2012 Community Health Needs Assessment Summary & Implementation Strategy

An assessment of the surrounding community, including the tri-state area, conducted jointly by Sumption & Wyland, Sage Project Consultants, LLC, and Coteau des Prairies Hospital

During 2012 a community health needs assessment (CHNA) was conducted by two independent consulting firms – Sumption & Wyland and Sage Project Consultants, both of Sioux Falls, SD, on behalf of Coteau des Prairies Hospital & Clinic based out of Sisseton, SD. The assessment targeted the surrounding community, considering the needs of over 3,800 individuals within the defined research area including adjacent rural communities such as Peever, SD; Rosholt, SD; Wheaton, MN; and Browns Valley, MN. The town of Sisseton, population 2,470[1], serves as both the county seat for Roberts County as well as the location of Coteau des Prairies Hospital. The area is classified as both rural and medically underserved[2], with the closest hospitals located approximately 50 miles away (critical access hospitals in Britton, SD; Milbank, SD; and Webster, SD). The closest larger, non-critical access medical facility is nearly 60 miles away (Watertown, SD). Coteau des Prairies is the only clinic and hospital provider in the community of Sisseton with the exception of Woodrow Wilson Keeble Memorial Health Care Center, an facility managed by Indian Health Service, also located in Sisseton.

Established in 1967, Coteau des Prairies Hospital & Clinic (CDP) has long been serving the community of Roberts County and the surrounding area. The Hospital's mission is to provide "Quality Care with a Personal Touch, Close to Home". CDP is governed by an 11-member Board of Directors.

CDP is a 25 bed, critical access acute care, community non-profit hospital that serves approximately 21,000 residents in the Glacial Lakes Region in north east South Dakota, and west central Minnesota. CDP Hospital, Inc. owns and operates the attached certified rural health clinic in Sisseton, the Browns Valley Clinic, which is located in Browns Valley, MN, and the Rosholt Clinic, in Rosholt, SD. In 1996, a 14,000 sq foot addition and remodeling project was completed, followed by a large clinic expansion and remodeling project in 2000. Currently, the hospital is poised to complete a multi-million renovation and expansion effort in 2013; the 22,000 square foot addition involves a new clinic, emergency room, laboratory and radiology department to support a growing number of patient visits.

Target Areas and Populations

Five (5) zip code areas were identified by the consultants and CDP CHNA team as comprising more than 75% of the service area of the Hospital; this area was the primary focus of community-based data for the assessment and action planning activities. As the area is largely rural with low population per sq mile, a broader geographic scan was conducted for secondary research of public data sets, including an area of just over 3,400 sq miles representing the counties of Day, Grant, Marshall, and Roberts in South Dakota; Richland and Sargent in North Dakota; and Big Stone and Traverse in Minnesota.

---

[1] 2010 U.S. Census Bureau; Sisseton, South Dakota
[2] HRSA; Roberts Service Area. Designation date: 1978/11/01

The area also represents a known area of disparate population (Agency Village) and includes a vast rural area surrounding and to the east of Sisseton, SD. Rural elderly are also considered a disparate population group within this region. The community of Sisseton is defined as medically underserved and thus including the entire population of this community was necessary in order to address the needs of this small, remote community in north east South Dakota.

The majority of residents (46.1%) in the area are between 18 and 65 years of age. Roberts County had a greater percentage of elderly residents (17.3%) than South Dakota overall (14.3%). The population is predominantly white, with Roberts County demonstrating the highest American Indian population (34.5% of the total population in Roberts County is American Indian).

Description of the Community served by the Hospital

Sociodemographics

- Roberts County has experienced a slight population increase (1.3% change) since 2000, which is lower than South Dakota's overall population increase (7.9% change).
- The SD-based counties in the research area demonstrate higher than state average (14.3%) percent of the population being classified as elderly (65+).
- All of the counties in the research area have homeownership rates higher than their respective state averages.

