PRAIRIE LAKES
Healthcare System

Prairie Lakes Healthcare System
Community Health Needs Assessment
April 2016

Mission

Prairie Lakes Healthcare System, through the efforts of its dedicated employees, physicians and partners, provides accessible, high quality, affordable and compassionate healthcare services for the people of the region.

Table of Contents

Prairie Lakes Healthcare System
The 2016 Community Health Needs Assessment
April 2016

INTRODUCTION

Prairie Lakes Healthcare System conducted the 2016 Community Health Needs Assessment (CHNA) to obtain information about the health status of the population and provide a basis for a Community Health Improvement Plan. The population assessed resides in ten counties in northeast South Dakota and western Minnesota that represent the medical service area of PLHS. This population is referred to as "**The Community**" and represents the target population of the 2016 Community Health Needs Assessment.

The purpose of this assessment was to address significant community health needs related to service gaps, to improve health for vulnerable populations, and to identify opportunities to work with other service organizations to improve population health. The assessment process included input from public health professionals; service agencies assisting vulnerable, low-income, and minority populations; government and public safety officials; and, other healthcare providers. Input was obtained through focus group discussions and key informant interviews. In addition, publically available health-related data was reviewed. This assessment is updated and revised every three years in order to provide data to evaluate progress made toward identified health priorities and for the selection of new ones.

Needs were identified in the following categories:

- Access to Healthcare Professionals
- Mental Health and Substance Abuse
- Chronic Disease Management
- Health Literacy

PLHS developed a Community Health Improvement Plan to meet needs identified and prioritized through this assessment. Community benefit activities were prioritized based on the ability of PLHS to have an impact, the capacity of other providers and service agencies, and available resources.

The CHNA provided a data and stakeholder driven process to ensure PLHS community benefit investments were responsive to the most significant community health needs.

This report contains three sections. The first section describes the role of the health system in community health improvement and the process used to complete the 2016 CHNA. Section two contains a broad array of demographic and public health data and provides the main body of the report. The third section summarizes significant issues and outlines a plan for addressing community health needs.

SUMMARY OF PROCESS AND METHODS

A comprehensive, data driven assessment was used to identify community health needs. PLHS utilized a two-step process to collect primary and secondary data. In Step One, PLHS solicited input from community health stakeholders including public health professionals; service agencies assisting vulnerable, low-income, and minority populations; healthcare providers; and, government and public safety officials. In order to address needs of the entire "Community," stakeholders included individuals from outside the primary service area of PLHS. Input was obtained through two focus group sessions and key informant interviews. Step Two consisted of evaluation of data related to demographics and health from the United States Census Bureau, South Dakota Department of Health, South Dakota Association of Healthcare Organizations, Minnesota Department of Health and other sources.

Step 1: Stakeholder Input

Focus Groups. In August 2015, PLHS held two focus groups to seek the input of community and healthcare leaders. The goal of these focus groups was to identify unmet healthcare needs, underserved populations, and limited access to care in the region.

Interviews. To ensure all populations and interests were represented, PLHS contacted key community and health leaders who were unable to attend either focus group for personal interviews. These interviews were conducted in August and September 2015.

The following tables identify stakeholders participating in the community health needs assessment through focus groups and interviews. PLHS diligently sought input related to low-income, minority, and other medically underserved populations, including children, the elderly, and those with chronic medical conditions. PLHS believes the government agencies, organizations and businesses that participated in this community health needs assessment properly represented those populations and spoke on their behalf in providing input, expressing concerns, and identifying needs.

Focus Group 1 Attendees August 11, 2015

Jeff Cook, CEO	Appleton Area Health Services
Sherrie Lee, RN	Appleton Area Health Services
Pam Martinson	Appleton Area Health Services
Sister Teresa Ann Wolf	Benedictine Multicultural Center
Briana Aadland	Day County Courthouse
Kaleb Hight	Golden Living Center
Dr. Chuck Sherman	Human Service Agency
Loren Diekman	Jenkins Living Center
Patty Foley	Lake Area Technical Institute, Department of Nursing
Sister Nancy Zemcuznikov	Mother of God Monastery – Bennet Place
Morgan Rinke	Roberts County Public Health
Jan DeBerg	Watertown Community Foundation
Doug Kranz	Watertown Fire & Ambulance
Patty Lunde	Watertown Fire & Ambulance
Tim Toomey	Watertown Police Officer
Alissa Larson	Watertown School District
Jennifer Heggelund	Watertown School District
Julie Gonsor	Watertown School District
Lesli Jutting	Watertown School District

Focus Group 2 Attendees August 20, 2015

Rita Rahlf	60s Plus Dining Program / Meals on Wheels
Dawn Sikkink	Beacon Center
Denise Ragels	Beacon Center
Liz Christianson	Boys & Girls Club
Mayor Steve Thorson	City of Watertown
Karla Moes	Codington County Public Health
Amber Amdahl	Countryside Public Health – Big Stone, Lac qui Parle & Yellow Medicine County
Angela Hunter	Hamlin County Public Health
Beth Lalim	Independent Living Choices
Kathy Johnson	Johnson Memorial Health Services, Dawson, MN
Mary K. Johnson	Lutheran Social Services
Linda Schurmann	Mount Marty College
Darcy Woertink	Prairie Lakes Healthcare System (Social Worker)
Julie Sampson	Prairie Lakes Healthcare System (Home Health)
Cindy Mydland	Sanford Clinic, Watertown
Melissa Terronez	Stoney Brook Suites Assisted Living
David Falconer	Terex Utilities
Heidi Schmidt	USD Nursing
Becky Delvo	Volunteers of America
Kim Rauss	Volunteers of America
Terry Hoffman	Watertown Area Transit, Inc.
Bill Rieffenberger	Watertown City Council
Glen Vilhauer	Watertown City Council

Survey Participants via Phone Fall 2015

Dr. Bob Buri	Bridgeway Counseling
Shawntel Harte	Head Start Pre-Birth to Five
Mike Cartney	Lake Area Technical Institute
Tonya Benson	Sanford Clinic, Estelline
Dr. Cathy Leadabrand	Prairie Lakes Healthcare System (Hospital Medicine)
Jackie Mack	Prairie Lakes Healthcare System (Wound Care)
Tracy Hlavacek	United Way
Doreen Endres	USD Nursing

Survey Participants via Email Fall 2015

Dot McAreavey	Prairie Lakes Healthcare System (Rehab Services)
Sara Coteau	Sisseton-Wahpeton Oyate of the Lake Traverse Reservation (Health Planner)

Step Two: Data Analysis

Demographic and health-related data was gathered between September and December, 2015.

Census and demographic data collected by the U.S. Census Bureau in 2010, as well as various other sources, were used to analyze population trends. This data included 2014 estimates for age, gender, and race compositions of the community. U.S. Census data was also used to calculate the number of uninsured people living in the community and average household income.

National, state, and county health information was obtained from various sources including the U.S. Department of Health & Human Services, the Centers for Disease Control and Prevention, the National Center for Health Statistics, the Substance Abuse and Mental Health Services Administration, the South Dakota Department of Health, the Minnesota Department of Health, and various other sources. See Appendix 1 for a detailed list of data sources.

PLHS contracted with CliftonLarsonAllen LLP, a professioinal services organization, to assist with this community health needs assessment.

PLHS invited the public to submit written comments related to the prior CHHA completed in 2013 but received no additional feedback. If any reader would like to provide input on the 2016 Community Health Needs Assessment, they can submit their comment(s), in writing, to the following address:

Attention: Kris Munger
RE: 2016 Community Health Needs Assessment
Prairie Lakes Healthcare System
401 9th Avenue NW
Watertown, SD 57201

While many needs were identified during the community health needs assessment process, this report focuses on those needs that were deemed *significant* by PLHS. A health need's significance was evaluated based on many factors. The factor given the most weight was the relative importance placed on the health need by the community participants as a whole. Other factors included the number of people in the community impacted by the health need, the impact of that health need on quality of life and length of life, and the impact on low-income, minority, and other medically underserved populations. The decision was made by a team of individuals from PLHS who were involved throughout the community health needs assessment process.

The significant community health needs were then prioritized by PLHS based on various factors including the number of people impacted, the impact of that health need on quality of life and length of life, PLHS' ability to respond effectively to the health need, and the estimated effectiveness of feasible interventions. This decision was made by the same team of individuals from PLHS who were involved throughout the community health needs assessment process.

HEALTH SYSTEM ROLE IN COMMUNITY HEALTH IMPROVEMENT

Since its formation in 1986, Prairie Lakes Healthcare System (PLHS) has assessed the needs of the community and developed many long-standing initiatives focused on improving health. Additional requirements for Community Health Needs Assessment (CHNA) were established as part of national healthcare reform. As a tax-exempt hospital, Prairie Lakes is required by Section 9007 of the Patient Protection and Affordable Care Act of 2010 (PPACA) to conduct a community health needs assessment at least once every three years and implement a strategy to meet the needs identified through the assessment. Hospitals must include input from persons who represent the broad interests of the community served, including those with special knowledge or expertise in public health. This encourages tax-exempt hospitals to partner with other providers in their community to identify needs and opportunities for serving their collective patient populations.

Prairie Lakes Healthcare System is an independent, not-for-profit, rural, regional medical center located in Watertown, South Dakota. The health system provides residents with access to medical, surgical, rehabilitation and post-acute care, as well as specialty services not typically found in a rural service area. Specialized services include interventional cardiology, cancer clinical trials, tomotherapy (cancer radiation treatment), and many advanced surgical procedures. Community-based physician specialties include cardiology, general surgery, hematology, medical oncology, nephrology, obstetrics/gynecology, ophthalmology, orthopedic surgery, otolaryngology, pediatrics, podiatry, pulmonology, radiation oncology, urology, and vascular surgery.

PLHS provides community hospital and specialty medical services to ten counties in northeast South Dakota and western Minnesota with a total population of 87,000. Rural outreach partnerships include:

1. Hemodialysis services in Sisseton, South Dakota, through a partnership with Indian Health Services and the Sisseton Wahpeton Oyate Tribe
2. Hemodialysis services in Ortonville, Minnesota, through a partnership with Ortonville Area Health Services, a critical access hospital
3. 13 specialty physician outreach clinics in 8 communities
4. Serving as a regional receiving hospital for Mission: Lifeline, a system of care developed by the American Heart Association to assure that heart attack victims receive immediate and effective treatment.

In 2003, PLHS made a commitment to improve regional health outcomes and access to care through recruitment of specialty physicians and medical program development. In some cases, residents in the region's rural communities had to travel more than 100 miles for specialty care such as cardiology or surgery. In 2007, PLHS was the first health system in the state to offer lifesaving, interventional cardiology procedures outside of a metropolitan center. Over the past decade, PLHS has successfully recruited over 20 specialty physicians to the community.

In 2012, the PLHS Board of Directors adopted a community benefit policy to provide additional guidelines for community benefit investment. The policy established community benefit spending guidelines that align with the healthcare mission and needs identified.

PLHS prioritized it charitable donation policy to support requests that address one of the following focus areas:

1. Improve access to healthcare especially for low-income and underserved individuals
2. Improve the health of people with cardiovascular disease, respiratory disease, obesity, diabetes and mental health needs
3. Support health education
4. Improve health by addressing the social determinants of health including economic development, income, housing and community safety

Community building activities that could impact the social determinants of health were also identified as community benefit. Social determinants of health are conditions in the environment that affect a wide range of health risks, functioning, and quality-of-life outcomes. By intervening through community building activities, individual and population health can be improved and health disparities reduced.

As part of its community benefit commitment for the 2013 Community Benefit Plan, PLHS provided $5.9 million in charity care and more than $5.6 million to subsidize Medicaid payment shortfalls. PLHS continued to invest in medical services and physician recruitment. For example, a new wound care program was developed, specialty physicians were recruited, and new services lines were started and some existing programs were expanded.

