Trinity Health Mid-Atlantic/Saint Francis Healthcare completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Hospital Community Board of Directors on April 27, 2020. Trinity Health Mid-Atlantic/Saint Francis Healthcare performed the CHNA in adherence with applicable federal requirements for not-for-profit hospitals set forth in the Affordable Care Act (ACA) and by the Internal Revenue Service (IRS). The assessment included a comprehensive review of secondary data, community health status, and social determinants of health, as well as primary data collection including input from community representatives, community members, and various community organizations.

The complete CHNA report is available electronically at: https://www.trinityhealthma.org/assets/documents/community-benefit/chna-sfhc-2020.pdf, or printed copies are available at Saint Francis Healthcare, 701 N. Clayton Street, Wilmington, DE 19805.

Hospital Information

For ninety-five years, Saint Francis Healthcare has served the Wilmington community and Northern New Castle County. Founded by the Sisters of Saint Francis of Philadelphia in 1924, Saint Francis Healthcare heeds a call to serve those in need. Our ministry is to serve all who require expert medical care regardless of religion, race, color, creed or economic status. A member of Trinity Health, Saint Francis Healthcare offers emergency care, cardiology, cancer care, family medicine and women's health among other services. In addition to providing health care in an acute setting, Saint Francis Healthcare also offers LIFE (Living Independently for Elders), a program of all-inclusive care for seniors, a Home Care program and a variety of affiliated physician practices. Saint Francis Healthcare sponsors many charity care programs. Our Saint Clare Medical Outreach Van provides medical care to people in the community who need it most. The Tiny Steps program assists women in need who may be expecting or planning a family, and children in the first year of life. The Center of Hope reaches out to persons who have health needs in the bilingual community. Our Cancer Outreach and Education series promotes cancer education and screenings. The Financial Assistance program helps people receive care regardless of their ability to pay. As a mission-driven innovative healthcare organization, we will become the leader in improving the health of our communities and each person we serve.
The Community We Serve

Saint Francis Healthcare primarily serves the City of Wilmington, with a population just over 70,000. Wilmington has some of the highest socio-economic needs zip codes in the State of Delaware — 19801, 19802 and 19805. Saint Francis Hospital is in 19805, just blocks from Census Tract 22, which includes one of Westside Wilmington’s highest poverty areas. Zip codes considered high need generally have poorer health outcomes than zip codes in more affluent neighborhoods.

60% of Children living in Census Tract 22 live below poverty

57% of Wilmington residents spend 30%+ of their income on rent

70% High School Graduation Rate (compared to 87% nationally)

41% Of residents age 65+ live alone in Wilmington

$25,407 The median Household Income in Census Tract 22

23.5 (per 100,000) Homicide Rate in Wilmington (compared to 5.5 nationally)
**Mission**

We, Saint Francis Healthcare, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

**Health Needs of the Community**

The CHNA completed on June 30, 2020, identified significant health needs within the Saint Francis Healthcare community. Those needs were then prioritized based on the urgency of the health problem and its impact the City of Wilmington. The significant health needs identified, in order of priority include:

1. **Behavioral Health (Substance Use Disorder & Mental Health Services)**
   - Delaware ranks 5th highest among drug overdose mortality rates in the nation.
   - Drug overdose fatalities increased 228% between 2011-2017 in New Castle County.
   - 4 out of 5 who died of a drug overdose in 2017 interacted with a Delaware health system the prior year.
   - Mental, behavioral, and neurodevelopmental disorders are often reasons those struggling with addiction are hospitalized.
Community survey responses (n=113) ranked substance use disorder and mental health as the #1 and #2 urgent health problem impacting Wilmington.

2. Trauma
   - Trauma from experiencing violence and poverty underlies many health issues.
   - Violent Crime for New Castle County is 551 per 100,000 compared to top performing counties who averaged 63 per 100,000.
   - The Homicide Rate in Wilmington is 23.5 per 100,000 compared to 5.5 per 100,000 nationally.
   - 50% of Wilmington residents live above 200% of the federal poverty level; only 23.7% of people in Census Tract 22 live above 200% poverty.

