Community Health Needs Assessment

Bennett County Hospital

Bennett County, SD

December 2021

Michael Christensen,
CEO

Community Health Needs Assessment
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Bennett County Hospital – Martin, SD - 2021 Community Health Needs Assessment (CHNA)

The previous CHNA for Bennett County Hospital was completed in 2018. (Note: The Patient Protection and Affordable Care Act (ACA) require not-for-profit hospitals to conduct a CHNA every three years and adopt an implementation strategy to meet the needs identified by the CHNA). Our assessment began in March of 2021 and was created by our team, under the direction of Michael Christensen, MHA, MBA, FACHE, FHFMA, CSSBB 6 Σ, CPM, PMP, CPHQ, HCQM

Creating healthy communities requires a high level of mutual understanding and collaboration among community leaders. The development of this assessment brings together community health leaders and providers, along with the residents, to research and prioritize county health needs and document community health delivery success. This health assessment will serve as the foundation for community health improvement efforts for the next three years. **Important community CHNA Benefits** for both the local hospital and other local providers,are as follows:

1.) Increases knowledge of community health needs and resources

2.) Creates a common understanding of the priorities of the community's health needs

3.) Enhances relationships and mutual understanding between and among stakeholders

4.) Provides a basis upon which community stakeholders can make decisions about how they can contribute to improving the health of the community

5.) Provides rationale for current and potential funders to support efforts to improve the health of the community

6.) Creates opportunities for collaboration in the delivery of services to the community and

7.) Provides guidance to the hospital and local community for how they can align their services and community benefit programs to best meet needs, and fulfill the Hospital Mission

County Health Area of Future Focus on Unmet Needs

Area Stakeholders held a community conversation to review, discuss and prioritize health delivery. A wide group of community members attended. Below are two tables reflecting community views and findings:

Bennett County, SD
2021 CHNA Priorities - Unmet Needs
CHNA Town Hall -
Primary Service Area (14 Attendees / 78 Total Votes)

#	Community Health Needs to Change and/or Improve	Votes	%	Accum
1	New hospital facility	17	21.8%	22%
2	New ambulance equipment	12	15.4%	37%
3	New CT, Lab, Portable radiology and US equipment	10	12.8%	50%
4	Health provider workforce shortage	9	11.5%	62%

5	Mental Health (Diagnosis, Treatment, Providers)	7	9.0%	71%
6	Uninsured / Underinsured	5	6.4%	77%
	Total Votes	78	100%	
Other needs receiving votes: Cancer, Child Care, Suicide, Awareness of HC services, Spiritual Health, Youth Activities, Dental, Obesity and nutrition				

Town Hall CHNA Findings: Areas of Strengths

Bennett Co. (SD) - "Community Health Strengths"			
#	Topic	#	Topic
1	Access to Quality Providers	6	Access to Healthy Foods
2	Potential USDA funds for the new facility	7	Hospital Collaborations/Partnerships
3	Potential for new equipment funds	8	Home Health
4	EHR Platform	9	Ambulance service
5	Rural Health Clinic	10	Stable governance leadership

Key CHNA Secondary Research Conclusions found:

SOUTH DAKOTA HEALTH RANKINGS: According to the 2021 Population Health Institute County Health Rankings, Bennett County, SD Average was ranked 54 of 57 in Health Outcomes, and 57 of 57 in Health Factors.

Bennett County's population is 3,406 (based on 2020), with a population per square mile of approximately 2.9 persons. About eight percent (7.5%) of the population is under the age of 5, while the population that is over 65 years old is 13.3%. As of 2020, 60.0% of citizens are Native American. 95% are living in the same house as one year ago.

In Bennett County, the average per capita income is $18,632 while 28.3% of the population is in poverty. The average commute time to work is 14.5 minutes. 11.2% of people are in a home where a language other than English is spoken in the home. Only 68.8% of homes have the internet.

84.4% of students graduated high school compared to the rural norm of 91.3%, and 22.4% have a bachelor's degree or higher.

Key CHNA Primary Research Conclusions Found:

Community Feedback from residents, community leaders and providers provided the following community insights via an online perception survey:

- Using a Likert scale, average between Bennett County stakeholders and residents that would rate the overall community health quality as "moving up or increasing"; is 45.1%.
- Bennett County stakeholders are satisfied with some of the following services: Ambulance Services, Emergency Room, Inpatient Services, and Outpatient Services
- When considering past CHNA needs, the following topics came up as the most pressing: Age and condition of Hospital, CT machine, Lab Equipment, portable Radiology , ultrasound and Ambulances, Behavioral / Mental Health, Drug / Substance Abuse, Wellness/Prevention, Obesity, and Alcohol Abuse.

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II. Methodology

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a. CHNA Scope and Purpose

The federal Patient Protection and Affordable Care Act (ACA) requires that each registered 501(c)3 hospital conduct a Community Health Needs Assessment (CHNA) at least once every three years and adopt a strategy to meet community health needs. Any hospital that has filed a 990 is required to conduct a CHNA. IRS Notice 2011-52 was released in the late fall of 2011 to give notice and request comments.

Goal #1: Meet/Report IRS 990 Required Documentation

i. A description of the community served by the facility and how the community was determined;
ii. A description of the process and methods used to conduct the CHNA;
iii. The identity of any and all organizations with which the organization collaborated and third parties that it engaged to assist with the CHNA;
iv. A description of how the organization considered the input of persons representing the community *(e.g., through meetings, focus groups, interviews, etc.)*, who those persons are, and their qualifications;
v. A prioritized description of all of the community needs identified by the CHNA and an explanation of the process and criteria used in prioritizing such needs; and
vi. A description of the existing health care facilities and other resources within the community available to meet the needs identified through the CHNA.

Section 501(r) provides that a CHNA must take into account input from persons who represent the broad interests of the community served by the hospital facility, including individuals with special knowledge of or expertise in public health. Under the Notice, the persons consulted must also include Government agencies with current information relevant to the health needs of the community and representatives or members in the community who are medically underserved, low-income, minority populations, and populations with chronic disease needs. In addition, a hospital organization may seek input from other individuals and organizations located in or serving the hospital facility's defined community (e.g., health care consumer advocates, academic experts, private businesses, health insurance and managed care organizations, etc.).

Goal #2: Making a CHNA Widely Available to the Public

The Notice provides that a CHNA will be considered to be "conducted" in the taxable year that the written report of the CHNA findings is made widely available to the public. The Notice also indicates that the IRS intends to pattern its rules for **making a CHNA "widely available to the public"** after the rules currently in effect for Form 990. Accordingly, an organization would make a **facility's written report** widely available by posting the final report on its website either in the form of

(1) the report itself, in a readily accessible format or

(2) a link to another organization's website, along with instructions for accessing the report on that website.

The Notice clarifies that an organization must post the CHNA for each facility until the date on which its subsequent CHNA for that facility is posted.

Goal #3: Adopt an Implementation Strategy by Hospital

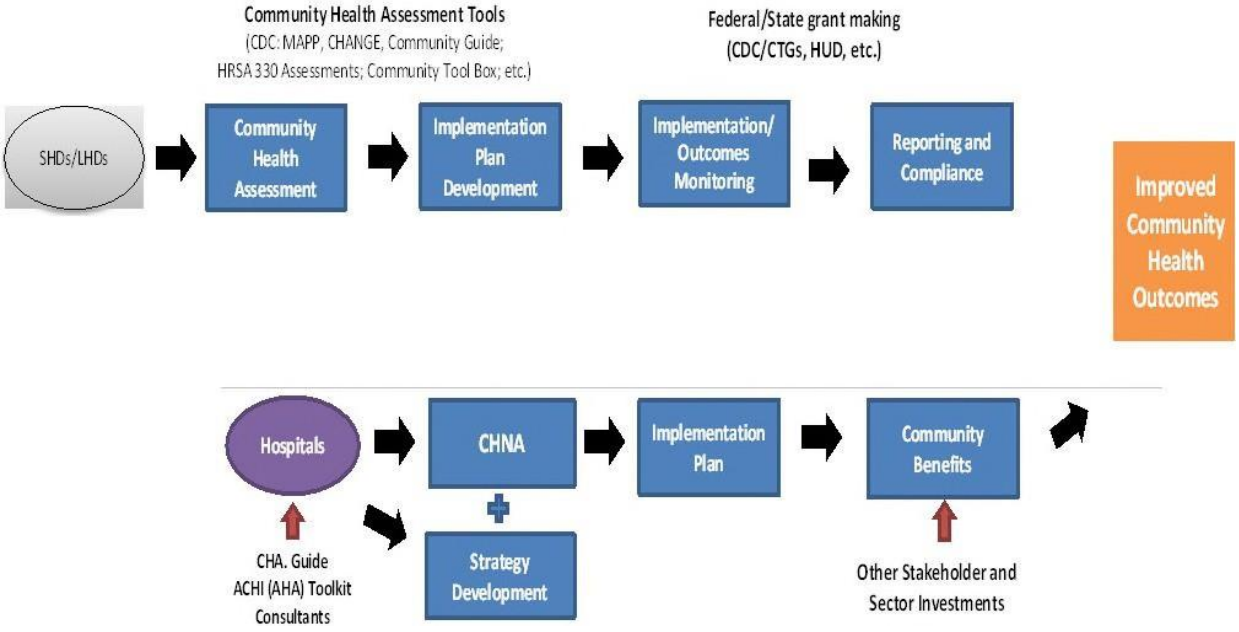
Section 501(r) requires a hospital organization to adopt an implementation strategy to meet the needs identified through each CHNA. The Notice defines an "implementation strategy" as a written plan that addresses each of the needs identified in a CHNA by either

(1) describing how the facility plans to meet the health need or

(2) identifying the health need as one that the facility does not intend to meet and explaining why the facility does not intend to meet it.

A hospital organization may develop an implementation strategy in collaboration with other organizations, which must be identified in the implementation strategy. As with the CHNA, a hospital organization that operates multiple hospital facilities must have a separate written implementation strategy for each of its facilities.

Great emphasis has been given to working hand-in-hand with leaders from hospitals, the state health depart,ent and the local health department. A common approach has been adopted to create the CHNA, leading to aligned implementation plans and community reporting.



IRS Requirements Overview (Notice 2011-52)

Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-exempt Hospitals

Applicability of CHNA Requirements to "Hospital Organizations"

The CHNA requirements apply to "hospital organizations," which are defined in Section 501(r) to include (1) organizations that operate one or more state-licensed hospital facilities, and (2) any other organization that the Treasury Secretary determines is providing hospital care as its principal function or basis for exemption.

How and When to Conduct a CHNA

Under Section 501(r), a hospital organization is required to conduct a CHNA for each of its hospital facilities once every three taxable years. ***The CHNA must take into account input from persons representing the community served by the hospital facility and must be made widely available to the public.*** **The CHNA requirements are effective for taxable years beginning after March 23, 2012**. As a result, a hospital organization with a June 30 fiscal year end must complete a CHNA full report every 3 years for each of its hospital facilities by fiscal June 30th.

Determining the Community Served

A CHNA must identify and assess the health needs of the **community served** by the hospital facility. Although the Notice suggests that geographic location should be the primary basis for defining the community served, it provides that the organization may also take into account the target populations served by the facility (e.g., children, women, or the aged) and/or the facility's principal functions (e.g., specialty area or targeted disease). *A hospital organization, however, will not be permitted to define the community served in a way that would effectively circumvent the CHNA requirements (e.g., by excluding medically underserved populations, low-income persons, minority groups, or those with chronic disease needs).*

Persons Representing the Community Served

Section 501(r) provides that a CHNA must take into account input from **persons who represent the broad interests of the community** served by the hospital facility, including individuals with special knowledge of or expertise in public health. Under the Notice, the persons consulted must also include: (1) government agencies with current information relevant to the health needs of the community and (2) representatives or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community. In addition, a hospital organization may seek input from other individuals and organizations located in or serving the hospital facility's defined community (e.g., health care consumer advocates, academic experts, private businesses, health insurance and managed care organizations, etc.).

Required Documentation

The Notice provides that a hospital organization will be required to separately document the CHNA for each of its hospital facilities in a **written report** that includes the following information:

1) a description of the community served by the facility and how the community was determined;

2) a description of the process and methods used to conduct the CHNA;

3) the identity of any and all organizations with which the organization collaborated and third parties that it engaged to assist with the CHNA;

4) a description of how the organization considered the input of persons representing the community

(e.g., through meetings, focus groups, interviews, etc.),

5) a prioritized description of all of the community needs identified by the CHNA and an explanation of the process and criteria used in prioritizing such needs; and

6) a description of the existing healthcare facilities and other resources within the community available to meet the needs identified through the CHNA.

Making a CHNA Widely Available to the Public

The Notice provides that a CHNA will be considered to be "**conducted**" in the taxable year that the written report of the CHNA findings is made **widely available to the public**. The Notice also indicates that the IRS intends to pattern its rules for making a CHNA "widely available to the public" after the rules currently in effect for Forms 990. *Accordingly, an organization would make a facility's written report widely available by posting on its website either (1) the report itself, in a readily accessible format, or (2) a link to another organization's website, along with instructions for accessing the report on that website. The Notice clarifies that an organization must post the CHNA for each facility until the date on which its subsequent CHNA for that facility is posted.*

How and When to Adopt an Implementation Strategy

Section 501(r) requires a hospital organization to adopt an implementation strategy to meet the needs identified through each CHNA. **The Notice defines an "implementation strategy" as a written plan that addresses each of the needs identified in a CHNA by either (1) describing how the facility plans to meet the health need, or (2) identifying the health need as one that the facility does not intend to meet and explaining why the facility does not intend to meet it**. A hospital organization may develop an implementation strategy in collaboration with other organizations, which must be identified in the implementation strategy. As with the CHNA, a hospital organization that operates multiple hospital facilities must have a separate written implementation strategy for each of its facilities.

