Community Health Needs Assessment Report

FY2016

Rush-Copley

Outline

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- Community Served
- Identified Community Health Needs
- Evaluation of Impact of the FY13 Implementation Strategy

Executive Summary

Executive Summary

In FY2016, 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, 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 IPLANs (Illinois Project for Local Assessment of Needs)
  - 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.
  1. The committee reviewed and discussed the findings from the community health survey, focus groups, secondary data analysis, and information from development of the Kane County and Kendall County IPLANs, as well as additional community input.
  2. 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 three health priorities in the community to be addressed:

1. Obesity, focusing on achieving a healthy weight through proper nutrition and exercise
2. Chronic disease, focusing on chronic disease self-management and preventative care
3. Access to care, focusing on understanding insurance coverage and care options

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 29, 2016.

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 525 physicians on staff and over 2,000 employees
  - Offers inpatient specialty care as well as comprehensive outpatient services
  - Provides services to over 90,000 individual patients annually
  - Holds more accreditations and disease specific certifications than any other area hospital
  - Recognized nationally, regionally, and locally for providing an outstanding workplace
  - Is the most preferred hospital by area consumers for key specialties and overall quality of care

- 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 well over 300 community-based programs and events, specifically groups aimed at improving the lives of children, women, or the underserved
  - Provides free educational programs and seminars including hand hygiene, diabetes, heart health, cancer prevention, weight control, smoking cessation, and more
  - Provides free and reduced cost health screenings
  - Provides language assistance services, volunteer programs, and professional education

- In FY2014, the hospital provided over $7 million in charity care and nearly $27 million in uncompensated government sponsored indigent health care. Additional discounts and expenses associated with the hospital providing care to the uninsured and underinsured totaled $41.6 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 and establish 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

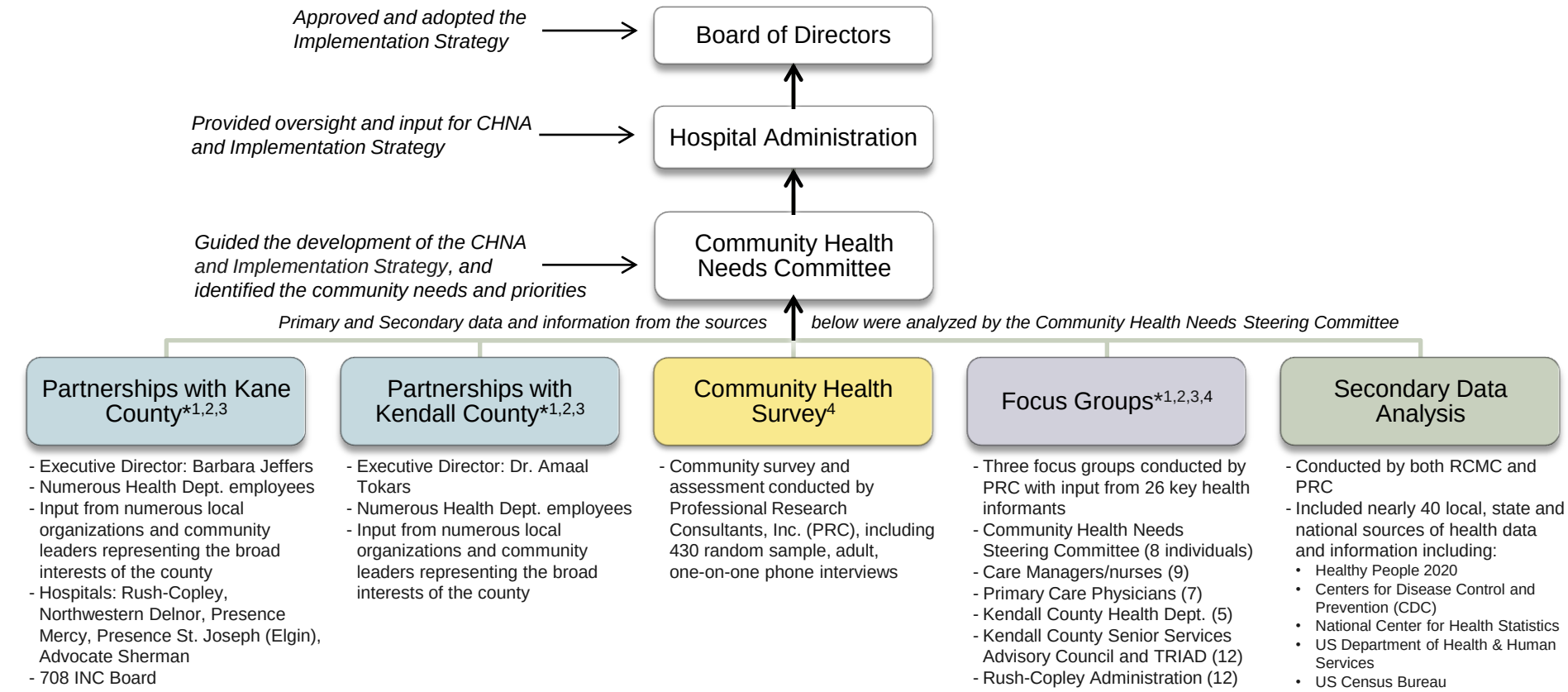
- The hospital conducted the Community Health Needs Assessment in FY2016. Community partnerships related to many of the components in the assessment process were established and on-going since the FY2013 assessment.

