

Presence Saint Joseph Hospital

Community Health Needs Assessment (CHNA) Implementation Strategy 2016

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Ministry Overview

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 (PH) 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.

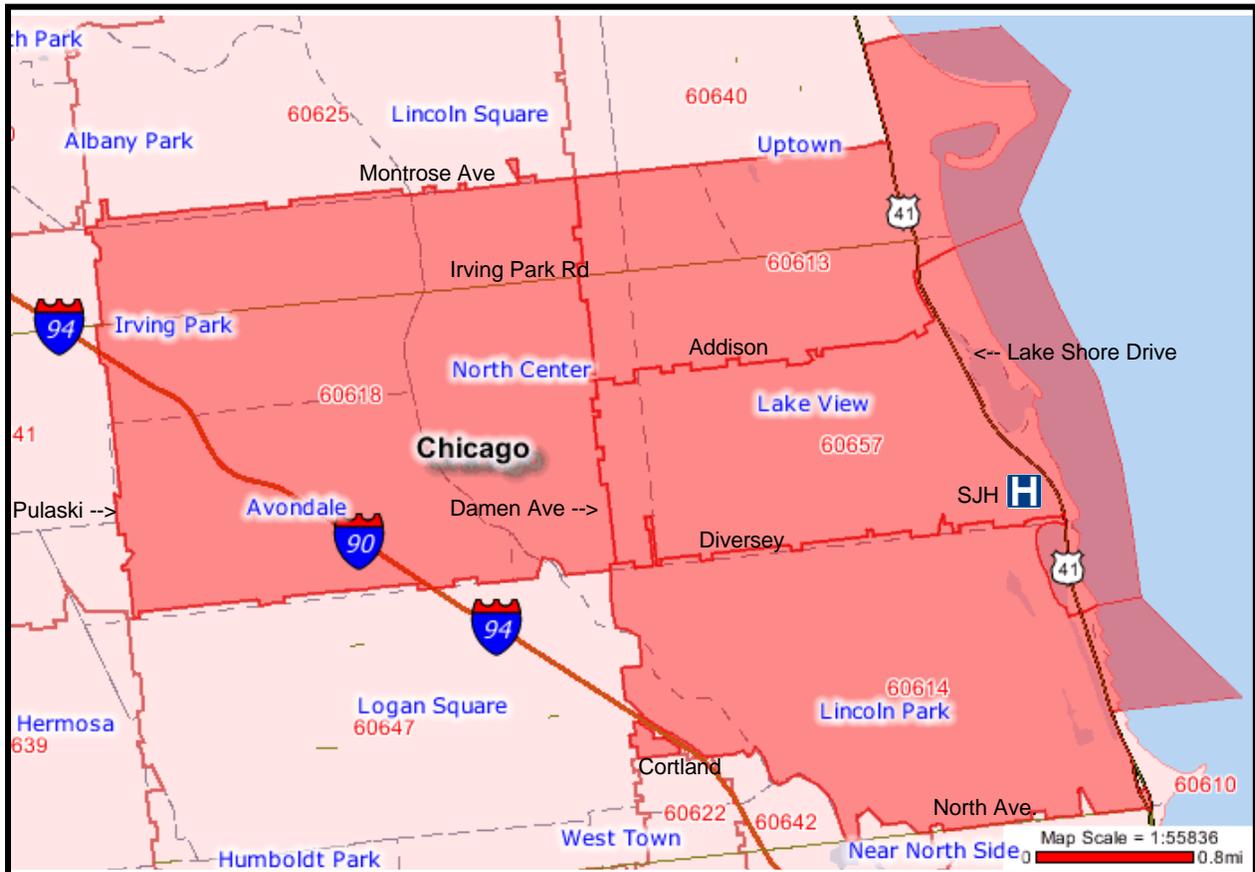
Presence Saint Joseph Hospital (PSJH) has been meeting the health needs of the Lakeview, and Lincoln Park residents for over 100 years. Founded in 1868 by the Daughters of Charity, PSJH continues to carry out its mission of providing “compassionate, holistic care with a spirit of healing and hope in the communities” it serves.

Saint Joseph Hospital is a full service health care facility licensed for 500 beds, located on the Chicago’s North side. The primary community areas served by the hospital include Lakeview, Lincoln Park, North Center and Avondale but treats patients from all over the City of Chicago. The hospital has a highly trained team of medical experts with specialties ranging from orthopedic/sports medicine and cancer care to cardiology, gastroenterology and advanced imaging services.

This report summarizes the plans for PSJH to sustain and develop new community benefit programs that 1) address prioritized needs from the 2012 Community Health Needs Assessment (CHNA) conducted by the PSJH Steering Committee, Community participants and the Illinois Public Health Department and 2) respond to other identified community health needs.

Target Areas and Populations

The service area around PSJH is made up of four community areas: Lakeview (zip codes 60657 and 60613), Lincoln Park (60614), North Center and Avondale (both part of 60618). North Center, Lincoln Park and Lakeview are very similar, more affluent, educated and less diverse, compared to Avondale. However, each area has a unique set of health related concerns.



Dashed lines indicate community areas and red lines indicate zip code boundaries.

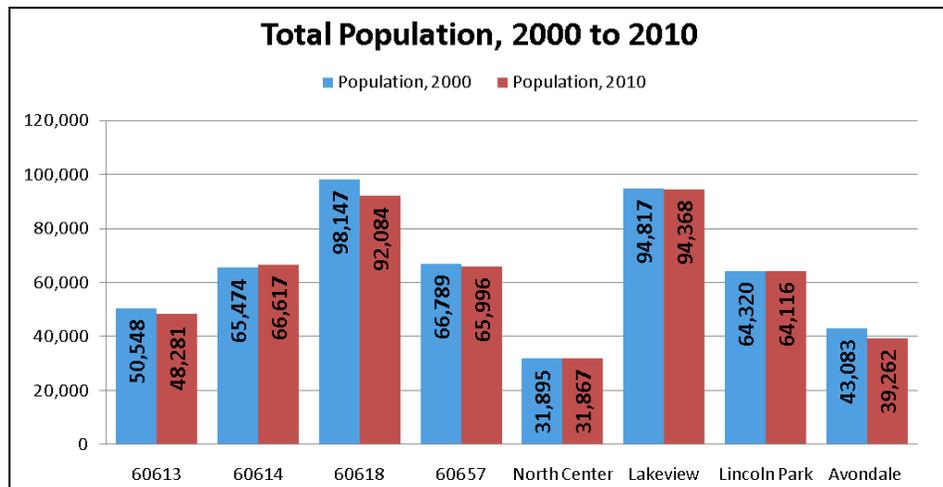
Demographics

In 2010, 229,613 people lived in the four communities of North Center, Lakeview, Lincoln Park and Avondale, with Lakeview as the largest, with over 90,000 residents. North Center (32,000) and Avondale (39,000) are the smallest communities. North Center, Lakeview and Lincoln Park have very low rates of adults without high school degrees, roughly 3-5%. However, 26% of Avondale residents lack a high school degree, which is also above the citywide rate of 21%. According to data from 2010, the percent of residents in the Avondale community (60618) has 22% of the population enrolled in Medicaid, significantly higher than the other service areas of the hospital; Lakeview (60657) had 3% of the population enrolled in Medicaid.

Target Areas and Populations

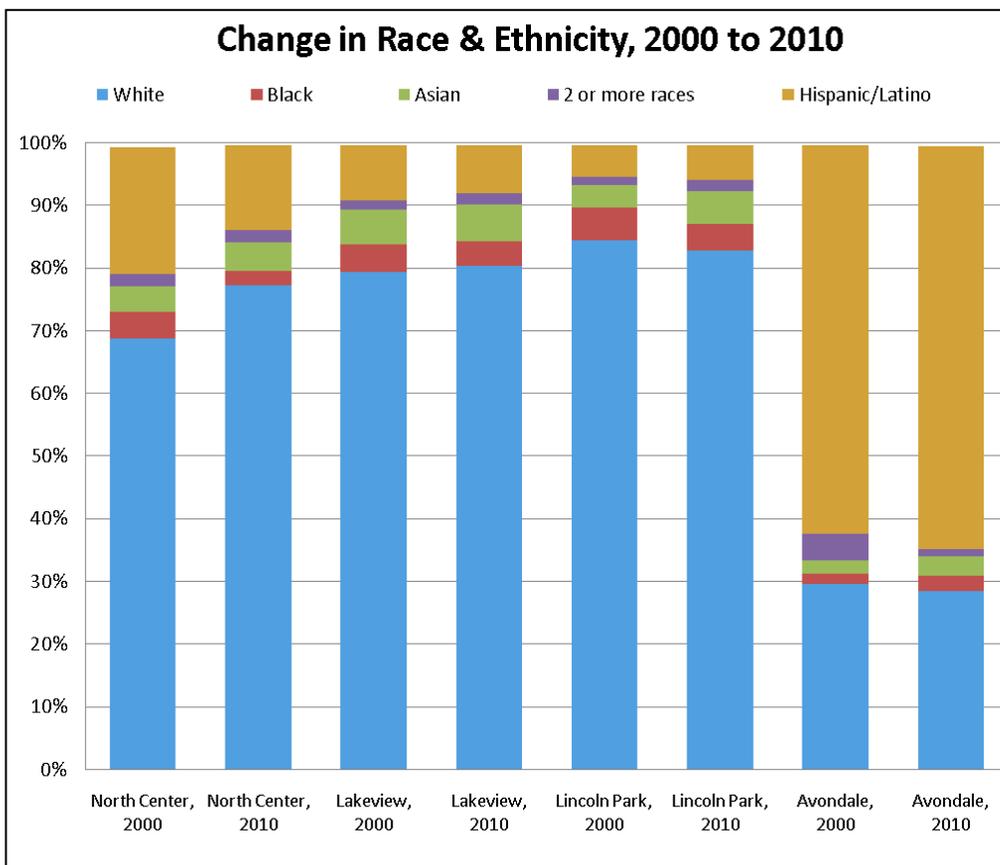
Population

The total population of North Center, Lakeview, Lincoln Park and Avondale in 2010 was 229,613. North Center and Avondale are the smallest areas, with roughly 32,000 and 39,000 residents, respectively; Lakeview is the largest, with over 90,000 residents.



