Sioux Falls Community

Community Health Needs Assessment Focus Group Report

Facilitated and Reported by:

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INTRODUCTION

In June, 2015, the collaborative team of Avera McKennan Hospital, Sanford Hospital, and the Sioux Falls City Health Department gathered to assess community health needs. The goal of the assessment was to inform the focus and direction of the hospitals in the community to meet the identified health care needs of the Sioux Falls area.

As part of this process, Sumption & Wyland, a Sioux Falls-based consulting firm, was contracted to conduct a series of three community focus groups. The focus group concepts and outline are included as Appendix E of this document. In addition, Sumption & Wyland was charged with developing and implementing a data validation interview series with up to 20 community influencers to finalize the this unique element of the data collection process. The data analysis contained herein is not designed to stand alone in determination of community needs. It is designed to be used as a part of a multi-pronged process of data collection and analysis structured to complete the needs assessment process.

Thirty-three people took part in the focus group data collection process. Individuals were broken into three random "community groups" invited by the organizations commissioning the study. All groups were facilitated by Margaret J. Sumption, LPC, SPHR. All groups were audio-recorded.

Thirteen persons completed the individual interview portion of the study. This portion of the study was designed to validate the conclusions drawn as part of the focus group process. The validation interviews included individuals representing business, banking, nonprofit human service, nonprofit childcare delivery, community college, student, minority service agencies, and faith-based services for minority populations.

The composition of the groups included:

Group	Representation	Age Range	Other Factors
1. Community Group	3-Faith Community 5-Nonprofit Executive Level 2-Healthcare Clinician 1-Social Work 1-Physician	< 35 - 0 36- 50 - 5 51-65 - 6 > 65 - 1	Dominate female group
2. Community Group	1-Faith Community 5-Nonprofit Executive Level 2-Healthcare Clinician 1-Physician 1- Governmental	< 35 - 1 36- 50 - 6 51-65 - 3 > 65 - 0	Dominate female group
3. Community Group	2-Volunteer 3-Nonprofit Executive Level 2-Healthcare Clinician 1-Case Manager	Age range 34- 57	Mixed group of male and female

Group	Representation	Age Range	Other Factors
	2-Physician 1- Governmental		
Individual Validation Interviews Total of 13 interviews	3 -Business 1- Banking 2- Nonprofit Human Services 2- Nonprofit Childcare Services 1- Community College Administration 1- Community College Student 1 - Minority Healthcare Provider (Native American) 1 - Faith-based Human Services 1- Healthcare Public Policy	Under 35 through age 65	Mixed group of male and female

The protocol for the focus groups included the following concepts:

- Community Strengths – Identification of those things the community can use to build upon in meeting the healthcare, wellness, and quality of life needs of the community.
- Gaps – Identification of most pressing gaps that stand in the way of health, wellness, and quality of life in the community.
- Resources to Meet Needs – Seeking understanding of what the community needs to address the gaps in health, wellness, and quality of life for out community.
- Recommended Actions – Identification of the one program, service, or resource that would move the community quickly to better health, wellness, and quality of life.
- Other Issues – Allowing members additional time to identify what may not have been shared in previous concept conversations.

This report details the findings from the focus groups. The report first details the areas of strength in the community and compiles the most common areas of resources that should leveraged in addressing the health of the community. The specific differences of viewpoint between the three community groups are noted. The results of the validation interviews are incorporated into the findings in each element of the study analysis.

The second section of the report details the areas of general need in the community and compiles the most common areas of identified concern across the respondent groups and validation interviews. The specific differences of viewpoint between the three community groups and the individual validation interviewees are also noted.

The report then details the impressions of the focus group and individual interview respondents regarding their impressions of the unique recommendations they would like to see in the community. And, finally, the report details the most common recommendations of participants on how they would like to see resources developed to meet identified community needs. A detailed listing of response ideas is also provided in an appendix to this document.

In general, we assess that the groups provided a series of compelling insights into the perceptions of community needs in the Sioux Falls and immediate surrounding communities. Members expressed strong understanding of the community and a commitment to supporting ongoing initiatives to meet the community's current and emerging needs.

MAJOR FINDINGS

Each of the three focus groups identified the areas of major concern they feel are affecting the lives of people in and around Sioux Falls. There was strong consistency among the groups interviewed. The validation interviews acted to support the themes presented in the focus group portion of the data collection. Variations are noted in the narratives supporting each section of the identified areas study.

Appendix A of this report provides an expanded listing of community strengths identified by all groups. A summary of the top seven key community strengths are highlighted:

- **Quality Healthcare** – The respondents identified excellence of healthcare providers in the community. Two fully-featured tertiary hospitals with numerous clinics were identified as a strength of the community. The addition of a robust community health center (FQHC) operated under the auspices of Sioux Falls city government was also lifted up as a support to round out the quality of services available in the community. The availability of a strong comprehensive inpatient and outpatient resource in Avera Behavioral Health Hospital was also identified as a key resource unique to our community. The availability of health and wellness services within the healthcare system and access to health insurance plans provided by the hospital systems was also noted as a strength.

