Community Health Needs Assessment Implementation Strategy

January 2019 to December 2021

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.

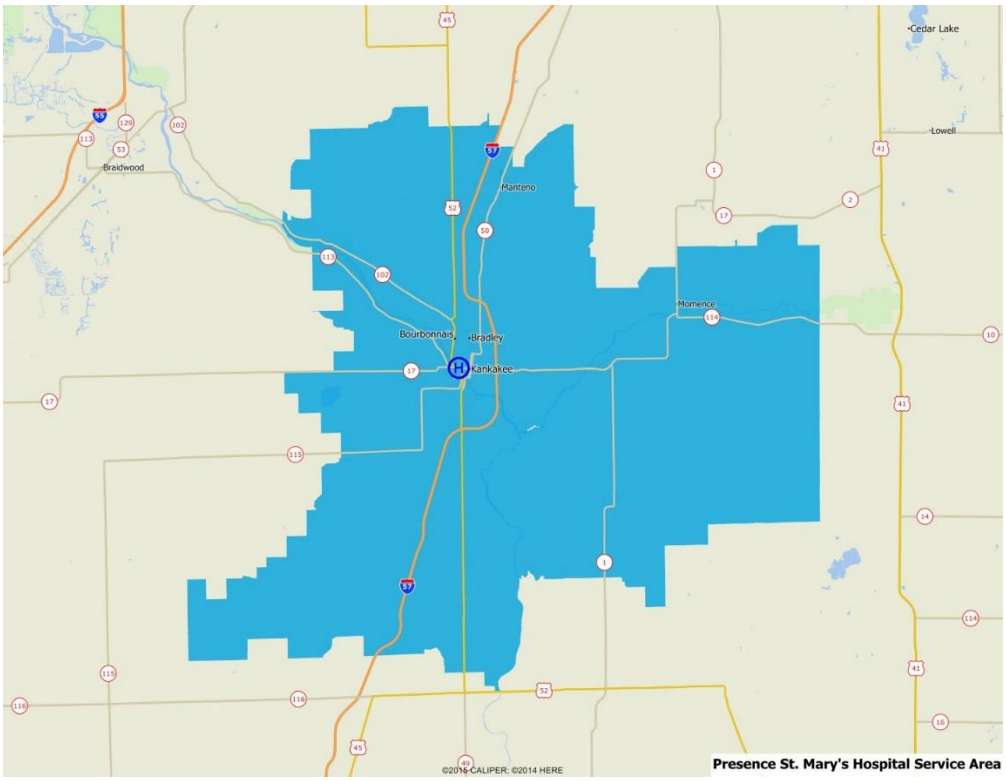
Presence St. Mary's Hospital

Community Health Needs Assessment Implementation Strategy
January 2019 – December 2021

Presence St. Mary's Hospital (PSMH) has been meeting the health needs of Kankakee County residents for over 120 years. Founded by the Servants of the Holy Heart of Mary, Presence St. Mary's Hospital continues to carry out its mission of providing "compassionate, holistic care with a spirit of healing and hope in the communities it serves."

In 2017 and 2018, Presence St. Mary's Hospital participated in the Partnership for a Healthy Community along with one other hospital, the Kankakee County Health Department, and more than 40 community organizations to complete a collaborative Community Health Needs Assessment for Kankakee County.

We define PSMH 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 St. Mary's Hospital (PSMH) serves the greater Kankakee County area, especially those that reside near the city of Kankakee. 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, men, Hispanic/Latino, races other than Caucasian and those that reside in the city of Kankakee or in the southern portion of the county.

Development of This Implementation Strategy

Following an analysis of community assessment data, Presence St. Mary's Hospital developed this Implementation Strategy through dialogue with hospital and community leaders. Most importantly, the Partnership for a Healthy Community, 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 St. Mary's Hospital, as part of the Kankakee County Partnership for a Health Community, 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 Health

Goal: Promote quality of life and healthy behaviors.

Healthy People 2020 states that access to comprehensive healthcare services is important for achieving health equity and improving quality of life for everyone. This strategic issue encompasses both access to care as well as chronic disease prevention. 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. Chronic diseases are the most common, costly, and preventable of all health problems. Heart disease is the second cause of hospitalizations and leading cause of death in Kankakee County. Heart disease accounts for over 50% of deaths in Kankakee County.

