# Community Health Needs Assessment

2014 – 2016

Advocate Lutheran General Hospital


December 2016

Accompanying this letter is Advocate Lutheran General Hospital's Community Health Needs Assessment (CHNA). Advocate is a faith based system. Meeting the health needs of the patients, families, and communities is at the core of our mission. While assessing and addressing the needs of our community is an ongoing process, every three years we do a comprehensive assessment. This assessment involves the collection of data to strategically steer our efforts to the people, communities, and health issues where they are most needed, and where we can make a measurable impact.

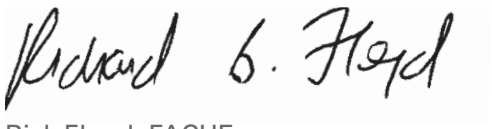
In our work in co-leading the north region of the Health Impact Collaborative of Cook County (HICCC), we have made the commitment to work as a partner to address Social Determinants of Health. In addition, Lutheran General Hospital has prioritized Access to Care. We are also committed to addressing the chronic health issues within our higher needs communities as outlined in this report.

All of these priorities align with Lutheran General Hospital's journey to be a leader in identifying and reducing health disparities and achieving health equity, which began in late 2008. At that time, holding true to our mission, Lutheran General Hospital conducted a Cultural and Linguistic Competence Self-Assessment with the National Center for Cultural Competence (NCCC) at Georgetown University to better assess the hospital's strengths and weaknesses in serving the growing cultural diversity of our Primary Service Area. Based on this assessment, we began our health equity journey with our Korean and Polish programs in 2011 and 2012 respectively, the creation of our South Asian Cardiovascular Center in 2013, and our National Initiative Health Disparities work with the Hispanic community starting in 2015. We look forward to furthering this important work.

We also will continue to work with numerous community partners to address the issues associated with the mental/behavioral health epidemic affecting all communities. All of these initiatives are in addition to our continuing community focused programs which include issues of seniors and older adults, injury prevention, youth health and safety, substance abuse treatment in correlation with mental health, intimate partner violence, and cancer.

Lutheran General Hospital is honored and committed to addressing the health needs of our community. A link is provided at the end of this report to provide us with feedback about our community health needs assessment process.

Sincerely,



Rick Floyd, FACHE
President, Advocate Lutheran General Hospital, Park Ridge, Illinois

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# I. Executive Summary

In support of a strong Mission, Values and Philosophy, Advocate Lutheran General Hospital is committed to building lifelong relationships and partnerships to improve the health of the individuals, families and communities it is privileged to serve. In 2015, all five Advocate Health Care hospitals principally serving Cook County, including Lutheran General Hospital, served as founding members of the Health Impact Collaborative of Cook County (HICCC). Lutheran General Hospital and the Advocate system made significant donations of staff leadership time as well as providing financial support for the collaborative. HICCC is a best practice Community Health Needs Assessment (CHNA) collaborative involving 26 hospitals, 7 health departments and nearly 100 community-based organizations. The goal of this initiative is to work collaboratively on a county-wide CHNA and implementation strategies once priorities are identified. The Illinois Public Health Institute (IPHI) served as the backbone organization for the collaborative providing facilitation, data coordination and report preparation activities.

Given the size and diversity of Cook County, the collaborative created three regions, North, Central and South—for purposes of organizing the assessment process. Lutheran General Hospital was appropriately assigned to and co–led the North Region consisting of both the north side of Chicago as well as northern and northwest suburbs of Cook County. (See the companion document to Lutheran General Hospital's CHNA, *Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region*, also posted on the Advocate website and at www.healthimpactcc.org/reports2016.)

In addition to leading the North region of the HICCC CHNA process, Lutheran General Hospital conducted a hospital specific CHNA. A Community Health Council consisting of 25 community and hospital leaders was convened in 2011 to oversee the CHNA and community health work at the hospital. The council was led by the Director and Coordinator, Community Health, with support of the two hospital Governing Council members on the Community Health Council.

For the purposes of the 2014-2016 CHNA cycle, Lutheran General Hospital defined "community" as the hospital's primary service area (PSA). This area includes approximately 1,069,146 individuals within 28 zip codes—25 in Cook County and 3 in Lake County, Illinois. Lutheran General Hospital serves a diverse population in a complex urban area. While the overall PSA population is 74.68% White, nearly 12% of the PSA is Asian. By ethnicity, nearly 20% of the population is Hispanic. There is also significant educational attainment and income disparity among the communities in the hospital's PSA.

Primary and secondary data were analyzed and presented to the Community Health Council. Primary data sources included three community surveys and a Korean American Community Health Needs Assessment. In addition to the primary data collected by the hospital, HICCC also conducted eight focus groups and a comprehensive Cook County survey which provided additional primary data for the CHNA. Secondary sources included access to 171 indicators through the Healthy Communities Institute database as well as multiple health indicators utilized for the HICCC North Region CHNA.

After considering significant data, the Community Health Council was asked to prioritize the identified health needs. Initially, the council considered the work of the HICCC process during which the HICCC chose 4 cross cutting priorities: Social Determinants, Mental Health, Chronic Diseases and Access to Care. All members of HICCC, including Lutheran General Hospital, agreed to work together to address Social Determinants which include employment, education, housing, transportation, food sufficiency and the built environment. Lutheran General Hospital's Community Health Council additionally chose Access to Care as a second priority identified by the HICCC process. The hospital will address Health Literacy and Cultural and Linguistic Competency, which aligns and continues the work that the hospital has been moving forward since 2008 on a journey to health equity.

Lutheran General Hospital's Community Health Council identified the 6 communities in the PSA with the greatest socio economic need. Zip code level hospital utilization data as well as data obtained by primary surveys were presented at a second prioritization meeting. The Hanlon Method, an evidence based voting process (see Appendix 3), was utilized to determine the additional health issue that the hospital would address. It was determined that cardiovascular disease/diabetes in the high risk communities would be Lutheran General Hospital's third priority for the 2014-2016 CHNA cycle.

In summary, Lutheran General Hospital's Community Health Council determined that Social Determinants, Access to Care and Cardiovascular Disease/Diabetes would be the three priorities addressed for the 2014-2016 CHNA cycle. Health needs not chosen, but considered included Cancer, Immunization and Infectious Disease Prevention, Respiratory Disease and Mental Health. While Mental Health was not specifically chosen as a priority, Lutheran General Hospital will continue its work and collaboration on this important issue.

HICCC has developed action teams to create strategies to address Access to Care and Social Determinants, and Lutheran General Hospital is an active participant in those meetings. The hospital will be partnering with Presence Resurrection Medical Center, which also has identified heart disease/diabetes as a priority, to address the issue in overlapping high risk communities.

# II. Description of Advocate Health Care and Advocate Lutheran General Hospital

## Advocate Health Care

Advocate Lutheran General Hospital (Lutheran General Hospital) is one of 11 hospitals in the Advocate Health Care (Advocate) system. Advocate is the largest health system in Illinois and one of the largest healthcare providers in the Midwest, operating more than 400 sites of care, including 11 acute care hospitals, the state's largest integrated children's network, 5 Level I trauma centers, 2 Level II trauma centers, the region's largest medical group and one of the region's largest home health care companies. The Advocate system trains more primary care physicians and residents at its four teaching hospitals than any other health system in the state.

Advocate is a faith-based, not-for-profit health system related to both the Evangelical Lutheran Church in America and the United Church of Christ. Advocate's mission is to serve the health needs of individuals, families and communities through a wholistic philosophy rooted in the fundamental understanding of human beings created in the image of God. This wholistic approach provides quality care and service and treats each patient with dignity, respect and integrity. To guide its relationships and actions, Advocate embraces the five values of compassion, equality, excellence, partnership and stewardship. The mission, values and wholistic philosophy (MVP) permeate all areas of Advocate's healing ministry and are integrated into every aspect of the organization; building a cultural foundation. The MVP calls Advocate to extend its services into the community to address access to care issues and to improve the health and well-being of the people in the communities Advocate serves. As an Advocate Hospital, Lutheran General Hospital embraces the Advocate system MVP.

## Advocate Lutheran General Hospital

Lutheran General Hospital began serving the community in 1897 and is now a 638-bed not-for-profit healthcare facility and one of the largest healthcare providers in Chicago's North and Northwest suburbs. Lutheran General Hospital is a tertiary care, academic and research hospital and a Level I Trauma Center. The hospital offers a full range of inpatient and outpatient services, as well as a variety of community outreach programs. The hospital employs approximately 4,200 associates, 1,150 physicians representing 51 specialties and subspecialties, and provides medical education to 20 fellows, 164 residents and 804 medical students each year. As a nationally recognized academic and research hospital, patients have access to the most advanced treatment in the areas of cardiology, cancer, neurosciences, orthopedics, pediatrics and women's health. Lutheran General Hospital is also designated as a Resource Hospital within its Emergency Medical Services regional area in the state, providing training and education to emergency medical providers. In 2016, Lutheran General Hospital was ranked as one of the 100 Top Hospitals by Truven© Health Analytics for the seventeenth time and has been a Magnet designated hospital for nursing excellence every year since 2005.

# III. 2011-2013 Community Health Needs Assessment Summary

## Community Definition

For the purpose of the 2011-2013 Community Health Needs Assessment (CHNA), Lutheran General Hospital defined "community" as the hospital's primary service area (PSA), a geographic area within which approximately 75% of the patients treated at the hospital reside. The PSA consisted of 28 zip codes surrounding the hospital. It was noted that the PSA was comparatively older than both Illinois and the US. The median age was 41 years old compared to Illinois' of 35 and the US of 37.2 years of age. It was also recognized that the PSA was becoming more diverse with the Hispanic community the largest diverse population, consisting of 18.1% of the hospital's PSA.

## Overall Process and Priorities Selected

Lutheran General Hospital convened a Community Health Council (Council) to oversee the assessment process and to link directly to the hospital governance structures. The Council members included representatives of the Cook County Department of Public Health as well as community and hospital leaders. Over the course of the three-year assessment process, the Council reviewed demographic data, health outcome data, hospital utilization data and health disparity data. Community experts also spoke to the Council regarding existing assets and needs within the community.

After considering all data presented as well as community assets, the Council initially identified 6 predominant health issues within the hospital's PSA, which included Cardiovascular risk issues, South Asian Cardiovascular risk issues, senior health issues, cancer, mental health/behavioral issues and issues pertaining to other specific ethnicities. Through a consensus process, the Council then narrowed the needs down to the top four. In deciding which 4 needs to select, the Council considered the following: (1) seriousness of the need; (2) size of the problem; (3) importance to the community; (4) degree to which programs were available to address this issue; (5) degree to which community assets could help address this need; and (6) degree to which community partners can solve/are involved in solving the problem.

Based on this criteria, Lutheran General Hospital prioritized community health initiatives around cardiovascular disease in the South Asian community, fall prevention, smoking cessation and stress management. A program strategy was developed for each health priority including an identified target population and measurable goals. In order to ensure progress, performance measures were created for each program.

### *Cardiovascular Health Disparity in the South Asian Community*

**South Asian Cardiovascular Center**

Lutheran General Hospital identified prevalence rates for cardiovascular disease were four times higher among individuals of South Asian descent. This particular population has a significant presence in the Chicago metropolitan area in communities surrounding the hospital. A literature review was conducted and a physician champion emerged. The hospital action team discerned that this higher risk was not being identified by traditional cardiovascular risk factor screenings, including the Framingham Risk Factor Profile Score (FRFPS). The South Asian Cardiovascular Center (SACC) was created to raise awareness, provide prevention education, appropriately screen and provide treatment to this unique population. The SACC does so through a unique combination of community outreach, culturally sensitive advanced clinical services and research.

Since 2013, the SACC has hired diverse staff including a medical director, nurse navigator, community outreach coordinator and nutritionist. In its first year of clinical operations, the Center found that 38% of new patients required invasive interventions (e.g., open heart surgery or percutaneous stent placement) for critical heart disease while an additional 30% of patients had genetically inherited cholesterol disorders or metabolic factors that required aggressive primary medical intervention. Due to raising awareness and preventive education efforts in the community, an average of 15-20 new patients have come to the SACC per month. All of these patients were either under treated or did not seek preventive care prior to the advent of the South Asian Cardiovascular Center.

Additionally, over the three years of operation, SACC has increased awareness through multiple community awareness raising events, including the first Red Sari event in the Chicago metropolitan area in collaboration with the American Heart Association, flyers in grocery stores owned by the largest South Asian grocery store chain, and the implementation of a South Asian healthy cooking program that aired on a local network news program. The SACC, through its South Asian Healthy Eating Benefits (SAHEB) program, catalyzed reduction in sodium content in the menus of four partnering South Asian restaurants by over 22% against a goal of 10%. In 2016, SAHEB expanded this initiative to include an additional 7 restaurants—4 on the northwest side of Chicago and 3 in Schaumburg Township. The hospital also partnered with a large Mosque to reduce sodium content in meals that the congregation delivers daily to over 800 individuals.

## *Senior Falls*

**Matter of Balance Program**

During the 2011-2013 CHNA process, Lutheran General Hospital noted that the median age for the PSA was higher than both Illinois and the US, as was the percentage of adults 65 years of age and older. Emergency Department (ED) utilization data indicated that falls were a significant risk within this group. In response, the evidence based Matter of Balance (MOB) program was implemented to reduce falls among seniors 65 and older in the hospital's PSA. MOB is designed to increase awareness of the participant's personal risk for falls, promoting exercise commitment and increased confidence to control their environment to reduce fall risk. Pre and post surveys were administered to determine the amount of change for each person in the areas listed above.

Since the program's inception in 2013, 84 class participants have participated in the Matter of Balance program's 7 cohorts. During each of the implementation years, Lutheran General Hospital's results have been positive, indicating a change in scores that are nearly twice the national benchmark average. Over 43% of program participants demonstrated an increase in their confidence to reduce falls (national average was 20%). Over 29% of these individuals demonstrated an increase in their ability to increase their physical strength (national average was 17%).

In 2015, Lutheran General Hospital staff members also became MOB master trainers which allowed the hospital to expand the program through the master trainers' ability to "train the trainer." In 2016, Lutheran General Hospital trained 10 new trainers in 3 different community organizations over the course of 2 sessions. These new trainers, in turn, held 5 more classes in the community in 2016, with an additional 54 participants.

## *Smoking Cessation*

**Multiple Approaches**

In its 2011-13 CHNA, Lutheran General Hospital identified smoking cessation as one of the six cardiovascular risk factors that was not being effectively addressed by either the hospital or a community-based organization. In response to this identified need, Lutheran General Hospital offered a variety of smoking cessation programs. The initial program included a 1:1 counseling design for individuals who were identified through lung screenings. This program was transitioned in 2015 to a medical model smoking cessation clinic using Mayo Clinic's evidence-based program, the *Nicotine Dependence Education Program*. This program included both medical management and group counseling sessions. The program was implemented in collaboration with Advocate Medical Group. 100% of participants completed both cycles of the program. In 2016, as a result of staffing changes, the hospital made the decision to offer the evidence based program, Courage to Quit, developed by the Respiratory Health Association. The program is comprised of 7 sessions and is offered in an open group discussion format. The first session in 2016 was at capacity with 6 participants and a second session, just started as of the posting of this report, at capacity with 8 participants. Of the 6 participants from the first program, 3 completely quit smoking and the other 3 reduced their smoking rate. The program will continue to be offered quarterly.

## *Stress Relief*

**Healthy Women A-Z**

During the 2011-2013 CHNA process, Lutheran General Hospital identified stress management as another one of the six cardiovascular risk factors that was not being effectively addressed by either the hospital or by another community partner. In response, Lutheran General Hospital partnered with the Park Ridge Park District to develop and offer stress management classes for women. *Healthy Women A-Z*, an innovative series of stress management classes for women aged 35-65, was offered. The class reinforced overall health while integrating stress management techniques that correlated with fitness, life style changes and nutrition. The class concluded after several cycles as more community programs addressing stress management became available. "Healthy Women A-Z" was successful in filling the gap before this wider range of community offerings were available.

## *Mental Health and Need for Collaboration*

During the 2011-2013 CHNA process, mental health was also identified as a significant health need. Due to the complexity and scope of this health issue, however, Lutheran General Hospital's Community Health Council did not choose it as a formal CHNA priority. The Council recognized that further assessment and collaboration with community partners was needed. Over the next three years, Lutheran General Hospital led survey projects in Park Ridge, Niles and Des Plaines that were focused on collecting primary data regarding various health needs, with significant foci on mental health and senior needs. Each community survey project included input from numerous organizations from each municipality resulting in the ability to tailor the survey to the specific community. Please refer to the Methodology section later in this report for a full discussion of this process.

Multiple mental health initiatives have been developed based on the results of these surveys. For example, citing the results of the survey in its budget, the City of Park Ridge hired a full-time social worker to provide centralized behavioral health education and resource information. The social worker has also partnered with the hospital and other community organizations to proactively address mental health. In addition, in response to the Healthier Park Ridge Survey results indicating that depression and anxiety were the top health issues in the community, the Park Ridge Police Department received a $100,000 grant from the Department of Justice in 2015. The grant, which was written in collaboration with the Center for Public Safety and Justice at the University of Illinois, and Lutheran General Hospital, provided funding for the development of a collaborative model that addresses community responses to people with mental illness with a goal to serve as a national demonstration project—which resulted in the drafting of a National Toolkit.

The grant included several strategies through which the City of Park Ridge became better equipped to respond to a range of mental health issues in the community, including: (1) a series of community-police Town Hall meetings to better understand the community's needs, concerns and questions; (2) a training workshop designed for community leaders to raise awareness about mental health issues and community responses to them; (3) 40-Hour certified CIT training for at least half of the sworn Park Ridge Police Officers as well as other city staff, hospital security staff members and other community members, as deemed appropriate; and (4) the implementation of a co-responder model of response to mental health-related calls in Park Ridge in cooperation with the hospital.

At the close of the grant in 2016, all of the Park Ridge police and numerous hospital safety officers were CIT trained. In addition, two town hall meetings and two trainings for community leaders had been held, and extensive planning meetings between the police department and Lutheran General Hospital were also held to initiate the co-responder model. In 2016, the co-responder model was initiated, including two components: (1) the ability of the police to call the social workers in Lutheran General's emergency department directly when dealing with a behavioral health issue, and to brief and prepare the emergency department for the arrival of the individual, similar to the briefing they receive when a trauma patient is coming; and (2) a Lutheran General Hospital social worker was scheduled for ride-along shifts with the police officers to help with calls involving behavioral issues. Both approaches have been beneficial to the individuals/patients, the police officers and ED department personnel.

The Healthier Niles survey provided similar survey results. Lutheran General Hospital, in collaboration with the Village of Niles, has held multiple focus groups to better understand mental health needs specific to the large Polish population residing in Niles. A Polish mental health program is currently being developed collaboratively with the Village of Niles.

## Lessons Learned

As Lutheran General Hospital sought to address the complex community problems identified in its first CHNA cycle, it became clear that collaborating with community partners would be essential in making a significant impact. As a result of this understanding and during the 2014-2016 CHNA cycle, Lutheran General Hospital became a participant and co-leader for the north region of the Health Impact Collaborative of Cook County HICCC.

Further, since 2011, Lutheran General Hospital has been on a journey to identify the unique needs of diverse populations within the hospital service area and to provide culturally competent care and programs to address the unique needs of these diverse communities. Culturally specific programs as well as health navigator positions have been implemented for Korean, Polish and South Asian population groups.

During the 2014-2016 CHNA cycle, Lutheran General Hospital identified the need to continue to assess ethnic specific and socioeconomic disparities. The 2011-2013 CHNA reflected that the Hispanic community was the largest diverse population in Lutheran General Hospital's PSA. While the ACCESS Genesis Clinic in Des Plaines (originally founded by Lutheran General Hospital) has been addressing the health needs of the Hispanic community for years, Lutheran General Hospital partnered with St. Stephen Protomartyr Roman Catholic Church in 2016 to introduce a diabetes prevention program. This program was part of the National Initiative – V of the Independent Medical Academic Centers (AIAMC) to address health disparities. Literature as well as hospital data indicated that diabetes rates are higher among Hispanic communities. Des Plaines (60018) was selected as the location to begin the initiative as the zip code had the highest Hispanic population (38%) in the hospital's PSA.

## Feedback from the Community

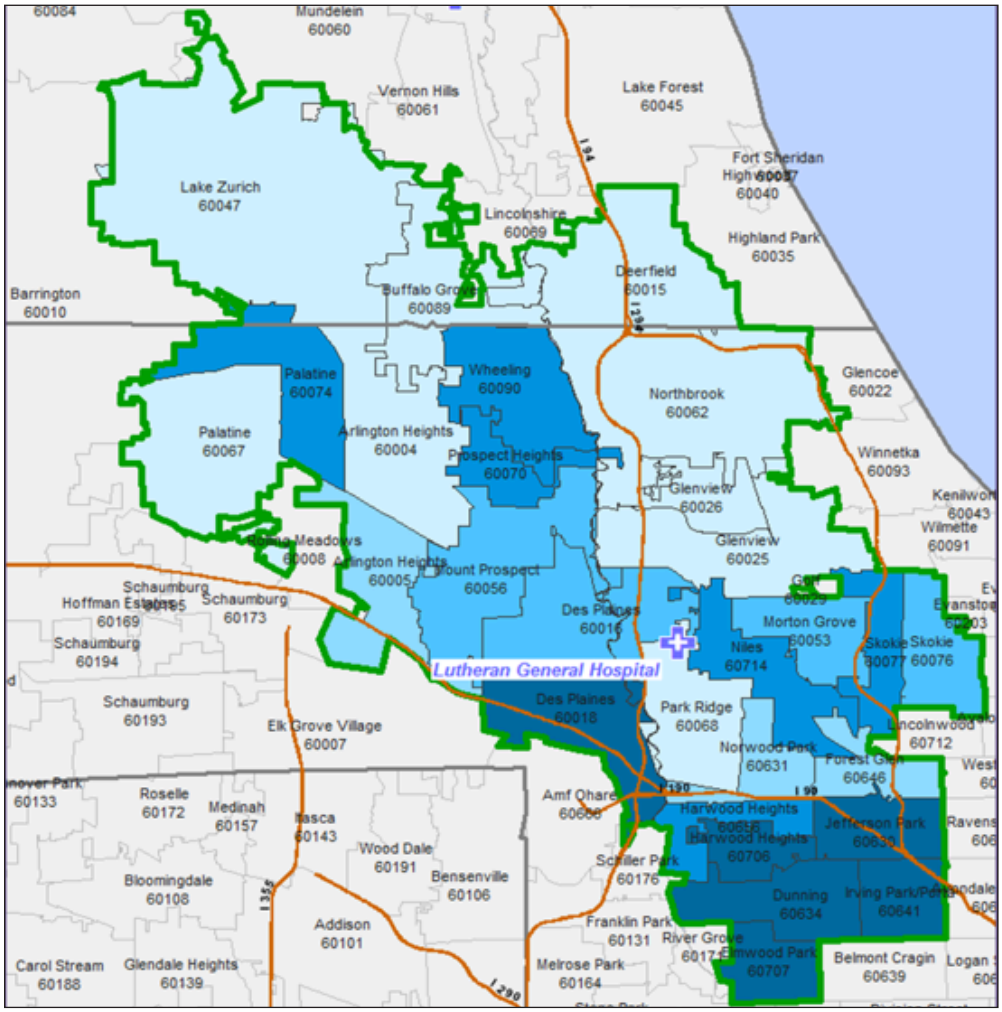
The 2011-2013 CHNA report was posted on the hospital website in December 2013 with a mechanism for the public to respond or participate in the CHNA process, from which Lutheran General Hospital received no public comments. The hospital chaired and financially supported three individual zip code level surveys as detailed later in this report. The results of these surveys, along with highlights of the hospital's CHNA findings, were presented in multiple venues throughout the communities the hospital serves. These venues included Town Hall meetings, City Council meetings and presentations to individual organizations. The feedback from those meetings also supported more collaboration in future community needs assessments and programming.

# IV. 2014-2016 Community Health Needs Assessment

## Community Definition

For the 2014-2016 CHNA cycle, Lutheran General Hospital defines "community" as the hospital's primary service area (PSA). This area includes approximately 1,069,146 individuals within 28 zip codes—25 in Cook County and 3 in Lake County. PSA designation is determined by the Advocate Health Care Strategic Planning Department, generally noted as the geographic area where 75% of patients reside. All 25 Lutheran General Hospital zip code communities in Cook County were part of the geographic area within the North Region of the Health Impact Collaborative of Cook County (HICCC). Please see the companion document to Lutheran General Hospital's CHNA, *Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region*, also posted on the Advocate website and at www.healthimpactcc.org/reports2016.

**Exhibit 1: SocioNeeds Index Map for PSA 2016**




Source: Healthy Communities Institute, Claritas, 2016.

Socioeconomic need was determined by the Healthy Communities Institute (HCI) calculations to create an index using six major socio-needs indicators that are correlated with poor health outcomes, including income, unemployment, occupation, education, language, and poverty. Indicators for the index are weighted to maximize the correlation of the index with premature death and preventable hospitalization rates. Index values range from 0 to 100 and can be compared across geographic locations. The ranking of 1-5 is a comparison of the index value for each zip code to all others within the PSA; a 5 represents areas of higher socio-economic need relative to others in the defined geographic area.

Lutheran General Hospital's PSA includes the following communities, listed in order of greatest socioeconomic to lowest socioeconomic need, as defined by the HCI SocioNeed index: Irving Park/Portage (60641), Dunning (60634), Des Plaines (60018), Elmwood Park (60707), Harwood Heights (60706),

Jefferson Park (60630), Palatine (60074), Mount Prospect (60656), Niles (60714), Skokie (60077), Prospect Heights (60070), Wheeling (60090), Des Plaines (60016), Skokie (60076), Morton Grove (60053), Harwood Heights (60056), Norwood Park (60631), Arlington Heights (60005), Forest Glen (60646), Arlington Heights (60004), Glenview (60025), Park Ridge (60068), Buffalo Grove (60089), Palatine (60067), Northbrook (60062), Glenview (60026) Lake Zurich (60047) and Deerfield (60015).

The three largest communities within Lutheran General Hospital's PSA are Dunning (60634) with a population of 75,196, Irving Park (60641) with a population of 70,970 and Des Plaines (60016) with a population of 61,060 (Healthy Communities Institute, Claritas, 2016). The city of Des Plaines has two zip codes with Des Plaines (60018) accounting for an additional population of 30,788 individuals. Additional communities with dual zip codes are Arlington Heights, Skokie, Glenview and Harwood Heights.

From 2010 to 2016, the average population growth within Lutheran General Hospital's PSA was 1.25%, which was higher when compared to the Illinois rate at 0.43%. The three communities with the highest percent population growth from 2010 to 2016 were Glenview (60026) at 9.71%, Mount Prospect (60656) at 5.42% and Palatine (60074) at 4.37%. The two communities that decreased in population size from 2010 to 2016 are Deerfield (60015) by -1.28% and Buffalo Grove (60089) by -1.19%.

## *Race/Ethnicity*

**Exhibit 2: Race and Ethnicity of PSA, North Cook County (2010) and Cook County, Illinois and US 2016**

| Race | U.S | Illinois | Cook | HICC North Cook | ALGH PSA |
|---|---|---|---|---|---|
| Total→ | 321,418,820 | 12,859,995 | 5,238,216 | 1,621,388 | 1,069,146 |
| White | 247,813,910 (77.1%) | 9,058,485 (70.30%) | 2,886,394 (54.90%) | 1,037,461 (63.98%) | 798,436 (74.68%) |
| Black/African American | 42,427,284 (13.2%) | 1,840,394 (14.28%) | 1,239,297 (23.57%) | 90,192 (5.56%) | 25,007 (2.34%) |
| Am Ind/AK Native | 2,892,769 (0.9%) | 46,012 (0.36%) | 22,077 (0.42%) | N/A | 3,856 (.36%) |
| Asian | 17,356,616 (5.4%) | 677,866 (5.26%) | 370,745 (7.05%) | 175,044 (10.8%) | 126,992 (11.88%) |
| Native HI/PI | 642,837 (0.2%) | 4,753 (0.04%) | 1,656 (0.03%) | N/A | 339 (0.03%) |
| Some Other Race | 2,249,931 (0.7%) | 930,499 (7.22%) | 589,973 (11.22%) | 30,772 (1.9%) | 85,807 (8.03%) |
| 2+ Races | 8,035,470 (2.5%) | 327,862 (2.54%) | 147,659 (2.81%) | N/A | 28,709 (2.69%) |
| | | | | | |
| Ethnicity | U.S | Illinois | Cook | HICC North Cook | ALGH PSA |
| Hispanic/ Latino | 55,926,874 (17.4%) | 2,199,562 (17.07%) | 1,331,792 (25.33%) | 287,919 (17.76%) | 208,124 (19.47%) |

POLISH
169,426
15.9% PSA

SOUTH ASIAN
46,316
4.3% PSA

KOREAN
19,977
1.9% PSA

(N/A) = Not Available

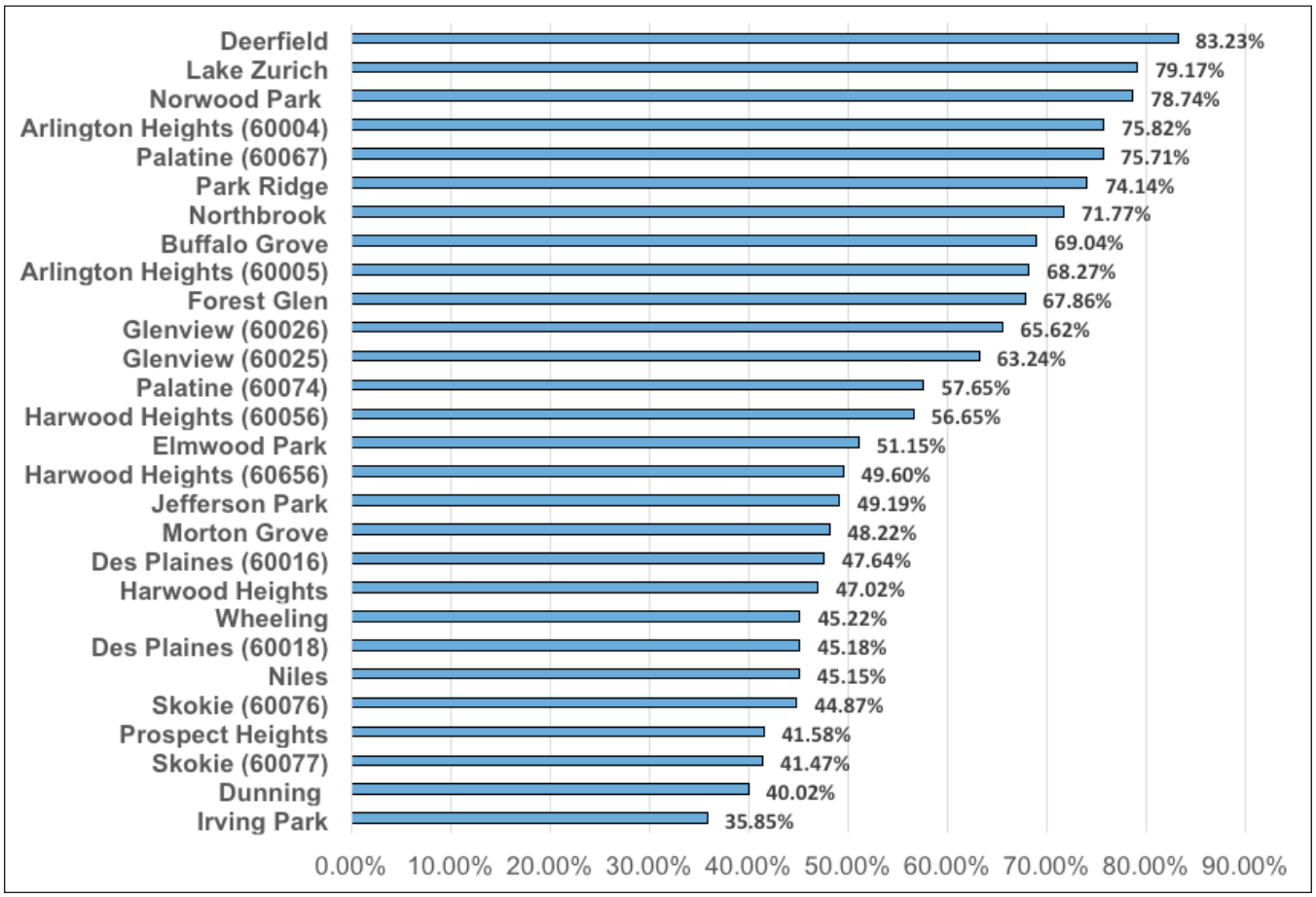
Sources: Healthy Communities Institute, Claritas, 2016; Health Impact Collaborative of Cook County, US Census Data, 2010; American Community Survey (Polish, Korean, South Asian), 2010-2014.

"Hispanic" is referred to as an ethnicity or origin and is not considered a race. According to the US census Bureau, "the concept of race is separate from the concept of Hispanic origin." Ethnicity is distinguished by culture, language, religion, geographic origin and customs. Race often refers to "a person's observed physical characteristics, with skin color the single most important determinant of an individual's racial status." (*Social Causes of Health and Disease*, pg.153, 2013.) While Polish, South Asian and Korean are also identified ethnic groups, the American Community Survey does not distinguish these specific origins. Polish are identified as White, while South Asians and Koreans are identified as Asian.

## *Language*

Lutheran General Hospital serves a predominately White, non-Hispanic population (74.6%). The two communities with the highest percentages "speaking English only at home" in ALGH PSA are Deerfield (83%) and Lake Zurich (79%). Both of these communities are in Lake County. Within Cook County, Norwood Park at 79%, Arlington Heights (60004) at 76%; Palatine (60067) at 76% and Park Ridge (60068) at 74% were identified as the highest "speaking English only at home" communities in the PSA. (Healthy Communities Institute, Claritas, 2016.)

**Exhibit 3: Percentage Reporting "Speak English at Home" by Zip Code in PSA 2016**

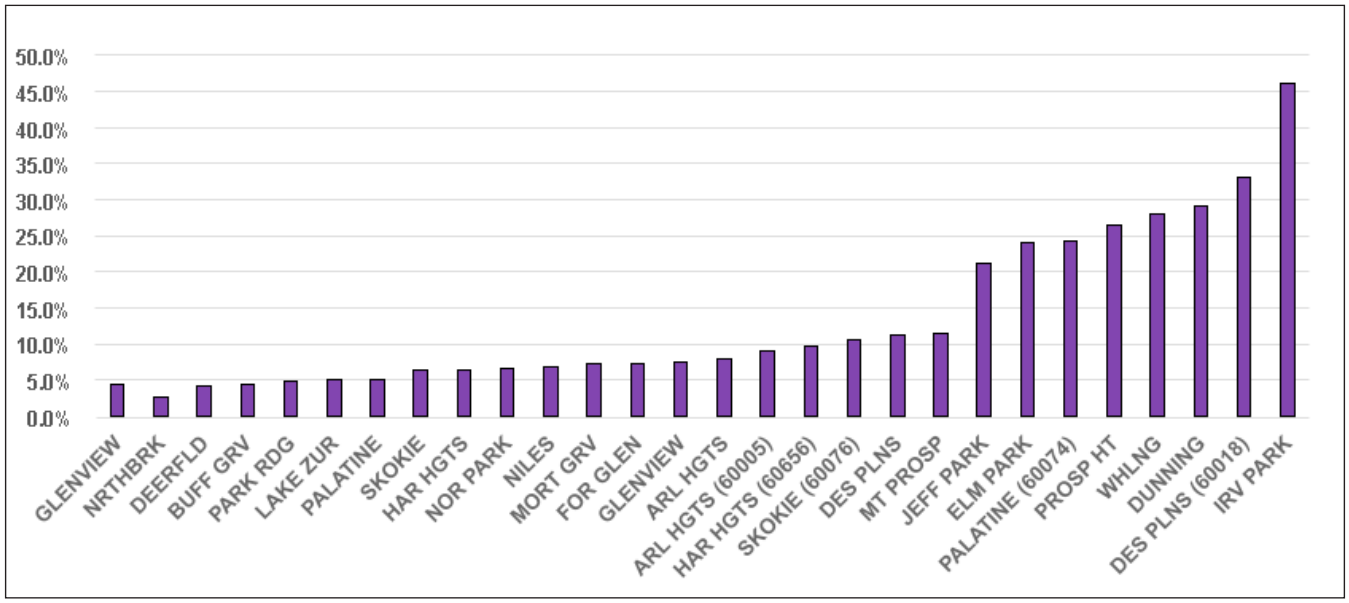



**Note:** Only those communities with more than one zip code have zip codes listed.

Source: Healthy Communities Insititute, Claritas, 2016.

