COMMUNITY HEALTH ASSESSMENT

Summary & Implementation Strategy

May 2018

Coteau des Prairies Health System

Coteau des Prairies HEALTH CARE SYSTEM

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EXECUTIVE SUMMARY

OVERVIEW

A community health needs assessment identifies and prioritizes the health needs of the community through collection of data and information to inform development of strategies to address priority health needs. A comprehensive assessment process gathers information using sound data collection methods and reflects the behaviors, beliefs, and demographics of community residents. A well-designed assessment will provide community planners, stakeholders, and partners with strong data to support local decision-making to address a healthy community environment. Moreover, multi-sector collaboration is integral to effectively understanding and addressing priority health needs, as well as integrate health equity into planning and practice.

To meet the requirements of the Patient Protection and Affordable Care Act and ensure that CDP Health System supports the community we serve, a community health needs assessment was conducted in collaboration with diverse partners and stakeholders. This process was implemented to understand the health issues that affect the community. Findings from the assessment informed development of a Community Health Improvement Plan, which support multi-sector collaborations, aligned to address priority health needs through evidence-based strategies. These efforts justify CDP's non-profit status and reinforces their guiding principles.

METHODOLOGY

CDP was awarded funding from the South Dakota Department of Health Office of Health Promotion and Chronic Disease Prevention to conduct a community health needs assessment to understand the health of the and identify priority health issues to improve population health in the CDP service area, including Roberts County, SD, Marshall County, SD, Day County, SD, Traverse County, MN, and Richland County, ND. The CDP service area also includes the Sisseton Wahpeton Oyate of the Lake Traverse Reservation. The process was guided by the DOH funding opportunity, as well as evidence-base practices for data collection.
CDP leadership convened a diverse sector of existing and new partners to support a community-driven process focused on comprehensive information gathering and data collection regarding local assets, gaps, and the health status of the service area. The CHNA process was guided by an established timeline which outlined steps and activities necessary to implement throughout the process. Methods to gather information and collect data included the following:

- **Partner, Stakeholder, and Community Members Focus Group:** B Consulting, LLC conducted two focus groups with members of the Stakeholder Committee and community members to understand priority health issues to address in the community survey. Findings from the focus groups were categorized into themes and supported development of the Community Health Survey.
- **Community Health Survey:** CDP leadership, project consultants, and B Consulting, LLC developed a survey to gather information from residents in the CDP service area regarding demographics, priority health issues, access to health care, substance use, mental and behavioral health and general health behaviors. The survey was disseminated electronically and paper copies throughout the service area through CDP partners and stakeholders, CDP clinics and hospitals, as well as at local events. A total of 202 surveys were completed and analyzed for key findings.

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- **Secondary Data Collection:** Comprehensive data was collected from valid and quality data sources on indicators that measure factors shown to affect health outcomes, including, mortality and morbidity, social determinants of health, maternal and child health, mental and behavioral health, health care resources, health behaviors, quality of life, clinical care, and measure relevant to the area tribal community.
- **Community Resource Inventory:** An inventory of available assets and resources, as well as gaps in those resources that support residents in the CDP service area to live, work, learn, and play healthy. The CDP Stakeholder Committee and CDP leadership supported information gathering, which supports understanding what the priority health issues are. Information was gathered regarding many resources, including health care providers and services, grocery stores available to support access to food, community coalitions, and neighborhood associations.

KEY FINDINGS

Community Health Survey and Focus Groups

Through this CHNA, the project partners attempted to survey key community leaders, stakeholders, and community members along with asking them to participate in the focus groups for determining the needs of the community. While many individuals participated, there are many community members who did not provide feedback through this assessment. The Community Health Survey (CHS) and focus groups asked for individual perceptions of community health issues and are subjective to individual experiences which may or may not be the current status of the community.

CHS included 28 questions that ranged from multiple-choice to open-ended questions along with several basic demographic questions, which took approximately ten minutes to complete. 202 individuals participated in the survey with an 87% completion rate. The ages of participants ranged from 18 to 75 plus years with an average age range of 45-54 and the majority identified as female (85%, N=150). There was very little diversity within the respondents as most identified as White (Caucasian, 77%, N=131) with Native American representing 28% (N=47) of the respondents. When respondents were asked to rate their community health, 66% (N=130) of the respondents stated their community had fair to poor health, but 71% (N=142) reported their own health state as good to very good health. However, the average number of days the respondent reported to having fair or poor physical health in the last 30 days was nearly 7 days. The survey also identified that the top five health conditions were: high blood pressure, depression, high cholesterol, anxiety, and arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia. The top preventative services accessed in last year included: Flu shot-67% (N=123), Blood Pressure Screening-56% (N=103), Dental Screening-46% (N=65), Blood Sugar Screening-36% (N=67), Cholesterol Screening-36% (N=67). The primary reasons for not accessing preventative services were that the screening was not necessary (40.46%, N=70) and Doctor Hasn't Suggested (29%, N=50). This indicates the need to educate the community on the benefits of preventive health care and maintenance along with reminding medical professionals to reinforce the education and benefits.

Additionally, 70% of respondents indicated they would access after-hour care on nights and weekends if it was available at a walk-in or urgent care clinic. The survey also indicated that nearly 60% of the respondents rated their mental health as fair to poor during the last 30 days with having an average of 12 days of feeling fair or poor and only 17% stated they needed treatment. However, near 40% of those individuals who stated they

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needed treatment were not able to access treatment due to no availability of treatment or thought they could handle it by themselves. Given these numbers, CDP catchment area would greatly benefit from additional mental health services.

While this community health needs assessment is comprehensive, it cannot measure all aspects of health in the CDP catchment area, nor can it adequately represent all possible populations of interest. Because of these information gaps, the ability to assess all the community health needs are limited in some ways. Both the quantitative (CH survey) and qualitative data (focus groups) have limitations, and, as a result, should not be used to confirm or deny a specific health issue within the area.

Secondary Data Collection

Secondary data research highlighted progress moving in the wrong direction to support healthy communities. Obesity and related risk factors continue to challenge the CDP service are with poor physical activity and nutrition behaviors, poor access to physical activity opportunity, and healthy foods for all residents of the service area. In addition, the food insecurity rate continues to increase in adults and children, as well as those who are ineligible for assistance with accessing food through programs such as SNAP or WIC.

Health behavior including sextually transmitted diseases (Chlamydia), tobacco use in pregnant mothers, utilization of preventative services and screenings for diseases, such as colon cancer, heart disease, etc., and alcohol impaired driving, contribute to poor disease and mortality rates. Specifically, the CDP service area has a high age-adjusted colon cancer incidence rate and a low percentage of adults age 50+ who have had a sigmoidoscopy/colonoscopy within the past 10 years.

Access to primary care physicians continues to be a challenge, and there are increasing rates of uninsured populations in the CDP services area, including 18-64 year old's, Native Americans, and children under 18 years of age.

Mental and behavioral health issues continue to affect the service with increasing rates of suicide in the Roberts County, SD area in people under the age of 25 and in American Indians. An increasing percentage of the Medicare population is reporting depression, as well as a higher percentage of adults aged 18 or older who self-report they receive insufficient social and emotional support.

PRIORITY HEALTH ISSUES AND IMPLEMENTATION STRATEGIES

CDP leadership and key partners convened for an action planning session to review data findings and determined priority issues that should be addressed in the CDP service area over the next three years. Priorities were identified based on current efforts underway to address the community's health issues, capacity of CDPHCS and partners to address issues, significance of the health issues, and to build on CDPHCS' prior work to address population health in the CDPHCS service area. Six priority issues along with strategies were identified with obesity and chronic disease management (e.g., heart disease, diabetes) identified as the number one priority.

- **Priority 1: Obesity and Chronic Disease Management**

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CDP will research development of Case Management Program for CDP patients to set strategy to improve the care of patients with chronic disease diagnosis and obesity. In addition, CDP will promote patient education programs to patients, the community and partners that focus on the chronic disease management, fruit and vegetable consumption, as well as breastfeeding to support healthy mothers and babies. Specifically, program such as the Better Choices, Better Health chronic disease management program will be promoted within the CDP service area. This program is available throughout South Dakota and currently there are trained facilitators in the CDP service area, available to host and facilitate these trainings. Patient education programs will also focus on the consumption of fruits and vegetables, such as the Pick It, Try It, Like It campaign. In addition, we will work with local partners, such as the WIC office to provide patient education to improve adoption of breastfeeding practices.

CDP will create and promote a wellness committee for health enrichment of the CDP staff, as well as develop a staffing plan, budget and design for a patient advocacy program that supports the strategies to address obesity and chronic disease management. CDPHCS has requested consultant to conduct a Readiness Assessment and provide operational expertise and assistance to implement strategies that will improve Chronic Disease Management performance within the evidence-based clinical practices and outcomes related to these chronic conditions.

- **Priority 2: Behavioral and Mental Health**
  CDP will continue to enhance the work outlined in the 2015 Implementation Plan and continue to implement a dual approach to address mental health issues in the CDP service area, focused on 1) creating and promoting an active place program for individuals afflicted by mental health issues and 2) partner with local law enforcement and mental health care providers to address and refine the mental health hold process to lessen wait time and increase access to care. We will work with health care providers to enhance screening of patients for mental health issues. We will also explore strategies to educate community members and patients life coping skills, as well as how to engage parents with their children more and be aware of any mental health issues their children may be facing.

- **Priority 3: Alcohol, Drug, and Substance Use/Abuse**
  Establish and foster partnerships with local community groups, including the SWO Tribal Health Board and Indian Health Service, to address the chronic issue of alcohol and drug use/abuse in the surrounding community. Specifically, CDP aims to target its prevention and at-risk behavior education towards youth via partnership with area school districts, both public and private, reinforce existing messaging mediums and expand programming. In addition, CDP plans to create consistent and direct messaging to patients and community members about active referral services for adults with chronic alcohol abuse issues. Educational resources will be given to health providers to foster an environment that is supportive of care practices and referrals for patients who are affected by this illness.

  In an effort to best coordinate these services, both inpatient and within the community, CDP will utilize the patient advocacy program in response to medical care close to home. The active placement program, an evaluation tool to access the needs of patients, described above in addressing mental health care would also be utilized here as well, wherein CDP could ultimately be in

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a position to improve the quality of services available in the community and increase access to those services for individuals with alcohol addiction.

- **Priority 4: Suicide Prevention**
  CDP will continue to enhance the activities outline in the 2015 Implementation Plan focused on suicide prevention including: continue to collaborate with existing community partners to increase awareness of suicide and prevention strategies. Existing partnerships, such as the Aliive Roberts County Coalition, are important to maintain in order to identify new partners and stakeholders to support suicide prevention efforts. CDP will explore strategies to integrate routine suicide screenings into care and educate health care providers to increase their level of comfort and understanding to assess suicide risk with patients. CDP will explore partnership opportunities with SWO and organizations who can support a "Zero Suicide Model" for suicide prevention.

- **Priority 5: Preventative Services**
  Secondary data and findings from the community survey found higher rates of chronic diseases in CDP service area, as well as not accessing preventive services to address and/or prevent chronic diseases. Efforts will focus on promotion of preventative services and encouraging providers to refer patients to preventative services. In addition, CDP will work with local partners, such as local health service agency and Sisseton Wahpeton Oyate tribe to advocate for preventative services and expand current efforts conducted in the community, which are focused on screenings for color cancer.

- **Priority 6: Access to care/telehealth to patients**
  Data from the CHNA highlight the challenge for patients in the CDP service area to access care, including physicians and geographic distance to CDP services. CDP will develop and execute a tactical plan for recruitment of family practice providers. In addition, will explore options for reducing barriers to accessing care by extending hours of operation, including after hours, extended hours, weekend, and a walk-in clinic. Physician recruitment will continue for family practice physicians.

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ACKNOWLEDGEMENTS

Coteau des Prairies (CDP) conducted the community health needs assessment and improvement plan in collaboration with key partners and stakeholders. These partnerships and stakeholders supported the process by providing data and information to help understand the health of our community, as well as identify evidence-based approaches to support community health improvement plans to address the health of our community collectively. CDP would like to acknowledge the following partners and stakeholders:

CDP STEERING COMMITTEE	
Name	Role
Colette Weatherstone	Project Director
April Hieb	Chief Nursing Officer
Leslie Hendrickson	Human Resources
Greg Weaver	Interim CEO

HEALTHY COMMUNITY GRANT STAKEHOLDER COMMITTEE		
Name	Sector	Organization
Sara DeCoteau, Health Coordinator	Tribal	Sisseton Oyate of the Lake Traverse Reservation
Sara Lincoln, Program Manager	Tribal	Sisseton Wahpeton Oyate Health & Fitness Center
Dr. Gail Mason, Native American Crisis Line	Tribal	Sisseton Wahpeton Oyate
DeLaine Rasmussen, Registered Dietitian/Diabetes Educator	Tribal	Indian Health Services
Michele Greseth, Federal Program Director	School	Sisseton School District 54-2
April Hieb, Chief Nursing Officer	Healthcare	CDP Health Care System
Leslie Hendrickson, Human Resource	Healthcare	CDP Health Care System
Greg Weaver, Chief Operating Officer	Healthcare	CDP Health Care System
Sara McGregor, Executive Director Prevention Agency	Community	Aliive Roberts County
Sara Johnson, RN	State Government, Healthcare	Bright Start, Office of Child and Family Services
Sara Pistorius, RN	State Government, Healthcare	Office of Child and Family Services

HEALTHY COMMUNITY GRANT CONTRACTORS		
Name	Role	Organization
Sandra Melstad	Technical Assistance & Facilitation	SLM Consulting, LLC
Hilary Larsen	Technical Assistance	VOA of the Dakotas
Brooke Blaalid	Evaluator	B Consulting, LLC
Jenae Hansen	Evaluation Coordinator	B Consulting, LLC

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INTRODUCTION

Implementation of a community health needs assessment identifies priority health needs through a systematic and comprehensive data collection and analysis process. The Patient Care and Affordable Care Act requires non-profit hospitals to conduct community benefit work that is responses to community need. To do this, a community health needs assessment, as well as an implementation strategy must be conducted at least once every three years, according to Schedule H tax cycle.

Coteau des Prairies (CDP) Health System conducted a community health needs assessment to support 2018-2021 community benefit work in the CDP service area, including Roberts County, SD, Marshall County, SD, Day County, SD, Traverse County, MN, and Richland County, ND. CDP was awarded funding from the South Dakota Department of Health Office of Chronic Disease Prevention and Health Promotion, focused on conducting a community health needs assessment to inform implementation of evidence-based strategies shown to improve population health.

The process was implemented from June 2017-May 2018 through a community-driven process, guided by DOH contractors, evaluation consultants, as well as a diverse group of partners and stakeholders from the CDP service area. Comprehensive data was collected through a variety of data collection and information gathering methods, focused on understanding the health of the CDP service and identify priority health issues important to address. CDP has outlined strategies based on the findings to implement in collaboration with partners and stakeholders over the next three years with the goal of moving the needle on the health of the CDP service area.

COTEAU DES PRAIRIES HEALTH SYSTEM

Coteau des Prairies Health Care System is a 25-bed, critical access, acute care, community non-profit hospital. CDP serves approximately 21,000 residents in the Glacial Lakes Region in Northeast South Dakota as well as West Central Minnesota. The hospital opened in 1967, and in 1996, a 14,000 square foot new addition and remodeling project—which cost $2.4 million—was completed. In 2000, we also completed a $400,000 clinic expansion and remodeling project. The latest project included a multimillion-dollar renovation and expansion effort that took place in 2013. This 22,000 square-foot addition was necessary to support the growing number of patient visits, which included a new clinic, an emergency room, birthing suites, a laboratory, and a radiology department.

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CDP's guiding principles reflect our commitment to addressing and improving the health of the communities we serve:

- **Mission:** At Coteau des Prairies Health Care System, we are passionate about the work we do. We believe in offering our patients individualized attention and care, emphasizing their unique needs and treating them as individuals on a human level.
- **Values:** We exist to serve our community and we strive to be an integral part of our community through strong and trusting relationships.
- **Respect:** We respect all those we serve and those who serve with us, and we demonstrate that respect in the way in which we care for and interact with those we serve as well as with other members of the care team.
- **Stewardship:** We (CDP) are a community asset and we are committed to being good stewards of the resources that have been entrusted to us.
- **Engagement:** We seek to engage with our staff, providers and community to ensure that everyone is invested in our organization. This engagement also demonstrates how our organization is invested in the community we serve and how we are working together to create a healthier community.
- **Growth:** We are committed to increasing access to the services our community needs.
- Quality: We are committed to improving the services we provide to ensure those we serve are receiving the highest quality of care possible. We continuously reach for new and innovative solutions to improve the health of those we serve.

COMMUNITY PROFILE

COMMUNITY SERVED BY COTEAU DES PRAIRIES HEALTH SYSTEM

CDP Health System serves approximately 21,000 residents in the Glacial Lakes Region in Northeast South Dakota as well as West Central Minnesota. CDP Health Care System owns and operates the attached certified rural health clinic in Sisseton; the Browns Valley Clinic in Browns Valley, Minnesota; and the Rosholt Clinic in Rosholt, South Dakota.

COMMUNITY DEFINED

The communities included in the CHNA and CHIP and served by CDP are located in the following counties and states (Figure 1):

- Roberts County, South Dakota
- Marshall County, South Dakota
- Day County, South Dakota
- Richland County, North Dakota
- Traverse County, Minnesota

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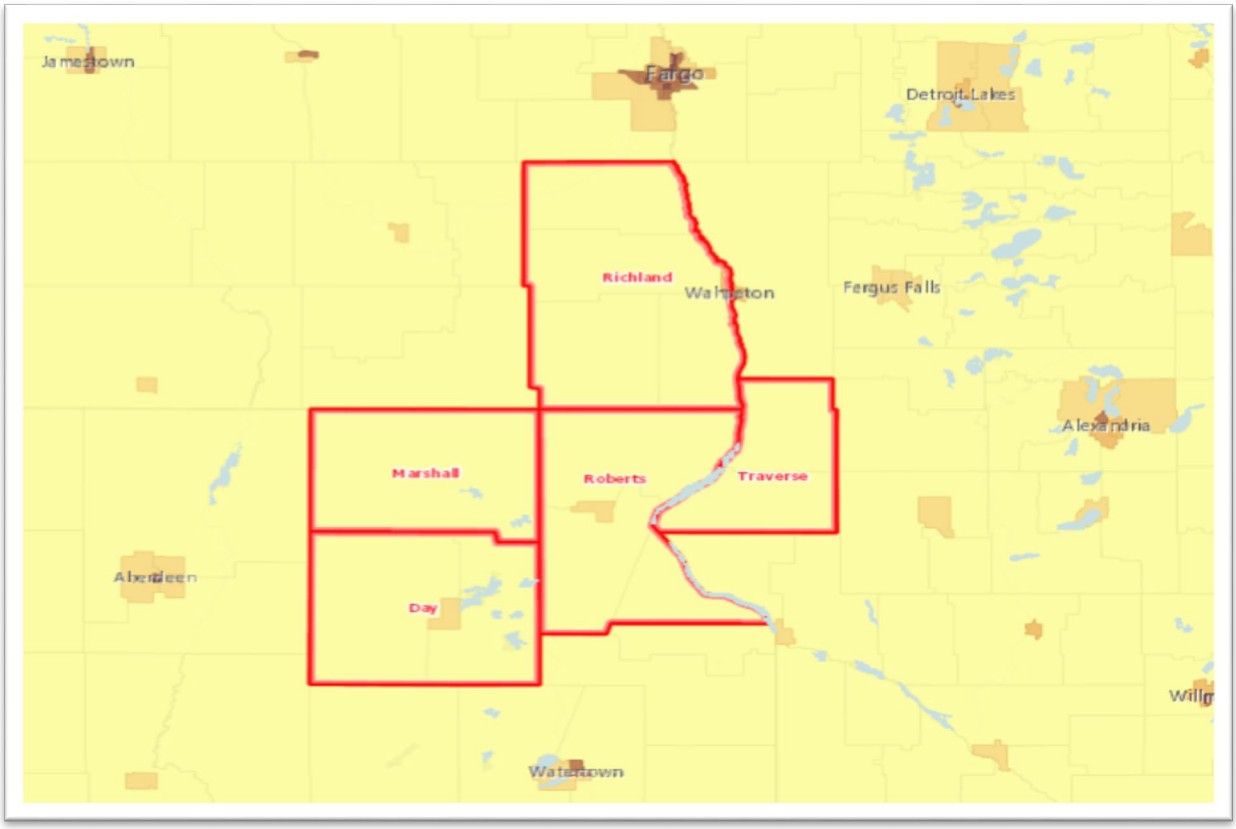
Figure 1: Coteau de Prairies Service Area



Source: Community Commons, 2018

PROCESS

CDP was awarded funding from the South Dakota Department of Health Office of Chronic Disease Prevention and Health Promotion Healthy Community Grant to implement a community health needs assessment (CHNA) from May 2017- April 2018 to understand the health and needs of the CDP community. The 2018-2021 Community Health Needs Assessment conducted a comprehensive data collection to understand the health of the community CDP serves and identified priority health issues to address through evidence-based approaches. The CHNA was conducted in collaboration with diverse partners and stakeholders to effectively understand the community, including underserved, health disparate, and priority populations. The process was led by a CDP Steering Committee and a Stakeholder Committee of key local partners from diverse sectors in the community, including tribal, healthcare, community, school, business, and government. In addition, DOH Contractors provided support with facilitation of the process, provided technical assistance, and secondary data collection. Evaluation consultants, B Consulting LLC, provided support with primary data collection, including facilitation of focus groups and a community survey. Findings from the collaborative assessment informed development of a comprehensive Community Health Improvement Plan, which supports multi-sector collaborations to address priority health concerns through evidence-based strategies. These efforts expand partnerships and capacity to work collectively towards improving health of the communities that CDP serves.

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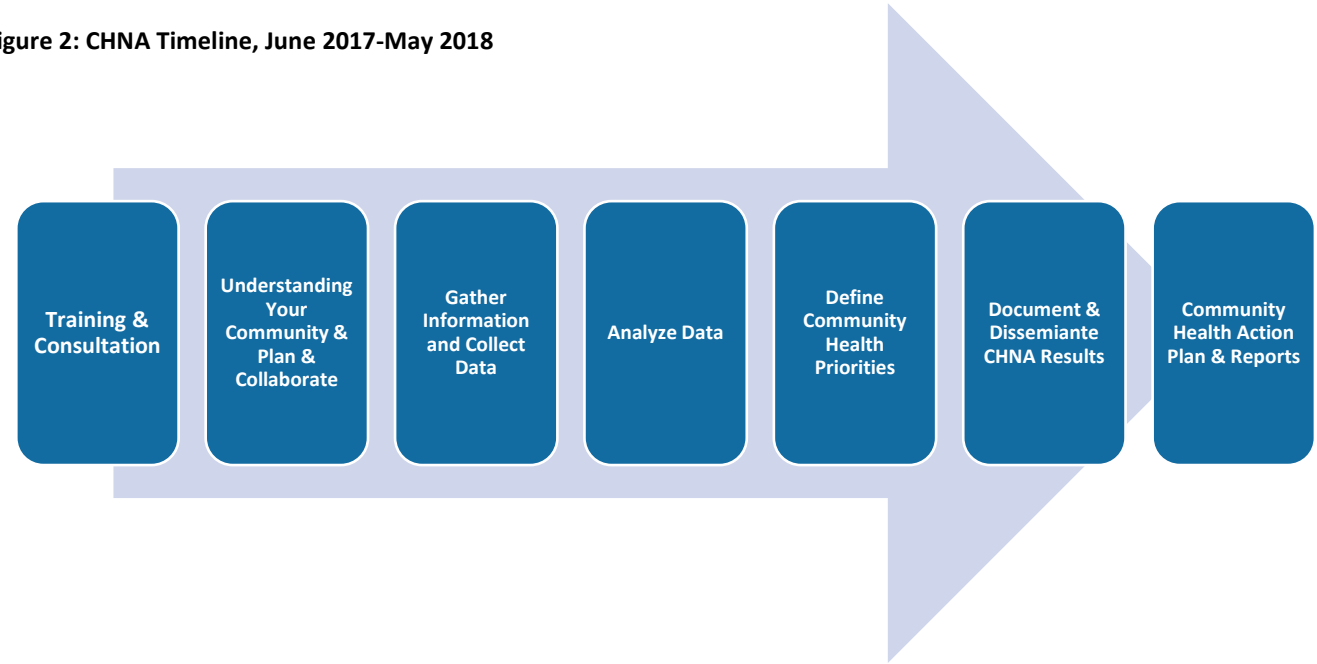
MODEL

Planning for the assessment began in June 2017, guided by funding awarded to CDP from the South Dakota Department of Health, as well as an evidence-based approach to implementing a CHNA. In addition, Sandra Melstad, SLM Consulting, LLC, a contractor with the SD DOH experienced in CNHA helped CDP facilitate the process, with support from external consultants, B Consulting, LLC, to support primary data collection methods. The assessment followed the South Dakota Community Health Needs Assessment and Improvement Planning model, as well as the Association of the Community Health Improvement Community Health Assessment Toolkit. These models were used to implement a community-driven process to convene and engage diverse partners, collect comprehensive data and information on the health of the community, identify priority health issues to address collectively, as well as build the foundation to make a lasting impact on the health of the community.

