SAINT ANTHONY HOSPITAL

FY14-FY16
Community Health Needs Assessment And Implementation Strategy

Saint Anthony Hospital
Chicago, Illinois

Approved by Saint Anthony Hospital Board of Directors
Peter V. Fazio, Jr., Chair
June 21, 2013

Available to the Public
at www.SAHChicago.org

and by calling
the Office of the Vice President of Mission and
Community Development
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SAINT ANTHONY HOSPITAL

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Executive Summary

Accredited by The Joint Commission, Saint Anthony Hospital is an independent, nonprofit, faith-based, acute care, community hospital. Our mission is to provide health, healing, and hope to the families of our community. We are engaged on many levels in improving and sustaining the overall health and well-being of our community.

Saint Anthony Hospital completed its latest Community Health Needs Assessment (CHNA) in 2012 in cooperation with the Metropolitan Chicago Healthcare Council (MCHC). Our community is defined by 10 zip codes on the Southwest and West Sides of Chicago. In our community there is a higher percentage of Latino and African American residents than in the city of Chicago overall. Our community is younger than the city overall and less educated. The median household income in our community is 25% less than the city's, and there are more people in poverty than in the city overall.

This CHNA, a follow-up to a similar assessment conducted in 2009, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in our community. It was conducted by Professional Research Consultants, Inc. (PRC), and it incorporates data from both quantitative and qualitative sources, including results from the PRC Community Health Survey and secondary research. Qualitative data input includes primary research gathered through a series of key informant focus groups. Because PRC conducted other CHNAs throughout the metropolitan Chicago area as part of a broader study facilitated by MCHC, comparisons were also made at a regional level.

Saint Anthony's CHNA Steering Committee includes the hospital's Vice President of Mission and Community Development and his Coordinator for Special Projects along with the Manager of Development Communications from the Saint Anthony Hospital Foundation. The Steering Committee digested the results of the assessment and then met to determine the process and criteria for prioritizing the Areas of Opportunity identified through the assessment. Through this process we agreed to focus on developing and/or supporting strategies and initiatives to improve:

1. Access to Health Services
2. Cancer
3. Diabetes
4. Family Planning
5. Heart Disease & Stroke
6. Injury & Violence Prevention
7. Maternal, Infant & Child Health
8. Mental Health & Mental Disorders
9. Nutrition, Physical Activity & Weight Status

Saint Anthony Hospital

Accredited by The Joint Commission, Saint Anthony Hospital is an independent, nonprofit, faith-based, acute care, community hospital. Our mission is to provide health, healing, and hope to the families of our community. With almost 1,000 associates and 400 affiliated physicians, we offer specialties from allergy to obstetrics to pediatrics to vascular surgery. Our 151-bed hospital includes 62 beds for medical/surgical care, 42 for psychiatry, 20 for obstetrics, 15 for intensive care, and 12 for pediatrics. Adjacent to the hospital is the Physician Center, our ambulatory care clinic. We operate five other neighborhood clinics. In 2012, we opened our first Immediate Care Center and Occupational Health Service Center.

For more than a century, Saint Anthony has been playing an active role in improving the well-being of the families in our community, and since 1993, we have been providing health education in the community. In 1998, we established Project Hope to provide services to immigrant families. In 2003, we established the Center for Diabetes, Nutrition, Obesity, and Metabolism to provide self-management education to children and adults with diabetes. In 2004, we partnered with local leaders to open Esperanza Health Centers - today a federally qualified health center - so that families could receive healthcare from primary care providers instead of our emergency department physicians. In 2008, we launched a Parish Nurse Program to promote well-being through health screenings and health education at local churches and their food pantries. In 2009, we revised our Community Wellness Program to more effectively and efficiently support families with young children. In 2012, in partnership with the Lawndale Christian Development Corporation, we opened a satellite office in the North Lawndale neighborhood for our Community Wellness Program to increase healthcare access; to provide health education, screenings, and counseling; and to host special wellness-related events for families.

In summary, Saint Anthony is engaged on many levels in improving and sustaining the overall health and well-being of our community. As a “community-centric” organization we define ourselves and our services around community needs to improve community health and further community development. We take our mission outside the hospital’s walls to address these needs, often in partnership with neighborhood schools, churches, and other nonprofit organizations.

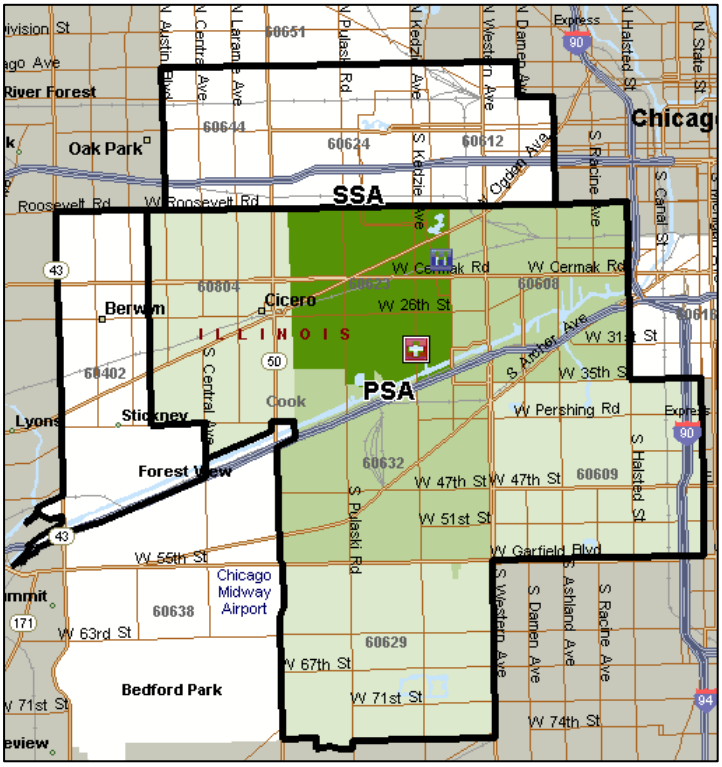
Definition of Saint Anthony’s Community

Saint Anthony Hospital completed its latest Community Health Needs Assessment (CHNA) in 2012 in cooperation with the Metropolitan Chicago Healthcare Council (MCHC). For the purpose of this CHNA Saint Anthony’s services area is defined as nine residential zip codes on the west and southwest sides of Chicago and one zip code in west suburban Cicero:

60608	60609	60612	60616
60623	60624	60629	60632
	60644	60804.	

According to the Saint Anthony Hospital Medical Staff Development Plan, completed in 2013 in cooperation with HealthCare Futures, our primary service area, that is, where 80% of our patients who were discharged in 2011 lived, covers six zip codes: 60608, 60609, 60623, 60629, 60632, and 60804. Our secondary service area, where the majority of the remaining 20% of our patients lived, covers the other four zip codes: 60612, 60616, 60624, and 60644.

More than a fourth (26%) of all of our patients discharged in 2011 lived in the 60623 zip code, which covers the Chicago community areas of South Lawndale and North Lawndale. Thirteen percent lived in the 60632 zip code, which covers Brighton Park, and 10% lived in 60608, which includes Lower West Side and McKinley Park.



Picture 1. Saint Anthony Hospital's primary and secondary service areas with the Eisenhower Expressway to the north and the Dan Ryan Expressway (90) to the east. Midway Airport is in the lower left-hand corner.

Demographics of Saint Anthony's Community

In Saint Anthony Hospital's community there is a higher percentage of Latino and African American residents than in the city of Chicago overall. Our community is younger than the city overall and less educated. The median household income in our community is 25% less than the city's, and there are more people in poverty than in the city overall. Table 1 below compares the demographics of our community with the city of Chicago. Table 2 has demographics for all 10 zip codes in our community as well as for Chicago overall.