Ethnicity

Two-thirds of residents in Avondale identify as Hispanic/Latino, compared with the other three community areas where the Hispanic population ranges from about 5% to 15%; these other communities are over two-thirds White. North Center, Lake View and Lincoln Park all have larger proportions of White residents than Chicago overall.



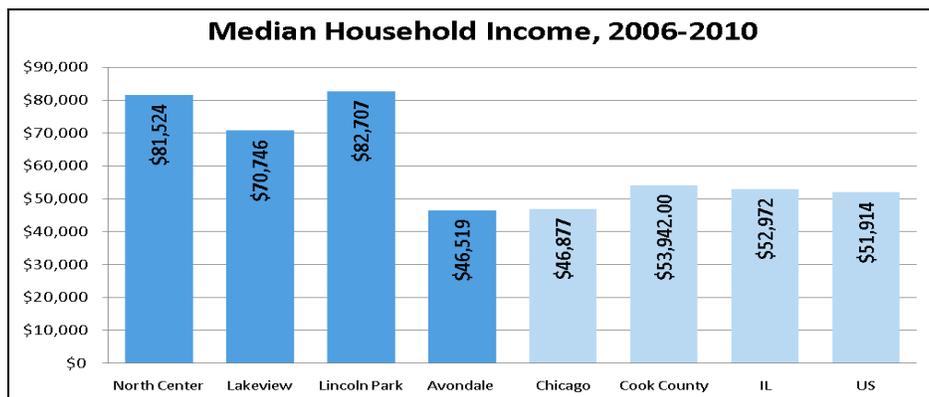
Target Areas and Populations

Language Spoken

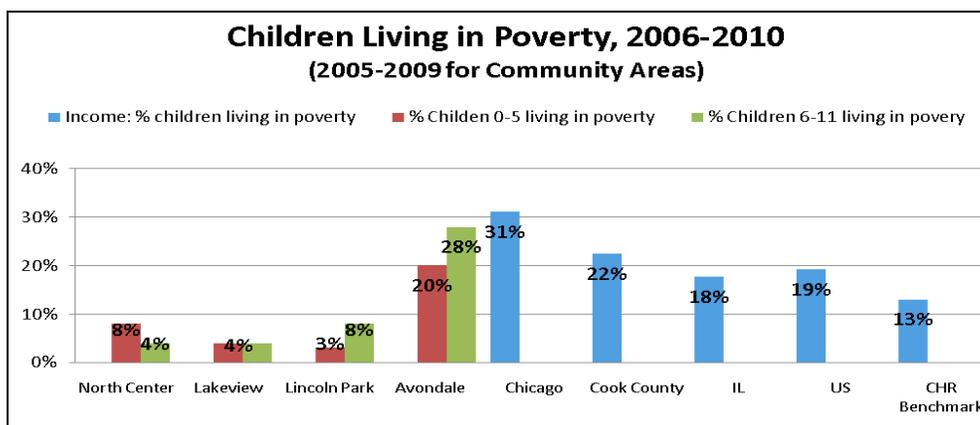
Compared to Chicago overall, North Center, Lakeview and Lincoln Park have very low rates of non-English speakers (5% or less.) Conversely, Avondale has one of the highest rates of the city at 35%. Spanish is the predominant non-English language, followed by Polish. In 2013, there were approximately 5,500 requests for interpreters at PSJH for 48 different languages. The most common request was for Spanish, followed by Russian and Polish.

Income

North Center, Lakeview and Lincoln Park all have median household incomes ranging from \$70,000 to \$82,000, considerably above the Chicago median. Avondale’s median household income, \$46,519, is almost exactly the same as the citywide median. Three of the community areas in this region have lower rates of children living in poverty than Chicago as a whole. However, Avondale has a much higher rate, 28% of 6-11 year olds and 20% of 0-5 year olds are living in poverty compared to 3-8% in the other community areas.

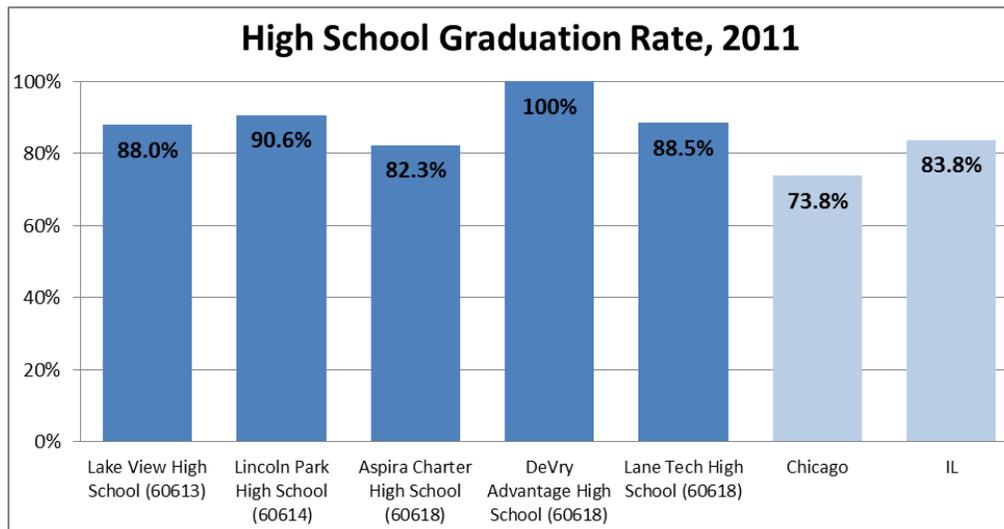


All of the community areas in this region have lower rates of children in poverty than Chicago as a whole except for Avondale which has a much higher rate, 28% of 6-11 year olds and 20% of 0-5 year olds living in poverty, compared to 3-8% in the other community areas. Avondale’s child poverty rate is slightly higher than Cook County, Illinois and the U.S. Twenty percent or fewer residents in North Center, Lakeview and Lincoln Park live below 200% of the poverty line, compared with 42% in Avondale and in Chicago overall.



Education

All of the high schools in three of the service areas have graduation rates over 80%, substantially higher than the city overall. North Center, Lakeview and Lincoln Park have very low rates of adults without a high school degree, approximately 3-5%. However, 26% of Avondale residents lack a high school degree, which is above the citywide rate of 21%.



Community Description and Greatest Needs

Lakeview, Lincoln Park, North Center

Three of the four communities served by the hospital have a similar profile. Lakeview (60657), Lincoln Park (60614) and North Center (60613) are two-thirds white, have a high household income and low poverty rates, with over 80% indicating that their immediate family goes to a physician’s office when they are in need of medical care. These three communities have less than 10% of their community enrolled in Medicaid, Lakeview (2.9%); Lincoln Park (4.7%) and North Center (8.5%). Compared to the rest of Chicago, the PSJH service area has a relatively low crime rate. These communities have a number of expensive homes, upscale retailers, boutiques, restaurants, bars and clubs, parks and have well-kept beaches along the Eastern border of these neighborhoods.

These three communities have a large number of Catholic schools and churches, an esteemed private school, some highly regarded public grade schools and high schools, good libraries and De Paul University, one of the largest Catholic universities in the country. The neighborhoods contain numerous parks, theaters and are home to two highly-rated hospitals, PSJH and Advocate Illinois Masonic. Lincoln Park is also home to the Lincoln Park Zoo, the Peggy Notebaert Nature Museum, and the Chicago History Museum. Lakeview is home to Wrigley Field and the Chicago Cubs. These communities are supported by several strong Chambers of Commerce, Neighborhood Associations and the Lakeview Citizens Council, a consortium of eleven neighborhood associations.

Target Areas and Populations

Lakeview is home to the city's largest number of lesbian, gay, bi-sexual, and transgender (LGBT) individuals. Two large organizations that provide health care and social services that support the LGBT community are the Center on Halsted and Howard Brown.

Despite the affluence of the community, there are still many individuals who are indigent, homeless, reside in Single Room Occupancy (SRO) hotels, low income housing in the Lakeview YMCA, and the local shelters. Within the community there are a large number of homeless Lesbian, Gay, Bisexual and Transgender (LGBT) youth. The Night Ministry organization in Ravenswood provides outreach, health care, food and support to the homeless youth within the Lakeview community. Individuals in the community who are without resources often depend upon the local churches, social service organizations and food pantries for meals, such as the Lakeview Pantry which provides both food and other support services. It has two sites in the community and serves 12,000 clients each year. A number are the working poor as only 3-5% are homeless clients.

Avondale

Avondale is the fourth community in the PSJH service area. As previously noted, there is a considerable difference in the communities of Lakeview, Lincoln Park and North Center with that of Avondale. Avondale (60618) is a blue-collar multi-ethnic community of Polish, Russian, Lithuanian, Eastern European immigrants, and other ethnic groups, including a large percentage of Hispanics. Avondale's Hispanic population has increased to 64% of the community. The issues of income, education, unemployment and lack of health insurance play a significant role in the community of Avondale which is among the hardest hit in city within these categories.

Some describe the community as suffering from high poverty, high alcoholism and high unemployment. Many of the men work as day laborers. There are a large number of new immigrants, including undocumented workers and residents. Because of the lack of financial resources, many single family dwellings are often shared by multiple individuals. The median household income for Avondale in 2006 – 2010 was \$46,519, below the average household income for Chicago and the United States. Approximately 15% of families live below the poverty line. The number of people enrolled in Medicaid is 22%, significantly higher than the other PSJH services areas and higher than the percentage for Illinois. There are mixed reports regarding issues of safety and violence within the neighborhood. Avondale also has several Catholic churches. Although many of the churches continue to have strong Polish affiliations and are just beginning to have masses available in Spanish.

