51,800		$54,900	
% of persons 100% below the Federal Poverty Level	thedataweb.rm.census.gov	2012-2016		13.40%		14.00%

School Readiness and Education Attainment

Indicators	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
High School Graduation Rate	countyhealthrankings.org	2013-2017		87.10%		91.40%
Percent of adults 25+ with a Bachelor's degree or higher	countyhealthrankings.org	2013-2017		23.70%		27.80%

Children

Indicators	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
Percent of Single parent households	countyhealthrankings.org	2012-2016		23.00%		32.00%
Percent of Children under 18 years of age in household	factfinder.census.gov	2010	720	24.60%	100,118	31.10%

Adequate, affordable, and safe housing						
Indicator	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
Severe Housing Problems - cost issues	countyhealthrankings.org	2015		7%		12%

Food Security						
Indicator	Data Source	Year (Group of Years)	[Name] County		State of SD	
			Number	%	Number	%
Limited Access to Healthy Foods - low income and do not live close to a grocery store	countyhealthrankings.org	2018		3		11
Food Insecurity - people who did not have access to a reliable food source	countyhealthrankings.org	2018		11		12

Transportation						
Indicator	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
Work in county of residence	factfinder.census.gov	2013-2017	2,634		342,085	
Traveling 20 or minutes to get to work	factfinder.census.gov	2010-2014		36.6		31.8

Health Behaviors-Adolescents						
Tobacco Use						
Indicator	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
Students grades 9-12 who had tried smoking	doh.sd.gov/statistics/YRBS	2015				33.3

Sexual Activity						
Indicators	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
Students grades 9-12 who had sexual intercourse	doh.sd.gov/statistics/YRBS	2015				37.2

Alcohol Use						
Indicator	Data Source	Year (Group of Years)	Hutchinson County		State of SD	
			Number	%	Number	%
Students grades 9-12 who have tried alcohol	doh.sd.gov/statistics/YRBS	2015				60.3

Clinical & Community Care						
Preventive Services						
Indicator	**Data Source**	**Year (Group of Years)**	**Hutchinson County**		**State of SD**	
			Number	**%**	**Number**	**%**
Women who are up to date on pap testing	statecancerprfiles.cancer.gov	2016				70.9

Access to Care						
Indicators	**Data Source**	**Year (Group of Years)**	**Hutchinson County**		**State of SD**	
			Number	**%**	**Number**	**%**
Ratio of population to primary care providers	countyhealthrankings.org	2015	1220:01:00		1290:01:00	
Ratio of population to NP or PA	countyhealthrankings.org	2017	670:01:00		801:01:00	

Women and Children						
Indicator	**Data Source**	**Year (Group of Years)**	**Hutchinson County**		**State of SD**	
			Number	**%**	**Number**	**%**
Low Birth Weight Infants	doh.sd.gov/statistics	2012-2016		5.2		6.4
Mothers receiving prenatal care in 1st trimester	doh.sd.gov/statistics	2012-2016		69.2		72

Longterm Outcomes				
Morbidity				
Indicators	**Data Source**	**Year (Group of Years)**	**Hutchinson County**	**State of SD**
			Rate	**Rate**
Adults with diabetes	cdc.gov/communityhealth/profile	2013	10.5	8.2
All types of cancer	cdc.gov/communityhealth/profile	2011-2015	132:100,000	154:100,000

Mortality				
Indicators	**Data Source**	**Year (Group of Years)**	**Hutchinson County**	**State of SD**
			Rate	**Rate**
Death due to Heart disease	doh.sd.gov/statistics	2012-2016	164	152.1
Death due to Cancer	doh.sd.gov/statistics	2012-2017	116.6	157.5
Death due to trachea,bronchus and lung cancer	doh.sd.gov/statistics	2012-2018	25.3	40.8
Death due to Colorectal Cancer	doh.sd.gov/statistics	2012-2019	15.5	16.3
Death due to pancreatic cancer	doh.sd.gov/statistics	2012-2020	6.6	10.8

Death due to breast cancer	doh.sd.gov/statistics	2012-2021	9.5	19
Death due to accidents	doh.sd.gov/statistics	2012-2022	5.9	48.9
Death due to motor vehicle accident	doh.sd.gov/statistics	2012-2023	23.9	16.8
Death due to Alzheimer's disease	doh.sd.gov/statistics	2012-2024	42.1	36.5
Death due to cerebrovascular disease	doh.sd.gov/statistics	2012-2025	56.7	36.5
Death due to diabetes mellitus	doh.sd.gov/statistics	2012-2026	15.7	23.1
Death due to influenza and pneumonia	doh.sd.gov/statistics	2012-2027	24.8	16.9
Death due to suicide	doh.sd.gov/statistics	2012-2028	LNE	18.3

DATE ADOPTED BY AUTHORIZED BODY OF HOSPITAL: 5/20/2019