Children's Care Hospital and School

Sioux Falls, South Dakota

Community Health Needs Assessment

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Introduction

Children's Care Hospital & School 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.

Children's Care has undertaken a Community Health Needs Assessment (CHNA), a process driven by recent 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 Children's Care 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

Wipfli's Role

In October of 2012, Wipfli LLP (Wipfli) was engaged by leadership at Children's Care Hospital & School to facilitate the Community Health Needs Assessment (CHNA) process alongside the hospital. This CHNA report was completed in compliance with the IRS requirements described in section 501(r)(3) of the Internal Revenue Code.

Community Served Determination

The service area for Children's Care was adopted from primary areas where patients who receive services from Children's Care reside. The service area was determined to be South Dakota (66 counties), northwest Iowa (9 counties), and southwest Minnesota (11 counties).

CCH Service Area Definition

South Dakota Service Area
All Counties in South Dakota

Minnesota Service Area	
Lac Qui Parle	Murray
Yellow Medicine	Nobles
Lincoln	Redwood
Pipestone	Cottonwood
Rock	Jackson
Lyon	

Iowa Service Area	
Cherokee	Osceola
Dickinson	Plymouth
Emmet	Sioux
Lyon	Woodbury
O'Brien	

CHNA Process

The CHNA process that Wipfli and Children's Care utilized to conduct the assessment has been adopted from several of the leading sources on the subject. These sources include:

- Association for Community Health Improvement
- Rural Health Works
- Flex Monitoring Team

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 (key stakeholders)

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 the 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

Interviews were conducted with stakeholders representing the three service area communities, as well as a representation of physicians who serve patients in the defined service area. These interviews were used to gather information and opinions from persons who represent the broad interest of the community served, including persons with special knowledge or expertise in public health and persons who represent the medically underserved and vulnerable populations. For the interviews, community stakeholders were identified by the Children's Care CHNA Advisory Committee. Stakeholders were contacted and asked to participate in the interviews. A list of the stakeholder focus group participants can be found in Appendix 1. A summary of the primary data collection findings begins on Page 5.

Secondary Data Collection

Secondary data was collected from a variety of local, county, and state sources to present a community profile, birth characteristics, access to health care, chronic diseases, social issues, and other demographic characteristics. Data was collected and presented at the national level and wherever possible, compared to South Dakota, Minnesota, and Iowa. Some data was not available for the specific counties represented in Minnesota and Iowa.

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

- Center for Disease Control (CDC)
- National Vital Statistics Reports
- IDEA Data Accountability Center, U.S. Office of Special Education

This report presents a summary that highlights the data findings, presents key needs, and opportunities for action.

Information Gaps

- The Children's Care service area is unique in that it spans over a large geographical area that is very rural in nature. Although the majority of services provided are to children with complex healthcare needs, some adults with disabilities are also served. Children with intellectual, developmental, physical, and behavioral disabilities, as well as significant medical or co-occurring mental health needs are the traditional patient profile. Statistical data for this patient population is very limited; especially for the smaller service area in Minnesota and Iowa (data is typically state-wide). The Center for Disease Control, the IDEA Data Accountability Center of the U.S. Office of Special Education, and the National Vital Statistics Reports provided data that showed trends that support this needs assessment.

Community/Demographic Profile – Primary Data Results

Population

The population in two of the three Children's Care service areas has grown over the past 3 years and is anticipated to continue growing. South Dakota's growth rate is more substantial than the service area in Iowa. The Minnesota service area population has declined somewhat and that trend is anticipated to continue. The service area as a whole is expected to grow by 37,450 people over the next five years. This growth could translate to a rise in demand for health care services within the service area.

Children's Care Hospital & School
Service Area Population Growth

	2008	2013	2018	% Change (2008-2013)	Change (2008-2013)	% Change 2013-2018	Change 2013-2018
CCHS Service Area							
South Dakota	802,314	835,570	872,677	4.1%	39,189	4.4%	37,107
Iowa	232,809	232,827	234,334	0.0%	-215	0.6%	1,507
Minnesota	137,650	135,383	134,219	-1.6%	-2,669	-0.9%	-1,164
Service Area Total	**1,172,773**	**1,203,780**	**1,241,230**	**2.6%**	**36,306**	**3.1%**	**37,450**

