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# Monument Health Lead-Deadwood Hospital Community Health Implementation Plan

FY 2023 - 2025

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#### VISION

##### **It starts with heart.**

Our vision is to be one team, to listen, to be inclusive,  
and to show we care.

**To do the right thing.** Every time.

#### VALUES

Trust  
Respect  
Compassion  
Community  
Excellence

#### PRIORITIES

Deliver high-quality care  
Provide a caring experience  
Be a great place to work  
Impact our communities  
Be here for generations to come

#### MISSION

**Make a difference.** Every day.

# About Monument Health Lead-Deadwood Hospital

Lead-Deadwood Hospital, located in Deadwood South Dakota, is owned, and operated by Monument Health, a tax exempt, community-based organization that is committed to preserving and strengthening health care for the people in the region. Monument Health offers care in 31 medical specialties and serves 12 communities across western South Dakota. With over 5,000 physicians and caregivers, Monument Health is comprised of 5 hospitals, and 38 medical clinics and specialty centers. Monument Health is a member of the Mayo Clinic Care Network.

Lead-Deadwood Hospital is a critical access hospital located in the northern Black Hills. The hospital offers 24-hour emergency service, inpatient and outpatient care. Lead-Deadwood Hospital is co-located with Monument Health Medical Clinic and Monument Health Urgent Care at 71 Charles Street.

Lead-Deadwood Hospital is dedicated to addressing its outreach objectives of serving the entire community, not only those who come through its doors. Building on a long tradition of service, the hospital utilizes its strengths alongside those of other well-established community partners. This strategy allows the hospital to better understand and reach the most vulnerable sectors of the community, while meeting pressing health care needs. The goal is to improve the community's health status by empowering citizens to make healthy life choices.

# Community Health Improvement Overview

In November 2021, Monument Health contracted with Professional Research Consultants (PRC) to conduct Community Health Needs Assessments (CHNA) for each of its hospital communities including the Rapid City Hospital service area. The CHNA is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents. The assessment provides information so that communities may identify issues of greatest concern and prioritize resources to those areas, thereby making the greatest possible impact on community health status.

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## Community Health Needs Assessment Methodology

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The CHNA report incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey.

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

# Identified Areas of Opportunity

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in Healthy People 2030. From these data, opportunities for health improvement exist in the area with regard to the following health issues. (See also the summary tables presented in the following section).

<b>Access to Healthcare Services</b>	<ul style="list-style-type: none"> <li>• Barriers to access</li> <li>• Appointment availability</li> <li>• Ratings of Local Healthcare</li> </ul>
<b>Cancer</b>	<ul style="list-style-type: none"> <li>• Cancer is the leading cause of death</li> <li>• Skin Cancer Prevalence</li> </ul>
<b>Diabetes</b>	<ul style="list-style-type: none"> <li>• Ranked as a top concern in the Online Key Informant Survey</li> </ul>
<b>Heart Disease &amp; Stroke</b>	<ul style="list-style-type: none"> <li>• Cardiovascular disease is a leading cause of death</li> <li>• Blood Pressure Screening</li> <li>• Blood Cholesterol Screening</li> </ul>
<b>Infant Health &amp; Family Planning</b>	<ul style="list-style-type: none"> <li>• Teen Births</li> </ul>
<b>Injury &amp; Violence</b>	<ul style="list-style-type: none"> <li>• Unintentional Injury Deaths, including Motor Vehicle Crash Deaths</li> <li>• Firearm-Related Deaths</li> <li>• Children’s Bicycle Helmet Use</li> </ul>
<b>Mental Health</b>	<ul style="list-style-type: none"> <li>• “Fair/Poor” Mental Health</li> <li>• Symptoms of Chronic Depression</li> <li>• Suicide Deaths</li> <li>• Ranked as a top concern in the Online Key Informant Survey</li> </ul>
<b>Nutrition, Physical Activity &amp; Weight</b>	<ul style="list-style-type: none"> <li>• Fruit/Vegetable Consumption</li> <li>• Low Food Access</li> <li>• Reliance on Food Banks/Free Meals</li> <li>• Obesity (Adults)</li> <li>• Medical Advice on Weight</li> <li>• Medical Advice on Physical Activity</li> <li>• Ranked as a top concern in the Online Key Informant Survey</li> </ul>

<b>Potentially Disabling Conditions</b>	<ul style="list-style-type: none"> <li>• Caregiving</li> </ul>
<b>Sexually Transmitted Diseases</b>	<ul style="list-style-type: none"> <li>• Gonorrhea Incidence</li> <li>• Chlamydia Incidence</li> </ul>
<b>Substance Abuse</b>	<ul style="list-style-type: none"> <li>• Cirrhosis/Liver Disease Deaths</li> <li>• Illicit Drug Use</li> <li>• Ranked as a top concern in the Online Key Informant Survey</li> </ul>
<b>Tobacco Use</b>	<ul style="list-style-type: none"> <li>• Cigarette Smoking Prevalence</li> <li>• Environmental Tobacco Smoke Exposure at Home</li> </ul>

