Presence℠
Saints Mary and Elizabeth Medical Center

Presence Saints Mary and Elizabeth Medical Center

Community Health Needs Assessment (CHNA) Implementation Strategy 2014

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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:

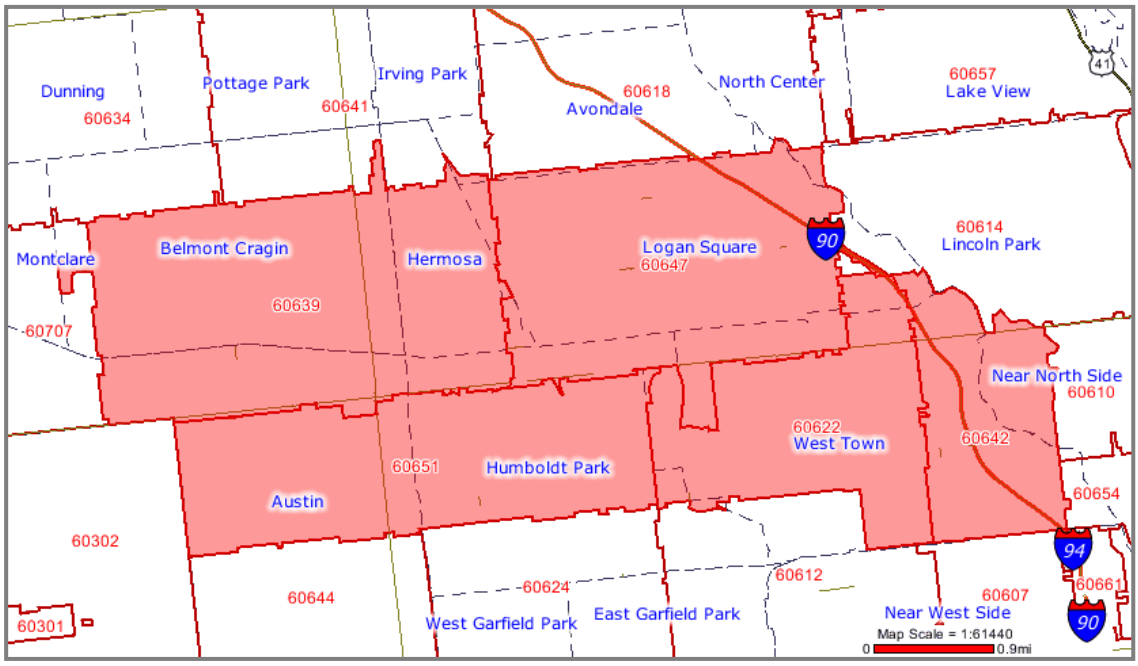
- **Honesty**: The value of Honesty instills in us the courage to always speak the truth, to act in ways consistent with our Mission and Values and to choose to do the right thing.
- **Oneness**: The value of Oneness inspires us to recognize that we are interdependent, interrelated and interconnected with each other and all those we are called to serve.
- **People**: 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.
- **Excellence**: 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 Saints Mary and Elizabeth Medical Center (PSMEMC) has been meeting the health needs of Belmont Cragin, Hermosa, Humboldt Park, Logan Square and West Town residents for over 100 years. Founded by the Poor Handmaids of Jesus Christ, PSMEMC continues to carry out its mission of providing “compassionate, holistic care with a spirit of healing and hope in the communities” it serves.

PSMEMC is located in Chicago and is a leading community employer. The medical center has more than 2,100 employees and about 530 physicians in 39 specialties on staff.

This report summarizes the plans for PSMEMC to sustain and develop new community benefit programs that 1) address prioritized needs from the 2015 Community Health Needs Assessment (CHNA) conducted by PSMEMC and community partners and 2) respond to other identified community health needs.

The service area around PSMEMC is made up of five community areas: Belmont Cragin, Hermosa, Humboldt Park, Logan Square and West Town. Each community has unique health related concerns.

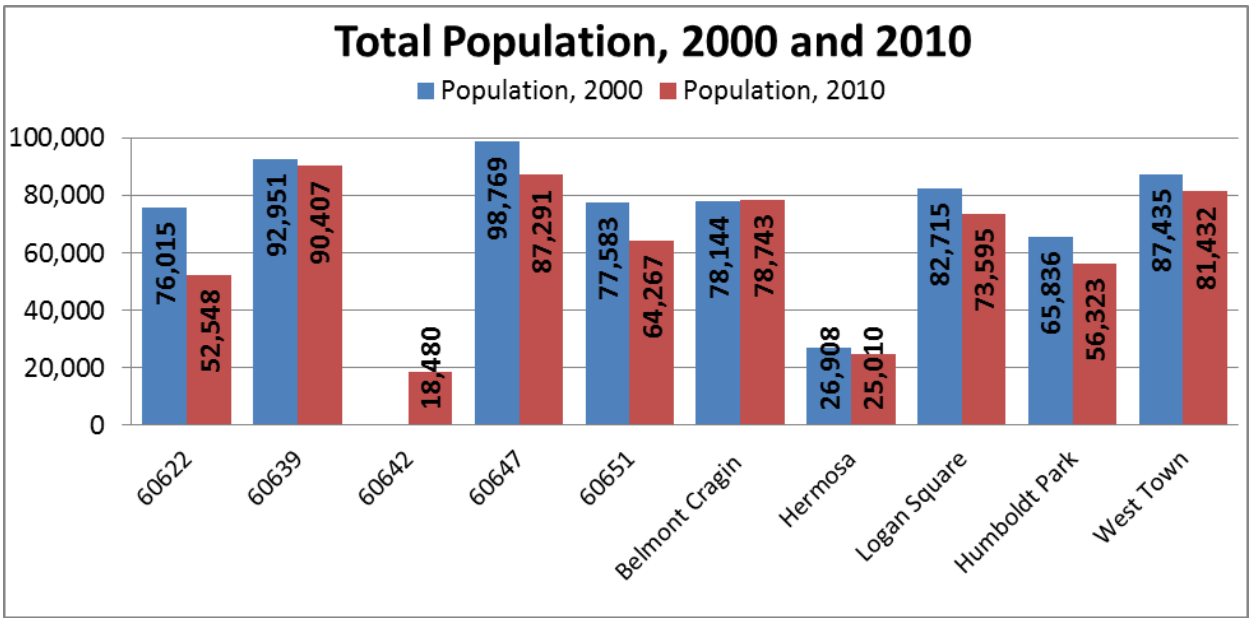


Demographics

Demographically, Belmont Cragin, Hermosa and Humboldt Park are quite similar. Logan Square and West Town share some similarities but differ somewhat from the other three communities. Humboldt Park has the highest rates of poverty and a larger Black population. While it lost 14% of its population from 2000 – 2010, Humboldt Park had one of the largest populations of individuals under 20 years old. At the same time, however, the Humboldt Park area had one of the largest increases in senior citizens, from 6% to 9% of the total population. West Town and Logan Square have the highest median incomes and lower rates of poverty; Logan Square is predominantly Hispanic/Latino, whereas West Town is the only area that is predominantly White, as of 2010, West Town is also the largest community area, with 81,000 residents. Belmont Cragin and Hermosa are largely Hispanic/Latino; Hermosa is the smallest community area, with only 25,000 residents. Belmont Cragin and Hermosa are made up of almost one-third young residents, under the age of 20. Up to 40% of residents in Belmont Cragin do not speak English well, compared to only about 12% in West Town.

