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I. Introduction

Overview of Palos Community Hospital

Palos Community Hospital is a 425-bed hospital in Palos Heights, Illinois serving the residents of southwestern Cook County and parts of northeastern Will County.

Palos Community Hospital's mission is to provide compassionate care, operating in accordance with the ethical and religious directives for Catholic healthcare facilities. Palos Community Hospital is committed to continuously reviewing and analyzing the changing needs of our communities. We respond with readily available services that encourage efficient use by physicians and patients, and we strive to adapt to these changes by quickly and effectively influencing the forces in our environment.

Palos Community Hospital's services include a comprehensive Emergency Department, an intensive care unit (ICU), comprehensive cardiovascular services, home health services, orthopedics, oncology, maternity care and women's health, pediatrics, physical and occupational therapy, and psychiatry and behavioral health.

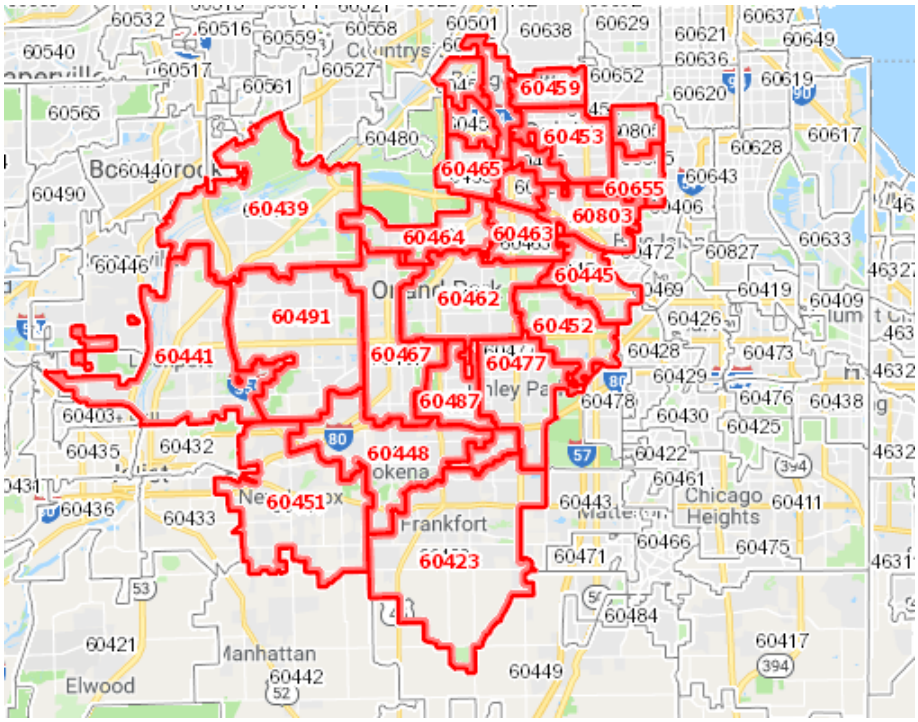
Communities Served by Palos Community Hospital

Palos Community Hospital's primary service area encompasses 11 cities in southwest Cook County, and the secondary service area includes 15 additional cities in Southwest Cook County and northeast Will County. Figure 1 is a map of the hospital's service area and list of cities and zip codes in the service area.

Figure 1. Palos Community Hospital Service Area Map and List of Communities

Cities and Zip Codes in Palos Community Hospital's Service Area

Primary Service Area		Secondary Service Area	
60445	Midlothian and Crestwood	60415	Chicago Ridge
60452	Oak Forest	60423	Frankfort
60462	Orland Park	60439	Lemont
60463	Palos Heights	60441	Lockport
60464	Palos Park	60448	Mokena
60465	Palos Hills	60451	New Lenox
60467	Orland Park	60453	Oak Lawn
60477	Tinley Park	60455	Bridgeview
60482	Worth	60457	Hickory Hills
60487	Orland Hills and Tinley Park	60458	Justice
		60459	Burbank
		60491	Homer Glen
		60655	Mt. Greenwood
		60803	Alsip
		60805	Evergreen Park



The total population in the area served by Palos Community Hospital is 629,000, and the population has grown by approximately 57,000 between 2000 and 2016. The largest cities in the area are Orland Park, Oak Lawn, and Tinley Park.

Overall, 23% of the residents are under 18, while 15% are over the age of 65. Figures 2 and 3 show the proportion of children and older adults by municipality. Across the Palos Community Hospital service area, there are approximately 2,500 grandparents raising grandchildren.

Figure 2. Children and Youth: Percentage of population under 18, 2016

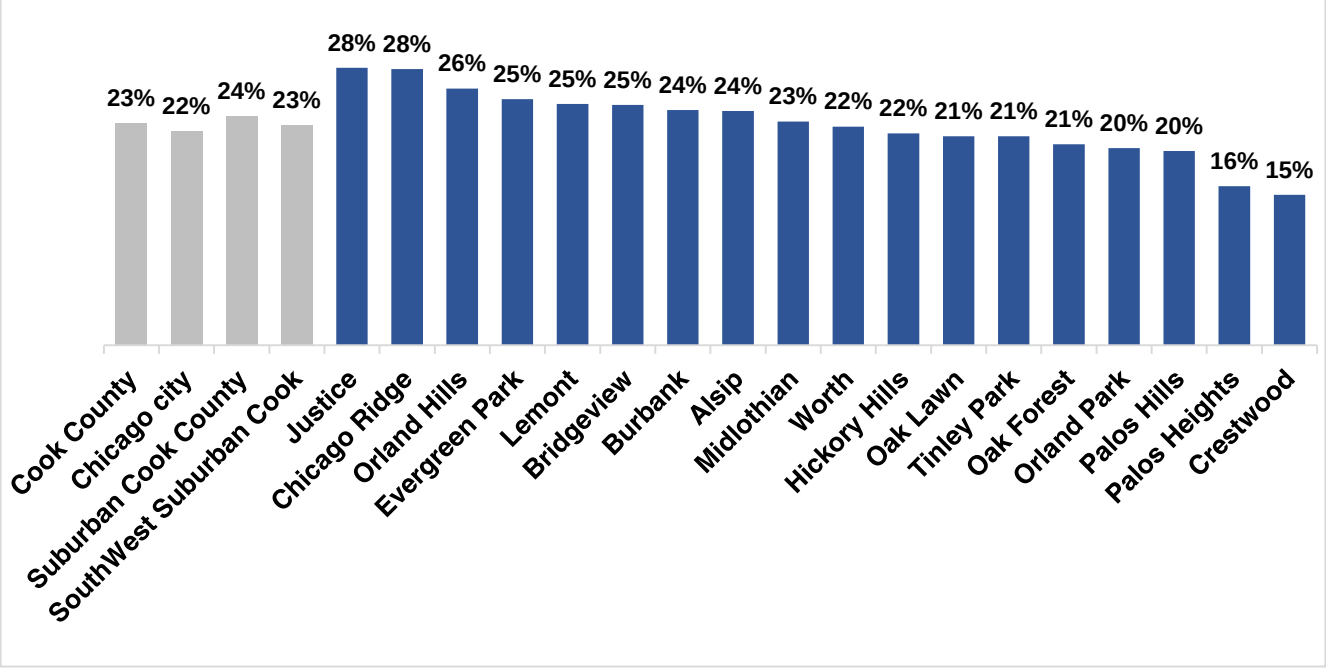
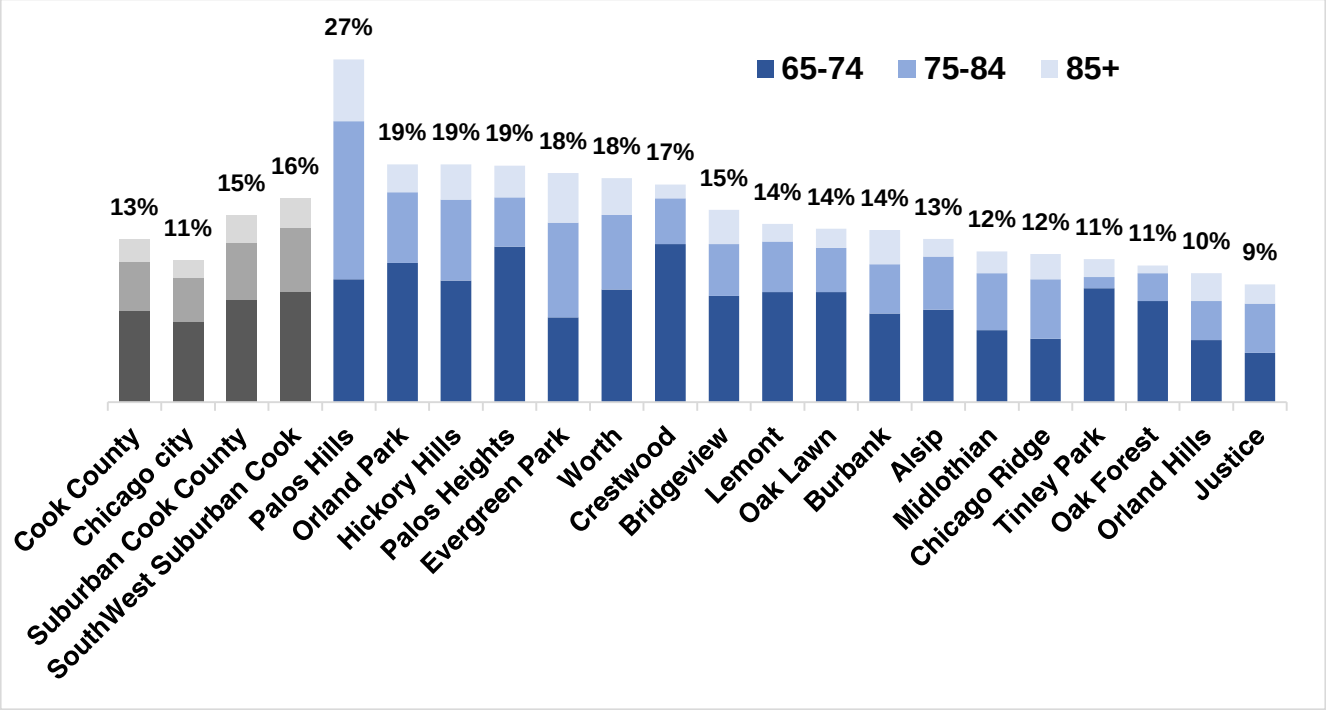
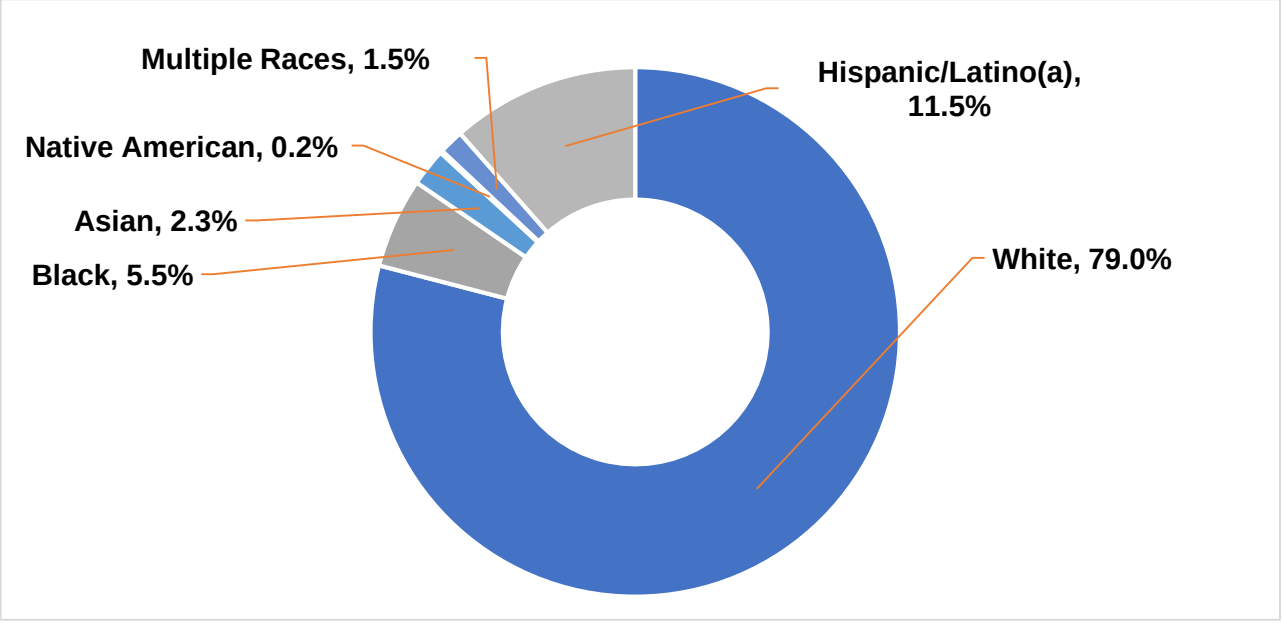


Figure 3. Older Adults: Percentage of population over 65, 2016



Data Source: US Census Bureau: American Community Survey, 2012-2016.

Figure 4. Race and Ethnicity: Palos Community Hospital Service Area, 2016



Data Source: US Census Bureau: American Community Survey, 2012-2016.

The communities served by Palos Community Hospital are predominantly non-Hispanic white (79%), with 11.5% of the population identifying as Hispanic/Latino, 5.5% black, and 2.3% Asian. Latino and Arab American communities are growing substantially in the area, and 18% of children under 18 are Hispanic/Latino.

II. **Alliance for Health Equity** - Collaborative Community Health Needs Assessment (CHNA) Process

The Affordable Care and Patient Protection Act (ACA) has allowed millions of individuals and families in the United States to gain health care coverage. In addition, it has accelerated the health care system's shift from a focus on clinical approaches to treating disease to a more comprehensive focus on overall wellness and prevention. To further encourage this shift, the ACA requires non-profit hospitals to conduct a comprehensive Community Health Needs Assessment (CHNA), identify community health priorities, and develop implementation strategies to address priority health needs every three years.

This CHNA was conducted to meet federal requirements and guidelines, including:

- clearly defining a community served by the hospital, and ensuring that defined community does not exclude low-income or vulnerable communities in proximity to the hospital;
- a clear description of the CHNA process and methods; community health needs; collaboration, including with public health experts; and a description of existing facilities and resources in the community;
- reporting on implementation activities from the previous CHNA;
- input from persons representing the broad needs of the community;
- opportunity for community comment on the CHNA and health needs in the community;
- posting the CHNA and making it available to the public;

Federal rules for CHNA allow for and encourage collaborative assessment, planning, and implementation. Palos Community Hospital is part of a collaborative Community Health Needs Assessment (CHNA) being conducted through a membership collaborative called the Alliance for Health Equity.

The Alliance for Health Equity includes 35 hospitals (33 nonprofit and two public), six local health departments, and approximately 100 regional and community-based partners working together on assessment, planning and implementation across Cook County, Illinois. The Illinois Public Health Institute (IPHI) serves as the backbone organization that convenes and facilitates the Alliance for Health Equity.

Cook County is the second most populous county in the United States. Most of the priority health issues faced by communities in Cook County are long-standing and driven by complex historical inequities. Due to the scope and complexity of health needs within the county, non-profit hospitals in Chicago and Suburban Cook County partnered to create the Health Impact Collaborative of Cook County in 2015. In partnership with local health departments and community-based organizations, the collaborative completed a county-wide CHNA in 2016. This unprecedented partnership effort enabled the organizations involved to align their efforts, efficiently share resources, foster collaboration with communities, and achieve more effective and sustainable community health improvement. In June 2017, the Health Impact Collaborative of Cook County merged with the Healthy Chicago Hospital Collaborative to form the Alliance for Health Equity. Palos Community Hospital joined the Alliance for Health Equity in 2017 and has been an active participant in planning and carrying out the collaborative CHNA.

Alliance for Health Equity Community Health Priorities

The 2015-2016 collaborative CHNA process focused on gaining an overall understanding of community health, health inequities, priority populations, and community assets. The 2018-2019 assessment continued cross-sector collaborations to provide an overall understanding of community health status. In addition, the current CHNA focused on creating a deeper understanding of community health needs within the Alliance focus areas and further developing strategies that directly address those needs.

The 2016 CHNA findings allowed Alliance for Health Equity partners to identify four overarching implementation focus areas for improving community health: addressing the social, structural, and economic determinants of health; improving mental health and reducing substance use disorders; increasing access to care and community resources; and chronic disease prevention.

During the process of implementation, Alliance partners determined that improving access to care and chronic disease prevention were cross-cutting priorities that should be integrated into the work of all workgroups and committees along with several additional cross-cutting priorities including: structural racism and inequities; trauma-informed services; systems to screen, refer, and connect to care, capacity building, and youth development (Figure 5).

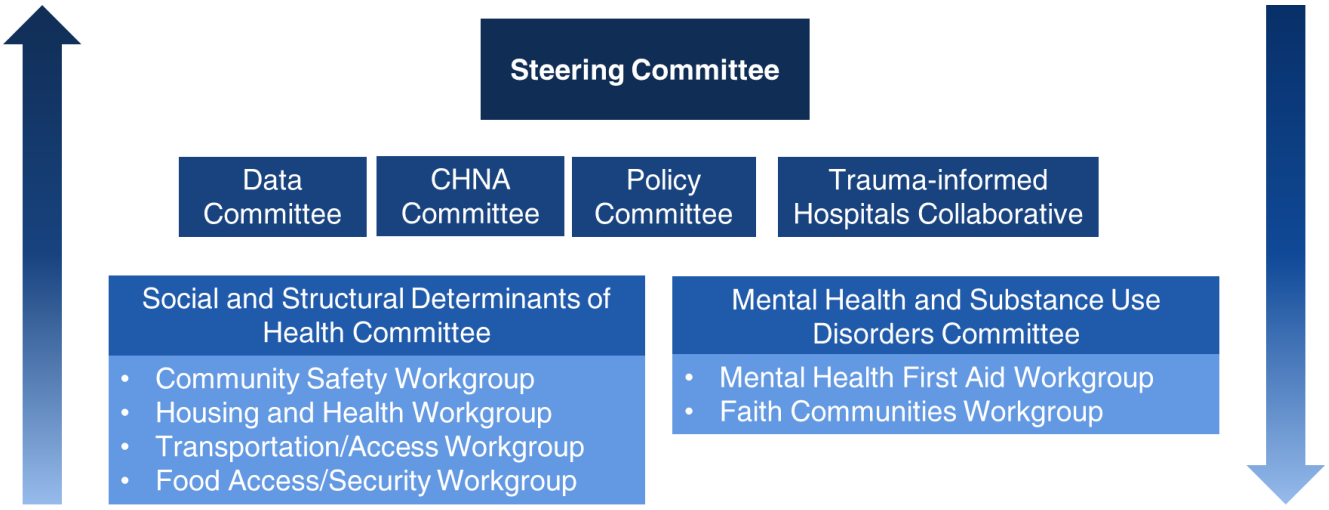
Figure 5. Alliance for Health Equity – Interconnected Community Health Priorities

These broad priorities that developed out of the Alliance for Health Equity 2015-2016 CHNA are very similar to the priority needs from Palos Community Hospital's 2015 CHNA—Access to Health Services; Cancer; Diabetes; Stroke, Heart Disease & Respiratory; and Mental Health & Substance Abuse. As a result, it has been smooth transition for Palos Community Hospital to join the Alliance for Health Equity collaborative CHNA process.

Alliance for Health Equity Structure

The Alliance for Health Equity is comprised of a steering committee and several workgroups and committees working on implementation strategies in different priority areas (Figure 6). A steering committee comprised of hospital and health department representatives provides oversight and guidance for the Alliance and ensures that all activities align with its purpose, vision, and values. Data and policy committees assist other workgroups with projects as needed and develop methods for information sharing and alignment of policy agendas. A CHNA committee provides oversight and assistance with the development of assessments and implementation plans. The Alliance for Health Equity partners with the Illinois Adverse Childhood Experiences (ACEs) Response Collaborative led by Health and Medicine Policy Research Group to develop strategies for integrating trauma-informed practices into healthcare, public health, and community-based organizations and projects.

Figure 6. Alliance for Health Equity Structure



Community Engagement

A core tenet of the Alliance for Health Equity approach to assessing and addressing community health needs is engagement of community members and stakeholders in all phases and aspects of the process. Community partners have been involved in the assessment and ongoing implementation process in several ways, both in providing community input and in decision making processes.

Methods of community engagement include:

- representation on the steering committee;
- participation in implementation committees and workgroups;
- hospital and health department community advisory groups; and
- collection of community input through surveys and focus groups

The types of community-based organizations engaged in the Alliance for Health Equity represent a broad range of sectors such as workforce development, housing services, food security, community safety, planning, community development, immigrant rights, primary and secondary education, faith communities, behavioral health services, advocacy, policy, transportation, older adult services, healthcare 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, older adults, individuals experiencing homelessness or housing instability, individuals living with mental illness or substance use disorders, unemployed youth and adults, and priority populations.

Purpose, Vision, Values

When the Alliance for Health Equity purpose, vision, and values reflect input from hospital partners, health departments, and community stakeholders. The purpose, vision, and values were first developed collaboratively in 2015 and have been refined over the past three years to reflect both assessment and implementation activities.

Figure 7. Purpose, Vision, and Values of the Alliance for Health Equity

Our Purpose

Improve population and community health by:

- Promoting **health equity**
- **Capacity building**, shared learning, and connecting local initiatives
- Addressing **social and structural determinants of health**
- Developing broad city/county wide initiatives and **creating systems**
- Engaging community partners and **working collaboratively** with community leaders
- **Developing data systems** for population health to support shared impact measurement and community assessment
- Collaborating on **population health policy and advocacy**

Our Vision

Improved health equity, wellness, and quality of life across Chicago and Cook County

Our Values

1. We believe the highest level of health for all people can only be achieved through the pursuit of **social justice and elimination of health disparities and inequities**.
2. We value having a shared vision and goals with alignment of strategies to achieve **greater collective impact while addressing the unique needs of our individual communities**.
3. Honoring the diversity of our communities, we value and will strive to include all voices through **meaningful community engagement and participatory action**.
4. We are committed to emphasizing assets and strengths and ensuring a process that identifies and **builds on existing community capacity and resources**.
5. We are committed to **data-driven decision making** through implementation of evidence-based practices, measurement and evaluation, and using findings to inform resource allocation and quality improvement.
6. We are committed to building **trust and transparency** through fostering an atmosphere of open dialogue, compromise, and decision making.
7. We are committed to **high quality work to achieve the greatest impact possible**.

