St. Vincent Dunn Implementation Strategy

Overview

St. Vincent Dunn is a critical access hospital that has been serving Lawrence County for over 100 years. As a nonprofit hospital, and part of St. Vincent Health, St. Vincent Dunn is dedicated to improving the health of Lawrence County residents, with special attention to the poor and vulnerable. St. Vincent Dunn Hospital is located in Southern Indiana and serves Lawrence County and surrounding areas. St. Vincent contracted Healthy Communities Institute (HCI) to help facilitate their system-wide Community Health Needs Assessment (CHNA) work and document all efforts into the 2016 reports for each hospital (http://www.stvincent.org/chna).

Community Health Needs Assessment (CHNA)

To identify community health needs, secondary data was obtained and analyzed by HCI. Indicator values for Lawrence County were compared to other counties in Indiana and nationwide to score health topics and compare relative areas of need. Other considerations for health areas of need included trends over time, Healthy People 2020 targets, and disparities by gender and race/ethnicity. The needs assessment was further informed by interviews with community members who have a fundamental understanding of Lawrence County's health needs and represent the broad interests of the community. Five key informants provided valuable input on the county's health challenges, the sub-populations most in need, and existing resources for county residents.

Prioritized Needs

Following input from, and in collaboration with each local hospital's Community Health Improvement team, the St. Vincent Community Development & Health Improvement Team identified three System-wide Health Improvement Priorities (SWHIPs) by utilizing the results of the 2016 CHNA Reports and following a three step process:

1. Stratified the top 5 health priorities by each hospital
2. Found the sum of each health priority
3. Ranked the health priorities by sum from greatest to least

The St. Vincent FY 2017-2019 Implementation Strategy specifically addresses the following three SWHIPs:

- Access to Health Services
- Exercise, Nutrition & Weight
- Behavioral Health

Ascension and St. Vincent System Initiatives

To meet the Ascension initiative, *Call to Action: Healthcare That Leaves No One Behind*, for FYs 2017-2019, hospitals will address and report on the first two health priorities: Access to Health Services and Exercise, Nutrition, & Weight. To meet the St. Vincent system initiative, hospitals will address and report on the third System-wide Health Improvement Priority, Behavioral Health.

Needs That Will Not Be Addressed

The hospital is committed to improving community health by directly, and indirectly, addressing prioritized health needs. However, certain factors impact the hospital's ability to fully address all priorities health needs. The needs listed below are not included in the hospital's implementation strategy plan for the following reasons:

Diabetes - This identified health need is not being monitored and evaluated in the Implementation Strategy due to limitations within the hospital's financials and human resources. However, St. Vincent Dunn does offer diabetes self-management education and a diabetes support group which focuses on this issue.

Maternal, Fetal & Infant Health - This issue is being addressed in the Access to Health Services priority.

Action Plan for Each Priority Area (following pages)

An implementation plan follows for each priority area, including the resources, proposed actions, planned collaboration, and anticipated impact of the actions. The 2016 CHNA Report and Implementation Strategy reports were adopted by the hospital's board on June 15, 2016.

For comments or questions about the 2016 CHNA Reports or Implementation Strategy, please contact St. Vincent Community Development & Health Improvement: **CommunityDevelopment@stvincent.org**

Prioritized Need #1: Access to Health Services (HP2020, AHS-1.1)

GOAL: Increase the proportion of persons with medical insurance.

Action Plan

STRATEGY 1: Educate people who do not have insurance about available insurance options then assist with the application and submission processes.

BACKGROUND INFORMATION:

- **Target population:** Individuals who do not have health insurance.
- **Social determinants of health, health disparities and challenges of the underserved**: The Pathways Navigation Tool addresses social determinants of health as possible barriers to obtaining health insurance.
- **Strategy source:** Evidence-based strategy

RESOURCES:

Resources include a part-time Health Access Worker (HAW), North Lawrence and Mitchell Community Schools, Lawrence County Fair, Persimmon Festival, and Lawrence County Service Providers. The RUAH Program uses the Pathways Model to track interventions and documents via the eCap (data tracking software).

COLLABORATION:

Family Social Services Administration (FSSA) is the collaborating organization for this priority need.

ACTIONS:

1. HAW assesses for eligibility and educates individuals about coverage options.
2. HAW submits application and works through any issues or delays.
3. HAW verifies eligibility in order to complete the Pathway.

ANTICIPATED IMPACT:

The hospital/ministry will use the RUAH Pathway Program to establish a baseline target value (i.e., number of FSSA verified pathways) at the end of FY 2017. The hospital/ministry will increase its reported number of completed pathways in FY 2017 by 5% each year for FY 2018-2019. Achieving this goal will contribute to the percentage of people who have health insurance in Lawrence County.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLANS:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
#1	Lawrence County baseline=82.82% insured persons in 2013 (Source: www.stvincent.org/chna)	HIP 2.0, CHIP	HP2020 baseline=83.2% insured persons in 2008; target=100% insured persons in 2020

Prioritized Need #2: Nutrition and Weight Status (HP2020, NWS-13)

GOAL: Reduce food insecurity and in doing so reduce hunger.

