



Community Health Needs Assessment
Implementation Strategy
January 2018 to December 2020



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.

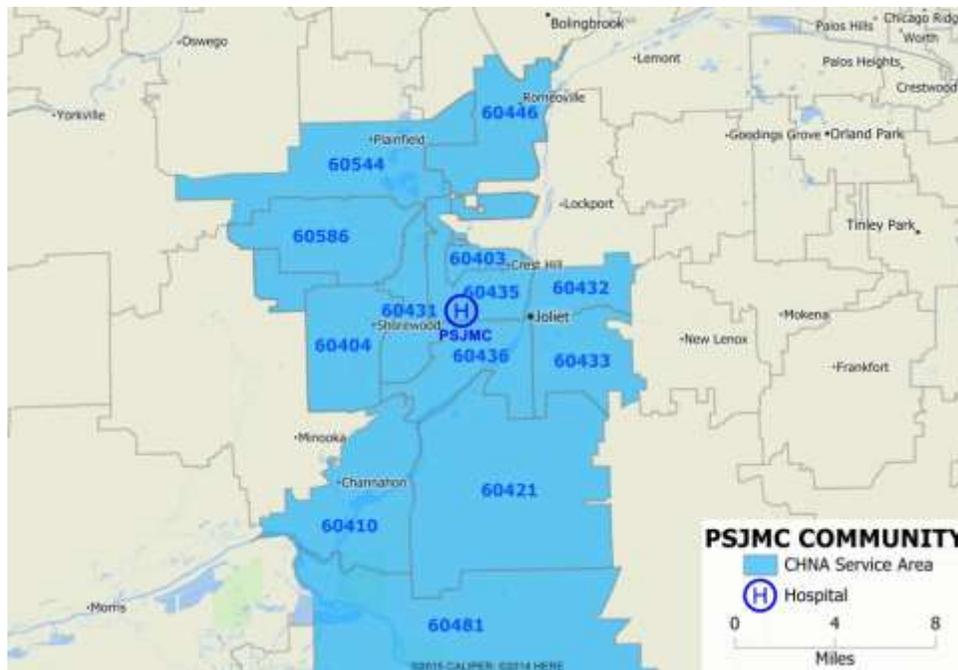
This Implementation Strategy was produced by the Mission and External Affairs Department of Presence Health, which is sponsored by Presence Health Ministries.

Presence Saint Joseph Medical Center Community Health Needs Assessment Implementation Strategy January 2018 – December 2020

Presence Saint Joseph Medical Center (PSJMC) has been meeting the health needs of Joliet and Will County area residents for over 135 years. Founded by the Franciscan Sisters of the Sacred Heart, Presence Saint Joseph Medical Center continues to carry out its mission of providing “compassionate, holistic care with a spirit of healing and hope in the communities it serves.”

In 2016 and 2017, Presence Saint Joseph Medical Center participated in the Will County MAPP Collaborative along with three other hospitals, the Will County Health Department, and more than 100 community organizations to complete a collaborative Community Health Needs Assessment for Will County.

We define PSJMC primary service area as the collection of ZIP codes where approximately 75% of hospital patients reside, as seen in the map below:



Target Areas and Populations

Presence Saint Joseph Medical Center (PSJMC) serves the greater Will County area, especially those that reside near Joliet. For each health priority, target populations were identified, when available. The most common target priority populations identified in the Community Health Needs Assessment were Medicaid recipients, Medicare recipients, Hispanic/Latino population and those that reside in Southern Will County or the following zip codes: 60432, 60433, 60436, and 60441.

Development of This Implementation Strategy

Following an analysis of community assessment data, Presence Saint Joseph Medical Center developed this Implementation Strategy through dialogue with hospital and community leaders. Most importantly, the Will County MAPP Collaborative, 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 Medical Center, as part of the Will County MAPP Collaborative CHNA, 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:



Access to Dental and Primary Care

Goal: Increase consumers' effective use of health systems

Healthy People 2020 states that access to comprehensive healthcare services is important for achieving health equity and improving quality of life for everyone. Access to comprehensive, quality healthcare services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity. Access is a complex issue with multiple components including availability, affordability, and timeliness.

Improving Behavioral Health

Goal: Increase access to coordinated health systems and behavioral health services

Goal: Reduce prescription drug and other opiate overdoses.

