Northwestern Medicine®

2024 Community Health Needs Assessment

Northwestern Medicine Kishwaukee Hospital

Your Feedback Makes Us Better

Northwestern Medicine is committed to building healthier communities. Your voice is important for helping us understand your lived experiences in your community.

Northwestern Medicine Kishwaukee Hospital encourages comments from the public regarding our Community Health Needs Assessment (CHNA) process or findings. Please submit comments to communityhealth@nm.org, and include your name and organization, if applicable.

This report was adopted by the Kishwaukee Community Hospital Board of Directors on July 30, 2024, and made available to the public on August 31, 2024. It was created in accordance with federal IRS regulations (26 C.F.R. § 1.501(r)-3).

Foreword

Our Commitment to Equity

The world has experienced dramatic change in the last few years. From the medical, social and economic challenges brought on by the COVID-19 pandemic, to the painful and increasing inequities that are affecting people across the country, now more than ever, we are called to be better.

Better is a philosophy that drives everything we do at Northwestern Medicine. Just as we are driven to provide better care, better treatments and better patient experiences, we also are relentless in our pursuit of building better communities.

Three pillars of community work

This Community Health Needs Assessment may be on a three-year cycle, but our community work happens every day, in every department. In short, this is who we are.

Two areas span our community pillars and touch every strategy we have for addressing the priority health needs of our communities.

Structural inequities and bias

We elevate initiatives that:

- Facilitate community engagement and cultivate new relationships
- Allow us to work with long-standing community allies to address health inequities
- Invest in disparity research
- Foster ongoing bias training for all employees and clinicians
- Ensure Northwestern Medicine is a safe and welcoming environment for all patients

Coordination and connection to community resources

We elevate initiatives that:

- Strengthen community-clinician relationships
- Lead to better care and coordination
- Connect patients with community resources

Every member of the Northwestern Medicine workforce is dedicated to our vision of a stronger, healthier and **better** life for those in the communities we are privileged to serve.

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Introduction to the Community Health Needs Assessment

Since 2009, Northwestern Medicine Kishwaukee Hospital has completed a comprehensive Community Health Needs Assessment (CHNA) every three years. This process helps us better understand who lives in the communities we serve as well as the biggest health issues they face.

Goals of our CHNA

The goals of the CHNA were to:

- Learn about the health needs of residents within the hospital's Community Service Area
- Identify which needs are most important to address
- Identify resources available to address those needs

Northwestern Medicine is committed to **improving the health of the communities we serve**. The CHNA process helps us achieve this mission.

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How we achieved our goals

For the 2024 CHNA, Northwestern Medicine Kishwaukee Hospital collaborated with Metopio to learn about the communities we serve and their health needs. Metopio is a software and service company that is grounded in the philosophy that communities are connected through places and people. Metopio uses data visualization to reveal valuable, interconnected factors that influence outcomes in various locations.

Together with Metopio, we gathered information from a variety of sources, including direct community input through surveys, focus groups and key informant interviews. After we collected and analyzed this information, we interpreted the findings to identify the most significant health needs affecting the communities we serve. Then, we worked with community representatives to help identify which needs were the most important for Northwestern Medicine to address over the next three years.

We identified health needs among people across all:

- Socioeconomic groups
- Races and ethnicities
- Sexual orientations and gender identities
- Ages

While we assessed information across our entire service area, this report highlights health inequities and needs that disproportionately impact people in communities that have been historically under-resourced and have a higher percentage of people with barriers to health and wellness, such as a lack of medical insurance.

Priority health needs

Many health needs were identified through the CHNA process. To identify which needs to address, we considered which were most widespread, severe and persistent. Then we considered which needs would be best addressed through a collaboration with community organizations. These needs are the priority health needs we will focus on over the next three years.

The priority health needs for Northwestern Medicine Kishwaukee Hospital in the 2024 CHNA are:

- **Access to Health Care**
- **Behavioral Health**
- **Cardiovascular Disease**

Addressing identified priority health needs

Northwestern Medicine Kishwaukee Hospital will use the information and insight gained through this assessment to guide our work on improving the health of the communities we serve. We will develop an implementation plan to detail how we will address priority health needs in collaboration with healthcare, social service, public health and policy organizations.

Drawing on our collective resources, **together we can address the priority health needs of residents** in our defined Community Service Area.

Acknowledgments

We rely on voices within the communities we serve to help us better understand the needs and issues that affect the health of their residents. This CHNA and the work that will come out of it would not have been possible without discussions with key community collaborators, organizations and residents. We are grateful to everyone who dedicated their time to share their insights with us.

We also gratefully acknowledge Metopio for their collaboration and significant efforts in the completion of this CHNA.

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Who We Are

Get to know Northwestern Memorial HealthCare

Who we are

Nonprofit | Growing, nationally recognized | World-class care

Who we serve

Rural | Suburban | Urban

People with a broad range of socioeconomic statuses and needs associated with social determinants of health

We are...

- Pushing boundaries in our research labs
- Training the next generation of physicians and scientists
- Pursuing excellence in patient care

Our mission

Provide quality medical care regardless of the patient's ability to pay

Transform medical care through clinical innovations, breakthrough research and academic excellence

Improve the health of the communities we serve

About Northwestern Medicine Kishwaukee Hospital

How we achieve our mission

As a pillar in its community, Northwestern Medicine Kishwaukee Hospital is uniquely positioned to lead efforts to positively impact community health.

- We provide culturally informed care to meet the needs of those who live in our communities.
- We maintain strong relationships with community organizations that share our vision of building stronger, healthier communities.
- We are a major economic driver in the communities we serve.

About Northwestern Medicine Kishwaukee Hospital

98 beds

Acute care

Located in **DeKalb County**, Illinois

Services: The hospital provides care through a broad range of specialties and unique services, including a state-of-the-art Breast Health Center, which opened in 2019. Located on the hospital's campus, Northwestern Medicine Ben Gordon Center provides mental health counseling and substance misuse treatment for DeKalb County residents.

Community: Mostly rural area

Northwestern Medicine Kishwaukee Hospital

Located in DeKalb, Illinois, Northwestern Medicine Kishwaukee Hospital is an acute-care, 98-bed community hospital with an enduring commitment to the residents of DeKalb County. Due to the low ratio of primary care physicians and advanced practice providers to residents in DeKalb County, portions of the county have been designated by the federal government as a Medically Underserved Population (MUP). Northwestern Medicine Kishwaukee Hospital provides much-needed access to quality health care in its community. In fiscal year 2023 (FY23), the medical staff of 349 physicians treated patients through more than 5,600 inpatient admissions and nearly 34,000 emergency department visits.

Northwestern Medicine Kishwaukee Hospital has a rich history of caring for the community.

We work with trusted community-based organizations to identify and respond to priority health needs within our community and systematically reduce barriers to patient care services. Together, we have developed important initiatives to minimize risk factors for chronic disease in addition to providing access to care.