3. Access to Healthcare
   - Wilmington fares poorly overall on indicators directly or indirectly measuring access to care including chronic disease prevention and management, infant mortality, dental care, and readmissions for ambulatory care sensitive conditions.
   - Equitable access to reproductive services, dental, and vision services remains an on-going challenge in low-income, minority communities.
   - Availability of services, transportation, language, and cultural factors were mentioned during community engagement meetings as common barriers to accessing quality care.

4. Affordable Housing
   - The Home Owner Vacancy Rate in Census Tract 22 is 9.35 compared to 2.7% in Wilmington and 1.6% in New Castle County.
   - 70.4% of renters living in Census Tract 22 spend 30% or more of their income on rent compared to 56.8% of renters in Wilmington and 49% in New Castle County.

5. Lack of Education
   - The High School Graduation Rate for Wilmington is 70% compared to 87% nationally.
   - 39% of residents living in Census Tract 22 have no high school diploma.
   - 26.2% of Wilmington residents have a bachelor’s degree or higher; only 9.9% do in Census Tract 22.

6. Poverty
   - 50% of Wilmington residents live above 200% of the federal poverty level; only 23.7% of people in Census Tract 22 live above 200% poverty.
   - 3.2% of households in Wilmington receive public cash assistance income while 7.8% of households in Census Tract 22 receive public cash assistance income.
   - Income Inequality (GINI Index) in Wilmington and in Census Tract 22 is .53.
7. Violence/Crime
- Violent Crime for New Castle County is 551 per 100,000 compared to top performing counties who averaged 63 per 100,000.
- The Homicide Rate in Wilmington is 23.5 per 100,000 compared to 5.5 per 100,000 nationally.

8. Food Insecurity
- 36% of New Castle County and 25% of Wilmington food insecure children are ineligible for food assistance compared to 8.5% nationally.
- 13% of New Castle County, or close to 65,000 households are Food Insecure.
- Only 5% of New Castle County residents have access to healthy foods.

9. Chronic Diseases
- Chronic Diseases are the leading cause of death in Delaware with cardiovascular diseases ranking #1 followed by cancer, lung diseases, and diabetes.
- Health disparities exist for almost all chronic disease indicators. Blacks and Hispanics are impacted by chronic diseases at higher rates than non-Hispanics whites.

10. Infant Mortality
- Delaware has the 14th highest Infant Mortality Rate in the Country.
- While trending down, New Castle County's infant mortality rate is 8.1 deaths per 1,000 live births, well above the national benchmark. Within New Castle County, the highest concentration of infant deaths is in the City of Wilmington — 12.5 infant deaths per 1,000 live births.
- Black babies born in Delaware are nearly 3.5 times more likely to die than white babies.
- In Wilmington, for the measurement period 2012-2016, 12.1% of births were babies weighing less than 5 lbs., 8 oz., which is significantly higher than the 7.8% HP 2020 goal and the New Castle County average of 8.9%. Premature births (less than 37 weeks) in Wilmington are 18.9% compared to 14.6% for New Castle County. The HP 2020 benchmark is 9.4%.

Hospital Implementation Strategy

Resources and overall alignment with the Saint Francis Hospital mission, goals and strategic priorities were taken into consideration when hospital leadership identified and prioritized the significant health needs the hospital would address.

Significant health needs to be addressed

Saint Francis Healthcare will focus on developing and/or supporting initiatives and measure their effectiveness, to improve the following health needs:
• Chronic Disease Prevention and Management (pages 15, 29, 30, 33-35).
• Food Insecurity (pages 26, 31, 33, 34-35).

Significant health needs that will not be addressed

Saint Francis Healthcare acknowledges the wide range of priority health issues that emerged from the CHNA process and determined that it could effectively focus on only those health needs which it deemed most pressing, under-addressed, and within its ability to influence. Saint Francis Healthcare will not address the following health needs:

• Trauma/Adverse Childhood Experiences – Saint Francis Healthcare will not directly address this need due to lack of resources at this time to fully implement a Trauma Informed Care approach to medicine.
• Affordable Housing – Saint Francis Healthcare will not directly address this need to avoid duplicating efforts already underway through an existing partnership between Trinity Health and Cinnaire.
• Access to Healthcare – Saint Francis Healthcare will not directly address this need to avoid duplicating efforts already underway. Access to care will be indirectly addressed in Chronic Disease program and planning.
• Lack of Education – Saint Francis Healthcare will not directly address this need because the hospital lacks expertise or competencies to effectively address the need.
• Poverty – Saint Francis Healthcare will not directly address this need because of resource constraints.
• Violence/Crime – Saint Francis Healthcare will not directly address this need because of the system’s relative lack of expertise or competency to effectively address the need.
• Infant Mortality – Saint Francis Healthcare will not directly address this need to avoid duplication of efforts currently underway through the Saint Francis Tiny Steps Program. Additionally, other organizations and task forces are addressing the need.

