LifeScape

Sioux Falls, South Dakota

Community Health Needs Assessment

June 2016

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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 LifeScape (formerly 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.

LifeScape 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 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

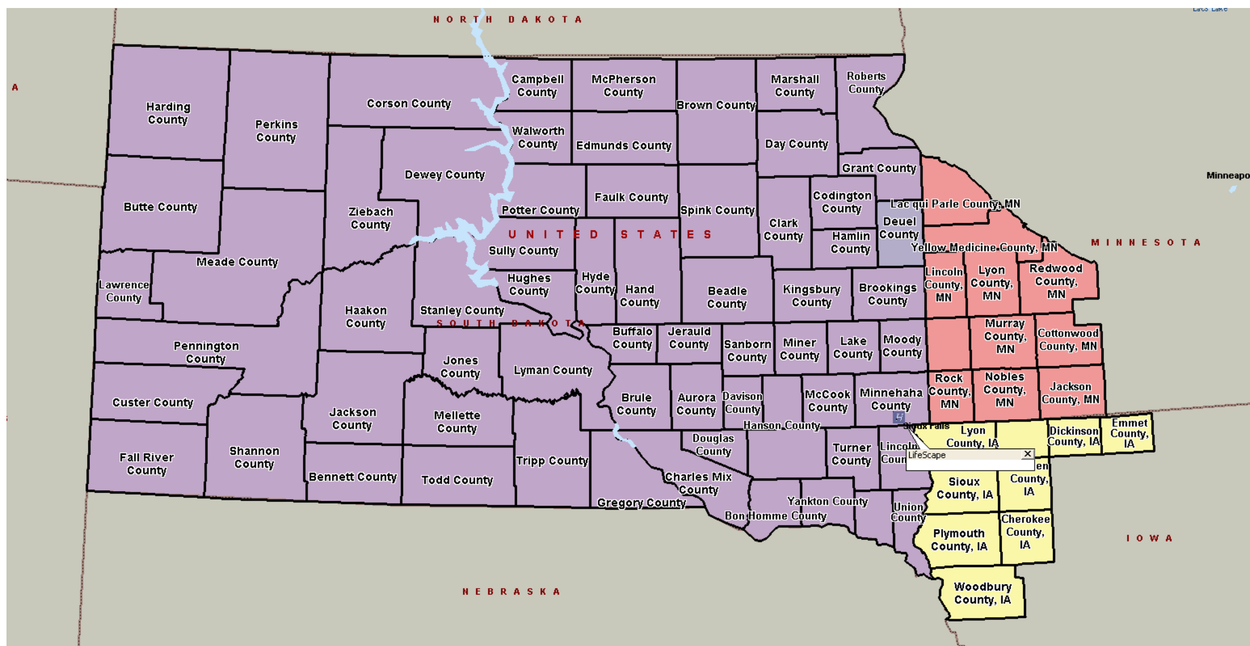
Community Served Determination

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 (66 counties), northwest Iowa (9 counties), and southwest Minnesota (11 counties).

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 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 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. A list of the interview participant categories 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
- ESRI, 2016 (Based on US Census Data)
- 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 two of the three LifeScape 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 54,338 people over the next five years. This growth could translate to a rise in demand for health care services within the service area.