## Areas of Opportunity Not Chosen for Action

In acknowledging the wide range of priority health issues revealed through the CHNA process, Monument Health Rapid City Hospital determined it could only focus on those which it deemed most pressing, most under-addressed, and within the ability to influence. The areas identified during the CHNA process that will not be directly addressed through this implementation plan are listed below. These identified needs are being addressed by other organizations in the community, are outside our core area of expertise, or require resources that are not available at this time.

<b>Health Priorities Not Chosen for Action</b>	<b>Reason</b>
<b>Infant health and Family Planning</b>	<i>Data from the CHNA revealed that infant mortality and teen births were of greatest concern in this area in the community. However, other community organization are focused on this area.</i>
<b>Injury &amp; violence</b>	<i>RCRH has partnered with Kohl's Cares, Safe &amp; Sound South Dakota, Farm Bureau of South Dakota, and Community Organized Resources in Educating Youth in order to address this area of opportunity. With these partnerships, Rapid City Hospital determined that progress is being made in this area and that other areas of opportunity required more immediate and focused attention.</i>
<b>Nutrition, Physical Activity, &amp; Weight</b>	<i>This issue will not be addressed as a primary need, but will be impacted through the Cancer, Heart Disease &amp; Stroke, and Diabetes priorities.</i>
<b>Potentially Disabling Conditions</b>	<i>This issue will not be addressed as a primary need, but will be impacted through the Cancer, Heart Disease &amp; Stroke, and Diabetes priorities.</i>
<b>Sexually Transmitted Diseases</b>	<i>Data from the CHNA revealed that incidence rates of Chlamydia and Gonorrhea were of greatest concern in this area in the community. This information will be shared with primary care; however, this is not prioritized for action.</i>
<b>Substance Abuse</b>	<i>This issue will not be addressed as a primary need, but will be impacted through the mental health priority.</i>

## Health Priorities and Strategies July 1, 2022 – June 30, 2024

In February 2022, the findings of the Community Health Needs Assessment (CHNA) were presented to the hospital's Patient and Family Advisory Council and other community groups including Live Well Black Hills, Community Services Connection, and Rapid City Community Conversations' Healers and Transformers. These groups reviewed the areas of opportunity identified in the CHNA and provided input on potential priority areas of focus. Based on this feedback and the organization's resources and expertise, Monument Health's Senior Executive leadership determined the following four priority areas as the focus of the next Community Health Improvement Plan; Cancer, Diabetes, Nutrition, Physical Activity and Weight, Heart Disease & Stroke, and Mental Health and Substance Abuse, and Access to Medical Services: Right Care, Right Place.

Rapid City Hospital commits to providing the resources necessary to carry out the goals, objectives, and strategies listed in this Community Health Implementation Plan. These resources include leadership and caregiver time and knowledge, financial support, and planning and reporting assistance.





## **Priority 1: Cancer**

GOAL: Explore, develop, and support opportunities that will positively impact the health of our communities related to cancer prevention and care.

### **OBJECTIVE 1: IMPROVE PATIENT ACCESS AND EXPAND SERVICES**

***Anticipated Impact:*** Improve access to providers, increase early detection and improve outcomes

#### **STRATEGIES:**

Expand Cancer Care institute at Rapid City Hospital: Anticipated completion date- July/ Aug 2023.  
Recruit additional Cancer Care Institute Providers/Specialists.  
Develop Multidisciplinary Lung Cancer Navigation Program and Lung Cancer Tumor Board.  
Establish a High-risk Cancer Clinic, which includes Genetic Counseling and Screening Surveillance.  
Develop Cancer Patient Financial Advocacy Program.  
Increase participation in Cancer Clinical Trials.

### **OBJECTIVE 2: PURSUE ACCREDITATIONS FOR CANCER PROGRAMS**

***Anticipated Impact:*** Standardize practices to improve survival and quality of life for cancer patients and increase recognition of our commitment for patient care

#### **STRATEGIES:**

Recruit an Accreditation Coordinator.  
Perform accreditation audits.  
Pursue Commission on Cancer (CoC) Accreditation (next 3-5 years), Astro Accreditation Program for Excellence (APEX), and National Accreditation for Breast Centers (NAPBC).