CDP leadership established a committee of diverse partners who represent different sectors in the community. The committee was convened through a series of face-to-face meetings and online communication throughout the process to ensure a comprehensive process was implemented. The CHNA process was also guided by an established timeline, Figure 2, which outlined steps and activities necessary to implement throughout the process, including deliverables, timeline and leadership for the activities.

Figure 2: CHNA Timeline, June 2017-May 2018



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METHODOLOGY

Comprehensive data collection and information gathering is integral to a community health needs assessment process to effectively understand the health of the community, assets, and gaps. Information and data collected that informed this CNHA relied upon mixed-methods, including group discussion within in the committee meetings and secondary data collection from publicly available data sources. CDP also contracted B Consulting, LLC to support primary data collection methods, including focus groups with committee and community members to develop a community health survey that was conducted in the CDP service area. Additional information was collected through a community resources inventory of local resources and services available to support the community. These methods aided in the understanding of the health in the communities that CDP serves and helpings to ensure that the social, economic, and environmental factors are addressed in the communities.

SURVEY

The Community Health Survey was developed in partnership with CDP leadership, DOH contractors, and B Consulting, LLC, staff to ensure questions were relevant in gathering a comprehensive understanding of the issues that affect the service area of CDP. The survey was finalized by B Consulting, LLC and participants were able to choose from one of two formats: electronic format using Survey Monkey OR a seven-page printed survey. The survey included 28 questions that ranged from multiple-choice to open-ended questions along with several basic demographic questions, which took approximately ten minutes to complete. The questions focused on the health of the community, preventative services accessed, health behaviors, current services utilized and utilization of new services if offered by CDP.

The electronic survey was disseminated through various outlets, including CDP Facebook page, Twitter, and the CNHA committee. Promotional handouts containing information about survey and links were also distributed at community events and CDP clinics. Hard copies were disseminated at CDP clinic sites and local community events as well.

FOCUS GROUPS

On October 18, 2017, CDP Healthcare System conducted two focus groups with member of the Sisseton community and surrounding area. B Consulting, LLC facilitated the focus group with community members. The purpose of these groups was to gather information about health of the community and identify data and/or questions they would like to see on the Community Health survey. Members from various community stakeholder groups were invited to participate. A diverse group of stakeholder and community leaders were invited to each of the focus groups; however, only a limited number attended.

The first focus group was held with key stakeholders working with in partnership with CDP on the community health needs assessment. The second group consisted of 3 individuals from the community who had an interest in the project. These individuals were from the local school district and Indian Health Services. Reponses to the questions were written and compiled to be used in developing a community health survey. Focus group discussion, along with survey and secondary data was used to set priorities for the community.

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A second round of focus groups that focused more on individual and community health was slated to take place on February 28th, 2018.

SECONDARY DATA COLLECTION

Comprehensive data was collected from secondary sources to reinforce data collected from the survey and focus group, as well as collect additional data that informs our understanding of the community. Data was collected from publicly available national, state, and local data sources, including Sisseton Wahpeton Oyate of the Traverse Lake Reservation, state health departments, Behavioral Risk Factor Surveillance System, the American Community Survey, County Health Rankings, and other relevant sources. Data was collected on focus areas, including demographics, maternal and child health, environment, clinical & community care, health care resources, social determinants of health, tribal, health behaviors, and long-term outcomes. Data was analyzed for key findings and utilized in the priority setting process.

COMMUNITY RESOURCES INVENTORY

Information was collected from committee members and information available from the Aliive-Roberts County Coalition on the resources available in the community to support residents, as well as to highlight gaps in resources to support a healthy community. Information gathered included a variety of areas, including health services, education, safety, and food.

KEY FINDINGS

SURVEY

Approximately, 81% (N=194) of respondents completed the survey electronically compared to the 9% (N=18) who chose to take via pen and paper. The ages of participants ranged from 18 to 75 plus years with an average age range of 45-54 and the majority identified as female (85%, N=150). There was very little diversity within the respondents as most identified as White (Caucasian, 77%, N=131) with Native American only representing 28% (N=47) of the respondents. Additionally, 50% (N=104) of respondents identified as having an associates or bachelor's degree, and a large portion of the respondents (72%, N=127) were employed full-time.

The World Health Organization (WHO) states that health is "a state of complete physical, mental, ad social well-being and not merely an absence of disease and infirmity" (World Health Organization, 2018). When participants where asked about the health of their community, 66% (N=130) rated their community to have fair to poor health; however, when respondents reported their own health state, 71% (N=142) stated they had good to very good health. However, the average number of days the respondent reported to having fair or poor physical health in the last 30 days was nearly 7 days. Additionally, the survey found that the top five health conditions were: high blood pressure, depression, high cholesterol, anxiety, and arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia. During the past year, 78% (N= of respondents needed medical care in last year, and 95% (N=145) of those individuals were able to receive the necessary care. The number one reason for not being able to receive care was inability to get an appointment, but others had barriers in transportation, child-care, and lack of insurance. A majority (67%, N=130) of respondents reported that they had health insurance through their employer. 81% (N=158) of individuals said there was a time in last 12 months when they needed medication and 91% (N=143) were able to receive the medication; however, of the

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individuals unable to receive the medication, reasons identified were costs, no insurance coverage, "I thought I could handle it without treatment," and complications with the pharmacy.

The top preventative services accessed in last year included: Flu shot-67% (N=123), Blood Pressure Screening-56% (N=103), Dental Screening-46% (N=65), Blood Sugar Screening-36% (N=67), Cholesterol Screening-36% (N=67). The primary reasons for not accessing preventative services were that the screening was not necessary (40.46%, N=70) and Doctor Hasn't Suggested (29%, N=50).

% of Individuals willing to Access Top 4 Services at CDP Healthcare Systems by Income				
	% Primary Care Provider	**% Emergency Services**	**% Laboratory Services**	**% Radiology**
Less than $20,000	58.33%	66.67%	50.00%	50.00%
$20,000-$39,999	63.89%	58.33%	50.00%	44.44%
$40,000-$69,999	70.21%	70.21%	44.68%	42.55%
$70,000-$119,999	77.59%	68.97%	62.07%	55.17%
$120,000 or more	76.92%	84.62%	53.85%	38.46%
% of Total Respondents	**74.42%**	**72.09%**	**55.81%**	**46.84%**

70% (N=119) of respondents indicated they would access after-hours care on nights and weekends at a walk-in clinic or urgent care for no emergencies. Nearly 21% (N=38) were undecided.

While physical health and the prevention of illness is important in one's overall health, mental health and well-being also play a major role. When respondents were asked about their mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health FAIR OR POOR, 58 % (N=114) stated that they had at least one or more days with the average amount of days being 12 days of have fair to poor mental health. Nearly 17% (N=33) of respondents said they needed treatment or counseling for a personal problem or mental health condition in the last 12 months. Of those individuals who needed treatment, 36% (N=12) they were not able to receive treatment, because they could handle it without treatment and no treatment was available. Two individuals out of the181 respondents reported having seriously considered attempting suicide in the last 12 months and one individual reported attempting suicide in the last year. Additionally, 3% (N=5) of the respondents stated that they needed alcohol and/or drug treatment during the last year as well. Two of these individuals were unable to get the treatment that they needed, but they did not specify an answer.

Electric Cigarette usage:	**Cigarette usage:**	**Chewing tobacco, snuff, or snus usage:**
• Everyday-0 • Somedays- .54% • Not at all-99.46%	• Everday-9.73% • Some days-7.57% • Not at all-82.70%	• Everday-1.62% • Somedays-1.08% • Not at all-97.30%

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During the past month, 60% (N=111) of respondents reported that they participated in physical activities or exercises other than their regular jobs. According to the USDA Economic Research Service, a portion of the CDP

Percentage of individuals who Consumed healthy foods in Last 30 days by Income						
	% Drank 100% Fruit Juice	% Ate Fruit	% Cooked or canned beans	% Dark Green Vegetables	% Orange Vegetables	% Other Vegetables
Less than $20,000	25.00%	66.67%	100.00%	100.00%	100.00%	100.00%
$20,000-$39,999	36.11%	72.22%	97.22%	97.22%	97.22%	97.22%
$40,000-$69,999	25.53%	65.96%	100.00%	95.74%	100.00%	100.00%
$70,000-$119,999	24.14%	82.76%	100.00%	100.00%	100.00%	100.00%
$120,000 or more	38.46%	84.62%	92.31%	92.31%	92.31%	92.31%
% of Total Respondents	**27.47%**	**75.41%**	**40.76%**	**66.48%**	**56.28%**	**71.20%**

service area is in a food desert due to low income and access to fresh food, but from the most part it is not. (United States Department of Agriculture, 2017). Survey data from the 2018 Community Health Service showed that across economic sectors, there was no change in consumption habits of healthy foods, except for fresh fruit. In the case of fruit, individuals with a higher annual salary were more likely to have consumed fresh fruit in the past 30 days.

FOCUS GROUPS

Two focus groups were conducted in October of 2017 with stakeholders and community change leaders. Tables 1.1-1.6 show common response per question and divided by focus group. Bold are responses that appeared in both focus groups.

Table 1.1

1.1 What are the strengths of your community? What resources exist?	
Key Stakeholder	• Variety of sports opportunities in community clubs and at school • Outdoor sporting activities (trails, hunting, fishing, water sports • Active youth clubs and groups (4-H, FFA, FBLA, FCCLA, Girls Scouts, Boys Scouts) • Quality education and school choice opportunities, including tribal college and community college • **School age after school program** • **Tribal resources (fitness & diabetic center, homeless center)** • **School opens wellness center to community** • Active Arts Council • Healthcare opportunities: Primary care providers, Indian health services psychiatrist, Advanced Life support (helicopter & plane), long-term care, assisted living. chiropractor, eye doctor, dentist • State accredited alcohol and drug program • Health teams for behavioral health, in home care, and community safety team • Mentorship between tribe and college • Food Shelf

.

	• **Bright start program.**
Community Members	• **Wellness center at school open to community and tribal fitness center** • Group fitness and exercise programs (including Weight Watchers) • **After school program** • **Summer recreational programs** • Swimming pool and lessons • Head start program • Tribal birth to 3 program • Senior nutrition programs (Rosie's, Eden, Veblen) • Golfing opportunities • Church communities providing night activities • Indian Health Services and tribe educational classes (parenting, prenatal, diabetic) • Allive Roberts County group • Nutrition and healthy cooking classes • **Bright start program** • 5K runs • Community transportation-rides for community members

Table 1.2

1.2 What does a healthy community look like? What things improve the quality of life?	
Key Stakeholder	• Access to multiple healthcare opportunities including traditional & nontraditional. • Education on different opportunities • Preventative care and chronic disease management • Affordable care and access to wellness and routine exams • **Opportunities to be active, walking, running, biking trails** • **Access to affordable fresh food, including healthy food options** on menus • Influencers promoting healthy living (elected officials and policy makers) • Healthy activities that also promote social connections • Mental health with support groups • Central location of events available • Community transportation available at low to no cost.
Community Members	• Clean environment and streets • Wellness rooms and exercise opportunities • **Walk & Bike trails** • **Availability of fresh food** • Access to well-staffed hospital • Community clinics

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	• Community wellness activities.

1.3 What are the gaps in resources in your community?	
Key Stakeholder	• **Transportation (lack of walkability, no public transportation)** • Communication and coordination between agencies • Community engagement • Mental health counseling • Job-career counseling • Access to community wellness center • Diverse support groups • Day care • Affordable Housing • **Employers who have health insurance**
Community Members	• Under-utilized services • Indoor swimming/therapy pool • Weekend Back-Pack food program • Exercise and activities for seniors • Shortage of first responders, especially I rural communities that are volunteer based. • Access to food in rural areas • **Transportation** • **Uninsured individuals and employers not offering insurance** • **Affordable and accessible prescription drugs**

Table 1.4

1.4 What are the health problems that exist in your community? Be specific.	
Key Stakeholder	Substance abuse, **diabetes,** mental health, **cancer**, suicide, **obesity**, adverse childhood experiences, **hypertension**, inability to manage personal health, trauma, addiction
Community Members	**Obesity**, **diabetes**, **hypertension**, depression, head lice, clean & safe homes, unhealthy eating behaviors, homeless, **cancer**, heart disease

Table 1.5

1.5 What "risky behaviors" in your community impact the health of your community? What things stop your community from being healthy?	
Key Stakeholder	• Improper use of car seats or not using one • **Teen pregnancy**

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	• **Drug use during pregnancy** • Immunizations beyond flu • STD rates • Unprotected sex.
Community Members	• Self-harm • alcohol use • substance abuse, early substance use (age 12-13) • **Substance use during pregnancy** • Tobacco use • Poor eating • Early age sex • **Teen pregnancy** • Single parents • Families not eating together

Table 1.6

1.6 What barriers do you see in accessing healthcare in the community?	
Key Stakeholder	• Education • Communication barrios • **Providers staying around a long time (continuation of care)** • No walk-in clinic • **Older population avoiding treatment** • Lack of access to mental health screenings (primary care provider not completing) • No temporary care for child care while parents see physician • Getting prescriptions from local pharmacy
Community embers	• Both parents working outside home • Racial divide between Native Americans and non-natives • School-based programing instead of community-based • Transportation • Lack of family involvement • Lack of awareness about programs available • Weather • Costs of health care • Number of providers available and **continuity of providers** (No Pediatrician) • **Denial that a problem exists** • **Fear of diagnosis and worst-case scenario.**

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SECONDARY DATA

DEMOGRAPHICS

Coteau des Prairies Hospital lies within Roberts County with a population of 10,294 people (50.2% male; 49.8% female). Roberts County residents by race are White (59.4%), African American (60%), and American Indian (36.7%). The median age for residents in Roberts County is 38.60 which is higher than the state of South Dakotas' median age of 36.08.

Additional counties in the CDP service area include Marshall County, SD and Day County, SD; Traverse County, MN, and Richland County, ND. The predominant race within these four rural counties is White (>85.7%) followed by American Indian. The average age range for residents is 38.20-49.10.

Among the CDP service area, Traverse County, MN has the highest elderly population (65 and over) of 26.3%. Roberts County has a higher elderly population rate (18.3%) compared to South Dakota's state rate (15.2%). In addition, the veteran population ranges 9.8-11.5% of the population within the CDP service area.

Indicator	Roberts	Marshall	Day	Traverse	Richland	SD	ND	MN
Total Population	10,294	4,743	5,588	3,397	16,329	851058	736162	5450868
Median Age	38.60	41.80	48.50	49.10	38.20	36.08	35.20	37.80
Population Under Age 18	20.46%	21.35%	21.39%	22.6%	28.3%	24.63%	22.78%	23.52%
Highest % of adults by age - 45 to 54 years	12.3%	12.3%	12.4%	13.16%	13.2%	12.3%	12.3%	13.9%
85 years and over	2.2%	3%	3.7%	6.8%	5.6%	2.4%	2.4%	2.1%
Veteran Population (%)	9.9%	316	11.5%	11.5%	8.8%	9.81%	8.81%	7.96%
Foreign Born Population	.85%	4.74%	.75%	1.42%	1.83%	3.2%	3.31%	7.83%
Race: White	59.4%	85.7%	88.1%	92.7%	93.7%	84.77%	88.2%	84.34%
Race: Black	60%	.6%	0%	.4%	.5%	1.65%	2.01%	5.7%
Race: American Indian	36.7%	10.3%	10%	0%	2.7%	8.72%	.005%	1.04%
Hispanic or Latino	2.5%	4.4%	2.1%	2.3%	2.5%	3.43%	3.12%	5.06%

Source: American Community Survey, 2012-2016

The population distribution by age and sex for each county in the CDP service area is reflected in the Figures 3-7

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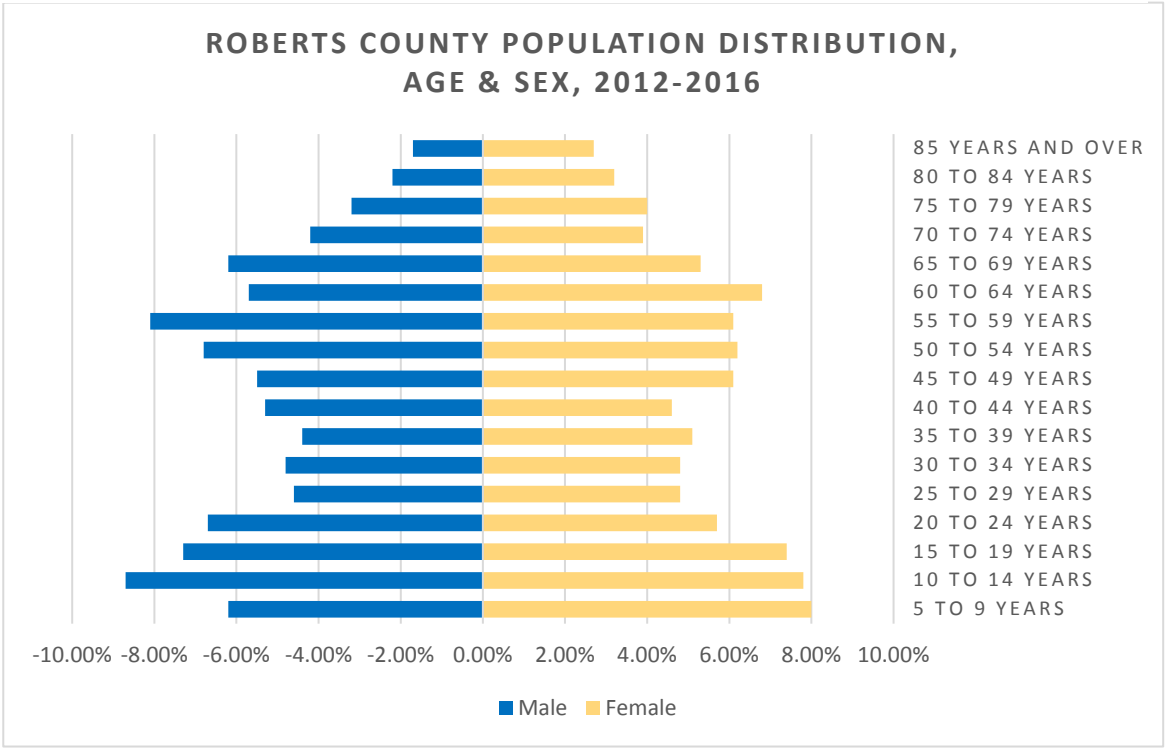
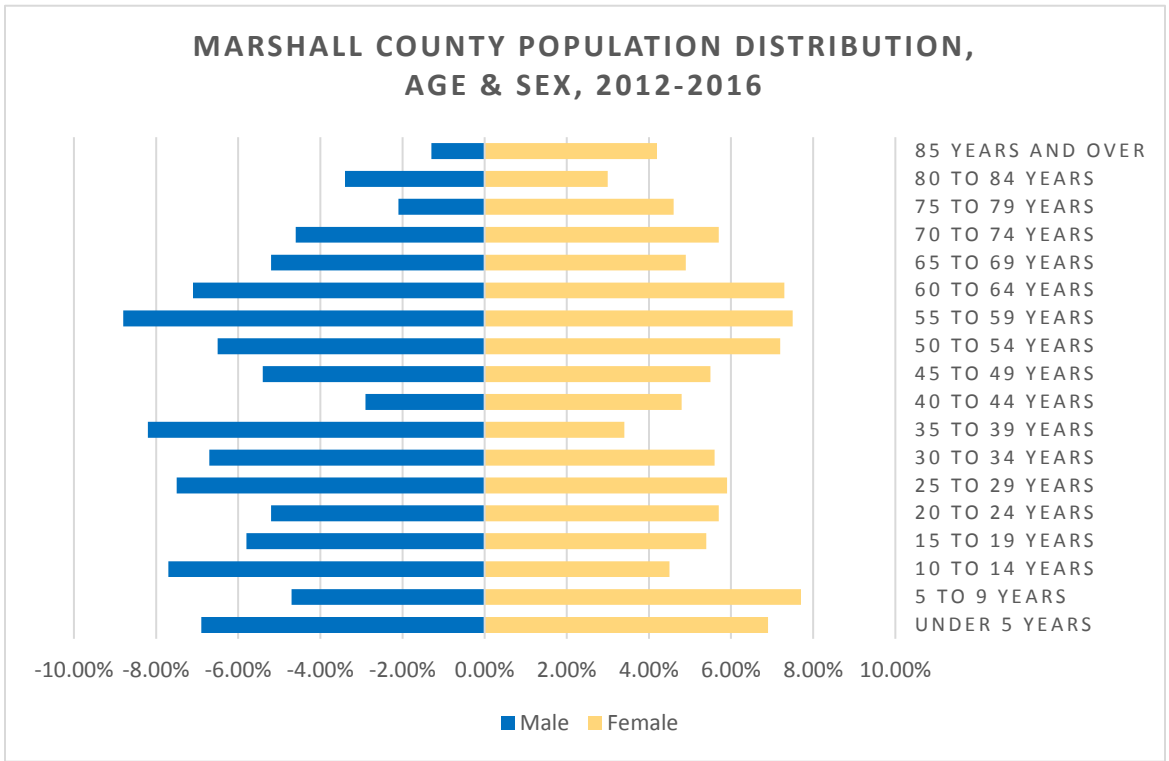
Figure 3



Source: American Community Survey

Figure 4



Source: American Community Survey

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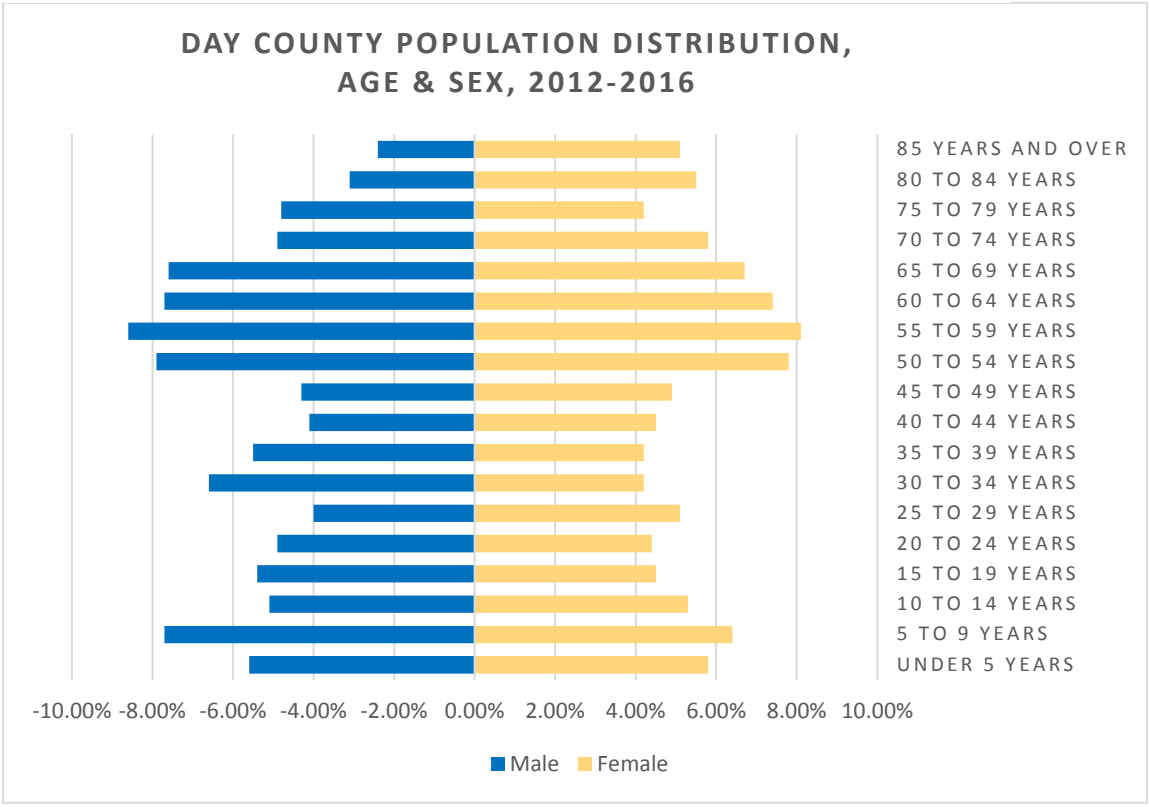
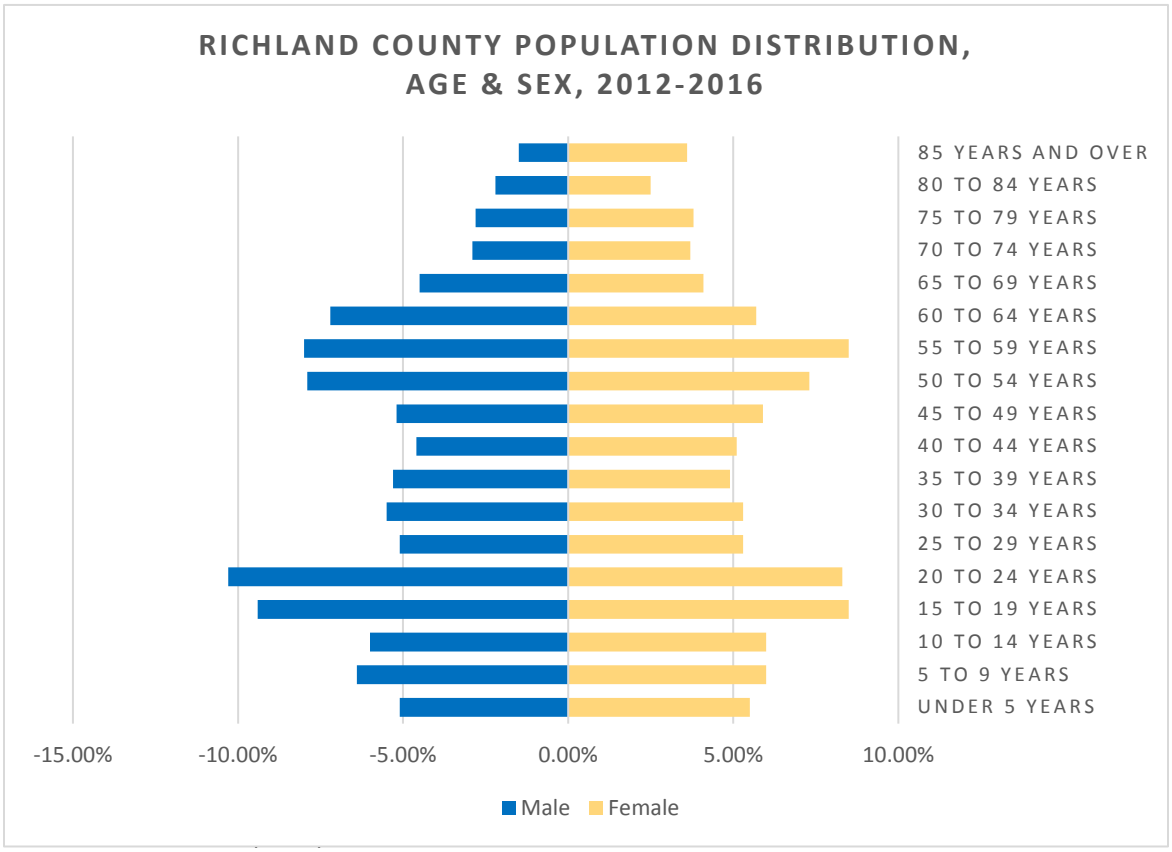
Figure 5



