LifeScape

Sioux Falls, South Dakota

Community Health Needs Assessment

June 2019

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Introduction

LifeScape has been open since 1952 and was the first hospital licensed as a Specialty Hospital in South Dakota. Originally named “Crippled Children’s Hospital & School”, it was the vision of orthopedic surgeon Dr. Guy Van Demark and nurse Irene Fischer Coon to serve the children afflicted with polio and confined to hospital rooms at Sioux Valley and McKennan Hospitals. Dr. E.B. Morrison was hired as the first executive director and began raising funds to build the hospital immediately. The doors opened in March 1952 and initially served 32 children who were primarily disabled with polio or cerebral palsy.

Over the years there were several additions to the facility as the needs of children in the state grew and changed. In 1999, the Children’s Care Rehabilitation Center and Rehabilitation Medical Supply Company opened, offering specialized mobility equipment, orthotics and prosthetics, and outpatient rehabilitation therapy services in Sioux Falls. In 2000, the 18-bed Rehabilitation and Medically Complex inpatient unit was opened as an addition of the main facility, bringing the numbered of licensed hospital beds to 114. Due to the changing needs of children served, 96 beds transitioned from hospital licensure to certification as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-ID) in 2011. In April, 2014, Children’s Care Hospital and School affiliated with another non-profit, South Dakota Achieve. Together, these two organizations became LifeScape and established a new mission, vision, and values for the organization. Services provided by the former Children’s Care Specialty Hospital continued as the organizations affiliated as LifeScape. In May of 2019, a second Rehabilitation Center was opened, named the Autism and Child Development Center, offering Behavior Therapy, Occupational Therapy, Physical Therapy and Speech Therapy.

LifeScape has undertaken a Community Health Needs Assessment (CHNA), a process driven by the passage of the Patient Protection and Affordable Care Act, which requires tax exempt hospitals to conduct needs assessments every three years. The purpose of the Community Health Needs Assessment is to uncover unmet health needs that exist within the community LifeScape serves. Through the assessment, input is gathered from the community and applicable needs are prioritized, with an implementation strategy created to address the prioritized needs.

