Franciscan St. Elizabeth Health – Lafayette East
Community Health Needs Assessment
2012-2013

TABLE OF CONTENTS

Introduction	**4**
CHNA Purpose	5
Objectives	5
Methodology	**5**
Analytic Methods	6
Data Sources	7
Healthy Communities Initiatives (HCI)	7
Information Gaps	8
Vulnerable Populations	8
Collaborating Organizations	8
Public Dissemination	9
Definition of the Community served	**9**
Secondary Data Assessment	**10**
Overview of Tippecanoe County	10
Demographics	10
Health Outcomes	11
Healthy Communities Institute Indicators	13
Existing Healthcare Facilities and Resources	**14**
Review of Other Community Needs Assessments	**16**
Primary Data Assessment	**16**
Results from Community Survey	16
Individual & Opinion Leader Comparison	21
Areas of Opportunity	**22**
Identification of persons providing input	22
Prioritization Process	22
Identified Priorities of Community Health Improvement	23
Collaboration Efforts with Tippecanoe County	23
Implementation Strategies – Franciscan St. Elizabeth Health - East	**26**
Priority Health Issues to be addressed and not addressed	26

Implementation Strategies and Action Plans **27**

Chronic Disease - Heart Failure 27

Diabetes Control through Education and Monitoring 29

Improving Breastfeeding Rates within Tippecanoe County 31

INTRODUCTION

Franciscan St. Elizabeth Health (FSEH) embarked on collaborative planning for a comprehensive community health needs assessment with other community organizations in 2011.

FSEH is part of Franciscan Alliance (FA), a thirteen hospital Catholic system located in Indiana and South Suburban Chicago. FSEH, based in Lafayette, Indiana, is a not-for-profit, two-campus hospital system serving Western Indiana. The Central campus has 875 employees and 99 licensed beds. East campus has 2,260 employees and 182 beds. The campuses are five miles apart and serve the same population but specialize in different aspects of service lines. FSEH provides services primarily to residents of Tippecanoe County, but also serves those in neighboring cities and towns. FSEH is accredited by the Healthcare Facilities Accreditation Program (HFAP).

The employees, physicians and volunteers of FSEH, along with the other FA hospitals in our system, work to live our mission: Continuing Christ's Ministry in Our Franciscan Tradition. In following our mission we live and work by a set of common values that include the respect for life, fidelity to our mission, compassionate concern, joyful service and Christian stewardship. FSEH provides the following services:

- Emergency Care
- Heart & Vascular
- Imaging
- Joint & Spine Care
- Neurosurgery
- Observation
- Orthopedics
- Outpatient Services
- Palliative Medicine
- Pediatrics
- Rehabilitation Services
- Stroke Care
- Wound Care
- Women's Health/Obstetrics/ Gynecology, including NICU

FSEH's Regional Board's Mission/HR Committee (Mission/HR Committee) is dedicated to addressing its outreach objectives of serving the entire community, not only those who come through its doors. It tracks this information through our Community Benefit Program. The purpose of that plan is to distinguish and identify the major goals, objectives, strategies, and tactics of each of the following: Community Health Needs Assessment, Access to Programs and Services, Tracking, and Reporting. Building on a long tradition of service, the Mission/HR Committee utilizes hospital strengths alongside those of other newly formed, and well-established community partners. Specifically, a major determinant of success for any hospital-based Community Benefit program lies in its ability to being fully able to identify the health needs of its service area. To that end, the Mission/HR Committee is responsible for addressing the requirements of Community Health Needs Assessment. The members of the Mission/HR Committee come from various sectors of the Greater Lafayette community, as well as representation from Crawfordsville and Montgomery County, and give their input to FSEH's Senior Management Team with the goal of better understanding and reaching the most vulnerable sectors of the community, while meeting pressing

healthcare needs. The goal is to improve the community's health status by empowering citizens to make healthy life choices.

CHNA Purpose

The purpose of the Community Health Needs Assessment (CHNA) is to provide an understanding of the current health status and needs of the Franciscan St. Elizabeth Health – Lafayette East and Lafayette Central campuses' service area whose primary service area is Tippecanoe County. The primary service area of Tippecanoe County was determined by identifying the origin of more than 66% of inpatient admissions. This information will be used to prioritize the identified needs, and to plan and act upon these health needs. The CHNA also will recognize community strengths, assets, and potential resources to address those needs.

Beyond the educational and informative aspect, the CHNA is a newly required legal document for tax-exempt health care organizations in the country. The CHNA must be conducted in order to be compliant with new Affordable Care Act (ACA) requirements. The Internal Revenue Service (IRS) has drafted guidelines of what must be included in the assessment. These guidelines state:

- A community health needs assessment must be conducted every 3 years
    - Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health
    - Be made widely available to the public
- Adopt an implementation strategy to meet the community health needs identified through the assessment
- Report how addressing the needs identified in the CHNA and a description of needs that are not being addressed with the reason why such needs are not being addressed

Objectives

1. Develop a comprehensive profile of health status, quality of care, and care management indicators overall for Tippecanoe County.
2. Identify the priority health needs (public health and healthcare) within the FSEH service area.
3. Serve as a foundation for developing subsequent detailed recommendations on implementation strategies that can be utilized by healthcare providers, communities, and policy makers in order to improve the health status of the FSEH service area.
4. Supply public access to the CHNA results in order to inform the community and provide assistance to those invested in the transformation to the community's healthcare network.
5. Improve access to health services, enhance population health, advance general knowledge, and relieve or reduce the burden of government to improve health of the FSEH service area.

Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research via a survey produced by the Tippecanoe County Health Department, in partnership with FSEH and secondary research (vital statistics and other existing health-related data). These quantitative components allow for comparison to benchmark data at state and national levels. The Tippecanoe County Health Department received input and financial support for the survey from Riggs Community Health Center (Riggs), Unity

Healthcare (Unity) and FSEH. Riggs, established over 25 years ago, is a Federally Qualified Health Center (FQHC). It offers quality, cost effective, comprehensive outpatient health care to those in need. Unity is an independent, comprehensive, multi-specialty healthcare provider composed of some 80 physicians and more than 28 specialty practices. Unity has satellite offices throughout North Central Indiana with one large office adjacent to FSEH-East. Unity and FSEH have several services in which they work together.

Analytic Methods

Preparation for a community survey resulted in a questionnaire of thirty (30) questions that centered on community issues, community services, health issues and health related services.

The survey was available online, paper and by Smartphone, in both English and Spanish. The assessment was launched with a press conference that included the mayors of West Lafayette and Lafayette and a Tippecanoe County commissioner. Local news and radio slots were also done. The local *Journal & Courier* newspaper carried several articles through the summer updating the public about the progress.

Paper copies (5,000) were mailed to residences randomly throughout the community. Paper copies were distributed by Health Coalition members, Mission/HR Committee members and others to as many locations as possible. Schools and businesses were contacted to ask if they would send the online link to their employees and they were on all the sponsors' websites. The local churches helped with getting survey results from the Hispanic and African American populations in Lafayette.

Gathering data from the low social-economic population was very important because this population is rarely sampled and often has the heaviest use of the community services. Therefore food pantries, mobile food pantries, homeless shelters, Salvation Army, Lafayette Transitional Housing and other locations had readily available paper surveys in both English and Spanish.

All the data was collected and analyzed by Pauline Shen, MPH, of the Tippecanoe County Health Department with the support of Purdue University research students. The survey report was made widely available on the county and FSEH websites. 2,300 surveys were returned, about half of which were online responses and the rest were hard paper copies. On May 24, 2012 a meeting was held with twenty-one (21) local social service organizations to review the results of the survey in order to see how collaboration could begin to happen. The organizations represented were the following: Bauer Family Resource Center, Senior Center at Jenks Rest, Central Presbyterian Church, Community Foundation of Greater Lafayette, Family Services, Inc., Food Finders Food Bank, FSEH, IU Health Arnett, Lafayette Crisis Center, Parish Nurses, Lafayette School Corp, Lafayette Urban Ministry, Mental Health America, Nutripledge, Purdue University Communication and Work Life Program, Riggs CHC, Tecumseh Jr. High, Tippecanoe County Health Dept., United Way, YMCA, and YWCA.

