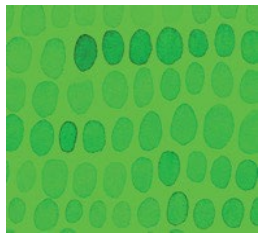
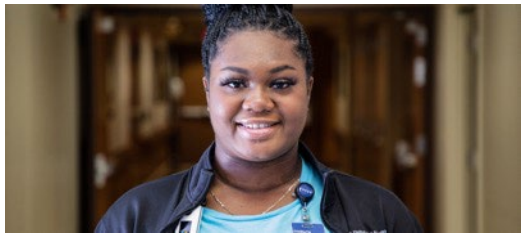


2025

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP)

UnityPoint Health – Trinity 2025-2027 Implementation Strategy in response to the 2024 Community Health Needs Assessment

UnityPoint Health

Introduction/Executive Summary

This document describes the work that is planned and will be executed in 2025 through 2027 to serve and address the needs of residents identified in Scott County & Muscatine County, Iowa and Rock Island County, Illinois 2024 Community Health Needs Assessment. UnityPoint Health, Trinity – Quad Cities Hospitals serve the Bi-State area, which includes eastern Iowa, and northwest Illinois.

UnityPoint Health – Trinity Hospitals have provided exceptional healthcare services to the Bi-State area since inception in 1893. A primary function of serving as a community hospital is the participation in the process of assessing the health needs of the entire community and then using that assessment to drive strategic planning. The foundation of the UnityPoint Health – Trinity Strategic Plan is the premise that through collaboration with regional agencies, organizations, and healthcare providers, will contribute to community partnerships to meet targeted community needs and to formulate improvement plans to enhance healthcare in the community.

A Community Health Needs Assessment and Community Health Improvement Plan (CHNA & CHIP) is required of local hospitals to obtain reimbursement under Medicare and Community Health Centers. The hospitals performed the CHNA in adherence with federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service.

The 2024 Community Health Assessment has been completed in collaboration with the Scott and Rock Island County Health Departments, Community Health Care, Inc., MercyOne Genesis, the Quad City Health Initiative, Trinity Muscatine Public Health, and UnityPoint Health - Trinity. Data on health behaviors, outcomes, community resources, and areas for improvement were collected through telephone surveys, secondary data, and focus groups.

The purpose of the health needs assessment is to learn about the community: the health of the population, factors that lead to higher health risks or poorer health outcomes of certain groups, and community resources available to improve the health of the community. The purpose of the health improvement plan is to describe how the community will work together to improve the health of the population. The community health improvement plan sets priorities, directs the use of resources, and is a roadmap for the development and implementation of projects, programs, and policies.

Our shared goal is to improve health status and quality of life in the Quad Cities through this collaborative effort. While the community shares a common health needs assessment, each collaborator is responsible for developing their own unique implementation strategy. This implementation strategy is UnityPoint Health, Trinity in the Quad Cities Metropolitan Area of Illinois and Iowa.

About UnityPoint Health – Trinity Hospitals

Our Mission, Our Vision, Our Values

At Trinity Hospitals, our top priority is you — it's putting you in the center of everything we do. We understand who you turn to for health care is a choice. That's why we want to thank you for choosing Trinity Hospital. Through our shared mission, vision and values, we show our people and communities of the Tri-State Area how much they matter.

Our Mission

As health care evolves, our core purpose stays the same. Improving the health of the people and communities we serve is our mission today – and always.

Our Vision

Our vision, “best outcome, every patient, every time,” is our approach to providing exceptional care for each person who walks through our doors – no matter if they live in one of our small communities or large metro locations.

Our FOCUS Values

Foster Unity.

Own the Moment.

Champion Excellence.

Seize Opportunities.

The “U” stands for UnityPoint Health, a reminder that regardless of what town, hospital, clinic or department someone is at, our team is united — through and through. Our values are more than just words on a wall. You can see and feel them every single day by how our team members show up for each other and the patients we care for.

Community Health Needs Assessment (CHNA) Priorities

Following the aggregation of all data sources, the CHNA revealed fifteen emergent needs. These needs were subsequently determined to be of the highest importance by the Quad Cities Metropolitan Community of Iowa and Illinois.

