Silver Cross Hospital
Community Health Benefit Implementation Plan
2021-2023

1900 Silver Cross Boulevard
New Lenox, IL 60451

www.silvercross.org
# Table of Contents

Executive Summary 3  
About Silver Cross Hospital 4  
Definition of Community Served 5  

**2020 Community Health Needs Assessment (CHNA) Summary:**  
Demographics of the Community 6  
Socioeconomics of the Community 7-8  
Existing Healthcare Facilities & Resources 9  
Behavioral Health Capacity 10-11  
Preventable Hospital Events 12-13  

Silver Cross 5 Star Strategic Plan 14  

The Social Determinants of Health 15-22  

FY2021-2023 Silver Cross Community Benefit Implementation Plan 23  
**Goals and Priorities:**  
Priority #1: Enhancing the quality of life in the community by reducing healthcare disparities & addressing social determinants of health. 24  
Priority #2: Increase Access to Health Services 25  
Priority #3: Focus on the Needs of Cancer and Diabetes Patients 26-27  

Conclusion 28
Executive Summary

With the March 2010 passage of the Patient Protection and Affordable Care Act, all not-for-profit hospitals (recognized as 501(c)(3) organizations) are required to complete a Community Health Needs Assessment (CHNA). A CHNA is designed to identify, prioritize, and address health issues in a hospital’s primary service area and must be completed at least once every three years for tax years beginning after March 2012. The IRS has provided guidelines on CHNA expectations, including but not limited to, a definition of community, reporting of health outcomes in the region, completion of community input, prioritization of health issues, and adoption of an implementation strategy authorized by the governing body of the hospital organization.

As a not-for-profit healthcare provider and community leader for 125 years, we take our responsibility to positively impact and help meet the needs of Will County and Southwest suburbs very seriously. To that end, Silver Cross Hospital contributes $10,000 annually to the Will County collaborative to develop a broad-based community needs assessment. The Will County Mobilizing for Action through Partnerships and Planning (MAPP) process, coordinated by the Will County Health Department, as well as other area hospitals, healthcare providers, and community leaders conducted a comprehensive CHNA. These groups analyzed data, surveys, and other local and national research to prioritize the social, environmental, and healthcare needs of our community.

As a result of this collaboration, the 2020 Will County Community Health Needs Assessment was created. The CHNA includes the following four assessments which are the Community Themes & Strengths Assessment, the Local Public Health System Assessment, the Forces of Change, and the Community Health Status Assessment as shown on the right. The CHNA provides methodology and major findings, along with an implementation plan specifying the necessary programs that need to be developed to meet local communities’ needs that will improve the quality of life of Will County residents. This report is the basis of Silver Cross Hospital’s 2020-2023 Community Benefit Implementation Plan.

The Report is available at:

https://the-will-county-mapp-collaborative-willcountygis.hub.arcgis.com/

Silver Cross Hospital executives and clinical staff continue to be active members of the Will County MAPP Project Steering Committee. We have taken leadership roles on several committees to ensure Silver Cross Hospital is thoroughly engaged in implementing these vital community programs. Also, Silver Cross staff helps support the MAPP process by providing information that was developed to gather all the services that are occurring throughout Will County to address the local communities’ needs.

In consideration of the top health priorities identified through the CHNA process — and taking into account organizational resources and overall alignment with the mission, goals and strategic priorities, the 2020-2023 Will County Community Health Needs Assessment Report will serve as Silver Cross Hospital’s three-year Community Benefit Plan for our annual Community Benefit Report.
About Silver Cross Hospital

Founded by the Will County Union of King’s Daughters and Son in 1895, Silver Cross Hospital has evolved into a 300-bed not-for-profit, independent, non-denominational acute-care hospital in New Lenox. Through our dedication to clinical quality and personal service, Silver Cross has been recognized as a Truven Health/IBM Watson 100 Top Hospitals National Award winner for eight years and honored with an “A” Hospital Safety Grade by The Leapfrog Group eleven times in a row. Silver Cross’s Corporate Mission, Vision and Core Values, Standards of Conduct, and Seven Behaviors are summarized below, inspire the organization to deliver superior health care and guide the overall strategic direction.

Mission
Our mission is to improve the health of those we serve and advance wellness in our community.

Vision
We, the Silver Cross Family, are known for our culture of excellence and will deliver an unrivaled healthcare experience for patients, their families, and the communities we serve.

Core Values
- Safety — do no harm
- Inclusiveness – work collaboratively and transparently
- Leadership — take initiative, demonstrate professionalism and be accountable
- Virtue — demonstrate integrity and ethical behaviors
- Excellence – achieve distinction for high reliability in quality and service
- Respect – honor the feelings, traditions, and rights of others

Standards of Conduct
- Promote quality health care and ethical behavior
- Ensure compliance with the law
- Demonstrate respect, fairness, and courtesy in the workplace
- Understand, avoid, and disclose conflicts of interest
- Maintain confidentiality of information
- Ensure safety and security

Seven Behaviors
1. Speak up for patient safety
2. Always introduce yourself
3. Wear your name badge appropriately
4. Always give explanation of processes
5. Escort patients and visitors
6. Keep the environment clean and safe
7. Always greet patients, visitors, physicians and colleagues

SAFEty Habits
1. Support Each Other
2. Ask Questions
3. Focus of the Details
4. Explain Clearly
Definition of the Community Served

CHNA Community Definition (Service Areas)

Will County has a total of 849 square miles (12 of which is water), 31 zip codes, 23 cities, and 5 area codes. According to 2017 population estimates, there are 12,802,023 Illinois residents with 5.4% (692,661) residing in Will County.