Methods

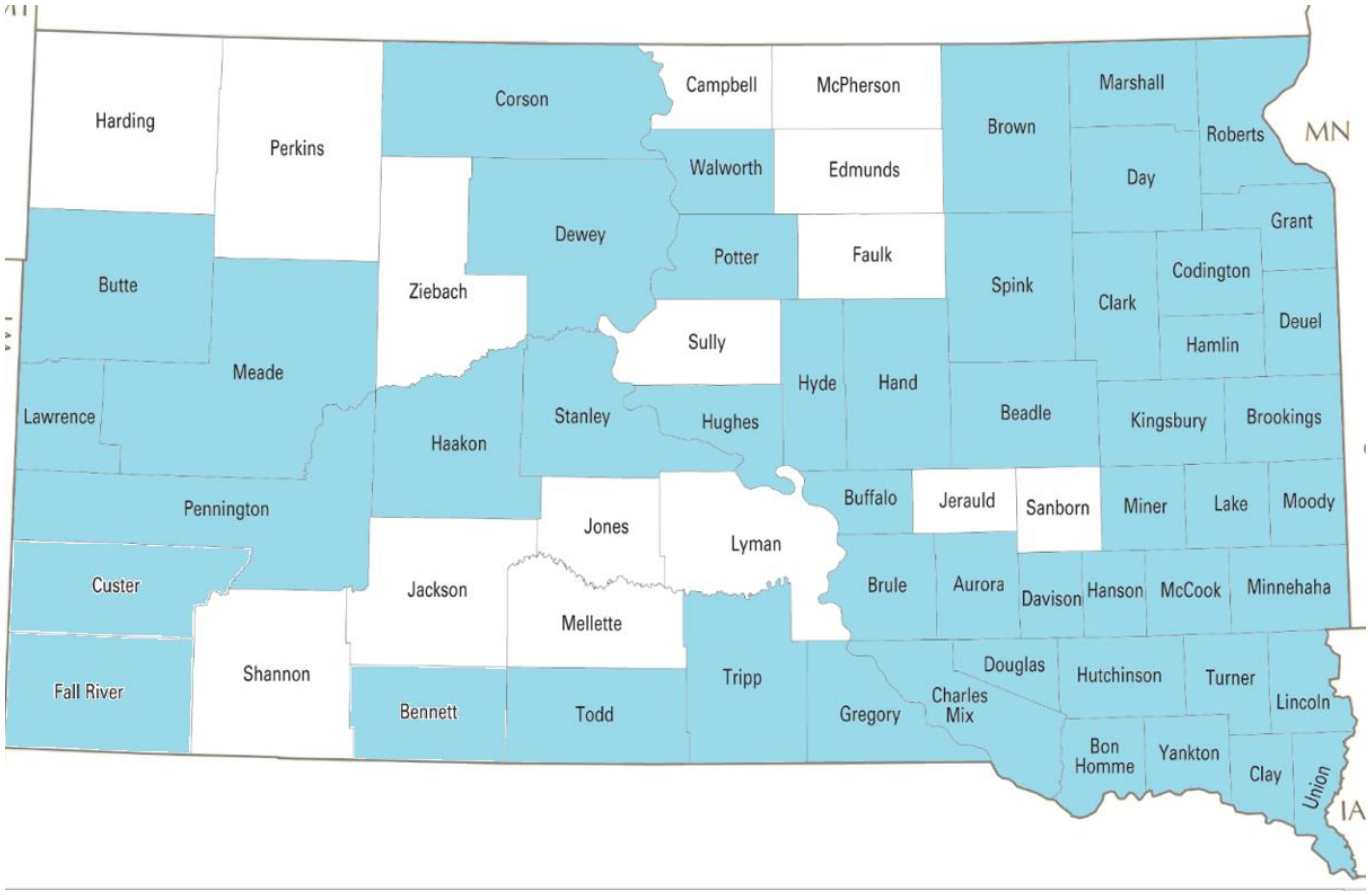
Community Served Determination

The service area for LifeScape was adopted from primary areas where patients who receive services from LifeScape reside. The service area was determined to be South Dakota (52 counties), northwest Iowa (15 counties), and southwest Minnesota (14 counties).

South Dakota Counties
52 Counties Served in South Dakota

Minnesota Service Area	
Big Stone	Murray
Cottonwood	Nobles
Jackson	Pipestone
Kandiyohi	Redwood
Lincoln	Rock
Lyon	Traverse
Martin	Yellow Medicine

Iowa Service Area	
Buena Vista	O'Brien
Cherokee	Osceola
Clay	Palo Alto
Dickinson	Plymouth
Emmet	Pocahontas
Ida	Sioux
Kossuth	Woodbury
Lyon	



CHNA Process

The following outline explains the process for conducting the CHNA. Each process is described in more detail throughout the report.

1. Formation of a CHNA advisory committee

2. Definition of the community served by the hospital facility
   a. Demographics of the community
   b. Existing health care facilities and resources

3. Data collection and Analysis
   a. Primary data
   b. Secondary data

4. Identification and prioritization of community health needs and services to meet community health needs

5. Adoption of goals and implementation strategy to respond to prioritized needs in collaboration with community partners

6. Dissemination of priorities and implementation strategy to the public.

Primary Data Collection

Key informational interviews/surveys were conducted with members of the community served by LifeScape. These individuals were identified by the Committee based on their qualifications to represent the broad interest of the community served. Generally, the interviewees included persons with special knowledge or expertise in public health and persons who represent the medically underserved and vulnerable populations. Interviewees were contacted and asked to participate in the key informational interviews/survey. Contacts can be found in Appendix 1. A summary of the key findings from the key informational interviews can be found further on in this document.

Secondary Data Collection

Secondary data was collected from a variety of local, county, and state sources to present a community profile, birth and death characteristics, access to health care, chronic diseases, social issues, and other demographic characteristics. Data was collected and presented at the county level and wherever possible, compared to the State of South Dakota and the Nation.

The secondary data collected for this analysis was collected from the following sources:

- Autism and Developmental Disabilities Monitoring Network
- Centers for Disease Control and Prevention (CDC)
- National Vital Statistics Reports
- US Department of Education, Individuals with Disabilities Education Act

This report presents a summary that highlights the data findings, presents key priorities identified through the CHNA, and LifeScape Board-Approved implementation plan.

Information Gaps

Every attempt was made to collect primary, secondary and health-related data relevant to the community served by LifeScape. In certain cases, LifeScape' ability to assess all of the community's health needs was limited by a lack of existing health-related data collected at the county level.

Community/Demographic Profile – Primary Data Results

Population

The population in one of the LifeScape service areas (South Dakota) is anticipated to grow over the next 6 years; whereas the other two service areas are anticipated to decline. The service area as a whole is expected to grow by 58,144 people over the next six years. This growth could translate to a rise in demand for health care services within the service area.

