Presence
Saint Francis Hospital

Presence Saint Francis Hospital

Community Health Needs Assessment (CHNA)
Implementation Strategy
2013 - 2016

Table of Contents

Ministry Overview 1

Target Areas and Populations 2

Identification of Community Needs 9

Identifying Community Priorities 13

Development of the Implementation Strategy 15

Action Plan with Saint Francis Hospital's Involvement in Addressing the Needs 16

Next Steps for Priorities 27

Implementation Strategy Approval 28

Implementation Strategy Communication 29

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 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:

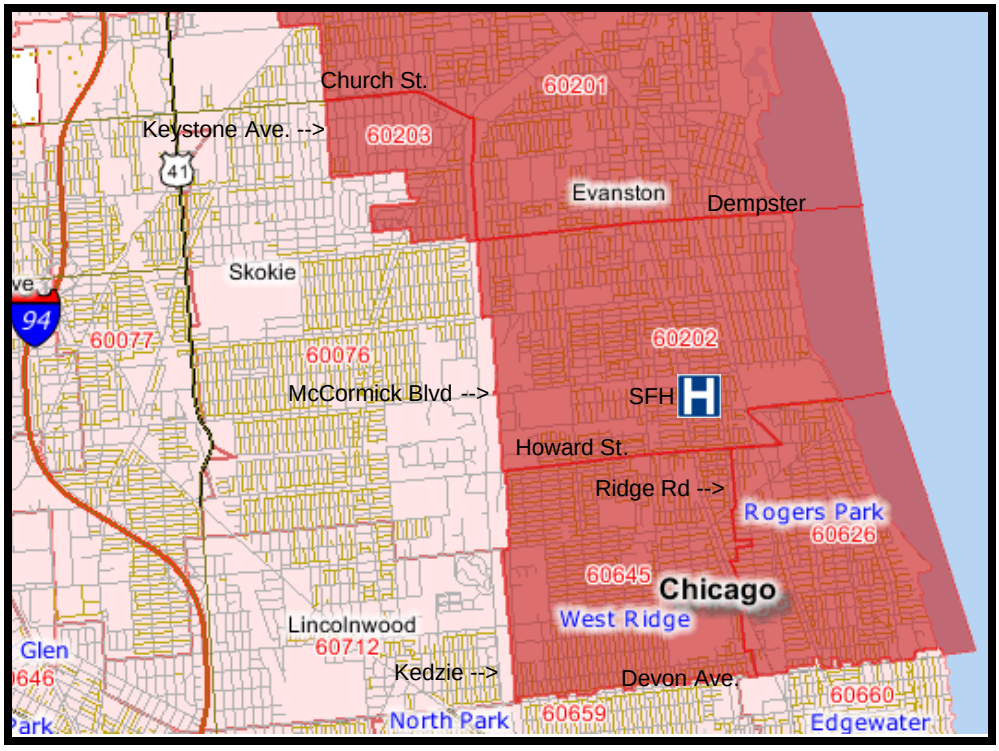
- **Honesty**: The value of Honesty instills in us the courage to always speak the truth, to act in ways consistent with our Mission and Values and to choose to do the right thing.
- **Oneness**: The value of Oneness inspires us to recognize that we are interdependent, interrelated and interconnected 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 Francis Hospital (PSFH) has been meeting the health needs of Evanston, Rogers Park and West Ridge residents for over 100 years. Founded by the Sisters of Saint Francis of Perpetual Adoration, PSFH continues to carry out its mission of providing “compassionate, holistic care with a spirit of healing and hope in the communities” it serves.

PSFH is a 271-bed, full service medical facility that provides high-quality, compassionate and family-centered medical care to residents of Evanston and its surrounding communities. The hospital is a recognized leader in cardiac and emergency trauma services.

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

The PSFH service area is made up of the Chicago community areas of Rogers Park and West Ridge, as well as the city of Evanston. The total population in the service area is approximately 201,000.



Demographics

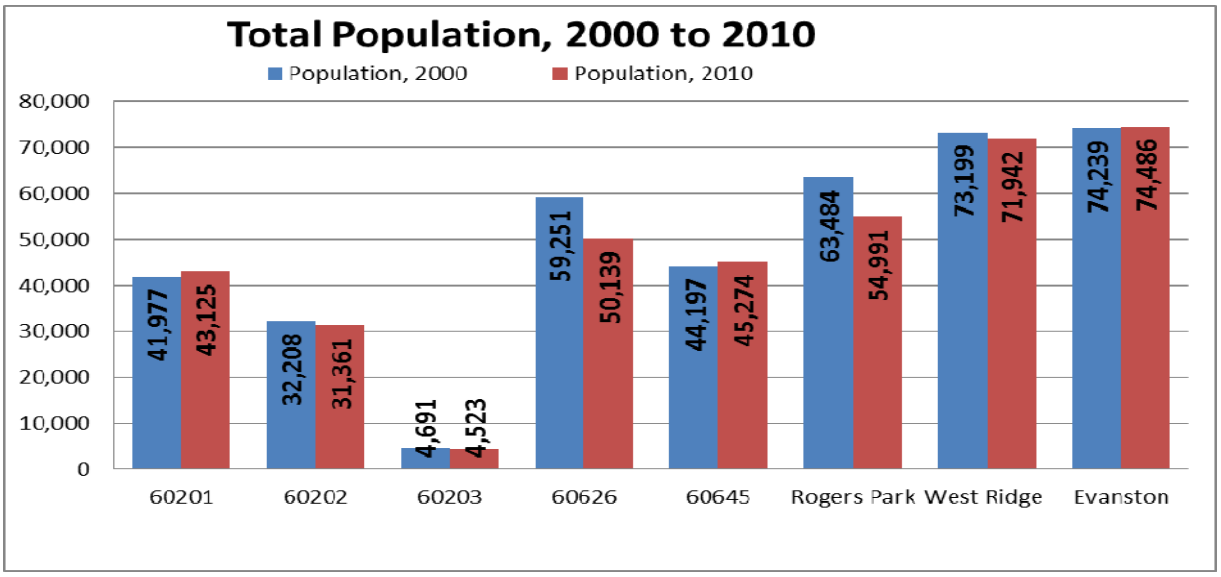
While the U.S. and Illinois population increased 10% and 3% respectively, the city of Chicago lost 7% of its population from 2000 to 2010. Similarly, Rogers Park lost 13% of its population during this time period. The population in Evanston and West Ridge remained relatively unchanged. Evanston (74,486) and West Ridge (71,942) have about the same size population, while Rogers Park has about 20,000 fewer residents than the other two communities. About a quarter of the population in all these communities is under 20 years of age, percentages that are quite similar to Chicago, Cook County, Illinois and the U.S. Between 8% (in Rogers Park) and 12% (in Evanston) of the population are over 65.

