



Community Health Needs Assessment

2014 - 2016



Advocate Illinois Masonic Medical Center



December 2016

Advocate Illinois Masonic Medical Center is honored to serve our community and committed to serving its health needs. We look forward to addressing the issues identified in this Community Health Needs Assessment (CHNA). We believe that collaborating with partners to assess health needs and collectively addressing health issues will have the deepest impact on our community.

Beginning in 2015, Advocate Health Care and Illinois Masonic Medical Center were among the founding organizations of the Health Impact Collaborative of Cook County (HICCC). HICCC is a national best practice model of broad collaboration, funded by hospitals. The collaborative members include 26 hospitals, 7 health departments and nearly 100 community-based organizations working collectively on CHNAs for the North, Central and South regions of Cook County. This CHNA is the result of active participation in the HICCC's North Region, along with aligning this work to the individual needs of Advocate Illinois Masonic Medical Center's primary service area.

In addition to the work with HICCC, Advocate Illinois Masonic Medical Center worked directly with community leaders and formed a Community Health Council (CHC). For the community/public health representatives on the council, special consideration was given to the geographic distribution of council members as well as their representation of unique population groups in the region. Additionally, we collected and analyzed key data for the communities that we serve. Together, all of these efforts guided our work to identify those health issues of the highest priority.

Contained in this report, you will find we are focusing on three health issues: Chronic Disease Prevention/Management, Behavioral Health, and Social Determinants of Health.

On behalf of Advocate Illinois Masonic Medical Center's staff and Governing Council, I hope you find this assessment an effective tool for improving the health of our community. If you would like more information, please contact Lisa Kritz, Director Community Health at 773.296.5804.

Sincerely,

Susan Nordstrom Lopez

President

Advocate Illinois Masonic Medical Center

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I. Executive Summary

Advocate Illinois Masonic Medical Center 2014-2016 Community Health Needs Assessment (CHNA)

The mission, values and philosophy of Advocate Health Care calls Illinois Masonic Medical Center 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 that the medical center serves. The purpose of the medical center's Community Health Needs Assessment is to identify and prioritize health needs that exist within the communities that the medical center serves and to develop a plan to address those needs. Below is a description of the 2014-2016 CHNA process and outcomes.

For the purposes of the 2014-2016 CHNA, the "community" is defined as the Primary Service Area (PSA) of the medical center which consists of 20 zip codes on the North Side of Chicago. Nearly 73% of the medical center's total patient volume comes from its PSA.

The total population of the PSA is 1,198,692 and it is a very diverse area. The communities within the PSA range from wealthy residents along Chicago's lakefront to areas where over 20 percent of the population is living below the poverty level. There are communities of long-time middle and working class Caucasians as well as several areas that are home to financially challenged immigrants. The medical center resides in the nation's first municipally recognized gay neighborhood. The PSA also includes a community area where it is estimated that residents are three times more likely to experience a mental health disorder than other Chicago community areas. (National Health Corps Chicago, Facing Mental Illness in Uptown, Caroline Sacko, Blog, February 14, 2014.)

The percent of the PSA population that is Hispanic is almost twice the percent of Hispanics that live in the US population as a whole. The Non-Hispanic African American population is only 9.9 percent of the PSA, yet 18.93 percent of the medical center's 2015 inpatient population. The Asian and Pacific Islander (non-Hispanic) population in the medical center's PSA (7.3 percent) is larger than the percent of Asian and Pacific Islanders that live in the US as a whole (5.4 percent).

Currently, 10.7 percent of the PSA population is over the age of 65. 16.9 percent of the PSA population over age 65 are living below the federal poverty level. In 2016, 6.9 percent of the PSA population is uninsured. (In the US, 8.4 percent of the population is uninsured.) 25.3 percent of the population within the PSA has Medicaid and 10.2 percent of the population within the PSA has Medicare.

Collaboration was an essential component of this CHNA. Beginning in 2015, Advocate Health Care and Illinois Masonic Medical Center were among the founding organizations of the Health Impact Collaborative of Cook County (HICCC). HICCC is a national best practice model of broad collaboration, funded by hospitals. The collaborative members include 26 hospitals, 7 health departments and nearly 100 community-based organizations working collectively on CHNAs for three regions in Cook County: North, Central and South. This CHNA is the result of active participation in the Health Impact Collaborative of Cook County's North Region collective CHNA process along with aligning this work to the individual needs of Illinois Masonic Medical Center's primary service area.

Many individuals participated in completing this CHNA. Illinois Masonic Medical Center's Community Health Council (CHC) provided oversight to this process. The 22 member CHC was comprised of diverse community and medical center leaders. Two members of the CHC serve on the medical center's Governing Council. The CHC reviewed data and selected three priority community health issues for the communities that the medical center serves. The CHC then submitted the CHNA and the selected health priorities to the Governing Council for approval. The Illinois Masonic Medical Center Governing Council approved the CHNA report on September 27, 2016.

The methodology for this CHNA had three components: 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); and 3) review of other available local and national data (1/2016-6/2016).

The Health Impact Collaborative of Cook County conducted its collaborative CHNA between February 2015 and June 2016. The Illinois Public Health Institute (IPHI), which staffed the collaborative, designed

and facilitated a community-engaged assessment based on the Mobilizing for Action through Planning and Partnerships (MAPP) framework. 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. This process included the use of community surveys as well as focus groups.

Healthy Communities Institute (HCI) data was a primary source of data. This data, customized for the Advocate system, provided access to data for the counties, service areas and zip codes served by the system's hospitals. This robust platform provided the hospitals with 171 indicators including a variety of demographic indicators and 31 hospitalization and emergency department (ED) visit indicators also at the service area and zip code levels.

Illinois Masonic Medical Center staff also collected additional pertinent data for the medical center's PSA and organized all data (including HICCC and HCI) to reflect the community health needs of the medical center's PSA. This data was presented to the medical center's Community Health Council. In addition to data provided by HICCC and HCI, data was collected from the medical center's strategic planning and finance departments, the Illinois Hospital Association, the Chicago Department of Public Health, the Illinois Department of Public Health, the US Census Bureau, the Centers for Disease Control and Prevention and other relevant sources. National data was used when it helped to define an issue.

The data and key findings are discussed at length in the CHNA report. Selected findings include the following:

- The PSA experiences higher rates of behavioral health issues than the whole of Illinois with certain communities within the PSA more deeply affected including: Uptown, Rogers Park, Wicker Park, Dunning, Fort Dearborn and Division Street.
- Chronic diseases accounted for approximately 64 percent of all deaths in Chicago in 2014. The leading causes of death under age 75 in Illinois Masonic Medical Center's PSA in 2010-2011 were: Cancer, Heart Disease, Accidents (excluding motor vehicles), Diabetes, Chronic Lower Respiratory Diseases, Stroke, Intentional self-harm, Chronic Liver Disease, Influenza and Pneumonia, and Kidney Diseases. Asthma, diabetes, hypertension, heart disease, hepatitis and HIV are all found at higher rates in the PSA than in Illinois as a whole. According to the Health Impact Collaborative of Cook County, the following communities in the PSA have the highest burden of chronic disease within the North Region of Cook County: Edgewater, Jefferson Park, Portage Park, Rogers Park and Uptown.
- The top five cancer incidence rates in the PSA (not age adjusted) five year average for 2008-2012 are: Breast Invasive, Prostate, Lung and Bronchus, Colorectal and Leukemia and Lymphomas.
- The Chicago Department of Public Health's Healthy Chicago 2.0, 2016-2020, reports that one in four adults in Chicago were obese in 2014. One in five kindergartners enrolled in Chicago Public Schools were obese in the 2013-2014 academic year.
- According to the Chicago Community Oral Health Forum 2013-2014 study, Healthy Smiles, Healthy Growth, approximately 52 percent of third grade children in Illinois had caries experience, suggesting that tooth decay is still a significant public health problem affecting Illinois children; over 22 percent had untreated decay and 2 percent had an urgent treatment need.
- A substantial amount of data was presented throughout the CHNA regarding the Social Determinants of Health in the medical center's PSA. Data was presented on poverty, income levels, employment and education disparities that exist within the medical center's PSA. The impact of race/ethnicity, income levels and sexual orientation/gender identification on health were discussed. All of these are significant issues impacting the overall health of the medical center's PSA. Additionally, housing instability, violence/sexual abuse and teen births were all identified as areas of need.

After discussion of the data, a ranking process and keeping in line with the medical center's commitment to the Health Impact Collaborative of Cook County process, the Community Health Council selected three issues by a unanimous vote as priority needs for the 2014-2016 Illinois Masonic Medical Center CHNA:

1. Chronic Disease Prevention/Management
2. Behavioral Health
3. Social Determinants of Health

Illinois Masonic Medical Center will strategically work to address these priority needs. Discussions around these issues and how to address them will include an examination of evidence-based, measurable strategies and identification of areas and/or populations that could most benefit from intervention.

Work on the issues will be coordinated with the work of HICCC, the Healthy Chicago Hospital Collaborative and other potential partners.

II. Description of Advocate Health Care and Advocate Illinois Masonic Medical Center

Advocate Health Care

Advocate Illinois Masonic Medical Center (Illinois Masonic Medical Center) 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 as 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, Illinois Masonic Medical Center embraces the Advocate system MVP.

Advocate Illinois Masonic Medical Center

Illinois Masonic Medical Center is a 397-bed teaching medical center located on Chicago's North Side. Illinois Masonic Medical Center is one of only four Level I Trauma Centers in Chicago, treating more than 900 trauma patients a year and has one of Chicago's most active emergency departments (EDs) with more than 44,000 emergency visits annually. The medical center's Level III Neonatal Intensive Care Unit (NICU) holds the state's highest designation. The medical center is fully accredited by Det Norske Veritas (Norway) and Germanischer Lloyd (Germany) (DNV-GL) with the exception of Outpatient Behavioral Health which is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and Laboratory Point of Service Testing which is accredited by The Joint Commission.

Illinois Masonic Medical Center has more than 900 active physicians on staff representing 43 medical specialties. It employs almost 800 registered nurses. The medical center offers a wide range of medical services and is nationally recognized for its medical expertise, innovative technologies, and dedication to patient safety, quality and service. Illinois Masonic Medical Center's major services include: behavioral health, comprehensive surgical services; emergency and trauma services; cancer care; cardiovascular services; digestive disease services; obstetric, midwifery and pediatric services and neuroscience services. Ambulatory and community health services include primary care; a dentistry program, including a mobile dental van; vision services; a deaf and hard of hearing program; the Pediatric Developmental Center; ear,

nose and throat services; urology and urogynecology; physical rehabilitative services; diagnostic imaging services; infusion therapy; pain management; rheumatology; and a unique relationship with school-based health centers.

Currently, the medical center employs over 2,300 associates and has more than 450 volunteers. Illinois Masonic Medical Center trains 225 residents and 563 medical students each year. The medical center is one of Illinois' largest non-university medical teaching hospitals and is affiliated with the University of Illinois at Chicago Health Sciences Center, Rosalind Franklin University and Midwestern University.

Exhibit 1: General Medical Center Annual Statistics 2015

Number of:	Total
Admissions **	14,609
Inpatient Days **	68,697
Emergency Visits ***	44,289
Outpatient Visits ****	152,368
Births	2,400
Surgeries	12,231

**Does not include normal newborn

***ER visits include patients that were admitted

****Outpatient visits include ER patients not admitted

Source: Finance Department, Illinois Masonic Medical Center, 2016.

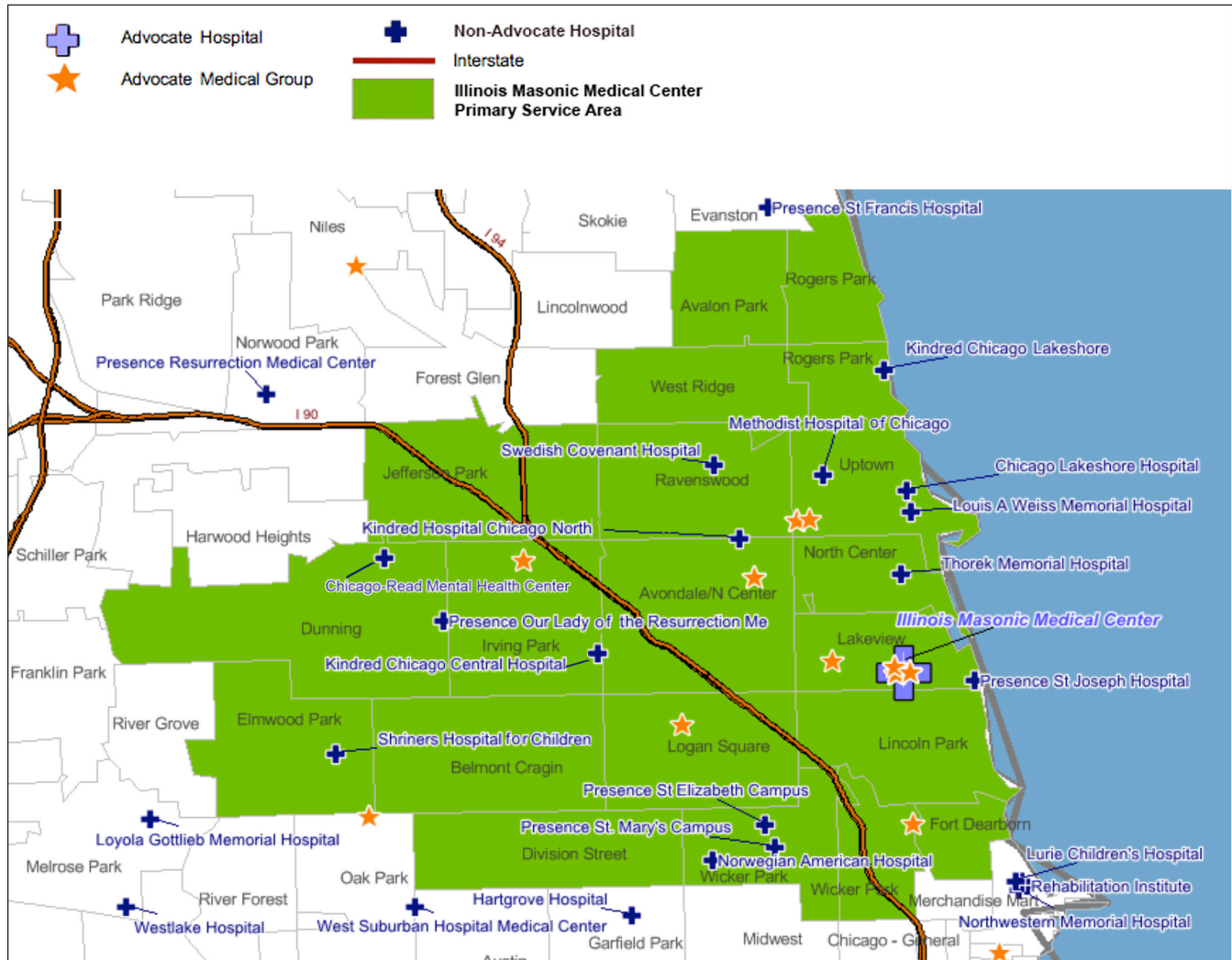
A commitment to community, medical education and ongoing clinical research affirms Illinois Masonic Medical Center's mission of providing patients the highest quality care in Chicagoland. This is illustrated by its many honors, including being ranked one of Illinois' Best Hospitals by *US News & World Report* for the past five consecutive years.

III. Summary of the 2011-2013 Community Health Needs Assessment (CHNA) and Program Implementation

Community Definition

For the purposes of the 2011-2013 CHNA cycle, Illinois Masonic Medical Center defined its “community” as the Primary Service Area (PSA) for the medical center. The medical center’s PSA consisted of 17 zip codes in Northeast Chicago. These zip codes included: 60610, 60613, 60657, 60614, 60618, 60622, 60625, 60626, 60630, 60634, 60635, 60639, 60640, 60641, 60645, 60647 and 60651.

Exhibit 2: Map of Illinois Masonic Medical Center Primary Service Area 2011-2013



Source: Advocate Health Care Strategic Planning Department, 2013.

The medical center’s PSA consisted of 1.2 million people. The White Non-Hispanic population comprised 48.3 percent of the PSA compared to 62.3 percent nationally. The Hispanic population comprised 32.3 percent of the PSA compared to 17.3 percent nationally. Black non-Hispanics accounted for 10.5 percent of the PSA population compared to 12.3 percent nationally. Asian & Pacific Islander Non-Hispanics accounted for 6.9 percent of the PSA compared to 5.1 percent nationally.

Within Illinois Masonic Medical Center’s PSA, one-quarter of households reported an income of \$25K-\$50K, which mirrored the percent total for the United States. Household incomes of \$25K or less were 26.6 percent, which was slightly higher than the percent total for the United States. Sixty-three percent of the population in the PSA had a post-high school education, including 42 percent with a bachelor’s degree or higher, while 16.6 percent reported no high school diploma or equivalent.

The PSA population was 51.1 percent male and 48.9 percent female, with 20.4 percent of the population under 18 years of age and 19.7 percent of the population 55 and older. (Neilsen-Truven Demographic Snapshot, 2012.)

CHNA Process

In 2011, Illinois Masonic Medical Center convened a Community Health Council (CHC) to oversee a comprehensive Community Health Needs Assessment to meet the requirements of the Patient Protection and Affordable Care Act. Data was collected and analyzed in 2011 and 2012.

The Community Health Council was co-chaired by the medical center's Vice President of Mission and Spiritual Care and Community Relations, and the Director of Hispanocare and Community Outreach. The Community Health Council membership was comprised of representatives from the medical center and the community.

Using both primary and secondary community health data, the council identified the medical center PSA's key health needs and then employed a priority-setting process to determine priority health needs on which to focus. This process included an examination of both the medical center's and the community's assets and challenges, and discussions with external and internal key informants to determine the potential for partnerships with other organizations to address the community needs.

Illinois Masonic Medical Center's Governing Council approved the selected priorities in December 2013. In April 2014, the Governing Council endorsed an Implementation Plan that outlined how the priorities selected would be addressed by the medical center.

Needs Identified and Priorities Selected

After reviewing substantial amounts of data, the Community Health Council identified five key areas of need: Behavioral Health, Cancer, Dental Health, Heart Disease and Obesity.

After deliberation, the Community Health Council selected Behavioral Health and Dental Health as the areas of focus for this three-year implementation cycle; based upon the availability of resources, current programs and the opportunities to impact community health outcomes.

Summary of Program Strategies and Outcomes to Meet Identified Priorities

Behavioral Health

First Access

Given the high number of admissions and ED visits for behavioral health conditions at Illinois Masonic Medical Center and the high number of discharged patients that were not keeping their outpatient follow-up appointments, the medical center's Behavioral Health Services Department created the First Access Program in 2013. The goal of First Access is to provide immediate access to follow-up behavioral health services to support recovery and prevent relapses.

Through First Access, behavioral health ED patients, as well as patients referred by the medical center's inpatient psychiatric unit, medical floors and physicians, are walked over to outpatient care by a staff member to ensure same day follow-up for outpatient appointments. Since its implementation, First Access has consistently increased Behavioral Health patients' appointment follow-through rates from 40 percent in 2013 to as high as 90 percent in 2015. Repeat ED visits in a sample representative population decreased by 75 percent from pre-First Access to post-First Access. Inpatient visits in a sample representative population decreased by 50 percent from pre-First Access to post-First Access. In 2015, First Access interventions demonstrated an 80% decrease in depression symptoms among the First Access population.

Dental Health

Mobile Dental Van

The Mobile Dental Van program at Illinois Masonic Medical Center provides access to oral health services for underserved and uninsured individuals. The goal of the Mobile Dental Van is to improve the oral health of vulnerable populations such as low income children and families, homeless individuals, older adults and persons with special needs. Services provided include dental screenings, treatment and education. The Mobile Van sees patients five days per week. In 2015, the program served 19 sites including high schools, elementary schools, organizations that serve the homeless, community health centers, as well as organizations that serve individuals with mental illness, developmental disabilities, and seniors.

In 2015, the program served 566 unique patients, providing 1,443 patient visits. In 2015, there was a 78 percent reduction in diseased teeth from pre and post surveys provided to patients that received services.

Special Needs Dentistry Program

Special needs patients and their families may overlook essential dental care in the face of more urgent health needs. Many dentists lack the training or equipment needed to effectively serve special needs patients and as a result, many people with disabilities lack access to even basic routine dental care. Additionally, patients with special needs may not understand the need for dental care or why a dentist wants to probe inside his or her mouth and may find it challenging to sit in a dental chair for extended periods of time. The Special Needs Dentistry program at Illinois Masonic Medical Center provides oral health care to patients with mental or physical disabilities such as Down syndrome, developmental delays and Cerebral Palsy. In addition to seeing patients at the clinic, the Special Needs Dentistry program provides educational outreach and screening services within the community. The program's dental hygienist travels to schools and residential facilities for the disabled and provides on-site oral hygiene instruction.