- 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 29, 2016.

- In order to conduct a comprehensive and efficient Community Health Needs Assessment, the hospital used the Association of Community Health Improvement's (ACHI) framework for developing a Community Health Needs Assessment, which includes the following six steps:
  1. Establishing the assessment infrastructure
  2. Defining the purpose and scope of the assessment
  3. Collecting and analyzing data
  4. Identifying needs and selecting priorities
  5. Documenting and communicating results
  6. Planning for action and monitoring progress

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 County IPLAN 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 IPLANs

(*IPLAN development & implementation and 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 IPLANs.
– 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 *(December 2014)*

– 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 questions, in order to obtain state and national comparative data and address identified gaps.
– 430 one-on-one adult 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

(November 2014 – June 2015)

– Nine focus groups were conducted by or on behalf of the hospital.
– Each focus group provided insights on different segments of the population and reflected the unique perspectives of the health needs of the community from residents, community health leaders/experts, hospital care managers and nurses, and primary care physicians.
  - PRC conducted three Kane County based focus groups. Key informant participants representing the broad interests of the community included physicians, other health professionals, social service providers, and other business and community leaders.
  - The hospital conducted six focus groups. Key informant participants included Care Managers, Primary Care Physicians, Senior Services Organizations, Kendall County Health Department Leadership, and Hospital Leadership .

Extensive Data Analysis

(January-June 2014)

– 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 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 IPLANs, 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 (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)

Information Sources and Gaps

- 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
• Telephone interviews – Community Health Survey • Focus Groups – Kane County Key Informants – Community Health Needs Steering Committee – Care Managers and Nurses – Primary Care Physicians – Kendall County Health Department – Kendall County Senior Services Advisory Council and TRIAD – Rush-Copley Administration • 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.	• 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 • 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 State Board of Education • 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 IPLAN 2011-2016 • National Cancer Institute, State Cancer Profiles • The Neilsen Company • OpenStreetMap (OSM) • RCMC FY2013 CHNA • 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 • Various additional articles and community reports

Information Sources and Gaps

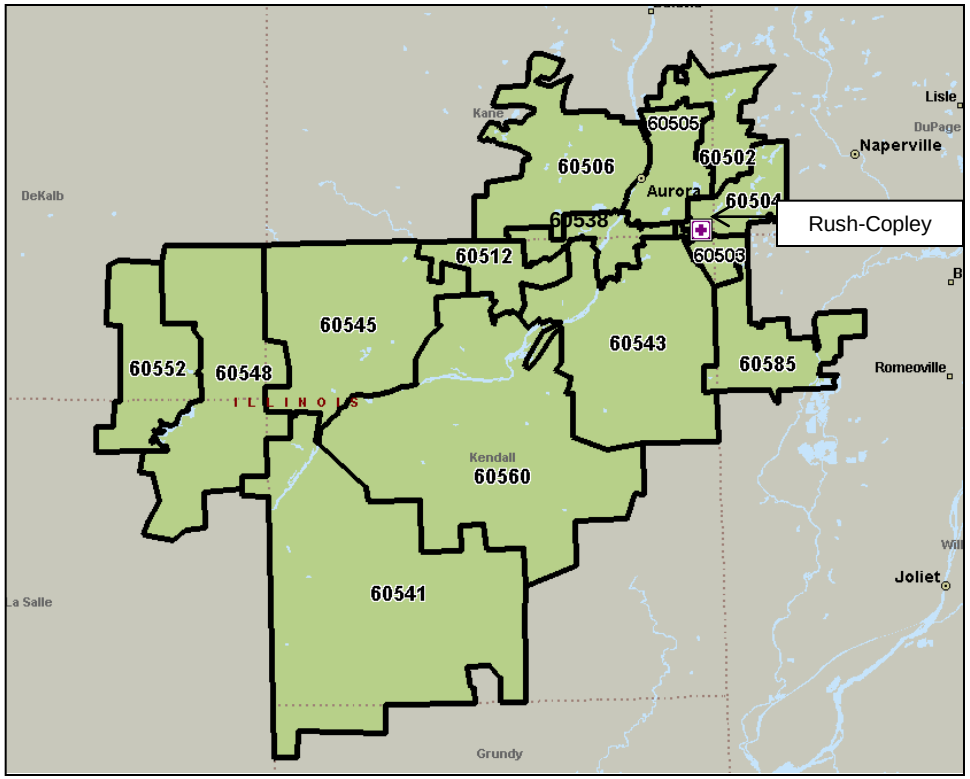
- While an extensive amount of data was gathered and analyzed, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. Identified data gaps include:
    1. Limited data for the community served was available for many of 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. However, it was available for 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 facilitated by the hospital.