Source: American Community Survey

Figure 6



Source: American Community Survey

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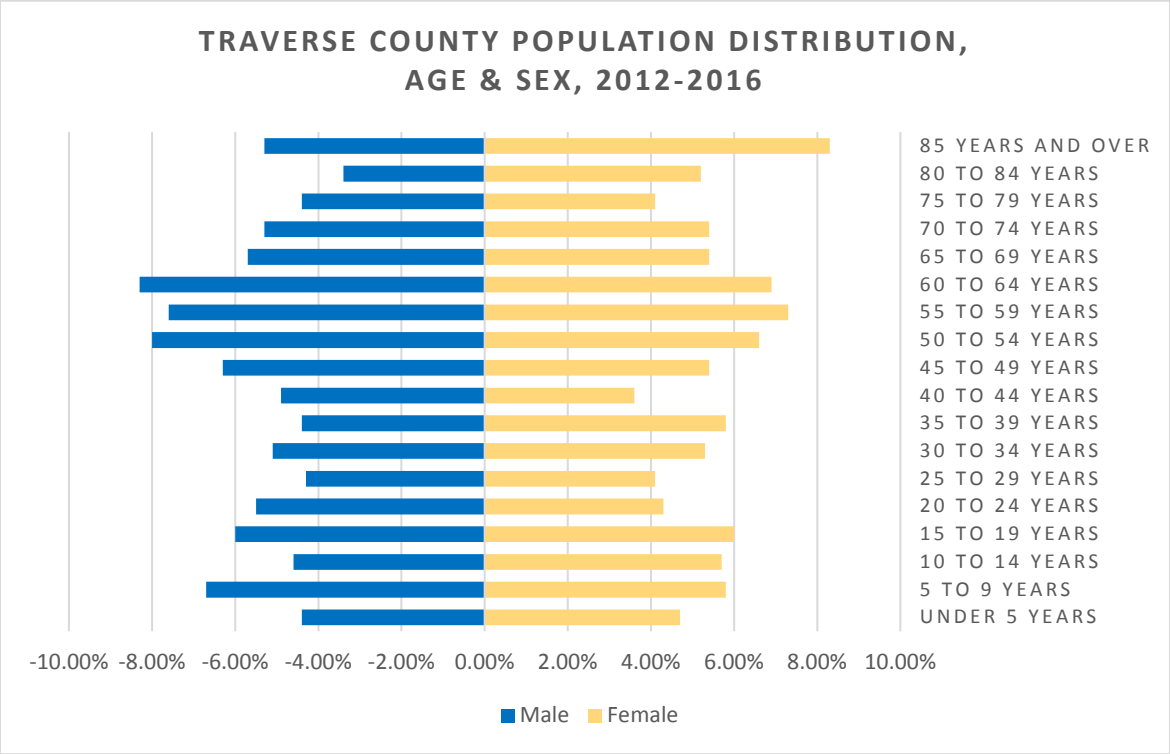
Figure 7



Source: American Community Survey

CLINICAL & COMMUNITY CARE

A lack of access to clinical care is a barrier to good health. Factors such as supply and accessibility of primary care providers, lack of access to health professionals, and transportation all affect access.

One hundred percent (100%) of the population CDP serves is considered to be living in a Health Professional Shortage Area, except for Richland County, ND (Table 3) which includes the shortage of primary medical care, dentists, and mental health providers.

Table 2: Population Living in a Health Professional Shortage Area, April 2016

Report Area	Total Area Population	Percentage of Population Living in a HPSA
Traverse County, MN	3,558	100%
Richland County, ND	16,321	0%
Day County, SD	5,710	100%
Marshall County, SD	4,656	100%
Roberts County, SD	10,149	100%
Minnesota	5,303,925	33.42%
North Dakota	672,591	10.76%
South Dakota	814,180	24.43%

Source: Health Resources and Services Administration

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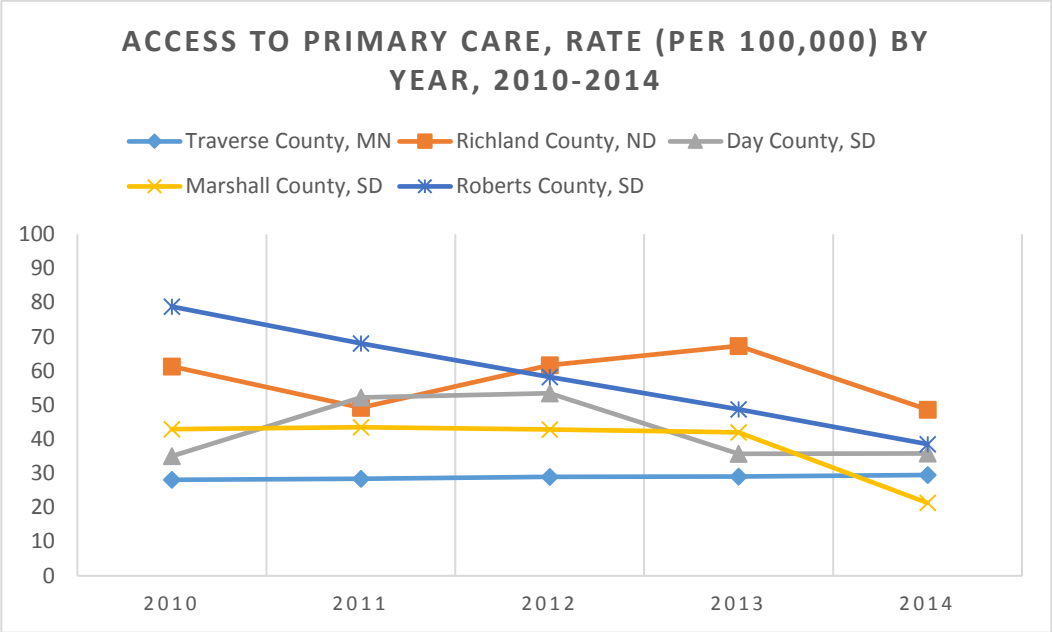
Within the service area, the county with the most primary care physicians is Richland County with 8 physicians per 100,000 people. Marshall County and Traverse County only have 1 provider per 100,000 people.

Figure 8

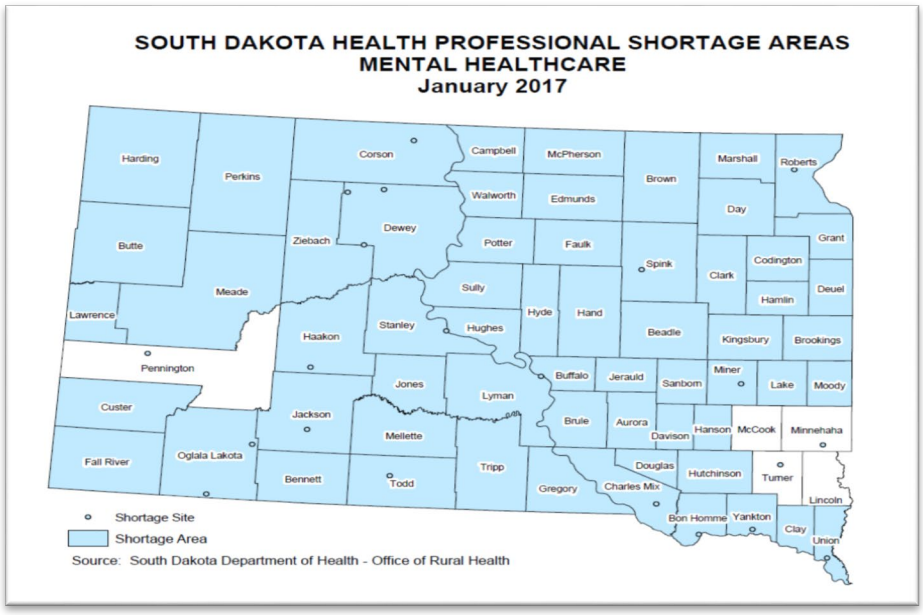


Source: Area Health Resource File

Within the last 12 months 8% of Marshall County adults could not afford to see their provider due to cost. The same was true in surrounding counties with 7% of Roberts County, 6% Day County, and 4% of Richland County adults unable to see a provider due to cost as well.

With limited access to mental health providers in this area, it is alarming that there are higher rates of depression and suicide when compared to state averages. Richland County has 5 providers, while Roberts County has 4 providers. The mental health care professional shortage area in South Dakota is highlighted in Figure 9.

Figure 9



Source: Health Resources and Service Administration

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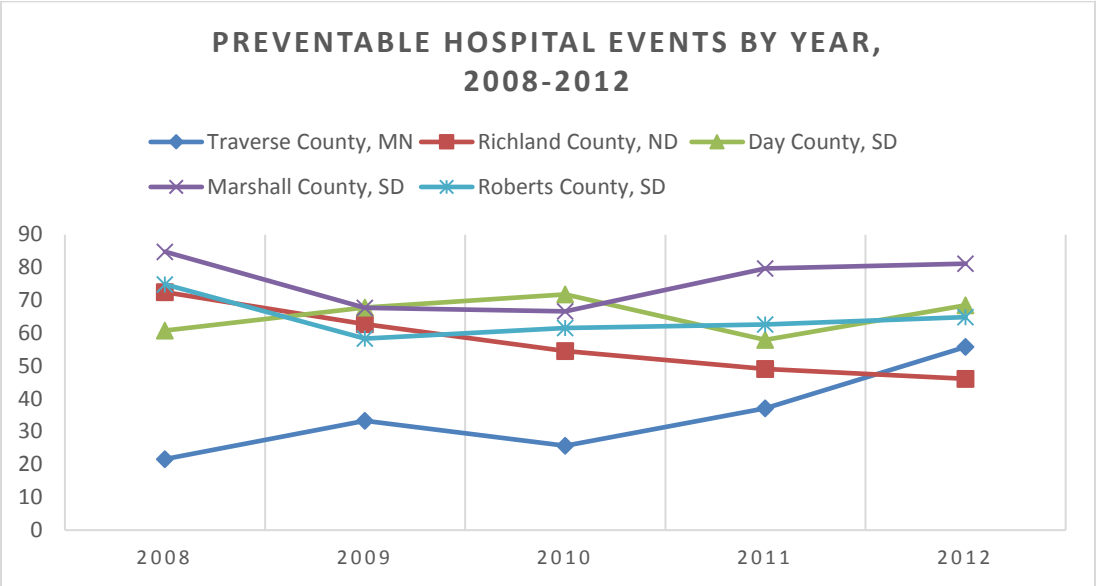
Preventable hospital events in the CDP service area from 2008 to 2015 have shown increased rates in all counties, except Richland County, ND (Figure 10). When compared to state averages of South Dakota, Minnesota, and North Dakota, the CDP service area rates are also higher. This indicator is important because analysis of ambulatory care sensitive discharges for Medicare enrollees shows potential for return on investment from evidence-based interventions that reduce admissions due better access to resources through primary care.

Figure 10



Source: Dartmouth Atlas of Health Care

Breast and colorectal cancer are two of the three leading cancers in the United States. Both of these cancers can be treated if caught early enough which is why regular screenings are so crucial. In South Dakota, 66.1% of females who are 67-69 years old and enrolled in Medicare have received one or more mammograms in the past two years. Both Day (73.9%) and Marshall County (71%) have the highest rates of Medicare females having mammograms within the last two years, surpassing South Dakota's rates. Roberts County is below South Dakota's rates with 59.1%, while Traverse County is higher than Minnesota's rates (64.5%) with 71.4%. Richland County has 67.5% which is close to meeting North Dakota's rate of 68.9%.

Adults above the age of 50 are encouraged to have a Sigmoidoscopy/Colonoscopy. Table 4 indicates the percentage of adults who had this procedure within the past 10 years. Marshall County (59%) had the highest screening rates for Sigmoidoscopy/Colonoscopy within the CDP serving counties. Richland County was next with 57%. Roberts County however had the lowest screening rate with 38.8%. South Dakota's rate for Sigmoidoscopy/Colonoscopy screenings as a whole is 59.2%.

Although Roberts County has lower rates in mammogram and colonoscopy screenings, they do surpass South Dakota's rate in providing women (18 and older) a pap smear test within the last 3 years. Roberts County reports 89.7% while South Dakota as a whole is 78.4%. Following counties rates are: Marshall County (77.6%), Richland County (76.6%), Day County (70.8%). Traverse County data was unavailable.

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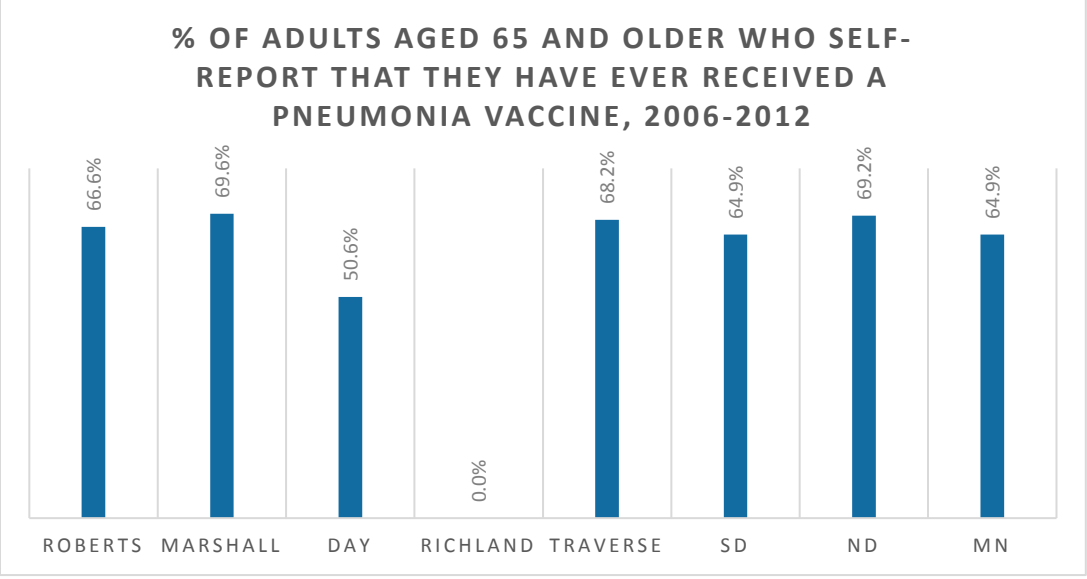
Table 4

Indicator	Roberts	Marshall	Day	Traverse	Richland	SD	ND	MN
% of female Medicare enrollees, age 67-69, who have received one or more mammograms in the past two years.	59.10%	71.00%	73.90%	71.40%	67.50%	66.10%	68.9%	64.5%
% of adults age 50+ who have had a Sigmoidoscopy/Colonoscopy within the past 10 years	38.80%	59.00%	50.20%	NA	57.00%	59.2%	55.4%	68.5%
% of women age 18+ who report having a pap smear test in the past 3 years	89.70%	77.60%	70.80%	NA	76.60%	78.4%	78.1%	80.4%

Source: The Dartmouth Atlas of Health Care, Behavioral Risk Factor Surveillance System

Preventative behaviors are important for early detection, treatment and prevention of health problems. Indicators in the CDP service area that highlight access and use of preventative care in older populations include annual hemoglobin A1c test, which measure blood sugar levels, and receiving a pneumonia vaccine. The percentage of adults aged 65 and older in the CDP service area who self-report ever having a pneumonia vaccine is over sixty percent in all counties, except Day County, 50.6% (Figure 11). These rates are slightly lower when compared to state rates in SD, MN, and ND.

Figure 11



Source: Behavior Risk Factor Surveillance System

The percentage of Medicare enrollees with diabetes with an annual hA1c test is markedly high, with approximately 90% of the CDP service area receiving one (Figure 12). Two counties are below the 90% threshold, with 83.7% of Traverse County and 88.5% of Day County enrollees receiving an annual exam. Richland County data was unavailable. These rates are comparable and slightly higher in some counties when compared to the state rates in SD, MN, and ND.

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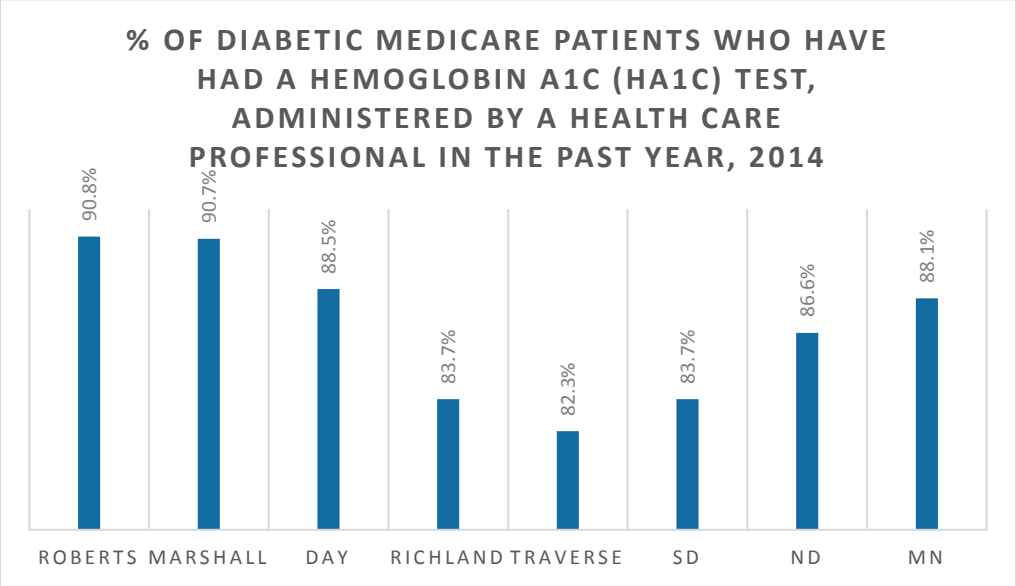
Figure 12



Source: Dartmouth Atlas of Health Care

HEALTH CARE RESOURCES

Ambulatory care sensitive conditions are conditions that typically with effective community care can help prevent an individual from having to admit to the hospital. One example of this condition is diabetes. If diabetes is properly taken care of further treatment and a hospital admission should not be needed. Throughout CDP serving counties, Traverse County has had the most consistent discharge rate of 1,000 Medicare enrolls for ambulatory care sensitive conditions. Roberts County has seen a steady decline with 72.52% in 2008 to 46.12% in 2015 (Table 5).

Table 5

Rate of Ambulatory Care Sensitive Condition Discharges (per 1,000 Medicare Part A Beneficiaries) by Year, 2008 through 2015					
Report Area	**2008**	**2009**	**2010**	**2011**	**2015**
Traverse County, MN	21.66	33.33	25.74	37.13	55.83
Richland County, ND	72.52	62.74	54.55	49.1	46.12
Day County, SD	60.86	67.81	71.84	57.98	68.54
Marshall County, SD	84.85	67.78	66.67	79.71	81.18
Roberts County, SD	74.89	58.37	61.59	62.67	64.88

Source: Dartmouth Atlas of Health Care

The amount of price-adjusted Medicare reimbursements per enrollee differs between each county as well. Day County has the highest price-adjusted per enrollee with $8,678. Roberts and Richland County both have the lowest with $7,606. Marshall County was $8,287 and Traverse County $8,087.

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LONGTERM OUTCOMES

Following national and state trends, the leading causes of death are heart disease and cancer in the CDP service area (Table 6). Risk factors for heart disease include diabetes and hypertension (high blood pressure). In Roberts County, 34.4% of adults report being diagnosed with high blood pressure. Of individuals with hypertension that qualify for Medicare fee-for-service, Roberts County's rate is 50.56% followed by Day County at 53.07%, and Richland County at 48.64%.

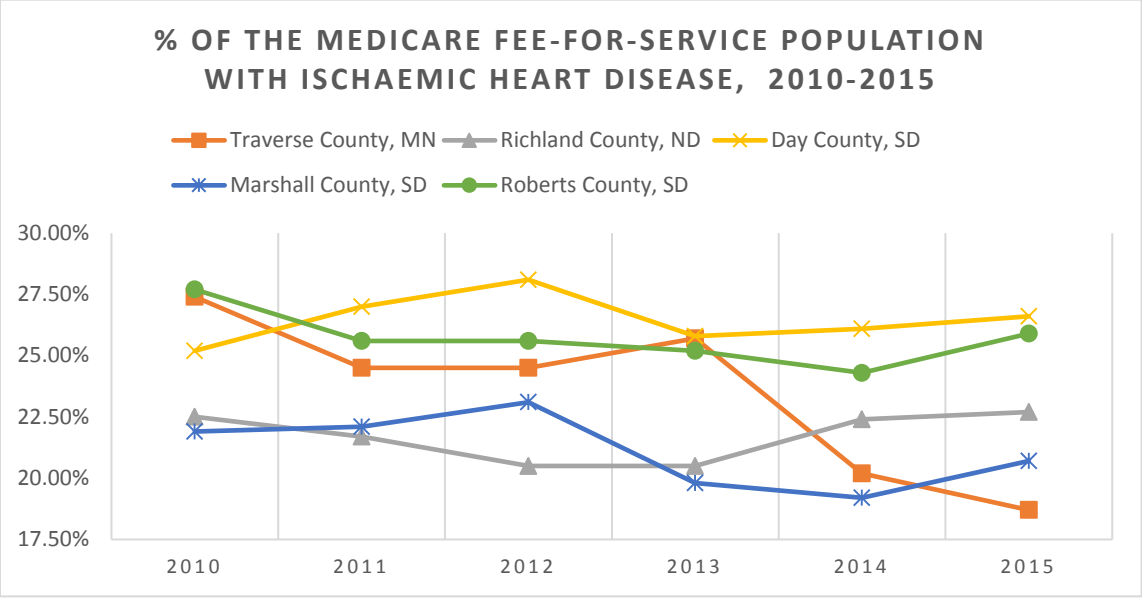
Table 6: Leading Causes of Death, 2016

Roberts	Marshall	Day	Traverse	Richland
Heart Disease	Heart Disease	Heart Disease	Heart Disease	Cancer
Cancer	Cancer	Cancer	Cancer	Heart Disease
Cerebrovascular Disease	Cerebrovascular Disease	Cerebrovascular Disease	Stroke	Accidents
COPD	COPD	Accidents	CLRD	Alzheimer's Disease
Accidents	Accidents	Alzheimer's Disease	Alzheimer's Disease/Diabetes	Cerebrovascular Disease

Source: South Dakota Department, Office of Health Statistics, North Dakota Department of Health Vital Records, Minnesota Center for Health Statistics

Ischemic heart disease (also known as coronary artery disease) is commonly caused by the buildup of plaque in the arteries. The CDP service area shows similar rates of adults of the Medicare fee-for-population compared to state rates (Figure 13). Day County (26.6%) and Roberts County (25.9%) have the highest rates of adults with ischemic heart disease. South Dakota in 2015 had a rate of 22%. Traverse County has seen significant differences between years 2013 to 2015 with their rates going from 25.7% to 18.7%.

