2022 AdventHealth Bolingbrook Community Health Needs Assessment

Extending the Healing Ministry of Christ

AdventHealth

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Letter From Leadership

Identifying community health needs and addressing them with a wholistic focus are central to fulfilling AdventHealth Great Lakes Region's mission of extending the healing ministry of Christ.

That's why our four hospitals, like other AdventHealth hospitals across the nation, complete a Community Health Needs Assessment every three years. This effort involves extensive collaboration with public health experts and community partners such as the Alliance for Health Equity, Impact DuPage and the Will County MAPP Collaborative. Working together, we take an in-depth look at the overall health of the communities served by AdventHealth Bolingbrook, AdventHealth GlenOaks, AdventHealth Hinsdale and AdventHealth La Grange. We also identify any barriers to improving community health.

Based on these assessments, we develop community health plans customized to address each community's needs. These plans seek to improve health in a lasting way through strategies aimed at fostering policy, systems and environmental changes that equitably enhance the conditions of the places where people live, work, learn and play. This approach has enabled us to launch initiatives that address specific needs, such as increasing access to care and community resources, reducing food insecurity and improving mental health services.

These efforts reflect AdventHealth's emphasis on providing wholistic care that heals and restores the whole person, including mind, body and spirit. Collectively, they're improving community health one person at a time, helping them get well and stay well. The impact of these efforts serves as a powerful testament to the value of our community partnerships, and we are deeply grateful to all of our partners for their support as we continue working to improve the health and well-being of the communities we serve.

Thor Thordarson
President and CEO
AdventHealth Great Lakes Region

Executive Summary

Adventist Bolingbrook Hospital d/b/a AdventHealth Bolingbrook will be referred to in this document as AdventHealth Bolingbrook or “the Hospital”. AdventHealth Bolingbrook in Bolingbrook, Illinois conducted a community health needs assessment from April 2021 to November 2022. The goals of the assessment were to:

- Engage public health and community stakeholders including low-income, minority and other underserved populations.
- Assess and understand the community’s health issues and needs.
- Understand the health behaviors, risk factors and social determinants that impact health.
- Identify community resources and collaborate with community partners.
- Publish the Community Health Needs Assessment.
- Use assessment findings to develop and implement a 2023-2025 Community Health Plan based on the needs prioritized in the assessment process.

The Collaborative

In order to ensure broad community input, AdventHealth Bolingbrook partnered with the Will County Mobilizing for Action through Planning and Partnerships (MAPP) Collaborative to complete the assessment process. The Will County MAPP Collaborative, referred to here as “the Collaborative”, was formed in 2011 and has representation from almost 100 social support and community organizations, health care systems, as well as public health and education institutions. The Collaborative includes intentional representation from those serving low-income, minority and other underserved populations.
A list of organizations which are members of the Collaborative can be found in the Process, Methods and Findings section.

The Committee and The Data, Evaluation and Monitoring Team

To guide the assessment process, the Collaborative formed a smaller executive committee of the larger collaborative. This executive committee’s membership included local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members. This executive committee is referred to here as “the Committee”. The Committee met several times in 2021 - 2022.

The Data, Evaluation and Monitoring (DEM) Team was created to collect, review and analyze the data found in the assessment process. The DEM Team serves as an established data resource for the Collaborative year-round, providing data and analysis during the assessment process and during ongoing evaluation efforts.
A list of Committee members can be found in Process, Methods and Findings.

Community Health Needs Assessment Committee

AdventHealth Bolingbrook also convened a Community Health Needs Assessment Committee (CHNAC). The purpose of the CHNAC was to select the needs the Hospital would address as a result of the findings in the assessment. The CHNAC made this decision by reviewing the priority needs selected by the Collaborative, the internal Hospital resources available and local resources existing in the community. With this information the CHNAC was able to determine where the Hospital could most effectively support the community. The CHNAC met several times in 2021-2022.
See Prioritization Process for more.

Data

The Collaborative collected both primary and secondary data for the assessment. Primary data included a community survey, a local public health system assessment and a forces of change assessment. In addition, public data was utilized from state and national data sources. Primary and secondary data was compiled and analyzed to identify the top six aggregate issues. To read more about the county level findings and data highlighted in the report, please visit the Will County MAPP CHNA 2022.
See Process, Methods and Findings for data sources.

Community Asset Inventory

The next step was to create a Community Asset Inventory. This inventory was designed to help the CHNAC understand existing community efforts to address the identified issues from aggregate primary and secondary data and to prevent duplication of efforts.
See Available Community Resources for more.

Prioritization and Selection Criteria

The Collaborative hosted a community forum which included reviewing key findings and providing information and data related to current health issues identified in the assessment and an opportunity to select the needs and initiatives to address them for the coming three years. During the forum, a consensus was reached to continue addressing the needs from the previous assessment. The Hospital also convened a Community Health Needs Assessment Committee (CHNAC) to review the data and priorities selected by the Collaborative and to identify the needs the Hospital would select. The CHNAC also considered the Hospital’s PSA-level secondary data, local community resources available, as well as the Hospital’s current resources and strategies to find ways to prioritize and address the needs most effectively.

