Community Health Needs Assessment Implementation Strategy

January 2017 to December 2019

Inspired by the healing ministry of Jesus Christ, we, Presence Health, a Catholic health system, provide compassionate, holistic care with a spirit of healing and hope in the communities we serve.

This Implementation Strategy was produced by the Mission and External Affairs Department of Presence Health, which is sponsored by Presence Health Ministries.

Presence Resurrection Medical Center

Community Health Needs Assessment Implementation Strategy
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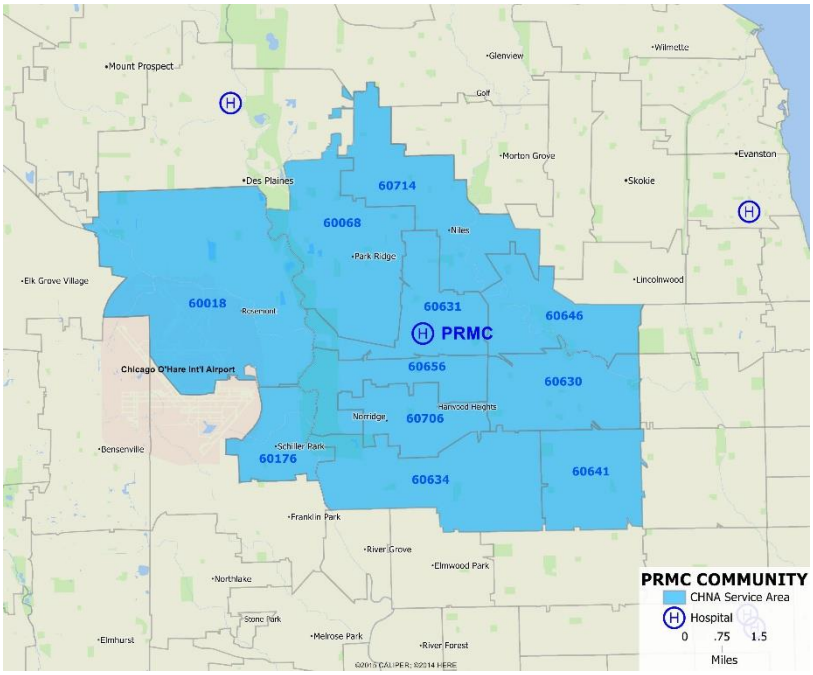
Founded by the Sisters of the Resurrection in 1953 to serve the poor and sick, Presence Resurrection Medical Center offers the full continuum of care - from a Level II Emergency Department and The Family Birthplace to treatment for cancer and heart disease. Our medical staff of over 500 doctors, including primary care physicians and specialists in 55 areas of expertise, has a proven track record of excellence. Many are leaders in their fields, conducting clinical research and teaching the next generation of care providers.

This Implementation Strategy follows on the 2016 Community Health Needs Assessment (CHNA) conducted by Presence Resurrection Medical Center and 25 other hospitals through the Health Impact Collaborative of Cook County. In this document, we summarize the plans of Presence Resurrection Medical Center to develop and sustain community benefit programs that address prioritized needs from the CHNA, along with the metrics used to evaluate these programs.

We define the PRMC primary service area as the collection of ZIP codes where approximately 75% of hospital patients reside, as seen in the map below:



Target Areas and Populations

The service area around PRMC is made up of seven community areas in Chicago and four cities outside of Chicago. Each has unique health-related concerns. The PRMC service area has a high proportion of population over 65 compared to Chicago, Illinois, and the United States. The majority of the population in each area is white, with the exception of Irving Park (majority Hispanic/Latino). PRMC serves a very language-diverse population and provided care in 57 separate languages in 2016.

Development of This Implementation Strategy

Following an analysis of community assessment data, Presence Resurrection Medical Center developed this Implementation Strategy through dialogue with hospital and community leaders. Most importantly, the Northwest Chicago Community Leadership Board, a group of community stakeholders and leaders, provided crucial input on community needs and opportunities.