Behavioral health is a term used to include both mental health and substance abuse disorders. Mental health disorders are among the most common causes of disability. Mental disorders attributed to 7.8% (5,783) of Will County hospitalizations in 2014, and is the third leading cause of hospitalizations overall. Behavioral health issues impact population groups across income levels as well as racial and ethnic groups.

Preventing and Reducing Chronic Disease

Goal: Increase access to and availability of healthy food and beverages.

Goal: Reduce household food insecurity.

Goal: Increase physical activity opportunities.

Goal: Improve prevention and management of diabetes.

Chronic diseases are the most common, costly, and preventable of all health problems. Heart disease is the second leading cause of hospitalizations in Will County and cancer is the fifth. Heart disease, cancer, and diabetes account for approximately 58% of all deaths in Will County. Many chronic diseases are linked to lifestyle choices, or health risk behaviors, which can be changed. Four of these health risk behaviors—lack of physical activity, poor nutrition, tobacco use, and excess alcohol consumption— cause much of the illness, suffering, and early death related to chronic diseases and conditions.

In addition to the three prioritized community needs, many of the strategies identified were determined to be cross-cutting across the selected health priorities which are labeled as Overarching Goals:

- Advocate for a Health in All Policies approach to improve Will County's built environment and transportation system
- Collect, analyze, and disseminate high quality public health data
- Explore becoming a trauma-informed county
- Increase business and philanthropy partnerships in community engagement
- Raise awareness of health inequities and expand understanding of health equity
- Reduce prevalence and inequities of obesity and obesity related diseases

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 social Catholic teaching. Before reviewing our programs to meet identified community needs, a few points bear further discussion.

1. 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 adverse social determinants, but also leads to decreased access to care and higher rates of unmanaged chronic illness and untreated behavioral health conditions. 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.

Given the interconnected nature of these problems, our efforts to address them do not fit neatly into separate boxes. 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.

2. Diversity and Inclusion Commitment

As a system, Presence Health is committed to diversity and inclusion. We are focused on 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.

3. 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.

Working for IMPACT

Through this Implementation Strategy, we intend to address all of the priority needs listed. We will also support other health care providers and public health departments in our community in collaborative efforts to improve outcomes.

In designing the Implementation Strategy, we focused our efforts around **IMPACT**: Informed and Measurable Programs, Partnerships, or Policies that Advance Community Transformation.

Logic Model

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).

Goal: Increase consumers' effective use of health systems

Strategy:

- Ensure communities with high rates of uninsured have certified application counselors to assist with enrollment and education on Marketplace and Medicaid benefits.

Key Interventions

Federally Qualified Health Centers (FQHC) and Free Clinic Partner Support

Provide financial, referral, and in-kind support to local FQHCs and free clinics

Open Enrollment

Expanding access to insurance and social service benefits by providing enrollment support and resources, on campus and at community partner sites

Time Frame	Action Plan
Baseline: Year 2017	<ul style="list-style-type: none"> • Evaluate community need (see related Community Health Needs Assessment)
Year 2018	<ul style="list-style-type: none"> • Continue involvement in open enrollment for Medicaid and ACA marketplaces • Continue and increase referrals to FQHCs • Identify communities with high rates of uninsured
Year 2019	<ul style="list-style-type: none"> • Provide enrollment and education to identified communities with high rates of uninsured • Continue and increase referrals to FQHCs
Year 2020	<ul style="list-style-type: none"> • Decrease emergency department visits for non-emergencies • Evaluate current initiatives

Partners to Engage

Will-Grundy Medical Clinic, Aunt Martha's Health Services, VNA Health Services, Will County Community Health Center, Will County MAPP Collaborative, Patient Innovation Center

Policies to Impact

Prevent funding cuts to FQHCs and protect expanded Medicaid coverage; Support legislation that expands care coordination and community-based care settings

Goal: Increase consumers' effective use of health systems

Strategy:

- Engage community partners to develop a community-specific comprehensive oral health improvement plan.