CHNA Process

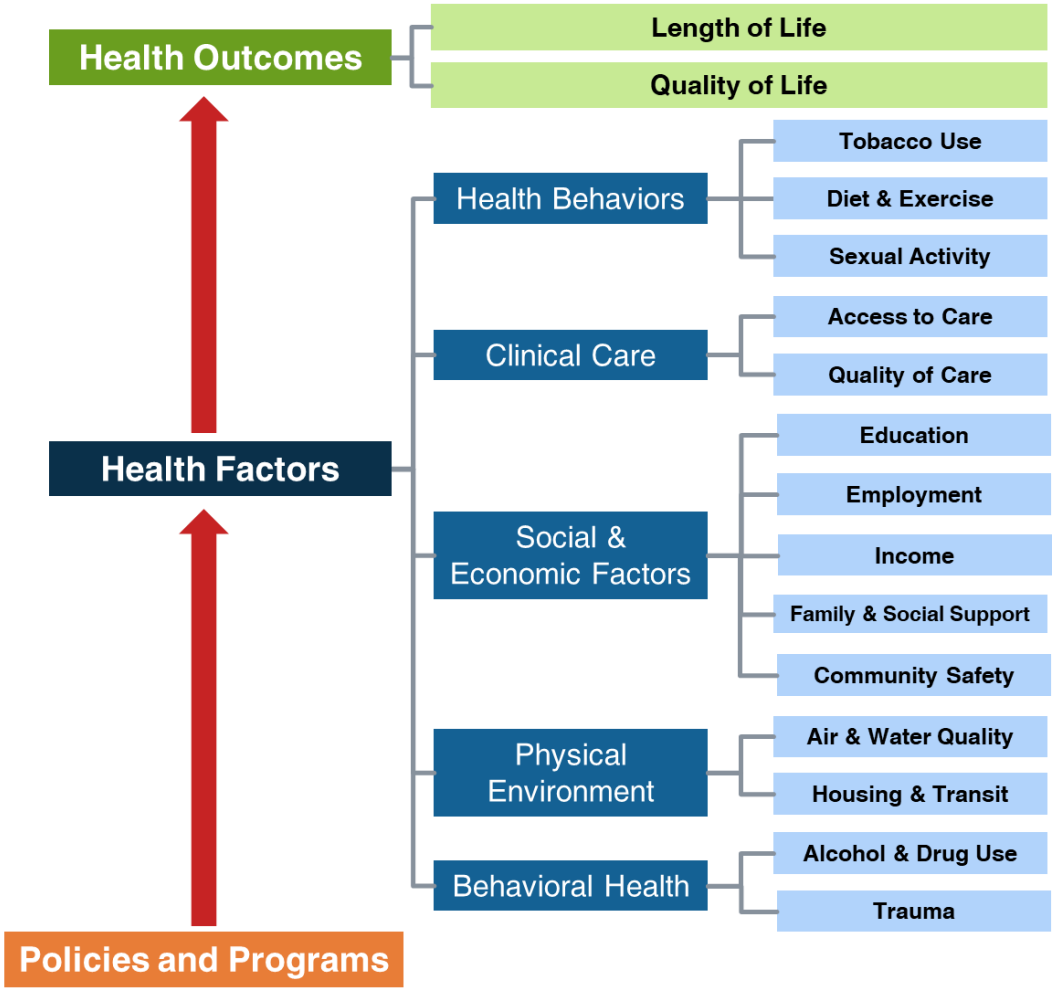
The Alliance for Health Equity began the collaborative CHNA in March 2018, and the final county-wide report will be published in Spring 2019. Given that Palos Community Hospital must post a CHNA by December 2018, Alliance for Health Equity staff and epidemiologists at the Cook County Department of Public Health have worked with Palos Community Hospital and local community partners in Southwest Cook County to complete the CHNA for the communities served by Palos Community Hospital in 2018.

The Alliance for Health Equity CHNA includes secondary data for approximately 135 health indicators collected and collated by the Chicago Department of Public Health and Cook County Department of Public Health. The data were collected for approximately 125 Suburban Cook County municipalities and 77 Chicago community areas. The data provide a comprehensive overview of the health status of communities in Cook County. The County Health Rankings and Roadmaps framework (Figure 8) provides the foundation for selecting indicators for the CHNA. In additional to the secondary data provided by health departments and primary data gathered from community input, findings from several external assessments and projects were integrated into this report as well.

Primary data was collected through community input surveys and community resident focus groups. Between October and November 2018, approximately 4,000 community input surveys were collected from individuals 18 or older living in Cook County, including over 250 in the Palos Community Hospital service area. The surveys asked respondents about health status of their communities and priority health needs. (Survey findings for the Palos Community Hospital service area are presented below on page 11.) Survey collection efforts were concentrated in communities and populations that are typically underrepresented in assessment processes.

Between August and November 2018, a total of 50 focus groups and community meetings were conducted throughout Chicago and suburban Cook County as part of the CHNA process. Twenty-five focus groups were conducted throughout the county with underrepresented priority populations such as veterans, individuals living with mental illness, communities of color, older adults, caregivers, teens and young adults, LGBTQ community members, adults and teens experiencing homelessness, families with children, faith communities, adults with disabilities, and children and adults living with chronic conditions such as diabetes and asthma. In addition, the Alliance for Health Equity partnered with a regional hospital collaborative called West Side United to conduct an additional 25 "learning map" focus groups on the West Side of Chicago with the same priority populations. Focus group questions asked participants about the health issues that they see in their communities and specific strategies for addressing those health needs.

Figure 8. Adapted County Health Rankings and Roadmaps Model



Modified from County Health Rankings and Roadmaps Model, 2014, http://www.countyhealthrankings.org

III. Key Findings

Palos Community Hospital partnered with the Alliance for Health Equity on three community and stakeholder input methods. Palos Community Hospital worked with community partners to host a focus group with social service providers and residents from local communities. Palos Community Hospital also collected stakeholder surveys from four additional community partner organizations that were not available to attend the focus group. As part of the Alliance for Health Equity community input survey, 252 surveys were collected from residents in communities served by Palos Community Hospital.

The local community organizations from the area that partnered on community input were:

- Beds Plus
- Cook County Department of Public Health
- Crisis Center of South Suburbia
- Illinois Public Health Institute
- Lemont Junior Women's Club
- Moraine Valley Community College
- Oak Ridge Community Trust Bank
- Palos Heights Fire Protection District
- PLOWS Council on Aging
- Restoration Ministries
- Together We Cope

Community Input Survey

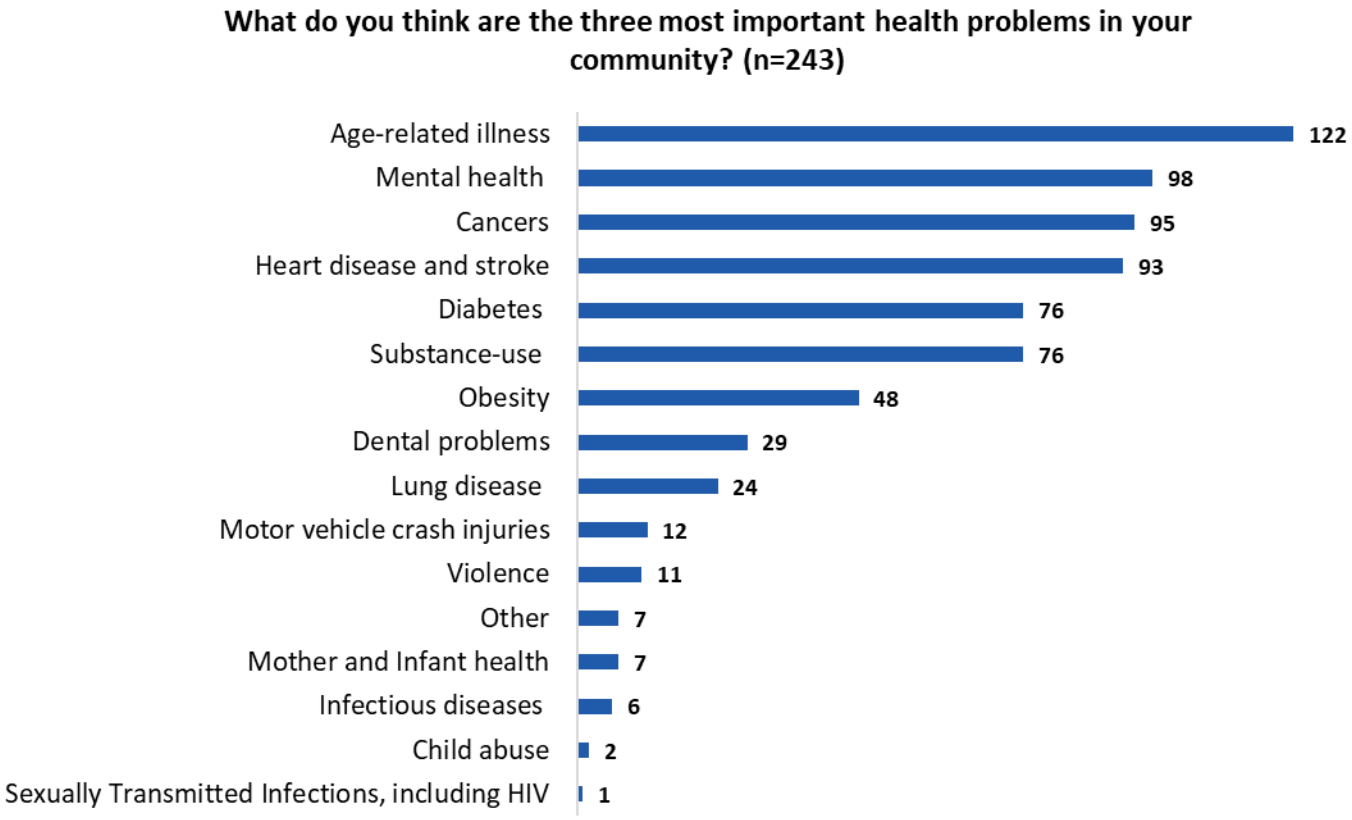
As part of the Alliance for Health Equity CHNA, Palos Community Hospital worked with other member hospitals across the county, health departments, and community partners to distribute a community input survey in October and November 2018. The survey was distributed both online and on paper in five languages (English, Spanish, Polish, Simple Chinese, and Ukrainian). In the Palos Community Hospital service area, 252 community residents responded to the survey (250 English and 2 Spanish). Of the 234 respondents who answered the demographic questions, 53% reported being 65 and older, 30% 45-64, and 17% 18-44. Three-quarters of respondents identified as female. The majority of respondents (73%) described their race/ethnicity as white, and 10% of respondents identified as African American/black and 8% Hispanic/Latino(a).

Greatest Strengths

In response to the question "What are the greatest strengths or best things in the community where you live? (List up to 3)", 191 community residents shared open-ended responses that were coded and categorized into themes. The table below shows the summary of the most common responses. Fifty-six respondents included **Positive Neighborhood Qualities** as one of their top three strengths. Neighborhood Qualities that were mentioned frequently were the "small town feel", "quiet", and "caring" neighborhoods or villages. A related strength – **Friendly People and Family-Friendly Communities** – was shared by 46 respondents. Fifty-three respondents emphasized strengths related to the **Convenient Location** of their community. Other strengths that were commonly mentioned were **Good Schools**, **Safety**, and **Availability and Quality of Community Services and Activities**. With respect to community services and activities, a number of respondents specifically mentioned local government services (police, fire, etc.), transportation, parks, hospitals, and libraries as well as stores, restaurants, and churches.

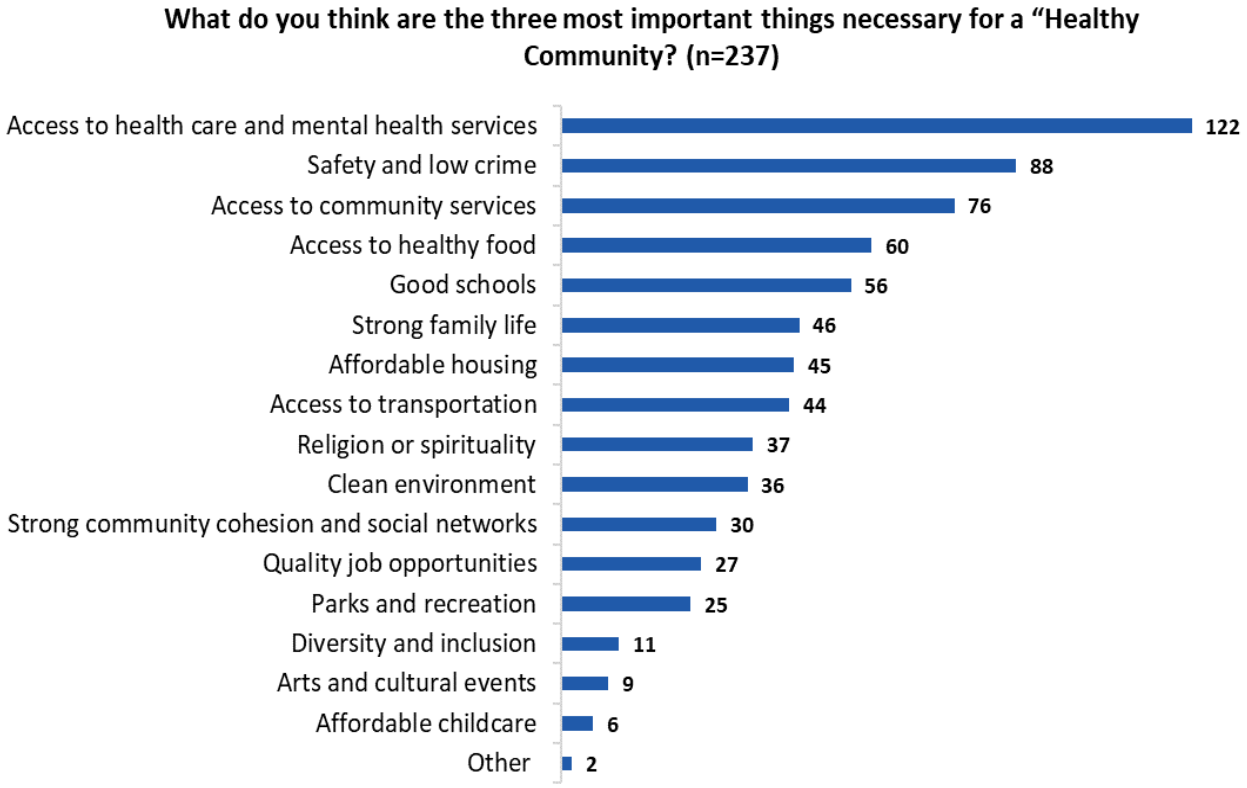
"What are the greatest strengths or best things in the community where you live? (List up to 3)"

Summary of Open-Ended Responses from 191 respondents	**# of Respondents mentioning this topic**
Neighborhood Qualities	56
Location Convenience	53
Schools	47
People-Friends, family, friendly qualities	46
Safe	46
Community Services/Activities	45
Stores and Shopping	29
Government agencies (mayor, police, fire dept.)	23
Transportation Options	20
Park District/Parks	19
Hospitals	16
Library	16
Restaurants and Grocery Stores	12
Churches	12
Housing	8
Nothing	3



Most Important Things Necessary for a Healthy Community

Community members were asked “What do you think are the three most important things necessary for a Healthy Community?” Six health issues rose to the top, and all were selected by at least 30% of respondents. Half of the respondents (51%) selected **Access to healthcare and mental health services** as one of the top three most important things necessary for a healthy community. **Safety and low crime, access to community services, access to healthy food, and good schools** were all prioritized by at least a quarter of respondents.

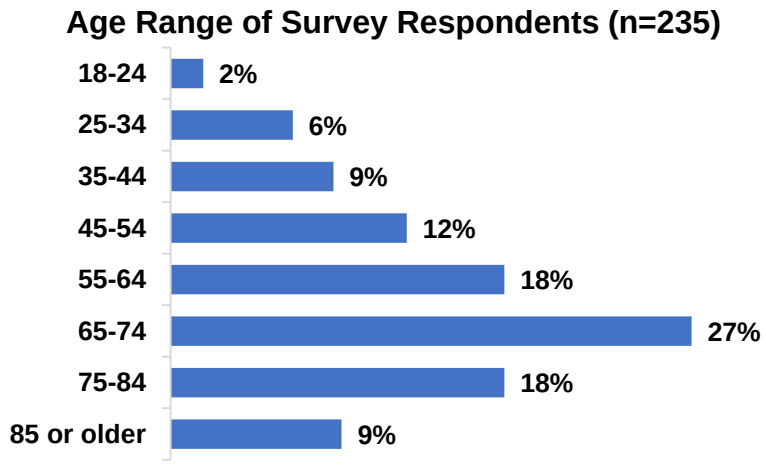


Community Improvement

In response to the question "What is one thing you would like to see improved in your community?", 140 community residents shared open-ended responses that were coded and categorized into themes. The responses echoed many of the same topics that were also raised as community strengths and as components needed for a healthy community. **Neighborhood maintenance and environment** emerged as the area for improvement identified by the most respondents (17%). Respondents specified maintenance needs such as a cleaner environment and upgrades to outdated buildings and streets. Fifteen percent of respondents indicated that **lower crime and law enforcement** are needed in their community. Eleven percent of respondents identified **transportation** as an area for improvement, with several respondents specifying a need for better transportation for older adults.

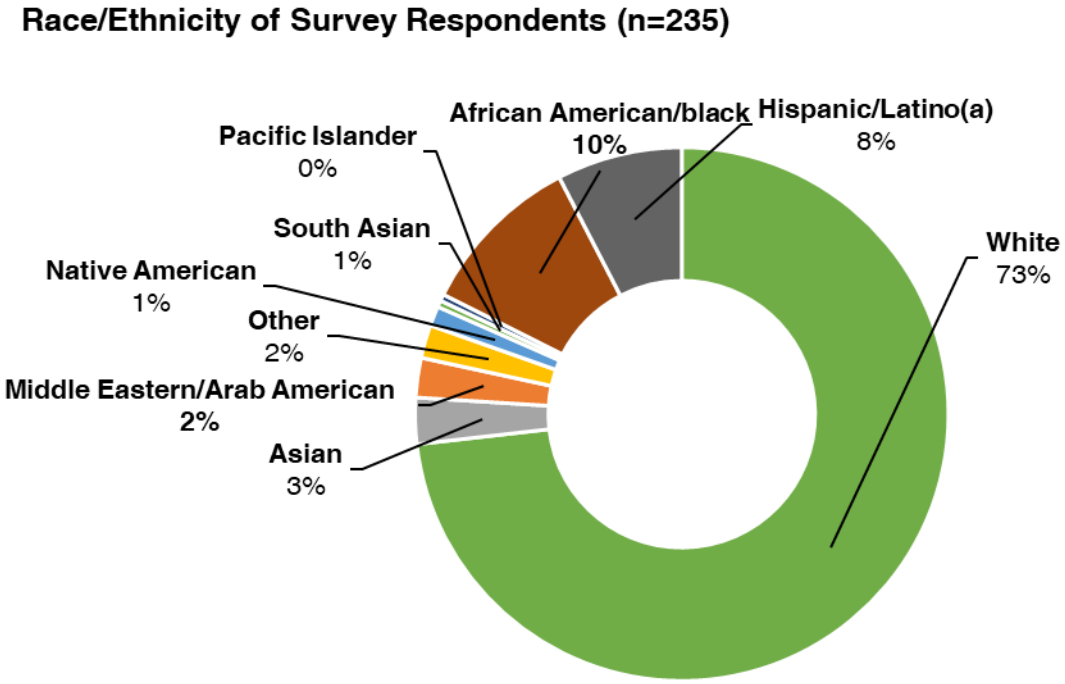
Summary of Open-Ended Responses (n=140)	# of Respondents mentioning this topic
Neighborhood Maintenance and Environment	25
Low Crime and Law Enforcement	21
Transportation	16
Access to Quality Health Care and Mental Health Services	15
Housing and Homelessness	15
Nothing	11
Access to Community Services and Activities	10
Taxes	9
Healthy Food Options	7
Community Cohesion	6
Quality Jobs	5
Substance-use	4
Schools	3
Childcare	2

Demographics of Survey Respondents

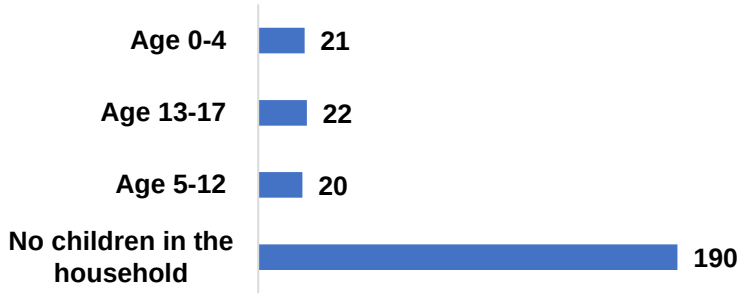


Gender of Survey Respondents (n=234)	
Female	76.3%
Male	22.9%
Non-Binary or Genderqueer	0.4%
Other	0.4%
Gender neutral	0
Transwoman	0
Transman	0

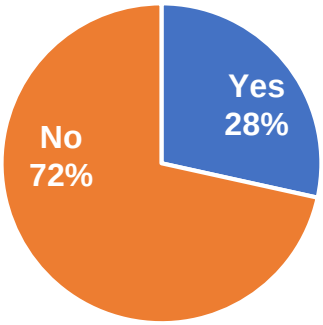
Sexual Orientation of Survey Respondents (n=234)	
Straight	88.9%
Gay or Lesbian	1.7%
Bisexual	0.4%
Prefer not to answer	8.1%
Other	0.9%



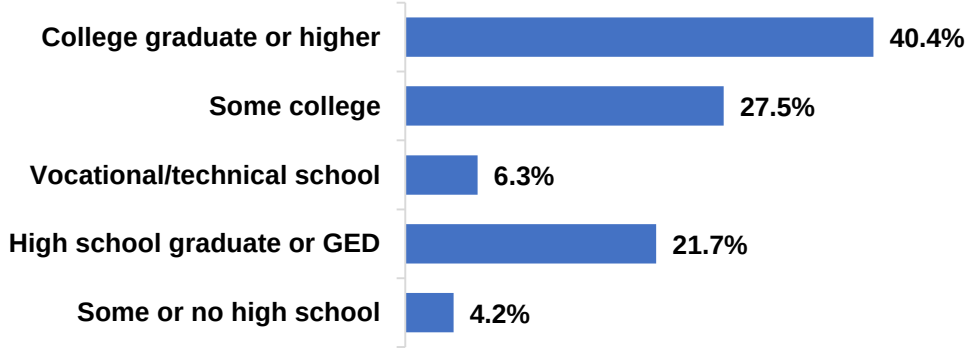
Child/Children in the Household (n=238)



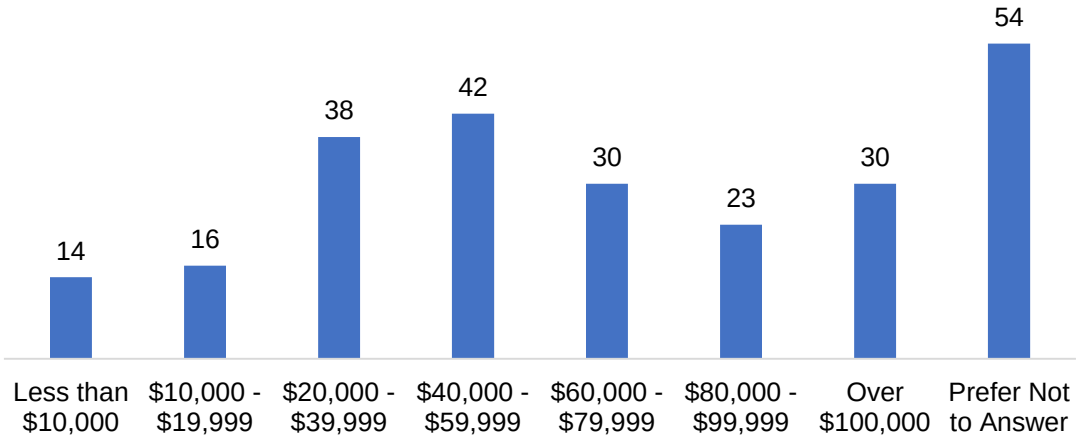
Person(s) in the Household with a Disability (n=239)



Highest Level of Education (n=240)



Annual Income (n=247)



Focus Group – September 26, 2018

Hosted by: PLOWS Council on Aging, Palos Heights, Illinois

11 Participants:

- 3 Community Residents/PLOWS Volunteers
- 8 Representatives of Community Organizations
  - Beds Plus (2)
  - Crisis Center of South Suburbia (2)
  - Lemont Junior Women's Club
  - Oak Ridge Community Trust Bank
  - PLOWS Council on Aging (2)

What makes a healthy community?

