Community Health Needs Assessment

Coteau Des Prairies Health Care System
2021-2023

BACKGROUND

Overview

A community health needs assessment identifies and prioritizes the health needs of the community through collection of data and information to inform development of strategies to address priority health needs. A comprehensive assessment gathers information using sound data collection methods and reflects the behaviors, beliefs, and demographics of community residents. A well-designed assessment will provide community planners, stakeholders, and partners with meaningful data to support local decision-making toward a healthy community environment. Moreover, multi-sector collaboration is integral to understanding and addressing priority health needs, and to integrate population health equity into planning and practice.

To meet the requirements of the Patient Protection and Affordable Care Act and ensure that Coteau Des Prairies Health System supports the community we serve, a community health needs assessment was conducted in collaboration with internal and external stakeholders. Findings from the assessment informed development of a Community Health Improvement Plan, which support multi-sector collaborations, aligned to address priority health needs through evidence-based strategies. These efforts help justify Coteau Des Prairies Health System's non-profit status and to reinforce guiding principles going forward.

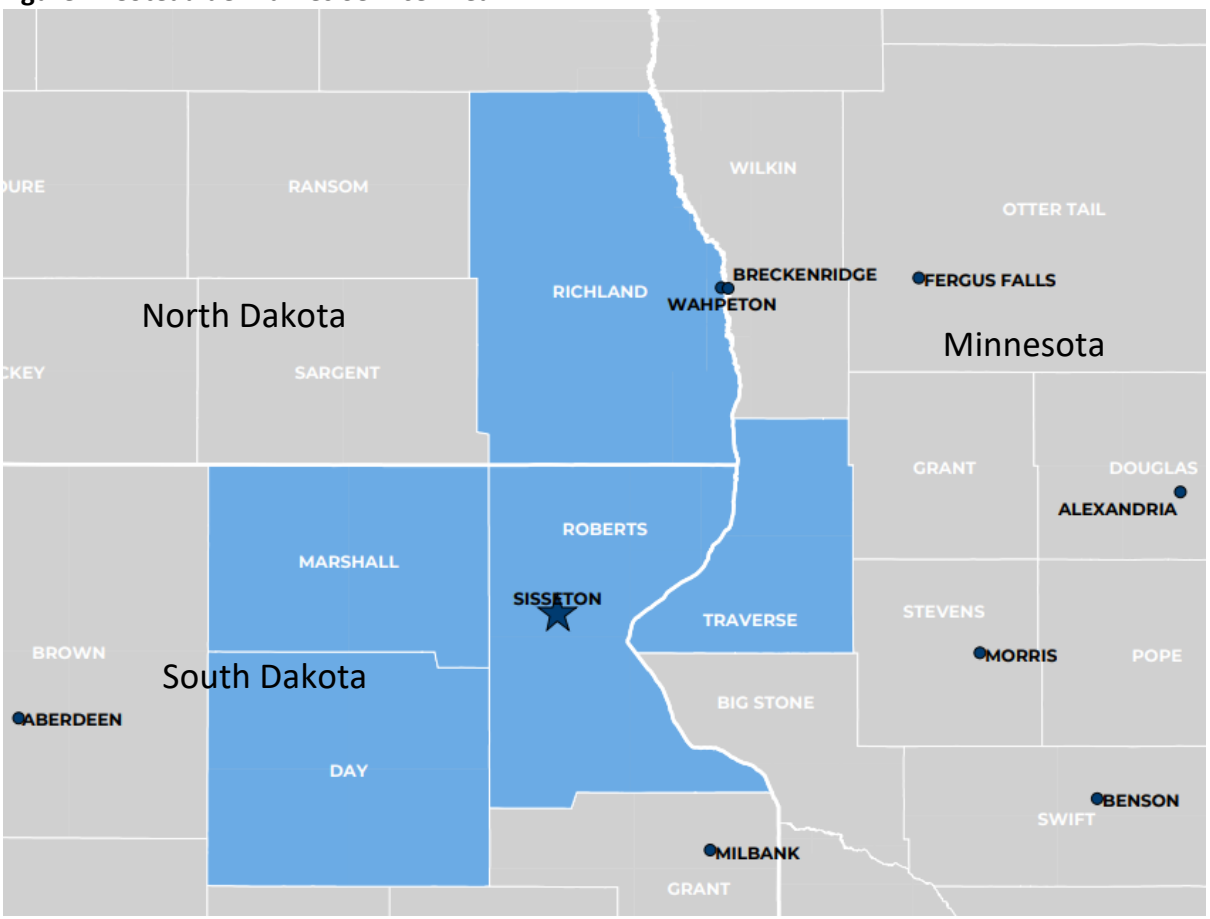
Community Served By Coteau Des Prairies Health Care System

