2015 Community Health Needs Assessment

Implementation Strategy

Saint Anthony Hospital (FY2016- FY2018)

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Community Health Needs Assessment

About Saint Anthony Hospital

In the fall of 2015, Saint Anthony Hospital embarked on a comprehensive Community Health Needs Assessment (CHNA) process to identify and address the key health issues for our community.

Saint Anthony Hospital is an independent, non-profit, faith-based, acute care, community hospital dedicated to improving the health and wellness of the families on the West Side and Southwest Side of Chicago. We have grown to provide medical care, social services, and community outreach to the residents of ten city neighborhoods: Archer Heights, Austin, Back of the Yards, Brighton Park, East Garfield Park, Little Village, McKinley Park, North Lawndale, Pilsen and West Garfield Park. Saint Anthony offers quality services close to home, caring for people regardless of their nationality, religious affiliation and ability to pay.

2015 Hospital facts and figures:

- 151-licensed beds
- 998-Employees
- 5,747-2015 Admissions
- 30,032-2015 Patient Days
- 1,557-2015 Births
- 36,903-2015 Emergency Department Visits
- 139,928-2015 Outpatient Care Center Visits
- 4,019-2015 Surgical Procedures

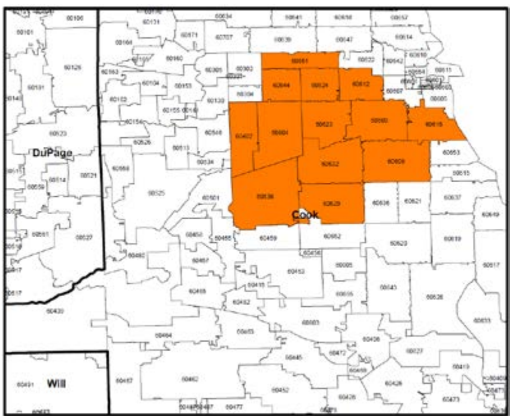
Saint Anthony Hospital completed its last Community Health Needs Assessment in 2015. ***[IRS Form 990, Schedule H, Part V, Section B, 3, 2015]***

Community Served

Definition of the Community Served

[IRS Form 990, Schedule H, Part V, Section B, 3a, 2015]

The study area for the survey effort (referred to as the “Saint Anthony Hospital Service Area” in this report, or “SAH Service Area”) is comprised of 13 residential ZIP Codes based on patient origination. This area definition is illustrated in the following map. This community definition was determined because greater than 90% of Saint Anthony Hospital’s patients originate from this area.



Demographics of the Community

[IRS Form 990, Schedule H, Part V, Section B, 3b 2015]

The general demographics of the Saint Anthony Hospital Service Area are as follows:

	Number
SEX AND AGE	
Total population (18+)	**613,468**
Age 18-39	309,279
Age 40-64	233,015
65 years and over	71,174
Male population (18+)	**249,763**
18 -39	158,918
Age 40-64	116,105
65 years and over	29,624
Female population (18+)	**250,932**
18 years-39	150,361
Age 40-64	116,910
65 years and over	41,550
RACE	
Total population (18+)	**613,468**
Non-Hispanic White (18+)	258,888
Non-Hispanic Black (18+)	160,825
Other Race (18+)	179,357
Two or More Races (18+)	14,398
Total population (18+)	**613,468**
Hispanic or Latino	299,656
Non-Hispanic or Latino	313,812

Source: GeoLytics: Demographic Data, US Census & GIS Software

Resources Available to Address the Significant Health Needs

[IRS Form 990, Schedule H, Part V, Section B, 3c 2015]

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

Access to Healthcare Services

- *Access Community Health Network*
- *Brighton Park Neighborhood Council*
- *Catholic Charities*
- *Chicago Commons/Nia Family Center*
- *Chicago Department of Public Health (CDPH)*
- *Cook County Health Department*
- *Erie Family Health Center*
- *Esperanza Health Centers*
- *Healthcare Alternative System*
- *Heartland Health Center*
- *Jorge Prieto Clinic, Cook County Health System*
- *La Casa Norte*
- *Little Company of Mary Hospital*
- *Logan Square Neighborhood Association*
- *Loretta Hospital*
- *Mile Square Health Center*
- *Near North Health Service Corporation*
- *PCC Wellness*
- *Roseland and St. Bernard Pediatric Mobile Units*
- *Safety Net Hospitals*
- *Specialist*
- *St. Bernard's Ambulatory Outpatient Center*
- *TASC*
- *Thrive Counseling Center*
- *West Humboldt Park Development Council*
- *West Suburban Hospital*
- *Westside Health Authority*

Arthritis, Osteoporosis & Chronic Back Conditions

- *Chiropractors, Naturopathy, Osteopathy*
- *Hospitals*
- *Chicago Park District*
- *Saint Anthony Hospital Physical Therapy*
- *Senior Centers*
- *Sports Therapy and Physical Therapy Businesses*
- *Universidad Popular*

Cancer

- *Academic Medical Centers*
- *Access Community Health*
- *Affordable Care Act*
- *AIDS Foundation*
- *American Cancer Society and Gilda's Club*
- *Cancer Support Centers*
- *Christ Hospital*
- *Englewood Health Center*
- *Erie Family Health*
- *Esperanza Health Center*
- *Health Department*
- *Healthy Eating through Park Districts*
- *John H. Stroger Hospital*
- *Largest Medical Districts in the World*
- *Lawndale Christian Health Center*
- *Local Physician Offices*
- *Metropolitan Chicago Breast Cancer Task Force*
- *Miles Square Health Clinic*
- *Mount Sinai Hospital*
- *North FQHCs*
- *PCC Community Wellness Center*
- *Saint Anthony Hospital*
- *St. Bernard Hospital*
- *University of Illinois Cancer Center*
- *Volunteer Health Associations*