Key Interventions	
<p>Oral Health Needs Assessment Conduct a comprehensive oral health needs assessment for Will County to develop further strategies to address dental issues.</p> <p>Community Education Educate community on findings of Oral Health Needs Assessment as well as develop educational campaign to increase usage of dental services</p>	
Time Frame	Action Plan
Baseline: Year 2017	<ul style="list-style-type: none"> • Evaluate community need (see related Community Health Needs Assessment)
Year 2018	<ul style="list-style-type: none"> • Conduct Oral Health Needs Assessment • Conduct strategic planning session to identify and prioritize issues
Year 2019	<ul style="list-style-type: none"> • Communicate oral health issues to educate the public and health care workers • Provide oral health education in the community
Year 2020	<ul style="list-style-type: none"> • Decrease emergency department visits for dental issues • Evaluate current initiatives
<p>Partners to Engage Will County MAPP Collaborative, FQHCs, Will-Grundy Medical Clinic, private dental providers accepting Medicaid, PH emergency department team</p>	
<p>Policies to Impact Prevent funding cuts to FQHCs and protect expanded Medicaid coverage</p>	

Goal: Increase access to coordinated health systems and behavioral health services

Strategies

- Conduct assessment of behavioral health systems capacity and develop and promote a behavioral health resource inventory.
- Promote Crisis Intervention Training for police officers and Mental Health First Aid Training for first responders.

Key Interventions

Behavioral Health Capacity Assessment

A county-wide assessment to determine the current barriers to care for behavior health.

Behavioral Health Resource Inventory

A comprehensive inventory of behavioral health services using GIS mapping.

Mental Health First Aid (MHFA)

Certificate-based program using national, evidence-based curriculum that teaches the skills to respond to the signs of mental illness and substance use disorders

Time Frame	Action Plan
Baseline: Year 2017	<ul style="list-style-type: none"> • Evaluate community need (see related Community Health Needs Assessment)
Year 2018	<ul style="list-style-type: none"> • Increase free MHFA trainings for police officers & other first responders • Conduct behavioral health capacity assessment • Review capacity assessment to analyze gaps in services
Year 2019	<ul style="list-style-type: none"> • Educate stakeholders, policy makers, legislatures and residents about gaps in services • Develop a behavioral health resource guide • Educate first responders on behavioral health resources
Year 2020	<ul style="list-style-type: none"> • Decrease emergency department visits for mental health issues • Evaluate current initiatives

Partners to Engage

Local law enforcement, MHFA trainers, Will County MAPP Collaborative, PH Social Workers

Policies to Impact

Improve insurance coverage for behavioral health; and additional training on mental health for public servants; reduce barriers of telehealth for mental health

Goal 3: Reduce prescription drug and other opiate overdoses.

Strategies

- Explore physician education initiative to reduce high-risk opioid prescribing.
- Expand prescription drug and other opiate overdose community education.

Key Interventions

Opioid Education: Providers

Conduct trainings for nursing, physicians and other providers on pain assessment, monitoring and safe opioid prescribing.

Opioid Education: Community

Conduct education campaign on opioid addiction awareness as well as safe use, storage, and disposal of opioids when prescribed.

Take-Back Bins

Promote the availability of take-back bins for opioids or host take-back days at PSJMC.

Time Frame	Action Plan
Baseline: Year 2017	<ul style="list-style-type: none"> • Evaluate community need (see related Community Health Needs Assessment)
Year 2018	<ul style="list-style-type: none"> • Plan and begin provider trainings • Inventory take-back bin availability • Implement bedside education for patients on prescribed opioids
Year 2019	<ul style="list-style-type: none"> • Plan community education on opioid addiction awareness • Continue provider trainings • Continue beside education • Host take-back bin event
Year 2020	<ul style="list-style-type: none"> • Decrease number of overdoses related to opioids • Evaluate current initiatives

Partners to Engage

Will County MAPP Collaborative, Will County Office of Substance Use Initiatives, PH Medical Staff, PH Nursing, PH Pharmacy, PH Social Work

Policies to Impact

Improve insurance coverage for behavioral health; improve Medicaid coverage of Substance Use Disorder treatment

Goal 4: Increase access to and availability of healthy food and beverages.

Goal 5: Increase physical activity opportunities.

Strategies

- Increase adoption and implementation of comprehensive workplace wellness policies and practices as well as improving and increasing access to physical activity opportunities.
- Increase adoption and implementation of healthy eating and physical activity policies and practices including limiting sugar-sweetened beverages in organizations and community.