Coteau Des Prairies Health Care System Health System serves approximately 21,000 residents in the Glacial Lakes Region in Northeast South Dakota as well as West Central Minnesota. Coteau Des Prairies Health Care System owns and operates the certified rural health clinic in Sisseton; the Browns Valley Clinic in Browns Valley, Minnesota; and the Rosholt Clinic in Rosholt, South Dakota. Sisseton is a city of approximately 2,500 located on the Northeast slopes of Coteau des Prairies or "Hills of the Prairies." The area is known for its natural beauty and abundant recreational opportunities. Within a drive of 20 minutes there are 30 lakes along with many state parks. Locals enjoy such activities as fishing, hunting, golfing, boating / watersports, horseback riding, arts, theatre, and festivals.

Community Defined

The communities included in the Community Health Needs Assessment served by Coteau Des Prairies Health Care System (Figure 1) are located in the following counties and states - Roberts County, South Dakota, Marshall County, South Dakota, Day County, South Dakota, Richland County, North Dakota, and Traverse County, Minnesota.

Figure 1: Coteau de Prairies Service Area



Community Demographics

Figure 2 shows the most recent demographic data available from the U.S Census Bureau for the counties that comprise the Coteau Des Prairies Health Care System operating area.[1] Roberts County, where Sisseton is located, varies from the South Dakota average notably in several measures for the time period 2015 - 2019.

- Persons without health insurance, under age 65 years, is 42% higher than the state average.
- Persons in poverty, is 65% higher than the state average.
- Population, percent change - April 1, 2010 to July 1, 2019 is 2% compared to the state average change of 9%. Three other counties are declining in population.
- Households with a computer, is 6% less than the state average.
- Households with a broadband Internet subscription, is 8% less than the state average.
- American Indian, percent of the population is 39% compared to the state average of 9%
- Educational attainment of Bachelor's degree or higher, persons age 25 years+, is 40% less than the state average.

Figure 2: U.S Census Bureau Data for Coteau Des Prairies Health Care System Operating Area

	Day County, South Dakota	Marshall County, South Dakota	Richland County, North Dakota	Traverse County, Minnesota	Roberts County, South Dakota	South Dakota
Population						
Population estimates, July 1, 2019	5,424	4,935	16,177	3,259	10,394	884,659
Population, percent change - April 1, 2010 (estimates base) to July 1, 2019	-5%	6%	-1%	-8%	2%	9%
Age and Sex *						
Persons under 5 years, percent	5%	8%	6%	6%	9%	7%
Persons under 18 years, percent	22%	24%	22%	21%	29%	25%
Persons 65 years and over, percent	26%	21%	19%	25%	20%	17%
Race and Hispanic Origin*						
White alone, percent	87%	88%	93%	90%	57%	85%
Black or African American alone, percent(a)	0%	1%	1%	1%	1%	2%
American Indian and Alaska Native alone, percent(a)	10%	10%	3%	7%	39%	9%
Asian alone, percent(a)	1%	0%	1%	1%	0%	2%
Two or More Races, percent	2%	2%	2%	2%	4%	3%
Hispanic or Latino, percent(b)	3%	8%	4%	4%	4%	4%
White alone, not Hispanic or Latino, percent	85%	83%	91%	87%	56%	82%
Housing						
Housing units, July 1, 2019,	3,832	2,660	7,798	2,103	5,097	401,862
Owner-occupied housing unit rate, 2015-2019	75%	74%	71%	80%	67%	68%
Median value of owner-occupied housing units, 2015-2019	100,500	118,900	127,900	81,400	103,600	167,100
Median gross rent, 2015-2019	532	597	664	620	583	747
Families & Living Arrangements						
Households, 2015-2019	2,574	1,873	6,777	1,608	3,873	344,397

