

Demographics of the Community [IRS Form 990, Schedule H, Part V, Section B, 1b 2013]

The population of the hospital's service area is estimated at 634,860 people. It is predominantly non-Hispanic White (57.3%), but also has substantial Hispanic (28.2%) and Asian (11.0%) populations.

As throughout the state and nation, our population is aging, with 11.0% currently age 65 and older. This is projected to increase in coming years, as is the need for services to meet the health needs of this older population.

16.5% of the families in our population remain below the poverty level.

US Census QuickFacts	SCH Service Area (c)	Cook County	Illinois
Population, 2015 estimate	634,860	5,238,216	12,859,995
Population, 2010	626,806	5,195,022	12,831,549
Persons under 5 years, percent, 2015	6.8%	6.4%	6.1%
Persons under 18 years, percent, 2015	23.2% (e)	22.4 %	23.0%
Persons 65 years and over, percent, 2015	11.0%	14.2%	13.2%
Female persons, percent, 2015	49.8%	51.5%	50.9%
White persons, percent, 2015 (a)	57.3%	65.7%	77.3%
Black persons, percent, 2015 (a)	8.4%	24.2%	14.7%
American Indian and Alaska Native persons, percent, 2015 (a)	0.3%	0.8%	0.6%
Asian persons, percent, 2015 (a)	11.0%	7.4%	5.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2015 (a)	.1%	0.1%	0.1%
Persons reporting two or more races, percent, 2015	3.3%	1.9%	1.9%
Persons of Hispanic or Latino Origin, percent, 2015 (b)	28.2%	25.2%	16.9%
White persons not Hispanic, percent, 2015	50.2% (d)	42.6%	61.9%
Living in same house 1 year & over, percent, 2010-2014	NA	86.4%	86.8%
Foreign born persons, percent, 2010-2014	NA	21.1%	13.9%
Language other than English spoken at home, percent age 5+, 2010-2014	46.3%	34.7%	22.5%
High school graduate or higher, percent of persons age 25+, 2010-2014	84.7%	84.8%	87.6%
Bachelor's degree or higher, percent of persons age 25+, 2010-2014	44.3%	35.3%	31.9%
Veterans, 2010-2014	NA	202,886	699,522
Mean travel time to work (minutes), workers age 16+, 2010-2014	37.6	32.0	28.2
Housing units, 2015	283,705	2,178,274	5,317,383
Homeownership rate, 2010-2014	44.4%	57.6%	66.9%
Median value of owner-occupied housing units, 2010-2014	\$275,264	\$222,200	\$175,700
Households, 2010-2014	254,606	1,937,060	4,778,633
Persons per household, 2010-2014	2.42	2.65	2.63
Per capita money income in the past 12 months (2014 dollars), 2010-2014	\$33,463	\$30,468	\$30,019
Median household income, 2010-2014	NA	\$54,828	\$57,166
Persons below poverty level, percent, 2010-2014	16.5%	17.1%	14.4%

(a) Includes persons reporting only one race.

(b) Hispanics may be of any race, so also are included in applicable race categories.

(c) SCH Service Area statistics are all based on U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates, except for row Population, 2010, which is based on 2010 Census Data.

(d) White person, percent margin of error is +/-5%.

(e) Persons under 18 years, percent, 2010 - 2014 margin of error is +/-3%.

The following represent potential measures and resources (such as programs, organizations, and facilities within the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

Access to Healthcare Services

- Local FQHCs, including Asian Human Services, Erie Family Health, Heartland Health and Access Community Health Network
- Centro Romero
- Churches
- Hamdard Center
- Illinois Coalition of Free and Charitable Clinics
- Korean American Community Services
- Oak Street Health

Arthritis, Osteoporosis & Chronic Back Conditions

- Chicago Back Institute at Swedish Covenant Hospital
- Galter LifeCenter
- Primary care providers, physical therapists, pain specialists

Cancer

- American Cancer Society
- Cancer Wellness Center
- Hospice care: Rainbow Hospice, Horizon Hospice & Palliative Care, Midwest Palliative & Hospice Care Center
- Integrated Cancer Care Program at Swedish Covenant Hospital

Chronic Kidney Disease

- National Kidney Foundation
- Individual dialysis clinics

Dementias, Including Alzheimer's Disease

- Catholic Charities
- Great Lakes Clinical Trials
- Hospitals, home health, nursing homes, primary care providers

Diabetes

- Diabetes Community Center at Swedish Covenant Hospital
- Diabetes care services, diabetes educators, primary care providers and FQHCs (Erie, Heartland, Asian Human Services)
- Galter LifeCenter and other fitness facilities
- School-based health services: Heartland Health Centers (Roosevelt High School and Hibbard Elementary); Erie Family Health Center (Amundsen High School)
- Wound clinics (Swedish Covenant Hospital)

Family Planning

- Midwest Access Project
- Planned Parenthood
- Primary care providers and local FQHC clinics
- WIC

Hearing & Vision

- Illinois College of Optometry

Heart Disease & Stroke

- American Heart Association/Stroke Association
- Community health screenings, nutrition education programs, parks and other facilities for exercise
- Exercise and Rehab Facilities (Galter LifeCenter and Cardiac Rehabilitation)
- National Stroke Association
- Physicians and local FQHCs
- Primary Stroke Centers (Swedish Covenant Hospital is one)

HIV/AIDS

- Howard Brown Health Center
- Ruth M. Rothstein CORE Center

Immunization & Infectious Diseases

- Local FQHCs, CDPH and IDPH
- Howard Brown Health Center
- School Health Centers
- Urgent Care Centers (Swedish Covenant Immediate Care is one)