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Defining the Community Service Area

How the Community Service Area was determined

Northwestern Medicine Kishwaukee Hospital defined the Community Service Area (CSA) used in this CHNA by considering:

- Geographic area served by the hospital
- Main functions of the hospital
- Areas that have been historically under-resourced
- Areas where we are currently working on addressing priority health needs, including work with community organizations

The defined CSA takes into account populations that are:

- Medically under-served
- Low-income
- Historically under-represented, minority populations

Our CSA definition does not take into account how much patients or their insurers pay for care or whether patients are eligible for financial assistance through Northwestern Medicine.

How the Community Service Area is defined

DeKalb County, Illinois

504.2 square miles

89,468 residents

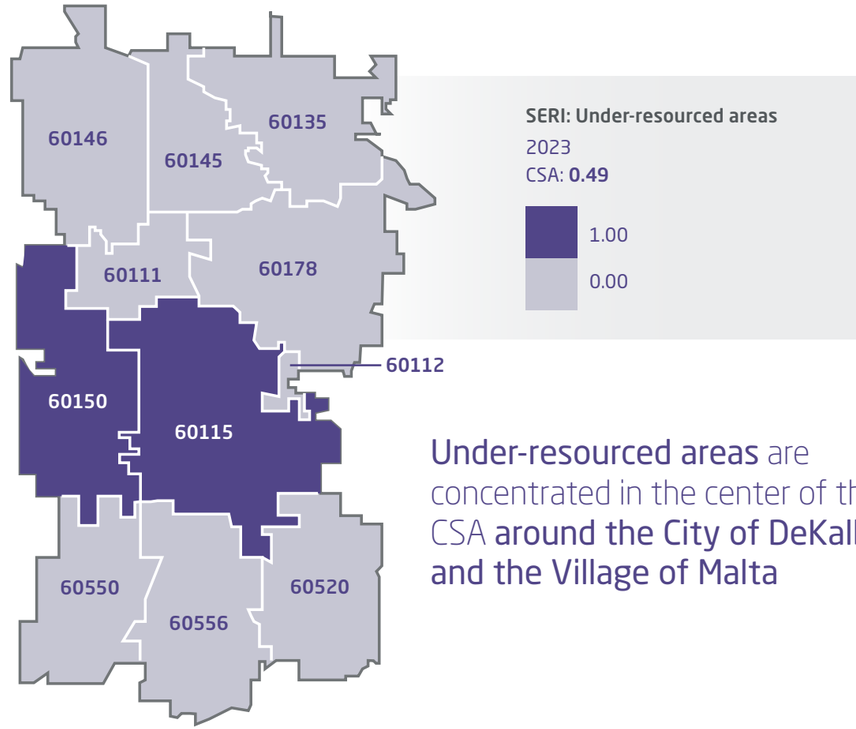
Predominantly **rural**

CSA Cities and ZIP Codes			
City	**ZIP Code**	**City**	**ZIP Code**
Clare	60111	Malta	60150
Cortland	60112	Sycamore	60178
DeKalb	60115	Hinckley	60520
Genoa	60135	Shabbona	60550
Kingston	60145	Waterman	60556
Kirkland	60146		

Community Service Area map

Once the CSA has been defined, we use the Socioeconomic Resource Index (SERI) to identify areas experiencing economic hardship. Under-resourced areas are identified based on multiple indicators, including:

- Unemployment (for individuals older than age 16 years)
- Education (those older than 25 years without a high school diploma)
- Per capita income level
- Crowded housing (more than one person per room)
- Dependents (younger than 18 or older than 64 years)
- Poverty (income below 200% of the federal poverty level)



Under-resourced areas are concentrated in the center of the CSA **around the City of DeKalb and the Village of Malta**

Northwestern Medicine Kishwaukee Hospital Community Service Area. Locations in dark purple have been identified as under-resourced communities by SERI.

Completing the Assessment

Northwestern Medicine performed the CHNA from October 2023 through April 2024. We worked with Metopio to plan for data collection and analysis, and we took an intentional approach to build on previous CHNAs.

We conducted surveys, focus groups and key informant interviews to gather primary data directly from those in the community. We also looked at secondary data, such as local health statistics. Taken together, the data allowed us to identify health trends and compare the health needs in our CSA to benchmarks at the city, county, state and national levels.

Once the data was collected, it was analyzed and reviewed by community health experts. Then, we presented it to key collaborators in the community and Northwestern Medicine Kishwaukee Hospital employees, who identified which needs should be prioritized.

Primary data

Community input is the most important data for the CHNA, as it provides the most real-time information about community health needs. This is particularly true in the context of the COVID- 19 pandemic, as we were able to gain first-hand information from communities most impacted by inequities that lead to poorer outcomes from COVID-19.

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Community input surveys at a glance

- Conducted from October 2023 to January 2024 by Metopio
- Insights collected from 1,683 survey participants within the defined CSA
- Intended to gain first-hand information from people who are typically under-represented in the assessment process including people of color, immigrants, people who identify within the LGBTQ+ community, people with disabilities and people with low incomes
- Collected from individuals 18 years and older
- Available online or on paper
- Disseminated in English and Spanish
- Seventy-six questions
- Asked about demographic data, community health status, strengths, opportunities for improvement and COVID-19 effects
- Promoted widely through social media, email blasts and in-person events
- Shared survey link and paper copies with community organizations for their distribution

Additional information regarding the survey can be found in Appendix D.

Focus groups at a glance

- Conducted in January and February 2024 by Metopio
- Four community focus groups within the CSA
- Participants were 18 years or older and represented a diverse range of ethnic, racial, religious and socioeconomic backgrounds
- Northwestern Medicine recruited participants through hospital community collaborations
- One focus group was held with healthcare and social service organizations
- Asked about community strengths, needs, underlying root causes of health needs, COVID-19 effects, solutions to identified health needs and communication strategies

Additional information on focus group sessions can be found in Appendix D.

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Key informant interviews at a glance

- Conducted in March and April 2024 by Metopio
- Interviews with 10 key informants from the CSA
- Participants represented a diverse range of ethnic, racial, religious and socioeconomic backgrounds
- Northwestern Medicine recruited participants through hospital community collaborations
- Asked about community strengths, needs, underlying root causes of health needs, COVID-19 effects, solutions to identified health needs and communication strategies

Additional information on key informant interviews can be found in Appendix D.

