2015 Principles for Community Health Care Report

NAME OF ORGANIZATION: Swedish Covenant Hospital
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MISSION OF THE ORGANIZATION: To provide a continuum of high quality healthcare services through which patients are cared for as whole persons within a healing atmosphere of professional excellence and human kindness.

1. **Identify the high risk/underserved and/or disadvantaged populations in the community(ies) that you serve and describe specifically the actions you have taken, based on relevant assessment data, to increase their accessibility to health services.**

Swedish Covenant Hospital (SCH) is a comprehensive health care facility providing health and wellness to Chicago's highly-diverse North and Northwest side communities. This 323-bed hospital is one of the few independent, non-profit hospitals in the area. The population of the hospital's service area is estimated at 631,311 people. It is predominately non-Hispanic White (63.66%), but also has substantial Hispanic (28.75%) and Asian (10.87%) populations. The median household income within the SCH service area is below the state average at $48,386, and 12.37% of the families in our population live below the federal poverty level. SCH is located in a federally designated Health Professional Shortage Area (HPSA) and Medically Underserved Area/Population (MUA/P) community area. Meeting the needs of community residents who are underserved due to financial and cultural barriers has always been core to the hospital's mission. To this end, SCH is a Federal Disproportionate Share and State of Illinois Medicaid Disproportionate Share and High Volume Adjustment (MHVA) and Medicaid Percentage Adjustment (MPS) hospital, and a State of Illinois Safety Net Hospital, serving a high percentage of Medicaid and uninsured patients. In FY14, over 35% of adults, age 18-64 were Medicaid recipients or uninsured. The hospital is located in one of the most diverse community areas in the country, which serves as a point-of-entry for immigrants and refugees from more than 60 nations. To reduce linguistic and cultural barriers to care, SCH recruits, trains, and hires a highly diverse medical staff. Hospital staff currently represents more than 50 nationalities and speak over 55 languages. SCH also employs Spanish, Korean, Russian, Polish, Arabic, and Bosnian/Serbian language interpreters and offers rapid access to telephone translation services in 180 languages.

The hospital was founded over 125 years ago by Swedish immigrants of The Evangelical Covenant Church to meet the needs of immigrants suffering from a variety of maladies and social problems. Since that time, the hospital has grown and transformed in furtherance of its mission and in response to emerging community needs. SCH maintains a department dedicated to addressing its outreach objectives of serving the entire community, not only those who come through its doors. Building on a long tradition of service, the Community Relations Department utilizes hospital strengths alongside those of other well-established community partners. This strategy allows SCH to better understand and reach the most vulnerable sectors of the community, while meeting acute healthcare needs. SCH undertakes a Community Health Needs Assessment (CHNA) every three years, with the most recent one completed in 2012.

The 2012 PRC Community Health Needs Assessment (CHNA) for SCH revealed, in addition to various other health concerns, that breast cancer screening rates among women 50-74 in SCH's service area were lower than that of the metro Chicago area overall (65% vs 78%). This reality, in addition to the tremendous financial and cultural barriers that women in the SCH community face in accessing breast health services has led the hospital to continue to expand the Community Breast Health Program. Through philanthropic support, this program provides high-quality, culturally-relevant breast health education, breast cancer detection, and patient navigation services at no charge to uninsured and underinsured, low-income women. Additionally, the same needs assessment identified that 42% of SCH service area adults reported difficulties in accessing health services, and nearly 30% of SCH emergency room visits were due to access barriers and/or the event occurring during weekend or after hours. To address these issues, SCH has implemented several key strategies to increase access, including a partnership with Erie Family Health Center to establish a federally-qualified health center (FQHC) on the hospital campus, training hospital staff to serve as Certified Application Counselors to assist patients with enrollment into Medicaid or insurance through the Health Insurance Marketplace, and the opening of two Immediate Care locations in the North and Northwest regions of the City to provide extended hours of care.

In addition, SCH participated in a collaborative 2015 CHNA for Cook, DuPage, and Lake Counties, Illinois with other hospitals and health systems, coordinated by the Metropolitan Chicago Healthcare Council (MCHC). Health priorities identified through these processes are used to inform decisions and guide efforts to improve community health and wellness, reduce health disparities among residents, and increase access to preventive services. This assessment identified 14 local health needs and gaps in services. Areas of opportunity identified through this assessment prioritized by SCH for FY2014-FY2016 include: 1) access to health services; 2) heart disease and stroke; 3) nutrition, physical activity and weight; 4) mental health; 5) cancer; 6) maternal, infant, and child health, and; 7) respiratory diseases. These priorities and supporting strategies continue to inform and support community programming supported by the hospital.

