Presence℠
Holy Family Medical Center

Presence Holy Family Medical Center
Community Health Needs Assessment (CHNA)
Implementation Strategy
2015

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Provena Health and Resurrection Health Care merged on November 1, 2011 to form a new health system, Presence Health, creating a comprehensive family of not-for-profit health care services and the single largest Catholic health system in Illinois. Presence Health embodies the act of being present in every moment we share with those we serve and is the cornerstone of a patient, resident and family-centered care environment. “Presence” Health embodies the way we choose to be present in our communities, as well as with one another and those we serve.

Presence Health is sponsored by five congregations of Catholic religious women: the Franciscan Sisters of the Sacred Heart, the Servants of the Holy Heart of Mary, the Sisters of the Holy Family of Nazareth, Sisters of Mercy of the Americas and the Sisters of the Resurrection.

Our Mission guides all of our work: 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.

Building on the faith and heritage of our founding religious congregations, we commit ourselves to these values that flow from our mission and our identity as a Catholic health care ministry:

- **H**onesty: The value of Honesty instills in us the courage to always speak the truth, to act in ways consistent with our Mission and Values and to choose to do the right thing.
- **O**neness: The value of Oneness inspires us to recognize that we are interdependent, interrelated and interconnected with each other and all those we are called to serve.
- **P**eople: The value of People encourages us to honor the diversity and dignity of each individual as a person created and loved by God, bestowed with unique and personal gifts and blessings, and an inherently sacred and valuable member of the community.
- **E**xcellence: The value of Excellence empowers us to always strive for exceptional performance as we work individually and collectively to best serve those in need.

Presence Holy Family Medical Center (PHFMC) has been meeting the health needs of Des Plaines residents for over 50 years. Founded by the Sisters of the Holy Family of Nazareth, PHFMC continues to carry out its mission of providing “compassionate, holistic care with a spirit of healing and hope in the communities” it serves.

PHFMC was founded in 1961 and is Illinois' only faith-based specialty hospital caring for medically-complex patients, and the only such hospital in the entire northwest Chicagoland area. PHFMC provides care for patients who are critically ill and require more intensive care. A majority of PHFMC’s patients are transferred from critical care units at other hospitals. PHFMC is located in Des Plaines, IL and has 10 nursing and rehabilitation centers with 1,786 beds and four retirement communities with 1,183 beds.

This report summarizes the plans for PHFMC to sustain and develop new community benefit programs that 1) address prioritized needs from the 2012 Community Health Needs Assessment (CHNA) conducted by PFHMC and community partners and 2) respond to other identified community health needs.

The PHFMC service area covered in this report is the community area of Des Plaines, Illinois. Des Plaines is a city located in Cook County and a suburb of Chicago. Northern portions of Des Plaines are part of the 60016 zip code and southern Des Plaines is in the 60018 zip code.

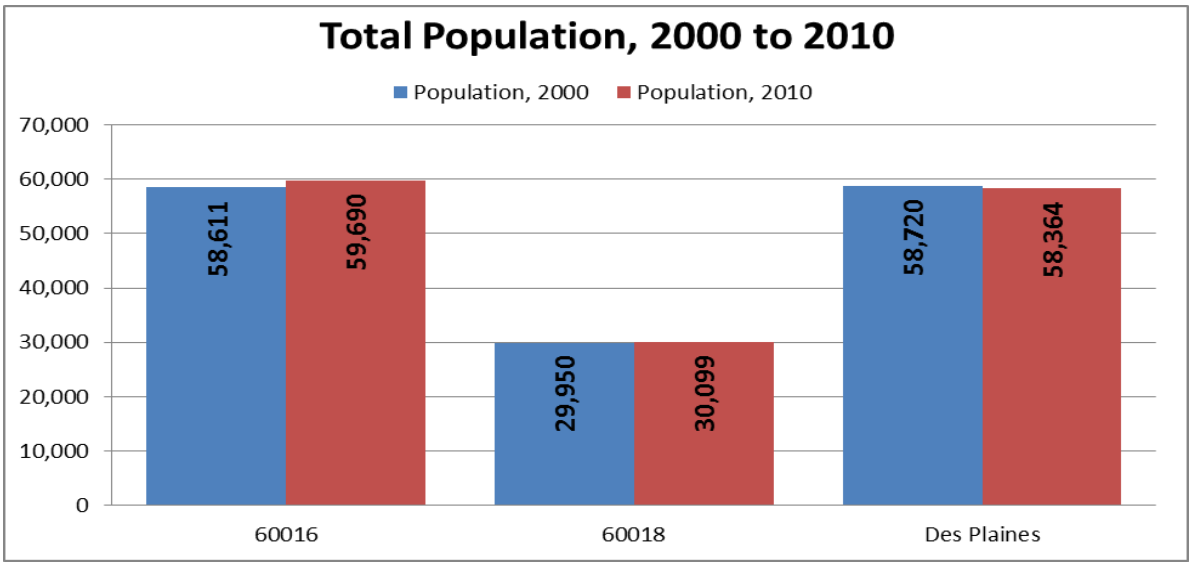
Demographics

In the past ten years, the population of Des Plaines decreased just slightly (0.6%), though much less than Chicago (7.0%), while in contrast the Illinois and U.S. populations saw increases of 3% and 10%, respectively. Within Des Plaines, about twice as many people live in the 60016 zip code (59,690) than in the 60018 zip code (30,099). Roughly a quarter of the population is under 20 years of age in Des Plaines and in the two zip codes, percentages that are similar to those for Cook County, Chicago, Illinois and the U.S. Seventeen percent (17%) of Des Plaines residents are over 65 years of age, a slightly higher percentage than is seen in the Chicago, Cook County, Illinois and the U.S. which range from 10% to 13%.

Whites are by far the majority population in Des Plaines although that proportion decreased from just over 80% to slightly under that 8 in 10 mark from 2000 to 2010. An increasing number of residents are Asian and Hispanic/Latino. The zip code 60016 has an increasing Asian population, while the zip code 60018 has an increasing Hispanic/Latino population. Spanish is the top language spoken by those with limited English, followed by Polish. Roughly 4.3% of students in Des Plaines have limited English skills, about half the percentage of Illinois students overall and about a quarter of the percentage for Chicago students.

