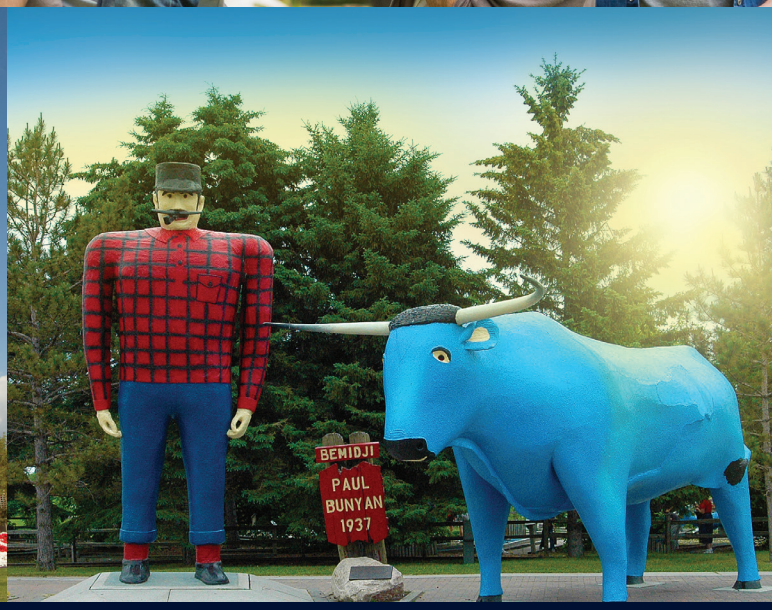

Sanford Medical Center Sioux Falls USD

Community Health Needs Assessment Implementation Strategy

2017-2019

SANFORD HEALTH

dba Sanford USD Medical Center EIN #45-0227855

Dear Community Members,

Sanford USD is pleased to present the 2016 Community Health Needs Assessment and Implementation Strategy. There is great intrinsic value in a community health needs assessment when it serves to validate, justify and defend not-for-profit status and create opportunity to identify and address community health issues.

During 2015 members of the community were asked to complete a generalizable survey to help identify unmet health needs. Analysis of the data and secondary research was used to identify health concerns and needs in the community. Community partners assisted with the development of an asset map that lists resources and assets that are available to address each need. A gap analysis and prioritization exercise was also conducted to identify the most significant health needs, and to further address these needs through the implementation strategies that are included in this document.

Sanford USD has set strategy to address the following community health needs:

- Crime/Safety – specifically addressing narcotics in the community
- Physical Health – focusing on chronic disease

At Sanford USD, patient care extends beyond our bricks and mortar. As a not-for-profit organization, ensuring that the benefits of health care reach the broad needs of communities is at the core of who we are. Through our work with communities, we can bring health and healing to the people who live and work across our communities. Together, we can fulfill this mission.

Sincerely,

Paul Hanson
President
Sanford Medical Center Sioux Falls USD

Implementation Strategies

2017-2019

Priority 1: Crime/Safety – Pharmaceutical Narcotics in our Community

Goal: Standardize narcotic prescribing protocols across the enterprise to reduce usage

The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that 4.3 million Americans engaged in non-medical use of prescription painkillers in the last month. Approximately 1.9 million Americans met criteria for prescription painkillers use disorder based on their use of prescription painkillers in the past year.

A number of opioids are prescribed by physicians to relieve pain. These include hydrocodone, oxycodone, morphine, and codeine. While many people benefit from using these medications to manage pain, prescription drugs are frequently diverted for improper use. In the 2013 and 2014 National Survey on Drug Use and Health (NSDUH), 50.5% of people who misused prescription painkillers got them from a friend or relative for free, and 22.1% got them from a physician. As people use opioids repeatedly, their tolerance increases.

Sanford has set strategy to reduce narcotic use across the system by providing alternative pain management methods. Policies and procedures to address the prescription of narcotics will be standardized across the health care system as part of this strategy. Pain medication prescriptions will be tracked and studied to identify areas for improvement.

Priority 2: Physical Health – Chronic Disease

Goal 1: Improve Care of Patients with Overweight or Obesity Diagnosis

Many of the chronic conditions experienced by our patients can be addressed through primary prevention. Weight gain itself has been shown to increase the risk of type 2 diabetes (Nurses Health Study), hypertension (NHANES III), gallstones (NHANESIII), osteoarthritis in the knee (Framingham Study and NHANES I), and endometrial cancer (Schottenfield et. Al, 1996). Weight gain is also associated with higher lipid levels, coronary heart disease, cardiovascular disease, and premature death from stroke and heart attack. (NHLBI, 1998).

Sanford has set strategy to improve the care of patients with overweight or obesity diagnosis. Patients who are overweight will be referred to internal and external services including registered dietitians, exercise physiologists, and health coaches. BMI changes will be studied and monitored.