This implementation strategy specifies community health needs that the hospital has determined to address in whole or in part and that are consistent with its mission. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During these three years, other organizations in the community may decide to address certain needs, indicating that the hospital then should refocus its limited resources to best serve the community.
CHNA IMPLEMENTATION STRATEGY
FISCAL YEARS 2020-2022

Hospital Facility: Saint Francis Healthcare

CHNA significant health need: Behavioral Health


Prioritization: #1

Brief description of need:
Delaware ranks 5th highest among drug overdose mortality rates in the nation. During 2017, 346 Delawareans died of a drug overdose. In New Castle County alone, drug overdose deaths from all substances increased 178% between 2011 and 2017 to 43.8 deaths per 100,000. Wilmington was not far behind the County. Its drug overdose mortality rate was 38.1. New Castle County and Wilmington mortality rates are staggeringly high when compared to the national drug related overdose death benchmark of 11.3 deaths per 100,00.

One of the most significant findings in a recent state drug overdose mortality report is that 81% (or 4 out of 5 persons) who died of a drug overdose in 2017 interacted with a Delaware health system in the year prior to their deaths. One in two drug overdose decedents visited a Delaware Emergency Department in the year prior to their death, though not necessarily due to their addiction. Around a quarter of drug overdose decedents had visited the ED for mental health related reasons. Other reasons for the ED visit included a previous overdose, or unmanaged pain diagnosis.

The same report reviewed hospitalization data which showed that approximately 12% of drug overdose decedents were hospitalized in the year prior to their deaths for mental, behavioral, or neurodevelopmental disorders.

Goal: Improve care delivery and coordination for patients who have substance use disorder and/or mental health issues.

Objective(s):
- Increase by 5% each year through year three the proportion of Saint Francis Hospital patients who screen positive for opioid addiction in the Emergency Room and who are initiated on Medication Assisted Treatment.
- Increase by 5% each year through year three the number of patients who receive a warm hand-off from the ED to addiction services.
- Improve access to behavioral health services for 10 St. Clare Medical Outreach Van patients per month by 2022.
# Actions the hospital facility intends to take to address Behavioral Health:

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Timeline</th>
<th>Committed Resources</th>
<th>Potential Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue partnership with Recovery Innovations, Inc. or another similar organization to embed peer coaches in the ED.</td>
<td>Y1 Y2 Y3</td>
<td>X X X</td>
<td>Peer Coaches (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Recovery Innovations, Inc. DE Division of Substance Abuse &amp; Mental Health Services</td>
</tr>
<tr>
<td>Implement the ED Bridge Program as a pilot project to support and ensure opioid addicted patients get the long-term care they need.</td>
<td>X X X</td>
<td>TBD.</td>
<td>Explore Grant Support</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Brandywine Counseling</td>
</tr>
<tr>
<td>Explore service expansion on the St. Clare Medical Outreach Van to include behavioral health assessments and on-site access to telepsychiatry visits.</td>
<td>X X X</td>
<td>TBD.</td>
<td>Explore Grant Support</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mid-Atlantic Behavioral Health Catholic Charities St. Paul’s Behavioral Health Services</td>
</tr>
</tbody>
</table>

## Anticipated impact of these actions:

<table>
<thead>
<tr>
<th>CHNA Impact Measures</th>
<th>CHNA Baseline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of ED patients who screen positive for opioid addiction and receive a warm handoff from Peer Coach to recovery services.</td>
<td>0%</td>
<td>15%</td>
</tr>
<tr>
<td>Number of patients screening positive for opioid addiction in the ED who are initiated on first dose MAT and referred to long term treatment.</td>
<td>0%</td>
<td>15%</td>
</tr>
<tr>
<td>Percent improvement in functional scores for St. Clare Van patients who receive behavioral health services on the Van.</td>
<td>0% (Behavioral Health Services are not currently offered on the St. Clare Van)</td>
<td>10%</td>
</tr>
</tbody>
</table>
Plan to evaluate the impact:
An interdisciplinary team of hospital staff will meet quarterly to review Behavioral Health measures for opioid addicted patients who present in the Emergency Room. The number of ED patients who were connected to a peer coach will be tracked through Cerner. The number of patients who screen positive for opioid addiction and who were initiated on Medication Assisted Treatment and referred to long term treatment will be noted in the patient chart. The MAT pilot project will be evaluated after year 1 with the goal of embedding the program in the hospital permanently.

