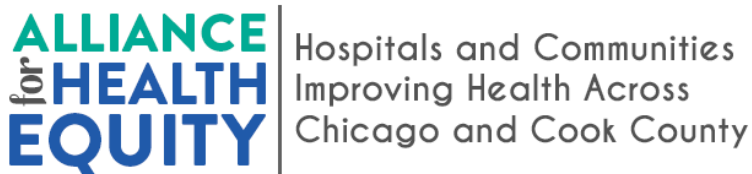




Community Health Needs Assessment

2019



Prepared by Illinois Public Health Institute

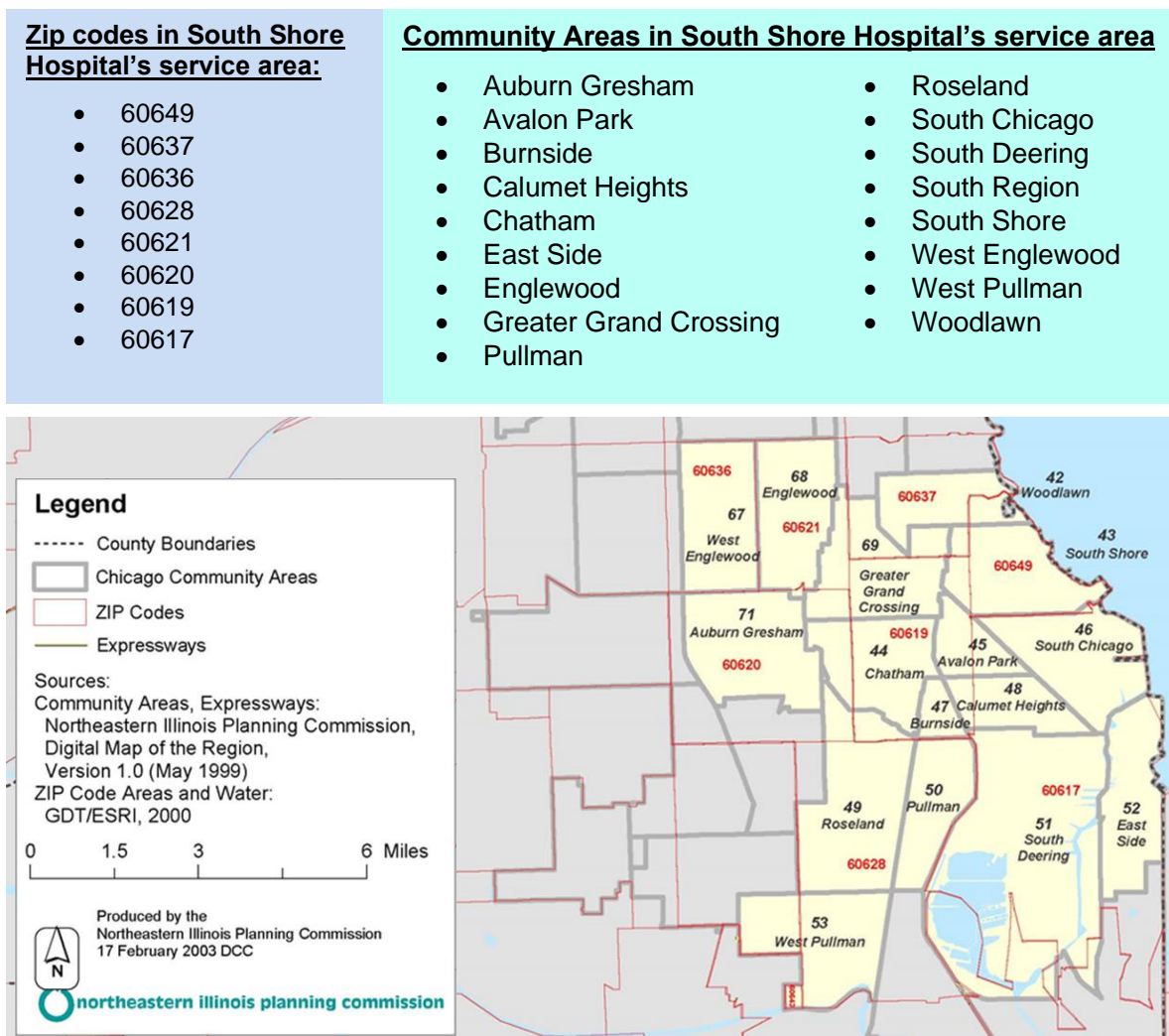
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I. Intro to South Shore Hospital and Description of South Shore Hospital Service Area

South Shore Hospital (SSH) is an independent general acute care hospital that has been in existence since 1912. The hospital is currently staffed at a level of 135 beds with licensing for up to 170 beds. In addition, SSH has five primary care outreach facilities. SSH employs over 470, including a medical staff of approximately 104 physicians. The following services are provided on an inpatient and outpatient basis: respiratory care, physical therapy, surgery, nuclear medicine, radiology, laboratory, vascular, diagnostics, pharmacy, non-invasive cardiology, detox services, chemical dependency, transportation, wound and skin care, emergency medicine, geriatric psychiatry, HIV/AIDS services, and gynecological services. SSH is located in the South Shore community area of Chicago and its service area encompasses 17 community areas in the City of Chicago (Figure 1) with an estimated population of 411,148 individuals (2016 5-year estimates, American Community Survey). The majority of the population within SSH’s service area identifies as African American/black (87%). Nine percent of the population identifies as Hispanic/Latinx and 3% as non-Hispanic white. The majority of the patient population resides in the communities surrounding the hospital. The primary patient population is geriatric with low to moderate income levels. SSH treats patients regardless of race, color, creed, or their ability to pay.

Figure 1. South Shore Hospital Service Area Map and List of Communities



II. Overview of the Community Health Needs Assessment (CHNA) process

SSH and members of the Alliance for Health Equity (AHE), a collaborative of 35 non-profit hospitals (Figure 2), two public hospitals, six health departments, and nearly 100 community-based organizations, worked together between March 2018 through March 2019 to conduct a comprehensive Community Health Needs Assessment (CHNA) for Chicago and Suburban Cook County.

The Affordable Care Act (ACA) includes a number of components designed to strengthen the healthcare system's focus on prevention in addition to treating people who are ill. Under the ACA, hospitals are now required to conduct a CHNA every three years that has specific components including:

- a description of the CHNA process, methods, collaborations, prioritized community health needs, and a description of existing facilities and resources in the community;
- input from persons representing the broad needs of the community;
- the CHNA must be posted and made available to the public; and
- the Hospital must adopt and submit an implementation strategy to IRS within 5½ months of posting the CHNA.

Summary of our collaborative health equity approach to CHNA

The AHE's collaborative CHNA combined robust public health data, community input, existing research, existing plans, and existing assessments to document the health status of communities within Chicago and Suburban Cook County and to highlight systemic inequities that are negatively impacting health. The CHNA also provided insight into community-based assets and resources that should be supported and leveraged during the implementation of health improvement strategies.

Primary and secondary data was collected from diverse sources to identify community health needs. The Illinois Public Health Institute (IPHI) worked with the AHE CHNA committee and AHE steering committee to design and facilitate a collaborative, community-engaged assessment. As with the 2015-2016 collaborative CHNA, this 2019 CHNA process is adapted from the Mobilizing for Action through Planning and Partnerships (MAPP) model, a community-engaged strategic planning framework that was developed by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). Both CDPH and CCDPH use the MAPP framework for community health assessment and planning. The MAPP framework promotes a system focus, emphasizing the importance of community engagement, partnership development, and three types of data: secondary data, community input, and system analysis. AHE chose this inclusive, community-driven process to leverage and align with health department assessments and to actively engage stakeholders, including community members, in identifying and addressing strategic priorities to advance health equity.

Primary data for the CHNA was collected through four methods:

- Community input surveys
- Community resident focus groups and learning map sessions
- Health care and social service provider focus groups
- Two stakeholder assessments led by partner health departments: A Forces of Change Assessment and Health Equity Capacity Assessment

Secondary data for the CHNA was compiled and analyzed in partnership with epidemiologists from CDPH, CCDPH, IPHI, and member hospitals. These partners worked with the AHE steering committee to select a common set of indicators based on an adapted version of the County Health Rankings and Roadmaps Model.

Data were organized into the following categories: overview of health inequities; social and structural determinants of health; mental health and substance use disorders; access to quality health care and community resources; and chronic conditions. Secondary data used in the CHNA were compiled from a range of sources, including the American Community Survey from the U.S Census Bureau and the Healthy Chicago Survey from the Chicago Department of Public Health. Additional information about data sources can be found in Figures 6 and 7 of the [Alliance for Health Equity CHNA report](#).

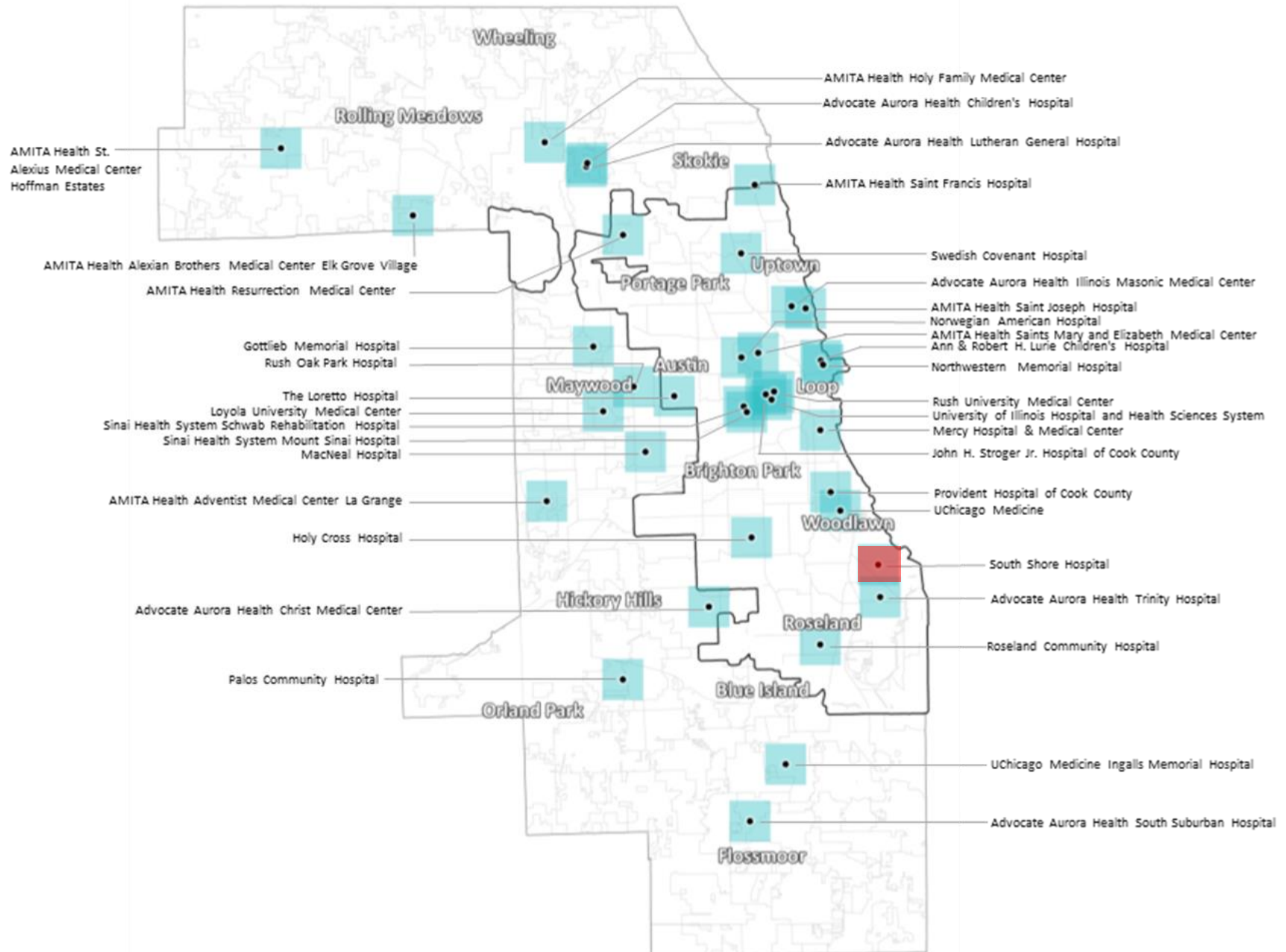
In alignment with their purpose, vision, and values, the Alliance for Health Equity prioritizes engagement of community members and community-based organizations as a critical component of assessing and addressing community health needs. Community partners have been involved in assessment, ongoing implementation, and decision-making processes (Figure 5 of AHE CHNA Report). The 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, 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.

