



Community Health Needs Assessment
Implementation Strategy
January 2016 to December 2018



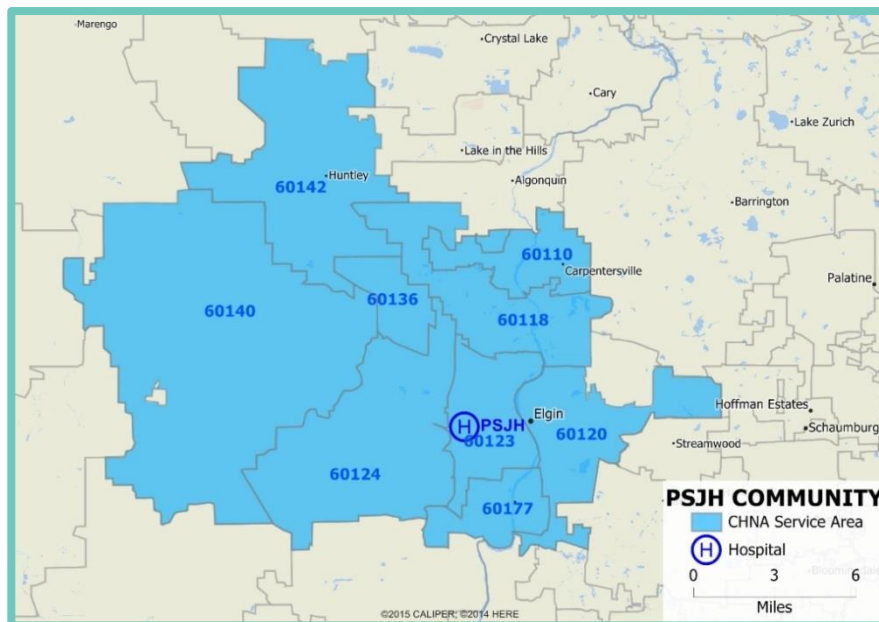
Inspired by the healing ministry of Jesus Christ, we, Presence Health, a Catholic health system, provide compassionate, holistic care with a spirit of healing and hope in the communities we serve.

This Implementation Strategy was produced by the Mission and External Affairs Department of Presence Health, which is sponsored by Presence Health Ministries.

Presence Saint Joseph Hospital Community Health Needs Assessment Implementation Strategy January 2016 – December 2018

Presence Saint Joseph Hospital-Elgin (PSJH-E) is a 184-bed hospital that has been meeting the health needs of Kane County residents for over 110 years. Founded by the Franciscan Sisters, PSJH-E offers the full continuum of care - from a Level II Emergency Department to treatment for cancer and heart disease. With over 1,200 associates and a medical staff of over 340 physicians across multiple specialties, PSJH-E offers a full range of inpatient and outpatient medical services for the Greater Elgin area and is known for providing leading-edge technologies and holistic care with compassion for the individual.

This Implementation Strategy follows on the 2015 Community Health Needs Assessment (CHNA) conducted by PSJH-E, together with other Kane County Public Health System Stakeholders, including four other hospitals and over 200 individuals, through the Kane County Community Health Needs Assessment (CHNA) Collaborative. In this document, we summarize the plans of Presence Saint Joseph Hospital-Elgin to develop and sustain community benefit programs that address prioritized needs from the CHNA, along with the metrics used to evaluate these programs.



Presence Saint Joseph Hospital Service Area

Target Areas and Populations

Presence Saint Joseph Hospital-Elgin (PSJH-E) primary service area includes Elgin, Carpentersville, Huntley, Hampshire, Gilberts and Dundee with a population of 254,607. Of these, Elgin makes up about 60% of the primary service area. It is a younger community as a whole and quite racially and ethnically diverse with approximately 32% population being Hispanic. Approximately 27% of Kane County residents live below the 200% of the federal poverty level and almost 6% of the residents are unemployed.

Development of This Implementation Strategy

Following an analysis of community assessment data, PSJH-E developed this Implementation Strategy through dialogue with hospital and community leaders. Most importantly, the Elgin Community Leadership Board, a group of community stakeholders and leaders, provided crucial input on community needs and opportunities.

We have implemented an evidence-based approach to meet each prioritized community need, either by developing a new program, strengthening an existing one, or borrowing a successful model from another context. We paid special attention to gaps in existing services, the needs of marginalized or vulnerable populations, and whether working in partnership with other organizations might help us address needs more holistically. These programs exist alongside other Community Benefit operations at Presence Health, such as a comprehensive financial assistance policy and a large outlay in Health Professions Education, which also help address community needs without the use of formal program evaluation.