[1] https://www.census.gov/quickfacts/fact/table/SD,US/PST045219

	Day County, South Dakota	Marshall County, South Dakota	Richland County, North Dakota	Traverse County, Minnesota	Roberts County, South Dakota	South Dakota
Persons per household, 2015-2019	2	3	2	2	3	2
Living in same house 1 year ago, percent of persons age 1 year+, 2015-2019	90%	91%	83%	91%	86%	84%
Language other than English spoken at home, percent of persons age 5 years+, 2015-2019	1%	4%	3%	4%	3%	6%
Computer and Internet Use						
Households with a computer, percent, 2015-2019	84%	88%	89%	87%	83%	89%
Households with a broadband Internet subscription, percent, 2015-2019	70%	74%	80%	76%	74%	81%
Education						
High school graduate or higher, percent of persons age 25 years+, 2015-2019	90%	92%	91%	93%	90%	92%
Bachelor's degree or higher, percent of persons age 25 years+, 2015-2019	22%	24%	21%	18%	17%	29%
Health						
With a disability, under age 65 years, percent, 2015-2019	5%	6%	7%	10%	6%	8%
Persons without health insurance, under age 65 years, percent*	14%	16%	8%	8%	17%	12%
Economy						
In civilian labor force, total, percent of population age 16 years+, 2015-2019	60%	68%	66%	65%	63%	68%
In civilian labor force, female, percent of population age 16 years+, 2015-2019	55%	65%	63%	60%	62%	64%
Income & Poverty						
Median household income (in 2019 dollars), 2015-2019	46,679	63,723	61,371	51,957	50,348	58,275
Per capita income in past 12 months (in 2019 dollars), 2015-2019	29,808	32,472	31,346	32,548	26,243	30,773
Persons in poverty, percent*	13%	12%	12%	12%	20%	12%
Businesses						
Total employer establishments, 2018	194	145	522	120	232	27,100
Total employment, 2018	1,427	1,075	6,013	781	2,135	359,771
Total employment, percent change, 2017-2018	1%	-6%	3%	-7%	1%	0%
Geography						
Population per square mile, 2010	6	6	11	6	9	11
Land area in square miles, 2010	1,028	838	1,436	574	1,101	75,811

**Estimates are not comparable to other geographic levels due to methodology differences that may exist between different data sources.*

(a) Includes persons reporting only one race, (b) Hispanics may be of any race, so also are included in applicable race categories, (c) Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

Coteau Des Prairies Health Care System Description

Coteau des Prairies Health Care System is a 25-bed, critical access, acute care, community non - profit hospital. Coteau Des Prairies Health Care System serves approximately 21,000 residents in the Glacial Lakes Region in Northeast South Dakota as well as West Central Minnesota. The hospital opened in 1967, and in 1996, a 14,000 square foot new addition and remodeling project - which cost $2.4 million - was completed.

The latest project included a multimillion-dollar renovation and expansion effort that took place in 2013. This 22,000 square-foot addition was necessary to support the growing number of patient visits, which included a new clinic, an emergency room, birthing suites, a laboratory, and a radiology department.

Services available at Coteau Des Prairies Health Care System include:

- Surgery
- Swing Bed Program
- Obstetrics / Birthing Room
- Emergency Services
- Home Health
- Long Term Care
- Laboratory Services
- Radiology
- Therapy Services
- Fitness Center
- Diabetic Education
- Women's Health

Coteau Des Prairies Health System's guiding principles reflect our commitment to addressing and improving the health of the communities we serve:

- Mission: At Coteau des Prairies Health Care System, we are passionate about the work we do. We believe in offering our patients individualized attention and care, emphasizing their unique needs and treating them as individuals on a human level.
- Values: We exist to serve our community and we strive to be an integral part of our community through strong and trusting relationships.
- Respect: We respect all those we serve and those who serve with us, and we demonstrate that respect in the way in which we care for and interact with those we serve as well as with other members of the care team.
- Stewardship: We are a community asset and we are committed to being good stewards of the resources that have been entrusted to us.
- Engagement: We seek to engage with our staff, providers and community to ensure that everyone is invested in our organization. This engagement also demonstrates how our organization is invested in the community we serve and how we are working together to create a healthier community.
- Growth: We are committed to increasing access to the services our community needs.
- Quality: We are committed to improving the services we provide to ensure those we serve are receiving the highest quality of care possible. We continuously reach for new and innovative solutions to improve the health of those we serve.