Over this same three year period, PLHS provided more than $452,000 in charitable donations to support agencies and programs engaged in community building such as United Way, The Boys & Girls Club, local fire and rescue providers, low income family planning services, community drug and alcohol detox services, foundations serving cancer and kidney dialysis patients, public transit services, and an equine therapy program for veterans suffering from post traumatic stress syndrome. These were only a few of the area services that PLHS supported to provide benefit to the community.

PLHS continued to refine its approach to community benefit as population health management was being discussed as a priority of national healthcare reform. Consistent with the goals of healthcare reform, the PLHS mission is evolving to address the broader health needs of the community rather than simply providing acute medical care services. In 2014, the Board of Directors adopted a strategic plan with the following objective related to population health:

> *Improve population health through partnerships with other healthcare providers, employers, community organizations and non-profits to improve access to care, expand preventative and health maintenance services, influence individual behavior, and address the social determinants of health.*

As a result, PLHS committed to enhanced partnerships and collaboration with other providers and non-profits engaged in the regional system of care and addressing the social determinants of health. Rather than attempt to improve the health of the population by acting separately, PLHS believes more can be done to improve the health of the population through partnerships with other entities. It is imperative now and over the next few years is to address the challenges of shared responsibility for population health among diverse stakeholders in the service area.

COMMUNITY HEALTH STAKEHOLDERS

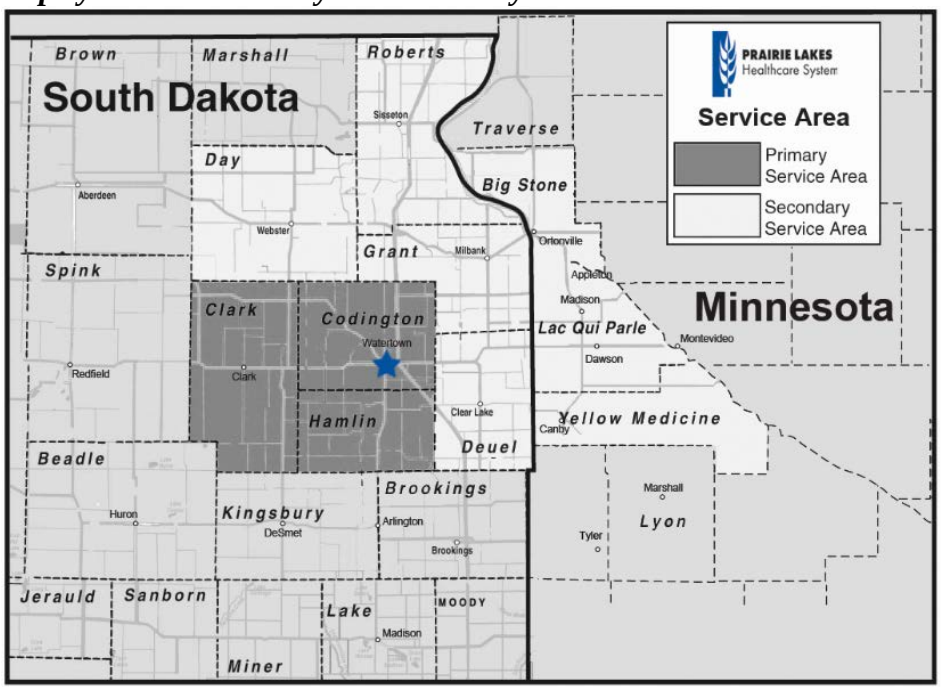
Definition of Community

For the 2016 Community Health Needs Assessment, the community is defined as the population of the PLHS service area. The service area includes ten counties in northeast South Dakota and western Minnesota with a total population of 87,214.

PLHS Service Area

Counties in the primary service area include Codington, Clark, and Hamlin. PLHS is the only licensed hospital in the primary service area (Display 1). The hospital meets the needs of residents in the three counties for essential services such as emergency care, inpatient and outpatient services, obstetrics, and post-acute care.

Display 1: PLHS Primary and Secondary Service Areas



Hospital Resources in the Service Area

Each county in the secondary service area is served by a Critical Access Hospital (CAH) (Display 3). Residents in the secondary service area are referred to PLHS or other providers for specialty services. In the secondary service area, PLHS focuses primarily on gaps in the availability of different medical and surgical specialty services and less on social determinants and health disparities. The CAHs complete their own separate community health needs assessments and plans to address social determinants of health and health disparities. At the present time, PLHS has limited collaboration related to these efforts in the secondary service area partly to avoid duplication of effort and partly because shared efforts to address population health for the entire geographic area is a work in progress with many challenges and issues. PLHS is focusing current efforts on relationship building as the basis for establishing shared agendas with communities in the secondary service area. In addition, several CAHs are owned or operated by larger health systems based outside the service area. These systems may also have similar challenges in connecting with community stakeholders.

Display 2: Critical Access Hospitals Located in the Secondary Service Area

Day County, SD	Sanford Webster Medical Center, Webster, SD
Deuel County, SD	Sanford Clear Lake Medical Center, Clear Lake, SD
Grant County, SD	Milbank Area Hospital Avera, Milbank, SD
Roberts County, SD	Coteau Des Prairies Healthcare System, Sisseton, SD
Big Stone County, MN	Ortonville Area Health Services, Ortonville, MN
Lac qui Parle County, MN	Johnson Memorial Health Services, Dawson, MN Madison Hospital, Madison, MN
Yellow Medicine County, MN	Sanford Canby Medical Center, Canby, MN

Focus Group and Key Informant Themes

Health Care Costs. During interviews and focus groups, the community participants emphasized concerns about the cost of health care for individuals in the community, especially for low-income, minority and other medically underserved individuals. PLHS offers a charity care program to individuals who apply for and who are eligible for assistance.

Access to Transportation. PLHS serves a large geographic area. Although critical access hospitals and medical clinics serve many individuals who do not live in Watertown, PLHS is the primary source of general healthcare for many of these individuals and is the primary source of specialty services for most. The geographic size of the community creates transportation problems for individuals. These problems relate to the time required to travel to a health care provider, the cost of that travel, and the funds to own a vehicle. Concerns raised by the focus group members included a need for additional transportation from outlying areas to Watertown as well as within the city of Watertown.

Focus group participants were particularly concerned about the ability of low-income individuals to travel to a health care provider. Low-income individuals may be less able to take time off of work, or less willing because they fear they may lose their job. Low-income individuals are less able to afford the cost of a vehicle or public transportation.

Focus group participants state the recently implemented PLHS program providing fare support for individuals seeking public transportation for healthcare purposes was positive. There is still a need for community education about transportation options and programs that are already available.

Access to Primary and Specialty Care Services. Focus group participants perceived the number of primary care providers in the primary and secondary service areas was inadequate to meet the needs of the population. Participants expressed interest for greater development of telemedicine services in the community. Specialties specifically identified by focus group participants as needing additional providers were ophthalmology, dermatology, otolaryngology, nephrology, psychology, psychiatry, neurology, vascular surgery, and podiatry. Other areas in which participants expressed a need for increased services included immunizations and dental services for all ages, breastfeeding support, and disability support, including for autism. Focus group participants indicated healthcare services in general could be expanded and modified to better serve the low-income and homeless individuals in the community.

Behavioral Health. During this community health needs assessment participants expressed concern regarding the availability of mental health services. During interviews and focus groups, community participants indicated a need for additional mental health services for all ages,

additional psychologists, an inpatient psychiatric unit, and increased grief counseling and support groups for those dealing with loss.

Focus group participants indicated a need for more chemical dependency services and alcohol treatment programs.

Health Literacy. Key informants expressed concern about the public's knowledge about and communication of current medications being taken. In addition, informants noted concerns of community perception regarding utilization of antibiotics when an antibiotic is not warranted.

Status of Initiatives Identified by Key Stakeholders

Since the completion of the 2013 Community Health Needs Assessment PLHS developed an action plan to address unmet community health needs. The following section summarizes actions completed or in progress to address community needs.

Access to Primary and Specialty Care Services

Community members surveyed as part of The 2013 Community Health Needs Assessment reported difficulty accessing primary care in the evenings and on weekends; difficulty scheduling annual exams; and, use of the hospital ER because they did not have a doctor or a doctor appointment could not be scheduled. ER utilization for non-urgent conditions was increasing. Groups that were particularly affected included low income, uninsured, or underinsured adults.

Actions:

- Financially supported the recruitment efforts made by community primary care clinics
- Provided recruiting assistance by sourcing candidates for critical access hospitals in the PLHS community
- Implemented mid-level providers in the Emergency Room department to improve care for less-urgent conditions
- Implemented interventional radiology services
- Transitioned from two on-site general radiologists to over 70 specialized radiologists
- Expanded scheduling access to vascular services and cardiology clinic
- Added an Otolaryngologist & Facial Plastic Surgeon, Pulmonologist, Urologist, Emergency Medicine physicians, and Hospitalists
- Expanded rural outreach clinics in cardiology, pulmonology, urology, medical oncology-hematology, and nephrology

Cardiovascular Disease

An opportunity to reduce inpatient heart failure readmission was identified by physicians and by reviewing readmission rates. The community lacked a coordinated approach to care transitions and care management for chronic disease such as heart failure. The primary reasons for minimal care management programming was lack of physician and hospital integration and lack of reimbursement for care coordination.

Actions:

- Implemented bedside education by a cardiac rehab nurse and dietician for all CHF hospitalized patients
- Implemented the Home Transition Program May 2015 to patients diagnosed with CHF or who have had an acute heart attack. The program provided one complimentary home

health visit by a home health nurse and four phone calls to assess patient surroundings, ensure understanding of discharge instructions and self-care, review the individual's medication list and setup, and provide education on the disease or condition
- Implemented CardioMEMS, a wireless remote monitoring technology (April 2015) to more closely monitor and manage CHF patients
- Provided general health education to the community and in business settings when given the opportunity
- Provided education to nursing home and assisted living facilities on post hospitalization care, pacemakers, implantable cardioverter defibrillator (ICD), remote monitoring, and CHF
- Implemented a vascular screening program to cardiac patients seen in the PLHS Cardiology Clinic due to the high correlation between heart and vascular diseases

Wound Care

There was a high demand for wound services but a program was not fully developed

Actions:

- Recruited a Wound Ostomy Certified Nurse in January 2015 to lead a fully integrated wound care service
- Started certification of additional nursing staff
- Added Physical and Occupational Therapy services to the wound care service
- Added an Occupational Therapist specializing in lymphedema
- The Wound Care Clinic averaged 10 visits per month in 2014 and averaged 250 visits per month in 2015
- The demand for lymphedema services increased from 10 visits per month to about 100 visits

Health Literacy

Health literacy refers to the capacity of individuals to obtain, process, and understand basic health information and services in order to make appropriate health decision. Focus groups expressed a need for community initiatives to address health literacy.

Actions:

- Improved access to childbirth and breastfeeding classes by waiving registration fees for all participants
- Offered free education to the public, service organizations, educational institutions, and businesses on health screening and health promotion topics
- Began a diabetes support group with a Certified Diabetic Educator in November 2014. This group met monthly with the exception of June through August.

Transportation

Focus groups expressed a need to expand low cost public transportation options that provide access to healthcare services.

Actions:

- Entered into an agreement with Watertown Area Transit April 1, 2015 offering Watertown area residents free rides to and from medical, dental, vision, hearing, chiropractor, mental health, pharmacy and community health nurse appointments
- The assessment also provided transportation to take hospitalized patients home if a caregiver was unavailable
- Made a donation to the Watertown Area Transit to assist with the purchase of new buses

Respiratory Disease

Respiratory disease services were not prioritized in the 2013 Community Health Needs Assessment. However, PLHS was able to recruit a full-time pulmonologist in July 2013. This allowed for additional pulmonary services development.

