AMITA Health Resurrection Medical Center Implementation Strategy FY2020-2022

Implementation Strategy Narrative

Overview

AMITA Health Resurrection Medical Center – Chicago (AHRMCC) has been meeting the health needs of the northwest side of Chicago and Suburban Cook County residents for over 50 years. AHRNCC is a 337-bed community-based teaching acute-care hospital with 502 physicians, 77 residents, 1,592 employees, and 180 volunteers contributing 53,000 hours. AHRMCC's Primary Service Area (PSA) is made up of six community areas in Chicago and seven cities outside of Chicago. The six community areas in Chicago are: Belmont-Cragin/Dunning/Montclare (60634), Edison Park/Norwood Park (60631), Forest Glen (60646), Irving Park/Portage Park (60641), Jefferson Park (60630), and Oriole Park/O'Hare (60656). The areas outside of Chicago but within Suburban Cook County are: Niles (60714), Harwood Heights (60706), Norridge (60706), Park Ridge (60068), Rosemont (60018), Des Plaines (60016), Schiller Park (60176), and Elmwood Park/Montclare (60707). New for this CHNA is 60707 which is Montclare and Elmwood Park. We define the primary service area as the collection of ZIP codes where approximately 75% of hospital patients reside.

In 2018 to 2019, AMITA Health Resurrection Medical Center – Chicago (AHRMCC) participated in the Alliance for Health Equity which included over 30 hospitals in Chicago and Suburban Cook County, seven health departments, and more than 100 community organizations, facilitated by the Illinois Public Health Institute. Together, the Alliance for Health Equity developed a collaborative Community Health Needs Assessment (CHNA). Alliance for Health Equity is a community collaborative with a mission of preparing and mobilizing around opportunities that impact key areas affecting the service area of AHRMCC. Using the Mobilizing for Action through Planning and Partnerships (MAPP) process, community input data were provided by residents, health care consumers, community leaders, health care professionals, and multi-sector representatives through a community survey and through community focus groups.

The joint CHNA and AMITA Health Resurrection Medical Center-Chicago has identified the following two focus areas as significant health needs. The needs were prioritized based upon input gathered from the CHNA, the implications for long-term health outcomes, the ability of the local health care system to have an impact on addressing the need, current priorities and programs, and the effectiveness of existing programs.

The identified priorities for AMITA Health Resurrection Medical Center-Chicago include:

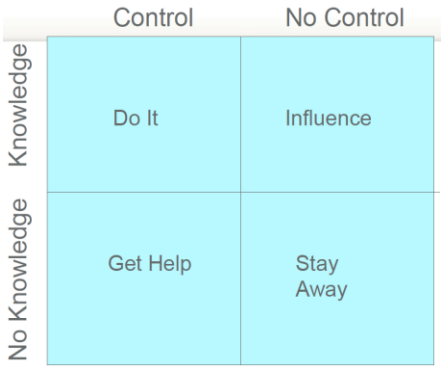
1. Social and Structural Determinants of Health which include policies that advance equity and promote physical and mental well-being; and conditions that support healthy eating and active living.
2. Access to Care, Community Resources, and Systems Improvements which consist of increased timely linkage to appropriate care including Behavioral Health and Social Services; and resources, referrals, coordination, and connection to community-based services.

Aligned with these focus areas, the priority health conditions will consist of Chronic Disease Prevention and Management (cancer, diabetes, hypertension, and obesity); Mental Health; and Substance Use Disorders.

Prioritized Needs

AMITA Health Resurrection Medical Center – Chicago with key hospital leaders, health system associates and leadership, and the Community Leadership Board (CLB) which includes our community leaders and representatives prioritized the needs of the communities we serve using the Control and Influence Method after reviewing the primary and secondary data. This tool provided guidance on what to focus on when trying to choose a topic to improve. The focus was on the needs that we have control and knowledge of.

Control and Influence Prioritization Method



These criteria were also considered:

- Severity of health need
- Opportunity to intervene at a prevention level
- Influence and ability to impact change
- Alignment with hospital and health system strategies and programming
- Existing resources and assets both in the hospital and in the community
- Capacity to address underserved populations as well as the most vulnerable

Each of the communities we serve have unique health needs, assets, and opportunities. Behavioral health, chronic disease management needs, health education, and healthy lifestyle behaviors are reoccurring themes for our communities as supported by our data review and community input. These are the two health needs that have been identified as priority health needs to address.

