



2021 Community Health Needs Assessment

Northwestern Medicine Palos Hospital



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Key Dates

Adopted by the Northwestern Medicine South Region Board of Directors July 8, 2021

Made available to the public August 31, 2021

Executive summary

Since 2012, Palos Community Hospital (Palos) has formally completed a comprehensive Community Health Needs Assessment (CHNA) every three years, in accordance with federal IRS regulations §1.501(r)-3, to better understand the population it serves as well as the health issues that are of greatest concern within its community. On January 1, 2021, Palos joined Northwestern Medicine and became Northwestern Medicine Palos Hospital (NMPH). As part of Northwestern Medicine, NMPH continues to work with the community to identify issues of greatest concern and opportunities to collaborate to address those needs in order to make the greatest impact on community health status.

The NMPH 2021 CHNA was conducted by Professional Research Consultants, Inc. (PRC). PRC is a nationally recognized healthcare consulting firm with extensive experience conducting CHNAs in hundreds of communities across the U.S. since 1994.

The goal of the CHNA was to assess the health needs of residents within the defined NMPH Community Service Area (CSA), identify and prioritize those needs, and identify resources potentially available to address priority health needs. PRC used a systematic, data-driven approach to conduct a CHNA that incorporated data from both quantitative and qualitative sources. After data collection and analysis, NMPH took steps to review and interpret findings and engage community organizations in the prioritization process.

Prevalent health needs were identified across all socioeconomic groups, races and ethnicities, ages (over 18 years old) and genders. The assessment highlighted health disparities and needs that disproportionately impact people who are medically underserved and uninsured.

While many health needs were identified through the CHNA process, NMPH prioritized health needs of the largest magnitude, seriousness and trend, as well as those that would be best addressed through a coordinated response from a collaboration of healthcare and community resources.

The NMPH 2021 priority health needs were identified as follows:

- Access to Healthcare Services
- Mental Health and Substance Use Disorders
- Heart Disease and Stroke

Working with dedicated healthcare, social service, public health and policy organizations, NMPH will develop an implementation plan, drawing on collective resources to make a positive impact on some of the most critical health needs of residents in its defined CSA. Information identified during the CHNA process will help NMPH determine how to best commit resources to address priority health needs that improve the health of its community.

Introduction

About Northwestern Memorial HealthCare

Northwestern Memorial HealthCare (NMHC) is committed to our mission to provide quality medical care regardless of the patient's ability to pay; transform medical care through clinical innovation, breakthrough research and academic excellence; and improve the health of the communities we serve. NMHC is a nonprofit, integrated academic health system committed to serving a broad community. NMHC provides world-class care at 11 hospitals (including Palos), three medical groups, and more than 200 diagnostic and ambulatory locations in communities throughout Chicago and the south, north, west and northwest suburbs.

NMHC hospitals are pillars in their respective communities and lead efforts to positively impact the health of the populations they serve. From facilitating collaborations with community organizations to serving as major economic drivers, NMHC strengthens our communities. We are sensitive to the needs of our communities, which span urban, suburban and rural populations. In doing so, NMHC serves four main roles for our communities:

- Provide quality medical care, regardless of the patient's ability to pay
- Conduct and support breakthrough research
- Educate the next generation of healthcare leaders and our communities
- Facilitate collaboration and lead initiatives to strengthen our communities and address the social determinants of health

About Northwestern Medicine

Working together as Northwestern Medicine (NM), NMHC and Northwestern University Feinberg School of Medicine (Feinberg) share a vision to transform medical care through clinical innovation, breakthrough research and academic excellence to make a positive difference in people's lives and the health of our communities.

NM's vision and values are deeply rooted in keeping patients at the center of care, which includes expanding to meet the growing demand for high-quality health care close to where people live and work. NM is a premier integrated academic health system where the patient comes first.

- We are all caregivers or someone who supports a caregiver.
- We are here to improve the health of our community.
- We have an essential relationship with Feinberg.
- We integrate education and research to continually improve excellence in clinical practice.
- We serve a broad community and bring the best in medicine closer to where patients live and work.

About Northwestern Medicine Palos Hospital

NMPH is a 425-bed, acute care hospital located in Palos Heights, Illinois, that serves Chicago’s southwest suburbs, including southwestern Cook County and northeastern Will County. The complete range of services include a comprehensive Emergency Department, an intensive care unit, comprehensive cardiovascular services, home health services, orthopedics, oncology, maternity care and women’s health, pediatrics, physical and occupational therapy, and psychiatry and behavioral health.

NMPH is committed to continuously reviewing and analyzing the changing needs of our community and responding quickly and effectively with services that positively impact our community. We realize that to have the greatest impact, we need to work with our neighbors and learn from them. Palos Community Hospital has a rich history of caring for its community, and NMPH will continue to uphold its promise to meaningfully improve access to high-quality health care and implement targeted programs that address the priority health needs of the community.

Acknowledgments

An essential component of any comprehensive assessment involves reaching out to key community stakeholders, organizations and residents to better understand the needs and issues that affect the health of its citizens. NMPH gratefully acknowledges the participation of community organizations and key stakeholders for their input on perceived needs and priorities within the communities we serve. These organizations work closely with the community, including people who are most in need. They have given generously of their time and expertise to help guide this CHNA.

Catholic Charities

City of Oak Forest

City of Palos Heights

Lemont Fire Department

Manor Care East (Palos Heights)

Manor Care West (Palos Heights)

Moraine Valley Community College

North Palos Fire Department

Oak Forest Fire Department

Palos School District 118

Park View Church

Pathlights (formerly PLOWS Council on Aging)

Village of Crestwood

Village of Orland Park

The Community Health Needs Assessment

Project overview

Northwestern Medicine commissioned PRC to conduct a comprehensive CHNA. The PRC CHNA framework consisted of a systematic, data-driven approach to determine the health status, behaviors and needs of the residents in the NMPH Community Service Area (CSA).

This CHNA identified health needs that are prevalent among residents across all socioeconomic groups, races and ethnicities, as well as issues that highlight health disparities that disproportionately impact people who are medically underserved and uninsured.

Information obtained through the CHNA enables NMPH leadership and key community stakeholders to identify health issues of greatest concern among its residents and decide how best to commit the hospital's resources to those areas. NMPH will use this information to guide new initiatives and enhance existing efforts that improve the health of our community.

CHNA goals

The NMPH CHNA serves as a tool toward reaching three related goals:

Improve residents' health status, increase life spans and elevate overall quality of life. A healthy community is one where its residents suffer little from physical and mental illness and enjoy a high quality of life.

Reduce health disparities among residents. By gathering demographic information along with health status and behavior data, it is possible to identify population segments who are most at risk for various diseases and injuries. Intervention plans targeting these segments may then combat some of the socioeconomic factors that have historically had a negative impact on residents' health.

Increase accessibility to preventive services for all residents. Access to preventive services may improve health status, life spans and overall quality of life, and impact the cost associated with care for late-stage diseases resulting from a lack of preventive care.

Community description

How the Community Service Area was determined

The NMPH CSA used in this CHNA was determined based on the following factors: (1) geographic area served by the hospital, including the primary and secondary service areas; (2) principal functions of the hospital; (3) areas of high hardship and historic need; and (4) location of existing organizations, initiatives and assets.

The defined CSA does not exclude medically underserved, low-income or minority populations, nor does it consider how much patients or their insurers pay for the care received or whether patients are eligible under the NM financial assistance policy.

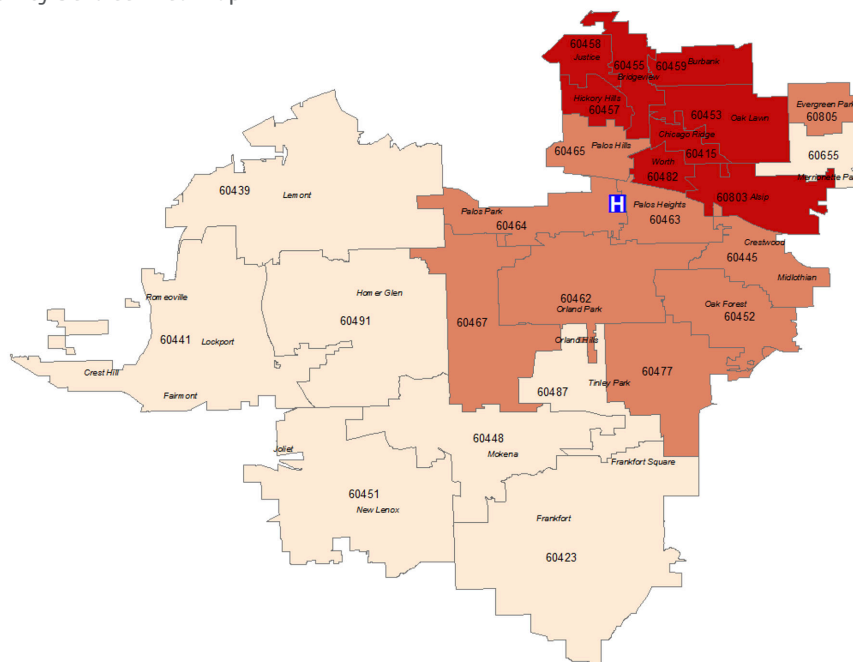
How the Community Service Area is defined

The NMPH CSA covers 26 residential ZIP codes, which comprise NMPH’s primary and secondary service areas in southwest Cook County and northwest Will County, Illinois. The following ZIP codes and communities represent the NMPH CSA:

NMPH CSA ZIP Codes

City	ZIP Code	City	ZIP Code	City	ZIP Code
Chicago Ridge	60415	Oak Lawn	60453	Orland Park-SW	60467
Crestwood	60418	Bridgeview	60455	Tinley Park/ Country Club Hills	60477
Frankfort	60423	Hickory Hills	60457	Worth	60482
Lemont	60439	Justice	60458	Orland Hills/Tinley Park	60487
Lockport	60441	Burbank	60459	Homer Glen	60491
Midlothian-Crestwood	60445	Orland Park	60462	Mt. Greenwood	60655
Mokena	60448	Palos Heights	60463	Alsip	60803
New Lenox	60451	Palos Park	60464	Evergreen Park	60805
Oak Forest	60452	Palos Hills	60465		

NMPH Community Service Area map



Methodology

Introduction

PRC conducted the assessment from January through May 2021. Development of the CHNA methodology was led by PRC and incorporated data from both quantitative and qualitative sources, including primary research (the PRC Community Health Survey and the PRC Online Key Informant Survey) and secondary research (vital statistics and other existing health-related data). Quantitative components allowed for trending and comparison to benchmark data at the state and national levels.

The data was collected, analyzed and reviewed by community health experts before it was presented to executive leadership and key community stakeholders for prioritization. All analyses conducted by PRC for this CHNA report are presented without citations. Data presented from other sources is cited as footnotes or parenthetically throughout the CHNA report.

Primary data: Community Health Survey

The PRC Community Health Survey instrument used for this CHNA was largely based on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys. Customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues were also included. The final survey instrument was developed by PRC and NMPH.

The 55-question survey was administered as an internet-based questionnaire to a stratified random sample of 207 individuals aged 18 and older in the NMPH CSA. This included 102 surveys from the Primary Service Area (PSA) and 105 in the Secondary Service Area (SSA). The questions targeted health status, experience and behaviors. Once the online interviews were completed, they were weighted in proportion to the actual population distribution to appropriately represent the NMPH CSA as a whole. All administration of the surveys, data collection and data analysis was conducted by PRC.

Sample characteristics

For statistical purposes, the maximum rate of error associated with a sample size of 207 respondents is $\pm 6.9\%$ at the 95% confidence level. To more accurately represent the population studied, it is a common practice to weight the raw data to improve representativeness. This is accomplished by adjusting the results of the sample to match the geographic distribution and demographic characteristics of the population surveyed (post-stratification), to eliminate any naturally occurring bias.

Primary data: Online Key Informant Survey

Key informants are individuals who have a broad interest in the health of the community and are in a position to advise healthcare organizations by providing a comprehensive biopsychosocial picture of community need. To solicit input from key informants, an Online Key Informant Survey was deployed. A list of recommended participants provided by NMPH 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 and the community overall.