CHNAC members were asked to consider the following question before voting on each issue and to rank the issue accordingly:

"What is the magnitude of the need for more focus and attention on this health issue?"
The needs were ranked on a scale of 1 to 5 (1 = no more focus needed, 3 = more focus needed, 5 = much more focus needed).

See Prioritization Process for more.

Priority Issues to be Addressed

The priority issues selected by the CHNAC to be addressed are:

1. Access to Care
2. Behavioral Health and Substance Misuse

See Prioritization Process for more.

Approval

On December 15, 2022, the AdventHealth Bolingbrook Board approved the Community Health Needs Assessment findings, priority issues and final report. A link to the 2022 Community Health Needs Assessment was posted on the Hospital's website prior to December 31, 2022.

Next Steps

AdventHealth Bolingbrook will work with the Collaborative and the CHNAC to develop a measurable implementation strategy called the 2023-2025 Community Health Plan to address the priority issues. The plan will be completed and posted on the Hospital's website prior to May 15, 2023.

About AdventHealth

AdventHealth Bolingbrook is part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth strives to heal and restore the body, mind and spirit through our connected system of care. More than 80,000 skilled and compassionate caregivers serve 4.7 million patients annually. From physician practices, hospitals, outpatient clinics, skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, wholistic care at nearly 50 hospital campuses and hundreds of care sites throughout nine states.

Committed to your care today and tomorrow, AdventHealth is investing in research, new technologies and the people behind them to redefine medicine and create healthier communities.

In a 2020 study by Stanford University, physicians and researchers from AdventHealth were featured in the ranking of the world's top 2% of scientists. These critical thinkers are changing medicine and shaping the future of health care.

Amwell, a national telehealth leader, named AdventHealth the winner of its Innovation Integration Award. This telemedicine accreditation recognizes organizations that have identified connection points within digital health care to improve clinical outcomes and user experiences. AdventHealth was recognized for its innovative digital front door strategy, which is making it possible for patients to seamlessly navigate their health care journey. From checking health documentations and paying a bill, to conducting a virtual urgent care visit with a provider, we are making health care easier by creating pathways to wholistic care no matter where your health journey starts.

AdventHealth is also an award-winning workplace aiming to promote personal, professional and spiritual growth with its workplace culture, having been recognized by Becker's Hospital Review on its "150 Top Places to Work in Healthcare" three years straight. This recognition is given annually to health care organizations that promote workplace diversity, employee engagement and professional growth.

AdventHealth Bolingbrook

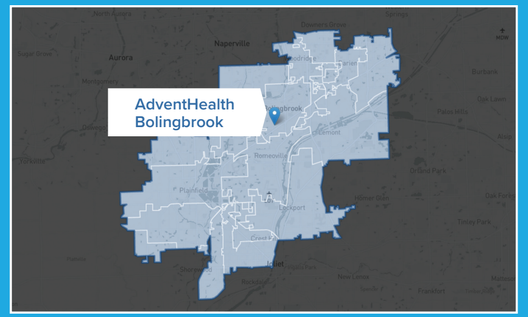
AdventHealth Bolingbrook is part of the AdventHealth Great Lakes Region. The AdventHealth Great Lakes region is comprised of AdventHealth LaGrange, AdventHealth Hinsdale, AdventHealth GlenOaks and AdventHealth Bolingbrook, all in the State of Illinois. AdventHealth Bolingbrook is a 138-bed acute care hospital offers family-friendly care and access to top-rated doctors in the western and southwestern Chicago, that includes emergency medical services, heart and vascular care, cancer care, obstetrics and women's services, lab and imaging services, surgical services and much more. AdventHealth Bolingbrook has earned a number of nationally recognized awards and safety grades, including the Joint Commission certified Primary Stroke, ED Level II Trauma Designation, American Heart Association's GOLDPLUS Get With The Guidelines® for Stroke and Type II Diabetes Distinction, Blue Distinction Center for Bariatrics, Blue Distinction Center for Maternity and Sleep Disorders Center by AASM.

COMMUNITY OVERVIEW

Community Description

Located in Will County, Illinois, AdventHealth Bolingbrook defines its community as the Primary Service Area (PSA), the area in which 75-80% of its patient population lives. This includes 16 zip codes across primarily Will County, although it does also include parts of Kendall and DuPage Counties.

According to the 2020 Census, the population in the AdventHealth Bolingbrook community has grown 3.2% in the last ten years to 523,630 people. This reflects a little less than half the percentage of growth seen in the United States, 7.1%, since the last Census but more than seen in the State of IL, which had decreased. Demographic and community profile data in this report are from publicly available data sources such as the US Census Bureau and the Center for Disease Control and Prevention unless indicated otherwise. Data are reported for the Hospital's PSA, also referred to as the community, unless listed for a specific county. The Collaborative conducted the CHNA with a county-level approach, therefore county-level data are included throughout the CHNA report in addition to Hospital PSA-level data. Data are also provided to show how the community compares locally, in the state and at a national level for some indicators.