Under the Notice, an implementation strategy is considered to be "**adopted**" on the date the strategy is approved by the organization's board of directors or by a committee of the board or other parties legally authorized by the board to act on its behalf. Further, the formal adoption of the implementation strategy must occur by the end of the same taxable year in which the written report of the CHNA findings was made available to the public. For hospital organizations with a June 30 fiscal year end, that effectively means that the organization must complete and appropriately post its first CHNA no later than its fiscal year ending June 30, 2013, and formally adopt a related implementation strategy by the end of the same tax year.

This final requirement may come as a surprise to many charitable hospitals, considering Section 501(r) contains no deadline for the adoption of the implementation strategy.

IRS Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(0(3) Last Reviewed or Updated: 21-Aug-2020

In addition to the general requirements for tax exemption under Section 501(c)(3) and Revenue Ruling 69-545hospital organizations must meet the requirements imposed by Section 501(r) on a facility-by-facility basis in order to be treated as an organization described in Section 501(c)(3). These additional requirements are:

1. Community Health Needs Assessment (CHNA) - Section 501(r)(3),
2. Financial Assistance Policy and Emergency Medical Care Policy - Section 501(r)(4),
3. Limitation on Charges - Section 501(r)(5), and
4. Billing and Collections - Section 501(r)(6).

Medically underserved populations include populations experiencing health disparities or that are at risk of not receiving adequate medical care because of being uninsured or underinsured, or due to geographic, language, financial, or other barriers. Populations with language barriers include those with limited English proficiency. Medically underserved populations also include those living within a hospital facility's service area but not receiving adequate medical care from the facility because of cost,

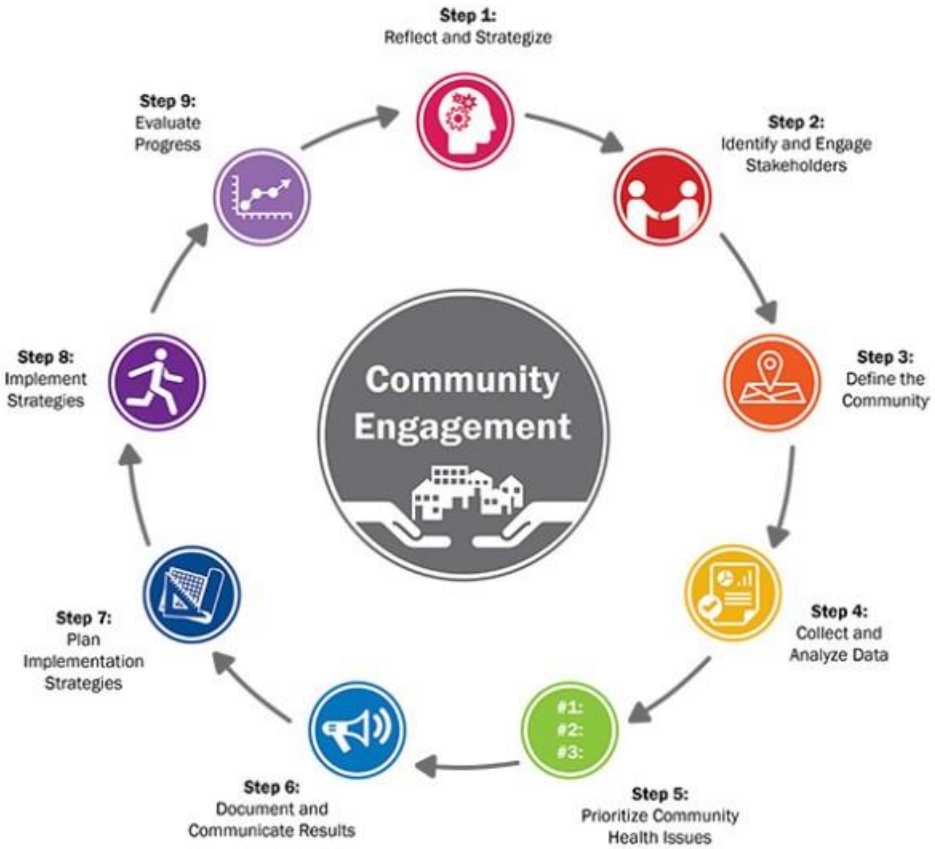
transportation difficulties, stigma, or other barriers.

Additionally, in determining its patient populations for purposes of defining its community, a hospital facility must take into account all patients without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital facility's financial assistance policy. If a hospital facility consists of multiple buildings that operate under a single state license and serve different geographic areas or populations, the community served by the hospital facility is the aggregate of these areas or populations.

Additional Sources of Input

In addition to soliciting input from the three required sources, a hospital facility may solicit and take into account input received from a broad range of persons located in or serving its community. This includes, but is not limited to:

- Health care consumers and consumer advocates
- Nonprofit and community-based organizations
- Academic experts
- Local government officials
- Local school districts
- Health care providers and community health centers
- Health insurance and managed care organizations,
- Private businesses, and
- Labor and workforce representatives



Although a hospital facility is not required to solicit input from additional persons, it must take into account input received from any person in the form of written comments on the most recently conducted CHNA or most recently adopted implementation strategy.

Adoption of Implementation Strategy
An authorized body of the hospital facility must adopt the implementation strategy. See the discussion of the Financial Assistance Policy below for the definition of an authorized body.· This must be done on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility finishes conducting the CHNA. This is the same due date (without extensions) of the Form 990.

Public Health Criteria:

Domain 1: Conduct and disseminate assessments focused on population health status and public health issues facing the community.

Domain 1 focuses on the assessment of the health of the population in the jurisdiction served by the health department. The domain includes systematic monitoring of health status; collection, analysis, and dissemination of data; use of data to inform public health policies, processes, and interventions; and participation in a process for the development of a shared, comprehensive health assessment of the community.

DOMAIN 1 includes 4 STANDARDS:

- **Standard 1.1 -** Participate in or Conduct a Collaborative Process Resulting in a Comprehensive Community Health Assessment
- **Standard 1.2 -** Collect and Maintain Reliable, Comparable, and Valid Data That Provide Information on Conditions of Public Health Importance and on the Health Status of the Population
- **Standard 1.3 -** Analyze Public Health Data to Identify Trends in Health Problems, Environmental Public Health Hazards, and Social and Economic Factors That Affect the Public's Health
- **Standard 1.4 -** Provide and Use the Results of Health Data Analysis to Develop Recommendations Regarding Public Health Policy, Processes, Programs, or Interventions

Required CHNA Planning Process Requirements:

a. Participation by a wide range of community partners.
b. Data / information provided to participants in CHNA planning process.
c. Evidence of community / stakeholder discussions to identify issues & themes. Community definition of a "healthy community" included along with list of issues.
d. Community assets & resources identified.
e. A description of CHNA process used to set priority health issues.

Drivers of Health Assessment & Improvement Planning

Different drivers have led health agencies and organizations to institutionalize community health assessment and community health improvement planning in recent years.

CDC Grant Requirements

CDC grants often require or encourage completing a community health assessment or improvement plan. In some cases, these plans provide valuable information for identifying priority health issues or needs. Examples include ; National Public Health Improvement Initiative (NPHII); Community Transformation Grants or REACH Core

The Public Health Accreditation board defines *community health assessment* as a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues. A variety of tools and processes may be used to conduct a community health assessment; the essential ingredients are community engagement and collaborative participation. Turnock B. *Public Health: What It Is and How It WorSD. Jones and Bartlett, 2009,* as adapted in *Public Health Accreditation Board Acronyms and Glossary of Terms Version 1.0* Cdc-pdf[PDF – 536KB]External, July 2011.

The Catholic Health Association defines a *community health needs assessment* as a systematic process involving the community to identify and analyze community health needs and assets in order to prioritize these needs, and to plan and act upon unmet community health needs." Catholic Health Association, *Guide to Assessing and Addressing Community Health Needs* Cdc-pdf[PDF-1.5MB]External, June 2013.

Social Determinants of Health

What Are Social Determinants of Health?

Social determinants of health (SDOH)external icon are defined as the conditions in which people are born, grow, live, work, and age. SDOH are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world. Differences in these conditions lead to health inequities or the unfair and avoidable differences in health status seen within and between countries.

Healthy People 2030 includes SDOH among its leading health indicators. One of Healthy People 2030's five overarching goals is specifically related to SDOH: Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.

Through broader awareness of how to better incorporate SDOH throughout the multiple aspects of public health work and the 10 Essential Public Health Services, public health practitioners can transform and strengthen their capacity to advance health equity. Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health, such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

II. Methodology
b. Collaborating CHNA Parties

Working together to improve community health takes collaboration. Listed below is an in depth profile of the local hospital and community CHNA partners**:**

Bennett County Hospital Profile

History: Bennett County Hospital is a 14-bed Critical Access Hospital(CAH), with a 3-bed emergency room area. It also includes the area's designated Community Health Clinic, a home health agency, as well as operating the emergency ambulance service. It is also listed as a trauma-receiving facility within the South Dakota Trauma system.

We pride ourselves on providing top-quality care for Bennett County and the surrounding area. We offer a broad range of services including 24-hour emergency care, convenient and specialized outpatient resources, Radiology, Laboratory, Physical Therapy, Inpatient Care, Swing beds, and top-quality services designed to improve the health and well-being of our community.

Diagnostic services include Radiology, Sonography, Computed Tomography (CT), Laboratory, and Bone Densitometry,

Mission Statement: "**Caring People Working Together as a Team, To Provide Quality Healthcare and Education for a Healthier Community**.

Bennett Cunty Hospital offers the following services to its community:

- Designated trauma receiving facility
- Emergency Room
- Acute care hospital
- Radiology
- Observation Care
- Skilled Care
- Evaluation & Rehabilitation
- Community health center
- Specialty Clinics
- Wound Care
- Home Health

II. Methodology

c. Other collaborating CHNA Parties

Horizon Health Care- the local FQHC

All emergency providers in the hospital

All EMT and ambulance volunteers

Bennett County Volunteer Fire Department

Law enforcement from City, County, State and Both reservations

Indian Health Service – local Service unit leadership

Eide Bailey Accountants and Consulting Services

II. Methodology

d. CHNA and Town Hall Research Process

Community Health Needs Assessment (CHNA) process began in March of 2021 for Bennett County Hospital located in Bennett County, SD to meet Federal IRS CHNA requirements.

In early November 2021, a meeting was called amongst the Bennett County Hospital leaders to review CHNA collaborative options.

To ensure proper PSA Town Hall representation (that meets the 80-20 Patient Origin Rule), a patient origin three-year summary was generated documenting patient draw by zips as seen below:

Population and Demographic Data of Service area

Census Tract	County	Area	Population	ATSDR SVI	EVI COVID Risk	EVI %	Median HH income	% Poverty	Employment Drop
9410	Bennett	Martin	1,636	.80	49.9	74	47,500	31.6	-3.6
9412	Bennett		1,789	.82					
9409	Oglala	East	4,842	1.0	66.7	99	31,997	40.1	-.8
9401	Todd	NW	4,465	.93	59.8	94	24,331	43.4	-4.6
9402	Todd	SW	5,730	.97	59.8	94			-5.7
9412	Jackson	South	2,190	.94	47.1	67	33,295	29.9	
	State of SD						58,275	11.9	-.2

We also utilized the available data from the EVI and SVI indexes to create the above table.
By pulling a two-year history of patient data, sorted by Zip Codes utilizing our database, with a particular focus on the past two years during which we have had COVID patients and COVID related deaths, we were able to create the following table of Patients by Zip Code:

Patients by Zip Code

Zip Code	Location	County	Percentage
57551	Martin	Bennett	41
57752	Kyle	Oglala Lakota	14
57714	Allen	Oglala Lakota	14
57577	Wanblee	Jackson	11
57770	Pineridge	Oglala Lakota	2
57716	Derby	Oglala Lakota	2
57772	Porcupine	Oglala Lakota	1
57750	Interior	Jackson	1
57547	Long Valley	Jackson	1
57555	Mission	Todd	1
57570	Rosebud	Todd	1

Further summary analysis lends the following data table:

Percentage of patients by county of household in service area

County	percentage
Bennett	46.5
Oglala	36.3
Jackson	14.7
Todd	2.2
All Other	.3

This data helps inform the process of review with analytical data demonstrating the level of needs
As required for this community needs assessment.

To meet IRS-aligned CHNA requirements and meet Public Health accreditation criteria stated earlier, a four-phase methodology was followed:

Phase I—Discovery:

Conduct a 30-minute conference call with the CHNA county health department and hospital participants. Review / confirm CHNA calendar of events, explain / coach to complete the required participant database ,and schedule / organize all Phase II activities.

