AMITA Holy Family Medical Center Implementation Strategy

FY2020-2022

Implementation Strategy Narrative

Overview

AMITA Health Holy Family Medical Center Des Plaines

AMITA Health Holy Family Medical Center in Des Plaines (AHHFMCDS), Illinois is a long-term acute care hospital (LTACH) caring for medically complex patients, the only such hospital in Northwest Chicagoland and the only faith-based LTACH in Illinois. It is the first long-term acute care hospital in Illinois to be certified in Disease Specific Care for Respiratory Failure by The Joint Commission.

Licensed for 178 beds, AMITA Health Holy Family Medical Center specializes in caring for patients who are critically ill with complex conditions and must be hospitalized for an extended period. Most patients here are transferred from critical care units at other hospitals. AHHFMC was the recipient of the 2017 Goldberg Innovation Award from the National Association of Long-Term Hospitals for the Dedicated Education Unit in training the next generation of nurse professionals as well as the 2018 National Guardian of Excellence for Patient Safety by Press Ganey. It has been recognized by the Illinois Hospital Association Award for Patient Safety.

This plan was adopted in October 2019.

Alliance for Health Equity

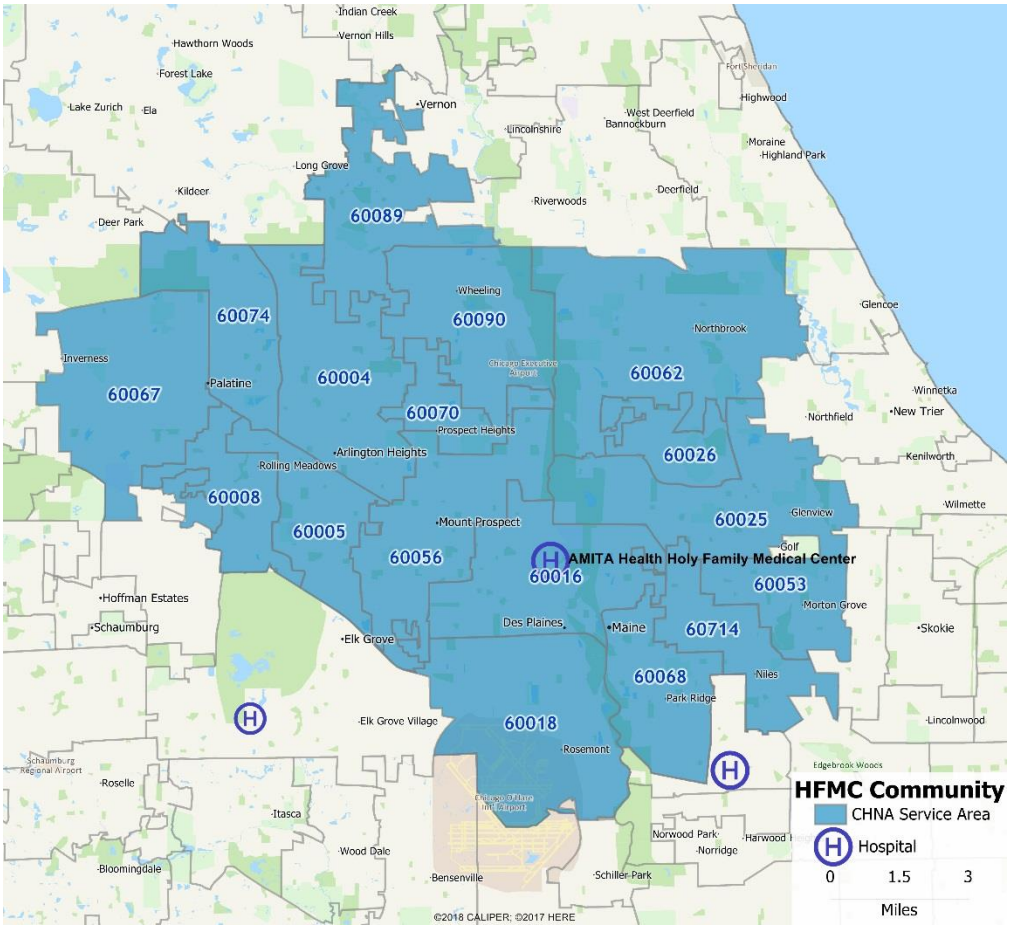
In 2018 and 2019, AMITA Health Holy Family Medical Center Des Plaines participated in the Alliance for Health Equity (AHE), facilitated by the Illinois Public Health Institute. Together, the Alliance developed a collaborative Community Health Needs Assessment (CHNA) for Cook County. This cover document for that CHNA provides more information about the service area of AHHFMC, its existing programs, and its specific needs within the context of the needs identified and prioritized in its service area.

