Franciscan St. James Health
Olympia Fields

2012-2013
Community Health Needs Assessment

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Executive Summary

Franciscan St. James Health (FSJH) has been a trusted leader in providing faith-based, integrated health care for more than 100 years. In response to the Accountable Care Act of 2010, Franciscan St. James Health developed this Community Health Needs Assessment (CHNA) throughout 2012-2013. Primary source data were gathered through a community survey and focus groups conducted by Professional Research Consultants, Inc. (PRC) in a collaborative project with a number of Chicago area hospitals coordinated by the Metropolitan Chicago Healthcare Council. PRC is a highly qualified organization in existence since 1994 that has conducted similar health need surveys and assessments throughout the country. An additional, supplemental survey was conducted by FSJH among selected communities part of its service area. Secondary source data through the Health Communities Institute (HCI) and other public sources of community and health data further supported the information gathered locally.

The reports and analysis found in these assessments are far more than numbers. They serve as our guide in determining the best programs and services available to more effectively meet the overall health needs of our communities. With this information and the resources available to us, Franciscan St. James Health is focusing on three issues in this first CHNA: diabetes, cardiovascular disease and access to care.

Franciscan St. James is pleased to provide access to important information underlying our ongoing commitment to improving health in our communities. The hospitals of the Franciscan Alliance are utilizing information provided by HCI, and made a part of the FSJH website, as a means of providing access to health indicators for themselves and for other community organizations and the general public. It is hoped that such shared information will also serve as a catalyst for discussion and exploration of collaborative activity to improve community health.

Franciscan St. James, a well-established source of health services to the community, is expanding its commitment to improve health by developing this more specific Community Health Needs Assessment and by adopting a Strategic Implementation Plan which describes specific programs being developed to improve community health.

Introduction

In the Spring of 2012, Franciscan St. James Health (FSJH) embarked on a comprehensive Community Health Needs Assessment (CHNA) process to identify and address the key health issues for our communities.

Franciscan St. James Health (FSJH) is a part of Franciscan Alliance, Inc., a 13 hospital Catholic hospital system based in Mishawaka, Indiana. FSJH is a two-campus operating unit of Franciscan Alliance, Inc. FSJH is located in Chicago Heights and Olympia Fields, Illinois and is licensed for a total of 451 beds with approximately 220 beds currently in operation. With approximately 1,500 employees, FSJH provides services primarily to residents of Southern Cook County, but also serves eastern Will County and those in neighboring cities and towns. FSJH is accredited by the Health Facilities Accreditation Program (HFAP).

The doctors and employees of Franciscan St. James Health, along with Franciscan Alliance hospitals, work to live our hospital's 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. Franciscan St. James Health provides the following services:

Cancer/Oncology Care	Pain Management
Durable Medical Equipment	Pediatrics
Emergency Services	Primary Care Physicians
Endocrinology	Rehabilitation Services
Heart & Vascular Care	Sleep Disorders
Home Health Care	Stroke Care
Hospice	Weight Loss/Bariatric
Imaging	Women's Health/OBGYN
Orthopedics	Stroke Care

Outreach activities at FSJH are coordinated through Mission Services and Marketing. FSJH is an integral part of the local community and is intent on providing services to the entire community within the limits of its resources. FSJH works with other community agencies so as to provide coordinated services without duplicating costly resources.

Purpose

The purpose of the Community Health Needs Assessment (CHNA) is designed to provide an understanding of the current health status and needs of the FSJH primary service area. This information will be used to prioritize the identified needs, and to plan and act upon these health needs. The CHNA will also recognize community strengths, assets and potential resources to address those needs.

Beyond the educational and informative aspect - the CHNA is a new legal requirement for tax-exempt health care organizations around the country. Other forms of assessments of community health have been a function that FSJH has been involved in for many years. This CHNA must be conducted in a specific manner 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 three years;

- Take into account input from persons who represent the broad interests of the communities 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

Objectives of this CHNA include:

1. Develop a comprehensive profile of health status, quality of care, and care management indicators overall and by county for those residing within the FSJH primary service area;

2. Identify the priority health needs (public health and healthcare) within the FSJH primary 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 persons residing in the FSJH primary 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 of 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 persons living in the FSJH primary service area.