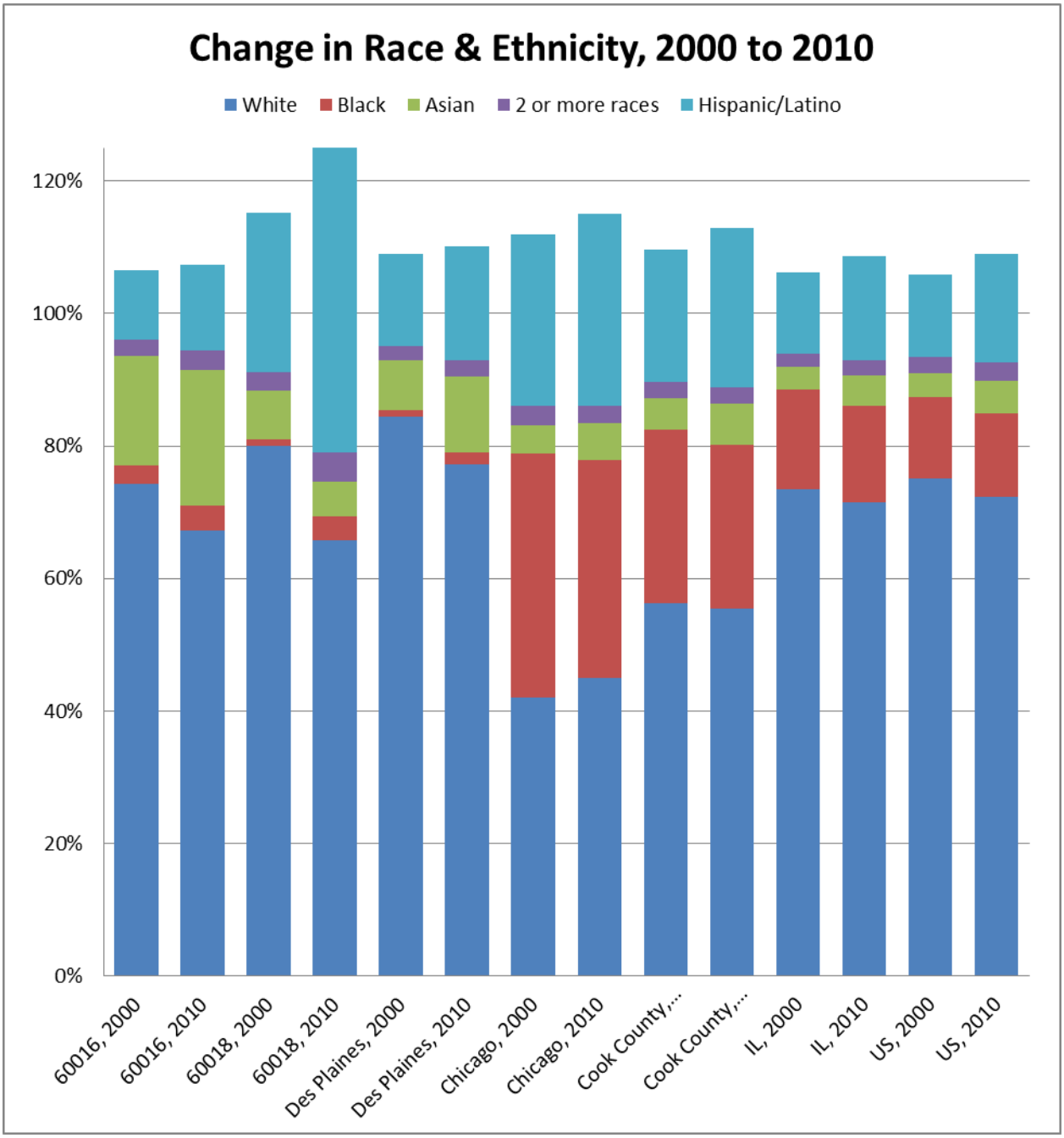
Population

The total population of zip codes 60016 and 60018 in 2010 was 89,789 – this population includes both the city of Des Plaines and unincorporated Maine Township. The total population of the city of Des Plaines was 58,364 in 2010. Between 2000 and 2010, zip code 60016 increased in population by 2% and 60018 had an increase of 0.5%. The population in the city of Des Plaines decreased just slightly (0.6%).



Ethnicity

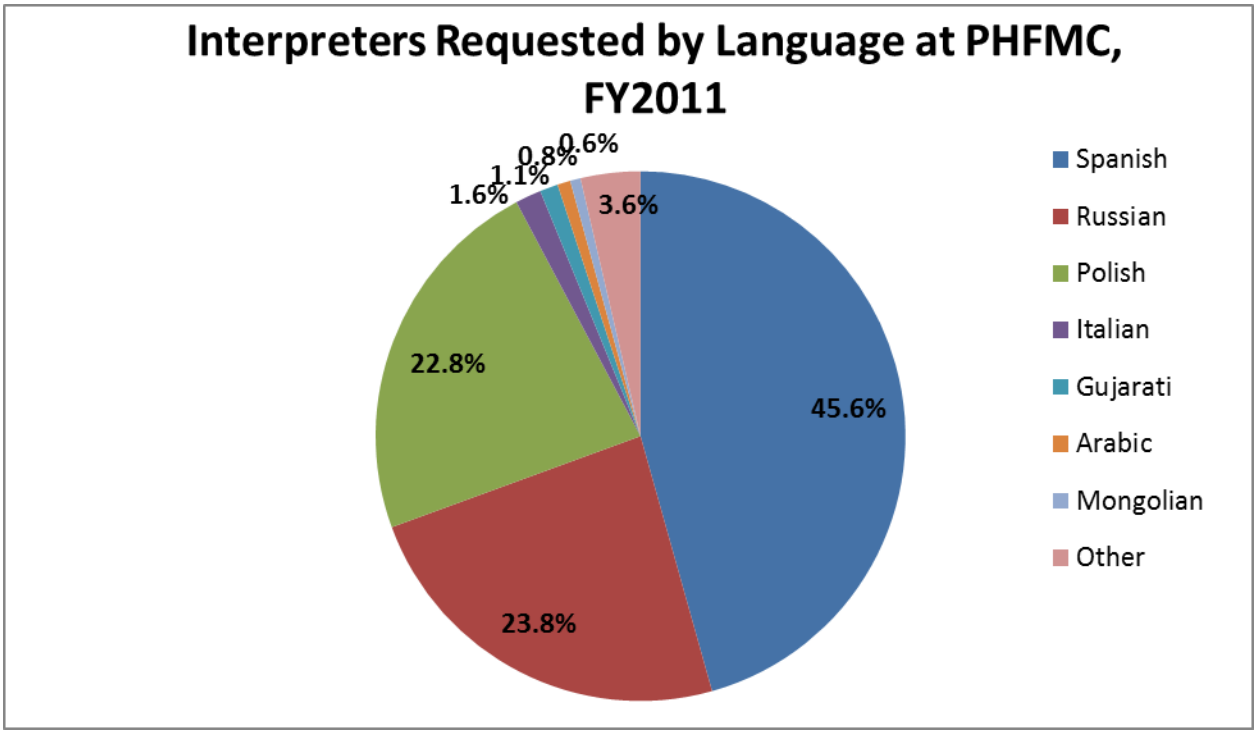
Between 2000 and 2010, the proportion of Whites in Des Plaines decreased from 84% to 77% while the percentage of Hispanic/Latinos and Asians increased. The increase of Hispanic/Latino residents was greater in southern Des Plaines (60018) with an increase from 24% in 2000 to 34% in 2010. The Asian population is higher in northern Des Plaines (60016) at 20% in 2010. The population of White residents decreased between 2000 and 2010 in both zip codes.



Language Spoken

In Des Plaines, the top language spoken by those with limited English was Spanish (14%), followed by Polish. The top languages in the 'other' category in Des Plaines include German, Italian, Korean, Slavic languages and Hindi.

Interpreters were requested for 20 different languages at PHFMC in 2011. Spanish, Russian and Polish made up over 90% of the requests. Russian interpreters were requested 150 times, making up 23.8% of the 654 total requests. This is significant to note because Russian is not reflected in the top languages spoken in Des Plaines, with only 159 residents that answered Russian to be their predominant non-English language.



Income

The median household income in Des Plaines is about $8,000 higher than the median household income of Illinois. Des Plaines residents, on average, also have a higher income than the U.S. overall. Des Plaines is similar to the median household income of greater Cook County ($60,489). The poverty rate of Des Plaines, 6.2%, is roughly half the Illinois poverty rate.

The percentage of children living in poverty in Des Plaines is lower than the percentage for Chicago by a factor of three, seven percentage points below that for Illinois, and nine points below the U.S. percentage. The rate is three percentage points below the national CHR benchmark.

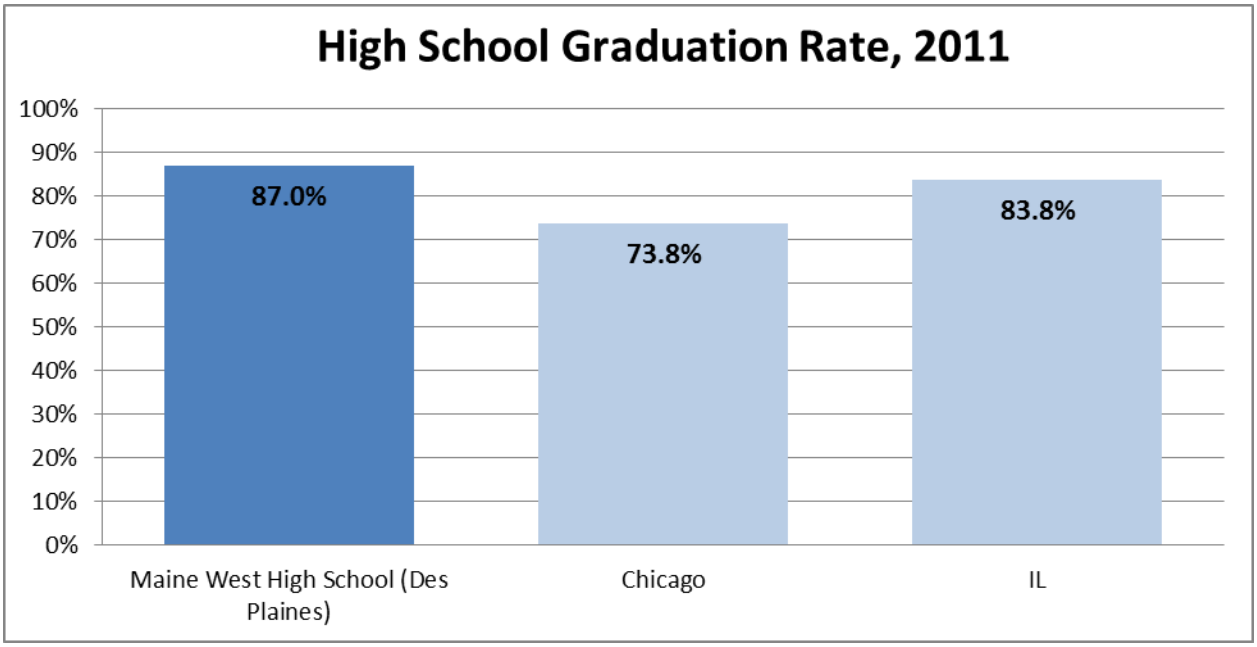
Twenty percent of Des Plaines residents are living at or below 200% of the poverty level compared to 29% in Illinois and 32% in the U.S. In suburban Cook County, the percentage of residents 200% below the poverty line is 23%, slightly higher than the rate in Des Plaines