Action Plan

STRATEGY 1: Provide a weekend food source to families by giving a child (family member) a backpack of nutritious food.

BACKGROUND INFORMATION:

- **Target population:** Eligibility can be based on one or more of the following criteria: (1) child enrolled at partnering school, (2) student receives free or reduced cost lunch, (3) referred by school staff
- **Social determinants of health, health disparities and challenges of the underserved:** The program addresses social determinants of health as possible barriers to being able to readily obtain nutritious food at all times in socially acceptable ways (e.g., without stealing or scavenging).
- **Strategy source:** Good idea

RESOURCES:

Resources to address this priority need include: Schools, food banks/pantries, St. Vincent funds contributed by individual hospitals, St. Vincent Associate at individual hospitals (time/talent), St. Vincent Community Development & Health Improvement (CDHI), CDC, USDA Economic Research Service, and the Hunger Free Colorado Toolkit.

COLLABORATION:

Collaborating organizations/staff for this priority need include schools, food sources, and St. Vincent Community Development & Health Improvement.

ACTIONS:

1. Complete the Weekend Feeding Program Preparation Checklist.
2. Meet with all stakeholders to determine program logistics.
3. Plan the specifics of your program's protocol.
4. Make final preparations for the program's "go live" date in FY 2018.
5. Distribute and collect surveys, enter survey data into software at the beginning and end of the school year (twice a year in FY 2018 and FY 2019).

ANTICIPATED IMPACT:

Each hospital/ministry will partner with a school and a food source to provide eligible students with a weekend backpack of nutritious food throughout the school year in order to reduce the school's number of families in FY 2018 who are food insecure (based on survey responses) by 5% at the end of FY 2019 (June 30, 2019). (NOTE: FY 2017 is the planning year for the program.)

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLANS:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
#1	*Placeholder* (updated after the *Checklist* is completed by the hospital)	Supplemental Nutrition Assistance Program (SNAP) and the Indiana Women, Infants, and Children (WIC) Nutrition Program	HP2020 baseline=14.6% of households were food insecure in 2008; target=6% in 2020

Prioritized Need #3: Tobacco Use (HP2020, TU-9)

GOAL: Increase tobacco screening in health care settings.

Action Plan

STRATEGY 1: Enhance existing state cessation systems by offering anyone who works in a health care setting Rx for Change training, which provides education about tobacco screening and referring to the Indiana Tobacco Quitline, at no charge.

BACKGROUND INFORMATION:

- **Target population:** Anyone who works with patients in a health care setting.
- **Social determinants of health, health disparities and challenges of the underserved:** The Rx for Change training indirectly addresses social determinants of health because it equips anyone who works in a health care setting with education and resources to help people quit smoking, which includes people who are underserved and/or have health disparities.
- **Strategy source:** Evidence-based

RESOURCES:

Resources for Rx for Change include in-person "Train the Trainer" sessions, free educational material and online refresher course training. Participant data will be entered into an online data system (developed by Ascension Information Services). The local library or community center can be used to hold the trainings. St. Vincent Communications and Marketing can assist with developing a promotion strategy.

COLLABORATION:

Collaborating organizations/staff for this priority need include the hospital/ministry, Rx for Change trained SV Associates, location that trainings are held, and St. Vincent Communications & Marketing Department.

ACTIONS:

1. Complete the Provider Training Checklist – Action Step #1.
2. Plan at least two Rx for Change trainings in your community in FY 2018 and ensure continuing education credits are available, if applicable (See Provider Training Checklist – Action Step #2).
3. Develop a strategy to promote trainings to the community.
4. Promote and offer at least two Rx for Change trainings at no charge to your community in FY 2018.
5. Enter FY 2018 baseline survey data into database within two weeks of each training.
6. For FY 2019 – Repeat Action Steps #2-4 to plan, develop, and promote and offer at least two Rx for Change trainings at no charge to your community in FY 2019.
7. Enter FY 2019 baseline survey data into database within two weeks of each training.

ANTICIPATED IMPACT:

The hospital/ministry will offer Rx for Change training at no charge to anyone who works in a health care setting to increase the proportion of training participants who screen and refer to the Indiana Tobacco Quitline by 10% by the end of FY 2019 (June 30, 2019). Achieving this goal will contribute to the percentage of tobacco users who have been screened and referred to the Indiana Tobacco Quitline.

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
#1	*Placeholder* (updated after the *Checklist* is completed by the hospital)	Indiana Quit Now (1.800.QUIT.NOW)	Increase tobacco screenings in health care settings by 10% (NOTE: Settings have different target goals, ranging from 54.8% - 68.6%, but the same goal of a 10% increase in screening)