Silver Cross Hospital’s Primary Service Area (PSA), as defined for the purpose of the Community Health Needs Assessment, is defined as the following residential Zip Codes in portions of Will and southwestern Cook counties, Illinois: 60403; 60421; 60423; 60432; 60433; 60435; 60436; 60439; 60441; 60442; 60448; 60451; 60467; and 60491.

Silver Cross’ Secondary Service Area (SSA) includes: 60440; 60446; 60490; 60544; 60586; 60404; 60410; 60431; 60447; 60450; 60408; 60416; 60481; 60487; 60443; 60449; 60462; 60464; and 60477.

Our service area is composed of widely diverse cross-sections of the population. Large sections of our community are more established in suburban areas and are rapidly growing. Here are also segments that are becoming more racially and ethnically diverse and that are more densely populated. Median incomes range broadly throughout the community – with distinct pockets that have very low incomes, with other areas that are significantly more affluent. Other sections of the community could be considered more rural in nature and are much smaller in terms of population size but growing and are less ethnically and racially diverse.
Demographics of the Community

The following data can be found in the U.S. Census Bureau;\(^1\) Will County’s population has grown rapidly over the past decade and is expected to continue outpacing the growth rate for Illinois.

The 2017 census indicates Will County’s population was comprised of approximately 692,661 persons. The population of Will County is predominantly non-Hispanic white (74.2%), while nearly 25% of the Will County population is non-white that includes Hispanic, African American, and Asian populations. Roughly 16.5% of the Will County population is of Hispanic or Latino ethnicity and that percentage has nearly doubled in the last decade.

Also, 8.76% of the population or 59,452 people have a disability. 6.4% of the total population are veterans and over 40% of the veteran population is over 65 years old.

The 2016 demographic distribution is as follows:

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Language Spoken at Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>English Only</td>
</tr>
<tr>
<td>Hispanic</td>
<td>Spanish</td>
</tr>
<tr>
<td>Black</td>
<td>Asian or Pacific Island Language</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Language Spoken at Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>English Only</td>
</tr>
<tr>
<td>Hispanic</td>
<td>Spanish</td>
</tr>
<tr>
<td>Black</td>
<td>Asian or Pacific Island Language</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population Distribution by Age Group in Will County, ACS 2012-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>65+ years old</td>
</tr>
<tr>
<td>Will County</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>6.15%</td>
</tr>
<tr>
<td>11.17%</td>
</tr>
<tr>
<td>15.43%</td>
</tr>
<tr>
<td>11.54%</td>
</tr>
<tr>
<td>14.51%</td>
</tr>
<tr>
<td>13.62%</td>
</tr>
<tr>
<td>9.08%</td>
</tr>
<tr>
<td>14.51%</td>
</tr>
<tr>
<td>11.60%</td>
</tr>
<tr>
<td>20.54%</td>
</tr>
<tr>
<td>12.55%</td>
</tr>
</tbody>
</table>

\(1\) Source: Will County Health Status Assessment 2018: US Census Bureau, American Community Survey 2012-2016 (pages 9-17).
The Socioeconomics of the Community

Poverty is considered a key driver of health status. Poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status. The percentage of individuals at or below the poverty level is now at 7.69% in Will County. The State of Illinois average is 13.98%. In 2016, more than 11% of children under the age of 18 were living under the poverty level in Will County and 19.55% in the State of Illinois according to the US Census Bureau. This represents a significant number of individuals. Fourteen percent of the Hispanic/Latino population was living in poverty, compared to 6.39% of the Non-Hispanic population. Fifteen percent of the Black or African American population was also living in poverty. The highest percent of the population living in poverty reside in the Joliet area in the 60432, 60433, and 60436 zip codes.

Socioeconomics of the Community (cont’d)

Socioeconomics Key Findings:
• The median household 2012 to 2016 was $77,507.
• There is an evident disparity in income by race and ethnicity.
• 7.69% of residents live below the poverty line.
• 14.27% of Hispanic/Latino population lives in poverty, vs. 6.39% of the Non-Hispanic population.
• There are more female than male single-parent families by a little over 10%.
• The unemployment rate was 3.9% in October 2018.
• 35.72% of children are eligible for free or reduced lunch.
• 9% of Will County households receive SNAP benefits, compared to 13.26% of Illinois residents and 13.05% of United States residents.
• Zip codes with more than 19% of their households receiving SNAP benefits include 60432, 60433, 60436, and 60484.
• As of 2016, 9% of residents over the age of 25 do not hold a high school diploma or GED. Educational attainment is linked to positive health outcomes.
• 16.43% of the Hispanic/Latino population reported having no health insurance coverage, compared to 5.42% of the non-Hispanic/Latino population without health insurance.
• There are 3,822 federally assisted housing units.
• On January 31, 2018, 341 unique individuals experienced homelessness in Will County, including 43 unsheltered individuals and 31.9% were children.
• 7.24% of the population in Will County is uninsured. 16.43% of the Hispanic/Latino population had no health insurance coverage compared to 5.42% of the non-Hispanic/Latino population.
• The percentage of Will County population enrolled in Medicaid is 14.36%.
• 8.32% of the population or 56,202 people have a disability.
• 6% of the total population or 32,514 people are veterans. Over 40% of the veteran population is over 65 years old. 3)

