Community Health Needs Assessment Report

FY2019

RUSH

Rush Copley Medical Center

Outline

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- Community Served
- Identified Community Health Needs
- Evaluation of Impact of the FY16 Implementation Strategy

Executive Summary

Executive Summary

In FY2019, Rush Copley Medical Center (RCMC) completed a comprehensive Community Health Needs Assessment (CHNA) process to identify, prioritize, and address the top health issues in the community served.

The community served by the hospital includes the geographic area from which approximately 80% of the hospital's patients reside. This area includes Aurora, Sugar Grove, Oswego, Montgomery, North Plainfield, and most of Kendall County.

Process and Methodology

- The hospital used four methods for collecting community input and health data, including the following:
  - Partnering with the Kane County and Kendall County Health Departments on the development of their respective CHAs/CHIPs (Community Health Assessment & Community Health Improvement Plan)
  - Community health survey
  - Focus groups
  - Extensive secondary data analysis
- The hospital established an internal team with health and community expertise to guide the development of the CHNA and establish the implementation strategy.
  - The committee reviewed and discussed the findings from the community health survey, focus groups, secondary data analysis, and information from the development of the Kane County and Kendall County CHAs/CHIPs, as well as additional community input.
  - Through a defined criteria process, the committee identified and prioritized the top health issues in the community.

Executive Summary

Identified and Prioritized Health Needs

Rush Copley identified the following as the top health needs in the community to be addressed in the implementation strategy:

1. Inequities caused by the social, economic and structural determinants of health, focusing on reducing inequities in vulnerable populations through improved identification and connection of patients in need to available community resources
2. Mental and behavioral health, focusing on reducing the misuse of opioids and opioid-related deaths
3. Prevent and reduce chronic disease by focusing on risk factors, specifically reducing tobacco usage (including smoking and vaping)

The hospital developed and adopted an implementation strategy to address these community health needs. The CHNA and Implementation Strategy were approved and adopted by the hospital's Board of Directors on March 26, 2019.

The CHNA Report, Data and Information Book, and Implementation Strategy are helpful community resources and are widely available to the public at www.rushcopley.com.

Execution of the implementation strategies has begun and will continue over the next three fiscal years.

Introduction

Rush Copley Medical Center

- Since its founding (originally as Aurora City Hospital) in 1886, Copley Memorial Hospital has been committed to serving the health needs of the greater Aurora community.
- Copley Memorial Hospital, otherwise known as Rush Copley Medical Center (RCMC),
  - Is a 210 bed, not-for-profit hospital with more than 500 physicians on staff and more than 2,500 employees
  - Offers inpatient specialty care as well as comprehensive outpatient services
  - Provides services to nearly 90,000 individual patients annually
  - Received A grades each of the 14 times the Leapfrog Group has rated hospitals since June 2012
  - Was awarded five stars, the highest possible rating, for hospital quality from the federal Centers for Medicare and Medicaid Services (CMS)
- Rush Copley is part of RUSH, an academic health system comprising of Rush University Medical Center, Rush Oak Park Hospital, and Rush University.

Rush Copley Medical Center

- The hospital's mission is to provide advanced medicine with quality outcomes and extraordinary care. To that end, the medical center seeks to serve the community in ways that engage, educate, and empower. Annually, the hospital:
  - Sponsors, partners, or participates in nearly 300 community-based programs and events, many specifically aimed at improving the lives of vulnerable populations
  - Provides free community educational programs and seminars that emphasize wellness, prevention of disease and early detection including diabetes, heart health, cancer prevention, weight control, smoking cessation, hand hygiene, and more
  - Provides free and reduced cost health screenings
  - Provides language assistance services, volunteer programs, and professional education
  - Contributes time, talent, and materials to community service organizations whose mission is consistent with that of the medical center
  - Participates in community health programs and health services in conjunction with local health departments and other regional health initiatives
- In FY2018, the hospital provided nearly $4 million in charity care and over $36 million in uncompensated government sponsored indigent health care. Additional discounts and expenses associated with the hospital providing care to the uninsured and underinsured totaled $32.4 million during the same time period.

Assessment Overview

- The Patient Protection and Affordable Care Act of 2010 requires private, not-for-profit hospitals to conduct a Community Health Needs Assessment (CHNA) at least once every three years and to adopt an implementation strategy to address the identified community needs.
- A CHNA provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.
- The purpose of this Community Health Needs Assessment is to objectively identify and prioritize the health needs of the community served.
  - This will be accomplished through a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the RCMC service area, including input from community stakeholders.
  - The assessment results will be used to develop and implement strategies and action plans to address the identified needs.