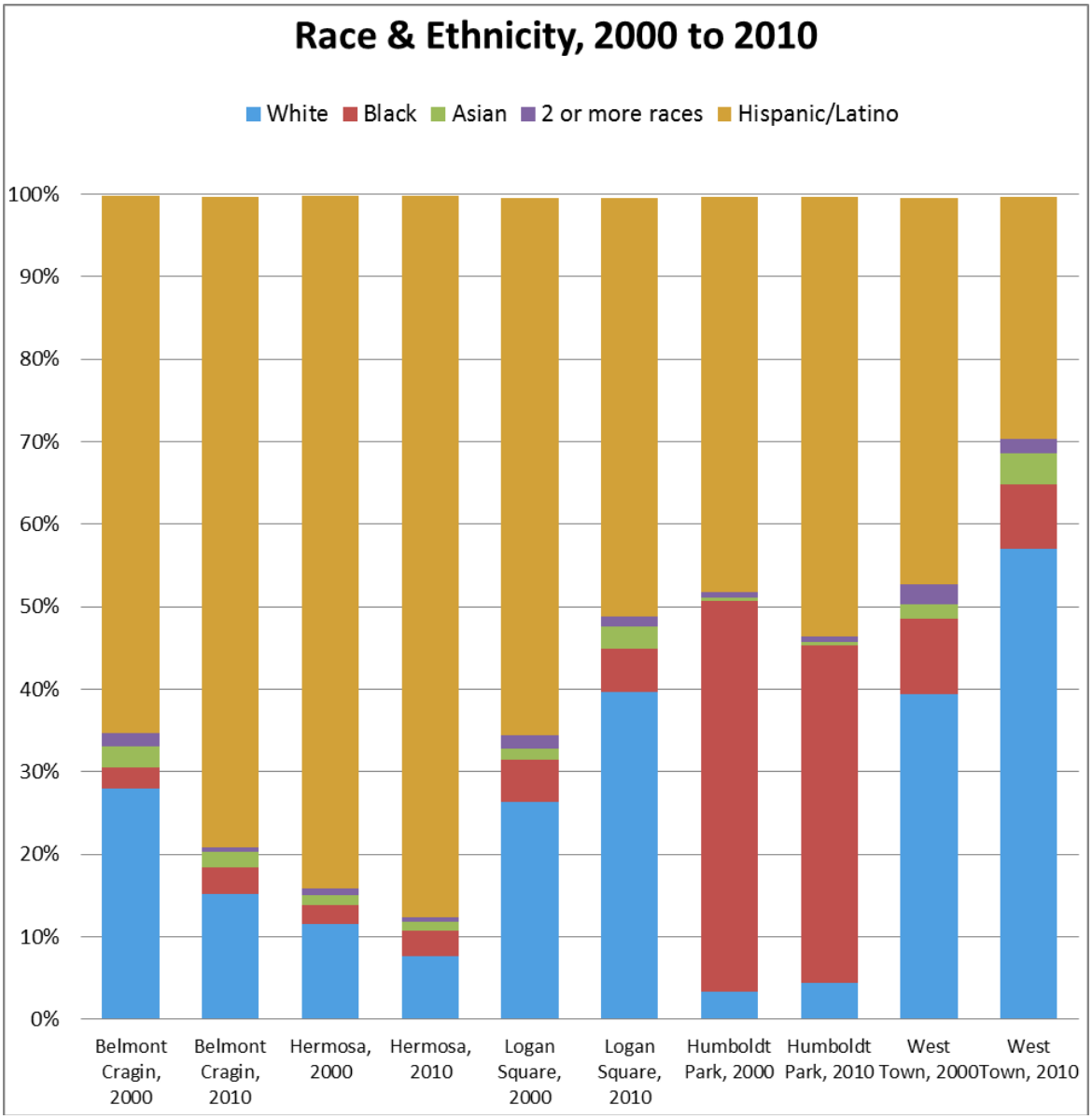
Population

As of 2010, the total population of Belmont Cragin, Hermosa, Logan Square, Humboldt Park and West Town is 315,103. West Town, Belmont Cragin and Logan Square are the most populous counties in the CHNA service area. Chicago's population decreased from 2000 to 2010 by 7% and Cook County by 3%. Hermosa, Logan Square, Humboldt Park and West Town decreased by 7, 11, 14, and 7 percent respectively. Only Belmont Cragin showed an increase in population, though it was small at only 1%. Humboldt Park and Logan Square experienced the greatest proportional decreases in population. Belmont Cragin's population size remained steady over the period.



Ethnicity

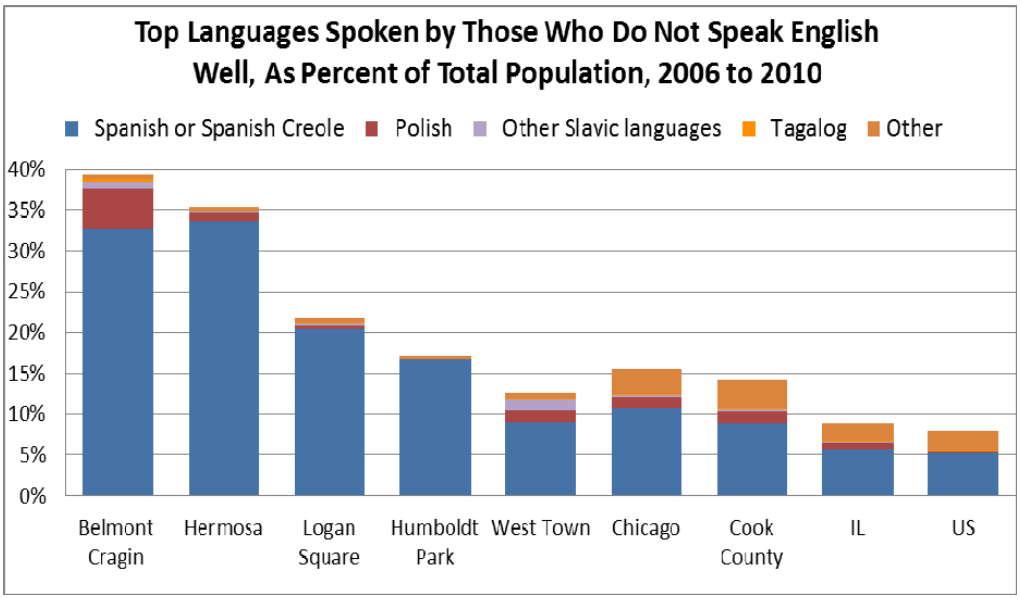
Between 2000 and 2010, the proportion of Hispanic/Latinos increased in Belmont Cragin, Hermosa and Humboldt Park, while it decreased in Logan Square and West Town. Logan Square and West Town also saw an increase in the proportion of White residents. Overall, the CHNA service area still has a very large Hispanic/Latino population as of 2010. More than three-fourths of residents in both Hermosa and Belmont Cragin identify as Hispanic/Latino, and half of residents in Logan Square and Humboldt Park identify as Hispanic/Latino. West Town has the smallest proportion of Hispanic/Latino residents at 30%%. Humboldt Park also has a large African American population, with almost half of residents identifying as Black.



