



Community Health Needs Assessment

2019

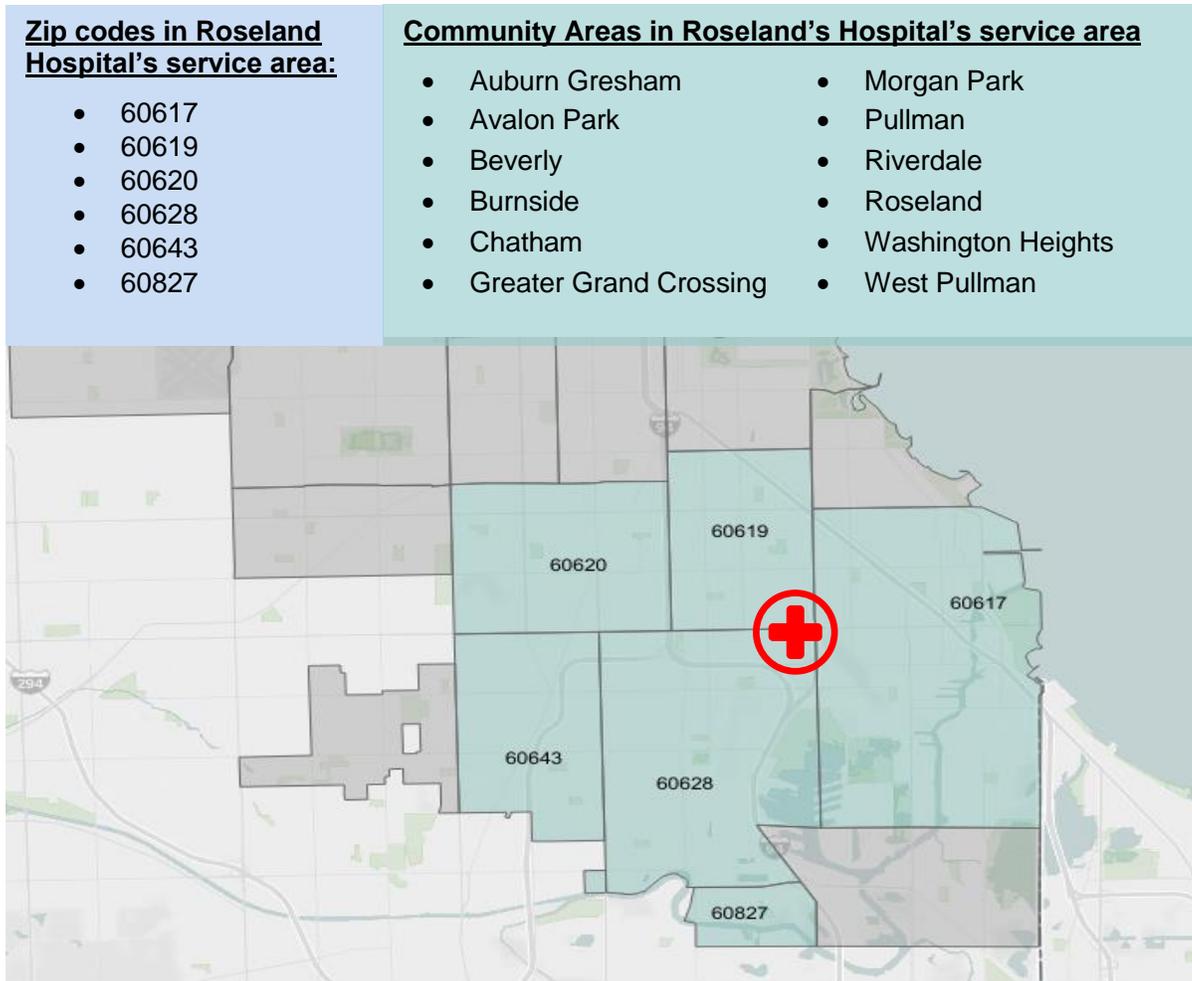
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I. Intro to Roseland Hospital and Description of Roseland Hospital Service Area

Roseland Hospital's service area spans across six zip codes containing 12 community areas in the City of Chicago (Figure 1). Around 300,000 individuals reside in Roseland Hospital's service area (2016 5-year estimates, American Community Survey) with 86% identifying as Non-Hispanic African American/black, 8% Non-Hispanic white, and 4% Hispanic/Latinx.

Figure 1. Roseland Hospital Service Area Map and List of Communities



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

Roseland Hospital (RH) and members of the Alliance for Health Equity (AHE), a collaborative of over 30 hospitals, 7 health departments, and 100 community partners, worked together between March 2018 through March 2019 to conduct a comprehensive Community Health Needs Assessment (CHNA) in Cook County.

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

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

Summary of our collaborative health equity approach to CHNA

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

AHE completed this collaborative CHNA between March 2018 and March 2019. Primary and secondary data from a diverse range of sources were utilized for robust data analysis and to identify community health needs in Chicago and Suburban Cook County. The Illinois Public Health Institute (IPHI) worked with the CHNA committee and steering committee to design and facilitate a collaborative, community-engaged assessment. As with the 2015-2016 collaborative CHNA, this 2019 CHNA process is adapted from the Mobilizing for Action through Planning and Partnerships (MAPP) model, a community-engaged strategic planning framework that was developed by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). Both the Chicago and Cook County Departments of Public Health use the MAPP framework for community health assessment and planning. The MAPP framework promotes a system focus, emphasizing the importance of community engagement, partnership development, and three types of data--secondary data, community input, and system analysis. AHE chose this inclusive, community-driven process to leverage and align with health department assessments and to actively engage stakeholders, including community members, in identifying and addressing strategic priorities to advance health equity.

Primary data for the CHNA was collected through four methods:

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

Secondary data for the CHNA was compiled and analyzed in partnership with epidemiologists from the Chicago Department of Public Health (CDPH) and Cook County Department of Public Health (CCDPH), IPHI, and member hospitals. The partners worked with the AHE steering committee to select a common set of indicators based on an adapted version of the County Health Rankings and Roadmaps Model. Data was organized in the following categories: overview of health inequities; social and structural determinants of health; mental health and substance use disorders; access to quality health care and community resources; and chronic conditions. Secondary data used in the CHNA were compiled from a range of sources, including the American Community Survey from the U.S Census Bureau, the Behavioral Risk Factor Surveillance

System, and the Health Chicago Survey from the Chicago Department of Public Health. Additional information can be found in Figures 6 and 7 of the full [Alliance for Health Equity CHNA report](#).

In alignment with the purpose, vision, and values, the Alliance for Health Equity prioritizes engagement of community members and community-based organizations as a critical component of assessing and addressing community health needs. Community partners have been involved in the assessment and ongoing implementation process in several ways both in providing community input and in decision-making processes (Figure 5 of Full CHNA Report). The community-based organizations engaged in the Alliance for Health Equity represent a broad range of sectors such as workforce development, housing services, food security, community safety, planning, community development, immigrant rights, primary and secondary education, faith communities, behavioral health services, advocacy, policy, transportation, older adult services, health care services, higher education, and many more. All community partners work with or represent communities that are disproportionately affected by health inequities such as communities of color, immigrants, youth, older adults and caregivers, LGBTQ+, individuals experiencing homelessness or housing instability, individuals living with mental illness or substance use disorders, individuals with disabilities, veterans, and unemployed youth and adults.

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

Alliance for Health Equity - Overall Community Health Focus Areas



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

The following section highlights primary and secondary data related specifically to the Roseland Hospital service area.

Primary Data

Community Input Survey

The community input survey was a qualitative tool designed to understand the community health needs and assets from the community residents. The community input surveys, along with focus group data, informed the priority areas and strategies for community health improvement in Chicago and suburban Cook County. There were 324 survey respondents from the Roseland Hospital service area.

Table 1. Demographics of Community Input Survey Respondents in Roseland Hospital Service Area.
The community survey asked residents about top health issues, top needs for a healthy community, greatest

Age (n=308)	%	Annual Household Income (n=324)	%
18-24	9%	Less than \$10,000	12%
25-34	11%	\$10,000 to \$19,999	10%
35-44	16%	\$20,000 to \$39,999	17%
45-54	16%	\$40,000 to \$59,999	15%
55-64	19%	\$60,000 to \$79,999	13%
65-74	19%	\$80,000 to \$99,999	5%
75-84	8%	Over \$100,000	8%
85 or older	3%	Prefer not to answer	19%

Race/Ethnicity (n=300)	%	Sexual Orientation (n=295)	%
Asian	0.3%	Straight	96%
African American/black	85%	Gay or Lesbian	2%
Hispanic/Latinx	8%	Bisexual	1%
Native American	0.3%		
White	1%		
Multiracial	5%		

Children in the household (n=300) <i>Multiple responses allowed per respondent</i>		%
No children in my household		62%
Child/children age 0-4 in my household		13%
Child/children age 5-12 in my household		18%
Child/children age 13-17 in my household		19%
No children in my household		62%