This CHNA, a follow-up to a similar study conducted in 2009, is a systematic, data driven approach to determining the health status, behaviors and needs of residents in the Primary Service Area of FSJH. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

The CHNA provides the information so that FSJH, communities and other organizations may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. The 2012 PRC Community Health Needs Assessment serves as a tool toward reaching three basic goals that the above objectives support:

- **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.

- **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

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.

Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative and qualitative data are found in the primary research done by the PRC Community Health Survey and quantitative data are found in several secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes the primary community survey done by PRC, focus group results and, an additional survey conducted by FSJH.

The survey instrument used for the PRC 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 PRC survey was a collaborative project sponsored by the Metropolitan Chicago Hospital Council, in which FSJH participated.

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 complete PRC Community Survey and Focus Group report can be reviewed by using this link:

http://franciscanalliance.org/community/community-needs-assessment/Documents/2012%20PRC-MCHC%20CHNA%20Report%20-%20Franciscan%20St.%20James%20Health.pdf

The supplemental community survey was conducted mainly to obtain more primary source information from people and organizations having activity in health, social services and education, as well as senior citizens. Although it did not have the scope or specificity of the PRC study, the issues identified did parallel the larger study. The concerns identified included: access to care; preventive education; Type II diabetes and cardiac disease. FSJH sent requests to participate in that survey process to sixteen elementary and high school districts, 15 municipalities in our primary and secondary service areas, senior groups, churches and over 400 physicians. The goal was to seek input from and about individuals in all age groups and income levels. Potential participants were provided two formats for participation – a paper survey and an online option.

Community Health Needs Assessment Steering Committee

To guide the CHNA process and to assess survey and other data research results, a Steering Committee was formed. This Committee, with assistance from the FSJH Mission Committee, also determined the needs that would be addressed in this CHNA initiative.

The Steering Committee Members were:

Seth Warner – President and CEO, FSJH

Cindy Brassea – Vice President and COO, FSJH

Carol Alexander, PhD – President of CAO and Community Member

Craig Berman – Finance Director, FSJH

Gina Blankenburger, RN - Manager of Patient Services, FSJH Home Health

Felicia Davis, RN, MSN, OCN – Manager, Comprehensive Cancer Institute, FSJH

Anthony Monahan, RD – Manager, Diabetes Center, FSJH

Sr. Madonna Rougeau – VP Mission Integration, FSJH

Michael Shepherd – VP Marketing, FSJH

Cathy Winnick, RN, BSN, MHA – Director, FSJH Home Health

Karen Yates – Director, Mission Integration And Volunteer Services

Barbara Zeng Kwasny, BSN,MS, NP-C – Manager, Cardiopulmonary Rehabilitation

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources were consulted to complement the research quality of this Community Health Needs Assessment. These secondary data were available at the county level; to best match the Primary Service Area, data from Cook and Will Counties were used. These were obtained from a variety of sources (specific citations are included in the CHNA report), such as:

- Healthy Communities Institute – a nationally recognized aggregator of community health and other supporting data
- Centers for Disease Control & Prevention
- National Center for Health Statistics, State Department of Public Health
- Illinois Department of Public Health
- Illinois State Police
- US Census Bureau
- US Department of Health and Human Services
- US Department of Justice, Federal Bureau of Investigation

Note that secondary data reflect community-level data (South Suburban Cook County) where possible, and county-level data (Cook County and Will County) where suburban data is unavailable.

Community Stakeholder Input

As part of the Community Health Needs Assessment, one focus group was held in South Cook County on June 20, 2012. The focus group included social service providers and other community leaders. A second focus group was held on June 21, 2012, with key informants from across Cook County, including: representatives from public health; physicians; other health professionals; social service providers; and, other community leaders.