This survey was distributed only in Tippecanoe County.

After initial review of the survey, FSEH determined to add two more components to the assessment. In the summer of 2012, some 200 leaders representing various governmental and outreach services within Tippecanoe County received an electronic survey, asking for their input into a more focused look at the healthcare concerns of the County. Thirty-seven (37) leaders responded to the online survey. Upon review of both surveys, face-to-face meetings were set up with various state and local political leaders, business, non-profit, community and school leaders. Twenty-three (23) interviews were conducted between October and December of 2012 by members of the Mission/HR Committee.

DATA SOURCES

In order to better understand the health of our community, it is important that we understand the environment in which we live. National, state and local governments have developed health priorities with the intention of increasing the health of Americans and Hoosiers, respectively. These priorities are set in order to observe, measure, gauge, analyze and identify the current communities' health needs.

Priorities set at the national level are identified and outlined in Healthy People 2020 by the U.S. Department of Health and Human Services. The goals are evidence-based and are created in 10-year increments for improving the health of all Americans. Healthy People 2020 priorities are based on four foundation health measures that include general health status, health-related quality of life and well-being, determinants of health, and disparities. Specifically, these priorities will provide measureable objectives and goals for the community to strive towards.

The Indiana State Department of Health has also identified statewide health priorities in a 5-year, Indiana State Health Improvement Plan (I-SHIP). This plan was partly developed on the basis of the Centers for Disease Control and Prevention "Winnable Battles"—conditions or diseases that have large health impacts and known, effective strategies to address them. I-SHIP is focused on six main health priorities (below) along with key system improvements. The detailed I-SHIP document can be viewed here.

http://www.state.in.us/isdh/files/Indiana_State_Health_Plan_FINAL_6_23_11.pdf

1. Assure Food Safety
2. Reduce Healthcare Associated Infections
3. Reduce the burden of HIV, Sexually Transmitted Diseases and Viral Hepatitis
4. Reduce Infant Mortality
5. Decrease prevalence of Obesity
6. Decrease Tobacco Usage

In addition to these national and statewide priorities, a variety of existing (secondary) data sources were consulted to complement the research quality of this Community Health Needs Assessment. Specifically, the newly adapted Healthy Communities Institute (HCI) helped to aggregate and report data at the county level. Additional information was obtained from a variety of sources (specific citations are included in the CHNA report), such as:

- Indiana State Department of Health
- Healthy Communities Institute (HCI)
- Healthy People 2020
- County Health Rankings.org
- US Census Bureau State & County QuickFacts

Healthy Communities Institute (HCI)

Healthy Communities Institute (HCI) is a third-party product that FA purchased in order to better understand and address the health of our communities. This resource aggregates national, state and county data into one convenient area that allows its users and their community to understand the environment in which they live. HCI has been recently recognized by the Health Data Initiative Forum III in Washington, D.C. and awarded the Best Community Health App. This resource allows its users to measure community health, share best practices, identify

new funding sources while improving community health. One of the visually appealing aspects of HCI is their use of the colored gauge. The colored gauge, as defined by HCI, "gives a visual representation of how our community is doing in comparison to other communities. The three-colored dial represents the distribution of values from the reporting regions (e.g. counties in the state) ordered from those doing the best to those doing the worst (sometimes lower values are better and in other cases higher values are better). From that distribution, the green represents the top 50th percentile, the yellow represents the 25th to 50th percentile, and the red represents the "worst" quartile."

Information Gaps

While this Community Health Needs Assessment is quite comprehensive and the sample size closely approximated the adult population of Tippecanoe County, FSEH recognizes that it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. Both the African American (5%) and Hispanic/Latino (7%) minorities were well represented, the Asian (1%) and Native American (1%) populations were not as well represented. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

Also, 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. However, paper-and-pencil surveys were utilized in order to target specific populations

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 some medical conditions that are not specifically addressed. To attempt to close the information gap qualitatively, FSEH conducted a special survey of 200 community leaders and special one-on-one interviews with 23 Opinion Leaders in the community to help gain a better understanding their unique perspectives relative to the areas in which they have knowledge and experience.

Vulnerable Populations

The large sample size was a close approximation of the adult population in Tippecanoe County. Comparisons could be made between race, age, income and gender with a 95% confidence interval. The minority populations of African American and Hispanic audiences were well represented. The Asian population was not well represented. This data is found in figures 1 through 4 in the Primary Data Assessment section later in the document. Information that reflects the interests of minorities, low-income and medically underserved populations was gained both from the survey and from the additional survey and interviews. Additionally, the close involvement of, and ongoing input from, Riggs served to enhance representation of those populations.

Collaborating Organizations

The community wide survey was overseen by the Tippecanoe County Health Department with input from FSEH, Riggs, and Unity. In addition, FSEH hospitals (East and Central) collaborated with other organizations and agencies in conducting and distributing this survey. They include the following: Greater Lafayette Commerce, Tippecanoe County Health Department, Riggs Community Health Center, Unity Healthcare and twenty-three (23) United Way Agencies.

Public Dissemination

This Community Health Needs Assessment Report is available to the public using the following URL: http://www.franciscanalliance.org/hospitals/lafayetteeast/about/Pages/community-health-needs-assessment.aspx

In addition, FA has recently purchased the Healthy Communities Institute (HCI) web-based product that measures community health, shares best practices, identifies new funding sources and drives improved community health. This can be found at the following link for each of the hospitals and their specific service areas within the FA system: http://www.franciscanalliance.org/community/community-needs-assessment/Pages/default.aspx

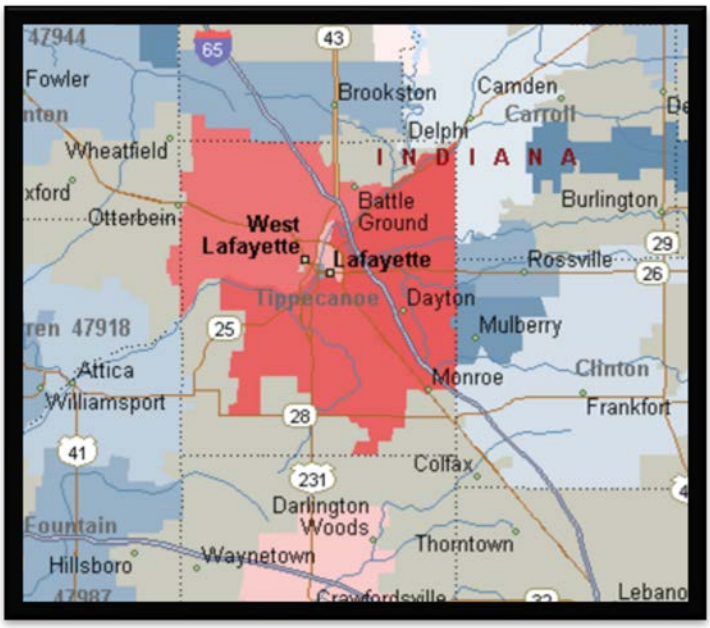
This site:

- 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.

FSEH will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. FSEH will also maintain at its facilities a hardcopy of the CHNA report that may be viewed by any who requests it.

Definition of the Community Served

The FSEH service area, as defined for the purposes of the Community Health Needs Assessment, was Tippecanoe County – from which > 66% of patients originate. A geographic description is illustrated in the following map.