Each program in this Strategy will be reviewed and updated annually according to the logic model below, and its stated outputs and outcomes, to ensure that it is appropriately addressing its prioritized community need. Updated progress metrics and lessons learned will be communicated to regulatory bodies and to the general public.

Prioritized Community Needs

Presence Saint Joseph Hospital-Elgin, as part of the Kane County CHNA Collaborative, identified the following prioritized community needs based on feedback from community stakeholders, social service providers, and members of the public, especially vulnerable and marginalized populations. These needs will be addressed over the next three years.

Chronic Disease

Goal: Reduce Chronic Disease in Kane County.

Chronic disease prevention was another strategic issue that arose in all the assessments. The number of individuals in the U.S. who are living with a chronic disease is projected to continue increasing well into the future. In addition, chronic diseases accounted for approximately 60% of deaths in Kane County in 2010. As a result, it will be increasingly important for the healthcare system to focus on prevention strategies addressing chronic disease prevention in Northern Kane County by targeting the focus areas of nutrition and physical activity.

Mental Health

Goal: Improve the Mental Health of Kane County Residents.

Mental health and substance arose as key issues in each of the four assessment processes. A total of 6.6% of Northern Kane County adults believe that their overall mental health is "fair" or "poor."

Research has shown that mental health plays a major role in people's ability to maintain good physical health. Further, the World Health Organization (WHO) emphasizes the need for a network of community-based mental health services. The WHO has found that the closure of mental health hospitals and facilities is often not accompanied by the development of community-based services and this leads to a service vacuum. In addition, research indicates that better integration of behavioral health services, including substance use treatment into the healthcare continuum, can have a positive impact on overall health outcomes. As a result, it will be increasingly important for the healthcare system to focus key strategies that include public education, community collaboration, and service coordination.

Income and Education

Goal: Reduce the proportion of Kane County residents living at or below 100% of poverty by 25%.

Both Elgin and Aurora had the lowest high school graduation rates in Kane County. In addition, 16.0% of Kane County children were living in poverty.

Research has shown that the social and structural determinants of health such as income and education are underlying root causes of health inequities. Additionally, social determinants of health often vary by geography, gender, sexual orientation, age, race, disability, and ethnicity. The strong connections between social, economic, and environmental factors and health are apparent in Kane County, with health inequities being even more pronounced than many national trends.

Notes on Approach to Addressing Community Needs

Notwithstanding the structure of this Implementation Strategy, Presence Health uses a collaborative approach to address complex and interrelated community needs, guided by the framework of inclusion and social justice provided to us by Catholic teaching. Before reviewing our programs to meet identified community needs, a few points bear further discussion.

Community Needs Are Interconnected

The needs our communities have prioritized are best understood as a complex web of cause and effect, rather than discrete topics. For instance, poverty (one of the social determinants of health) is not only a risk factor for other social determinants, but also leads to decreased access to care and higher rates of unmanaged chronic illness and untreated behavioral health conditions. Similarly, barriers in one area, such as access to care, can create a ripple effect across others areas like substance abuse and violence.

Given the interconnected nature of these problems, our efforts to address them do not fit neatly into separate boxes. Our workforce development efforts, for example, will impact both poverty and violence. Likewise, our efforts to diminish food deserts will address both social determinants of health and chronic disease. We have classified our programs under the prioritized need that is most directly impacted. Furthermore, the burdens of poverty and poor health are not distributed equally among all groups. Rates of chronic disease, for instance, vary across gender, economic, geographic, and racial/ethnic lines. Thus, recognition of health disparities and a commitment to their elimination is embedded throughout this document.

Diversity and Inclusion Commitment

As a system, Presence Health is committed to diversity and inclusion. Our key goals in this area include increasing the diversity and cultural competence of our workforce, standardizing language access services, and improving data collection on race, ethnicity, and language. These efforts, in turn, support the health needs identified through the CHNA process, including access to care and chronic disease. We are also seeking out local, minority and women-owned vendors to incorporate into our supply chain. This will help to address the social determinants of health by keeping economic resources in many of our hardest-hit communities.

Partnerships

Finally, we recognize that progress in addressing our prioritized health needs would not be possible without many partners, because the scope and nature of these problems are larger than any one organization or sector could hope to solve alone. Therefore, all Presence Health hospital ministries are active participants in collaborative county-wide CHNA efforts, where we help guide task forces to analyze and address community needs beyond the formal CHNA document. Our Community Leadership Boards further our ties with the community through quarterly meetings that review our progress in addressing prioritized needs. Collaboration with schools, in particular, is a key strategy within our implementation plans. Engaging youth and their parents and guardians is critical to our success in many areas, and we are deeply committed to fostering a culture of health among the next generation of community residents.