The unemployment rate in Des Plaines (6.4%) is lower than Chicago (11.1%), suburban Cook County (7.9%), state (8.6%) and national (7.9%) averages.

Education

The high school graduation rate at Maine West High School (87%) was 13% higher than the city of Chicago and 3% higher than the Illinois rate. It is important to note that Maine West High School serves most of Des Plaines and a portion of Rosemont.

In Des Plaines, 12.7% of residents over 25 do not have a high school degree. This rate was similar to the overall Illinois rate but 2.3% lower than U.S. rate and 8% below the Chicago rate.



The percentage of uninsured residents in Des Plaines is the same as that for Illinois (13.1%), about four points lower than the Cook County rate and two points lower than the U.S. rate. The current percentage in Des Plaines is higher than the CHR benchmark of 11%.

The two zip codes in the service area have a lower percentage of residents enrolled in Medicaid than Cook County. Southern Des Plaines (60018) has a 5% higher proportion enrolled in Medicaid than northern Des Plaines (60016).

Process Used to Identify Community Needs

The Affordable Care Act (ACA) requires all tax-exempt hospitals to complete a community health needs assessment (CHNA) and develop an implementation strategy every three years. Presence Health viewed this mandate not only as a legislative requirement, but as an opportunity to bring community partners together to engage in effective dialogue and solutions to improve the health of the communities we serve. Limited resources are a common problem across many communities, including those served by Presence Health. By taking a community approach to both the assessment and implementation strategies, the goal is to ensure the data, processes and outputs add value to all community partners rather than just the hospital.

In July 2012, Presence Holy Family Medical Center (PHFMC) coordinated a broad array of community stakeholders from the community areas of Des Plaines and unincorporated Maine Township to form a CHNA Steering Committee. This committee's role was to provide oversight and input into the CHNA process, as well as to identify data-driven community priorities so as to engage in community solutions through partnerships and collaborations.

The CHNA Steering Committee developed the following mission, vision, and values to guide their work and interactions throughout the process and beyond.

CHNA Community
(includes Des Plaines)

MISSION

Through embracing cultural and linguistic diversity, collaboration and community participation, the CHNA Steering Committee will assist in conducting a community health assessment, with the purpose of identifying priority issues, creating and implementing action plans to improve and evaluate the health of the people of the community based on identified community need.

VISION

An engaged community that maximizes the use of diverse partnerships and collaboration among all sectors improving community health from a holistic standpoint including; wellness, quality of life and health equity.

VALUES

Respect: Every life has value. We respect each other and the diverse community we are members of by acting with dignity, fairness and compassion.

Health Equity: We believe all individuals should have the opportunity to realize their full potential and to achieve the highest quality of life.

Transparency and Communication: We believe in open and honest dialogue and the sharing of the data, materials and plans. We believe in an interactive and engaged process with the community.

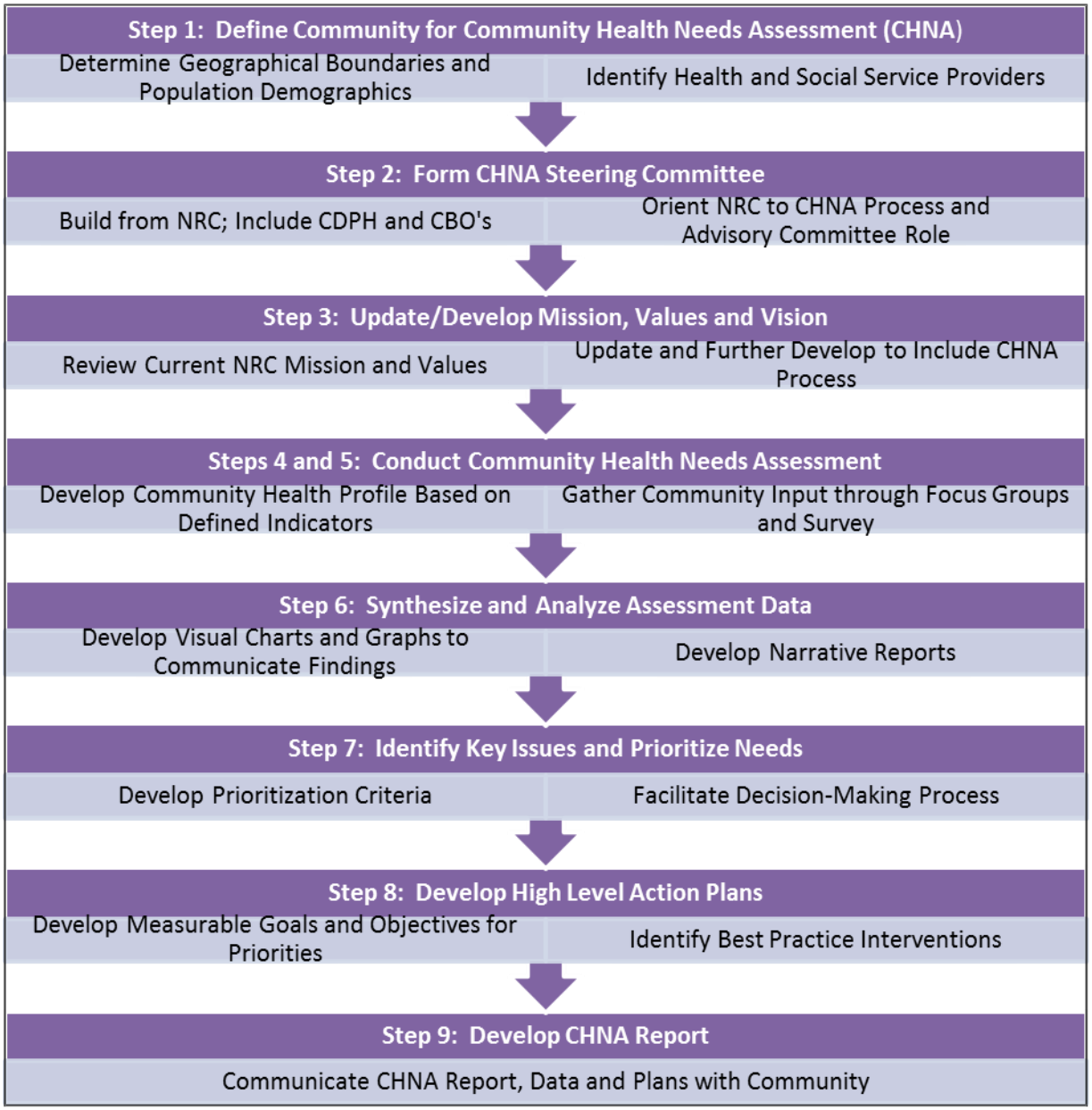
Commitment: We believe we are accountable to the community we serve.

Quality: We believe in continuous improvement and innovation.

Collaboration: We believe in partnerships and linking people together for the common good of our community. We believe in using our human and economic resources wisely to engage the community to improve the overall health.

