AdventHealth
Hinsdale
Community Health Needs Assessment
Extending the Healing Ministry of Christ
Letter From Leadership

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

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

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

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

In His service,
Adam Maycock
President & CEO
AdventHealth Hinsdale and AdventHealth LaGrange
Executive Summary
Adventist Midwest Health dba AdventHealth Hinsdale will be referred to in this document as AdventHealth Hinsdale or “the Hospital”. AdventHealth Hinsdale in Hinsdale, Illinois conducted a community health needs assessment from October 2021 to November 2022. The goals of the assessment were to:

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

The Collaborative
In order to ensure broad community input, AdventHealth Hinsdale took part in the Impact DuPage Community Health Needs Assessment process. Impact DuPage, referred to here as “the Collaborative” was formed in 2013 to create a common understanding of community needs, gaps and priorities with the goal of advancing the well-being of the DuPage County community. The Collaborative has representation from social support and community organizations, health care systems, as well as public health and education institutions. The Collaborative includes intentional representation from those serving low-income, minority and other underserved populations.

The Committee
To guide the assessment process, the Collaborative created the Impact DuPage Steering Committee to guide the overall assessment, planning and evaluation process. This committee’s membership included local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members. This steering committee is referred to here as “the Committee”. The Committee met several times in 2021 - 2022. A list of Committee members can be found in the Process, Methods and Findings.

Community Health Needs Assessment Committee
AdventHealth Hinsdale also convened a Community Health Needs Assessment Committee (CHNAC). The purpose of the CHNAC was to select the needs the Hospital would address as a result of the findings in the assessment. The CHNAC made this decision by reviewing the priority needs selected by the Collaborative, the internal Hospital resources available, the unique demographic data of the community the Hospital serves, when different from county level data, and local resources existing in the community. With this information the CHNAC was able to determine where the Hospital could most effectively support the community. The CHNAC met several times in 2021 - 2022. A list of CHNAC members can be found in the Prioritization Process.

Data
The Collaborative collected both primary and secondary data for the assessment. Primary data included a community survey, a local public health system assessment and a forces of change assessment. In addition, public data was utilized from state and national data sources. Primary and secondary data was compiled and analyzed to identify the top nine aggregate issues. To read more about the county level findings and data highlighted in the report, please visit the Impact DuPage Community Assessment.

Selection Criteria
The Hospital convened the Community Health Needs Assessment Committee (CHNAC) to review the data and priorities selected by the Committee and to identify the needs the Hospital would select. The CHNAC also considered the Hospital’s PSA-level secondary data, local community resources available, as well as the Hospital’s current resources and strategies to find ways to prioritize and address the needs most effectively.
The Collaborative and CHNAC members were asked to consider the following question before voting on each issue and to rank the issue accordingly:

“What is the magnitude of the need for more focus and attention on this health issue?”

The needs were ranked on a scale of 1 to 5 (1 = more focus needed, 3 = more focus needed, 5 = much more focus needed).

See Prioritization Process for more.

Priority Issues to Be Addressed

The priority issues selected by the CHNAC to be addressed are:
1. Mental Health and Substance Use
2. Prevention and Management of Serious Illness
   — Addressing Social Determinants of Health
   — Chronic Disease and Serious Illness Awareness

See Prioritization Process for more.

Approval

On December 15, 2022, the AdventHealth Hinsdale Board approved the Community Health Needs Assessment findings, priority issues and final report. A link to the 2023 Community Health Needs Assessment was posted on the Hospital’s website prior to December 31, 2022.

Next Steps

AdventHealth Hinsdale will work with the Collaborative and the CHNAC to develop a measurable implementation strategy called the 2023-2025 Community Health Plan to address the priority issues. The plan will be completed and posted on the Hospital’s website prior to May 15, 2023.
Community Description
Located in DuPage County, Illinois, AdventHealth Hinsdale defines its community as the Primary Service Area (PSA), the area in which 75-80% of its patient population lives. This includes 39 zip codes across mainly DuPage County and smaller areas in Will, Kendall and Cook Counties.