Priority Health Needs:

1. Social Determinants of Health: Conditions that Support Healthy Eating and Active Living and Policies that Advance Equity and Promote Physical and Mental Well-being
2. Access to Care, Community Resources, and Systems Improvements

Needs That Will Not Be Addressed

AMITA Health Resurrection Medical Center-Chicago will not directly address the following focus areas/priorities identified in the 2019 CHNA:

- Economic Vitality and Workforce Development
- Education and Youth Development
- Housing, Transportation, and Neighborhood Environment
- Violence and Community Safety, Injury, including Violence-related injury
- Trauma-Informed Care
- Maternal and Child Health

While critically important to overall community health, these specific priorities did not meet internally determined criteria that prioritized addressing needs by either continuing or expanding current programs, services, and initiatives to steward resources and achieve the greatest community impact. For these areas not chosen, there are service providers in the community better resourced to address these priorities. AMITA Health Resurrection Medical Center will work collaboratively with these organizations as appropriate to ensure optimal service coordination and utilization.

Summary of Implementation Strategy

An action plan follows for each prioritized need which will include the resources, proposed actions, planned collaboration, and anticipated impact of each strategy.

This plan was approved by the Community Leadership Board AMITA Health Resurrection Medical Center-Chicago in May 2019 and adopted October 2019.

Prioritized Need #1: Social Determinants of Health: Conditions that Support Healthy Eating and Active Living and Policies that Advance Equity and Promote Physical and Mental Well-being

GOAL: Improve the opportunities for access to and consumption of healthy foods through programming and healthy lifestyle classes.

STRATEGY 1: Increase availability and access to fresh vegetables for those in need through our **Community Garden.**

BACKGROUND INFORMATION:

- **Target population**: The poor, vulnerable, and underserved at the local food pantry
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved**: Limited access to healthy foods, such as fruits and vegetables, is a major barrier to healthy eating. Low-income, underserved communities are at the highest risk for obesity because they often lack supermarkets, leaving convenience stores or fast-food chains as the main source of meals [5]. Expensive fruits and vegetables may also be cost-prohibitive for low-income families. Community gardens provide residents of underserved communities the opportunity to increase access and affordability. Gardens may offer physical and mental health benefits by providing opportunities to eat healthy fresh fruits and vegetables, engage in physical activity, skill building, and creating green space, decrease some violence in some neighborhoods, and improve social well-being through strengthening social connections.
- **Strategy source**: Centers for Disease Control and Prevention (CDC) Healthy Places: Community Gardens https://www.cdc.gov/healthyplaces/healthtopics/healthyfood/community.htm

RESOURCES:

- Centers for Disease Control and Prevention (CDC) https://www.cdc.gov/healthyplaces/healthtopics/healthyfood/community.htm
- National Gardening Association (NGA) http://www.garden.org/home is non-profit a leader in plant-based education. NGA connects people to gardening in five core fields: plant-based education, health and wellness, environmental stewardship, community development, and responsible home gardening.
- The American Community Gardening Association (ACGA) http://communitygarden.org/ is a binational, nonprofit membership organization of professionals, volunteers, and supporters of community greening in urban and rural communities. ACGA's Web site provides information, tools, links, and resources for starting a community garden and locator tool for finding the nearest community garden.

COLLABORATION:

- Boy Scouts of America
- AHRMCC Community Leader Board (CLB)
- New Hope House Northwest, aka New Hope Community Food Pantry
- Unforgettable Edibles

ACTIONS:

1. Evaluate the community need (see related Community Health Needs Assessment)
2. Organize meetings of interested people
3. Identify the resources and supplies needed
4. Select the site, the plots, and prepare for planting
5. Organize volunteers to plant various vegetables and fruits
6. Organize volunteers to weed, to maintain, to water, and to pick the produce once ripened
7. Tally and track all the produce that is donated to the food pantry and the number of clients

STRATEGY 1: Increase availability and access to fresh vegetables for those in need through our **Community Garden.**

ANTICIPATED IMPACT/OBJECTIVES:

I. Short term objective (Process Objective): Each year, 100% of the produce from the community garden will be donated to the underserved clients of the local food pantry: New Hope House Northwest, aka New Hope Community Food Pantry

II. Medium term objective (Impact Objective): The amount of underserved clients served with the donated produce will increase by 10% each year**.**

III. Long term objective (Outcome Objective): By 2022, the percent of adults that consume vegetables less than one time per day will increase to more than 24.3% (IL 2015).

