

La Rabida Children's Hospital

2016 – 2018 Community Benefit Report

ABOUT LA RABIDA

La Rabida Children's Hospital provides specialized, family-centered health care to children with medically complex conditions, disabilities, and chronic illness. Through expertise, compassion, and advocacy we help children and their families reach their fullest potential, regardless of their ability to pay.

Our not-for-profit hospital, licensed for 49 beds, helps transition children from neonatal or pediatric intensive care to home, by providing medical, rehabilitative and developmental care, and by training families to continue treatments and manage the necessary equipment in the home. La Rabida also provides extensive rehabilitation for those recovering from wounds or burns and treatment for exacerbations of chronic conditions.

The hospital's enhanced pediatric patient-centered medical home provides primary care to children with complex medical conditions and their siblings. Children with medical homes elsewhere come to La Rabida for specialty services. In all programs, children are supported in their emotional and developmental growth, particularly in cases where such growth has been interrupted by accident or disease.

Finally, La Rabida provides forensic and treatment services for children exposed to abuse and neglect, comprehensive assessments for wards of the state, early intervention for children between 0 and 3 years of age, and care coordination services for medically complex children who are covered by several health plans and receiving care from providers in Cook County and beyond.

As a specialty hospital, La Rabida maintains close relationships with our referring hospitals, which include most of the academic medical centers and major community hospitals in the region. In addition, because many of the families we serve face multiple impediments to healthful living – income, food or housing insecurity, for example – we actively assist our families with identifying obstacles and finding solutions, whether it be identifying and enlisting informal supports, obtaining access to benefits, or assembling an array of community-based services to support the family for caring for their child at home.

La Rabida programs have earned the gold seal of approval from the Joint Commission and recognition from the National Committee for Quality Assurance.

COMMUNITY ASSESSMENT: GOALS and PROCESSES

Our families come from specific environments which can either enhance or challenge their abilities to care for their medically complex children. The goal of our community needs assessment is to understand the context in which our families live – particularly as informed by Chicago’s mission to improve community health (see [Measuring Chicago’s Health: Findings from the 2014 Healthy Chicago Survey](#)ⁱ) and the health status data, gathered and made publicly available online by the Chicago Department of Public Healthⁱⁱ.

We participate in two collaboratives, the Chicago Southside HealthCare Collaborative (anchored by the University of Chicago) and the Healthy Chicago Hospital Collaborative, both of which share information and mount collaborative efforts to improve community health. We participate in the Medical Home Network, an organization of safety net providers dedicated to improving health and service outcomes for those served by Medicaid. We provide care coordination on behalf of two Medicaid Managed Care organizations, both of which actively review resources, processes and outcomes in order to improve services received by those served by Medicaid.

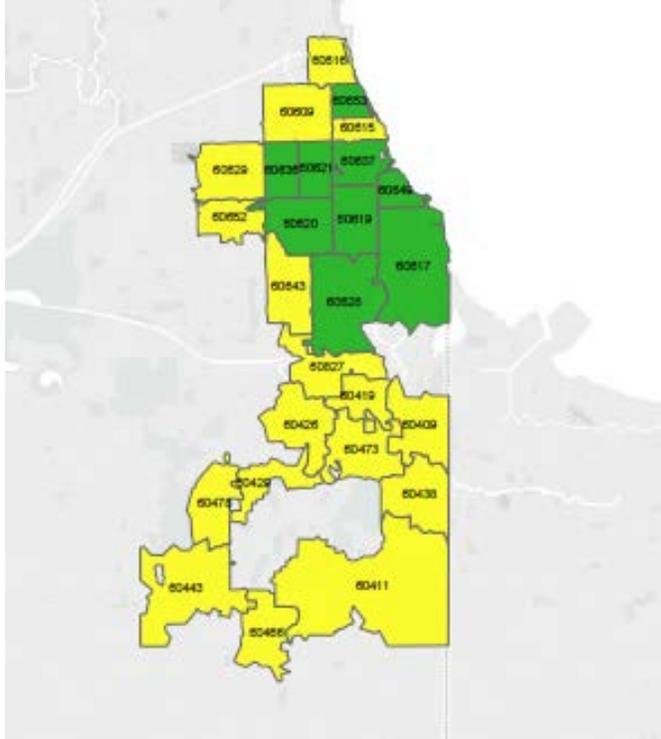
Finally, because we work with families to reduce barriers to health and health services, both for children being cared for by La Rabida programs and for 2500 children being cared for elsewhere across the region, we are in active, daily conversations about the immediate and long term needs of and options available to families in the region, and, have been able, by collaborating with other agencies or with health plans, to expand options available to our families.

These sources drive enhancements and refinements to our programming to build on assets families already have, better meet challenges they face, and improve or expand the services we provide. For this report, we will look first at the characteristics of the primary geographic areas we serve, and then at the results of a survey of our clinic attendees about the challenges they face. We expect both of these investigations, plus information garnered from the relationships described above, to inform program enhancements to be made over the next 1 to 3 years, with priority given to ways we can boost our own programs and processes to help our subset of the population, families caring for medically complex children, reach their health goals.

Notwithstanding this rich influx of information, both the environment and the health industry are changing rapidly, and the impact of both on our families is complex and at times, overwhelming. While this information, and the information gathered by our clinic survey described below, informs our own contributions to improved community health, we are one puzzle piece of a large, complex and dynamic mosaic of threats and assets which combine to impact the lives of the children we serve.

DEFINITION OF THE COMMUNITY SERVED

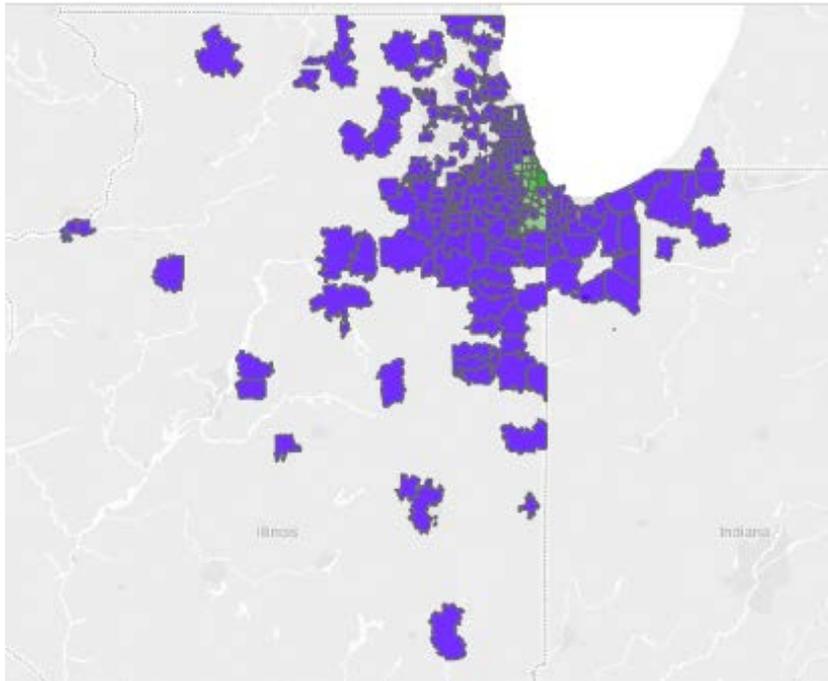
Nearly fifty percent of La Rabida families (those who have used inpatient and/or outpatient services) come from 9 zip codes – what we are identifying as our primary service area - bounded by West Garfield and then E. 35th street to the north, State Street and then Western Avenue south to 95th street, then reaching further east and south to Racine and 130th or so, all the way east to the Indiana border. This area is indicated in green in the map below.