The Sanford Health *fit* initiative, http://sanfordfit.org/ a childhood obesity prevention initiative, continues to grow and mature as we work to refine the offerings and enable broad replication and meaningful use. Supported by the clinical experts of Sanford Health, *fit* educates, empowers and motivates families to live a healthy lifestyle through a comprehensive suite of resources for children, parents, teachers and clinicians. *fit* is the only initiative focusing equally on the four key contributing factors to childhood obesity: Food (nutrition), Move (activity), Mood (behavioral health), and Recharge

(sleep). Sanford's *fit* Initiative has come a long way since its inception in 2010. Through *fit* we are actively working to promote healthy lifestyles in homes, schools, daycares, our clinical settings, and throughout the community by way of technology, engaging programs, and utilizing key role models in a child's life.

- The *fit* website for Juniors, Kids and Teens creates an entertaining and interactive on-line environment where they can play games, watch videos and take daily challenges. Parents benefit from their own set of resources where they can find tips and tools on becoming healthy role models and raising *fit* kids. To date, the children's and parent's sites have received more than 7.5 million visitors. Over 700 pieces of content have been added to the sites including videos, slideshows, games, articles, and even *fit* songs!

- In addition to the web, *fit* is developing meaningful school resources to bring value and fun into the primary education setting. We are doing this by integrating *fit* points into science and math components to provide health promotion, an avenue into the classroom without taking valuable time away from those critical subjects.

- *fit*4theclassroom.com – *fit* 4 the Classroom is an on-line school resource developed in cooperation with Discovery Education that incorporates topics into math and science curriculum. The on-line resource for the classroom went live in September of 2012. To date the program has 14 STEM (integrating science, technology, engineering, and math) unit plans that can be downloaded for classroom use.
    - Reached 50,000 schools
    - 180,000 page views from educators across the country
    - 12,000 lesson plan downloads, representing 600,000+ students

  We are also reaching thousands of students through several pilot school programs.
    - *fit*4Schools – *fit*4Schools, which includes unique *fit*-based lessons integrated into daily classroom activities, is in its final phase of development. It is being piloted in seven elementary schools in the Sanford region.

- Community
    - The *fit* friends, Denny, Abby, Sam, Alex and Marty, along with the *fit* team, have been making a variety of appearances at events across the Sanford footprint! *fit* has been at over 2 dozen events interacting with more than 15,000 children and parents to spread the word about the *fit* platform and resources.
    - Smartphone Apps – Through a series of fun and engaging apps, *fit* will continue to activate kids at the touch of a fingertip to live a fit and healthy lifestyle related to Mood, Recharge, Food and Move.
    - MOVE2Draw is a simple and fun way for kids to move and create their own unique drawings. Once a drawing is completed, it can be stored on the MOVE2Draw website.
    - eMOODicam is a photo application that allows the user to enhance a photo and bring the mood to life and share with others.

- Looking Forward
    - *fit* is continuing to look to the future for ways to continue to make a meaningful impact on children and families both on-line and off-line. Other exciting expansions that are in the works include:

- Clinical Setting – Resources for the clinical setting to spur actionable and understandable discussions between health care providers and families.
- Health Coaches – Exploring meaningful ways for health coaches to promote healthy choices with children and adults.
- Engage Key Role Models – Firefighters and youth sport coaches are role models and have a big influence on children so that's why *fit* is developing resources for them to teach the principles of *fit* along with sports fundamentals and other outreach

Goal 2: Improve Care of Patients with Diabetes

According to the American Diabetes Association, approximately 30 million children and adults have diabetes in the United States. Out of that number, nearly 95% have type 2 diabetes, a condition characterized by high blood glucose levels caused by either a lack of insulin or the body's inability to use insulin efficiently. Type 2 diabetes develops most often in middle-aged and older adults but can appear in young people. Sadly, the problem is even greater for minority and ethnic populations.

Sanford has set strategy to provide optimal diabetes care and to measure the outcomes for systolic and diastolic blood pressure, LDL cholesterol, Hemoglobin A1C, tobacco use and aspirin use. These outcomes are part of the optimal care recommendations for people living with diabetes.

Sanford offers a comprehensive diabetes education program. Sanford diabetes clinics and centers are dedicated to empowering people with diabetes to feel better and prevent long-term complications. Sanford offers assessment and personalized education care to give patients and their families the tools they need to manage diabetes while living well. Endocrinologists, certified diabetes nurses, and certified diabetes dieticians provide diagnosis, assessment, one-on-one education, and instruction.

The chronic disease self-management program Better Choices, Better Health at Sanford is offered free of charge to community members. Better Choices, Better Health is modeled after Stanford University's chronic disease self-management program. The workshops are 2½ hours long and meet weekly for 6 weeks. The program is facilitated by two trained lay leaders and one or both have a chronic condition. Research has found that after participating in the program individuals are better able to manage their symptoms, communicate more easily with their doctors, are less limited by the disease, and generally feel better.