The goal of the Special Needs Dentistry Program is to improve access to oral health for children and adults with special needs and therefore to improve the oral health of children and adults with special needs. In 2015, there were 2,263 patient visits that served 104 children and 874 adults with special needs. More than 150 individuals with special needs were screened at Shore Training Center, Chicago Lighthouse for the Blind, Shore Lois Lloyd Center and the Victor C. Neumann Association.

Input from Community for 2011-2013 CHNA

Illinois Masonic Medical Center convened a Community Health Council to oversee its CHNA conducted between 2011 and 2013. Members representing community needs included three local church pastors, a local school principal and a representative from the Chicago Department of Public Health. Additional community representatives were added as the process evolved to fill in any Community Health Council gaps in expertise.

Additionally, the medical center's Governing Council, that gave final approval for the CHNA and its implementation plans, represents leadership from the community. Of the 15 members, eight (53 percent) represent the community.

After the CHNA was completed, it was posted on the medical center's website for public comment. Subsequently, the CHNA's progress has been posted on the medical center's website each year for community information and comment. No comments have been received from the public regarding the 2011-2013 CHNA report or implementation plan.

Lessons Learned from the 2011-2013 CHNA

Valuable lessons were learned from conducting the 2011-2013 CHNA. The medical center recognized that a great deal of duplication may be avoided, more in-depth data/research may be produced and broader reaching issues may be addressed if the CHNA process is conducted in a more collaborative manner. Thus, in 2015, the medical center began participating in the Health Impact Collaborative of Cook County, a project involving 26 hospitals, 7 health departments and nearly 100 community-based organizations. The goal of this initiative is to work collaboratively on a CHNA and an implementation plan once priorities have been identified. The medical center is also participating in another collaborative in Chicago; the Healthy Chicago Hospital Collaborative. The purpose of this collaborative is to collectively address three priorities that were identified during the previous CHNA cycle—mental health, obesity and access to care.

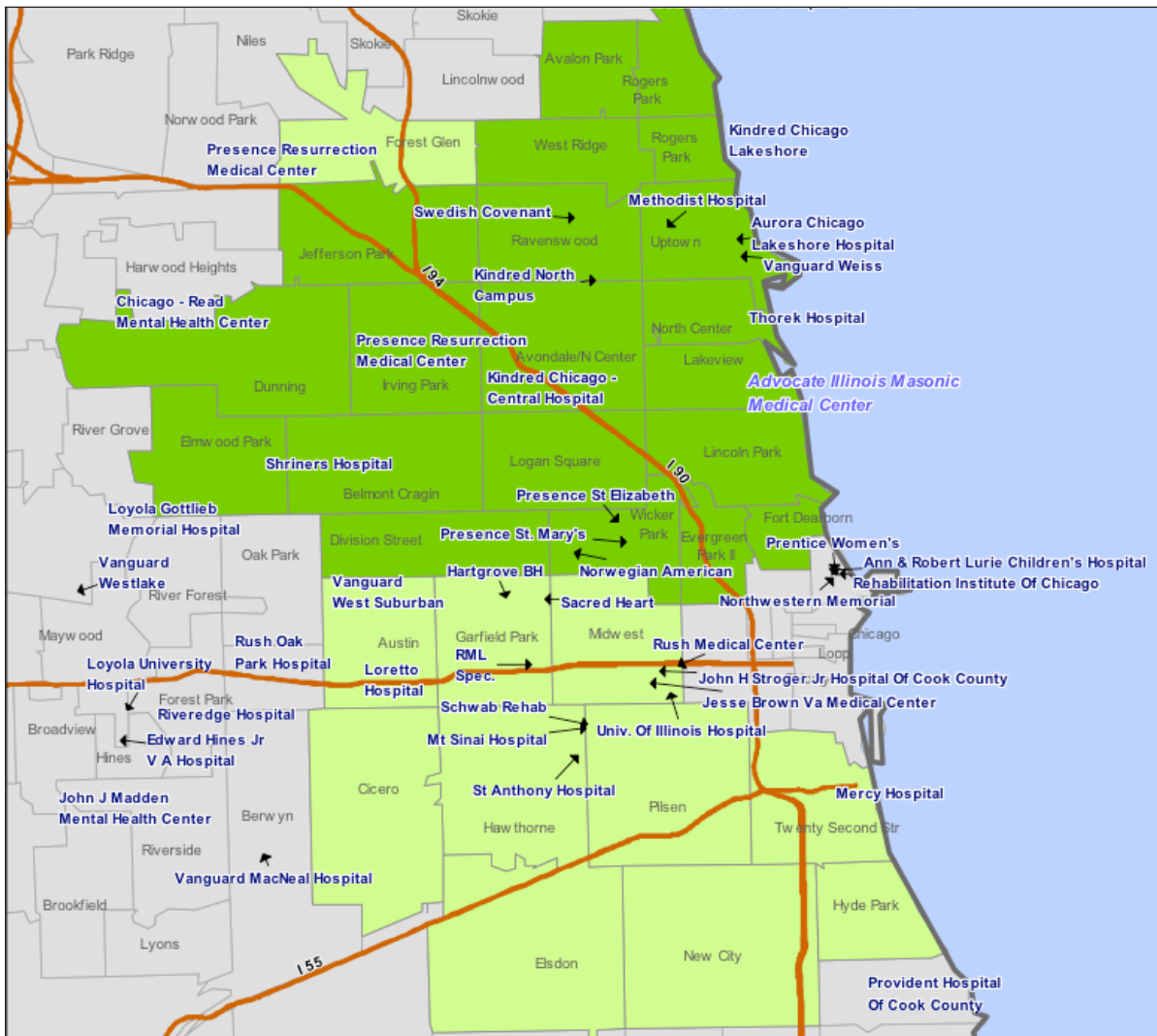
IV. 2014-2016 Community Health Needs Assessment

CHNA Community Definition

Nearly 73 percent of Illinois Masonic Medical Center’s total patient volume is from its Primary Service Area (PSA) while 7.2 percent comes from the Secondary Service Area (SSA), and 19.9 percent of the patient population comes from outside of the Total Service Area (TSA). (Illinois Masonic Medical Center Patient Origin Report, 2015.) Therefore, for the purpose of this CHNA, “community” is defined as the medical center’s PSA.

In 2016, the total population for the PSA is 1,198,692. (The Nielsen Co., Truven Health Analytics Inc., 2016.)

Exhibit 3: Map of Illinois Masonic Medical Center Primary Service Area



Source: Advocate Health Care Strategic Planning Department, 2016.

The PSA consists of 20 zip codes with the following community areas assigned to each by the medical center’s Strategic Planning Department: 60610 (Fort Dearborn), 60640 (Uptown), 60613 (North Center), 60641 (Irving Park/Portage Park), 60614 (Lincoln Park), 60642 (Wicker Park), 60618 (Avondale/North Center), 60645 (West Ridge), 60622 (Wicker Park), 60647 (Logan Square), 60625 (Ravenswood), 60651 (Division Street), 60626 (Rogers Park), 60657 (Lakeview), 60630 (Jefferson Park), 60659 (West Ridge), 60634 (Dunning), 60660 (Rogers Park), 60639 (Belmont Cragin) and 60707 (Elmwood Park).

The City of Chicago divides Chicago into 77 unique community areas. Below is a City of Chicago Community Area Map. The dark line outlines the medical center’s PSA.

Exhibit 4: City of Chicago Communities Within Illinois Masonic Medical Center PSA 2016



Source: The Chicago 77, 2016. (<http://www.thechicago77.com/about-the-chicago-77/>)

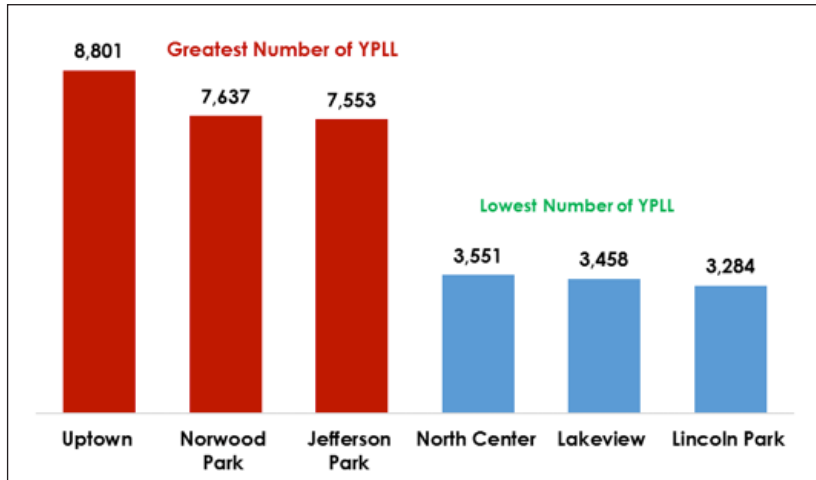
Consideration of the zip codes comprising the PSA reveals that Illinois Masonic Medical Center serves residents of the following community areas as defined by the City of Chicago: Near North Side, Lincoln Park, Lakeview, Uptown, Edgewater, Rogers Park, West Ridge, Lincoln Square, North Park, Albany Park, Avondale, Logan Square, West Town, Jefferson Park, Portage Park, Belmont Cragin, Humboldt Park, Dunning, Elmwood Park, Evergreen Park, Hermosa, Irving Park, North Center and Montclare.

Communities identified by the medical center’s Strategic Planning Department and the City of Chicago will be referred to throughout this report. Community designation will vary depending on what source of data is being referenced.

Illinois Masonic Medical Center’s PSA is a diverse area. The communities within the PSA range from wealthy residents along Chicago’s lakefront to areas where over 20 percent of the population is living below the poverty level. There are communities of long-time middle and working class Caucasians as well as several areas that are home to financially challenged immigrants. The medical center resides in the nation’s first municipally recognized gay neighborhood. The percent of the PSA population that is Hispanic is almost twice the percent of Hispanics that live in the US population as a whole. The PSA also includes a community area where it is estimated that residents are three times more likely to experience a mental disorder than other Chicago community areas. (National Health Corps Chicago, Facing Mental Illness in Uptown, Caroline Sacko, Blog, February 14, 2014.)

Below is a chart illustrating the level of health diversity that exists within the PSA. This exhibit shows Years of Potential Life Lost (YPLL), comparing communities within Chicago in the North Region of Cook County with the highest number of YPLL to Chicago communities in the North region of Cook County with the lowest number of YPLL. Five of the communities are within Illinois Masonic Medical Center’s PSA. All three of the lowest YPLL numbers are in the PSA, while two of the communities with the highest number of YPLL are also in the PSA (Uptown and Jefferson Park).

Exhibit 5: Years of Potential Life Lost (YPLL) comparing Communities in Chicago in the North Region of Cook County 2009-2013



Source: Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region, 2016; Chicago Department of Public Health Data, 2009-2013.

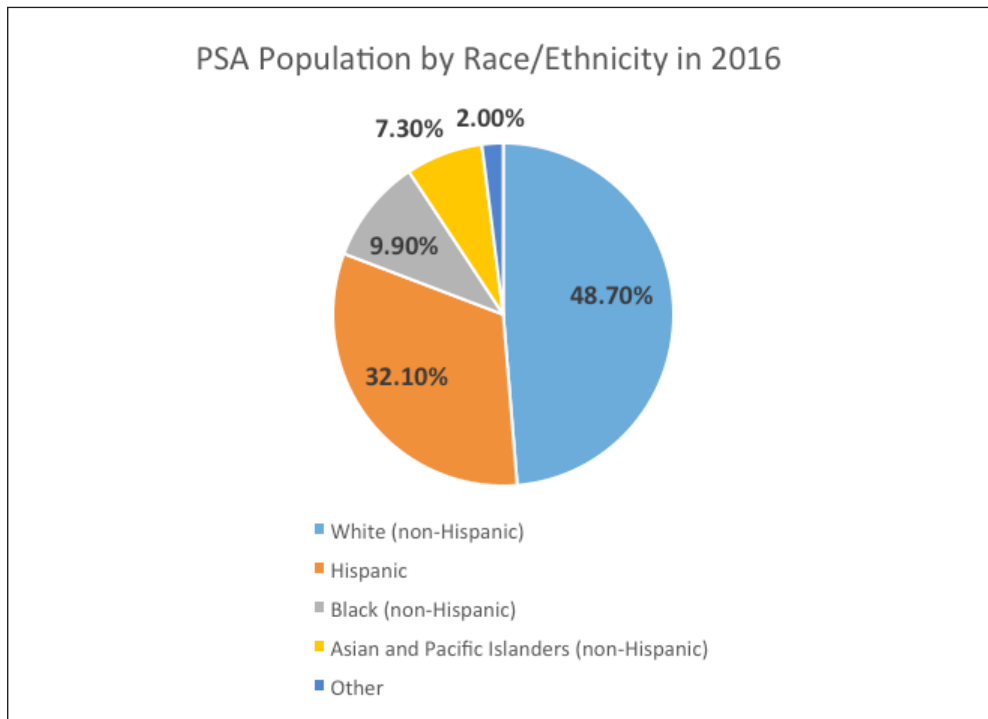
Sociodemographic Description of PSA

The term “sociodemographic” refers to sociological and demographic characteristics. The importance of understanding the sociodemographic characteristics of a group or area lies in its contribution to identifying the issues and demands of given populations. Below are some sociodemographic descriptions of Illinois Masonic Medical Center’s PSA or sociodemographic information that is relevant to the medical center’s PSA.

Race/Ethnicity

Two charts are presented here to reflect the racial/ethnic make-up of the community that Illinois Masonic Medical Center serves. The first chart shows the race/ethnicity percentages of people living within the medical center’s PSA. The second chart shows the race/ethnicity percentages of patients that the medical center serves.

Exhibit 6: Illinois Masonic Medical Center PSA Population by Race/Ethnicity 2016



Source: The Nielsen Co., Truven Health Analytics Inc., 2016.

Exhibit 7: Percent of Illinois Masonic Medical Center Patients Served in Inpatient, Outpatient and Emergency Department (ED) Settings by Race/Ethnicity 2015

Race/Ethnicity	Total Inpatient	Total Outpatient	Outpatient/ED
Non-Hispanic Caucasian	36.70%	39.29%	39.34%
Hispanic	30.92%	35.92%	36.80%
Non-Hispanic-African American	18.93%	16.50%	18.48%
Non-Hispanic Asian	3.82%	4.43%	2.94%
Non-Hispanic-Native American/ Alaska Native	.33%	.30%	.26%
Non-Hispanic-Pacific Islander/ Hawaiian	.11%	.12%	.08%
Other	.29%	.22%	.18%
Unknown	8.90%	3.21%	1.92%

Source: Finance Department, Illinois Masonic Medical Center, 2016.

The medical center’s PSA has a large percentage of Hispanic residents (32.1 percent). This is almost double the percentage of Hispanics that live in the US as a whole. The medical center also serves a high percentage of Hispanic patients—30.92 percent of inpatients and 35.92 percent of outpatients in 2015. In 2015, Illinois Masonic Medical Center’s Strategic Planning Department projected that by 2020, the Hispanic population in the TSA will increase 2.7 percent.

The Non-Hispanic African American population is only 9.9 percent of the PSA, although it comprises 18.93 percent of the medical center’s 2015 inpatient population and 16.50 percent of the medical center’s 2015 outpatient population. In 2015, Illinois Masonic Medical Center’s Strategic Planning Department estimated that by 2020, the African American population will decline by 5.8 percent in the TSA.

The Asian and Pacific Islander (non-Hispanic) population in the medical center’s PSA (7.3 percent) is larger than the percent of Asian and Pacific Islanders that live in the US as a whole (5.4 percent.) In 2015, Illinois Masonic Medical Center’s Strategic Planning Department estimated that by 2020, the Asian population will increase by 7.2 percent in the TSA.

The race/ethnicity percentages for the PSA have remained fairly constant since the last CHNA was conducted.

Below is a table of Chicago community areas within Illinois Masonic Medical Center’s PSA by race/ethnicity. While the PSA as a whole consists of different percentages of racial/ethnic groups, the community areas within the PSA do as well. In some cases, a particular racial/ethnic group may account for a large percentage of a given community area. For example, there are two communities that are over 80% White (Lincoln Park and Lakeview). There are six community areas that are over 50% Hispanic (Avondale, Logan Square, Humboldt Park, Hermosa, Montclare and Belmont Cragin). There is one community area that is over 40% Non-Hispanic African American (Humboldt Park). There are two communities that are over 20% Non-Hispanic Asian (West Ridge and North Park).

Exhibit 8: Chicago Community Areas within Illinois Masonic Medical Center PSA by Race/Ethnicity 2010

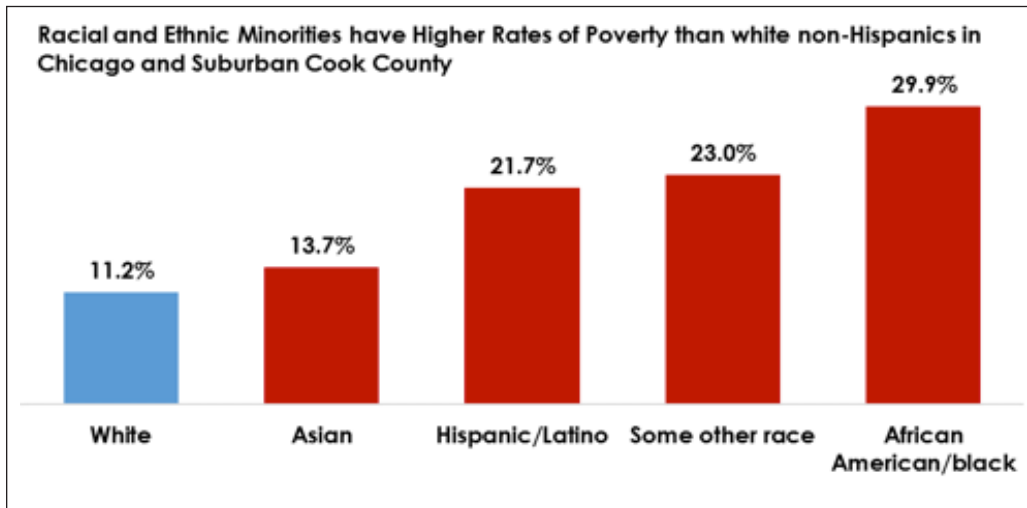
Community	% White	% Non-Hispanic African American	% Hispanic	% Non-Hispanic Asian
USA	63.7%	12.2%	16.3%	4.7%
Chicago	31.7%	32.9%	28.9%	.1%
Illinois	63.7%	14.3%	15.8%	4.5%
Near North	72.1%	10.8%	4.9%	10.1%
Lincoln Park	82.9%	4.3%	5.6%	5.1%
Lakeview	80.4%	3.9%	7.6%	6.0%
Uptown	51.6%	20%	14.2%	11.4%
Edgewater	54.7%	14.3%	16.5%	11.6%
Rogers Park	39.3%	26.3%	24.4%	6.4%
West Ridge	42.7%	11.1%	20.4%	22.5%
Lincoln Square	63.1%	3.8%	19.1%	11.1%
North Park	49.3%	3.2%	18%	25.7%
Albany Park	29.2%	4.0%	49.4%	14.4%
Avondale	28.4%	2.5%	64.4%	3.0%
Logan Square	39.6%	5.3%	50.7%	2.6%
West Town	57%	7.8%	29.3%	3.7%
Jefferson Park	68.7%	1%	19.4%	8.9%
Portage Park	53.5%	1.3%	38.8%	4.6%
Belmont Cragin	15.2%	3.2%	78.9%	2%
Humboldt Park	4.4%	40.9%	53.3%	.4%
Dunning	70.4%	.7%	23.8%	3.8%
Elmwood Park	72.1%	1.9%	23%	2.3%
Evergreen Park	68.7%	18.7%	10.3%	1.2%
Hermosa	7.6%	3%	87.4%	1.2%
Irving Park	41.7%	3.3%	45.6%	7.1%
North Center	73.3%	2.3%	13.6%	4.5%
Montclare	37.5%	4.5%	54%	2.8%

Source: Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region, 2016; US Census Bureau, 2010.