Chronic Kidney Disease

- *Affordable Care Act*
- *Davita Dialysis*
- *Local Health Departments*
- *Major Academic Medical Centers*
- *National Kidney Fund of Illinois*
- *Saint Anthony Hospital Little Village Clinic*

Dementias, Including Alzheimer's Disease

- *Alzheimer's Center*
- *Behavioral Health Referral at LHD*
- *Cook County Health Systems*
- *Department of Aging*
- *Primary Care Providers*
- *Public Health Nursing*
- *Senior Center for Case Management*
- *Support Groups*
- *The Greater Illinois Chapter of Alzheimer's Association*
- *West Suburban Hospital*

Diabetes

- *Access Community Health Network*
- *Affordable Care Act Extending Coverage*
- *American Cancer Society*
- *Aunt Martha's*
- *Beloved Community Family Wellness Center*

Boys and Girls Club
Chicago Food Depository
Chicago Park District
CLOCC
Community Health Clinic
CVS Minute Clinics
Diabetes Care Center at St. Anthony
Diabetes Educators
Doctor's Office
Educational Programs through Community
Englewood Health Center
Esperanza Health Center
FQHCs
Free Educational Materials in Waiting Areas
Growing Home Farm
Health Fairs
Hospital Based Classes
LCM Diabetic Educational Classes
Local Health Department
Major Academic Medical Centers
Mercy Hospital
Miles Square Health Center
Mount Sinai Hospital
New Life Center
Northwestern Memorial Hospital
Norwegian American Hospital
Pak Park Farmer's Markets
PHN Meet with DM Patients
Pilot Produce Stands
Pak Park Farmer's Markets
PHN Meet with DM Patients
Rush University Medical Center
Saint Anthony Hospital
St. Bernard Hospital
Support Groups
Universidad Popular Health Literacy Program
Walgreens
Whole Foods Cooking Classes

Family Planning

Alivio Medical Center
CDPH
DHS Office
Family Focus
FQHCs
Health Centers
Lawndale Christian Health Center
Monticello Medical Clinic
Near North Health Service
New Moms
Planned Parenthood
Public School Sex Education
Saint Anthony Hospital
St. Bernard Women's Wellness Program
Westside Health Authority
Women's Health Clinics

Hearing & Vision

Local Private Practices
Oasis for the Visually Impaired Support Group
Progress Center in Blue Island
Reading for the Blind
Sertoma
St. Bernard Pediatric Health Mobile Unit
Testing at Birth

Heart Disease & Stroke

American Heart Association
Area FQHCs
Beloved Community Family Wellness Center
Christ Hospital Educational Seminars
CLOCC
Community Health Screenings
Englewood Health Center
Healthy Chicago Healthy Hearts Campaign
Keep Your Heart Healthy
Local Health Departments
Major Academic Medical Centers
Mile Square Health Center
Nutrition Education at Senior Centers
Parks and Other Facilities for Exercise
Whole Foods Classes

HIV/AIDS

AFC
Affordable Care Act
Behavioral Health and Substance Abuse Programs
CDPH HIV Bureau
Health Department
Healthcare Alternative Systems
Heartland Alliance
Howard Brown
Lawndale Christian Health Center
Norwegian American Hospital
Ruth M. Rothstein CORE Center
Sinai Health System
The AIDS Foundation of Chicago
The Gift House
Vida/SIDA, Puerto Rican Cultural Center

Immunization & Infectious Diseases

Access Community Health Network
Chicago Monticello Medical Center
Erie Family Health Center
Mile Square Health Center
Near North Health
Norwegian American Hospital
Sinai Health System
The Gift House

Infant & Child Health

Access Community Health Network
Affordable Care Act Extending Coverage
Carole Robertson Center

- CDPH MCH Program
- CDPH/CPS Teen Pregnancy Prevention Program
- Churches
- Cook County Department of Public Health
- EverThrive Illinois
- Family
- Federally Qualified Health Centers
- Gads Hill Center
- Growing Network of Community Health Workers
- Healthcare Alternative Systems
- Illinois Action for Children
- Lawndale Christian Health Center
- Mile Square Health Center
- New Moms
- Norwegian American Hospital
- Planned Parenthood
- Saint Anthony Hospital
- School Programs
- Sinai Children's Hospital
- Social Services
- St. Bernard Hospital Pediatric Mobile Unit
- WIC

Injury & Violence

- Cease Fire
- Home of the Sparrow
- Mujeres Latinas en Accion
- Police Department
- Saint Anthony's Hospital Community Wellness Program
- Shelters
- Social Services
- Wings