2015 and 2020 Population

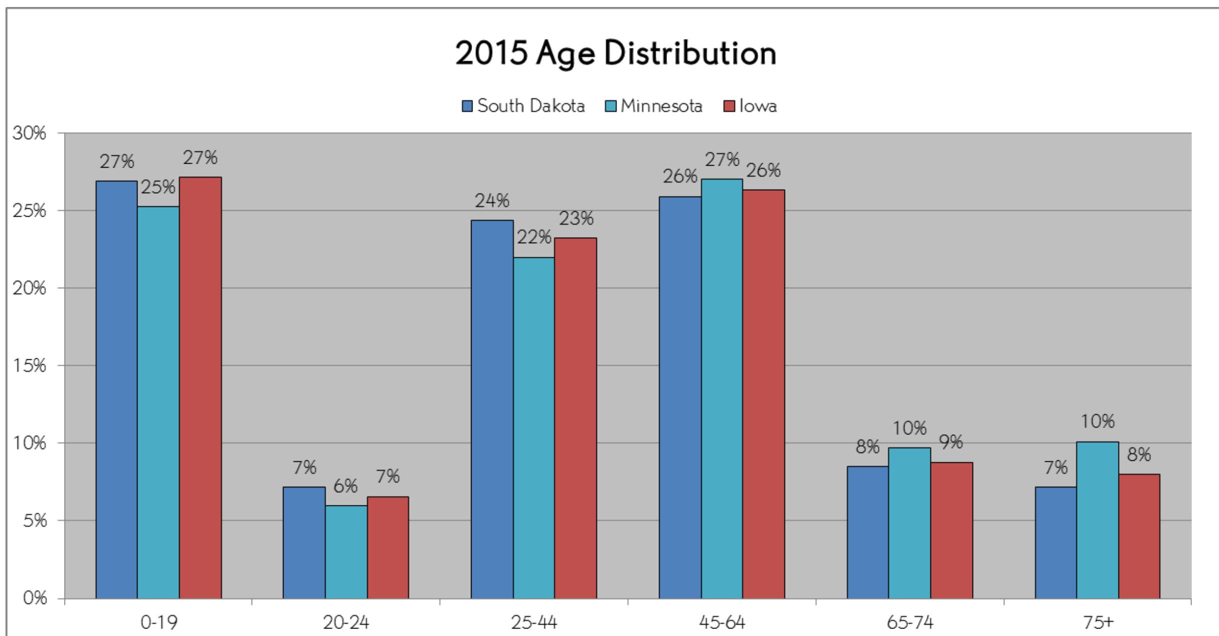
	2010	2015	2020	% Change (2010-2015)	Change (2010-2015)	% Change (2015-2020)	Change (2015-2020)
LifeScape Service Area							
South Dakota	814,180	854,685	905,515	5.0%	40,505	5.9%	50,830
Minnesota	136,848	136,720	136,630	-0.1%	-128	-0.1%	-90
Iowa	232,344	234,982	238,580	1.1%	2,638	1.5%	3,598
Service Area Total	**1,183,372**	**1,226,387**	**1,280,725**	**3.6%**	**43,015**	**4.4%**	**54,338**

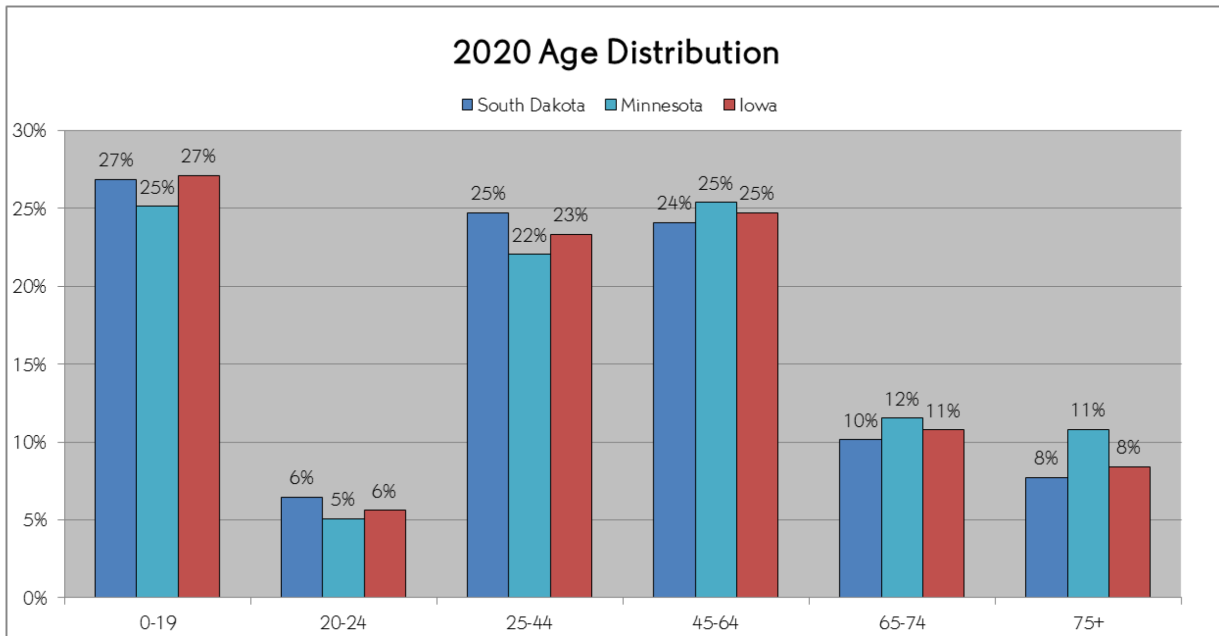
ESRI Business Information Solutions, 2016