Infant & Child Health

- Local FQHCs and primary care providers
- WIC

Injury & Violence

- Apna Ghar
- Between Friends
- Cease Fire
- KAN-WIN
- Mujeres Latinas en Accion
- Local police departments
- Salvation Army
- Violence Prevention Program at Swedish Covenant Hospital

Mental Health

- Behavior health programs at FQHCs

- Detox/Rehab facilities
- Emergency departments
- Haymarket Center
- Hospitals
- Inpatient adult or adolescent psychiatric units
- The Kedzie Center
- Lutheran Social Services of Illinois
- North River Mental Health
- Primary care physicians
- Salvation Army
- Thresholds
- Turning Point
- Welcoming Center (at Swedish Covenant Hospital, through LSSI)

Nutrition, Physical Activity & Weight

- Chicago Park District, Forest Preserve
- Dietitians and nutrition counselors
- Galter LifeCenter and other exercise facilities
- Local health providers

Oral Health

- College of Dentistry, University of Illinois at Chicago
- Local FQHCs and dentists

Respiratory Diseases

- American Lung Association
- Heart & Lung Center at Swedish Covenant Hospital

Sexually Transmitted Diseases

- CDPH, IDPH
- Local FQHCs and primary care physicians
- Planned Parenthood

Substance Abuse

- Alcoholics Anonymous
- Haymarket Center
- Lutheran Social Services of Illinois

Tobacco Use

- Illinois Quitline/American Lung Association
- Private doctors

Collaboration

[IRS Form 990, Schedule H, Part V, Section B, 4]

The Community Health Needs Assessment was sponsored by the Swedish Covenant Hospital Foundation; it has been facilitated by the Metropolitan Chicago Healthcare Council (MCHC) on behalf of participating member hospitals and health systems. These hospitals and health systems include: Alexian Brothers Health System/Amita Health (Alexian Brothers Behavioral Health Hospital, Alexian Brothers Medical Center, St. Alexius Medical Center); Amita Health (Adventist Bolingbrook Hospital, Adventist Glen Oaks Hospital, Adventist Hinsdale Hospital, Adventist LaGrange Memorial Hospital); Edward–Elmhurst Healthcare (Edward Hospital & Health Services, Elmhurst Memorial Hospital); Franciscan Alliance (Franciscan St. James Health); Ingalls Health System (Ingalls Memorial Hospital); Little Company of Mary Hospital and Health Care Centers; Northwest Community Healthcare (Northwest Community Hospital, Northwestern Memorial Hospital); Northwestern Medicine (Central DuPage Hospital, Northwestern Lake Forest Hospital); Palos Community Hospital; Rush System for Health (Rush Oak Park Hospital, Rush University Medical Center); Saint Anthony Hospital; St. Bernard Hospital and Health Care Center; Swedish Covenant Hospital; Thorek Memorial Hospital; and the University of Chicago Medicine. The project also received input from dozens of key external and internal stakeholders, which were comprised of representatives of the partnering organizations as well as others chosen for their relevant experience and interests.

CHNA Goals & Objectives

This Community Health Needs Assessment, a follow-up to a similar study conducted in 2009 and 2012, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the service area of Swedish Covenant Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

The Community Health Needs Assessment provides the 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 2015 PRC Community Health Needs Assessment serves as a tool toward reaching three basic goals:

- **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.
- **To increase the accessibility of preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience

conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

CHNA Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels.

Qualitative data input includes primary research gathered through an Online Key Informant Survey.

Community Health Survey

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by PRC, with input from SCH and the other community sponsors.

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 400 individuals age 18 and older in the Swedish Covenant Hospital Service Area. Once the interviews were completed, these were weighted in proportion to the actual population distribution at the zip code level so as to appropriately represent the Swedish Covenant Hospital Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC). For statistical purposes, the maximum rate of error associated with a sample size of 400 respondents is $\pm 4.9\%$ at the 95 percent level of confidence.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Swedish Covenant Hospital Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Centers for Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, 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
- ESRI ArcGIS Map Gallery
- Illinois Department of Public Health
- Illinois State Police
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- 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 Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect Cook County data.

Community Stakeholder Input [\[IRS Form 990, Schedule H, Part V, Section B, 1h & 3\]](#)

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Metropolitan Chicago Healthcare Council; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 29 community stakeholders took part in the Online Key Informant Survey, as outlined in the following table:

Online Key Informant Survey Participation*		
Key Informant Type	Number Invited	Number Participating
Community/Business Leader	13	5
Other Health Provider	15	9
Physician	8	2
Public Health Expert	9	5
Social Service Representative	18	8

*Note that key informants were not asked about the Swedish Covenant Hospital Service Area specifically, but instead to consider either Cook County, North Cook County, or Northwest Cook County based on the geography their organization serves.

Final participation included representatives of the organizations outlined below.

- Metropolitan Chicago Healthcare Council
- North Park University
- Northwest Community Healthcare
- Northwest Compass, Inc.
- Swedish Covenant Hospital
- Village of Arlington Heights
- Wheeling Township General Assistance Office

Through this process, input was gathered from several individuals whose organizations work with low-income, minority populations (*including African-American, Arabic, Asian, disabled, Eastern European, ethnic minorities, Hispanic, the homeless, immigrants, Indian, Japanese, Korean, LGBT population, low-income residents, Muslim, Non-English Speaking, Polish, Russian, undocumented*) or other medically underserved populations (*including the disabled, elderly, free care, homeless, immigrants, LGBT community, Medicaid/Medicare, the mentally ill, pregnant teens, substance abusers, undocumented, uninsured/underinsured, veterans, young adults, youth*).

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such, and how these might be better addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.