- "A healthy community is one that helps people in need get access to services and resources so everybody in the community can prosper"
- **Healthy Environment** – physical environment, air, and water
  - Healthy green spaces, forest preserves, and **parks**
- **Diversity** - ages, culture, religions, and incomes in any community, and tolerance!
- Affordable and Accessible **Transportation**
  - "I work with the seniors in the area and some of them have a very hard time getting to doctors and hospital appointments"
  - Access to transportation for getting to many services and activities
- Accessible, quality **healthcare** with early detection for **mental illnesses**
  - Assistance with enrollment and **navigating the system** as a whole
  - Universal healthcare
  - Access to psychiatric behavioral healthcare
  - Biggest shortages of care are in mental health and also in **domestic violence**
- Safe havens for homeless and low barrier shelters
  - Knowing where to go in a crisis
  - **Safe affordable housing for all**
- Youth development activities and **preparing youth for life**
- **Access to grocery stores** and community farms and gardens
  - Fruits and vegetables
- **Partnerships in communities**

What are the unique health challenges for Older Adults in the community?

- Need for more services for older adults living at home and also supports for caregivers
- Need for more **home health services**
  - Including periodic wellness visits just to check in on older adults to see how they are doing
  - One person suggested we need a DCFS for adults (we have it for children but not adults, and several others agreed
- There is **stigma** with home health care
  - You feel a guilt if you can't take care of your family members and need someone else to come in
  - People don't want to admit that they need help
- Somebody who is specially trained and can help people navigate
  - Nurse Navigators and/or Congregational Nurses
  - Some communities are developing a village concept, they have transportation through the village

- Would like to see an affordable push button device for **in-home emergencies**
    - Agency called Cantata (Brookfield) that is working to keep people safe in the home. Working on a tech solution, piloting it now.
- See several **seniors in the homeless population**

What is needed for caregivers?

- If we help seniors help themselves it removes the burden from **caregivers**
- Need more information readily available for navigating insurance
- The wait list for supportive housing is two years or more
- **Financial literacy** is crucial
- Talking to young people about financial matters so that when they are older they have resources

What would help older adults in the community age in place?

- **Affordable services**
    - Older adults just stop doing things because they can't afford services
    - There are services for very poor and services for those that have income for it - but there is very little for the in-between group
- Some things that need to be done are simple:
    - Help with landscaping
    - Cleaning
    - Delivered groceries
    - Having meals prepared in a way that is affordable
- **Elder abuse** can be very passive like neglect
    - Reporting abuse is anonymous, but people are afraid of getting involved whether they are identified are not.

How hard is it to access services for assistance with day-to-day activities?

- **Communication** is one of the biggest problems, people don't know about services
- Seniors also **can't afford services**
    - Lawn care and grocery services are very expensive
- **Meals on wheels is a gateway program** that helps us get our foot in the door and build trust
- **Affordability issues - it is so expensive**
    - There are very expensive places available, but where is the middle ground for people on Medicare?
    - Family member's biggest issue with moving out to a residential facility was the cost. She didn't want to pay someone so much money just to do her laundry.
- There needs to be a **senior community call center** where you can just call and identify what you need, and it has employees or volunteers available that can arrange services for older adults
- **Seniors end up homeless or in housing they can't afford**
    - "We have a lot of clients that haven't recovered from housing crisis and they're under water. For them to sell and move is nearly impossible because anything they would put towards living somewhere else is gone, the equity is gone.

What are some possible solutions and what role can older adults play in these solutions?

- **Have seniors work on the community call center**
- One thing a can say after working in this field for a long time - **it cannot be solved by volunteerism**
- **Tax credits for helping older adults** - it is being built into village concept in some areas of Chicago, they have an exchange, it's like a co-op

What role can hospitals and health departments play?

- Funders don't cover support staff, so where is that money coming from?
- **Seed money** is needed to spur and support new solutions
- **Navigating and linking to services:** Hospitals and medical providers need to be more educated on how to direct individuals to services and how to have these different conversations with people
- **Marketing**
    - Need to get information out economically so that active seniors see it when they are in crisis mode for themselves for a loved one they can access it?
    - How do we get info to homebound caregivers?
    - **Target active older adults at places that they go**
    - **Digital marketing**
        - Seniors may not be there - but baby boomers are, and they will be seniors, and many are taking care of their parents
        - Get them when they are young they are not trying to figure it out when they are older. It becomes a part of society instead of targeting only those that need the services
- How can we engage pharmaceutical companies more in community services?

How to make sure the voice of the older population is heard?

- Vote for people who will actually listen to you
- Focus groups that gather information and take it to lobbyist and the government

What is the primary issue that you would like to see addressed? [Round Robin]

- **Stigma** - with seniors and low-income individuals - better access to care
- **Access to affordable services**
- Entire **culture shift teaching young people to be a part of the solution**
- Universal healthcare - doctor tells you what you need
- Collaboration with state and local government officials
- **Navigator concept** - central location where you go to get help and you are paired with somebody that could help you with your problems
- Availability of **mental health services** and practitioners that know anything about aging because it is a unique field and very few people are going into it
- Right now, we work off the concept of referring to other agencies but maybe it **needs to be more of a collaboration and sharing of resources** (rather than just referring to another agency)
- Do something small, help your neighbor, **do what you can do**, **get the word out**

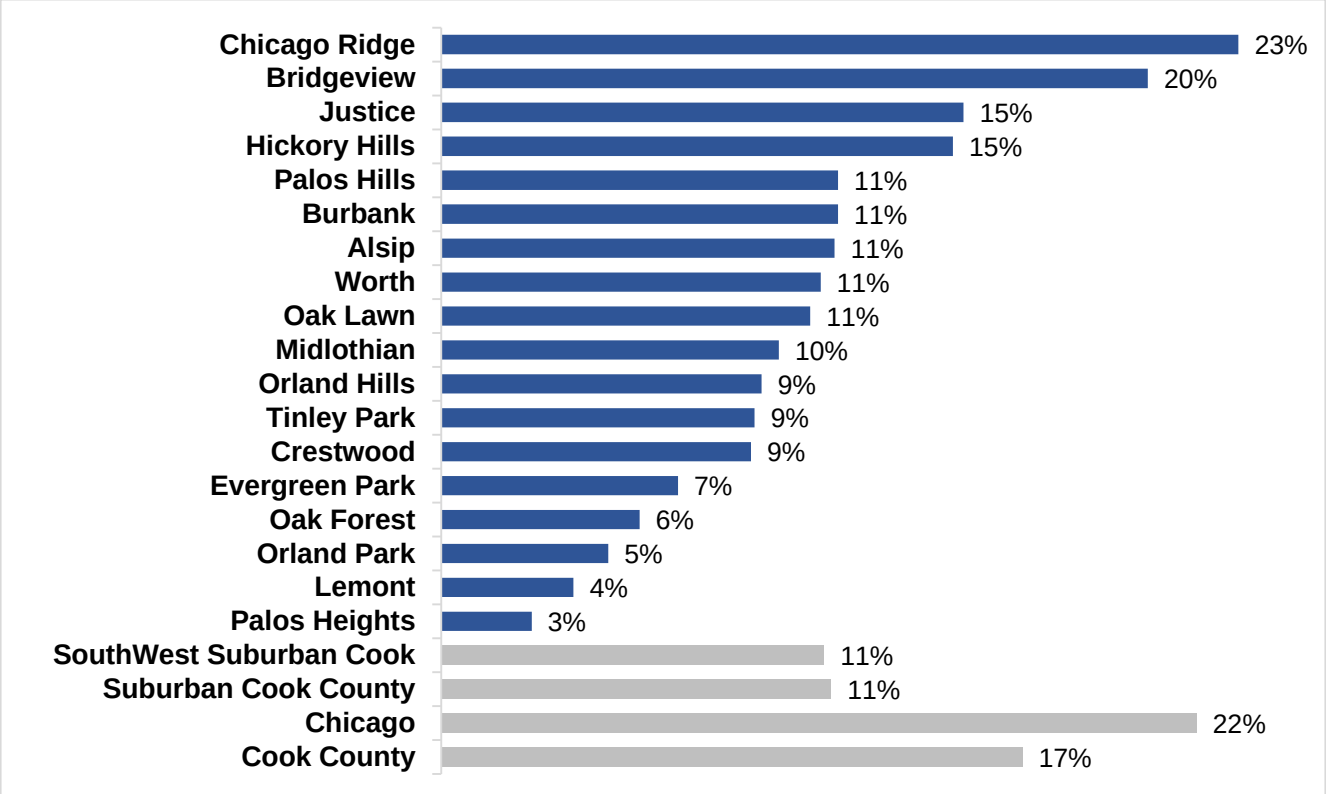
Surveys from 4 additional community partner organizations

The surveys from four community partner organizations echoed the responses from community resident surveys. In terms of greatest strengths, community partner organizations cited **diversity**, **proximity to Chicago**, **safety**, a **sense of community** public interest and togetherness, **resilience**, and **green spaces and parks**. When asked about the greatest health problems, both **mental health** and **substance use** were prioritized by 3 out of 4 respondents. Obesity, heart disease, and maternal and child health were all selected as well. When asked what contributes to a health community, all four respondents included **safety/low crime** as one of their three selections. In response to the questions about on thing to improve in the community, the four respondents highlighted the following opportunities for improvement: more **investment in higher education**, housing growth and **affordable housing**, **health and wellness services** for low-income residents, and **affordable childcare**.

Social, Economic, and Structural Determinants of Health

Household poverty rates range from 3% to 23% of households in the communities served by Palos Community Hospital. (Figure 9) Three of the cities served by Palos Community Hospital have over 25% of children living in poverty – Bridgeview, Chicago Ridge, and Hickory Hills. (Figure 10) Over 10% of older adults are living in poverty in Justice, Crestwood, and Bridgeview. (Figure 11 Median household income ranges from $43,000 in Chicago Ridge to $89,000 in Lemont. There are also large disparities in per capita income. Per capita income in Palos Heights ($43,635) is 2.2 times per capita income in Chicago Ridge ($19,438).

Figure 9. Poverty: Percentage of households living below the federal poverty level, 2012-2016



Data Source: US Census Bureau: American Community Survey, 2012-2016.

Figure 10. Unemployment: Percentage of civilian unemployment, 2012-2016

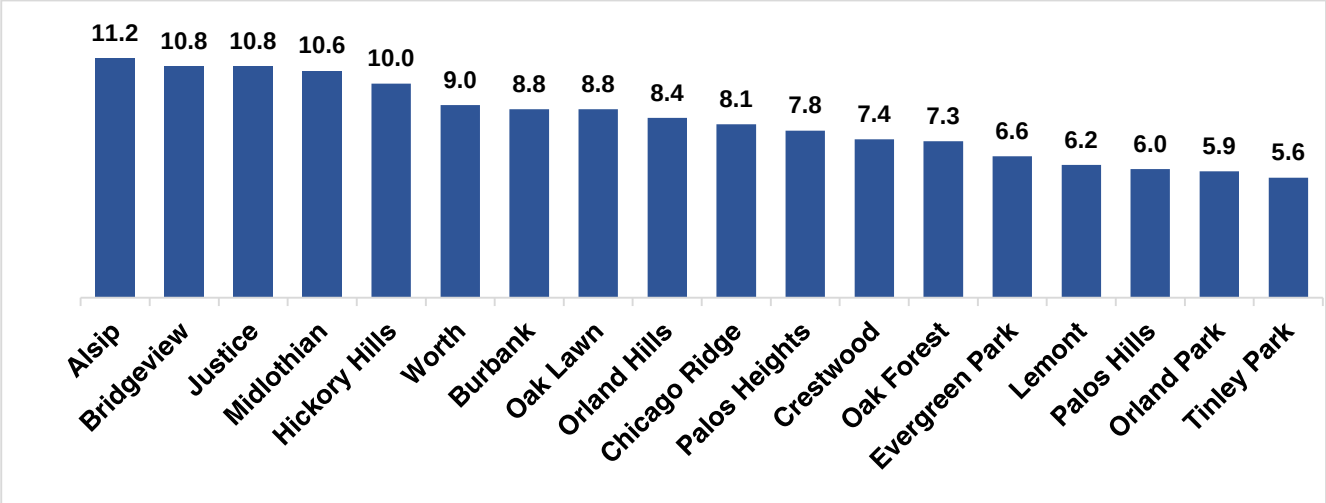


Figure 11. Childhood Poverty: Children under 18 living below the federal poverty level, 2016

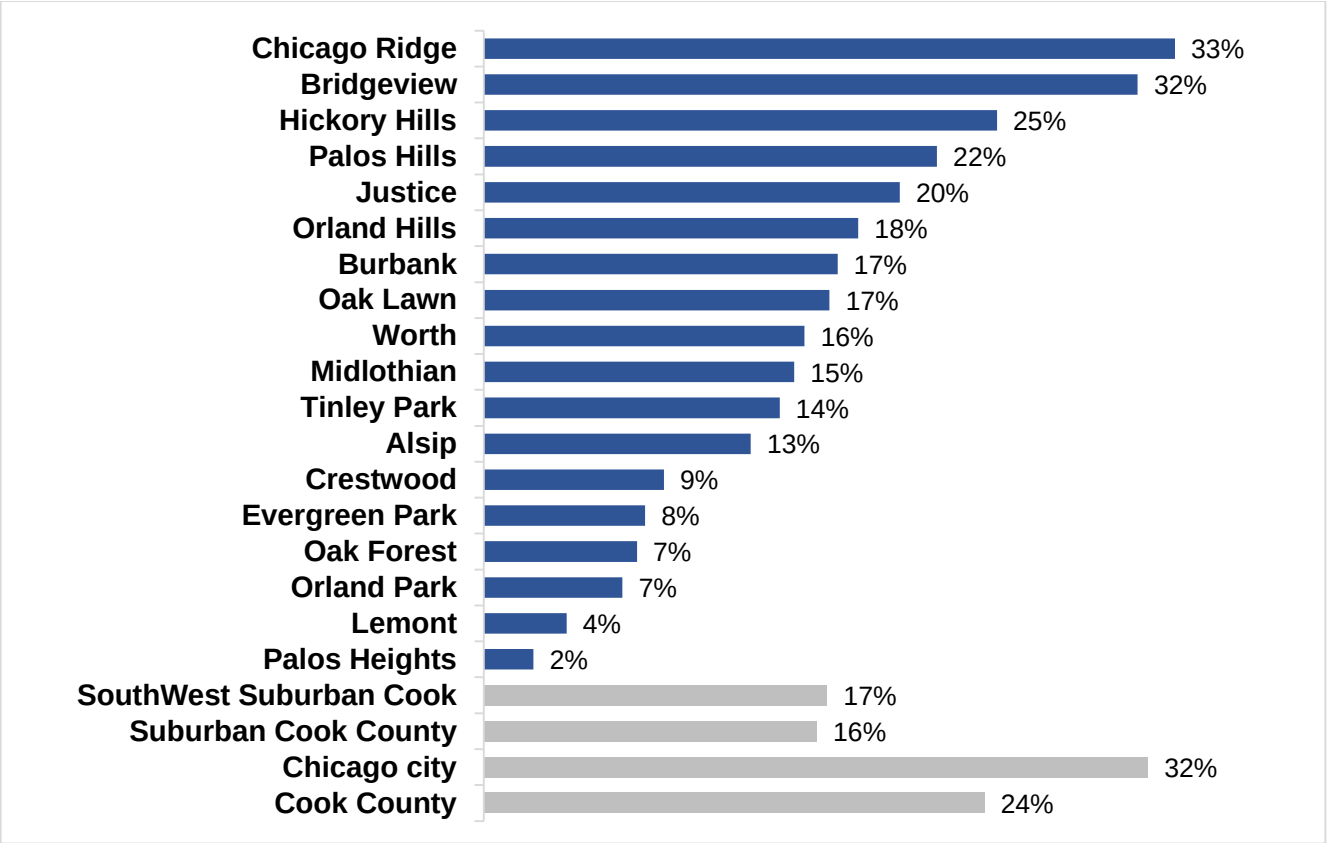
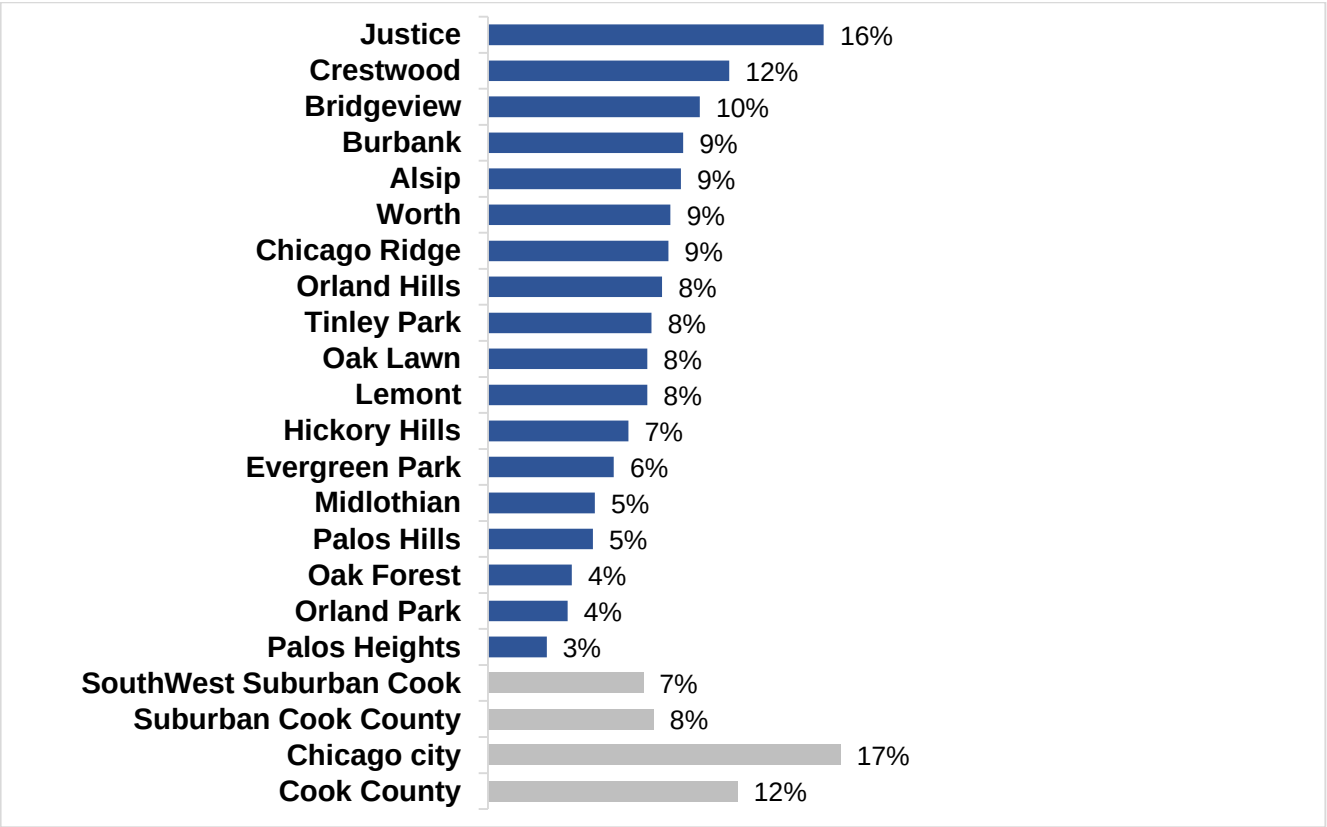


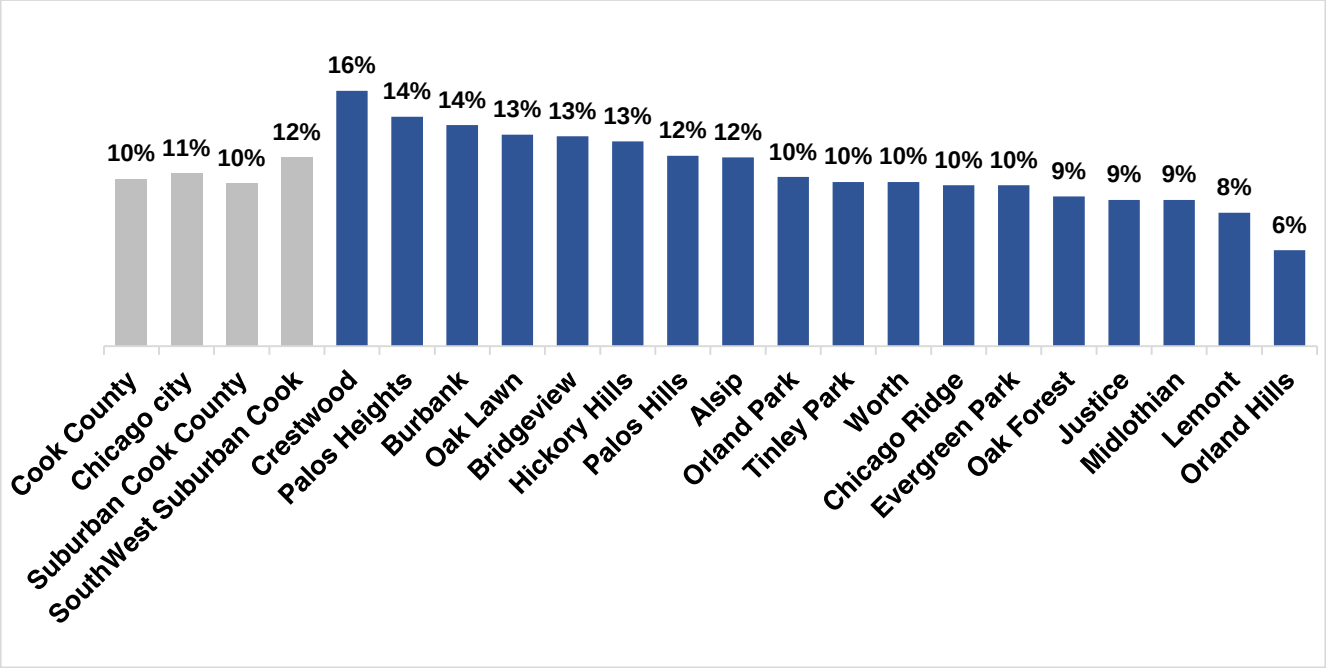
Figure 12. Older Adult Poverty: Over 65 living below the federal poverty level, 2016



Data Source: US Census Bureau: American Community Survey, 2012-2016.