Actions:

- Recruited a full-time pulmonologist who began practicing in July 2013
- Started a pulmonary rehabilitation program
- Implemented the Home Transition Program to patients with COPD, which provides one complementary home health visit by a home health nurse and four phone calls to assess patient surroundings, ensure understanding of discharge instructions and self-care, review the individual's medication list and setup, and provide education on the disease or condition
- Installed a new pulmonary function machine with additional functionality
- Established four rural outreach clinics
- Maintained pulmonology services after the death of provider through temporary physician staffing

DEMOGRAPHIC DATA

Population

The Centers for Disease Control and Prevention (CDC) recommends review of key demographics to identify populations at risk for health issues. Social determinants, such as economics (education, employment, finances, health behaviors, and access to health services), influence the health of people and communities.

Total Population (2010-2014). From 2000 to 2014, the total population in the service area has remained stable. The primary service area experienced a 2% population increase between 2010 and 2014. The secondary service area population decreased by 1.8%. Through 2020, the population of the service area is projected to remain stable.

Display 3: PLHS Service Area Population Trends by County

Primary Service Area	2010 Act.	2014 Est.	% Change from 2010		Population Projection 2020	% Change from 2014
Codington County, SD	27,227	27,938	2.6%		28,406	0.02%
Clark County, SD	3,691	3,645	-1.2%		3,395	-0.07%
Hamlin County, SD	5,903	5,989	1.5%		5,993	0.00%
Total Primary	**36,821**	**37,572**	**2.0%**		**37,794**	**0.01%**
Secondary Service Area						
Day County, SD	5,710	5,588	-2.1%		5,105	-0.09%
Deuel County, SD	4,364	4,312	-1.2%		3,690	-0.14%
Grant County, SD	7,356	7,241	-1.6%		6,758	-0.07%
Roberts County, SD	10,149	10,374	2.2%		9,413	-0.09%
Big Stone County, MN	5,269	5,127	-2.7%		5,388	0.05%
Lac qui Parle County, MN	7,259	6,891	-5.1%		7,452	0.08%
Yellow Medicine County, MN	10,438	10,109	-3.2%		10,680	0.06%
Total Secondary	**50,545**	**49,642**	**-1.8%**		**48,486**	**-0.02%**
Total Community	**87,366**	**87,214**	**-0.2%**		**86,280**	**-0.01%**

(U.S. Census Bureau, 2015), (South Dakota State University, 2008), and (Minnesota State Demographic Center, 2014)

Population by Age. The service area's largest age cohort is persons 19 years to 64 years old and comprises over 56% of the total population in comparison to the state population of 60% for this same age group. The service area has a greater percent of persons 65 years and over (19%) than the state (15%).

Display 4: Service Area Population by Age

	Primary	Secondary	Total Area	South Dakota
Population, 2014 estimate	37,572	49,642	87,214	853,175
Age				
Persons under 5 years, percent, 2014	7.52%	6.42%	6.90%	7.1%
Persons under 18 years, percent, 2014	24.45%	23.42%	24.30%	24.7%
Persons 19 years to 64 years, percent, 2014	58.25%	55.10%	56.46%	60.0%
Persons 65 years and over, percent, 2014	16.29%	21.47%	19.24%	15.3%

(U.S. Census Bureau, 2015)

Hamlin and Roberts Counties in South Dakota have significantly higher populations of individuals under age 18, compared to the other counties and the state of South Dakota. Every county in the PLHS community has a higher percentage of adults age 65 and over than the state of South Dakota. Day County and Big Stone and Lac qui Parle Counties have the highest rates of adults age 65 and over.

Display 5: County Population by Age

	Clark	Codington	Hamlin	Day	Deuel	Grant	Roberts	Big Stone	Lac qui Parle	Yellow Medicine
Population, 2014 estimate	3,645	27,938	5,989	5,588	4,312	7,241	10,374	5,127	6,891	10,109
Age										
% of persons under 5 years, 2014	8.3%	7.0%	9.5%	5.7%	5.5%	5.7%	8.7%	6.1%	5.2%	6.4%
% of persons under 18 years, 2014	23.9%	24.4%	31.3%	22.0%	23.0%	22.4%	28.5%	20.6%	20.4%	23.4%
% of persons 65 years and over, 2014	20.4%	15.5%	17.5%	24.4%	21.0%	20.0%	18.1%	25.7%	24.9%	20.1%

(U.S. Census Bureau, 2015)

Population by Race/Ethnicity. As of 2014, minorities represented 6.65% of the primary service area population and 14.93% of the secondary service area population, as compared to 18.0% across the state of South Dakota.

Display 6: Service Area Population by Race/Ethnicity

	Primary	Secondary	Total Area	South Dakota
Population, 2014 estimate	37,572	49,642	87,214	853,175
Race				
White persons not Hispanic, percent, 2014	93.78%	85.66%	89.16%	83.0%
Persons of Hispanic or Latino Origin, percent, 2014	2.21%	2.66%	2.47%	3.6%
Black persons, percent, 2014	0.81%	0.59%	0.68%	1.9%
American Indian and Alaska Native persons, percent, 2014	1.81%	9.61%	6.25%	8.9%
Asian persons, percent, 2014	0.65%	0.43%	0.53%	1.3%
Native Hawaiian and Other Pacific Islander persons, percent, 2014	0.00%	0.03%	0.02%	0.1%
Persons reporting two or more races, percent, 2014	1.17%	1.60%	1.42%	2.2%

(U.S. Census Bureau, 2015)

The PLHS secondary service area has more minorities than the primary service area. In particular, 36.6% of Roberts County residents and 8.8% of Day County residents identify themselves as American Indian. These were primarily members of the Sisseton-Wahpeton Oyate of the Lake Traverse Reservation. Outside of these populations, there are very few other minorities in the service area.

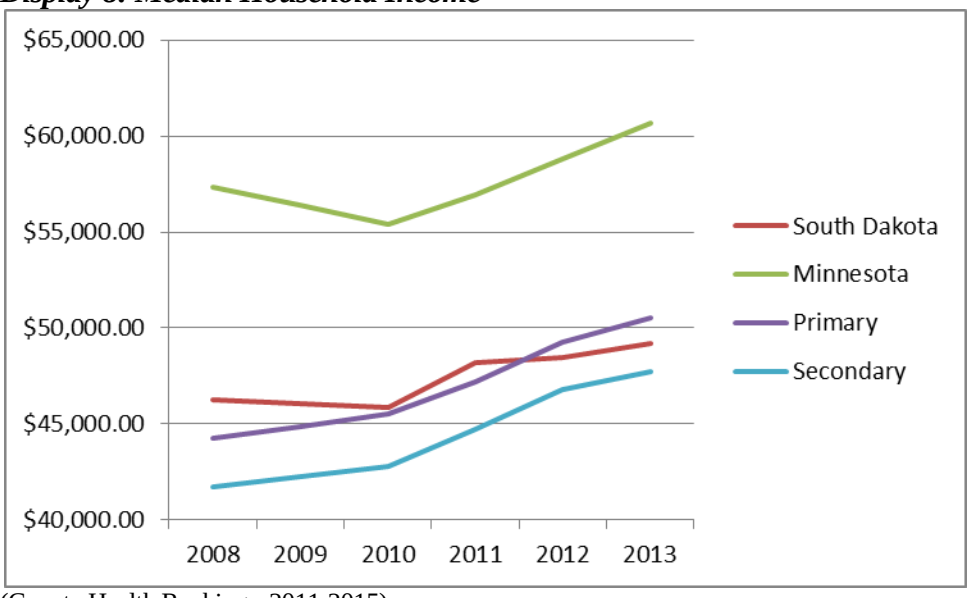
Display 7: County Population by Race/Ethnicity

	Clark	Codington	Hamlin	Day	Deuel	Grant	Roberts	Big Stone	Lac qui Parle	Yellow Medicine
Population, 2014 estimate	3,645	27,938	5,989	5,588	4,312	7,241	10,374	5,127	6,891	10,109
Race										
% of White persons not Hispanic, 2014	94.9%	93.4%	94.9%	86.7%	94.7%	94.1%	58.3%	97.0%	95.8%	90.6%
% of persons of Hispanic or Latino Origin, 2014	2.8%	1.9%	3.3%	2.1%	3.1%	2.8%	2.4%	1.1%	2.0%	4.2%
% of Black persons, 2014	1.4%	0.8%	0.5%	0.6%	1.0%	1.0%	0.6%	0.4%	0.3%	0.4%
% of American Indian and Alaska Native persons, 2014	0.2%	2.3%	0.5%	8.8%	0.4%	0.9%	36.6%	0.7%	0.3%	3.4%

(U.S. Census Bureau, 2015)

Median Household Income. Both Minnesota and South Dakota experienced a decrease in median household income during the 2007-2009 recession, but both states have rebounded and shown overall growth through 2013 (Display 8). The median household income in both the primary and secondary service areas grew between 2008 and 2013. The growth in the seven South Dakota counties was generally greater than the growth in the three Minnesota counties.

Display 8: Median Household Income



(County Health Rankings, 2011-2015)

The service area as a whole has a lower median household income compared to the state.

Display 9: Service Area Median Household Income

	Primary	Secondary	Total Area	South Dakota
Population, 2014 estimate	37,572	49,642	87,214	853,175
Median household income, 2010-2014	$49,314	$48,702	$48,965	$50,338

(U.S. Census Bureau, 2015)

Hamlin County has the highest median household income in the service area. Day County has the lowest median household income of $37,901, which is significantly less than the state median household income of $50,338.

Display 10: County Median Household Income

	Clark	Codington	Hamlin	Day	Deuel	Grant	Roberts	Big Stone	Lac qui Parle	Yellow Medicine
Population, 2014 estimate	3,645	27,938	5,989	5,588	4,312	7,241	10,374	5,127	6,891	10,109
Median household income, 2010-2014	$49,016	$47,891	$56,134	$37,901	$52,717	$51,277	$48,441	$47,537	$48,426	$52,160

(U.S. Census Bureau, 2015)

Poverty. Compared to South Dakota, the PLHS service area has a smaller population of people living below the poverty level.

Display 11: Service Area Poverty

	Primary	Secondary	Total Area	South Dakota
Population, 2014 estimate	37,572	49,642	87,214	853,175
Persons below poverty level, percent, 2014	10.32%	13.04%	11.86%	14.2%

(U.S. Census Bureau, 2015)

Roberts and Day Counties have the highest percent of persons below the poverty level, 19.7% and 14.3% respectively. Deuel County has 9.2% of persons living below the poverty level, the lowest in the service area.

Display 12: County Poverty

	Clark	Codington	Hamlin	Day	Deuel	Grant	Roberts	Big Stone	Lac qui Parle	Yellow Medicine
Population, 2014 estimate	3,645	27,938	5,989	5,588	4,312	7,241	10,374	5,127	6,891	10,109
% of persons below poverty level, 2014	12.0%	10.1%	10.3%	14.3%	9.2%	10.5%	19.7%	12.8%	10.5%	10.8%

(U.S. Census Bureau, 2015)

Education. The high school graduation rate in the service area is very similar to the South Dakota average of 90.7%. The service area population with a bachelor's degree or higher is 18.76% compared to the state average of 26.7%.

Display 13: Service Area Education

	Primary	Secondary	Total Area	South Dakota
Population, 2014 estimate	37,572	49,642	87,214	853,175
Other				
High school graduates, percent of persons age 25+, 2010-2014	90.65%	89.41%	89.94%	90.7%
Bachelor's degree or higher, percent of persons age 25+, 2010-2014	20.13%	17.73%	18.76%	26.7%

(U.S. Census Bureau, 2015)

Roberts County has the lowest high school graduation rate at 87.3% and Lac qui Parle County has the highest graduation rate at 91.7%. Roberts County has the lowest college completion rate in the community (15.8% of adults) and Deuel County has the greatest rate (22.1% of adults).