Information Gaps

[IRS Form 990, Schedule H, Part V, Section B, 1i]

While this Community Health Needs Assessment is quite comprehensive, SCH and PRC recognize that it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

Vulnerable Populations

[IRS Form 990, Schedule H, Part V, Section B, 1f]

The CHNA analysis and report yielded a wealth of information about the health status, behaviors and needs for our population. A distinct advantage of the primary

quantitative (survey) research is the ability to segment findings by geographic, demographic and health characteristics to identify the primary and chronic disease needs and other health issues of vulnerable populations, such as uninsured persons, low-income persons, and racial/ethnic minority groups.

For additional statistics about uninsured, low-income, and minority health needs please refer to the complete PRC Community Health Needs Assessment report, which can be viewed online at <http://swedishcovenant.healthforecast.net>.

Public Dissemination

[IRS Form 990, Schedule H, Part V, Section B, 5-5c]

This Community Health Needs Assessment is available to the public using the following URL: <http://swedishcovenant.healthforecast.net>. HealthForecast.net™ is an interactive, dynamic tool designed to share CHNA data with community partners and the public at large.



This site:

- Informs readers that the CHNA Report is available and provides instructions for downloading it;
- Offers the CHNA Report document in a format that, when accessed, downloaded, viewed, and printed in hard copy, exactly reproduces the image of the report;
- Grants access to download, view, and print the document without special computer hardware or software required for that format (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital organization or facility or to another entity maintaining the website.

Links to this dedicated HealthForecast.net™ site are also made available at SCH's hospital website at: www.SwedishCovenant.org. SCH will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. SCH will also maintain at its facilities a hardcopy of the CHNA report that may be viewed by any who request it.

Areas of Opportunity for Community Health Improvement

The following “health priorities” (listed in alphabetical order) represent recommended areas of intervention, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in *Healthy People 2020*. From these data, opportunities for health improvement exist in our service area with regard to the following health areas (see also the complete Community Health Needs Assessment for additional health indicators).

Areas of Opportunity Identified Through This Assessment	
Access to Healthcare Services	<ul style="list-style-type: none"> • Activity Limitations • Barriers to Access <ul style="list-style-type: none"> ◦ Inconvenient Office Hours • Children’s Dental Care • Eye Care
Cancer	<ul style="list-style-type: none"> • Cancer Deaths <ul style="list-style-type: none"> ◦ Including Prostate Cancer, Female Breast Cancer, Colorectal Cancer Deaths • Cancer Incidence <ul style="list-style-type: none"> ◦ Including Prostate Cancer, Cervical Cancer, Colorectal Cancer Incidence • Female Breast Cancer Screening • Colorectal Cancer Screening
Chronic Kidney Disease	<ul style="list-style-type: none"> • Kidney Disease Deaths
Diabetes	<ul style="list-style-type: none"> • Prevalence of Borderline/Pre-Diabetes • <i>Diabetes ranked as a top concern in the Online Key Informant Survey.</i>
Heart Disease & Stroke	<ul style="list-style-type: none"> • Heart Disease Deaths • High Blood Pressure Prevalence • High Blood Cholesterol Management
Infant Health & Family Planning	<ul style="list-style-type: none"> • Low-Weight Births • Infant Mortality • Unwed Mothers
Injury & Violence	<ul style="list-style-type: none"> • Safety Seat/Seat Belt Usage [Children] • Firearm-Related Deaths • Homicide Deaths • Violent Crime Rate • Perceive Neighborhood to be “Not At All Safe” from Crime
Mental Health	<ul style="list-style-type: none"> • “Fair/Poor” Mental Health • Diagnosed Depression • Symptoms of Chronic Depression • Stress • Suicide Deaths • <i>Mental Health ranked as a top concern in the Online Key Informant Survey.</i>
Nutrition, Physical Activity & Weight	<ul style="list-style-type: none"> • Trying to Lose Weight [Overweight Adults] • Healthy Weight [Children 5-17] • <i>Nutrition, Physical Activity & Weight ranked as a top concern in the Online Key Informant Survey.</i>

Areas of Opportunity Identified Through This Assessment (continued)	
Respiratory Diseases	<ul style="list-style-type: none"> • Chronic Obstructive Pulmonary Disease (COPD) Prevalence • Asthma Prevalence [Adults] • Pneumonia/Influenza Deaths
Sexually Transmitted Diseases & HIV/AIDS	<ul style="list-style-type: none"> • Gonorrhea Incidence • Chlamydia Incidence • HIV Prevalence • Multiple Sexual Partners
Sickle-Cell Anemia	<ul style="list-style-type: none"> • Sickle-Cell Anemia Prevalence
Substance Abuse	<ul style="list-style-type: none"> • Illicit Drug Use • <i>Substance Abuse ranked as a top concern in the Online Key Informant Survey.</i>
Tobacco Use	<ul style="list-style-type: none"> • Environmental Tobacco Smoke Exposure at Home <ul style="list-style-type: none"> ○ Including Households With Children ○ Including Non-Smokers

Prioritization of Health Needs

[IRS Form 990, Schedule H, Part V, Section B, 1g, 6g]

After reviewing the Community Health Needs Assessment findings, nearly 100 external and internal stakeholders met on March 23, 2016, to evaluate, discuss and prioritize health issues for the community, based on findings of the 2015 PRC Community Health Needs Assessment (CHNA). During the a detailed presentation of the CHNA findings, consultants from PRC used audience response system (ARS) technologies to lead steering committee members through a process of understanding key local data findings (Areas of Opportunity) and ranking identified health issues against the following established, uniform criteria:

- **Magnitude.** The number of persons affected, also taking into account variance from benchmark data and Healthy People targets.
- **Impact/Seriousness.** The degree to which the issue affects or exacerbates other quality of life and health-related issues.
- **Feasibility.** The ability to reasonably impact the issue, given available resources.
- **Consequences of Inaction.** The risk of not addressing the problem at the earliest opportunity.