The percentage of people living with a disability in the municipalities served by Palos Community Hospital ranges from 6% in Orland Hills to 16% in Crestwood. Palos Heights, Burbank, Oak Lawn, Bridgeview, Hickory Hills, Palos Hills, and Alsip also have higher rates of people living with a disability compared to the county overall.

Figure 13. Individuals living with a disability, 2016



Data Source: US Census Bureau: American Community Survey, 2012-2016.

Within the communities served by Palos Community Hospital, there are 20,700 limited English speaking households, accounting for 4.1% of households in the area. As shown in the map in Figure 14, a large proportion of those households are in the northern part of Palos Community Hospital's service area – 39.5% of households in 60455 (Bridgeview), 37.1% of households in 60459 (Burbank), 31.9% of households in 60458 (Justice), 32.8% of households in 60465 (Palos Hills), and 25.3% in 60457(Hickory Hills).

Figure 14. Limited English Speaking Households, 2012-2016

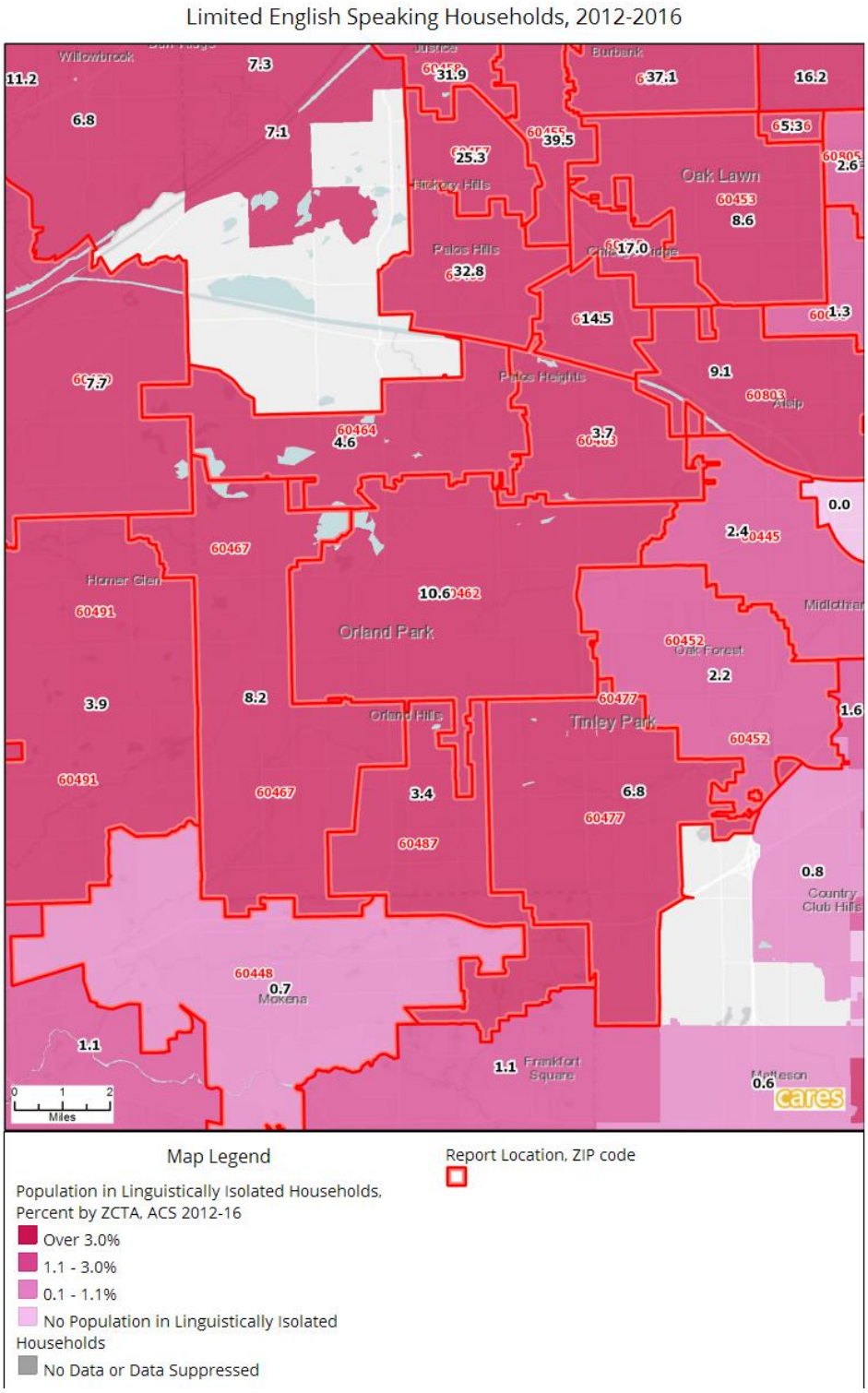
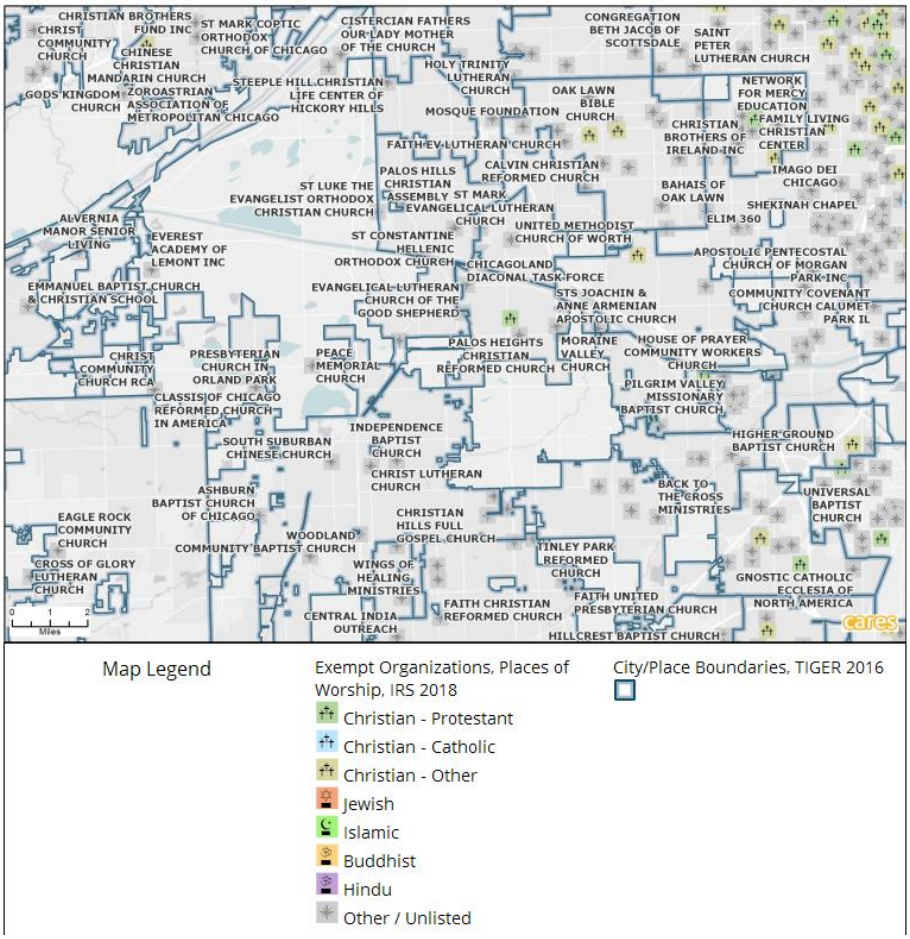


Figure 15. Places of Worship, 2018



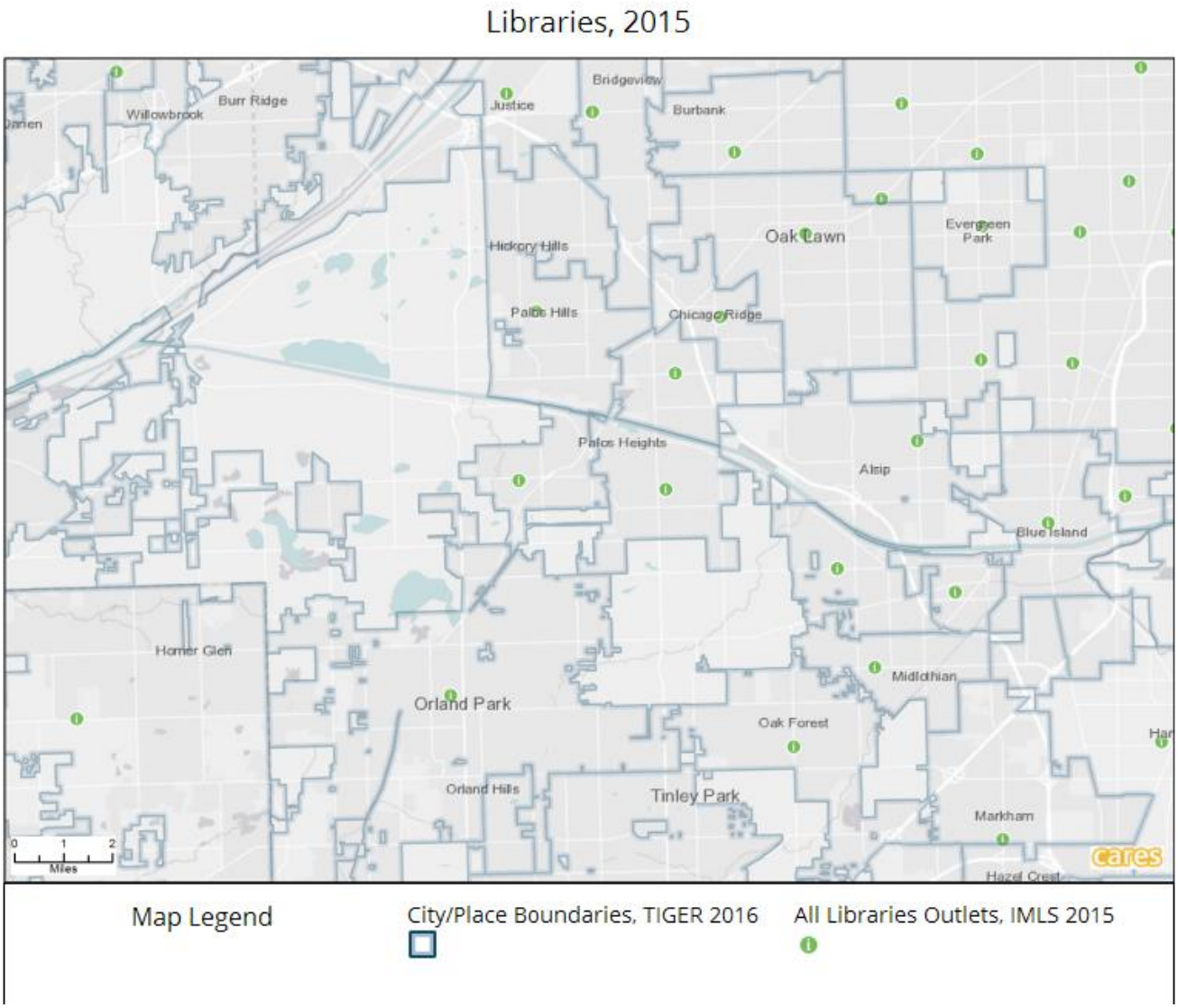
Data Source: Internal Revenue Service, 2018 via CARES Engagement Network.

Catholic congregations

Incarnation Church, Palos Heights
Most Holy Redeemer, Evergreen Pk
Our Lady of Loretto, Hometown
Our Lady of the Ridge, Chicago Ridge
Our Lady of the Woods, Orland Park
Queen of Martyrs, Evergreen Park
Sacred Heart, Palos Hills
St. Albert the Great, Burbank
St. Alexander, Palos Heights
St. Benedict, Blue Island
St. Bernadette, Evergreen Park
St. Cajetan, Chicago
St. Catherine Alexandria, Oak Lawn
St. Christopher, Midlothian
St. Damian, Oak Forest
St. Donatus, Blue Island
St. Elizabeth Seton, Orland Hills
St. Emeric, Country Club Hills
St. Fabian, Bridgeview
St. Francis of Assisi, Orland Park
St. George, Tinley Park
St. Gerald, Oak Lawn
St. Gerard, Markham
St. Germaine, Oak Lawn
St. James at Sag Bridge, Lemont
St. Julie Billiart, Tinley Park
St. Linus, Oak Lawn
St. Louis De Montfort, Oak Lawn
St. Michael, Orland Park
St. Patricia, Hickory Hills
St. Stephen Deacon and Martyr, Tinley Park
St. Terrence, Alsip

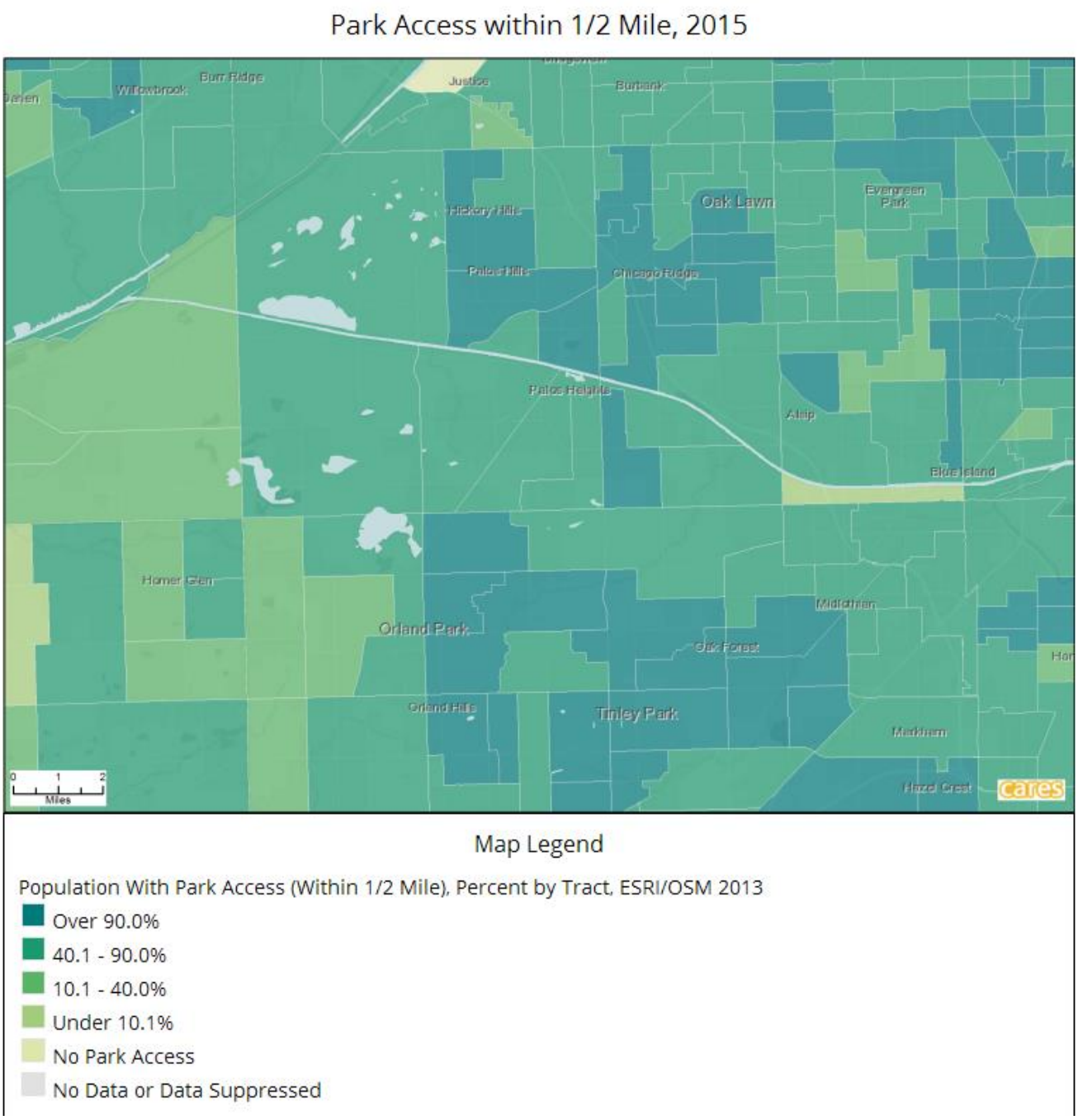
Data source: Archdiocese of Chicago, https://www.archchicago.org/parish-map

Figure 16. Library locations, 2015



Data Source: Institute of Museum and Library Sciences, 2015 via CARES Engagement Network

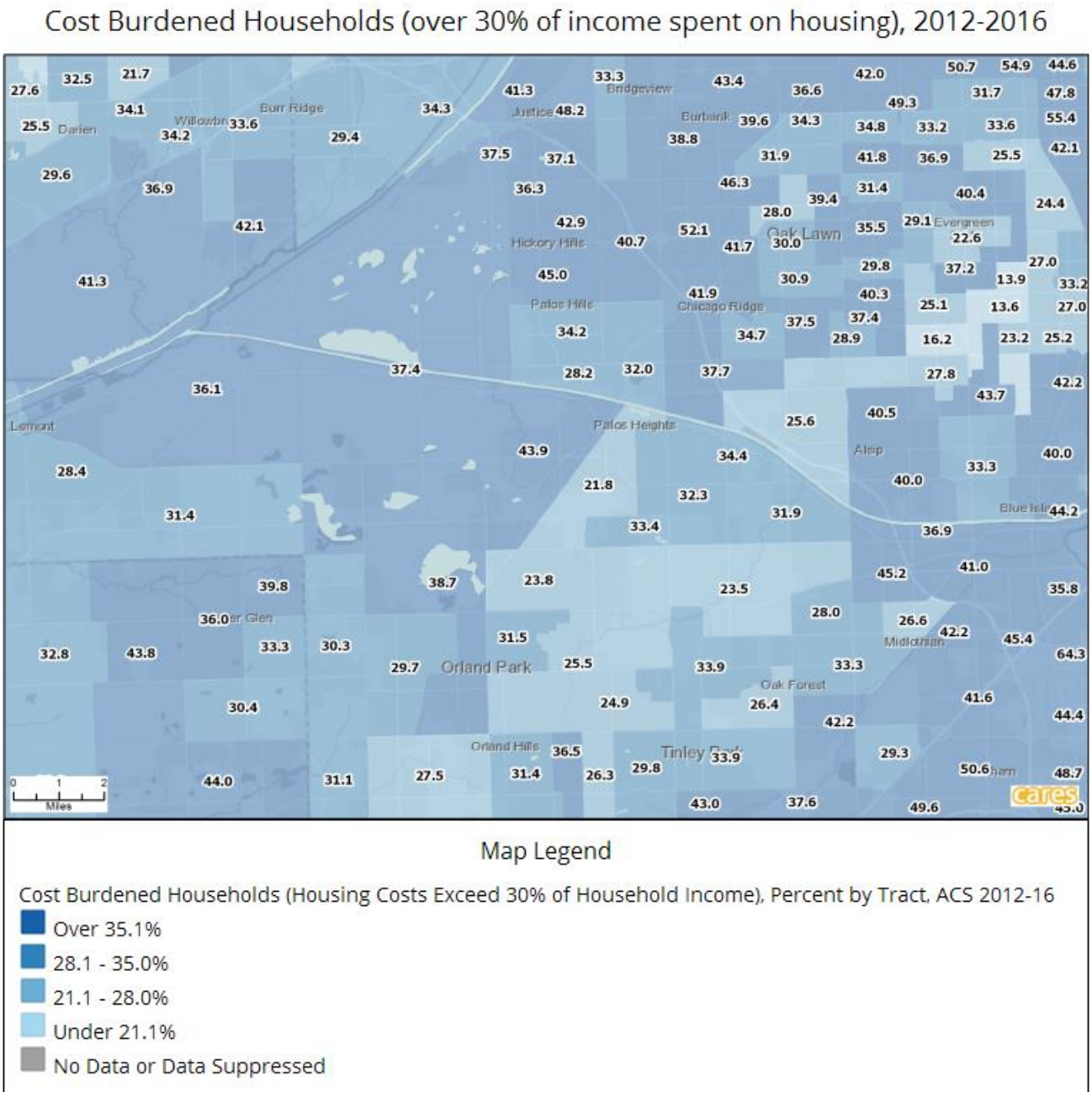
Figure 17. Park Access, 2015



Data Source: 2015 via CARES Engagement Network.