Community Health Needs Assessment Purpose

The purpose of a community health needs assessment is to develop a comprehensive view of the population's health and the prevalence of disease and health issues within our community. Findings from the assessment serve as a catalyst to align expertise and develop a Community Health Needs Assessment and Implementation plan of action. The community health needs assessment validates not-for-profit status, creates opportunity to identify and address public health issues from a broad perspective and identifies the community's strengths and areas for improvement. The assessment is a critical component of the Community Health Needs Assessment and Implementation plan that builds on community assets, promotes collaboration, improves community health, and promotes innovation and research.

Methodology

Coteau Des Prairies Health System, in coordination with leaders in the local community, conducted a multi-faceted assessment designed to establish pathways for evaluation and determination of health needs priorities. The 2021 Community Health Needs Assessment was developed as follows:

1. Reviewed prior work conducted in the 2018 Community Health Needs Assessment including the 2018 stakeholder survey and results of 2018 community stakeholder meetings.[2]

2. Reviewed recent internal surveys and studies including:

Annual Sisseton Area Health Network (SAHN) Survey Results - October 27, 2020

- The Sisseton Area Health Network (SAHN) was established in 2019 bringing together community leaders and healthcare providers to develop strategies for improving the health of our community through coordination and efficiencies, expanding access to health care services, and strengthening our rural health care system. Members of the SAHN are as follows:

    - Colette Weatherstone, Project Director, Coteau Des Prairies Health System
    - Craig Kantos, Chief Executive Officer, Coteau Des Prairies Health System
    - April Hieb, Chief Nursing Officer, Coteau Des Prairies Health System
    - Angie Gaikowski, Nurse Practitioner, Coteau Des Prairies Health System
    - Jamie Messerli, Evaluation Services, Sanford Health Research
    - Susan Kroger, Evaluation Services, Sanford Health Research
    - Tammy Meyer, Superintendent, Sisseton Schools
    - Randy Jordan, Chief Executive Officer, IHS Woodrow Wilson Keeble Memorial Health Center
    - Lori Sampson, Chief Nursing Officer, IHS Woodrow Wilson Keeble Memorial Health Center
    - Pat Dady, CDP Board Member, Community Member
    - Lori Moen, Chief Operating Officer, Grow South Dakota
    - Sara Pistorius, Community Health Nurse, SD Department of Health
    - Heather Nelson, Community Health Nurse, SD Department of Health
    - Sara DeCoteau, Health Coordinator, Sisseton Wahpeton Oyate

- The value of this network was demonstrated in our recent community-wide planning in response to the COVID 19 pandemic (trusted partners, resources,

[2] https://www.cdphealth.com/About-Us/Community-Health-Needs-Assessment-Reports.aspx

reliable information). Community leaders, tribal and healthcare providers came together to address the unique challenges the COVID 19 pandemic presents.

- To further strengthen our rural healthcare system, on February 2020, the SAHN completed a review of our community health needs and identified behavioral health and prenatal substance use as important issues. Prenatal substance use is a critical public health concern that is linked to long-term negative health outcomes for both mothers and infants.

- Based upon this identified priority, the SAHN formed an alliance of healthcare, educational, tribal, and community service providers to create a coordinated prenatal care initiative. This is an opportunity to establish a community-wide strategy integrating education and screening, as well as treatment for addiction and recovery support services into the healthcare plans for expectant parents. Coteau Des Prairies Health Care System has been awarded grant funding to support this initiative. The award period is October 2020 through September 2022.

- A second follow-up SAHN survey was conducted and prepared for SHAN by Sanford Research Evaluation Services. A broad range of topics were addressed including specific questions regarding board relations and communications, roles and responsibilities, priorities for the next year, vision and mission of the network, needs of the community, strategic alignment, diversity, decision making, accountability, member investments, strategy execution, member commitment, lessons learned, level of trust, change management, and outcomes measurement. The specific question regarding priorities for next year (2021) generated responses in the areas of wellness, treatment facilities, suicide and mental health among youth, chronic disease and heart disease, cardiovascular disease prevention, and improving nutrition in the community.