Quality of Life Key Findings:
• Life expectancy at birth is higher than in Illinois and the United States.
• Access to parks and recreational facilities has decreased since 2010.
• Of 34,000 children who have uncertain access to food, 46% do not qualify for any sort of help.
• Many areas have low access to a supermarket or grocery store.
• 35.12% of occupied housing units have one or more substandard conditions.
• The age group, 45-54, have the highest number of active voters than other age groups. 4/}

Existing Healthcare Facilities & Resources

Three hospitals are located within Will County including AMITA Health Adventist Medical Center (Bolingbrook), AMITA Health Saint Joseph Medical Center (Joliet), and Silver Cross Hospital (New Lenox). A fourth hospital, Edward Hospital (Naperville), is located just outside of Will County, but serves a large number of Will County residents and has a freestanding emergency center and other outpatient services located in Plainfield. There are three health centers, of which two are federally qualified health centers, that serve the ambulatory care needs of Will County residents; Aunt Martha’s (Joliet), VNA Health Care (Bolingbrook, Joliet, and Romeoville) and Will County Community Health Center (Joliet). In Will County, there are a total of 923 inpatient beds. Edward Hospital, located just outside of Will County, adds another 354 beds.

Health Resource Availability Key Findings:
- Will County has dialysis facilities, nursing homes, and other outpatient treatment centers.
- According to the Illinois Health Facilities and Services Review Board latest Addendum to the Inventory of Health Care Facilities (2017), there is a need for 83 medical/surgical beds and 11 intensive care beds.
- There were approximately 73,000 hospital patients in 2016 in area hospitals and about 21.6% were under or uninsured (Medicaid/Private Pay or Charity Care).
- There is a shortage of primary care physicians, mental and dental health providers.
- Will County’s ambulatory care sensitive condition discharge rate (69) is higher than both Illinois (59) and the U.S (38), however, the rate has decreased from (92.1) since 2010.
- The closing of the Tinley Park Mental Health Facility in June of 2012 reduced the availability of hospital beds for Will County residents due to mental health disorders. Will County MAPP Collaborative assessment findings in 2016 and 2018 confirmed that mental and substance use disorder treatment was difficult to access for many residents. In response to this need, Silver Cross Hospital partnered with US Health Vest to bring a 100-bed behavioral health hospital to Will County in early 2019.

Physicians, Dentists, and Mental Health Providers
In terms of clinical care, Will County is ranked 35th out of 102 counties in the state. These measures suggest a shortage of providers available in the community. Will County has a total of 391 primary care physicians yielding a ratio of population to primary care physicians of 1,800:1 compared to 1,240:1 for Illinois and 1,030:1 nationally. Will County has a total of 366 dentists yielding a ratio of population to dentists of 1,860:1 compared to 1,330:1 for Illinois and 1,280:1 nationally. Will County had a total of 614 mental health providers yielding a ratio of population to mental health providers of 1,120:1 compared to 530:1 for Illinois and 330:1 nationally. The U.S Department of Health Resources and Service Administration (HRSA) has developed shortage designations that are used to determine if areas or population groups are Health Professional Shortage Areas (HPSA). HPSAs may be designated as having a shortage of primary medical care, dental or mental health providers. In Will County, the east side of Joliet has been identified as a HPSA for primary care, dentists, and mental health providers.

Behavioral Health Capacity

The Will County MAPP Collaborative has found through a capacity assessment of key stakeholders that behavioral health is a key area of need in Will County. Results indicated that five barriers for clients to access services were identified; transportation problems (79%), wait for services (76%), distance to services (71%), cost of needed services (66%), and client/patient resistance (63%). The survey also found that per providers, psychiatric services were hardest to access, especially for mental health disorders.

Social and Mental Health Key Findings:
• There are limited resources for inpatient hospitalization for mental health and addiction disorders.
• 91,148 adults (19.2%) in Will County report having inadequate social and emotional support.
• Burglary offenses have decreased by almost 50% and theft offenses by 34% since 2010.
• Crime and drug arrest rates have decreased. Reports of hate crimes and school incidents have risen.
• The rate of child abuse and neglect cases showed a decrease from 21.4 per 1000 in 2010 to 18.4 per 1,000 in 2015.
• 35% of 12th graders have experienced depression in 2018 which is a 5% increase from 2016
• There were 80 suicides in 2017 with 81.25% testing positive for drug and alcohol use.
• In 2018, 14% of 10th graders and 16% of 12th graders have considered suicide.