A list of recommended participants for the focus groups was provided by the sponsors. 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. Participants included a representative of the county department of public health, as well as several individuals who work with low-income, minority or other medically underserved populations, and those

who work with persons with chronic disease conditions. Additionally, a community member served on the CHNA Steering Committee.

Information Gaps

While this Community Health Needs Assessment is quite comprehensive, 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.

Vulnerable Populations

The CHNA analysis and report yielded a wealth of information about the health status, behaviors and needs of 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.

Public Dissemination

This Community Health Needs Assessment is available to the public at www.franciscanalliance.org/community.

In addition, Franciscan Alliance recently purchased the Healthy Communities Institute (HCI) web-based product that measures community health, shares best practices, identifies new funding sources, compares actual performance to Healthy People 2020 Goals and, supports improved community health. HCI is a nationally recognized organization (recent winner of the Best Community Health Application) that serves the informational needs of the community health sector nationally. It aggregates national, state and county information into one convenient site for easy access and review. This can be found at the following link for each of the hospitals and their specific service areas within the Franciscan Alliance 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.

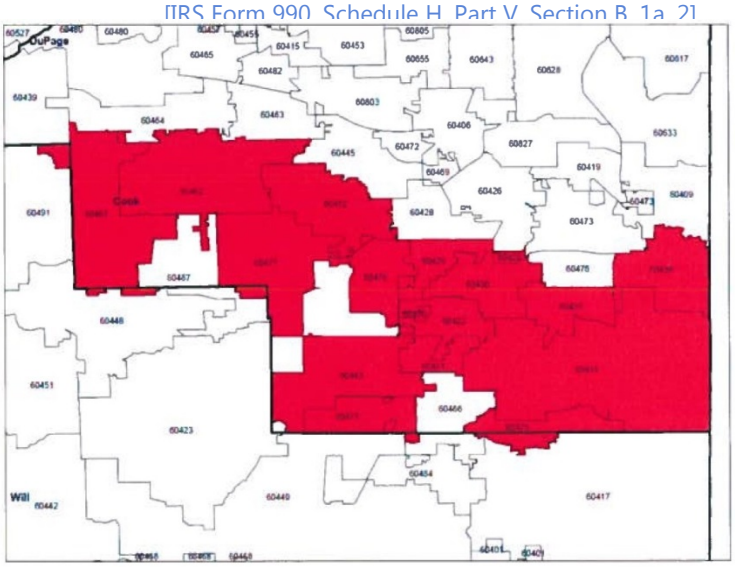
FSJH will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. FSJH will also maintain at its facilities a hardcopy of the CHNA report that may be viewed by any who request it.

Definition of the Community Served

IRS Form 990, Schedule H, Part V, Section B, 1a, 2)

Community Definition for this Assessment

The study area for the survey effort (referred to as the "Franciscan St. James Health Service Area" or "FSJHSA" in this report) is defined as each of the 15 residential ZIP Codes comprising the hospital's primary service area. A geographic description is illustrated in the adjacent map.



This community definition was determined because >80% of FSJH's patients originate from this area.

The communities included are:

Chicago Heights

Olympia Fields

Beecher	Homewood	New Lenox
Crete	Lynwood	Richton
Flossmoor	Matteson	Steger
Ford Heights	Mokena	Park Forest
Frankfort	Monee	

Demographics of the Community

The demographic information presented in the table below includes the total of both Cook County and Will County, though it should be noted that only small portions of the total counties comprise the primary service area for FSJH.