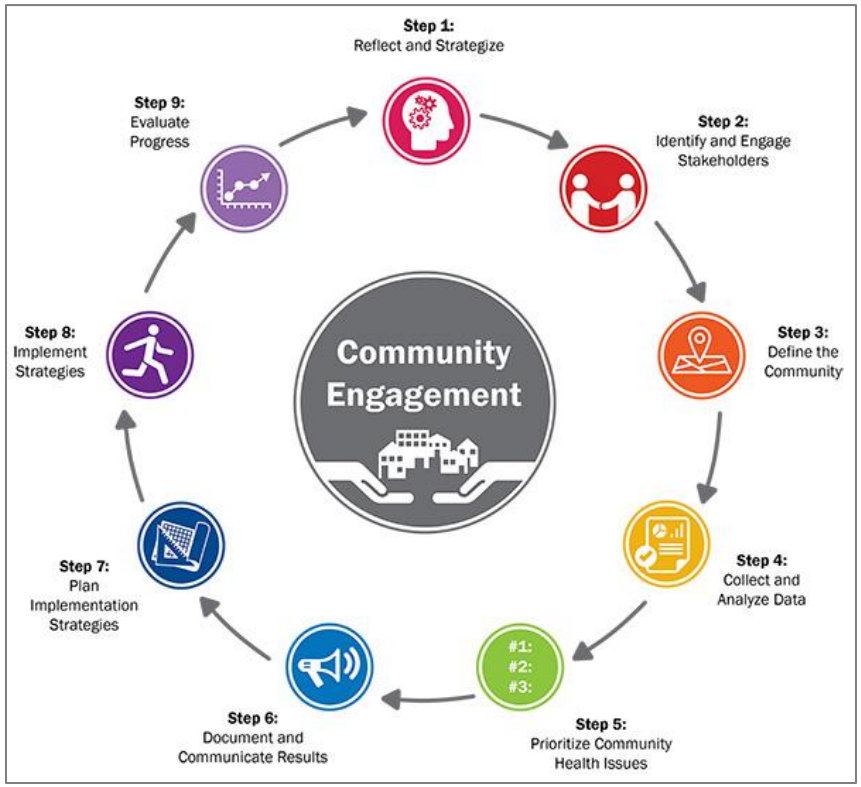
Assessment Goals

- Rush Copley's goals of the Community Health Needs Assessment include:

  1. Determine, establish, and update information about the health status of the community. The information acquired and assembled for this assessment will be used to help establish trends in future CHNAs.
  2. Identify all of the health needs of the community
  3. Prioritize the identified community health needs
  4. Develop and implement strategies and action plans to address the identified and prioritized community health needs

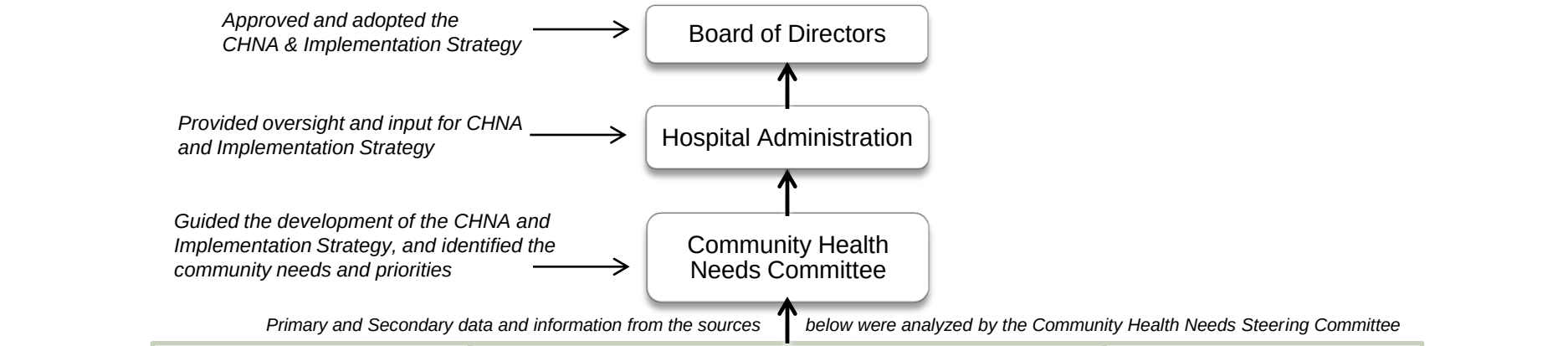
Process and Framework

- The hospital conducted the Community Health Needs Assessment in FY2019. Community partnerships related to many of the components in the assessment process were established and on-going since the FY2013 assessment.
- The hospital developed and adopted an implementation strategy to address the identified community health needs. The Community Health Needs Assessment and Implementation Strategy were approved and adopted by the hospital's Board of Directors on March 26, 2019.
- The hospital followed the Association of Community Health Improvement's (ACHI) framework for developing a comprehensive and efficient Community Health Needs Assessment, which is displayed in the graphic to the right.



Structure and Inputs

- The hospital established an internal team with health and community expertise to guide the development of the Community Health Needs Assessment and identify and prioritize the community needs.
- In addition, the hospital took into account input from a number of people representing the broad interests of the community served.
  - Those who provided input are experts in a range of areas including public health, minority populations, disparities in health care, social determinants of health, and health & social services.
  - Their input helped to ensure that the hospital identified all of the health needs in the community.
- The flow chart below illustrates the scope of participants, assessment methodology, and input process.



*A full list of contributors and participants can be found in the Kane and Kendall County IPLANs and the Rush Copley Data and Information Book

1. Persons with special knowledge of or expertise in Public Health; 2. Local health departments with data and information relevant to the health needs of the community; 3. Leaders, representatives, and members of medically underserved, low-income, and minority populations, and populations with chronic disease needs in the community; 4. Other persons and organizations

Analytical Methodology

- In order to identify the community health needs, the hospital used a number of analytical methods, including both qualitative and quantitative processes.
- There were four key methods used in the data and information collection and analysis component of the assessment process that were critical in developing an accurate picture of the health of the community served. The four key methods include the following:

Partnering with the local county health departments in the development of their CHAs/CHIPs

(CHA/CHIP development & implementation partnerships are on-going)

– The hospital collaborated with the Kane County and Kendall County health departments, as well as other community partners and health experts, to develop and implement their respective CHAs/CHIPs.
– Through these collaborations, the hospital actively participated in the identification and prioritization of needs and the development of improvement strategies for key topics that would improve the health and well-being of the residents of the respective counties.

