APPENDIX 2:
EVALUATION OF PAST ACTIVITIES

Addressing Significant Health Needs

Saint Anthony Hospital conducted its last CHNA in 2021 and reviewed the health priorities identified through that assessment. Taking into account the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined at that time that Saint Anthony Hospital would focus on developing and/or supporting strategies and initiatives to improve:

- Injury & Violence/Substance Use
- Diabetes/Nutrition, Physical Activity & Weight
- Mental Health
- Access to Healthcare Services

Strategies for addressing these needs were outlined in Saint Anthony Hospital's Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by Saint Anthony Hospital to address these significant health needs in our community.

Evaluation of Impact

Priority Area: Injury & Violence/Substance Use	
Community Health Need	Saint Anthony Hospital is not a trauma center; however, Injury & Violence will be prioritized due to high incidents of domestic violence and substance use that leads to Injury & Violence.
Goal(s)	• Utilize Coordinated Care to improve outcomes of patients who seek services due to substance abuse and domestic violence. • Reduce readmission rate of patients who seek services for needs related to injury, violence and substance abuse. • Increase overall health of patients seeking services • Address the root cause of health needs

Strategy #1: Develop a coordinated care system to be utilized across the hospital for patients experiencing DV, SUD.	
Strategy Was Implemented?	Yes
Target Population(s)	This strategy will focus on patients being served by the Emergency Department, Medical Stabilization Unit, and the Community Wellness Program.
Results/Impact	• Provided a total of 1362 referrals through coordinated care in the ED. • 2022 had 59 referrals • 2023 (Jan through June) had 175 referrals • 2024 (through Sept) had 1128 referrals

Strategy #2: Annually evaluate readmission rates within the hospital by department and reason for admission.	
Strategy Was Implemented?	Yes
Target Population(s)	This strategy will focus on patients being served by the Emergency Department, Medical Stabilization Unit, and the Community Wellness Program.
Results/Impact	• 551 total patients were readmitted within the month they were discharged. • 169 readmissions in 2022 • 185 readmissions in 2023 • 197 readmissions in 2024 (through Sept)

Strategy #3: Conduct community education around SUD, DV and trauma-informed services	
Strategy Was Implemented?	Yes
Target Population(s)	This strategy will focus on patients being served by the Emergency Department, Medical Stabilization Unit, and the Community Wellness Program.
Results/Impact	• Conducted a total of 100 community education sessions • 70 sessions were conducted in 2022 • 30 sessions were conducted in 2023 (Jan through June) • 0 sessions were conducted in 2024 (through Sept)

Priority Area: Diabetes/Nutrition, Physical Activity & Weight	
Community Health Need	Saint Anthony Hospital provides services to patients who reside in areas considered Food Deserts. The COVID pandemic and surges in community violence have hindered access to safe exercise in the community. As a result, community members have reported overweight and obesity rates of 72.9 and 43.4 respectively. Nutrition, Physical Activity & Weight contribute to multiple health concerns, including Diabetes, Heart Disease and Stroke.
Goal(s)	• Provide education to patients admitted for Diabetes, Heart Disease and Stroke around the importance of Nutrition, Physical Activity & Weight. • Provide referrals and support for outpatient diabetes patients to prevent admission • Improve awareness of locations to access healthy foods. • Partner with local organizations, including park districts, to connect patients to opportunities for safe physical activities.

Strategy #1: Increase patient education around the relationship between nutrition, physical activity & weight and health conditions such as diabetes, stroke and heart disease.	
Strategy Was Implemented?	Yes
Target Population(s)	Target population will include diabetes patients, heart disease patients, stroke patients from the Saint Anthony Hospital PSA.
Results/Impact	• Conducted a total of 57 workshops • 22 workshops conducted in 2022 • 7 workshops conducted in 2023 • 28 workshops conducted in 2024 (through Sept)

Priority Area: Mental Health	
Community Health Need	COVID 19 and high rates of community violence have led to increased concerns around Mental Health. During the most recent CHNA, 41.2% of those surveyed reported having fair/poor mental health, while only 19.9% have sought services. Since the beginning of the pandemic, 25.6% of those surveyed reported symptoms have gotten worse. Since 59% of those surveyed reported they would accept mental health treatment, it has been determined to be a priority.
Goal(s)	• Increase access to mental health service reach during and after the pandemic through the use of telehealth services, distributing supplies for in home privacy. • Increase opportunities for group mental health services through school outreach and increased partnerships. • Continue outreach to undocumented community members

Strategy #1: Provide free mental health services (group, family and individual) to uninsured or underinsured residents within the PSA at the Community Wellness locations.	
Strategy Was Implemented?	Yes
Target Population(s)	Residents within the PSA, undocumented people throughout Chicago, LGBTQ+ population within the PSA.
Results/Impact	• Provided a total to 4777 free mental health sessions (group therapy, family therapy, couple's therapy, and individual therapy) • 2979 sessions in 2022 • 1336 sessions in 2023 • 462 sessions in 2024 (through Sept) • 498 total unique individual who received free outpatient mental health services • 249 individuals in 2022 • 230 individuals in 2023 • 19 individuals in 2024 (through Sept)

Strategy #2: Offer mental health groups, individual therapy and psychiatric diagnoses in inpatient services.	
Strategy Was Implemented?	Yes
Target Population(s)	Residents within the PSA, undocumented people throughout Chicago, LGBTQ+ population within the PSA.
Results/Impact	• 2934 total unique individuals who received mental health services • 1298 individuals in 2022 • 12 individuals in 2023 • 966 individuals in 2024 (through Sept)

Priority Area: Access to Healthcare Services	
Community Health Need	In 2021, 41.3% of respondents reported they went without coverage in the past year and 53.5% reported they had difficulty accessing healthcare needs such as prescriptions and primary care appointments in the past year. The community identified several barriers to accessing healthcare: Insurance instability, lack of health insurance, office hours, the cost of physician visits, appointment availability, lack of transportation, finding a physician and not accommodating the culture or language of participants. Key stakeholders indicated a high need for increased health literacy opportunities in the community.
Goal(s)	• Facilitate more timely and improved healthcare by increasing patients' access to and utilization of health-related, wrap-around services. • Address the local barriers for access to healthcare (i.e. language barrier, health literacy education, transportation, financial challenges, and computer literacy).

Strategy #1: Provide assistance and support to seniors, adults, and families with children enrolling in health-related government programs and public benefits.	
Strategy Was Implemented?	Yes
Target Population(s)	Families in the PSA who are uninsured or underinsured. Community members who are in need of health literacy and support.
Results/Impact	• Provided assistance and support to seniors, adults, and families with children enrolling in health-related government programs and public benefits to a total of 1863 unique clients • 744 unique clients in 2022 • 526 unique clients in 2023 • 593 unique clients in 2024 (through Sept)

Strategy #2: Promote health literacy to community members by conducting outreach in collaboration with partner organizations, (i.e., schools, faith-based organizations, community-based organizations).	
Strategy Was Implemented?	Yes
Target Population(s)	Families in the PSA who are uninsured or underinsured. Community members who are in need of health literacy and support.
Results/Impact	• Provided a total of 83 presentations on healthcare literacy to the community • 70 presentations in 2022 • 3 presentations in 2023 • 10 presentations in 2024 (through Sept)