---

Behavioral Health Capacity (cont’d)

Behavioral Health Issues
Behavioral health continues to be a concern among Will County residents. The term behavioral health is inclusive of mental health and substance use disorders. Resources in Will County are limited for hospitalizations for mental health disorders as well as inpatient treatment for substance use.

In response to the state facility closing, the Illinois Department of Human Services Division of Mental Health has initiated a Crisis Care System to service consumers in the community when presenting to the hospital emergency departments. This service is contracted to the Will County Health Department’s Division of Behavioral Health and Cornerstone Services, Inc. for Will County residents. Only non-insured persons are eligible to participate in these services. Hospitalizations due to mental disorders attributed to 7.8% of Will County hospitalizations in 2014. It is the third leading cause of hospitalizations. 7)

Behavioral Risk Factors Key Findings:

ADULTS
• 28.2% of adults have high blood pressure, and 26% of these adults with high blood pressure were not taking blood pressure medication as of 2009.
• 31.1% of adults are considered obese in 2015 and 37.90 are considered overweight in 2014.
• More adults in Will County are physically inactive than adults in Illinois and the U.S.
• Tobacco use among Will County adults has decreased since 2009.
• 23.6% of adults heavily consume alcohol which is higher than IL (20%) and the US (16.4%).

YOUTH
• Alcohol is the primary substance used among 12th graders.
• 6% of 12th graders currently smoke. 35% or 12th graders reported using e-cigarettes in 2018.
• Many children are spending as many as 5 hours or more in front of a television or computer each day. 8)

Preventable Hospital Events

The discharge rate in Will County is 69 per 1,000 Medicare enrollees for conditions that are ambulatory care sensitive (ACS).\(^9\) As a result, Will County’s ACS discharge rate is higher than both Illinois and the United States rates. ACS conditions include pneumonia, dehydration, asthma, diabetes, and other conditions which could have been prevented if adequate primary care resources were available and accessed by those patients. This is relevant because analysis of ACS discharges allows demonstrating a possible “return on investment” from interventions that reduce admissions (for example, for uninsured or Medicaid patients) through better access to primary care resources.

Cancer Screening\(^{10}\)

- 70% of women aged 18 and older said they have had a Pap test in the past year.
- 58% of women aged 40 and older said they have had a mammogram in the past year.

This is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing the utilization of services.

Breast Cancer

Breast cancer is the most common type of cancer among women and accounts for one of four cancer diagnoses in women in the U.S. Mortality from breast cancer can be reduced substantially if the tumor is discovered at an early stage, and mammography is the most effective method for detecting these early malignancies. In 2015, the Will County Breast Cancer mortality rate was 21.4 deaths per 100,000 females. This is slightly lower than Illinois’ Breast Cancer mortality rate of 22.2 deaths per 100,000 females. In Illinois, approximately 58.4% of women ages 40 and older have reported having a mammogram in the past year. This is a significant decrease from 2007-2009 in which 68.8% of this population reported the same. While the breast cancer mortality rate in Will County is lower than the state and national rate, the percentage of women who have had a mammogram in the past year is significantly below the healthy people 2020 target.

Colorectal Cancer

Colorectal cancer is the third most commonly diagnosed cancer among men and women, as well as the third leading cause of cancer deaths among both genders. While the Colorectal Cancer mortality rate for Will County is 11.2 per 100,000 population and below the 14.5 Healthy People target.

Lung Cancer

Lung cancer is the most common cause of cancer death among both females and males. Cigarette smoking is the most significant risk factor for lung cancer, though other risk factors include environmental sources such as tobacco smoke and air pollution, radiation exposure, and occupational exposure to organic chemicals such as radon and asbestos. In 2015, the Will County lung cancer mortality rate of 47.1 deaths per 100,000 population rose above the Illinois rate of 46.3 deaths per 100,000 population.


\(^{10}\) Source: Will County Health Status Assessment 2018: US Census Bureau, American Community Survey 2010-2014 (pages 88-100)
Prostate Cancer
Prostate cancer is the most commonly diagnosed cancer among men and is the second leading cause of male cancer death. The incidence rate of prostate cancer in Will County is above both the rates of Illinois and the United States. There are also disparities among the Black population, which have a higher incidence rate in Will County. However, the mortality rate in Will County is lower than the Healthy People 2020 target as well as Illinois and the United States rates.  

![Prostate Cancer Incidence Rate](chart.png)

*Sources: State Cancer Profiles. 2011-15.*

Diabetes
Over the past decade, mortality due to diabetes has slowly decreased in Will County and Illinois overall. In 2014, the age-adjusted mortality rate of diabetes was 17.7 deaths per 100,000 people, well below the Healthy People 2020 target of 66.6 deaths per 100,000 people. Studies have found that only 35%-40% of people who die from diabetes have the disease listed on their death certificate and only 15% have it listed as the underlying cause of death. Instead, conditions associated with complications from diabetes, such as cardiovascular disease, coronary heart disease, non-traumatic lower-extremity amputations, and end-stage renal disease, are generally the final conditions that result in death. Therefore, the Will County Diabetes mortality rate may be misleading.