Secondary data

With help from Metopio, secondary data was identified, compiled and analyzed. The following key topics were chosen for analysis:

- Social Determinants of Health
- Health Conditions
- Health Behaviors

Secondary data sources at a glance

- Peer-reviewed literature and white papers
- Existing assessments and plans focused on key topic areas
- Local data compiled by DeKalb County government agencies
- Local data compiled by community-based organizations
  - Feeding America
  - Mapping COVID-19 Recovery Initiative
- Illinois Health and Hospital Association/COMPdata: Hospitalization and emergency department rates
- State agencies:
  - Illinois State Board of Education
  - Illinois Department of Healthcare and Family Services
  - Illinois Department of Human Services
  - Illinois Department of Public Health
- Federal sources:
  - Centers for Disease Control and Prevention PLACES project
  - Centers for Medicare & Medicaid Services data accessed through the Dartmouth Atlas of Health Care
  - Environmental Protection Agency
  - Health Resources and Services Administration
  - Housing and Urban Development
  - United States Census Bureau American Community Survey
  - United States Department of Agriculture

Key Findings

The following describes the data we collected for Northwestern Medicine Kishwaukee Hospital.

Who lives in the communities we serve

Demographics

Demographics affect each person's ability to be healthy. Considering the demographic makeup of a community is crucial for shaping community health initiatives to improve health outcomes.

Population[1]

89,468
residents

Sex[1]

45,108
(50.4%)
females

44,360
(49.6%)
males

Accurate and complete data for people who are transgender, nonbinary and gender-nonconforming in DeKalb County is limited.

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Age[1]

Age Group	Population in the CSA	Percentage in the CSA
17 and younger	18,988	21.2%
18 to 39	34,853	39.0%
40 to 64	24,091	26.9%
65 and older	11,536	12.9%

This information is important, as different age groups have unique health needs that must be considered when planning a response to community need.

Race and ethnicity[1]

- Majority non-Hispanic white population
- The non-Hispanic black population and Hispanic/Latin American population have increased over the last decade

Race and Ethnicity	Population in the CSA	Percentage in the CSA
Non-Hispanic White	65,121	72.9%
Hispanic/Latin American	11,345	12.7%
Non-Hispanic Black	7,522	8.4%
Two or more races	3,010	3.4%
Non-Hispanic Asian	2,303	2.6%
Indigenous American	68	0.1%

Language[1]

Language skills affect the ability to access, understand and act on health information.

6.8% of CSA residents
were not born in the United States (as compared with 14.1% of residents in Illinois)

1.9% of CSA residents
speak limited English (as compared with 3.9% of residents in Illinois)

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Social determinants of health

Up to 80% of health outcomes are influenced by the ways in which people live, work, play and worship, known as social determinants of health (SDOH).[2] SDOH relate to social and economic opportunities, community resources, quality education, workplace safety, environmental factors and the nature of social interactions and relationships. SDOH help explain why some people in the United States are healthier than others.

Access to Health Care

Access to health care is broadly defined as the "timely use of personal health services to achieve the best health outcomes."[3] The ability to access health insurance is essential for promoting and maintaining health as well as preventing and managing disease.

According to Healthy People 2030, people without insurance are less likely to have a primary care physician, and they may not be able to afford the healthcare services and medications they need.[4]

Healthcare access and quality can vary greatly between communities. Within the CSA, 4.5% of residents do not have medical insurance, which is 2.5 percentage points lower than the state average (7.0%).[1]

Health insurance is not the only factor affecting the ability to access health care. Even those with health insurance can face barriers to accessing appropriate and timely care related to:

- Ease of access to health clinics
- Insurance coverage and public benefit
- Immigration status
- Access to linguistically and culturally appropriate services
- Extensive paperwork and approvals before accessing care

Focus groups noted DeKalb County residents face transportation barriers, including lack of public transit and limited access to ride-hailing services (such as Lyft and Uber), affecting their ability to access social services.

Focus groups also noted transportation barriers impact elderly and disabled individuals the most.

Community Input:[23] Access to Health Care

"We hear about a lot (of access challenges) just because of where we are geographically, and how wide the distance within our county to be able to get places. Most of our social services and health care resources are centralized in the DeKalb-Sycamore area. And so, we hear a lot about those who are in the North part of the county in the South part of the county, maybe not having equal access to those services."

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Economic Stability

Poverty is a key driver of health status and outcomes, such as life expectancy, infant mortality and development of chronic health conditions. It creates barriers to accessing things that are important for good health, such as medical care and healthy food.

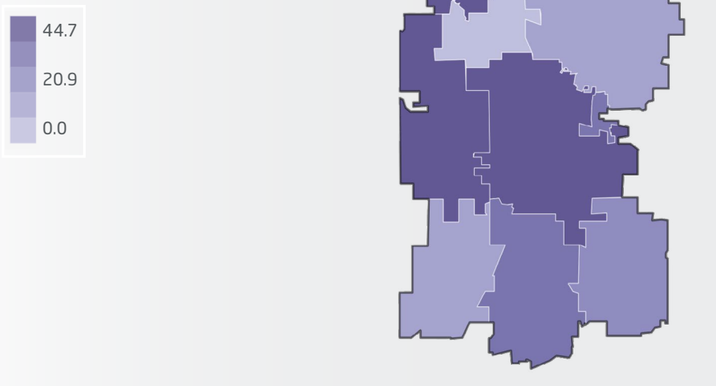
In Illinois, the median household income is $71,917, which is higher than the CSA's median household income at $61,321. When looking at the communities making up the hospital CSA, DeKalb (ZIP code 60115) has an even lower median household income at $43,380.[1]

Socioeconomic Status	Population in the CSA	Percentage in the CSA
Persons Living at or Below the Federal Poverty Level	15,031	16.8%
Persons Living at or Below 200% of the Federal Poverty Level	28,361	31.7%

Below 200% of poverty level

2018-2022

CSA: **31.70** ±2.51% of residents



Education

Poverty, unemployment and underemployment are highest among those with less education. A higher level of education is linked to positive health outcomes.

Within the CSA[1]:

- 92.8% of residents 25 years and older have at least a high school degree (or equivalent).
- That value is 90.1% for the state of Illinois.

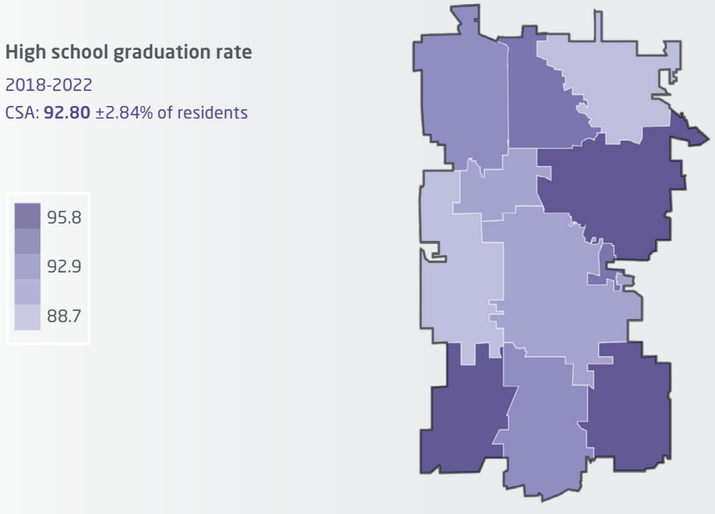
Community Input:[23] Education:

One focus group participant mentioned that the DeKalb School District has implemented various measures to support children's mental health, including social emotional learning (SEL) lessons and a reporting system for bullying and self-harm.