Community Served

Community Served

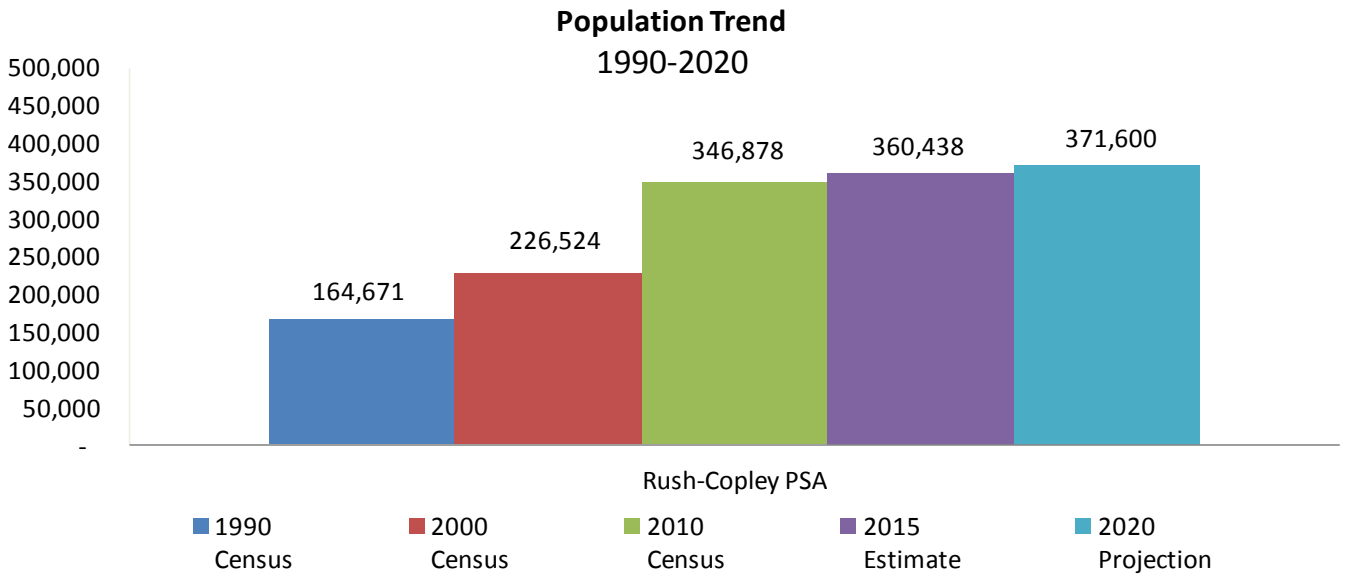
- The hospital is located in the city of Aurora, IL, which is the second largest city in Illinois.
- The community served by the hospital is defined as the geographic area identified by the contiguous zip codes, from which approximately 80% of the hospital's discharged patients reside. The hospital also 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.
  - Kendall County was the nation's fastest growing county between 2000 and 2010
  - Kane County has the second largest Hispanic population in IL, which is concentrated in Aurora
- The community served also includes very limited portions of DeKalb, LaSalle, Grundy, DuPage and Will Counties.