Community Profile

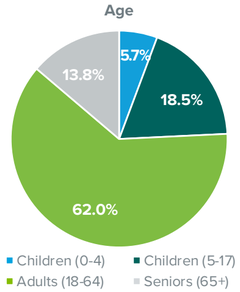
Age and Sex

The median age in the Hospital's community is 38.7, higher than that of state which is 38.3 and that of the US, 38.2.

Females are the majority, representing 50.8% of the population. Middle aged women, 40-64, are the largest demographic group at 17.2%. Middle aged men are the second largest demographic in the community at 16.4%.

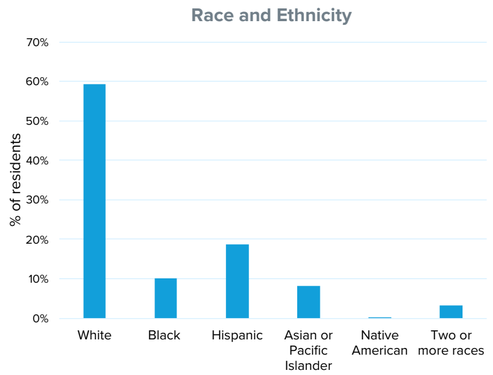
Children are 24.2% of the total population in the community. Infants, those zero to four, are 5.7% of that number. The community birth rate is 53 births per 1,000 women aged 15-50, this is higher than the US rate of 51.9 and that of the state, 51.5. In the Hospital's community, 9.2% of children aged 0-4 and 9.2% of children aged 5-17 live in poverty.

Seniors, those 65 and older, represent 13.8% of the total population in the community. Females are 55.3% of the total senior population.



Race and Ethnicity

In the Hospital's community, 59.3% of the residents are non-Hispanic White, 10.2% are non-Hispanic Black and 18.8% are Hispanic or Latino. Residents that are of Asian or Pacific Islander descent represent 8.1% of the total population, while .1% are Native American and 3.3% are two or more races.



Social Determinants of Health

According to the CDC, social determinants of health (SDOH) are the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. Social determinants of health are increasingly seen as the largest contributing factor to health inequities in communities throughout the country.

The Hospital categorized and analyzed SDOH data following the Healthy People 2030 model. This approach was chosen so, when possible, the Hospital could align its work with national efforts when addressing social determinants of health. For the purposes of the CHNA the Hospital will follow this model for reporting any related data.

The Healthy People 2030 place-based framework outlines five areas of SDOH:

Economic Stability: This includes areas such as income, cost of living, food security and housing stability.

Education Access and Quality: This focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.

Health Care Access and Quality: This includes topics such as access to health care, access to primary care and health insurance coverage.

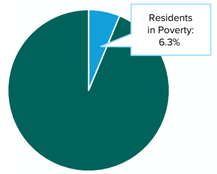
Neighborhood and Built Environment: This includes areas like quality of housing, access to transportation, availability of healthy foods and neighborhood crime and violence.

Social and Community Context: This focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Economic Stability

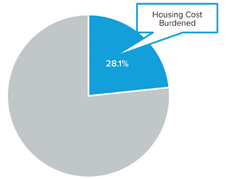
Income

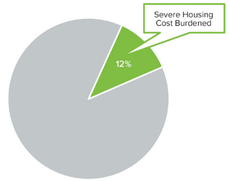
The median household income in the Hospital's community is $101,401. This is above the median for the state ($72,117) and the US ($68,498). The poverty rate in the community is 6.3%, which is below the state and national rate.



Food Insecurity and Housing Stability

People who are food insecure, having reduced quality and/or amount of food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.[1] Feeding America estimates for 2020[2], showed the food insecurity rate in the Hospital's community as 9%.





Increased evidence is showing a connection between stable and affordable housing and health.[3] When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more than 50%.

1 Food Insecurity - Healthy People 2030 | health.gov
2 Map the Meal Gap 2020 Combined Modules.pdf (feedingamerica.org)
3 Severe housing cost burden* | County Health Rankings & Roadmaps

Education Access and Quality

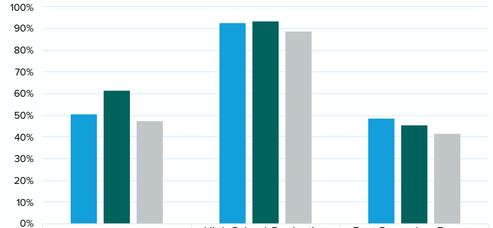
Research shows education can be a predictor of health outcomes, as well a path to address inequality in communities.[4] Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

In the Hospital's community, there is a 92.7% high school graduation rate, which is higher than the state and national rate. The rate of people with a post-secondary degree is also higher in the Hospital's community than both that of the state and the nation.

Early childhood education is uniquely important and can improve the cognitive and social development of children. This helps provide the foundation for long term academic success, as well as improved health outcomes. Research on early childhood education programs show that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings.[5]

In the Hospital's community, 50.5% of 3-4-year-olds were enrolled in preschool. This is lower than the state (54.6%) rate and higher than the national rate (47.3%). There is a large percentage of children in the community who may not be receiving these early foundational learnings.