<u>Coteau Des Prairies Health Care System Network Planning Grant - FY2019 External Environmental Scan</u>

- Three types of data were collected: survey data from the SAHN, qualitative anecdotal/survey data from SAHN members, and secondary data from both SAHN members and various online resources.

- Analysis was completed by contracted evaluators at Sanford Research who specialize in data collection and analysis. Evaluators collected secondary data from both SAHN network members' current activities and local/state websites to assess opportunities and threats within the community related to healthcare and social determinants of health. Evaluators then coded that data into distinct categories: mental health/substance abuse, heart disease, diabetes, social determinants of health, and community health. Survey data was then collected to determine SAHN members' views on the most urgent needs in the community as well as the most practical approach to community needs. These results were communicated back to SAHN network members.

- The most significant concern for the SAHN network is lack of resources. Opportunities and threats were identified in areas including workforce staffing, access to social services, opioid addiction, mental health for farmers, and methamphetamine treatment and prevention.

Sisseton Wahpeton Oyate Lake Traverse Reservation Health Plan Community Survey - September 11, 2020.

- This survey was conducted and prepared by Aliive-Roberts County and went to tribal community members and stakeholder members of the Sisseton Wahpeton Oyate Lake Traverse Reservation.

- The top needs identified from the survey included mental health services, career and professional development to develop health professionals from within our community, home visiting to families expecting new babies and with infants and preschoolers, child care that is reliable and affordable, and food that is healthy and affordable.

3. The process included an analysis of secondary data based on University of Wisconsin Population Health Institute School of Medicine and Public Health County Health Rankings. Current rankings were reviewed for each of the counties served; Roberts County, South Dakota, Marshall County, South Dakota, Day County, South Dakota, Richland County, North Dakota, and Traverse County, Minnesota.[3] Specifically, the areas where Roberts County, South Dakota is significantly worse than top U.S performers were analyzed and discussed including:

    - Percentage of adults aged 20 and above with diagnosed diabetes.
    - Percentage of driving deaths with alcohol involvement.
    - Number of newly diagnosed chlamydia cases per 100,000 population.
    - Number of births per 1,000 female population ages 15-19.
    - Percentage of population who are low-income and do not live close to a grocery store.
    - Number of motor vehicle crash deaths per 100,000 population.
    - Percentage of population under age 65 without health insurance.
    - Ratio of population to mental health providers. (people per provider)
    - Percentage of people under age 18 in poverty.
    - Percentage of children that live in a household headed by single parent.
    - Number of reported violent crime offenses per 100,000 population.
    - Number of deaths due to injury per 100,000 population.
    - Index of dissimilarity where higher values indicate greater residential segregation between Black and White.
    - Number of deaths due to suicide per 100,000 population.

4. Coteau Des Prairies Health Care System assembled an internal core team of experts responsible for assessing the findings and developing a recommendation to the Coteau Des Prairies Health Care

[3] https://www.countyhealthrankings.org/app/south-dakota/2020/overview

System board of directors based on their internal expertise and knowledge of the community. Members of the Core Team are as follows:

- Craig Kantos, Chief Executive Office
- April Heib, Chief Nursing Officer
- Colette Weatherstone, Marketing Coordinator
- Thomas Olson, ED -Trauma Coordinator
- Kayla Bartnick, Outpatient/Outreach Coordinator
- John Rudrud, Sanford Health - Strategic Planning Advisor

The Coteau Des Prairies Health Care System Core Team met on November 5th to review and assess the data described above. In order to move forward to the selection of the community needs priorities for the 2021 Community Health Needs Assessment update the Core Team considered areas where we felt we could have the greatest direct impact and the greatest ramifications for the community.

Another objective of the Core Team was to come up with a more focused set of priorities than we had in the 2018 Community Health Needs Assessment which consisted of six separate priorities. By focusing on broader upfront issues such as access to primary care, more timely and targeted referrals, and early detection, we believe we will be able to have a downstream impact on a wide range of conditions and diseases such as asthma/ chronic lower respiratory disease, back problems, cancer, cerebro-vascular disease/ stroke, depression/ suicide/ mental health, diabetes, heart disease, homicide, HIV/ AIDS, infant mortality, injuries and trauma, obesity, and osteo-arthritis.