Hispanic is the fastest growing, minority population (19.5%) in Lutheran General Hospital Hospital's PSA. The communities with the highest Hispanic/Latino population within Lutheran General Hospital Hospital's PSA are: Irving Park with 58%, Dunning with 39%, and Des Plaines (60018) with 38%. Additionally, Exhibit 4 shows that 46% of the population in Irving Park speaks Spanish, followed by 33% in Des Plaines (60018), and 29% in Dunning. (Healthy Communities Institute, Claritas, 2016.)

**Exhibit 4: Top PSA Zip Code Percentages Reporting "Speak Spanish at Home" 2016**

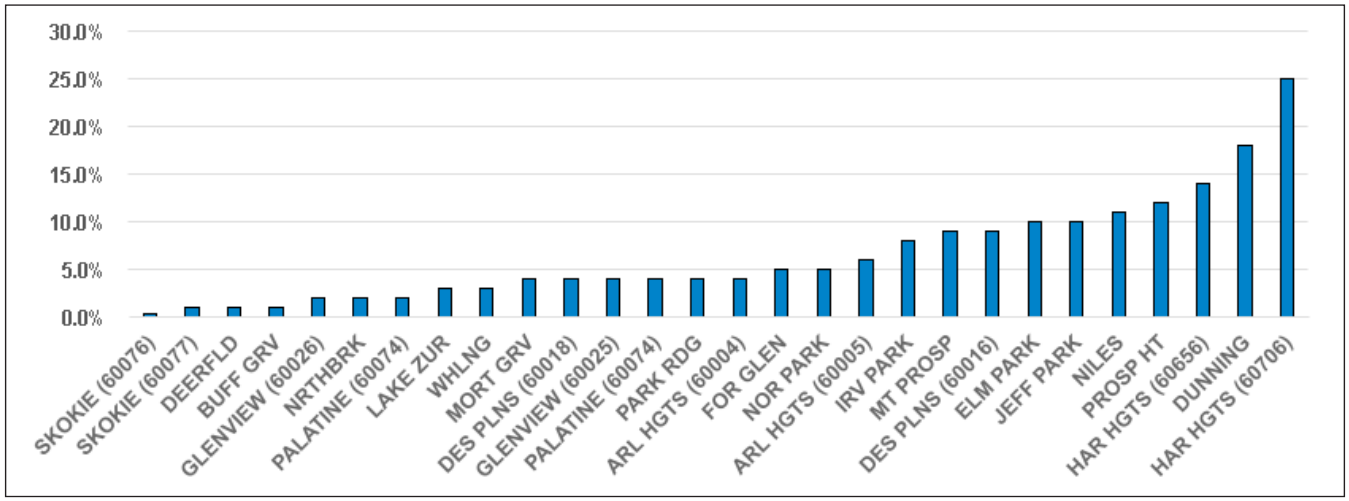



**Note:** Only those communities with more than one zip code have zip codes listed

Source: Healthy Communities Institute, Claritas, 2016.

For Lutheran General Hospital's PSA, 7.3% of the population 5 years of age and older speak Polish at home, which translates to 75,232 Polish speaking individuals in the PSA. The zip codes reporting the highest speaking Polish at home percentages were, Harwood Heights (60706) with 25%, Dunning with 18%, Harwood Heights (60656) with 14% and Niles with 11%. It is important to note that Dunning and Irving Park are two of the largest communities within Lutheran General Hospital's PSA, which impacts the actual number of Polish speaking individuals (American Community Survey, 2010-2014).

**Exhibit 5: Top PSA Zip Code Percentages Reporting "Speak Polish at Home"2010-2014**

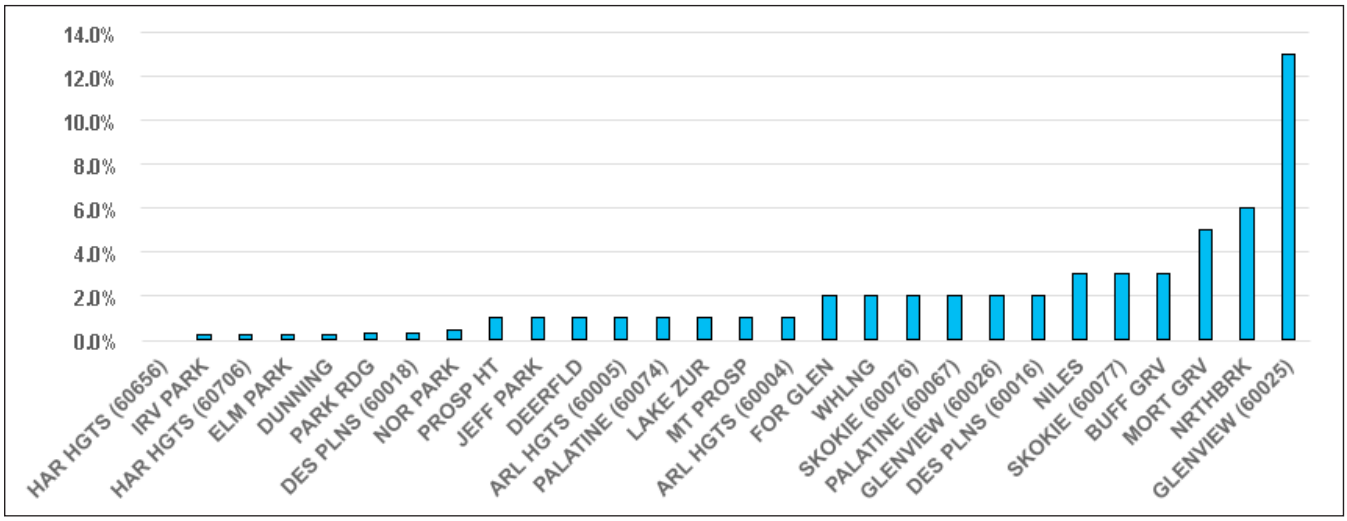



Note: Only those communities with more than one zip code have zip code listed

Source: American Community Survey, 2010-2014.

Lutheran General Hospital also serves a growing Asian (11.9%) population that when compared to Illinois (5.3%), is much larger. The data indicates that Morton Grove at 31%, Skokie (60077) at 31% and Skokie (60076) at 28% have the highest Asian population within Lutheran General Hospital's PSA. By language, 1.6% of the population 5 years of age and older speaks Korean at home, which is equivalent to 16,398 individuals for the PSA. Exhibit 6 shows that Glenview (60025), Northbrook and Morton Grove reported having the highest percentages for speaking Korean at home in Cook County; Buffalo Grove is part of Lake County but still within Lutheran General Hospital's PSA (American Community Survey, 2010-2014).

**Exhibit 6: Top PSA Zip Code Percentages Reporting "Speak Korean at Home" 2010-2014**



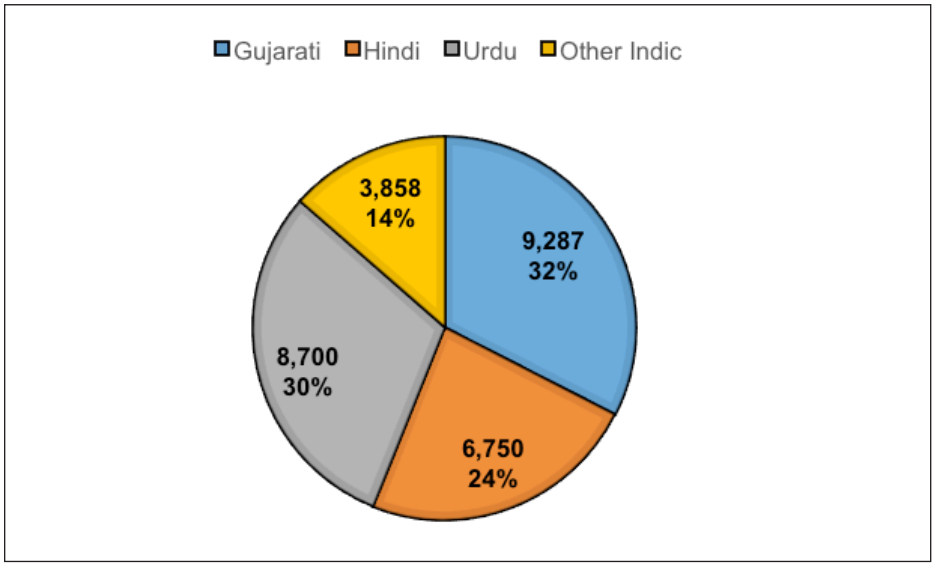

**Note:** Only those communities with more than one zip code have zip codes listed

Source: American Community Survey, 2010-2014.

South Asians comprise 4.3% of the hospital's PSA. Des Plaines (60016), Mount Prospect (60056) and Wheeling are the top-three Asian Indian communities. When an individual marks Asian on the American Community Survey as their race, a second more specific designation is requested.

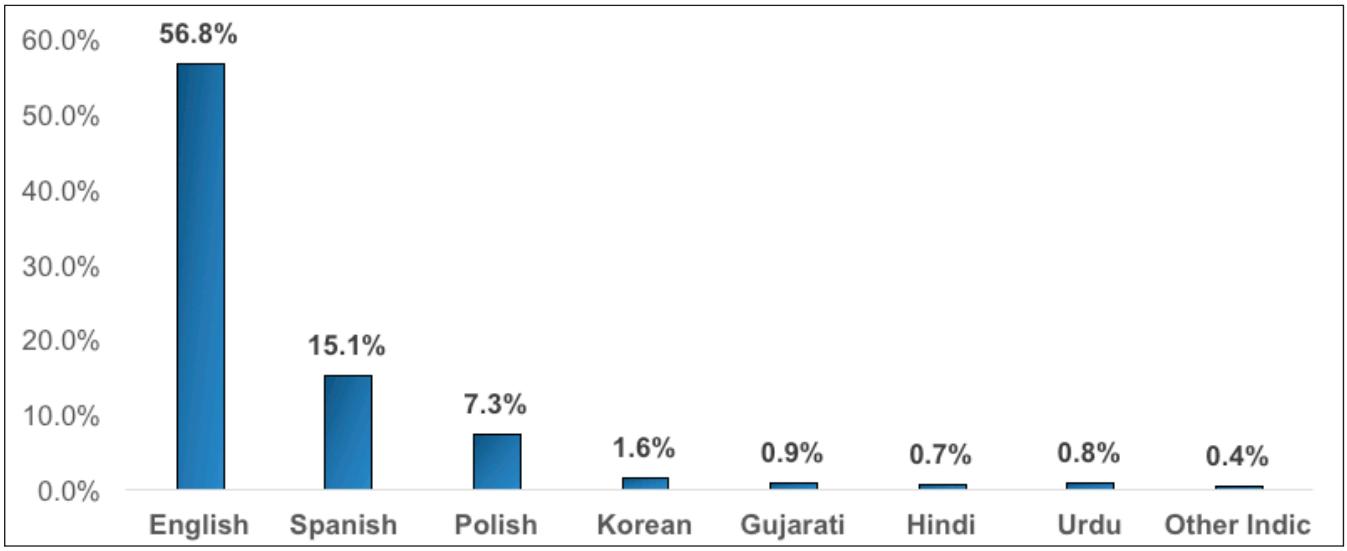
In Lutheran General Hospital's PSA, 46,315 residents or 4.35% marked a South Asian racial category, including Asian Indian at 39,685 (3.7%), Pakistani at 19,977 (1.9%), Bangladeshi at 273 (0.0%) and Sri Lankan at 81 (0.0%). The number of individuals speaking a South Asian language at home are 28,595 (2.8%), of which the largest linguistic groups are those who speak Gujarati, 9,287 (0.9%), Urdu, 8,700 (0.8%) and Hindi, 6,750 (0.7%). See Exhibit 7. Specifying a South Asian birthplace are 34,778 (3.3%), primarily persons who were born in India, 28,695 (2.7%) or Pakistan, 5,126 (0.5%).

**Exhibit 7: Percentage Reporting "Speak South Asian Language at Home" in PSA by Language 2010-2014 (n=28,595)**




Source: American Community Survey, 2010-2014.

**Exhibit 8: Predominant Languages Spoken at Home in PSA 2010-2014**



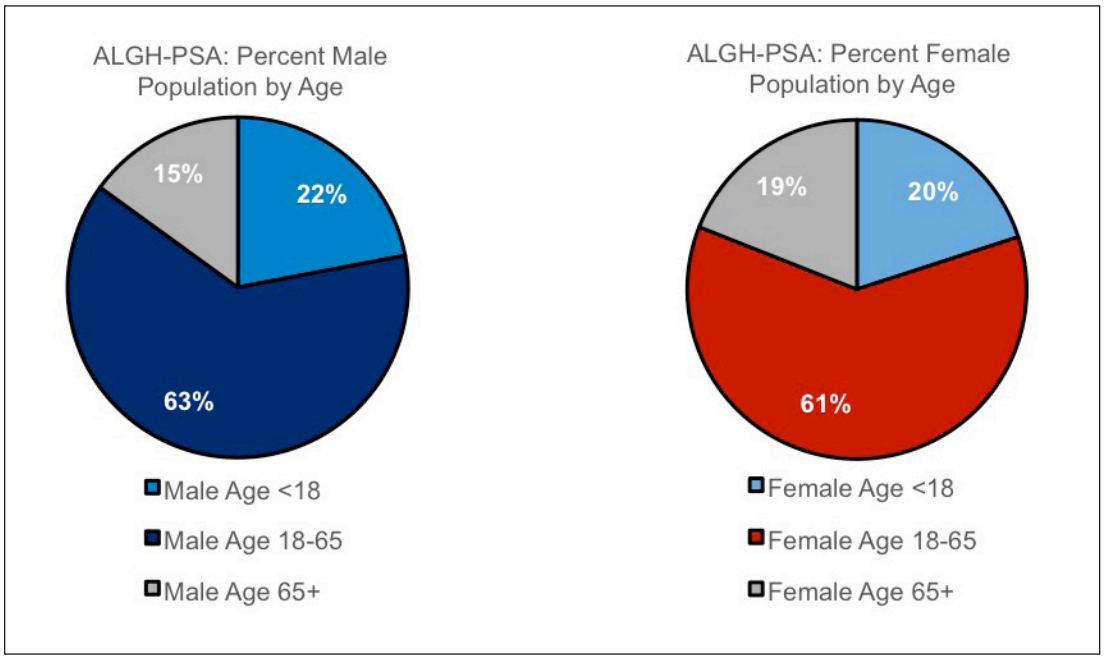

Sources: Healthy Communities Institute, Claritas (English and Spanish), 2016; American Community Survey (Polish, Korean, Gujarati, Hindi, Urdu and Other), 2010-2014.

## *Age*

The median age for males within Lutheran General Hospital's PSA is 40.19 and the median age for females is 43.56. The median age for the entire population is 41.94. Lutheran General Hospital's population is older when compared to the median age for Illinois which is 37.80, with 17% of the hospital's PSA population over the age of 65. The two communities with the highest population over age 65 in the hospital's PSA are Niles (60714) at 27% and Northbrook (60062) at 25%. The population between 18 and 65 years of age comprises 62% of the population within the PSA. Twenty one percent of the population within Lutheran General Hospital's PSA is under 18 years of age. (Healthy Communities Institute, Claritas, 2016.)

## *Gender*

**Exhibit 9: Percent Female and Male by Age in PSA 2016**

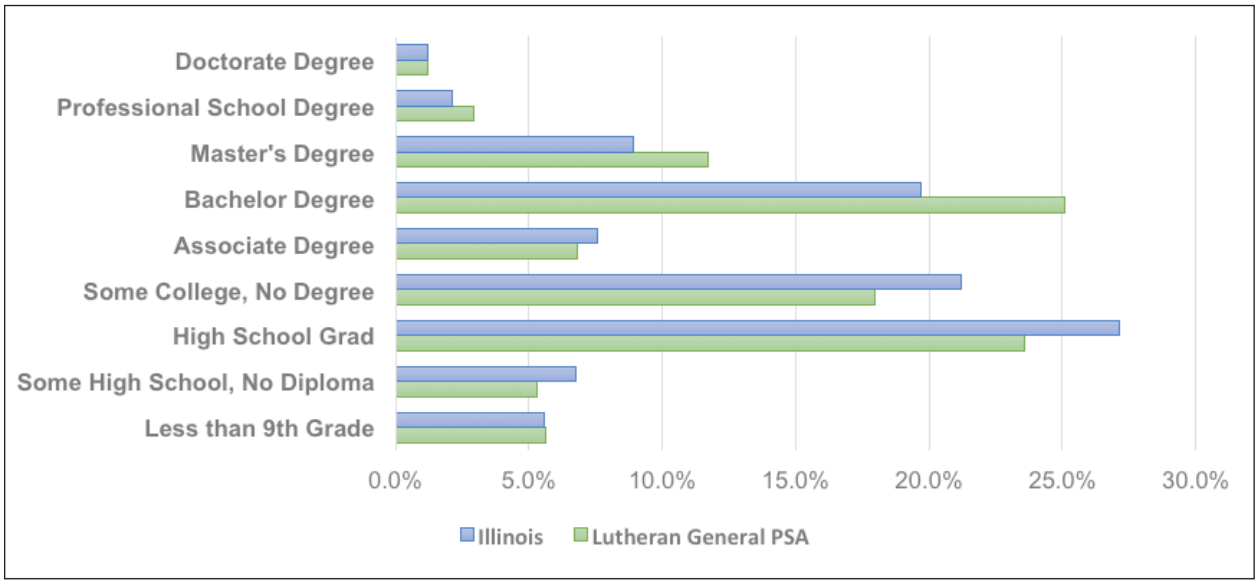



Source: Healthy Communities Institute, Claritas, 2016.

## *Education*

Within the hospital's PSA, 89.2% percent of people age 25 years older and above possess a high school degree or higher, and 41.7% have a bachelor's degree or higher. (Healthy Communities Institute, Claritas, 2016.) The three communities with the highest percentage of population 25 years and older that have less than a high school education are: Irving Park-Portage (60641) at 23.6%, Des Plaines (60018) at 20.5%, and Dunning (60634) at 17.6%. (Health Communities Institute, Claritas, 2016.) Research suggests that communities with lower levels of education also experience lower income, higher poverty rates and are more likely to suffer from chronic diseases, when compared to more affluent communities. (Healthy Communities Institute, Claritas, 2016.)

**Exhibit 10: Educational Attainment in PSA Compared to Illinois 2016**

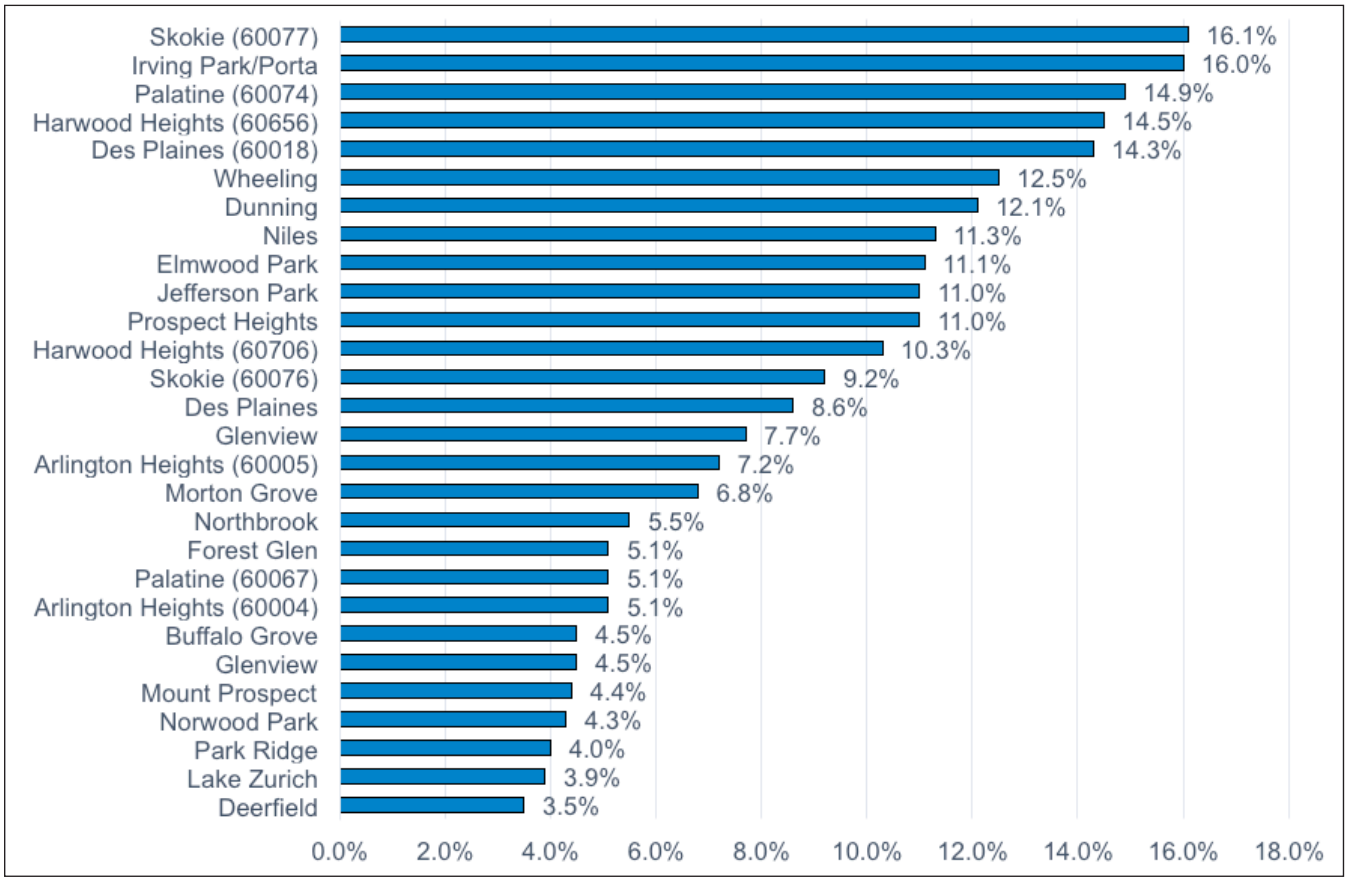



Source: Healthy Communities Institute, Claritas, 2016.

## *Poverty*

According to the 2016 US Federal Poverty Guidelines, an individual person making $11,880 is considered to be living in poverty; that figure is increased by $4,160 for each additional household member. For a family size of six, the federal poverty level is $32,570. (US Department of Health and Human Services, 2016.) For Lutheran General Hospital's PSA, the communities with the highest poverty rates are Skokie (60077), Irving Park/Portage, and Palatine (60074). Poverty is a major determinant of health and an underlying factor for poor health outcomes and chronic diseases. When compared to Exhibit 3 (listed above), zip codes that reported higher percentages for speaking English at home also have lower poverty rates. Exhibit 11 displays the zip codes with the highest poverty rates by zip code.

**Exhibit 11: Percent of Population Living below Federal Poverty Level in PSA 2008-2012**

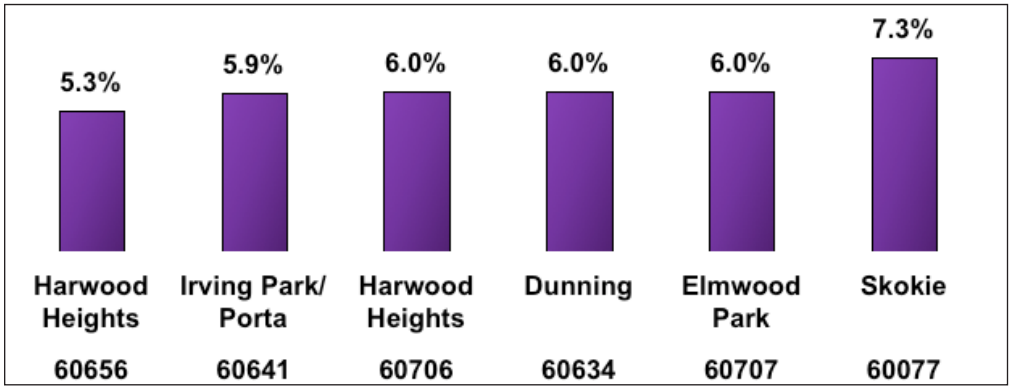



Source: American Community Survey, 2008-2012.

## *Insurance*

Approximately 8.4% of the US population is uninsured. (Truven Insurance Coverage Estimates, 2016.) Within Illinois, approximately 5.9% of the population is uninsured, with Lutheran General Hospital's PSA uninsured rate at 4.5%. Lutheran General Hospital serves a large senior population, age 65 and over, most of whom are covered by Medicare. Niles at 26.1%, Northbrook at 24.3% and Harwood Heights (60706) at 21.8% reported having the highest percentages of Medicare beneficiaries. While Skokie (60077) was not ranked highest for overall socioeconomic need, it is has the highest uninsured rate within Lutheran General Hospital's PSA.

**Exhibit 12: Percent Uninsured in PSA by Zip Codes with Highest Uninsured Rate 2016**

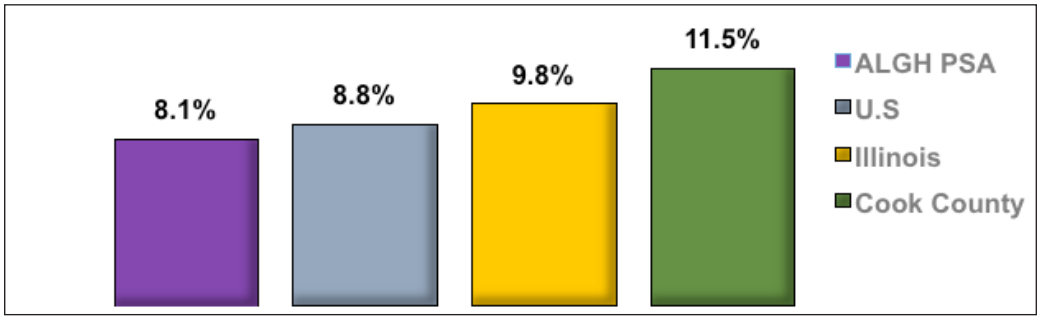



Source: Truven Insurance Coverage Estimates, 2016.

## *Unemployment*

Unemployment rates within Lutheran General Hospital's PSA have decreased as compared to 2014. In 2014, 9.4% of Lutheran General Hospital's PSA was unemployed, with the current unemployment rate decreasing to 8.1%. The current hospital PSA unemployment rate of 8.1% is lower than the current Illinois rate of 9.8%. (Truven, 2016.) Irving Park/Portage Park (12.5%), Elmwood Park (11.6%), Dunning (11.2%) and Jefferson Park (10.9%) have higher unemployment rates than other communities in the hospital's PSA—much higher than the Illinois rate as well. Employment is an important determinant of health and can have adverse effects in high need communities.[1]

**Exhibit 13: Percent of PSA/US/Illinois/Cook County Population Age 16+ Unemployed 2016**




Source: US Census Bureau, Census File, 2010; Truven Health Estimates, 2016.

# Key Roles in the 2014-2016 Community Health Needs Assessment

The 2014-2016 Lutheran General Hospital CHNA is the product of work conducted with multiple collaborating partners. Below is a description of those participants and partners.

## *System and Hospital Leadership*

In 2014, Advocate Health Care began organizing resources to implement the 2014-2016 CHNA cycle. The system signed a three-year contract with the Healthy Communities Institute (HCI), now a Xerox Company, to provide an internet-based data resource for their eleven hospitals during the 2014-2016 CHNA cycle. This robust platform offered the hospitals 171 health and demographic indicators including thirty-one (31) hospitalization and emergency department (ED) visit indicators at the service area and zip code levels. In addition, system leaders collaborated with the Strategic Planning Department to create sets of demographic, mortality and utilization data for each hospital site. This collaboration with Strategic Planning continued during the three year cycle ensuring that each hospital site had detailed inpatient, outpatient and emergency department data for its site.

Also in 2014, a new Department of Community Health for Advocate Health Care was centralized to the corporate office with all community health leaders reporting to the new Vice President, Community Health, Faith Outreach and Mission Integration. Lutheran General Hospital's CHNA was led by the Director, Community and Health Relations, who has been at the hospital since 2011, and the Coordinator, Community Health, who was hired in early 2016.

## *Health Impact Collaborative of Cook County*

In 2015, all five Advocate hospitals principally serving Cook County, including Lutheran General Hospital, served as founding members of the Health Impact Collaborative of Cook County (HICCC). Lutheran General Hospital and the Advocate system made significant donations of staff leadership time as well as providing financial support for the collaborative. HICCC is a best practice CHNA collaborative involving 26 hospitals, 7 health departments and nearly 100 community-based organizations. The goal of this initiative is to work collaboratively on a county-wide CHNA and implementation plan once priorities have been identified. The Illinois Public Health Institute (IPHI) served as the backbone organization for the collaborative providing facilitation, data coordination and report preparation activities.

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[1] Employment, for most individuals, is a basic requirement for accessing essential life requirements. In the article Effects of Unemployment on Mental and Physical Health, results suggest that "unemployment produces adverse psychological symptoms and that utilization of health services, when they are available, are increased substantially." (Linn, PhD, Margaret, W; American Journal of Public Health. Web, September 2016.)

Cook County, the second largest county in the United States, is a county in northeastern Illinois that includes Chicago and several of its closer suburbs. Cook County's population is 5,238,216. (Healthy Communities Institute, Claritas, 2016.) The City of Chicago's population is 2,695,598 (City of Chicago, Website, 2016), which is just over half of the population of Cook County. Lutheran General Hospital's PSA includes 6 zip codes within the Chicago city limits with the largest part of the PSA in Cook County. Five of the 6 zip codes within the Chicago city limits are among the top ranked communities with high socioeconomic needs.

Given the size and diversity of Cook County, the collaborative created three regions—North, Central and South—for purposes of organizing the assessment process. Lutheran General Hospital was appropriately assigned to and co-led the north region consisting of both the north side of Chicago as well as the northern and northwest suburbs of Cook County. The complete list of hospitals and health departments participating in the north region included the following: Advocate Illinois Masonic Medical Center; Advocate Lutheran General Hospital; Northshore University Health System including Evanston, Glenview, and Skokie Hospitals; Presence Holy Family Medical Center; Presence Resurrection Medical Center; Presence Saint Francis Hospital; and Presence Saint Joseph Hospital. In addition, the four-participating health departments in the north region were the Chicago Department of Public Health, Cook County Department of Public Health, Evanston Health Department and Skokie Health Department. A regional stakeholder group was also organized including members of community-based organizations representing various sectors, with approximately 30 stakeholders in the north region.

From February 2015 through June of 2016, the collaborative completed an extensive community health assessment process within each of the three regions using the public health process MAPP, Mobilizing for Action through Partnerships and Planning. More details regarding the data collection and prioritization process will be presented later in this report.

## *Lutheran General Hospital Governing Council*

Lutheran General Hospital's Governing Council is comprised of 67% community members representing community organizations beyond the hospital, including members that are from faith communities, school districts, the state legislature, other branches of state government, banking and legal sectors of the community. The Governing Council chairperson is the Superintendent of Roundout School District #72 and has been actively involved in the hospital's Community Health Council since its inception in 2011.

## *Lutheran General Hospital Community Health Council*

Lutheran General Hospital's Community Health Council was first convened in 2011. After completing the 2011-2013 CHNA, the council continued to meet quarterly with agendas including data presentations, program development and oversight, education on health issues and community partner presentations.

**Lutheran General Hospital Community Health Council Members**

- ACCESS Genesis Center for Health and Empowerment, Coordinator, Community Engagement
- American Heart Association, Senior Director, Community Health
- City of Des Plaines, Nurse
- City of Des Plaines, Social Worker
- City of Park Ridge, Environmental Health Officer
- City of Park Ridge, Social Worker
- Cook County Department of Health, Regional Health Officer
- Community Leader, Lutheran General Hospital Governing Council, Member
- Illinois Public Health Institute, Manager
- Lutheran Social Services (LSSI), Director, Mental Health Services
- Maine Township--MaineStay Youth and Family Services, Director
- National Alliance for Mental Illness (NAMI), Program Director
- Park Ridge Police, Chief

- Roundout School District #72, Superintendent; Lutheran General Hospital Governing Council Chairperson
- Schaumburg Township, Supervisor
- Triton Community College, Manager, Center for Health Professionals
- Village of Niles, Director, Family Services
- Village of Niles, Director, Fitness Center
- Village of Niles, Nurse
- Advocate Medical Group Behavioral Health and Addiction Treatment Program, Community Relations Representative
- Lutheran General Hospital, Coordinator, Community Health
- Lutheran General Hospital, Director, Community and Health Relations; Lutheran General Hospital Community Health Council Chairperson
- Lutheran General Hospital, Director, Older Adult Services
- Lutheran General Hospital, Director, Public Affairs and Marketing
- Lutheran General Hospital, Executive Clinical Director, Heart/Vascular/CC/ED/Trauma Director, Operations-Rehab/Out Patient Psychology/Neurology
- Lutheran General Hospital, Executive Director, Women's Health Services
- Lutheran General Hospital, Korean Concierge/Patient Navigator
- Lutheran General Hospital, Manager, Mental Health Services
- Lutheran General Hospital, Polish Patient Navigator
- Lutheran General Hospital, Vice President, Mission and Spiritual Care

### *Additional Collaborative Partners*

Lutheran General Hospital engages with numerous collaborative partners in the community to develop joint programs and initiatives and addressing systems, policy and environmental change. These partners include the American Diabetes Association, the American Heart Association, the American Cancer Society, Hanul Family Alliance, Lutheran Social Services of Illinois, Maine Township, the National Alliance on Mental Illness (NAMI), the Polish American Association and the Healthier Park Ridge, Healthier Des Plaines and Healthier Niles Coalitions.

## Methodology Used for the 2014-2016 Community Health Needs Assessment

The methodology utilized for the 2014-2016 CHNA cycle included the use of both primary and secondary data and as well as significant collaboration with community partners. The CHNA process was comprised of five major components, including: 1) the MAPP process used by the Health Impact Collaborative of Cook County (2/2015-6/2016); 2) use of the Healthy Communities Institute platform to review county, service area and zip code data (3/2014-6/2016); 3) review of other primary data from local surveys in Park Ridge, Niles, Des Plaines and the Korean American community; 4) review of other health data pertinent to the Lutheran General Hospital PSA; and 5) a children's community profile completed by Advocate Children's Hospital, which is co-located on the hospital campus. (See Appendix 4 for detailed profile.)