St. Clare Medical Outreach providers will administer an evidenced based behavioral health assessment tool for patients needing behavioral health services twice during the initial year of service, i.e. pre and post counseling.
Hospital facility: Saint Francis Healthcare

CHNA significant health need: Chronic Disease Prevention and Management

CHNA reference pages: 15,29,30,33-35

Prioritization: #2

Brief description of need:
Poorly managed diabetes often signals a problem with accessing healthcare services. Delaware ranks 36th in the nation for diabetes. Eighteen percent (18%) of adults living in Census Tract 22 have diabetes compared to 14% in Wilmington and 10% in New Castle County. The CDC 500 Cities diabetes benchmark is 9.9% of adults. The prevalence of Delaware adults with diabetes has been slowly creeping upward from a low of 6.6% in 2008 to 10.1% in 2018.

Diabetes nationally and in Delaware disproportionately affects minority and older populations. Approximately 15% of non-Hispanic blacks were diagnosed with diabetes in 2018 compared to 11.8% of non-Hispanic white and 6.9% of Hispanics. With respect to age, 21.9% of individuals diagnosed with diabetes are aged 65 and older compared to 16% who are aged between 45-64.

Cost of devices and supplies, lack of or limited insurance, and lack of access to routine care are the most common barriers those with chronic diseases encounter.

Goal: Improve diabetes management among St. Clare Van patients by reducing or preventing diabetes related complications arising from access barriers.

Objective(s):
- Increase by 5% each year for 3 years the number of St. Clare Van patients enrolled in the Dispensary of Hope insulin program.
- Increase the number of eligible uninsured St. Clare Van patients who successfully enroll in Medicaid by 15 each year.
- Increase by 5 each year for 3 years the number of St. Clare Van patients who have the supplies and devices needed for successful diabetes management.
### Actions the hospital facility intends to take to address Access to Care:

<table>
<thead>
<tr>
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<th>Committed Resources</th>
<th>Potential Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screen and enroll eligible St. Clare Van Patients in Medicaid at first visit.</td>
<td>Y1 Y2 Y3</td>
<td>1 MA</td>
<td>State Service Centers</td>
</tr>
<tr>
<td>Expand pharmacy charity care programs to include insulin and other medications.</td>
<td>Y1 Y2 Y3</td>
<td>$7,500</td>
<td>Dispensary of Hope Americare</td>
</tr>
<tr>
<td>Provide glucometers, test strips, etc. to St. Clare Van patients who are unable to afford supplies or equipment.</td>
<td>X X X</td>
<td>TBD.</td>
<td>Grant Funding</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Division of Public Health YMCA DPP</td>
</tr>
</tbody>
</table>

### Anticipated impact of these actions:

<table>
<thead>
<tr>
<th>CHNA Impact Measures</th>
<th>CHNA Baseline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Eligible SCV patients enrolled in Medicaid Plan</td>
<td>58</td>
<td>103</td>
</tr>
<tr>
<td>Number of 30-day refills provided through Dispensary of Hope</td>
<td>639</td>
<td>800</td>
</tr>
<tr>
<td>Number of St. Clare Van patients whose A1C decreases by at least 1% six months after receiving needed supplies and equipment.</td>
<td>15 with A1C &gt; 8</td>
<td>10 with A1C&gt;8</td>
</tr>
</tbody>
</table>

### Plan to evaluate the impact:

The number of eligible St. Clare Van patients enrolled in Medicaid will be noted in the EMR and measured bi-annually. Outreach strategies for Medicaid enrollment will be adjusted based on enrollment demographics. The number of patients reached through expansion of pharmacy donation programs will be tracked quarterly through Dispensary of Hope’s and Americare’s reporting systems. We will measure each diabetic patient’s A1C every 6 months to determine if access to diabetes supplies (glucometer, test strips, lancets, etc.) improves disease management.
Hospital facility: Saint Francis Healthcare