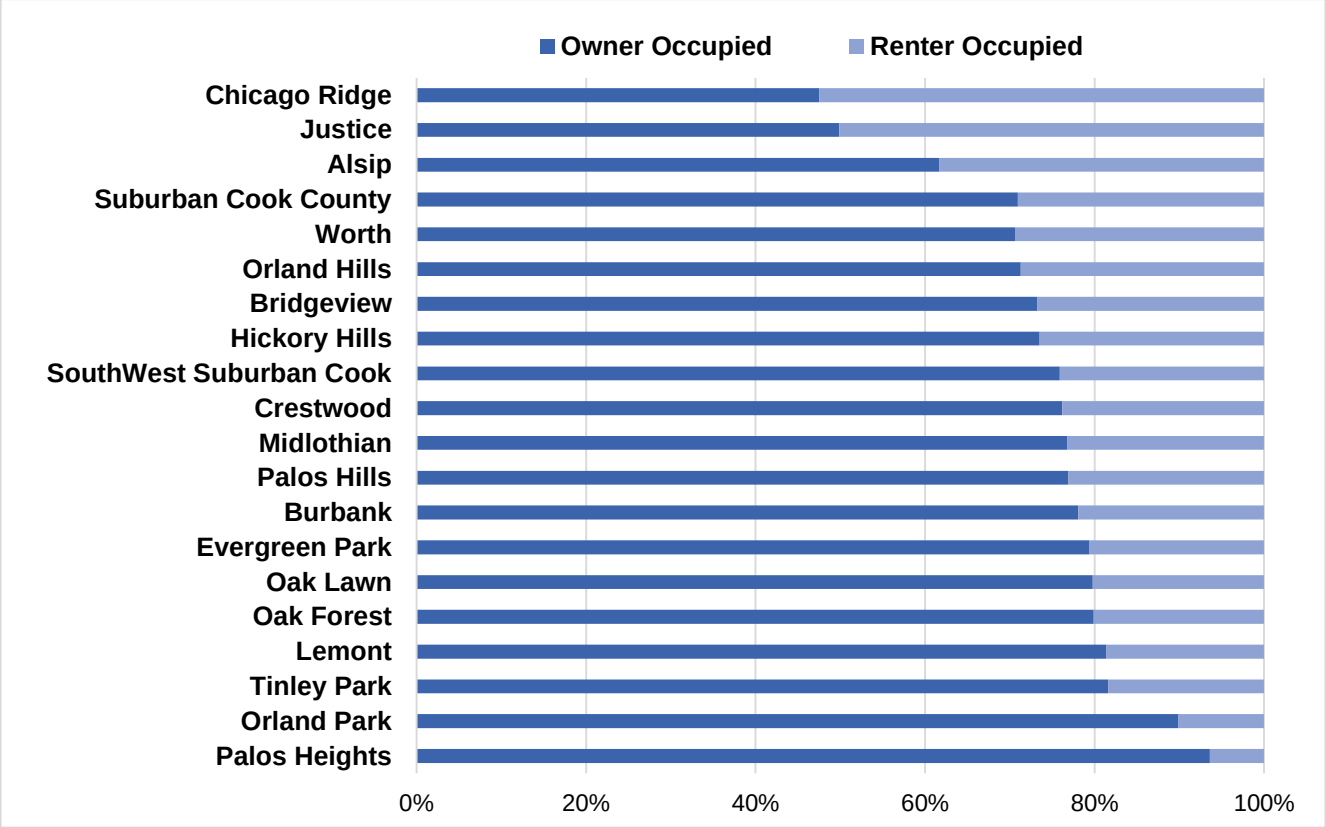
One-third of households (33.2%) in the communities served by Palos Community Hospital are "Housing Cost-Burdened", meaning they spend over 30% of household income on housing costs. As shown in Figure 18, this housing affordability issue impacts households across the geographic region. Figure 19 shows some of the variation across the area in terms of rental vs owner occupied housing and vacancies.

Figure 18. Cost burdened housing, 2012-2016



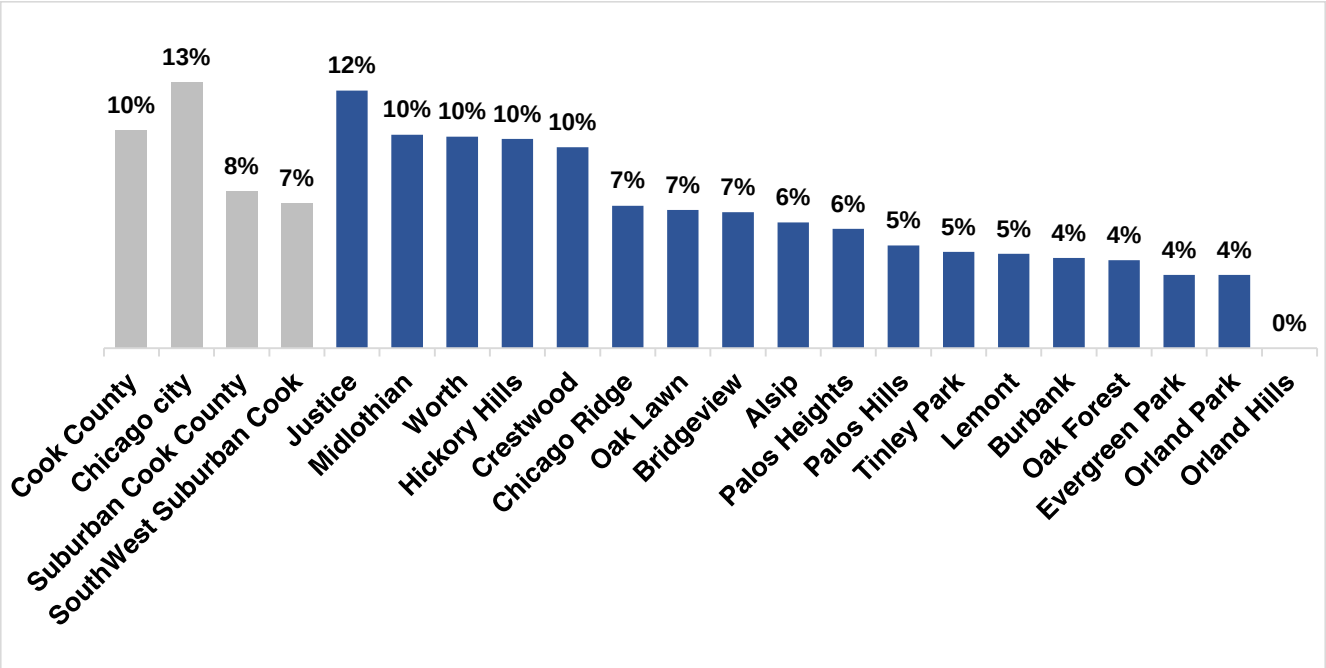
Data Source: US Census American Communities Survey, 2012-2016 via CARES Engagement Network

Figure 19. Renter and Owner Occupied Housing, 2012-2016



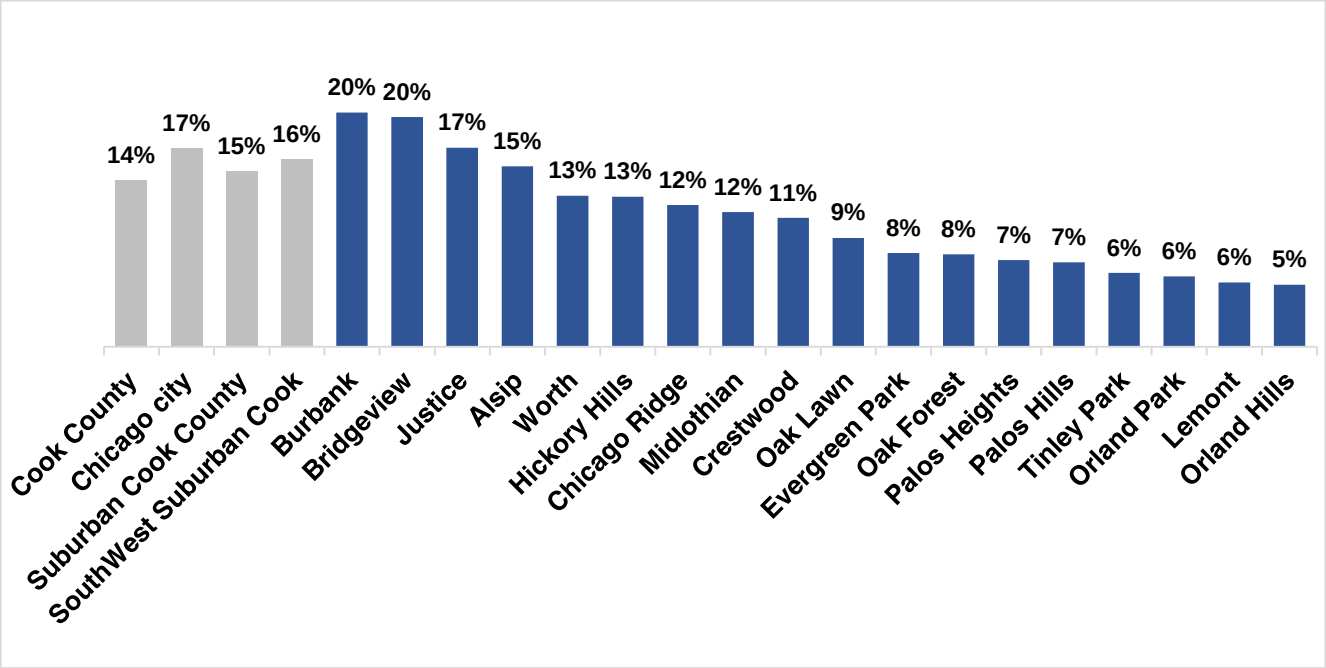
Data Source: US Census American Communities Survey, 2012-2016

Housing Vacancies, 2012-2016



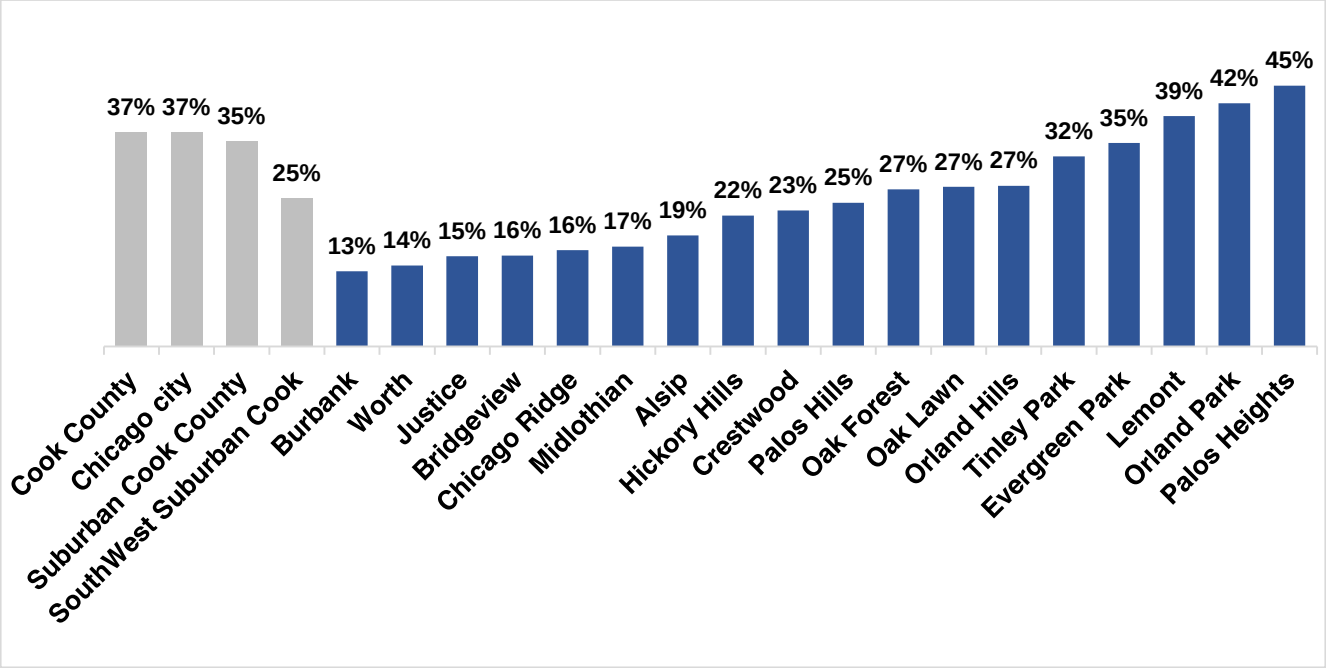
Data Source: US Census American Communities Survey, 2012-2016 via CARES Engagement Network

Figure 20. Less than High School Education, 2016



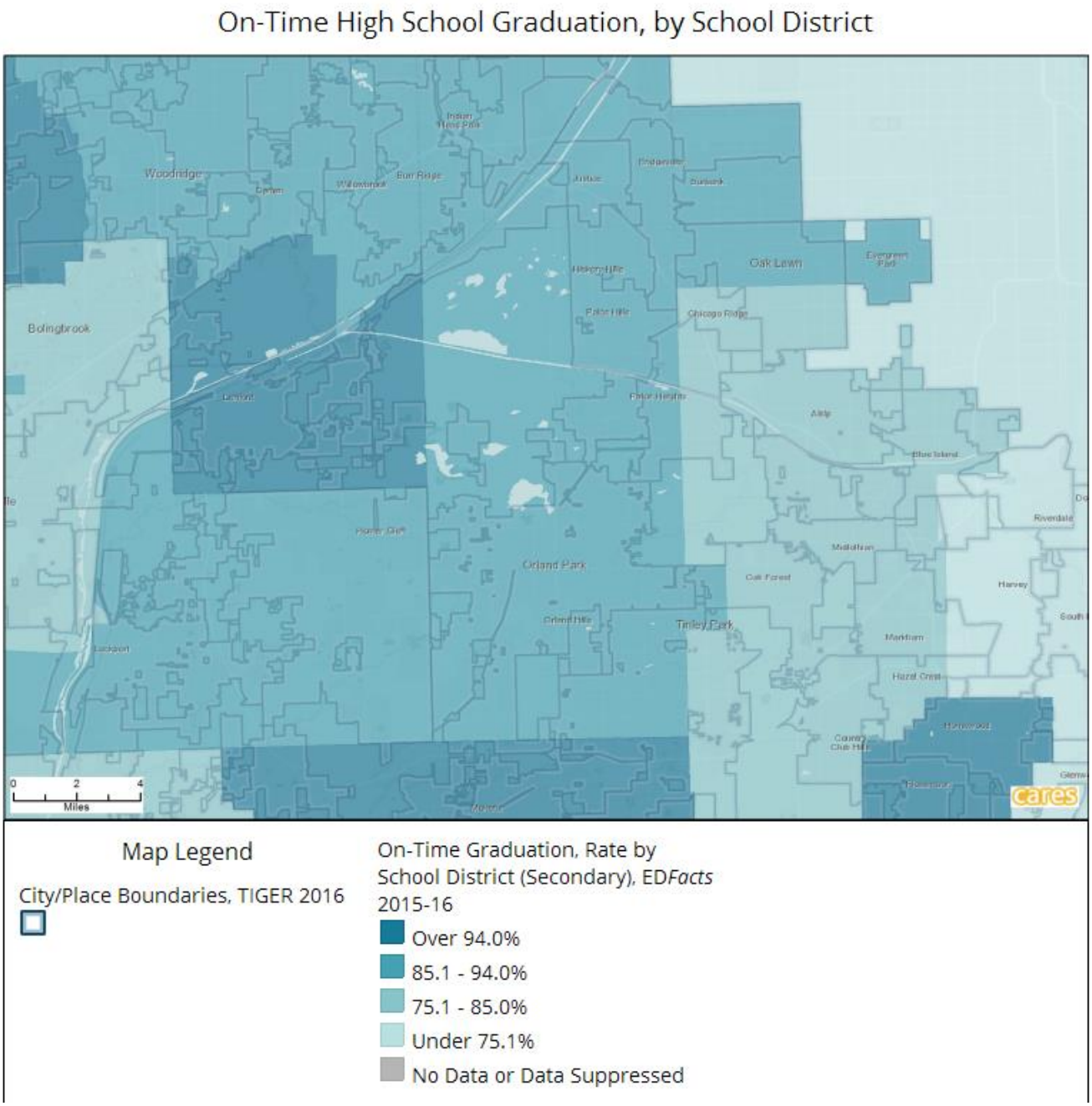
Data Source: US Census Bureau: American Community Survey, 2012-2016.

Figure 21. Bachelor's Degree or Higher, 2016



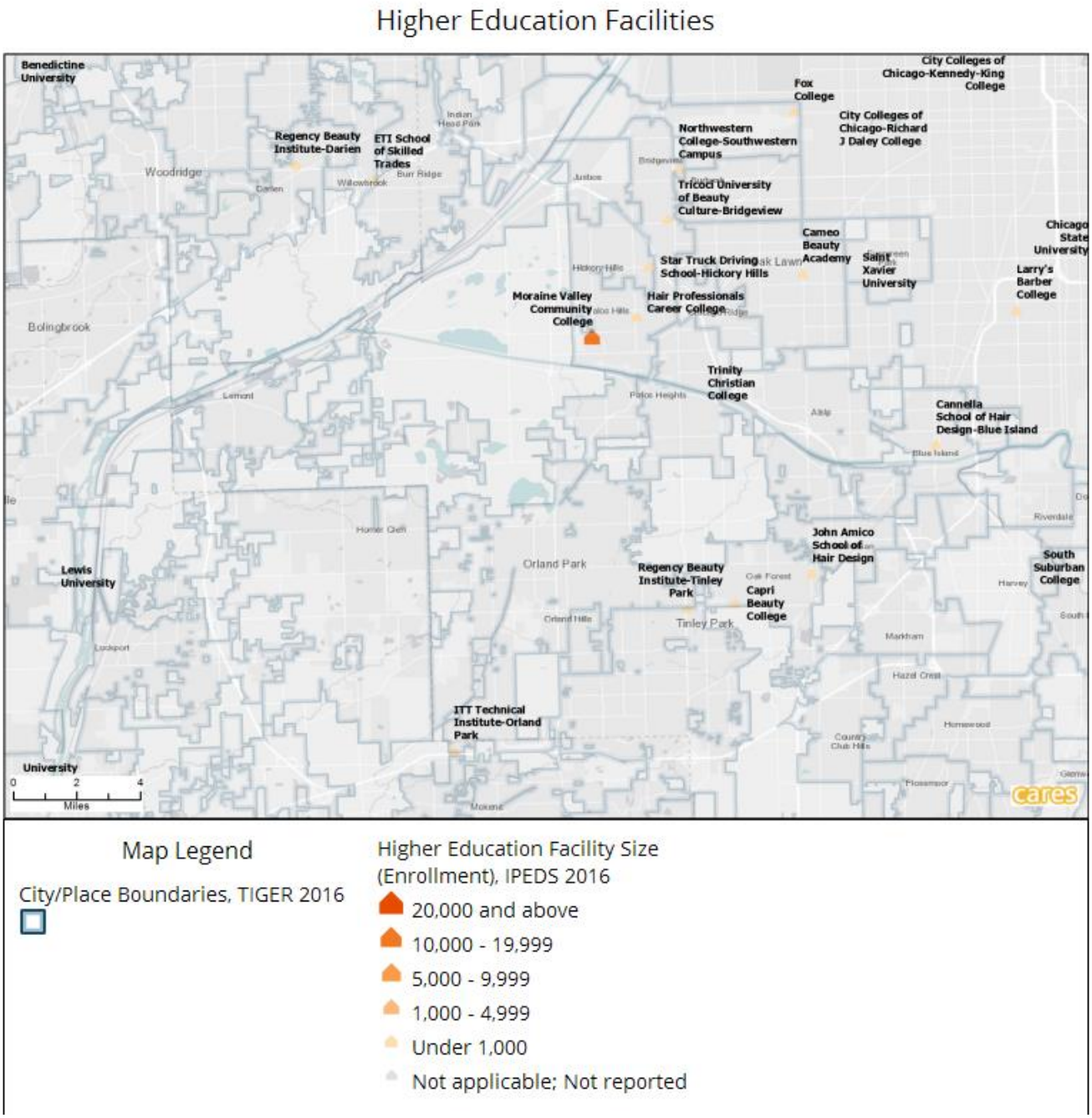
Data Source: US Census Bureau: American Community Survey, 2012-2016.