According to the 2020 Census, the population in the AdventHealth Hinsdale community has grown 2.5% in the last ten years to 1,176,776 people. This is less than the percentage of growth seen in the United States since the last Census but more than seen in the State of Illinois, which had decreased. Demographic and community profile data in this report are from publicly available data sources such as the US Census Bureau and the Center for Disease Control and Prevention unless indicated otherwise. Data are reported for the Hospital’s PSA, also referred to as the community, unless listed for a specific county. Data are also provided to show how the community compares locally, in the state and at a national level for some indicators.

Community Profile
Age and Sex
The median age in the Hospital’s community is 39, higher than that of state which is 38.3 and that of the US, 38.2.

Females are the majority, representing 50.8% of the population. Middle aged women, 40-64, are the largest demographic group at 16.3%. Middle aged men are the second largest demographic group at 16.1%

Children are 24% of the total population in the community. Infants, those zero to four, are 6.2% of that number. The community birth rate is 54.5 births per 1,000 women aged 15-50, this is higher than the US average of 51.9 and that of the state, 51.5. In the Hospital’s community, 9.8% of children aged 0-4 and 10.6% of children aged 5-17 live in poverty.
Race and Ethnicity

In the Hospital’s community, 56% of the residents are non-Hispanic white, 7% are non-Hispanic Black and 28% are Hispanic or Latino. Residents that are of Asian or Pacific Islander descent represent 5.7% of the total population, while 0.1% are Native American and 2.7% are two or more races.

Social Determinants of Health

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

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

Social Determinants of Health

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

- **Economic Stability**: This includes areas such as income, cost of living, food security and housing stability.
- **Education Access and Quality**: This focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.
- **Health Care Access and Quality**: This includes topics such as access to health care, access to primary care and health insurance coverage.
- **Neighborhood and Built Environment**: This includes areas like quality of housing, access to transportation, availability of healthy foods and neighborhood crime and violence.
- **Social and Community Context**: This focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Economic Stability

- **Income**: The median household income in the Hospital’s community is $90,096. This is above the median for the state ($72,317) and the US ($68,498). The poverty rate in the community is 8.0%, which is below the state and national rate.

Food Insecurity and Housing Stability

- **People who are food insecure, having reduced quality and/or amount of food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not. Feeding America estimates for 2020 showed the food insecurity rate in the Hospital’s community as 10.4%. Increased evidence is showing a connection between stable and affordable housing and health. When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more than 50%.”

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

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

In the Hospital’s community, there is an 89.5% high school graduation rate, which is slightly lower than the state rate but higher than the national rate. The rate of people with a post-secondary degree is higher in the Hospital’s community than both that of the state and the nation.

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

In the Hospital’s community, 56.8% of 3-4-year-olds were enrolled in preschool. This is higher than the state and the national rate. There is a large percentage of children in the community who may not be receiving these early foundational learnings.

Health Care Access and Quality

In 2020, 7.1% of community members aged 18-64 were found to not have health insurance. A lack of health insurance can lead to delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person’s ability to access care, there are other potential barriers that can delay care for many people.

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

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital’s community, 74.9% of people report visiting their doctor for routine care.
Neighborhood and Built Environment

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

A person’s diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet. In the Hospital’s community, 60% of the community lives in a low food access area, while 19.6% live in a very low food access area.

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and maintaining employment. In the community, 5.3% of the households do not have an available vehicle.

Social and Community Context

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

In the community, 4.7% of youth aged 16-19 were reported as disconnected, which means they were neither enrolled in school nor working at the time. Also, in the community 26.6% of seniors (age 65 and older) report living alone and 5% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.
Process, Methods and Findings

The Process

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

The Hospital took part in the Impact DuPage Collaborative to complete the assessment. Impact DuPage, “the Collaborative”, was formed in 2013 to create a common understanding of community needs, gaps and priorities with the goal of advancing the well-being of the DuPage County community. The Collaborative has representation from social support and community organizations, health care systems, as well as public health and education institutions. The Collaborative includes intentional representation from those serving low-income, minority and other underserved populations.