Overview: Demographics of the Community Served

US Census QuickFacts	Cook County	Will County	Illinois
Population, 2012 estimate	918,977	143,191	6,537,334
Population, 2010	903,393	139,654	6,483,800
Persons under 5 years, percent, 2011	7.7%	6.7%	6.6%
Persons under 18 years, percent, 2011	25.1%	26.0%	24.5%
Persons 65 years and over, percent, 2011	10.7%	12.5%	13.2%
Female persons, percent, 2011	51.8%	50.8%	50.8%
White persons, percent, 2011 [(a)]	67.8%	94.7%	86.8%
Black persons, percent, 2011 [(a)]	27.0%	1.5%	9.4%

American Indian and Alaska Native persons, percent, 2011 [(a)]	0.5%	0.3%	0.4%
Asian persons, percent, 2011 [(a)]	2.1%	2.1%	1.7%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 [(a)]	0.1%	Z	0.1%
Persons reporting two or more races, percent, 2011	2.5%	1.4%	1.7%
Persons of Hispanic or Latino Origin, percent, 2011 [(b)]	9.6%	3.2%	6.2%
White persons not Hispanic, percent, 2011	59.6%	91.8%	81.3%
Living in same house 1 year & over, 2007-2011	80.6%	85.5%	84.4%
Foreign born persons, percent, 2007-2011	8.2%	3.4%	4.5%
Language other than English spoken at home, pct age 5+, 2007-2011	11.7%	4.9%	7.9%
High school graduates, percent of persons age 25+, 2007-2011	84.2%	90.7%	86.6%
Bachelor's degree or higher, pct of persons age 25+, 2007-2011	27.1%	26.4%	22.7%
Veterans, 2007-2011	59,999	10,011	478,030
Mean travel time to work (minutes), workers age 16+, 2006-2010	22.5	25.9	23.1
Housing units, 2011	417,800	57,319	2,800,614
Homeownership rate, 2007-2011	57.9%	75.2%	71.1%
Housing units in multi-unit structures, percent, 2007-2011	31.6%	15.6%	18.5%
Median value of owner-occupied housing units, 2007-2011	$120,700	$145,000	$123,300
Households, 2007-2011	40,943	51,420	3,843,997
Persons per household, 2007-2011	2.46	2.62	2.53
Per capita money income in past 12 months (2010 dollars) 2007-2011	$24,575	$28,694	$24,497
Median household income 2007-2011	$43,197	$62,754	$48,393
Persons below poverty level, percent, 2007-2011	18.3%	8.5%	14.1%

(a) Includes persons reporting only one race
(b) Hispanics may be of any race and are included in applicable race categories.
(Z) Value greater than zero but less than half unit of measure shown

The population of the hospital's primary service area is estimated at 113,698 people. It is predominantly non-Hispanic White (73.1%), but also has substantial African American (15.5%) and Hispanic (9.2%) populations that are concentrated in southern portions of Cook County and of the northern portion of eastern Will County.

Chicago Heights is a city located in Cook County, Illinois. Chicago Heights is located immediately south of the City of Chicago. The latest census (2010) reported a population of 30,276, a decline of 26% from the population peak of 40,900 reported in the 1970 census.

Chicago Heights is a diverse community, with many different races and ethnicities represented. Approximately one-third of the population identifies itself as having a Hispanic or Latino origin (from all races). Forty-one and a half percent of the population is African American and 38% report a white/Caucasian race. Notably, 16.6% of the population fell into the category of "Some other Race." Nearly 27% of the population and approximately 40% of the population under age 18 is below the poverty line.

The village of Olympia Fields, while relatively close to Chicago Heights, is a substantially different community. Olympia Fields is also located in Cook County, Illinois. The population of Olympia Fields is 4,998 according to the 2010 census. Almost 70% of the population is African American. Olympia Fields is one of the wealthiest communities in the United States among those with a majority of the population being African American. About 8% of the population lives below the poverty line.

As throughout the state and nation, our population is aging, with 13.7% currently age 65 and older. This is projected to increase in coming years, as is the need for services to meet the health needs of this older population.

Median household income is just above the state average at $50,484; however, 15.0% of our population remains below the federal poverty level.