Community Health Survey *(June 2018)*

– The hospital contracted with Professional Research Consultants, Inc. (PRC) to conduct a health status phone survey of adult residents from the community served, using both landlines and cell phones.
– The survey questions were based largely on the CDC's Behavioral Risk Factor Surveillance System (BRFSS), as well as additional custom questions, in order to obtain state and national comparative data and address identified gaps.
– 460 one-on-one adult resident phone surveys were completed using a random sample. The survey results provided the hospital with a comprehensive and comparative view of the health status and behaviors of the community.

Identified Community Health Needs

Focus Groups and Key Informant Surveys

(June 2018 – October 2018)

– Seven focus groups and two online key informant/stakeholder surveys were conducted by or on behalf of the hospital.
– Each focus group and key informant survey provided insights on different segments of the population and reflected unique perspectives regarding the health needs of the community. Participants included residents, social service providers, local health department leadership and staff, physicians, nurses, care managers, hospital leadership, schools, food pantries, libraries, homeless shelters, and other governmental, business and community leaders.

Extensive Data Analysis

(June 2018 - January 2019)

– An extensive secondary data analysis was conducted, which included internal utilization data, IHA COMPdata, local public health data, statewide and nationwide behavioral risk assessments data, and Healthy People 2020 goals and baseline data.
– When available, the data indicators for the community, IL, and U.S. were aligned and compared to both the Healthy People 2020 national baseline data and goals, as well as the FY2013 and FY2016 Rush Copley CHNA data and findings. These comparisons helped with the identification of community health needs from a quantitative perspective.

Identification/Prioritization Methodology

- The Community Health Needs Steering Committee guided the process to identify and prioritize the health needs.
- The core of the Committee's work included the following:
  1. To review the findings from the community health survey, information and key findings from the development of the Kane County and Kendall County CHAs/CHIPs, focus groups findings, and secondary data analysis
  2. To identify and prioritize the community health needs using the criteria described below

Needs Identification Criteria

The method used in the health needs identification process included applying the following criteria to the findings from the analytic process:

1. The severity of the indicator/problem (e.g., the number of people or the percentage of population impacted)
2. The magnitude of the indicator/problem (e.g., the degree to which health status is worse than the national norm)
3. A high need among vulnerable populations

Needs Prioritization Criteria

In order to prioritize the identified community health needs, the hospital established evaluation criteria based upon the Association of Community Health Improvement's guidelines, which included:

1. The community's capacity to act on the issue, including any economic, social, cultural, or political considerations (i.e., the community will embrace it as a priority)
2. The likelihood or feasibility of having a measurable impact on the issue
3. The current community resources that are already focused on an issue (e.g., collaborative programs, funding; to reduce duplication of effort and to maximize effectiveness of limited resources)
4. Whether the issue is a root cause of other problems thereby possibly affecting multiple issues
5. Existing interventions focused on the issue
6. Trending health concerns in the community

Information Sources

- The hospital used the most current and up-to-date data available to identify the health needs of the community.
- The table below includes the data sources used in the assessment.

Primary Sources	Secondary Sources
• Community Telephone Interviews – PRC Community Health Survey • Focus Groups – Compañeros en Salud/Partners in Health – Kendall County Health Department – Kendall County Senior Services Advisory Council – Rush Copley Nurses – Rush Copley Care Managers – Rush Copley Health Equity Index (HEI) Committee – Rush Copley Patient Family Advisory Council (PFAC) • Online Key Informant/Stakeholder Surveys – Kane County Key Informants – RCMG Physicians and Advanced Practice Providers • Written comments regarding the most recent CHNA and Implementation Strategy, however, no public comments were received regarding the posted draft of the assessment on the hospital's website	• Advisory Board • Association for Community Health Improvement (ACHI) • Center for Applied Research and Environmental Systems (CARES) • Centers for Disease Control & Prevention (CDC), Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention • Centers for Disease Control & Prevention (CDC), Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS) • Centers for Disease Control & Prevention (CDC), Office of Public Health Science Services, National Center for Health Statistics • Community Commons • County Health Rankings and Roadmaps • Drug Abuse Warning Network, www.samhsa.gov • Environics Analytics • ESRI ArcGIS Map Gallery • Fit Kids 2020 Plan (Kane County) • IHA COMPdata • Illinois Department of Public Health (IDPH) • Illinois Behavioral Risk Factor Surveillance System • Illinois Department of Public Health State Cancer Registry • Illinois Department of Human Services • IDPH Division of Health Data and Policy • Healthy People 2020 • Kane County Health Department • Kane County Community Health Assessments and supportive reports 2011, 2016 • Kane County Community Health Improvement Plan 2012-2016, 2017-2020 • Kendall County Health Department • Kendall County IPLANs 2011-2016, 2016-2021 • National Cancer Institute, State Cancer Profiles • National Institute on Drug Abuse • RCMC FY2013 and FY2016 CHNAs • RCMC internal data systems • RealtyTrac • Robert Wood Johnson Foundation • US Census Bureau, American Community Survey • US Census Bureau, County Business Patterns • US Census Bureau, Decennial Census • US Department of Agriculture, Economic Research Service • US Department of Health & Human Services • US Department of Health & Human Services, Health Resources and Services Administration (HRSA) • US Department of Health & Human Services, The Office of Minority Health • US Department of Justice, Federal Bureau of Investigation • US Department of Labor, Bureau of Labor Statistics • Walkscore.com • World Health Organization • Various additional articles and community reports

Information Sources and Gaps

- While an extensive amount of data was gathered and analyzed, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. Identified data gaps include:

    1. Limited data for the community served was available for many of the health needs topics by demographic subgroups and socio-economic subgroups (i.e., race, ethnicity, age, gender, income, education attainment, homeless, etc.)