Goal 3: Improve Care of Patients with Hypertension

Hypertension is also known as high blood pressure. Often there are no symptoms with this condition which is why it is called the "silent killer". The American Heart Association reports that 1 in three adults, or approximately 80 million people in the United States will have high blood pressure. Other than pregnancy, hypertension is the most common reason for adult office visits. Despite the number of resources used to treat hypertension, only about 50% of hypertensive patients have their BP under control using the definition of less than 140/90.

Studies show 35 to 60% of health care professionals measure BP incorrectly. Surprisingly, even a small difference in measurement can have a considerable impact on the prevalence of cardiovascular events and life expectancy. Researchers approximate overestimating BP could lead to nearly 30 million

Americans receiving inappropriate treatment each year, unnecessarily exposing them to potential adverse side effects and increased health care costs. On the other hand, measuring BP even 5 mmHg too low will miss as many as 21 million people with hypertension in the U.S. each year.

Sanford has set strategy to address hypertension through standardized protocol, frequent blood pressure monitoring, and referral. Outcome measures include a blood pressure of less than 140/90 for all ages 18 – 59, and for age 60+ with diabetes, vascular or renal disease. For patients 60 or older without diabetes, vascular or renal disease, the goal is a blood pressure of 150/90.

Goal 4: Improve Care of Patients with Ischemic Vascular Disease

According to the American Heart Association, Ischemia is a condition in which the blood flow (and thus oxygen) is restricted or reduced in a part of the body. Cardiac ischemia is the name for decreased blood flow and oxygen to the heart muscle.

Ischemic vascular disease is the term given to heart problems caused by narrowed heart arteries. When arteries are narrowed, less blood and oxygen reach the heart muscle. This is also called coronary artery disease and coronary heart disease. This can ultimately lead to a heart attack.

Sanford has set strategy to address ischemic vascular disease by standardizing protocols for optimal vascular care. Outcome measures include systolic blood pressure <140, diastolic blood pressure < 90, LDL statin indications, tobacco free recommendations, and a daily use of aspirin.

Community Health Needs Assessment

Implementation Strategy for Sanford Medical Center Sioux Falls USD

FY 2017-2020 Action Plan

Priority 1: Crime/Safety - Pharmaceutical Narcotics in Our Community

Projected Impact: Alternative pain management methods are adopted across the enterprise and narcotic usage is reduced

Goal 1: Standardize narcotic prescribing protocols across the enterprise to reduce usage

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations
Policies and procedures to address the prescription of narcotics are standardized across the enterprise	Track narcotic prescriptions Identify areas for improvement	Behavioral Health Triage Therapists, Physicians	Dr. Mike Wilde, Dr. Dan Heinemann, Dr. Allison Suttle	Sioux Falls Police Department

Priority 2: Physical Health - Chronic Disease

Projected Impact: Improve chronic disease outcomes

Goal 1: Improve Care of Patients with Overweight or Obesity Diagnosis

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Patients who are overweight or obese will be referred to internal/external services	Internal referrals are tracked; change in BMI is monitored through quality metrics	Kelly Hasvold/ Quality Team, Health Coaches, Exercise specialists, Sanford Dietitians, Sanford *fit*	Dr. Mike Wilde, Dr. Dan Heinemann, Dr. Allison Suttle	
Provide Sanford *fit* Program to the local schools and child care centers	Sanford *fit* is available to all students and families in the area through classroom and *fit* website	Sanford *fit* leadership, classroom teachers	Sanford leaders	Local schools, child care leaders

Goal 2: Diabetes – Improve Care of Patients with Diabetes

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Adopt optimal diabetes care for patients ages 18-75 with diabetes	• Systolic B/P <140 • Diastolic B/P < 90 • LDL – per statin indications • HbA1C < 8 • Tobacco free • Daily aspirin if Ischemic Vascular Disease	Kelly Hasvold/ Quality Team, Health Coaches, Exercise specialists, Sanford Dietitians	Dr. Mike Wilde, Dr. Dan Heinemann, Dr. Allison Suttle	

Goal 3: – Improve Care of Patients with Hypertension

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations - if applicable
Standardized hypertension protocols are in place in all primary care settings	• B/P < 140/90 for ages 18-59 • B/P < 140/90 for age 60+ with DM, vascular or renal disease • B/P < 150/90 for age 60 without DM, vascular or renal disease	Kelly Hasvold/ Quality Team, Health Coaches, Exercise specialists, Sanford Dietitians	Dr. Mike Wilde, Dr. Dan Heinemann, Dr. Allison Suttle	

