Community Health Needs Assessment

2014 – 2016

Advocate South Suburban Hospital

December 2016

Thank you for taking the time to learn more about Advocate South Suburban Hospital and its mission to serve the residents of Hazel Crest and the surrounding communities through this Community Health Needs Assessment (CHNA). Advocate South Suburban Hospital conducts a CHNA every three years to assess needs and to develop plans to improve the health of its community. By collecting and analyzing data, as well as partnering with other community organizations, the assessment guides efforts to address the highest priority needs.

For this survey cycle, Advocate hospitals in Cook County partnered with the Health Impact Collaborative of Cook County to implement a shared plan to maximize health equity and wellness in the county. The collaborative was developed so that participating organizations could efficiently share resources, work together on a regional CHNA and then partner to address common needs. The county was divided into north, central and south regions to enable the involvement of other local stakeholders and identify the local needs of this diverse county. Advocate South Suburban Hospital was appropriately assigned to the South Region consisting of both the south side of Chicago as well as southern suburbs of Chicago.

In addition, the hospital expanded its data analysis to focus on specific needs of its primary service area. Our organization is dedicated to improving the health of the community it serves. This comprehensive assessment ensures that we will continue to look at the community in a thorough and thoughtful manner that will help us meet unaddressed health needs.

At the end of this report, you will find a link to provide feedback. To receive a copy of the report, please contact the Community Health department at South Suburban Hospital. South Suburban Hospital has been privileged to serve its community since 1946, and as we celebrate our 70th anniversary, it is our mission and an honor to continue to meet the health needs of the communities we are privileged to serve. On behalf of the 1,400 hospital associates and more than 700 physicians on our medical staff, we thank you for taking the time to review this assessment.

Sincerely,

Richard Heim
President
South Suburban Hospital

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I. Executive Summary

With this Community Health Needs Assessment (CHNA) report, Advocate South Suburban Hospital continues to demonstrate strong commitment to building lifelong relationships to improve the health of individuals, families and communities. In 2015, all five Advocate Health Care hospitals principally serving Cook County, including South Suburban Hospital, were founding members of the Health Impact Collaborative of Cook County (HICCC). HICCC is a best practice community health initiative involving 26 hospitals, 7 health departments and nearly 100 community-based organizations. The goal of this collaborative is to work together on a county-wide health assessment and common implementation strategies once priorities are identified. The Illinois Public Health Institute (IPHI) served as the backbone organization for the collaborative—providing facilitation, data coordination and report preparation activities.

Given the size and diversity of Cook County, the collaborative created three regions—North, Central and South—for purposes of organizing the assessment process. South Suburban Hospital was appropriately assigned to the South region consisting of both the south side of Chicago and the south suburbs of Cook County. Please see the companion document to South Suburban Hospital's CHNA, Health Impact Collaborative of Cook County, Community Health Needs Assessment, South Region, which is also posted on the Advocate website and at www.healthimpactcc.org/reports2016.

In addition to participating in the Cook County collaborative, South Suburban Hospital conducted a community health assessment targeting its defined community-–the hospital's primary service area (PSA). This area consists of 22 zip codes in southern Cook County with parts of Park Forest and Frankfort in Will County. With a population of 496,633, the PSA is a diverse community with 12.5% of its residents of Hispanic ethnicity and a racial distribution that is 43% white, 47% Black/African American and 10% other. The median age of residents in the hospital PSA is 38 years and seniors age 65 and older represent 14% of the population—very similar to percentages for the county and state.

There are disparities that exist among the communities in the hospital's PSA in relation to education and income. The percent of the population with no high school diploma ranges from 2.6% for Flossmoor to 23.3% for Harvey. While the PSA as a whole has 22% of residents insured by Medicaid, that percentage ranges from 52.3% in Harvey to 7.5% in Tinley Park. While the median household income for the PSA is $61,147, this figure ranges from $99,098 in Frankfort to $42,479 in Markham to $27,939 in Harvey.

South Suburban Hospital convened a Community Health Council (CHC) on February 24, 2016. The Council's responsibilities were to oversee the community health work of the hospital including the data review and prioritization of health needs for the 2014-2016 community health needs assessment and the development of an implementation plan to address community health needs.

South Suburban Hospital's community health team reviewed data from primary and secondary sources. This data highlighted the prevalent health issues within the hospital's primary service area (PSA). After review of the hospital, HICCC, county, state and HCI data, the leading causes of death, hospitalization and overarching health issues were summarized and presented to the CHC for prioritization. Data presented to the CHC centered on the following health conditions identified as important in South Suburban Hospital's primary service area: asthma, cancer, diabetes, heart disease, stroke and hypertension. By unanimous decision, the council selected two priority health needs to address for implementation planning—asthma and diabetes.

Data from the Health Impact Collaborative of Cook County was presented to the CHC including the HICCC priority-setting process that identified Social Determinants of Health, Mental Health/ Substance Abuse, Access to Care and Chronic Disease as the four county-wide priorities. All hospitals that participated in HICCC agreed to accept Social Determinants as one of their priorities, with South Suburban Hospital identifying that one of their strategies within this priority would be a focus on housing. This naturally fit with the ongoing asthma priority, as housing problems create barriers to successful asthma management.

In addition to housing, the CHC also selected asthma and diabetes as priorities. South Suburban Hospital is currently developing implementation plans for each of the three priorities selected. Community health staff will be participating in the action planning teams on Social Determinants of Heath and Chronic Disease Prevention convened as part of the HICCC. For housing, the hospital is considering working with

the Metropolitan Tenants Organization to provide healthy homes education to tenants and to incorporate a healthy homes initiative into the Kickin' Asthma program. For the asthma priority, the community health team is planning to expand their school collaborations into some of the high risk areas identified in this assessment. For the diabetes priority, the team plans to implement the National Diabetes Prevention Program (DPP), Prevent T2, in community areas in partnership with community-based organizations and faith communities.

II. Description of Advocate Health Care and Advocate South Suburban Hospital

Advocate Health Care

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, South Suburban Hospital embraces the Advocate system MVP.

Advocate South Suburban Hospital

Advocate South Suburban Hospital, located in Hazel Crest, Illinois, is a 284-bed acute-care hospital providing comprehensive inpatient, outpatient, diagnostic and ambulatory care services. The hospital is fully accredited by Det Norske Veritas (DNV), with its integrated skilled nursing facility (SNF) accredited by the Joint Commission. South Suburban Hospital also recently earned its ISO 9001 certification, validating its commitment to clinical excellence and continuous improvement. The hospital is an Illinois Department of Public Health-designated Stroke Center and has earned the American Heart Association's Get with the Guidelines-Stroke Gold-Plus Quality Achievement Award. The hospital's Nurses Improving Care for Healthcare Elders (NICHE) program is one of only three in the state to have earned Exemplar status, the highest level of recognition for efforts to improve care and service to older adults.

More than 11,000 patients are admitted to South Suburban Hospital each year. There are about 146,000 annual outpatient visits to the hospital, including 51,000 Emergency Department (ED) visits. South Suburban Hospital has more than 750 physicians on staff and employs 1,460 associates which includes 550 nurses.

The hospital features a broad range of medical services that include an Ambulatory Surgery Center, an accredited Cancer Center, a dedicated Breast Care Center, an Orthopedic Center of Excellence unit, a state-of-the-art intensive care unit and a full-service Emergency Department. Specialty services include skilled nursing, hospice care, cardiovascular and physical rehabilitation departments.

South Suburban Hospital also features a sexual assault nurse examiner (SANE) program recognized by the Illinois Coalition Against Sexual Assault (ICASA) and Metropolitan Chicago Healthcare Council as a benchmark and model for other hospitals. Recently, a Pediatric Asthma Initiative was developed to decrease trips to the ED amongst kids with asthma.

III. Summary of the 2011-2013 CHNA

Community Definition

For the 2011-2013 assessment, the Community Health Council defined its community as South Suburban Hospital's primary service area (PSA), which included twenty-two zip codes in South Cook County with parts of Park Forest and Frankfort in Will County, Illinois. The zip codes and corresponding cities, towns or villages in the PSA were: 60409 Calumet City; 60411 Chicago Heights and Ford Heights; 60419 Dolton; 60422 Flossmoor; 60423 Frankfort; 60425 Glenwood; 60426 Harvey; 60428 Markham; 60429 Hazel Crest; 60430 Homewood; 60438 Lansing; 60443 Matteson; 60445 Midlothian; 60452 Oak Forest; 60461 Olympia Fields; 60466 Park Forest; 60471 Richton Park; 60473 South Holland; 60476 Thornton; 60477 Tinley Park; 60478 Country Club Hills; and 60487 Tinley Park.

The US Census reported that the PSA population was 499,720 in 2012 and experienced a 3.39 percent decrease between 2000 and 2010 (Census Viewer, 2011-2012). The population was 47% African American and 38% Caucasian. Other races, including American Indian, Asian and Native Hawaiian, comprised the remaining 3% of the total population. Twenty-six percent of the population was less than 18 years old; 34% was 18-34 years; 27% was 45-64 years and 13% was 65 years and older.

2011-2013 CHNA Process

South Suburban Hospital convened a Community Health Council (CHC) in 2012 to oversee the comprehensive 2011-2013 CHNA. The CHC was chaired by the hospital's Vice President of Mission and Spiritual Care and comprised of hospital and community representatives. The Council used primary and secondary community health data to identify the key health needs in the PSA. This process included an examination of data related to the community's health, the barriers to improved health and community assets. The process also involved discussions with external key informants to determine potential opportunities to address community health needs with collaborative partners.

Needs Identified and Prioritization Process

The CHC identified asthma, cardiovascular disease, stroke, cancer, diabetes, and teen pregnancy as the most significant health needs in the hospital's PSA. After identifying the top needs, the CHC then discussed which priority area would be selected for new community health planning and implementation through a prioritization process. The following criteria were considered in selecting priorities:

- Most prevalent health needs identified based on public health data and South Suburban Hospital patient utilization data;
- Health issues where significant disparities existed;
- Current resources available for design and implementation of new community health programs; and
- Availability of community partnerships/existing relationships that provided the opportunity to work collaboratively to address health needs.

Summary of Program Strategies and Outcomes to Meet Identified Priorities

Asthma was selected as the top health need to address given the magnitude of this health issue in the hospital's primary service area. To address this issue, the hospital implemented three strategies to improve the health of children with asthma.