    2. Very limited to no data was available for undocumented residents in the community

    3. Health status and behaviors data was not available specific to children in the community served, with the exception of children residing in Kane County

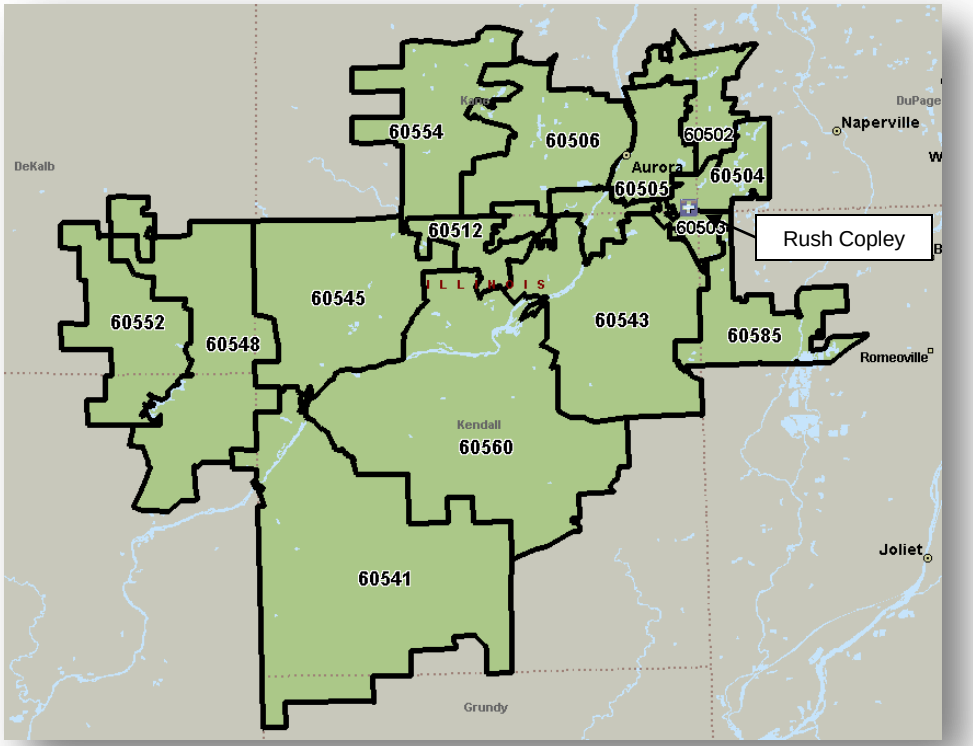
    4. While this assessment was designed to provide a comprehensive and broad picture of the health of the overall community, there are a number of medical conditions that are not specifically addressed

- In order to address most of the data gaps mentioned above, the hospital asked questions regarding health disparities in the community through focus groups and online key informant/stakeholder surveys facilitated by or on behalf of the hospital.

Community Served

Community Served

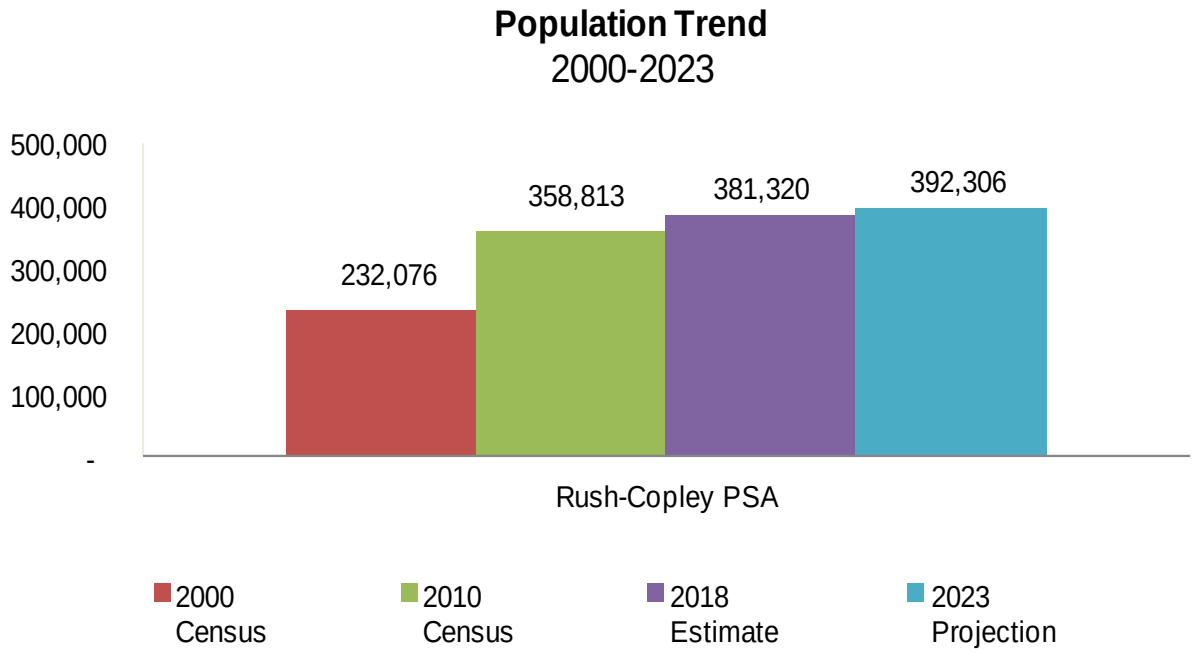
- The hospital is located in the city of Aurora, IL, which is the second largest city in Illinois.
- The community served by the hospital is defined as the geographic area identified by the contiguous zip codes from which approximately 80% of the hospital's discharged patients reside. The hospital also refers to this geographic area as the Rush Copley Primary Service Area (PSA).
- As seen in the map to the right, the community served includes all of Aurora and most of Southern Kane and Kendall Counties.
  - Kane County was the third in Illinois population growth between 2017 and 2018 and has the second largest Hispanic population in IL, which is concentrated in Aurora.
  - Kendall County was the nation's fastest growing county between 2000 and 2010, and it had the greatest population growth of any county in Illinois between 2017 and 2018.
- The community served also includes very limited portions of DeKalb, LaSalle, Grundy, DuPage, and Will Counties.