Mental Health

- A Safe Haven Foundation
- Access Community Health Network
- Ada S. McKinley Social Services
- Anonymous Support Groups
- Association House of Chicago
- Behavior Health Programs at FQHCs
- Bobby E. Wright
- Catholic Charities
- Chicago for Homeless
- Church
- City Department of Health
- Community Counseling Centers of Chicago-C4
- Community Mental Health Agencies
- Erin Family Health Center
- Family Guidance Centers
- Gateway Foundation
- Healthcare Alternative Services
- Heartland Alliance
- Heartland International Health Center
- Hospitals
- Howard Brown Health Center
- HRDI
- I Am Able
- Illinois Children's Healthcare Foundation
- Inpatient & Outpatient Services at St. Bernard Hospital
- Jail
- LHD Behavioral Health Department
- Local Faith Based Organizations
- Mental Health of America – Illinois
- Metropolitan Family Health
- Mt. Sinai
- Nonprofit Aging Agencies
- PADS Homeless Shelter
- Pillars
- Pilsen Wellness Center
- Presence Behavioral Health
- Primary Care Physicians
- Programs run out of the 63rd Street Clinic
- SAH Mental Health Wellness Program
- Saint Anthony Hospital
- School Counselors
- St. Bernard Hospital
- Thresholds
- Thrive Counseling Center
- Trilogy

Nutrition, Physical Activity & Weight

- Access for Divvy Bikes
- Access to Parks
- Active Transportation Alliance
- Affordable and Healthy Restaurants
- American Heart Association
- Beaches and Playgrounds
- Boys and Girls Club
- Ceasefire
- Chicago Park District
- Christ Hospital Exercise Programs
- Clubs and Support Groups
- Community Improvements, Sidewalks and Lights
- Community Sports Programs
- Consortium to Lower Obesity in Chicago Children (CLOCC)
- Fitness Boot Camps at Hamilton Park
- Growing Homes Wood St. Urban Farm
- Health Centers
- Hospitals and Clinics
- I Grow Chicago
- Illinois AAP
- Illinois Alliance to Prevent Obesity
- Kells Park
- Let's Move Campaign
- Logan Square Neighborhood Association
- Nutritional Information in Restaurants
- Parks

Pilot Produce Market Projects
Primary Care Providers
Programs at FQHCs
Schools
Senior Nutrition Programs
The Chicago Park District and Cook County Forest Preserve
The Chicago Partnership for Health Promotion
UP Healing Program
Weight Watchers
West Humboldt Park Development Council
WIC Nutritional Counseling
Workplace Wellness
YMCA

Oral Health

Access Community Health Network
Affordable Care Act
Aunt Martha's Health Center
College of Dentistry, University of Illinois at Chicago
Dental Office
Dental School Clinics
Erie Family Health Center
IFLOSS
LaGrange Community Nurse
Local Dental Societies
On-call Oral Surgeons at Hospitals
PCC Community Wellness Center
Private Dental Practices
St. Bernard Dental Center

Respiratory Diseases

Access Community Health Center
Affordable Care Act
American Lung Association
Chicago Stop Smoking Program
Erie Family Health Center
Health Departments
Hospitals and Medical Offices
Mount Sinai Asthma Program
Norwegian American Hospital
Primary Care Physicians
Respiratory Health Association
Sinai Health System/Mount Sinai Hospital

Sexually Transmitted Diseases

Beloved Health Center
Chicago Department of Public Health
Chicago Monticello Medical Center
Clara's House
Community Health Clinic
Core Center
Englewood Health Center
Federally Qualified Health Centers
Free Condoms
Health Department
Howard Brown Health Center
Imagine Englewood
Near North
Planned Parenthood
Primary Care Physicians
Schools
St. Bernard Hospital

Substance Abuse

Chicago Recovery Alliance
Community Outreach Intervention Projects
DFSS Substance Abuse
Gateway
Haymarket
Healthcare Alternative Systems
Hospitals
Illinois DASA
Local Support Groups
MacNeal Hospital, Berwyn
PADS
Rosecrance
St. Bernard Hospital
Substance Abuse Programs at FQHCs
TASC
Wayback Inn, Maywood
Women's Treatment Center, Chicago

Tobacco Use

Affordable Care Act
American Lung Association
Chicago Stop Smoking Program
E-Cigarette Incentives
Local Health Departments
Quitline
Respiratory Health Association
Smoking Cessation Programs

Collaboration

[IRS Form 990, Schedule H, Part V, Section B, 6a, 2015]
[IRS Form 990, Schedule H, Part V, Section B, 6b, 2015]

The 2015 Community Health Needs Assessment was facilitated by the Metropolitan Chicago Healthcare Council (MCHC) on behalf of participating member hospitals and health systems. These hospitals and health systems include: Alexian Brothers Health System/Amita Health (Alexian Brothers Behavioral Health Hospital, Alexian Brothers Medical Center, St. Alexius Medical Center); Amita Health (Adventist Bolingbrook Hospital, Adventist GlenOaks Hospital, Adventist Hinsdale Hospital, Adventist LaGrange Memorial Hospital); Edward–Elmhurst Healthcare (Edward Hospital & Health Services, Elmhurst Memorial Hospital); Franciscan Alliance (Franciscan St. James Health); Ingalls Health System (Ingalls Memorial Hospital); Little Company of Mary Hospital and Health Care Centers; Loretto Hospital; Northwest Community Healthcare (Northwest Community Hospital); Northwestern Medicine (Central DuPage Hospital, Northwestern Memorial Hospital, Northwestern Lake Forest Hospital); Palos Community Hospital; Rush System for Health (Rush Oak Park Hospital, Rush University Medical Center); Saint Anthony Hospital; St. Bernard Hospital and Health Care Center; Swedish Covenant Hospital; Thorek Memorial Hospital; and the University of Chicago Medicine.

How CHNA Data Were Obtained

[IRS Form 990, Schedule H, Part V, Section B, 3d, 2015]

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels.

Qualitative data input includes primary research gathered through an online key informant survey.

Community Health Survey

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) 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. The final survey instrument was developed by PRC, with input from Saint Anthony Hospital and the other community sponsors.

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities.