- Implement the American Lung Association's Kickin' Asthma program which targets students in schools to help them identify and address asthma triggers. This program promotes individual responsibility, self-management and early action among adolescents. The over-arching goal of the program is to improve asthma management and decrease acute care utilization among children ages 11 to 16.
- Develop an internal asthma task force to review internal hospitalization data and address the needs of children who presented to the hospital with asthma-like symptoms. The committee met quarterly to evaluate the effectiveness of the goals set for inpatient and emergency department utilization. After the second year, and realizing that children are not diagnosed in the hospital but by their primary care physician, the task force refocused its goals solely on emergency department data with the intention to

ensure that children receive the appropriate treatment, asthma education, an asthma action plan and a follow-up phone call to insure that prescriptions have been filled. Representatives on the internal South Suburban Hospital Asthma Task Force included:

- Assistant Clinical Manager, Emergency Department
- Clinical Data Analyst
- Clinical Information Analyst
- Coordinator, Community Health
- Director, Critical Care Services
- Director, Public Affairs and Marketing
- Manager, Birth Center and Pediatric Services
- Manager, Clinical Informatics
- Manager, Continuity of Care
- Manager, Emergency Department
- Manager, Respiratory Services
- Clinical Respiratory Specialist
- Vice President, Mission and Spiritual Care Services
- Vice President Operations (Executive Sponsor)

- Provide education to community organizations regarding asthma, including how to recognize worsening asthma, administer quick-relief medications, and when to decide to call for emergency services. Those community partners included churches, local park districts, PTO associations, local rotary, and high school athletic departments (freshmen class) and other community organizations. The goal is to continue to provide asthma education to at least five organizations and also conduct at least 16 hours of asthma education in the community annually.

Program outcome indicators are represented in Exhibit 1, 2 and 3.

Exhibit 1: South Suburban Hospital Kickin' Asthma Program Outcomes 2014-2016

Metric	2014 Results	2015 Results	2016 Results	Comment
Develop school-based asthma programs in 80% of schools within ASSH primary service area.	17%	26%	*	Enrolled schools began 2nd quarter 2016. Program data will be available January 2017.
100% of students will create an asthma action plan for intervention and maintenance.	100%	100%	*	Enrolled schools began 2nd quarter 2016. Program data will be available January 2017.
100% of students will be able to understand asthma and recognize their signs/symptoms and triggers through pre and post-tests.	100%	100%	*	Enrolled schools began 2nd quarter 2016. Program data will be available January 2017.

*No data available until the end of the year 2016.

Source: Advocate South Suburban Hospital, Asthma Task Force, 2016.

Exhibit 2: South Suburban Hospital Asthma Metrics for ED Patients 2014-2016

Metric	2014 Results	2015 Results	2016* Results	Comment
100% of pediatric patients, age 5 – 17 years, with a diagnosis of Asthma in the ED shall be discharged home with an Asthma Action Plan.	29%	48%	29%	
100% of pediatric patients, age 5 – 17 years, with a diagnosis of Asthma in the ED shall be discharged home with asthma education.	35%	50%	38%	
100% of eligible pediatric patients with a diagnosis of asthma in the ED shall be discharged home with steroids.	96%	90%	89%	
100% of patients with a primary diagnosis of asthma in the ED will have filled prescriptions on discharge call.	97%	95%	94%	
Decrease the percentage of ED pediatric readmissions within 12 months by 10%.	18% decrease	29% decrease	19% decrease	

*Only six months of data are provided.

Source: Advocate South Suburban Hospital, Asthma Task Force, 2016.

Exhibit 3: South Suburban Hospital Asthma Metrics for Community Partnerships 2014–2016

Metric	2014 Results	2015 Results	2016 Results	Comment
Train at least five community partners totaling 16 education hours on available resources and asthma triggers in the ASSH primary service area.	9	38	5*	*2016 partial year data.

Source: Advocate South Suburban Hospital, Asthma Task Force, 2016.

Input from the Community

A link was incorporated into the online CHNA to encourage community members to provide comments or concerns about the posted CHNA. No comments were received. To make the community more aware of the hospital's Kickin' Asthma program, a video featuring students and nurses from Southwood Junior High School in Country Club Hills, Illinois was filmed in February 2015 and was posted online in the Community Album for Advocate Health Care. The hospital continued its outreach efforts by conducting education for community partners through a variety of venues. It is expected that the Kickin' Asthma program will continue to serve children in the hospital's PSA.

Lessons Learned

Lessons learned during the 2013 CHNA cycle included the need to develop additional strategies for program implementation in the schools, including engaging more high-risk schools in the PSA. One strategy to be included in the coming CHNA implementation cycle is outreach to schools before the start of the school year. A second issue identified was the need for additional community partners on the Community Health Council to provide a broader view of the health needs of the communities served in the hospital's PSA. More community outreach partners have been solicited for the council for the 2014-2016 CHNA cycle including school nurses, a family medicine physician, representation from the regional mayors and managers association, local residents and representatives from a local university.

IV. 2014-2016 Community Health Needs Assessment

Community Definition

The South Suburban Hospital Community Health Council (CHC) defines the community as South Suburban Hospital's primary service area (PSA) for the 2014-2016 Community Health Needs Assessment (CHNA). The community includes twenty-two zip codes in south Cook County with parts of Park Forest and Frankfort located in Will County, Illinois. The zip codes and corresponding cities, towns or villages are listed in Exhibit 4.

Exhibit 4: Table of Zip Codes and Corresponding Community Names for PSA

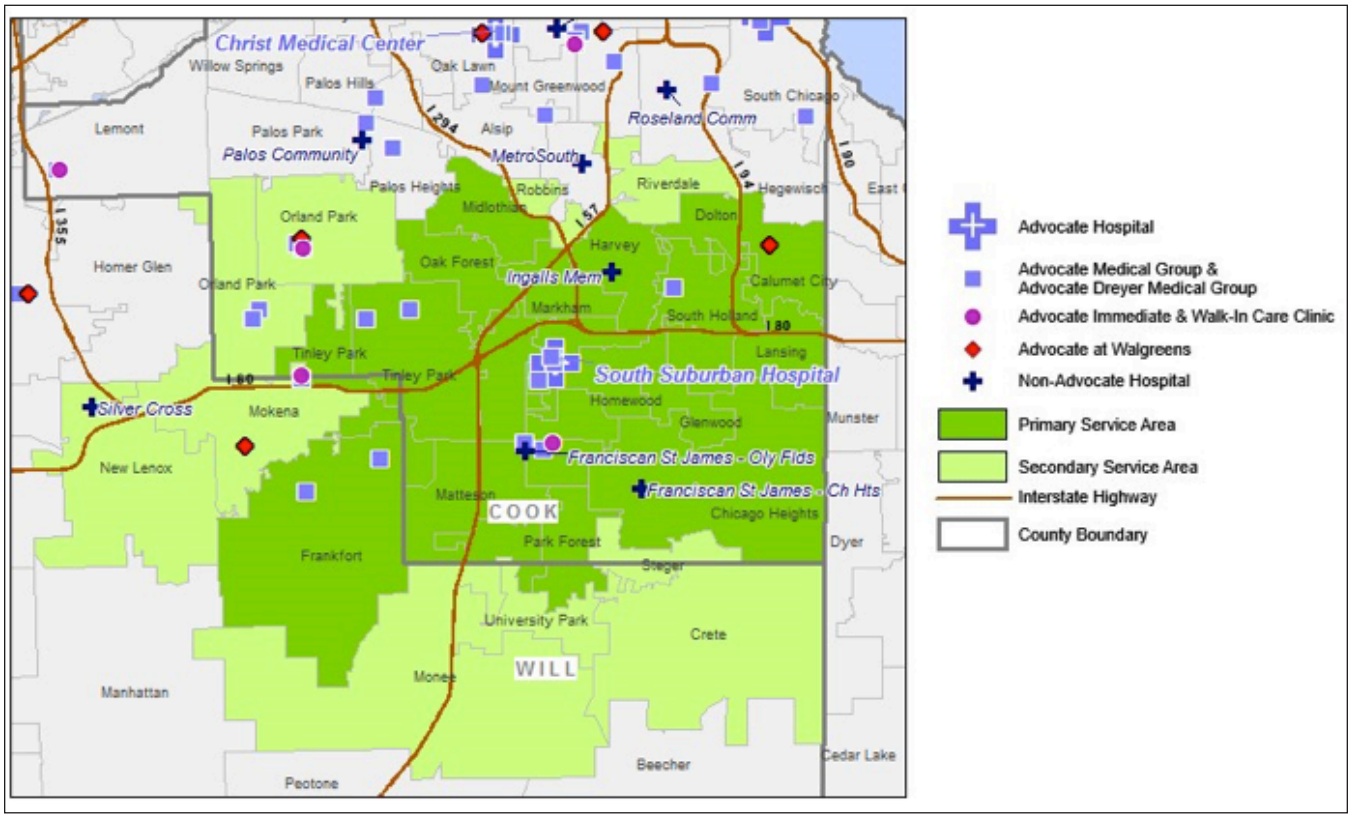
Zip Code	Community
60409	Calumet City
60411	Chicago Heights and Ford Heights
60419	Dolton
60422	Flossmoor
60423	Frankfort
60425	Glenwood
60426	Harvey
60428	Markham
60429	Hazel Crest
60430	Homewood
60438	Lansing
60443	Matteson
60445	Midlothian
60452	Oak Forest
60461	Olympia Fields
60466	Park Forest
60471	Richton Park
60473	South Holland
60476	Thornton
60477	Tinley Park
60478	Country Club Hills
60487	Tinley Park

Source: Advocate Health Care Strategic Planning Department, 2016.

The hospital's PSA, highlighted in Exhibit 5, serves a total population of 496,633 lives, a 0.42% growth in population when comparing 2010 to 2016. Comparatively, the State of Illinois grew by 0.43% and Cook County by 1.22% for the same time period (Healthy Communities Institute, Claritas, 2016).

In addition, there are a number of other hospitals and Federally Qualified Health Centers (FQHCs), and a county health department clinic which serves the area. The other hospitals include: Ingalls, Harvey; Franciscan Alliance, Chicago Heights and Olympia Fields; and Metro South Medical Center, Blue Island. The FQHCs include: ACCESS Community Health Network, Blue Island and Chicago Heights; Aunt Martha's Community Health Center, Chicago Heights, Harvey and Hazel Crest; and Family Christian Health Center, Harvey. One county clinic is the Cook County Health Center in Oak Forest.

Exhibit 5: South Suburban Hospital Primary and Secondary Service Area Map



Source: Advocate Health Care Strategic Planning Department, 2016.

Ethnicity and Race

South Suburban Hospital's PSA population is 12.29% Hispanic/Latino and 87.71% non-Hispanic/Latino. Comparatively, the Hispanic population in Cook County is 25.33% while the State of Illinois' Hispanic/Latino population is 17.07%.

Exhibit 6: Population by Ethnicity of the PSA 2016

	PSA		Cook County		Illinois	
Hispanic/Latino	61,026	12.29%	1,331,792	25.33%	2,199,562	17.07%
Not Hisp/Latino	435,607	87.71%	3,926,009	74.67%	10,686,309	82.93%

Source: Healthy Communities Institute, Claritas, 2016.

With regard to race, the PSA population is 47% African-American, 43% White, 10% other races including American Indian and Native Hawaiian/Pacific Islander. The PSA has a substantially higher representation of the African American population when compared to Cook County and the state of Illinois. See Exhibit 7.

