FY 2026-2028

COMMUNITY HEALTH IMPLEMENTATION PLAN

RELEASED NOVEMBER 2025

MONUMENT HEALTH LEAD-DEADWOOD HOSPITAL

Lead-Deadwood Hospital, located in Deadwood South Dakota, is owned, and operated by Monument Health, a tax exempt, community-based organization that is committed to preserving and strengthening health care for the people in the region. Monument Health offers care in 31 medical specialties and serves 12 communities across western South Dakota. With over 5,000 physicians and caregivers, Monument Health is comprised of 5 hospitals, and 40+ medical clinics and specialty centers. Monument Health is a member of the Mayo Clinic Care Network.

Lead-Deadwood Hospital is a critical access hospital located in the Northern Black Hills. The hospital offers 24-hour emergency service, inpatient and outpatient care. Lead-Deadwood Hospital is co-located with Monument Health Lead-Deadwood Clinic.

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

COMMUNITY HEALTH IMPROVEMENT OVERVIEW

In November 2024, Monument Health contracted with Professional Research Consultants (PRC) to conduct a Community Health Needs Assessments (CHNA) for each of its hospital communities including the Lead-Deadwood Hospital service area. The CHNA is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents. The assessment provides information so that communities may identify issues of greatest concern and prioritize resources to those areas, thereby making the greatest possible impact on community health status.

CHNA METHODOLOGY & IDENTIFIED AREAS OF OPPORTUNITY

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

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

The following "Areas of Opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in Healthy People 2030. This data highlights opportunities to improve health outcomes related to the following issues. (See the summary tables presented in the following section).

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 ▪ Lack of Financial Resilience ▪ Emergency Room Utilization ▪ 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.
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ High Blood Pressure Prevalence ▪ Overall Cardiovascular Risk
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 ▪ Overweight & Obesity [Adults]
SUBSTANCE ABUSE	▪ Alcohol-Induced Deaths ▪ Cirrhosis/Liver Disease Deaths ▪ Unintentional Drug-Induced Deaths ▪ Illicit Drug Use ▪ Key Informants: *Substance Use* ranked as a top concern.

COMMUNITY HEALTH IMPROVEMENT OVERVIEW

AREAS OF OPPORTUNITY NOT CHOSEN FOR ACTION

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

DISABLING CONDITIONS	▪ Multiple Chronic Conditions ▪ Activity Limitations ▪ High-Impact Chronic Pain ▪ Osteoporosis ▪ Alzheimer's Disease Deaths
HOUSING	▪ Housing Insecurity ▪ Housing Conditions ▪ Experience of Homelessness ▪ Key Informants: *Social Determinants of Health (especially Housing)* ranked as a top concern.
INFANT HEALTH & FAMILY PLANNING	▪ Infant Deaths ▪ Teen Births
INJURY & VIOLENCE	▪ Motor Vehicle Crash Deaths ▪ Falls [Age 65+] Deaths ▪ Violent Crime Experience ▪ Intimate Partner Violence
ORAL HEALTH	▪ Dental Insurance Coverage
RESPIRATORY DISEASE	▪ Asthma Prevalence [Adults]
SEXUAL HEALTH	▪ Chlamydia Incidence ▪ Gonorrhea Incidence
TOBACCO USE	▪ Use of Vaping Products

HEALTH PRIORITIES AND STRATEGIES

JULY 1, 2026 – JUNE 30, 2028

In April 2024, the findings of the Community Health Needs Assessment (CHNA) were shared with Monument Health's Clinical Practice Leadership. They reviewed the areas of opportunity identified in the CHNA and provided input on potential priority areas of focus.

Based on this feedback and the organization's resources and expertise, Monument Health's Executive Leadership, the Monument Health Rapid City Hospital Board and the Monument Health Network Board determined the following five priority areas as the focus of the Community Health Improvement Plan:

- Access to Medical Services
  - Children's Services
  - Obstetric Services
- Cancer
- Diabetes
  - Nutrition, Physical Activity and Weight Management
- Heart Disease and Stroke
- Mental Health
  - Maternal Mortality
  - Substance Abuse

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

PRIORITY 1: **ACCESS TO HEALTH SERVICES**

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

OBJECTIVE 1: IMPROVE PATIENT ACCESS

Anticipated Impact: Enhance patient experience and operational efficiency by streamlining scheduling, reducing delays and improving care coordination and communication

STRATEGIES:

- Align visit types, providers and template build tools to maximize system accuracy and staff efficiency
- Increase APP utilization to unlock physician capacity for new patients
- Turn on additional Epic features like Wait Lists and Fast Pass to fill appointment times
- Equip staff with training to build trust in system tools and reduce manual overrides
- Implement Epic Cheers and integration to the telephone system to more quickly address patient needs and provide seamless communication