Goal 4: Improve Care of Patients with Ischemic Vascular Disease

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Adopt standardized protocols for optimal vascular care	• Systolic B/P <140 • Diastolic B/P < 90 • LDL – per statin indications • Tobacco free • Daily aspirin if Ischemic Vascular Disease	Kelly Hasvold/ Quality Team, Health Coaches, Exercise specialists, Sanford Dietitians	Dr. Mike Wilde, Dr. Dan Heinemann, Dr. Allison Suttle	

Community Health Needs Assessment Key Findings

The assessed needs from the 2016 primary and secondary research include::

- Aging – the cost of long term care
- Children and Youth – bullying
- Safety – presence of street drugs and alcohol in the community, presence of drug dealers in the community, crime, child abuse and neglect, and domestic violence
- Health Care Access – access to affordable health insurance, health care and prescription drugs
- Physical Health – cancer, chronic disease, inactivity, poor nutrition and obesity
- Mental Health/Behavioral Health – underage drug use and abuse, alcohol use and abuse

How Sanford Medical Center Sioux Falls USD is Addressing the Needs

Identified Concerns	How Sanford Medical Center Sioux Falls USD is Addressing the Needs
Aging • Cost of long term care	Cancer • Continuing options for hospice care with home health care, hospice cottages (routine hospice care), and acute hospice inpatient and in progress creation of Hospice facility for routine and acute patients with dedicated pediatric and adult services. HRSA Grant • HRSA grant is in its second year of deploying a dedicated interprofessional (IP) into 4 sites in community settings to promote health, identify health risk, provide IP interventions thru Co-Ops/clinics and home visits to reduce use of high end services, including delaying the need for LTC. • Community partners/sites include Active Generations in SF, Wellness Center SF, America Legion Valley Springs, and Our Lady of Guadalupe Free Clinic affiliation w/downtown location in Worthington MN.
Children and Youth • Bullying	Sanford Children's CHILD Services – Bullying • Conducts social emotional trainings and technical assistance to child care providers in 29 counties in southeast and northeast South Dakota to address the needs of young children learning social skills early and to prevent bullying.
Crime/Safety • Presence of street drugs and alcohol in the community • Presence of drug dealers in the community • Crime • Child abuse and neglect • Domestic violence	Sanford has set an implementation strategy to address narcotics usage. Sanford CHILD Services – Child abuse and neglect early intervention/prevention • Parent side program works with Child Protection Services to provide parent education and support to at risk families in Minnehaha and Lincoln counties. • Conducts community parent education classes for parents regarding appropriate developmental expectations for young children and appropriate discipline techniques.

Identified Concerns	How Sanford Medical Center Sioux Falls USD is Addressing the Needs
	• Security officers on site 24/7. One officer is always stationed at the Children's Hospital. • Secured units; Children's, Emergency Department, Birth Place • Security works with HR for specifically identified domestic violence issues with employees • Hugs & Kisses system • Child's Voice program • Social Work services • Mental Health services • Counseling for employees through EAP • Police Dept. 605-367-7212 • Minnehaha Sheriff 605-367-4300 • Child Protection 605-367-5444 • SD Child Advocacy Center 605-333-2226 • Children's Inn (services for family violence, child abuse) 605-338-0116 • Substance Abuse resources: o Glory Home 605-332-3273 o Keystone Outreach 605-413-1493 o Sioux Falls VAMC 605-336-3230 o Tallgrass Recovery 605-368-5559 o Bartels Counseling 605-310-0032 o Choices Recovery 605-334-1822 o Counseling Resources 605-331-2419 o Dakota Drug & Alcohol Prevention 605-331-5724 o First Step 605-361-1505 o Carroll Institute 605-336-2556 o Sioux Falls Urban Indian Health 605-339-0420 o Transitional Living Corporation 6005-368-5559 o Sioux Falls Treatment Center 605-332-3236 o Arch Halfway House 605-332-6730 o Changes & Choices Recovery Center 605-332-9257 o Face it Together 605-2274-2262 o Minnehaha Co. Detox Center 605-367-5297
Access to Health Care/Cost of Health Care • Access to affordable health insurance • Access to affordable health care • Access to affordable prescription drugs	HRSA Grant • The HRSA grant increases access to inter-professional health care services by deploying these services further into the community and homes where daily self-care occurs. Co-Ops are held 4 times each week in four community settings. • HRSA Co-Ops target those receiving Medicare, Medicaid or those who are uninsured. • Early outcomes indicate potential reduced cost of health care. Cancer • Affordable Rx drugs – drug replacement and subsidy program for cancer patients available for infusion and oral chemotherapy.
Physical Health • Cancer • Chronic disease o High cholesterol	Sanford has developed an implementation strategy to address chronic disease and obesity.

