Avera McKennan Hospital & University Health Center
Avera Heart Hospital

FY 2016, 2017, and 2018
Community Health Needs Assessment
Implementation Plan
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INTRODUCTION

Health is a result of our behaviors, our individual genetic predisposition to disease, the environment in which we live, the clinical care we receive, and the policies and practices of our health care and prevention systems. Each of us—individually, as a community, and as a society—strives to optimize these health determinants to ensure a long, disease-free and robust life, regardless of race, gender, or socioeconomic status.

According to the Centers for Disease Control and Prevention (CDC), chronic diseases affect almost 50 percent of Americans and account for seven of the ten leading causes of death in the United States. Preventable health risk factors such as tobacco use and exposure, insufficient physical activity, and poor nutrition contribute greatly to the development and severity of many chronic diseases.

The Community Health Needs Assessment (CHNA) process helps a community build the capacity to support policy, systems, and environmental changes that will positively impact and improve community health. It involves collecting and analyzing data, including statistics on health status, health needs, and other public health issues.

Organized and informed community action can combat the prevalence of chronic disease, reduce health risk factors, and reduce health disparities. The 2012 Community Health Status Report for Sioux Falls, produced by the City of Sioux Falls Health Department, was the first collaborative effort to understand our community’s health and to develop evidence-based strategies to help us live well as a community. That report resulted in the creation of the Live Well Sioux Falls initiative. Avera McKennan Hospital & University Health Center (Avera McKennan), including the Avera Heart Hospital as well as other Live Well stakeholders, completed their own Community Health Needs Assessments in 2013.

Beginning in the fall of 2013, the Live Well Sioux Falls CHNA collaborative was formed for the purpose of assembling the 2016 CHNA, and was comprised of representatives from the City of Sioux Falls Health Department (SF Health Dept), Avera McKennan, the Avera Heart Hospital and Sanford Health (Sanford).
HOSPITAL PROFILES AND ORGANIZATION MISSION

Avera McKennan Hospital & University Health Center
Avera McKennan Hospital & University Health Center is a 545-bed hospital in Sioux Falls. Founded in 1911, Avera McKennan has a century-long history of health ministry. It is the flagship hospital of Avera Health, a system comprised of 345 locations in 100 communities across a five-state region. Avera is home to innovative programs that include the world’s most robust telemedicine program of its kind – Avera eCARE™, and the Avera Cancer Institute Center for Precision Oncology, which collaborates with partners across the nation and world to offer cutting-edge, personalized cancer care.

Avera McKennan provides a complete continuum of care in more than 60 medical specialties, including oncology, cardiology, critical care, emergency medicine and trauma, air ambulance services, behavioral health, gastroenterology, endocrinology and diabetes care, hospice, imaging, medical education and research, brain and spine care, women’s health care, pediatrics, neonatology, orthopedics, rehabilitation, and a full range of wellness services. Avera McKennan is home to the region’s only bone marrow transplant program, longest-standing kidney transplant program, and the regions only liver and pancreas transplant programs.

Avera, headquartered in Sioux Falls, S.D., employs more than 16,000 individuals, which includes more than 6,700 in the Sioux Falls region and 900 physicians. Avera McKennan is accredited by The Joint Commission, and has been designated as a Magnet® hospital by the American Nurses Credentialing Center since 2001. Sponsored by the Benedictine and Presentation Sisters, Avera is distinguished by its mission.

Avera Heart Hospital
The Avera Heart Hospital, founded in 2001 in Sioux Falls, is the region’s first hospital dedicated to cardiac and vascular care. As the region’s first Accredited Chest Pain Center, Avera Heart Hospital has the lowest risk-adjusted heart attack mortality and readmission rates in the region. Specialized services include cardiac catheterization, electrophysiology, surgery, and a full range of diagnostic and rehabilitation services.

Avera Mission Statement
Avera is a health ministry rooted in the Gospel. Our mission is to make a positive impact in the lives and health of persons and communities by providing quality services guided by Christian values.

Avera Vision Statement
Working with its partners, Avera shall provide a quality, cost-effective health ministry, which reflects Gospel values. We shall improve the health care of the people we serve through a regionally integrated network of persons and institutions.

Avera Values
Compassion, Hospitality, and Stewardship.
COMMUNITY SERVED

The population of South Dakota has grown since the 2013 Community Health Needs Assessment, increasing from 814,180 to 853,175, a growth rate of 4.8 percent. With a population density of 10.7 persons per square mile, South Dakota is one of the least-densely populated states in the nation.