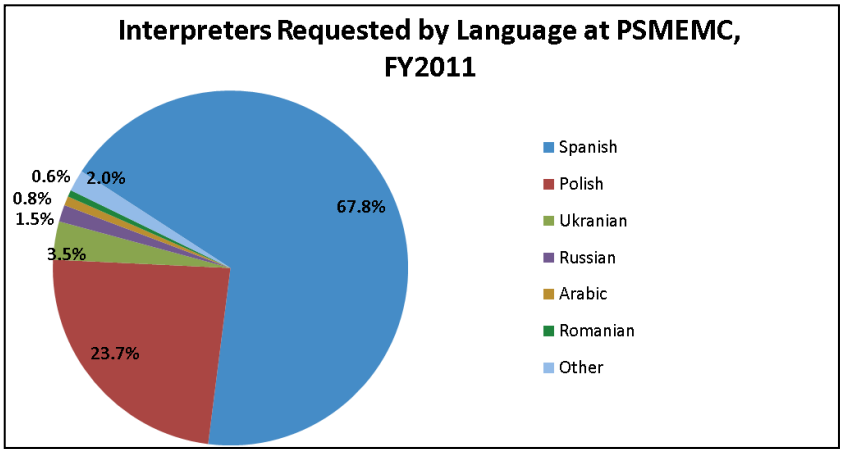
Language Spoken

Among the total population, Spanish was self-reported as the top language spoken in all communities, followed by Polish. Belmont Cragin was the most diverse area in terms of language, while Humboldt Park was the least diverse. One third of residents in Belmont Cragin and Hermosa identify Spanish as their primary language.

Kelvyn Park and North Grand High Schools had rates of limited English—speaking students similar to Chicago overall, while the other high schools in this service area had a lower percentage (less than 10%). It is important to note that high schools in Chicago draw students from a wide geographic area, so not all students in these high schools live in the CHNA service area.

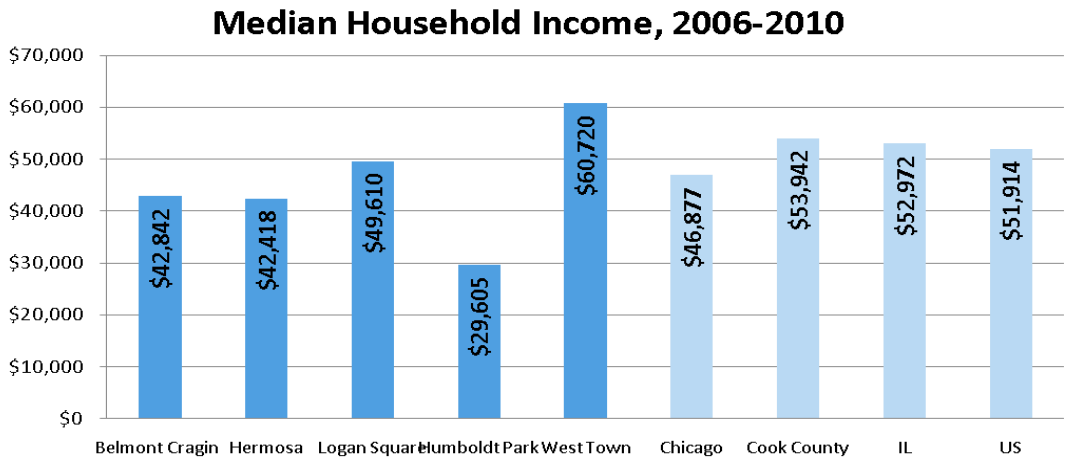


Interpreters were requested for 33 different languages at PSMEMC IN 2011. Spanish and Polish made up over 80% of the requests, which reflects the languages spoken in the community. There were 6,204 total requests for interpreters.

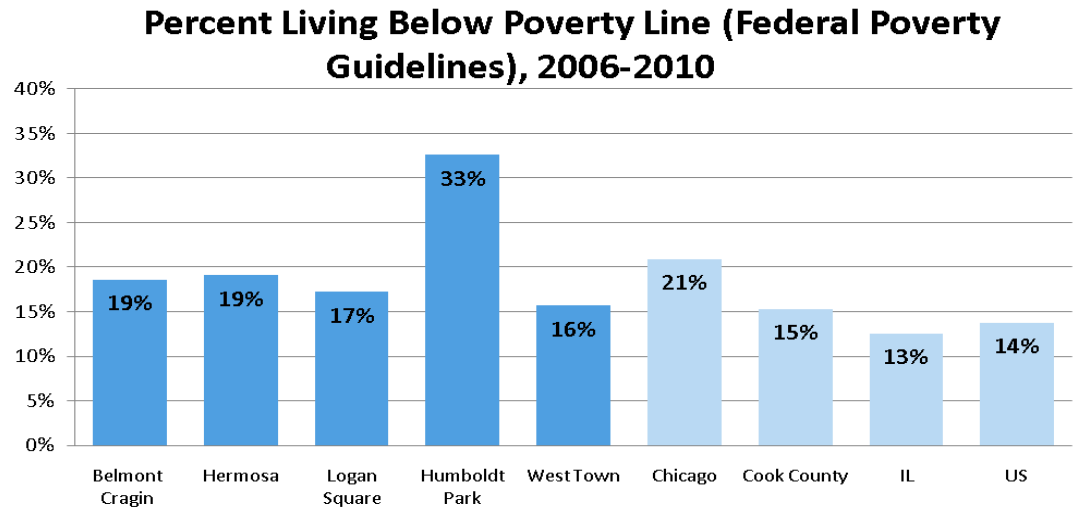


Income

Humboldt Park has the lowest median income in the CHNA service area, less than $30,000. Moreover, 33% of Humboldt Park residents live below the poverty line, compared to 21% in Chicago overall and only 13% in Illinois overall. All of the communities in the service area have poverty rates over 16% - higher than Cook County, Illinois and the US. The median household incomes of Logan Square and West Town are above the Chicago median and West Towns is above the national median.