Display 14: County Education

	Clark	Codington	Hamlin	Day	Deuel	Grant	Roberts	Big Stone	Lac qui Parle	Yellow Medicine
Population, 2014 estimate	3,645	27,938	5,989	5,588	4,312	7,241	10,374	5,127	6,891	10,109
Other										
% of persons age 25+ who are high school graduates, 2010-2014	89.8%	90.9%	90.0%	88.1%	88.8%	88.9%	87.3%	89.7%	91.7%	91.2%
% of persons age 25+ with a bachelor's degree or higher, 2010-2014	20.2%	20.3%	19.3%	17.8%	22.1%	17.2%	15.8%	18.3%	18.6%	17.3%

(U.S. Census Bureau, 2015)

ACCESS TO HEALTHCARE

Access to primary care and specialty services, as well as financial ability to pay for health care services, were identified as health needs in the PLHS community during the 2013 Community Health Needs Assessment. PLHS made efforts to address these needs and increase access in recent years. PLHS has reached out to other healthcare systems in the community to improve local access to specialty physicians. However, access continues to be a significant health need in the community.

Across the nation individuals are becoming increasingly aware of the importance of preventative health care. The rising cost of health care in the United States combined with the recession that took place between 2007-2009, have limited individuals' ability to afford and receive these health care services.

Insurance Status. Insurance status is a major driver of an individual's ability to receive appropriate health care.

Display 15: Demographics by Service Area

	Primary	Secondary	Total Area	South Dakota
Population, 2014 estimate	37,572	49,642	87,214	853,175
Uninsured, Under 65, All Income Levels, 2014	12.03%	12.82%	12.48%	11.4%

(U.S. Census Bureau, 2015)

Display 16: Demographics by County

	Clark	Codington	Hamlin	Day	Deuel	Grant	Roberts	Big Stone	Lac qui Parle	Yellow Medicine
Population, 2014 estimate	3,645	27,938	5,989	5,588	4,312	7,241	10,374	5,127	6,891	10,109
% of uninsured, Under 65, 2014	14.1%	11.4%	13.7%	15.9%	12.7%	13.1%	17.5%	10.3%	9.1%	10.0%

(U.S. Census Bureau, 2015)

South Dakota has experienced a decrease in the number of uninsured individuals from 18.0% in 2009 to 16.7% in 2012. The counties in the PLHS community have experienced similar declines, although many of the counties have a higher incidence of uninsured adults than the state average (Display 17). PLHS expects these trends to continue as health insurance exchanges and similar programs from the Affordable Care Act of 2010 continue to be implemented in the state.

Display 17: Health Insurance

	% Uninsured in 2009	% Uninsured in 2012
Primary Service Area		
Codington County, SD	16.6%	15.5%
Clark County, SD	21.9%	19.1%
Hamlin County, SD	19.5%	17.4%
Secondary Service Area		
Day County, SD	24.4%	20.8%
Deuel County, SD	18.5%	17.1%
Grant County, SD	17.4%	16.1%
Roberts County, SD	25.4%	24.7%
Big Stone County, MN	14.3%	11.5%
Lac qui Parle County, MN	11.4%	9.9%
Yellow Medicine County, MN	11.6%	11.2%

(County Health Rankings, 2012-2015)

The rates of uninsured individuals in the community are important because of the impact insurance status has on receiving appropriate health care. The South Dakota Department of Health's Behavioral Risk Factor System shows that insured South Dakotans are twice as likely to have seen a doctor for a routine checkup in the last year while uninsured South Dakotans are approximately three times less likely to have seen a doctor for a routine checkup at any time in the last five years (Display 18). Finally, uninsured South Dakotans are approximately five times more likely to avoid seeing a doctor because of cost. Although the percentages are different, national data shows similar trends.

Several PLHS community participants indicated concern for the middle class in the community. These individuals tend to have health insurance, but they may have high deductibles. This situation has grown worse across the nation in recent years as employers are increasingly moving to higher deductible health plans that require the individual to pay higher out of pocket deductibles before health insurance plans pay for services. Focus group participants expressed concern that the middle class community may become medically underserved, similar to the uninsured population.

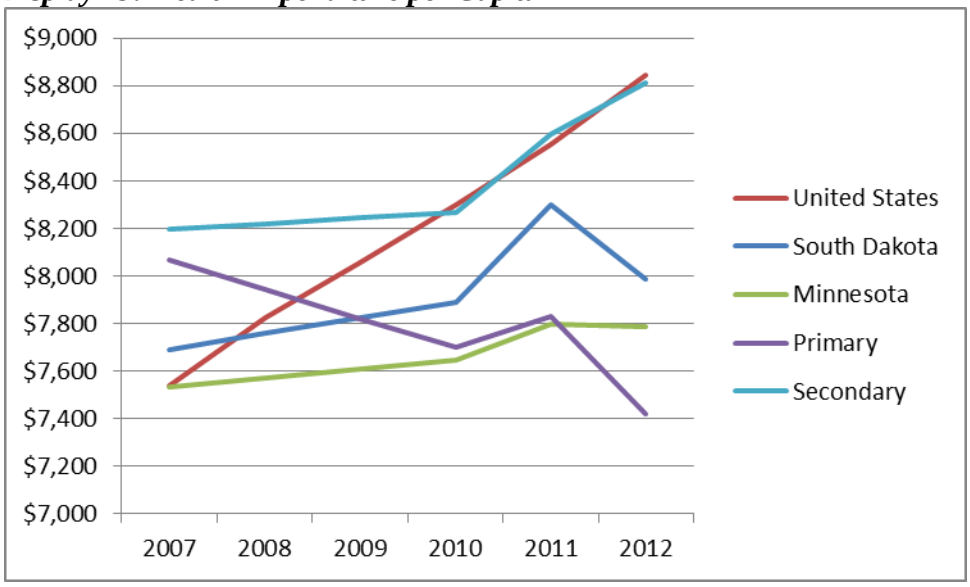
Display 18: Impact of Health Insurance in South Dakota

	With Insurance	Without Insurance
Saw a doctor for a routine checkup in the last year	66%	31%
Have not seen a doctor for a routine checkup within the last 5 years	12%	33%
Did not see a doctor within the last year because of cost	8%	44%

(South Dakota Department of Health, 2011-2013)

Cost of Health Care. Between 2007 and 2012, annual health care costs per person in the primary service area decreased from $8,065 to $7,373. The annual costs per person in the secondary service area increased from $8,197 to $8,810 (Display 19). The decrease in cost in the primary service area was largely driven by a decrease in Clark County from $8,638 per person in 2007 to $7,671 per person in 2012. The increase in cost in the secondary service area was driven by increases in Deuel and Roberts Counties in South Dakota as well as Big Stone and Yellow Medicine Counties in Minnesota.

Display 19: Health Expenditure per Capita



(County Health Rankings, 2012-2015) and (The World Bank, 2015)

Comparing the change in median household income with the change in per capita health care cost shows an encouraging trend. The median household income over the five years between 2007 and 2012 increased by 11.0% in the primary service area and 11.5% in the secondary service area, resulting in an overall increase of 11.3% in the PLHS community (Display 20). The health care costs per capita over the five years between 2008 and 2013 decreased by 8.6% in the primary service area and increased by 7.5% in the secondary service area, resulting in an overall increase of 2.7% in the

PLHS community. The fact that household incomes are growing faster than health care costs is an encouraging trend.

It is important to note that health care costs are increasing faster than median household income in each of the three Minnesota counties, especially in Big Stone and Yellow Medicine Counties. It is unfortunate that the individuals in these areas are experiencing greater growth in health care costs than they are in median household income. This implies that receiving appropriate care is relatively more difficult in more recent years than it was in the past because it is consuming a larger part of family income.

Display 20: Comparison of Per Capita Health Care Cost and Median Household Income

Primary Service Area	2008 Health Care Cost	2013 Health Care Cost	% Change		2007 Median Household Income	2012 Median Household Income	% Change
Codington County, SD	$7,879	$7,839	-0.5%		$44,999	$49,022	8.9%
Clark County, SD	$8,638	$7,671	-11.2%		$42,413	$45,592	7.5%
Hamlin County, SD	$7,677	$6,609	-13.9%		$49,091	$56,860	15.8%
Total Primary	**$8,065**	**$7,373**	**-8.6%**		**$45,501**	**$50,491**	**11.0%**
Secondary Service Area							
Day County, SD	$9,002	$8,560	-4.9%		$37,186	$44,188	18.8%
Deuel County, SD	$8,715	$9,454	8.5%		$45,772	$52,527	14.8%
Grant County, SD	$8,555	$7,612	-11.0%		$45,436	$51,065	12.4%
Roberts County, SD	$7,795	$8,544	9.6%		$39,057	$44,626	14.3%
Big Stone County, MN	$6,801	$9,139	37.0%		$40,829	$44,637	9.3%
Lac qui Parle County, MN	$9,203	$9,622	4.5%		$44,852	$46,805	4.4%
Yellow Medicine County, MN	$7,306	$8,559	17.1%		$46,595	$50,311	8.0%
Total Secondary	**$8,197**	**$8,810**	**7.5%**		**$42,818**	**$47,737**	**11.5%**
Total Community	**$8,157**	**$8,379**	**2.7%**		**$43,623**	**$48,563**	**$11.3%**

(County Health Rankings, 2011-2015)

Census of Healthcare Providers. Between 2012 and 2015, the number of primary care providers in the PLHS community has decreased from 57 to 50. The impact was greater in the secondary service where the number of physicians decreased from 33 in 2012 to 24 in 2015. The loss of primary care physicians in rural America is influenced by geographic remoteness and the national shortage of primary care providers. It is challenging to recruit physicians to South Dakota from other parts of the nation. In addition, the number of primary care providers across the nation is on the decline, primarily as new physicians choose specialty services over primary care. This pattern of decline in primary care is expected to continue in the future. Health care facilities utilized certified nurse practitioners and physician assistants to help bridge the gap. Access to subspecialists can be difficult for certain services depending on appointment availability and the location of the provider. The advancement of telemedicine services is being explored by PLHS to help bridge this gap in services/coverage.

Display 21: ***Composition of the Active Medical Staff by Specialty***

	2012				2015*		
Specialty	**Number of Physicians in Primary Service Area**	**Number of Physicians in Secondary Service Area**	**Total**		**Number of Physicians in Primary Service Area**	**Number of Physicians in Secondary Service Area**	**Total**
Family Practice	17	27	44		17	22	39
Internal Medicine	4	5	9		5	2	7
Pediatrics	3	1	4		4	0	4
Total Primary Care	**24**	**33**	**57**		**26**	**24**	**50**
Family Medicine – APP					7	24	31
Internal Medicine – APP					2	0	2
Total APP	**numbers were not tracked in 2012*				**9**	**24**	**33**
Cardiology	3	0.3	3.3		3	0.4	3.4
Dermatology	0	0.2	0.2		0	0.2	0.2
Gastrointestinal	0.5	0	0.5		0.5	0	0.5
Oncology	2	0.1	2.1		1	0.1	1.1
Nephrology	1	0.25	1.25		1	0.1	1.1
Neurology	0	0.1	0.1		0	0.1	0.1
Pulmonology	0	0.1	0.1		1	0.1	1.1
Pediatric Specialty	0	0.1	0.1		0	0.1	0.1
Radiation Oncology	1	0	1		1	0	1
Other	1	0	1		0	0	0
Total Other Medical Specialties	**8.5**	**1.15**	**9.65**		**7.5**	**1.1**	**8.6**
General Surgery	3.5	2	5.5		3.5	2	5.5
Obstetrics/Gynecology	4	1	5		4	1	5
Orthopedic Surgery	3	0	3		3	0	3
Urology	1	0	1		2	0	2
Ophthalmology	2	0	2		2	0	2
ENT	0	0.1	0.1		1	0.1	1.1
Neuro/Spine Surgery	0	0.2	0.2		0	0.1	0.1
Vascular	0	0.25	0.25		0	0.2	0.2
Other	1	0.2	1.2		0	0	0
Total Surgical Specialties	**15**	**3.75**	**18.75**		**15.5**	**3.4**	**18.9**

*Numbers as of May 31, 2015

State and Federally Designated Health Professional Shortages. Six of the ten counties in the community— Roberts, Day, Clark, Hamlin, Deuel, and Lac qui Parle —have been designated as health professional shortage areas and medically underserved areas by the U.S. Bureau of Primary Health Care's Division of Shortage Designation.