- **Community Commitment to Health and Wellness** – The evolution of the healthcare provider community was identified as a welcome movement in access to care. The availability of after-hours care, walk-in clinics, and clinics in schools were lifted up as welcome and high quality additions to access to healthcare services. Specifically, the inclusion of a Mobile Crisis Team developed in the city to support law enforcement and emergency personnel was identified as important and having high impact on supporting the needs of individuals with mental health concerns. Support groups, women's and children's resources, and feeding programs in schools were also identified as adding to the wellness of our citizens.

- **Strong Municipal Government Support for a Health-Friendly Community** – The actions of the city were given high marks by respondents. The availability of well-maintained parks, bike trails, city-sponsored athletic events, swimming venues, golf courses, and related investments send a strong message that wellness of citizens is valued.

- **An Attitude of Caring and Partnership** – The attitude of collaboration was a key strength noted by participants. The partnership of governmental, nonprofit, business, and volunteer service groups in pushing the city to identify needs, invest, work collectively, and tackle difficult issues together was a common theme. The importance of the availability of health recreation, fitness, and leisure pursuits were a common view by all groups.

- **Quality Educational System and Adult Learning Resources** – The Sioux Falls School District was identified by participants as a strength in numerous ways to the health, wellness, and quality of life for citizens. The availability of strong K-12 education that is open to including Head Start programs for young children, inclusion of school-based clinics, school-based health screening, quality nutrition programs, and partnership with other agencies to refer children and families were identified as assets to be incorporated into future planning. The availability of higher education options, speciality training in mental health, public service education, training of physicians through the medical school, and the outreach and partnership of the hospitals to the schools was noted.

- **Strong Faith Community** – The faith community is robust in the Sioux Empire. The churches of the community play an active role in meeting the needs of those in need in the community. Specifically, the inclusion of parish nursing, numerous outreach ministries, and support partnerships with many of the nonprofit service sector agencies was identified as strong.

Appendix B of this report provides an expanded listing of gaps identified by all groups. A summary of the top five gap areas of the community in the focus groups are as follows:

- **Coordination of Care Services Continuum** –The most-often cited gap in the healthcare systems in our community is "the hand-off", a term coined by the focus group participants in one of the three focus groups. There was strong sentiment by all focus group members that we have very high quality resources in the community, but our community is weak in making sure that individuals stay connected across the continuum of services delivery. This challenge, according to participants, goes beyond referral within and across medical care providers to identified weakness in follow-up and monitoring as individuals are referred for all types of community services.

- **Funding Medical Care** – Wages, access to after hours and free clinic care, getting to care, cost of care, access to insurance, access to providers (predominately dental) for people who have Medicaid, and the insurance gap caused by the Affordable Care Act and the state's decision not to expand Medicaid were just some of the numerous challenges identified by participants. Navigating the complex system of paying for healthcare is, by its nature, causing people to not proactively seek out services that could prevent more serious problems if managed early. Participants in one focus group highlighted that the continued strain on the emergency departments of hospitals is an example of how complexity is resulting in consumer behavior that is counter to health and wellness.

- **Transportation** – Transportation was identified by all groups as a critical need area in the community. The majority of focus group members indicated that the current public transit system is inadequate in meeting the needs of citizens. The lack of service in the evenings and on Sunday was cited as the most common complaint. The timeliness of the service as also noted as a critical limiting factor, with stories of it taking up to two hours to travel each way for work, healthcare, shopping and other services making it simply unmanageable for many people. The availability of transit services for outlying towns

from Sioux Falls was also identified as a serious gap. One very specific concern was the challenges in getting people to medical appointments resulting in poor medical outcomes for patients and increased overhead costs for medical providers.

- **Housing, Including Specialized Housing** – A common cited fact is that the Sioux Falls community has a three-year or longer waiting list for low income housing certificates. The crunch in affordable housing has reached critical proportions according to the vast majority of focus group members. Many focus group members were familiar with an attempt to develop a coordinated community response to this critical shortage and indicated that this is one of the most critical issues facing people in poverty in our community. Many focus group members were clear in pointing out that housing issues are not an area of "quick fix" as many families live under 30% of poverty for long periods of time and need ongoing resource support to have safe, dependable housing for their families. Validation interviewees went further with their concern, highlighting housing gaps beyond low income populations, stating that two-income households have significant concerns paying the very high rents in the community. In addition to housing challenges was the need for specialized services that include living. Shortage of nursing home beds (skilled nursing care, long term care for individuals and families who are homeless, and specialized housing with supports for people with mental health needs) were also lifted up.