High school graduation rate

2018-2022

CSA: **92.80** ±2.84% of residents



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Employment

Financial security makes it easier for individuals and families to obtain resources for healthy living and serves as a predictor for positive health outcomes.

From 2018-2022[1]:

- The unemployment rate in the CSA was 7.3%.
- Hinckley (60520) had the highest unemployment rate in the CSA at 14.8%.

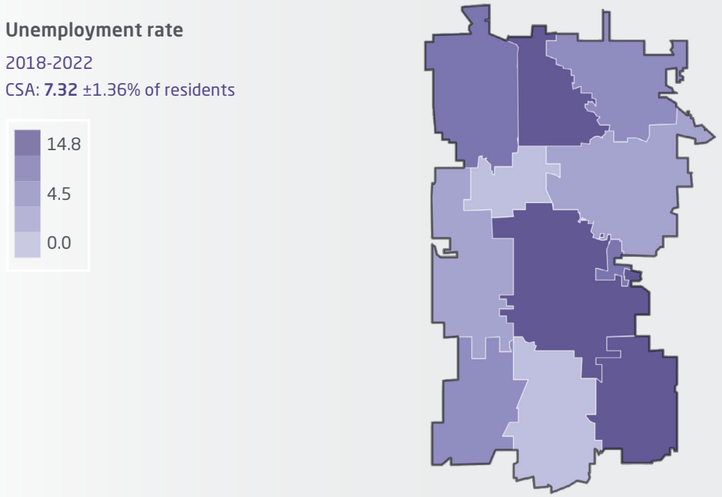
Community Input:[23] Employment

"Families don't have the disposable income that they used to have."

Unemployment rate

2018-2022

CSA: **7.32** ±1.36% of residents



Environmental Equity

Another socioeconomic factor – a healthy or livable environment – refers to the surroundings in which an individual resides, lives and interacts. DeKalb County has a wide range of environmental conditions, from denser suburbs to farms to wilderness.

A clean, safe and healthy environment is a significant contributor to the health of individuals and populations.

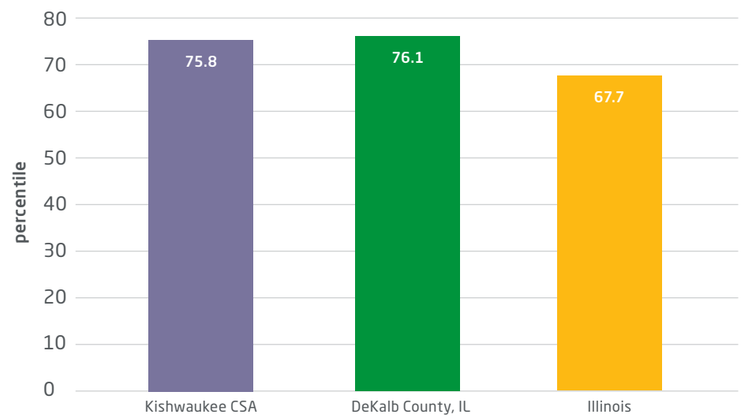
The neighborhood environment can affect health outcomes in many ways. Particulate matter is one of the most dangerous pollutants because these particles can penetrate deep into the lungs and cause negative health effects. This includes premature death from cardiovascular disease or lung cancer, and increased health problems such as asthma attacks.

In the CSA, vulnerability to particulate matter was estimated in the 76th percentile, which is higher than Illinois in the 68th percentile.[6] This rating is based on the Particulate Matter Environmental Justice Index, in which 0 is the lowest exposure and 100 is the highest exposure.

Additionally, research has shown that emissions from farms outweigh all other human sources of fine-particulate air pollution in much of the United States. Agricultural air pollution comes mainly from ammonia from fertilizers and animal waste that combine in the air with industrial emissions to form solid particles.

Particulate matter Environmental Justice Index, 2022

Kishwaukee CSA and comparison



Created on Metopio | metop.io/i/8yfzo658 | Data source: Environmental Protection Agency (EPA): EJScreen: Environmental Justice Screening (EJSCREEN)

Particulate matter Environmental Justice Index: Weighted index of vulnerability to particulate matter. Measures exposure to PM 2.5 in the air, weighted by population vulnerability and reported as a percentile nationally, where 0 - lowest exposure, and 100 - highest exposure. Weighting by the vulnerability of residents can provide a better estimate of the disproportionate impact of environmental hazards.

Food Access and Security

A healthy food environment gives residents the ability to buy healthy foods close to where they live. Those who cannot afford or access healthy food are more likely to have a less healthy diet, which increases risk of illnesses such as cardiovascular disease, some cancers, obesity, Type 2 diabetes and anemia.

In addition, people who do not have enough food to eat may have a harder time learning, may not develop properly, and may have physical and psychological health challenges.

Inflation since the COVID-19 pandemic has significantly impacted the food environment. Families with children are more likely to have experienced food and nutrition insecurity since the start of the pandemic.

Food insecurity is defined as limited or uncertain access to adequate food and may be caused or exacerbated by cost or distance to a grocery store. In the CSA, an estimated 14.2% of residents experience food insecurity, which is higher than the state (8.3%).[8]

Community Input:[23] Food Access and Security

One focus group participant mentioned that walking to the nearest Women, Infants, and Children (WIC)* clinic would take a long time and may not be safe for expectant mothers in cold weather. Another focus group participant highlighted the lack of public transportation, making it difficult to access resources like WIC.

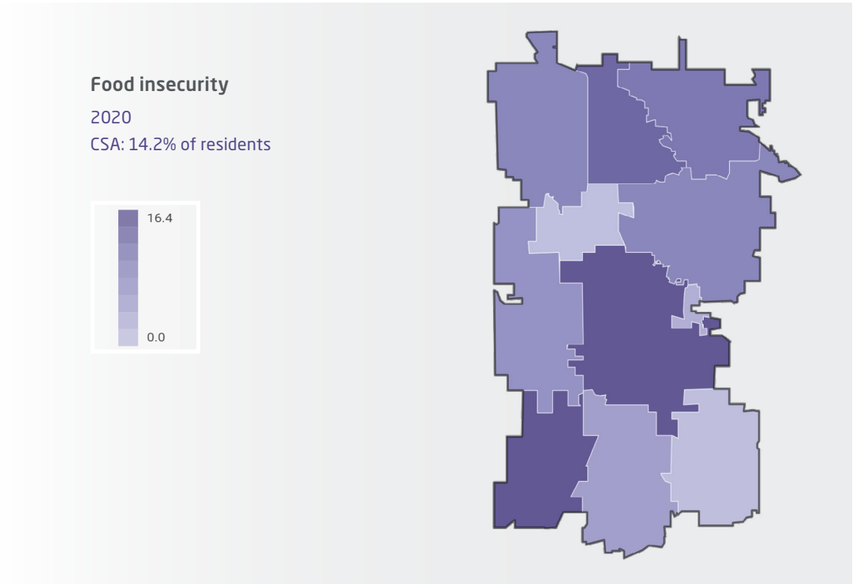
Another focus group participant thought that the WIC program struggles to provide enough benefits for groceries.