For the purpose of the CHNA report, the “community” was defined as the Sioux Falls Metropolitan Statistical Area (MSA), which includes the counties of Lincoln, McCook, Minnehaha, and Turner. This large population growth area represents where 50 percent of the Sioux Falls hospital inpatient discharges originate. While South Dakota counties are predominantly rural, the majority of Minnehaha County, including the city of Sioux Falls, is classified as urban.

The population in Sioux Falls and the surrounding area has grown over the past three years. The city of Sioux Falls has been adding 3,000-4,000 new residents each year, or an annual growth rate of 2.1 percent. Lincoln County was among the top 25 fastest growing counties in the United States from 2013 to 2014 (Figure 1 Source: US Census Bureau).

Figure 1: Population
KEY DEMOGRAPHICS

According to the most recent census data (Source: US Census Bureau), the Sioux Falls MSA is 49.95% female and 50.05% male. The community's racial composition, while still predominantly white at 82%, is rapidly becoming more diverse. Statewide, nearly 25 percent of South Dakotans are under the age of 18. Persons age 65 and over make up 15.3 percent of the population, which is slightly higher than the national average of 14.5 percent.

Figure 2: Racial Composition

The Sioux Falls area unemployment rate decreased over the past year and is lower than any point in 2013 or 2014. The portion of Sioux Falls in Minnehaha County is at 2.3 percent, and the portion in Lincoln County is even lower, at 1.7 percent. The state unemployment rate is 2.5 percent. A tight labor market results in large numbers of positions remaining unfilled, including many lower-skilled, lower-paying occupations.
Within this area of the MSA there are six Census Block Groups with median household incomes below the poverty threshold for a family of four. Three of these Census Block Groups also meet the definition of concentrated poverty, with more than 40 percent of their households living below the poverty line. These block groups are located immediately west and north of downtown Sioux Falls. The block group south of Harrisburg also contains between 20 and 40 percent of households below the poverty line (Figure 3 Source: City of Sioux Falls, SD DOT, Sioux Falls MPO, US Census Bureau, Center for Economic Studies).

Figure 3: Households in Poverty

(Map showing distribution of households in poverty with specific data and sources provided.)
IMPLEMENTATION STRATEGY PROCESS - BETTER TOGETHER

Conducting a CHNA and developing implementation strategies are required of tax-exempt hospitals, like Avera McKennan, Avera Heart Hospital and Sanford, as a result of the Patient Protection and Affordable Care Act. The process must be completed every three years, and the hospitals are also required to seek input from those who represent the broad interests of the community and who have special knowledge or expertise in public health.

In 2013, Avera McKennan, including the Avera Heart Hospital, and Sanford each completed separate CHNA reports in addition to participating in the assessment led by the SF Health Dept. These three separate assessments resulted in nearly identical results relative to the health needs of the community. **To reduce this duplication and to develop a comprehensive look at community health, the SF Health Dept, Avera McKennan, including the Avera Heart Hospital, and Sanford embarked on a collaborative CHNA process in 2013.**

These partners share the common vision of Live Well Sioux Falls:

> Live Well Sioux Falls will transform the health of our community to create a more vibrant, active, and livable city. We are creating a culture of health and well-being in Sioux Falls to make the healthy choice the easy choice.

To achieve the most comprehensive community assessment possible, the partners developed a multi-pronged process of data collection and analysis that included the following quantitative and qualitative methods:

**Generalizable resident survey – Sanford**
Sanford led the distribution of a generalizable survey of residents in the Sioux Falls Metropolitan Statistical Area (MSA), which includes Minnehaha, Lincoln, Turner, and McCook counties in South Dakota. The survey instrument and analysis was developed in partnership with the Center for Social Research at North Dakota State University (NDSU).

**Focus groups and key informant interviews – Avera McKennan**
Avera McKennan coordinated the focus group and key informant interview process, contracting with Sumption & Wyland, a Sioux Falls-based consulting firm. The firm also developed and implemented a data validation interview series with community influencers. Thirty-three people took part in the focus group data collection process on May 19 and 20, 2015. Individuals were divided into three random community groups. All groups were facilitated by Margaret J. Sumption, LPC, SPH, and were audio recorded for accurate data collection.

**Community sector assessment – SF Health Dept**
All community members have a role to play in improving health, so for the CHNA process, the city used the South Dakota Good & Healthy Community Checklist (Checklist), which is a valid and tested tool, to help communities assess local policy, regulations, and
environment, as well as education and awareness regarding physical activity, nutrition, tobacco use, chronic disease management, and school health.

**Secondary data review**
In addition to the primary data collection methods described in this section, the CHNA also compared Sioux Falls MSA public health data to secondary data sets to describe the community’s health status. Tools utilized include the Sioux Falls Metropolitan Statistical Area Calculator, Sioux Falls Tomorrow 2014: A Vision for the Future, and The National Citizen Survey™ 2015.

