2024 COMMUNITY HEALTH NEEDS ASSESSMENT

Lawrence, Meade & Pennington Counties, South Dakota

Sponsored by

Monument Health Lead-Deadwood Hospital

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Prepared by
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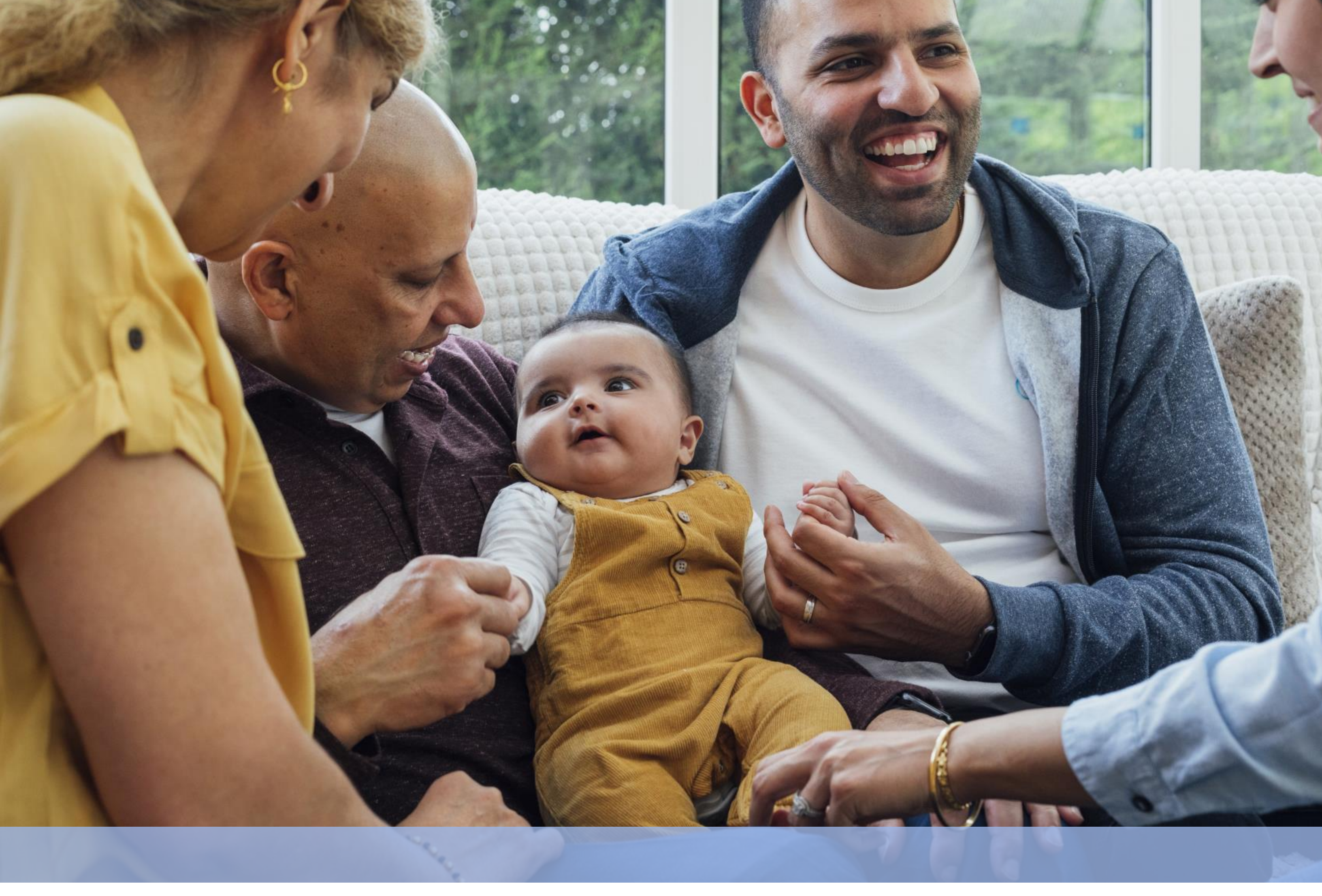


INTRODUCTION

PROJECT OVERVIEW

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2012, 2015, 2018, and 2021, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Monument Health Lead-Deadwood Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

This assessment was conducted on behalf of Monument Health and Monument Health Lead-Deadwood Hospital by Professional Research Consultants, Inc. (PRC), a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

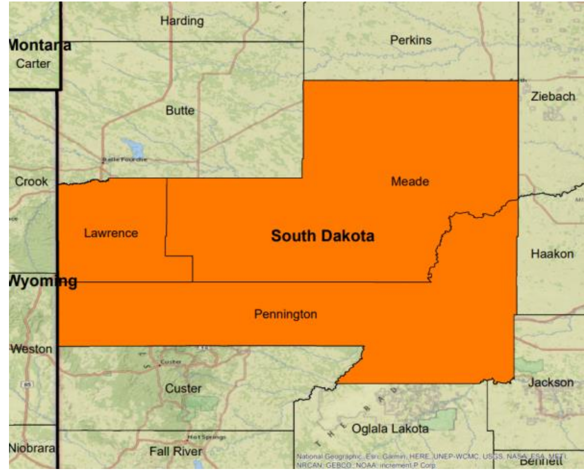
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Monument Health and PRC and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “MHLDH Service Area” or “MHLDH” in this report) is comprised of the following counties: Lawerence, Meade, and Pennington. This area represents the primary service area of Monument Health Lead-Deadwood Hospital and includes those counties from which 80% of the hospital’s admissions are derived; this community definition is illustrated in the following map.



Sample Approach & Design

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

The sample design used for this effort consisted of a random sample of 426 individuals age 18 and older in the MHLDH Service Area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the MHLDH Service Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

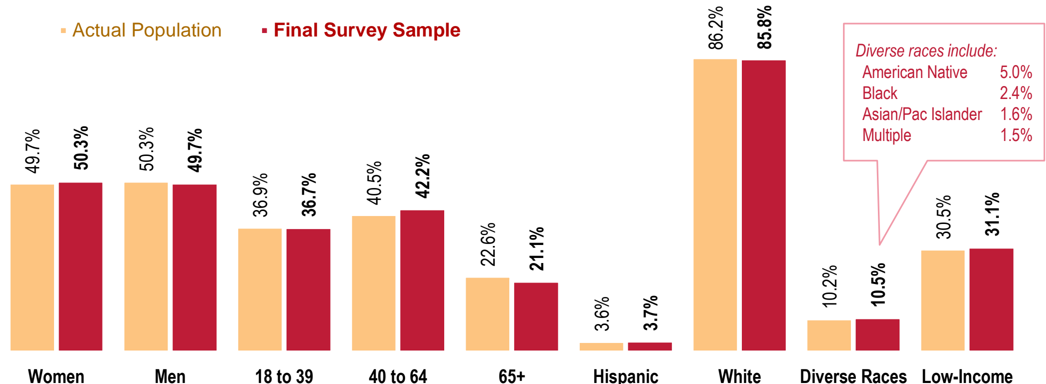
For statistical purposes, the maximum rate of error associated with a sample size of 426 respondents is ±4.9% at the 95 percent confidence level.

Sample Characteristics

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

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

Population & Survey Sample Characteristics
(MHLDH Service Area, 2024)



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

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

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

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Monument Health; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. Note that key informant input was drawn from a broader, regional administration that included Butte, Custer, Fall River, Harding, Lawrence, Meade, Oglala Lakota, and Pennington counties in South Dakota, as well as Crook and Weston counties in Wyoming. In all, 100 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	6
Public Health Representatives	1
Other Health Providers	23
Social Services Providers	22
Other Community Leaders	48

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the organizations outlined below.

- Action for the Betterment of the Community
- Bad River Senior Citizens Center
- BankWest
- Bennett County Hospital
- Bethany Christian Services
- Big Brothers Big Sisters
- Black Hills Area Community Foundation
- Black Hills Powwow Association
- Black Hills Special Services Cooperative
- Box Elder City Government
- Butte County Sheriff's Office
- Central States Fair
- Century 21/Spearfish Realty
- City of Hulett
- City of Kadoka
- City of Philip
- City of Rapid City
- Coca-Cola
- Complete Health
- Cornerstone Apartments
- Cornerstone Rescue Mission
- CUH Advisory Council
- Custer County Library
- Fall River Auditor and Welfare Office
- Feeding South Dakota
- Foundation For Health

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

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

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Benchmark Data

Trending

Similar surveys were administered in the MHLDH Service Area in 2012, 2015, 2018, and 2021 by PRC on behalf of Monument Health and Monument Health Lead-Deadwood Hospital. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Monument Health System Data

Because this survey was administered more broadly throughout the region, a comparison is also provided to the full Monument Health service area (referred to as “Monument Health” or “MH” in this report). These data include Butte, Custer, Fall River, Harding, Lawrence, Meade, Oglala Lakota, and Pennington counties in South Dakota, and Crook and Weston counties in Wyoming.

South Dakota Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030

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

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

Determining Significance

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

Information Gaps

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

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

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

Public Comment

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

IRS Form 990, Schedule H Compliance

For nonprofit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2022)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	4
Part V Section B Line 3b Demographics of the community	26
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	117
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	11
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	12
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	124

SUMMARY OF FINDINGS

Significant Health Needs of the Community

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

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

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

— continued on the following page —

AREAS OF OPPORTUNITY (continued)	
INFANT HEALTH & FAMILY PLANNING	▪ Infant Deaths ▪ Teen Births
INJURY & VIOLENCE	▪ Falls [Age 65+] Deaths ▪ Violent Crime Experience ▪ Intimate Partner Violence
MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Diagnosed Depression ▪ Symptoms of Chronic Depression ▪ Stress ▪ Suicide Deaths ▪ Receiving Treatment for Mental Health ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: *Mental Health* ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Food Insecurity ▪ Low Food Access ▪ Leisure-Time Physical Activity ▪ Overweight & Obesity [Adults]
SUBSTANCE USE	▪ Alcohol-Induced Deaths ▪ Cirrhosis/Liver Disease Deaths ▪ Unintentional Drug-Induced Deaths ▪ Illicit Drug Use ▪ Key Informants: *Substance Use* ranked as a top concern.
TOBACCO USE	▪ Use of Vaping Products

Community Feedback on Prioritization of Health Needs

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

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

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

Hospital Implementation Strategy

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

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

Summary Tables: Comparisons With Benchmark Data

Reading the Summary Tables

In the following tables, Monument Health Lead-Deadwood Hospital Service Area (MHLDH) results are shown in the larger, gray column.

The columns to the right of the MHLDH column provide trending, as well as comparisons between service area data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether the MHLDH Service Area compares favorably (☼), unfavorably (☂), or comparably (☁) to these external data.

TREND SUMMARY

(Current vs. Baseline Data)

SURVEY DATA INDICATORS:

Trends for survey-derived indicators represent significant changes since 2012 (or earliest available data).

OTHER (SECONDARY) DATA INDICATORS:

Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade).

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

SOCIAL DETERMINANTS	MHLDH	MHLDH vs. BENCHMARKS				TREND
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	
Linguistically Isolated Population (Percent)	0.3	0.3	1.0	3.9		
Population in Poverty (Percent)	11.2	13.9	12.3	12.5	8.0	
Children in Poverty (Percent)	14.4	18.3	15.5	16.7	8.0	
No High School Diploma (Age 25+, Percent)	5.4	6.9	7.3	10.9		
Unemployment Rate (Age 16+, Percent)	1.8	2.1	1.9	4.5		3.8
% Unable to Pay Cash for a $400 Emergency Expense	25.5	25.3		34.0		16.6
% Worry/Stress Over Rent/Mortgage in Past Year	32.6	32.6		45.8		26.0
% Unhealthy/Unsafe Housing Conditions	10.4	12.2		16.4		2.6
% Homeless in the Past Two Years	7.2	6.6				2.1
Population With Low Food Access (Percent)	27.8	27.7	29.1	22.2		
% Food Insecure	28.4	29.9		43.3		17.7

better similar worse

OVERALL HEALTH	MHLDH	MHLDH vs. BENCHMARKS				TREND
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	
% "Fair/Poor" Overall Health	19.4	20.0	15.0	15.7		12.4

better similar worse

ACCESS TO HEALTH CARE SERVICES	MHLDH	vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
		MHLDH vs. BENCHMARKS				
% [Age 18-64] Lack Health Insurance	**17.3**	16.1	8.6	8.1	7.6	14.2
% Difficulty Accessing Health Care in Past Year (Composite)	**50.7**	50.3		52.5		40.3
% Cost Prevented Physician Visit in Past Year	**24.9**	23.0	7.6	21.6		15.0
% Cost Prevented Getting Prescription in Past Year	**15.9**	16.1		20.2		10.8
% Difficulty Getting Appointment in Past Year	**28.0**	27.2		33.4		17.6
% Inconvenient Hrs Prevented Dr Visit in Past Year	**15.3**	16.9		22.9		12.6
% Difficulty Finding Physician in Past Year	**14.2**	15.7		22.0		8.6
% Transportation Hindered Dr Visit in Past Year	**10.7**	11.7		18.3		8.8
% Language/Culture Prevented Care in Past Year	**1.7**	2.2		5.0		0.1
% Stretched Prescription to Save Cost in Past Year	**18.4**	18.3		19.4		14.1
% Difficulty Getting Child's Health Care in Past Year	**7.9**	10.0		11.1		4.5
Primary Care Doctors per 100,000	**101.1**	86.0	79.9	74.9		
% Have a Specific Source of Ongoing Care	**73.1**	72.0		69.9	84.0	73.6
% Routine Checkup in Past Year	**66.7**	67.0	75.8	65.3		59.7
% [Child 0-17] Routine Checkup in Past Year	**80.2**	82.9		77.5		79.3
% Two or More ER Visits in Past Year	**13.1**	15.2		15.6		10.6

ACCESS TO HEALTH CARE SERVICES (continued)	MHLDH	MHLDH vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% Outmigration for Care	**21.8**	22.1				28.8
% Rate Local Health Care "Fair/Poor"	**18.5**	19.2		11.5		16.5

better similar worse

CANCER	MHLDH	MHLDH vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000 (Age-Adjusted)	**147.1**	153.7	148.9	146.5	122.7	160.8
Lung Cancer Deaths per 100,000 (Age-Adjusted)	**33.5**	35.2	34.5	33.4	25.1	
Female Breast Cancer Deaths per 100,000 (Age-Adjusted)	**20.1**	18.7	19.1	19.4	15.3	
Prostate Cancer Deaths per 100,000 (Age-Adjusted)	**20.3**	22.0	18.7	18.5	16.9	
Colorectal Cancer Deaths per 100,000 (Age-Adjusted)	**12.3**	13.3	14.0	13.1	8.9	
Cancer Incidence per 100,000 (Age-Adjusted)	**414.6**	411.6	457.8	442.3		
Lung Cancer Incidence per 100,000 (Age-Adjusted)	**54.0**	54.8	55.9	54.0		
Female Breast Cancer Incidence per 100,000 (Age-Adjusted)	**129.6**	125.2	123.8	127.0		
Prostate Cancer Incidence per 100,000 (Age-Adjusted)	**87.1**	87.3	123.2	110.5		
Colorectal Cancer Incidence per 100,000 (Age-Adjusted)	**34.9**	35.7	39.8	36.5		
% Cancer	**10.0**	10.0	10.6	7.4		11.0

CANCER (continued)	MHLDH	MHLDH vs. BENCHMARKS vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% [Women 50-74] Breast Cancer Screening	**83.2**	83.8	72.9	64.0	80.5	75.9
% [Women 21-65] Cervical Cancer Screening	**69.7**	67.7		75.4	84.3	79.4
% [Age 45-75] Colorectal Cancer Screening	**73.4**	71.1	69.9	71.5	74.4	63.7

better similar worse

DIABETES	MHLDH	MHLDH vs. BENCHMARKS vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Diabetes Deaths per 100,000 (Age-Adjusted)	**19.7**	25.9	26.4	22.6		15.1
% Diabetes/High Blood Sugar	**8.7**	10.2	9.1	12.8		11.7
% Borderline/Pre-Diabetes	**13.3**	12.8		15.0		6.7
Kidney Disease Deaths per 100,000 (Age-Adjusted)	**4.0**	5.4	6.0	12.8		4.7
% Kidney Disease	**2.6**	3.5	2.6	4.1	11.4	1.9

better similar worse

DISABLING CONDITIONS	MHLDH	MHLDH vs. BENCHMARKS vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	**49.6**	50.8				38.3
% Activity Limitations	**31.2**	30.0		27.5		23.5
% High-Impact Chronic Pain	**25.7**	24.7		19.6	6.4	18.0

DISABLING CONDITIONS (continued)	MHLDH	MHLDH vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% Sciatica/Chronic Back Pain	28.9	27.8				23.6
% [50+] Arthritis/Rheumatism	40.3	38.6				39.9
% [50+] Osteoporosis	14.7	14.9			5.5	8.9
Alzheimer's Disease Deaths per 100,000 (Age-Adjusted)	32.8	31.8	38.8	30.9		25.9
% Caregiver to a Friend/Family Member	22.4	23.0		22.8		25.8

better similar worse

HEART DISEASE & STROKE	MHLDH	MHLDH vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Heart Disease Deaths per 100,000 (Age-Adjusted)	148.6	155.7	156.5	164.4	127.4	143.2
% Heart Disease	8.3	9.6	7.2	10.3		6.6
Stroke Deaths per 100,000 (Age-Adjusted)	28.3	31.4	33.8	37.6	33.4	33.1
% Stroke	3.2	2.9	2.6	5.4		3.6
% High Blood Pressure	43.0	43.3	33.5	40.4	42.6	36.7
% High Cholesterol	34.6	34.6		32.4		33.6
% 1+ Cardiovascular Risk Factor	88.8	89.4		87.8		85.5

better similar worse

INFANT HEALTH & FAMILY PLANNING	MHLDH	MHLDH vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Teen Births per 1,000 Females 15-19	23.5	26.0	20.0	16.6		
Low Birthweight (Percent of Births)	7.4	7.5	6.9	8.3		
Infant Deaths per 1,000 Births	7.0	8.0	6.4	5.5	5.0	6.3

better similar worse

INJURY & VIOLENCE	MHLDH	MHLDH vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Unintentional Injury Deaths per 100,000 (Age-Adjusted)	49.2	57.5	52.7	51.6	43.2	43.9
Motor Vehicle Crash Deaths per 100,000 (Age-Adjusted)	12.6	17.4	15.7	11.4	10.1	
[65+] Fall-Related Deaths per 100,000 (Age-Adjusted)	107.8	113.7	105.9	67.1	63.4	
Homicide Deaths per 100,000 (Age-Adjusted)	4.4	5.1	3.8	5.9	5.5	
% Victim of Violent Crime in Past 5 Years	5.7	5.7		7.0		2.8
% Victim of Intimate Partner Violence	19.4	18.7		20.3		10.7

better similar worse

MENTAL HEALTH	MHLDH	MHLDH vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	**25.4**	22.0		24.4		5.0
% Diagnosed Depression	**29.5**	26.5	17.9	30.8		14.9
% Symptoms of Chronic Depression	**41.8**	40.7		46.7		20.3
% Typical Day Is "Extremely/Very" Stressful	**19.0**	17.5		21.1		7.6
Suicide Deaths per 100,000 (Age-Adjusted)	**24.6**	26.1	20.4	13.9	12.8	18.4
Mental Health Providers per 100,000	**306.4**	272.4	227.0	313.7		
% Receiving Mental Health Treatment	**23.9**	21.8		21.9		13.9
% Unable to Get Mental Health Services in Past Year	**9.4**	9.8		13.2		1.9

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	MHLDH	MHLDH vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	**27.2**	29.2		30.0		23.3
% No Leisure-Time Physical Activity	**25.3**	26.1	23.5	30.2	21.8	19.3
% Meet Physical Activity Guidelines	**28.3**	27.7	21.7	30.3	29.7	20.4
% [Child 2-17] Physically Active 1+ Hours per Day	**51.8**	52.1		27.4		53.8
% Overweight (BMI 25+)	**72.2**	71.7	72.2	63.3		73.1
% Obese (BMI 30+)	**45.3**	46.8	36.8	33.9	36.0	27.7

NUTRITION, PHYSICAL ACTIVITY & WEIGHT (continued)	MHLDH	MHLDH vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% [Child 5-17] Overweight (85th Percentile)	25.5	28.9		31.8		32.0
% [Child 5-17] Obese (95th Percentile)	15.3	17.7		19.5	15.5	8.6

better similar worse

ORAL HEALTH	MHLDH	MHLDH vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% Have Dental Insurance	64.9	64.0		72.7	75.0	60.0
% Dental Visit in Past Year	65.2	63.6	69.7	56.5	45.0	59.5
% [Child 2-17] Dental Visit in Past Year	79.6	75.8		77.8	45.0	78.4

better similar worse

RESPIRATORY DISEASE	MHLDH	MHLDH vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Lung Disease Deaths per 100,000 (Age-Adjusted)	38.2	39.7	41.9	38.1		44.7
Pneumonia/Influenza Deaths per 100,000 (Age-Adjusted)	12.0	13.7	16.3	13.4		12.9
COVID-19 Deaths per 100,000 (Age-Adjusted)	83.6	90.1	127.0	85.0		
% Asthma	13.2	14.4	8.3	17.9		11.4

RESPIRATORY DISEASE (continued)	MHLDH	MHLDH vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% [Child 0-17] Asthma	8.0	6.8		16.7		9.0
% COPD (Lung Disease)	5.2	5.1	6.9	11.0		15.2

better similar worse

SEXUAL HEALTH	MHLDH	MHLDH vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Chlamydia Incidence per 100,000	558.7	614.4	567.1	495.0		
Gonorrhea Incidence per 100,000	400.3	461.8	337.1	194.4		

better similar worse

SUBSTANCE USE	MHLDH	MHLDH vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000 (Age-Adjusted)	24.0	31.4	20.8	11.9		15.6
Cirrhosis/Liver Disease Deaths per 100,000 (Age-Adjusted)	23.6	30.4	13.4	12.5	10.9	
% Excessive Drinking	16.8	17.2	20.3	34.3		17.7
Unintentional Drug-Induced Deaths per 100,000 (Age-Adjusted)	7.2	7.2	7.6	21.0		5.0
% Used an Illicit Drug in Past Month	5.2	4.2		8.4		0.8
% Used a Prescription Opioid in Past Year	15.0	15.9		15.1		20.2

SUBSTANCE USE (continued)	MHLDH	vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
		MHLDH vs. BENCHMARKS				
% Ever Sought Help for Alcohol or Drug Problem	**6.5**	(similar) 6.7		(similar) 6.8		(similar) 4.6
% Personally Impacted by Substance Use	**41.7**	(similar) 41.6		(similar) 45.4		(similar) 37.7

better · similar · worse

TOBACCO USE	MHLDH	vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
		MHLDH vs. BENCHMARKS				
% Smoke Cigarettes	**16.0**	(similar) 17.7	(similar) 14.1	(better) 23.9	(worse) 6.1	(better) 23.1
% Someone Smokes at Home	**13.9**	(similar) 14.1		(similar) 17.7		(similar) 12.0
% Use Vaping Products	**13.4**	(similar) 12.1	(worse) 6.6	(better) 18.5		(worse) 4.6

better · similar · worse

DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population-based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

COMMUNITY CHARACTERISTICS

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

Total Population
(Estimated Population, 2018-2022)

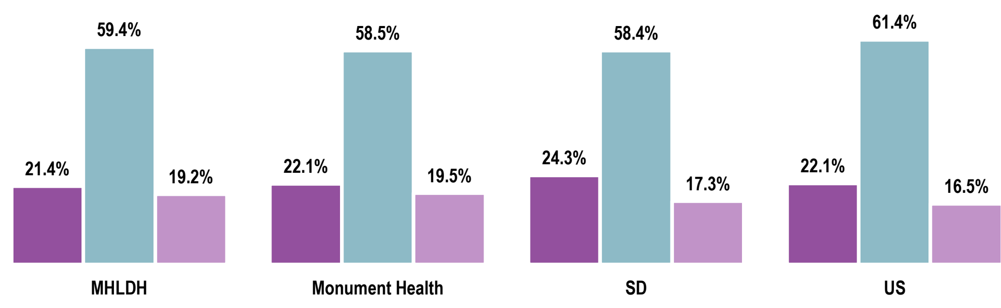
	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
MHLDH Service Area	166,403	7,047.75	24
Monument Health	221,365	22,612.25	10
South Dakota	890,342	75,807.90	12
United States	331,097,593	3,533,269.34	94

Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2024 via SparkMap (sparkmap.org).

Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

Total Population by Age Groups
(2018-2022)



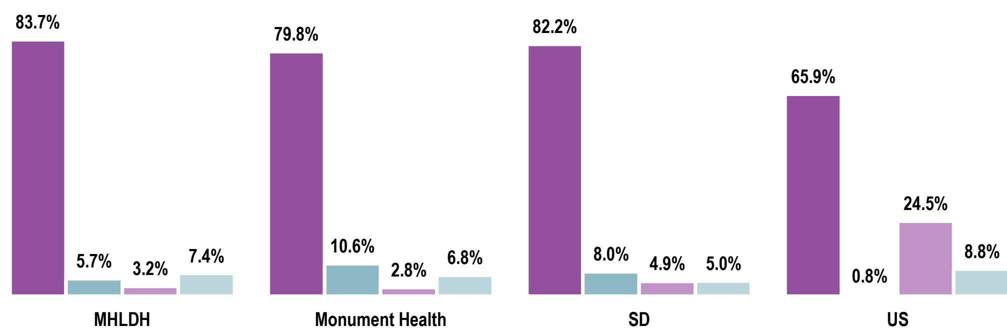
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2024 via SparkMap (sparkmap.org).

Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community.

