RUSH
Rush Copley

2022 Community Health Needs Assessment and Community Health Implementation Plan FY23-FY25

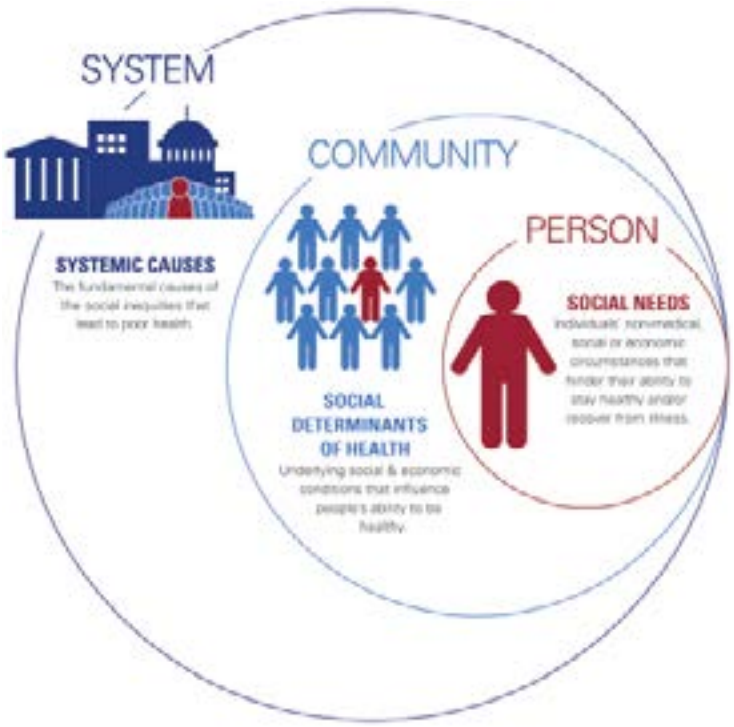
Introduction

Founded in 1886 as Aurora City Hospital, Rush Copley Medical Center has a 136-year-old rich history of providing healthcare services to residents of Aurora and the greater Fox Valley area. And while we love and embrace the rich diversity of our community, we also recognize that this diversity includes inequities and barriers in health, employment, income, and education.

Much of health happens beyond the walls of hospitals and health systems. As a matter of fact, physical environment, social determinants and behavioral factors drive an estimated 80% of health outcomes. Together, with residents, community organizations and leaders, it is an ongoing priority to be a catalyst for community health by addressing the inequities and breaking down those barriers to health. Societal factors are multifaceted and complex, and can only be taken on in partnership with public and private community stakeholders. Recent events — COVID-19 and the social unrest around racism and equity — add a sense of urgency to this essential work. Never have partnerships been more critical as these factors changed the game on how we provide services: changed but did not deter.

As a result, Rush Copley through the Office of Community Engagement has adopted the American Hospital Association's' **Societal Factors that Influence Health Framework** to develop comprehensive strategies that have an impact at the **individual, community** and **systemic** level.

The core of Rush Copley's plan and strategies is derived from it's Community Health Needs Assessment (CHNA) and Community Health Implementation Plan (CHIP).



Individual/Person

This is Rush Copley's greatest strength and opportunity. Patient-level interventions, at the point of care, can mitigate non-medical social and economic challenges.

Community

As an anchor institution in this community, Rush Copley will lead, convene, collaborate, invest in or support activities that improve the community environment with multi-sector stakeholders. : This is our community – where we live, learn, work, play and pray.