- **Health Promotion, Prevention, and Screening** – Helping people navigate the health care system in order to stay well was a common theme of concern for participants. People need to know that preventative care is important. They need education, access, and encouragement to practice healthy behaviors and lifestyles. Living Well Sioux Falls was lifted up as one strategy that is working and should be promoted. A community-wide wellness initiative that includes understanding of the importance of healthy lifestyle behaviors, wellness promotion, healthy eating and exercise, and screening/active prevention services was identified as a gap that, if filled, could have a profound effect on the overall wellness of the community. Validation interviewees did not highlight this gap as significantly as did the focus group respondents. Their feeling generally was that the community has high commitment and offerings in this area.

SPECIFIC RECOMMENDATIONS IN HEALTH CARE

Focus group members and validation interviewees were asked to narrow their thinking to specifically identify those areas they felt were critically important in the area of health and wellness. An expanded listing is identified in Appendix C of this report. The following three areas identify the key areas of priority the groups projected through this narrowed lens:

- **Remove Barriers to Healthy Lifestyles and Increase Access to Healthcare –** Focus group participants understand the complexity of care delivery, funding, and assuring continuity of care. There was strong motivation that the community of Sioux Falls served by Avera McKennan and Sanford hospitals could be a model for improved coordinated care and services. Promoting a structure to connect the healthcare delivery structures to social, welfare, community, and governmental entities into a singular cohesive network should be our goal. One focus group participant lifted up an idea that highlights this notion of collaborative network. The idea identified a loosely formed coalition of medical

providers, faith community representatives, human services agency providers, and governmental providers who would have a weekly briefing together to discuss things that are working and gaps in support for people in the community. Using this collaborative network, an ongoing development of safety net services could evolve. Along with this theme was the need to multiply efforts by the community to educate community members on the importance of reaching out, securing, and sustaining preventative care and chronic disease management in order to lessen the incidence and severity of medical events.

- **Off Hours Access to Primary Care and Urgent Care –**The expanding need for care that is delivered where and when people can access it was identified as something we can do as a community to build a stronger, healthier population. Access to clinic operations in smaller communities around Sioux Falls that have expanded hours (e.g., open later in the evening) access to primary care, access to care in downtown Sioux Falls, and inclusion of primary care coupled with urgent care outside day hours were identified. In addition developing a system of shared information among healthcare and human services providers of care was identified as a way to meet the current gap in care delivery.

SPECIFIC RECOMMENDATIONS FOR PROGRAM DEVELOPMENT

Focus groups and validation interview respondents were provided with an opportunity to identify one single program or service they believe would have the most dynamic impact in our community. These ideas offered specific suggestions of how the community might accomplish goals not now being specifically identified. A complete listing of suggestions by respondents is provided in Appendix D of this report. The following are the most commonly agreed recommendations from the majority of participants:

- **Community Navigation Network** – This broad label identifies the most common theme of recommendations for the community to focus its attention. Ideas had a broad range of navigation options all clustered in the concept of creating local connection. Creation of a "one stop shop" for all services regardless of presenting condition or issue was identified. Navigation leaders within this structure could point people in right direction AND act as a guide to follow-up to make sure services happen. This concept had several variations from a "Block Nursing Program", central intake assessment center, and neighborhood community centers concept.

- **Integrated Data Network –** The second most common theme for participants was centered around data collection, access, and sharing. Variations on this theme include:

    - The delivery of a "health data card" or network application available in the cloud that people of the community could have with them at all times. A central card reader in all healthcare and community agency locations and/or authority-to-access PIN number provided by the person seeking supports would allow healthcare, social services, human services, funding, and charity support services (faith-based and secular) to have information at the fingertips. Follow-up and coordination of care could be navigated through prompts delivered to the individual.

- Development of a community database which healthcare, social services, human services, funding, and charity supports organizations could access in order to move a person to the care they need. The centralized database would also allow the community to monitor how it is doing in moving health and wellness indicators for the community forward.
- A universal Emergency Medical Record (EMR) that could be easily portable across the health systems, community health, and other providers to allow for optimal information transfer.

- **Removal of Funding Barriers –** Participants identified numerous variations on the issue of healthcare affordability. A concentrated commitment to move the state to address the gap in coverage by expanding Medicaid was identified as an important effort. A more broad theme of making healthcare more affordable, allowing people in the community to get care regardless of ability to pay, was also supported by several participants.