Existing Healthcare Facilities & Resources

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

Acute-Care Hospitals/Emergency Rooms

- Ingalls Hospital
- Advocate South Suburban Hospital
- Silver Cross Hospital
- Palos Community Hospital

Federally Qualified Health Centers & Other Safety Net Providers

- Aunt Martha's (FQHC)
- Access Health Centers

Nursing Homes/Adult Care

- Prairie Manor Rehabilitation and Healthcare
- ManorCare
- St. James Manor & Villas
- Beecher Manor
- Applewood Center
- Glenshire Nursing & Rehabilitation
- Glenwood Healthcare & Rehab
- South Suburban Rehabilitation Center

Mental Health Services/Facilities

- Grand Prairie Services
- Madden Mental Health Center, Hines, IL
- Will County Health Department Mental Health & Addiction Services
- Ingalls Hospital, Inpatient Psychiatric Unit

Emergency Medical Services (EMS)

- Kurtz Ambulance
- Municipal provided EMS services in most communities

Home Healthcare

- St. James Home Care Services
- Ingall's Home Health Services
- Awakened Alternatives

- First Choice
- Jencare

Hospice Care

- VITAS Hospice
- Horizon Palliative Care and Hospice

School Health Services

- Chicago Heights Elementary School District 170
- Chicago Heights High School District 206
- Crete Monee Elementary and High School District 201-2
- Flossmoor School District 161
- Homewood District 153
- Matteson School District 162
- Mokena School District 159
- New Lenox School District 122
- Park Forest School District 163
- Peotone Elementary and High School District 207-U
- Rich Township District 227
- Sauk Village Public Schools
- Steger Elementary School District 194

Other Community-Based Resources

- United Way
- Respond Now - emergency services, utilities, food, clothing
- South Suburban PADS (homeless shelter)
- South Star
- Southland Ministerial Association
- Rich Township Food Pantry
- Jones Memorial Community Center
- CEDA (Community and Economic Development Association of Cook County)

Collaboration

There was collaboration in the gathering of essential information for this CHNA and there is ongoing collaboration that FSJH enjoys with a variety of community organizations and physicians in the many services provided. The specific programs adopted by FSJH in this CHNA project will involve collaboration as described in that section of this report.

Areas of Opportunity for Community Health Improvement

The following "health priorities" represent recommended areas of intervention, based on the information gathered through the PRC survey and focus groups. The entire PRC report can be seen at:

Link to PRC

Areas of Opportunity Identified Through This Assessment	
Access to Health Services	☐ **Barriers to Access** o **Cost of Medical Visits** o **Appointment Availability** o **Finding a Doctor** o **Insurance Instability** o **Lack of Insurance/Being Underinsured *(focus group concern)*** o **Lack of Transportation *(focus group concern)*** o **Inconvenient Hours *(focus group concern)***
Cancer	☐ **Cancer Deaths — Prostate, Female Breast and Colorectal** ☐ **Mammography Screening**
Chronic Kidney Disease	☐ **Kidney Disease Deaths**
Diabetes	☐ **Diabetes Deaths**
Heart Disease	☐ **High mortality rates due to heart disease** ☐ **High hospital readmission rates due to heart disease**
Immunization and communicable Diseases	☐ **Low immunization rates for influenza and pneumonia** ☐ **Significant rates of sexually transmitted disease**
Injury & Violence Prevention	☐ **Violent Crime (Rates & Experience)** ☐ **Firearm-Related deaths** ☐ **Homicides**
Maternal, Infant & Child Health	☐ **Prenatal Care** ☐ **Low-Weight Births** ☐ **Infant Mortality**
Mental Health & Mental Disorders	☐ **Stigma *(focus group concern)*** ☐ **Stress *(focus group concern)*** ☐ **Lack of Providers/Inpatient Facilities *(focus group concern)***

Nutrition, Physical Activity & Weight	☐ **Fruit/Vegetable Consumption** ☐ **Access to Affordable Produce/Food Deserts *(focus group concern)*** ☐ **Nutrition Education *(focus group concern)*** ☐ **Low Physical Activity Levels *(focus group concern)***
Respiratory Diseases	☐ **Pneumonia/Influenza Deaths**
Substance Abuse	☐ **Excessive use of alcohol** ☐ **High ER and Hospitalization rates due to Alcohol**

Prioritization Process

At the conclusion of both key informant focus groups, participants were asked to write down what they individually perceived as the top five health priorities for the community, based on the group discussion as well as on their own experiences and perceptions. Their responses were collected, categorized and tallied to produce the top-ranked priorities as identified among key informants. It should be noted that the PRC Survey results and the Focus Group results represent the opinions (sometimes well-informed) of the participants which may be different from objective, scientifically developed data. Similarly, the results of the Supplemental Survey represent the opinions of the participants. These were considered in conjunction with the findings that emerged from the quantitative data.

