2022 AdventHealth LaGrange Community Health Needs Assessment

Extending the Healing Ministry of Christ

AdventHealth

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Letter From Leadership

At AdventHealth, we have a sacred mission of Extending the Healing Ministry of Christ. That obligation goes beyond our walls and into the communities we serve. Our commitment is to address the healthcare needs of our community with a wholistic focus; one that strives to heal and restore the body, mind and spirit. We want to help our communities get well and stay well.

Every three years, AdventHealth hospitals across the nation complete a Community Health Needs Assessment. During this assessment we talk to, and work with, community organizations, public health experts and people like you, who understand our communities best. This in-depth look at the overall health of our communities and the barriers to care they experience help AdventHealth better understand the unique needs in the various communities we serve.

We use this information to create strategic plans that address the issues that impact our communities most. At AdventHealth, we know that a healthy community is not a “one size fits all” proposition and that everyone deserves a whole health approach that meets them where they are and supports their individual health journey.

This work would not be possible without the partnership of public health experts, community organizations and countless community members who helped inform this report. Through these ongoing partnerships and collaboration, AdventHealth will continue to create opportunities for better health in all the communities we serve.

Adam Maycock
President and CEO
AdventHealth LaGrange

Executive Summary

Adventist Midwest Health d/b/a AdventHealth LaGrange will be referred to in this document as AdventHealth LaGrange or “the Hospital”. AdventHealth LaGrange in LaGrange, Illinois conducted a community health needs assessment from May 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 LaGrange partnered with in the collaborative Community Health Needs Assessment for Cook County through its membership in the Alliance for Health Equity, referred to as “the Collaborative”. The Alliance for Health Equity is a collaborative of health care systems and providers, working with health departments and community-based organizations with a shared vision to improve health equity, wellness and quality of life across Chicago and Cook County. 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 Process, Methods and Findings.

The Committee

To provide strategic guidance for the Collaborative and guide the assessment process a smaller steering committee of the larger collaborative was formed. The steering committee’s membership included individuals from health care systems and public health departments who represent the interests of medically underserved, low-income and minority community members. This steering committee is referred to here as “the Committee”.

Community Health Needs Assessment Committee

AdventHealth LaGrange 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, the unique demographic data of the community the Hospital serves, when different from county level data, 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, focus groups 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 aggregate issues. To read more about the county level findings and data highlighted in the report, please visit the Alliance for Health Equity 2022 CHNA report.
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.

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.

The Collaborative and 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 and Community Resources
2. Priority Health Conditions (Prevention & Treatment)

See Prioritization Process for more.

Approval

On December 15, 2022, the AdventHealth LaGrange 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 LaGrange 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 LaGrange 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 LaGrange

AdventHealth LaGrange is part of the AdventHealth Great Lakes Region. The AdventHealth Great Lakes region is comprised of AdventHealth GlenOaks, AdventHealth Hinsdale, AdventHealth Bolingbrook and AdventHealth LaGrange, all in the State of Illinois. AdventHealth LaGrange is a 196- bed, full service medical facility that provides high-quality, compassionate and family-centered medical care to the residents of LaGrange and the surrounding communities. AdventHealth LaGrange offers emergency medical services, heart and vascular care, cancer care, obstetrics and women's services, lab and imaging services and surgical services. AdventHealth LaGrange has earned a number of nationally recognized awards and safety grades including, ANCC Magnet Designation, Joint Commission Hospital Behavioral Health and Home Health accreditation, Joint Commission Advanced Primary Stroke Center Certification, Blue Distinction Specialty Care for Hip and Knee Replacement and CMS Start Rating program – 5 Star.

COMMUNITY OVERVIEW

Community Description

Located in Cook County, Illinois, AdventHealth LaGrange defines its community as the Primary Service Area (PSA), the area in which 75-80% of its patient population lives. This includes 21 zip codes across Cook and DuPage Counties.

According to the 2020 Census, the population in the AdventHealth LaGrange community has grown 2.4% in the last ten years to 528,987 people. This is less than the percentage of growth seen in the United States since the last Census but more than seen in the State of Illinois, 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. Data are also provided to show how the community compares locally, in the state and at a national level for some indicators.

Community Profile

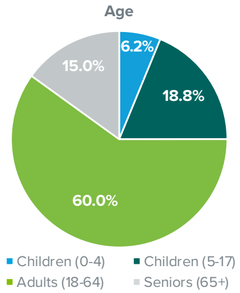
Age and Sex

The median age in the Hospital's community is 38.8, higher than that of state which is 38.3 and that of the US, 38.2.