The largest racial group in Evanston is White (over 60%) with about 20% of the population identifying as Black and about 8% Hispanic/Latino. In West Ridge, the Asian and Hispanic/Latino population combined is slightly larger (44%) than the White population (40%.) In Rogers Park, both the Black and Hispanic/Latino populations each comprise about 25% of the total while the White proportion is near 40%.

One in five of the residents in West Ridge are limited English speakers, compared to about 15% in Rogers Park and just over 5% in Evanston. While Spanish is the most common language spoken in all areas, West Ridge stands out for the diversity of languages spoken.

Population

As of 2010, the total population of Evanston, Rogers Park and West Ridge is 201,419. The total population in Evanston and West Ridge remained almost unchanged between 2000 and 2010, while Chicago's population decreased by 7%. The population of Rogers Park decreased by 13% over this period. West Ridge and Evanston are of approximately the same size at just under 72,000 and just under 75,000 respectively, while Rogers Park has about 20,000 fewer residents than the other two communities.

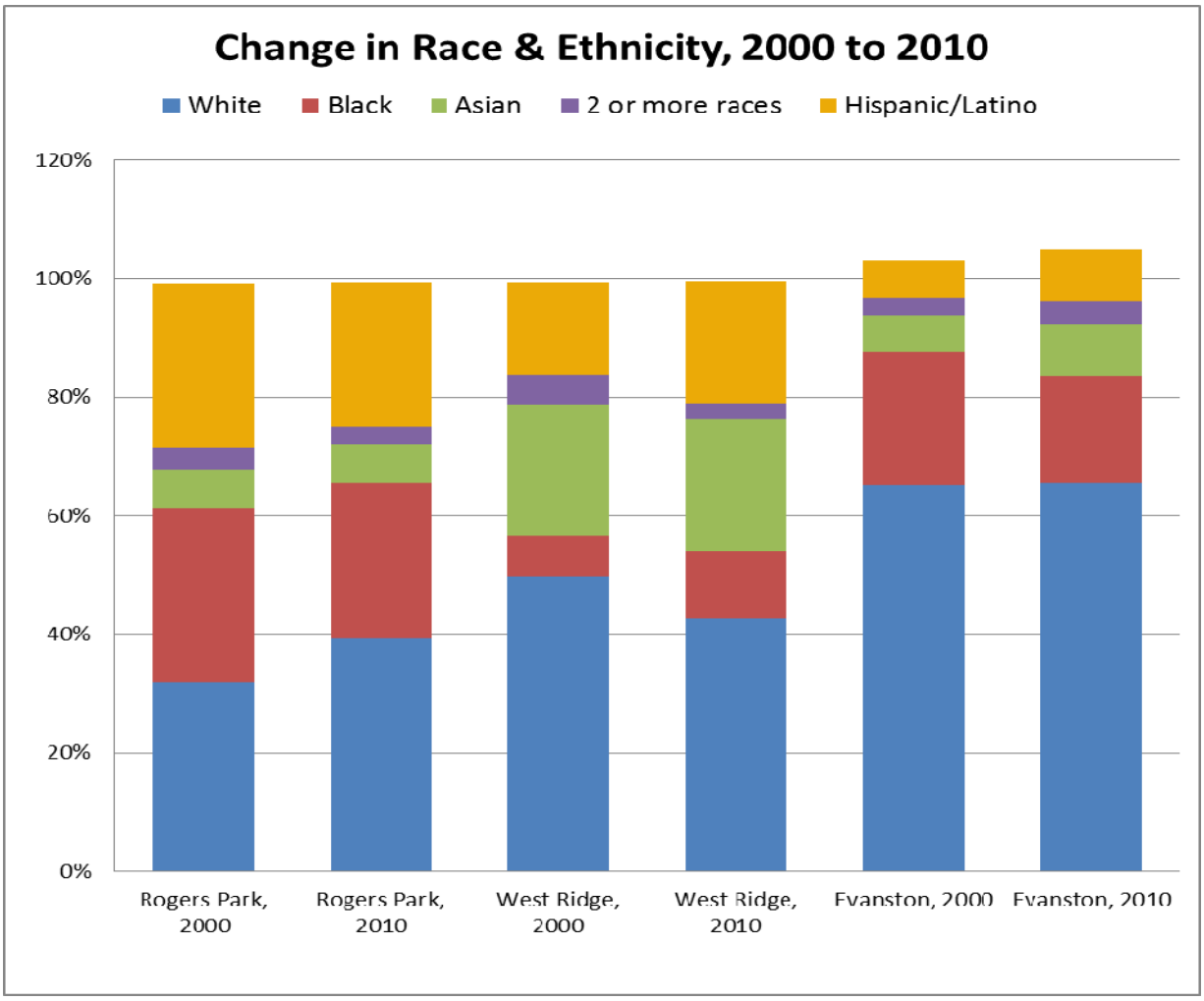


Ethnicity

Over 60% of Evanston residents are White. About 20% of Evanston residents identify as Black/African American, but the proportion of African American residents in Evanston did decrease slightly from 2000 to 2010. The Hispanic/Latino population increased during the same period to about 8% of the population in 2010.

West Ridge has substantial proportions of both Asian (23%) and Hispanic/Latino (21%) residents which combined, is greater than the White population of about 40%. The Black/African American population represents about 10% of the total population in West Ridge as of 2010.