Service Areas:
 Primary (green)
 Secondary (yellow)

An additional 25% of patients come from 18 more zip codes (our secondary service area), reaching extensively into Chicago's south suburbs. These zip codes are indicated in yellow above.

The final 25% spans a broad region indeed, comprising of 264 additional zip codes, and demonstrating our role as a regional specialty hospital. Note the zip codes shown in purple below.



Total Service Area

For purposes of this study we will concentrate on the demographics of our primary service area, the 9 zip codes that are home to 49% of our patient families.

DEMOGRAPHICS AND CHARACTERISTICS OF OUR PRIMARY SERVICE AREA



Health data developed by the Chicago Department of Public Healthⁱⁱⁱ (the source of the data cited below) are sorted by community, an array of 77 communities first defined in the 1920s. These are numbered and labeled in black below, in a map created by the Northeastern Illinois Planning Commission (2003). These do not align precisely with zip codes (drawn and labeled in red below), but an overlay of those communities on a zip code map tells us where to focus; 22 communities roughly correspond to the 9 zip codes of interest.

For the purpose of illustrating the distribution of an attribute by zip code, we've assigned each community area to the zip code where it predominates (see map). In some zip codes this correlation is precise; in others it is approximate. In addition, where zip codes contain areas of greatly differing characteristics, the effect of

those outliers is muted by aggregating the data in this way.

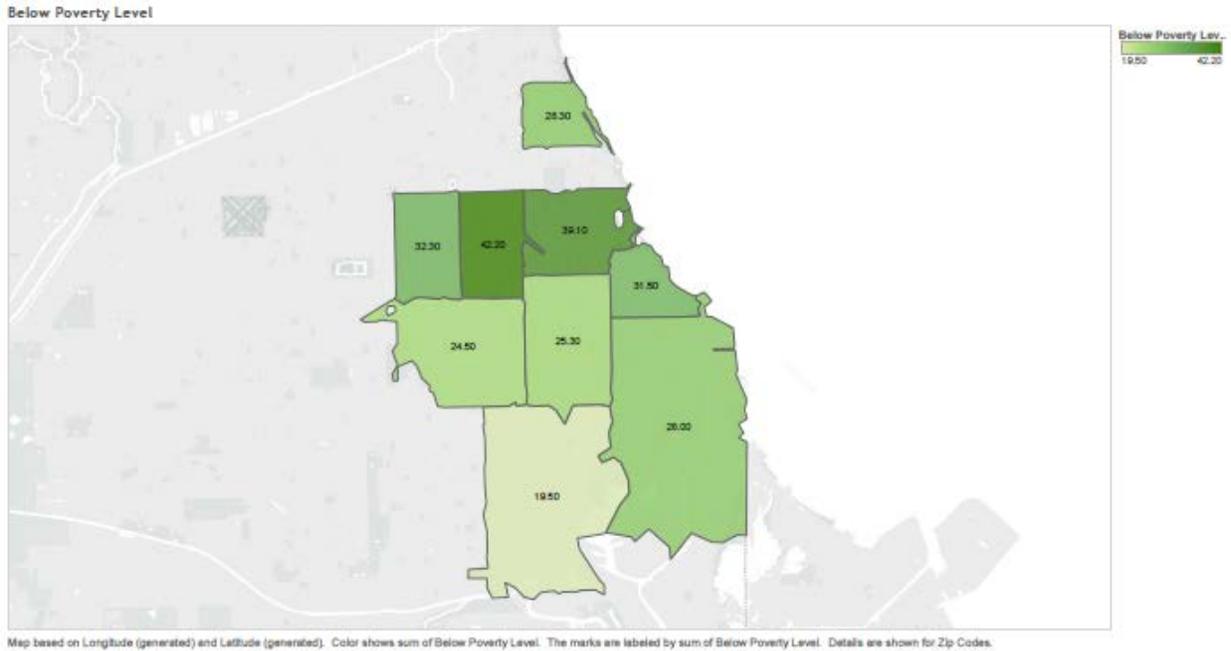
Impact of Poverty

As noted in [Measuring Chicago's Health](#), poverty is shown to be significantly correlated to measures of poor mental and physical health, including inhibition of physical activity because of poor health. In addition, poverty is related to fewer people with health insurance coverage, fewer families with established personal physicians, fewer dental visits and some cancer screenings, such as for colorectal cancer. Poverty is also strongly associated with reduced consumption of fruits and vegetables and lower levels of aerobic and strength-building physical activity. Although poverty did not appear to impact the use of neighborhood outdoor spaces in this first study, it is associated with a perception of less safety in those spaces. Finally, it is strongly associated with current tobacco use, as well as with specific biological markers associated with chronic disease: high blood pressure, obesity. Prevalence of chronic disease is also higher in poorer families: coronary heart disease, asthma, depression, serious psychological distress.

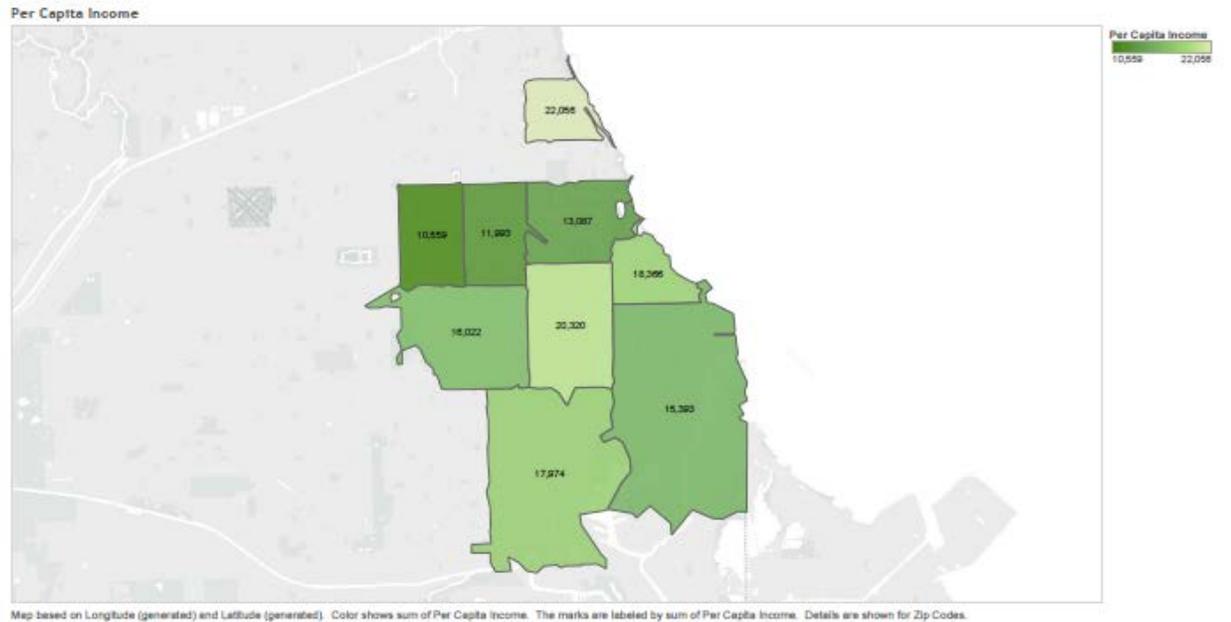
Chicago's health department has compiled a "hardship index", comprising six indicators of hardship:

- the percent of people living below the federal poverty level
- per capita income
- the percent of people over the age of 16 who are unemployed
- the percent of people over 25 years of age who lack a high school diploma
- a measure of dependency, that is, percent of people over 65 or under 18
- a measure of crowded housing, or occupied units with more than one person per room