Systemic

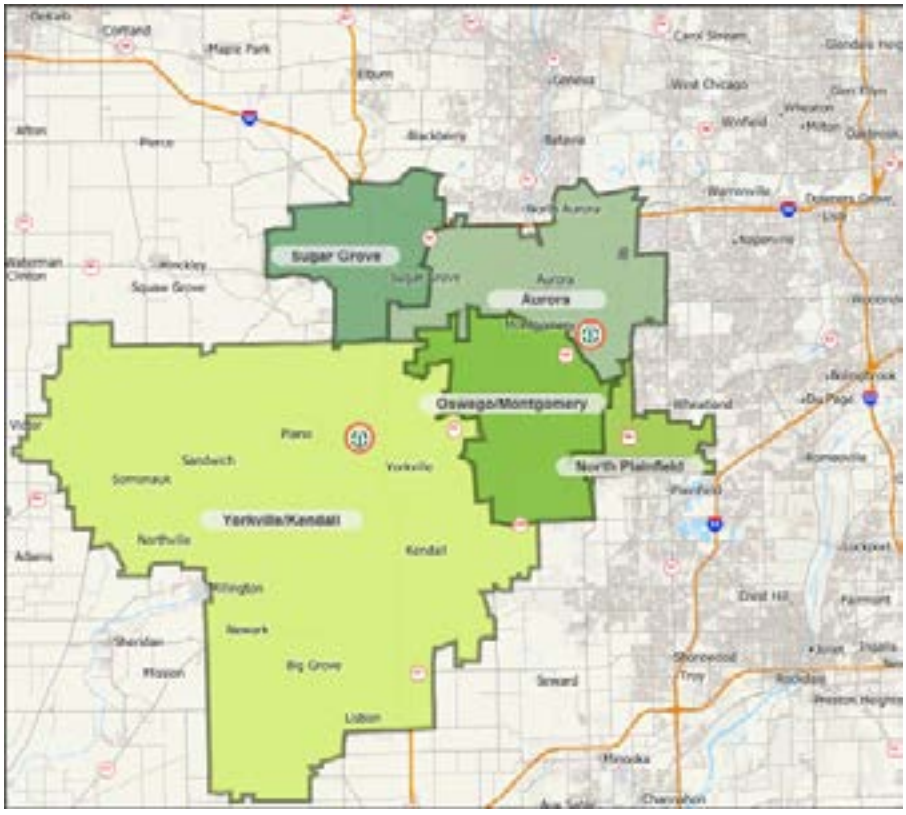
In partnership with other stakeholders, support and affect policy, system, environmental and cultural changes to achieve widespread impact on societal issues such as racism, sexism, generational poverty, redlining by financial institutions, environmental injustice or educational systems.

Service Area/Community Needs

The CHNA and CHIP focuses specifically on the community served by Rush Copley. That community 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 below, the community served includes all of Aurora and most of Southern Kane and Kendall Counties.
- Includes 17 zip codes and 13 cities/villages.
  - 60505 – Aurora
  - 60506 – Aurora
  - 60504 – Aurora
  - 60503 – Aurora
  - 60502 – Aurora
  - 60543 – Oswego
  - 60538 – Montgomery
  - 60560 – Yorkville
  - 60545 – Plano
  - 60548 – Sandwich
  - 60542 – North Aurora
  - 60544 – Plainfield
  - 60564 – Naperville
  - 60585 – Plainfield
  - 60554 – Sugar Grove
  - 60563 – Naperville
  - 60586 – Plainfield
- Covers six counties: Kane, Kendall, DeKalb, LaSalle, DuPage and Will.

The primary service area has a population of over 383,000 residents. There are 67.1% White, 8.2% Black/African American, 0.4% American Indian/Alaskan Native, 6.2% Asian, 0.1% Native Hawaiian/Pacific Islander, 14.7% Some Other Race, and 3.3% Two or More Races. Approximately 33.5% of the population is of Hispanic or Latino origin. The median age of the community is 34.3 years.



About the Community Health Needs Assessment (CHNA)

Background

The Patient Protection and Affordable Care Act of 2010 requires private, not-for-profit hospitals to conduct a CHNA at least once every three years and to adopt an implementation strategy to address the identified community needs.

Every three years, Rush Copley completes a comprehensive CHNA process to identify, prioritize, and address the top (three to five) health issues in the communities served. Once priorities are identified, a subsequent CHIP is developed to address those priorities. The CHIP is comprised of actionable initiatives — some already in place, some to be developed, but almost all implemented collaboratively with community partners.

Framework

Rush Copley follows the Association of Community Health Improvement's (ACHI) framework from the American Hospital Association which develops a comprehensive and efficient Community Health Needs Assessment, which is displayed in the graphic to the right.

Methodology

Rush Copley utilizes four key methods used in the data and information collection and analysis component of the assessment process that are critical in developing an accurate picture of the health of the community served.