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

The Committee

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

Community Organizations

- Laura Olson Beard, Chief Professional Officer—West Suburban Region, United Way of Metro Chicago
- David Roth, Executive Director, DuPage Federation on Human Services Reform
- Jenifer Fabian, Executive Director, People’s Resource Center
- Bart Szczepaniak, Director of Programs, DuPage Foundation

Health Care Systems and Providers

- Angela Beck, Vice President for Social Impact, Duly Health and Care
- Gina Sharp, President & CEO, Linden Oaks Behavioral Health
- Nicholas Edmonds, Community Health Manager, Advocate Good Samaritan Hospital
- Fabiola Zavala, Director of Community Benefit, AdventHealth

Public Health Experts

- Karen Ayala, Executive Director, DuPage County Health Department
- Kara Murphy, President, DuPage Health Coalition
- Nansel Angelopoulos, Mental Health Clinical Consultant, DuPage County Public Defender’s Office

Public Service Institutions

- Mary Keating, Director of Community Services, DuPage County
- Marisa Wiesman, Managing Attorney, Prairie State Legal Services, Inc.
- The DuPage County Health Department (DCHD) Leadership staff, DCHD Program Manager staff and the DCHD Board of Health.
Community Input
The Collaborative collected input directly from the community and from health care and social service providers working in organizations addressing the needs and interests of the community. This was collected through a community survey, a local system assessment and a forces of change assessment.

Community Survey
• Provided in English and Spanish to anyone in DuPage County and accessible online through weblinks and QR codes. Paper surveys were given to partners to place at their organizations with the goal of reaching those who might not have access otherwise and experience barriers to responding electronically.
• Surveys were shared through social media posts, flyers, newsletters and emails via outreach by the Collaborative with community partners including public health organizations. Partners were provided links to the online survey, with the request that it be sent to listservs, electronic mailing lists they maintained and when possible shared on their own social media channels
• Individuals were asked questions designed to help understand the following questions:
  • What is important to our community?
  • How is quality of life perceived in our community?
  • What assets do we have that can be used to improve community health?

Local System Assessment
• Designed to provide input on the strengths and weaknesses of the local public health system. An online survey was shared by the Collaborative targeting stakeholders in organizations that affect the quality of life and health in the community, including public, health, local hospitals and health systems, mental and behavioral health, education, housing, public safety, local government, local nonprofit and faith-based organizations.
• Survey participants were invited to join follow up discussions to review the findings from the survey and provide valuable feedback regarding how well the system is performing and opportunities for improvement and to brainstorm on related important trends, factors and events that affect our quality of life and the associated threats and opportunities.

Forces of Change Assessment
• Facilitated through 15 brainstorming sessions conducted with community leaders to identify forces such as trends, factors or events that were influencing the quality of life and health of the community. The goal of the sessions was to answer the questions: “What is occurring or might occur that affects the well-being of our residents or the local system?”
• “What specific threats or opportunities are generated by these occurrences?”
• The groups that participated in the brainstorming sessions were the Community Hunger Network, Impact DuPage Steering Committee, ADAPT (Alliance of DuPage Advocates for Pregnant and Parenting Teens), Bensenville Interfaith Council, DuPage Federation’s Council of Community Leaders, Choose DuPage, Behavioral Health Collaborative, Prevention Leadership Team, WeGo Together for Kids, Addison Resources Connect, DuPage Early Childhood Collaborative, the DuPage County Health Department (DCHD) Leadership staff, DCHD Program Manager staff and the DCHD Board of Health.