Sources: Environics Analytics and US Census Bureau, Decennial Census
Please note: Sugar Grove (60554) and Millbrook (60536) were added to the Rush Copley PSA in FY2019.

Demographics

- In 2018, there were 381,320 residents living in the community.
- Since the 2010 census, the community experienced a population increase of 6.3% (+22,507 residents).
  - During the same time period, the IL population decreased by 0.5% and the U.S. population increased by 5.8%.
- Population growth in the community is expected to continue at a slow growth pace with only 2.9% growth projected from 2018 to 2023.

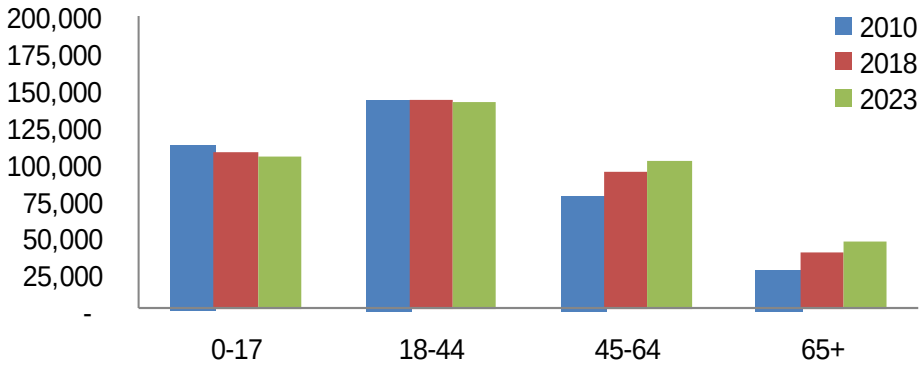


Source: Environics Analytics

Demographics

- The average age in the community is 35.2 years, which is younger than the average age in IL and the U.S. (IL = 39.1; U.S. = 39.3).
- While there is a large youth population that represents 28.2% of the total population, this cohort decreased by 3.5% since 2010 and is projected to continue to decrease over the next five years.
- As the community continues to age, population growth will continue to be concentrated in the 45+ years cohort.
  - The 45-64 age cohort increased 20.5% between 2010 and 2018 and is projected to increase an additional 8.3% over the next five years to over 100K residents.
  - The 65+ population increased the most rapidly between 2010 and 2018 and is projected to increase an additional 20.6% between 2018 and 2023 to over 46K residents.

