AMITA Health Saints Mary and Elizabeth Medical Center
Implementation Strategy
FY2020-2022

Implementation Strategy Narrative

Overview

AMITA Health Saints Mary & Elizabeth Medical Center Chicago

AMITA Health Saints Mary and Elizabeth Medical Center (AHSMEMCC) is an award-winning medical center on Chicago's near northwest side that has been meeting the health needs of Belmont-Cragin, Hermosa, Humboldt Park, Logan Square and West Town residents for over 100 years. Founded by the Poor Handmaids of Jesus Christ, AHSMEMC continues to carry out its mission of providing “compassionate, holistic care with a spirit of healing and hope in the communities it serves.”

Alliance for Health Equity

In 2018 and 2019, AMITA Health Saints Mary & Elizabeth Medical Center Chicago 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. The link to our Collaborative Community Health Needs Assessment for Chicago and Suburban Cook County can be found at allhealthequity.org/2019-chna-reports/. This cover document for that CHNA provides more information about the service area of AHSMEMC, its existing programs, and its specific needs within the context of the needs identified and prioritized in its service area.

This plan was adopted in October 2019.

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, AHSMEMCC will continue to partner with local public health departments across Chicago 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.

AHSMEMCC 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 Saints Mary and Elizabeth Medical Center Chicago 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 Saints Mary and Elizabeth Medical Center Chicago will work collaboratively with these organizations as appropriate to ensure optimal service coordination and utilization.

Summary of Implementation Strategy

- **Social and Structural Determinants of Health**

  Strategy 1: To increase the consumption of and access to regionally produced fruits and vegetables to the community by increasing usage and expanding the West Town Health Market.
  Resources & Collaboration: Community Based Organization, Faith Based Organizations, Local Businesses/Owners; grant funds; Greater Chicago Food Depository; Greater West Town Community Development; West Town Bikes
  Anticipated Impact: Increase in the availability of and access to fruits and vegetables among low income populations.

- **Access to Care Community Resources and Systems Improvements**

  Strategy 1: Aunt Bertha (Search & Connect): Connecting people in need with the programs that serve them with dignity and ease. Through this public directory providers, staff, the public and community partners are able to search a vetted and updated directory of social services on our website, connecting to (i.e. food, housing, transportation, health, etc.). This directory provides a need based customized list of services for patients and provide the hospitals with various reports related to the needs. Additionally, the tool helps to address the social and structural determinants of health such as poverty, access to community resources, education and housing that are underlying root causes of health inequities.

  Resources & Collaboration: AMITA Health Community Resource Directory; Aunt Bertha, Community Based Organization, Faith Based Organizations, Front Line Associates

  Anticipated Impact: Increase the number of direct referrals between patients and community organizations to reduce patient/community social determinants of health.

- **Mental Health and Substance Use Disorders**

  Strategy 1: Mental Health First Aid: In response to a demonstrated system and state-wide need of addressing barriers to accessing and utilizing mental health services, AMITA Health Saints Mary and Elizabeth Medical Center Chicago and its community partners implemented an evidence-based program, Mental Health First Aid (MHFA), to reduce the stigma associated with mental illness and improve the coordination of mental health care throughout a six county service area. MHFA trains community residents and first responders to recognize, respond, and seek assistance for signs of mental illness and substance abuse.
  Resources & Collaboration: AmeriCorps, Community-based organizations (CBOs), Faith-based organizations (FBOs), First responders/law enforcement, Mental Health First Aid USA, Trilogy
  Anticipated Impact: A reduction in self-reporter poor mental health days as a result of greater identification of those in need of help.

- **Chronic Condition Prevention and Management**

  Strategy 1: The CANDO Camp is a three-week program that targets children (ages 11-14) to teach them how to live healthier lifestyles. The following topics are covered in the program: obesity, health and nutrition, abstinence, bullying and education.

  Resources & Collaboration: Local schools; SMEMC educator staff; grant funds;

  Anticipated Impact: Reduction in obesity among local youth ages 11-14.

  Strategy 2: Provide a **Diabetes Prevention Program (DPP)** for those at risk and those who have pre-diabetes to prevent the onset of type II diabetes.

Resources & Collaboration: Community-based organizations (CBOs); Faith-based organizations (FBOs); Touchpoint; Nursing Education

Anticipated Impact: Reduction in the prevalence of adult diabetes.

Prioritized Need #1: Social and Structural Determinants of Health

GOAL: Increasing access to care and community resources to reduce social and structural determinants of health.