- **Other –** Participants offered many other examples of ways the Sioux Falls community can move healthcare access, quality of life, and wellness forward. Low occurrence/single occurrence ideas included:
  - Expansion of low income housing to assure housing for all. This would ensure that people were not living in motels and on the streets;
  - Creation of a campus of services that includes housing for vulnerable people, transitional programs, and resources to meet healthcare, social, and resource needs;
  - Building a collaborative network among the two healthcare systems that truly addresses the needs of citizens and removes the competition that results in lack of continuity of care;
  - Having hospital clinical staff serve as navigators or mentors for an individual or family by making it part of their job responsibilities;
  - Volunteer-driven navigation centers that match people with individuals in need;
  - Expansion of educational curriculum in schools that would teach youth about how to access healthcare, why it is important to be well, prevention strategies, and how to get the healthcare insurance and related supports to assure healthcare needs are met;
  - Creation of a 24-hour triage center for mental health;
  - Broaden the transportation network to assure transportation is not a factor in accessing care;
  - Creating a network of resources for people who have behavioral challenges, are on the sex offender registry, or have other barriers to entry into needed housing and care service systems;
  - Increase services in outlying communities to allow people to age in place;
  - Develop a program that would help reduce the number of "adverse childhood events" in families, understanding that these events act to lessen the quality of health, mental health, and quality of life status for individuals throughout adulthood.

SUMMARY AND CONCLUDING REMARKS

The data collection process revealed many common themes regarding the needs of the community and generally consistent viewpoints about how to address and meet those needs. There was universal agreement that the community has many very high-quality services and resources; yet, these resources continue to be scattered and difficult to navigate for people in need.

An integrated communications network, the ability of the healthcare systems of the community to talk seamlessly with each other, the integration of the healthcare system with its community social service, human service, faith, and wellness partners is critical for a systemic response to meet the needs of citizens.

Appendix A – What This Community Has Going For It!

Response	Incidence	Total
Health care	lllll lllll lllll lllll lllll lllll lllll lllll lllll ll	52
Excellent providers in Avera and Sanford, Falls Community Clinic		
Specialty services/providers/NICUs, VA, CCHS et. al. ,		
Easy access to Mental Health Facilities (i.e Southeastern Behavioral)		
Access to care quickly at all levels of care including urgent care		
Diverse breadth of healthcare options (primary and specialty)(abundant and competing)		
Access to wellness facilitator		
Access to insurance/health plans		
Community Health/Expansion	lllll lllll lllll lllll lllll lllll lllll lllll 1	41
Leadership in healthcare, community is getting better		
Providing care through walk in clinics/dental clinic/clinics at schools		
Preventive screenings/newborn screenings		
Free clinic or sliding scale fee		
Mobile crisis		
Local Public Health/City Health Dept.		
Strong EMS		
Health Support Network/ Support groups		
Productive/women's and children's resources		
Food programs through the school district		
City Government supports wellness/Park and Rec Opportunities	lllll lllll lllll lllll lllll lllll	30
City gov. that encourages health through parks, walkways, bike trail, Sponsored 5k/10k walk/runs, downtown Sioux Falls, year-round sports, golf courses		
Attitude of caring	lllll lllll lllll lllll ll	22
Community has "upgrade" feel that encourages health as a value		
Community support (Midwest values)		
Community support network(clubs, fitness clubs etc.)		
Face It Sioux Falls		
Create model of community	lllll lllll llll	14
Community resources/partnering and coordination between agencies		
Sense of Community		
View of community by others as positive, lots of resources, healthy		
Entertainment opportunities in the community for leisure		
Low cost of living		
Education	lllll lllll 1	11
Strong K-12		
Higher Education		
Teaching focus by Doctors (Sanford School of Medicine)		

Response	Incidence	Total
NAMI training		
Public Service Education		
Research focus of hospitals		
Faith-based resources/strong church community/spiritual support	lllll lllll lllll lll	18
Nurses as an outreach of the church		
Philanthropy	lllll llll lllll	14
Great non-profit community presence across diverse areas		
More philanthropic funding than many other cities in US		
Safe home/schools	lllll lll	8
Healthy environment – low crime, opportunities for wellness		
Clean		
Employers/Employees/Economic development	lllll	5
Strong employers		
Opportunities for employment and benefits when employed		
Many doctors are active lay persons very concerned about marginalized persons		
Adult and Senior living and supports	llll	4
Programs for adult health (smoking, diabetes, blood pressure)		
Number of social resources for elderly citizens		
Vision	llll	4
Forward thinking/innovative		
Goal focus on building long term health goals		
Able to execute	lll	3
Medical research that gets transferred to direct care		
Resources and leadership combined to execute even large scale endeavors		
Technical	lll	3
E Nurse/E Care		
Strong EMS		
Health Support Network/ Support groups		
Productive/women's and children's resources		
Food programs through the school district		
Homeless services	lll	3
Safe sports/wellness outcomes	1	1

