AMITA Health Saint Francis Hospital Implementation Strategy FY2020-2022

Implementation Strategy Narrative

Overview

AMITA Health Saint Francis Hospital Evanston

AMITA Health Saint Francis Hospital Evanston (AHSFHE) is a 215-bed, full service medical facility that provides high-quality, compassionate and family-centered medical cate to residents of Edison Park, Rogers Park, Evanston and the surrounding communities. The hospital is a recognized leader in cardiac and Level 1 emergency trauma services. AHSFHE was also awarded the Magnet Nursing Designation by the American Nurses Credentialing Center, the U.S. News and World Report Best Hospital, Metro Chicago and the Joint Commission Certified Primary Stroke Center and Chest Pain Center.

Alliance for Health Equity

In 2018 and 2019, AMITA Health Saint Francis Hospital Evanston 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, AHSFHE 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.

AHSFHE 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 Saint Francis Hospital Evanston 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 Saint Francis Hospital Evanston 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; 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 Saint Francis Hospital Evanston 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.
  Strategy 2: Trilogy Program Linkage Program: An embedded mental health worker provides instant referrals and case management of patients or community members who present to AHSFHE needing connection to mental health or other social services.
  Resources & Collaboration: Trilogy, Case management, Emergency Department associates; physicians, grant funding, Community-based organizations (CBOs).
  Anticipated Impact: A reduction in the persons in a mental health crisis.

- **Chronic Condition Prevention and Management**

  Strategy: Diabetic Programs (Self-Management & Prevention): In response to continued need to reduce the number of individuals with Type II diabetes as well as to lower the hospitalization rate of those diagnosed with Type II diabetes, AMITA Health is committed to providing additional programing for diabetic programming in the community.

  Resources & Collaboration: Community-based organizations (CBOs), Faith-based organizations (FBOs), TouchPoint, YMCAs

  Anticipated Impact: Reduction in the prevalence of adult diabetes.

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Prioritized Need #1: Social and Structural Determinants of Health; 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:

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

ANTICIPATED IMPACT/OBJECTIVES:

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.

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).**
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. **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**.**

Alignment with Local, State & National Priorities

(Long-Term Outcomes for Prioritized Need #1)

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

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Prioritized Need #2: 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:

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

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.

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

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.

STRATEGY 2: An embedded mental health worker provides instant referrals and case management of patients or community members who present to AHSFHE needing connection to mental health or other social services.

BACKGROUND INFORMATION:

- **Target population:** Community members and patients in the primary service area of the hospital in need of connection to mental heath services and treatment as well as social service needs.
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved:** The community mental health worker will connect persons to treatment and programs 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:** https://mhpsalud.org/community-health-workers-improve-mental-health-outcomes/

RESOURCES:

- https://mhpsalud.org/community-health-workers-improve-mental-health-outcomes/
- Grant funding

COLLABORATION:

- Community-based organizations (CBOs)
- Faith-based organizations (FBOs)
- Trilogy
- Case Management
- Emergency Department
- Physicians

ACTIONS:

1. Expand associate education (nursing, case management, physicians) on the role and services of the Trilogy mental health worker.
2. Track process measures & outcomes from the mental health worker.
3. Apply for additional funding to expand hours of service.

STRATEGY 2: An embedded mental health worker provides instant referrals and case management of patients or community members who present to AHSFHE needing connection to mental health or other social services.
4. Continue & expand relations with community-based organizations to provide direct referrals of community members and patients in need. 5. With additional funding, expand program to in-patient units of hospital.
ANTICIPATED IMPACT/OBJECTIVES: **Short term objective (Process Objective):** **Medium term objective (Impact Objective):** **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 #2)

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
Trilogy Linkage Program	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. Emergency Department visits for mental health in the hospital's primary service area range from 75.1 visits to 661.0 visits per 10,000.	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

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Prioritized Need #3: Chronic Condition Prevention and Management

GOAL: Preventing and reducing chronic conditions, with a focus on risk factors.

STRATEGY 1: Provide a **Diabetes Prevention Program (DPP)** or **Diabetic Self-Management Program (DSMP)** Program for those at risk, those with pre-diabetes and those with 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 as well as those who are routinely hospitalized for uncontrolled Type II 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 do not know they have diabetes, which can lead to high hospitalization. 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; Center for Disease Control and Prevention (CDC) Diabetic Self-Management Program Stanford University developed course:https://www.cdc.gov/learnmorefeelbetter/programs/diabetes.htm

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
- Center for Disease Control and Prevention (CDC) Diabetic Self-Management Program Stanford University developed course:https://www.cdc.gov/learnmorefeelbetter/programs/diabetes.htm
- 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
- YMCAs

ACTIONS:

1. Identify those with the risk factors for pre-diabetes, those with pre-diabetes and/or those with hospitalizations for uncontrolled diabetes.
2. Schedule a pre-assessment with Certified Diabetes Educator (CDE) or outpatient dietitians.
3. Provide one-on-one initial assessments will be scheduled with our CDE and our Registered

STRATEGY 1: Provide a **Diabetes Prevention Program (DPP)** or **Diabetic Self-Management Program (DSMP)** Program for those at risk, those with pre-diabetes and those with type II diabetes.

4. Enrolment in designated program depending on patient/community member need (s).
5. Conduct follow-ups at 3-month, 6-month, and annually
6. Provide a monthly support group after completion of the program

ANTICIPATED IMPACT/OBJECTIVES:
I. Short term objective (Process Objective): By the end of May 2020, there will be at least 200 individuals assessed for the Diabetes Prevention Program or Diabetic Self-Management 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 service area; by 2022 there will be 5% reduction in hospitalizations for uncontrolled diabetes.

Alignment with Local, State & National Priorities

(Long-Term Outcomes for Prioritized Need #3)

Strategy:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	NATIONAL PLAN:
Diabetes Prevention Program (DPP) or Diabetic Self-Management Program (DSMP)	Diabetes is a leading cause of death in Suburban Cook County as identified on the CHNA.	Diabetes is the seventh leading cause of death in Illinois. In Illinois, approximately 1.3 million (12.5% of the population) adults have diabetes, but roughly 341,000 of those do not know they have diabetes, which can lead to high hospitalization.	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 HP2030: D-2030-01 Reduce the annual number of new cases of diagnosed diabetes in the population

	D-2030-08 Increase the proportion of persons with diagnosed diabetes who ever receive formal diabetes education