Race reflects those who identify with a single race category, regardless of Hispanic origin. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Total Population by Race Alone
(2018-2022)

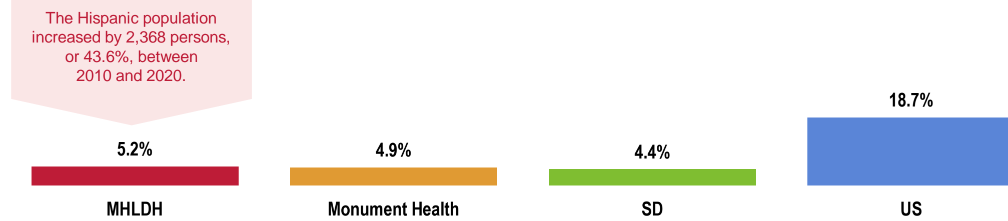


Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2024 via SparkMap (sparkmap.org).

Notes:
- "Diverse Races" includes those who identify as American Indian or Alaska Native, Asian, or Native Hawaiian/Pacific Islander, without Hispanic origin.

Hispanic Population
(2018-2022)

The Hispanic population increased by 2,368 persons, or 43.6%, between 2010 and 2020.



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2024 via SparkMap (sparkmap.org).

Notes:
- People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Social Determinants of Health

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

– Healthy People 2030 (https://health.gov/healthypeople)

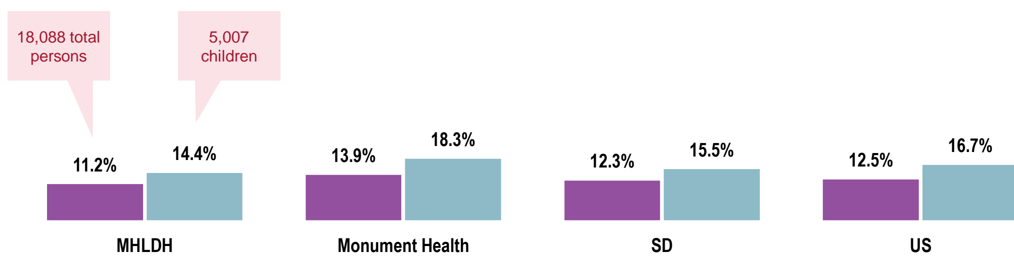
Income & Poverty

Poverty

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to health status.

The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions.

Percent of Population in Poverty
(2018-2022)
Healthy People 2030 = 8.0% or Lower

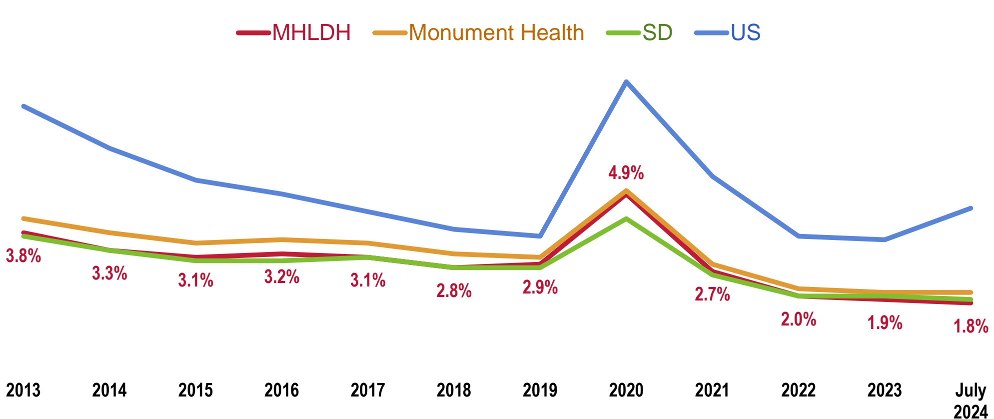


Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Employment

Note the following trends in unemployment data derived from the US Department of Labor.

Unemployment Rate



Sources: • US Department of Labor, Bureau of Labor Statistics.
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2024 via SparkMap (sparkmap.org).
Notes: • Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

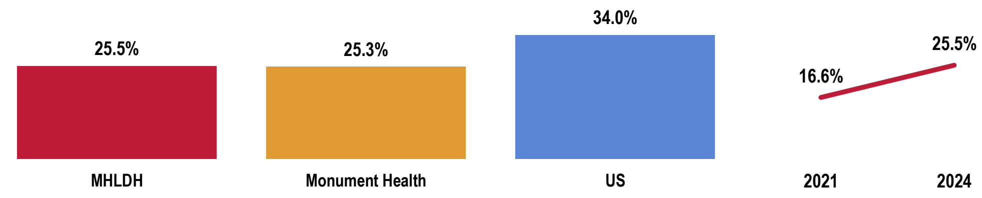
Financial Resilience

PRC SURVEY ▶ "Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

The following charts detail "no" responses in the MHLDH Service Area in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, income [based on poverty status], and race/ethnicity).

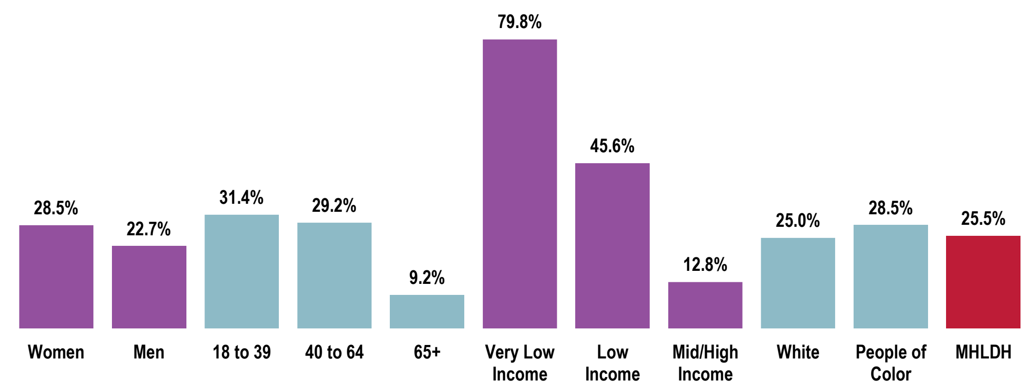
Do Not Have Cash on Hand to Cover a $400 Emergency Expense

MHLDH Service Area



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 53]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(MHLDH Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

INCOME & RACE/ETHNICITY

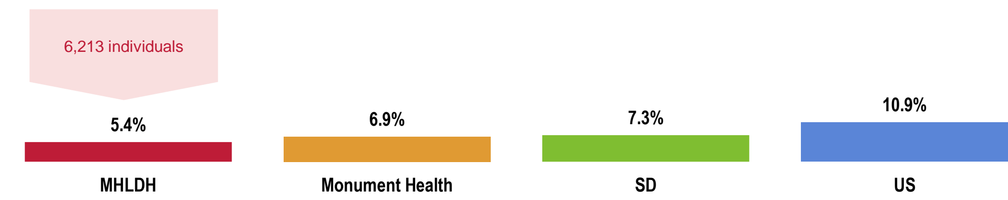
INCOME ► Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2023 guidelines place the poverty threshold for a family of four at $30,000 annual household income or lower). In sample segmentation: "very low income" refers to community members living in a household with defined poverty status; "low income" refers to households with incomes just above the poverty level and earning up to twice (100%-199% of) the poverty threshold; and "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. "White" reflects those who identify as White alone, without Hispanic origin. "People of Color" includes those who identify as Hispanic, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races.

Education

Education levels are reflected in the proportion of our population without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes.

Population With No High School Diploma
(Adults Age 25 and Older; 2018-2022)



Sources: • US Census Bureau American Community Survey, 5-year estimates.
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2024 via SparkMap (sparkmap.org).

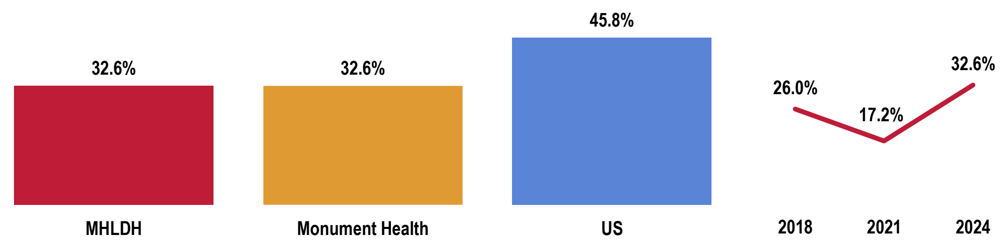
Housing

Housing Insecurity

PRC SURVEY ▶ "In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year

MHLDH Service Area



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 56]
• 2023 PRC National Health Survey, PRC, Inc.

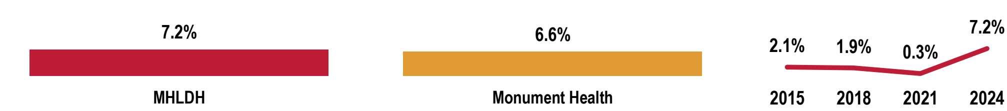
Notes: • Asked of all respondents.

Experience of Homelessness

PRC SURVEY ▶ "Has there been any time in the past two years when you were living on the street, in a car, or in a temporary shelter?"

Lived on the Street, in a Car, or in a Temporary Shelter at Some Point in the Past Two Years

MHLDH Service Area



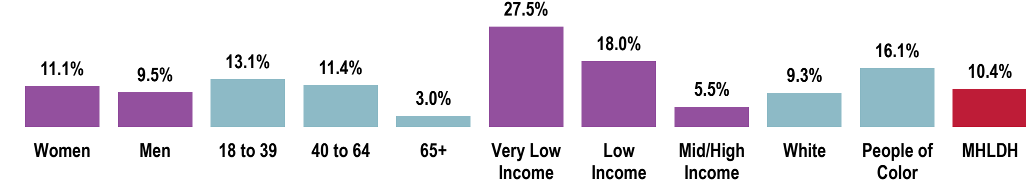
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 318]
Notes: ● Asked of all respondents.

Unhealthy or Unsafe Housing

PRC SURVEY ▶ "Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

Unhealthy or Unsafe Housing Conditions in the Past Year (MHLDH Service Area, 2024)

Among homeowners 6.3%
Among renters 13.5%



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 55]
Notes: ● Asked of all respondents.
● Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Food Insecurity

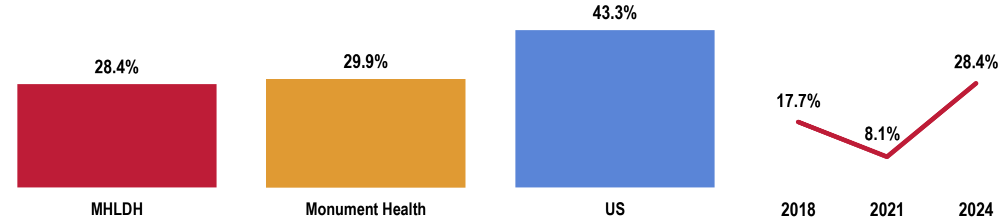
PRC SURVEY ▶ "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

- 'I worried about whether our food would run out before we got money to buy more.'
- 'The food that we bought just did not last, and we did not have money to get more.'"

Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.

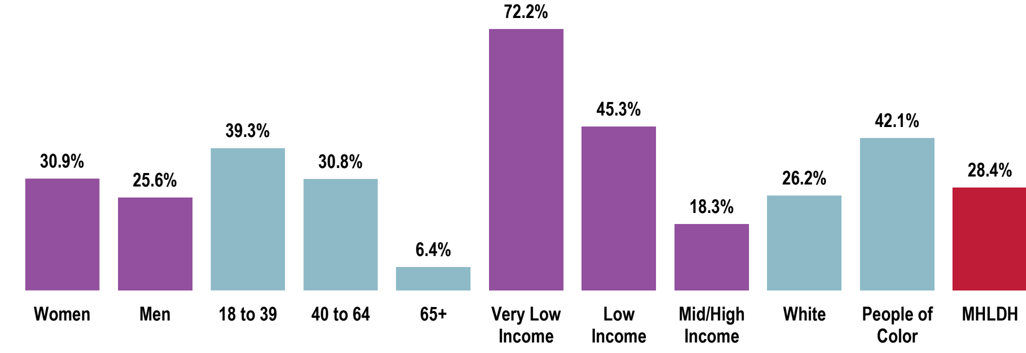
Food Insecurity

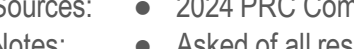
MHLDH Service Area



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 98]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Food Insecurity
(MHLDH Service Area, 2024)

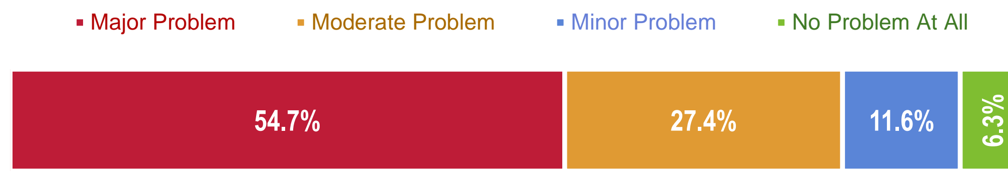




Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 98]
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Key Informant Input: Social Determinants of Health

The following chart outlines key informants' perceptions of the severity of *Social Determinants of Health* as a problem in the community:



Sources: ● 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Housing

> High rent, low availability, clients with no rental history or consistent income. Case management to help with all of it, MLB housing is wonderful but lists for them are long and hard to continue programming with vouchers and needs. – Community Leader
>
> Housing costs and food costs are extremely high, and average wages earned are low because most positions are minimum-wage jobs, which doesn't cover the cost of living. The expense of providing for basic needs doesn't allow for many to have the opportunity for higher education of some sort. – Community Leader
>
> Housing is a huge issue in Spearfish and surrounding areas due to the high cost of housing. – Other Health Provider
>
> Lack of housing, lack of motivation to break the cycle, lack of desire to get a job because of social programs. – Community Leader
>
> Systemic barriers to people struggling with access to affordable housing, mental health, healthy food, and transportation are getting more difficult in light of inflation. – Social Services Provider
>
> Lack of housing, poverty, and toxic environment allow for negative impacts on people. – Other Health Provider
>
> The cost of housing in the Rapid City area is extremely high compared to the wages people receive. Even low-income housing is expensive for many and also very difficult to get into. – Other Health Provider
>
> Housing is a major barrier, and it makes it hard for individuals/families to obtain other goals when they do not have stable housing. – Social Services Provider
>
> Housing is expensive. The dropout rate in Rapid City is too high. DEI efforts in the state are lagging, although Monument has embraced DEI strongly. There are food deserts throughout our communities. Income in South Dakota lags behind other states, but the cost of living is steadily increasing. – Physician
>
> Lack of low-income/affordable housing. Limited opportunities for yearlong employment – many summer, seasonal jobs. Living-wage jobs year-round are limited. Limited opportunities for workforce or entry-level housing. Lack of transportation for those without a personal vehicle. – Physician
>
> The housing cluster in any of the communities on the reservation is a den of social issues. No work income, instead grey income with selling drugs; poor attendance or high dropout due to home and community environment not caring. – Community Leader
>
> The challenges of finding affordable housing that is clean and safe are becoming harder and harder to find. The challenge of finding suitable housing increases the stress of taking care of families, which is hindered by income constraints and limited assets. – Community Leader
>
> Huge lack of affordable housing in this area – we need thousands of units of low-income housing for people to live in. Many do not make enough money to provide for their families, much less an apartment that costs $1,500 a month, and a house is out of the question. Deciding between food and medicine is difficult enough, and that is even for people who are forced to live in their cars. – Social Services Provider
>
> My patients are spending a high percentage of their fixed income on rent. Food insecurity is high, and the lack of transportation limits where people can shop. Medications are out of reach for some people due to cost. Drug assistance is great, but paperwork is very time-consuming for caregivers. – Other Health Provider

> High cost of housing and low wages. Some in our community do not attend or pursue higher education. – Social Services Provider
>
> Low-income housing availability continues to be an issue with the increasing costs of housing. Transportation (and the challenges in the rural area of South Dakota) is limited. Long-standing challenges related to Native American discrimination issues. Substance use adds to the problem. – Other Health Provider
>
> Severe shortage of affordable housing, minimum wage increases that are less than the rate of inflation, the need for parents to hold multiple jobs to make ends meet for their families, low-income census tracts in Rapid City and Box Elder, and counties in the service area that are among the 10 poorest in the U.S., affordability of secondary education, poverty stigma, prevalent racial discrimination, bias against LGBTQIA+ individuals, lack of adequate public transportation for low-income individuals/families. – Social Services Provider
>
> Housing is too expensive, as well as gas and food. Our day care systems are a so lacking and a mess. – Community Leader
>
> The extensive costs of housing, which have worsened in the last year, has increased the houseless population. Many are couch surfing or living in unhealthy living conditions. This then affects their ability to maintain employment, compounding the income issues. – Social Services Provider

Income/Poverty

> Significantly high rate of low- to no-income households. Lack of education and opportunities. Proximity to one of the poorest counties in the United States, and a lack of services and opportunities on the reservations. – Social Services Provider
>
> Low-paying jobs/low-income populations. Shortage of affordable housing. Lack of child care. Scarceness of public transportation (into broader Rapid City area). – Social Services Provider
>
> People that are struggling financially many times eliminate health appointments and prescriptions from their budget. – Community Leader
>
> Many low-income people with limited resources. Some don’t have the mental or social capacity to apply for help that they may have access to. Not a lot of support for higher education or the importance of quality education. We do have low-income housing but still lack affordable housing for the working poor to middle-income. Many don’t pay for health care because of the cost and too much out of their income. Ranching communities have a lack of liquid assets. Transportation limitations due to distance and cost are a large issue here. Due to lack of education, many have to work multiple low-paying jobs. Lack of day care for working parents. Lack of housing overall to help draw more professionals to support the community. – Physician
>
> We have a large population of low-income households. I believe that those households often lack knowledge and access to a better life. – Community Leader
>
> Poverty, housing, child care, food. – Community Leader
>
> Lower-paying jobs, poor affordable housing choices, few child care options. – Community Leader

Homelessness

> We have more unhoused people than ever, based on people in our downtown and parks. With our Native American population, the discrimination is seen in our schools, health care, and income. – Other Health Provider
>
> Homeless population is way out of control. – Social Services Provider
>
> Homelessness, decreased wages, cost of living, not enough affordable housing, food insecurity. – Other Health Provider
>
> Number of homeless people in town. Physical violence causing women and children to seek shelter. – Other Health Provider
>
> There is a huge homeless population in Pennington County, as well as other counties. The lack of affordable housing in our community is very high. There are a lot of apartments being built in Rapid City, but they are not affordable. Single mothers end up living in unsafe areas, or two people working hard to pay rent and go without food, fuel, utilities, etc. – Social Services Provider
>
> There continue to be unhoused people who go to the hospital for care and have no place to go upon discharge. – Other Health Provider

Incidence/Prevalence

> Just look around downtown and North Rapid; it’s everywhere. – Social Services Provider
>
> All of these areas need to be addressed in a comprehensive way. Although this is nothing new, these issues have existed for years – we seem to always be in analysis paralysis. Our community has spent a significant amount of time assessing issues but not as much time on problem-solving. There are definitely some of these areas that are being slowly chipped away at, but for every year that these needs go unaddressed, the harder it is to turn the ship around, and what is lost sometimes cannot be recovered – an unhealthy child usually becomes an unhealthy adult. – Community Leader
>
> These are major problems everywhere. Our community is no exception. There is a lack of mental health services in our community. – Community Leader

Impact on Quality of Life

> I consider myself fairly well informed as to what is going on in the world, and that includes locally, nationally, and internationally. It is my understanding that the experts who study these things have made it pretty clear that social determinants are key to successfully living in a society. – Community Leader
>
> Social determents of health. They affect multiple medical conditions but keep patients from being able to focus on their health. – Physician

Affordable Care/Services

> The overall cost of health care, housing, and child care does not match the overall income for many families in the area. Recent studies have shown this, resulting in individuals putting off health care needs to meet the current costs of other basic needs. – Social Services Provider

Disease Management

> Lack of compliance, lack of transportation, missing appointments, not getting needed medications, drug and alcohol problems, housing difficulties, food insecurity. – Social Services Provider

Racism

> There are diverse ethnicities within the community. There are areas of prejudice. – Community Leader

Transportation

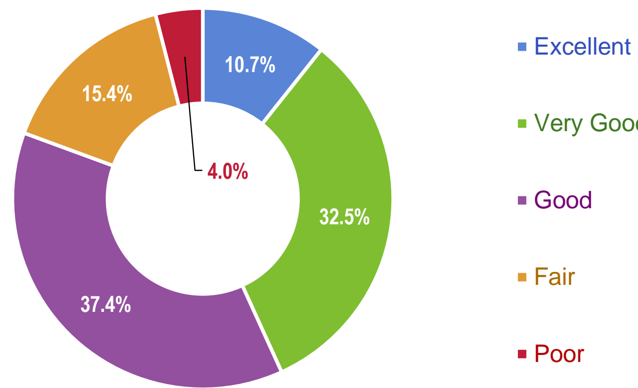
> Lack of transportation and safe housing. – Public Health Representative

HEALTH STATUS

Overall Health

PRC SURVEY ▶ "Would you say that, in general, your health is: excellent, very good, good, fair, or poor?"

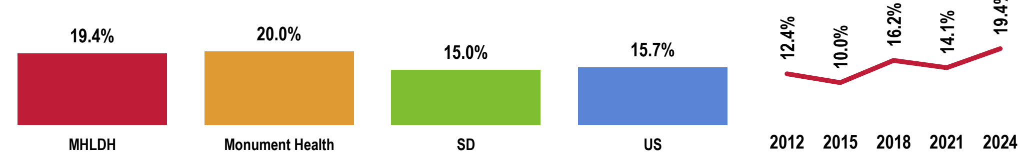
Self-Reported Health Status
(MHLDH Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.

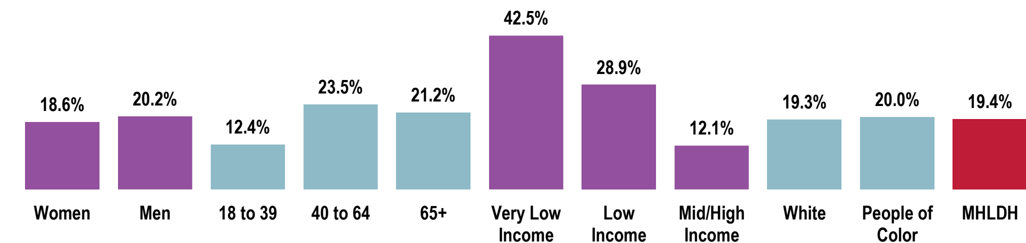
Experience "Fair" or "Poor" Overall Health

MHLDH Service Area



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(MHLDH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

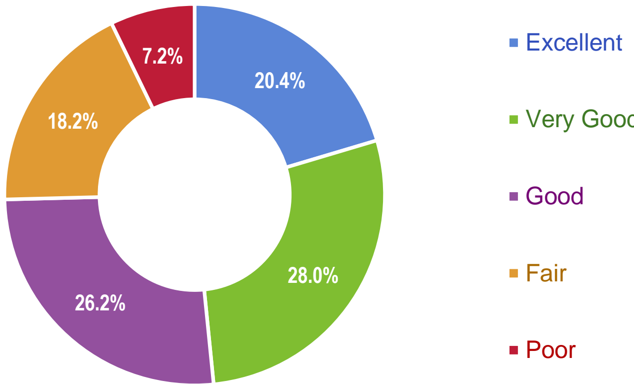
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Status

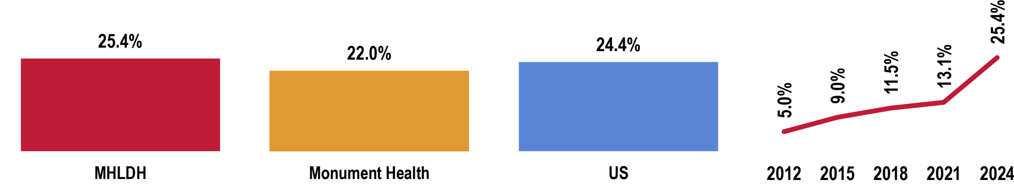
PRC SURVEY ▶ "Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Mental Health

MHLDH Service Area



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 77]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

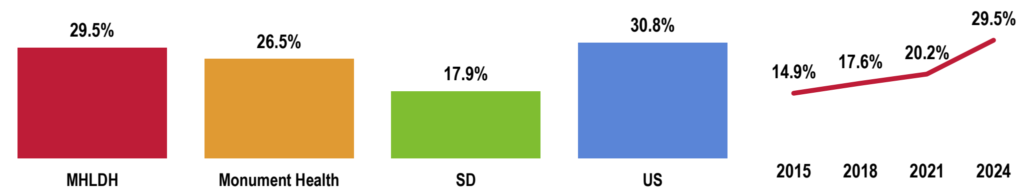
Depression

Diagnosed Depression

PRC SURVEY ▶ “Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”

Have Been Diagnosed With a Depressive Disorder

MHLDH Service Area

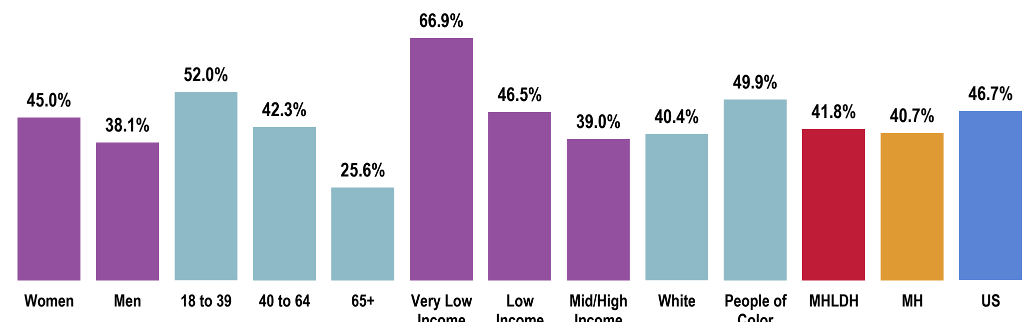


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 80]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

PRC SURVEY ▶ "Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"

Have Experienced Symptoms of Chronic Depression
(MHLDH Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

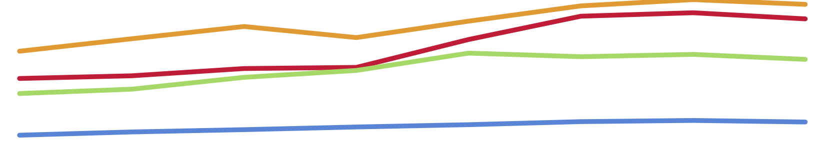
Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population.