SECONDARY DATA ASSESSMENT

OVERVIEW: DEMOGRAPHICS OF THE COMMUNITY SERVED

People QuickFacts	Tippecanoe Co.	Indiana
Population, 2012 estimate	177,513	6,537,334
Population, 2010 (April 1) estimates base	172,780	6,483,800
Population, percent change, April 1, 2010 to July 1, 2012	2.7%	0.8%
Population, 2010	172,780	6,483,802
Persons under 5 years, percent, 2012	6.2%	6.5%
Persons under 18 years, percent, 2012	20.5%	24.3%
Persons 65 years and over, percent, 2012	9.9%	13.6%
Female persons, percent, 2012	49.0%	50.8%
White persons, percent, 2012 (a)	86.6%	86.6%
Black or African American alone, percent, 2012 (a)	4.6%	9.4%
American Indian and Alaska Native alone, percent, 2012 (a)	0.4%	0.4%
Asian alone, percent, 2012 (a)	6.5%	1.8%
Native Hawaiian and Other Pacific Islander alone, percent, 2012 (a)	0.1%	0.1%
Two or More Races, percent, 2012	1.9%	1.8%
Hispanic or Latino, percent, 2012 (b)	7.8%	6.3%
White alone, not Hispanic or Latino, percent, 2012	79.5%	81.0%
Living in same house 1 year & over, percent, 2007-2011	71.0%	84.4%
Foreign born persons, percent, 2007-2011	10.3%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	13.6%	7.9%
High school graduate or higher, percent of persons age 25+, 2007-2011	90.5%	86.6%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	35.8%	22.7%
Veterans, 2007-2011	9,873	478,030
Mean travel time to work (minutes), workers age 16+, 2007-2011	17.5	23.1
Housing units, 2011	71,824	2,800,614
Homeownership rate, 2007-2011	54.6%	71.1%
Housing units in multi-unit structures, percent, 2007-2011	33.2%	18.5%
Median value of owner-occupied housing units, 2007-2011	$130,400	$123,300
Households, 2007-2011	65,100	2,472,870
Persons per household, 2007-2011	2.41	2.53
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$22,892	$24,497
Median household income, 2007-2011	$43,485	$48,393
Persons below poverty level, percent, 2007-2011	20.8%	14.1%

(a) Includes persons reporting only one race.

(b) Hispanics may be of any race, so also are included in applicable race categories.

Source: US Census Bureau State & County QuickFacts

DEMOGRAPHICS (SOURCE HCI WEBSITE)

- Estimated 176,970 individuals live in Tippecanoe County, IN.
- Race/Ethnicity Makeup:
    - 82.87% White (9.67% of which are Hispanic/Latino)
    - 4.35% Black/African American

- 0.26% Am Indian/Alaska Native
- 6.6% Asian
- 0.03% Native HI/PI
- 3.5% Some other Race
- 2.39% 2+Races

- Income Distribution
  - $39,702 is the median income for Tippecanoe County residents in 2013.
  - 10.8% of households live below the federal poverty level (FPL) in 2013.

HEALTH OUTCOMES

Use the most recent data: Taken from http://www.countyhealthrankings.org/Indiana/Tippecanoe

8/22/2013	Tippecanoe County	Error Margin	Indiana	National Benchmark*	Trend	Rank (of 92)
Health Outcomes						**8**
Mortality						**7**
Premature death	5,826	5,419-6,233	7,520	5,317		
Morbidity						**21**
Poor or fair health	15%	12-18%	16%	10%		
Poor physical health days	3.2	2.7-3.7	3.6	2.6		
Poor mental health days	3.6	2.9-4.3	3.6	2.3		
Low birth weight	6.90%	6.5-7.3%	8.30%	6.00%		
Health Factors						**8**
Health Behaviors						**3**
Adult smoking	17%	14-20%	24%	13%		
Adult obesity	28%	24-32%	31%	25%		
Physical inactivity	24%	20-28%	27%	21%		
Excessive drinking	18%	14-22%	16%	7%		
Motor vehicle crash death rate	8	‘6-10	13	10		
Sexually transmitted infections	304		351	92		
Teen birth rate	25	24-27	41	21		

	Tippecanoe County	Error margin	Indiana	National benchmark*	Trend	Rank (of 92)
Clinical Care						**25**
Uninsured	19%	17-21%	17%	11%		
Primary care physicians**	1,517:1		1,557:1	1,067:1		
Dentists**	2,498:1		2,165:1	1,516:1		
Preventable hospital stays	71	67-76	76	47		
Diabetic screening	86%	81-91%	83%	90%		
Mammography screening	67%	61-72%	64%	73%		
Social & Economic Factors						**28**
High school graduation**	83%		86%			
Some college	70%	67-73%	59%	70%		
Unemployment	7.70%		9.00%	5.00%		
Children in poverty	21%	17-25%	23%	14%		
Inadequate social support	15%	12-18%	20%	14%		
Children in single-parent households	31%	28-34%	32%	20%		
Violent crime rate	248		327	66		
Physical Environment						**60**
Daily fine particulate matter	12.7	12.6-12.9	13	8.8		
Drinking water safety	0%		2%	0%		
Access to recreational facilities	8		9	16		
Limited access to healthy foods**	10%		6%	1%		
Fast food restaurants	48%		50%	27%		

* 90th percentile, i.e., only 10% are better.

** Data should not be compared with prior years due to changes in definition.

Note: Blank values reflect unreliable or missing data

Healthy Communities Institute Indicators

The following describes those conditions that were found to be the farthest from the Health Population 2020 Goals. The colored gauge gives a visual representation of how our community is doing in comparison to other communities. The three-colored dial represents the distribution of values from the reporting regions (e.g. counties in the state) ordered from those doing the best to those doing the worst (sometimes lower values are better and in other cases higher values are better). From that distribution, the green represents the top 50th percentile, the yellow represents the 25th to 50th percentile, and the red represents the "worst" quartile. By going to the url http://www.franciscanalliance.org/community/community-needs-assessment/Pages/default.aspx, supporting detail can be viewed.

Healthy Communities Institute (HCI) "Red" or "Yellow" Indicators for Tippecanoe County

Indicators for County: Tippecanoe, IN

View the Legend

Health		
Chlamydia Incidence Rate MAP	Comparison: IN Counties	
Mothers who Received Early Prenatal Care MAP	Comparison: IN Counties	
Lung and Bronchus Cancer Incidence Rate NEW MAP	Comparison: U.S. Counties	
Prostate Cancer Incidence Rate NEW MAP	Comparison: U.S. Counties	
Physical Environment Ranking MAP	Comparison: IN Counties	
Age-Adjusted ER Rate due to Pediatric Asthma NEW MAP	Comparison: IN Counties	
Adults who Drink Excessively MAP	Comparison: U.S. Counties	
Age-Adjusted ER Rate due to Alcohol Abuse NEW MAP	Comparison: IN Counties	
Age-Adjusted Death Rate due to Breast Cancer NEW MAP	Comparison: U.S. Counties	
Age-Adjusted Death Rate due to Lung Cancer NEW MAP	Comparison: U.S. Counties	

Breast Cancer Incidence Rate NEW MAP	Comparison: U.S. Counties	
Age-Adjusted ER Rate due to Diabetes NEW MAP	Comparison: IN Counties	
Age-Adjusted ER Rate due to Long-Term Complications of Diabetes NEW MAP	Comparison: IN Counties	
Poor Mental Health Days MAP	Comparison: U.S. Counties	
Age-Adjusted Death Rate due to Alzheimer's Disease MAP	Comparison: U.S. Counties	
Age-Adjusted ER Rate due to Dehydration NEW MAP	Comparison: IN Counties	
Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases MAP	Comparison: U.S. Counties	
Age-Adjusted ER Rate due to Adult Asthma NEW MAP	Comparison: IN Counties	
Age-Adjusted ER Rate due to Asthma NEW MAP	Comparison: IN Counties	
Age-Adjusted ER Rate due to COPD NEW MAP	Comparison: IN Counties	
Low-Income Preschool Obesity MAP	Comparison: U.S. Counties	
Babies with Very Low Birth Weight	Comparison: IN State Value	

Existing Healthcare Facilities & Resources

FSEH recognizes that there are many existing healthcare facilities and resources within the community that are available to respond to the health needs of residents of Tippecanoe County. These organizations include the following:

Hospitals

Franciscan St. Elizabeth Health – Central
Franciscan St. Elizabeth Health – East
Indiana University Health Arnett - FSEH collaborates with IU and Riggs to sponsor and fund a family practice residency program.

FQHC – Riggs Community Health Center – FSEH had provided land, buildings and funding to assist and increase access to care for the uninsured and underinsured for the past 25 years.