1) **Partnering with the local county (Kane & Kendall) health departments.** Rush Copley collaborates with the Kane County and Kendall County health departments, as well as other community partners and other local health providers/experts (including AMITA HealthMercy Medical Center, AMITA Health Saint Joseph Hospital, Northwestern Medicine Delnor Hospital, Advocate Sherman Hospital, and the INC Board), 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. In addition, as a part of the Kane Health Counts Collaborative, Rush Copley partnered with Conduent Healthy Communities Institute (HCI) to conduct provide a specific Rush Copley CHNA as a derivative of the Kane County CHNA.

2) **Community Health Surveys.** Rush Copley contracted with Conduent HCI to conduct an online health status survey of adult residents from the community served. The survey questions related to top health needs in the community, individuals' perception of their overall. It included 47 questions and was available in both English and Spanish to seek resident feedback on the communities' needs. 1,515 adult participants responded.

   Rush Copley conducted an additional online survey specially among the PSA and obtained 711 responses. They survey was available online, in English and Spanish and included 20 questions.

3) **Focus Groups and Key Informant Surveys.** Two key informant surveys, three Kane Health Counts Focus Groups and six RCMC focus groups provided unique perspectives of the health needs in the community from residents, patients, healthcare leaders and experts.

4) **Extensive Secondary Data Analysis.** Rush Copley accessed 40+ local, state and national sources of health data and information. These data indicators aligned & compared to the FY13, FY16, FY19 CHNAs and Healthy People 2030 data and goals. These data sources can be found here.

This entire (16 to 18-month) process is overseen and facilitated by the Office of Community Engagement. Once the research is complete and all input gathered, a collaborative steering committee, with healthcare and community expertise, guided the development of the CHNA and CHIP. In evaluating the many community priorities, that steering committee considers the following *Needs Identification Criteria:*

1. The **severity** of the indicator/problem
2. The **magnitude** of the indicator/problem
3. A high need among **vulnerable populations**

And when determining which priorities to address, the following Needs Prioritization Criteria are considered:

1. The community's **capacity to act** on the issue, including any economic, social, cultural, or political considerations
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
4. Whether the issue is a **root cause** of other problems

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	
• Online Community Health Survey - Conduent Community Health Survey • Focus Groups • Compañeros en Salud/Partners in Health • Kendall Country Interagency Council (KCIC) • Rush Copley Nursing Management • Rush Copley Care Managers • Rush Copley Health Equity • Rush Copley Patient Family Advisory Council (PFAC) • Online Key Informant/Stakeholder Surveys – Kane County Forces of Change – 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 web site.	• 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, 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, Office of Public Health Science Services, National Center for Health Statistics • Centers for Disease Control & Prevention, PLACES: Local Data for Better Health • Community Commons • County Health Rankings and Roadmaps • Drug Abuse Warning Network, www.samhsa.gov • ESRI ArcGIS Map Gallery • Fit Kids 2020 Plan (Kane County) • IHA COMPdata • Illinois Department of Public Health • Illinois Behavioral Risk Factor Surveillance System • Illinois Department of Public Health State Cancer Registry • Illinois Department of Human Services • Healthy People 2030 • Kane County Health Department	• Kane County Community Health Assessments and supportive reports 2011, 2016, 2018 • Kane County Community Health Improvement Plan 2012-2016, 2017-2020, 2021-2024 • Kendall County Health Department • Kendall County IPLANs 2011-2016, 2016-2021 • National Cancer Institute, State Cancer Profiles • National Institute on Drug Abuse • The Neilsen Company • RCMC FY2013, FY2016 and FY2019 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:

- 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.)
- Very limited to no data was available for undocumented residents in the community
- While this assessment was designed to provide a comprehensive and broad picture of the health of the overall community, there are several medical conditions that are not specifically addressed
- The online survey analysis demonstrated limitations on community representation among specific populations group (Black and Africans populations, Hispanic and Latino populations, and men)
- 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.

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 while conducting this Community Health Needs Assessment.