Economic Disparities by Race/Ethnicity

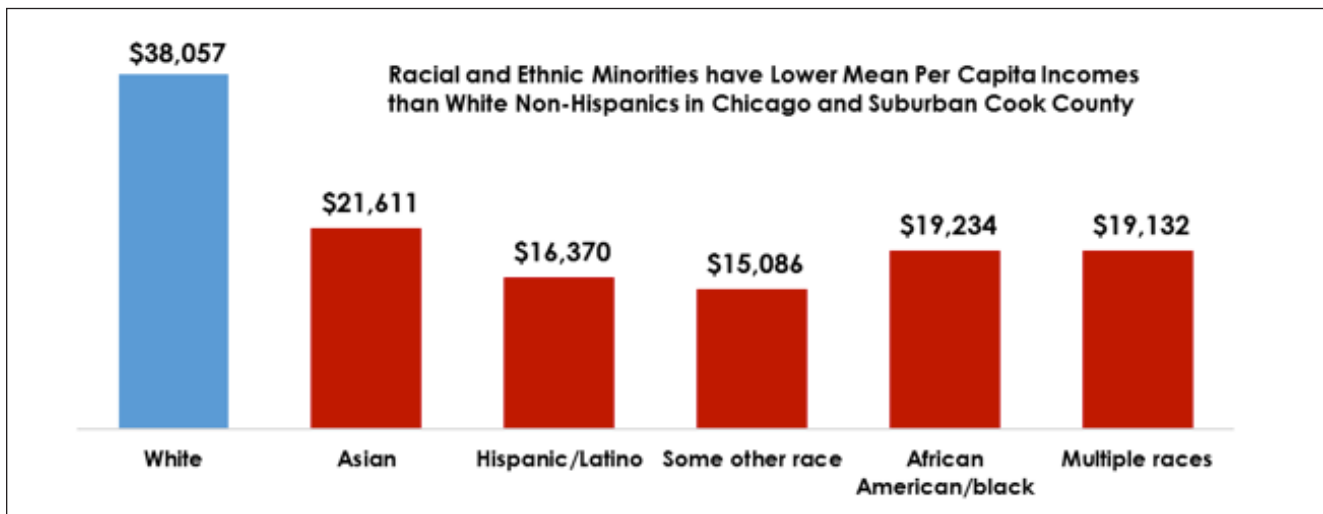
Understanding the racial/ethnic make-up of the PSA only tells part of a story. Economic disparities exist between racial/ethnic groups. The data below shows these disparities in the northern region of Cook County. African Americans are the racial/ethnic group with the highest percentage of people living below 100 percent of the federal poverty level, have lower per capita income and the highest unemployment rate. The Hispanic population has almost twice the percentage of people living below 100 percent of the federal poverty level than Whites, less than half of the per capita income of Whites and the second highest unemployment rate. These populations of color experience economic disparities.

Exhibit 9: Percentage of the Population Living at or Below 100% of the Federal Poverty Level in the North Region of Cook County by Race and Ethnicity 2009-2013



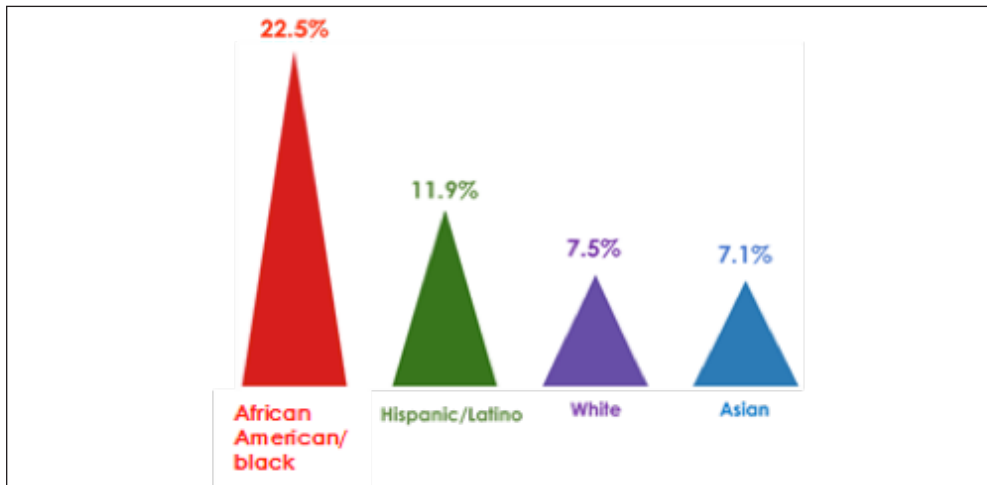
Source: Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region, 2016; American Community Survey, 2009-2013.

Exhibit 10: Per Capita Income in the North Region of Cook County by Race and Ethnicity 2009-2013



Source: Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region, 2016; American Community Survey, 2009-2013.

Exhibit 11: Unemployment Rates in the North Region of Cook County by Race and Ethnicity 2009-2013



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

Income

There is great diversity of income levels existing within the Illinois Masonic Medical Center PSA. While 26.7 percent of the PSA was reported in 2016 to have had a household income of over \$100,000 annually, there are eight community areas in the PSA where over 20 percent of the population lives below the federal poverty level.

Exhibit 12: Household Income Distribution in PSA 2016

Household Income	% of PSA Population	% of US Population
<\$15K	14.5%	12.3%
\$15-25K	9.6%	10.4%
\$25-50K	21.7%	23.4%
\$50-75K	16.3%	17.6%
\$75-100K	11.2%	12.0%
Over \$100K	26.7%	24.3%

Source: The Nielsen Co., Truven Health Analytics Inc., 2016.

Exhibit 13: PSA Community Populations living in Households with Incomes below the Federal Poverty Level 2009-2013

USA	15.6%
Chicago	22.6%
Illinois	14.1%
PSA Communities	
Humboldt Park	34.7%
Rogers Park	27.7%
Uptown	25.9%
Albany Park	20.9%
West Ridge	20.8 %
Belmont Cragin	20.6%
Logan Square	20.4%
Hermosa	20.3%
Avondale	18%
Edgewater	17.8%
West Town	16%
Irving Park	14.5%
Montclare	14%
Portage Park	13.6%
Near North	13.1%
Lincoln Park	12.7%
Lincoln Square	12.7%
Lakeview	12.2%
North Park	11.7%
Dunning	10.4%
Evergreen Park	8.7%
Elmwood Park	7.7%
Jefferson Park	7.7%
North Center	5.9%

Source: Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region, 2016; US Census Bureau, American Community Survey, 2009-2013.

Education and Employment

In 2016, the unemployment rate for the population over age 16 within the medical center’s PSA was 9.2 percent. The United States unemployment rate for the population over age 16 was 5.8 percent. In terms of education, in 2016, 15.3 percent of the medical center’s PSA population over 25 years old had no High School diploma. This is compared to 13.6 percent of the entire US population over 25 years old that had no High School diploma. Forty-four percent of the PSA over the age of 25 holds a Bachelor’s Degree or greater compared to 29.4 percent of the US population in 2014. (The Nielsen Co., Truven Health Analytics Inc., 2016.)

Health Insurance Coverage

In 2016, 6.9 percent of the Illinois Masonic Medical Center PSA population was uninsured compared to 8.4 percent of the US population as a whole. Medicaid covered 25.3 percent of the PSA, while Medicare covered an additional 10.2 percent. (Truven Insurance Coverage Estimates, 2016.) However, as can be seen in Exhibit 14, over 30 percent of medical center admissions in 2015 were for patients covered by Medicare and 29 percent for patients covered by Medicaid.

Exhibit 14: Illinois Masonic Medical Center Reported Payer Mix for Admissions 2015

Source	% of Admissions
Medicare	30.97%
Medicaid	29%
Managed Care	14.48%
Blue Cross	21.68%
Self-Pay	2.68%
Other	1.12%

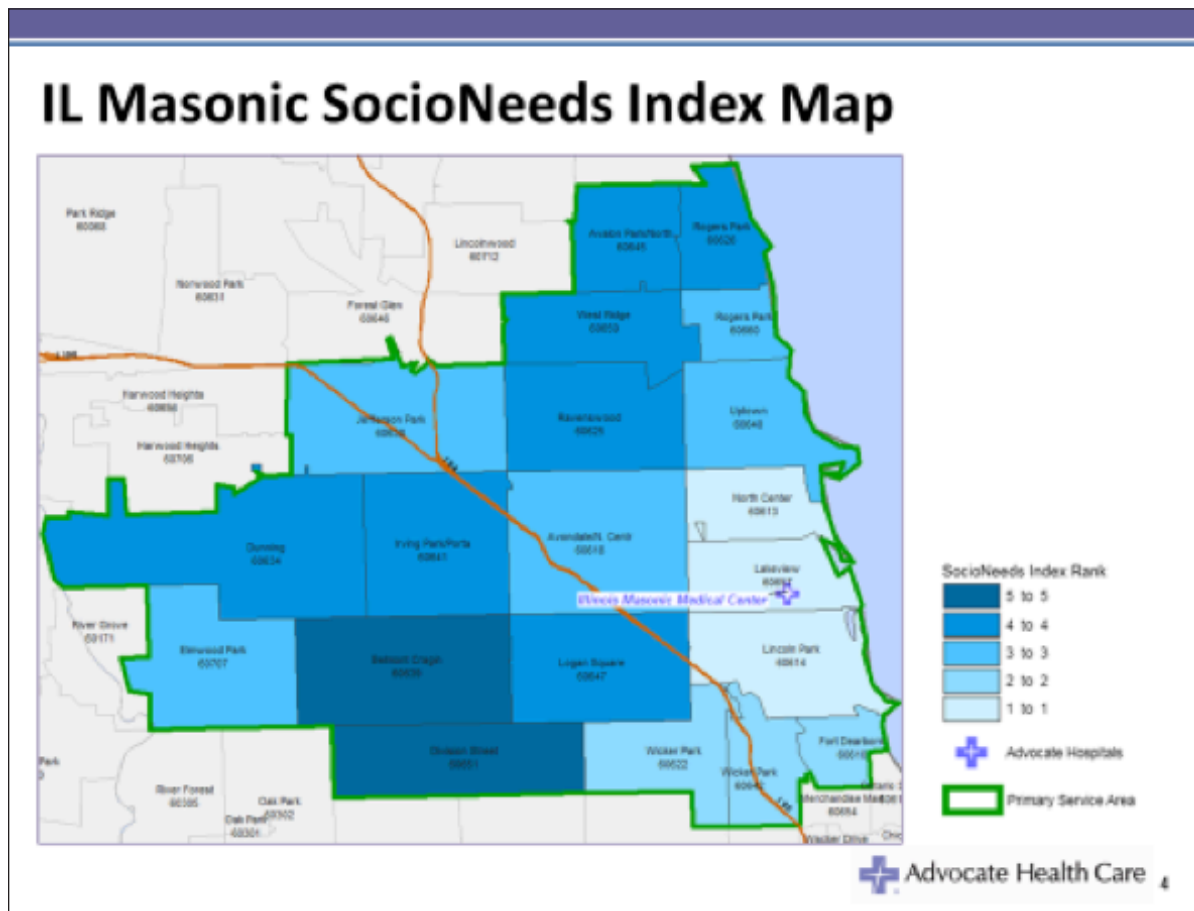
Source: Finance Department, Illinois Masonic Medical Center, 2016.

Socioeconomic Need

To clearly illustrate the disparity of income and other socioeconomic factors that exist within Illinois Masonic Medical Center's PSA, it is useful to examine a map of the PSA that indicates areas of high socioeconomic need. 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 socioeconomic need. The ranking of 1-5 is a comparison of each zip code to all others within the PSA; a 5 represents areas of highest socioeconomic need in comparison to others in the specific geographic area under consideration.

The two areas in the darkest blue, with an index rank of 5, have overall index scores in the high 90's. The areas with an index rank of 4, have overall index scores that lie between 68.8 and 82.6. The areas with an index rank of 1 have overall index scores of between 3.9 and 9.6.

Exhibit 15: Illinois Masonic Medical Center SocioNeeds Index Map



Source: Healthy Communities Institute, 2016.

Languages Spoken

In a 2014 report that surveyed hospital patients about the languages they spoke:

- 13.5 percent reported speaking Spanish.
- 1.6 percent reported speaking Polish.
- Other languages frequently reported by less than 1 percent of the patients were sign language, Vietnamese, Serbian, Russian, Hindi, Bosnian and Arabic.

The Health Impact Collaborative of Cook County examined limited English proficiency by communities using data from the American Community Survey, 2009-2013. Three community areas from Illinois Masonic Medical Center’s PSA were identified as communities within the North Region as having the highest percentages of households with limited English proficiency. They were: Avondale, Albany Park and West Ridge.

Gender

Exhibit 16: PSA Population by Gender 2016

Male	49.7%
Female	50.3%

Source: The Nielsen Co., Truven Health Analytics Inc., 2016.

Additionally, 24.4 percent of the total PSA population was reported as females of child bearing ages (15-44.)

Sexual Orientation and Gender Identification

Limited community demographic data exists for the Lesbian, Gay, Bisexual, Queer, Intersex and Asexual (LGBQIA) and Transgender population. However, the following data helps to define the predominance of this population in the medical center's PSA:

- Illinois Masonic Medical Center resides in the nation's first municipally recognized gay neighborhood.
- According to the website ChooseChicago.com, this neighborhood "is one of the largest lesbian, gay, bisexual and transgender communities in the United States."
- According to a 2014 USA Today article, this neighborhood "and its adjacent neighborhood account for about 12 percent of the city's self-identified same-sex households according to Census figures. It is the highest concentration in Chicago."
- According to provisional data from the Chicago Department of Public Health, based upon a 2015 *Healthy Chicago Survey*, it is estimated that 116,293 persons in Chicago identify as Lesbian, Gay or Bisexual.
- According to staff from Howard Brown Health Clinic (HBH), a health center in the medical center's PSA that serves the Lesbian, Gay, Bisexual, Queer, Intersex and Asexual (LGBQIA) and Transgender population, from 2010-2015, there was a 370 percent increase in Transgender/Gender Non-Conforming (TGNC) patients at the clinic. Thirty new TGNC patients join HBH per month. As of 2016, the clinic had 2,100 TGNC patients.

Age

Exhibit 17: Age Distribution in PSA 2016

Age	% of PSA
0-14	17.8%
15-17	2.9%
18-24	7.9%
25-34	21.5%
35-54	29.1%
55-64	10.2%
65+	10.7%

Source: The Nielsen Co., Truven Health Analytics Inc., 2016.

The 25-34 age group (21.5 percent) is significantly higher than the national percentage for this age group (13.3 percent.)

While only 10.7 percent of the PSA population is individuals 65 years of age and older, this population accounted for 42 percent of Illinois Masonic Medical Center's 7,669 medical and surgical admissions in 2014. (Hospital Profile submitted to Illinois Department of Public Health by Illinois Masonic Medical Center, 2014.) Additionally, according to the Strategic Planning Department at Illinois Masonic Medical Center, the 65+ age group is the fastest growing segment of the population, with a projected growth of 16 percent in the next five years.

In 2010-2014, the percent of people 65 years and older living below the poverty level in the medical center's PSA was 16.9 percent. (Healthy Communities Institute, American Community Survey, 2010-2014.) Healthy Communities Institute also reported that Illinois Masonic Medical Center's PSA had a higher percent of people over 65 years old living below the poverty level in comparison to other counties in the United States.

Key Roles in the 2014-2016 Community Health Needs Assessment

This CHNA is the result of active participation in the Health Impact Collaborative of Cook County's collective CHNA process and alignment of this work with the identified needs in Illinois Masonic Medical Center's own PSA. It is the product of work conducted by several key players. Below is a description of those players.

System and Medical Center 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, 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 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 had hospital-specific detailed inpatient, outpatient and emergency department data.

By the end of 2014, a new Department of Community Health was established at Advocate Health Care under Mission and Spiritual Care, a vice-president was named to lead the department and a plan was developed to ensure that each hospital in the system would have ample resources to complete their respective CHNAs. In 2015, participation began in the Health Impact Collaborative of Cook County. A master's prepared director of community health began at Illinois Masonic Medical Center in January of 2016, responsible for coordinating and promoting the medical center's involvement in policies, programs and services to improve the overall health status of the communities it serves. The Community Health Needs Assessment process, the convening of the Community Health Council and the co-administering of the medical center's community benefits reporting process are all responsibilities of the director of community health.

Health Impact Collaborative of Cook County (HICCC)

In 2015, Advocate Health Care and its five hospitals principally serving Cook County (including Illinois Masonic Medical Center) contributed financially and provided in-kind resources to the formation and development of the Health Impact Collaborative of Cook County, a project 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) serves as the backbone organization for the collaborative including coordinating the data collection and report preparation activities.

Cook County is a county in northeastern Illinois that includes Chicago and several of its closer suburbs. Cook County's population is 5,294,664 (Oxford Dictionary, 2016.) The City of Chicago's population is 2,695,598 (City of Chicago Website, 2016); just about half of the population of Cook County. The Primary Service Area for Illinois Masonic Medical Center is located on the North Side of Chicago, including only one suburb. The PSA population is 1,198,692; a little less than half of the population of Chicago.

Given the size and diversity of Cook County (second largest county in the United States), the collaborative created three regions--North, Central and South—for purposes of organizing the assessment process. Illinois Masonic Medical Center was appropriately assigned to the North Region consisting of both the North Side of Chicago as well as some of the northern suburbs of Chicago.

Non-Hispanic whites are the largest racial or ethnic group in the North region, representing 64 percent of the population. Asian residents make up 10.8 percent of the North region. Approximately 17.8 percent of individuals in the North region identify as Hispanic/Latino and 5.6 percent identify as African American/Black. Despite an overall decrease in the total population of the North region, the Asian and Hispanic/Latino populations grew by 6 percent and 7 percent, respectively, between 2000 and 2010.

As will be described in more detail in the accompanying report—Health Impact Collaborative of Cook County: Community Health Needs Assessment, North Region—a regional leadership team was formed for the North region including representatives from the hospitals and health departments in the region. A regional stakeholder group was also organized including members of community organizations representing various sectors. 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.

Illinois Masonic Medical Center Community Health Council

In January 2016, the Community Health Director began re-forming a Community Health Council (CHC) for the Illinois Masonic Medical Center. The CHC serves as a decision-making and advisory body to medical center leadership and the medical center Governing Council regarding community health assessment, strategies and programs. The goal of the CHC is to improve the health equity and the overall health status of the communities that the medical center serves. The objectives of the CHC are to identify the health needs of the communities that the medical center serves; determine priority areas of need; advise on evidence-based strategies to address those needs; and assist in the evaluation of implemented community health programs and services that have medical center involvement. A principal responsibility of the CHC is participation in the medical center's Community Health Needs Assessment process.

The new CHC charter explicitly stated: "Membership of the CHC will consist of medical center staff who have involvement in policies, programs and/or services that improve the health equity and/or the overall health status of the communities that the medical center serves; two medical center Governing Council members and a minimum of 30 percent representation from community and/or public health organizations."

For the community/public health representation, special consideration was given to the geographic distribution of council members as well as representation of unique population groups in the region. The Community Health Council was instrumental in shaping the assessment findings and priority issues that are presented in this CHNA.

The 2016 CHC consists of twenty two members—45 percent of which are representatives from the community and/or public health organizations. Members include:

- Asian Health Coalition, Executive Director
- Centro Romero, Resource Developer
- Chicago Department of Public Health, Director, Healthy Chicago 2.0
- Chuhak & Tecson, Principal; Illinois Masonic Medical Center Governing Council Member
- Heartland Health Centers, Vice President, Strategy and Development
- Howard Brown Clinic, Manager, Clinical Quality Improvement
- Illinois African American Coalition on Prevention, Coordinator, Special Initiatives
- Lakeview Rehabilitation and Nursing Center, Chief Operations Officer of Parent Organization
- Metropolitan Family Services, Director, North Center
- Northeastern Illinois University, Professor, Community Health and Wellness Program
- WJ Brodine & Co, President*; Illinois Masonic Medical Center Governing Council Member
- Illinois Masonic Medical Center, Vice President, Clinical Operations
- Illinois Masonic Medical Center, Director, Community Health*
- Illinois Masonic Medical Center, Director, Hispanocare and Community Outreach
- Illinois Masonic Medical Center, Director, Medical Education
- Illinois Masonic Medical Center, Director, Physician Services
- Illinois Masonic Medical Center, Faith Community Nurse
- Illinois Masonic Medical Center, First Year Medical Resident
- Illinois Masonic Medical Center, Manager, Case Management
- Illinois Masonic Medical Center, Manager, Community Relations
- Illinois Masonic Medical Center, Manager, Strategic Planning and Business Development
- Illinois Masonic Medical Center, Special Projects Coordinator, Foundation and Physician Services

*CHC Co-Chairs

Illinois Masonic Medical Center Governing Council

The principal roles of each Governing Council member are: 1) to support medical center leadership in their pursuit of the medical center's goals; and 2) to represent the community's interests to the medical center and to serve as an ambassador in the community. The role of the Governing Council for the Community Health Needs Assessment, specifically, is to review and approve the recommendations of the Community Health Council regarding the CHNA. In addition, two Governing Council Members serve on the CHC, and one co-chairs the CHC.

The Governing Council at Illinois Masonic Medical Center also represents leadership from both the medical center and the community. Of the 15 members, eight, or 53 percent, represent the community.

Methodology Used for the 2014-2016 Community Health Needs Assessment

The methodology for this CHNA had three components: 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); and 3) review of other available local and national data (1/2016-6/2016).

MAPP Process/Health Impact Collaborative of Cook County

The Health Impact Collaborative of Cook County conducted its collaborative CHNA between February 2015 and June 2016. IPHI designed and facilitated a 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 as well.

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.

Exhibit 18: MAPP Framework



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 its 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, as well as data from their respective Community Health Status Assessments.

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 could be used to improve communities.

More detail on the findings of the MAPP Assessments can be found in the companion to the Illinois Masonic Medical Center CHNA report—Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region. The HICCC report, along with this report, are also available online at <http://www.advocatehealth.com/chnareports> or the HICCC report can be found at <http://www.healthimpactcc.org/reports2016>.