Key informants were contacted by an email that introduced the purpose of the survey and provided a link to take the survey online. Reminder emails were sent as needed to increase participation. In all, 32 community stakeholders participated between February and April 2021.

Participants included representatives of the following organizations:

Alsip Fire Department	Our Lady of the Ridge
Beds Plus Care	Palos District 118
Chicago Ridge Fire Department	Palos Fire Protection District
City of Palos Heights	Pathlight (formerly PLOWS)
Cook County Department of Public Health	Sertoma
Crisis Center for South Suburbia	Saints Constantine & Helen (Palos Hills)
GiGi's Playhouse	Saint Francis of Assisi (Orland Park)
Good Shepherd (Palos Heights)	Saint Julie (Tinley Park)
Holy Family Villa	Village of Chicago Ridge
Lemont Fire Department	Village of Crestwood
Lexington Health Network	Village of Midlothian
Midlothian Fire Department	Village of Orland Park
Military Boxes	Village of Palos Park
North Palos Fire Department	Village of Worth
Oak Forest Fire Department	Village of Palos Heights

Through this process, input was gathered from several individuals whose organizations work with low-income, minority or other medically underserved populations. Key informants were asked to rate the degree to which various health issues are a problem in their community. Follow-up questions asked them to describe why they identified problem areas as such and how they might better be addressed. Rating results and participant comments are included in this report as they relate to the data presented. These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area and therefore are not necessarily based on fact.

Secondary data

A variety of existing (secondary) data sources were consulted to complement the research quality of this CHNA. Secondary data for NMPH was obtained from the following sources, which reflect Cook County data:

Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)

CDC Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

CDC Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance

CDC Office of Public Health Science Services, National Center for Health Statistics

Esri ArcGIS Map Gallery

National Cancer Institute, State Cancer Profiles

OpenStreetMap

U.S. Census Bureau, American Community Survey

U.S. Census Bureau, County Business Patterns

U.S. Census Bureau, Decennial Census

U.S. Department of Agriculture, Economic Research Service

U.S. Department of Health and Human Services

U.S. Department of Health and Human Services, Health Resources and Services Administration

U.S. Department of Justice, Federal Bureau of Investigation

U.S. Department of Labor, Bureau of Labor Statistics

The following indicators were selected for the analysis:

Access to Health Care and Clinical Care

Behavioral Health (Mental Health and Substance Use)

Chronic Disease

Health Behaviors

Health Outcomes (Birth Outcomes, Morbidity and Mortality)

Physical Environment

Social and Structural Determinants of Health

Benchmark data

Statewide and nationwide risk factor data were used (when available) as an additional benchmark against which to compare findings. Source data included BRFSS, trend data published by the CDC and the 2020 PRC National Health Survey. State- and national-level vital statistics were also provided for comparison of secondary data indicators.

Information gaps

PRC and NMPH made efforts to comprehensively collect and analyze CHNA data. However, this assessment cannot measure all possible aspects of health in the community or adequately represent all possible populations of interest. Information gaps might in some ways limit the ability to assess all community health needs. This assessment was designed to provide a comprehensive, broad picture of the health of the overall community. However, certain medical conditions and social determinants of health are not specifically addressed.

The following are limitations to consider while reviewing the findings:

Population health and demographic data are often delayed in their release, so data is presented for the most recent years available for any given data source.

There is variability in the geographic level at which datasets are available, ranging from census tract to statewide or national geographies. Whenever possible, the most relevant localized data is reported.

Due to variations in geographic boundaries, population sizes and data collection techniques for suburban and city communities, some datasets are not available for the same time spans or at the same level of localization throughout the county.

There are persistent gaps in data systems for certain community health issues, such as homelessness, mental health and substance use disorders (youth and adults), crime reporting, environmental health and education outcomes.

Public dissemination

The NMPH 2021 CHNA report is available to the public at no charge and can be accessed in the following ways:

Online: nm.org/about-us/community-initiatives/community-health-needs-assessment

Call: 312.926.2301

Email: communityhealth@nm.org

Visit: Northwestern Medicine Palos Hospital, 12251 South 80th Avenue, Palos Heights, Illinois 60463; inquire at the main customer service desk on the first floor

Public comment

Palos Community Hospital made its prior CHNA report publicly available through its website and by making a paper copy available on request without fee. CHNA comments were welcomed from the public, but at the time of this writing, NMPH had not received comments. Northwestern Medicine will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs. Please submit comments to communityhealth@nm.org, and include your name, organization (if applicable) and any feedback you have regarding the NMPH CHNA process or findings.

Although feedback was not received through the website, extensive input from the broader community was gathered through the Community Health Survey and Key Informant Survey and taken into consideration when identifying and prioritizing the significant health needs of the community.

Key findings

The dataset and key findings presented in this CHNA report highlight opportunities for improving health and form the basis for identification and prioritization of current community needs of the NMPH CSA.

Demographics

The assessment found that the NMPH CSA is complex and diverse, encompassing a range of socioeconomic characteristics, such as race and ethnicity, household income, education attainment and foreign-born status.

Total population

Data from the U.S. Census Bureau reveals the following statistics for Cook County relative to size, populations and density.

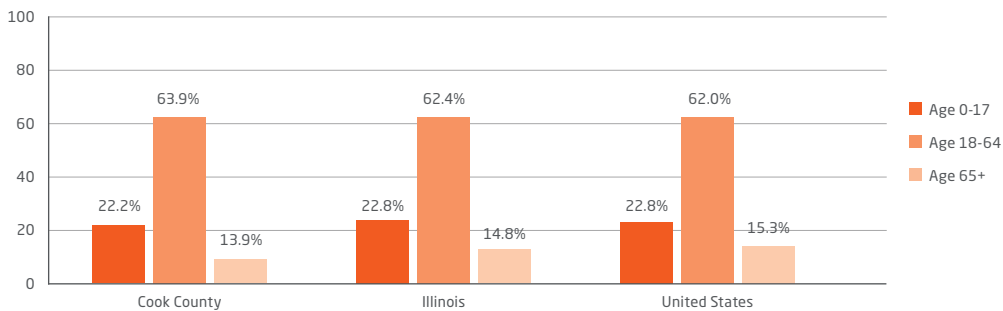
	Total Population	Total Land Area (square miles)	Population Density (per square mile)
Cook County	5,223,719	944.94	5,528.12
Illinois	12,821,497	55,517.13	230.95
United States	322,903,030	3,532,068.58	91.42

A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources. Between the 2000 and 2010 U.S. Census, the population of Cook County decreased by 178,917 persons, or -3.3%, which reflects a decrease greater than state or national trends.

Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that must be considered when planning a response to community need. It is widely accepted that the U.S. population will be shifting with the aging baby-boomer population. However in Cook County, 22.2% of the population are children aged 0-17; 63.9% are aged 18-64; and only 13.9% are aged 65 and older. The median age in Cook County is 36.4, which is similar to state and national medians.

Total Population by Age Groups (2014-2018)

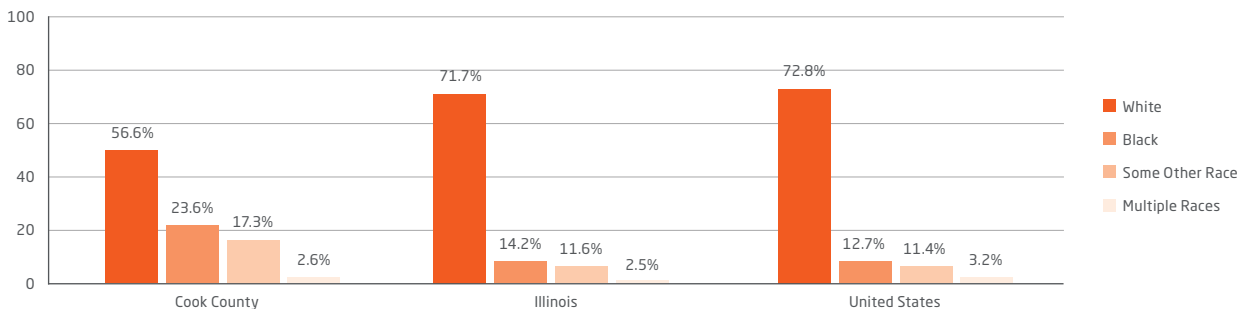


Sources: • US Census Bureau American Community Survey 5-year estimates
 • Center for Applied Research and Engagement systems (CARES), University of Missouri Extension, February 2021 via SparkMap (Sparkmap.org).

Race and ethnicity

The following chart illustrates the racial and ethnic makeup of Cook County. Origin can be viewed as the heritage, nationality group, lineage or country of birth of the person or the person’s parents or ancestors before their arrival in the U.S.; people who identify their origin as Hispanic, Latino or Spanish may be of any race. Looking at race independent of ethnicity, 56.6% of residents are White, 23.6% are Black, 17.3% are some other race, and 2.6% are multiple races. The Hispanic population increased by 173,061 persons, or 16.2% between 2000 and 2010, which is greater than state or national averages.

Total Population by Race alone (2014-2018)



Sources: • US Census Bureau American Community Survey 5-year estimates
 • Center for Applied Research and Engagement systems (CARES), University of Missouri Extension, February 2021 via SparkMap (Sparkmap.org).

Discrimination

The NMPH survey included a question on race and ethnicity and its impact on recent healthcare experiences. The question was asked of all respondents. Although the sample size was too small to segment by race or ethnicity, all respondents who said that they were treated worse were non-Hispanic White adults.

“Thinking about all of your healthcare experiences in the past 12 months, in general, do you feel your experiences were better, the same or worse than people of other races?”

Linguistic isolation

A total of 6.9% of Cook County residents age 5 and older live in a home where no person older than 14 is proficient in English. This is higher than state and national reports.

Social determinants of health

Healthy People 2030 emphasizes that health starts in the home, schools, workplaces, neighborhoods and communities. Our health is determined in part by access to social and economic opportunities, community resources, quality education, workplace safety, environmental factors and the nature of our social interactions and relationships. The conditions in which we live, work and play are known as social determinants of health (SDOH), and explain, in part, why some people in the U.S. are healthier than others. These factors are paramount when assessing the health of our community.

Income and poverty

Poverty is a key driver of health status because it creates barriers to accessing such things as health services, healthy food and other necessities, contributing to poor health status. The latest census estimates show 7.3% of Cook County residents (778,020 persons) are living below the poverty level.

Financial resilience

All respondents were asked, based on their current financial situation, if they would be able to pay an emergency expense that costs \$400, either with cash, by taking money from a checking or savings account, or by putting it on a credit card that could be paid in full at the next statement. The finding was that 23.6% of respondents do not have cash on hand to cover the \$400 emergency expense, which is similar to the 24.6% national average.

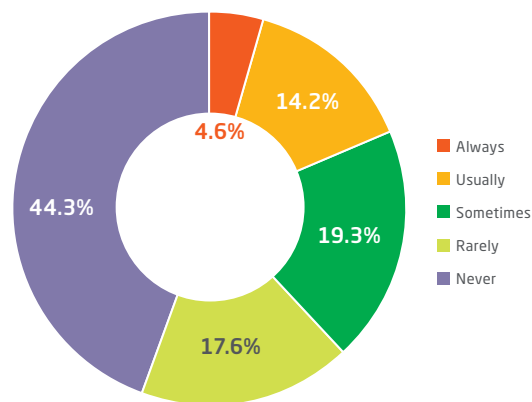
Housing burden

Housing burden refers to the percentage of the households where housing costs (rent or mortgage costs) exceed 30% of total household income. This serves as a measure of housing affordability and excessive shelter costs. The data also aids in the development of housing programs to meet the needs of people at different economic levels. In Cook County, 36.5% (718,837 households) have housing costs that exceed 30% of household income.

Housing insecurity

All respondents were asked how often they worried or stressed about having enough money to pay rent or mortgage. In the NMPH CSA, 38.1% reported they always, usually or sometimes worried about paying rent or mortgage in the past year. In addition, the frequency of worry or stress over paying rent or mortgage can be seen in the following chart.

Frequency of Worry or Stress Over Paying Rent or Mortgage in the Past Year
(Palos Health, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 303]
Notes: • Asked of all respondents.