Refer to "Leading Causes of Death" for an explanation of the use of age-adjusting for these rates.

Suicide: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
MHLDH	18.4	18.7	19.4	19.6	22.4	24.9	25.2	24.6
MH	21.2	22.5	23.8	22.6	24.4	25.9	26.6	26.1
SD	16.8	17.3	18.5	19.2	21.0	20.7	20.9	20.4
US	12.5	12.8	13.1	13.4	13.6	13.9	14.0	13.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

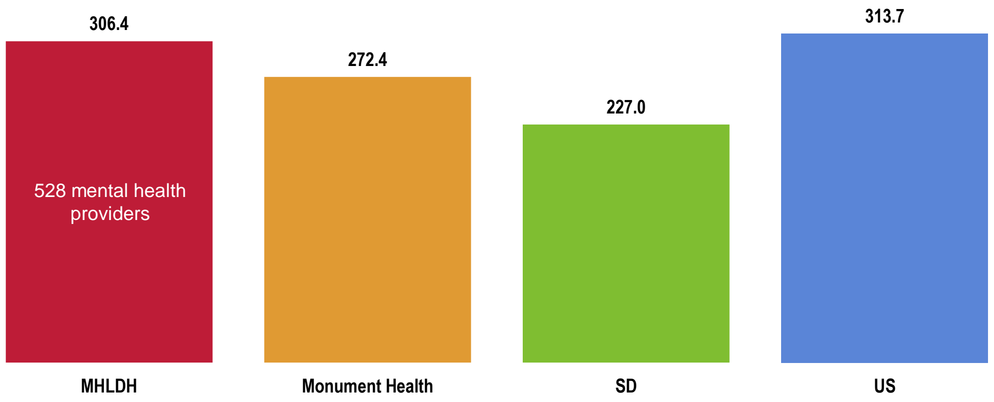
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Mental Health Treatment

Note that this indicator only reflects providers practicing within the study area and residents within the study area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care) per 100,000 residents.

Number of Mental Health Providers per 100,000 Population (2023)



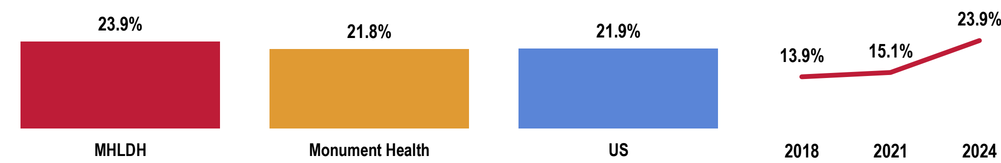
Sources: • Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2024 via SparkMap (sparkmap.org).

Notes: • This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care.

PRC SURVEY ▶ "Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"

Currently Receiving Mental Health Treatment

MHLDH Service Area

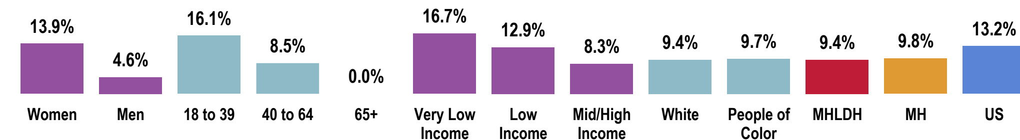


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 81]
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

PRC SURVEY ▶ "Was there a time in the past 12 months when you needed mental health services but were not able to get them?"

Unable to Get Mental Health Services When Needed in the Past Year
(MHLDH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 82]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:

Perceptions of
Mental & Emotional Health as a Problem in the Community
(Key Informants; MHLDH Service Area, 2024)

▪ Major Problem ▪ Moderate Problem ▪ Minor Problem ▪ No Problem At All

Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Not enough counseling services in town. Limited mental health case management. West River Mental Health has an office in Hot Springs and Rapid City but not in Custer. So, although they are helpful in helping patients access meds and sliding scale cost for counseling, patients have to travel, and patients with mental health services are often limited in funds or vehicles. – Physician
>
> Mental health facilities are few and far apart. Hospitals do not like to admit mental health patients, leaving them with few options. – Community Leader
>
> Access to quality care and treatment. – Community Leader
>
> Timelines for initial appointments and follow-up care appointments are sometimes scheduled far out. – Community Leader

Access, cost, and maintenance – with the continual rise in anxiety, depression, and suicide (especially for our young people), we are clearly missing something. The social determinants of health should speak to many of the issues that cause people stress, from low-level stress events to severe trauma – we have a cowboy-up mentality in our area, and it makes it that much more challenging for people to seek help. Cost, too many unknowns for the cost of mental health resources, or it is just too expensive. Access – we have a shortage of qualified people who could be providing these services. We too often rely on nonprofits to meet that need, but most of them have staff shortages, leading to spreading everyone thin, leading to burnout. All of this leads to many people self-medicating with drugs, alcohol, or other risky behaviors, because being in pain, either physically or mentally, is too much, but we all know that those easy escapes amplify those issues. – Community Leader

It's a huge issue with not enough local support. – Community Leader

I suspect many people with mental health issues can't find a place to be seen. Also, I assume there are payment issues. – Community Leader

Access to care, such as therapy services, that are local and consistent. Pediatric medical management services, as well as counseling services. – Community Leader

Access to mental health services. Even when there has been access, families have a hard time managing to get to appointments. – Physician

Little to no regular access to mental health services. What is available is virtual. – Other Health Provider

Adequate mental health professionals to provide help. – Community Leader

There is a need for service for inpatient services. Affordable care. The negative stigma of people feeling they shouldn't seek help. – Social Services Provider

Lack of access to qualified mental health providers. – Other Health Provider

Access to qualified providers. We have a significant issue with the number of providers in relation to the number of individuals that are in need of mental health care. – Community Leader

The lack of resources. Poverty, hopelessness, and substance abuse. Lack of quality mental health providers, or it takes weeks to see a provider. – Social Services Provider

Accessing mental health providers. Waiting lists are too long. – Social Services Provider

Access to care. There is a shortage of trained mental health providers in the area, and the future outlook is bleak with the numbers of people going into the field. This includes master's-prepared professionals, along with PhD and psychiatrists. – Social Services Provider

Many families are strained for one reason or another, albeit financial, dysfunction, chaos in the home, substance abuse, or a myriad of other things. I see it in schools, in children, in adults in my daily life, and in the news. The biggest challenge is that people do not know when they need help before they are too far into the mental crisis. Secondly, the access for mental health is very limited. Third, the cost of taking care of your mental health is sometimes overbearing. Next is the stigma. Next is the fact that people think they can fix it alone. This all fractures and strains the family unit ... and if you have a mental issue, how are you going to have the wherewithal and strength to get over all these barriers to help yourself or your loved one? – Community Leader

Access to care and local inpatient support. – Other Health Provider

Access to appointments. The wait time. Medication management. Lack of psychiatrists. – Social Services Provider

Not enough help for mental health. – Social Services Provider

Availability, affordability, and stigma attached to mental health. – Community Leader

Long waiting lists for counseling. Expensive, very short inpatient stays at Behavioral Health. – Social Services Provider

The geography is so expansive. It is logistically very challenging to take health care to the patients. – Community Leader

Access, affordability, lengthy wait lists, unreliable transportation to appointments or lack of technology in the home to access telehealth services, stigma, and extreme lack of licensed mental health professionals in most of Western South Dakota. – Social Services Provider

No immediate 24-hour placement resources and not enough treatment facilities, particularly in Western South Dakota. – Social Services Provider

Lack of Providers

We don't even have half of the mental health providers we need in this community. The families our organization serve s... some kids and families are desperate for help, and they're on one- to two-year waiting lists. My own daughter was on a waiting list for 1.5 years for anxiety and depression. That's a massive disservice to our community members. – Social Services Provider

No doctors or proper facilities. – Community Leader

Lack of providers, especially for those without insurance, or those with Medicaid. Lack of care management for these patients on a communitywide level. – Other Health Provider

Not enough counselors, resources, safe houses, or real-time meetings with those in crisis. – Social Services Provider

Lack of providers. – Social Services Provider

There is a lack of mental health professionals, and there is such a need for more immediate access to a mental health professional. – Community Leader

Lack of providers. – Other Health Provider

There are not enough providers to manage the high number of patients who need mental health care. Primary care is frequently managing many of these patients, but they are time-consuming in an environment where physicians need to turn patients over quickly to meet production requirements. – Physician

Lack of therapists. Lack of places to put them when they need help. Lack of community help. – Community Leader

Not enough providers. – Other Health Provider

There is a shortage of mental health providers in the community and very limited access to behavioral health inpatient care. Staffing at the receiving facility or patient acuity is often a barrier to getting patients in acute crisis transferred from our emergency room. – Other Health Provider

There is a shortage of licensed mental health providers who accept Title XIX and who have sliding fee scales, especially for our rural communities. – Social Services Provider

Lack of providers. Difficulty in getting screened and seeing providers, particularly for low-income and homeless patients. – Social Services Provider

Follow Up/Support

Inability to navigate a complex system without case management and family support. Need more marketing on the utilization of Pivot Point to engage individuals into accessing service providers in the community vs. constantly using the emergency room, with limited referrals to community resources, reducing bed space for individuals in need of medical emergencies. – Social Services Provider

There's not a lot of support for people dealing with mental health problems in our community. Even if the case is severe, the only option seems to be to send them to Yankton, where they usually send them back before the issue is resolved. Some people seem to self-medicate. Some people have severe mental health issues, where they are paranoid and hear voices. They end up having no options besides hanging out at the library. Some people with mental health issues run away often, requiring search and rescue and law enforcement's help to find them. – Community Leader

Social work and counseling. We don't have social support for high need patients. We have one psychiatrist and a few counselors in town. Primary care has to do a majority of treatment, and we don't have enough providers overall. – Physician

Homeless Population

The homeless population has a huge instance of mental health issues. The native population that uses drugs and alcohol is terrible. – Community Leader

Many of the homeless population here have an underlying mental health issue. With better care and medication compliance, these folks could work, have a home, and feel like they are part of the community. – Other Health Provider

Vulnerable Populations

Health care, mental and physical, on the reservations. So many health issues that need to be addressed. Not sure of the solution. – Community Leader

Adolescent/children's health and mental health services. – Social Services Provider

Incidence/Prevalence

Depression and anxiety attitudes. – Other Health Provider

High rates of mental health issues. Low volume of providers and facilities to address these needs. – Other Health Provider

Access to Care for Uninsured/Underinsured

Access to mental health care for all patients, especially patients with no insurance or Medicaid. Also, there are not enough providers for the need. – Physician

Affordable Medications/Supplies

Getting care. Having money for medications. Remembering to take medications when they are homeless or "couch surfing." – Other Health Provider

Denial/Stigma

> The stigma surrounding mental health may be the biggest challenge. Behind stigma is access to care. The community does not have enough providers to accommodate the people that need services. – Other Health Provider

Disease Management

> Behavior management. – Community Leader

Due to COVID-19

> This issue has only worsened since the COVID lockdowns. And mental health needs to be addressed beyond the IHS clinics. There are very compromised folks in our communities, families, and schools. They need help; they need appropriate support to get wholesome once again. – Community Leader

Family Support

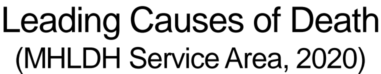
> Some don't have family in the area and are left to fend for themselves, which exacerbates the problem. They become homeless or end up incarcerated. There is no inpatient facility in Fall River County for mental illness. – Community Leader

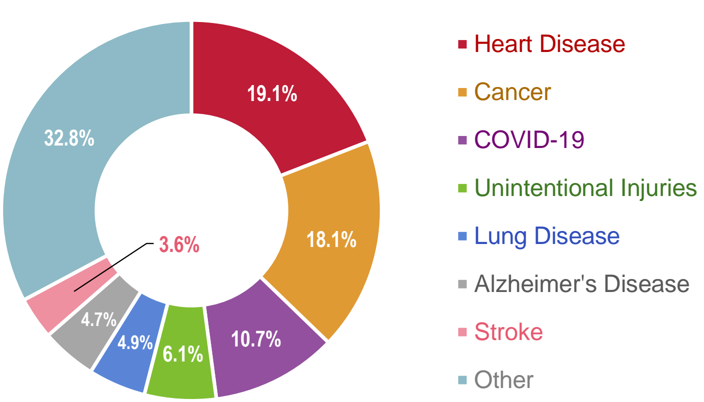
DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

The following outlines leading causes of death in the community.





Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.

Notes: • Lung disease includes deaths classified as chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, South Dakota and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

Note that deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death.

Age-Adjusted Death Rates for Selected Causes
(2018-2020 Deaths per 100,000 Population)

	MHLDH Service Area	MH	SD	US	Healthy People 2030
Heart Disease	148.6	155.7	156.5	164.4	127.4*
Cancers (Malignant Neoplasms)	147.1	153.7	148.9	146.5	122.7
Falls [Age 65+]	107.8	113.7	105.9	67.1	63.4
COVID-19 (Coronavirus Disease) [2020]	83.6	90.1	127.0	85.0	—
Unintentional Injuries	49.2	57.5	52.7	51.6	43.2
Lung Disease (Chronic Lower Respiratory Disease)	38.2	39.7	41.9	38.1	—
Alzheimer's Disease	32.8	31.8	38.8	30.9	—
Stroke (Cerebrovascular Disease)	28.3	31.4	33.8	37.6	33.4
Suicide	24.6	26.1	20.4	13.9	12.8
Alcohol-Induced Deaths	24.0	31.4	20.8	11.9	—
Cirrhosis/Liver Disease	23.6	30.4	13.4	12.5	10.9
Diabetes	19.7	25.9	26.4	22.6	—
Motor Vehicle Deaths	12.6	17.4	15.7	11.4	10.1
Pneumonia/Influenza	12.0	13.7	16.3	13.4	—
Unintentional Drug-Induced Deaths	7.2	7.2	7.6	21.0	—
Homicide [2011-2020]	4.4	5.1	3.8	5.9	5.5
Kidney Disease	4.0	5.4	6.0	12.8	—

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople.

Note:
- *The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Heart Disease & Stroke Deaths

The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community.

The greatest share of cardiovascular deaths is attributed to heart disease.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
MHLDH	143.2	145.0	142.5	142.9	145.9	148.9	152.0	148.6
MH	149.6	155.6	151.6	150.1	151.3	155.1	158.9	155.7
SD	153.2	153.4	151.9	153.0	151.5	153.3	154.8	156.5
US	171.3	169.6	168.9	167.5	166.3	164.7	163.4	164.4

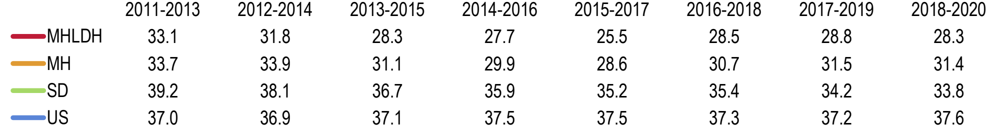
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
MHLDH	33.1	31.8	28.3	27.7	25.5	28.5	28.8	28.3
MH	33.7	33.9	31.1	29.9	28.6	30.7	31.5	31.4
SD	39.2	38.1	36.7	35.9	35.2	35.4	34.2	33.8
US	37.0	36.9	37.1	37.5	37.5	37.3	37.2	37.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

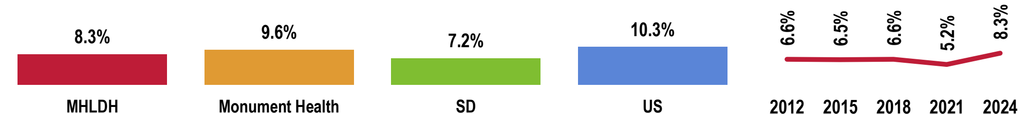
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Heart Disease & Stroke

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with heart disease, including heart attack or myocardial infarction, angina, or coronary heart disease?"

Prevalence of Heart Disease

MHLDH Service Area



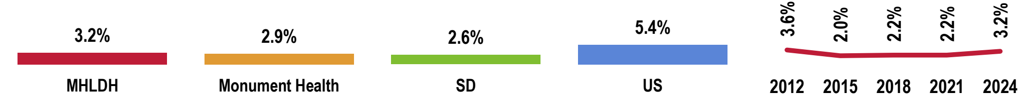
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 South Dakota data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with a stroke?"

Prevalence of Stroke

MHLDH Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

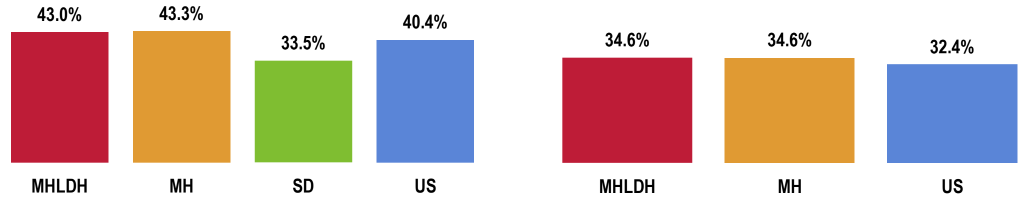
Blood Pressure & Cholesterol

PRC SURVEY ▶ "Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

PRC SURVEY ▶ "Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"

Prevalence of
High Blood Pressure
Healthy People 2030 = 42.6% or Lower

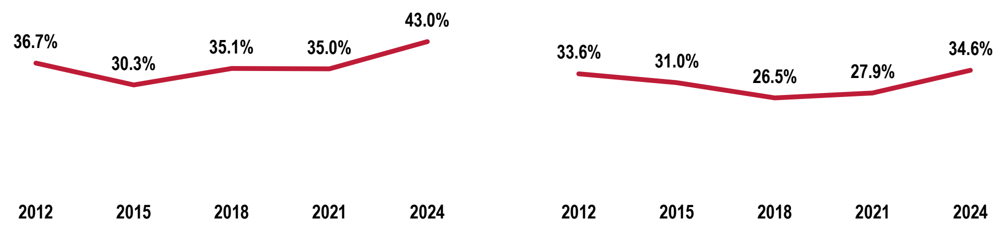
Prevalence of
High Blood Cholesterol



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 29-30]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
● 2023 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents.

Prevalence of
High Blood Pressure
(MHLDH Service Area)
Healthy People 2030 = 42.6% or Lower

Prevalence of
High Blood Cholesterol
(MHLDH Service Area)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 29-30]

● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents.

Total Cardiovascular Risk

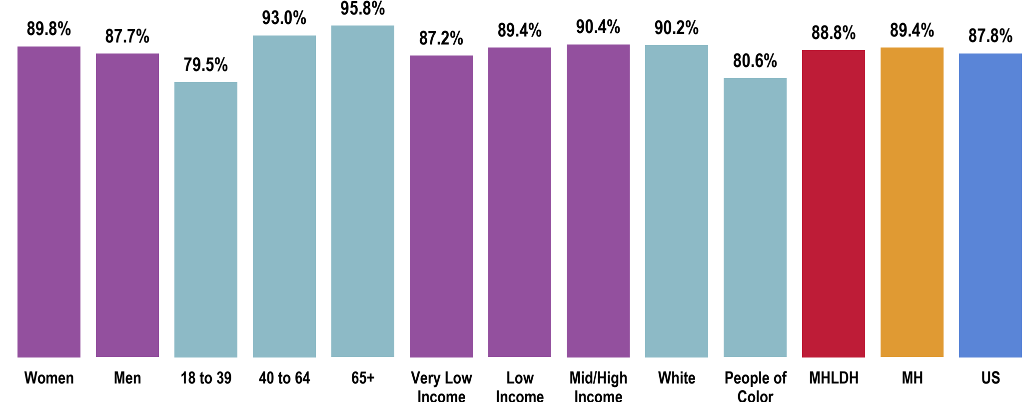
Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

The following chart reflects the percentage of adults in the MHLDH Service Area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.

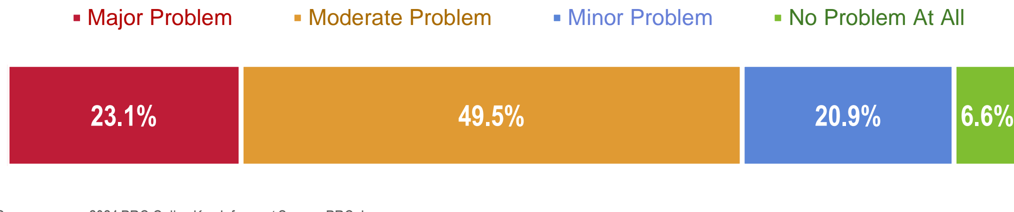


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 100]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> These are increasing problems everywhere. – Community Leader
>
> It impacts a large number of people. – Community Leader
>
> In general, many of the people in groups I am involved with have issues with cholesterol, are currently on a plan for prevention, or are receiving treatments or surgeries to directly "fix" a heart anomaly. Interestingly, these same groups have so many that are seemingly living a "healthy" lifestyle but still have issues. – Community Leader
>
> The number of people in the community that voice problems with heart conditions and those that had strokes. It appears the patients are young in their 30s and 40s, along with the aging population. Again, healthy eating and lifestyle is a barrier for most. – Social Services Provider

Access to Care/Services

> Expanded immediate or emergency care is lacking. Fall River Health Services does not provide emergency surgery, so they have to transfer to Rapid City. – Community Leader
>
> We are about 60 miles from the nearest cath lab and neuro-intervention facility. It can be very difficult to be in the window of opportunity to help people maintain as much brain or cardiac tissue. There is distance to the critical access hospital, some lack of trained EMS in the rural locations, and then distance to Rapid City if they are not on diversion. Worse is when Rapid City is overloaded and we have to fly patients routinely to Scottsbluff, Nebraska; Wyoming; Denver; Sioux Falls; Mayo; or Omaha, Nebraska, to have access to higher-level care. – Physician
>
> No rehab unit in town. Have to travel to Rapid City. – Social Services Provider

Awareness/Education

> Being aware or associates, friends, and relatives who frequently report problems in these areas. – Community Leader
>
> Lack of education and exercise. – Community Leader
>
> People don't see routine health care as important and also can't afford food that is good to prevent heart disease. – Other Health Provider

Prevention/Screenings

> People do not visit their primary care doctor regularly, and they do not take care of themselves. – Other Health Provider
>
> We have not prioritized preventive care – it seems like people are having more major diseases earlier and earlier, and it seems like some preventative screenings would be beneficial in the long run. Much like Planet Heart through Avera – pay a base fee for several screening tools so people can have a baseline idea of health before it gets to a point when an artery is severely blocked. Cost of care and prevention is scary for many people who live on fixed incomes – this leads to people waiting for services until something drastic happens. – Community Leader

Aging Population

> Aging population, poor nutrition in general, and demographics of the area contribute. Oyate doesn't offer cardiology services, limiting access for a significantly at-risk portion of the population. – Other Health Provider
>
> We have an aging population who are more at risk for stroke and heart issues. Also, due to the lifestyle choices, many people are at risk for developing heart disease or stroke. – Social Services Provider

Lifestyle

> Inadequate physical activity and poor diet due to food insecurity among low-income individuals. – Social Services Provider
>
> Poor diet and exercise. Lack of quality food. – Social Services Provider

Impact on Quality of Life

> There are immediate, debilitating results. – Community Leader

Cancer

ABOUT CANCER

Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

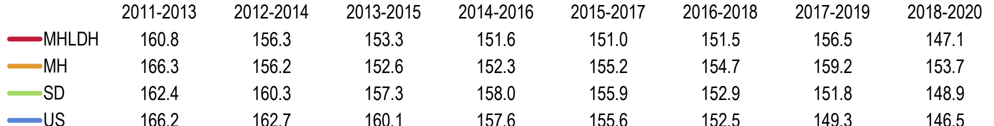
Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types).

Cancer: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 122.7 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
MHLDH	160.8	156.3	153.3	151.6	151.0	151.5	156.5	147.1
MH	166.3	156.2	152.6	152.3	155.2	154.7	159.2	153.7
SD	162.4	160.3	157.3	158.0	155.9	152.9	151.8	148.9
US	166.2	162.7	160.1	157.6	155.6	152.5	149.3	146.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Lung cancer is by far the leading cause of cancer deaths.

Age-Adjusted Cancer Death Rates by Site
(2018-2020 Annual Average Deaths per 100,000 Population)

	MHLDH Service Area	Monument Health	SD	US	Healthy People 2030
ALL CANCERS	147.1	153.7	148.9	146.5	122.7
Lung Cancer	33.5	35.2	34.5	33.4	25.1
Prostate Cancer	20.3	22.0	18.7	18.5	16.9
Female Breast Cancer	20.1	18.7	19.1	19.4	15.3
Colorectal Cancer	12.3	13.3	14.0	13.1	8.9

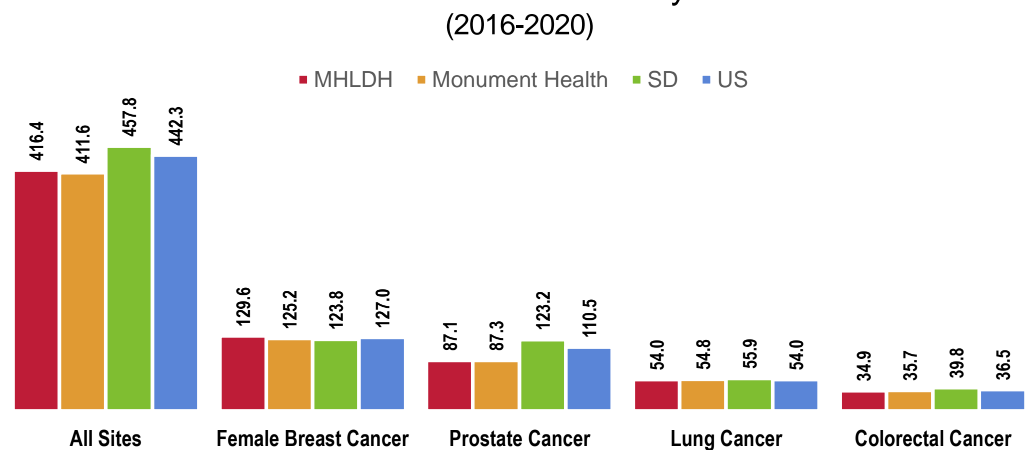
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

Cancer Incidence Rates by Site
(2016-2020)



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population.