Females are the majority, representing 50.6% of the population. Middle aged women, 40-64, are the largest demographic group at 15.93%. Middle aged men are the second largest demographic group at 15.86%.

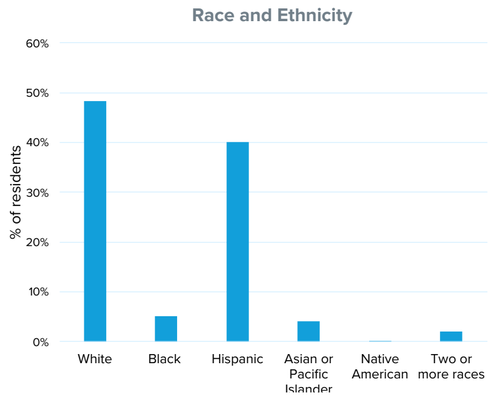
Children are 25% of the total population in the community. Infants, those zero to four, are 6.2% of that number. The community birth rate is 54.2 births per 1,000 women aged 15-50, this is higher than the US average of 51.9 and that of the state, 51.5. In the Hospital's community, 11.3% of children aged 0-4 and 12.9% of children aged 5-17 live in poverty.

Seniors, those 65 and older, represent 15% of the total population in the community. Females are 56.6% of the total senior population.



Race and Ethnicity

In the Hospital's community, 48.3% of the residents are non-Hispanic White, 5.1% are non-Hispanic Black and 40.1% are Hispanic or Latino. Residents that are of Asian or Pacific Islander descent represent 4.1% of the total population, while .1% are Native American and 2.1% 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.

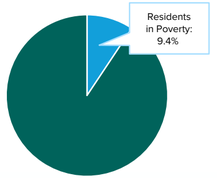
Neighborhood and Built Environment: This includes areas like quality of housing, access to transportation, availability of healthy foods and neighborhood crime and violence.

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

Economic Stability

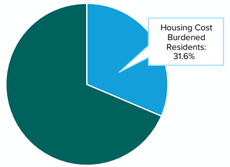
Income

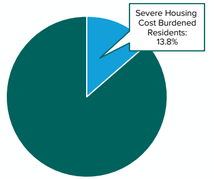
The median household income in the Hospital's community is $84,928. This is above the median for the state and that of the US. The poverty rate in the community is 9.4% which is lower than the state and national rate.



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 11.2%.





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

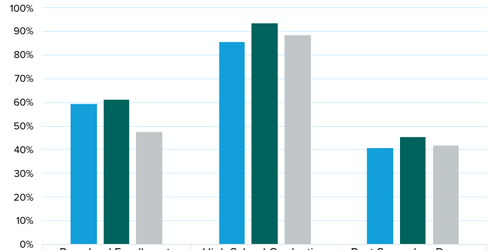
Research shows education can be a predictor of health outcomes, as well a path to address inequality in communities.[4] Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased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

In the Hospital's community, there is an 85.5% high school graduation rate, which is lower than the state and national rate. The rate of people with a post-secondary degree is also lower 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, 59.2% of 3-4-year-olds were enrolled in preschool. This is higher than both the state and the national rate. 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	59.2%	85.5%	40.7%
IL	54.6%	89.7%	43.7%
US	47.3%	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

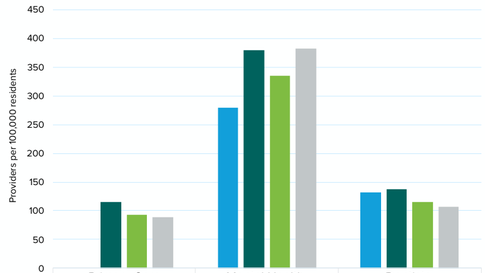
In 2020, 9.1% of community members aged 18-64 were found to not have health insurance. A lack of health insurance can lead to delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability 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.