AHE has several focus areas that different partners are working together to address including the social and structural determinants of health, mental health and substance use disorders, chronic conditions, access to care and community resources, maternal and child health, and injury prevention.

Alliance for Health Equity - Overall Community Health Focus Areas



Figure 2. Hospitals participating in the Alliance for Health Equity



III. Community Input and Key Community Health Data in Communities Served by SSH

The following section highlights primary and secondary data from South Shore Hospital’s service area.

Primary Data

Community Input Survey

The community input survey was a qualitative tool designed to understand the health needs and assets within communities. Community input surveys and focus group data combined with secondary health data informed the selection of priority areas and strategies for community health improvement. Demographics of the 454 survey respondents living within SSH’s service area are presented in Table 1.

Table 1. Demographics of Community Input Survey Respondents in South Shore Hospital Service Area.

Age (n=432)	Percent (%)
18-24	11%
25-34	14%
35-44	14%
45-54	16%
55-64	19%
65-74	16%
75-84	7%
85 or older	3%

Race/Ethnicity (n=424)	Percent (%)
Asian	0.5%
Pacific Islander	0%
African American/black	84%
Hispanic/Latinx	8%
Middle Eastern/Arab American	0.2%
Native American	0.2%
White	2%
Multiracial	6%

Sexual Orientation (n=418)	Percent (%)
Straight	93%
Gay or Lesbian	3%
Bisexual	2%
Prefer not to answer	2%
Other	0%

Children in the household (n=420)	Percent (%)
No children in my household	55%
Child/children age 0-4 in my household	12%
Child/children age 5-12 in my household	18%
Child/children age 13-17 in my household	20%

Multiple responses allowed

Annual Household Income (n=452)	Percent (%)
Less than \$10,000	15%
\$10,000 to \$19,999	11%
\$20,000 to \$39,999	18%
\$40,000 to \$59,999	15%
\$60,000 to \$79,999	11%
\$80,000 to \$99,999	4%
Over \$100,000	6%
Prefer not to answer	20%

The community survey asked residents about top health issues, top needs for a healthy community, greatest strengths in the community, and what needs to be improved.

The top health issues identified by respondents in the communities served by SSH were diabetes, mental health, violence, substance-use, age-related illness, heart disease and stroke (Figure 3). All of these health issues were selected by 25% or more of survey respondents.

Figure 3. Community Input Survey Data – Top Health Issues
(Note: 442 respondents from the SSH service area answered this question)

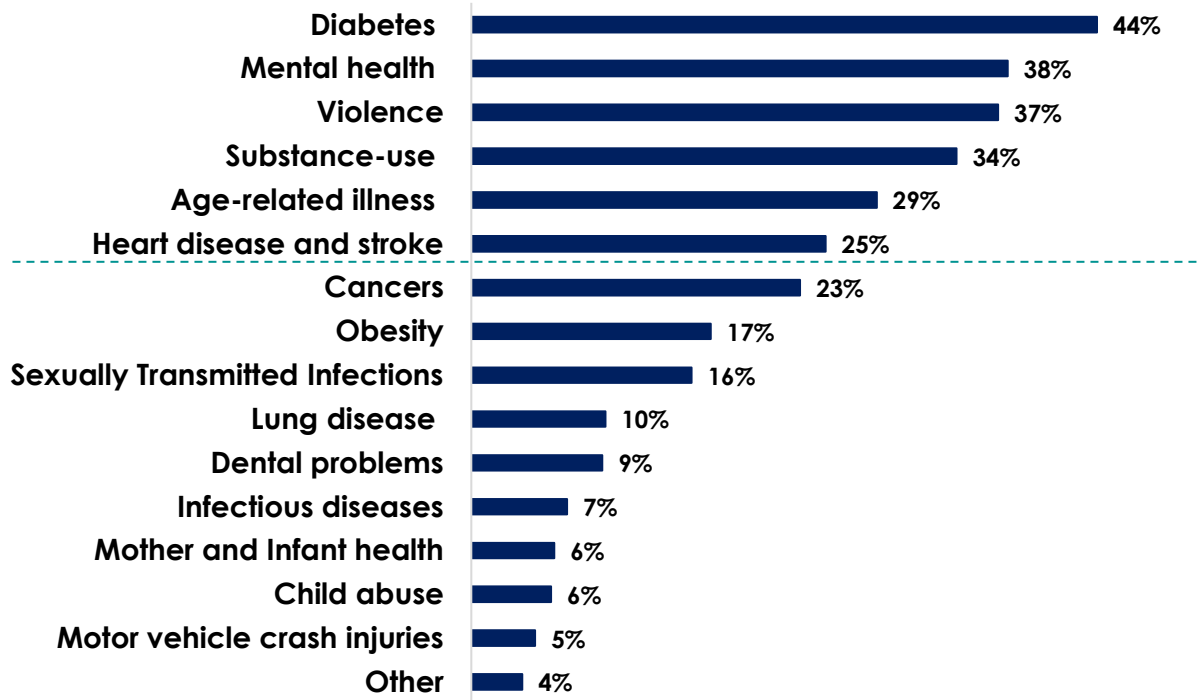


Figure 4 displays the most important factors for a healthy community identified by survey respondents from SSH's service area. This include access to healthcare and mental health services, safety and low crime, access to community services, access to healthy food, and quality job opportunities. All of these health needs were selected by 25% or more of respondents.

Figure 4. Community Input Survey Data – Most Important Factors for a Healthy Community

(Note: 431 respondents from the SSH service area answered this question)

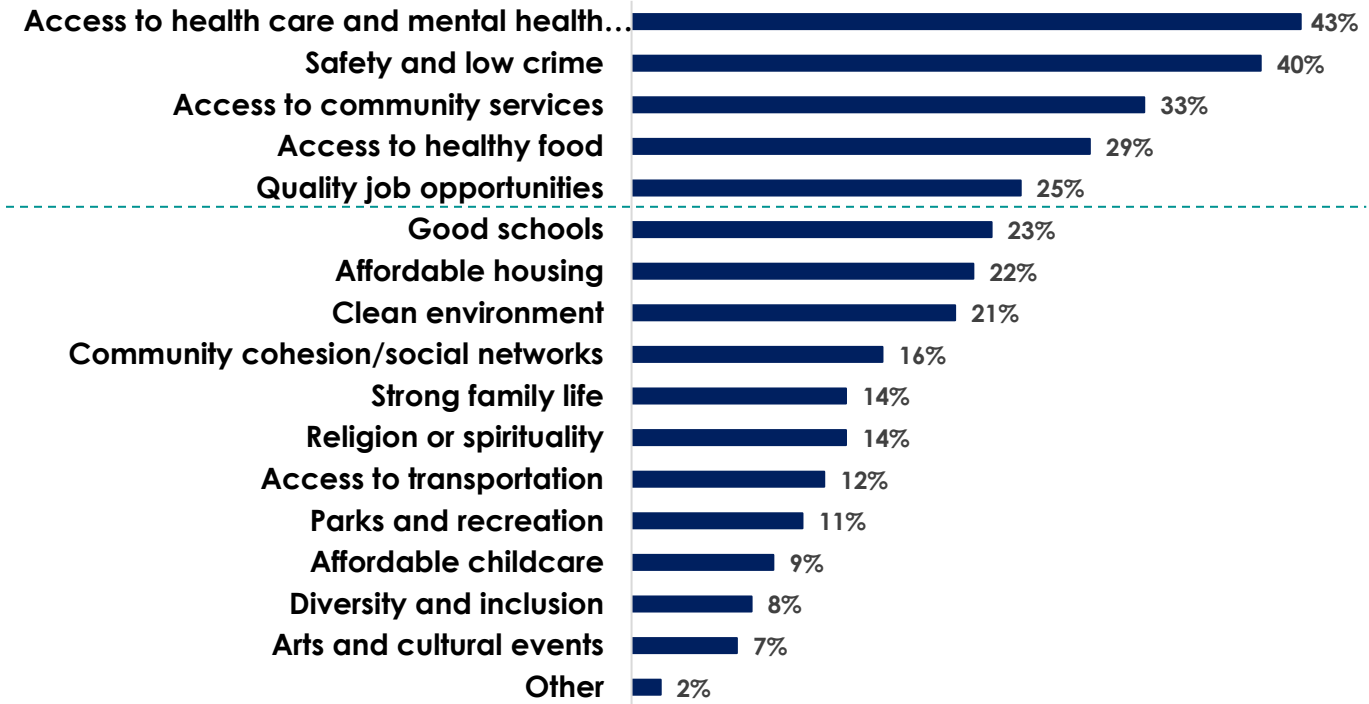


Figure 5. Community Input Survey Data – Greatest strengths and areas for improvement

What are the greatest strengths in the community where you live? (open-ended, n=442)

Responses most commonly related to the following categories:

- Community Cohesion
- Transportation
- Parks and Recreation
- Safety and Low Crime
- Education
- Accessibility

What is one thing that you would like to see improved in your community? (open-ended, n=336)

Responses most commonly related to the following categories:

- Safety and Low Crime
- Economic Development
- Health Care
- Infrastructure
- Community Cohesion
- Food Accessibility
- Cleanliness

Community Focus Groups

Between August 2018 and February 2019, Alliance for Health Equity partners collaborated to conduct a total of 57 focus groups with 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.

Thirty-six focus groups were conducted by IPHI and 21 Learning Map Sessions were led by West Side United, a regional collaboration of hospitals serving the West Side of Chicago and West Suburban Cook County, with notetaking by IPHI. IPHI developed the focus group questions using resources from existing CHNA toolkits and peer-reviewed studies, in consultation with the CHNA committee and colleagues at partner health departments. Each focus group was hosted by a hospital or community organization. The sessions were approximately 60-90 minutes long with an average of 8-12 participants. A total of 5 learning map sessions/focus groups were conducted with residents living within SSH’s service area (Table 2).

Table 2. Focus group and Learning Map Sessions conducted within SSH’s service area

Focus Group and Learning Map Sessions
ABJ Community Services
Affinity Community Services
Gary Comer Youth Center
NAMI Chicago Family Members
NAMI Chicago Individuals
Teen Living Program (<i>Currently Ignite</i>)
Theace Goldsberry Community House (x2)
Timothy Community Corporation

The major themes that emerged from focus groups on the South Side included social determinants of health, food systems, chronic diseases such as asthma and diabetes, access to care and community resources, behavioral health, and community safety and violence. Additional community input is highlighted in the secondary data section.

Social Determinants of Health

Socioeconomic inequities were mentioned by several focus groups. Inequities in community economic investment and development, employment opportunities, quality affordable housing, education opportunities, community safety, and food access were highlighted.

Employment

A lack of employment opportunities was one of the most frequently discussed issues among focus group participants. Participants living in the South regions of the county described having the least number of quality job opportunities and employment resources. However certain populations such as those living with mental illness, young adults, homeless individuals, and formerly incarcerated were highlighted as having significant barriers to employment regardless of their geographic location. In addition, multiple youth of color on the South Side described instances where they felt that their racial or ethnic background prevented them from obtaining employment. Within certain communities, jobs are available, but they are described as lacking benefits, part-time, temporary, and/or low-paying.

“I’ve been to multiple temp agencies and there is a racial tension on the job. Certain ones like black people and others don’t.”

– Community youth resident from Teen Living Program focus group

Education

Education was another widely discussed topic among focus group participants who mentioned the importance of quality education opportunities. The major education-related concerns expressed by focus group participants on the South Side of Chicago included school closures, diminishing education opportunities, and poor-quality schools. Youth on the South Side of Chicago mentioned that school closures have led to more student dropouts. Multiple adult participants across Chicago mentioned serious concerns about the quality of Chicago schools, particularly schools that are majority students of color. Participants identified education as an underlying root cause of unemployment. Additionally, they linked education issues to many of the same problems caused by unemployment such as higher rates of community violence, increases in health issues such as substance use disorders and mental illness, and generational poverty.

Housing

Homelessness and housing instability are associated with high rates of mortality and morbidity (Kushel, Gupta, Gee, & Haas, 2006). Housing instability does not have a standard definition and encompasses several issues including difficulty paying rent, overcrowding, frequent moves, living with relatives, and cost-burdened housing (Frederick, Chwalek, Hughes, Karabanow, & Kidd, 2014; Kushel et al., 2006).