Focus Group Assessment of Priority Needs

1. Access, including Transportation and Trauma Centers – Mentioned resources available to address this issue: Schools; Faith-Based Organizations; Community Health Centers; Various Hospitals; UIC School of Public Health; PACE Bus System; Cook County Hospital; Healthcare Consortium of Illinois; Southland Healthcare Forum; South Suburban Council on Alcoholism & Substance Abuse; United Way; Private Foundations; Christ Hospital

2. Prevention – Mentioned resources available to address this issue; City of Chicago; Faith-Based Organizations; Physicians; Community-Based Organizations; UIC School of Public Health; Schools; Health Departments; Hispanic Health Care Coalition

3. Obesity, including Nutrition – Mentioned resources available to address this issue: Hospitals; Schools; Non-Profit Agencies; Chicago Heights Park District; Public Schools; Business Leaders, CTA/PACE; Health Clubs; Urban Vegetable Gardens

4. Mental Health – Mentioned resources available to address this issue: Private Providers; County Providers; Federally Qualified Health Centers; School-Based Health Centers; Health Departments; Public Schools; South West Community Services; SERTOMA; Thresholds; National Alliance for Mental Illness (NAMI)

After reviewing the Community Health Needs Assessment findings, the FSJH CHNA Steering Committee met in February 2013 to determine the health needs to be prioritized for action in FY2014-FY2016.

Following the presentation of the CHNA findings, including the HCI data, the Steering Committee focused on the findings (Areas of Opportunity) and ranked the identified health issues against the following 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.

From this exercise, the Areas of Opportunity were prioritized as follows:

1. **Access to Health Services**
2. **Mental Health & Mental Disorders**
3. **Diabetes**
4. **Cancer**
5. **Cardio-Pulmonary Disease**
6. **Injury & Violence Prevention**
7. **Nutrition, Physical Activity & Weight**
8. **Kidney Disease**
9. **Substance Abuse**
10. **Nutrition, Physical Activity & Weight Status**

These areas of concern are subject to the discretion of area providers, the steering committee, or other local organizations and community leaders as to feasibility and priority. FSJH does not have the resources (financial and knowledge or expertise) to develop programs to address each of these prioritized needs.

Community-Wide Community Benefit Planning

As individual organizations begin to parse out the information from the 2012 - 2013Community Health Needs Assessment, it is FSJH's hope and intention that this will foster greater desire to embark on a community-wide health improvement planning process. FSJH has expressed this intention to partnering organizations and is committed to being a productive member in this process as it evolves.

Additionally, this FSJH CHNA report and the accompanying Strategic Implementation Plan will be incorporated into the overall FSJH Strategic Plan.

Franciscan St. James Health
Olympia Fields
FY2014-FY2016 Implementation Strategy

For more than 100 years, Franciscan St. James Health has demonstrated its commitment to meeting the health needs of South Suburban Cook County and parts of Will County.

This summary outlines Franciscan St. James' 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.

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 Franciscan St. James Health would focus on developing and/or supporting strategies and initiatives to improve:

- **Diabetes**
- **Cardiac Disease Management**

These were selected because of the need to limit the focus for implementation, yet address issues that affect large segments of the total population. Our sister facility in Chicago Heights is addressing Access to Health Care. Essentially, there is a common thread that runs through these issues, in that lack of access to care further complicates the control of diabetes and cardiac disease. It is felt that, given the resources of FSJH, improvement in these three focused areas has the greatest opportunity for overall improvement of the health of the community at large.