Figure 13



Source: The Dartmouth Atlas of Health Care

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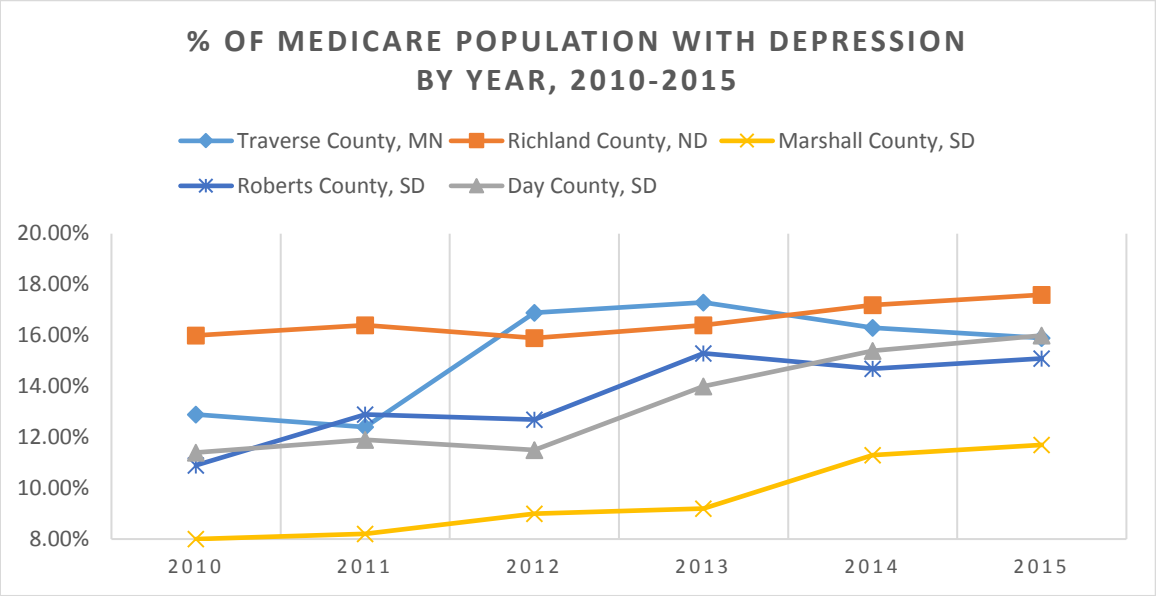
Adults who have reported being diagnosed with diabetes is relatively low. In 2013, Roberts County had the highest rate with 9.9% of adults being diagnosed with diabetes. Richland County had the lowest rate with 7.2%.

The top three most common cancers in this region are Lung, Breast, and Colorectal cancer, once again this is consistent with United States trends. Lung and bronchus cancer incidence rates were only available for the Richland County (48.1%), Day County (43.8%), and Roberts County (33.7%). Incidence rate for Breast Cancer was highest in Day County with 129.7%. According to State Cancer Profiles, Day County's trend is beginning to decrease while Roberts County (119.6%) and Richland County's (119.1%) incidence rates have stayed relatively the same. Colon cancer rates among Day (42.8%) and Roberts (42%) County have stayed stable over the past few years compared to South Dakota's incidence rate of 44.8%. However, Richland County is much higher with 66.9% and the overall rate of North Dakota is 46.6%.

The percentage of Medicare population with depression has steadily increased from 2010-2015 in all counties CDP serves (Figure 14). In 2015 Richland County had the highest rate of depression with 17.6%. However, Day County has had the biggest increase going from 11.4% in 2010 to 16% in 2015.

Figure 14



Source: The Dartmouth Atlas of Health Care

Mental health issues are an ongoing struggle within the CDP service area. In particular, suicide rates have been increasing in South Dakota, North Dakota, and Minnesota. However, the number of suicide events reported in the CDP service area have been highest in Roberts County, Marshall County, and Day County (Figure 14).

Data from the South Dakota Department of Health regarding suicide, highlights that SD has the 14th highest suicide rate in the United States, with SD's suicide rate, 16.7, is higher than the US, 12.9 (Figure 15). Suicides are also higher in younger populations compared to national rates with young men ages 19-21 being at the highest suicide risk in SD. In addition, American Indian suicide rates are 1.8 time higher than Whites in SD. Figure 14, indicates overall crude suicide rates by county in South Dakota.

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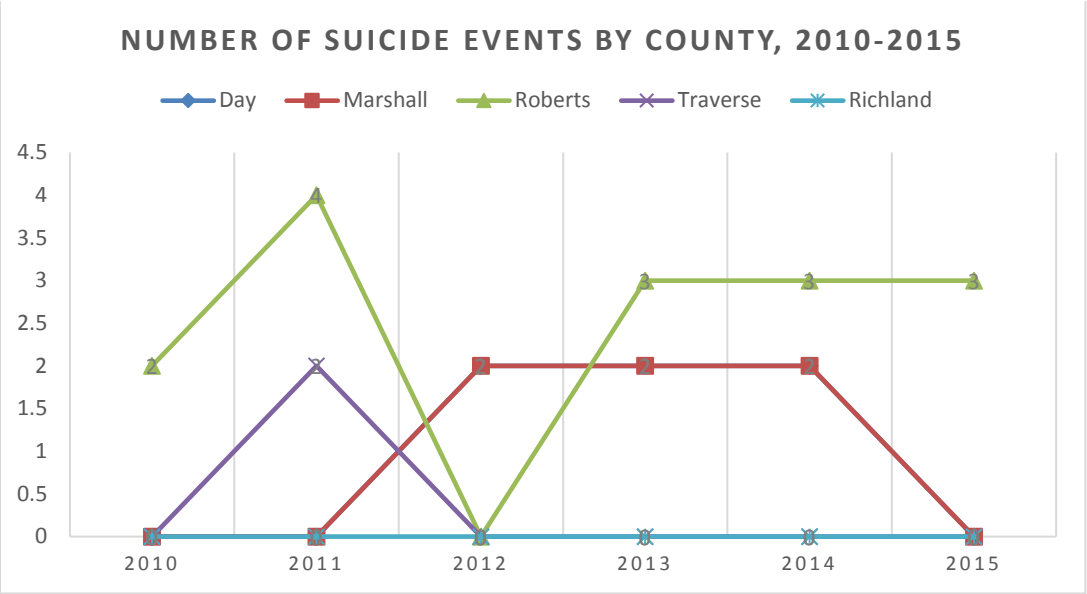
Suicide is the ninth leading cause of death overall in North Dakota, and the second leading cause of death for those between the ages of 15 and 24. The number of suicide events in Richland County have not been reported from 2011-2015, however, nine suicides were reported in 2016. Males commit suicide four time more frequently than females. In addition, suicide deaths are increasing in Minnesota, however a low number of suicide events have been reported in Traverse County.

Figure 15



Source: South Dakota Department of Health Office of Health Statistics, North Dakota Department of Health Vital Record, Minnesota County Health Tables

Suicide methods by age, sex, and race are also indicated in Figure 16 below for South Dakota. Firearms were the most common method for suicide death, accounting for 51% of all suicide death. In addition, firearms were the most common cause of suicide in all age groups, except children ages 10-19 where hanging was prevalent.

Figure 16: Suicide methods by age, sex and race, South Dakota, 2004-2015

	Total	Firearms (%)	Hanging (%)	Poison or Gas (%)	Other (%)
Total	**1,574**	**798 (50.7%)**	**507 (32.2%)**	**219 (13.9%)**	**50 (3.2%)**
Age group					
10-19 yrs	**208**	63 (30.3%)	131 (63.0%)	12 (5.8%)	2 (1.0%)
20-29 yrs	**325**	158 (48.6%)	134 (41.2%)	28 (8.6%)	5 (1.5%)
30-39 yrs	**252**	113 (44.8%)	92 (36.5%)	38 (15.1%)	9 (3.6%)
40-49 yrs	**280**	127 (45.4%)	67 (23.9%)	75 (26.8%)	11 (3.9%)
50-59 yrs	**262**	152 (58.0%)	61 (23.3%)	38 (14.5%)	11 (4.2%)
60-69 yrs	**125**	89 (71.2%)	11 (8.8%)	20 (16.0%)	5 (4.0%)
70-79 yrs	**75**	58 (77.3%)	8 (10.7%)	7 (9.3%)	2 (2.7%)
80+ yrs	**47**	38 (80.9%)	3 (6.4%)	3 (6.4%)	3 (6.4%)
Sex					
Male	**1,260**	714 (56.7%)	389 (30.9%)	121 (9.6%)	36 (2.9%)
Female	**313**	84 (26.8%)	117 (37.4%)	98 (31.3%)	14 (4.5%)
Race					
White	**1,230**	736 (59.8%)	270 (22.0%)	185 (15.0%)	39 (3.2%)
Am Indian	**299**	45 (15.1%)	216 (72.2%)	32 (10.7%)	6 (2.0%)
Other race	**45**	17 (37.8%)	21 (46.7%)	3 (6.7%)	1 (2.2%)

Source: South Dakota Department of Health

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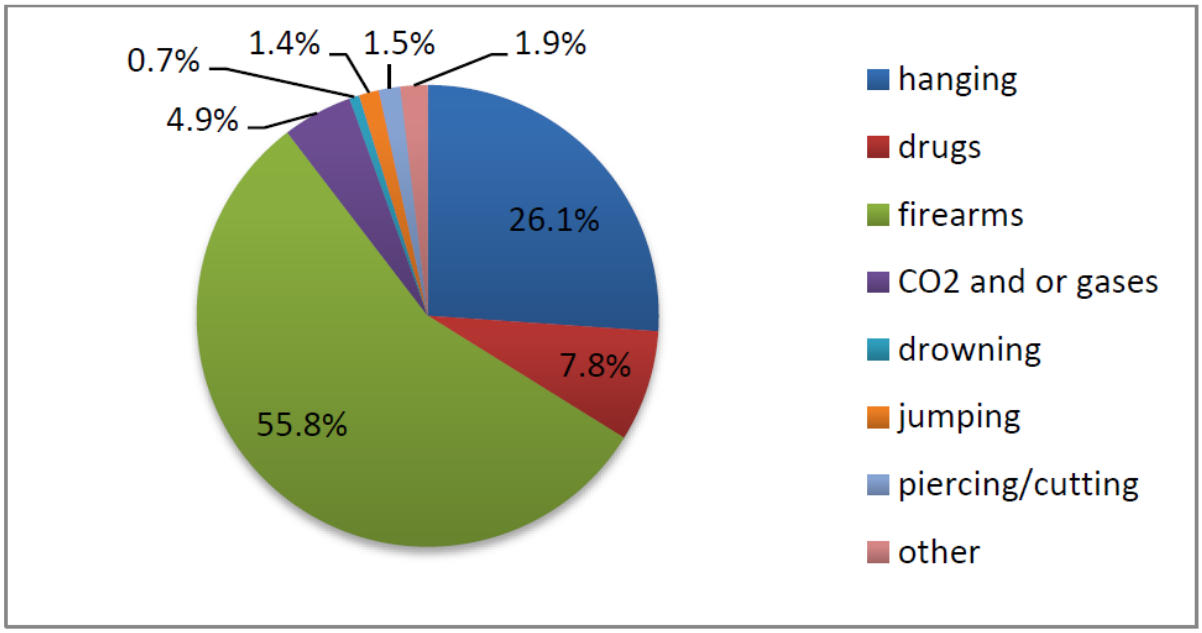
The lethal means used in North Dakota suicide death also reports firearms as the primary means as noted in Figure 17.

Figure 17: Lethal Means Used in North Dakota Suicide Deaths, 1908-2015



Source: North Dakota Department of Health, Vital Records

Hospitalizations and emergency department visits for self-inflicted injury by county of residence in South Dakota, including Grant, Marshall, and Roberts are reflected in Table 7 below. Data was unavailable for Traverse County and Richland County.

Table 7

	Roberts	Marshall	Day	Traverse	Richland
Hospitalizations	90	28	31	NR	NR
Emergency Department Visits	59	0	12	NR	NR

Source: South Dakota Department of Health

HEALTH BEHAVIORS

As of 2013, the percent of adults in South Dakota who are considered obese (BMI >30) is 29.5%. When specified into counties the BMI's in the service area of CDP are all above the state average. Roberts County is 31.7%, Marshall County is 31.9%, Day County is 30.2%, Traverse County is 32%, and Richland County is 32.9%. Figure 18 shows history of BMI. Roberts County has decreased their BMI from 2015 to 2013 by 2%. Traverse County, MN on the other hand has increase their BMI percentage by 2%. Marshall County has also increased 1% every year.

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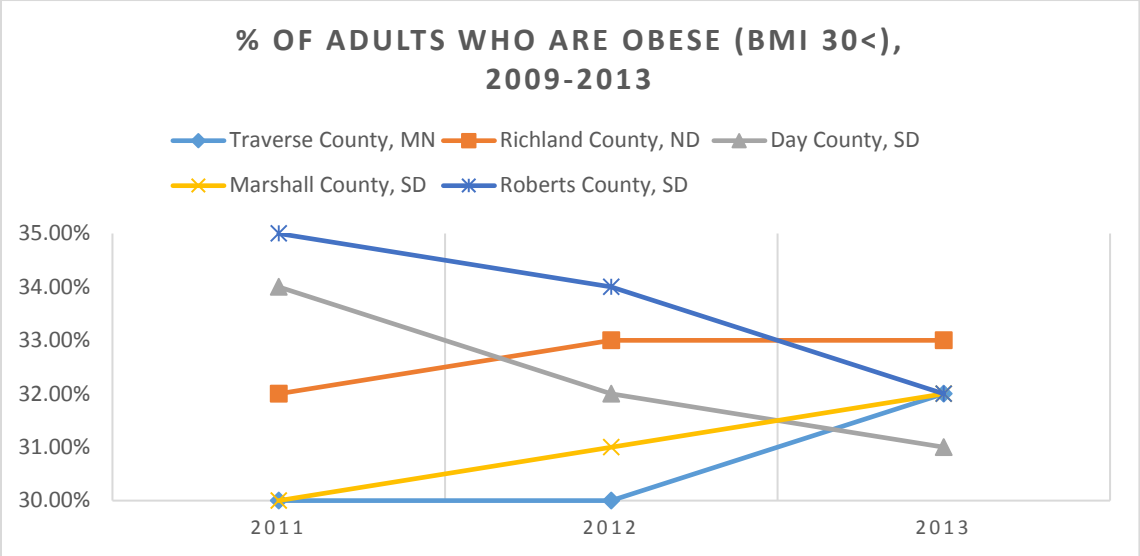
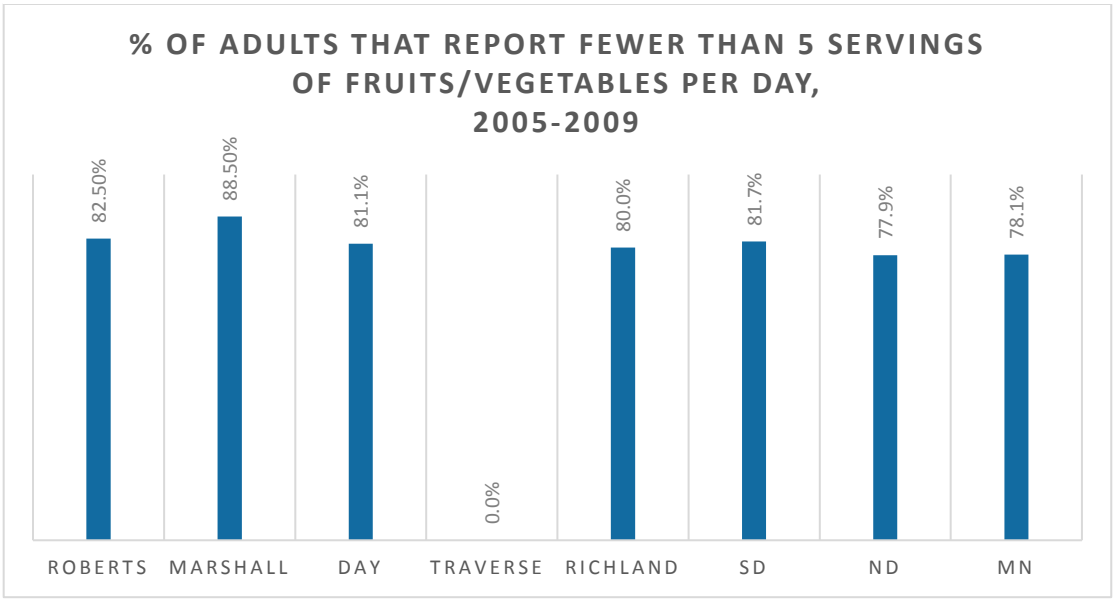
Figure 18



Source: Behavior Risk Factor Surveillance System

Eating fruits and vegetables can help to lower your risk of health problems as you get older, which is why it is recommended that adults eat at least 5 servings of fruits/vegetables a day. However, due to rural areas and the ability to access fruits and vegetables, the percentage of adults in CDP serving counties who meet this daily recommendation is relatively low. 88.5% of Marshall County adults report not eating 5 servings of fruits and vegetables, 82.5% in Roberts County, 81.1% in Day County, and 80% in Richland. No data is available for Traverse County.

Figure 19



Source: Behavior Risk Factor Surveillance System

Leisure-time physical activity is defined as participating in light to moderate physical activity for more than 30 minutes at 5 or more times a week or participating in vigorous physical activity for at least 20 minutes 3 times or more a week In Roberts County, 22.3% of adults reported meeting these levels of physical activity, 20.4% in

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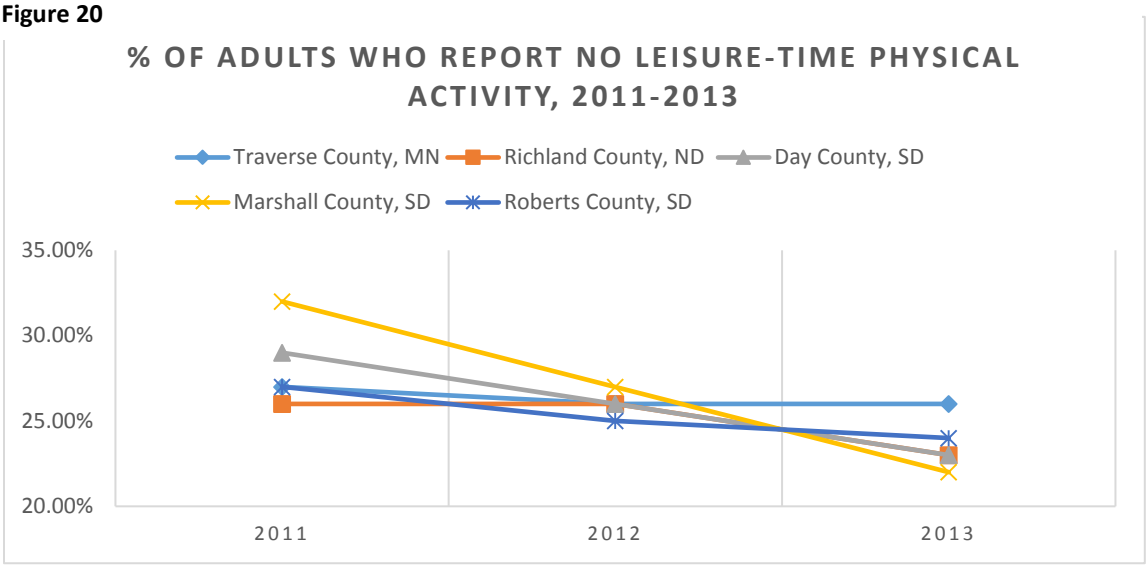
Marshall County, 20.3% Day County, and 23% in Traverse County, and 22% in Richland County. 20.9% of adults reported no leisure-time physical activity in South Dakota.

Figure 20



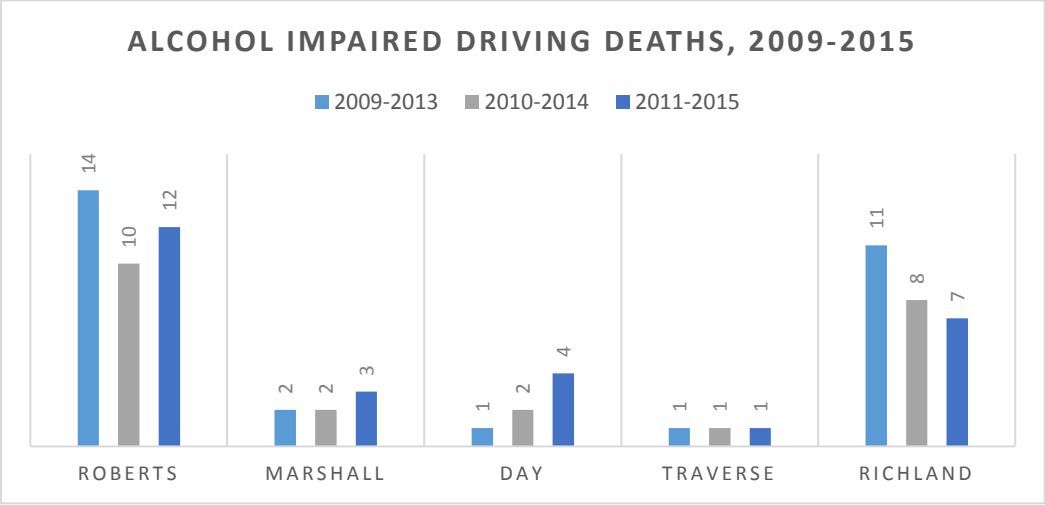
Source: Behavior Risk Factor Surveillance System

Using tobacco can increase your risk for multiple diseases including heart disease and many types of cancers. The overall percentage of adults (18 and older) who currently smoke cigarettes in Roberts County is 21%. This is 1% higher than the total rate in South Dakota (20%). In Marshall County smoking rates are 15%, Day County 17%, Traverse County 14%, and Richland County 16%.

Binge or heavy drinking is defined as consuming 5 or more drinks during the same occasion. (CDC) In South Dakota, 20.7% of adults (18 and older) report binge or heavy drinking. Richland County is the only county CDP serves that is higher than the state rate with 24%. Marshall and Traverse County both reported 19%, Roberts County is 16%, and Day County is 15%.

In addition to binge drinking rates, the percentage of driving deaths that occur with alcohol involvement is concerning. According to the Fatality Analysis Reporting System, in 2011-2015 Roberts County had a driving death rate due to alcohol of 12%. Richland County had 7%, Day County had 4%, Marshall County had 3%, and Traverse County had 1%. Overall in South Dakota the driving death rate due to alcohol is 35%.

Figure 21



Source: Behavior Risk Factor Surveillance System

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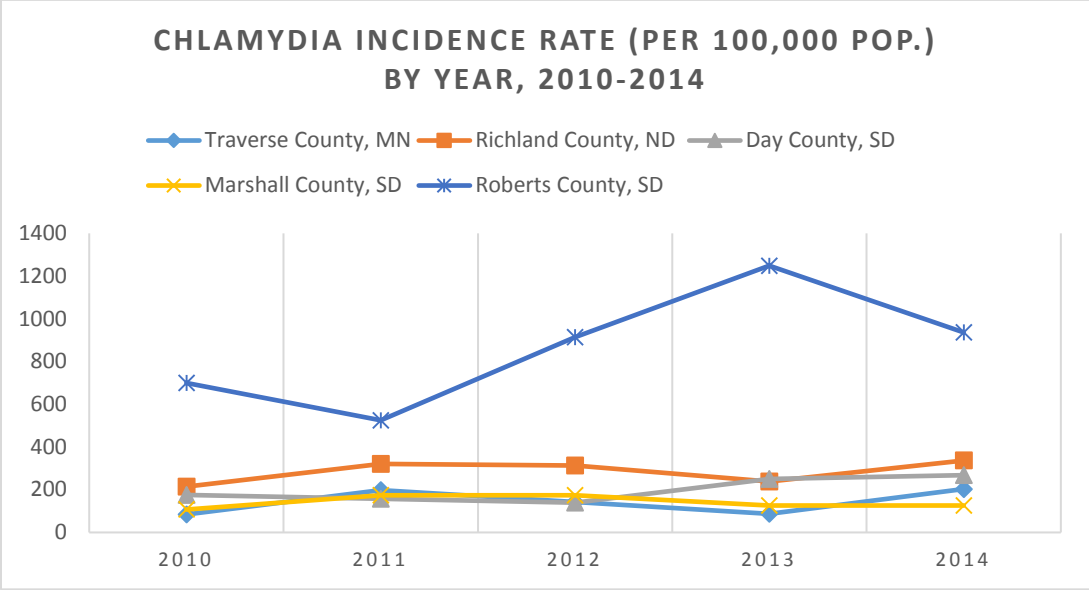
Overall, South Dakota has seen an increase in Sexually Transmitted Diseases (STD) over the past decade. Chlamydia rates have doubled since 2003. In 2014, South Dakota's incident rate was 493.1%. In Roberts County, the incidence rate of 936.5% nearly doubled. The lowest incidence rate was 126% in Marshall County. Looking at Figure 22, Roberts County trend in Chlamydia rate is significantly higher than other CDP serving counties.