	City of Chicago	Saint Anthony Community	Variance
Population	2,695,598	698,226	26% of city pop
Persons under 18	23.1%	28.6%	24% more than in city
African American persons	32.9%	38.1%	16% more than in city
Hispanic/Latino persons	28.9%	43.9%	52% more than in city
High school graduates	80.2%	66.2%	18% fewer than in city
Median household income	$47,371	$35,713	25% lower than in city
Persons below poverty	21.4%	28.3%	32% more than in city

Table 1. Demographics of Chicago vs. Saint Anthony Hospital's Community

	60608	60609	60612	60616	60623	60624	60629	60632	60644	60804	Chicago
A	82,739	64,906	33,472	48,433	92,108	38,105	113,916	91,326	48,648	84,573	2,695,598
B	22.9%	32.2%	24.6%	15.3%	33.7%	30.4%	32.5%	33.2%	28.0%	33.6%	23.1%
C	7.3%	7.3%	8.5%	13.8%	6.6%	10.1%	6.6%	6.6%	11.3%	5.9%	10.3%
D	44.0%	50.1%	52.1%	51.4%	49.9%	53.6%	50.6%	48.8%	54.3%	49.0%	51.5%
E	16.5%	14.1%	19.5%	24.0%	1.8%	1.3%	9.2%	10.7%	1.8%	9.2%	31.7%
F	17.7%	28.2%	61.0%	25.7%	33.0%	94.4%	22.4%	1.6%	93.7%	3.2%	32.9%
G	55.9%	53.1%	12.9%	8.7%	64.5%	3.0%	67.2%	84.2%	3.3%	86.6%	28.9%
H	35.3%	26.2%	11.1%	34.6%	33.6%	0.5%	32.1%	43.3%	2.1%	43.5%	21.0%
I	61.3%	48.3%	18.7%	47.3%	60.5%	2.9%	60.9%	82.4%	4.0%	82.3%	35.5%
J	61.9%	63.9%	78.9%	79.0%	52.9%	72.9%	63.6%	56.7%	70.1%	61.8%	80.2%
K	3.1%	4.5%	4.3%	4.6%	2.7%	4.8%	3.8%	2.6%	5.7%	2.6%	4.8%
L	30.3	33.1	29.6	26.7	35.8	36.2	36.9	33.8	37.1	31.3	33.7
M	2.9	3.2	2.5	2.2	3.6	3.1	3.7	3.8	2.7	3.9	2.6
N	$35,477	$34,725	$35,013	$43,085	$30,624	$22,982	$41,549	$40,340	$28,235	$45,101	$47,371
O	28.6%	28.6%	31.6%	21.5%	34.8%	43.7%	22.5%	21.4%	33.2%	17.4%	21.4%

Table 2. Key Demographics of Saint Anthony Hospital's Community by Zip Code

Key:
A – Population (2010)
B – Persons under 18
C – Persons 65 and over
D – Female persons
E – White persons alone, not Hispanic or Latino
F – Black persons alone, not Hispanic or Latino
G – Hispanic or Latino persons
H – Foreign born persons
I – Language other than English spoken
J – High school graduate or higher
K – Veterans
L – Mean travel time to work (minutes)
M – Average household size
N – Median household income
O – Persons below poverty level

Sources:
- QuickFacts from the United States Census Bureau
- United States Census Bureau, American FactFinder, Profile of General Population and Housing Characteristics, 2010 Demographic Profile Data
- United States Census Bureau, American FactFinder, Selected Social Characteristics in the United States, 2007-2011 American Community Survey 5-year Estimates

Healthcare Facilities in Saint Anthony's Community

Listed below are most but not all of the healthcare facilities in our service area that respond to the health needs of our community's residents. We partner with many of these facilities in an effort to provide a seamless healthcare delivery system that is compassionate, responsive, and flexible. For example, we provide inpatient and specialty outpatient care to patients of federally qualified health centers. We transfer critically ill newborns and children to larger hospitals. We use home health agencies to help patients heal at home. We refer patients in our Psychiatry Department and families in our Emergency Department to local mental health agencies. We educate chronically ill residents of nursing homes on how they can help prevent avoidable re-admissions.

Acute Care Hospitals/Emergency Rooms

- Holy Cross Hospital
- Loretto Hospital
- Mercy Hospital and Medical Center
- Mount Sinai Hospital
- Rush University Medical Center
- Sacred Heart Hospital
- John H. Stroger Hospital of Cook County Health and Hospitals System
- University of Illinois Hospital & Health Sciences System

Federally Qualified Health Centers & Other Safety Net Providers

- Access Ashland Family Health Center
- Access Cabrini Health Center
- Access Kedzie Family Health Center
- Access Warren Family Health Center
- Access Westside Family Health Center
- Alivio Medical Center
- Bethany Family Health Center
- Cicero Health Center of Cook County Health and Hospitals System
- Erie Family Health Center
- Esperanza Health Centers
- Fantus Health Center of Cook County Health and Hospitals System
- Interfaith House
- Lawndale Christian Health Center
- Madison Family Health Center
- Mercy Family Health Center
- Near West Family Health Center
- PCC Austin Family Health Center
- PCC South Family Health Center
- Pilsen Family Health Center
- Servicios Medicos La Vallita
- University of Illinois Mile Square Health Center
- Westside Family Health Center

Nursing Homes/Adult Care

- Albany Terrace
- Alden Town Manor
- Bronzeville Park
- California Gardens Nursing & Rehabilitation Center
- Cedar Point Rehab & Nursing Center
- Clearview Nursing Home
- Columbus Manor Residential Care Home
- Heritage Woods
- International Nursing & Rehab Center
- Jackson Square Skilled Nursing & Living Center
- Mayfield Nursing Home
- Monroe Pavilion Health & Treatment Center
- Park House Nursing & Rehab Center
- Pershing Nursing Home
- Renaissance at Midway
- Sacred Heart Home

- Saint Agnes Healthcare & Rehab Center

Mental Health Services/Facilities

- Behavioral Health Counseling Services
- Bobby E. Wright Comprehensive Behavioral Health Center
- City of Chicago Lawndale Mental Health Center
- Esperanza Health Centers
- Grand Prairie Services
- Habilitative Systems
- Haymarket Center
- Healthcare Alternative Systems
- I Am Able
- Inner-city Muslim Action Network
- Jorge Prieto Health Center
- Lawndale Christian Health Center
- Madden Mental Health Center
- Mount Sinai Child and Adolescent Behavioral Health Center
- Mount Sinai Hospital
- Pilsen Wellness Center
- St. Pius V Church
- University of Illinois Hospital & Health Sciences System
- Women's Treatment Center

Home Healthcare

- Advanced Home Health
- Alliance Home Health
- Bronzekey Home Health
- Complete Home Health
- Delta Home Health
- Global Home Health Care
- Golden Heart
- Heritage Home Health Care
- Liberty Home Care
- McNeal Home Health Care Services
- Preferred Health Care Ltd.
- Quality Home Health Care
- Resurrection Home Care Services
- Superior Home Care

Hospice Care

- Peace Hospice
- Seasons Hospice
- Vitas Hospice

School Health Services

- Crane Tech Prep high School
- Dunbar vocational high School
- Farragut Academy
- Orr-Rezin Academy
- Ryerson Elementary School
- Young Women's Leadership Charter School

Other Community-based Resources

- Circle Family Healthcare Network
- Lower West Neighborhood Health Clinic of Chicago Department of Public Health
- RML Specialty Hospital
- Schwab Rehabilitation Center

How Data for This CHNA Was Obtained

This CHNA, a follow-up to a similar assessment conducted in 2009, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in Saint Anthony Hospital's community. It is a tool to assist us in reaching three basic goals:

- improving residents' health status, increasing their life spans, and elevating their overall quality of life,
- reducing the health disparities among residents, and
- increasing accessibility to preventive services for all community residents.

This CHNA was conducted by Professional Research Consultants, Inc. (PRC), a nationally-recognized healthcare consulting firm with extensive experience conducting assessments in hundreds of communities across the United States since 1994. It incorporates data from both quantitative and qualitative sources. Quantitative data input includes results from the PRC Community Health Survey and secondary research. Qualitative data input includes primary research gathered through a series of key informant focus groups. The survey instrument used for this CHNA was based largely on the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues.

To ensure the best representation of the population surveyed, a telephone interview methodology, incorporating both landline and cell phone interviews, was employed. The sample design used for this effort consisted of a random sample of 396 individuals age 18 and older in Saint Anthony's service area. All administration of the surveys, data collection, and data analysis was conducted by PRC.