Education

Educational attainment is linked to positive health outcomes. Among Cook County residents aged 25 and older, an estimated 13.3% (477,426 individuals) do not have a high school diploma.

Employment

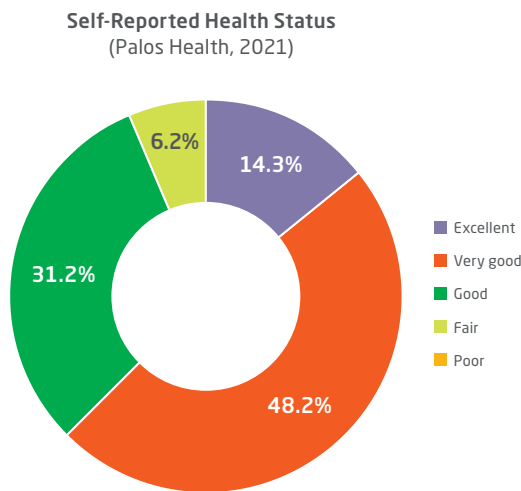
Financial security makes it easier to obtain resources of healthy living and predicts most health outcomes: life expectancy, infant mortality and chronic conditions such as asthma, cardiovascular disease and obesity.¹

1. Office of Disease Prevention and Health Promotion, Healthy People 2020 Social Determinants of Health Topic Area: Employment. U.S. Department of Health and Human Services, [healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/employment#8](https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/employment#8).

Health status

Overall health

A total of 6.25% of NMPH CSA adults believe their overall health is fair or poor. This is less than proportions reported statewide (12.6%) and nationally (17.7%).



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

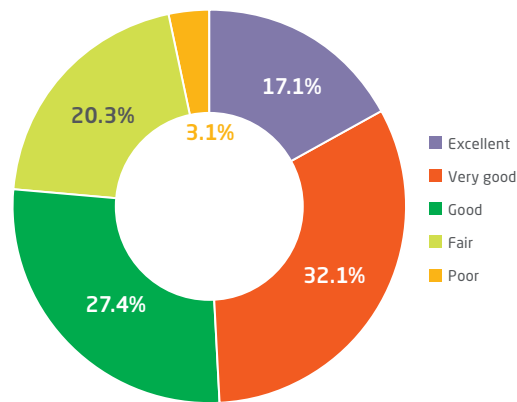
Mental health

About half of all people in the U.S. will be diagnosed with a mental disorder at some point in their lifetime. Mental disorders affect people of all ages and racial/ethnic groups, but some populations are disproportionately affected. Estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need (Healthy People 2030).

Self-reported mental health status for the NMPH CSA was assessed by asking respondents to think about their mental health, including stress, depression and problems with emotion. Results were that 23.4% reported experiencing fair or poor mental health, and 28.3% reported receiving a diagnosis of a depressive disorder, including depression, major depression, dysthymia or minor depression.

Self-Reported Mental Health Status
(Palos Health, 2021)

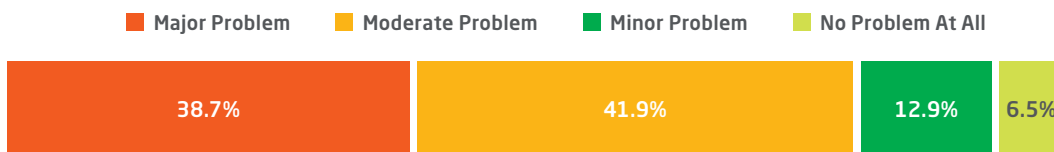


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 27]
Notes: • Asked of all respondents.

In addition, 38.7% of key informants in this CHNA perceived mental health as a major problem in the community, and provided the following reasons:

- Limited access to care, community resources and treatment
- Mental health issues exacerbated by COVID-19 and compounding access challenges
- Limited housing and shelter options
- Denial and stigma

Perceptions of Mental Health as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

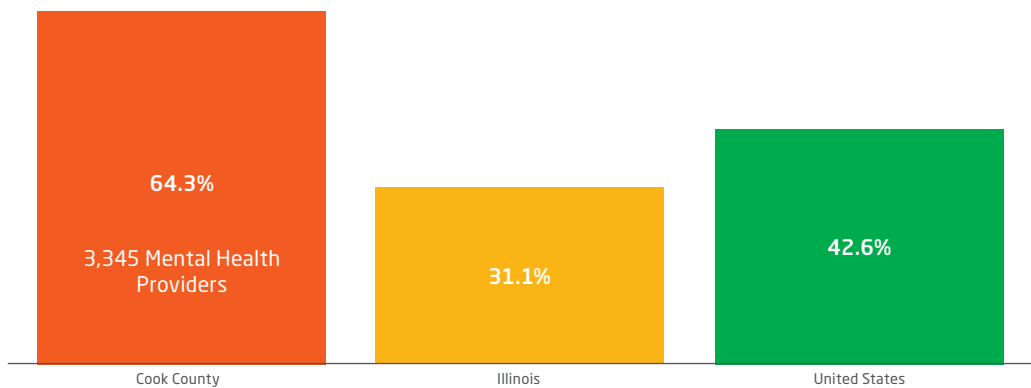
Suicide

Between 2013 and 2017, there was an annual average, age-adjusted suicide rate of 8.2 deaths per 100,000 population in Cook County. This was slightly lower than the state rate of 10.8 and the national rate of 13.6.

Access to mental health treatment

Mental health providers include psychiatrists, psychologists, clinical social workers and counselors who specialize in mental health care. In 2020, there were 64.3 mental health providers for every 100,000 population (or a total of 3,325 providers). This number is above state and national averages. When asked if there was a time in the past 12 months that a respondent needed mental health services but was not able to get them, 7.3% of the NMPH CSA were unable to get mental health services, which is in line with the national average.

Access to Mental Health Providers
(Number of Mental Health Providers per 100,000 Population, 2020)



Sources:

- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

Notes:

- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

Chronic conditions

Cardiovascular disease and stroke

Heart disease is the leading cause of death in the U.S., and stroke is the fifth leading cause. Heart disease and stroke can result in poor quality of life, disability and death. Through both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency – such as stroke, heart attack or cardiac arrest – get timely recommended treatment can reduce the risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need (Healthy People 2030).

Between 2014 and 2018, the annual average age-adjusted coronary heart disease mortality rate was 89.1 deaths per 100,000 population in Cook County, which is similar to state and lower than national rates. The rate is lower than the Healthy People 2030 objective of 90.9 or lower. However, this does not negate the need for aggressive health promotion activities aimed at maintaining a healthy lifestyle and limited modifiable risk factors to prevent the onset of heart disease.

Between 2014 and 2018, the annual average age-adjusted stroke mortality rate was 39.8 deaths per 100,000 population in Cook County, which is similar to state and national rates. However, this rate is higher than the Healthy People 2030 objective of 33.4 or lower.

Among key informants rating Heart Disease and Stroke as a major problem in the community, the following concerns were noted:

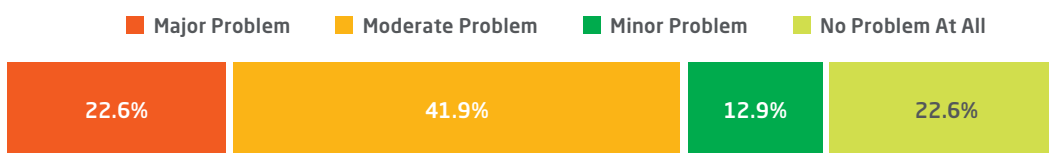
Incidence and prevalence

Aging population

Contributing factors

Access to care and services

Perceptions of Heart Disease and Stroke as a Problem in the Community
(Key Informants, 2021)



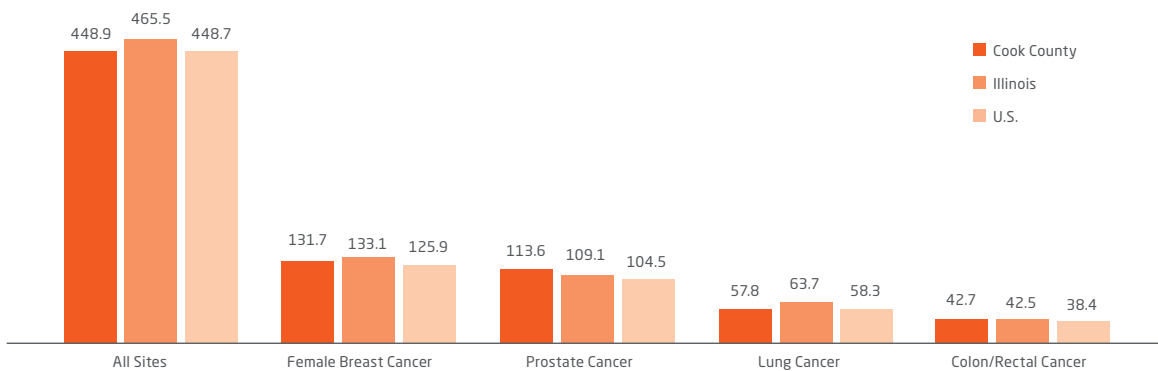
Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Cancer

Cancer is the second leading cause of death in the U.S. The cancer death rate has declined in recent decades, but more than 600,000 people still die from cancer each year. Death rates are higher for some cancers and in some racial/ethnic groups. These disparities are often linked to SDOHs, including education, economic status, and access to health care.

Between 2014 and 2018, the annual average age-adjusted cancer mortality rate was 161.3 deaths per 100,000 population in Cook County, which is similar to the state rate (162.1) yet higher than the national rate (155.3). The highest cancer incidence rates (number of newly diagnosed cases) were for breast and prostate cancers.

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2013-2017)



Sources: • State Cancer Profiles.
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).
Notes: • This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

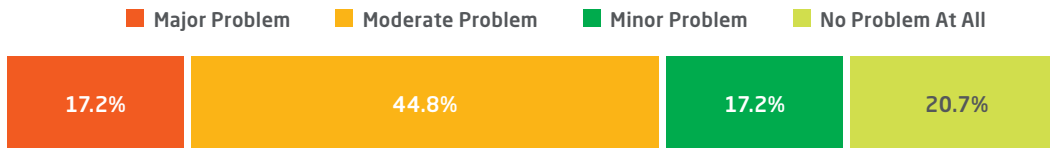
Prevalence of cancer in the NMPH CSA was 7.6%, with the most common type of cancer cited as breast cancer (21.6%), skin cancer (18.6%), and prostate cancer (13.0%). The percentage of Cook County women age 35+ enrolled in Medicare who received a mammogram in the past year was 32%, which is in line with state (34%) and national (32%) rates.

Among key informants rating cancer as a major problem in the community, the following concerns were noted:

Incidence and prevalence

Contributing factors (cancer is impacted by SDOHs)

Perceptions of Cancer as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Respiratory disease

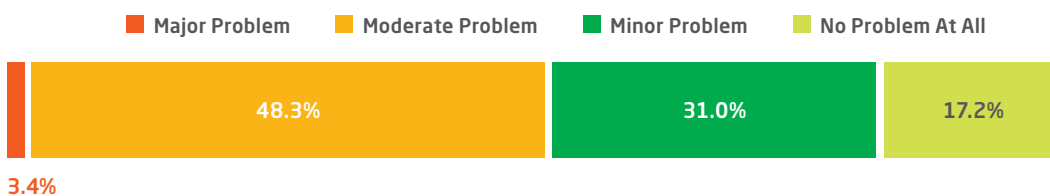
Respiratory diseases affect millions of people in the U.S. More than 25 million people in the U.S. have asthma and more than 16 million have chronic obstructive pulmonary disease (COPD). Strategies to reduce environmental triggers and prevent disease are key to reducing respiratory disease deaths (Healthy People 2030).

Between 2014 and 2018, the annual average age-adjusted lung disease mortality rate was 28.9 deaths per 100,000 population in Cook County, which is lower than both the state (37.8) and national (40.6) rates.

Within the NMH CSA, 11.4% of respondents have been diagnosed with asthma and 4.3% have been diagnosed with COPD (including bronchitis or emphysema).

Among key informants rating respiratory diseases as a major problem in the community, no specific concerns were noted.