Appendix B – Gaps In Resources

Response	Incidence	Total
Lack of coordination of care services and shared service delivery including after care/discharge planning/follow-up services/including faith based organizations including MH patients	lllll lllll lllll lllll llll	24
Money – funding care	lllll lllll lllll llll	19
Medicaid funding/expansion		
Help fund more free transportation to resources		
Help fund more free clinic/evening urgent care clinics		
Support of doctors who try to be more cost conscious		
Increase in what private costs insurance pays/health insurance for some		
Wages		
Under employment/qualified workforce		
Transportation:	lllll lllll lllll lllll lllll	24
Public transit		
Transportation to appointments		
Transitional services to get people out of poverty		
Para transport in rural communities		
Housing	lllll lllll lllll lllll lllll lll	23
Low Income housing		
Nursing home beds		
Affordable housing		
Tenant/Housing resource center/discharge planning for housing		
Chronic homeless services		
Long term plan for homeless		
Mental Health living		
Sex offenders as they age and need supported living		
Education (affordable) in how to access care/importance of preventative care/promotion of health lifestyles through Live Well SF/prevention screening/how to navigate the health care system (for parents, other cultures, children/students, community)	lllll lllll lllll	15
Drug and alcohol programs	lllll lll	8
Detox programs that have access and connection to primary care, emergency care, mental health etc.		
Places for alcoholics, safe home places		
Increase access and promotion of tobacco cessation programs		
Low income addiction counseling		
Downtown Acute Care	lllll ll	7
ACA gap	lllll lllll l	11
Chronic pain management services	llll	4
Options for people with high use needs but reactive/MH including individuals with developmental disabilities	llll	4
Neighborhoods not health ready	llll	4
Clinics located in need areas		

Response	Incidence	Total
Affordable, nutritious food	lll	3
Eye Doctor/dental for low income children AND adults	lll	3
Lack of community resources outside of the city/long term care/rural home health nursing	lll	3
Access and affordable medications; MB use	ll	2
Adult Social Services for aging/social work network	ll	2
Coverage and supports for all our citizens (mental health)	ll	2
Crisis management for people with dual diagnoses	ll	2
Free standing triage which looks at all issues/ER for those with addiction		
Culture of acceptance for alcohol use/enabling of dependency	ll	2
Lack of understanding of poverty in our community/poverty	ll	2
Legislation on repeat CD patient that is in and out of services yet roaming streets when services are there for them to access	ll	2
Preschool Access/wrap-around services for school-based children	ll	2
Alternative to incarceration		
Reduce the stigma around mental health care	ll	2
Respite Care	ll	2
Services for MH patients/behavior health affects access to services	ll	2
Access to women's health	l	1
Attitudes about seeking care	l	1
"Better Choices, Better Health" program Dr. ordered for all chronic disease patients	l	1
CD patient needs: shortage of services; patient readiness	l	1
Government offices open in evening hours	l	1
Social support networks	l	1

Appendix C – Ideas to Address Gaps

Response	Incidence	Total
Remove barriers to healthy lifestyles/access to healthcare	llllll llllll ll llllll llll llll	26
Pioneer a service delivery model where all citizens had affordable and immediate access to Medicaid, MH, SA services w/o burden. The program would be run by volunteers and would begin at intake and not end until the 'provider' and patient determined care was complete.		
Each employee of each hospital would serve as a mentor/navigator to a family or person who is in need of support/education.		
Expand Medicaid for those in the 'gap' and can't afford insurance but don't qualify for Medicaid		
Expanded hours of operation and create medical health homes for people		
Increase services outside of SF so people can age in place- save tax payers and increase quality of life for patients from the communities		
Program that coordinates care/follow-up/community resource/case management, etc.		
All providers come under the umbrella of one health care system provided for by the City of Sioux Falls. Health care provided by dedicated personnel.		
Evenings urgent care appointments for people who are poor and appoints for primary care	lll	3
Centralized city schedules to get follow-up care coordinated		
System that collects SF community health data, develops strategies collectively to positively impact health status of the community, and supports the implementation of these strategies and then measures the impact		
Create way for all providers to share info on shared clients/patients to ensure that they get the best medical care and with reduced costs to all		
Single payer system		
More cooperation, less competition between providers – mission vs. business mentality		
Integrating consumers into healthcare planning/training	lllll	5
Every resident would be provided a head to toe comprehensive health assessment in the location of their choosing be it home are a health care agency. This would occur annually via "e" technology via an app, website, etc. Goals would be developed, resources needed identified, etc.		
Assisted living for low income elderly/nursing home beds	ll	2
Increase and quality available – lift moratorium on nursing home beds		
Education for low income people on how to use care; school based, too	ll	2
Taking services to the neighborhoods	ll	2
No more buildings. Bring services within current agency providers.		
Upgrade follow-up care after health episodes	ll	2