2018, 2020, and 2025 Population

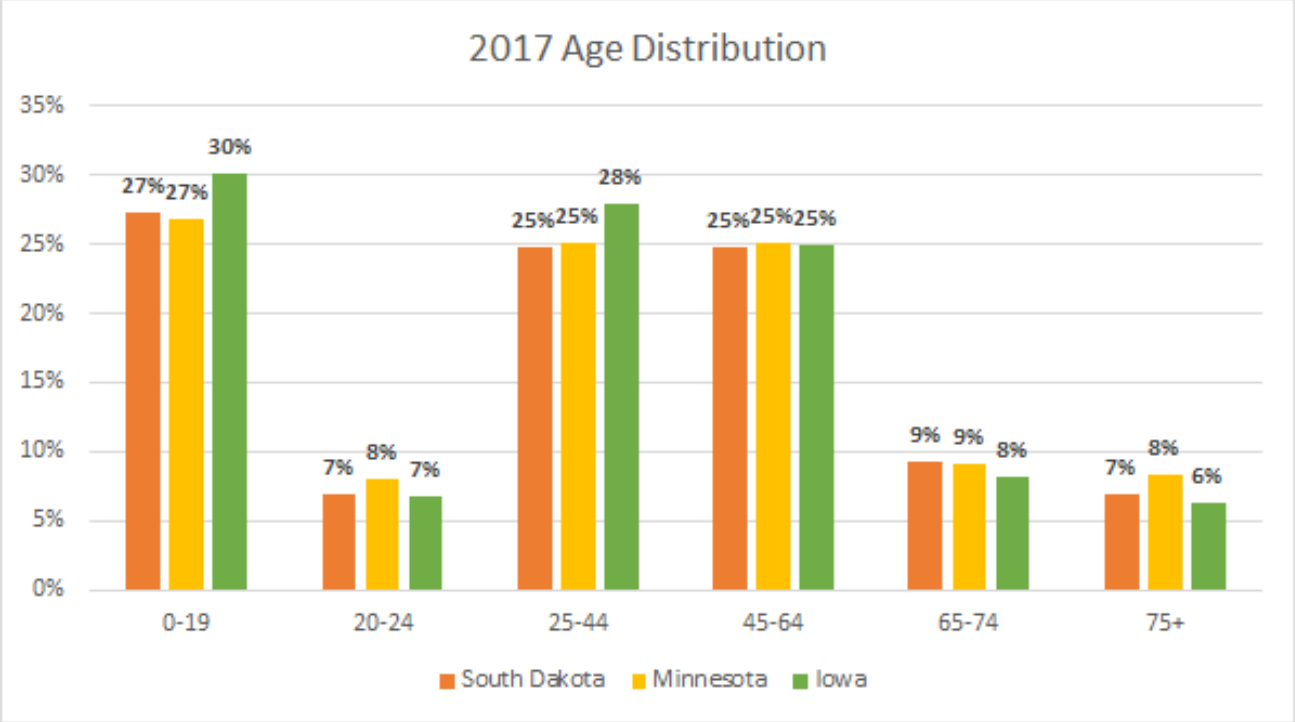
	2018	2020	2025	Change (2018-2020)	Change (2020-2025)
LifeScape Service Area					
South Dakota	849,371	851,113	882,884	1742	31771
Minnesota	356,388	351,514	350,288	-4874	-1226
Iowa	792,591	792,147	819,746	-444	27599
Service Area Total	**1,998,350**	**1,994,774**	**2,052,918**	**-3576**	**58,144**

Sources: Vintage 2018 Population Estimates, US Census Bureau
SD: 2017 Population Estimate Program. Census Bureau. Projections based on the 2010 population data from the US Census Bureau (2014)
Iowa: 2017 Annual Population estimates from the U.S. Census Bureau
MN: MN State Demographic Center, based on 2014 data (2017)

Population by Age

Population was grouped into major age categories for comparison for the year of 2017. The number of individuals in the age 0-19 age group is 27% of the total population in South Dakota and Minnesota and 30% of the total population in Iowa.

2017 Population Age Distribution



Sources: SD: 2017 Population Estimate Program. Census Bureau. Projections based on the 2010 population data from the US Census Bureau (2014)
Iowa: 2017 Annual Population estimates from the U.S. Census Bureau
MN: MN State Demographic Center, based on 2014 data, produced in 2017

Population by Race and Ethnicity

LifeScape's service areas are predominantly white, equating to 76-85% of the total population within each service area. Most of the remaining population in Iowa and Minnesota is Hispanic/Latino, while the American Indian and Alaska Native population makes up most of South Dakota's remaining population.