Secondary Data
To inform the assessment process, existing health related and demographic data about the community from publicly available sources was collected. This included topics in the areas of health, social determinants of health and quality of life indicators. The most current public data for the assessment was compiled and sourced from government and public health organizations including, but not limited to:
• US Census Bureau
• Center for Disease Control and Prevention
• US Department of Health and Human Services
• County Health Rankings
• Various State of Illinois Department Databases
• DuPage County Health Department
The Findings

Throughout the assessment process, there were reoccurring issues and needs which consistently rose to the top. The top areas of concern identified were:

- Affordable and adequate housing
- Mental health
- Social media
- Transportation issues
- Access to health care
- Social determinants of health
- Chronic diseases
- Obesity
- Substance use disorders
- Dental care
- Immunizations
- Preventive services
- Cancer

Transportation options

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

Mental health

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

Substance use

Substance use disorders can involve illicit drugs, prescription drugs, alcohol or tobacco. Opioid use disorders, which stem from the improper use of prescription drugs, have become especially problematic in recent years. Substance use disorders are linked to many health problems and overdoes can lead to emergency department visits and deaths.

Being overweight/obese/healthy food access and increasing physical activity

Obesity is a medical condition in which excess body fat has accumulated to an extent that it may have a negative effect on health. Obesity is measured by an individual’s body mass index (BMI). The prevalence of obesity continues to increase in the United States. Obesity is common, serious and costly. This epidemic is putting a strain on American families, affecting overall health, health care costs, productivity and military readiness. Moreover, obesity can have negative health outcomes since obesity can lead to type 2 diabetes, heart disease and some cancers.

Being physically active means moving the body to get from one place to another, do work or for leisure. Regular physical activity is proven to help prevent and manage noncommunicable diseases such as heart disease, stroke, diabetes and some cancers. It also helps prevent hypertension, maintain healthy body weight and can improve mental health, quality of life and well-being.

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

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

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

Cancer: Addressing cancer rates

Cancer is a disease in which some of the body’s cells grow uncontrollably and form tumors in the body. Cancer can start almost anywhere in the human body, which is made up of trillions of cells. Normally, human cells grow and multiply through a process called cell division from new cells as the body needs them. When cells grow old or become damaged, they die, and new cells take their place. Sometimes, cells become damaged, and abnormal or damaged cells grow and multiply when they shouldn’t. These cells can form tumors, which are lumps of tissue.

Cancers can be cancerous or not cancerous (benign).

Chronic diseases

Chronic diseases are defined broadly as conditions that last 1 year or more and result in loss of work productivity and activity and may limit activities of daily living or both. Chronic diseases such as heart disease, cancer and diabetes are the leading causes of death and disability in the United States. They are also leading drivers of the nation’s $4.1 trillion in annual health care costs. Six in ten adults in the US have a chronic disease and four in ten adults have two or more. Many chronic diseases are caused by a short list of risk behaviors: tobacco use and exposure to secondhand smoke; poor nutrition, including diets low in fruits and vegetables and high in sugar and saturated fats; physical inactivity; excessive alcohol use.
Prioritization Process

In March 2022, the Impact DuPage steering committee met to review primary and secondary data, completed a survey, then discussed and voted to narrow down and prioritize the needs that Impact DuPage would address for the next three years in their community health implementation plan. The Committee felt that many of the initial priorities were interdependent and could be addressed under broader categories, which resulted in the priorities below for DuPage County:

- Mental health and substance use
- Prevention and management of serious illness
- Addressing Social Determinants of Health (SDOH)/Drivers of Health
- Access to Chronic Disease Management
- Awareness of Equity Issues, Chronic Disease and Serious Illness

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

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

“What is the magnitude of the need for more focus and attention on this health issue?”

The needs were scored on a scale of 1 to 5 (1 = no more focus needed, 3 = more focus needed, 5 = much more focus needed).