We have implemented an evidence-based approach to meet each prioritized community need, either by developing a new program, strengthening an existing one, or borrowing a successful model from another context. We paid special attention to gaps in existing services, the needs of marginalized or vulnerable populations, and whether working in partnership with other organizations might help us address needs more holistically. These programs exist alongside other Community Benefit operations at Presence Health, such as a comprehensive financial assistance policy and a large outlay in Health Professions Education, which also help address community needs without the use of formal program evaluation.

Each program in this Strategy will be reviewed and updated annually according to the logic model below, and its stated outputs and outcomes, to ensure that it is appropriately addressing its prioritized community need. Updated progress metrics and lessons learned will be communicated to regulatory bodies and to the general public.

Prioritized Community Needs

Presence Resurrection Medical Center, as part of the Health Impact Collaborative of Cook County, identified the following prioritized community needs based on feedback from community stakeholders, social service providers, and members of the public, especially vulnerable and marginalized populations. These needs will be addressed over the next three years.

The prioritized focus areas were agreed upon based on the needs throughout the North Region of Cook County. The PRMC service area has specific needs within these focus areas, which are described in more detail below. These specific needs were also guided by informal feedback from community and hospital stakeholders. These focus areas represent significant health needs for the Northwest Chicago neighborhood as well as throughout Cook County.

Social, Economic, and Structural Determinants of Health

Goal: Improving social, economic, and structural determinants of health while reducing social and economic inequities.
The social and structural determinants of health such as poverty, unequal access to community resources, unequal education funding and quality, structural racism, and environmental conditions are underlying root causes of health inequities. Additionally, social determinants of health often vary by geography, gender, sexual orientation, age, race, disability, and ethnicity. The strong connections between social, economic, and environmental factors and health are apparent in Chicago and suburban Cook County, with health inequities being even more pronounced than many national trends.

Mental Health and Substance Abuse

Goal: Improving mental health and decreasing substance abuse.
Mental health and substance arose as key issues in each of the four assessment processes. Community mental health issues are exacerbated by long-standing inadequate funding as well as recent cuts to social services, healthcare, and public health. The World Health Organization (WHO) emphasizes the need for a network of community-based mental health services. The WHO has found that the closure of mental health hospitals and facilities is often not accompanied by the development of community-based services and this leads to a service vacuum. In addition, research indicates that better integration of behavioral health services, including substance use treatment into the healthcare continuum, can have a positive impact on overall health outcomes.

Chronic Disease

Goal: Preventing and reducing chronic disease, with a focus on risk factors – nutrition, physical activity, and tobacco.
Chronic disease prevention was another strategic issue that arose in all the assessments. The number of individuals in the U.S. who are living with a chronic disease is projected to continue increasing well into the future. In addition, chronic diseases accounted for approximately 64% of deaths in Chicago in 2014. As a result, it will be increasingly important for the healthcare system to focus on prevention of chronic disease and the provision of ongoing care management.

Access to Care and Community Resources

Goal: Increasing access to care and community resources.
Healthy People 2020 states that access to comprehensive healthcare services is important for achieving health equity and improving quality of life for everyone. Disparities in access to care and community resources were identified as underlying root causes of many of the health inequities experienced by residents in Cook County.

Notes on Approach to Addressing Community Needs

Notwithstanding the structure of this Implementation Strategy, Presence Health uses a collaborative approach to address complex and interrelated community needs, guided by the framework of inclusion and social justice provided to us by social Catholic teaching. Before reviewing our programs to meet identified community needs, a few points bear further discussion.

1. Community Needs Are Interconnected

The needs our communities have prioritized are best understood as a complex web of cause and effect, rather than discrete topics. For instance, poverty (one of the social determinants of health) is not only a risk factor for other adverse social determinants, but also leads to decreased access to care and higher rates of unmanaged chronic illness and untreated behavioral health conditions. Furthermore, the burdens of poverty and poor health are not distributed equally among all groups. Rates of chronic disease, for instance, vary across gender, economic, geographic, and racial/ethnic lines. Thus, recognition of health disparities and a commitment to their elimination is embedded throughout this document.

Given the interconnected nature of these problems, our efforts to address them do not fit neatly into separate boxes. Our workforce development efforts, for example, will impact both poverty and violence. Likewise, our efforts to diminish food deserts will address both social determinants of health and chronic disease. We have classified our programs under the prioritized need that is most directly impacted.