Exhibit 7: Population by Race of the PSA Compared to Cook County and Illinois 2016

	Primary Service Area		Cook County		State of Illinois	
Race	Count	Percentage	Count	Percentage	Count	Percentage
White	213,950	43.08%	2,886,394	54.90%	9,058,485	70.30%
Black/Af Amer	232,285	46.77%	1,239,297	23.57%	1,840,394	14.28%
Am Ind/AK Native	1,350	0.27%	22,077	0.42%	46,012	0.36%
Asian	8,231	1.66%	370,745	7.05%	677,866	5.26%
Native HI/PI	134	0.03%	1,656	0.03%	4,753	0.04%
Other Races	28,005	5.64%	589,973	11.22%	930,499	7.22%
2+ Races	12,678	2.55%	147,659	2.81%	327,862	2.54%

Source: Healthy Communities Institute, Claritas, 2016.

Gender

Forty-seven percent of the PSA population is male while 53% is female. The PSA male population percentage is below the state of Illinois at 49%, while the female population percentage is higher than the state at 51%.

Exhibit 8: Population by Gender for the PSA and State of Illinois 2016

Category	PSA	Percentage	Illinois	Percentage
Male	235,734	47.47%	6,332,151	49.14%
Female	260,899	52.53%	6,553,720	50.86%

Source: Healthy Communities Institute, Claritas, 2016.

Age

The median age in the hospital's PSA is 38 years, comparable to the state and higher than the county age of 37 years. The largest population in the PSA is individuals age 45-64 years (27%). The largest population in the county is individuals age 24-44 years (29%), with the Illinois population age groups 25-44 years and 45-64 years ranked equally high (26.4% and 26.2%, respectively). (Healthy Communities Institute, Claritas, 2016.)

Exhibit 9: Population by Age in PSA, Cook County and Illinois 2016

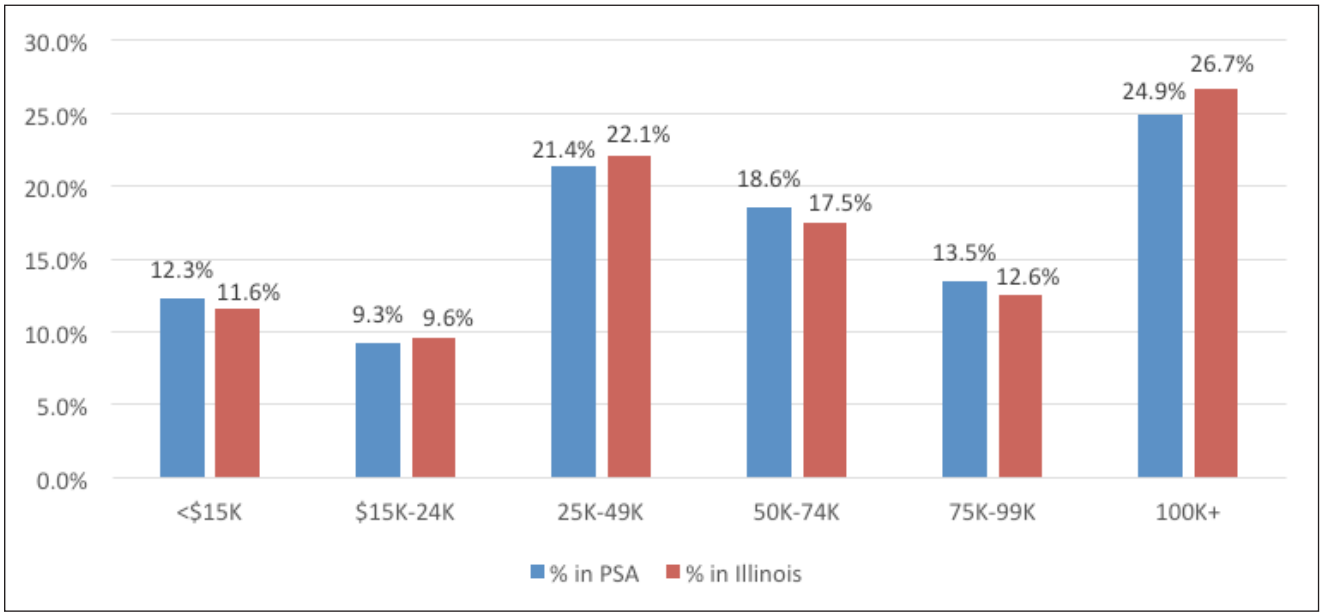
Age	PSA	Percentage	County	Percentage	Illinois	Percentage
0-17 Years	117,965	24%	1,195,042	23%	2,970,095	23%
18-24 Years	50,776	10%	482,821	9%	1,264,449	10%
25-44 Years	120,740	24%	1,550,600	29%	3,410,431	26%
45-64 Years	135,652	27%	1,319,088	25%	3,377,377	26%
65 and Older	71,500	14%	710,250	14%	1,863,519	14%
Total Population	**496,633**		**5,257,801**		**12,885,871**	
Median Age	38		37		38	

Source: Healthy Communities Institute, Claritas, 2016.

Household Income

In 2016, the household income in the PSA was similar to household income trends for the state of Illinois across income categories. However, there was a slightly higher percentage of households with incomes less than $15,000 in the PSA and a higher percentage of households at the highest income level (over $100,000) at the state level. See Exhibit 10.

Exhibit 10: Household Income in the PSA and State of Illinois 2016



Source: Healthy Communities Institute, Claritas, January 2016.

Poverty

The number of families in the PSA in 2016 that are living below 100% of the federal poverty level (FPL) is 15,249, or 12% of the population, compared to 10.79% in the state and 13.83% in Cook County. At the same time, the number of families in the PSA with children that are living below the FPL is 11,975, or 9.42% of the population compared to 8.43% in the state and 10.65% in Cook County. (Healthy Communities Institute, Claritas, 2016.)

Educational Attainment and Employment

There is a lower percentage of residents age 25 and over with less than a high school diploma in the PSA (10.4%) when compared to percentages for Illinois (12.3%) and Cook County (15.0%). The percentage of the population sixteen and over that is unemployed is higher in the PSA at 14.2% in comparison to Illinois at 9.9% and Cook County at 11.5%. See Exhibits 11 and 12.

Exhibit 11: Population 25+ with Less than High School Graduation for PSA, Cook County and Illinois 2016

	PSA Number	Percent of Population	Cook County Number	Percent of Population	Illinois Number	Percent of Population
Male	16,961	11.4%	265,675	15.6%	539,343	12.9%
Female	17,284	9.7%	270,976	14.4	524,904	11.7%
Total Population	34,245	10.4%	536,651	15.0%	1,064,247	12.3%

Source: Healthy Communities Institute, Claritas, 2016.

Exhibit 12: Percent Labor Force 16+ Unemployed in PSA, Cook County and Illinois 2016

	PSA	Cook County	Illinois
Total	14.17%	11.52%	9.86%
Male	15.36%	11.58%	10.20%
Female	13.02%	11.45%	9.49%

Source: Healthy Communities Institute, Claritas, 2016.

Health Insurance Coverage

In 2016, 6.4% of residents in the hospital's PSA were uninsured compared to the Cook County rate of 6.9% and the Illinois rate of 5.9%. The percent of residents in the hospital's PSA that are covered by Medicaid is 22.4%, less than the county rate of 24.6% and more than the state rate of 21.7%. The percent of residents in the hospital's PSA covered by Medicare is 13.8% as compared with 12.9% for Cook County and 14.4% for Illinois.

Exhibit 13: Percent Uninsured or with Medicaid or Medicare for PSA, Cook County and Illinois 2016

	PSA	Cook County	Illinois
Uninsured	6.4%	6.9%	5.9%
Medicaid	22.4%	24.6%	21.7%
Medicare	13.8%	12.9%	14.4%

Source: Truven Insurance Coverage Estimates, 2016.

Exhibit 14 shows the payer mix for hospital admissions for 2015. With over 50% of admissions paid by Medicare, the hospital must have a strong focus on the care of elderly population.

Exhibit 14: Payer Source by Percent of Admissions for South Suburban Hospital 2015

Payer	Percent of Admissions
Medicare	51.38%
Medicaid	18.98%
Managed Care	10.52%
Blue Cross	11.34%
Self-Pay	7.31%
Other	0.46%
	100.00%

Source: Advocate South Suburban Hospital Finance Department, 2016.

SocioNeeds Index

The SocioNeeds Index is a tool developed by the Healthy Communities Institute to measure the socioeconomic needs of the population which correlate with poor health outcomes. All zip codes in the United States are given an Index Value from 0 (low need) to 100 (high need). The 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 and why there is a need to focus efforts on those areas. To help find the areas of highest need in a community, zip codes are ranked from 1 to 5 based on their Index Value, color-coded and displayed on an interactive map.

It is important that community health improvement efforts determine what sub-populations are most in need in order to most effectively focus services and interventions. Social and economic factors are well known to be strong determinants of health outcomes–those with a low socioeconomic status are more likely to suffer from chronic conditions such as diabetes, obesity, and cancer. The SocioNeeds Index summarizes multiple socioeconomic indicators into one composite score for easier identification of high need areas by zip code or county.

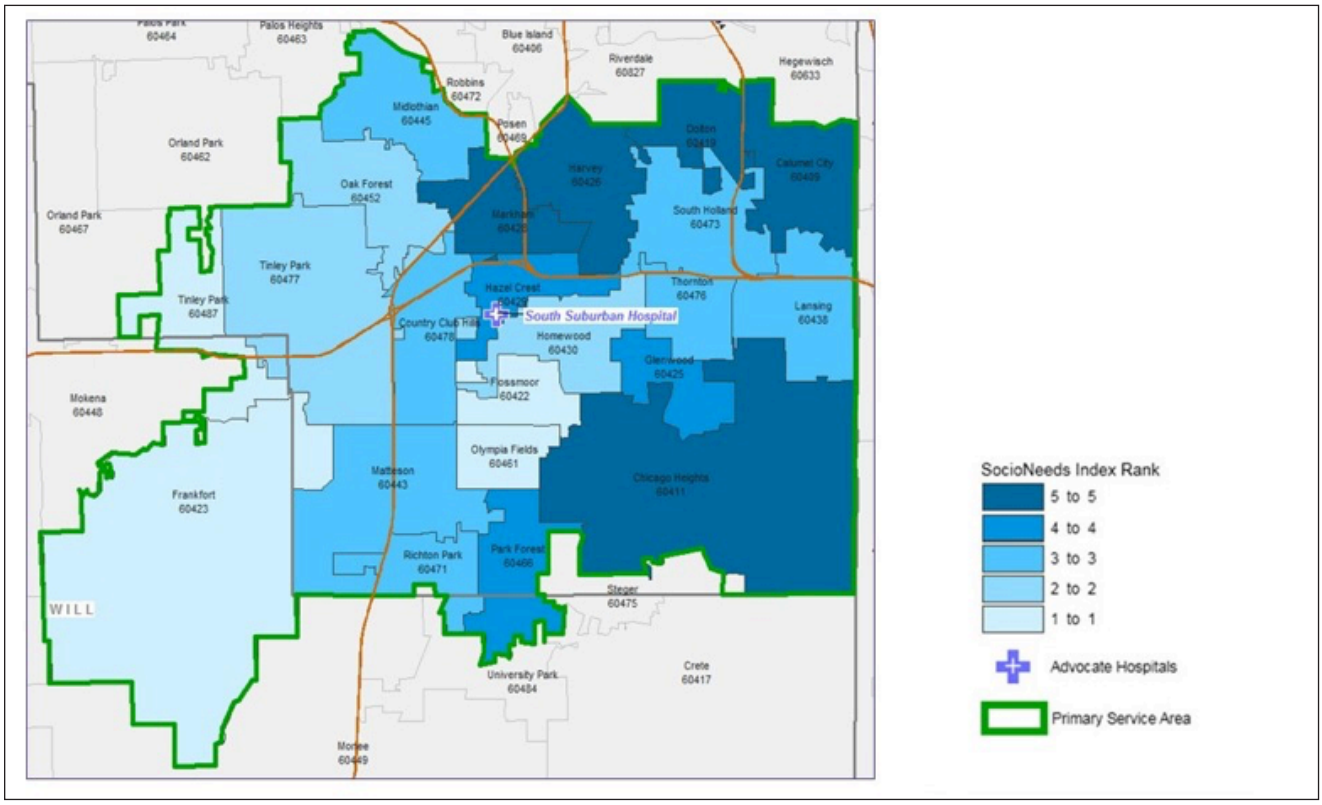
As indicated in Exhibits 15 and 16, there are five communities in the hospital's PSA that are especially at high risk, as identified by very high SocioNeeds Index values, with all receiving a comparative rank of 5 within the primary service area. These communities include Harvey, Chicago Heights, Markham, Calumet City and Dolton.