Focus group participants on the South Side of Chicago highlighted that segregation results in poor quality housing being concentrated in communities of color with high rates of violence and poverty. Some of the housing quality issues mentioned included dilapidated and crumbling structures, incomplete units, plumbing problems, and pest infestations. Renters described how these issues can be left unaddressed by landlords and property owners for extended periods of time or indefinitely. Some homeowners described these issues within their own homes but stated that they lacked the financial resources to address them. The health problems that were most often associated with these housing quality problems included exposure to mold, asthma, and stress. Children were identified as being at a higher risk for health problems associated with poor quality housing. A further complication is that several residents reported living in buildings where smoking is allowed within units and explained that this can further exacerbate health issues such as asthma.

Homelessness

Adults and youth who are experiencing homelessness and housing instability reported several health problems that were a direct result including hypothermia, frost bite, severe weight fluctuations, gangrene, poor sleeping habits, and severe stress. Behavioral health conditions such as mental illness and substance use disorders were identified as both a cause of homelessness and the direct result of homelessness or housing instability.

“Not having the right shelter to go to. There are a lot of bad shelters where people do things you don’t want to be involved in.”

- Community resident from Teen Living Program focus group

Homeless shelters and housing services were difficult to access for some community members. Homeless youth reported that shelters are particularly dangerous for teens and young adults and that they often resorted to staying on the streets or breaking into abandoned houses as an alternative. Multiple homeless teenage youth under age 18 reported being turned away from shelters in favor of families with children. They explained that they felt it was often due to them being young men of color. As a result, youth emphasized the need for more youth-specific services and homeless resources.

Food Systems

Participants on the West and South Sides of the city county reported a high proportion of fast food restaurants and limited access to grocery stores selling healthier options. Community members living with chronic diseases such as diabetes explained that living in communities with less access to healthy food options and more access to fast food made it more difficult to manage their conditions.

Both youth and adults from multiple communities reported that having a healthy diet can be difficult for several other reasons as well including:

- youth often find healthy foods unappealing particularly if they have had limited exposure to them;
- the cost of healthy foods was frequently described as a barrier, but there was often disagreement among groups on this issue;
- food pantries do not always provide healthy options;
- fast foods are more convenient particularly for working parents with children; and
- many lack the knowledge of how to prepare healthy meals.

“I work out a lot but I'm not always good with food. It is expensive to eat healthy food, but it is more expensive to be sick. It scares me because unhealthy food is there. You eat things just because you want to eat late at night.”

- ***Community resident from Timothy Community Corporation focus group***

Community Safety and Violence

Community safety and violence was a cross-cutting theme that mentioned by multiple focus groups in a variety of contexts. The mostly commonly mentioned safety issues included gun violence, gang activity, drug-related activities, burglaries, and armed robberies. Participants related that the prevalence of violence in their communities has led to health issues such as chronic stress, decreased mental well-being, trauma among children and adults, and decreased physical activity due to a reluctance to exercise in unsafe neighborhoods.

Behavioral Health

A major theme that emerged from the focus groups was chronic stress. Focus group participants linked chronic stress to several different health effects. Community members reported that stress impacted their ability to cope with chronic illnesses such as diabetes and could disrupt their ability to engage in behaviors such as healthy eating and exercise. Parents caring for children with asthma reported that the stress of caring for a family member had negative impacts on their mental and physical well-being. Youth living with asthma reported that stress was a trigger for their asthma attacks. Participants from one focus group directly linked chronic stress to the development of substance use disorders.

In addition to chronic stress, focus group participants described multiple situations that have led to trauma among community members living on the South Side including:

- child abuse,
- domestic violence,
- living in high crime neighborhoods,
- continual discrimination against marginalized racial and ethnic groups, and
- homelessness.

“Everyone in the city is suffering from some level of trauma due to fear”

- ***Community resident from Affinity Community Services focus group***

Chronic Diseases

In addition to behavioral health, chronic diseases such as asthma and diabetes were identified as major health priorities for South Side community members. The major themes that were mentioned by participants included:

- social determinants of health such as poverty, limited access to healthy foods, exposure to violence, and housing conditions are both underlying root causes of chronic disease and are barriers to the management of chronic disease;
- education about preventing chronic disease, risk factors, and when to seek medical help is lacking in communities;
- chronic illness such as asthma can be isolating for youth, parents, and adults;

- taking care of a child with a life-threatening chronic illness can often cause severe chronic stress; and
- community groups that share information about resources and support each other with adjusting to healthier lifestyles would be extremely helpful to communities.

Access to care and community resources

Multiple participants on the South Side of Chicago mentioned barriers that impede their ability to access the healthcare system and community resources including:

- the complexity of obtaining and keeping public benefit coverage;
- the high cost of some private insurance plans;
- an unequal distribution of healthcare services and facilities; and
- poor quality healthcare options particularly for LGBTQ+ individuals and people of color.

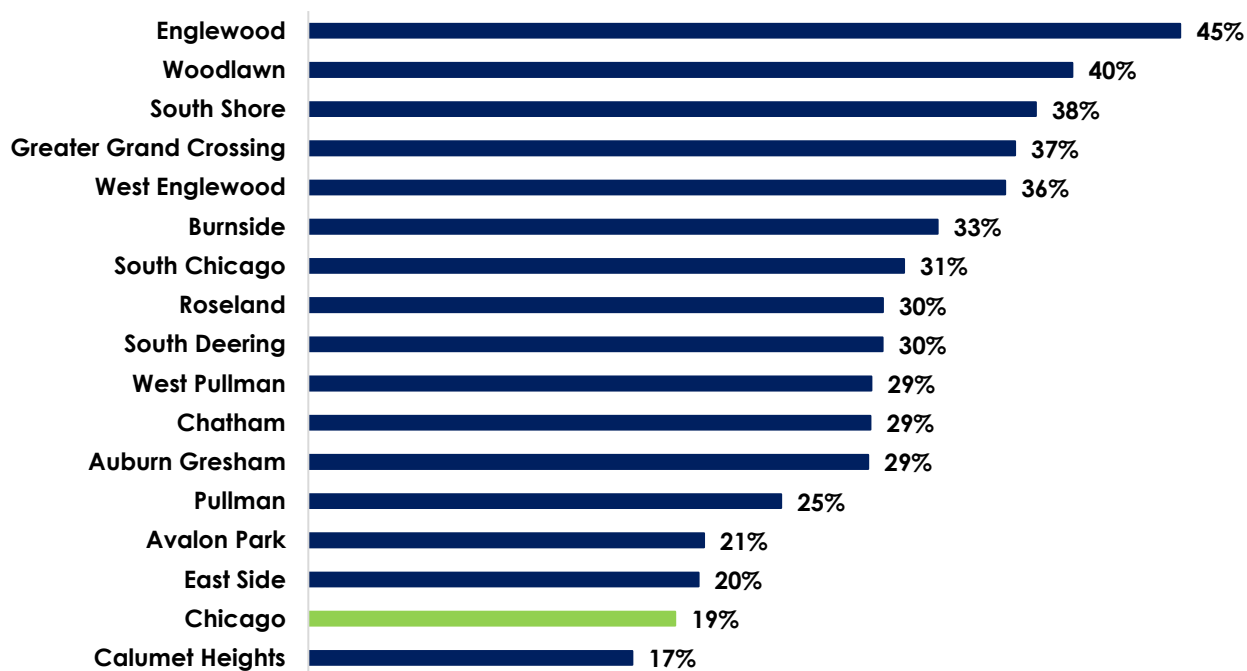
Secondary Data

The following section highlights key data pertaining to social determinants of health including socioeconomic factors, housing, food insecurity, community belonging, and health outcomes. These quantitative data findings are supported by community members' input during focus group sessions.

Poverty

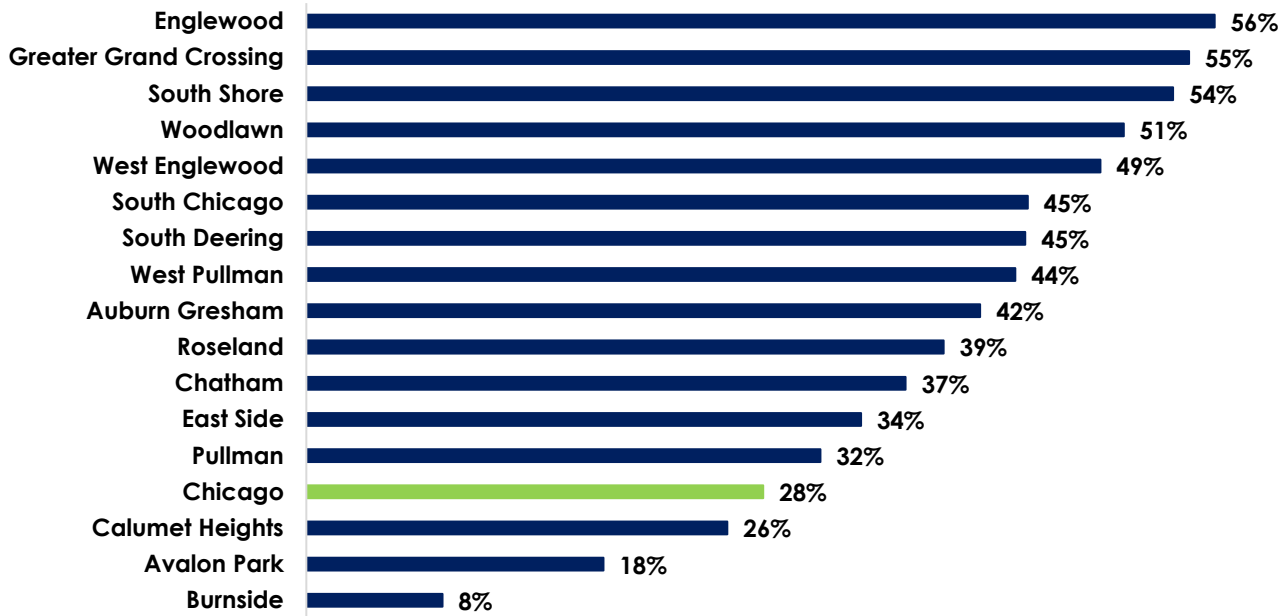
Figures 6 and 7 present poverty rates for the communities in South Shore Hospital's service area. In SSH's service area, the number of people living at or below 100% of the federal poverty level ranges from 17% in Calumet Heights to 45% in Englewood. With the exception of Calumet Heights, all of the communities in SSH's service area have poverty rates higher than that of the overall citywide and Suburban Cook County South region (19% and 18% respectively). There is an extreme disparity in poverty rates among households with children within SSH's service area, with over half of children living in poverty in Woodlawn, South Shore, Greater Grand Crossing, and Englewood.

Figure 6. Percentage of persons in poverty (100% Federal Poverty Level-FPL), 2012-2016



Data Source: American Community Survey, 2012-2016

Figure 7. Percentage of children in poverty, (100% Federal Poverty Level-FPL), 2012-2016



Data Source: American Community Survey, 2012-2016

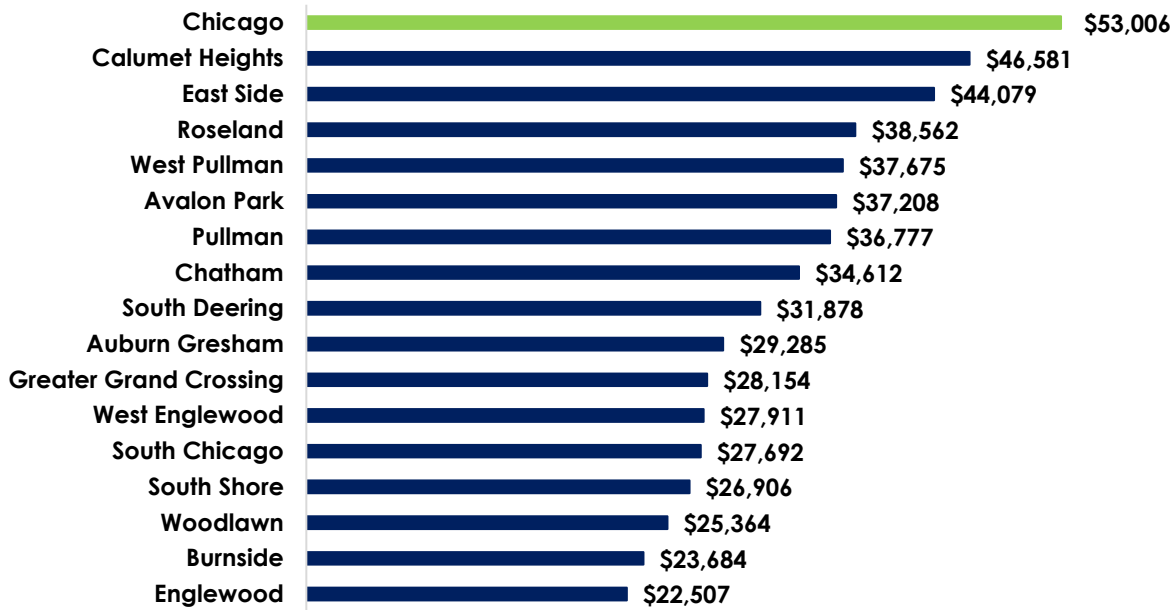
Income and Unemployment

All of the communities within SSH’s service area have a median household income that is less than the citywide median household income of \$53,000 (American Community Survey, 2012-2016 5-year estimates, U.S. Census Bureau). Unemployment rates within SSH’s service area are higher than the citywide rate of 8%. The unemployment rate in West Englewood and Englewood is four times greater at 34% and 35% respectively. Unemployment can create financial instability, and, as a result, can create barriers to accessing healthcare services, insurance, healthy foods, and other basic needs.