2. Diversity and Inclusion Commitment

As a system, Presence Health is committed to diversity and inclusion. We are focused on increasing the diversity and cultural competence of our workforce, standardizing language access services, and improving data collection on race, ethnicity, and language. These efforts, in turn, support the health needs identified through the CHNA process, including access to care and chronic disease. We are also seeking out local, minority and women-owned vendors to incorporate into our supply chain. This will help to address the social determinants of health by keeping economic resources in many of our hardest-hit communities.

3. Partnerships

Finally, we recognize that progress in addressing our prioritized health needs would not be possible without many partners, because the scope and nature of these problems are larger than any one organization or sector could hope to solve alone. Therefore, all Presence Health hospital ministries are active participants in collaborative county-wide CHNA efforts, where we help guide task forces to analyze and address community needs beyond the formal CHNA document. Our Community Leadership Boards further our ties with the community through quarterly meetings that review our progress in addressing prioritized needs. Collaboration with schools, in particular, is a key strategy within our implementation plans. Engaging youth and their parents and guardians is critical to our success in many areas, and we are deeply committed to fostering a culture of health among the next generation of community residents.

Working for IMPACT

Through this Implementation Strategy, we intend to address all of the priority needs listed. We will also support other health care providers and public health departments in our community in collaborative efforts to improve outcomes.

In designing the Implementation Strategy, we focused our efforts around **IMPACT**: Informed and Measurable Programs, Partnerships, or Policies that Advance Community Transformation.

Logic Model

Every program in this Implementation Strategy follows a Logic Model that maps the inputs and activities to the results we hope to achieve. This provides accountability and allows us to periodically evaluate and improve upon programs to ensure that they are effective.

Inputs are the human, organizational, and community resources required to implement the program.

Examples: staff resources, community partnerships, supplies, dollars

Activities are the events, interventions, and other observable actions that occur during program implementation. Activities use program inputs to bring about the desired changes in the target population.

Examples: educate and screen program participants, inspect home for asthma triggers

Outputs are the direct products or deliverables of the activities, expressed numerically, which ensure that the program is running according to plan.

Examples: 200 homes inspected, 300 participants served, 150 vaccinations delivered

Outcomes are changes in program participants caused by the program activities. These can include changes in knowledge, skills, attitudes/beliefs, behavior, status, and/or level of functioning, and are further separated into short-term, medium-term, and long-term outcomes.

Examples: Increased knowledge of asthma triggers in the home, weight loss, improved quality of life

Impacts are long-term changes in the communities, institutions, or systems that the program targets. These can take 7-10 years or longer and involve the entire population or community.

Examples: reduced burden of disease in community, reduced healthcare utilization, changes in social norms, legislation enacted

Based on W.K. Kellogg Foundation (2004) and K4Health (2016).

Goal 1: Reduce Inequities and Improve Social, Economic, and Structural Determinants of Health

Strategy 1a. Improve the economic vibrancy, broad prosperity and financial security of our communities

Key Interventions

Anchor Mission
Utilize the ministry's position as an anchor institution to drive investment in vulnerable communities

Healthcare Workforce Collaborative
A series of partnerships aimed at aligning available healthcare jobs and the skills of current job seekers

School-Based Career Pipeline
Work with our academic partners to provide exposure and training for students interested in healthcare careers

Youth Summer Employment
Program that employs at-risk youth (16-24) in summer jobs and apprenticeships

Time Frame	Action Plan
Baseline: Year 2016	• Evaluate community need (see related Community Health Needs Assessment)
Year 2017	• Provide healthcare career exposure or apprenticeship to students in targeted geographic areas • Create a roadmap to local purchasing and supply chain sourcing • Participate in the Healthcare Workforce Collaborative
Year 2018	• Expand and refine internship and career exposure opportunities • Foster inclusive economic growth through purchasing and investing in socially vulnerable neighborhoods in our primary service areas
Year 2019	• Achieve diversity hiring targets, fully implement the Anchor Mission investment strategy, evaluate for further opportunities to support economic vibrancy

Partners to Engage

Safer Foundation, CARA, Instituto del Progreso Latino, One Million Degrees, CASE, Maine Township, EMT and First Responders, CPS high schools

Policies to Impact

Expand training programs; fund targeted community college programs; and explore distant-learning for workforce development programs

Goal 1: Reduce Inequities and Improve Social, Economic, and Structural Determinants of Health

Strategy 1b. Improve the health, safety and accessibility of housing

Key Interventions

Green and Healthy Homes Initiative
Program to remediate environmental health conditions that cause poor health such as asthma triggers, lack of home ventilation and lead paint.