STRATEGY 2: Provide a **Diabetes Prevention Program (DPP)** for those at risk and those who have pre-diabetes to prevent the onset of type II diabetes.

BACKGROUND INFORMATION:

- **Target population:** Individuals identified with the risk factors for pre-diabetes or those who are in need of an intervention to prevent the onset of diabetes and for those who have been diagnosed with pre-diabetes
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved:** According to the Centers for Disease Control and Prevention (CDC), an astounding 1 in 3 adults have prediabetes and 9 out of 10 adults do not know that they have pre-diabetes. In Illinois, approximately 1.3 million (12.5% of the population) adults have diabetes, but roughly 341,000 of those don't know they have diabetes. It is estimated that 84 million Americans have prediabetes, of which 3.6 million live in Illinois. Diabetes is the seventh leading cause of death nationally and in Illinois. By making healthy lifestyle changes, an individual can cut their chance of getting type 2 diabetes by 50%.
- **Strategy source**: Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program is an evidence based program: https://www.cdc.gov/diabetes/prevention/index.html

RESOURCES:

- Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program is an evidence based program: https://www.cdc.gov/diabetes/prevention/index.html
- National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) https://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp

COLLABORATION:

- Community-based organizations (CBOs)
- Faith-based organizations (FBOs)
- Touchpoint

STRATEGY 2: Provide a **Diabetes Prevention Program (DPP)** for those at risk and those who have pre-diabetes to prevent the onset of type II diabetes.

ACTIONS:

1. Identify those with the risk factors for pre-diabetes and those with pre-diabetes
2. Schedule a pre-assessment with our Certified Diabetes Educator (CDE)
3. Provide one-on-one initial assessments will be scheduled with our CDE and our Registered Dietician (RD) which includes A1c, Lipid Panel, BP, BMI, weight, diet diary, and knowledge survey.
4. Provide five (5) diabetes prevention education classes which include nutrition counseling, information on exercise, problem solving, other lifestyle modifications, and how to monitor one's health.
5. Provide post-assessment which includes A1c, Lipid Panel, BP, BMI, weight, diet diary, and knowledge survey
6. Conduct follow-ups at 3-month, 6-month, and annually
7. Provide a monthly support group after completion of the program

ANTICIPATED IMPACT/OBJECTIVES:

I. Short term objective (Process Objective): By the end of May 2020, there will be at least 200 individuals assessed for the Diabetes Prevention Program.

II. Medium term objective (Impact Objective): By the end of the program, at least 50% will have an improvement in their health indicators which includes A1c, Lipid Panel, BP, BMI, weight, or knowledge survey**.**

III. Long term objective (Outcome Objective): By 2022, there will be a 10% reduction of the individuals diagnosed with pre-diabetes in Chicago.

STRATEGY 3: Improve access to healthy meals for children by providing the **Kids Summer Meals Program** and to increase the access to nutritious and easy-to-prepare food for the weekend with the **weekend backpack food rescue program** for those children and families in need.

BACKGROUND INFORMATION:

- **Target population:** Children 18 years and younger
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved:** Many kids who rely on school meals struggle to get enough to eat during the summer months. Hunger fact is that 43% of low-income families say it's harder to make ends meet during summer. The percentage of children in poverty is higher for Cook County than IL and US. 50% of enrolled school children in the North region of Cook County are eligible for free or reduced lunches. In IL, 17.3% of children 18 years and younger live in food insecure homes. In 2015, 14.1% of children in IL participated in the summer meals programs, based on the number of low-income students who qualified for free or reduced-price lunch during the school year. (Food Research & Action Center [FRAC])
- **Strategy source**: No Kids Hungry https://www.nokidhungry.org/who-we-are/hunger-facts
  Greater Chicago Food Depository https://www.chicagosfoodbank.org/childrens-programs/

RESOURCES:

- Greater Chicago Food Depository https://www.chicagosfoodbank.org/childrens-programs/

COLLABORATION:

- Greater Chicago Food Depository (GCFD)
- New Hope House Northwest, aka New Hope Community Food Pantry
- Union Ridge School

ACTIONS:

1. Identify the location of the Kids Summer Meals Program and submit the application to GCFD
2. Once application approved, attend the annual mandatory training at the GCFD
3. Create the flyer, communication plan, and send the correspondents
4. Prepare the volunteer schedule and revise the volunteer worker checklist
5. Monitor the daily deliveries, daily temperatures of refrigerator and milk, tallies of complete lunches, and submit numbers to Minute Menu.
6. Track the demographics of the children attending with zip codes, ages, and school affiliation
7. During the school year, provide weekly food deliveries for the low-income children/families identified in the weekend backpack food rescue program.