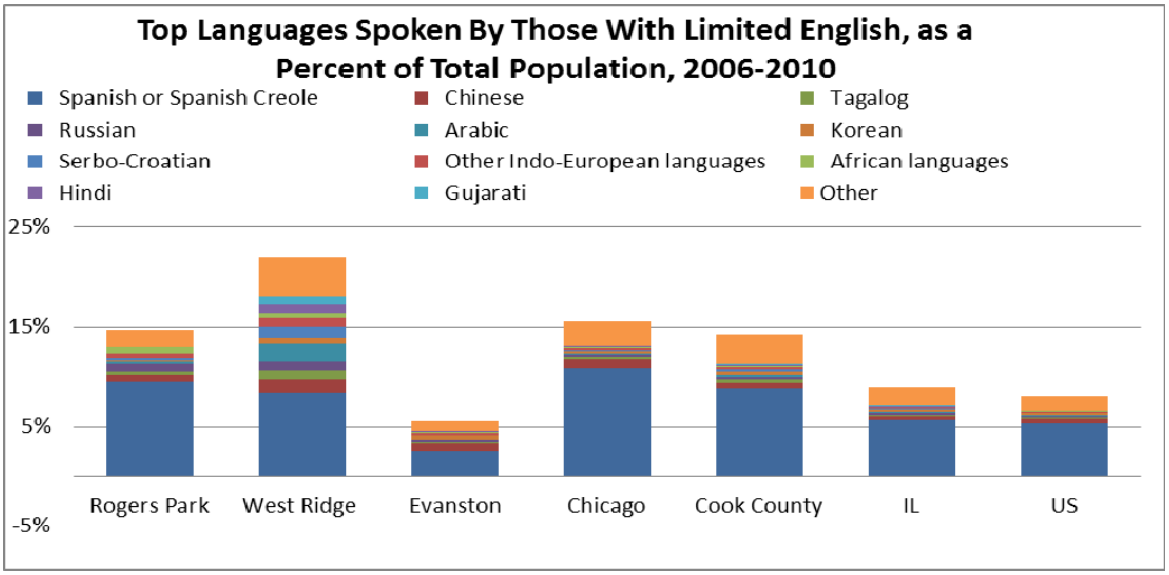
The proportion of Whites in Rogers Park was about 40% as of 2010. About a quarter of the Rogers Park population identifies as Black/African American, and another quarter identify as Hispanic/Latino. Both of these race/ethnic groups decreased in size in Rogers Park between 2000 and 2010.



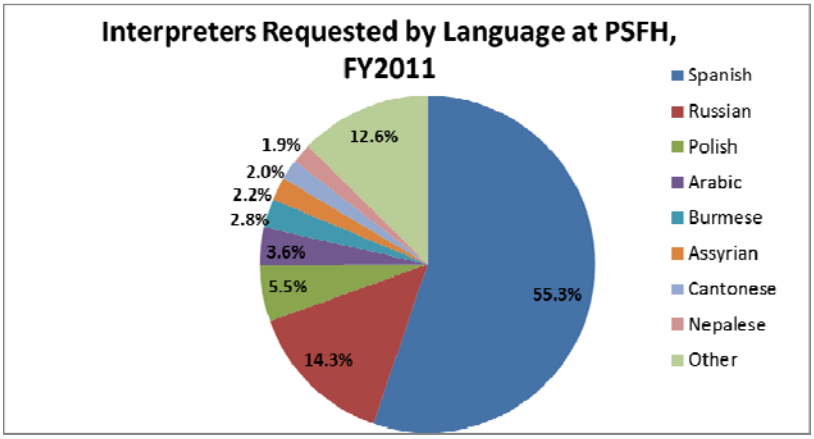
Language Spoken

Over 20% of residents in West Ridge are limited English speakers, compared to about 15% in Rogers Park and just over 5% in Evanston. Spanish is the most common language spoken in all areas, followed by Chinese, Arabic, Russian and Tagalog. West Ridge stands out for the diversity of languages spoken.

Data on limited English-speaking students is not available for all schools, but Sullivan High School in Rogers Park has a high rate of limited English-speaking students, with almost a quarter of enrolled students identified as limited English-speaking. This is substantially higher than the overall rate for high schools in Chicago.

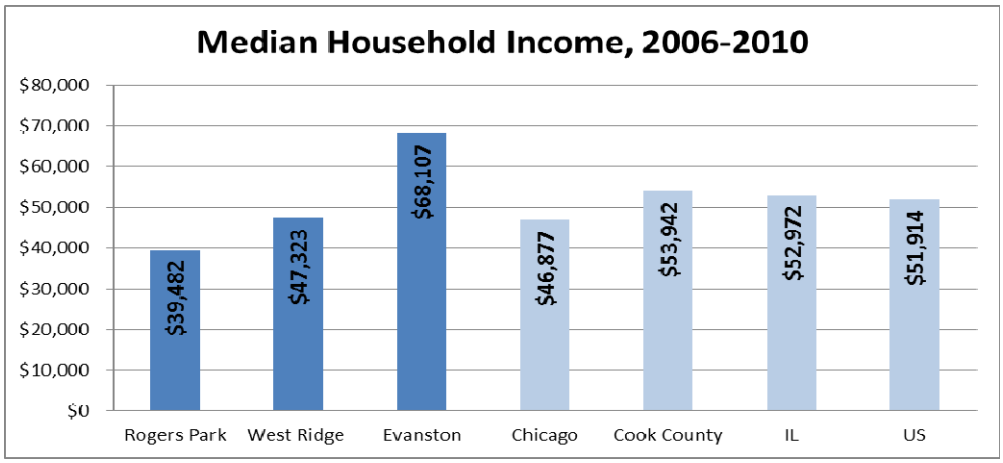


There were 3,839 requests for interpreters at PSFH in FY2011. Over half of the requests were for Spanish, which was the most common language spoken in these communities, followed by Russian. There were requests for a wide variety of language interpretation, with 60 different languages requested over the year.