Avondale has numerous public and Catholic schools. Several of the public schools are 80 to 90% Spanish speaking with a high percentage of the children qualifying for free or reduced lunches, an indication of the economic status of the families. Many of the schools teach in both English and Spanish in the lower grades if needed, until the children transition to all English classes. Many of the schools are concerned about health and exercise, particularly preventing childhood obesity and have established exercise and other prevention programs within the school. Currently, there is not a Chicago Public Library, a food pantry nor a hospital or health

Target Areas and Populations

care center within Avondale. It also is considered to be a neighborhood without sufficient park space. Avondale residents report that 20% of the community experiences food insecurity, i.e. they either do not have enough to eat or don't know where their next meal is coming from.

Avondale has had a resurgence of interest in home buying in the community felt to be in part due to the high cost of home ownership in other areas on the north side. This attraction of home buyers has led to a growing interest in the development of the community. The community prides itself on the diversity of the community, the wide array of multi-ethnic grocers and restaurants. Some of the restaurants are noted to be among the most highly rated within the city. The community also revitalized the Avondale Neighborhood Association and the Avondale/Logan Square Chamber of Commerce which has taken a leadership role in trying to address the needs of both the residents, the businesses as well as helping to maintain a vibrant and healthy community. The boundaries of the Avondale community are within four different wards (35th, 33rd, 31st, and 30th) and as such have four different Aldermen representing them.

Identification of Community Needs

Based on the needs identified in the CHNA report, PSJH has combined the outreach to the immediate community with that of particularly focusing on the needs of the Avondale community in particular. Working in the Avondale community targets those individuals that experience high levels of poverty, lack of insurance and a lack of health care.

Process Used to Identify Community Needs

PSJH coordinated a broad array of community stakeholders from the community areas of Avondale, North Center, Lakeview and Lincoln Park to form a CHNA Steering Committee. This committee's role was to provide oversight and input into the process, as well as to identify data-driven community priorities so as to engage in community solutions through partnerships and collaborations.

Community representation on the CHNA Steering Committee included individuals who live within the PSJH service areas, organizations and businesses that provide services within the areas, local Chambers of Commerce, social service agencies, representatives from local elected officials' offices, Neighborhood Associations, De Paul University, churches, food pantries, organizations that serve the needs of individuals throughout the city, such as the American Cancer Society, Catholic Charities and the Chicago Hispanic Health Coalition.

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; Gathering community input; Identify key issues; Developing high-level action plans and communicating results with the community.

In 2012, the CHNA Steering Committee met monthly under the direction and leadership of the PH Community Health Strategies Department and the Illinois Public Health Institute (IPHI). The IPHI was commissioned to assist with the CHNA assessment, collection of secondary data and facilitating the CHNA Steering Committee meetings and focus groups.

Summary of Key Findings from PSJH Community Stakeholders

The top four health issues from the PSJH needs assessment survey were:

1. Obesity/overweight
2. Cholesterol
3. Diabetes
4. High Blood Pressure

In addition to the above health concerns, other issues were identified that specifically affect the low income resident who may be uninsured, under served and often without the financial resources to provide for a dignified quality of life. The committee agreed that to improve the health of the community the issues must be addressed from a holistic standpoint including wellness, quality of life and promoting access and health equity and meeting community needs.

Identification of Community Needs

Focus groups were held with the CHNA Steering Committee and with primary care physicians whose practices were located in areas of high need and whose patients were under insured or underserved. Within the PSJH service area over 1500 surveys were distributed in a variety of methods, both by mail, via email, at the local library and at events at community organizations, particularly those organizations that service a large number of low income individuals. Four hundred and twenty-six surveys were returned and analyzed.

The Community Health Profile for PSJH also analyzed over 50 indicators. Secondary data indicators (data already published and available) included: populations trends, race, income, poverty levels, percentage of uninsured, health professional shortages, leading causes of death, teen births, birth weights, tobacco use, physical activity, crime rates, and food insecurity. A final report of the data from the surveys, secondary data and focus groups was completed by the Illinois Public Health Institute and Presence Health.

The following is a summary of the key indicators for the PSJH service area from the secondary data sources:

Key Indicators for PSJH Service Areas

Demographic Indicators

- The percentages of the population under age 20 and over age 65 in the CHNA service area are smaller proportions of residents than in Chicago, Cook County, Illinois or the U.S. Data Source: U.S. 2010 Census (DP01) www.robparal.com/ChicagoDemographics2010.html
- Two-thirds of residents in Avondale identify as Hispanic/Latino.
- Between 5 and 15% of the Lincoln Park, Lakeview and North Center populations are Hispanic/Latino. Data source: U.S. 2010 Census (DP01) www.robparal.com/ChicagoDemographics2010.html
- Avondale has one of the highest rates of non-English speakers in the city at 35%. Spanish is the predominant non-English language spoken, followed by Polish. Data source: American Community Survey (B16001)

Socioeconomic Indicators

- North Center, Lakeview and Lincoln Park all have median household incomes ranging from \$70,000 to \$82,000, considerably above the Chicago median. Avondale's median household income - \$46, 519 – is almost exactly the same as the citywide median.
- All communities in the CHNA service area have lower adult poverty rates than the city of Chicago (20.9%), ranging from 7% in North Center to 15% in Avondale.
- Avondale has a higher rate of children living in poverty than the other communities in the service area and the city of Chicago as a whole. Data Source: American Community Survey (S1903), www.robparal.com/ChicagoDemographics2010.html.

Identification of Community Needs

- Twenty percent or fewer residents in North Center, Lakeview and Lincoln Park live below 200% of the poverty line, compared with 42% in Avondale and in Chicago overall. www.robparal.com/ChicagoDemographics2010.html
- At all of the schools in Avondale, 70% or more of students are eligible for free or reduced lunch. In North Center, Lakeview and Lincoln Park, there was a wide range, from schools with less than 10% to schools with over 70% of students on free and reduced lunch. Data source: Common Core of Data from U.S. Department of Education's National Center for Education Statistics

Education

- All of the high schools in this serve area have graduation rates over 80%, substantially higher than the city overall.
- North Center, Lakeview and Lincoln Square have very low rates of adults without high school degrees, approximately 3-5%.
- However, 26% of Avondale residents lack high school degrees, which is above the citywide rate of 21%.
Data Source: Illinois State Board of Education (webprod.isbe.net/ereportcard/publicsite/)

Unemployment

- The unemployment rate between 2006 and 2010 was 15% in Avondale, substantially higher than Chicago at 11%.
- Unemployment in Avondale was more than triple the rate for Lakeview, Lincoln Park and North Center, at less than 5% compared to 8% nationwide. Data Source: American Community Survey (DP03), City of Chicago (data.cityofchicago.org/d/kn9c-c2s2)

Access to Health Care

- The percent uninsured in Chicago is higher than both the national and state percentages, with almost 20% of the city's population uninsured.
- Medicaid was quite low in enrollment in Lakeview and Lincoln Park (zip codes 60657, 60614, 60613, (3%, 5%, and 8% respectively).
- However, Medicaid enrollment was much higher in the North Center/Avondale zip code 60618 (22%). Data Source: Illinois Department of Healthcare & Family Services (www2.illinois.gov/hfs/agency/Program%20Enrollment/Pages/default.aspx) 2010)
- About one in four emergency room outpatients (23%) at PSJH were enrolled in Medicaid compared to 34% in Illinois. At PSJH 9% were self-paying outpatients. Data Source: IL Comp Data 2011)
- Avondale is the only community in the service area that is a health professional shortage area for primary care. There are no shortage areas for primary care in North Center, Lakeview or Lincoln Park. Data Source: US Bureau of Health Professions (bhpr.hrsa.gov)
- All four community areas have a shortage of mental health services for low-income residents. (Data Source: US Bureau of Health Professions (bhpr.hrsa.gov) 2011)

Health Status

- Cancer and heart disease are the leading age-adjusted causes of mortality across the service area, which is very similar to Chicago overall. Data Source: City of Chicago (data.cityofchicago.org/d/j6cj-r444, data.cityofchicago.org/d/j6cj-r445 CDC, (www.cdc.gov/hchs/data/nvsr/nvsr59/nvsr59_04.pdf, www.cdc.gov/nchs/data/nvsr/nvsr59_10.pdf) 2004-2008)
- Diabetes, lung cancer and stroke follows cancer and heart disease as the leading causes of death for the PSJH service area.
- In Avondale, unintentional injury is one of the top five causes of death.
- Homicide and liver disease are also leading causes in years of potential life lost in Avondale, unlike the other PSJH service area.
- Breast Cancer is one of the five leading causes in Lakeview and Lincoln Park. Data source: City of Chicago (data.cityofchicago.org/d/j6c-r444, data.cityofchicago.org/d/j6cj-r445)
- The years of potential life lost (YPLL) to unintentional injury in Avondale is the highest for any cause across all four communities. Data Source: City of Chicago (data.cityofchicago.org/d/j6cj-r444, data.cityofchicago.org/d/j6cj-r445) 2009)
- At PSJH, the top diagnoses for non-admitted ER outpatients were chest pain and alcohol abuse. Data Source: IL Comp Data 2011
- Within the PSJH service area 16% have been diagnosed with major depression and 36.1% have sought help from a professional for a mental or emotional program. Data Source: Metropolitan Chicago Healthcare Council (MCHC) 2012
- Teen births in Avondale are 63.4 per 1,000, which is above the Chicago average of 57.0 per 1,000. Teen births are especially low in Lincoln Park at 2.1 per 1,000 teens
- Low birth weight babies (less than 5.5 pounds) ranged from 6.3 to 9.1% across the four communities, compared to 9.7 for Chicago citywide. Data Source: City of Chicago (data.cityofchicago.org/d/g5zk-9ycw, CDC (www.cdc.gov/nchs/births.htm))
- While the rate of asthma hospitalizations in all areas was below the U.S. Rate, Lincoln Park had the highest rate at 101 per 100,000. Data Source: City of Chicago, (data.cityofchicago.org/d/vazh-t57q)
- Lakeview has a very high rate of annual HIV infection at 65.2 per 100,000 compared to Chicago at 40.5 per 100,000.
- Both the incidence and prevalence of HIV/AIDS in the Lakeview community are much higher than rates than for the city of Chicago, 1170.9 compared to 756.5 per 100,000. The other community areas for PSJH have rates from 300 to 367 per 100,000. Data Source: City of Chicago (data.cityofchicago.org/d/fbxr-9u99, www.cityofchicago.org/city/en/depts./cdph/provdrs/pol_plan_report/alerts/2011/dec/2011_hiv_surveillancereport.html), CDC (www.cdc.gov/hiv/surveillance/resources/reports/2010report/index.htm) 2010
- The rate of tuberculosis cases is highest in Avondale at 9 per 100,000, compared with a rate of 6 per 100,000 for Chicago and the rates for Illinois and the U.S. Data Source: City of Chicago (data.cityofchicago.org/d/ndk3-zftj, Cook County Health Department (www.cookcountypublichealth.org/data-reports_))

Identification of Community Needs

Language

- At PSJH there were almost 6,000 requests for interpreters. The most common request was for Spanish, followed by Russian and Polish. Data Source: Presence Health Internal Data FY 2011.