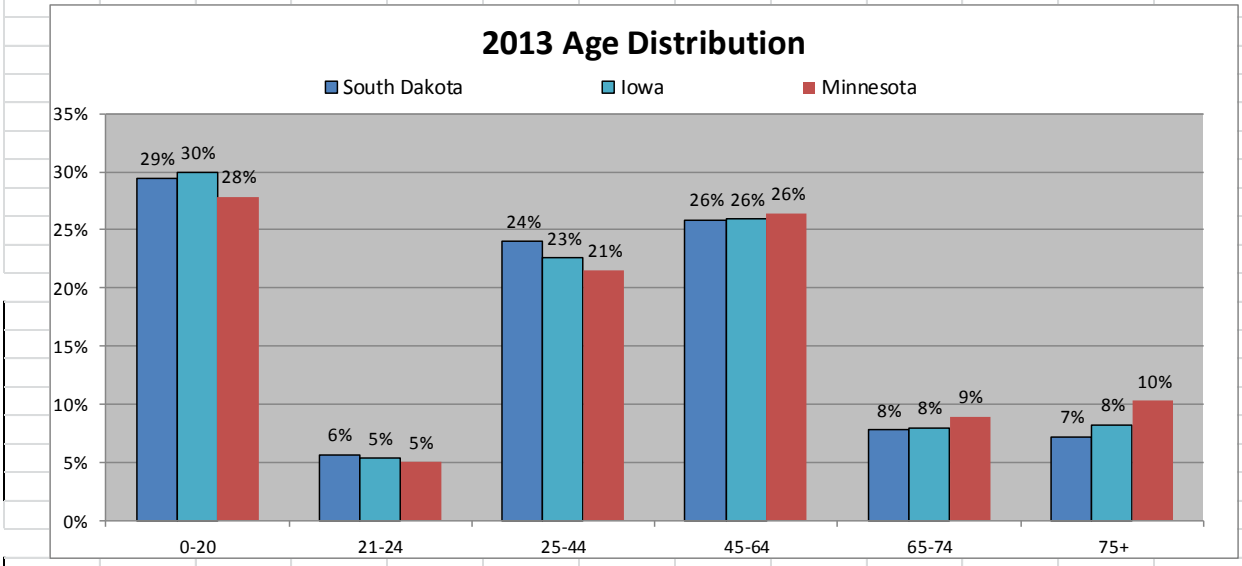
Source: Nielson Company, 2012

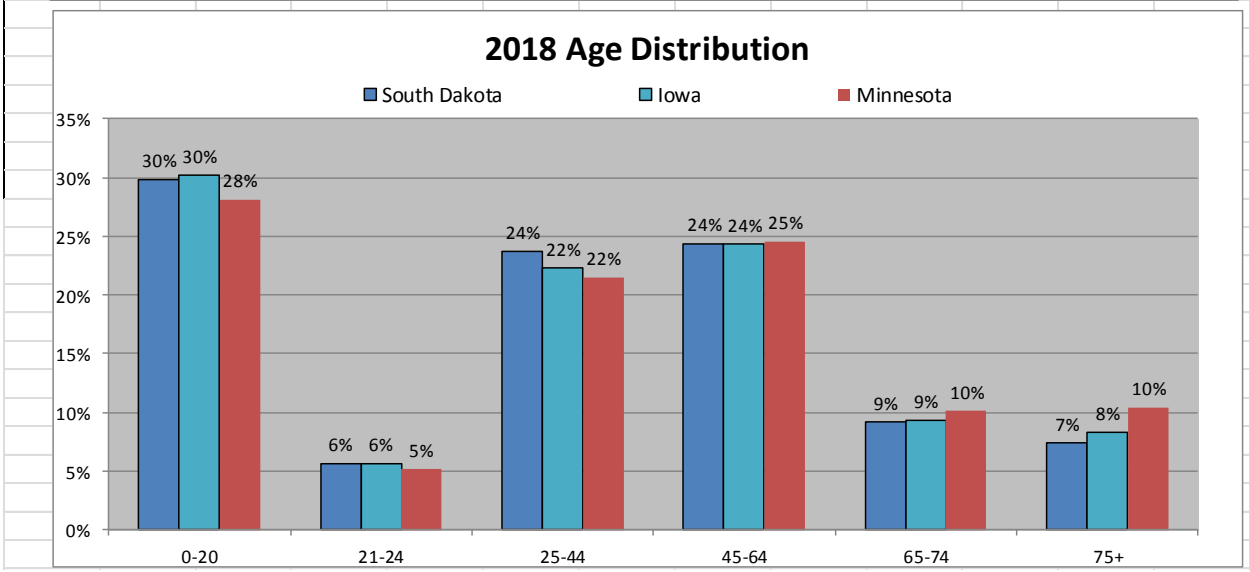
Population by Age

Population was grouped into major age categories for comparison. It is anticipated that the number of individuals in the age 0-21 group will increase slightly in South Dakota and remain steady in Iowa and Minnesota counties in the service area. The service area population over age 21 is not anticipated to change significantly.