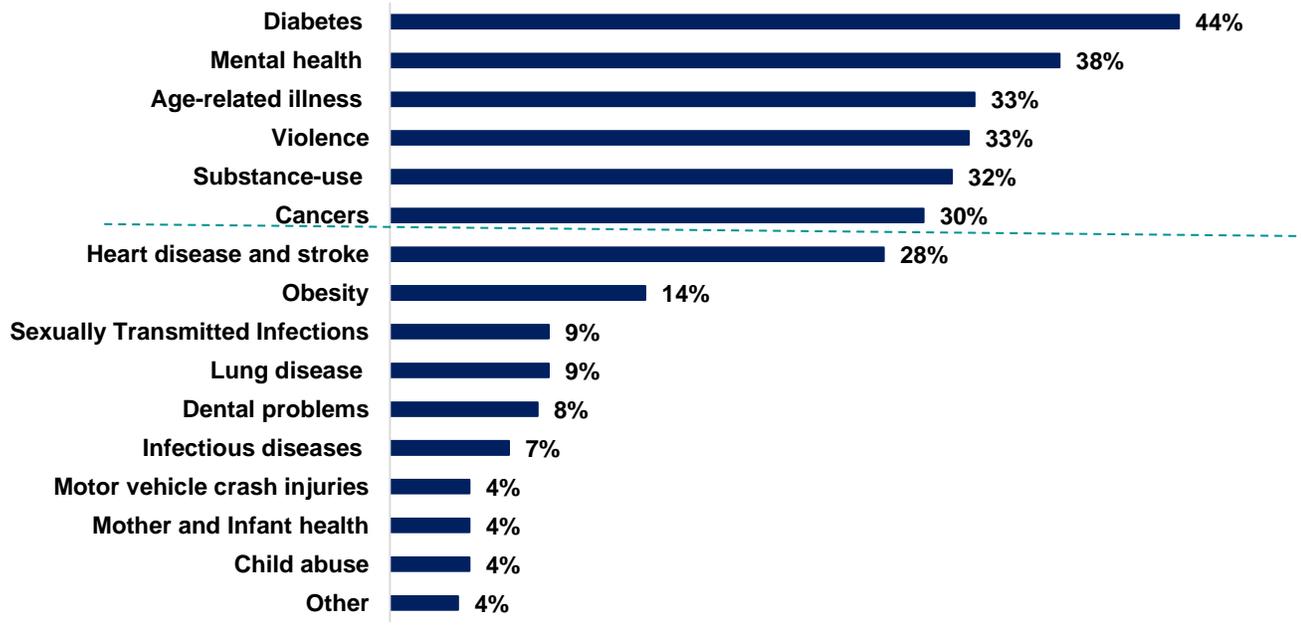
Anyone in the household have a disability? (n=299)	%
No	73%
Yes	27%

strengths in the community, and what needs to be improved.

The top health issues identified by respondents in the communities served by Roseland Hospital were diabetes, mental health, age-related illness, substance-use, and cancers. All of these health issues were selected by 30% or more of survey respondents.

Figure 3. Community Input Survey Data – Top Health Issues

(Note: 313 respondents from the Roseland Hospital service area answered this question and multiple responses allowed per respondent)



Survey respondents also identified the top needs for a healthy community. These top needs include access to healthcare and mental services, safety and low crime, access to community services, access to healthy foods, and quality job opportunities (Figure 4). These community needs were selected by 25% or more of the survey respondents.

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

(Note: 313 respondents from the Roseland Hospital service area answered this question and multiple responses allowed per respondent)

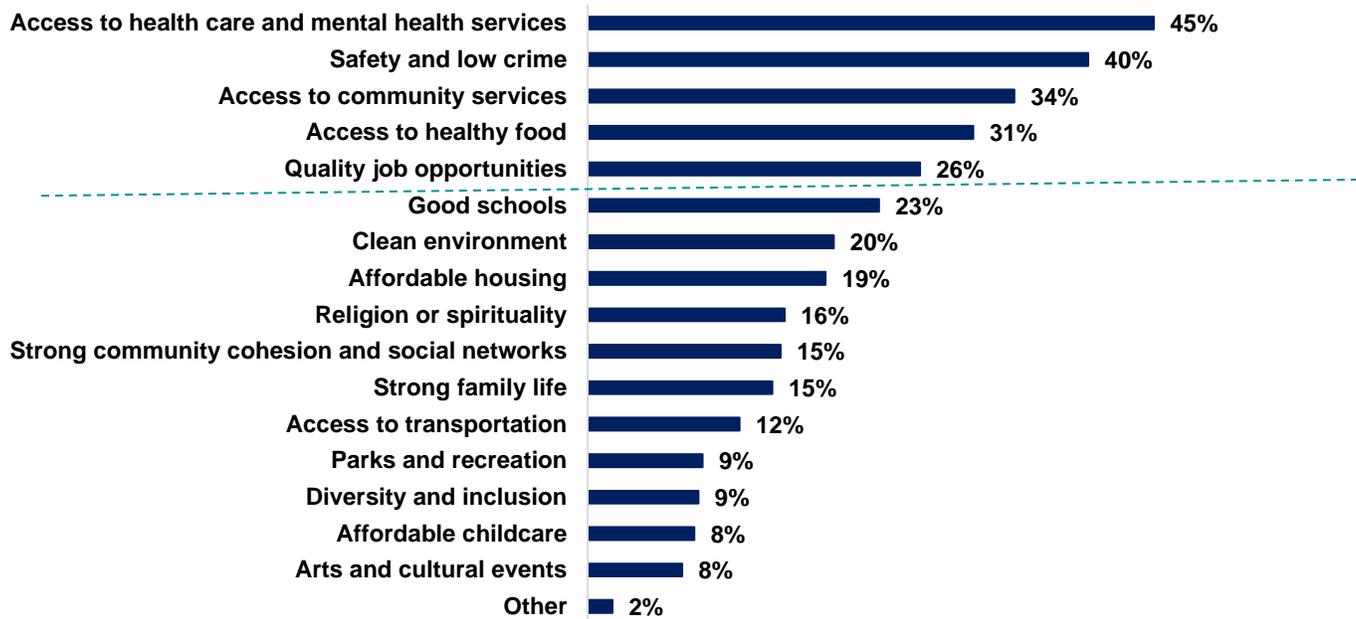


Figure 5. Community Input Survey Data – Greatest strengths and areas for improvement

What are the greatest strengths in the community where you live? (open-ended, n=254)

Responses most commonly related to the following categories:

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

What is one thing that you would like to see improved in your community? (open-ended, n=227)

Responses most commonly related to the following categories:

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

Community Focus Groups

Between August 2018 and February 2019, Alliance for Health Equity partners collaborated to conduct a total of 57 focus groups with priority populations such as veterans, individuals living with mental illness, communities of color, older adults, caregivers, teens and young adults, LGBTQ+ community members, adults and teens

experiencing homelessness, families with children, faith communities, adults with disabilities, and children and adults living with chronic conditions such as diabetes and asthma.

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

Table 2. Focus group sessions conducted within Roseland Hospital's service area

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

Community Priorities

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

Social Determinants of Health

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

Employment

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

“Access is one of the main things within our community - black community, people of color community. There are many stressors when we don't have benefits, jobs, and access to healthcare.”

- Community resident from Affinity Community Services focus group

Education

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

Housing

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

“I think I have mold in my house. I have a lot of stress in me, I could be managing it better, but it is still there.”

- Community resident from ABJ Community Services focus group

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

Homelessness

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

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

- Community resident from Teen Living Program focus group

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

Food Systems

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

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

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

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

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

Community Safety and Violence

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

Behavioral Health

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

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

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

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

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

Chronic Diseases

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

- social determinants of health such as poverty, limited access to healthy foods, exposure to violence, and housing conditions are both underlying root causes of chronic disease and are barriers to the management of chronic disease;
- education about preventing chronic disease, risk factors, and when to seek medical help is lacking in communities;
- chronic illness such as asthma can be isolating for youth, parents, and adults;
- taking care of a child with a life-threatening chronic illness can often cause severe chronic stress; and
- community groups that share information about resources and support each other with adjusting to healthier lifestyles would be extremely helpful to communities.

Access to care and community resources

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

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

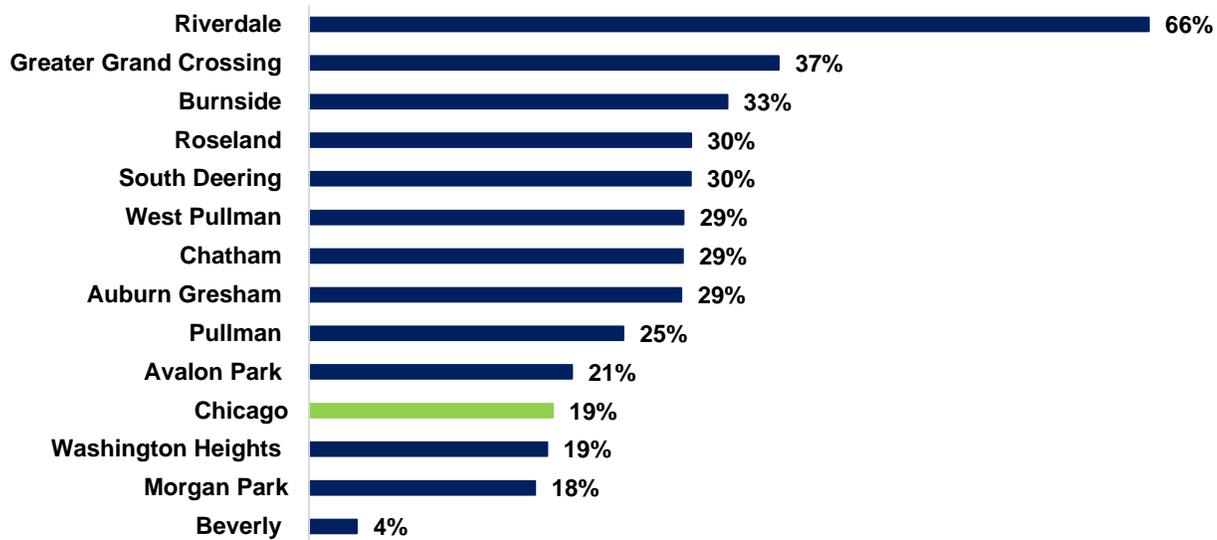
Secondary Data

This section highlights key data pertaining to social determinant of health indicators including, socioeconomic factors, housing, food insecurity, community belonging, and health outcomes. These quantitative data findings are supported by community members' input during focus group sessions to showcase the importance of the findings from the community health needs assessment.