Socioeconomics

- The SD- and MN-based counties of the research area demonstrate lower than state average median household income and per capita money income rates.
- The unemployment rates in South Dakota, North Dakota, and Minnesota are 4.8%, 4.3%, and 8.0% respectively. The SD-based counties and ND-based counties within the study area all exhibit higher than state average unemployment rates. The MN-based counties within the study area exhibit lower than state average unemployment rates.
- All but one county in SD is above the state average for persons (%) below poverty, that being Day County (11.6%). Generally, the SD-based counties have much higher rates of persons below poverty than other counties within the study area.
- Roberts County [SD] has a much higher rate of children in poverty as compared to the other counties.
- All counties surveyed demonstrated high school graduate/GED completion rates less than their respective state averages, the lowest of which was found in Grant County [SD].
- Marshall and Roberts Counties in South Dakota demonstrate higher than state average access to healthy food, whereas Day and Grant Counties are significantly lower in this regard with less than 30% of people residing in those areas having access to healthy food sources.

Community Health Profile

- According to County Health Rankings, Roberts County ranks #45 in Health Factors and #21 in Health Outcomes as compared to other counties within the State.
- Roberts County's leading cause of death, like the State of South Dakota, is heart disease. Second to heart disease is cancer, followed by accidents and cerebrovascular disease.
- Roberts and Grant Counties both exhibited higher than state average cause of death by suicide. 18.4 incidences per 100,000 population of

suicide were noted for Roberts County. The state average is 16.0 deaths per 100,000 population.
- Day County has a higher rate of reported cases of female breast cancer than the state average; all other SD-counties within the study were below state average rates.
- Roberts, Marshall, and Grant Counties all demonstrate higher than state average incidence rates for colorectal cancer. The incidence rate in Grant County is more than double that of the state average.
- Roberts County has a higher incidence of obesity (33%) than the state average.
- An age-adjusted estimate of the prevalence of diabetes in South Dakota is 6.4% of the total population. Counties in this area with rates higher than the State average include: Day (7.3%), Grant (7.1%), Marshall (7.2%), Roberts (8.5%), Sargent (7.3%), Big Stone (6.5%) and Traverse (6.6%).
- Percentage of the population in each county utilizing the Supplemental Nutrition Assistance Program (SNAP) to aid with monthly food expenses is less than the State average (12.4%) with the exception of one county, Roberts (20.7%).
- Physical inactivity rates for this region are all higher than the State average, 26%.
- All SD-based counties within the research area were above the state average for adult smoking rates.

Healthcare Access & Utilization
- For South Dakota specifically, sixteen percent (16%) of adults (age 18-65) are uninsured, based off data from the Small Area Health Insurance Estimates provided by the U.S. Census Bureau. Counties that had higher rates than the State average include: Day (22%), Marshall (24%), and Roberts (22%).
- 14.1% of the statewide population is eligible for medical programs through the SD DSS (Medicaid and CHIP); out of the SD-based counties surveyed only Roberts County demonstrated a higher than state average eligibility rate at 21%.

How the Assessment was Conducted

In February 2012 Coteau des Prairies Hospital & Clinic contracted Sumption & Wyland and Sage Project Consultants, LLC, both of Sioux Falls, SD to conduct a comprehensive community health needs assessment, and to develop an action plan to address any identified needs from the assessment. The assessment was designed to accomplish several key objectives:

- Identify, assess, and report on facts, attitudes, perceptions, and ideas about the current and future health of the surrounding community.
- Ensure compliance with the Patient Protection and Affordable Care Act of 2010, which requires all hospitals that are charitable entities (nonprofit organizations under Section 501(c)3 of the Internal Revenue Code) to perform a community healthcare needs assessment every three years.
- Engage the surrounding community members in taking a critical look at their own health status and the health status of the community at large.
- Educate the Hospital leadership of CDP about the perceived and/or actual needs of the community, and allow them the opportunity to make actionable, educated steps towards addressing some or all of those needs.

The assessment was conducted in three phases:

Phase I – Assessment Design and Collection of Secondary Data: Following initial consultation and kick-off meeting with CDP leadership the consultants queried all available public data sets regarding community health status and community demographics, including socioeconomic and sociodemographic factors. The assessment design was established, which defined the targeted research area based upon known areas of disparity overlaid with the Hospital's service area per inpatient/outpatient incidence records (2011).