In addition, three focus groups were held as part of this CNHA:

- June 19, 2012, with key informants from the Southside of Chicago (including health professionals, social service providers, and other community leaders),
- June 21, 2012, with key informants from throughout Cook County (including representatives from public health; physicians; other health professionals; social service providers; and other community leaders), and
- June 22, 2012, with key informants from the Loop and the Westside of Chicago (a physician, social service providers, and another community leader).

MCHC and Saint Anthony provided PRC with a list of recommended participants for the focus groups. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work as well as of the community overall. Audio from the focus group sessions was recorded; participants were asked to speak candidly and assured of confidentiality. These findings represent qualitative rather than quantitative data. The group was designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.

A variety of secondary data sources was consulted to complement the research quality of this CHNA. Data for Saint Anthony's service area were obtained from the following sources:

- Centers for Disease Control & Prevention
- National Center for Health Statistics
- Illinois Department of Public Health
- Illinois State Police
- U.S. Census Bureau
- U.S. Department of Health and Human Services and
- U.S. Department of Justice, Federal Bureau of Investigation.

Because PRC conducted other CHNAs throughout the metropolitan Chicago area as part of a broader study facilitated by MCHC, comparisons were also made at a regional level. These regional data are referred to as the "MCHC Region" and include Cook, DuPage, and Lake Counties, Illinois. Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings. These data are reported in the most recent BRFSS Prevalence and Trend Data. State-level vital statistics are also provided for comparison of secondary data indicators. Nation-wide risk factor data are taken from PRC's 2011 National Health Survey. National-level vital statistics are also provided for comparison of secondary data indicators.

Health Needs of Saint Anthony's Community

Nearly a third of the adults (32%) in Saint Anthony Hospital's community rate their overall health as excellent (5 points) or very good (4). Yet a fourth (25%) believe their health is fair (2 points) or poor (1), up from 19% in 2009 and higher than the MCHC region's rate of 15.4%. More than half of the adults (54%) say their mental health is excellent or good. Yet more than a fifth (22%) say it is fair or poor, more than double the rate in 2009 and nearly twice the rate for the MCHC region. While the 2012 rates for adults who report having been diagnosed with major depression and having experienced symptoms of major depression are unchanged from 2009, more than one in 10 adults (11%) perceive most days as extremely or very stressful, up from 6% in 2009. This is comparable to the MCHC region.

	SAH Service Area	SAH Service Area	MCHC Region
	2009	2012	2012
Consume 5 or more servings of fruits & vegetables	36.1%	33.5%	44.4%
Very or somewhat difficult to buy affordable, fresh produce	N/A	29.9%	18.4%
Meets physical activity recommendations	41.1%	46.4%	50.3%
Very or somewhat difficult to access safe, affordable places for exercise	N/A	26.0%	16.8%
No leisure-time physical activity in past month	33.8%	22.3%	17.8%
Spend 3 or more hours on screen time (TV, computer, video games, etc.)	N/A	62.0%	48.2%
Prevalence of overweight and obese (Adults)	61.6%	72.5%	64.3%
Prevalence of obesity (Adults)	31.0%	31.3%	29.0%

Prevalence of overweight and obese (Children)	48.8%	42.4%	32.5%
Prevalence of obesity (Children)	33.5%	22.6%	18.2%
Current smokers	23.8%	17.8%	15.0%
Skipped or reduced prescription doses to save money	17.9%	19.1%	14.9%

Table 3. Health Characteristics of Residents of Saint Anthony's Community: 2009 vs. 2012

Subsequently, the following health opportunities represent recommended areas of intervention, based on the information gathered through this CHNA and the guidelines set forth in Healthy People 2020, the science-based, 10-year, national objectives for improving the health of all Americans.

Health Needs / Areas of Opportunity	
Access to Health Services	• Lack of Healthcare Coverage • Prescription Coverage • Medicare Supplemental Coverage • Insurance Instability • Medicaid Reimbursement Rates • Difficulty Accessing Healthcare • Tested Barriers to Healthcare Access (Cost, Hours, Availability, Transportation) • Prescription Medication Cost • Childcare • Cultural Competence/Interpretive Services • Patient Navigators • Specific Source of Ongoing Care (Medical Home) • Emergency Department Utilization • Availability of Trauma Care
Cancer	• Cancer Deaths (Including Prostate, Female Breast, and Colorectal Cancers)
Chronic Kidney Disease	• Kidney Disease Deaths
Diabetes	• Diabetes Deaths • Prevalence of Diabetes
Family Planning	• Teen Births • Births to Unwed Mothers
Heart Disease & Stroke	• Heart Disease Deaths • Stroke Deaths • Blood Pressure Screening & Prevalence
HIV	• HIV/AIDS Deaths

Injury & Violence Prevention	• Neighborhood Safety • Violent Crime • Firearm-related Deaths • Homicide Rate • Domestic Violence
Maternal, Infant & Child Health	• Prenatal Care • Low Birth Weight
Mental Health & Mental Disorders	• Mental Health Status • Chronic Depression • Mental Health Treatment • Availability of Providers/Facilities • Coordination with Primary Care • Dual Diagnoses with Substance Abuse • Stress • Education • Stigma
Nutrition, Physical Activity & Weight Status	• Prevalence of Overweight • Fruit & Vegetable Consumption • Access to Affordable Fresh Produce/Food Deserts • Nutrition Education • Low Levels of Physical Activity • Access to Safe, Affordable Exercise Facilities • Youth Physical Activity • Children's Screen Time
Oral Health	• Dental Visits (Adults) • Dental Insurance
Respiratory Diseases	• Pneumonia/Influenza Deaths • Pneumonia Vaccination • Tuberculosis Incidence
Sexually Transmitted Diseases	• Incidence of STDs • Gonorrhea • Primary/Secondary Syphilis • Chlamydia
Sickle-Cell Anemia	• Prevalence of Sickle-Cell Anemia
Substance Abuse	• Cirrhosis/Liver Disease Deaths • Drinking & Driving • Illicit Drug Use
Tobacco Use	• Exposure to Environmental Tobacco Smoke
Vision	• Blindness/Trouble Seeing • Routine Vision Care

Uninsured & Low-income Persons & Minority Groups

As stated earlier, 82% of the residents in Saint Anthony's service area are minorities, and 28% have incomes below the poverty level. According to Illinois Health Matters, there may be as many as 88,950 residents newly eligible for Medicaid January 1, 2014 under the Affordable Care Act and as many as 52,991 undocumented residents who will continue to be uninsured. Our CHNA segmented findings by geographic, demographic, and health characteristics to identify the primary and chronic disease needs and other health needs of uninsured persons, low-income persons, and minority groups. For these statistics, please see Saint Anthony Hospital's complete assessment report from PRC on our website.

Process for Prioritizing Community Health Needs

Saint Anthony Hospital completed this CHNA in cooperation with MCHC and PRC in 2012. As soon as MCHC presented the final report to us, we formed a CHNA Steering Committee that included the hospital's Vice President of Mission and Community Development and his Coordinator for Special Projects along with the Manager of Development Communications from the Saint Anthony Hospital Foundation.

Our CHNA Steering Committee independently read and digested the results of the assessment. In April 2013, they met to determine the process and criteria for prioritizing the 18 Areas of Opportunity identified through the assessment. The four criteria the committee established were:

- feasibility – the ability to reasonably impact the issue given available resources,
- magnitude of problem in our service area – the number of people affected, taking into account variances from benchmark data in the assessment,
- impact/implications – the degree to which issue affects or exacerbated other quality of life and health-related issues, and
- relativity to the "Community Top 5 List" – the list of top five concerns identified by community key informants during PRC's focus groups, which were 1) access, 2) education/prevention (on all health issues), 3) obesity, including nutrition, 4) mental health, and 5) trauma centers.

Below is a summary of the application of these criteria to each of the 18 areas.

At the end of April the Steering Committee presented a draft of the prioritization results to Saint Anthony's Executive Council, which consists of the CEO, General Counsel, Chief Financial Officer, Chief Nursing Officer, Chief Human Resources Officer, and Vice Presidents of Development and Marketing, Mission and Community Development, Physician Services, and Professional Services. The Executive Council gave further input and recommendations before approving the prioritization.