1. Mental Health
2. Access to Health Care
3. Nutrition, Physical Activity and Weight
4. Diabetes
5. Heart Disease & Stroke
6. Housing
7. Infant Health and Family Planning
8. Cancer
9. Substance Abuse
10. Oral Health
11. Injury & Violence
12. Disabling Conditions
13. Sexual Health
14. Respiratory Disease
15. Tobacco Use

Source: 2024 Community Health Needs Assessment (Scott County & Muscatine County, Iowa and Rock Island County, Illinois). Prepared by PRC. Sponsors and data available at quadcities.healthforecast.net.

Community Health Improvement Plan (CHIP) Priorities

The fifteen identified community health needs were voted on by community stakeholders and consolidated by the CHNA Steering Committeee into three priorities. These priorities were identified to allow us to sharpen our focus, show a common vision and strategic alignment among the partners

We ensured that objectives already being addressed by existing Trinity strategies were aligned with and incorporated into new strategies ensuring a coordinated approach.

This produced the following list of priorities:

1. Behavioral Health (Mental Health & Substance Abuse)
2. Access to Health Care Services
3. Nutrition, Physical Activity and Weight

UnityPoint Health, Trinity - Quad Cities Hospitals will continue to support community health needs and champion work in areas not included in the top three priorities.

Community Health Improvement Plan (CHIP) Background

The Patient Protection and Affordable Care Act, signed into law in March 2010, requires that nonprofit hospitals conduct a Community Health Needs Assessment at least once every three years beginning in March 2012. Departments of Public Health require local public health agencies to conduct a CHNA at least every five years.

These requirements present the opportunity for local community health leaders to join forces and identify priorities that can serve as a guide for programs, policies, and investments. Working together often creates efficiencies, new partnerships, and increased collaboration. Ultimately, community members benefit when data, resources and expertise are shared to attain the common goal of a healthier community. This CHNA was conducted in full partnership with the local health departments, hospitals, and many other community health organizations.

Conducting this comprehensive CHNA involved surveying community members and leaders as well as gathering relevant health data. The choice of our priorities reflects the idea that a high quality medical/clinic system is essential to treat people who are sick, and critical to help restore people's health; but it is not where health is created. Health is created in people's homes, workplaces, neighborhoods, and communities where people make healthy or unhealthy choices and establish healthy or unhealthy habits. The framework for those choices is the social, economic, and built environments we create. These are the Social Drivers of Health (SDoH).

The ACA also requires nonprofit hospitals to complete an **implementation strategy** in response to each CHNA. A hospital's implementation strategy must be a written plan that, for each significant health need identified, describes how the hospital facility plans to address the health need. In describing how a hospital plans to address a significant health need identified through the CHNA, the implementation strategy must:

- Describe the actions the hospital facility intends to take to address the health need and the anticipated impact of these actions.
- Identify the resources the hospital plans to commit to address the health need.
- Describe any planned collaboration between the hospital and other facilities or organizations in addressing the health need.
- Be adopted by an authorized body of the hospital facility.

Implementation Strategy

To facilitate the implementation strategy, the attached work plan will be used as a guide to identify the initiatives, actions, anticipated impact, partners, and resources for each priority. These templates will serve as a working document as we carry out this plan over the next three years. The initial development of these templates started with identifying existing tactics that UPH – Trinity has in place to address each priority. Capitalizing on existing work provided a solid point to start as we continue the work and strategic alignment with our community CHIP steering committee partners.

The team responsible for advancing this work is the:

Community Health Implementation Plan (CHIP) Steering Committee, which consists of hospital and system services leaders from administration, UnityPoint Clinic, Robert Young Center, Trinity Muscatine Public Health, various service lines, outreach, and communications.

The CHIP Steering Committee will convene quarterly to:

- Identify new tactics that may have been implemented that align with the work.
- Identify progress and measures that align with the identified initiatives.
- Consider changes or additions that may need to be made within the initiatives. Consider opportunities for identifying new partners and resources.