Phase II – Collection of Primary Data & Needs Validation: Primary data collection was initiated with the community needs assessment survey, which was developed using established research methodology and best practices from current evaluators in the field. The survey instrument was edited and approved by the CDP CHNA team, and deployed to the community at large for their response. As a bonus, the consultants also developed and launched a similarly phrased survey instrument directed at internal staff/stakeholders of CDP to provide an internal view of the community health needs. Following the analysis of results, top need areas were identified and then further explored via two independent phone-based interview surveys, one with a random sampling of community members and one with a pre-determined list of key community leaders. Using the combined results of Phase I and Phase II the report of findings was drafted and the Community Health Needs Assessment (Appendix A) was reviewed by the CDP CHNA team.

Phase III – Development of the Implementation Strategy: Using the validated community health needs from Phase II, the consultants facilitated an action plan retreat on site in Sisseton, SD, with the CDP CHNA team to review the findings, prioritize the needs identified, and develop individual action plans for each area of priority. Specific goals and actions/objectives were formulated during the retreat and will serve as the basis for subsequent work plan development.

The assessment in its entirety (Appendix A) provides a comprehensive report of findings. The summary and implementation strategy are also available on the website of Coteau des Prairies [www.cdphospital.com], and an abbreviated version will be disseminated to the community at large (approximately 4,000 direct mail pieces) during Q1 2013. The summary and all appendices can be obtained by contacting the administrative offices of Coteau des Prairies Hospital & Clinic directly.

Health Needs Identified

The health needs identified for the community per the findings of the community needs assessment survey included the following:

- General health of the community: The majority of respondents (63.2%) categorized their personal health as good/somewhat healthy.
- Top three (3) most important needs in the Sisseton community:
    1) affordable health care services
    2) economic development
    3) affordable housing
- Top five (5) unhealthy behaviors:
    1) alcohol abuse
    2) drug abuse
    3) smoking/tobacco use
    4) illegal drug abuse
    5) poor eating habits

- Top five (5) issues of greatest concern:
  1) suicide/attempted suicide
  2) incidence of cancer
  3) incidence of chronic diseases (e.g. diabetes, heart disease)
  4) availability of services for the aging and elderly
  5) children's health
- Important community health services: Out of 15 common community service items, ranging from access to medical and dental care to availability of healthy food, all were identified by the community as "important" by at least 70% of the population. The services that scored the highest in terms of importance to the community were access to a) medical care and b) access to dental care, with more than 96% of all respondents rating this as "important". The services that scored the lowest included a) chronic disease self-management programs, b) school based sex education, and c) community parks and gardens.
- Where people go for routine health care (respondents asked to check all that apply, so percentages do not equal 100):
  1) Sisseton (93.7% respondents)
  2) Fargo, ND (16.9% respondents)
  3) Watertown, SD (16.2% respondents)
- #1 reason people go outside of the community for health services: needed services not available

Summaries: Assessments & Priorities

In an effort to validate the findings of both the secondary research and the community needs assessment survey, a series of phone-based interviews were conducted with two population groups – a random sampling of community members and a group of identified key community leaders. The interviews provided the consultants the ability to examine the identified needs of the community via more in-depth conversation.

Community Interviews: The most important healthcare resources identified by respondents that CDP should be focusing on included recruitment and retention of physicians, the provision of sustainable emergency and ambulance care to the community, and a continued investment in expanding CDP's footprint and services to better serve the community. Out of all responses (n=39), 34 or 87% indicated these issues as most important. Having "local doctors, clinics, and a hospital that will care for us" was top of mind for these respondents. While several respondents indicated that CDP was "working hard at getting new technology" and expanding its service line, that it needs to do more in the way of offering diagnostic, screening, and preventative services for the community of Sisseton.

When asked to discuss the leading causes of death in the community (heart disease, cancer, and accidents) the community respondents shared a similar story; CDP should provide more diagnostic and treatment services at the local level, or partner with other service providers that can set up outreach clinics in or near CDP. Further, in the opinion of the respondents, CDP should also do what it takes to ensure the longevity of existing high-quality emergency care that the residents feel they receive.