AHHFMC and members of the Alliance for Health Equity, a collaborative of over 30 hospitals, 7 health departments, and 100 community partners, have worked together over the last 12 months to build this comprehensive Community Health Needs Assessment (CHNA) in Chicago and Cook County. Using the Mobilizing for Action through Planning and Partnerships (MAPP) model for the CHNA, the Alliance engaged diverse groups of community residents and stakeholders and gathered robust data from various perspectives about health status and health behaviors.

AHHFMC Community

As an integrated health system, AMITA Health provides high-quality primary and specialty care, as well as community benefit support throughout the region. AHHFMC has identified its community served in terms of a primary and secondary geography to assess need for both our hospital service area and other communities where we also have an impact on health. AHHFMC provides services, has membership, and

supports community health throughout the defined regions. We define the AHHFMC primary service area as the collection of ZIP codes where approximately 75% of hospital patients reside, and we focus our community health improvement on this service area.



Needs That Will Be Addressed

Together with our community stakeholders, we have identified the following prioritized health needs in our community:

1. **Social and Structural Determinants of Health**, including policies that advance equity and promote physical and mental well-being, and conditions that support healthy eating and active living.
2. **Access to Care, Community Resources, and Systems Improvements**, consisting of timely linkage to appropriate care, and resources, referrals, coordination, and connection to community-based services.
3. **Mental Health and Substance Use Disorders**, especially reducing stigma, increasing the reach and coordination of behavioral health services, and addressing the opioid epidemic.

4. **Chronic Condition Prevention and Management**, focusing especially on metabolic diseases such as diabetes, heart disease, and hypertension, and on asthma, cancer, and complex chronic conditions.

To be successful, AHHFMC will continue to partner with local public health departments across Chicago and suburban Cook County to adopt shared and complimentary strategies and leverage resources to improve efficiencies and increase effectiveness for overall improvement. Data sharing across the local public health departments was instrumental in developing this CHNA and will continue to be an important tool for establishing, measuring, and monitoring outcome objectives. The shared leadership model driving the CHNA will be essential to continue to balance the voice of all partners in the process including the hospitals, health departments, stakeholders, and community members.

AHHFMC has developed a Community Health Implementation Plan for the next three years that describes the programs we are undertaking to address these prioritized health needs in our community.

Needs That Will Not Be Addressed

AMITA Health Holy Family Medical Center- Des Plaines will not directly address the following focus areas/priorities identified in the 2019 CHNA:

- Economic Vitality and Workforce Development
- Education and Youth Development
- Housing, Transportation, and Neighborhood Environment
- Violence and Community Safety, Injury, including Violence-related injury
- Trauma-Informed Care
- Maternal and Child Health

The community health needs assessment inevitably identified more significant health needs than the hospitals, health system, and community partners can or should address as priority health needs. While critically important to overall community health, these specific priorities did not meet internally determined criteria that prioritized addressing needs by either continuing or expanding current programs, services, and initiatives to steward resources and achieve the greatest community impact. For these areas not chosen, there are service providers in the community better resourced to address these priorities. AMITA Health Holy Family Medical Center will work collaboratively with these organizations as appropriate to ensure optimal service coordination and utilization.

Summary of Implementation Strategy

An action plan follows for each prioritized need, including the resources, proposed actions, planned collaboration, and anticipated impact of each strategy.

Prioritized Need #1: Social and Structural Determinants of Health – Food Insecurity

GOAL: To provide nutritious easy-to-prepare food to feed elementary District 62 school students for the weekends to bridge the gap from the lunch on Friday until they return to school on Monday.

Action Plan/Intervention: Backpack Ministry

STRATEGY 1: Improve access to food by providing easy-to-prepare meals every weekend for 5 elementary school children and their families during the academic school year.