Service	Health Care Facility and Resource	
Health Care Facilities and Providers	• Aunt Martha's Health & Wellness • Advocate Aurora Health Care • Independent Physicians/Providers • AMITA Mercy Medical Center • Rush Copley Medical Center • Northwestern Medicine Valley West Hospital • VNA Healthcare • Community Health Partnership: Aurora Medical and Dental Clinic	• Dental Offices • Drug Store Based Clinics • Planned Parenthood • Open Door Clinic • Long-term care facilities such as Alden of Waterford and Tillers • Palliative care professionals such as Seasons Hospice and Hands of Hope • TriCity Family Services • Home health agencies
Mental and Behavioral Health	• Association for Individual Development (AID) • Aunt Martha's Health & Wellness • Breaking Free, Inc. • Northwestern Medicine Behavioral Health Services • Communities in Schools • Advocate Aurora Health Care • 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 • Waterford Place Cancer Resource Center
Other Agencies, Programs and Resources	• City of Aurora • Compañeros en Salud/ Partners in Health • Fit for Kids Program • Healthy Living Council • Kane County Health Department • Kendall County Health Department • Kendall County Interagency Council • Women, Infants and Children (WIC) Program • 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 • Local Emergency Medical Services • Local Nutritionists • Senior Services Associations • Kendall Area Transit (KAT) • PACE Bus • American Cancer Society • American Diabetes Association • Local Grocery Stores and Food Panties • Northern Illinois Food Bank • United Way • Kane Kares

Section: Where We've Been: 2019 CHNA and 2020-2022 CHIP

Rush Copley conducted its last CHNA and developed a subsequent CHIP in FY19. Here are those previously identified and prioritized health needs:

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)

Despite the onset of the pandemic early in this CHIP period (spring of FY20), which required a significant realignment of staffing and resources, there have been outstanding accomplishments and progress toward addressing these priorities. In review:

Reduce inequities: through improved identification and connection of patients in need to available community resources

Strategy 1: Identify, measure and mitigate the social determinants of health among those at greatest risk through improving the connection between vulnerable populations and needed socioeconomic resources

- In collaboration with Rush University Medical Center, implemented a screening tool for RCMC inpatients and select ambulatory area patients that is now used to help identify the social, economic and structural determinants of health that could be affecting patient's health.
- As patient needs are identified through the screening, increased and improved the referral process to resources that can help reduce inequities (NowPow).
- Leveraged use of the EPIC medical record throughout the process
- Rush Copley Promise Pantry established in March of 2021 to address food insecurity among Rush Copley patients, family members and caregivers
    - All in-patient departments, Emergency Department, Cancer Care Center, Diabetes Center, Pediatric Offices, and Waterford Place Cancer Resource Center
    - First year a total of 845 (4,225 meals provided) Promise Pantry Bags distributed
- Collaboration with Aurora Are Interfaith Food Pantry and Top Box Foods
    - Summer 2020, Two pop up pantries hosted that served 93 cancer care patients and caregivers
    - Summer 2021, One pop up pantry hosted that served 250 community members

Strategy 2: Provide staff and physician education focused on the unique needs of vulnerable populations

- Developed and implemented an education plan regarding social determinants of health to increase knowledge and awareness among care providers
- Developed and implement care provider education focused on the unique needs of vulnerable populations. Gender affirming care modules made available to medical staff
- Sexual orientation and gender identity screening incorporated in to patient profile to best meet the needs of each person.

Strategy 3: Participate in local community health improvement collaborative(s)

Participated in and partnered with city and county agencies, health systems, and community organizations, including but not limited to:

- The Kane Health Counts Executive Committee and committee for income, job-ready workforce, and education
- Oswego Senior Center committee for Senior/dementia-friendly community
- FUSE (Frequent Users System Engagement) initiative with the City of Aurora

Mental and Behavioral Health: Reduce the misuse of opioids and opioid-related deaths in the community

Strategy 1: Reduce the number of opioid prescriptions and quantity prescribed

- Incorporated intelligent design through the EPIC build and implementation processes that serves as a tool in the efforts to reduce opioid prescriptions/quantity prescribed. Included the following:
    - Updated order sets to optimize pain management while reducing the use of opioids
    - Implemented dose warnings for high morphine equivalent per day doses and prescribing advice of Narcan (naloxone) antidote
    - Developed opioid dashboards and reports to track and benchmark opioid use
    - Removed default durations in orders for opioid prescriptions
- In partnership with Rush Copley Medical Group, implemented EPIC enhancements with Best Practice Advisories with MME (Morphine Equivalents)
- Developed and implemented provider education programs regarding the opioid crisis and ways to optimize pain management
- System wide continuing education program rolled out around opioid ordering and using alternatives, which produced the following positive results.
    - Realized a 42% decrease in opioid prescriptions written for greater than 7 days
    - Realized a 60% decrease in opioid prescription written for greater than 90 Morphine Milligram Equivalents (MME) per day. These dose levels have the highest risk of overdoses.
    - Realized a 49% decrease in opioid prescriptions written for greater than 50 MME per day