COUNTY HEALTH RANKINGS

The Robert Wood Johnson Foundation's County Health Rankings & Roadmaps provide *health outcomes* rankings at the county-level for every state in the country. There are two primary sub-categories that comprise the health outcomes ranking: length of life and quality of life. The county that is ranked 1st is considered the healthiest county in the state. Three counties rank in the top ten with notable improvements in Clark, Codington, Deuel, and Grant counties. Lac qui Parle County dropped in ranking from 2012 to 2015 from 12th to 50th. Roberts County remains in the bottom tier and dropped in ranking from 2012 to 2015.

Display 22: County Health Outcomes Rankings

	2012	**2015**
South Dakota (out of 60 counties)		
Clark	29th	5th
Codington	22nd	9th
Day County	10th	13th
Deuel	40th	20th
Grant	46th	25th
Hamlin	6th	6th
Roberts	33rd	42nd
Minnesota (out of 87 counties)		
Big Stone	30th	44th
Lac qui Parle	12th	50th
Yellow Medicine	69th	53rd

(County Health Rankings)

County Health Rankings also provide health factors rankings at the county level for every state. The sub-categories that comprise the health factors rankings include health behaviors, clinical care, social and economic factors, and physical environment. Clark and Hamlin were the only counties showing improvements in health factors rankings in 2015. Day, Deuel, Roberts, and Grant were in the bottom third tier. The most notable ranking declines in 2015 were in Lac qui Parle and Yellow Medicine Counties.

Display 23: County Health Factors Rankings

	2012	**2015**
South Dakota (out of 60 counties)		
Clark	44th	31st
Codington	18th	23rd
Day County	45th	46th
Deuel	34th	42nd
Grant	24th	41st
Hamlin	35th	28th
Roberts	48th	51st
Minnesota (out of 87 counties)		
Big Stone	6th	20th
Lac qui Parle	21st	47th
Yellow Medicine	19th	55th

(County Health Rankings)

MORTALITY

Heart disease and cancer are the leading causes of death in South Dakota. Risk factors for heart disease include high blood pressure, high cholesterol, and smoking. In addition, diabetes, obesity, poor diet, physical inactivity, and excessive alcohol consumption may increase risk. (Display 24). Risk factor mitigation in the United States has mixed results. Between 1960 and 2010, the incidences of smoking, hypertension, and high cholesterol decreased in the United States, but the incidence of obesity increased dramatically, from approximately 45% of the adult population in 1960 to about 70% in 2010.

Display 24: South Dakota Resident Leading Causes of Death, 2010-2014

	Total	2010	2011	2012	2013	2014
Heart Disease	8,190	1,611	1,615	1,652	1,617	1,695
Malignant Neoplasms (Cancer)	8,183	1,651	1,656	1,623	1,574	1,679
Chronic Lower Respiratory Diseases	2,268	451	485	479	413	440
Alzheimer's Disease	2,139	401	423	462	420	433
Cerebrovascular Diseases	2,116	411	442	410	414	439
Accidents	2,100	391	407	417	424	461
Diabetes Mellitus	1,189	241	267	219	239	223
Influenza and Pneumonia	898	166	178	188	186	180
Intentional Self-Harm (Suicide)	687	139	125	135	147	141
All Others	8,450	1,625	1,673	1,698	1,645	1,809

(South Dakota Department of Health, 2015)

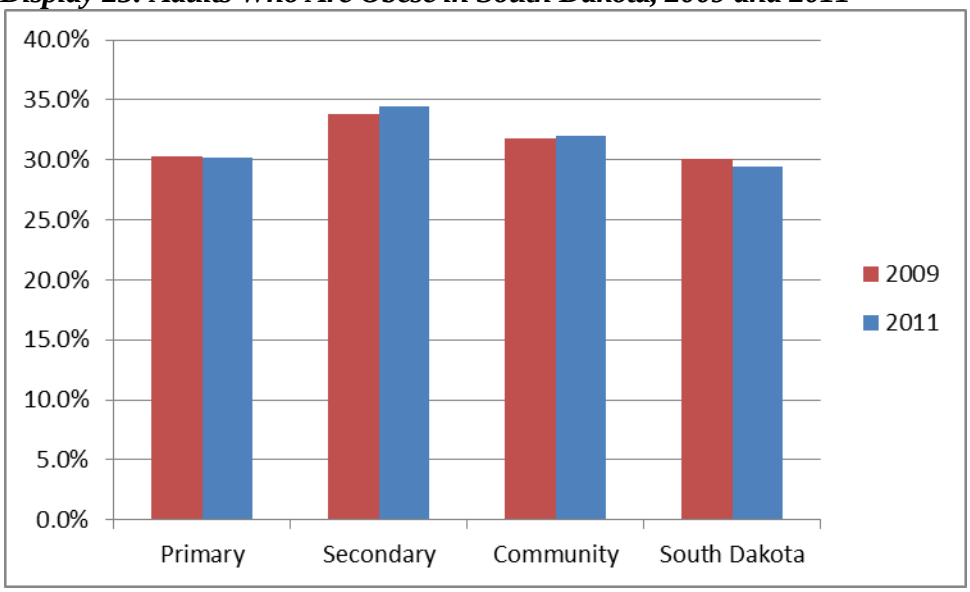
OBESITY AND PHYSICAL ACTIVITY

Many chronic diseases are linked to obesity, including heart disease, stroke, type 2 diabetes, and certain types of cancer. Between 2005 and 2012, obesity among adults in the United States increased from 33.9% to 35.3% and obesity among children in the United States increased from 16.1% to 16.9%. Between 2009 and 2012, obesity rates among adults in South Dakota declined slightly, from 30.1% to 29.4% (Display 25). However, during that same period, the obesity rate in the primary service area remained fairly constant while the obesity rate in the secondary service area increased from 33.9% to 34.4%. Focus group participants expressed a need for obesity prevention and resources for all ages.

The community's highest obesity rate occurred in Roberts County in both 2009 and 2011. However, Roberts County obesity rates also showed slight decline during that time. The percentage of obese adults in Roberts County decreased from 36.4% in 2009 to 34.9% in 2011. Three counties in the PLHS community (Day, Grant and Yellow Medicine) showed increase in adult obesity rates of at least 1.5%. In 2015, 10.6% of South Dakotans and 5.9% of Minnesotans reported limited access to healthy foods.

PLHS registered dieticians saw an average of 270 new and follow-up patients annually to provide outpatient dietary education. This number is on the decline. Medicaid recently stopped paying for weight loss counseling which may be a factor influencing access to such services.

Display 25: Adults Who Are Obese in South Dakota, 2009 and 2011

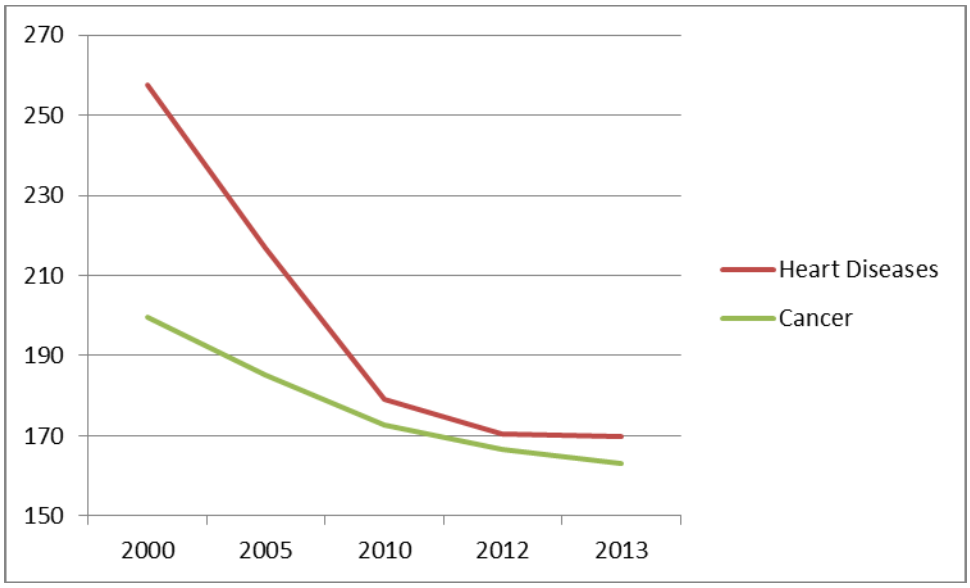


(County Health Rankings, 2012 and 2015)

CANCER

Cancer is the second leading cause of death in South Dakota and the United States. Overall mortality rates for heart disease and cancer are similar. In the United States, the mortality rates for heart disease and cancer have declined, but the decrease has been more pronounced in heart disease. Similar trends are observed in South Dakota. Between 2010 and 2014, 8,190 individuals died from heart disease in South Dakota while 8,183 individuals died from cancer, a difference of only seven individuals (Display 26).

Display 26: Comparison of Age-Adjusted Death Rate per 100,000 Population in the United States



(National Center for Health Statistics, 2014)

Incidence of Cancer. In South Dakota, the four most diagnosed cancer sites (female breast, lung, prostate, and colorectal) accounted for 50.6% of all cancer cases in 2012 (Display 27). Eight other cancers (bladder, kidney and pelvis, corpus and uterus, oral cavity and pharynx, melanoma, non-Hodgkin lymphoma, leukemia, and thyroid) each occurred over 100 times per 100,000 persons during the same year and accounted for another 28.1%. In 2012, South Dakota had higher rates of female breast and colorectal cancer than the national average and lower rates of prostate and lung cancer.

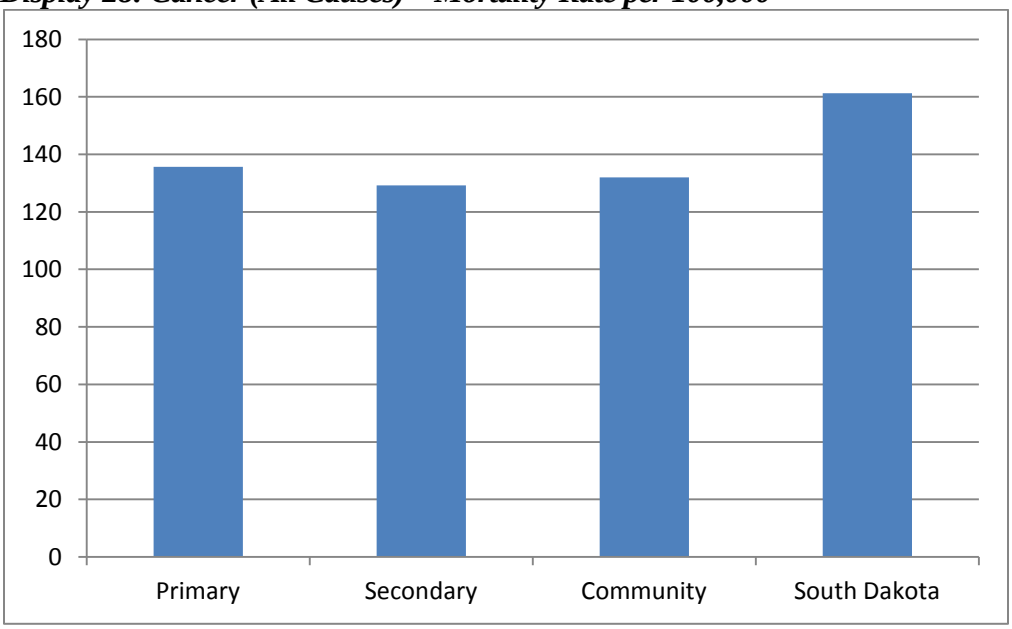
Display 27: Incidence of Cancer by Type per 100,000 population (2012)

	South Dakota	United States
Female Breast	141.4	122.2
Prostate	102.3	105.3
Lung and Bronchus	54.6	60.4
Colorectal	39.9	38.9
Corpus and Uterus	23.7	25.7
Melanomas of the Skin	22.6	19.9
Non-Hodgkin Lymphoma	20.3	18.5
Bladder	19.4	20.2
Kidney and Pelvis	13.9	15.9
Leukemia	13.7	13.2

(Centers for Disease Control and Prevention, 2012)

The overall cancer mortality rate for the PLHS community (132.0 deaths per 100,000 persons) is lower than the state average (161.2 deaths per 100,000 persons). A review of mortality rates by cancer type shows that the PLHS community's incidences of colorectal, female breast, and prostate cancers are fairly consistent with the state average (Display 28). Between 2012 and 2015, the percentage of female Medicare enrollees ages 67-69 that received mammography screening decreased in both South Dakota and Minnesota. The rates decreased in five PLHS counties (Lac qui Parle, Yellow Medicine, Codington, Deuel, and Grant), but it increased in the other five. The PLHS community's lung cancer mortality rate is significantly below the state average (27.7 deaths and 43.3 deaths, respectively, per 100,000 persons).