2017 Population by Race

2017 - Population Estimates by Race	South Dakota		Minnesota		Iowa	
	Number	Percent	Number	Percent	Number	Percent
Non-Hispanic						
White	689,878	82%	302,959	85%	760,688	76%
Black or African American	17,559	2%	14,386	4%	41,070	4%
American Indian and Alaska Native	66,495	8%	2,214	1%	8,741	1%
Asian	12,517	1%	7,874	2%	30,196	3%
Native Hawaiian and Other Pacific Islander	457	0%	192	0%	1,350	0%
Two or More Races	17,689	2%	4,679	1%	18,748	2%
Hispanic	31,944	4%	23,202	7%	145,574	14%
Total	**836,539**	**100%**	**355,506**	**100%**	**1,006,367**	**100%**

Sources: SD: 2017 Population Estimate Program. Census Bureau. Projections based on the 2010 population data from the US Census Bureau (2014)
Iowa: 2017 Annual Population estimates from the U.S. Census Bureau
MN: MN State Demographic Center, based on 2014 data, produced in 2017

Unemployment

Unemployment rates in the South Dakota, Iowa and Minnesota trend down from 2013 to 2018, with the whole service area falling under the U.S. unemployment rate in 2018.

Service Area	2013	2014	2015	2016	2017	2018
South Dakota	3.8%	3.4%	3.10%	3.0%	3.2%	3.0%
Iowa	4.7%	4.2%	3.80%	3.6%	3.1%	2.5%
Minnesota	5.0%	4.2%	3.70%	3.9%	3.4%	2.9%
United States	7.4%	6.2%	5.30%	4.9%	4.4%	3.9%

Source: Bureau of Labor Statistics https://www.bls.gov/lau/

Poverty

The poverty rate in South Dakota, Iowa, and Minnesota continue to remain lower than the United States.

2015 and 2017 Poverty Rate

Service Area	2015	2017
South Dakota	13.9%	10.5%
Iowa	10.4%	9.1%
Minnesota	7.8%	9.2%
United States	13.5%	12.3%

Source: United States Census Bureau https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-people.html Table 21. Number of Poor and Poverty Rate, By State

Secondary Data Results

Live Births (per 1000 population)

Live birth rates were reviewed for the United States and the three states in LifeScape's service area (county data was not available). The trend in the three states from 2011 to 2015 stayed consistent in birth rate with slight fluctuations each year.

Service Area	2011	2012	2013	2014	2015
South Dakota	77.1%	78.1%	78.1%	77.8%	78.2%
Minnesota	65.5%	65.7%	65.9%	66.4%	66.3%
Iowa	66.1%	66.8%	67.1%	67.8%	67.1%
United States	63.2%	63.0%	62.5%	62.9%	62.5%

Source: March of Dimes

Preterm Birth

According to the Center for Disease Control, preterm births are those that occur at less than 37 weeks gestation. Preterm births represent a small percentage of all births, but pre-term related problems are the highest cause of infant death. Babies born before 37 weeks gestation require special care and those who survive may have lifelong disabilities such as intellectual disabilities, cerebral palsy, breathing and respiratory problems, visual problems, hearing loss, and feeding/digestive problems. Preterm births have decreased slightly in the United States. South Dakota, Minnesota, and Iowa showed a similar trend from 2007 to 2018.

Area	2007	2018
South Dakota	9.5%	9.3%
Minnesota	9.0%	8.9%
Iowa	9.7%	9.2%
United States	10.4%	9.9%

Source: March of Dimes

Low Birthweight

The CDC defines low birth weight as less than 5.5 pounds. Infants born weighing less than 5.5 pounds are 40 times more likely to die in the first four weeks of their life than infants weighing above 5.5 pounds. Infants with a low birth weight are at an increased risk for neurodevelopmental disabilities and respiratory conditions. Rates in Iowa, Minnesota and South Dakota were lower than the United States in 2017.

Location	All Races	Non-Hispanic Black	Non-Hispanic White	Hispanic
South Dakota	6.3%	8.1%	6.0%	7.1%
Minnesota	6.5%	9.3%	5.9%	6.3%
Iowa	6.7%	10.9%	6.4%	6.2%
United States	8.0%	13.2%	7.0%	7.1%

Source: March of Dimes

Autism Spectrum Disorders in U.S. 2000-2014

The CDC reports that about 1 in 59 children have been identified with an autism spectrum disorder (ASD) in 2014 based on estimates from the Autism and Developmental Disabilities Monitoring Network (ADDM).

