UnityPoint Health – Trinity’s
Community Health Improvement Plan
2014 - 2016
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Executive Summary

In coordination with Community Health Care, Genesis Health System, the Quad City Health Initiative, the Rock Island County Public Health Department and the Scott County Public Health Department, UnityPoint Health-Trinity conducted a 10 month community health needs assessment in 2012. In 2013 Trinity built on the outcomes of that assessment to create a **community health improvement plan (CHIP)** in partnership with community agencies and individuals representative of the diversity of the Quad Cities. This plan spans calendar years 2014 - 2016.

It was clearly understood that Trinity “could do anything but it could not do everything” hence, in collaboration with UnityPoint Health - Trinity’s Mission Effectiveness Committee (MECR), expert clinical staff and community partners the following key health priorities were identified:

- **INCREASED ACCESS TO HEALTHCARE**
  - Heart Disease and Stroke
  - Diabetes
  - Behavioral Health

- **WELLNESS, PHYSICAL FITNESS AND PREVENTION**

In continued partnership with clinical staff and stakeholders, Trinity then developed goals and objectives for each of its priorities as well as related measures and strategies that comprise the current plan. Critical to the effective implementation of this plan it was clear that it must:

- Be fiscally realistic
- Be Collaborative
- Relationship Centered
- Reach out to the targeted groups
- Be culturally, socially & linguistically appropriate
- Be Inclusive
- Be transparent
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- Be Inclusive
- Be transparent
COMMUNITY ENGAGEMENT

To develop an encompassing but realistic and responsive plan the following teams of clinical staff and community members were organized to contribute to its development:

HEART DISEASE and STROKE
- Kate Cuellar, American Heart Association
- Betsy Demarest, Director of Surgical Services
- Jodi Dykema, Director of Rehabilitation Services
- Ida Johnson, United Neighbors
- Tarcicio Macias, Hola America
- Bobette Patterson, Director of Cardiac Services
- Dan Saskowski, Manager of Cardiac Rehab
- Scott VandeWoestyne, Quad City Chamber

DIABETES
- Tom Bowman, Community Health Care
- Leslie Cox, Diabetic Educator
- Frankie Cunningham, Rock Island County Public Health
- Dee Lazio, Generations
- Tarcicio Macias, Hola America
- Dan Saskowski, Manager of Cardiac rehab and Healthaware Screenings
- Jeni Tackedtt, Clinical Dietitian
- Tavia Vital, Diabetic Educator
- Jane Wiggins, Director, Mother/Baby
- Michael Winnekamp, 2 Rivers YMCA

BEHAVIORAL HEALTH
- Jackie Anhalt, Genesis
- Annie Armknecht, Vera French
- Tom Bowman, Community Health Care
- Heidi Bradley, Genesis
- Dr. David Deopere, Robert Young Community Mental Health Center
- Max Ewalt, National Alliance for the Mentally Ill (NAMI)
- Michael Freda, Robert Young Center
- Dr. Chris McCormick-Pries, Vera French
- Berlinda Tyler-Jamison, UnityPoint Health-Trinity
- Dan Ebener - Facilitator
THE TARGET POPULATION; Why?

The community health needs assessment revealed serious problems that are not uncommon to the Quad Cities or to other communities throughout the country i.e. that “race” and “income” are health disparity factors.

African Americans and Hispanics in the Quad Cities generally experience poorer health status, have a higher prevalence for chronic disease, much more difficulty accessing medical and dental care and report a lower quality of life.

- Lower income residents experience notably poorer health status; have a higher prevalence of chronic disease and greater difficulty accessing healthcare.

38.7% of Quad City Children ages 5 to 17 years are overweight or obese (in 2007 15.6% were obese. In 2012 22.4% were obese)

- The safety net for the sickest and poorest chronically mentally ill persons is breaking.