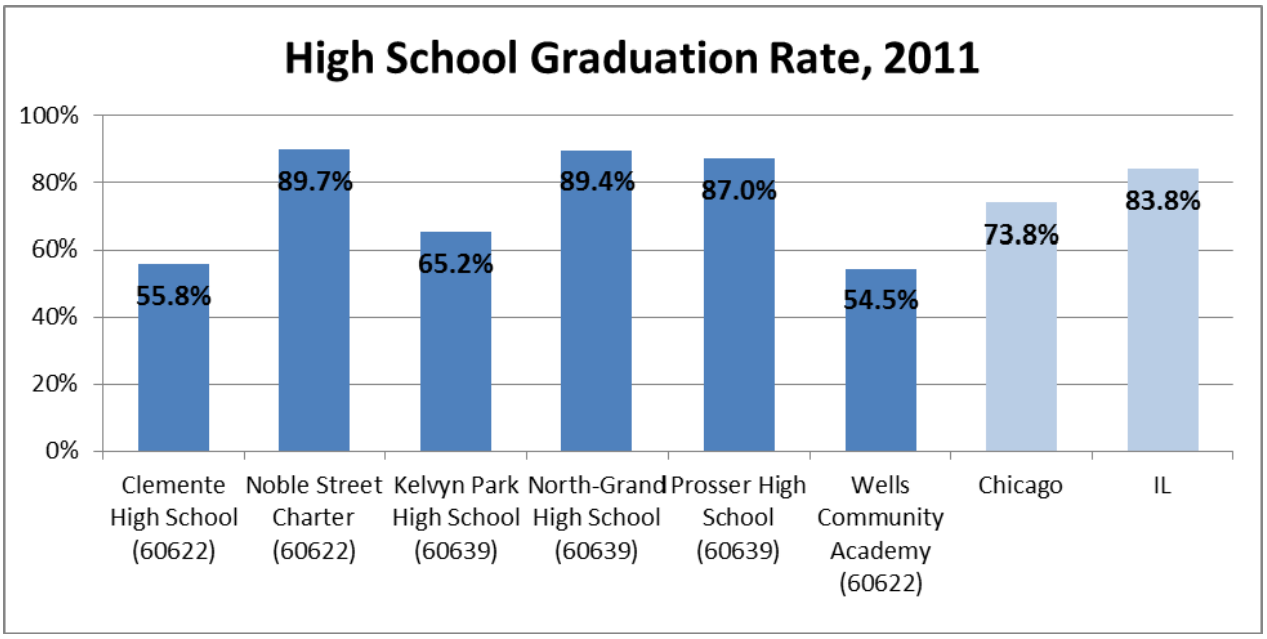
Humboldt Park also has the highest rates of residents living below 200% of the poverty line at 61%. Over half of Belmont Cragin and Hermosa residents also live below 200% poverty, with Logan Square not far behind at 43%. By looking at the numbers for adults living below 100% poverty and 200% of poverty, we calculate that a third of residents in Belmont Cragin, Hermosa and Humboldt Park live somewhere between 100% and 200% of poverty. This is substantially higher than the city of Chicago as a whole.



Education

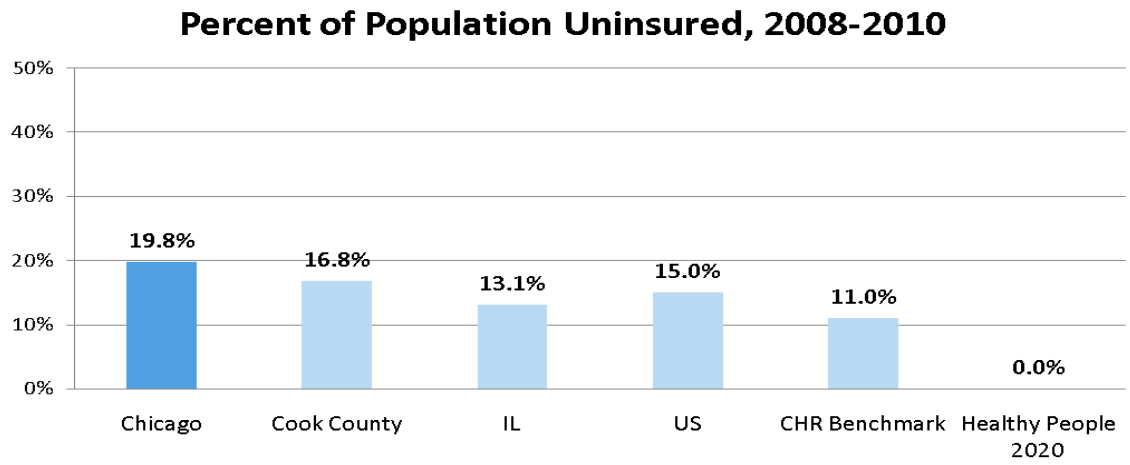
Three of the schools in this service area had higher graduation rates than Chicago and Illinois overall. However, Clemente, Kelvyn Park, and Wells High Schools had lower graduation rates than Chicago and Illinois. It is important to note that high schools in Chicago draw students from a wide geographic area so the student population at these high schools are not confined to students living in the CHNA service area. Also, these graduation rates track the success of entering freshman; however, they do not capture information about youth who exit the education system prior to high school.

Belmont Cragin, Hermosa and Humboldt Park all had close to 40% of adult residents without a high school degree, much higher than the Chicago average of 21%. West Town, where only 13.4% of the population does not have a high school diploma, is the only community in the area with a percentage that is similar to Illinois and the U.S.

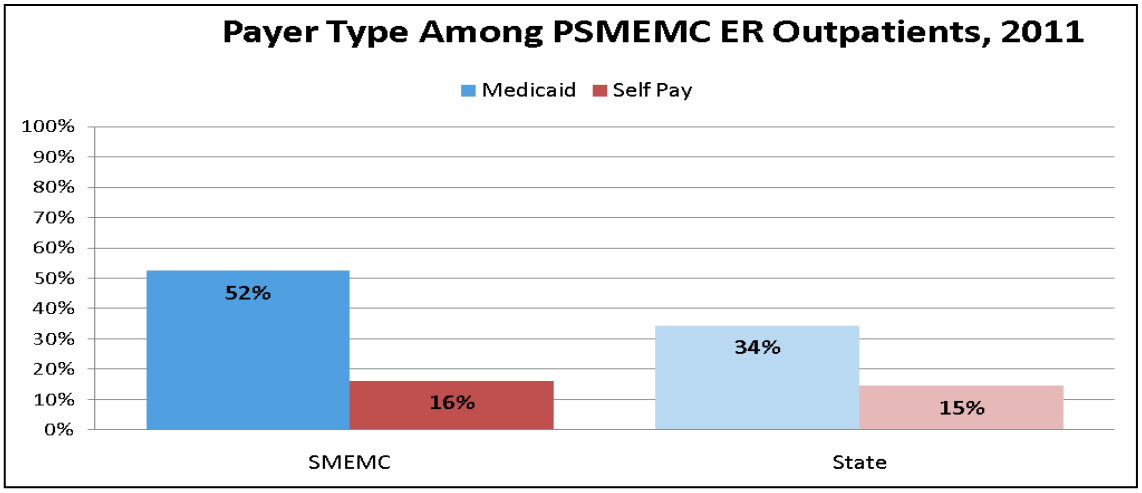


Access to Health Care

In terms of access to healthcare, 20% of Chicagoans are uninsured, which is higher than the national rate of 15%. Over 40% of residents in the Belmont Cragin, Hermosa and Humboldt Park zip codes are enrolled in Medicaid. Among patients who came to the PSMEMC emergency room (ER) but did not have to stay at the hospital, 52% were on Medicaid, compared to the state average of 34%. The percent self-paying was the same at both PSMEMC and the state. As reflected in the languages spoken in the community, 90% of requests for interpreters at PSMEMC were for either Spanish or Polish.