Coronary Heart Disease
Will County’s coronary heart disease mortality rate is 95.6 per 100,000 people and is slightly higher than the Illinois mortality rate of 94.44 per 100,000 people but lower than the Healthy People 2020 target of 103.4 per 100,000 the population. Also, the Will County rate has decreased since the last assessment date from 2014 in which the rate was 101.7 per 100,000. The African American community has an increased mortality rate for coronary heart disease. This is consistent with the Illinois rate.

Delivering Value
Silver Cross Hospital, always at the forefront of key changes and trends, rolled out its 5 Star, 5 Year Strategic Plan in the fiscal year 2020. The plan outlines five major focus areas. The areas are designed to help the hospital meet the challenges and opportunities while navigating through rapidly changing seasons in healthcare.

The hospital’s 5 year strategic plan addresses:
- Growth
- Fiscal Responsibility
- SCH Medicine
- Culture
- Value

Delivering value in healthcare includes managing health, advancing wellness, identifying barriers to care, and improving the health and well-being of the community we serve. Our strategic plan is also designed to identify and address health inequities that result from socio-economic influences by focusing on the health disparities, and social determinants of health.

Healthcare systems continue to provide quality care to their patients through treatment for chronic disease, emergency services, and surgeries along with community-based screenings and health education programs. More healthcare systems are also moving toward upstreaming and creating strategies to improve the health of our community by reducing healthcare disparities and addressing social determinants of health.
The Social Determinants of Health

Health Disparities

Health Equity
**Situation**
Health Equity continues to be an ongoing concern. What is health equity? According to the Centers for Disease Control and Prevention (CDC), health equity is when everyone has the same opportunity to be as healthy as possible. 12

Data from the 2020 Will County Community Health Status Assessment (CHSA) and Healthy People 2020, show significant disparities in healthcare outcomes among race, age, language, ethnic, and socio-demographic categories within our community. 13 What are health disparities? Health disparities are differences in health outcomes and their causes among groups of people.

According to the 2020 CHSA, where it relates to race, ethnicity, gender, and treatment at school, work, and on the streets of our community, at least 13 percent identified with discrimination three or more times in the following settings (see chart below). Six percent of all respondents stated that they perceive discrimination to be an issue all or most of the time within the county. Among the resident respondents, 11 percent of all individuals identified with feeling concerned with “unfair treatment due to race, ethnicity, and color”. 14

The study also discussed the Social Determinants of Health (SDOH). SDOH is defined as conditions in the environment in which people are born, live, work, play, worship. SDOH includes social and physical conditions. Examples of SDOH including:

- **Access to health and health care**
- **Education**
- **Social and Community Context**
- **Economic Stability**
- **Neighborhood and Built Environment** (including physical environment and public transportation)

More recently, the COVID-19 global pandemic has highlighted health gaps and created an opportunity to address the causes underlying these inequities. Studies reveal people of color disproportionately contracted COVID-19. The main causes and spread of the virus were found to be pre-existing conditions, health disparities, and SDOH. The underlying causes of health disparities can include social and structural determinants of health.

According to PwC’s Health Research Institute, clinical care is 20% of a patient’s care and 80% is attributed to health behaviors, the physical environment, and socio-economic conditions.

**Background**

Hospitals and/or health systems are often the leaders in their local area when it comes to improving the health of their community and overcoming disparities. The health system’s role is to identify which inequities are impacting their patient population and then work in partnership with their communities to eliminate them. Healthcare providers are working hard to ensure that every person in every community receives high-quality, equitable, and safe care and to eradicate health care disparities.

Addressing health disparities is a priority at Silver Cross and should be a priority in every hospital. The hospital continues to work closely with the Silver Cross Healthy Community Commission (HCC) to identify needs in the community. HCC was initially formed to focus on the betterment of the eastside of Joliet, (60432, 60433, 60434, 60436, and Fairmont area of 60441), which had suffered greatly due to the lack of economic development over the past decades.

Since 2008, the HCC has given over $2.4 million to community organizations that provide programs that address inequities in the community such as education, food insecurities, workforce development, and other quality of life programs but there is still much work to do to bridge the gap of inequities.

---

**Assessment**

After reviewing the 2020 Will County Community Health Needs Assessment (CHNA), we identified the following socioeconomic factors that have adversely impacted our community.

**Poverty** - Studies show that poverty is considered a key driver of health status. Poverty creates barriers to access health services, healthy food, and other needed necessities. The highest percent of the population living in poverty reside in the Joliet area in the 60432, 60433, and 60436 zip codes.

**Food Insecurity and Grocery Store Access** - Will County has a particularly high population with low food access (31.8%) compared to the state of Illinois (17.39). The rate of establishments in Will County is less than Illinois and the United States.

**Unemployment** - As of April 2020, the unemployment rate in Will County is 17.5%, compared to 16.9% in Illinois. This number is exacerbated. Prior to COVID-19, the unemployment rate was below 4%. Unemployment can cause financial difficulties that can ultimately cause barriers to healthcare services, insurance coverage, healthy foods, and other necessities.