Surveillance Year	Birth Year	Number of ADDM Sites Reporting	Combined Prevalence per 1,000 Children (Range Across ADDM Sites)	This is about 1 in X children...
2000	1992	6	6.7 (4.5-9.9)	1 in 150
2002	1994	14	6.6 (3.3-10.6)	1 in 150
2004	1996	8	8 (4.6-9.8)	1 in 125
2006	1998	11	9 (4.2-12.1)	1 in 110
2008	2000	14	11.3 (4.8-21.2)	1 in 88
2010	2002	11	14.7 (5.7-21.9)	1 in 68
2012	2004	11	14.5 (8.2-24.6)	1 in 69
2014	2006	11	16.8 (13.1-29.3)	1 in 59

Source: Centers for Disease and Control https://www.cdc.gov/ncbddd/autism/data.html

Children with Special Needs

The Individuals with Disabilities Act (IDEA), Part B, provides for special education services for children ages 3-21. State child count numbers in each special education category was reviewed. The number of children with disabilities is increasing in South Dakota and Iowa, however the number has declined in Minnesota. Each specific disability can be interpreted in the charts below:

State	Year	All Disabilities	Autism	Deaf-blindness	Emotional disturbance
South Dakota	2016	19527	1,163	3	1,107
South Dakota	2017	20312	1,326	3	1,158
South Dakota	2018	21190	1,512	4	1,190
South Dakota % Change	**2016 - 2018**	**9%**	**30%**	**33%**	**7%**
Minnesota	2016	128218	17,591	81	14,928
Minnesota	2017	131865	18,391	93	15,447
Minnesota	2018	118800	17,562	89	15,666
Minnesota % Change	**2016 - 2018**	**-7.3%**	**-0.2%**	**10%**	**5%**
Iowa	2016	63822	714	0	6,216
Iowa	2017	64875	729	0	6,322
Iowa	2018	65935	736	0	6,421
Iowa % Change	**2016 - 2018**	**3%**	**3%**	**0%**	**3%**

Source: US Department of Education, Individuals with Disabilities Education Act

State	Year	Hearing impairments	Intellectual disabilities	Multiple disabilities	Orthopedic impairments	Other health impairments
South Dakota	2016	151	1,760	531	71	2,541
South Dakota	2017	148	1,872	550	65	2,640
South Dakota	2018	139	1,908	593	68	2,787
South Dakota % Change	**2016 - 2018**	**-8%**	**8%**	**12%**	**-4%**	**10%**
Minnesota	2016	2,369	7,574	1,481	1,609	18,782
Minnesota	2017	2,379	7,594	1,493	1,578	19,409
Minnesota	2018	2,058	7,396	1,460	1,445	19,671
Minnesota % Change	**2016 - 2018**	**-13%**	**-2%**	**-1%**	**-10%**	**5%**
Iowa	2016	443	10,994	350	714	84
Iowa	2017	453	11,179	354	729	86
Iowa	2018	455	11,363	362	736	83
Iowa % Change	**2016 - 2018**	**3%**	**3%**	**3%**	**3%**	**-1%**

Source: US Department of Education, Individuals with Disabilities Education Act

State	Year	Specific learning disabilities	Speech or language impairments	Traumatic brain injury	Visual impairments
South Dakota	2016	6,762	4,065	65	52
South Dakota	2017	6,851	4,300	57	46
South Dakota	2018	6,995	4,503	56	51
South Dakota % Change	**2016 - 2018**	**3%**	**11%**	**-14%**	**-2%**
Minnesota	2016	30,306	21,050	446	449
Minnesota	2017	31,263	21,215	447	467
Minnesota	2018	32,320	17,176	425	428
Minnesota % Change	**2016 - 2018**	**7%**	**-18%**	**-5%**	**-5%**
Iowa	2016	38,556	5,498	169	84
Iowa	2017	39,171	5,593	173	86
Iowa	2018	39,835	5,685	176	83
Iowa % Change	**2016 - 2018**	**3%**	**3%**	**4%**	**-1%**

Summary of Key Findings and Prioritized Needs

A list of interview/survey participants can be found in Appendix 1. The LifeScape Advisory Committee selected individuals with a wide range of backgrounds in health-related agencies and with health-related qualifications to participate in the interviews. These individuals represent the broad interests of the community served by LifeScape.

Interview/survey participants were presented with a series of questions. These questions were developed from a variety of nationally accepted health improvement models and tailored to uncover the health needs that may exist within the LifeScape community. Questions can be found in Appendix 2. Responses were recorded and later condensed into common themes. The following top priorities were identified through the CHNA process:

Underserved Populations:

1. People with Autism.
2. People with dual diagnoses (intellectual disability and co-occurring mental illness.
3. People who live in poverty, underinsured, and cannot afford high deductibles and co-pays.
4. Childhood obesity.
5. Medicare patients.