The CHNA Steering Committee followed a 9-step process that involved the following: Identifying the community and its geographic boundaries; Forming a steering committee; Adopting a mission, vision and values; Analyzing secondary data (the focus of this report); Gathering community input, Identifying key issues; Developing high-level action plans and communicating results with the community.

It should be noted that the steps in the process are not purely sequential—many occurred simultaneously, as its implementation continuously informed and enhanced the process. Below is a visual of the process.



Community Health Profile

The Community Health Profile is a compilation of secondary data (data already published and available) about a particular community. The profile provides comparative information to assist in understanding the needs and priorities of a community. The Community Health Profile for PHFMC analyzed over 50 indicators. Example indicators include: population trends, race, income, poverty levels, and percentage of uninsured, health professional shortages, leading causes of death, teen births, birth weights, tobacco use, physical activity, crime rates, and food insecurity. Findings of the Community Health Profile include:

- Caucasians make up the majority population in Des Plaines, although that proportion decreased from 2000 to 2010. An increasing number of residents are Asian (in 60016) and Hispanic/Latino (in 60018).
- About 5% of students in Des Plaines have limited English-speaking skills. Spanish is the predominant non-English language spoken.
- Over 6% of all Des Plaines residents and over 10% of Des Plaines children are living in poverty. One in five Des Plaines residents lives below 200% of the federal poverty level.
- From 2000 to 2010, the unemployment rate more than doubled in Des Plaines, from 2.5 to 6.4%.
- 13% of residents are uninsured. A higher percentage of the 60018 population is enrolled in Medicaid (22%) than the 60016 population (17%).
- There were 654 total requests for interpreters at HFMC in 2011. Spanish, Russian, and Polish made up over 90% of the total language requests.
- Heart disease and cancer are the leading age-adjusted causes of mortality across the service area. Diabetes, lung cancer, and stroke are also leading causes of death.
- Des Plaines experienced a reduction in the average number of new cases of tuberculosis from 2000 to 2010 (from 15.3 to 14.1), but the 2010 rate is still four times higher than the average for suburban Cook county.
- Among PHFMC service area residents, 17.5% are considered at risk for binge drinking. One in ten residents is a current smoker.
- In some areas of Des Plaines, there are limited options for purchasing healthy food. This is especially true in the southwest area of Des Plaines, which is considered a food desert by the United States Department of Agriculture. About 14.5% of residents experience food insecurity.
- Des Plaines residents spend about a quarter of their income on housing and transportation costs.

CHNA Community Input Report

The community input process was completed between August and October 2012. The process included creating and administering a community input survey in Spanish, Polish and Russian as well as English, facilitating three focus groups, and completing an asset and resources inventory. The community survey explored residents' perceptions of issues surrounding quality of life, health, and social factors and collected respondents' demographics including insurance coverage. Seven hundred seventy-seven (777) community residents completed the survey. The findings of the Community Input Report include information on the following page.

Among community survey respondents, when asked what quality of life factors were not present in the community, the following top issues were identified:

- Good jobs
- Good and available daycare and before/after-school programs
- Affordable housing

According to survey respondents, the top five most problematic health issues in this community are:

- Obesity
- Diabetes
- High blood pressure, heart disease, and stroke
- Physical inactivity (lack of exercise)
- Senior issues

Results of the 2013 Needs Assessment

The following themes surfaced across all data collection methods and were prioritized by the CHNA Steering Committee:

- Access to Primary Care
- Chronic Disease Prevention and Management
- Food Access, Nutrition, and Education
- Mental Health, Substance Abuse & Gambling

PHFMC's review of current community benefit programs found that the hospital is meeting existing community needs through the New Beginnings program which offers prenatal care to uninsured women in the community, the Let's Move Our Number Program which provides community education and screening programs on a variety of health and wellness topics in the community and Senior Health Workshops offered at the Frisbie Senior Center.

PHFMC recognizes that priority setting is a critically important step in the community benefit planning process. Decisions around priorities have a pivotal impact upon the effectiveness and sustainability of the endeavor. PHFMC worked with the CHNA Steering Committee to identify priority issues for the county.

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Methodology and Prioritization Criteria

The CHNA Steering Committee generated a list of their identified cross-cutting themes and community issues based on their review of the PHFMC Health Profile, Community Input Report, and Community Assets. Nominal group technique methodology was first employed to generate this preliminary list (below). This method is used in the early phases of prioritization when there exists a need to generate many ideas in a short amount of time, and when input from multiple individuals must be taken into consideration. Prioritization criteria included consideration of: impact of problem, availability of resources to solve problem, size of program, feasibility of interventions, ease of implementation, impact on systems or health, urgency of solving the problem, availability of solutions, and potential negative consequences for not addressing.

Cross-cutting Themes and Issues Identified

- Access, cost and lack of adequate insurance coverage as barriers to receiving health care, particularly primary care and preventive services
- Safety and violence, including gangs
- Poverty; need for good jobs and affordable housing
- Mental health
- Substance abuse
- Health literacy, patient education, awareness of resources
- Transportation
- Chronic diseases – prevention and management
- Obesity, heart disease, diabetes – education, access to care, affordability of healthy foods and recreational facilities
- Limited after-school programs that are affordable
- Services for seniors

Identified Prioritized Needs

Due to the length of the list generated, Multi-voting Technique methodology was employed to narrow down the list to pinpoint the top priorities. This process involved multiple rounds of democratic voting wherein the list was condensed after each round based on the percentage of total votes per item. An advantage of Multi-voting is that the process allows a health problem which may not be a top priority for any individual but is favored by all, to rise to the top. In contrast, a straight voting technique would mask the popularity of this type of health problem making it more difficult to reach a consensus. Voting was repeated until the list was narrowed to four identified prioritized community needs.

The following four community needs were prioritized:

1. Access to Primary Care
2. Chronic Disease Prevention and Management
3. Food Access, Nutrition, and Education
4. Mental Health, Substance Abuse & Gambling

As PHFMC, the CHNA Steering Committee, and other community partners move into action planning and implementation to address CHNA priorities, further data collection is recommended to understand the particular needs and barriers to health for vulnerable and underserved populations in the communities served by PHFMC. Gathering further community input will help PHFMC and its partners better understand community-specific needs, barriers and assets in order to effectively address these specific priority issues and improve community health across the CHNA service area.

PHFMC's Implementation Strategy was developed based on the findings and priorities established by the 2013 CHNA and a review of the hospital's existing community benefit activities.

After the health issues were identified in the assessment, PHFMC leadership identified internal resources to serve on the appropriate CHNA Action Teams. After considering staff resources and expertise, staff was matched with the most appropriate objectives, goals and strategies under each health issue within the community. The action teams were assigned to work collaboratively toward implementation of the objectives, goals and strategies under the health issues that PHFMC was best equipped to address.

CHNA Action Teams were designated for each prioritized health need, and were initially comprised of a co-chair member from the CHNA Steering Committee as well as a PHFMC expert or champion of that particular specialty area. The two co-chairs then identified community partners and members to serve on the action team to foster a collaborative spirit consistent with the guiding mission, vision and values. Co-chairs of each of the action teams also committed to continued membership on the CHNA Steering Committee.

The CHNA Steering Committee will continue to meet to provide oversight and communication between the Action Teams throughout the three year period of the planning and implementation process.

The PHFMC Senior Leadership Team and the Governing Board have a strong commitment to community health initiatives. Community initiatives and activities have ongoing monitoring and evaluation for program effectiveness. The following programs are existing community benefit programs PHFMC sponsors in the community. PHFMC will work with the Presence Health Community Health Strategy Department to enhance the existing programs by developing metrics to measure improvements in the overall health of program participants. PHFMC will also see how these existing programs can tie into the overall goals of the CHNA Action Teams.

NEW BEGINNINGS

Program Description

New Beginnings is a program that offers pre-natal and educational support for young, uninsured women with limited access to care. Each woman who participates is offered education, counseling and emotional support, as well as:

- Bilingual staff
- Initial exam and routine office visits
- Lab tests/ultrasounds
- Nutrition counseling
- Childbirth, infant care, parenting and breastfeeding classes
- Assistance in filing Medicaid/All kids forms for the underinsured and uninsured
- For those who qualify - free infant car seat

Labor, delivery and postpartum care take place in The Family Birthplace at Resurrection Medical Center with expert care, modern delivery capabilities and pleasant, comfortable birthing suites.