Nursing Homes/Adult Care – FSEH has a strong relationship with Mulberry. FSEH has elevated the nursing practices used at the facility which has resulted in a greater mutual understanding of how the two organizations can work to give a better quality of life to the patients/residents. FSEH's pharmacy and dietary have also been involved in better educating the residents. The hope is that this type of partnership can be created with the other agencies in the future.

- Mulberry Heath and Retirement Center
- Heritage Healthcare
- Signature Healthcare Of Lafayette
- Rosewalk Village Of Lafayette
- Saint Anthony Health Care, INC.
- St. Mary Health Care Center
- University Place
- Westminster Village
- Milner Community Health Care
- Cumberland Pointe Health Campus
- Indiana Veterans Home
- Creasy Springs

Mental Health Services

- Wabash Valley Outpatient Services – FSEH receives and refers patients to this service, even coordinating further to help place patients in the right program
- Bauer Counseling Center
- RAJ Clinic - FSEH receives and refers patients to this service
- Alpine Clinic - FSEH refers patients to this service
- Family Services, Inc. - FSEH refers patients to this service
- Riggs Community Health Center – FSEH does refer patients with no pay source and with physical issues to this service. They do send some with Mental Health issues to the ED.
- Sycamore Springs - FSEH refers on occasions to their inpatient services and we refer to their out-patient services, on rare occasions they refer to us
- Turning Point Counseling Services
- NAMI – FSEH uses this service as a resource for our patients and families and also have 2 employees serving on the board of directors. NAMI's office is in the School of Nursing and they use other parts of the School of Nursing for larger meetings.
- Mental Health America - FSEH uses this service as a resource for our patients, families and education offerings for our staff
- CAPS (Purdue's Mental Health for students) – FSEH receives and refers patients to this service
- Cummins in Crawfordsville – FSEH receives and refers patients to this service
- Lighthouse in Monticello - we refer for addictions treatment and on occasion we receive patients from them

Emergency Medical Services

- TEAS, Inc. - FSEH runs the service in conjunction with IU Health Arnett and Tippecanoe County

Home Healthcare

- St. Elizabeth Home Health Care
- Physio Care Home Health Care
- Anchor Home Health Care
- Clarian Home Care/Hospice
- BrightStar Home Health
- Nurse Finders Home Health Care (no PT, OT, or ST)

Hospice Care

- St. Elizabeth Hospice
- Serenity Hospice
- Southern Care Hospice
- Guardian Angel Hospice, Inc

Other Community – based Resources

- Tippecanoe County Health Department

Review of Other Community Health Need Assessments

In order to understand and prioritize the needs of our community, it is crucial that we recognize others' additions to the field. Understanding what other Community Health Needs Assessments have found will help to better align efforts while reducing the need to "reinvent the wheel." Going forward we will be able to share information about our work and learn what others are doing in the community to meet healthcare needs.

Primary Data Assessment

Primary Data collection occurred until December, 2012. 2,300 Community participants within the FSEH service area answered our thirty **(30)** question survey via online and paper format. In addition, 200 general and hospital Opinion Leaders within the FSEH community were invited to answer a 20 question online survey that focused more on their community assessment rather than personal assessment. We had thirty-seven (37) leaders respond to this survey. That endeavor was followed by twenty-three (23) face to face interviews with political, business, non-profit, community and school leaders to assess their reaction to the results and then help us prioritize our focus. The link to the full Needs Assessment Survey results is:

http://www.franciscanalliance.org/hospitals/lafayetteeast/about/Pages/community-health-needs-assessment.aspx

Results from Community Survey

The majority of the respondents were Caucasian/White (85%), females (72%) and between 35 and 64 years of age (63%). 13% of respondents stated they did not have health insurance. Health insurance information is provided in Figures 7 – 10.