5. Coteau Des Prairies Health Care System Board of Directors, comprised of local community leaders, met on November 24, 2020 to discuss core team recommendations and provide additional insight from an external stakeholder perspective on where to focus Community Health Needs Assessment priorities for 2021. Members of the Coteau Des Prairies Health Care System Board of Directors are as follows:

    - Terry Jaspers, Board Chair President, Financial Officer
    - Faye Johnston, Vice Chair, County Commissioner
    - Matt Glynn, Secretary, Insurance
    - Yvonne Hippen, Treasurer, Retired
    - Steve McCleerey, Board Member, Farmer
    - Erin Cameron, Board Member, Attorney
    - Pat Dady, Board Member, Retired
    - Dave Gleason, Board Member, Retired
    - Lyle Bien, Board Member, Retired

    The agenda for this meeting consisted of a review of the information analyzed by the Core Team, a discussion of the process the Core Team used to arrive at the final priority selections for 2021, a presentation and discussion of the proposed 2021 priorities and supporting action items, and a discussion on how the proposed priorities for 2021 align with external needs of the community.

6. Asset mapping was conducted to identify additional community resources available to partner with Coteau Des Prairies Health Care System to address assessed needs.

7. An Implementation plan was developed by Coteau Des Prairies Health Care System leadership.

Limitations

The studies and surveys listed in this analysis provide a snapshot of behaviors, attitudes, and perceptions of residents living in the community. A good faith effort was made to secure input from a broad base of the community. To mitigate limitations, the Community Health Needs Assessment evaluates community health from a number of perspectives; a stakeholder and community survey, surveys of community leaders that have special knowledge and expertise regarding populations, secondary data sources such as the census or County Health Rankings, any public comments from previous assessments, and institutional knowledge by Coteau Des Prairies Health Care System employees locally.

COMMUNITY HEALTH NEEDS ASSESSMENT FINDINGS

The Community Health Needs Assessment process led to the selection of two specific priority areas of focus for Coteau Des Prairies Health Care System for the 2021-2023 implementation cycle:

Priority 1 - Improving access to care and use of telehealth technologies

Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity in our community. Access includes insurance coverage, health services, and timeliness of care. When considering access to health care, it is important to also consider new telehealth technological capabilities that can improve ease of access, particularly for a rural community.

Lack of access to health services leads to unmet health needs, delays in receiving appropriate care, inability to get preventive services, financial burdens for the patient, and preventable hospitalizations.

Priority 2 - Addressing behavioral and mental health needs including alcohol, drug, and substance use disorders.

For people in our community with mental health problems and mental illness to have access to the right care at the right time, a range of inter-connected clinical and community service options need to be readily available and affordable. These services should be responsive to the needs of people with mental health problems and mental illness when they arise, and they should promote positive outcomes and facilitate sustained recovery. These services include primary care, acute care and other community support services that can be provided by public and/or private sector services.

Asset Mapping

Local asset mapping identifies current resources available in the community that can serve to improve outcomes in these priorities areas and that will complement and support the action items we are proposing.

Local Asset Mapping - Improving Access	
Identified area of community need	**Community resources that are available to address this need**
Priority 1 - Improving access to care and use of telehealth technologies	Roberts County Community Health
	Bright Start Home Visit – Child & Family Services
	Better Choices, Better Health
	SWO Diabetic Education Program
	CDP Nutritionist
	CDP Self Blood Pressure Monitoring Program
	Department of Social Services
	CDP Telehealth Services
	Avera eEmergency-Telehealth
	Home Care Services
	Community Education Programs: CDP, WWKMHC
	South Dakota Cardiovascular Collaborative
	Compass Care

Local Asset Mapping - Addressing Behavioral and Mental Health	
Identified area of community need	**Community resources that are available to address this need**
Priority 2 - Addressing behavioral and mental health needs including alcohol, drug, and substance use disorders.	Compass Care-Outpatient SUD Treatment
	Human Service Agency
	SWO Behavioral Health
	South Dakota Crisis Hotline 211
	Face It Together
	Project Recovery
	Avera eCARE Behavorial Health
	SWO Dakotah Pride
	SWO Mayueca Day Treatment
	Avoid Opioids
	Aliive Roberts County
	National Suicide Prevention Hotline (available 24 hours/day), 1-800-273-8255 Text HOME to 741741
	Farm Aid Hotline 800-327-6243
	US Department of Health & Human Services: https://www.mentalhealth.gov
	US Department of Health & Human Services: https://www.samhsa.gov/find-help/national-helpline
	South Dakota Department of Social Services: https://dss.sd.gov/
	Farm and Rural Stress Hotline - Avera: https://www.avera.org/services/behavioral-health/farmer-stress-hotline/
	National Farmers Union Farm Crisis Center: www.farmcrisis.nfu.org
	Mental Health America - Mental Health Screening: https://screening.mhanational.org/screening-tools