LET'S MOVE OUR NUMBERS

Program Description

The Let's Move Our Numbers program provides community education and screening programs on a variety of health and wellness topics both in the community and main hospital location. Components of the program include: blood pressure, blood glucose, blood lipid panel, body mass index (BMI) and/or body fat analysis. Health education topics on chronic disease include obesity, hypertension, heart disease, stroke, diabetes, and cancer.

HEALTH WORKSHOPS FOR SENIORS

Program Description

PHFMC partners with the Frisbie Senior Center, Park Ridge Senior Center, and MaineStay to provide education to seniors on a variety of health topics.

FOOD DAY

Program Description
PHFMC is planning to partner with local schools in 2015 to do MyPlate education and provide fresh fruits and vegetables to students.

PHFMC's CHNA Action Teams have developed the following action plans to address the community needs identified in the needs assessment process. PHFMC will facilitate the action teams, but the efforts listed below will be collaborative with the community partners listed in the appendix.

PRODUCEMOBILE

Program Description
PHFMC is planning to partner with the Chicago Food Depository in 2015 as part of the overall goal of improving the health and well-being of the community with a special focus on the needs of the most vulnerable and to have access to fresh fruits and vegetables, to bring the ProduceMobile program to the PHFMC facility and distribute food to all individuals who express need.

The ProduceMobile distributions are a quick, efficient means for distributing perishable food to needy clients in the community to ensure that all people who are hungry in Cook County have access to fresh fruits and vegetables. The ProduceMobile will alternate sites between Presence Holy Family and Presence Resurrection one day per month for at least two (4) hours (distribution day and time to be determined mutually by GCFD, PRMC, and PHFMC alternating sites every other month). There will be no eligibility requirements for clients besides name and zip code (if possible) and signature for each household.

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FOOD ACCESS CHNA ACTION TEAM

PHFMC's Food Access CHNA Action Team has developed the following action plan to address this issue.

Community Need: Access to affordable/accessible fruits and vegetables for the target community.

Aim Statement: Presence Health and its community partners seek to implement a community-based program to reduce stigma and improve the coordination of mental health care throughout a six county area.

2014 Objectives	2014 Strategies	2014 Progress	Ministry Role	Community Partner Role	Measureable Outcomes
By December 31, 2013, research and identify a viable system-wide strategy to address mental health stigma and improve coordination of care & resources.	• Create a system-wide mental health action team to provide clinical direction and oversight. • Include local mental health teams in system strategy. • Review extant literature and evidence-based practices for community programs. • Create a community inventory of existing resources for six county areas of mental health services and resources.	• System mental health action team was created with local and system representatives; chaired by VP of behavioral health and Director of Community Health Strategy; team meets quarterly. • Sub-committee created to research and report on evidence-based strategies. • Mental Health First Aid identified as a low cost prevention strategy. • Community behavioral health inventories completed.	• Presence Health system and local employees serve on the mental health action teams. Presence Health team members researched evidence-based practices and presented to larger action team for review and approval. Community behavioral health inventories were compiled.	• Numerous community-based agencies participate on the local mental health action teams. • Members of these teams were solicited for their knowledge and expertise in identifying and providing information on community mental health resources for compiling into the inventories.	• MHFA was identified as a viable, low-cost, evidence-based prevention strategy for reducing community stigma. • To address the coordination of care and resources component, community behavioral health inventories were compiled with the intent of widespread dissemination in partnership with the Mental Health First Aid program. • By December 31, 2013, approval was obtained by

					local and system leadership for the implementation of the Mental Health First Aid program.

CHRONIC DISEASE CHNA ACTION TEAM

PHFMC's Chronic Disease CHNA Action Team has developed the following action plan to address this issue.

Community Need: Prevention of Chronic Disease.

Aim Statement: To increase education and motivation about prevention and management of common risk factors for chronic diseases and to expand access or primary care coverage for persons living in Des Plaines (60016 and 60018).

2014 Objectives	2014 Strategies	2014 Progress	Ministry Role	Community Partner Role	Measureable Outcomes
• Motivate and educate residents about the risk factors of obesity, Type 2 Diabetes, Heart Disease, and cancer – specifically, physical inactivity, poor nutrition, hypertension, and age-related complications – in order to reduce their risk for chronic disease states. • Address healthy eating and physical activity as they have an impact on both obesity and diabetes and other chronic diseases. • Increase	• Increase awareness of options for physical activity within the local community. • Expand access of primary care coverage. • Educate and inform of smoking cessation and provide smoker cessation support to smokers who want to quit. • Increase physical activity of residents in the local community. • Increase awareness of options for healthier nutritional choices within the local community. • Improve the nutrition of residents in the local community. • Educate local residents	• Educating parents and children about the benefits of healthy eating and physical activity. • Offer clinical screening and education in the community. • Produce exhibits that show the negative effects of chronic disease states. • Utilize community organizations to promote specific campaigns related to chronic disease states. • Work with local businesses to promote healthy choices - food and physical activity. • Promote opportunities for physical activity within the community. • Promote self-monitoring	• Assist in securing and provide resources as needed to the Action Teams for integration within community-wide health improvement plans for Des Plaines. • Build upon community assets and/or re-focus on existing programs to meet prioritized health needs within chronic disease.	• Chronic Disease CHNA Action Team.	• Track number of patients with primary care physicians. • Tracking for referrals to smoking cessation counseling, assistance, or support. • Track attendees at clinical screenings. • Track attendees at community health education events and programs. • Track participants in fitness and exercise programming.

awareness of early detection and prevention.	on the importance of maintaining appropriate blood pressure readings. • Increase awareness of educational opportunities and support networks available within the local community. • Improve access to places that support physical activity, healthy eating, and routine medical monitoring. • Reduce barriers.	of BMI and blood pressure for residents within the community.			

ACCESS TO PRIMARY CARE CHNA ACTION TEAM

PHFMC's Access to Primary Care CHNA Action Team has developed the following action plan to address this issue.

Community Need: Access to High Quality Primary Care Services

Aim Statement: To increase and distribute current information on access to appropriate healthcare.

2014 Objectives	2014 Strategies	2014 Progress	Ministry Role	Community Partner Role	Measureable Outcomes
• Decrease unnecessary ER visits. • Make public transportation information more accessible and in a format more easily read for patients to access healthcare facilities within Des Plaines community. • Patients will have increased access to high quality primary care, • Increase aware of clinical services.	• Consult and obtain feedback from the DPFD on how to best inform residents about alternative methods of urgent treatment. • Have Provider Relations from PHFC to follow-up with community sites (ie. Salvation Army) to provide additional information of services available. • Utilize ICC for more urgent non-emergency visits. • Provide list of identified and typical "non-emergency" illnesses within the community and how best to utilize the proper access to healthcare. • Identify and provide	• Consult and obtain feedback from DPFD on how to inform residents about alternative methods of urgent treatment. • Access Genesis to educate patients on resources and additional healthcare (i.e. New Beginnings) within the community. • Obtain educational material from the ACS/Walgreen/Walmart to distribute to PCP offices of free support for cancer patients. • Create a "navigation course" on public transportation available within Des Plaines. • Work with Pace, Metra, and other transportation providers to identify	• Assist in securing and provide resources as needed to the Action Teams for integration within community-wide health improvement plans for Des Plaines. • Build upon community assets and/or re-focus on existing programs to meet prioritized health needs in regards to access to primary care. • Build upon relationship between Provider Relations and the Salvation Army and other	• Access to Primary Care CHNA Action Team	• Track expansion of bus routes within the community. • Track increase use of Care Van services available at PHFMC. • Track request for replenishment of health education materials at Walgreens/Walmart/ACS. • Track increase of request for transportation resources at PACE and Metra train services.

	listings of ICC resources within PCP offices for non-emergent and appropriate access to healthcare. • Identify bus and train routes within city of Des Plaines for easier access to healthcare facilities. • Reduce barriers to health insurance enrollment and increase health care coverage for underinsured.	routes, hours of operation, etc. • Distribute available transportation resources and information to identified community sites and PCP offices.	community partners to provide information of services available at HFMC.		

MENTAL HEALTH, SUBSTANCE ABUSE AND GAMBLING CHNA ACTION TEAM

PHFMC's Mental Health, Substance Abuse and Gambling CHNA Action Team has developed the following action plan to address this issue.