Health Behaviors

- The community areas served by PSJH self-reported an obesity rate of 19.6%. This rate was lower than self-reported obesity rates in Chicago, Illinois and the United States overall. Data Source: BRFSS 2009; SJH area data from Metropolitan Chicago Healthcare Council (MCHC) 2012
- Of the individuals within the PSJH service area 91% self-reported that they had exercise or physical activity within the month of the survey, which is 15% greater than the City of Chicago. Data Source BRFSS 2009; SJH area data from Metropolitan Chicago Healthcare Council (MCHC) 2012
- Approximately 50% in the PSJH service area respondents in the survey are identified as at risk for binge drinking and are also more at risk for chronic drinking compared to Chicago, Illinois and the US overall. Data Source: BRFSS 2009; Metropolitan Chicago Healthcare Council (MCHC) 2012
- One in five respondents residing in the PSJH service area identify as smokers. This is higher than Chicago, Illinois and US overall. Data Source: BRFSS 2009; Metropolitan Chicago Healthcare Council (MCHC) 2012
- Admission rates for both substance abuse and mental health are lower in the PSJH service area than Chicago overall.
- Lakeview had the highest rate of mental health admissions at 905.8 per 100,000 compared to 1111 per 100,000 for Chicago. Data Source: Community Area Health Inventory.
- The community areas for PSJH had lower rates of suicide than IL or the U.S. overall. Data Source: City of Chicago (data.cityofchicago.org/d/j6c-r444) CDC (wisqars.cdc.gov:8080/cdcMapFramework/mapModuleInterface.jsp).
- The communities served by PSJH self-reported an obesity rate of 19.6% compared to 26.2 for Chicago and 27.6 for the State and the U.S. Data Source: BRFSS 2009; SJH area data from Metropolitan Chicago Healthcare Council (MCHC) 2012
- 20% of the respondents in the PSJH service area identify as smokers, compared to 14.2% for Chicago and 16.9% for IL.
- Approximately half of the respondents in the PSJH service area are considered at risk for binge drinking. Data Source: BRFSS 2009; Metropolitan Chicago Healthcare Council (MCHC) 2012.

Environment

- All the communities in the PSJH region had lower rates of elevated lead than Chicago overall. From 0.3 to 1.0 per 1,000. Compared to 1.3 in Chicago. Data Source: City of Chicago (data.cityofchicago.org/d/v2z5-jyrrq), IDPH Lead Surveillance Report.

Identification of Community Needs

- None of the community areas within the PSJH service area are considered food deserts by the USDA. According to the USDA, food deserts are areas where “over 33% of the population or over 500 people have low access to health food.” Data Source: USDA www.usda.gov/wps/portal/usdahome 2009
- Approximately 10% of residents in North Center, Lakeview and Lincoln Park experience food insecurity, 20% of Avondale residents experience food insecurity. This is above the Chicago rate of 15%. Food insecurity generally means cutting back on food or not having regular meals due to lack of food. Data Source: Greater Chicago Food Depository; USDA (www.ers.usda.gov/briefing/foodsecurity/) 2009

Crime and Safety

- The PSJH service area had substantially fewer crimes overall compared to Chicago. Only 5.1 8% of all Chicago crimes occurred in the CHNA service area. Data Source: City of Chicago Data Portal 2011
- Child abuse rates were low in most of the PSJH service areas, however, the rate in Avondale/North Center (60618) was 7.9 per 1000, which is higher than the 5.7 for Cook County overall. Data Source: Illinois Department of Children and Family Services. (www.stte.il.us/dcfs/library/com_communications_zipcants.shtml)

Housing

- Residents in the PSJH service area reveal that 50% of the residents in Avondale were cost-burdened regarding their housing. Cost burdened is when 30% of their income is spent on housing.
- Lakeview and Lincoln Park had the least-cost burdened populations. Data Source: Chicago Rehab Network 2009. Data Source: Chicago Rehab Network

Summary of the Key Indicators for the PSJH Service Area

The indicators for socioeconomic status including, poverty, unemployment, and education play a particularly significant role in the total health of the community and its residents. These indicators as summarized in this report reflect that the Avondale community is more negatively affected in each of these categories than Lincoln Park, Lakeview, and North Center, the other communities in the PSJH service area. Access to health care and the lack of primary health care facilities in Avondale further reflects the disparities within these communities served by the hospital. Our commitment to partner with other organizations to positively impact these indicators is reflected in the work of the PSJH Action Teams as described in this report.

Identification of Community Needs

Inventory of Community Assets and Resources

The determination of the assets of the community was made in several ways and throughout the CHNA process. Initially, organizations that were felt to be able to contribute to helping understand or address some of the needs within the community were invited to be on the CHNA Steering Committee. In addition, during the focus group sessions with the CHNA Steering Committee additional individuals and a list of community assets was outlined. Lastly, as the Action Teams were convened and during their subsequent meetings, new members and organizations that could impact the problems were also approached to participate.

Identifying Community Priorities

For our initial CHNA assessment in 2012, PSJH worked with many of the community organizations identified as an asset and resource for the respective communities for our service area. Regarding health care facilities, Avondale does not currently have any healthcare facilities within its boundaries. For Lakeview, in addition to PSJH, Advocate Illinois Masonic is located in Lakeview and also serves the community.

Methodology for Prioritizing Needs

The CHNA Steering Committee generated a list of their identified cross-cutting themes and community issues based on their review of the PSJH Health Profile, Community Input Report and Community Assets. Nominal Group Technique methodology was first employed to generate the preliminary list. Following the discussion of the preliminary list of issues and needs, a multi-voting technique process was implemented to narrow down the list to the top priorities.

Prioritization criteria included consideration of: impact of problem, availability of resources to solve the 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.

Top Priorities for PSJH Implementation Plan

Taking into consideration all data findings and community needs, the goal of the CHNA Committee was to narrow the list to the top four identified prioritized community needs. What emerged are the following top four priorities generated by the methodology and process identified above for the PSJH service area to address in the CHNA implementation plan:

1. Chronic Disease Prevention and Management
2. Economic Disparities and Access to Health Care
3. Mental Health Issues, including substance abuse (especially resources for the low income person)
4. Poverty, Homelessness and Affordable Housing

It was noted that health literacy and language barriers should be addressed throughout all priorities and strategies.

Gaps identified in the PSJH Community Health Needs Assessment

The CHNA Steering Committee and the Illinois Public Health Institute analyzed a wide array of issues that impact the community. It is felt that the assessment, surveys, and analyses of both the primary and secondary data sources was very comprehensive and that there are no obvious gaps in information for the PSJH community service areas. Every effort was made to obtain input from a cross section of the community and organizations that service the community.

Results of the 2012 PSJH Community Health Needs Assessment

The health issues that cut across all four communities mirror those that affect the nation as a whole, obesity/overweight issues, cholesterol, diabetes, and high blood pressure. These issues contribute to coronary heart disease as a top cause of death within the PSJH service area.

Identifying Community Priorities

Cancer is also a leading cause of death, within the PSJH service area. But unlike the rest of the country, diabetes is among the top five in causes of death for the communities served by PSJH. These health issues are the primary conditions that contribute to chronic disease. It is believed that the opportunity to help individuals prevent and better manage these medical problems would lead to an improved quality of life and community wellness.

Equally important as the health issues affecting the community, the 2012 Community Health Needs Assessment for PSJH revealed the strong connection between low income wages, unemployment and lack of affordable housing as it affects the economic disparities felt by many within the community. These same issues often affect the individual and their family's access to health care, especially for the working poor or the undocumented individual. The tendency to avoid seeking medical care due to the cost or lack of insurance only exacerbates the problems. Likewise, it is difficult to break the cycle of poverty, without access to jobs, a good education, a good school system and decent affordable housing.

Prioritization of Issues

Presence Saint Joseph Hospital 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. PSJH worked with the PSJH Community Health Needs Assessment Steering Committee to identify priority issues for the county.

As cited earlier the PSJH Community Health Needs Assessment Steering Committee discussed the issues in great depth including, the contributing factors, the hospital and the organization's ability to address the issues and the relationship of the issues to impact a person's quality of life and well-being. The process was facilitated by the Illinois Public Health Institute.

Since the CHNA Steering Committee agreed that we would have four Action Teams to address the four major issues, each of these was considered of equal importance. Each team would determine and prioritize the activities of the respective team. The only issue that did emerge as a priority was the need to ensure that we were particularly addressing those members of the community that are the most vulnerable. It was agreed within each Action Team that the committee's initiatives would seek to identify opportunities to provide programs in the Avondale community, since it was clearly identified as having a disproportionate share of need.

Development of the Implementation Strategy

Process for Developing the Implementation Strategy

PSJH's Implementation Strategy was developed based on the findings and priorities established by the PSJH Community Health Needs Assessment. This began with the formation of the CHNA Steering Committee and a review of the hospital's existing community benefit activities.