Age Distribution of the Community

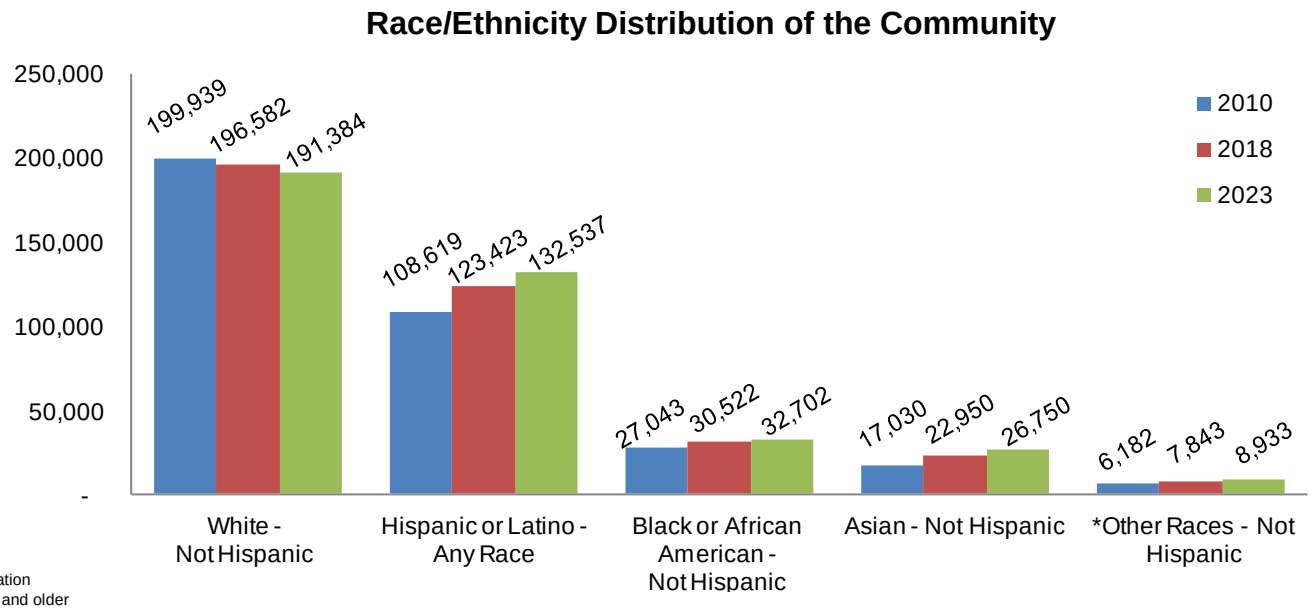


Population	0-17	18-44	45-64	65+
2010	111,356	143,515	77,344	26,598
2018	107,481	142,370	93,210	38,259
2023	104,301	140,947	100,929	46,129
% Growth 2010-2018	-3.5%	-0.8%	20.5%	43.8%
% Growth 2018-2023	-3.0%	-1.0%	8.3%	20.6%

Source: Environics Analytics

Demographics

- Between 2000 and 2010, the service area experienced rapidly changing demographics as the community became more diverse. However, between 2010 and 2018, the rate of change slowed and is projected to continue at a slower rate through 2023.
  - The population of the combined minority races increased by 22.0% between 2010 and 2018, and it is projected to increase an additional 11.5% by 2023 (+7,070 for a total of 68,385 residents).*
  - The Hispanic/Latino population increased by 13.6% between 2010 and 2018, and it is projected to increase an additional 7.4% by 2023 (+9,114 for a total of 132,537 residents).
- Hispanics and Latinos account for 32.4% of the population, which is nearly double the national and state rates (IL= 17.5%; U.S.=18.3%)
- Approximately 25% of the residents in the community speak Spanish at home.**



Source: Environics Analytics
*Does not include the Hispanic or Latino population
**Primary language based on residents ages 5 and older

Socioeconomics Characteristics

- The community continues to recover from the economic downturn and has shown significant improvement in a number of areas since 2015*:
  - Median housing values increased 6.2%
  - Median household income increased by 14.3%
  - Foreclosure rates in Kane and Kendall Counties continue to improve
  - Unemployment rates improved significantly in the local counties and are comparable to the IL and U.S. rates (the U.S. rate of 3.8% is the lowest in 50-years). However, underemployment continues to be a concern.
  - Attainment of higher education in the community, IL and U.S. continues to increase
- Poverty rates in Kane County, Kendall County, IL, and U.S. have remained fairly consistent since 2010.

	Rush Copley PSA	Kane County	Kendall County	IL	U.S.
Median housing value – 2018	$212,770	$245,761	$225,481	$193,046	$200,102
Foreclosure rate (as of 7/2018)	Not available	1:1,160	1:818	1:1,176	1:1,835
Median household income (2018)	$79,348	$76,789	$93,900	$64,872	$61,045
% Unemployment rate (as of 5/2018)	Not available	3.8	2.9	4.3	3.8
% Poverty rate of the total population (2016)	Not available	11.0	5.4	14.0	15.1
% no high school diploma or GED	16.6%	17.1%	6.3%	11.6%	13.0%
% Achieved a bachelor's degree or higher (2018)	32%	32%	35%	33%	31%

Source: Environics Analytics, unless otherwise noted, which can be found in the FY2019 RCMC CHNA Data and Information Book
*2015 data can be found in the FY2016 Rush Copley Community Health Needs Assessment

Existing Health Care Facilities & Resources

The table below outlines existing facilities and resources available to address the significant health needs identified in this report. This list is not exhaustive, but rather it includes those resources identified in the course of conducting this Community Health Needs Assessment.

Health Care Facilities and Providers	Mental and Behavioral Health	Other Agencies, Programs and Resources
• Rush Copley Medical Center • Amita Mercy Medical Center • Valley West Community Hospital • VNA Health Care • Aunt Martha's • Advocate Dreyer Medical Clinic • Independent Physicians/Providers • Community Health Partnership: Aurora Medical and Dental Clinic • Dental Offices • Drug Store Based Clinics • Planned Parenthood • Open Door Clinic • Skilled nursing facilities such as Alden of Waterford and Tillers • Palliative care professionals such as Seasons hospice and Hands of Hope • Long term care facilities including assisted living, supportive care living and custodial care • Waterford Place • Home health agencies • Additional providers included in the PRC report	• Association for Individual Development (AID) • Aunt Martha's • Breaking Free, Inc. • Northwestern Medicine Health Behavioral Health Services • Advocate Dreyer Medical Clinic • Ecker Center for Mental Health • Elderday Center • Family Counseling Services • Gateway Foundation – Aurora • Hope for Tomorrow, Inc. • Kendall County Health Department Mental and Substance Abuse Treatment Clinicians • Mutual Ground, Inc. • Amita Mercy Medical Center • Amita St. Joseph Hospital (Elgin) • Senior Services Associates • TriCity Family Services • VNA Health Care • Suicide Prevention Services • Linden Oaks Behavioral Health • Rosecrance • Additional providers included in the PRC report	• City of Aurora • Compañeros en Salud/ Partners in Health • Fit for Kids Program • Healthy Living Council • Kane County Health Department • Kendall County Health Department • Aurora Primary Care Consortium • 708 INC Board • Local park districts such as Fox Valley Park District and Oswego Park District • Local Fitness Clubs/Centers • Local K-12 School Programs • Local Colleges and Universities • Local Law Enforcement Agencies and EMS • Local Nutritionists • Senior Services Associations • Kendall Area Transit (KAT) • PACE Bus • American Cancer Society • American Diabetes Association • Local Grocery Stores and Food Panties • Northern IL Food Bank • United Way • Kane Kares • Public Libraries such as Aurora, Oswego and Montgomery Public Libraries • Public and Private Sports programs • Women, Infants and Children (WIC) Program • Worksite Wellness Programs • 211 Call Center

Identified Community Health Needs

Identified and Prioritized Health Needs

- The Rush Copley Community Health Needs Steering Committee identified and prioritized the following community health needs using the process and methodology outlined on page 14 of this report.
- Many of these needs are aligned with the top needs identified in the Kane County, Kendall County, and Rush University community health assessments.