Educational Attainment



	Preschool Enrollment Rate	High School Graduation Rate	Post Secondary Degree Rate
Hospital's Community	50.5%	92.7%	48.7%
IL	61.2%	93.3%	45.5%
US	47.4%	88.5%	41.6%

4 The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015 | Archives of Public Health | Full Text (biomedcentral.com)
5 Early Childhood Education| Health Impact in 5 Years | Health System Transformation | AD for Policy | CDC

Health Care Access and Quality

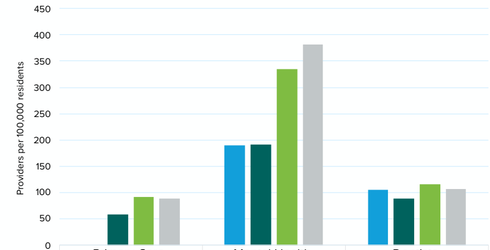
In 2020, 5.2% of community members aged 18-64 were found to not have health insurance. A lack of health insurance can lead to delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people.[6]

Accessing health care requires more than just insurance, there also need to be available health care professionals to provide care. When more providers are available in a community access can be easier, particularly for those experiencing transportation challenges.

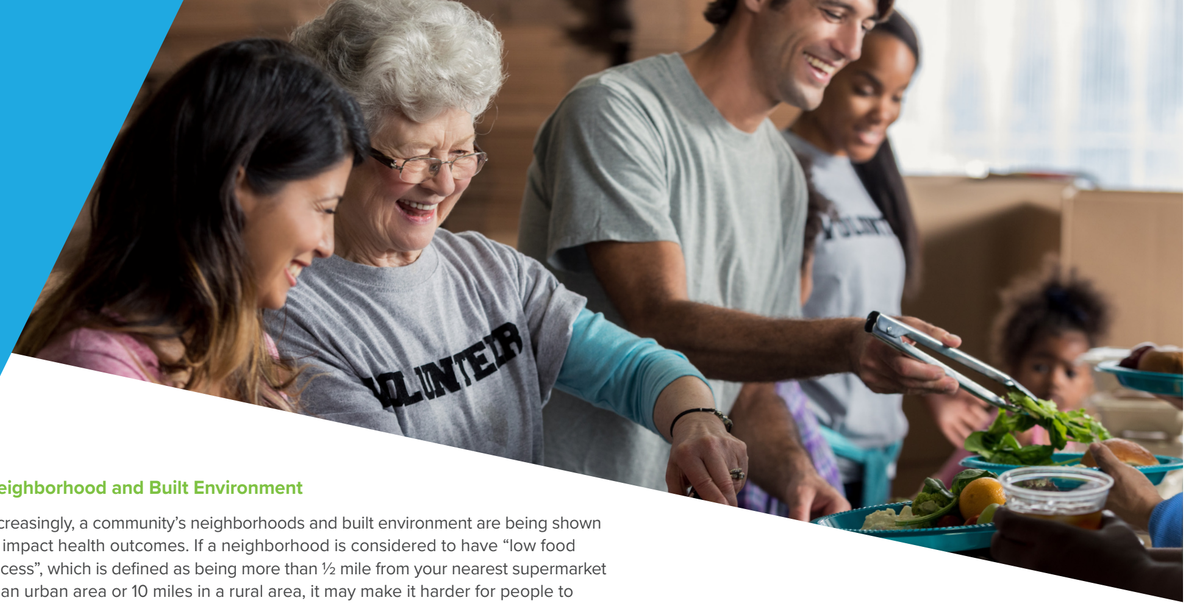
Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 75.4% of people report visiting their doctor for routine care.

6 Health Insurance and Access to Care (cdc.gov)

Providers Per Capita



	Primary Care	Mental Health	Dentists
Hospital's Community	N/A	189.8	105.4
Will County	58.8	190.6	89.2
IL	92.4	334.4	115.7
US	89.1	381.9	106.4

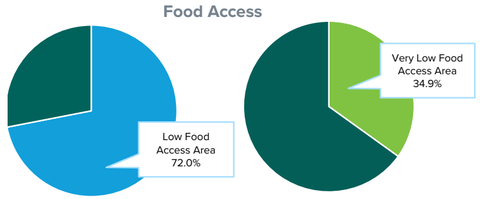


Neighborhood and Built Environment

Increasingly, a community's neighborhoods and built environment are being shown to impact health outcomes. If a neighborhood is considered to have "low food access", which is defined as being more than ½ mile from your nearest supermarket in an urban area or 10 miles in a rural area, it may make it harder for people to maintain a healthy diet. A very low food access area is defined as being more than 1 mile from your nearest supermarket in an urban area or 20 miles in a rural area.

A person's diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet.[7] In the Hospital's community, 72% of the community lives in a low food access area, while 34.9% live in a very low food access area.

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and maintaining employment. In the community, 3.1% of the households do not have an available vehicle.