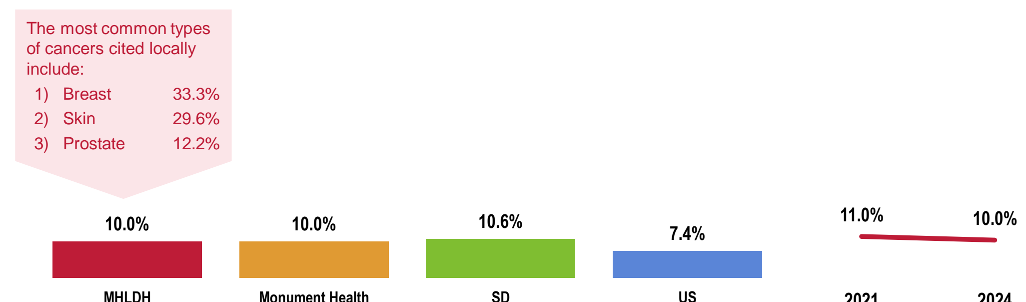
Prevalence of Cancer

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with cancer?"

PRC SURVEY ▶ "Which type of cancer were you diagnosed with?" (If more than one past diagnosis, respondent was asked about the most recent.)

Prevalence of Cancer

MHLDH Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 24-25]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cancer Screenings

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 45 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Screening levels in the community were measured in the PRC Community Health Survey relative to the following cancer sites:

Breast Cancer Screening

PRC SURVEY ▶ "A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

Cervical Cancer Screening

PRC SURVEY ▶ "A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"

[If Pap test in the past five years] **"HPV, or the human papillomavirus, is a common infection that can cause several types of cancer. When you received your last Pap test, were you screened for HPV?"**

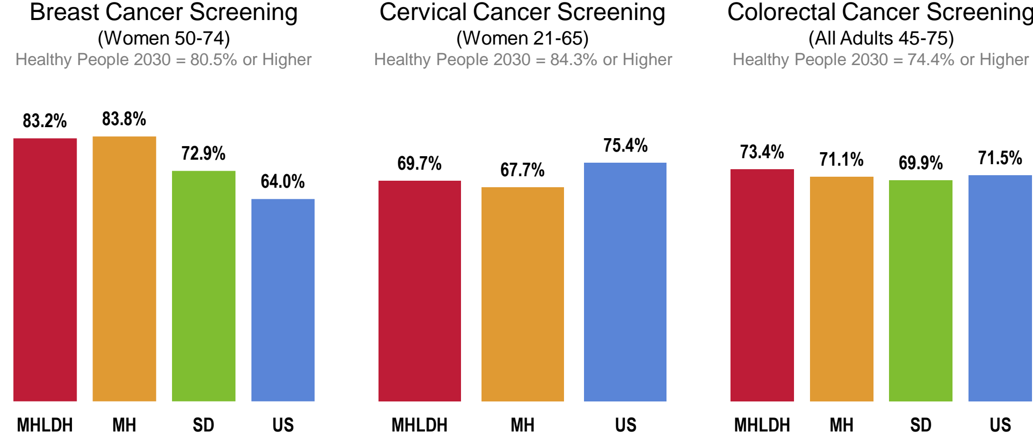
"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

Colorectal Cancer Screening

PRC SURVEY ▶ "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"

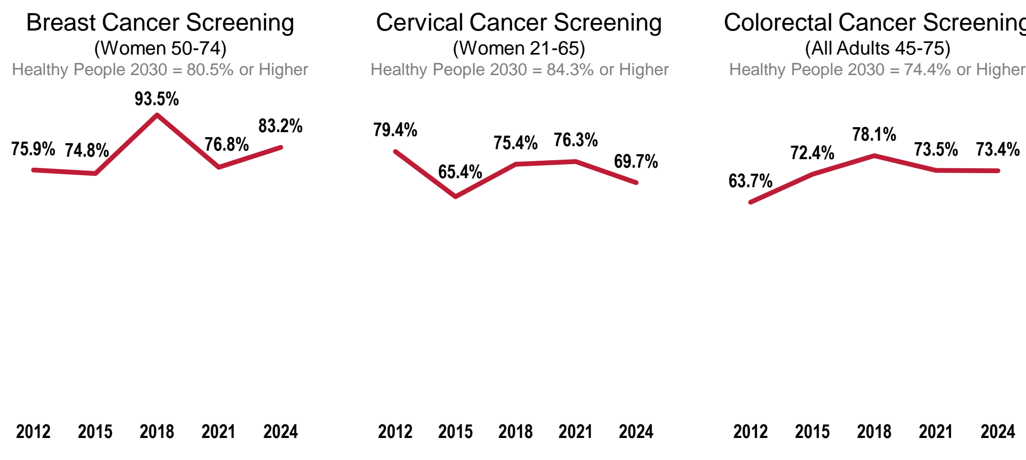
PRC SURVEY ▶ "A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" includes adults age 45 to 75 with a fecal occult blood test within the past year and/or lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 South Dakota data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- Note that state and national data for colorectal cancer screening reflect the age group (50 to 75) of the previous recommendation.

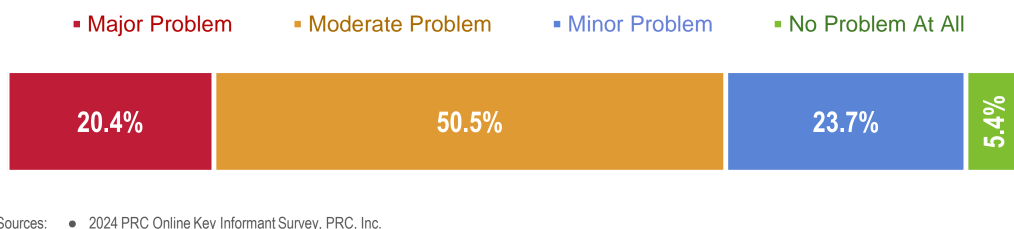


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- Note that trend data for colorectal cancer screening reflect the age group (50 to 75) of the previous recommendation.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

It is increasingly common among residents in all demographics. – Community Leader

It seems that there is a prevalence along with growing numbers across generations of many types of cancers. Regardless of the type, this causes strain in mental, emotional and lifestyle wellness for the patient and family. To add to this, easy access for the treatment(s) for the prognosis is reduced as rural areas are numerous. This lowers the ability for the patient and often family member (or caregiver) to bring in their income due to travel and time away from home, among other geographical complexities. Since cancer has more of a metered treatment plan, it seems to plague the family and patient for a longer-term, requiring support that is often not readily available. Lack of mental health options, increased needs financially, disruption of homelife, along with the unknown future of the disease and mortality, it seems to be there is someone in everyone's life who is dealing with cancer as a disease. – Community Leader

Large number of cancer deaths and diagnosis. – Community Leader

It seems like there are more diagnoses, which could be good because people are catching it sooner. It affects many people. – Community Leader

There appears to be an increase in cancer, many that are considered rare in occurrence, but it is happening more frequently. – Community Leader

Frequency of occurrence, lack of timely access to screening, distance from facilities with the ability to treat it with chemo and radiation, and associated expenses of travel and overnight housing. – Other Health Provider

Many people are getting this diagnosis. – Other Health Provider

Our community has lost a lot of young individuals to cancer as well as the older generation, and we hear about new cases on a regular basis. This takes a toll on the individuals, family members, and the community as a whole. In addition, our health care facility does not have the means to provide the needed cancer treatments, requiring individuals to travel miles to seek help. – Community Leader

Access to Care/Services

Anyone in our community has to travel to Rapid City from Fall River County to participate in any sort of treatment for cancer. Women have to travel to Custer for a dense tissue mammogram. – Community Leader

Accessing proper medical care is a long and arduous process. It takes so long for appointments and tests to be arranged and completed. – Other Health Provider

Multiple cancer diagnoses with difficulty getting to Rapid City an hour away each direction for radiation and oncology treatments. Trying to do a full cancer workup prior to having the patient seen by oncologists can be difficult with getting appropriate labs done, imaging, and biopsies. Financial and transportation constraints limit optimal care. No mammography in town. No scopes available for screening or diagnostics. – Physician

All patients have to drive to Rapid City to see an oncologist and for chemo and radiation. At one time, we had a visiting oncologist in Spearfish, and the hospital was able to provide chemo services. Those services were taken away. This was a huge benefit to our communities. – Other Health Provider

Affordable Care/Services

> Cancer seems to leave no family untouched. The costs of treatment can be debilitating for the families, especially if they don't have insurance. However, even with insurance, the costs are excessive. – Social Services Provider

Awareness/Education

> Not enough resources for education and information on ways to prevent cancer and what causes cancer. – Social Services Provider

Environmental Contributors

> We have a high occurrence of glioblastoma. There may be an environmental reason for this. – Community Leader

Respiratory Disease

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Respiratory Disease Deaths

Lung Disease

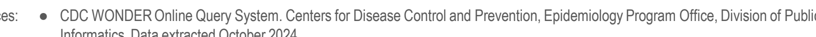
Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for lung disease is illustrated in the charts that follow.

Lung Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
MHLDH	44.7	43.8	42.6	37.7	39.1	38.1	41.0	38.2
MH	49.3	49.7	47.8	43.8	43.6	41.5	43.1	39.7
SD	44.1	41.9	41.8	41.5	43.0	42.4	44.7	41.9
US	42.0	41.7	41.8	41.3	41.0	40.4	39.6	38.1

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.

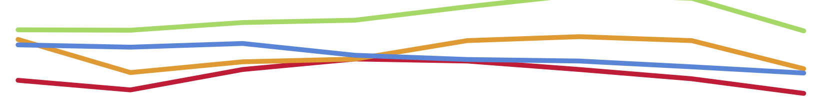
Notes: • Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
• Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.



Pneumonia/Influenza

Pneumonia and influenza mortality is illustrated here.

Pneumonia/Influenza: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
MHLDH	12.9	12.2	13.6	14.4	14.2	13.6	13.0	12.0
MH	15.7	13.4	14.2	14.4	15.6	15.9	15.6	13.7
SD	16.4	16.3	16.9	17.0	18.0	18.8	18.5	16.3
US	15.3	15.2	15.4	14.6	14.3	14.2	13.8	13.4

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

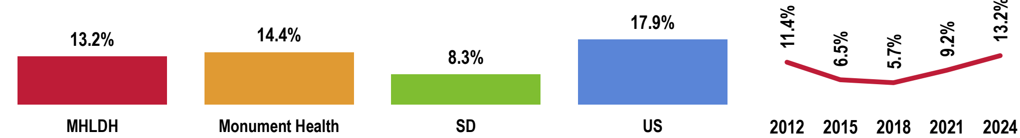
Prevalence of Respiratory Disease

Asthma

PRC SURVEY ▶ "Do you currently have asthma?"

Prevalence of Asthma

MHLDH Service Area



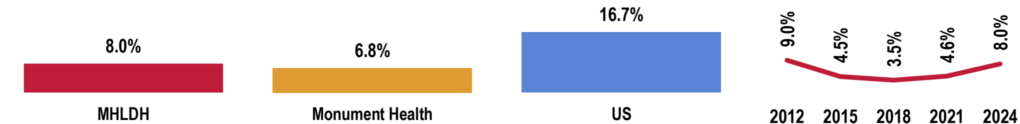
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 26]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

PRC SURVEY ▶ "Has a doctor, nurse, or other health professional ever told you that this child had asthma?"

Prevalence of Asthma in Children
(Children 0-17)

MHLDH Service Area



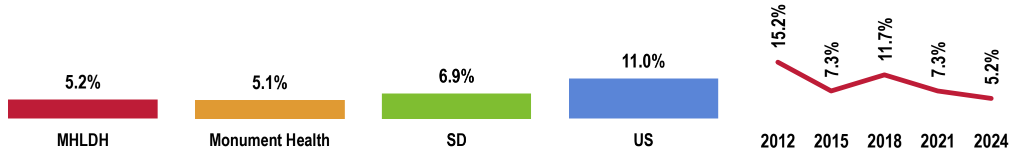
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 92]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children age 0 to 17 in the household.

Chronic Obstructive Pulmonary Disease (COPD)

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with any of the following medical conditions: COPD or chronic obstructive pulmonary disease, including chronic bronchitis or emphysema?"

Prevalence of
Chronic Obstructive Pulmonary Disease (COPD)

MHLDH Service Area

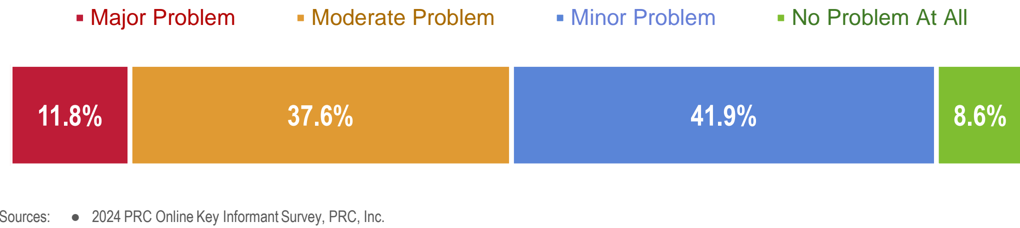


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 21]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes conditions such as chronic bronchitis and emphysema.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:

Perceptions of Respiratory Disease as a Problem in the Community
(Key Informants; MHLDH Service Area, 2024)



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Tobacco Use

> Smoking, drugs, and alcohol use have all made respiratory diseases increase without proper treatments. Not being able to have mobile oxygen packs to go about the day at work or school, instead having heavy tanks that are hard to manage. – Community Leader
>
> Smoking and drugs are rampant. The other problem is having enough respiratory specialists in town who can assist those in need. – Community Leader

Incidence/Prevalence

> Childhood asthma seems to be at an alarming rate. Also, COPD from grain dust and/or smoking. – Other Health Provider
>
> There appears to be a huge number of people with asthma, COPD, and other respiratory problems. Some were developed after COVID, making everyone in the community believe the illness was brought on by that disease. – Social Services Provider

Aging Population

> Age of people. – Community Leader

Awareness/Education

> People don't believe in staying home when they are ill. – Other Health Provider

Due to COVID-19

> An issue that is just coming to light: Long COVID. There are no Long COVID clinics in the communities, and few medical personnel are aware or believe that Long COVID exists. – Social Services Provider

Environmental Contributors

> High altitude is a problem for some people. – Community Leader

Injury & Violence

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

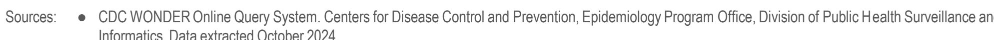
Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area.

Unintentional Injuries: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 43.2 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
MHLDH	43.9	43.1	42.6	46.5	48.5	47.7	48.4	49.2
MH	52.3	50.7	50.1	56.9	60.8	61.4	58.4	57.5
SD	46.4	47.8	48.5	50.7	53.0	52.0	51.9	52.7
US	39.2	40.6	41.9	44.6	46.7	48.3	48.9	51.6



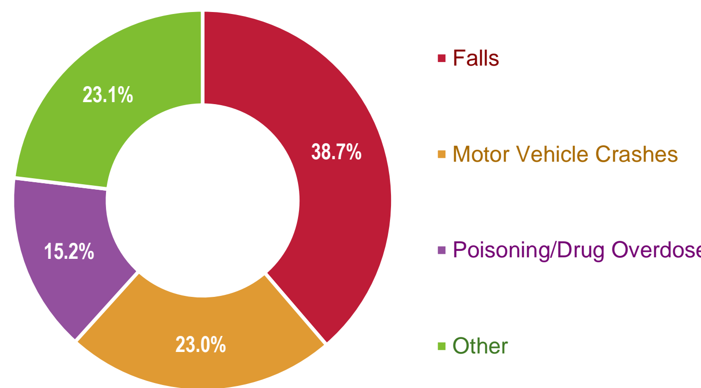
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Leading Causes of Unintentional Injury Deaths

The following outlines leading causes of accidental death in the area.

RELATED ISSUE
For more information about unintentional drug-induced deaths, see also *Substance Use* in the **Modifiable Health Risks** section of this report.



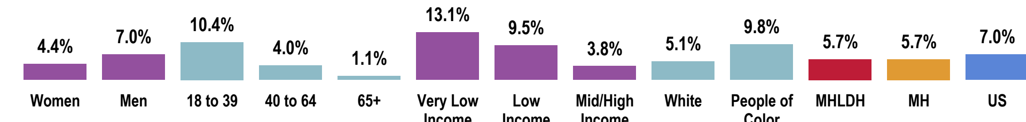
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.

Intentional Injury (Violence)

Violent Crime Experience

PRC SURVEY ▶ "Thinking about your own personal safety, have you been the victim of a violent crime in your area in the past 5 years?"

Victim of a Violent Crime in the Past Five Years
(MHLDH Service Area, 2024)

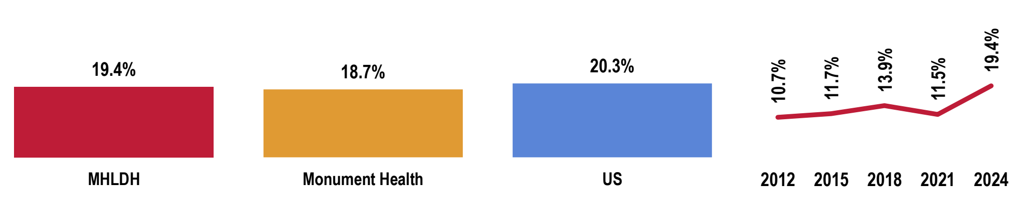


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 32]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Intimate Partner Violence

PRC SURVEY ▶ "The next question is about violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"

Have Ever Been Hit, Slapped, Pushed,
Kicked, or Hurt in Any Way by an Intimate Partner

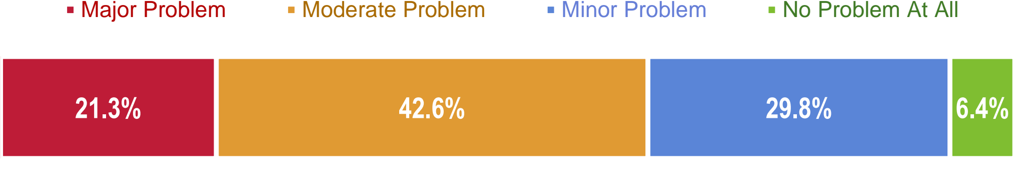


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 33]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:

Perceptions of Injury & Violence as a Problem in the Community
(Key Informants; MHLDH Service Area, 2024)



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Alcohol/Drug Use

> Violence is at a high level in Rapid City based on population, and much is drug- and gang-related. – Social Services Provider
>
> Drug and alcohol abuse and reluctant law enforcement to act in the fullest of the law. – Other Health Provider
>
> Substance abuse plays a large part in injury and violence. People under the influence will sometimes fight or drive. – Other Health Provider
>
> Increase in substance abuse, lack of adequate quality and quantity of housing, poverty, and driving under the influence. – Social Services Provider

> Because of substance abuse, I think there is violence, shame, and a lack of education on such problems. – Community Leader
>
> Domestic violence and violence due to drugs are not highly reported. There are not enough resources and support systems for victims, but there seems to be many for those causing the problems. – Community Leader

Incidence/Prevalence

> South Dakota, and especially the Black Hills area, have high incidences of violence, trauma, and injury. We have some of the highest per capita. – Social Services Provider
>
> There are reports at least weekly of violent activity, such as shootings, murders, or others. If you don't watch TV, listen to the news, or read the paper, you may think it is not a problem. The reports otherwise speak for themselves. – Other Health Provider
>
> Increase of injury and violence in the communities – and more so in the housing clusters within the reservation. Drugs are at the heart of it, and there is no sufficient police force to provide security to communities. No police resource officers on school campuses; lack of respect for authority by youth and adults who are using drugs and alcohol. Increase of rapes of young ones, increase of child abuse. – Community Leader

Income/Poverty

> Demographics and the challenges of social determinants of health, such as lower income, mental health, and substance use issues, result in injury and violence. Lack of resources for victims. – Other Health Provider
>
> For individuals and families in poverty, constantly in crisis mode, substandard housing conditions, addictions and other mental health issues, prevalent domestic violence, prevalent child neglect and abuse, etc. – Social Services Provider

Teen/Young Adult

> An increasing population of a younger generation addicted to drugs and alcohol. Lack of family support and early interactions with the judicial system. Lack of prevention in schools and elsewhere. – Social Services Provider

Stress

> Families come in and report stressful events that are significant. – Physician

Diabetes

ABOUT DIABETES

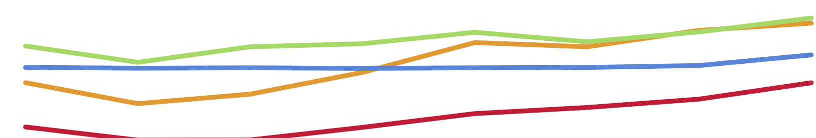
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart.



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
MHLDH	15.1	13.7	13.8	15.1	16.5	17.1	18.0	19.7
MH	19.7	17.5	18.5	20.8	23.9	23.4	25.2	25.9
SD	23.5	21.8	23.4	23.8	25.0	24.0	25.0	26.4
US	21.3	21.2	21.3	21.2	21.3	21.3	21.5	22.6

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Diabetes

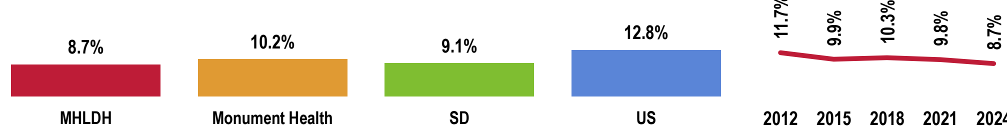
PRC SURVEY ▶ "Have you ever been told by a doctor, nurse, or other health professional that you have diabetes, not counting diabetes only occurring during pregnancy?"

PRC SURVEY ▶ "Other than during pregnancy, have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?"

Prevalence of Diabetes

Another 13.3% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

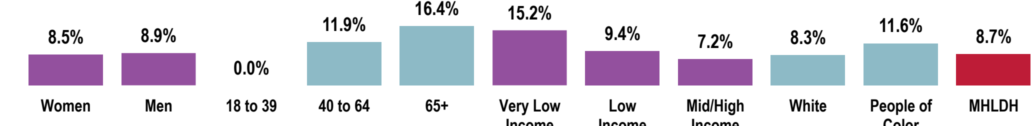
MHLDH Service Area



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 106]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
● 2023 PRC National Health Survey, PRC, Inc.

Notes: ● Asked of all respondents. Excludes gestational diabetes (occurring only during pregnancy).

Prevalence of Diabetes
(MHLDH Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 106]
Notes: ● Asked of all respondents.
● Excludes gestational diabetes (occurring only during pregnancy).

ABOUT KIDNEY DISEASE & DIABETES

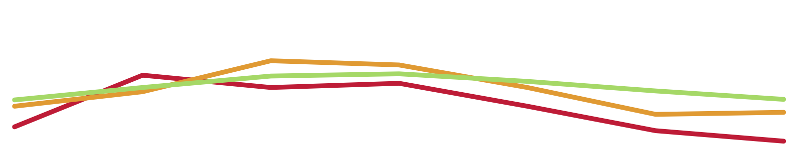
Chronic kidney disease (CKD) is common in people with diabetes. Approximately one in three adults with diabetes has CKD. Both type 1 and type 2 diabetes can cause kidney disease. CKD often develops slowly and with few symptoms. Many people don't realize they have CKD until it's advanced and they need dialysis (a treatment that filters the blood) or a kidney transplant to survive.

– Centers for Disease Control and Prevention (CDC)
https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html

Age-Adjusted Kidney Disease Deaths

Age-adjusted kidney disease mortality for the area is shown in the following chart.

Kidney Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



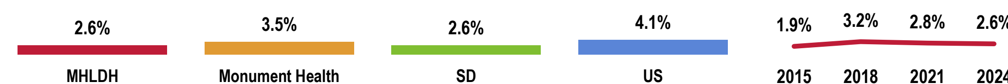
	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
MHLDH	4.7	7.2	6.6	6.8	5.7	4.5	4.0
MH	5.7	6.4	7.9	7.7	6.6	5.3	5.4
SD	6.0	6.6	7.2	7.3	6.9	6.4	6.0
US	13.2	13.3	13.3	13.2	13.0	12.9	12.8

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Kidney Disease

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with kidney disease?"