Community Need: Mental Health, Substance Abuse and Gambling

Aim Statement: To increase affordable mental health/addiction services and to enhance access for inpatient and outpatient services to the Des Plaines community. The target population will have adequate information and access to mental health and addiction services to meet their needs in a reasonable time frame.

2014 Objectives	2014 Strategies	2014 Progress	Ministry Role	Community Partner Role	Measureable Outcomes
• Connect links to all available services from City of Des Plaines Website to create a one stop-shop of mental health resources within community. • Educate Des Plaines community on Mental Health & Addiction Issues available resources in community • Provide additional resources to community of Des Plaines.	• Coordinate City of Des Plaines Service Organizations and website to include Maine Township • Mental Health Mobile Clinic (staffed with psychiatrist and case workers) which can dispense medications and triage needs & possible in-home assessments • Education of current services available • Outpatient clinic with on-site psychiatrist (Scott Nolan Center) for mental health/addiction services. Adult and adolescent psychiatrists to support Maine Center Inc. patient demands.	• Utilize community organizations to promote specific resources to educate community of services • Design and create comprehensive resource booklet and website of services related to mental health and substance abuse within community. • Mental Health Service Information provided at upcoming events. • Free seminars within Des Plaines on the ACA. • Utilize Des Plaines Cable Channel & Calendar to include PSAs by Medical Director - Keys to Recovery.	• Assist in securing resources to Action Teams for integration within community-wide plans for Des Plaines. • Build upon community assets and/or re-focus on existing programs to meet prioritized needs for mental health and substance abuse. • Secure grant monies to support psychiatrist salary and mobile van.	• Mental Health, Substance Abuse, and Gambling CHNA Action Team	• Increase capacity for mental health & substance abuse health services. Track hours of access and number of patients served. • Track attendees to support groups. • Track number of calls for referrals to mental health resources and facilities within community. • Track number of support sessions, attendees, and referrals.

MENTAL HEALTH FIRST AID (MHFA)

Program Description

In response to a demonstrated system and state-wide need of addressing barriers to accessing and utilizing mental health services, Presence Health and its community partners implemented an evidence-based program, Mental Health First Aid (MHFA), to reduce the stigma associated with mental illness and improve the coordination of mental health care throughout a six county service area. A system-wide action team was created to oversee the process, with administrative, local and behavioral health representatives that earned support from applicable Senior and Executive leadership teams. Community stakeholders partnered in the development of the strategy and its implementation throughout the process, recruiting trainees, identifying resources, and disseminating findings. Program participants increased recognition of mental health disorders, increased understanding of appropriate treatments, improved confidence in providing help to others during crisis situations, and decreased stigmatizing attitudes. Having demonstrated its effectiveness, the program continues to expand and add both participants and partners.

Community Need: Mental Health: Addressing Barriers to Care

Aim Statement: Presence Health and its community partners seek to implement a community-based program to reduce stigma and improve the coordination of mental health care throughout a six county area.

2014 Objectives	2014 Strategies	2014 Progress	Ministry Role	Community Partner Role	Measureable Outcomes
By December 31, 2013, research and identify a viable system-wide strategy to address mental health stigma and improve coordination of care & resources.	• Create a system-wide mental health action team to provide clinical direction and oversight. • Include local mental health teams in system strategy. • Review extant literature and evidence-based practices for community programs. • Create a community inventory of existing resources for six county areas of mental health	• System mental health action team was created with local and system representatives; chaired by VP of behavioral health and Director of Community Health Strategy; team meets quarterly. • Sub-committee created to research and report on evidence-based strategies. • Mental Health First Aid identified as a low cost	• Presence Health system and local employees serve on the mental health action teams. Presence Health team members researched evidence-based practices and presented to larger action team for review and approval.	• Numerous community-based agencies participate on the local mental health action teams. • Members of these teams were solicited for their knowledge and expertise in identifying and providing information on community mental	• MHFA was identified as a viable, low-cost, evidence-based prevention strategy for reducing community stigma. • To address the coordination of care and resources component, community behavioral health inventories were

	services and resources.	prevention strategy. • Community behavioral health inventories completed.	Community behavioral health inventories were compiled.	health resources for compiling into the inventories.	compiled with the intent of widespread dissemination in partnership with the Mental Health First Aid program. • By December 31, 2013, approval was obtained by local and system leadership for the implementation of the Mental Health First Aid program.
By April 30, 2014, initiate pilot implementation of Mental Health First Aid.	• Identify community partner trained to administer Mental Health First Aid and solidify legal agreement. • Synthesize community inventories into indexed resource guides for ease of use. • Create evaluation plan, including measurement tools. • Schedule two pilot Mental Health First Aid programs, one rural and one urban. • Initiate system communication plan.	• Community Counseling Centers of Chicago (C4) identified as partner to administer trainings. • MOU drafted and signed by Presence Health and C4. • Community inventories were indexed with the inclusion of payer mix/cost, populations served, and how to access. • Evaluation plan drafted, including pre- and post-measures, 3 month interview/focus group, and 6 month survey follow-up.	• Presence Health Community Health Strategy division initiated contract with C4 and assumed program budget. • This division also initiated the system communication plan with Executive Leadership Team and engaged communication departments for internal and external news	• Community Counseling Centers of Chicago (C4) administered the Mental Health First Aid program. • Local action team members and community agencies identified local leaders and interested parties to participate in the training (up to 30 per program pilot site). • Identified community	• By April 30, 2014, two successful pilot Mental Health First Aid programs were implemented in Kankakee and north-west side Chicago sites. 44 attendees attended the program.

		• Kankakee and north-west side Chicago markets identified as pilot sites. • Local leaders and community members for each site identified trainees (30 per program) in late February, early March 2014. • Internal and external communication of program (Today Counts, PNN, Press Releases, social media) took place late April 2014.	briefings. • Behavioral Health division provided in-kind support of the Crisis Line for program participants to disseminate and utilize themselves post-mental health first aiding.	members included representatives from: community-based agencies, ministers, educators, non-profit representatives (food pantry, teen drug and alcohol prevention services), chaplains, food service workers, youth outreach workers, nurses, librarians, public health practitioners, and parish nurses. • All trainees received and disseminated resource guides.	
By July, 2014, evaluate the viability of the identified mental health strategy for system-wide implementation.	• Leverage system expertise to evaluate the Mental Health First Aid program. • Present findings to program sponsor and leadership to determine approval level for system-wide implementation.	• Pre and Post Personal and Perceived Stigma Scales were entered into program database in addition to demographic data and overall knowledge, attitudes and skills questionnaires. • Data were analyzed	• Presence Health evaluated the program using a trained analyst in program evaluation.	• C4 provided in-kind support for the review of findings. • University of Illinois at Chicago provided a public health intern to assist with the evaluation	• Program findings were highly favorable; participants significantly decreased personal stigma associated with mental illness ($p < .05$).

		using repeat measures analysis of variance, with a significance level set at $p < .05$. • Program analyses were presented to system program sponsor and system action team for approval of additional implementation.		process.	• Program participants significant improved their recognition of mental health disorders ($p < .05$), and increased their understanding of various treatments for mental illness. • Mental Health First Aid program was determined a viable system-wide strategy.
By October 2014, roll out system-wide implementation of Mental Health First Aid and obtain 200 total program participants.	• Plan dates and identify locations for future program implementation. • Engage in continuous program evaluation and improvement; evaluate longitudinal program impact through 3 and 6 month evaluation plans. • Provide quarterly reports of program to system leadership and sponsors.	• Locations identified for Fall 2014 implementation. • Elgin and Aurora markets have identified two new coalition partnerships to participate in the training. • C4 continued partnership solidified. • 3 and 6 month program evaluation plans underway.	• Local and system action team members continue to identify community partners and representatives to be program participants. • The Presence Health Community Health Strategy division continues to provide measurement and program evaluation support.	• Local partners and community members continue to disseminate the resource guides and provide feedback on the program. • Past program participants continue to engage in ongoing measurement and feedback to ensure quality improvement and program fidelity. • Additional	• TBD

				resources continue to be provided for the resource guides, which are updated regularly with new information.	