Integration With Operational Planning

Beginning in 2013, FSJH includes a Community Benefit section within its operational plan. Though resources are limited, a designated amount was made available to contribute to the cost of community health improvement, health education and promotion within the community.

Priority Health Issues That Will Not Be Addressed & Why

In acknowledging the wide range of priority health issues that emerged from the CHNA process, FSJH determined that it could only effectively focus on a few of those needs which it deemed most under-addressed, and most within its ability to influence. Consequently, the following needs were not chosen for focused attention.

Health Priorities Not Chosen for Action	*Reason*
Cancer	*Limited resources excluded this as an area chosen for action, though ongoing efforts will continue. Currently FSJH is working cooperatively with the American Cancer Society and Aunt Martha's FQHC to provide colonoscopy screenings. Mammography screenings are also provided.*
Chronic Kidney Disease	*FSJH has limited resources, services and expertise available to address chronic kidney disease as a focus of attention. Other community organizations have infrastructure and programs in place to better meet this need. As FSJH addresses Diabetes, a segment of the population with Chronic Kidney Disease will, however, also be impacted.*
Maternal, Infant & Child Health	*FSJH works closely with Aunt Martha's FQHC, and this organization has a primary focus for maternal child care. Limited resources and lower priority excluded this as an area chosen for action.*
Mental Health & Mental Disorders	*FSJH has limited resources. Though this is a huge area of need, FSJH feels that this issue can only be addressed with coordinated community input. Other organizations with in the community are better positioned to take the lead on this issue.*
Respiratory Diseases	*Limited resources excluded this as an area chosen for action, though routine efforts will continue.*
Injury & Violence Prevention	*FSJH believes that this priority area falls more within the purview of the county health department and other community organizations. Limited resources and lower priority excluded this as an area chosen for action.*
Sexually Transmitted Diseases	*Though this is an identified need, FSJH is not focusing on this issue, as its observance of the Ethical and Religious Directives for Catholic Health Care limits its ability to utilize all options of treatment that society may expect. This issue is endorsed to the FQHCs in the area.*

FSJH DIABETES Plan	
Reason for Program	• A total of 11.8% of the FSJH service area adults report having been diagnosed with diabetes, compared to 8.7% in Illinois and 10.1% in the USA. • The Cook County diabetes rate is notable higher among Blanks (35.3%) and Hispanics (25.8%)when compared to Whites (17.6%) and Asians (19.3%).
Community Partners	• Village of Frankfort for sponsored Health fair with screenings & education • Health and Wellness Institute for screenings at Day of Dance • Southland Ministerial Association to arrange for screening &/or educational opportunities for diabetics &/or caregivers • Independent physicians • Diabetes Center at FSJH-Olympia Fields
Goal	• Improve the accuracy and processes to identify new diabetics within the community • Connect participants with opportunity for accessing Primary Care Physician • Screen more individuals so as to get appropriate persons into proper care regimens • Provided educational information for diabetics and caregivers
Outcome Measures	• Year over year, increase the number of individuals receiving diabetic screenings in the community • Year over year, increase the identification of new diabetics in the community • Year over year increase in number of new diabetics receiving education at the Diabetes Center
Timeframe	January 2014-December 2016
Scope	The African-American population at selected church congregations within the FSJH service area **AND/OR** The identified at-risk patients referred by the FSJH Chronic Care Team

Strategies & Objectives	**Strategy #1 Continue to participate in local health fairs to raise awareness about diabetes and screen at-risk populations** • Go out into the community to meet with Church leaders and train representatives from their membership to do screenings, referrals to primary care physicians , and education **Strategy #2 Education for those with diabetes** • Continue to offer diabetes education to those with public aid • Continue to offer diabetes at a discounted rate for those without insurance • Continue to offer a free session of diabetes education to those individuals who were recently discharged from the hospital and referred by the Chronic Care Team • Go out into the community and meet with church leaders and train representative to teach diabetes survival skills • Train church representatives to recognize at-risk individuals who need referral to the Diabetes Center for more intensive education
Resource Commitment	To be Determined - Ongoing
Anticipated Outcomes	• Year over year increase in the number of individuals receiving diabetic screenings in the community • Year over year increase in the identification of new diabetics in the community • Year over year increase in number of new diabetics receiving education at the Diabetes Center
Results To be analyzed	