“There are a lot of single parent households and they have access to some jobs but not jobs that allow you to take care of a household.”

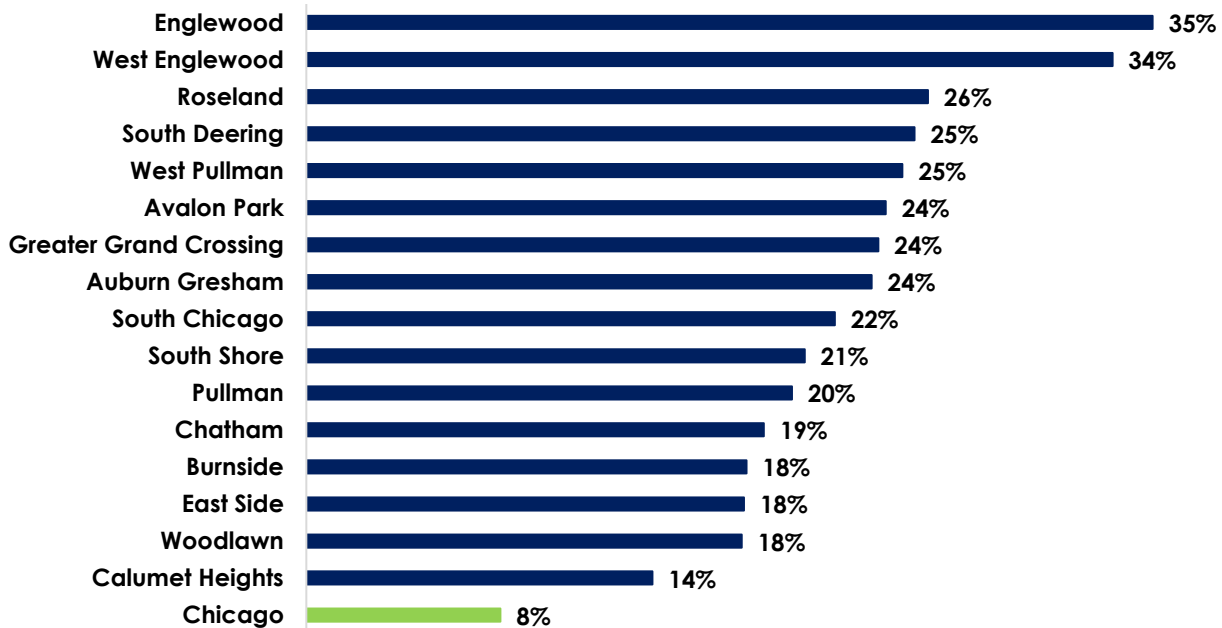
– Community resident from NAMI Chicago Family focus group session

Figure 8. Median household income in the past 12 months (in inflation-adjusted dollars)



Data Source: American Community Survey, 2012-2016

Figure 9. Percentage of unemployed adults 16 years and over in the civilian labor force

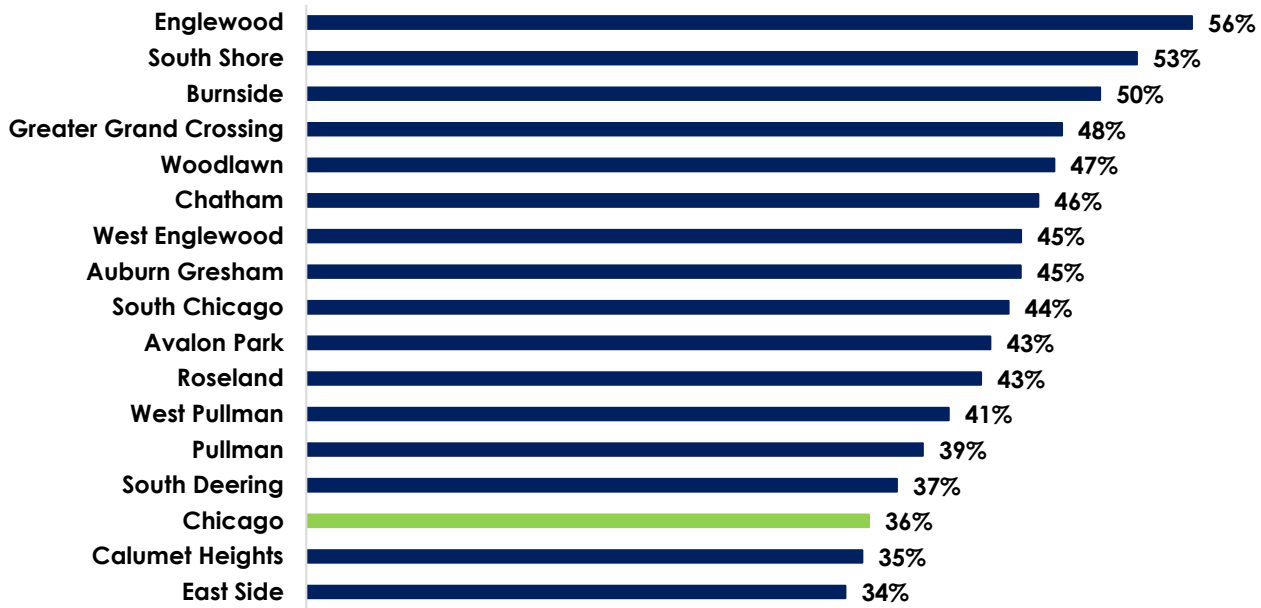


Data Source: American Community Survey, 2012-2016

Housing

Housing is considered to be cost-burdened when a household’s housing costs exceed 30% of that household’s total income. Most of the communities within South Shore Hospital’s service area have a higher cost-burdened rate than the city of Chicago at 36%. The percentage of cost-burdened of households is extremely high with 12 communities having a rate higher than 40%. Being cost-burdened can lead to detrimental health trade-offs such as not being able to afford food or medications.

Figure 10. Percentage of cost-burdened households (housing costs exceed 30% of household income)

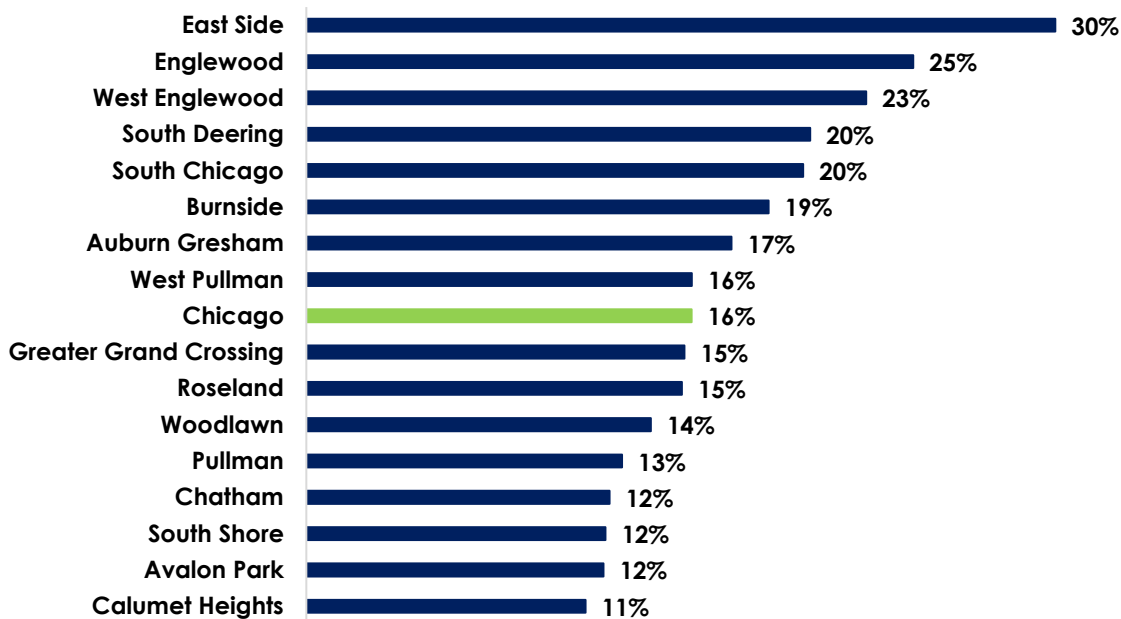


Data Source: American Community Survey, 2012-2016

Education

Education is an important social determinant of health, because the rate of poverty is higher among those without a high school diploma or GED. The rates of individuals with less than a high school diploma or equivalent within the communities of SSH’s service area range between 11% and 30%. Eight communities have rates higher than the citywide rate of 16% with West Englewood, Englewood, and East Side each having a rate higher than 20%.

Figure 11. Percentage of Individuals with Less Than a High School Diploma or Equivalent, 2012-2016

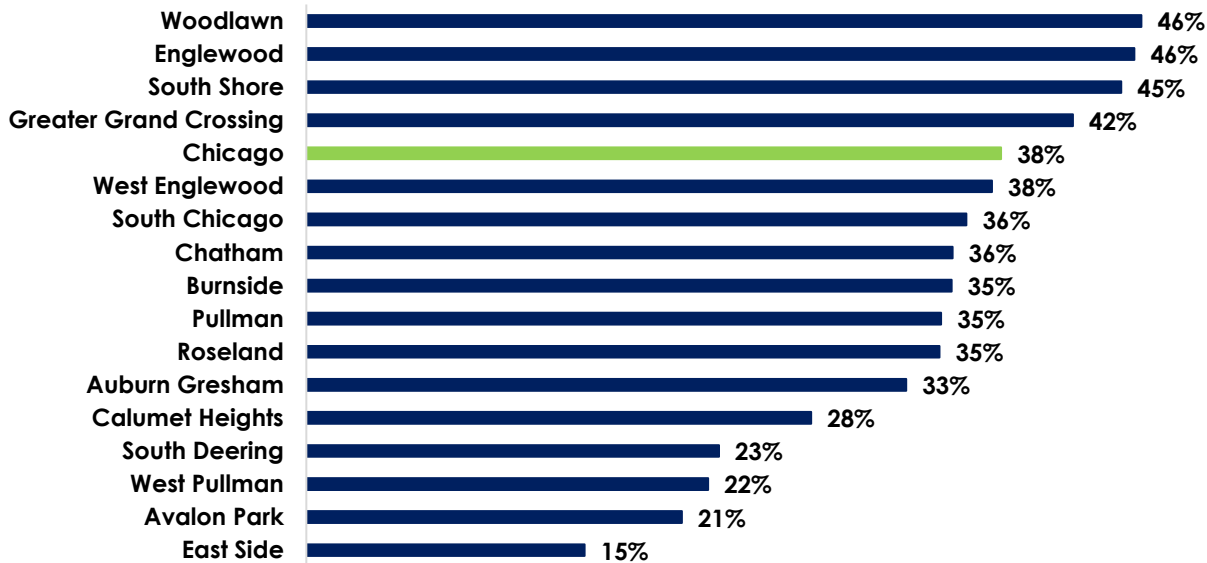


Data Source: American Community Survey, 2012-2016

Commuters Using Active Transportation

Active transportation (commuting to work by walking, biking, or public transit) is another important social determinant of health. Active transportation varies considerably between the communities in SSH’s service area. Workers who reside in Woodlawn (46%), Englewood (46%), South Shore (45%), and Greater Grand Crossing (42%) report using active transportation at higher rates than the citywide rate of 38%. Conversely, workers in East Side have the lowest rate of workers using active transportation at 15%.