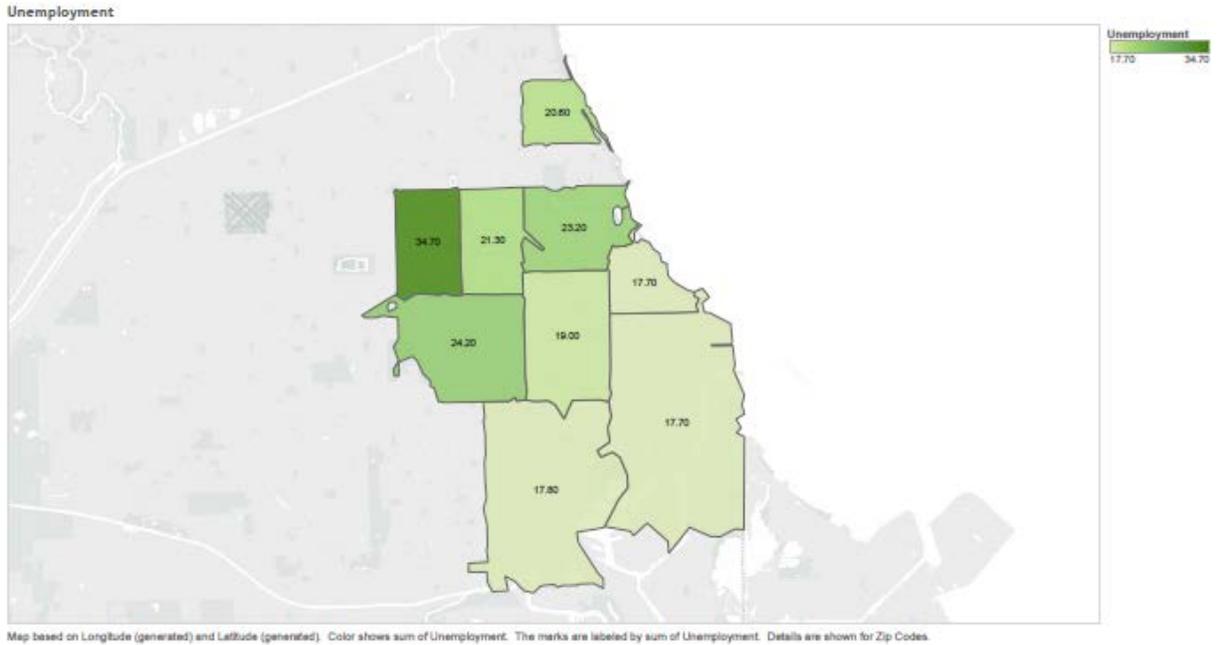
Living below the federal poverty level: In our primary service area, percentage of residents living below the federal poverty level ranges from 61% to 12%. By contrast the state average for Illinois is about 14.5%^{iv}.



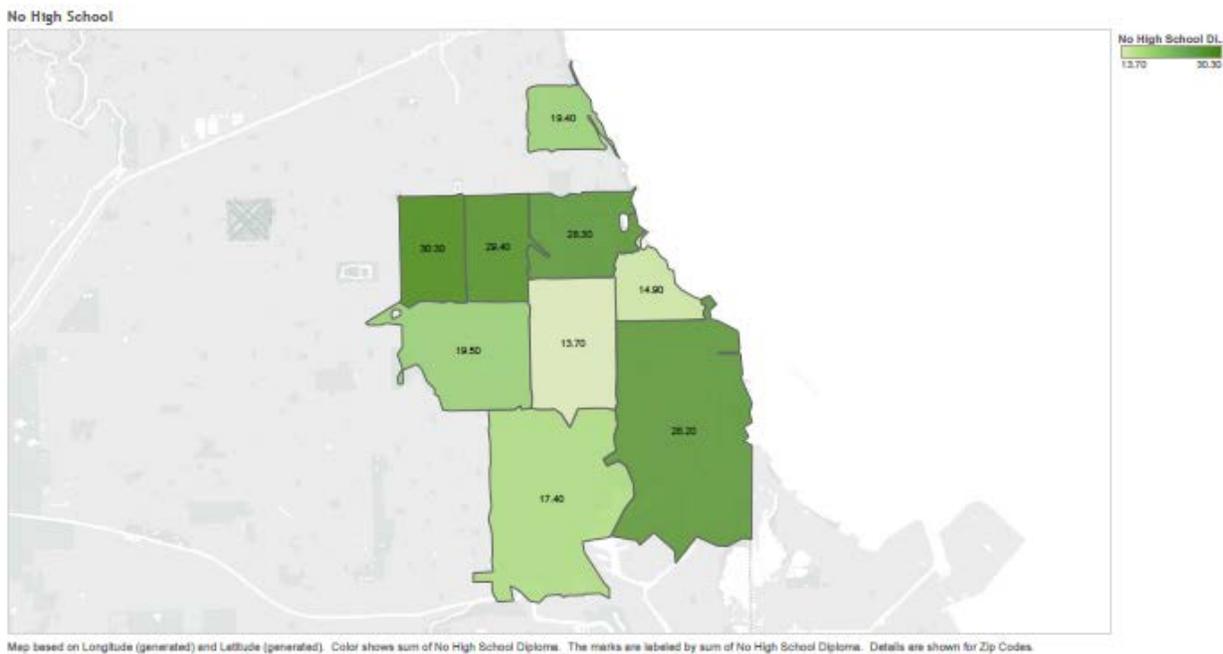
Per capita income ranges from \$8,535 to \$28,977. Poverty is particularly localized in the northwest corner of our service area, though pockets of deep poverty occur elsewhere in the region, such as in Burnside, and the entire region is lower than average. By contrast, per capita income in the state is about \$30,000.



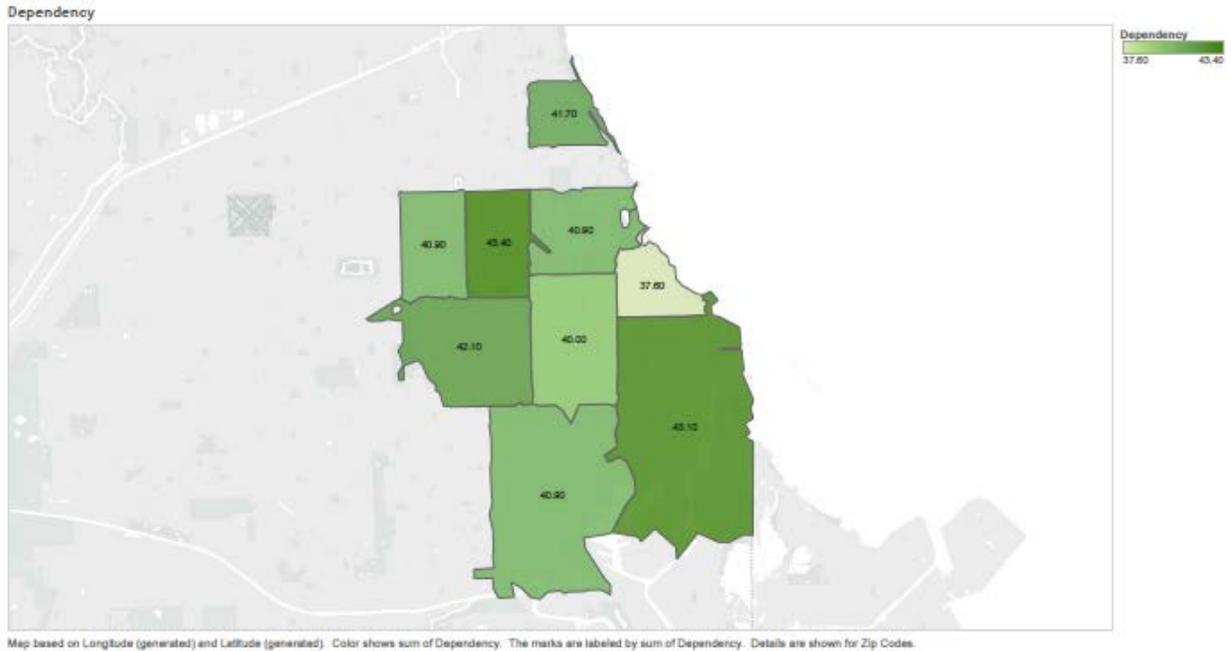
Unemployment: High rates of unemployment also occur throughout the region, ranging from a high of 35% in West Englewood to a low of 12% in the southeast community of South Deering.