Strategy 2: Reduce the number of opioids already existing in the community

- Assessed the feasibility of implementing a prescription drop-off box on site and/or pharmaceutical disposal via mail
    - Additionally, disseminated information to providers, patients, and community on opioid take back locations
- Assessed the feasibility of distributing Dispose Rx (or similar material) with opioid prescriptions

Strategy 3: Develop and implement community, patient, and care provider education

- Developed and implemented community and healthcare provider education programs regarding:
    - How to manage pain without medications
    - Education to consumers and providers regarding opioid use
    - How to properly dispose of unused medications
- Improve discharge instructions and education through EPIC regarding opioid use

Strategy 4: Participate in local community health improvement collaborative(s)

Participated in and partnered with city and county agencies, health systems, and community organizations, including but not limited to:

- Kane Health Counts Executive Committee
- Kane County Opioid Task Force
- Kane County Behavioral Health Council
- Rush University System for Health Opioid Workforce
- Kendall County to teach Narcan (naloxone) administration to the community

Prevent and Reduce Chronic Disease: Reducing tobacco usage in the community (including smoking and vaping)

Strategy 1: Develop/enhance and implement education and resources to help patients and the community quit smoking/vaping

- Developed/enhanced and implemented education, resources, and/or programs to help the community quit smoking
    - Continued to improve awareness through creating or utilizing materials in both English and Spanish as well as having access to additional resources in other native languages for the patient population at Rush Copley
    - Implemented promotion and utilization of Pro-Change for Rush Copley and Rush Copley Medical Group patients and employees (web-based digital coaching for smoking cessation)
    - Hosted Spanish language Freedom from Smoking (FFS) programs in the community
    - Provided the FFS flyer to community partners to distribute among their population that are current smokers

- Partnered with local school districts and health departments to discuss efforts around vaping/e-cigarette prevention and education for pre-teens, adolescents, and parents.
    - Community Education at schools with parents, students, school nurses and at after school program

Strategy 2: Leverage the use of the EMR to improve documentation and reduce tobacco usage

- Improved the assessment and documentation of patients' smoking history by implementing tools in the EPIC EMR to quantify the number of patients that smoke, as well as calculate and document their smoking history (pack year history)
- Developed and implemented a tobacco smart set in the EPIC EMR for both the hospital and RCMG that will:
    - Track provider referrals for Freedom From Smoking program
    - Track provider referrals to the Illinois Tobacco Quitline
- Participated in the pilot program for the Automation Referral for the Illinois Tobacco Quitline
- Enhanced patient discharge instructions in the EPIC EMR system so that it incorporated and provided tobacco cessation resources for patients (state, local and Rush System resources)

Strategy 3: Develop/enhance care provider education to increase engagement of tobacco cessation and assessment of willingness to quit

- Strategically developed staff and physician education around engagement of tobacco cessation and addressing patients' willingness to quit smoking (among current smokers)
    - Began with education among RCMG practices and then transitioned into RCMC department education
    - Assessed and determined the best teaching methods for each department in order to engage their respective patient population(s) in tobacco cessation discussions and assessment of willingness to quit, which translated into a positive patient experience vs. a negative experience
- Educated clinical staff regarding utilization of the Illinois Tobacco Quitline Referral Forms on Policy & Procedures Portal
    - Tobacco Cessation Resources SmartSet has been completed among clinical and non-clinical staff
    - Vaping and Marijuana CME

Strategy 4: Participate in local community and Rush System health improvement collaborative(s)

Participated in and partnered with city and county agencies, health systems, and community organizations, including but not limited to:

- Kane Health Counts Executive Committee
- Kane County Tobacco Coalition
- Rush University's Tobacco Oversight Committee
- Became a Rush System partner in supporting Tobacco 21 in IL

Section: FY22 CHNA Priorities and FY23-25 CHIP

Despite environmental and societal factors and obstacles, Rush Copley's commitment to the 2019 CHNA priorities and subsequent CHIP plan remained steadfast. COVID-19 not only did not ultimately deter progress, it also served as a catalyst for Rush Copley to re-commit resources as these community needs have become even more urgent.