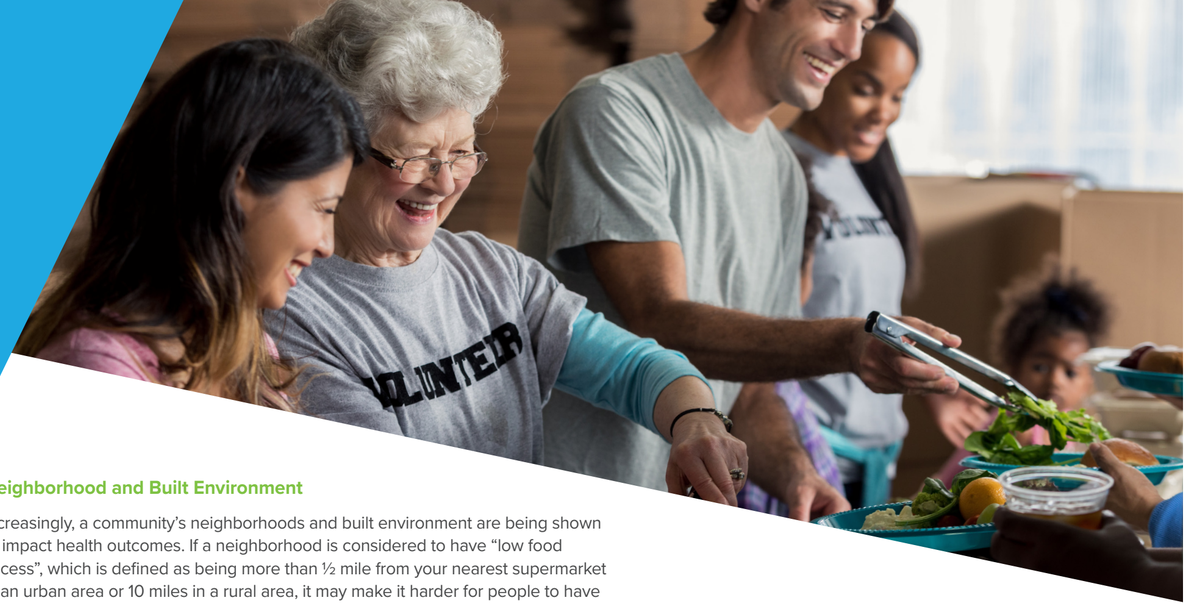
Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 73.9% of people report visiting their doctor for routine care.

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

Providers Per Capita



	Primary Care	Mental Health	Dentists
Hospital's Community	N/A	278.8	131.7
Cook County	115.2	379.7	137.3
IL	92.4	334.4	115.7
US	89.1	381.9	106.4



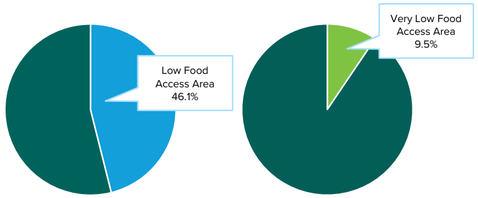
Neighborhood and Built Environment

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 have 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, 46.1% of the community lives in a low food access area, while 9.5% 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, 6.3% of the households do not have an available vehicle.

Food Access



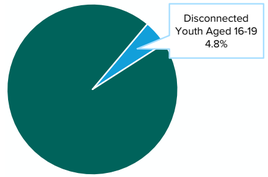
7 A Neighborhood's Built Environment May Have Numerous Effects on Its Residents' Health - RWJF

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, 4.8% 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 25.6% of seniors (age 65 and older) report living alone and 7.4% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.

Disconnected Youth



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 collaborative Community Health Needs Assessment for Cook County through its membership in the Alliance for Health Equity, referred to as “the Collaborative”. The Alliance for Health Equity is a collaborative of health care systems and providers, working with health departments and community-based organizations with a shared vision to improve health equity, wellness and quality of life across Chicago and Cook County.

The community-based organizations engaged in the Alliance for Health Equity represent a broad range of sectors such as workforce development, housing and homeless services, food access and food justice, community safety, planning and community development, immigrant rights, youth development, community organizing, faith communities, mental health services, substance use services, policy and advocacy, transportation, older adult services, health care services, higher education and many more. All community partners work with or represent communities that are disproportionately affected by health inequities such as communities of color, immigrants, youth, older adults and caregivers, LGBTQ+, individuals experiencing homelessness or housing instability, individuals living with mental illness or substance use disorders, individuals with disabilities, veterans and unemployed youth and adults.

The Committee

To provide strategic guidance for the Collaborative and guide the assessment process a smaller steering committee of the larger collaborative was formed. The steering committee's membership included individuals from health care systems and public health departments who represent the interests of medically underserved, low-income and minority community members. This steering committee is referred to here as "the Committee".

Health Care Systems and Providers

- Advocate Aurora Health
- AMITA Health
- Ann & Robert H. Lurie Children's Hospital
- Jackson Park Hospital
- Loyola University Health System
- MacNeal Hospital
- Mercy Hospital and Medical Center
- Northwestern Medicine
- Norwegian American Hospital
- Palos Health
- Roseland Community Hospital
- Rush
- Sinai Health System
- Swedish Hospital
- University of Illinois Hospital & Health Systems

Public Health Experts

- Chicago Department of Public Health
- Cook County Department of Public Health

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, focus groups and a forces of change assessment.