Figure 12. Percentage of workers aged 16 years and older who commute to work by walking, biking, or public transit

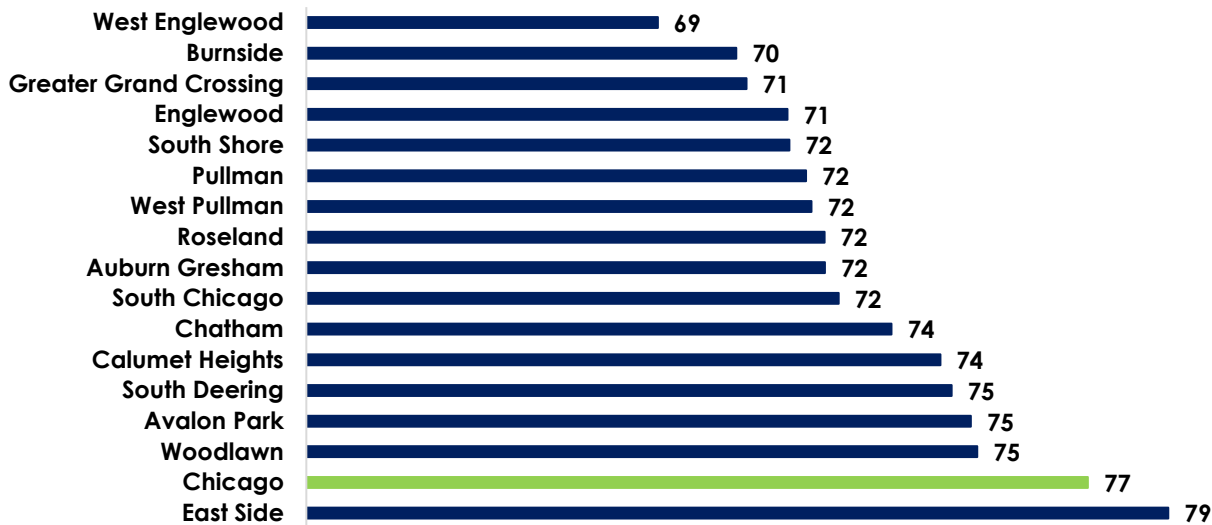


Data Source: American Community Survey, 2012-2016

Life Expectancy

Life expectancy is the average number of years an individual is expected to live. There are significant disparities in life expectancy within South Shore Hospital’s service area. Life expectancy in West Englewood is ten years shorter than in East Side at 69 years and 79 years respectively. With the exception of East Side, all community areas in South Shore Hospital’s service area have lower life expectancies than the citywide life expectancy of 77 years.

Figure 13. Life expectancy at birth within South Shore Hospital’s service area (in years)

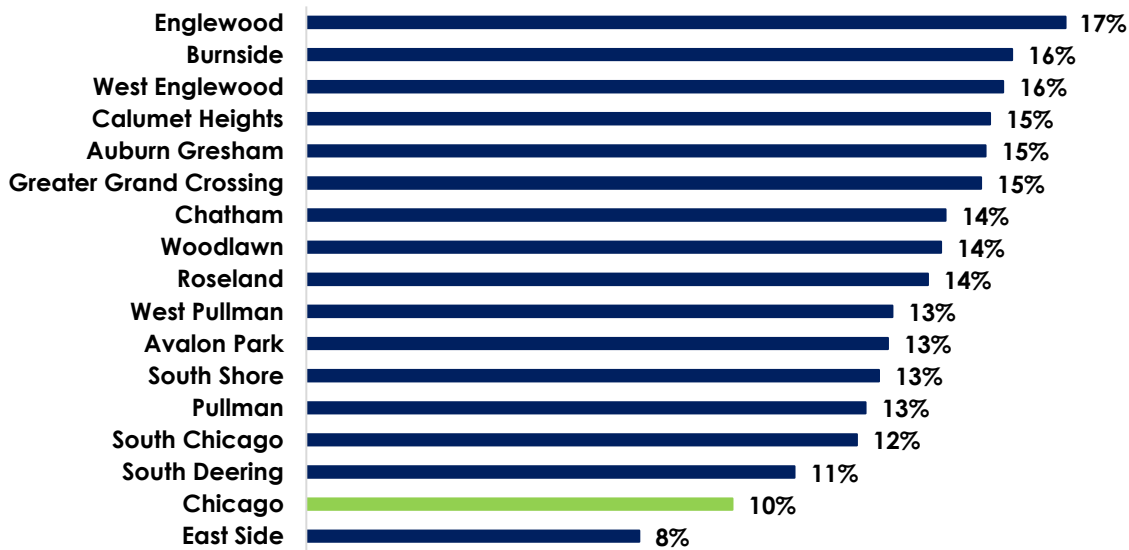


Data Source: CDPH, CCDPH, IDPH Vital Stats, 2016

Maternal and Child Health

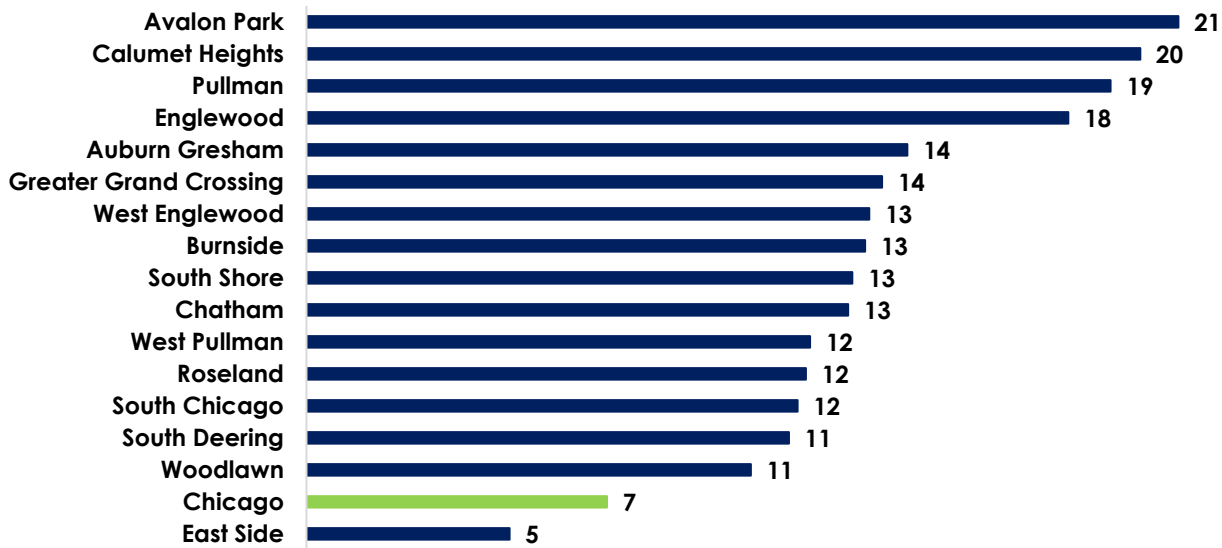
The following graphs illustrate the overall inequities in maternal and child health across the communities served by South Shore Hospital. With the exception of East Side, all communities in SSH’s service area have higher rates of low birthweight and infant mortality compared to the citywide rates. Percent of births with low birthweight ranges between 8% in East Side to 17% in Englewood. The rate of infant mortality follows a similar trend with East Side having the lowest rate at five infant deaths per 1,000 births and all other communities within SSH’s service area having an infant mortality rate greater than the citywide rate of 10 infant deaths per 1,000 births. All communities within SSH’s service area have higher rates of teen birth than the citywide rate.

Figure 14. Low Birthweight (Percent of births with a birthweight less than 2,500 grams among the total number of number of births)



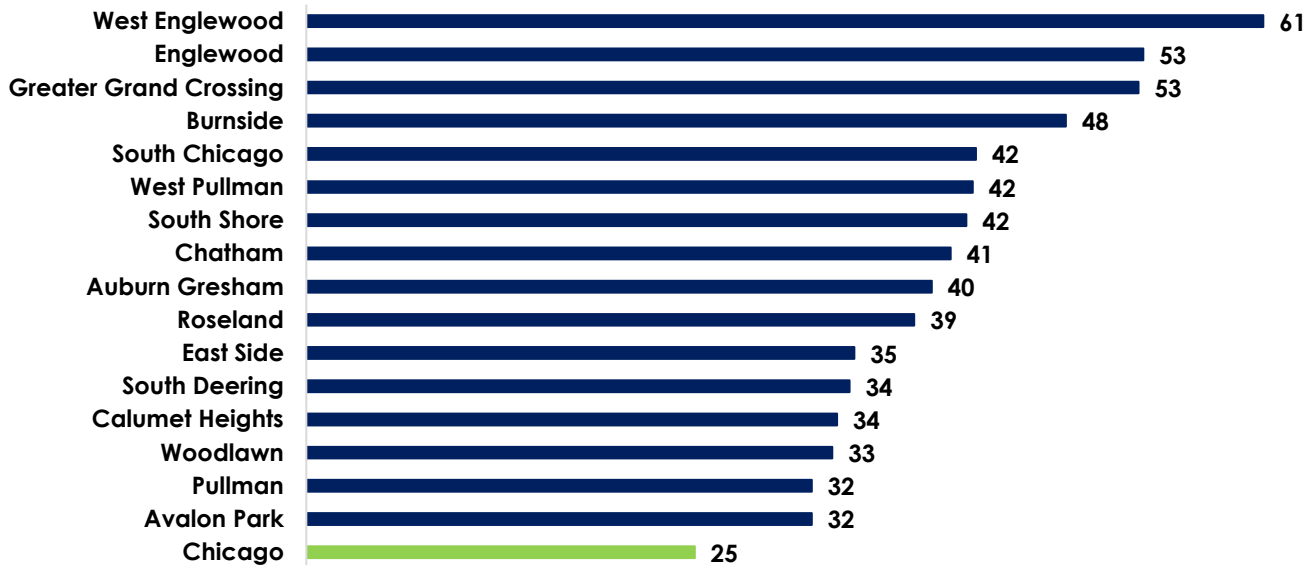
Data Source: CDPH, CCDPH, IDPH Vital Stats, 2012-2016

Figure 15. Infant mortality (Number of deaths of infants less than one year old per 1,000 live births)



Data Source: CDPH, CCDPH, IDPH Vital Stats, 2012-2016

Figure 16. Teen births (Total births where the mother's age is 15-19 years of age at time of delivery per 1,000 population of females aged 15-19 years)



Data Source: CDPH, CCDPH, IDPH Vital Stats, 2012-2016

Medical Professional Shortages

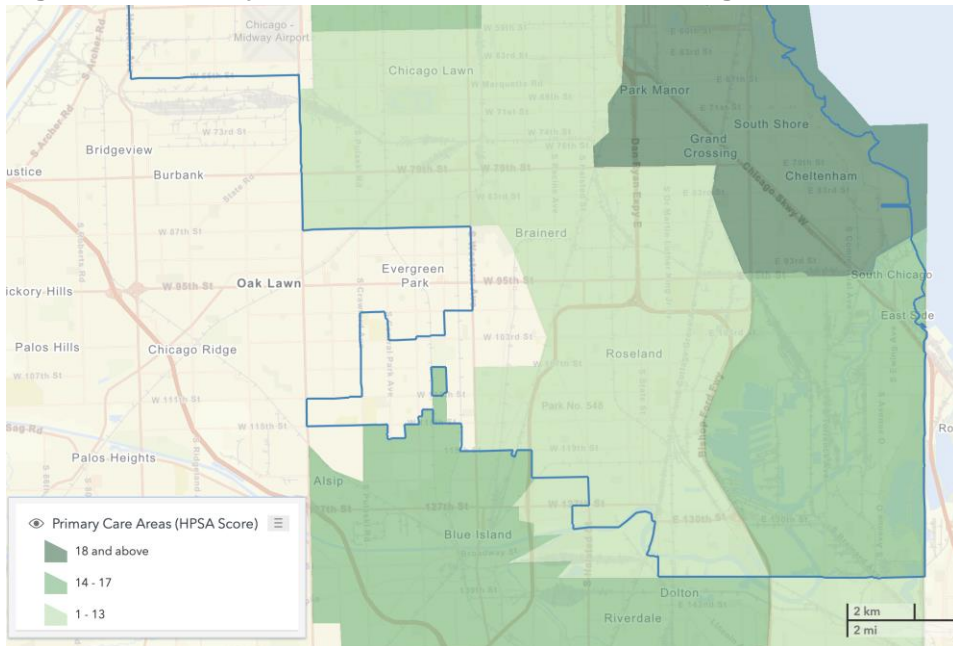
Health Professional Shortage Areas (HPSAs) are geographic areas of health care provider shortages in primary care, mental health, or dental health. Primary care and mental health HPSAs are scored on a scale of 0-25 with higher scores indicating greater need.¹ As shown in Figure 17, the communities of South Shore Hospital’s service area, particularly South Shore Greater Grand Crossing, South Chicago, and East Side are in great need of primary care health providers. In regard to mental health, all communities in SSH’s service area have mental health professional shortages as indicated in Figure 18.