### *MAPP Process/Health Impact Collaborative of Cook County*

The Health Impact Collaborative of Cook County conducted a collaborative CHNA between February 2015 and June 2016. IPHI designed and facilitated a collaborative, community-engaged assessment based on the Mobilizing for Action through Planning and Partnerships (MAPP) framework. MAPP is a community-driven strategic planning framework that was developed by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). Both the Chicago and Cook County Departments of Public Health use the MAPP framework for community health assessment and planning. The MAPP framework promotes a system focus, emphasizing the importance of community engagement, partnership development and the dynamic interplay of factors and forces within the public health system. The Health Impact Collaborative of Cook County chose this inclusive,

community-driven process so that the assessment and identification of priority health issues would be informed by the direct participation of stakeholders and community residents. The MAPP framework emphasizes partnerships and collaboration to underscore the critical importance of shared resources and responsibility to make the vision for a healthy future a reality.


The key phases of the MAPP process include:

- Organizing for Success and Developing
- Partnerships
- Visioning
- Conducting the Four MAPP Assessments
- Identifying Strategic Issues
- Formulating Goals and Strategies
- Taking Action – Planning, Implementing, Evaluating

The four MAPP assessments are:

- Community Health Status Assessment (CHSA)
- Community Themes and Strengths Assessment(CTSA)
- Forces of Change Assessment (FOCA)
- Local Public Health System Assessment (LPHSA)

As part of continuing efforts to align and integrate community health assessment across Chicago and Cook County, the Health Impact Collaborative leveraged recent assessment data from local health departments where possible for this CHNA. Both the Chicago and Cook County Departments of Public Health completed community health assessments using the MAPP model between 2014 and 2015. As a result, IPHI was able to compile data from the two health departments' respective Forces of Change and Local Public Health System Assessments for discussion with the North Stakeholder Advisory Team, and data from the Community Health Status Assessments was also incorporated into the data presentation for this CHNA.

The Community Themes and Strengths Assessment included both focus groups and community resident surveys. The purpose of collecting this community input data was to identify issues of importance to community residents, gather feedback on quality of life in the community and identify community assets that can be used to improve communities.

## *Community Survey*

By leveraging its partners and networks, the Collaborative collected approximately 5,200 resident surveys between October 2015 and January 2016, including approximately 1,700 in the North region. The survey was available on paper and online and was disseminated in five languages – English, Spanish, Polish Korean, and Arabic.[2] The majority of the responses were paper-based (about 75%) and about a quarter were submitted online.

**Community Resident Survey Topics**

- ✓ Adult Education and Job Training
- ✓ Barriers to Mental Health Treatment
- ✓ Childcare, Schools, and Programs for Youth
- ✓ Community Resources and Assets
- ✓ Discrimination/Unfair Treatment
- ✓ Food Security and Food Access
- ✓ Health Insurance Coverage
- ✓ Health Status
- ✓ Housing, Transportation, Parks & Recreation
- ✓ Personal Safety
- ✓ Stress

The community resident survey was a convenience sample survey, distributed by hospitals and community based organizations through targeted outreach to diverse communities in Chicago and Cook County, with a particular interest in reaching low income communities and diverse racial and ethnic groups to hear their input into this Community Health Needs Assessment. The community resident survey was intended to complement existing community health surveys that are conducted by local health departments for their IPLAN community health assessment processes. IPHI reviewed approximately 12 existing surveys to identify possible questions, and worked iteratively with hospitals, health departments, and stakeholders from the 3 regions to hone in on the most important survey questions. IPHI consulted with the University of Illinois at Chicago (UIC) Survey Research Laboratory to refine the survey design.

The data from paper surveys was entered into the online SurveyMonkey system so that electronic and paper survey data could be analyzed together. Survey data analysis was conducted using SAS statistical analysis software, and Microsoft Excel was used to create survey data tables and charts. The majority of survey respondents from the North region identified as heterosexual (89%, n=1140) and white (71% n=1148). Seventeen (17%) percent of survey respondents identified as Asian/Pacific Islander, 6% Black/ African American, and 2% Native American/American Indian. Approximately 19% (n=1082) of survey respondents in the North region identified as Hispanic/Latino and approximately 4% identified as Middle Eastern (n=1082).[3] Roughly 0.6% (n=1256) of survey respondents from the North region indicated that they were living in a shelter or were homeless. Most respondents from the North region had a college degree or higher (53%, n=1205). The majority of North region respondents reported an annual household income of $60,000 or less (63%, n=1067).

[2] Written surveys were available in English, Spanish, Polish and Korean; all surveys with Arabic speakers were conducted with the English version of the survey along with interpretation by staff from a community based organization that works with Arab-American communities.

[3] Race and ethnicity categories do not add to 100% because a few paper-based surveys included write-in responses and because 163 surveys that were conducted with Arab American Family Services included an additional race option of "Arab."

## *Focus Groups*

IPHI conducted eight focus groups in the North region between October 2015 and March 2016. The collaborative ensured that the focus groups included populations who are typically underrepresented in community health assessments, including racial and ethno-cultural groups, immigrants, limited English speakers, low-income communities, families with children, LGBQIA and transgender individuals and service providers, individuals with disabilities and their family members, individuals with mental health issues, formerly incarcerated individuals, veterans, seniors, and young adults. The main goals of the focus groups were to understand needs, each of the focus groups was hosted by a hospital or community based organization, and the host organization recruited participants. IPHI facilitated the focus groups, most of which were implemented in 90-minute sessions with approximately 8 to 10 participants. IPHI adjusted the length of some sessions to be as short as 45 minutes and as long as two hours to accommodate the needs of the participants, and some groups included as many as 25 participants.

**Exhibit 14: Health Impact Collaborative of Cook County North Region Focus Groups 2016**

| Focus Groups | Location (Date) |
|---|---|
| **Adult Down Syndrome Center – Advocate Lutheran General Hospital**<br>Participants included parents and families of individuals with Down syndrome, medical providers, a representative from a residential facility, and adults living with Down syndrome. | Park Ridge, Illinois (1/28/16) |
| **Asian Human Services (AHS)**<br>Participants were staff members with AHS. AHS is a Social Service Organization serving immigrants, refugees, and other underserved communities in Chicago and the northern suburbs of Cook County. | West Ridge, Chicago, Illinois (1/27/16) |
| **Hanul Family Alliance**<br>Participants were Korean-American community members | Albany Park, Chicago, Illinois (1/13/16) |
| **Harper College**<br>Focus group participants included students and faculty in the college's Health Services Department as well as community partners including staff at social service organizations and representatives from local government. | Palatine, Illinois (2/8/16) |
| **Healthy Rogers Park Network**<br>Participants included representatives from local social service organizations, clinics, hospitals, and community groups. | Rogers Park, Chicago, Illinois (1/20/16) |
| **Howard Brown Health**<br>Participants were LGBQIA and transgender community members from across Chicago and Suburban Cook County and staff who were residents of surrounding communities. | Uptown, Chicago, Illinois (3/11/16) |
| **Norwood Park Senior Center**<br>Focus group participants were family members and caregivers of individuals requiring assisted living or full-time care. | Norwood Park, Chicago, Illinois (1/24/16) |
| **Polish American Association**<br>Focus group participants were staff who were also community members. | Portage Park, Chicago, Illinois (2/9/16) |

Source: Health Impact Collaborative of Cook County, North Region, Focus Groups, 2016.

### *Healthy Communities Institute (HCI) Data Platform*

Since early 2014, each hospital in the Advocate system has had access to the Healthy Communities Institute data platform, customized for the system through providing access to data for the counties, service areas and zip codes served by the hospitals. This robust platform provided the hospitals with 171 indicators at the county level including a variety of demographic indicators and thirty-one (31) hospitalization and emergency department (ED) visit indicators also at the service area and zip code levels. Utilizing the Illinois Hospital Association's (IHA) COMPdata, HCI was able to summarize, age adjust and average the hospitalization and ED data for five time periods from 2009-2015. The HCI contract also provided a wealth of county and zip code data comparisons; cross tabulation of data by age, race, ethnicity and gender; a SocioNeeds Index visualizing vulnerable populations within service areas and counties; a Healthy People 2020 tracker and a database of promising and evidence-based interventions. One of the most important contributions of this resource has been the availability of utilization data for both inpatient hospitalization and the emergency department at the zip code level, which enabled a more in-depth analysis of at risk communities.

## Lutheran General Hospital Collaborative Primary Surveys

Lutheran General Hospital financially supported and led three primary data survey processes for three communities surrounding the hospital; Park Ridge (2013-2014), Niles (2014-2015) and Des Plaines (2015-2016). Each survey process brought together a coalition of 25-30 community leaders and community based organizations in order to create a survey to identify needs in the community.

The primary purposes of the surveys were to assess and identify:

- Perceptions of community assets and gaps;
- Evaluation of community services, need for expanded services;
- Issues needing greater attention;
- Situations faced by household members and services needed to assist them;
- Mental health, personal and behavioral problems;
- Reasons that services were not accessed;
- Ability to perform activities of daily living, outside help needed at home.

The survey coalitions worked with an experienced epidemiologist to draft the survey, analyze the responses and write a report of findings. In addition to multiple choice and demographic questions, each survey contained one open-ended question about individual needs, experiences, and changes that could improve the quality of life in the community. Results were widely disseminated across the communities and were utilized to develop programming and successful grant applications. Please see Appendix 1 for a summary of each survey's results.

### *Healthier Park Ridge Survey*

Leadership for the 2013-2014 Healthier Park Ridge survey as well as for the Healthier Park Ridge Coalition was provided and financially supported by Lutheran General Hospital. The Healthier Park Ridge Coalition was comprised of 24 organizations seeking to identify and address the health and human services needs in the community. It was the first such survey administered in over a decade. Seven thousand eight-page questionnaires were mailed to randomly selected households in the 60068 zip code--about one of two homes in the community. At the cut-off date, 1,239 useable surveys had been returned or 17.7% of the sample. The survey margin of error was determined to be less than 1%. A comparison of the respondent characteristics to census figures revealed that the survey respondents were generally representative of the community. Results were tabulated and a final report was written. The report was disseminated throughout the community utilizing various communication vehicles.

Participating partners in drafting and promotion of the survey included: Advocate Lutheran General Hospital, Park Ridge Healthy Community Partnership, City of Park Ridge, Park Ridge Police Department, Park Ridge Fire Department, Maine Township, Park Ridge Health Commission, Lutheran Social Services of Illinois, Park Ridge Human Needs Task Force, Park Ridge Chamber of Commerce Health Care Forum, Park Ridge Community Fund, Park Ridge Library, Park Ridge Park District, Park Ridge Ministerial Association, Avenues to Independence, Center of Concern, Maine Center, School District 64, School District 207, Kiwanis, Park Ridge Rotary, The Park Ridge Park District Senior Center, Lions Club, and Senior Services, Inc.

## *Healthier Niles Survey*

Leadership for the 2013-2014 Healthier Niles survey as well as for the Healthier Niles Coalition was provided and financially supported by Lutheran General Hospital. The Niles survey was offered in English with instructions at the top of the document in four different languages regarding who to contact if assistance was needed in filling out the survey. The survey was sent to all 11,096 households in the Village of Niles via the Village Newsletter. Though over 500 surveys were received, only 492 were able to be used resulting in a return rate of 4.1%. The margin of error was determined to be + or – 4.3%. Results indicated that 11.8% of participating households spoke a language other than English at home, well below the 57.8% level reported by the American Community Survey for Niles. Results were tabulated and a final report was written. The report was disseminated throughout the community utilizing various communication vehicles.

Participating partners in drafting and promotion of the survey and results included: Advocate Children's Hospital, Advocate Lutheran General Hospital, Center of Concern, Genesis Access Community Health Network, Leaning Tower YMCA, Lions Club, Maine Center, Maine Township, Niles Chamber of Commerce and Industry, Niles Family Services, Niles Fire Department, Niles Healthy Community Partnership, Niles Park District, Niles Police Department, Niles Public Library District, Niles Senior Center, Niles Teen Center, Niles Township, School District 219, School District 63, School District 64, School District 71, United Way of Metropolitan Chicago, Village of Niles.

## *Healthier Des Plaines Survey*

Leadership for the 2016 Healthier Des Plaines survey as well as for the Healthier Des Plaines Coalition was provided and financially supported by Lutheran General Hospital. Thirty-two community based organizations participated in the Coalition. The survey was sent to 7,000 households chosen randomly in zip codes 60016 and 60018. After learning from the Healthier Niles survey that other languages were underrepresented, each home in the sample received both an English and a Spanish survey. Living in the two zip codes are 33,966 households, so that about one in five homes received the survey. About 600 anonymous surveys were received of which 583 were usable. This is 8.3% of the 7,000 households who received the survey. The margin of error was determined to be + or –3.9%. Results indicated that 10.9% of participating households spoke a language other than English at home, which was well below the 53.9% level reported by the American Community Survey for the two zip codes. Results were tabulated with the final report still being written when this CHNA report was finalized.

Participating partners in the drafting and promotion of the survey included: Advocate Children's Hospital, Advocate Lutheran General Hospital, Center of Concern, City of Des Plaines, Des Plaines Arts Council, Des Plaines Chamber of Commerce, Des Plaines Library, Des Plaines Park District, Elk Grove Township, Frisbie Senior Center, Genesis Access Community Health Network, Lattof YMCA, Maine Center, Maine Community Youth Assistance Foundation, Maine Township, National Alliance of Mental Illness (NAMI) Cook County North Suburban, Oakton Community College, Presence Center for Health, School District 59, School District 62, School District 63, School District 207, School District 214, United Way North-Northwest and Wheeling Township.

### *Korean American Community Health Needs Assessment*

In 2014, under the sponsorship and partnership of Lutheran General Hospital, Hanul Family Alliance (Hanul) led a comprehensive assessment of the health needs of Korean individuals and families living in the Chicago metropolitan area. Hanul is a community-based support organization providing social services to the Korean American Community. Hanul is a strong partner of Lutheran General Hospital.

In 2014, Hanul and Lutheran General Hospital engaged in a collaborative agreement to conduct a 6-month analysis and assessment of the current health status, health needs and health behaviors of the Korean American population in the Chicagoland area. This project included an assessment of the individuals who attended Korean Health fairs held annually at Lutheran General Hospital from 2011-2013. A second component of the project was a broader health assessment of the Korean population. Forty-nine of the 216 health fair participants were surveyed over the telephone to assess changes in their health status since the health fair and to determine whether the implementation of the ACA had any impact on their health behaviors. Eight health fair participants also attended a focus group to give more specific feedback. Additionally, 100 written surveys were received from the local Korean population. Results were analyzed and a final report was written by Hanul. Report results were communicated to the community by Lutheran General Hospital and Hanul through various methods including presenting the findings on Korean television, radio and newspapers, and posting the report on the Hanul website. The final report was also distributed to the Asian Health Coalition, Illinois Coalition for Immigrant and Refugee Rights, Lake County Community Foundation, Consulate General of the Republic of Korea in Chicago, and the Korean American Human Service Coalition.

## Review of Other Health Data

Multiple sources of primary and secondary data were analyzed during the CHNA process. In addition to the HICCC North Region and HICCC Lutheran General Hospital specific data and the 4 local community surveys, hospitalization and ED utilization data were reviewed and analyzed. See Appendix 2 for a complete list of primary and secondary data sources.

In addition to the previously outlined primary and secondary data, throughout the 2014-2016 CHNA cycle, the Community Health Council had data and informational presentations by the following organizations: Cook County Department of Health, American Heart Association, National Alliance on Mental Illness (NAMI), Lutheran Social Services of Illinois, Turning Point, and MaineStay Youth & Family Services. Data and program presentations were also given by the following Advocate programs or departments: Addiction Treatment Program, the Cancer Committee, Behavioral Health Services, Central Access, the South Asian Cardiovascular Center, Korean and Polish Navigator Programs, Advocate Physician Partners (APP) Health Disparities Project, Advocate Care Managed Medicaid and Medicare Programs, Older Adult Services and Advocate Children's Hospital.

# V. Data and Prioritization of Needs

## Health Impact Collaborative of Cook County – Priority Setting

Through a data-driven collaborative prioritization process described in the North Region Report, the HICCC identified four priority focus areas. (See Exhibit 15.) Addressing the social, economic and structural determinants of health was agreed upon as an overarching priority for collaborative planning and implementation among all hospital participants. In addition to social determinants, all hospitals agreed to select one additional priority to address.

**Exhibit 15: Health Impact Collaborative of Cook County Prioritized Health Needs 2016**

| **Improving social, economic, and structural determinants of health while reducing social and economic inequities.** | | |
|---|---|---|
| • Economic inequities and poverty<br>• Education inequities<br>• Healthy environment<br>• Housing and transportation<br>• Safety and violence<br>• Structural racism | | |
| **Improving mental health and reducing substance use.** | **Preventing and reducing chronic disease prevention.** | **Increasing access to care and community resources.** |
| • Overall access to services and funding<br>• Violence and trauma, and ties to mental health | • Focus on risk factors – nutrition, physical activity, and tobacco<br>• Healthy environment | • Cultural & linguistic competency/ humility<br>• Health literacy<br>• Access to healthcare and social services, and navigating the system, particularly for uninsured and underinsured<br>• Linkages between healthcare providers and community-based organizations for prevention |

Source: Health Impact Collaborative of Cook County, North Region, 2016.

## Lutheran General Hospital Selection of HICCC Priorities

As a result of the Health Impact Collaborative of Cook County (HICCC), Lutheran General Hospital's Community Health department began its prioritization in collaboration with the Community Health Council by first considering the health issues identified as priorities by the HICCC. Prior to the initial prioritization meeting, a community health profile including health issues and data specific to Lutheran General Hospital's PSA was sent to each Community Health Council member. At the first prioritization meeting, the Council was fully briefed via PowerPoint lecture on the following: 1) the four HICCC priorities with clarifying definitions; 2) HICCC data for the north region and HICCC data specific to Lutheran General Hospital's PSA; 3) HCI data on key health outcomes for the hospital's PSA; 4) Lutheran General Hospital's utilization data; 5) primary data results from the Lutheran General Hospital supported surveys for Park Ridge, Niles and Des Plaines; and 6) data from the Korean American community assessment.

Council members then met in small groups to review and discuss the data presented with a large group discussion following. The Council then voted on the HICCC priorities. Poll Everywhere, a web-based platform which uses smartphones, was utilized for the voting process. The Community Health Council selected Access to Care as the additional priority to address related to the HICCC process.

The key categories identified as access to care factors in the North region of Cook County included cultural and linguistic competence, insurance coverage, use of preventive care, and provider availability. Access to care barriers affecting Lutheran General Hospital's PSA included issues such as unemployment. As of 2016, the unemployment rate for the PSA was 8.1%, much lower than the Cook County average (11.5%) and slightly lower than the State average of 8.8%. (Truven, Nielsen, 2016.) Additionally, the Forces of Change Assessment identified that 29% of community residents in the North region reported "little or no good jobs in their communities." (Health Impact Collaborative of Cook County, 2015.) When comparing racial and ethnic disparities for unemployment in the North region, 22.5% of African Americans are unemployed, followed by 11.9% of Hispanics – much higher rates when compared to the 7.5% of unemployed Whites and 7.1% unemployed Asians. (Health Impact Collaborative of Cook County, American Community Survey, 2013.)

## *Priority One—Access to Care*

Access to care is complex for people living in poverty. Many working class poor also find accessing appropriate care at the appropriate time in the appropriate place highly challenging. The HICCC noted that 12% of the population in the HICCC North region lives at or below 100% of the federal poverty level. (Health Impact Collaborative of Cook County, American Community Survey, 2013.) Within Lutheran General Hospital's PSA, 6.8% of families live below the federal poverty level with Irving Park-Portage having the highest rate at 16%. (Healthy Communities Institute, 2016.) HICCC reported that racial and ethnic minorities experience higher rates of poverty such as African Americans/Black accounting for 29.9% and Hispanics for 21.7% living at or below 100% poverty level as compared to 11.2% for Whites. (Health Impact Collaborative of Cook County, CHNA, North Region, 2016; American Community Survey, 2009-2013.)

Additional findings from the HICCC focus groups with long standing hospital's partners in the North Region supported the access to care priority.

- All of the focus groups expressed need for affordable health care and a need for centralization of community resources, social services and healthcare services.
- Caregivers in the Norwood Park Senior Center group mentioned that there is a need for advice and information about resources and benefits.
- Families, care providers and adult individuals with Down syndrome indicated that it took families longer to find resources as there was no consolidated resource center and existing databases needed improvement.
- Harper College discussed the difficulty for those with Medicaid and the uninsured in being able to find care or being prematurely discharged.
- Hanul Family Alliance, Polish American Association (PAA) and Asian Human Services indicated the need for additional culturally and linguistically competent providers across the continuum of care including prevention programs.
- Polish American Association participants expressed fear of deportation and undocumented status as barriers to accessing care.
- Hanul and the PAA highlighted the need for more detailed data collection practices in hospitals to fully assess the needs of the diverse communities that they serve.

For Lutheran General Hospital's PSA, the Healthier Park Ridge, Niles, and Des Plaines surveys reinforced much of the above. Findings related to access to care included:

- Respondents from all 3 communities indicated that if they were not receiving services they needed, the cause was that "they did not know where to go" and "cost of services or treatment, unable to pay."
- Primary stressors were identified as financial pressure and health care in all three communities.
- Barriers identified for access to care within all three communities were: financial concerns, health problems, cost of health care and lack of free time.
- In Park Ridge, 32.9% of survey respondents answered "high health care costs" were a problem. In Niles, 10.4% reported "difficulty finding affordable medical services," 10% reported "delayed health care services because of cost or lack of insurance."

Through primary data gained in partnership with Hanul, Lutheran General Hospital was able to supplement HICCC findings on access to care for the Korean population in the hospital's service area. The Lutheran General Hospital/Hanul Family Alliance survey identified that "regardless of increased rate of insurance among the Korean population, there was not a big change in their healthcare behavior to seek regular medical care." (Hanul Family Alliance, Korean American Community Survey, December 2014.)

## *Selecting Additional Priorities*

To complement the access to care priority, the Community Health Council at Lutheran General Hospital also chose to assess health issues within the communities identified as having the highest HCI socioeconomic need index values within the hospital's PSA. When compared to the other 28 communities within Lutheran General Hospital's PSA, the six communities that were identified as having the highest socioeconomic needs were Irving Park, Dunning, Des Plaines, Elmwood Park, Harwood Heights and Jefferson Park.

To identify and prioritize the health issues in the high risk communities of Lutheran General Hospital's PSA, data available at the zip code level was analyzed. HCI served as a valuable resource for this process as it supplied inpatient and emergency room data at the zip code level, which as noted earlier in the report, enables more in-depth analysis of the at risk communities. The HCI data analysis was evaluated in context of the social determinant data and access to care findings, as both are related to health outcomes. HICCC data provided mortality rates for some of the identified health concerns. In addition to the specific zip code data, some overall PSA information as well as Cook County and US data were presented to give an overview of the health conditions.

## *Summary of Data for High Risk Communities*

The HCI data available at the zip code level included the following health issues: Diabetes, Heart Disease, Mental Health and Substance Abuse (Behavioral Health)[4], Immunization and Infectious Disease, and Respiratory Disease. HCI provides several health indicators for each of the listed health issues by community. HCI's graphic dashboard was utilized to depict comparisons between Lutheran General Hospital Hospital's PSA zip codes' health outcomes compared to Illinois Counties.

| | |
|---|---|
| **Green (Good):** | When a high value is good, community value is equal to or higher than the 50th percentile (median), or, when a low value is good, community value is equal to or lower than the 50th percentile. |
| **Yellow (Fair):** | When a high value is good, community value is between the 50th and 25th percentile, or when a low value is good, the community value is between the 50th and 75th percentiles. |
| **Red (Poor):** | When a high value is good, the community value is less than the 25th percentile, or when a low value is good, the community value is greater than the 75th percentile. |

[4] As noted in the North Region HICCC report, mental health and substance abuse together are referred to jointly as behavioral health. They were treated as one health issue for purposes of this CHNA report as well.

**Diabetes**

All seven HCI indicators for diabetes were evaluated and presented to the Community Health Council: Age-Adjusted ER Rate due to Diabetes; Age-Adjusted ER Rate due to Long-Term Complications of Diabetes; Age-Adjusted ER Rate due to Uncontrolled Diabetes; Age-Adjusted Hospitalization Rate due to Diabetes; Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes; Age-Adjusted Hospitalization Rate due to Short-Term Complications of Diabetes; and Age-Adjusted Hospitalization Rate due to Uncontrolled Diabetes. Lutheran General Hospital identified diabetes-related complications, predominantly in Irving Park, Elmwood Park, Jefferson Park, Harwood Heights (60706), Des Plaines (60018) and Dunning.

The major health issue associated with diabetes for Lutheran General Hospital's high need communities is the hospitalization rate due to long-term complications. When compared to the hospitalization rate for the PSA, high need communities displayed much higher rates per 10,000 population. As shown in Exhibit 16, five of the six-high risk communities had higher rates than Lutheran General Hospital's overall rate of 7.0/10,000, with Irving Park/Portage Park the highest at 13.6/10,000 and Elmwood Park at 12.4/10,000.

**Exhibit 16: Age-Adjusted Hospitalization Rate per 10,000 Population due to Long-Term Complications of Diabetes for High Risk Communities in PSA 2012-2014**

| ALGH: PRIMARY SERVICE AREA | Irving Park/ Portage Park (60641) | Dunning (60634) | Des Plaines (60018) | Elmwood Park (60707) | Harwood Heights (60706) | Jefferson Park (60630) |
|---|---|---|---|---|---|---|
| Comparison: IL Counties | Comparison: IL Counties | Comparison: IL Counties | Comparison: IL Counties | Comparison: IL Counties | Comparison: IL Counties | Comparison: IL Counties |
| 7.0 hospitalizations/10,000 population 18+ years | 13.6 hospitalizations/10,000 population 18+ years | 8.2 hospitalizations/10,000 population 18+ years | 8.2 hospitalizations/10,000 population 18+ years | 12.4 hospitalizations/10,000 population 18+ years | 8.6 hospitalizations/10,000 population 18+ years | 9.9 hospitalizations/10,000 population 18+ years |
| Measurement Period: 2012-2014 | Measurement Period: 2012-2014 | Measurement Period: 2012-2014 | Measurement Period: 2012-2014 | Measurement Period: 2012-2014 | Measurement Period: 2012-2014 | Measurement Period: 2012-2014 |

Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2015.

The Community Health Council also considered the findings from the Health Impact Collaborative of Cook County, which included the 2008-2012 Illinois Department of Public Health Mortality data. The diabetes mortality rate for the northern region was 43.0/100,000; data for diabetes-related deaths were also available at the zip code level for the PSA. See Exhibit 17. Diabetes mortality rates per 100,000 for the northern region disproportionately affect African Americans (107/100,000) and Hispanic/Latinos (72/100,000) compared to Asians (58/100,000) and Whites (38/100,000). (Health Impact Collaborative of Cook County, CHNA, North Region, Appendix D; Illinois Department of Public Health, Mortality Files, 2008-2012).

**Exhibit 17: Diabetes Mortality Rates per 100,000 in High Risk Communities in PSA 2008-2012**

| Health Impact Collaborative of Cook County Diabetes Mortality Rates per 100,000 population | | | | | | |
|---|---|---|---|---|---|---|
| Mortality Rates | Irving Park/ Portage Park (60641) | Dunning (60634) | Des Plaines (60018) | Elmwood Park (60707) | Harwood Heights (60706) | Jefferson Park (60630) |
| Diabetes Related Complications | 63.7 per 100,000 populations | 48.2 per 100,000 populations | 50.4 per 100,000 populations | 61.3 per 100,000 populations | 39.8 per 100,000 populations | 49.4 per 100,000 populations |

Source: Health Impact Collaborative of Cook County, 2016; Illinois Department of Public Health, Mortality Files, 2008-2012.

In the Healthier Des Plaines survey results, 20.4% of respondents indicated that they had been told they have diabetes or high blood sugar and 16.5% indicated that someone in their household had been told that they have diabetes or high blood sugar. In comparison, for the Hispanic respondents, only 11.8% indicated that they had been told they have diabetes or high blood sugar and only 15.4% indicated that someone in their household had been told that they have diabetes or high blood sugar. These were both less than the total survey respondents' percentages. It was noted that only 20 surveys were received in which Hispanic was marked as the primary race/ethnic category. The Hispanic age distribution was also relatively low with a median age of 55, and 7 of the 20 were under 45 years old. While this may indicate that more Hispanics were not aware of their or their families' conditions, this data should be read with caution. With the small response rate, the potential for error was significant.

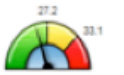
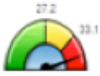
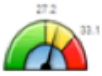
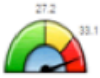
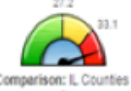
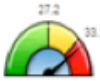
**Cardiovascular Disease**

Hospitalization rates due to heart failure and hospitalization rates due to hypertension were the two major health conditions affecting the six-high need communities related to cardiovascular disease within Lutheran General Hospital's PSA. For Cardiovascular Disease, four indicator outcomes were evaluated and presented to the Community Health Council: Age-Adjusted ER Rate due to Heart Failure; Age-Adjusted ER Rate due to Hypertension; Age-Adjusted Hospitalization Rate due to Heart Failure; and Age-Adjusted Hospitalization Rate due to Hypertension.

In 2011, the age-adjusted hospitalization rate due to hypertension for Lutheran General Hospital's PSA was 3.2 per 10,000 population. As of 2014, the rate has declined to 2.9 hospitalizations due to hypertension per 10,000 population. However, in Des Plaines (60018), in 2014 the hospitalization rate due to hypertension has increased from 3.1 in 2011 to 4.0 per 10,000 population. (Healthy Communities Institute, 2015.) While in certain communities, such as Irving Park, the rate has only increased slightly from 4.2 in 2011 to 4.4 in 2014, the rate continues to exceed the HCI red zone cut-off mark of 3.5 hospitalizations per 10,000 population for that community. (Healthy Communities Institute, 2015.)

When compared to Illinois (36.6), the hospitalization rates due to heart failure, per 10,000 population, at Lutheran General Hospital tend to be lower. (Healthy Communities Institute, Illinois Hospital Association, 2012-2014.) From 2009-2011, Lutheran General Hospital's overall PSA hospitalization rate due to heart failure was 29.6 per 10,000 population. As of 2012-2014 the hospitalization rates for heart failure have declined to 26.5. While the rates for several high need communities have gradually decreased as well, the hospitalization rates for heart failure and hypertension remain disproportionately higher when compared to the overall PSA. Exhibit 18 compares high need communities to the overall rate for the PSA.

**Exhibit 18: Age-Adjusted Hospitalization Rate per 10,000 Population Due to Heart Failure in High Risk Communities in PSA 2012-2014**

| ALGH: PRIMARY SERVICE AREA | Irving Park/ Portage Park (60641) | Dunning (60634) | Des Plaines (60018) | Elmwood Park (60707) | Harwood Heights (60706) | Jefferson Park (60630) |
|---|---|---|---|---|---|---|
|   Comparison: IL Counties 26.5 hospitalizations/10,000 population 18+ years **Measurement Period:** 2012-2014 |   Comparison: IL Counties 38.2 hospitalizations/10,000 population 18+ years **Measurement Period:** 2012-2014 |   Comparison: IL Counties 36.7 hospitalizations/10,000 population 18+ years **Measurement Period:** 2012-2014 |   Comparison: IL Counties 27.6 hospitalizations/10,000 population 18+ years **Measurement Period:** 2012-2014 |   Comparison: IL Counties 41.9 hospitalizations/10,000 population 18+ years **Measurement Period:** 2012-2014 |   Comparison: IL Counties 38.6 hospitalizations/10,000 population 18+ years **Measurement Period:** 2012-2014 |   Comparison: IL Counties 33.5 hospitalizations/10,000 population 18+ years **Measurement Period:** 2012-2014 |

Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2015.

While CVD affects all communities, HICCC identified higher CVD mortality rates in the same underserved communities acknowledged by Lutheran General Hospital. The average mortality rate for the north region was 97.3 deaths per 100,000 population in 2012. Exhibit 19 provides mortality rates specifically for high need communities within the PSA and identified rates to be nearly two-times greater than the overall rate for the north region.

**Exhibit 19: Cardiovascular Disease Mortality Rate per 100,000 in High Risk Communities in PSA 2008-2012**

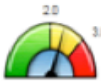
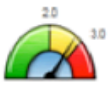
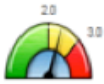
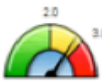
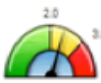
| CVD Mortality Rates per 100,000 population | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mortality Rates | HICC North Region | Irving Park/ Portage Park (60641) | Dunning (60634) | Des Plaines 60018) | Elmwood Park (60707) | Harwood Heights (60706) | Jefferson Park (60630) |
| Cardiovascular/ Heart Disease Mortality | 97.3 per 100,000 populations | 200.4 per 100,000 populations | 194.7 per 100,000 populations | 194.7 per 100,000 populations | 182.9 per 100,000 populations | 145.2 per 100,000 populations | 192.2 per 100,000 populations |

Source: Health Impact Collaborative of Cook County, 2016; Illinois Department of Public Health, Mortality Files, 2008-2012.

**Immunizations and Infectious Disease**

Six health indicators were analyzed and presented to the Community Health Council regarding Immunization and Infectious Disease: Age-Adjusted ER Rate due to Bacterial Pneumonia; Age-Adjusted ER Rate due to Immunization-Preventable Pneumonia and Influenza; Age-Adjusted ER rate due to hepatitis; Age-Adjusted Hospitalization Rate due to Bacterial Pneumonia; Age-Adjusted Hospitalization Rate due to Hepatitis; and Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza.

**Exhibit 20: Age-Adjusted Hospitalization Rate per 10,000 Population Due to Immunization-Preventable Pneumonia and Influenza in High Risk Communities in PSA 2012-2014**

| ALGH: PRIMARY SERVICE AREA | Irving Park/ Portage Park (60641) | Dunning (60634) | Des Plaines (60018) | Elmwood Park (60707) | Harwood Heights (60706) | Jefferson Park (60630) |
|---|---|---|---|---|---|---|
|  Comparison: IL Counties 2.9 hospitalizations/10,000 population 18+ years Measurement Period: 2012-2014 |  Comparison: IL Counties 2.5 hospitalizations/10,000 population 18+ years Measurement Period: 2012-2014 |  Comparison: IL Counties 2.9 hospitalizations/10,000 population 18+ years Measurement Period: 2012-2014 |  Comparison: IL Counties 4.8 hospitalizations/10,000 population 18+ years Measurement Period: 2012-2014 |  Comparison: IL Counties 2.2 hospitalizations/10,000 population 18+ years Measurement Period: 2012-2014 |  Comparison: IL Counties 2.9 hospitalizations/10,000 population 18+ years Measurement Period: 2012-2014 |  Comparison: IL Counties 2.6 hospitalizations/10,000 population 18+ years Measurement Period: 2012-2014 |

Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2015.

From 2009-2011, the age-adjusted hospitalization rate due to immunization-preventable pneumonia and influenza, for Lutheran General Hospital's PSA was 1.2 hospitalizations/10,000 population. As of 2012-2014, the rate increased to 2.9 hospitalizations per 10,000 population. The high risk communities were either equal to or less than that rate, with the exception of Des Plaines which was nearly two times higher at 4.8/10,000 population.