Coordination and follow-up will be the responsibility of the CHIP Steering Committee. The implementation of many of these tactics will require its own strategic plan. In many cases various partners will be needed to move the work forward including foundations, healthcare systems, public health, and government agencies. It will also at times require closer local and regional UnityPoint Health partners. Some of the tactics identified will require collaboration with UnityPoint Health System Services and UnityPoint Clinic to be successful.

To carry out some of these tactics will require a dynamic approach as some of them respond to issues that can be fluid within the changing environment of healthcare and communities. Some of the tactics are also bold and large in scale. This will require leveraging significant resources and partners.

UPH Trinity CHIP Project Team

Steering Committee Members

1. **Shawn Morrow** – UnityPoint Health Quad Cities President, Executive Sponsor
2. **Daniel Joiner –** Chief Diversity and Community Impact Officer, UnityPoint Health – System Services
3. **Matt Behrens** – Regional Vice President, UnityPoint Clinic
4. **Kate O'Brien-Ham** - Director Clinic Operations, UnityPoint Clinic
5. **Amy Terrill** – Director Clinic Operations, UnityPoint Clinic
6. **Noel Bush** – Director Clinic Operations, UnityPoint Clinic
7. **Jen Craft** – Director Public Health, UnityPoint Health – Muscatine
8. **Mary Petersen** – Chief Operating Officer/Director Behavior Health Services, Robert Young Center
9. **Joe Lilly** – Director Outpatient Services, Robert Young Center
10. **Ibrahim Tarawneh** – Director Behavioral Health Community Services, Robert Young Center
11. **Kathy Pulley** – Director Cardiology and Imaging Services, UnityPoint Health – Trinity
12. **Linda Guebert** – Manager Parish Nurse Program, UnityPoint Health – Trinity
13. **Sherri DeVrieze** – Military Program Coordinator, UnityPoint Health – Trinity
14. **Tammy Pauwels** – Community Health Program Coordinator, UnityPoint Health – Trinity
15. **Courtney Greene** – Dir. External Partnerships & Community Engagement, UnityPoint Health – System Services

2025-2027 Initiatives to Address Community Health Needs

	INITIATIVE	PRIORITY SUPPORTED		
		Behavioral Health	Access to Health Care	Nutrition/ Physical Activity/Weight
1	Create and leverage provider training opportunities to improve knowledge, services and understand veteran needs. Develop initiatives to assist community organizations and service providers in helping Veterans.	X		
2	Improve ease and timely access to behavioral health services.	X		
3	Expand evidence-based practices to screen, assess, and treat chronic depression.	X		
4	Implement early detection and interventions to address alcohol related deaths.	X		
5	Enhance Crisis Services.	X		
6	Reduce unnecessary Emergency Department Visits.		X	
7	Increase access to preventative care for uninsured and underinsured individuals.		X	
8	Increase preventative screenings for adults and children.		X	
9	Expand age range for breast cancer screening and expand focus on HPV vaccinations.		X	
10	Increase support for patients with diabetes, aiming to decrease the number of patients with diabetes and uncontrolled diabetes.		X	
11	Remove barriers for Veterans and Military community members to access health care by engaging with community partners to connect with Veterans directly.		X	
12	Educate children and parents on healthy weight for children as well as provide education on healthy lifestyles.			X

2025-2027 Initiatives to Address Community Health Needs

	INITIATIVE	PRIORITY SUPPORTED			
		Behavioral Health	Access to Health Care	Nutrition/ Physical Activity/Weight	
13	Increase enrollment in Pritikin program offering community members education regarding lasting lifestyle changes to manage their heart and health with a focus on prevention.			X	
14	Offer community education presentations about behaviors that lead to a healthy lifestyle, including healthy eating, physical movement and mental health.			X	
15	Increase community member referrals to medical care who have been screened and found to be at high risk for controllable risk factors related to high blood pressure, overweight/obesity, nutrition and exercise.			X	
16	Identify community members at physical and/or mental health risk and facilitate health care referrals.			X	
17	Increase community member education on overall healthy lifestyle, exercise, balance & fall, and nutrition.			X	
18	Increase Obesity, Physical Activity, Nutrition, education and awareness for military and civilian personnel employed at the RI Arsenal.			X	

CHIP Overview Focus Areas

Initiatives:

Priority 1: Behavioral Health Page 12-14
Priority 2: Access to Health Care Services Page 15-18
Priority 3: Nutrition, Physical Activity, Weight Page 19-22