Exhibit 15: South Suburban Hospital PSA SocioNeeds Index and Rank for PSA Zip Codes 2016

Zip Code	Community	Index	Rank	Population
60426	Harvey	97.4	5	28,292
60411	Chicago Heights	91.1	5	57,257
60428	Markham	90.2	5	12,442
60409	Calumet City	88.0	5	36,212
60419	Dolton	85.7	5	21,810
60429	Hazel Crest	77.2	4	15,461
60466	Park Forest	74.3	4	21,561
60425	Glenwood	66.8	4	9,025
60478	Country Club Hills	59.1	3	16,522
60438	Lansing	57.5	3	28,938
60476	Thornton	56.9	3	2,293
60473	South Holland	54.6	3	22,428
60471	Richton Park	53.6	3	14,303
60445	Midlothian	49.4	3	26,292
60443	Matteson	44.2	3	22,699
60452	Oak Forest	31.6	2	27,907
60430	Homewood	23.6	2	20,184
60477	Tinley Park	22.1	2	39,685
60461	Olympia Fields	12.7	1	5,023
60487	Tinley Park	8.3	1	26,994
60423	Frankfort	5.9	1	31,595
60422	Flossmoor	5.6	1	9,710

Source: Healthy Communities Institute, 2016.

Exhibit 16: SocioNeeds Index Ranking Map for Zip codes within the PSA 2016



Source: Healthy Communities Institute, 2016.

V. Key Roles in 2014-2016 CHNA

System and Hospital Leadership

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

By the end of 2014, a new Department of Community Health was established under Mission and Spiritual Care, a vice-president named to lead the department, and a plan developed to ensure that each hospital in the system would have a community health expert to coordinate its community health work. In the South Region which includes South Suburban Hospital, a master's prepared community health director was hired to oversee the activities of the hospitals. Additionally, a coordinator of community health was hired at South Suburban Hospital in August 2015. This community health expert is responsible for coordinating and promoting the hospital's involvement in policies, programs and services to improve the overall health status of the communities it serves. Oversight is provided by the director of community health for the community health needs assessment process, the convening of the community health council and the administration of the hospitals' community benefits reporting process.

Community Health Council

Advocate South Suburban Hospital convened a Community Health Council (CHC) on February 24, 2016. The CHC's responsibilities were to oversee community health work for the hospital and to review data and prioritize health needs identified for the 2014-2016 community health needs assessment and to contribute to the development of an implementation plan to address community health needs. Chaired by a member of South Suburban Hospital's Governing Council and managed by the regional director of community health, the council is comprised of a variety of representatives from the community. The CHC functions as a subset of the hospital's Governing Council and all activities and decisions made by the CHC regarding the CHNA will be submitted for approval by the full Governing Council. The affiliations and titles of South Suburban Hospital's Community Health Council members are indicated below:

- Country Club Hills School District 160, School Nurse 1
- Country Club Hills School District 160, School Nurse 2
- Faith Lutheran Church of Homewood, Pastor; Advocate South Suburban Hospital Governing Council member; Community Health Council, Chair
- Governors State University, Assistant Professor 1
- Governors State University, Assistant Professor 2
- Hazel Crest Community Resident 1
- Hazel Crest Community Resident 2
- Hazel Crest Community Resident 3
- South Suburban Family Health, SC, Family Medicine Physician
- South Suburban Mayors and Managers Association, Community Development Planner
- Advocate Health Care, Regional Director, Community Health
- Advocate Medical Group, General Surgeon; Advocate South Suburban Hospital Governing Council member
- Advocate South Suburban Hospital, Coordinator, Community Heath
- Advocate South Suburban Hospital, Marketing Specialist, Public Affairs and Marketing
- Advocate South Suburban Hospital, Vice President, Operations; Community Health Executive Sponsor

Governing Council

The Board of Advocate Health Care supports the creation of local Governing Councils at each Advocate hospital. South Suburban Hospital has a diverse Governing Council that includes seven physicians, two clergy and nine community members from surrounding areas and businesses. Governing Council members support hospital leadership in their pursuit of the hospital's goals, represent the community's interest to the hospital, and serve as ambassadors in the community. A total of 67 percent of the current Governing Council members are community representatives; the remainder are physicians and others representing the hospital.

Health Impact Collaborative of Cook County

South Suburban Hospital is a member of the Health Impact Collaborative of Cook County (HICCC). HICCC is a partnership of hospitals, health departments and community organizations working to assess community health needs and assets, and to implement a shared plan to maximize health equity and wellness in Chicago and Cook County. This collaborative was developed so that participating organizations could efficiently share resources and work together on data collection, priority setting and implementation planning. Cook County was divided into north, central and south regions to enable the involvement of other local stakeholders and identify the local needs of this diverse county. South Suburban Hospital participated in the HICCC South region assessment.

As will be described in more detail in the accompanying report—*Health Impact Collaborative of Cook County: Community Health Needs Assessment, South Region*—a regional leadership team was formed for the South 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 2016, the collaborative completed an extensive community health assessment process within each of the three regions using the public health process—MAPP—**M**obilizing for **A**ction through **P**artnerships and **P**lanning process. More details regarding the data collection and prioritization process will be presented later in this report.

VI. Methodology

The methodology for the 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 (3/2014-8/2016); and 3) review of other available national and local data (1/2016-8/2016).

Health Impact Collaborative of Cook County (HICCC)

MAPP Process

The Health Impact Collaborative of Cook County (HICCC) conducted a collaborative CHNA between February 2015 and June 2016. The Illinois Public Health Institute (IPHI) designed and facilitated a collaborative, community-engaged assessment based on the Mobilizing for Action through Planning and Partnerships (MAPP) framework. MAPP is a community-driven strategic planning framework that was developed by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). Both the Chicago and Cook County Departments of Public Health use the MAPP framework for community health assessment and planning. The MAPP framework promotes a system focus, emphasizing the importance of community engagement, partnership development and the dynamic interplay of factors and forces within the public health system. The Health Impact Collaborative of Cook County chose this inclusive, community-driven process so that the assessment and identification of priority health issues would be informed by the direct participation of stakeholders and community residents. The MAPP framework emphasizes partnerships and collaboration to underscore the critical importance of shared resources and responsibility to make the vision for a healthy future a reality.

Exhibit 17: 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)

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

The collaborative used the County Health Rankings model to guide the selection of assessment indicators. IPHI worked with the health departments, hospitals, and community stakeholders to identify available data related to Health Outcomes, Health Behaviors, Clinical Care, Physical Environment, and Social and Economic Factors. The Collaborative decided to add Mental Health as an additional category of data indicators.

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

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

Community Survey

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

By leveraging its partners and networks, the Collaborative collected approximately 5,200 resident surveys between October 2015 and January 2016, including 2,288 in the South region. The survey was available on paper and online and was disseminated in five languages – English, Spanish, Polish, Korean, and Arabic.[1] The majority of the responses were paper-based (about 75%) and about a quarter were submitted online.

The community resident survey was a convenience sample survey, distributed by hospitals and community-based organizations through targeted outreach to diverse communities in Chicago and Cook County, with a particular interest in reaching low income communities and diverse racial and ethnic groups to hear their input into this Community Health Needs Assessment. The community resident survey was intended to complement existing community health surveys that are conducted by local health departments for their IPLAN community health assessment processes. IPHI reviewed approximately 12 existing surveys to identify possible questions, and worked iteratively with hospitals, health departments, and stakeholders from the three regions to hone in on the most important survey questions. IPHI consulted with the 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 South region identified as heterosexual (91%, n=2146) and African American/black (57%, n=2146). Twenty-seven percent (27%) of survey respondents identified as White, 2% Asian/Pacific Islander, and 2% Native American/American Indian. Approximately 25% (n=1651) of survey respondents in the South region identified as Hispanic/Latino and approximately 10% identified as Middle Eastern (n=1651).[1] Two-percent of survey respondents from the South region indicated that they were living in a shelter and 1% indicated that they were homeless (n=2257). The South region had the highest percentage of individuals with less than a high school education (12%, n=2027) compared to the North and Central regions of Cook County, and the majority of respondents from the South region (68%, n=1824) reported an annual household income of less than $40,000.

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

Focus Groups in South Region

IPHI conducted eight focus groups in the South region between October 2015 and March 2016. The collaborative ensured that the focus groups included populations who are typically underrepresented in community health assessments, including racial and ethno-cultural groups, immigrants, limited English speakers, low-income communities, families with children, LGBQIA and transgender individuals and service providers, individuals with disabilities and their family members, individuals with mental health issues, formerly incarcerated individuals, veterans, seniors, and young adults.

The main goals of the focus groups were to:

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

Each of the focus groups were 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 to10 participants. IPHI adjusted the length of some sessions to be as short as 45 minutes and as long as two hours to accommodate the needs of the participants, and some groups included as many as 25 participants. A description of the focus group participants from the South region is presented in Exhibit 18.