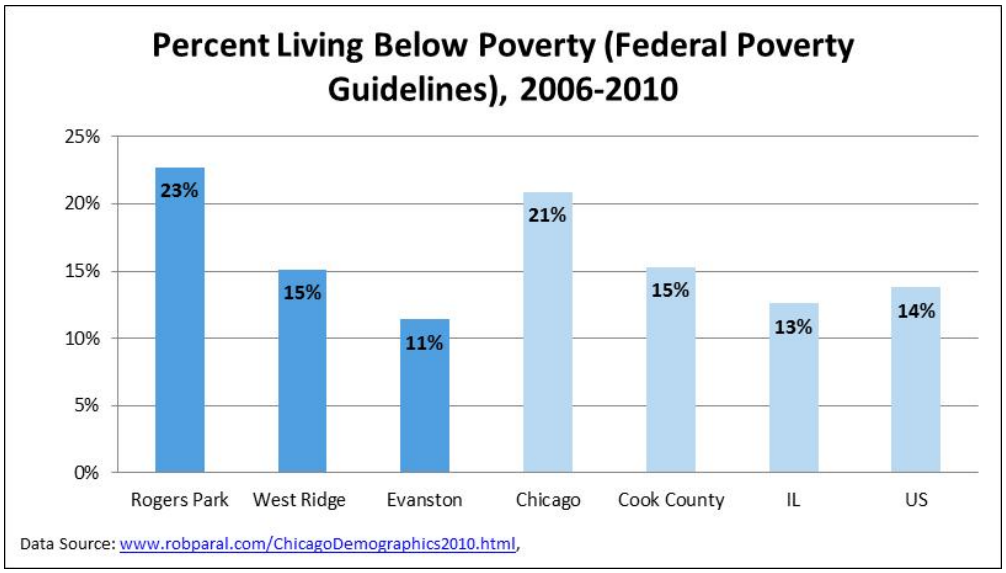


Income

Rogers Park has the lowest median income, slightly less than $40,000, with almost a quarter of the residents living below the poverty line. The median income in West Ridge ($47,323) is similar to the citywide median (about $47,000). The poverty rate in West Ridge (15%) is lower than the citywide rate, but similar to Cook County, Illinois and the U.S. The median income for Evanston is almost $20,000 more than for Chicago. Ten percent of Evanston residents live below the federal poverty line.



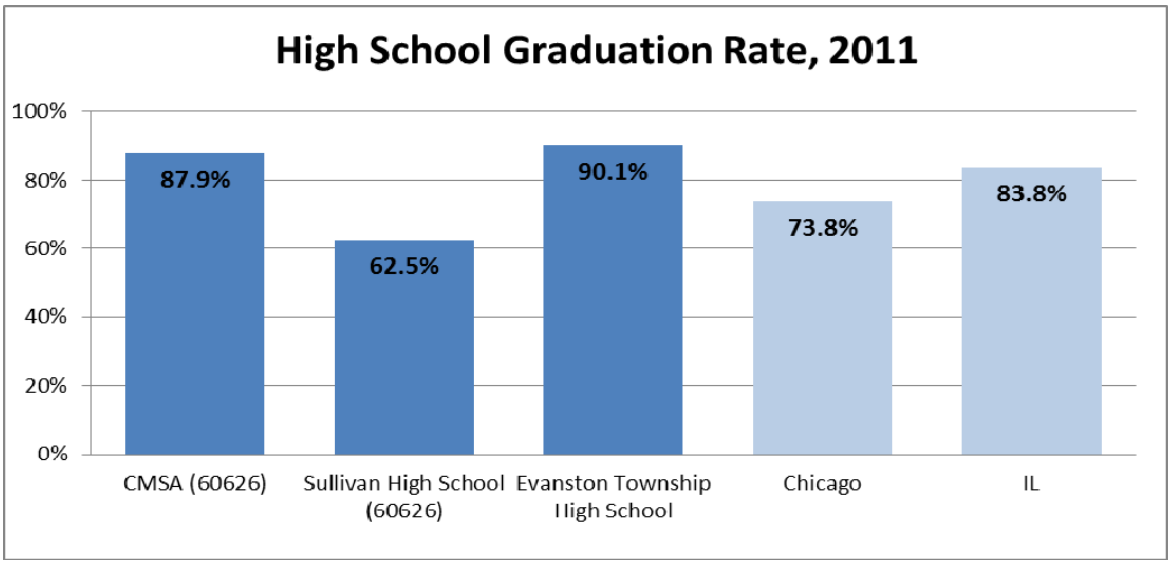
Nearly half of the population in Rogers Park lives below 200% of the Federal Poverty Level, as well as 40% of the population in West Ridge. These rates are similar to Chicago and substantially higher than Cook County, Illinois and the U.S. By looking at the numbers for adults living below 100% poverty (on the preceding page) and 200% of poverty, PSFH calculated that 35% of residents in West Ridge and 23% of residents in Rogers Park live somewhere between 100% and 200% of poverty.



Education

High school graduation rates are above the state average in Evanston and Chicago Math and Science Academy (CMSA), but below the Chicago average at Sullivan High School in Rogers Park. It is important to note that graduation rates track the success of entering freshman; however, they do not capture information about youth who exit the education system prior to high school. Also, high schools in Chicago draw students from a wide geographic area so the student population at these high schools are not confined to students living in the service area.

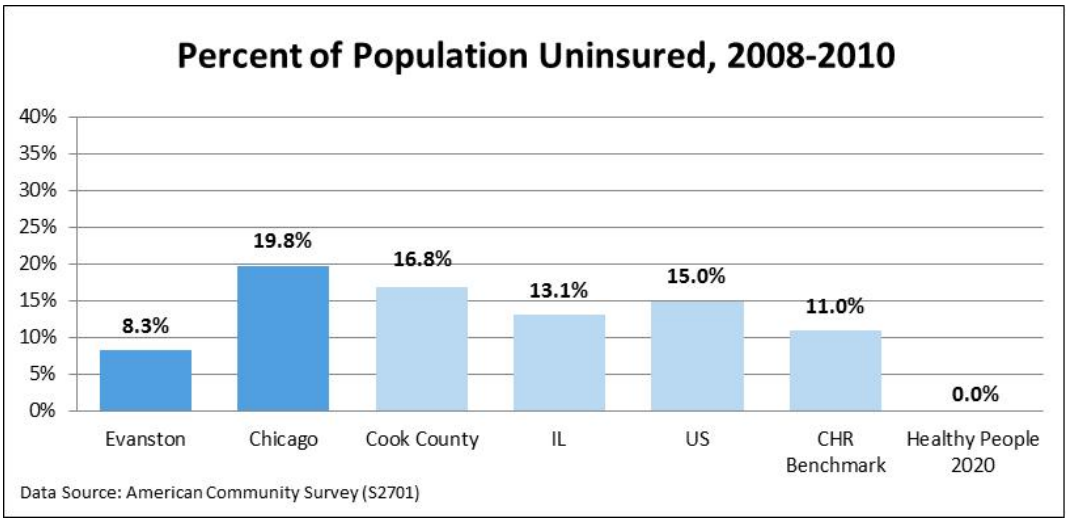
Only 6% of residents in Evanston lack a high school degree, compared with 18 to 20% in Rogers Park and West Ridge. The rates in Rogers Park and West Ridge are similar to Chicago overall and higher than Cook County, Illinois, and the U.S.