Community Survey

- Provided in English and Spanish to anyone 10 and older in the Chicago or Suburban Cook County area 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.
- Paper surveys were provided at focus groups and at select in-person events.
- Hospitals, community-based organizations and health departments distributed the surveys to gain insight from priority populations that have been historically excluded in assessment processes.
- Individuals were asked to provide information on topics such as, but not limited to:
  - Health needs and status of their communities
  - Community strengths
  - Opportunities for improvement

Community Resident Focus Groups

- Between September 2021 and April 2022, 43 focus groups with community members were held.
- Input from communities that are historically marginalized and systematically excluded form assessment and decision-making processes was a focus of the Collaborative.
- Participants were 14 years old or older and represented a diverse range of ethnic, racial, religious and socioeconomic backgrounds.

Forces of Change Assessment

- Designed to elicit 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 influence the public health system in the near future.
- Experts were asked to present and facilitate discussion on the following seven topics:
  - Policy
  - Data
  - Public health workforce
  - Public health issues
  - Equity
  - Housing and homelessness
  - Economic justice/poverty
- Insight from these discussions was used to identify key system opportunities and barriers to consider when evaluating community and public health needs. 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 by epidemiologists from Cook County Department of Public Health (CCDPH) and Chicago Department of Public Health (CDPH) and Metopio. This included data on 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:

- US Census Bureau
- Center for Disease Control and Prevention
- Illinois Department of Public Health
- US Department of Health and Human Services
- County Health Rankings
- Various State of Illinois Department Databases
- Cook County Health Department

The Findings

Throughout the assessment process, there were reoccurring themes which consistently rose to the top. Although specific health conditions and barriers were identified, the underlying drivers behind them often were the same or quite similar. The Collaborative grouped the findings into three issues, which included not only specific health conditions, but also related social determinant of health influences and other contributing factors.

Social and Structural Determinants of Health:

- Addressing structural racism and advancing health equity
- Conditions that support healthy eating, active living and social connectedness
- Food Access and Food Security
- Housing, Transportation and Neighborhood Environment

Priority Health Conditions (Prevention & Treatment):

- Chronic conditions
- COVID-19
- Maternal and child health
- Mental health and substance use disorders

Access to Care and Community Resources:

- Culturally and linguistically appropriate care
- Resources, referrals, coordination and connection to community-based services
- Timely linkage to quality care, including behavioral health and social services
- Workforce development and support for healthcare, behavioral health and human services

PRIORITIES SELECTION

Prioritization Process

Following a review of the Collaborative's findings, 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 and Community Resources
- Priority Health Conditions (Prevention & Treatment)

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
Angela Curran, CEO	Pillars Community Health
Kamar Anderson, Community Benefit Specialist	AdventHealth Corporate
Maria S. Pesqueira, President/ CEO	Healthy Communities Foundation
Amber Windsor-Hardy, Community Benefit Manager	AdventHealth Corporate
Kimberly Knake, Executive Director	National Alliance of Mental Illness – Metro Suburban
Alap Shah, MD, Director	LaGrange Family Medicine
Adam Maycock, President/ CEO	AdventHealth Hinsdale & LaGrange
Bela Nand, MD, Chief Medical Officer	AdventHealth Hinsdale & LaGrange
Susan Herrman, Executive Director	AdventHealth Hinsdale & LaGrange, Magnet
Benjamin Layman, Chief Operating Officer	AdventHealth Hinsdale & LaGrange
Rich Matula, Director	AdventHealth Marketing
Fabiola Zavala, Regional Director	AdventHealth Community Benefit
Chris Zurales, Manager	AdventHealth Marketing
Kathleen Downey, Vice President of Nursing Operations	AdventHealth Hinsdale and LaGrange
Danae Still, Chief Financial Officer	AdventHealth Hinsdale and LaGrange
Tina Rounds, Executive Director	BEDS Plus
Michael Kingdom, Manager	AdventHealth Chaplain/ Pastoral Care
Lyn Burgess, Manager	AdventHealth Hinsdale & LaGrange, Public Relations
Candace Wroblewski, Director	AdventHealth Care Management
Cynthia Chesna, Regional Director of Operations	AdventHealth Home Health & Hospice
Dru Lazarra, Regional Executive Director	AdventHealth Behavioral Health
Vickie Moxley, Manager	AdventHealth Care Management