The respondents overwhelming advocated for the Hospital when asked what CDP could do to address affordable health care, affordable housing, and economic development – three top tier issues called out by the community survey. CDP is not in position to control or influence these issues, in the public's opinion, and should therefore continue to provide the high quality

services it already provides and simply ensure that the public, regardless of other lifestyle circumstances, has access to medical care close to home when they need it and/or choose to use it.

Community respondents largely indicated they were “not surprised” to hear that alcohol abuse was identified as the single most important unhealthy behavior in the community as per community survey results obtained in June 2012. When asked how CDP should respond, the community indicated that providing educational programs that emphasize prevention, disease/addiction awareness, and healthy living would be most effective, with particular emphasis placed on direct messaging to young adults and youth. Some respondents also indicated that this issue (alcohol abuse) was outside of the Hospital’s ability to directly control or influence, and rather attributed much of the responsibility on the individual with the problem, noting that “you can’t force people to attend helpful resources or educational efforts,” and “this is an individual choice.” In addition to the self-help, self-responsibility aspects of this social and medical issue, CDP in the eyes of the community could still have a beneficial role in turning the community into a recovery oriented one.

When asked to discuss the top resulting issues of healthcare concern as identified in the community survey (suicide/attempted suicide, chronic diseases, and services for the aging/elderly) they generally felt that CDP should continue doing what it’s doing with the exception of addressing suicide and attempted suicide. In that respect, the respondents largely advocated for a comprehensive suicide education and awareness campaign to include meetings, activities, and public-service announcements broadcast at regular intervals. Further, the respondents also advocated for the expansion of mental health care services with the addition of high quality, trained social workers and/or counselors to make better attempt at diagnosing individuals with possible mental health issues, including suicidal tendencies, and not lose those individuals to follow-up.

Finally, respondents identified the top issues that CDP should focus on moving forward: 1) provide local services/treatment and access to specialists, 2) sustain and/or expand emergency care services. Not surprisingly, these issues are synonymous to those identified earlier in the interview. The community is both consistent and clear in implying that local access to medical care, close-to-home, and the ability to effectively and with high quality triage emergency situations should be top priorities for CDP moving forward. Of note, however, there was a reasonably sized distribution of respondents that felt that CDP is providing services that are adequate, and that the needs of the community are being met as is.

Elite Interviews: The intent of the elite interview process was two-fold: a) to validate the findings of prior research conducted as part of this assessment, and b) to examine the identified needs of the community at a deeper level with a smaller, yet broad constituency of community leaders.

When asked to consider the stagnant population growth of the Sisseton area as it related to ensuring the availability of health care resources within the community respondents largely felt that their medical care should be accessible and close-to-home. Emergency care and ambulance transport need to be highly prioritized to ensure longevity of accessible, quality service. ER services were noted as both “essential” and “vital” in a community the size of Sisseton. Further, respondents indicated that a key element of a close-to-home medical model is the recruitment and retention of physicians, including specialists, to

provide services and diagnostic testing at the local level. These physicians would not only provide hospital-based services, but also have clinic hours so as to increase access to care in the community, and reduce the burden of transportation, distance, and associated costs for care in other, larger communities.

Of related note, the continuation of a reportedly strong and reliable emergency patient triage-transport system for patients at CDP was highlighted as a top priority in ensuring the needs of the community are met. By ensuring access to air flights, ambulance transports, and similar means of triage and referral to other more specialized facilities, the community feels that they are afforded the best possible care given their rural and remote location. “We have an amazing hospital for triage” and “our emergency services are set up well” represent a sampling of comments in this regard. Although emergency care was viewed in high regard in its present state, the respondents did indicate a strong need for the provision of more diagnostic and treatment services available locally. “Continue the screening partnership with Sanford [heart disease]”, and “make cancer treatment more locally available” were common themes amongst respondents in this regard.

The community survey indicated that a) affordable health care, b) economic development, and c) affordable housing were the most important needs of the community surrounding CDP.