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 remain steady in South Dakota, Iowa, and Minnesota counties in the service area. The service area population over age 21 is not anticipated to change significantly.

2015 and 2020 Population Age Distribution





ESRI Business Information Solutions, 2016

Population by Race and Ethnicity

LifeScape's service areas are predominantly white, equating to roughly 83% 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.

2015 and 2020 Population by Race

2015 - Population by Race	South Dakota		Minnesota		Iowa	
	Number	Percent	Number	Percent	Number	Percent
Hispanic or Latino	33,204	4%	11,064	8%	23,779	9%
White	717,227	83%	121,403	83%	208,898	82%
African American	19,619	2%	2,058	1%	3,468	1%
Native American	74,061	9%	1,748	1%	2,609	1%
Asian	10,976	1%	3,541	2%	3,465	1%
Pacific Islander	497	0%	51	0%	211	0%
Other	10,706	1%	5,574	4%	10,985	4%
Total	866,290	100%	145,439	100%	253,415	100%

2020 - Population by Race	South Dakota		Minnesota		Iowa	
	Number	Percent	Number	Percent	Number	Percent
Hispanic or Latino	40,595	4%	12,908	9%	28,076	11%
White	750,265	81%	119,371	81%	208,165	80%
African American	26,247	3%	2,351	2%	4,109	2%
Native American	77,560	8%	1,888	1%	2,761	1%
Asian	13,290	1%	3,859	3%	3,824	1%
Pacific Islander	588	0%	51	0%	286	0%
Other	12,898	1%	6,537	4%	13,019	5%
Total	921,443	100%	146,965	100%	260,240	100%

ESRI Business Information Solutions, 2016

Unemployment

Unemployment rates in the South Dakota, Iowa and Minnesota trend down from 2010 to 2015, with the whole service area falling under the U.S. unemployment rate in 2015.

Service Area	2010	2011	2012	2013	2014	2015
South Dakota	5.0%	4.7%	4.3%	3.8%	3.4%	3.1%
Iowa	6.0%	5.5%	5.1%	4.7%	4.2%	3.7%
Minnesota	7.4%	6.5%	5.6%	4.9%	4.2%	3.7%
United States	9.6%	8.9%	8.1%	7.4%	6.2%	5.3%

Bureau of Labor Statistics

Poverty

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

2012 and 2014 Poverty Rate

Area	2012	2014
South Dakota	11.4%	12.8%
Minnesota	10.0%	8.3%
Iowa	10.3%	10.3%
United States	15.0%	14.8%

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 LifeScape's service area (county data was not available). The trend in the three states from 20010 to 2014 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 2010 to 2014.

Area	2010	2011	2012	2013	2014
South Dakota	14.5%	14.4%	14.4%	14.7%	14.4%
Minnesota	12.9%	12.8%	12.8%	12.8%	12.8%
Iowa	12.7%	12.5%	12.6%	12.7%	12.8%
United States	13.0%	12.7%	12.6%	12.4%	12.5%

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, Minnesota, and Iowa showed a similar trend from 2006 to 2013.

Area	2006	2013
South Dakota	12.7%	10.8%
Minnesota	10.5%	9.9%
Iowa	11.6%	11.1%
United States	12.8%	11.4%

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. Rates in Iowa, Minnesota and South Dakota were lower than the United States in 2014.

Location	All Races	Non-Hispanic Black	Non-Hispanic White	Hispanic
United States1	**8.0%**	**13.2%**	**7.0%**	**7.1%**
Iowa	6.7%	11.7%	6.3%	6.8%
Minnesota	6.6%	8.9%	6.1%	6.4%
South Dakota	6.5%	10.3%	6.2%	7.3%

Source: Center for Disease Control (CDC)

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. 2000-2010

The CDC reports that about 1 in 68 children have been identified with an autism spectrum disorder (ASD) based on estimates from the Autism and Developmental Disabilities Monitoring Network (ADDM).