Cardiovascular Disease

Reason for Program **(Sources available in CHNA report)**	• Suburban Cook County heart disease mortality is unfavorably high among non-Hispanic Whites and Non-Hispanic Blacks. • Heart disease mortality rate has decreased in South Suburban Cook County (2000-2008), echoing the decreasing regional, state and national trends, yet it remains above the Healthy People 2020 target • A total of 5.4% of surveyed adults report having been diagnosed with heart disease. • Less than 30% of those who should have cardiac rehab following procedures actually attend this evidence based therapy.
Community Partners	• Local churches and businesses in South Suburban Cook and Eastern Will County • FSJH Home Health Agency • Specialty Physicians of Illinois, LLC
Goal	1. Improve access to screening, information and training regarding Cardiovascular risk factors 2. Increase the number of individuals participating in Cardiac Rehab following a cardiac event or diagnosis 3. Increase the numbers of home health patients with heart failure receiving tele-health monitoring and follow-up as needed 4. Provide an outpatient Community Care Center resource for members of our community with chronic health issues to reduce disease exacerbations and readmissions after discharge
Timeframe	January 2014-December 2016
Scope	The African-American population at selected church congregations within the FSJH service area. Those high-risk patients seen at the Community Care Center who have been identified as needing additional resources to manage their chronic condition.
Strategies & Objectives	**Strategy #1 Provide screening activities** • Regular free Heart Risk screening by appointment at the Heart and Vascular Institute including Ankle Brachial Index(ABI), BP, FBG, Waist girth, and BMI measurement and an individualized risk factor review with a cardiovascular RN • Frequent health fair screening events including BP, BMI and ABI measurements **Strategy #2 Take Educational programs to local churches – taking the education to the community rather than trying to pull the community out of their familiar environment.** • Frequent presentations to local church and community groups regarding cardiac disease and risk factors with handouts provided • Regular participation in health fair events with clinicians present to review lab results and discuss cardiovascular risk factors with attendees **Strategy #3 Implement coordinated supportive programs to better control heart disease on an outpatient basis to prevent/reduce hospitalization** • The AACVPR certified Franciscan St. James Cardiopulmonary Rehabilitation has the capacity to care for up to 96 patients for Phase 2 Cardiac Rehab and 100 patients in Phase 3 Cardiac rehab • Franciscan St. James Home Health Department has the capacity to provide Tele-health monitoring to 50 patients

	• The opening of the Community Care Center provides a resource/treatment point of care for individuals with heart failure care as well as other chronic and cardiovascular issues.
Outcome Measures	• The number of participants at screenings, • The number of individuals who learned of a new health issue at the screening. • The number of participants who did not have a PCP but received information regarding available physicians • The number of participants in Phase 2 and Phase 3 Cardiac Rehabilitation • The number of Home Health enrollees in the tele-health monitoring program • The number of patients seen in the Community Care Center and their readmission rates
Financial Commitment	To be Determined - Ongoing
Anticipated Outcomes	• Increase participant awareness of their health risk status • Increased participant access to primary care providers • Increased enrollment in Phase 2 and 3 Cardiac Rehab over 2013 • Increased enrollment in Home Health Care tele-health monitoring program • Reduced hospital readmission rates
Results	To be analyzed

Adoption of Implementation Strategy

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

On September 26, 2013, the South Suburban Chicago Regional Board (SSCR) of Franciscan Alliance, met to discuss this plan for addressing the community health priorities identified through our Community Health Needs Assessment. The Franciscan Alliance Corporate Board of Trustees approved the CHNA Report and this Implementation Strategy on October 7, 2013. The related budget items to undertake these measures to meet the health needs of the community is included in the Franciscan St. James Health operating budget for 2014.

Franciscan Alliance Corporate Board of Trustees

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Name and Title

_____

Date