Poverty

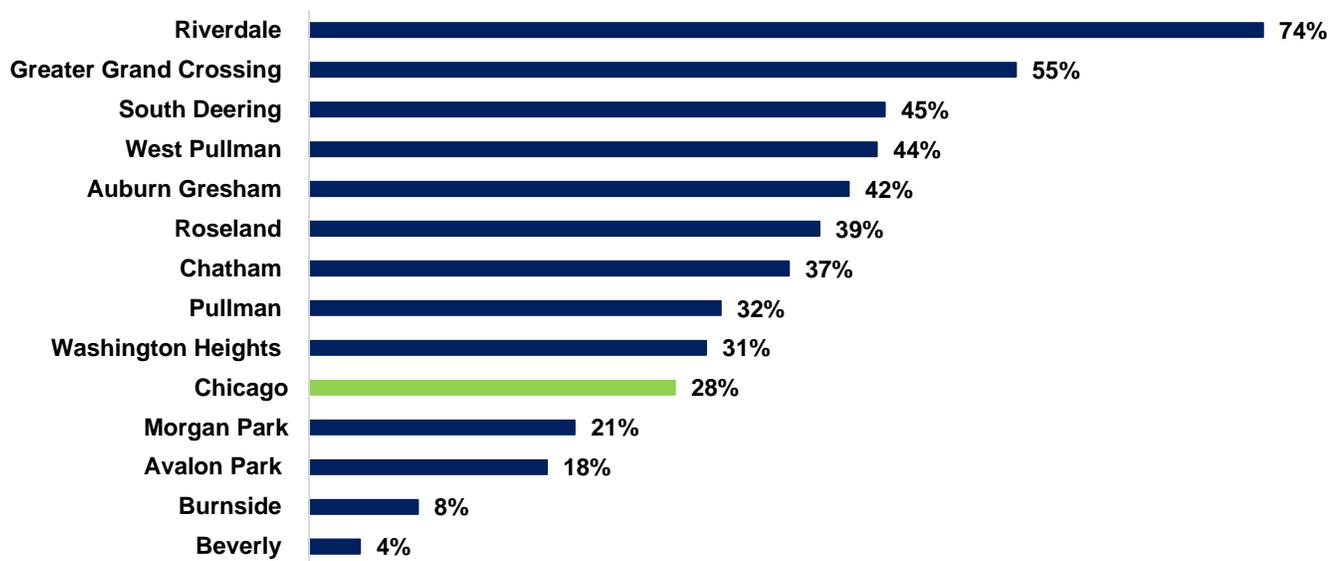
There is an extreme disparity in poverty rates among the communities of Roseland Hospital's service area with Riverdale having a rate of 66% while Beverly has a poverty rate of 4%. Ten out of the 13 communities within Roseland Hospital's service area have more than 20% of their population living in poverty, which is higher than the citywide rate of 19% (Figure 6). Of particular concern from a health perspective, child poverty is very high in the Roseland Hospital service area. Riverdale has a child poverty rate of 74%, more than twice as much as the citywide child poverty rate of 28% (Figure 7).

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



Data Source: American Community Survey, 2012-2016

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

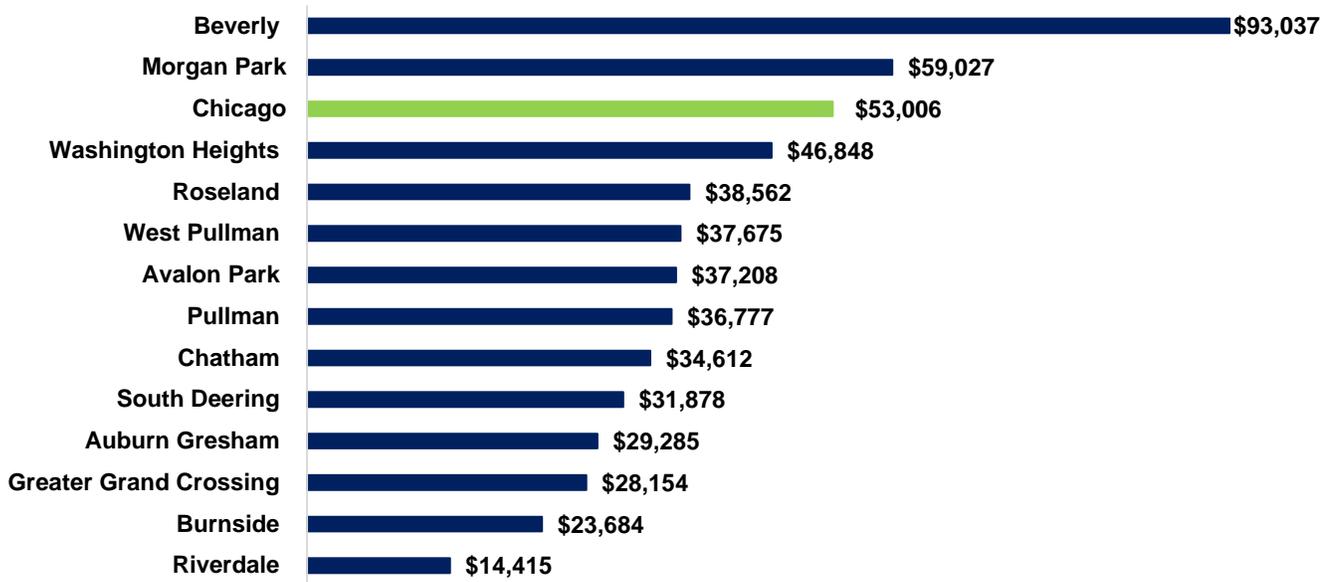


Data Source: American Community Survey, 2012-2016

Income and Unemployment

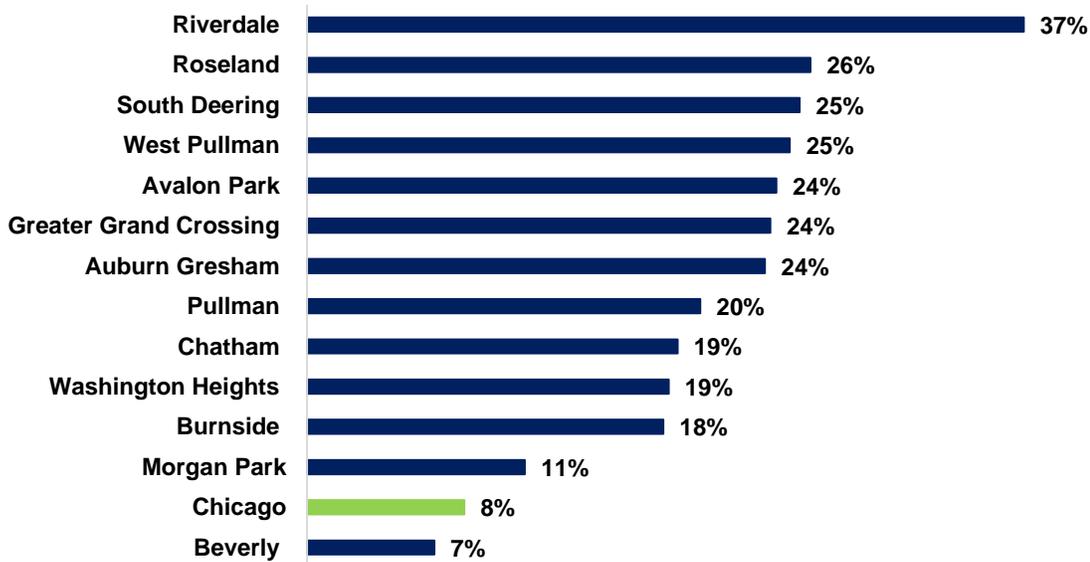
Median household incomes within the communities of Roseland Hospital's service area are extremely divergent with Beverly having a median household income of \$93,037 while Riverdale has a median household income of \$14,415. With the exception of Beverly and Morgan Park, all of the communities in RH's service area have a lower median household income than the citywide amount (Figure 8). Unemployment rates are higher in all communities of RH's service area than the citywide unemployment rate of 8%, with Riverdale having the highest unemployment rate at 37%. This is more than five times higher than Beverly's unemployment rate of 7%.

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



Data Source: American Community Survey, 2012-2016

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

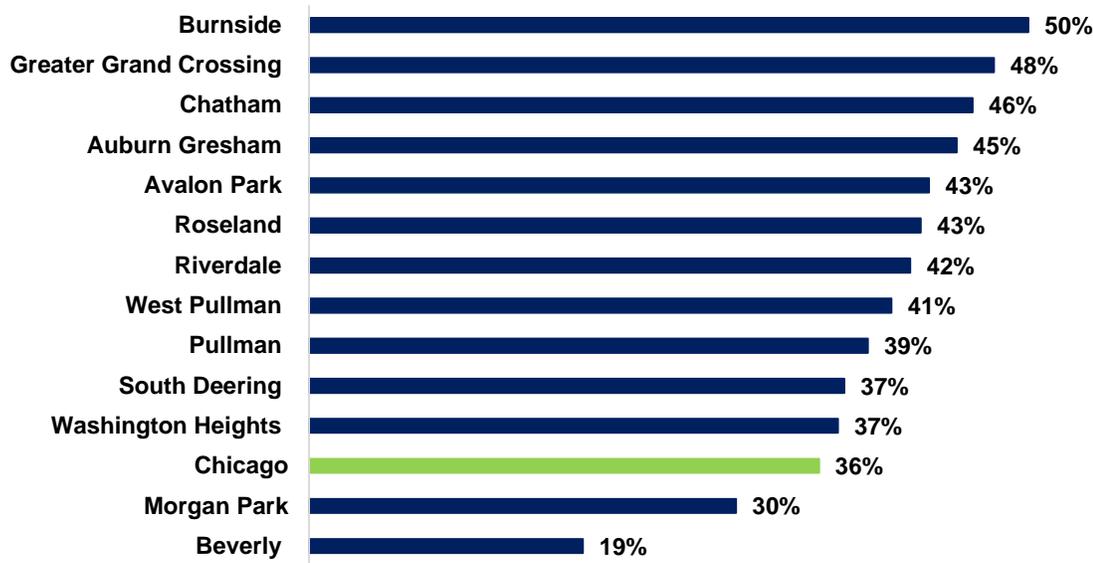


Data Source: American Community Survey, 2012-2016

Housing

Housing is considered to be cost-burdened when a household’s housing costs exceed 30% of that household’s total income. In Roseland Hospital’s service area, most communities have higher rates of cost burdened households than the citywide rate of 36%. Burnside has the highest cost burdened household rate at 50% while Beverly has the lowest (19%).