Phase II—Qualify Community Need:

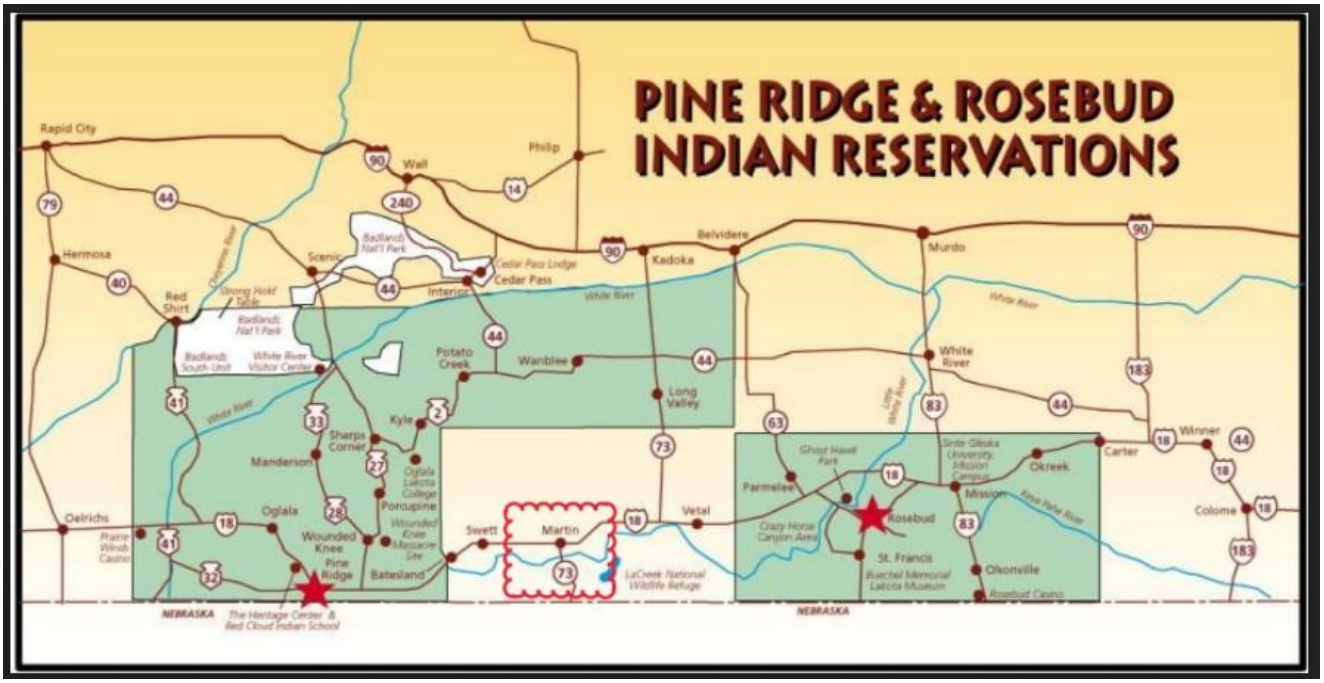
A) Conduct secondary research to uncover the following historical community health status for the primary service area. Use valid health indicator sources cited to document the current state of county health. Also document social indicators of health.

Location and History

Bennett County Hospital and Nursing Home provides critical primary medical care and emergency health services for Bennett County, located in Western South Dakota, a community uniquely recognized by the Federal Government as being entirely within the Wazí Aháŋhaŋ Oyáŋke (Pine Ridge Indian Reservation or Agency) . To the East is the Rosebud Indian Reservation, occupied by Sicangu Oyate, also known as Sicangu Lakota, and the Rosebud Sioux Tribe (RST), a branch of the Lakota Nation. The Lakota name Sicangu Oyate translates into English as "Burnt Thigh Nation". This land for centuries has been the traditional territory of the Oglala Lakota, also known as the Sioux and has been part of their legally defined territory since the treaty of 1851. A full 59.68% of this county is Native American, one of the highest concentration of Native Americans in any county in America. We also provide care and treatment for patients from neighboring Todd, Jackson and Oglala Lakota counties.

The Bennett County Hospital and Nursing Home is the only medical care facility in South Dakota within an 80-mile radius from Martin, other than the IHS facilities that are for the most part exclusive to tribal members. For the residents of Bennett County this hospital and nursing home is the place where they seek treatment for both critical emergency care and basic medical care. For needs that cannot be met at this facility, residents must travel to Rapid City (120 miles, 152 miles currently because of occasionally closed highways through the reservations due to COVID-related checkpoints); Valentine, NE (80 miles) or Gordon, NE (48 miles); Winner, SD (102 miles); Phillip, SD (79 miles), or Pierre, SD (154 miles). The BC Hospital and Nursing home is the largest employer for the City of Martin and is vital to the town's existence. The facility is outdated and does not provide an adequate function for the needs of the County.

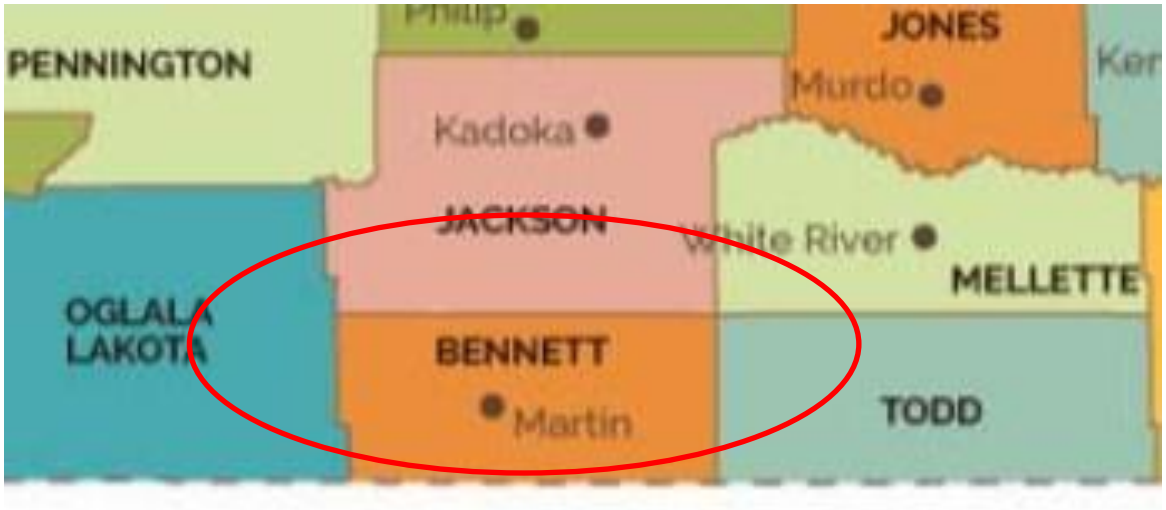
A graphic example of the location of Martin, SD between reservations is below:



Below is another map from National Geographic demonstrating the location of our project

Within the City of Martin, is the location of our Hospital and Nursing Home

This map shows the general location of the service area as well as the location of the City of Martin and Bennett County as it is associated with Todd to the East, Jackson to the North, and Oglala Lakota to the West



This is a table showing general demographics of our communities and service area by Census Tract utilizing the most Recent demographic data available from the census bureau from the 2010 Census and pulling numbers and data from The US Census Quick Facts sheets on Bennett, Oglala Lakota, Jackson and Todd Counties.

We believe it also will demonstrate a weighted point review of all the Available data. By calculating weighted Median Household Income by county and percentage of our Patient census we arrived at the following:

Weighted Median Household income

County	5 SD MHI	% of patients	weighted
Bennett	81.5%	41%	33.41
Oglala Lakota	54.9%	32%	17.56
Jackson	57.1%	13%	7.42
Todd	41.7%	2%	.83
TOTAL			**59.22**

We believe that this clearly demonstrates that our community's need is great. Our facility is located i n a rural community having a population of 5,000 or less (Bennett County has a population of only 3,425) and the median household income of the population to be served by the proposed facility is below 60 percent of the State nonmetropolitan median household income (as shown above this number is 59.22)

In Bennett County, we suffer from a substantial number of the population living below the poverty l ine, compared to the respective national rate. Additionally this county is ranked 25th poorest in America. The Pine Ridge Reservation, South Dakota, is the second poorest reservation in the US and this reservation has the lowest life expectancy rate in the U.S. and the second lowest in the Western hemisphere. The Pine Ridge Reservation is designated as one of the poorest areas in the United States. The Reservation has few natural resources and no industry. Many residents travel more than 120 miles to Rapid City for seasonal employment. Tribal and federal governments provide the few jobs that are available on the Reservation. Only one Oglala in five has a job.

To our East, the Rosebud Reservation is also economically depressed and ranks second (after the Pine Ridge Reservation) in lowest per capita income on Plains Reservations. Unemployment sometimes reaches over 80%, and the lack of job opportunities leaves a devastating mark on Rosebud families. Many heads of the family are forced to leave the reservation to seek work. Extended families pool their meager resources together in order to try to provide their basic needs.

Indian Country Today has reported that one out of three residents of the Rosebud Reservation was homeless and that six out of ten live in substandard housing. Overcrowding is common, as most families will not turn away even extended family members in need of a place to stay. Sadly, gangs and other social ills impact some of the youth struggling to come to terms living in an environment with an uncertain future.

The following information will clearly provide sufficient documentation to demonstrate how Bennett County Hospital primarily serves rural areas, is located in a rural area, and serves only a rural population with a median household income below the state Median Household Income level. We only serve rural areas with small populations.

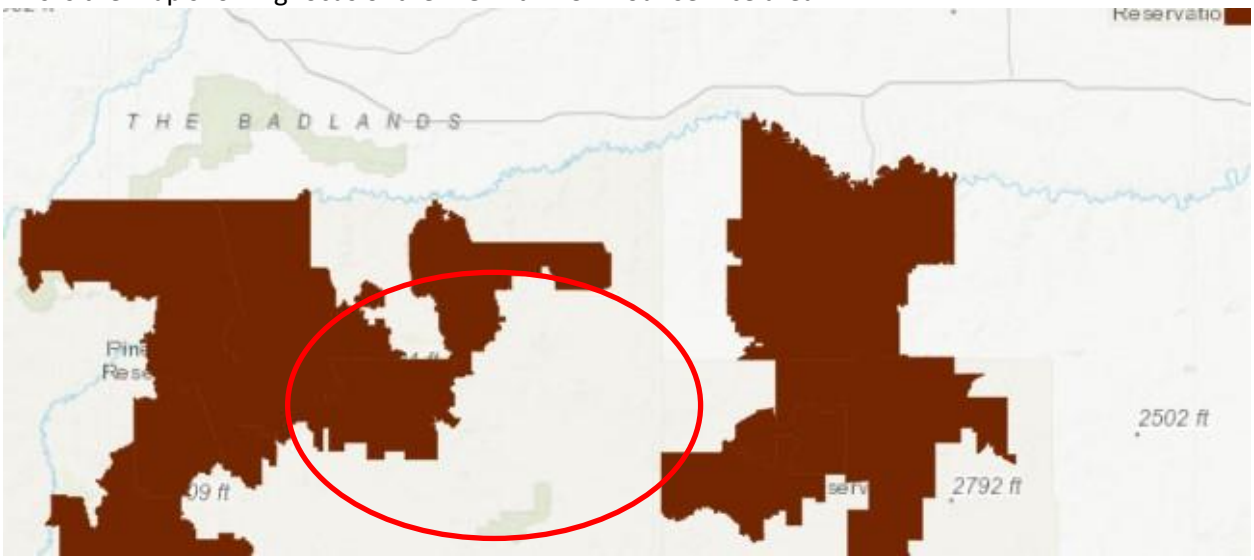
We also recognize that while not being required there are other clear indications of the equity focus this needs assessment is addressing. Some of the additional areas we wish to point out in our review include:

SOCIAL INDICATORS OF HEALTH:

Distressed communities

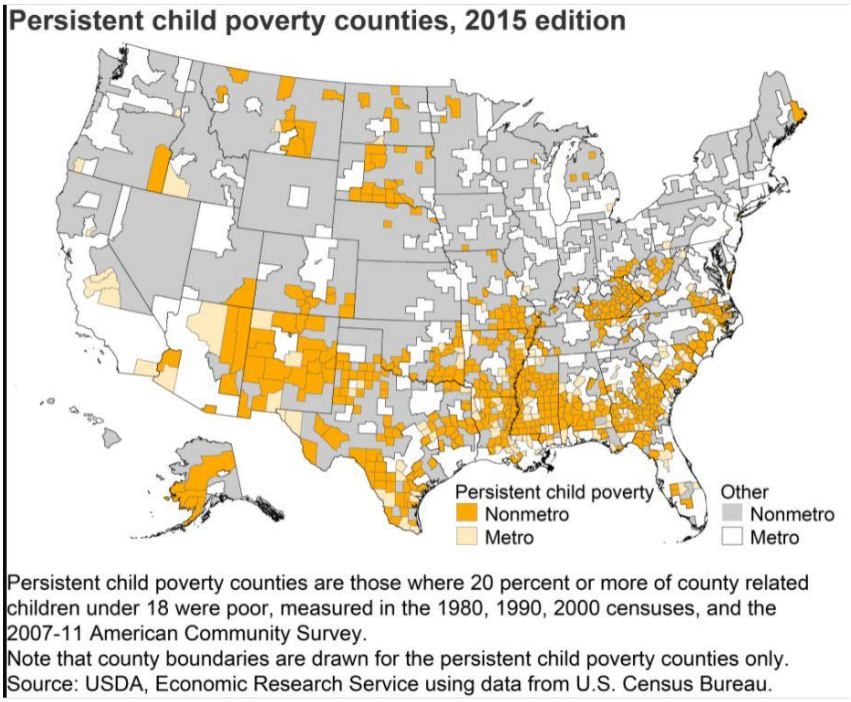
This USDA program is designed to assist essential community facilities located in rural areas, primarily serving rural areas, and serving populations with median household income that is lower than ninety percent of the State nonmetropolitan median household income. Within these parameters, the Agency is further encouraging investment in distressed communities. RD utilizes the Distressed Communities Index (DCI) , developed by the Economic Innovation Group (EIG),

This is the map showing focus of the EIG with DCI in our service area.