STRATEGY 1: To increase the consumption of and access to regionally produced fruits and vegetables to the community by increasing usage and expanding the West Town Health Market.

BACKGROUND INFORMATION:

- **Target population:** Low-income and underserved population in the communities we serve.
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved:** The market aims to increase the consumption of fresh fruits and vegetables to SNAP (Supplemental Nutrition Assistance Program) recipients by doubling the value of their SNAP dollars with local produce vendors.
- **Strategy source:** https://snaped.fns.usda.gov/library/materials/douple-national-network

RESOURCES:

https://snapedtoolkit.org/framework/index/

COLLABORATION:

- Community-based organizations (CBOs)
- Faith-based organizations (FBOs)
- Local Businesses/Owners; grant funds
- Greater Chicago Food Depository
- Greater West Town Community Development
- West Town Bikes
- Grant funding

ACTIONS:

1. Continue provision of weekly market format during the peak growing season (May-November).
2. Expand the provision of the Nutrition Rx program in conjunction with the market prior to each market season.
3. Continue community-based Food Buck program.
4. Begin offering 3-for-1 SNAP dollar matching on all LINK transactions.

ANTICIPATED IMPACT/OBJECTIVES:

STRATEGY 1: To increase the consumption of and access to regionally produced fruits and vegetables to the community by increasing usage and expanding the West Town Health Market.
III. Short term objective (Process Objective): Increase the number of Nutrition Rx participants by 5%. **II. Medium term objective (Impact Objective):** Increase the redemption percentage of Nutrition Rx to 75% or greater. **III. Long term objective (Outcome Objective):** Increase the number of LINK (SNAP) transactions each season by 5%.

Alignment with Local, State & National Priorities

(Long-Term Outcomes for Prioritized Need #1)

STRATEGY:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	NATIONAL PLAN:
West Town Health Market	In our CHNA, the estimated number of adults (18 years and older) who reported eating five or more servings of fruits and vegetables (combined) daily was only 18-30%.	Percent of adults that consume vegetables less than one time per day in is 24.3% (IL 2015)	Percent of adults that consume vegetables less than one time per day is 22.3% (National 2015) HP 2020: NWS-13 Reduce household food insecurity and in doing so reduce hunger

Prioritized Need #2: Access to Care, Community Resources and Systems Improvements

GOAL: Increasing access to care and community resources to reduce social and structural determinants of health.

STRATEGY 1: Improve access by referring social service organizations to the underserved and most vulnerable in the communities that we serve from the **AMITA Health Community Resource Directory (formerly Aunt Bertha).**

BACKGROUND INFORMATION:

- **Target population:** Low-income and underserved population in the communities we serve
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved:** This is a community-wide software 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. In our CHNA, the community identified the top two things needed for a healthy community: access to health care and mental health services as well as access to community services.
- **Strategy source:** AMITA Health Community Resource Directory www.amitahealth.org/patient-resources/community-resources

RESOURCES:

- AMITA Health Community Resource Directory www.amitahealth.org/patient-resources/community-resources

COLLABORATION:

- Aunt Bertha
- Community-based organizations (CBOs)
- Faith-based organizations (FBOs)
- Front Line Associates

ACTIONS:

5. AMITA Health partnering with Aunt Bertha to provide the software platform
6. Internal associates identified to become train the trainers and training session provided
7. Training sessions provided to our community-based organizations and faith-based organizations
8. Programs not found in the platform are entered under “Suggest a Program”
9. Create and implement a communication plan for residents in the communities we serve

ANTICIPATED IMPACT/OBJECTIVES:

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

II. Medium term objective (Impact Objective): By 2020, there will be at least 10,000 social service resources in the directory to assist the low-income residents of the communities that we serve.

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

(Long-Term Outcomes for Prioritized Need #2)

STRATEGY:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	NATIONAL PLAN:
AMITA Health Community Resource Directory	In our CHNA, the community identified the top two things needed for a healthy community: access to health care and mental health services as well as access to community services.		HP 2030: AHS-2030-05 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care AHS-2030-07 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary prescription medicines SDOH-2030-03 Reduce the proportion of persons living in poverty

Prioritized Need #3: Mental Health and Substance Use Disorders

GOAL: Improving mental health and decreasing substance abuse.