Prioritization Results

Based on the hospital's areas of expertise and partnerships with local community organizations, the Areas of Opportunity were prioritized as follows:

1. Access to Healthcare Services
2. Diabetes
3. Mental Health
4. Heart Disease & Stroke
5. Cancer
6. Nutrition, Physical Activity & Weight
7. Infant Health & Family Planning
8. Substance Abuse
9. Injury & Violence

10. Respiratory Diseases

11. Tobacco Use

12. Sexually Transmitted Diseases & HIV/AIDS

13. Chronic Kidney Disease

14. Sickle-Cell Anemia

Community-Wide

Community Benefit Planning

[IRS Form 990, Schedule H, Part V, Section B, 6c-6d]

As individual organizations begin to parse out the information from the 2015 Community Health Needs Assessment, it is Swedish Covenant Hospital's hope and intention that this will foster greater desire to embark on a community-wide community health improvement planning process. SCH has expressed this intention to partnering organizations and is committed to being a productive member in this process as it evolves.

As part of our commitment to collaboration with local community organizations, SCH has launched a Community Ambassador Program, whereby SCH employees are encouraged to reach out to local organizations and become active participants in these groups, generating deeper awareness about important health issues within our community and sharing relevant resources with these individuals. Additionally, leaders of the organizations will be invited to engage in ongoing conversation with the hospital's CEO and other executives to dialogue further about local health priorities. Swedish Covenant Hospital will continue to serve as a local leader, identifying and strengthening collaborations among surrounding organizations.

SCH is also partnering with North Park University's Nursing Program to further analyze results from this Community Health Needs Assessment and recommend best practices, local opportunities and local potential partnerships to enhance and improve the outcomes of the top identified health needs.

The hospital is also committed to aligning with the county health department and other surrounding hospitals, to collectively dialogue and address community health needs through a collaborative and cooperative process. Several groups, including the Healthy Chicago Collaborative and the Health Impact Collaborative of Cook County, currently exist. The hospital will explore the evolution of these groups and will continue to be an active participant in the discussion.

Swedish Covenant Hospital

FY2017-FY2019 Implementation Strategy

For more than 130 years, Swedish Covenant Hospital has demonstrated its commitment to meeting the health needs of Chicago’s north and northwest communities.

This summary outlines Swedish Covenant Hospital’s plan (Implementation Strategy) to address our community’s health needs by 1) sustaining efforts operating within a targeted health priority area; 2) developing new programs and initiatives to address identified health needs; and 3) promoting an understanding of these health needs among other community organizations and within the public itself.

Hospital-Level Community Benefit Planning

Priority Health Issues To Be Addressed

In consideration of the top health priorities identified through the CHNA process — and taking into account hospital resources and overall alignment with the hospital’s mission, goals and strategic priorities — it was determined that Swedish Covenant Hospital would focus on developing and/or supporting strategies and initiatives to improve:

- **Cancer**
- **Diabetes**
- **Heart Disease & Stroke**
- **Injury & Violence**
- **Mental Health**
- **Nutrition, Physical Activity & Weight**

Integration With Operational Planning

[IRS Form 990, Schedule H, Part V, Section B, 6e]

The Strategic Operating Plan has an unyielding focus on community. It addresses many of the major prioritizations of the Community Benefits plan through the expansion and redesign of the Emergency Department, the robust, ongoing outreach efforts and care delivery within the Mayora Rosenberg Women’s Health Center, and the long-term integration of services with on-campus partner Galter LifeCenter.

Priority Health Issues That Will Not Be Addressed & Why

[IRS Form 990, Schedule H, Part V, Section B, 7]

In acknowledging the wide range of priority health issues that emerged from the CHNA process, Swedish Covenant Hospital determined that it could only effectively focus on those which it deemed most pressing, most under-addressed, and most within its ability to influence.

Health Priorities Not Chosen for Action	Reason
Access to Healthcare Services	<i>Since the completion of the community surveys, SCH has opened two immediate care centers to provide increased access to health services, especially during evenings and weekends. The hospital is also in the midst of a renovation and redesign of the Emergency Department to better meet those needs of the surrounding community. SCH also continues to support the community's access to healthcare services by partnering with local FQHCs who have opened new clinic sites in recent months. Limited resources have excluded this as an area chosen for further action.</i>
Chronic Kidney Disease	<i>SCH regularly partners with organizations including the National Kidney Foundation to provide free screenings to the ethnicities most vulnerable to this disease. Limited resources excluded this as an area chosen for further action.</i>
Infant Health & Family Planning	<i>SCH continues to partner with local FQHCs (including on-campus partner Erie Family Health) in addition to OB/GYN, Midwives and Pediatricians at the hospital, in an effort to positively impact outreach regarding family planning education and infant health issues. The hospital is also engaged in a long-standing on-campus partnership with Lurie Children's Hospital. Limited resources excluded this as an area chosen for further action.</i>
Respiratory Diseases	<i>SCH provides respiratory screenings and 1-1 free inhaler instruction/consultation throughout the year. Community stakeholders felt that more pressing health needs existed, thus limited resources and lower priority excluded this as an area chosen for further action.</i>
Sexually Transmitted Diseases & HIV/AIDS	<i>SCH believes that this priority area falls more within the purview of the county health department and other community organizations. Limited resources and lower priority excluded this as an area chosen for action.</i>
Sickle-Cell Anemia	<i>SCH has limited resources, services and expertise available to address sickle-cell anemia, and the hospital has opted to focus on health issues impacting a larger subset of the local population. Limited resources and lower priority excluded this as an area chosen for action.</i>
Substance Abuse	<i>SCH has limited resources, services and expertise available to address alcohol and other drug issues. Other community organizations have infrastructure and programs in place to better meet this need. Limited resources excluded this as an area chosen for action.</i>
Tobacco Use	<i>SCH has limited resources, services and expertise available to address tobacco use issues, but is supportive of community organizations including the American Lung Association, Illinois Tobacco Quitline and the American Cancer Society. Limited resources excluded this as an area chosen for action.</i>

The following displays outline SCH's plans to address those priority health issues chosen for action in the FY2017-FY2019 period.