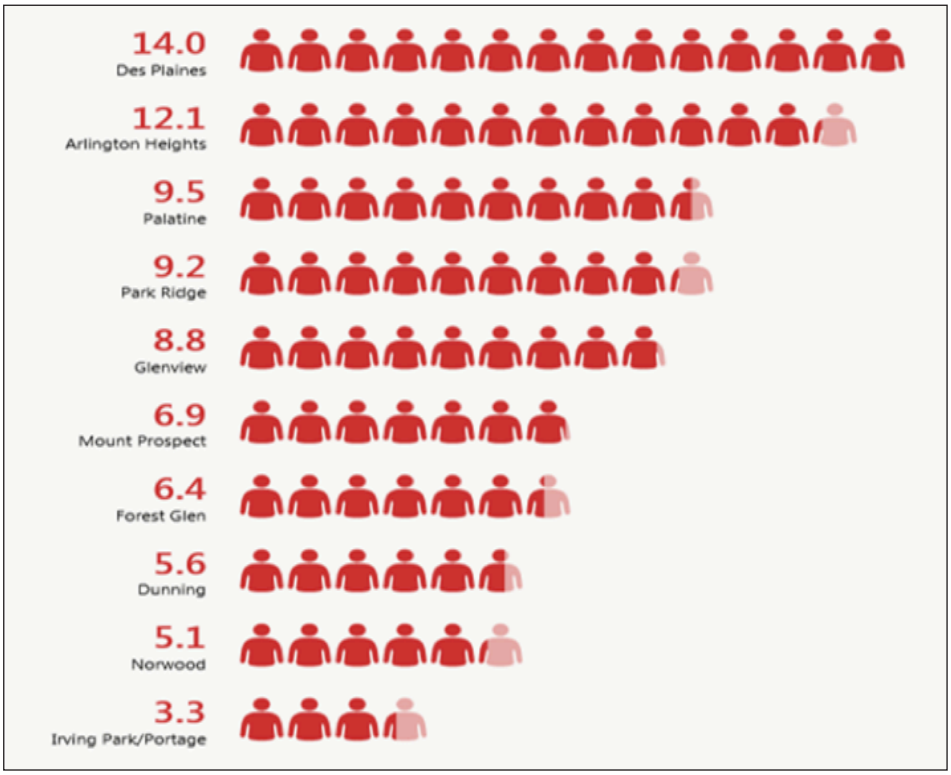
While the median age for Des Plaines is 38.7, younger than the 41.9 median age for the PSA, 15.9% of the population is 65 and older. The age-adjusted hospitalization rate due to immunization-preventable pneumonia and influenza increases for the population 65 years and older, predominantly affecting the population 85 and older. (Healthy Communities Institute, Claritas, 2016.)

**Mental Health and Substance Abuse (Behavioral Health)**

Five indicator outcomes were analyzed and presented to the Community Health Council regarding Mental Health and Substance Abuse: Age-Adjusted ER Rate due to Mental Health; Age-Adjusted ER Rate due to Suicide and Intentional Self-inflicted Injury; Age-Adjusted ER Rate due to Alcohol Abuse; Age-Adjusted ER Rate due to Substance Abuse; and Age-Adjusted Hospitalization Rate due to Alcohol. All of these indicators were in the HCI green zone for the high risk communities, although it was noted that primary survey data indicated that mental health was perceived as a serious health issue.

The highest suicide rates/100,000 population did not correlate with the high need communities with the exception of Des Plaines. Des Plaines had the highest suicide rate in the PSA with a rate of 14/100,000. More low SocioNeed Index communities had the higher suicide rates with Arlington Heights at 12.1/100,000, Palatine at 9.5/100,000, Park Ridge at 9.2/100,000 and Glenview at 8.8/100,000, rounding out the top five highest suicide rate communities in the hospital's PSA.

**Exhibit 21: Suicide Rate per 100,000 population in PSA for High Risk Communities**




Source: Health Impact Collaborative of Cook County, 2016; Illinois Department of Public Health, Mortality Files, 2008-2012.

Primary surveys administered in Park Ridge, Des Plaines and Niles indicated that respondents perceived depression and anxiety to be top health concerns. In addition to local surveys, national data was presented from the 2014 National Survey on Drug Use and Health. According to the report, 43.6 million adults (18.1%) in the United States had "any mental illness" in the past year (including mental, behavioral, or emotional disorders, but excluding developmental and substance use disorders). In addition, mental illness was more prevalent among women (21.8%) than men (14.1%), and occurred among about a fifth of adults ages 18 to 25, as well as a fifth of adults ages 26 to 49. (National Survey on Drug Use and Health, 2014.)

The Centers for Disease Control and Prevention suggest that, "Mental illness is associated with use of tobacco products and abuse of alcohol." (Centers for Disease Control, Division of Health Informatics and Surveillance, 2011.) Figure 22 below shows the emergency room (ER) rates due to alcohol abuse in high need communities compared to Illinois zip codes. Alcohol abuse is a health concern that affects all communities, and it is a significant health issue affecting Lutheran General Hospital's PSA. The emergency room rate due to alcohol abuse has increased from 32.6 per 10,000 in 2009 to 47.8 per 10,000 in 2014. The hospitalization rates for alcohol abuse exceed the healthy "green" cut-off mark of 24.5 for Lutheran General Hospital Hospital's PSA. (Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2012-2014.)

**Exhibit 22: Age-Adjusted ER Rate per 10,000 Population Due to Alcohol Abuse in High Risk Communities in PSA 2012-2014**

| ALGH: PRIMARY SERVICE AREA | Irving Park/ Portage Park (60641) | Dunning (60634) | Des Plaines (60018) | Elmwood Park (60707) | Harwood Heights (60706) | Jefferson Park (60630) |
|---|---|---|---|---|---|---|
| IL Counties | IL Zip Codes | IL Zip Codes | IL Zip Codes | IL Zip Codes | IL Zip Codes | IL Zip Codes |
| 47.8 | 83.0 | 102.1 | 49.0 | 81.1 | 51.5 | 53.8 |
| ER visits/ 10,000 population 18+ years | ER visits/ 10,000 population 18+ years | ER visits per 10,000 population 18+ years | ER visits per 10,000 population 18+ years | ER visits per 10,000 population 18+ years | ER visits per 10,000 population 18+ years | ER visits per 10,000 population 18+ years |
| **Measurement Period:** 2012-2014 | **Measurement Period:** 2012-2014 | **Measurement Period:** 2012-2014 | **Measurement Period:** 2012-2014 | **Measurement Period:** 2012-2014 | **Measurement Period:** 2012-2014 | **Measurement Period:** 2012-2014 |

Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2015.

Additionally, for 2014, the BRFSS and Healthy Chicago Survey found that nearly 34%-44% of adults in Chicago and suburban Cook County self-reported not having enough social or emotional support. (Health Impact Collaborative of Cook County, CHNA, North Region, 2016.) In the north region report, the highest ED admission rates for Mental Health were in Edgewater, Rogers Park and Uptown – communities that fall in the secondary service area (SSA) of the hospital.

**Respiratory Disease**

Six Respiratory Disease indicator outcomes were analyzed and presented to the Community Health Council: Age-Adjusted ER Rate due to Adult Asthma; Age-Adjusted ER Rate due to Asthma; Age-Adjusted ER Rate due to COPD; Age-Adjusted Hospitalization Rate due to COPD; Age-Adjusted Hospitalization Rate due to Adult Asthma; and Age-Adjusted Hospitalization Rate due to Asthma.

In Illinois, the age-adjusted hospitalization rate due to asthma at 11.3/10,000 population was higher than the rate for Lutheran General Hospital's PSA, 9.1/10,000. Overall, Lutheran General Hospital's PSA was not at high risk for respiratory-related complications. However, as expected, high SocioNeeds Index communities had higher emergency room rates when compared to communities with lower index values. See Exhibit 23. Age adjusted hospitalization rates per 10,000 population for Asthma is in the HCI red zone for 5 of the high SocioNeeds Index communities. Harwood Heights was lower when compared to other high risk communities but still a concern. Children and seniors are at higher risk for respiratory disease. (Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2012-2014.) When evaluating the trajectory over time, from 2009-2011, the rates have not increased substantially. In 2011, the rates for asthma hospitalizations were 8.6/10,000 population for the PSA.

**Exhibit 23: Age-Adjusted Hospitalization Rate per 10,000 Population Due to Asthma in High Risk Communities in PSA 2012-2014**

| ALGH: PRIMARY SERVICE AREA | Irving Park/ Portage Park (60641) | Dunning (60634) | Des Plaines (60018) | Elmwood Park (60707) | Harwood Heights (60706) | Jefferson Park (60630) |
|---|---|---|---|---|---|---|
| Comparison: IL Counties | Comparison: IL Counties | Comparison: IL Counties | Comparison: IL Counties | Comparison: IL Counties | Comparison: IL Counties | Comparison: IL Counties |
| 9.1 hospitalizations/10,000 population | 16.6 hospitalizations/10,000 population | 12.2 hospitalizations/10,000 population | 10.5 hospitalizations/10,000 population | 13.7 hospitalizations/10,000 population | 7.1 hospitalizations/10,000 population | 12.5 hospitalizations/10,000 population |
| **Measurement Period:** 2012-2014 | **Measurement Period:** 2012-2014 | **Measurement Period:** 2012-2014 | **Measurement Period:** 2012-2014 | **Measurement Period:** 2012-2014 | **Measurement Period:** 2012-2014 | **Measurement Period:** 2012-2014 |

Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2015.

### Selection of Final Priority

Following the presentation of data regarding high risk communities to the Community Health Council, the evidence based *Hanlon Method for Prioritizing Health Problems* was utilized by the Council to rank the health needs in the high risk communities. The Hanlon method requires participating members to select a number from 1 to 10 based on three criteria: (1) size of the problem; (2) seriousness of the health problem; and (3) effectiveness of interventions. A list of potential evidence based programs, the number of existing programs, and the cost burden for each health issue were presented and supplied in hard copy to assist the Council in making the selection. Please refer to Appendix 3 for a detailed description of the Hanlon process and materials provided before the Hanlon exercise, including data summary sheets.

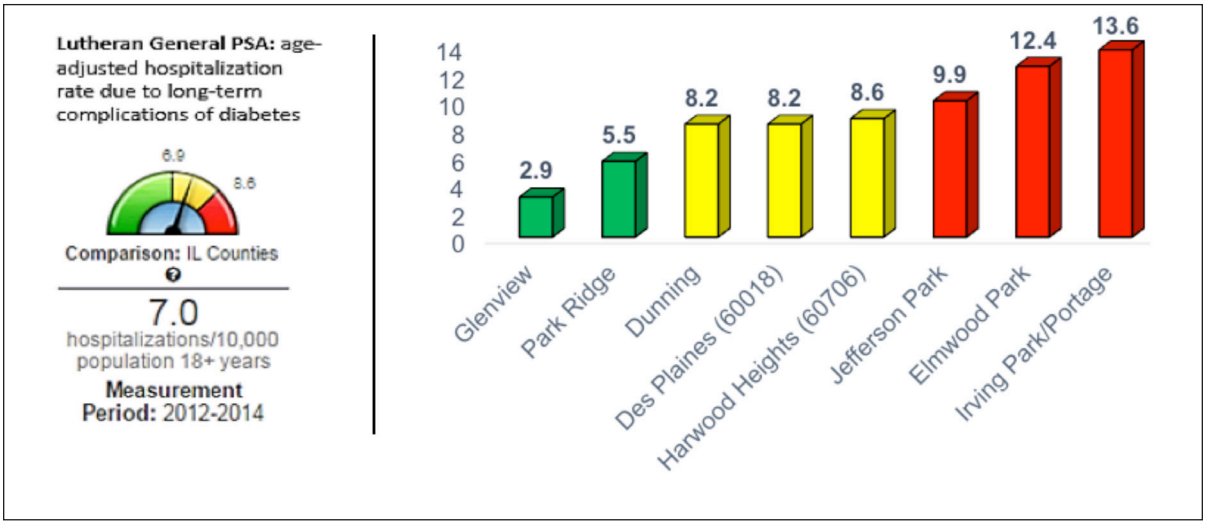
**Exhibit 24: Hanlon Results for High Risk Communities Priority Setting**

| Top Health Concerns | Averages |
|---|---|
| Cardiovascular Disease | 161.05 |
| Diabetes | 142.48 |
| Immunizations and Infectious Disease | 132.71 |
| Mental Health and Substance Abuse | 124.74 |
| Respiratory Disease | 118.13 |

Based on the calculated results, the Lutheran General Hospital Community Health Council rated cardiovascular disease and diabetes as the two highest health priorities. Since cardiovascular disease and diabetes are closely related, the hospital team elected to address both chronic diseases in the high risk communities.

Significant findings that supported these priorities was the data comparing the hospitalization rates and mortality rates of the low SocioNeed Index communities to the high SocioNeed Index communities. As shown in the two Exhibits below, when compared to lower risk communities, the hospitalization and death rates for diabetes related complications were higher for the identified high risk communities. Mortality rates also were higher for the high risk communities when compared to the lower risk communities within Lutheran General Hospital's PSA.

**Exhibit 25: Age-Adjusted Hospitalization Rate per 10,000 Due to Long-Term Complications of Diabetes in Highest to Lowest Need Communities in PSA 2012-2014**



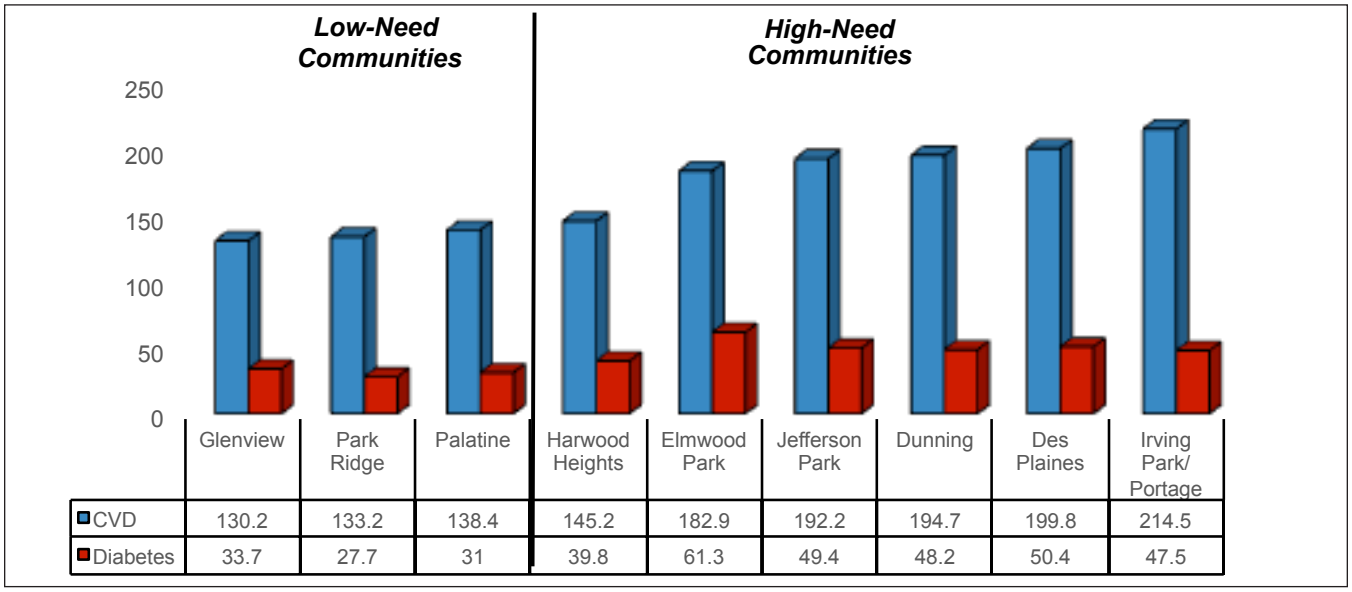

Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2015.

**Exhibit 26: Diabetes Mortality Rates in Highest and Lowest Need Communities in PSA 2008-2012**


Source: Health Impact Collaborative of Cook County, 2016; Illinois Department of Public Health, Mortality Files, 2008-2012.

In addition, when comparing the mortality rates for both diabetes and cardiovascular disease together, the low need communities have lower morality rates for both, while the high need communities have higher rates for both.

**Exhibit 27: Mortality Rates per 100,000 for Diabetes and Cardiovascular Disease in Higher and Lower SocioNeeds Index Communities in PSA 2008-2012**




| | Glenview | Park Ridge | Palatine | Harwood Heights | Elmwood Park | Jefferson Park | Dunning | Des Plaines | Irving Park/ Portage |
|---|---|---|---|---|---|---|---|---|---|
| CVD | 130.2 | 133.2 | 138.4 | 145.2 | 182.9 | 192.2 | 194.7 | 199.8 | 214.5 |
| Diabetes | 33.7 | 27.7 | 31 | 39.8 | 61.3 | 49.4 | 48.2 | 50.4 | 47.5 |

Source: Health Impact Collaborative of Cook County, 2016; Illinois Department of Public Health, Mortality Files, 2008-2012.

Finally, Irving Park/Portage Park and Dunning were chosen as the two communities of the six high risk communities that specifically would be addressed as they had the two highest SocioNeeds Index values of 82.2 and 71.2, respectively. In addition, Irving Park/Portage Park is the 2nd largest community in the hospital's PSA (70,790) and has the fastest growing Hispanic community (58%), the highest number of Spanish speakers (46%), the second highest Polish speaking community (8%), and the highest population of 25 year olds with less than a high school education (23.6%). It also has the second highest poverty rate (16%), the 3rd highest uninsured rate (6%), and the highest unemployment rate (12.5%).

Dunning, the largest community in Lutheran General Hospital's PSA (75,196), has the third fastest growing Hispanic population (18%), the highest percentage Polish speaking community (28%), the third highest population of 25 year olds with less than a high school education (17.6%), the seventh highest poverty rate (12.1%), the third highest uninsured rate (6.0%), and the third highest unemployment rate (11.2%) in the PSA. While there was high need in zip code 60018 in Des Plaines, it was recognized that Lutheran General Hospital was already doing a comprehensive diabetes intervention with St. Stephens Catholic Church in that community.

## Priority Needs Selected to Address

In summary, Lutheran General Hospital selected the following three priorities to address following its 2014-2016 CHNA process.

1. Social Determinants of Health
2. Access to Care
3. Heart Disease/Diabetes in PSA High Risk Communities

## Explanation Why Other Needs Not Selected as Priorities

**Mental/Behavioral Health**

While mental health was not selected as a priority by the Community Health Council at either the PSA level or the high risk community level, Lutheran General Hospital will continue to work on this important issue. It was recognized by the Council that Mental Health is a growing issue in the hospital's PSA. Community collaboration related to mental health will continue, including partnerships with the Park Ridge Police Department and Lutheran Social Services of Illinois (LSSI). Additionally, the hospital will continue to provide both inpatient and outpatient behavioral health services.

A Community Health Council Member, who manages Behavioral Health for LSSI, indicated after prioritization, that LSSI has multiple offices and mental health services available for individuals in the identified at risk communities. The hospital will work with LSSI to educate high risk community members about affordable behavioral health services within their community.

Lutheran General Hospital continues to work with the Healthier Park Ridge, Niles and Des Plaines Coalitions, which include numerous mental health professionals and entities such as NAMI to address mental health in its communities.

**Respiratory Disease**

The Community Health Council did not select respiratory disease as a priority health issue. Respiratory disease is a general term for several medical conditions affecting the lungs. The common conditions evaluated at Lutheran General Hospital were, asthma and COPD. Lutheran General Hospital currently provides an on-site, smoking cessation program to the community as a way to reduce chronic conditions associated with respiratory disease. While smoking is not the only factor associated with respiratory disease, it is a major contributor to lung and bronchus cancer as well.

**Immunizations and Infectious Disease Prevention**

While immunizations and infectious disease prevention are always a public health priority, the Community Health Council agreed that there is existing capacity to address this need through the public health and provider channels. Lutheran General Hospital continues to work towards expanding preventive services in this area by providing on-site vaccinations and working with Advocate Children's Hospital to expand early interventions.

**Cancer**

Due to its significance, an overview of cancer data for Lutheran General Hospital was presented to the Community Health Council. A more detailed analysis of cancer data for the hospital's PSA, however, was created for the hospital's Cancer Committee. This committee completes a Community Health Needs Assessment to meet the requirements as mandated by the Commission on Cancer (COC). Due to the Cancer Committee's own assessment, the high quality Lutheran General Cancer Survivorship Center and the hospital's comprehensive oncology program, cancer was not considered for a priority for this CHNA. In 2015, the Cancer Committee presented its patient population data to the Community Health Council ensuring the council is updated on significant cancer data and programs. As part of a strategy for improving access to care, the community health department at Lutheran General Hospital will continue to collaboratively work with the hospital's Cancer Committee to share data, support programming and expand preventive services in the community.

# VI. Implementation Planning for 2014-2016 CHNA

As a result of the 2014-2016 CHNA, Lutheran General Hospital will strategically work to expand program implementation around its identified priorities.

## Social Determinants of Health

The hospital will address this priority collaboratively with the members of the Health Impact Collaborative of Cook County. Action teams began meeting in October to develop strategies to address this priority within HICCC. Initial strategies being considered include addressing poverty and economic inequities, education quality and inequities, structural racism, housing, transportation, health environments and/or safety/violence prevention/trauma. Lutheran General Hospital is participating in strategic planning related to education quality and inequities as well as trauma informed care within the Children's Hospital.

## Access to Care – Health Literacy; Language and Cultural Competency; Navigation

The Health Impact Collaborative of Cook County identified access to care as one of the cross-cutting themes in Cook County, including the north region and Lutheran General Hospital's service area. The HICCC, through the Forces of Change Assessment (FOCA) and Community Health Status Assessment (CHSA) data identified multiple factors that influence access to care including poverty, insurance coverage, and self-reported use of preventative care, hospitalization statistics and provider availability.

Lutheran General Hospital will address access to care by hardwiring ongoing initiatives with strategies around cultural and linguistic competency, health literacy, and ethnic specific care and navigation that Lutheran General Hospital initiated in 2011. In addition, Lutheran General Hospital will focus on barriers associated with navigating complex health care and hardwiring a strategy for expanding access to preventive services provided by the hospital.

At its programming and implementation Community Health Council meeting, Dr. Jennifer Banas, MPH, MSEd, EJD, an Associate Professor at Northeastern Illinois University, presented the program, *Adolescent Health Care Brokering*. The program first assesses the need and then provides education along with training, for young adults to become competent health literate individuals. The Council agreed to further explore the possibilities of partnering with the local high school district and with Advocate Children's Hospital.

Also presented and discussed was an evidenced based health literacy program in a clinical setting. The Community Health Council member from Access Genesis Clinic was going to explore this program. Additional health literacy interventions such as effective print communication, culturally sensitive care, health communication and marketing, Community Health Workers and health insurance outreach were also discussed. Finally, the Council discussed a health literacy program for the community, attaching it to existing programs such as those being done by the Village of Niles social services, the Park Ridge Mental Health Coalition and the Polish and Korean programming at Advocate Lutheran General Hospital.

The Council decided to first explore the Adolescent Health Literacy with the School District and Advocate Children's Hospital and also the possibility of the Genesis Clinic and/or community programming. Further details of these programs were discussed again at the Community Health Council Meeting in November 2016. It was also decided to partner with the HICCC co-participant, Access to Care in moving this priority forward. Access to Care facilitates access to primary health services for resident of suburban Cook County and northwest Chicago who lack such access because of financial barriers.

At a system level, Advocate Health Care continues to expand its diversity and inclusion program. For Lutheran General Hospital, connecting health literacy to the culture of inclusion program will be a focus area and strategy to impact multiple outcomes. In order to effectively reduce health care disparities, implementing culturally sensitive programs are essential to the overall focus on access to care.

Lutheran General Hospital will continue to work internally to partner with faith communities, Hanul Family Alliance, the Polish American Association, the South Asian and Hispanic communities on its journey to reduce health disparities and achieve health equity.

## Heart Disease/Diabetes in Lutheran General Hospital High Risk Communities

Based on the data analysis, the Community Health Council elected to target diabetes and cardiovascular disease in high need communities. Lutheran General Hospital explored partnership opportunities with Presence Health around diabetes and cardiovascular disease as Resurrection Medical Center also identified diabetes and cardiovascular disease as a growing concern within the overlapping, high need communities of Irving Park/Portage and Dunning. As noted, these were also the largest communities in Lutheran General Hospital's PSA so more lives potentially could be impacted. Presence Resurrection Medical Center indicated an interest in partnering with the Million Hearts Initiative which was discussed at the meeting. The American Heart Association member indicated that they would want to partner on this with the two hospitals as well.

Also presented to the Council were diabetes programs such as the CDC's National Diabetes Prevention Program (DPP) and the Paso Adelante program offered in both Spanish and English using Community Health Workers. The hospital's South Asian Cardiovascular program was already participating in a DPP. Also presented and discussed was evidenced based Heart Disease programs such as BetterU, a 12-week behavior modification program tailored to women. However, as the Million Hearts Initiative would involve an existing hospital partner and the American Heart Association, this program was chosen to address cardiovascular disease in the Irving Park/Portage Park and Dunning communities. Details were finalized at the November 16, 2016, Community Health Council Meeting.

The hospital will continue its work in the Des Plaines 60018 zip code on pre-diabetes detection, self-management and prevention education. A diabetes screening was held in September and a 5-week program was run beginning in October 2016. Processes for long term, consistent follow up were established and completed in the fall of 2016. The goal was to create a sustainable, measurable evidence-based program that integrates a culturally relevant approach to diabetes prevention and enables feasible access to care and reduces health disparities – a continuing long-term objective of Lutheran General Hospital and Advocate Health Care.

## Governing Council Approval

Advocate Lutheran General Hospital's CHNA Report was endorsed by the hospital's Community Health Council on September 21, 2016, and approved by Advocate Lutheran General Hospital Hospital's Governing Council on November 14, 2016.

# VII. Communication with the Community and Feedback Mechanisms

Thank you for reading this CHNA Report. We welcome your feedback. If you would like to comment on this report, please click on the link below to complete a CHNA feedback form. We will respond to your questions/comments within thirty days. Your comments will also be considered during our next CHNA assessment cycle. http://www.advocatehealth.com/chnareportfeedback

If you experience any issues with the link to our feedback form or have any other questions, please click below to send an email to us at:
AHC-CHNAReportCmtyFeedback@advocatehealth.com

This report can be viewed online at Advocate Health Care's CHNA Report webpage via the following link:
http://www.advocatehealth.com/chnareports

A paper copy of this report may also be requested by contacting the hospital's Community Health Department.

## Other Communication and Feedback Opportunities

In addition to the opportunity to provide feedback through the means described above, Advocate Lutheran General Hospital also plans to communicate the CHNA findings and preliminary implementation plans, as available, to the community through presentations to the Healthier Park Ridge, Niles and Des Plaines Coalitions, and to other community organizations as requested.

# VIII. Appendices

## Appendix 1: Summary of Community Surveys for Lutheran General Hospital

### *Healthier Park Ridge Survey Executive Summary*

# HEALTHIER PARK RIDGE PROJECT SURVEY RESULTS

SURVEY RESULTS PRESENTATION
February 21, 2016
St. Luke's Lutheran Church
*Paula Meyer Besler*



## INTRODUCTION

- The Healthier Park Ridge Survey, first community survey in a decade, sought to provide information for creating a better quality of life for residents.
- The survey was created by a partnership of 24 Park Ridge organizations who convened to develop the questionnaire. Partners helped to fund and publicize the survey. Many will use the results to implement change in the community.



## SURVEY METHODOLOGY

- The eight-page questionnaire included a cover letter explaining the survey purpose and a business reply envelope for response.
- 7,000 surveys were mailed, about one of two residences in Park Ridge with a follow-up reminder postcard ten days later.
- At the cut-off date, 1,239 useable surveys had been returned or 17.7% of the sample.
- The margin of error is less than + or – 1%.



## RESPONDENT CHARACTERISTICS

- A comparison of respondent characteristics to Census figures revealed that the survey respondents were generally representative of the community.
- However, those responding were a bit older and somewhat better educated than the Census figures indicated.
- Survey households included 3,351 persons or nearly one in ten Park Ridge residents..

## QUALITY OF LIFE IN PARK RIDGE
### What is valued most?

In the first survey question, local citizens were asked to choose FIVE characteristics of 27 listed which describe what they VALUE MOST ABOUT LIVING IN PARK RIDGE.

The clear leaders were these three.

1. Safe, low crime
57.4%

2. Good schools
56.1%

3. A good place to bring up children
50.9%



## QUALITY OF LIFE IN PARK RIDGE
### What is valued most?

Rounding out the top ten characteristics VALUED MOST about living in Park Ridge:

- 4. Good local health care. 33.8%
- 5. Good library services. 29.0%
- 6. Peaceful small town. 28.7%
- 7. Close to family, friends. 26.8%
- 8. Good public transportation. 21.1%
- 9. Good parks, recreation. 19.5%
- 10. Access to stores, serv., rest. 18.3%



## QUALITY OF LIFE IN PARK RIDGE
### What is missing?

- In the next question, local citizens were asked to choose FIVE characteristics of the same 27 listed which they feel are MISSING IN PARK RIDGE. The average number marked was 3.6.
- Cited most as missing by residents were:
  1. "Fair property taxes" 63.3%
  2. "Affordable housing" 35.7%
  3. "Lack of traffic congestion" 29.6%
  4. "Job opportunities" 27.0%
  5. "Good air quality" 26.8%



## QUALITY OF LIFE IN PARK RIDGE
### What is missing?

- Rounding out the top eleven characteristics MISSING IN PARK RIDGE:
- 6. Tolerance of differences 18.6%
- 7. Good community leadership 16.8%
- 8. Access to stores, services, rest. 16.4%
- 9. Open, green spaces 14.9%
- 10. Programs, services for the elderly 13.7%
- 11. Good public transportation 11.5%

## RATINGS OF COMMUNITY SERVICES

- Survey participants were asked to rate 13 community services as "excellent", "good", "fair" or "poor". Don't know could also be marked if not familiar with the service. Many persons did feel able to rate certain services.
- Community services were analyzed in two ways:
- Percent of respondents rating the community service as "excellent or good".
- A mean rating score when excellent = 4, good = 3, fair = 2 and poor = 1. "Don't know" and "no answer" were excluded from these calculations.



## RATINGS OF COMMUNITY SERVICES

| Community Service | % Excint/Good | Mean Score |
|---|---|---|
| Quality of local public education | 93.6% | 3.45 |
| Availability of health care services | 89.2% | 3.26 |
| Quality of local Park District services | 74.8% | 2.90 |
| Availability of public transportation | 71.1% | 2.86 |
| Availability of services for senior citizens | 63.6% | 2.67 |
| Availability of social services overall | 63.4% | 2.65 |
| Quality of City services | 62.3% | 2.65 |
| Availability of services for youth | 59.4% | 2.60 |
| Availability of cultural activities, arts | 57.5% | 2.57 |
| Availability of services for the disabled | 49.2% | 2.44 |
| Centers in which to stay during emergencies | 41.9% | 2.28 |
| Access to local government decision makers | 39.2% | 2.28 |
| Cooperation among local governments | 23.2% | 1.96 |



## PROBLEMS NEEDING GREATER ATTENTION

- In this set of questions, survey respondents were given the opportunity to indicate which of 26 community issues listed require *greater attention*.
- Any number could be chosen by the respondent.
- The "average respondent" marked 3.9 or about four problems for greater attention.



## TOP TEN PROBLEMS NEEDING GREATER ATTENTION IN PARK RIDGE

| Problem needing greater attention | Percent |
|---|---|
| 1. Activities for teens | 38.4% |
| 2. High health care costs | 32.9% |
| 3. Need for housing in all price ranges | 29.4% |
| 4. Caring for isolated neighbors | 23.2% |
| 5. Activities for seniors | 21.6% |
| 6. Job retraining, coping with job loss | 21.2% |
| 7. Support for caregivers | 17.4% |
| 8. Respite care for caregivers | 17.4% |
| 9. Substance aAbuse | 17.2% |
| 10. Gangs, delinquency, youth violence | 16.8% |

## HOUSEHOLD SITUATIONS EXPERIENCED

- This section of the questionnaire asked survey participants to mark each situation that they or someone else in the home experienced during the **past year.**
- Thirteen possible situations were listed or respondents could write in "others". Problems paying property tax was written in most often with 11 mentions.
- In these results, 1% = 141 households when applied to the entire Park Ridge population.



## HOUSEHOLD SITUATIONS EXPERIENCED BY HOUSEHOLD

| Household Situation Experienced | Percent |
|---|---|
| Difficulty paying bills | 18.1% |
| Difficulty finding affordable dental services | 14.9% |
| Experienced unemployment due to an involuntary job loss | 11.8% |
| Difficulty finding affordable medical services | 11.6% |
| Delayed health care or taking medicine due to cost or no ins. | 10.3% |
| Difficulty finding supportive services for an older adult | 8.5% |
| Difficulty finding child care | 4.8% |
| Home mortgage foreclosed or at-risk | 4.4% |
| Difficulty finding services for family member with special needs | 4.3% |
| Unable to find affordable local behavioral counseling or therapy | 4.3% |
| Senior housing assistance, help with transitions | 4.2% |
| Difficulty finding older adult day care program | 3.9% |
| Hunger, insufficient food available | 1.0% |



## CAUSES OF STRESS

- In this question, survey respondents were asked to indicate whether they experience stress and, if so, what are the primary causes.
- One of twelve (8.3%) local residents said that they do not experience stress, primarily among the elderly who had 13.4% without stress.
- For those with stress, 2.3 causes were marked on average of the 24 causes listed. Once again, property tax led items written in with 17 such responses.



## LEADING CAUSES OF STRESS

| Cause of Stress | Percent |
|---|---|
| Financial concerns | 30.8% |
| Cost of health care | 24.4% |
| Health problems | 21.7% |
| Lack of free time | 20.1% |
| Current job | 19.1% |
| Caregiver for an older person | 11.6% |
| Family relationships | 11.1% |
| Unable to exercise | 9.4% |
| Parenting, children's behavior | 8.3% |
| Loss of loved one | 7.7% |
| Can't find a job | 7.0% |

## SERVICES NEEDED, BUT NOT RECEIVED

- This survey portion listed 22 possible services, with the respondent instructed to mark any service needed, but not received for themselves or any other household member.
- No individual service needed, but not received was marked by more than 5% of the survey households.
- Those which exceeded 2% of households are shown on the following slide.



## SERVICES NEEDED, BUT NOT RECEIVED

| Service needed, but not received | Percent |
|---|---|
| Counseling and support services for senior citizens | 4.5% |
| Support groups for coping with daily living, stress | 4.4% |
| Behavioral or mental health services | 3.8% |
| Counseling services | 3.2% |
| Support group for families coping with family member with behavioral issues | 3.2% |
| Bereavement services or help coping with death | 3.0% |
| Couples therapy | 2.9% |
| Smoking cessation | 2.9% |
| Eating disorders treatment | 2.4% |



## REASONS FOR NOT RECEIVING NEEDED SERVICES

| Reason for Not Getting Services | Percent |
|---|---|
| Didn't know where to go for services | 11.5% |
| Cost of treatment, unable to pay | 8.8% |
| Lack of insurance to help with treatment cost | 7.8% |
| Concern about privacyor confidentiality | 5.5% |
| Negative reaction (stigma) to disability or health problem | 3.1% |
| Others might have a negative view of me for using such services | 2.7% |
| Lack transportation to get to services | 2.5% |
| The wait for help is too long | 2.5% |
| No local agency has the services I need | 2.3% |
| | |
| Percent is of all survey respondents | |



## BEHAVIORAL PROBLEMS

- The prevalence of 29 behavioral issues in the household during the past year was asked of local residents. These were problems which affected activities of daily living for at least one household member.
- Those present at 3% or greater are shown in the following slide.