Perceptions of Respiratory Diseases as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

COVID-19

The NMPH CSA survey asked about financial loss due to the COVID-19 pandemic, and 30.1% of respondents stated that a household member had lost a job, hours, wages or health insurance as a result of the pandemic.

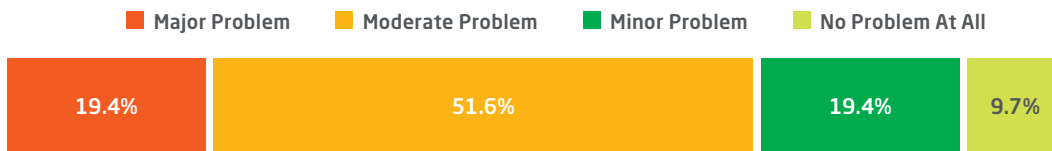
Among key informants rating COVID-19 as a major problem in the community, the following concerns were noted:

Vaccination rollout (lack of organization, awareness and technology issues with scheduling the vaccination)

Diagnosis and treatment (testing sites, monitoring spread)

Incidence and prevalence

Perceptions of Coronavirus Disease/COVID-19 as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Injury and violence

Unintentional injuries are the leading cause of death in children, adolescents and adults younger than 45 years in the U.S. Many unintentional injuries are caused by motor vehicle crashes and falls, while intentional injuries involve gun violence and physical assault. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces and communities.

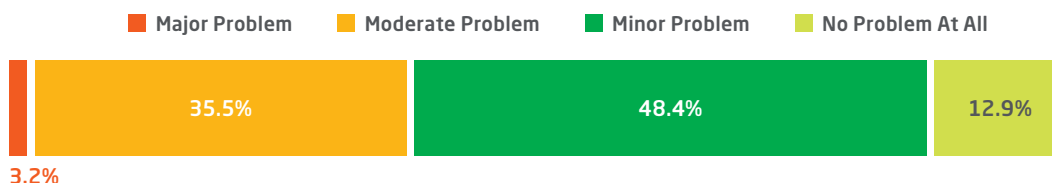
Between 2014 and 2018, the annual average age-adjusted unintentional injury mortality rate was 35.2 deaths per 100,000 population in Cook County, which is lower than both the state (40.0) and national (45.7) rates.

Among the NMPH CSA, respondents were asked about different types of violence in relationships with an intimate partner, specifically if an intimate partner has ever hit, slapped, pushed, kicked or hurt the respondent in any way. (Intimate partner was defined as any current or former spouse, boyfriend or girlfriend, including someone you were dating, or romantically or sexually intimate with.) In the NMPH CSA, 15.5% answered positively compared with 13.7% in the U.S.

Among key informants rating injury and violence as a major problem in the community, the following concerns were noted:

Lack of fear or respect for authority

Perceptions of Injury and Violence as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Diabetes

Diabetes is the seventh leading cause of death, and more than 30 million people in the U.S. have it. Some racial and ethnic minorities are more likely to have diabetes, and many people with diabetes do not know that they have it. Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss and kidney damage. However, interventions to help people manage diabetes can help reduce the risk of complications, and strategies to increase healthy eating and physical activity can also help prevent new cases.

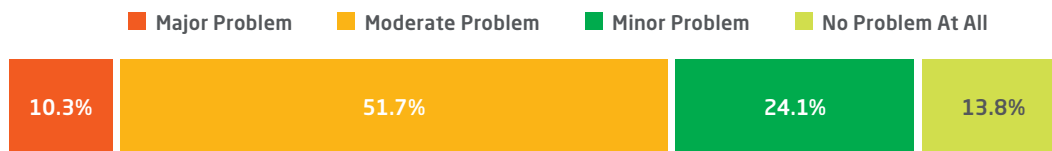
Among the NMPH CSA, the prevalence of diabetes was 14.6%, compared to 11.3% in Illinois and 13.8% nationally.

Among key informants rating diabetes as a major problem in the community, the following concerns were noted:

Contributing factors

Awareness and education

Perceptions of Diabetes as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Kidney disease

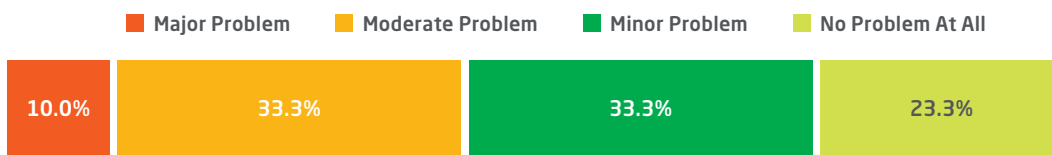
More than one in seven adults in the U.S. may have chronic kidney disease (CKD), with higher rates among low-income and racial and ethnic minority groups. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can also help people get the treatment that they need (Healthy People 2030).

Among key informants rating kidney disease as a major problem in the community, the following concerns were noted:

Incidence and prevalence

Diagnosis and treatment

Perceptions of Kidney Disease as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Potentially disabling conditions

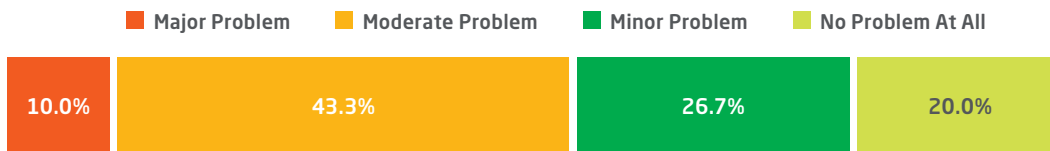
Studies have found that people with disabilities are less likely to get the preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving health. In addition, strategies to make homes, schools, workplaces and public places easier to access can help improve quality of life and overall well-being for people with disabilities (Health People 2030).

Disability data come from the U.S. Census Bureau’s American Community Survey, Survey of Income and Program Participation and Current Population Survey. All three surveys ask about six disability types: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty and independent-living difficulty. Respondents who report any one of the six disability types are considered to have a disability. Between 2015 and 2019, the percentage of civilian, non-institutionalized population in Cook County with a disability was 10.2%, compared with 11.0% at the state level and 12.6% at the national level.

Among key informants rating disability and chronic pain as a major problem in the community, the following concerns were noted:

- Pain management (large senior population)
 - Incidence and prevalence
-

Perceptions of Disability and Chronic Pain as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among key informants rating dementia and Alzheimer’s disease as a major problem in the community, the following concerns were noted:

- Aging population
 - Denial and stigma
 - Impact on quality of life
 - Incidence and prevalence
-

Birth outcomes and risks

Improving the well-being of mothers, infants and children is an important public health goal for the U.S. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities and the healthcare system. Infant and child health are similarly influenced by sociodemographic factors such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for Black people. These differences are likely the result of many factors, including SDOHs.

Lack of prenatal care

Early and continuous prenatal care is the best assurance of maternal and infant health. A total of 5.6% of 2007-2010 Cook County births did not receive first trimester prenatal care. This is similar to the state rate (5.4%) but less than the national rate (17.3%).

Infant mortality

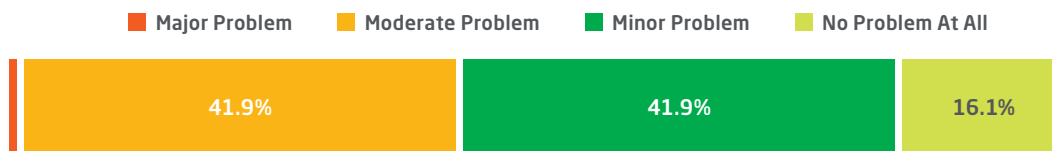
Infant mortality includes the death of a child before his or her first birthday, and is expressed as the number of such deaths per 1,000 live births. Between 2006 and 2010, the annual average infant deaths per 1,000 live births was 7.4. This infant mortality rate was more than state (6.9) and national (6.5) rates. It was also well above the Healthy People 2030 target of 5.0 or lower.

Family planning

Nearly half of pregnancies in the U.S. are unintended. Unintended pregnancy is linked to many negative outcomes for both women and infants, such as preterm birth and postpartum depression. Between 2012 and 2018, there were 24.5 births to women age 15-19 per 1,000 women age 15-19 in Cook County. This rate was higher than state (21.3) and national (22.7) rates.

Among key informants rating infant health and family planning as a problem in the community, no specific concerns were noted.

Perceptions of Infant Health and Family Planning as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

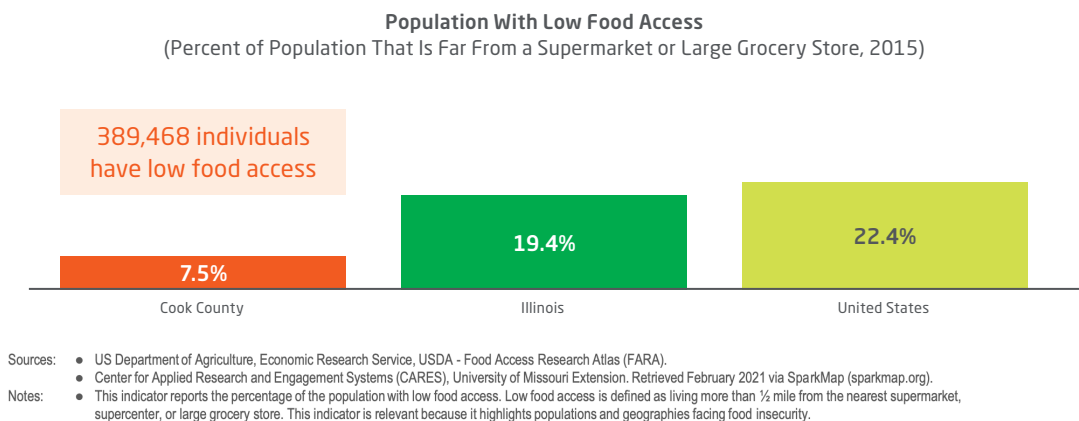
Modifiable health risks

Nutrition

It is widely accepted that diet and lifestyle have significant effects on health outcomes, yet many people in the U.S. do not eat a healthy diet. People who eat unhealthy foods are at increased risk for obesity, heart disease, diabetes and other health problems. Some people do not have the information they need to choose healthy foods, while others do not have access to healthy foods or cannot afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and improving health (Healthy People 2030).

Within the NMPH CSA, only 15.6% of respondents found it very or somewhat difficult to buy affordable fresh produce. In addition, 26.2% were either sometimes or often worried about running out of food in the past year. This is slightly less than the national trend of 30.0%.

The U.S. Department of Agriculture data shows that 7.5% of Cook County residents (more than 389,468 individuals) have low food access, which was defined as living more than one-half mile from the nearest supermarket, supercenter or large grocery store. This is notably less than state (19.4%) or national (22.4%) trends.



The latest data shows that there are 90.9 fast food restaurants in Cook County for every 100,000 residents. This data is slightly higher than state (81.4) and national (81.3) trends.

Physical activity

Regular physical activity can improve the health and quality of life of people of all ages, regardless of the presence of a chronic disease or disability. For people who are inactive, even small increases in physical activity are associated with health benefits. Personal, social, economic and environmental factors all play a role in physical activity levels among youth, adults and older adults. Understanding barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

A total of 32.0% of NMPH CSA residents reported no leisure-time activities in the past month. This was higher than the state trend (24.6%) and comparable to the national trend (31.3%). Parents of children (aged 2-17) in the NMPH CSA reported that their child is physically active for one or more hours per day at 27.4%. This is less than the national trend (33.0%).

There were 12.2 recreation and fitness facilities identified for every 100,000 residents. This was comparable to state (11.9) and national (11.8) data.

Weight status

Obesity is a growing problem that is linked to many serious health problems, including type 2 diabetes, heart disease, stroke and some types of cancer. Some racial and ethnic groups are more likely to have obesity, which increases their risk of chronic diseases (Healthy People 2030).

A total of 63.4% of NMPH CSA residents reported heights and weights that indicated they were overweight or obese. This is lower than both the state (31.6%) and national (31.3%) trends. A measure called body mass index (BMI) is the ratio of weight to height. The definition of overweight is having a BMI \geq 25.0, regardless of gender, and the definition of obesity is a BMI \geq 30.