2013 and 2018 Population Age Distribution

Children's Care Hospital & School
Service Area Age Distribution





Source: Nielson Company, 2012

Population by Race and Ethnicity

The Children's Care service areas are predominantly white, equating to roughly 80% of the total population. Most of the remaining population in Iowa and Minnesota is Hispanic/Latino, while the Native American population makes up most of the rest of South Dakota's population. Anticipated trends do not show a significant change in the mix of race/culture in any part of the service area.

2013 and 2018 Population by Race

Children's Care Hospital & School
Service Area Race Distribution

2013	South Dakota		Iowa		Minnesota	
	Number	Percent	Number	Percent	Number	Percent
Hispanic or Latino	25,211	3%	22,275	10%	10,117	7%
White	685,535	82%	186,320	80%	111,025	82%
African American	11,769	1%	3,069	1%	1,953	1%
Native American	76,237	9%	2,727	1%	1,627	1%
Asian	8,488	1%	3,145	1%	3,363	2%
Hawaiian/Pacific Is.	438	0%	173	0%	57	0%
Other	27,892	3%	15,118	6%	7,241	5%
Total	**835,570**	**100%**	**232,827**	**100%**	**135,383**	**100%**

2018	South Dakota		Iowa		Minnesota	
	Number	Percent	Number	Percent	Number	Percent
Hispanic or Latino	30,024	3%	25,436	11%	11,752	9%
White	701,451	80%	182,029	78%	106,149	79%
African American	14,486	2%	3,316	1%	2,352	2%
Native American	83,519	10%	2,981	1%	1,757	1%
Asian	9,821	1%	3,138	1%	3,783	3%
Hawaiian/Pacific Is.	505	0%	208	0%	62	0%
Other	32,871	4%	17,226	7%	8,364	6%
Total	**872,677**	**100%**	**234,334**	**100%**	**134,219**	**100%**

Nielson Company, 2012

Unemployment

Unemployment rates in the Children's Care service area trend up from 2008 to 2013, with the whole service area falling under the U.S. unemployment rate in 2013. A range is provided for the Minnesota and Iowa counties in the service area.

2008 and 2013 Unemployment Rates

Service Area	2008 (Feb)	2013 (Feb)
South Dakota	3.4%	4.4%
NW Iowa Counties	2.9%-5.5%	3.3%-7.5%
SW Minnesota Counties	3.6%-7.4%	4.1%-6.9%
United States	5.9%	7.7%

Source: US Dept of Labor, Bureau of Labor Statistics

Poverty

The poverty rate in South Dakota, Iowa, and Minnesota increased at a similar trend as the increase in poverty for the United States.

2008 and 2011 Poverty Rates

Area	2008	2011
South Dakota	12.1%	13.9%
Iowa	11.6%	12.8%
Minnesota	9.8%	11.9%
United States	13.3%	15.9%

Source: U.S. Census Bureau

Secondary Data Results

Live Births (per 1000 population)

Live birth rates were reviewed for the United States and the three states in the Children's Care service area (county data was not available). The trend in the three states from 2008 to 2010 is a slight decline in birth rate, although South Dakota and Iowa declined at a slighter lesser rate than Minnesota. This decline is consistent with the decline in births for the U.S. as a whole from 2008 to 2010.

2008 and 2010 Live Birth Rate

Area	2008	2010
South Dakota	15.0	14.5
Iowa	13.4	12.7
Minnesota	13.9	12.9
United States	14.0	13.0

Source: National Vital Statistics Reports

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 showed a similar trend from 2008 to 2010. Iowa and Minnesota had very small increases in their percentage of preterm births.

2008 and 2010 Preterm Births

Area	2008	2010
South Dakota	11.9%	11.4%
Iowa	11.5%	11.6%
Minnesota	10%	10.2%
United States	12.3%	12.0%

Source: National Vital Statistics Reports

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. Trends in the United States show a decreasing percentage of low birth weight infants from 2010 to 2008. The percentage did not change in Minnesota and slightly increased in both South Dakota and Iowa.