Figure 22. <u>On-Time High School Graduation, by School District</u>, 2015-16



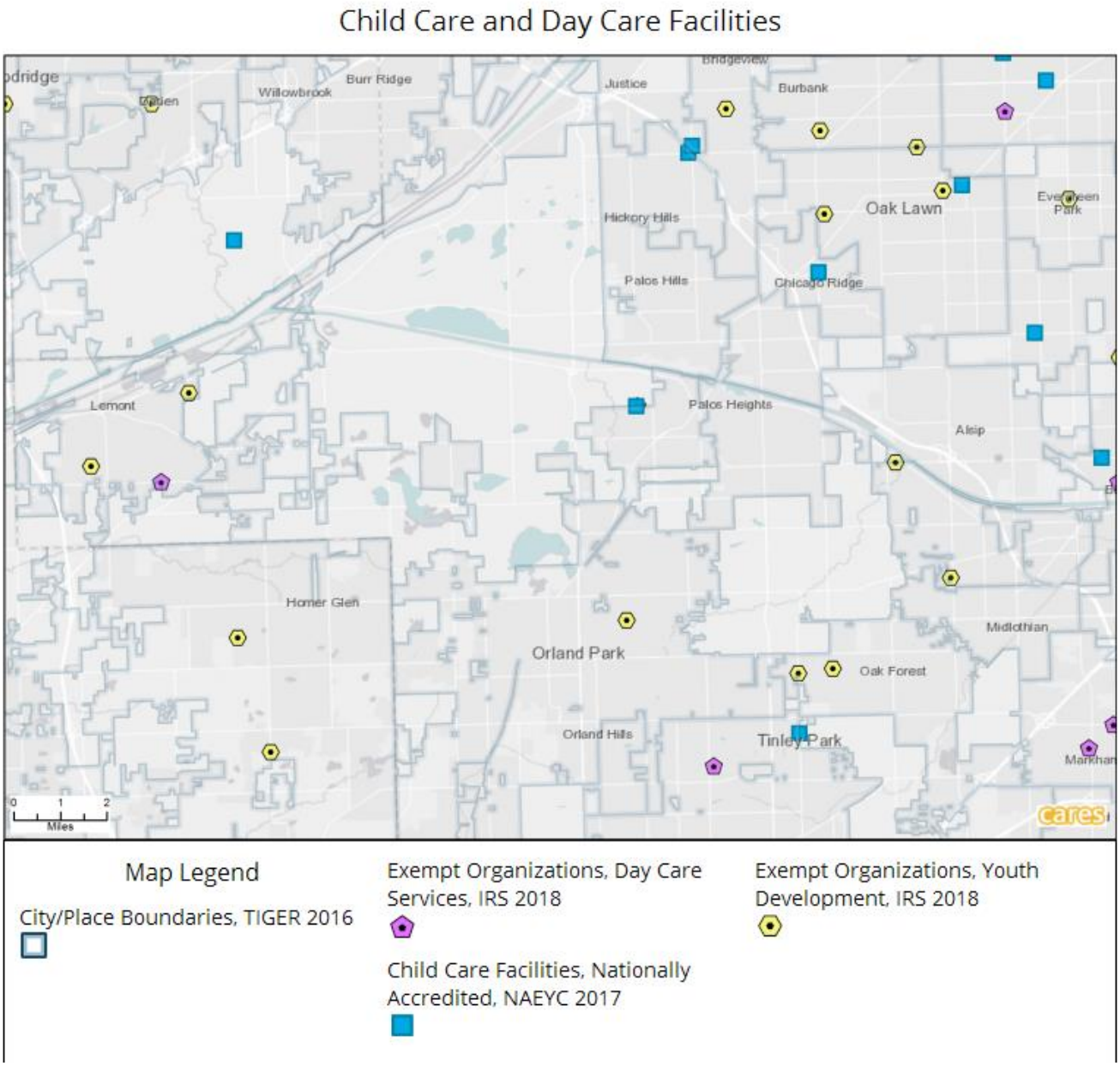
Data Source: EDFacts, 2015-16 via CARES Engagement Network

Figure 23. Higher Education Facilities, 2016



Data Source: Integrated Postsecondary Education Data System (IPEDS), 2016 via CARES Engagement Network

Figure 24. Early Childhood Education, 2018

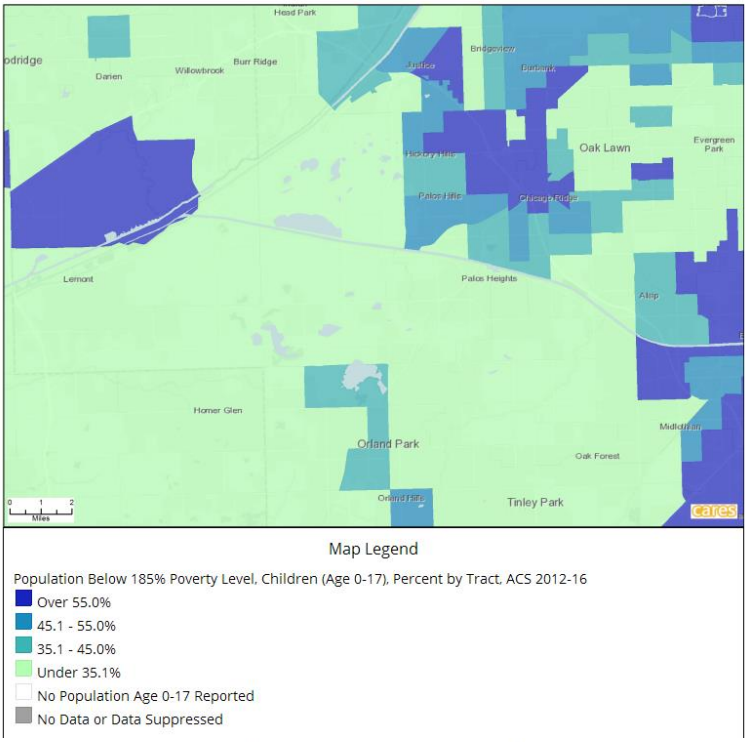


Data Source: IRS, 2018 via CARES Engagement Network

The Greater Chicago Food Depository recommends looking at population under 185% of the poverty level as the best estimate for food insecure households. The maps in Figure 25 show the communities in Palos Community Hospital's service area with the greatest concentration of children and older adults living under 185% of the poverty level.

Figure 25. Food Insecurity Estimates, 2012-2016

Food Insecurity Estimate, Children Under 18

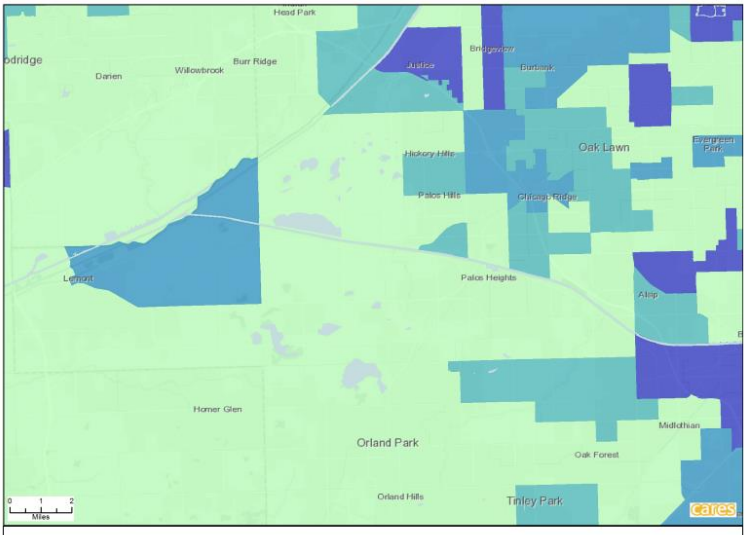


Map Legend

Population Below 185% Poverty Level, Children (Age 0-17), Percent by Tract, ACS 2012-16

- Over 55.0%
- 45.1 - 55.0%
- 35.1 - 45.0%
- Under 35.1%
- No Population Age 0-17 Reported
- No Data or Data Suppressed

Food Insecurity Estimate, Seniors 65+



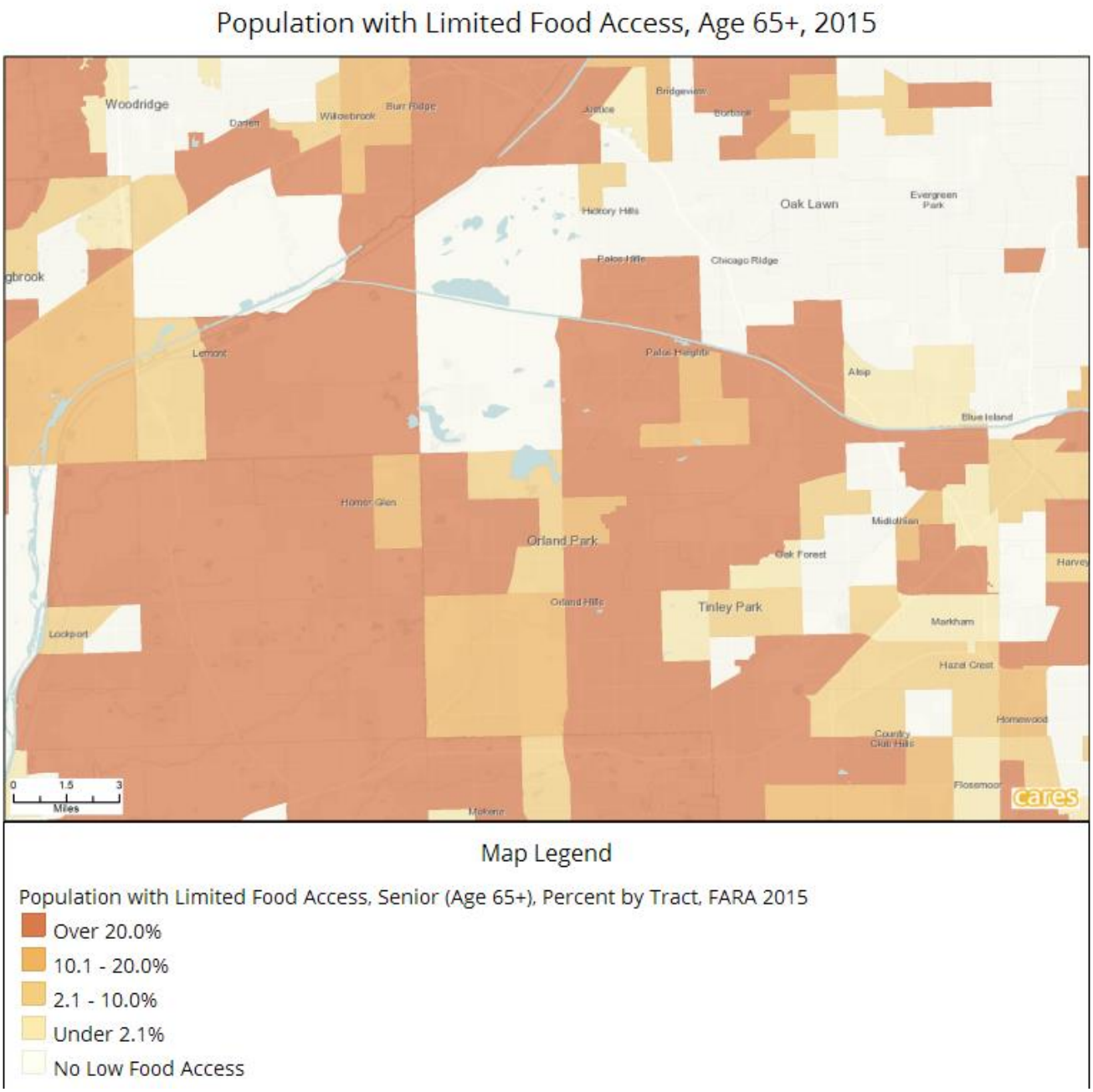
Map Legend

Population Below 185% Poverty Level, Adult (Age 65+), Percent by Tract, ACS 2012-16

- Over 40.0%
- 33.1 - 40.0%
- 27.1 - 33.0%
- Under 27.1%
- No Population Age 65+ Reported
- No Data or Data Suppressed

Data Source: US Census American Communities Survey, 2012-2016 via CARES Engagement Network

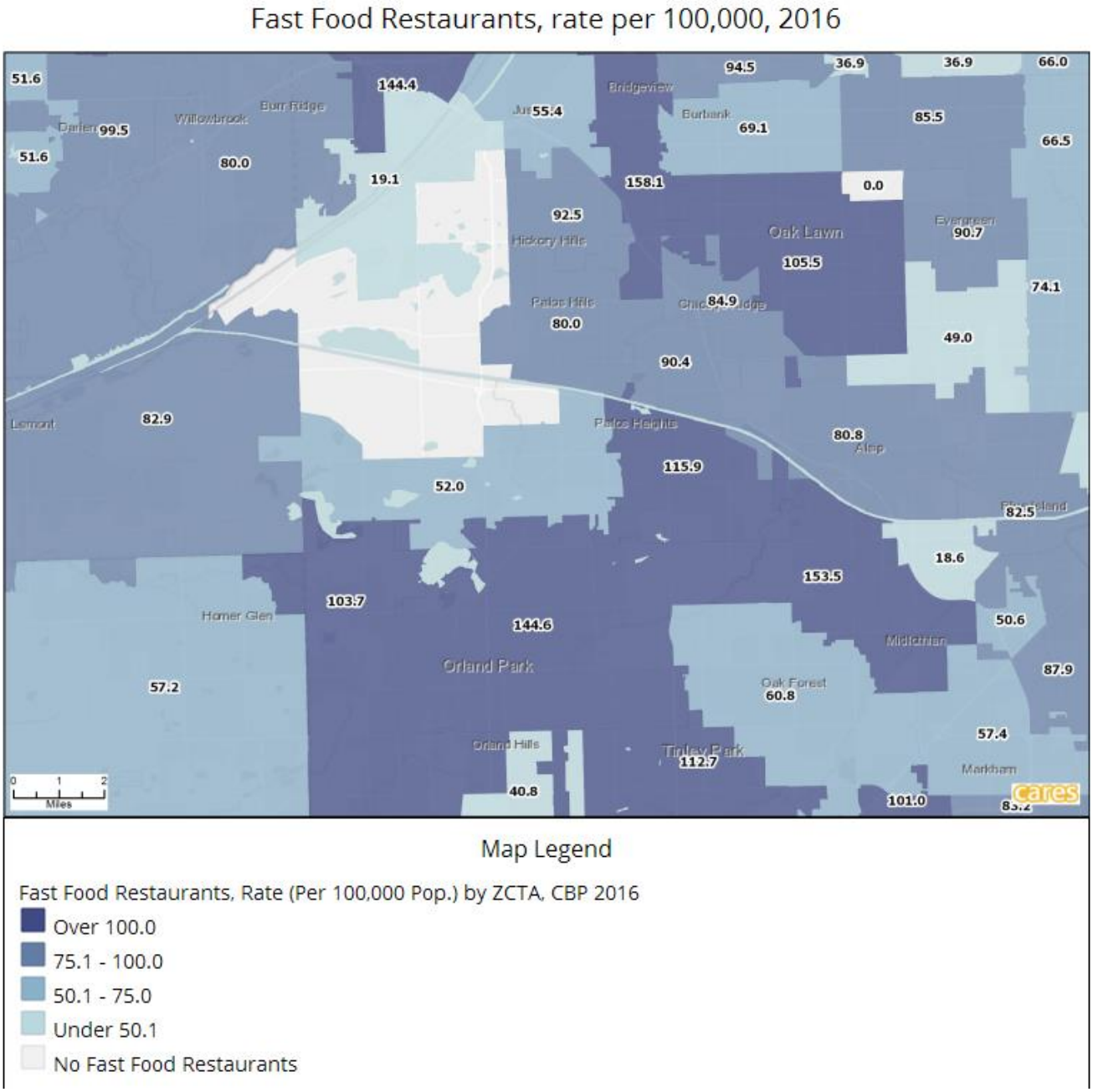
Figure 26. Population with Limited Food Access, 2015



Data Source: USDA Food Access Research Atlas (FARA), 2015 via CARES Engagement Network

Across the communities served by Palos Community Hospital, there are 81.4 fast food restaurants per 100,000 residents which is comparable to the statewide rate. By comparison, in the Palos Community Hospital service area, there are 20.8 grocery store establishments per 100,000. Between 2010 and 2016, the number of fast food restaurants per 100,000 Illinois residents grew from 70 to 79.

Figure 27. Fast Food Restaurants, 2016



Data Source: US Census County Business Patterns (CBP), 2016 via CARES Engagement Network

Mortality and Leading Causes of Death

The top causes of death in the communities served by Palos Community Hospital are **heart disease and cancer**, similar to Suburban Cook County overall. Diabetes-related mortality is increasing across the area, and is the third leading cause of death followed by cerebrovascular and chronic lower respiratory disease. See Figure 28 for detailed mortality rates by municipality.

Figure 28. Leading Causes of Death, 2012-2016

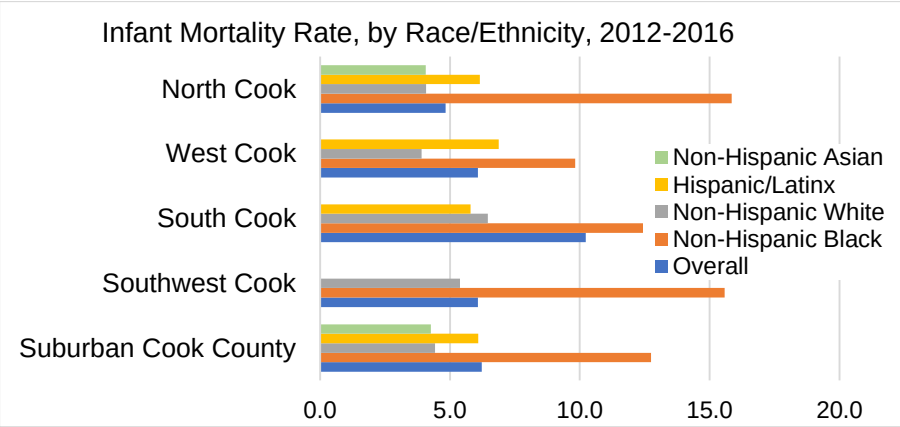
	All Cause Mortality	Heart Disease	Cancer	Diabetes-Related	Cerebrovascular/ Stroke	Chronic Lower Respiratory	Other Accidents	Alzheimer's	Drug-Related
	Age-Adjusted Rates per 100,000								
Suburban Cook County	677.6	161.5	168.1	46.5	35.8	31.3	20.8	20.7	11.7
Southwest Cook County	726.8	183.7	177.5	49.4	38.5	34.3	25.1	20.5	14.9
Alsip	880.5	231.8	209.6	65.0	39.4	44.4	34.0	*n/a*	*n/a*
Bridgeview	933.8	245.7	213.9	72.3	38.0	48.5	33.8	26.0	*n/a*
Burbank	757.0	187.7	182.3	52.0	40.3	33.8	39.4	23.2	21.9
Chicago Ridge	893.4	261.4	210.9	70.1	59.8	40.7	28.3	*n/a*	*n/a*
Crestwood	795.0	204.4	214.9	63.3	47.9	43.1	*n/a*	*n/a*	*n/a*
Evergreen Park	730.0	185.1	198.0	44.4	43.7	27.2	29.5	19.4	*n/a*
Hickory Hills	798.1	174.8	198.2	44.4	44.0	34.3	29.9	*n/a*	*n/a*
Justice	*n/a*	360.2	298.8	85.8	72.9	73.5	*n/a*	*n/a*	*n/a*
Midlothian	953.6	234.2	229.1	57.0	49.9	64.4	34.3	*n/a*	*n/a*
Oak Forest	892.6	223.8	243.0	55.2	48.6	50.7	25.3	24.1	15.4
Oak Lawn	674.6	174.6	156.0	48.1	34.0	32.0	21.1	20.0	11.5
Orland Hills	*n/a*	243.0	368.1	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*
Orland Park	769.4	183.7	209.1	46.1	38.7	34.0	26.1	24.7	15.3
Palos Heights	762.9	168.6	198.8	41.1	34.4	34.8	*n/a*	20.9	*n/a*
Palos Hills	645.1	170.2	163.5	62.1	33.9	24.5	21.8	14.3	*n/a*
Palos Park	*n/a*	307.2	386.7	89.9	74.6	54.9	*n/a*	33.7	*n/a*
Tinley Park	873.3	229.6	244.7	61.5	43.0	41.9	19.8	18.7	11.3
Worth	934.7	205.2	256.0	72.2	37.1	48.8	54.4	*n/a*	36.9

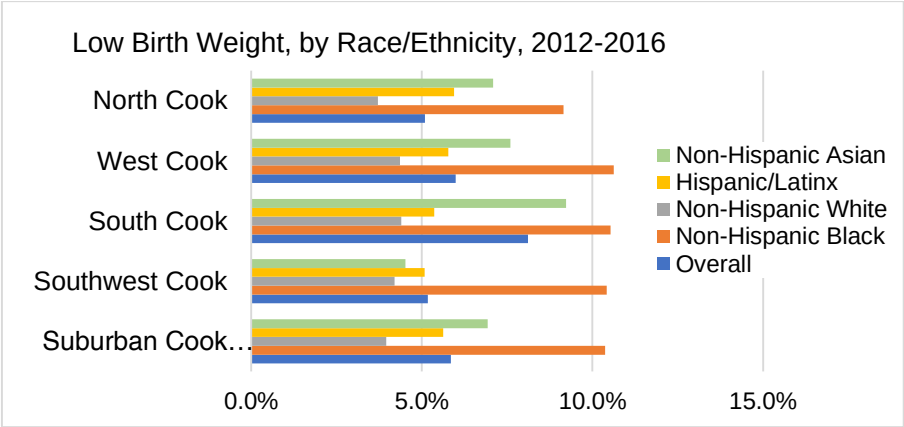
Data Source: Cook County Department of Public Health, 2012-2016.