BACKGROUND INFORMATION:

- **Target Population**: Low-income students and their families who qualify for free or reduced breakfast and lunch attending School District 62 within 60016 and 60018.
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved**: This strategy addresses that there are barriers to, and disparities in the availability and access to food. Nearly 60% of District 62 students qualify for free or reduced lunches. Students attending three of the schools within D62 all qualify for free or reduced breakfast and lunch living in food-insecure homes.
- 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 Chicago and suburban Cook County, with health inequities being even more pronounced than many national trends.
- 17% of children under age 18 living in households that experienced limited or uncertain availability of safe, nutritious food at some point during the year.
- There are more than 13.1 -million children in this country who are at risk of hunger. Poor nutrition can result in a weaker immune system, increased hospitalization, lower IQ, shorter attention spans, and lower academic achievement. Children are fed during the school week by federal government programs, but we want to make sure they're getting nutritional meals over the weekend, too.
- **Strategy source**: This strategy is research and evidenced based as found on the Greater Chicago Food Depository, No Kids Hungry, Feeding America.

RESOURCES:

- AMITA Health
- Program budget

COLLABORATION:

- School District 62
- Cumberland School
- First Congregational United Church of Christ

STRATEGY 1: Improve access to food by providing easy-to-prepare meals every weekend for 5 elementary school children and their families during the academic school year.

ACTIONS:

1. Establish relationship and work directly with school's social worker.
2. Identify 5 students within School Dist. 62 who qualify for both free or reduced breakfast and lunch.
3. Identify food storage area within hospital and create food packing teams.
4. Host volunteer packing events to engage hospital associates.
5. If need is determined to sponsor/assist additional students.
6. To secure additional funding sources if need is determined to assist additional students.
7. Contribute to efforts to reduce stigma with being food insecure.
8. Provide regular updates of program to AHHFMC leadership and Community Leadership Board to increase awareness of and addressing food insecurity within the community

ANTICIPATED IMPACT:

I. **Short term objective (Process Objective):** A minimum of three associate volunteers have been trained to assist with packing and delivery of backpacks.

II. **Medium term objective (Impact Objective):** If need is determined, by the end of the academic school year 2020, there will be an increase of more than 7 families in the weekend Backpack Ministry project.

III. **Long term objective (Outcome Objective):** By 2022, there will be a reduction from 1 in 6 children living in hunger.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1)

Strategy:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2030" (or OTHER NATIONAL PLAN):
Backpack Ministry Program	The percentage of children in poverty is higher for Cook County than IL and US. 50% of enrolled school children in the North region of Cook County are eligible for free or reduced lunches.	Percent of high school students that ate vegetables three or more times per day is 12.7% (IL 2015) In IL, 17.3% of children 18 years and younger live in food insecure homes. In 2015, 14.1% of children in IL participated in the summer meals programs, based on the number of low-income students who qualified for free or reduced-price	Percent of high school students that ate vegetables three or more times per day is 14.8% (National 2015) More than 12 million children in the United States live in "food insecure" homes. That phrase may sound mild, but it means that those households don't have enough food for every family member to lead a healthy life. 1 in 6 children in the United States lives with hunger (No Kid Hungry, n.d.)

	lunch during the school year. (Food Research & Action Center [FRAC])

Prioritized Need #2: Access to Care

GOAL: Improving social, economic, and structural determinants of health while reducing social, racial, and economic inequities.

Action Plan/Intervention: AMITA Health/Aunt Bertha

STRATEGY 1: Launch of AMITA Health Community Resource Directory – a community-wide referral network to improve access and connect users to available social services and resources in their community.

BACKGROUND INFORMATION:

- **Target Population**: Low-income persons uninsured, or underinsured in need of social supports and resources, and organizations providing social services within in 60016 and 60018 and surrounding areas.
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved**: This is a platform, to connect community residents to available social services in their community. Connecting people and programs in searching for free or reduced cost services such as medical care, food, job training, transportation, housing, legal, and more.
- 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 Chicago and suburban Cook County, with health inequities being even more pronounced than many national trends.
- This strategy address health disparities and barriers to social services and promotes health equity by increasing access to resources.
- This strategy is research and evidenced based as found on the Alliance for Health Equity and the Illinois Public Health Institute.