Response	Incidence	Total
Home visits		
Downtown health care access to specialty care for uninsured.		
Each health care facility investing in the schools so education about health care is talked about and taught to our children and with more school clinics.		
Access to mental health resources/counseling 24 hours 7 days a week	1	1
Address mental health stigma	1	1
An understanding and open talk about poverty	1	1
Centralized coordinated intake social service system	1	1
Create incentives for people to practice healthy actions	1	1
Drug screening Medicaid recipients	1	1
EMR that works with all health care systems or services.	1	1
Figure out a way to dialogue about issues with Police Force	1	1
Health and wellness educator: food, exercise, lifestyle	1	1
One care support person to follow individuals through system	1	1
Peer support applied learning	1	1
Program to reduce number of 'adverse childhood events' experienced by kids	1	1
Provider groups coordination (a forum for integration)	1	1
All stakeholders working together to meet the needs of individuals struggling immediately.		
Respite care giver training	1	1
Short term stabilization for individuals with disabilities	1	1
Triage center for addiction/MH	1	1

Appendix D – One Big Idea

This listing is taken directly from focus group participants and are provided without edit. The ideas listed are not in any order of preference.

- The children are our future – each facility – investing in the schools so that education about healthcare, medicaid, insurance, preventative care, is talked about and taught to our children and involve them in how we can work to make things better for all. Some kids I think unable to be seen in school due to out-of network – which if both facilities working together then would be more affordable.

- Vastly expand the screening opportunities for people in the community – in the schools, at pharmacies, where people work, and in community agencies. This would change the bar and help encourage people to get care before they become acutely ill or get a chronic long term disease. This coordinated effort would raise the bar on people staying well..... not just getting care when they are sick.

- Sioux falls would pioneer a service delivery model (which will be replicated) where all citizens had affordable/immediate access to medical care services without burden. The program would be run by volunteers and would begin a intake and note end until the providers and the patient determine care was completed.

- Engage employers in the mix of planning and implementation of health and wellness. Make resources available to employers as they have contact with employees and their families. Give them tools ..... maybe that employers DON'T pay for but have access to them ..... employers could be the entry point for people to be more conscientious about their health.

- Invest in a mental health safety network as a community. Develop more coordinated healthcare, law enforcement, employer, and community agency networks dedicated to finding solutions that keep individuals with mental illness from ending up in the hospital or homeless on the streets.

- Look toward initiatives and community efforts that change the culture of health and healthcare.... instead of people going to the emergency room when they are acutely ill, they should be getting care to stay well. This is a MAJOR shift of culture in and could only be done with a collaborative community effort. Who better to run point on this than the healthcare systems?

- Each employee of each hospital serves as a mentor or navigator for a family/person who is in need of support/education.

- Less competition and more cooperation between healthcare organizations so as to reduce overuse, misuse of resources, duplication of resources. See healthcare once again as a priority and a calling to mission more than a business.

- All healthcare entities come together to provide care for all individuals. The infrastructure is provided by the city of Sioux Falls and healthcare is provided by dedicated personnel. There would be expanded hours of operation.

- A campus meeting various needs. Housing for vulnerable patients, also transitional programs for mental health, etc. I would be a training ground to teach employable skills and offer GED/educational support and etc. Also encourage mentoring in the community.

- Have enough low income housing for everyone so no one lives on the streets or in motels.

- Develop a program which would help reduce number of "adverse childhood events" experienced by kids. ACE episodes increase the health risks, drug and alcohol abuse, mental health issues, and general health status, risk factors, and even cancer.

- Drug screening Medicaid recipients. (We -the people of South Dakota- are paying for their medicaid. It does not seem fair for those on medicaid to be abusing the system -illegal drugs -. Just a thought.

- Increase services in the communities outside of Sioux Falls so people can age in place, save tax payers and increase quality of life not only for the patient but also for the communities. I don't think more nursing home beds are the answer. WE are in the top five nationally of the use of nursing home beds as we in the top 5 nationally of underutilized community services.

- 1. Place for patients to go for nursing home and assisted living for behavior, sex offenders. No current facilities will accept and they sit on acute care setting for weeks longer than needed. 2. Integrated services.

- Transportation network would be broadened in depth and breadth – Clinic hours have expanded – need to bring people there – infrastructure in a clinic very costly to replicate.

- Access to mental health resources 24 hours a day 7 days a week. A facility that works together with HSC, Avera BH, Southeastern Directions for Life to meet the needs of those individuals who struggle immediately. Figure out a way to eliminate use of police for issues that just need to be talked through.

- Access to safe housing and food for all.

- Expand Medicaid – affordable services! For those in the "gap" – can't afford insurance, don't qualify for medicaid.

- Incentivize the people who have ideas of improving services, coordination. Those people who have direct experiences with people who have no hope. And use a common sense portal of informed resources persons for housing, referral and services – Look to modes in Madison WI and Twin Cities.

- Medicaid for the uninsured. Downtown healthcare access to specialty care for uninsured. Link with consult and in community settings.

- It would be great to share client information among other medical facilities to insure the client is getting the best medical care that would include, medications, physical health and mental health! Coordinating services and exchange of information would result in lower medical costs because procedures are not being updated.