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)
2010	14.7% (1 in 68 children)

Source: Autism and Developmental Disabilities Monitoring Network

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 Minnesota, however the number has declined in Iowa. Each specific disability can be interpreted in the charts below:

State	Year	All disabilities	Autism	Deaf-blindness	Developmental delay	Emotional disturbance
South Dakota	2009	17,907	716		1,340	1,088
South Dakota	2011	18,005	834		1,286	1,141
South Dakota	2015	18,975	978		1,233	1,122
South Dakota % Change	**2009-2015**	**6%**	**37%**		**-8%**	**3%**
Minnesota	2009	121,359	13,764	69	9,726	16,125
Minnesota	2011	123,353	15,278	65	10,331	15,716
Minnesota	2015	125,437	16,984	66	10,949	14,760
Minnesota % Change	**2009-2015**	**3%**	**23%**	**-4%**	**13%**	**-8%**
Iowa	2009	66,636	751			6,495
Iowa	2011	67,990	759			6,622
Iowa	2015	63,866	721			6,220
Iowa % Change	**2009-2015**	**-4%**	**-4%**			**-4%**

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	2009	144	1,413	678	85	1,694
South Dakota	2011	156	1,492	561	81	1,830
South Dakota	2015	149	1,665	521	76	2,399
South Dakota % Change	**2009-2015**	**3%**	**18%**	**-23%**	**-11%**	**42%**
Minnesota	2009	2,256	8,743	1,122	1,650	15,700
Minnesota	2011	2,304	8,366	1,295	1,690	16,600
Minnesota	2015	2,300	7,633	1,478	1,637	18,149
Minnesota % Change	**2009-2015**	**2%**	**-13%**	**32%**	**-1%**	**16%**
Iowa	2009	469	11,483	365	751	86
Iowa	2011	476	11,716	376	759	89
Iowa	2015	447	10,998	347	721	84
Iowa % Change	**2009-2015**	**-5%**	**-4%**	**-5%**	**-4%**	**-2%**

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	2009	6,184	4,460		
South Dakota	2011	6,292	4,217	66	
South Dakota	2015	6,644	4,077	55	54
South Dakota % Change	**2009-2015**	**7%**	**-9%**		
Minnesota	2009	6,184	20,708	450	397
Minnesota	2011	30,277	21,160	451	410
Minnesota	2015	29,627	20,970	449	435
Minnesota % Change	**2009-2015**	**379%**	**1%**	**0%**	**10%**
Iowa	2009	40,226	5,745	179	86
Iowa	2011	41,064	5,855	185	89
Iowa	2015	38,571	5,504	169	84
Iowa % Change	**2009-2015**	**-4%**	**-4%**	**-6%**	**-2%**

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

Summary of Key Findings and Prioritized Needs

A list of interview participant groups can be found in Appendix 1. Individuals selected have 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 participants 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 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:

Top Issues Identified

1. Lack of transportation to appointments.
2. Lack of providers/access to care in rural areas and Indian reservations – especially preventative or specialty care.
3. Lack of mental health services and providers.
4. Cultural and language barriers for immigrant/non-English speaking population.
5. Lack of availability of affordable healthcare/low fee clinics.
6. Access to adequate health insurance coverage.

Underserved Populations Identified

1. Non-English speaking immigrants.
2. People with mental health/substance abuse issues or co-occurring disorders (ID/MH or MH/Substance abuse)
3. Native Americans
4. The “working poor”, those who are underinsured, and those who cannot afford high deductibles and co-pays.

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 Support 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)
4. A to Z World Languages Inc.
5. Community Interpreter Services
6. Multi-Cultural Center

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. 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 Minn)
26. Nan’s Van (SW Minnesota)
26. RIDES (NW Iowa)

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

REFERENCES

Autism and Developmental Disabilities Monitoring Network

ESRI, 2016 (Based on US Census Data)

U.S. Census Bureau

National Vital Statistics

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

Center for Disease Control

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 for Disabilities
- Hospital personnel – case managers, discharge planners
- Public School Nurses
- Family Support Coordinators

Appendix 2

LifeScape - 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 LifeScape 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 LifeScape to inform the community about events and services?