Supportive Housing and Care Linkages for the Homeless
Program to remediate homelessness and transient living by providing closer care coordination and referrals to transitional and supportive housing.

Advocating for the Expansion of Affordable Housing Credits
Improving the landscape of affordable housing in Illinois by advocating for greater use of housing vouchers and more financial support for subsidized housing.

Screen for Housing and Utility Security
Develop a screening tool with our hospital and health department partners to identify patients and community members living in unstable housing or suffering from utility burdens

Time Frame	Action Plan
Baseline: Year 2016	• Evaluate community need (see related Community Health Needs Assessment)
Year 2017	• Launch pilot to remediate environmental health conditions that cause poor health such as asthma triggers, lack of home ventilation, and lead paint • Educate the community to keep their asthma clinic follow-up appointments which typically occur every 3 to 6 months until stable • Partner with organizations to provide transitional and supportive housing for homeless • Develop screening tool
Year 2018	• Support efforts to expand healthy, stable housing near our hospital campuses • Advocate for increased affordable housing resources • Implement screening tool and refer patients to partner social service groups
Year 2019	• Refine and improve care linkages for homeless individuals who present in our hospitals • Expand asthma home health remediation • Evaluate screening tool and make adjustments as needed

Partners to Engage

La Casa Norte; Center for Health & Housing; Asian Human Services, The Boulevard, Green & Healthy Homes Initiative; Elevate Energy, Deborah's Place, Catholic Charities

Policies to Impact

Funding for the Illinois Affordable Housing Trust Fund, Homeless Prevention Program and Rental Housing Support

Goal 1: Reduce Inequities and Improve Social, Economic, and Structural Determinants of Health

Strategy 1c. Reduce violence and mitigate the impact it has on the health and well-being of our neighbors

Key Interventions

Anti-Bullying Campaign
Develop strategies in collaboration with local partners to reduce bullying and circumvent cycles of violence

Anti-Human Trafficking
Human trafficking victims are subjected to force, fraud or coercion for the purpose of sex or forced labor, and many can be interdicted at hospitals by professionals trained to recognize possible exploitation

Gun Violence Prevention Task Force
Serve on a task force comprised of community stakeholders to develop interventions for gun violence and the resultant trauma appropriate to the circumstances of the community

Safe Passage Routes & Safe Haven Program
Safe Passage is designed to provide safe routes for students while traveling to and from school. Safe Haven program are sites (hospitals, businesses, libraries) identified by a signed placed in the location, to alert the child that they can find a friendly shelter inside and ask for assistance.

Time Frame	Action Plan
Baseline: Year 2016	• Support and promote Human Trafficking Awareness Day (January 11th)
Year 2017	• Promote anti-bullying partners and incorporate into school-based partnerships • Deepen partnerships with CAPS and local police precincts' gang reduction work
Year 2018	• Align with the Catholic Health Association on anti-human trafficking initiatives • Support with resources CPS and CPD Summer Safe Passage and Presence sites serve as Save Havens
Year 2019	• Provide resources and support for domestic violence groups

Partners to Engage

CAPS; Catholic Health Association (CHA); Chicago Dream Center; The Dreamcatcher Foundation; Chicago Alliance Against Sexual Exploitation and the End Demand Illinois Campaign; Catholic Charities; CeaseFire;

Policies to Impact

Expand training to identify victims of human trafficking; help victims recover from the legal, financial and emotional effects of human trafficking; increase funding for violence prevention and intervention services; and increase access and participation in mentoring programs. Support legislation aimed specifically cracking down on illegal gun trafficking and straw-purchasing.