Identified Concerns	How Sanford Medical Center Sioux Falls USD is Addressing the Needs
○ Hypertension ○ Arthritis • Obesity • Poor nutrition and eating habits • Inactivity and lack of exercise ○ 66.4% of respondents report that they are overweight or obese ○ Only 11.2% report having 3 or more vegetables/day ○ Only 24.4% report having 3 or more fruits/day ○ 48.3% report moderate exercise at least 3x/week	Sanford Women's Mutch Center for Health Enrichment – Chronic Disease • Conducts Healthy Lifestyle Coaching for the general public • Conducts nutrition consultations for the general public • Conducts small group fitness for women with classes specifically designed for bone health and individuals struggling with physical movement due to chronic disease for the general public Sanford CHILD Services – Pediatric Obesity • Conducts fitCare classes for child care providers in 29 counties in northeast and southeast South Dakota focusing on health and wellbeing relevant to pediatric obesity prevention • Conducts Physical Activity Technical Assistance to child care providers in 16 counties in southeast South Dakota to assist caregivers in putting more physical activity into a child's day in order to prevent pediatric obesity. • Conducts fitClub4 Girls in 8 schools with the Sioux Falls School district focusing on health and wellbeing relevant to pediatric obesity prevention HRSA Grant • Community screenings through the HRSA grant for hyperlipidemia may be funded in 2016 for testing of HDL and total cholesterol • BP thresholds are monitored for all HRSA grant participants with diagnoses of HTN • The IP team includes a dedicated PT and OT who work with those with arthritis to promote better function • All grant participants have a calculated BMI and are coached by RNs and the dietician for weight loss. • Community classes are offered for diabetes management, weight loss and exercise. Cancer • Screening – Increasing screening rate for breast and colon cancer through use of primary care and Medical Home. Health maintenance reminders for breast, colon and cervical cancer screening. Addition of lung cancer screening program for early detection with dedicated lung nodule clinic. • Risk Assessment – Implementation of Edith Sanford Athena Breast Cancer Risk assessment program to identify and intervene with women at high risk of breast cancer. Expansion of high risk breast clinic to develop personalized screening plans. Identification of patients and families at high risk for colon and endometrial cancer through consistent genetic tumor testing. Genetic counseling imbedded in clinics for easy access to familial cancer risk assessment. • Treatment – Advanced treatment including targeted therapy based upon tumor genomic analysis and immunotherapy. Clinical trials including NCI-sponsored, investigator-initiated and commercial available for patients locally.

Identified Concerns	How Sanford Medical Center Sioux Falls USD is Addressing the Needs
	• Survivorship – Survivor treatment summaries, care plans and visits serve to encourage healthy behaviors, reoccurrence prevention and quality of life. Plans include exercise, nutrition, health screenings and mental health aids. Other • Camp Fuel – Week-long camp held at the Sanford Wellness Center for kids ages 9-12 to teach them about healthy eating and physical activity • General nutrition education for K-12 students in Sioux Falls schools and surrounding communities • General nutrition education presentations to employees of Sioux Falls businesses • Serve as part of the HRSA grant interdisciplinary health care team • Serve as part of the Healthy SD Community work group • Cooking classes and nutrition education to Boy and Girl Scouts • Nutrition presentations to groups with cancer and other chronic conditions (breast cancer, COPD, diabetes, etc.) • Health fairs • Fuel Up to Play 60 Coach for the Brandon Valley School District (FUTP 60 is an in-school program that promotes healthy eating and physical activity) • Nutrition education for pregnant women and new moms (B4 Baby, New Baby & Me, Centering Pregnancy) • One-on-one nutrition counseling for Wellness Center and Mutch Women's members • Participate in TV, radio, and newspaper interviews regarding nutrition topics in the news • Diabetes Prevention Program

Mental Health
• Underage drug use and abuse
• Alcohol abuse
  ○ 29.1% of respondents report binge drinking
	Mindfulness Based Stress Reduction (MBSR) courses provided to the community 2014, 2015, 2016
	• Mindfulness is moment-to moment, non-judgmental awareness. MBSR is a research-based intensive training course designed to assist people. Developed by Dr. Jon Kabat-Zinn at the University of Massachusetts Medical Center
	  ○ Manages anxiety, depression, stress, chronic pain, and a range of conditions.
	  ○ Uses a combination of mindfulness meditation, body awareness, and yoga to help people become more mindful.
	  ○ Beneficial effects, including stress reduction, relaxation, and improvements to quality of life.
	