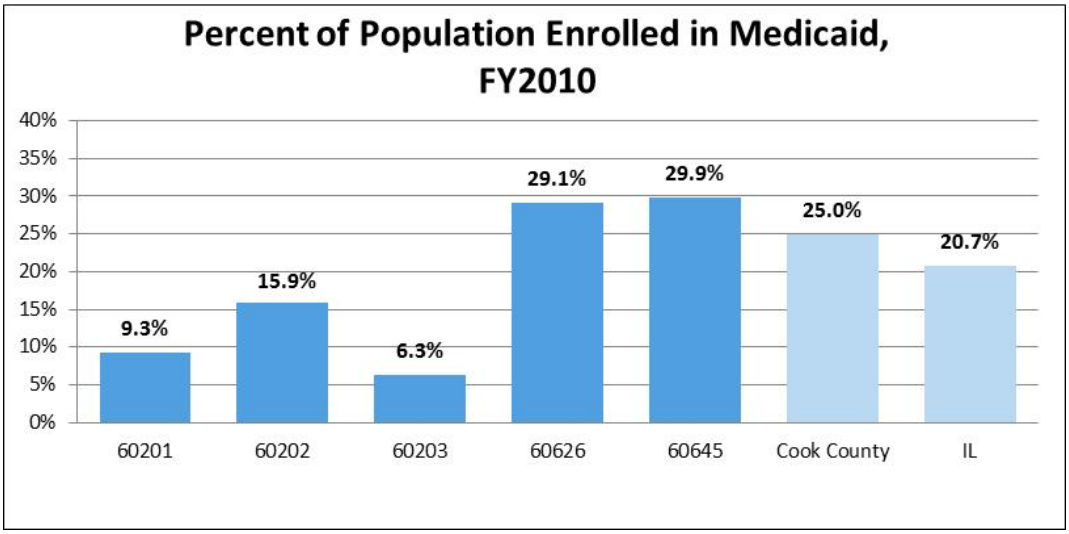
Almost two-thirds of Evanston residents over 25 have a college degree, compared to only one-third of Chicago residents. This is partially due to the large number of graduate students studying at universities in Evanston.

Access to Health Care

The percentage of people uninsured in Chicago (19.8%) is higher than the national and state averages; the uninsured rate in Evanston (8.3%) is more than 10 percentage points lower than Chicago. About 30% of residents in the West Ridge and Rogers Park zip codes are enrolled in Medicaid. While the rates of self-pay among ER outpatients at PSFH were similar to the state (18% and 15% respectively), 45% of outpatients at PSFH were on Medicaid, compared to only 34% statewide.



In terms of the percentage of population enrolled in Medicaid, zip codes 60203 and 60201 (north Evanston) have the lowest rates. About 30% of residents in zip codes 60626 (Rogers Park) and 60645 (West Ridge) are enrolled in Medicaid, slightly more than the Cook County and Illinois rates.



Process Used to Identify Community Needs

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

In July 2012, PSFH coordinated a broad array of community stakeholders from the community areas of Evanston, Rogers Park and West Ridge to form a CHNA Steering Committee. This committee's role was to provide oversight and input into the CHNA process, as well as to identify data-driven community priorities so as to engage in community solutions through partnerships and collaborations.

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

CHNA Community

(includes Evanston, Rogers Park and West Ridge)

MISSION

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

VISION

A participative and engaged community that maximizes the use of diverse community partnerships and collaboration among all sectors improving community health from a holistic standpoint including; wellness, quality of life and promoting health equity through access to care.

VALUES

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

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

Transparency and Communication: We are conducting a community health needs assessment and action plan inclusive of the community. We believe in open and honest dialogue and the sharing of the data, materials and plans. We believe in an interactive and engaged process with the community.

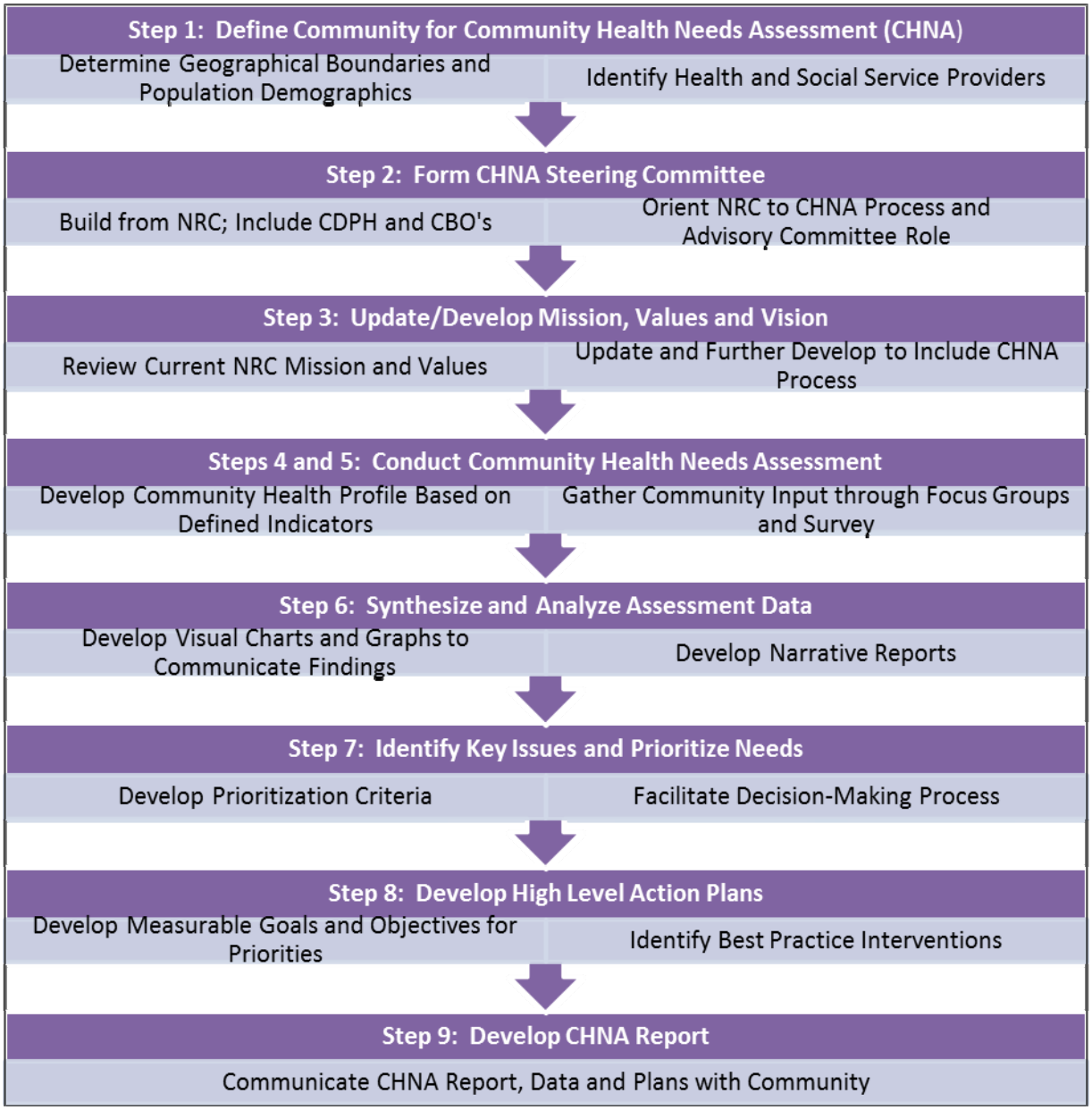
Commitment: We believe we are accountable to the community we serve. We believe adding value is doing what we say we will do.