Figure 1: Response Rate of Surveyed Population by Race

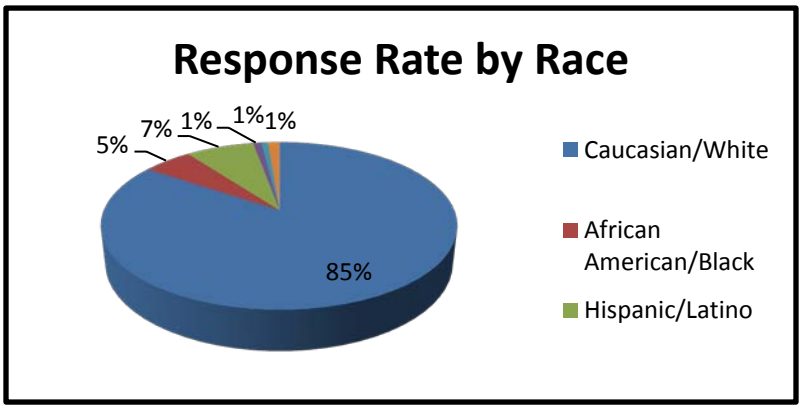


Figure 2: Response Rate by Gender

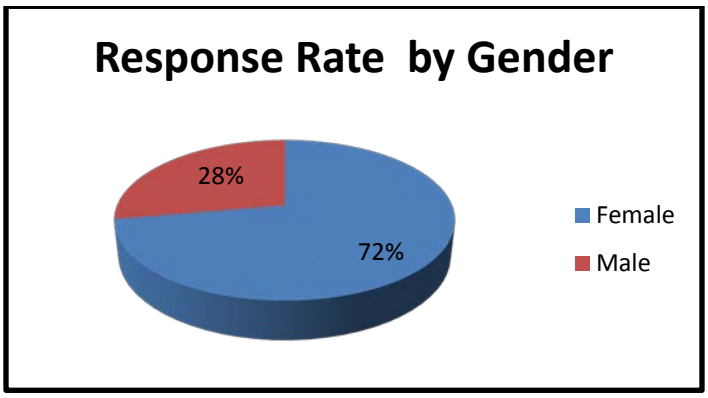


Figure 3: Respondent Population by Age

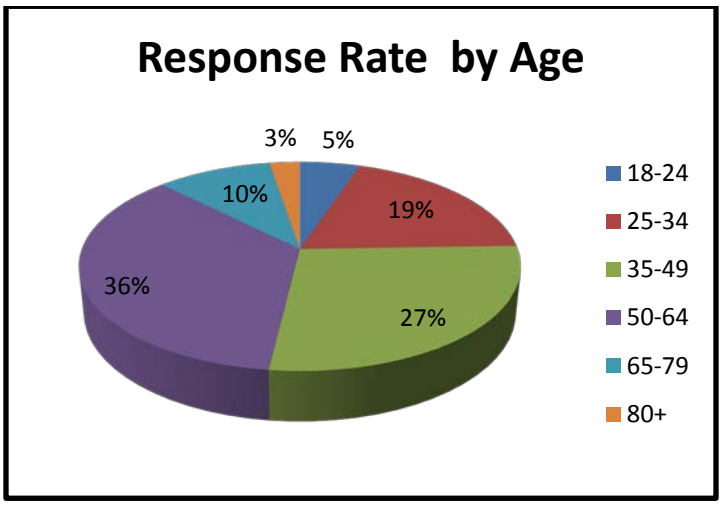


Figure 4: Respondent Population by Employment Status

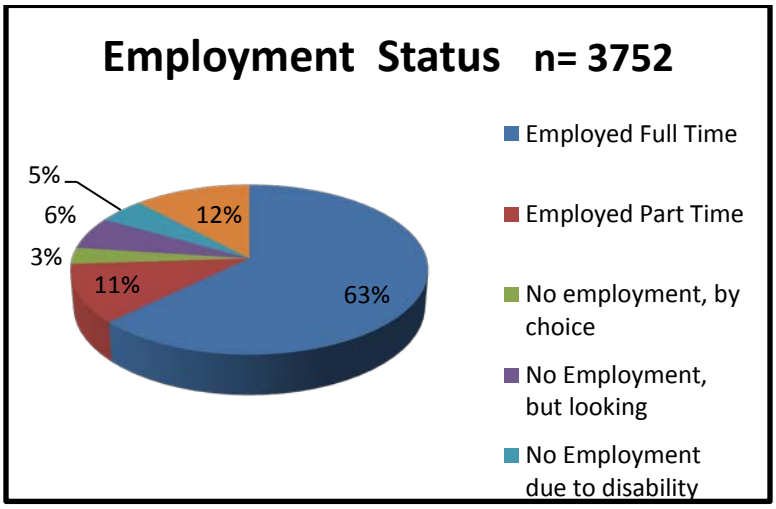


Figure 5: Respondent Population by Household Income

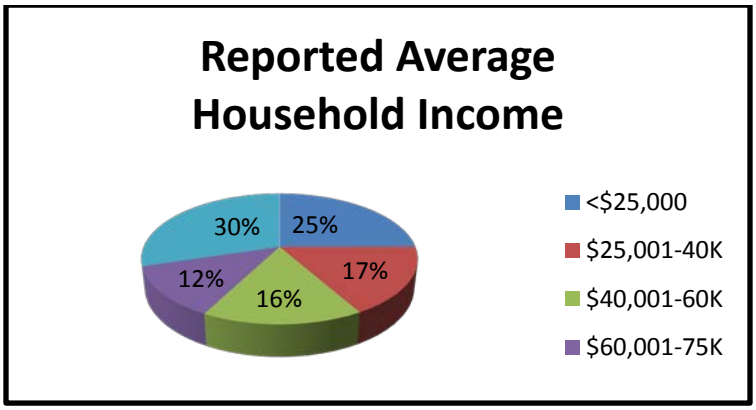


Figure 6: Respondent Population by Highest Level of Education Achieved

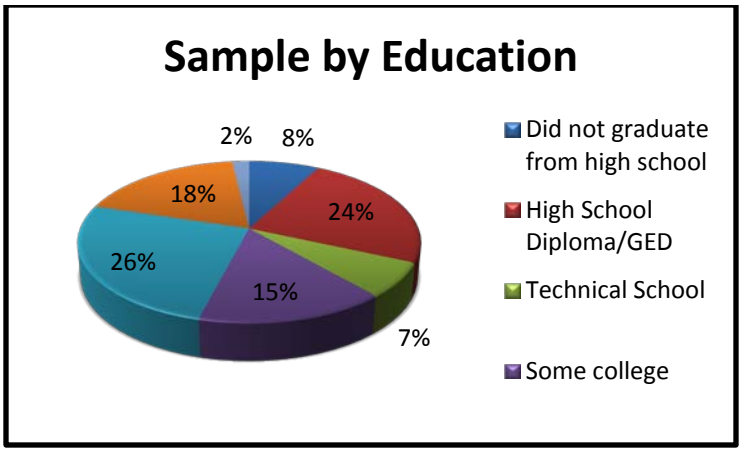


Figure 7: Respondent Population by Health Insurance Status

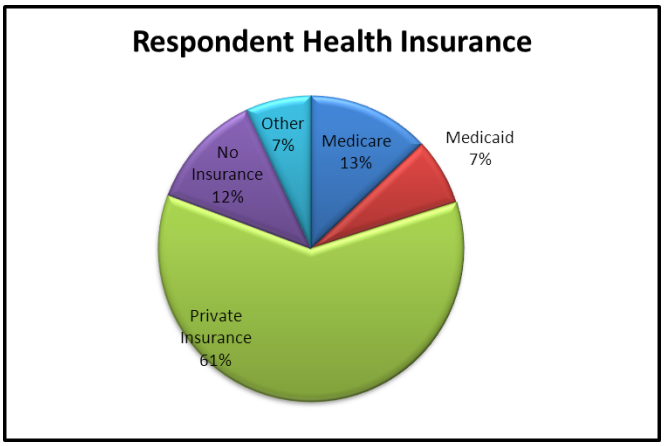


Figure 8: Adult Insurance Status

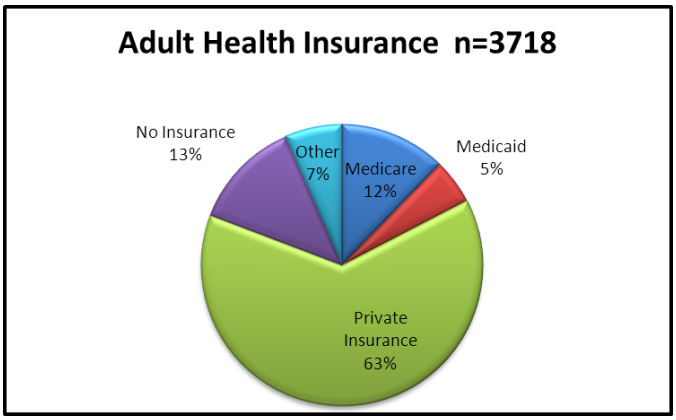


Figure 9: Children Health Insurance Status

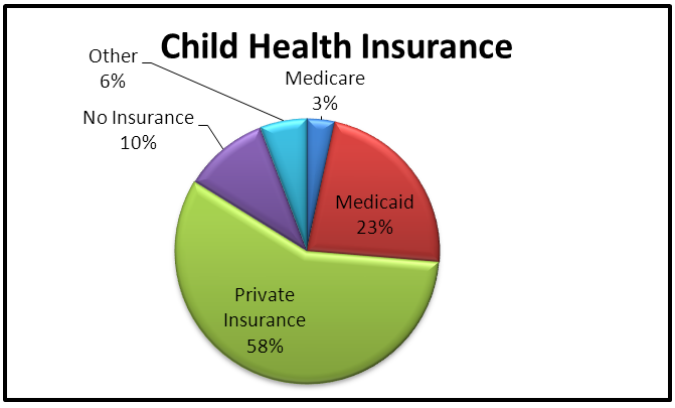
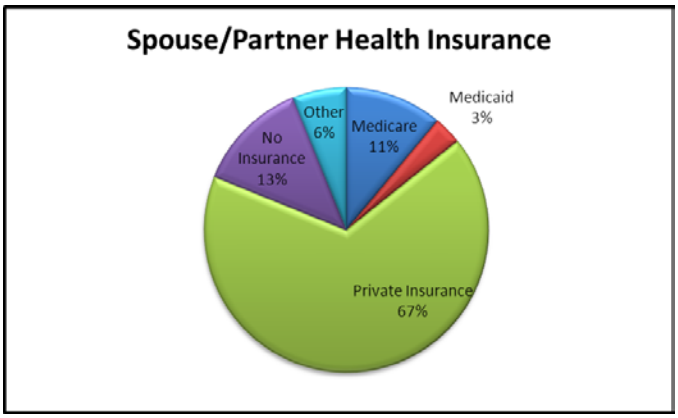


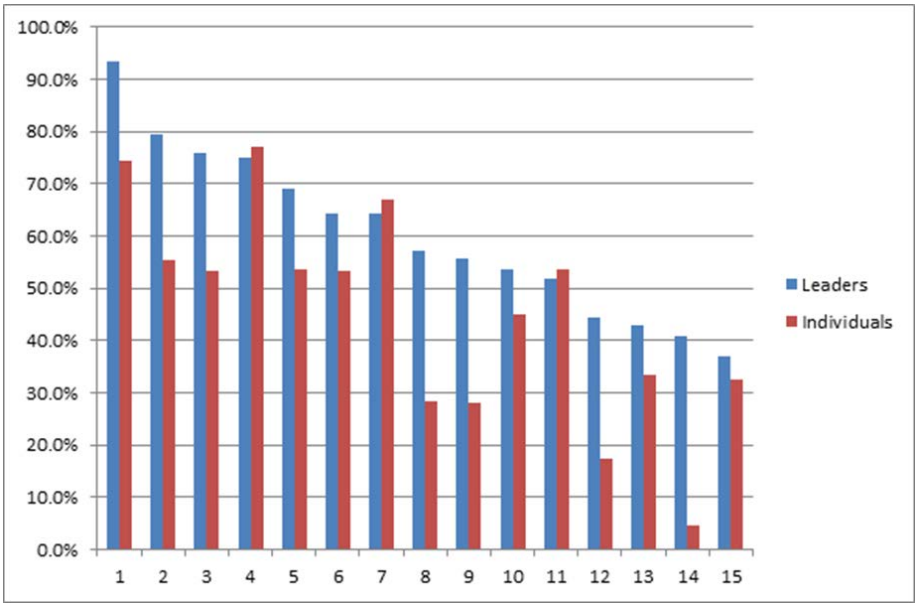
Figure 10: Spouse/Partner Health Insurance Status