Figure 22



Source: Behavior Risk Factor Surveillance System

Similar trends were found in Gonorrhea rates. Roberts County had an incidence rate of 47.78% while Marshall, Day, and Traverse County all had 0%. South Dakota's overall incidence rate was 105.6%.

MATERNAL & CHILD HEALTH

Infant mortality rate is the number of infant deaths under one years old per 1,000 live births. Knowing the infant mortality rate can help give an important insight into the overall health of a community. Overall, within the CDP service area there are high rates of infant mortality compared to state rates. Traverse County has the highest rate with 16.8% compared to Minnesota's rate of 7.8%. Day and Marshall County also have higher rates than the South Dakotas rate of 6.4% (Day County is 14.5%; Marshall County 11.98%).
Low birth weight rates are highest in Richland County, ND (9%). Day County low birth rate is 6.8%, Marshall County 6.6%, Roberts County 4.3%, and Traverse County 3%. Research has shown that babies born at a low birth weight have an increased risk for diabetes, heart disease, obesity, and metabolic syndrome later in life.

Table 8

Indicator	Roberts	Marshall	Day	Traverse	Richland	SD	ND	MN
Low Birth Weight Rate	4.30%	6.60%	6.80%	3.00%	9.00%	6.00%	6%	4.9%
Infant Mortality Rate (rate of deaths less than one year of age per 1,000 births)	5.54	11.98	14.50	16.8	4.86	6.4	6.07	7.8

Source: National Vital Statistics System, 2006-2012

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Breastfeeding is important to support early life and maternal health. Breastfeeding initiation rates are high throughout South Dakota. Data available within CDP service for Roberts County, Marshall County, and Day County reports over 65% of new mothers are breastfeeding at discharge, with Marshall County having the highest percentage of new mothers who are breastfeeding at discharge, 82%, and Roberts County with the lowest, 68.9% (Table 9). Data was unavailable for Traverse County and Richland County.
Additional data available regarding breastfeeding rates in the CDP service area highlight low rates, with high rates of formula fed infants. Roberts County WIC program 9.8% fully breastfed and 9% partially breastfed infants for a total of 18.8% of mothers who breastfeed. A significant percentage of mothers, 81.2%, use formula to feed their infants.

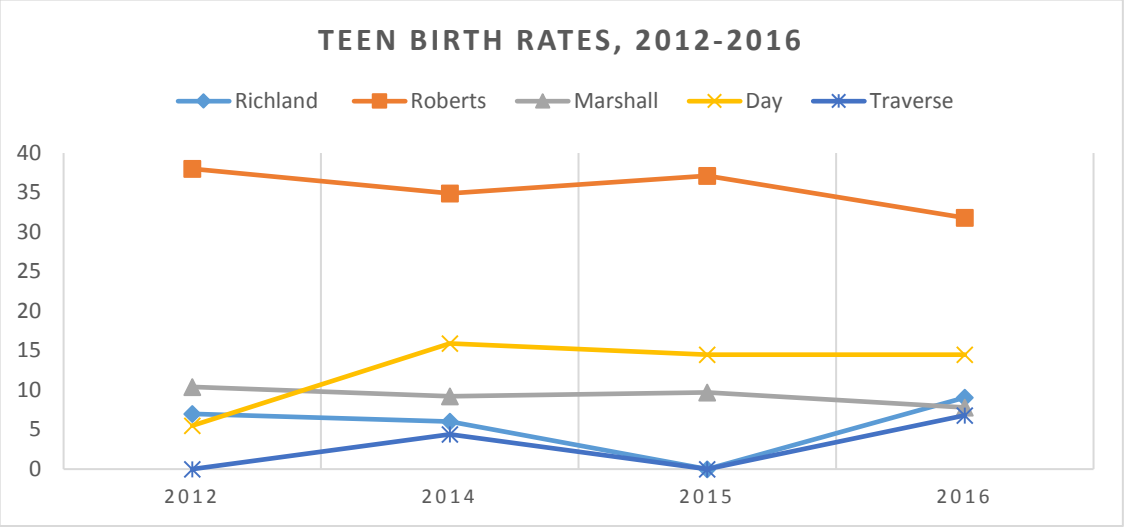
Table 9: Breastfeeding Data by State and Local Agencies, FY16

Indicator	Roberts County WIC	Marshall	Day	Traverse	Richland County WIC	SD	ND	MN
Fully Breastfed	9.8%	NA	NA	NA	11.9%	16.9%	14.3%	13.7%
Partially Breastfed	9%	NA	NA	NA	11.9%	10%	13.7%	22.1%
Formula Fed Infant	81.2%	NA	NA	NA	76.1%	73.1%	72%	64.2%

Source: WIC Breastfeeding Data Local Agency Report

Teenage birth rates are also high, especially in Roberts County with a teenage birth rate 31.8%. This rate is close to South Dakota's state rate of 34%. Figure 23 below shows the trend of teenage birth rate of CDP serving counties.

Figure 23



Source: US Vital Statistics

Pregnant women who use tobacco has been identified by the South Dakota's Tobacco Control Program as a priority population in South Dakota. Roberts County has continued to have the highest rates among CDP's serving area with 28.2%, Day County 26.1%, Traverse County 24.2%, and Marshall County 16.5%.

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YOUTH

A measure of youth health can be partially assessed by Youth Risk Behavior Data, which measures risk behaviors in students grades 9-12 in South Dakota. Health behaviors in South Dakota youth from 2007 to 2015 that contribute to obesity, dietary behaviors and weight control practices, sexual behaviors, and behaviors related to suicide are indicated in Table 10. Overall these health behaviors have not improved.

Table 10

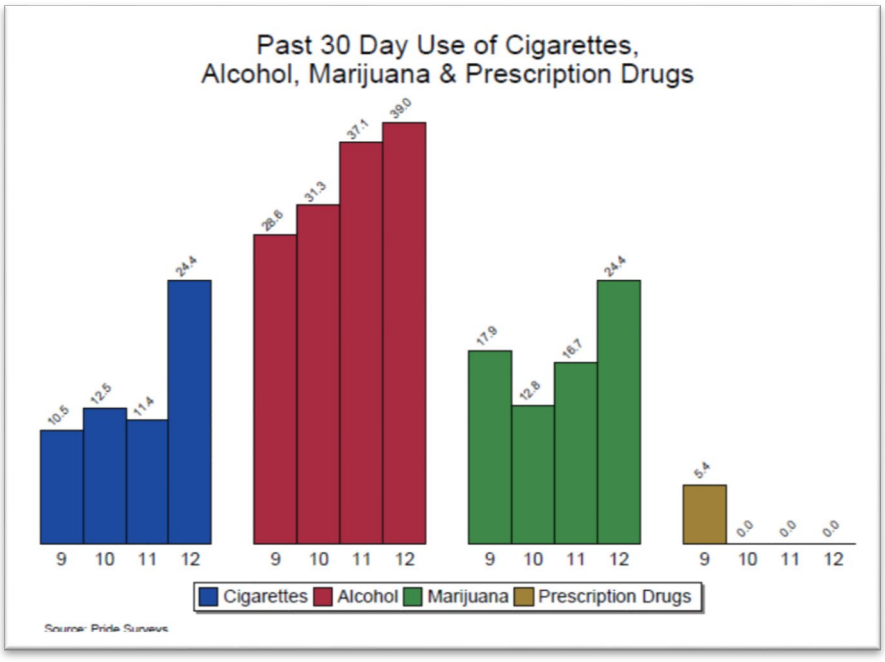
Indicator	2007	2009	2011	2013	2015
% Obese	9.00%	9.50%	9.80%	11.90%	14.70%
% Overweight	14.40%	12.50%	14.10%	13.20%	14.50%
% of students who age fruits or drank 100% fruit juice one or more times per day during the past seven days.	57%	57.60%	58.80%	63.10%	55.20%
% of student who ate vegetables one or more times per day during the past seven days.	60.30%	60.60%	61.20%	64.30%	59.20%
% of students who drank a can, bottle, or glass of soda or pop one ore more times per day during the past seven days.	28.20%	28.80%	28.40%	23.60%	23.20%
% of students who were physically active for a total of at least 60 minutes per day on five or more of the past seven days.	44%	46.70%	48.60%	47.10%	47.40%
% of students who ever had sexual intercourse.	46.50%	47%	47.40%	40.10%	37.20%
% of students who have ever been tested for any sexually transmitted disease (STD).	NA	14%	13.50%	13.20%	9.60%
% of students who have seriously considered suicide during the past 12 months	18.30%	17%	17.80%	16%	16.10%

Source: Youth Risk Behavior Survey

In addition to health behaviors related to risk factors for chronic disease, mental health issues and substance use in the CDP service area are on the rise. Local data is collected from students enrolled grades 6-12 in area schools regarding mental and physical health, drug use, risk and protective factors.

Past 30-day use in students surveyed include: cigarette, alcohol, marijuana and prescription drugs, Data indicates a higher percentage of alcohol use when compare to other drugs. Rates are higher across all drug use in grade 12 except for higher prescription drug use in ninth grade students (Figure 24).

Figure 24



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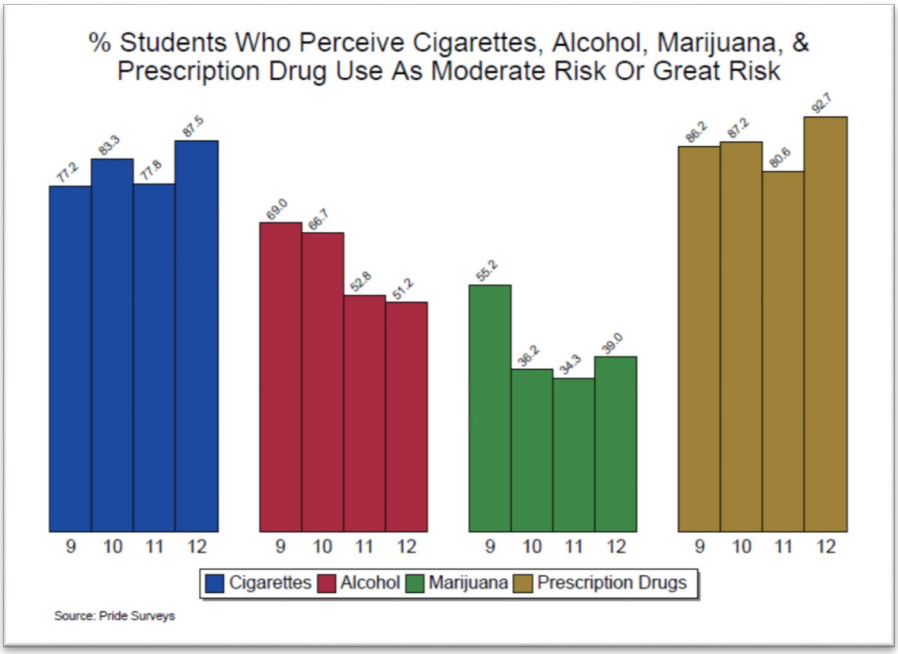
Students perception of risk as it pertains to use of cigarettes, alcohol, marijuana, and prescription drug use is over 80 percent for cigarette and prescription drug use, with 12th grade students perceiving the highest risk. Approximately 43% of students perceive moderate or great risk with marijuana use, with students in eleventh grade who have the lowest perception of risk. Alcohol risk was perceived the highest in ninth grade students, 69%, with the lowest perceived risk identified by students in 12th grade, 51.2%, who also reported the high alcohol use in the past 30 days (Figure 25).

Figure 25



Students were asked to report when they use tobacco, alcohol, and marijuana, and highest percentage of students reported on the weekend and after schools.

Figure 26

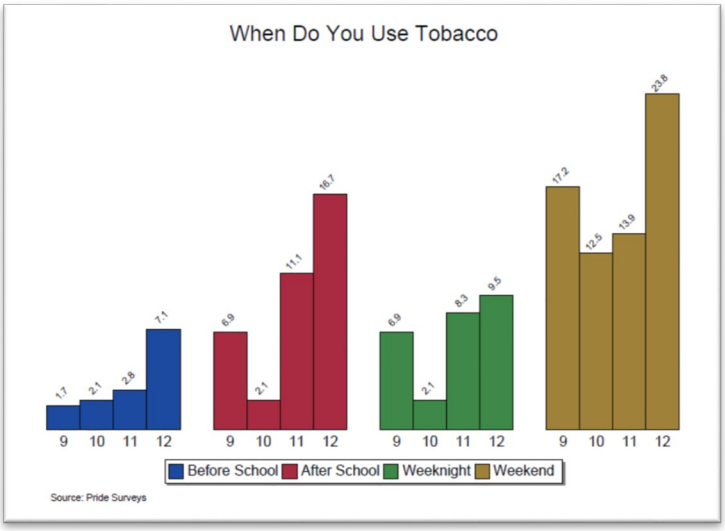


Figure 27

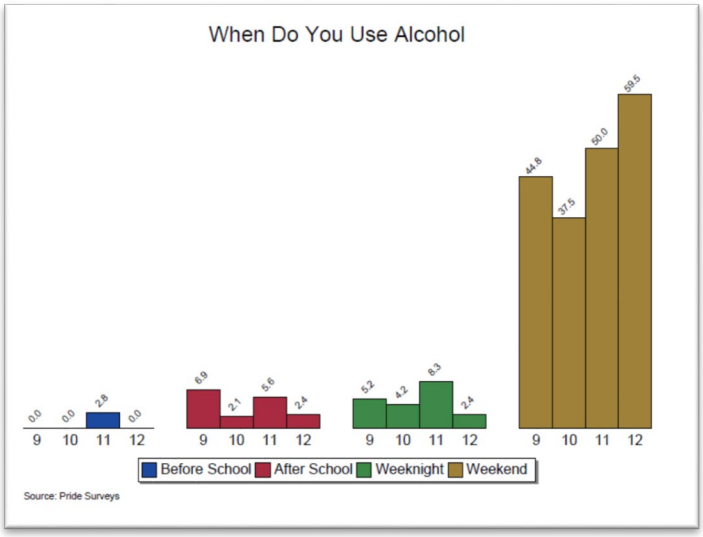


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Figure 28

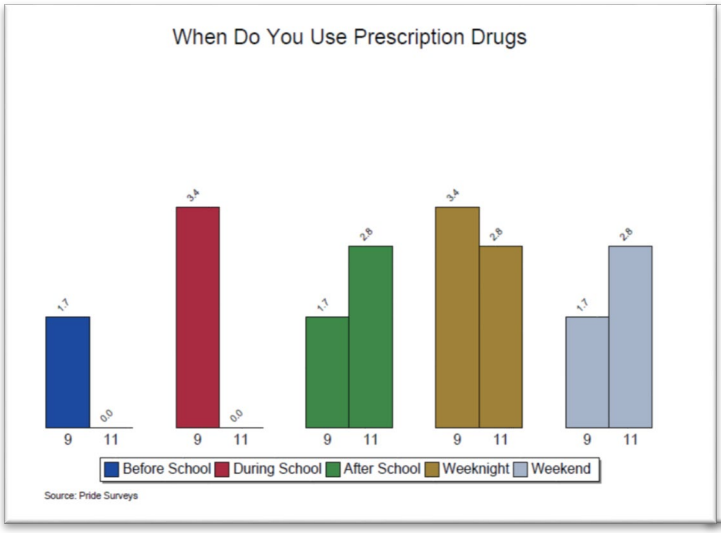
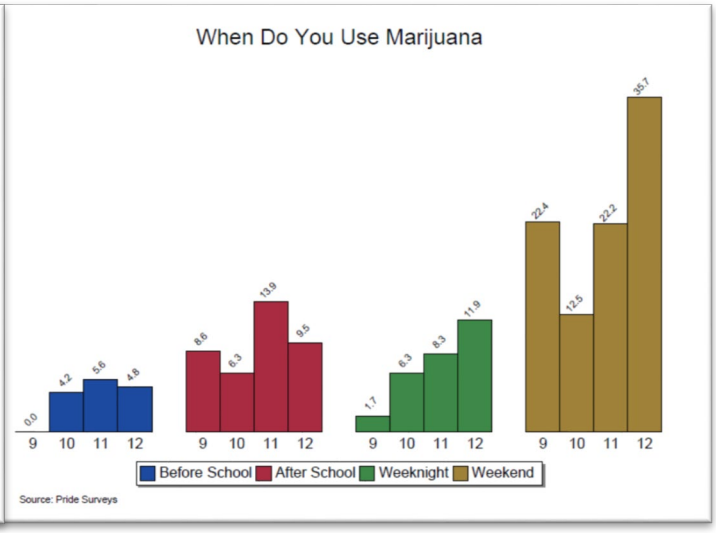


Figure 29



Violence indicators are also measured of students in the Pride Survey, reflected in Figure 30 below.

Table 25: Violence Indicators

Violence Indicator	Num	Pct
Get into trouble with police	55	30.6%
Threatened a fellow student	32	18.0%
Thought *often* or *a lot* about suicide*	27	15.0%
Being hurt at school	23	13.0%
Being afraid at school	20	11.5%
Participated in gangs	18	9.9%

Source: Pride Survey

QUALITY AND LENGTH OF LIFE

Quality and length of life are important indicators for healthy living. Trends in the percentage of adults in the CDP service area who report fair or poor health are highest in Marshal County (Figure 31), which have been stable since 2013 and increased since 2011. Roberts County increased slightly from 2014 to 2015 but have shown a decrease from 2011 to 2013. In addition, the year of potential life lost before age 75 in CDP service area is highest in Richland County, 460, compared to Roberts County, 100 (Figure 32).

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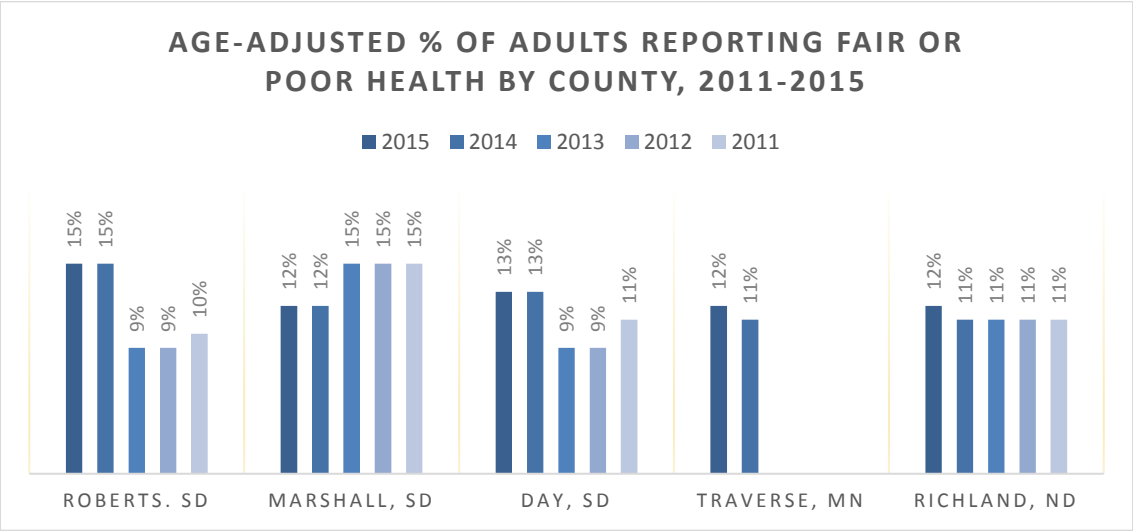
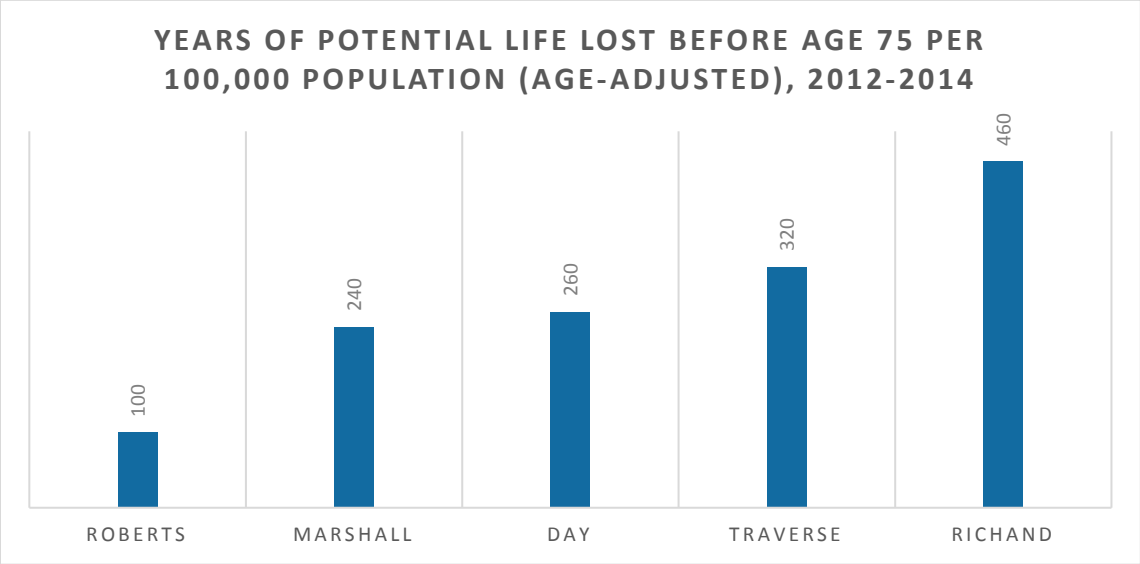
Figure 31



Source: Behavioral Risk Factor Surveillance System

Figure 32



Source: Behavioral Risk Factor Surveillance System

PHYSICAL ENVIRONMENT

The physical environment affects a community's ability to be healthy. A safe and clean environment provides access to physical activity and recreational opportunities, as well as access to healthy foods.

Access to physical activity and recreational opportunities in the CDP service area is relatively low, with Richland County, ND as the only county with recreational facilities available. In addition, living close to a park provides low-cost or no-cost opportunities for people to be physically active. One quarter of the Day County, SD population lives within ½ mile of a park, with 21% of Marshall County, SD living within ½ mile of a park. Only 9% of Traverse County, MN lives within ½ mile of a park.