Community Surveys

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 percent) 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 with hospitals, health departments, and stakeholders from the three 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)³ of survey respondents in the North region identified as Hispanic/Latino and approximately 4% identified as Middle Eastern (n=1082). 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).

²Written 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.

³Race 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, LGBTQIA 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:

1. To understand the needs, assets and potential resources in the different communities of Chicago and suburban Cook County.
2. To start to gather ideas about how hospitals can partner with communities to improve health.

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.

Exhibit 19: Health Impact Collaborative of Cook County Focus Groups in North Region 2016

Focus Groups	Location (Date)
Adult Down Syndrome Center (Advocate Lutheran General Hospital) 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 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 Participants were Korean-American community members.	Albany Park, Chicago, Illinois (1/13/16)
Harper College 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 Participants included representatives from local social service organizations, clinics, hospitals, and community groups.	Rogers Park, Chicago, Illinois (1/20/16)
Howard Brown Health Participants were LGBTQIA 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 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 Focus group participants were Polish American staff who were also community members.	Portage Park, Chicago, Illinois (2/9/16)

Focus groups within the Illinois Masonic Medical Center PSA included the groups held at Howard Brown Health Center, Asian Human Services, Hanul Family Alliance, Polish American Association and Healthy Rogers Park Network.

Use of Healthy Communities Institute Data Platform

Since early 2014, each hospital in the Advocate system has had access to the Healthy Communities Institute data platform; customized to the system and 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 including a variety of demographic indicators and 31 hospitalization and emergency department (ED) visit indicators also at the service area and zip code levels. Utilizing the Illinois Hospital Association's COMPdata data, 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 Socio Needs 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 hospitalization and emergency department utilization data at the zip code level, enabling more in-depth analysis of at-risk communities.

Review of Other Available Local and National Data

Between April of 2016 and June of 2016, Illinois Masonic Medical Center staff collected additional pertinent data for the medical center's PSA and organized all data (including HICCC and HCI) to reflect the community health needs of the medical center's PSA. In addition to data provided by HICCC and HCI, data was collected from the medical center's strategic planning and finance departments, the Illinois Hospital Association, the Chicago Department of Public Health, the Illinois Department of Public Health, the US Census Bureau, the Centers for Disease Control and Prevention and other relevant sources. National data was used when helpful to define an issue. A comprehensive list of data sources can be found in Appendix 1. PSA data was organized as socioeconomic data, health/disease indicator data or health disparities data.

Key Findings for Illinois Masonic Medical Center's PSA

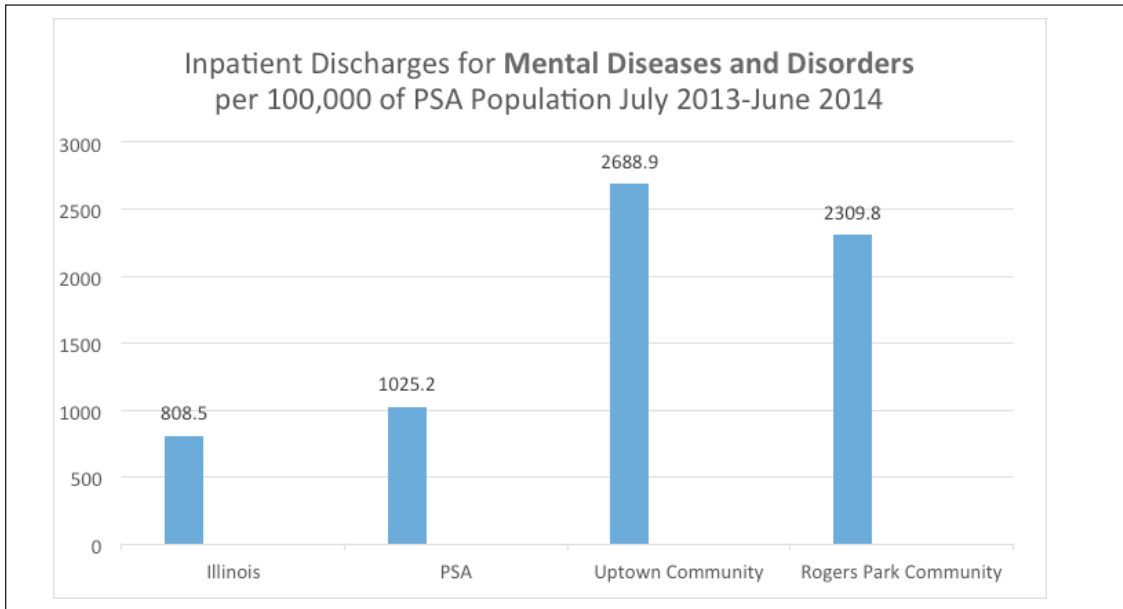
This section summarizes the striking needs and issues that emerged from the data for the medical center's PSA. In order to maintain a manageable data analysis process, staff presented the Community Health Council with only community health data where a disparity seemed evident for the PSA or a community within the PSA. The data chosen for presentation was data that, at least preliminarily, indicated some level of need for the medical center's PSA or a community within the PSA.

Behavioral Health

This section summarizes data related to mental health, substance abuse and alcohol abuse; referred to jointly as "Behavioral Health." The data indicators show that the PSA experiences higher rates of Behavioral Health issues than the whole of Illinois with certain communities within the PSA more deeply affected including: Uptown, Rogers Park, Wicker Park, Dunning, Fort Dearborn and Division Street.

Between July 2013 and June 2014, the rate of inpatient discharge for mental diseases and disorders per 100,000 of the PSA population was 1025.2. This is compared to an 808.5 rate for the population of Illinois as a whole. Not only does the PSA have a higher rate but there are communities within the PSA that experience rates of inpatient discharge for mental diseases that are more than double that of the PSA and at or near triple the rate of Illinois. The Uptown community (60640) has a rate of 2688.9 and the Rogers Park community (60626) has a rate of 2309.8. (Illinois Hospital Association, COMPdata, July 2013-June 2014.)

Exhibit 20: Inpatient Discharges for Mental Diseases and Disorders per 100,000 of PSA Population July 2013-June 2014



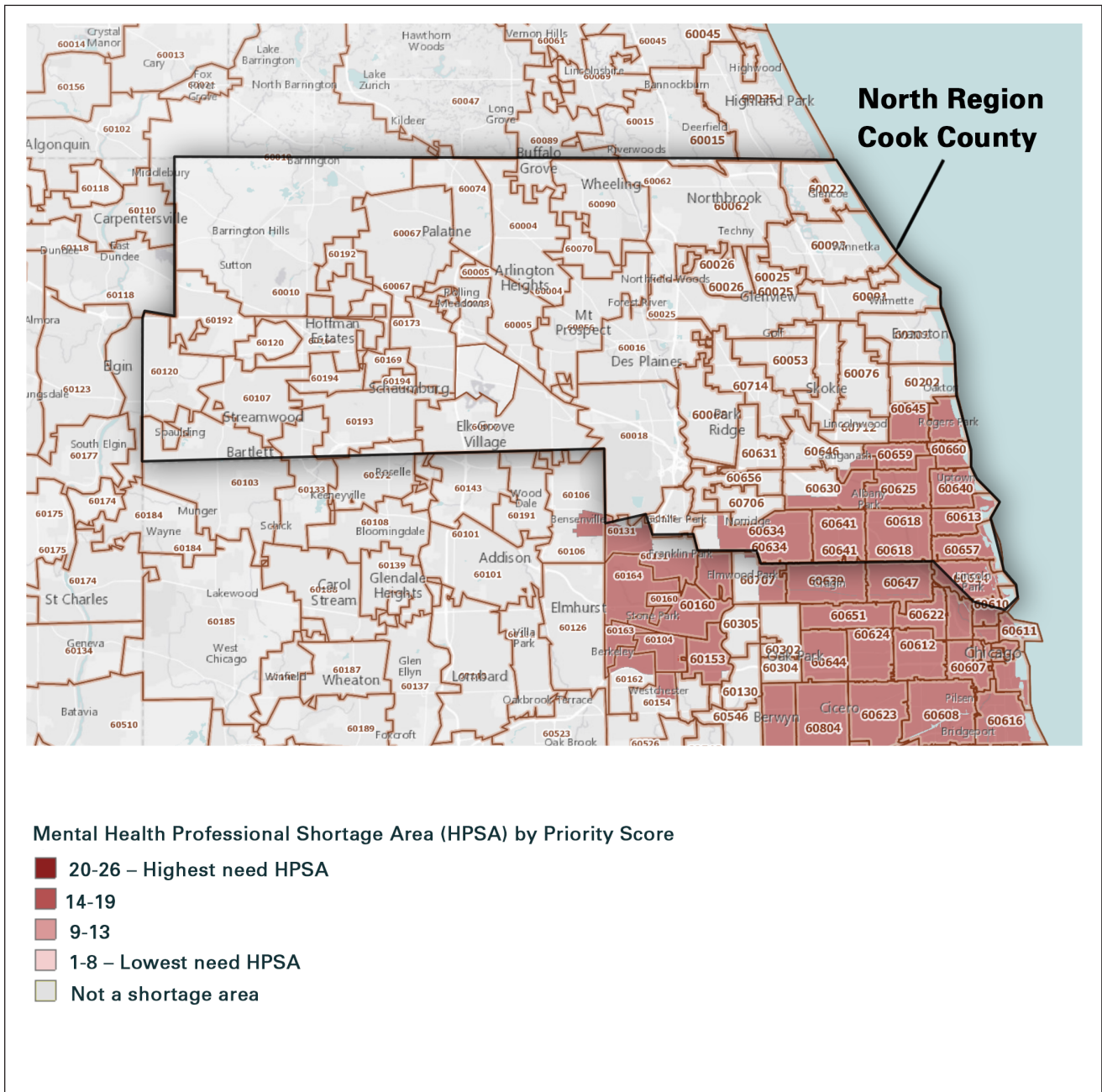
Source: Illinois Hospital Association, COMPdata, July 2013-June 2014.

According to data from 2012 to 2014, the following zip code communities had at least a 1.5 times higher rate of age adjusted ER usage due to mental health compared to the PSA as a whole: Uptown, Rogers Park and Division Street. Wicker Park had the next highest rate compared to the PSA as a whole. (Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2015.)

Data provided by the Illinois Hospital Association (IHA) on trends in emergency room visits and hospitalizations for people in psychiatric or behavioral health crisis show that as the state eliminated more than \$113 million in community mental health treatment services between fiscal years 2009 and 2011, hospitalizations and institutional placements increased. (Thresholds' *The Path Forward: Illinois Community Mental Health System*, Policy Brief, November 2013.)

There are several communities in the North region of Cook County that have mental health professional shortage areas. Mental Health Professional Shortage Areas are designated by the Health Resources and Services Administration (HRSA) as areas having shortages of mental health providers. Each shortage area is assigned a score (1-22) based on a variety of different factors including geographic area (a county or service area), population (e.g., low income or Medicaid eligible), or the presence of different types of facilities (e.g., Federally Qualified Health Centers, or state or federal prisons). The higher a score is for an area, the greater the need for mental health professionals, services, or facilities. The zip codes in the North region of Cook County that are designated as mental health professional shortage areas include zip codes that are all located in the medical center's PSA: 60625 (Ravenswood), 60613 (North Center), 60634 (Dunning), 60618 (Avondale), 60657 (Lakeview), 60659 (West Ridge), 60641 (Irving Park/Portage Park), 60626 (Rogers Park), 60640 (Uptown) and 60645 (West Ridge). (American Hospital Association, *Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes*, 2012.)

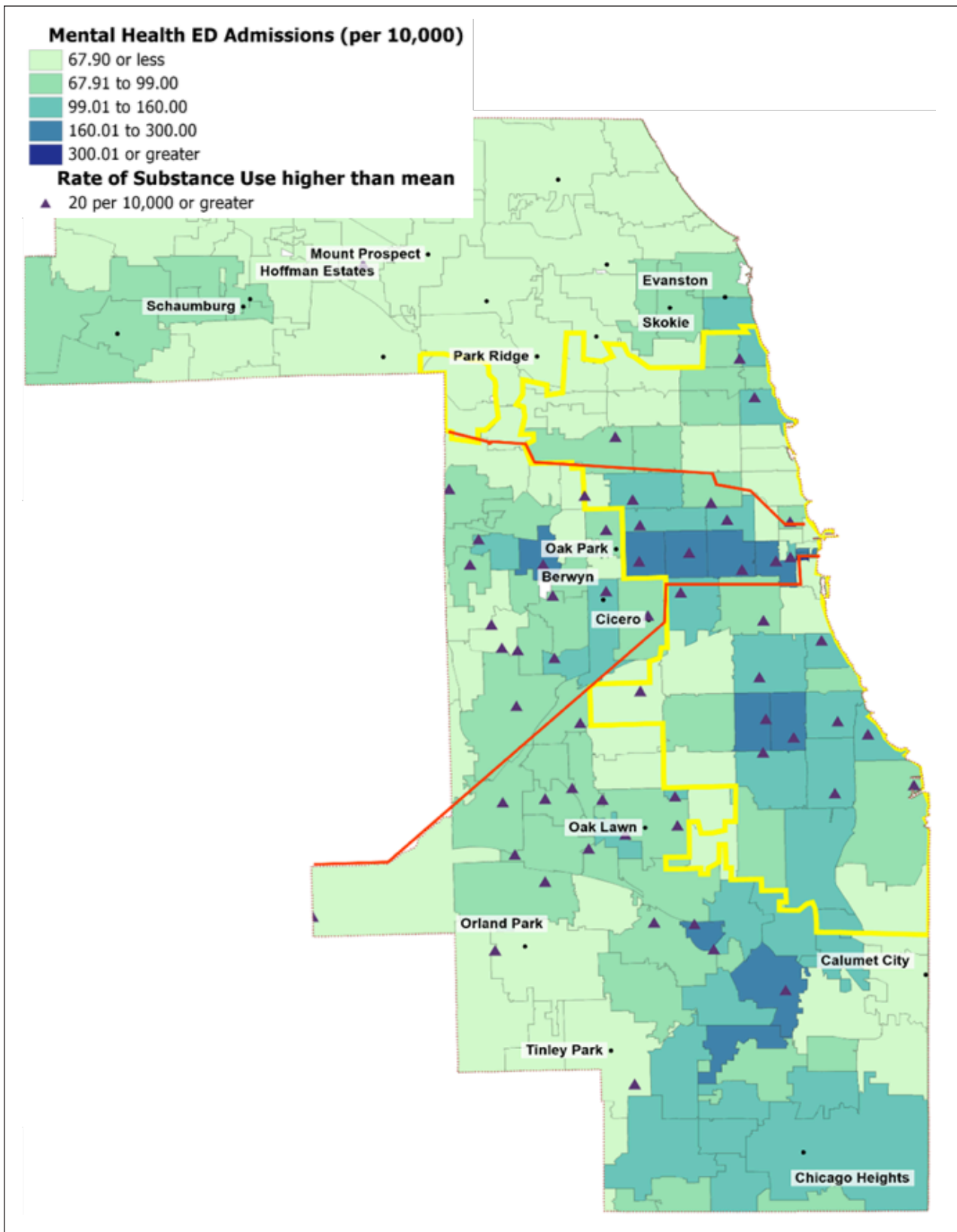
Exhibit 21: Mental Health Professional Shortage Areas – North Region Cook County



Source: Health Resources and Services Administration, HPSA Database, April 2016.

There is a high prevalence of co-morbidity between mental illness and drug use. (National Institutes of Health, National Institute on Drug Use, 2010.) The map below shows the communities in which high ED visit rates for mental illness overlap with high ED visit rates for substance use.

Exhibit 22: Emergency Department (ED) Visits for Mental Health and Substance Use in Cook County (Age-Adjusted Rates per 10,000) 2012-2014

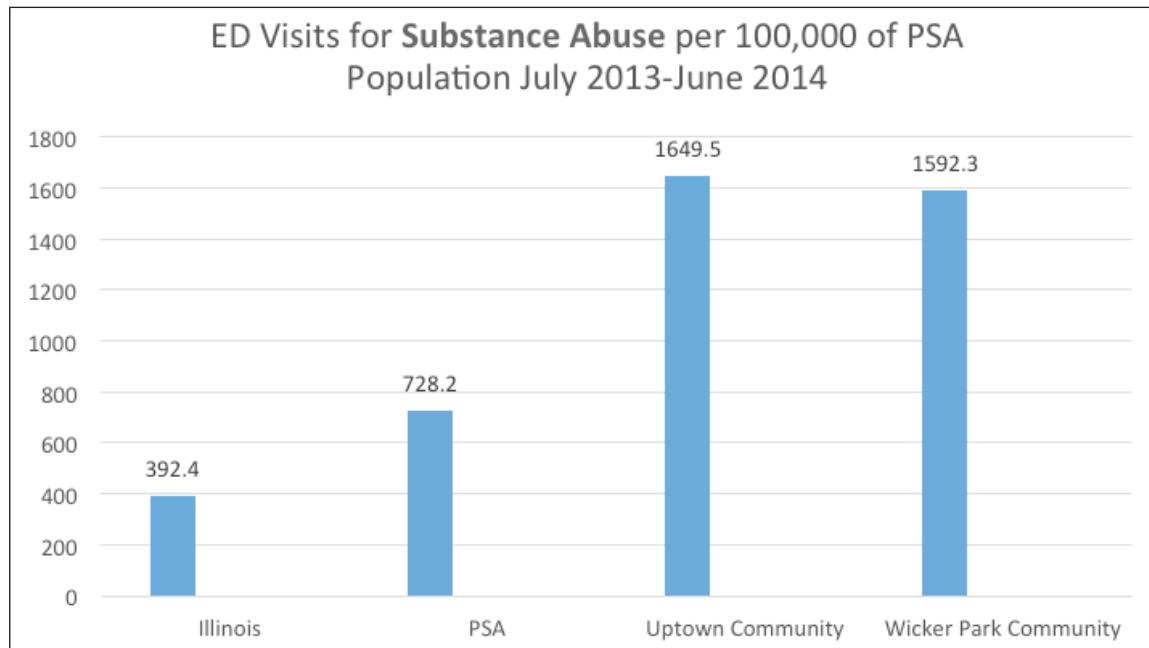


Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2012-2014.

The communities within the PSA that have the highest co-indicators of Emergency Department admission rates for mental health and substance abuse are Uptown and Rogers Park.

Between July 2013 and June 2014, the rate of ED visits for substance abuse in the medical center's PSA population was over 1 and a half times the rate in Illinois as a whole. The number of ED visits for substance abuse per 100,000 of the PSA population was 728.2 while the rate for Illinois as a whole was 392.4. (Illinois Hospital Association, COMPdata, July 2013-June 2014.) Two zip code communities experienced a disproportionate burden. Uptown's rate was 1649.5 while the Wicker Park community had a rate of 1592.3. (Illinois Hospital Association, COMPdata, July 2013-June 2014.)

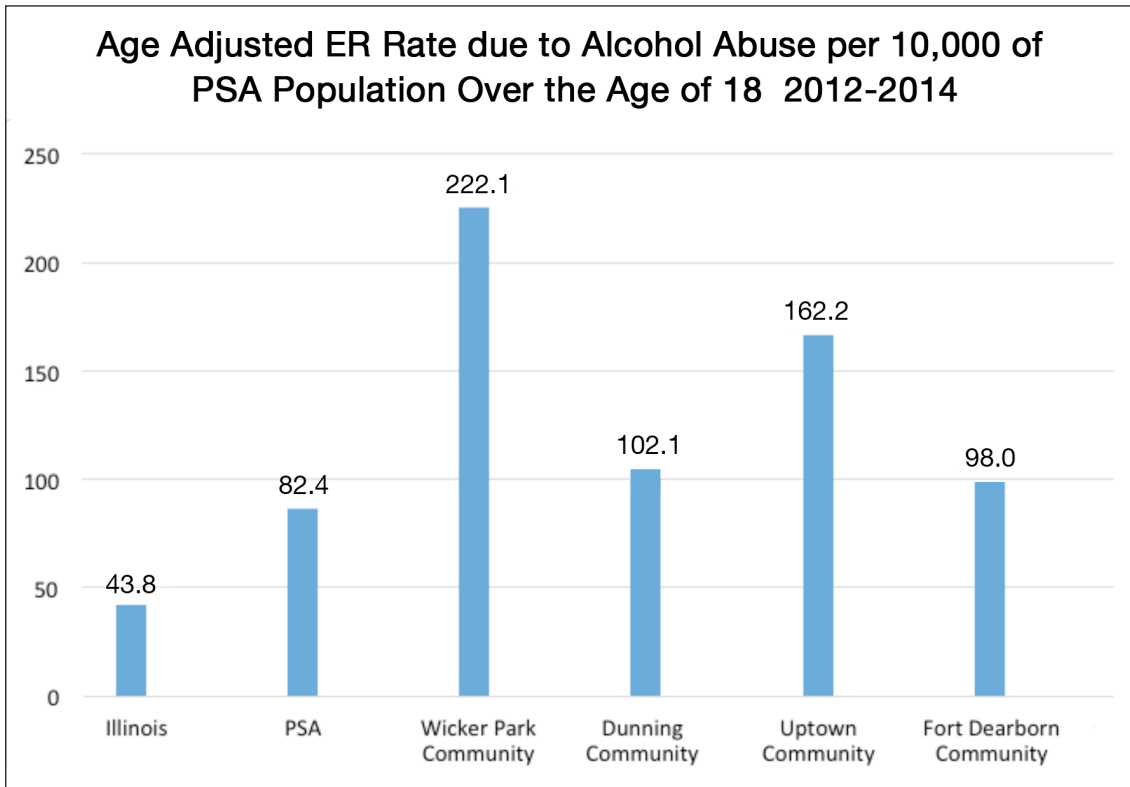
Exhibit 23: ED Visits for Substance Abuse per 100,000 of PSA Population July 2013-June 2014



Source: Illinois Hospital Association, COMPdata, July 2013-June 2014.