More than half of ER outpatients at PSMEMC were enrolled in Medicaid, compared to only 34% overall in IL. The percentage of self-paying patients (16%) was similar to the state.



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 insure the data, processes and outputs add value to all community partners rather than just the hospital.

In July 2012, PSMEMC coordinated abroad array of community stakeholders from the community areas of Belmont Cragin, Hermosa, Humboldt Park, Logan Square and West Town 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 Belmont Cragin, Hermosa, Humboldt Park, Logan Square and West Town)

MISSION

Through embracing cultural and linguistic diversity, collaboration and community participation, the CHNA Steering Committee will assist in conducting a community health assessment, identification of priority issues, creation and implementation of action plans to improve the health of the people of the community based on identified community need.

VISION

A participative and engaged community that maximizes the use of diverse community partnerships and collaboration among all sectors improving community health from a holistic standpoint including; wellness, quality of life and promoting 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. We value the strengths of our cultural and linguistic diversity.

Transparency and Communication: We are conducting a community health needs assessment and plan for and with the community. 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. We will ensure our findings are tested, feedback is received and we have ecological validity.

Commitment: We believe we are accountable to the community we serve. We believe adding value is doing what we say we will do. We believe in providing hope for the people in our community.

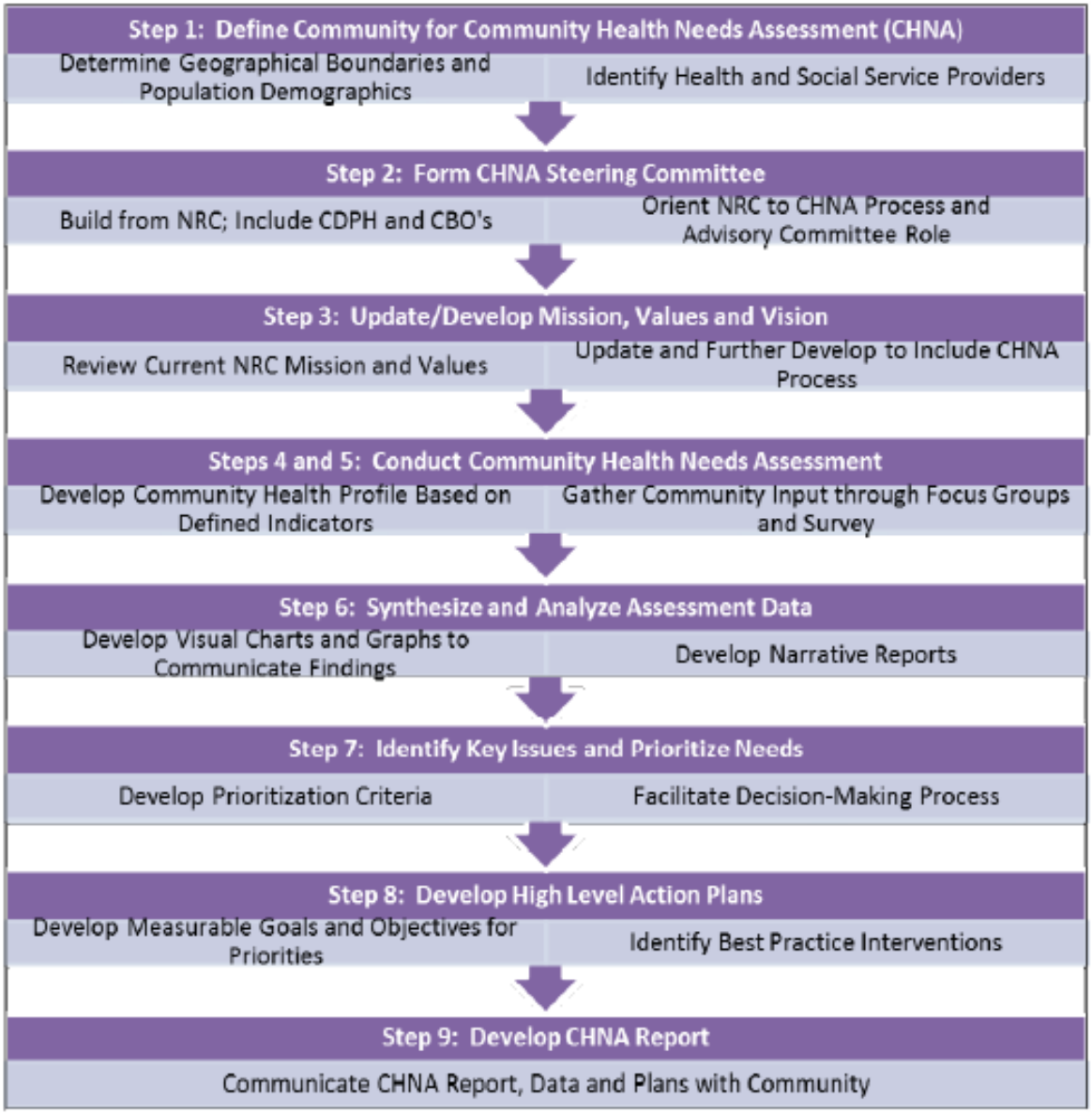
Quality: We strive for high quality in everything we do. We believe in continuous improvement and innovation and that everything we do is worth doing well.

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

Health: We believe health is a state of complete physical, mental and social well-being and not merely the absence of disease.

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.



CHNA 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 PSMEMC 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:

- Humboldt Park has the highest rates of poverty, a larger Black/African American population, and has high populations of senior citizens and children under 20 years old.
- West Town and Logan Square have the highest median incomes and lower rates of poverty. Logan Square, Belmont Cragin and Hermosa are predominantly Hispanic/Latino, whereas West Town's community is predominantly White/Caucasian.
- Almost 40% of Belmont Cragin residents do not speak English well, compared to only about 12% in West Town. Spanish is the predominant non-English language spoken, followed by Polish.
- Humboldt Park has the highest rate of children living in poverty, almost 50%; all the areas had at least one in five children living below the federal poverty level. Almost all schools in the service area have 70% or greater of students eligible for free or reduced lunch.
- The 2006-2010 unemployment rates for Humboldt Park, Belmont Cragin, and Hermosa were above the Chicago average of 11%. Logan Square and West Town rates were 7.5% and 6% respectively.
- 20% of Chicago residents are uninsured. Over 40% of residents in Belmont Cragin, Hermosa, and Humboldt Park are enrolled in Medicaid.
- Over half (52%) of emergency room outpatients at PSMEMC were enrolled in Medicaid, while 16% were self-paying outpatients.
- Belmont Cragin, Hermosa, Logan Square, and Humboldt Park have a shortage of primary care physicians. In West Town, the shortage is primarily for low-income residents. Mental health care shortages are experienced across the PSMEMC service area.
- Heart disease and cancer are the leading age-adjusted causes of mortality across the CHNA service area.
- In terms of health outcomes, Humboldt Park stands out as having particularly poor health for almost every indicator examined.
- At PSMEMC, the top diagnoses for non-admitted ER outpatients were for acute upper respiratory infections, urinary tract infections, abdominal pain, ear infections, and chest pain.
- One in three residents in the service area is considered at risk for binge drinking. Over 19% of residents are current smokers.
- Logan Square, Humboldt Park, and Belmont Cragin all have areas where there are few or no healthy food options compared to the number of fast food choices. All communities in the service area have food insecurity rates higher than the U.S. average.
- Almost 50% of residents in the CHNA service area were cost burdened (meaning they paid more than 30% of their income on housing); owners were more likely to be cost burdened than renters.