8. What is your perception of the current role LifeScape plays in the community? What role could or should LifeScape play in the community?

Appendix 3

Criteria Used to Prioritize Health Needs

LifeScape CHNA 2016
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
Questions 1-3: *Healthcare needs, gaps in availability/access, and barriers.*	**Lack of mental health services & providers**	5	5	5	y	y	25
	Lack of providers in rural areas & Indian reservations – preventative and specialty care	5	5	2	n	y	17
	Lack of transportation to services/appointments	5	5	1	n	y	16
	Availability of affordable healthcare/low fee services	4/5	5	1	n	y	15.5
	Access to health adequate insurance coverage	3/4	5	1	n	y	14.5
	Cultural/Language barriers for immigrant/non-English speaking people	4/5	5	2/3	n	y	17

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. *Underserved Populations*	**Non-English speaking immigrants**	4/5	5	2/3	n	y	17
	Native Americans	4/5	5	2/3	n	y	17
	People with mental health, substance abuse or co-occurring disorders	5	5	4/5	y	y	24.5
	People in poverty, "working poor", and underinsured	5	5	1	n	y	16
Question 5*: Ideas to improve health/access to services for underserved.*	**Increase access to care & system navigation support for minority populations (cultural and linguistically based)**	5	5	3	n	y	18
	Increase outreach programs into rural areas (and across the border) & tele-med services	5	5	2	n	y	17
	Increase prenatal care supports on Indian Reservations and rural areas.	5	5	2	N	N	12

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: *Ideas to improve health/access to services for underserved.*	**Broaden eligibility guidelines for low-fee care/sliding scale**	4	5	1	N	Y	15
	Provide in-state (SD) diabetes pump supply distribution	1	2	1	N	N	4
	Improve responsiveness, timeliness of services on Indian Reservations	5	5	2	N	Y	17
	Develop services for in home and community-based autism/ABA treatment	5	5	5	Y	Y	25
	Supports for people with co-occurring mental health/intellectual disabilities – all ages	5	5	5	Y	Y	25

Continued on next page

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
6. - 8. *Opportunities, role in the future*	**Increase awareness of services to the general public**	5	4/5	5	y	y	24.5
	Educate public about people with disabilities.	3	2/3	5	y	y	20.5
	Offer more opportunities for families/other community members to gather.	1	1	5	y	y	17
	Expand business hours into the evenings and weekends (outpatient)	3	1	3	N	y	12
	Clarify what services are offered in the homes of children.	1	1	2	Y	Y	14
	Speaking opportunities to school nurses and Community Health Clinic providers.	1	1	3	Y	Y	15
	More inpatient programs in Western and Northern parts of the state	3	3	1	N	Y	12
	Partner with existing or start new home health nursing services.	4	3	1	N	Y	13

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
	Offer housing near 26th ST. location for families with children in Rehab or Medically Complex.	2	1	1	N	Y	7
	Hire up staff to be able to fill 18 beds on Fisher Coon.	3	1	2	N	Y	11

Appendix 4

LifeScape Community Health Needs Assessment Implementation Plan June 2016

SUMMARY OF 2016 FINDINGS

Through the completion of a Community Health Needs Assessment, LifeScape has identified two key priority areas of need: 1) In LifeScape's service area, there is a lack of mental health services and providers and 2) the non-English speaking immigrant population experience cultural and language barriers that impede their access to healthcare. Although several other needs were identified, these two align well with the mission and vision of LifeScape as well as 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 diagnosis and ID/D.

Tactics (How)

1) Provide training to clinical psychologist interns and new clinical psychology staff on LifeScape's existing services and the needs of our patient population.
2) Explore and develop new mental health services/programs as well as enhance already existing services.
3) Research evidence based practices and develop mental health programs that can be provided by other clinicians such as occupational and speech therapists due to limited availability of clinical psychologists.
4) Fully explore the needs of patients/people served by LifeScape in all program areas.
5) Develop ongoing mental health training courses for LifeScape staff.
6) Assess and develop mental health training programs for parents and caregivers.