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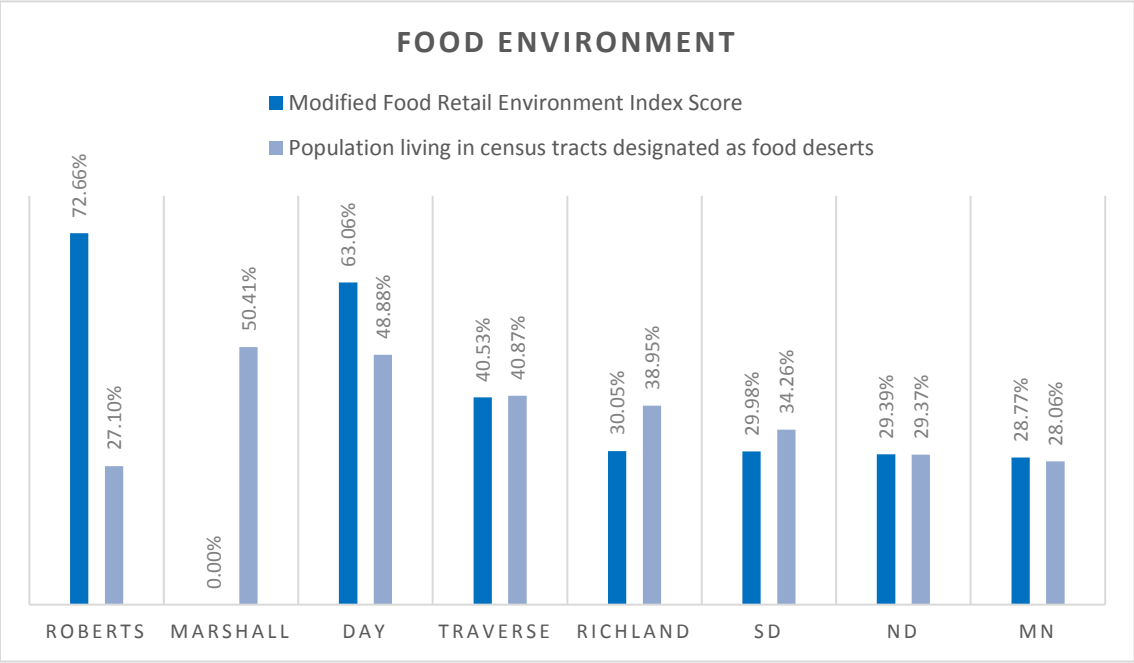
Access to food, especially healthy foods, is a significant factor in the environment that affects the ability to live, work, learn, and play healthy. A significant percentage of South Dakota lives in a food desert where there is low-access to food due to lack of grocery stores, farmers' markets, and healthy food providers. A larger percentage of counties in the CDP service area live in census tracts designated as food deserts, half of Marshall County, SD who live in a food desert. Followed by over 40% of Day County, SD, 48.88% and Traverse County, MN, 40.87%, populations who live in a food desert. A little over one quarter of Roberts County, SD lives in a food desert, which is lower than the South Dakota rate of 34.26%. Access to healthy foods is also barrier in service area, with over 70% (72.66%) of Roberts County, SD who do not have access to healthy foods as highlighted by the Modified Food Retail Environment Index Score, which is the percentage of population living in census tracts with no or low access to health retail food stores.

Figure 33



Source: USDA Food Access Research Atlas, 2011, 2015

Poverty is also associated with low access to food. 37.34% of the low-income population in the CDP service has low access to food. Marshall County, SD has the highest percentage of low-income population with low access to food, 62.2%, with Roberts County, SD having the lowest, 24.89%. Counties in the service area are higher when compared to SD, MN, and ND. In low-income populations by race with low access to food in the CDP service area is highest in American Indians (AI), with over 90% of low-income AI populations with low-food access in Marshall County, SD, Traverse County, MN, and Traverse County, MN. Almost 80% of the low-income Hispanic or Latino population in Day County, SD has low-access to food (Figure 34).

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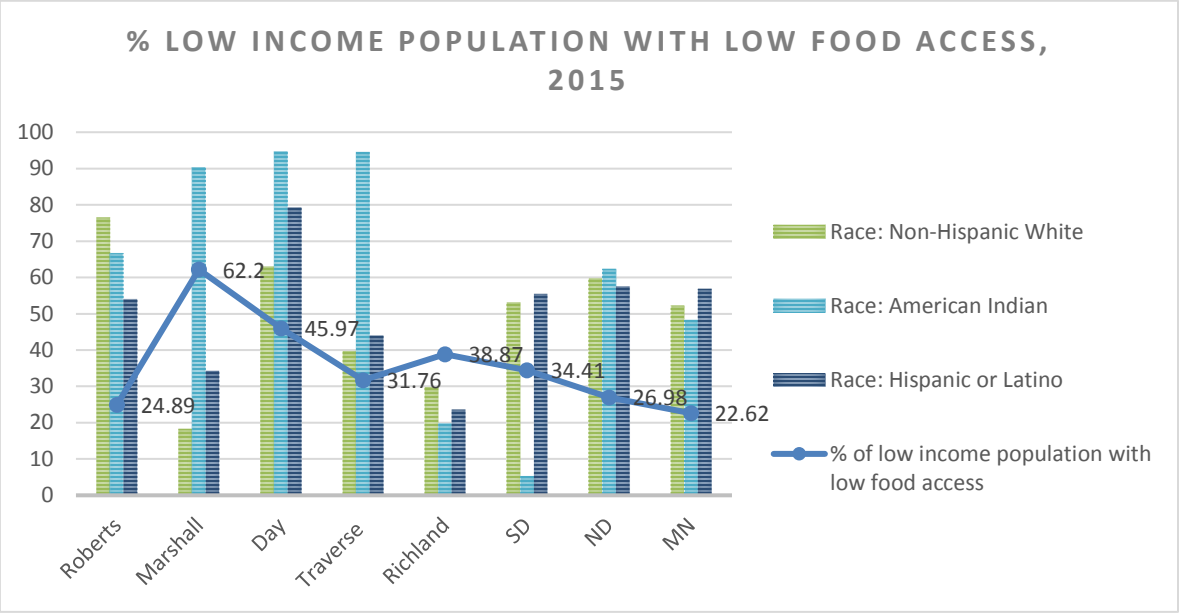
Figure 34



Source: USDA Food Access Research Atlas

The rate of establishments, including food stores, fast food restaurants, and grocery stores in the CDP service area to support access to food is noted in Table 11.

Table 11

Indicator	Years	Roberts	Marshall	Day	Traverse	Richland	SD	ND	MN
Number of fast food restaurants per 100,000 population	2015	39.41	42.96	70.05	28.11	61.27	67.92	67.95	65.86
Number of grocery stores per 100,000 population	2015	29.56	64.43	17.51	56.21	18.38	23.58	26.61	17.74
Number of SNAP-Authorized food stores per 10,000 population	2016	13.79	8.59	12.26	8.43	4.29	8.94	6.99	6.43
Number of food stores and other retail establishments per 100,000 population	2015	68.1	65.3	34.8	28.4	30.8	28.4	31.4	23.4

Source: U.S. Census Bureau County Business Patterns, USDA Supplemental Nutrition Assistance Program Location, USDA Food Environment Atlas

Transportation methods are an important indicator of how the physical environment is designed to support active living and community design. Due to the vast rural design of the CDP service area, as well as South Dakota, North Dakota, and Minnesota, public transportation is not widely available. This can limit access to good and services to support health living (Table 11).

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Table 11

Indicator	Years	Roberts	Marshall	Day	Traverse	Richland	SD	ND	MN
% of population using public transportation as their primary means of commute to work (buses, trolley cars, etc.)	2015-2016	0.00%	0.22%	0.06%	0.00%	0.51%	0.48%	3.54%	0.00%
% of population that commutes to work by walking or riding a bicycle	2015-2016	4.5%	6.4%	3.8%	5.6%	4.5%	4.0%	3.6%	4.5%

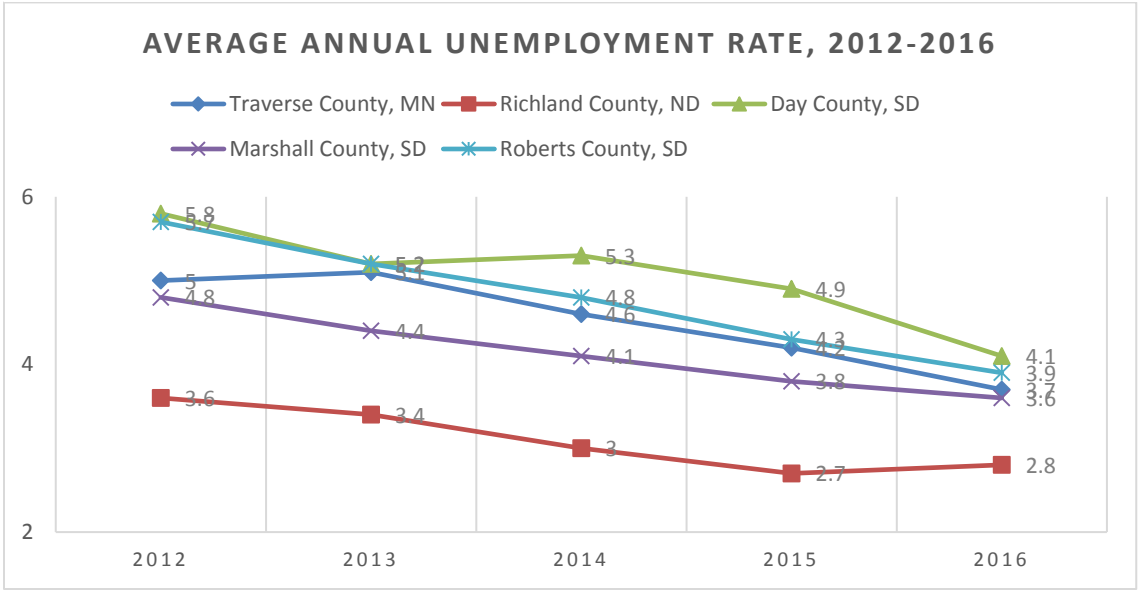
Source: American Community Survey

SOCIAL DETERMINANTS OF HEALTH

Social and economic factors, including education, income, housing, insurance, and food security, affect health outcomes more than genetics and health care combined. In the CDP Service Area, these factors are largely higher in Roberts County when compared to other counties.

Recent 2016 data reports that Day County, 3.5%, and Roberts County, 3.2%, have the highest unemployment rates in the service area, however the average unemployment rate in the service area has decreased from 2015-2016 across all counties (Figure 35).

Figure 35



Source: United State Department of Labor

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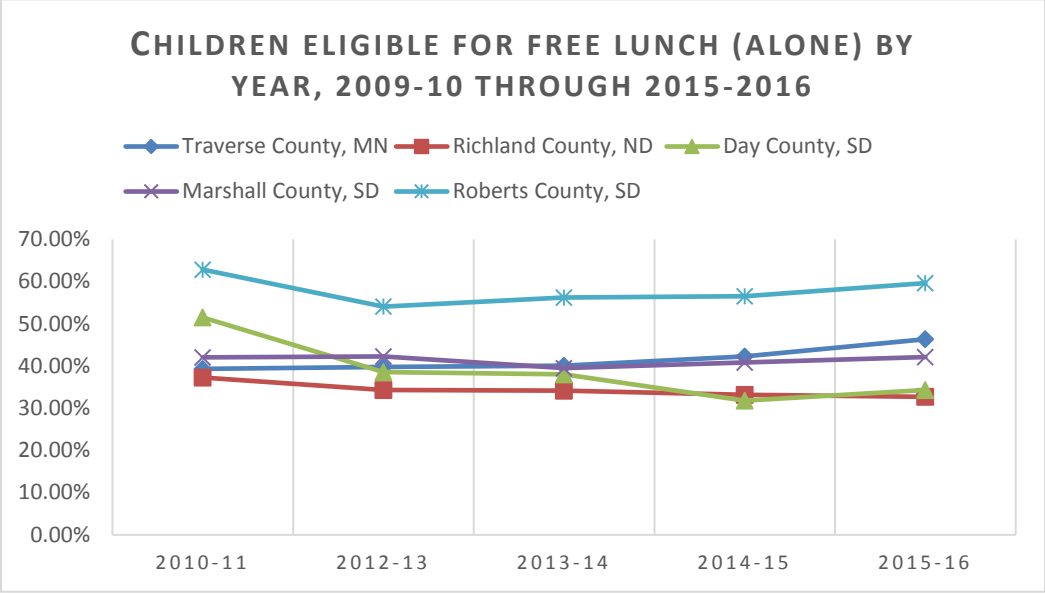
Economic security and financial resources affect residents in the CDP Service Area, with 17.9% of persons in Roberts County 100% below the Federal Poverty Level (FDL) well as approximately 25% of households with children under 18 years of age in poverty (Small Area Income and Poverty Estimates, 2016). Traverse County follows closely behind with approximately 21% of households with children under 18 years of age in poverty. Richland County, ND has the lowest percentage of persons below the 100% FDL, 10.2%, and children under 18 years of age in poverty, 11.8%. Richland County's median household income is $59,556, with Day County having the lowest median household income at $43,602. The percentage of the population who receives SNAP Benefits to supplement food is also an indicator of economic security and financial resources, with almost 21% of Roberts County receiving these benefits, which is significantly higher than other counties in the service area which range from 6.1% to 12.2%. A higher percentage of Roberts County's population is disproportionately affected by economic security and financial resources when compared to South Dakota and other states in the service area.

Education is a factor that affects health outcomes, including high school graduation rate and having a college degree. The high school graduation rate schools and school districts in the CDP Service area remained relatively unchanged in Richland County, ND, Webster, SD, and Rosholt, SD, however it has declined in the Sisseton School District, Roberts County, SD, as well as Traverse County, MN.

Children have unique health needs compared to other populations. Social, economic, and environmental factors affect children's health outcomes, including poverty, and access to health insurance. The percentage of children eligible for free or reduced lunch in the CDP Service Area increased from 2010-2016 (Figure 36) and when compared to South Dakota, Minnesota, and North Dakota. Roberts County, SD has the highest percentage of eligible children, 59.66% with Richland County, ND having the lowest, 32.39%.

Figure 36



Source: KIDS Count Data Center

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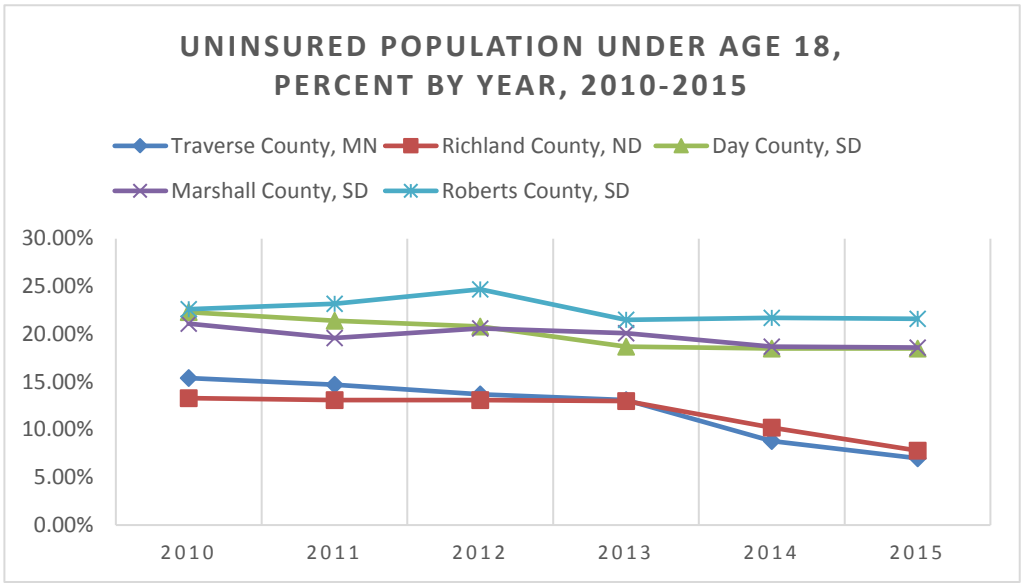
In addition, the percentage of the population under age 18 uninsured in the service area has decreased from 2010 to 2015, however almost 22% of Roberts County, SD population under age 18 are still uninsured, with Day and Marshall counties both having almost 19% of their population under age 18 as uninsured. Under 10% of Traverse County's population under age 18 are uninsured (Figure 37).

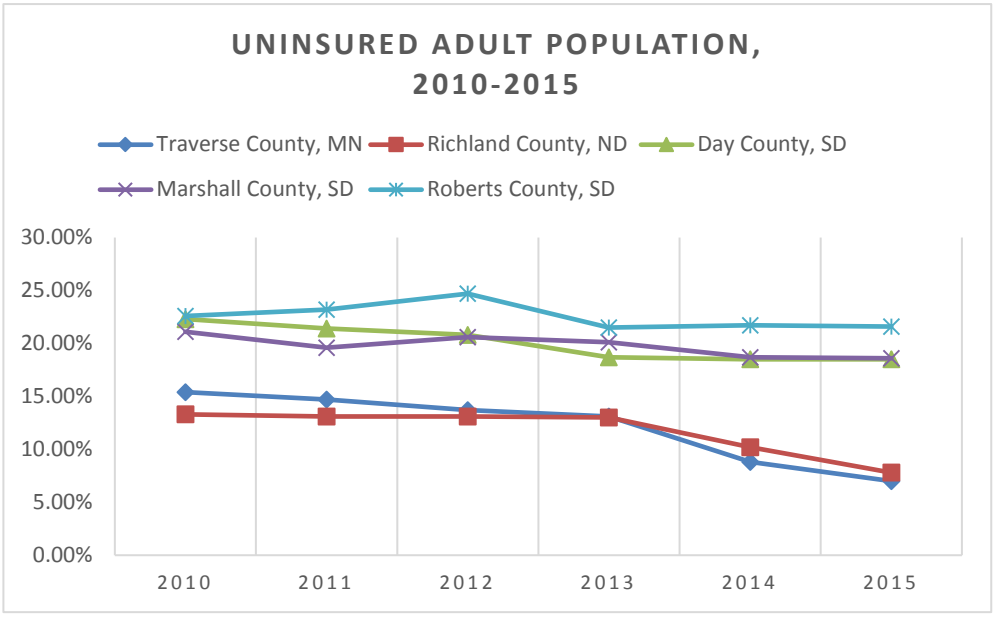
Figure 37



Source: Small Area Health Insurance Estimates

The uninsured adult population over age 18 has decreased from 2010 to 2015, however over 20% (21.6%) of Roberts County remains uninsured with only 7% of Traverse County uninsured **(Figure 38).** Further analysis indicates the uninsured population by race is highest in Native American/Alaska Natives across the service area, with Day County, SD having the highest percentage of uninsured Native Americans, 60.08%. Over 60% of the population who are Black or African American in Roberts County are uninsured.

Figure 38



Source: Small Area Health Insurance Estimates

Marshall County also has high percentage of Asian population who is uninsured, 100%.

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Housing quality and costs can place a burden on families and contribute to poor health outcomes. Substandard housing is present in approximately 20% of the CDP service area, which includes having at least one of four problems: lacks complete kitchen facilities and/or plumbing facilities, is severely overcrowded, or is severely cost burdened. 25.35% of households in Day County, SD have at least one of four housing problems, which is the highest burden compared to other counties in the service area. In addition, approximately 18% of households have housing costs that exceed 30% of the household income, with 25.03% Day County, SD households whose housing costs exceed 30% of the total household income. The rate of HUD-funded assistance house units available to renters in the service area is highest in Traverse County, MN, which is significantly higher than other counties in the service area, as well as is higher than the Minnesota state rate of 390.51 (Table 12).

Table 12

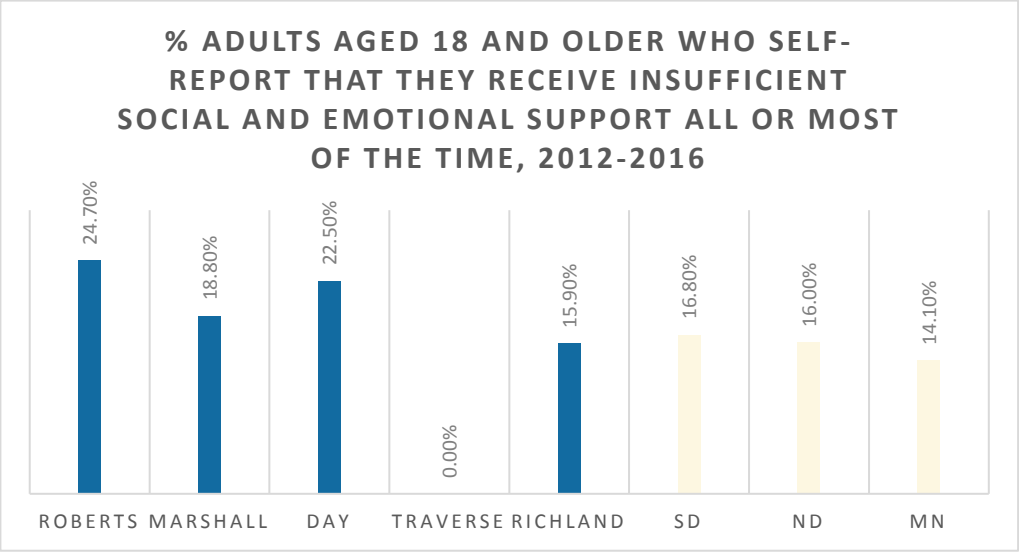
Indicator	Years	Roberts	Marshall	Day	Traverse	Richland	SD	ND	MN
Substandard Housing (% of households having at least 1 of 4 housing problems)	2015-2016	19.80%	17.85%	25.35%	16.18%	19.55%	24.72%	22.03%	28.66%
% of the households where housing costs exceed 30% of total household income	2015-2016	18.32%	16.88%	25.03%	16.04%	19.42%	23.86%	21.45%	28.6%
Total number of HUD-funded assisted housing units available to renters per 10,000 total households	2011-2015	191.64	71.03	159.78	499.8	303.91	377.34	419.37	390.51

Source: US Department of Housing and Urban Development, 2011-2015; American Community Survey, 2015-2016

Additional factors including a lack of social and emotional support, a lack of motor vehicle, food security and lack of health insurance are important indicators of health outcomes.

Social and emotional support is linked to educational achievement and economic stability, as well as is critical to the lifespan. The percentage of social and emotional support reported in the CDP service area is approximately 20% (19.6%), with 24.7% of Roberts County reporting a lack of social or emotional support, followed closely by Day County, 22.5%. The South Dakota counties in the service area are higher when compared to South Dakota, while Richland County, ND, 15.9%, is comparable to the state of North Dakota, 16%.

Figure 39



Source: Behavior Risk Factor Surveillance System

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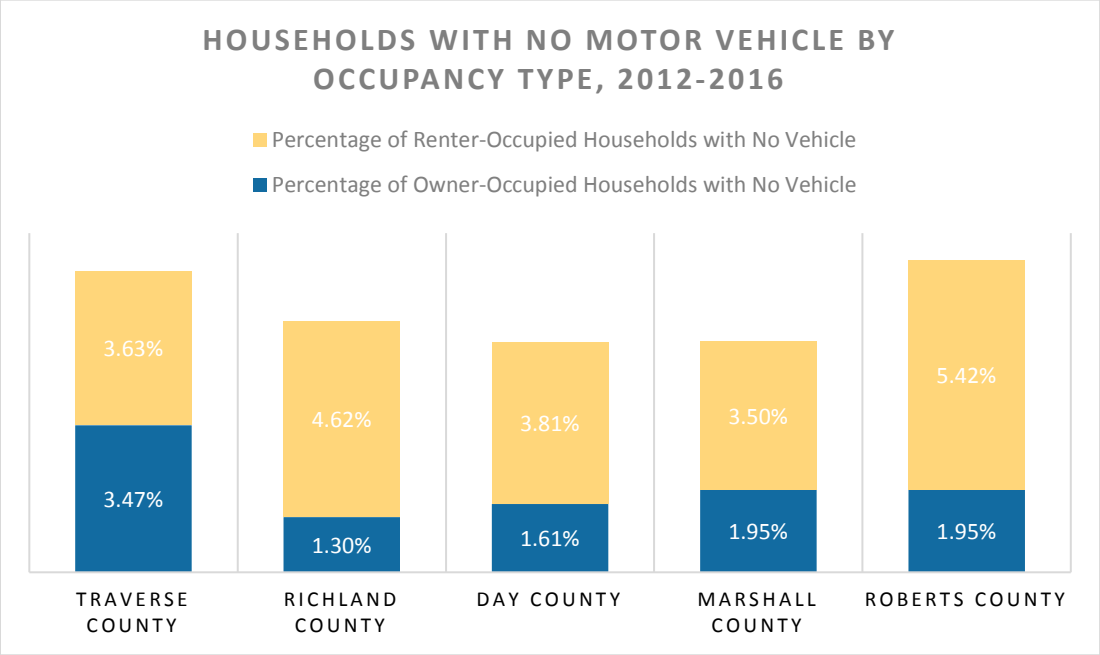
The percentage of households in the service area with no motor vehicle is less than 10% and slightly lower when compared to South Dakota, North Dakota, and Minnesota. Considering the rural nature of most counties across South Dakota, North Dakota, and Minnesota, a lack of motor vehicle present significant barriers to accessing goods and services and employment necessary to live healthy. Comparatively, the percentage of renter-occupied households with no motor vehicle is higher than owner-occupied households with no motor vehicle (Figure 40).

Figure 40



Source: American Community Survey

Food security is arguably one the more important factors that affects health outcomes because of uncertain access to adequate food due to economic and social factors. Approximately 11% of the CDP service area 18 years or older is food insecure, with over 14% of Roberts County, SD and Day County, SD populations are food insecure, which are higher than the South Dakota, 12.4%. In addition, 11.35% of Marshall County, SD residents are food insecure. The percentage of food insecure children under age 18 is higher in the CDP service area when compared to South Dakota, Minnesota, and North Dakota. Specifically, over 20% of children under age 18 are food insecure in Day County (24.35%), Roberts County (23.82%), and Marshall County (20.58%). Richland County, ND has the lowest percentage of food insecure children, 11.54%, in the CDP service area, however this higher when compared to the state of North Dakota, 10.44% (Table 13).