Sources: The Neilsen Company and US Census Bureau, Decennial Census

Demographics

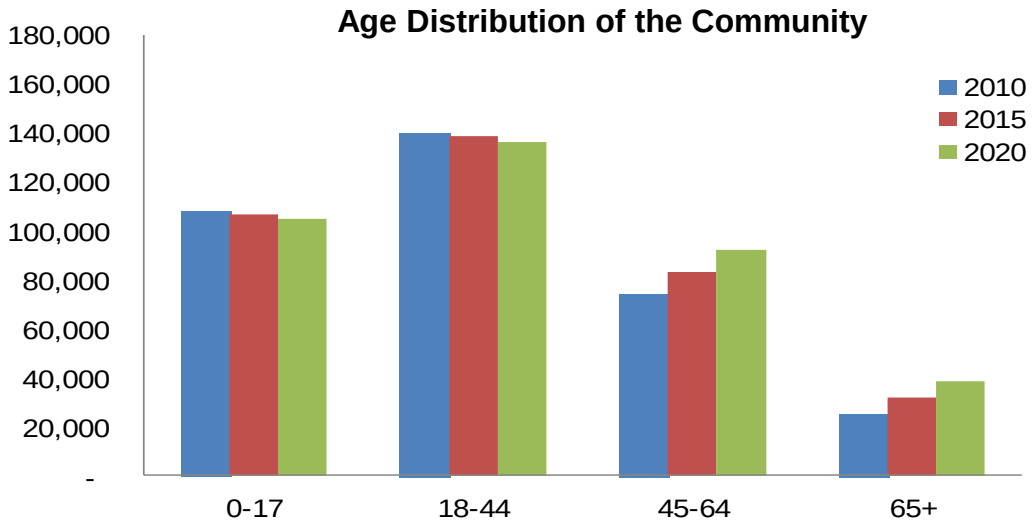
- In 2015, there were 360,438 residents living in the community.
- Since the 2010 census, the community experienced a population increase of 3.9% (+13,560 residents).
  - During the same time period, the IL population increased by 0.6% and the U.S. population increased by 3.5%.
- Population growth in the community is expected to continue at a slow growth pace with only 3.1% growth projected from 2015 to 2020.



Source: The Neilsen Company

Demographics

- The average age in the community is 34.1 years, which is younger than the average age in IL and the U.S.
  (IL = 38.4; U.S. = 38.7).
- There is a large youth population that represents nearly a third of the total population, but this cohort is projected to decrease slightly over the next five years.
- Although it is considered a young community, population growth is concentrated in the 45+ years cohort.
  - The 45-64 age cohort increased 12.5% between 2010 and 2015, and is projected to increase an additional 10.7% over the next five years to over 92,000 residents.
  - The 65+ population increased the most rapidly between 2010 and 2015, and is projected to increase an additional 20% between 2015 and 2020 to nearly 40,000 residents.