According to data from 2012 to 2014, Illinois Masonic Medical Center's PSA population has a higher Age Adjusted ER rate due to Alcohol Abuse compared to Illinois as a whole. The Illinois Age Adjusted ER Rate due to Alcohol Abuse (ER visits per 10,000 population 18 years and older) from 2012-2014 was 43.8. The same rate for the medical center's PSA was 82.4. (Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2015.) Zip code communities with disproportionate burdens include Wicker Park (222.10), Dunning (102.1), Uptown (162.2), and Fort Dearborn (98.0).

Exhibit 24: Age-Adjusted ER Rate due to Alcohol Abuse per 10,000 of PSA Population Over the Age of 18 – 2012-2014



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

According to data from Healthy Communities Institute (Illinois Hospital Association), the Age Adjusted ED rate due to Alcohol Abuse in the PSA is increasing.

Within the Health Impact Collaborative of Cook County focus groups held in the PSA, behavioral health was mentioned as a high priority issue several times. The Howard Brown Clinic focus group discussed the importance of reducing the stigma surrounding behavioral health issues, particularly in ethnic or racial communities. Participants also discussed the behavioral health impact of discrimination. The group held at the Polish American Association also identified mental health and substance abuse services, especially for youth, as a priority need. Participants in the Healthy Rogers Park Community Network identified mental health and substance abuse services as a priority community health need as well.

Eighteen percent of HICCC Community Survey respondents in the North region indicated that they, or a family member, did not seek needed mental health treatment because of cost or lack of insurance coverage. Fourteen percent of respondents indicated that they, or a family member, did not seek mental health treatment due to a lack of knowledge about where to get services. Ten percent of respondents indicated that they, or a family member, did not seek mental health treatment due to the perception that other people might have a negative opinion of them.

Chronic Disease

Chronic disease affects health and quality of life. More than two-thirds of all deaths in the US are caused by one or more of five chronic diseases: heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes. (US Department of Health and Human Services, December 2010.)

Exhibit 25: Leading Causes of Death under the Age of 75 in PSA 2010-2011

1.	Cancer
2.	Diseases of the heart
3.	Accidents excluding motor vehicles
4.	Diabetes
5.	Chronic lower respiratory diseases
6.	Cerebrovascular diseases (Stroke)
7.	Intentional self-harm
8.	Chronic liver disease
9.	Influenza and pneumonia
10.	Nephritis, nephrotic syndrome and nephrosis (kidneys)

Source: Illinois Department of Public Health Death Rates, 2010-2011.

Chronic diseases accounted for approximately 64% of all deaths in Chicago in 2014. The leading causes of death across Chicago in 2014 were heart disease, cancer and stroke. (Chicago Department of Public Health, Healthy Chicago, 2.0, Partnering to Improve Health Equity, 2016-2020.)

Exhibit 26: Chicago Communities in the North Region of Cook County with a High Burden of Chronic Disease across Multiple Indicators* 2012

	• Edgewater
	• Jefferson Park
	• Norwood Park
	• Portage Park
	• Rogers Park
	• Uptown
* Indicators included here are mortality (heart disease, cancer, stroke, diabetes) and hospitalization data (asthma and diabetes).	

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

It should be noted that five of the six Chicago community areas in the North region identified above are in the medical center's PSA.

When measuring the impact of chronic disease on a community, it is common to examine mortality and hospitalization rates due to chronic disease in communities (as was done in Exhibit 26). Internal medical center readmission data and ED utilization data indicates that chronic disease is indeed a burden on the health system. When the medical center studied patients that were a part of Advocate's value-based payment arrangements, in 2015, it was found that:

- Heart failure, diabetes, and asthma were in the top-20 diagnoses for 30-day readmissions.
- Asthma and diabetes were in the top-25 diagnoses for frequent ED visits (defined as ≥ 3 ED visits at any facility within a 12-month period).

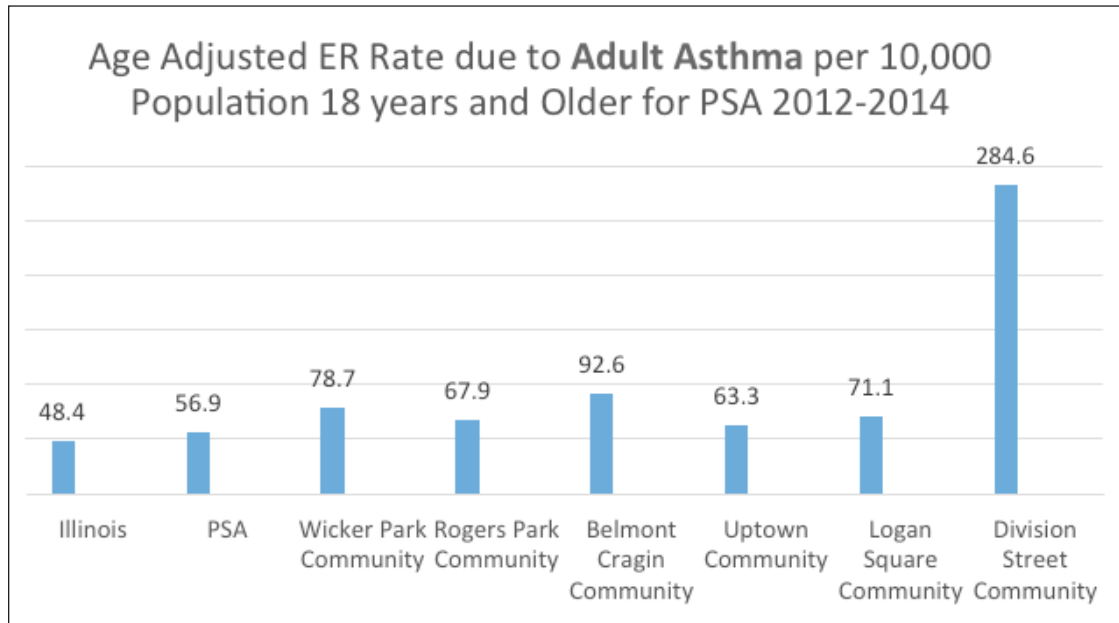
Source: Advocate Physician Partners (APP), Clinical Innovation Reports, 2/1/15-1/31/16.

The following chronic diseases were identified as issues of concern for the PSA and specific communities.

Asthma

From 2012 to 2014, Illinois Masonic Medical Center's PSA population had a higher Age Adjusted ER Rate due to Adult Asthma (ER visits per 10,000 population 18 years and older) compared to Illinois as a whole. The rate for the PSA was 56.9 and the Illinois rate was 48.4. Zip code communities with disproportionate burdens included: Wicker Park (78.7), Rogers Park (67.9), Belmont Cragin (92.6), Uptown (63.3), Logan Square (71.1) and Division Street (284.6). (Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2015.)

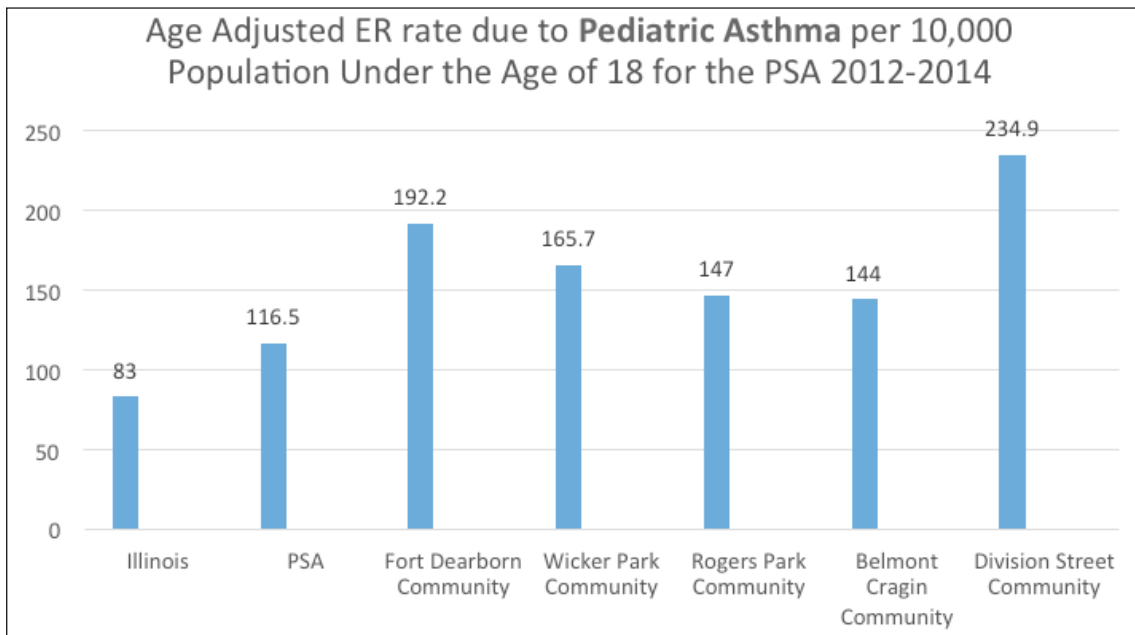
Exhibit 27: Age-Adjusted ER Rate due to Adult Asthma per 10,000 Population 18 Years and Older for PSA 2012-2014



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

This same data showed that from 2012 to 2014, Illinois Masonic Medical Center's PSA population had a higher Age Adjusted ER Rate due to Pediatric Asthma (average annual ER visit rate due to asthma per 10,000 population age 18 years and younger) compared to Illinois as a whole. The rate for the PSA was 116.5 and the Illinois rate was 83.0. Zip code communities with disproportionate burdens include: Fort Dearborn (192.2), Wicker Park (165.7), Rogers Park (147), Belmont Cragin (144) and Division Street (234.9).

Exhibit 28: Age-Adjusted ER Rate due to Pediatric Asthma per 10,000 Population Under the Age of 18 for PSA 2012-2014



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

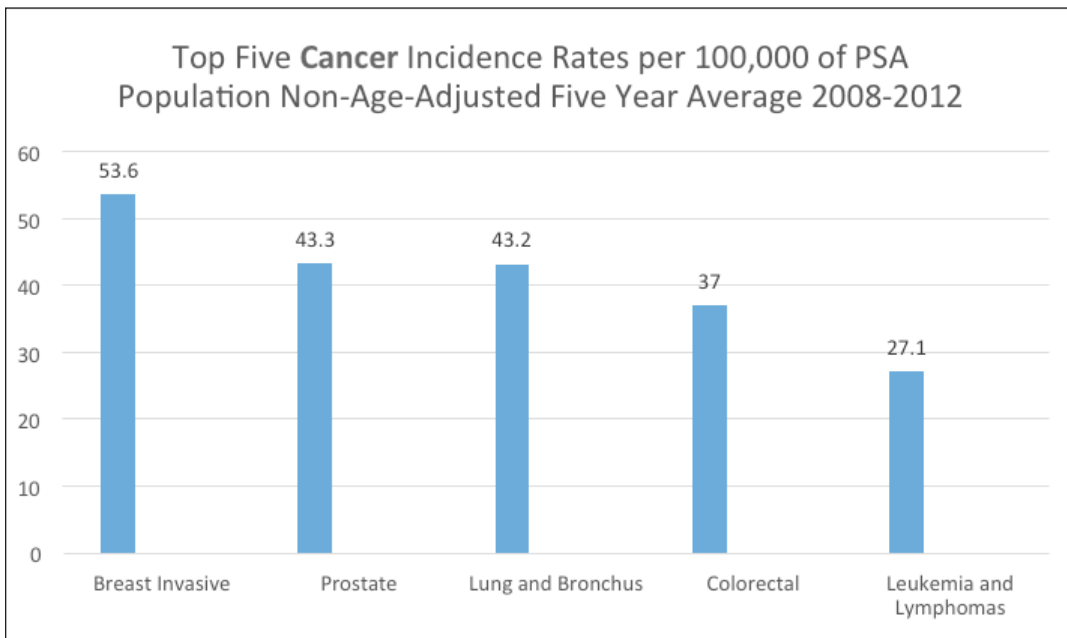
ER visits for asthma are indicative of increased exposure to environmental contaminants that can trigger asthma as well as poorly managed asthma. (Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region, 2016.) According to data from the Healthy Communities Institute, the Age Adjusted ER Rate due to Adult Asthma is actually decreasing for the PSA. However, the Age Adjusted ER Rate due to Pediatric Asthma remains constant for the PSA.

Cancer

The top five cancer incidence rates in the PSA (not age adjusted), five year average for 2008-2012, are:

1. Breast Invasive (rate: 53.6 per 100,000 population)
2. Prostate (rate: 43.3 per 100,000 population)
3. Lung and Bronchus (rate: 43.2 per 100,000 population)
4. Colorectal (rate: 37 per 100,000 population)
5. Leukemia and Lymphomas (rate: 27.1 per 100,000 population)

Exhibit 29: Top Five Cancer Incidence Rates per 100,000 of PSA Population Non-Age-Adjusted Five Year Average 2008-2012



Source: Illinois Department of Public Health, Illinois Cancer Registry, Public Data Set, March 2016.

While cervical cancer had an incidence rate far lower than the top five cancers in the medical center’s PSA, cervical cancer was the only cancer that had a higher incidence rate (5 year average rate per 100,000 population 2008-2012) in the medical center’s PSA than Illinois as a whole. The Illinois rate was 4.3 and the PSA rate was 4.5. (Illinois Department of Public Health, Illinois State Cancer Registry; Neilson Demographics, 2010; Public Dataset, March 2016.) Additionally, in data prepared by Illinois Masonic Medical Center’s Cancer Committee, there is evidence that patients are presenting at Illinois Masonic Medical Center with later stage cervical cancer.

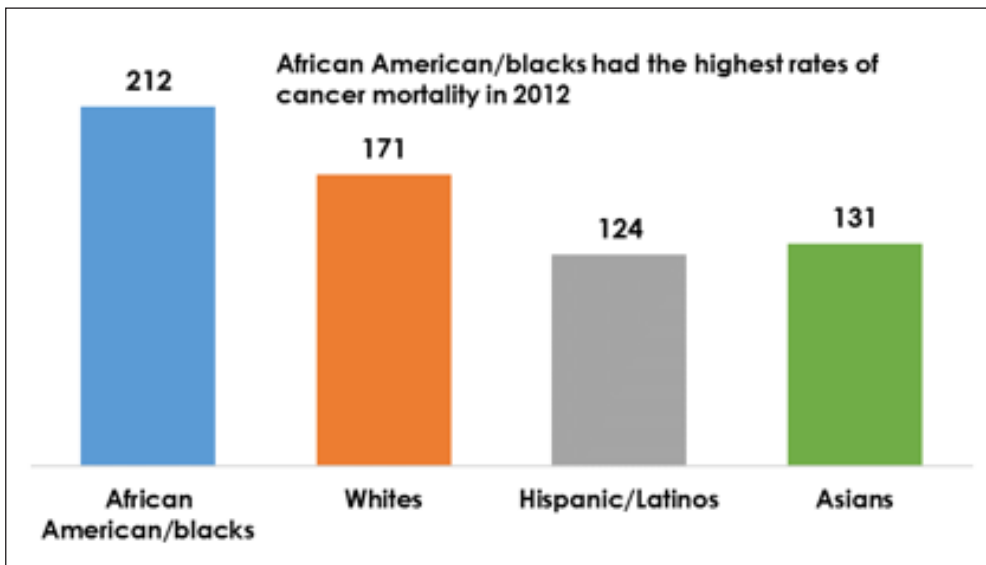
2015 national data indicates that between 2007 and 2011, the following race/ethnicity disparities existed for the following cancers:

- Breast Cancer
 - Non-Hispanic White females have the highest incidence rate.
 - Non-Hispanic Black females have the highest mortality rate (42% higher).
- Colon/Rectum Cancer
 - Non-Hispanic Black males and females have the highest incidence rate and mortality rate.
 - Hispanic males and females have a lower screening rate.
- Lung/Bronchus Cancer
 - Non-Hispanic Black males have the highest incidence rate and mortality rate.
- Prostate Cancer
 - Non-Hispanic Black males have the highest incidence rate and mortality rate.
- Cervical Cancer
 - Latinas have the highest incidence rate of cervical cancer.
- Liver/Intrahepatic Bile Duct Cancer
 - Asian and Pacific Islander males have the highest incidence and mortality rates.
- Stomach Cancer
 - Asian and Pacific Islander females have the highest incidence and mortality rates.

Source: American Cancer Society, North American Association of Central Cancer Registries, 2014; Centers for Disease Control and Prevention, National Center for Health Statistics, US Mortality Data, 2007-2011.

For all cancers, in the north region of Cook County, African American/Blacks had the highest rate of cancer mortality in 2012.

Exhibit 30: Cancer-Related Mortality per 100,000 for the North Region of Cook County by Race and Ethnicity 2012

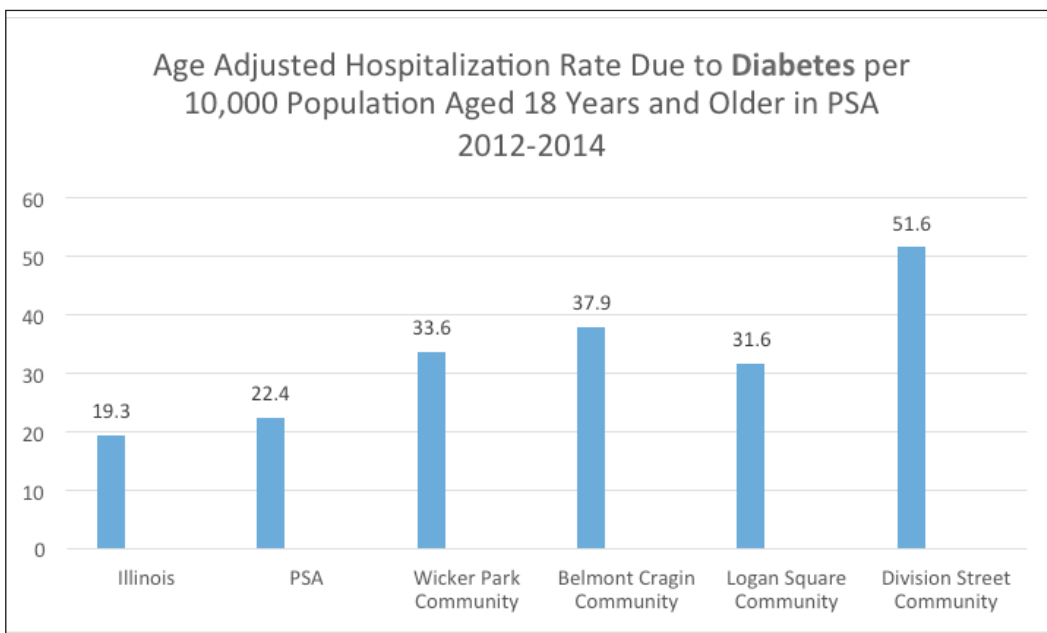


Source: Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region, 2016; Illinois Department of Public Health Data, 2012.

Diabetes

From 2012 to 2014, Illinois Masonic Medical Center’s PSA population had a higher Age Adjusted Hospitalization Rate due to Diabetes (per 10,000 population age 18 years and older/cases of gestational diabetes excluded) compared to Illinois as a whole. The rate for the PSA was 22.4 and the Illinois rate was 19.3. Zip code communities with disproportionate burdens include: Wicker Park (33.6), Belmont Cragin (37.9), Logan Square (31.6), and Division Street (51.6.) (Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2015.)