Key Lessons Learned

Mental Health First Aid was a new Presence Health program in 2014 enacted in response to the system-wide identified need of addressing mental health and mental health related stigma. After pilot testing the program, several lessons learned were acknowledged so as to incorporate meaningful change prior to system-wide implementation. Of note, the 8 hour session length made for scheduling difficulties with partners and participants. Therefore, the lead time for planning and coordinating was longer than expected and should be budgeted for at least 8 weeks prior to the target training date. In addition, the long session length was aided by the provision of breakfast and lunch on-site, which is a practice that should be continued. Some of the participants that serve a more clinical or first responder role wanted more in-depth information on crisis management for conditions rather than disease causes; other layperson participants such as librarians and social service providers instead wanted more information on condition identification and ongoing symptom management. Managing these divergent interests led to the idea that perhaps more targeted modules based on profession or personal objective could be created to best tailor the participant intent with the program content. Some of these ideas are currently being explored for feasibility. In addition, offering the training in Spanish would also expand the reach. Finally, the evaluations and follow-up were lengthy, leading to fewer participants completing the evaluations. Providing enough time for completing the evaluations pre- and post-training as well as shortening the overall length of the evaluation are key lessons learned to facilitate obtaining valuable program data.

Action Plan with PHFMC's Involvement in Addressing the Needs

2013 Baseline	2013 Outcome	2014 Target Objective	2014 Measureable Outcomes
No baseline was used in 2013, as the Mental Health strategy was being developed. The objective was to determine which mental health program to implement.	Mental Health First Aid was selected as the strategy to pilot for system-wide implementation.	• By April 30, 2014, initiate pilot implementation of selected strategy. • By July, 2014, evaluate the viability of the identified mental health strategy for system-wide implementation. • By December 2014, roll out Phase I of system-wide implementation of Mental Health First Aid.	• By April 30, 2014, 2 successful pilot Mental Health First Aid programs were implemented in Kankakee and north-west side Chicago sites. 44 attendees attended the program. • Program findings were highly favorable; participants significantly decreased personal stigma associated with mental illness ($p < .05$). • Program participants significant improved their recognition of mental health disorders ($p < .05$), and increased their understanding of various treatments for mental illness. • Mental Health First Aid program was determined a viable system-wide strategy. • At three month follow-up, trainees had increased confidence in their ability to help someone with a mental health problem ($p = .0003$, 95% CI = -1.300 to -0.40). Trainees also improved in their ability to correctly identify mental illnesses based on presented vignettes, particularly in the recognition of schizophrenia.

ENROLLMENT STRATEGY

Program Description

In response to a demonstrated community need of improving affordable access to health care, Presence Health and its community partners engaged in the development of a community-wide enrollment strategy so as to decrease the percentage of Illinois residents without health insurance. A multi-disciplinary Enrollment Steering Committee was convened to oversee the process with support garnered from applicable Senior and Executive leadership teams' support. An over-arching strategy was created in partnership with community stakeholders to guide the 2013-2014 Open Enrollment period. The model boasts a four-pronged approach: 1. Certified Application Counselors, 2. In-Person Counselor Partnerships, 3. Directional Support and Navigation, and 4. Public Outreach and Education.

Community Need: Access to Care

Aim Statement: In conjunction with the implementation of the Affordable Care Act, Presence Health and its community partners seek to decrease the percentage of uninsured Illinois residents by facilitating enrollment into expanded Medicaid or Marketplace insurance plans.

2014 Objectives	2014 Strategies	2014 Progress	Ministry Role	Community Partner Role	Measureable Outcomes
• **Certified Application Counselors:** Leverage hospital-level capacity to assist uninsured community members with Enrollment by October 2013.	• Applied for grant funding through CMS to initiate an Enrollment program; did not receive grant—subsequently opted to proceed anyway. • Contractually registered all 12 Presence Health hospitals as Certified Application Counselor (CAC) Organizations through CMS.	• Legal review of relevant legislation and CAC program; drafting agreement and confidentiality forms, withdrawal policies, and relevant contracts • Identified existing financial counselors and patient access coordinators to fulfill CAC role • 58 CACs went through 20+ hours of federal and state training and certification with Illinois Dept. of Insurance • Patient Access and Financial Counselors (CACs) trained on new ABE system to enroll into Illinois Medicaid • Approximately 10,000 MANG screenings conducted using	• Presence Health served as the lead applicant for CMS grant as well as contracting agency with CMS for CAC contracts at 12 ministry sites. Presence Health also trained internal financial counselors and patient access leaders as CACs by assuming staffing costs to	• Received letters of support from community-based agencies as well as linguistic support services from other local organizations to generate a referral network in each service area. • Existing Medicaid vendor Miramed (also a CAC organization) assisted patients with enrollment process; all uninsured outpatients >$2500 screened for Medicaid post-	• Throughout the Open Enrollment period, 217,000 Illinois residents obtained health insurance through the Marketplace. An additional 287,000 qualified for expanded Medicaid.

	• Trained CACs to enroll consumers in expanded Medicaid and the Marketplace. • Expand existing role of hospital Financial Counselors to increase Medicaid "reach" from in-house to community population.	expanded criteria. • All uninsured bedded patients (Inpatient and Observe.) interviewed at bedside for Medicaid eligibility – averaged 400 in-house patient interviews/week. • Posted all sites on Healthcare.gov for Find Local Help search tool. • Created tracking mechanism for enrollment activities. • Met weekly throughout open enrollment period to report progress and troubleshoot issues.	cover non-productive time.	discharge.	
• **In-Person Counselor Partners**: Generate and create contracted partnerships with local In-Person Counselor grantees to expand capacity for community enrollment.	• Conduct local network analysis of In-Person Counselor (IPC) grant recipients. • Formally partner with IPCs on enrollment strategy. • Create regularly scheduled times at ministry sites for IPC partners to assist community members with enrollment. • Ensure enrollment support provides	• Identified local IPC organizations for partnership. • Vetted list with local CEOs and regional leadership to determine strategic "fit". • Drafted a Site License agreement for local IPC organizations to perform enrollment activities in Presence Health ministry sites. • 10 organizations signed Site License agreement and regular schedules at ministry sites were agreed upon and communicated through various internal and external communication means. • Worked with HR and Employee Health to coordinate logistics of having non-employees serve functional roles in our hospitals. • Bilingual IPC counselors were	• Presence Health provided designated space in high traffic areas of hospital sites for community IPC partners as well as signage and internal/external communication reflecting partnerships.	• Community IPC partners provided enrollment assistance to members of the community at large with respect to cultural and linguistic competence. • Partners included: – PrimeCare – Puerto Rican Cultural Center – Thresholds – Healthcare Alternative Systems (HAS) – Kankakee County Health Department	• Ten IPC organizations formally partnered to provide on-site enrollment education and assistance to more than 7,000 community members. **Due to the complex nature of IPC and CAC contracts with CMS, actual numbers are unable to be

	linguistic and cultural competency.	deployed on site: Spanish, Polish, Ukrainian, Russian languages.		– Will County Health Department – Aunt Martha's Youth Service Center – ACCESS Community Health – American Indian Health Service of Chicago – Enroll America	determined with respect to completed enrollment numbers. Estimate is based on education materials provided and number of individual appointments scheduled.
• **Directional Support and Navigation:** Utilize strategic communication efforts to provide directional support to consumers who are navigating the Health Insurance Marketplace and care options.	• Leverage system resources to best assist consumers in navigating the Marketplace and enrollment options. • Internally engage system "gatekeepers" to organically guide directional support (e.g. INFOline, physicians, employees).	• Created a unique Presence Health Enrollment help phone line (voicemail box with bi-lingual greeting). • Presence Health enrollment email address created and responds directly to inquiries or to make appointments. • Internal INFO line trained to respond to inquiries about enrollment with respect to caller geography; could assist with scheduling appointments. • Developed communication piece for prospective enrollees on key steps to prepare for Enrollment ("Preparing for your Marketplace Appointment"). • Drafted communication piece for Presence Medical Group physicians to communicate to	• Presence Health trained internal employees and support staff on providing directional assistance to community members. • Presence Health assumed the cost of engaging employees in enrollment activities and initiatives during work time, as well as all direct costs related to outreach/ navigational	• All IPC partners listed above were engaged in the creation and approval of all communications. Scheduling of IPCs and availability were set by community partners with respect to time of day analyses conducted of hospital traffic flows. • Educational material from community partners was largely used and tailored according to target population. • www.Healthcare.gov,	• Over 2000 unique calls and emails were fielded specifically by the Enrollment help phone line and email address. • More than 1,000 website hits were made by consumers. • Over 4,000 INFO line callers were provided directional support to enrollment assistance.