	Mindfulness courses for 2016 includes community groups with chronic diseases including:
	• Breast cancer
	• Neurological conditions
	• Older adults

Identified Concerns	How Sanford Medical Center Sioux Falls USD is Addressing the Needs

	Transition Nursing:
	• At Sanford Medical Center Sioux Falls USD in Sioux Falls, an experienced nurse case manager provides nursing care to support complex patients for a defined period of time after discharge from the hospital, usually 4 weeks.
	• The patient is referred and assessed prior to discharge
	  ○ Provides early identification and response to health risks
	• Multidisciplinary approach working with health care team
	• Service provided:
	  ○ The transition nurse makes a home visit soon after discharge
	  ▪ Medication review
	  ▪ Health status monitoring
	  ▪ Provide/reinforce discharge education
	  ▪ Assure follow-up appointments are made and accessible to the patient
	  ○ Telephone encounters are provided to continue monitoring and provide support
	  ○ Additional home visits are made based on patient need
	  ○ The nurse coordinates care with patient's provider and the team
	• The transition nurse provides hand-off to the clinic and provider at the end of the transition period
	• Research has demonstrated a reduction in readmission, decreased cost, decreased length of stay
	
	Emergency Department Case Management:
	Sanford Medical Center Sioux Falls USD provides nurse case managers in the emergency department to support complex patients who access care in this setting, working with the multidisciplinary team to support the needs of the individual. The nurse case manager is available to consult with patients who need additional support to manage complex social, health or chronic conditions and provides referrals to resources in the community as appropriate for the assessed needs. The nurse case manager is a broker of services, linking the individual to community- based services including:
	• Establishing a primary care provider
	• Referrals to mental health and substance abuse resources
	• Medication assistance
	• Food and housing assistance
	
	Referrals to community, state and federal programs **Behavioral Health Triage Therapist (BHTT):**
	
	The BHTT serves as an integral core team member within the patient-centered Medical Home. The BHTT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom

Identified Concerns	How Sanford Medical Center Sioux Falls USD is Addressing the Needs
	work collaboratively to provide the best care to patients. The BHTT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The BHTT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, on-site crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow up to ensure continuity of care and those patients are receiving appropriate behavioral health management. BHTT Key Points: • BHTT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease. • BHTT works to ensure seamless interface between primary care and specialty and/or community-based resources. • They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety. **<u>Addiction Services:</u>** • Sanford Health Psychiatry and Psychology Clinic is hiring a Llicensed Addiction Counselor to provide outpatient addiction/chemical dependency care. • Incorporation of Peer Support Advocate (PSA) position to enhance addiction services provided by Sanford Health o The PSA brings an understanding and insight from the perspective of "lived experience" that can be extremely helpful to the patient struggling with addiction. o The primary role of the PSA is to assist and direct people in recovery from addiction to the proper resources for ongoing care, promoting accountability and mitigating relapse. o Examples of the above would be: assist patient with successfully attending after-care appointments, assist with successful completion of tasks outlined by the treatment team's plan of action and ultimately improve duration of sustained adherence to treatment plan. Sanford is participating in the community initiative to address behavioral health.

Sioux Falls/MSA Assessed Concerns and Resource/Asset Mapping

Identified concern	Community resources that are available to address the need
Aging Population	Home Care/Respite Care resources: • Sanford Home Care 605-328-5900 • Home Care Assistance of SF 605-275-9183 • Synergy Home Care 605-274-2191 • Comfort Keepers 605-679-6408 Long Term Care resources: • Good Samaritan 605-361-3311 / 605-336-6232 • Dow Rummel Village 605-336-1490 • Bethany Lutheran Home 605-338-2351 • Luther Manor 605-336-1997 • Southridge Health Care Center 605-338-9891 • Avera Prince of Peace 605-322-5600 • Golden Living Center 605-361-8822 Sioux Falls Helping Hands Emergency Center SD Department of Social Services 605-367-5444 Assisted Living for the elderly: • Stoney Brook Suites 605-373-0013 • Inn on Westport 605-362-1210 • Primrose Retirement Community 605-334-9100 • Good Samaritan Society 605-331-5507 • Washington Crossing 605-271-9273 • Meadows on Sycamore 605-332-0938 • Trail Ridge 605-339-4847 • Avera Prince of Peace 605-322-5600 • Waterford 605-335-1117 • Edgewood Vista 605-367-9570 • Prairie Crossings 605-361-0012 • Dow Rummel Village 605-336-1490 • Green Leaf 605-275-0074 • Cayman court 605-271-8540 Home Care resources: • Sanford Home Care 605-328-5900 • Home Care Assistance of SF 605-275-9183 • Synergy Home Care 605-274-2191 • Comfort Keepers 605-679-6408 Respite Care facilities: • SD Dept. of Human Services Respite Care Program 800-265-9684 • Inn on Westport 866-662-2111 • Edgewood Vista 866-662-2624 • Home Care Assistance of SF 605-275-9183