Exhibit 31: Age-Adjusted Hospitalization Rate Due to Diabetes per 10,000 Population Age 18 Years and Older in PSA 2012-2014

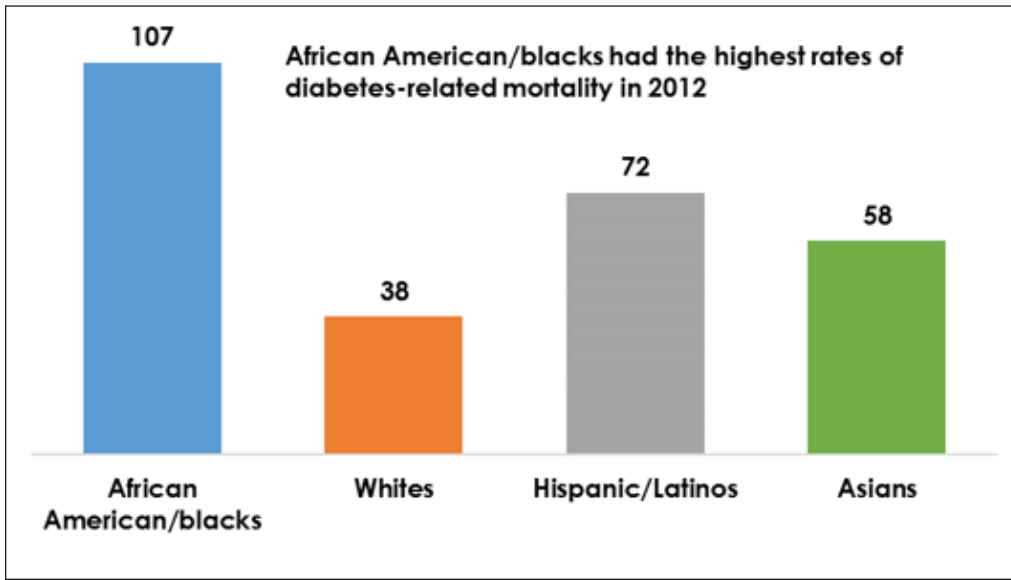


Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2015.

According to data from the Healthy Communities Institute (Illinois Hospital Association, COMPdata, 2015), the Age Adjusted Hospitalization Rate due to Diabetes in the PSA is remaining constant.

Poorly controlled diabetes can lead to severe or life-threatening complications such as heart and blood vessel disease, nerve damage, kidney damage, eye damage and blindness, foot damage and lower extremity amputation, hearing impairment, skin conditions, and Alzheimer’s disease. (American Hospital Association, Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs, and Outcomes, 2012.) Non-Hispanic African American/Blacks and Hispanic/Latinos in the north region of Cook County have higher diabetes-related mortality rates than non-Hispanic Whites and Asians.

Exhibit 32: Diabetes Related Mortality for the North Region of Cook County by Race and Ethnicity (Age-Adjusted per 100,000) 2012



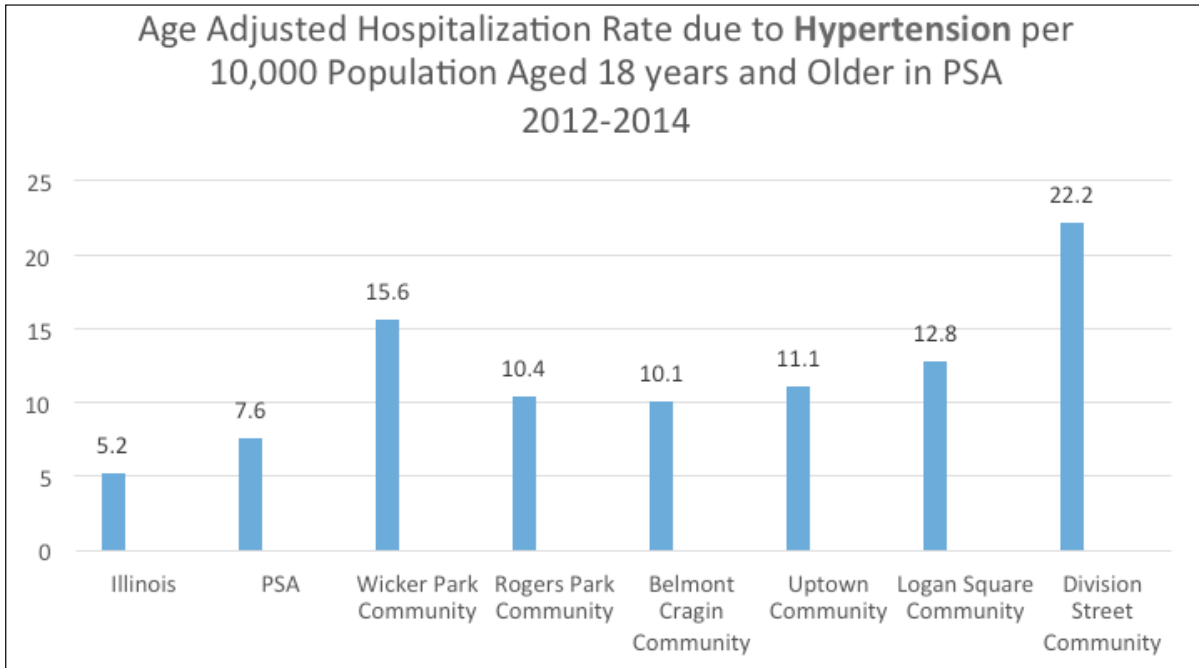
Source: Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region, 2016; Illinois Department of Public Health Data, 2012.

Diabetes was among the top ten causes of death for people under the age of 75 in the Illinois Masonic Medical Center PSA in 2010-2011.

Hypertension

Hypertension increases the risk for heart disease and stroke. Heart diseases and stroke were also among the top ten leading causes of death for people under the age of 75 for the Illinois Masonic Medical Center PSA in 2010-2011. For 2012 to 2014, the medical center’s PSA population had a higher average Age Adjusted Hospital rate due to Hypertension (per 10,000 population age 18 years and older) compared to Illinois as a whole. The rate for the PSA was 7.6 and the Illinois rate was 5.2. Zip code communities with disproportionate burdens include: Wicker Park (15.6), Rogers Park (10.4), Belmont Cragin (10.1), Uptown (11.1), Logan Square (12.8), and Division Street (22.2.)

Exhibit 33: Age-Adjusted Hospitalization Rate due to Hypertension per 10,000 Population Age 18 Years and Older in PSA 2012-2014



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

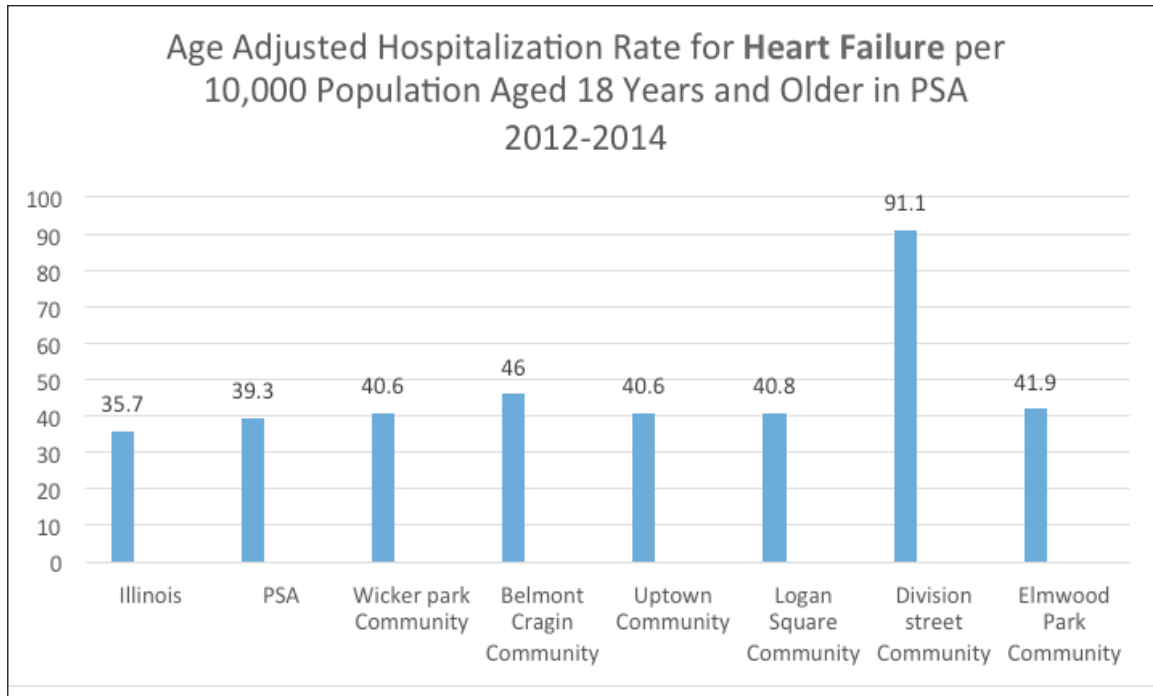
According to data from Healthy Communities Institute (Illinois Hospital Association), the Age Adjusted Hospital rate due to Hypertension in the PSA is remaining constant.

Older adults, non-Hispanic blacks, US-born adults, and adults with lower family income, lower education, public health insurance, diabetes, obesity, or a disability, have a higher prevalence of hypertension than their counterparts. (Centers for Disease Control and Prevention, CDC Health Disparities and Inequalities Report, 2011.)

Heart Disease

For 2012 to 2014, Illinois Masonic Medical Center’s PSA population had a higher average Age Adjusted Hospitalization Rate due to Heart Failure (non-hypertensive heart failure, including rheumatic heart failure, per 10,000 population age 18 years and older) compared to Illinois as a whole. The rate for the PSA was 39.3 and the Illinois rate was 35.7. Zip code communities with disproportionate burdens include: Wicker Park (40.6), Belmont Cragin (46), Uptown (40.6), Logan Square (40.8), Division Street (91.1) and Elmwood Park (41.9).

Exhibit 34: Age-Adjusted Hospitalization Rate for Heart Failure per 10,000 Population Age 18 Years and Older in PSA 2012-2014

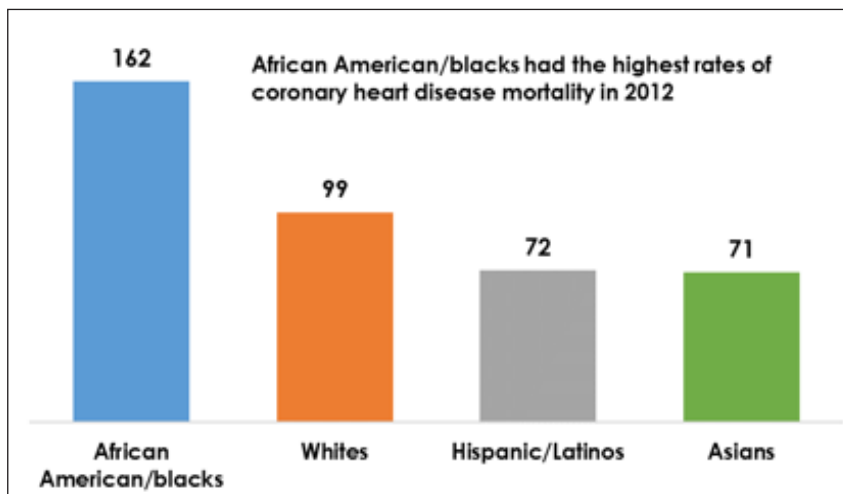


Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2015.

According to data from Healthy Communities Institute (Illinois Hospital Association), the Age Adjusted Hospitalization Rate due to Heart Failure in the PSA is increasing.

Non-Hispanic African American/Blacks in the North region of Cook County have higher coronary heart disease mortality rates.

Exhibit 35: Coronary Heart Disease Mortality for the North Region of Cook County by Race and Ethnicity 2012

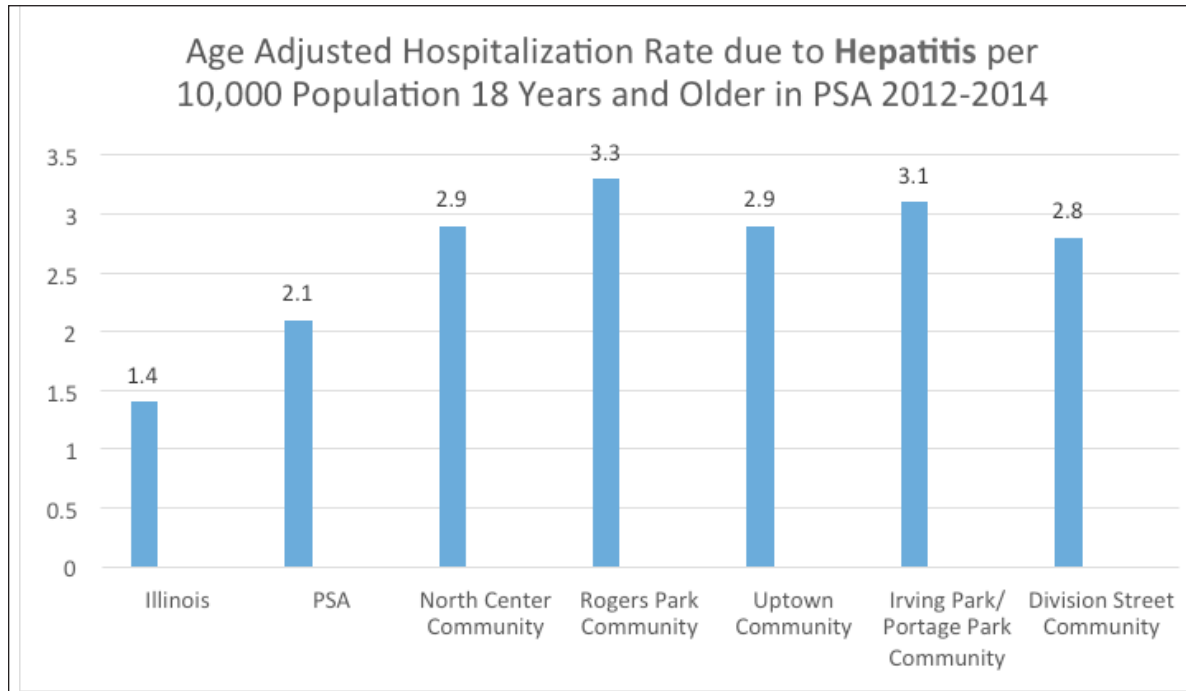


Source: Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region, 2016; Illinois Department of Public Health Data, 2012.

Hepatitis

Hepatitis means inflammation of the liver. Hepatitis is often caused by a virus. The most common types of viral hepatitis are Hepatitis A, Hepatitis B and Hepatitis C. For 2012 to 2014, Illinois Masonic Medical Center's PSA population had a higher average Age Adjusted Hospitalization Rate due to Hepatitis (per 10,000 population age 18 years and older) compared to Illinois as a whole. The rate for the PSA was 2.1, almost double the Illinois rate of 1.4. Zip code communities with disproportionate burdens include: North Center (2.9), Rogers Park (3.3), Uptown (2.9), Irving Park/Portage Park (3.1), and Division Street (2.8).

Exhibit 36: Age-Adjusted Hospitalization Rate due to Hepatitis per 10,000 Population Age 18 Years and Older in PSA 2012-2014



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

According to data from the Healthy Communities Institute (Illinois Hospital Association), the Age Adjusted Hospitalization Rate for the PSA due to Hepatitis is remaining constant.

Asian Americans and Pacific Islanders (AAPIs) make up less than 5 percent of the total population in the United States, but account for more than 50 percent of nearly one million Americans living with chronic Hepatitis B. Nearly 70 percent of Asian Americans are foreign-born and estimates have found that approximately 58 percent of foreign-born people with chronic Hepatitis B are from Asia. (Centers for Disease Control and Prevention, Viral Hepatitis CDC Recommendations for Specific Populations and Settings, 2016.)

An estimated 20 percent of new Hepatitis B cases in the US occur in gay or bisexual men. Sharing needles or other equipment used to inject drugs also puts a person at risk for Hepatitis B and Hepatitis C. Of people with HIV infection, 10 percent also have Hepatitis B and 25 percent have Hepatitis C.

Centers for Disease Control and Prevention of Viral Hepatitis Fact Sheet, 2013,

<http://www.cdc.gov/hepatitis/hcv/index.htm>

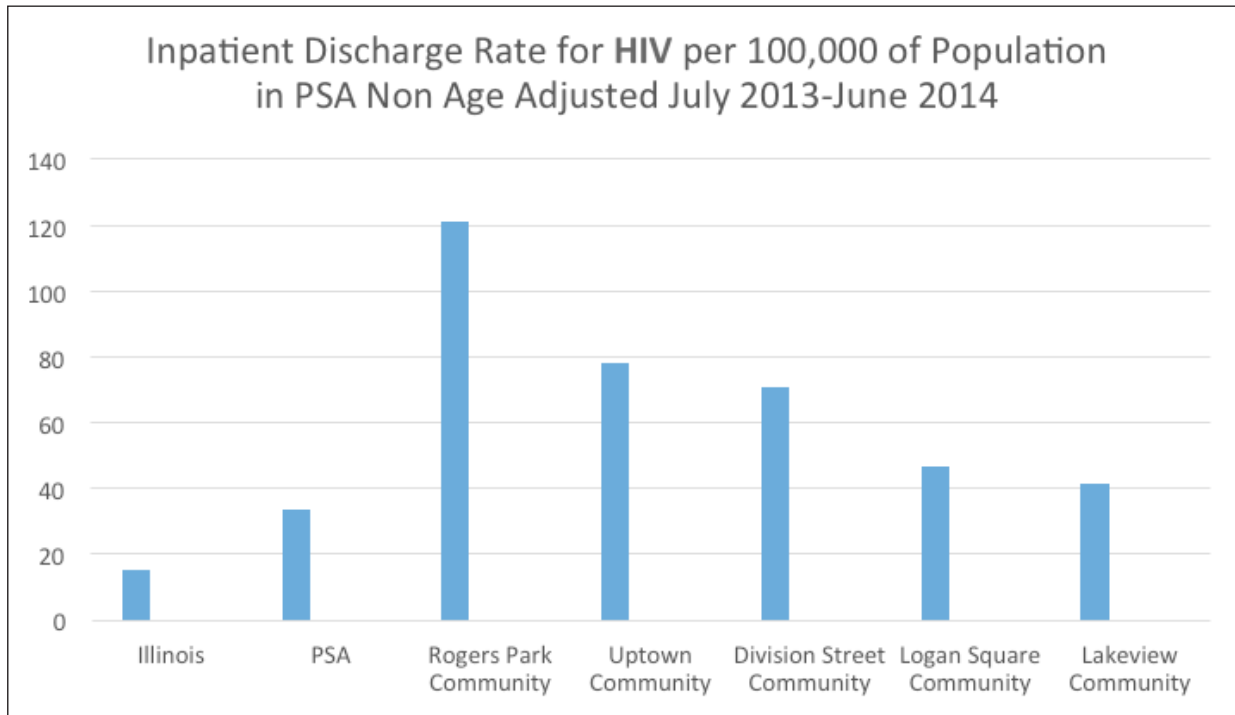
HIV

According to data (which is not age adjusted) from the medical center’s strategic planning department, from July 2013 to June 2014, the rate of inpatient discharge for Human Immunodeficiency Virus Infections (HIV) per 100,000 people for the total Illinois Masonic Medical Center PSA population was double what it was for the total population of Illinois:

Rate for Illinois:	15.2
Rate for the PSA:	33.5
60626 (Rogers Park):	121.3
60640 (Uptown):	78.3
60651 (Division Street):	71.0
60660 (Rogers Park):	50.5
60647 (Logan Square):	46.7
60657 (Lakeview):	41.4

Source: Illinois Hospital Association, COMPdata, July 2013-June 2014.

Exhibit 37: Inpatient Discharge Rate for HIV per 100,000 of Population in PSA Non-Age-Adjusted July 2013-June 2014



Source: Illinois Hospital Association, COMPdata, July 2013-June 2014.

Because of antiretroviral therapy, individuals with HIV are now living longer lives with better quality of life. Consistent use of antiretroviral therapy along with regular clinical care slows the progression of HIV, keeps individuals with HIV healthier and greatly reduces their risk of transmitting HIV. (Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region, 2016; Centers for Disease Control and Prevention, Living with HIV, 2016.) However, as the population of Persons Living with HIV/AIDS (PLWHAs) grows, it is important to have systems in place for their continuity of care. (Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region, 2016; Chicago Department of Public Health, HIV/STI Bureau, Chicago EMA HIV/AIDS Profile, 2016.)

