AMITA HEALTH®

In sickness and in health™

IMPLEMENTATION STRATEGY PLAN
FY 2017 - 2019

AMITA HEALTH ST. ALEXIUS MEDICAL CENTER
HOFFMAN ESTATES, IL

CONTENT OUTLINE

Executive Summary

Mission

Demographics & Methodology

Priority Issues

Implementation Plan

Contact Information

EXECUTIVE SUMMARY

The AMITA Health St. Alexius Medical Center assessment was conducted by the Professional Research Consultants, Inc. in cooperation with MCHC and other partnering hospitals. It incorporates data from both quantitative and qualitative sources. The goals of the assessment were to:

- Engage public health and community stakeholders including low-income, minority and other underserved populations
- Assess and understand the community's health issues and needs
- Understand the health behaviors, risk factors and social determinants that impact health
- Identify community resources and collaborate with community partners
- Make the Community Health Needs Assessment widely available
- Use Assessment findings to develop and implement a 2017 – 2019 Community Health Plan (implementation strategy) based on the Hospital's prioritized issues

The information in this presentation is not exhaustive or conclusive, rather an overview of the issues most prominent in the primary and secondary services areas. In addition, the strategies presented are focal points, but do not represent all supporting education, contributions, and collaborations with the general community or partnering agencies on a wide-range of community needs.

The mission of AMITA Health is to extend the healing ministry of Jesus.

Our Community Benefit Program is Integral to our Mission.

It Responds to identified needs in the community.

It Empowers local organizations serving the most vulnerable populations.

It Supports the government's efforts to enhance population health.

It Helps families living in poverty to access affordable healthcare.

It Improves the health of the communities we live in.

DEMOGRAPHICS & METHODOLOGY

In the SAMC service area, the population is slightly older with 15.4% of residents over age 65 as compared to 13.9% in Illinois. 19.2% of the population is Hispanic, a higher percentage as compared to 16.7% in Illinois and 17.4% in the US. The community's social determinants are fairly average, except that there are 7.6% of residents that is considered "linguistically isolated" i.e. do not speak English. Nearly 15% of the population lives at or below 100% of the poverty level and 32.3% are at or below the 200% of the poverty level, representing 2,174,865 individuals. The service area for the hospital is comprised of 84 residential zip codes based on patient origin. A complete description of sample size and survey design is available on the website at amitahealth.org/communityneeds.

SURVEYS

An Online Key Informant Survey was conducted as part of this assessment. Key informants comprised those individuals who have a broad interest in the health of the community. There was a total of 60 stakeholders participants for this region. A list of stakeholders was provided by MCHC member hospitals participating in the overall assessment process

INTERVIEWS

The strategy used for this assessment entailed a telephone interview methodology of 1,033 individuals age 18 and older in the Total Service Area. The surveys were distributed to individual hospitals that were part of the larger assessment thus involving multiple regions and hospital service areas.

DATA

This assessment incorporates a selection of secondary data from 17 sources in order to support the research quality. Benchmark data was collected from the Centers for Disease Control and the U.S. Department of Health and Human Services. The nationwide risk factor data was taken from the 2013 PRC National Health Survey and Healthy People 2020.

PRIORITY ISSUES

The key issues to be addressed as determined by the CHNA are Mental Health, Diabetes and Nutrition, Physical Activity and Weight. These are the areas which were identified by community stakeholders, and confirmed by internal observation, as the most critical issues. Each of the identified priorities overlap with other Community Health issues as identified below.

Mental Health (including but not limited to Family Violence, Substance Abuse, Community Violence, Dementia)

Diabetes (contributing factor in Heart Disease/Stroke , Chronic Kidney Disease)