ANTICIPATED IMPACT/OBJECTIVES:

I. Short term objective (Process Objective): There will be at least 20 children participating daily in the Kids Summer Meals Program.

II. Medium term objective (Impact Objective): By the end of the school year 2020, there will be an increase of more than 6 families in the weekend backpack food rescue program**.**

STRATEGY 3: Improve access to healthy meals for children by providing the **Kids Summer Meals Program** and to increase the access to nutritious and easy-to-prepare food for the weekend with the **weekend backpack food rescue program** for those children and families in need.

III. Long term objective (Outcome Objective): By 2022, there will be a reduction from 1 in 6 children living with hunger.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1)

Strategy:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2030" (or OTHER NATIONAL PLAN):
Community Garden	In our CHNA, the estimated number of adults (18 years and older) who reported eating five or more servings of fruits and vegetables (combined) daily was only 18-30%.	Percent of adults that consume vegetables less than one time per day in is 24.3% (IL 2015)	Percent of adults that consume vegetables less than one time per day is 22.3% (National 2015) HP 2030: Overarching Goal: Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death. NWS-2030-01: Reduce household food insecurity and in doing so reduce hunger NWS-2030-06: Increase consumption of total vegetables in the population aged 2 years and older NWS-2030-07: Increase consumption if dark green vegetables, red and orange vegetables, and beans and peas in the population aged 2 years and older HP2020: NWS-13: Reduce household food insecurity and in doing so reduce hunger
Diabetes Prevention Program (DPP)	Diabetes identified as the second top health issue in CHNA	In Illinois, approximately 1.3 million (12.5% of the population) adults have diabetes, but roughly 341,000 of those don't know they have diabetes. It is estimated that 3.6 million have pre-	National Diabetes Statistics Report, 2017: - Total: 84.1 million adults aged 18 years or older have prediabetes (33.9% of the adult US population) - 65 years or older: 23.1 million

		diabetes. Diabetes is the seventh leading cause of death in Illinois.	adults aged 65 years or older have prediabetes HP 2030: D-2030-09: Reduce the proportion of adults with undiagnosed prediabetes HP 2020: D-16 Increase prevention behaviors in persons at high risk for diabetes with prediabetes D-16.1 Increase the proportion of persons at high risk for diabetes with prediabetes who report increasing their levels of physical activity D-16.2 Increase the proportion of persons at high risk for diabetes with prediabetes who report trying to lose weight D-16.3 Increase the proportion of persons at high risk for diabetes with prediabetes who report reducing the amount of fat or calories in their diet
Kids Summer Meal Program/Weekend Backpack Rescue Food Program	The percentage of children in poverty is higher for Cook County than IL and US. 50% of enrolled school children in the North region of Cook County are eligible for free or reduced lunches.	Percent of high school students that ate vegetables three or more times per day is 12.7% (IL 2015) In IL, 17.3% of children 18 years and younger live in food insecure homes. In 2015, 14.1% of children in IL participated in the summer meals programs, based on the number of low-income students who qualified for free or reduced-price lunch during the school year. (Food Research & Action Center [FRAC])	Percent of high school students that ate vegetables three or more times per day is 14.8% (National 2015) More than 12 million children in the United States live in "food insecure" homes. That phrase may sound mild, but it means that those households don't have enough food for every family member to lead a healthy life. 1 in 6 children in the United States lives with hunger (No Kid Hungry, n.d.) HP 2030: Overarching Goal: Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death. NWS-2030-01: Reduce household food insecurity and in doing so reduce hunger

	NWS-2030-06: Increase consumption of total vegetables in the population aged 2 years and older NWS-2030-07: Increase consumption if dark green vegetables, red and orange vegetables, and beans and peas in the population aged 2 years and older

Prioritized Need #2: Access to Care, Community Resources, and Systems Improvements

GOAL: Increase the connection of those people in need of social service assistance with the programs that can serve them.