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
Social and Structural Determinants of Health	• Aging Care Connections, Pillars Community Health, Food Pantries at St. Francis Xavier, St. Blasé, St. Cletus and Lyons Township, Housing Forward, New Moms, All of Our Children's Advocacy, National Alliance for Mental Illness – Metro Suburban, BedsPlus, LaGrange Area Department of Special Education, Helping Hands, Community Support Services, El Valor, Family Focus, Mujeres Latinas en Acción	• Inpatient and outpatient behavioral health services, Hinsdale Mobile Food Pantry
Access to Care and Community Resources	• Pillars Community Health, Aging Care Connections, LaGrange Area Department of Special Education, Helping Hands, El Valor, Family Focus, Mobile Care Chicago, Alivio Medical Center, Esperanza	• Mission Clinic; Whole Health Hub; LaGrange Family Medicine Clinic, Financial assistance services
Priority Health Conditions (prevention and treatment)	• National Alliance for Mental Illness - Metro Suburban, Pillars Community Health, Latino Alzheimer's Memory Disorder Association (LAMBDA), Aging Care Connections, Esperanza, Family Mental Health Service Center of Cicero, Youth Crossroads.	• LaGrange Family Medicine Opioid MAT clinics, Mental Health First Aid Trainings, Collaboration with Pillars Community Health

Priorities Addressed

The priorities addressed include:

Access to Care and Community Resources

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 Cook 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.

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Priority Health Conditions (Prevention & Treatment)

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 Cook 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

Social and Structural Determinants of Health

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: Social and Structural Determinants of Health

In the 2019 assessment, the Hospital chose to address social and structural determinants of health. The social and structural determinants of health such as poverty, unequal access to community resources, unequal education funding and quality, structural racism and environmental conditions are underlying root causes of health inequities. Additionally, social determinants of health often vary by geography, gender, sexual orientation, age, race, disability and ethnicity. The strong connections between social, economic and environmental factors and health are apparent in Chicago and suburban Cook County, with health inequities being even more pronounced than many national trends.

In addressing the need, the Hospital focused on increasing access to healthy and nutritious food. It has been found 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. As part of its efforts to address the need, the Hospital partnered with the Northern Illinois Food Bank, Hinsdale Seventh Day Adventist Church and the Community Memorial Foundation. Through this collaboration, the partners provide a Rx Mobile Food Pantry twice a month. The Rx Mobile Food Pantry provides free produce, meat and dairy to patients screened for food insecurity as well as to the community at large. There are also wrap around services such as SNAP benefit enrollment opportunities available at micro-pantries offered on site at the Hospital. By the end of 2021, the Hospital had hit a monthly high of 786 individuals served during the twice monthly event.

Priority 2: Access to Care, Community Resources and Systems Improvements

Access to care, community resources and systems improvements 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 Cook County. Increasing timely linkage to appropriate care including behavioral health and social services is a priority.

As part of its efforts to address the need, the Hospital partnered with Pillars Community Health and the LaGrange Family Residency Clinic. The organizations collaborated to provide individuals who were already on site for day programs with health consultations and linkages to routine health services. By the end of 2021, more than 90% of day program participants had been connected to doctors to establish a permanent medical home. In addition, 22 individuals had been connected to dental care and 51 to mental health care in addition to doctors.

Priority 3: Mental Health and Substance Use Disorders

The Hospital selected mental health and substance use disorders as a result of the findings in the 2019 assessment. 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. Behavioral health continues to be a primary concern in Cook County. Addressing behavioral health requires attention to substance use disorders as well as mental health.

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 Bolingbrook, AdventHealth GlenOaks and AdventHealth Hinsdale, 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, eight community members had been trained.

Priority 4: Chronic Condition Prevention and Management

The Hospital also selected chronic condition prevention and management. In the United States, chronic diseases are the leading causes of disability and death. In addition, chronic disease rates are accelerating globally across all socioeconomic classes. However, socioeconomic inequities have profound impacts on which populations and communities have the greatest burden of disease. Chronic conditions such as heart disease, stroke, cancer, diabetes, arthritis, asthma, mental illness and HIV/AIDs account for 90% of the nation's $3.3 trillion in annual health care expenditures Prevention and management of chronic illness can help reduce the costly physical and socioeconomic burden of these diseases for individuals and society as a whole. The number of individuals in the US who are living with a chronic disease is projected to continue increasing well into the future. Sixty-five percent of deaths in suburban Cook County were due to chronic diseases. As a result, it will be increasingly important for the health care system to focus on prevention of chronic disease and the provision of ongoing care management.

As part of its effort to address the need, the Hospital partnered with Pillars Community Health to provide adults and youths with elevated BMI levels a documented follow up plan and physical activity sessions. Access to nutrition and physical activity provides individuals and families the tools needed to live a healthy lifestyle, a key component to chronic disease management.

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 Midwest Health d/b/a AdventHealth LaGrange

CHNA Approved by the Hospital Board on December 15, 2022

For questions or comments please contact:
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