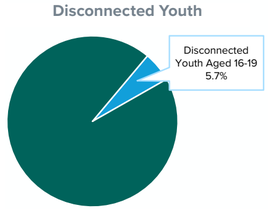


7 A Neighborhood's Built Environment May Have Numerous Effects on Its Residents' Health - RWJF

Social and Community Context

People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being.[8] When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can connect through work, community clubs or others to build their own relationships and social supports. There can be challenges to building these relationships when people don't have connections to create them or there are barriers like language between groups.

In the community, 5.7% of youth aged 16-19 were reported as disconnected, which means they were neither enrolled in school nor working at the time. Also, in the community 21.4% of seniors (age 65 and older) report living alone and 3% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.



8 Social and Community Context - Healthy People 2030 | health.gov

Process, Methods and Findings

Process and Methods

The Process

The health of people living in the same community can be very different because there are so many influencing factors. To understand and assess the most important health needs of its unique community and the people in it, input was solicited directly from the community and from individuals who represent the broad interests of the community. A real effort was made to reach out to all members of the community to obtain perspectives across age, race/ethnicity, gender, profession, household income, education level and geographic location. Publicly available data was also collected and reviewed. This data helped to inform how the community fared across health, social determinants of health and quality of life indicators compared to other communities in Illinois and the US.

The Hospital took part in the Will County Mobilizing for Action through Planning and Partnerships (MAPP) Collaborative. The Will County MAPP Collaborative, or "the Collaborative", was formed in 2011 and has representation from almost 100 social support and community organizations, health care systems, as well as public health and education and education institutions.

Data

A Data, Evaluation and Monitoring (DEM) Team was also created to collect, review and analyze the data found in the assessment process. The DEM Team serves as an established data resource for the Collaborative year-round, providing data and analysis during the assessment process and during ongoing evaluation efforts.

The Committee

The Committee includes representation from numerous organizations in the Collaborative. The representatives provide their expertise and knowledge on behalf of the communities served by their organizations and advocate on their behalf.

Community Organizations

- Aunt Martha's Health & Wellness
- Catholic Charities
- Easterseals Joliet Region, Inc.
- Greater Joliet YMCA
- Holstein Human Capital Development
- Nat'l Hookup of Black Women
- Northern Illinois Food Bank
- Senior Services of Will County
- Spanish Community Center
- Steppingstones, Inc.
- United Way of Will County

Health Care Systems and Providers

- AdventHealth Bolingbrook
- Ascension Saint Joseph Joliet
- AMITA Health
- Chestnut Health Systems
- Edward-Elmhurst Health
- Silver Cross Hospital
- Silver Oaks Behavioral Health Hospital
- Will Grundy Medical Clinic

Public Health Experts

- Will County Health Department
- Will County Community Health Center

Education and Public Service Institutions

- Governors State University
- Lewis University
- Valley View School District
- Will County Center for Community Concerns
- Will County Executive's Office

Community Input

The Collaborative collected input directly from the community and from health care and social service providers working in organizations addressing the needs and interests of the community. This was collected through a community survey, a local public health system assessment and a forces of change assessment.

Community Survey

- Provided in English and Spanish to anyone in Will County and accessible online through weblinks and QR codes.
- Surveys were shared through targeted social media posts, press release and via outreach with community partners including public health organizations. Partners were provided links to the online survey, with the request that it be sent to listservs, electronic mailing lists they maintained and when possible shared on their own social media channels.
- Flyers and presentations were also given to promote the survey through collaboration with community partners.
- Individuals were asked to provide information on topics such as, but not limited to:
  - Quality-of-life issues (personal satisfaction/happiness or dissatisfaction/ unhappiness with the conditions in which the respondents live)
  - Opinions of health issues in the home, neighborhood and county, where the respondents live.
  - Important issues, based on health indicators and indexes.
  - The perception of equity in our community.
  - Resources that are available to residents.

Local Public Health System Assessment

- Designed to provide input on the strengths and weaknesses of the local public health system. This online survey targets stakeholders in organizations that affect the quality of life and health in the community; including social service agencies, schools, government, faith institutions and any agency that influences health.
- Participants were invited to take the survey online via emails, social media, websites and direct contact methods.
- Respondents' perceptions and actual knowledge of activities related to their job duties within the public health system, are used to assess the strengths and weaknesses that exist within the local public health system.

Forces of Change Assessment

- An online survey designed to elicit broad community input to identify the trends, factors or events that are impacting the health and quality of life in the county. Participants were asked to weigh in on topics from social to economic and environmental to identify any threats and/or opportunities which may be influencing factors on health.
- Surveys were sent to stakeholders working in health care systems and community partners who provide health care and social services in Will County. Health care providers included professionals such as physicians, dentists and advanced registered nurse practitioners; community partners included social service workers, counselors and others who provide community-based services.
- Participants were invited to participate in the online survey via an email invitation.
- A focus was on hearing from stakeholders who represent or serve communities that are underserved, underrepresented, lower income and/or who are more likely to be impacted by the social determinants of health.