RESOURCES:

- AMITA Health
- AMITA Health Community Engagement Council
- Community based organizations
- Faith based organizations
- Program budget

COLLABORATION:

- Aunt Berta, a Public Benefit Corporation

ACTIONS:

1. AMITA Health partnering with Aunt Bertha to provide the software platform
2. Identify 1-2 internal associates to become trainers.
3. Provide training sessions to identified community-based organizations and faith-based organizations
4. Recruit community programs currently not found in the platform to join the community resource directory.
5. Create and implement a communication plan for residents in the communities we serve to bring awareness of the resource directory and software platform.

ANTICIPATED IMPACT: *(List SMART objectives; ensure specific and measurable outcomes, i.e., change(s) in learning, actions and/or conditions):*

STRATEGY 1: Launch of AMITA Health Community Resource Directory – a community-wide referral network to improve access and connect users to available social services and resources in their community.

I. **Short term objective (Process Objective):** By the end of 2019, there will be at least 25 community-based organizations and faith-based organizations trained to use and refer AMITA Health Community Resource Directory.

II. **Medium term objective (Impact Objective**): By 2020, there will be 10% increase of social service resources in the directory as new referral providers.

III. **Long term objective (Outcome Objective):** By 2022, there will be a 25% increase in the number of referrals directly through the ANITA Health Community Resource Directory.

GOAL: Improving social, economic, and structural determinants of health while reducing social, racial, and economic inequities.

Action Plan/Intervention: New Beginnings Prenatal Program

STRATEGY 2: Provide comprehensive outpatient prenatal services and support to expectant mothers with limited financial resources and to increase the proportion of pregnant women who receive early and adequate prenatal care.

BACKGROUND INFORMATION:

- **Target Population**: Young, uninsured women within 60016 and 60018 with limited access to care and limited financial resources.
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved**: Disparities in access to care and community resources were identified as underlying root causes of many of the health inequities experienced by residents in Cook County. Increasing access to care among uninsured, low-income persons addresses social determinants of health and reduces health disparities and barriers to care that are often experienced by the target population.
- The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy), prenatal (during pregnancy), and interconception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of developmental delays and disabilities and other health conditions among infants can prevent death or disability and enable children to reach their full potential.
- This strategy is research and evidenced based as found on the Healthy People 2030. https://www.healthypeople.gov/search2?query=prenatal+care

RESOURCES:

- AMITA Health
- Program budget

COLLABORATION

- Salvation Army
- City of Des Plaines Department of Health & Human Services
- AllKids
- Maryville Academy
- Walmart

ACTIONS:

1. Evaluate current staff availability for the increased need among patients to access to prenatal care.
2. Identify opportunities for collaborative partnerships and referrals within the community.
3. Increase enrollment of ACA for Medicaid eligible patients.

ANTICIPATED IMPACT:

I. **Short term objective (Process Objective):** Increase the number of referrals to prenatal care for pregnant women with limited financial resources.

STRATEGY 2: Provide comprehensive outpatient prenatal services and support to expectant mothers with limited financial resources and to increase the proportion of pregnant women who receive early and adequate prenatal care.
II. **Medium term objective (Impact Objective):** Increase number of women who have attended the prenatal education classes in 60016 and 60018 Des Plaines. **III. Long term objective (Outcome Objective):** Reduction in low birth weight, and infant mortality in Cook County or Des Plaines community 60016 and 60018

Prioritized Need #3: Mental Health and Substance Use Disorders

GOAL: Improving the Mental Health of the adult population and decreasing substance abuse in NW Cook County (60016, 60018).

Action Plan/Intervention: Mental Health First Aid (MHFA)

STRATEGY 1: Increase awareness of Mental Health conditions and decrease the stigma associated with mental illness by providing access to free Mental Health First Aid trainings.