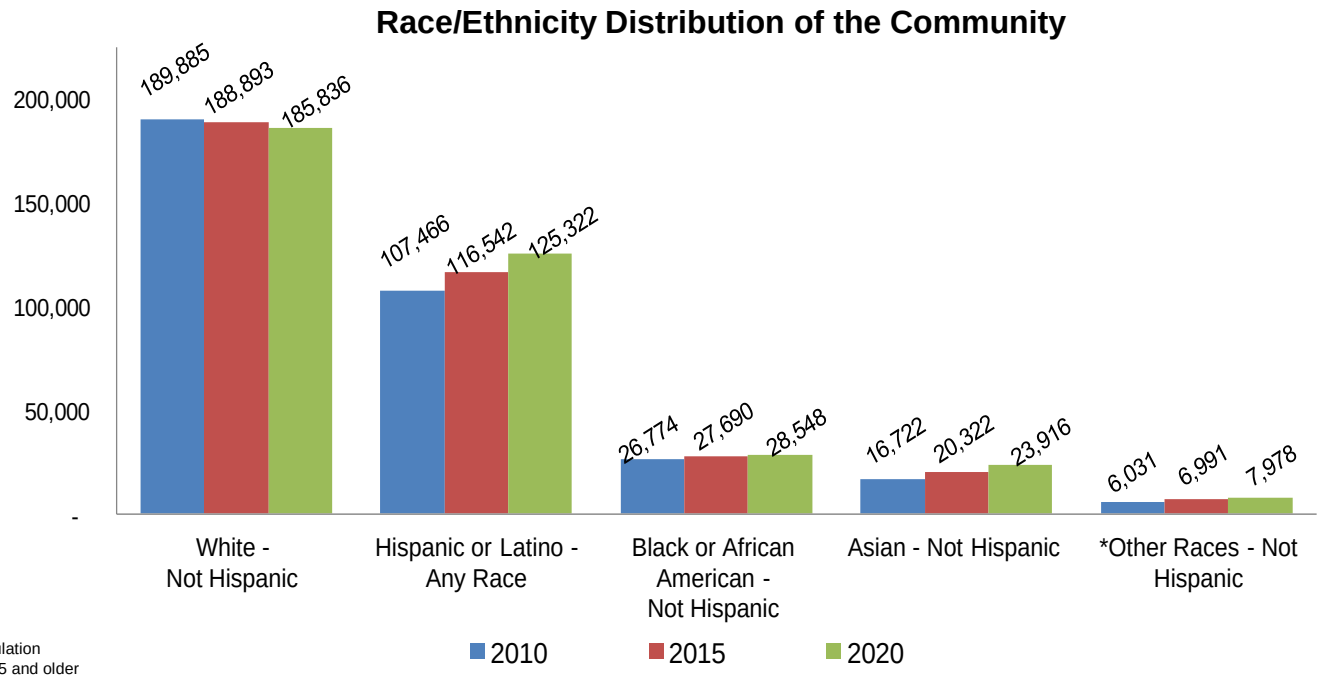


Population	0-17	18-44	45-64	65+
2010	107,975	139,558	73,947	25,395
2015	106,737	138,832	83,204	31,665
2020	104,936	136,429	92,134	38,101
% Growth 2010-2015	-1.1%	-0.5%	12.5%	24.7%
% Growth 2015-2020	-1.7%	-1.7%	10.7%	20.3%

Source: The Neilsen Company

Demographics

- Between, 2000 and 2010 the service area experienced rapidly changing demographics as the community became more diverse. However, between 2010 and 2015, the rate of change slowed and is projected to continue at a slower rate through 2020.
  - The population of the combined minority races increased by 11.1% between 2010 and 2015, and it is projected to increase an additional 9.9% by 2020 (+5,439 for a total of 60,442 residents).*
  - The Hispanic population increased by 8.4% between 2010 and 2015, and it is projected to increase an additional 7.5% by 2020 (+8,780 for a total of 125,322 residents).
- Hispanic and Latinos account for 32% of the population, which is nearly double the national and state rates (IL= 17%; U.S.=18%)
- Approximately 26% of the residents in the community speak Spanish at home.**



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

Socioeconomics Characteristics

- The economic downturn had a negative impact on the community served, however, there is progress toward a recovery. Since, 2012*:
  - Median housing values increased 7.7%
  - Median household income increased by 3.6%
  - Foreclosure rate improved significantly, however, IL currently has the 2nd highest rate in the nation. Kendall County has the fifth highest foreclosure rate in IL. [24]
  - Unemployment rates are also improving in the local counties, and continue to be comparable to the IL and national rates (Kane = 6.1%; Kendall = 5.8%).
- 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 – 2015	$200,439	$222,808	$232,133	$186,870	$191,227
Foreclosure rate (as of 3/2015)[24]	Not available	1:471	1:306	1:453	1:1,082
Median household income (2015)	$69,436	$68,242	$81,045	$57,978	$53,706
% Unemployment rate (as of 3/2015)[25]	Not available	6.1	5.8	6.0	5.5
% Poverty rate of the total population (2013)[22]	Not available	11.1	4.8	14.1	15.4
% Achieved a bachelor's degree or higher (2015)	31%	32%	33%	31%	29%

Source: The Neilsen Company, unless otherwise noted, which can be found in the FY2016 RCMC CHNA Data and Information Book
*2012 data can be found in the FY2013 Rush-Copley Community Health Needs Assessment

Existing Health Care Facilities & Resources

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

Health Care Facilities and Providers	Mental and Behavioral Health	Other Agencies, Programs and Resources
• Aurora Medical Clinic • Aunt Martha's Youth Services Center • Dreyer Medical Clinic • Independent Physicians/Providers • Presence Mercy Medical Center • Rush-Copley Medical Center • Valley West Community Hospital • VNA Health Care • Community Health Partnership	• Association for Individual Development (AID) • Aunt Martha's Youth Services Center • Breaking Free, Inc. • Northwestern Cadence Health Behavioral Health Services • Communities in Schools Fred Rodgers Community Center • Dreyer Medical Clinic • Ecker Center for Mental Health • Elderday Center • Family Counseling Services • Fox Valley Volunteer Hospice • Gateway Foundation – Aurora • Hope for Tomorrow, Inc. • Kendall County Health Department Mental and Substance Abuse Treatment Clinicians • Mutual Ground, Inc. • Open Door Clinic • Presence Mercy Medical Center • Presence St. Joseph Hospital (Elgin) • Senior Services Associates • TriCity Family Services • VNA Health Care • Suicide Prevention Services	• City of Aurora • Compañeros en Salud/ Partners in Health • Fit for Kids Program • Fox Valley Park District • Healthy Living Council • Kane County Health Department • Kendall County Health Department • Kane Community Health Access Integrated Network (KCHAIN) • Women, Infants and Children (WIC) Program • Aurora Primary Care Consortium • 708 INC Board • Local Fitness Clubs/Centers • Local K-12 School Programs • Local Law Enforcement Agencies • Local Nutritionists • Senior Services Associations • YMCA

Identified Community Health Needs

Identified and Prioritized Health Needs

- The Community Health Needs Steering Committee identified and prioritized the following community needs using the process and methodology outlined on page 13 of this report.
- As part of a collaborative community process, the Committee agreed to include all of the top health needs/threats identified by Kane County in their IPLAN.