Through this process, Saint Anthony ranked the top community health needs as so:

1. Access to Health Services
2. Cancer
3. Diabetes
4. Family Planning
5. Heart Disease & Stroke
6. Injury & Violence Prevention
7. Maternal, Infant & Child Health
8. Mental Health & Mental Disorders
9. Nutrition, Physical Activity & Weight Status

Prioritizing Health Needs / Areas of Opportunity	
Access to Health Services	• **Feasibility** o Financial Assistance and Uninsured Discounts o Assistance Applying for Medicare, Medicaid, and Other Public Benefits and Programs o Parish Nursing o Community-based Health Education and Screenings o Participation in Health Fairs o Transportation Services o Childcare to Participate in Community Wellness Services • **Magnitude** – 33.6% uninsured and unfavorable in comparison to all state and national benchmarks. • **Impact/Implications** – High • **Related to Community Top 5 List** - Yes
Cancer	• **Feasibility** o Silver Lining Foundation Free Mammogram Screening Program • **Magnitude** – Overall cancer death rate 194; unfavorable in comparison with all benchmarks. Breast cancer death rate also unfavorable in comparison to all state and national benchmarks but frequency of mammograms similar. • **Impact/Implications** – High • **Related to Community Top 5 List** - Yes
Chronic Kidney Disease	• **Feasibility** o Saint Anthony Hospital's Infusion Center • **Magnitude** – Death rate 23 and 3.2% of population have kidney disease. Unfavorable death rate in comparison with all state and national benchmarks; similar to MCHC Region for % of population with kidney disease. • **Impact/Implications** – Moderate • **Related to Community Top 5 List** - No
Diabetes	• **Feasibility** o Center for Diabetes, Nutrition, Obesity, & Metabolism o Parish Nursing • **Magnitude** – Death rate 23 and unfavorable in comparison with MCHC Region, IL, and Healthy People 2020; 13.5% have diabetes, which is unfavorable or similar to local and national benchmarks. • **Impact/Implications** - High • **Related to Community Top 5 List** – Yes
Family Planning	• **Feasibility** o Reproductive Health Education for Students in 9^{th}-12^{th} Grades o Teen Parent Support and Education Services • **Magnitude** - 52% of births to unwed mothers; 12% births to teenagers; both unfavorable to all benchmarks. • **Impact/Implications** – High • **Related to Community Top 5 List** - No
Heart Disease & Stroke	• **Feasibility** o Free Blood Pressure Screening through Parish Nursing and Health Fairs • **Magnitude** – Death rate 199.3 and unfavorable compared to all benchmarks; stroke death rate 44.8 and also unfavorable to all. Also 90.9% have had blood pressure checked in past 2 years but % still unfavorable to all benchmarks. • **Impact/Implications** – High • **Related to Community Top 5 List** - No

HIV	• **Feasibility** ○ HIV Education for Students in 9th-12th Grades • **Magnitude** – Overall death rate 8.2 and unfavorable in comparison with all benchmarks. 34.7% have had HIV test in past year, which is favorable to all available benchmarks. • **Impact/Implications** - Moderate • **Related to Community Top 5 List** - No
Injury & Violence Prevention	• **Feasibility** ○ ACT against Violence Parent Education Groups • **Magnitude** – Violent crime rate 785.3 and DV rate 1297.9; unfavorable in comparison with all benchmarks. • **Impact/Implications** - High • **Related to Community Top 5 List** - Yes

Maternal, Infant & Child Health	• **Feasibility**
	  ○ Free Pregnancy Tests
	  ○ Hospital-based and Individualized Prenatal Education
	  ○ Infant/child CPR
	  ○ Prenatal Case Management
	  ○ Gestational Diabetes Management
	  ○ Breast Feeding Support and Education
	  ○ Community Wellness' Maternal and Early Childhood Services, Including Teen Parenting Support Services
	• **Magnitude** – 23.6% no prenatal care in first trimester and unfavorable in comparison with all benchmarks; 9.7% low birthweight births and 7.4 infant death rate, both also unfavorable in comparison with all benchmarks.
	• **Impact/Implications** – High
	• **Related to Community Top 5 List** - No

Mental Health & Mental Disorders	• **Feasibility** ○ Community-based Mental Health Services • **Magnitude** – 21.5% with "fair/poor mental health" and unfavorable in comparison to available benchmarks; 32.4% symptoms of chronic depression and also unfavorable in comparison to available benchmarks. • **Impact/implications** – High • **Related to Community Top 5 List -** Yes

Nutrition, Physical Activity & Weight Status	• **Feasibility**
	  ○ Center for Diabetes, Nutrition, Obesity, and Metabolism
	  ○ Parish Nursing
	• **Magnitude** – 72.5% overweight and unfavorable in comparison with all benchmarks.
	• **Impact/implications** – High
	• **Related to Community Top 5 List** - Yes

Oral Health	• **Feasibility** ○ No Existing Resources or On-going Initiatives • **Magnitude** – 53.5% adults who have had dental visit in past year is unfavorable to local and national benchmarks but comparable to Healthy People 2020 goals. • **Impact/implications** – Low • **Related to Community Top 5 List** - No
Respiratory Diseases	• **Feasibility** ○ No Existing Resources or On-going Initiatives • **Magnitude** – CRLD death rate 29.4 but favorable compared to all benchmarks. Pneumonia/Influenza death rate 23.1 and unfavorable to all benchmarks. All other respiratory diseases comparable to all benchmarks. • **Impact/implications** - Moderate • **Community Top 5 List** - No

Sexually Transmitted Diseases	• **Feasibility** o No Existing Resources or On-going Initiatives • **Magnitude** – Gonorrhea incidence rate 306.2, syphilis incidence rate 29.2, chlamydia incidence rate 884.8 and all unfavorable to all benchmarks. • **Impact/Implications** – Moderate • **Related to Community Top 5 List** - No
Sickle-Cell Anemia	• **Feasibility** o No Existing Resources or On-going Initiatives • **Magnitude** – 2.2% of population but unfavorable compared to MCHC Region. • **Impact/Implications** - Low • **Related to Community Top 5 List -** No
Substance Abuse	• **Feasibility** o No Existing Resources or On-going Initiatives • **Magnitude** – Cirrhosis/Liver Disease death rate 11 but unfavorable compared to all benchmarks. 9.4% driving drunk or riding with a drunk driver and less favorable than MCHC Region and US benchmarks. 4.5% illicit drug use in past month but comparable to MCHC region and favorable compared to Healthy People 2020, but unfavorable to US benchmark. • **Impact/Implications** - Moderate • **Related to Community Top 5 List –** No
Tobacco Use	• **Feasibility** o No Existing Resources or On-going Initiatives • **Magnitude** – 21% someone smokes in the home and unfavorable to available benchmarks. • **Impact/Implications** – Low • **Related to Community Top 5 List -** No
Vision	• **Feasibility** o No Existing Resources or On-going Initiatives • **Magnitude** – 12.8% blindness/trouble seeing and 50.9% have had eye exam in past two years, but both are unfavorable compared to available benchmarks. • **Impact/Implications** – Low • **Related to Community Top 5 List** – No

Consulting with Persons with Community Interests

In 2013, Saint Anthony Hospital partnered with Enlace Chicago and other community agencies and residents to develop a Quality of Life Plan for the South Lawndale community that includes transformative ideas related to health and wellness for the next five to ten years. Our Vice President for Mission and Community Development serves on the steering committee for the Quality of Life Plan and is the principal editor for the plan's health topic areas. In this role he is able to share and merge priorities from the CHNA with this broader, community-wide plan.

Saint Anthony hosted a focus group as part of the Quality of Life Plan planning process. A total of 650 individual and more than 80 organizations participated and contributed to the Quality of Life Plan, which reflects a community with more resources, stronger organizations, more experience, and deeper connections than existed at the time of the last plan in 2003.

In 2011, Saint Anthony completed an assessment in North Lawndale. We reviewed existing data, research, and published information about the community, including health and psycho-social

health indicators. We contacted local agencies with experience in the areas of services for pregnant women, early childhood and parenting education, school-age children, and public benefits, and we made community visits, held, meetings, and conducted in-depth interviews with their representatives.