For a comprehensive methodology review, please see the full Community Health Needs Assessment report located at [www.avery.org](http://www.avery.org).
SIGNIFICANT HEALTH NEEDS
The data collection process used for the CHNA allowed for analysis and prioritization of numerous issues that impact community health. Partners identified priorities using criteria such as size, urgency, economic feasibility, potential for impact, availability of community assets, and value to the community. Through the use of a resident survey, focus groups, key interviews, a sector assessment, and secondary data review, the CHNA partners identified the following health issues as those that should be addressed through a community-wide effort:

**Obesity** - includes nutrition, physical activity and other chronic disease risk factors.

Obesity rates differ by region, age and race/ethnicity. The 2015 *State of Obesity Report* indicates American Indian/Alaska Natives have the highest adult obesity rate (54 percent) of any racial or ethnic group in the nation. Obesity rates in the United States are 47.8 percent for Blacks (24.3 percent in South Dakota); 42.5 percent for Latinos (27.1 percent in South Dakota); and 32.6 percent for Whites (28.9 percent in South Dakota).

Overall, South Dakota ranked as the 23rd most obese state in the country and the CHNA survey showed that over two-thirds of adults in the Sioux Falls MSA are overweight or obese based on the Body Mass Index scale.

Body Mass Index (BMI) is also used to measure childhood overweight and obesity. The South Dakota Department of Health, in cooperation with the South Dakota Department of Education, has analyzed height and weight data since the 1998-1999 school year. The most recent report (2013-2014) found that 32.3 percent of students (ages 5-19) are overweight or obese. The Education Service Agency region that includes the Sioux Falls MSA is the only region below the state average, with a combined overweight and obesity rate of 30.4 percent. While there was not a significant difference in combined overweight/obesity among male (32.9 percent) and female (31.8 percent) students in South Dakota, there were differences among race:

- American Indian—48.4 percent
- Other Races—35.4 percent
- Multi-race/Unspecified—33.6 percent
- White—29.8 percent

Overall, overweight and obese percentages decreased compared to last school year. South Dakota students who measured overweight in the last school year (16.6 percent) decreased to 16.5 percent and obese students last year (16.0 percent) dropped slightly to 15.8 percent in the current school year.
**Substance Abuse and Mental Health** - includes behavioral health, alcohol and drug use.

In the 2015 report *Focus on South Dakota: A Picture of Health*, published by the Leona M. and Harry B. Helmsley Charitable Trust, residents in the Sioux Falls MSA were asked if they needed medical care, mental health care, or treatment for alcohol or drug use over the past 12 months. If they responded "yes" to any of these areas, responses were recorded as a "need for treatment." If respondents answered that they received "some but not all care" or received "no care," that was recorded as an unmet need.

- Need for Mental Health Care: 10.06%
- Need for Alcohol or Drug Treatment: <1%
- Unmet Medical Needs: 9.35%
- Unmet Mental Health Needs: 29.88%

Additionally, the CFNA resident survey asked several questions related to substance abuse. When asked to rank their level of concern about various issues on a scale of 1 to 5, with 1 being "not at all" and 5 being "a great deal" of concern, residents responded accordingly:

**Figure 4 – Substance Use Survey**

| Presence of Street Drugs, Prescription Drugs, and Alcohol in the Community | 3.84 |
| Presence of Drug Dealers in the Community | 3.62 |
| Underage Drug Use and Abuse | 3.51 |
| Drug Use and Abuse | 3.31 |
| Underage Drinking | 3.25 |
| Alcohol Use and Abuse | 3.25 |
| Timely Access to Substance Abuse Providers | 2.55 |
| Timely Access to Prevention Services | 2.50 |
Survey respondents were also asked about their own behaviors related to the use of alcohol or other substances. Excessive alcohol use, either in the form of binge drinking (5 or more drinks on an occasion for men, or 4 or more drinks on an occasion for women) or heavy drinking (15 or more drinks per week for men or 8 or more drinks per week for women) is associated with an increased risk of many health problems, such as liver disease and unintentional injuries. The level of binge drinking in the Sioux Falls MSA has increased slightly (from 19 percent in 2010).

Alcohol and substance use not only impact the individual, but also their employers. Among clients of Face It TOGETHER Sioux Falls, an addiction support program, 64.6 percent report they are employed while receiving peer-based addiction support services from the agency, and 31.5 percent report being unemployed. Of that group, 10.9 percent say they are not looking for work for a variety of reasons, including disability and treatment.