¹ Health Professional Shortage Areas (HPSAs). (May 2019). Retrieved from: <https://bhw.hrsa.gov/shortage-designation/hpsas-on-October-31>, 2019.

“Patients need to have access to healthcare financially, geographically, and logistically”

- **Community resident from citywide NAMI Chicago – Family focus group**

Figure 17. Primary Care Health Professional Shortage Area

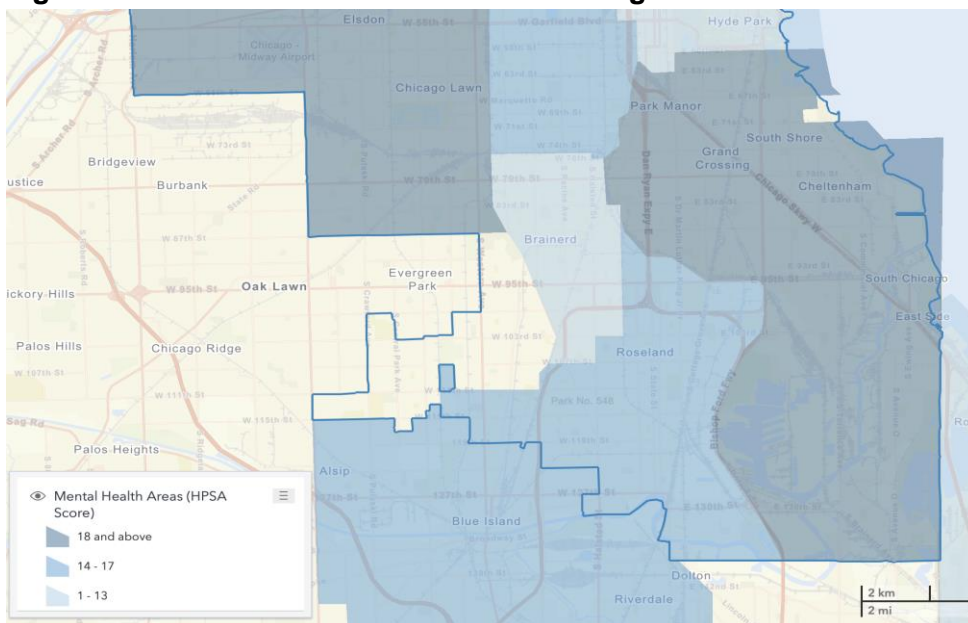


Source : <https://data.hrsa.gov/maps/map-tool/>

“It is unlike any city I've been to. I drive to Wisconsin to see a psychiatrist once a month because I can't find a psychiatrist, even with insurance.”

- **Community resident from citywide NAMI Chicago – Individual focus group**

Figure 18. Mental Health Professional Shortage Area

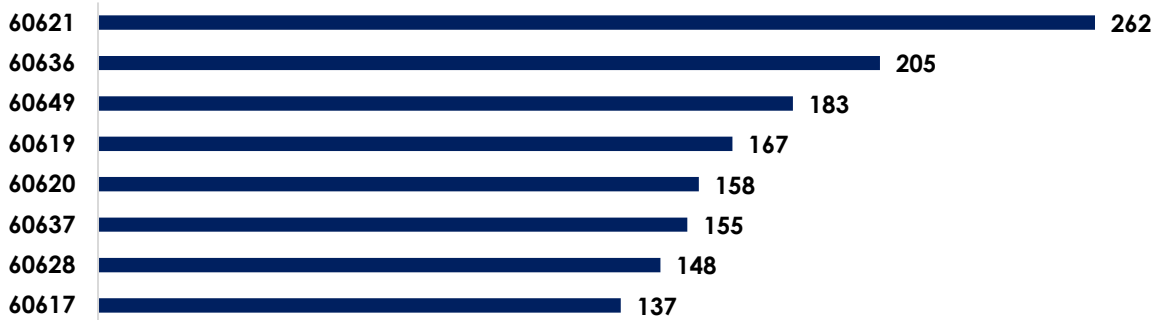


Source : <https://data.hrsa.gov/maps/map-tool/>

Mental Health and Substance Use Disorders

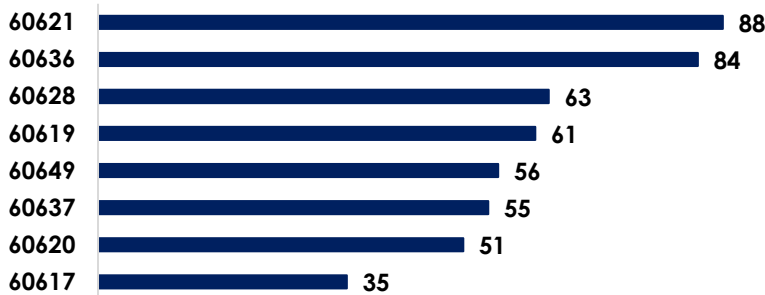
Mental Health provider shortages are experienced across the SSH service area. The rate of emergency room usage due to mental health is relatively high in SSH's service area and varies greatly between zip codes. The lowest rate is 137 per 10,000 persons in zip code 60617 and the highest is 262 per 10,000 persons in zip code 60621 (Figure 19). The rate of emergency room usage due to substance use ranges from 35 per 10,000 persons in zip code 60617 and 88 per 10,000 persons in zip code 60621 (Figure 20).

Figure 19. Emergency Department visits due to Mental Health among adults, (age-adjusted rate per 10,000)



Data Source: Illinois Hospital Association COMPdata, 2015-2017 (Healthy Communities Institute analysis)

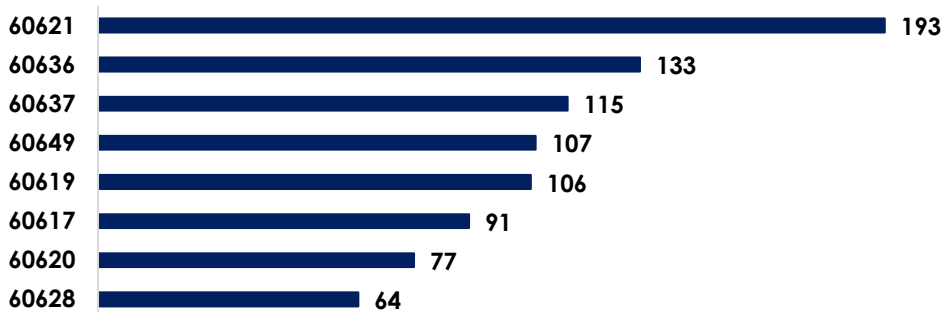
Figure 20. Emergency Department Rate due to Substance Abuse, (age-adjusted rate per 10,000)



Data Source: Illinois Hospital Association COMPdata, 2015-2017 (Healthy Communities Institute analysis)

Emergency room usage due to alcohol is somewhat high in SSH's service area with five out of eight zip code areas having rates higher than 100 per 10,000 persons.

Figure 21. Emergency Department Rate due to Alcohol, (age-adjusted rate per 10,000)



Data Source: Illinois Hospital Association COMPdata, 2015-2017 (Healthy Communities Institute analysis)

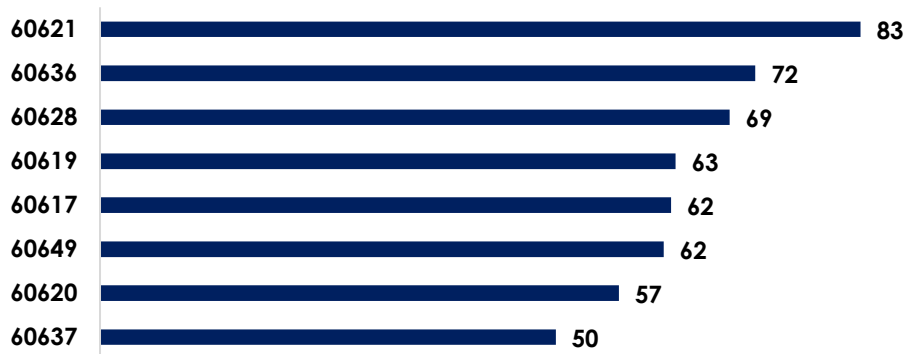
Leading Causes of Death and Chronic Disease Risk Factors

Rates of obesity and overweight adults in Chicago are similar to national rates; 39.8% of adults reported being overweight, and 31% of adults reported obesity in Chicago for the time period between 2015 and 2017. With the exception of Pullman, all communities served by SSH have obesity rates higher than the citywide rate. The rate of self-reported diabetes in Chicago is 9% among adults, and the rates are higher in almost all of the communities within SSH’s service area. The rate of emergency department visits due to diabetes is high in zip code 60621 at a rate of 83 per 10,000 people.

“We need to change the generational curse. Families keep quiet about what occurs in our families. You can have a mother pass away and the family doesn't know that they died of - diabetes or cancer. We need to change that tradition of being quiet so that we can save some people. We as a community don't talk about what is hurting our family's health wise.”

- Community resident from Timothy Community Corporation – South Side of Chicago focus group

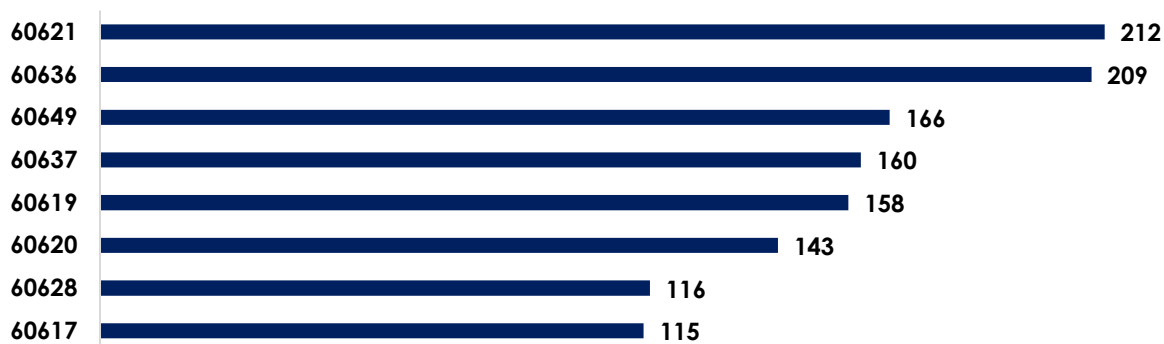
Figure 22. Emergency Department (ED) Rate due to Diabetes, (age-adjusted rate per 10,000)



Data Source: Illinois Hospital Association COMPdata, 2015-2017 (Healthy Communities Institute analysis)

Emergency department visits due to asthma are particularly high in the SSH service area. Every zip code in SSH’s service area has more than 100 per 10,000 emergency department visits due to asthma, with zip codes 60636 and 60621 having greater than 200 per 10,000 per persons.