Goal 1: Reduce Inequities and Improve Social, Economic, and Structural Determinants of Health

Strategy 1d. Improve access to quality, healthy affordable food

Key Interventions

Farmer's Market
Sponsor and host seasonal farmer's markets on ministry grounds to provide access to healthy food to community residents, patients, and associates

Surplus Project
Utilize excess food produced in ministry cafeterias by packaging and distributing to summer lunch programs, homeless shelters and food banks

SNAP Benefits
Improve enrollment and advocate for expanded benefits

Time Frame	Action Plan
Baseline: Year 2016	• Evaluate community need (see related Community Health Needs Assessment)
Year 2017	• Launch or expand Farmer's Markets, Summer Meals and Cooking Matters programs at the ministry • Increase enrollment in SNAP and WIC programs by aligning with Open Enrollment
Year 2018	• Implement a screen & refer tool for food insecurity in the ministry • Launch the Surplus Project in partnership with local food banks, schools and homeless shelters • Advocate for increased SNAP benefits
Year 2019	• Evaluate and grow farmers markets and surplus projects

Partners to Engage
Greater Chicago Food Depository; Patient Innovation Center; Breakthrough Urban Ministries; Greater West Town Community Development Center

Policies to Impact
Double the value of SNAP benefits at farmers' markets; and expand efforts to enroll eligible individuals in SNAP to under-enrolled populations

Goal 2: Improve Mental Health and Decrease Substance Abuse

Strategy 2a. Increase awareness of mental health conditions and reduce stigma

Key Interventions

Mental Health First Aid (MHFA)
Certificate-based program using national, evidence-based curriculum that teaches the skills to respond to the signs of mental illness and substance use disorders

Trauma-Informed Communities
Partner with local and county health departments to achieve the designation by helping train city and county workforce in trauma-informed service delivery, provide resource guides and support policy change

Time Frame	Action Plan
Baseline: Year 2016	• Supported awareness initiatives for Mental Health Awareness Month
Year 2017	• Prepare community-based "first responders" in community organizations and public services by offering free MHFA trainings • Support achievement of "Trauma-Informed Community" effort led by local health departments
Year 2018	• Improve access to mental health services by developing a behavioral health resource guide • Evaluate outcomes of MHFA trainings and expand to new community groups • Provide awareness initiatives for Mental Health Awareness Month
Year 2019	• Implement and offer through primary care physician a depression screening & care

Partners to Engage
Des Plaines Health Department; Cook County Department of Public Health; Patient Innovation Center; Breakthrough Urban Ministries; Trilogy; schools, churches and elected officials

Policies to Impact
Increase access to mental health services through telehealth technology; improve insurance coverage for behavioral health; and additional training on mental health for public servants

Goal 2: Improve Mental Health and Decrease Substance Abuse

Strategy 2b. Develop telehealth policy solutions to address mental health professional shortages

Key Interventions	
Telehealth Bill Provide input and advocacy support to a statewide bill to allow reimbursement for telehealth services in areas of critical need. Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care and patient and professional health-related education.	
Time Frame	**Action Plan**
Baseline: Year 2016	• Evaluate community need (see related Community Health Needs Assessment)
Year 2017	• Seek partnerships with schools, churches and communities (in line with an existing Proviso Township pilot) to offer access to mental health professionals for vulnerable populations, especially non-English speaking
Year 2018	• Launch partnerships to offer access to mental health professionals
Year 2019	• Evaluate partnerships offering access to mental health professionals
Partners to Engage Adler School of Psychology; The Family Institute; Presence Behavioral Health, Partnership for a Connected Illinois	
Policies to Impact Telehealth policy solutions to encourage remote care delivery; Support the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and its impact on telehealth; Support CMS initiatives that encourage telehealth; Support Illinois Telehealth Initiatives	

Goal 2: Improve Mental Health and Decrease Substance Abuse

Strategy 2c. Increase access to Substance Abuse interventions and recovery programs

Key Interventions

Adolescent and Teen Drug and Alcohol Prevention
Provide information of long-term effects of drug and alcohol use to reduce the level of adolescent drug and alcohol drug abuse and promote positive mental health among teens in our community

Partner with Addiction and Recovery Groups
Provide space, resources and support for community-based addiction and recovery partners