Identified Community Health Needs (listed in order of importance from highest to lowest)
1. Inequities caused by the social, economic and structural determinants of health[1,3] • Inequities in vulnerable populations (children, seniors[2], Spanish speaking, LGBTQ) • Access to transportation to and from health services
2. Mental and Behavioral Health (includes both mental health and substance abuse)[1,2,3] • Access to mental and behavioral health services • Lack of knowledge of the services available in the community and how to access those services • Substance abuse with a focus on opioid misuse and opioid-related deaths
3. Access to care and community services[2,3] • Lack of knowledge of the services available in the community and how to access those services • Insurance access and coverage stability
4. Prevent and reduce chronic disease by focusing on risk factors[1,3] • Obesity due to poor nutrition and physical inactivity • Tobacco usage (including smoking and vaping) • Medication noncompliance

1: Identified as a community health threat in the Kane County 2018-2020 IPLAN
2: Identified as a health priority in the Kendall County 2016-2020 IPLAN
3: Identified as a community health need in the Rush University 2016 and 2019 CHNAs

Identified and Prioritized Health Needs

- Rush Copley identified the following as the top health priorities in the community to be addressed through an implementation strategy:

  1. Inequities caused by the social, economic and structural determinants of health, focusing on reducing inequities in vulnerable populations through improved identification and connection of patients in need to available community resources
  2. Mental and behavioral health, focusing on reducing the misuse of opioids and opioid-related deaths
  3. Prevent and reduce chronic disease by focusing on risk factors, specifically reducing tobacco usage (including smoking and vaping)

- The hospital developed and adopted an implementation strategy to address these community health needs.

Inequities and Social Determinants

Need: Inequities caused by the social, economic and structural determinants of health, focusing on reducing inequities in vulnerable populations through improved identification and connection of patients in need to available community resources

Why is this an identified health need?

Health is determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. (Healthy People 2020)

- There is a measurable percent of the population in the community that is impacted negatively by social determinant factors. Of note:
  - 13.9% are linguistically isolated (Kane County)
  - 26.5% are food insecure
  - 16.6% do not have a high school diploma or GED
- The impact of and need to address social determinants of health was identified as a top health issue through the Kane County CHA/CHIP and in nearly all of the focus groups.
- As awareness and impact of this need in the community continues to increase, many agencies are looking to collaborate to improve collective impact (i.e., FUSE, Senior Services, etc.).
- RCMC is in a unique position to help connect vulnerable patients with needed resources in the community.
- Reducing inequities in vulnerable populations will have a positive impact on the overall health of residents and the community.

Indicator	RCMC PSA	Kane Cty	Kendall Cty	IL	U.S.
Linguistic Isolation	n/a	13.9	n/a	9.0	8.5
Poverty	n/a	11.0	5.4	14.0	15.1
Food Insecure	26.5	23.4	n/a	n/a	27.9
No High School Diploma/GED	16.6	17.1	6.3	11.6	13.0
Hispanic/Latino	*47.9*	*51.6*	*17.4*	*35.8*	*34.3*
Unemployment Rate	n/a	3.8	2.9	4.3	3.8
% Uninsured	8.2	8.8	n/a	10.7	13.7
Median HH Income	$79K	$77K	$94K	$65K	$61K
Hispanic/Latino	*$58K*	*$54K*	*$72K*	*$53K*	*$48K*

Mental and Behavioral Health

Need: Mental and behavioral health, focusing on reducing the misuse of opioids and opioid-related deaths

Why is this an identified health need?

- Opioid overdoses are now a major killer of Americans, with opioid-related deaths sharply increasing since 1999.
  - The misuse of prescription opioids has significantly contributed to this epidemic.
  - According to the National Safety Council, the probability of dying from an opioid overdose is now greater than that of dying in a car accident (1:96 vs. 1:103).
- This is a national, state and local health issue as related drug use and related mortality has rapidly increased over the last few years.
  - IL has experienced a dramatic increase in drug overdose deaths (~2,300 in 2016), of which over 80% are opioid-related.
  - In the PSA, illicit drug use increased from 2.0% to 6.2% of the population in the last three years.
  - The number of opioid-related deaths in Kane and Kendall Counties combined increased by 147% over the last five years.
- The need to address the opioid epidemic in the community was identified in a number of focus groups.
- There is a high capacity for the community (including RCMC) to collectively impact this need/issue over the next 3 years. A Kane County Opioid Task Force has been implemented and related resources are being developed.
- Additionally, RCMC is in a unique position to help address this issue through a focus on prevention with surveillance.