Health Issues Saint Anthony Will Not Address & Why

Saint Anthony Hospital takes pride in addressing the health care needs of our community, and we recognize the importance of each of the areas of opportunity that emerged from the CHNA process. However, we are only a piece of the puzzle and must stay focused in our efforts in order to be effective and efficient with our limited resources and stay within our scope of practice and expertise. For this reason we have chosen to focus on nine out of the 18 areas of opportunity identified through the CHNA.

The other nine areas – oral health, sexually transmitted diseases, sickle-cell anemia, tobacco use, vision, and, for the most part, chronic kidney disease, respiratory disease, substance abuse, and HIV – were excluded from our implementation strategy because we have limited or no expertise and services in each of these areas. When we come into contact with patients and community members with these specific issues, we refer them to other community organizations or healthcare providers with more experience and resources that meet their needs. Furthermore, although chronic kidney disease, respiratory disease, and substance abuse are all within Saint Anthony's scope of practice, they were not selected for action at this time because of limited resources and higher priorities.

Information Gaps

While this CNHA is quite comprehensive, it cannot, according to PRC, measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess the entire community's health needs. For example, certain population groups, such as the homeless and institutionalized persons, are not represented in the survey data. Other population groups – for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain other racial/ethnic or immigrant groups – might not be identifiable or might not be represented in numbers sufficient for independent analyses. While, in terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community, there are certainly a great number of medical conditions that are not specifically addressed.

Priority Issues Saint Anthony Will Address

From FY14 to FY16, Saint Anthony Hospital will focus on developing and/or supporting strategies and initiatives to improve:

1. Access to Health Services
2. Cancer
3. Diabetes
4. Family Planning
5. Heart Disease & Stroke
6. Injury & Violence Prevention
7. Maternal, Infant & Child Health

8. Mental Health & Mental Disorders
9. Nutrition, Physical Activity, & Weight Status

Saint Anthony's FY2014-FY2016 Implementation Strategy

The following logic models outline Saint Anthony's action plan to address our community's health needs. We are committed to sustaining and improving our efforts and initiatives within each targeted health priority area and promoting an understanding of these health needs among other community organizations and community residents.

1. Access to Health Services Implementation Strategy	
Community Partners and Resources	Partners include but are not limited to: • 10th & 15th District Chicago Police Department • ABC Polk Bros. • American Diabetes Association • Breakthrough Urban Ministries • California Garden Nursing Home • Catalyst Howard Charter School • Chicago Department on Aging • Chicago Youth Center • Cook County Health & Hospital System • Deborah's Place • Department of Supportive Services - Senior Companion Program • El Hogar del Niño • Enlace Chicago • Esperanza Health Centers • Facing Forward • Family Focus • Family Health Network • Gads Hill • Greater Chicago Food Depository • Illinois Coalition for Immigrant and Refugee Rights • Illinois Department of Human Services Local Offices • Illinois Hunger Coalition • Heritage Manor Supportive Living • Jackson Square Nursing Home • Jesse White Tumblers • Lawndale Christian Development Corporation • Lawndale Christian Health Center • Little Village Chamber of Commerce • Marillac House • Marshall Square Resource Network • Mujeres Latinas en Acción • Piotrowski Park Senior Group • Rauner Family YMCA • Real Men Cook • Respiratory Health Association • Saint Anthony Hospital Parish Nursing, Community Wellness and Senior Wellness Programs • Senior Suites of Chicago • Taller de Jose

	• Westside Coalition for Seniors • WIC offices in Lawndale
Goal(s)	Facilitate more timely and improved healthcare by increasing patients' access to and utilization of health-related wrap-around services.
Outcome Measure(s)	Portion of community residents and patients who are familiar with or have utilized Saint Anthony Hospital's wrap-around services in order to access needed healthcare (as reported in the next Community Health Needs Assessment).
Timeframe	FY2014 – FY2016
Scope or target population	Residents in the hospital's service area (zip codes 60608, 60609, 60612, 60616, 60623, 60624, 60629, 60632, 60644, 60804).
Strategies & Objectives	**Strategy #1: Provide charity care and need-based financial assistances to patients for medically necessary services provided through the hospital's inpatient acute, outpatient, and behavioral health care settings** • As appropriate, write-off 100% of the charges for services for patients with income less than or equal to 200% of the Federal Poverty Level (FPL), which may be adjusted by the hospital for cost of living utilizing the local wage index compared to the national wage index. • At a minimum, patients with incomes above 200% of the FPL but not exceeding 400% of the FPL, subject to local wage index adjustments, will receive a discount on the services provided to them based on a sliding scale. • 100% charity will be given to all undomiciled patients at the time of discharge and all denied MANG applicants upon receipt of denial. • Patients who do not qualify for charity care but are in need of financial assistance will be offered appropriate extended payment terms or other payment options that take into account the patient's financial status. • Uninsured patients with the ability to pay will be provided with self-pay discounts. • Financial counselors will be made available to all patients as needed. **Strategy #2: Provide assistance and support to seniors, adults and families with children enrolling in health-related government programs and benefits** • Conduct public information sessions, mass outreach, and flyer distribution to ensure that residents are aware of government benefits they may be eligible to receive. • Provide enrollment assistance, targeted case management, and advocacy to individuals seeking to access government benefits, including Medicare, Medicaid, prescription drug coverage, food stamps, senior housing, and senior companion program. • Provide clients with information and referrals for other health and social

	services as needed. **Strategy #3: Provide community health education and screening services** • Provide health education, mini-workshops, screenings, immunizations, student physicals, and other health-related resources through an annual summer festival open to all community residents. • Provide churches and community organizations access to a Parish Nurse in order to: 1) nurture individuals through holistic care (physical, psychological, emotional and spiritual); 2) increase individuals' health awareness and knowledge so that they can be more responsible for their own health and well-being and improve their quality of life; 3) improve adherence to health care goals; and 4) link community residents to needed health and social services. • Provide women's health education groups focusing on breast health, well women care, and reproductive and sexual health. • Participate in community-based events and health fairs and provide health workshops and screenings as requested. • Host a quarterly breakfast for local seniors. **Strategy #4: Provide transportation to patients as necessary** • Provide free door-to-door transportation to and from the hospital to elderly and low-income patients in the community so that they can access medically necessary, life-prolonging treatment that they may otherwise forgo, in whole or in part, because of inadequate transportation. • Provide bus passes to patients when hospital transportation is unavailable or less convenient. • Facilitate and cover the cost of cab service to and from the hospital for patients when hospital transportation is unavailable or less convenient. **Strategy #5: Provide childcare for patients accessing services through the Community Wellness Program** • Provide free individual and group-based childcare to clients who otherwise would not be able to participate in services.
Anticipated outcomes	**Strategy #1: Patient financial services** • In a 12-month period provide 6.86% of charity care to gross patient revenue. **Strategy #2: Assistance with health-related government programs and benefits** In a 12-month period: • Complete applications for 375 individuals applying for Medicaid benefits • Complete applications for 450 individuals applying for SNAP (food stamps) benefits • Complete applications for 200 individuals applying for Medicare

	• Complete applications for 25 individuals applying for Senior Housing • Supervise a caseload of 15 Senior Companion beneficiaries • Complete a minimum of 200 public information, mass outreach, or flyer distribution sessions regarding government programs and benefits • Provide a minimum of 1,150 referrals to other needed health and social services. **Strategy #3: Health education and screenings** In a 12-month period: • Provide health education, screenings, and other health-related resources to a minimum of 3,000 community members through Summer Fest. • Maintain regular contact with a minimum of 10 churches and community organizations through the Parish Nurse, offering weekly or monthly health-related activities, depending on the site. • Provide individual health counseling and screening by a Parish Nurse to 1,600 individuals. • Disseminate health resources to the community through participation in a minimum of 50 health fairs and community events. • Complete 240 encounters with senior-specific health topics and resources through quarterly breakfast meetings. • Conduct four women's health education group series comprised of four sessions each and serving a minimum of 40 women total. **Strategy #4: Transportation** • In a 12-month period have a minimum of 4,000 encounters for which transportation is provided to or from the hospital. **Strategy #5: Child care** • In a 12-month period a minimum of 150 children will receive childcare while their parents participate in a service of the Community Wellness Program.
Financial Commitments	**Strategy #1: Patient Financial Services** • $6,565,000 a year **Strategy #2: Government Benefits Assistance** • $182,372 a year **Strategy #3: Health Education and Screenings** • $111,106 a year **Strategy #4: Transportation** • $207,310 a year **Strategy #5: Childcare** • $27,114 a year
Results	Pending