2008 and 2010 Low Birth Weight

Area	2008	2010
South Dakota	6.5%	6.8%
Iowa	6.6%	7.0%
Minnesota	6.4%	6.4%
United States	10.2%	8.1%

Source: National Vital Statistics Reports

Developmental Disabilities

The CDC in conjunction with researchers from the Health Resources and Services Administration (HRSA) published a study in *Pediatrics*: Trends in the Prevalence of Developmental Disabilities in U.S. Children (1997-2008) showed that developmental disabilities occur in about 1:6 children in the U.S.

Trends in Prevalence of Developmental Disabilities 1997-2008

Disability Category	Trend in Prevalence from 1997 - 2008
Developmental Disabilities	+17.1%
Autism	+289.5%
ADHD	+33%
Hearing loss	+30.9%

Source: Center for Disease Control (CDC)

Autism Spectrum Disorders in U.S. 2000-2008

The CDC reports that about 1 in 88 children have been identified with an autism spectrum disorder (ASD) based on estimates from the Autism and Developmental Disabilities Monitoring Network (ADDM).

2000 to 2008 Prevalence of Autism

Surveillance Year	Prevalence per 100 Children
2000	6.7% (1 in 150 children)
2002	6.6% (1 in 150 children)
2004	8.0% (1 in 125 children)
2006	9.0% (1 in 110 children)
2008	11.3% (1 in 88 children)

Source: Center for Disease Control (CDC)

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. It would appear that states interpret or code children differently who fall under multiple categories, so it is difficult to draw comparisons across the states. The overall number of children with special needs shows an increasing trend in both South Dakota and Minnesota from 2007 to 2011. Iowa showed a decline from 2007 to 2009 and then an increase in 2011, although 2011 numbers remained lower than 2007.

	2007			2009			20011		
Special Education Category	**South Dakota**	**Iowa**	**Minnesota**	**South Dakota**	**Iowa**	**Minnesota**	**South Dakota**	**Iowa**	**Minnesota**
Deaf/Blind	*	*	55	*	*	69	*	*	65
Emotionally Disturbed	*	6,747	16,652	1088	6,495	16,125	1,141	6,622	15,716
Intellectual Disability	1,215	11,542	9,024	1,413	11,483	8,743	1,492	11,716	8,366
Hearing Loss	162	701	2,283	144	469	2,256	156	476	2,304
Specific Learning Disability	6,496	39,482	31,344	6,184	40,226	6,184	6,292	41,064	30,277
Multiple Disabilities	914	386	819	678	365	1,122	561	376	1,295
Orthopedic Impairments	88	784	1,685	85	751	1,650	81	759	1,690
Vision Loss	*	*	417	*	86	397	*	89	410
Speech/Language Impairments	4,587	7,529	21,534	4,460	5,745	20,708	4,217	5,855	21,160
Other Health Impairments	1,462	*	14,437	1,694	86	15,700	1,830	89	16,600
Autism	613	1,153	11,217	716	751	13,764	834	759	15,278
Traumatic Brain Injury	*	*	452	*	179	450	66	185	451
Developmental Delay (preschool ages 3-5)	1,370	*	9,413	1,340	*	9,726	1,286	*	10,331
Total	**17,971**	**69,204**	**119,332**	**17,907**	**66,636**	**121,359**	**18,005**	**67,990**	**123,353**

Source: IDEA Data Accountability Center, U.S. Office of Special Education
*: none or less than 4 in category.

Summary of Key Findings and Prioritized Needs

The Children's Care Advisory Committee selected individuals from a wide range of backgrounds from health-related agencies and with health-related qualifications to participate in the interviews. Some of the participants' expertise includes: Physicians, Nurses, Community Health Clinic Directors, Case workers, Health & Human Services employees (state), Home Health Agency director, Parent Resource Centers, Community Support Providers, families, and advocates of the medically underserved.