- 1. Community based database fo individuals utilizing healthcare in the community does not necessarily contain medical records, but a list of obtained services with potential date of service. 2. Nor more buildings! Bring services within current agency providers. Lewis Drug on SEBHC community health in Terry Redlin. Medicaid providers at Bishop Dudley House. 3. Life moratorium on nursing home beds. Reduction/bonus system if you go outside of Sioux Falls. 4. Change limits on Medicaid.

- Medicaid Data Card

- System of health service that collects community health data, develops strategies collectively to positively impact the health status of the community, and supports the implementation of those strategies and measure impact.

- EMR that works with ALL healthcare systems!!! or services

- The idea that comes to mind for me is a really somewhat of a "Blast from the past" with the addition of technology. Every single resident would be provided a head to toe comprehensive health assessment in the location of their choosing, i.e, in their home, in a clinic, in a health home community center. This would occur annually and could occur via "e" technology as well where you dial in via an APP, website, etc. Goals would be developed, resource needs identified.

- A collaborative ministry center for those who are struggling that proactively educates and offers dignity and purpose in its style of ministry.

- Centralize coordinated intake social services system.... easy access point for any one needing help - simple to reach out for help. System provides a core support person to follow them through the system.

- Neighborhood community centers: – different activities for different ages – organized events – health screening – on site mental health – on site dietitian – transportation to and from.

- Integrated network of supports and services to truly meet the needs of all people in a timely fashion. True collaboration.

- Medicaid expansion ..... Triage Center for additions/mental health.

- "Block Nursing Program" supported by health systems, churches, city health department, medicaid program fully integrated with community partners and transportation, mental health – build on relationships with individuals – take from experiences of faith community nursing.

- One Stop Shop for all services regardless of income or disease that communicates with all entities.

- A program that operates to coordinate care/followup care/community resources for those in need. Case managers for those families. Organization should be independent and willing to assist families with connecting to any and all resources.

- Integrated services – access to information across disciplines including family perspective.

- Centralized city scheduling to get follow-up care.

- Nutrition program that is ground to table. – grow food, cooking class, healthy meal planning - super nutritionally. OR Face It Together on steroids – fully working with more employers and getting people well and in full continuum of care.

Appendix E – Focus Group Concepts and Outline

Protocol – Focus Groups - Avera/Sanford – May 19-20, 2015

Concept 1: Introduction of Members

- There is a **yellow** sheet of paper in front of you. Please write the number ____ in the upper right hand corner of the paper. Then answer these four questions. First, identify your current roles in the community. For example, you might answer that you are a nonprofit executive, who sits on the xx board (s), etc. Second, provide a description of your connection to the issue of healthcare needs in our community. Third, identify how long you have been a living in this community. Fourth, provide information about your age range – under 35, 36-50, 51-65, or over 65.

Concept 2: What does this community have "going for it" with regard to meeting the healthcare needs of its citizens.

- I would like to talk first about what this community has "going for it" in the area of health. This is the BIG definition of health. These resources could be directly related to medical care, or it could be prevention, or lifestyle opportunities, or other factors that make this a place that helps our citizens to grow up and maintain being healthy. After you have thought about it a bit, write down at least five things you think this community has going for it. Use the bottom half of the **yellow sheet** of paper in front of you to write down these ideas. We will go around the table so you can share your ideas after you have had time to do this task.

Concept 3: Current community gaps – The most pressing things that stand in the way of people staying healthy, getting healthy, or managing ongoing health conditions .

- Remember now that we are here today talking about our community with a focus on the community's health. I'd like you to think a bit about what is missing in the Sioux Falls area that stands in the way people getting the resources they need to remain healthy, get healthy, and or manage their health care on an ongoing basis. These gaps or needs can include areas outside of Sioux Falls in neighboring communities. After you think for a bit, I'd like you to write down **(using the BLUE sheet)** the five or so needs that you believe are the most pressing gaps in the community. Use the BLUE sheet of paper in front of you to write down these ideas. Oh, be sure to write the number _____ on the upper right hand corner of the BLUE sheet. This helps me match it to this specific focus group. We will go around the table so you can share your ideas after you have had time to do this task.

Concept 4: Resources to meet the identified community gaps.

- Our community has a resource network of healthcare providers, multiple full features hospitals and other speciality services to meet the health care needs of our citizens. Being well is critical for all of us. We are here today to help our community hospitals better understand ways to meet the health needs of our citizens. What are the resources, services, or other actions would you say are the most pressing right now to assure our citizens have good health, are supported when they have active health care issues, and are supported to manage health care conditions need that is most pressing right now? How about longer term needs? Using the BACK side of the **BLUE sheet of paper** in front of you, first write down the top five things you would lift up as the most important to help people who be well, stay well, and get well. We will take time to share these and talk about these in a few minutes. After you have listed the top five – take a moment to reflect and put a star by the one you think is the most critical.