Prevalence of Kidney Disease
Healthy People 2030 = 11.4% or Lower



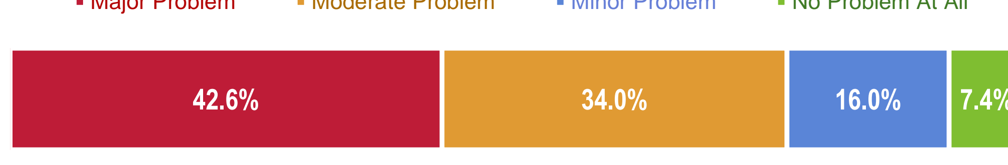
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 316]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:

Perceptions of Diabetes as a Problem in the Community
(Key Informants; MHLDH Service Area, 2024)



Sources:
- 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> Education on proper diet and programs. – Other Health Provider
>
> Good education and resources. – Other Health Provider
>
> Patient education is not enough. Patients need help to refrain from making emotional decisions that affect their health. Mastering a mindset is entirely different than providing left-brain, intellectual information. – Community Leader
>
> Accurate information on the contributors to diabetes, fresh foods, lousy food for school-age children who are not being fed the right foods, too much processed food in the school, no exercise programs for all students to do daily, and commodity foods are insufficient for healthy selection. – Community Leader
>
> Need better education and support on the prevention side. – Community Leader
>
> Access to nutritional education and support services. – Other Health Provider

Understanding the disease and what behaviors are needed to deal with the disease process, and then sticking with a treatment plan. – Community Leader

Education regarding managing diabetes. Access to healthy food choices. – Other Health Provider

Education in what foods are best for people with diabetes. Then the cost of these foods is a deterrent to changing their lifestyle. – Social Services Provider

Education and support. – Community Leader

Affordable Medications/Supplies

Cost of insulin. – Social Services Provider

Cost of supplies and cost of good food when you are on a limited budget. – Other Health Provider

When I used to work in a community service position, some members of the community would complain to me about being unable to afford their diabetes medicine, so they just weren't controlling their levels. Their health was deteriorating rapidly. I also think that our community could do a better job with education and outreach about diabetes and type 2 diabetes prevention. – Community Leader

Access to affordable supplies and medications. – Other Health Provider

Getting medicines. – Physician

Access to medications, healthy whole foods, stress management, and their mental health. – Physician

Getting medications and supplies, as well as a lack of following treatment plans. – Other Health Provider

Access to Affordable Healthy Food

Access and affordability of nutritious food. Inadequate physical activity; gym memberships are not affordable for low-income individuals. Access to diabetic supplies due to lack of transportation, lack of insurance, distance to clinics or medical facilities. – Social Services Provider

They do not have adequate quality fresh food options. The stores in the area are pricey and have limited quantities. Affordability of medications such as insulin and supplies. In-depth education opportunities with follow-up. Transportation. – Social Services Provider

Costs associated with good nutrition, medication, and testing supplies. – Other Health Provider

Access to affordable healthy foods. – Physician

There is limited availability for people in poverty to afford healthy options. – Social Services Provider

For low-income families, it is access to affording fresh fruits/veggies and other nutritious food for a healthy, well-balanced diet. Education on how to prepare food/cook less processed foods; also knowing that some people may not have working appliances or are living in hotels/substandard housing. – Social Services Provider

Access to Care/Services

Access to regular health care, ability to afford medications, and education as to how to care for yourself. – Social Services Provider

Patients lack access to services, medications, healthy food, and education regarding their disease state. The newer medications tend to be very expensive and often out of reach for the most vulnerable people. There tends to be a fatalism among many diabetics – they don't believe they can improve their condition and have lost many relatives to diabetes, so motivation to improve is lacking, because many people don't see the point in fighting it. There are many food deserts in the area where fast food and convenience stores are the only options within walking distance. Often, the food that people can afford on SNAP benefits are the worst foods for people with diabetes. In addition, primary care physicians don't have the time or resources to competently manage this very complex disease. It can be difficult to get the data out of EPIC that can help us identify patients who are falling out of compliance with diabetes recommendations. – Physician

Access to specialist care, affordable medications, and social determinants of health are contributing factors. Those without insurance are often needing to be managed in the community health center through primary care because Monument is the only one with an endocrinologist (and they need to apply and be accepted, delaying access). Only one pediatric endocrinologist in town. And not enough for adults. More demand than services available overall. – Other Health Provider

Access to treatment for those in more remote areas. – Social Services Provider

Disease Management

Lack of care on the patient's part. People do not take the disease seriously. – Other Health Provider

Patient noncompliance with medications, checking blood sugar, and going to appointments. – Social Services Provider

Incidence/Prevalence

> The rates of diabetes and pre-diabetes seem to be elevated in our region. Limited access to care in the more rural areas compounds this issue. Native American population is greatly impacted by diabetes. – Social Services Provider
>
> We have very high rates of diabetes, which is leading to large numbers of patients needing dialysis. – Public Health Representative

Diagnosis/Treatment

> Dialysis treatments. – Social Services Provider

Lack of Providers

> One of the biggest challenges is the lack of providers for the clinics. Wait times for specialties are also challenging. Motivation to care for themselves, such as taking medications, attending doctor appointments, and exercising, for some is another challenge. – Other Health Provider

Nutrition

> Proper nutrition and activity levels to help manage health before it becomes a serious issue. Increasing education and guidance for those diagnosed with the disease. – Community Leader

Vulnerable Populations

> We serve a large Native American population, and diabetes seems to overly affect this population. We have a large number of youth and adults who have poor eating habits and lifestyles that contribute to type 2 diabetes. – Social Services Provider

Disabling Conditions

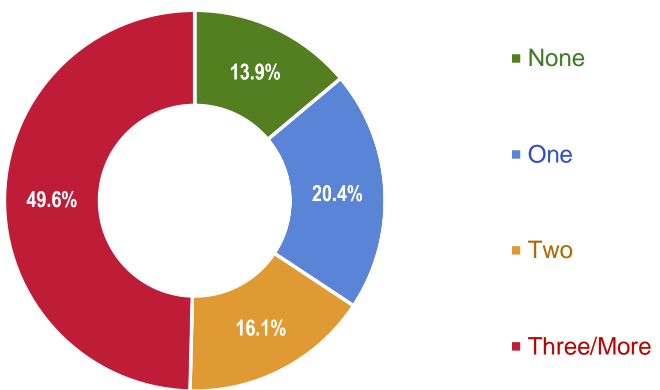
Multiple Chronic Conditions

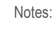
For the purposes of this assessment, chronic conditions include:

- Arthritis
- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart disease
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Osteoporosis
- Sciatica
- Stroke

The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

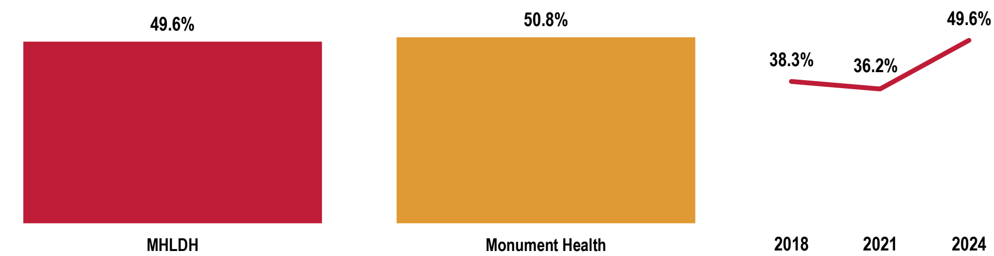
Number of Chronic Conditions
(MHLDH Service Area, 2024)





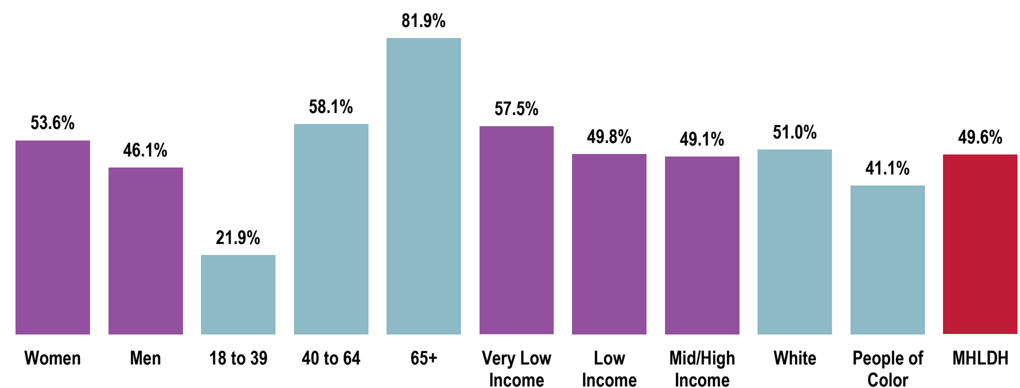
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 107]
Notes: • Asked of all respondents.
• In this case, chronic conditions include arthritis, asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, kidney disease, lung disease, obesity, osteoporosis, sciatica, and/or stroke.

Have Three or More Chronic Conditions



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 107]
Notes: ● Asked of all respondents.
● In this case, chronic conditions include arthritis, asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, kidney disease, lung disease, obesity, osteoporosis, sciatica, and/or stroke.

Have Three or More Chronic Conditions
(MHLDH Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 107]
Notes: ● Asked of all respondents.
● In this case, chronic conditions include arthritis, asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, kidney disease, lung disease, obesity, osteoporosis, sciatica, and/or stroke.

Activity Limitations

ABOUT DISABILITY & HEALTH

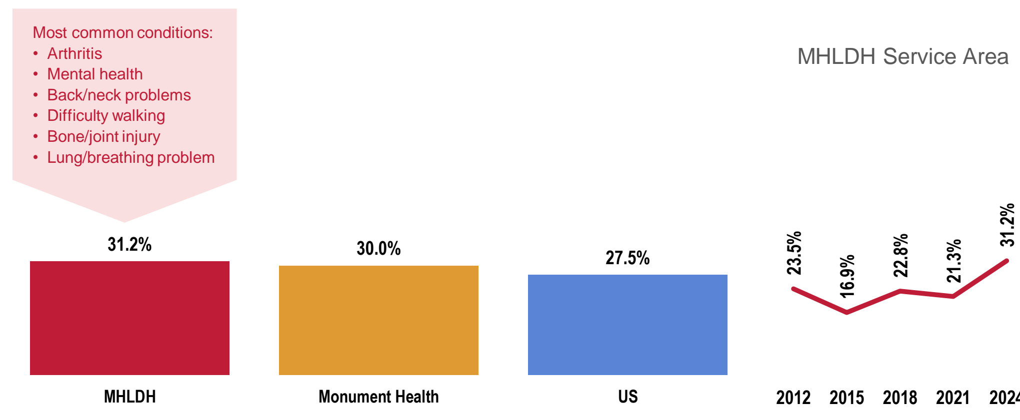
Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

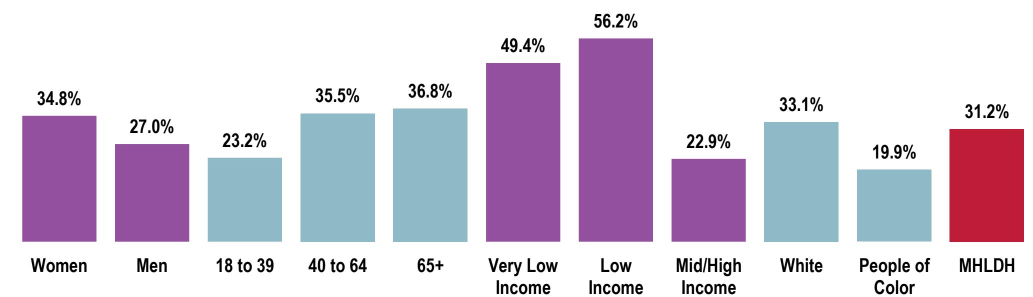
PRC SURVEY ▶ "Are you limited in any way in any activities because of physical, mental, or emotional problems?"

PRC SURVEY ▶ [Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Items 83-84]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Limited in Activities in Some Way
Due to a Physical, Mental, or Emotional Problem
(MHLDH Service Area, 2024)

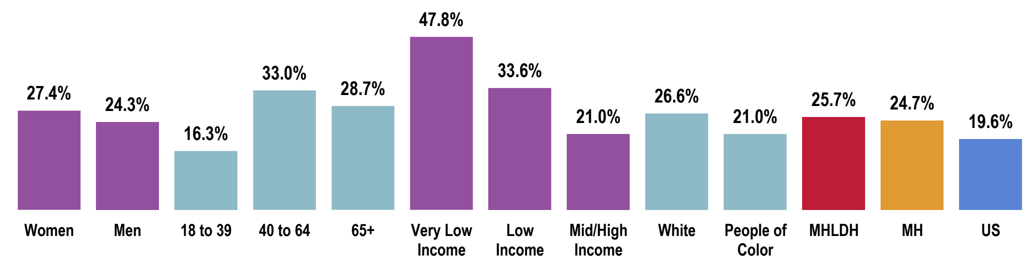


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: • Asked of all respondents.

High-Impact Chronic Pain

PRC SURVEY ▶ "Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?" (Reported here among those responding "most days" or "every day.")

Experience High-Impact Chronic Pain
(MHLDH Service Area, 2024)
Healthy People 2030 = 6.4% or Lower



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 31]
• 2023 PRC National Health Survey, PRC, Inc.
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: • Asked of all respondents.
• High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Potentially Disabling Conditions

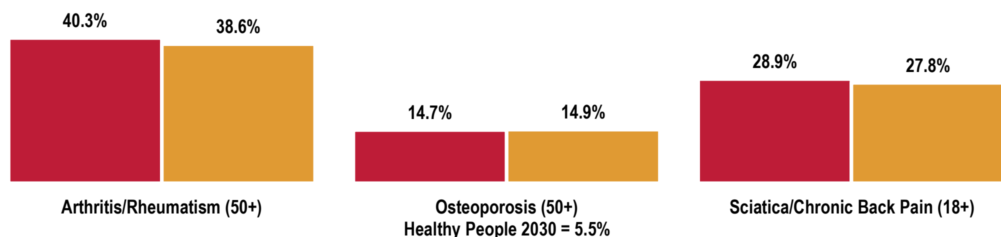
PRC SURVEY ► "Have you ever suffered from or been diagnosed with arthritis or rheumatism?" (Reported here among those respondents age 50 and older.)

PRC SURVEY ► "Have you ever suffered from or been diagnosed with osteoporosis?" (Reported here among those respondents age 50 and older.)

PRC SURVEY ► "Have you ever suffered from or been diagnosed with sciatica or chronic back pain?" (Reported here among those respondents age 18 and older.)

Prevalence of Potentially Disabling Conditions
(MHLDH Service Area, 2024)

▪ MHLDH ▪ Monument Health



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Items 314, 322-323]
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes: • The sciatica indicator reflects the total sample of respondents; the arthritis and osteoporosis columns reflect adults age 50+.

Alzheimer’s Disease

ABOUT DEMENTIA

Alzheimer’s disease is the most common cause of dementia… . Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there’s no cure for Alzheimer’s disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Alzheimer’s Disease Deaths

Age-adjusted Alzheimer’s disease mortality is outlined in the following chart.

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
MHLDH	25.9	27.1	25.5	26.3	27.4	29.3	30.4	32.8
MH	25.5	25.8	24.0	25.3	26.7	29.3	30.1	31.8
SD	37.0	36.8	35.3	36.0	36.3	36.8	37.9	38.8
US	23.1	24.7	27.4	29.7	30.2	30.6	30.4	30.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.

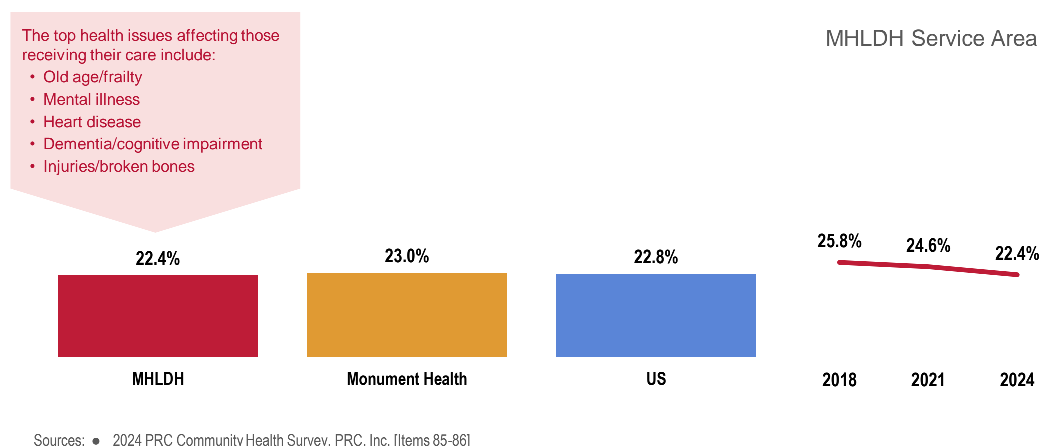
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Caregiving

PRC SURVEY ▶ **“People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?”**

PRC SURVEY ▶ [Among those providing care] **“What is the main health problem, long-term illness, or disability that the person you care for has?”**

Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability

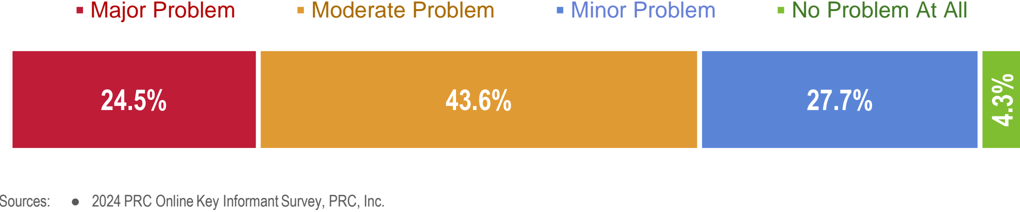


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 85-86]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Disabling Conditions

The following chart outlines key informants' perceptions of the severity of *Disabling Conditions* as a problem in the community:

Perceptions of Disabling Conditions as a Problem in the Community
(Key Informants; MHLDH Service Area, 2024)



Sources: ● 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

No chronic pain treatment is available other than medication through primary care. No specialty services for dementia or chronic pain. DME has to be brought to town or patient has to go to Rapid City. Optometry is available. No hearing evaluation available in town. – Physician

They have nowhere to stay if they have chronic pain or limitations. We do have a dementia unit, so that's good. No vision or hearing in Philip, and getting a resident to an appointment is a burden on the elderly. We used to have an eye doctor, which was fabulous. – Social Services Provider

We have limited hours of public transportation assistance. Limited access for home support services. No dementia caregiver support group in town. No adult day care for dementia patients so caregivers have respite. Limited counseling services in town for those with chronic pain. Crosswalks do not have audible signals for crossing for people with low vision. – Physician

It is hard to get in to see many of the doctors who treat these types of patients. Many times, it is faster to go out of town, and the services provided are better if you are able to get out of Rapid City. – Community Leader

I currently have a patient who has been in the hospital for eight months because we cannot find placement for her. I frequently have patients who are housed in the inpatient setting because they are not safe to live independently, but don't qualify for SNF or assisted living. Many patients live in suboptimal situations where home health can't go because it isn't safe, but then the patient cannot receive possible lifesaving or improving services. As the Baby Boom generation ages, we will see more and more of these cases. – Physician

It takes months to see specialists for a lot of these issues – Alzheimer's, for example. It takes months to get into a neurologist, then to get a referral for testing, months to get into an individual who does the testing, then months to get back into a neurologist, etc. It's a horrible cycle for the patient and the caregiver while they are going through something completely scary. Then, once they get the diagnosis, the specialist doesn't even give any resources to the caregiver. People are fumbling around blind without resources and education. – Social Services Provider

There are few resources available in our community to assist people with disabilities. – Community Leader

I see a huge number of people in the community that appear to suffer from some neurological issue. They may walk with a cane, walker, or wheelchair, and there are not enough resources in the community to assist people in need, especially if they are homebound. Most, if not all, disabled people do not have the money to hire someone to come into the home to help with basic needs and hygiene on a daily basis. – Social Services Provider

Aging Population

It seems a large population of those 55+ are suffering from disabling conditions. – Community Leader

I think it is primarily because the median age of Custer County residents is so high. The last time I checked, it was the highest in the state. Since we have an older population, we have more community members dealing with dementia, hearing loss, and vision loss. – Community Leader

Our community is aging. We need resources to address the health needs of an aging population, including affordable home health care, more transportation, and housing options. – Community Leader

Dementia. Psych issues of all kinds. – Other Health Provider

A significant aging and retired population in the community adds to this growing need, with limited access for individuals for these conditions, especially for the uninsured and low-income. Neuropsychic evaluations have very limited access. If you're uninsured, there is a long process that can be a hurdle. The result is that disabling conditions remain disabling at a higher level for those that are low-income and most disenfranchised in the community. – Other Health Provider

Due to the age of the people in our community. – Community Leader

Built Environment

There are no sidewalks in the community to permit those in wheelchairs to access the post office, the IHS clinic, the grocery store, or other services. There are no crosswalks with vision-/hearing-impaired signals for individuals to cross safely; many are homebound, without CHR services to go to appointments. – Community Leader

Area infrastructure is not made to accommodate disabilities. It takes several attempts to apply for disability benefits. – Social Services Provider

Vision Care

Resources are sorely missing for low-cost or no-cost vision care (basic eye exams and prescription eyeglasses) for socioeconomically disadvantaged adults who tend to be at greater risk for undiagnosed and uncorrected eye disorders and diseases. Medicare does not cover the costs of routine eye exams or eyeglasses for those 65+, even as a part of some otherwise covered exams, and while Medicaid provides for basic eye exams and eyeglasses for those under 18, it is not an option for those 18 and over; thus, many adults are held back from gaining employment, living independently, and providing for themselves and their family due to simply needing an eye exam and a pair of corrective eyeglasses. LifeSight, a Rapid City-based nonprofit, is the sole organization in the region with programming to mitigate this disability through a combination of education, access to medical care, and provision of eyeglasses; however, extra financial resources are greatly needed to support this outreach. – Social Services Provider

Work Related

We have a lot of blue collar and physical labor jobs in our area, which inevitably leads to issues with pain. It may be small when it starts, but as people age, it certainly gets worse. This leads to less activity, which further contributes to the problem. Traditionally, pain meds are given, which can lead to other issues. I think there could be better pain management and solutions that could be pursued. – Community Leader

Follow Up/Support

Many people with dementia and elderly people that cannot take care of themselves all alone. – Other Health Provider

Housing

Not enough housing. – Social Services Provider

BIRTHS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

– Healthy People 2030 (https://health.gov/healthypeople)

Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

Low-Weight Births
(Percent of Live Births, 2016-2022)

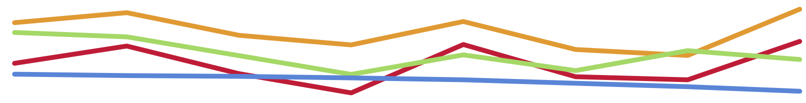
Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2024 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. High infant mortality can highlight broader issues relating to health care access and maternal/child health.

Infant Mortality Trends
(Annual Average Infant Deaths per 1,000 Live Births)
Healthy People 2030 = 5.0 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
MHLDH	6.3	6.9	6.0	5.4	6.9	5.9	5.8	7.0
MH	7.6	7.9	7.2	6.9	7.6	6.8	6.6	8.0
SD	7.3	7.1	6.6	6.0	6.6	6.1	6.7	6.4
US	6.0	5.9	5.9	5.9	5.8	5.7	5.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted October 2024.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Family Planning

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Here, teen births include births to women age 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

The following chart outlines local teen births, compared to the state and nation. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior.

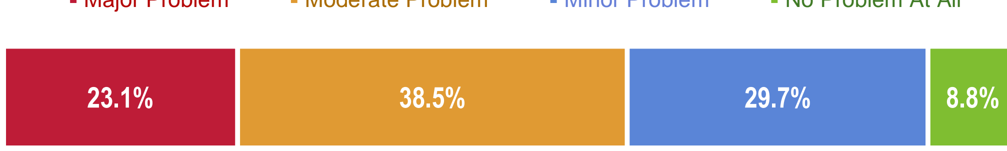
Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19.

Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health & Family Planning* as a problem in the community:

Perceptions of Infant Health & Family Planning as a Problem in the Community
(Key Informants; MHLDH Service Area, 2024)



Sources:
- 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Limited access to health services, especially on the reservations. Limited care during the early stages of pregnancy. Substance use and other social determinants of health factors are high. – Other Health Provider
>
> There is a lack of prenatal care in our community. People must travel to go to their appointments. – Public Health Representative
>
> Access to care in rural areas. Driving distance and cost. – Community Leader
>
> Obstetric care in Rapid City is becoming very limited. With government changes and several of our physicians retiring, women's health care is lacking. – Other Health Provider

> With Medicaid covering child care for the first year, people can get health care for babies. The problem again is transportation. For family planning, transportation and getting appointments are issues. – Other Health Provider
>
> We have a high number of pregnant patients with late, limited, or no prenatal care. We see a lot of drug and alcohol use during pregnancy and a lot of untreated STDs. Women are sometimes uninsured, don't seek assistance, and/or struggle with transportation. – Social Services Provider
>
> Health deserts, disparities in health care, limited access to quality health care, and transportation issues. Lack of knowledge. – Social Services Provider

Awareness/Education

> Young women getting pregnant. No facilities with education. – Community Leader
>
> Public education and information have lost ground with the change of assignments and roles in Community Health Nurse. – Other Health Provider

Lack of Providers

> No OB and limited prenatal care in town. Community Health Nurse is spread thin and has difficulty interfacing with the systems. State programs are still on older computer systems or paper that don't work well with large EHRs. No OB outreach here and not enough health providers to take on this duty. We do see newborns and take care of children fairly well. – Physician

Alcohol/Drug Use

> The number of births occurring with mothers suffering from substance use disorders and untreated mental health conditions. – Social Services Provider

Incidence/Prevalence

> Just watching the media, reading, newspaper, and watching TV. People on the sidewalks in my own neighborhood involved with a women's shelter. – Community Leader

Need a Mentorship Program

> I would love to see a mentorship program for young families to teach cooking skills, personal finance, and connection within the community to support young families. – Physician

Infant Mortality

> South Dakota has one of the highest infant death rates in the nation, with the Native American population being at increased risk. – Social Services Provider

Noncompliance

> Noncompliance with prenatal care. – Social Services Provider

Immunizations

> Many children are not as immunized as they should be. Large numbers of delinquent children. There are large numbers of unplanned pregnancies. – Other Health Provider

Unplanned Pregnancies

> Rate of unplanned and single-parent pregnancies. Lack of prenatal care in large portions of the population. Very high rate for gestational and infant mortality. – Other Health Provider

Lack of Parenting Skills

> Lack of parenting skills. If children could learn at home the essentials and are fed properly, they can learn at school. – Community Leader

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

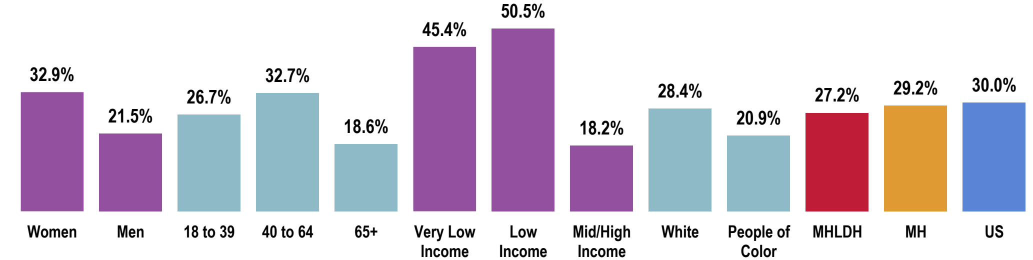
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Fresh Produce

PRC SURVEY ▶ "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"

Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce
(MHLDH Service Area, 2024)



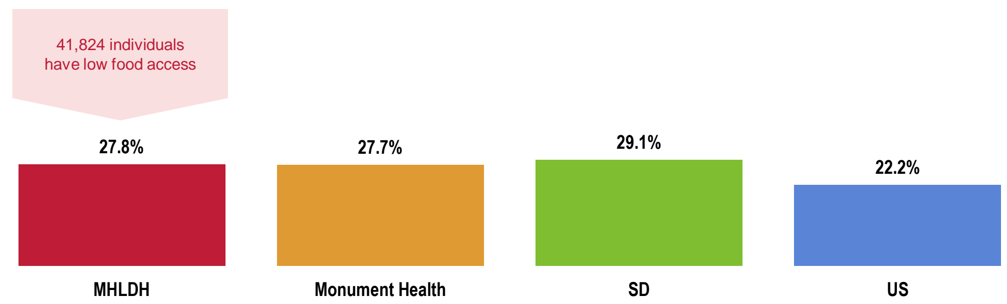
Sources:

Notes: Asked of all respondents.