Display 28: Cancer (All Causes) – Mortality Rate per 100,000



(S.D. Department of Health, 2015)

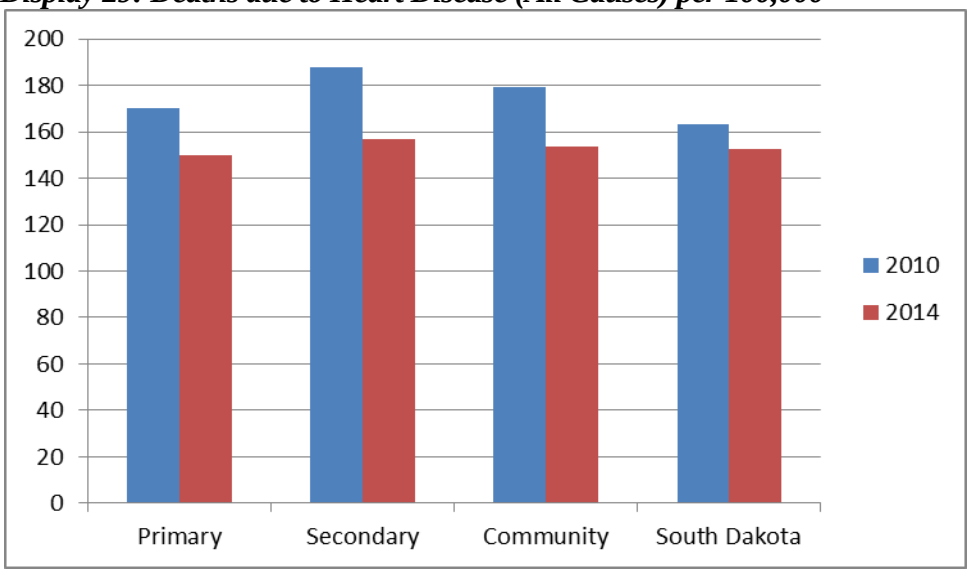
CARDIOVASCULAR DISEASE

Cardiovascular disease is a broad term that includes heart attack, stroke, heart failure, hypertensive heart disease, and diseases of the arteries, veins, and circulatory system. In the United States, cardiovascular disease is the leading cause of death for both men and women, causing approximately 610,000 deaths per year, which equates to one in four deaths. In the United States, someone has a heart attack every 43 seconds and dies from a heart disease-related event every minute.

Between 2010 and 2014, heart disease was the leading cause of death in South Dakota, although it is followed closely by cancer. Each of these conditions kills three to four times as many people as chronic lower respiratory diseases, the third leading cause of death. According to the South Dakota Department of Health, as the population grows older, heart disease, stroke, and the economic costs associated with treatment and rehabilitation will also increase.

In 2010, the community had a higher heart disease mortality rate (all causes) than the state average. However in 2014, the community's heart disease mortality rate is much closer to the state average (154 and 153 deaths per 100,000, respectively) (Display 29). In 2014, Roberts County's heart disease mortality rate was 179.1 deaths per 100,000 individuals.

Display 29: Deaths due to Heart Disease (All Causes) per 100,000



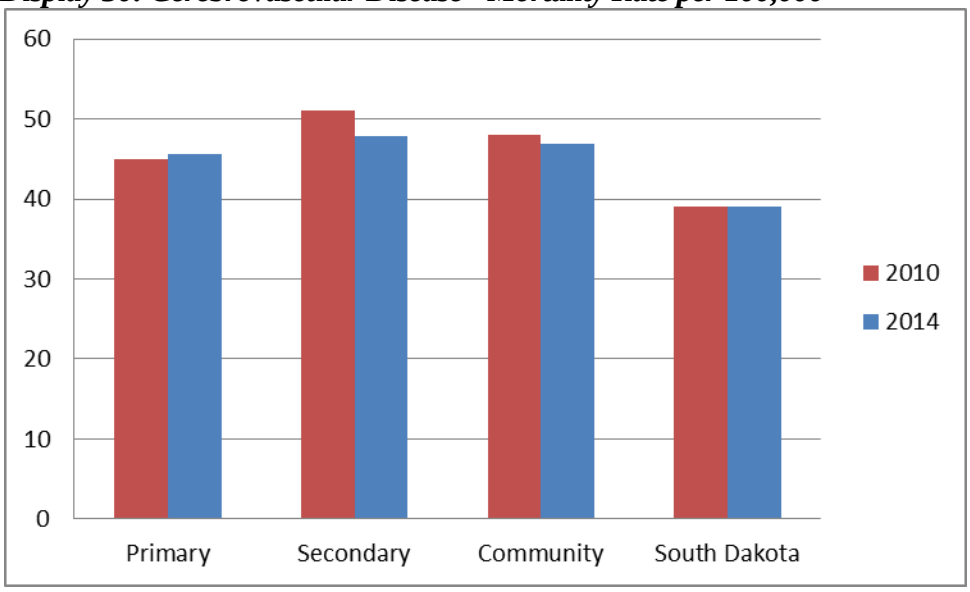
(S.D. Department of Health, 2012 and 2015)

Heart Failure. An opportunity to reduce inpatient heart failure readmission was identified by physicians and by reviewing readmission rates. The primary reasons for minimal care management programming are lack of physician and hospital integration and lack of reimbursement for care coordination.

STROKE

From 2006 to 2010, South Dakota was one of two states that saw a decline in stroke prevalence, from 2.2% to 1.8% (CDC, 2012). However, the mortality rate for cerebrovascular disease in both PLHS' primary and secondary service areas was higher than the state average (Display 30). Clark and Day counties showed significantly higher rates of cerebrovascular disease mortality rates at 57 and 56 per 100,000, respectively.

Display 30: Cerebrovascular Disease - Mortality Rate per 100,000



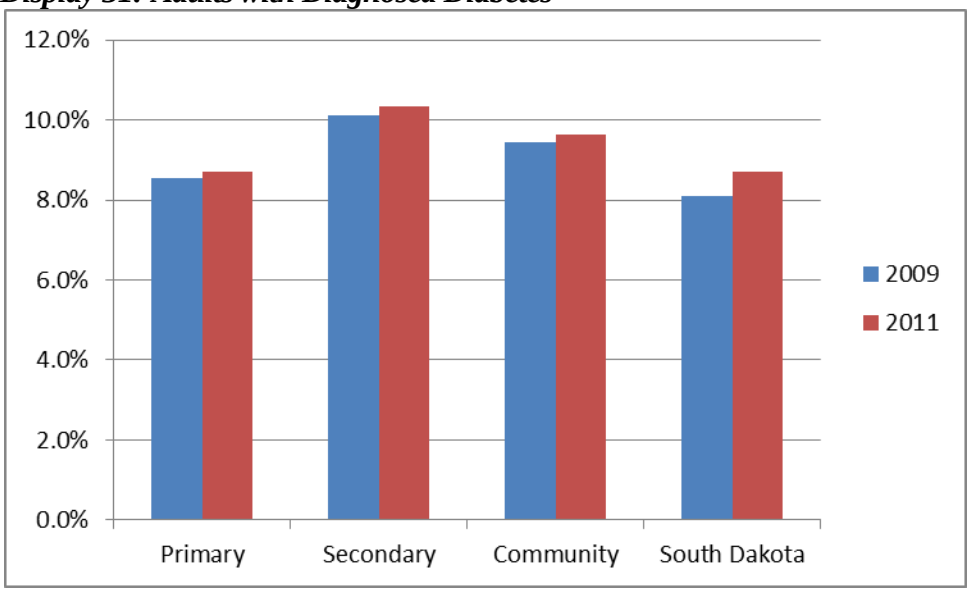
(S.D. Department of Health, 2012 and 2015)

DIABETES

Between 1988 and 2012, the diabetes rate among adults in the United States increased from 8.8% to 11.7%. The prevalence of diabetes increases with age, with an incidence of 3.7% in adults age 20-44; 16.2% in ages 45-64; and, 26.8% in ages 65 and over. In 2010, 6.9% of South Dakotans were diagnosed with either Type 1 or Type 2 diabetes. The South Dakota Diabetes Coalition estimates an additional 25% of South Dakotans have undiagnosed diabetes and that another 35% are at risk of developing diabetes. In total, these estimates mean approximately two-thirds of South Dakotans either have or are at risk of developing diabetes.

Between 2009 and 2011, the prevalence of diabetes increased in the primary and secondary service areas (Display 31).

Display 31: Adults with Diagnosed Diabetes



(County Health Rankings, 2012 and 2015)

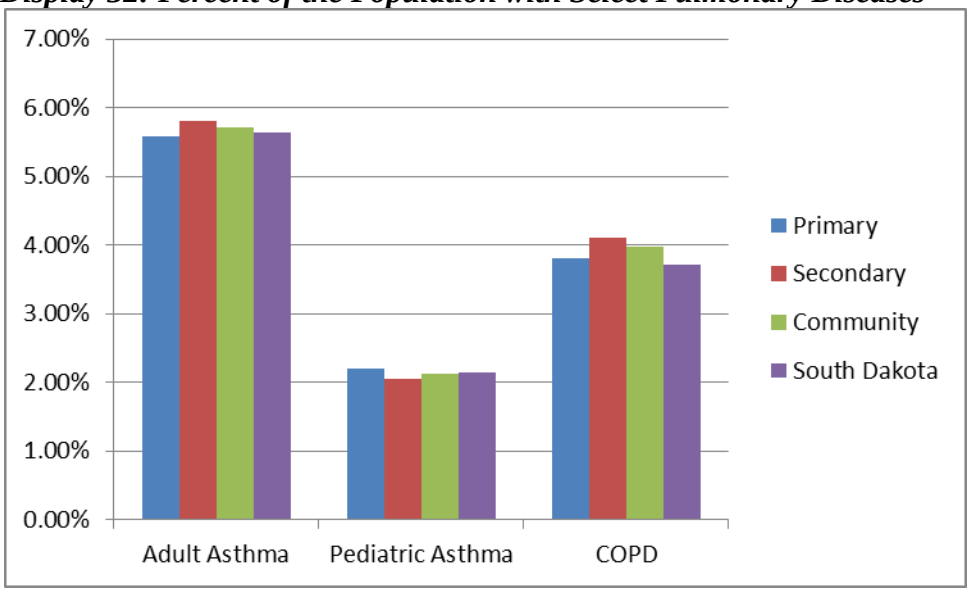
PULMONARY DISEASE

According to the National Institutes of Health, if all types of chronic lower respiratory diseases were considered, it is the number three killer in the United States. The term lung disease refers to many disorders affecting the lungs, such as asthma, chronic obstructive pulmonary disease (COPD), infections like influenza, pneumonia bronchitis, and tuberculosis.