Key Interventions

American Lung Association Tobacco 21 Act

Increasing the minimum age of sale for tobacco products to at least 21 years old will significantly reduce youth tobacco use and save thousands of lives

Campus Fit Loop

Create visible, marked walking trails on and around ministry to encourage activity and physical fitness

Rethink Your Drink

Reduce sugary beverage consumption to ameliorate chronic disease

WeWill WorkHealthy Awards

County-wide worksite wellness awards process to increase healthy worksites

Time Frame	Action Plan
Baseline: Year 2017	<ul style="list-style-type: none"> • Evaluate community need (see related Community Health Needs Assessment)
Year 2018	<ul style="list-style-type: none"> • Conduct WeWill WorkHealthy Awards • Advocate for Tobacco 21 Act & Rethink Your Drink
Year 2019	<ul style="list-style-type: none"> • Design, build & promote Fit Loop • Conduct WeWill WorkHealthy Awards
Year 2020	<ul style="list-style-type: none"> • Increase number of minutes physically active • Evaluate and monitor initiatives impact

Partners to Engage

American Lung Association, Illinois Alliance to Prevent Obesity, Will County MAPP Collaborative, PH dieticians/food & nutrition leadership

Policies to Impact

Tobacco 21 to restrict youth access to tobacco; sugary drink taxes to reduce consumption and increase funding for health care programs; and preserve school physical education requirements

Goal 6: Reduce household food insecurity.

Strategies

- Work with food pantries and emergency meal program to stock and deliver healthy foods and beverages.
- Explore food insecurity screenings and referral system to connect individuals at risk for food insecurity with local food resources.

Key Interventions

Mobile Food Pantry

Host mobile food pantry trucks in designated food deserts.

Food Bank App

Map existing food bank/pantry providers and link to mobile application for community users.

Food Insecurity Screenings

Conduct routine screenings on patients regarding their access to healthy foods and provide resources.

Time Frame	Action Plan
Baseline: Year 2017	<ul style="list-style-type: none"> • Evaluate community need (see related Community Health Needs Assessment)
Year 2018	<ul style="list-style-type: none"> • Develop a food pantry resource list, by creating an interactive GIS map of food pantries in Will County • Link food pantry list with mobile application and promote • Increase number of mobile food pantries in key shortage areas
Year 2019	<ul style="list-style-type: none"> • Determine greatest need for grocery store and advocate with municipalities • Develop and implement food insecurity screening tool • Partner with food pantries to offer healthier options • Increase number of mobile food pantries in key shortage areas
Year 2020	<ul style="list-style-type: none"> • Decrease the percentage of low income population that has low access to food • Increase the rate of grocery establishments • Evaluate and monitor initiatives impact

Partners to Engage

Will County MAPP Collaborative, Will County GIS, Northern Illinois Food Bank, PH Patient Access, Area Churches & Community Centers, Food Pantries

Policies to Impact

Additional funding for SNAP; incentives for business to accept SNAP/WIC

Goal 7: Improve prevention and management of diabetes.

Strategies

- Increase access to and utilization of community-based services for diabetes prevention, risk reduction and disease management.
- Implement referral systems in health care settings that link patients to community resources.

Key Interventions

Diabetes Prevention Program (DPP)

Diabetes screening and education program focusing on the prevention of type 2 diabetes through lifestyle and nutrition therapy.

Fitness Prescription Program

Improve access to affordable fitness resources through shared-use agreements and partnerships with Park Districts, YMCAs, and local green spaces.

Diabetes Resource Guide

A comprehensive guide of services for diabetes and pre-diabetes for providers and community.

Time Frame	Action Plan
Baseline: Year 2017	<ul style="list-style-type: none"> • Evaluate community need (see related Community Health Needs Assessment)
Year 2018	<ul style="list-style-type: none"> • Increase referrals to diabetes prevention programs. • Increase usage of fitness prescription program • Create comprehensive guide for diabetes and pre-diabetes
Year 2019	<ul style="list-style-type: none"> • Distribute guide in community • Continue referrals to programs & fitness prescription targeting Medicare and African American populations
Year 2020	<ul style="list-style-type: none"> • Decrease the rate of preventable hospitalizations for uncontrolled diabetes • Evaluate and monitor initiatives impact

Partners to Engage

YMCAs, Park District, Will County MAPP Collaborative, Will-Grundy Medical Clinic, FQHCs, PH Dieticians

Policies to Impact

MCOs to cover DPP programs, sugary drink taxes to reduce consumption and increase funding for health care programs; and preserve school physical education requirements



Adoption

Presence Saint Joseph Medical Center 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 Shannon M. Jermal at shannon.jermal@presencehealth.org.

The delegated authority to approve this Implementation Strategy resides with the Will County Community Leadership Board, comprised of community and hospital stakeholders. The below signatures indicate that this plan has been reviewed and adopted for 2018 – 2020.

Adopted by the Will County Community Leadership Board

3/13/18
Date Adopted

Plan Prepared By:

Shannon M. Jermal
Regional Director, Community Health Integration