Mental health, or behavioral health, is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family, and interpersonal relationships, and the ability to contribute to community or society.

As a general health question, the CHNA resident survey asked respondents about their level of concern regarding mental health as well as about status of their own mental health. Forty-seven percent of respondents reported that they had been diagnosed by a health provider with a mental health issue and the following respondents reported poor mental health days in the previous month:

**Figure 5 - Respondents Reporting Poor Mental Health Days in the Last Month**

![Pie Chart showing percentages of mental health days](image-url)
Access to Care - includes issues such as availability, cost, and coordination of care. Access to high-quality and affordable measures, including screening and appropriate follow-up, are essential steps in saving lives, reducing disabilities, and lowering costs for medical care.

Quality health care is a strong area for Sioux Falls, with two fully-featured tertiary hospitals and numerous primary care and specialty care clinics in the community. In addition, having a Federally Qualified Health Center (FQHC), Falls Community Health, operated under the auspices of Sioux Falls City government, supports the quality of services available in the community.

Despite the numerous health care assets available in the community, residents did identify needs relative to access. The most-often cited gap is the “hand-off,” a term coined by the focus group participants that refers to making sure that individuals stay connected across the continuum of service delivery. This challenge, according to participants, goes beyond referrals within and across medical care providers and should include more emphasis on follow-up and monitoring as individuals are referred for all types of community services outside the medical clinic or hospital setting. Additional access gaps include transportation, health care cost, limited or no insurance, and an overall knowledge of the availability of health care assets.
SIGNIFICANT HEALTH NEEDS NOT ADDRESSED

As noted in the full CHNA report, the social determinants of health are impacted by a variety of social, economic and environmental factors.

Factors impacting community health that were identified during the CHNA process that will not be directly addressed through this implementation plan, but may be addressed via other Avera system or community initiatives, are noted below. These identified needs will not be addressed by Avera McKennan or the Avera I Heart Hospital as they are being addressed by other organizations in the community (local school officials and non-profits, including the United Way, are addressing Youth and Education needs, and Housing areas of concern are being addressed by the City of Sioux Falls, Bishop Dudley Hospitality House, Homelessness Coalition, and SF Housing and Redevelopment). Additionally, we feel that these areas of concern fall outside of our core area of expertise, and other agencies are better equipped to handle these specific issues. Finally, as we have committed to taking on five multi-faceted initiatives – many of which are in an infancy stage – we determined our finite resources are best spent focusing on no more than five initiatives, in order to make the greatest impact in the lives of those we serve and on our community’s health.

<table>
<thead>
<tr>
<th>Youth and Education</th>
<th>Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Bullying</td>
<td>- Affordable</td>
</tr>
<tr>
<td>- Services for at-risk youth</td>
<td>- Safe housing/neighborhoods</td>
</tr>
<tr>
<td>- School drop-out rates</td>
<td>- Location walkability</td>
</tr>
<tr>
<td>- School absenteeism</td>
<td>- Homelessness</td>
</tr>
</tbody>
</table>

**Defer to: Local school officials and non-profits**

**Defer to: City of Sioux Falls, Bishop Dudley Hospitality House, Homelessness Coalition, SF Housing and Redevelopment**
Three Year Implementation Plan
Goal #1 Community Based Behavioral Health Strategies

Support collaborative efforts to address behavioral health needs, including access to behavioral health services, referrals to behavioral health services, coordination of care, and public education and awareness about mental health.

Phase I – Specific Actions and Strategies – In Process
- Develop a Community Behavioral Health Task Force
- Understand behavioral health status of the community
- Facilitate a community conversation among behavioral health experts regarding the health of the community in order to develop a collaborative action plan to address 1 - 3 specific issues

Phase II – Specific Actions and Strategies
- Work with subgroup to determine community capacity and barriers for one specific known problem.
  - Problem statement: Perceived lack of access to inpatient substance abuse treatment for the indigent population
- Examine gaps in regulation and reimbursement
  - License requirements
  - Reimbursement
  - Reciprocity agreements of other states
- Cross-reference SD license requirements with other states and identify gaps and significant differences
- Reconvene the full group to review the work product(s) of the Data/Measures subgroup and the Regulation and Reimbursement subgroup

Anticipated Impact
The Community Behavioral Health Task Force will develop a shared, clearly defined understanding of our community’s behavioral health status, target demographics, and top issues, as well as determine and understand the license requirements and reciprocity agreements of other states. As a result, this shared understanding will assist the task force in developing an action plan to address the top 1-3 specific issues facing our community. It is anticipated that addressing these issues will positively impact individuals’ ability to access mental health care in a timely, coordinated way, as well as increase the public’s awareness and knowledge related to mental health in our community.