IMPLEMENTATION PLAN

Priority 1: Improving access to care and use of telehealth technologies.
We believe that the following specific actions would help to address this need:

1. Team Based Care - Draw on the expertise of a variety of team members to accomplish shared goals within primary care settings to achieve coordinated, high-quality care.
2. Screening Anxiety/Depression - Recognize conditions at an earlier stage when intervention is more effective.
3. Preventative Screening - Improve early detection when treatment is more effective.
4. Uninsured Population - Address financial barriers of patients.
5. Extending Hours - Expand hours of operation.
6. Recruitment of Providers - Improve recruitment of required specialties.
7. Promote Telehealth Use - Improve access through telehealth technologies.

Projected Impact
Upon completion of the action plan, the Community will have improved access to care and more use of telehealth technology.

Actions/Tactics	Measurable Outcomes & Timeline
Team Based Care • Create a formal team based approach program for primary care that addresses patients' needs across a broad continuum of care. • Select pilot team members. • Develop team based care workflows and responsibilities. • Train and implement team based care model. • Track outcomes and optimize/improve process going forward.	• Create a Team Based Care committee - in place by 3Q 2021. • Team based workflows and training complete by 4Q 2021. • Team based care model in place by 4Q 2021. • Increase in number of team based visits expected by 1Q 2022. • Provide feedback on screening rates quarterly.
Screening Anxiety/Depression • Review protocols for screening in the primary care and ED settings that ensure we are identify all patients needing further referral or treatment. • Develop screening process workflows and training. • Implement formal screening program in primary care and ED settings. • Track outcomes and optimize/improve process.	• Complete workflows and staff training by 2Q 2021. • Increase in number of screening tests completed in PC and ED expected by 3Q 2021. • Increase in number of appropriate referrals expected by 3Q 2021. • Provide feedback on screening rates quarterly.
Preventative Screening • Develop marketing strategies for preventative screening.	• Marketing plan complete by 2Q 2021. • Communications plan roll-out to the community complete by 3Q 2021.

• Roll-out marketing communications plan to the community. • Review and formalize protocols for screening in primary care. • Implemented screening model. • Track outcomes and optimize/improve process.	• Complete staff training by 3Q 2021 • Increase in number of screening tests completed in PC expected by 4Q 2021. • Provide feedback on screening/documentation and follow-up for preventative screening quarterly.
Uninsured Population • Identify and develop enhanced insurance liaison role and have staff resources in place to support. • Track encounters visits with insurance liaison. • Develop and review marketing and communications plans. • Roll-out communications to the community regarding available resources. • Review financial assistance and resources available to connect with patients in need. • Identify community resources and ensure they are accessible.	• Formal staff resources in place by 1Q 2022. • Increase number of visits with liaison by 3Q 2022. • Communications plan roll-out to the community complete by 2Q 2022. • Increase number of referrals to financial assistance and resources by 3Q 2022. • Update patient materials for financial assistance and resources annually. • Update price transparency assistance to patients annually.
Extending Hours • Review access to available appointment data. • Identify community demand patterns and access needs. • Review extended hour model options. • Implement new extended hours.	• Complete community survey of access to care by 1Q 2022 • Offer new hours of availability and communicate to the community by 3Q 2021. • Improve next available appointment performance by 3Q 2022. • Improve patient satisfaction with access by 4Q 2021.
Recruitment of Providers • Formalize a recruitment committee. • Establish a recruitment plan. • Identify recruitment needs. • Identify and engage a recruitment agency. • Recruit and hire needed providers.	• Formalize a recruitment committee by 1Q of 2021 • Provide recruitment plan by 4Q 2021. • Complete contract with recruitment agency 2Q 2021.
Promote Telehealth Use • Establish telehealth service advisor team. • Develop and review protocols for telehealth services and training. • Develop marketing strategies for telehealth services. • Promote patient use of telehealth.	• Telehealth advisory team in place by 3Q 2021. • Protocols and training complete by 4Q2021. • Promotion plan roll-out to the community complete by 2Q 2022. • Post and update telehealth access information quarterly for employees. • Monitor use of telehealth services quarterly and provide feedback.