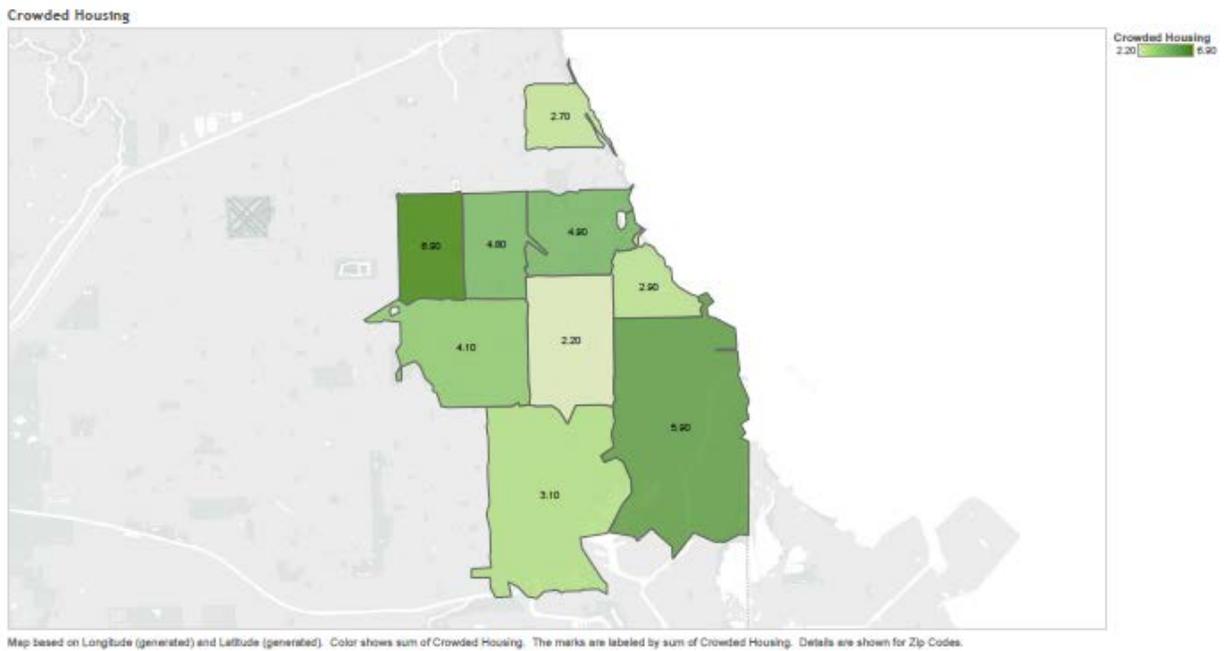
No high school diploma: East Side is notable as the community with the highest percentage of adults (35.5%) lacking a high school diploma (or GED equivalency), likely reflecting a higher concentration of immigrants. Otherwise, the data largely tracks the areas that exhibit the other hardship indicators.



Dependency: Riverdale to the far south has a notably high dependency rate (50%) and Hyde Park stands out as a particularly low outliers (27%). All other communities cluster within the range of 40%-38%.



Crowded Housing: This is a proxy for the stress of living in crowded conditions; it measures the percent of occupied house in which there are more than one person per room. Our primary service area ranges from 8% in East Side to 0.6% in Avalon Park.



Impact of Population Decline

Each of these 9 zip codes have experienced significant population decline, although four are estimated to have made slight gains since 2010. Measuring from the 2000 census to the estimated population in 2013, the region overall has lost 17% of its population:

		Population			
		2000	2010	Est. 2013	13 YR Decline
60653	Grand Boulevard/Oakland*	34,502	29,908	31,086	-10%
60636	West Englewood	51,451	40,916	39,918	-22%
60621	Englewood	47,514	35,912	33,608	-29%
Woodlawn/Washington Park/Greater Grand					
60637	Crossing	57,090	49,503	48,270	-15%
60620	Auburn Gresham*	85,771	72,216	73,253	-15%
60619	Chatham/Burnside/Greater Grand Crossing*	74,963	63,825	64,922	-13%
60649	South Shore	54,823	46,650	45,444	-17%
60617	South Deering/East Side	96,288	84,155	83,435	-13%
60628	Roseland	87,827	72,202	71,710	-18%
TOTAL		555,727	465,379	460,560	-17%
*Four zip codes experienced a slight increase in population from 2010 to 2013					
Source: city-data.com/zips					

An interesting and unexpected feature is that those who remain have lived in their homes longer than average^v. This counters the experience of churning in these communities observed by service providers, but suggests that those who remain have less ability to move^{vi}. The general exodus, particularly of the African American population from the Chicago metro area (35,000 since 2010), is reported to be fueled by a desire for economic opportunity and safety.^{vii}

This hollowing out of communities leaves empty buildings behind and tears at the social infrastructure, which is a key determinant of community resilience^{viii} and informal support for families.

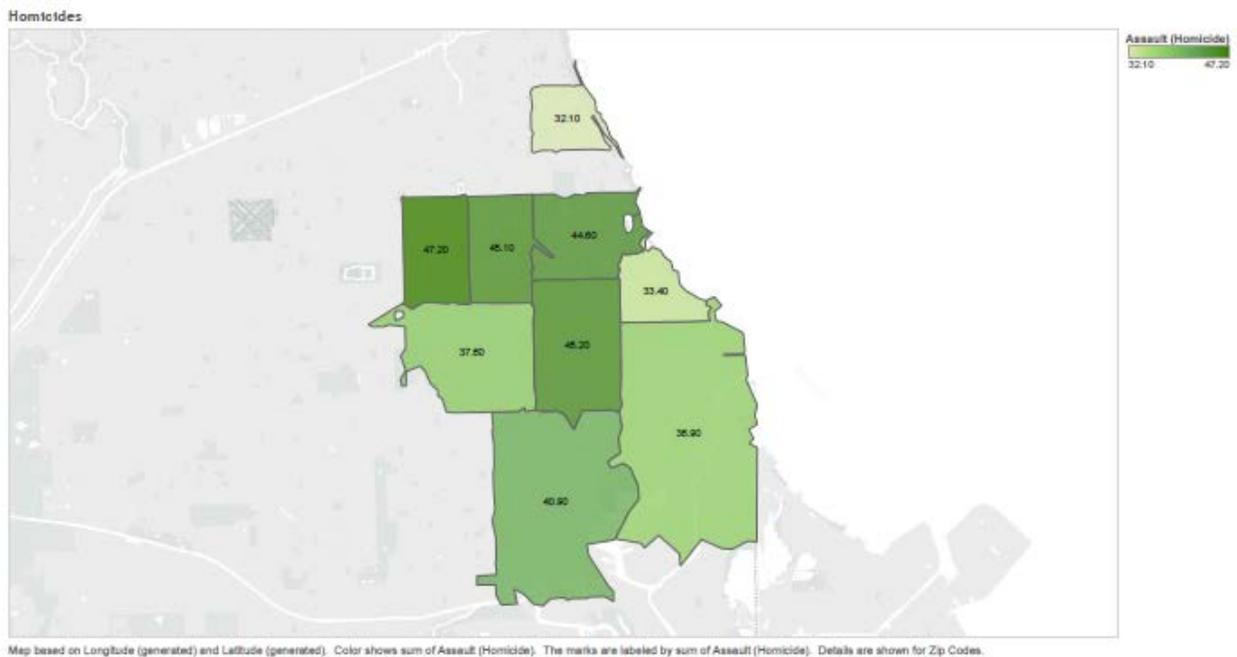
Impact of Racial and Age Disparities

The residents of seven of the nine zip codes in our primary service area are African American (94 – 98%). South Deering/Calumet Heights (60617) has a sizeable Latino population (36%), settled largely in the East Side community. Woodlawn is predominantly African American (78%), but also has small White (13%), Asian (4%) and Latino (2%) populations. The Healthy Chicago survey identified self-reported health status to vary significantly by ethnicity, with nearly 29% of Latinos reporting fair or poor health, compared to 20% for African Americans and nearly 12% for Whites.