Resources and Partners
As the leading provider of behavioral health services in the area, Avera McKennan will be heavily involved for the entirety of this project. Resources dedicated to this project include physician/provider time and input, as well as significant time from Steve Lindquist, AVP of Avera Behavioral Health Center. As the project expands, the number of Avera Behavioral Health Center individuals involved will expand also. Additional community resources who will be involved in the project include individuals from the following organizations:

AMH&UHC and AHH Implementation Plan
- Avera Health
- Avera McKennan Behavioral Health
- Sanford Health
- Minnehaha County
- State of SD; Division of Behavioral Health
- Carroll Institute
- City of Sioux Falls: Public Health
- Southeastern Behavioral HealthCare
- South Dakota Urban Indian Health
- Helpline Center (211)
- Lutheran Social Services
- Catholic Social Services
- National Alliance on Mental Illness (NAMI)

Measurement/Evaluation
- Metrics yet to be defined
Goal #2 Hayward “Thrive”!

Implement a pilot project to address social determinants of health in the Hayward neighborhood of Sioux Falls. This includes developing strategies in such areas as obesity, access to care, the built environment, behavioral health, and engaging neighborhood residents in developing strategies to address community health.

Phase I – Specific Actions and Strategies

Implement Pilot Programs and Neighborhood Assessment – In Process

- Create a community task force that includes resources from across the community and within the neighborhood. Task force will be responsible for conducting assessments, engaging with the community and planning future activities.
- Utilize school based clinic for screenings and assessments with a focus on surveys related to awareness of available health services and evaluation of health literacy. Basic health screenings would include weight, BMI and blood pressure.
- Promote existing community center classes scheduled during this time period, but incorporate an evaluation to determine other types of programming that might be desired by participants.
- Conduct a needs assessment/gaps analysis of current program offerings and determine what types of evidence-based programming might be effective.
assessment could be in the form of surveys and/or focus groups to better understand the households in the neighborhood. Questions could relate to fruit and vegetable consumption, kitchen space/tools available, who is in the household to cook, physical activity habits, if they have a healthcare provider, do they have transportation, other barriers to participation in screenings and programs, etc.

- Begin planning for a neighborhood event featuring a national expert in neighborhood/community engagement and organization. This will contribute to the development of neighborhood champions and a neighborhood association.

**Design and Implement Interventions – In Process**

This phase will use information gained during the assessment period, along with input from the project partners, to determine what existing programs can be tailored for this population or what additional programs or resources may be needed. Based on our current knowledge of this neighborhood, proposed interventions may include:

- Hosting monthly programs based on the Live Well principles: Breathe Well, Eat Well, Feel Well and Move Well. Start with topics that have been successful in other locations, and then engage the identified neighborhood champions in the planning of subsequent events during the remainder of the grant period. Programs designed and implemented by Avera Heart Hospital professionals may address such topics as healthy shopping and cooking, use of foods provided through the Backpack Program, healthy meals on a budget, and school/community gardening. Budget would provide for accompanying materials such as cutting boards, vegetable peelers, grocery bags, can openers, and materials not able to be produced through in-house printing.
- Placing fitness equipment for children and adults in the community center.
- Displaying Avera Heart Hospital MegaHeart in the gym/community center to show the effects of an unhealthy lifestyle on the heart.
- Promoting oral health services available at the Hayward site of Falls Community Health, including outreach to the neighborhood and education on proper dental care.
- Using neighborhood and church-based activities to take programming into the neighborhood (e.g. promote and enhance “block parties” that have been organized in the past by Hope Next Door, a partner organization).
- Utilize incentives for participation in assessment and program activities (e.g. grocery gift cards, Parks & Rec class gift cards).
- Offering wellness screenings by the Avera Heart Hospital, including blood pressure, vascular screenings and BMI.

**Phase II – Specific Actions and Strategies**

**Implementation and Evaluation**

We will use information learned throughout 2016 to repeat successful programs, develop new programs in cooperation with neighborhood champions, provide re-screening on
health measures, and complete a comprehensive evaluation of the entire grant period. We will establish a model for taking this approach to other neighborhoods in the community where a school/clinic/community center exists.

**Anticipated Impact**

Hayward area residents will be invited to participate in programs designed to improve and maintain good health, as well as overall quality of life, for themselves, their families, and their neighborhood.

The primary desired results are to:

- Empower people to live healthy.
- Link people to local area resources that will help achieve and sustain good health.
- Encourage sustainable neighborhood and community engagement, ownership, and empowerment.

A successful pilot program will create positive and measureable health outcomes for residents in the neighborhood surrounding the school site. Primary indicators to this will include: quality of life assessment, self-care assessment, health-age assessment, health behavior status and a satisfaction survey.