## BEHAVIORAL PROBLEMS

| Household prevalence | Percent |
|---|---|
| Major disruptions in the quality of sleep | 10.9% |
| Sadness or blue mood > 3 weeks (depression) | 9.0% |
| Frequently anxious & fearful (general anxiety, panic attacks) | 6.9% |
| Difficulty focusing or easily distracted (attention deficit disorder) | 4.5% |
| Marital problems | 4.0% |
| Loss of ability to think or remember (Alzheimer's or other dementia) | 3.6% |
| Bullying, cyber bullying | 3.2% |
| Mood swings from high to low (bipolar disorder or manic depression) | 3.0% |



## NEED FOR PROFESSIONAL HELP

*Two questions dealt with professional help for personal problems in the past year.

One of five (22.2%) persons thought about getting help.

However, only about half of those (48.7%) actually sought help.

Therefore, one of ten persons (10.8%) sought help in the past year.



## TAKING MEDICATION FOR BEHAVIORAL PROBLEMS

- Asked if they are currently taking medication for emotional or behavioral problems, 7.8% replied affirmatively.
- The highest levels for individuals taking medication for behavioral reasons were the following:

Sought behavioral help 36.8%

Thought about behavioral help 24.3%

Feel stress due to isolation 17.3%



## SUICIDE

*9.9% of respondents had ever thought about suicide.

Feel stress due to isolation 32.7%

## ABUSE

- 3.6% of respondents reported that they had been abused *physically, emotionally or sexually* during the past year.
- 5.2% of respondents were taken advantage of by someone using their *belongings. (includes financial)*



## HEALTH CARE NEEDS

- Asked "During the past year have you or anyone in your household been unable to receive care that was needed for any of the following health problems"
  Eight health care services were listed.
- A follow-up question asked the respondent to elaborate on the reasons that the needed health care was not received.



## HEALTH CARE NEEDED, BUT NOT RECEIVED

| Health Care Need | Percent |
|---|---|
| Dental Problems | 8.2% |
| Medical Problems | 5.7% |
| Vision Problems | 3.9% |
| Preventive Tests, Screenings | 3.6% |
| Mental Health Problems | 2.3% |
| Hearing Problems | 2.2% |
| Behavioral Health Problems | 1.1% |
| Substance Abuse | 0.6% |



## REASONS NEEDED CARE WAS NOT RECEIVED

| Reason Care Was Not Received | Percent |
|---|---|
| Financial concerns, cost of care | 11.2% |
| Lack of insurance | 5.4% |
| Lack of prescription coverage | 2.7% |
| Have no regular doctor | 2.0% |
| Long wait to get appointment | 1.9% |
| Lack of trust in doctors, health care | 1.8% |
| Fear or dislike of health care | 1.5% |
| Office times inconvenient | 1.5% |
| Physician would not take Medicare | 1.3% |
| No transportation | 1.2% |
| Specialist not available locally | 1.1% |
| Physician would not take PublicAid/Medicaid | 1.0% |

## ISOLATION

- 4.8% of respondents said that being "isolated, living alone" is a source of stress.
- Isolation was spread across all age groups, highest in the 45-64 (5.0%) age group rather than the elderly.
- One of nine (9.9%) said that they do not have anyone they feel close to who they can talk to about problems.

One of five respondents (20.6%) did not talk with someone interested in their welfare in the past week.



## ACTIVITIES OF DAILY LIVING

- In another survey section, respondents indicated their capability to care for themselves in performing activities of daily living.
- Respondents could indicate which activities are difficult for them to perform and which require help.
- On the next slide, the results are shown for the entire survey sample and also for the elderly age groups.



## ACTIVITIES OF DAILY LIVING BY AGE GROUP

| Activity of Daily Living | Some Difficulty | | | Need Help | | |
|---|---|---|---|---|---|---|
| Task | All | 65-74 | 75+ | All | 65-74 | 75+ |
| Perform Housekeeping | 5.4% | 2.1% | 16.0% | 1.8% | 0.0% | 4.6% |
| Bathe | 3.6% | 3.4% | 8.8% | 0.5% | 0.4% | 2.0% |
| Pay bills, manage money | 3.5% | 1.3% | 4.9% | 1.6% | 0.9% | 3.3% |
| Shop, buy groceries | 3.0% | 2.1% | 8.4% | 1.7% | 0.8% | 6.4% |
| Walk around your home | 2.6% | 2.6% | 7.3% | 0.3% | 0.4% | 1.2% |
| Control bodily functions | 2.5% | 3.0% | 7.3% | 0.4% | 0.4% | 1.6% |
| Do laundry | 2.4% | 2.6% | 6.5% | 1.0% | 0.4% | 6.9% |
| Prepare meals | 2.3% | 2.1% | 6.9% | 1.0% | 0.4% | 3.7% |
| Drive | 1.9% | 2.1% | 6.2% | 2.9% | 2.1% | 9.1% |
| Dress yourself | 1.5% | 1.3% | 3.2% | 0.5% | 0.4% | 1.6% |
| Call for help in an emergency | 1.1% | 0.0% | 5.4% | 0.6% | 0.4% | 1.7% |



## ACTIVITIES OF DAILY LIVING II HELP RECEIVED OR NEEDED

| Task | Help from Family or Friend | Help from Gov, Agency, Church | Still Need Help, Not Yet Received |
|---|---|---|---|
| Home repairs, odd jobs | 16.6% | 1.1% | 4.0% |
| Lawn, yard work | 13.2% | 1.9% | 2.7% |
| Computer basics | 10.6% | 1.6% | 3.7% |
| Car repairs | 9.9% | 2.4% | 2.8% |
| Housework, clean, chores | 9.8% | 1.5% | 2.7% |
| Legal, will | 6.6% | 2.0% | 4.0% |
| Help with forms | 5.3% | 1.1% | 2.0% |

## Appendix 1: Summary of Community Surveys for Lutheran General Hospital (cont'd)

*Healthier Niles Survey Results 2014*

# HEALTHIER NILES PROJECT - 2014 SURVEY RESULTS

Healthier Niles Coalition, chaired by
Advocate Lutheran General Hospital



## INTRODUCTION

- The Healthier Niles Project Survey sought to provide information which could be used for improving the quality of life for residents of the Village of Niles.
- The survey was created by the partnership of 27 Niles organizations who convened to develop the questionnaire. Partners also helped to publicize the survey.
- Partners and other local organizations, as well as Niles citizens, will be able to use the results to implement desired changes in the community.



## SURVEY METHODOLOGY

- The eight-page questionnaire, along with a business reply envelope for response, were included in the Fall 2014 Focus on Niles newsletter.
- A message in the village newsletter from Niles Mayor Andrew Przybylo urged residents to complete and return the enclosed questionnaire.
- Though over 500 surveys were returned, 492 were useable. According to the 2010 Census, Niles contains 11,906 households, so that the response was 4.1% of the village households.
- The sample margin of error is + or - 4.3%.



## RESPONDENT CHARACTERISTICS

- Survey households included 1,125 persons or nearly one in 25 Niles residents.
- The average household size for the sample homes (2.29) was a bit lower than the Census figure (2.41).
- A comparison of respondent characteristics to Census figures revealed that the survey respondents were generally representative, but with definite exceptions.
- 65.9% of surveys were completed by women, not unusual for household surveys, especially when health and human services are the topics.
- Only one in nine (11.8%) respondents reported speaking a language other than English at home. (Census – 57.8%)

## RESPONDENT CHARACTERISTICS

- AGE DISTRIBUTION OF RESPONDENTS (householder for Census)

| Age Group | Survey | Census |
|---|---|---|
| 18-44 | 12.0% | 23.4% |
| 45-64 | 29.1% | 38.4% |
| 65-74 | 25.8% | 14.5% |
| 75+ | 33.1% | 23.8% |

Nearly six in ten residents completing the survey were aged 65 or older.



## RESPONDENT CHARACTERISTICS

- EDUCATION OF RESPONDENT (The Census reports educational attainment only for persons 25+)

| Education | Survey | Census |
|---|---|---|
| HS or less | 35.9% | 47.4% |
| Some College | 24.8% | 17.9% |
| Associate Degree | 9.7% | 5.6% |
| Bachelor's Degree | 20.9% | 19.6% |
| Grad/Prof. Degree | 20.5% | 9.3% |



## QUALITY OF LIFE IN NILES
### What is valued most?

In the first survey question, local citizens were asked to choose FIVE characteristics which describe what they VALUE MOST ABOUT LIVING IN NILES from the 30 listed. The average respondent marked 4.7 items.

The clear leaders were these three Niles characteristics:

1. Safe, low crime 44.3%
2. Access to stores, services and restaurants 35.6%
3. Good library services 33.5%



## QUALITY OF LIFE IN NILES
### What is valued most?

Rounding out the top eleven characteristics VALUED MOST about living in Niles are these:

- 4. Good local health care. 24.6%
- 5. Good schools. 24.0%
- 6. Access to Chicago. 23.6%
- 7. Fair property taxes. 23.0%
- 8. Good community services. 22.2%
- 9. Good place to raise children. 22.0%
- 10. Avail. of services for elderly. 20.7% (tie)
- 10 Peaceful, quiet environment. 20.7% (tie)

## QUALITY OF LIFE IN NILES
## What is missing?

- In the next question, local citizens were asked to choose FIVE characteristics from the same 30 listed which they feel are MISSING IN NILES.
- The average respondent marked 3.0 items, fewer than the the "what is valued most" question in which 4.7 items were marked.
- Cited most often as missing by residents were:
  1. Lack of traffic congestion. 63.3%
  2. Fair property taxes. 35.7%
  3. Cultural activities, arts. 29.6%
  4. Walkability, walking paths. 27.0%
  5. Job opportunities. 26.8%



## QUALITY OF LIFE IN NILES
## What is missing?

Rounding out the top ten characteristics MISSING IN NILES were:

- 6. Good community leadership. 18.6%
- 7. Bikeability, bike paths. 16.8%
- 8. Affordable housing. 16.4%
- 9. Peaceful, quiet environment, 14.9%
- 10. Green spaces, trees. 13.7%



## DEMOGRAPHIC VARIATIONS VALUED MOST/MISSING

- Other than the top three overall (safe, stores, library), certain groups placed other factors in their top three as VALUED MOST:
- 18-44 Good place to bring up children. 1
- 75+ Good schools. 3
- 65-74 Good local health care. 3
- Non-Eng. Peaceful, quiet environment. 2
- Non-Eng. Access to Chicago. 3

- Other than the top three overall (lack of traffic congestion, fair property taxes, cultural activities and arts) other factors placing in the top three as MISSING:
- 18-44 Need for jobs. 2
- Bach Dg. Walkability, paths. 2
- 75+ Walkability, paths. 3
- Males Walkability, paths. 3



## CHARACTERISTICS VALUED BY SOME, MISSING FOR OTHERS

- Residents did not always agree with each other. For a few of the factors, they appeared in both lists.

| Characteristic | Valued Most Pct. | Missing Pct. |
|---|---|---|
| Fair property taxes. | 23.0% | 31.1% |
| Peaceful, quiet envrnmt. | 20.7% | 11.4% |
| Good comm. leadership. | 8.7% | 13.6% |
| Green spaces, trees. | 8.7% | 10.2% |
| Affordable housing. | 7.5% | 11.8% |
| Close to jobs, training. | 6.1% | 6.1% |

## RATINGS OF COMMUNITY SERVICES

- Survey participants were then asked to rate 13 community services as "excellent", "good", "fair" or "poor". Don't know could also be marked if not familiar with the service. Many persons did not feel able to rate certain services.
- Community services were analyzed in two ways:
- Percent of respondents rating the community service as "excellent or good".
- A mean rating score when excellent = 4, good = 3, fair = 2 and poor = 1. "Don't know" and "no answer" were excluded from these calculations.



## RATINGS OF COMMUNITY SERVICES

| Community Service | % Excll/Good | Mean Score |
|---|---|---|
| Quality of local Park District services. | 88.9% | 3.21 |
| Availability of public transportation. | 84.8% | 3.20 |
| Availability of services for senior citizens. | 83.4% | 3.15 |
| Availability of health care services. | 83.6% | 3.09 |
| Quality of Village services. | 82.2% | 3.09 |
| Availability of social services overall. | 77.5% | 2.97 |
| Quality of local public education. | 79.9% | 2.96 |
| Availability of services for youth. | 79.0% | 2.94 |
| Centers to stay during emergencies. | 72.7% | 2.90 |
| Availability of services for the disabled. | 60.4% | 2.58 |
| Cooperation among local governments. | 53.8% | 2.50 |
| Access to local gov. decision makers. | 45.5% | 2.34 |
| Availability of cultural activities, arts. | 38.1% | 2.22 |



## DEMOGRAPHIC VARIATIONS IN COMMUNITY SERVICES RATINGS

- Responses were similar across groups, but some variations appeared:
- Community services ratings increase with age.
- Women rated community services higher than men.
- Among residents who speak a language other than English at home, ratings were generally lower.
- Though ratings generally rose with age, exceptions were public transportation, Park District – same across groups.
- The highest "excellent or good" score for senior services was among those with a bachelor's degree.
- The lowest "excellent or good" score was for cultural activities, arts among respondents 45-64.



## PROBLEMS NEEDING GREATER ATTENTION

- In the next set of questions, survey respondents were given the opportunity to indicate which of 27 community issues listed require *greater attention*. Any number could be chosen by the respondent.
- The "average respondent" marked about three problems which they feel require greater attention.

## TOP TEN PROBLEMS NEEDING GREATER ATTENTION IN NILES

| Problem needing greater attention | Percent |
|---|---|
| 1. O'Hare plane noise, pollution. | 42.1% |
| 2. High health care costs. | 25.6% |
| 3. Caring for isolated neighbors. | 25.2% |
| 4. Gangs, delinquency, youth violence. | 25.0% |
| 5. Job retraining, coping with job loss. | 22.0% |
| 6. Respite services for caregivers. | 16.7% |
| 7. Crime. | 16.3% |
| 8. Activities for seniors. | 14.0% |
| 9. Activities for teens. | 13.6% |
| 10. Housing in all price ranges. | 11.8% |



## HOUSEHOLD SITUATIONS EXPERIENCED

- This section of the questionnaire asked survey participants to mark each situation that they or someone else in their home experienced during the **past year.**
- Fifteen possible situations were listed or respondents could write in "others". Written in were flooding (4), taxes (3) and snow removal (3).



| Household Situation Experienced | Percent |
|---|---|
| 1. Difficulty paying bills. | 21.1% |
| 2. Difficulty finding affordable dental services. | 16.3% |
| 3. Difficulty finding affordable medical services. | 10.4% |
| 4. Difficulty finding supportive services for an older adult. | 10.0% |
| 4. Delayed health care services due to cost or lack of insurance. | 10.0% |
| 6. Delayed taking medicine due to cost or lack of insurance. | 8.3% |
| 7. Experienced unemployment due to an involuntary job loss. | 7.9% |
| 8. Senior housing assistance, help with transitions. | 5.9% |
| 9. Unable to find affordable local behavioral counseling. | 5.3% |
| 9. Difficulty finding older adult day care program. | 5.3% |
| 11. Difficulty finding special needs services for family member. | 4.9% |
| 12. Difficulty finding child care. | 4.7% |
| 13. Home mortgage foreclosed or at risk. | 3.9% |
| 14. Hunger, insufficient food available. | 3.3% |
| 15. Homeless or forced to live with others. | 1.8% |



## DEMOGRAPHIC VARIATIONS FOR HOUSEHOLD SITUATIONS

- "Difficulty paying bills" reached 36.2% for the younger (18-44) respondents.
- "Difficulty finding affordable dental care" was most common among non-English speakers and persons aged 65-74. Many elderly are not covered for dental care since Medicare does not include routine dental.
- "Experienced unemployment due to involuntary job loss" placed among the top three situations for individuals with "some college" as their highest educational level.
- Two cohorts, 75+ and females placed "difficulty finding supportive services for an older adult" in their top three lists.

## TREATMENT OR SUPPORTIVE SERVICES BEING USED OR NEEDED

- This survey portion listed 25 possible treatment or supportive services, with the respondent asked to mark any service being used or still needed for themselves or another household member.
- The average respondent marked one service.
- Two services are being used or are still needed by 4% or more of the survey households. These were:
  - *Health insurance, Medicare help.
  - *Counseling and supportive services for senior citizens.



## TOP TEN SERVICES NOW BEING USED OR STILL NEEDED IN HOME

| Service needed, but not received | Percent |
|---|---|
| 1. Counseling, support services for senior citizens. | 4.5% |
| 2. Support groups for coping with daily living, stress. | 4.4% |
| 3. Behavioral or mental health services. | 3.8% |
| 4. Counseling services. | 3.2% |
| 4. Support group for families coping with family member with behavioral issues. | 3.2% |
| 6. Bereavement services or help coping with death. | 3.0% |
| 7. Couples therapy. | 2.9% |
| 7. Smoking cessation. | 2.9% |
| 9. Eating disorders treatment. | 2.4% |



## REASONS FOR NO SERVICES

| Reason for Not Getting Services | Pct. Of All |
|---|---|
| 1. Didn't know where to go for services. | 12.8% |
| 2. Cost of treatment, unable to pay. | 11.4% |
| 3. Concern about privacy or confidentiality. | 6.3% |
| 4. Lack of insurance to help pay for help. | 5.7% |
| 5. Lack of transportation to get to services. | 5.3% |
| 5. The wait for help is too long. | 5.3% |
| 7. No local agency has the services I need. | 4.7% |
| 8. Negative reaction (stigma) to problem. | 4.5% |
| 8. Asking for help is a sign of weakness. | 4.5% |
| 10. Others may have a negative view of me. | 2.4% |
| 11. Agencies don't understand language/culture. | 1.2% |
| 11. Need language/translation help. | 1.2% |
| 13. Owe money to the agency I would go to. | 1.0% |



## CAUSES OF STRESS

- In this question, survey respondents were asked to indicate whether they experience stress and, if so, what the primary causes are for the stress. The average respondent marked 2.5 causes.
- One in ten (10.4%) local residents said that they do not experience stress, even higher among the elderly 65-74 (12.0%) and 75+ (17.5%).
- Men (14.0%) were more likely to say that they live without stress than do women (9.0%).

## LEADING CAUSES OF STRESS

| | Cause of Stress | Percent |
|---|---|---|
| 1. | Health problems. | 29.1% |
| 2. | Financial concerns. | 25.8% |
| 3. | Cost of health care. | 20.8% |
| 4. | Paying property tax. | 20.1% |
| 5. | Traffic. | 16.3% |
| 6. | Lack of free time. | 14.8% |
| 7. | Current job. | 12.4% |
| 8. | Caregiver for an older person. | 11.2% |
| 9. | Family relationships. | 10.4% |
| 10. | Neighbors. | 8.9% |
| 11. | Unable to exercise. | 8.5% |
| 11. | Loss of a loved one. | 8.5% |



## DEMOGRAPHIC VARIATIONS FOR STRESS CAUSES

- Though "health problems" and "cost of health care" were the leading stress causes for most groups, a few variations were seen.
- For persons 18-44 and 45-64, "financial problems" led and "current job" appeared in the top three.
- Non-English speakers placed "property tax" on top.
- "Lack of free time" appears in the top three stress lists for those 18-44 and non-English speakers.
- Traffic stood third among stress causes for men.



## BEHAVIORAL PROBLEMS

- The prevalence of 29 behavioral issues in the household during the *past year* was asked of local residents. These problems were marked if they affected the activities of daily living for at least one household member.
- Those behavioral problems present at 2.5% or greater will be shown in the slide on the following page.
- Additional questions dealt with suicide and abuse. 4.9% of respondents said that they thought about suicide in the past *two* years. Abuse in the *past year was as follows:*
- *3.5% had been abused physically, emotionally or sexually.*
- *4.3% had experienced someone taking advantage of them by using their belongings or financial resources.*



## LEADING BEHAVIORAL PROBLEMS

| | Household prevalence (any member) | Percent |
|---|---|---|
| 1. | Major disruptions in the quality of sleep. | 10.4% |
| 2. | Sadness or blue mood > 3 weeks (depression.) | 7.9% |
| 3. | Frequently anxious & fearful (general anxiety, panic). | 6.7% |
| 4. | Marital problems. | 3.9% |
| 5. | Mood swings from high to low (bipolar disorder). | 3.7% |
| 6. | Loss of ability to think/remember (Alzheimer's, dementia). | 3.5% |
| 7. | Bullying, cyberbullying. | 3.0% |
| 7. | Developmental delay or disability. | 3.0% |
| 9. | Difficulty focusing or easily distracted (ADD). | 2.9% |
| 9. | Afraid to be around people (social anxiety). | 2.9% |
| 11. | Trouble controlling anger or violent behavior. | 2.6% |
| 11. | Anxiety following a terrifying event (PTSD). | 2.6% |

## NEED, USE OF PROFESSIONAL HELP

*Two questions dealt with professional help for personal problems in the past year:

*One of six (17.1%) persons thought about getting help.

*However, only about half of those (53.6%%) actually sought help.

*Therefore, one of eleven persons (9.2%) sought help in the past year through professional counseling. Use declines with age, increases with education.

*7.7% of residents are taking medications for behavioral issues, also decreasing with age, rising with education.



## DEMOGRAPHIC VARIATIONS FOR BEHAVIORAL ISSUES

- Anxiety declines with age as follows: 18-44 (13.8%), 45-64 (9.2%), 65-74 (4.2%) and 75+ (3.8%).
- Depression (12.1%) and sleep deprivation (15.6%) are highest in the 45-64 age group.
- Most likely to consider and receive professional counseling are those 18-44 and 45-64. Counseling use is highest in the better educated groups.



## SOME PERSONS FEEL ISOLATED

- 5.7% of respondents said that being "isolated, living alone" is a source of stress for them.
- By age group, perceived isolation was highest in the older 65-74 (8.0%) and 75+ (8.8%) groups. Also relatively high for feeling isolated as a cause of stress were those with some college (12.1%) and men (8.9%).
- One of six (16.5%) persons said that they do not have anyone they feel close to whom they can talk to about problems. One of four respondents (24.6%) did not talk with anyone interested in their welfare during the past week.



## HEALTH CARE NEEDS

- Respondents were asked whether, during the past year, they or anyone else in the household had been unable to receive care that was needed for any of eight listed health problems.
- A follow-up question then asked the reason(s) that the needed health care had not been received.

## HEALTH CARE NEEDED, BUT NOT RECEIVED

| Health care needed, but not received | Percent |
|---|---|
| 1. Dental Problems. | 12.4% |
| 2. Medical Problems. | 7.3% |
| 3. Vision Problems. | 5.1% |
| 4. Preventive Tests, Screenings. | 4.3% |
| 4. Hearing Problems. | 4.3% |
| 6. Mental Health Problems. | 2.2% |
| 7. Behavioral Health Problems. | 0.6% |
| 7. Substance Abuse. | 0.6% |



## LEADING REASONS NEEDED HEALTH CARE WAS NOT RECEIVED

| Reason Care Was Not Received | Pct. of all |
|---|---|
| 1. Financial concerns, cost of care. | 13.2% |
| 2. Lack of insurance. | 6.5% |
| 3. Physician would not take Medicaid. | 3.3% |
| 4. No transportation. | 2.8% |
| 5. Lack of prescription coverage. | 2.6% |
| 6. Long wait to get appointment. | 2.2% |
| 7. Have no regular doctor. | 2.0% |
| 7. Lack of trust in doctors, health care. | 2.0% |
| 9. Fear or dislike of health care. | 1.8% |
| 9. Physician would not take Medicare. | 1.8% |
| 9. Specialist not available locally. | 1.8% |



## HEALTH CARE COMMUNICATION

- Eight questions explored patient/provider interaction. Results were generally positive, but one area for possible improvement is encouraging patients to ask questions.

| In past year visits, did the provider: | Always or Usually | Sometimes or Never | NA |
|---|---|---|---|
| Encourage you to ask questions? | 68.3% | 17.7% | 14.0% |
| Listen carefully to visit reasons? | 76.2% | 10.4% | 13.4% |
| Clearly explain the condition? | 76.2% | 9.8% | 14.0% |
| Give easy to understand instructions? | 79.1% | 7.7% | 13.2% |
| Did you or do you understand: | | | |
| Forms that you completed or signed? | 78.9% | 5.1% | 16.1% |
| Instructions given to help your condition? | 78.3% | 5.5% | 16.3% |
| Why you are taking medications? | 75.8% | 4.3% | 19.9% |
| Steps to prevent major diseases? | 72.4% | 8.7% | 18.9% |



## ACTIVITIES OF DAILY LIVING I

- In another survey section, respondents indicated their capability to care for themselves and which activities are difficult for them to perform or require help.
- Performing housekeeping is a task posing "some difficulty" for 7.3% of Niles residents, while another 4.5% "require help". Also imposing "some difficulty" or "requiring help" are driving (6.9%), paying bills (6.5%), laundry (5.8%) and bathing (5.1%).
- Elderly residents 75+ experience even greater difficulty with many tasks, especially housekeeping (13.1% "some difficulty", 9.4% need help), shopping for groceries (8.1%,7.5%), doing laundry (6.9%, 5.0%).

## Appendix 1: Summary of Community Surveys for Lutheran General Hospital (cont'd)

### *Healthier Des Plaines Area Survey*

**Healthier Des Plaines Area Survey Preliminary Summary of Results**

The Healthier Des Plaines Area Survey brought together a coalition of community leaders, organizations and interested individuals to conduct a survey to help make the area a better place to live, work and play through collaborative action. The questionnaire was sent to 7,000 households chosen randomly in zip codes 60016 and 60018. Each home in the sample received both an English and a Spanish survey. Living in the two zip codes are 33,966 households, so that about one in five homes received the survey. A cover letter describing the reasons for the survey, the instrument and a postage-paid reply envelope addressed to Advocate Lutheran General Hospital were provided. In addition to Lutheran General, 32 other organizations were project partners who had helped to develop the survey. About 600 anonymous surveys were received of which 583 were usable. This is 8.3% of the 7,000 households who received the survey. The margin of error is + or – 3.9% with a 95% confidence.

The responding survey households included 1,318 persons (of 89,709 in the two zip codes) with an average household size of 2.26 (Census: 2.64). The mean age of survey respondents was 66.4. A small majority, 53.5% of survey respondents were 65 or older.

The distribution for respondents providing gender was 66.1% female. Women typically respond to surveys for the entire household. 47.2% of survey respondents hold a bachelor's degree, somewhat higher than the Census ACS level of 32.3%. 10.9% of participating households speak a language other than English at home, which was well below the 53.9% level shown by the American Community Survey for the two zip codes.

Asked what they value most about living in Des Plaines, the leading factors named were "good local health care" (34.8%), "good library services" (28.5%), "safe; low crime" (26.4%), and "access to stores, services, restaurants" (25.6%). Said to be missing in the Des Plaines area are "lack of traffic congestion" (38.8%), and "fair property taxes" (31.0%).

Asked to rate certain community characteristics as excellent (4), good (3), fair (2) or poor (1), the top average scores went to "availability of library services" (3.33) "quality of Park District services" (3.26),"availability of spiritual enrichment, involvement" (3.02) and "availability of health care services" (3.01). Low were "availability of cultural activities, arts" (2.22) and "access to local government, decision makers" (2.23). As for problems needing greater attention, the leaders were "O'Hare plane noise, pollution (45.1%), "high health care costs" (37.6%), and "gangs, delinquency, youth violence" (35.3%). The most common household situations experienced during the past year were "difficulty paying bills, property taxes" (26.2%), and "difficulty finding affordable dental services" (20.1%).

Primary causes of stress were reported as "financial concerns" (33.6%), "health problems" (28.8%), "cost of health care" (23.7%) and "paying property tax" (23.7%).

Supportive or treatment that would be valuable right now for a household member at the highest levels were "weight loss/dietary help" (24.9%), "coping with daily living/stress management" (16.3%) and "help with health coverage, insurance, Medicare, Medicaid" (13.4%).

Reasons that local residents could not receive needed services included "didn't know how or where to go for services" (14.6%) and "cost of services or treatment, unable to pay" (13.7%). Emotional, behavioral or other issues experienced by a household member and affecting daily living included "adult weight issues" (16.8%), "sleep disruption" (16.1%), and "sadness or depression" (11.7%). Nearly one of five (18.7%) respondents said that they considered professional help for personal problems during the past year. Of those, about half (50.5%) actually sought care. Overall, then, about one in eleven (9.4%) Des Plaines residents sought professional counseling in the past year.

Health problems for which someone in the home needed care, but didn't receive help included dental (13.6%), medical (6.9%) and hearing (5.3%). Financial reasons are the most common barrier to accessing the required care. Almost half ( 48.2%) of respondents reported that they have "advance directives", a document that states wishes for health care decisions if unable to make them yourself. Other responses included "no document" (38.1%), "not sure" (7.7%), and "no answer" (6.0%).

One of five (20.4%) respondents has ever been told by a health professional that they have diabetes or high blood sugar. Other than the respondent 16.5% of households contain a member with diabetes or high blood sugar. About one of seven respondents (15.4%) does not have anyone they can talk to about problems other than family members. Nearly a quarter (23.8%) of respondents did not see or talk to anyone interested in their welfare during the past week.

10.6% are currently taking medication for behavioral problems and 12.5% have ever thought about suicide. 2.6% reveal that they have actually planned a suicide. 4.0% reported having been abused physically, emotionally or sexually during the past year, while 4.1% said that someone took advantage of them by taking or using belongings or financial resources. Financial concerns and lack of insurance were the primary reasons that needed health care had not been received.

Survey respondents generally felt that their health care provider always or usually communicates well and that they understood important aspects of care. Some improvement could take place in providers encouraging patients to ask questions.

Respondents were asked about two groups of daily activities, whether they have some difficulty, help is being used or is still needed. Housekeeping is somewhat difficult for 7.7% and another 4.3% need help. Many individuals currently pay for outside help with car repairs (41.3%), yard work (26.1%) and home repairs, odd jobs (25.2%).

**Healthier Des Plaines Area Survey: Diabetes Prevalence by Category**

| | Told They Have Diabetes | Other HH Member with Diabetes |
|---|---|---|
| **Gender** | | |
| Male | 25.8% | 16.1% |
| Female | 18.5% | 18.4% |
| **Age of Respondent** | | |
| 18-44 | 5.7% | 11.4% |
| 45-64 | 15.9% | 17.5% |
| 65-74 | 26.2% | 17.9% |
| 75-84 | 28.7% | 17.7% |
| 85+ | 31.8% | 28.2% |
| **Education of Respondent** | | |
| High School or less | 24.5% | 20.6% |
| Some College | 23.9% | 18.8% |
| Associate Degree | 14.8% | 18.4% |
| Bachelor's Degree | 17.3% | 17.8% |
| Graduate or Professional | 22.8% | 12.2% |
| **Language Spoken at Home** | | |
| English | 20.3% | 15.6% |
| Other than English | 31.7% | 30.5% |
| (Spanish) | 11.7% | 15.4% |
| **Race/Ethnicity** | | |
| White, not Hispanic | 19.4% | 14.7% |
| Other than White, not Hispanic | 31.0% | 35.7% |
| (Hispanic) | 11.8% | 17.6% |
| Total | 20.4% | 16.5% |

# Korean Community Health Needs Assessment

**Summary and Comparison Report on Health Surveys and Focus Groups of General Korean Population and Korean Health Fair Participants at the Advocate Lutheran General Hospital.**

**Sponsored by**

Advocate Lutheran General Hospital

**Prepared by**

한울종합복지관
Hanul Family Alliance

**December 2014**

**Conclusions:**
After conducting three annual health fairs, and with the roll out of Affordable Care Act, Hanul and ALGH have conducted a 6 month research project to assess and analyze the impact of the health fairs. In the process, Hanul and ALGH were able to draw out extremely significant and valuable data regarding needs, behaviors of Korean community. Because this research was a two part research which targets health fair participants and general Korean community comparing needs and behavior of the two groups was also possible. All of these data will serve as an important guide for the future partnership of Hanul and Lutheran to promote community health.

Among many important findings, we found the following results most interesting and significant:

- Number of Korean Americans who are uninsured significantly dropped due to enactment of Affordable Care Act.
- Concerns about language barrier is becoming less significant because of increased access to interpretation/ translation services.
- High blood pressure, diabetes, high cholesterol and osteoporosis are the top four health conditions that most of Koreans are concerned with.
- Hanul-ALGH Health Fair played a critical role to connect with the Korean population, which resulted in higher satisfaction score of ALGH doctors and services, and higher level of awareness about ALGH Korean programs.
- Regardless of increased rate of insurance among Korean population, there was not a big change in their healthcare behavior to seek regular medical care. Respondents wanted to see more of free screening, immunization services and health seminars at community-based-organizations such as Hanul

When asked what Hanul and ALGH could do to improve health and quality of life in the Korean community, participants emphasized the need to improve communication and awareness about existing services. They suggested more cooperation, collaboration, and information sharing between community-based organizations and local hospitals. Participants suggested that agencies should work together to coordinate referrals and promote information about available programs.

Overall, participants saw the need for more community outreach and health education especially in the following health topics:

- Cancer
- Osteoporosis
- Cardiac Disease
- Nutrition
- High Blood Pressure
- Diabetes

In addition, the study showed increased percentage of people who are insured does not interpret back as more access to services. Many people are still hesitant to seek healthcare services due to unfamiliarity with their insurance policy, high deductible, and still struggling to find a quality medical provider that shares same culture and language skill, and covered by their insurance policy.

The focus group participants expressed that they were grateful for the opportunity to share their thoughts and experiences, and at the end of the sessions, many expressed support for community-wide efforts to improve health care access and better understanding of changing health care policy.

Based on the feedback from the qualitative surveys and focus groups, access to health care, awareness of available resources, quality Korean programs, understanding and utilization of their insurance plans, building systematic referral process are important issues in the Korean community.

Health fair as a matter of fact played an important role to connect Korean population with available services at ALGH. Although number of people who are newly enrolled in health insurance has risen, several themes appeared as areas of opportunity within Hanul and ALGH Partnership.

**Areas of Opportunity**

1. Lack of community awareness of available programs and resources to promote health services such as free education, screenings and immunization programs
2. Need for centralized place to get information and listing of available resources, which not only provides interpretation and translation services, but also application and follow-up assistance
3. Need for health education and wellness programs that is held at convenient locations and time
4. Need for individual counselor/navigator's consistent follow-up care to coordinate collaborative network with efficient referral system
5. Need for more assistance with communication assistance in general

## Appendix 2: Sources of Data

***(All data and website links were verified as of the date of Governing Council approval.)***

**Primary Resources**

Lutheran General Hospital Utilization data, TSI, Thomson Reuters, 2012-2014.

Healthier Park Ridge Survey, 2013-2014.

Healthier Niles Survey, 2015-2016.

Healthier Des Plaines Area Survey (Demographic Results), 2015.

Hanul Family Alliance/Lutheran General Hospital Korean Community CHNA, 2014.

St. Stephens Church in Des Plaines, Spanish Survey and Focus Group results, 2016.

**Secondary Sources**

American Community Survey, 2010-2014.
http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

American Diabetes Association, Diabetes Statistics, 2016.
http://www.diabetes.org/?loc=bb-dorg

American Heart Association, US Department of Health and Human Services, 2016.
http://www.heart.org/HEARTORG/

Centers for Disease Control and Prevention. National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States. Atlanta, GA: US Department of Health and Human Services, 2014.

Centers for Disease Control and Prevention, Diabetes Data and Statistics, 2012.
http://www.cdc.gov/diabetes/atlas/countydata/atlas.html

Centers for Disease Control and Prevention, Mental Illness Surveillance, 2011.
http://www.cdc.gov/ophss/csels/dhis/index.html

Centers for Medicare and Medicaid Services, 2014.
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html

Claritas, 2016. Web unavailable.