**Education** - Nine percent of the Will County population above age 25 has not graduated high school or received their GED. A higher population of those without a high school diploma reside in the Joliet area in the 60432, 60433, and 60436 zip codes.

**Other socioeconomics Key Findings for Will County:**

- There is an evident disparity in income by race and ethnicity.
- 7.69% of residents live below the poverty line.
- There are more female than male single-parent families by a little over 10%.
- 35.72% of children are eligible for free or reduced lunch.
- 9% of Will County households receive SNAP benefits, compared to 13.26% of Illinois residents and 13.05% of United States residents.
- Zip codes with more than 19% of their households receiving SNAP benefits include 60432, 60433, 60436, and 60484.
- Of 34,000 children who have uncertain access to food, 46% do not qualify for any sort of help.
- There are 3,822 federally assisted housing units.
- On January 31, 2018, 341 unique individuals experienced homelessness in Will County, including 43 unsheltered individuals. 31.9% were children.
- 7.24% of the population in Will County is uninsured. 16.43% of the Hispanic/Latino population had no health insurance coverage compared to 5.42% of the non-Hispanic/Latino population. 17

---

• The percentage of Will County population enrolled in Medicaid is 14.36%.
• 8.32% of the population or 56,202 people have a disability.
• Access to parks and recreational facilities has decreased since 2010.
• 35.12% of occupied housing units have one or more substandard conditions.

Other Health Key Findings:
• Will County has a higher incidence rate of prostate cancer than Illinois & United States, especially among the Black population that has almost double the incidence rate of the White population.
• The stroke hospital admission rate is exceptionally high for the Hispanic/Latino population in Will County compared to Illinois for that same population.
• Lung cancer is the most common cause of cancer death in both men and women.
• Will County's coronary heart disease mortality rate is slightly higher than Illinois' mortality rate. The African American community has an increased mortality rate for coronary heart disease.
• The Hispanic/Latino population as well as the Black population have much higher hospital admissions for diabetes than other races and ethnicities. Hospitalization for diabetes is linked to unmanaged diabetes or the lack of primary care to manage the disease.
  o Unmanaged diabetes can cause cardiovascular disease, coronary heart disease, non-traumatic lower-extremity amputations, and end-stage renal disease, which are commonly the final conditions that result in death.  

Silver Cross Hospital and Healthy Community Commission continue to evaluate the ongoing needs of our community. The 2020 CHNA has provided critical information and data. It also gives both the hospital and the Commission the tools and the opportunity to address the current needs of the community we serve.

Attaining health equity is a communitywide effort. For hospitals across the nation to address health equity robustly, the American Hospital Association launched the #123forEquity Pledge to Act Campaign. Silver Cross Hospital has SIGNED the pledge along with 700 other hospitals around the country!! This program builds on the National Call to Action to Eliminate Health Care Disparities. The #123forEquity Pledge to Act Campaign asks every hospital to commit to the following:

- **Sign & Assess.** Evaluate your community and patient population for health disparities.
- **Taking action.** If there are disparities, develop a strategic plan to address issues specific to the area’s patient population.
- **Telling others.** Achieve the goals and be recognized. Tell your story and share what you have learned with others.

---

We know that Silver Cross Hospital and the Commission has been at the forefront addressing social determinants of health in our community. Other hospitals around the nation have addressed health concerns by supporting micro or macro level investments. Micro-level investments address quality of life programs such as pantries or medication vouchers. Macro investment funds programs such as affordable housing units. Please find below programs other hospitals have developed and introduced that address health inequities and disparities in their specific area.

St. Mary’s Regional Medical Center
The Nutrition Center at St. Mary’s Regional Medical Center developed a program called *Lots to Gardens*, which transformed abandoned lots around Lewiston into community gardens. Established in 2006, the Nutrition Center (NC) promotes community health through organizing, advocacy, and education with a special focus on supporting people with limited income who are at risk of becoming food insecure.

**Outcomes**
- The urban community gardens support 140 low-income households to grow their food.
- The school garden and children’s cooking programs have reached more than 900 students in 40 classrooms.
- The Nutrition Center provides cooking skills and nutrition education programs for more than 800 adults and seniors and an intensive leadership development and job-training program for more than 50 teens annually.
- The food pantry handles emergency food distribution so that more than 2,500 people enjoy fresh produce and groceries from the pantry each month.

United Ambulance Service Community Paramedic Program
In the Community Paramedic Program, the paramedic takes on a preventive and educational role, working with high-risk, frequent users of the health care system. The paramedic visits patients in their homes to provide basic medical intervention, improve patients’ awareness of how to manage their health, and evaluate the living spaces for hazards.

**Outcomes**
- The program has resulted in reduced 911 calls, decreased nonemergency ED visits, and reduced hospital readmissions.
- In 2016, United Ambulance made 1,954 community paramedicine interventions in the community.
**St. Vincent Healthcare**
The state of Montana gave St. Vincent Healthcare a grant for diabetes prevention. The hospital is in partnership with the local YMCA. Program participants also have access to YMCA exercise classes and facilities with no upfront membership fee. The services provided through the YMCA are partially funded through grants and hospital donations.

