Rochelle Community Hospital
July 16, 2019

COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGY

Establishing Health Priorities Reporting Document

Introduction

Rochelle Community Hospital (RCH) is a 25-bed critical access hospital (CAH) located in Rochelle, Illinois, within Ogle County. It is a 501 (c)3 organization.

Rochelle Community Hospital agreed to participate in the Community Health Needs Assessment (CHNA) process administrated by the National Rural Health Resource Center (The Center) of Duluth, Minnesota. In January 2019, The Center conferred with leaders from the hospital to discuss the objectives of a CHNA, including focus groups, a secondary data analysis, and implementation planning. In April 2019, report findings were presented via webinar, as well as a presentation highlighting national changes in the health care system. In July 2019, The Center facilitated virtual implementation planning with sixteen hospital leaders and community agency representatives to identify community health priorities and develop strategic actions.

Description of Community Served

Input was sought from the following communities that are within the service area: Rochelle, Creston, Franklin Grove, Ashton, Oregon, Davis Junction, and Steward.

Input from Broad Interests

In January 2019, The Center conferred with leaders from Rochelle Community Hospital to discuss the objectives of a regional CHNA survey to obtain quantitative data. A mailed survey instrument was developed to assess the health care needs and preferences in the service area. The survey instrument was designed to be easily completed by respondents. Responses were electronically scanned to maximize accuracy. The survey was designed to assemble information from residents regarding:

- Demographics of respondents
- Utilization and perception of local health services
- Perception of community health

Rochelle Community Hospital provided The Center with a list of inpatient hospital admissions. Zip codes with the greatest number of admissions were stratified in the initial sample selection. Each area would be represented in the sampling proportionately to both the overall served population and the number of past admissions. Eight hundred residents were selected randomly from PrimeNet Data Source, a marketing organization. Although the survey samples were proportionately selected, actual surveys returned from each population area varied. One-hundred twenty-seven (127) of the mailed surveys were returned, providing a 17.4% response rate. Seventy-two of the original 800 surveys sent were returned by the U.S. Postal Service as undeliverable Based on the sample size, surveyors are 95% confident that the responses are representative of the service area population, with a margin of error of 7.91.

In March 2019, The Center conducted four focus groups with a total 28 people attending. Each focus group represented a specific demographic focus and included representatives form businesses, health care, senior citizens, and vulnerable populations. The questions and discussions were led by The Center. No identifiable information is disclosed to maintain confidentiality.

Prioritized Health Needs

On July 16, 2019, sixteen members of the hospital leadership and representatives (The Team) from Sinnissippi Centers, Economic Development, Rochelle Fire Department, and Rochelle Park District were assembled to:

- Discuss the changing health care environment toward value and population health
- Review the CHNA survey results, secondary data, and focus group findings
- Identify the top community health priorities
- Begin the implementation plan to include actionable items

The Team met virtually for the implementation planning session. The Team worked as a group to identify the top community health needs to prioritize. Each participant then had an opportunity to vote for the need(s) they felt was a top priority. The top health needs identified from the quantitative and qualitative data are:

- Improve Access to Substance Abuse and Mental Health Services
- Improve Access to Primary Care & Specialty Care
- Include and Engage the Population to Reduce Barriers
- Collaborate Towards a Healthy Community

These needs were then evaluated based on those that best relate to the hospital's mission, urgency, feasibility within the hospital's resources, existing community strengths, and opportunities to partner with other local organizations.

A facilitation method designed to achieve group consensus-based decisions that respects the diversity of participant perspectives, inspires individual action, and moves the group toward joint resolve and action was utilized. This method creates awareness about new relationships between data and acknowledges the level of the group's consensus at any given moment. The conversation is aimed towards identifying actions the Team can take towards addressing the community's top health needs identified.

Team members began by individually brainstorming potential actions to address each strategy. Team members then shared their ideas in small groups and identified the top potential actions they wished to share with the full group. After the actions were organized, the Team collectively developed objectives to describe the potential activities the Team could pursue to address all four priorities:

- Improve Access to Substance Abuse and Mental Health Services
- Improve Access to Primary Care & Specialty Care
- Include and Engage the Population to Reduce Barriers
- Collaborate Towards a Healthy Community

The list of potential activities identified by the Team will be reviewed by hospital leadership and integrated with the hospital's strategic plan where applicable. Hospital leadership will then operationalize a plan of actions to address the identified health goal by completing the Community Health Needs Assessment Action Plan Worksheet.