### **OBJECTIVE 3: INCREASE AWARENESS OF AVAILABLE CANCER RESOURCES IN OUR COMMUNITY**

#### **PARTNERS**

**ASTRO  
COMMISSION ON CANCER  
NATIONAL ACCREDITATION  
PROGRAM FOR BREAST CENTERS**

**Anticipated Impact:** Gain better community understanding of Cancer Care services available

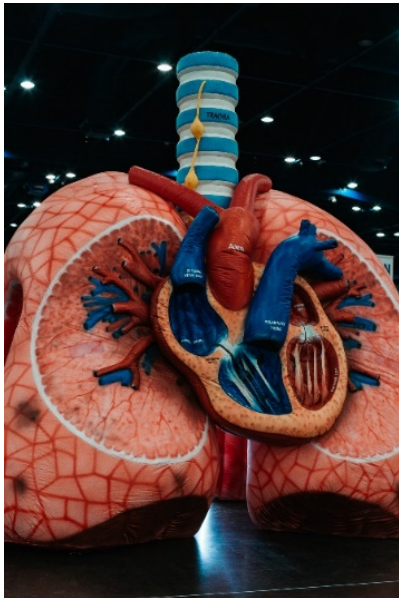
STRATEGIES:

Provide Screenings and Education at Community Health Fairs/Events

Improve patient education materials, offerings, and practices to focus on the importance of cancer prevention and early detection to reduce cancer incidence in our region

Incorporate integrative medicine and therapies program at the Cancer Care Institute

Grow the survivorship program and resources



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## Priority 2: Heart Disease & Stroke

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**GOAL:** Explore, develop, and support opportunities that will positively impact the health of our communities related to heart disease and stroke.

### **OBJECTIVE 1: INCREASE COMMUNITY AND PROVIDER EDUCATION FOR HEART DISEASE & STROKE**

**Anticipated Impact:** Increased participation in health promotion programs and improve health outcomes related to heart disease and stroke.

STRATEGIES:

Provide Screenings and Education at Community Health Fairs/Events

Host an Ongoing Stroke Support Group

Educate providers in the area through the annual Cardiac Symposium and a regular cardiovascular journal club

Increase smoking cessation initiatives by actively identifying patients who smoke prior to discharge

Improve consistency of patient education distributed virtually and through inpatient and outpatient patient encounters – especially for patients with heart failure, atrial fibrillation, or cardiovascular surgery related concerns

## **OBJECTIVE 2: IMPROVE PATIENT ACCESS FOR SPECIALISTS AND PROCEDURES**

***Anticipated Impact:*** Improve access to heart and stroke providers, increase early detection and improve outcomes

### **STRATEGIES:**

Explore opportunities with our Advance Practice Providers to provide outreach in additional communities

Expand Calcium Scoring Screening availability throughout Monument Health service areas

Recruit additional providers for the Heart & Vascular Institute and Neurology Care

Streamline workflow and processes within the newly developed Neurovascular Service Line

Develop tele-stroke platform to continue to improve early Stroke treatment and outcomes

Improve Stroke TPA Door to Needle Time to 50% administration within 45 minutes

Further develop Acute and Chronic Limb Salvage Program

Advance Structural Heart Program into other valve anatomies

Establish access to Advanced Heart Failure Treatments and Therapies

### **PARTNERS**

**DEPARTMENT OF HEALTH  
NATIONAL HEART HEALTH  
PROGRAM**

**MAYO CLINIC**

**ABBOTT NORTHWESTERN  
HOSPITAL**

**OMAHA CHILDREN'S HOSPITAL**

**AMERICAN HEART ASSOCIATION**

## **Priority 3: Diabetes, Nutrition, Physical Activity, and Weight**



Goal: Explore, develop, and support opportunities that will positively impact the health of our communities related to diabetes.

## **OBJECTIVE 1: INCREASE COMMUNITY AWARENESS OF DIABETES PREVENTION AND MANAGEMENT PROGRAMS THAT PROMOTE HEALTHY LIFESTYLE CHOICES**

***Anticipated Impact:*** Increased participation in health promotion programs and improved diabetic health outcomes

### **STRATEGIES:**

Provide screenings and education at community health fairs

Explore partnership with local Native American agency and Community Health Center to market Diabetes Awareness Month

Provide certified trainers for the Monument Health Diabetes Prevention Program and Better Choices Better Health programs

Expand annual Diabetes Symposium to a multi-day event with national speakers, provider education, and community health fair

Implement Lifestyle Medicine to assist individuals and families to adopt and sustain healthy behaviors that affect health and quality of life

## **OBJECTIVE 2: IMPROVE TRANSITION FROM INPATIENT TO OUTPATIENT CARE**

***Anticipated Impact:*** Improved diabetic health outcomes

### **STRATEGIES:**

Develop and implement a system-wide approach to education and documentation in the electronic medical record

Provide education and equipment to patients and follow-up, as appropriate, following discharge

Utilize case managers and clinic champions to assist patients in navigating through social determinants preventing them from managing their disease