INDIVIDUAL & OPINION LEADERS COMPARISON

The Opinion Leaders Survey and the Individual Survey both asked questions about ranking needed health-related services within our County. However, the statements were phrased a little differently so a complete comparison is not possible. Below shows the overlapping concepts:

	Health Indicator Key – these numbers tie to the horizontal data on the chart below.
1	Affordability of healthcare services
2	Access to appropriate and affordable dental care
3	Mental health programs I services
4	Affordability of prescription or over the counter medications
5	Addictions -drug, alcohol
6	Access to appropriate and affordable eye care
7	Overweight I obesity (weight control education or services)
8	Children's health care
9	Preventive health (screenings)
10	Chronic disease care (cancer, heart disease, diabetes, etc)
11	Substance abuse (drug I alcohol)
12	Health and nutrition education programs immunizations
13	Teenage pregnancy
14	Tobacco use
15	Prenatal health



For the majority of concerns, the rankings by the two groups were relatively similar.

AREAS OF OPPORTUNITY

IDENTIFICATION OF PERSONS PROVIDING INPUT

Individuals with various backgrounds were sought to give input into the creation and dissemination of the three survey levels. The Mission/HR committee of the Board is comprised of members of the FSEH Regional Board, physicians, community leaders representing education, social services, and FSEH directors. The online opinion leaders' survey was sent to the leadership of various agencies in the County. The Mission/HR Committee also conducted the face-to-face meetings with the mayors of Lafayette and West Lafayette, State Representatives, HR directors in various industries, directors of various social services, school superintendents and Purdue University.

PRIORITIZATION PROCESS

After reviewing the Community Health Needs Assessment findings, as well as objective data, the Mission/HR Committee, Foundation Board members , and Senior Management gave input in determining the health needs to be prioritized for action in FY2014 - FY2016. The local findings reflected the respondents' opinions and these were considered against the more objective findings of the HCI and County data. During a detailed presentation of the CHNA findings, steering committee members and FSEH Senior Management were talked through a process of understanding key local data findings (Areas of Opportunity) and ranking identified health issues against the following established, uniform criteria:

- **Magnitude**. The number of persons affected, also taking into account variance from benchmark data and Healthy People targets.
- **Impact/Seriousness**. The degree to which the issue affects or exacerbates other quality of life and health-related issues.
- **Feasibility**. The ability to reasonably impact the issue, given available resources.
- **Consequences of Inaction**. The risk of not addressing the problem at the earliest opportunity.
- **Balance**. The ability to weigh the results of the survey respondents alongside the more objective data from HCI, Healthy 2020 and other statewide statistics.

IDENTIFIED PRIORITIES OF COMMUNITY HEALTH IMPROVEMENT

The following "health priorities" represent recommended areas of intervention, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in *Healthy People 2020*. From this data, opportunities for health improvement exist in the region with regard to the following health areas:

	Areas of Opportunity relative to County data provided by individuals surveyed and interviewed.	
1	Affordability/Accessibility of healthcare services	There are 27,956 uninsured residents in Tippecanoe County. (ISDH 2011)
2	Affordable/Accessible Medications	Fifty percent with chronic diseases do not take their prescribed medications. (Brown and Bussell, 2011)
3	Overweight/Obesity	High percentage of population considered obese—Indiana tied 8th for most obese state
4	Substance Abuse	Above the state and National averages for excessive drinking
5	Chronic disease care (cancer, heart disease, diabetes, etc)	Increased ER rate due to Diabetes; COPD, Chronic Lower Respiratory
6	Tobacco Use	Above national average
7	Mental Health Programs	Above national average for poor mental health days
8	Children's Healthcare	Low-income Preschool Obesity
9	Affordable/accessible Health Education	Increased ER rate due to Long-term complications of Diabetes
10	Prenatal Health	Low-income Preschool Obesity Low percentage of mothers receiving Early Prenatal Care
11	Preventive health screenings	Increasing number of preventable hospital stays Behind national benchmark for screenings of diabetes and mammographies

COLLABORATION EFFORTS WITH TIPPECANOE COUNTY

Various programs exist within Tippecanoe County that currently work at addressing the opportunities identified. FSEH is working to identify collaboration opportunities with them on various issues as identified in our Implementation Plans. The following chart lists many such community organizations and the areas on which they focus there services.

Agency		1. Affordable/ accessible Healthcare	2. Affordable/ accessible Medication	3. Overweight/Obesity – Lack of Physical Activity	4. Substance Abuse \	5. Chronic Disease (High Cholesterol, Hypertension, Heart, Diabetes, Asthma)	6. Tobacco Use	7. Mental Health Programs/Services (Outpatient focus, Depression)	8. Children's Healthcare	9. Affordable /accessible Health Education	10. Prenatal Health
Access		x		x							
Adult Protective Services					x						
Alcoholics Anonymous					x	x				x	
American Cancer Society		x				x	x			x	
American Red Cross										x	
Area IV Agency on Aging			x	x	x	x				x	
Care-A-Van		x		x							
**Caregiver Companion						x					
**A45Center @ Jenks Rest: Columbian Park				x	x	x	x			x	
**Churches				x						x	
Bauer Family Resources		x		x	x	x		x	x	x	x
Crisis Center					x			x			
Cummins Mental Health Center		x			x		x	x		x	
Department of Child Services									x	x	x
Division of Family Resources				x	x	x		x	x	x	
Elston Community Education Center										x	
Families Unites Inc.					x			x	x		
Family Services				x	x	x	x	x	x	x	x
Fowler Apartments				x		x					
Friendship House				x		x			x		
FSEH - Healthy Living Center				x	x	x				x	x
Hanna Community Services				x		x		x	x	x	
Health Department, Tippecanoe County		x	x	x	x	x	x	x	x	x	x
HIV Care Coordination		x				x					
Home With Help/Hope					x		x	x	x	x	x
Hoosier Healthwise		x	x		x		x		x	x	x
Kathryn Weil Center for Education				x	x	x	x	x	x	x	x
Lafayette Adult Resource Academy							x				
Lafayette Head Start				x					x		
Lafayette Transitional Housing								x			
**Lafayette Urban Ministry				x	x			x		x	
Legal Aid Corporation of Tippecanoe County			x								
Love in the name of Christ (LINC)				x	x		x	x			x
Matrix Lifeline Pregnancy Center			x						x	x	x
Mental Health America of Tippecanoe County		x	x	x	x			x			

Agency		1. Affordable/ accessible Healthcare	2. Affordable/ accessible Medication	3. Overweight/Obesity – Lack of Physical Activity	4. Substance Abuse \	5. Chronic Disease (High Cholesterol, Hypertension, Heart, Diabetes, Asthma)	6. Tobacco Use	7. Mental Health Programs/Services (Outpatient focus, Depression)	8. Children's Healthcare	9. Affordable /accessible Health Education	10. Prenatal Health
NAMI - Nation Alliance on Mental Illness		x		x	x			x		x	
**Parish Nurse Program				x		x	x			x	x
Riggs Community Health Center		x	X	x	x	x	x	x	x	x	x
S.U.R.F Club (service, Unity, Recovery and Fellowship)				x	x		x				
Salvation Army			X		x						
School of Nursing - St. E.		x		x		x	x			x	x
Schools				x	x		x		x	x	x
Senior Center of Tippecanoe			X	x		x	x	x		x	
The Child Care Resource Network				x					x	x	x
Bauer Counseling Center					x			x	x		x
Right Steps Child Development Center				x					x	x	
Trinity Mission					x		x				
United Way - HAT (Healthy Active Tippecanoe Committee)				x		x	x			x	x
Unity Healthcare		x	X	x	x	x	x		x		
Vocational Rehabilitation Services										x	
Volunteer Bureau											
**Wabash Center		x	X	x	x		x	x	x	x	
Wabash Valley Hospital, INC.		x	X	x	x	x	x	x			
Wabash Valley Hospital, INC.- Outpatient Service		x	X		x		x	x			
Women, Infants, Children (WIC)		x		x		x			x	x	x
**YWCA (DVIPP, Women's Cancer Program)		x		x		x	x		x	x	x

Franciscan St. Elizabeth Health - East

FSEH FY2014 - FY2016 Implementation Strategy

FSEH has served the Lafayette Community for over 137 years. It was the seed of what now is FA, a system of 13 hospitals across Indiana and South Suburban Chicago Illinois.