2. Cancer Implementation Strategy	
Community Partners and Resources	Partners include but are not limited to: • A Silver Lining Foundation • Esperanza Health Centers • Lawndale Christian Health Center
Goal(s)	Increase early detection of breast cancer by improving access to mammogram screenings and diagnostics.
Outcome Measure(s)	Number of patients tracked through McKesson Hospital Information System as having received a mammogram through the Silver Lining Foundation program.
Timeframe	FY2014 – FY2016
Scope or target population	Uninsured and underinsured individuals
Strategies & Objectives	Provide free screening and diagnostic mammograms to uninsured and underinsured individuals referred through the Silver Lining Foundation program.
Anticipated outcomes	Provide a minimum of 120 mammograms and diagnostics at no cost to the patient in a twelve-month period.
Financial Commitment	$16,200 a year
Results	Pending

3. Diabetes 9. Nutrition, Physical Activity, & Weight Status Implementation Strategy	
Community Partners and Resources	Partners include but are not limited to: • Access Community Health Network • Lawndale Christian Health Center • Leukemia & Lymphoma Society • Meridian Health Plan
Goal(s)	• Bring diabetes education and management services to more residents in the hospital's service area and increase referral rate from calendar year 2013 by 10%. • Employ best practice strategies that lead to diabetes prevention, quality diabetes outcomes, and reduction in the hospital's readmission. • Maintain educational and clinical competencies endorsed by the American Diabetes Association. • Maintain patient satisfaction surveys above 95% rate.
Outcome Measure(s)	• Referral rates • No show rates • Patient self-reports regarding individual goals • Patient satisfaction surveys
Timeframe	FY2014 – FY2016
Scope or target population	Residents in the hospital's service area (zip codes 60608, 60609, 60612, 60616, 60623, 60624, 60629, 60632, 60644, 608004)
Strategies & Objectives	**Strategy #1: Provide systematic care coordination for patients in order to increase access to and availability of diabetes nutrition and management services through the Center for Diabetes, Nutrition, Obesity & Metabolism** • Promote internal and external partnerships focused on increasing referrals and bringing the Center's services to locations beyond the hospital's walls. • Eliminate barriers to accessing services through targeted care coordination and case management activities, including reminder calls, coordination with transportation, and patient financial services. • Provide free glucose screenings, diabetes assessments, and referrals to adults at Summer Fest and other community health fairs. **Strategy #2: Provide individual and group-based diabetes self-management education to patients referred to the Center for Diabetes, Nutrition, Obesity & Metabolism, including women experiencing gestational diabetes** • Provide nutrition and diabetes management services in English and Spanish

	• Decrease patients' A1C levels • Bring patients' blood pressure and cholesterol levels within normal limits • Increase physical activity among patients **Strategy #3: Provide a healthy lifestyle management program to overweight children, adolescents, and obese adults (with or without diabetes)** • Assist program participants in setting personal goals • Provide education and support related to healthy shopping and eating practices, physical activity, identifying barriers to health and problem solving, and identifying coping strategies **Strategy #4: Provide support and education related to diabetes issues, including eating habits and lifestyle choices, to community members through a Parish Nurse** • Provide individualized health counseling by a Parish Nurse and follow-up referrals as appropriate.
Anticipated outcomes	**Strategy #1** **In a 12-month period:** • Provide care coordination to a minimum of 975 referred patients. • Maintain no-show rate below 37%. **Strategy #2** **In a 12-month period:** • Provide charity care to an average of 12 patients per month receiving individual or group-based diabetes self-management education. • 85% of patients will achieve personal goals in nutrition, physical activity, or managing glucose levels. **Strategy #3** **In a 12-month period:** • Enroll a total of 60 patients in one of six 7-week courses with 50-60% of patients attending all 7 classes. • 40-50% of participants will achieve personal goal related to nutrition or physical activity. • 75% of patients completing the course will report maintaining behavior change and continue to adhere to goal three months after graduation; 65% will maintain behavior change and continue to adhere to goal six months after graduation. • 50% of course graduates seen will have improved weight, heart rate, blood pressure and body mass index compared to when they began the program.

	Strategy #4 • See Access to Health Services – Strategy #3 Health Education and Screenings for more information •
Financial Commitment	**Strategy #1** • $50,000 a year **Strategy #2 and 3** • Portion of $6,565,000 budgeted through Patient Financial Services (see 1. Access to Health Services – Strategy #1 for more information) **Strategy #4** • See 1. Access to Health Services – Strategy #3, health education and screenings for more information
Results	Pending

4. Family Planning (and HIV) Implementation Strategy	
Community Partners and Resources	Partners include but are not limited to: • Al Raby School for Community and Environment • Christian Community Alternative Academy • Collins Academy • Connect 2 Protect • Family Focus • Lawndale Christian Health Center • North Lawndale College Preparatory High School • Metropolitan Family Services
Goal(s)	• Ensure that adolescents are making more informed and healthy choices related to reproductive health by providing access to information about important issues, including HIV.[1] • Ensure that pregnant and parenting teens receive support and have access to information and resources to improve birth and child outcomes and delay subsequent pregnancies.
Outcome Measure(s)	• Pre- and post-program questionnaires • Attendance records
Timeframe	FY2014 – FY2016
Scope or target population	9th – 12th graders in North Lawndale schools

Strategies & Objectives	• Provide comprehensive and culturally competent reproductive and HIV health education to students through high schools and/or social service agencies.
	  • Use the *Family Life and Sexual Health* (FLASH) curriculum to present information related to reproductive health and the following topics:
	  o Puberty/bodily changes
	  o Decision making
	  o Reproductive System
	  o Touch and Abstinence
	  • Use the *American Red Cross African American HIV and Prevention* to present information related to HIV and the following topics:
	  o Discussing the Facts About HIV and AIDS
	  o Building Prevention Skills
	  o Community Mobilizations
	• Provide educational/support groups to pregnant and parenting teens

[1] Saint Anthony Hospital staff present information but does not present opinions about choices individual should make related to reproductive health.

Anticipated outcomes	**In a 12-month period:** • 250 students will participate in the reproductive and HIV education classes • 32 curriculum modules will be delivered • 25% of participants completing pre and post questionnaire will report decrease in sexually risky behaviors • 80% of participants completing pre and post questionnaire will report a increase in knowledge regarding how HIV/AIDS/STIs are transmitted • 80% of participants completing pre and post questionnaire will report increase knowledge on where to receive HIV/AIDS/STI testing.
Financial Commitment	• $7,020 a year
Results	Pending

5. Heart Disease and Stroke Implementation Strategy	
Community Partners and Resources	Partners include but are not limited to: • Blessed Sacrament • Casa Catalina • Collins High School • Greater Galilee Baptist Church • Greater Original Baptist Church • Friendship Baptist Church • Jesus Word Baptist Church • Launch Out into The Deep • Little Village Community Council • Marillac House • North Lawndale Community Wellness Program • Saint Agatha's Catholic Church • United Baptist Church
Goal(s)	• Identify individuals who are at-risk of heart disease and stroke based on blood pressure readings. • Link patients with high blood pressure to follow-up services and on-going care as appropriate.
Outcome Measure(s)	• Number of blood pressure screenings and related health counseling encounters
Timeframe	FY2014 – FY2016
Scope or target population	Community residents in the hospital's service area (zip codes 60608, 60609, 60612, 60616, 60623, 60624, 60629, 60632, 60644, 60804)
Strategies & Objectives	**Strategy #1:** • Provide on-going blood pressure screenings, related health counseling, and referrals by a Parish Nurse at a minimum of 10 churches and/or community agencies. • Provide blood pressure screenings and referrals at community events and health fairs as requested.
Anticipated outcomes	**In a 12-month period:** • provide a minimum of 1,600 blood pressure screenings and blood pressure screenings at a minimum of 25 community events and fairs.
Financial Commitment	• Portion of $111,106 a year budgeted for 1. Access to Health Services – health education and screening
Results	Pending