Perceptions and Experience of Safety

According to the Healthy Chicago Survey, 82% of adults reported that they felt somewhat or very safe in their neighborhood parks, although only 49% of those surveyed reported using those parks. Perceptions of safety correlated with poverty, with 74% of those at or below the poverty level reporting that they felt safe, compared to 90% of those at 400% or above the poverty level. Perceptions of safety also varied significantly by race, with 92% of non-Latino Whites feeling safe, but only 71% of African Americans reporting the same. Seventy-eight percent of Latinos reported feeling safe.

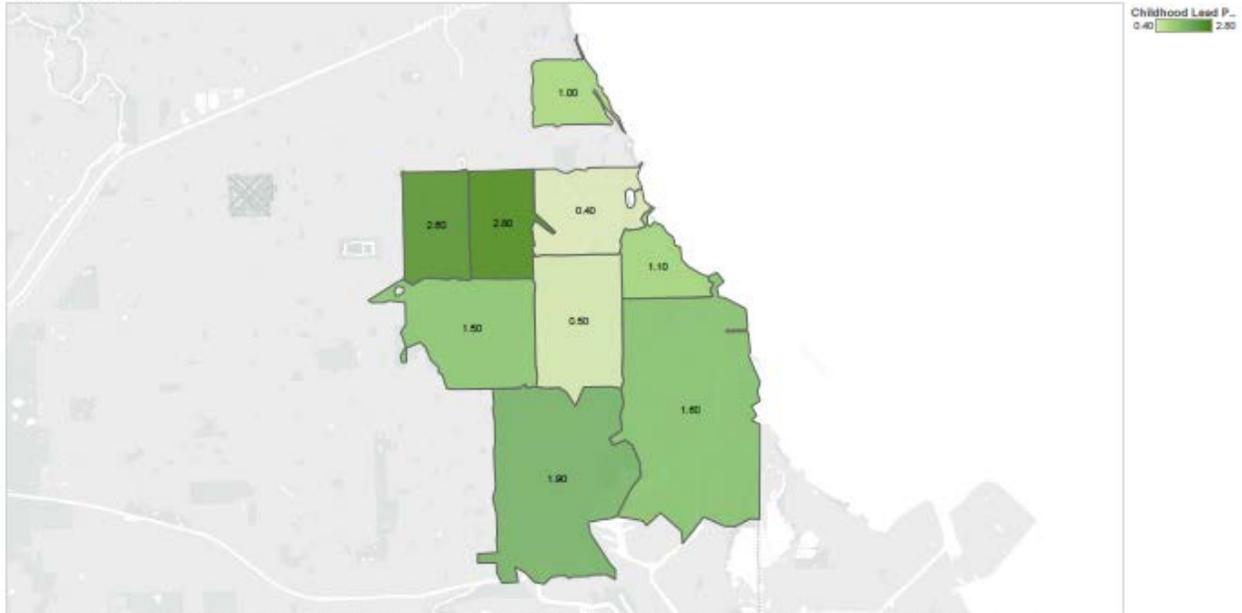
Actual experience of violence is highly localized, with some of our communities experiencing high rates of violence. Measures of homicide, for example, range from 70 per 1000 in Burnside to 6 per 1000 in Hyde Park.



Other Environmental Stressors

The housing stock in our primary service area is older than average^{ix}, perhaps contributing to the increased exposure to lead, with lead poisoning findings ranging from 3.7 per 1000 for Pullman to 0 for Hyde Park (data for Riverdale not available).

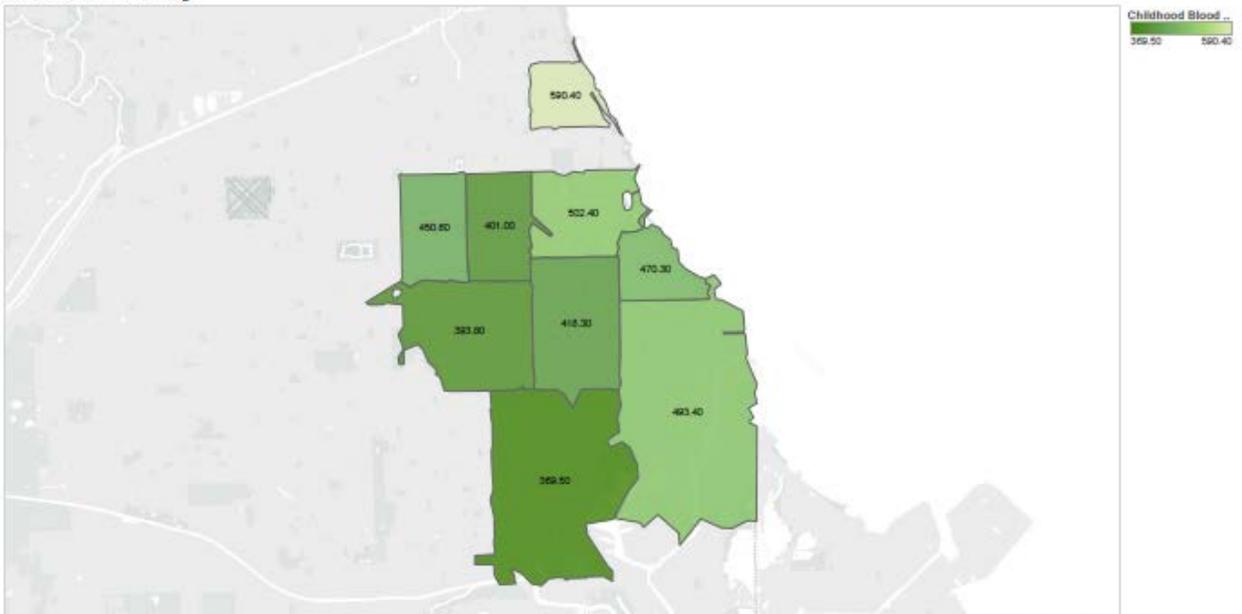
Childhood Lead Poisoning



Map based on Longitude (generated) and Latitude (generated). Color shows sum of Childhood Lead Poisoning. The marks are labeled by sum of Childhood Lead Poisoning. Details are shown for Zip Codes.

Collectively, less than half of all children are tested for lead, ranging from 590 per 1000 to 369 per 1000.

Childhood Lead Screening



Map based on Longitude (generated) and Latitude (generated). Color shows sum of Childhood Blood Lead Level Screening. The marks are labeled by sum of Childhood Blood Lead Level Screening. Details are shown for Zip Codes.