CANCER	
Community Partners/Planned Collaboration	<ul style="list-style-type: none"> • Rush University Medical Center • American Cancer Society • Cancer Wellness Center • Susan G. Komen Foundation • National Breast Cancer Foundation • Insight Medical Genetics • Seasons Hospice & Palliative Care • Chicago Metropolitan Breast Cancer Task Force • Local FQHCs, community centers and cultural organizations
Goal	To increase awareness about breast cancer and provide screening, diagnosis and navigation in a culturally-sensitive manner to uninsured and underinsured women in our community through the Susan G. Komen Foundation and other breast health grants. To augment standard cancer care with psychosocial support, nutrition counseling, exercise, rehabilitation, and palliative care resources, as well as complementary treatments. Additionally, to educate the community about cancer screening guidelines and provide cancer screening events throughout the year for prostate, cervical and skin cancer screening.
Timeframe	FY2017-FY2019
Scope	SCH Service Area
Strategies & Objectives	<p>Strategy #1: Serve the uninsured and underinsured women in our community by providing free and reduced-cost mammograms and breast cancer screening treatment through charity care as well as grant-funded programs.</p> <ul style="list-style-type: none"> • Partner with National Breast Cancer Foundation and Susan G. Komen Foundation to provide breast health services through SCH's Community Breast Health Program, including: screening and diagnostic mammograms, breast biopsy and breast ultrasound, transportation assistance and navigation services. • Partner with local community centers and/or cultural organizations to provide awareness and access to culturally-sensitive screening services, including transportation to and from the organizations, via "Mammogram Days." <p>Strategy #2: Enhance cancer treatment by complementing standard cancer care with psychosocial and other supports via the Integrated Cancer Care Program.</p> <ul style="list-style-type: none"> • Facilitate support groups, nutrition counseling and additional resource linkages via full-time Survivorship Navigator and Nutrition Counselor, as well as enhancements of palliative support services. • Partner with Galter LifeCenter, the certified medical fitness facility on the hospital's campus, to provide complimentary access to exercise, massage and other integrative services. • Partner with Cancer Wellness Center (CWC) to provide short term counseling including bereavement counseling to individuals, couples, and families affected by a cancer diagnosis within the ICCP. Further partnership with CWC includes education/support for SCH staff and the exploration of collaboration and research opportunities. <p>Strategy #3: Provide cancer screenings and cancer prevention education seminars throughout the community.</p> <ul style="list-style-type: none"> • Provide annual cancer screenings to the community for prostate, skin and cervical cancer (cervical screening through annual Korean Health Fair). • Raise awareness about the importance of cancer screening and educate the community about age guidelines, access to resources, screening options and genetic counseling. • Conduct community outreach surrounding aspects of cancer prevention, including healthy nutrition habits, fitness and other healthy lifestyle recommendations.
Financial Commitment	\$17,000 Rush affiliation annual fee; \$10,000 for Cancer Wellness Center counseling services; \$100,000 breast health navigation staffing; \$112,000 Integrated Cancer Care providing unreimbursed care (Navigator + Oncology Dietitian); approximately \$200,000 annually provided by external grantors and \$75,000 annually provided by SCH Foundation

Anticipated Impact	<ul style="list-style-type: none"> • Increase number of women who receive screening mammograms annually. • Increase community awareness regarding the importance of breast cancer screening, as well as other cancers. • Increase number of individuals who access psychosocial support and other resources provided through the Integrated Cancer Care Program (ICCP).
Plan to Evaluate Impact	<ul style="list-style-type: none"> • Track number of women receiving free breast health services at SCH via various grant-funded programs. • Track number of women receiving mammograms for the first time. • Track number of diagnosed cancer patients vs. number of cancer patients who access ICCP services.
Results	<i>Pending</i>