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

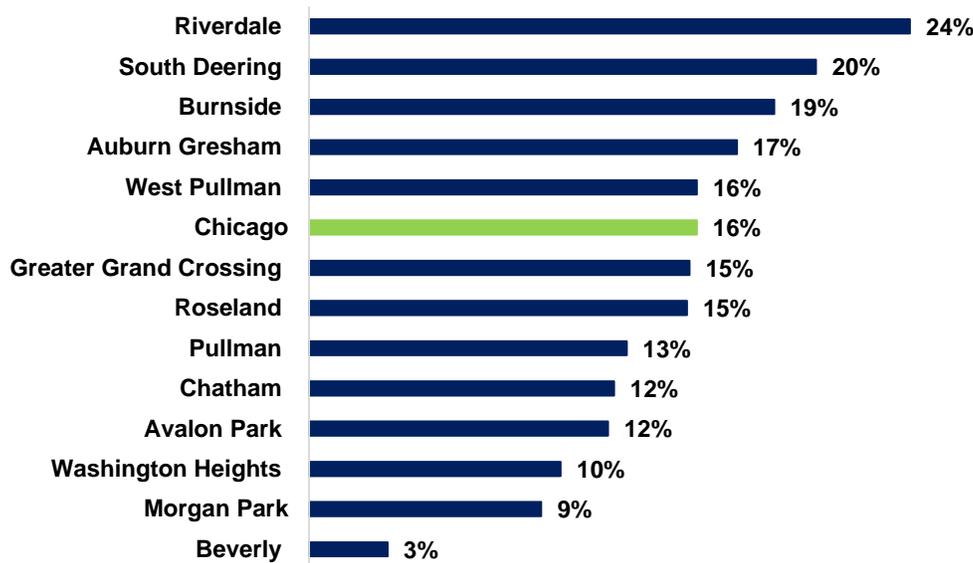


Data Source: American Community Survey, 2012-2016

Education

The rates of individuals with less than a high school diploma or equivalent within the communities of Roseland Hospital’s service area vary widely. At 3%, Beverly has the lowest percentage of individuals with less than a high school degree or equivalent while Riverdale has the highest percentage at 24% - eight times higher. As education is an important social determinant of health, because the rate of poverty is higher among those without a high school diploma or GED, this is of particular concern.

Figure 11. Percentage of Individuals with Less Than a High School Diploma or Equivalent



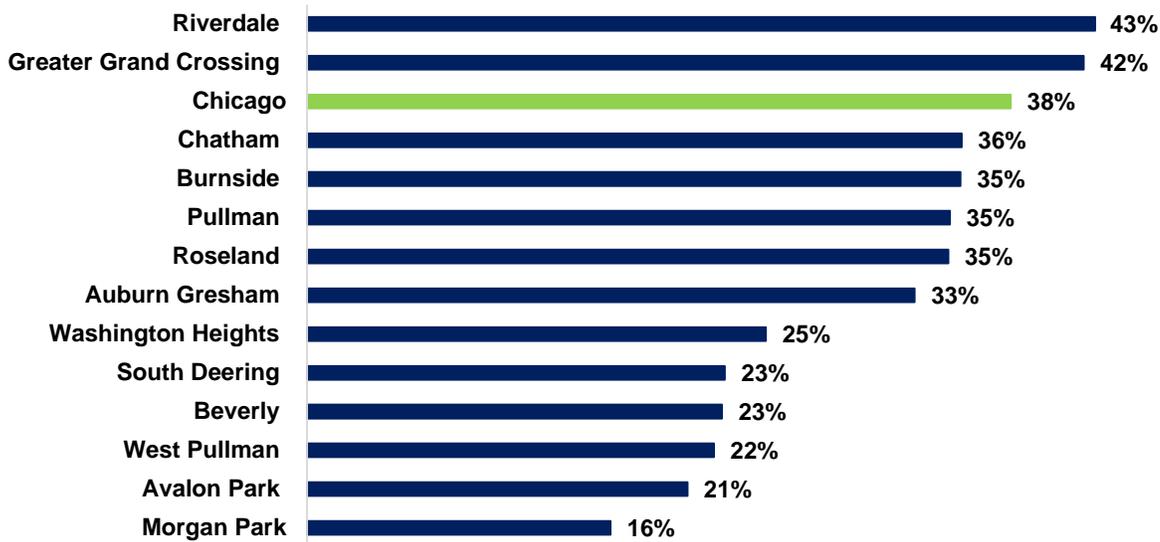
Data Source: American Community Survey, 2012-2016

“There are a lot of jobs out here, but we are not qualified. We don’t have the education.”
 - Community resident from Teen Living Program focus group (Youth Participant)

Commuters Using Active Transportation

Active transportation (commuting to work by walking, biking, or public transit) is another important social determinant of health. There is a wide range in the rates of active transportation between the communities in Roseland Hospital’s service area. Workers who reside in Riverdale and Greater Grand Crossing report the highest rates of using active transportation at 43% and 42% respectively. Conversely, workers in Morgan Park have the lowest rate of workers using active transportation at 16%.

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

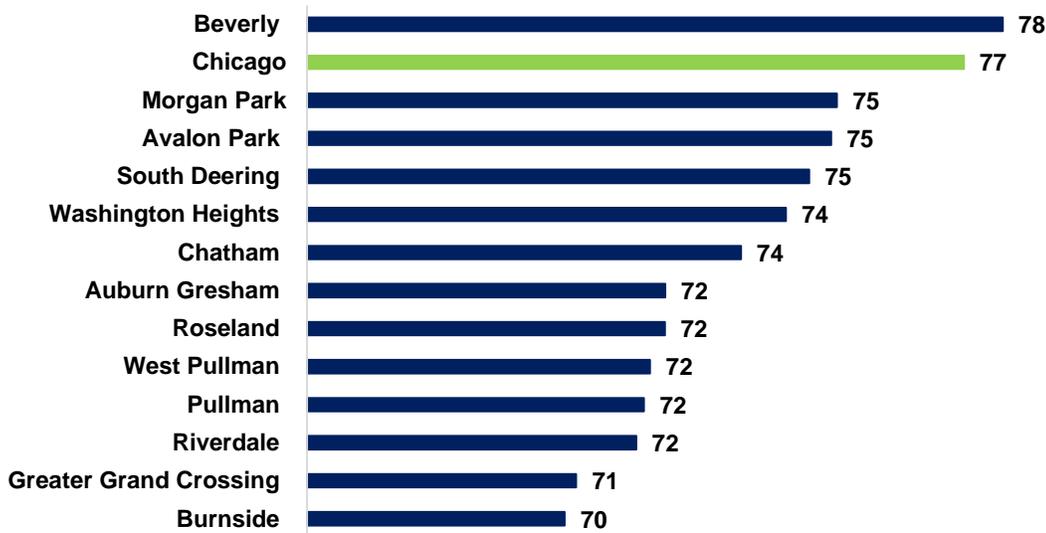


Data Source: American Community Survey, 2012-2016

Life Expectancy

Life expectancy is the average number of years an individual is expected to live. Figure 13 displays the life expectancy for the communities within Roseland Hospital’s service area. There is an eight-year disparity in life expectancy between Beverly (78 years) and Burnside (70 years). With the exception of Beverly, all community areas in Roseland Hospital’s service area have lower life expectancies than the citywide life expectancy of 77 years.

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

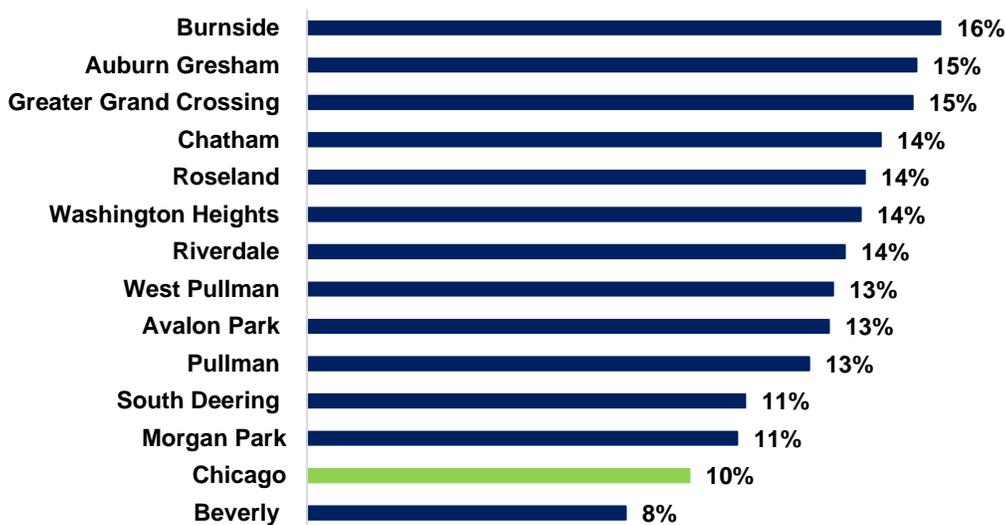


Data Source: CDPH, CCDPH, IDPH Vital Stats, 2016

Maternal and Child Health

Maternal and child health outcomes vary across the communities of Roseland Hospital’s service area, highlighting the overall inequities present. Figure 14 shows the percent of births with low birthweight ranges between 8% in Beverly to 16% in Burnside. Again, Beverly has the lowest rate of infant mortality (Figure 15) at 5 deaths of infants less than one year old per 1,000 while Avalon Park has a rate of 21 per 1,000. There is an extreme disparity in teen birth rates within the communities of RH’s service area: Greater Grand Crossing has a teen birth rate that is eight times greater than the teen birth rate in Beverly. With the exception of Beverly, and Morgan Park for teen birth rate, all communities in RH’s service area have higher rates than the citywide rates for maternal and child health indicators.