Behavioral Health

Goal: Improve behavioral health by ensuring coordination and access to appropriate behavioral health services.

Behavioral health is a term used to include both mental health and substance abuse disorders. Mental health is defined as a state of well-being in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively, and is able to make a contribution to their community. Compared to Illinois, there are more suicides, more emergency room visits for mental health, and more days reported as mentally unhealthy among Kankakee County residents. Behavioral health issues impact population groups across income levels as well as racial and ethnic groups

Education & Employment

Goal: Enhance workforce development to improve employability of community members which will boost economic vibrancy and personal health.

Education is an important social determinant of health, because the rate of poverty is higher among those without a high school diploma or GED. In addition without a high school education are at a higher risk of developing certain chronic illnesses, such as diabetes. Unemployment can create financial instability, and, as a result can create barriers to accessing healthcare services, insurance, healthy foods, and other basic needs. The unemployment rate for Kankakee County (6.2) is higher than the rates for Illinois (5.9) and the U.S. (5.2). The percent of the Kankakee County population living in poverty is 16%, while the percent for both Illinois (14%) and the US (15%) are lower. Poverty can create barriers to accessing health services, healthy food, and other necessities needed for good health status.

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).

Access to Health Goal: Promote quality of life and healthy behaviors.

Strategies:

- Increase use of programs that promote healthy lifestyles.
- Improve community members' effective use of health systems and community resources.
- Define Social Determinants of Health, identify those at risk and connect to resources.

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 **Social Determinants of Health Screenings & Good Neighbor Program** Conduct routine screenings on patients regarding their access to services and resources. Provide resource and assistance to those patients to ensure access to health. **Mobile Food Pantry & Micro Pantry Development** Host mobile food pantry trucks and place micro pantries in designated food deserts. **RN in a Library** Place a PSMH Community Health Nurse at the public library to answer health questions, link individuals to health and other social services to address social determinants of health. **Diabetes Prevention Program (DPP)** Diabetes screening and education program focusing on the prevention of type 2 diabetes through lifestyle and nutrition therapy. **We Fit! & Fit N Healthy** Provide exercise and health programs in low-income areas for youth and adults. **Smoke Free Faith** Work with local parishes to adopt smoke free campuses and challenges. **PADS Program/Fortitude** Provide volunteers, funding and in-kind services to the faith-based, homeless shelters.

Time Frame	Action Plan
Baseline: Year 2018	• Evaluate community need (see related Community Health Needs Assessment)
Year 2019 & 2020	• Continue involvement in open enrollment for Medicaid and ACA marketplaces including populations with high uninsured • Continue and increase referrals to FQHCs and free clinic • Develop a food pantry resource list • Increase number of mobile food pantries in key shortage areas • Increase number of micro pantries in key shortage areas • Explore partnership for diabetes prevention program or implement program at PSMH • Implement RN in a Library Program • Develop and implement social determinants of health screening tool & Good Neighbor Program • Continue We Fit! and Fit N Healthy programs in low-income communities • Partner with parishes to adopt smoke-free faith communities • Increase volunteers for PADs shelters
Year 2021	• Decrease emergency department visits for non-emergencies • Decrease rate of uninsured • Decrease rate of population with food insecurity • Decrease incidence of diabetes • Decrease the rate of tobacco use among adults & youth • Evaluate current initiatives
Partners to Engage Aunt Martha's Health Services, Partnership for a Healthy Community; Northern Illinois Food Bank; Food Pantries; Churches; Kankakee Public Library; YMCA;	
Policies to Impact Prevent funding cuts to FQHCs and protect expanded Medicaid coverage; Support legislation that expands care coordination and community-based care settings; Additional funding for SNAP; Incentives for business to accept SNAP/WIC; MCOs to cover DPP programs, sugary drink taxes to reduce consumption and increase funding for health care programs; increase tobacco purchase age	

Behavioral Health Goal: Improve behavioral health by ensuring coordination and access to appropriate behavioral health services.

Strategies

- Increase community education and outreach on substance use disorders; prevention, intervention, and recovery.
- Increase awareness of mental health conditions to reduce stigma and increase awareness of mental health programs and services in the community.
- Increase trauma awareness, education, and prevention throughout the community to improve health outcomes.