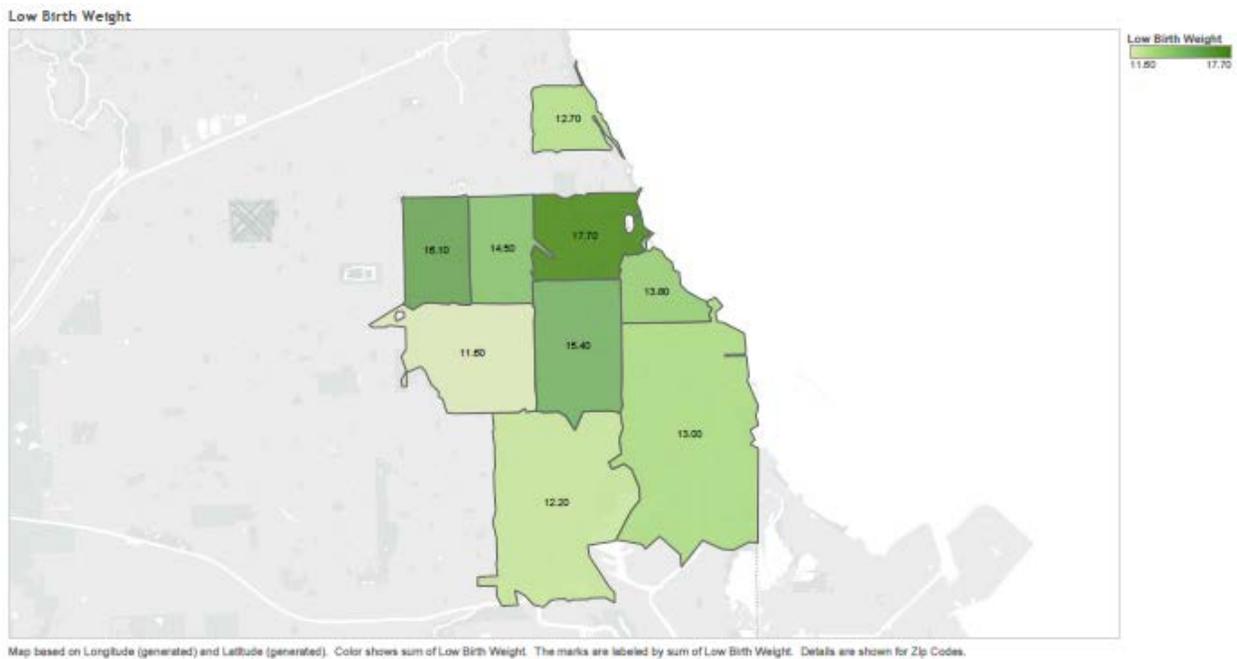
Mental Health Indicators

According to the Chicago Health Survey, severe psychological distress is not correlated with age, gender or ethnicity, but is highly correlated with poverty, with 10 percent of those living at or below the federal poverty level reporting distress compared to less than 1 percent of those living at 400% of the federal poverty level or above. Similarly, 22% of the poorest among us have ever been diagnosed with depression, compared to 12% of those at 400% of the federal poverty level or above. These findings are particularly significant for the population we serve, as families in such distress have less capacity to care for their medically complex children.

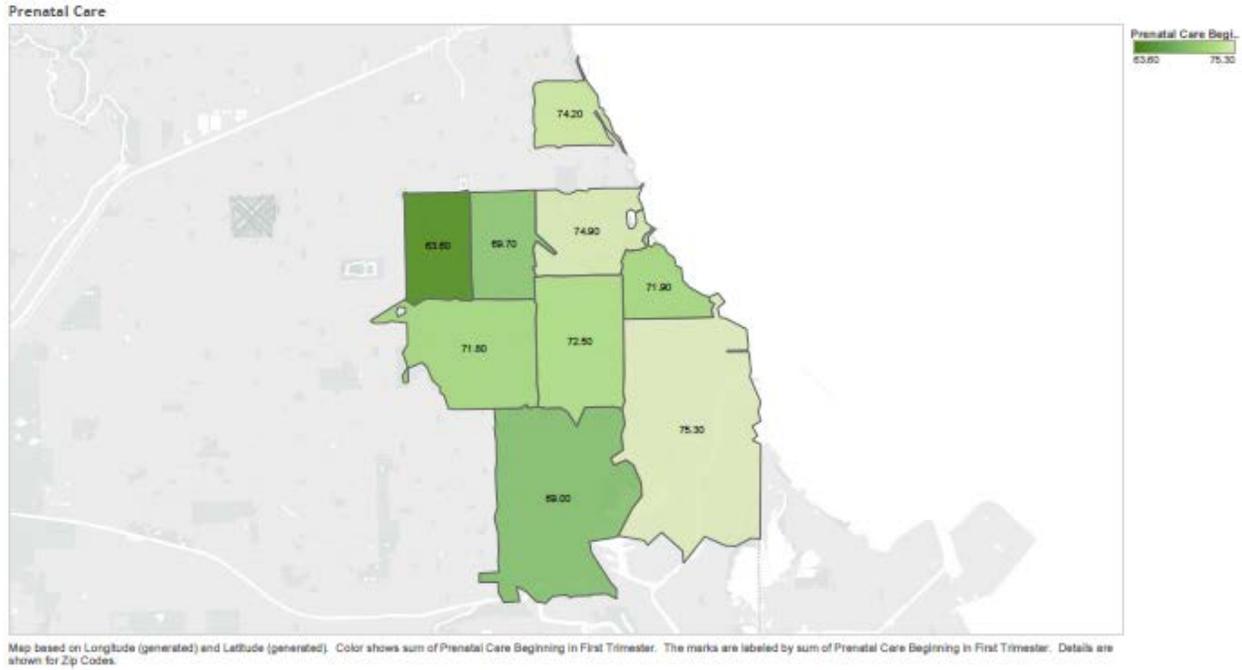
Child-Related Health Indicators

Indicators for a number of chronic diseases correlate with the factors noted above. The adult measures reflect an increased prevalence of diseases, including cancer, stroke, diabetes, and asthma. Our families may be juggling their own poor health while caring for their medically complex children. As La Rabida serves a population of children, however, we'll focus particularly on those measures here.

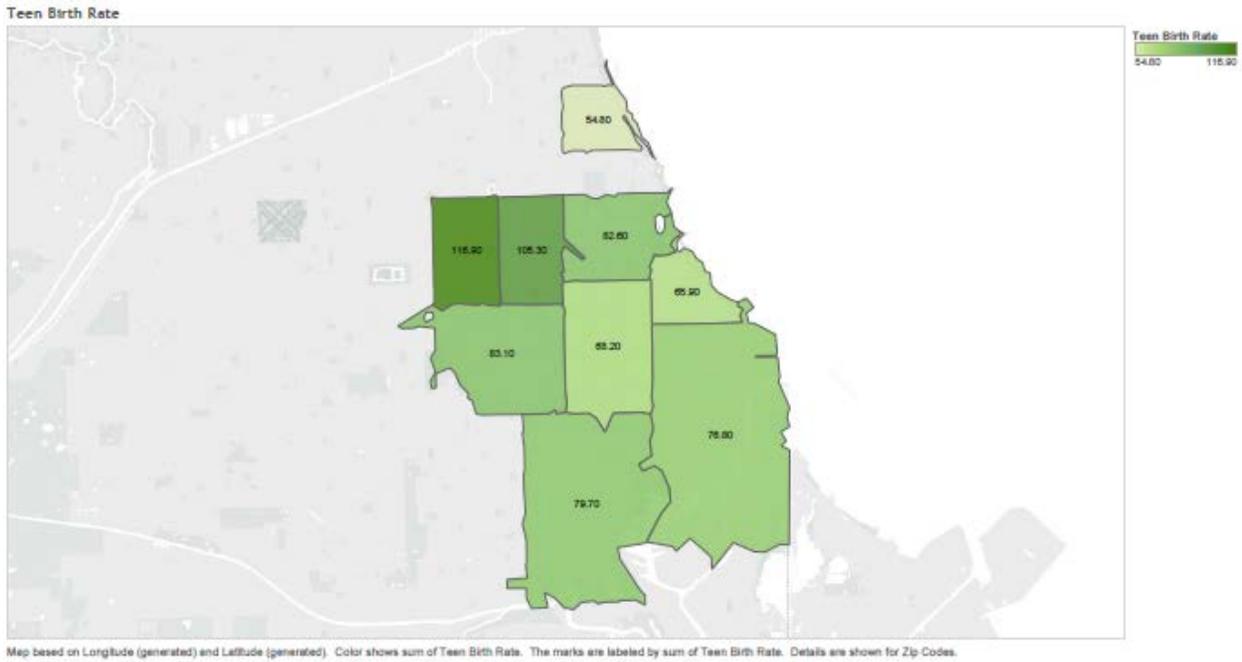
Low Birth Weight is associated with increased risk for poor health. In our area low birth rate babies per 1000 births ranges from 20 per 1000 in Avalon Park to 6 in Hyde Park.