6. Injury & Violence Prevention Implementation Strategy	
Community Partners and Resources	Partners include but are not limited to: • Al Raby School for Community and Environment • Better Boys Foundation • Carole Robertson Center for Learning • Casa Central • Chicago Public Schools • Chicago Youth Centers • Collins Academy • Enlace Chicago • Erie Neighborhood House • Esperanza Health Centers • Family Focus • Illinois Department of Children and Family Services (DCFS) • Mason Elementary School • Mujeres Latinas en Acción • Rainbow House • Roots to Wellness
Goal	Improve parents and other primary caregivers' parenting skills and disciplinary practices that protect children from violence by increasing their knowledge of: • basic elements of child development, • roots and consequences of violence in the lives of children, • protective factors and skills related to violence prevention, • how to become involved in school and community efforts related to violence prevention.
Outcome Measure(s)	• Attendance records • pre- and post-questionnaires completed by program participants.
Timeframe	FY2014 – FY2016
Scope or target population	The target audience is parents and other primary caregivers of children between the ages of 0-8 in Saint Anthony's service area. Priority is given to the following individuals: (1) clients already receiving another service through the Community Wellness Program, (2) clients of a partner agency or school providing space for the group, (3) clients recruited or referred to us through DCFS, physicians and other partner agencies, and (4) clients on the wait list. Special effort is placed in recruiting both parents and encouraging them to attend the group together.

Strategies & Objectives	**Strategy #1: Group-based parent education program** An 11-week parenting education program based on the "Parents Raising Safe Kids" curriculum developed by the American Psychological Association through the Act Against Violence (ACT) initiative. Childcare is provided in order to support parents' consistent attendance and full participation. When possible the child-oriented activities of the curriculum are incorporated in the experiences and activities provided to children while their parents attend the group. The 11 sessions are structured as follows: 1. Introduction to the curriculum and pre-program evaluation 2. Understanding child development 3. Motivational Interviewing 4. Children and violence 5. Anger awareness and anger management 6. Positive conflict resolution 7. Positive discipline (Part I) 8. Positive discipline (Part II) 9. Decreasing media influence on children 10. Parents' role in raising safe kids (review) 11. Post-program evaluation and celebration Each session is two-hours long and incorporates the following learning methods: • Icebreakers • Large and small group discussions • Brainstorming exercises and activities • Role plays • Video clips • Handouts
Anticipated outcomes	**Strategy #1: Group-based parent education program** In a 12-month period: • A minimum of 8 group series will be completed (4 in Spanish and 4 in English). • A minimum of 10 adults will be enrolled in each series. • 80 parents and other primary caregivers will participate in the group series. • 25% of participants completing pre- and post-questionnaire will report a decrease in the use of physical aggression when their child misbehaves. • 50% of participants completing pre- and post-questionnaire will report a decrease in the use of degrading language toward their children when s/he does something they do not like • 50% of participants completing pre- and post-questionnaire will report an increase in limiting the time TV is on in their house. • 50% of participants completing pre- and post-questionnaire will report an

	increase in their ability to control their anger when they have difficulties with their children
Financial Commitment	$43,500 a year
Results	Pending

7. Maternal, Infant & Child Health Implementation Strategy	
Community Partners and Resources	Partners include but are not limited to: • Al Raby School for Community and Environment • American Red Cross • Carole Robertson Center for Learning • Casa Central • Chicago Public Schools Child Find • Chicago Youth Centers • Christian Community Alternative Academy • Collins Academy • Cicero Health Center Cook County • Community Access Clinics • Dominican University • Early Intervention • El Valor • Englewood Clinic • Esperanza Health Center • Family Focus • Family Resource Center • Gads Hill Center • Healthy Families Chicago • Heartland Alliance Safe Start • Hogar del Niño • Illinois Action for Children • Illinois Chapter – March of Dimes • John H. Stroger, Jr. Hospital of Cook County • Lawndale Christian Health Center • Mount Sinai Under the Rainbow • North Lawndale College Prep • Pillars • Pilsen Wellness Center • Project Launch • Rainbow House • Jorge Prieto Family Health Center • Saint Agnes of Bohemia parish • Saint Anthony Hospital Community Wellness services • St. Pius V parish • Taller de Jose • UIC Colbeth Clinic For Child and Adolescent Psychiatry • WIC clinics in Lawndale

Goal(s)	• Ensure access to prenatal health care and education to women in the community. • Improve likelihood of a healthy pregnancy and birth outcomes of children in the community. • Improve the health, development, and well-being of children under the age of eight in the community.
Outcome Measure(s)	• Number of free pregnancy tests completed and reported in the Daily Dashboard • Number of women receiving individual prenatal education and management • Number of women referred to a prenatal care provider • Number of individuals participating in group prenatal education classes • Number of individuals participating in other child and family support services
Timeframe	FY2014 – FY2016
Scope or target population	Pregnant women and families with children under the age of eight in the hospital's service area (zip codes 60608, 60609, 60612, 60616, 60623, 60624, 60629, 60632, 60644, 608004).
Strategies & Objectives	**Strategy #1: Free pregnancy tests** • Provide free pregnancy tests on a walk-in basis at all of Saint Anthony Hospital Affiliate Clinics and the Community Wellness Program for women who think they might be pregnant or who need verification of pregnancy in order to apply for public health insurance. **Strategy #2: Maternity ward services** • Provide group-based prenatal education on a regular basis in English and Spanish using the March of Dimes *Becoming a Mom* curriculum. • Provide Infant/Child CPR and safety sponsored by the American Red Cross • Provide community-based breastfeeding education and support to pregnant women by a breastfeeding peer counselor. **Strategy #3: Diabetes management for pregnant women with gestational diabetes** • See 3. Diabetes – Strategy #2, individual and group-based diabetes self-management education **Strategy #4: Individual prenatal education and management** • Provide individualized prenatal education and targeted case management services to pregnant women by phone or in-person appointments. • Link pregnant women to a prenatal care provider and ensure that ongoing prenatal care is established. • Link pregnant women to public benefits and other needed health and social services resources during pregnancy and the postpartum period. • Provide tailored prenatal education based on gestational age and patients'

	interest utilizing the March of Dimes' *Becoming a Mom* curriculum. **Strategy #5: New mothers support group ("First-Time Moms Club")** • Promote the development of secure attachments between mothers and their babies. • Promote the optimal health and well-being of infants and mothers. • Provide mothers with access to a social support network. **Strategy #6: Interactive parent-child development group** • Weekly group running for six-months at a time, limited to 20 children and their caregivers and staffed by a multi-disciplinary team of professionals. • Semi-structured play-time for children and parents. • Structured parent-child activities that promote the various areas of development and encourage parent involvement based. • Coach parents during interactions with their children to help them become more responsive to their children's developmental and emotional needs. • Model positive discipline strategies for inappropriate behaviors. • Share knowledge and information related to child health and development and normalizing children's behaviors for parents. • Target support, intervention, monitoring and linkage to other services related to individualize parent and child needs. **Strategy #7: Developmental support services** • Provide direct support to patients under the age of 8 and their families related to developmental concerns or issues. • Meet with patients and families one-on-one or work with them over the phone as necessary to address developmental concerns. • Triage patients to other needed early childhood-related evaluations and services in the Community Wellness Program and elsewhere.
Anticipated outcomes	**Strategy #1: Free pregnancy tests** • In a 12-month period complete a minimum of 1,000 pregnancy tests across all our clinics and community wellness locations. **Strategy #2: Hospital-based maternity support services** In a 12-month period: • 25 prenatal education classes will be completed in English and Spanish • 300 individuals will participate in a group-based prenatal education class **Strategy #3: Diabetes management for gestational diabetes** • See 3. Diabetes – Strategy #2, individual and group-based diabetes self-management education **Strategy #4: Individual prenatal education and management services** In a 12-month period:

	• 175 pregnant women will receive individual prenatal education and management through the Community Wellness Program • 30% of women (or 52 women) who do not already have a provider will be linked to a prenatal care provider. **Strategy #5: New mothers' support group** In a 12-month period: • 52 group sessions will be offered. • An average of 12 participants per session (6 moms & 6 children). • 30% participant retentions (defined as number of mothers attending at least 6 sessions over the course of months (i.e. repeat attendees). • 80% of repeat attendees will report increased confidence in parenting capacity. • 80% of repeat attendees will report increased knowledge of infant care and development. • 80% of repeat attendees will report increased knowledge of community resources. • 50% of repeat attendees will report decreased anxiety related to being a new mother. • 50% of repeat attendees will report decreased sense of isolation. **Strategy #6: Interactive parent-child development group** In a 12-month period: • Two "six-month group series" offered • A minimum of 40 children and 20 adults will participate • 75% of families enrolled in each group series will complete. • 70% of parents will report an increase in the amount of time or frequency with which they play, read or sing to their children. • 40% of parents will report an increase in the use of routines with children. • 50% of parents will report an increase in their child's comfort level in new and different large group settings. • 50% of parents will report progress or improvement in at-least one of five areas of development: speech and language, fine motor, gross motor, social, and emotional. **Strategy #7: Developmental support services** • 90% of patients needing a diagnostic evaluation will be successfully linked to evaluation services. • 200 patients and families will receive individualized education and support related to a developmental concern.
Financial Commitments	**Strategy #1: Free pregnancy tests** • $1,000 a year **Strategy #2: Hospital-based maternity support services** • $13,000 a year

	Strategy #3: • $10,000 a year **Strategy #4 - 7:** (Individual Prenatal Education and Management, New Mother's Support Group, Interactive Parent-Child Development Group, and Developmental Support Services) • $294,000 a year
Results	Pending

8. Mental Health & Mental Disorders Implementation Strategy	
Community Partners and Resources	Partners include but are not limited to: • Behavioral Health Counseling Services • Beyond the Ball • Enlace Chicago • Esperanza Health Centers • Healthcare Alternative Systems (H.A.S.) • I Am Able • Inner-city Muslim Action Network • Jorge Prieto Health Center • Latino Mental Health Providers Network • La Villita Community Church • Little Village and Woods Boys and Girls Club • Mujeres Latinas en Acción • Mount Sinai Hospital's Under the Rainbow Program • New Life Church • Pilsen Wellness Center • Rainbow House • Roots to Wellness • St. Agnes of Bohemia Church • St. Pius V Church • Universidad Popular
Goal(s)	• Improve the mental health status of uninsured, Spanish-speaking, high functioning, adult, Latino immigrants seeking counseling services. • Increase the number of Spanish-speaking clinicians in the mental health profession who are culturally sensitive in serving the Latino immigrant community. • Decrease the stigma associated with mental health issues and increase access to services among Latinos.
Outcome Measure(s)	• Attendance and caseload records • 1-page Client Assessment Tool with 16 questions to evaluate clients in four areas thought to be important to the target population (self-awareness, self-expression, self-worth, and problem solving) • Patient Health Questionnaire (PHQ-9) to evaluate symptom alleviation, a useful clinical tool and a reliable and valid measure of depression severity (Kroenke, 2001).
Timeframe	FY2014 – FY2016
Scope or target	Latino immigrants living in the South Lawndale and surrounding

population	neighborhoods. We specialize in offering counseling services in Spanish to a high-functioning adult population, except when requested by a pregnant or parenting minor. Specifically, we serve Latino immigrants without insurance, who are low-income and would otherwise have limited access to counseling services. The following clients are referred elsewhere to more appropriate service providers: • individuals with severe and diagnosable mental illness that require constant monitoring of medications • individuals presenting with eating disorders • individuals seeking a substance abuse program • individuals seeking a domestic violence program • fluent English speakers • individuals with insurance • children and adolescents • immediate crisis intervention including attempt at suicide or harm to others. In FY14 the Mental Health Program will expand to serve 5th – 8th graders and their caregivers on a limited basis.
Strategies & Objectives	**Strategy #1: Intake and assessment** Referrals are made by multiple sources, including self-referrals. When a potential client calls, they are transferred to a designated intake line and private voicemail that is managed by the mental health staff. The designated staff person will review the intake line voicemail and complete an initial intake and assessment by phone within 2 business days. Based on the assessment, the individual will be offered an in-person intake appointment, put on the waiting list, or will be referred to another organization. If the individual is at risk for perinatal depression, as rated by the Edinburg *Postnatal Depression Scale or as determined by mental health staff during the intake*, the individual will be offered an immediate appointment for further evaluation, at which time a plan for follow-up is made if necessary. We provide targeted case management to ensure she receives the service where appropriate. **Strategy #2: Therapeutic interventions** Individual and couples psychotherapy: Clients receive 45-minute sessions on a weekly basis. Duration and frequency of therapy vary depending on client needs and varies from a few weekly sessions to over a year. Therapeutic and psycho-educational groups: Groups are offered 3 times a year. Each group lasts approximately 12 weeks and has 5-7 participants. **Strategy #3: Educational presentations**

	Presentations are given by request in community settings and are usually one-time events. Subjects include depression, anxiety, trauma, stress management/relaxation techniques, among other topics and always include an orientation to therapy. **Strategy #4: Social work intern site placement** The Community Wellness Program serves as site placement for at least one, bilingual, master's level, social work intern during the school year. Interns receive supervision and mentorship and participate in all aspects of direct service. An intern's caseload is based on the number of hours they work per week. **Strategy #5: Referral services** In order to better serve those who seek services and to address the limited scope of our current program, mental health staff and interns will maintain a resource guide of mental health resource to serve as a referral guide for people seeking services that for whatever reason cannot be served here. Staff will also participate in available mental health networks as a method to promote the continued education of staff and to develop strong relationships with other mental health providers of the region in order to identify and cultivate relationships for referrals and resources. **Strategy #6: Therapeutic service to families of at-risk youth** Parents play a crucial role in the life and well-being of their children. Therefore, proper supports for the entire family are essential. Yet many youth-serving organizations do not have the capacity, time, or expertise to provide ongoing counseling to families. Our project will support parents so that they have the skills to support the healthy development of their children. Families will be referred to us by outreach workers from youth-serving organizations in Little Village, especially those that are partners with Enlace. Our project will: 1) accept referrals from outreach workers who are part of Enlace, 2) conduct psycho-educational workshops for families using Adults and Children Together (ACT) against Violence, developed by the American Psychological Association, and 3) provide family counseling in individual sessions.
Anticipated outcomes	**Strategy #1: Intake and assessment; Strategy #2: Therapeutic interventions; Strategy #3: Educational presentations; Strategy #4: Social work intern site placement; Strategy #5: Referral services** During a 12-month period: • The full-time therapist will manage an average caseload of 22 clients per week through individual and couples counseling sessions. The clinical supervisor will manage an average caseload of 15 clients per week through individual and couples counseling sessions. Intern

	caseload will fluctuate throughout the year, increasing as they gain experience. • Conduct 6 therapeutic groups having on average 6 participants per group. • Offer 10 community presentations. • Maintain a resource guide of available mental health services within the area, updating the resource guide twice a year. • Develop and expand relationships with other providers of mental health services within the region. • Regularly attend scheduled meetings of the Latino Mental Health Providers Network and the Little Village Mental and Roots to Wellness. **Strategy #6: Therapeutic service to families of at-risk youth** During a 12-month period: • The At-Risk Youth Project will serve 105 individual participants, including 5th to 8th graders and their parents/caregivers. o 8 outreach workers will be trained every 12 months on identifying the mental health needs of families, parents, and at-risk youth o 20 parents and 40 children will participate in one 4 ACT groups o 15 families (an average of 45 persons) will participate in family counseling every 12 months; the number of sessions they participate in will not be limited o
Financial Commitment	$155,000 a year
Results	Pending

Adoption of Implementation Strategy

On June 21, 2013, the Board of Directors of Saint Anthony Hospital met to discuss this plan for addressing the community health priorities identified through our Community Health Needs Assessment. Upon review, the Board approved this Implementation Strategy to undertake these measures to meet the health needs of our community.

By (Name and Title)

June 21, 2013.