Objectives and Actions

Collaborate Towards a Healthy Community *(5.5 votes)*	**Improve Access to Substance Abuse and Mental Health Services** *(19 votes)*	**Include and Engage the Population to Reduce Barriers** *(11.5 votes)*	**Improve Access to Primary Care and Specialty Care** *(13 votes)*
• Wellness screening and prevention education/services • Obesity/wellness • Community wellness • Community wellness (screenings, prevention, healthy behaviors) • Partnering on prevention with schools and other providers and resources in Rochelle • Transportation and accessibility to transportation • Improve knowledge and access to financial assistance	• Substance abuse and mental health treatment • Mental health services • Substance abuse and mental health treatment • Mental health/substance abuse – psych with MAT • Mental health expanded services Inc. increased adolescent services, inpatient MH facility • Substance abuse services Inc. detox	• Engage, connect, and serve Hispanic population and other vulnerable groups (low-income, homeless, children, people with disabilities) • Hispanic population • Language barriers • Direct outreach to Spanish speaking population – culture and language, teaching English as much as providing Spanish materials and providers	• Specialty providers • Increased access to primary care and increased specialty care • Access to PCP follow-up and need for internal medicine for ageing population

Rochelle Community Hospital
July 16, 2019

CHNA ACTION PLAN WORKSHEET

**=easiest to implement / start with*

Community Health Priority: Improve Access to Substance Abuse and Mental Health Services					
Objective (Action)	**Activity Lead**	**Timeline**	**Partners**	**Resources Needed**	**Measure of Success**
Psychiatric services in the community	Jennifer	5+ years	• Health Department, • Mental health providers • Schools • Police • Collaborate with other treatment centers that are reachable • Colleges and Universities that have Psych Grads.	Psychiatrist, finances, support staff, possibly Tele-Psych services	Securing a consistent Mental Health Professional (Physician or ARNP) that will be present in the community. TelePsych service is available.
Community education about mental health and substance abuse issues.	Jennifer, Michelle Le Page, Nurse Educator	1 year	Add hospital, local government, county government, Law enforcement, Schools.	Data regarding MH/SA diagnoses in our community.	One community forum/town hall in the next 12 months
*Promote organizations to assist in substance abuse (AA, NA, NAMI, ALANON, churches, etc.)	Jennifer, Michelle Le Page, RCH Marketing	Currently in place <1 yr.	AA and NA leads, churches, hospital, SA professionals, police, drug court, IP Treatment	Reliable and skilled AA/NA facilitators, Comprehensive list of support	Distribution of quarterly support group/services newsletter to community.

			facilities, MH Centers and IP Psych facilities.	services available.	
Crisis Prevention Team, including different areas in the community (law enforcement, hospital, etc.).	Have had 1st meeting	In process	Local Police, Sheriff, Courts, Sinnissippi, Probation	Transportation, safe harbors	Services would be available 24/7 for SA/MH interventions

Community Health Priority: Improve Access to Primary Care & Specialty Care

Objective (Activities)	Activity Lead	Timeline	Partners	Resources Needed	Measure of Success
Increase number of primary care providers by recruiting through our own training program - including increasing number of Spanish-speaking providers	• CEO	36 months	• Rural residency program to expand PCP • Tele-medicine option • Own PCP • U of I College of Medicine (Rockford)	Rural Residency Program Partner FHC physician support	*Rural primary care physician residency program identified and relationship established. 1 rotation offered at RCH* *Completed physician manpower assessment completed and one successful recruitment completed according to need.*
Increase access to specialties, including mental health, neuro, and other services through tele-medicine	CEO	12 months	OSF and or Mercy Health Sinnissippi Centers	Telehealth partner.	*One telehealth service offered to community based on need and feasibility.*
Transportation	Karen Case Management	12 months	Local transport companies.	Inventory local transportation resources.	Provide reference guide to local providers outlining

	Michelle				transportation resources.
Implement a triage system for scheduling same-day appointments within a practice - Include process for scheduling follow up appointments through ED and CC	Karen Tracy	24 months	FHC physicians	Enhance established protocols and clinic operations.	Increase primary physician access 10%.
Expand hours of PCPs to include evenings and Saturdays	Karen Tracy	24 months	FHC physicians		Expand hours: 1 evening 1 Saturday Per month