STRATEGY 1: Improve access by referring the underserved and vulnerable to social service organizations the communities that we serve from the **AMITA Health Community Resource Directory (formerly Aunt Bertha).**

BACKGROUND INFORMATION:

- **Target population:** Low-income and underserved population in the communities we serve
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved:** This is a community-wide software platform, to connect community residents to available social services in their community. Connecting people and programs in searching for free or reduced cost services such as medical care, food, job training, transportation, housing, legal, and more. In our CHNA, the community identified the top two things needed for a healthy community: access to health care and mental health services as well as access to community services.
- **Strategy source:** AMITA Health Community Resource Directory www.amitahealth.org/patient-resources/community-resources

RESOURCES:

- AMITA Health Community Resource Directory www.amitahealth.org/patient-resources/community-resources

COLLABORATION:

- Aunt Bertha
- Community-based organizations (CBOs)
- Faith-based organizations (FBOs)

ACTIONS:

1. AMITA Health partnering with Aunt Bertha to provide the software platform
2. Internal associates identified to become train the trainers and training session provided

STRATEGY 1: Improve access by referring the underserved and vulnerable to social service organizations the communities that we serve from the **AMITA Health Community Resource Directory (formerly Aunt Bertha).**

3. Training sessions provided to our community-based organizations and faith-based organizations
4. Programs not found in the platform are entered under "Suggest a Program"
5. Create and implement a communication plan for residents in the communities we serve

ANTICIPATED IMPACT/OBJECTIVES:

I. Short term objective (Process Objective): By the end of 2019, there will be at least 25 community-based organizations and faith-based organizations trained with the AMITA Health Community Resource Directory.

II. Medium term objective (Impact Objective): By 2020, there will be at least 10,000 social service resources in the directory to assist the low-income residents of the communities that we serve.

III. Long term objective (Outcome Objective): By 2022, there will be a 25% increase in the number of referrals through the AMITA Health Community Resource Directory**.**

STRATEGY 2: To increase the number of community residents who know the risks for colon cancer and to provide those at risk with the **Flu/Fecal Occult Blood Test (FOBT) screening.**

BACKGROUND INFORMATION:

- **Target population:** The low-income, underserved, and those at risk for colorectal cancer.
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved:** Reducing colorectal cancer is a major public health concern. Colorectal cancer is the second leading cause of death in the United States among men and women combined, yet it's the most preventable. Estimated costs for one year of treatment for a patient with metastatic (late-stage) colon cancer are as high as $310,000 with an estimated annual cost nationwide of $14 billion. Best practice guidelines from the American Cancer Society is to screen adults ages 45-75 years old and 75-85 years old to check their physicians about testing.
- **Strategy source:** American Cancer Society
  https://www.cancer.org/latest-news/american-cancer-society-updates-colorectal-cancer-screening-guideline.html
  U.S. Preventive Services Task Force
  https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening2

RESOURCES:

- American Cancer Society
  https://www.cancer.org/latest-news/american-cancer-society-updates-colorectal-cancer-screening-guideline.html
- U.S. Preventive Services Task Force
  https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening2

COLLABORATION:

- American Cancer Society
- Community-based organizations (CBOs)
- Faith-based organizations (FBOs)

ACTIONS:

1. Collaborate with CBOs and FBOs for dates and locations of the screening
2. Order all the supplies necessary
3. Screen all participants those might be at risk or eligible for the take home kit
4. Educate all the participants on the new 2018 guidelines
5. Follow the flow chart for the take home kit screening
6. Nurse navigator will follow-up with any positive results

ANTICIPATED IMPACT/OBJECTIVES:

I. Short term objective (Process Objective): By the end of 2019, there will be at least 400 individuals screened for colorectal cancer.

STRATEGY 2: To increase the number of community residents who know the risks for colon cancer and to provide those at risk with the **Flu/Fecal Occult Blood Test (FOBT) screening.**

II. Medium term objective (Impact Objective): By 2020, at least 50% will know the new age guidelines for colorectal cancer screening**.**

III. Long term objective (Outcome Objective): By 2022, there will be a 10% increase in the colorectal cancer screenings from 65.1 (Il 2015).