Identified Community Health Needs (listed in order of importance from highest to lowest)
Obesity: Achieving a healthy weight through proper nutrition and exercise
Chronic disease[1]: Chronic disease self-management and preventative care
Access to care: Understanding insurance coverage and care options
Behavioral health, including mental health and substance abuse[1]
Access to care: Transportation for health care services
Income, job-ready workforce, and education[1]

1: Identified as one of the top three health priorities in the Kane County 2017-2020 IPLAN

Please note: At the time of the RCMC assessment process, Kendall County was in the beginning phases of their latest IPLAN and had not yet determined the top health needs in the County. Therefore, those needs are not identified in this assessment. However, input provided by Kendall County was taken into consideration when determining the top health needs in the community served by RCMC.

Identified and Prioritized Health Needs

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

    1. **Obesity, focusing on achieving a healthy weight through proper nutrition and exercise**

    2. **Chronic disease, focusing on chronic disease self-management and preventative care**

    3. **Access to care, focusing on understanding insurance coverage and care options**

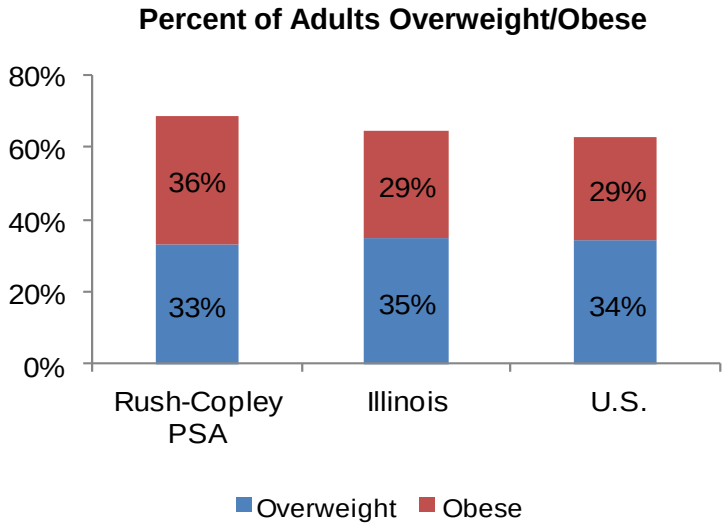
- The hospital developed and adopted an implementation strategy to address these community health needs.

Obesity

Achieving a healthy weight through proper nutrition and exercise

Overview

- Obesity is defined as having excess body fat and a body mass index (BMI) equal to or greater than 30.
- Obesity is a major public health problem contributing to 112,000 preventable deaths each year.
- Obesity is a root cause of other health problems.
  - Obesity-related conditions include heart disease, stroke, cancers, liver and gallbladder disease, and type 2 diabetes, some of which are among the leading causes of death.
  - As the rate of obesity continues to increase, so does the rate of obesity related diseases.
- Good nutrition, physical activity, and healthy weight are essential parts of a person's overall health and well-being.



Why is this an identified health need?

- The obesity epidemic in the United States includes the community served by the hospital. The severity of this problem is high in the community and continues to increase.
  - 68.8% of the adults in the community are either overweight or obese (as compared to 65.2% in FY2013)
  - 16.8% of children in the community ages 5-17 are obese, with an additional 25.9% overweight
- The following factors contribute to the severity of obesity in the community:
  - 56.7% of adults meet the recommended level of physical activity, which is an improvement from the last assessment and higher than the U.S. rate of 50.3%. However, that still means over 40% of adults are not meeting physical activity guidelines.
  - Only 17.6% of adults and 51.1% of children in the community eat at least five servings of fruits and vegetables per day. While the rate for children improved (25.5% in 2012), the adult rate remains nearly the same as the findings from the last assessment.
- Obesity disproportionally affects Hispanic Americans as this population is 1.2 times as likely to be obese than White Non-Hispanics.
- Obesity was identified as a top health problem in the community through the Kane County IPLAN and through a number of focus group discussions including those with the Kendall County Health Department and primary care physicians.
- Reducing the prevalence of obesity would have a positive impact on the health of the community and would also contribute to the reduction of the incidence of chronic diseases.