The sample design used for this effort consisted of a random sample 358 individuals age 18 and older in Saint Anthony Hospital's Primary Service Area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Primary Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Saint Anthony Hospital Service Area were obtained from the following sources:

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention,

Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- ESRI ArcGIS Map Gallery
- Illinois Department of Public Health
- Illinois State Police
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Community Stakeholder Input

[IRS Form 990, Schedule H, Part V, Section B, 3h, 2015]
[IRS Form 990, Schedule H, Part V, Section B, 5, 2015]

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Saint Anthony Hospital and other participating members of the Metropolitan Chicago Healthcare Council; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. 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.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 41 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation

Key Informant Type	Number Invited	Number Participating
Community/Business Leader	58	12
Other Health (Non-Physician)	21	8
Physician	28	3
Public Health Expert	26	6
Social Services Representative	38	12

Project Assistance

This assessment was conducted by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

Vulnerable Populations

[IRS Form 990, Schedule H, Part V, Section B, 3f, 2015]

The CHNA analysis and report yielded a wealth of information about the health status, behaviors and needs for our population. A distinct advantage of the primary quantitative (survey) research is the ability to segment findings by geographic, demographic and health characteristics to identify the primary and chronic disease needs and other health issues of vulnerable populations, such as uninsured persons, low-income persons, and racial/ethnic minority groups.

Information Gaps

[IRS Form 990, Schedule H, Part V, Section B, 3i, 2015]

While this Community Health Needs Assessment is quite comprehensive, Saint Anthony Hospital and PRC recognize that it cannot 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 all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — 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 racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

Public Dissemination

[IRS Form 990, Schedule H, Part V, Section B, 7a-7c, 2014]

This Community Health Needs Assessment is available to the public using the following URL: http://sah.healthforecast.net/.

HealthForecast.net® is an interactive, dynamic tool designed to share CHNA data with community partners and the public at large.

This site:

- Informs readers that the CHNA Report is available and provides instructions for downloading it;

- Offers the CHNA Report document in a format that, when accessed, downloaded, viewed, and printed in hard copy, exactly reproduces the image of the report;
- Grants access to download, view, and print the document without special computer hardware or software required for that format (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital organization or facility or to another entity maintaining the website.

Links to this dedicated HealthForecast.net™ site are also made available at Saint Anthony Hospital's website at: http://www.saintanthonyhospital.org/index.php/about-us/46-community-health-needs-assessment

Saint Anthony Hospital will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. Saint Anthony Hospital will also maintain a hardcopy of the CHNA report that may be viewed by any who request it in the Mission and Community Development Department.

Health Needs of the Community

Significant Health Needs of the Community

[IRS Form 990, Schedule H, Part V, Section B, 3e, 2015]

The following "areas of opportunity" represent the significant health needs of the community, based on the information gathered through the 2015 Community Health Needs Assessment for Saint Anthony Hospital. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

Areas of Opportunity Identified Through This Assessment	
Access to Healthcare Services	• Barriers to Access ○ Finding a Physician ○ Lack of Transportation • Skipping/Stretching Prescriptions • Specific Source of Ongoing Medical Care • Routine Medical Care (Children) • Emergency Room Utilization • Attendance at Health Promotion Events • Regular Dental Care
Cancer	• Cancer Deaths ○ Including Prostate Cancer, Female Breast Cancer, Colorectal Cancer Deaths • Cancer Incidence ○ Including Prostate Cancer, Cervical Cancer Colorectal Cancer Incidence • Colorectal Cancer Screening
Chronic Kidney Disease	• Kidney Disease Deaths
Diabetes	• Diabetes Prevalence • Prevalence of Borderline/Pre-Diabetes • *Diabetes ranked as a top concern in the Online Key Informant Survey.*
Heart Disease & Stroke	• Heart Disease Deaths • Heart Disease Prevalence • High Blood Pressure Prevalence • Overall Cardiovascular Risk • *Heart Disease & Stroke ranked as a top concern in the Online Key Informant Survey.*
Infant Health	• Low-Weight Births • Infant Mortality • Unwed Mothers • *Family Planning ranked as a top concern in the Online Key Informant Survey.*
Injury & Violence	• Firearm-Related Deaths • Homicide Deaths • Violent Crime Rate • Violent Crime Experience • *Injury & Violence ranked as a top concern in the Online Key Informant Survey.*
Mental Health	• "Fair/Poor" Mental Health • Diagnosed Depression • Symptoms of Chronic Depression • Suicide Deaths • Seeking Help for Mental Health • *Mental Health ranked as a top concern in the Online Key Informant Survey.*

continued next page

Areas of Opportunity (continued)	
Nutrition, Physical Activity & Weight	• Fruit/Vegetable Consumption • Overweight & Obesity [Adults] • Overweight & Obesity [Children] • Meeting Physical Activity Guidelines 　○ Vigorous Physical Activity • *Nutrition, Physical Activity & Weight ranked as a top concern in the Online Key Informant Survey.*
Potentially Disabling Conditions	• Arthritis Prevalence (50+) • Blindness/Vision Trouble • Osteoporosis Prevalence (50+) • Regular Eye Care • Sciatica/Back Pain Prevalence
Respiratory Diseases	• Asthma Prevalence [Adults] • Pneumonia/Influenza Deaths • *Respiratory Diseases ranked as a top concern in the Online Key Informant Survey.*
Sexually Transmitted Diseases & HIV/AIDS	• HIV Prevalence • Gonorrhea Incidence • Chlamydia Incidence • *Sexually Transmitted Diseases ranked as a top concern in the Online Key Informant Survey.*
Substance Abuse	• Excessive Drinking • *Substance Abuse ranked as a top concern in the Online Key Informant Survey.*
Tobacco Use	• Environmental Tobacco Smoke Exposure at Home 　○ Including Among Households with Children 　○ Including Among Non-Smokers • Cigar Smoking Prevalence • *Tobacco Use ranked as a top concern in the Online Key Informant Survey.*

Identify & Prioritizing Health Needs

[IRS Form 990, Schedule H, Part V, Section B, 3g, 2015]

Identification of Health Needs

The significant health needs (“Areas of Opportunity” outlined above) were determined after consideration of various criteria, including: standing in comparison with benchmark data; identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue.