Secondary Data

To inform the assessment process, existing health related and demographic data about the community from publicly available sources was collected. This included topics in the areas of health, social determinants of health and quality of life indicators. The most current public data for the assessment was compiled and sourced from government and public health organizations including, but not limited to:

- Center for Disease Control and Prevention
- US Department of Health and Human Services
- County Health Rankings
- Various State of Illinois Department Databases
- Will County Health Department

The Findings

The Collaborative hosted a community forum which included reviewing key findings and providing information and data related to current health issues identified in the assessment and an opportunity to select the needs and initiatives to address them for the coming three years. The following issues were selected as the priorities for Will County.

Access to Care:

Many people face barriers that prevent or limit access to needed health care and social services, which may increase the risk of poor health outcomes and health disparities. Access to health care is the timely use of personal health services to achieve the best possible health outcomes. Two important factors in accessing care involve having an adequate number of providers in a community and adequate health insurance coverage.

Inadequate health insurance coverage is one of the largest barriers to health care access and the unequal distribution of coverage contributes to disparities in health. Out-of-pocket medical care costs may lead individuals to delay or forgo needed care (such as doctor visits, dental care and medications), and medical debt is common among both insured and uninsured individuals.

Lack of health insurance coverage may negatively affect health since uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer and cardiovascular disease. Similarly, children without health insurance coverage are less likely to receive appropriate treatment for conditions like asthma or critical preventive services such as dental care, immunizations and well-child visits that track developmental milestones.

Behavioral Health and Substance Abuse:

Behavioral health is a term that includes both mental health and substance use disorders. Mental disorders and substance use disorders often occur together. Substance use disorders can involve illicit drugs, prescription drugs, alcohol or tobacco. Opioid use disorders, which stem from the improper use of prescription drugs, have become especially problematic in recent years. Substance use disorders are linked to many health problems and overdoses can lead to emergency department visits and deaths.

Mental illnesses are conditions that affect a person's thinking, feeling, mood or behavior, such as depression, anxiety, bipolar disorder or schizophrenia. Such conditions may be occasional or long-lasting (chronic) and affect someone's ability to relate to others and function each day. Mental health includes our emotional, psychological and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Access to Food and Nutrition:

A lack of food access can lead to food insecurity, when community members do not have physical and economic access to sufficient safe and nutritious food that meets their dietary needs and food preferences. A lack of food security has been linked to negative health outcomes in children and adult, as well as potentially causing trouble for children in schools.

Access to food does not mean access to nutritious food. Many people in the United States do not eat a healthy diet, which could be because some people do not have the information needed to choose healthy foods or do not have access to healthy foods or can not afford to buy enough food. People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes and other health problems.

Stabilizing the Built Environment :

Housing instability encompasses a number of challenges, such as having trouble paying rent, overcrowding, moving frequently or spending the bulk of household income on housing. These experiences may negatively affect physical health and make it harder to access health care.

Considered a social determinant of health, housing can affect a wide range of health and quality-of life outcomes. Everyone needs a place to live, regardless of age, job, race, ability, income or position in life, but not everyone's home is affordable. The Department of Housing and Urban Development (HUD) defines "affordable housing" as consuming no more than 30% of a household's monthly income, including utilities. This is the maximum level a family should spend. Generally, when families or individuals spend more than 30% of their income on housing, they do not have enough income to withstand financial setbacks or meet other basic needs such as food, clothing and medical insurance.

Transportation is also an often-mentioned barrier to access in the built environment. Transportation issues include lack of vehicle access, inadequate infrastructure, long distances and lengthy times to reach needed services, transportation costs and adverse policies that affect travel. Transportation challenges affect rural and urban communities. Because transportation touches many aspects of a person's life, adequate and reliable transportation services are fundamental to healthy communities. Transportation issues can affect a person's access to health care services. These issues may result in missed or delayed health care appointments, increased health expenditures and overall poorer health outcomes.

PRIORITIES SELECTION

Prioritization Process

The Collaborative hosted a community forum which included reviewing key findings and providing information and data related to current health issues identified in the assessment and an opportunity to select the needs and initiatives to address them for the coming three years. During the forum, participants also reviewed the needs and progress to address them since the previous assessment. Given the progress that had been made since the last assessment and the often-long term effort required to create a sustainable impact, a consensus was reached to continue addressing the needs from the previous assessment. The top priority areas in Will County for 2022 will be: Access to Care, Behavioral Health and Substance Misuse, Access to Food and Nutrition and Stabilizing the Built Environment:.

Following the Collaborative's selection, the Hospital convened a Community Health Needs Assessment Committee (CHNAC) to review the priorities selected by the Collaborative and to identify the needs the Hospital would select. The CHNAC reviewed the data behind the Collaborative's priorities and the unique demographic data of the community the Hospital serves, when different from county level data. The CHNAC also considered the Hospital's PSA-level secondary data, local community resources available, as well as the Hospital's current resources and strategies to find ways to prioritize and address the needs most effectively.

After review and discussion, the CHNAC voted via a zoom poll to narrow the list to two priorities. CHNAC members were asked to consider the following question before voting on each issue.