Exhibit 18: HICCC Focus Groups Conducted in the South Region 2015-2016

Focus Groups	Location (Date)
Arab American Family Services Participants in the focus group at Arab American Family Services were residents in the South region and staff at the organization. Their clients include Arab American immigrants and families.	Bridgeview, Illinois (12/4/2015)
Chinese American Service League Participants in the focus group at the Chinese American Service League were residents of the Chinatown neighborhood in Chicago and staff at the organization. Their clients include multiple immigrant groups, children, older adults, disabled individuals, and families.	Chinatown, Chicago, Illinois (1/19/2016)
Human Resources Development Institute (HRDI) Participants were clients in HRDI's day programs on the South Side of Chicago. Individuals in the focus group had experienced mental illness at some point in the past and some had previous interactions with the criminal justice system.	West Roseland, Chicago, Illinois (12/15/2015)
National Alliance on Mental Illness (NAMI) South Suburban Participants included the parents, families, and caregivers of adults with mental illness living in South suburban Cook County.	Hazel Crest, Illinois (1/21/2016)
Park Forest Village Hall Community residents, health department staff, service providers, and local government representatives in the South Cook suburbs.	Park Forest, Illinois (11/12/2015)
Sexual Assault Nurse Examiners (SANE) SANE providers serving the South side of Chicago and South suburbs at Advocate South Suburban Hospital.	Hazel Crest, Illinois (12/17/2015)
Stickney Senior Center Participants were older adults participating in the services provided at a senior center in the South Cook suburbs.	Burbank, Illinois (12/3/2015)
Veterans of Foreign Wars (VFW) Post 311 Participants included veterans, retired military, and former military living in the South Cook suburbs.	Richton Park, Illinois (1/28/2016)

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

There were residents from the South region that participated in focus groups that were conducted in other regions. A focus group in the Austin community area (in the central region) that was conducted with formerly incarcerated individuals and hosted by the National Alliance for the Empowerment of the Formerly Incarcerated included participants who were residents in the South region. A focus group in the Lakeview community area (in the north region) that was conducted with LGBQIA and transgender individuals and hosted by Howard Brown Health Center also included several participants who were residents in the South region.

More detail on the findings of the MAPP Assessments can be found in the companion document to the South Suburban Hospital CHNA report—*Health Impact Collaborative of Cook County, Community Health Needs Assessment, South Region*—that is also posted on the Advocate website and at healthimpactcc.org/reports2016.

Use of Healthy Communities Institute (HCI) Data Platform

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

HCI provides a gauge that illustrates comparison of indicators across counties, service areas and zip codes.

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

Throughout the CHNA, indicators may be referred to as being in the green, yellow or red zone, in reference to the above value ratings from HCI.

Review of Other National and Local Data

From May 2016 through August 2016, South Suburban Hospital also reviewed data related to the assessment process from the Illinois Department of Public Health, Cook County Department of Public Health, the American Cancer Society, and the American Heart Association. Input also included data from the hospital's Finance Department and the Advocate Health Care Strategic Planning Department which provided hospital-specific PSA data.

VII. Summary of Results

Health Impact Collaborative of Cook County, Community Health Needs Assessment, South Region

Participation by the hospital in the Health Impact Collaborative of Cook County (HICCC) resulted in access to a substantial amount of quantitative and qualitative data that is contained in the South Region report, a companion document to this CHNA. The report served as a foundational document to the assessment process at South Suburban Hospital. Important findings from this collaborative project including data from southern Cook County are summarized in Exhibit 19.

Exhibit 19: Major Findings from the HICCC Assessment

Health inequities in Chicago and suburban Cook County

- African Americans experienced an overall increase in mortality from cardiovascular disease between 2000-2002 and 2005-2007 in suburban Cook County while whites experienced an overall decrease in cardiovascular disease-related mortality during the same time period.
- In the South region, African Americans have the highest mortality rates for cardiovascular disease, diabetes-related conditions, stroke, and cancer compared to other race/ethnic groups in the region.
- Hispanic and African American teens have much higher birth rates compared to white teens in Chicago and Suburban Cook County.
- African American infants are more than four times as likely as white infants to die before their first birthday in Chicago and suburban Cook County.
- Homicide and firearm-related mortality are highest among African Americans and Hispanics.
- In 2012, the firearm-related mortality rate in the South region (20.4 deaths per 100,000) was more than four times higher than the rate for the North region (4.6 deaths per 100,000). In 2012, the homicide mortality rate in the South region (19.8 deaths per 100,000) was more than six times higher than the rate for the North region (3.1 deaths per 100,000).
- There are significant gaps in housing equity for African American/blacks and Hispanic/Latinos compared to whites and Asians.
- The life expectancy for Chicagoans living in areas of high economic hardship is five years lower than those living in better economic conditions.

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

Primary Service Area Data for South Suburban Hospital

In addition to information from HICCC, South Suburban Hospital's community health team completed an initial data review by analyzing multiple indicators from the Healthy Communities Institute data platform. Other public health data sources used included the Cook County Department of Public Health, the US Census Bureau and the Illinois Department of Public Health. The criteria used to identify and evaluate the PSA's health needs included the following:

- Number of cases/people affected by the health issue and its increase or decrease over time;
- Percentage of people affected by the health issue;
- Incidence and prevalence rates in comparison to County and State levels; and
- Indicators identifying that health disparities existed.

Health indicators identified through the data analysis were summarized using the above criteria and presented to South Suburban Hospital's Community Health Council for review and prioritization. Key health needs identified in the hospital's PSA include asthma, cancer, diabetes, heart disease, hypertension and stroke.

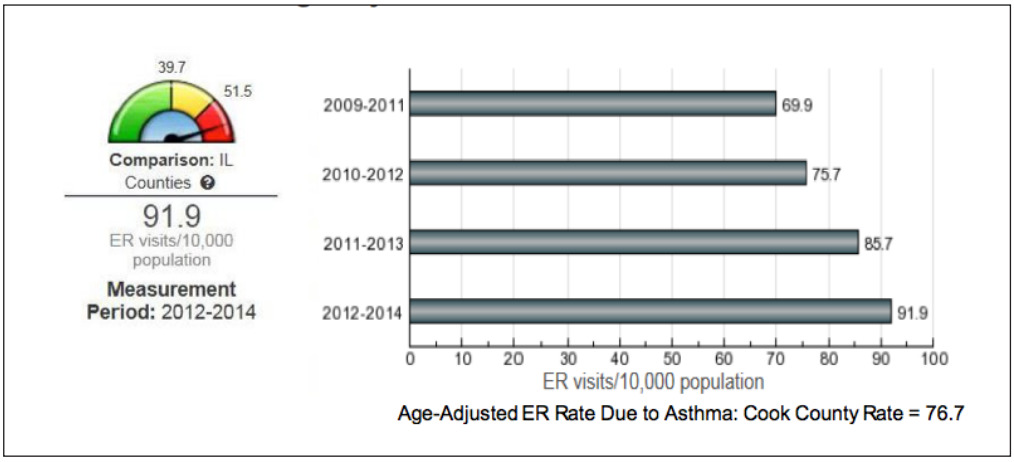
The Health Impact Collaborative of Cook County CHNA South Region findings emphasized that preventing chronic disease requires a focus on risk factors such as nutrition and healthy eating, physical activity and active living, and tobacco use. The findings emphasized that chronic disease is an issue that affects population groups across income levels, and race and ethnic groups in the south region. Social and economic inequities have profound impact on chronic disease prevalence. Priority populations to consider regarding chronic disease prevention include children and adolescents, low-income families, immigrants, diverse racial and ethnic groups, older adults and caregivers, uninsured individuals and those insured through Medicaid, individuals living with mental illness, individuals living in residential facilities, and incarcerated or formerly incarcerated individuals.

Asthma

Asthma is a disease that affects the lungs. It is one of the most common chronic diseases and affects people of all ages. Asthma causes wheezing, breathlessness, chest tightness and coughing at night or early in the morning. According to the Illinois Department of Public Health, approximately 850,000 people in Illinois currently have asthma—8.7% of adults and 13.6% of children. Because asthma can have a traumatic effect on individuals, each person with asthma must learn to manage symptoms and work/school-life balance daily. On average, 1 in 2 children (54.7%) with asthma will miss at least one day of school in a 12-month period due to their asthma; while in 2010, adults in Illinois were unable to work or carry out their usual activities accounting for a total of 3,089,988 missed days from work due to their asthma. In Illinois 74.1% of adults and 76.5% of children do not have their asthma under control. This is a large number of individuals who are at risk for hospitalization and even potential death from a severe asthma episode. (CDC and Illinois Department of Public Health's Center for Health Statistics (ICHS), Behavioral Risk Factor Surveillance System Prevalence Data, 2012 adults; 2010 children.)

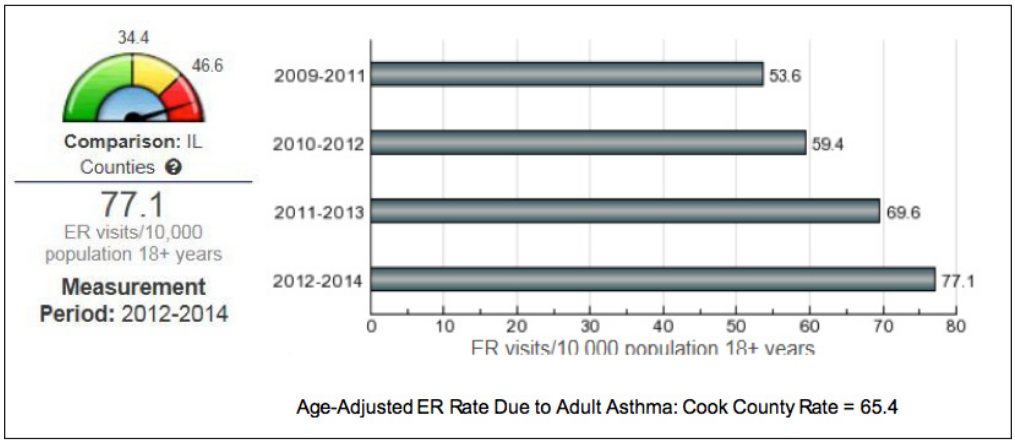
PSA data indicate that hospitalization rates for overall asthma, adult asthma and pediatric asthma exceed the overall Cook County rates and they have been increasing since 2009. They are also all in the HCI red zone when compared to other Illinois counties. Exhibit 20 shows that the PSA age-adjusted ER rate due to asthma is 91.9/10,000 population in 2012-2014 as compared to the county rate of 76.7. Exhibit 21 shows that the PSA age-adjusted ER visit rate due to adult asthma/per 10,000 population age 18 and older in 2012-2014 is 77.1 compared to the county rate of 65.4. Finally, Exhibit 22 shows that the PSA age-adjusted ER visit rate due to pediatric asthma/per 10,000 population 0-17 in 2012-2014 is 134.3/10,000 population 0-17 compared to the county rate of 109.3.

Exhibit 20: PSA Age Adjusted ER Visit Rates due to Asthma 2009-2014



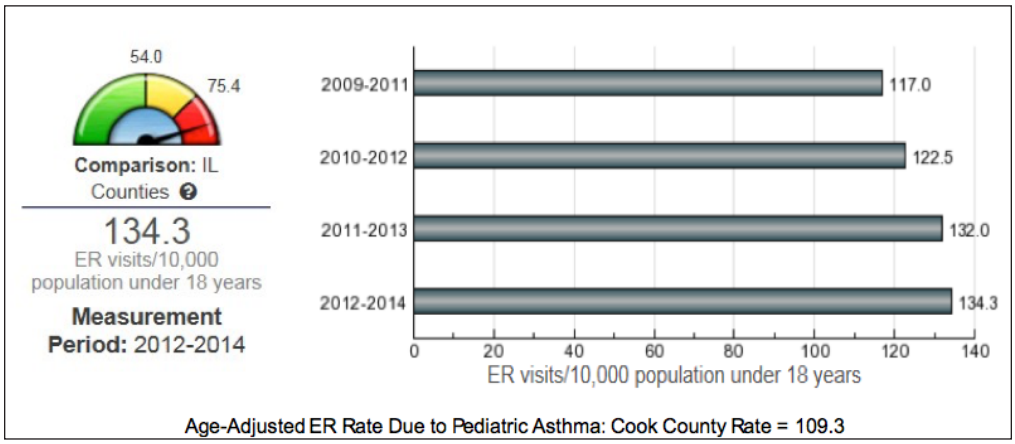
Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2015.