*Health Impact Collaborative of Cook County* (HICCC). (See detailed accompanying report – *Health Impact Collaborative of Cook County: Community Health Needs Assessment North Region.*)

Healthy Communities Institute (HCI), A Xerox Company, 2016 access via a Contract with Advocate Health Care. Website unavailable to the public. The following data sources were accessed through the HCI portal:

- Illinois Hospital Association, COMPdata, 2012-2014.
- US Census Data, 2010.
- American Community Survey, 2010-2014.

Kaiser Family Foundation, Agency for Healthcare Research and Quality, National Healthcare Disparities Report, 2011.
http://kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/

**Articles**

Baker, David P. et al. *The Education Effect on Population Health: A Reassessment, Population and Development Review*, 2011; 37.2:307-332; Web, September 2016.

Linn, Margaret W. et al. *Effects of Unemployment on Mental and Physical Health. American Journal of Public Health*. Web, September 2016.

**Books**

Cockerham, Williams C., *Social Causes of Health and Disease.* Polity Press, 2013.

Mayo Clinic, *The Essential Diabetes Book*. Oxmoor House, 2014.

## Appendix 3: Hanlon Method Process Description and Implementation

NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

### Community Health Assessments and Community Health Improvement Plans for Accreditation Preparation Demonstration Project

#### Hanlon Method

This is a quantitative tool that objectively ranks specific health problems based on the criteria of seriousness, magnitude and effectiveness. Below is a brief description of how to use this method.

1. Give each health problem a numerical rating on a scale of 0-10 for each of the three criterion shown in the columns. Below is an example of how this can be established.

| Rating | Size of Health Problem *(% of population w/health problem)* | Seriousness of Health Problem | Effectiveness of Interventions |
|---|---|---|---|
| 9 or 10 | >25%<br>(STDs) | Very serious<br>(e.g. HIV/AIDS) | 80% - 100% effective<br>(e.g. vaccination program) |
| 7 or 8 | 10% - 24.9% | Relatively Serious | 61% - 80% effective |
| 5 or 6 | 1% - 9.9% | Serious | 41% - 60% effective |
| 3 or 4 | .1% - .9% | Moderately Serious | 21 - 40% effective |
| 1 or 2 | .01% - .09% | Relatively Not Serious | 5% - 20% effective |
| 0 | < .01%<br>(Meningococcal Meningitis) | Not Serious<br>(teen acne) | <5% effective<br>(access to care) |
| **Guiding considerations when ranking health problems against the 3 criteria** | Size of health problem should be based on baseline data collected from the individual community. | Does it require immediate attention?<br>Is there public demand?<br>What is the economic impact?<br>What is the impact on quality of life?<br>Is there a high hospitalization rate? | Determine upper and low measures for effectiveness and rate health problems relative to those limits. |

2. **Apply the 'PEARL' Test** – Once health problems have been rated for all criteria, use the 'PEARL' Test to screen out health problems based on the following feasibility factors:
   - **P**ropriety – Is a program for the health problem suitable?
   - **E**conomics – Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
   - **A**cceptability – Will a community accept the program? Is it wanted?
   - **R**esources – Is funding available or potentially available for a program?
   - **L**egality – Do current laws allow program activities to be implemented?
3. **Calculate priority scores** – Based on the three criteria rankings assigned to each health problem in Step 1 of the Hanlon Method, calculate the priority scores using the following formula:
   - **D = [A + (2 x B)] x C**
   - Where: D = Priority Score
   - A = Size of health problem ranking
   - B = Seriousness of health problem ranking
   - C = Effectiveness of intervention ranking
4. **Rank the health problems**– Based on the priority scores calculated in Step 3 of the Hanlon Method, assign ranks to the health problems with the highest priority score receiving a rank of '1,' the next high priority score receiving a rank of '2,' and so on.

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This document informed by Marni Mason of MarMason Consulting, Lisa McCracken of Holleran Consulting and Leslie Beitsch, courtesy of the Catholic Health Association, The Public Health Memory Jogger, and NACCHO. To access more resources for issue prioritization **and community health improvement processes, please visit the CHA/CHIP Resource Center at** www.naccho.org/chachipresources. **For more detailed examples on issue prioritization tools, please see NACCHO's** *Guide to Prioritization Techniques*.

## *Hanlon Method – Rating Criteria*

***Note:** The scales in Table 1 are arbitrary models of how numerical scales are established and are not based on real epidemiological data; LHDs should establish scales that are appropriate for the community being served.

| Advocate Lutheran General Hospital: Community Health Council<br>The Hanlon Method: Rating Criteria | | | |
|---|---|---|---|
| **Rating** | **Size of Health Problem** (% of population w/health problem) | **Seriousness of Health Problem** | **Effectiveness of Interventions** |
| **9 or 10** | >60% | Very Serious | 80% - 100% effective (e.g. vaccination program) |
| **7 or 8** | 50-59% | Relatively Serious | 60% - 80% effective |
| **5 or 6** | 40-49% | Serious | 40% - 60% effective |
| **3 or 4** | 30-39% | Moderately Serious | 20% - 40% effective |
| **1 or 2** | 20-29% | Relatively Not Serious | 5% - 20% effective |
| **0** | 0-19% | Not Serious | <5% effective<br>(access to care) |
| **Guiding considerations when ranking health problems against the 3 criteria** | **• Size of health problem should be based on baseline data collected from the individual community.** | **Does it require immediate attention? • Is there public demand? • What is the economic impact? • What is the impact on quality of life? • Is there a high hospitalization rate?** | **Determine upper and low measures for effectiveness and rate health problems relative to those limits.<br>• For more information on assessing effectiveness of interventions, visit http://www.communityguide.org to view CDC's Guide to Community Preventive Services** |

## *Participant Rating Handout*

| Indicator | Size of affected population (approx.) | Seriousness of Disease | Effectiveness of Interventions | Effectiveness of Interventions<br>Evidence-Based/Effective Practice<br>Men/Women/Adults/Elderly/Families<br>Racial Ethnic Minorities |
|---|---|---|---|---|
| **Diabetes** | 3.1 | | | 241 Promising Practices<br>- Community Health workers<br>- National Diabetes Prevention Program |
| **Cardiovascular Disease/ Heart Disease** | 5.6 | | | 245 Promising Practices<br>- Strong Women – Healthy Hearts |
| **Mental Health & Substance Abuse** | 7 | | | 558 Promising Practices<br>- Community Health Workers<br>- CDC Community Guide: Behavioral and Social<br>- Project Viva<br>- FRIENDS projects |
| **Immunization and Infectious Disease** | 5.4 | | | 281 Promising Practices<br>- Text4Health<br>- Healthy Futures |
| **Respiratory Disease** | 5.7 | | | 351 Promising Practices<br>- A.I.R Harlem<br>- Disinfection School Programs |

**Note:** The diseases taken into considerations have been suggested by the Healthy Communities Institute. The prioritization table is specifically for 6 "*high-need*" communities under Advocate Lutheran General Hospital's PSA: Irving Park, Des Plaines (60018), Dunning, Elmwood Park, Harwood Heights (60706) and Jefferson Park. The table takes into account 28 health indicators for 5 identified health concerns in high need communities: 7 for Diabetes, 4 for Heart Disease, 5 for Mental Health & Substance Abuse, 6 for Immunization, and 6 for Respiratory Disease. The sum population for the 6 communities combined: 296,418
**Additional Note:** The only indicators taken into account were yellow (high risk) and Red (high need). While Mental Health is in Green (low-need), it is a growing issue for Advocate Lutheran General Hospital's Service Area. *Pediatrics was not consider for the purpose of this evaluation.*

***High-Risk Issues***

***High-Need Issues***

**Size:** Sum population (296,418) x Seriousness of Disease = Approximate # of people affected
**Seriousness of Disease:** Sum of Red & Yellow indicators per Disease / by number of total indicators per Disease

## *Criteria 1 – Size of Health Problem Handout*

## *Economic & Population Impact of the Top Six Health Priorities:*

**Diabetes:**
The CDC estimates the direct economic cost of diabetes in the United States to be about ***$100 billion per year.*** This figure does not take into account the indirect economic costs attributable to potential work time lost to diabetes- related illness or premature death.

**Heart Disease:**
Heart failure is a condition in which the heart can't pump enough blood to the body's other organs. This can result from a variety of conditions including coronary artery disease, diabetes, past heart attack, hypertension, heart infections, diseases of the heart valves or muscle, and congenital heart defects.

Around 5 million people in the United States have heart failure, and more than 287,000 people in the United States die each year with the disease.

- The estimated direct cost for heart failure in the US in 2006 was ***$29.6 billion***. According to the National Hospital Discharge Survey, hospitalizations for heart failure have increased from 402,000 in 1979 to 1,101,000 in 2004

**Mental Health & Mental Disorders:**
Mental disorders are one of the leading causes of disability in the United States. In any given year, approximately 13 million American adults have a seriously debilitating mental illness.

- Each year, serious mental illness costs American $193 billion in lost earnings (American Journal of Psychiatry)
- Suicide costs over $44.6 billion a year in combined medical and work loss costs (CDC)

**Respiratory Disease:**
Symptoms can include tightness in the chest, coughing, and wheezing. These symptoms are often brought on by exposure to inhaled allergens (like dust, pollen, cigarette smoke, and animal dander) or by exertion and stress.

- Nationwide, 15.7 million non-institutionalized adults and 6.5 million children had been diagnosed with asthma in 2005.
- The yearly cost of asthma in the US is around ***$56 billion***. The direct costs make up almost ***$50.1 billion***

**Substance Abuse:**
There are approximately ***75,000 deaths*** attributable to excessive alcohol use each year in the United States. This makes excessive alcohol use the 3rd leading lifestyle-related cause of death for the nation.

- Alcohol abuse costs the US ***$191.6 billion*** and drug abuse costs $151.4 billion (SAMSHA)
- ***$223.5 billion*** in 2006, or about ***$1.90*** per drink. Binge drinking,76% of cost (CDC)

**Immunizations and Infectious Diseases:**
According to the Mayo Clinic, more than ***60,000 Americans die of pneumonia every year***. Pneumonia is an inflammation of the lungs that is usually caused by infection with bacteria, viruses, fungi or other organisms.

**Access to Care:**
Nationally, the average E.R. visit cost ***$383***, whereas the average doctor's office visit costs ***$60*** (BCBS)

## *Effectiveness of Interventions Handout*

***Diabetes:***

**241** Promising Practices identified by HCI:

- **Paso Adelante:** Chronic disease prevention program for Mexican-Americas residing in the US. A lifestyle intervention, with culturally appropriate material that aims to control chronic diseases such as heart disease and diabetes
- **National Diabetes Prevention Program:** Encourages collaboration to prevent or delay the onset of type 2 diabetes among people with pre-diabetes in the United States.

***Heart Disease:***

**245** Promising Practices identified by HCI:

- ***Strong Women – Healthy Hearts:*** Strong Women – Healthy Hearts is a targeted education and behavioral prevention program created by Tufts University and run by the Cooperative State Research, Education, and Extension Service of the US Department of Agriculture. Cardiovascular disease is the leading cause of death for women in the United States, claiming 500,000 lives per year.
- ***Project Health Education Awareness Research Team (HEART):*** Participants included individuals with at least on cardiovascular disease risk factor. The classes led by trained community health workers. Result showed that participants had significant improvement in self-reported behaviors.

***Mental Health & Substance Abuse:***

**558** promising practices identified by HCI:

- **Assessment and Referral:** First Call provides adults and adolescents confidential, one-on-one evaluations with a certified substance abuse professional and referrals for appropriate care. Over 1,700 assessments in 2013 and half showed significant improvements in addiction.

***Immunization and Infectious Disease:***

**281** Promising Practices identified by HCI:

- **Popular Opinion Leader (POL):** is an intervention program that identifies and trains well-liked people in a community to function as AIDS educators. Popular Opinion Leader was found to reduce the percentage of men who had any unprotected sex by 30% and use condoms by 35%.
- **Text4Health:** is a mobile health research program that uses text messages to remind individuals of due-date for vaccinations. Aims to improve rates in urban, underserved, low-income populations via text messaging.

***Respiratory Disease:***

**351** Promising Practices identified by HCI:

- **A.I.R Harlem:** which stands for asthma intervention and relief, was created to help asthmatic kids stay healthy, in school, and out of the hospital. A.I.R. Harlem is a community-based intervention designed to help families who have children with asthma through a comprehensive approach that includes care coordination, home visits, and monitoring of the home environment
- **CDC Community Guide:** Asthma Control: These interventions involve home visits by trained personnel to conduct two or more activities. The programs in this review conducted environmental activities that included: assessment of the home environment, changing the indoor home, environment to reduce exposure to asthma triggers and education about the home environment

***Access to Appropriate Health Care***

108 Promising Practices identified by HCI:

- Hospital Diversion Initiative: Connects individuals who chronically utilize the inpatient and ER room with outpatient care

## *Process Description and Community Ranking*

The Lutheran General Hospital had pre-calculated criteria #1, size of the health problem by using the HCI data. The Hanlon rating criteria was scaled specifically for the six, high-need communities. Combining the overall population for the six communities (296,418) provided the team with a baseline number for the potential size of population affected by each condition. Advocate Lutheran General's Primary Service Area high need communities were: Irving Park, Des Plaines (60018), Dunning, Elmwood Park, Harwood Heights (60706) and Jefferson Park. Next, 28 combined health indicators from HCI were taken into account for each community: 7 for Diabetes, 4 for Heart Disease, 5 for Mental Health and Substance Abuse, 6 for Immunization, and 6 for Respiratory Disease. For each of the six-communities, only the red (high need) and yellow (high risk) health indicators (found in HCI) for each disease were weighted. The green (low need) indicators were not taken into account, as they suggest good health outcomes. Based on this analysis, the #2 criteria, seriousness of the health problem, the numerical value was pre-calculated and provided on the rating sheet for the Council members.

The Council members then individually evaluated the data on a rating sheet and choose a number from 1 to 10 for each of the two remaining criteria: #2, the seriousness of the Health problem and #3, effectiveness of the interventions. While doing so, they also had summary sheet of the data for each of the high risk communities, the potential evidenced base interventions summary sheet as well as the cost burden summary sheet. All members' calculations were then tabulated using the Hanlon formula, averaged and ranked in order. The figure below provides a community ranking by percentage, with Irving Park/Portage Park ranking highest in need community.

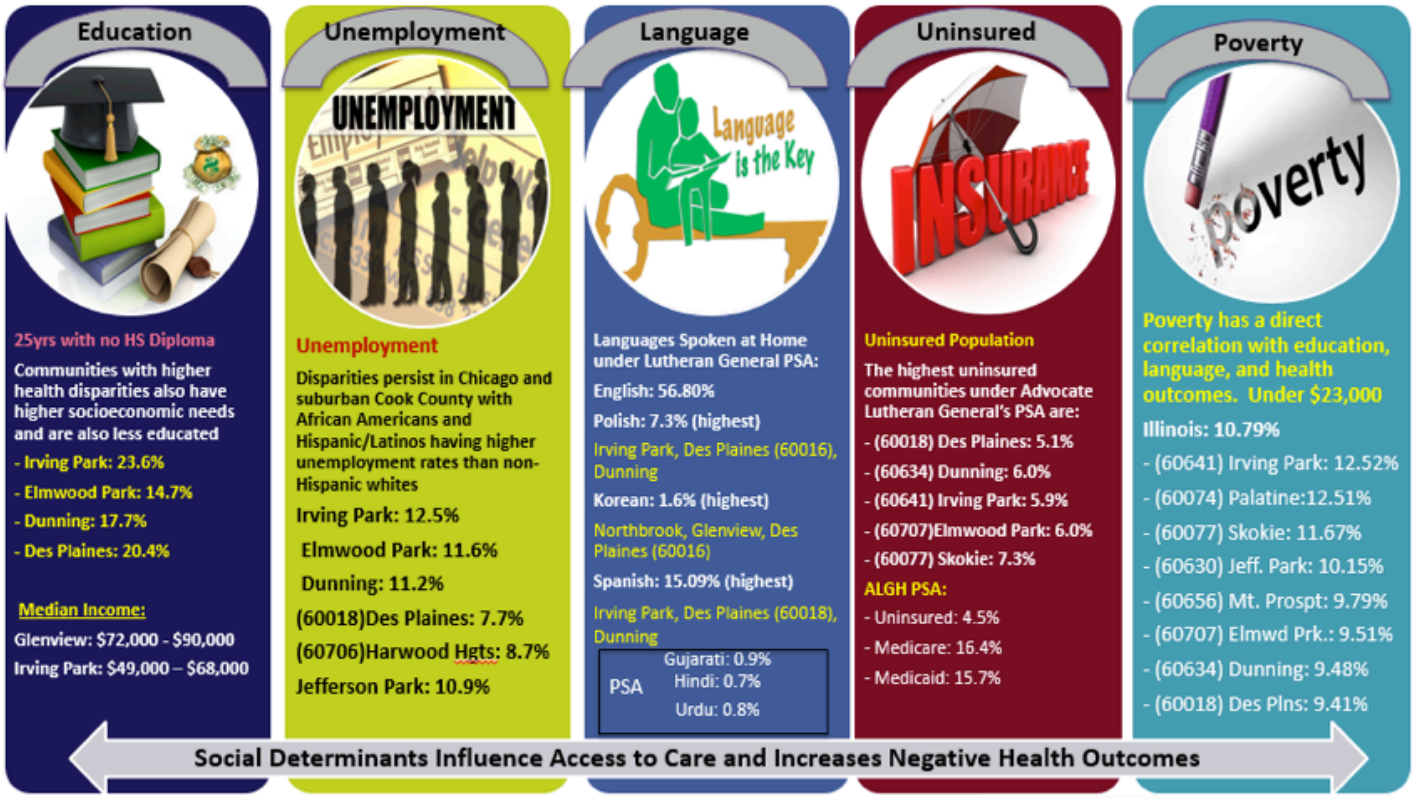
| Summary Results of Top 6 High Need Communities Evaluated | Irving Park/ Portage Park (60641) | Dunning (60634) | Des Plaines (60018) | Elmwood Park (60707) | Harwood Heights (60706) | Jefferson Park (60630) |
|---|---|---|---|---|---|---|
| Health Indicators Total : | 15/28 | 14/28 | 9/28 | 14/28 | 7/28 | 12/28 |
| Community Ranking by Percentage (%) | 54% | 50% | 32% | 50% | 25% | 43% |

**Note: All pediatrics data was excluded for the purpose of this analysis, which would increase the numerator and denominator for certain outcomes, in certain communities. In addition, Mental Health is a growing concern for Advocate Lutheran General Hospital's PSA, but displays green indicators, suggesting not a severe threat at the moment. Also, some communities have more or less indicators based on data distribution. However, this prioritization table takes into account 28 health indicators for 5 health concerns in each community: 7 for Diabetes, 4 for Heart Disease, 5 for Mental Health and Substance Abuse, 6 for Immunization, and 6 for Respiratory Disease. Due to uneven distribution of health indicators per disease, outcomes may reflect differently, but take into account that all health concerns are of high-priority.

***High-Risk Issues***

***High-Need Issues***

## *Summary of Data – Social Determinants*




| Zip & Pop. | Health | Health Concerns | Unemployment & Poverty | Economy | Education | Language |
|---|---|---|---|---|---|---|
| 60641 Irving Park 70,970 | | Diabetes Hospitalization/Uncontrolled<br>Heart Failure/hypertension<br>Hepatitis<br>Urinary tract infections/dehydration<br>COPD/Asthma → Alcohol abuse | **Unemployment:** 12.5%<br>**Population Below Poverty:** 12.52% | • Foreclosure risk<br>• Low homeownership<br>• Spending 30% on rent<br>• High 65+ older living below poverty<br>• **Per Capita: $22,941** | **Adults 25+ completed:**<br>• 76.4%- high school<br>• 23.4%- B.A (good)<br>**Less than H.S** :11,319 (23.59%) | • English: 23,597 ( 35.85%)<br>• Spanish: 30,425 (46.22%)<br>• Polish: 5,925 (8%)<br>• Korean: 34 (near 0%)<br>• Gujarati: 49/ Hindi: 49/ Urdu: 100 (0%) |
| 60634 Dunning 75,196 | | Diabetes long term complications<br>Heart Failure<br>Asthma hospitalizations | **Unemployment:** 11.2%<br>**Population Below Poverty:** 12.1 | • Foreclosure risk<br>• Stable economy<br>• Median Income: $55,324<br>• **Median Income:**<br>• **Per Capita: $24,392** | **Adults 25+ completed:**<br>• 82.3 %- high school<br>• 20.3%- B.A<br>**Less than H.S:** 9,418 (17.65%) | • English: 28,305 (40.02%)<br>• Spanish: 20,622 (29.16%)<br>• Polish: 13,266 (18%)<br>• Korean: 147 (near 0%)<br>• Gujarati, Hindi, Urdu: --- |
| 60018 Des Plaines 30,788 | | Diabetes long term complications<br>Heart failure and hypertension<br>Hepatitis & pneumonia/influenza<br>Asthma hospitalization<br>Alcohol abuse | **Unemployment: 7.7%**<br>**Population Below Poverty:** 14.3% | • Foreclosure risk<br>• Stable economy<br>• **Median income: $54,817**<br>• **Per Capita: $24,634** | **Adults 25+ completed:**<br>• 79.6%- high school<br>• 22.6%- B.A<br>**Less than H.S:** 4,252 (20.25%) | • English: 13,021 (30.09%)<br>• Spanish: 9,537 (33.09%)<br>• Polish: 1,208 (4%)<br>• Korean: 89 (0.2%)<br>• Gujarati: 969 (3%) / Hindi: 129 (0.4%)/ Urdu: 295 (0.9%) |
| 60707 Elmwood Park 42,996 | | Diabetes long term complications<br>Heart Failure<br>Hepatitis<br>Adult/pediatric Asthma<br>Alcohol abuse | **Unemployment:** 11.6%<br>**Population Below Poverty:** 11.1% | • Foreclosure risk high<br>• Spending 30% on rent<br>• 65+ older living below poverty<br>• **Median Income: $53,394**<br>• **Per Capita: $25,896** | **Adults 25+ completed:**<br>• Good<br>• 85.3%- high school<br>• 26.5%- B.A<br>**Less than H.S:** 4,384 (14.60%) | • English: 20,647 (51.15%)<br>• Spanish: 9,682 (23.99%)<br>• Polish: 4,311 (10%)<br>• Korean: 87 (0.2%)<br>• Urdu: 123 (0.3%)/ Hindi: 6 (near 0%) |
| 60706 Hardwood Heights 22,581 | | Diabetes long term complications<br>Heart Failure<br>Hepatitis<br>Alcohol abuse | **Unemployment: 8.7%**<br>**Population Below Poverty: 10.3%** | • Stable Economy<br>• High 65+ older living below poverty<br>• **Median income: $55,324**<br>• **Per Capita: $26,341** | **Adults 25+ completed:**<br>• Good<br>• 85.6%- high school<br>• 22.8%- B.A<br>**Less than H.S:** 2,464 (14.30%) | • English: 10, 187 (47.02%)<br>• Spanish: 1,407 (6.49%)<br>• Polish: 5,742 (25.4%)<br>• Korean: 34 (0.1%)<br>• Gujarati, Hindi, Urdu: ---- |
| 60630 Jefferson Park/Chicago 53,887 | | Diabetes complications<br>Hepatitis<br>Heart Failure<br>Adult/ Pediatric Asthma<br>Alcohol abuse ER/Hospitalization | **Unemployment:** 10.9%<br>**Population Below Poverty:** 11.0% | • Foreclosure risk high compared to other counties<br>• **Median income: $62,853**<br>• **Per Capita: $28,114** | **Adults 25+ completed:**<br>• Good<br>• 86.7%- high school<br>• 32.6%- B.A<br>**Less than H.S:** 5,039 (13.22%) | • English: 24,875 (49.19%)<br>• Spanish: 10,732 (21.22%)<br>• Polish: 5,578 (10.3%)<br>• Korean: 243 (0.4%)<br>• Gujarati: 486(0.9%)/ Hindi:45/ Urdu: 256 (0.5%) |

Diabetes
Heart Disease & Stroke
Immunization & Infectious Disease
Mental Health
Other/Urinary tract infections & dehydration
Respiratory/Asthma
Substance & Alcohol abuse

## Appendix 4: Advocate Children's Hospital Profile

### *Advocate Children's Hospital – Park Ridge, Illinois*

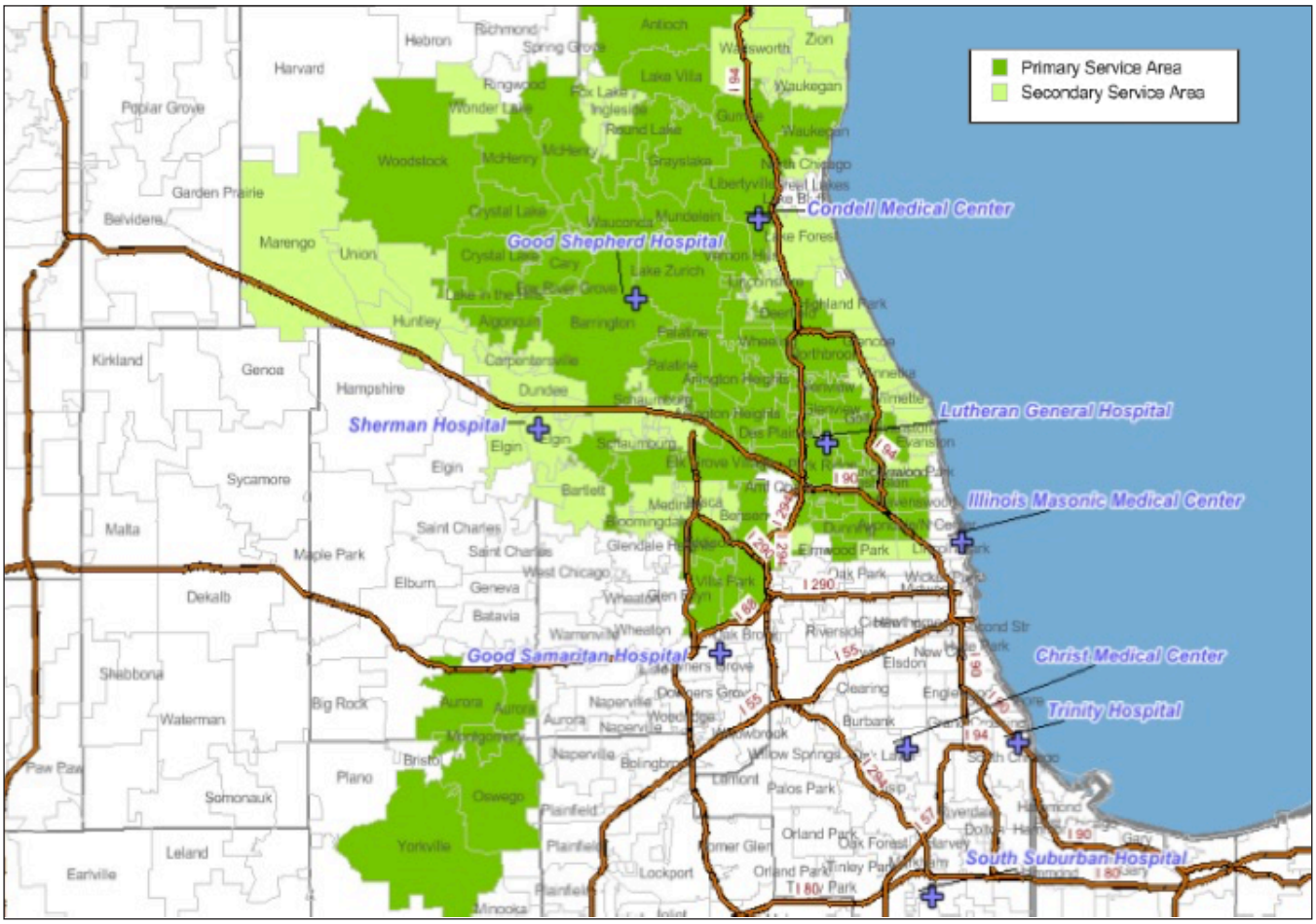
Advocate Children's Hospital, located on two campuses in the Chicagoland area, serves children ages 0-17. The north campus is located on the grounds of Advocate Lutheran General Hospital in Park Ridge, IL (Advocate Children's Hospital Park Ridge) with which it shares the same tax ID number. The south campus is located on the grounds of Advocate Christ Medical Center in Oak Lawn, IL (Advocate Children's Hospital Oak Lawn) with which it also shares the same tax ID number. A community profile was completed to supplement the comprehensive Community Health Needs Assessment (CHNA) process of the respective Advocate hospitals. This supplemental profile and plan has been completed as part of Advocate Lutheran General's CHNA process and covers the Advocate Children's Hospital Park Ridge service area.

Advocate Children's Hospital Park Ridge is located in north Cook County and is in close proximity to the Chicago city limits. While an important part of Lutheran General Hospital campus, administratively and operationally, all pediatric services report to the Advocate Children's Hospital leadership team.

### *Community Profile—Advocate Children's Hospital, Park Ridge Total Service Area*

Exhibit 1 shows the primary and secondary service areas of Advocate Children's Hospital Park Ridge. These combined service areas are known as the hospital's total service area (TSA.) The TSA of Advocate Children's Hospital Park Ridge also includes geographic areas or communities served by Advocate Good Shepherd Hospital in the northwest suburbs, Advocate Condell Medical Center in the north suburbs and portions of Advocate Illinois Masonic Medical Center on the north side of Chicago. The total pediatric population, ages 0-17 years, within the Children's Hospital Park Ridge TSA is 841,812 children in 109 communities or 27% of the total population within the same area.

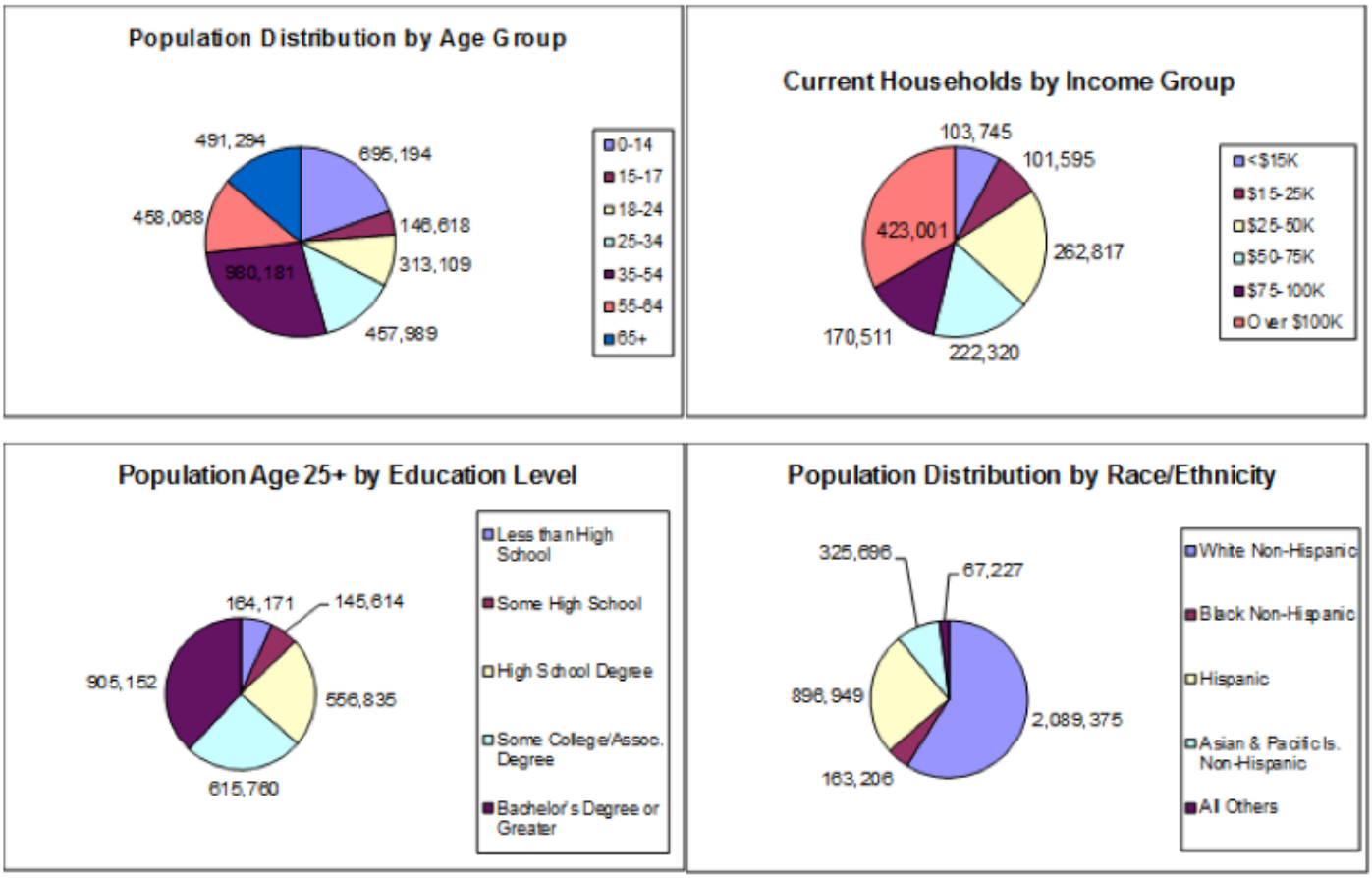
**Exhibit 1: Advocate Children's Hospital Park Ridge Total Service Area**




Source: Advocate Health Care Strategic Planning Department, 2013.

Exhibit 2 illustrates the Advocate Children's Hospital Park Ridge TSA demographic snapshot including household income showing that 16% of households in the TSA earn less than $25,000/year and 36% have a high school education or less. The TSA is 5% Black/Non-Hispanic, 59% White/Non-Hispanic, 25% Hispanic and 9% Asian/Pacific Islander. Within the TSA, 43.2% of patients (children ages 0-17) are covered by Medicaid, 51% are covered by managed care health insurance and .5% are on Medicare and 5.3% have other payment plans. Advocate Children's Hospital, Park Ridge has 129 beds and 170 pediatricians and specialists on staff, and reported over 6,286 admissions, nearly 3,424 surgeries, over 17,280 emergency department visits, 1,649 medical transports between Advocate and other hospitals, and nearly 200,000 patient office visits.