Among key informants rating nutrition, physical activity and weight as a major problem in the community, the following concerns were noted:

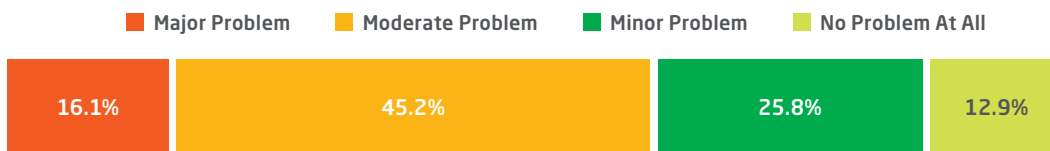
Contributing factors (such as access to affordable/healthy foods, physical activity, tobacco-free living and preventative health services)

Lifestyle

Awareness and education

Obesity

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Substance use disorder

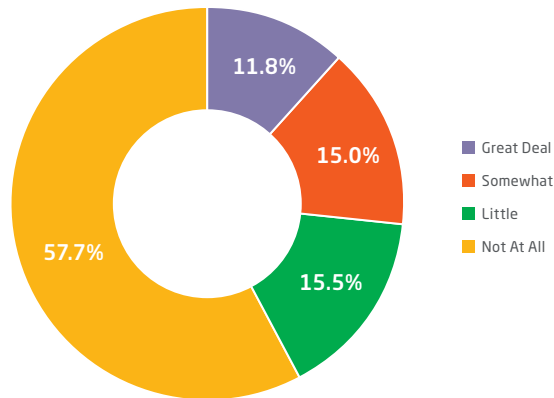
Substance use disorder refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. It affects more than 20 million adults and adolescents in the U.S. and can involve illicit drugs, prescription drugs or alcohol. Social attitudes and political and legal response to the consumption of alcohol and illicit drugs make substance use disorder one of the most complex public health issues. Improved evaluation of community-level prevention has enhanced researchers' understanding of factors that contribute to the initiation of substance misuse, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific settings.

In the NMPH CSA, 41.5% self-reported a history of excessive drinking (defined as the number of persons aged 18 years and over who drank five or more drinks on a single occasion for men or four or more drinks on a single occasion for women during the past 30 days). This is significantly more than the state (19.9%) and national (23.6%) averages.

Opioids are a class of drugs used to treat pain. Examples include morphine, codeine, hydrocodone, oxycodone, methadone and fentanyl. Within the NMPH CSA, 8.5% reported using a prescription opioid in the past year, which is less than the national trend (12.9%).

Further, within the NMPH CSA, 26.8% reported that their life has been somewhat or a great deal negatively affected by substance abuse, which is less than the national average of 35.8%.

Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's)
(Palos Health, 2021)

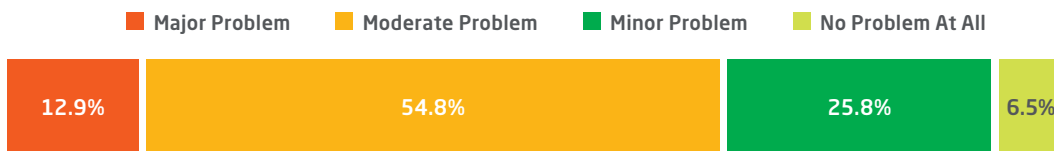


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 24]
Notes: • Asked of all respondents.

Among key informants rating substance use disorders as a major problem in the community, the following concerns were noted:

- Access to care and services (more treatment centers are needed to help those in need)
- Contributing factors (COVID-19 closures, long wait lists, limited staff, patients not having insurance or proper ID)
- Awareness and education (education about services)

Perceptions of Substance Abuse as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Tobacco use

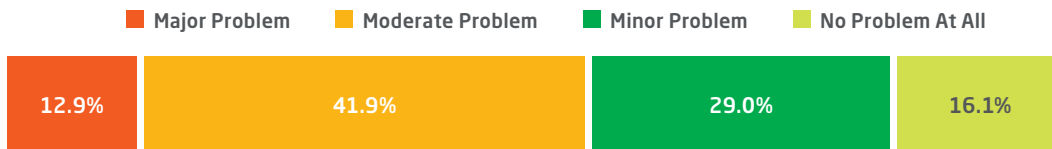
More than 16 million adults in the U.S. have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year. Although smoking is widespread, it is more common in certain populations, including men, American Indian/Alaska Native people, people with behavioral health conditions, LGBTQ people and people with lower incomes and education levels.

A total of 26.7% of NMPH CSA adults currently smoke cigarettes either regularly or occasionally. This rate is higher than state (14.5%) and national (17.4%) trends. It is also significantly higher than the Healthy People 2030 target of 5.0% or lower. A total of 20.6% of NMPH CSA adults use vaping products, which is well above the national (8.9%) trend.

Among key informants rating tobacco use as a major problem in the community, the following concerns were noted:

- Incidence and prevalence
- Easy access
- Teen and young adult usage

Perceptions of Tobacco Use as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Sexual health

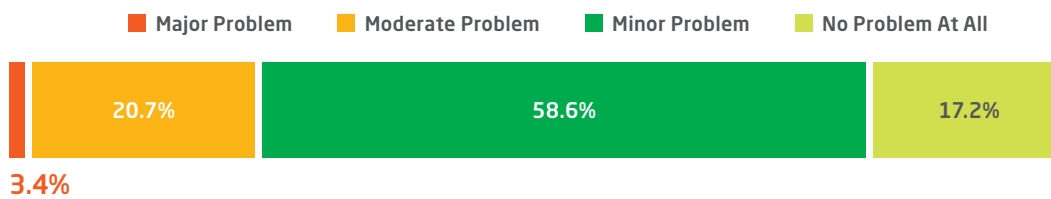
Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the U.S. each year, and rates are increasing. Adolescents, young adults and men who have sex with men are at higher risk of getting STIs, and people who have an STI may be at higher risk of getting HIV. Strategies to increase education, screening and testing for STI can assess risk and help people with getting treatment, improving their health and making it less likely that STIs will spread.

In 2018, there was a prevalence of 577.4 HIV cases per 100,000 population in Cook County. This is above the state (334.5) and national (372.8) rates (CDC National Center for HIV, Viral Hepatitis, STD and TB Prevention).

In 2018, the chlamydia incidence rate in Cook County was 830.3 cases per 100,000 population. The county gonorrhea incidence rate was 309.3 cases per 100,000 population. Each rate was above the state and national rates. These indicators are relevant as they measure poor health status and indicate the prevalence of unsafe sex practices.

Among key informants rating sexual health major problem in the community, no concerns were noted.

Perceptions of Sexual Health as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Access to healthcare

Lack of health insurance coverage

Access to comprehensive, quality healthcare services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts overall physical, social and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Regarding a lack of health insurance coverage among adults aged 18-64 years, 4.6% of NMPH CSA residents reported having no insurance coverage for healthcare expenses. In addition, 10.0% of parents reported that children aged 0-17 years were without insurance coverage or they had trouble obtaining medical care for their child in the past year. This was above the national average of 8.0%.

Difficulties accessing healthcare

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps (Healthy People 2020):

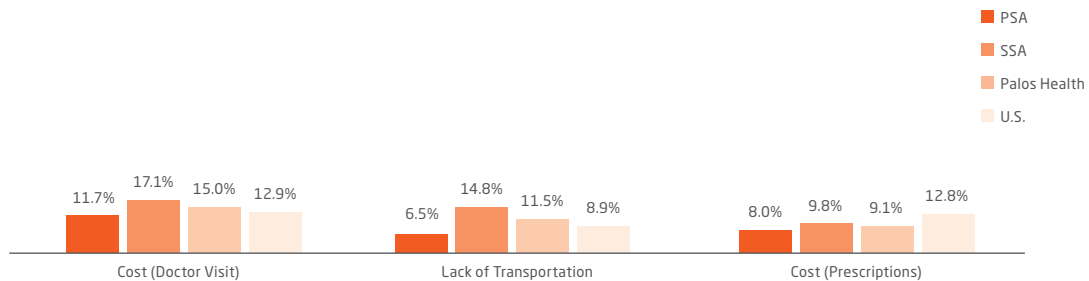
Gaining entry into the healthcare system

Accessing a healthcare location where needed services are provided

Finding a healthcare provider with whom the patient can communicate and trust

To better understand healthcare access and barriers, survey participants were asked to identify barriers that prevented them from seeing a physician or obtaining needed prescriptions in the past year. The percentages in the following chart reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Medical Care in the Past Year

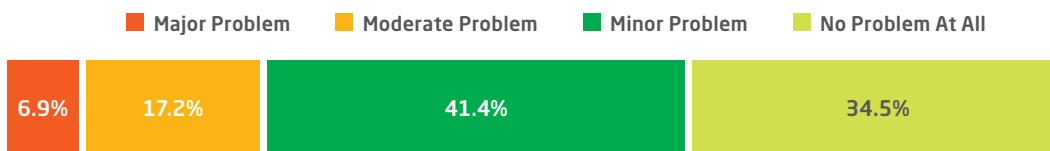


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 6-8]
 Sources: • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Among key informants rating access to healthcare services as a major problem in the community, the following concerns were noted:

Contributing factors (provider shortages, complexity of obtaining and keeping public benefit coverage, policy changes, fear within the immigrant communities and cost)

Perceptions of Access to Health Care Services as a Problem in the Community
 (Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
 Notes: • Asked of all respondents.

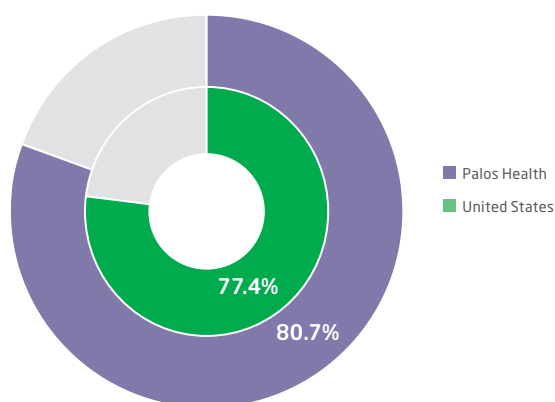
Primary care services

Improving healthcare services depends in part on ensuring that people have a usual and ongoing source of care. This is also known as having a medical home. People with a medical home have better health outcomes and fewer disparities and costs. Having a primary care physician (PCP) as the usual source of care is especially important because PCPs can develop meaningful and sustained relationships with patients and provide coordinated and integrated services while practicing in the context of family and community.

There are 4,863 PCPs in Cook County, translating to a rate of 93.4 per 100,000 population. This finding was more favorable than the state (80.1) and national (76.6) rates.

In the NMPH CSA, 59.2% of adults have visited a physician for a checkup in the past year; 80.7% of children aged 0-17 have visited a physician for a routine checkup in the past year, compared to 77.4% nationally.

Child Has Visited a Physician for a Routine Checkup in the Past Year
(Parent of Children 0-17)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 47]
 Sources: • 2020 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents with children 0 to 17 in the household.

Oral health

Oral health is essential to overall health. Good oral health improves a person’s ability to speak, smile, smell, taste, touch, chew, swallow and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many people. Good self-care, such as brushing with fluoride toothpaste, daily flossing and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include tobacco use, excessive alcohol use and poor dietary choices.

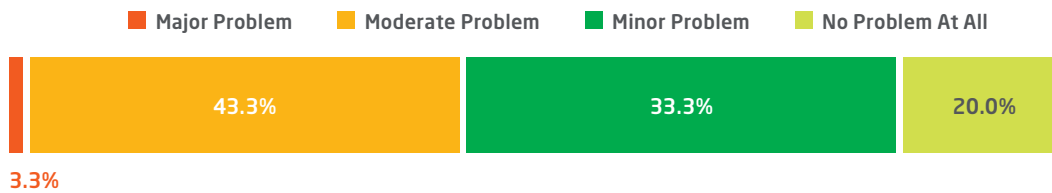
However, some people in the U.S. do not have access to preventive programs. A person’s ability to access oral healthcare is associated with factors such as education level, income, race and ethnicity. Barriers that can limit a person’s use of preventive interventions and treatments include limited access to and availability of dental services, lack of awareness of the need for care, cost and fear of dental procedures.