Programs/Resources to Commit (Who)

- Administration
- Outpatient and Behavioral Services teams

Impact of Programs/Resources on Health Needs

- Due to limited workforce, providers must find innovative ways to utilize existing workforce/clinicians to meet the mental health needs of patients with ID/D and/or co-occurring disorders.
- Training for staff, parents, and caretakers is critical for continuity and provision of community-based supports. People with co-occurring mental health diagnoses and ID/D require highly specialized services that produce the best outcomes when staff and families are well-trained. Training could be expanded to other providers in the community.
- New services and enhancements to current services will better serve the needs of patients as well as provide more options/services to the community.

Accountable Parties

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

Partnerships/Collaboration

- Community Support Providers throughout the region.
- Other related service providers
- State agencies
- Physicians/hospitals

PRIORITY #2: Culture and language barriers impact access to healthcare for immigrants who do no not speak English as their primary language.

Objective/Strategy

Non-English speaking patients will have on overall improved experience when receiving LifeScape services resulting in better home program follow-through and a decrease in missed appointments.

Tactics (How)

1. Meet with Lutheran Social Services (LSS) and/or other organizations that assist immigrant populations move into our service area to discuss ways that we can work together to improve services.
2. Provide education on existing supports and services available at LifeScape to LSS and other agencies who help immigrant populations.
3. Explore feasibility and funding of employing a social worker for Outpatient Services who would support patients/families of Non-English speaking patients.
4. Explore translation services and products to ensure we are utilizing the services that best fits the needs of our patients and clinicians.
5. Determine fiscal responsibility for interpreter fees when appointments are missed so that patients better understand the process.

6. Determine if patient-related documents/forms/written materials should be translated based on volume of people receiving services and the most common languages.

Programs/Resources to Commit (Who)

- Outpatient Services leadership team

Impact of Programs/Resources on Health Needs

- Cultural and language barriers result in missed appointments and poor follow-through of home programs, etc. resulting in less than desired outcomes. By addressing these issues, patients will have a better healthcare experience and see better results from treatment.
- The cost of interpreter fees directly impacts the cost of providing services in a healthcare environment with limited reimbursement options. Improving services by helping people keep their appointments and do home program/follow-through will impact the cost of providing services.

Accountable Parties

- Sr. Leadership and Outpatient Services Leadership

Partnerships/Collaboration

- Lutheran Social Services and other stakeholders who intersect with immigrant populations
- Interpreter service providers
- State agencies/funding sources

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Other Priorities Not Addressed

Priority Need	Rationale for Not Responding
Broaden guidelines/increase access to low fee/sliding scale services for people in poverty/working poor who are underserved.	As a provider with limited reimbursement, we are not able to impact guidelines for low fee/sliding scale services.
Improve responsiveness, timeliness of services on Indian Reservations; increase services for Native Americans who are underserved; provide prenatal care to Native Americans.	LifeScape serves many Native Americans through inpatient, outpatient, and outreach services, but outreach services are limited to school-based therapy contracts. It is beyond our scope to provide medical services on the reservations. It is also beyond our scope to provide prenatal care to women.
Increase outreach programs into rural areas (and across the border), including telemedicine.	Again, LifeScape outreach services are primarily school-based, although there are some limited services provided through outreach. Reimbursement and licensing requirements limit expansion of outreach efforts.

STATUS UPDATE ON 2013 PRIORITY

In 2013, LifeScape (at that time known as Children's Care Hospital & School) identified one priority to address following completion of a Community Health Needs Assessment. Significant progress was made on this priority. Below is a summary of progress.

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.

Accomplishments:

- Provided training through statewide Dakota Digital Network to providers and other stakeholders on autism and behavioral supports.
- Successfully worked with State and funding sources to support individual with higher medical/behavioral needs within a community based environment.
- Achieved Council on Leadership (CQL) accreditation for children's ICF services.
- Hired clinical psychologists in both Sioux Falls and Rapid City outpatient programs to provide mental health services.
- Initiated an internship program with the University of South Dakota clinical psychology program to provide advanced learning opportunities working with patients with intellectual/developmental disabilities.
- Ongoing collaboration with State partners, Avera Behavioral Health, law enforcement, and the Minnehaha Mobile Crisis team to improve response and treatment for people with co-occurring IDD/MH during times of crisis.