Community Health Priority: Include and Engage the Population to Reduce Barriers					
Objective (Activities)	**Activity Lead**	**Timeline**	**Partners**	**Resources Needed**	**Measure of Success**
Health education programs in Spanish – diabetes, marketing in Spanish	• Margaret • Emma Bauer • Julia • Janet • Kyle	12 months	• LULAC • Churches		Provide two programs in Spanish: • CPR • Diabetes Education • Safe Sitter
Increase diversity of workforce to include bilingual (Spanish speaking) employees		36 months		Does RCH application state bi-lingual Spanish preferred? Yes	Increase number of bilingual employees by 5%
Increase diversity of workforce to include bilingual primary care provider(s)		36 months		Approach Dr. Alanis and Dr. Wade?	Recruit 1 bilingual provider
Provide 1 month access to RCH Fitness Center to patients as needed	• Janet	12 months	• LULAC • RCH Foundation	Determine how many people will be sponsored Will RCH Foundation sponsor	10 memberships/year provided to qualified patients

Open days that patients can meet face to face with Medicaid rep for help	• Kyle • Janet • Doris		• Ogle County Health Dept • RCH		1 day per quarter
RCH will support school-based clinic in the community.	• Kyle • OCHD Health Educator •		Ogle County Health Dept Whiteside County Rochelle Township High School Faith Lutheran		Hospital representative at school based clinic project meetings conducted by OCHD Provide support as needed
Daily transportation			LOTS		
Pool of certified translators	• Margaret • Susie • Vicki • Laura				Two Certified Medical Translators over next 12 months

Community Health Priority: Collaborate Towards a Healthy Community

Objective (Activities)	Activity Lead	Timeline	Partners	Resources Needed	Measure of Success
Resources for insurance - collaborate with employers in the community, insurance sales people and insurance companies to ensure hospital and local providers are included in the networks. Then collaborate with local schools, churches, community groups to educate about insurance	Doris Lori Michelle Janet	Part 1 – Gathering data from employers and brokers (6 months) Part 2 – Educating community (12 months), contracting with any new insurances (12 – 18 months)	• Schools • Churches • Local community groups • Insurance companies • Local employers • Local Insurance brokers	• List of employers and their health plan. • List of local brokers	• Being contracted with 95% of local employers' insurance plans
Collaborate with schools, health dept, community groups, local providers, churches to provide education and resources for obesity and wellness initiatives.	• Michelle • Janet • Nurse Educator	2 years	• Schools • Health Department • Churches • Local Providers • Local Community groups (Rotary, Golden K, LULAC,	Catch program (long term goal/implement in one school) Resources with colleges in community Healthy eating programs and physical activity programs	Quarterly presentations at the Senior Center Two presentations at the High School School tours One Healthy Heart presentations

			Senior Center, etc)		Breast cancer awareness presentations Two Healthy Eating demonstrations per year
Expand current community services list including financial assistance opportunities to include all resources available in the community and educate the community and share the list with organizations in the community to share	• Case Management • Janet • Michelle	3 months to compile list 12 months for educating community	• Schools • Health Department • Churches • Local providers • Local community groups • HOPE • Homeless shelter • Community Foundation	Lists from local organizations on assistance they offer (rent, utility assistance, etc)	10 groups educated about the list Post list on hospital website and share with other organizations

Dissemination

- Rochelle Community Hospital posted a summary of the community health needs assessment findings and implementation strategy online at https://www.rochellehospital.com/about-us/community-health-needs-assessment/

- Rochelle Community Hospital disseminated a summary of the community health needs assessment findings and implementation strategy to community partners.

Implementation Strategy

- Hospital leadership assembled to operationalize the community health assessment action plan which identifies the objectives, partner opportunities, activity leads, a timeline, and how the objective will be measured for success (see Community Health Assessment Action Plan above).

Resolution to Approve Community Health Needs Assessment Implementation Plan

Whereas the board of Rochelle Community Hospital approved of and oversaw the implementation of a Community Health Needs Assessment process for the purpose of improving community health status and meeting Internal Revenue Service mandates enacted through the Patient Protection and Affordable Care Act;

Now therefore be it resolved that the board of Rochelle Community Hospital does hereby adopt this resolution to accept the Community Health Needs Implementation Plan presented on this day to address to the following prioritized health needs:

- Improve Access to Substance Abuse and Mental Health Services
- Improve Access to Primary Care & Specialty Care

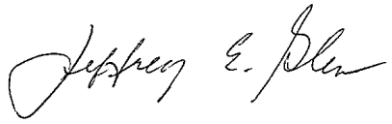
- Include and Engage the Population to Reduce Barriers
- Collaborate Towards a Healthy Community

Upon vote taken, the following voted:

For:
Against:

Whereupon said Resolution was declared duly passed and adopted this 24th day of July, 2019.

Board chair
Noah Carmichael
Board chair



Attest: Board Secretary
Jeffrey E. Glen
Attest: Board Secretary