Food Access and Security (continued)

In focus group discussions, community members discussed food insecurity in the area and potential solutions, including Meals on Wheels and Elder Care Services programs.

In the CSA, food insecurity is highest in DeKalb (60115) with 16.4% of residents experiencing food insecurity and in Shabbona (60550) with 14.3%.[8]

In addition, 12.7% of households in the CSA receive Supplemental Nutrition Assistance Program* (SNAP) benefits.[1]



*WIC is a federal nutrition program for women, infants and children up to age 5 years who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating including breastfeeding promotion and support, and referrals to health care.[7]

*Supplemental Nutrition Assistance Program (SNAP) is a federal nutrition program that improves access to food for those who are eligible. SNAP benefits can be used to purchase foods at grocery stores, convenience stores and farmers markets. People without documented status are generally not eligible for federal assistance programs such as SNAP.

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Homelessness and Housing Instability

In the CSA, **36.0% of survey respondents said affordable and safe housing** was a top concern. Homelessness was identified as both a root cause and a direct outcome of substance use disorders and chronic disease. Addressing housing issues offers a unique opportunity to address an important SDOH.[2]

In addition, 33.7% of households in the CSA are considered housing cost burdened, which means that the household spends more than 30.0% of their income on housing.[1] This percentage is 29.0% in the state of Illinois.[1] This significantly impacts their ability to pay for other necessities, such as food, transportation and health care.

Further, 15.3% of households in the CSA are considered severely housing cost burdened, which means that the household spends more than 50.0% of their income on housing.[1] This percentage is 13.6% in the state.[1]

Community Input:[23] Homelessness and Housing Instability

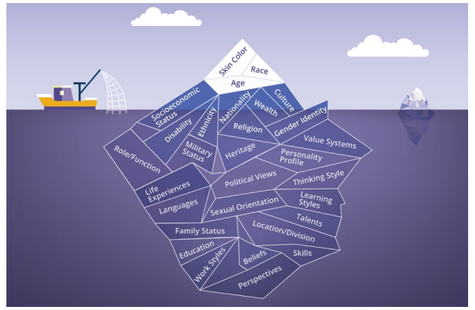
Regarding intergenerational households, one focus group participant shared their experience living in the same house they grew up in after both parents passed away.

Another focus group participant noted that intergenerational households are common in the community, with adult children unable to live independently because of financial stress or other reasons.

Many households have reported experiencing **serious financial problems** as a result of the global economic impact of the pandemic.[1] Focus group participants noted that **housing instability is a major issue in the community,** with many families facing financial difficulties and crowded living spaces.

Additionally, focus group participants discussed the inaccessibility to housing for vulnerable populations. One participant noted that the application for affordable housing and internet plans may be too complex for some families to understand. Another participant said that DeKalb County is making strides towards more accessible housing for vulnerable populations such as homeless veterans and individuals with mental illness.

Structural Inequities and Bias



Northwestern Medicine is a community of caregivers who welcome, respect and serve all people without regard to age, race, color, national origin, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression or military or veteran status.

Community Input:[23] Structural Inequities and Bias

A focus group participant said that in DeKalb, international students and families face challenges accessing support services because of language barriers and cultural differences, with limited resources available beyond individual advocacy and support groups.

Another focus group participant highlighted the importance of building relationships with families and primary medical clinicians to ensure health equity.

Another focus group participant emphasized the need to understand the diversity of the community and approach health equity with a lens of strength within every family.

Disability Cultural Responsiveness

The Americans with Disabilities Act (ADA) defines disability as a physical or mental impairment that substantially limits one or more major life activities of an individual. Major life activities can include caring for yourself, speaking, thinking, walking or performing manual tasks.

Northwestern Medicine provides reasonable accommodations to patients with disabilities when requested or needed. Patients and companions with disabilities have a right to request reasonable accommodation. These are provided at no cost to the patient or companion. Northwestern Medicine also provides reasonable accommodations through an interactive process to its employees and clinicians.

By providing reasonable accommodations, Northwestern Medicine ensures equitable care, effective communication and compliance with disability rights laws (such as the ADA).

LGBTQ+ Cultural Responsiveness

Providing a safe, affirming environment is essential to welcome patients from the LGBTQ+ community. There is evidence that sexual minorities (LGBTQ+) and transgender or gender-nonconforming patients can have significant difficulty in accessing appropriate care, developing trust in the care team and receiving safe and effective health care throughout their lives.[21]

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Structural Inequities and Bias (continued)

Structural Racism

Structural racism is defined as "the totality of ways in which societies foster [racial] discrimination, via mutually reinforcing [inequitable] systems (in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc.) that in turn reinforce discriminatory beliefs, values, and distribution of resources," reflected in history, culture and interconnected institutions.[9]

Structural racism, also known as systemic racism, is racial bias among institutions and across society[9]. It involves the cumulative and compounding effects of an array of societal factors, including the history, culture, ideology and interactions of institutions and policies that systemically advantage white people and disadvantage people of color.

Systemic and structural racism play a large part in determining where people live and therefore have a downstream effect on health outcomes. These realities make it more likely that people from certain minority groups will live in areas that lack access to:

- Healthy food
- Transportation
- Housing
- Parks, playgrounds and other places to connect with community

Transportation

In the CSA, **24.6% of survey respondents indicated transportation** was an important community issue. Safe and reliable transportation is essential to accessing healthcare appointments, social services, work, school and grocery stores. A lack of transportation is associated with adverse health outcomes.

Although most households in the CSA have access to a car, many people still lack access to reliable and affordable public transportation.

The CSA does not have a large public transit network, so only 0.8% of residents commute to work by bus, compared with 7.0% statewide.[1]

For those who do have a vehicle, the cost of gas has made it more difficult to use that vehicle to perform daily tasks such as driving to work, school, medical visits or grocery shopping.

Community Input:[23] Transportation

Residents struggle with limited public transportation options and lack of access to local grocery stores, gyms and the wellness center.

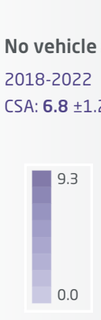
DeKalb residents face transportation barriers, including lack of public transit and limited access to ride-hailing services, affecting their ability to access social services.