Saint Joseph Hospital ministry participated in the CHNA process by providing the following participants:

- Roberta Luskin Hawk, M.D., President and Chief Executive Officer
- Irma Alvarado, R.N., House Manager, Nursing Administration
- Ronna Atlas, MS, BSN, RN, Manager, Emergency Department
- Maria Chicchelly, MBA, RN, Director Patient Care Services
- Rosemary Kaminski, BA, RN, Manager, Laboure Clinic
- Beverly Millison, MSW, Director, Community Health
- Father Ted Ploplis, Coordinator, Spiritual Services

Community Partners participating in the CHNA process included:

- Matt Bennett, Office of State Representative Sara Feigenholtz
- Ruth Buntman, Community Resident, The Hallmark
- David Collins, Lakeview East Chamber of Commerce
- Jesse Dudley, Rainbow Hospice and Palliative Care
- Gary Garland, Executive Director, Lakeview Pantry
- Jessica Katsuko Smith, American Cancer Society
- Jennifer Kelly, Avondale Neighborhood Association
- Kevin Kelly, Avondale Neighborhood Association
- Mark Knight, Manager, State Bank of Countryside-Lakeview
- Laura Leon, Campaign for Better Health Care
- Krystan Lordahl, Community Resident
- Maureen Martino, Executive Director, Lakeview East Chamber of Commerce
- Claretta Meier, Community Resident, Lakeview
- Gretchen Moore, Northside Latin Progress
- Elizabeth Muscare, Avondale Neighborhood Association
- Magalie Oscar, Catholic Charities of the Archdiocese of Chicago
- Laura Prohov, CJE SeniorLife
- Felix A. Quintiliani, Lakeview East Chamber of Commerce
- Ashley Rezai, Campaign for Better Health Care
- Dalia Rocotello, Catholic Charities of the Archdiocese of Chicago
- Jeanette Santana, Gilda's Club – Chicago
- Alexandra Schaible, Healthy Schools Campaign
- Esther Sciammarella, Executive Director, Chicago Hispanic Health Coalition
- Padraic Swanton, Lincoln Park Chamber of Commerce
- Kay Thurn, PhD., R.N., Professor and Special Assistant to the Provost, De Paul University
- Reverend Polly Toner, Ministry Associate, Holy Covenant United Methodist Church

Development of the Implementation Strategy

- Cathie Whitford, SeniorBridge
- David Winner, Community Resident, Former President, Lakeview Citizens Council

The PSJH Action Teams were developed to coordinate the implementation strategy to address the issues. Several members of the above CHNA Steering Committee volunteered to be on one of the four Action Teams. Each team was formed with a PSJH staff person and a community representative as the co-chairs of the team. The teams met to brainstorm on the programs and issues that could potentially address the needs identified in the CHNA report. Once an Action Team decided to implement a program or in the case of expanding existing programs, the Director of Community Health worked with the Senior Systems Analyst from PH Community Strategies to develop appropriate measures of success.

As specific programs were identified, the hospital and each of the members of the Action Teams determined what role they could take on and to what extent they or their organization could actively participate. In instances where there was not a direct role for their participation, they supported the program as an active member of the team by providing consultation and ideas for the program. An outline of the programs, roles of each partner and the measures of success are listed in the table below.

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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. An over-arching strategy was created in partnership with community stakeholders to guide the 2014-2015 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 through Enroll America.

Community Need: Access to Health 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.					
2015 Objectives	2015 Strategies	2015 Progress	Ministry Role	Community Partner Role	Measureable Outcomes
<ul style="list-style-type: none"> Decrease the rate of uninsured populations in 6 counties (Cook, Kane, Will, Kankakee, Vermillion & Champaign) through community partner engagement and targeted outreach. Directly enroll uninsured patients into Medicaid or Marketplace 	<ul style="list-style-type: none"> Steering Committee: Engage a multi-disciplinary team to oversee the Enrollment process so as to facilitate communication and partnerships locally and system-wide. Certified Application Counselors: Leverage hospital-level capacity of financial counselors and patient access leaders to assist uninsured community members 	<ul style="list-style-type: none"> Continued the Certified Application Counselor (CAC) program (initiated in 2013) for 12 hospitals through CMS and completed all requisite training and re-certification; 54 in-house CACs trained All uninsured bedded patients (Inpatient and Observ.) interviewed at bedside for Medicaid eligibility, and enrollments were facilitated where applicable. Posted all sites on Healthcare.gov for Find Local Help search tool. Create regularly scheduled times at ministry sites for IPC partners to assist community members with enrollment (site licenses obtained). A total of 19 community partner organizations bolstered Marketplace enrollment in 6 languages in over 30 	<ul style="list-style-type: none"> Presence Community Health/Mission division organized and led the enrollment effort with designated Enrollment Coordinator. Presence Health contracted with CMS for CAC contracts at 12 ministry sites. Presence Health also trained internal financial counselors and patient access leaders as CACs 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> In Cook County, the uninsured rate dropped from 17% in 2013 to 10% in 2014 and down to 9% in 2015, reflecting a net 8% decrease in uninsured. In Will County, the uninsured rate dropped from 10% in 2013 to 7% in 2014 and down to 5% in 2015, reflecting a net 5% decrease in

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<p>plans and provide health literacy training.</p> <ul style="list-style-type: none"> • Increase knowledge and awareness of Open Enrollment 2 by reaching at least 30,000 residents in a 6 county area through grassroots mobilization and awareness campaign. 	<p>with Enrollment into Exchange plans or Medicaid.</p> <ul style="list-style-type: none"> • In-Person Counselor Partners: Foster partnerships with local enrollment assisters to expand system capacity for community member enrollment. • Directional Support and Navigation: Utilize strategic communication efforts to route consumers and patients to assistance at the right place and the right time. • Public Outreach and Education: Produce targeted communications to uninsured on the Marketplace and the benefits of the Affordable Care Act. • Enroll America Partnership: Employ a system-wide partnership to 	<p>community and hospital settings</p> <ul style="list-style-type: none"> • Internally engage system “gatekeepers” to organically guide directional support (e.g. INFOline, physicians, employees). • Broad-based employee engagement campaign was initiated through screen-savers, emails calling employees to action, buttons, and campaign-style posters. • Physician integration and awareness through “pocket cards” that directed patients directly to an enrollment hotline set-up specifically for Presence Health • 6 press conferences and “enrollment blitz” events were held at ministry sites with high volume. • Integrated the 2013 unique Presence Health Enrollment help phone line to a live chat and appointment scheduler. • Updated the Presence Health website to include a direct appointment scheduler. www.presencehealth.org/marketplace. • Marketing materials were created and placed for high visibility. Integration to where IPC partners were located on site as well as the ED. • Modifications made to uninsured patient statements with Enrollment information. • Scripting developed for uninsured 	<p>by assuming staffing costs to cover non-productive time.</p> <ul style="list-style-type: none"> • 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. • Presence Community Health contracted with Enroll America for additional grassroots campaign-style reach of uninsured through \$115k contract & sponsorship of “chase program.” • Presence Health assumed the cost of engaging employees in enrollment 	<p>>\$2500 screened for Medicaid post-discharge.</p> <ul style="list-style-type: none"> • Community IPC partners provided enrollment assistance to members of the community at large with respect to cultural and linguistic competence. <p>Partners included:</p> <ul style="list-style-type: none"> – PrimeCare – Puerto Rican Cultural Center – Association House – Reliable Home Care Providers – Kankakee County Health Department – Will County Health Department – Aunt Martha’s Youth Service Center – ACCESS Community Health 	<p>uninsured.</p> <ul style="list-style-type: none"> • In Kane County, the uninsured rate dropped from 13% in 2013 to 8% in 2014 and down to 7% in 2015, reflecting a net 6% decrease in uninsured. • In Kankakee County, the uninsured rate dropped from 17% in 2013 to 11% in 2014 and down to 9% in 2015, reflecting a net 8% decrease in uninsured. • In Vermillion County, the uninsured rate dropped from 20% in 2013 to 12% in 2014 and down to 10% in 2015, reflecting a net 10% decrease in uninsured.
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Action Plan with PSJH's Involvement in Addressing the Needs

	<p>promote Enrollment and Health Insurance Literacy through market-tested messaging and grassroots, campaign-style mobilization of uninsured community members.</p>	<p>patient registration regarding Enrollment information and resources.</p> <ul style="list-style-type: none"> • Direct mailing sent to current uninsured patients in area • Extensive social media campaign, including the first-ever Presence Health #TwitterChat, reaching over 5,000. 	<p>activities and initiatives during work time, as well as all direct costs related to outreach/navigational support.</p> <ul style="list-style-type: none"> • Presence assumed the cost of recruiting and training an enrollment counselor who could also serve as enrollment hotline representative. 	<ul style="list-style-type: none"> - American Indian Health Service of Chicago - PEER Services - Family Guidance Centers - Campaign for Better Health Care - VNA Health Care - Greater Elgin Family Care Center - Cook County Health Department - Chicago Department of Public Health - Salvation Army - Get Covered Illinois - Enroll America • All IPC partners listed above were engaged in the creation and approval of all communications. 	<ul style="list-style-type: none"> • In Cook County, the uninsured rate dropped from 16% in 2013 to 10% in 2014 and down to 8% in 2015, reflecting a net 8% decrease in uninsured. • In partnership with Enroll America, over 26,000 consumers were contacted during open enrollment. 12,571 phone calls were made to uninsured, and 4,666 applications were sent in for Medicaid & Marketplace. 9,708 total conversations were had, 3,318 of which were in-person. • 101 large-scale enrollment
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				<p>Scheduling of IPCs and availability were set by community partners with respect to time of day analyses conducted of hospital traffic flows. A total of 3,442 on site appointments were made available through partner organizations.</p> <ul style="list-style-type: none"> • www.Healthcare.gov, EnrollAmerica and GetCoveredIllinois were extensively referenced and utilized in providing directional support and navigation. • Partner organizations provided the staffing and infrastructure to hold large-scale press events and enrollment blitz 	<p>events were had, either at Presence Health ministries or in partnership with other organizations at ambulatory sites.</p> <ul style="list-style-type: none"> • Over 50,000 individuals were reached through direct mail, grassroots mobilization, or social media. • Over 45,000 individuals selected plans on the Health Insurance Marketplace in Presence Health primary service area zip codes, the targeted reach of this Implementation Strategy. • Medicaid numbers are unavailable at zip code or
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				sign-ups at Presence Health ministries. <ul style="list-style-type: none"> • Presence contracts with local radio were leveraged to do radio-spots on enrollment. 	county level, but results show 95,406 individuals enrolled in Medicaid during Open Enrollment 2 in Illinois.
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Key Lessons Learned