BACKGROUND INFORMATION:

- **Target Population**: Community-dwelling persons, organizations, and those in public facing jobs within in 60016 and 60018 and surrounding areas.
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved**: Just as CPR training helps a person with no clinical training assist an individual following a heart attack, Mental Health First Aid training helps a person assist someone experiencing a mental health crisis such as contemplating suicide. In both situations, the goal is to help support an individual until appropriate professional help arrives. Mental Health First Aiders learn a single 5-step action plan known as ALGEE, which includes assessing risk, respectfully listening to and supporting the individual in crisis, and identifying appropriate professional help and other support. Participants are also introduced to risk factors and warning signs for mental health or substance use problems, engage in experiential activities that build understanding of the impact of illness on individuals and families, and learn about evidence-supported treatment and self-help strategies
- Mental Health is an important indicator of health outcomes and a serious concern in Chicago and Suburban Cook County. Access to health care and mental health services was chosen by 50% of respondents as an important factor for a healthy community.
- Community mental health issues are exacerbated by long-standing inadequate funding as well as recent cuts to social services, healthcare, and public health.
- This strategy is research and evidenced based found on the National Council for Behavioral Health and Mental Health First Aid USA.
  https://www.thenationalcouncil.org/
  https://www.mentalhealthfirstaid.org/

RESOURCES:

- AMITA Health
- Program budget
- AmeriCorps
- The Kennedy Foundation
- National Alliance on Mental Illness (NAMI)

COLLABORATION:

- Health 360
- Association House
- Trilogy

STRATEGY 1: Increase awareness of Mental Health conditions and decrease the stigma associated with mental illness by providing access to free Mental Health First Aid trainings.

- Linden Oaks

ACTIONS:

1. Provide 3-5 MHFA trainings per year
2. Train and certify 50 people per year
3. Identify existing and new CBO's and FBO's to offer/provide MHFA trainings.
4. Identity venues and local sites for training sessions.
5. Continuous promotion of MHFA training in all community informational exchanges.
6. Coordinate and provide complimentary breakfast and lunch for each training session.
7. Participate as a community partner in local Mental Health collaborative.

ANTICIPATED IMPACT:

Short term objective (Process Objective): By the end of 2019, there will be a least 5 MHFA trainings (adult and/or Youth) in the communities that we serve.

Short term objective (Process Objective): By the end of 2019, there will be a reduction in stigma from < 50% persons that participated in MHFA trainings coordinated by AHHFMC.

Short term objective (Process Objective): Increase in the percentage pf participants who will either agree or strongly agree that they are more confident about recognizing and correcting misconceptions about mental health and mental illness.

Medium term objective (Impact Objective): By 2020, <75% of people that participated in MHFA trainings coordinated by AHHFMC will have an increased knowledge and awareness of Mental Health issues.

Medium term objective (Impact Objective): By 2020, 10% of participants from MHFA trainings coordinated by AHHFMC will have made a referral to mental health resource.

Medium term objective (Impact Objective): Train clinical and non-clinical staff at Amita Health Holy Family Medical Center.

Long term objective (Outcome Objective): Increase in the percentage of participants who can refer individuals to an appropriate resource for mental health and suicide (as measured through pre-and post-test).

Long term objective (Outcome Objective): By 2020, reduce the number of days that Des Plaines adults reported their mental health was not good in the past 30 days.

Long term objective (Outcome Objective: Increase in the percentage of participants will score 90% or above on the Mental Health First Aid course exam.

GOAL: Reduce substance abuse to protect the health, safety, and quality of life for all and provide access to high-quality care, comprehensive, and holistic treatment for substance use.

Action Plan/Intervention: Keys to Recovery

STRATEGY 1: Provide education and outreach efforts to the community regarding substance use and the relationship between substance use and mental health.

BACKGROUND INFORMATION:

- **Target Population**: Uninsured, or underinsured adults in need of social supports and resources.
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved community.** Using alcohol and/or other drugs can cause issues such as health problems, impaired control, and social problems. Social problems can include continuing to use the substance despite negative consequences or placing a higher priority on consuming the substance than other activities and obligations, even to the point that it causes a failure to meet major life responsibilities. The most commonly used substances include (in order) alcohol, marijuana, methamphetamines, opioids, and prescription pills.
- In 2016, an estimated 21.0 million people aged 12 or older needed substance use treatment. This translates to about 1 in 13 people needing treatment. Among young adults aged 18 to 25, however, about 1 in 7 people needed treatment.
- Substance use disorders (SUDs) represent clinically significant impairment caused by the recurrent use of alcohol or other drugs (or both), including health problems, disability, and failure to meet major responsibilities at work, school, or home.
- In 2005, an estimated 22 million American struggles with a drug or alcohol problem. Almost 95 percent of people with substance use problems are considered unaware of their problem. Of those who recognize their problem, 273,000 have made an unsuccessful effort to obtain treatment. These estimate highlight the importance of increasing prevention efforts and improving access to treatment for substance abuse and co-occurring disorders.
- An estimated 8.2 million adults aged 18 or older (3.4 percent of all adults) had both AMI and SUDs in the past year, and 2.6 million adults (1.1 percent of all adults) had co-occurring SMI and SUDs in the past year. About half of the adults with co-occurring AMI and an SUD in the past year did not receive either mental health care or specialty substance use treatment, and about 1 in 3 adults with co-occurring SMI and an SUD did not receive either type of care.
- This strategy is research and evidenced based found on the National Survey on Drug Use and Health (NSDUH).

  https://www.hhs.gov/ash/oah/adolescent-development/substance-use/original-alcohol/index.html

  https://www.niaaa.nih.gov/

  https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse

RESOURCES:

- AMITA Health
- National Alliance on Mental Illness (NAMI)
- National Survey on Drug Use and Health (NSDUH)

COLLABORATION:

- MaineStay Youth and Family Service

STRATEGY 1: Provide education and outreach efforts to the community regarding substance use and the relationship between substance use and mental health.

- Des Plaines Police Department
- Park Ridge Police Department
- Niles Township

ACTIONS:

1. Host seminars, presentations, education, and outreach for the community, with an emphasis on decreasing stigma on substance use and increasing hope.
2. Host seminars, provide education, and outreach for the community about substance use.
3. Continue to offer the Family Program for families of those with substance use disorders.
4. Continue to offer Alcoholics Anonymous 12 step program for individuals and families of those with substance use disorders.
5. Provide education and outreach efforts to the community about the relationship between substance use and mental health.
6. Placement of drug collection boxes at Des Plaines Police Department and Park Ridge Police Department.

ANTICIPATED IMPACT:

Short term objective (Process Objective): Increase the number of seminars, presentations, other outreach efforts provided in the community.

Short term objective (Process Objective): By the end of 2020 create and implement 1-2 new sustainable alcohol prevention programs with local partner MYCAF (Maine Community Youth Assistance Foundation).

Short term objective (Process Objective): Integrate mental health treatment into all substance use treatment services.

Medium term objective (Impact Objective): Educate the community about substance use, empower them to recognize problems as they arise and seek treatment proactively.

Long term objective (Outcome Objective): KTR clinical staff to serve as subject matter experts and thought leaders on the issue of substance use.

Long term objective (Outcome Objective): Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for substance use problems in the past year.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #2)

STRATEGY:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2030" (or OTHER NATIONAL PLAN):
Keys to Recovery	In our CHNA, the community identified the top two things needed for a healthy community: access to health		HP 2030: Access to comprehensive, quality health care services is important for promoting and maintaining health,

	care and mental health services as well as access to community services.		preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans.
			HP 2030: Preventing alcohol and tobacco use among youth. Tobacco use is a global epidemic among young people. As with adults, it poses a serious health threat to youth and young adults in the United States and has significant implications for this nation's public and economic health in the future. The impact of cigarette smoking and other tobacco use on chronic disease, which accounts for 75% of American spending on health care.
Mental Health First Aid (MHFA)	According to the County Health Rankings, residents of Cook County reported 3.6 poor mental health days compared to Illinois that had 3.5 days and nationally at 3.1 days.	In IL, the suicide death rate (2015) is at 10.3% compared to 13.3 nationally	Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. In any given year, an estimated 18.1% (43.6 million) of U.S. adults ages 18 years or older suffered from any mental illness and 4.2% (9.8 million) suffered from a seriously debilitating mental illness. Neuropsychiatric disorders are the leading cause of disability in the United States, accounting for 18.7% of all years of life lost to disability and premature mortality. Suicide is the 10th leading cause of death in the United States, accounting for the deaths of approximately 43,000 Americans in 2014 HP 2020: MHMD-9 Increase the proportion of adults with mental health disorders who receive treatment