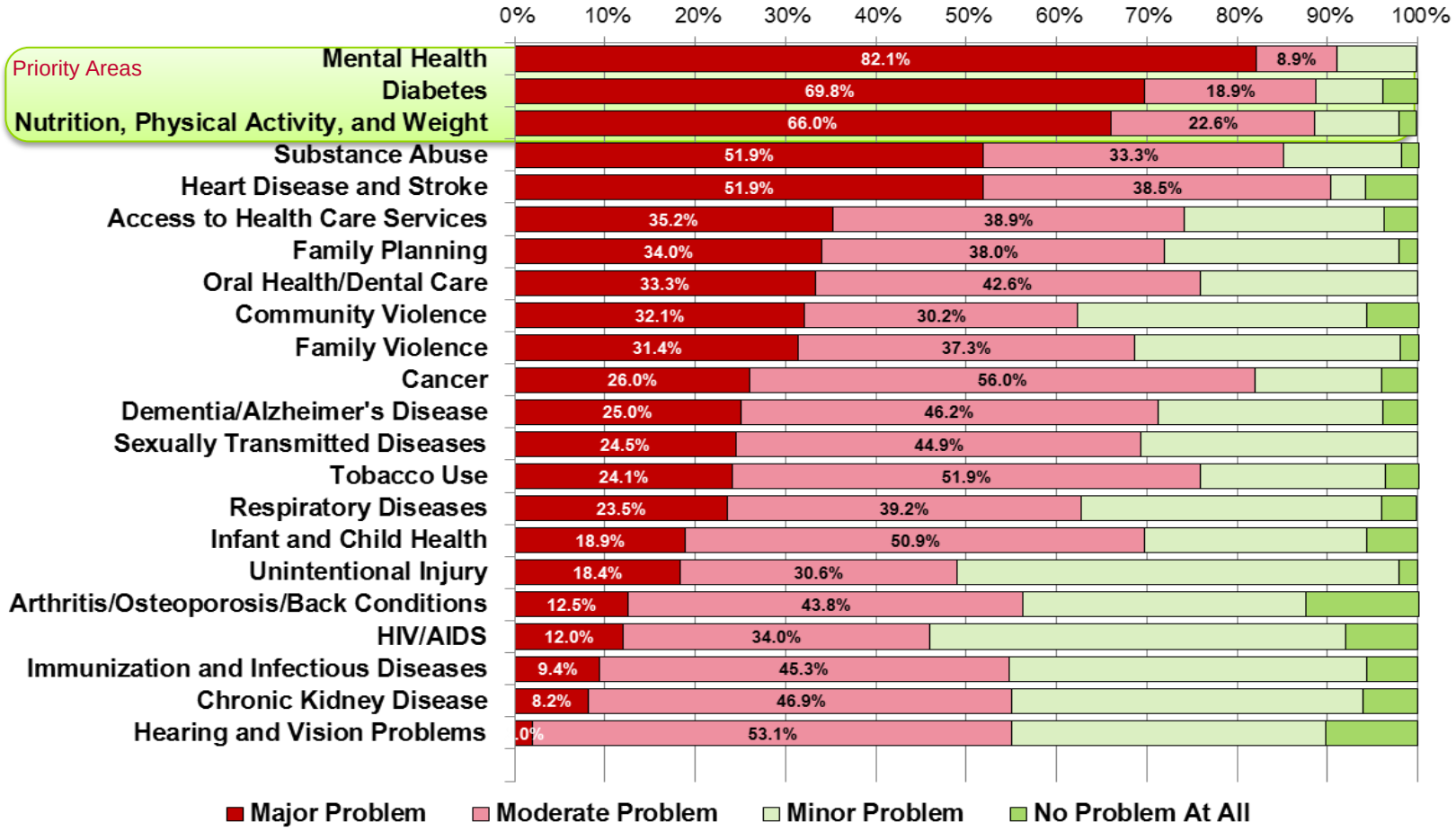
Nutrition, Physical Activity and Weight (preventing Diabetes, Heart Disease, Stroke)

SAMC addresses other priorities identified as issues in the community on a continuous basis through screenings, education and treatment. Cancer, Respiratory Diseases, Infant and Child Health, Unintentional Injury, Arthritis and Osteoporosis; HIV/AIDS and Immunizations are amongst those conditions which we routinely provide services and outreach to members of the community.

Priorities which we have chosen not to specifically address in our community include Family Planning, Sexually Transmitted Diseases, Oral Health/Dental Care and Hearing and Vision Problems. Family Planning is a service which is provided in our community by private physicians, FQHCs and social service agencies, and are easily accessible to the general public. Sexually Transmitted Diseases are also covered by social service agencies and physicians in the community. Oral Health/Dental Care was explored as a potential community benefit. However, it was determined that local FQHCs provide dental services and members of the community have access to these services. The lowest priority, Hearing and Vision Problems, has not been identified by our community partners as an unmet need.

PRIORITY ISSUES cont

The chart below reveals the substantial areas of opportunity as it relates to community benefit. There is a special emphasis placed on priority areas although many community health issues are being supported. The key issues to be addressed determined by the CHNA are Mental Health, Nutrition, Physical Activity, and Weight and Substance Abuse.



IMPLEMENTATION PLAN: MENTAL HEALTH

Goal: Maintain and expand existing community mental health services despite lack of state funding.

Strategy: Financial support for external community mental health agencies to protect the mental health services for the underinsured and insured.

Community Partner: The Ecker Center

Public Policy: Advocate for state and federal funding for our community mental health centers.

Expected Impact: The Ecker Center will add to the hours of psychiatric care for low income children previously diagnosed with mental illnesses and have been waitlisted. The Ecker Center estimates 15 new clients would receive a psychiatric evaluation and follow up medication management visits. By 2019, a total of 24 news clients will be served. The total psychiatric hours planned for each year is 42 hours.

IMPLEMENTATION PLAN: DIABETES

Goal: Support community programs that aim to reduce the rate of Type II Diabetes.

Strategy: Invest in federally vetted programming throughout the AMITA community which provides affordable and accessible services to community members at high risk for Type II Diabetes.

Community Partner: Golden Corridor Family YMCA

Public Policy: Advocate for expansion and sustainability of the Diabetes Prevention Program with our federal and state representatives to provide reimbursement for Medicare and coverage for Medicaid recipients.

Expected Impact: We will enroll 15 community members participate in the program the first year. In the subsequent two years, the we hope to educate 30 participants per year. Among those completing the program will have reduced their risk of Type II Diabetes by lowering their body weight by 5 to 7% and increase physical activity to 150 minutes per week.

IMPLEMENTATION PLAN: NUTRITION, PHYSICAL ACTIVITY, AND WEIGHT

Goal: Provide opportunities for children to be physically active in their daily lives.

Strategy: Provide Go Noodle, an online interactive suite of videos which combine learning and physical activities in districts with low-income and minority families.

Community Partner: School District 46

Public Policy: Support the efforts of local elected officials for long-term and sustainable programs designed to prevent childhood obesity.

Expected Impact: Go Noodle is a mature program in U46, but each year has seen modest but steady increases. The aim is to increase the number of teachers reporting by 5% or 31 additional teachers for a total of 660 teachers. Increase the number of students participating from 15,596 to 16,000 students.

Contact: Sendy Soto
Director of Community Benefit & Advocacy
(847) 590-2681
Sendy.Soto@amitahealth.org

AMITA Health Website: http://www.amitahealth.org

Community Benefit Webpage:
http://www.amitahealth.org/communityneeds