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:

Identified Community Health Needs
1. Access to Health Services Leverage patient and community-driven data to advance health equity.
2. Behavioral Health (includes mental health and substance abuse) Increase awareness on behavioral health conditions and navigation of behavioral health services in the community. Continue focus on reducing the misuse of opioids and opioid-related deaths.
3. Chronic Disease: Health Behaviors and Management Reduce health behaviors related to chronic health conditions and increase management of chronic disease in the community.
4. Inequities in vulnerable populations Reduce inequities caused by the social, economic, and structural determinants of health

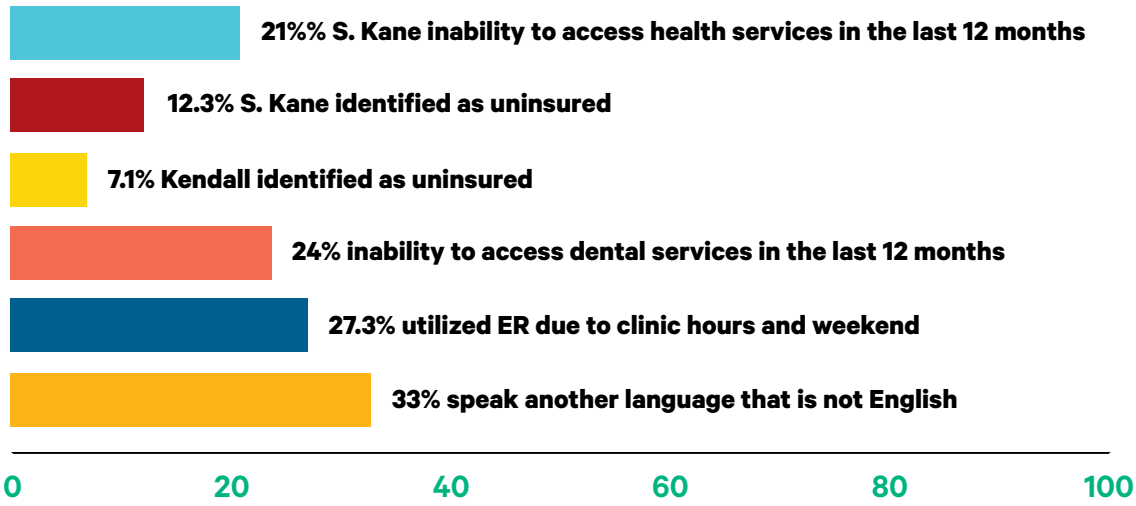
Rush Copley developed and adopted an implementation strategy to address these community health needs. The CHNA and Implementation Strategies were approved and adopted by the hospital's Board of Directors on March 30, 2022.

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

FY2022 CHNA priorities and the FY2023-2025 Strategies

Access to Health Services: Leverage patient and community-driven data to advance health equity

Top priority through Kane Health Counts assessment and Rush Copley's assessment. Health literacy issues and language barriers make seeking or renewing healthcare coverage difficult, especially for older adults and immigrant populations.



Identified barriers:

- Lack of funds for medication
- 35% Cost of care
- 28% Closure due to Covid-19 pandemic

Strategies

- Increase referrals to a primary care provider or medical home for patients seen in the Emergency Room
- Continue partnership with local federally qualified healthcare centers to connect uninsured patients with insurance benefits
- Create culturally sensitivity training for staff on capturing Race, Ethnicity and Language (REAL) and Sexual Orientation and Gender Identity (SOGI) patient data
- Continue to provide accessible community programing: Tobacco Cessation, Diabetes Management, Movement Disorders Program and Waterford Place Cancer Resource Center
- Participate in local community health improvement collaborative(s)

Priority Population

Community served by Rush Copley Medical Center. Vulnerable populations (racial and ethnic minorities, low-income population, uninsured, children, seniors, members of the LGBTQ+ community) served by Rush Copley Medical Center

Anticipated Impact

- Increase the number of patients connected with a primary care provider or medical home
- Reduce the number of uninsured patients
- Increase staff knowledge around REAL and SOGI Data
- Increase staff comfortable level on asking REAL and SOGI Data
- Incorporate REAL and SOGI data into health outcome dashboards
- Increase participation in Rush Copley's community programs

Behavioral Health: Increase awareness on behavioral health conditions and navigation of behavioral health services in the community. Continue focus on reducing the misuse of opioids and opioid-related deaths.