Given these findings, the following target populations for UnityPoint - Trinity’s community health improvement plan were identified:

- the African-American community in the Quad Cities
- the Hispanic community in the Quad Cities
- the lower income residents in the Quad Cities
- children ages 5 - 17 who are enrolled in area elementary, middle or high school in the Quad Cities
- the sickest and poorest chronically mentally ill in the Quad Cities
OUR VISION

The following three principles (or values) emerged during the planning process and are essential to achieving UnityPoint - Trinity’s vision for a healthy Quad Cities:

ALIGNMENT/COORDINATION - Engage UnityPoint’s community partners to identify shared priorities and develop effective partnerships

COMMUNITY “CONNECTEDNESS” - Promote community connectedness that support the Quad Cities’ health and wellbeing

HEALTH EQUITY - To help reduce disparities re: health access and health outcomes in the Quad Cities’ African-American, Hispanic and lower income communities
OUR PRIORITIES

As noted in the executive summary, UnityPoint Health - Trinity’s community health priorities were determined by its Mission Effectiveness Committee, staff and members of the agencies and organizations representative of the Quad Cities. 20 issues or “opportunities” for change emerged from the community health needs assessment. They were prioritized on the following variables:

- “Fit” The issue fits within our definition of “health”
- “Need” The issue addresses an unmet need or gap in service as identified by the community health needs assessment
- “Reach” The issue affects a significant number of Quad Citians
- “Alignment” The issue’s consistency with our mission, vision and goals
- “Actionable” Results are achievable
- “Resources” The local resources needed to mobilize against the issue exist
- “Impact” There can be a measurable impact on this issue in terms of health/quality of life outcomes
- “Non-duplicative” Action on this issue will not be duplicative
- “Community Support” Efforts to address this issue can generate community support

Access to Healthcare

Wellness, physical fitness, prevention

Heart Disease and Stroke
Diabetes
Behavioral Health

Heart Disease and Stroke
Diabetes
Behavioral Health
Our Goals and Objectives

Goal Statement 1 - To help Quad Citians at risk for or diagnosed with diabetes improve their health

- To increase the number of African-Americans, Hispanics and lower income adults in the metro Quad Cities receive health care services (to include preventive care)
- To increase the number of African-Americans, Hispanics and/or lower income Quad Citians with diabetes improve the self management of their disease

Goal Statement 2 - To improve cardiovascular health in the Quad Cities

- To increase the number of African-Americans, Hispanics and lower income persons in the metro Quad Cities receive health care services
- To increase the number of African-Americans, Hispanics and lower income adults in the metro Quad Cities practice heart healthy behavior

Given UnityPoint’s support of the Quad City Health Initiative and our active participation in its governance and project implementation, UnityPoint will address the issue of wellness, physical fitness and nutrition via the QCHI initiative. Following are that entity’s goals and strategies

Goal Statement 3 - To promote a “healthy Quad Cities”

- To increase physical activity among adults and children in the Quad Cities
- To increase healthy eating for children and adults in the Quad Cities

Members of the Community Mental Health Initiative (which consists of staff from the Robert Young Center, Vera French Mental Health Center, Community Health Care, Unity Point Health-Trinity, NAMI and Genesis) are currently developing and will complete the action plan re: Behavioral Health hence Unity Point Health - Trinity will address this issue by supporting and utilizing that plan

Goal Statement 4 - To help rebuild the Safety Net for the sickest and poorest mentally ill in the Quad Cities

- To increase awareness and convey the urgency of the “safety net” crisis
- To increase the community’s ownership re: finding a solution to the crisis

24 agencies to include the Robert Young Center and UnityPoint Health-Trinity are members of a consortium who wishes to develop a broader system of mental health care for children ages 5 to 17 in Rock Island County, Hence Trinity will address this issue by supporting and participating in this initiative

Goal Statement 5 - To optimize the mental and behavioral health of children in Rock Island County

- To support and grow a mental health system of care for children that is accessible, effective and equitable in Rock Island County
**Our Primary Strategies and Tactics**  
(for heart disease & stroke, diabetes and wellness goals)

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<tr>
<th>Strategy</th>
<th>Form Faith and Public Health Partnerships to reach and serve the targeted population</th>
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**Tactic:** In partnership, establish a Parish Health Watch Program in churches with a significant African-American, Hispanic and/or lower income congregation (the latter may be more difficult to identify). Allied health professionals, health ministers of churches in addition to nurses who are members of the churches would be the identified “champion of health” in the church and would help perform the following:

- Participate in screenings
- Be a support system
- Reinforce self management
- Secure Medical Home
- Navigate Health System
- Access Resources

**Parish Health Watch Program**

**Phase 1 Faith Partners**
- Second Baptist Church in Rock Island, Third Missionary Baptist Church in Davenport, St. Mary’s Catholic Church in Moline and St. Mary’s Catholic Church in Davenport.