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. Five hundred fifty-four (554) community residents completed the survey. The findings of the Community Input Report include:

- 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
  - Safe neighborhoods/ low crime
  - Good and available daycare and before/after-school programs
- According to survey respondents, the top five most problematic health issues in this community are:
  - Diabetes
  - Obesity
  - Drug use
  - Community violence
  - High blood pressure, heart disease, and stroke

Results of the 2012 Needs Assessment

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

1. Safety, Violence, Jobs, Education
2. Mental Health & Substance Abuse
3. Obesity and Diabetes: Prevention & Management
4. Health Literacy

Note: Economic disparities and language barriers will be addressed throughout all priorities and strategies.

PSMEMC's review of current community benefit programs found that the hospital is meeting existing community needs through the Kids CANDO Camp, Block by Block, Let's Move Our Numbers program, the Diabetes Center, Josephinum Academy health sessions, LifeSmart, and the Breast Health Initiative.

PSMEMC 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. PSMEMC worked with the CHNA Steering Committee to identify priority issues for the county.

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 PSMEMC 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 exist 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.

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 PSMEMC 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:

Cross-cutting Themes and Issues Identified

- Chronic diseases – prevention and management
  - Diabetes is a particular issue across the service area
  - Risk factors for chronic disease such as obesity, high blood pressure and smoking are also concerns
- Safety and violence
- Economic needs and poverty, particularly lack of good jobs
- Housing issues related to both affordability and quality
- Access, cost and lack of education are barriers to good health and receiving health care
- Education attainment
- Mental health & substance abuse
- Health literacy, awareness of resources, and need for bilingual patient navigators
- Need for culturally relevant strategies to address all health issues

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. Safety, Violence, Jobs, Education
2. Mental Health & Substance Abuse
3. Obesity and Diabetes: Prevention & Management
4. Health Literacy

**The CHNA Steering Committee also determined that economic disparities and language barriers should be addressed throughout all priorities and strategies.

As PSMEMC, 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 PSMEMC. Gathering further community input will help PSMEMC 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.

PSMEMC's Implementation Strategy was developed based on the findings and priorities established by the 2012 CHNA and a review of the hospital's existing community benefit activities.

After the health issues were identified in the assessment, meetings involving PSMEMC leaders were held to begin identifying current programs and/or interventions that already existed and those that could be developed.

Next, PSMEMC 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 PSMEMC was best equipped to address.

Once the goals and strategies were determined, action plans were submitted to Senior Leadership identifying the need based on community assessment findings, internal resources with expertise, program goals, and objectives, and measures of success or evaluating.

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 PSMEMC expert or champion of that particular specialty a rea. 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 join 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 PSMEMC 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 PSMEMC sponsors in the community. PSMEMC 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. PSMEMC will also see how these existing programs can tie into the overall goals of the CHNA Action Teams.

LIFESMART

Program Description
PSMEMC provides a 10 week program to seniors and women in the community to provide health education on topics such as nutrition, exercise, domestic violence and cardiovascular disease. The program is held in seven different locations throughout the community, including Julia Center Women's Group, schools and parent groups. Screenings are provided in the first and last sessions to observe the progress each individual has made.

JOSEPHINUM ACADEMY HEALTH SESSIONS

Program Description
PSMEMC teaches health class at this school on topics such as abstinence, the reproductive system, healthy relationships and healthy nutrition.

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. The results are given to the diabetic nurse educator for any follow-up that is needed.

BLOCK BY BLOCK

Program Description
Block-By-Block is an initiative of the Greater Humboldt Park Community Campaign Against Diabetes. The program was developed by community organizations, local universities, and hospitals working together to improve the health of the community. The Campaign is a one-of-the-kind, community driven, study/intervention designed to reduce the impact of diabetes in the Humboldt Park community.

The Block by Block Campaign focuses on a 72 block area in Chicago where diabetes prevalence rates are highest. PSMEMC supports this program by providing a secretary to help organize the educational sessions with local residents.

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM

Program Description

PSMEMC's Community Education Department provides breast and cervical health education throughout the CHNA service area, particularly for women who are uninsured. The educators also help women apply for financial aid. Presence Health physicians provide access to care for women who are most vulnerable in the community.

CHILDREN'S AWARENESS OF NUTRITION, DIABETES AND OBESITY (CANDO) CAMP

Program Description

The CANDO Camp is a three week program that targets children (ages 11-14) to teach them how to live healthier lifestyles. The following topics are covered in the program: obesity, health and nutrition, abstinence, bullying and education. This program will be expanded into local schools in April. SMEMC educators receive grant funding to provide this program in the community.

DIABETES EMPOWERMENT CENTER

Program Description

PSMEMC's diabetic educators provide community training and will determine if their initiatives can be linked to the CHNA Action Team's work.

Action Plans with PSMEMC's Involvement in Addressing the Needs

HEALTH LITERACY CHNA ACTION TEAM

Program Description

PSMEMC's Health Literacy CHNA Action Team has developed the following action plan to address this issue in the community.

Community Need: Health Literacy					
Aim Statement: To identify, assess and replicate best practices in health literacy to ensure clear, meaningful communications that support activities to positively change individual and population health outcomes in the communities we serve.					
2014 Objectives	**2014 Strategies**	**2014 Progress**	**Ministry Role**	**Community Partner Role**	**Measureable Outcomes**
Develop guiding principles for health literacy. Initiate, recruit and retain members of a Community Advisory Board of Health Literacy for advocacy purposes.	• Create a charter for the development of a Community Advocacy Board of Health Literacy. • Produce guiding principles, approach, and educational tools for community-inspired health literacy.	TBD – see key lessons below.	PSMEMC will be facilitating the work of the action team as well as its own internal programs around this issue.	The member's role are Education & Outreach, Research & Development. Business & Resident, and Social Service & Advocacy	The Health Literacy CHNA Action Team is currently developing measures of success.
Pilot health literacy principles, approach and educational tools	• Implement a pilot that tests the efficacy of our checklist (i.e., comprehension, trust, self- efficacy, participation rates, improved usage of health care and coordination).		PSMEMC will take the lead to implement a pilot that tests the efficacy of our checklist (i.e., comprehension, trust, self-efficacy, participation rates, improved usage of health care and coordination.		Will measure the impact(s) that health literacy has in improving health outcomes, piloted in CHNA obesity and diabetes action teams.
Publish outcomes and	• Identify best		PSMEMC will be		Will look at the

Action Plans with PSMEMC's Involvement in Addressing the Needs

results	practices for health literacy intervention for broader implementation.		facilitating the work of the action team as well as its own internal programs around this issue.		structural barriers analysis: what are the opportunities/obstacles for broader implementation of a health literacy campaign.
Launch broader community-wide health literacy campaign.	• Presented this issue to Steering Committee for new candidates to be involved. • Limit the time commitment • More conference call meetings vs. in-person.		Recruit at least seven (7) new community advocacy members. Demonstrate best practices for community-wide health literacy campaign.		The Literacy Team dissolved after their last meeting on April 30, 2013 due to Chairperson and Co-Chair changing role in their pertaining organization. This goal will continue to be a focus in 2015 because it's so essential in our primary community and PSMEMC.