Number one priority identified among Kane Health Counts and RCMC Assessments. Pandemic amplified the behavioral health crisis. Social isolation highlighted among children, youth and older adults. Anxiety and stress that parents and families with children are experiencing presently due to pandemic. Teen and adolescent use/abuse of illegal substances and the interconnectedness to peer pressure, bullying, and self-esteem.

- 40% of survey respondents identified mental health as the most important community health issue
- 28% of survey respondents identified alcohol and other substance use as the most important community health issue
- 15% S. Kane couldn't access services in the last 12 months
- Age-adjusted suicide, drug and opioid-involved overdose death rate higher in males
- Age-adjusted hospitalization rate due to opioids and substance abuse higher among Black/AA males

Barriers

- Cost and affordability
- Availability of appointments
- Navigation and/or knowledge about available services
- Highest among minority populations and individuals 18-54 y/o

Strategies

- Develop partnership with Kane County Health Department's Integrated Referral and Information System (IRIS) to provide close loop referrals
- Develop partnership for "soft handoff" with community behavioral health organizations
- Continue reduction on the number of opioid prescriptions and assess other opportunities to address the opioid crisis

- Collaborate with local community based behavioral health organizations to establish educational opportunities
- Participate in local community health improvement collaborative(s)

Priority Population

Community served by Rush Copley Medical Center, minority populations and individuals 18-54-year-olds

Anticipated Impact

- Establish Rush Copley as a member of Kane County Health Department's Integrated Referral and Information System (IRIS)
- Increase provider and clinician knowledge on behavioral health services in the community
- Connect patients with behavioral health services
- Reduce the number of opioid prescriptions in the community
- Increase community member knowledge on behavioral health conditions
- Reduce stigma on utilizing of behavioral health services

Chronic Disease: Reduce health behaviors related to chronic health conditions and increase management of chronic disease in the community.

Rush Copley data analysis demonstrated a strong need for education on chronic disease management. Health behaviors choices linked to chronic disease were highlighted through the assessment related to tobacco, nutrition, physical activity and weight.

- 30% of survey respondents identified nutrition, physical activity and weight as the most important community health issue

Chronic disease is the leading cause of death and disability.

- 6 in 10 Americans have a chronic disease
- 4 in 10 Americans have more than two chronic diseases (CDC, 2022)

Disparities highest among Black/African American and Hispanic/Latinos in regards to:

- Age adjusted ER rates and hospitalization due to diabetes 2, complications from diabetes, and uncontrolled diabetes

Disparities highest among Black/African American

- Age adjusted hospitalization due to hypertension
- Age adjusted ER rates and hospitalization due to asthma

PLACES: Local Data for Better Health, 2019	Plano	Oswego	Aurora	East Aurora
Healthcare				
Lack Health Insurance 18-64y/o	17.4%	10.8%	21.5%	40.5%
Obesity 18+y/o	36.1%	32.2%	32.8%	41.5%
Had Annual Health Visit	70%	72.2%	71%	67.7%
Had Dental Health Visit	65.1%	75.6%	60.4%	47.5%
Smoking	19.8%	15.6%	18.2%	21.8%

Strategies

- Adopt the Steps to Healthy Living, Chronic Disease Self-Management Workshop
- Leverage community referral resource system (i.e. IRIS, Now Pow, Kane 211, etc.) to generate referrals for the Chronic Disease Self-Management Workshop
- Continue to provide community programing: tobacco cessation, diabetes management, Movement Disorders and Waterford Place Cancer Resource Center
- Partner with Kane County Health Department to create and develop a backbone entity in the community that builds and supports community-based programming related to nutrition, exercise and weight
- Participate in local community health improvement collaborative(s)