When asked to comment on what this means at the community level, most respondents felt the relationship between “housing” and “healthcare” was intimate; “without affordable housing you cannot grow, and the hospital has a hard time bringing in staff because of this.” Further, this respondent went on to say, “Without affordable health care and housing, people are forced to choose between their necessities, and it impacts their ability to buy groceries [basic needs]. [This] causes people’s needs to not be properly met.” While the majority of interviewees felt the same as this respondent, they all generally acknowledged that the hospital (CDP) does not have much direct power or influence on this issue. In fact, nearly half (7) of all interviewees either did not know, did not respond, or indicated the hospital was not in a position to control or influence the synergy between affordable housing in Sisseton and affordable health care.

By large margin, respondents indicated that enhanced educational programs that emphasize prevention, disease/addiction awareness, and healthy living would be the most effective way in which CDP could approach the issue of alcohol/drug addiction in the Sisseton community. It was also noted by several respondents that inter-agency referrals between IHS and CDP need to happen in order to address the problem at the acute level. Finally, it was suggested that the community consider the development of a long-term rehab facility for alcohol addiction so as to broaden the continuum of care in this regard from a presently acute-treatment level to a community that is recovery-oriented.

When asked to validate the community’s concern around increasing suicide and attempted suicide rates, the respondents largely concurred. Although several respondents were careful to note that “suicide is a personal choice” and “it [suicide] is hard to predict”, most respondents agreed that a grass-roots education and awareness campaign co-sponsored by CDP and the community at large would be a step in the right direction towards reduced suicide attempts and casualties. Of close relation, community leaders felt that the expansion of mental health care services, specifically the addition of trained staff (social

workers, counselors, etc) offered by CDP would be highly beneficial to the community in addressing this recognized and validated concern.

The top three things CDP "should be doing" as it addresses the identified needs within this study include:

1. Mindful and strategic efforts towards enhanced chronic disease prevention and education, including alcoholism;
2. Expansion of mental health care services offered by CDP, with the addition of highly qualified, reputable staff to meet the various needs (e.g. depression, suicidal indicator assessments); and
3. Provide local services and treatment options to patients and their family members.

Implementation Strategy for FY2013-2015

The following summarizes the action plan developed by Coteau des Prairies Hospital's CHNA team in response to the identified needs in the surrounding community. The action plan in its full form is available upon request by contacting Dan Ellis, CEO, Coteau des Prairies Hospital at (605) 698-7647 or via e-mail at cdph@cdphospital.com. The plan below identifies what elements the Hospital aims to sustain, grow, or develop to address and respond to the prioritized needs resulting from the 2012 CHNA assessment conducted by the third-party, independent consultants and CDP CHNA Team.

How the Implementation Strategy was Developed

Project leadership and oversight was provided by CDP CEO, Dan Ellis. Other members of the CDP CHNA team included representatives from Hospital leadership as well as from the governing Board of Directors. All components of the CHNA, including but not limited to the secondary data research and analysis, community wide survey, and individual interviews were managed by the independent consultants to the project. The Implementation Strategy was developed using the findings and priority need areas established by the CHNA. The independent consultants gathered and analyzed public health data, designed and managed the community wide needs assessment survey, designed and facilitated the individual interviews, and facilitated the implementation strategy retreat for the CDP CHNA team.

A report of findings (Appendix A) for the CHNA was prepared by the independent consultants to the project and provided to CDP leadership in preparation for the implementation strategy retreat held in November 2012. The CDP CHNA team collectively reviewed, prioritized, and addressed the identified community need areas during this retreat and formulated an action plan by which to move forward over the coming three (3) years. The CDP CHNA team intends to meet on a quarterly basis to monitor progress towards achieving the goals set forth in this action plan, and to address interventions if necessary to the timeline and resource allocation in order to achieve those goals as intended.