Key Interventions
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
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.
Trauma & Adverse Childhood Experiences (ACEs) Education Provide training for associates and community on Adverse Childhood Experiences to become a trauma informed community.
RN in a Library Place a PSMH Community Health Nurse at the public library to answer health questions, link individuals to health and other social services to address social determinants of health.
Social Determinants of Health Screenings & Good Neighbor Program Conduct routine screenings on patients regarding their access to services and resources. Provide resource and assistance to those patients to ensure access to health.
Children's Mental Health 2.0 Initiative (Project Sun) Partner in community collaborative to remedy system for children's mental health services.

Time Frame	Action Plan
Baseline: Year 2018	• Evaluate community need (see related Community Health Needs Assessment)
Year 2019 & 2020	• Increase free MHFA trainings for police officers & other first responders • Join Opioid Task Force & Children's Mental Health 2.0 workgroup • Plan and begin provider trainings on opioid addiction awareness • Plan and begin community education on opioid addiction awareness • Inventory take-back bin availability & host events • Implement bedside education for patients on prescribed opioids • Conduct ACEs training • Implement RN in a Library Program • Develop and implement social determinants of health screening tool & Good Neighbor Program
Year 2021	• Decrease emergency department visits for mental health issues • Decrease number of overdoses related to opioids • Increase trauma-awareness among associates • Evaluate current initiatives
Partners to Engage MHFA trainers, Partnership for a Healthy Community; First Responders; ACE trainers; Kankakee Public Library; Kankakee County Opioid Task Force; Children's Mental Health 2.0	
Policies to Impact Improve insurance coverage for behavioral health; Additional training on mental health for public officials; Reduce barriers of telehealth for mental health; Improve Medicaid coverage of Substance Use Disorder treatment	

Education & Employment Goal: Enhance workforce development to improve employability of community members which will boost economic vibrancy and personal health.

Strategies

- Increase utilization of training programs and resources.
- Foster partnerships between schools and employers to increase workforce readiness.

Key Interventions

RN in a Library
Place a PSMH Community Health Nurse at the public library to answer health questions, link individuals to health and other social services to address social determinants of health.

Social Determinants of Health Screenings & Good Neighbor Program
Conduct routine screenings on patients regarding their access to services and resources. Provide resource and assistance to those patients to ensure access to health.

Poverty Education & Collaboration
Host education session to build collaborative aimed at addressing root causes of poverty.

Anchor Mission
Alignment of hiring and procurement practices locally to ensure vitality in the communities we serve.

Health Clinic @ School
Implement health clinic on school campus to increase healthcare training opportunities as well as access to care.

PSMH Mentoring Program & Speaker Bureau
Partner with local high schools to develop mentoring opportunities and speaking engagements for youth to learn about various health careers.

Time Frame	Action Plan
Baseline: Year 2018	• Evaluate community need (see related Community Health Needs Assessment)
Year 2019 & 2020	• Implement RN in a Library Program • Develop and implement social determinants of health screening tool & Good Neighbor Program • Develop more robust relationships to align anchor mission • Host poverty education session & build collaborative • Plan & implement health clinic on school campus

	• Increase speaking engagements with area high school(s) • Develop mentoring program with area high school(s)
Year 2021	• Decrease unemployment rate • Decrease poverty rate • Increase graduation rates • Evaluate and monitor initiatives impact
Partners to Engage Kankakee School District; Kankakee Public Library; Partnership for a Healthy Community; Olivet Nazarene University; Kankakee Community College	
Policies to Impact Increase funding for workforce training programs; Secure funding for Temporary Assistance for Needy Families (TANF) program;	

Adoption

Presence St. Mary's Hospital 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 Kankakee River Valley Community Leadership Board, comprised of community and hospital stakeholders. The below signatures indicate that this plan has been reviewed and adopted for 2019 – 2021.

Adopted by the Kankakee River Valley Community Leadership Board

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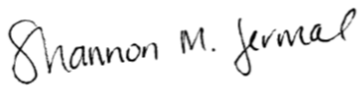
Date Adopted

Plan Prepared By:



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Shannon M. Jermal
Regional Director, Community Health Integration

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