		patients "What you need to know about Enrollment." • Created Presence Health website for Enrollment information and navigation: www.presencehealth.org/marketplace. • Rack cards and Enrollment fliers created in conjunction with Marketing division and distributed to all hospitals, outpatient sites, and Medical Group—strategically placed in areas of high traffic and visibility. • Point of service signs created and posted throughout patient registration areas, near the EDs, and other points of high visibility. Marketing and patient access leaders at each ministry facilitated this execution. • Modifications made to uninsured patient statements with Enrollment information. • Scripting developed for uninsured patient registration regarding Enrollment information and resources. • Developed an all staff communication strategy, including screen savers on all employee computers with instructions on how to direct someone to enrollment assistance/education.	support. • Presence assumed responsibility for responding to consumer inquiries through the Enrollment line and email address. • The Enrollment Steering Committee guided strategy of engaging system gatekeepers.	EnrollAmerica and GetCoveredIllinois were extensively referenced and utilized in providing directional support and navigation.	• Over 15,000 uninsured inpatients received the standard scripting developed by patient access leaders regarding Enrollment information and resources. • Over 22,000 staff members were included in communication strategy on navigational assistance for patients and consumers.

• **Public Outreach and Education:** Produce targeted communications to identified uninsured populations on the Health Insurance Marketplace and targeted education events on the benefits provided under the Affordable Care Act.	• Generate targeted enrollment communication strategy that encompasses a wide range of audiences and breadth. • In collaboration with community partners, coordinate a system-wide week of enrollment to generate a final push at the end of the Open Enrollment period.	• Education sessions on the Affordable Care Act and Health Insurance Marketplace held regularly for members of general community. • Communication directly to benefit eligible employees eligible for open enrollment. • Worked in collaboration with Marketing to highlight the program through various outlets. • Direct mailing series sent to current uninsured patients in area (2 drops of approximately 33,000 each). • Fall campaign postcard had information and a link to web-site—targeted uninsured households—sent to approximately 433,000 households. • Statement stuffers sent in all uninsured patient bills. • Social media outreach – Twitter & Facebook used to drive education content. • Hosted and posted enrollment and education events on external partner site: Enroll America. • EverThrive Illinois partnered with ministry sites to provide on-site educational didactic events. • Responded to all external inquiries from the press, including	• Presence Health engaged system level efforts in undertaking public outreach and education on the Health Insurance Marketplace. • Multi-disciplinary efforts stemmed from grants/ government partnerships, community health strategy, patient access, marketing/ communications, and public relations to convey positive messaging. • Presence Health provided funding for outreach and educational events held.	• Enroll America, HealthCare.gov and Get Covered Illinois were invaluable resources in providing consumers with education on the Marketplace and their health insurance options. • Further, EverThrive Illinois was a partner in providing ongoing education to community members. • All 10 of the IPC partnerships also had regularly scheduled educational events that were widely broadcasted.	System Wide Week of Enrollment yielded the following outputs: • 13 community partners • 58 distinct events held • 5 print media stories • 1 WLS ABC Channel 7 Live News Story • 61 INFOline calls • 175 web hits • 34 social media interactions • Over 1,150 community members received information and enrollment assistance

		press releases and news stories. • Held a system-wide Week of Enrollment March 10-14, 2014 in collaboration with community partners.			

Key Lessons Learned

Subsequent to the 2013-2014 Access to Care strategy of enhancing access to affordable health insurance through the Affordable Care Act, Presence Health had a debriefing meeting to discuss lessons learned. While the successes of the program were many, several key areas for improvement were culled. 1) Communication to senior leadership at local sites was delayed and could have been improved in its efficiency. 2) Staff across Presence Health were made aware of enrollment strategies and efforts, although surveyed awareness and engagement was reported to be low. Engaging employees to refer patients, families and community members would significantly improve the reach of the program. 3) The terms of the site license were significant with regard to legal obligation for partners, leading to delays or refusals to participate with the agreement. In 2014-2015, the terms of the site license will be reviewed and revised to be more accommodating to partners. 4) Cultural competence could be improved; the vast majority of signage and assistance provided was in English. While several IPC partners provided assistance in other languages, Presence Health could ensure assistance on site is improved with regard to cultural competence. 5) The social media strategy was delayed. Engaging the audience of social media can help consumers in real time obtain the information they need as well as direct them to a local application counselor. Further, this platform can be used to send targeted messages to consumers using proven marketing strategies as well as inform consumers of critical information they need for their appointments through visual media such as linked video.

Action Plan with PHFMC's Involvement in Addressing the Needs

2013 Baseline	2013 Outcome	2014 Target Objective	2014 Measureable Outcomes
Presence Health aimed to provide education and enrollment assistance to Illinois residents in the communities it serves. No baseline was used for 2013 due to this being the first year the law was implemented. 2013 was used to generate a baseline.	• Throughout the Open Enrollment period 217,000 Illinois residents obtained health insurance through the Marketplace. An additional 287,000 qualified for expanded Medicaid. • Ten IPC organizations formally partnered to provide on-site enrollment education and assistance to more than 7,000 community members. • Directional support and navigation was provided to over 22,000 consumers.	Presence Health aims to increase its scope and reach for Open Enrollment 2014-2015 by providing enrollment assistance to 100,000 Illinois residents across 6 counties. Presence Health seeks to increase the number of community partnerships in number and geography to 20 by the start of Open Enrollment 2014-2015. Directional support and navigation will increase, to be provided to 25,000 consumers.	

In addition, PHFMC will continue to meet community needs by providing charity care, Medicaid and SHIP services, and by working with community partners to address the identified needs listed above.

Next Steps for Priorities

For each of the priority areas listed above, PHFMC will work with the City of Des Plaines, Des Plaines Chamber of Commerce, Des Plaines Library, Des Plaines school districts, Maryville Academy, the Scott Nolan Center, Frisbie Senior Center, Oakton Community College, MaineStay, Catholic Charities, other and community partners to:

- Identify any related activities being conducted by others in the community that could be enhanced by collaborating with one another.
- Develop measurable goals and objectives so that the effectiveness of their efforts can be measured.
- Build support for the initiatives within the community and other health care providers.
- Develop detailed work plans and continually monitor progress.

Implementation Strategy Approval

Presence Holy Family Medical Center

In alignment with our mission of providing compassionate, holistic care with a spirit of healing and hope in the communities we serve, Presence Health is committed to providing meaningful and measurable community benefit activities. In order to accomplish our mission, a formal approval process has been established both at the board and leadership levels. Annually the Implementation Strategy must be reviewed and approved by the Senior Leadership Team, Ministry Mission Committee of the Board and the Board of Directors.

The following plan has been developed based on documented community need and analysis that reviewed community and ministry resources. This plan will be implemented in 2015.

The below signatures signify that this plan has been reviewed and approved for 2015.

_____ _____
John Baird Date
President and CEO
Presence Holy Family Medical Center

_____ _____
Dougal Hewitt Date
Chief Mission Officer
Presence Health

Insert names and titles of primary staff responsible:

_____
Plan Prepared By:
Ella Woodford-Parker, Community Liaison

_____
Board of Directors Approval Date
Presence Holy Family Medical Center

Implementation Strategy Communication

PHFMC will share the 2015 Implementation Strategy with all internal stakeholders including employees, volunteers and physicians. This document is available at www.presencehealth.org and is also broadly distributed within our community to stakeholders including community leaders, government officials, service organizations and community collaborators.

The following notice is posted in several areas of PHFMC to assure community awareness of the Community Benefit Act. This report is on file with the Illinois Attorney General's Office:

Illinois Community Benefits Act
This hospital annually files a report
of its Community Benefit Plan with the
Illinois Attorney General's Office.
This report is public information and
available to the public by
contacting:

Charitable Trusts Bureau
Office of the Attorney General
100 West Randolph Street, 3rd Floor
Chicago, Illinois 60601-3175
(312) 814-3942

Required by Section 20(c) of Public Act 093-0480