Participants interviewed were asked a series of questions formed by the Advisory Committee. These questions were developed from a variety of nationally accepted health improvement models and tailored by the committee to uncover the health needs that may exist within the Children's Care community. Questions can be found in Appendix 2. Each interview lasted approximately 30 minutes. A few participants preferred to answer the questions independently and return them to Children's Care. Open participation and dialogue between interviewees was encouraged to generate optimal responses. Responses were recorded and later condensed into common themes. These themes can be found in Appendix 3. The following health needs were identified through the CHNA process:

1. Lack of mental health services & providers
2. Lack of providers in rural areas/need for outreach programs in rural areas
3. Lack of care coordination/system navigation
4. Lack of timely appointments/after hours care
5. Children with complex/severe developmental disabilities are underserved
6. People with co-occurring mental health diagnoses are underserved
7. Non-English speaking immigrants are underserved
8. Lack of awareness of available services/need for dissemination of marketing/service materials/need for website to assist in easily locating services

The health needs were prioritized by the CHNA Advisory Committee. The criteria used to prioritize the health needs can be found in Appendix 4. The criteria measures were established by Wipfli and the committee, drawing from recommendations from several national resources. Through the completion of a Community Health Needs Assessment, Children's Care Hospital and School identified three priority areas: 1) there is a lack of mental health services and providers, 2) people with mental health diagnoses are an underserved population, and 3) children with complex developmental/medical conditions are an underserved population. Because of Children's Care's mission to provide excellence in person-centered services for individuals with special healthcare and education needs, the three priorities were blended to create the implementation plan for 2013 to meet the needs of the niche population that is served by the organization

Existing Health Care 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)

TRANSLATION SERVICES

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

SERVICES FOR CHILDREN WITH COMPLEX/SEVERE DEVELOPMENTAL NEEDS

1. Sanford Children's Hospital
2. Avera McKennan Children's Hospital
3. Rapid City Regional Hospital
4. Universal Pediatric Nursing
5. Children's Care Hospital & School

RURAL HEALTHCARE/OUTREACH

1. Indian Health Services
2. Avera Healthcare
3. Sanford Healthcare
4. Rapid City Regional Healthcare
5. Children's Care Hospital & School

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 Minn)
26. RIDES (NW Iowa)

Existing Health Care Facilities & Resources, cont.

PARENT RESOURCE CENTERS

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

Implementation Strategy

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 need, and identify health needs the hospital does not intend to meet and why.

With the support of Wipfli, 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 the identified priority can be found in Appendix 5 and provides supporting tactics, programs/resources, accountable parties, and potential partnerships/collaboration for the strategy.

References

Association for Community Health Improvement

Rural Health Works

Flex Monitoring Team

The Nielson Company, 2012

U.S. Census Bureau

National Vital Statistics

US Dept of Labor, Bureau of Labor Statistics

Center for Disease Control

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

Appendix 1

Stakeholder Interview Categories

1. Community Support Providers (CSP)
2. Community Health Clinics/Centers
3. Indian Health Services
4. Parents
5. Health and Human Services State Agencies
6. Parent Resource Centers
7. Physicians
8. Other: Helpline Center, USD Center for Disabilities, Home Health Nursing Agency

Appendix 2

Children's Care Hospital - CHNA Interview Questions

General Health Needs

1. Based on your experience, what are the three most significant health care or environmental needs or concerns in your community?

Barriers / Access to Care

2. Where are the gaps in the availability and/or access to health care services in the community?

3. What are the main reasons or barriers to obtaining health care in the community or taking care of significant health needs? What are they, and how can they be addressed?

Underserved

4. What groups within our patient population in your community are underserved regarding their health care needs? What are the major obstacles to reaching and serving these groups? What individuals or organizations currently serve these populations?

Services

5. If you were in charge of improving the health of the community, what programs or services would you offer to enhance the health and well-being of the community? How would you improve access to care for the medically underserved within our patient population?

6. What is your perception of Children's Care overall and of specific programs and services? What are some opportunities to improve current programs and services, as well as highlight service and program gaps?

Communications / Hospital Relations

7. Do you think most people within our patient population know about the kind of health services are available to them? How do they learn about them? What are the best ways for Children's Care to inform the community about events and services?

8. What is your perception of the current role Children's Care plays in the community? What role could or should Children's Care play in the community?

Appendix 3

Common Themes – Interview Questions

1. Lack of mental health services & providers
2. Lack of providers in rural areas/need for outreach programs in rural areas
3. Lack of care coordination/system navigation
4. Lack of timely appointments/after hours care
5. Children with complex/severe developmental disabilities are underserved
6. People with co-occurring mental health diagnoses are underserved
7. Non-English speaking immigrants are underserved
8. Lack of awareness of available services/need for dissemination of marketing/service materials/need for website to assist in easily locating services