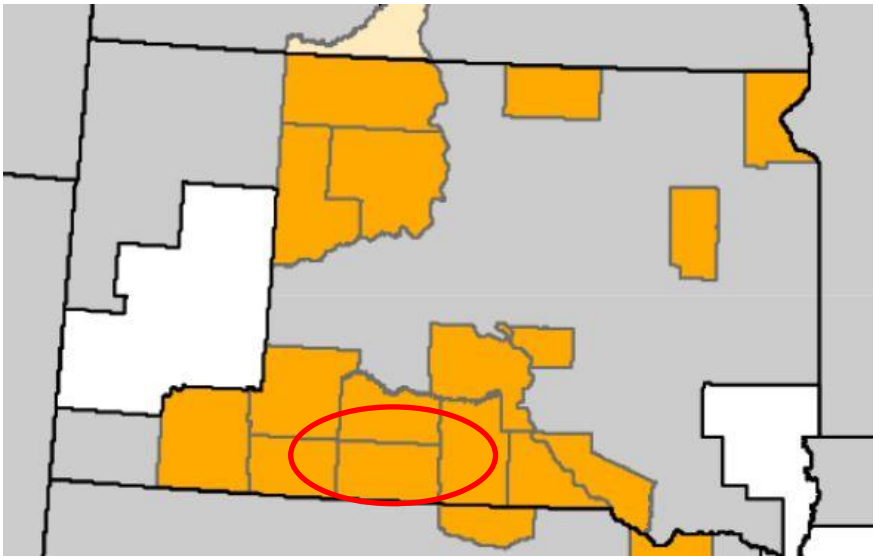


Persistent child poverty Counties

Another measure the USDA uses to identify need and to identify risks is the map of **persistent child poverty Counties**. This is the National map:

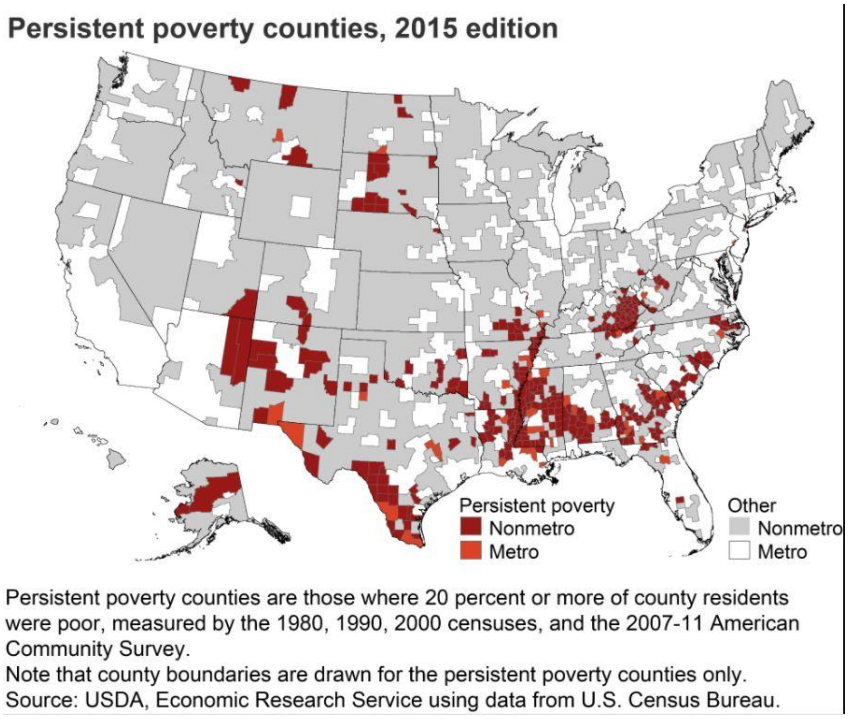


This is the South Dakota Persistent Child Poverty map, again with a circle around our service area Demonstrating the significant need in our area.



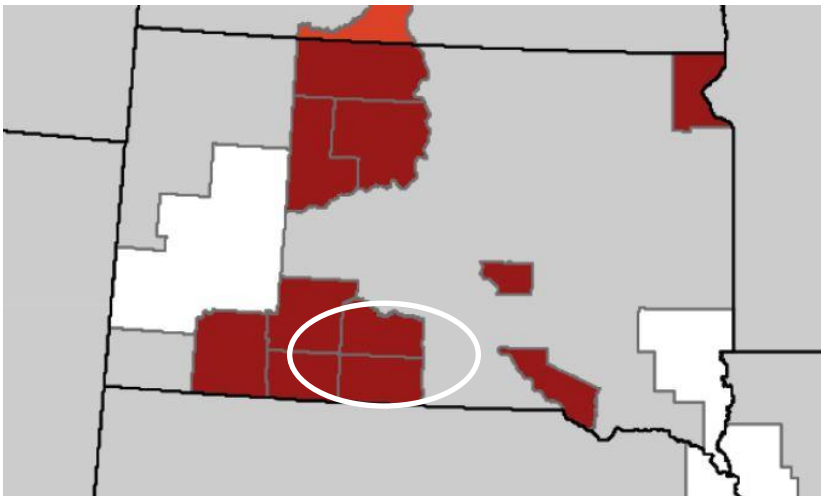
Persistent Poverty Counties:

On a national and local basis another graphic measure of need is the use of the USDA, Persistent Poverty Map
This is the US national map:



Persistent poverty counties are those where 20 percent or more of county residents were poor, measured by the 1980, 1990, 2000 censuses, and the 2007-11 American Community Survey.
Note that county boundaries are drawn for the persistent poverty counties only.
Source: USDA, Economic Research Service using data from U.S. Census Bureau.

An once again using this same mapping tool to identify the Persistent Poverty areas in South Dakota With our service area circled to demonstrate our level of severe needs.



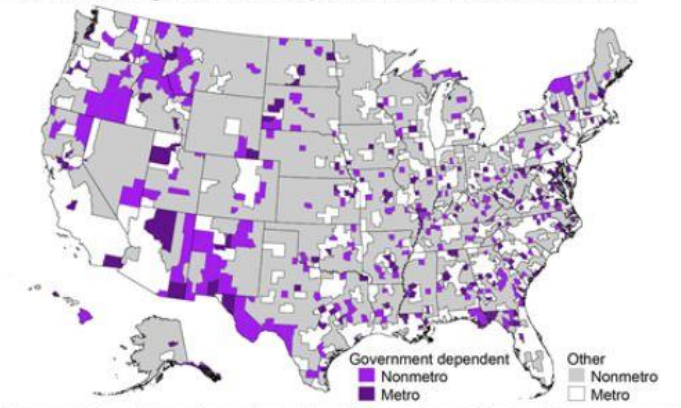
Federal /State Government Dependent:

Another common graphic that the USDA uses to identify need is the Government Dependency map This is the national map:

Federal/State Government-Dependent

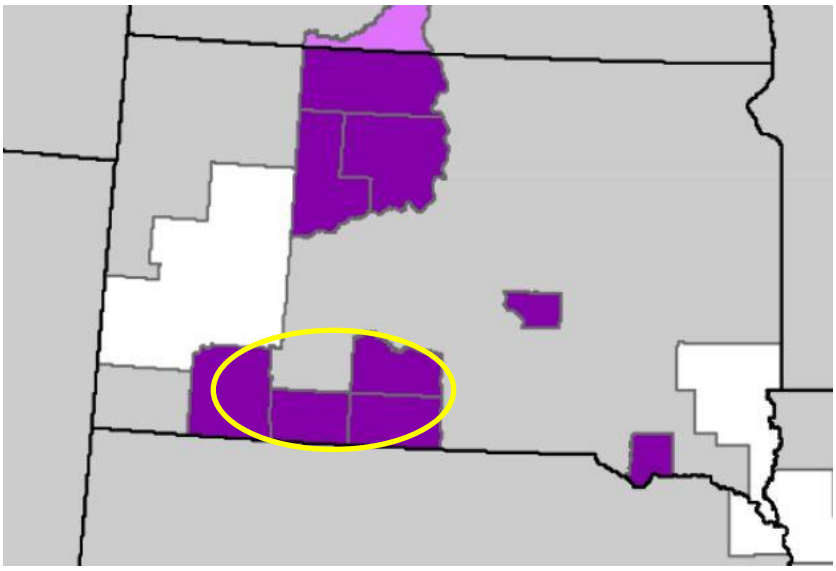
Federal/State government-dependent (407 total, 239 nonmetro) counties: 14 percent or more of average annual labor and proprietors' earnings derived from Federal and State government or 9 percent of total employment during 2010-12.

Federal/State government-dependent counties, 2015 edition



Government-dependent counties are those where 14 percent or more of the county's average annual labor and proprietors' earnings were derived from Federal/State government, or 9 percent or more jobs were in Federal/State government as measured by 2010-12 Bureau of Economic Analysis, Local Area Personal Income and Employment data. Note that county boundaries are drawn for the government-dependent counties only. Map revised May 2017; see errata for details.
Source: USDA, Economic Research Service using data from Bureau of Economic Analysis.

This is the Government Dependency Map for South Dakota, with a circle identifying our service area.



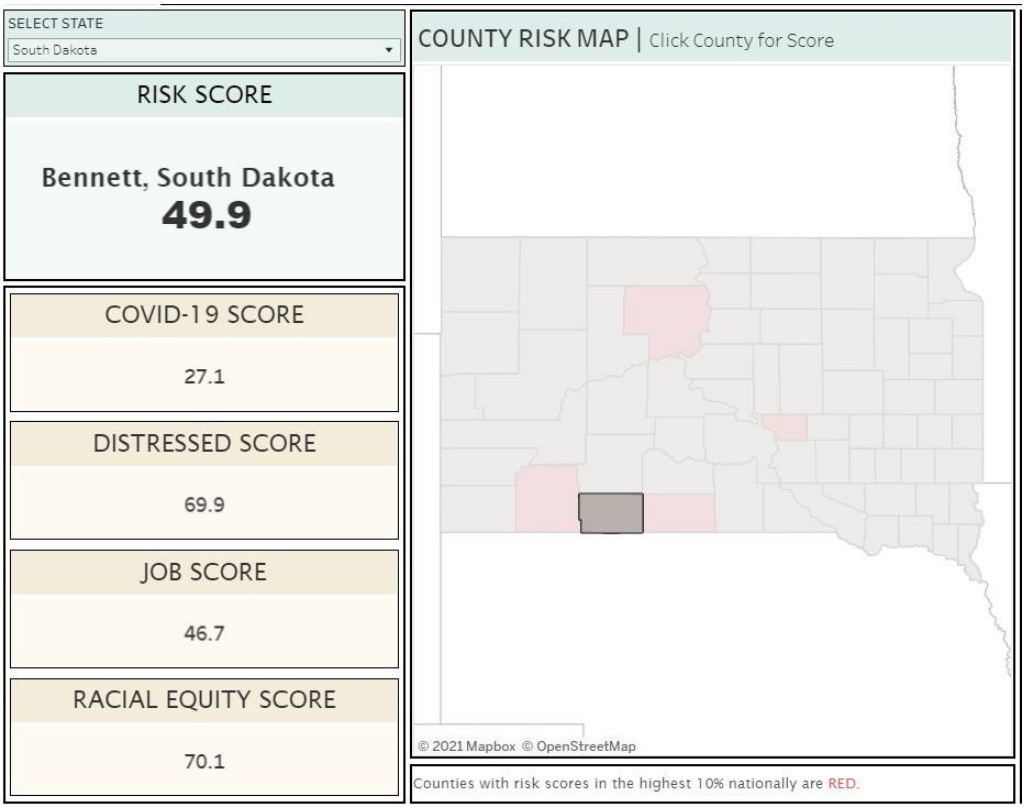
<u>COVID Testing and Administration</u>

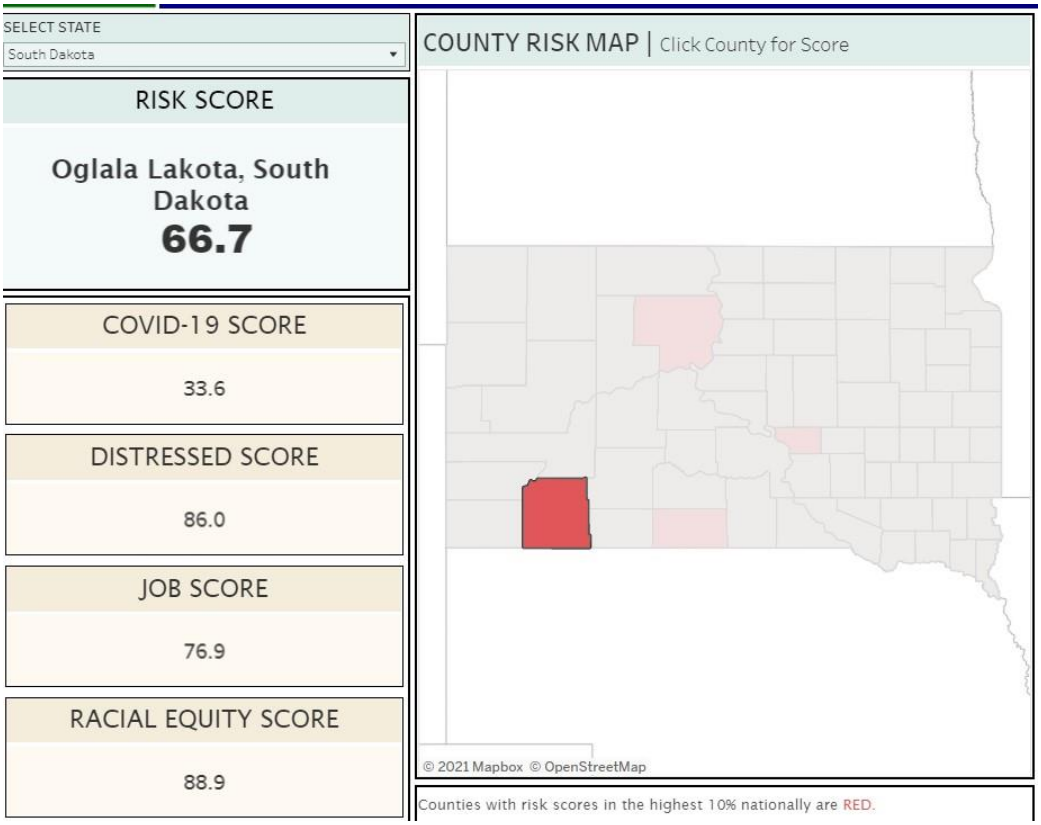
Bennett County Hospital and rural health clinic is a major testing location in our service area as well as the site for Providing two of the three vaccination interventions for our community. We are also the single largest site for vaccination and COVID testing in our service area. We additionally have been working to address vaccine hesitancy with a grant for an increased activity to encourage and promote vaccinations. A major focus for the current needs assessment is related to support activities to administer COVID– 19 vaccines or conduct COVID–19 testing and to support preparedness for a future pandemic event, and to increase access to