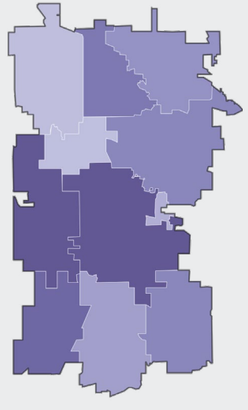
Within the CSA, **6.8%** of households have no vehicle available. That percentage climbs to 9.3% in DeKalb (60115).[1]

No vehicle available

2018-2022

CSA: **6.8** ±1.29% of households





Violence and Community Safety

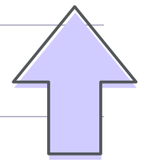
The root causes of community violence are multifaceted and include issues such as:

- Concentration of poverty
- Education inequities
- Poor access to health services
- Mass incarceration
- Differential policing strategies
- Generational trauma

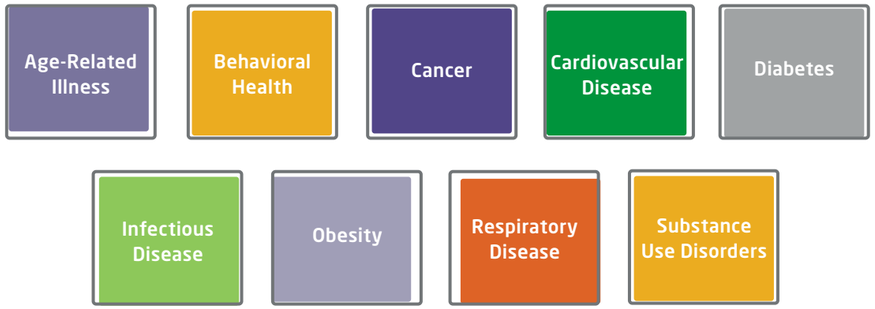
COVID-19 has increased economic instability and stressors within communities, contributing to increased gun violence, interpersonal violence and child abuse.

Within the CSA, 20.0% of survey respondents report that safety is a top concern in the community.

Overall, violent **crime has been increasing** in DeKalb County over the past decade.[10]



Health conditions



Overall, estimates of disease burden in the CSA are similar or slightly lower than those reported for the state of Illinois.

Health Condition[11]	Prevalence in the CSA	Prevalence in Illinois
Obesity	35.7%	33.6%
High Blood Pressure	26.6%	29.0%
Diabetes	7.6%	9.8%
Asthma	10.4%	9.5%
Cancer (diagnosis rate per 100,000 residents)	667	571

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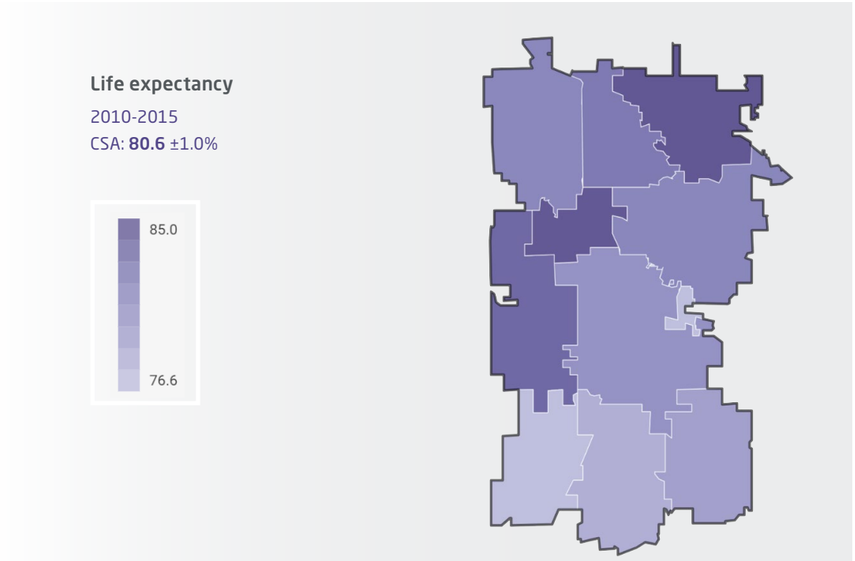
Life expectancy in the CSA

Life expectancy is a core measure of the overall health of a community. It allows for comparisons between generations and to understand the long-term impact of macro changes in community conditions, such as an epidemic or systemic poverty and a lack of access to resources. In the CSA, there is an eight-year gap between the community with the highest life expectancy (Genoa) and the lowest life expectancy (Cortland).[12]

Overall life expectancy in the CSA: **80.6 years**

Lowest life expectancy: **76.6 years** in Cortland (60112)

Highest life expectancy: **85.0 years** in Genoa (60135)



Age-Related Illness

In the survey of residents in the CSA, age-related illness (especially Alzheimer's disease) emerged as an important health issue. For the purposes of this report, age-related illness includes:

- Alzheimer's disease and dementia
- Arthritis
- Vision and hearing difficulty

Alzheimer's Disease Mortality:
Annual Deaths per 100,000 Residents[13]

CSA: **33.7**

Illinois: **25.9**

Arthritis[11]

CSA:
18.9% of adults

Illinois:
20.4% of adults

Vision Difficulty[1]

CSA:
2.0% of adults

Illinois:
2.1% of adults

Hearing Difficulty[1]

CSA:
2.7% of adults

Illinois:
3.0% of adults

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Behavioral Health

Mental health disorders are common and affect people of all demographics. Conditions 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.

Within the CSA, **43.0% of survey respondents selected adult mental health as a top health need** within the community. Additionally, 36.0% of survey respondents selected adolescent mental health as a top community health need.

The suicide and self-injury hospitalization rate in the CSA is 34 residents per 100,000 residents, which is lower than the state's rate of 46 residents per 100,000 residents.[14]

The suicide mortality rate for the CSA is **15.3 deaths per 100,000** residents, which is higher than Illinois' rate of 10.9 deaths per 100,000.[13]

12.2% of survey respondents reported being told they have a depressive disorder. Additionally, 24.8% of survey respondents reported needing mental health treatment or counseling in the past 12 months. A total of 73.8% of individuals who reported needing treatment were able to get treatment. However, of the individuals who reported not being able to receive treatment, 38.0% reported that was because they were put on a waitlist for treatment.

Focus group participants highlighted an increase in mental health issues after the pandemic, with long wait times and limited access to care.

Community Input:[23] Behavioral Health

"We continue to be challenged in addressing the behavioral health issues that we have in the community. The needs around behavioral and mental health services are real. We still haven't effectively met the need locally."

One focus group participant shared the strengths of the DeKalb area include community organizations, agencies and faith networks that provide services for mental health and substance use issues.

Focus group participants highlighted the following needs:

- Improved access to treatment, including more mental health workers and adequate emergency room care for mental health crises
- Improved continuity of care for individuals transitioning from hospital to home
- Increased mental health services for youth

Cancer

In the CSA, **29.4% of community input survey respondents identified cancer** as an important health need in the community. Focus group participants identified inadequate access to health services, insurance issues and environmental factors as contributors to the prevalence of cancer in the community.