Exhibit 21: PSA Age Adjusted ER Rates due to Adult Asthma 2009-2014



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

Exhibit 22: PSA Age Adjusted ER Rates due to Pediatric Asthma 2009-2014



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

Cancer

According to the American Cancer Society, cancer is the second most common cause of death in Illinois and Cook County, and also ranks second in the hospital's primary service area. Many types of cancer can be prevented, and the prospects for surviving cancer are better than ever before and continue to improve. Early detection and improved treatments are allowing more people who are diagnosed with cancer to live longer and better lives. By adopting a healthier lifestyle and by visiting a physician regularly for cancer-related checkups, people can reduce their chances of developing or dying from cancer. Screening examinations, conducted regularly by a health care professional, can result in the detection of cancers of the breast, tongue, mouth, colon, rectum, cervix, prostate, testes and melanomas at earlier stages, when treatment is more likely to be successful. (American Cancer Society, Cancer Facts and Figures, 2016.)

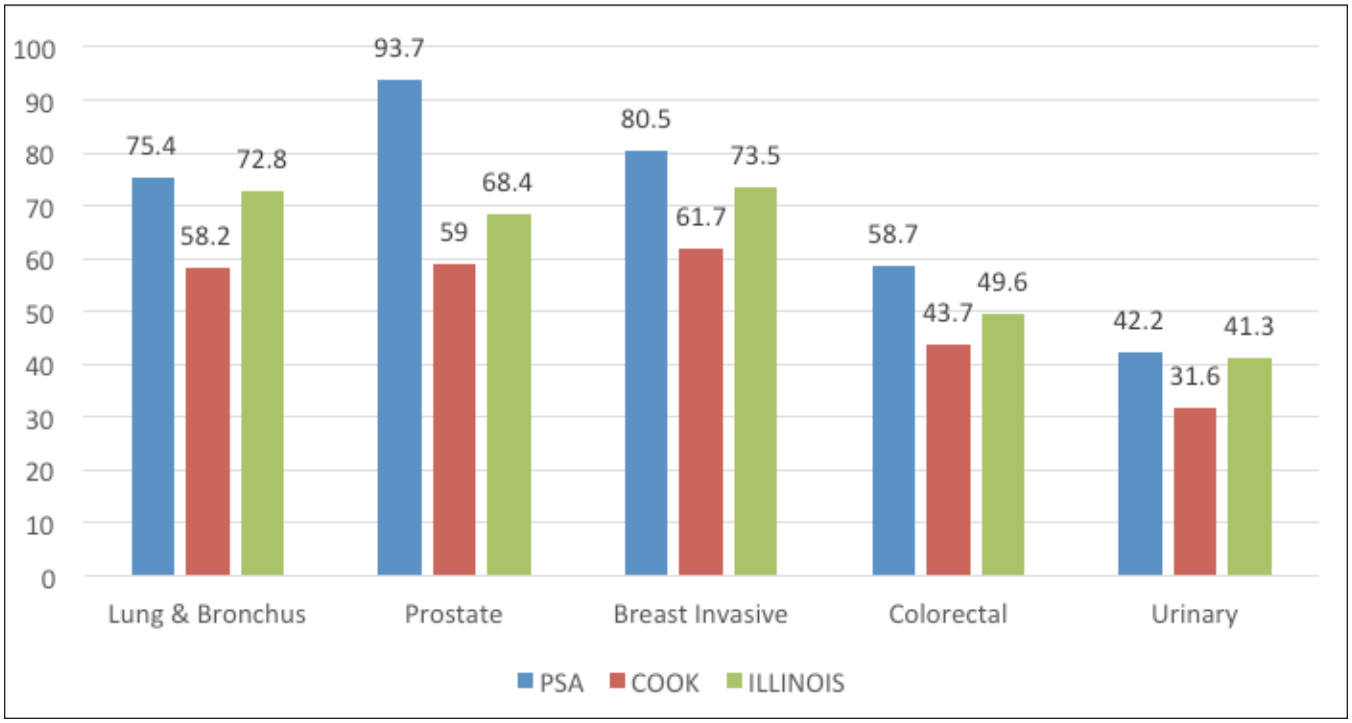
The top five cancer incidence rates in the PSA (age adjusted), five year average for 2008-2012, are:

1. Lung & Bronchus (rate: 75.4 per 100,000 population)
2. Prostate (rate: 93.7 per 100,000 population)
3. Breast Invasive (rate: 80.5 per 100,000 population)
4. Colorectal (rate: 58.7 per 100,000 population)
5. Urinary (rate: 42.2 per 100,000 population)

Source: Illinois Department of Public Health, Illinois State Cancer Registry; Nielson Demographics 2010, Public Dataset, March 2016.

Exhibit 23 shows the top five cancer incidence rates per 100,000 population for the PSA in comparison to the Cook County rates and to the Illinois rates. In the PSA, lung and bronchus, prostate, breast invasive, colorectal and urinary rates are higher than both state and county rates during the same time period.

Exhibit 23: PSA 5 Year Average Cancer Incidence Rate per 100,000 Population 2008-2012



Source: Illinois Department of Public Health, Illinois State Cancer Registry, Nielson Demographics, 2016.

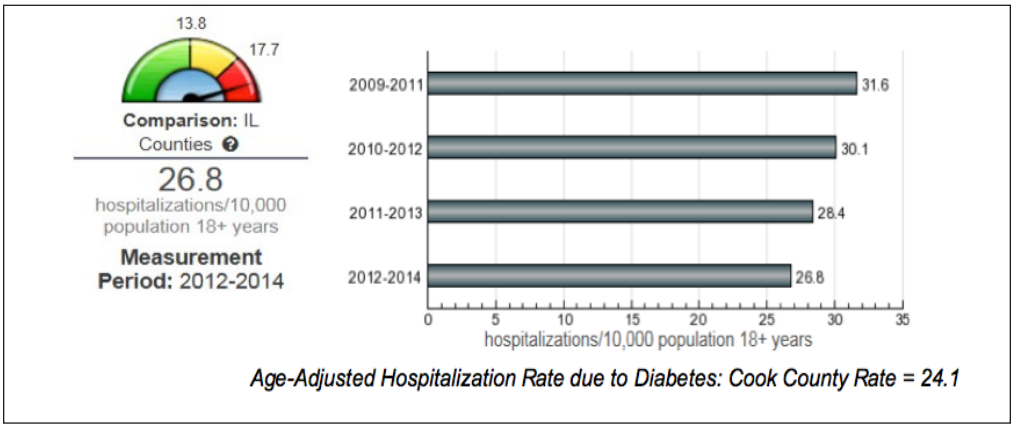
Diabetes

According to the Illinois Department of Public Health, nearly 26 million children and adults in the United States (8.3% of the population) have diabetes mellitus. About one-third of these people are unaware that they have diabetes and are not under medical care. Each year, 1.9 million new cases of diabetes are diagnosed in people age 20 years and older. In Illinois, approximately 800,000 people 18 years of age and older have diagnosed diabetes, with another 500,000 people who are unaware that they have the disease.

Individuals with diabetes are at increased risk for heart disease, blindness, kidney failure, and lower extremity amputations (not related to injuries). Diabetes and its complications occur among all age, racial and ethnic groups.

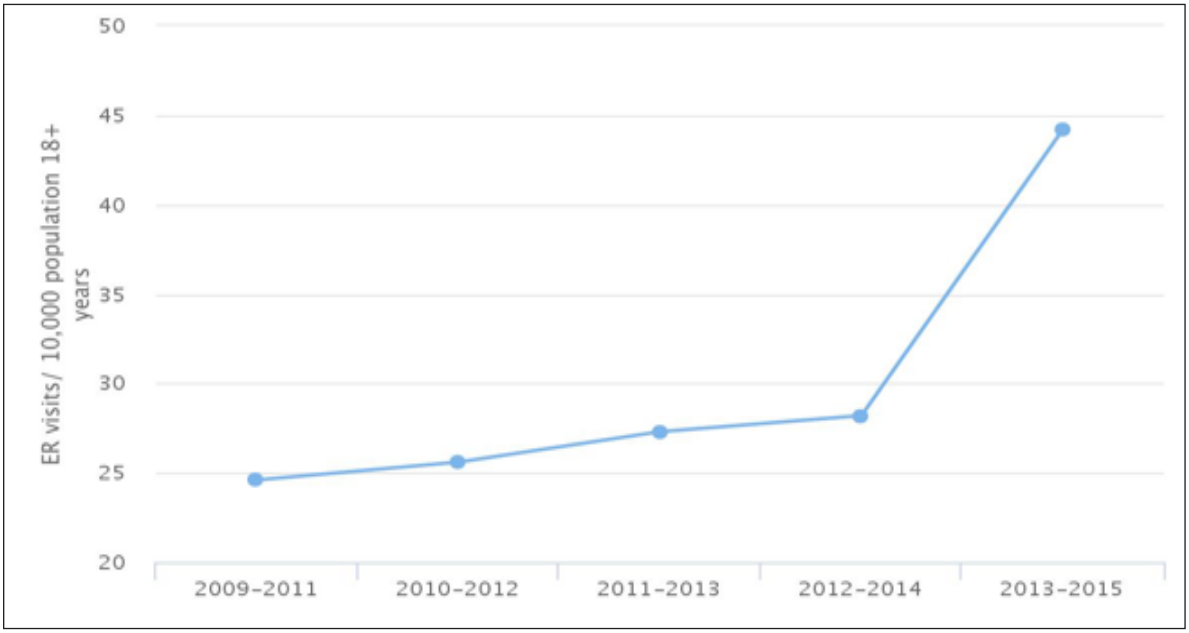
Although there have been improvements in the age-adjusted hospitalization rate for diabetes since 2009, the PSA rate at 26.8/10,000 population 18+ years of age continues to be above the county rate of 24.1. The PSA hospitalization rate is in the HCI red zone compared to other Illinois counties. (Exhibit 24) Exhibit 25 shows the time series of the age-adjusted ER rate due to diabetes in the PSA from 2009-2015 indicating a sharp increase in 2013-2015. When compared to the state rate of 24.0/10,000 population and county rate of 27.0/10,000 population, the PSA rate is close to double at 44.2/10,000 population. The age-adjusted ER rate due to diabetes is also in the HCI red zone when compared to other Illinois counties. (Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2016.)