Low Food Access

Low food access is defined as living more than one mile from the nearest supermarket, supercenter, or large grocery store in urban areas (10 miles in rural areas). This related chart is based on US Department of Agriculture data.

Population With Low Food Access
(2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2024 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store for urban census tracts, and 10 miles for rural ones.

Physical Activity

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

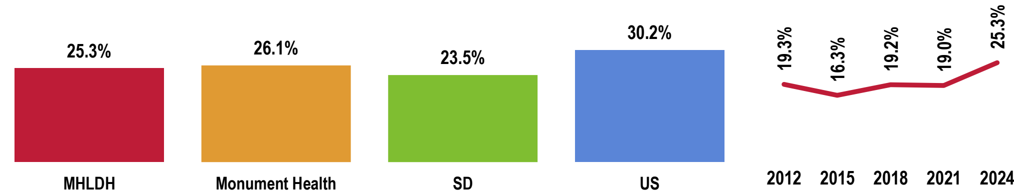
Leisure-Time Physical Activity

PRC SURVEY ▶ "During the past month, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower

MHLDH Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 69]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

- **Aerobic activity** is at least 150 minutes per week of light-to-moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- **Strengthening activity** is at least 2 sessions per week of exercise designed to strengthen muscles.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

To measure physical activity frequency, duration and intensity, respondents were asked:

PRC SURVEY ▶ "During the past month, what type of physical activity or exercise did you spend the most time doing?"

PRC SURVEY ▶ "And during the past month, how many times per week or per month did you take part in this activity?"

PRC SURVEY ▶ "And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

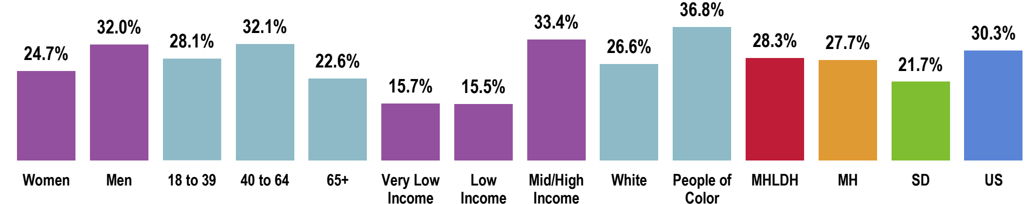
Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

PRC SURVEY ▶ "During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."

Meets Physical Activity Recommendations
(MHLDH Service Area, 2024)

Healthy People 2030 = 29.7% or Higher



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 110]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Children's Physical Activity

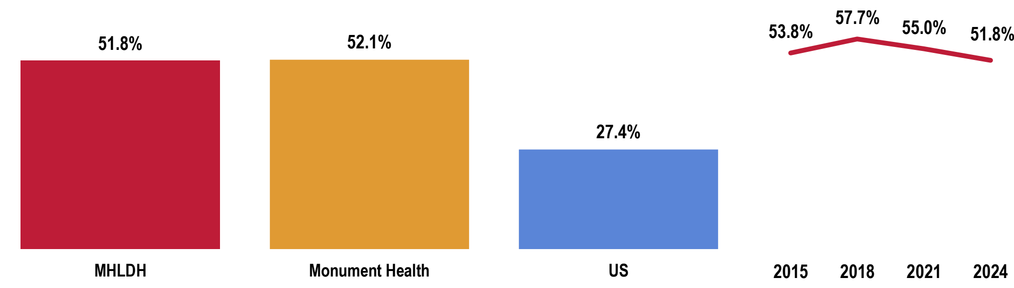
CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

PRC SURVEY ▶ "During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"

Child Is Physically Active for One or More Hours per Day
(Children 2-17)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 94]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children age 2-17 at home.
● Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Weight Status

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

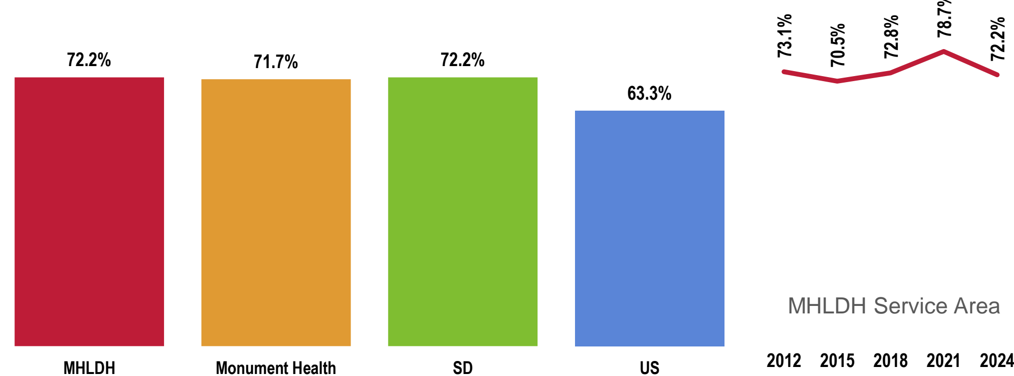
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

PRC SURVEY ▶ "About how much do you weigh without shoes?"

PRC SURVEY ▶ "About how tall are you without shoes?"

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight (Overweight and Obese)

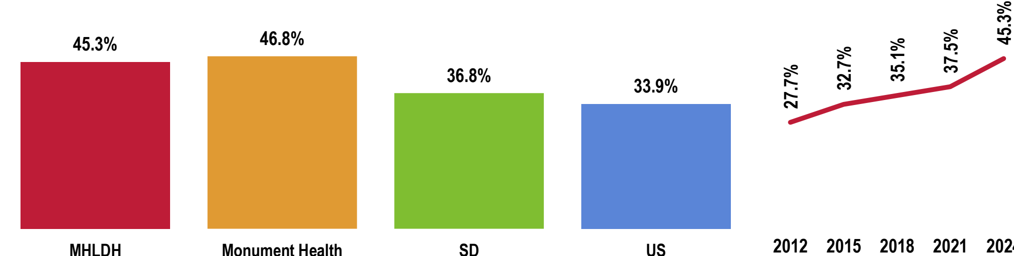


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

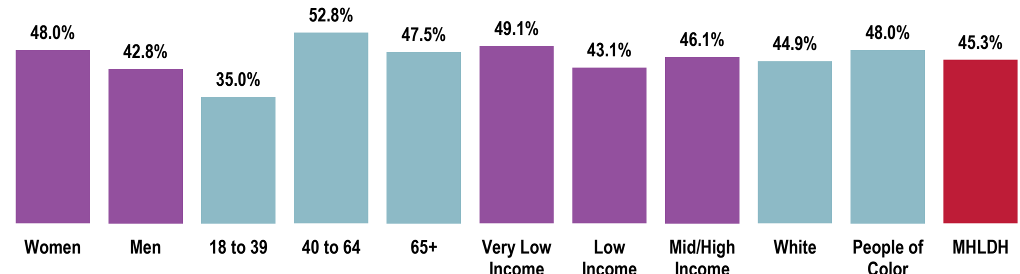
Healthy People 2030 = 36.0% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.

Prevalence of Obesity
(MHLDH Service Area, 2024)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Children's Weight Status

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

– Centers for Disease Control and Prevention

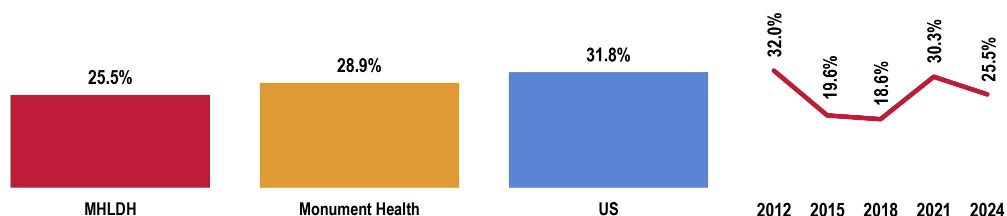
The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

PRC SURVEY ▶ "How much does this child weigh without shoes?"

PRC SURVEY ▶ "About how tall is this child?"

Prevalence of Overweight in Children
(Children 5-17)

MHLDH Service Area



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 113]
• 2023 PRC National Health Survey, PRC, Inc.

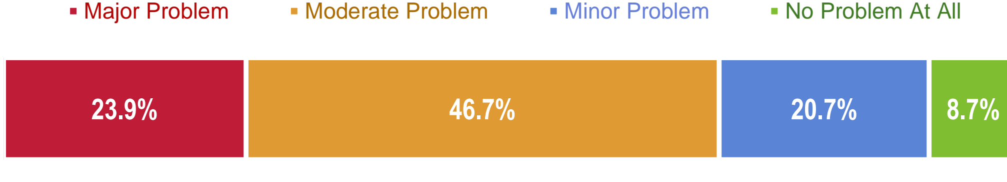
Notes: • Asked of all respondents with children age 5-17 at home.
• Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity & Weight as a Problem in the Community
(Key Informants; MHLDH Service Area, 2024)

▪ Major Problem ▪ Moderate Problem ▪ Minor Problem ▪ No Problem At All



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Lifestyle

> People do not stay active or in shape. They also do not concentrate on nutrition. – Other Health Provider
>
> Food insecurity and poor nutrition choices. Low access to organized physical activities. Many outdoor options. Single parents working shifts, and households have less time and money for physical activity. – Community Leader
>
> Obesity, a lack of exercise, and a lack of healthy foods. Encouragement to get outside. People often spend great amounts of time indoors playing video games. – Social Services Provider
>
> Access, cost, and knowledge. We have limited resources for healthy food options when someone is living on a fixed income, and in rural areas, there are so many people who have no quick access to food. The same goes for physical activity – if you live in an area that has limited resources or facilities that cost too much, most people will have to rely on walking but living in an area with four seasons – this can be a deterrent or dangerous in some instances. Once you have an injury, that can really lead to a downward spiral for so many people, particularly our elderly population. Each of these subject areas are intertwined – once the scale is tipped on any of them, you will most likely have issues in all of them. – Community Leader
>
> People are sedentary, and quality food is expensive. – Community Leader
>
> Not enough activity. – Community Leader

Access to Affordable Healthy Food

> Affordable healthy food. – Physician
>
> Lack of options for lower-income individuals to access healthy foods, weight loss programming, and preventative care to reduce obesity. – Social Services Provider
>
> Limited access to healthy food choices. One small grocery store is unable to stock a variety of items. – Other Health Provider
>
> Cost of food that is appropriate for health and weight loss. Desire to work out. – Other Health Provider
>
> Access to affordable, healthy food choices. Food is expensive. Less healthy choices have to be made when there are families to feed on a budget. – Other Health Provider

Nutrition

> Bad nutrition habits. – Community Leader
>
> Food deserts are a real problem in rural areas and on the north side of Rapid City. If patients don't have reliable transportation, getting to stores with healthy food choices is nearly impossible. – Physician

Awareness/Education

> We need to have cooking classes for those getting food assistance. Schools need to return to basic home economics kinds of curricula so adolescents learn how to cook better meals. Physical education classes should include lifetime physical activities (vs. basketball and football always), as well as nutrition. Somehow, we need to "reset" so that obesity is not OK and is not the norm. – Community Leader

Lack of Providers

> No nutritionists are able to come to rural health clinics and bill for services. We have a dietician who comes to Monument Clinic on a few "Diabetes Days" per month. We have a lot of overweight people on low income who can't afford activities or ideal food. – Physician

Cultural/Personal Beliefs

> Cultural influences drive eating habits and physical activity habits. Cost and availability of food are also concerns. – Other Health Provider

Food Industry

> The food industry had a history of making food more addictive. Addiction to screen time. – Physician

Substance Use

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

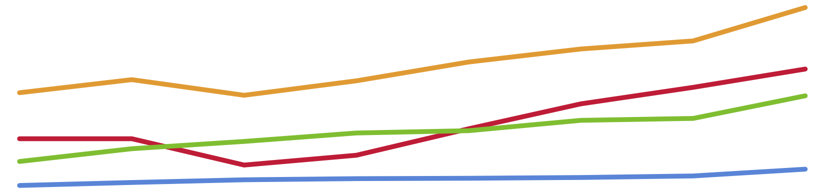
– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol

Age-Adjusted Alcohol-Induced Deaths

The following chart outlines age-adjusted, alcohol-induced mortality in the area.

Alcohol-Induced Deaths: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
MHLDH	15.6	15.6	12.4	13.6	16.8	19.8	21.8	24.0
MH	21.1	22.7	20.8	22.6	24.9	26.4	27.4	31.4
SD	12.8	14.4	15.3	16.3	16.6	17.8	18.0	20.8
US	9.9	10.3	10.6	10.8	10.8	10.9	11.1	11.9

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Excessive Drinking

PRC SURVEY ▶ "During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

PRC SURVEY ▶ "On the day(s) when you drank, about how many drinks did you have on average?"

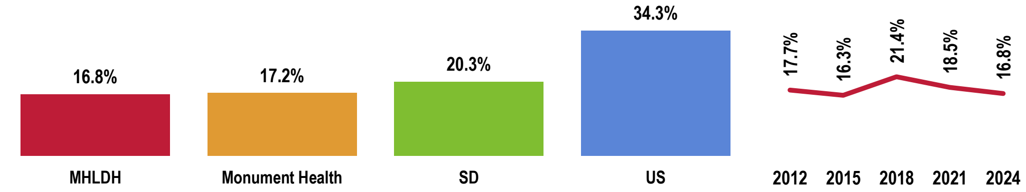
PRC SURVEY ▶ "Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)**/4** (if female) **or more drinks on an occasion?"**

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKING ▶ men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKING ▶ men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

Engage in Excessive Drinking

MHLDH Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
- 2023 PRC National Health Survey, PRC, Inc.

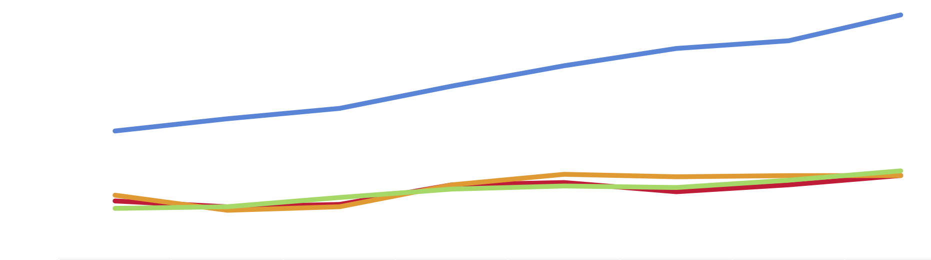
Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drugs

Age-Adjusted Unintentional Drug-Induced Deaths

Unintentional drug-induced deaths include all deaths, other than suicide, for which drugs are an underlying cause. A “drug” includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines local age-adjusted mortality for unintentional drug-induced deaths.

Unintentional Drug-Induced Deaths: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
MHLDH	5.0	4.5	4.7	6.4	6.6	5.8	6.4	7.2
MH	5.5	4.2	4.5	6.4	7.3	7.1	7.2	7.2
SD	4.4	4.5	5.3	6.0	6.3	6.2	6.8	7.6
US	11.0	12.1	13.0	14.9	16.7	18.1	18.8	21.0

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2024.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

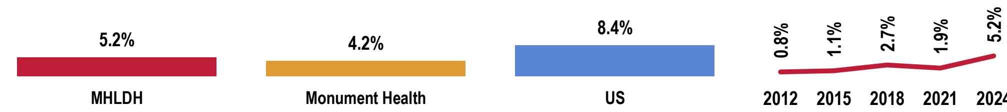
Illicit Drug Use

PRC SURVEY ▶ “During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?”

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

Illicit Drug Use in the Past Month

MHLDH Service Area



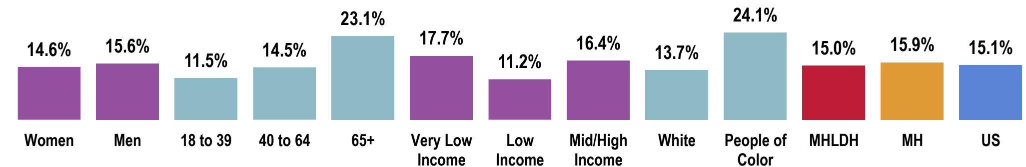
Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 40]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

PRC SURVEY ▶ "Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"

Used a Prescription Opioid in the Past Year
(MHLDH Service Area, 2024)



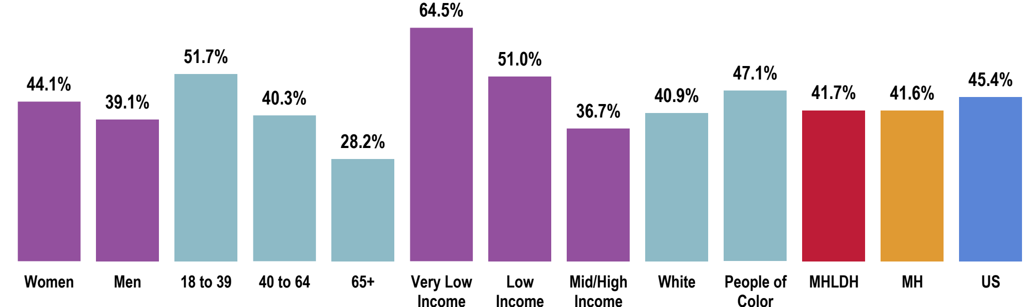
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 41]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Personal Impact From Substance Use

PRC SURVEY ▶ "To what degree has your life been negatively affected by your own or someone else's substance use issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)
(MHLDH Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 43]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," or "a little."

Key Informant Input: Substance Use

The following chart outlines key informants' perceptions of the severity of *Substance Use* as a problem in the community:

Perceptions of Substance Use as a Problem in the Community
(Key Informants; MHLDH Service Area, 2024)

Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Wait times for assessments, long lists, and available beds. This is a statewide issue, and it is difficult even for those who are doing their very best to get people into programming. – Community Leader

Treatment facilities, both inpatient and outpatient. – Community Leader

Access, cost, and availability. We also do not invest enough in prevention. Many people with substance abuse disorders are usually also dealing with unmet mental health needs or a pervasive health issue, and that further complicates the issue. – Community Leader

The lack of treatment facilities in this particular area poses a great barrier. Unwillingness to participate in treatment is a huge issue, as well. – Other Health Provider

Lack of programs. Lack of insurance. – Other Health Provider

There are not enough substance abuse treatment centers. – Community Leader

Lack of space and providers who can focus on substance use treatment. We lack the support system of counseling, social work, and enough providers who can focus time and attention on this. – Physician

Lack of addiction services in town. – Physician

Inpatient counseling. Alcohol treatment centers are lacking in West River. – Community Leader

Lack of treatment facilities. – Community Leader

We need small local clinics in each district for this. In every community, mandatory treatment, if unable to make a successful recovery from nonresidential, have a residential treatment facility off-reservation that is a minimum of six months to one year. Include job skills and life skills training for those in treatment. Many may have dual diagnoses and need mental health support. – Community Leader

Access to enough services, and people's desire to seek services. – Community Leader

Lack of available treatment beds. – Social Services Provider

Lack of inpatient treatment centers or rehabs for detoxing and recovering patients. – Public Health Representative

Inpatient rehab facilities are not local. The distance to travel is quite far for those. – Community Leader

The amount of programs to help, the accessibility of the current programs, and the effectiveness of current treatment processes. – Community Leader

Availability of treatment facilities within the communities. – Social Services Provider

Shortage of addiction treatment facilities, shortage of addiction counselors, cost of services, distance to treatment facilities, and lack of aftercare services. – Social Services Provider

Access to and affordability of long-term treatment. Lack of treatment options, as few medications are effective in treating substance abuse and prolonging abstinence. Scarcity of treatment facilities in South Dakota. – Social Services Provider

Again, lack of resources and education. – Social Services Provider

There is not a resident care provider for substance treatment, except for pregnant mothers. – Other Health Provider

Stigma/Denial

Getting people to the point where they are ready for treatment services. Lack of follow-through by the patients and few resources available upon discharge from treatment facilities to avoid going back to the same households. – Social Services Provider

The denial of people that they have a problem. – Social Services Provider

Many people probably know they have a problem but are not motivated to get going and do something about it. Maybe raising awareness about what is available would help. – Community Leader

The addicts have to want treatment. It is a disease, which is a daily battle, and they have to want to go to battle against it. There are many facilities available to assist. – Community Leader

Patient readiness and follow-through. – Social Services Provider

Awareness/Education

Not knowing of treatment services available in our community. – Social Services Provider

Lack of knowledge regarding availability of resources. – Other Health Provider

Knowing where to go, probably for higher income earners. Stop the shame. Privacy. – Community Leader

Education starting in elementary school is about violence and drug abuse, and having their parents attend parenting classes of children who are tardy, absent, disruptive in class, or falling behind. – Community Leader

Lack of Providers

Staffing challenges in many programs, lack of services in rural communities, and types of treatment available to treat more recent substance issues, in particular methamphetamine. – Social Services Provider

We need more providers who are comfortable providing substance abuse treatment. We have seen some positive trends this year and with Project Recovery, but it is difficult to get long-term treatment for substance use. As far as I am aware, there are no local inpatient treatment centers in Western South Dakota, nor are there any sober living facilities. – Physician

There are limited providers in the West River area. Frequently, youth have to go across the state for residential treatment, and when released back to their communities, have no access to aftercare. There are also limited services for adults. – Social Services Provider

Diagnosis/Treatment

The challenges of substance use: It's incredibly difficult and expensive to adequately treat. – Other Health Provider

This is hard because it is so dependent on the person who is experiencing the SUD and what kind of support they have. They have to get a D/A assessment, and that means they have to make it to the appointment or make it to a walk-in clinic. Then they have to get a referral for a place to go. – Social Services Provider

Treatment programs are too short to create lasting change for people, so recidivism is high and costly. – Social Services Provider

Incidence/Prevalence

Illicit drug use and high incidence of emergency room visits linked to illicit drug use, such as methamphetamine. – Other Health Provider

End-stage liver disease. I have worked at MH for 15 of the last 18 years, and I have personally cared for several dozen patients under the age of 40 who have died from liver disease, primarily attributable to alcohol use. We lack access to reliable substance abuse treatment, as well as access to transplant services. It is a critical need in our community. – Physician

Affordable Care/Services

Long-term affordable care and treatment. – Social Services Provider

Treatment is available but quite expensive. A bigger issue is our acceptance of those behaviors. – Community Leader

Easy Access

Easy to get, and the community thrives on it. – Community Leader

Funding

Funding for professionals to operate programs. – Other Health Provider

Social Norms/Community Attitude

> The attitude that "it is only beer." The difficulty law enforcement has in arresting drug dealers. – Other Health Provider

Transportation

> Transportation and shame/pride. – Community Leader

Tobacco Use

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

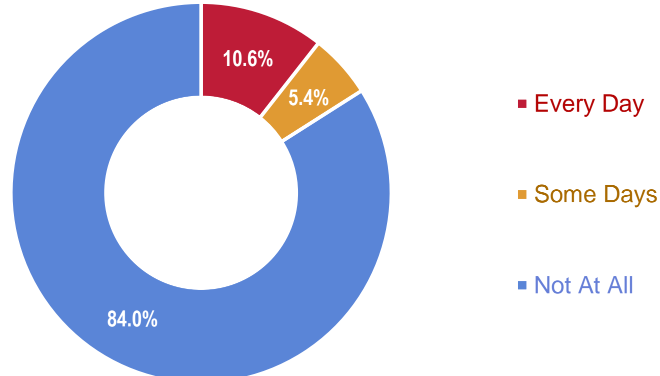
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

PRC SURVEY ▶ "Do you currently smoke cigarettes every day, some days, or not at all?"
("Currently Smoke Cigarettes" includes those smoking "every day" or on "some days.")

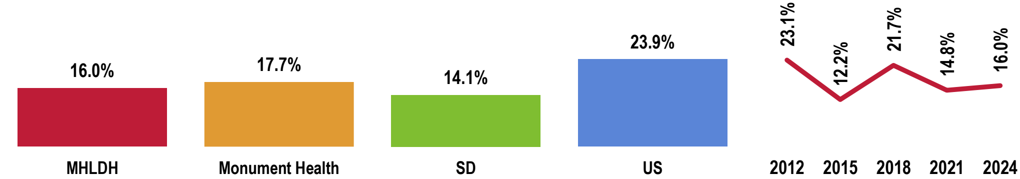


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: ● Asked of all respondents.

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower

MHLDH Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.