2. **Describe specifically the strategies you have used to gather input from high risk, underserved and/or disadvantaged population and their leaders as a basis for program or service development.**

SCH uses focus groups, surveys, patient satisfaction questionnaires, key informant interviews, and advisory boards to gather critical input from community residents and leaders to guide service design. For instance, in developing the 2012 CHNA, SCH employed a telephone interview methodology to gather feedback from a random sample of 515 individuals age 18 and older in the SCH service area. In addition, seven focus groups were held among key informants in the community. These key informant focus groups allowed for input from persons with special knowledge of or expertise in public health, as well as others who represent the interests of key cultural groups represented in communities served by Swedish Covenant Hospital. In all, 50 key informants participated, including physicians, other health professionals, social service providers, business leaders, ethnic/cultural organizations and other community leaders.

In addition, SCH utilizes community advisory boards to inform program design and ensure alignment with community needs. For example, as part of the SCH Women's Health Initiative,

which coincided with the opening of the new Mayora Rosenberg Women's Health Center, SCH formed a Women's Health Community Board. This group is comprised of women leaders from a diverse range of community organizations and groups, including the Albany Park Community Center, Centro Romero, the Indo-American Association, Erie Family Health Center, the Albany Park CEDA WIC office, the Cambodian Association, the Polish Initiative of Chicago, and Korean American Community Services, among others. New in 2015, SCH is implementing a new model of prenatal care, Centering Pregnancy, which promotes care in a group setting to encourage a sense of community and empowerment for expectant mothers. As part of this initiative, an Advisory Committee will be formed comprised of SCH staff and community partners to guide the development of the program. These examples demonstrate the commitment of SCH to engage and gather input from underserved, high-need community members and partner organizations serving these populations to guide program design and implementation across the hospital.

3. **Describe specific partnerships with other providers and community-based organizations to promote continuity of health care for high risk/underserved and/or disadvantaged populations.**

SCH partners with a wealth of community-based organizations committed to serving some of the City's highest-need, most vulnerable populations. In addition, the hospital works with a variety of cultural organizations serving the diverse populations within SCH's service area; these groups face a variety of barriers to accessing health care. For example, through the Community Breast Health Program, SCH provides breast health education, breast cancer screening and diagnostic services, and comprehensive patient navigation at no cost to low-income women (and men) who are uninsured and underinsured. To ensure the program reaches those most in need and reduce disparities, program staff works closely with many community health and human service organizations, including Heartland International Health Centers, Korean American Community Services, Centro Romero, Vietnamese Association of Illinois, Casa Ecuatoriana, Chinese Mutual Aid Association, Cambodian Association of Illinois, the South-East Asia Center, Asian Health Coalition, Westside Health Authority, and the Metropolitan Chicago Breast Cancer Task Force. The program also delivers breast cancer detection services to underserved women through a partnership with the A Silver Lining Foundation.

As part of its Women's Health Initiative, Swedish Covenant Hospital has launched a Violence Prevention Program to strengthen its capacity to identify and respond to women, men, and children who are victims of domestic violence, sexual assault and human trafficking. In a 2012 community health needs assessment of Swedish Covenant's service area, 15% of women surveyed reported having been hit, slapped, pushed, kicked or hurt by an intimate partner in their lifetime. In focus groups conducted as part of the needs assessment, community residents and leaders noted that violence against women is under-reported, particularly in immigrant communities, due to stigma and fear of deportation. Swedish Covenant is in a unique position as a key "first responder" because of our local community ties. The role afforded our medical professionals allows them to see a woman alone and to become privy to highly sensitive information. Based on this opportunity, Swedish Covenant has created the Violence Prevention Program to institute a truly coordinated, comprehensive programmatic response to victims of domestic violence, sexual assault and human trafficking. A key strategy for the program in its first year has been to formalize partnerships with domestic violence, sexual assault, and human

trafficking providers within SCH's service area who are culturally and linguistically capable of meeting the needs of our diverse population. To this end, the program's Women's Health Advocate works with local organizations Between Friends, Apna Ghar (a domestic violence shelter serving primarily Asian women and children), KAN WIN (serving Korean American and immigrant survivors of gender-based violence), as well as others, to connect survivors of abuse with comprehensive support services to address their needs and end the cycle of abuse.

4. **Provide two examples of how you have used the community-oriented approach to program development specified in the attached principles to develop a program of service for high risk/underserved and/or disadvantaged populations specified in the guidelines. Include in each description components of the current program and the following quantitative information for the most recent year available:**

Swedish Covenant Hospital's new cancer survivorship program, the Integrated Cancer Care Program (ICCP) augments standard cancer care with psychosocial support, nutrition counseling and supplementation, exercise programming, rehabilitation, and, palliative care assessment and planning; as well as complementary treatments. Care integration occurs through interdisciplinary case conferencing (i.e., a survivorship board) and patient navigation. Newly diagnosed patients and those in treatment meet with the Survivorship Coordinator/Navigator (or Breast Cancer Survivorship Navigator) as part of the treatment planning process. The Navigator provides an overview of survivorship services and completes a series of screenings to identify needs and the survivorship services of greatest value to the patient.