Between 2007 and 2011, 39.5 million Americans reported having asthma at some point in their lives. In 2012, approximately 8.9% of American adults and 9.0% of children had asthma. Between 2007 and 2011, 12.7 million Americans had COPD. In 2012, 2.9% of the total American adult population had been diagnosed with COPD, 3.7% had been diagnosed with chronic bronchitis, and 1.7% had been diagnosed with emphysema within the last 12 months.

A comparison of the community to South Dakota as a whole shows very consistent respiratory disease rates (Display 32). There is a 7.8% incidence of asthma and 4.0%incidence of COPD, compared to state rates of 7.8% and 3.7%, respectively.

Display 32: Percent of the Population with Select Pulmonary Diseases



(American Lung Association, 2014)

MENTAL HEALTH

Mental health is a major factor in overall physical health. Depression rates are increased for individuals with obesity, diabetes, lack of leisure-time exercise, high blood pressure, high cholesterol, smoking, heavy drinking, less than 6 hours of sleep, lack of health insurance, angina or coronary heart disease, cancer, asthma, arthritis, COPD, kidney disease, severe vision impairment, recent increased confusion and/or memory loss.

In 2014, about 20% of American adults experienced a mental health issue, approximately 10% of American youth experienced a period of major depression, and approximately 4% of Americans lived with a serious mental illness such as schizophrenia, bipolar disorder or major depression. Suicide accounts for the loss of more than 41,000 lives per year, which is more than double the number of lives lost from homicide. Depression and suicide tend to occur more frequently in women than in men and more often in low-income individuals. In 2012-13, the prevalence of serious psychological distress was more than 9 times as high for individuals living below the poverty level (14.5%) as for those living at 400% or more of poverty (1.5%).

Within South Dakota, mental health issues are trending about the same from year to year. Between 2009 and 2013, the percentage of South Dakotan adults who considered suicide decreased from 3.9% to 3.7%. Between 2011 and 2013, the percentage of South Dakotan adults who were told they have depression decreased from 16% to 14%. This decrease was attributed to reporting changes with South Dakotan males, in which the depression reporting rate decreased from 12% to 8% while it stayed constant at 21% for females. Finally, the rate of major depressive episodes among South Dakotan adolescents decreased from 8.8% to 8.6% between 2009 and 2013.

Similar trends can be seen in the community. Between 2012 and 2015, the ratio of mental health providers to adults has shown improvement. Every county in the community has been designated as a Health Professional Shortage Area including shortages of mental health providers. The ratio of mental health providers to adults improved from 2012-2015. Codington County improved from 3,278:1 to 664:1 and Roberts County improved from 4,976:1 to 2,563:1. PLHS continues to financially support local organizations providing mental health services and assists in recruiting efforts. PLHS shares resources on where to find mental health services that are in the community (County Health Rankings).

SUBSTANCE ABUSE

Between 2008 and 2012, the percentage of U.S. adults who reported excessive drinking within the last 30 days remained constant at 27.1%. Across the United States, the percentage of adolescents who reported using alcohol or illicit drugs in the past 30 days decreased from 18.4% to 17.4% between 2008 and 2012.

Similarly, the percentage of adolescents binge drinking in South Dakota decreased from 20.6% in 2009 to 17.8% in 2013. Unfortunately, the percentage of South Dakota adolescents has consistently exceeded the national average, which is likely correlated with the fact that 63% of South Dakota adolescents indicated in 2013 that they saw no great risk in binge drinking.

In 2012, the excessive drinking rate was generally higher among the Minnesota counties in the community (approximately 25%) than in the South Dakota counties (approximately 20%). The percentage of people who drink excessively increased in most PLHS counties between 2012 and 2015.

The percentage of adults who smoked decreased by half in the PLHS counties between 2012 and 2015. Deuel and Grant Counties saw a significant increase. Similar to alcohol use, the percentage of South Dakotan youths who smoke decreased from 10.3% to 8.0% between 2009 and 2013, although the rate was consistently higher than the national average. This is likely correlated with the fact that 35% of South Dakota adolescents indicated in 2013 that they saw no great risk in smoking at least one pack of cigarettes per day (County Health Rankings).

COMMUNITY HEALTH NEEDS

PLHS conducted a comprehensive, data-driven assessment to identify significant health needs in the PLHS community. These needs were categorized into the following areas: access to healthcare professionals, mental health and substance abuse, chronic disease management, and health literacy. In addition, PLHS analyzed trends and demographic data, as this data is used to project disease incidence and determine needs for physicians and healthcare services.

Access to Healthcare Professionals

There continues to be a need for increased access to both primary and specialty care in the PLHS community. Barriers to care currently include: difficulties in traveling to care locations, lack of specialty services, inability to see primary care physicians in a timely manner or when services are

needed, and inability to pay for services. The ability to pay for health care has generally improved in the PLHS community, as evidenced by the fact that annual household income has increased more than annual health care costs. In addition, ways to increase access to primary care needs to be explored in order to allow access to care in a timely manner; decrease inappropriate use of the emergency department, provide care to low income, uninsured, and underinsured populations.

Mental Health and Substance Abuse

Mental health is a significant concern for the community members. Depression is the most prevalent condition, impacting women and low-income individuals the most. Tobacco use and excessive alcohol consumption are also major concerns. Excessive alcohol consumption has increased in the community in recent years. Alcohol abuse and tobacco use by adolescents is more prevalent in the community than in South Dakota or the nation.

Chronic Disease Management

PLHS' community members struggle with diseases and illnesses, similar to the rest of the nation. Conditions of highest concern include cardiovascular disease, cerebrovascular disease, cancer, diabetes, pulmonary disease, and obesity. While the community's health has improved in some ways in recent years, it has deteriorated in others. Overall, the healthcare needs and disease prevalence data indicates a need to address chronic disease education, prevention, and management.

Health Literacy

The public's ability to maintain a current detailed listing of medications to provide to health care providers across the continuum of care is lacking. Further, the expectations for prescription of antibiotics for unwarranted conditions is concerning. Overall, the concerns indicate a need to address public education and expectations.

Exhibit 1
Prairie Lakes Healthcare System
Community Health Needs Implementation Plan

HEALTH NEEDS TO BE ADDRESSED

1. MENTAL HEALTH

Objective:

Improve access to mental health services through partnerships with other healthcare providers to facilitate improved access to care.

Key Initiatives:

A. Develop the infrastructure needed to identify specific needs and solutions

B. Seek out collaboration opportunities to increase access

2. ACCESS TO HEALTHCARE - TRANSPORTATION

Objectives:

Decreases barriers to health care access related to transportation.

Key Initiatives:

A. Sustain partnership with Watertown Area Transit providing free ride service to medical appointments

B. Explore options for increased marketing and dissemination of information to increase awareness of public transportation options

3. CHRONIC DISEASE MANAGEMENT

Objective:

Improve quality of life and clinical outcomes for people with chronic disease.

Key Initiatives:

A. Cardiovascular Disease

- Continue to enhance home transitions program

- Enhance patient education

B. Diabetes

- Continue to enhance home transitions program
- Explore the need for diabetic specific trained staff

C. Respiratory Disease

- Continue to enhance home transitions program
- Recruit a pulmonologist
- Reinstate outreach clinics

D. Cerebrovascular Disease (Stroke)

- Enhance patient education
- Evaluate stroke protocols

4. HEALTH LITERACY

Objective:

Improve medication safety for the community.

Key Initiatives:

A. Develop the infrastructure needed to provide public education

B. Explore the development of medication protocols for select health conditions

HEALTH NEEDS NOT ADDRESSED

1. ACCESS TO PRIMARY AND SPECIALTY CARE SERVICES

PLHS provides recruiting resources and financial assistance for the recruitment of physicians to the community. PLHS will continue to explore the need for additional specialties needed and pursue recruitment as necessary. Telehealth services will also be explored to assist in meeting specialty care needs.

2. SUBSTANCE ABUSE

The lifestyle health issues related to tobacco use and excessive alcohol consumption are addressed through a number of community initiatives. PLHS will continue to support these initiatives through cash donations.

3. OBESITY

Obesity is currently being addressed through community nutrition, physical activity, and weight loss initiatives. Primary care clinics, the hospital, and the community recreation center provide a number of programs. The hospital will evaluate opportunities to provide cash donations to support community initiatives that address inequities associated with providing services.

4. CANCER

PLHS has a fully developed cancer program. Cash donations are made annually to community groups who provide assistance to cancer patients with needs. No specific initiatives are planned but the organization will continue to provide cash donations to community groups providing support of cancer patients.

5. HEALTHCARE COSTS

PLHS has a financial assistance policy to provide charity care to low-income and medically underserved individuals that qualify.

Appendix 1
Secondary Data Sources

The following publicly available data was utilized in determining the community's significant health needs.

- Behavioral Health Barometer, South Dakota, 2014, United States Department of Health & Human Services
- The Behavioral Risk Factor Surveillance System, South Dakota Department of Health, https://doh.sd.gov/statistics/2013BRFSS/default.aspx
- Cancer in South Dakota, Preliminary Report of Cancer Among South Dakotans in 2013, February 2015, South Dakota Department of Health, https://getscreened.sd.gov/documents/2013_SDCR_Preliminary_Report.pdf
- County Health Rankings and Roadmaps, The Robert Wood Johnson Foundation, http://www.countyhealthrankings.org/
- Diabetes Statistics, South Dakota Diabetes Coalition, http://sddiabetescoalition.org/Resources-(1)/About-Diabetes/Diabetes-Statistics.aspx
- Estimated Prevalence and Incidence of Lung Disease, May 2014, American Lung Association, http://www.lung.org/assets/documents/research/estimated-prevalence.pdf
- Health Expenditure per Capita (Current U.S. $), The World Bank, http://data.worldbank.org/indicator/SH.XPD.PCAP
- Health Professional Shortage Areas, 2015, Minnesota Department of Health, http://www.health.state.mn.us/divs/orhpc/shortage/
- Health, United States, 2014, With Special Feature on Adults Aged 55-64, National Center for Health Statistics
- Healthy People 2020 Leading Health Indicators: Progress Update, March 2014, United States Department of Health & Human Services
- Heart Disease Fact Sheet, United States Department of Health & Human Services, http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_heart_disease.htm
- Leading Causes of Death, Centers for Disease Control and Prevention, http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm
- Mental Health Myths and Facts, United States Department of Health & Human Services, http://www.mentalhealth.gov/basics/myths-facts/
- Minnesota Critical Access Hospitals, June 2007, Minnesota Office of Rural Health & Primary Care, http://www.health.state.mn.us/divs/orhpc/flex/map.pdf

- Minnesota County Population Projections by Age and Gender, 2015-2045, Minnesota State Demographic Center, March 2014, http://mn.gov/admin/demography/data-by-topic/population-data/our-projections/

- NHLBI Fact Book, Fiscal Year 2012, National Institutes of Health, http://www.nhlbi.nih.gov/about/documents/factbook/2012/chapter4#4_5

- South Dakota Cancer Registry, 2012, South Dakota Department of Health, http://getscreened.sd.gov/registry/data/2012CancerReport.aspx

- South Dakota Critical Access Hospitals, July 2013, South Dakota Office of Rural Health, https://doh.sd.gov/providers/assets/CAHmap.pdf

- South Dakota Health Professional Shortage Areas, 2015, South Dakota Department of Health, https://doh.sd.gov/providers/ruralhealth/shortage.aspx

- South Dakota State and County Demographic Profiles, South Dakota State University College of Agriculture and Biological Sciences, May 2008

- South Dakota Vital Statistics Report: A State and County Comparison of Leading Health Indicators, 2014, South Dakota Department of Health, https://doh.sd.gov/statistics/2014Vital/default.aspx

- United States Cancer Statistics, 2012, Centers for Disease Control and Prevention, https://nccd.cdc.gov/uscs/statevsnational.aspx

- United States QuickFacts, United States Census Bureau, http://www.census.gov/quickfacts/table/PST045214/00

- U.S. Business Cycle Expansions and Contractions, The National Bureau of Economic Research, http://www.nber.org/cycles/cyclesmain.html

Appendix 2
Available Community Resources

The following resources are available in the community to address the significant health needs that were identified in this community health needs assessment.