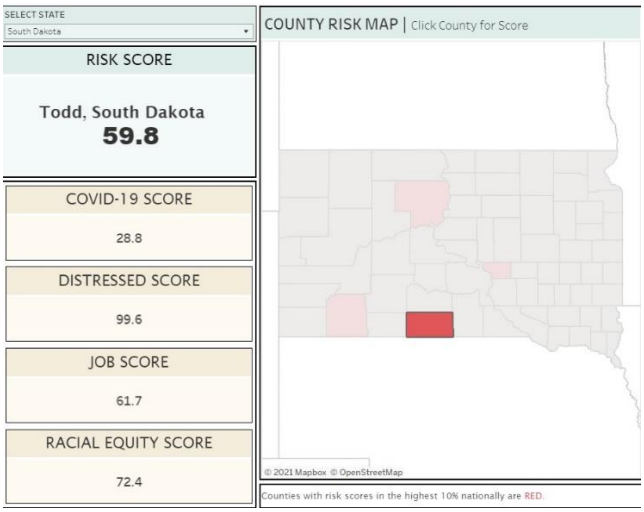
quality healthcare services to improve community health outcomes.

COVID Risk Indicators

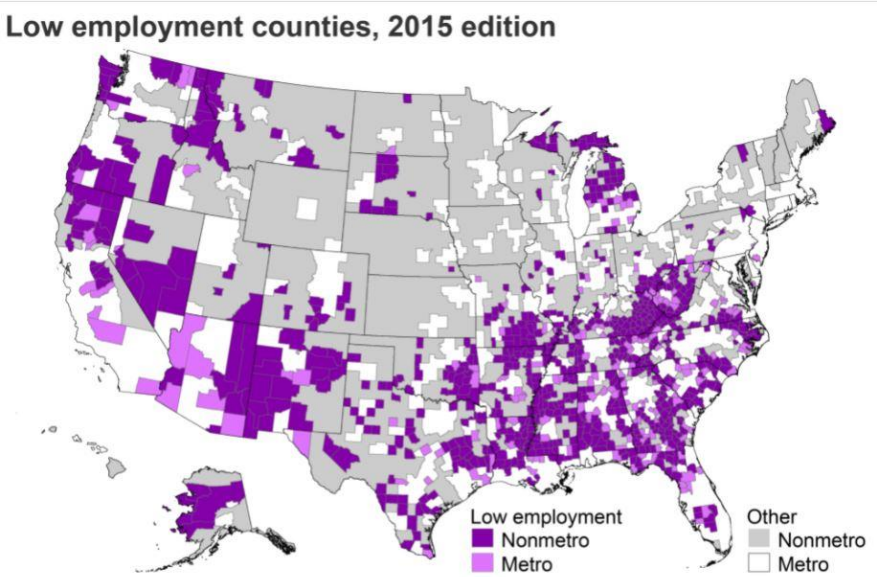
One of the selected methods for determining a value for COVID risk is the use of the PUBLIC COVID DASHBOARD -4 FACTORS ONLY | Tableau Public to identify and assess risk. These are the scores for the counties in our service area:





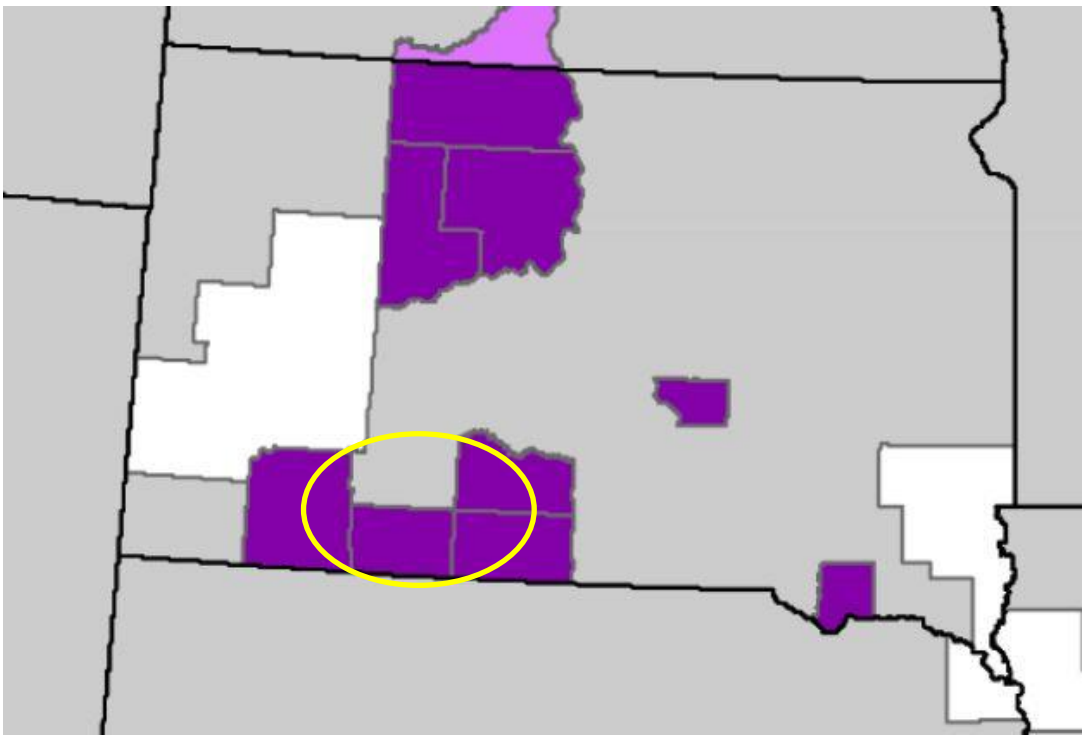


Low Employment Counties: Another clear indication of need is the tracking of Job loss and low employment numbers. This is the national map:



Low employment counties are those where less than 65 percent of county residents age 25-64 were employed, determined by the American Community Survey 5-year average data for 2008-12.
Note that county boundaries are drawn for the low employment counties only.
Source: USDA, Economic Research Service using data from U.S. Census Bureau.

To help graphically show the same need in our service area, we have added the South Dakota Low employment map highlighting out service area.



SVI Index

Another index useful in demonstrating our need is the Social Vulnerability Index or the SVI. This is the data for our service area by county

LOCATION	RPL_THEME1 (Socioeconomic)	RPL_THEME2 (Household Composition & Disability)	RPL_THEME3 (Minority Status and Language)	RPL_THEME4 (Housing Type & Transportation)	**RPL_THEMES (SVI Overall)**
Census Tract 9410, Bennett County	0.7223	0.8456	0.5312	0.7858	0.7981
Census Tract 9412, Bennett County	0.9704	0.8198	0.5874	0.4118	0.821
Census Tract 9409, Oglala Lakota Cc	0.9813	0.847	0.8318	0.9966	0.9965
Census Tract 9401, Todd County, Sc	0.9913	0.6606	0.6959	0.8281	0.9286
Census Tract 9402, Todd County, Sc	0.9526	0.7106	0.6162	0.9902	0.9655
Census Tract 9412, Jackson County,	0.975	0.8377	0.4269	0.9474	0.9444

:

B) Survey Community Stakeholders to inquire about past CHNA unmet needs and obtain current health delivery trends and document on going health issues.

Phase III—Quantify Community Need:

Conduct a widely publicized two hour Town Hall meeting with required community primary service area residents. At each Town Hall meeting, CHNA secondary data will be reviewed, facilitated group discussion will occur and a group ranking activity to determine the most important community unmet health needs was administered. This was well attended with a wide range of community members.

Phase IV—Complete Data Analysis and Create Comprehensive Community Health Needs Assessment:

Complete full documentation to create each CHNA section documented in Table of Contents. Also to publish hard copy reports for partner use usage plus create a full CHNA report pdf to be posted on the hospital website to meet government CHNA regulation criteria.

Detail CHNA Development Steps Include:

Development Steps taken to Create Comprehensive Community Health Needs Assessment (CHNA)	
Step # 1 Commitment	***Determine the interest level of area healthcare leaders (Hospital, Health Dept., Federally Qualified Health Centers, Volunteer Services, Schools, Churches, Physicians etc.),***
Step # 2 Planning	***Prepare brief CHNA Project Work Calendar*** **- list goals, objectives, purpose, outcome, roles, community involvement, etc. Hold Community Kick-off meeting.**
Step # 3 Secondary Research	***Collect & Report Community Health Published Facts. Gather data health practice data from*** **published secondary research sources i.e. census, county health records, behavioral risk factors surveillance, etc.**
Step # 4a Primary Research - Town Hall prep	***Collect Community Opinions. (Quantitative Research).*** **Gather Stakeholders / Community opinions regarding community health needs and healthcare practices.**
Step # 4b Primary Research - Conduct Town Hall	***Conduct "Conversation with Community" Town Hall (Qualitative Research). Review Secondary & Primary Data findings. Facilitate community conversation to build consensus; discuss*** **opinions / identify health needs.**
Steps # 5 Reporting	***Prepare/Present a a comprehensive CHNA report (to community leader and facilitate the development of a CHNA Implementation Plan (Actions to improve health)*** **.** **Formal report will follow IRS Notice 2011-52 regs & PHAB requirements.**

Data & Benchmark Review

Community health assessments typically use both primary and secondary data to characterize the health of the community:

- **Primary data** are collected first-hand through surveys, listening sessions, interviews, and observations.
- **Secondary data** are collected by another entity or for another purpose.
- **Indicators** are secondary data that have been analyzed and can be used to

compare rates or trends of priority community health outcomes and determinants.

Data and indicator analyses provide descriptive information on demographic and socioeconomic characteristics; they can be used to monitor progress and determine whether actions have the desired effect. They also characterize important parts of health status and health determinants, such as behavior, social and physical environments, and healthcare use.

Community health assessment indicators should be.

- Methodologically sound (valid, reliable, and collected over time)
- Feasible (available or collectible)
- Meaningful (relevant, actionable, and ideally, linked to evidence-based interventions)
- Important (linked to significant disease burden or disparity in the target community)

Jurisdictions should consider using data and indicators for the smallest geographic locations possible (e.g., county-, census block-, or zip code-level data), to enhance the identification of local assets and gaps.