**Resources and Partners**

Seven Avera employees are already involved with Hayward THRIVE. Two Avera McKennan employees serve on the Community Engagement group; one Avera McKennan and one Avera Health employee serve on the Events committee; an Avera Health employee sits on the Data committee, which is co-chaired by an Avera McKennan employee; and an Avera McKennan employee serves on the Walk Audit subgroup. An Avera Heart Hospital employee will also serve on this project beginning in Phase II. In addition to significant contributions of time, Avera McKennan has provided $60,000 in financial support. These employees will continue to serve throughout Phases I and II of this program. Additional community resources who will be involved in the project include individuals from the following organizations:

- Avera McKennan Administration
- Avera McKennan Innovation
- Avera McKennan Facilities
- Avera Health Marketing
- Avera Heart Hospital
- Sanford Health
- City of Sioux Falls
  - Public Health
  - Community Development
  - Planning
  - Public Works
- Police and Fire
- Samaritan's Feet
- Feeding South Dakota
- GroundWorks
- Sioux Falls Public Schools
- American Heart Association
- Siouxland Libraries
- Country View Mobile Home Park
- Sunnycrest Church
- Sioux Falls Area Community Foundation
- Westside Lutheran

Measurement/Evaluation
- Re-screening on health measures
  - Clinical: height, weight, body fat, waist circumference, BMI blood pressure, cholesterol and glucose
  - Behavioral: quality of life, self-care, nutrition, emotional health and health behavior
  - Processes: total number of participants in screenings, classes or other programs and average number of "events" per participant
  - Awareness: email newsletter read rates, website hits, social media interactions, programs/resources available
  - Satisfaction: ratings on each component of program delivery, and one overall average rate
  - Financial: estimated return on investment of total program, estimated health cost savings/return per clinical and behavioral metrics, quality of life return, health-age return
- Sustainability
  - Number of implemented strategies that can be maintained long term by the neighborhood without the direct reliance/interventions by the formal pilot committee.

Budget Planning
The budget on the following page outlines our proposed scope of work. We are excited about the collaboration between public and private entities, particularly engaging the two health systems in this work. Our primary focus in this project is to learn directly from the neighborhood about the challenges they have in trying to "Live Well." We will use these resources toward programs that engage community members and residents and retain their interest, while at the same time empowering them to establish sustainable health habits.

In-kind support for administrative costs will come in the form of City of Sioux Falls staff time and operating expenses, Multimedia Support (in-house printing department), and the Falls Community Health and Parks & Recreation facility space at Hayward Elementary.
Paid time from other community partners, including the two health systems, who are part of various classes and events, is also included as in-kind support.

The statistics and the burden of disease are substantial, but so is the thirst for accessible and affordable programming. Especially within our underserved populations, health assessments and opportunities for preventive programming are out of reach or unaffordable. That can be changed by meeting people where they live and breaking down the barriers of transportation and cost.
<table>
<thead>
<tr>
<th>Requested Support from the Wellmark Foundation</th>
<th>$60,000</th>
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<tbody>
<tr>
<td>Matching and In-Kind Resources to Support the Project</td>
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<tr>
<td>• In-Kind Support</td>
<td>$80,000</td>
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<tr>
<td>o City of Sioux Falls: Live Well Sioux Falls, Falls Community Health and Sioux Falls Parks &amp; Recreation (staff salaries and operating expenses); Supplies; In-house printing</td>
<td></td>
</tr>
<tr>
<td>o Community Partners: Donated (paid) staff time for grant projects and events</td>
<td></td>
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<tr>
<td>• MATCH Dollars from Community Partners</td>
<td>$30,000</td>
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<tr>
<td>Total New and In-Kind Support</td>
<td>$170,000</td>
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<table>
<thead>
<tr>
<th>Proposed Expenses (2-year project)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Neighborhood Association Development</td>
<td>$20,000</td>
</tr>
<tr>
<td>• The purpose of this activity is to identify neighborhood champions and support them in the formation of a formalized neighborhood association. This would include a public neighborhood event featuring a nationally-known expert in neighborhood engagement.</td>
<td></td>
</tr>
<tr>
<td>Health Assessments</td>
<td>$25,000</td>
</tr>
<tr>
<td>• Pre- and post-program assessments: health screenings and surveys. The cost estimate is based on value of health assessments used by health care providers. Grant dollars will not be used for direct care (billable) expenses.</td>
<td></td>
</tr>
<tr>
<td>Enhance Bike and Pedestrian Facilities</td>
<td>$30,000</td>
</tr>
<tr>
<td>• Conduct a neighborhood walk audit, provide new bike rack(s) for the school/clinic/community center facility and identify areas to enhance crosswalks and/or on-street bike facilities (bike lanes or sharrows).</td>
<td></td>
</tr>
<tr>
<td>Health Education Programs</td>
<td>$35,000</td>
</tr>
<tr>
<td>• Host monthly programs based on the Live Well principles: Breathe Well, Eat Well, Feel Well and Move Well. Budget would provide for accompanying class/program materials and items not able to be produced in-house.</td>
<td></td>
</tr>
<tr>
<td>Physical Activity Programs</td>
<td>$20,000</td>
</tr>
<tr>
<td>• Additional class equipment for the community center to expand programming for youth and adults.</td>
<td></td>
</tr>
<tr>
<td>Public Awareness and Marketing</td>
<td>$20,000</td>
</tr>
<tr>
<td>• Printed and Web-based Resources (such as recipes or cooking tips, at-home exercises, grocery shopping tips, interactive online health assessment, etc.)</td>
<td></td>
</tr>
<tr>
<td>• Text messaging to support health programming (two years of monthly fees for text messaging service plus costs-per-text, both outbound and inbound, based on four messages per month)</td>
<td>$10,000</td>
</tr>
<tr>
<td>• Participation incentives (for focus groups or other events, such as $10 grocery store gift cards, public transit cards or &quot;gift cards&quot; for Parks &amp; Recreation programs not otherwise included in the pilot project)</td>
<td>$10,000</td>
</tr>
<tr>
<td>Total Proposed Expenses:</td>
<td>$170,000</td>
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Goal #3 Sioux Empire Network of Care