Identified concern	Community resources that are available to address the need
Children and Youth	Counselors for children who are troubled by bullying: • DAKota Oak Counseling 605-759-8359 • Sioux Falls Psychological Services 605-334-2696 • Great Plains Psychological Services 605-323-2345 • Behavioral Health Triage Therapists within Sanford Family Medicine and Pediatric clinics • Psychiatry and Psychology Clinic 605-312-8700 Preschool programs: • Sioux Falls School District early childhood programs 605-367-7900 • Embe 605-336-3660 • Christian Center School 605-361-8002 • St. Mary School 605-334-9881
Crime/ Safety	Police Dept. 605-367-7212 Minnehaha Sheriff 605-367-4300 Child Protection 605-367-5444 SD Child Advocacy Ctr. 605-333-2226 Children's Inn (services for family violence, child abuse) - 605-338-0116 Substance Abuse resources: • Glory Home 605-332-3273 • Keystone Outreach 605-413-1493 • Sioux Falls VAMC 605-336-3230 • Tallgrass Recovery 605-368-5559 • Bartels Counseling 605-310-0032 • Choices Recovery 605-334-1822 • Counseling Resources 605-331-2419 • Dakota Drug & Alcohol Prevention 605-331-5724 • First Step 605-361-1505 • Carroll Institute 605-336-2556 • Sioux Falls Urban Indian Health 605-339-0420 • Transitional Living Corporation 6005-368-5559 • Sioux Falls Treatment Center 605-332-3236 • Arch Halfway House 605-332-6730 • Changes & Choices Recovery Center 605-332-9257 • Face it Together 605-2274-2262 • Minnehaha Co. Detox Center 605-367-5297 • Sanford Psychiatry and Psychology Clinic 605-312-8700
Cost of Health Care/ Access to Health Care	Sanford Health Community Care Programs Medical Home Program Sanford Health Case Managers Sanford Health Parish Nurses Sanford Health Social Workers

Identified concern	Community resources that are available to address the need
	Health Care clinics: • Sanford Family Medicine Clinics (26th & Sycamore 605-328-9000; 49th & Oxbow 605-328-1850; 69th & Minnesota 605-328-5800; 69th & Louise 605-312-8000; 41st & Sertoma 605-328-9600; 34th & Kiwanis 605-328-9100; USD Family Medicine 605-312-8300; 4th & Sycamore 328-2999; Brandon 605-582-5820; Hartford 605-312-5600; Lennox 605-647-2841;) • Sanford Internal Medicine Clinics (Internal Medicine 605-328-7500; Womens Internal Medicine 605-328-9700; • Sanford Childrens Clinics (26th & Sycamore 605-328-9080; 69th & Louise 605-312-8000; MB2 605-328-7800) • Sanford Acute Care and Walk-In Clinics (26th & Sycamore, 41st & Sertoma, 69th & Minnesota, Walk-In Stevens Center 605-332-2883) • Falls Community Health 605-367-8793 • Avera McKennan 605-322-8372 • SF VA Center 605-336-3230 Low income eye care: • Sioux Falls Family Vision 605-275-6100 • Falls Community Health 605-367-8793 • SD Sept. of Social Services/Medicaid 605-773-3165 Low income dental care: • Sioux River Valley Health Center 605-367-8760 • SD Sept. of Social Services/Medicaid 605-773-3165 Prescription Assistance programs: • CancerCare co-payment Assistance Foundation 866-552-6729 • Freedrugcard.us • Rxfreecard.com • Medsavercard.com • Yourrxcard.com • Medicationdiscountcard.com • Needymeds.org/drugcard • Caprxprogram.org • Southdakotarxcard.com • Gooddaysfromcdf.org 877-968-7233 • NORD Patient Assistance Programs 800-999-6673 • SD Partnership for Prescription Assistance 888-477-2669 • Patient Access Network (PAN) Foundation 866-316-7263 • Pfizer RX Pathways 866-776-3700 • RXhope.com
Physical Health	Health Care clinics: • Sanford Family Medicine Clinics (26th & Sycamore 605-328-9000; 49th & Oxbow 605-328-1850; 69th & Minnesota 605-328-5800; 69th & Louise 605-312-8000; 41st & Sertoma 605-328-9600; 34th & Kiwanis 605-328-9100; USD Family Medicine 605-312-8300; 4th & Sycamore 328-2999; Brandon 605-582-5820; Hartford 605-312-5600; Lennox 605-647-2841;) • Sanford Internal Medicine Clinics (Internal Medicine 605-328-7500; Womens Internal Medicine 605-328-9700;