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



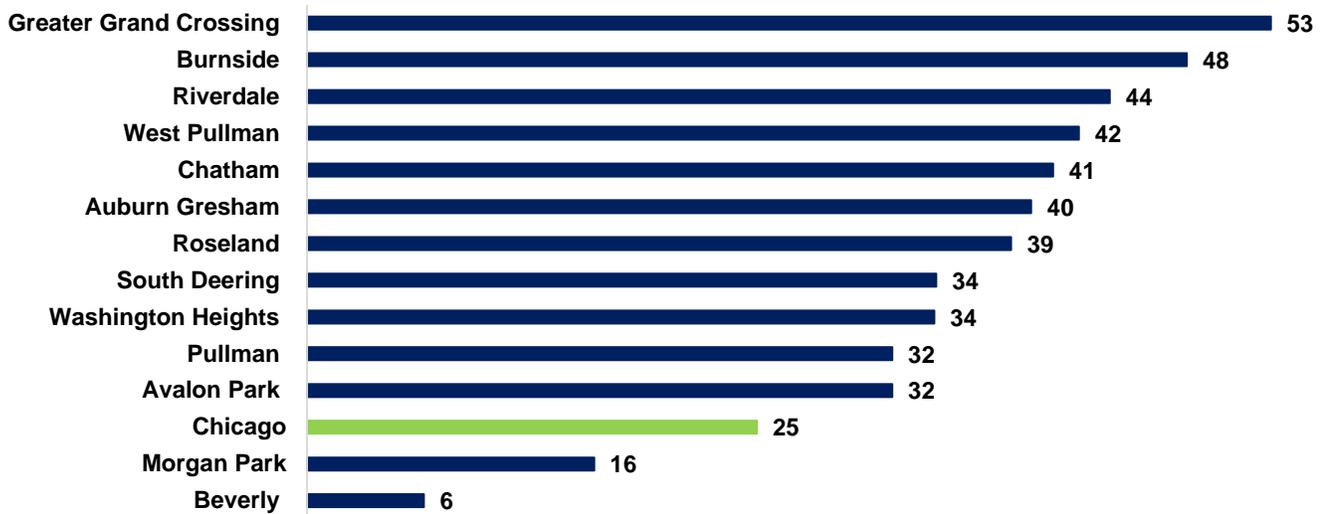
Data Source: CDPH, CCDPH, IDPH Vital Stats, 2016

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



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

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



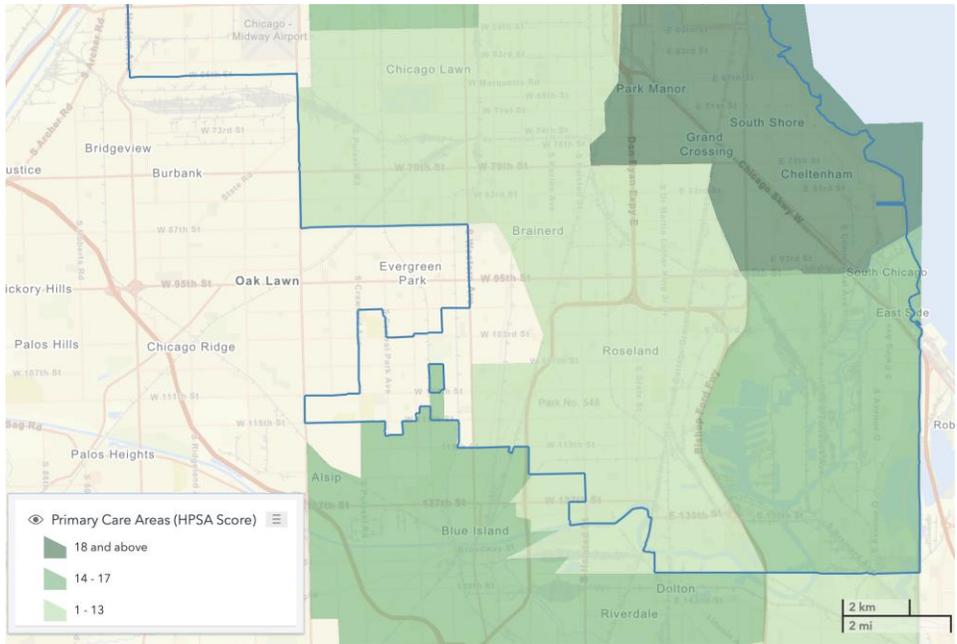
Data Source: CDPH, CCDPH, IDPH Vital Stats, 2016

Medical Professional Shortages

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

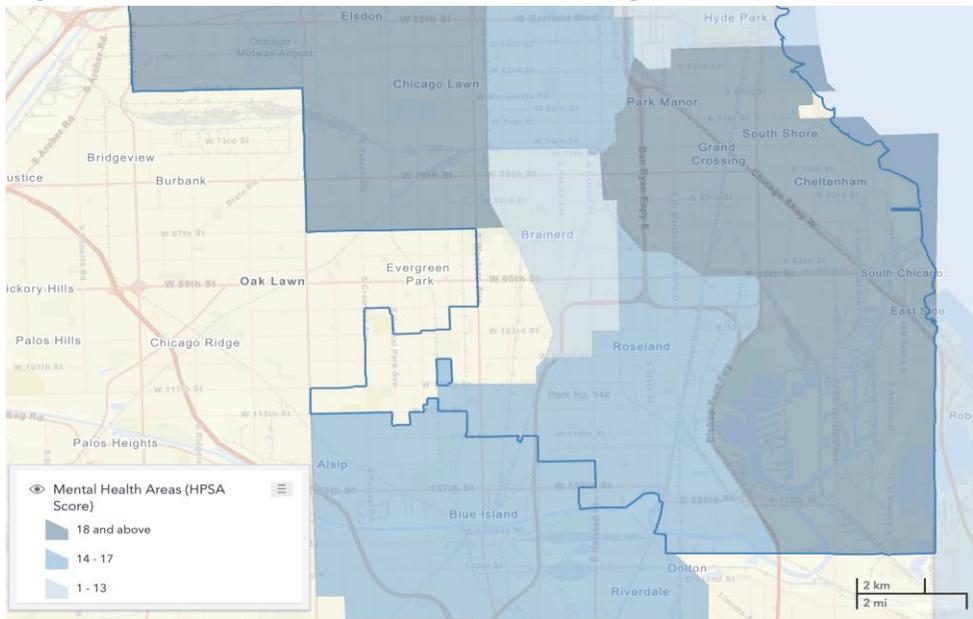
¹ Health Professional Shortage Areas (HPSAs). (May 2019). Retrieved from: <https://bhw.hrsa.gov/shortage-designation/hpsas-on-October-31>, 2019.

Figure 17. Primary Care Health Professional Shortage Area



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

Figure 18. Mental Health Professional Shortage Area



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

Mental Health and Alcohol

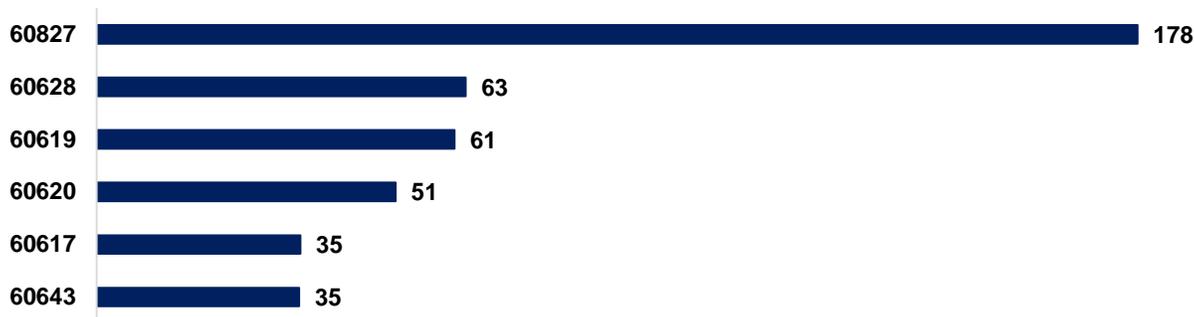
Mental Health provider shortages are experienced across the Roseland Hospital service area. The rate of emergency room usage due to mental health varies between zip codes. The lowest rate is 107 per 10,000 persons in zip code 60643 and the highest is 167 per 10,000 persons in zip code 60619 (Figure 19). Emergency department usage due to substance use is almost three times higher at a rate of 178 ED visits per 10,000 persons in zip code 60827 than the next highest rate of 63 ED visits per 10,000 persons in zip code 60628. Zip codes 60617 and 60643 have the lowest rates of emergency department visits at 35 per 10,000 persons each (Figure 20).