Presence Health made significant changes to its Access to Care strategy of enhancing access to affordable health insurance through the Affordable Care Act after a thorough debrief of the 2013-2014 Implementation plan. Most significantly, staff engagement throughout the system was greatly improved through running a grassroots methodology and treating this effort like a political campaign. All front-line staff had buttons to wear throughout Open Enrollment 2 (OE2) as well as talking points to learn. Leaders were encouraged to organize and mobilize their employees as well. Signage and campaign materials were offered also in Spanish and Polish, which were especially helpful for these populations to help navigate the process and feel comfortable. Communication with leadership was also improved, from managers all the way to CEO and Board of Directors. Utilizing top-down and bottom-up strategies in conjunction with signage, custom emails and screen savers ensured high levels of employee engagement. Cultural competence was also enhanced, as 6 languages of coverage help were available. Social media was expanded, and even pushed Presence Health to expand its applications into TwitterChats and gifs. The site license for partners was made substantially easier for the IPCs, which allowed for us to grow to 19 partners, up 90% from the previous year. Partnering formally and financially with Enroll America was a tremendous asset in getting the technical coordination of appointments as well as grassroots “feet on the street.” The greater number of partners enabled not only a broader reach, but a deeper one that ultimately led to more sign-ups. While health literacy efforts were initiated in OE2, these efforts could be strengthened to include post-enrollment wraparound services that ultimately follow up with consumers about their experience, how they are achieving wellness, and in their health care utilization patterns. Focusing on engaging new enrollees will ultimately help change the culture of the health care experience that will ultimately help link people with the right health care at the right place and at the right time.

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2014-2015 Baseline	2014-2015 Outcome	2015-2016 Target Objective	2015-2016 Measureable Outcomes
<ul style="list-style-type: none"> -Decrease the rate of uninsured populations in 6 counties (Cook, Kane, Will, Kankakee, Vermillion & Champaign) through community partner engagement and targeted outreach. -Directly enroll uninsured patients into Medicaid or Marketplace plans and provide health literacy training. -Increase knowledge and awareness of Open Enrollment 2 by reaching at least 30,000 residents in a 6 county area through grassroots mobilization and awareness campaign. 	<ul style="list-style-type: none"> -The rate of uninsured decreased (since 2013, ACA implementation) by 8% in Cook County, 5% in Will County, 6% in Kane County, 8% in Kankakee County, 10% in Vermillion County, and 8% in Champaign County. -Over 45,000 selected Marketplace plans in Presence Health Primary Service Areas zip codes. -Over 95,000 selected Medicaid plans during Open Enrollment in Illinois. -Over 50,000 residents were engaged through grassroots mobilization and awareness campaign. 	<ul style="list-style-type: none"> -Continue to decrease the rate of uninsured population in 6-county area Presence Health serves by 1% in each county. -Leverage partner organizations to continue to do grassroots mobilization and sign-up as well as post-acute service integration (wraparounds). -Improve knowledge of health insurance plans & benefits (e.g. understanding of deductibles, coverage, etc.) and increase health literacy. -Mobilize new enrollees to utilize annual wellness visit benefit through targeted campaign to trigger ongoing health literacy through PCP engagement. 	<ul style="list-style-type: none"> -Rate of uninsured will be measured by county -Marketplace plan selection by targeted zip code -Direct enrollments from Presence Health facilities and partners -Wrap-around service utilization with post-enrollment services. -Health literacy questionnaire -Follow-up questionnaire on self-reported PCP visits.

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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: Reducing Stigma and Improving Access to Care

Aim Statement: Presence Health and its community partners seek to implement Mental Health First Aid training for residents across a 6-county area to reduce stigma related to mental health.

2015 Objectives	2015 Strategies	2015 Progress	Ministry Role	Community Partner Role	Measurable Outcomes
Reduce stigma related to mental health for residents of Presence Health communities, and improve coordination of care and access to mental health resources in the community.	<ul style="list-style-type: none"> Implement Mental Health First Aid training to at least 150 laypersons Update community-specific inventories of existing resources for six county areas of mental health services and resources and distribute through Presence Health INFO line and behavioral health services. Apply for and receive 	<ul style="list-style-type: none"> Community behavioral health inventories completed. Evaluation plans solidified and standardized to include the Personal and Perceived Stigma scale. Identified partner agency, Trilogy, to facilitate the trainings and drafted an MOU agreement to standardize pricing. Identify existing groups 	<ul style="list-style-type: none"> Presence Health system and local employees serve on the mental health action teams. Community behavioral health inventories were compiled and distributed through local and system channels. Presence System office handled the 	<ul style="list-style-type: none"> Numerous community-based agencies participate on the local mental health action teams. Members of these teams provided information on community mental health resources for compiling into the inventories. Trilogy facilitated the MHFA trainings 	<ul style="list-style-type: none"> Program findings were highly favorable; participants significantly decreased personal stigma associated with mental illness ($p < .05$). Program participants (n=224) significant improved their recognition of

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	<p>grant funding to subsidize the cost of trainings (\$5000 from Hermitage trust, renewable and contingent on successful outcomes).</p>	<p>that could benefit from MHFA in the future (aldermen, city/county staff, park districts, libraries, first responders, and patient navigators).</p> <ul style="list-style-type: none"> Data were analyzed 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. 	<p>training costs and management of obtained grant funds.</p> <ul style="list-style-type: none"> Community Health leaders coordinated logistics of trainings at ministry sites. Presence Behavioral Health division provided in-kind support of the Crisis Line for program participants to disseminate and utilize themselves post-mental health first aiding. Community Health Strategy evaluated the program with trained analyst. 	<p>and certifications for participants.</p> <ul style="list-style-type: none"> Community partners identified trainees and helped promote awareness of trainings. All trainees received and disseminated resource guides. 	<p>mental health disorders ($p < .05$), and increased their understanding of various treatments for mental illness.</p>
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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. In 2015, the Mental Health First Aid training was offered in several locations throughout the Presence Health ministry and in the broader community so as to expand its reach and continue to grow. It has received attention from the Kennedy Forum as well as the Heritage Trust, which granted the program \$5000 to continue to implement the program at no cost to participants. In 2016, the program will be expanded to include Spanish specific training as well as training on youth and

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adolescent mental health. The inclusion of a module on PTSD specific for organizations serving veteran populations is being explored. The revised length of the evaluation using an evidence-based measure (The Personal and Perceived Stigma Questionnaire) was well received and alleviated participant burden while highlighting significant effects of reducing stigma and identifying mental illness. In 2016, we aim to train 300 persons including special groups of aldermen and their staffs, city and county workers, librarians, and parks/recreation employees. The City of Chicago in particular has endorsed Presence Health’s strategy for reducing mental health stigma and improving mental health awareness by requiring its employees to complete this certification in 2016. Further, the Health Insurance Navigators from several enrollment assistance groups will also be completing this training as a regular practice.

2015 Baseline	2015 Outcome	2016 Target Objective	2016 Measureable Outcomes
Presence Health continued to expand its Mental Health First Aid Program.	Presence Health received a grant of \$5,000 to continue to implement the program at no cost to the participants.	Presence health plans to train 300 persons including staff from agencies in Mental Health First Aid. Health Insurance Navigators from several enrollment assistance groups will also be completing the Mental Health first aid training.	- Number of persons trained in Mental Health First Aid.

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PREVENTING AND MANAGING CHRONIC DISEASE

Program Description

There are several initiatives that PSJH is engaged in to address the issue of Preventing and Managing Chronic Disease. The Preventing and Managing Chronic Disease Action Team goal is to decrease chronic disease through collaboration and the implementation of programs focusing on obesity. One of the primary goals was to identify opportunities to work with the residents in the Avondale community, where the need seemed to be the greatest among the communities served by the hospital. As a result, PSJH developed a relationship with two local Chicago Public Schools in the Avondale community to collaborate on obesity-related prevention and education initiatives. Since many of the schools have also adopted various childhood obesity programs it was felt this would be an opportunity to build on existing programs, potentially impacting the entire family, including the children, parents and grandparents.

Aim Statement: Decrease chronic disease through collaboration and implementation of programs focusing on obesity.					
2015 Objectives	2015 Strategies	2015 Progress	Ministry Role	Community Partner Role	Measureable Outcomes
Implement nutrition classes for parents at the Carl Von Linne School to educate them on nutrition and its relationship to good health and prevention of obesity and diabetes.	<ul style="list-style-type: none"> Provide on-site nutrition education in Spanish to the parents of the students that attend the Carl Von Linne School in the Avondale community. 	<ul style="list-style-type: none"> A new program, <i>Look Good, Feel Good: Healthy Eating for Life</i> was initiated in September 2015 by a bi-lingual, bi-cultural Licensed Practical Nurse from PSJH. Held joint educational cooking demonstrations with PSJH instructor and the school’s Culinary Arts teacher for the children. 	<ul style="list-style-type: none"> PSJH provides the LPN that provides the nutrition education classes for the adults. PSJH provides the Zumba classes for the parents. PSJH provides for the Laboure clinic staff that delivered the Step into Health program. PSJH provides lab staff that conducts onsite 	Partners include: <ul style="list-style-type: none"> Renee Mackin, Principal, Carl Von Linne Chicago Public School provides the support and the space for the Look Good, Feel Good classes. Kay Thurn, DePaul University co-chair, Chronic Disease Action Team. Jennifer Herd, City of Chicago is a member and has provided 	<ul style="list-style-type: none"> 10 parents participated in the <i>Look Good, Feel Good: Healthy Eating for Life Program</i>. 100% of the participants demonstrated increased knowledge in all 10 areas of nutrition education that were assessed and evaluated. PSFH nurse/coordinator actively involved