Time Frame	Action Plan
Baseline: Year 2016	• Evaluate community need (see related Community Health Needs Assessment)
Year 2017	• Expand and continue programming with local area high schools, park districts, and community centers.
Year 2018	• Expand addiction support groups and services at the hospital campus • Launch faith-based partnership to provide awareness and linkages to services
Year 2019	• Evaluate programming and services

Partners to Engage

Des Plaines Police Department; SAMHSA; Chicago Police Department, Chicago Department of Public Health

Policies to Impact

Increase education and mentorship programs; provide a path to recovery and rehabilitation for juvenile justice involved youth who have addition issues

Goal 3: Prevent and Reduce Chronic Disease

Strategy 3a. Create a healthy care delivery community

Key Interventions

American Lung Association Tobacco 21 Act
Increasing the minimum age of sale for tobacco products to at least 21 years old will significantly reduce youth tobacco use and save thousands of lives

Smoke Free Faith
Increase smoking cessation attempts using evidence-based strategies by adult smokers in faith community settings

Campus Fit Loop
Create visible, marked walking trails on and around our ministries to encourage activity and physical fitness

Rethink Your Drink
Reduce sugary beverage consumption to ameliorate chronic disease

Sodium Reduction Initiative
Reduce sodium consumption from food served on the hospital campus

Time Frame	Action Plan
Baseline: Year 2016	• Evaluate community need (see related Community Health Needs Assessment)
Year 2017	• Design Fit Loop
Year 2018	• Build Fit Loop • Advocate for Active Design guidelines for building projects
Year 2019	• Evaluate and monitor initiatives impact

Partners to Engage
American Lung Association, Respiratory Health Association, Chicago Asthma Consortium, American Cancer Society, Archdiocese of Chicago

Policies to Impact
Tobacco 21 to restrict youth access to tobacco; Active Design guidelines in local building codes; sugary drink taxes to reduce consumption and increase funding for health care programs; and preserve school physical education requirements; Green building standards

Goal 3: Prevent and Reduce Chronic Disease

Strategy 3b. Provide effective programming and partnerships for at-risk community members to lead active lives

Key Interventions

A-List Diabetes Prevention Program
Diabetes screening and education program focusing on the prevention of type 2 diabetes through lifestyle and nutrition therapy.

We're Out Walking (WOW) Program
WOW is a 12 week program that creates a supportive environment to motivate those who live, work and play in Evanston to lead healthier lives.

Fitness Prescription Program
Improve access to affordable fitness resources through shared-use agreements and partnerships with Park Districts, YMCAs, and local green spaces

Time Frame	Action Plan
Baseline: Year 2016	• Evaluate community need (see related Community Health Needs Assessment)
Year 2017	• Launch "We're Out Walking" (WOW) program aligned with local police precincts • Launch A-List pilot
Year 2018	• Create shared-use agreements and partnerships with the Park District and Forest Preserve • Expand A-List Diabetes Prevention Program
Year 2019	

Partners to Engage
American Lung Association, Respiratory Health Association, Chicago Asthma Consortium, Cook County Forest Preserve, Des Plaines Parks Department

Policies to Impact
Preserve school physical education requirements

Goal 4: Increase Access to Care and Community Resources

Strategy 4a. Further align and partner with our faith communities to provide care, advocate for coverage and promote health and wellness

Key Interventions

Faith Community Nursing
A practice specialty that focuses on the intentional care of the spirit, promotion of an integrative model of health and prevention and minimization of illness within the context of a community of faith.

Faith Leader Health and Wellness
A program that focuses on self-care and support for faith leaders, especially those who minister in vulnerable and disadvantaged communities

Time Frame	Action Plan
Baseline: Year 2016	• Evaluate community need (see related Community Health Needs Assessment)
Year 2017	• Advocate for immigrant protections, ALLKIDS, Health Illinois, the ACA and other initiatives that protect vulnerable populations • Develop wellness program for community faith leaders
Year 2018	• Increase parish engagement through an expanded Faith Community Nursing Program • Expand faith leader wellness program to more faith communities
Year 2019	• Support faith leader health and wellness initiatives

Partners to Engage
Access to Care, Archdiocese of Chicago, Faith Communities

Policies to Impact
Protect CHIP and AllKids programs to ensure access to health care for children; preserve the increase in Medicaid coverage for adults expanded under the Affordable Care Act

Goal 4: Increase Access to Care and Community Resources

Strategy 4b. Increase capacity and availability of clinical and community resources for vulnerable populations

Key Interventions

FQHC and Free Clinic Partner Support
Provide financial, referral, and in-kind support to local FQHCs and free clinics

New Beginnings Prenatal Program
Program that offers outpatient pre-natal and educational support for young, uninsured women with limited access to care and limited financial resources. Each woman who participates is offered education, counseling and emotional support, as well as assistance in filing for Medicaid/All kids financial assistance.