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



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

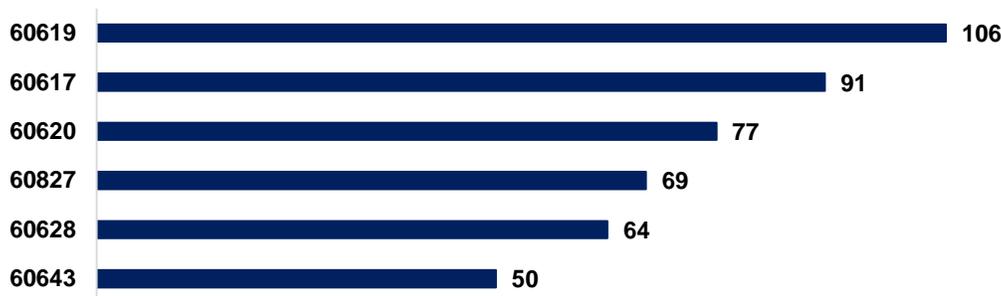
Figure 20. Emergency Department (ED) Rate due to Substance Abuse, (age-adjusted rate per 10,000)



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

Figure 21 displays the rates of emergency room usage due to alcohol which range from 50 per 10,000 in zip code 60643 to 106 per 10,000 in zip code 60619 (Figure 21).

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



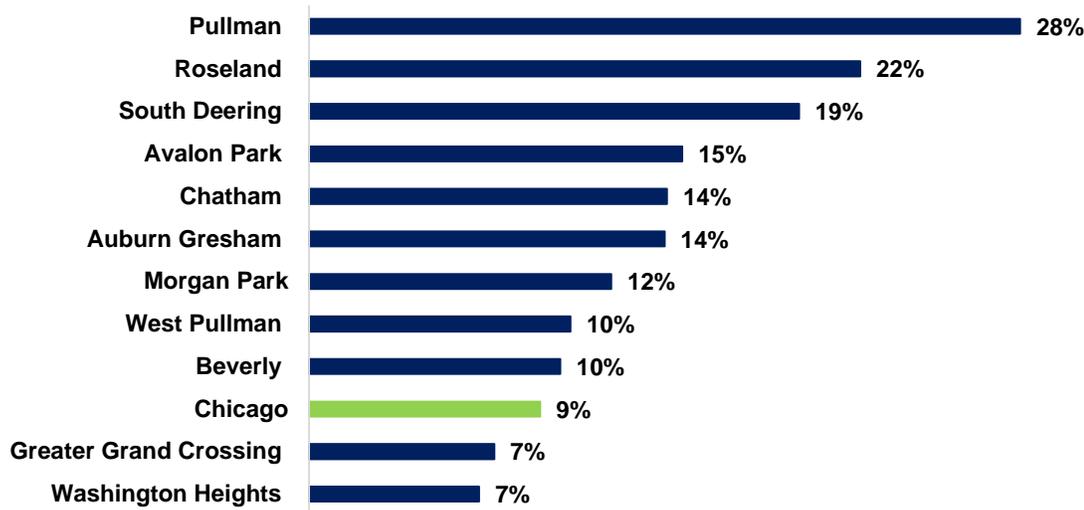
Data Source: Illinois Hospital Association COMPdata, 2015-2017 (Healthy Communities Institute analysis)

Leading Causes of Death and Chronic Disease Risk Factors

Rates of obesity and overweight adults in Chicago are similar to national rates; 39.8% of adults reported being overweight, and 31% of adults reported obesity in Chicago for the time period between 2015 and 2017. With the exception of Riverdale and Pullman, all communities served by Roseland Hospital have obesity rates higher than the citywide rate (data for Burnside not available). In Chicago, the percentage of adults with self-reported diabetes is 9%. Figure 22 shows the percentage of adults with self-reported diabetes in most of the communities that Roseland Hospital serves.

Figure 22. Percentage of adults (18 years and older) who reported that a doctor, nurse or other health professional has diagnosed them with diabetes (excludes pre-diabetes or diabetes only during pregnancy)

Data for Burnside and Riverdale not available.



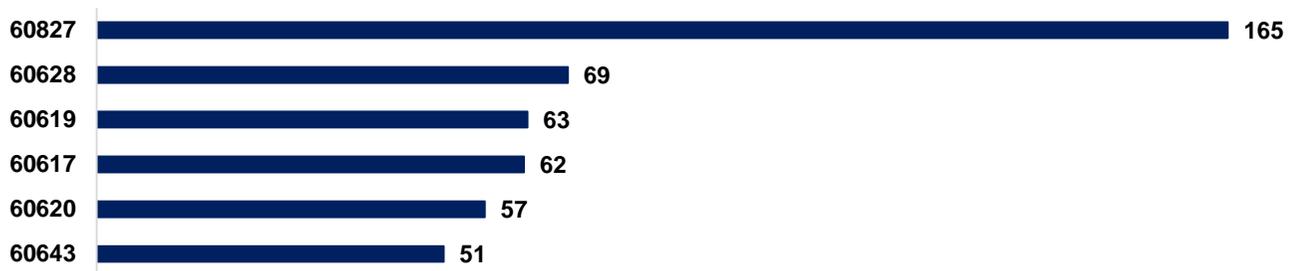
Data Source: Healthy Chicago Survey, Chicago Department of Public Health, 2016

“One of my concerns is that I have diabetes and so does my daughter. Sometimes when I get home, I make food and sometimes I just grab chicken. I hear some people meal prep. I leave home at 6am and get home at 6 or 7pm, it is hard for me.”

- Community resident from Timothy Community Corporation focus group

The rate of emergency department visits due to diabetes is extremely high in zip code 60827 at a rate of 165 per 10,000 people (Figure 22).

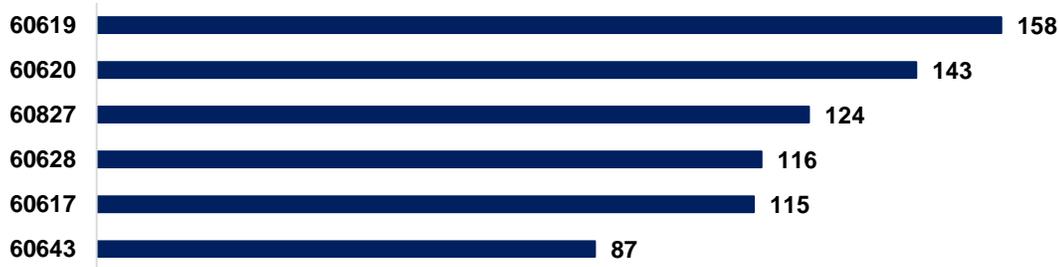
Figure 23. Emergency Department (ED) Rate due to Diabetes, (age-adjusted rate per 10,000)



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

Emergency department visits due to asthma among adults ranges from 87 visits per 10,000 persons in zip code 60643 to 158 visits per 10,000 persons in zip code 60619 (Figure 24). Emergency department visits due to asthma among children within Roseland Hospital’s service area is of great concern as rates are high. As Figure 25 shows, all zip codes in RH’s service area have rates of emergency department visits due to asthma that are higher than 100 visits per 10,000 children, with zip code 60619 having the highest rate at 217 visits per 10,000 children.

Figure 24. Emergency Department (ED) Rate due to Asthma, (age-adjusted rate per 10,000)



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

“I always take my child to the ER. As he gets older, it’s has gotten more severe, and he is agitated. He asks questions about when he can stop taking medications.”

- *Community resident from Theace Goldsberry Community House focus group*

Figure 25. Emergency Department (ED) Rate due to Pediatric Asthma, (age-adjusted rate per 10,000)



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

HIV

In 2017, the total amount of new diagnosis of HIV in Chicago was significantly lower than the previous year. However, HIV still disproportionately effects individuals aged 20-29, men, Non-Hispanic African American/Blacks, and men who have sex with men (MSM)². Figure 26 displays the rates of people newly diagnosed with HIV. All of the communities within RH’s service area (of which there is available data) have a higher rate of individuals newly diagnosed with HIV compared to the citywide rate of 31 per 100,000 persons. Most communities within Roseland Hospital’s service have lower rates of individuals living with HIV (prevalence) than the citywide rate of 903 people living with HIV per 100,000 persons. The communities of Chatham and Greater Grand Crossing have rates of people living with HIV that are higher than the citywide rate at 1047 per 100,000 persons and 1098 per 100,000 persons respectively (Figure 27).

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

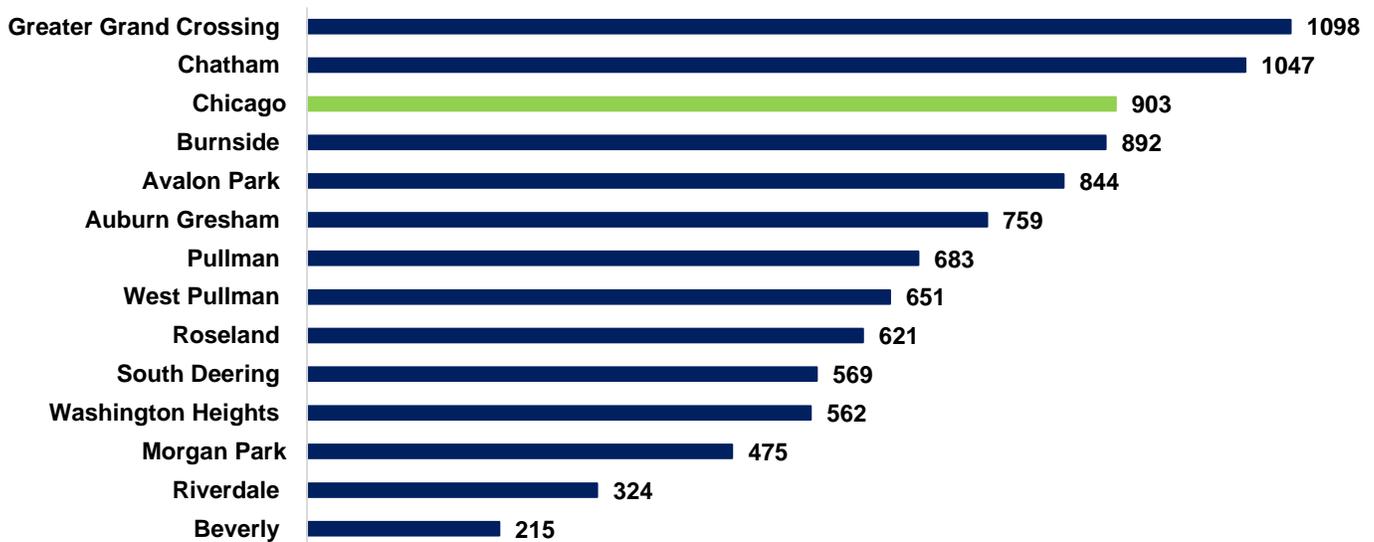
Figure 26. Crude rate of people newly diagnosed with HIV per 100,000 people

Data for Beverly, Burnside, Morgan Park, Pullman, Riverdale, and South Deering not available.