Priority 1: Behavioral Health

Initiative	Focused Tactics	Anticipated Impact	Measurement	Existing/Planned collaborations	Resources
• Create and leverage provider training opportunities to improve knowledge, services and understand veteran needs. Develop initiatives to assist community organizations and service providers in helping Veterans.	• Provide Military Culture Training for healthcare and mental health providers. • Suicide prevention training for healthcare and mental health providers – Counseling on Access to Lethal Means (CALM).	• Improved diagnosis, treatment, awareness and understanding regarding the unique behavioral health challenges faced by veterans and military personnel resulting in better outcomes.	• Track number of participants in CALM sessions. Pre and post test results. Training Feedback (x% will implement training) • RYC military culture training- ○ 2025: a minimum of 75% of staff undergo trainings focusing on military culture. ○ 2026: Increase in staff understanding of military culture and the behavioral health challenges for veterans and military personnel, which would enhance the experience for veterans and military personnel receiving behavioral health services at Robert Young Center leading to better outcomes.	• Women Veterans of the Quad Cities. • Transformation Tuesday series – collaboration of UnityPoint Health and Rock Island Arsenal. UPC/UPH collaboration. U.S. Dept. of Veteran Affairs.	• Outreach, education and promotional materials and women Veterans. • RYC financial and staff support.

Priority 1: Behavioral Health

Initiative	Focused Tactics	Anticipated Impact	Measurement	Existing/Planned collaborations	Resources
• Improve ease and timely access to behavioral health services.	• Expand access to care in both Iowa and Illinois through implementation of Certified Community Behavioral Health Clinic (CCBHC) required services. • Deliver community education on mental health through Mental Health First Aid trainings.	• Improve overall behavioral health outcomes. • Ensure appropriate timely access to behavioral health services. • Reduce stigma associated with seeking behavioral health services.	• Mental Health First Aid training. MHFA trained staff would recognize signs and symptoms of various mental health conditions leading to early detection and intervention, improve communication skills, enhance response for clients in crisis, and reduce stigma, leading to more positive client experience and outcomes. ○ 2025: Provide MHFA training to at least 75 staff members. ○ 2026: Enhancing awareness and understanding of mental health conditions for MHFA trained staff.	• Iowa HHS • Illinois HFS • SAMHSA (Substance Abuse and Mental Services Administration), and various community collaborations.	• Financial and Staff support. • SAMHSA grant funding (Substance Abuse and Mental Health Services Administration).
• Expand evidence-based practices to screen, assess, and treat chronic depression.	• Screen all patients for Social Drivers of Health (SDOH). • Screen all patients 12 years and older seeking behavioral health services for depression using a PHQ-9. • Reassess for depression remission in six-month intervals.	• Early detection and intervention. • Achieve clinically significant reductions in depression symptoms for community members seeking treatment.	• Chronic Depression - conducting SDOHs helps RYC achieve clinically significant reductions in depression symptoms for community members seeking treatment. ○ 2025 - Conduct 9000 PHQ-9s. Conduct SDOH for 750 clients. ○ 2026: Conducting and monitoring the PHQ-9s and SDOHs	• Iowa HHS • Illinois HFS • UnityPoint Health-Trinity Hospital	• Screening tools: Social Drivers of Health (SDOH) and Patient Health Questionnaire-9 (PHQ-9).