STRATEGY 1: Provide the Mental Health First Aid (MHFA) trainings to the communities that we serve

BACKGROUND INFORMATION:

- **Target population:** The faith-based organizations, school, and those who are interested in the MHFA trainings
- **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
- **Strategy source:** Mental Health First Aid USA https://www.mentalhealthfirstaid.org/

RESOURCES:

- Mental Health First Aid USA https://www.mentalhealthfirstaid.org/

COLLABORATION:

- AmeriCorps
- Community-based organizations (CBOs)
- Faith-based organizations (FBOs)
- First Responders/Law Enforcement
- Mental Health First Aid USA
- Trilogy

ACTIONS:

1. Identify CBOs and FBOs to have the MHFA trainings
2. Identify the dates and locations of the trainings
3. Confirm with our collaborative partners for the lead instructor
4. Order the continental breakfast and lunch for all the participants
5. Train at least 10 participants per session
6. Follow-up with each participant after training completed

ANTICIPATED IMPACT/OBJECTIVES:

III. **Short term objective (Process Objective):** By the end of 2019, there will be at least 2 MHFA (Youth and/or Adult) trainings in the communities that we serve.

II. Medium term objective (Impact Objective): By 2020, 50% of the participants will have made a referral for someone to a mental health resource.

III. Long term objective (Outcome Objective): By 2022, there will be a reduction in the number of poor mental health days reported by the communities that we serve.

Alignment with Local, State & National Priorities

(Long-Term Outcomes for Prioritized Need #3)

STRATEGY:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	NATIONAL PLAN:
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	According to the National Behavioral Health Council, more than 2 million individuals have been trained in Mental Health First Aid (MHFA). Additional funding to ensure MHFA training is available to police officers, teachers and other critical audiences in every community is critical. 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 HP2030: MHMD-2030-01 Reduce the suicide rate MHMD-2030-03 Increase the proportion of children with

	mental health problems who receive treatment MHMD-2030-04 Increase the proportion of adults with serious mental illness (SMI) who receive treatment

Prioritized Need #3: Chronic Condition Prevention and Management

GOAL: Reduce childhood obesity among youth ages 11-14 years.

STRATEGY 1: Provide the CANDO Camp to children (ages) to teach them how to live healthier lifestyles using the following topics: obesity, health and nutrition, abstinence, bullying and education.

BACKGROUND INFORMATION:

- **Target population:** Students 6th-8th grade within primary and secondary hospital service area.
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved:** The areas surrounding the hospital campus, notably going further west, are more socially economically disadvantaged students. Outreach for participation into this program is targeted to schools in those areas. The children are educated on the importance of maintaining healthy lifestyle habits. Sessions include the importance of making healthy food choices, puberty, abstinence from self-destructive behaviors, self-esteem development, positive behavior modifications, physical activity and diabetes awareness classes. Classes are taught by youth leaders, nurses and an exercise physiologist. The program aims to educate high risk children and their families on key health indicators that they should monitor such as BMI and ultimately understand the significance of how a healthy diet and regular physical activity correlate to screening results.
- **Strategy source: CANDO Camp Information & Video**

http://www.pages03.net/ascensioninformationservices/ANBriefAugust2019/CANDO_Camp/?spMailingID=40423947&spUserID=ODU2MTI0NjU5NTE0S0&spJobID=1581301576&spReportId=MTU4MTMwMTU3NgS2

RESOURCES:

- https://stateofchildhoodobesity.org

COLLABORATION:

- Local schools (schools within our primary and secondary hospital service areas are targeted, but no student who wants to attend is turned away).
- SMEMC Educators, dieticians, contractual speakers and exercise physiologist
- Grant funding (White Sox Charity and Fogelson Foundation, Brach, Blue Cross Blue Shield, the Washington Square Foundation have been previous funders.)
- Community Health Education Department and staff.

STRATEGY 1: Provide the CANDO Camp to children (ages) to teach them how to live healthier lifestyles using the following topics: obesity, health and nutrition, abstinence, bullying and education.

ACTIONS:

1. Recruit new participants throughout the school year as we host in school CANDO programs and as we conduct various parent groups.
2. Maintain enrollment of 40 students enrolled each summer.
3. Evaluate program objectives at the conclusion of each summer.
4. Ensure budget and grant funding are secure for each summer.

ANTICIPATED IMPACT/OBJECTIVES:

III. **Short term objective (Process Objective):** 80% completion rate of students enrolled int eh camp each summer.

II. Medium term objective (Impact Objective): 85% percent or more of the students will demonstrate an increase of knowledge of nutrition and physical activity. 75% will lower or maintain their BMI.

III. Long term objective (Outcome Objective): Enrollment should include 50% of returning students each summer. 80% contractual speakers would be previous CANDO graduates creating mentorship in the community.

Prioritized Need #3: Chronic Condition Prevention and Management

GOAL: Reduce diabetes in at-risk adults.