In 2015, there were 4,437 dentists for every 100,000 residents in Cook County. This was higher than both state and national rates. In addition, a total of 59.2% of residents in the NMPH CSA visited a dentist or dental clinic within the past year, which is higher than the Healthy People 2030 target of 45.0% or higher.

Among key informants rating oral health as a major problem in the community, the following concerns were noted:

Populations who are disproportionately affected (such as people experiencing homelessness)

Perceptions of Oral Health as a Problem in the Community (Key Informants, 2021)

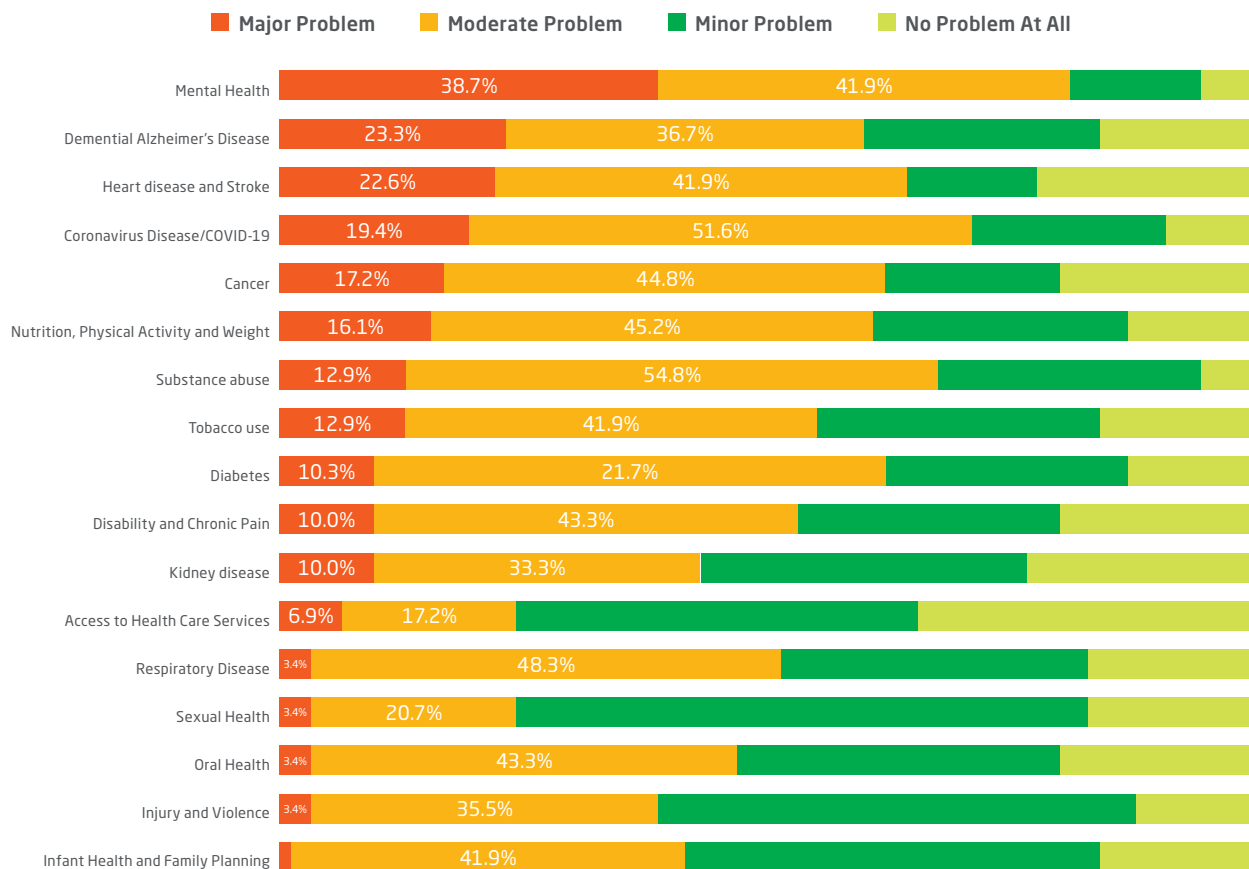


Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key informant perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 17 health issues are a problem in their own community, using a scale of major problem, moderate problem, minor problem or no problem at all. The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)

Key Informants: Relative Position of Health Topics as a Problem in the Community

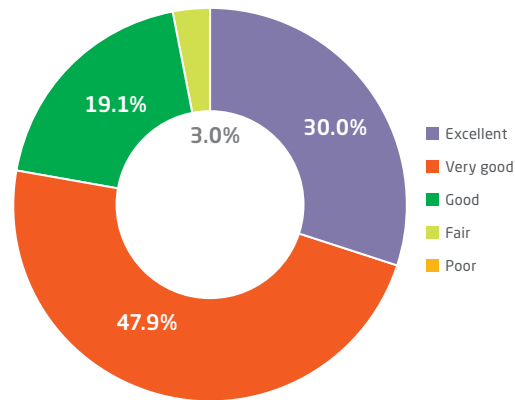


Local resources

Perceptions of local healthcare services

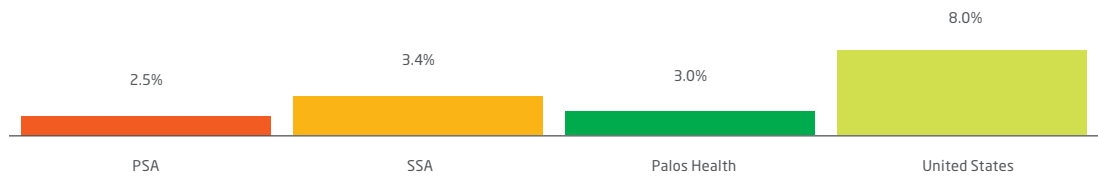
The NMPH CSA was asked, “How would you rate the overall healthcare services available to you?” More than 77% rated overall healthcare services available in the community as excellent or very good. The 3.0% who rated local healthcare services as fair is well below the national trend of 8.0%.

Rating of Overall Health Care Services Available in the Community
(Palos Health, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

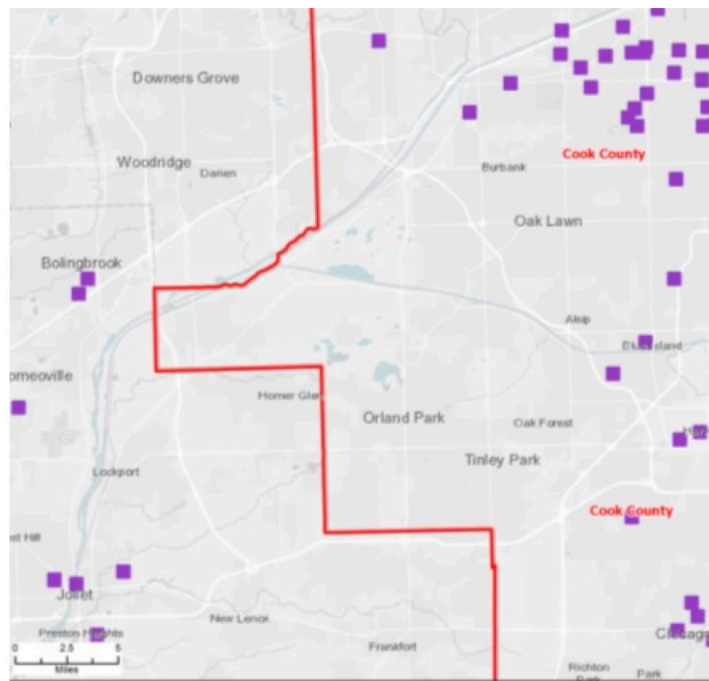
Perceive Local Health Care Services as “Fair/Poor”
(Key Informants, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Sources: • 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents..

Federally Qualified Health Centers

The following map details Federally Qualified Health Centers (FQHCs) in nearby areas as of September 2020.



Map Legend

Federally Qualified Health Centers, POS
September 2020

Report Location, County

SparkMap

Areas of opportunity for community health improvement

The following areas of opportunity represent the significant health needs of the community based on information gathered through the CHNA, including local data, benchmark data, the number affected and key informant input. These areas of opportunity were considered in the prioritization process and represent potential areas to consider for intervention.

Topic	Identified Needs
Access to Healthcare Services	Routine medical care
Cancer	Leading cause of death Key informant: Cancer ranked as a top concern
Heart Disease and Stroke	Leading cause of death Key Informant: Heart disease and stroke ranked as a top concern
Mental Health	Fair or poor mental health Diagnosed depression Key informant: Mental health ranked as a top concern
Nutrition, Physical Activity and Weight	Overweight and obesity Difficulty accessing fruits and vegetables
Potentially Disabling Conditions	Key informant: Dementia and Alzheimer's disease ranked as a top concern
Oral Health	Regular dental care
Respiratory Disease	Chronic Obstructive Pulmonary Disease prevalence Key informant: COVID-19 ranked as a top concern
Substance Use Disorder	Binge drinking
Tobacco Use	Cigarette smoking prevalence Use of vaping products Use of vaping products

Interpreting and prioritizing health needs

Community Health Council

Following completion of the CHNA, NMPH leadership convened the Community Health Council (CHC) to review the findings. This multidisciplinary committee was made up of key internal stakeholders who were selected based on strong collaborative efforts to improve the health of the community, including medically underserved, minority and low-income populations. The varied backgrounds of the committee members provided diverse insight into prioritizing identified health needs. Departments represented and rationale for inclusion are outlined in the table.

NMPH Department	Knowledge Area
Community Affairs	Community relationships, data and hospital resources
Analytics	Patient data, information systems and analytics
Case Management	Social determinants of health, patient barriers and communities
Emergency Medicine	Patient needs and social determinants of health
Hospital Operations	Hospital and staff operations
Human Resources	Diversity and inclusion strategies
Medical Staff	Medical staff operations
Nursing	Patients, barriers and community nursing
Philanthropy	Community programming and fundraising opportunities
Process Improvement	Process improvement strategies
Quality	Hospital quality data and resources
Strategy	Business development and strategies

Community stakeholders

The following community organizations, who are representative of the assessed community area (including those who serve medically underserved, low-income and minority populations), were formally engaged to participate in the NMPH prioritization process. These key stakeholders were selected based on strong collaborative efforts to improve the health of the community, and their varied backgrounds provided diverse insight into prioritizing the identified health needs.

Catholic Charities	North Palos Fire Department
City of Oak Forest	Oak Forest Fire Department
City of Palos Heights	Palos School District 118
Lemont Fire Department	Park View Church
Manor Care East (Palos Heights)	Pathlights (formerly PLOWS Council on Aging)
Manor Care West (Palos Heights)	Village of Crestwood
Moraine Valley Community College	Village of Orland Park

Prioritization process

In May 2021, NMPH convened two online meetings to evaluate, discuss and prioritize health issues for the community based on findings of this CHNA: one with a group of community stakeholders (representing a cross-section of community-based agencies and organizations) and one with the Northwestern Medicine Palos Hospital Community Health Council. PRC began each meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see the section earlier “Areas of opportunity for community health improvement”). All data identified during the CHNA were used in the prioritization process, including primary and secondary data and community input. Following the data review, PRC answered questions. Participants were provided an overview of the prioritization exercise that followed.

To assign priority to the identified health needs (the areas of opportunity), participants used an online voting platform to register ratings for each issue. The participants were asked to evaluate each health issue along two criteria:

Scope and severity: The first rating was to gauge the magnitude of the problem. Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

Ratings also considered the following:

How many people are affected?

How does the local community data compare to state or national levels, or Healthy People 2030 targets?

To what degree does each health issue lead to death or disability, impair quality of life or impact other health issues?