Integrate pharmacists in medication management for diabetes patients

### **PARTNERS**

**MONUMENT HEALTH DIABETES  
PREVENTION PROGRAM  
BETTER CHOICES BETTER HEALTH  
COMMUNITY HEALTH CENTER  
RAPID CITY SCHOOL DISTRICT  
DEPARTMENT OF HEALTH**

## **OBJECTIVE 3: IMPROVE PATIENT ACCESS FOR PRIMARY CARE, SPECIALISTS, AND DIAGNOSTIC PROCEDURES**

***Anticipated Impact:*** More access for vulnerable populations, improved productivity in primary care, improved outcomes related to diabetes

### **STRATEGIES:**

Expand outreach clinics to additional communities

Implement a diabetes telehealth program

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## **Priority 4: Mental Health**

**GOAL:** Increase access and awareness of mental health and substance abuse resources and education



## **OBJECTIVE 1: INCREASE AWARENESS OF AVAILABLE MENTAL HEALTH RESOURCES IN**

### **OUR COMMUNITY**

***Anticipated Impact:*** Better understanding of mental health services available

### **STRATEGIES:**

Partner with Call to Freedom to Provide resource marketing related to Human Trafficking

Collaborate with Pennington County Care Campus

Arrange site visits from Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program to provide education on available services

Consider new support groups or ways to provide support to family members of behavioral health patients.  
 Expand Alcoholics Anonymous (AA) meeting availability to patients within our facility, creating an ongoing resource for when they are discharged  
 Expand substance abuse support to groups including Young Life, Wellfully and other local agencies.

**OBJECTIVE 2: EXPAND ACCESS TO MENTAL HEALTH PROVIDERS**

***Anticipated Impact:*** More access for vulnerable populations, improved productivity in primary care, improved outcomes related to mental health

**STRATEGIES:**

Explore grant opportunity for Intermediate Discharge program to support transition of patients back into the community  
 Expand the availability of counselors in Primary Care Facilities  
 Recruit additional Psychiatrists and Psychologists

**OBJECTIVE 3: IMPROVE MENTAL HEALTH SCREENING PROCESS ACROSS THE BLACK HILLS REGION (STARTING WITH MONUMENT HEALTH SYSTEM)**

***Anticipated Impact:*** More people seeking services for mental health related issues

**STRATEGIES:**

Provide Zero Suicide training to additional care areas  
 Partner with Call to Freedom to provide training on detection of Human Trafficking  
 Standardize process for referrals of patients who are identified at-risk

PARTNERS
MONUMENT HEALTH BEHAVIORAL HEALTH CENTER CALL TO FREEDOM COMMUNITY SERVICES CONNECTION BEHAVIOR MANAGEMENT SYSTEM CARE CAMPUS PROTECTION & ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS ALANO SOCIETY

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## **Priority 5: Access to Medical Services: Right Care, Right Place**

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GOAL: Increase access to care and improve existing services to meet current and future demands.



### **OBJECTIVE 1: IMPROVE PATIENT ACCESS**

***Anticipated Impact:*** Improve appointment availability and access to care, including ease of scheduling.

#### **STRATEGIES:**

Improve number of days to 3<sup>rd</sup> next available new patient appointment  
Improve number of days to 3<sup>rd</sup> next available established patient appointment  
Increase number of same day available appointments  
Optimize number of minutes a nurse spends in each patient room  
Increase percentage of appointments self-scheduled as a percentage of total appointments

### **OBJECTIVE 2: IMPROVE PATIENT ACCESS**

***Anticipated Impact:*** Improve Access to care by expanding or optimizing patient care areas

#### **STRATEGIES:**

Utilize NORDIC to Improve Provide/Physician Clinic Flow  
New Primary Care and Urgent Care Clinic to open in Box Elder  
4<sup>th</sup> floor buildout in Rapid City at Flormann Street Clinic to expand Primary Care  
Expansion of Rapid City Hospital's Children's Department  
Expansion of Spearfish Hospital and new Multi-disciplinary Clinic

### **OBJECTIVE 3: IMPROVING HEALTH OF POPULATIONS**

***Anticipated Impact:*** Improve patient outcomes by focusing on delivering care in the right setting.

#### **STRATEGIES:**

Recruit additional Primary Care Providers and Advanced Practice Providers  
Implement Clinical Integrative Network strategies to allow for more focus on preventative medicine

# Adoption of Community Health Implementation Plan

On November 15, 2022, the Monument Health Rapid City Hospital Board of Directors met and discussed this plan for addressing the selected community health priorities identified through the Community Health Needs Assessment process. Upon review, the Board approved the adoption of this plan for Rapid City Hospital and the related resources required to achieve the goals, objectives, and strategies outlined within that work to meet the health needs of the community.