Each county's health department provides numerous services to the residents of that county. We recommend that you visit your county's health department to obtain further information about all of the services and programs it offers. The county health departments can be contacted at:

- Codington County Community Health Nurse
  - 14 1st Avenue SE, Watertown, SD 57201
  - (605) 882-5177
  - http://codington.org/community-health-nurse/
- Clark County Health Care
  - http://www.clarksd.com/healthcare.htm
- Day County Community Health Nurse
  - 711 West First, Webster, SD 57274
  - (605) 345-3882
  - http://day.sdcounties.org/community-health-wic/
- Deuel County Public Health Nurse
  - Deuel County Memorial Hospital – 701 3rd Avenue S, Clear Lake, SD 57226
  - (605) 874-2555
- Grant County Community Health Nurse
  - 210 East 5th Avenue, Milbank, SD 57252
  - (605) 432-4596
  - http://grantcounty.sd.gov/stateofsd/community_health_nurse.php
- Hamlin County Community Health Services
  - 300 4th street, Hayti, SD 57241
  - (605) 783-3681
  - http://www.hamlincountysd.org/#!nurse/c1bv3
- Roberts County Community Health Nurse
  - 405 Chestnut E, Sisseton, SD 57262
  - (605) -698-4183
  - http://roberts.sdcounties.org/community-health/
- Countryside Public Health (Big Stone, Lac qui Parle, and Yellow Medicine Counties)
  - Ortonville Office
    - 342 2nd Street NW, Ortonville, MN 56278
    - (320) 839-6135
  - Madison Office
    - 422 5th Avenue, Suite 305, Madison, MN 56256
    - (320) -598-7313
  - Granite Falls Office
    - 415 9th Avenue, Granite Falls, MN 56241
    - (320) 564-3010
  - http://www.countrysidepublichealth.org/

In addition to government support, the following facilities and programs are available in the community to address the significant health needs identified in this Community Health Needs Assessment Report. Some of these locations offer services related to multiple needs, such as general health care, mental health care, dental care, and eye care.

Hospitals

- Prairie Lakes Healthcare System
  - 401 9th Avenue NW, Watertown, SD 57201
  - (605)882-7000
  - www.prairielakes.com
- Sanford Webster Medical Center
  - 1401 W 14st Street, Webster, SD 57274
  - (605) 345-3336
  - www.sanfordwebster.org
- Sanford Clear Lake Medical Center
  - 701 3rd Avenue S, Clear Lake, SD 57226
  - (605) 874-8484
  - www.sanfordclearlake.org
- Avera Milbank Area Hospital
  - 901 E Virgil Avenue, Milbank, SD 57252
  - (605) 432-4538
  - www.avera.org/milbank/
- Coteau Des Prairies Hospital
  - 205 Orchard Drive, Sisseton, SD 57262
  - (605) 698-7647
  - www.cdphealth.com
- Ortonville Area Health Services
  - 450 Eastvold Avenue, Ortonville, MN 56278
  - (320) 839-2502
  - oahs.us
- Essentia Health-Holy Trinity Hospital
  - 115 2nd Street, Graceville, MN 56240
  - (320) 748-7223
  - http://www.essentiahealth.org/holytrinityhospital/find-a-clinic/essentia-healthholy-trinity-hospital-graceville-96.aspx
- Johnson Memorial Health Services
  - 1282 Walnut Street, Dawson, MN 56232
  - (320) 769-4323
  - jmhsmn.org
- Madison Hospital
  - 900 2nd Avenue, Madison, MN 56256
  - (320) 598-7556
  - mlhmn.org/Madison-hospital-services/

- Sanford Canby Medical Center
  - 112 St. Olaf Avenue S, Canby, MN 56220
  - (507) 223-7277
  - www.sanfordcanby.org
- Granite Falls Municipal Hospital
  - 345 10th Avenue, Granite Falls, MN 56241
  - (320) 564-3111
  - www.granitefallshealthcare.com

Clinics – Clark County

- Clark Care Center – 201 8th Avenue NW, Clark, SD 57225
- Sanford Health Clark Clinic – 211 N Commercial Street, Clark, SD 57225
- Clark Family Dental Center – 415 1st Avenue W, Clark, SD 57225

Clinics – Codington County

- Prairie Lakes Healthcare System – 1404 9th Avenue SW, Watertown, SD 57201
- Prairie Lakes Cancer Center – 401 9th Avenue NW, Watertown, SD 57201
- Prairie Lakes Pulmonology Clinic – 600 4th Street NE, Watertown, SD 57201
- Prairie Lakes Mallard Pointe Surgical Center – 1201 Mickelson Drive, Watertown, SD 57201
- Brown Clinic – 506 1st Avenue SE, Watertown, SD 57201
- Brown Clinic – 511 14th Avenue NE, Watertown, SD 57201
- Northridge Clinic – 511 14th Avenue NE, Watertown, SD 57201
- Physicians Vein Clinics – 2420 9th Avenue SE, Watertown, SD 57201
- Sanford Health Watertown Clinic – 901 4th Street NW, Watertown, SD 57201
- Sanford Health Watertown Ear, Nose & Throat Clinic – 600 4th Street NE, Watertown, SD 57201
- South Dakota Academy of Family Physicians – 3912 Golf Course Road, Watertown, SD 57201
- Watertown Family Planning – 703 S Broadway, Watertown, SD 57201
- Watertown VA Outpatient Clinic - 917 29th Street SE, Watertown, SD 57201

Mental Health Care

- Glacial Lakes Professional Counseling Services – 525 5th Street SE, Watertown, SD 57201
- NESD Alcohol-Drug Prevention Resource Center – 123 19th Street NE, Watertown, SD 57201
- Serenity Hills (psychiatrists) – 1500 SD-20, Watertown, SD 57201

Eye Care

- Hanson-Moran Eye Clinic – 705 14th Avenue NE, Watertown, SD 57201
- Johnson Eye & Vision Clinic – 700 9th Avenue SE, Watertown, SD 57201
- Kunkel-Snyder Optometric – 1225 4th Street NE, Watertown, SD 57201
- Meier Visual Clinic – 26 5th Street NE, Watertown, SD 57201
- Pearle Vision – 901 29th Street SE, Watertown, SD 57201
- Vision Care Associates – 1520 4th Street NE, Watertown, SD 57201
- Watertown Family Eyecare – 22 19th Street SE, Watertown, SD 57201
- Watertown Optical Company – 1039 4th Street NE, Watertown, SD 57201
- Weiss Eyecare Clinic – 1300 19th Street NE, Watertown, SD 57201

Dental Care

- Albertson Dental Lab – 314 9th Avenue NE, Watertown, SD 57201
- Family Dental Care – 324 4th Street NE, Watertown, SD 57201
- Family Dental Center – 20 19th Street SE, Watertown, SD 57201
- Gertsen & Saylor (Oral Surgeons) – 1155 4th Street NE, Watertown, SD 57201
- Longworth Orthodontics – 6 S Broadway, Watertown, SD 57201
- Northeast Orthodontic Associates – 25 5th Street NE, Watertown, SD 57201
- Northside Dental Offices – 415 16th Avenue NE, Watertown, SD 57201
- Watertown Dental Care – 600 4th Street NE, Watertown, SD 57201

Clinics – Day County

- Avera Medical Group Webster – 401 E Highway 12, Webster, SD 57274
- Ophthalmology Associates – 101 Peabody Drive, Suite 2, Webster, SD 57274
- Hruby Dental – 101 Peabody Drive, Suite 3, Webster, SD 57274

Clinics – Deuel County

- Deuel Clinic – 701 3rd Avenue S, Clear Lake, SD 57226
- Deuel County Good Samaritan Center – 913 Colonel Pete Street S, Clear Lake, SD 57226
- Clear Lake Dentist – 210 3rd Avenue S, Clear Lake, SD 57226

Clinics – Grant County

- Medical Group Milbank Avera– 803 E Milbank Avenue, Milbank, SD 57252
- Avera Big Stone City Clinic – 451 Main Street, Big Stone City, SD 57216
- Revillo Clinic of Milbank Area Hospital – 305 N 2nd Avenue, Revillo, SD 57259
- Milbank Eyecare Center – 224 S Main Street, Milbank, SD 57252
- Ophthalmology Associates – 411 S Main Street, Milbank, SD 57252
- Johnson Family Dentistry – 1016 S Dakota Street, Milbank, SD 57252
- Northeast Orthodontic Associates – 104 W 4th Avenue, Milbank, SD 57252

Clinics – Hamlin County

- Bryant Clinic – 110 W Main Street, Bryant, SD 57221
- Sanford Health Lake Norden Clinic – 512 Main Avenue, Lake Norden, SD 57248
- Hayti Medical Clinic – 102 Main Avenue, Hayti, SD 57241

Clinics – Roberts County

- Prairie Lakes Dialysis Unit – 100 Lake Traverse Drive, Sisseton, SD 57262
- Rosholt clinic – 116 W Main Street, Rosholt, SD 57260
- Grimsrud Visual Clinic – 121 E Maple Street, Sisseton, SD 57262

Clinics – Big Stone County

- Prairie Lakes Dialysis Unit – 814 Roy Street, Ortonville, MN 56278
- Northside Medical Center – 465 Eastvold Avenue, Ortonville, MN 56278
- Conroy Eye Care – 123 2nd Street NW, Ortonville, MN 56278
- Ophthalmology Associates – 750 Eastvold Avenue, Ortonville, MN 56278

Clinics – Lac qui Parle County

- Boyd Community Health Center – 115 3rd Street, Boyd, MN 56218
- Dawson Clinic – 1272 Walnut Street, Dawson, MN 56232
- Lac qui Parle Clinic of Madison – 900 2nd Avenue, Madison, MN 56256
- Woodland Centers (psychiatrists) – 1296 Chestnut Street, Dawson, MN 56232
- Heartland Eyecare Center – 878 6th Street, Dawson, MN 56232
- Madison Optical – 323 6th Avenue, Madison, MN 56256
- Madison Dental Clinic – 622 3rd Avenue, Madison, MN 56256
- Stephen Morris Dental Clinic – 737 Pine Street, Dawson, MN 56232

Clinics – Yellow Medicine County

- Affiliated Community Medical Centers – 295 10th Avenue, Granite Falls, MN 56241
- Sioux Valley Canby Campus – 112 Saint Olaf Avenue S, Canby, MN 56220
- Pathways of West Central Minnesota – 665 Highway 212 W, Granite Falls, MN 56241
- Granite Family Eye Care – 870 Prentice Street, Granite Falls, MN 56241
- Heartland Eye Care Center – 107 1st Street E, Canby, MN 56220
- Sioux Valley Dental Clinic – 112 Saint Olaf Avenue S, Canby, MN 56220

In addition to the agencies and facilities listed here, there are many other facilities located in towns that are close to, but outside of, the community. Examples include De Smet, South Dakota and Morris and Montevideo, Minnesota. We did not include these facilities, although community members near such towns should consider the alternatives available there.