Environmental Tobacco Smoke

PRC SURVEY ▶ "In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars, or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents.

Member of Household Smokes at Home

MHLDH Service Area

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 35]
- 2023 PRC National Health Survey, PRC, Inc.

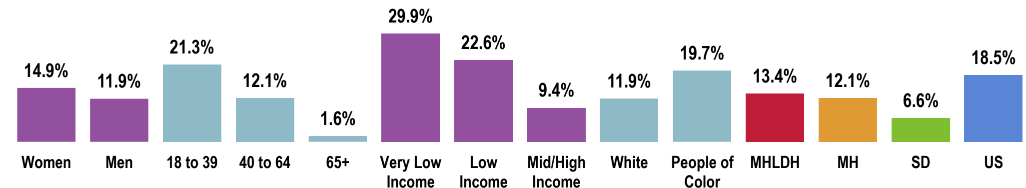
Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Use of Vaping Products

PRC SURVEY ▶ "Electronic vaping products, such as electronic cigarettes, are battery-operated devices that simulate traditional cigarette smoking but do not involve the burning of tobacco. Do you currently use electronic vaping products, such as electronic cigarettes, every day, some days, or not at all?"

("Currently Use Vaping Products" includes use "every day" or on "some days.")

Currently Use Vaping Products
(MHLDH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 36]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
• 2023 PRC National Health Survey, PRC, Inc.

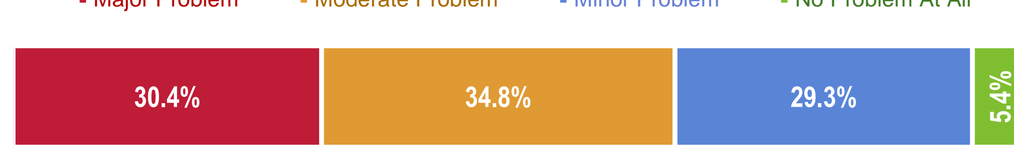
Notes: • Asked of all respondents.
• Includes those who use vaping products every day or on some days.

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:

Perceptions of Tobacco Use as a Problem in the Community
(Key Informants; MHLDH Service Area, 2024)

▪ Major Problem ▪ Moderate Problem ▪ Minor Problem ▪ No Problem At All



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Many people smoke regularly. – Community Leader
>
> The number of people you see smoking seems quite high compared to other areas traveled. – Community Leader
>
> High incidence of hospitalizations with pulmonary problems that are likely linked to smoking or smoking history. – Other Health Provider

I am surprised by how many people still smoke. It seems like there was a time when it seemed like it was decreasing, but I feel like I am seeing more and more people picking the habit up. I know that for many people, smoking is a way to cope with depression and anxiety, and it is more accessible than conventional treatment. I think we still have a fair amount of people who use smokeless tobacco. Nicotine is a very challenging substance to break free without some good intervention like cessation medication. I have known so many people over the years who quit, only to take it back up years later. Again, I think that is directly tied to people needing alternative methods to cope with the stressors of life. – Community Leader

Many people of all ages are still smoking, and lots of vape use by young people. – Physician

Chewing tobacco is a serious problem, and so is smoking. – Other Health Provider

Utilization is high. – Other Health Provider

People are highly addicted. – Social Services Provider

E-Cigarettes

I'm including vaping into the category of tobacco use. I believe there has become an acceptance of this as a less harmful method of tobacco use, and it has become more prevalent with middle and high school students. – Social Services Provider

Addictive, new, and "exciting" ways to use through vaping. Access for underage smokers. – Social Services Provider

Impact on Quality of Life

It is a waste of money and has many adverse effects health-wise. – Community Leader

It warms individuals' health, along with the people around them. – Social Services Provider

Lifestyle

Some people believe it has calming benefits. Both chewing tobacco and cigarettes are a problem. – Community Leader

Many people use tobacco as a coping mechanism. – Social Services Provider

Social Norms/Community Attitude

"Traditional" Midwest. Availability of products, maybe just nicotine, such as Zyn, Zimo, and others. – Community Leader

Tobacco use is a common practice in Western culture, and this area of the country has more tobacco users than most other areas of the United States. Many tobacco users don't comprehend, or they ignore the health risks. – Social Services Provider

Child/Youth Use

Gateway drugs lead to use of other substances and compromised health. Children and the youth see it and try it to be "grown-up." – Community Leader

Income/Poverty

People in lower-income brackets lean heavily on tobacco, yet often lack adequate access to health care, compounding the issues caused by tobacco use. – Social Services Provider

Access to Care/Services

There is currently no tobacco addiction programs in the area. – Community Leader

Addiction

It is a highly addictive substance. – Other Health Provider

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

Sexually Transmitted Infections (STIs)

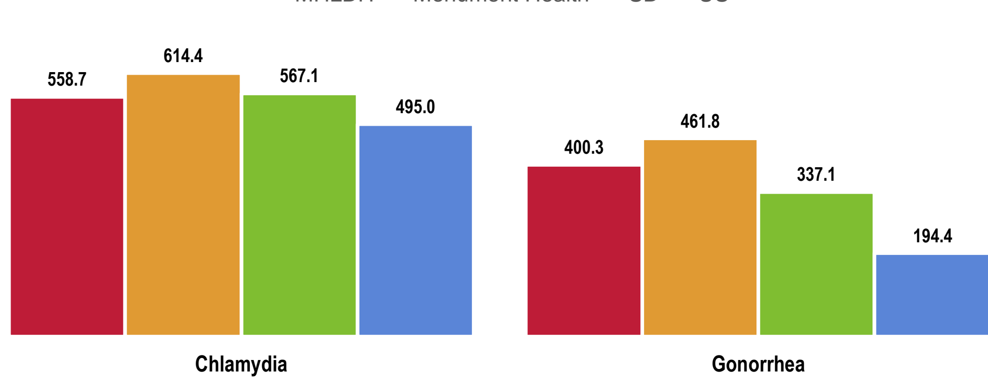
Chlamydia

Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

Gonorrhea

Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

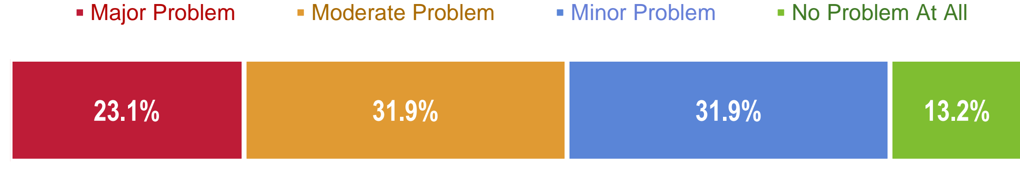
The following chart outlines local incidence for these STIs.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2024 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual Health* as a problem in the community:



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Increase in STDs. – Other Health Provider
>
> Community discussions about how STDs are high in the community. – Social Services Provider
>
> Large number of STDs in our area. There is also a large number of people who do not complete their entire treatment plan. – Public Health Representative
>
> Congenital syphilis is on the rise. – Other Health Provider
>
> We have an extremely high rate of STDs and so many youths and adults who are not practicing safe sex. They also are not seeking out medical assistance when issues arise and continue to be irresponsible in their sexual activities. – Social Services Provider
>
> South Dakota is number one in syphilis. – Physician

Awareness/Education

> College community. Little education within schools regarding the topic. Limited resources for education and related health care. – Community Leader
>
> Lots of STIs. I have heard that the sexual health education at the school is lacking. No state family planning office in town – OCPS clinic used to get STI meds from the state to administer to exposed patients, no longer provided by the state. Cost of testing or clinic visits to get meds is a barrier. Would be great to have a county health nurse and state medications. – Physician
>
> Lack of education and prevention in schools and homes. – Social Services Provider

Prevention/Screenings

> Many of those who have STDs are young and don't have access to prevention or care without a parent's signature. Homeless and people who are "couch surfing" oftentimes have multiple partners and don't seem to know the health history of the partners they are having sex with. People using drugs "pay" for drugs with exchanging sex for drugs. – Other Health Provider

Vulnerable Populations

> One of the worst rates of syphilis in the United States; particularly rampant with Native American population. Lack of services and the remote nature of the reservation contributes to the problem. Substance use is a major contributing factor. Lack of resources – limited access for HIV care. Ongoing stigma related to sexual health issues, exacerbated by the conservative nature of Western South Dakota. – Other Health Provider

Alcohol/Drug Use

> Drugs, mental health issues, violence, and injury have all been part of the sexual health concerns. The rapes of young ladies and some boys. Child abuse. – Community Leader

Disease Management

> Noncompliance. Patients do not reach out to physicians, do not get treated, or get re-exposed. – Social Services Provider

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Lack of Health Insurance Coverage

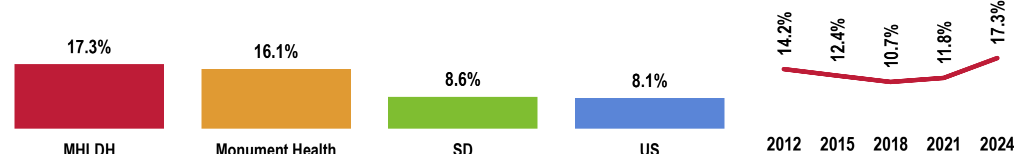
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans.

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

PRC SURVEY ▶ "Do you have any government-assisted health care coverage, such as Medicare, Medicaid, or VA/military benefits?"

PRC SURVEY ▶ "Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself or get through a health insurance exchange website; or, you do not have health insurance and pay entirely on your own?"

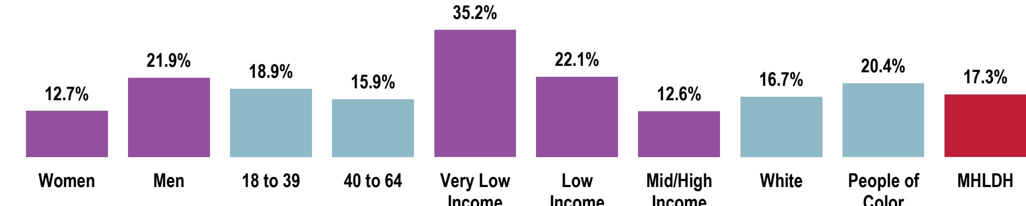
Lack of Health Care Insurance Coverage
(Adults 18-64)
Healthy People 2030 = 7.6% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage
(Adults 18-64; MHLDH Service Area, 2024)
Healthy People 2030 = 7.6% or Lower



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: • Reflects respondents age 18 to 64.

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand health care access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

PRC SURVEY ▶ **"Was there a time in the past 12 months when you needed medical care but had difficulty finding a doctor?"**

PRC SURVEY ▶ **"Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"**

PRC SURVEY ▶ **"Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?"**

PRC SURVEY ▶ **"Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"**

PRC SURVEY ▶ **"Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"**

PRC SURVEY ▶ **"Was there a time in the past 12 months when you needed a prescription medicine but did not get it because you could not afford it?"**

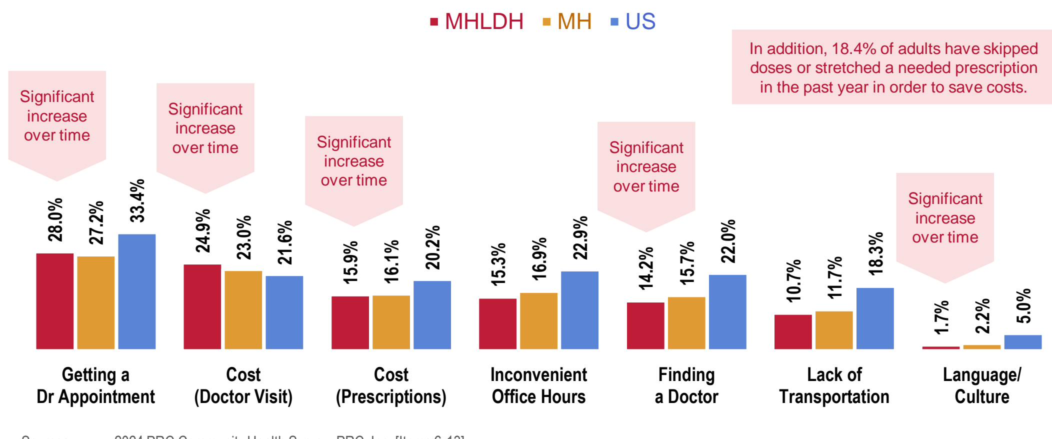
PRC SURVEY ▶ **"Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"**

Also:

PRC SURVEY ▶ **"Was there a time in the past 12 months when you skipped doses or took smaller doses in order to make your prescriptions last longer and save costs?"**

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Medical Care in the Past Year

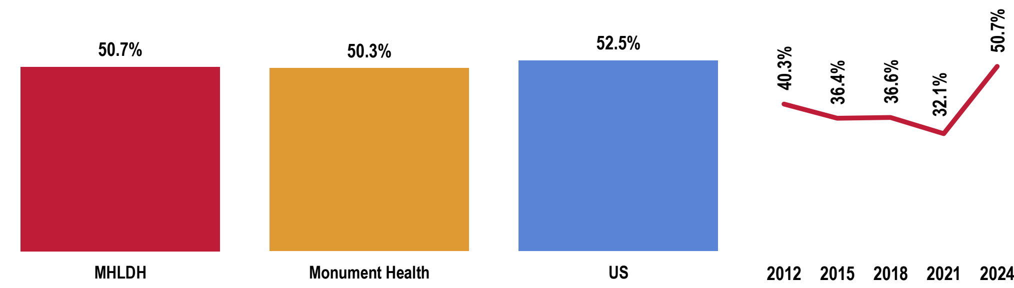


Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Items 6-13]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

The following charts reflect the composite percentage of the total population experiencing problems accessing health care in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

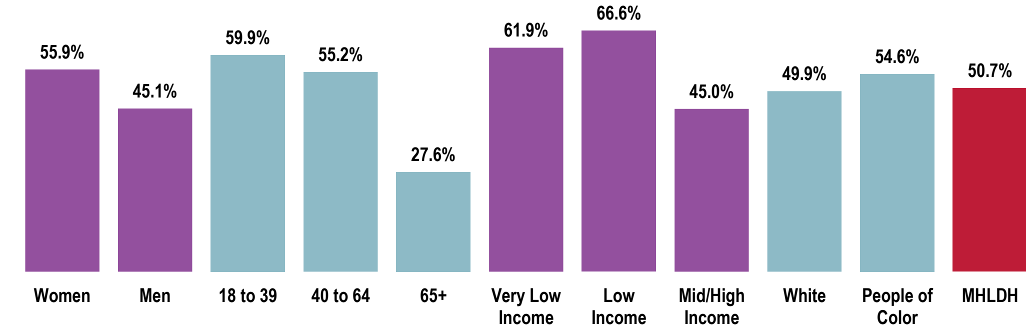
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year

MHLDH Service Area



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 119]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(MHLDH Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 119]
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

PRC SURVEY ▶ "Was there a time in the past 12 months when you needed medical care for this child but could not get it?"

Had Trouble Obtaining Medical Care for Child in the Past Year
(Children 0-17)

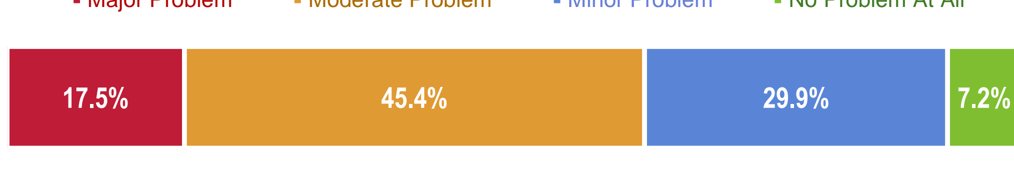
MHLDH Service Area

Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 90]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents with children age 0 to 17 in the household.

Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:

Perceptions of Access to Health Care Services as a Problem in the Community
(Key Informants; MHLDH Service Area, 2024)



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> The times clinics are open, the best times, especially in the summer, would be 7 to 10 p.m. The cost of urgent care and clinics when asking for payment at the time of registration before you can see a physician. The ED is used as a clinic for almost all persons in poverty because they don't demand money at the time of service, which causes a huge volume of patients that can be seen in a clinic setting. Mental health care is badly needed. There are so many people that have nowhere to turn for help; again, cost may deter most from seeking help. The communities need more facilities for emergency mental health situations, someone to address issues in real time and not wait for an appointment or until 8 a.m., when a counselor can be seen. – Social Services Provider
>
> Transportation. The cost and copays. For mental health, the long wait to get an appointment. – Social Services Provider
>
> Lack of transportation to get to services. The lack of having basic needs covered so they are worried about those and don't see routine health care and good nutrition as a priority. – Other Health Provider
>
> Lack of public transportation. High cost of living, including housing, food, health insurance, and health care. Lack of access to high-quality health information. – Community Leader
>
> Transportation is not always available for Native American community members to get to doctor appointments or to and from the hospital. – Other Health Provider
>
> Transportation, costs, perceived versus actual cultural barriers. – Other Health Provider
>
> Due to limited facilities, staff, and/or insurance. Need more prevention efforts and education or awareness of their importance. – Community Leader
>
> Limited access to quality health care. The members of this community have to travel great distances, in upward of 45-minute commutes to seek care. The care is at a lower level with long wait times. Oftentimes, families have limited access to means of transportation. – Social Services Provider

Access to Care for Uninsured/Underinsured

> Not many have insurance. – Social Services Provider
>
> Uninsured or underinsured individuals and families. As a result, many do not seek out services preventively and instead end up in crisis. Those who have insurance frequently can't afford the copays. Also, so many don't have a primary physician who can follow them throughout. They receive services from urgent care and the ED. – Social Services Provider

Affordable Care/Services

> Lack of affordable health care, especially for specialty services. The churn of patients off Medicaid – and the complexity/confusion regarding eligibility and maintaining eligibility – leads to a lack of access, even when it's available. The result is the delay in accessing preventive care and exacerbation of health issues. The strain on those organizations with affordable access avenues (sliding scales, etc.) leads to long delays in getting in to see a provider, particularly in areas like dental care and mental health care. Areas of particular need are neurology, cardiology, rheumatology, endocrinology, obstetrics/gynecology for those on Medicaid and uninsured cash pay. – Other Health Provider

> Individuals of low socioeconomic status are unable to afford care, even at times with insurance, as costs and deductibles are too high and there are higher priorities, such as shelter, food, child care, etc. – Social Services Provider

Lack of Providers

> Not enough physicians. Having to wait weeks or months to get into appointments. The cost of health care is through the roof, and people will go without care instead of accruing the debt. – Social Services Provider
>
> Not enough providers of care. Few support people for the providers in town. Lack of social work support is very big. The logistics of providing high-quality care to many people with low incomes, limited transportation, and with a limited support system is extremely difficult. Nurses and physicians all take on the extra task of trying to help with these logistics, which then limits access to care overall. – Physician

Inequities

> Inequities in services across the region. Inequities in financing, needed services, and medical needs. – Social Services Provider

Primary Care Services

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

Access to Primary Care

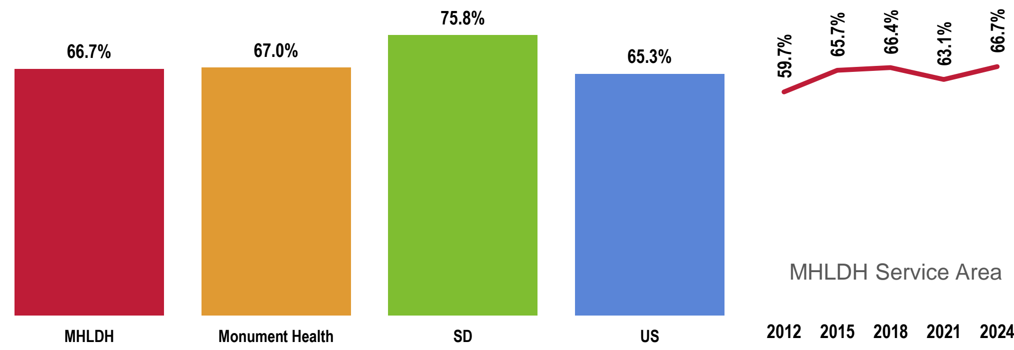
The following chart shows the number of active primary care physicians per 100,000 population. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Sources: • Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2024 via SparkMap (sparkmap.org).

Notes: • Doctors classified as "primary care physicians" by the AMA include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs, and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

Utilization of Primary Care Services

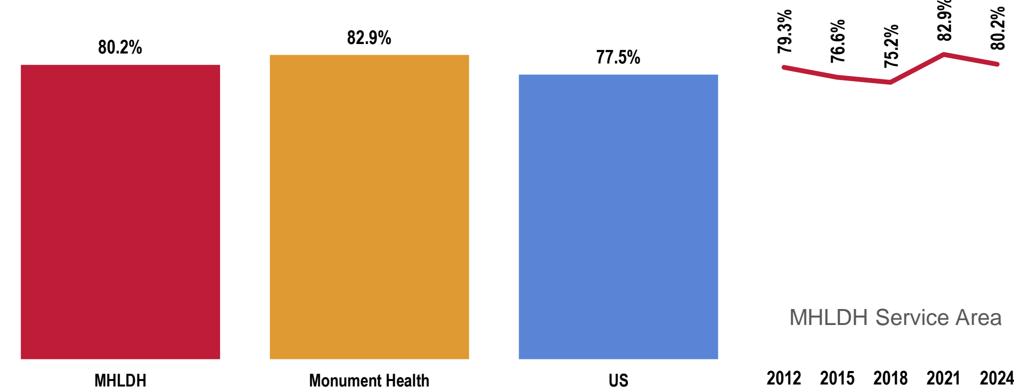
PRC SURVEY ▶ "A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?"



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 16]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 South Dakota data.
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

PRC SURVEY ▶ "About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 91]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children age 0 to 17 in the household.

Oral Health

ABOUT ORAL HEALTH

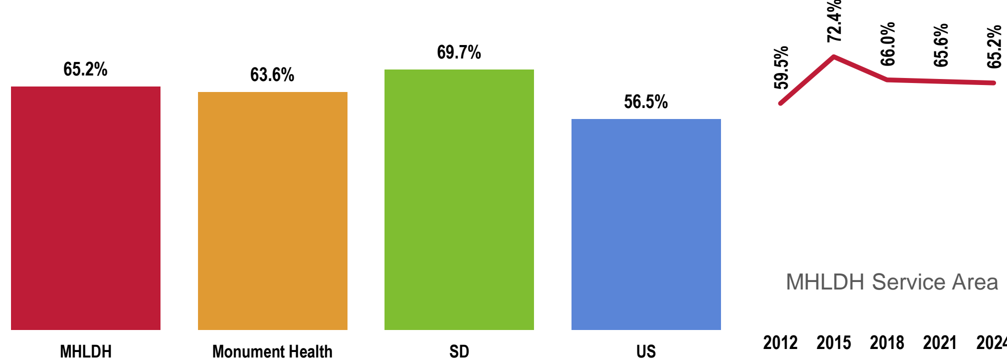
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

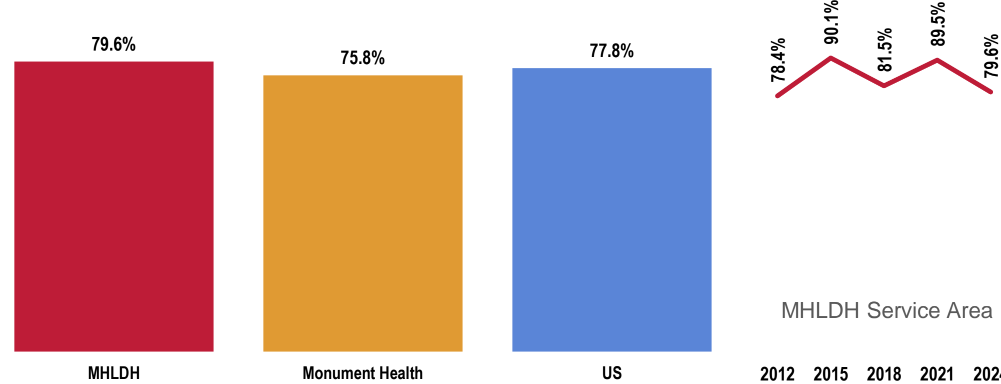
PRC SURVEY ▶ "About how long has it been since you last visited a dentist or a dental clinic for any reason?"



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 17]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 South Dakota data.
● 2023 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes: ● Asked of all respondents.

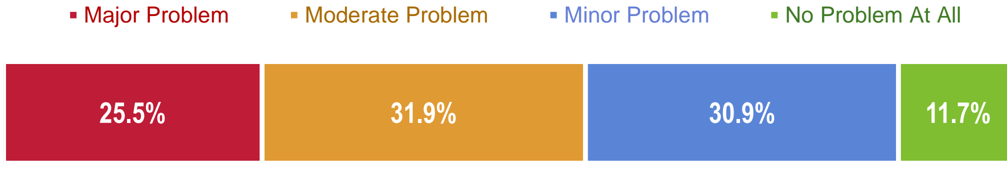
PRC SURVEY ▶ [Children Age 2-17] **"About how long has it been since this child visited a dentist or dental clinic?"**



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 93]
● 2023 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents with children age 2 through 17.

Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:



Sources: ● 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Affordable Care/Services

> Lack of affordable dental care for low-income. Complete Health has a wonderful program, but it takes months to get in, and if you have an abscessed tooth, you just have to live in pain. – Social Services Provider
>
> Lack of dental care for low-income individuals, which increases medical issues. – Social Services Provider
>
> Access and cost. Since Medicare doesn't cover dental, many of our seniors go without proper dental care. Although we have seen a steady increase in dental providers, there are still a limited number of people who will see kids and take Title XIX. This leaves our two most vulnerable population without dental care – with the ties to so many other health problems, dental care should be the first line of attack for disease prevention – but the dental community and medical community do not seem to collide. – Community Leader
>
> Cost prohibitive. – Other Health Provider

> Cost is prohibitive. There is a lack of insurance coverage, and private dentists do not accept Medicaid. – Other Health Provider
>
> Most people do not have dental insurance. Dental care is expensive. – Community Leader
>
> If you don't have insurance, you can't afford to get it, and most people don't have insurance. Those with low incomes avoid preventive health care as a result. – Other Health Provider
>
> My husband serves on a committee that awards free orthodontics to kids in Rapid City. There is a great need for it, and only a few kids get the care. – Other Health Provider

Access for Medicare/Medicaid Patients

> No one takes Medicaid for dental. – Social Services Provider
>
> If a patient has Medicaid, getting in to see a dentist for emergency care, much less preventative dental care, is nearly impossible. I have had patients with life-threatening dental problems whose only option is to sit at Community Health starting at 7 a.m. in hopes that they may get a walk-in appointment for treatment. Primary care does a poor job of including fluoride treatments for the pediatric population, and there needs to be more awareness among those providers. – Physician
>
> Dentists don't take very many patients who are on Medicaid. – Other Health Provider
>
> Not everyone has dental insurance, and dental care is expensive, so it doesn't become a priority. Lack of dentists that take Medicare/Medicaid. – Social Services Provider

Lack of Providers

> Many communities in the service area are Medically Underserved Areas or Health Professional Shortage Areas, which includes dental providers. A limited number of dental practices accept Title XIX patients, and many adults lack dental insurance. Barriers to oral health for individuals in poverty: transportation to appointments, availability of appointments, lack of education/awareness about the importance of oral health, etc. – Social Services Provider
>
> Lack of access to care in the dental department. There are not enough dentists to serve a population of this size. Good oral hygiene is another problem. – Other Health Provider
>
> One dentist. She is great, but only one. – Physician
>
> Lack of dentists in town. Many kids rely on the dental bus that comes if they qualify for free care. Many low-income adults do not get dental care. – Physician

Alcohol/Drug Use

> Due to drug use in part, and also for others extremely poor nutrition, we have many adults who have lost teeth, which leads to not eating well and compromised health. – Community Leader

Awareness/Education

> Education and lack of resources. – Community Leader

Lack of Preventative Care

> For the most part, people do not access dental services until there is a serious problem. – Other Health Provider

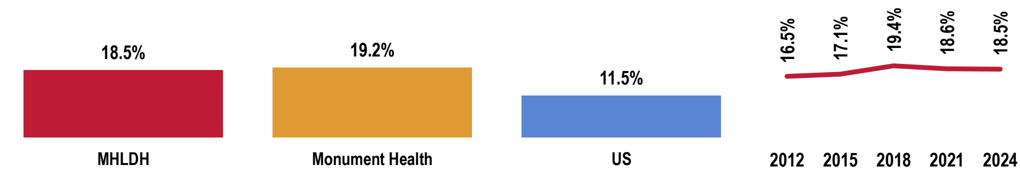
LOCAL RESOURCES

Perceptions of Local Health Care Services

PRC SURVEY ▶ "How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"

Perceive Local Health Care Services as "Fair/Poor"

MHLDH Service Area



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 5]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

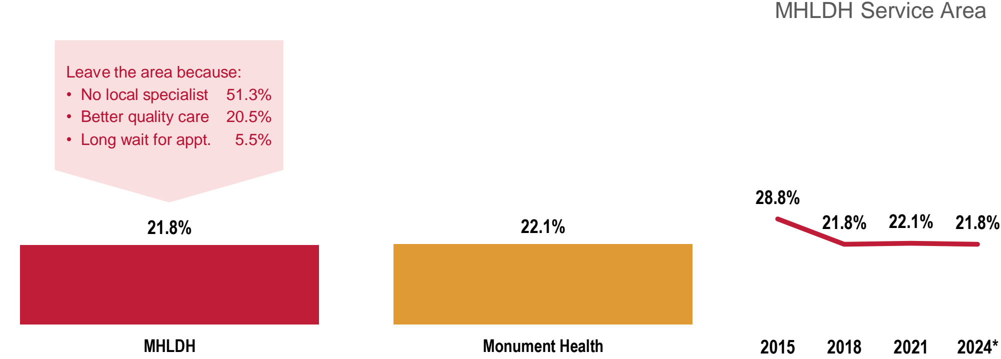
Outmigration for Care

PRC SURVEY ▶ "Is there any health care service for which you feel the need to leave the Black Hills, Eastern Wyoming, and Western South Dakota area to receive care?"

PRC SURVEY ▶ "What would you say is the main reason you feel the need to leave the Black Hills, Eastern Wyoming, and Western South Dakota area for care?"

Feel the Need to Leave the Area to Receive Medical Care

MHLDH Service Area



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 311-312]
Notes: ● Asked of all respondents.

● *Beginning in the 2024 survey, the area was specifically defined for respondents as the Black Hills, Eastern Wyoming, and Western South Dakota.

Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- 211
- Black Hills Surgical Hospital
- Care Campus
- Churches
- Complete Health
- Connect Health
- Crisis Care
- Doctors' Offices
- Fall River Health System
- Four Directions
- Full Circle
- Head Start Programs
- Horizons
- Journey On
- Kyle Health Center
- Lacreek
- Mommy's Closet
- Monument Health
- Monument Health Family Medicine Residency
- Monument Health Rural Health Clinic
- One Heart
- Oyate Health
- Pine Hills Independent and Assisted Living
- Pine Ridge Health Care Services
- Senior Center
- Social Services
- South Dakota State University Extension Office
- Tribal Transportation
- Veterans Affairs
- Volunteers of America
- Walk-In Clinics
- West River Mental Health
- Working Against Violence, Inc.

Cancer

- Black Hills Road Trip of Hope
- Breast Cancer Awareness
- Breast Cancer Survivor Group
- Cancer Care Institute
- Cancer Support
- Cancer Support Groups
- Doctors' Offices
- Fall River Health System
- Foundation for Health
- Fundraisers
- Home Health
- Hospitals
- Indian Health Services
- Lab Services
- Mayo Clinic
- Monument Health
- Monument Health Rural Health Clinic
- Nursing Homes
- Philip Health Services
- Philip Hospital Auxiliary
- Prairie Hills Transit
- Rapid City Medical Center
- Realtors for Kids
- South Dakota Special Funds
- Support Groups
- Transportation System
- Vucurevich Cancer Institute

Diabetes

- American Diabetes Association
- Caregiver Resources
- Complete Health
- Cosmopolitan Club
- Diabetes Awareness
- Diabetic Educators
- Dialysis Centers
- Doctors' Offices
- Family Medicine Residency Food Pantry
- Feeding South Dakota
- Flormann Clinic
- Food Assistance
- Food Pantry
- Kyle Health Center
- Meals on Wheels
- Medicaid Programs
- Medication Assistance Programs
- Monument Custer Hospital and Clinic

- Monument Health
- Monument Health Diabetes
- Monument Health Family Medicine Residency
- Oglala Sioux Tribe Diabetes Program
- Oyate Health
- Pharmacy
- Philip Clinic
- Rapid City Medical Center
- School System
- Senior Center
- Service to the Blind and Visually Impaired
- South Dakota Diabetes Coalition
- Southern Hills Family Medicine
- Women, Infants, and Children

Disabling Conditions

- Black Hills Orthopedic
- Black Hills Surgical Hospital
- Chiropractic
- Community Health
- Custer County Library
- Custer Senior Care Center
- Department of Social Services
- Doctors' Offices
- Home Health
- Hospitals
- Housing for Low Income
- Medical Facilities
- Monument Health
- Nursing Homes
- Physical Therapy/Chiropractic
- Prairie Hills Transit
- Prairie Hills Transit
- Premier Family Eye Care
- Privately Hired People
- Rapid City Medical Center
- Silverleaf
- Social Security Administration
- South Dakota State University Extension Office
- Southern Hills Family Medicine
- Urgent Psych Care
- Vision Source
- Western Resources for the Disabled
- YMCA

Heart Disease & Stroke

- A Path to Renewal
- American Heart Association
- Community Health
- Complete Health
- Doctors' Offices
- Fall River Health System
- Good Shepherd Clinic
- Google
- Health Care System
- Hospitals
- Ignite
- Mayo Clinic
- Monument Custer Hospital and Clinic
- Monument Health
- Monument Health Heart and Vascular Institute
- Oyate Health
- Parks and Recreation
- Philip Clinic
- Physical Therapy/Chiropractic
- Rapid City Medical Center
- The Heart Doctors
- YMCA

Infant Health & Family Planning

- Birth to Three
- Black Hills Pediatrics
- Bright Start Home Nurse Visiting Program
- Community Health
- Complete Health
- Deadwood Monument Health Clinic
- Doctors' Offices
- Fall River Health System
- Four Directions
- Indian Health Services
- Kyle Health Center
- Lacreek
- Medicaid Programs
- Midwives
- Monument Health
- Monument Health Family Medicine Residency
- Native Women's Health Clinic
- Oyate Health
- Pine Ridge Clinic
- South Dakota Department of Health
- South Dakota Department of Health Bright Start
- Spearfish Plan Title X Clinic
- Women and Children's Center
- Women, Infants, and Children
- YMCA
- Youth & Family Services

Injury & Violence

- Addiction Recovery Center
- Ambulance Services
- Bureau of Indian Affairs Police
- Care Campus
- Children's Home Society
- Community Health
- Counseling
- Detox
- Domestic Violence Organizations
- Hospitals
- Journey On
- Mission
- Monument Health
- Oglala Sioux Tribe Housing
- Oglala Sioux Tribe Tribal Police
- Oyate Health
- Pennington County Victims Assistance
- Police Department
- Public Safety
- Red Horse Healing
- Substance Abuse Treatment
- Urgent Care
- Volunteers of America
- West River Mental Health
- Working Against Violence, Inc.
- Youth & Family Services

Mental Health

- 211
- 988
- AA/NA
- Back Porch Coalition
- Behavior Management Systems
- Behavioral Health West
- Black Hills Counseling
- Black Hills Psychiatry
- Boys Club
- Care Campus
- Care Center
- Caregiver Resources
- Catholic Social Services
- Celebrate Recovery
- Churches
- Community Health
- Complete Health
- Cornerstone Rescue Mission
- Counseling
- Crisis Care
- Deadwood Monument Health Clinic
- Doctors' Offices
- East River Psychiatry Residency
- Enso
- Fall River Health System
- Good Shepherd Clinic
- Health Care System
- Hope Counseling
- Hospitals
- Indian Health Services
- Kyle Health Center
- Lutheran Social Services
- Manlove Psychiatric Clinic
- Mental Health Services
- Monument Custer Hospital and Clinic
- Monument Health
- Monument Health Behavioral Health
- Monument Health West
- Monument Sturgis Clinic
- National Alliance on Mental Illness
- Nonprofit Organizations
- One Heart
- Oyate Health
- Pivot Point
- Rapid City Mental Health
- School System
- Social Services
- Spearfish Counseling
- Suicide Hotline
- Therapists
- Urgent Psych Care
- Veterans Affairs
- Wellfully
- Wellspring
- West River Mental Health
- Yankton
- Youth & Family Services

Nutrition, Physical Activity, & Weight

- Adult Education Courses
- Bodies in Motion
- Community Health
- Deadwood Monument Health Clinic
- Doctors' Offices
- Evans Plunge
- Family Medicine Residency Food Pantry
- Farmer's Market
- Feeding South Dakota
- Food Pantry
- Health 4 Life
- Healthy Hometown
- Ignite
- Love INC
- Monument Health Diabetes

- Parks and Recreation
- Philip Clinic
- Rapid Ride
- School System
- Social Services
- Weight Watchers
- YMCA

Oral Health

- Black Hills Pediatric Dentistry
- Community Health
- Complete Health
- Connect Health
- Delta Dental
- Dental 4 Kids
- Dental Bus
- Dentists' Offices
- Indian Health Services
- Kyle Health Center
- Massa Dental
- Monument Health
- Oyate Health
- Ronald McDonald Care Mobile
- Southerland Dental
- Youth & Family Services

Respiratory Diseases

- Doctors' Offices
- Monument Custer Hospital and Clinic

Sexual Health

- 211
- Community Health
- Complete Health
- Deadwood Monument Health Clinic
- Doctors' Offices
- Great Plains Tribal Chairmans Board
- Indian Health Services
- Monument Health
- Monument Health Family Medicine Residency
- Oyate Health
- Rapid City Medical Center
- South Dakota Department of Health
- State-Funded Antibiotic Treatments
- Volunteers of America

Social Determinants of Health

- 211
- ABC
- Black Hills Homeless Coalition
- Black Hills Housing Trust
- Black Hills Special Services
- Boys and Girls Club
- Brookside
- CAP Office
- Care Campus
- Care-A-Ride
- Catholic Social Services
- Children's Home Society
- Churches
- City of Rapid City
- CommonBond Communities
- Community Action
- Community Health
- Complete Health
- Consumer Credit Counseling Services of the Black Hills
- Cornerstone Rescue Mission
- Department of Social Services
- Early Learning Rapid City
- Education
- Elevate Rapid City
- Family Medicine Residency Food Pantry
- Feeding South Dakota
- Food Pantry
- Government Programs
- Habitat for Humanity
- Health and Human Services
- Indian Health Services
- Lakota Lands Tour
- Local Charities
- Love INC
- Low Income Housing
- Metro Plains
- MLB Housing
- Neighbor Works Dakota Homes Resources
- Neighborhood Housing
- One Heart
- Oxford House
- Oyate Health
- Pennington County Housing
- Pennington County Human Services
- Poverty 101
- Prairie Hills Transit
- School System
- Section 8 Housing
- Social Services
- The Circle
- Tribal Resources

- Volunteers of America
- Vucurevich Cancer Institute
- Western CAP Office
- Western South Dakota Community Action
- Women, Infants, and Children
- Working Against Violence, Inc.
- YMCA
- Youth & Family Services

Substance Use

- 211
- 24/7 Program
- AA/NA
- Action For the Betterment of Our Community
- Addiction Recovery Center
- Addiction Treatment Services
- Alcohol and Drug Treatment Center
- Anpetu Luta Otipi
- Behavior Management Systems
- Care Campus
- Churches
- Community Health
- Compass Point
- Counseling
- Crisis Care
- Deadwood Monument Health Clinic
- Doctors' Offices
- Drug Court
- Fall River County Jail
- Full Circle
- Health and Human Services
- Hot Springs VA Substance Abuse Programming
- Inpatient Drug Rehab and Detox
- Lifeways
- Medicaid Programs
- Medical Air Rescue Company
- Monument Health
- Monument Health West
- New Dawn
- One Heart
- Oyate Health
- Pennington County Detox
- Police Department
- Project Recovery
- ROADS Inc
- School System
- Social Services
- Southern Hills Drug and Alcohol
- Substance Abuse Treatment
- Treatment Centers
- Veterans Affairs
- Volunteers of America
- Wellfully
- West River Mental Health

Tobacco Use

- Addiction Providers
- Alternatives to Help Quitting
- Deadwood Monument Health Clinic
- Doctors' Offices
- Education
- Helpline
- Lifeways
- Monument Health
- School System
- South Dakota Quit Line

APPENDIX

EVALUATION OF PAST ACTIVITIES

Monument Health System Community Health Implementation Plan (CHIP) Update FY24

During FY24, Monument Health focused on the following five priority areas identified through the most recent Community Health Needs Assessment (CHNA):

- Cancer
- Heart Disease and Stroke
- Diabetes, Nutrition, Physical Activity and Weight
- Mental Health and Substance Abuse
- Access to Medical Services: Right Care, Right Place

Teams comprised of representatives from Rapid City Hospital, Same Day Surgery Center, Monument Health Network, and the community worked on the priority areas selected for each facility's Community Health Improvement Plan (CHIP).

Priority Area: Cancer	
Overview	Below outlines updates and initiatives within the Community Health Implementation Plan (CHIP), specifically focusing on cancer prevention, treatment, survivorship, and patient advocacy.
Strategy #1: Cancer Prevention	
Cancer Prevention & Genetics Clinic	Established in July 2023, the clinic integrates advanced genetic cancer risk assessments with a certified provider. It collaborates with the City of Hope Clinical Cancer Genomics Community Practice.
Screening Initiatives	Supported Monument Health's strategic goals with breast, colon and lung cancer screenings. Aligned efforts with South Dakota's 2021-2025 Comprehensive Cancer Control Program.
Strategy #2: Cancer Treatment	
Facility Expansion	Completed capital renovations and now the facility can accommodate 202 unique patients with 364 daily appointments.
Workforce Growth	Investments were made in team-based care models, physicists and oncology specialists aim to ensure timely, safe and quality care.
Genetics & Genomics	Automated genetic testing referrals increased genomic sequencing tests by 96% from 2021 to 2024.
Technological Enhancements	Included AI-powered chemotherapy scheduling, weighted blanket infusion comfort and advanced radiation oncology equipment.
Strategy #3: Survivorship	
Support Services	**Offered a range of integrative services, including therapy, nutrition and specialized classes like yoga and Pilates.**
Cancer Rehab	Featured lymphedema management and therapy options for occupational, speech and physical needs.
Survivors Day	Hosted annual events focused on celebrating and supporting cancer survivors.
Strategy #4: Patient Advocacy	
Health Care Decision Support	Annual advocacy events assisted with treatment costs and medication expenses through grants, financial aid and travel assistance.
Indigenous Health Grants	$2M was awarded to improve lung cancer outcomes for American Indians in South Dakota.
Volunteer Services	Volunteer services had over 1,550 guest interactions per month including wig fittings, wayfinding and hand massages.
Strategy #5: Future Directions	
Patient Support	Expanded roles for patient navigators, a dedicated survivorship clinic and a reimbursable structure for psychosocial services.
Alignment with National Programs	Continued alignment with initiatives like the Biden Cancer Moonshot and the American Cancer Society's programs.

These efforts demonstrate a robust commitment to advancing cancer care through innovation, community engagement, and a focus on patient-centered outcomes.

Priority Area: Heart Disease and Stroke	
Overview	Below summarizes key statistics and achievements in cardiac care at Monument Health, with insights into procedural volumes, outcomes and trends.
Strategy #1: Procedure Volumes	
Cardiac Cath and PCI	In 2022, Monument Health performed 1,798 coronary angiograms, of which 862 included PCI (percutaneous coronary intervention).
Chest Pain and MI Cases	515 AMIs (acute myocardial infarctions) were treated, comprising 345 NSTEMI (non-ST elevation myocardial infarctions) and 170 STEMI (ST elevation myocardial infarctions). A notable 25% increase in AMI cases over previous years was attributed primarily to NSTEMI cases.
Strategy #2: Performance Metrics	
Post-PCI Performance	2022 recorded the lowest number of post-PCI deaths and Monument Health achieved better-than-90th-percentile performance in post-PCI in-hospital risk-standardized mortality among 1,700+ participating CathPCI Registry sites.
Chest Pain-MI Registry	In the Chest Pain-MI Registry, Monument Health's AMI in-hospital mortality was also at the 90th percentile compared to 700+ participating sites.
Strategy #3: Recognition	
Chest Pain-MI Award	Monument Health was awarded the Chest Pain–MI Platinum Achievement Award for the 12th consecutive year, reflecting sustained excellence in acute myocardial infarction care.
AMI Performance Composite Scores	AMI performance composite scores remained better than the national average.
Strategy #4: Outcomes and Trends	
Improved Care Delivery	Despite a significant rise in patient load, the number of AMI-related deaths in 2022 remained stable, indicating improved care delivery.
Cardiovascular Services Stability	Coronary angiography and PCI volumes showed stability across recent years, reinforcing consistency in cardiovascular services.
Strategy #5: Surgical and Program Growth	
Growth	The facility highlighted ongoing growth in cardiovascular surgery programs and other developments, ensuring excellent clinical outcomes and meeting increased patient demand.

Monument Health's consistent high performance underscores its commitment to exceptional cardiac care, as evidenced by its robust procedural outcomes and industry recognition.

Priority Area: Diabetes, Nutrition, Physical Activity and Weight	
Overview	Below outlines a comprehensive update on community health initiatives focusing on diabetes, emphasizing three main objectives: increasing community awareness, improving transitions from inpatient to outpatient care and enhancing patient access to care.
Strategy #1: Community Awareness	
Screening and Education	359 Diabetes Risk Assessments were completed across 20 community events.
Prevention Programs	Monument Health offered Diabetes Prevention Programs and collaborated with Better Choices Better Health initiatives. Medicare DPP classes began in Fall 2023, alongside a 16-week Pathway to Wellness program in several locations.
Events	The annual Diabetes Symposium saw success in 2022 and 2023. In 2023 Monument Health also held a Community Diabetes Health Fair which featured guest speaker Charlie Kimball and involvement from various organizations.
Statewide Leadership	Monument Health is the first in South Dakota to use the Diabetes Prevention and Management Programs, aiming to identify prediabetic individuals through provider referrals.
Strategy #2: Inpatient to Outpatient Care Transition	
Provider Collaboration	Hospitalists worked with endocrinologists for effective discharge planning.
Patient Education	Nurses were tasked with teaching insulin injection techniques as part of 2024 quality metrics.
Referral Process	Case management teams streamlined outpatient referrals, ensuring effective communication with primary care providers.
Support Expansion	New staff, including a CNP, have been added to handle inpatient diabetes caseloads. Diabetes-specific post-hospital assessments were integrated into discharge calls.
Improvement Focus	Simplified insulin orders for physicians, taught patients how to manage their own medication, improved collaboration among teams, enhanced management from the endocrinology team, and followed up with patients through calls to identify and close gaps in care.
Strategy #3: Improved Access	
Outreach Clinics	Regular clinics were held in several communities, including Spearfish, Sturgis and Hot Springs, ensuring rural access to specialists. These clinics are currently booked four to five months in advance, with the potential to expand clinic days to meet growing demand.
Dietetic Services	Standardized referral processes and enhanced caregiver education, particularly in medical weight management and disordered eating.

Overall, these efforts highlight significant strides in diabetes education, care transition and access, showcasing Monument Health's commitment to addressing diabetes comprehensively across the region.

Priority Area: Mental Health and Substance Abuse	
Overview	Below outlines an update on Monument Health's focus on stabilizing, resetting and reimagining their behavioral health system. The efforts emphasize restructuring leadership, enhancing safety protocols and improving care delivery for behavioral health patients.
Strategy #1: Stabilize	
Leadership Restructure	Key changes in this phase include a leadership restructuring, such as contracting a Director of Nursing and eliminating specific management positions to ensure a more efficient and effective leadership structure.
Staffing Adjustments for Safety	Staffing was revised to improve safety, including filling vacancies with contract labor, providing caregivers with personal panic buttons, upgrading security measures and mandating safety training.
Enhance Safety Practices	Safety practices such as the "No One Left Alone" policy were implemented and security cameras were upgraded to further ensure patient and staff safety.
Strategy #2: Reset	
Strengthening Leadership & Collaboration	Efforts focused on enhancing collaboration between medical and administrative leadership, alongside adding advanced practice providers for increased support.
Caregiver Support	Onsite caregiver support was developed to help support mental health needs of caregivers.
Capacity & Coverage Expansion	The psychiatric strategic planning team was expanded to strengthen its capacity to guide psychiatric services. Risk assessment coordinators were added to the emergency services team to help expand coverage.
Strategy #3: Reimagine	
Substance Abuse Disorder Care	Aligned programming with national standards, evaluating resources and expanding outpatient services.
Labor Challenges	Addressed staffing issues with robust recruitment plans, telemedicine strategies and role optimization in both inpatient and outpatient settings.
Therapeutic Programming	Improved inpatient therapeutic services and clarified operational structures to better serve patients.
Patient Flow Strategies	Standardized guidelines for patient flow, improved geriatric psychiatric care and optimized outpatient operations, particularly focusing on smoother patient transitions from the ER.
Health Equity	Partnered with community organizations like Indian Health Services to better serve diverse populations and create strategies that address population health needs.
Patient Access and Financial Opportunities	Enhanced scheduling tools, improved Medicaid funding, and optimized billing practices to better meet the community's needs and improve financial sustainability.

In addition to these strategic areas, Monument Health has also formed a new partnership with Signet, focusing on behavioral health and recruitment for the department.

While significant progress has already been made in collaborating and developing new plans, there remains much work to be done to address the challenges facing behavioral health care delivery. This comprehensive approach seeks to resolve current challenges and lay a strong foundation for sustainable and equitable care delivery moving forward.

Priority Area: Access To Medical Services: Right Care, Right Place	
Overview	Below outlines an update that emphasizes the focus on access to medical services by providing the right care and the right place.
Strategy #1: Visit Volume and Patient Acquisition	
Visit Volume	Increased visit volume through optimized templates and greater provider availability.
Patient Acquisition	Increased patient acquisition through digital options/convenience (e.g., online scheduling).
Patient Retention	Increased patient retention through referral capture (where applicable), resulting in additional visits and downstream ancillary revenue
Patient Engagement	Improved patient engagement through simplified and digitized Care Access options.
Strategy #2: Scheduling and Workflow Optimization	
Scheduling	Increased scheduling accuracy to route patients to the correct provider and reduced rescheduling needs. Developed accurate scheduling templates, locations and security. Streamlined scheduling processes across locations. Reviewed and adjusted intended scheduling processes and openings. Aligned scheduling templates to provider in-clinic time.
Staff Efficiency	Increased staff efficiency through standardized and optimized workflows. Implemented staff cross-coverage within Patient Contact Center to ensure workflow continuity.
Strategy #3: Nurse Triage and Integrated Team	
Nurse Triage	Prioritized patient care based on clinical assessment and Schmidt and Thompson protocols. Improved patient experience and communication. Supported provider practice efficiencies.
Integrated Team	Efficiently used patient and clinician time. Assigned patient to appropriate level of care quickly. Improved patient experience and communication. Clarified and supported roles based on licensure.
Strategy #4: Referrals and Recruitment	
Referrals	Focused on proactive management of ordered services. Developed close-the-loop follow-up procedures to promote continuity of care. Increased provider satisfaction (internal and external) with streamlined workflows and simplified processes for referrals and close-the-loop.
Recruitment	Focused on Primary Care recruitment.

Monument Health has implemented a series of strategic initiatives to optimize patient care and operational efficiency. A commitment to continuous improvement is evident through the expansion of roles, efficient resource allocation and a focus on delivering high-quality care while addressing staffing and operational challenges.