Opioid Overdose Deaths by County

	2014	2015	2016	2017	2018*	5-Yr Change n	5-Yr Change %
Kane	25	25	45	70	64	39	156%
Kendall	7	7	22	14	15	8	114%
Subtotal	32	32	67	84	79	47	147%
DuPage	67	78	111	124	117	50	75%
Will	62	79	103	124	105	43	69%
Total	161	189	281	332	301	140	88%

*2018 has not yet been finalized. Source: IDPH Division of Health Data and Policy

What are opioids? Opioids are a class of drugs that includes heroin, prescription pain relievers such as oxycodone and hydrocodone (i.e., Oxycontin® , Percocet® , Vicodin®), and dangerous synthetic opioids such as fentanyl and carfentanil.

Chronic Disease

Need: Prevent and reduce chronic disease by focusing on risk factors, specifically reducing tobacco usage (including smoking and vaping)

Why is this an identified health need*?*

While the community served has lower prevalence/incidence rates for most chronic diseases as compared to IL and the U.S., it is still identified as a top health priority due to higher risk factor rates, specifically smoking and vaping.

- Chronic disease continues to be the leading cause of death in the community (includes cancers, heart disease, COPD, etc.).
- Smoking is a leading root cause of chronic disease and is the single most preventable cause of death in the U.S.
- The smoking rate in the PSA decreased since the FY16 CHNA from 15.3 to 13.3, however:
  - The current adult smoking rate in the PSA continues to be above the HP2020 goal of 12.0
  - The adult vaping rate in the PSA is nearly 3X the IL and U.S. rates
  - Tobacco usage is high among Hispanics/Latinos
  - Awareness of the tobacco quit line decreased by 21%
- The prevalence of chronic diseases was identified as a top health problem in the community through the Kane County CHA/CHIP and through a number of focus groups.
- Reducing the prevalence of tobacco use would have a positive impact on the health of the community and would reduce of the incidence of chronic diseases.

Rates by Chronic Disease	RCMC PSA	IL	U.S.
Angina, heart attack, or coronary heart disease	2.7	n/a	8.0
Has had a stroke	0.6	3.1	4.7
COPD	5.9	6.2	8.6
Asthma (adults only)	7.2	8.9	11.8
Cancer incidence	Kane: 429 Kendall: 494	464	441
Risk Factors (adults only)			
Obesity	32.4	31.6	32.8
Diabetes	9.6	10.4	13.3
Current smoker	13.3	15.8	11.0
Vaping	11.2	4.3	3.8

Evaluation of Impact of the FY16 Implementation Strategy

Rush-Copley

FY2016 CHNA Progress Update

Rush Copley has made significant progress toward the strategies and initiatives adopted to address the top identified health priorities described in the FY2016 CHNA and Implementation Strategy Plan.

Progress and accomplishment highlights include:

- Developed and implemented new healthy weight-related programs & resources
  - FamilyFIT (healthy lifestyle program for families)
  - Familia Saludable (healthy lifestyle program for Hispanic/Latino families)
  - Bilingual nutrition posters and education at local food pantries
  - Healthy eating cooking demonstration videos
  - Developed, communicated, and shared the “Eat the Rainbow” Rush Smart Minute educational video with community partners
  - Partnered with Kane County’s Food Hub for a pilot food prescription program
  - Developed a program to provide healthy food boxes to low-income patients who are food insecure

Three healthy weight education projects designed for the Hispanic/Latino community

- Developed and implemented a new chronic disease education series for the community, including community presentations, podcasts, and a webpage with community resources
- Developed and piloted a medication reconciliation program for heart failure & coronary intervention patients
- Developed and implemented education and resource materials regarding appropriate care settings
- Developed and implemented a Care Manager program to schedule follow-up care appointments for high-risk and chronic disease patients before discharge
- Provided over 80 community education programs with over 2,700 participants that addressed the topics of healthy weight, chronic disease, or access to care
- Collaborated with community partners to identify strategies to improve health in Aurora
- Continued active participation and collaboration through Kane Health Counts committees and initiatives
- Also, continued a number of programs developed during the FY2013 CHNA cycle

Impact of Actions

The actions taken since the FY2016 assessment have had a positive impact on the health of the community.

Highlights include:

- The prevalence rate of adult obesity in the community decreased from 35.5% to 32.4%.
- The prevalence rate of diabetes in the community decreased from 13.0% to 9.6%.
- Ran 13 healthy weight/lifestyle programs with over 175 total participants. A majority of participants experienced positive results in their physical activity performance/weight/BMI and improved knowledge gained about healthy lifestyle.
- Improved the understanding of the benefits of healthy eating through education and resources provided to four local food pantries, additional shared community resources, healthy eating education programs, and the food prescription pilot program.
- Improved follow-up care adherence for high-risk patients and chronic disease patients treated in the emergency department through Care Managers scheduling ~5,500 follow-up appointments with a primary care provider before patient discharge.
- Improved follow-up care adherence for chronic disease inpatients with diabetes, CHF, and stroke through Care Managers scheduling post-discharge follow-up appointments for nearly all of these patients.
- Care Managers provided one-on-one education to over 3,000 patients who were treated in the ED who did not have a PCP or were unaware of their PCP, especially those who were vulnerable, had a chronic disease, and/or were high utilizers of the ED.
- Reduced preventable readmissions for COPD and stroke.
- Improved self-management of chronic disease for those who participated in the medication adherence pilot program or chronic disease education series.
- Reduced the number of non-emergency ED visits at RCMC by 9% from FY16 to FY18.
- The positive impacts noted above are also anticipated in the Hispanic/Latino community due to the targeted effort to address vulnerable populations.