Local reporting (County specific) sources of community-health level indicators:

CHNA Detail Sources
USDA Community Health factors
Centers for Medicare and Medicaid Services
CMS Hospital Compare
County Health Rankings
Quick Facts - Geography
South Dakota Health Matters
South Dakota Association of Health Organizations (SDAHO)
Quick Facts - People
U.S. Department of Agriculture - Food Environment Atlas
U.S. Center for Disease Control and Prevention

Sources of community-health level indicators:

- County Health Rankings and Roadmaps
  The annual Rankings measure vital health factors, including high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income inequality, and teen births in nearly every county in America. They provide a snapshot of how health is influenced by where we live, learn, work and play.
- Prevention Status Reports (PSRs)
  The PSRs highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to prevent or reduce important public health problems.
- Behavioral Risk Factor Surveillance System
  The world's largest, ongoing telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the US Virgin Islands, and Guam.
- The Selected Metropolitan/ Micropolitan Area Risk Trends project was an outgrowth of BRFSS from the increasing number of respondents who made it possible to produce prevalence estimates for smaller statistical areas.
- CDC Wonder Databases using a rich ad-hoc query system for the analysis of public health data. Reports and other query systems are also available.
- Center for Applied Research and Engagement Systems external icon
  Create customized interactive maps from a wide range of economic, demographic, physical and cultural data. Access a suite of analysis tools and maps for specialized topics.
- Community Commons external icon
  Interactive mapping, networking, and learning utility for the broad-based healthy, sustainable, and livable communities' movement.
- Dartmouth Atlas of Health Care external icon
  Documented variations in how medical resources are distributed and used in the United States. Medicare data used to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians.
- Disability and Health Data System
  Interactive system that quickly helps translate state-level, disability-specific data into valuable public health information.
- Heart Disease and Stroke Prevention's Data Trends & Maps
  View health indicators related to heart disease and stroke prevention by location or health indicator.
- National Health Indicators Warehouse external icon
  Indicators categorized by topic, geography, and initiative.
- US Census Bureau external icon
  Key source for population, housing, economic, and geographic information.
- US Food Environment Atlas external icon
  Assembled statistics on food environment indicators to stimulate research on the determinants of food choices and diet quality, and to provide a spatial overview of a community's ability to access healthy food and its success in doing so.
- Centers for Medicare & Medicaid Services Research and Data Clearinghouse external icon
  Research, statistics, data, and systems.
- Environmental Public Health Tracking Network
  System of integrated health, exposure, and hazard information and data from a variety of national, state, and city sources.
- Health Research and Services Administration Data Warehouse external icon
  Research, statistics, data, and systems.
- *Healthy People 2030* Leading Health Indicators external icon
  Twenty-six leading health indicators organized under 12 topics.
- Kids Count external icon
  Profiles the status of children on a national and state-by-state basis and ranSD states on 10 measures of well-being; includes a mobile site external icon.
- National Center for Health Statistics
  Statistical information to guide actions and policies.
- Pregnancy Risk Assessment and Monitoring System
  State-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy.
- Web-based Injury Statistics Query and Reporting System (WISQARS)
  Interactive database system with customized reports of injury-related data.
- Youth Risk Behavior Surveillance System
  Monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults.

II. Methodology

e)Community Profile (A Description of Community Served)

Bennett County (SD) Community Profile

Bennett County is a county in the U.S. state of South Dakota. As of the 2010 census, the population was 3,431. Its county seat is Martin. The county lies completely within the boundaries of the Pine Ridge Indian Reservation according to federal cartographers. To the east is the Rosebud Indian Reservation, occupied by Sicangu Oyate, also known the Upper Brulé Sioux Nation and the Rosebud Sioux Tribe (RST), a branch of the Lakota people.

The North American continental pole of inaccessibility is in Bennett County, Historically, ranching and dry land farming have been the chief agricultural pursuits possible given climate and soil conditions.

This land has for centuries been the traditional territory of the Oglala Lakota, also known as the Sioux; it has been part of their legally defined territory since the treaty of 1851 and has remained within its legal boundaries through various other Treaties and Acts that reduced their land base to the current boundaries of the Pine Ridge Indian Reservation when the reservation was created by the Act of March 2, 1889 . Despite its reservation status, most of the county was opened for settlement by the Act of May 27, 1910, where the US Congress "authorized and directed the Secretary of Interior to sell and dispose of all that portion of the Pine Ridge Indian Reservation, in the State of South Dakota, lying and being in Bennett County". Open settlement was ended by a Secretarial Order of June 10, 1936, which restored "to tribal ownership of all lands which are now, or may hereafter be, classified as undisposed-of surplus opened lands of the Pine Ridge Reservation...."

The county was created in 1909, with land partitioned from Fall River County. On April 27, 1912, the county's first board of commissioners was elected. In November 1912, residents chose the town of Martin as the county seat.

2010 census

As of the 2010 United States Census, there were 3,431 people, 1,090 households, and 766 families in the county. The population density was 2.9 inhabitants per square mile (1.1/km2). There were 1,263 housing units at an average density of 1.1 per square mile (0.42/km2). The racial makeup of the county was 61.5% American Indian, 33.7% white, 0.4% Asian, 0.1% Pacific islander, 0.1% black or African American, 0.2% from other races, and 4.0% from two or more races. Those of Hispanic or Latino origin made up 2.0% of the population. In terms of ancestry, 20.9% were German, 5.1% were Swedish, and 1.9% were American.

Of the 1,090 households, 42.9% had children under the age of 18 living with them, 40.3% were married couples living together, 20.1% had a female householder with no husband present, 29.7% were non-families, and 24.3% of all households were made up of individuals. The average household size was 3.11 and the average family size was 3.73. The median age was 28.7 years.

The median income for a household in the county was $32,841 and the median income for a family was $38,487. Males had a median income of $40,158 versus $31,406 for females. The per capita income for the county was $16,153. About 24.3% of families and 32.1% of the population were below the poverty line, including 42.3% of those under age 18 and 15.4% of those age 65 or over.

The Federal Government recognizes Bennett County as being entirely within the Pine Ridge Indian Reservation.

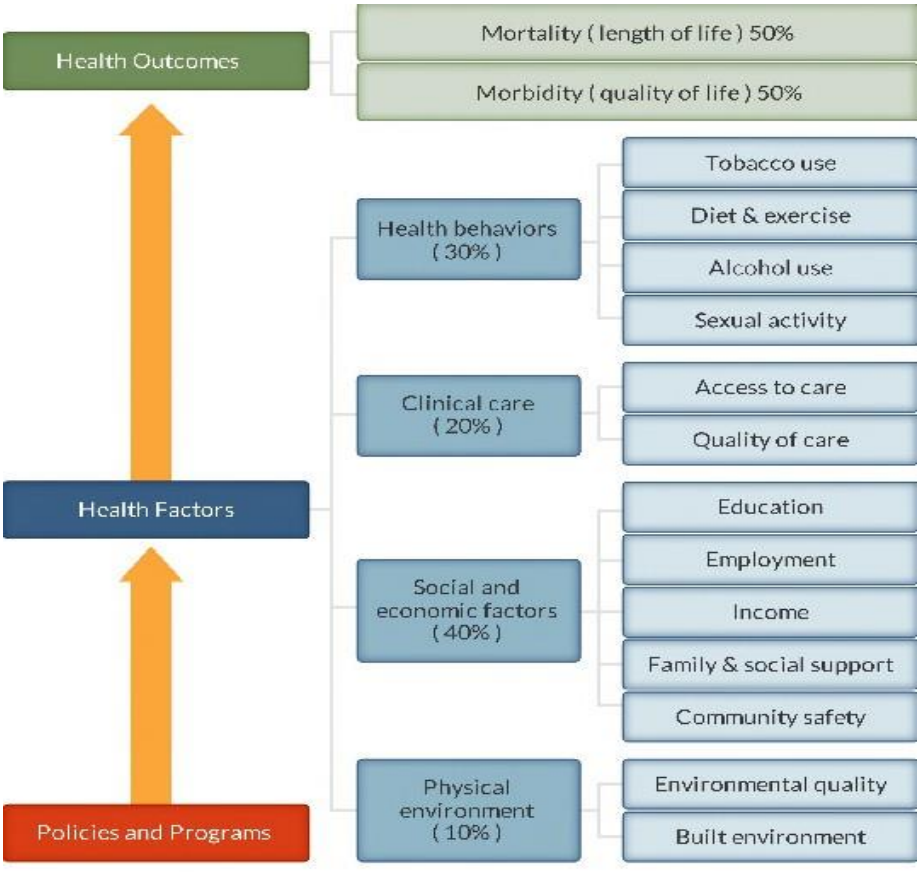
I. Community Health Status

III. Community Health Status

a) Historical Health Statistics- Secondary Research

Health Status Profile

This section of the CHNA reviews published quantitative community health indicators from public health sources and results of community primary research. Note: The Robert Wood Johnson Foundation collaborates with the University of Wisconsin Population Health Institute to release annual *County Health Rankings.* As seen below, RWJ's model use a number of health factors to rank each county.



County Health Rankings model ©2012 UWPHI

National Research – Year 2021 RWJ Health Rankings:

United States

United States

Demographic Information

2019 Population Information

Subject	Number	Percent
Total population	328,239,523	100.0
White	197,309,822	60.1
Hispanic	60,572,237	18.5
Black or African American	41,147,488	12.5
Asian	18,905,879	5.8
American Indian & Alaska Native	2,434,908	0.7
Pacific Islander	595,908	0.2
Multi-Racial	7,273,281	2.2
Under 5 years	19,404,835	5.9
Under 18 years	72,967,785	22.2
65 years and over	54,074,028	16.5

Source: United States Census Bureau, 2019 Population Estimates

Health Status Indicators[1]

Natality – 2019

Percent of Low Birth Weight Infants	8.3
Percent of Mothers Receiving Care in 1st Trimester	77.6
Percent of Mothers Who Smoked Cigarettes While Pregnant[2]	6.0
Percent of Births Less Than 37 Wks. of Gestation	10.2
Average Age of Mother	29.1
Teenage Birth Rate[3]	6.7
Percent White, Non-Hispanic Births	51.1
Percent American Indian, Non-Hispanic Births	0.8
Percent Hispanic Births	23.7
Percent Unmarried	40.0
Percent WIC births	33.9
Percent Breastfeeding at discharge	83.6
Percent Payment-Private Insurance	50.2
Percent Payment-Medicaid	42.1
Percent C-Section	31.7

[1]Only one year of U.S. data are given to compare with five years of state and county data because the numbers on the national level are much greater and do not fluctuate as much annually.
[2]Data for mothers who smoked cigarettes are self-reported.
[3]Teenage birth rate is live births per 1,000 females age 15-17.

Mortality - 2019

	Rate[4]
All Causes	715.2
Heart Disease	161.5
Cancer	146.2
Trachea, Bronchus, & Lung	33.4
Colon, Rectum, & Anus	13.1
Female Breast	19.4
Pancreas	11.0
Prostate	18.3
Leukemia	5.8
Chronic Lower Respiratory Diseases	38.2
Alzheimer's Disease	29.8
Stroke	37.0
Unintentional Injuries	49.3
Motor Vehicle Accidents	11.5
Diabetes	21.6
Influenza and Pneumonia	12.3
Suicide	13.9
Chronic Liver Disease and Cirrhosis	11.3
Infant Mortality (2018)	5.6

Leading Causes of Death	Total Deaths
1. Heart Disease	647,457
2. Cancer	599,108
3. Unintentional Injuries	169,936
4. Chronic Lower Respiratory Disease	160,201
5. Stroke	146,383
6. Alzheimer's Disease	121,404
7. Diabetes	83,564
8. Influenza and Pneumonia	55,672
9. Kidney Disease	50,633
10. Suicide	47,173

[4]The mortality rates, except infant mortality are age-adjusted death rates per 100,000 population. Age-adjusting to the standard million population eliminates differences between populations, making them easier to compare. Infant mortality is calculated as the number of infant (less than one year old) deaths per 1,000 live births.

Source: National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Hyattsville, Maryland.

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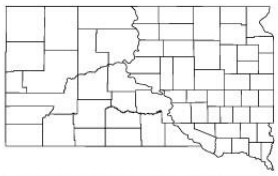
South Dakota

South Dakota

Demographic Information



South Dakota is located in the north central portion of the United States and averages 11.8 persons per square mile.

2020 Population Information

Subject	Number	Percent
Total population	892,717	100.0
White	724,153	81.1
American Indian & Alaska Native	72,996	8.2
Hispanic	39,604	4.4
Black or African American	20,466	2.3
Asian	14,643	1.6
Pacific Islander	552	0.1
Multi-Racial	20,303	2.3
Under 5 years	60,464	6.8
Under 18 years	218,479	24.5
65 years and over	157,177	17.6

Source: United States Census Bureau, 2020 Population Estimates

Health Status Indicators 2016-2020

Natality

• Percent of Low Birth Weight Infants	6.9
• Percent of Mothers Receiving Care in 1st Trimester	75.3
○ Percent of Mothers Who Smoked Cigarettes While Pregnant[1]	11.8
• Percent of Births Less Than 37 Wks. of Gestation	9.3
Average Age of Mother	28.3
○ Teenage Birth Rate[2]	9.7
Percent White, Non-Hispanic Births	71.2
Percent American Indian, Non-Hispanic Births	14.2
Percent Hispanic Births	5.5
• Percent Unmarried	36.5
• Percent WIC births	28.2
• Percent Breastfeeding at discharge	80.5
○ Percent Payment-Private Insurance	60.9
• Percent Payment-Medicaid	30.2
• Percent C-Section	24.7

•Denotes a health status indicator which is significantly lower than the national average.
○Denotes a health status indicator which is significantly higher than the national average.
[1]Data for mothers who smoked cigarettes are self-reported.
[2]Teenage birth rate is live births per 1,000 females age 15-17.

Mortality

	Rate[3]
All Causes	756.0
• Heart Disease	154.6
Cancer	151.9
Trachea, Bronchus, & Lung	35.9
Colon, Rectum, & Anus	14.3
Female Breast	18.7
Pancreas	11.3
Prostate	18.9
Leukemia	6.1
COVID-19 (2020)	130.0
○ Chronic Lower Respiratory Diseases	41.8
○ Alzheimer's Disease	38.1
• Stroke	34.6
Unintentional Injuries	53.4
○ Motor Vehicle Accidents	16.7
○ Diabetes	25.6
○ Influenza and Pneumonia	16.9
○ Suicide	20.8
○ Chronic Liver Disease and Cirrhosis	19.1
○ Infant Mortality (2011-2020)	6.7

Leading Causes of Death

	Deaths per Year
1. Heart Disease	1,779
2. Cancer	1,701
3. COVID-19 (2020)	1,497
4. Unintentional Injuries	515
5. Chronic Lower Respiratory Diseases	476
6. Alzheimer's Disease	463
7. Stroke	403
8. Diabetes	277
9. Influenza and Pneumonia	198
10. Suicide	178
Percent of Deaths due to tobacco use	19.2
Median age at death	79

•Denotes a health status indicator which is significantly lower than the national average.
○Denotes a health status indicator which is significantly higher than the national average.
[3]All mortality rates except infant mortality are age-adjusted death rates per 100,000 population. Infant mortality is the number of infant (less than one year) deaths per 1,000 live births.