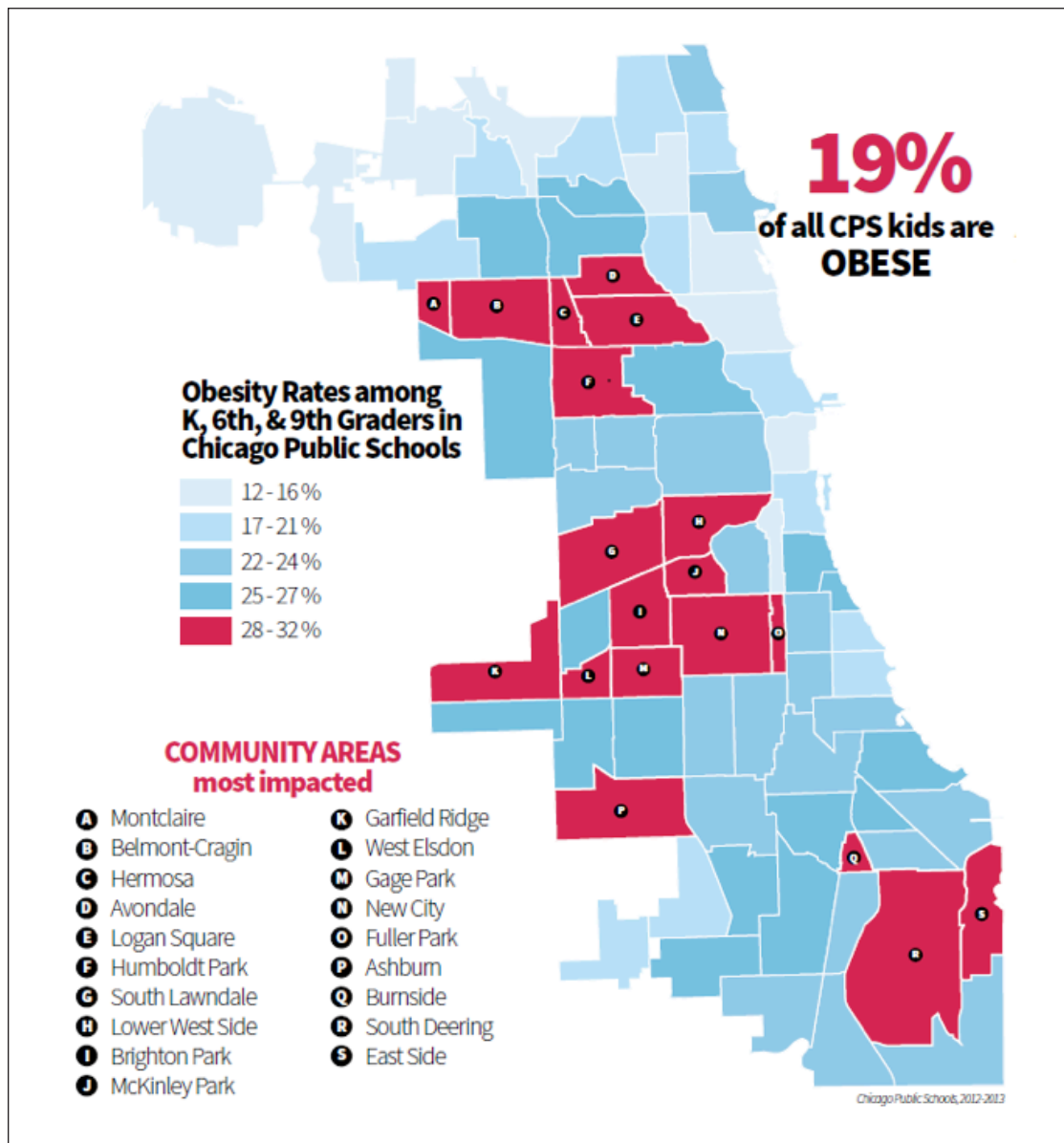
In addition to geographic disparities in PLWHA, there are also disparities related to gender, age, race/ethnicity, and sexual orientation. African American/Black men who are young and have sex with men are most seriously affected by HIV. (Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region, 2016; American Hospital Association, Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, 2012.) Overall, African American/Blacks have the most severe burden of HIV compared to all other racial and ethnic groups. (Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region, 2016; Chicago Department of Public Health, STD/HIV/AIDS Chicago, Winter, 2005-2006.)

Obesity

According to the National Institutes of Health, being overweight or obese greatly raises the risk for other health problems such as coronary artery disease, angina, heart failure, high blood pressure, stroke, and Type 2 diabetes.

The Chicago Department of Public Health’s, Healthy Chicago 2.0, 2016-2020, reports that one in four adults in Chicago were obese in 2014. One in five kindergartners enrolled in Chicago Public Schools were obese in the 2013-2014 academic year.

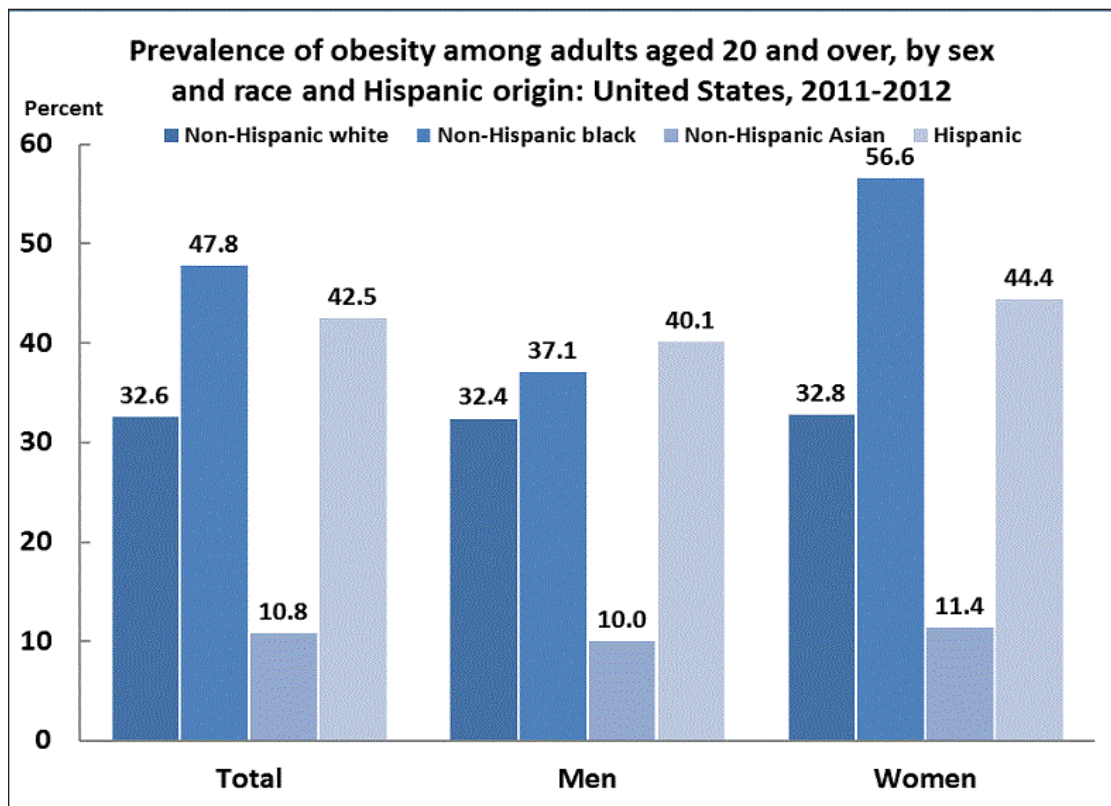
Exhibit 38: Community Areas Most Impacted by Obesity Rates Among K, 6th and 9th Graders in Chicago Public Schools 2016-2020



Source: Chicago Department of Public Health, Healthy Chicago 2.0, 2016-2020.

As seen in the data above, communities in the medical center’s PSA most impacted by childhood obesity are Montclare, Belmont Cragin, Hermosa, Avondale, Logan Square and Humboldt Park. All of these communities are over 50% Hispanic. The exhibit below shows that nationally, Hispanics and Non-Hispanic Blacks have higher rates of obesity.

Exhibit 39: Age-Adjusted Prevalence of Obesity by Sex, Race and Hispanic Origin Among Adults Age 20 and Over in US 2011-2012



Note: Obesity is defined as BMI \geq 30 kg/m².

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey, 2011-2012.

Within the Health Impact Collaborative of Cook County focus groups held in the PSA, participants from the Asian Human Services group specifically identified the need for education on healthy eating and exercise for immigrants. The Healthy Rogers Park Community Network identified the need for education on how to eat healthy for less money.

Poor diet and a lack of physical activity are two major predictors of obesity. More than a quarter of adults in Chicago (29 percent) reported not engaging in physical activity during leisure time while 22 percent of Chicago youth reported the same lack of physical activity. (Health Impact Collaborative of Cook County, Community Health Needs Assessment, North Region, 2016; Behavioral Risk Factor Surveillance System and Healthy Chicago Survey, 2014.)

Dental Health

According to the Chicago Community Oral Health Forum 2013-2014 study *Healthy Smiles, Healthy Growth*, approximately 52 percent of third grade children in Illinois had caries experience, suggesting that tooth decay is still a significant public health problem affecting Illinois children; over 22 percent had untreated decay and 2 percent had an urgent treatment need.

In 2013, the Chicago Dental Society published a white paper on oral health care in Chicago and Cook County entitled *Broken Smiles*. This paper concluded that more than half of Chicagoland residents surveyed in 2011 had delayed dental treatment because of financial reasons in the last year.

Social Determinants of Health (SDOH)

SDOH are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. SDOH includes such issues as poverty and economic inequities, education quality and inequities, structural racism, housing, transportation, health environments and safety. Conditions in the places where people live, learn, work and play can affect a wide range of health risks and outcomes. Limited access to quality housing, healthy foods, safe neighborhoods, education and health care can all impact health. Differences in health are striking in communities with poor living conditions such as unstable housing, unsafe neighborhoods, or substandard education. (Centers for Disease Control and Prevention, Social Determinants of Health, 2014.)

There has been a substantial amount of data presented in this document regarding the Social Determinants of Health in the medical center's PSA. Data was presented on poverty, income levels, employment and education disparities that exist within the medical center's PSA. The impact of race/ethnicity, income levels and sexual orientation/gender identification on health were discussed. All of these are significant issues impacting the overall health of the medical center's PSA. Additionally, the following SDOH issues were identified specifically as areas of need.

Housing

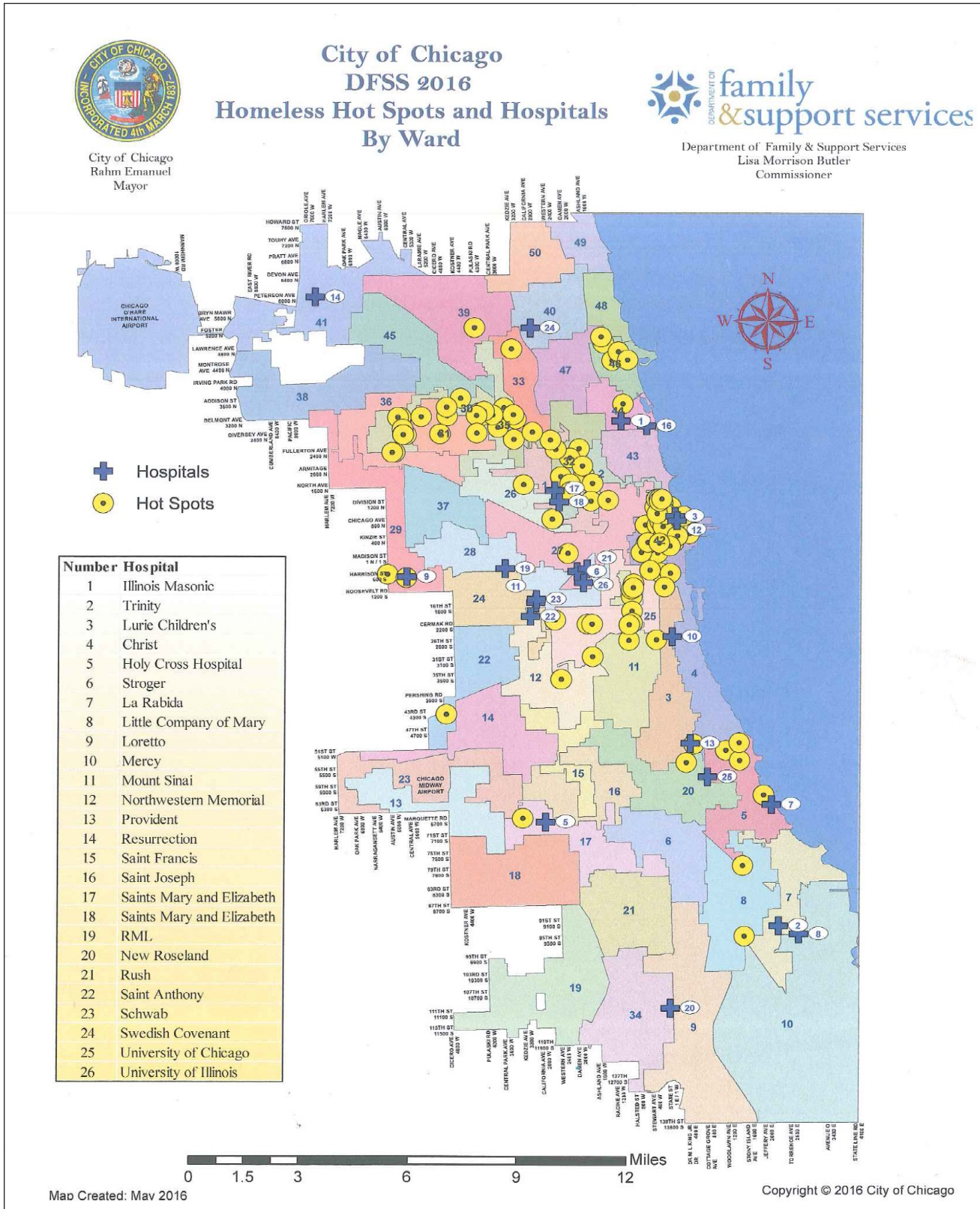
The Community Health Council spent a great deal of time discussing the high correlation between housing stability and staying healthy and out of the hospital. Stable housing provides the foundation upon which people build their lives. Without a safe, affordable place to live, it is almost impossible to achieve good health.

An analysis by the Chicago Coalition for the Homeless estimated that 125,848 Chicagoans were homeless in the course of the 2014-15 school year. <http://www.chicagohomeless.org/faq-studies/>

According to the Chicago Department of Public Health Healthy Chicago 2.0 Report, 39 percent of Chicago households spend more than 1/3 of their monthly income on housing costs.

The following is a map from the City of Chicago displaying homeless “hot spots” in Chicago. The vast majority of the hot spots are on the North Side of Chicago.

Exhibit 40: City of Chicago Homeless “Hot Spots” and Hospitals by Ward 2016



Source: City of Chicago Family and Support Services, 2016.

Within the Health Impact Collaborative of Cook County focus groups held in the PSA, the need for affordable housing was mentioned several times. The Polish American Association participants noted that undocumented immigrants experience difficulty accessing affordable housing. The Healthy Rogers Park Community Network also noted overcrowded homes as an issue.

Approximately 31 percent of HICCC survey respondents for the North region responded that housing in their communities was not affordable.

There is a clear link between unstable housing and behavioral health. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in January 2014 in the US, one in five people experiencing homelessness had a serious mental illness, and a similar percentage had a chronic substance use disorder. <http://www.samhsa.gov/homelessness-housing>

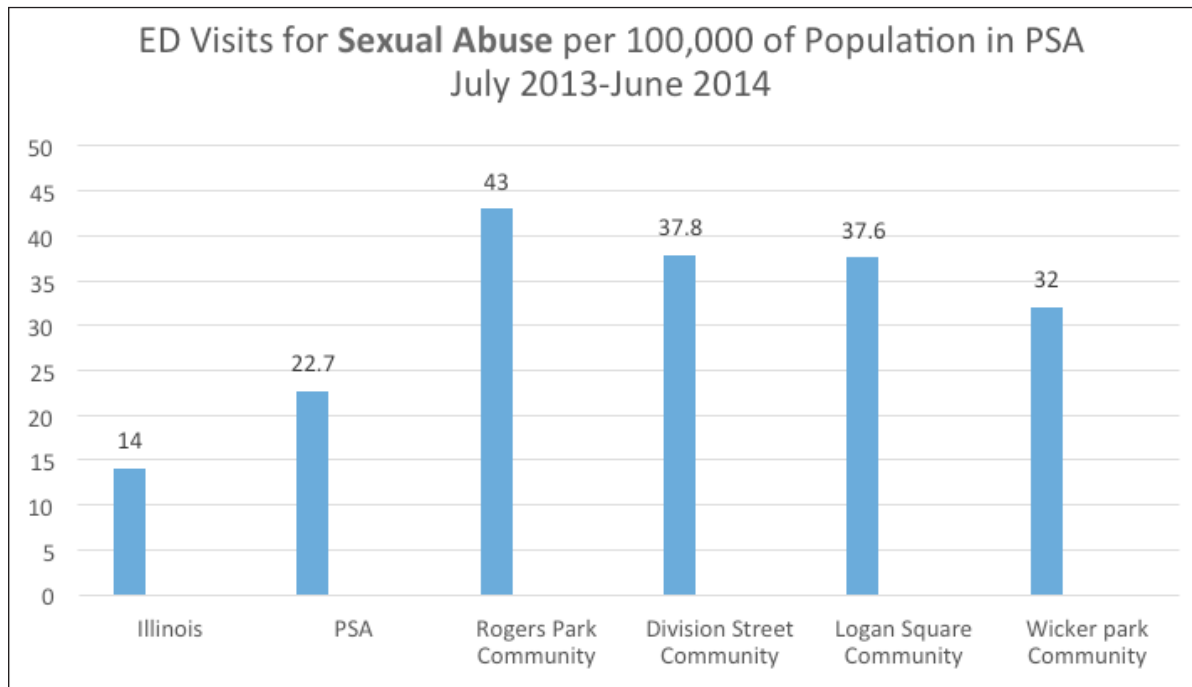
It should also be noted that, according to The Night Ministry, a nondenominational organization serving runaway and homeless youth in Chicago, there are between 12,000 and 15,000 homeless youth in Chicago. Between 1,448 and 3,000 homeless youth are LGBT based on estimations by the Night Ministry, the Chicago Coalition for the Homeless and the Survey Research Laboratory at the University of Illinois at Chicago. (National Gay and Lesbian Task Force Fact Sheet: Homeless Lesbian, Gay, Bisexual and Transgender Youth in Chicago, Illinois, posted 2016. http://www.thetaskforce.org/static_html/downloads/reports/fact_sheets/HomelessYouthChicago012507.pdf)

Violence/Sexual Abuse

The Healthy Rogers Park Community Network focus group held by the Health Impact Collaborative of Cook County identified violence prevention as a specific community need. While violence in general is an issue, the Community Health Council also focused on the higher rates of Sexual Abuse that exist within the medical center's PSA.

The rate of ED visits between July 2013 and June 2014 for sexual abuse per 100,000 people was more than 1.5 times higher in the PSA than Illinois as a whole. The rate for the PSA was 22.7 while the rate for Illinois was 14.0. Rogers Park (60626), Division Street (60651), Logan Square (60647) and Wicker Park (60622) experience a disproportionate burden with rates of 43, 37.8, 37.6 and 32, respectively. (Illinois Hospital Association, COMPdata, July 2013-June 2014.)

Exhibit 41:



Source: Illinois Hospital Association, COMPdata, July 2013-June 2014.

Teen Births

Nationally, 30 percent of all teenage girls who drop out of school cite pregnancy and parenthood as key reasons. Educational achievement affects the lifetime income of teen mothers: two-thirds of families started by teens are poor, and nearly one in four will depend on welfare within three years of a child's birth. Many children will not escape this cycle of poverty. Only about two-thirds of children born to teen mothers earn a high school diploma, compared to 81 percent of their peers with older parents. National Conference of Legislators Website, 2016. <http://www.ncsl.org/research/health/teen-pregnancy-affects-graduation-rates-postcard.aspx>

Nationally, in 2014, non-Hispanic Black and Hispanic teen birth rates were still more than two times higher than the rate for non-Hispanic white teens. Additionally, less favorable socioeconomic conditions, such as low education and low income levels of a teen's family, may contribute to high teen birth rates. Centers for Disease Control and Prevention Website, 2016. <http://www.cdc.gov/teenpregnancy/about/index.htm>

The teen birthrate (the number of births by teens age 15-19 per 1000 births) in the PSA between October 2014 and September 2015 was 24.6 compared to an Illinois rate of 20.5.

Four zip codes in the PSA had teen birthrates over 35 percent:

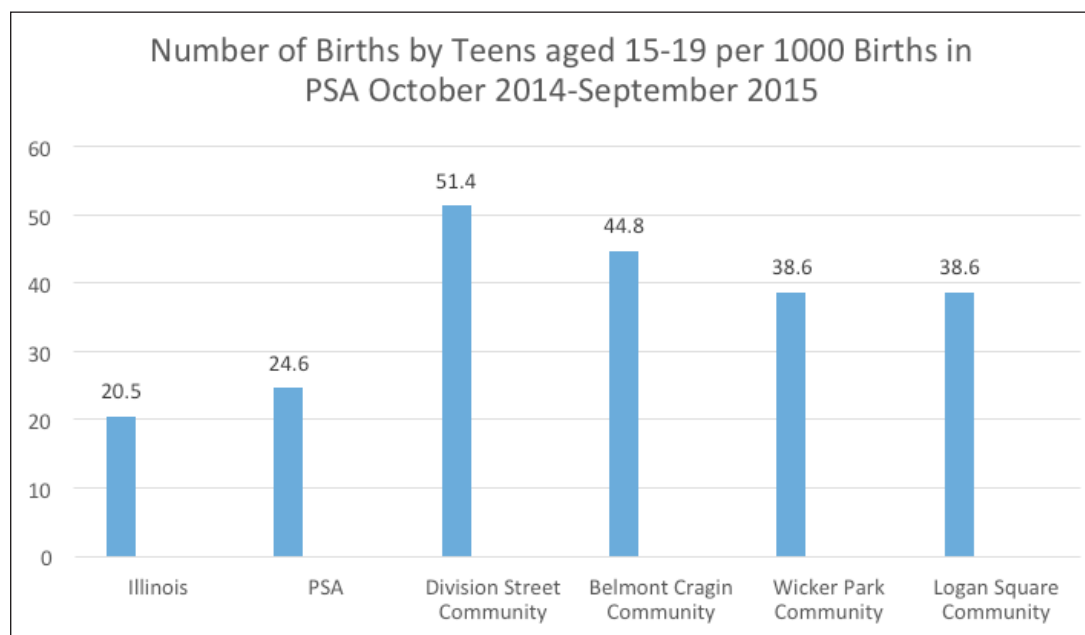
60651 (Division Street) 51.4

60639 (Belmont Cragin): 44.8

60622 (Wicker Park): 38.6

60647 (Logan Square): 38.6

Exhibit 42: Number of Births by Teens Age 15-19 per 1000 Births in PSA October 2014-September 2015



Source: Illinois Hospital Association, COMPdata, October 2014-September 2015.