Top Issues Identified:

1. Lack of mental health services and providers.
2. Lack of parent training and education.
3. Lack of coordination of connecting families to resources in the community.
4. Lack of transportation to services.
5. Lack of availability of affordable healthcare/low fee clinics.

The health needs were prioritized by the CHNA Advisory Committee. The criteria used to prioritize the health needs can be found in Appendix 3. The criteria measures were established by the committee, drawing from recommendations from the National Rural Health Association.

Existing Health Care and other Facilities and Resources

The following health care facilities and resources are available within the community to meet the health needs identified through the CHNA:

MENTAL HEALTH SERVICES

1. Avera Behavioral Health
2. Southeastern Behavioral Healthcare
3. Rapid City Regional Behavioral Health Center

4. South Dakota Human Services Center
5. South Dakota Developmental Center
6. Seasons Center for Behavioral Health (IA)
7. NW Iowa Mental Health Center
8. Southwestern Mental Health Center (MN)
9. Community Based Service Providers of South Dakota (19 locations)
10. LifeScape

TRANSLATION SERVICES
1. Interpreter Services Inc
2. Communication Services for the Deaf
3. Lutheran Social Services of South Dakota (SD & SW MN)

SERVICES FOR CHILDREN WITH COMPLEX/SEVERE DEVELOPMENTAL NEEDS
1. Sanford Children's Hospital
2. Avera Children's Hospital
3. Rapid City Regional Hospital
4. Universal Pediatric Nursing
5. LifeScape

RURAL HEALTHCARE/OUTREACH
1. Indian Health Services
2. Avera Healthcare
3. Sanford Healthcare
4. Rapid City Regional Healthcare
5. LifeScape

TRANSPORTATION SERVICES FOR INDIVIDUALS WITH DISABILTIES
1. Sioux Falls Paratransit
2. Rapid City Paratransit
3. Aberdeen Ride Line
4. Brandon City Transit
5. Brookings Area Transit Authority
6. City of Groton Transit
7. Dell Rapids Transit
8. Huron - People Transit
9. Inter-Lakes Community Action
10. Lake Andes - Rural Office of Community Services
11. Lemmon - Arrow Public Transit
12. Madison - East Dakota Transit
13. Mitchell - Palace Transit
14. Pierre - River Cities Transit

15. Redfield - Spink County Public Transit
16. Sisseton - Community Transit
17. Spearfish - Prairie Hills Transit
18. Vermillion - South East Transit
19. Watertown Area Transit
20. Woonsocket - Sanborn County Transit
21. Yankton Transit
22. Medivan Inc (Worthington)
23. Peoples Express (SW Minn)
24. Handi Van Service, (SW Minn)
25. AmeriCare Mobility Van LLP (SW
26. RIDES (NW Iowa)

PARENT RESOURCE CENTERS

1. SD Parent Connections
2. PACER Minnesota
3. ASK Resource Center Iowa

Implementation Plan

Once the health needs were prioritized by the CHNA Advisory Committee, the final step in the CHNA process involved developing an implementation strategy. The purpose of the implementation strategy is to develop a clear set of goals to respond to the priorities identified through the CHNA. The implementation strategy should include a written plan that addresses each of the community health needs identified through the CHNA, describe how the hospital plans to meet the health needs, and identify health needs the hospital does not intend to meet and why.

The CHNA Advisory Committee developed the implementation strategy. The committee addressed the following implementation strategy components within each priority identified:

1. Objectives/Strategy
2. Tactics (How)
3. Programs/Resources to Commit
4. Impact of Programs/Resources on Health Need
5. Accountable Parties
6. Partnerships/Collaboration

The detailed implementation strategy for each priority can be found in Appendix 5. In summary, the following priorities were addressed through the implementation strategy:

Priority 1: There is a lack of mental health services and providers in our service area.
Priority 2: There is a lack of parent training and education in our service area.
Priority 3: There is a lack of coordination of connecting families to resources in our service area.

The implementation strategy detail for each priority located in Appendix 5 provides supporting tactics, programs/resources, accountable parties, and potential partnerships/collaboration for each strategy.

References

Autism and Developmental Disabilities Monitoring Network

U.S. Census Bureau

U.S. Department of Labor, Bureau of Labor Statistics

Center for Disease Control

March of Dimes

IDEA Data Accountability Center, U.S. Office of Special Education

Appendix 1

Interviewee Categories

- Patients/Families
- Physicians
- Community Health Clinics/Centers
- Health and Human Services State Agencies
- Parent Resource Center
- Helpline Center
- USD Center of Disabilities
- Hospital Personnel – Case Managers, Discharge Planners
- Family Support Coordinators
- LifeScape Therapy, Nursing and Case Management Staff

Appendix 2

LifeScape – CHNA Interview Questions

Underserved

What groups are underserved regarding their health care needs in your community?