The primary purpose of the Sioux Empire Network of Care project is to build a coordinated social service system through a partnership collaborative to address healthcare access issues. The Bush Foundation has provided a grant to fund the efforts of the Sioux Empire Network of Care.

Specific Actions and Strategies – In Process

The primary purpose of the Collaborative Task Force is to:

- Understand the background information needed for a better coordinated social service system.
- Problem solve as a group potential solutions for a coordinated social service system.
- Narrow solutions and make broad recommendations of a solution to the Steering Committee. The Steering Committee will refine and pilot the solution(s).
- Establish a collaborative of social service partners that is committed to improving the social service system in the community.
- Create a coordinated social service system that improves data collection, reporting and analysis.
- Create a coordinated social service system that has the ability to track real-time resource availability to allow partners to collaborate.
- Improve the social service for those being served to help them move from surviving to thriving.
- Implement a culture change among social service organizations to move from a transactional approach (service provided/outputs) to a systems approach that allows the person in need to be served as a whole.
- Use the data generated from the coordinated system to identify gaps in the system, improve efficiency and avoid duplication.

Anticipated Impact

- Connect all social service agencies, via software, to reduce duplication for both client and provider.
- Ensure a more coordinated client hand-off between and among health care providers and participating non-profit entities.

Resources and Partners

Avera McKennan has been involved since the beginning of this project, with an employee participating on the initial task force. Another Avera McKennan employee serves on a working group, looking at the legal and confidentiality considerations, ensuring this solution works for the agencies and community, while keeping patient/client data and personal information confidential and protected. Both employees will play an ongoing role in this community-wide initiative. Additionally, upon a successful pilot, it is assumed the program’s solution will grow to include additional agencies, including Avera McKennan. As AMH&UHC and AHH Implementation Plan
such, our contributions of human resources will continue and likely expand to include Social Work, Case Management, HIM, IT, etc., and financial support may also be provided after the grant period.

Task Force membership shall be comprised of 25 - 30 members representing social service agencies, consumers, funders, and stakeholders. The Task Force will initially be comprised of the following individuals, with additional individuals invited to join as needed:

- Avera McKennan
  - Innovation
  - Compliance
- Sanford Health
- Community Volunteers
- St. Francis House
- Minnehaha County
- Bishop Dudley Hospitality House
- Inter-Lakes Community Action Partnership
- Sioux Falls City Council
- Feeding South Dakota
- Our Savior’s Lutheran Church
- Goodwill of the Great Plains
- Community Outreach
- Betsy Homan Helpline Center
- Lutheran Social Services
- Helpline Center
- Sioux Empire United Way
- Sioux Falls Area Community Foundation
- Sioux Falls Housing
- Salvation Army
- Center of Hope
- Falls Community Health
- Homeless Advisory Board
- Sioux Falls School District
- Department of Social Services

*IT and legal representation would be brought on as consultants as needed. Additional members will be brought on to the task force as needed.