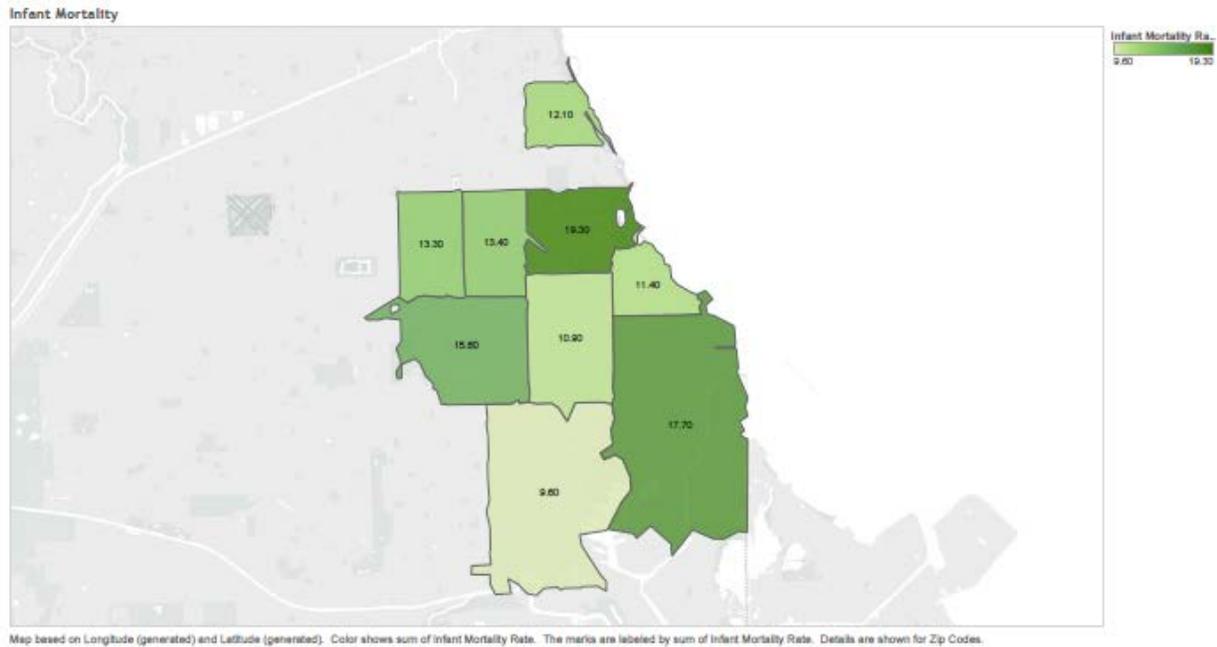
On the other hand, **receiving prenatal care** in the first trimester is a hedge against low birth weight and other pregnancy-related conditions. About three quarters of our mothers receive first trimester care, ranging from 64% in West Englewood to 80% in Hyde Park.



Teen pregnancy is also associated with poorer health outcomes. The frequency of teen births in our primary service area ranges broadly from 117 per 1000 in West Englewood to 8 in Hyde Park.



Infant Mortality is a stark outcome of multiple stressors. In our service area the rate of infant mortality ranges from 19 births per 1000 in Washington Park to 4 in East Side.



PRIMARY SERVICE AREA ASSETS

Health Care

The health care entities in (or abutting) our primary service areas are as follows:

- Acute-Care Hospitals/Emergency Rooms:
Comer (University of Chicago), Sinai (including Holy Cross), Advocate Trinity, St. Bernard, Jackson Park, Roseland
- Federally Qualified Health Centers & Other Safety Net Providers
Friend Family Health Center, Mile Square Health Center, ACCESS Community Health Network sites, Chicago Family Health Center, Near North Health Services Corp sites, Beloved Community Family Wellness Center
- Long term care facilities for children:
Children's Habilitation, Alden Village
- Mental Health Services/Facilities:
Ada S. McKinley, Metropolitan Family Services
- Dental Services:

University of Illinois at Chicago, St. Bernard Hospital, U of I South Shore Clinic

- HeadStart

Multiple locations within service area

- Early Intervention:

Child and Family Connections, # 8 and #10

- Home Healthcare and Hospice:

Addus, Advantage, American, Independence Plus, Maxim, PSA, Horizon Hospice, Vitas Hospice

- Respite Care:

NIA Comprehensive Center, Abraham Lincoln Center, Chicago Association for Retarded Citizens, Community Support Services

- Other Community-Based Resources:

WIC, Ounce of Prevention, Division of Specialized Care for Children, First Transit, Chicago Medical-Legal Partnership for Children, Developmental Disabilities Family Clinics

Expansion of Medicaid Managed Care Organizations

New since our last report is the expansion of Medicaid managed care, which have been granted a significantly increased opportunity to include a flexible array of barrier-reducing services and are being held to an actively monitored requirement to provide risk screening and care coordination to high and moderate risk enrollees. Serving our region with affiliated or contracted care coordination services are: Meridian, Molina Healthcare, BCBS of Illinois, Cigna HealthSpring, Next Level Health, CountyCare and Illinicare Health. (La Rabida Care Coordination is providing services specifically designed to support medically complex children for enrollees of CountyCare and Illinicare Health.) In addition, other Medicaid Managed Care entities (such as FHN, Aetna) are providing enhanced coordination services from within their own infrastructure.

Community-Based Assets

Other community assets are less well documented, although there are several efforts, such as Purple Binder, to document assets in a way that encourages them to be incorporated into service plans. In addition, we at La Rabida have developed a compendium of services we draw on to help individual families assemble the resources that they need. Every zip code has schools, parks, grocery stores and public transportation, although there are limitations in each of these areas, and these assets are not always equally distributed across neighborhoods. The region has two community colleges anchoring it, and a major anchor in the University of Chicago, both in the weight of its own enterprise, its variety of projects and its efforts to collaborate with the community via its Office of Community Engagement. Finally there are community organizing agencies, such as The Woodlawn Organization and Helping Hands in Englewood, that bring together coalitions of churches, block clubs, schools, agencies and public officials to collaborate on projects to create opportunity and reduce violence. A prime example of this collaboration is the entry of Whole Foods into Englewood, and the concomitant efforts to promoting local hiring, include for sale products developed by local small businesses and the encouragement of

additional nearby investment. A second example is a relatively new business, Growing Home, Inc., which employs local residents to grow and distribute organic vegetables to local markets now but expecting soon to sell to larger institutions.

Finally there are the families we serve, who despite significant adversity nonetheless demonstrate strength and resilience in order to take care of their children.

SURVEY OF LA RABIDA CLINIC PATIENTS

We surveyed La Rabida Clinic patients to elicit their perceptions of community features and the impact of those features on their perceived access to health and health care.

Three hundred surveys were distributed over a several week period, both in English and Spanish, to adult family members presenting in the clinic with their child for pre-scheduled appointments. The distribution yielded a convenience sample of 75, or a return of 25%.