Action Plans with PSMEMC's Involvement in Addressing the Needs

Key Lessons Learned

The Health Literacy Team worked for a year in trying to develop a checklist and principles other task groups could incorporate into their objectives and execution plans. The committee planned to join their discussions and planning upon request to help groups brainstorm health literacy and specific considerations. The committee understood how people should incorporate health literacy but wanted to hear from other committees as to the WHYs to contextualize their How's and the guidelines to partner with other task force's missions. They were planning to develop a resource list for the focus groups, and their identified causes.

Unfortunately the Literacy Team has not met since April 30, 2013 due to chairperson and co-chair changing role in their pertaining organization and this goal was not met.

2014 Baseline	2014 Outcome	2015 Target Objective	2015 Measureable Outcomes
Initiate, recruit and retain members on committee and community Advisory Board.	• Due to loss of co-chairs, the team phased out and new membership was requested by Steering Team. The Community Advisory Board never was implemented.	• To recruit new committee members or change the goal.	To be determined
Pilot Health Literacy principles, approach and educational tool for the ACA enrollment dates and to improve the outreach in a more aggressive and educational approach.	• After the first year pilot on checklist items for ACA literature and applications and education. The 2nd year will be more marketing and more navigators available. Goal is to sign-up more community residents and to assist those who are already registered to offer the many options for a new Plan.	• To increase the number of applicants with new members and assisting in educating residents on looking for a better Plan for 2015.	**Ongoing until February 2015** **Publish outcome and results none reported for this term.**

Action Plans with PSMEMC's Involvement in Addressing the Needs

MENTAL HEALTH CHNA ACTION TEAM

Program Description

PSMEMC's Mental Health CHNA Action Team has developed the following action plan to address this issue in the community. They will also work with the Presence Health Behavioral Health Department to work on System strategies of addressing mental health in the community.

Community Need: Mental Health					
Aim Statement: To develop a strong continuum of care between all caregivers within the target population.					
2014 Objectives	**2014 Strategies**	**2014 Progress**	**Ministry Role**	**Community Partner Role**	**Measureable Outcomes**
To create a continuum of care to prevent, reduce, and manage Mental Health and Substance Abuse among the community served.	• Define the target population in Belmont Cragin, Hermosa, Humboldt Park, Logan Square and West Town.	Exchange of information among the health care providers along with individuals/families within target population area.	Our ministry role as the number one Catholic Mental Health/Substance Abuse Provider in the State is to partner with as many providers in our service area with our in-patient and out-patient programs from children to adult in three languages, English, Spanish and Polish.	The partners' role is to develop a communication mechanism with the hospital on a referral process and follow-up with the clients.	We will measure success of this program by identifying existing resources, notify the community service area and align this with our system goal to compare our differences.

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2014 Baseline	2014 Outcome	2015 Target Objective	2015 Measureable Outcomes
• To have a model of coordination care and access to care for Mental Health/Substance Services • To find representatives from the community to be trained for the Mental Health First Aid Training.	• A Resource Directory was developed and added to the System Directory. • We submitted 10 names from our community, but no one attended the training.	• To be more involved with the system, Mental Health goals and implement them on our local level. • New members and chairs for our team and to open another training at our site.	• **On-Going**

Action Plans with PSMEMC's Involvement in Addressing the Needs

OBESITY AND DIABETES CHNA ACTION TEAM

Program Description

PSMEMC's Obesity and Diabetes Action Team has partnered with the YMCA to promote physical activity and healthy lifestyle.

Community Need: Obesity and Diabetes

Aim Statement: To develop and identify existing programs and approaches to the prevention and treatment of these important health problems. Committed to creating awareness and utilization of available resources in the community to facilitate collaboration between the PSMEMC and the broader community.

2014 Objectives	2014 Strategies	2014 Progress	Ministry Role	Community Partner Role	Measureable Outcomes
Create a unified calendar of all ongoing events/ activities in the community with continued evaluation and update.	• Creation of Diabetes/Obesity Asset Map to include all assets of physical activity and nutrition education.	Gathered available resources related to diabetes and obesity in the community; nutrition and physical activity.	Produce educational/awareness tools and resources for providers/clinicians to be able to provide to our patients and community.	Creation of Diabetes/Obesity Asset Map to include all assets of physical activity and nutrition, education throughout our service areas.	The Map was started but could not continue without lead from Jose Luis Rodriguez and needed grant monies. This objective will continue in 2015 and on.
Plan and implement three annual signature events in the community related to diabetes/obesity.	To communicate with each other over events that are happening at all their sites to promote and have a bigger impact for our residents in the community.	Events held included: • Move for Life, April 6th, 2013 and 2014 • Physical Activity Promotion – Robert Sweetgall, June 27, 2013 • Diabetes Awareness Month Celebration – November 2013/2014	To participate in all of our partner's events in some capacity.	To share information of their site and special events.	These events will be more focused and separated to get more participation from the community in multiple events.
Physician Engagement to	5 physicians were in-serviced on	Actively referring patients	YMCA-Provides packets and 7 day	Community agencies to assist in making	Referral tracking and membership

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"prescribe" physical activity. • Identify a physician champion(s). • Increase physical activities time and decrease screen times. • Choosing healthier options when making food choices • Acquire knowledge pertaining to positive character building	prescribing physical activity and receive packets in office weekly.		passes with information of activities	healthier life style options concerning nutrition, physical activity, health	
Gather information on all existing community activities related to diabetes and obesity in the designated zip codes.	April – May 2013	Ten organizations were contacted that had existing programs in the surrounding zip codes and obtain specific information regarding programs/cost/contact person/etc.		All committee members	Participated in the Healthy Corridors Initiative (HCI) and CCT Humboldt Park in motion.
Collaborate with CHNA Health Literacy team to identify the best practice in communicating to our community	To meet with the Health Literacy team at least quarterly. Exchanged information at Steering Committee Meeting	In Process			This objective will continue in 2015 and on.
Identify opportunities for new programs	Identify at least 5 community based	In Process	Gladys Aguirre and her educators went out		This objective will continue in 2015 and

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where there are gaps and create a "speaker bureau"	settings where programs can be implemented.		to schools to implement.		on.
Create Obesity/ Discharge packet & video to be used for discharge planning to be used by interdisciplinary team and in waiting rooms.	Discharge packet production with monthly updates were distributed to interdisciplinary team (ex. Social Work, Case Management, Dietitians).	In Process			This objective will continue in 2015 and on.
Increase physician engagement to promote nutrition and physical activity	Successful implementation and tracking of referrals with a new partnership with the YMCA	• Role out program to entire medical staff at PSMEMC • Employee wellness program – YMCA onsite programs • Grocery store tours in collaboration with Jewel Osco dietitian			• Membership at the YMCA directly related to physician referral. • Monitor enrollment in programs provided at PSMEMC onsite.