The following health needs were chosen as priorities:

- Mental health and substance use
- Prevention and management of serious illness
- Addressing Social Determinants of Health
- Awareness of Equity Issues, Chronic Disease and Serious Illness
### CHNAC Members

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Angela Curran, CEO</td>
<td>Pillars Community Health</td>
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<tr>
<td>Kamee Anderson, CBUS</td>
<td>AdventHealth Corporate</td>
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<tr>
<td>Greg DeBoer, CEO</td>
<td>Community Memorial Foundation</td>
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<tr>
<td>Maria S. Pressgar, CEO</td>
<td>Healthy Communities Foundation</td>
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<tr>
<td>Amanda Windsor-Holden</td>
<td>AdventHealth Corporate</td>
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<tr>
<td>Kimberly Knake, ED</td>
<td>National Alliance of Mental Illness – Metro Suburban</td>
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<tr>
<td>Alij Shaheen, MD, ED</td>
<td>LaGrange Family Medicine</td>
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<tr>
<td>Adam Mycock, President</td>
<td>AdventHealth Hinsdale and LaGrange</td>
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<td>Bono Naid, MD, CEO</td>
<td>AdventHealth Hinsdale and LaGrange</td>
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<tr>
<td>Susan Hermann, ED</td>
<td>AdventHealth Hinsdale and LaGrange</td>
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<tr>
<td>Benjamin Lewis, COO</td>
<td>AdventHealth Hinsdale and LaGrange</td>
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<tr>
<td>Rich Metulski, ED</td>
<td>AdventHealth Hinsdale and LaGrange Marketing</td>
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### Available Community Resources

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

#### Top Issues

<table>
<thead>
<tr>
<th>Current Community Programs</th>
<th>Current Hospital Programs</th>
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<tbody>
<tr>
<td>Mental Health and Substance Use Disorders</td>
<td>Safer Side Suicide Prevention Program, Inpatient and Outpatient Behavioral Health, Mental Health First Aid Training</td>
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<tr>
<td>Prevention and Management of Serious Illness</td>
<td>DuPage Public Information, DuPage Health Coalition, Access, Hinsdale Mobile Food Pantry</td>
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#### Mental Health and Substance Use Disorders
- DuPage Prevention Leadership Team Youth Substance Prevention Program, DuPage Behavioral Health Collaborative, National Alliance for Mental Illness - Metro Suburban & DuPage, Pillars Community Health
- Safer Side Suicide Prevention Program, Inpatient and Outpatient Behavioral Health, Mental Health First Aid Training

#### Prevention and Management of Serious Illness
- DuPage Public Information, DuPage Health Coalition, Access, Hinsdale Mobile Food Pantry, Whole Health Hub, Financial Assistance Programs, Hinsdale Family Medicine
**Priorities Addressed**

**Priority 1: Mental Health and Substance Misuse**

During the assessment, 54% of community survey respondents shared they believed mental health issues were in the top three health concerns in DuPage County. Almost a quarter of survey respondents (22%), believe drug abuse to also be in the top three health concerns in DuPage County. The assessment also found due to a shortage of mental health care providers and an increased need for care during the COVID-19 pandemic, the demand for mental health and substance use care cannot be met within the community. It is harder for people in historically marginalized communities or people who are uninsured/under-insured to find care that fits their unique needs. Stigma regarding mental health as well as substance abuse treatment facilities is still present, however it seems there is some additional awareness of mental health issues in recent years.

Awareness and the need to address mental health disorders and substance use has been growing in the country. In addressing these as a priority, the Hospital can align to local efforts in DuPage County, as well as state and national initiatives for collaboration to create better outcome opportunities over the next three years.

**Priority 2: Prevention and Management of Serious Illness**

**Addressing Social Determinants of Health**

Awareness of Equity Issues, Chronic Disease and Serious Illness

There were many priority issues found in the assessment that were interdependent and could be addressed under broader categories. Through the priority Prevention and Management of Serious Illness many of the issues identified will be addressed. Prevention can reduce the risk for diseases and serious illness, while appropriate disease management can improve an individual’s health outcomes and quality of life.

Prevention and management efforts can be more clinical in nature, such as ensuring community members receive timely screenings and health care or providing case management support to manage a diagnosis. Efforts can also focus on social determinant of health factors which influence health, this could include increasing access to healthy and nutritious foods in food deserts or providing free fitness classes in areas with limited recreational fitness options.