Exhibit 24: PSA Age Adjusted Hospitalization Rate for Diabetes 2009-2014



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

Exhibit 25: Age-Adjusted ER Rate due to Diabetes per 10,000 population Age 18+ in PSA 2009-2015



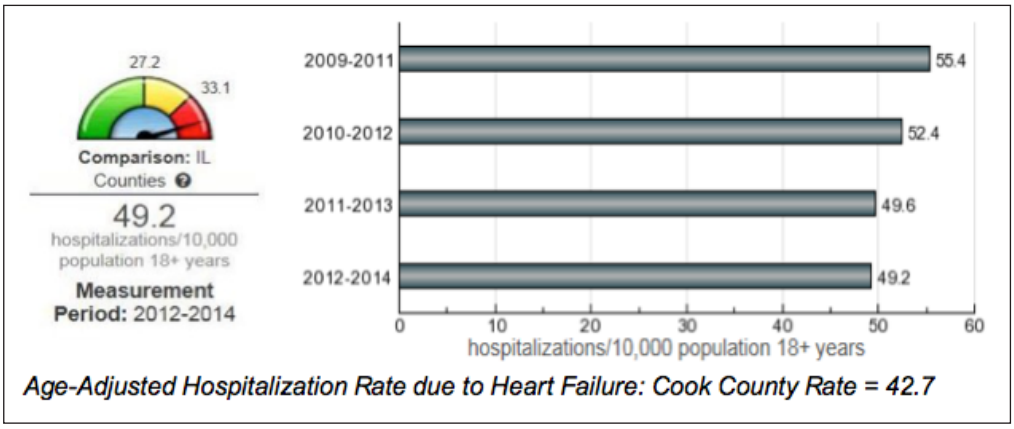
Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2016.

Heart Disease

Heart disease consists of several different types of heart conditions of which the most common form is coronary artery disease. Heart disease and related conditions include heart attack, coronary artery disease, stroke, high blood pressure, and heart failure. According to the Centers for Disease Control and Prevention, coronary artery disease is the most common type of heart disease, causing nearly 400,000 deaths per year and costing over $100 billion overall in health services, medication, and lost productivity. In the PSA, the heart disease age-adjusted mortality rate (2008-2012) ranges from 143.7 per 100,000 population up to 301.9 per 100,000 population in some communities. In comparison, the state rate is 112.1 per 100,000 population. (Health Impact Collaborative of Cook County, Community Health Needs Assessment, Illinois Department of Public Health, Mortality Files, 2008-2012.)

Heart disease is the No. 1 killer for all Americans, and is the leading cause of death in Illinois, Cook County and the hospital's PSA. The risk of having heart disease is even higher for African-Americans. According to the American Heart Association, among non-Hispanic blacks age 20 and older, 44.4% of men and 48.9% of women have cardiovascular disease (CVD). In the PSA, the age-adjusted hospitalization rate due to heart failure decreased over time from 55.4 to 49.2 hospitalizations per 10,000 population in those 18 years and older; however, the rate remains above the county level of 42.7 and is in the HCI red zone in comparison to all Illinois counties.

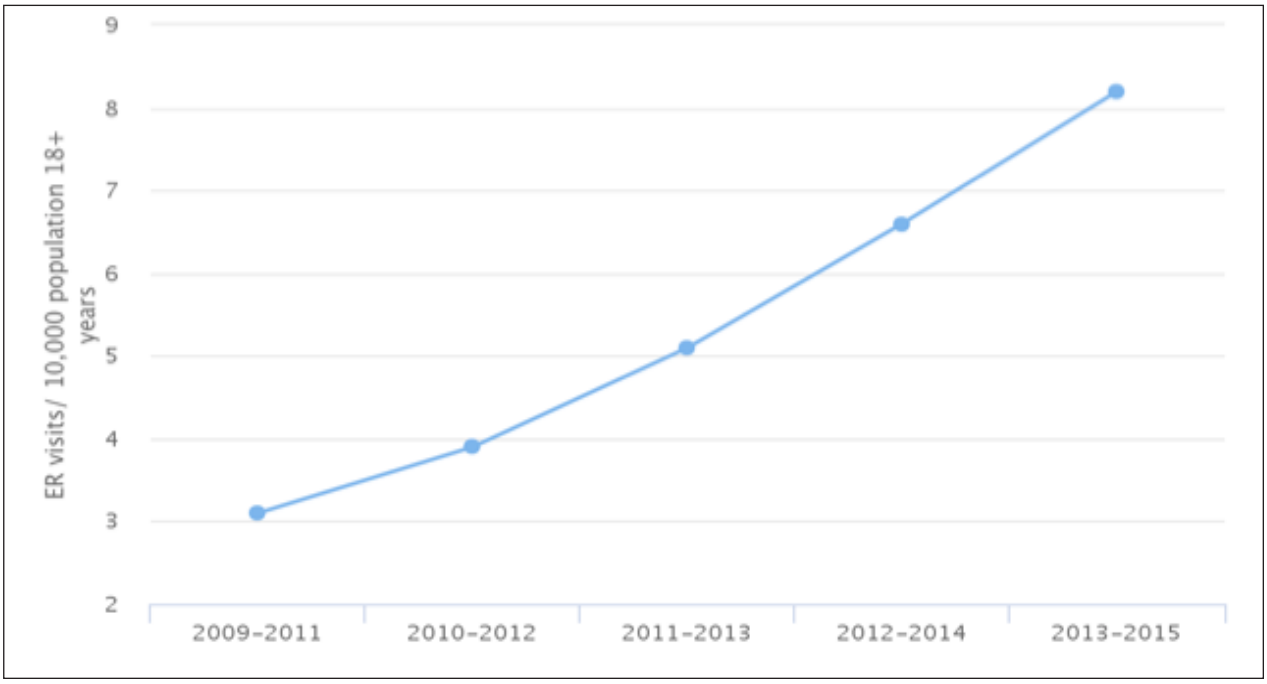
Exhibit 26: Age Adjusted Hospitalization Rate for Heart Failure Age 18+ in the PSA 2009-2014



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

In the PSA, for 2013-2015, the age-adjusted ER rate due to heart failure per 10,000 population in the 18 and older age group is 8.2/10,000 population compared to the state rate of 8.1/10,000 and the county rate of 6.1/10,000. Although the rate in the PSA is close to the state rate, there is an increasing rate trend over time from 2009–2015.

Exhibit 27: Age-Adjusted ER Visit Rate Age 18+ due to Heart Failure in PSA 2009-2015



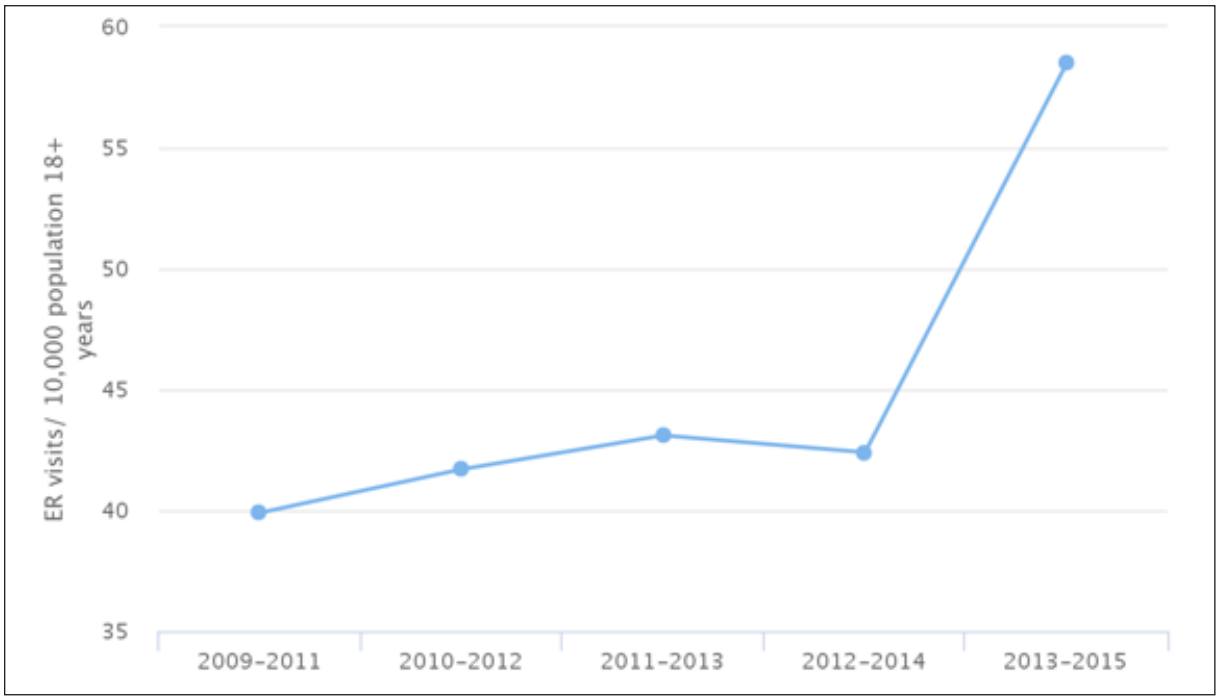
Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2016.

Hypertension and Stroke

High blood pressure is the common name that is used to describe hypertension. High blood pressure is a significant increase in blood pressure in the arteries. Many people with hypertension may not experience symptoms, even if their blood pressure is dangerously high. Hypertension increases the risk for heart disease and is a major risk factor for cerebrovascular disease also known as stroke (Centers for Disease Control and Prevention, 2014). The stroke mortality rate in the South region was 40.1 deaths/100,000 population in 2012. The Healthy People 2020 target is 34.8/100,000 population (Health Impact Collaborative of Cook County, Community Health Needs Assessment, South Region, 2016). Noticeable disparities are observed in the following communities within South Suburban Hospital's PSA with reported rates higher than the south region rate of 40.1 and Illinois rates of 39.5. These communities include: Chicago Heights with 70.4 deaths/100,000 population; Markham 73.0; and Hazel Crest 67.8 (Health Impact Collaborative of Cook County, Illinois Department of Public Health, Mortality Files, 2008-2012).