Service Needs

What are the most significant health care or environmental needs or concerns in your community? Are there any gaps in the availability or access to healthcare in your community?

Barriers

Are there any barriers to accessing services in your community? What are they? How can they be addressed?

Opportunity for Improvement

What are your perceptions of LifeScape? Do you think people know about the services offered in the community? How can we improve services? What role should we play in the community?

Appendix 3

Criteria Used to Prioritize Health Needs

LifeScape CHNA 2019
Decision Matrix

Interview Question	Theme/Priority	Severity of Problem? 1-5	Potential Impact on Health of Population? 1-5	Feasibility of Change? 1-5	Resources Available to Address Problem? Y/N (Y = 5)	Alignment with mission, Strengths, Priorities? Y/N (Y=5)	Overall Priority Score
Question 3: *Underserved populations*	People with Dual Diagnosis: Development Disability / Mental Health issues	5	5	3	y	y	23
	People with Autism	5	5	5	y	y	30
	People in poverty, underinsured	5	5	1	N	Y	16
	Medicare patients	2	2/3	2	N	Y	11.5
	Childhood obesity	3	4	2	Y	Y	19
	Services for persons over 21 years of age	5	5	2	Y	Y	22

Interview Question	Theme/Priority	Severity of Problem? 1-5	Potential Impact on Health of Population? 1-5	Feasibility of Change? 1-5	Resources Available to Address Problem? Y/N (Y = 5)	Alignment with mission, Strengths, Priorities? Y/N (Y=5)	Overall Priority Score
Question 4. Healthcare needs and gaps	Lack of mental health services	5	5	3	y	y	23
	Lack of parent training and education	5	4	4	y	y	23
	Lack of coordination of connecting families to resources in the community/providing resources	5	4	4	y	y	23

Interview Question	Theme/Priority	Severity of Problem? 1-5	Potential Impact on Health of Population? 1-5	Feasibility of Change? 1-5	Resources Available to Address Problem? Y/N (Y = 5)	Alignment with mission, Strengths, Priorities? Y/N (Y=5)	Overall Priority Score
Question 5*: Barriers to access*	Insurance coverage/ financial burden	5	5	2	Y- inpatient N- outpatient	y	19.5
	Transportation/geographical location	3	4	1	N	y	13
	Waiting list	3	3	4	y	y	20

Interview Question	Theme/Priority	Severity of Problem? 1-5	Potential Impact on Health of Population? 1-5	Feasibility of Change? 1-5	Resources Available to Address Problem? Y/N (Y = 5)	Alignment with mission, Strengths, Priorities? Y/N (Y=5)	Overall Priority Score
Question 7*: Opportunities for improvement*	Increase training and development opportunities for clinicians/service providers	3	4	4	y	y	21
	Be more prominent in low-income areas to educate regarding the services available	3	3	3	Y	Y	19
	Expand services provided in-home	4	4	1	N	Y	14
	Increase marketing efforts to better educate the community about services that are available	4	3/4	4	Y	Y	21.5
	Add additional locations for services / expand staff	1	1	3	Y	Y	15
	Partner with universities for students to help with group therapy	1	1	1	Y	Y	13
	Develop transition place for people aging out of services with high medical needs	4	4	1	Y	Y	19

Appendix 4

LifeScape Community Health Needs Assessment Implementation Plan June 2019

SUMMARY OF 2019 FINDINGS

Through the completion of a Community Health Needs Assessment, LifeScape has identified three key priority areas of need: 1) In LifeScapes' service area, there is a lack of mental health services and providers, 2) there is a lack of parent training and education in our service area; and 3) there is a lack of coordination of connecting families to resources in our service area. Although there are other needs that were identified, these three align well with the mission and vision of LifeScape, our strategic plan, as well as the scope of services provided.

PRIORITY 1: There is a lack of mental health services and providers in our service area.

Objective/Strategy:
LifeScape will expand their capacity to provide mental health services to individuals with intellectual/developmental disabilities (ID/D) and/or those with co-occurring mental health diagnoses.

Tactics (How):
1. Research new business line for mental health services that would allow us to expand mental health providers.

2. Assess needs/gaps in mental health trainings/resources for staff and parents/caregivers.

3. Further develop staff training on mental health topics impacting patients and their caregivers.

3. Assess and further develop mental health training programs for parents and caregivers on various platforms.

4.Determine feasibility of becoming an accredited American Psychological Association (APA) internship site.