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

Figure 27. Crude rate of people living with HIV per 100,000 people



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

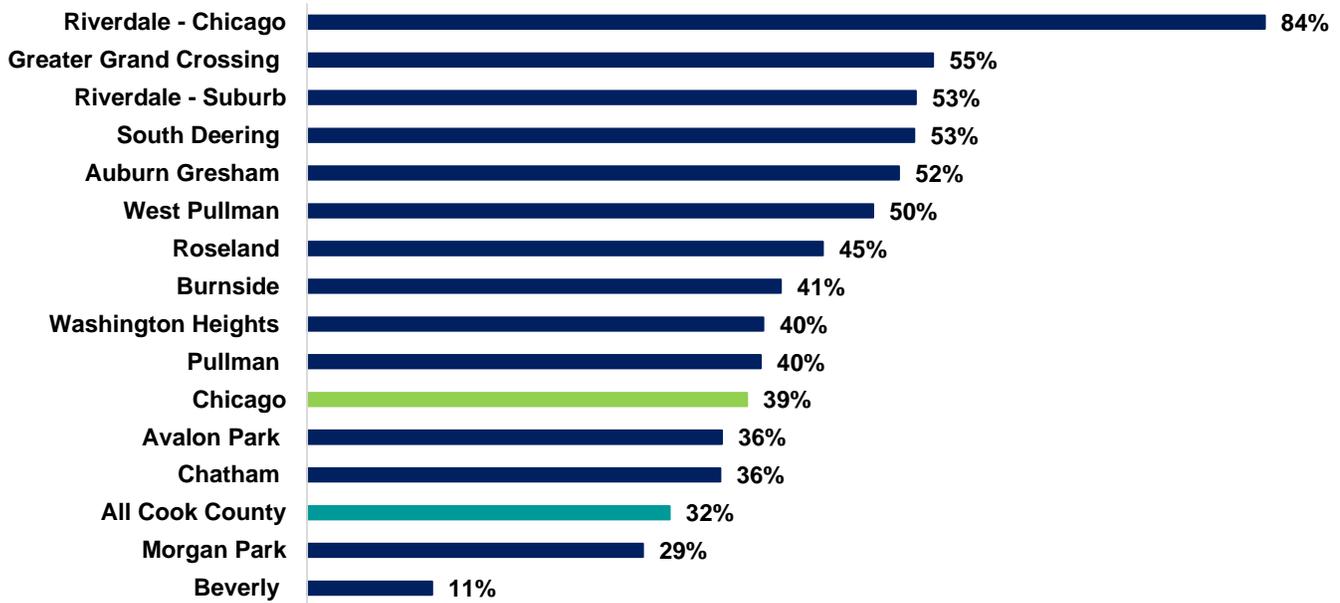
Food Insecurity and Food Access

There is an extreme disparity in the risk of food insecurity among the communities of Roseland Hospital’s service area. Beverly has the lowest risk of food insecurity at 11% risk while the portion of Riverdale that is within Chicago city limits has 84% risk of food insecurity. Most communities within RH’s service area have a higher risk of food insecurity than the citywide risk of 39% (Figure 28).

“Build more stores like Whole Foods, Cermack, and Mariano’s on the low ends instead of places like Popeyes.”

- *Community resident from Gary Comer Youth Center focus group*

Figure 28. Risk (Percent) of Food Insecurity Among Communities within Roseland Hospital’s Service Area



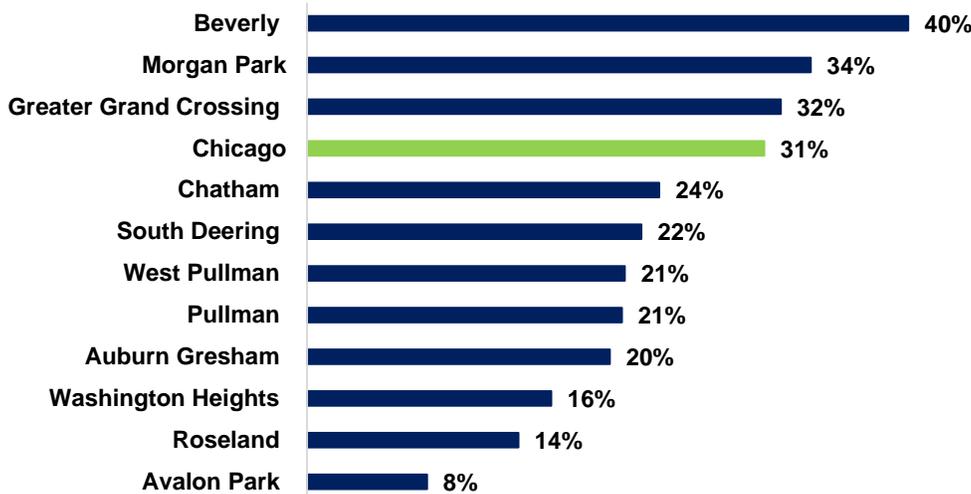
Data Source: US Census Bureau, American Community Survey 2013-2017

Health Behaviors Related to Food

In regard to health behaviors related to food consumption, there is a great among the communities of Roseland Hospital’s service area. Most of the communities that Roseland Hospital serves have a lower percentage of fruit and vegetable consumption than the citywide percentage of 31% with Roseland and Avalon Park reporting the lowest percentages, at 14% and 8% respectively (Figure 29). With the exception of Beverly, all of the communities in Roseland Hospital’s service area have higher percentages of daily sweetened beverage consumption than the citywide percentage of 26% (Figure 30) with Avalon Park having the highest percentage at 60%.

Figure 29. Percentage of adults who reported eating five or more servings of fruits and vegetables (combined) daily

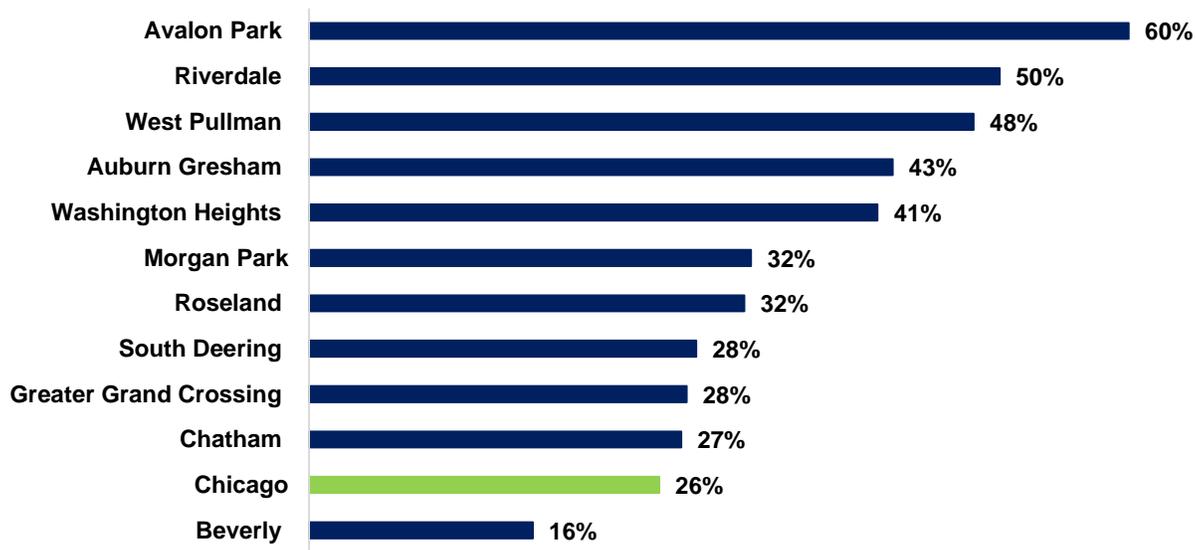
Data for Burnside and Riverdale not available.



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

Figure 30. Percentage of adults who drank soda or pop or other sweetened drinks like sweetened iced tea, sports drinks, fruit punch or other fruit-flavored drinks at least once per day in the past month

Data for Burnside and Pullman not available.