Priority 1: Behavioral Health

Initiative	Focused Tactics	Anticipated Impact	Measurement	Existing/Planned collaborations	Resources
• Implement early detection and interventions to address alcohol related deaths.	• Integrate mental health and substance use treatment. • Complete Alcohol Use Disorders Identification Test (AUDIT) screenings. • Deliver interventions based upon risk stratification.	• Improve the health outcomes of those diagnosed with an alcohol use disorder.	• Early detection and early intervention would Improve health outcomes for those diagnosed with an alcohol use disorder. ○ 2025: Conduct 750 AUDITs. ○ 2026: TBD	• Iowa HHS • Illinois HFS • Center for Alcohol and Drug Services (CADS).	• Financial and staff support. • Screening tools: Alcohol Use Disorders Identification Test (AUDIT).
• Enhance Crisis Services.	• Increase access to community-based crisis services such as Mobile Crisis Response. Assess all patients in crisis using the Columbia Suicide Severity Rating Scale (C-SSRS). • Complete safety planning with all consumers dealing with a behavioral health crisis. • Plan for behavioral health urgent care centers with observation units.	• Improve access to care for those in crisis. • Reduce suicide rates and improve mental health outcomes. • Reduce emergency department visits.	○ 2025: Conduct 300 mobile crisis responses. ○ 2025: Provide 3500 Crisis evaluations and safety plans. ○ 2026: Provide adequate timely responses to crises and conducting crisis evaluations with safety plans. Enhance crisis services which will improve access to care for those in crisis, reduce emergency department visits, reduce suicide rates, and improve mental health outcomes.	• Iowa HHS • Illinois HFS • SAMHSA, • Foundation 2 • CESSA Workgroups.	• Financial and Staff Support. • Screening tools: Columbia-Suicide Severity Rating Scale (C-SSRS).

Priority 2: Access to Health Care

Initiative	Focused Tactics	Anticipated Impact	Measurement	Existing/Planned collaborations
• Reduce unnecessary Emergency Department Visits.	• Educate on “Where to Go Matters” for UPC patients with two or more visits in 12-month period. • Add “WTGM” document to new patient packets. Clinic leaders will review PAED visits monthly, focusing on patients with 5 or more PAEDs in a 12-month timeframe.	• Increase care in appropriate care settings. Decrease wait times in ED.	• Will use NYU algorithm to determine visits that are unnecessary or potentially avoidable. ○ Baseline: in 2024, patients with UPC PCPs had 9,704 potentially avoidable ED visits. ➢ 2025 goal: decrease by 500 potentially avoidable ED visits (5%).	• Internal collaborations with care management team and patient access coordinator.
• Increase access to preventative care for uninsured and underinsured individuals.	• Create specific work queue for patients without PCPs that visit specified UPC locations. • Patient Access Coordinator will follow up to schedule them with PCP if patient desires • Partner with CHC for timelier establish care visits that UPC can provide.	• More patients will receive comprehensive care. Increase in care for CHC and UPC.	• Will track number of patients in the work queue and how many we were able to establish with a PCP. • Will also track number of patients we encouraged to establish with CHC.	• CHC and UPC Patient Access Coordinator.

Priority 2: Access to Health Care

Initiative	Focused Tactics	Anticipated Impact	Measurement	Existing/Planned collaborations
• Increase preventative screenings for adults and children.	• Create a position to focus on patients assigned to UPC providers from payors that may not be current on critical preventative exams and timely well child visits.	• Increased cervical and colorectal screenings. Increase well child visits.	• Will measure new patients to primary care clinics. • We will also evaluate our adherence to preventative screenings. ○ 2024 baseline: ▪ Breast 16,343 patients with mammograms (86.2% of patients eligible, ages 50-75). ▪ Cervical: 30,447 (84.2% of patients eligible). ➢ Goal to increase # of patients to 31,000. ▪ Colorectal: 31,808 (77.8% of patients eligible) ➢ Goal to increase # of patients to 32,808. ▪ Well child visits: 11,770 (83.5% of patients eligible ages 3-18). ➢ Goal to increase to 12,000 (85%).	• UPC and UPH