Appendix 4

Criteria for Healthcare Needs Prioritization

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
Questions 1-3: *Healthcare needs, gaps in availability/access, and barriers.*	Lack of mental health services & providers	4	4	3	5	5	21
	Lack of providers in rural areas	5	5	2	0	0	17
	Lack of care coordination / system navigation	3	3	1	0	5	11
	Lack of timely appointments/after hours services	4	4	2	5	5	20
Question 4. *Underserved Populations*	Children with complex/severe developmental disabilities	4	4	4	5	5	22
	Non-English speaking immigrants	2	4	2	5	0	13
	People with mental health/co-occurring disorders	4	5	3	5	5	22
Question 5*: Ideas to improve health/access to services for underserved.*	Increase outreach programs in rural areas (and across the border)/ Increase healthcare accessibility	5	5	2	0	5	17
6. - 8. *Opportunities, role in the future*	Expand dissemination of educational materials to local community health agencies, other providers, schools, county health/human services offices, etc.	3	3	4	5	5	20
	Improve website for ease of locating services	2	2	5	5	5	19

Appendix 5

Implementation Strategy

Summary: Through the completion of a Community Health Needs Assessment, Children's Care Hospital and School identified three priority areas: 1) there is a lack of mental health services and providers, 2) people with mental health diagnoses are an underserved population, and 3) children with complex developmental/medical conditions are an underserved population. Because of Children's Care's mission to provide excellence in person-centered services for individuals with special healthcare and education needs, the three priorities were blended to create the implementation plan for 2013 to meet the needs of the niche population that is served by the organization.

PRIORITY: There is a lack of services and providers for individuals with intellectual disabilities and co-occurring mental health diagnoses or complex medical conditions.

Objective/Strategy

- To expand the capacity for Children's Care and other providers to meet the mental health and/or complex medical needs of individuals with intellectual disabilities.

Tactics (How)

- Collaborate with the State of South Dakota, providers, and other stakeholders to provide training related to specific treatment approaches for individuals with co-occurring intellectual/mental health disorders to increase capacity for services.
- Work with funding sources to achieve an appropriate level of funding for individuals with high level needs (medical, intellectual, mental health, etc.) within a community based environment.
- Achieve Council on Quality Leadership (CQL) accreditation in order to become a provider of community-based residential services for individuals with complex intellectual disabilities and co-occurring mental health disorders or complex medical conditions.
- Increase clinical capacity by hiring an Outpatient clinical psychologist for the Sioux Falls and Rapid City outpatient clinics for provision of mental health services.

Programs/Resources to Commit (Who)

- Administration
- Clinical operations teams

Impact of Programs/Resources on Health Need

- Increasing the clinical knowledge of State agencies and other providers should increase the capacity within the region for providing mental health services for individuals with co-occurring intellectual disorders and mental health needs.
- Achieving CQL accreditation is necessary for Children's Care to become a licensed Community Support Provider (CSP) in South Dakota, which will allow for Children's Care to provide community-based residential services for individuals with intellectual disabilities and co-occurring mental health needs or complex medical conditions.
- The hiring of two clinical psychologists for our Outpatient clinics will expand our capacity to provide mental health services to our community/service area on an Outpatient basis.

Accountable Parties

- Sr. Leadership team

Partnerships/Collaboration

- State Agencies (Department of Health, Department of Social Services, Department of Human Services)
- Local Community Support Providers
- Community Support Providers of South Dakota (state association)
- Other community agencies vested in services for individuals with mental health and/or complex medical conditions.

OTHER PRIORITIES

Priority Need	Rationale for Not Responding
Lack of providers in rural areas	Our hospital provides some outreach services, but there are not sufficient resources available to expand these services into rural areas.
Lack of care coordination/system navigation	Our hospital provides this service to inpatients during hospitalization and upon discharge. There is no funding mechanism for provision of services beyond an inpatient stay.
Lack of timely appointments/after hours services	Our Outpatient Rehabilitation department does offer extended hours. It would be difficult for our hospital to make a significant impact in the service area due to the location of the outpatient clinic and large geographical nature of our service area.
Non-English speaking immigrants are underserved	Children's Care does offer translation services to non-English speaking patients, but it is not within our mission or scope to offer those services to individuals seeking care through other providers.
Need for increase outreach programs in rural areas/increase healthcare accessibility	Our hospital provides some outreach services, but there are not sufficient resources available to expand these services into rural areas.
Need for expanding dissemination of educational materials to local community health agencies, other providers, etc.	Children's Care does disseminate educational materials to current and prospective patients and providers, as well as the general community throughout the service area.
Need for improving website for ease of locating services.	Children's Care is currently in the process of replacing our current website with a new and improved website with a goal of providing ease to users when searching for services.