**Exhibit 2: Advocate Children's Hospital Park Ridge TSA Demographic Snapshot**



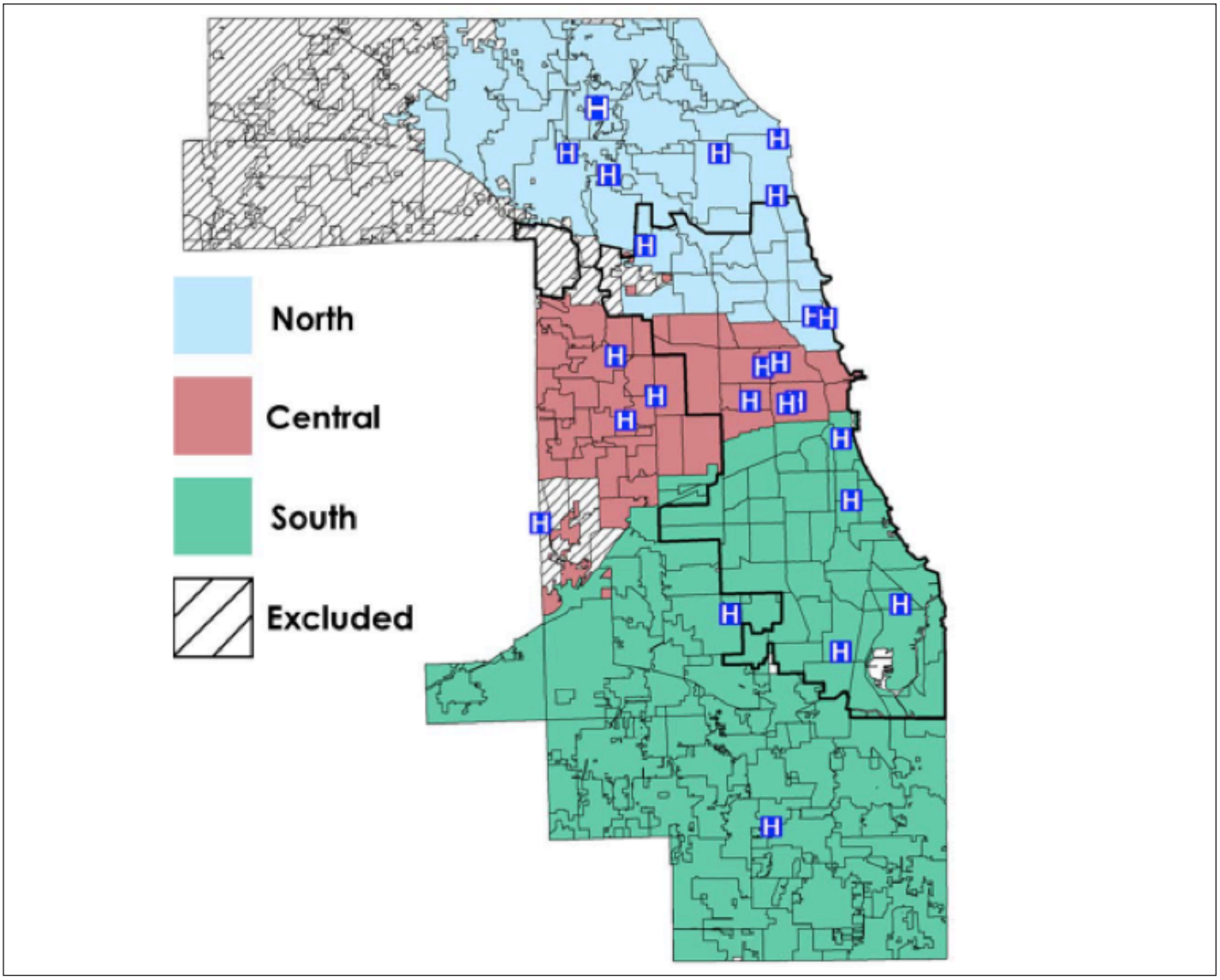

Source: Truven Health Analytics, The Nielson Company, 2016.

## *Methodology for Profile – Community Partners*

As Advocate Children's Hospital Park Ridge serves children within multiple communities located in both the city of Chicago as well as suburban Cook County, the hospital elected to participate in two different hospital collaborative efforts. The Health Impact Collaborative of Cook County (HICCC) is a coalition of 27 hospitals, 6 health departments and over 100 community stakeholders designed to assess community health needs and assets and implement a shared plan to maximize health equity and wellness. HICCC is described in detail in the Lutheran General Hospital CHNA report. Advocate Children's Hospital was an active participant in the HICCC process in both the north and south regions as the respective campuses are located in those regions. Given the large geography of Cook County, the Collaborative decided to divide into three regions. Exhibit 3 shows a map of these three regions across Cook County.

Advocate Children's Hospital has also been an active participant in the Healthy Chicago Hospital Collaborative which is working together to address three health issues identified by participating hospitals during the 2014-2016 CHNA cycle, including access to care, mental health and obesity.

**Exhibit 3: HICCC CHNA Regions in Cook County Illinois**




*Advocate Children's Hospital is co-located at the Advocate Lutheran General Hospital (North region) and Advocate Christ Medical Center (South region) sites and does not have a separate Hospital icon.

Source: Health Impact Collaborative of Cook County, South Region Report, 2016.

This profile was created using primary and secondary data from multiple sources including hospital utilization and Emergency Department visit data, focus group data and publicly available health outcome and demographic data, as well as pertinent data gathered from the primary surveys administered by the HICCC survey process which was disseminated in four languages available in paper and online formats. Approximately 5,200 surveys were collected from community residents through targeted outreach to communities affected by health disparities across the city and county between October 2015 and January 2016. About 1,500 or 29% of the surveys were collected from residents in the north region largely served by Advocate Children's Hospital Park Ridge.

Through collaborative prioritization processes involving hospitals, health departments, and Stakeholder Advisory Teams, the Health Impact Collaborative of Cook County identified four focus areas as significant health needs:

1. Improving social, economic and structural determinants of health while reducing social and economic inequities.
2. Improving mental health and decreasing substance abuse.
3. Preventing and reducing chronic disease, with a focus on risk factors – nutrition, physical activity and tobacco.
4. Increasing access to care and community resources.

All hospitals within the Collaborative will include the first focus area - Improving social, economic and structural determinants of health—as a priority in their CHNA and implementation plan. Each hospital will also select at least one of the other focus areas as a priority.

Advocate Children's Hospital has also been an active participant in the Healthy Chicago Hospital Collaborative which is working together to address three health issues identified by participating hospitals during the 2014-2016 CHNA cycle, including access to care, mental health and obesity. The Healthy Chicago Hospital Collaborative concentrated its efforts on data collected by and input from the Chicago Department of Public Health.

## *Key Findings*

Advocate Children's Hospital's active participation in the HICCC assessment process yielded significant data which is helpful in defining children's health needs in the north region and in shaping plans to address them. Guiding the HICCC process is the mission, vision, and values which has a strong focus on improved health equity in Chicago and suburban Cook County. Social and structural determinants of health such as poverty, unequal access to healthcare, lack of education, structural racism, and environmental conditions, are underlying root causes of health inequities. Additionally, social determinants of health often vary by geography, gender, sexual orientation, age, race, disability, and ethnicity. (Centers for Disease Control and Prevention, 2013, CDC Health Disparities and Inequalities Report, Morbidity and Mortality Weekly Report, 62.3). The strong connections between social, economic, and environmental factors and health are apparent in Chicago and suburban Cook County, with health inequities being even more pronounced than most of the national trends. Disparities related to socioeconomic status, built environment, safety and violence, policies, and structural racism were identified in the north region as being key drivers of community health and individual health outcomes.

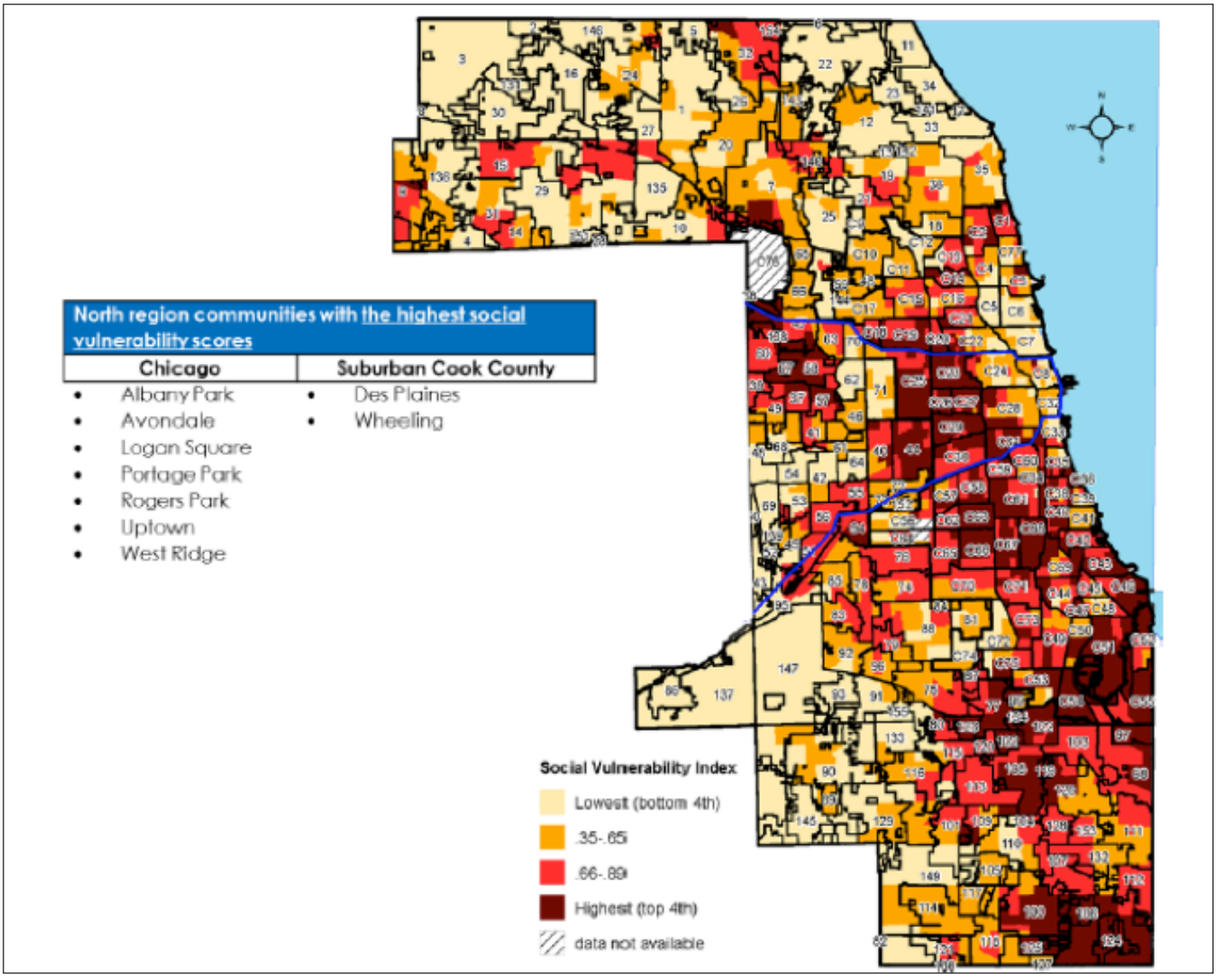
- Hispanic and African American teens have much higher birth rates compared to white teens in Chicago and suburban Cook County.
- African Americans, Hispanic/Latinos and Asians have higher rates of poverty and lower annual household incomes than non-Hispanic Whites.
- More than a third (34%) of children and adolescents in the HICCC north region live at or below the 200% Federal Poverty Level.
- Homicide and firearm-related mortality are highest among Hispanic/Latinos and African American/blacks in the north region.
- Nearly 20% of women in Illinois and suburban Cook County do not receive adequate prenatal care prior to the third month of pregnancy or receive no prenatal care.
- 50% of enrolled school children in the north region of Cook County are eligible for free or reduced price lunches.

Data and information illustrating the current state of community health in the North region are found below, as well as indicators that can contribute negatively to children's health in the area.

**Social Vulnerability Index**

The Social Vulnerability Index is an aggregate measure of the capacity of communities to prepare for and respond to external stressors on human health such as natural or human-caused disasters, or disease outbreaks. The Social Vulnerability Index ranks each census tract on 14 social factors, including poverty, lack of vehicle access, and crowded housing. Communities with high Social Vulnerability Index scores have less capacity to deal with or prepare for external stressors and as a result are more vulnerable to threats on human health. Many communities in Advocate Children's Hospital's TSA rank high in social vulnerability which can have a negative impact on children's health.

**Exhibit 4: HICCC North Region Social Vulnerability Index by Census Tract, 2010**

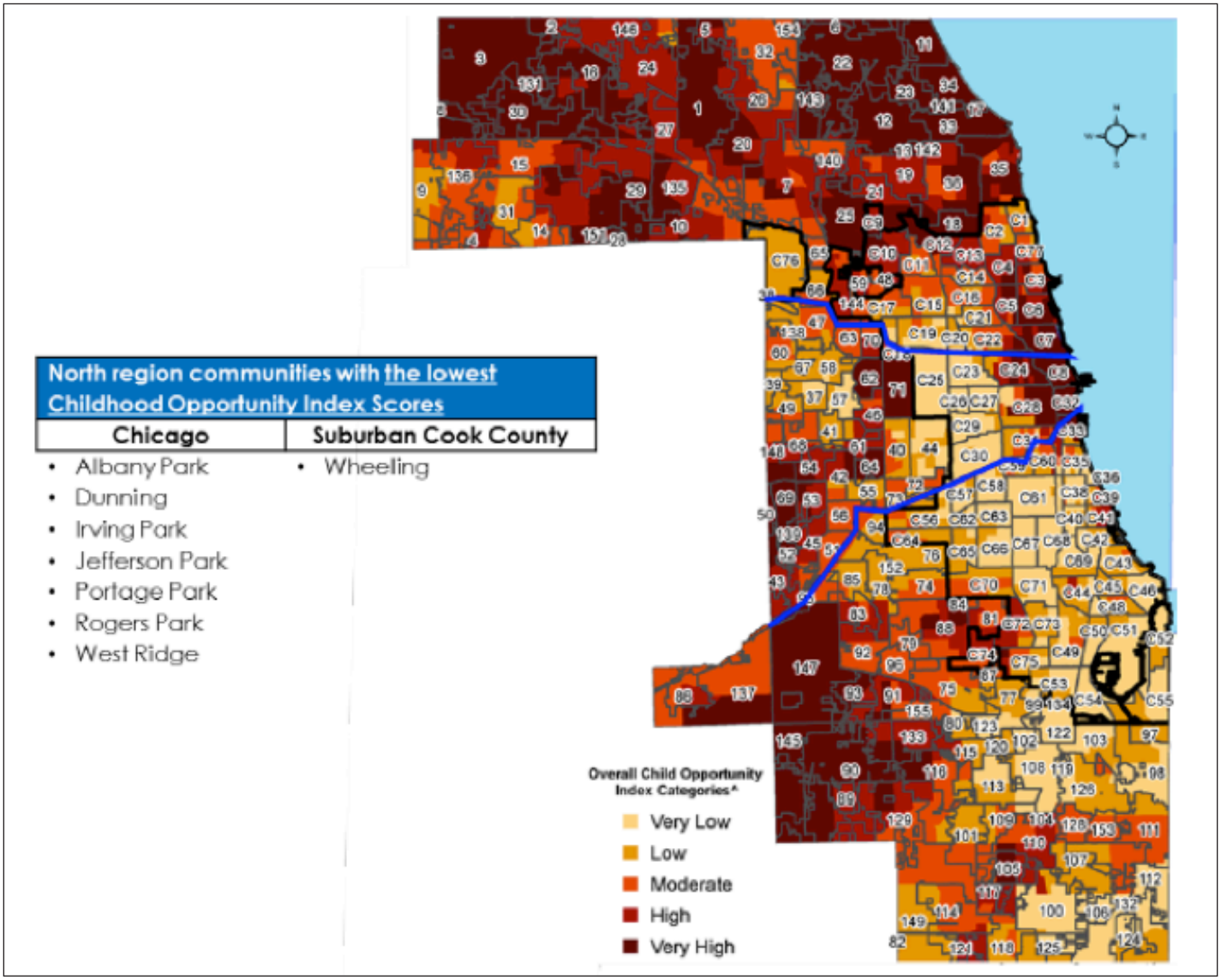



Source: Health Impact Collaborative of Cook County, 2016; Agency for Toxic Substances and Disease Registry, 2014. The Social Vulnerability Index. http://svi.cdc.gov/.

**Childhood Opportunity Index**

The Childhood Opportunity Index is based on several indicators in each of the following categories: demographics and diversity; early childhood education; residential and school segregation; maternal and child health; neighborhood characteristics of children; and child poverty. Children who live in areas of low opportunity have an increased risk for a variety of negative health indicators such as premature mortality, are more likely to be exposed to serious psychological distress, and are more likely to have poor school performance.

**Exhibit 5: HICCC North Region Childhood Opportunity Index by Census Tract 2007-2013**



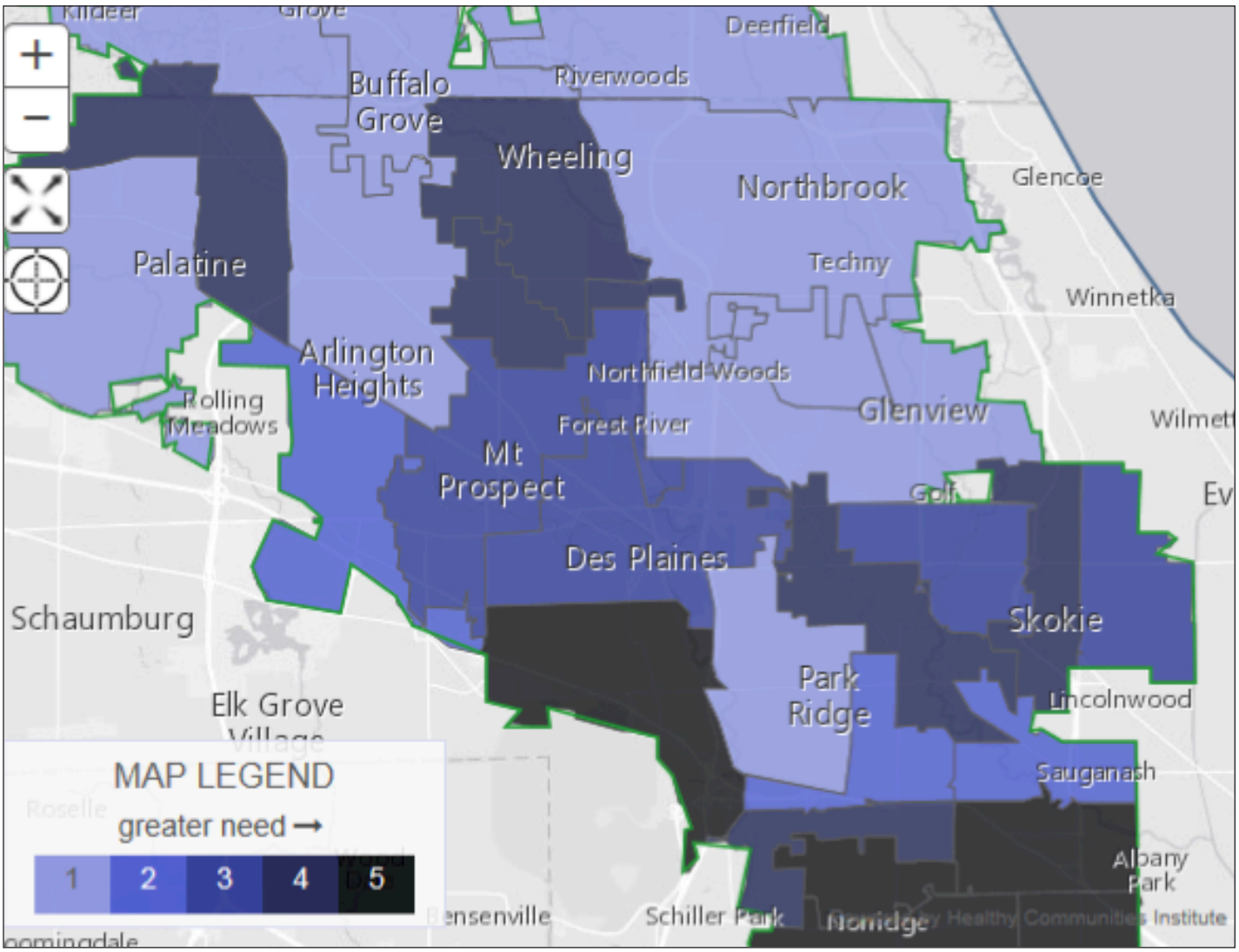

Source: Health Impact of Cook County, Community Health Needs Assessment, North Region, Collaborative, 2016.

## *SocioNeeds Index*

To clearly illustrate the disparity of income and other socioeconomic factors that exist within much of the Advocate Children's Hospital service area, it is useful to examine how the SocioNeeds index varies across zip codes. Created by the Healthy Communities Institute, the SocioNeeds Index is a measure of socioeconomic need that is correlated with poor health outcomes. Indicators for the index are weighted to maximize the correlation of the index with premature death rates and preventable hospitalization rates. This index combines multiple socioeconomic indicators into a single composite value. As a single indicator, the index can serve as a concise way to explain which areas are of highest need. The scores can range from 1 to 100. A score of 100 represents the highest socio-economic need.

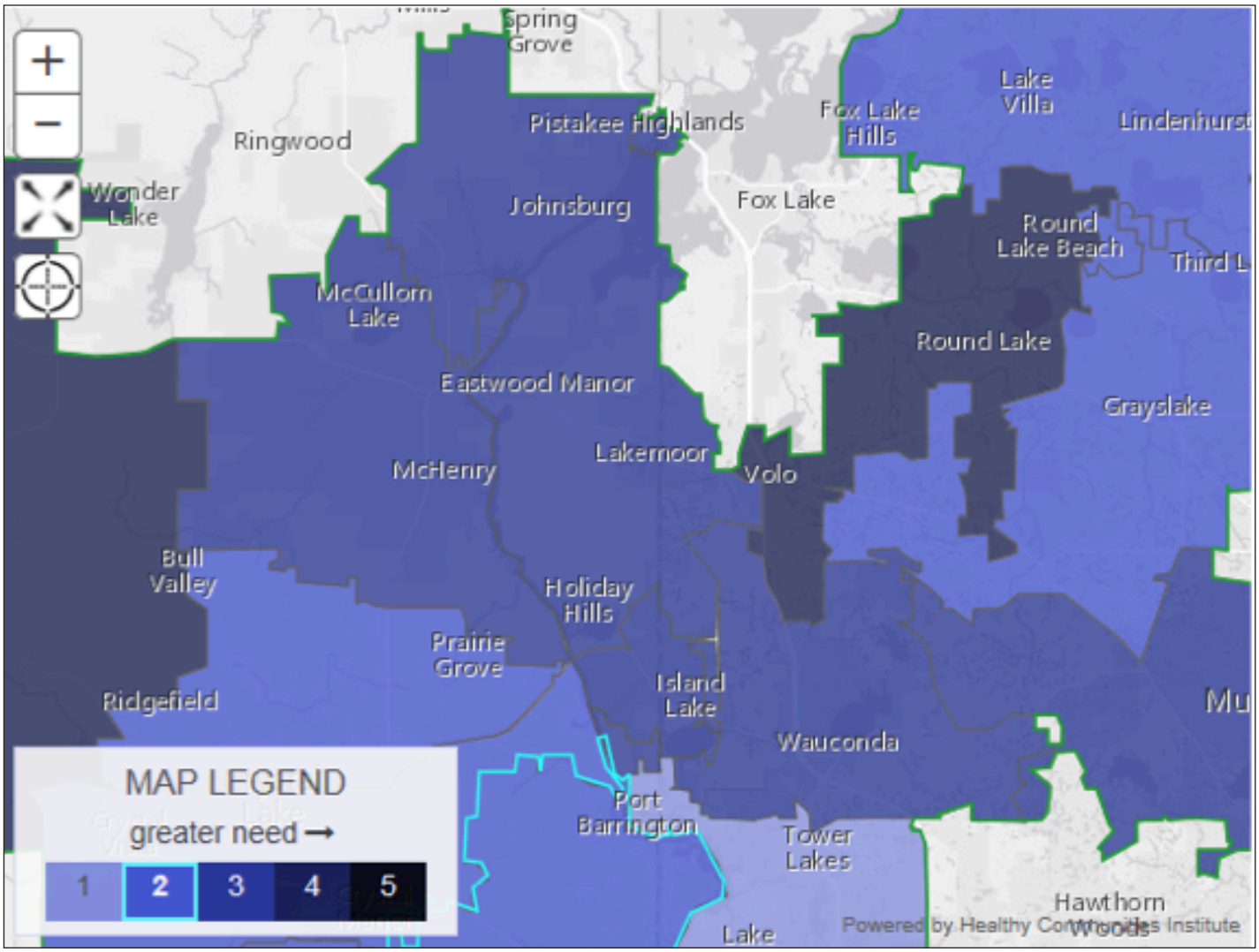
As a SocioNeeds Index is not available specifically for Advocate Children's Hospital TSA, Lutheran General Hospital's SocioNeeds Index for primary services area and secondary service area will be used in this report. Within a service area, the ranking of 1-5 is a comparison of each zip code to all others within the primary service area; a 5 represents zip codes of highest socio-economic need. The index value for each zip code is compared to all zip codes within a service area and assigned a relative rank (1-5) using natural breaks classification. Exhibit 4 illustrates Lutheran General's primary service area only, whereas Exhibit 5 depicts the secondary service area. The communities with the highest need within Advocate Children's Hospital Park Ridge's primary service area, represented by a score of 3, 4 or 5, include suburban Des Plaines, Palatine, Skokie, Morton Grove, Round Lake, Streamwood, Elk Grove Village, Waukegan, Mundelein, Wauconda, McHenry and Woodstock, while Chicago's neighborhoods with highest need include Jefferson Park, Irving Park, Dunning and Harwood Heights. Communities with the highest socioeconomic need in the secondary service area include suburban Schaumburg and Franklin Park while in Chicago, the Belmont-Cragin, Avondale, Ravenswood and Avalon neighborhoods have the highest need.

**Exhibit 4: Advocate Children's Hospital Primary Service Area SocioNeeds Index Map**




Source: Healthy Communities Institute, 2016.

**Exhibit 5: Advocate Children's Hospital Secondary Service Area SocioNeeds Index Map**




Source: Healthy Communities Institute, 2016.

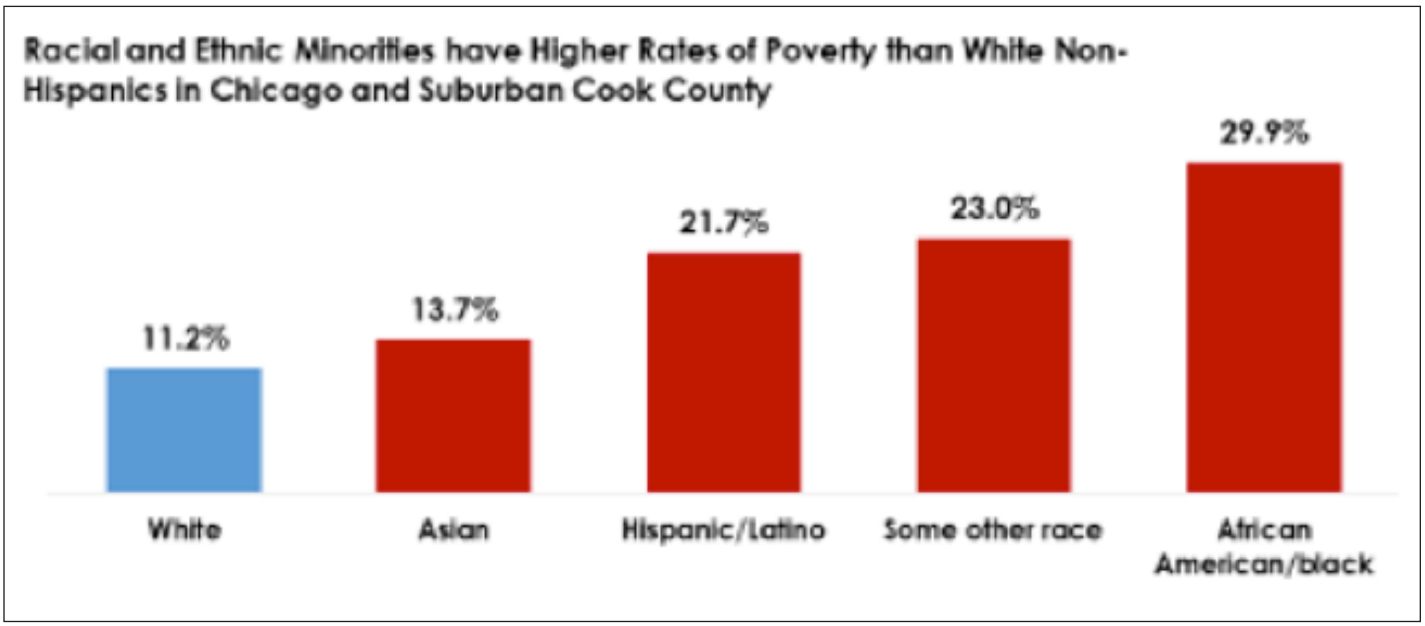
**Poverty, Economic and Education Inequity**

Poverty can create barriers to accessing health services, healthy food, and other necessities needed for good health status. (Health Impact Collaborative of Cook County, American Community Survey, 2010-2014; CommunityCommons.org CHNA Data, 2015). Poverty can also affect housing status, educational opportunities, an individual's physical environment, and health behaviors. (Health Impact Collaborative of Cook County, 2016; American Community Survey, 2010-2014; CommunityCommons.org CHNA Data, 2015.)

The Federal Poverty Guidelines define poverty based on household size, ranging from $11,880 for a one-person household to $24,300 for a four-person household and $40,890 for an eight-person household. (US Department of Health and Human Services. 2016, Poverty Guidelines, https://aspe.hhs.gov/poverty-guidelines).

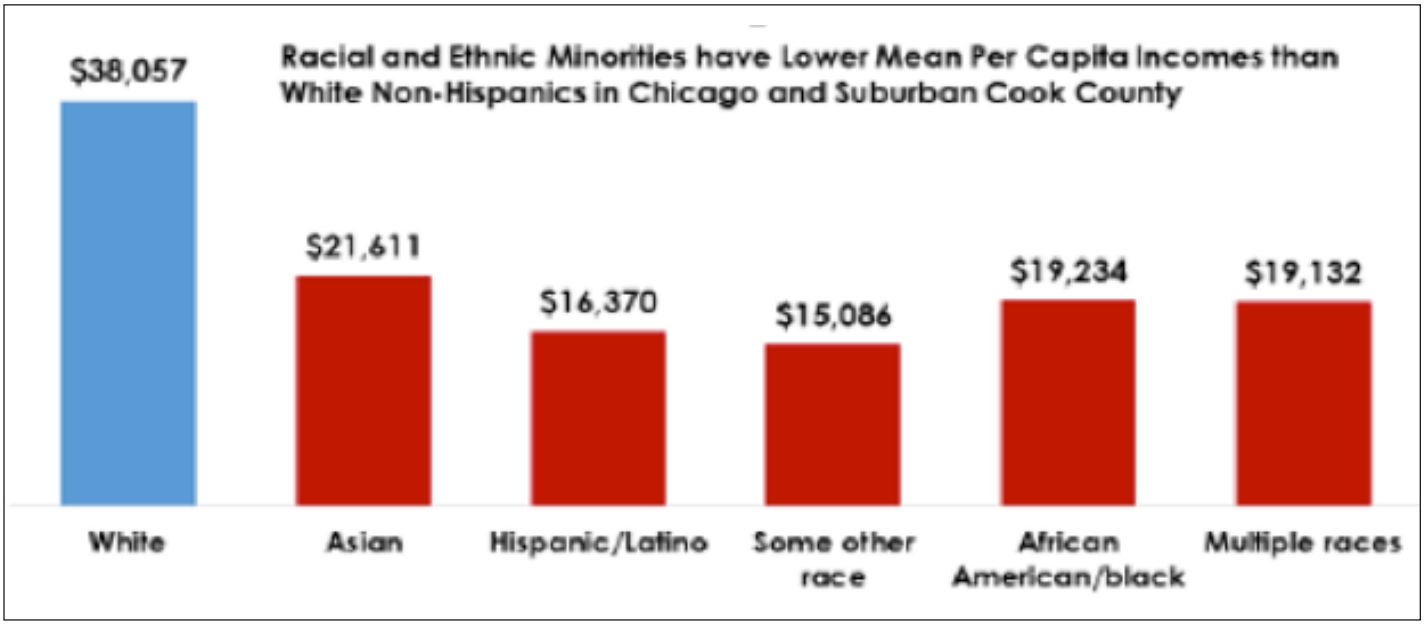
Nearly half of all children living in Chicago and Cook County live at or below 200% of the federal poverty level. The percentage of children in poverty is higher for Cook County than it is for Illinois and the U.S., and African American and Latino children have much higher poverty rates than non-Hispanic white children. Although the number of children living in poverty decreased overall in Chicago between 2009 and 2013, the number of children living in poverty doubled in suburban Cook County. As shown in the map of the Childhood Opportunity Index in Exhibit 3, there are large inequities in childhood opportunity across Chicago and suburban Cook County.

**Exhibit 5: Percentage of Population Living at or Below 100% Federal Poverty Level by Race and Ethnicity 2009-2013**




Source: Health Impact Collaborative of Cook County, South Region Report, 2016; American Community Survey, 2009-2013.

**Exhibit 6: Per Capita Income by Race and Ethnicity 2009-2013**




Source: Health Impact Collaborative of Cook County, South Region Report, 2016; American Community Survey, 2009-2013.

As reported in Healthy Chicago 2.0, 835,249 Chicagoans were living in high economic hardship in 2014 as defined by crowded housing, poverty, unemployment, education, dependency, income. Chicago Communities most impacted – 2 are in Advocate Children's Hospital Park Ridge's TSA (*).

- Belmont-Cragin*
- Hermosa*
- Humboldt Park
- West Garfield Park
- East Garfield Park
- North Lawndale
- South Lawndale
- Lower West Side
- Armour Square
- Archer Heights
- Brighton Park
- New City
- Fuller Park
- Oakland
- Gage Park
- Chicago Lawn
- West Englewood
- Englewood
- Washington Park
- Greater Grand Crossing
- Auburn Gresham
- Burnside
- South Chicago
- Riverdale
- Austin
- West Elsdon

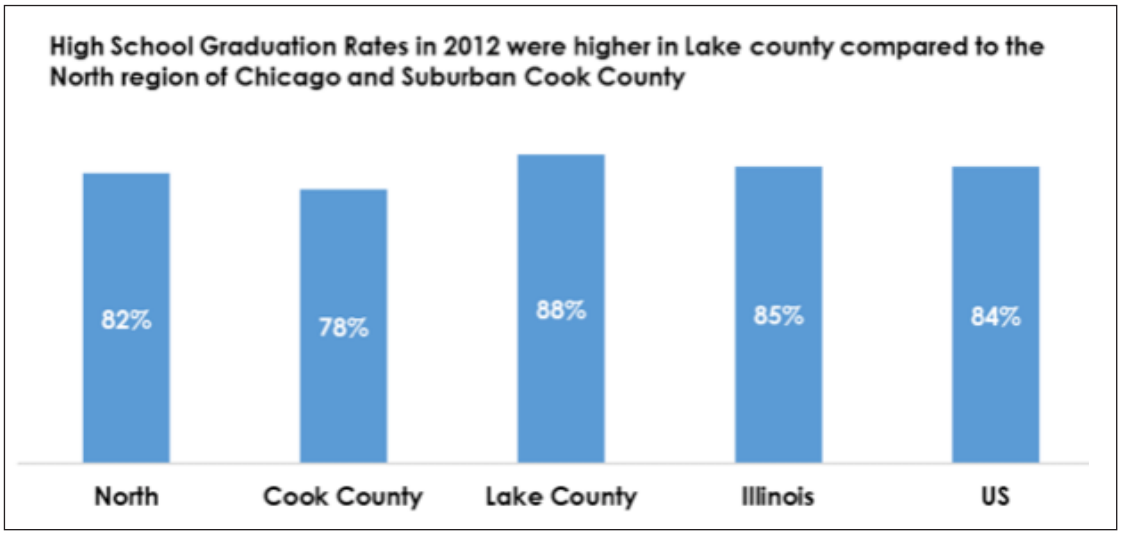
Source: Chicago Department of Public Health; Healthy Chicago 2.0, 2016.