Priority 2: Access to Health Care

Initiative	Focused Tactics	Anticipated Impact	Measurement	Existing/Planned collaborations
• Expand age range for breast cancer screening and expand focus on HPV Vaccinations.	• In 2025, primary care and OBGYN providers metric for breast cancer will now focus on women starting at age 40, versus 50. • In 2025, HPV vaccinations for children aged 9-13 will be a focus on the family medicine and pediatric clinics. Formerly it was a focus for just the pediatric clinics.	• Increase in mammograms and earlier detection of breast cancer. • Increase in vaccinations for HPV and future decrease of HPV-caused cancers.	• Will measure against 2024 baselines: ○ Mammograms: 84.3% patients ages 50-75 had a recent mammogram. ➢ We will expand that age range to 40-75 and aim to improve adherence, despite broadening the age range.	• UPC providers and teams
• Increase support for patients with diabetes, aiming to decrease the number of patients with diabetes and uncontrolled diabetes.	• Add nurse practitioner to the endocrinology clinic to expand access. • Endocrinologist to start e-consults for PCPs to provide guidance diabetes care. • Primary care to focus on controlled diabetes (A1Cs under 8%) and timely diabetic eye exams.	• More patients with controlled diabetes. • More patients with specialized care within the endocrinology clinic.	• Will monitor access to care timeline for endocrinology. Will track patients with diabetes and the percentage that have an A1C under 8% (must have an A1C in calendar year) and will track the number of patients with current diabetes eye exams. ○ Baseline for A1Cs under 8% is 76.4% (7,951 of 10,405) ➢ Goal to increase to 80%. ○ Eye exams baseline is 60.8% (6,641 of 10,930) ➢ Goal to increase to 65%	• UPC providers and teams

Priority 2: Access to Health Care

Initiative	Focused Tactics	Anticipated Impact	Measurement	Existing/Planned collaborations	Resources
• Remove barriers for Veterans and Military community members to access health care by engaging with community partners to connect with Veterans directly.	• Quad Cities Veterans Experience Action Center (VEAC) - Grassroots approach to provide Veterans the means to resolve pending or new concerns by providing a one-stop shop to access in-person VA and community resources.	• Increase in health care provided to Quad Cities community veterans and military.	• Increase Veterans served year over year at VEAC. ○ 2023 participants – 482. ○ 2023 filed claim – 179. ○ 2023 visit VHA enrollment – 237.	• Veterans Engagement Board. • U.S. Dept. of Veteran Affairs. • Community partners and volunteers. • UPC departments (Community Engagement, RYC, Hospice, PACE, Volunteer Service).	• Sponsorship and volunteer support. • Community partners. • Educational and promotions materials. • Veterans Health Administration. • Veterans Benefits Administration.

Priority 3: Nutrition, Physical Activity & Weight

Initiative	Focused Tactics	Anticipated Impact	Measurement	Existing/Planned collaborations	Resources
• Educate children and parents on healthy weight for children as well as provide education on healthy lifestyles.	• Patients under 18 years that have any type of well visit with a UPC family medicine or pediatrician will receive healthy lifestyle information (automatically added to their after-visit summary). • Increase the number of patients with a recorded BMI to increase educational information dissemination.	• More education for families and decrease in BMIs in children.	• Increase the number of patients that are seen for well child visits to increase the number of families that receive healthy lifestyle education. ○ In 2024,11,770 patients ages 3-18 received a well visit (83.5%). ➢ The goal is to increase the patient base and the percentage of patients receiving well child visits.	• UPC Providers and teams	• Education and Educational materials.
• Increase enrollment in UPH Trinity Pritikin program offering community members education regarding lasting lifestyle changes to manage their heart and health with a focus on prevention.	• Through UPH Trinity Pritikin program offer a comprehensive lifestyle modification program focused on cardiac rehabilitation, significant dietary changes, medically supervised exercise and education on health behavior patterns to make lasting lifestyle changes.	• Program implemented to promote healthy eating, physical movement, and mental health which should continue to decrease chronic conditions and improve health outcomes.	• Increase the enrollment in the Pritikin program year over year. ○ 2024 – 282 participants	• Promote on UPH website. • Collaboration with providers and media to increase community program referrals, highlight success stories and program value.	• Outreach, education and promotional materials. • UPH website.

Priority 3: Nutrition, Physical Activity & Weight

Initiative	Focused Tactics	Anticipated Impact	Measurement	Existing/Planned collaborations	Resources
• Offer community education presentations about behaviors that lead to a healthy lifestyle, including healthy eating, physical movement and mental health.	• Connect with community members via Heart-to-Heart program to provide healthy lifestyle education.	• Program implemented to promote healthy eating, physical movement, and mental health which should continue to decrease chronic conditions and improve health outcomes.	• Increase attendance at Heart-to-Heart events and growth in readership for digital online heart health monthly newsletter year over year. ○ 2025 – 2,531	• Promote on UPH website. • Collaboration with providers to increase community program awareness.	• Outreach, education and promotional materials. • UPH website.
• Increase community member referrals to medical care who have been screened and found to be at high risk for controllable risk factors related to high blood pressure, overweight/obesity, nutrition and exercise.	• Provide community blood pressure screenings and education around healthy lifestyle choices through Heart-to-Heart program to identify community members at risk and refer to medical care.	• Program implemented to screen for risk factors and refer community members for medical care, which should continue to decrease chronic conditions and improve health outcomes.	• Provide blood pressures at community events and track by blood pressure category. Each blood pressure category has a protocol for referral.	• Promote on UPH website. • Collaboration with providers to increase community program awareness.	• Outreach, education and promotional materials. • UPH website.