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		<ul style="list-style-type: none"> • Presence Health Physician’s Medical Group (PMG) Office in Avondale invited to provide class on obesity and diabetes from their Registered Dietitian. • PMG Registered Dietitian and Office Manager invited to attend the PTA meeting with the LPN instructor. • PSJH instructor invited to be a member of the school’s Wellness Committee. • PSJH instructor invited to attend the school’s Parent Teacher Association meetings. • PSJH sponsored the on-site Zumba classes for the parents for the school year of 	<p>complimentary health screenings, including full lipid panel cholesterol and A1C diabetes screenings, and nurses who provide bmi and bp screenings.</p>	<p>information on obesity rates regarding the Chicago Public School.</p> <ul style="list-style-type: none"> - Karen Lechowich, R.D., former Executive Director at the Academy of Nutrition and Dietetics - Other members were previously on the team but are unable to participate at this time. - All members contribute to the ideas, information and decisions of the team. - Contracted with Sylvia - Registered Dietitian and Chef from Hispanic Nutrition, Inc. to provide nutrition information to the parents at the Carl Von Linne Health Fair. 	<p>with the school’s principal and teacher.</p> <ul style="list-style-type: none"> - Zumba exercise classes provided on site at the school to the parents. Attendance ranges from 10 – 40 parents.
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		<p>Sept. 2015 to June 2016.</p> <ul style="list-style-type: none"> PSJH contracted with a Registered Chef from a private Hispanic Nutrition Company to provide nutrition education information. 			
<ul style="list-style-type: none"> Implement the Step into Health classes at the Carl Von Linne School. 	<ul style="list-style-type: none"> Provide on-site nutrition and exercise classes to the students. Revise Pre-Post evaluation of the classes 	<ul style="list-style-type: none"> PSJH Laboure clinic staff provided 2 fourth grade classes with the Step into Health program. Pre-Posttest was revised with input from the Obesity Action team and the Presence Health System Community Health staff. However, students continued to have difficulty understanding the pre-post test questions. 	<p>PSJH nurses from the Laboure clinic provide the Step into Health classes' onsite at the school.</p> <p>PH Systems Analysts assisted with the revisions of the pre-posttest.</p>	<ul style="list-style-type: none"> Chronic Disease and Obesity Action Team members assisted with the review and revisions of the pre-posttest. Met with Jane Mentzinger, Executive Director, Communities in Schools of Chicago and Katrina Pavlik, Senior Community Partnership Specialist. This organization provides a vital 	<ul style="list-style-type: none"> 5 dates were offered to the school for the Step into Health, but only 1 date was accepted. Two 4th grade classrooms were provided instruction in nutrition and education. Average pre-test score was 48%, post-test score was 48% for classroom one. Average pre-test score was 55%, average post test score was 60%. In 2015 the pre-post-test was

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				<p>service in working with community organizations and linking them with the schools within their program. Since Carl Von Linne is within their program, this will allow us to work more closely with the Communities in School and their direct connections within Carl Von Linne.</p>	<p>revised to include multiple right answers for each question. Unfortunately, the students did not understand this concept</p> <ul style="list-style-type: none"> - Consequently, the pre-posttest has been changed again to only have one right answer.
<ul style="list-style-type: none"> • Provide health screenings to the adults in Avondale, including bmi, cholesterol, bp and A1C for diabetes. 	<ul style="list-style-type: none"> • Provide complimentary health screenings to the parents of the students. • Provide follow up to the parents who receive an abnormal health screening result 	<ul style="list-style-type: none"> • Participated in the Carl Von Linne Health fairs. Provided free health screenings to the adults. 	<ul style="list-style-type: none"> - PSJH provides the onsite free screenings. - PSJH provides the nursing and certified diabetes educators that conduct the follow up with the individuals screened. 	<ul style="list-style-type: none"> - Carl Von Linne provided the space for the health screenings and coordinated the fair. 	<ul style="list-style-type: none"> - 37 parents received a health screening from PSJH. All adults who had abnormal screening results had health education provided on site by the RN or by telephone from the Certified Diabetic Nurse Educator.
<ul style="list-style-type: none"> • Provide information to the 	<ul style="list-style-type: none"> • Provide on-site information and 	<ul style="list-style-type: none"> • Parents provided information at the 	<ul style="list-style-type: none"> - PSJH Labourer Clinic provides 	<p>Carl Von Linne provided the space.</p>	<ul style="list-style-type: none"> - Numbers are included in the

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<p>parents on options for primary health care, including care for undocumented individuals.</p>	<p>assistance with obtaining a primary care provider if needed.</p> <ul style="list-style-type: none"> • Provide enrollment in the Affordable Care Act by the Laboure Clinic’s financial counselor. • Provide assistance with enrollment in the Laboure Clinic. 	<p>School’s health fair.</p> <ul style="list-style-type: none"> • Follow-up provided by the PSJH financial counselor for ACA enrollment and Laboure enrollment. • Undocumented parents advised of ability to enroll their family in the Laboure Clinic. 	<p>the financial counselor who attends health screening events to provide the health care options information.</p>		<p>Access to Health care information.</p>
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Key Lessons Learned

The partnership with the Principal of the Carl Von Linne School continues to be extremely important for our current work of the Chronic Disease and Obesity’s Action Team’s effectiveness. The team understood that starting the *Look Good, Feel Good: Healthy Eating for Life* Program would take time for the program to develop. We realized that a significant factor in the knowledge and acceptance of the program would be having an appropriate person to provide the classes. We feel that hiring the LPN in Community Health from PSJH who is both bi-lingual and bi-cultural has been well received by the principal, the teachers and the parents. This is reflected in her being invited to participate in other school related activities where she can get to know the teachers and the parents and explain the program. We also had an unexpected benefit in that the LPN also works in the Presence Health Medical Group Office in Avondale, which is located around the corner from the school. This medical office, which was recently opened by PH, has Latino physicians and staff is the only health care facility within the Avondale community. We this project was begun there were no such facilities in this community. It also afforded us the opportunity to utilize the registered dietitian from the PMG Avondale office as a supplement to the program.

One of the unanticipated observations is that while the parents that participate in the Look Good, Feel Good program have been enthusiastic when they attend, program attendance has varied from week to week. Since these are often young parents with multiple responsibilities during the daytime they cannot attend every week. This variation in attendance will most likely continue. Similarly, while the Step into Health

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classes was offered for 5 dates, the school was only able to accommodate one date for the 2015 school year. As mentioned above, for 2016 we will also work with the Communities in School program to assist with scheduling needs.

We also learned that we needed to change our marketing of the program. Initially, the school’s principal requested that the program be held immediately after the Zumba class on Wednesday mornings. Consequently, we targeted the classes to those participating in the Zumba classes. However, we found that the majority of those attending the Zumba classes appeared to be healthy, in shape physically and had good baseline screening results. We immediately changed the marketing materials and promoted the program to the general parent community rather than just this select group. We also knew that we needed to seek support from the physical education teacher who is chair of the school’s Wellness Committee to help us promote the program to the broader parent body.

Development of relationships, especially within the school setting takes time. We recognize that time is very limited for administrators and teachers and there is a lot to be accomplished. Having outside community resources certainly is highly desired but must be balanced with the multiple demands upon the school’s time. While the hospital utilized staff from the Laboure Clinic for some of the screenings and contracted with an outside dietitian, providing the classes by a PSJH associate within the Community Health Department has been much more effective. It has also been especially helpful in allowing us a much greater opportunity to develop the necessary relationships with the school personnel and parents. This is exemplified in the collaboration between the PSJH associate coordinating the Look Good, Feel Good program with the Culinary Arts Teacher at the school. This allows both the school and the Look Good program to reinforce that improving the way the family eats; both children and parents will benefit everyone in the family and decrease the risk of diabetes, a major health issue that affects the community. We look forward to continuing to strengthen these relationships as we continue to work to have a measurable impact on the chronic health needs of the parents in this Avondale School community.

2015 Baseline	2015 Outcome	2016 Target Objective	2016 Measureable Outcomes
<ul style="list-style-type: none"> - Implement nutrition classes for parents at the Carl Von Linne School. - Implement the Step into Health nutrition education classes at the Carl Von Linne 	<ul style="list-style-type: none"> - Look Good, Feel Good: Healthy Living for Life classes implemented. - Registered Dietitian from PMG Office in Avondale presented to parents of the Look Good, Feel Good classes on nutrition and diabetes. 	<ul style="list-style-type: none"> -Increase by 25% number of parents enrolled in the <i>Look Good, Feel Good: Healthy Living for Life</i> Program -Increase number of parents who demonstrate increased nutrition knowledge and report improved nutrition habits. -Increase number of parents who 	<ul style="list-style-type: none"> - Number of parents participating in the Nutrition classes. - Number of parents who demonstrate increased nutrition knowledge and report improved nutrition habits. - Number of students who

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<p>School.</p> <ul style="list-style-type: none"> - Provide health screenings to the adults in Avondale. 	<ul style="list-style-type: none"> - LPN coordinator from PSJH invited to participate on the school's Wellness Committee and attend Parent Teacher Association Mtgs. - On site Step into Health classes implemented by the Laboure Clinic. - Health screenings provided to the parents of Carl Von Linne. - Financial Counselor from Laboure Clinic attended health screenings and provided on-site information on the ACA and sign-up for the Laboure Clinic. 	<ul style="list-style-type: none"> - Continue onsite Step Into Health Classes provided by the Laboure clinic to the students. Demonstrate students increased knowledge of the relationship between nutrition, exercise, and effect upon disease prevention and good health. -Work with Communities in Schools Program to help facilitate Step into Health implementation at the school. -Meet with leadership of Resurrection Catholic Church in Avondale community. Identify opportunities to collaborate to serve the needs of the Carl Von Linne parents and/or residents of the community. -Meet with the local Spanish grocer. Assess availability of fresh fruits and vegetables. Identify interest in partnering with PSJH on nutrition education. Explore opportunity to partner with both the Grocer and the PMG Registered Dietitian. 	<p>demonstrate increased knowledge of nutrition and exercise.</p> <ul style="list-style-type: none"> -Number of additional community partners collaborating with PSJH and the Chronic Disease Action Team.
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Action Plan with PSJH's Involvement in Addressing the Needs

ANTI-POVERTY/HOMELESSNESS/ECONOMIC DISPARITIES AND AFFORDABLE HOUSING

Program Description

One of the primary programs developed by the Anti-Poverty, Anti-Homelessness and Economic Disparities Action Team is to address opportunities to provide individuals with gainful employment. The ability to acquire and maintain a job is the single largest prerequisite to begin to remedy the issue of poverty and homelessness. Since many of the individuals who face the greatest risk of poverty are often the most challenged due to inadequate education, training or experiences with the criminal justice system, we collaborated with a highly regarded local community organization, The Cara program whose mission is to transform the lives of these individuals; their website indicates "The Cara program prepares and inspires motivated individuals to break the cycle of homelessness and poverty, transforms their lives, strengthen our communities, and forge paths to real and lasting success."