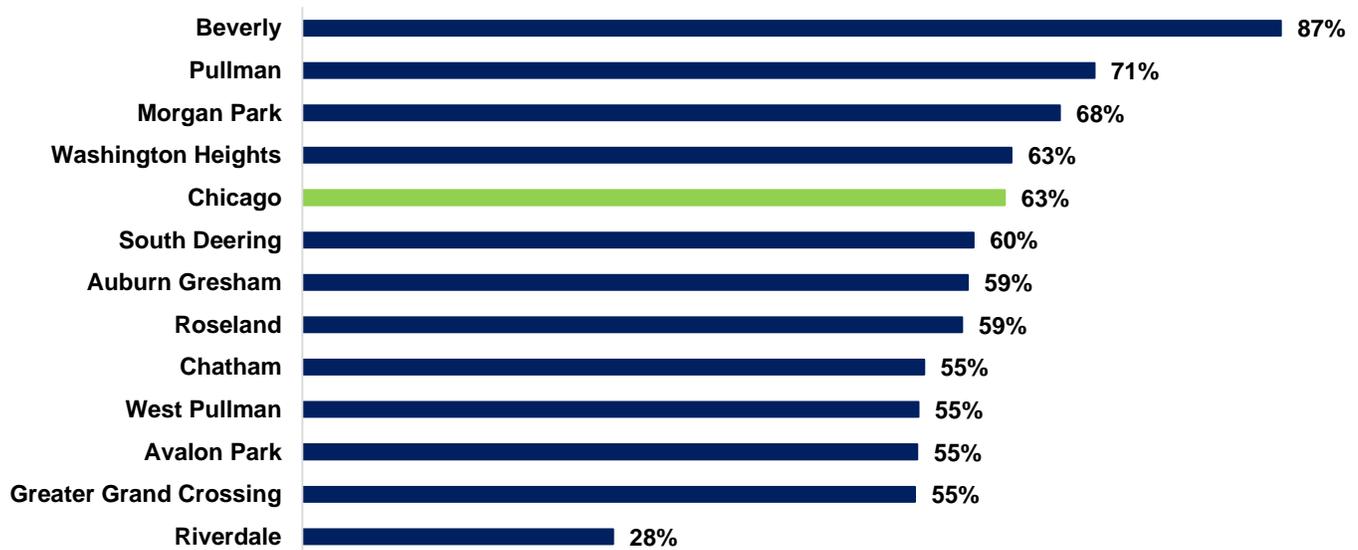
Data Source: Healthy Chicago Survey, Chicago Department of Public Health, 2015-2017

Community Belonging/Engagement

There is a wide range of percentage of adults who report a sense of community belonging within the communities that Roseland Hospital serves (Figure 31). The community of Beverly reports a high percent of a sense of community belonging at 87%. Pullman, Morgan Park, and Washington Heights report a higher percentage than the citywide rate of 63%.

Figure 31. Percentage of adults who reported that they strongly agree or agree that they really feel part of their neighborhood

Data for Burnside not available.



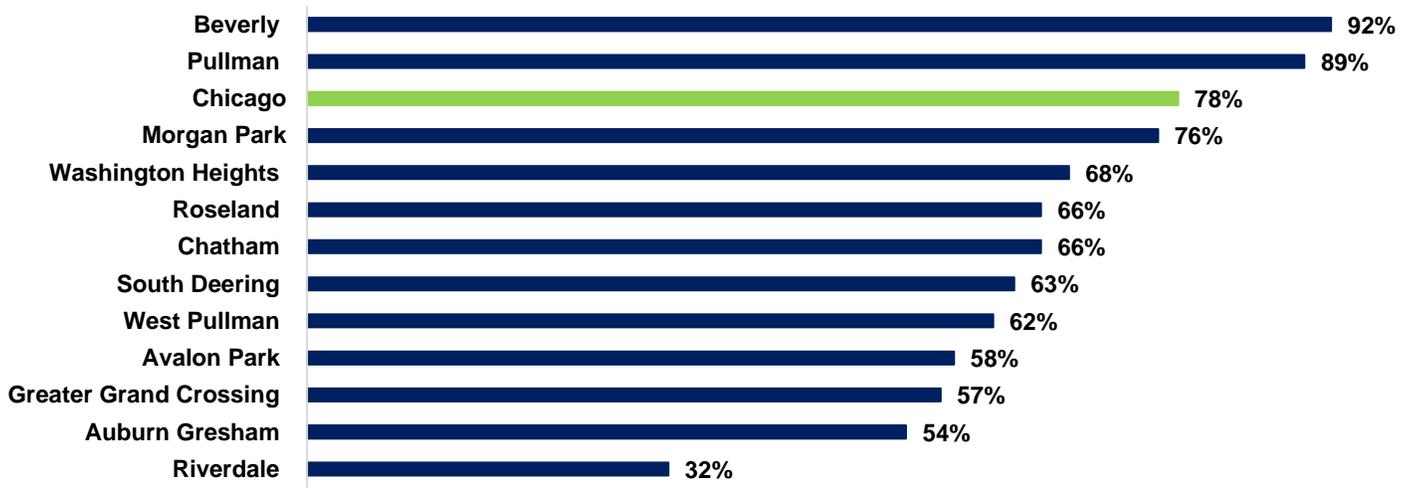
Data Source: Healthy Chicago Survey, Chicago Department of Public Health, 2016-2018

Community Safety and Violence

Similar to Community Belonging, communities within Roseland Hospital’s service area report a wide range of perceived neighborhood safety (Figure 32). Beverly and Pullman report higher rates of perceived neighborhood safety than the citywide rate of 78% (92% and 89% respectively). Almost all communities that Roseland Hospital serves, with the exception of Beverly and Morgan Park, have a higher rate of violent crimes compared to the citywide rate (Figure 33). Greater Grand Crossing has the highest violent crime rate with 10,680 incidences of violence per 100,000 persons.

Figure 32. Estimated Percent of Adults who Report Feeling Safe in their neighborhood all of the time or most of the time

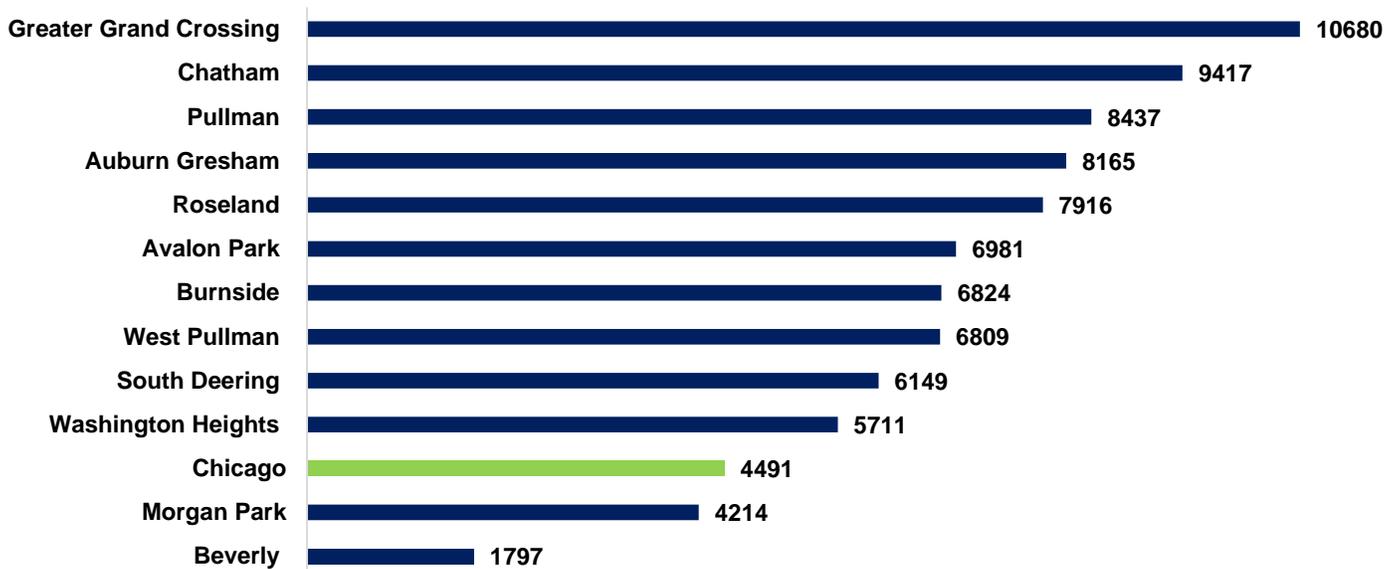
Data for Burnside not available.



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

Figure 33. Crude violent crime* rates (per 100,000 population)

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



Data Source: Chicago Police Department, 2016

IV. Summary of Roseland Hospital's Previous CHNA Implementation Activities, 2016-2019

Roseland Hospital's previous implementation strategies were based on assessed community health needs and included the following activities:

Access to Care

- Mobile health services were established that addressed critical needs for services that were unavailable locally. The hospital's Dental Services Van treated 1,182 children in 2019. The program continues to grow, and the number of children treated in 2020 is expected to exceed 2,000.
- Roseland expanded outpatient services through a new outpatient clinic that provided follow-up services for primary care, obstetrics, cardiology, asthma, and wound care.
- The hospital established a wound healing center to treat patients with critical wounds.
- An outpatient pharmacy within the hospital was opened to provide patients with the ability to leave the hospital with prescribed medications.

Maternal-Child Health

- A Maternal Fetal Medicine clinic was established to address the critical issue of high-risk pregnancies and to increase positive outcomes for both mothers and babies.

Substance Use Disorders

- A DHS grant was used to expand warm hand-offs of medically stabilized patients experiencing opioid use disorder diagnoses to continued care within linked treatment centers. As a result of the program, the Medical Stabilization Unit Readmission rate decreased from 75% to 5%.
- In 2019, Roseland Hospital was an active member of the Alliance for Health Equity's Hospital Opioid Treatment and Recovery Learning Collaborative. The collaborative provided technical assistance and opportunities for shared learning through six in-person learning sessions over 9-months on topics such as warm-handoffs, Medication for Opioid Use Disorders (MOUD), Naloxone distribution, program design, staff training, funding structures, legal barriers, and more. During the hospital's participation in the learning collaborative progress was made in several areas including:
 - Increased community outreach through the establishment of recovery coaches.
 - Increased capacity to provide MAT – a provider attended MAT waiver training.
 - At least four new partnerships with community MOUD treatment providers.
 - The development of a draft policy for naloxone distribution in ED and outpatient units at discharge.
 - Outpatient pharmacists were trained on the naloxone standing order.

This Community Health Needs Assessment (CHNA) was approved by representatives of the Roseland Community Hospital board on February 03, 2020. To comment on this CHNA or to request more information or paper copies of the CHNA, please contact Roseland Community Hospital at PublicAffairs@roselandhospital.org or (773) 995-3015 Hospital Administration.