Sources: Healthy People 2020, PRC RCMC Community Survey, FY2013 RCMC CHNA, U.S. Department of Health and Human Services, The Office of Minority Health, and American Medical Association

Chronic Disease

Chronic disease self-management and preventative care

Overview

- Chronic diseases are diseases of long duration, generally slow progression, and are non-communicable (includes arthritis, asthma, heart disease, cancer, diabetes, obesity, and chronic obstructive pulmonary disease).
- Chronic diseases and conditions are among the most common, costly, and preventable of all health problems.
- Chronic diseases are the leading cause of death and disability in the United States. They cause 7 out of 10 deaths each year. Heart disease, cancer, and stroke alone cause more than 50% of all deaths each year.
- There are four common risk behaviors identified by the CDC that cause much of the illness, suffering, and early death related to chronic diseases and conditions: lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption.
- If no education and preventative action is taken, these diseases will continue to be more prevalent as the population ages.

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 indentified as a top health priority.

- Chronic disease continues to be the leading cause of death, specifically cancer and cardiovascular disease, which are estimated to account for one-half of all deaths in the community.*
- The prevalence of many types of chronic disease were identified as top health problems in the community through the majority of focus group discussions including those with care managers/nurses, primary care physicians, Kendall County Health Department, and Kane County Key Health Informants. Kane County also identified chronic disease as a top health threat in their recent IPLAN.
- Often those with chronic disease do not understand when and where to seek care before their symptoms become unmanageable. Improved preventative education will result in improved health and quality of life, while reducing acute episodes and hospitalizations.
    - Care managers, nurses, and primary care physicians identified the need for improved education regarding self-management, preventive care, and treatment of chronic disease.

	Rush-Copley PSA	Illinois	U.S.
Diabetes (adults only)	13.0	9.9	11.7
Angina, heart attack, or coronary heart disease	4.0	n/a	6.1
COPD	6.1	n/a	8.6
Asthma (adults only)	7.8	7.6	9.4
Has had a stroke	2.6	2.8	3.9
Osteoporosis (50 years+)	10.8	n/a	13.5
Cancer incidence	Kane: 452.2 Kendall: 482.6	482.5	467.7

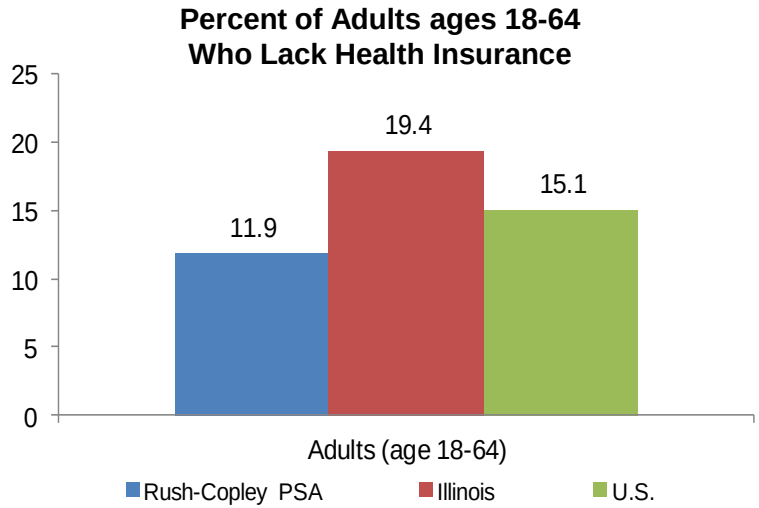
Sources: Healthy People 2020, PRC RCMC Community Survey, FY2013 RCMC CHNA, CDC, IDPH, and American Medical Association
*Rate is reflective of Kane County.

Access to Care

Understanding insurance coverage and care options

Overview

- Regardless of age, geography, or socioeconomic circumstance, quality health care should be available to everyone.
  - Access to care is important for the achievement of health equity and for increasing the quality of a healthy life for everyone.
  - Access to health services encompasses four components: coverage, services, timeliness, and workforce.
  - Barriers and disparities in access to health services negatively affect individuals and society.
- Barriers to care and health services include:
  - Lack of availability
  - High costs and lack of insurance coverage
  - Language and cultural barriers
  - Lack of transportation
- In addition to the barriers listed above, a critical component of access is being able to effectively navigate the health care system. This means understanding insurance coverage, the health care services and care options available, and how to receive care in the appropriate setting.