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

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

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

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



CHNA Community Health Profile

The Community Health Profile is a compilation of secondary data (data already published and available) about a particular community. The profile provides comparative information to assist in understanding the needs and priorities of a community. The Community Health Profile for PSFH analyzed over 50 indicators. Example indicators include: population 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. Findings of the Community Health Profile include:

- The largest racial group in Evanston is White/Caucasian (over 60%), with about 20% of the population identifying as Black/African American, and about 8% as Hispanic/Latino. In West Ridge, the Asian and Hispanic/Latino populations combined are slightly larger (44%) than the White/Caucasian population (40%). In Rogers Park, both the Black/African American and the Hispanic/Latino populations each comprise about 25%.
- One in five West Ridge residents is limited English-speaking, compared to about 15% in Rogers Park and just over 5% in Evanston. Spanish is the predominant non-English language spoken, followed by Russian.
- West Ridge and Rogers Park have high rates of both adults and children living below the federal poverty line. 15% of adults in West Ridge and 23% in Rogers Park live in poverty; 25% of children in West Ridge and 37% in Rogers Park live in poverty. 70% or more of students receive free or reduced lunch in all schools in Rogers Park. In Evanston, these rates are much lower: 10% of adults and fewer than 10% of children are living in poverty.
- The unemployment rate between 2006 and 2010 was between 6 and 8% for the communities in the PSFH service area.
- The uninsured rate in Evanston is about 8%. About 30% of residents in West Ridge and Rogers Park are enrolled in Medicaid.
- 45% of emergency room outpatients at PSFH were enrolled in Medicaid, while 18% were self-paying outpatients.
- Cancer and heart disease are the leading age-adjusted causes of mortality across the service area.
- While cancer is the leading cause of years of potential life lost (YPLL) in all three areas, unintentional injury is the second leading cause of YPLL in Rogers Park and third in West Ridge. YPLL due to homicide is also high in both Rogers Park and West Ridge.
- Both the incidence and prevalence of HIV/AIDS in the Rogers Park community are much higher rates than for the city of Chicago.
- At PSFH, the top diagnoses for non-admitted ER outpatients were for upper respiratory infections, abdominal pain, chest pain, sore throat, and urinary tract infections.
- One in four residents in the service area is considered at risk for binge drinking. Over 17% of residents are current smokers.
- Within the PSFH service area, Rogers Park reported more homicides, drug crimes, and violent crimes against both community and persons when compared to West Ridge and Evanston. Evanston reported more weapons violations compared to Rogers Park and West Ridge.

- 47% of West Ridge residents and 43% of Rogers Park residents were cost-burdened by housing (meaning they paid more than 30% of their income on housing); renters were more likely to be cost burdened than owners. Evanston residents spend an average of 34% of their income on housing and transportation.

CHNA Community Input Report

The community input process was completed between August and October 2012. The process included creating and administering a community input survey in Spanish, Polish and Russian as well as English, facilitating three focus groups, and completing an asset and resources inventory. The community survey explored residents' perceptions of issues surrounding quality of life, health, and social factors and collected respondents' demographics including insurance coverage. Nine hundred twenty-one (921) community residents completed the survey. The findings of the Community Input Report include:

- Among community survey respondents, when asked what quality of life factors were not present in the community, the following top issues were identified:
  - Good jobs
  - Affordable housing
  - Safe neighborhoods/ low crime
- According to survey respondents, the top five most problematic health issues in this community are:
  - Obesity
  - High blood pressure, heart disease and stroke
  - Diabetes
  - Physical Inactivity (lack of exercise)
  - Senior Issues

Results of the 2012 Needs Assessment

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

- Access to Mental Health Care (including strategies to address substance abuse)
- Adolescent Issues
- Obesity and Chronic Diseases
- Safety and Violence

Note: Economic Disparities, Health Literacy, Affordability and Language Barriers will be addressed throughout all priorities and strategies.

PSFH's review of current community benefit programs found that the hospital is meeting some of the identified community needs through its Links, Know Your Numbers and Women Out Walking programs.