The Hospital will focus its efforts on initiatives which address social determinants of health and have an equity-based lens and approach. The Hospital will work with others who are addressing this priority through efforts with Impact DuPage and other community partners.
Priorities Not Addressed

Prevention and Management of Serious Illness

Chronic Disease Management

Although the Hospital would like to address all the needs of the community, it will not address chronic disease management directly, as it did not perceive the ability to have a measurable impact on the issue within the three years allotted for the Community Health Plan with the current resources available. The Hospital may continue to support other efforts addressing this through advocacy, community partnerships and public health collaborations as needed.
Next Steps

The Hospital will work with the Collaborative and other community partners to develop a measurable Community Health Plan for 2023-2025 to address the priority issues. For each priority, specific goals will be developed including measurable outcomes, intervention strategies and the resources necessary for successful implementation. Evidence based strategies will be reviewed to determine the most impactful and effective interventions. For each goal, a review of policies that can support or deter progress will be completed with consideration of opportunities to make an impact. The plan will be reviewed quarterly with an annual assessment of progress. A presentation of progress on the plan will also be presented to the Hospital board annually.

A link to the Community Health Plan will be posted on AdventHealth.com prior to May 15, 2023.
The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually. The following is a summary of progress made on our most recently adopted plan.

**Behavioral Health**

In the 2019 assessment, behavioral health was identified as a priority. Behavioral health is a term that includes both mental health and substance use disorders. The burden of mental illness in the United States is among the highest of all diseases, and mental disorders are among the most common causes of disability for adults, children and adolescents. When mental health disorders are untreated, those affected are at high risk for many unhealthy and unsafe behaviors, including alcohol or drug abuse, violent or self-destructive behavior and suicide. Mental health disorders are the 11th leading cause of death in the United States for all age groups and the second leading cause of death among people age 25 to 34. Behavioral health continues to be a primary concern in DuPage County. Addressing behavioral health requires attention to substance use disorders as well as mental health. The recent CHNA also emphasized the need for prevention of substance use at an early age and the reduction of stigma surrounding behavioral health.

Drug abuse and mental health issues were the top two concerns on the community survey during the last assessment.

The Hospital focused its efforts on increasing education and building community-level networks for mental health support. Efforts to address this were part of a collaborative effort between the Hospital, AdventHealth Bolingbrook, AdventHealth GlenOaks and AdventHealth LaGrange, which serve overlapping communities. As part of this effort, a facilitator completed the Mental Health First Aid instructor certification.

Having received the certification, the team member was able to provide classes training community members on how to help someone who may be experiencing a mental health or substance use challenge. By the end of 2021, six community members had been trained.

The Hospital also chose to address health status improvement based on data from the assessment. The assessment identified a need for a continued focus on issues involving residents' access to health and a movement towards more positive health outcomes for DuPage residents. Access to health care and health insurance especially for the low-income persons in the DuPage community continued to be an issue. Eighty-five percent of DuPage County reported having usual health care provider while a top “risky behavior” noted on the last assessment resident survey was being uninsured.

In addressing the need, the Hospital focused on increasing access to healthy and nutritious food. It has been found a person's diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet. As part of its efforts to address the need, the Hospital partnered with the Northern Illinois Food Bank, Hinsdale Seventh Day Adventist Church and the Community Memorial Foundation. Through this collaboration, the partners provide a Rx Mobile Food Pantry twice a month. The Rx Mobile Food Pantry provides fresh produce, meat and dairy to patients screened for food insecurity as well as to the community at large. There are also wrap-around services such as SNAP benefit enrollment opportunities available on site.

By the end of 2021, the Hospital had hit a monthly high of 786 individuals served during the twice monthly event.

The Hospital also provided financial support to the Silver Access program for Access DuPage. Financial support was provided from a partnership between the Hospital and AdventHealth GlenOaks, both of which serve the same community. The Silver Access program provides a financial subsidy to qualifying residents to cover the costs of insurance premiums to increase access to health care. By the end of 2021, 476 community members had been helped through the program.
2019 Community Health Needs Assessment Comments

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