5.Further explore and develop new mental health services/programs as well as enhance already existing services.

Programs/Resources to Commit (Who):

- Administration
- Outpatient Services Teams

Impact of Programs/Resources on Health Needs

- Training of multiple stakeholders- parents/caregivers, staff, providers- is crucial to aid in meeting the mental health demand confronting our communities. Multiple platforms to provide training will assist in reaching more individuals across communities.
- Exploring a new business line for mental health services will allow us to expand our workforce to meet the community need.
- New services and enhancements to current services will allow us to better meet the needs within the community.

Accountable Parties

- LifeScape Senior Leadership team, Outpatient Services Leadership, Behavioral Services Leadership, Human Resources

Partnerships/Collaboration

- Physicians/hospitals
- State agencies
- Universities
- Other related service providers

PRIORITY #2: There is a lack of parent training and education in our service area.

Objective/Strategy
LifeScape will expand the parent training and education provided.

Tactics (How)
1. Conduct an assessment on training needs/gaps and method of training for parents and caregivers.

2. Determine types of training platforms to disseminate education to stakeholders.

3. Develop plan for implementation of trainings.

4. Research funding sources for parent/caregiver trainings.

5. Establish plan for clinical staff development and growth.

Programs/Resources to Commit (Who)

- Administration
- Outpatient/Inpatient therapy teams
- Hospital nursing services
- Training department

Impact of Programs/Resources on Health Needs

- We will gain a better understanding of the training needs/gaps for those that we serve in our community. As a result, we will be able to develop an action plan to address top training issues facing our community. It is anticipated that by addressing top issues identified by parent/caregivers, we will positively impact the families' ability to address needs.
- The cost of providing trainings impacts the cost of services in a healthcare environment with limited reimbursement options.

Accountable Parties

- LifeScape Senior Leadership team, Specialty Hospital Inpatient and Outpatient Leadership, Training Department

Partnerships/Collaboration

- State agencies
- Grants
- LifeScape Foundation
- Other Service Providers
- Local Health Systems

PRIORITY # 3: There is a lack of coordination of connecting families to resources in our service area.

Objective/Strategy

LifeScape will find innovative ways to improve connecting families to resources within the community.

Tactics (How)

1.Research and analyze social work services in the outpatient setting.

2.Explore current resources that are available to families/caregivers within our communities.

3.Evaluate current social work services in hospital and determine areas for improvement.

4.Determine best platform to disseminate resources to parents, caregivers and staff.

Programs/Resources to Commit (Who)

- Administration
- Outpatient/Inpatient clinical teams

Impact of Programs/Resources on Health Needs

- Improve access to resources available to families/caregivers across our hospital settings.

Accountable Parties

- LifeScape Senior Leadership team, Specialty Hospital Inpatient and Outpatient Leadership

Partnerships/Collaboration

- State agencies
- Non-profit organizations
- Community Health Systems
- Local Health Systems

STATUS UPDATE ON 2016 PRIORITY

In 2016, LifeScape identified two priorities to address following completion of a Community Health Needs Assessment.

Below is a summary of progress.

PRIORITY 1: There is a lack of mental health services and providers in our service area.

Objective/Strategy: LifeScape will expand the capacity to provide mental health services with intellectual/developmental disabilities (ID/D) and/or those with co-occurring mental health diagnosis and ID/D.

Accomplishments:

- LifeScape has hired 3 additional clinical psychologists in our Outpatient Services.
- We continue to educate providers, staff and families on our psychology services as we general mental health needs.
- We have expanded multidisciplinary clinics by adding in psychology services- Early Start Denver Model, Constipation Clinic, and Feeding Clinic.
- We are collaborating with Black Hills Works Psychologist for Autism Evaluations in our Rapid City clinic.
- Clinical Psychology Internship program with the University of South Dakota continues.
- LifeScape has increased our capacity to do more Outpatient Diagnostic Autism Evaluations.
- We have expanded our Outpatient Services and opened a new clinic on West side of town called the Autism and Child Development Center.

PRIORITY 2: Culture and language barriers impact access to healthcare for immigrants who do not speak English as their primary language.

Objective/Strategy: Non-English speaking patients will have an overall improved experience when receiving LifeScape services resulting in better home program follow-through and a decrease in messed appointments.

Accomplishments:

- Collaborated with Lutheran Social Services to gain a better understanding of their services as well as educating them on our services.
- Added additional translation services to meet our needs in the Outpatient clinics.
- Outpatient services has translated intake paperwork and patient education materials into Spanish.