Sixteen (21%) of these surveys were returned by families who live outside our primary service area; those were set aside, as we wished to compare what we heard back from our patients to the data collected by the Department of Public Health about the communities they live in. However, responses from respondents outside our primary service area often mirrored those of patients living in our primary service area.

The data below reflect responses from the 59 respondents who live in our primary service area. A convenience sample does not permit precise extrapolations to a population as a whole, but it does serve to illuminate the concerns on the minds of those we serve – which we can then place in context of the communities from which they come.

Survey questions

The survey was designed to be easily and quickly completed and asked about:

- Perceived access to health services
- Desired enhancements to health and health services
- Respondent's child's chronic conditions
- Primary sources of health information

Perceived access to care

Most (92%) of respondents said their children were able to visit a physician if needed, perhaps a reflection of the fact that they were already at their physician's office when filling out their survey. Those reporting difficulty taking their child to a physician when needed (8% or 5 respondents) were invited to check multiple barriers (or offer their own). Transportation was cited as a barrier by 3 of the 5.

Enhancements desired to improve health and health care

Respondents were asked to identify three things needed to improve the health of their families and neighbors from among the following: healthier food, job opportunities, mental health services, dental services, vision services, transportation, health education, safe places to walk or play, injury prevention and safety. They also were offered “other” with the opportunity to fill in the blank.

Of these options, three stood out among the rest: job opportunities (54%), followed by safe places to walk and play (47%) and healthier food (47%).

The next five options were given about the same level of importance: improved access to dental services, mental health services and transportation (each at 22%) and vision services and health education each at 19%. Of least concern was injury prevention and safety (5%).

Respondents’ children’s chronic conditions

Respondents were asked to name the top three health conditions their children were facing. Asthma was the leading condition named (37%), followed by allergies (27%), developmental delays (22%) and diabetes (17%). Multiple other conditions were mentioned in smaller numbers.

(Another indication of the complexity of our patient population: the average number of diagnoses individual children in our clinics have noted on their medical records is 8.)

Health Education

Respondents were asked where they get most of their health information, with options to check as many sources as applied, including doctor/health care provider, hospital, internet, family/friends, newspaper or magazine, school, health department, TV, library, workplace, Facebook/Twitter, other social media, other.

Most everyone (97%) named their physician, to be expected for respondents with children with complex medical challenges seen at a clinic which invests heavily in education. About one third (32%) relied also on their hospital or cited the health department for information, followed by family or friends at 22% and church at 14%. The remaining options were chosen by 10% or fewer respondents.

Discussion of survey results

The primary importance of job opportunities to our survey respondents parallels the reports emerging from the larger community; indeed, this is a major reason cited in the Tribune’s discussion for the outmigration of African Americans from Chicago. As noted above, unemployment ranges from 35% to 12% in our primary service area, compared to a long term state average of 7%.^x Survey respondents living outside our primary service area also highlighted the same issue as their top concern, suggesting that job insecurity is not just a local south side phenomenon.

Having safe places to walk and play was one of the two second most cited concerns in our patient survey. Although parks are fairly well distributed in many (though not all) of our communities, the Healthy Chicago survey reports that perception of their safety varies with age, with ethnicity and with poverty.

Our survey indicates a much higher concern for safety than is captured in the Healthy Chicago survey and that same concern about lack of safety is cited in the Tribune article as a major reason people have left our neighborhoods.

Our respondents cited healthier foods as equally important to them as safety. Looking back at the Healthy Chicago survey results, those who are the poorest eat the least amount of fruits and vegetables. Not surprisingly, in a 2006 study of food deserts and their impact in the Chicago region, 18 of the 22 community areas roughly corresponding to our primary service area are highlighted as either partial or complete food deserts.^{xi}

The desire for better access to dental services, mental health services and transportation mirrors our own experience that these services are difficult to obtain in our region. We note that the almost as compelling wish for better access to vision services and health education.

Finally, of the chronic conditions most frequently cited in our survey, asthma and allergies are significantly impacted by environmental air quality, which is poorer along highways and industrial areas, both prominently located in parts of our primary service area. Managing diabetes is heavily dependent upon balancing a diet of high-quality food with physical activity – and access to both have been identified as significant challenges, as noted above.

ⁱ Measuring Chicago's Health: Findings from the 2014 Healthy Chicago Survey

ⁱⁱ Chicago Department of Public Health Data Portal

ⁱⁱⁱ Community-level data are from the Chicago Department of Public Health Data Portal

^{iv} State measures are from the United States Census QuickFacts Illinois

^v www.city-data.com/zips

^{vi} Eltagouri, Marwa "Chicago's black exodus expanding" Chicago Tribune, June 25, 2016

^{vii} Ibid.

^{viii} See Robert Putnam, Bowling Alone, 1980 and Robert Sampson, Great American City: Chicago and the Enduring Neighborhood Effect, 2012

^{ix} www.city-data.com/zips

^x YCharts.com

^{xi} Gallagher, Mari *Good Food: Examining the Impact of Food Deserts on Public Health* in Chicago, 2006, page 19

IMPLEMENTATION PLAN

A committee of La Rabida senior executive staff reviewed the outcomes of the community assessment and the clinic survey noted in the discussion above. We also reviewed the prior implementation plan, and ascertained that there were no written comments received in response to that plan. We reviewed the plan of the major medical center that is closest to us, as well as some other community initiatives underway in which we have the option to participate.

We also evaluated the unique role La Rabida plays as a small specialty hospital in the constellation of providers in our community, and discussed the best ways to build on those assets to the benefit of the community.

In general, we wish to bring enhanced services and/or access to services in the areas of general behavioral health, caregiver well-being, trauma-informed services and three pediatric medical conditions: asthma, sickle cell and diabetes.

Topic	Action/Rationale	Time	Resources	Champion
<p>Expand access to behavioral health services</p>	<p>Improve access of patients to behavioral health services, in recognition of the environmental as well as condition-specific stressors impacting their health:</p> <ul style="list-style-type: none"> • Embed BH providers in outpatient clinics • Train primary care providers to treat ADHD, depression and anxiety, including standard prescribing protocols. • Expand child psychiatry to include secondary support of PCP provision of primary behavioral health services as well as continuing treatment of more complex cases. 	<p>FY 17</p>	<p>Refocus current resources</p>	<p>Soglin, Liebler</p>
<p>Increase focus on well-being and self-care</p>	<p>Ascertain wellness and stress management opportunities within reach of our patients' families and heighten attention given to caregiver self-care.</p> <ul style="list-style-type: none"> • Insert caregiver well-being checks into standard visit templates. • Insert inquiry into informal supports available to family (neighbors, church) into standard visit templates. • Develop information to safe alternatives to playing outside for families who live in self-identified dangerous neighborhoods. • Use local sources of produce or other goods where feasible (such as Growing Home) which help support local jobs. 	<p>FY 17</p>	<p>Refocus current resources</p>	<p>Soglin, Mayhugh, Carvalho</p>

<p>Expand provision of trauma-informed services.</p>	<p>Become a trauma-informed service provider</p> <ul style="list-style-type: none"> • Train internal staff on trauma-informed services • Train two people in the Triple-P program, an evidence-based, tiered program shown to reduce child abuse in a randomized study in South Carolina. 	<p>FY 18</p>	<p>Refocus current resources</p>	<p>Soglin, Liebler, Henry</p>
<p>Collaborate with medical center partner on community asthma interventions</p>	<p>Collaborate with the University of Chicago Medical Center to improve asthma in the surrounding community. D. Soglin, MD is on asthma outreach advisory committee and L. Giles, MD is clinical lead. Overall project is led by senior UCMC administrator.</p>	<p>FY 18</p>	<p>Refocus current resources</p>	<p>Soglin, Giles</p>

These goals were reviewed by senior staff and incorporated into our institutional oversight mechanisms and work plans in October, 2016.