Table 13

Indicator	Roberts	Marshall	Day	Traverse	Richland	SD	ND	MN
% of the population that experienced food insecurity at some point during the report year	14.17%	11.35%	14.65%	9.26%	6.99%	12.40%	8.00%	10.40%
Child Food Insecurity Rate	23.83%	20.58%	24.35%	16.00%	11.54%	19.21%	10.44%	15.99%

Source: Feeding America, 2014

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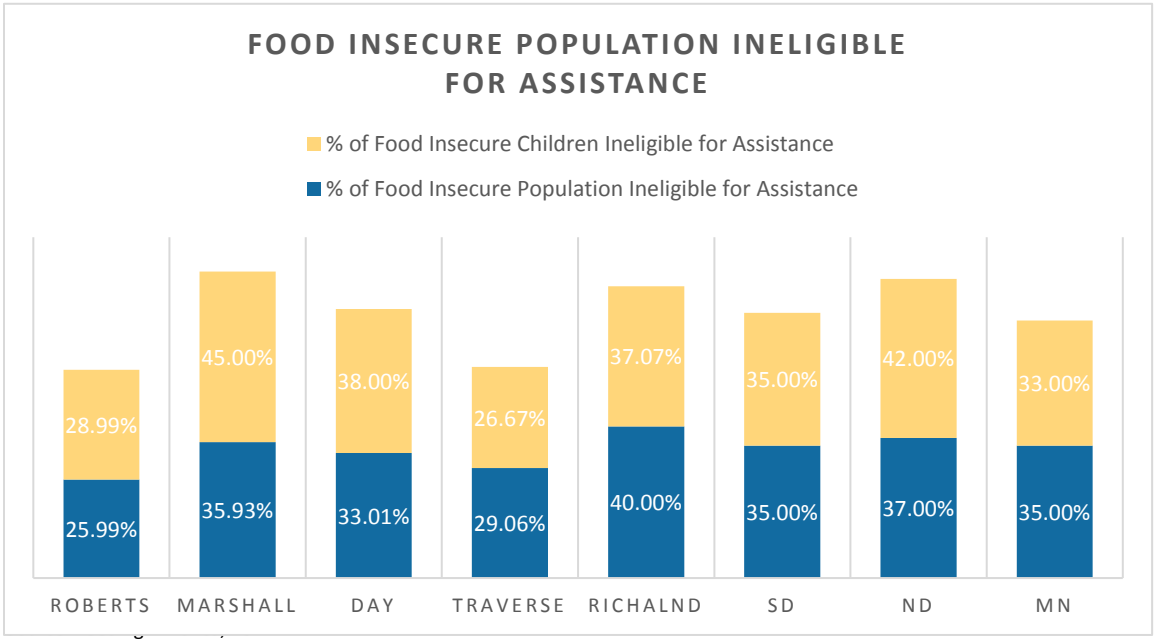
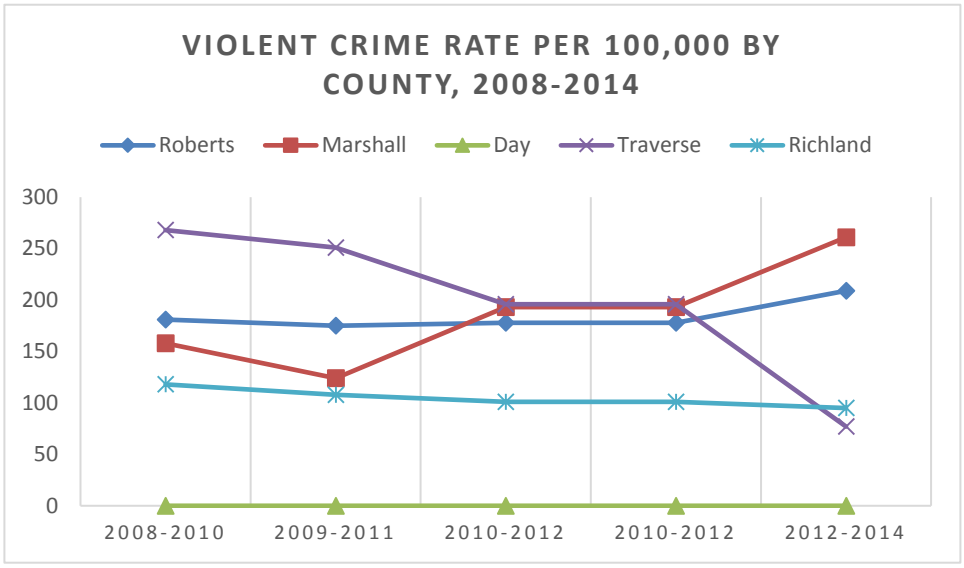
Unfortunately, over one quarter of the food insecure population in the CDP service area, including children, who are ineligible for assistance. Richland County, ND has the highest percentage of food insecure population who is ineligible for assistance, 40%, which is higher than North Dakota, 37%. Marshall County has the highest percentage of food insecure children under age 18 ineligible for assistance, 45%, which is higher than the state rate, 35%, with Traverse County having the lowest percentage, 26.67%, which is lower than the Minnesota rate, 33% (Figure 41).

Figure 41



Crime is also a factor that affects populations abilities to live, work, learn, and play if they are not safe. The violent crime rate per 100,000 in Roberts County and Marshall County has increased from 2008-2014, while rates in Traverse County, MN and Richland County, ND have decreased. Day County, SD did have data available (Figure 42).

Figure 42



Source: Uniform Crime Reporting – FBI, County Health Rankings

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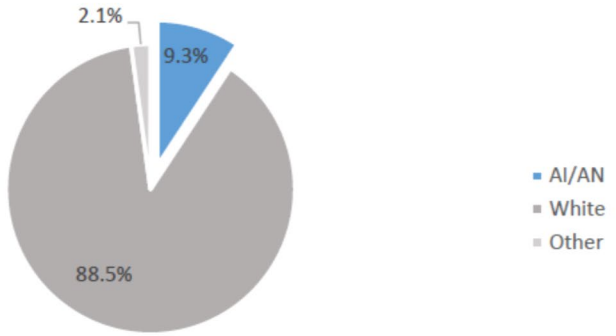
2017 Sisseton Wahpeton Oyate Community Health Profile

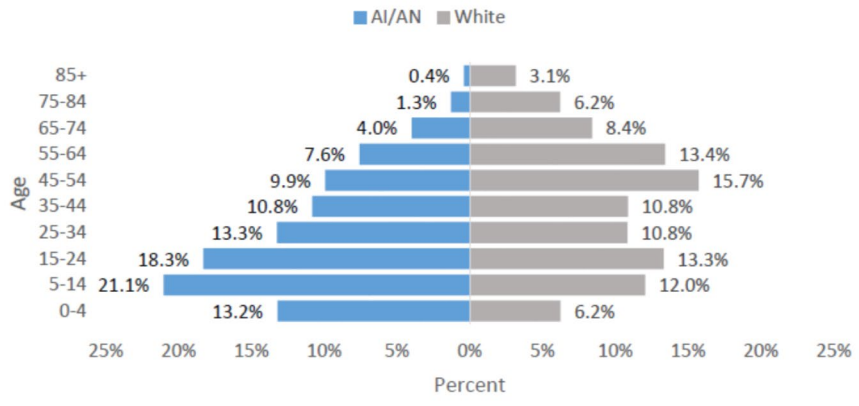
At a glance data from the Community Health Profile show that within the SWO area American Indian/Alaska Natives comprise approximately 9.3% of the population. AI/AN maters are a high risk for many risk factors, such as tobacco use and late care in their pregnancy. Chlamydia and Gonorrhea rates are high in AI/AN females. AI/AN suffer from a disproportionate prevalence of diabetes, chronic liver disease, and accidents when compared to whites. Heart disease was the leading cause of death in AI/AN in the SWO, with suicide as the 10th leading cause of death.

Figure 1: Distribution of Race, Sisseton-Wahpeton Oyate Area, 2010[1,2]



Source: U.S. Census Bureau.

Figure 2: Distribution of Age by Race, Sisseton-Wahpeton Oyate Area, 2010[1,2]



Source: U.S. Census Bureau.

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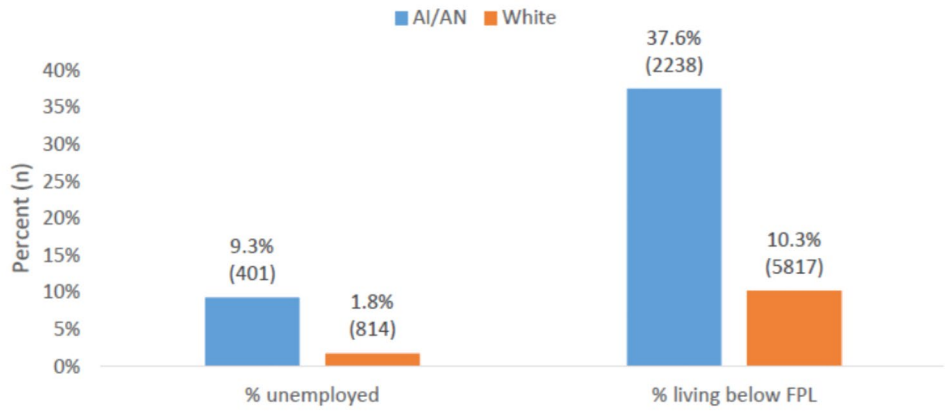
Figure 3: Economic Indicators by Race, Sisseton-Wahpeton Oyate Area, 2011-2015[1, 2, 3, 4]



Source: American Community Survey, U.S. Census Bureau.

Table 1: Maternal Risk Factors by Race, Sisseton-Wahpeton Oyate Area, 2011-2015[2]

Maternal Risk Factors	Births to teens 17 & under		Births to teens 18-19		Reported tobacco use during pregnancy		Diagnosed with or treated for an STD during pregnancy		Diagnosed with or treated for Gestational Diabetes during pregnancy	
	AI/AN	White	AI/AN	White	AI/AN	White	AI/AN	White	AI/AN	White
SD Counties	44	31	82	133	354	513	75	49	43	142
ND Counties	NR	NR	NR	15	11	135	8	24	5	5
Live Births	954	3769	954	3769	954	3769	954	3769	954	3769
Min Total	45	32	83	148	365	648	83	73	48	192
Percent	4.7%	0.8%	8.7%	3.9%	38.3%	17.2%	8.7%	1.9%	5.0%	5.1%
Max	48	35	86	148	365	648	83	73	48	192
Percent	5.0%	0.9%	9.0%	3.9%	38.3%	17.2%	8.7%	1.9%	5.0%	5.1%

Source: North Dakota Department of Health; South Dakota Department of Health

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Table 2: Time of Entry into Prenatal Care by Race, Sisseton-Wahpeton Oyate Area, 2011-2015[2, 5]

Time of Entry into Prenatal Care	1st Trimester		2nd Trimester		3rd Trimester		No Prenatal Care (OR UNKNOWN)	
	AI/AN	White	AI/AN	White	AI/AN	White	AI/AN	White
SD Counties	409	2220	360	535	99	81	29	33
ND Counties	46	792	7	57	NR	40	NR	11
Live Births	954	3769	954	3769	954	3769	954	3769
Min Total	455	3012	376	592	100	121	30	44
Percent	47.7%	79.9%	38.5%	15.7%	10.5%	3.2%	3.1%	1.2%
Max Total	455	3012	376	592	103	121	33	44
Percent	47.7%	79.9%	38.5%	15.7%	10.8%	3.2%	3.5%	1.2%

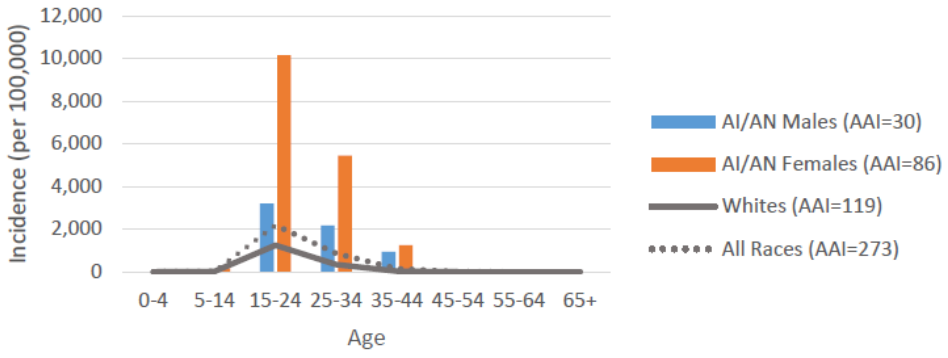
Source: North Dakota Department of Health; South Dakota Department of Health

Table 3: Infant Mortality Rate by Race, Sisseton-Wahpeton Oyate Area, 2011-2015[2, 6]

Time of Entry into Prenatal Care	Infant Mortality (birth – 364 days)		Neonatal Mortality (birth – 27 days)		Post-neonatal Mortality (28 – 364 days)	
	AI/AN	White	AI/AN	White	AI/AN	White
SD Counties	8	12	3	8	5	4
ND Counties	0	NR	0	NR	0	0
Live Births	954	3769	954	3769	954	3769
Min Total	8	13	3	9	5	4
Rate (per 1,000)	8.4	3.4	3.1	2.4	5.2	1.1
Max Total	8	16	3	12	5	4
Rate (per 1,000)	8.4	4.2	3.1	3.2	5.2	1.1

Source: North Dakota Department of Health; South Dakota Department of Health

Figure 7: Average Annual Incidence of Chlamydia by Race and Age, Sisseton-Wahpeton Oyate Area, 2012-2016[1, 2, 7]



Source: North Dakota Department of Health; South Dakota Department of Health

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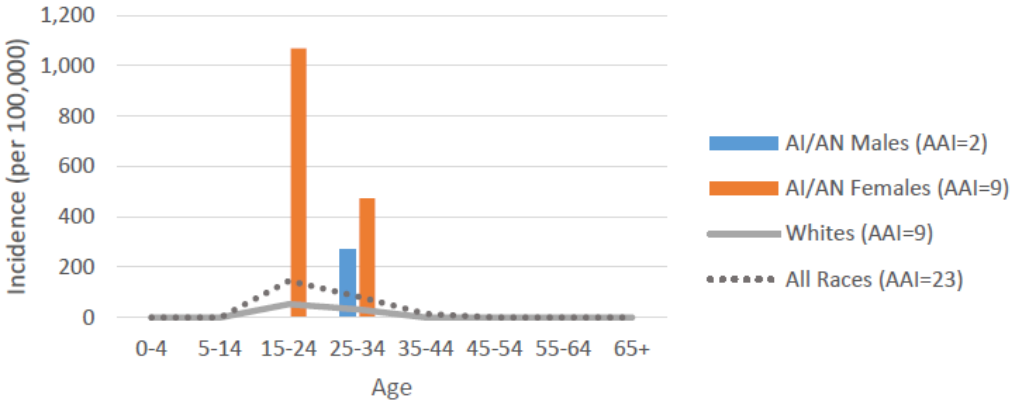
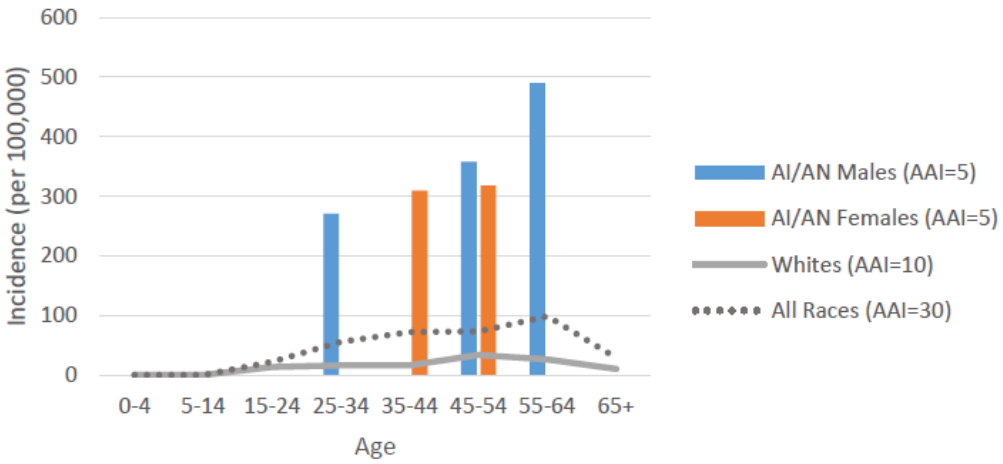
Figure 8: Average Annual Incidence of Gonorrhea by Race and Age, Sisseton-Wahpeton Oyate Area, 2012-2016[1, 2, 7]



Source: North Dakota Department of Health; South Dakota Department of Health

Figure 9: Average Annual Incidence of Hepatitis C by Race and Age, Sisseton-Wahpeton Oyate Area, 2012-2016[1, 2, 7]



Source: North Dakota Department of Health; South Dakota Department of Health

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2017 Sisseton-Wahpeton Oyate Community Health Profile

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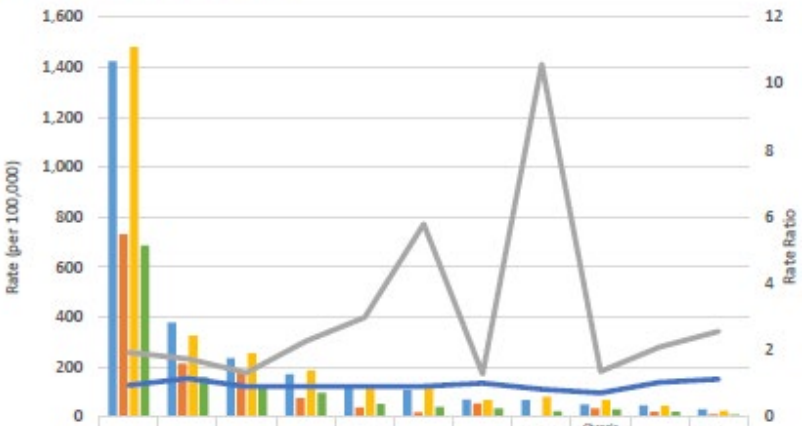
Figure 10: Leading Causes of Mortality by Cause and Race, Sisseton-Wahpeton Oyate Area, 1990-2014[2,8]



	All Causes of Death	Diseases of Heart	All Malignant Cancers	Other Cause of Death	Accidents and Adverse Effects	Diabetes Mellitus	Cerebrovascular Diseases	Chronic Liver Disease and Cirrhosis	Chronic Obstructive Pulmonary Disease and Allied Cond	Pneumonia and Influenza	Suicide and Self-Inflicted Injury
SWO/AI/AN RATE	1423.9	378.7	235.9	173.3	117.5	110.0	70.6	68.8	50.7	47.4	31.2
SWO WHITE RATE	701.5	215.8	176.9	76.1	39.3	19.0	54.2	6.5	36.9	22.5	12.1
GP AI/AN RATE	1480.6	325.0	255.6	187.5	128.0	118.2	68.7	82.1	69.3	45.3	27.3
US AI/AN RATE	686.4	160.4	125.9	96.7	53.2	40.3	36.3	23.5	31.1	22.8	10.7
SWO AI/AN TO SWO WHITE RATE RATIO	1.95	1.75	1.33	2.28	2.99	5.79	1.30	10.58	1.37	2.11	2.58
SWO AI/AN TO GP AI/AN RATE RATIO	0.96	1.17	0.92	0.92	0.92	0.93	1.03	0.84	0.73	1.05	1.14

Source: Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) SEER*Stat Database: Mortality - All CDD, Aggregated With County, Total U.S. (1990-2014) <Katrina/Rita Population Adjustment> - Linked To County Attributes - Total U.S., 1969-2015 Counties, National Cancer Institute, DCCPS, Surveillance Research Program, released December 2016. Underlying mortality data provided by NCHS (www.cdc.gov/nchs).

COMMUNITY RESOURCE INVENTORY

Information gathered from partner organizations and stakeholders highlighted a variety of resources and services available in the CDP service area to support healthy living. However, the CDP still struggles with access to primary care and resources to support physical activity and access to healthy food. Assessment of resources available identify some gaps and needs to better support healthy living. A list of the resources in the Community Resource Inventory is included in the Appendices.

LIMITATIONS TO THE PROCESS

Low participation of a diverse sector of stakeholders and partners limited the breadth of data collected, including focus groups, community health survey, and community resource inventory, regarding health of the service area.

FOCUS GROUPS

CDP contacted several organizations to promote the opportunity to participate; however, no members from the community or stakeholders group attended. The readiness to participate from the community appears to be low due to zero participation in the second round of focus groups. It is also unclear if the community members truly understood the importance of the focus groups and the impact of the Community Health Survey.

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SURVEY

One shortcoming that is a concern to this needs assessment is the smaller survey respondent rate. The survey demographic results did not accurately reflect the population of the CDP service area. The respondents were predominantly female, with full time jobs, higher income, and Caucasian. The results of the survey also did not accurately reflect the diverse geographical area of the CDP service area. Surveys were not made available to the other clinics in the CDP health care system outside of Sisseton in a timely manner, making for fewer responses. This could produce an external threat of validity. External validity is "the ability to generalize from one set of research findings to other situations," (Buttolp Johnson & Reynolds, 2008, p. 179).

Additionally, the readiness to change was lower in surrounding communities, which resulted in the Community Health survey not being available at community events in the area. There was also a concern from the Sisseton-Wahpeton Tribe. While tribal members and representatives were part of early discussion on survey distribution, CDP staff and contractors were not made aware of an approval process to distribute the survey to tribal members. This affected the ability to reach the large Native American population within the CDP service area. This population also largely represents a population of lower income and more restriction to accessing health care.

Strategies to address some of the limitations of the data collection process will be addressed moving forward by CDP, focused on fostering current and new partnerships to support population health improvement and future CHNA processes.

SECONDARY DATA COLLECTION

Local data is not readily available to support secondary data collection and much of the data available is from the county or state levels. In addition, states do not collect the same data on indicators, so it proves challenging to compare measures throughout the CDP service area. Tribal data is also not always feasible to access, thus a clear understanding of SWO health needs is not feasible. Partners provided access to databases, that supported secondary data collection, however, additional resources provided by partner organizations would have supported comprehensive secondary data collection.

COMMUNITY RESOURCE INVENTORY

Information was collected from partners organizations and existing resources in the CDP service area regarding available services and resources. A thorough inventory would be better supported in the future by collecting more information directly from partners and at stakeholder meetings. An Assett Mapping process may be considered in the future to support comprehensive information gathering.

COMMUNITY HEALTH PRIORITY ISSUES

The CDP leadership team and key partners reviewed the information and data collected for the process and identified six priority areas that CDP will focus on. Priorities were identified based on current efforts underway to address the community's health issues, capacity of CDPHCS and partners to address issues, significance of the health issues, and to build on CDPHCS' prior work to address population health in the CDPHCS service area. Obesity and Chronic Disease Management (e.g., heart disease, diabetes) were identified as the number one priority. Efforts to address these identified priorities will be implemented through existing partnerships, as well as building multi-sector partnerships with the SWO tribe and other key partners in the community. CDP

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will also seek external expertise to support systems change approach that focuses on population health and prevention.

1. Obesity and Chronic Disease Management	4. Suicide Prevention
2. Behavior and Mental Health	5. Preventative Services
3. Alcohol, Drug, and Substance Use/Abuse	6. Access to care/telehealth for patients

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COMMUNITY HEALTH IMPROVEMENT PLAN 2018-2021

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2018-2021 IMPLEMENTATION STRATEGY

1. Obesity and Chronic Disease Management

Obesity is prevalent across the CDP service area, along with associated chronic diseases, heart disease and cancer. In addition, a large percentage of the population in the CDP service area does not engage in regular physical activity and consumption of healthy foods. Poor access to food and physical activity opportunities in the CDP service area are barriers to addressing factors that contribute to obesity and chronic diseases. CDP will focus on addressing the following activities to support this priority:

- Research development of Case Management Program for CDP patients to set strategy to improve the care of patients with chronic disease diagnosis and obesity.
- CDP will promote patient education programs to patients, the community and partners that focus on the chronic disease management, fruit and vegetable consumption, as well as breastfeeding to support infant and maternal health. Specifically, program such as the Better Choices, Better Health chronic disease management program will be promoted within the CDP service area. This program is available throughout South Dakota and currently there are trained facilitators in the CDP service area, available to host and facilitate these trainings. Patient education programs will also focus on the consumption of fruits and vegetables, such as the Pick It, Try It, Like It campaign…In addition, we will work with local partners, such as the WIC office to provide patient education to improve adoption of breastfeeding practices.
- CDP will create and promote a wellness committee for health enrichment of the CDP staff.
- CDP will develop a staffing plan, budget and design for a patient advocacy program that supports the strategies to address obesity and chronic disease management.

2. Behavioral and Mental Health

CDP will build off of work outlined in the 2015 Implementation Plan and continue to implement a dual approach to address mental health issues in the CDP service area, focused on 1) creating and promoting an active place program for individuals afflicted by mental health issues and 2) partner with local law enforcement and mental health care providers to address and refine the mental health hold process to lessen wait time and increase access to care. We will work with health care providers to enhance screening of patients for mental health issues. We will also explore strategies to educate community members and patients life coping skills, as well as how to engage parents with their children more and be aware of any mental health issues their children may be facing.