Ability to impact: A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies and spheres of influence. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individual ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

- | | |
|--------------------------|--|
| Mental Health | Nutrition, Physical Activity, and Weight |
| Heart Disease and Stroke | Tobacco Use |
| Substance Use Disorder | Access to Healthcare Services |
| Cancer | Potentially Disabling Conditions |
| Respiratory Disease | Oral Health |

Priority health needs

NMPH identified three priority health needs that will enable us, together with the community, to maximize the health outcomes generated by our collective resources. In selecting priorities, we considered the degree of the community need, capacity and available resources to meet the need and the suitability of our own expertise to address the need. In particular, priority health needs were selected that would be best addressed through a coordinated response from a range of healthcare and community resources. We believe these health needs will be impacted through the integrated efforts of our organization and community organizations.

Through this process, the NMPH 2021 priority health needs were identified as follows:

Access to Healthcare Services

Mental Health and Substance Use Disorder

Heart Disease and Stroke

Development of the implementation plan

NMPH will continue to work with the NMPH CHC and external community stakeholders to develop a comprehensive Community Health Implementation Plan (CHIP) that will address each priority health need. NMPH and community health organizations share the vision of a healthy community and are committed to working together to address priority health needs. NMPH is committed to providing culturally competent care that is responsive to the needs of our community and will collaborate with community organizations, including health and social service organizations, to develop community-based health initiatives designed to address health disparities.

As part of an academic health system, NMPH can support efforts to positively change the health status of our community by taking on a variety of roles.

Northwestern Medicine Palos Hospital Roles

Civic Leader	Education	Research	Clinical Provider
<ul style="list-style-type: none"> • Partner/convener • Advocate • Funder 	<ul style="list-style-type: none"> • Training • Youth programs • Knowledge transfer 	<ul style="list-style-type: none"> • Medical/biomedical research • Community-based evaluation • Outcomes data • Proof of concept 	<ul style="list-style-type: none"> • Financial assistance • Medicaid • Safety net partners

The CHIP will specify NMPH's strategies, anticipated impacts, resources and planned collaborations for each priority health need.

A general list of assets that could be directed toward impacting priority health issues includes:

Clinical care resources and facilities of NMPH and community organizations	Policies and procedures that broaden and simplify access to healthcare for people who are uninsured or underinsured
Established, replicable community-based health promotion programs addressing both highly prevalent and targeted chronic health conditions	Advocacy resources at NMPH and community organizations
Research and education expertise	Planning and oversight resources
Financial assistance programs at NMPH	Management expertise in quality improvement and information technology

Priority health needs not addressed

The CHIP will also specify significant health needs identified through the CHNA that NMPH did not prioritize and does not plan to address, together with the reason that they will not be addressed.

Existing resources

NMPH recognizes that a large number of healthcare facilities and organizations within the NMPH CSA respond to health needs and support health improvement efforts. A list of resources potentially available to address priority health needs identified through the CHNA was identified by PRC and is included in Appendix A.

Actions taken to address Palos Community Hospital 2019 priority health needs

In 2019, Palos Community Hospital (Palos) worked with the Alliance for Health Equity (AHE) to conduct a Community Health Needs Assessment. Significant health needs were determined through a comprehensive assessment that took into consideration survey data, focus group feedback, benchmark data, trends and the potential health impact of a given issue.

Palos leadership met to review CHNA findings and prioritize health issues of greatest need for the CSA. In selecting priorities, Palos considered the following criteria: magnitude, scope and severity, ability to impact and risk of inaction. In addition to the needs, Palos also took into consideration hospital resources and alignment with the hospital's mission, goals and strategic priorities.

Through this process, Palos identified the following priority health needs:

- Access to Health Services
 - Mental Health and Substance Abuse
 - Chronic Disease
 - Transportation and Housing
-

This status report summarizes the impact of the strategies outlined in the Palos Community Hospital 2019 CHNA Implementation Plan.

Priority health need 1: Access to Health Services

Goal:

Improve the availability and access to primary and specialty healthcare services to residents of the service area and provide outreach and support to efforts focused on encouraging healthy behaviors and management of chronic disease through care coordination.

Strategy 1.1:

Continue to grow the Palos Medical Group (PMG) in terms of number of providers and locations, including primary care and specialties, while improving efficiencies to reduce wait times for appointments.

PMG continued its strategy of growth, both in terms of providers and specialties. At the outset of fiscal year (FY) 2019 until March 2021, PMG added 16 providers and new specialties that include Colorectal Surgery and

Pulmonology. The most significant addition, with respect to addressing priority issues chosen for action in the FY2019-FY2021 period, was the establishment of the Cardiovascular Institute, which consists of eight physicians and six advanced practice providers. New procedures were also put in place to reduce patient wait times by obtaining patient information prior to a patient's appointment.

Strategy 1.2:

Inform patients during the scheduling process about availability of exams at the free-standing Imaging Center to offer patients a lower-cost option.

The Scheduling Department initiated a process to inform patients that the Palos Imaging and Diagnostic Center is a lower-cost option. In addition, during the checkout process at PMG, patients are informed about the Palos Diagnostics and Imaging Center and its lower-cost option.

Strategy 1.3:

Introduce a cardiac diagnostics at the free-standing Imaging Center to offer new lower-cost options to patients.

Non-Invasive Cardiology testing at the South campus provides patients an alternative, convenient place for the same high level of cardiac testing as available at the hospital. Cardiology exams available at the South Campus include EKG, Holter and event monitoring, exercise stress, stress-echo and cardiac nuclear testing. PMG cardiologists also have appointments available to see patients at this convenient location.

Strategy 1.4:

Collaborate through the clinical affiliation with Loyola University Medical Center (LUMC) to ensure the availability of specialists and specialty programs in the local community.

Palos Hospital and LUMC had a clinical affiliation from 2015 to 2020. Program initiatives that began within the context of that affiliation and continued through 2019 and 2020 include:

- The establishment of a telestroke service by which LUMC provided real-time remote physician access and consultation services through a robotic process for patients presenting at the Palos Emergency Department with stroke symptoms

- The establishment of a joint-venture entity, South Campus Partners, to provide radiation oncology services to patients on a local basis, including access to an MRI-guided linear accelerator, the only one in the State of Illinois

- The establishment of a licensed ambulatory surgical center, the Palos Health Surgery Center, with Palos Hospital, LUMC and United Surgical Partners, which had its first procedure in April 2019

- LUMC provided infusion services on the Palos Health South Campus throughout 2019-2020

Each of these initiatives resulted in enhancing access to more specialized care and physicians for the residents of the Palos service area.

Strategy 1.5:

Encourage use of Palos MyChart to facilitate access to relevant patient-specific clinical information to promote continuity and efficiency in the delivery of care.

MyChart:

In July 2020, Palos enhanced MyChart patient portal features to include the capability to securely release records to patients via MyChart. This gives patients easy access to their records without having to come to the hospital.

In February 2021, PMG patients age 65 and older received an invitation to schedule a COVID-19 vaccination appointment. Invitations were based on vaccine supply and sent on a rolling basis. When patients became eligible to schedule an appointment, they were notified through Palos MyChart. If patients did not have a MyChart account, invitations were sent via phone call or email.

As of January 2021, more than 50,000 patients were using the Palos MyChart patient portal. This represents a 36.0% increase in utilization from January 2020.

Telehealth:

Palos started the patient telephone and telehealth video visits at the end of March 2020 to reduce in-person visits during the COVID-19 pandemic. In the early months, PMG providers conducted about 1,100 virtual visits per month. Endocrinology, Behavioral Health and the Cardiovascular Institute used this technology the most. Usage has since declined, but telehealth functionality remains as an alternative to in-person visits.

Strategy 1.6:

Expand care coordination efforts to manage patient acuity and deploy resources intended to provide support to patients in dealing with disease and reduce acute episodic treatment.

Care Coordination:

Care coordination is an integral part of the Chicago Health Colleagues' population health initiatives. Registered nurse care coordinators employed by Palos Health conduct phone outreach to the patients of the Chicago Health Colleagues employed and independently participating providers. Some topics addressed with patients include assessing barriers to care, assistance with appointment setting, education on disease management and post-discharge planning. As a result of the COVID-19 pandemic, care coordination services became even more critical. Patients could not rely on a caregiver to assist them with recalling and understanding hospital discharge instructions because of limited visitation policies. Patients diagnosed with COVID-19 needed ongoing education, support and connection to healthcare services after their discharge from the hospital or Emergency Department (ED).

Health Equity and Unconscious Bias Training:

Chicago Health Colleagues engaged in a project with our commercial Accountable Care Organization (ACO) to offer Health Equity and Unconscious Bias Training to both the employed and independently practicing primary care providers in Chicago Health Colleagues network. The purpose of the Health Equity and Unconscious Bias Training was to increase clinicians' knowledge on unconscious bias and other health-equity, practice-based skills, by applying learned knowledge in case-based learning scenarios. A benchmark completion rate of 80% was set as a measure of success for the network's eligible providers, which Chicago Health Colleagues providers exceeded.

Race, Ethnicity and Language Health Disparity Analysis:

Chicago Health Colleagues conducted an analysis of the race, ethnicity and language demographics of our commercial ACO population. The analysis sought to identify the race, ethnicity and language makeup of the ACO population and to identify any potential disparities in care observed for common preventive health measures. Using claims data for our commercial ACO population and demographics information collected and stored in the Epic electronic health record (EHR), Chicago Health Colleagues was able to stratify patients into their respective racial, ethnic and language groups and analyze these groups against gaps in care. Chicago Health Colleagues did not observe any disparities in the analyzed population related to race, ethnicity or language across health metrics such as rates of breast, cervical and colorectal cancer screening. We did identify the need for further opportunities to expand the selection of ethnic groups available in the Epic EHR. This could add more refinement and sensitivity for future analyses.

Strategy 1.7:

Improve relations with area skilled-nursing facilities to enhance continuity of patient care.

Palos providers (three physicians and four advanced practice registered nurses) oversaw the care of post-acute Palos Hospital patients in eight area skilled nursing facilities.

When patients transition home, continuity in care is provided through home healthcare. In the event patients require long-term skilled nursing care, they may wish to transition to palliative care, which is also available through our providers.

Strategy 1.8:

Explore alternative delivery models and provide new options to reduce costs to patients.

Chronic Care Management Pilot Project:

Chicago Health Colleagues, along with leaders of Palos Home Health, Community-Based Medicine and Care Coordination, developed a pilot plan for the implementation of a chronic care management (CCM) program. The mission of this program was to develop the technical, clinical and administrative infrastructure needed to enroll, monitor and care for patients eligible for CCM as stipulated by Medicare CCM program guidelines. A central goal of the program is to deliver personalized, interactive outreach and care planning to patients with multiple chronic conditions between their regular provider appointments. The purpose of this individualized patient engagement is to reduce avoidable ED visits, hospital admissions and improve the quality of life for patients.

Commercial ACO ED Avoidance Pilot Project:

Chicago Health Colleagues was engaged by our commercial Accountable Care Organization (ACO) to take part in a pilot project for intervention with patients who have chronic lung disease. The pilot program uses predictive modeling to identify patients who may be at risk for an ED encounter in the near future. Leaders of care coordination and the Heart and Lung Wellness Center engaged with our commercial ACO to offer insights, feedback and strategies to enhance the effectiveness of the predictive model. Collaboration between clinical leaders and our commercial ACO continues. We hope to use this information to be able to reach patients with the tools at the disposal of our care coordination team, before an event leading to a potentially avoidable ED encounter or hospital admission.

Strategy 1.9: Use a clinically integrated network to improve the coordination of care between the hospital and physicians.

Provider Educational Opportunities:

Chicago Health Colleagues engaged in the creation and distribution of several important educational opportunities for the provider network. Educational opportunities on a variety of subjects, diseases, therapies and treatments were created in conjunction with our network providers. Two CME-accredited events on Pulmonary Embolism and Prostate-Specific Antigen were well attended. These events brought together employed and independent providers to learn about best practices that could be used to inform their patient care practices. Chicago Health Colleagues was able to improve accessibility to CME content through the use of a new virtual format for our Quarter 4 CME event. Overall, these efforts resulted in a 30% increase in providers meeting Chicago Health Colleagues annual participation criteria. In total, Chicago Health Colleagues network providers engaged with these educational offerings more than 700 times throughout 2020.

Priority health need 2: Mental Health and Substance Abuse

Goal:

Serve as a resource and provide a complement of inpatient, outpatient and supportive services focused on the treatment and recovery of mental illness and substance use in collaboration with community-based programs and initiatives.