Priority 3: Nutrition, Physical Activity & Weight

Initiative	Focused Tactics	Anticipated Impact	Measurement	Existing/Planned collaborations	Resources
• Identify community members at physical and/or mental health risk and facilitate health care referrals.	• Through the Parish Nurse Outreach Program, identify community members who are at risk and connect members to health care services by facilitating health care referrals.	• Program implemented to promote healthy lifestyle and connect community members to services which should continue to decrease chronic conditions and improve health outcomes.	• Increase number of health care provider referrals to all types of locations (MD/ARNP, New MD/ARNP, Walk-in-clinic, Home Care) year over year. ○ Baseline 2024 - 500	• Promoted to community members through Parish Nurse outreach program.	• Outreach, education and promotional materials. • Parish nurse monthly tracking form.
• Increase community member education on overall healthy lifestyle, exercise, balance & fall, and nutrition.	• Connect with community members via Parish Nurse Outreach Program to provide healthy lifestyle education.	• Program implemented to educate and promote healthy lifestyle which should continue to decrease chronic conditions and improve health outcomes.	• Increase number of educational programs provided year over year. ○ Baseline 2024 - 150	• Promoted to community members through Parish Nurse outreach program.	• Outreach, education and promotional materials. • Parish nurse monthly tracking form.

Priority 3: Nutrition, Physical Activity & Weight

Initiative	Focused Tactics	Anticipated Impact	Measurement	Existing/Planned collaborations	Resources
• Increase Obesity, Physical Activity, Nutrition, education and awareness for military and civilian personnel employed at the RI Arsenal.	• Transformation Tuesday series at the RI Arsenal presentations by UnityPoint Health experts on heart health, nutrition, diabetes, and other health-related topics.	• Program implemented to increase knowledge, awareness, and benefits of a healthy lifestyle which should continue to decrease chronic conditions and improve health outcomes.	• Number of participants. • Post survey feedback.	• Promoted to RI Arsenal military and civilian personnel through outreach - Rock Island Arsenal Ready & Resilient Division - Army Sustainment Command. • UPH experts provide presentations.	• Outreach, education and promotional materials.

Communication Plan

Review final CHIP Plan – Trinity CHIP Steering Committee

- January 20, 2025

Approval by UPH – Trinity Medical Center Board of Directors

- February 18, 2025

Email final CHIP to cha-chip@hhs.gov

Other tactics:

- Draft press release for distribution to local media (optional)
- Post final CHIP to the UnityPoint.org website
- Inclusion in The Bridge Newsletter and the Diversity and Community Impact Newsletter

Glossary of Focused Tactics Addressing CHIP Priorities and Initiatives

UnityPoint Health

Descriptions (Page 1 of 2)

AUDIT: The Alcohol Use Disorders Identification Test (AUDIT) is a simple and effective method of screening for unhealthy alcohol use, defined as risky or hazardous consumption. Or any alcohol use disorder.

CADS: Center for Alcohol and Drug Services (CADS). CADS offers a variety of substance abuse services focused on support, care and treatment designed to meet the needs of families and individuals of all age groups in the community.

CALM: Counseling on Access to Lethal Means (CALM) is a powerful addition to existing strategies to reduce the risk of suicide death in at-risk people while respecting their rights and autonomy.

CCBHC: Certified Community Behavioral Health Clinic (CCBHC) is a specially – designated clinic that provides comprehensive range of mental health and substance use service. CCBHCs serve anyone who walks through the door, regardless of their diagnosis and insurance status.