Prioritization of Health Needs

On March 10, 2016 approximately 100 stakeholders working in the Saint Anthony Hospital service area met to evaluate, discuss and prioritize health issues for the community, based on findings of the 2015 PRC Community Health Needs Assessment (CHNA). Professional Research Consultants, Inc. (PRC) began the

meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above).

Following the data review, PRC answered any questions and facilitated a group dialogue, allowing participants to advocate for any of the health issues discussed. Finally, participants were provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

- **Scope & Severity** — The first rating was to gauge the magnitude of the problem in consideration of the following:
  - How many people are affected?
  - How does the local community data compare to state or national levels, or Healthy People 2020 targets?
  - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

  Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

- **Ability to Impact** — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criterion were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. **Access to Healthcare Services**
2. **Cancer**
3. **Chronic Kidney Disease**
4. **Diabetes**
5. **Heart Disease & Stroke**
6. **Infant Health**
7. **Injury & Violence**
8. **Mental Health**
9. **Nutrition, Physical Activity & Weight**
10. **Potentially Disabling Conditions**

11. **Respiratory Diseases**

12. **Sexually Transmitted Diseases & HIV/AIDS**

13. **Substance Abuse**

14. **Tobacco Use**

Implementation Strategy

Implementation Strategy Adoption

[IRS Form 990, Schedule H, Part V, Section B, 8-10, 2015]

This summary outlines Saint Anthony Hospital's plan (Implementation Strategy) to address our community's health needs by 1) sustaining efforts operating within a targeted health priority area; 2) developing new programs and initiatives to address identified health needs; and 3) promoting an understanding of these health needs among other community organizations and within the public itself.

On, September 23, 2016 the Board of Directors of Saint Anthony Hospital approved this Implementation Strategy to undertake the outlined measures to meet the health needs of the community.

This Implementation Strategy document is posted on the hospital's website at: www.sahchicago.org.

Hospital-Level Community Benefit Planning

[IRS Form 990, Schedule H, Part V, Section B, 11, 2015]

Priority Health Issues to Be Addressed

In consideration of the top health priorities identified through the CHNA process — and taking into account hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined that Saint Anthony Hospital would focus on developing and/or supporting strategies and initiatives to improve:

- **Access to Healthcare Services**
- **Diabetes**
- **Infant Health**
- **Injury & Health**
- **Mental Health**
- **Nutrition, Physical Activity & Weight**

Priority Health Issues That Will Not Be Addressed & Why

In acknowledging the wide range of priority health issues that emerged from the CHNA process, Saint Anthony Hospital determined that it could only effectively focus on those which it deemed most pressing, most under-addressed and most within its ability to influence.

The other eight areas; substance abuse, tobacco use, cancer, potentially disabling conditions, chronic kidney disease, sexually transmitted diseases and HIV/AIDS, heart disease & stroke and respiratory diseases were excluded from the implementation strategy because we have limited resources or minimal expertise to address this area. Other affiliate clinics and community-based organizations have infrastructure and programs in place to better meet this need. Although Saint Anthony Hospital provides services surrounding cancer, potentially disabling conditions, chronic kidney disease, sexually transmitted diseases & HIV/AIDS, heart disease & stroke, substance abuse & tobacco and respiratory diseases, they were not selected for action at this time because of limited resources and higher priorities identified by the community.

Implementation Strategies & Action Plans

The following displays outline Saint Anthony Hospital's plans to address those priority health issues chosen for action in the FY2016-FY2018 period.

ACCESS TO HEALTHCARE SERVICES	
Community Partners/ Planned Collaboration	A Safe Haven A Silver Lining Center Home Hispanic Elderly Chicago Suburban Westland Empowerment Network Enlace Esperanza Health Center Garfield Park Community Council Chicago Department of Public Health Illinois 7th Congressional District Illinois Hunger Coalition Instituto del Progresso Latino New City Supportive Living North Lawndale Community Coordinating Council Ombudsman Community Advisory Council Pilsen Wellness Center Prime Care Health Services Sankofa State Farm Insurance Agency (Darren Tillis) United for Better Living United Way of Metropolitan Chicago
Goal	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).
Timeframe	FY2016-FY2018
Scope	Connect individuals to clinical services and enroll in public benefits programs.
Strategies & Objectives	**Strategy #1: Provide community health education, health fairs, and screening services** • Provide health education, health fairs, 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 Community Nurse in order to: 1) nurture individuals through holistic care (physical, psychological, emotional and spiritual); 2) increase individuals' health awareness and knowledge so 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. • Support at-risk and vulnerable populations transitioning from the hospital to the community by connecting them with the necessary services. **Strategy #2: Provide assistance and support to seniors, adults, and families with children enrolling in health-related government programs and public 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 open enrollment assistance, targeted case management, and advocacy for individuals seeking access to government benefits including: Medicare, Medicaid, prescription drug coverage, food stamps, senior housing, and the senior companion program.