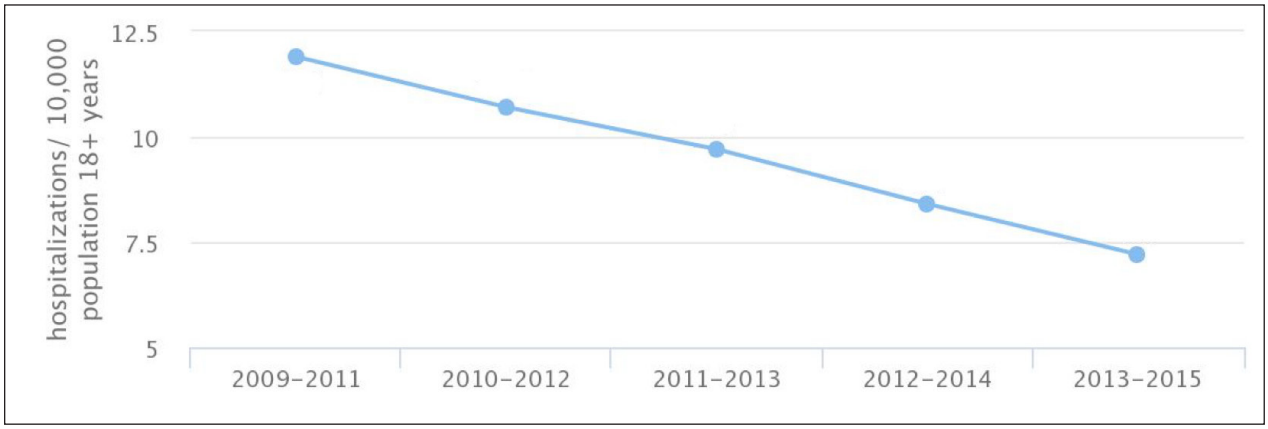
Exhibit 28 depicts the 2013-2015 PSA Age-Adjusted ER Rate due to hypertension at 58.5/10,000 population 18 and older, showing a sharp increase from 2012 to 2015. In Exhibit 29, although the age-adjusted hospitalization rate due to hypertension in the PSA decreased to 7.2 in 2013-2015, the rate is higher than the state rate at 4.8/10,000 and the county rate of 6.5/10,000 in 2013-2015.

Exhibit 28: Age-Adjusted ER Rate due to Hypertension per 10,000 population Age 18+ in PSA 2009-2015



Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2016.

Exhibit 29: Age-Adjusted Hospitalization Rate due to Hypertension per 10,000 population 18+ in the PSA 2009-2015



Source: Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2016.

VIII. Identifying Priorities

Health Impact Collaborative of Cook County (HICCC)

Through a data-driven collaborative prioritization process, the HICCC identified four priority focus areas (Exhibit 30). As the collaborative moves from assessment planning, the partners are 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. Thus for South Suburban Hospital an initial priority for implementation is to collaboratively address one or more of the social, economic and structural determinants of health.

Exhibit 30: The Four Focus Areas for the Health Impact Collaborative of Cook County

1. **Improving social, economic, and structural determinants of health / reducing social and economic inequities. ***
2. **Improving mental and behavioral health.**
3. **Preventing and reducing chronic disease**

   (Focus on risk factors – nutrition, physical activity, and tobacco).
4. **Increasing access to care and community resources.**

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

****Policy, Advocacy, and Data Systems are strategies that should be applied across all priorities.***

Key Community Health Needs for Each of the Collaborative Focus Areas:

Social, economic and structural determinants of health	Mental health and substance abuse (Behavioral health)	Chronic disease	Access to care and community resources
• Economic inequities and poverty • Education inequities • Systemic racism • Housing • Healthy environment • Safety and violence	• Overall access to services and funding • Violence and trauma, and its ties to mental health	• Focus on risk factors – nutrition, physical activity, tobacco • Healthy environment	• Cultural & linguistic competency/ humility • Health literacy • Access to healthcare and social services, particularly for uninsured and underinsured • Navigating complex health care system and insurance

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

Community Health Council Priority Setting

In addition to actively participating in HICCC, South Suburban Hospital's community health team reviewed additional data from primary and secondary sources. This data highlighted the prevalent health issues within the hospital's primary service area. After review of hospital, HICCC, county, state and HCI data, the leading causes of death, hospitalizations and overarching health issues were summarized and presented to the hospital's Community Health Council for prioritization. Data presented to the council targeted the following health conditions identified as important in South Suburban Hospital's primary service area: asthma, cancer, diabetes, heart disease, and hypertension and stroke. The following criteria were also considered in making selections:

- Degree to which community partners are involved in solving/addressing the health issue;
- Hospital and community resources available to address the health issue;
- Hospital's capacity to address the health issues;
- Importance of the health problem to the community; and
- Degree to which effective programs are available to the community.

After discussion and review of significant data findings, the CHC members were instructed to rank the five health conditions by voting on those that they perceived to be the most important to address for the communities within the hospital's primary service area. The multi-voting strategy resulted in asthma and diabetes receiving the highest number of votes. Housing was selected as a focus area by CHC members as the social, economic or structural determinant of health related to the HICCC. The council selected housing as this has a significant impact on asthma.

Therefore, for the 2014-2016 CHNA, South Suburban Hospital has selected three priorities for implementation planning: asthma, diabetes, and housing (social determinant of health).

Needs Not Selected

Although cancer, heart disease and hypertension/stroke were not selected to address during the CHNA process, South Suburban Hospital remains committed to serving the health needs of the community for individuals with these health conditions.

Cancer

South Suburban Hospital's Cancer Center offers an array of services including radiation therapy, brachytherapy, image guided radiation therapy, intensity modulated radiation therapy, and minimally invasive approaches to cancer treatment. The Breast Health Center offers early detection services as well as advanced procedures including Sentinel lymph node biopsy for breast cancer treatment for cancer diagnosis and staging. Additionally, South Suburban Hospital has an active Cancer Committee and Cancer Care Team that are dedicated to developing a comprehensive, multidisciplinary approach throughout the year. A number of community education and screening programs are also held in the community and at the hospital that focus on breast, lung and prostate cancers. Some services include genetic counseling, patient navigation, clinical trials and research—all designed to improve quality of life for patients and their families.

Heart Disease

South Suburban Hospital through the Advocate Heart Institute offers a continuum of services from screening to diagnosis and treatment. Advanced treatment and services include comprehensive diagnostic services including minimally-invasive endovascular procedures, electrophysiological procedures, computed tomography scanning, three-phase cardiac rehabilitation and a congestive heart failure program. The hospital commits to community prevention programs by conducting heart health education classes and free and reduced heart risk screenings for cardiovascular health. The Congestive Heart Failure program is a comprehensive inpatient and outpatient program designed to strengthen the heart, improve health and monitor change. The overall goal is to restore cardiac health and reduce hospitalization through therapy, diet and other services. The Cardiac Rehabilitation program is for individuals requiring rehabilitation services following a cardiovascular incident. This individualized program is designed to reduce blood pressure, body mass index and stress levels though customized exercise programs, yoga and strengthening techniques.

Hypertension and Stroke

South Suburban Hospital is an Illinois Department of Public Health-designated Primary Stroke Center and has earned the American Heart Association's Get with the Guidelines-Stroke Gold-Plus Quality Achievement Award. The IDPH designation signifies that the hospital delivers the critical stroke care elements required to achieve long-term success in improving outcomes. Achieving stroke certification ensures that the hospital offers the highest level of care for those who are experiencing and recovering from a stroke. The hospital also offers community education events and a stroke support group for individuals and their caregivers that is held monthly at the hospital.

Approval of CHNA by Governing Council

The South Suburban Hospital Governing Council met on December 1, 2016, to review the findings of the CHNA and the recommended implementation strategy. The board voted to approve the CHNA Report.

IX. 2017 Implementation Planning

While the full implementation plan for addressing South Suburban Hospital's three priorities will be posted in 2017, this section reviews the goals, potential strategies and potential partners for each of the health needs selected, as well as a plan for disseminating results of the CHNA to the community.

Priority Area: Social Determinants of Health – Housing

Goal

Implement a healthy homes awareness program to improve health outcomes for asthma patients in the primary service area.

Potential Strategies

- Incorporate healthy homes initiative into the "Kickin" Asthma program within the PSA.
- Partner with Metropolitan Tenants Organization to provide healthy homes education to decrease asthma triggers in homes in PSA communities.
- Work with the Health Impact Collaborative of Cook County to identify additional resources to support the healthy homes initiative.

Priority Area: Asthma

Goal

Reduce the incidence of uncontrolled asthma among children within South Suburban Hospital's primary service area.

Potential Strategies

- Continue implementation of the Kickin' Asthma program by expanding to additional schools in high need communities.
- Continue to work with internal hospital committee to improve disease self-management skills for patients and families with asthma.
- Continue education programs for community organizations to teach asthma management education in community settings.

Priority Area: Diabetes

Goal

Reduce the incidence of Type 2 diabetes in the primary service area of South Suburban Hospital.

Potential Strategies

- Implement the National Diabetes Prevention Program (DPP), Prevent T2, in community areas in partnership with community-based organizations and faith communities.
- Work to establish South Suburban Hospital as a designated diabetes prevention program approved site by collaborating with the clinical diabetes education team.
- Increase community educational opportunities to support diabetes self-management skills.

X. 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 the link below to complete a CHNA feedback form. We will respond to your questions/comments within thirty days. Your comments will also be considered during our next CHNA assessment cycle.

http://www.advocatehealth.com/chnareportfeedback

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

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

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

Other Communication and Feedback Opportunities

In addition to the opportunity to provide feedback through the means described above, South Suburban Hospital will also communicate the CHNA findings and preliminary implementation plans throughout 2017 to hospital leadership, the Governing Council and, as requested, to other local and civic organizations.

XI. Appendix: Sources for 2014-2016 CHNA

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

Advocate Health Care Strategic Planning Department

Truven Insurance Coverage Estimates, 2016.

Advocate South Suburban Hospital Financial Services, 2016.

American Cancer Society

Cancer Facts and Figures, 2016.
http://www.cancer.org/acs/groups/content/@research/documents/document/acspc-047079.pdf

American Heart Association

African-Americans and Heart Disease, Stroke, 2015.
http://www.heart.org/HEARTORG/Conditions/More/MyHeartandStrokeNews/African-Americans-and-Heart-Disease_UCM_444863_Article.jsp

http://www.heart.org/idc/groups/heart-Is this American Heart Association?public/@wcm/@sop/@smd/documents/downloadable/ucm_319568.pdf

Centers for Disease Control and Prevention, National Center for Health Statistics

FastStats-Asthma, 2014. http://www.cdc.gov/nchs/fastats/asthma.htm

CDC and Illinois Department of Public Health's Center for Health Statistics (ICHS) Behavioral Risk Factor Surveillance System Prevalence Data, 2012.
http://www.cdc.gov/brfss/data_documentation/index.htm and http://app.idph.state.il.us/brfss/

Cook County Department of Public Health, Community Profiles, 2006-2008.
http://www.cookcountypublichealth.org/files/pdf/data-and-reports/community-profiles-06-08/south-district-0608r.pdf

Health Impact Collaborative of Cook County, Community Health Needs Assessment, South Region, 2016.
http://healthimpactcc.org/wp-content/uploads/2016/10/South-Region-CHNA-report-with-Appendices.pdf

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

Claritas, 2016.

Illinois Hospital Association, COMPdata, 2009-2015.

Illinois Department of Public Health, 2016.

Illinois Department of Public Health, Healthbeat, 2011.
http://www.idph.state.il.us/public/hb/hbdiabet.htm

Leading Causes of Death, 2011. http://www.idph.state.il.us/health/bdmd/leadingdeaths11.htm

The Impact of Asthma in Illinois, 2016.
http://www.dph.illinois.gov/sites/default/files/publications//idphasthmainfographic.pdf

Advocate South Suburban Hospital

17800 South Kedzie Avenue
Hazel Crest, IL 60429
708.799.8000
advocatehealth.com/ssub

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