Logic Model

Through this Implementation Strategy, we intend to address the priority needs of Chronic Disease and Mental Health. We will also provide advocacy and support for local partnerships that help address the Social Determinants of Health-Income and Education. PSJH-E will continue to serve in the Kane County Income and Education Action Team.

Every program in this Implementation Strategy follows a Logic Model that maps the inputs and activities to the results we hope to achieve. This provides accountability and allows us to periodically evaluate and improve upon programs to ensure that they are effective.



Inputs are the human, organizational, and community resources required to implement the program.

Examples: staff resources, community partnerships, supplies, dollars

Activities are the events, interventions, and other observable actions that occur during program implementation. Activities use program inputs to bring about the desired changes in the target population.

Examples: educate and screen program participants, inspect home for asthma triggers

Outputs are the direct products or deliverables of the activities, expressed numerically, which ensure that the program is running according to plan.

Examples: 200 homes inspected, 300 participants served, 150 vaccinations delivered

Outcomes are changes in program participants caused by the program activities. These can include changes in knowledge, skills, attitudes/beliefs, behavior, status, and/or level of functioning, and are further separated into short-term, medium-term, and long-term outcomes.

Examples: Increased knowledge of asthma triggers in the home, weight loss, improved quality of life

Impacts are long-term changes in the communities, institutions, or systems that the program targets. These can take 7-10 years or longer and involve the entire population or community.

Examples: reduced burden of disease in community, reduced healthcare utilization, changes in social norms, legislation enacted

Based on W.K. Kellogg Foundation (2004) and K4Health (2016).

Chronic Disease

Program

Goal: Improve diabetes disease management.

Program	Logic Model					
<p>A1C Achiever Diabetes Management Program</p> <p>A 2-3 month education program that combines diabetes self-management training and medical nutrition therapy concurrently. Participants work toward achieving control of their diabetes upon program completion.</p>	<p>Inputs Certified Diabetes Educators (CDE), Registered Dietitians, Adults 18 years and older, laboratory testing, program materials, community partners, physicians.</p> <p>Activities 1. Associates screen for program participants at local health fairs and other screening venues. 2. Primary care provider refers patients to program for training. 3. CDE conducts individual initial assessment to determine the plan of care, glycemic target ranges and healthy behavioral goals. 2. CDE conducts post assessment sessions with participants that complete programs 3. Patients attend six 1.5 hour diabetes self-management training sessions. 5. Participants will have a pre and post A1C test.</p>					
	Outputs and Outcomes		2015 Baseline	2016	2017	2018 Target
	Total individuals served		126	83	90	100
	Total program completions		60	54	60	75
	% of participants with increased knowledge of glycemic targets		100%	100%	100%	100%
	% of participants with A1C of <7%		62%	69%	70%	75%
	% of participants with a 1% or greater drop in A1C		66%	70%	75%	80%
	Diabetes hospitalization rate in PSJH-E service area (per 100k)		3,610	TBD	TBD	2,800

275

Yearly inpatient admissions for avoidable diabetes-related complications in the PSJH-E service area

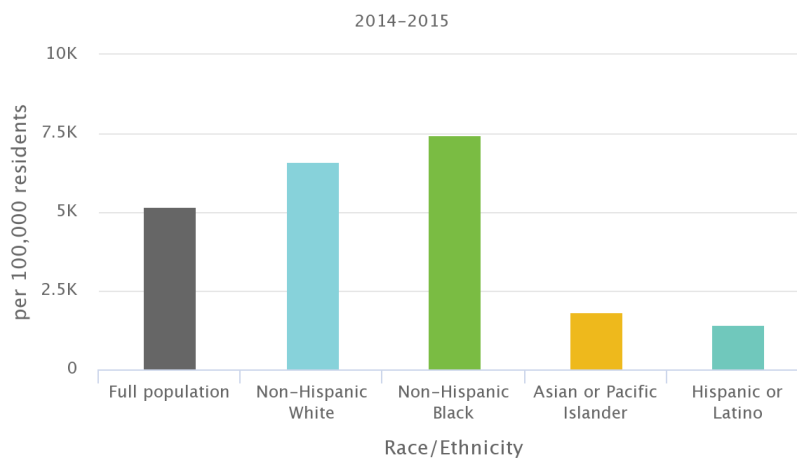
Mental Health

Program

Goal: Increase access to mental health first aid training in lay community.