	• Provide assistance and resources to seniors and their caregivers through the Senior Wellness Program. Services include but not limited to: medical management, connecting individuals to physicians, assistance with government related services, etc. • Provide clients with information and referrals for other health and social services needed. **Strategy #3: Provide curbside transportation services as necessary** • Provide free door-to-door transportation to and from the hospital for elderly and low-income patients in the community so they can access medically necessary, life-prolonging treatment 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 #4: 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. **Strategy #5: Provide charity care and need-based financial assistance 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 the cost of living utilizing the local wage index compared to the national wage index. • 100% charity will be given to all undomiciled patients at the time of discharge and all denied MANG applicants upon receipt of denial. • Uninsured patients with the ability to pay will be provided with self-pay discounts.
Financial Commitment	**Strategy #1 and #2**: **Health-based education and enrollment in government-related programs** • $340,000 annually **Strategy #3: Transportation** • $205,000 annually **Strategy #4: Childcare** • $27,000 annually **Strategy #5: Patient Financial Services** • $16,450,000 annually
Anticipated Impact	• Reducing transportation as a barrier to accessing healthcare services. • Provide charity care those patients that have financial challenges that hinder them from accessing healthcare services. • Enroll qualified individuals into public benefits programs.
Plan to Evaluate Impact	**Strategy #1: Community based health education** In a 12-month period: • Reach 200 residents through community based health presentation. • Maintain regular contact with 10 churches and community-based organizations providing health related activities based on organization's need. • Provide health resources thought participation in a minimum of 30 health fairs. **Strategy #2: Provide assistance and support to seniors, adults, and families with children enrolling in health-related government programs and public benefits** In a 12-month period: • Complete 500 applications for individuals applying for Medicaid benefits.

	• Complete 140 applications for individuals applying for SNAP (food stamps). • Support 200 seniors with Medicare enrollment. • Provide 350 referrals to other needed health and socials services. **Strategy #3: Transportation** In a 12-month period: • Provide 4,000 encounters for patients who need transportation for clinical services to the hospital. **Strategy #4: Childcare** In a 12-month period: • A minimum of 150 children will receive childcare while their parents receive services via the Community Wellness Program. **Strategy #5: Patient Financial Services** In a 12-month period: • Provide 4.5% of charity care to gross patient revenue.
Results	*Pending*

INFANT HEALTH	
Community Partners/ Planned Collaboration	Austin Coming Together Carole Robertson Center for Learning Casa Central Chicago Public School Child Find Chicago Youth Centers Early Intervention El Valor Esperanza Health Center Family Focus Gads Hill Child Development Center Healthy Families Chicago Hogar del Nino Illinois Action for Children Illinois Chapter-March of Dimes Lan 67 Community Action Team Marillac House Social Center New Moms North Lawndale Innovation Zone Men Making a Difference Ounce of Prevention Pillars Taller de Jose Pilsen Wellness Center WIC Clinics in Lawndale
Goal	Ensure access to prenatal healthcare and education to women in the community. Improve the likelihood of healthy pregnancy and birth outcomes of children in the community.
Timeframe	FY2016-FY2018
Scope	Provide prenatal, antenatal and postpartum services while promoting healthy development in children 0-8 years of age.
Strategies & Objectives	**Strategy #1: Prenatal Case Management** • OB Patient Care Navigator will support women with their individual prenatal, antenatal, and postpartum care and maternity needs. The navigator will help connect patients with the appropriate resources throughout pregnancy (i.e. doctors, midwifery, education, etc). **Strategy #2: Education for women** • Offer prenatal classes for all mothers (especially teen moms, first time moms, and women who lack resources). The following classes are offered: birthing class, newborn class, breastfeeding class, and infant CPR class. • Offer tours of the Family Birthing Center so mothers can get acquainted with the available services. **Strategy #3: 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 #4: Promote newborn safety** • All patients delivering at Saint Anthony Hospital will receive a car seat with a newborn starter kit. • A Certified Child Passenger Technician will install car seats at the time of patient discharge. **Strategy #5: Diabetes management for pregnant women with gestational diabetes** • Provide educational workshops for gestational diabetes patients.

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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.
- 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 individual parent and child needs.

Strategy #7: Developmental support services

- Provide direct support to patients under the age of eight 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 through the Community Wellness Program and elsewhere as necessary.

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Financial Commitment

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Strategy #1, Strategy 2, and Strategy 4: Prenatal Case Management Services, education for women and newborn safety

- $125,000 annually

Strategy #3: Free pregnancy tests

- $1,000 annually

Strategy #5: Diabetes management for pregnant women with gestational diabetes

- $61,530 annually

Strategy #6: Interactive parent-child development group:

- $56,043 annually

Strategy #7: Developmental support services

- $70,053 annually

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Anticipated Impact

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- Improve likelihood of a healthy pregnancy and birth outcomes of children in the community
- Improve the heath, development, and well-being of children under the age of eight in the community

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Plan to Evaluate Impact

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Strategy #1: Prenatal Case Management Services

In a 12-month period:

- The OB Navigator will have a minimum of 500 encounters with expected mothers.

Strategy #2: Education for women

In a 12-month period:

- Provide group-based prenatal education in Spanish and English weekly. Topics included are birthing, newborn, and CPR.
- Infant CPR class will be offered every six months in partnership with the American Red Cross.
- Provide individual and group tours of Saint Anthony Hospital's maternity center a minimum of four times per month.