STRATEGY 2: Provide a **Diabetes Prevention Program (DPP)** for those at risk and those who have pre-diabetes to prevent the onset of type II diabetes.

BACKGROUND INFORMATION:

- **Target population:** Individuals identified with the risk factors for pre-diabetes or those who are in need of an intervention to prevent the onset of diabetes and for those who have been diagnosed with pre-diabetes
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved:** According to the Centers for Disease Control and Prevention (CDC), an astounding 1 in 3 adults have prediabetes and 9 out of 10 adults do not know that they have pre-diabetes. In Illinois, approximately 1.3 million (12.5% of the population) adults have diabetes, but roughly 341,000 of those don't know they have diabetes. It is estimated that 84 million Americans have prediabetes, of which 3.6 million live in Illinois. Diabetes is the seventh leading cause of death nationally and in Illinois. By making healthy lifestyle changes, an individual can cut their chance of getting type 2 diabetes by 50%.
- **Strategy source**: Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program is an evidence based program: https://www.cdc.gov/diabetes/prevention/index.html

RESOURCES:

- Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program is an evidence based program: https://www.cdc.gov/diabetes/prevention/index.html
- National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) https://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp

COLLABORATION:

- Community-based organizations (CBOs)
- Faith-based organizations (FBOs)
- Touchpoint

ACTIONS:

1. Identify those with the risk factors for pre-diabetes and those with pre-diabetes
2. Schedule a pre-assessment with our Certified Diabetes Educator (CDE)
3. Provide one-on-one initial assessments will be scheduled with our CDE and our Registered Dietician (RD) which includes A1c, Lipid Panel, BP, BMI, weight, diet diary, and knowledge survey.
4. Provide five (5) diabetes prevention education classes which include nutrition counseling, information on exercise, problem solving, other lifestyle modifications, and how to monitor one's health.
5. Provide post-assessment which includes A1c, Lipid Panel, BP, BMI, weight, diet diary, and knowledge survey
6. Conduct follow-ups at 3-month, 6-month, and annually
7. Provide a monthly support group after completion of the program

STRATEGY 2: Provide a **Diabetes Prevention Program (DPP)** for those at risk and those who have pre-diabetes to prevent the onset of type II diabetes.
ANTICIPATED IMPACT/OBJECTIVES: III. **Short term objective (Process Objective):** By the end of May 2020, there will be at least 200 individuals assessed for the Diabetes Prevention Program. **II. Medium term objective (Impact Objective):** By the end of the program, at least 50% will have an improvement in their health indicators which includes A1c, Lipid Panel, BP, BMI, weight, or knowledge survey**.** **III. Long term objective (Outcome Objective):** By 2022, there will be a 10% reduction of the individuals diagnosed with pre-diabetes in Chicago.

Alignment with Local, State & National Priorities

(Long-Term Outcomes for Prioritized Need #4)

STRATEGY:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	NATIONAL PLAN:
CANDO Camp	Self-reported risk factors for adolescents (2017) in Chicago include 50% did not each vegetables at least once per day; 76% did not eat breakfast all 7 days per week; 81% were not physically active for at least 60 minutes all 7 days per week; 18% report obesity.		PA-2030-05 Increase the proportion of adolescent who meet the current aerobic physical activity guideline. NWS-2030—03 Reduce the proportion of children and adolescents aged 2-19 years who have obesity. AH-2030-07 Increase the proportion of students participating int eh School Breakfast Program.

Diabetic Prevention Program	65% of deaths in Chicago were due to chronic diseases. Diabetes is a leading cause of death.	In Illinois, approximately 1.3 million (12.5% of the population) adults have diabetes, but roughly 341,000 of those don't know they have diabetes. It is estimated that 3.6 million have pre-diabetes. Diabetes is the seventh leading cause of death in Illinois.	National Diabetes Statistics Report, 2017: - Total: 84.1 million adults aged 18 years or older have prediabetes (33.9% of the adult US population) - 65 years or older: 23.1 million adults aged 65 years or older have prediabetes HP 2030: D-2030-09: Reduce the proportion of adults with undiagnosed prediabetes HP 2020:D-16 Increase prevention behaviors in persons at high risk for diabetes with prediabetes D-16.1 Increase the proportion of persons at high risk for diabetes with prediabetes who report increasing their levels of physical activity D-16.2 Increase the proportion of persons at high risk for diabetes with prediabetes who report trying to lose weight D-16.3 Increase the proportion of persons at high risk for diabetes with prediabetes who report reducing the amount of fat or calories in their diet