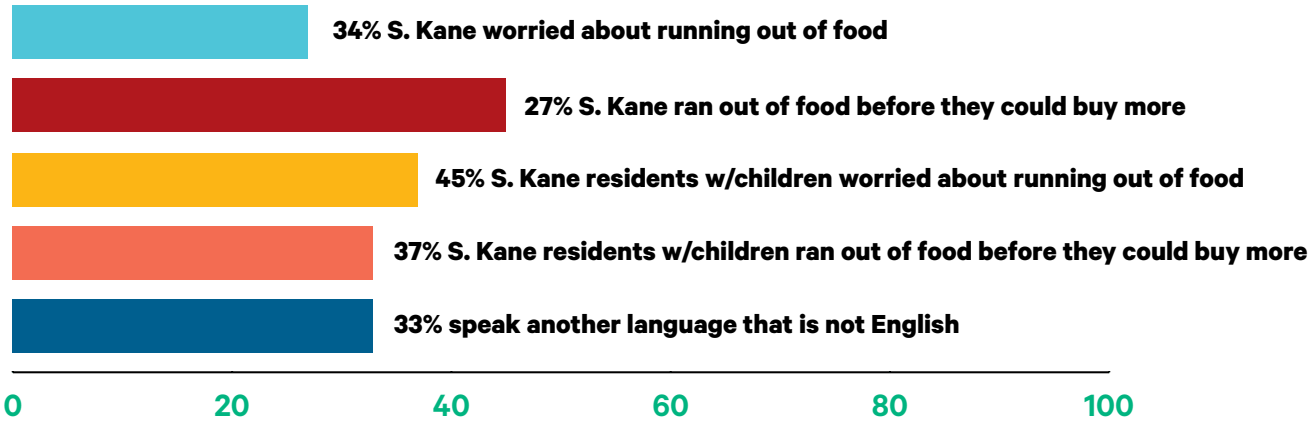
Priority Population:

Community served by Rush Copley

Anticipated Impact

- Implement the Steps to Healthy Living, Chronic Disease Self-Management Workshop
- Increase management of chronic health conditions through the Steps to Healthy Living, Chronic Disease Self-Management Workshop
- Decrease risk of chronic health conditions by changing health behaviors
- Increase support to individuals facing a movement disorder
- Increase patients understanding of diabetes managemental
- Reduce tobacco use in the community
- Increase participation in Rush Copley's community programs

Inequities in vulnerable populations: Reduce 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.



60505, 60506 and 60545 have the highest level of socioeconomic need among zip codes within Rush Copley's PSA.

Strategies

- Identify benchmarks for Social Determinants of Health (SDoH) screening
- Continue to develop and establish SDoH screening to emergency room and ambulatory departments
- Assess potential impact of a community health worker to conduct SDoH screening in Emergency Room
- Partner with local food pantry to provide a healthy box of produce and protein to patients that screen positive for the SDoH, close loop referral
- Participate in local community health improvement collaborative(s)

Priority Population

Community served by Rush Copley Medical Center. Vulnerable populations (racial and ethnic minorities, low-income population, uninsured, children, seniors, members of the LGBTQ+ community) served by Rush Copley Medical Center

Anticipated Impact

- Increase the number of patients screened by SDoH
- Increase number of patients connected with community resources
- Establish dashboard for SDoH screening
- Provide interventions for patient populations that have a high prevalence of screening positive on the SDoH
- Establish Community Health Worker in Emergency Room
- Reduce misuse of emergency room services
- Provide close loop referral process through Now Pow for patients facing food insecurity

Significant Health Needs and Health Indicators Not Addressed

Given limited resources, and the strength of partner organizations in the community, a number of identified health needs are not being directly addressed, including:

- Immunization and Infectious Diseases: Being addressed at the County level with participation of Rush Copley
- Maternal, fetal, and infant health: A relatively low priority assigned to the need by CHNA
- Exercise, Nutrition & Weight: Being addressed at the County level and Rush Copley has incorporated within the Chronic Disease priority
- Education: Other facilities or organizations in the community are addressing the need
- Environment: Other facilities or organizations in the community are addressing the need
- Older Adults & Aging: A relatively low priority assigned to the need by CHNA
- Other Chronic Diseases: Rush Copley's analysis demonstrated a relatively low priority assigned to the need
- Public Safety: Other facilities or organizations in the community are addressing the need
- Teen & Adolescent Health: A relatively low priority assigned to the need
- Transportation: Other facilities or organizations in the community are addressing the need

Public Comment

Rush Copley Medical Center's Community Health Needs Assessment and Community Health Implementation Plan can be access by the public by visiting https://www.rush.edu/about-us/rush-community/chnachip-reports-and-cbr/rush-copley-chna-report. For more information or to provide public comment on our CHNA, please contact:

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Conclusion

This joint Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP), was completed through an extraordinarily collaborative effort. As an anchor in this community, Rush Copley stands committed to serving the health needs well beyond the walls of our hospital and offices.

Alone, we can do so little; Together, we can do so much

—Helen Keller