Key Lessons Learned

Chronic Disease/Prevention of chronic disease/Life Smart for Women

2014 Baseline	2014 Outcome	2015 Target Objective	2015 Measureable Outcomes
Life Smart is a 10 week program (1 hour per week) • Pre health knowledge assessment • Ten Educational sessions • Pre and post	The program was provided for 7 groups for a total of 114 women. Most groups were parent groups at neighboring schools and two groups were	Short-term goals • Increase awareness of health issues and open communication about health issues	• 57% of participants improved their score between the pre and post assessments. • 1 out of 3 participants showed

evaluations of classes • Educational topics included. 1. Communication 2. Cardiovascular disease/stroke/chest pain 3. Diabetes 4. Nutrition 5. Physical Activity 6. Stress management 7. Substance Abuse 8. Cancer Awareness 9. Aging Well 10. Family health	held at community centers. 110 women completed the entire program. As an addition to the program health screenings such as glucose, blood pressure, BMI and cholesterol screenings were offered. Information was provided on our Women's Program which offers free mammograms and pap smears to uninsured women.	with others. **Long term goals** Acquire knowledge and skills to practice healthier life style behaviors for oneself and family members.	decrease in blood pressure, glucose and cholesterol.

Key Lessons Learned

CHILDREN'S AWARENESS OF NUTRITION, DIABETES AND OBESITY (CANDO) CAMP

2014 Baseline	2014 Outcome	2015 Target Objective	2015 Measureable Outcomes
The CANDO Camp is a three week program that targets children (ages 11-14) to teach them how to live healthier lifestyles. The following topics are covered in the program: obesity, health and nutrition, abstinence, bullying	• Health Educational sessions • Examples of healthy breakfast and lunch are provided to participants daily • Pre and post health screenings • Daily exercise • Pre and post	• Instructor from Fun Fitness instructed children 8 to 10 times a week and engaged the campers in physical activity. • Nurses provided nutrition classes • Field trips to go swimming and to	Participants increased engagement in physical activities, improved in choosing healthier foods, and increased their self-esteem. Participants showed an average decrease in BMI by 1%.

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and education. This program will be expanded into local schools in April. SMEMC educators receive grant funding to provide this program in the community.	fitness tests • Pre and post questionnaire on choosing healthy foods and options • Recording of food, exercise and screen logs. • Character building classes specific for age groups • 29 children ages 11-14 participated in the summer camp.	the White Sox game. • CPR and First Aid • Etiquette classes provided to participants.	

Action Plans with PSMEMC's Involvement in Addressing the Needs

SAFETY AND VIOLENCE CHNA ACTION TEAM

Program Description

Community Need: Safety and Violence

Aim Statement: Committed to creating awareness and utilization of available resources in the community to facilitate collaboration between the PSMEMC and the broader community.

2014 Objectives	2014 Strategies	2014 Progress	Ministry Role	Community Partner Role	Measureable Outcomes
To develop a neighborhood resource directory to assist neighborhood families in connecting the available services in the areas of social services, education, employment and healthcare.	Gather information and contacts from all the team members on programs that already exist. Create a Community Advocacy Board.	A community Directory "Be in the Know – Your Guide to Community Services" was published. 500 copies were purchased at a cost of $1300. The Directory has been disseminated to the following organizations: • BUILD • Block Club Federation • Wicker Park • First Congregational Church • Logan Square (LSNA) • Columbus Elementary • Diabetes Empowerment Center • Family Practice Center • CAPS • St. Joseph Services • And other CHNA partners.	Hospital worked closely with community partners in calling agencies/communities to get updated information for this directory. Discussions held regarding having a community portal on our website that could be updated by team member.	• CPD and Board of Education and the community partners assisted with the gathering of information and edited/proof-reading of the directory.	Follow up with these organizations to check how many directories were given out. Will continue to distribute to other organizations.
To create a platform	Need to break down	Targeting youths from 13	Planning various		Hospital participated

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for the youth to not only share their experiences, but to also have a direct impact in developing a pilot program that includes: Youth from the age of (13-18) years of age that includes parent involvement and existing programs.	the target audience we are focusing on to realistic goals in a 3 year term and which areas will be prioritized throughout this time span.	– 18 and also will work with parents. Suggestions were made by members from CAPS, Block Club Federation and other partners on community issues in our society and suggested the following activities.	workshops for the new year: • Bullying • Domestic Violence • Keeping It Real • Teen Dating • Difference between "snitching" and saving a life by reporting something that is wrong.		in the Domestic Violence Rally March that started by Clemente High School and concluded at the 14th District Police Station. Bullying Seminar planned for March 2015 Keeping It Real workshop planned for March 2015.
Produce more productive members (youth) to society and change the perception of parents to be more supportive by defining the disparities that we are addressing.	To work more closely with BUILD, Inc. and the youth leadership to develop a community program for the youth in our schools, parks and after school programs.	Much information was gathered in 2013 and part of 2014. There was a great representation of young adults and community organizers. Focusing on the following: • Jobs (especially for first time ex-convicts • After School Programs • Workshops with this age group and assisting area high school students to receive credit hours.		The partner role phased out because BUILD, Inc. moved out of the service area and were the leading role for this to be achieved.	This objective will continue in 2015 and on or will have to be redefined.

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Key Lessons Learned

2014 Baseline	2014 Outcome	2015 Target Objective	2015 Measureable Outcomes
This was the largest Action Team from the beginning because it is an issue that impacts every person, agency and service area	As the years moved on our membership started to dwindle due to agencies closing, change of positions and re-locations.	This target will need to find new members that already have youth programs, after school activities that impact the targeted age range that is agreed upon.	**TBD**

In addition, PSMEMC will continue to meet community needs by providing charity care, Medicaid and State Health Insurance Assistance Program (SHIP) services, and by providing oversight and communication between the Action Teams through the three year period of the planning and implementation process.

Next Steps for Priorities

For each of the priority areas listed above, PSMEMC will work with its 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.
- Implement evaluation findings into program improvement efforts.
- Build support for the initiatives within the community and other health care providers.
- Develop detailed work plans and continually monitor progress.

Implementation Strategy Communication

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 2014.

The below signatures signify that this plan has been reviewed and approved for 2014.

_____ _____
Regional President & CEO - MCC Date
Presence Saints Mary and Elizabeth Medical Center

Celia Gonzalez, Community Relations Rep/CBISA Coordinator
Presence Saints Mary and Elizabeth Medical Center
Plan Prepared By

Victor Villalobos, Director, Community Relations
Presence Saints Mary and Elizabeth Medical Center
Plan Prepared By

Board of Directors Approval Date
Presence Saints Mary and Elizabeth Medical Center

_____

Action Plans with PSMEMC's Involvement in Addressing the Needs

Presence Saints Mary and Elizabeth Medical Center will share the annual updates to the Implementation Strategy with all internal stakeholders including employees, volunteers and physicians. This document is available at www.presencehealth.org/community 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 Presence Saints Mary and Elizabeth Medical Center 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