In the CSA, the cancer mortality rate is **167 deaths per 100,000 residents,** which is higher than the Illinois' rate of 155 deaths per 100,000 residents.[13]

Cancer Diagnosis Rates[15]

	CSA	Illinois
All invasive cancers	667	571
Invasive breast cancer (females)	168	161
Colorectal cancer	56	47
Lung cancer	83	73
Prostate cancer (males)	181	142
Other cancers	205	168

Prevention and Screening in the CSA vs. Illinois[11]

77.1%
of females aged 50-74 had a mammography screening
Illinois: 75.0%

77.2%
of females aged 18-64 had a Pap smear
Illinois: 81.0%

66.4%
residents aged 50-75 had a colorectal cancer screening
Illinois: 67.0%

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Cardiovascular Disease

Cardiovascular diseases were the leading cause of death in DeKalb County in 2022.[13]

Heart disease and stroke can result in poor quality of life, disability and death. Although both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

Rates of High Cholesterol[11]

CSA: **28.8%**

Illinois: **28.2%**

Rates of High Blood Pressure[11]

CSA: **26.5%**

Illinois: **29.0%**

The stroke hospitalization rate in the CSA is similar to the state's: 216.8 per 100,000 residents in the CSA compared with 218.0 per 100,000 residents in Illinois. When stratifying by race and ethnicity, the rate is highest for the non-Hispanic Black population when comparing with the state's rate, 583.6 vs. 316.2 hospital admissions per 100,000 residents.[14]

The heart attack hospitalization rate in the CSA is 185.4 per 100,000 residents, which is higher than Illinois (165.8). This rate is noticeably greater for the non-Hispanic white population (211.3) compared with the state's (176.5).[14]

Heart Disease Mortality:
Annual Deaths per 100,000 Residents[13]

DeKalb County: **155.6**

Illinois: **165.3**

Stroke Mortality:
Annual Deaths per 100,000 Residents[13]

DeKalb County: **39.9**

Illinois: **39.1**

Making sure people who experience a cardiovascular emergency – such as stroke, heart attack or cardiac arrest – get timely recommended treatment is essential to 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.[4]

Diabetes

In the survey of CSA residents, **20.0% listed diabetes** as a top health challenge in the community.

Prevalence of Diagnosed Diabetes Among Adults[11]

CSA: **7.6%**

Illinois: **9.8%**

In the CSA, the uncontrolled diabetes emergency department rate is 209.1 residents per 100,000, which is higher than the state's rate of 188.5 residents per 100,000.[14]

Furthermore, the uncontrolled diabetes hospitalization rate in the CSA for the full population is 23.9 residents per 100,000. However, when stratified by race and ethnicity, the rate for the non-Hispanic Black population increases 3.5 times, to a rate of 85.3 residents per 100,000.[14]

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Infectious Disease

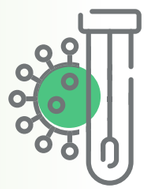
Prior to the COVID-19 pandemic, infectious disease assessments primarily focused on rates of sexually transmitted infections (STIs) and influenza.

The STI infection rate for DeKalb County is 813.3 per 100,000 residents compared with 1,161.4 in Illinois.[16]

The pneumonia and influenza hospitalization rate in DeKalb County in 2022 was

198.1 per 100,000 residents, which was slightly higher than the state at 176.3.[14]

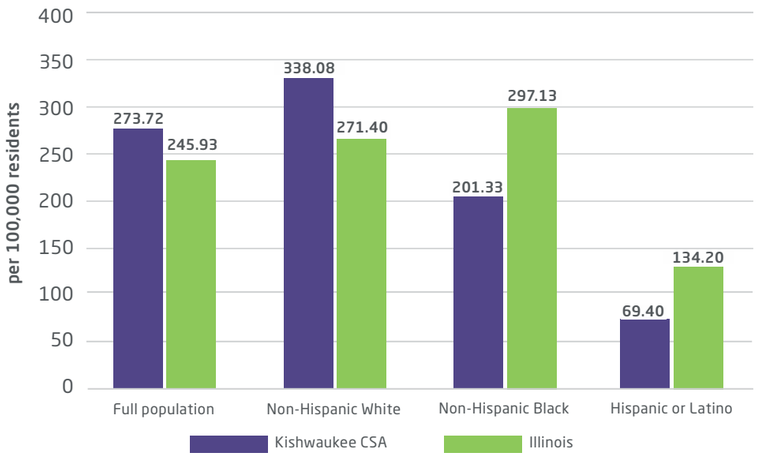
In the CSA, **44.0%** of survey respondents reporting receiving the flu vaccine.



Regarding COVID-19, the annual hospital admissions for the CSA in 2022 was higher than the Illinois rate (273.7 residents per 100,000 vs. 245.9).[14] Additionally, the percentage of residents in the CSA who received at least 1 dose of a COVID-19 vaccine was also lower than the state's rate (61.3% vs. 77.9%).[17]

COVID-19 hospitalization rate by Race/Ethnicity, 2022

Kishwaukee CSA and comparison



Created on Metopio | metop.io/i/2jvsaepi | **Data sources:** Wisconsin Health Association Information Center (WHAIC) (Calculated by Metopio), IHA COMPdata Informatics (Calculated by Metopio)
COVID-19 hospitalization rate: Annual hospital admissions for COVID-19 per 100,000 residents. Risk-adjusted by age and sex. All hospital providers, all payers, based on patient residence.

Obesity

Among community input survey respondents, **32.0% believe obesity to be a challenge** within the community.

Rates of Obesity Among Adults[11]

CSA: **35.7%**

Illinois: **33.6%**

Obesity is linked to many serious health problems, including:

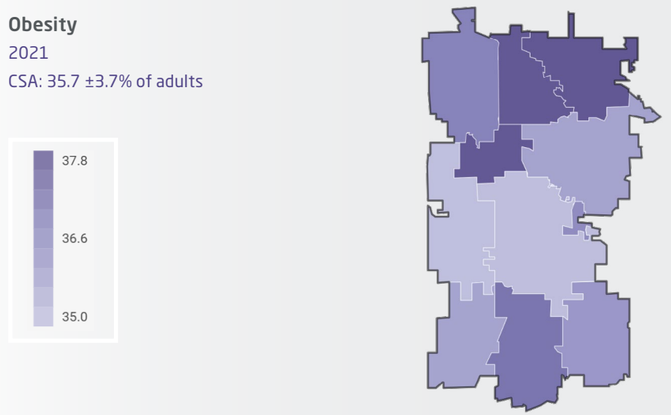
- Type 2 diabetes
- Stroke
- Heart disease
- Some types of cancer