"What is the magnitude of the need for more focus and attention on this health issue?"
The needs were scored on a scale of 1 to 5 (1 = no more focus needed, 3 = more focus needed, 5 = much more focus needed).

Based on the data review and discussion, the CHNAC voted to prioritize:

- Access to Care
- Behavioral Health and Substance Misuse

CHNAC Members

Members serving on the CHNAC were selected to provide their expertise and knowledge regarding the unique communities served by the Hospital. These individuals were relied on to represent the interests of the populations they serve and ensure their voices were at the table.

Name	Organization	Services Provided
Derek Cazeau, Executive Director	AdventHealth, Administration	Health Care
Kamar Anderson, Community Benefit Specialist	AdventHealth Corporate, Community Benefit	Health Care
Kamala Martinez, President/ CEO	United Way Will County	Social Support Services
Sue Olenek, Executive Director	Will County Health Department	Public Health
Rebecca Beardsley, Manager	AdventHealth, Marketing	Health Care
Jill Jennings, Director of Clinical Programs	AdventHealth Bolingbrook	Health Care
Kelly Clancy, Executive Director	AdventHealth, Government Affairs	Health Care
Mark Bondarenk, Executive Director	AdventHealth, Mission Integration	Health Care
Bela Nand, MD, Interim Chief Medical Officer	AdventHealth Bolingbrook	Health Care
Kim Gilette, Director	AdventHealth, Case Management	Health Care
Jared Brown, Chief Financial Officer	AdventHealth Bolingbrook	Health Care
Kathy Ragusa, Vice President/ Chief Operating Officer	AdventHealth Medical Group	Health Care
Fabiola Zavala, Regional Director	AdventHealth, Community Benefit	Health Care

Available Community Resources

As part of the assessment process, a list of resources or organizations addressing the top needs in the community was created. Although not a complete list, it helped to show where there were gaps in support and opportunities for partnership in the community when the CHNAC chose which priorities to address.

Top Issues	Current Community Programs	Current Hospital Programs
Access to Care	• Will County Health Department, Community Health Center, Wellness House, VNA Healthcare, Hamdard Health Alliance	• Financial Services
Behavioral Health and Substance Abuse	• Will County Health Department, Community Health Center	• Collaboration with Bolingbrook Police Department LCSW part of crisis response team in the community
Access to Food and Nutrition	• Will County Health Department, University of Illinois Extension	• Mobile Food Pantries, Micropantries, Food for Life
Stabilizing the Built Environment	• Community Service Council of Will County, Will County Will Ride	

Priorities Addressed

The priorities addressed include:

Access to Care

Access to care is a key driver to health. Access can be influenced by both cost and availability. According to 30% of community survey respondents, their households are never, rarely or only sometimes able to pay for health care (family doctor, prescriptions, etc.). An important factor is availability of care and requires having an adequate number of providers in a community. There is a shortage of primary care, mental health and dental care providers in the county. The county has fewer providers by population compared to both the state and the nation. For example, the rate of primary care providers in Will County is 1,810:1, compared to the IL rate of 1,240:1 and the national rate of 1,030:1. Focusing on access to care will enable the Hospital to align to local efforts and resources to create targeted strategies to improve access for all resident in its community.

Behavioral Health and Substance Misuse

During the assessment, 47.2% of community survey respondents shared depression/anxiety were a problem in their home. It was also found that 5.3% believed prescription drug use was a problem in their home and nearly 53% believe it is a problem in Will County. Public data also found that 56% of 12th graders use alcohol, with 16% reporting they have engaged in binge drinking in the last two weeks. Awareness and the need to address behavioral health has been growing in the country and locally. By addressing behavioral health as a priority, the Hospital can align to local, state and national efforts for resource collaboration and to create better outcomes opportunities over the next three years.

Priorities Not Addressed

Access to Food and Nutrition

According to community survey respondents, almost 40% shared that food they had bought did not last and they did not have money to get more. Public data also found areas of northern Will County had pockets of low food access, while the rate of supermarkets per 10,000 residents decreased well below state and national rates. It was also found that the number of SNAP authorized retailers in Will County was lower than in Illinois and in the United States.

Although access to healthy affordable food is a key driver of health outcomes, the Hospital did not choose to address this priority. The Hospital believes that other organizations are better positioned in the community to address this need directly and will support those efforts when able.

Stabilizing the Built Environment

During the assessment, affordability and access of transportation and safe housing was cited often by community members as a barrier to quality of life and good health. During the assessment, 31% of community survey respondents shared they never or rarely have access to public transportation for activities such as grocery shopping, getting to work or appointments, etc. The Hospital decided that housing and transportation, although an identified need for a multitude of reasons, is being addressed as countywide by other organizations better positioned to address it and the Hospital could not make meaningful change in the time allotted for the next community health plan.

COMMUNITY HEALTH PLAN

Next Steps

The Hospital will work with the Collaborative and other community partners to develop a measurable Community Health Plan for 2023-2025 to address the priority issues. For each priority, specific goals will be developed including measurable outcomes, intervention strategies and the resources necessary for successful implementation.