The goals of the program are to: 1) to increase cancer survivors' access to a comprehensive and evidence-based array of supportive services, and 2) through these services, improve their health and wellbeing. As it pertains to cancer survivors' health and wellbeing, the specific objectives of the program are to: 1) reduce distress; 2) enhance quality of life and mood; 3) increase treatment adherence; 4) reduce the onset and severity of cancer cachexia; 5) improve functional status; and, 6) promote patient satisfaction with cancer survivorship care.

Supportive services are offered to address the holistic needs of survivors; patients are able to receive fitness programming and integrative treatments at the hospital's medical fitness facility, Galter LifeCenter (GLC), as well as group and individual personal training and rehabilitation consultation and massage therapy on-site in the cancer center. Support groups are offered three times per month on different topics, facilitated by the ICCP Navigator and often another ICCP team member (e.g., dietician, meditation instructor) or guest speaker. A weekly art therapy group is also offered through the program. The program has also expanded access to mental health services through the addition of a psychiatric nurse practitioner on-site in the cancer center. The program has also finalized and begun to implement a standard Survivorship Care Plan which satisfies the plan elements recommended in the Institute of Medicine's 2006 report, From Cancer Patient to Cancer Survivor: Lost in Transition and the American College of Surgeons' Commission on Cancer requirements.

1. Number of clients served: 173 patients in FY2015
2. Total amount budgeted by your organization for the program: $351,810 (FY15)
3. Percent that program budget is of total agency budget: less than 1%
4. Percent of program budget that is directly reimbursed by third party payers: 0%

5. Percent of program budget that is covered by public/private grants: 58% (2015)

The goal of the Chronic Disease (CD) Care Transitions Program is to address the post-discharge needs of low-income, vulnerable patients with chronic diseases. Since its inception in 2011, this multi-tiered program targets patients who will be returning home, but are not homebound, and who are at heightened risk of readmission due to a variety of factors (e.g., history of repeated readmissions, comorbidities, polypharmacy, low health literacy). The objectives of the Chronic Disease Care Transitions program are to: 1) increase patients' access to follow-up community care; 2) increase medication safety and adherence from hospital to home; 3) increase patients' capacity to manage their illness; and, 4) decrease hospital readmission.

Chronic disease patients are screened for readmission risk before discharge and those at high risk receive a pre-discharge visit from the Wellness Coach who conducts an intake assessment, explains the program, and identifies the service level best suited to their needs. Basic Care Transition Services (approximately 4 hours of service) include a home visit and 3 telephone calls in the month following discharge. Services focus on: post-discharge physician follow-up, medication reconciliation, and CD self-management coaching. Patients requiring a higher level of care receive Advanced Care Transition Services (ACTS), which span 3 months and include, as needed, nutrition or diabetes interventions, daily home telemonitoring, and care coordination. Patients receiving ACTS receive 10 – 25 hours of service. CD patients evidencing malnutrition are referred to the Nutritionist, who makes 3 home visits and 3 telephone calls, focused on nutrition assessment and development of a customized nutrition plan, nutrition counseling tailored to the patient's health literacy level, and monitoring of patient progress. Patients are provided a 6-week supply of nutrition supplements. Patients with uncontrolled diabetes are referred to the Certified Diabetes Educator, who makes 3 home visits and 3 telephone calls, focused on helping patients understand the disease and its risks, and coaching patients to manage their diabetes through prescribed medication usage, regular blood sugar monitoring, diet, and other lifestyle changes. As needed, patients are provided glucometers, test strips and lancets for testing blood sugar levels. Patients at highest risk for readmission receive 3 home visits from the Wellness Coach, daily telemonitoring (utilizing wireless equipment installed in the patient's home, which transmits patient health data to the Nurse Coordinator), and care management.

Since the program's inception, the program has served over 1,500 patients, and 30-day readmission rates for patients with CD have decreased significantly, from 27% to 9%. Furthermore, since the program's inception in 2011, the overall 90-day readmission rate for CD patients has decreased 20 percentage points, from 35% to 15%. This is a significant accomplishment given that SCH sees approximately 4,800 CD patient admissions annually, and less than 10% of these patients (those at the highest risk of readmission) receive program services.

1. Number of clients served: 323 patients in 2014
2. Total amount budgeted by your organization for the program: $307,650 (FY15)
3. Percent that program budget is of total agency budget: less than 1%
4. Percent of program budget that is directly reimbursed by third party payers: 0%
5. Percent of program budget that is covered by public/private grants: 82% (2015)