Priority 2: Addressing behavioral and mental health needs including alcohol, drug, and substance use disorders.

We believe that the following specific actions would help to address this need:

1. Identification/Screening - Quickly assess the severity of condition and identify appropriate level of treatment.
2. Brief Intervention - Focus on increasing insight and awareness regarding condition and motivation toward behavioral change.
3. Referral to Care - Provide those identified as needing more extensive treatment with access to specialty care or care coordination.
4. Behavioral Health/Telehealth Services - Improve access to mental health, psychiatric, marriage and family counseling and addictions treatment.

Projected Impact

Upon completion of the action plan, the Community will have improved access to behavioral healthcare and more use of telehealth technology.

Actions/Tactics	Measurable Outcomes & Timeline
Identification/Screening, Brief Intervention, and Referral to Treatment • Establish a screening, intervention and referral process in the ED and Primary Care setting for SUD • Review SBIRT models in the ED and Primary Care setting for SUD. • Develop a SBIRT workflows for ED. • Develop a SBIRT workflows for Primary Care • Implemented SBIRT. • Track outcomes and optimize/improve process.	• Increase number of educational trainings for SUD annually. • Increase number of training sessions focused on patient awareness, behavior, and motivation by 4Q 2021. • Increase in number of patients responding favorably to the intervention by 1Q 2022. • Increase in number of patients referred to additional care 4Q 2021.
Behavioral Health/Telehealth Services • Develop a formal behavioral telehealth project plan. • Review behavioral telehealth models. • Implement a behavioral telehealth program. • Promote program in the community.	• Present options for telehealth services to clinic by 3Q 2021. • Begin deployment 3Q 2021 • Telehealth plan in place by 4Q 2021 with technology platforms in place and training complete. • Communications plan roll-out to the community complete by 4Q 2021.

EVALUATION OF 2019-2021 Community Health Needs Assessment

The 2018 Community Health Needs Assessment helped identify concerns within the community and determine areas where improvement efforts should be focused. Implementation strategies were put in place that have been successful overall. Local community members have been very appreciative of the efforts we have made to address these issues. Below are some specific accomplishments**:**

Priority 1: Obesity and Chronic Disease Management

- Implemented CDP Wellness Committee which hosted wellness events and educational series
- Increased additional certified lactation personnel on staff to provide education
- Implementation of self- blood pressure monitoring program through clinic
- Developed Sisseton Area Health Network (SAHN)

Priority 2: Behavioral and Mental Health

- Implemented screen tools, workflow and feedback process
- Optimized use of eEmergency Behavioral Health Services
- Partnered with local resources and programs
- Developed a resource directory

Priority 3: Alcohol, Drug, and Substance Use/Abuse

- Partnered with several community resources
- Partnered with law enforcement on Naloxone training and Drug Take Back events
- Implemented MAT program and Care Coordination through Compass Care
- Developed Sisseton Area Health Network (SAHN)

Priority 4: Suicide Prevention

- Expanded relationships with various community resources.
- Implemented screen tools, workflow and feedback process

Priority 5: Preventative Services

- See 2021 Community Health Needs Assessment

Priority 6: Access to care/telehealth to patients

- See 2021 Community Health Needs Assessment

CONTACT INFORMATION

The Community Health Needs Assessment, Implementation Plan, and survey data are available online at: https://www.cdphealth.com/. The website includes current and historical reports.

Anyone wishing to receive a free printed copy, obtain information on any topic brought forth in the report, or offer public comments for consideration during the implementation plan or future Community Health Needs Assessment work, please contact us at: 205 Orchard Drive - Sisseton SD, 57262
(605) 698-7647.

APPROVAL

The information presented in the Community Health Needs Assessment and Implementation Plan were approved by the Coteau Des Prairies Health Care System Board of Directors at their December 22, 2020 meeting.