Evidence based strategies will be reviewed to determine the most impactful and effective interventions. For each goal, a review of policies that can support or deter progress will be completed with consideration of opportunities to make an impact. The plan will be reviewed quarterly with an annual assessment of progress. A presentation of progress on the plan will also be presented to the Hospital board annually.

A link to the Community Health Plan will be posted on AdventHealth.com prior to May 15, 2023.

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2020 Community Health Plan Review

The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually. The following is a summary of progress made on our most recently adopted plan. The full evaluation is available upon request.

Priority 1: Behavioral Health and Substance Use

In the 2019 assessment, behavioral health was identified as a priority. Behavioral health is a term that includes both mental health and substance use disorders. The burden of mental illness in the United States is among the highest of all diseases, and mental disorders are among the most common causes of disability for adults, children and adolescents. When mental health disorders are untreated, those affected are at high risk for many unhealthy and unsafe behaviors, including alcohol or drug abuse, violent or self-destructive behavior and suicide. Mental health disorders are the 11th leading cause of death in the United States for all age groups and the second leading cause of death among people age 25 to 34. In the AdventHealth Bolingbrook, county area mental health disorders attributed to 7.8% of Will County hospitalizations in 2014 and is the third leading cause of hospitalizations overall. Behavioral health continues to be a primary concern in the Hospital's community.

The Hospital focused its efforts on increasing education and building community level networks for mental health support. Efforts to address this were part of a collaborative effort between the Hospital, AdventHealth GlenOaks, AdventHealth Hinsdale and AdventHealth LaGrange, which serve overlapping communities.

As part of this effort, a facilitator completed the Mental Health First Aid instructor certification. Having received the certification, the team member was able to provide classes training community members on how to help someone who may be experiencing a mental health or substance use challenge. By the end of 2021, 11 community members had been trained.

Priority 2: Access to Health Care

Access to care was also a priority selected by the Hospital in the previous assessment. Healthy People 2020 states that access to comprehensive healthcare services is important for achieving health equity and improving quality of life for everyone. Disparities in access to care and community resources were identified as underlying root causes of many of the health inequities experienced by residents in Will County. In 2016, 10.35% of the Will County working age population (18-64 years old) was uninsured. Access has multiple components to address including availability, affordability, proximity and timeliness. Addressing the coordination and linkage to a primary medical home, benefits enrollment and access to services and resources are opportunities to address.

As part of its effort to increase access, the Hospital is engaging in a system wide strategy to increase awareness of and connection to resources and services to social support services that address SDOH. The Hospital is working to create a comprehensive closed loop referral network to social support services in the community. This initiative will provide an online directory of free or reduced cost services that address social needs such as medical care, food, job training, utility assistance, housing, transportation, legal services and more. Hospital team members will be able to refer to organizations in the network to address social needs not often covered in clinical care.

Priority 3: Access to Food and Nutrition

The Hospital also selected access to food and nutrition as a priority as a result of the findings it the assessment. Adults who are food insecure can be at an increased risk for negative health outcomes, including obesity and other chronic diseases. In addition, it can impact children, putting them at an increased risk of developmental problems. Food insecurity in Will County affects nearly 10% of all residents, of which even more have no access to healthy food retailers. Of the more than 34,000 children experiencing food insecurity, 46% are ineligible for assistance programs. There are geographic food deserts in parts of Will County that are primarily in low-income areas. Obesity continues to be an issue for adults as well as high rates of hospitalization for diabetes among the Hispanic and Latino ethnicities.

As part of its efforts to address the need, the Hospital partnered with the Islamic Circle of North America (ICNA) Relief and Neighborhood Family Food Pantries. ICNA Relief provides transitional homes, refugee services, free health clinics, counseling services and more, in addition to the food pantry network. The Hospital also provides a micro pantry on site for patients through the partnership. By the end of 2021, the micropantries were serving just less than 30 individuals a month.

Priority 4: Stabilizing the Built Environment

As a result of the findings in the assessment, the Hospital also chose to address the built environment as a priority. Improving health outcomes includes addressing social determinants of health such as the built environment. Where people live can impact their health and well-being. Those living in poverty are at greater risk of food insecurity, homelessness, infectious diseases, environmental hazards and poor academic performance. In Will County, housing security is nested as an issue in all major strategic categories.

The Hospital is working on developing a program to connect community members in need to the appropriate resources using the local library as a place of contact. The program provides a licensed clinical social worker at a library to connect individuals who are experiencing homelessness, chronic unemployment, mental illness and other complex needs with appropriate referrals and social support resources. The program is still in development, with a goal of launching by the end of 2022.

2019 Community Health Needs Assessment Comments

We posted a link to the most recently conducted CHNA and most recently adopted implementation strategy on our Hospital website as well as AdventHealth.com prior to May 15, 2020 and have not received any written comments.

AdventHealth

Adventist Bolingbrook Hospital d/b/a AdventHealth Bolingbrook

CHNA Approved by the Hospital Board on December 15, 2022

For questions or comments please contact:
CORP.CommunityBenefitSupport@AdventHealth.com

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