This document outlines FSEH's 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 within the public itself.

Hospital-Level Community Benefit Planning

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 FSEH would focus on developing and/or supporting strategies and initiatives to improve:

- Chronic disease management of
    - Diabetes
    - Congestive Heart Failure
- Healthy Mothers and Babies

Priority Health issues That Will Not be Addressed & Why

In acknowledging the wide range of priority health issues that emerged from the CHNA process, FSEH determined that it could effectively focus on those which it deemed most pressing, most under-addressed, and most within its ability to influence. Upon review of the above data health priorities, the following were determined not be to our major focus at this time:

1. Obesity – the programs directed at Congestive Heart Failure and Diabetes will include attention nto weight control, as will the work with mothers. Additionally, FSEH works collaboratively with HAT – Healthy Active Tippecanoe which has a program aimed especially at children.
2. Substance Abuse and Tobacco Use – will be partially addressed in the adopted programs described.
3. Preventative Health Screenings – FSEH and many others are doing this in many areas on a regular basis.
4. Chlamydia Incidence – present solutions are not in line with our Catholic religious values.
5. Medication Access – we will begin some ground work on collecting baseline data and connecting with other organizations to see what is feasible moving forward.
6. Pre-natal care in first trimester – we are collecting data but not able to create a full strategy yet.
7. Cancer and respiratory illnesses – these areas are being somewhat addressed in other existing programs.
8. In addition, there are other community needs that may impact some aspects of health such as transportation, public education, environmental issues, air quality, crime, etc. Challenges such as these that fall outside the hospitals area of knowledge, which are the appropriate responsibility of other public

bodies and require levels of funding not possible at the hospital, were not selected as possible programs for implementation.

Implementation Strategies & Action Plans

The following outline FSEH's plan to address those priority health issues chosen for action in the FY2013-FY-2016 period.

FOCUS: Chronic Disease-Heart Failure

Reason for Program	American Heart Association (AHA, 2010) reported heart failure is reaching epidemic proportions; there are over 670,000 new cases of heart failure diagnosed each year. Heart failure is taking an unprecedented toll on lives, quality of life and health care dollars; greater than 30 billion dollars being spent annually on heart failure. Heart failure is the number one reason for hospital admissions nationally. The Community Health Needs Assessment indicated: HF 2010-2012: Tippecanoe Co. realized 8.4 Heart Failure (HF) Emergency Department (ED) visits for HF/10,000 population 18+ (Goal is green= <11.3 and Red is >17) Tippecanoe County is considered within the 'green' on this indicator. We believe there remains significant opportunity for improvement in this area. Improvements will impact the lives of the many patients with HF in Tippecanoe County and reduce costs to both the patient and the healthcare industry. Congestive Heart Failure (CHF) is the leading cause of hospitalizations in adults over the age of 65. Approximately twenty-four percent (24%) of the patients with CHF are readmitted within thirty (30) days. Locally, the inpatient mortality rate for CHF patients is 10-12%. References American Heart Association (2010). *Heart failure: Tools for targeting heart failure*. Retrieved from http://www.heart.org/idc/groups/heart-public/@wcm/@private/@hcm/@gwtg/documents/downloadable/ucm_310295.pdf Community Health Needs Assessment (2013) retrieved from www.franciscanalliance.org/community/community-needs-assessment
Community Partners / Planned Collaboration	FSEH-Lafayette partners include: Riggs Community Health, area extended care facilities, Purdue's Delphi/Monon Clinic, and several Tippecanoe county physicians.
Goal	Minimize avoidable readmissions associated with HF 20% by 2016. This goal is in alignment with the "Hospital to Home" (H2H) challenge and is sponsored by the American College of Cardiology and the Institute for Healthcare Improvement. The H2H challenge was launched in 2009 with the goal of reducing avoidable acute

	myocardial infarction, heart failure, and pneumonia readmissions by 20% by 2012. This continues to be a local goal. In 2012 there were 173 HF discharges from FSEH-East. Hospital Compare posted the FSEH-East HF readmission rate as 21.8% for 2012. Hospital to Home (2009). *Hospital to home challenge*. Retrieved from http://www.h2hquality.org/LinkClick.aspx?fileticket=2G%2b5u4wKzAo%3d&tabid=168
Timeframe	Franciscan Healthy Living Center (FHLC), an important element to this program, was established in 2012. The HF initiatives will continue through 2013-2016 due to the complex nature of managing chronic disease such as a HF.
Scope	Enhance quality of care through the continuum; quality of life, enhancing healthcare efficiencies, and minimizing costs associated with the care of chronic illness such as HF. The target population is those patients hospitalized at FSEH.
Strategies & Objectives	The purpose of the FHLC is to provide a multidisciplinary team approach to address the complex healthcare needs of patients with chronic diseases such as heart failure, diabetes, and COPD. The FHLC utilizes a nurse practitioner model with robust multidisciplinary team support. 1. Facilitate physician office or FHLC visit within 7 days post hospitalization (sooner if patient acuity dictates). 2. Facilitate an individualized and collaborative plan to support patient care goals and self-management. a. Patient/family education of disease process, worsening symptoms, collaborative plan of care with defined and individualized care goals. b. Pharmacy counseling, patient/family education, medication reconciliation with each clinic visit, address access to medication issues. c. Dietary counseling and individualized dietary plan. d. Respiratory therapy support to address complex educational and treatment needs. e. Social service support to address complex psychosocial needs. f. Self-management diuretic /potassium replacement protocols (HF patients). g. Life coaching with occupational therapy support. 3. Improve quality of life indicators utilizing various tools to assess outcomes such as: a. Quality of Life Screening b. Depression Screening c. Six-minute walk (functional capacity). 4. Facilitate care/communication among healthcare team across the continuum. 5. Provide early education/coaching for newly diagnosed HF and/or COPD patients or patients at risk for HF and/or COPD (partner with local physicians and Kathryn Weil Center for Education). 6. Partner with local ECFs to manage HF and/or COPD patients (Diuretic and

	COPD protocols) to minimize risk for avoid hospital admissions. 7. Restructure FHLC licensure so fee schedules can be nominal so at risk patients can be served by this service
Financial Commitment	To be Determined - Ongoing
Anticipated Impact	Improve quality of life of patients with chronic disease such as HF in Tippecanoe and surrounding patients while enhancing quality of care and minimizing health care dollars spent managing these chronic illnesses.
Plan to Evaluate Impact	1. Financial metrics a. ED visits b. 30 day hospital readmissions 2. Quality of Life Metrics a. Quality of Life Assessments b. Depression Screening c. Six-minute walk (functional capacity)
Results	To be analyzed