Our work with the Kelvyn Park High school in a series of hospital work force initiatives in another opportunity to inspire individuals to graduate high school, continue on to either employment or college and to expose them to the opportunities available should they decide to choose a career in health care. This series includes students attend the hospital's job shadow day, site visit day and students who participate in the PSJH 6 week internship, Achieving Dreams. Students are assigned to clinical areas of the hospital and also participate in job readiness, college readiness and general mentoring.

Lastly, related to our work for those who are indigent or underserved is our initiative to provide outreach on-site at community organizations, such as food pantries and churches who serve the indigent. This outreach provides an opportunity to provide health screenings and encourage individuals who are without any health insurance to enroll in Medicaid, if eligible, or the hospital's Laboure clinic which accepts individuals regardless of their financial status or citizenship. While this goal is also a part of the Access to Health Care Action team it is also an important element in addressing the issues of those who are affected by poverty, homelessness and economic disparities. It is also important in our work with the Avondale community and the Carl Von Linne School, since many of the families are immigrants or may be undocumented and cannot access health services through the Affordable Care Act.

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Community Need: Anti-Poverty, Anti-Homelessness and Economic Disparities and Affordable Housing					
Aim Statement: Reduce poverty and increase access and cohesiveness of services to address the issues of poverty, homelessness, economic disparities and affordable housing. Target communities include: Lakeview, Lincoln Park, North Center and Avondale.					
2015 Objectives	2015 Strategies	2015 Progress	Ministry Role	Community Partner Role	Measureable Outcomes
<ul style="list-style-type: none"> • Increase the number of CARA clients who complete an application at PSJH. • Increase the number of CARA applicants who receive an interview at PSJH. • Increase the number of CARA clients who receive an offer for a position at PSJH. 	<ul style="list-style-type: none"> • Joint meeting held with the leadership of the CARA program and the Director of Human Services at PSJH. • Identified issues and opportunities to increase the number of applications with the potential of hiring CARA clients. 	<ul style="list-style-type: none"> • There continued to be a decrease in the number of CARA clients applying for positions at PSJH. • PSJH underwent a change in the structure of Human Resources, moving to a centralized off-site model. • No CARA clients have been hired at PSJH since the inception of this strategy. 	<p>PSJH Director of Human Resources and Director of Community Health held meetings with CARA administrators and staff at PSJH.</p>	<ul style="list-style-type: none"> • CARA Program worked to identify and have clients apply for positions. • Gary Garland, Executive Director, Lakeview Pantry, co-chair of the Action Team. • Leslee Carver, co-chair of the Action team. • Other members were previously on the team but due to various reasons did not continue their participation. 	<p>No results accomplished in 2015 for this strategy related to the CARA program.</p>
<ul style="list-style-type: none"> • Provide on-site health career mentoring experiences for students from Kelvyn Park CPS high school. 	<ul style="list-style-type: none"> • Provide opportunities for students from low-income communities to receive mentoring to increase their 	<ul style="list-style-type: none"> • Provided two sessions of Job Shadow Days, Site Visit and a 6 week internship for the students at PSJH. 	<p>- PSJH Directors, Managers and Associates functioned as mentors and provided supervision of the</p>	<ul style="list-style-type: none"> • Delisa Johnson, Department of Career and Technical Education, CPS • Nina Calloway, teacher, Kelvyn 	<ul style="list-style-type: none"> • Fifteen students offered a slot for the 6 week “Achieving Dreams” internship at PSJH; 12

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	<p>opportunities to graduate from high school to obtain a career and enroll in college post high school.</p>	<ul style="list-style-type: none"> • Provided educational guest lectures to the students. 	<p>- students. PSJH physicians provided educational lectures to the students.</p>	<p>Park High School</p> <ul style="list-style-type: none"> • Lois Richards, Michael Reese Health Trust • Dr. Gwendolyn Rice, Associate Dean of Nursing, City Colleges of Chicago • Mr. Roy Walker, Associate Dean of Health Careers 	<p>students accepted and participated over the summer.</p> <ul style="list-style-type: none"> • Two job shadow days held in 2015. 28 students participated. • 19 students participated in a half day site visit at the PSJH. • 3 students in the 6 week internship program enrolled in the Malcom X Health Career program. • One person that attended the 6 week internship was hired as a CNA and received the Support and Caring Award at the Annual Nurses' Award Ceremony.
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Key Lessons Learned

From the outset the Anti-Poverty Action team felt that the PSJH managers should continue to select the best person for any given vacancy. However, given the continued high unemployment, there are still many overly qualified applicants competing with the CARA clients for the jobs that they are most likely to be eligible. We believe not having hired anyone from CARA may have impacted their clients desire to submit applications. It should be noted that most CARA clients are looking for full time positions, rather than registry or part-time work. Additionally, since the PH system centralized Human Resources, the development of relationships between the PSJH Employment Coordinators and the CARA Individual Specialists is not feasible. We will no longer pursue this strategy at PSJH for 2016.

The work done with the CPS students for the Hospital Workforce Initiative, “Achieving Dreams” is one of the most important initiatives that we can engage in to stem the next generation of young adults from living in poverty. Providing students with the mentorship needed to encourage them to remain in school and to pursue further education for a professional career is one that can make the most significant difference in their improving their economic status and ability to provide a living wage for themselves and their family. Kelvyn Park High School is located in the Hermosa community, adjacent to the Avondale community. The majority of the students, 98% are classified as minority with 89% being Hispanic. This community school is a Level 2 school with a graduation rate of 52.2%.

Given our work with the parents of the Carl Von Linne school, located in Avondale, a highly economically disadvantaged community, in 2016 we will explore the opportunity to identify programs and resources that can impact the status of parents, beyond our obesity initiative. Two such needs that were identified by the parents were classes in English as a Second Language and GED classes. Similar to the comments above regarding opportunities to improve economic status and earn a livable wage, the ability for the parents to speak English and have a GED is often a prerequisite for employment. The opportunity to expand our existing partnership with the school, with De Paul University and potentially other community partners, will hopefully facilitate the execution of this strategy in 2016.

2015 Baseline	2015 Outcome	2016 Target Objective	2016 Measureable Outcomes
Original baseline for this project started at zero. In 2014 the strategy to partner with the CARA program produced 15	<ul style="list-style-type: none"> No job applications from the CARA program were submitted to PSJH for 2015. No CARA program clients 	<ul style="list-style-type: none"> Discontinue this strategy for 2016 	

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<p>completed applications and 5 interviews. However, no CARA clients were selected for a position at PSJH. In 2015, there were no applications for employment at PSJH for this program.</p>	<p>were hired by PSJH for 2015.</p>		
<p>Students from the Kelvyn Park High School participated in the PSJH Hospital Work Force Initiative.</p>	<ul style="list-style-type: none"> • 6 week internship “Achieving Dreams” held at PSJH. Program restructured to provide more job readiness, college readiness and direct guidance on pursuing a career in the health care field. • Held 2 job shadow days at PSJH. • Held 1 site visit day at PSJH. • Increased the number of clinical departments involved in the program from the previous year by more than 50%. 	<ul style="list-style-type: none"> • Continue to maintain high level of involvement from clinical staff at PSJH participating in this program. • Continue to have guest speakers who can provide meaningful career and college readiness advice to the students. 	<ul style="list-style-type: none"> • Number of students participating • Number of clinical mentors from PSJH • Number of students that participate in the program that graduate (This information will need to be provided by CPS.)
		<ul style="list-style-type: none"> • Evaluate efficacy of partnering with De Paul University to provide English as a Second Language classes to the parents of Carl Von Linne. (See further details in the Anti-Poverty Section of this report for 2016 Objectives.) • Explore community partners that could provide GED classes to the parents of Carl Von Linne. 	<ul style="list-style-type: none"> • Number of individuals that participate in the classes if offered. • Additional measurements of outcomes to be determined by the University or organization providing the classes.

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Next Steps for Priorities

In addition, to each of the goals and objectives listed in the above four Action Teams, Presence Saint Joseph Hospital will continue to meet community needs by providing charity care, Medicaid and State Health Insurance Assistance Program (SHIP) services.

For each of the priority areas listed above, Presence Saint Joseph Hospital will work with its community partners on each Action Team 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 Approval

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 2016.

The below signatures signify that this plan has been reviewed and approved for 2016.

_____	_____
President & CEO	Date
Roberta Luskin Hawk, M.D.	

_____	_____
President & CEO	Date
Presence Life Connections	

_____	_____
Vice President, Mission Services	Date
Dougal Hewitt	

_____	_____
Vice President, Mission Services	Date
Presence Life Connections	

Insert names and titles of primary staff responsible:

<u>Beverly Millison, MSW, Regional Director Community Health</u>	<u>12-17-15</u>
Plan Prepared By	Date

Mission Committee of the Board Adoption Date

Mission Committee of the Board Adoption Date

Presence Life Connections

Board of Directors Approval Date

Presence Saint Joseph Hospital

Board of Directors Approval Date

Presence Life Connections

Implementation Strategy Communication

Presence Saint Joseph Hospital 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 Saint Joseph Hospital 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