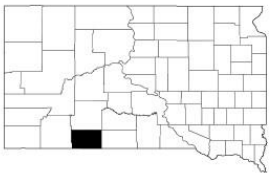
See technical notes for more information.

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

Bennett County

Bennett County

Demographic Information



Bennett County is located on the southern border in western South Dakota and averages 2.9 persons per square mile. Martin is the largest city in Bennett County.

2020 Population Information

Subject	Number	Percent
Total population	3,399	100.0
American Indian & Alaska Native	1,863	54.8
White	1,129	33.2
Hispanic	205	6.0
Asian	18	0.5
Black or African American	17	0.5
Pacific Islander	2	0.1
Multi-Racial	165	4.9
Under 5 years	296	8.7
Under 18 years	1,135	33.4
65 years and over	461	13.6

Source: United States Census Bureau, 2020 Population Estimates

Health Status Indicators 2016-2020

Natality

Percent of Low Birth Weight Infants	6.1
● Percent of Mothers Receiving Care in 1st Trimester	62.5
○ Percent of Mothers Who Smoked Cigarettes While Pregnant[1]	20.1
Percent of Births Less Than 37 Wks. of Gestation	8.6
● Average Age of Mother	26.3
Teenage Birth Rate[2]	23.0
Percent White, Non-Hispanic Births	23.7
Percent American Indian, Non-Hispanic Births	65.6
Percent Hispanic Births	2.9
○ Percent Unmarried	69.9
○ Percent WIC births	50.5
● Percent Breastfeeding at discharge	61.7
● Percent Payment-Private Insurance	23.2
○ Percent Payment-Medicaid	49.6
Percent C-Section	24.4

●Denotes a health status indicator which is significantly lower than the state average.
○Denotes a health status indicator which is significantly higher than the state average.
[1]Data for mothers who smoked cigarettes are self-reported.
[2]Teenage Birth rate is live births per 1,000 females age 15-17.

Mortality

	Rate[3]
○ All Causes	1,169.7
Heart Disease	228.7
Cancer	168.9
Trachea, Bronchus, & Lung	35.2
Colon, Rectum, & Anus	LNE
Female Breast	LNE
Pancreas	17.1
Prostate	LNE
Leukemia	LNE
COVID-19 (2020)	224.4
Chronic Lower Respiratory Diseases	77.1
● Alzheimer's Disease	16.2
Stroke	38.4
Unintentional Injuries	91.2
Motor Vehicle Accidents	32.3
○ Diabetes	127.3
Influenza and Pneumonia	22.7
Suicide	31.6
○ Chronic Liver Disease and Cirrhosis	60.3
Infant Mortality (2011-2020)	15.7

Leading Causes of Death	Deaths per Year
1. Heart Disease	8
COVID-19 (2020)	8
3. Cancer	6
4. Diabetes	4
5. Unintentional Injuries	3
Chronic Lower Respiratory Diseases	3
7. Chronic Liver Disease and Cirrhosis	2
8. Stroke	1
Suicide	1
Septicemia	1
Percent of Deaths due to tobacco use	24.0
Median age at death	69

●Denotes a health status indicator which is significantly lower than the state average.
○Denotes a health status indicator which is significantly higher than the state average.
[3]All mortality rates except infant mortality are age-adjusted death rates per 100,000 population. Infant mortality is the number of infant (less than one year) deaths per 1,000 live births.

See technical notes for more information.

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

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PSA Secondary Research:

When studying community health, it's important to document health data by topical areas for primary service areas (PSA). Below is a summary of key findings organized by subject area.

Note: Each area has been trended to reflect County trends to NORM.

PSA Primary Research:

For each CHNA evaluation, a community stakeholder survey has been created and administered to collect "current" healthcare information for Bennett Co. SD.

Chart #1 – Bennett County, SD Online Feedback Response (N=145)

Bennett Co. - CHNA YR 2021			
For reporting purposes, are you involved in or are you a ...?	Bennett Co SD N=170	Trend	2021 Norms N=4,393
Business / Merchant	14.7%		13.3%
Community Board Member	10.3%		10.7%
Case Manager / Discharge Planner	0.0%		1.0%
Clergy	1.1%		1.5%
College / University	5.4%		4.4%
Consumer Advocate	0.0%		1.9%
Dentist / Eye Doctor / Chiropractor	1.1%		1.1%
Elected Official - City/County	1.6%		2.8%
EMS / Emergency	1.1%		2.5%
Farmer / Rancher	19.0%		10.5%
Hospital / Health Dept	14.7%		24.1%
Housing / Builder	0.0%		1.0%
Insurance	1.6%		1.3%
Labor	0.0%		2.9%
Law Enforcement	0.5%		1.5%
Mental Health	0.0%		1.9%
Other Health Professional	0.0%		13.1%
Parent / Caregiver	16.8%		21.7%
Pharmacy / Clinic	0.0%		2.5%
Media (Paper/TV/Radio)	0.0%		0.5%
Senior Care	3.8%		5.0%
Teacher / School Admin	6.0%		10.4%
Veteran	2.2%		4.3%
Other (please specify)	0.0%		10.1%
TOTAL	184		2777

Chart #2 – Overall Community Health Quality Trend

Bennett Co - CHNA YR 2021			
When considering "overall community health quality", is it...	Bennett Co SD N=170	Trend	2021 Norms N=4,393
Increasing - moving up	45.1%		48.3%
Not really changing much	44.4%		43.6%
Decreasing - slipping	10.4%		8.0%
Valid N	144		4,063

II. Inventory of Community Health Resources

Inventory of Health Services - Bennett County, SD (2021)				
Cat	HC Services Offered in the county: Yes / No	Hospital	Health Dept	Other
Clinic	Primary Care	Yes		
Hosp	Alzheimer Center	No		
Hosp	Ambulatory Surgery Centers	No		
Hosp	Arthritis Treatment Center	No		
Hosp	Bariatric/weight control services	No		
Hosp	Birthing/LDR/LDRP Room	No		
Hosp	Breast Cancer	No		
Hosp	Burn Care	No		
Hosp	Cardiac Rehabilitation	No		
Hosp	Cardiac Surgery	No		
Hosp	Cardiology services	No		
Hosp	Case Management	Yes		
Hosp	Chaplaincy/pastoral care services	Yes		
Hosp	Chemotherapy	No		
Hosp	Colonoscopy	No		
Hosp	Crisis Prevention	No		
Hosp	CTScanner	Yes		
Hosp	Diagnostic Radioisotope Facility	No		
Hosp	Diagnostic/Invasive Catheterization	No		
Hosp	Electron Beam Computed Tomography (EBCT)	No		
Hosp	Enrollment Assistance Services	Yes	Yes for Our Participants	
Hosp	Extracorporeal Shock Wave Lithotripter (ESWL)	No		
Hosp	Fertility Clinic	No		
Hosp	FullField Digital Mammography (FFDM)	Yes		
Hosp	Genetic Testing/Counseling	No		
Hosp	Geriatric Services	No		
Hosp	Heart	No		
Hosp	Hemodialysis	No		
Hosp	HIV/AIDS Services	No	Yes - Testing/Education/Referral	
Hosp	Image-Guided Radiation Therapy (IGRT)	No		
Hosp	Inpatient Acute Care - Hospital services	Yes		
Hosp	Intensity-Modulated Radiation Therapy (IMRT) 161	No		
Hosp	Intensive Care Unit	No		
Hosp	Intermediate Care Unit	No		Yes
Hosp	Interventional Cardiac Catherterization	No		
Hosp	Isolation room	No		
Hosp	Kidney	No		
Hosp	Liver	No		
Hosp	Lung	No		
Hosp	MagneticResonance Imaging (MRI)	No		
Hosp	Mammograms	No		
Hosp	Mental health Services	Yes		
Hosp	Multislice Spiral Computed Tomography (<64 slice CT)	No		
Hosp	Multislice Spiral Computed Tomography (<64+ slice CT)	No		
Hosp	Neonatal	No		
Hosp	Neurological services	No		
Hosp	Obstetrics	No		Yes

Inventory of Health Services - Bennett County, SD (2021)				
Cat	HC Services Offered in county: Yes / No	Hospital	Health Dept	Other
Hosp	Occupational Health Services	Yes		
Hosp	Oncology Services	No		
Hosp	Orthopedic services	No		
Hosp	Outpatient Surgery	No		
Hosp	Pain Management	Yes		
Hosp	Palliative Care Program	No		
Hosp	Pediatric	No		
Hosp	Physical Rehabilitation	Yes		
Hosp	Positron Emission Tomography (PET)	No		
Hosp	Positron Emission Tomography/CT (PET/CT)	No		
Hosp	Psychiatric Services	Yes		Yes
Hosp	Radiology, Diagnostic	Yes		
Hosp	Radiology, Therapeutic	No		
Hosp	Reproductive Health (Pre-conception counseling/ED)	No	Yes	
Hosp	Robotic Surgery	No		
Hosp	Shaped Beam Radiation System 161	No		
Hosp	Single Photon Emission Computerized Tomography (SPECT)	No		
Hosp	Sleep Center	No		
Hosp	Social Work Services	Yes	Yes for Our Participants	
Hosp	Sports Medicine	Yes		Yes
Hosp	Stereotactic Radiosurgery	No		
Hosp	Swing Bed Services	Yes		
Hosp	Transplant Services	No		
Hosp	Trauma Center- receiving facility	Yes		
Hosp	Ultrasound	Yes		
Hosp	Women's Health Services	Yes	Yes	Yes
Hosp	Wound Care	Yes		
SR	Adult Day Care Program	No		
SR	Assisted Living	No		
SR	Home Health Services	Yes		
SR	Hospice	No		
SR	LongTerm Care	No		
SR	Nursing Home Services	Yes		
SR	Retirement Housing	No		
SR	Skilled Nursing Care	Yes		
ER	Emergency Services	Yes		
ER	Urgent Care Center	No		
ER	Ambulance Services	Yes		
SERV	Access to Farmworker Program and TB Control Program	No	Yes	
SERV	Alcoholism-Drug Abuse	No		
SERV	Annual Influenza Clinics locally and in surrounding communities	Yes	Yes	
SERV	Blood Donor Center	No		
SERV	Child Care Licensing, surveys and compliance evaluation	No	Yes	
SERV	Chiropractic Services	No		
SERV	Complementary Medicine Services	Yes		
SERV	Dental Services	No		Yes

Inventory of Health Services - Bennett County, SD (2021)				
Cat	**HC Services Offered in county: Yes / No**	**Hospital**	**Health Dept**	**Other**
SERV	Developmental Screening	No	Yes	
SERV	Early Infant and Childhood Screenings and intervention/services	No	Yes	
SERV	Fitness Center (Rehab facilities allow people to come in for a fee)	No		Privately owned
SERV	Healthy Start Home visits for prenatal, postnatal and infants/families	No	Yes	
SERV	Health Education Classes	Yes	Yes	Yes
SERV	Health Fair (Annual)	Yes	Yes with the hospital	
SERV	Health Information Center	No		
SERV	Health Screenings	Yes	Yes	
SERV	Immunizations and Foreign Travel	Yes	Yes	
SERV	Infant/toddler/booster car seats with law enforcement agency	No	No	Yes
SERV	Maternal and Child Health Services	No	Yes	
SERV	Meals on Wheels	No		Yes
SERV	Nail Care Clinics	No		
SERV	Nursing Health Assessments	Yes		
SERV	Nutrition Programs (WIC)	No	Yes/WIC	
SERV	Outreach clinics at Senior Centers and Elderly Housing	Yes	Yes	
SERV	Parenting Classes (Just starting)	No		
SERV	Patient Education Center	Yes		
SERV	Pre-conception counseling	No	Yes	
SERV	Retail Store for Breastfeeding equipment and aids	No		Yes
SERV	Sexually Transmitted Infection Screening and Treatment	Yes	Yes	
SERV	Support Groups (Diabetic and BF Coalition)	No	Yes	Yes
SERV	Teen Outreach Services	No	Yes	
SERV	Tobacco Treatment/Cessation Program	Yes	Cessation	
SERV	Transportation to Health Facilities	No		x
SERV	Tuberculosis Screening, referral and treatment/prevention medications	Yes	Yes	
SERV	Wellness Program	Yes	Yes with Extension Office	

2021 Bennett County Help Resources

Community Resources

Emergency Numbers

Police/Sheriff	**911**
Fire	**911**
EMS/Ambulance	**911**

Bennett County Ambulance
102 Major Allen St., Martin, SD 57551 (605) 685-6622

III. Detail Exhibits

a)

ASSESSMENT SCOPE AND PROCESS

- **Pre-Assessment:** Completed analysis of data and KPIs for each functional area identified for the assessment.
- **Remote Assessment:** Staff questionnaires were sent to gain a high-level understanding of processes and knowledge. From there, we met with management and staff for each functional area of the revenue cycle to include Patient Access, Health Information Management, Chargemaster and Charge Capture, and Business Office.
- **Post-Assessment:** Compiled information obtained to identify opportunities for BCH to implement for improved accounts receivables.
- **Final Report:** Report of our findings, recommendations and next steps.