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

Methodology and Prioritization Criteria

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

Cross-cutting Themes and Issues Identified

- Obesity and chronic diseases – prevention and management
  - Includes a focus on ensuring residents have access to healthy food choices and opportunities to engage in active living
- Adolescent health issues such as violence, STIs, and substance abuse, pregnancy, access to quality education and extracurricular activities
- Access to affordable health care
- Cuts in funding for health care and social service programs
- Socioeconomic factors and economic disparities, especially need for good jobs
- Safety and violence, including community violence and domestic violence
- Mental health
- Substance abuse
- Health literacy, knowledge and awareness of resources
- Access, cost, unemployment and lack of education are barriers to wellness and receiving health care
- Diverse immigrant communities dealing with language barriers, lack of knowledge of the system, and issues related to legal status
- Need for bilingual and culturally relevant strategies to address all health issues

Identified Prioritized Needs

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

The following four community needs were prioritized:

1. Access to Mental Health Care (including strategies to address substance abuse)
2. Adolescent Issues
3. Obesity and Chronic Diseases
4. Safety and Violence

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

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

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

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

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

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

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

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

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

LINKS PROGRAM

Program Description
Family Focus and LINKS collaborate with PSFH's clinical dietician to promote healthy eating habits and physical activity for low income children. Participants enrolled in the program receive free health education information and counseling for body mass index.

WOMEN OUT WALKING

Program Description
The Women Out Walking (WOW) Program is a 12 week program sponsored by the Department of Health which encourages women to increase their daily physical activity. PSFH donates $4,000 to this program and also provides dieticians, physicians and other speakers to educate women on the importance of preventative screenings. PSFH provides free health screenings at the beginning and end of the program to monitor the success of participants.

KNOW YOUR NUMBERS

Program Description
Screenings of blood glucose, blood pressure, cholesterol and weight are offered free to the community at a variety of health fairs. Individuals receive a Know Your Numbers card with an explanation of what the numbers mean and health information provided by a registered nurse.

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

Community Need: Access to Mental Health Care					
Aim Statement: Increase awareness of existing mental health resources and how to access them by working with local community partners to provide better linkages.					
Outcomes	**Strategy**	**Action Steps**	**Ministry Role**	**Community Partner Role**	**Evaluation Plan/ Measures of Success**
Educate residents about mental health resources in the community.	• Connect with the city of Evanston Mental Health Board. • Access Evanston community (i.e. WOW, Evanston library staff, etc.) • Create a directory of existing mental health resources in the community.	• Market existing resources and educate the community on what services are available to them.	PSFH will be facilitating the work of the action team as well as its own internal programs around this issue.	The Mental Health CHNA Action Team will be working on the identified strategies.	The Mental Health CHNA Action Team is currently developing measures of success.
Match existing resources to community needs.	• Provide Crisis Line numbers to providers and uninsured/ underinsured population.	• Use directory listed above to match residents with the resources they need. • Track the use of Crisis Line numbers to determine if educational outreach has made an impact.		The Mental Health CHNA Action Team will be working on the identified strategies.	The Mental Health CHNA Action Team is currently developing measures of success.
Develop mental health linkages	• Assist in helping	• Work with the Presence		The Mental Health CHNA	The Mental Health CHNA

within Presence Health and the local communities.	people use appropriate mental health services rather than local fire and police departments, EMS, etc.	Health Behavioral Health department to link people with resources across the system.		Action Team will be working on the identified strategies.	Action Team is currently developing measures of success.

Community Need: Adolescent Issues					
Aim Statement: Improve adolescent health and well-being through targeted interventions to reduce risky behaviors to address (1) teen sexual health, (2) teen substance use and abuse, and (3) teen violence.					
Outcomes	**Strategy**	**Action Steps**	**Ministry Role**	**Community Partner Role**	**Evaluation Plan/ Measures of Success**
Decrease the teen pregnancy rate, teen birth rate, and teen infection with STDs and HIV.	• Develop a resource booklet for sexual health care and contraception resources within the community. • Bring organizations that provide sexual health care and/or contraception together to share data, network, and collaboratively reach out to the community. • Provide teens with more access (and more consistent access year over year) to comprehensive sex education programs.	• Distribute paper copies through community resource centers (public libraries, park district centers, community non-profits, etc). Include schools if they will allow it. • Make available online through library, non-profit, and other websites. • Invite participants from Links (Northfield), Reponse (Skokie), Erie Clinic (Evanston), Heartland Health Center (Rogers	PSFH will be facilitating the work of the action team as well as its own internal programs around this issue, but as a Catholic hospital, PSFH will abide by the Ethical and Religious Directives for Health Care Services (ERDs).	The Adolescent Issues CHNA Action Team will be working on the identified strategies.	The Adolescent Issues CHNA Action Team is currently developing measures of success.

		Park), Rogers Park Family Health Center (Rogers Park), Planned Parenthood (Rogers Park), and possibly Peterson Family Health Center (near West Ridge). • Provide schools in the targeted communities with with 1) information about sex education programs provided by local agencies, 2) information about national sex education standards			
Decrease teens' misuse of alcohol, marijuana, prescription drugs and other risky substances.	• Collaborate with the Evanston Substance Abuse Prevention Coalition, PEER Services, LAN 40 and ETHS to increase teens' awareness of the risks and consequences of adolescent substance abuse, as well as of the available resources for help. • Increase awareness of the risks and consequences of adolescent substance abuse, as	• Support social marketing campaign coordinated by the Evanston Substance Abuse Prevention Coalition. • Provide community training on the SBIRT (Screening, Brief Intervention, Referral to Treatment) Model.		The Adolescent Issues CHNA Action Team will be working on the identified strategies.	The Adolescent Issues CHNA Action Team is currently developing measures of success.

	well as the available resources for help, among parents of teens. • Increase awareness of the risks and consequences of adolescent substance abuse, as well as of the available resources for help, among those who work with teens and can help to inform them. • Collaborate with LAN 40, LIFT and the Evanston Public Library to produce and distribute both a paper and an electronic resource directory of teen services that includes substance abuse early intervention and treatment services. Distribute paper copies through community resource centers (public libraries, park district centers, community non-profits, etc.). Make available online through library, non-profit, and other websites. • Increase the number of teens accessing substance abuse resources. (Collect current data and measure change				

	over time).				
Decrease teen violence.	• Make connections with organizations currently working to address youth violence prevention i.e., YWCA (dating violence); Moran Center; Family Focus; Peace Pioneers of Evanston; Ceasefire; Evanston Mentors (YOU, Project, Big Brother/Big Sister, Evanston Scholars). • Map resources for violence prevention e.g., youth job programs.	• Support school-based programs to prevent or reduce violent behavior. These programs teach students about the problem of violence and provide skills intended to reduce aggressive or violent behavior. • Support a research-based model of strategic planning that empowers committees to assess their gang problems and develop a complement of anti-gang strategies and program activities.		The Adolescent Issues CHNA Action Team will be working on the identified strategies.	The Adolescent Issues CHNA Action Team is currently developing measures of success.