**Education**

The high school graduation rate in the HICCC north region (82%) is slightly lower than the state (85%) and national averages (84%), however, the high school graduation rate for the north region (82%) is definitely lower than the rates in neighboring Lake county (88%) and in other local counties such as Du Page (94%) and Will (91%.) Education is an important social determinant of health, because the rate of poverty is higher among those without a high school diploma or GED. In addition, as previously mentioned, those without a high school education are at a higher risk of developing certain chronic illnesses, such as diabetes.

The Forces of Change Assessment (FOCA) conducted by The Chicago and Cook County Departments of Public Health identified multiple trends and factors influencing educational attainment in Chicago and suburban Cook County including inequities in school quality and early childhood education, school closings in Chicago, and unequal application of discipline policies for black and Hispanic/Latino youth. These factors and trends produce threats to health such as lack of job and college-readiness as well as an increased risk of becoming chronically involved with the criminal justice system as an adult. Opportunities to address education issues include efforts to apply evidence-based school improvement programs, vocational learning opportunities, advocacy, and using maternal/child health funding to improve early childhood outcomes.

**Exhibit 7: High School Graduation Rates in Chicago and Suburban Cook County 2011-2012**




Source: Health Impact Collaborative of Cook County, South Region Report, 2016; US Department of Education, EDFacts, 2011-2012.

Seven out of the eight focus groups in the HICCC north region mentioned schools and education as a major component of health in their communities. Multiple focus group participants indicated that quality education should be available to all students regardless of where they live. In addition, several residents and community workers indicated that in many parts of Chicago and Suburban Cook County, including the north region, the education system has failed tremendously. Approximately 30% of Community Resident Survey respondents from the north region indicated that the schools in their community were less than good.

**Food Access and Food Security**

Food insecurity is defined as the household-level economic and social condition of limited or uncertain access to adequate food. Factors and trends related to food and systems that were identified in the FOCA include lack of healthy food access, unhealthy food environments driven by federal food policies and food marketing, and increasing community gardens/urban agriculture. Threats to health related to the forces of change include increasing obesity and chronic disease and lowered school performance. Numerous opportunities were identified to address food systems in Chicago and suburban Cook County, including SNAP double bucks programs, incentivizing grocery store and community gardens, using hospital campuses/land as places for gardens, increasing the number of farmers markets and grocery stores and the workforce development prospects for urban agriculture. Approximately 15% of the population in Chicago and suburban Cook County experienced food insecurity in the report year 2013. According to the USDA in 2014, all households with children, single-parent households, non-Hispanic black households, Hispanic/Latino households, and low-income households below 185% of the poverty threshold had higher food insecurity rates compared to other populations in the U.S. (Health Impact Collaborative of Cook County North Region Report, 2016; USDA, 2014; http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics.aspx#insecure).

Focus group participants reported that there is high food insecurity among children in some of the communities on the North side of Chicago and that it has profound effects on child health and development. Approximately 29% of survey respondents from the North region indicated that they or their families have had to worry about whether or not their food would run out before they had the money to buy more. Half of enrolled school children in the North region of Chicago and Suburban Cook County are eligible for free or reduce price lunch. In addition, 9% of all households in the North region are receiving SNAP benefits.

**Safety and Violence**

Although violent crime occurs in all communities, violent crime disproportionately affects communities of color in Chicago and suburban Cook County. Factors and trends in safety and violence identified in the FOCA include gun violence, intimate partner violence, police violence, and bullying. The threats to health from these forces include the links between community violence, chronic disease, and mental health problems, plus the impact of fear and stress on health and well-being. Opportunities to address safety and violence issues in Chicago and suburban Cook County include supporting the role of schools in violence prevention and services for families, increasing understanding of adverse childhood experiences by health care workers and increasing communication between communities and police. (Health Impact Collaborative of Cook County, North Region Report, 2016; Chicago Department of Public Health, Healthy Chicago 2.0, 2016.)

In addition, there are multiple negative health outcomes associated with exposure to violence and trauma. There are large disparities in homicide and firearm-related mortality between regions. Homicide mortality in the South region is six times higher than the rate in the North region and firearm-related mortality is four times higher in the South compared to the North, however, there are multiple communities in the North region that share a disproportionate burden of violent crime. The major safety issues identified by focus group participants on the North Side of Chicago and in the North Cook County suburbs included drug trafficking, gangs, human trafficking, violence in residential facilities, and vandalism.

The focus group results were mirrored in the Community Resident Survey where respondents from the north region indicated that gang activity (16%), drug use/drug dealing (13%), and graffiti/vandalism (12%) are the most common reasons respondents felt unsafe in the last 12 months.

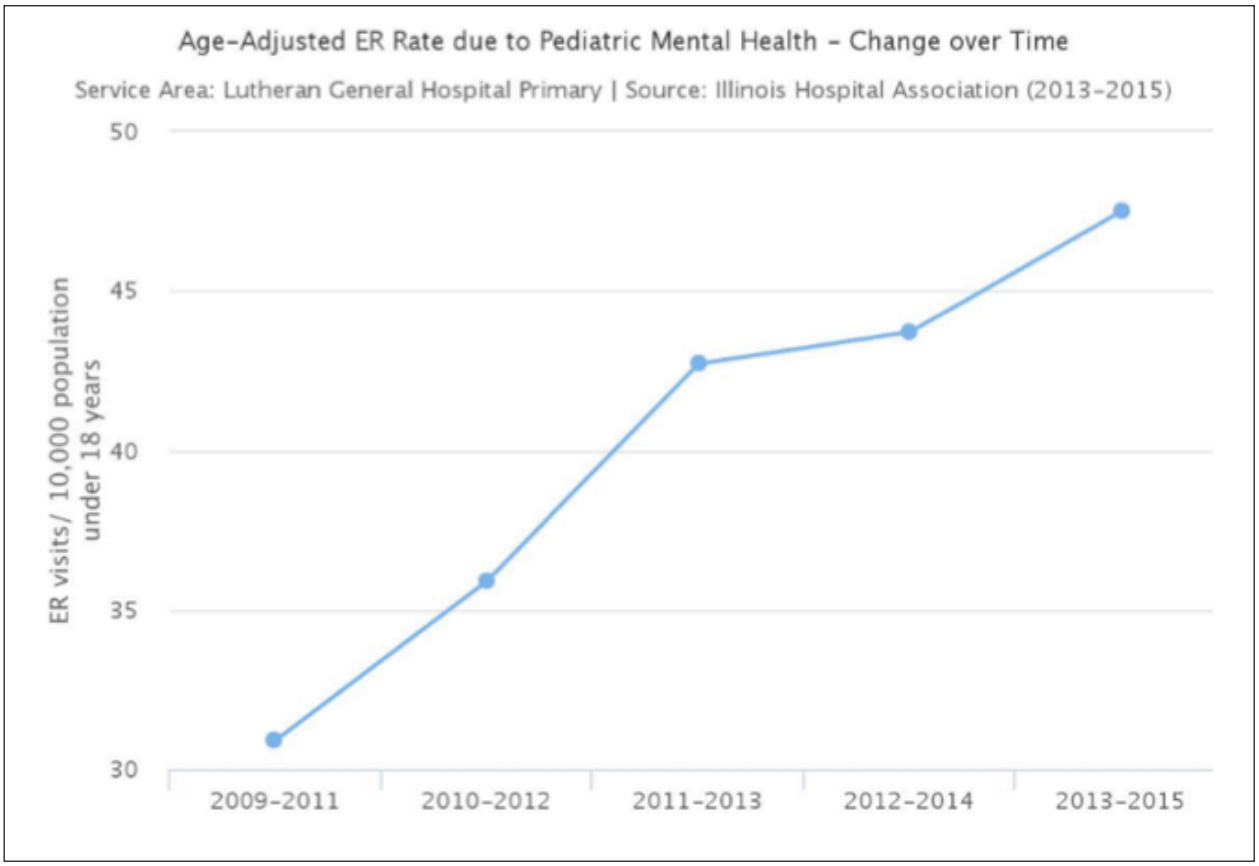
**Improving Mental Health and Decreasing Substance Abuse**

Mental health and substance use rose as key issues in the assessment process in the North region. In particular, the HICCC CHNA found that funding and systems are inadequate across the board to support the behavioral health needs of communities in Chicago and Cook County. Illinois Hospital Association COMPdata shows that the Pediatric Mental Health ER rates in Lutheran General Hospital's primary service area has increased steadily since 2009, from a value of 30.9 ER visits/10,000 population in 2009 to 47.5/10,000 population in 2015. (Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2013-2015.) Stigma and lack of open conversation about behavioral health are also factors that contribute to community mental health and substance use issues in youth and adults.

Community mental health issues are exacerbated by long-standing inadequate funding as well as recent cuts to social services, healthcare, and public health. The World Health Organization (WHO) emphasizes the need for a network of community-based mental health services. (Health Impact Collaborative of Cook County North Region Report, 2016; World Health Organization, 2007; http://www.who.int/mediacentre/news/notes/2007/np25/en/).

In addition, research indicates that better integration of behavioral health services, including substance use treatment into the healthcare continuum, can have a positive impact on overall health outcomes. The WHO has found that the closure of mental health hospitals and facilities is often not accompanied by the development of community-based services and this leads to a service vacuum. (Health Impact Collaborative of Cook County, North Region Report, 2016; American Hospital Association, Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs, and Outcomes, 2012. http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf.)

**Exhibit 8: Age Adjusted ER Rate due to Pediatric Mental Health 2013-2015**




Source: Healthy Communities Institute, 2016; Illinois Hospital Association, COMPdata, 2013-2015.

Advocate Children's Hospital utilization data shows that 2,337 pediatric patients were discharged with a behavioral health related diagnosis which is roughly 10% of all hospital admissions and ED visits at the Park Ridge campus. In the 9-counties served by Advocate Children's Hospital, 13,927 patients were seen for behavioral health issues, meaning that the Park Ridge campus saw 17% of all behavioral health patients. (Advocate Children's Hospital Utilization Data, Advocate Decision Support System – EPSI, 2015).

In terms of the connections between trauma and mental health, substantial evidence has emerged over the past decade that adverse childhood experiences (ACEs) strongly relate to a wide range of physical and mental health issues throughout a person's lifespan. ACEs include physical and emotional abuse and neglect, observing violence against relatives or friends, substance misuse within the household, mental illness in the household, and forced separation from a parent or close family member through incarceration or other means. (Health Impact Collaborative of Cook County, North Region Report, 2016; World Health Organization, 2007, http://www.who.int/mediacentre/news/notes/2007/np25/en.)

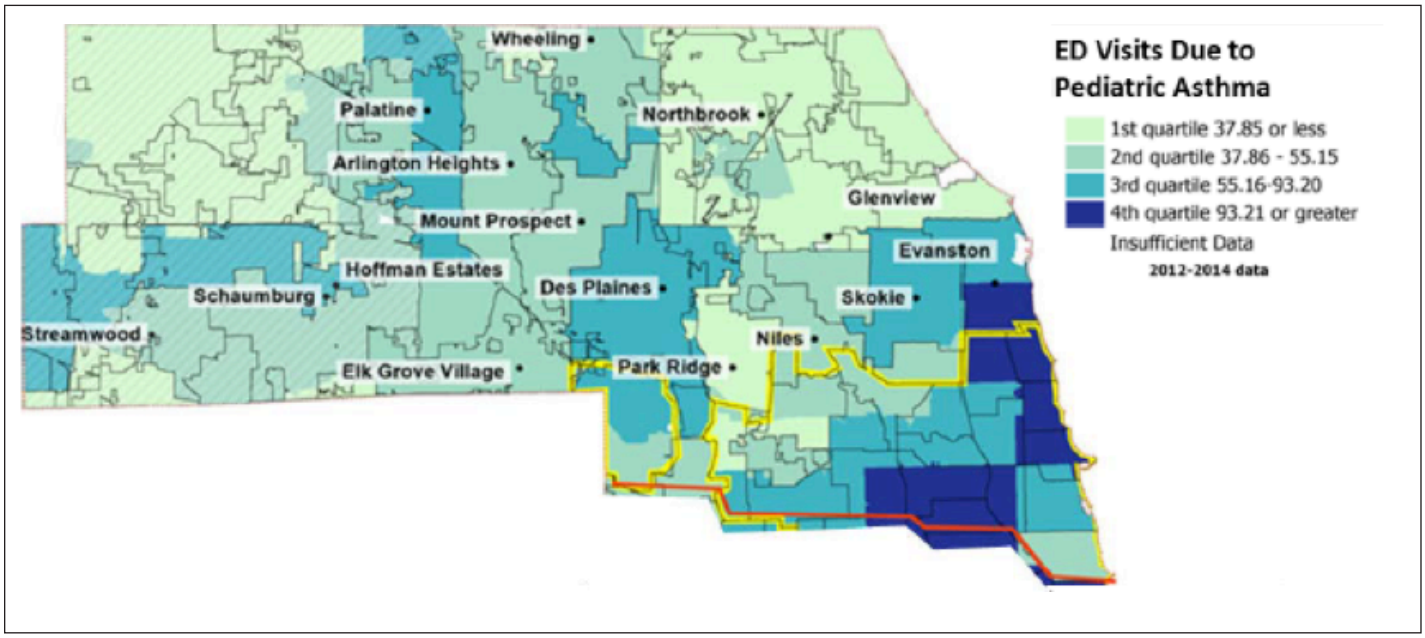
**Chronic Disease and Conditions Affecting Children**

Chronic diseases are a significant health burden for children. This section summarizes needs and issues related to the chronic diseases affecting children, including obesity and asthma. The north region CHNA findings emphasize that preventing chronic disease requires a focus on risk factors such as nutrition and healthy eating, physical activity and active living and tobacco use. The findings across all assessments emphasized that chronic disease is an issue that affects population groups across income levels and race and ethnic groups in the north region. However, social and economic inequities have profound impacts on which individuals and communities are most affected by chronic disease. Priority populations to consider in terms of chronic disease prevention include: children and adolescents, low-income families, immigrants, diverse racial and ethnic groups, uninsured individuals, and those insured through Medicaid, individuals living with mental illness, individuals living in residential facilities, and incarcerated or formerly incarcerated individuals.

**Asthma**

Exhibit 9 shows the geographic distributions of emergency department (ED) visits due to pediatric asthma. Communities on the North Side of Chicago and North Cook County suburbs have areas of elevated rates of ED visits for asthma. ED visits are indicative of increased exposure to environmental contaminants that can trigger asthma as well as poorly managed asthma. Hospital utilization data shows that asthma is one of the top 5 discharge diagnoses for both pediatric inpatients and ED visits. (Advocate Children's Hospital Utilization Data; Advocate Decision Support System, EPSI, 2015.)

**Exhibit 9: Emergency Department (ED) Visits HICCC North Region Due to Pediatric Asthma (age-adjusted rates per 10,000) by Zip Code 2012-2014**



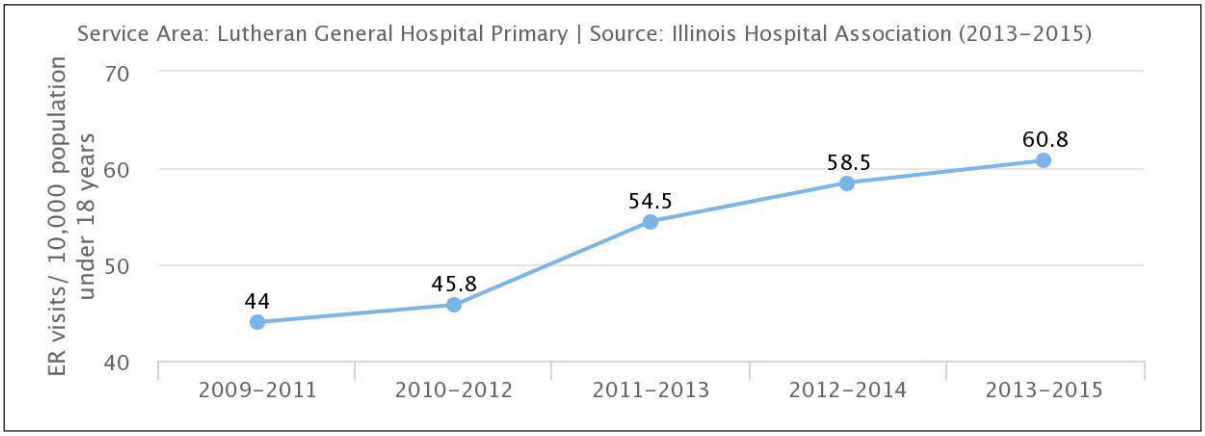

Source: Health Impact Collaborative of Cook County, North Region Report, 2016; Healthy Communities Institute; Illinois Hospital Association, COMPdata, 2012-2014.

Top 10 sources (communities) of asthma diagnoses which account for 61% of all asthma discharges at Advocate Children's Hospital Park Ridge include:

- Des Plaines
- Park Ridge
- Mount Prospect
- Dunning
- Norwood Park
- Harwood Heights
- Morton Grove
- Wheeling
- Glenview

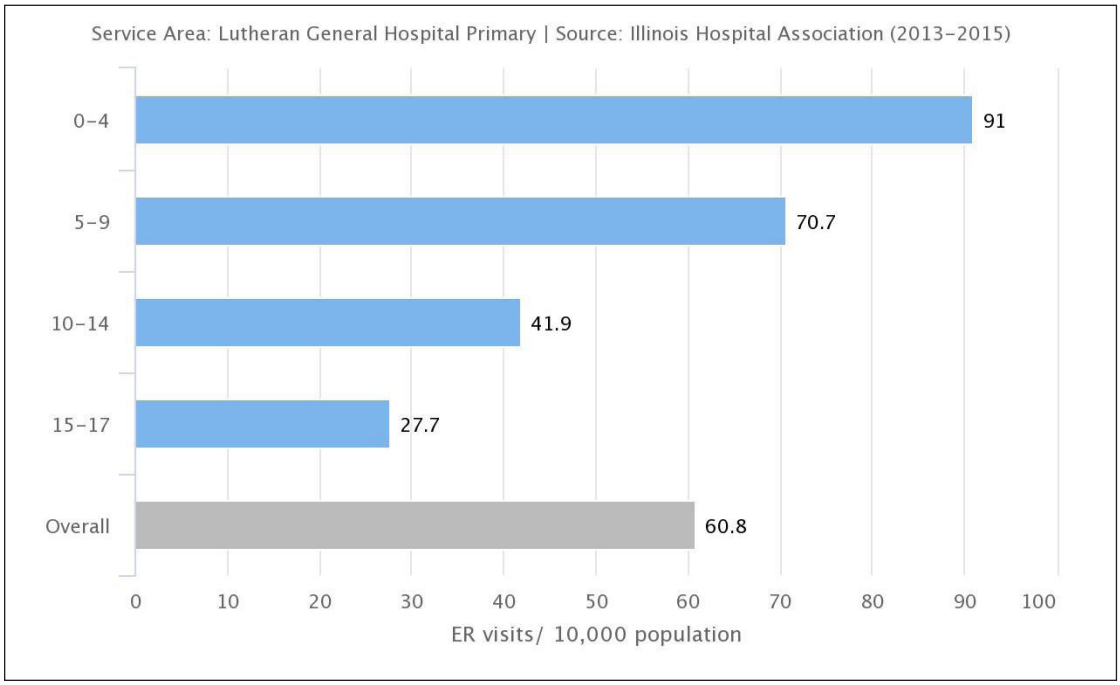
Source: Advocate Children's Hospital Utilization Data, Advocate Decision Support System, EPSI, 2015.

**Exhibit 10: Advocate Children's Hospital Park Ridge Age-adjusted Emergency Department Rate for Pediatric Asthma 2013-2015**



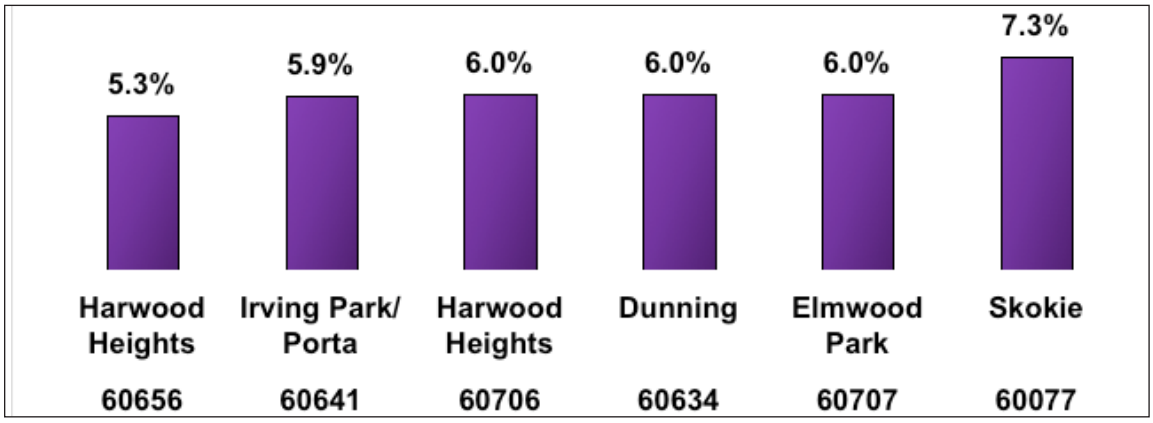

Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2013-2015.

**Exhibit 11: Advocate Children's Hospital Park Ridge ER Rate due to Pediatric Asthma by Age 2013-2015**




Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2013-2015.

**Exhibit 12: Advocate Children's Hospital Park Ridge Age-Adjusted Hospitalization Rate Due to Pediatric Asthma 2013-2015**




Source: Truven Insurance Coverage Estimates, 2016.

Advocate Children's Hospital utilization data shows the following top 10 communities in Chicago and north suburbs for asthma diagnoses. These communities account for 61% of all asthma patient discharges and potential areas of concentration for intervention activities.

Top Sources (communities) of Asthma Diagnoses (account for 61% of all asthma discharges)

- Des Plaines (both zips)
- Park Ridge
- Mount Prospect
- Dunning
- Norwood Park
- Harwood Heights
- Morton Grove
- Wheeling
- Glenview

Source: Advocate Children's Hospital Utilization Data, Advocate Decision Support System, EPSI, 2015.

**Obesity**

Poor diet and a lack of physical activity are two of the major predictors for obesity and diabetes. Low consumption of healthy foods may also be an indicator of inequities in food access. Fifty percent of enrolled school children in the HICCC north region of Chicago and suburban Cook County are eligible for free or reduced price lunch, and 9% of all households in the north region report receiving SNAP benefits. In addition, approximately 16% of youth in suburban Cook County and 22% of youth in Chicago report not engaging in physical activity during leisure time. Furthermore, one in five kindergarteners enrolled in Chicago Public Schools were obese in the 2012-2013 academic year and 19% of all CPS students are obese. In 2014, 71% of adults living in Chicago consumed LESS than the recommended five or more servings of fruits and vegetables daily, compared to 85% in Suburban Cook County in 2012. Less than 20% of Chicago high school students DID consume the recommended amount as reported in 2013 and only 19.6% of high school students met the recommended federal physical activity guidelines for youth. (Chicago Department of Public Health, 2016; Healthy Chicago 2.0).

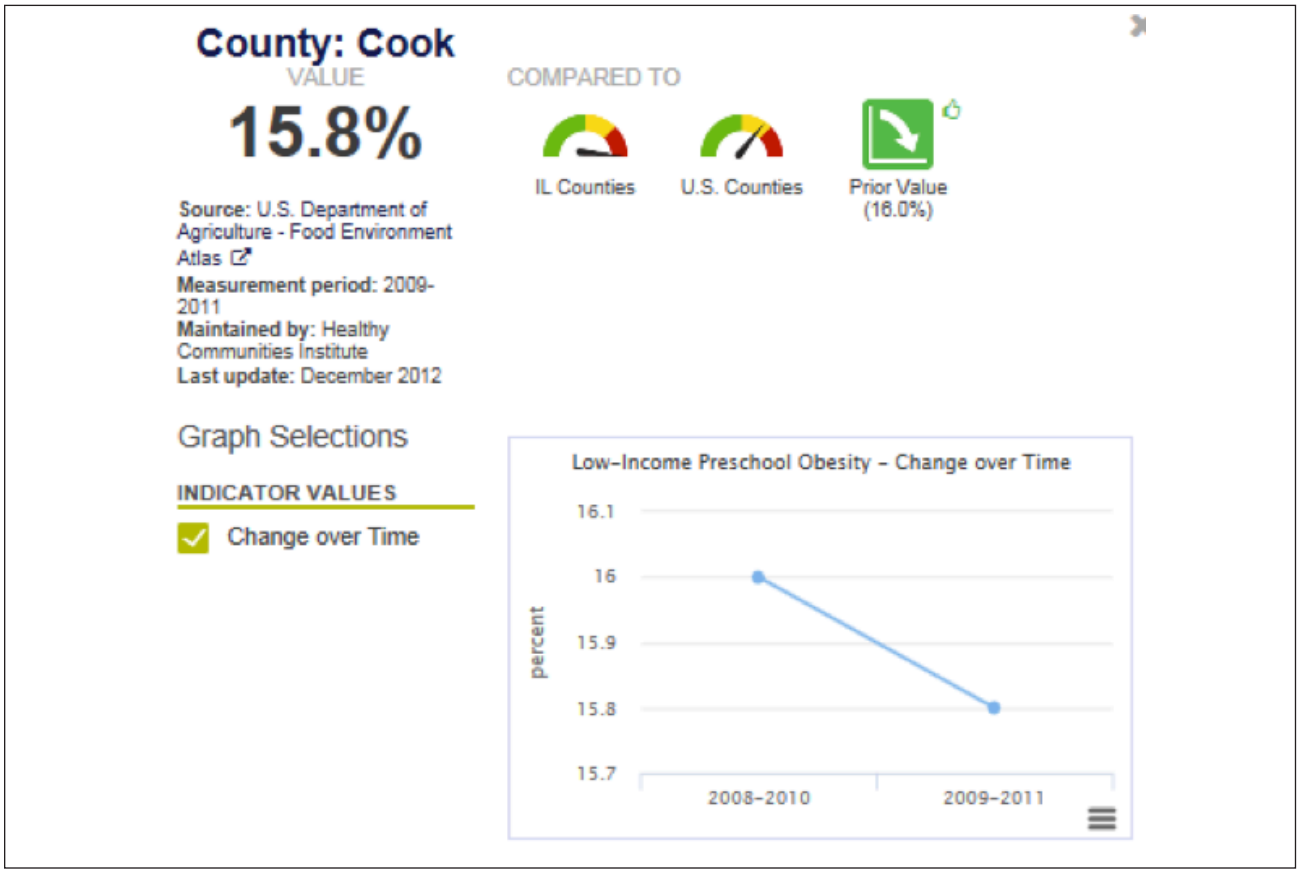
Obesity rates among K, 6th and 9th graders in Chicago Public Schools – 19% of all CPS kids are obese. Chicago Community Areas most impacted - 5 of 19 are in Advocate Children's Hospital Park Ridge TSA*.

- Montclare*
- Belmont-Cragin*
- Hermosa*
- Avondale*
- Logan Square*
- Humboldt Park
- South Lawndale
- Lower West Side
- Garfield Ridge
- West Elsdon
- Gage Park
- New City
- Fuller Park
- Ashburn
- Burnside
- South Deering
- Brighton Park
- McKinley Park
- East Side

Source: Chicago Department of Public Health, 2016; Healthy Chicago 2.0.

Obesity rates for Pre-schoolers in Cook County are also high relative to other U.S. Counties

**Exhibit 13: Cook County Low Income Preschool Obesity**




Source: Healthy Communities Institute, US Department of Agriculture, Food Environment Atlas, 2009-2012.

**Increasing Access to Care and Community Resources**

Healthy People 2020 states that access to comprehensive healthcare services is important for achieving health equity and improving quality of life for everyone. Disparities in access to care and community resources were identified as underlying root causes of many of the health inequities experienced by residents in the north region. Access is a complex and multi-faceted concept that includes potential obstacles such as proximity, affordability, availability, convenience, accommodation, and reliability; quality and acceptability; openness, cultural competency, appropriateness and approachability.

Some specific priority needs related to access that were emphasized in Health Impact Collaborative of Cook County North Report findings include:

- Need to improve cultural and linguistic competency and humility;
- Inadequate access to healthcare, mental health services, and social services, particularly for uninsured and underinsured;
- Opportunities to coordinate and link access to healthcare and social services;
- Need to improve health literacy;
- Navigating complex healthcare systems and insurance continues to be a challenge in the post Affordable Care Act environment.

Several priority populations were identified through the community focus groups and Forces of Change Assessment (FOCA) of the HICCC North Region Report as being more likely to experience inequities in access to care and community resources including low income households, diverse racial and ethnic groups, immigrants and refugees, older adults, children and adolescents, LGBQIA individuals, transgender individuals, people living with physical or intellectual disabilities, individuals living with mental illness, individuals living in residential facilities, those currently or formerly incarcerated, single parents, homeless individuals, veterans and former military, and people who are uninsured. (Health Impact Collaboration of Cook County North Region Report, 2016).

Several communities in the North region have high rates of negative health indicators and poor health outcomes which indicates a possible lack of access to healthcare and community resources.

**Exhibit 13: HICCC North Region Communities with High Rates of Negative Indicators and Poor Health Outcomes**

| Communities in the North region have high rates of negative health indicators and poor health outcomes | |
|---|---|
| Chicago | Suburban Cook County |
| • Albany Park<br>• Avondale<br>• Dunning<br>• Irving Park<br>• Portage Park<br>• Rogers Park<br>• West Ridge | • Des Plaines<br>•Maine Township<br>• Northfield Township<br>• Skokie |

Source: Health Impact Collaborative of Cook County, North Region Report, 2016.

Advocate Children's Hospital's Ronald McDonald Care Mobile Program works to increase access to care for the north region's most vulnerable children. The Care Mobile is a doctor's office on wheels providing free physicals and immunizations to low income and uninsured/underinsured students in the community. In 2015, the Care Mobile team saw 2,292 patients, gave 1,141 physicals and 1,709 vaccines. (Advocate Children's Hospital Utilization Data; Advocate Decision Support System, EPSI, 2015.)

## *Cultural Competency and Humility*

The north region of the HICCC is home to diverse racial and ethnic populations including many immigrants and limited English speaking populations. Focus group participants in the north region observed that immigrants are at increased risk for health issues related to isolation, behavioral health, aging in place, and discrimination and have less access to quality medical care. The importance of culturally and linguistically competent providers across the spectrum of care and prevention programs was mentioned in six of the eight groups. Although language interpretation services are available at hospitals, a few groups cited long wait times for interpreters and incorrect interpretations of medical terminology as barriers to utilizing those services. Participants cited lack of sensitivity to cultural difference as a significant issue impacting health of diverse racial and ethnic groups in the north region. Several participants stated that a lack of cultural sensitivity can result in unfair treatment and perceptions that hospitals are not welcoming to diverse populations. Undocumented immigrants and linguistically isolated individuals were mentioned as being more vulnerable to poor treatment.

Participants recommended sensitivity training for providers and staff to ensure that immigrants feel that they are treated with dignity and respect, and several representatives of community based organizations emphasized the knowledge and expertise that community-based organizations can contribute related to this work. A lack of culturally and linguistically competent staff was also cited as a problem in government agencies including local police and emergency responders. Korean immigrant community members at Hanul Family Alliance stated that they had trouble reporting crimes and communicating with police due to language barriers.

## *Advocate-Sponsored Medicaid Managed Care Program Enrollee Utilization*

Illinois recipients of Medicaid, a federally funded program that assists low-income families or individuals with hospitalization and medical insurance, began enrolling in Medicaid managed care programs in 2014. During this enrollment period, Advocate Health Care offered the largest health care provider-sponsored program in the state. The goal of Medicaid Managed Care is to reduce the cost of providing health care benefits while improving the quality of care and health outcomes of this vulnerable population. Advocate Children's Hospital will manage the health care of approximately 52,000 children in the Hospital's Park Ridge service area. 100,000 children total are enrolled across Advocate Children's Hospital's Oak Lawn and Park Ridge service areas.

Analyzing historical claims utilization data for this population helps the hospital pinpoint services needed to maintain or improve health status for these potentially vulnerable, underserved children. Below represents

utilization rates for currently enrolled pediatric patients. This data reflects what was stated earlier that communities on the North Side of Chicago and North Cook County suburbs have areas of elevated rates of ED visits for asthma. ED visits are indicative of increased exposure to environmental contaminants that can trigger asthma, as well as poorly managed asthma. Relative to access to care issues, this data also makes the comparison between areas of high economic hardship and access to primary care given that patients seek medical care for relatively low level illnesses in the ED. The following area utilization and diagnoses statistics for Medicaid Managed Care patients in the Advocate Children's Hospital Park Ridge service area.

Top 5 Diagnoses for Hospital Admissions of the Pediatric Medicaid Managed Care Patients

- Newborn births
- Bronchitis
- Asthma
- Appendicitis
- Pneumonia

Top 5 Diagnoses for Emergency Department Visits

- Upper Respiratory Infections/Asthma
- General Symptoms
- Otitis Media
- Digestive System Symptoms
- Head Wounds

Top 10 Communities Utilizing Emergency Department Services

- Round Lake
- Wheeling
- Des Plaines
- Elgin
- Palatine
- Avondale (Chicago)
- Mundelein
- Carpentersville
- Des Plaines
- Mount Prospect

Top 10 Communities Utilizing Inpatient Hospital Admissions

- Waukegan
- Des Plaines
- Wheeling
- Elgin
- Dunning (Chicago)
- Mount Prospect
- Mundelein
- Niles
- Portage Park (Chicago)
- Palatine

Source: Advocate Children's' Hospital, Managed Care Data, Clinical Innovations, Advocate Physician Partners, 2015.

## *Advocate Children's Hospital Park Ridge Children's Health Issues to be Addressed 2017-2019*

**Violence and Adverse Childhood Experiences**
Plans include becoming the first trauma-informed children's hospital in the metropolitan Chicago area, as well as furthering the partnership with the Adverse Childhood Experiences (ACE) program of the Health and Medicine Policy Research Group to determine best practices for training the hospital's clinical team on ACEs and their impact on improving health outcomes. Advocate Children's Hospital will also work closely with the Chicago Department of Public Health to assist in reaching its Healthy Chicago 2.0 goal of becoming a trauma-informed city and with Illinois Senator Dick Durbin to support legislation to further trauma-informed care for children.

**Medicaid Managed Care/Population Health Initiative**
Plans include offering targeted, school-based health services to high risk, low income children receiving Medicaid. Services to include primary medical care, immunizations, asthma and weight management, wellness and health education. Advocate Children's Hospital will work closely with the Healthy Schools Campaign and the Chicago Public Schools to develop and pilot a sustainable and replicable model for the delivery of comprehensive and coordinated health services in schools with plans for expansion to the suburban area. The model will include an integrated team of Children's Hospital clinicians and school staff to create an overall environment to promote health and wellness among students, their families and school staff.

Under this model, schools become an important delivery point for screening, prevention and disease management services to support children's physical, mental and behavioral health. Advocate will pilot the program in select schools that have a high percentage of Medicaid Managed Care patients, but is committed to serving all students in the selected schools. Mobile Health Services provided by the Hospital's Ronald McDonald Care Mobile will be an integral part to the school-based, coordinated health program.

**Cultural Competency and Literacy**
Plans include partnering with Advocate Lutheran General Hospital on a health literacy program to provide local high school students with education and training to become competent, health literate individuals. Consideration will also be given to populations of students where English is not the primary language spoken at home in the effort to reduce potential access to care concerns in the community. At a Lutheran General Hospital community health council meeting, Dr. Jennifer Banas, MPH, MSEd, EJD, an Associate Professor at Northeastern Illinois University, presented the program, A*dolescent Health Care Brokering* which will serve as the road map for future programming to be provided.

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