Concept 5: What one action, service, program, or resource would the group members like to see initiated to help the most in assuring a health community.

- Identify one program, or resource in this community that doesn't exist here that should be created to make this the best place in the world for people to live and be well. What role should our community hospitals play in helping make this a reality? What one thing should we put on our LONG TERM MUST HAVE LIST. Think big or small: what one program, or service, or resource would you most like to see. Write these things on the GREEN sheet of paper and be sure to put the number _____ on the upper right hand corner to help me sort things out. We will talk about ideas once you have had a chance to think and write.

Concept 6: Concluding thoughts and summary

- Have we missed anything? Is there something you intended to mention but did not have the opportunity?

Appendix F – Validation Interviews Outline

Protocol – Focus Groups - Avera/Sanford/Avera Heart – July 27-31, 2015

Concept 1: Introduction of Interviewee

- First, please answer a few questions that tell me a little bit about you First, identify your current roles in the community. For example, you might answer that you are a nonprofit executive, who sits on the xx board (s), etc. Second, provide a description of your connection to the issue of healthcare needs in our community. Third, identify how long you have been a living in this community. Fourth, provide information about your age range – under 35, 36-50, 51-65, or over 65.

Concept 2: What does this community have "going for it" with regard to meeting the healthcare needs of its citizens.

- I would like to talk first about what this community has "going for it" in the area of health. In the focus groups, members identified six key things they thought, collectively were strengths:
    - We have **excellent healthcare providers** in the community
    - Our **community expresses a commitment to health and wellness** – after-hours care, mobile crisis team for people with mental health concerns, feeding programs, and several other things were identified as examples.
    - **Out municipal government** supports a health-friendly community. Bike trails, city-sponsored athletic events, swimming, golf, and parks were identified as some examples.
    - **An attitude of caring and partnership**. Nonprofit giving, business partnerships, were identified as just some.
    - **Great schools** and adult learning options.
    - A **strong faith community**

Of these six, which would you identify as to TOP TWO strengths our community has going for us? Why.

Concept 3: Current community gaps – The most pressing things that stand in the way of people staying healthy, getting healthy, or managing ongoing health conditions .

- Remember now that we are here today talking about our community with a focus on the community's health. When we asked focus group members to identify gaps in the community, they mentioned five things that really stand in the way of having quality of life and good health in our community. These included:

- **Coordination of the service continuum.** People "fall through the cracks". There is poor "hand-offs" of care.
- **Funding care is really tough.** Wages, free clinic care, cost of care and insurance were brought up a lot. The failure of the state to fund expanded Medicaid meaning poor people are eligible for care subsidy, and getting care – especially oral health care – for people on Medicaid is a challenge.
- **Transportation**. People can't get to care, the bus system is not easy to use and doesn't run off hours, travel to outlying towns, getting to health care appointments were all identified as gaps in care.
- **Housing.** Especially housing for people who are poor. Three year waits for low income housing certificates was noted often
- **Health promotion, prevention care, and screening.** People often don't take care of the preventative care needs and, as a result get sicker. The concern over lifestyle wellness choices, including preventative care were identified.

Of these items, what would identified as the TOP TWO gaps that stand in way of a health community? Why did you pick those.

Concept 4: Resources to meet the identified community gaps.

- Our community has a resource network of healthcare providers, multiple full featured hospitals and other speciality services to meet the health care needs of our citizens. Being well is critical for all of us. The goal of the Community Health Needs Assessment is to give community hospitals ideas to better understand ways to meet the health needs of our citizens. The Focus groups were very clear in two key areas they would like to see expansion and/or change in helping citizens of our community. They are:

    - Removing barriers to healthy lifestyles and increasing access to health care. The focus groups felt that the three hospitals should somehow build a "collaborative network" that connects health care delivery to the social services/human services network of our community. They offered themes for educating our community, establishing prevention/screening networks, and building a collaborative network to help people to stay well.

    - Off hours access to primary care and urgent care was another area the focus groups lifted up as a way to build a stronger, healthier Sioux Falls area. This included access to clinic operations and very importantly, sharing information across healthcare, human service,

and social service systems.

What would be your top recommendation about how we could build a better community that promotes health and well-being for people living in Sioux Falls and the surrounding community? How should this be done? Who should lead it?

Concept 5: What one action, service, program, or resource would the group members like to see initiated to help the most in assuring a health community.

- This is your chance to tell Avera McKennan, Sanford, and Avera Heart Hospitals what they should be doing, investing in, or partnering with other entities to build a stronger community. What advice — or one big thing — do you recommend they do individually and/or collectively?

Concept 6: Concluding thoughts and summary

- Have I missed anything? Is there something you intended to mention but did not have the opportunity?