Major Needs and How Priorities were Established

The independent consultants, with oversight from CDP leadership, undertook a structured approach to the research deployed for this project. Key steps included a 1) comprehensive review of public health data sources, including hospital association datasets; 2) a broadly distributed community needs assessment survey; 3) an internal CDP staff-stakeholder survey to provide the view of care providers; 4) individual phone-based interviews with randomly selected community members; and 5) individual phone-based elite affinity interviews with key community and business leaders from the research area. The interviews were conducted to validate and/or refute the findings from the

prior research, and to provide context for the formulation of prioritized need areas for the community.

Following the gathering of the afore-mentioned data sets and the issuance of the report of findings (Appendix A) the consultants provided the CDP CHNA team a list of identified health needs (Appendix B) which were then discussed at length during the implementation strategy planning retreat held November 7, 2012. From this master list of identified health needs the CDP CHNA team as a large group prioritized the needs using a set of criteria which included seriousness of the issue, number of individuals impacted by the issue, the appropriateness of the Hospital being involved in addressing the issue, and the presence of other community resources to address the issues.

The prioritization process identified five (5) key priority issues for the community:

1. Access to care, close to home
2. Access to mental health care
3. Alcohol and drug use/abuse
4. Suicide prevention
5. Physician/specialist recruitment

The five (5) priority issues were most heavily addressed during the implementation strategy retreat; however, the other issues of concern were also discussed and goals/actions developed by which to address those areas of concern. The full Action Plan (Appendix C) representing strategies by which to address both the priority issues and other issues of concern.

Action Plans

1. **Access to care, close to home:** CDP presently offers a variety of medical services in the community and surrounding communities (Browns Valley and Rosholt), however recognizes that the community and outreach physicians serving the community are likely not aware of some of the services that CDP offers. Presently, physicians are at times referring their patients for care outside of the Sisseton community. In order to encourage access to health care, close to home, CDP will raise awareness amongst its patients to all health and mental care services that are provided locally by a) developing educational materials to disseminate in the clinic and community at large for referral services presently available in the community; b) encouraging outreach physicians to discuss locally available referral services to their patients, and to actively refer their patients to these services; and c) promote its long-standing swing bed service line to the community as a local solution for rehabilitation. In addition, and of notable significance, CDP will create and promote a patient advocacy program by which to help its community members navigate their own health care. To do this, CDP will strategically develop, using industry best practices from other critical access/small community hospitals, a patient advocacy program to coordinate individual patient care both at home and out of town in the instance of referrals, so no one is lost to follow-up due to distance or lack of understanding. Further, CDP leadership intends to develop a staffing plan, associated budget, and procedures for the operation of a patient advocacy program out of the Hospital in Sisseton. By the end of the present implementation strategy period (FY2015) CDP intends to seek Board approval for the launch of this program, and begin providing these coordinated care services if approved.

2. **Access to mental health care:** In an effort to address the need for

accessible mental health care in the community CDP intends to utilize a dual approach: 1) to create and promote an active placement program for individuals with mental illness to ensure access to and continuity of care, and 2) to 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:** In similar fashion CDP again intends to partner with other community groups 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. 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. In an effort to best coordinate these services, both inpatient and within the community, CDP will leverage the patient advocacy program previously described 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.

4. **Suicide prevention:** CDP will continue its collaboration with existing community partners to increase awareness within the community of suicide incidence and prevention. By enhancing the existing partnership with Roberts County Alive, a community-based prevention task force, leverage that relationship to encourage and recruit new community partners to contribute to the common mission of increased suicide awareness and prevention, CDP will be poised to create direct messaging to its community members designed to educate the public on these very issues. The active placement program described above in addressing mental health care and alcohol addiction would also be leveraged here as well.

5. **Physician/specialist recruitment:** CDP is actively engaged in the execution of a previously developed tactical plan aimed at addressing this key community need. It is a strategic goal of CDP to recruit physicians and specialists to the community in order to provide high quality care close to home for its community members. CDP is investigating formal agreements with other independent hospitals and/or health systems to either provide full-time service in the community, or to augment the current service population. CDP is also continuing to coordinate with Indian Health Services based out of Sisseton in an attempt to build bridges of health services and to develop strategies that supplement the health services provided at both IHS and CDP while eliminating redundancies when possible.