Figure 23. Emergency Department (ED) Rate due to Asthma, (age-adjusted rate per 10,000)



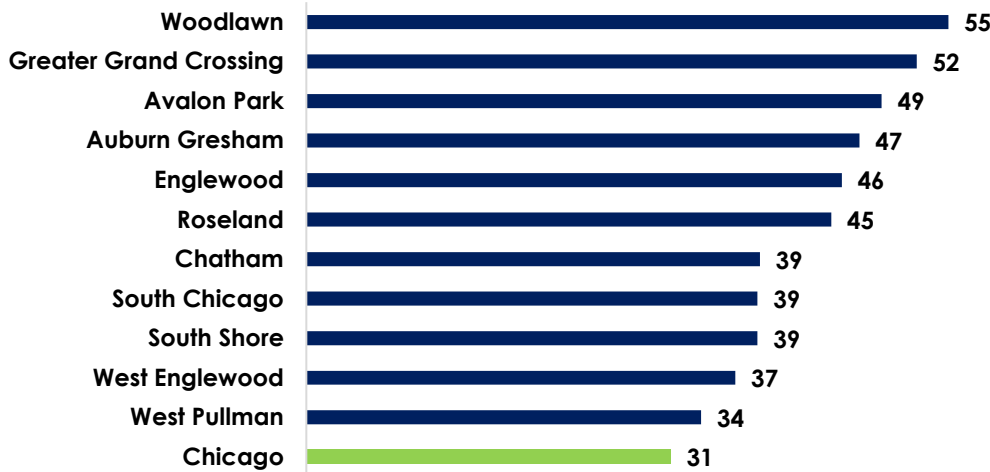
Data Source: Illinois Hospital Association COMPdata, 2015-2017 (Healthy Communities Institute analysis)

HIV

In 2017, the total amount of new diagnosis of HIV in Chicago was significantly lower than the previous year. However, HIV still disproportionately affects individuals aged 20-29, men, Non-Hispanic African American/blacks, and men who have sex with men (MSM)². As shown in Figure 24, all of the communities within SSH’s service area have a higher rate of individuals newly diagnosed with HIV compared to the citywide rate of 31 per 100,000 persons. Six communities in SSH’s service area have higher rates of individuals living with HIV (prevalence) than the citywide rate, with South Shore having the rate at 1,271 per 100,000 persons.

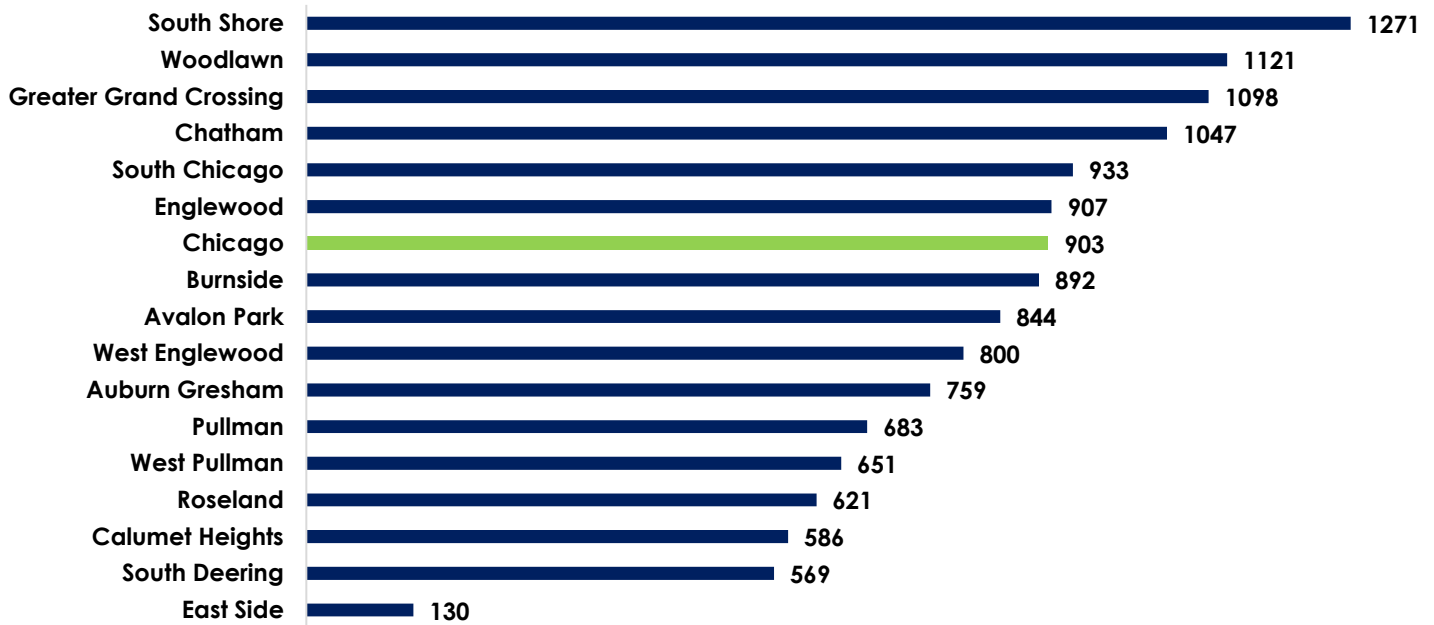
Figure 24. Crude rate of people newly diagnosed with HIV per 100,000 people

Data for Burnside, Calumet Heights, Pullman, South Deering, East Side not available.



Data Source: Healthy Chicago Survey, Chicago Department of Public Health, 2016

Figure 25. Crude rate of people living with HIV per 100,000 people



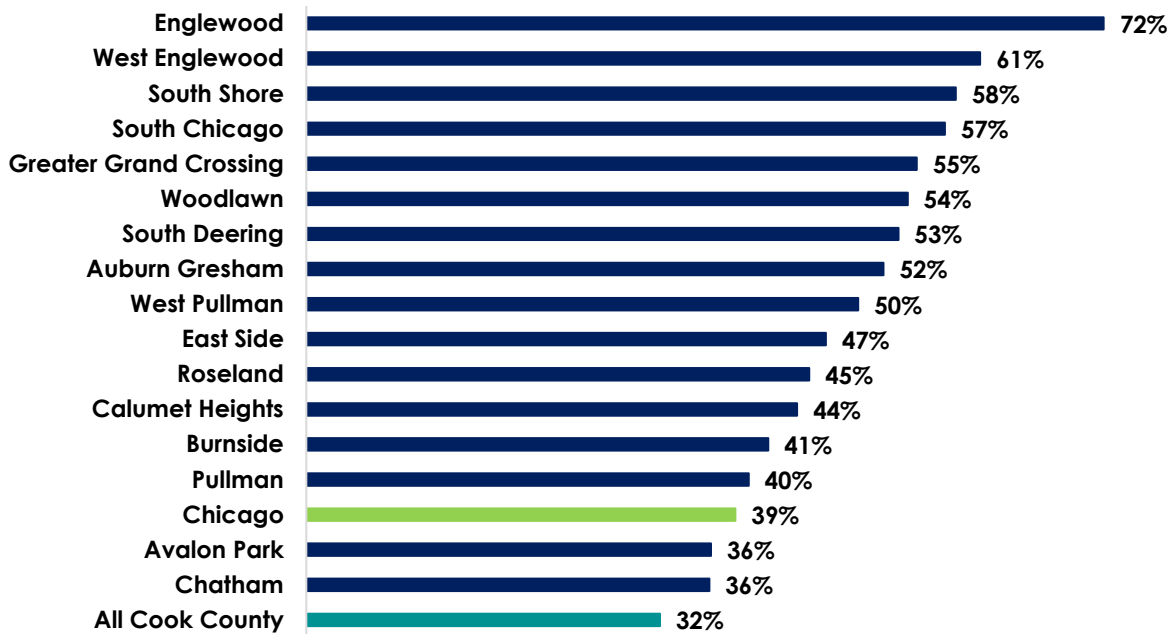
Data Source: Healthy Chicago Survey, Chicago Department of Public Health, 2016

² Chicago Department of Public Health. HIV/STI Surveillance Report 2017. Chicago, IL: City of Chicago, December 2018.

Food Insecurity and Food Access

Risk of food insecurity disproportionately affects almost all of the communities within SSH's service area at alarmingly high rates. With the exception of Chatham and Avalon Park, all of the communities in SSH's service area have a risk higher than the citywide risk of 39%. Englewood has the highest risk of food insecurity at 72%.

Figure 26. Risk (Percent) of Food Insecurity



Data Source: US Census Bureau, American Community Survey 2013-2017

Health Behaviors Related to Food

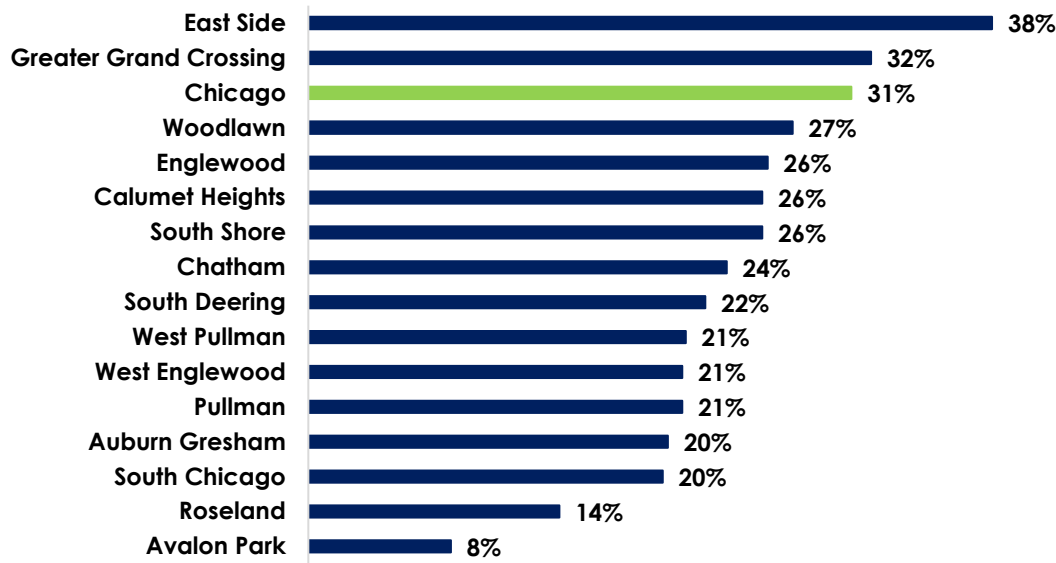
There is significant disparity in the consumption of the recommended five or more servings of fruits and vegetables among those that reside in SSH's service area. Most of the communities that SSH serves have a lower percentage of fruit and vegetable consumption than the citywide percentage of 31% with Roseland and Avalon Park reporting the lowest percentages, at 14% and 8% respectively (Figure 27). All of the communities in SSH's service area have higher percentages of daily sweetened beverage consumption than the citywide percentage of 26% (Figure 28).

“Healthy food is not normalized for us - you say fried chicken, and everyone knows what that is - the first time I heard quinoa, I didn't know what it was.”

- Community resident from Gary Comer Youth Center focus group

Figure 27. Percentage of adults who reported eating five or more servings of fruits and vegetables (combined) daily

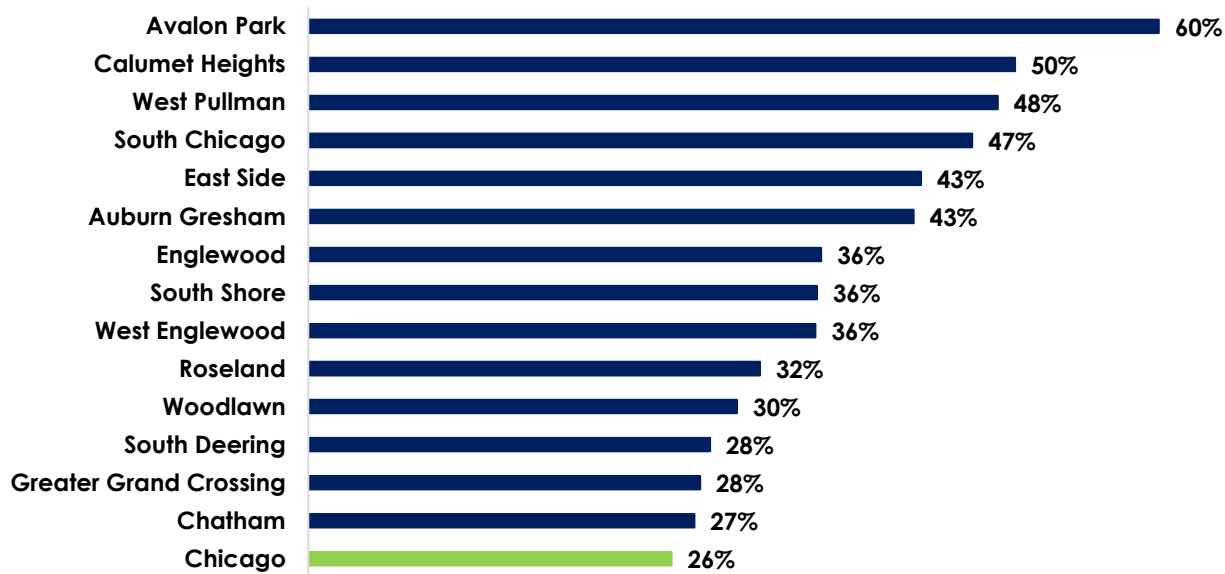
Data for Burnside not available.