STRATEGY 3: Provide the Mental Health First Aid (MHFA) trainings to the communities that we serve

BACKGROUND INFORMATION:

- **Target population:** The faith-based organizations, school, and those who are interested in the MHFA trainings
- **Briefly describe if/how the strategy addresses social determinants of health, health disparities and challenges of the underserved:** Just as CPR training helps a person with no clinical training assist an individual following a heart attack, Mental Health First Aid training helps a person assist someone experiencing a mental health crisis such as contemplating suicide. In both situations, the goal is to help support an individual until appropriate professional help arrives. Mental Health First Aiders learn a single 5-step action plan known as ALGEE, which includes assessing risk, respectfully listening to and supporting the individual in crisis, and identifying appropriate professional help and other support. Participants are also introduced to risk factors and warning signs for mental health or substance use problems, engage in experiential activities that build understanding of the impact of illness on individuals and families, and learn about evidence-supported treatment and self-help strategies
- **Strategy source:** Mental Health First Aid USA https://www.mentalhealthfirstaid.org/

RESOURCES:

- Mental Health First Aid USA https://www.mentalhealthfirstaid.org/

COLLABORATION:

- AmeriCorps
- Association House
- Community-based organizations (CBOs)
- Faith-based organizations (FBOs)
- Mental Health First Aid USA
- Trilogy

ACTIONS:

1. Identify CBOs and FBOs to have the MHFA trainings
2. Identify the dates and locations of the trainings

STRATEGY 3: Provide the Mental Health First Aid (MHFA) trainings to the communities that we serve

3. Confirm with our collaborative partners for the lead instructor
4. Order the continental breakfast and lunch for all the participants
5. Train at least 10 participants per session
6. Follow-up with each participant after training completed

ANTICIPATED IMPACT/OBJECTIVES:

I. Short term objective (Process Objective): By the end of 2019, there will be at least 2 MHFA (Youth and/or Adult) trainings in the communities that we serve.

II. Medium term objective (Impact Objective): By 2020, 50% of the participants will have made a referral for someone to a mental health resource.

III. Long term objective (Outcome Objective): By 2022, there will be a reduction in the number of poor mental health days reported by the communities that we serve.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #2)

STRATEGY:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2030" (or OTHER NATIONAL PLAN):
AMITA Health Community Resource Directory	In our CHNA, the community identified the top two things needed for a healthy community: access to health care and mental health services as well as access to community services.		HP 2030: Overarching Goals: Promote healthy development, healthy behaviors and well-being across all life stages. Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all. ECBP-2030-D06: Increase the number of community-based organizations providing population-based primary prevention services. HP 2020: Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all.
Flu/FOBT	In our CHNA, colorectal incidence is highest in Dunning, Portage Park, and	In IL (2014), there were 65.1% of persons aged 50+ who have ever had a	HP 2030: Overarching Goals: Promote healthy development, healthy behaviors and well-being

	Norwood Park. Colorectal Cancer Deaths are highest in Montclare, Dunning, Norridge, Elmwood Park, and Norwood Park.	sigmoidoscopy or colonoscopy	across all life stages. Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all. C-2030-07: Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines HP 2020: C-18 Increase the proportion of adults who were counseled about cancer screening consistent with current guidelines
Mental Health First Aid (MHFA)	According to the County Health Rankings, residents of Cook County reported 3.6 poor mental health days compared to Illinois that had 3.5 days and nationally at 3.1 days.	In IL, the suicide death rate (2015) is at 10.3% compared to 13.3 nationally. Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. In any given year, an estimated 18.1% (43.6 million) of U.S. adults ages 18 years or older suffered from any mental illness and 4.2% (9.8 million) suffered from a seriously debilitating mental illness. Neuropsychiatric disorders are the leading cause of disability in the United States, accounting for 18.7% of all years of life lost to disability and premature mortality. Suicide is the 10th leading cause of death in the United States, accounting for the deaths of approximately 43,000 Americans in 2014	HP 2030: Overarching Goals: Promote healthy development, healthy behaviors and well-being across all life stages. Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all. MHMD-2030-01: Reduce the suicide rate MHMD-2030-04: Increase the proportion of adults with serious mental issues (SMI) who receive treatment HP 2020: MHMD-9 Increase the proportion of adults with mental health disorders who receive treatment

AMITA Health 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, please contact Mariana Wrzosek at mariana.wrzosek@amitahealth.org.

The delegated authority to approve this Implementation Strategy resides with the AMITA Health/Presence Health Chicago Board, comprised of community and hospital stakeholders. The below date and signature indicate that this plan has been reviewed and adopted for FY2020–2022.

Adopted by the AMITA Health/Presence Health Chicago Board

10.24.2019

Date Adopted

Plan Prepared By:

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