	Rush-Copley PSA	U.S.
% of adults who had difficultly accessing health care in the past year (composite)	34.6	39.9
% due to inconvenient hours	14.7	15.4
% cost prevented physician visit	13.6	18.2
% difficulty finding a physician	8.9	11.0
% transportation hindered physician visit	6.1	9.4
% of adults who have a specific source of ongoing care	76.2	76.3
% of adults that had two or more ER visits in the past year	8.9	8.9

Sources: Healthy People 2020, Robert Wood Johnson Foundation, Kaiser Health News, "Many Patients Struggling to Understand New Health Insurance", http://obamacarefacts.com, JAMA, "Why Health Insurance Literacy Matters"

Access to Care

Understanding insurance coverage and care options

Why is this an identified health need?

- While the implementation of the ACA helped millions of people gain access to health care services, including residents in the community served by Rush-Copley, barriers to care still remain. This is evidenced by nearly 35% of adults in the community that had difficulty accessing health care over the last year. Based on the community survey, key barriers include the following:
  - Do not have a regular/on-going health care provider: 23.8%
  - Inconvenient hours: 14.7%
  - Cost: 13.6%
  - Finding a physician: 8.9%
  - Transportation: 6.1%
- Additionally, the majority of newly insured and many of those who already have insurance find it difficult to navigate the health care system, including insurance plans. The degree to which individuals understand this information has significant implications on effective use of available health care services. This issue was identified in all of the focus groups.
  - Many of the focus groups identified that this access issue impacts all insured residents to some degree, regardless of their insurance plan.
  - Newly insured residents have less experience navigating the health care system and understanding insurance coverage.
  - Nearly one-third of RCMC patients have Medicaid or Medicaid Managed Care plans, which pose additional access challenges.
  - The senior services focus group commented that the senior population often has a difficult time understanding the many layers Medicare insurance coverage and benefits.
- As a provider, the hospital is in a unique position to help address the access to care issues described above by reducing existing barriers and improving residents' understanding of insurance coverage and care options.

Sources: Healthy People 2020, Robert Wood Johnson Foundation

Evaluation of Impact of the FY13 Implementation Strategy

Rush-Copley

FY2013 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 FY13 CHNA and Implementation Strategy Plan.
Progress and accomplishment highlights include:

- Developed and implemented a healthy weight web page and shared community resources
- Developed and implemented a healthy weight program (called YouFIT), which was developed by Rush-Copley staff, physicians, dieticians, and Healthplex personal trainers
- Developed a family-based healthy weight/lifestyle program for adults and children (called FamilyFIT), which was developed by Rush-Copley staff, physicians, dieticians, and Healthplex personal trainers
- Developed and implemented a community walking club, which included community presentations, walking resources, and pedometers for all participants
- Developed and implemented a community toolkit and resources for residents to start their own Couch to 5K club
- Partnered with Sci-Tech to develop and implement an interactive education display for children related to childhood obesity
- Implemented the Mindful eating program in the hospital cafeteria and achieved Gold Certification
- Developed a funding program and partnership with Walgreens to provide medication assistance to those in need
- Partnered with Walgreens to implement the *Well Transitions* program to ensure chronic disease patients understand their home medication(s) and have an available resource to ask questions once discharged
- Created and implemented a widely used web-based inventory of universal medication assistance programs
- Developed a plan for and are in the process of achieving Advanced Inpatient Diabetes Care Certification through the Joint Commission
- Worked with community leaders to develop a standard evidence based approach for diabetes follow-up care
- Provided diabetes screenings and education at a number of community events

Impact of Actions

The actions taken since the FY2013 assessment have had a positive impact on the health of the community. **Highlights include:**

- The prevalence rate of childhood obesity decreased from 21.8% to 16.8%
- Healthy behaviors regarding proper nutrition and physical activity improved
  - 57% of adults meet the recommended level of physical activity as compared to 49% in FY2013
  - 51% of children in the community eat the recommended daily servings of fruits and vegetables as compared to 26% in FY2013
- Over 65 residents participated in the YouFIT healthy weight program. The average weight loss during the 12-week program was 8 lbs with an average of 2.3% loss in body fat.
- As part of the walking club initiatives, over 200 residents were provided pedometers at no cost. Of those who completed both the pre-test and post-test, 91% said they felt better as a result of walking and nearly 60% said they increased the number of times they exercise each week.
- The prevalence rate of diabetes in the community decreased from 14.9% to 13.0%
- Medication access and adherence was improved as:
  - Inpatients and high-risk emergency patients at Rush-Copley are now able to receive their medication before discharge
  - Physicians and Rush-Copley staff regularly accessed the medication assistance program inventory for their patients
  - Over 150 patients were provided needed medications at no cost through the newly established Charity Care fund
  - The FY2016 focus groups no longer identified medication access as a critical health need in the community