**Outcomes**
- 104 participants enrolled in the Diabetes Prevention Program, including 49 Medicaid beneficiaries and 78 with a walking disability.
- Nearly half of participants achieved a 5 percent weight loss after 10 months, with a mean weight loss of 10.3 pounds at four- and 10-month evaluation period.

**Texas Health Harris Methodist Hospital Azle**
After determining that a large portion of their emergency room visits were for issues related to chronic diseases, the hospital chose to focus on chronic disease management, including improved access to healthy foods and nutrition education. Access to affordable, healthy food is a significant issue for Texas Health Azle’s patients, where more than half of their population lives in rural areas without a nearby grocery store.

Texas Health Azle designed a coordinated system of food hubs to provide increased access to affordable fruits and vegetables for anyone in the surrounding communities they serve. This program utilizes an existing relationship with a vendor who provides produce for the hospital. Locally grown fresh produce is purchased in bulk at a reduced rate, which allows the savings to be passed to the consumer. Twenty to 25 pieces of fresh produce are sorted and sold for $5 per bag, typically at least 50 percent less than the cost at a local grocery store.

**Outcomes**
- A pre/post survey of program participants showed a 20 percent increase in the consumption of fruits and vegetables per week. Also, Texas Health Azle recently helped to initiate three community gardens, which offer an additional opportunity for residents to access fresh produce.

**Integris Health**
To get men to participate in a health initiative they created a program called “Men-U” which used male-friendly activities. Events include “Prostates and Pancakes” and car shows paired with health screenings. The hospital initiated a partnership with the local sports radio station that has become a central point of the initiative. Doctors from INTEGRIS go on the show to chat with the hosts about a variety of men’s health issues. Though they use humor, the message is clear – get checked. Men are incentivized to remain
engaged in their health by collecting points on their “Man Card,” which also enables INTEGRIS to track the involvement of men in the program. Participants can apply their Man Points toward tickets to sporting events or other designated activities.

**Outcomes**

- Since its inception, the program has reached thousands of men and their families across Oklahoma and created awareness of the importance of men’s health. Over the past few years, Men-U has started targeting minority populations for health promotion. INTEGRIS is reaching out to African American men through churches, barbershops, and designated community champions.

**Bon Secours Hospital**

Bon Secours Hospital serves West Baltimore, one of the most socioeconomically disadvantaged neighborhoods in Maryland, which has a high prevalence of poverty, chronic disease, and health disparities. Bon Secours collaborated with Enterprise Homes, an affordable housing developer. The hospital manages the engagement with the community, partnerships with local government and financing, and ongoing operations of the properties. Enterprise was responsible for construction, design, and accounting. The property consists of 648 units of senior/disabled and family housing in six apartment buildings and 59 renovated row homes.

**Outcomes**

- The West Baltimore Street corridor is revitalized; a three-block area that was once two-thirds vacant was transformed into a vibrant safe community where families live, work, and play.
- Bon Secours’ successful housing investment is beginning to attract other affordable developers to the neighborhood.
- Bon Secours and its neighborhood have developed a successful track record of planning and implementation; the program is identified as a credible partner to state, local, and private investors/funders.

---


FY2021-2023
Goals

In acknowledging the wide range of priority health issues that emerged from the CHNA process and opportunities to improve the health of the community and reduce disparities within healthcare, Silver Cross decided to focus on those deemed most pressing, most under-addressed, and most within the Hospital’s ability to influence. Silver Cross Hospital’s Community Benefit Implementation Plan will directly focus on these key areas:

1. Enhance the quality of life in the community by reducing healthcare disparities and addressing social determinants of health.
2. Increase access to healthcare and health education.
3. Focus on the prevention of and treatment chronic diseases specifically diabetes and patients with lung cancer.
Priority #1: Reducing Healthcare Disparities and Addressing Social Determinants of Health.
Silver Cross will continue to focus on reducing healthcare disparities by safely providing unrivaled, quality, healthcare, expanding awareness of healthcare services and community resources, and offering access to educational and employment opportunities.

1. **Re-focus and target Healthy Community Commission funding to lead efforts to decrease health inequities:**
   **Healthy Community Commission:**
   - a) Inform agencies to submit proposals tied to wellness.
   - b) Partner with community organizations to promote health education, healthy living, physical exercise:
     - National Hook-Up Black Women
     - Spanish Community Center
     - Local Ministries
   - c) Continue individual scholarships for healthcare jobs or college tuition and expand efforts to recruit back to the community.