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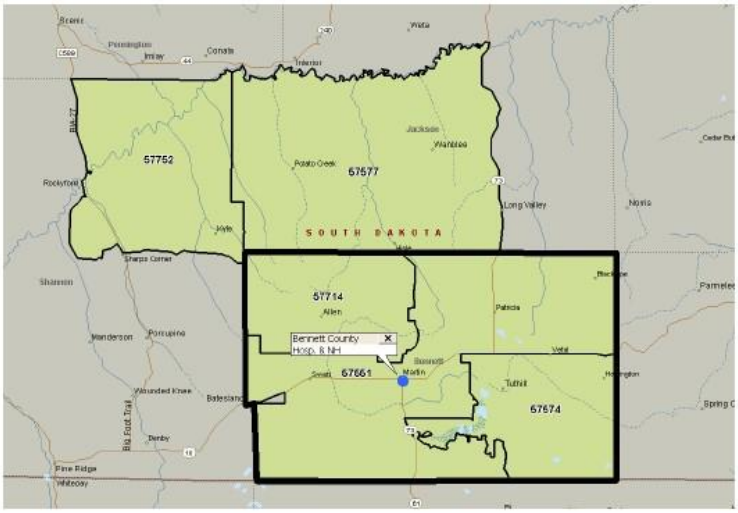
b)

SERVICE AREA

- 83% of BCH inpatient volume (prior two years) and 82% of clinic volume (prior three years) was for residents of five zip codes, referred to as BCH's primary service area (PSA).
- In-migration (patients coming to BCH from outside this region) is then measured to be 17% and 18% for inpatient and clinic services, respectively.
- Three PSA zip codes fall within Bennett County. Zip code 57577 extends into Jackson County and zip code 57752 reaches into Shannon County.



Zip Code	City/Town	Acute Origin	Clinic Origin
57551	Martin	33%	63%
57752	Kyle	18%	7%
57714	Allen	16%	6%
57577	Wanblee	15%	4%
57574	Tuthill	1%	2%
	Total Origin	83%	82%
	Inmigration	17%	18%

Source: BCH historical patient data

Bennett County Hospital & Nursing Home

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9

C

PHYSICIAN NEED

Given the widespread application/presence of mid-level providers and differing approaches to patient care and panel size across the U.S., it's hard to define what the *right* number of providers is for a given geography. Data from the Association of American Medical Colleges shows provider counts and counts per population for the State of South Dakota. While stopping short of saying these are the *right* levels, a statewide view is beneficial for comparison and can reveal which provider types may be in short supply for a given geography compared to statewide ratios. The following page shows data for the State of South Dakota, and ratios are then applied to the PSA's 2022 population. Below are summary points:

The State of South Dakota has the following counts of active care physicians per 100,000 population:

- Active patient care (all specialty) physicians: 229.2
- Active patient care primary care physicians: 87.8
- Active patient care general surgeons: 8.4

- The State of South Dakota has one emergency medicine physician per 10,053 people.

Applying these ratios to the 2022 PSA population, the implied physician needs are:

- Active patient care (all specialty) physicians: 15.9
- Active patient care primary care physicians: 6.1
- Active patient care general surgeons: 0.6
- Emergency medicine physicians: 0.7

Data from AAMC indicate physician counts and not FTE, so the resulting implied patient panel sizes are low. Physician demand may be overstated.

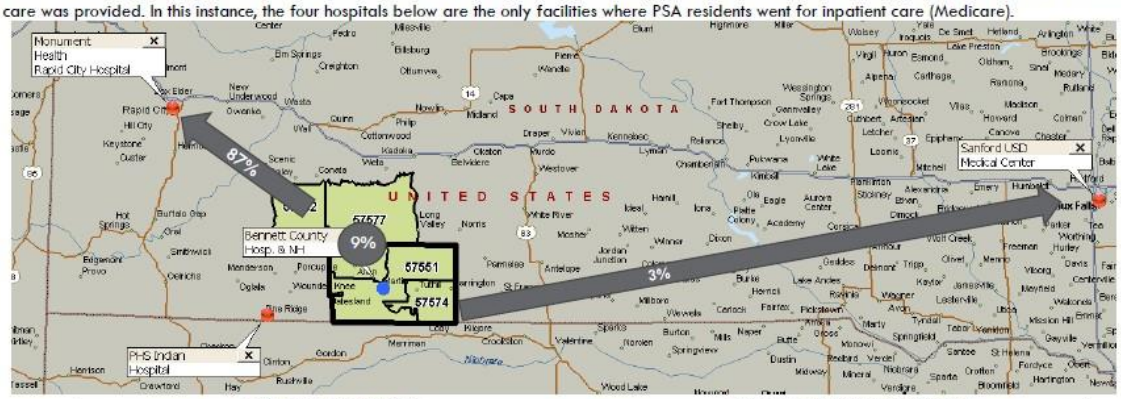
BCH has four family practice and two emergency medicine (physician and mid-level) providers. Given the above comparisons and considering how FTE status may impact estimated physician demand, BCH does not appear to have significantly short provider supply (primary care and emergency services). There is likely a short supply of specialty providers. Current active provider panel size, workload, number of patients per day, wait time for appointments, and patient and community satisfaction, all combined are the best indicators for whether more of fewer providers are needed.

Bennett County
Hospital & Nursing Home

d)

MARKET SHARE AND OUTMIGRATION

Most inpatient utilization (Medicare) for PSA residents was at Monument Health Rapid City Hospital, which carried 87% (average) market share from 2017 to 2020. BCH carried 9% (average) market share from 2017 to 2020, and it trended downward, from 10% in 2017 to 5% in 2020. Sanford USD Medical Center carried a small market share during this time (3% average). Market share analysis usually reveals 3-6 hospitals where the majority of PSA residents go for care, and an *all-others* category summarizes the 5-20 other hospitals where inpatient care was provided. In this instance, the four hospitals below are the only facilities where PSA residents went for inpatient care (Medicare).



Medicare Inpatient Days, (PSA residents)

Hospital	2017	2018	2019	2020	4yr Total	Change 2017 - 2020	% Change 2017 - 2020
Monument Health Rapid City Hospital	1,208	820	1,023	1,049	4,100	-159	-13%
Bennett County Hospital	137	106	122	65	430	-72	-53%
Sanford USD Medical Center		53		79	132	79	-
Pine Ridge Hospital	30				30	-30	-100%
PSA Total	1,375	979	1,145	1,193	4,692	-182	-13%

Source: CMS Hospital Service Area File
CMS terminated Pine Ridge (IHS) certification in 2017

Medicare Inpatient Market Share (days), (PSA residents)

Hospital	2017	2018	2019	2020	4yr Total	Change 2017 - 2020
Monument Health Rapid City Hospital	88%	84%	89%	88%	87%	0%
Bennett County Hospital	10%	11%	11%	5%	9%	-5%
Sanford USD Medical Center	0%	5%	0%	7%	3%	7%
Pine Ridge Hospital	2%	0%	0%	0%	1%	-2%
PSA Total	100%	100%	100%	100%	100%	

Source: CMS Hospital Service Area File
CMS terminated Pine Ridge (IHS) certification in 2017

e)

HEALTHCARE UTILIZATION - INPATIENT

Data and Analytics | Market Estimator - Inpatient

Inpatient Discharges by Service Line (PSA)	2021
Cardiac Services	49
ENT	7
General Medicine	206
General Surgery	41
Gynecology	6
Invalid	1
Neonatology	149
Neurology	24
Neurosurgery	4
Obstetrics	81
Oncology/Hematology (Medical)	17
Ophthalmology	1
Orthopedics	33
Other Trauma	5
Rehabilitation (Acute Care)	0
Spine	11
Thoracic Surgery	3
Urology	7
Vascular Services	8
Total Inpatient Discharges	652
BCHNH inpatient discharges (2020)*	66

**sourced from ahd.com; total number of inpatient discharges (all payors) taken from most recent Medicare Cost Report, W/S S-3, part I, line 14, column 8.*

A note about Advisory Board: Advisory Board's market estimator tool provides current and projected patient utilization estimates for any given geographic area in the U.S. The tool is intended to support planners and hospital executives as they make business development and strategic decisions. Inpatient volumes represent estimated inpatient discharges. Outpatient volumes represent outpatient visits that have been organized to the primary service received (otherwise known as an outpatient claim grouping or OCG) during their visit by the Advisory Board's proprietary grouping algorithm. Estimates are constructed by applying national-level per-1,000 utilization rates, adjusted by age and sex, to demographic data for the market area of interest. Advisory Board takes the local population of the area that you've selected and considers the changing characteristics of that market, such as aging (the movement of people from one demographic group to another) and population growth, using demographic data from Applied Geographic Solutions (AGS). Further, qualitative research is embedded into a wide variety of key market drivers that are expected to impact utilization in the future. Contrary to conventional wisdom, demographics alone do not generate accurate forecasts of utilization demand. In fact, over the past twenty-five years the trend in utilization of hospital services has diverged considerably from what demographics alone would predict. Therefore, when projecting future demand, Advisory Board considers an array of non-demographic growth drivers.

f)

HEALTHCARE UTILIZATION - OUTPATIENT

Service Line	BCH Volumes 2020	AB Estimator 2020 PSA	BCH Share 2020
ER Patients	2,535	3,132	81%
CT Procedures	815	688	118%
X-Ray Procedures	1,812	2,177	83%
Ultra Sound	146	1,029	14%
EKG's	692	898	77%
PT Procedures	5,116	4,141	124%
Speech Therapy	89	169	53%

For outpatient services that BCH performs and for which Advisory Board has volume estimations, a comparison is useful to see approximately what *share* of PSA resident volume BCH is capturing. BCH shares appear to be significant. CT and PT procedure shares are greater than 100%, and this could indicate very high *in-migration* (people coming to BCH from outside the service area) and/or misalignment in what types of tests/visits/procedures are being counted at Advisory Board versus BCH.

g) Primary Research Detail

Bennett County Community Health Survey - 2021

1. When considering "overall community health quality" in Bennett County, is it....?

Increasing	Not Changing Much	Decreasing
1 □	1 □	1

2. In your opinion, what are the top health needs in Bennett County? (Please select 4)

1 a) Drug / Substance Abuse
1 b) Obesity
1 c) Alcohol Abuse
1 d) Affordable Healthcare Insurance
1 e) Mental Health Access
1 f) Fitness/Exercise Options
1 g) Nutrition/Healthy Food Options
1 h) Teen Pregnancy
1 i) Wellness/Prevention
1 j) Oncology (Cancer)
1 k) Chronic Health
1 l) Awareness of Existing Healthcare Services
1 m) Personal Health Management
1 n) Primary Care Access
1 o) Sexually Transmitted Diseases
1 p) Vaccinations

3. In your opinion, what are the root causes of "poor health" in Bennett County? (Please select 2)

1 a) Lack of Health & Wellness Education
1 b) Chronic Disease Prevention
1 c) Limited Access to Mental Health Assistance
1 d) Elderly Assistance Programs
1 e) Lack of Awareness of Existing Local Programs, Providers & Services
1 f) Family Assistance Programs
1 g) Case Management Assistance
1 h) Other_____

4. In the past 2 years, did you or someone you know receive health care outside of Bennett County?

1 Yes 1 No 1 Don't Know

5. How would you rate the following health services in Bennett County?

	Very Good	Good	Fair	Poor	Very Poor
a) Ambulance / EMS Services	1 □	1 □	1 □	1 □	1 □
b) Child Care	1 □	1 □	1 □	1 □	1 □
c) Chiropractors	1 □	1 □	1 □	1 □	1 □
d) Dentists	1 □	1 □	1 □	1 □	1 □
e) Emergency Room	1 □	1 □	1 □	1 □	1 □
f) Eye Doctor/Optometrist	1 □	1 □	1 □	1 □	1 □
g) Senior Care	1 □	1 □	1 □	1 □	1 □
h) Family Planning Services	1 □	1 □	1 □	1 □	1 □
i) Home Health	1 □	1 □	1 □	1 □	1 □
j) Hospice	1 □	1 □	1 □	1 □	1 □

6. How would you rate the following health services in Bennett County?

	Very Good	Good	Fair	Poor
a) Inpatient Services	□	□	□	
b) Mental Health	□	□	□	
c) Nursing Home	□	□	□	
d) Outpatient Services	□	□	□	
e) Pharmacy	□	□	□	
f) Physicians' Clinics	□	□	□	
g) Public Health	□	□	□	
h) School Nurse	□	□	□	
i) Specialists	□	□	□	

7. What "new" community health programs should be created to meet current community health needs? Can we partner somehow with others?

□

□
□

8. For reporting purposes, are you involved in any of the following?

- ☐ a) Business Owner
- ☐ b) Community Board Member
- ☐ c) Case Manager/Discharge Planner
- ☐ d) Clergy
- ☐ e) College Student
- ☐ f) Dentist/Optometrist/Chiropractor/Pharmacy Employee
- ☐ g) Elected Official (City/County)
- ☐ h) EMS/Emergency Services
- ☐ i) Farmer/Rancher
- ☐ j) Hospital/Health Department
- ☐ k) Insurance
- ☐ l) Law Enforcement
- ☐ m) Parent/Caregiver
- ☐ n) Senior Care
- ☐ o) Teacher/School Admin
- ☐ p) Veteran

9. Your 5-digit zip code?

Any questions about this report can be directed to Michael Christensen, CEO Bennett County Hospital

(605) 685-6622

Bennett County Hospital, Nursing Home, & Rural Health Clinic