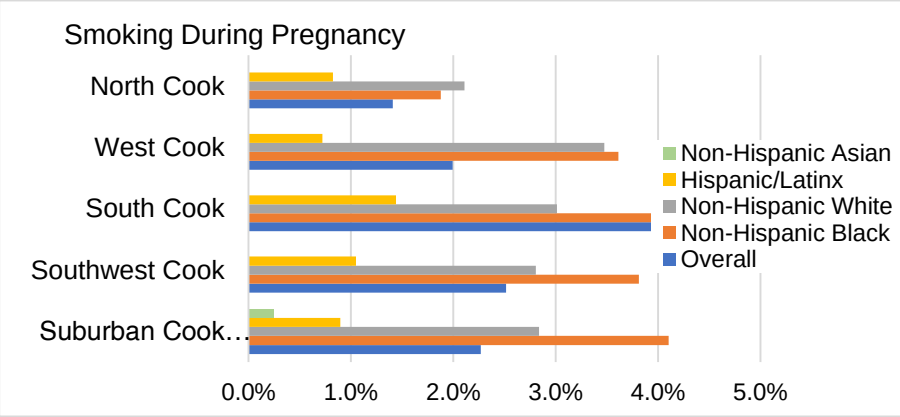
Maternal and Child Health

There are substantial disparities in birth outcomes for different racial and ethnic groups in the Palos Community Hospital service area. In particular, African American and Latina mothers and babies experience higher infant mortality rates and low birthweight babies.

Figure 29. Maternal and Child Health, by race/ethnicity	**Southwest Suburban Cook, Overall**	**Southwest Suburban Cook, Non-Hispanic Black**	**Southwest Suburban Cook, Non-Hispanic White**	**Southwest Suburban Cook, Hispanic/Latina**	**Southwest Suburban Cook, Non-Hispanic Asian**
Infant Mortality Rate, per 1000 births	6.1	15.6	5.4	n/a	n/a
Low Birth Weight, per 1000 births	5.2%	10.4%	4.2%	5.1%	4.5%
Smoking in Pregnancy, percentage	2.5%	3.8%	2.8%	1.0%	n/a





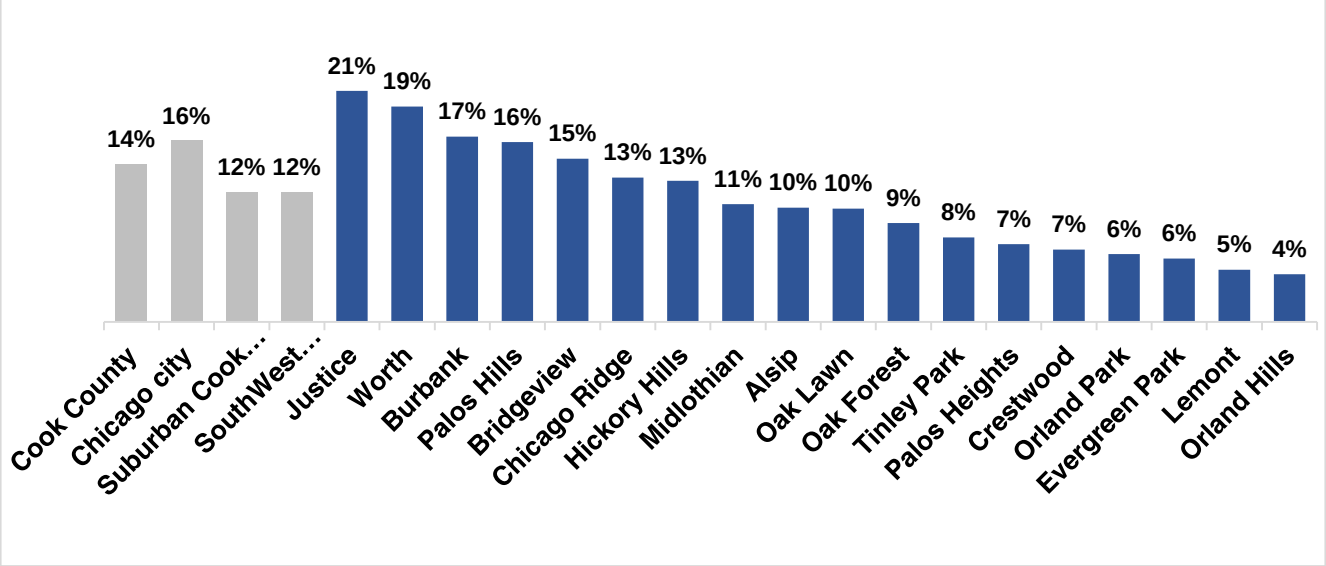


Data Source: Cook County Department of Public Health

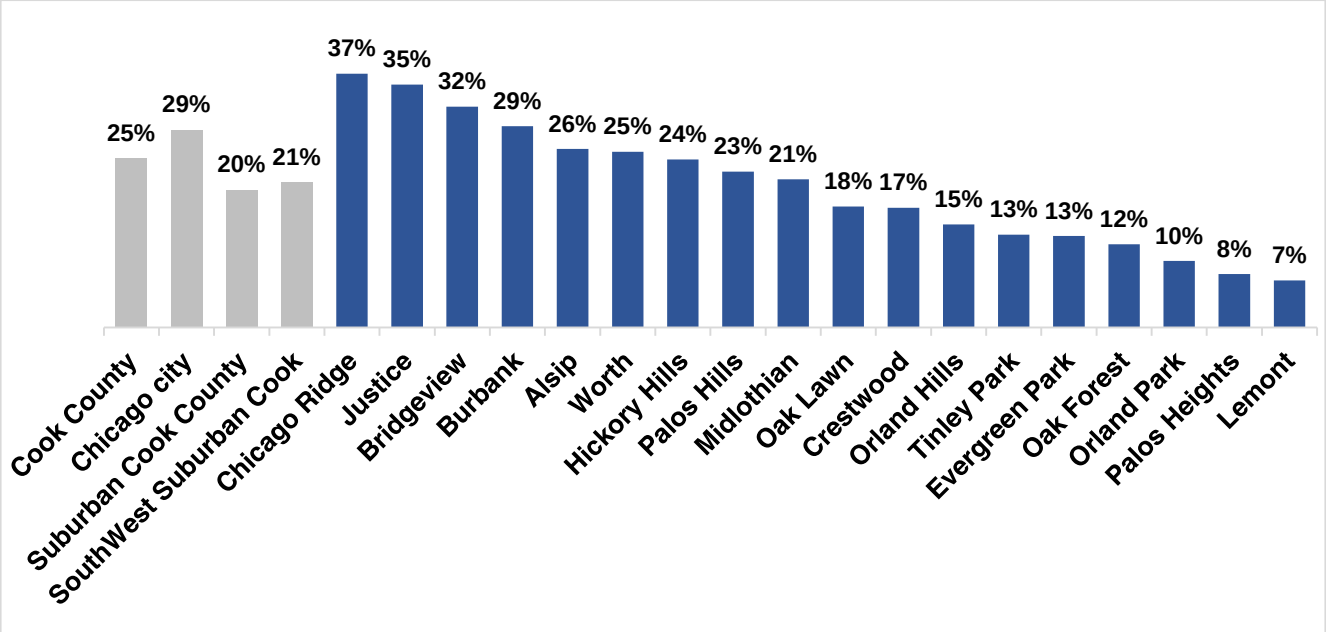
Access to Care and Community Resources

Rates of uninsured individuals continue to go down, but significant disparities remain when comparing rates across different communities, as shown in Figure 30. Within the communities served by Palos Community Hospital, some of the areas with larger immigrant populations continue to present with greater than 15% uninsured. Particularly with the new draft "public charge" rules under consideration by the federal government, we have heard through focus groups and stakeholder meetings that there is a renewed need to close the insurance gap for immigrants and their families.

Figure 30. Uninsured (self-reported), 2012-2016

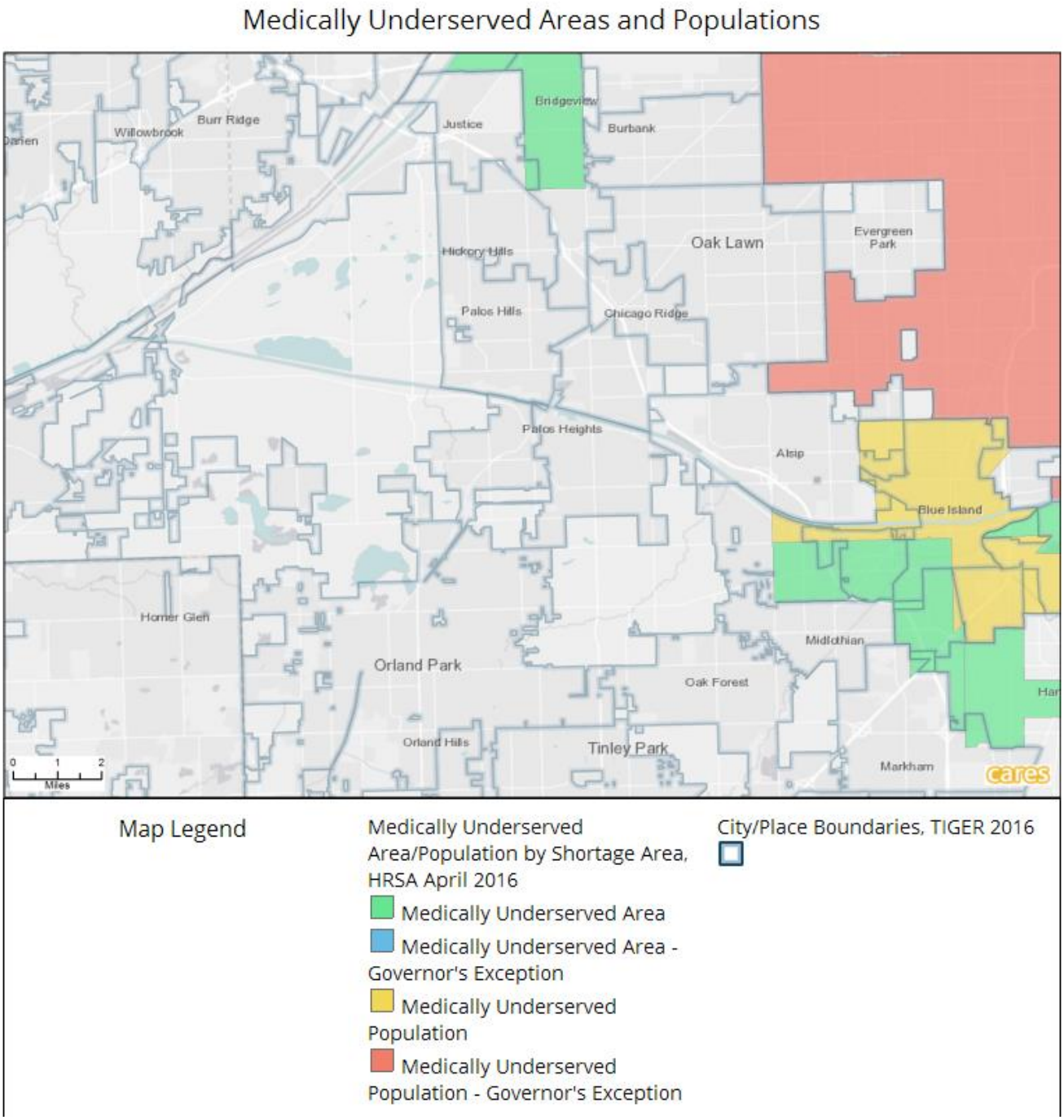


Public Insurance (self-reported), 2012-2016



Data Source: US Census Bureau: American Community Survey, 2012-2016.

Figure 31. <u>Healthcare Shortage Areas,</u> 2016



Data Source: Health Resources and Services Administration (HRSA), 2016 via CARES Engagement Network.

Figure 32. Access to and Utilization of Preventive Care

	Palos Community Hospital Service Area	Cook County, IL	Will County, IL
Diabetes Management - Hemoglobin A1c Test			
Medicare Enrollees with Diabetes	6,449	42,545	6,617
Medicare Enrollees with Diabetes with Annual Exam	85%	85%	86%
Prevention - Mammogram			
Female Medicare Enrollees with Mammogram in Past 2 Years	3470	22842	3575
Percent Female Medicare Enrollees with Mammogram in Past 2 Year	65%	64%	66%
Ambulatory Care Sensitive Condition – Hospital Discharge			
Ambulatory Care Sensitive Condition Discharge Rate	51.5	48	63.7
Access to Dentist and Primary Care			
Dentists, 2015	486	4437	364
Dentists, Rate per 100,000 Pop.	76.7	84.7	53
Primary Care Physicians, 2014	678	6464	403
Primary Care Physicians, Rate per 100,000	106.9	123.21	58.8

Chronic Disease

Chronic disease affects health across the life course, and heart disease, cancer and diabetes are the leading causes of death in the Palos Community Hospital service area. Figure 33 provides a summary of data for older adults related to high blood pressure and diabetes. Fifty-seven percent of Medicaid beneficiaries in the communities served by Palos Community Hospital have been diagnosed with high blood pressure.

Figure 33. High Blood Pressure and Diabetes among Medicare Beneficiaries

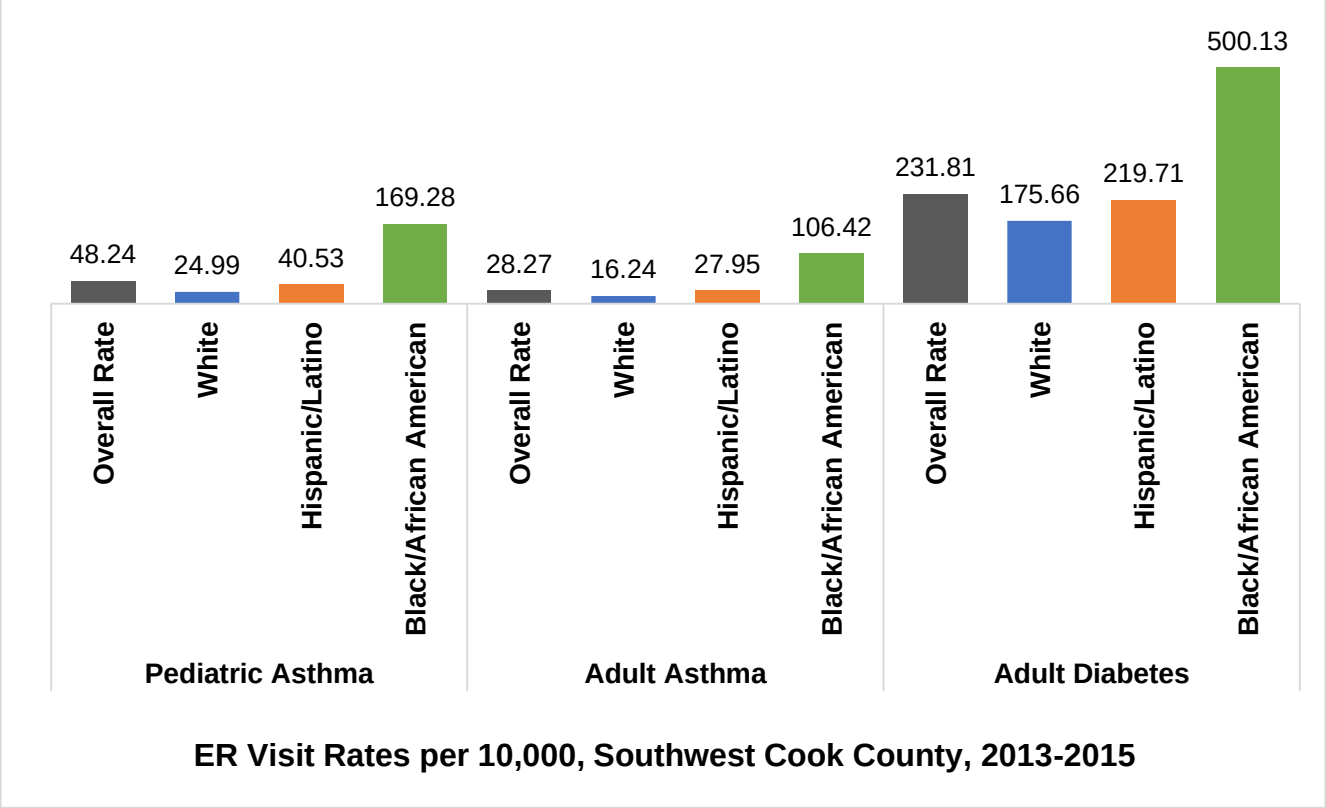
	Medicare Beneficiaries with High Blood Pressure	Percent with High Blood Pressure
Palos Community Hospital Service Area	**40,024**	**57%**
Cook County, IL	**274,535**	**56%**
Will County, IL	**36,326**	**59%**

	Medicare Beneficiaries with Diabetes	Percent with Diabetes
Palos Community Hospital Service Area	**19324**	**27%**
Cook County, IL	**133985**	**27%**
Will County, IL	**16917**	**27%**

Data Source: Dartmouth Atlas of Health Care. 2015.

Chronic disease also impacts children and youth. Over 20% of children and adolescents are obese in suburban Cook County, and type 2 diabetes among children is on the rise as well. Approximately 10% of children 0-17 currently have asthma in Illinois, and the proportion is likely slightly higher in this area. Of particular concern are the increased prevalence and risk among black and Hispanic children. As shown in Figure 34, the rates of ER visits for pediatric asthma in Southwest Suburban Cook are drastically different for different racial and ethnic groups. The ER visit rate for black children with asthma in our area is 169.28 per 10,000, over 6 times the rate for white children.

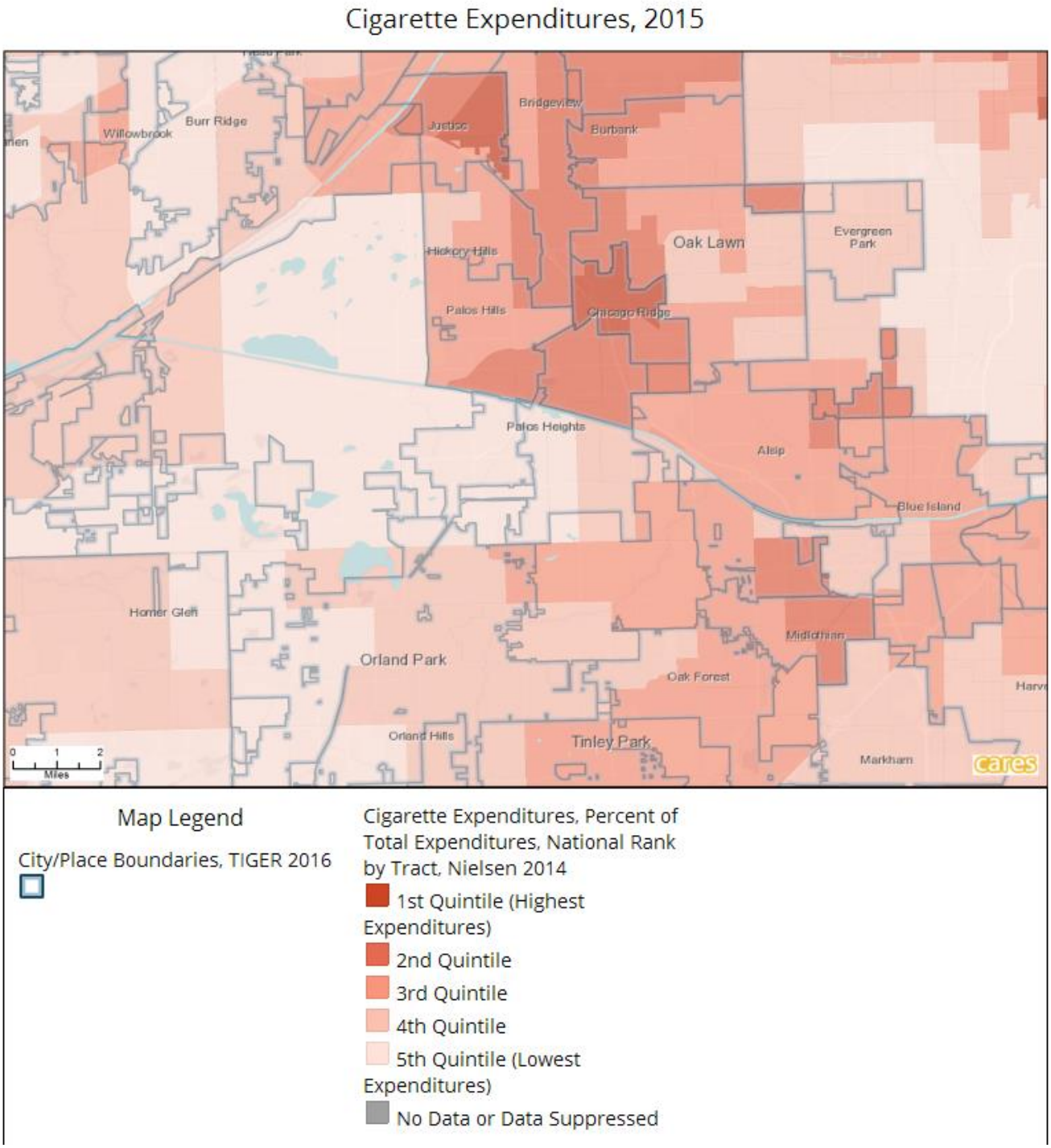
Figure 34. ER Visit Rates, by Race and Ethnicity, Southwest Cook County, 2013-2015



Source: Cook County Department of Public Health analysis

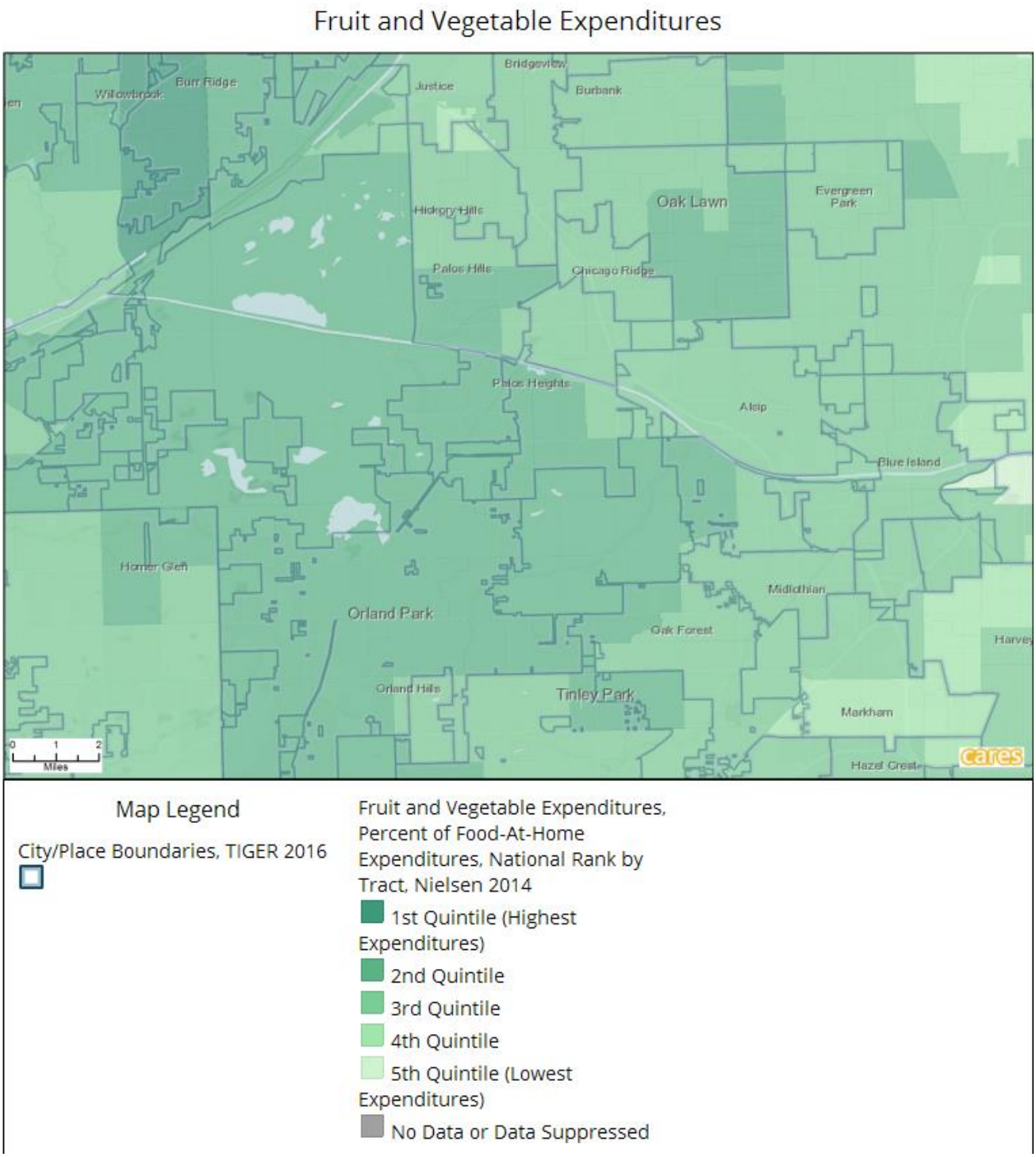
There are a number of common risk factors for chronic disease including tobacco, physical activity and nutrition. The 2018 Illinois Youth Survey data for suburban Cook County shows that 34% of high school seniors that responded reported using tobacco or vaping products at least once in the past 30 days. One key finding from the survey was that e-cigarettes are by far the most commonly used tobacco product used by the teens who participated in the survey.