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	Strategy #3: Free pregnancy tests In a 12-month period: • Complete a minimum of 1,000 pregnancy test across all Saint Anthony Hospital clinics and Community Wellness Program. **Strategy #4: Promote newborn safety** In a 12-month period: • 100% of moms who deliver at Saint Anthony Hospital will receive a car seat at no cost. • Car seat education and installation will be provided to 100% of families who deliver at Saint Anthony Hospital. **Strategy #5: Diabetes management for pregnant women with gestational diabetes** In a 12-month period: • Gestational diabetes patients will receive individual or group-based diabetes self-management education. **Strategy #6: Interactive parent-child development group** In a 12-month period: • Provide weekly groups for a minimum of 60 children and 30 adults. • 75% of families enrolled in each group will complete a six-month period. • 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 and increase in their child's comfort level in new and different large groups 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** In a 12-month period: • 90% of patients needing a diagnostic evaluation will be successfully linked to evaluation services. • 150 patients and families will receive individualized education and support related to development concern. • Community Wellness program will facilitate a minimum of two infant health workshops to pediatricians and pediatric residents.
Results	*Pending*

INJURY AND VIOLENCE	
Community Partners/ Planned Collaboration	Better Boys Family Services Casa Central Chicago Police Department District 10th, 11th &15th Chicago Youth Centers Lawndale Christian Legal Center Marshall Square Resource Network Peace Hub North Lawndale Preservation of Life Campaign TR4IM UCAN Universidad Popular
Goal	Provide supportive services to those affected by violence as well as offering spaces of healing and support to families to support violence prevention.
Timeframe	FY2016-FY2018
Scope	Provide support to parents and primary caregivers of children between the ages of 0-8 within Saint Anthony Hospital's service area.
Strategies & Objectives	**Strategy #1: Family and Supportive Services** In a 12-month period • Offering group-based parent education programs (Adults and Children Together). • Offering a therapeutic family support program for parents and their 5th-8th grade youth. • Offering Adolescent and Parents Education Program for children 10-13 years old. • Serving as a host to Grupo Consuelo, a therapeutic support space for those families whose children have been directly impacted by community violence. • Expansion of Grupo Consuelo to meet the needs of families who have suffered traumatic loss in other communities that Community Wellness Program targets. **Strategy #2: Serving as a trauma informed approach agent** In a 12-month period • Screening for exposure to violence and trauma in the hospital and utilizing the Community Wellness Program to serve as a connector to appropriate social services and therapeutic support. • Focus on building collaborative partnerships with first responders to violent incidents in the communities Community Wellness Program serves (such as Padres Angeles or the YMCA's Youth Safety and Violence Prevention team). Community Wellness Program is uniquely positioned to provide early and long-term engagement of violent injury victims and the families of homicide victims. Currently there is no other mental health provider in Chicago that has created a functional linkage along these lines serving the adult population. **Strategy #3: Injury prevention** • All patients delivering at Saint Anthony Hospital will receive a car seat with a newborn starter kit. • A Certified Child Passenger Technician will install car seats at the time of patient discharge .
Financial Commitment	**Strategy #1: Family and Supportive Services** • $118,220 annually

<table>
<tr><td></td><td>Strategy #2: Serving as a trauma informed approach agent
$81,011 annually
Strategy #3: Injury prevention
Cost included in Priority area #1, Infant health</td></tr>
<tr><td>Anticipated Impact</td><td>Engage parents and primary caregivers with understanding basic elements of child development, protective factors and skills related to violence prevention as well as roots and consequences of violence.
Decrease the number of car sear injuries by educating parent on safe installation and the importance car seat safety.</td></tr>
<tr><td>Plan to Evaluate Impact</td><td>Strategy #1: Family and Supportive Services
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; reaching a minimum of 80 parents per year.
Host a minimum of 6 education groups to strengthen relationships between parents and their pre-adolescent children.
Provide a minimum of 24 support grants for parents who have lost children to violence.
Strategy #2: Serving as a trauma informed approach agent
In a 12-month period:
Engage and support three community-based collaborations that address trauma within communities in Saint Anthony Hospital's service area.
Strategy #3: Injury prevention
In a 12-month period
See Infant Health-Strategy #2, provide car seats to all families who deliver at Saint Anthony Hospital.</td></tr>
<tr><td>Results</td><td>Pending</td></tr>
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MENTAL HEALTH	
Community Partners/ Planned Collaboration	Behavioral Health Counseling Services Bobby E. Wright Behavioral Health Center Brighton Park Neighborhood Council Deer Rehabilitation Services Esperanza health Center Garfield Park Behavioral Hospital Healthcare Alternative Systems (H.A.S.) Chicago Department of Public Health I AM ABLE Inner-city Muslim Action Network Mount Sinai Hospital's Under the Rainbow Mujeres Latinas en Accion The Learning Center Roots to Wellness TR4IM Universidad Popular
Goal	Increase awareness of associated social determinants of mental health among providers and the community, as well as, increase access to mental health services for community residents.
Timeframe	FY2016-FY2018
Scope	Connect uninsured and underinsured individuals with quality mental health services.
Strategies & Objectives	**Strategy #1: Offer free therapeutic intervention services to uninsured and underinsured individuals throughout our service areas via community wellness centers.** • Individual and couple psychotherapy: Clients receive 45-minute sessions. Duration and frequency of therapy vary depending on client needs, and varies from a few weekly sessions to over a year. • Therapeutic groups: Each group lasts approximately 12 weeks. • Socialization groups: Creating a variety of socialization groups for clients that report social isolation. **Strategy #2: Become a source of referral to connect community residents to resources.** • Developing relationships with community partners and resources that support case management and accompaniment to address social needs of participants of the Mental Health Program. • Actively participate in the referral networks established by Roots to Wellness and TR4IM Mental Health coalitions in order to coordinate referrals utilizing a centralized electronic referral system. • Staff will update and maintain a provider resource tool to serve as a referral guide for people seeking services that cannot be received at our sites. **Strategy #3: Support the development of coalitions and increase awareness of resources between providers through participation and leadership within community and healthcare coalitions.** • Actively engage with community partners, including but not limited to church groups, community groups, and schools to offer community presentations on how to access services and information on mental health topics • Staff will participate in available mental health networks as a method to promote the continued education of staff, and develop strong relationships with other mental health providers and community stakeholders of the region in order to identify and cultivate relationships for referrals and resources. • Continue to co-convene Roots to Wellness with community-based organizations, mental health providers, and community residents to come together and to coordinate, advocate, and provide support that builds on the