Strategy 2.1:

Provide a broad range of outpatient services, including partial hospitalization, intensive outpatient programming and counseling.

Inpatient services:

Crisis stabilization, structure group, individual and family therapy, medication evaluation and management, detox services, aftercare coordination and introduction to the 12-step program.

Outpatient services:

Partial hospitalization program (PHP), intensive outpatient program (IOP), and the substance use disorder intensive outpatient program (SUDIOP).

Outpatient behavioral health appointments (PMG Behavioral Health Services):

Medication-assisted treatment for addictions, psychiatric medication management, individual and family therapy and eye movement desensitization and reprocessing (EMDR) therapy.

Transcranial magnetic stimulation (TMS):

A noninvasive treatment for depression.

Strategy 2.2:

Promote the availability of mental health providers (including psychiatrists) to meet the growing demand for services.

	2019	2021
Psychiatrist	4	6
Advanced practice registered nurse	3	5
Addiction specialist	1	0
Psychologist	1	0
Licensed clinical social worker	2	4
Total	11	15

Strategy 2.3:

Provide free community-based seminars on issues impacting mental health and substance abuse.

Community presentation: Addiction and Your Loved One (March 13, 2019)

Community presentation: Breaking Free From Depression (April 10, 2019)

Community presentation: One Step At a Time: Treating Anxiety (May 6, 2019)

Community presentation: Suicide Prevention (November 7, 2019)

Mental Health Awareness Month: Informational Tables at hospital and South Campus (May 2019)

Anonymous People Movie Night, followed by brief question-and-answer session (September 26, 2019)

Zoom Webinar on Mental Wellness for Orland Park and Tinley Park Chambers of Commerce (May 7, 2020)

Strategy 2.4:

Improve awareness of mental health and substance abuse and address issues related to stigma.

Advertisements:

Behavioral Health Services: one page ad (Perspective, Winter 2019)
Class on Promoting Addiction Recovery (Facebook, March 2019)
Class on Managing Depression (Facebook, April 2019)
Mental Health Awareness Month (Facebook, May 2019)
National Recovery Month and Promoting Behavioral Health Movie Night (Facebook, September 2019)
Promoting Suicide Prevention Class (Facebook, November 2019)
TMS Therapy (Facebook, July 2020)
Behavioral Health half-page ad (Vitality, Fall 2020)
COVID-19 Related Anxiety and Depression (Facebook, November 2020)

Articles:

TMS Therapy (Palos Health website, 2020)
Coping with Pandemic Stress (Palos Health Website, 2020)
Struggling Emotionally During COVID-19 (Facebook, March 2020)
TMS Therapy (Facebook, July 2020)

Strategy 2.5:

Develop stronger relationships with referring agencies such as Pathlights and Crisis Center for South Suburbia.

Crisis Center for South Suburbia: Staff Christmas donations
National Suicide Prevention Lifeline: Crisis line phone number included on all discharge paperwork, after-visit summaries and patient safety plans
Alcoholics Anonymous (AA): Provide meeting space so AA volunteers can regularly meet with patients in both the inpatient and outpatient programs
Emotions Anonymous (EA): Provide meeting space and refer patients
Trinity Services, Inc.: Mutual participation in the Reducing Risk and Recidivism initiative, which is a three-year federal grant focusing on developing a mobile crisis response unit; providing training to officers, behavioral health providers and the community; and holding resource awareness events to connect community members to services. This initiative began in October 2019, and Maria Singer, RN, represented Palos on the interagency committee. Palos committed to a working relationship with the police departments and Trinity Services for patients with mental health and substance use disorders in the community. This collaboration includes:
Police departments (six): Orland Park, Orland Hills, Palos Park, Palos Heights, Oak Forest, Midlothian
Hospitals (three): Palos, Ingalls, Silver Oaks
Trinity Services, Inc.
EMS and first responders
Representatives from local community agencies
Office of the State's Attorney
Office of Guardianship and Advocacy (Illinois)

Strategy 2.6:

Expand support group offerings to increase options for family members with loved ones facing mental health or substance misuse issues.

AA	Recovery Group (patients discharged from SUDIOP or PHP/IOP Dual Diagnosis)
Al-Anon	
Emotions Anonymous	Mental Health Recovery Group (PMG)
Smart Recovery (began 2018 and facilitated by Palos Health staff, with an additional group started by community members in 2019)	Family Wellness Recovery Group (family members of current patients in PHP/IOP)
Smart Recovery Family & Friends (began 2018 and facilitated by Palos Health staff)	Aftercare - Staying on your Path (patients who successfully completed SUDIOP or Co-Occurring Programs)

Priority health need 3: Chronic Disease

Goal:

Serve as an educational resource regarding the importance of food and nutrition as it relates to the prevention and management of chronic disease.

Strategy 3.1:

Enhance care coordination program to help patients manage their condition through appointments and resources.

Caregiver Resource Center

Newly opened in 2018; 143 family contacts

In 2019, 570 family contacts

October 10th, 2019: 88 people attended Alzheimer's: Effective Communication Strategies

May 8, 2019: 110 people attended Understanding and Responding to Dementia-Related Behaviors

Pathlights, Palos Health and the Alzheimer's Association coordinated these events

In 2020, the center was closed for in-person visits much of the year due to COVID-19, but was available for phone and 276 family contacts were made

In 2021, the center began to gradually reopen, mirroring visiting regulations at the hospital

Caregiver Support Groups

2018: 93 participants

2019: 124 participants

2020: 62 participants

2021: 17 participants in January and February

Bereavement (non-hospice)

We currently have 122 bereaved participants in the community receiving all or one of the following: mailings, attending groups and phone support.

Other events

Presentation on hospice and palliative care at St. Damian School by Bernie Crean, Barbara Carroll and Kathy Beary (January 16, 2019)

Cancer Resource Fair coordinated by Nancy Stang and assisted by the Caregiver Resource Center (October 1, 2019)

Presentation on safety and balance by Mike Muchowicz at Gaelic Park for Pathlights (October 19, 2019)

Strategy 3.2:

Improve relationship with area food pantries to educate clients about how nutrition impacts long-term health.

Palos Health Nutrition and Food Service Department's involvement with Beds Plus Care:

Starting in 2018, the Nutrition and Food Service department began saving leftover food items for donation to Beds Plus Care.

Leftover food items were properly packaged, labeled and stored throughout the week.

A driver associated with Beds Plus Care picked up the food items each Friday.

These food items were used to feed the residents at the shelter in La Grange, Illinois.

These food donations were paused when the COVID-19 pandemic began.

Strategy 3.3:

Work with area homeless shelters to provide nutritious meals.

Palos and its employees are committed to working with area homeless shelters to provide nutritious meals. This program was able to grow because of a cash donation, which enabled the delivery of food to clients staying in motels during the pandemic. In addition, personal care items were provided via care packages, and recipients received healthy lunches and dinners for an additional day.

A total of 540 meals and clients were served during this time frame. (Note that March and April 2020 plans were cancelled because of COVID-19).

The Pastoral Care Department provided a donation of \$515 to provide microwavable meals to people in need.

Homeless Shelter Beds			
	2019		2020-2021
January	60	October	60
February	60	November	60
March	60	December	60
April	60	January	60
		February	60
Total	240 meals and clients	Total	300 meals and clients

Strategy 3.4:

Review opportunities for growth of Palos Hospital's Home-Delivered Meal program.

The Home-Delivered Meal program provides access to nutritious food, in addition to a wellness check for participants. Any changes in a client's health or other issues are reported. Clients have reported appreciation for the kind-hearted volunteers.

A total of 14,503 meals were served during this time frame.

During the pandemic, the need for this service was amplified because of an increased number of seniors sheltering in place and needing access to food.

Program outcomes are regularly provided to Social Services and Home Health Care.

Clients have the option to receive a protein drink, free of charge, with their meal.

Improvements are planned to increase awareness among physicians so they can connect patients to a hot healthy meal and increase food access.

Home-Delivered Meal Program		
Type	2019	2020
Hot meals	3,340	4,326
Hot and cold meals	2,969	3,868
Total	6,309	8,194

Priority health need 4: Transportation and Housing**Goal:**

Develop new avenues for delivering care to patients to address issues related to transportation.

Strategy 4.1:

Grow community-based medicine to address the healthcare needs of patients who are homebound.

There are 112 bereaved people from the community in the program who receive all or one of the following: mailings, group sessions and phone support. (This is in addition to the 800 families in the hospice program.)

The bereavement program is a hospice Medicare benefit; if a bereaved person is not attending sessions or receiving individual calls or support after 13 months, the care plan is resolved.

The Community-Based Medicine program has a census of more than 700 patients and provides a combination of house calls and palliative care.

Strategy 4.2:

Launch a pilot program that provides discounted transportation for patients receiving rehabilitation therapy.

This strategy was not addressed because of unforeseen circumstances.

Appendix A

Resources Available to Address the Significant Health Needs

The following list represents potential healthcare facilities and community organizations available to address the significant health needs identified in this report. This list was identified by key informants and reflects input from the Online Key Informant survey. This list should not be considered exhaustive or all-inclusive as a list of available resources.

Access to Healthcare Services	<ul style="list-style-type: none"> Arab American Family Services Cook County Department of Public Health Federally Qualified Healthcare Centers Shriver Center, Get Care Illinois
Cancer	<ul style="list-style-type: none"> Advocate Christ Medical Center Cook County Department of Public Health Healthcare facilities Hospitals Northwestern Medicine Palos Hospital Rush University Medical Center
COVID-19	<ul style="list-style-type: none"> Cook County Department of Public Health Physicians' offices Federally Qualified Healthcare Centers Healthcare facilities
Dementia and Alzheimer's disease	<ul style="list-style-type: none"> Advocate Christ Medical Center Healthcare facilities Home services Northwestern Medicine Palos Hospital
Diabetes	<ul style="list-style-type: none"> American Diabetes Association Physicians' offices Healthcare facilities
Disabilities	<ul style="list-style-type: none"> AMITA Health Bridgeview Health Care Center Advocate Christ Medical Center Metropolitan Family Services Pillars Community Health

Heart Disease	American Heart Association American Lung Association Physicians' offices Healthcare facilities Hospitals Respiratory Health Association
Injury and Violence	Police departments
Kidney Disease	Healthcare facilities Hospitals
Mental Health	Advocate Family Health Network Cook County Department of Public Health Education First responders Hospitals Metropolitan Family Services NAMI Northwestern Medicine Palos Hospital Pillars Community Health Private facilities Social Services TASC (Treatment Alternatives for Safe Communities) The Cognitive Clinic
Nutrition, Physical Activity and Weight	Active Transportation Alliance Chicago Food Policy Action Council Cook County Department of Public Health Parks and recreation
Oral Health	Aspen Dental Beloved Community Family Wellness Center Bridgeview Smiles Pillars Community Health
Respiratory Disease	American Lung Association

Substance Use Disorder

Gateway Foundation
Haymarket Center
Hospitals
Lutheran Social Services of Illinois
South Suburban Council on Substance Abuse
Southwood Interventions
Treatment facilities

Tobacco Use

American Cancer Association
American Heart Association
American Lung Association
Cook County Department of Public Health
Drugstores
Freedom From Smoking app
Hospitals
Northwestern Medicine Palos Hospital
Respiratory Health Association

Appendix B

Timeline for the Northwestern Medicine Palos Hospital 2021 Community Health Needs Assessment

Phase	Description	Date
Assessment and analysis	Overall	January to May 2021
	Population survey	February to April 2021
	Key Informant Survey (Online)	March to April 2021
Prioritization	Overall	May to June 2021
	Community Stakeholders (people representing the broad interest of the community)	May 20, 2021
	NMPH Community Health Council (internal)	May 25, 2021
	NMPH Community Affairs (internal)	May 27, 2021
Approval	South Region Board of Directors	July 8, 2021
Report made widely available to the public	Website	August 31, 2021
	Paper copy available at no charge on request	August 31, 2021
Public comment	NMPH 2021 CHNA	August 31, 2021, through August 30, 2027
	Palos Community Hospital 2019 CHNA	December 31, 2018, through August 30, 2022



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