Next Steps for Priority Areas

For each of the priority areas listed above, CDP intends to conduct the following next steps:

- Identify any other community, state, or regional organizations that are working in these areas of need so as to build upon prior work, and leverage best practices already developed.
- Further define the goals and actions within the Action Plan (Appendix

C) to include measures, timeline, and resource allocation so that the effectiveness of their efforts can be measured and monitored.

- Disseminate the findings of the CHNA and Implementation Strategy within the community at large so as to build awareness and support for the initiatives identified.
- Assign work teams to address each of the five (5) key need areas, and an additional work team to address the other issues of concern collectively. Structures the work teams such that community representation is included, and develop detailed work plans to address each need area within the upcoming three (3) years.
- Create a master timeline for the three (3) year implementation strategy.
- Establish a meeting schedule for the CDP CHNA team by which to monitor overall progress in implementing the action strategies identified, and keeping the work teams accountable for their individual deliverables and milestones.

Priority Areas Not Addressed and Rationale

Out of the 13 individual need areas identified as part of this research and prioritization process, three (3) areas were determined by the CDP CHNA team as areas that would not be addressed during the three (3) year implementation period.

- **Teen pregnancy/unsafe sex:** After considerable discussion on this issue the planning committee did not feel that additional activities in support of reduced teenage pregnancy and unsafe sex would provide benefit to the expressed need of the community in the upcoming 3-year period. Several key constituent groups within the community have established programs that address these issues, including but not limited to the local school districts, community health, and Indian Health Services. The methods currently in place by these constituent groups include distribution of low-cost/no-cost birth control methods, educational materials, and sex education, amongst other services. In addition, Coteau des Prairies already has in place the following activities that specifically address this need, and fully intends to continue these programs:
    a. Distribution of pamphlets and other educational materials to clinic patients and visitors that highlight the risks associated with unsafe/unprotected sex
    b. Provision of high quality obstetrics care to patients by a specialist
    c. Provision of breast-feeding/lactation classes for new moms in an effort to positively influence post-natal care and the healthy development of infants
    d. Facilitation of post-natal care for mom and baby both in-clinic and at-home. A home-health nurse from Coteau des Prairies visits each new mom after a birth.

  In summary, the planning committee emphasized that the Hospital's role and responsibility is to care for mothers and their children, regardless of the circumstances that brought them to need pre-natal, delivery, or post-natal services. The committee also recognized the complex cultural environment within the community where teenage pregnancy is not necessarily perceived as a problem, and is more of a societal norm. This theory was not validated as part of this exercise, yet the planning committee acknowledged that while validation of this theory would be ideal and of interest moving forward, that detailed

analysis is not likely to occur due to resource limitations and sensitivity constraints.

- **Affordable health care:** Although identified as an issue of concern/need in the community survey, follow-up discussions with community members (one-on-one) did not validate this finding. In fact, these validation activities stated that affordable health care is a national issue – one much larger than can be adequately addressed by a small, critical access hospital – and that the community is accepting of this situation given those complex barriers to lowering health care costs. Given these findings, the planning committee agreed unanimously to not directly address impact the costs of health care in the community.

- **Economic development/affordable housing:** The planning committee discussed at length several key activities that are either underway or have been considered with regards to economic development in the community. The committee determined, after much discussion, that the activities underway adequately addressed the need expressed by the community members throughout this assessment. These activities included the following:
    a. Recruitment of specialist providers to the area in order to spur local opportunity, and keep business local.
    b. Education of new members of the committee about locally available health care services as part of the welcome kit.
    c. Creation of outreach clinics in surrounding communities to generate economic activity in Sisseton for "flagship" appointments at Coteau des Prairies Hospital & Clinic.
    d. Construction of homes priced mid-range for the area ($160,000 average price) to permit access to affordable housing within the community.

Approval

The CDP CHNA team with the help of independent consultants, Sumption & Wyland and Sage Project Consultants, has developed this summary and action plan report for approval by the governing board of Coteau des Prairies Hospital.

Coteau des Prairies Hospital & Clinic Board of Directors Approval:

____

Name and Title

____

Name and Title

____

Date