**Phase 2 Faith Partners**
- Mt. Zion Baptist Church in East Moline, Tabernacle Baptist Church in Moline, Progressive Baptist Church in Davenport, Iglesia San Jose Obrero in East Moline

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<thead>
<tr>
<th>Strategy</th>
<th>Establish a “healthaware” partnership between our Wellness Department and reps. of the targeted populations and conduct screenings in multi-cultural and accessible locations</th>
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7
Primary Strategies and Tactics - continued

Strategy: Secure/help create culturally competent medical homes for the targeted populations and partner with Community Health Care and Trinity Clinics re: their Medical Homes initiatives

Culturally Competent

- The application of cultural knowledge, behaviors and interpersonal skills that enhances a provider’s effectiveness in patient care and increases the patient’s comfort. It is more than providing unbiased care. It reflects an appreciation for diversity. It is socially, culturally and linguistically appropriate behavior.

Medical Home

- The patient’s healthcare needs are coordinated through a health provider to ensure the patient receives the necessary care in a manner that both the patient and provider understand.

Primary Strategies and Tactics re: Physical Activity and Healthy Eating per the Quad City Health Initiative

- Promote development and adoption of worksite wellness programs/policies
- Promote development and implementation of comprehensive school wellness policies
- Promote development and implementation of nutrition and physical activity interventions in preschool and child care
- Increase the number of people who have primary care physician driven medical homes
- Develop a built environment that supports active living
- Increase access to healthy foods especially fresh fruits and vegetables

Primary Strategies and Tactics re: the Rebuilding Safety Net for the sickest and poorest

- Initiate a “Call to Action” for the Community re: this crisis.
  - Develop a “white paper” i.e. The Safety Net in Peril
  - Engage in a media campaign to inform and educate the public while at the same time advocating for change
  - Initiate a sustained dialogue with state and federal legislators re: the Excellence in Mental Health Act
  - Initiate a sustained dialogue with local business representatives re: the need for local solutions i.e. funds etc.
  - Conduct “In Their Own Voices” with constituents such as the Mission Effectiveness Committee
Primary Strategy and Tactic re: growing and supporting a mental health system of care for children in Rock Island

- Implement a System of Care model
  - Organize youth, family and provider panels
  - Promote the creation of one treatment plan that drives the care being provided by multiple providers

**Children who take medication for Attention Deficit Disorder**

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<tr>
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<th>% Meds</th>
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<tbody>
<tr>
<td>Rock Island Co</td>
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<tr>
<td>Scott Co</td>
<td>5</td>
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<tr>
<td>National</td>
<td>10</td>
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“**Rock Island County Children’s Mental Health System of Care Model**

“A broad, flexible array of effective services and supports for children aged 5 10 17 years that is organized into a coordinated network; integrates services/supports planning, service coordination and management across multiple levels; is culturally competent and builds meaningful partnerships with families and youth at service delivery, management and policy levels.”
Indicators

**Heart Disease and Stroke**
- % of targeted populations with one or more cardiovascular risk factors
- % of targeted population who have ever been told they have high blood pressure
- % of targeted population with high blood pressure who are taking action to control it

**Diabetes**
- % of targeted population with diabetes/high blood sugar
- % of targeted population taking action to control their diabetes

**Shared Measure**
- % of target population with medical homes

**Wellness (from QCHI)**
- % of adults at healthy weight (bmi 18.5 - 24.9)
- % of children ages 5 - 17 at a healthy weight
- % of adults reporting no leisure time physical activity in past month
- % of adults reporting participating in regular, sustained, moderate or vigorous physical activity
- % of children (5-17) participating in moderate and vigorous physical activity on six or seven days per week
- % of adults reporting eating 5+ servings of fruits/vegetables per day

Must establish a baseline for the % of targeted population who have been screened for heart disease and diabetes