Community Need: Obesity and Diabetes

Aim Statement: Collaborate with community partners to decrease obesity and chronic disease through implementation of programs focused on increasing healthy eating and physical activity.

Outcomes	Strategy	Action Steps	Ministry Role	Community Partner Role	Evaluation Plan/ Measures of Success
Develop partnerships with other agencies or organizations that are working on obesity-related initiatives. Have	• Develop an asset list to include agencies within the targeted communities that would be	• Narrow the asset list to specific organizations that address obesity related issues. • Meet with the leadership of	PSFH will be facilitating the work of the action team as well as its own internal programs around this	The Obesity and Diabetes CHNA Action Team will be working on the identified strategies.	The Obesity and Diabetes CHNA Action Team is currently developing measures of success.

a partnership with five organizations by year 3.	potential partners. • Enhance existing programs or design new programs to fill the gaps; identify funding and stakeholders to collaborate and implement such programs.	local community organizations or institutions to establish partnerships. Agencies below are identified as potential partners: – Consortium to Lower Obesity in Chicago Children (CLOCC) – Nurture – Campaign of Good Foods – Ridgeville's Farmers Market – Talking Farm – Whole Foods – Schools are Gardening in Evanston (SAGE) – Campagnola • Identify gaps in the targeted communities.	issue.		
Make healthy foods and beverages easily accessible to all children (and their families) where they live, learn and play.	• Increase local healthy food production. • Disseminate evidence-based health messages to educate children and families about the importance of a healthy diet through popular	• Partner with SAGE to expand and enhance community gardening in schools. • Host taste-testing events in the community to increase fruits and vegetables consumption. • Partner with the Ridgeville Farmer's Market		The Obesity and Diabetes CHNA Action Team will be working on the identified strategies.	The Obesity and Diabetes CHNA Action Team is currently developing measures of success.

	media, outdoor advertising space and in public buildings. • Increase the availability of healthy foods and beverages in our communities.	and the City of Evanston Friends of the Farmers Market to provide education about healthy food choices. • Partner with the Health Department to focus on one food (fruit or vegetable) for one community. Highlight a new fruit or vegetable each month. • Partner with UIC Health Extension with Take Charge of Your Health educational information. • Adapt ethnic recipes to make healthier options - provide samples to taste the difference. • Work with food pantries and local meal programs to stock and deliver healthy foods and beverages. • Partner with Nurture to utilize their nutrition curriculum to education children and families about			

		the importance of eating healthy.			
Increase physical activity within our community.	• Expand existing city-wide physical activity strategies. • Increase community awareness of availability and importance of physical activity opportunities.	• Develop a list of existing physical activity resources in the target communities. • Identify community partners to expand existing physical activity opportunities. • Improve access (availability and affordability) to formal physical activity programs within the community (i.e. YMCAs, Park Districts, gyms, fitness centers, etc.)		The Obesity and Diabetes CHNA Action Team will be working on the identified strategies.	The Obesity and Diabetes CHNA Action Team is currently developing measures of success.

Community Need: Safety and Violence

Aim Statement: Creation of a safe community for all, sustainable through community-wide commitment, led by Presence Saint Francis Hospital, to ongoing public health/safety events and dynamic marketing of depth of services available to support safe spaces.

Outcomes	Strategy	Action Steps	Ministry Role	Community Partner Role	Evaluation Plan/ Measures of Success
Increase awareness of safety as a public health issue in the three target communities.	• Through PSFH's current efforts and in partnership with community agencies, break down barriers to service and have residents gain additional awareness of	• PSFH creates materials based upon information provided by committee on available information about safety and violence. • Develop a	PSFH will be facilitating the work of the action team as well as its own internal programs around this	The Safety and Violence CHNA Action Team will be working on the identified strategies.	The Safety and Violence CHNA Action Team is currently developing measures of success.

	impact of violence on the community and existing community resources.	community-wide non-violence newsletter or other type of communication to market existing resources. • Publicize and assist marketing existing local agencies who deal with safety and anti-violence in the service area. • Partner with community events to publicize services related to safety. Integrate into SFH's existing fairs and community events. • Assessment at fairs regarding awareness of safety issues. Collate results of assessment to determine impact and recommend next steps by 2015.	issue.		
Develop/increase awareness of safe havens in the three target communities.	• Develop a list of safe havens in the community and educate residents on what they are and how to access them.	• Define what a safe haven is: align with the existing definition through the Chicago Police CAPS Program. • Educate local businesses/agencies on how they can become a safe haven. • Partner with local		The Safety and Violence CHNA Action Team will be working on the identified strategies.	The Safety and Violence CHNA Action Team is currently developing measures of success.

		business/agencies to become safe havens in the community; develop a letter of commitment or use existing one through CAPS Program. • Educate community on what a safe haven is and where they can access them. • Develop signage for local stores to identify themselves as safe havens. • Partner with local police and alderman. • Partner with the mayor of Evanston as this fits into the city of Evanston's plan for 2016.			

In addition, PSFH will continue to meet community needs by providing charity care, Medicaid and State Health Insurance Assistance Program (SHIP) services, and by working with community partners to address the identified needs listed above.

Next Steps for Priorities

For each of the priority areas listed above, PSFH will work with the CHNA Steering Committee and community partners to:

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

Implementation Strategy Approval

Presence Saint Francis Hospital

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 2013.

The below signatures signify that this plan has been reviewed and approved for 2013.

Jeff Murphy
President & CEO
Presence Saint Francis Hospital

June 21 13
Date

Insert names and titles of primary staff responsible:

Nancy Stermer
Plan Prepared By
Nancy Stermer,

June 21, 2013
Board of Directors Approval Date
Presence Saint Francis Hospital

PSFH will share the 2013 Implementation Strategy with all internal stakeholders including employees, volunteers and physicians. This document is available at www.presencehealth.org and is also broadly distributed within our community to stakeholders including community leaders, government officials, service organizations and community collaborators.

The following notice is posted in several areas of PSFH 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