	inherent strengths and existing resources within the community while also addressing the impact that trauma has on the residents of the southwest side of Chicago. **Strategy #4: Increase mental health awareness in our community service areas and address stigma through educational presentations** • Presentations are given by request in community settings. Subjects include: depression, anxiety, trauma, stress management/relaxation techniques, among other topics, and always include an orientation to therapy. **Strategy #5: Social work intern site placement** • The Community Wellness Program serves as a 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.
Financial Commitment	**Strategy #1: Strategy#5** • $312,500 annually
Anticipated Impact	• Improve mental health status of uninsured and underinsured high functioning adults. • Decrease the stigma related to mental health services. • Support advocacy work related to mental health services and addressing trauma.
Plan to Evaluate Impact	**Strategy #1: Offer free Mental Health Services** In a 12-month period: • Provide mental health services to 300 community residents through individual, couples and group therapy. • Implement a one-page Client Assessment Tool to evaluate clients in four areas (self-awareness, self-expression, self-worth, and problem solving). • Patient Health Questionnaire (PHQ-9) to evaluate symptom alleviation. **Strategy #2: Connect community residents to resources** In a 12-month period: • Track the number of mental health clients referred to additional supportive services as needed. **Strategy #3: Support community-based coalitions surrounding mental health** In a 12-month period: • Work with a minimum of four coalitions that address and support mental health programs. **Strategy #4: Increase mental health awareness** In a 12-month period: • Provide mental health workshops to a minimum of 200 residents. **Strategy #5: Social work intern site placement** In a 12-month period: • Provide internship placements for a minimum of two interns.
Results	*Pending*

NUTRITION, PHYSICAL ACTIVITY & WEIGHT DIABETES	
Community Partners/ Planned Collaboration	American Diabetes Association Better Boys Foundation Family Focus Lawndale Christian Development Corporation Lawndale Christian Health Center North Lawndale Community Coordinating Council Parkview Rehabilitation Center Rauner YMCA Sinai Community Institute Sinai Urban Health Institute The Learning Center YMCA North Lawndale
Goal	Bring diabetes education and management services to more residents in the hospital's service area. Employ best practice strategies that lead to diabetes prevention, quality diabetes outcomes, and reduction in the hospitals readmission; Maintain educational and clinical competencies endorsed by the American Diabetes Association; Increase awareness of healthy foods and increase physical activity in the community.
Timeframe	FY2016-FY2018
Scope	Provide outpatient support and education for individuals with diabetes and weight management.
Strategies & Objectives	**Strategy #1: Provide systemic care coordination for patients in order to increase access to and availability of diabetes nutrition and management services through expanding the Center for Diabetes and implementing the Diabetes Connect Program.** • Promote internal and external partnerships focused on increasing referrals and bringing the Center's services to locations beyond the hospital's walls. • Diabetes Connect Program will provide targeted care coordination; individual case management; medication management; track each individual's progress through the program by measuring A1C levels; connect patients to free resources in the community to help maintain a healthy lifestyle. **Strategy #2: Provide the Wellness that Works Program to provide healthy lifestyle management and education on nutrition and accessing healthy foods.** • A nutrition specific program which provides education and support related to healthy shopping and eating practices, physical activity, identifying barriers to health and problem solving, and identifying coping strategies. • Assist program participants in setting personal goals related to maintaining a healthy lifestyle. **Strategy #3: Provide support and education related to diabetes issues, including eating habits and lifestyle choices, to community members through Community Nurse.** • Provide individualized health counseling by the Community Nurse and follow-up referrals as appropriate.
Financial Commitment	**Strategy #1: Provide access to patients to support with diabetes and prevention** • $312,500 annually **Strategy #2: Nutrition Education** • $61,000 annually **Strategy #3: Collaboration** • $49,224 annually

Anticipated Impact	• Decrease patients A1C levels. • Provide Health education and screenings for nutrition and diabetes.
Plan to Evaluate Impact	**Strategy #1: Provide access to patients to support with diabetes and prevention** In a 12-month period: • Provide care coordination for 190 patients at risk that are at risk for diabetes. • Track and monitor AIC levels. **Strategy #2: Nutrition Education** In a 12-month period: • Enroll a total of 40 individuals in a 6-week nutrition education workshops with 75% of participants obtaining 100% attendance. **Strategy #3: Collaboration** In a 12-month period: • Maintain a relationship with 10 community-based organizations to provide health education, workshops, and screenings.
Results	*Pending*