Program	Logic Model					
Mental Health First Aid Mental Health First Aid (MHFA) is a program aimed at reducing the stigma associated with mental illness.	Inputs MHFA training instructors, funding, community participants, community partners, program materials, location for workshops, PSJH-E associates Activities 1. Establish two new partnerships annually. 2. Provide 1 youth and 1 adult training workshop for community. 3. Provide certification for program completion. 4. Provide 2 PSJH-E associates opportunity to become MHFA trainers.					
	Outputs and Outcomes		2015 Baseline	2016	2017	2018 Target
	Individuals completing training		0	35	40	45
	Trainings conducted in community		0	2	3	4
	% of participants reporting increased knowledge after training		0	90%	95%	100%
	Readmission rate for behavioral health issues		-	TBD	TBD	15%

Behavioral health admission rate (any diagnosis) by Race/Ethnicity



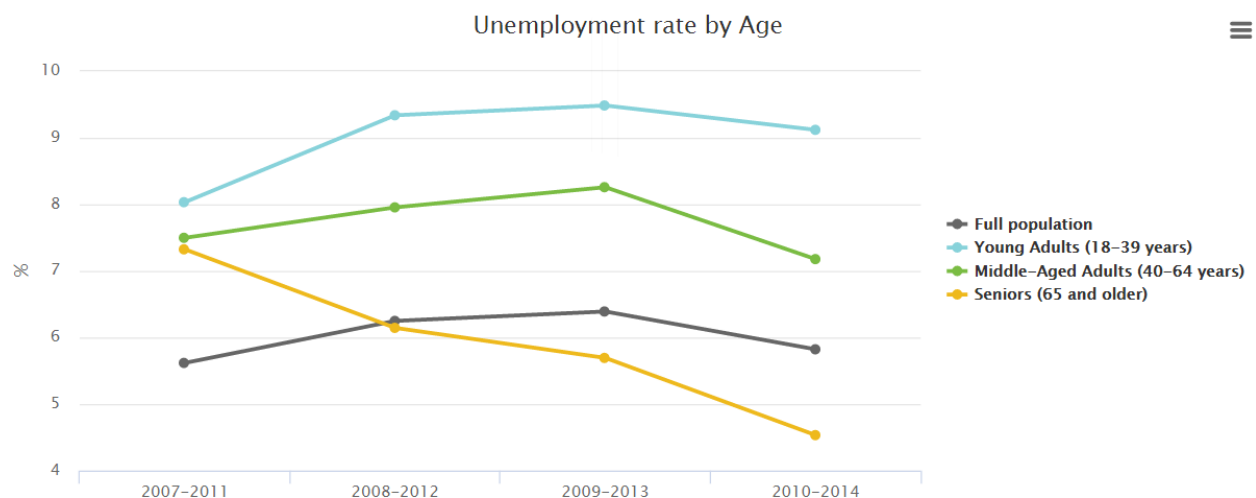
Behavioral health admission rate by race/ethnicity for the PSJH-e service area, showing disparities that primarily affect the white and black populations.

Income and Education

Partnership

Goal: Reduce economic inequality by improving partnerships with local schools.

Program	Logic Model				
Local School Partnerships We work with area schools to develop training and internship programs for students, improve health education, and strengthen the economic vibrancy of our neighborhood.	Inputs PSJH-E clinical and non-clinical associates, community partners				
	Activities 1. Provide advocacy and support for local partnerships with schools and school districts. 2. Provide opportunities for hospital internships where available. 3. Expand health education partnerships with schools.				
	Outputs and Outcomes	2015 Baseline	2016	2017	2018 Target
	Annual education partnership meetings	-	2	4	6
Classes and trainings conducted at local schools	-	3	5	7	



In the PSJH-E service area, the unemployment rate for young adults (18-39 years) is much higher than for other age groups, and has remained high over time.

Adoption

Presence Saint Joseph Hospital-Elgin welcomes feedback from the public and community stakeholders on this Implementation Strategy and its related Community Health Needs Assessment. To provide feedback or learn more about the process for conducting the Community Health Needs Assessment and determining community needs, please contact Maria Aurora Diaz at 630.801.5756 or MariaAurora.Diaz@PresenceHealth.org.

The Board of Directors of Presence Saint Joseph Hospital-Elgin has formally delegated authority to approve this Implementation Strategy to the Elgin Community Leadership Board, comprised of community and hospital stakeholders and business leaders. The below signatures indicate that this plan has been reviewed and adopted for 2016 – 2018.

Adopted by the Elgin Community Leadership Board

Date Adopted

Plan Prepared By:

Maria Aurora Diaz
Regional Director, Community Health Integration & Clinical Services