CHNA significant health need: Food Insecurity

CHNA reference pages: 26,31,33, 34-35

Prioritization: #3

Brief description of need:
Data collected from the Delaware Health Tracker identified 12.9% of Delaware households as food insecure, which is higher than the national average 11.8%; and, 5.9% of households as very low food insecure, again higher than the national average 4.5%. Although there is no available food insecurity data specific to the City of Wilmington, in New Castle County 64,730 persons out of 555,036 or 11.7% are food insecure.

Paradoxically, food insecure adults had a significantly higher prevalence of obesity. Food insecurity has been associated with low food expenditure, low fruit and vegetable consumption, and a less-healthy diet. Overconsumption of low-cost, energy-dense foods may result in a greater energy intake and lead to obesity, which in turn, increases one’s risk for heart disease, diabetes, cancer, and other chronic diseases.

Barriers to accessing food, especially healthy food, include limited transportation and limited or no access to grocery stores. In New Castle County, 16.4% of residents have transportation issues and 22.7% of residents have low access to a grocery store.

Goal: Increase consumption of healthy foods among patients with high risk factors for food insecurity and diet-related health conditions.

Objective(s):
- Increase enrollment in the Food Prescription Program by 10 each year for 3 years.
- Decrease by 10% the BMI of each Food Prescription Program participant between the first and last program visit.
- Increase by 2 the number of inner-city neighborhood grocery stores who offer produce and healthy foods.
### Actions the hospital facility intends to take to address Food Insecurity:

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Timeline</th>
<th>Committed Resources</th>
<th>Potential Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue Contract with Food Bank of DE to connect patients to food.</td>
<td>Y1: X</td>
<td>Hospital: Contract</td>
<td>Food Bank of DE</td>
</tr>
<tr>
<td></td>
<td>Y2: X</td>
<td>Other Sources:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Y3: X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explore contract with a CSA to provide fruits and vegetables to patients and community members who fail food insecurity screening.</td>
<td>Y1: X</td>
<td>Hospital: Contract</td>
<td>Latin American Community Center Catholic Charities Ministry of Caring</td>
</tr>
<tr>
<td></td>
<td>Y2: X</td>
<td>Other Sources:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Y3: X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expand Food Rx Program to include additional family practice clinics</td>
<td>Y1: X</td>
<td>Hospital: TBD.</td>
<td>Saint Francis Family Practice</td>
</tr>
<tr>
<td></td>
<td>Y2: X</td>
<td>Other Sources:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Y3: X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocate for a Healthy Corner Store Policy to provide incentives to inner city stores that carry a certain % of produce and healthy foods.</td>
<td></td>
<td>Hospital: TBD.</td>
<td>Cornerstone West Westside Health (FQHC) Community Garden Consortium American Heart Association</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Sources:</td>
<td></td>
</tr>
</tbody>
</table>

### Anticipated impact of these actions:

<table>
<thead>
<tr>
<th>CHNA Impact Measures</th>
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<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clinic patients who screen positive for food insecurity and are connected to healthy food options</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Number of Saint Francis Healthcare clinics implementing Food Rx Program</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Number of corner grocery stores in Census Tract 22 offering produce/healthy foods</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Plan to evaluate the impact:
Patients identified as food insecure will be documented and tracked through an ICD-10 code in the outpatient EMR. Patients who screen food insecure at the beginning of the program will be evaluated at the 6-month period to determine if there is a change in food security status and in BMI. Additional metrics to be collected and reviewed monthly include number of participants enrolled in the program, patient demographics, and the number of vouchers written compared to the number of food vouchers used. Evaluations will also pin point participants who live in high risk zip codes/census tracts.

Adoption of Implementation Strategy

On October 19th, 2020, the Hospital Community Board of Directors for Saint Francis Healthcare, met to discuss the 2020-2022 Implementation Strategy for addressing the community health needs identified in the 2020 Community Health Needs Assessment. Upon review, the Board approved this Implementation Strategy and the related budget.

Brandon Harvath
10 / 28 / 2020
Name & Title
Date