Data Source: Healthy Chicago Survey, Chicago Department of Public Health, 2015-2017

Figure 28. Percentage of adults who drank soda or pop or other sweetened drinks like sweetened iced tea, sports drinks, fruit punch or other fruit-flavored drinks at least once per day in the past month

Data for Burnside and Pullman not available.



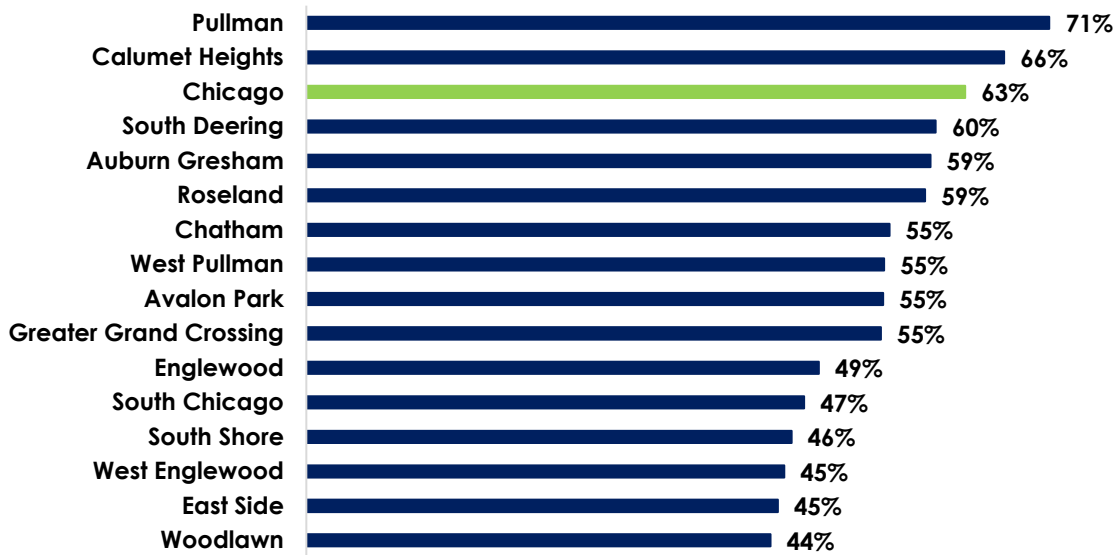
Data Source: Healthy Chicago Survey, Chicago Department of Public Health, 2015-2017

Community Belonging/Engagement

Within SSH’s service area, most communities report a sense of community belonging. The communities of Calumet Heights and Pullman report a higher percentage than the citywide rate of 63%.

Figure 29. Percentage of adults who reported that they strongly agree or agree that they really feel part of their neighborhood

Data for Burnside not available.



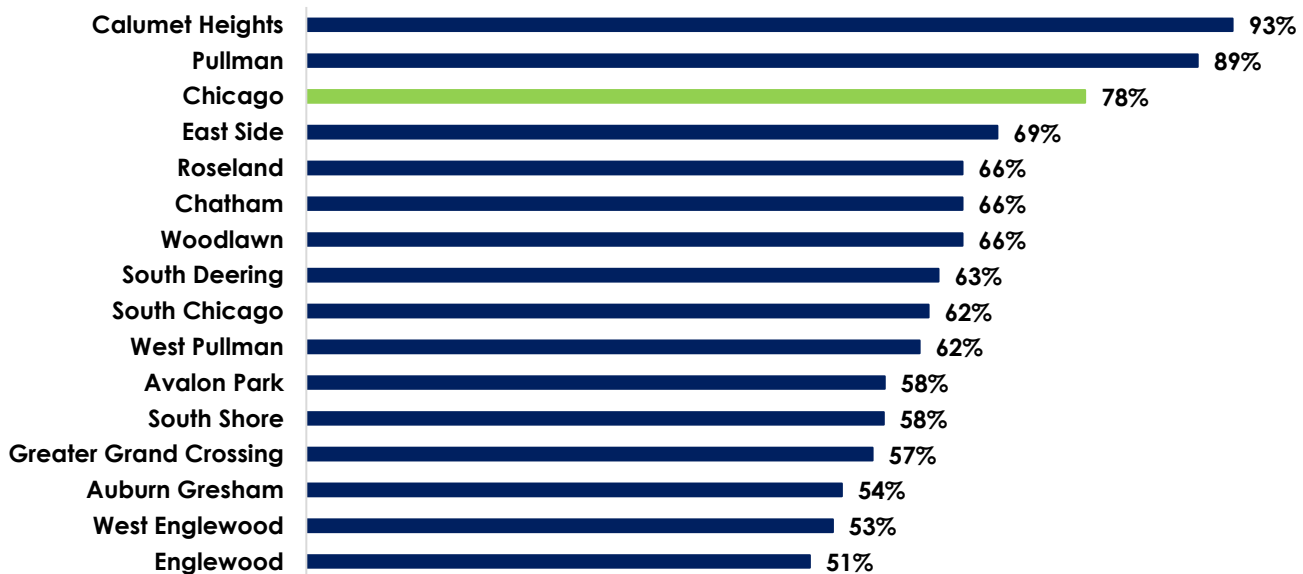
Data Source: Healthy Chicago Survey, Chicago Department of Public Health, 2016-2018

Community Safety and Violence

Communities around SSH’s service area report a wide range of perceived neighborhood safety (Figure 30). Calumet Heights and Pullman report higher rates of perceived neighborhood safety than the citywide rate of 78% (93% and 89% respectively). With the exception of East Side, all communities within SSH’s service area have a higher rate of violent crimes compared to the citywide rate (Figure 31).

Figure 30. Estimated Percent of Adults who Report Feeling Safe in their neighborhood all of the time or most of the time

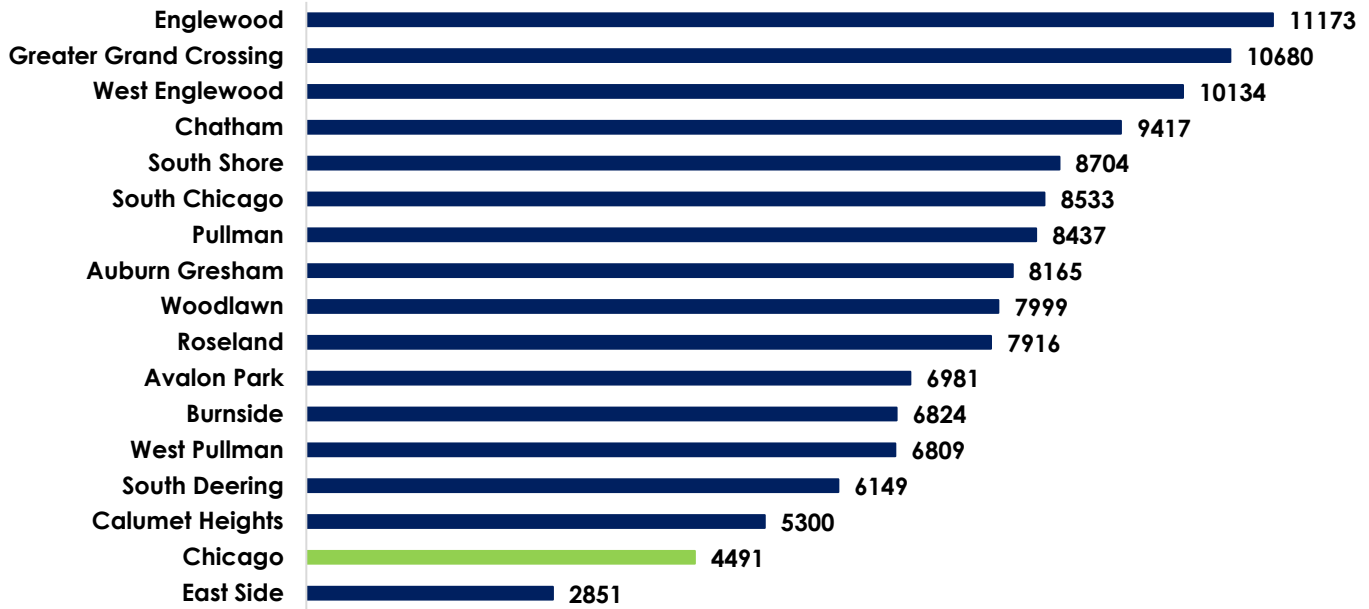
Data for Burnside not available.



Data Source: Healthy Chicago Survey, Chicago Department of Public Health, 2015-2017

Figure 31. Crude violent crime* rates (per 100,000 population)

*Crime incidents relating to violence including homicide, criminal sexual assault, robbery, aggravated assault, and aggravated battery



Data Source: Chicago Police Department, 2016

“My mom has been stuck up a couple times [while running] and she is scared. She saw a guy trying to hurt his girlfriend and she had to hide in a park bathroom and call the police.”

- Community resident from Gary Comer Youth Center focus group

IV. Summary of South Shore Hospital's Previous CHNA Implementation Activities, 2013-2016

Based on the 2016 CHNA, SSH identified four focus areas for implementation:

- Chronic Disease: Preventing and reducing chronic disease;
- Access: Increasing access to care and community resources;
- Behavioral Health: Improving mental health and reducing substance abuse; and
- Social Determinants: Improving social, economic, and structural determinants of health.

South Shore Hospital prioritized these needs to address throughout the 2016-2019 implementation cycle because they were deemed the most pressing, under-addressed, and within South Shore Hospital's ability to influence. The following is a summary of community health implementation activities carried out during the period 2016-2019.

Mental Health Treatment and Referrals (Behavioral health)

SSH's goal was to provide mental health treatment and education in the South Shore community to improve patients' quality of life and understanding of mental illness. To achieve this goal, the hospital maintained a 15-bed geriatric psychiatric unit that treated 1,089 patients between 2017 and August 2019. SSH was unable to secure resources to open a 15-bed adult unit, however, they partnered with Metropolitan Family Services, Human Resources Development Institute (HRDI), and Horizon Healthcare Treatment Centers to refer patients to quality community-based outpatient care.

Substance Use Disorders (Behavioral Health)

SSH's goal was to provide detoxification and chemical dependency rehabilitation services in the South Shore community to improve patients' quality of life and understanding of substance use disorders as diseases. To achieve this goal the hospital continued an inpatient chemical dependency unit and expanded it to 22 beds. As a result, 809 patients were treated for chemical dependency between 2017 and August 2019. SSH maintained four chemical detoxification beds and treated 496 patients during the same time period. The hospital has obtained a license to create an outpatient chemical dependency program and it is slated to open before the end of 2019. In addition, SSH hospital partnered with South East Alcohol and Drug Abuse Center and a Suboxone clinic to refer patients to community-based care and recovery assistance.

HIV/AIDS (Access to Care and Chronic Disease)

SSH's goal was to improve HIV/AIDS treatment and education in the South Shore community to improve patients' quality of life and understanding of disease. To accomplish this goal, a clinic center was maintained at 2525 E. 83rd St. in the South Shore/South Chicago community to provide primary healthcare services to HIV/AIDS patients. Approximately 780 individuals were tested for HIV/AIDS and 368 individuals were treated at the clinic between 2017 and 2019 YTD. Health education and outreach was conducted by a peer coordinator and screener working directly within communities. In addition, approximately 23,000 condoms were distributed in the community during outreach and education events.

Asthma (Chronic Disease)

SSH's goal was to explore ways to improve asthma prevention, education, management, and treatment in the South Shore community to improve quality of life. The possibility of opening an asthma center for excellence was explored but was found to not be financial feasibility at the time. However, SSH provided educational materials to community members and maintained relationships with local Federally Qualified Health Centers and other community resources so that patients could be referred to effective community-based care.

Uninsured and Cancer (Access to Care)

SSH had two additional goals related to access to care: to improve access to care for uninsured and to provide inpatient and outpatient chemotherapy services to improve access to cancer treatment. Due to extreme resource constraints, SSH was unable to achieve all the objectives planned in these focus areas. However, SSH maintained a part-time financial counselor who assists self-pay patients with enrollment into public benefits and insurance plans with reasonable deductibles in order to continue improving access to care for community members. In addition, SSH provided approximately 1.5 million dollars in charity care per year between 2017 and 2019.