Identified concern	Community resources that are available to address the need
	• Sanford Childrens Clinics (26th & Sycamore 605-328-9080; 69th & Louise 605-312-8000; MB2 605-328-7800) • Sanford Acute Care and Walk-In Clinics (26th & Sycamore, 41st & Sertoma, 69th & Minnesota, Walk-In Stevens Center 605-332-2883) • Falls Community Health 605-367-8793 • Avera McKennan 605-322-8372 • SF VA Center 605-336-3230 Sanford Dietitians Sanford Power Center Sanford *fit* Farmers Markets: • Falls Park Farmers Market 605-360-1623 • Sioux Empire Farmers Market 605-651-3624 • MTM Euro Farmers Market 605-271-9099 Exercise Facilities: • Great Life Woodlake Athletic Club 605-361-0445 • Anytime Fitness 605-275-5556 • Sanford Wellness Center 605-328-1600 • Planet Fitness 605-330-9990 • Avera McKennan Fitness Center 605-322-5300 • Fitness 19 605-271-6019 • 9 Round Fitness 605-275-8855
Mental Health/ Behavioral Health	Substance Abuse resources: • Glory Home 605-332-3273 • Keystone Outreach 605-413-1493 • Sioux Falls VAMC 605-336-3230 • Tallgrass Recovery 605-368-5559 • Bartels Counseling 605-310-0032 • Choices Recovery 605-334-1822 • Counseling Resources 605-331-2419 • Dakota Drug & Alcohol Prevention 605-331-5724 • First Step 605-361-1505 • Carroll Institute 605-336-2556 • Sioux Falls Urban Indian Health 605-339-0420 • Transitional Living Corporation 6005-368-5559 • Sioux Falls Treatment Center 605-332-3236 • Arch Halfway House 605-332-6730 • Changes & Choices Recovery Center 605-332-9257 • Face it Together 605-2274-2262 • Minnehaha Co. Detox Center 605-367-5297 Mental Health resources: • Catholic Family Services 605-988-3775 • Heuermann Counseling Clinic 605-336-1974 • LifeMarks Behavioral Health 605-334-1414

Identified concern	Community resources that are available to address the need
	• Psychiatry and Psychology Clinic 605-312-8700 • Southeastern Behavioral HealthCare 605-336-0503 / 605-336-0510 PTSD resources: • VA / Vet Center 605-330-4552 • Avera Health 605-322-8000

Demonstrating Impact

The following unmet needs were identified through a formal community health needs assessment, resource mapping and prioritization process for 2013:

- Elderly
- Dental Needs

Implementation Strategy: Elderly

- Consider the recruitment of Geriatricians.
- Nurse-led clinics - explore external funding opportunities to:
    - Consider expansion of CareSpan (walk-in nurse-run elder care clinic) hours and locations
    - Consider expansion of foot care clinics hours and locations
- Continue and expand community-based nurse-led dialogues regarding advance directives and end-of-life care.
- Consider establishing an older adult population advisory council within the community.

Implementation Strategy: Dental

- Explore opportunities to help promote either free or sliding scale fee dental services and programs already offered in the community (i.e. Falls Community Health Center and Ronald McDonald Mobile Care Unit).

Impact of the 2013 CHNA Implementation Strategies

When the 2013 community health needs assessment was conducted we learned of the concerns for the aging population in our community and the need for additional services. Implementation strategies were put into place to address the needs of the increasing aging population. Sanford has expanded the nurse-led clinics, including the expansion of CareSpan (walk-in nurse-run elder care clinic) and foot care clinics to more days per week and at additional locations. Sanford supported professional staff to become trained facilitators of the Better Choices Better Health classes in Sioux Falls in partnership with South Dakota Department of Health and the SDSU Extension Program. Better Choices Better Health is designed to help those living with a chronic illness improve self-management. Sanford is hosting several workshops at clinic and community sites, as well as coordinating with other partners to offer Better Choices Better Health sessions across the city in churches and community centers.

Community members expressed concern about the need to understand end-of-life choices and what decisions must be made to determine that choices are honored. Nurse-led dialogues regarding advance directives and end-of-life care brought forth a new initiative to provide education about advanced directives and assistance for community members with the completion of these documents.

As a result a new initiative around advanced care planning has begun at Sanford using the Gunderson model.

Sanford supports education and resources for agencies serving older adults such as Active Generations, Arthritis Foundation, Alzheimer's Association, National Parkinson's Foundation SD, etc. and the following initiatives: Moving Day, PD Support Group, Arthritis Support Group, High Noon education.

Sanford also serves on the advisory board of Senior Companions, and the Sanford faith community nurses serve as a station to help supervise senior companions.

We have learned that the needs for services for our aging population continue to increase and remain a high concern among community members. The cost and availability of long term care and the availability of memory care are among the highest of concerns.

Implementation strategies were also put into place to address dental care in the Sioux Falls community. Poor dental health can be a disability for community members and can prevent students from learning well in school. The need for dental services for community members who did not have dental insurance served as a catalyst for the implementation strategy to address dental services. Sanford supports free or sliding scale fee dental services and programs already offered in the community such as the Falls Community Health Center and Ronald McDonald Mobile Care Unit. We have learned that the need for dental health services continues today - the gap in workforce is making this need more difficult to address.

SANFORD HEALTH

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