DIABETES	
Community Partners/Planned Collaboration	<ul style="list-style-type: none"> American Diabetes Association Ackermann Foundation Galter LifeCenter Local community and cultural organizations Local elementary schools
Goal	To raise awareness about diabetes including risk factors and disease indicators, and to provide education and resources for ongoing lifestyle management (including healthy eating, exercising and monitoring) to patients and community members via 1-1 counseling, small group sessions, support groups, and community awareness programming.
Timeframe	FY2017-FY2019
Scope	SCH Service Area
Strategies & Objectives	<p>Strategy #1: Provide 1-1 counseling services to community members, outpatients and inpatients via the hospital's Diabetes Community Center and Transitional Care Program.</p> <ul style="list-style-type: none"> Provide inpatient diabetic counseling for inpatients with elevated A1C levels of 7 and above. Partner with the Ackermann Foundation to provide up to three monthly home visits to willing diabetic inpatients (with severely elevated levels of 9 and above) after release from the hospital via the hospital's transitional care team. Educate physicians and community about 1-1 diabetic support, including raising awareness about coverage by Medicare and most private insurance providers. Advocate to local legislators about the importance of coverage for 1-1 diabetes support among Medicaid patients. <p>Strategy #2: Provide free support groups and monthly small group education sessions to offer strategies for ongoing diabetes lifestyle management.</p> <ul style="list-style-type: none"> Facilitate free support groups and monthly small group education sessions via the Diabetes Community Center's certified diabetes educators (all of whom are either registered dietitians or registered nurses). Partner with Galter LifeCenter, the certified medical fitness facility on the hospital's campus, to host monthly sessions and inform community about free offerings. Provide resources to patients who cannot attend 1-1 sessions due to financial barriers or other limitations. <p>Strategy #3: Provide diabetes prevention and education seminars throughout the community and schools via the hospital's certified diabetic educators.</p> <ul style="list-style-type: none"> Deliver programs on and off the hospital campus to inform community members about the prevalence of diabetes, warning signs, risk factors, available resources and management tools. Partner with area schools to provide preventative diabetes education programs. Pursue grant opportunities related to diabetes outreach among specific cultural groups.
Financial Commitment	\$50,000 Ackermann Foundation and/or other grants; \$200,000 covered by SCH for in-kind staffing time for inpatient visits and home visits related to Transitional Care team for diabetic patients, as well as supplies and equipment for transitional care program in excess of grant funding; \$5,000 Diabetes Community Center staffing of monthly support groups and other educational sessions provided by SCH staff on and off campus.
Anticipated Impact	<ul style="list-style-type: none"> Among those served by the transitional care program, 60% of patients will demonstrate increased self-efficacy in managing their chronic disease. 50% of patients served by the transitional care program with uncontrolled diabetes reduce their HbA1c by 20% or more at 3 months. Lower A1C levels in 75% of patients visiting the Diabetes Community Center. Improve the eating habits by 50%, for at least 75% of the Diabetes Community Center patients. Improve awareness among inpatients with undiagnosed diabetes. Raise awareness about diabetes within the community.

Plan to Evaluate Impact	<ul style="list-style-type: none">• Pre and post-test patient survey to measure self-efficacy in managing chronic disease• Track HbA1c level for patients visiting the Diabetes Community Center at initiation and conclusion of education sessions, as well as for patients served by the transitional care program.• Track eating habits (via a self-administered survey) for patients visiting the Diabetes Community Center at initiation and conclusion of education sessions.• Track identification and outreach to inpatients with elevated A1C level without a previous diabetes diagnosis.• Track knowledge of diabetes via pre and post-testing at community education seminars.
Results	<i>Pending</i>

HEART DISEASE & STROKE	
Community Partners/Planned Collaboration	<ul style="list-style-type: none"> • Ackermann Foundation • American Heart Association • American Stroke Association • National Stroke Association • Galter LifeCenter • Local community and cultural organizations • Local elementary schools
Goal	To raise awareness about heart disease and stroke including risk factors and disease indicators, and to provide education and screening events in partnership with the hospital's cardiology department, stroke coordinator and other physicians and clinicians. Also, to provide additional support, care and education to heart disease and stroke patients via the hospital's Transitional Care Team and Wellness Coach.
Timeframe	FY2017-FY2019
Scope	SCH Service Area, as well as heart disease/stroke patients at risk for readmission (regardless of insurance status)
Strategies & Objectives	<p>Strategy #1: Provide community outreach and education related to heart disease and stroke risk factors, warning signs and how to respond in an emergency.</p> <ul style="list-style-type: none"> • Deliver programs on and off the hospital campus to inform community members about heart disease and stroke warning signs and risk factors. • Provide monthly heart disease screening events for the community, hosted in the hospital's Heart & Lung Center. • Engage with local schools to educate children about heart disease and stroke via the American Heart Association's "Be the Beat" framework. • Partner with area elected officials and other community groups to provide education and blood pressure screening events throughout the community to further raise awareness about heart disease and stroke. <p>Strategy #2: Engage with the hospital's Transitional Care Team, Wellness Coaches and Rehabilitation Team to provide in-depth support, care and education to heart disease and stroke patients during and after discharge from the hospital.</p> <ul style="list-style-type: none"> • Deliver coordinated education and resources to patients which may include discharge navigators and wellness coaches, phone calls, home visits and home telemonitoring. • Partner with Galter LifeCenter (GLC), the certified medical fitness facility on the hospital's campus, to facilitate Phase 2 and 3 of Cardiac Rehab via the hospital's longstanding and highly successful Cardiac Rehab Program. • Facilitate free monthly support groups for patients recovering from stroke and their family members, featuring a range of topics and guest speakers. • Leverage partnership with GLC to further educate community members about fitness/nutrition programs such as Fundamental Fitness for those transitioning out of cardiac rehab.
Financial Commitment	\$50,000 Ackermann Foundation and/or other grants; \$200,000 in-kind staffing time for inpatient visits and home visits related to Transitional Care team for heart patients, as well as supplies and equipment for transitional care program in excess of grant funding; \$5,000 staffing of monthly support groups, blood pressure screening events, and other educational sessions on and off campus with MDs, RNs, RDs, etc.
Anticipated Impact	<ul style="list-style-type: none"> • Reduce 30-day readmission rates for Heart Failure and Heart Attack. • Increase heart failure self-care knowledge. • Raise awareness about heart disease and stroke risk factors and warning signs within the community, as well as how to respond in an emergency.
Plan to Evaluate Impact	<ul style="list-style-type: none"> • Track readmission rates for heart failure patients. • Track readmission rates for heart attack patients. • Track knowledge of heart disease and stroke via pre and post-testing at related community education seminars. • Deliver pre and post assessments regarding patients' ability to manage chronic illnesses related to heart and stroke.
Results	<i>Pending</i>