Access to Care Partnership
Presence Holy Family Medical Center partners with Access to Care to provide free/severely discounted testing and radiology services to suburban Cook County residents without insurance

Time Frame	Action Plan
Baseline: Year 2016	• Evaluate community need (see related Community Health Needs Assessment)
Year 2017	• Build and strengthen connection with Salvation Army's existing "Breakfast with Babies" initiative and establish long-term partnership with Walmart and Kimberly Clarke distributors.
Year 2018	• Increase enrollment of ACA for Medicaid eligible patients by increasing knowledge, awareness of options.
Year 2019	• Evaluate current initiatives

Partners to Engage
Silver Lining Foundation; PrimeCare; Laboure Clinic; Erie Family Health Center; Community Health; ACCESS Community Health Network, Pin-A-Sister; IBCCP; ACS

Policies to Impact
Prevent funding cuts to FQHCs and protect expanded Medicaid coverage

Goal 4: Increase Access to Care and Community Resources

Strategy 4c. Improve community members effective use of the health system and community resources

Key Interventions

Open Enrollment
Expanding access to insurance and social service benefits by providing enrollment support and resources, on campus and at community partner sites

Wellness Screenings
Develop community access points (health fairs, screenings, etc.) to improve health in the community

Time Frame	Action Plan
Baseline: Year 2016	• Evaluate community need (see related Community Health Needs Assessment)
Year 2017	• Continue involvement in open enrollment for Medicaid and ACA marketplaces
Year 2018	• Achieve cultural & linguistic competency by providing community health language services in top five primary languages spoken in each service area
Year 2019	• Evaluate current initiatives

Partners to Engage
Patient Innovation Center; ACCESS Community Health Network

Policies to Impact
Protect expanded Medicaid coverage; Support legislation that expands care coordination and community-based care settings

Goal 4: Increase Access to Care and Community Resources

Strategy 4d. Improve transportation resources

Key Interventions	
Voucher Support Provide vouchers for rideshare services and public transportation to patients without easy access to transportation to their follow-up appointments, leading to improved continuity of care **Active Transportation Alliance** Support the efforts of the Active Transportation Alliance to improve transportation infrastructure in Cook County to focus on people-centered design through proposals like shared streets	
Time Frame	**Action Plan**
Baseline: Year 2016	• Support existing collaborative efforts (Divvy Bikes, Transit Table, Complete Streets)
Year 2017	• Provide CTA or public transport passes to qualifying patients
Year 2018	• Partner with Lyft or other transportation companies to get patients without transportation access to and from appointments
Year 2019	• Link qualifying patients to medical transportation companies to get to and from medical appointments on an ongoing basis
Partners to Engage Lyft; Active Transportation Alliance; other transportation services	
Policies to Impact Support shared streets and strong public transportation systems	

Adoption

Presence Resurrection Medical Center welcomes feedback from the public and community stakeholders on this Implementation Strategy and its related Community Health Needs Assessment. To provide feedback or learn more about the process for conducting the Community Health Needs Assessment and determining community needs, please contact Mariana Wrzosek at MWrzosek@presencehealth.org.

The delegated authority to approve this Implementation Strategy resides with the Northwest Chicago Community Leadership Board, comprised of community and hospital stakeholders. The below signatures indicate that this plan has been reviewed and adopted for 2017 – 2019.

Adopted by the Northwest Chicago Community Leadership Board

5/12/17
Date Adopted

Plan Prepared By:

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Mariana Wrzosek, MPH, BSN, BS, RN, CPN, CHES
Regional Director, Community Health Integration

Presence Health®