Figure 35. Cigarette Expenditures, 2015



Data Source: Nielsen, 2015 via CARES Engagement Network.

Figure 36. Fruit and Vegetable Expenditures, 2015



Data Source: Nielsen, 2015 via CARES Engagement Network.

Mental Health and Substance Use Disorders

As noted in the community and stakeholder input, mental health wellbeing and addressing substance use disorders are priority community health issues. The map in Figure 38 shows how behavioral health issues impact people and healthcare institutions across Cook County including the cities and communities served by Palos Community Hospital. There are a number of treatment facilities and providers, as shown in Figures 39 and 40, but there continues to be a need to address stigma and build innovative partnerships to advance mental health well-being and provide the services that individuals and families need in the community. The rate of opioid-related deaths in suburban Cook County increased from 8.8 per 10,00 in 2015 to 13.7 per 10,000 in 2016.

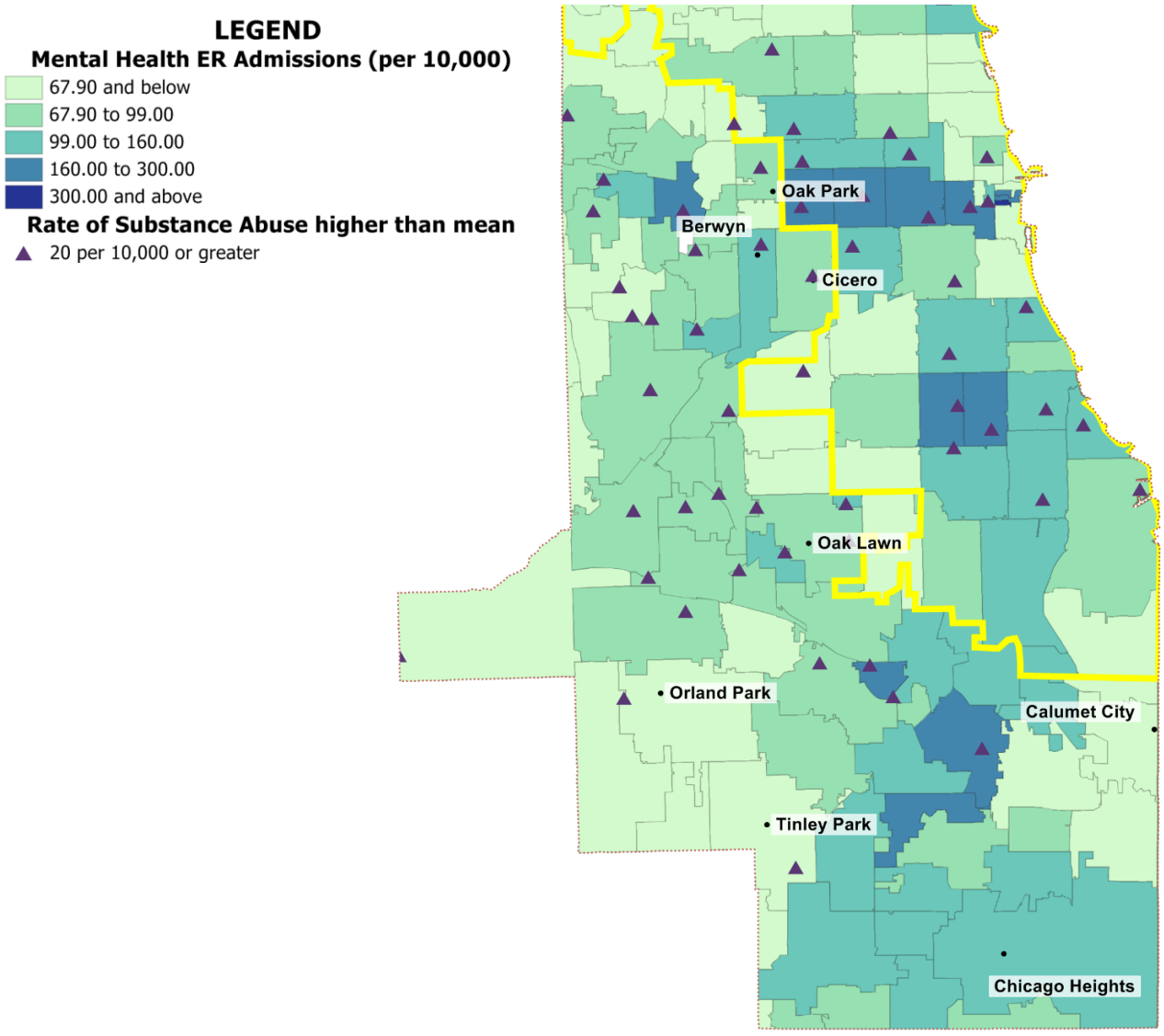
Data from the 2018 Illinois Youth Survey shows that 30% of 8th, 10th, and 12th graders responding to the survey in suburban Cook County said that within the past 12 months they "Felt so sad or hopeless almost every day for two weeks or more in a row that I stopped doing some usual activities." Thirty-nine percent of 8th grade respondents from Suburban Cook County reported being bullied. Depression and mental health conditions also impact older adults, as shown in Figure 37.

Figure 37. Medicare Beneficiaries with Depression

	Medicare Beneficiaries with Depression	
Palos Community Hospital Service Area	9638	14%
Cook County, IL	66801	14%
Will County, IL	8422	14%

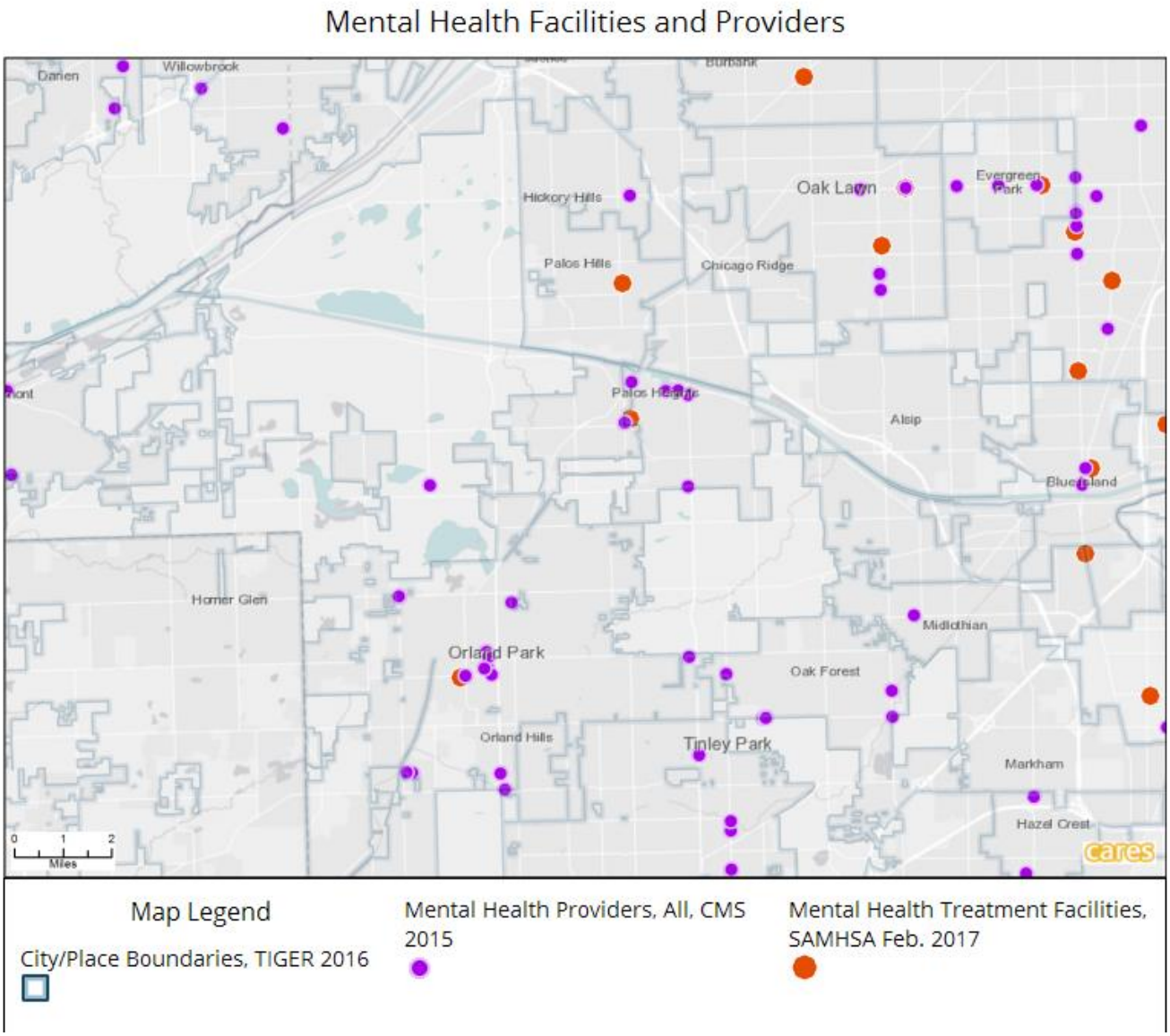
As discussed in the focus group summary above, It is easy for an older adult to feel isolated, and we must collectively work to meet the needs of both seniors and caregivers. In our focus groups, we also heard the importance of having culturally competent behavioral health and healthcare providers and building a workforce that allows for inclusion of people with lived experience.

Figure 38. Behavioral Health in Emergency Departments: ED admission rate for mental health and substance abuse, adults, 2012-2014



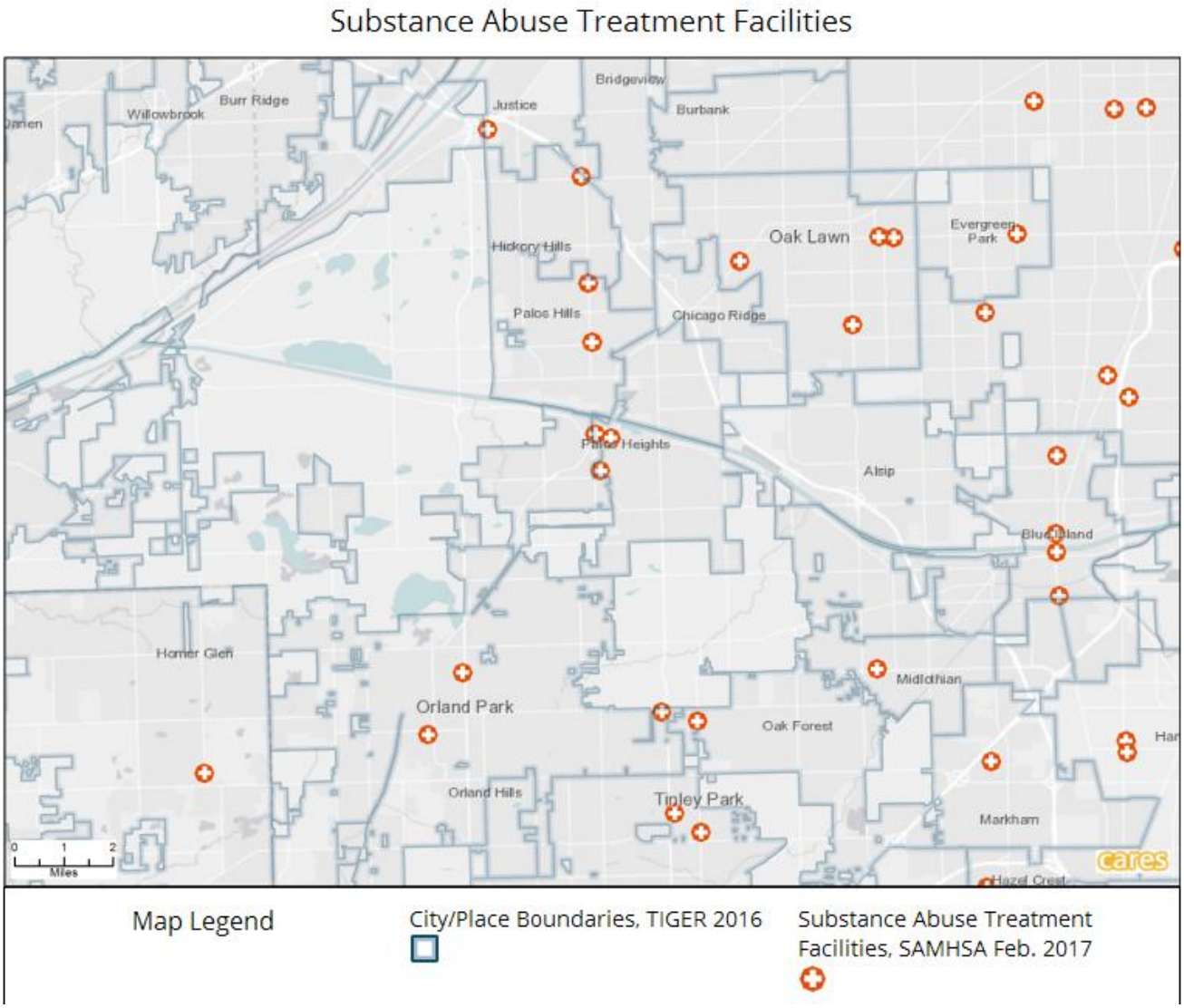
Data Sources: Healthy Communities Institute, Illinois Hospital Association COMPdata, 2012-2014

Figure 39. Mental Health Facilities and Providers, 2017



Data Source: SAMHSA, 2017 via CARES Engagement Network.

Figure 40. Substance Abuse Treatment Facilities, 2017



Data Source: SAMHSA, 2017 via CARES Engagement Network.

IV. Summary of Palos Community Hospital's CHNA Implementation Activities, January 2016-November 2018

In 2015, five priority areas were identified in the Palos Community Hospital Community Health Needs Assessment (CHNA):

- Access to Health Services
- Cancer
- Diabetes
- Stroke, Heart Disease & Respiratory
- Mental Health & Substance Abuse

Palos Community Hospital utilized a multidisciplinary approach to address these priorities assembling a team of clinicians from throughout the organization.

Access to Health Services
Palos Community Hospital made great strides in improving access to health services including offering lower price options, increasing options in how care is delivered and ease accessing care.

To provide enhanced access to health services, Palos Community Hospital:

- Enhanced education for patients preparing for lower extremity joint replacement surgery
- Hired additional care coordinators to help patients with chronic illness such as COPD and heart failure
- Expanded services available in the Palos Heart & Lung Wellness Clinic to treat asthma
- Launched a community-based medicine program to deliver medical care to individuals with mobility issues unable to visit a physician's office
- Increased the number of family practice providers within Palos Medical Group
- Established Palos Imaging & Diagnostics, a new modern center featuring advanced technology offers patients a quality option for images in a non-provider based setting allowing for a less expensive option

Cancer
Palos Community Hospital established a goal to address screening, diagnosis, treatment and rehabilitative services and promote early diagnosis and effective treatment and recovery of cancer. To address this health priority, Palos Community Hospital:

- Offered colorectal cancer screening kits as a tool to aid in the detection of possible instance of cancer
- Provided education in the community on skin cancer prevention at well attended community events
- Sponsored a program offering 50 free screening mammograms to women over 40 without insurance
- Strengthened the relationships with community-based support resources such as The Cancer Support Center and the American Cancer Society.
- Hosted Survive and Thrive event to provide education and support to cancer patients/survivors
- Introduced a new community education program focused on nutrition while facing the side effects of cancer

- Opened Palos Imaging and Diagnostics providing area residents access to advanced imaging technology at a reduced cost
- Launched community-based medicine program delivering Palliative and Supportive Care to patients unable to visit physician's office
- Supported and participated in the American Cancer Society's Making Strides Against Breast Cancer event during 2016, 2017 and 2018.

Diabetes

Cases of diabetes and conditions related to the disease are on the rise in the surrounding community. To focus on diabetes, Palos Community Hospital:

- Offered community education programming focused on diabetes and pre-diabetes
- Hosted annual diabetes fair to education community members about resources available
- Added a podiatrist to Palos Medical Group to address to complications caused by diabetes related to foot health
- Enhanced resources through our electronic medical record system to assist physicians caring for challenging patients

Heart Disease, Stroke & Respiratory Diseases

The community we serve is aging and as a consequence the risk of heart disease, stroke and respiratory diseases increases with age. To address these common conditions, Palos Community Hospital:

- Offered low-dose CT lung screenings to qualifying individuals at risk of lung cancer
- Provided free smoking cessation programs
- Expanded services available in the Heart and Lung Wellness Clinic
- Added offerings at Palos Imaging & Diagnostics to include cardiac diagnostics
- Held community education programs focused on heart health focused on arterial fibrillation, nutrition and more
- Participated in the American Heart Association Heart Walk in 2016
- Opened the Electrophysiology lab to address the increasing incidences of arterial fibrillation
- Established a telemedicine program with Loyola University Health System for patients experiencing a stroke
- Added heart failure to the CMS bundled payments for care improvement initiatives including additional support of care coordinators for patients and enhanced relationships with area skilled nursing facilities caring for heart failure patients

Immunizations & Infectious Diseases

Many infectious diseases are preventable through proper compliance of recommended vaccination series. Being a "good community citizen" includes doing what we can to keep our community healthy. Palos Community Hospital:

- Held flu vaccination fairs through October 2017 making it convenient for area residents to receive influenza vaccines
- Continued Palos employee annual flu vaccine program
- Focused on administering pneumonia vaccines for inpatient population and Palos Medical Group patients
- Utilized Electronic Medical Record system to identify patients with gaps in care

Mental Health & Substance Abuse
Mental Health and Substance Abuse issues continue to be common health concerns faced by area residents. Many years ago, Palos Community Hospital committed itself to addressing the mental health needs of the community it serves. Palos Community Health continued to dedicate new resources to the community when it:

- Introduced Transcranial Magnetic Stimulation as a treatment option for patients with chronic depression
- Hired additional providers to help meet patients' mental health needs
- Worked with the Cook County Court Bridgeview Division to establish a mental health court to help non-violent offenders. Palos provides care to qualified individuals facing mental health issues while potentially preventing future crimes if left untreated. Services available include outpatient program options intended to respond to crisis situations while providing ongoing treatment and support programs.
- Expanded Palos Medical Group's Behavioral Health team to include an addictionologist
- Provided support and assistance with the crisis phone line
- Offered community education about resources for individuals facing substance abuse issues
- Added two free programs SMART Recovery, an abstinence-based mental health and educational program focused on changing addictive behaviors, and SMART Recovery Family & Friends Group, for those with a loved one facing substance abuse or addiction issues.
- Served as a member of the Orland Park Substance Awareness Forum

V. Conclusion

The key heath issues that have surfaced through data analysis and community input in this CHNA closely align with Palos Community Hospital's ongoing strategic community health priorities - Access to Health Services, Cancer, Diabetes, Stroke, and Mental Health and Substance Use. As part of the collaborative work with the Alliance for Health Equity, Palos Community Hospital is also partnering on initiatives related to social determinants of health such as food access, housing, or transportation.

Palos Community Hospital continues to participate in the Alliance for Health Equity and in local partnerships for community health improvement. Driven by a shared mission and a set of collective values, Palos Community Hospital and the Alliance for Health Equity will work together with regional and community partners to develop implementation plans and collaborative action to achieve the shared vision of improved health equity, wellness, and quality of life across Chicago and Cook County.

To comment on this CHNA or to request more information or paper copies of the CHNA, please contact Lori Mazeika at lmazeika@paloshealth.com