OBJECTIVE 2: IMPROVE PATIENT ACCESS AND EXPAND SERVICES

Anticipated Impact: Improve access to care through expanding or optimizing patient care areas and services

STRATEGIES:

- Expand Rapid City Hospital's Women's and Children's department
- Build a free-standing emergency department in Rapid City
- Build a vascular hybrid operation room at Rapid City Hospital
- Expand advanced diagnostic imaging technology in collaboration with Dakota Radiology
- Expand the Spearfish Hospital
- Partner with Cornerstone Rescue Mission and Rapid City Fire Department to provide respite care through temporary housing for unhoused individuals recovering after hospital discharge
- Launch pediatric and obstetric hospitalist programs
- Recruit pediatric subspecialists
- Establish a pediatric sedation program for procedures and diagnostic examinations

OBJECTIVE 3: IMPROVING HEALTH OF POPULATIONS

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

STRATEGIES:

- Identify and collaborate with community-based organizations and subject matter experts to support and amplify their efforts in addressing social determinants of health for patients
- Continue to strengthen our food pantry and community closet as vital resources for patients and families served by the Family Medicine Residency Clinic
- Embed case management within Spearfish OB/GYN and Pediatric clinics to support patient care while also expanding outpatient OB/GYN access through outreach days in Sturgis
- Foster partnerships within the community to enhance education, health care and the effective use of pediatric resources

PRIORITY 2: **CANCER**

GOAL: Explore, develop and support opportunities that will aid in decreasing the cancer death rate for the communities and patients we serve

COMMUNITY PARTNERS			
Astro	Commission on Cancer	National Accreditation Program for Breast Cancer	Black Hills Road Trip of Hope

OBJECTIVE 1: IMPROVE PATIENT ACCESS TO ONCOLOGY SERVICES

Anticipated Impact: Maintain/improve patient expectations and access metrics, despite the expected rise in new cases for all cancer types; specifically targeting early onset patients, young adults, older adults and survivors

STRATEGIES:

- Continue to recruit oncologists (all-current specialties)
- Increase physical space to address growth in infusions and radiation therapy
- Implement benign hematology e-consults
- Redesign clinical and non-clinical support staff throughout the projected workforce shortages to maximize schedule capacity
- Maximize the chronic care management cancer program
- Enhance patient financial advocacy services
- Explore an oncology urgent care clinic model of care
- Bolster genetics clinic and early screening for high-risk patients
- Educate PCPs on referral process to streamline cancer referrals and workup requests

OBJECTIVE 2: EXPAND CURRENT SERVICES & OFFER NEW SERVICES

Anticipated Impact: Enhance and develop new treatment and non-treatment type services; specifically targeting early onset patients, young adults, older adults and survivors

STRATEGIES:

- Pilot an Oncology Hospitalist Service & explore adding new inpatient treatments (i.e. Bispecific Antibodies)
- Develop a Survivorship Clinic & Education Program
- Expand cancer research/clinical trial offerings and participation
- Chronic Care Management Cancer Program
- Radiopharmaceuticals
- Cold Cap Therapy
- Enhance Support Services
- Consider new radiation modalities

PRIORITY 2: **CANCER (CONTINUED)**

GOAL: Explore, develop and support opportunities that will aid in decreasing the cancer death rate for the communities and patients we serve

OBJECTIVE 3: REMOVE BARRIERS TO ONCOLOGY CARE

Anticipated Impact: Effectively encompass existing disparities in cancer prevention, early detection, treatment and quality of life in order to provide an opportunity for everyone to be healthy

STRATEGIES:

- Gynecologic Oncology Partnership with Oyate Health Center
  - PAP-A-THON
  - Honor Every Woman Program/Women's Clinic
- Continue to foster patient financial advocacy & programs
- Focus on prevention by promoting awareness & screenings through focused community outreach
- Improve access to screenings
- Support clinical programs, community-based programs and resources that address the needs of cancer patients and their caregivers

PRIORITY 3: **DIABETES**

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

COMMUNITY PARTNERS			
Better Choices Better Health	Community Agencies supporting social determinants of health	Diabetes Incorporated	South Dakota Department of Health

OBJECTIVE 1: INCREASE EDUCATION OF DIABETES PREVENTION AND MANAGEMENT PROGRAMS THAT PROMOTE HEALTHY LIFESTYLE CHOICES

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

STRATEGIES:

- Provide screenings and education at community health fairs, career fairs, media spotlights, speaking opportunities
- Provide certified trainers for the Monument Health Diabetes Prevention Program and Better Choices Better Health programs
- Continue annual Diabetes Symposium to offer evidence-based education for diabetes care and management
- Provide Pathway to Wellness Program to engage individuals and families in adopting and sustaining healthy behaviors that affect health and quality of life

OBJECTIVE 2: IMPROVE TRANSITION FROM INPATIENT TO OUTPATIENT CARE

Anticipated Impact: improved diabetic health outcomes

STRATEGIES:

- Continue to develop and optimize a system-wide approach to education and documentation in the electronic medical record
- Provide education and equipment to patients and follow-up, as appropriate, following discharge
- Utilize case managers and ancillary support to assist patients in navigating through social determinants preventing them from managing their disease
- Grow and develop pharmacists' integration in medication management for diabetes patients
- Utilize available EHR such as Care Companion, Tidepool, MyChart to engage and educate patients for best practice disease management

OBJECTIVE 3: IMPROVE PATIENT ACCESS TO PROVIDERS & SERVICES

Anticipated Impact: More access for vulnerable populations and improved outcomes related to diabetes

STRATEGIES:

- Continue system outreach clinics
- Recruit and develop endocrinology providers

PRIORITY 4: **HEART DISEASE & STROKE**

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

COMMUNITY PARTNERS

Mayo Clinic	SD Department of Health	National Heart Health Program	American Heart Association
Omaha Children's Hospital	University of Minnesota	Abbott Northwestern Hospital	Rapid City Fire Department EMS Services

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

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

STRATEGIES:

- Provide free heart health screenings at local community events and locations
- Engage the community through education at community events, health fairs, speaking opportunities and public awareness efforts
- Develop more community heart hubs at centralized local locations
- Support ongoing Stroke Support Group
- Educate providers in the area through the annual Cardiac Symposium and a regular cardiovascular journal club
- Increase smoking cessation initiatives by identifying patients who smoke prior to discharge
- Improve consistency of patient education distributed virtually and through inpatient and outpatient patient encounters – especially for patients with heart failure, atrial fibrillation or cardiovascular surgery related concerns

OBJECTIVE 2: IMPROVE PATIENT ACCESS FOR SPECIALISTS AND PROCEDURES

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

STRATEGIES:

- Explore advanced practice provider outreach opportunities in additional communities
- Expand Calcium Scoring Screening availability throughout Monument Health service areas
- Recruit additional providers for the Heart & Vascular Institute and Neurology Care
- Streamline workflow and processes within developed Neurovascular Service Line
- Develop tele-stroke platform to continue to improve early Stroke treatment and outcomes
- Work on improving Stroke TNK Door to Needle Time to less than 45 minutes
- Further develop Acute and Chronic Limb Salvage Program and add an Advanced Wound Care Program Medical Director
- Advance Structural Heart Program into other valve anatomies
- Establish access to Advanced Heart Failure Treatments and Therapies with a circulatory support program

PRIORITY 5: **MENTAL HEALTH**

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

COMMUNITY PARTNERS

Pivot Point	West River Mental Health Services	Pennington County Care Campus	Rapid City Fire Department/Mobile Medic
Journey On	Quality of Life Unit Rapid City Police Department	Alano Society	

OBJECTIVE 1: INCREASE AWARENESS OF MENTAL HEALTH RESOURCES IN OUR COMMUNITY

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

STRATEGIES:

- Provide behavioral health education and stigma-reduction materials at health fairs, screenings and community events to normalize mental health conversations
- Identify and collaborate with community-based organizations and subject matter experts to support and amplify their efforts in addressing mental health, substance abuse and maternal mortality
- Arrange site visits from Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program to provide education on available services
- Consider new support groups or ways to provide support to family members of behavioral health patients.
- Expand availability of recovery support groups to patients creating an ongoing resource for when they are discharged

OBJECTIVE 2: EXPAND ACCESS TO MENTAL HEALTH PROVIDERS AND SERVICES

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

STRATEGIES:

- Sustain and enhance our addiction medicine inpatient services as well as our outpatient services delivered through a patient-centered medical home model
- Recruit additional social workers and/or psychologists
- Expand the availability of counselors in Primary Care facilities

OBJECTIVE 3: IMPROVE MENTAL HEALTH ENVIRONMENT AND SCREENING PROCESS

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

STRATEGIES:

- Provide suicide prevention and awareness to additional care areas
- Standardize the process for referrals of patients who are identified at-risk
- Explore opportunities to incorporate multi-sensory therapeutic environments to support patients
- Expand therapeutic programming to support patients
- Implement ongoing safety enhancements at our Behavioral Health Center
- Continue to integrate behavioral health screening and poverty-informed care into primary care visits at our Family Medical Residency Clinic
- Increase awareness and screening for postpartum depression at our Family Medical Residency Clinic

ADOPTION OF COMMUNITY HEALTH IMPLEMENTATION PLAN

In October 2025, the Monument Health Rapid City Hospital Board of Directors and Monument Health Network Board met and discussed this plan for addressing the selected community health priorities identified through the Community Health Needs Assessment process. Upon review, the Boards approved the adoption of this plan for Lead-Deadwood Hospital and the related resources required to achieve the goals, objectives and strategies outlined within that work to meet the health needs of the community.