Health Disparities

Several disparities have been identified throughout this document. In terms of Chronic Disease (excluding hepatitis and HIV where there are additional risk factors), the data illustrates that there is a greater burden of chronic disease in particular communities. The communities affected are lower income and communities of color. The areas repeatedly identified included: Wicker Park, Rogers Park, Belmont Cragin, Uptown, Logan Square, Division Street and Fort Dearborn. These areas have percentages of people living below 100% of the poverty level between 13.1% and 27.7%. Four of the areas are within communities where over 20% of the people live below 100% of the poverty level: Rogers Park, Belmont Cragin, Uptown and Logan Square. Except for Uptown where persons of color make up 48.4 percent of the population, the other three communities are areas that are made up of over 50% of populations of color.

There is national data that supports the disparities identified in the local data.

Hispanics

The 2013 CDC Health Disparities & Inequalities Report (CHDIR) is an assessment that highlights health disparities and inequalities in the United States. Examples of some important health disparities in the Hispanic population as reported in the CHDIR are:

- Obesity among female Mexican American adults
- There is also a higher prevalence of obesity in Hispanic children (Kaiser Family Foundation Analysis of CDC National Health and Nutrition Examination Survey, 2011-2014).
- A higher prevalence of diabetes
- A higher prevalence of periodontitis
- A higher rate of HIV infection
- A higher teen birth rate
- A lower rate of colorectal cancer screenings
- A lower rate of blood pressure control

According to *Healthy Chicago 2.0*, 28 percent of Hispanics have no health insurance. Nationally, the Hispanic population has the highest (tied with American Indians and Alaska Natives) rate for being uninsured (Kaiser Family Foundation Analysis of March 2015 Current Population Survey, Annual Social and Economic Supplement.)

According to the American Cancer Society's Cancer Facts and Figures 2015, Latinas have a higher incidence rate of cervical cancer.

LGBQIA and Transgender Population

LGBQIA and Transgender individuals encompass all races and ethnicities, religions and social classes. Sexual orientation and gender identity questions are not asked on most national and state surveys, making it difficult to estimate the number of LGBTQ individuals and their health needs. However, according to the Healthy People 2020 Report, research suggests that the LGBTQ community faces disparities linked to societal stigma, discrimination, and denial of their civil and human rights. These factors have been associated with higher rates of psychiatric disorders, substance abuse, suicide and experience with violence and victimization.

This report also identifies that:

• LGBQIA and Transgender youth are more likely to be homeless.
• Lesbians are less likely to get preventive services for cancer.
• Gay men are at higher risk of HIV and other Sexually Transmitted Infections (STIs); especially among communities of color.
• Lesbians and bisexual females are more likely to be overweight or obese.
• Transgender individuals are less likely to have health insurance.
• LGBQIA and Transgender populations have the highest rates of tobacco, alcohol and other drug use.

Source: Healthy People 2020, Lesbian Gay Bisexual and Transgender Health, 2016.

African Americans

According to a 2014 report from Families USA, some of the more common health disparities that affect African Americans in the United States compared to Non-Hispanic Whites include:

• Higher rates of diabetes.
• A higher likelihood of death from asthma.
• A higher likelihood of death from stroke.
• A higher likelihood of death from cervical cancer.
• A higher prevalence of obesity.
• A higher prevalence of HIV infection.
• African American children are twice as likely to die as an infant, twice as likely to die of SIDS, twice as likely to have asthma and 73 percent more likely to be obese.

Source: Families America, African American Health Disparities Compared to Non-Hispanic Whites, 2016.

According to the American Cancer Society's Cancer Facts and Figures for African Americans 2016-2018:

- Breast cancer death rates are 42 percent higher in Black women compared to White women despite similar incidence rates.
- Incidence rates for colon cancer for Black men and women are higher than for White men and women.

Additionally, non-Hispanic Black males have the highest incidence and mortality rates for lung and bronchus cancer. (American Cancer Society, North American Association of Central Cancer Registries, 2014; Centers for Disease Control and Prevention, National Center for Health Statistics, US Mortality Data, 2007-2011.)

According to the Kaiser Family Foundation Analysis of the CDC Behavioral Risk Factor Surveillance System, 2014, Black adults have a higher rate of smoking. (Kaiser Family Foundation, Key Facts on Health and Health Care by Race and Ethnicity, June 2016.)

Asian Populations

According to the CDC website from information last updated in 2014, Asian Americans have disproportionately high prevalences of the following conditions and risk factors:

• HIV/AIDS
• Hepatitis A and B
• Tuberculosis (TB)

Source: Centers for Disease Control and Prevention, Health Disparities in HIV/AIDS, HIV Aids and Asians/Pacific Islanders, 2011.

The Asian/Pacific Islander male population has the highest incidence and mortality rates for Liver and Intrahepatic Bile Duct cancer. Asian/Pacific Islander women have the highest incidence and mortality rate for stomach cancer. (American Cancer Society from the North American Association of Central Cancer Registries, 2014; Centers for Disease Control and Prevention, National Center for Health Statistics, US Mortality Data, 2007-2011.)

Identifying Priorities

Health Impact Collaborative of Cook County

Through a data-driven collaborative prioritization process, the Health Impact Collaborative identified four priority focus areas. (See Exhibit 43.) As the Health Impact Collaborative moves from assessment to planning, the partners, including Illinois Masonic Medical Center, will be working together to determine the best infrastructure for implementing collaborative strategies related to the four focus areas. Addressing the social, economic and structural determinants of health has been identified as an overarching priority that will be an important focus for collaborative planning and implementation among all hospital participants.

Exhibit 43:

Health Impact Collaborative of Cook County Collaborative focus areas and key identified community health needs plus crosscutting policy and data system strategies across all priorities		
Improving social, economic, and structural determinants of health while reducing social and economic inequities.		
<ul style="list-style-type: none"> • Economic inequities and poverty • Education inequities • Healthy environment • Housing and transportation • Safety and violence • Structural racism 		
Improving mental health and reducing substance use.	Preventing and reducing chronic disease prevention.	Increasing access to care and community resources.
<ul style="list-style-type: none"> • Overall access to services and funding • Violence and trauma, and ties to mental health 	<ul style="list-style-type: none"> • Focus on risk factors — nutrition, physical activity, and tobacco • Healthy environment 	<ul style="list-style-type: none"> • Cultural & linguistic competency/humility • Health literacy • Access to healthcare and social services, and navigating the system, particularly for uninsured and underinsured • Linkages between health care providers and community-based organizations for prevention

Illinois Masonic Medical Center Community Health Council

Data was sent to the CHC in early June of 2016 to review before its June 29, 2016, meeting. The CHC was given 40 pages of data to review which included the socioeconomic data, health/disease indicator data and health disparities data for the PSA collected from HICCC, HCI and the other sources identified above. Presented data primarily focused on the magnitude and severity of each issue.

After discussion, the CHC and medical center staff agreed to group the community health issues for the PSA that emerged from the data and discussion into 26 topics. Chronic Disease Prevention/Management was added as a topic in addition to individual chronic diseases. This was to allow discussion to focus on both chronic diseases as a whole and particular diseases individually. Additionally, recognizing the interrelatedness among mental health, alcohol abuse and substance abuse, the CHC recommended that all of these issues be grouped together under the umbrella of behavioral health. The council also grouped vaccine-preventable diseases together even though hepatitis B and C do cause chronic liver disease.

The topic options defined by the CHC were:

1. Asthma
2. Autism
3. Behavioral Health (including Mental Health, Alcohol Abuse and Substance Abuse-Non-Tobacco)
4. Breast Cancer
5. Cervical Cancer
6. Chronic Disease Prevention/Management (including asthma, diabetes, heart failure, kidney disease, hypertension, chronic lower respiratory disease and obesity)
7. Chronic Liver Disease
8. Chronic Lower Respiratory Disease
9. Colorectal Cancer
10. Data Collection
11. Dental Health
12. Diabetes
13. Health Literacy/Language & Cultural Competency
14. Heart Failure
15. HIV
16. Housing Instability
17. Hypertension
18. Influenza and Pneumonia
19. Kidney Disease
20. Obesity (raises the risk for heart disease, high blood pressure, stroke and diabetes.)
21. Sexual Abuse
22. Sexually Transmitted Infections
23. Stroke
24. Substance Abuse – Tobacco and Vaping/Lung & Bronchus Cancer
25. Teen Birth
26. Vaccinations (meningitis, hepatitis, HPV)

Additional information on the identified health issues for the PSA was sent to the CHC in the beginning of July 2016. The more in-depth information included:

- Evidence-based strategies to address the issue;
- Information regarding what the medical center is currently doing to address the issue; and
- Information regarding the work of potential partners on the issue.

Between the June 2016 and the July 2016 meetings of the council, members were asked to review data related to the identified needs in the PSA and use nine prioritization criteria to individually rank their five highest priorities for the PSA. Prioritization criteria included:

1. Health Equity – Addressing the issue can improve health equity and address disparities.
2. Root Causes/Social Determinants of Health – Solutions have the potential to impact multiple problems.
3. Community Priority – Issue is identified as an important issue or priority by focus groups or non-medical center Community Health Council members.

4. Evidence-based, Measureable Interventions – Approaches exist to address the issue that are proven to be effective and results are measureable.
5. Availability of Resources/Feasibility – Resources, such as money, human capital, existing programs and assets can be made available to address the issue; Program implementation and goals are obtainable.
6. Prevention focus – Intervention is prevention focused, rather than treatment focused.
7. Magnitude and Severity – There is a high incidence/or the issue causes great harm.
8. Collaborative Approach – Collaboration is needed in order to implement an effective solution.
9. Connectedness to the findings of the Health Impact Collaborative of Cook County.

The individual rankings were aggregated by staff. Only those need issues that received points were on the final list of 18 issues (issues that received no points were excluded). The highest ranked need received 55 points and the two lowest ranked needs received one point each. (See Appendix B for list of ranked needs.) The Council agreed to eliminate any issues that received less than 10 points as a contender for a priority need area. The Council then focused their priority selection discussion on the top seven issues, none of which received less than 13 points.

Priorities Selected to Address

After a discussion of the rankings made by the Community Health Council and the medical center’s commitment to the Health Impact Collaborative of Cook County process, three issues were selected by a unanimous vote as priority needs for this CHNA:

1. Chronic Disease Prevention/Management
2. Behavioral Health
3. Social Determinants of Health

After the three priority areas were selected, at the August 2016 meeting of the CHC, the council began a discussion of evidence-based strategies to address each of the identified priorities.

The priorities and the preliminary implementation strategies were presented to the medical center’s Governing Council by one of the CHC’s two Governing Council members. The Governing Council voted to approve Illinois Masonic Medical Center’s 2016 CHNA Report at its September 27, 2016, meeting.

Explanation Why Other Needs Not Selected as Priorities

Of the seven priority health issues ultimately discussed by the Community Health Council as potential CHNA selections, two were incorporated into Chronic Disease Prevention/ Management (Obesity, which ranked third as an independent issue; and Diabetes, which ranked sixth as an independent issue). Two issues of the top seven health issues were not selected as priorities for this CHNA: Health Literacy/ Language and Cultural Competency, and Breast Cancer.

Health Literacy/Language & Cultural Competency

Health literacy is the degree to which an individual has the capacity to obtain, communicate, process and understand basic health information and services to make appropriate health decisions. The Community Health Council initially ranked this issue fourth. The medical center’s Diversity and Inclusion Workgroup is spearheading work on this issue. Several medical center Community Health Council members serve on the Diversity and Inclusion Workgroup so coordination between the two groups is easily achievable. Strategies to address this issue include increasing the amount of Spanish materials produced and disseminated; the creation of an LGBTQ Taskforce; cultural competence training for staff; and greater use of case managers and Community Health Workers.

Breast Cancer

As breast cancer has the highest cancer incidence rate within the medical center’s PSA, the Community Health Council ranked this issue among its top seven. The council was also concerned about the fact that African American women have higher breast cancer mortality rates.

The medical center received a grant from the Komen Foundation in 2016 to hire a part-time Community Health Worker (CHW) to conduct breast health education and outreach within the African American population. For those African American patients already in the cancer program, the CHW will provide additional support in overcoming barriers to obtaining timely treatment and act as a communication bridge for the patient and her treatment team. Additionally, the CHW will work within the African American community to provide education on breast cancer and on the importance of timely screenings and treatment after diagnosis.

The Creticos Cancer Center—the cancer care facility on the Advocate Illinois Masonic Medical Center campus—unites all cancer care and research under one roof for more efficient and personalized planning and treatment. The Center offers a wealth of services to address the unique needs of cancer patients throughout the continuum of care; including bilingual Spanish/English psychosocial support, counseling and financial navigation. Nurse navigators provide linkage with community programs, physical medicine and rehabilitation, pain management services and palliative care, and hospice and home care programs. The Center hosts the American Cancer Society’s Look Good, Feel Better program and each year at the medical center, the Amber Foundation facilitates the sponsorship of free mammograms, counseling and education about breast cancer at the medical center targeting the Polish community in Chicago. The Center also has a breast cancer support group for Latinas and is developing a cancer support group for the LGBTQ community.

In addition, the medical center works closely with two important programs that address community health needs in breast health. The medical center works with the Illinois Breast and Cervical Cancer program to ensure that uninsured women have access to screening and treatment for breast or cervical cancer. The medical center is also a participant in Silver Linings, a privately funded program that provides funding for underinsured women to access mammograms, ultrasounds and other diagnostic tools.

Hispanocare, a part of Illinois Masonic Medical Center; is dedicated to providing affordable, quality, bilingual, bicultural health care to Chicago’s Latino community. It provides education, screening and follow-up for breast cancer in the surrounding community. Services are provided in both English and Spanish.

V. Implementation Planning for 2014-2016 CHNA

Implementation Plans

As a result of the 2014-2016 Community Health Needs Assessment, Illinois Masonic Medical Center will strategically work to address the following identified priorities:

Chronic Disease Prevention/Management

Much of chronic disease, the complications of chronic disease and related costs are preventable. Behaviors such as poor diet, lack of physical activity and use of tobacco; non-adherence to medication protocols; limited access to health care and unhealthy environments can all result in a dramatic increase in chronic conditions. It is also known, however, that there are strategies and interventions that can prevent onset of chronic disease and improve care management.

Discussions around this issue and how to address it will include examination of such diseases and conditions as asthma, diabetes, hypertension, chronic respiratory disease, heart disease, hepatitis, HIV and obesity. Additionally, areas and/or populations with high incidence of these diseases and conditions will be targeted within the PSA for interventions.

Chronic Disease Prevention/Management strategies will have the goal of reducing avoidable Emergency Department (ED) visits and admissions for chronic diseases. Evidence-based, measurable strategies will be examined such as:

- Developing and implementing Community Health Worker (CHW) programs at Illinois Masonic Medical Center; using CHWs to address chronic disease prevention/management.
- Working with the Chicago Housing Authority (CHA) to provide chronic disease education to seniors that reside in subsidized housing in the medical center's service area.
- Strengthening the medical center's relationship with Advocate Clinics at Walgreens in the medical center's service area in order to provide alternate sites for primary care-associated, low-acuity conditions.
- Improving coordination of care with Federally Qualified Health Centers (FQHCs).
- Creating a scalable program to address obesity in a local school or organization that serves children. Existing relationships would be leveraged, and nurses and residents would be encouraged to participate.
- Partnering with community organizations to pool resources to provide obesity education.
- Supporting medical center in investigating non-surgical interventions for obesity.
- Supporting medical center in seeking Baby Friendly designation.
- Supporting medical center's Women and Children's Services in developing community-based breast-feeding programs.

Potential partners include schools, local Federally Qualified Health Centers, local community-based organizations, Chicago Housing Authority, Chicago Public Schools and Walgreens.

Work on this issue will be coordinated with the work of HICCC and the Healthy Chicago Hospital Collaborative.

Behavioral Health

Certain areas of the PSA experience higher rates of behavioral health conditions. There is a strong relationship between behavioral health and other issues such as chronic disease and housing instability.

The goals for implementing a behavioral health strategy will be to maximize the use of existing resources for mental health and alcohol abuse and substance abuse; improving the coordination of follow-up services for behavioral health patients after acute care is provided and; reducing ED and inpatient behavioral health visits for the PSA. Areas and/or populations with high incidence of behavioral health conditions will be targeted for intervention within the PSA.

Evidence-based, measurable strategies will be examined such as:

- Providing prevention education to community residents that focuses on trauma and ACE (Adverse Childhood Experiences) issues; exploring Mental Health First Aid and/or First Episode Psychosis strategies.
- Continuing to improve bi-directional coordination of follow-up behavioral health services after acute care; seeking sustainable relationships with primary care providers and behavioral health organizations that will integrate primary care with mental health, alcohol abuse and substance abuse services.
- Producing a Behavioral Health Resource Directory as a collaborative effort with other providers in Chicago.
- Continuing to support the medical center's First Access and Medically Integrated Crisis Community Support (MICCS) programs.
- Exploring a collaborative Living Room Model with other providers in Chicago. A Living Room Model is a community crisis respite center that offers individuals in crisis an alternative to obtaining services in an emergency department.

Potential partners include Mental Health First Aid providers, Federally Qualified Health Centers and area behavioral health providers.

Work on this issue will be coordinated with the work of HICCC and the Healthy Chicago Hospital Collaborative.

Social Determinants of Health (SDOH)

In order to take effective action on SDOH that address health inequities, communities must work together. These are systemic issues that call for large-scale, collaborative approaches. Strategy implementation to address this priority is being carried out with the Health Impact Collaborative of Cook County (HICCC) and may include addressing such issues as poverty and economic inequities, education, structural racism, housing, transportation, built environments and/or violence and trauma. The Health Impact Collaborative of Cook County began the planning process for a health equity strategy in August 2016. Illinois Masonic Medical Center is, and will continue to be, an active participant in this process.

Additionally, the CHC was enthusiastic about the medical center's participation in the new Advocate Workforce Development Project. This initiative will strive to provide healthcare focused, skill-based training for mid-skill occupations to unemployed and underemployed populations throughout the Advocate system. This program is expected to come to Illinois Masonic Medical Center in 2017.

In addition to participating in the HICCC process, work will be coordinated with the Healthy Chicago Hospital Collaborative as well.

VI. Vehicle for Community Feedback

We welcome your feedback regarding this Community Health Needs Assessment (CHNA) Report. 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-CHNAReportCmtFeedback@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 medical center's Community Health Department.

Other Communication and Feedback Opportunities

In addition to the opportunity to provide feedback through the means described above, Illinois Masonic Medical Center will communicate the CHNA findings and preliminary implementation plans, as available, to the community through the following:

The final CHNA report will be presented to the Illinois Masonic Medical Center Community Health Council in January of 2017. The public is welcome to attend. For more information on this meeting call: 773.296.5804. Additional presentations can be scheduled as requested.

VII. Appendices

Appendix 1: 2014-2016 Community Health Needs Assessment Data Sources

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

Primary Sources

Advocate Health Care Strategic Planning Department.

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Chicago Department of Public Health Data, 2009-2013.
<http://www.cityofchicago.org/city/en/depts/cdph.html>

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STD/HIV/AIDS Chicago, Winter, 2005-2006.
www.aidschicago.org

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Healthy Chicago Hospital Collaborative, North Side Percent without Health Insurance Map, 2016.

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<http://www.minorityhealth.hhs.gov>

Appendix 2: Results of Community Health Council Prioritization Process

1. Chronic Disease Management : **55**
2. Behavioral Health: **37**
3. Obesity: **37**
4. Health Literacy/Language & Cultural Competency: **26**
5. Housing Instability: **18**
6. Diabetes: **17**
7. Breast Cancer: **13**
8. Stroke: **9**
9. Dental Health: **9**
10. STI/HIV: **8**
11. Colorectal Cancer: **6**
12. Cervical Cancer: **6**
13. Sexual Abuse: **5**
14. Data Collection: **5**
15. Heart Failure: **3**
16. Hypertension: **2**
17. Teen Birth: **1**
18. Vaccinations: **1**

Each issue could get a maximum of 90 points.

94% of the Community Health Council responded.

 Advocate Illinois Masonic Medical Center

836 West Wellington Avenue
Chicago, IL 60657
773.975.1600
advocatehealth.com/masonic