2. **Connect Silver Cross Hospital efforts directly to the work of the Healthy Community Commission**
   **Silver Cross Hospital:**
   - a) Evaluate funding level for Commission.
   - b) Create diabetes prevention program and opportunity to make program mobile and more accessible in the community.
   - c) Deliver program similar to Crossroads to Health into community through partnering agencies.
   - d) Promote lung cancer screenings and smoking cessation programs.
   - e) Launch Healthy Eating and Active Living Campaign (H.E.A.L.) program.
     Stand up Food Farmacy and connect to health incentives
   - f) Analyze social determinants of health data from admission screening to drive future efforts and evaluate technology to connect people to community resources (i.e. Aunt Betha Pieces Technology).
Priority #2: Increase Access to Health Services and Health Education

Silver Cross will expand services and access points, coordinate care, and enhance the ease of use in the community through the following initiatives:

1. Continuing to communicate and apply the Silver Cross financial assistance policy to eligible individuals.

2. Recruiting more primary care physicians to address the physician shortage.

3. Increasing access to primary and preventative care by using technology and partnership with community agencies.

4. Promoting the Integrated Mobile Health program with local fire departments. Silver Cross will continue to fund the EMS so paramedics can perform home safety check visits for the most vulnerable patients with chronic disease.

5. Offering Telemedicine services to the community for urgent care at a low cost.

6. Creating more touchpoints through the development of ambulatory settings including an ambulatory surgery center, imaging, and urgent care.

7. Educating the community on infection prevention and pandemic safety.

8. Serving as the resource hospital for the Silver Cross EMS System, training paramedics from local fire departments and ambulance services including dispatch centers within Will, Cook, and Grundy Counties. To continue to subsidize funding to provide resource hospital duties.

9. Providing training for nursing educators, behavioral health technicians, prenatal clinicians, and certified CPR instructors.
Priority #3: Focus on the Prevention and Treatment of Lung Cancer and Diabetes Patients

Silver Cross will continue to serve the community by offering the following initiatives:

### Cancer

#### Prevention

- Offering annual continuing education programs for physicians, nurses, and allied health professionals on advancements in cancer prevention, diagnosis, and treatments.

- Distributing educational information relating to risks, symptoms, and treatment of lung cancer to persons in high-risk communities.

- Continually providing care through the recruitment of thoracic surgeons from Rush University to treat lung cancer patients here at Silver Cross.

- Collaborating with hospital foundation to pursue grants directed to organizations focused on health initiatives impacting lung cancer.

#### Treatment

- Providing patients with convenient access to cancer specialists at the University of Chicago Medicine Comprehensive Cancer Center at Silver Cross Hospital and the latest chemotherapy and radiation therapy, as well as access to more clinical trials than any other program in Illinois, and a facility close to home.

- Supplying state-of-the-art diagnostic testing and compassionate oncology care for inpatients.

- Sharing current resources and cancer care models being used by hospital staff.

- Facilitating weekly multidisciplinary Tumor Boards that focus on breast, lung, and gastrointestinal cancers identifying the best course of treatment for the patient.

- Providing exercise, nutrition, survivorship, and support services through the Cancer Support Center for cancer patients and their families.
Silver Cross will continue to serve the community by offering the following initiatives:

### Diabetes

#### Prevention

- Offering free screenings to help detect potential risk for diabetes throughout the service area.

- Linking underserved individuals diagnosed with diabetes to the appropriate community resources for treatment and ongoing management.

- Continuing to promote health initiatives by partnering with a community group, as part of our HEAL Campaign, and launching a diabetes prevention program in November 2020, while acknowledging November as National Diabetes Month.

- Collaborating with hospital foundation to pursue grants directed to organizations focused on health initiatives impacting diabetes.

#### Treatment

- Sharing current resources and diabetes care models being used by hospital staff in English and Spanish.

- Operating the Silver Cross Diabetes Center offering inpatient and outpatient services including:
  - Medication Management/Insulin Instruction
  - Insulin Pump Therapy Sensor Training, CGMS (Continuous Glucose Monitoring)
  - Meal Planning/Weight Management
  - Self-Blood Glucose Monitoring
  - Exercise Planning
  - Management of Gestational Diabetes.
Conclusion

Achieving Our Goals, Now and in the Future

Silver Cross Hospital is committed to addressing the needs of the community even outside of the hospital walls. Studies show that an investment of $10 per person per year in programs to increase physical activity, improve diet, and prevent tobacco use could save the country more than $16 billion in annual health care costs within five years and for every $1 spent in community-based prevention, the return equates to $5.60.\(^{22}\) This return on investment only accounts for medical cost savings and does not include how this affects the quality of life. For example, improved health can produce higher work productivity and less school or work absenteeism.

For over 125 years, Silver Cross has proven to be a vital and active member of New Lenox, Joliet, Will County, and the southwest suburbs with the mission of meeting the population’s healthcare needs. As outlined in the CHNA Implementation Plan, we have thoughtfully crafted strategies and initiatives to improve the quality of life for the communities we serve by:

- Reducing Healthcare Disparities and Addressing Social Determinants of Health
- Providing Access to Health Services and Health Education
- Focusing on the needs of Cancer and Diabetes patients in the communities

This plan reflects a unique and comprehensive approach to community benefit that extends beyond the hospital and addresses the socio-economic needs of the community.

\(^{22}\) Prevention Institute, Putting Prevention at the center of community well-being.
https://www.preventioninstitute.org/sites/default/files/publications/Prevention%20for%20a%20Healthier%20America_0.pdf