INJURY & VIOLENCE

<p>Community Partners/Planned Collaboration</p>	<ul style="list-style-type: none"> • Lutheran Social Services of Illinois (LSSI) – Project IMPACT • Between Friends • Apna Ghar • Korean Women in Need (KAN-WIN) • Chicago Metropolitan Battered Women’s Network • MedEx Ambulance Service • Cook County Task Force on Human Trafficking • Cook County Multidisciplinary Team for Sexual Assault Response • The Salvation Army (“STOP-IT” program) • Chicago Police Department District 17 & 20 • Rape Victims Advocates • Local universities and schools, including North Park University and Northeastern Illinois University (NEIU) • North Side Community Justice Center
<p>Goal</p>	<p>To strengthen Swedish Covenant Hospital’s capacity to identify and respond to individuals impacted by violence (domestic violence, sexual assault and human trafficking), and to prevent future violence through education, awareness-raising and advocacy. Additionally, to work with local law enforcement and community groups to address rising safety concerns within the community.</p>
<p>Timeframe</p>	<p>FY2017-FY2019</p>
<p>Scope</p>	<p>SCH Service Area</p>
<p>Strategies & Objectives</p>	<p>Strategy #1: Identify and respond to individuals impacted by violence in a skilled and sensitive manner.</p> <ul style="list-style-type: none"> • Improve policies and protocols and the screening process for identifying individuals who are impacted by violence. • Enhance facilities within the Emergency Department to create a safer, more private and more supportive environment for patients who have experienced violence. • Provide comfort care packages for victims of violence who present in the emergency department following a traumatic event. • Provide victims with information about options, safe transportation and streamlined referrals to comprehensive, culturally-appropriate resources, including north side domestic violence, sexual assault and human trafficking service providers. • Display multilingual signage in public washrooms which lists phone numbers for community organizations that provide services to victims of violence. <p>Strategy #2: Facilitate ongoing training throughout the organization to increase level of staff awareness and quality of response.</p> <ul style="list-style-type: none"> • Increase staff training workshops to recognize the dynamics and red flags of abuse and to be sensitive to patient barriers to disclosure. • Train first responder crisis and social workers to provide information about options for counseling, legal support and shelter; engage in safety planning; and connect patients with services in the community. <p>Strategy #3: Broaden partnership and engagement within the community around topics of violence, sexual assault and human trafficking to elevate awareness and education around violence as a health issue.</p> <ul style="list-style-type: none"> • Engage in ongoing dialogue with local and regional partners in efforts to enhance service and sensitivity provided to those impacted by violence. • Develop and disseminate educational materials to teach at-risk patients and community members about the dynamics of domestic violence and human trafficking. • Organize and participate in awareness-raising events with community partners. • Develop online information and education in multiple languages for the community related to violence, and local resources for individuals to access. • Participate in school-based education to establish a dialogue about violence and safety within the community. • Seek additional outside funding for the program beyond seed funding from SCH Foundation.

Financial Commitment	\$100,000 currently covered by SCH Foundation including costs for clinician training, outreach/education, transportation, program oversight/implementation, research/analysis and comfort packages; \$32,000 in-kind staffing time for management-level work group meetings; \$35,000 in-kind staffing time for training; \$35,000 specialized SANE room (Sexual Assault Room) as part of Emergency Department renovation project (FY17).
Anticipated Impact	<ul style="list-style-type: none"> • Victims of violence receive prompt, sensitive care throughout the organization and are appropriately connected with our community partners. • Create a culture of awareness that increases patient safety and reduces isolation, stigma and fear associated with these forms of violence. • Increase in number of individuals who are identified as victims of violence (based in part on increased staff training and sensitivity to violent relationship dynamics). • Increase referral to community partners.
Plan to Evaluate Impact	<ul style="list-style-type: none"> • Analysis of number of patients who disclose violence. • Analysis of number of individuals who are referred to community partners. • Analysis of Violence Prevention Program data on response. • Analysis of staff training hours completed annually. • Analysis of awareness-raising and community engagement activities.
Results	<i>Pending</i>

MENTAL HEALTH

Community Partners/Planned Collaboration	<ul style="list-style-type: none"> • Lutheran Social Services of Illinois (LSSI); Project IMPACT and Welcoming Center • MADO Healthcare Centers • The Kennedy Forum of Illinois • Local FQHCs (Erie, Heartland, Asian Human Services, PCC) • BeWell Partners • The Kedzie Center • Greenwood Care • Albany Care • Riveredge Hospital
Goal	<p>To expand and extend mental health services in Illinois to mentally ill residents via a multi-leveled approach to address needs within our immediate service area; Additionally, to advocate and collaborate to expand mental health services provided across the city, county, state and nation.</p>
Timeframe	<p>FY2017-FY2019</p>
Scope	<p>SCH Service Area primarily; advocacy to extend beyond</p>
Strategies & Objectives	<p>Strategy #1: Improve linkage and treatment outcomes of individuals presenting in the SCH ED with substance abuse (SA) disorders.</p> <ul style="list-style-type: none"> • Partner with LSSI to connect SA patients to dedicated LSSI staff within the SCH ED, via Project IMPACT. • Direct patients to outpatient LSSI Welcoming Center across the street from SCH ED when appropriate. • Share the successful care partnership model between SCH and LSSI's Welcoming Center with others across the state and country for broader implementation. • Enhance ED facilities in response to the behavior health needs of our community. <p>Strategy #2: Transfer qualified patients in mental health crisis efficiently and safely from SCH ED to MADO Healthcare Centers and other Specialized Mental Health Rehabilitation Facilities (SMHRF).</p> <ul style="list-style-type: none"> • Partner with LSSI/Project IMPACT staff to evaluate patients who present in the ED and may qualify for crisis residential care provided by a MADO center or other SMHRF facility. • Coordinate transfer of qualified patients to MADO sites or other SMHRF sites. <p>Strategy #3: Broaden partnership and engagement with mental health providers to elevate awareness of mental health issues.</p> <ul style="list-style-type: none"> • Provide letters of support to local care sites seeking SMHRF funding. • Continue to advocate on behalf of the Safety Net Hospital efforts to increase funding and support of mentally ill individuals. • Partner with the Cook County Jail and Judicial System, via Tom Dart, Sheriff, to evaluate opportunities for collaborating on care coordination for those prisoners with mental illness once they are released into our local community. • Create ongoing dialogue with the Kennedy Forum Illinois and other organizations aligned in efforts to enhance mental health outreach. • Commit to serve as a leader regarding the City of Chicago's homeless outreach initiative, in collaboration with Chicago Department of Public Health and Chicago Department of Family and Support Services. <p>Strategy #4: Provide community programs which address stress levels of community members.</p> <ul style="list-style-type: none"> • Facilitate weekly new moms group, open to all new moms within the community, to foster a healthy dialogue between local new moms. • Promote other health and wellness offerings via SCH and GLC programming. • Develop online assessment tools for the community to access related to depression and anxiety, and provide information on local resources for individuals to access.
Financial Commitment	<p>SCH capital investment for design and creation of four customized behavioral health rooms within the ED as part of 2017 renovation project; substantial in-kind staffing time for ED planning, research and design phases and other mental health partnership outreach.</p>