FOCUS: Diabetes Control through Education and Monitoring

Reason for Program	Diabetes is a costly chronic disease and is continuing to increase. Diabetes is a major cause of heart attack and stroke. The CDC reports as of 2010, 8.3% of all Americans and 26.9% of Americans age 65 and over have Type 2 diabetes. If current trends continue by 2050, 1 in 4 Americans may have diabetes. Prevalence of diabetes in Tippecanoe County is 7.9% or 13,746 people of the 174,724 population in 2011 and the rate of ER visits per capita is high. Multiple studies have demonstrated that diabetes education, routine follow up and monitoring improves diabetes control, reduces the risk of complications, improves quality of life, and decreases hospital days and use of the ER
Community Partners / Planned Collaboration	Franciscan Healthy Living Center (FHLC) - Diabetes Education is currently collaborating with Franciscan Physician Network (FPN), the physician group which is part of our Accountable Care Organization. We continue to work with business development to establish a support relationship with Indiana Packers Employee clinic to plan for access to FHLC diabetes educators for quality instruction in diabetes prevention and/or diabetes self- management. We have met with Riggs Community Health Clinic and developed a plan and have requested that patients who have met with the Riggs Center Diabetes Educator and are not meeting A1c goal be referred to Franciscan Healthy Living Center - Diabetes Education. Diabetes education also participates in area health fairs as requested, providing diabetes risk assessments and basic information.
Goal	Collaborate with FPN to maximize opportunity for improved diabetes outcomes: 1. FPN goal is to increase A1c testing in patients with diabetes and/or

	identified risk according to national benchmarks compared to 2013. 2. FHLC-Diabetes Education goal is to meet with FPN quality manager quarterly to review progress of patients participating in the ADA diabetes education program. 3. FPN has developed a screening tool to prompt staff to refer patients meeting criteria-new diagnosis, or A1c>8. 4. In 2014 monitor whether or not FPN patients having hospital admissions with A1c>8.0, with a primary diagnosis of Type 1 or Type 2 Diabetes, have received diabetes education and facilitate referral as needed 5. Offer 2 free educational programs open to the public in 2014 6. Meet with James Parson's and Unity Clinic Manager to establish plan for supporting Indiana Packers Clinic by end of January.
Timeframe	January 2014 – December 2016
	FSEH has an ADA Recognized Diabetes Education Program (since 1989) This program meets National Standards for Diabetes Education and ensures patients receive current information from qualified instructors. Recognition status is applied for and renewed every 4 years.
Scope	The ADA program is designed to meet the diabetes education needs of any person in the community with Pre-Diabetes, Type 1, Type 2 and gestational diabetes. Because this program is available by physician referral only, we will focus on the patients within our newly formed ACO initially. Registered nurses and registered dietitians who are certified diabetes educators and/or who are eligible and meet continuing education requirements provide instruction. We utilize a multi-disciplinary approach in addressing the needs of a population coping with a physically, emotionally, and financially demanding chronic disease.
Strategies & Objectives	1) Facilitate outpatient diabetes education referrals for inpatients who have an A1c> 8.0 during hospital stay. 2) Increase appropriate A1c testing of FPN patients with diabetes per ADA national standards. 3) Encourage initial diabetes education for all newly diagnosed patients within FPN physician practices. 4) Encourage referral for education of all patients within FPN practices who have poorly controlled diabetes. 5) Care coordination between the FPN and HLC-Diabetes Education to ensure consistent education is delivered. 6) Initiate Monthly Diabetes Topical Series in 2014. 7) Increase community outreach by offering quarterly program on diabetes risk reduction, promoting early intervention and prevention strategies.
Financial Commitment	To be Determined - Ongoing

Anticipated Impact	1. Promote better quality of life for persons living with diabetes. 2. Increased awareness of diabetes in the community. Education will improve communities understanding of the disease process and promote lasting behavior change. 3. Decreased number of preventable readmissions through follow up and education. 4. Minimize health care dollars spent on preventable emergency room visits and inpatient stays. 5. Increased screening of A1C will lead to better control and decreased complications.
Plan to Evaluate Impact	1) FPN will evaluate current A1c screening rate in FPN and increase by 3% yearly to meet national benchmarks. 2) FHLC will monitor A1c outcomes available in EPIC in following hospitalization in 2013 and/or initial FHLC visits and compare with subsequent A1c's over 3 years. 3) Determine number admissions all patients hospitalized with primary diagnosis Type 1 or Type 2 Diabetes and/or A1c >8.0 in 2013. Monitor patients who were referred and attended outpatient diabetes education following inpatient stay and monitor readmissions over 3 years compared to those who did not attend outpatient diabetes education.
Results	To be analyzed

FOCUS: Improving Breastfeeding Rates within Tippecanoe County

Reason for Program	**Breast feeding rates in the United States have continued to slowly increase. Reference article:** Breastfeeding: A Clinical Imperative written by Michelle G. Brenner, M.D., IBCLC, and E. Stephen Buescher, M.D. in the **The Journal of Women's Health, Volume 20, Number12, 2011,** states: **"**Hospital breastfeeding initiation rates (75%) show that most mothers in the United States want to breastfeed and are trying to do so. Even from the very start, however, mothers may not be getting the breastfeeding support they need. Low breastfeeding rates at 3, 6, and 12 months illustrate that women face multiple additional barriers to maintaining breastfeeding." A 75% breast feeding initiation rate meets the Healthy People 2020 goal, however national research indicates the rate of breastfeeding drops significantly after three months. New breastfeeding initiation goals from Healthy People 2020 increases the goal for the proportion of infants who are breast fed **ever** to 81.9% and 60.6 % @ 6 months. Health reasons for encouraging and sustaining breast feeding after the baby goes home: • Reduced risk of common causes of infant morbidity. • Significantly lower rates of diarrhea, otitis media, lower respiratory tract infections, Type 1 and Type 2 diabetes, childhood leukemia, necrotizing enterocolitis and Sudden Infant Death Syndrome . • Women who breastfeed have a lower risk of Type 2 diabetes, breast, and ovarian cancer. • Recent evidence suggests that reduction in the risk for

	cardiovascular and other related diseases may be added to the benefits of breastfeeding for women. • Potential long term benefits of decreased childhood obesity.
Community Partners / Planned Collaboration	• Riggs Community Health Center • WIC (Women, Infants and Children) • Franciscan Physician Network (FPN) OB/GYN Physician Group and their Clinical Operations Group (COG) • Greater Lafayette Breast Feeding Coalition • Healthy Active Tippecanoe
Goal	Establish a baseline percent of Mothers who ever breastfeed, and those who continue to breastfeed at 2 weeks , one month and three months post-partum. Based on those scores, increase percentages annually by 2% beginning in 2014.
Timeframe	October 2013 – August 2016 (three year plan)
Scope	This initiative will focus on all Mothers who give birth at Franciscan St. Elizabeth East as well as the clients at WIC and Riggs. IU Health Arnett will be included if they so desire through our common relationship in HAT.
Strategies & Objectives	**Objective One:** Expand availability of Lactation Education Strategy: • FSEH to provide lactation education at Riggs Clinic o Incorporate Lactation consultation/educational sessions for Women's Health, Lafayette OBGYN, and Premier Physician' patients by scheduling a group consult as part of their continuum of prenatal care. • Work with staffs to increase lactation consultation referrals at the time of dismissal from the Women's Center unit. • Improve staff knowledge of dept. protocol to have all moms with a nipple shield referred for a lactation consultation. **Objective Two:** Participate in the WIC initiative 'Co-ffective' program to improve consistency in recommendations and advice offered by lactation consultants from WIC, FSEH and Kathryn Weil Center for Education (KWCE) programs. • Consider opportunity for WIC peer counselors to make rounds to see patients in-house prior to dismissal • Suggest that a similar process of in-house pre-dismissal visits be followed by KWCE lactation nurses as well. **Objective Three:** Investigate pursuing criteria for 'Baby Friendly Status' to determine its value to our patient population.
Financial Commitment	To be Determined - Ongoing
Anticipated Impact	Increased breast feeding rates at 2 weeks, 1 month and 3 months. Implement a minimum of 2 baby friendly concepts per year over the next three years.

Plan to Evaluate Impact	Follow phone and/or post card surveys ongoing @ 3days post partum (occurs from WC unit) @ 2 Weeks, 1 month and 3 months post partum. Cross reference with follow up data from KWCE lactation consult clients and follow up calls. Assess data from One Chart records on “ever breast fed”. Cross reference data provided by WIC on percentage of clients switching from breast feeding to bottle feeding and duration of breast feeding prior to introducing bottle feeding
Results	To be analyzed

On October 7, 2013, the Franciscan Alliance Corporate Board of Trustees reviewed and approved this CHNA Report and Strategic Implementation Plan for implementation. Previously, the Regional Board of the Western Indiana Region of the Franciscan Alliance reviewed and recommended such approval to the Corporate Board.