3. Drug, Alcohol, and Substance Use and Abuse

CDP will build off of the work outlined in the 2015 Implementation Plan for drug, alcohol, and substance use and abuse.

- We will establish and foster partnerships with local community groups, including the SWO tribal health board and Indian Health Service, to address the chronic issue of alcohol and drug use/abuse in the surrounding community. Specifically, CDP aims to target its prevention and risky behavior education towards the community's youth via partnership with area school districts, both public and private, to reinforce existing messaging mediums and expand programming.

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- In addition, CDP plans to create consistent and direct messaging to its patients and other impacted community members about active referral services for adults with chronic alcohol abuse issues. Provider education will be provided and fostered to support care practices and referrals for affected patients.
- In an effort to best coordinate these services, both inpatient and within the community, CDP will leverage the patient advocacy program in response to medical care close to home. The active placement program described above in addressing mental health care would also be leveraged here as well, wherein CDP could ultimately be in a position to improve the quality of services available in the community and increase access to those services for individuals with alcohol addiction.
- We will explore partnering with the Bright Start program to provide further education to current tobacco users, such as pregnant mothers, as well as referrals to available programs.

4. Suicide Prevention

CDP will build off of activities outline in the 2015 Implementation Plan focused on suicide prevention, including:

- Continue collaborate with existing community partners to increase awareness of suicide and prevention strategies. Existing partnerships, such as the Aliive Roberts County Coalition, is important to foster in order to identify new partners and stakeholders to support suicide prevention efforts.
- CDP will explore strategies to integrate routine suicide screenings into care and educate health care providers comfort and understanding to discuss and assess suicide risk with patients.
- CDP will explore partnership opportunities with SWO and organizations who can support a “Zero Suicide Model” for suicide prevention.

5. Preventative Services

Secondary data and findings from the community survey found that higher rates of chronic diseases in CDP service area, as well as are not accessing preventive services as recommended to address and/or prevent chronic diseases.

- We will promote recommended preventative services, including develop and distribute educational materials and information regarding preventative services, such as Colorectal and Breast Cancer screening, FlutFit kits, heart disease, etc., to CDP patients and the community. Additional education efforts will focus a community campaign, “Know your Numbers”.
- We will also work with CDP providers to encourage referrals to utilized preventative services.
- Efforts to support these active will be guided by development of a staffing plan, budget, and design for implementation of multicomponent interventions for preventative services.
- CDP will partner with local health service agency to advocate for preventative services, as well as Sisseton-Wahpeton Oyate tribal colon campaign that has been ongoing and was implemented three years ago.

6. Access to care and telehealth for CDP Patients

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Data from the CHNA highlight the challenge for patients in the CDP service area to access care, including physicians and geographic distance to CDP services.

- CDP will develop and execute a tactical plan for recruitment of family practice providers.
- In addition, we will explore options for reducing barriers to accessing care by extending after hours of operation, including after hours, extended hours, weekend, and a walk-in clinic.
- Physician recruitment will continue for family practice physicians.

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2015 IMPLEMENTATION STRATGIES

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DEMONSTRATING IMPACT

The 2015 CHIP identified the following priorities to address unmet needs in the community:

1. Access to care, close to home
    a. Raise community awareness of CDP's current services
    b. Create and promote a patient advocacy program
2. Access to mental health care
    a. Create and promote an active placement program for individuals with mental illness to ensure access to and continuity of care.
    b. Partner with local law enforcement and mental health care service providers to redefine the mental health hold process at the local level in order to lessen wait time and increase access to care for community members.
3. Alcohol and drug use/abuse
    a. Target education towards the community's youth via partnership with area school districts, both public and private, to reinforce existing messaging and expand programming.
    b. Create consistent and direct messaging to our patients and other impacted community members about active referral services for adults with chronic alcohol abuse issues.
    c. CDP will leverage the patient advocacy program previously described in response to medical care close to home to address alcohol & drug use/abuse and related mental health needs.
4. Suicide Prevention
    a. Continue collaboration with existing community partners to increase awareness within the community of suicide incidence and prevention.
    b. Enhance existing partnership with Aliive Roberts County Coalition to encourage and recruit new community partners to contribute to the common mission of increased suicide awareness and prevention.
    c. The active placement program described above in in address mental health care and alcohol addiction would also be leveraged here as well.
5. Physician/specialist recruitment
    a. Execute the tactical plan already underway for CDP.
    b. Investigate formal agreements with other independent hospitals and/or or health systems to either provide services in the community.
    c. Continue relationship building with Indian Health Services in an attempt to build bridges of health services.

Efforts that have been implemented to address those priorities and demonstrate that CDP is making an impact, including the following:

Access to Care, Close to Home
• CDP worked to create new small media materials, including provider rack cards, services line cards, et. to raise community awareness of CDP services. • We established and implemented the federal Health Homes program, which focuses on services of nursing care in home and coordination of services for Medicaid patients. A social worker and case manager have been hired to support this program. • Provider staffing has been restructured in clinical and ER settings for 24/7 coverage

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- CDP hosted various events to raise awareness of healthy lifestyles, prevention and screening, including a Health Expo, “Color the Day Pink”, which was a community-wide event focused on promoting health lifestyles, as well as hosted multiple 5k race events on annual basis. In addition, we collaborated with Sanford Health to offer Heart and Vascular screening to the community and CDP service area.
- An antimicrobial stewardship program was implemented as a coordinated effort to promote the appropriate use of antimicrobials including antibiotics, improve patient outcomes, reduce microbial resistance, and decrease the spread of infections caused by multiple-resistant organisms.
- Capacity for surgical services was increased to offer expanded care services to patients in the CDP service area.

Access to Mental Health Care

- CDP has collaborated with the Aliive Roberts County Coalition, a local coalition focused on mental health issues, to address access to mental health care for community members through partnership
- We partnered with many local health and law enforcement agencies to address redefining the mental health hold process focused on lessening wait time and increase access to mental health care for community members.

Alcohol & Drug Use/Abuse

- We implemented a Medical Disposal program on the CDP main campus in Sisseton which supports safe disposal of unwanted or expired medications.
- We collaborated with the Sisseton-Wahpeton Oyate Tribe, as well as Human Service Agency to set strategy to reduce alcohol and drug use in community.
- The 1000 Days Initiative research and data collection on Epi Aid on Drug use during pregnancy.

Suicide Prevention

- We continue to enhance our partnership and collaboration with the Allive Roberts County Coalition to focus on increasing awareness within the community of suicide incidence and prevention, as well as encourage and recruit new community partners to support these efforts.

Physician/Specialist Recruitment

- We hired an agency to support recruitment of physicians to the CDP health system and service area, which resulted in hiring two family practice physicians, one general surgeon, one OBY/GYN physician, and three Nurse Practitioners.
- CDP collaborated with the Collaborate Independent Network to support independent health care systems in the state of SD by sharing information and networking.
- We continue build relationships with the Indian Health Services and Sisseton Wahpeton Oyate tribe to build bridges of health services and access.

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APPENDICES

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COMMUNITY HEALTH SURVEY

Coteau des Prairies HEALTH CARE SYSTEM

Welcome Community Member,

Coteau des Prairies Health Care System is conducting a Community Health Needs Assessment. This process assists community leaders in understanding the health status of the area and identifying priority health issues affecting our fellow community members. **We encourage you to share your thoughts and opinions by completing this brief 10-minute survey.**

This survey is important! It is about health, daily activities, and related health issues. The last part of the survey will ask for information about you to help us learn more about our community. Your responses, along with others will be grouped together to identify issues and concerns in your community related to health. You can make a difference in your community.

Your participation is voluntary. Your individual answers are kept confidential. B Consulting, LLC has been contracted to collect and analyze survey data. B Consulting, LLC ensures that all answers are kept strictly confidential, and no identifying information will ever be linked to you.

At the end of the survey, you will have a chance to enter your email to receive updates on the needs assessment and participate in upcoming events.

Thank you for taking the time to complete this Community Health Needs survey!

If you would rather complete this survey online, go to:

https://www.surveymonkey.com/r/CDPhealth2017

If you choose to complete the paper survey, please return to the information desk at Coteau des Prairies Hospital in Sisseton.

205 Orchard Drive– Sisseton SD 57262

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Coteau des Prairies Healthcare System 2017 Community Health Survey

Please answer the questions only as they apply to you. Dot not answer questions on behalf of other family members, unless the question asks for that. You may be asked to skip some questions. If you are not sure how to answer a question, please give the best answer you can and then write any comment you wish next to the question.

Answer the questions with clear markings. Use an X or Check mark. Otherwise write in answers as requested. Please make sure written comments are easy to read.

Thank you for taking the time to complete this survey!

1.How would you rate the health of our community?

__Poor __Fair __Good __Very Good __Excellent

2.How would you rate your own personal health?

__Poor __Fair __Good __Very Good __Excellent

3.Thinking about your physical health, which includes physical illness & injury, for how many days during the past 30 days was your physical health FAIR or POOR?

_____(Number between 0-30)

4.Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health FAIR or POOR?

_____(Number between 0-30)

5.Has a doctor, nurse, or other health professional EVER told you that you have any of the following health conditions?: (Check all that apply)

__Gestational Diabetes	__High Blood Pressure	__Breast Cancer	__Prostate Cancer
__Pre-diabetes/ borderline diabetes	__Skin Cancer	__Depression	__Other Cancer (Please Specify)_____
__Diabetes	__Cervical Cancer	__High Cholesterol	__Chronic Obstructive
__Heart Disease	__Colorectal Cancer	__Alzheimer's or dementia	(COPD) Emphysema, or chronic bronchitis
__Arthritis, rheumatoid arthritis, gout, lupus,	__PTSD (Post Traumatic Stress Syndrome)	__Addiction	

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6.Was there a time in the last 12 months when you needed medical care?__Yes ____No

(If no, skip to Question 8)

7.If you needed medical care in the last 12 months, were you able to get it?

___Yes ____No *If no, why not?*

__It cost to much	__I didn't know where to go for treatment	__I didn't have childcare
__I didn't have health insurance	__Treatment was not available	__I couldn't get an appointment soon enough
__My insurance wouldn't cover the treatment	__I didn't have transportation	__I thought I could handle it without treatment
__I was worried about what people would think	__I was afraid of what might happen	__Other:

8. Where do you normally go to access medical care for yourself and family? (Check all that apply)

__CDP Hospital (Sisseton) __CDP Clinic (Browns Valley) __CDP Clinic (Herman)

__CDP Clinic (Sisseton) __CDP Clinic (Rosholt) __Indian Health Services

___Other (Please specify):

9. What type of healthcare coverage do you have?

__None	__Medicaid	__Medicare
__Health insurance through employer	__Heath insurance individual or family	__Indian Health Services
___Prepaid Plans (HMOS)	___Other (Please specify):	

10. Where do you get most of your health-related information? (Choose all that apply)

__Government websites (i.e. Local public health, CDC)	__Non-government websites (i.e. WebMD)	__Medical professional
__Television	__Alternative health	__Family or friends
__Magazine, newspapers, books	__Health Helpline (Telephone)	__Other (Please specify):

11.Was there a time in the last 12 months when you needed treatment or counseling for a personal problem or mental health condition? ____Yes ____No

(If no, skip to Question 13)

12. If you needed treatment or counseling for a personal problem or mental health condition in the last 12 months, were you able to get it?

___Yes ____No *If no, why not?*

__It cost to much	__I didn't know where to go for treatment	__I didn't have childcare
__I didn't have health insurance	__Treatment was not available	__I couldn't get an appointment soon enough
__My insurance wouldn't cover the treatment	__I didn't have transportation	__I thought I could handle it without treatment
__I was worried about what people would think	__I was afraid of what might happen	__Other :

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13. **Was there a time in the last 12 months when you needed medication?**

____Yes ____No (If no, skip to Question 15)

14. **If you needed treatment or counseling for a personal problem or mental health condition in the last 12 months, were you able to get it?**

___Yes ____No *If no, why not?*

__It cost to much
__I didn't know where to go for medication
__I thought I could handle it without medication
__I didn't have health insurance
__Medication was not available
__I couldn't get an appointment soon enough
__My insurance wouldn't cover the medication
__I didn't have transportation
__Other:
__I was worried about what people would think
__I was afraid of what might happen

15. **Was there a time in the last 12 months when you needed treatment or counseling for your use of alcohol or any drug, not counting tobacco use?**

____Yes ____No (If no, skip to Question 17)

16. **If you needed treatment or counseling for a personal problem or mental health condition in the last 12 months, were you able to get it?**

___Yes ____No *If no, why not?*

__It cost to much
__I didn't know where to go for medication
__I thought I could handle it without medication
__I didn't have health insurance
__Medication was not available
__I couldn't get an appointment soon enough
__My insurance wouldn't cover the medication
__I didn't have transportation
__Other :
__I was worried about what people would think
__I was afraid of what might happen

17. **Which of these preventative services have you had in the last year? (Check all that apply)**

__Blood Pressure Screen
__Blood Sugar Screen
__Bone Density Test
__Cardiovascular Screen
__Cholesterol Screen
__Dental Screen
__Flu Shot
__Glaucoma Test
__Hearing screen
__Immunizations
__HPV Test
__Hysterectomy
__Blood stool test
__Pelvic Exam
__STD Test
_Vascular Screen
__Breast Cancer Screen
__Cervical Cancer Screen
__Prostate Cancer Screen
__Skin Cancer Screen
__Other (Please specify) _____

18. **What is the primary reason you did not access preventative health care services in the last year? (Choose one)**

__Doctor hasn't suggested
__Fear of results
__Cost
__Unable to access care
__Fear of procedure
__Not necessary
__Other (please specify) _____

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19. **During the past 30 days, on average, how many times per day did you:**

	___Per Day	Never	Don't know /not sure
Drink 100% fruit juices? (Not including fruit-flavored drinks, i.e. Kool-aid, Hi-C, lemonade, sunny delight, etc with sugar added)			
Eat fruit? (Fresh, frozen, or canned)			
Eat cooked or canned beans? (refried, black, garbanzo, edamame, tofu, etc)			
Eat dark green vegetables ?(broccoli, leafy greens, spinach, etc)			
Eat orange-colored vegetables? (Sweet potatoes, pumpkin, squash, carrots, etc.			
Consume other vegetables? (V-8, corn, eggplant, peas, lettuce, or non-fried potatoes)			

20. **During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?**

___Yes ___No ___Don't know/Not sure

21. **Do you smoke cigarettes everyday, some days, or not at all?**

___Everyday ___Some Days ___Not at all

22. **Do you currently use chewing tobacco, snuff, or snus everyday, some days, or not at all?**

___Everyday ___Some Days ___Not at all

23. **Do you currently smoke electronic cigarettes or use vaping products everyday, some days, or not at all?**

___Everyday ___Some Days ___Not at all

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24. **During the last 30 days, how many days did you:**

	# between 0-30
Have at least one alcoholic beverage?	
Have 4 or more drinks in one sitting?	
Use prescription drugs that were not prescribed to you?	
Use marijuana or another product containing THC?	
Use Methamphetamine?	
Use Heroine?	

25. **In the last 12 months, have you seriously considered attempting suicide?**

___Yes ___No

26. **In the last 12 months, have you attempted suicide one or more times?**

___Yes ___No

27. **Which of the following services would you access at Coteau des Prairies healthcare system?**

__Primary Care Provider __General Surgery __Dialysis __Mental Health

__Cancer care __Long-term care __Swing bed program __Obstetrics/Birth room

__Emergency Services __Home health __Laboratory services __Radiology

__Therapy Services __Fitness Center __Diabetic Education __Telemedicine

__Community Day Care __Other (Please specify)

28. **If Coteau des Prairies offered after hours care on nights and weekends in the form of a walk-in clinic or urgent care for non emergencies, would you access services there?**

___Yes ___No __I don't know

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Please tell us a about yourself, so we can learn more about our community.

Gender: __Male __Female ___Other (Please specify)_____

Age: __18-24 years __25-34 years __35-44 years

__45-54 years __55-64 years __65-74 years

__75 or older

What is your current height, without shoes on? _____

What is your current weight, without shoes on? _____

Marital Status: __Married __Divorced __Single

__Widowed __Separated

Number of individuals in the household:_____

Individuals under 18:_____

What is the average household income?

__Less than $20,000 __$20,000-$39,999 __$40,000-$69,999

__$70,000-$119,999 __120,000 or more

Race:

__White (Caucasian) __Native American or Alaska Native __Hispanic

__Black or African American __Asian or Pacific Islander

Zip Code:_____

Highest Education Level Obtained:

__Some high school __High school diploma/GED __Associate's Degree

__Bachelor's Degree __Graduate Degree __Professional/Doctorate Degree

Which best describes your current employment situation?

__Full-time employment for wages (36+ hours per week) __Part-time employment for wages (under 36 hours a week) __Self-employed

__Homemaker __Retired __A student

__Unable to work __Out of work less than 1 year __Our of work for 1 year or more

If you would like to receive updates on the CDP Community Health Needs Assessment, please write your email below.

_____

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COMMUNITY RESOURCES

COMMUNITY-BASED

Citizen Association	
Kiwanis Club	605-698-7642
Volunteers of America	1404 W 51 St, Sioux Falls, SD 57109
Masons	605-698-3148
Sisseton Area Chamber of Commerce	City Hall, 406 2 Ave W, Sisseton, SD 57262
Sisseton Economic Development Corporation	City Hall, 406 2 Ave W, Sisseton, SD 57262
VFW Post 3342	605-698-3846
Neighborhood Association	
Friends and Neighbors Club	605-698-7550
Sisseton Area Partners for Progress	605-698-7079
Hills and Valley Riding Club	PO Box 82, Sisseton, SD 57262
Northeast Trailblazers	605-698-7829
Cultural Organizations	
Sisseton Arts Council	PO Box 313, Sisseton, SD 57262
Faith-based Organizations	
Christian Womens Club	Sisseton, SD
Sisseton Ministerial Association	120 E Chestnut, Sisseton, SD 57262
Catholic Family Services	120 E Chestnut, Sisseton, SD 57262

TRIBAL

Wac'ang'a	‘
Association of America, Indian Affairs	Sisseton, SD
Old Agency Commodity Program	Agency Village, SD
Sisseton Wahpeton Oyate, Tribal Headquarters	Agency Village, SD
Sisseton Wahpeton Oyate Child Protection Program	Agency Village, SD
Sisseton Wahpeton Oyate Community Health Representative Program	Agency Village, SD
Sisseton Wahpeton Oyate MCH Family Planning	Agency Village, SD

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HEALTH CARE SERVICES

Hospitals	
Prairie St. John Hospital and Clinic Psychiatric	Fargo, ND
Avera St. Luke's Hospital	Aberdeen, SD
Coteau des Prairies Health System	205 Orchard Drive, Sisseton, SD
Sanford Health	Fargo, ND
Essentia Health	Fargo, ND
Prairie Lakes Healthcare System	Watertown, SD
Private Physicians	
ActiveCare Chiropractic	New Effington, SD
Grimsrud Visual Clinic	Sisseton, SD
Thielen Chiropractic Clinic	Sisseton, SD
Sisseton Dental Clinic	Sisseton, SD
Medical Clinics	
Woodrow Wilson Keeble Memorial Health Care Center	Sisseton, SD
Coteau des Prairies Hospital and Clinic	Sisseton, SD
Browns Valley Clinic	Browns Valley, MN
Rosholt Clinic	Rosholt, SD
Marshall County Medical Clinic	Britton, SD
Community Health Centers, Free Clinics & Services	
Woodrow Wilson Keeble Memorial Health Care Center	Sisseton, SD
All Women Count!	Day County Medical Center, Webster; and Sanford Family Center, Webster; Avera Big Stone City Clinic, Big Stone City; Avera Milbank Area Hospital, Milbank; Milbank Medical Center, Milbank; Revillo Clinic, Revillo; Avera Marshall County Clinic, Britton; Coteau des Prairies Clinic and Hospital, Sisseton; Woodrow Wilson Keeble Memorial Health Care Center, Sisseton
Community Health Services, WIC & Family Planning	Sisseton, SD
Public Health Departments	
South Dakota Department of Health-Roberts County	10 Hickory ST, Sisseton, SD

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Bright Start Nurse Family Partnership Home Visiting	10 Hickory ST, Sisseton, SD
Catholic Family Services	10 Hickory ST, Sisseton, SD
Behavioral Health	
Roberts County Human Service Agency	301 Veterans Ave, Sisseton, SD
Community Mental Health and Mental Health Providers	
Avera St. Luke's Hospital, In-Patient Mental Health	Aberdeen, SD
Suicide Preventions Lifeline	605-273-8255
Volunteers of America Dakotas	Native Hope, Sisseton, SD
Substance Abuse Treatment and Recovery Providers	
Dakotah Pride Treatment Center	Agency Village, SD
Lutheran Social Services	Watertown, SD
SWO Native Connection Crisis Line	605-419-1036
Keystone Treatment Center	Canton, SD
Nursing Homes, Rehabilitation, Home Health & Hospice	
Tekakwitha Living Nursing Center	Sisseton, SD
Browns Valley Health Center, Inc.	Browns Valley, MN
Countryside Inn Assisted Living	Rosholt, SD
Edgewood Assisted Living	Sisseton, SD
Rosholt Care Center	Rosholt, SD
Countryside Inn	Rosholt, SD
Coteau des Prairies Hospital Home Care	Sisseton, SD
Prairie Lakes Home Care	Sisseton, SD
Prairie Lakes Hospice Sisseton/Webster Site	Sisseton, SD

MEDIA

Sota Iya Ye Yapi, Tribal Newspaper	Sisseton Wahpeton Oyate of the Lake Traverse Reservation
Sisseton Courier	Sisseton, SD
Wahpeton Daily News	Richland, ND
Marshall County Journal	Britton, SD
Reporter & Farmer	Webster, SD

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CULTURAL

Joseph N. Nicollet Tower and Interpretive Center	Sisseton, SD

RECREATIONAL

YMCA & Non-profit Recreation and Fitness Organizations CDP Fitness Center	
Sisseton-Whapeton Oyate Fitness Center	Agency Village, SD
CDP Fitness Center	205 Orchard Drive, Sisseton, SD
Private Membership Fitness Clubs	
Johnny's Gym	Sisseton, SD

FOOD SYSTEM

Full-service Grocery Stores	
Teal's Market	Sisseton, SD
Dakota Crossing	Sisseton, SD
Farmer's Market	
Sisseton Farmer's Market	Sisseton, SD

PUBLIC SAFETY

Police and Fire Departments	
Browns Valley Ambulance Service	Browns Valley, MN
Rosholt Ambulance Service	Rosholt, SD
Grant/Roberts Ambulance	Sisseton, SD
Roberts County Sheriff	Sisseton, SD
Rosholt Police Department	Rosholt, SD
Sisseton-Wahpeton Oyate Tribal Police	Agency Village, SD
Sisseton Police Headquarters	Sisseton, SD

EMPLOYMENT

Unemployment and Job-placement Services	
South Dakota Career Center	Sisseton, SD

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Sisseton-Whapeton Oyate Tribal Employment Right	Agency Village, SD

TRANSPORTATION

Public Transportation Providers	
Community Transit	605-698-7511

HOUSING

Homeless Prevention and Housing Organizations	
Sisseton Wahpeton Oyate Housing Authority	605-698-3463
Weatherization, Home Improvement, and Home Safety Programs	
Grow South Dakota	605-698-7654

EDUCATIONAL

Childcare and Preschool Providers (0-5)	
Early Childhood Intervention Program	Agency Village, SD
Head Start NESD	Sisseton, SD
Rainbow Daycare	Sisseton, SD
SWO Head Start	Agency Village, SD
Westside After School Program	Sisseton, SD
K-12 School Districts	
Browns Valley School District	Browns Valley, MN
Enemy Swim Day School	SWO
Rosholt School District	Rosholt, SD
Sisseton School District	Sisseton, SD
Tiospa Zina Tribal School	SWO
Colleges and Universities	
Sisseton Wahpeton Oyate College	Agency Village, SD
Public Libraries	
Browns Valley Public Library	Browns Valley, MN
Sisseton Memorial Library	Sisseton, SD

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ORGANIZATIONAL

Multi-sector Coalitions	
Aliive Roberts County Coalition	Sisseton, SD
Alcoholics Anonymous	Sisseton, SD
Gamblers Anonymous	Sisseton, SD

GOVERNMENT

City/state/Local Government	
Veterans Services	Sisseton, SD
South Dakota Highway Department	Sisseton, SD
South Dakota State University Extension Office	Sisseton, SD
Telecommunications	
Venture Communications	Sisseton, SD

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16) South Dakota Department of Health. (2007-2015). *South Dakota Youth Risk Behavior Survey Summary.*
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