**Measurement/Evaluation**

Evaluation will be based on the six pilot agencies and their successful implementation of the identified software solution. A specific goal regarding the number of clients that will be served through the software has yet to be determined, but could impact as many as 2,000 individuals.
Goal #4 Expand Transportation Services

Design and implement a collaborative pilot project to address health care access needs related to transportation challenges. Partner with transport providers and explore non-traditional transport solutions.

Specific Actions and Strategies
- Convene a partner task force to identify consequences due to gaps in transportation
- Identify gaps/ridership in existing public and paratransit routes
- Identify key pilot demographic and collect and analyze associated data
- Set pilot criteria and secure pilot funding
- Partner with transportation provider to execute pilot

Anticipated Impact
- Reduction in no-show appointments in the pilot population
- Increase in medication compliance rates in the pilot population
- Reduction in ED usage in the pilot population

Resources and Partners
Avera McKennan is leading this initiative, bringing several Avera departments, including Avera Heart Hospital, and local transportation resources together. Avera McKennan staff will identify the problem; collect and analyze pre- and post-data; design and implement the pilot; and measure impact. Additionally, staff will assess outcomes and adjust the pilot accordingly, with the ultimate goal of offering transportation to patients who would otherwise not be able to attend appointments and/or receive necessary medications. In addition to the time contributed by Avera staff, financial resources will be provided by the Avera McKennan Foundation, underwriting the cost of offering transportation services to patients most in need. Additional community resources who will be involved in the project include individuals from the following organizations:

- Avera McKennan Administration
- Avera McKennan Foundation
- Avera McKennan Innovation
- Avera McKennan Social Work & Case Management
- AMG Coordinated Care
- AMG Primary & Specialty Care
- Avera Behavioral Health
- Avera Heart Hospital
- River Cities Transit
- Sioux Area Metro

Measurement/Evaluation
- Metrics yet to be determined
Goal #5 Childhood Obesity

Design and implement a pilot project within a defined student population, with key community stakeholders, to identify strategies for addressing childhood obesity.

Specific Actions and Strategies
- Engage with a local school to partner on the pilot program
- Collect baseline data relative to health (fruit/vegetable consumption, physical activity, weight, blood pressure, etc.)
- Develop health programming to engage and educate elementary school children
- Set program criteria
- Track group health stats over the next several years
- Avera Heart Hospital will provide fun, educational programming to children covering topics such as:
  - Hidden sugar in popular soft drinks
  - How the heart works
  - Exercise and making a healthy heart
  - Providing handouts/worksheets that children can take home
  - Providing programs to parents on eating healthy on a budget and how to make food more enticing to children.

Anticipated Impact
- Increased awareness about participating in one’s own health/wellness
- Improved health and well-being of pilot population
- Increased health literacy

Resources and Partners
The Primary Care Innovation Council includes multiple staff members from Avera McKennan, who contribute to the design of the pilot program and will continue to participate as the program evolves. Avera McKennan financially supports GroundWorks, a partner in this initiative, and facilitates the connection between Avera McKennan, AMG physicians, HyVee, and Sioux Falls Catholic Schools. Avera McKennan will continue to contribute staff and financial resources throughout the pilot program and beyond. Additional community resources who will be involved in the project include individuals from the following organizations:

- AMG Primary Care Innovation Council
- Avera Heart Hospital
- Avera Clinical Intelligence
- AMG Primary Care
- Sioux Falls Catholic Schools
- HyVee
- GroundWorks
• Additional partners added as needed

**Measurement/Evaluation**
• Improved year-over-year baseline scores
• Number of touch points, per participant, over the pilot period
Board Approval

This fiscal year 2016 Community Health Needs Assessment report was prepared and approved at the June 6, 2016, meeting of the Avera McKennan Hospital & University Health Center Board of Trustees.

This implementation strategy, addressing priorities identified in the most recent Community Health Needs Assessment, was prepared for the October 24, 2016 meeting of the Avera McKennan Hospital & University Health Center Board of Trustees.

Avera McKennan Hospital & University Health Center Board of Trustees Approval:

[Signature]

Name and Title
Jim Wiederrick, Chair

Date
10/24/2016
Board Approval

This fiscal year 2016 Community Health Needs Assessment report was prepared and approved at the May 31, 2016, meeting of the Avera Heart Hospital of South Dakota Board of Directors.

This implementation strategy, addressing priorities identified in the most recent Community Health Needs Assessment was sent via email to Avera Heart Hospital of South Dakota Board of Directors on October 26, 2016 for review.

Avera Heart Hospital of South Dakota Board of Directors Approval:

[Signature]

Name and Title
Tommy Reynolds, MD, Chairman of the Board

Date
10/27/16