CESSA Workgroups: Community Emergency Services and Supports Act. It's an Illinois law that requires emergency response operators to direct calls seeking mental health support to a new service. This service can then dispatch a team of mental health professionals instead of police.

CHC: Community Health Care Center. A non-profit health care organization that provides primary and preventative medical care to underserved communities.

C-SSRS: The Columbia-Suicide Severity Rating Scale (C-SSRS) is a unique suicide risk assessment tool that supports suicide risk assessment through a series of simple, plain language questions that anyone can ask.

Foundation 2 Mobile Crisis/Crisis Services: Free, 24/7 crisis support for anyone experiencing a mental health or suicide related situation or concern. Phone, text, chat and in-person services are available.

Heart to Heart: Free community education series hosted by UPH Trinity and led by experts from Trinity Heart Center to educate the community on heart health related topics and help them live a more heart-healthy life.

IL HFS: The Illinois Department of Healthcare and Family Services (HFS) is responsible for providing healthcare coverage for adults and children who qualify for Medicaid and providing Child Support Services to help ensure that Illinois children receive financial support from both parents. .

Iowa HHS: The Iowa Department of Health and Human Services provides high quality programs and services that protect and improve the health and resiliency of individuals, families, and communities in Iowa.

Mental Health First Aid: Mental Health First Aid is a course that teaches you how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives you the skills you need to reach out and provide initial help and support to someone who maybe developing a mental health or substance use problem or experiencing a crisis.

Glossary of Focused Tactics Addressing CHIP Priorities and Initiatives

UnityPoint Health

Descriptions (Page 2 of 2)

NYU Algorithm: The NYU Center for Health and Public Service Research has developed an algorithm to help classify ED utilization.

PACE: Program of All-Inclusive Care for the Elderly.

PAED: Potentially Avoidable Emergency Department Visits.

Parish Nurse Program: The Parish Nurse Program is a partnership between UnityPoint Health, Trinity and churches in the Quad Cities and surrounding region. The program takes a holistic approach to health care by promoting wellness in body, mind and spirit.

PHQ-9: Patient Health Questionnaire-9. It is a self-report questionnaire used to screen for and assess the severity of depression.

Pritikin Program: The program is an advanced cardiac nutritional and exercise program, where attendees are introduced to a new type of lifestyle around healthy eating, exercise and a healthy mindset.

SAMHSA: Substance Abuse and Mental Health Services Administration. It is an agency within the U.S. Department of Health and Human Services that leads public health efforts to improve the behavioral health of the nation.

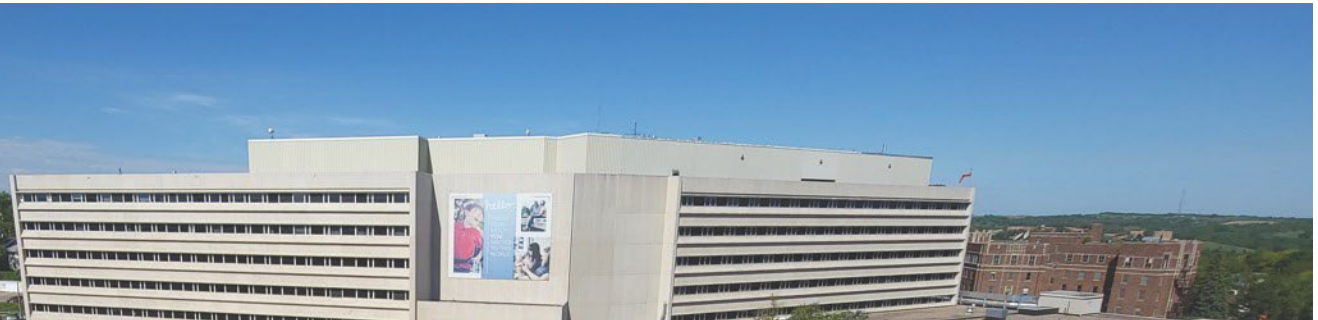
SDOH: Social Determinants of Health. These are the non-medical factors that influence a person's health and wealth.

VEAC: Veterans Experience Action Center is a program run by the Department of Veterans Affairs (VA) that offers services to veterans.


Heart
CENTER


MAIN ENTRANCE


Main Entrance

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