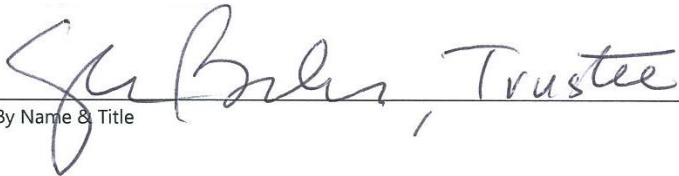
Anticipated Impact	<ul style="list-style-type: none"> • Mentally-ill individuals efficiently receive the right level of care (inpatient, outpatient, extended stay at SMHRF). • Decrease number of mentally-ill individuals who present to the ED for non-medical concerns. • Reduce ED recidivism for individuals with mental illness.
Plan to Evaluate Impact	<ul style="list-style-type: none"> • Analysis of number of mentally ill patients who present in the ED • Analysis of number of individuals with mental illness who utilize LSSI's outpatient Welcoming Center site, in coordination with the Illinois Hospital Association (IHA), to specifically evaluate patients who have been successfully routed to appropriate outpatient care vs. improper ED usage
Results	<i>Pending</i>

NUTRITION, PHYSICAL ACTIVITY & WEIGHT

Community Partners/Planned Collaboration	<ul style="list-style-type: none"> • Budlong Elementary School + other local elementary schools • CPS • Galter LifeCenter • Healthy Chicago Collaborative • Local community and cultural organizations • Mariano’s Fresh Market • Peterson Garden Project • Purple Asparagus
Goal	To raise awareness about healthy eating, exercise and healthy lifestyles among local elementary school students and the community at large, via the hospital’s registered dietitians as well as fitness professionals from on-campus partner Galter LifeCenter (GLC).
Timeframe	FY2017-FY2019
Scope	SCH Service Area
Strategies & Objectives	<p>Strategy #1: Provide community outreach and education related to healthy eating, physical activity and healthy weight.</p> <ul style="list-style-type: none"> • Deliver programs on and off the hospital campus to inform community members about nutrition, physical activity and weight. • Partner with area elected officials and other community groups to provide educational events on a range of nutrition and fitness topics. • Provide monthly nutrition programming, in conjunction with Peterson Garden Project’s (PGP) Community Cooking School and interactive kitchen demonstrations. • Support the community gardening movement by hosting an edible community garden on campus for both employees and general community members, in partnership with Peterson Garden Project. <p>Strategy #2: Engage with local CPS schools to provide education about the importance of balanced nutrition and physical activity.</p> <ul style="list-style-type: none"> • Partner with Purple Asparagus to deliver healthy eating curriculum “Delicious Nutritious Adventures” monthly to one grade level of students per year at Budlong Elementary School, adjacent to the hospital campus. • Engage in CPS’ LearnWELL program through the Healthy Chicago Collaborative to provide guidance on nutrition and physical activity to select local schools. • Provide healthy nutrition and fitness programming throughout the year to area schools, including Walk-a-Thon events, health fairs and special events, in partnership with GLC’s fitness team. • Educate community members about GLC’s vast offerings for all abilities and fitness levels, in an effort to further inform the community about fitness/nutrition resources. <p>Strategy #3: Explore grant funding and other support opportunities related to nutrition and healthy lifestyle habits.</p> <ul style="list-style-type: none"> • Work with SCH Foundation to identify grants and mini-grants which support nutrition initiatives, focusing on women, children or specific cultural groups within the community. • Dialogue with leaders from North Park University about potential programming opportunities.
Financial Commitment	\$15,000 (sponsorship of Budlong’s nutrition curriculum + staffing time for outreach and education to other schools + staff time for other educational programs throughout the community)
Anticipated Impact	<ul style="list-style-type: none"> • Provide healthy eating and fitness programs to at least five local schools annually. • Increase awareness about the importance of physical activity and healthy, balanced eating.
Plan to Evaluate Impact	<ul style="list-style-type: none"> • Dialogue with Healthy Chicago Collaborative hospitals and CPS to assess value of LearnWELL integration with schools. • Analyze data from Purple Asparagus to determine benefits of nutrition curriculum with students and their families.
Results	<i>Pending</i>

On September 17, 2016, the Board of Swedish Covenant Hospital, which includes representatives from throughout Chicagoland, met to discuss this plan for addressing the community health priorities identified through our Community Health Needs Assessment. Upon review, the Board approved this Implementation Strategy and the related budget items to undertake these measures to meet the health needs of the community.

SCH Board Approval & Adoption:


By Name & Title

Lyle Banks, Trustee

By Name & Title

9/17/16

Date