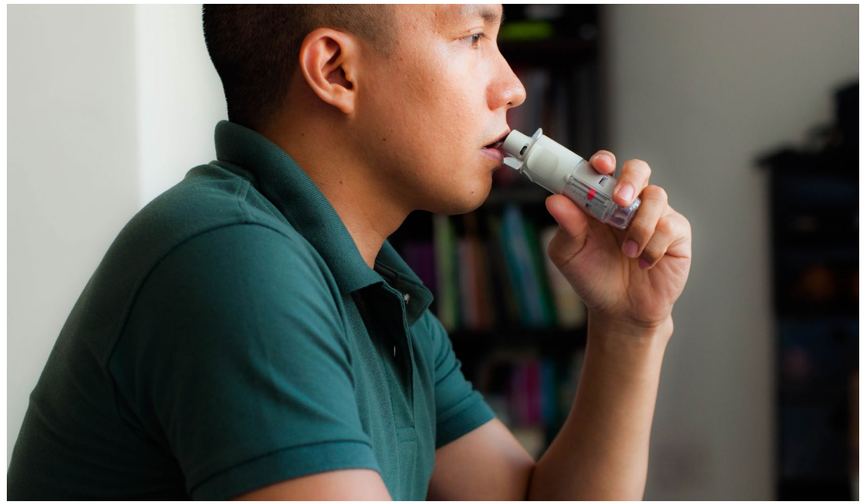
Some people in certain racial and ethnic groups are at higher risk of obesity because they live in communities with a lack of access to healthy food and easy availability of fast food, and other SDOH that increase their risk of chronic diseases.[4]

Obesity

2021

CSA: 35.7 ±3.7% of adults





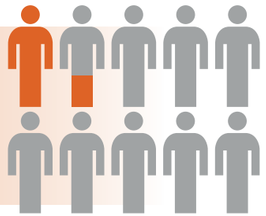
Respiratory Disease

In the CSA, **9.6% of survey respondents indicated lung diseases** were a top community health challenge. Additionally, 9.0% of respondents indicated they had been told by a health professional that they had asthma. Another 3.5% of respondents reported being told by a health professional that they had chronic obstructive pulmonary disease (COPD).

Rates of Asthma[11]

CSA: **10.4%**

Illinois: 9.5%



Rates of COPD[11]

CSA: **5.4%**

Illinois: 5.6%

Substance Use Disorders

A substance use disorder is a complex condition. If use of a substance cannot be controlled and continues despite harmful consequences and impairment in day-to-day functioning, it is termed substance use disorder.[18]

The COVID-19 pandemic not only highlighted the increasing burden of substance use disorders, but it also led to an increase in substance use. As of June 2020, the Centers for Disease Control and Prevention estimated that 13.0% of people in the United States started or increased substance use to cope with the stress and uncertainty of the pandemic.[19]

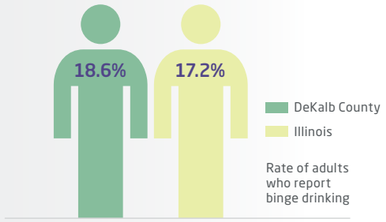
In the CSA, substance use was identified as a top health need in the community by 16.0% of survey respondents.

Community Input:[23]
Substance Use Disorders

One focus group participant mentions the difficulty of finding trained professionals to provide mental health services in rural areas, particularly for substance abuse treatment.

Another focus group participant mentions stigma and discrimination against people with addiction disorders remains a significant challenge in the medical field.

The drug overdose mortality rate for the full population in DeKalb County is slightly lower than the rate for Illinois (19.6 deaths per 100,000 residents compared with 22.3 deaths per 100,000 residents).[13]



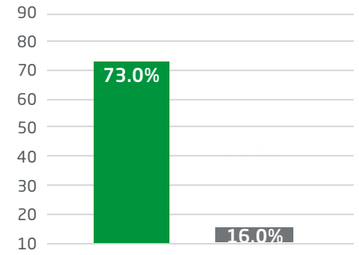
DeKalb County has a binge drinking rate at 18.6% of adults, which is slightly higher than Illinois (17.2% of adults).[11]

Health behaviors

Research has shown that a person's health is not solely defined by their socioeconomic status or available resources. In fact, a person's health is greatly influenced by their health behaviors such as food choices, physical activity and substance use.[22]

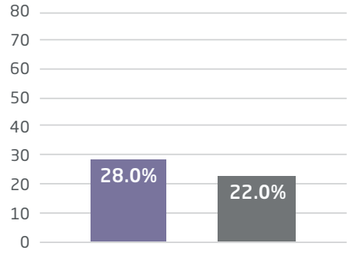
Health Behaviors by ZIP Code in the CSA (Adults)

Households in Poverty Not Receiving Food Stamps (SNAP)[1]



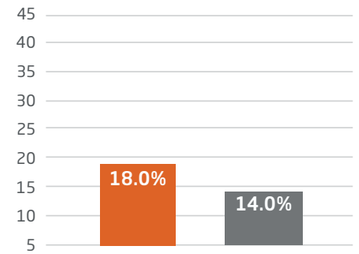
Highest: 73.0% in Kingston (60145)
Lowest: 16.0% in Kirkland (60146)

No exercise[11]



Highest: 28.0% in Shabbona (60550)
Lowest: 22.0% in Malta (60150) and Sycamore (60178)

Prevalence of cigarette smoking[11]



Highest: 18.0% in Genoa (60135)
Lowest: 14.0% in Sycamore (60178), DeKalb (60115) and Malta (60150)

Negative behaviors correspond with a higher burden of disease in many of the same communities and highlight structural inequities that contribute to poor health.

Nutrition

Access to affordable food was considered a top community issue by **27.0% of survey respondents** in the CSA.

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. In fact, 15.3% of residents in the CSA live in food deserts, which is defined as having a low income and living further than one mile from a supermarket (urban) or 20 miles (rural). This percentage statewide is 4.3%.[20]

Community Input:[23] Nutrition

Community members and organizations in DeKalb County are working together to address childhood obesity through nutrition education and whole-family classes, with a focus on sustainability and funding.

Without access to affordable, healthy foods in safe and accessible locations, individuals cannot reasonably make good nutritional choices for themselves and their families.

When investing in healthy food options for a community, it is important to understand the history and culture of that community. Programs should make every effort to take a culturally competent approach to create sustainable change in nutrition access.

14.2% of CSA residents live with food insecurity[8]

Illinois: 8.3%

12.7% of CSA households receive SNAP benefits[1]

Illinois: 13.0%

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Physical Activity

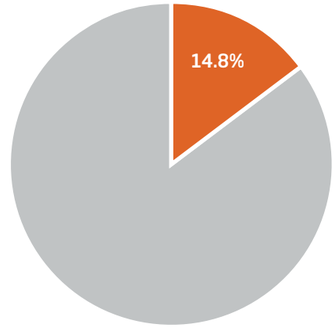
Regular physical activity can improve the health and quality of life of people of all ages. For people who are inactive, even small increases in physical activity are associated with health benefits.

Among survey respondents, **26.0%** **reported not exercising at all.** Guidelines recommend **at least 150 minutes of moderate aerobic activity per week.**

Personal, social, economic and environmental factors all play a role in physical activity levels among youth, adults and older adults. Many families cannot afford gym memberships or fees to exercise. 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.

Tobacco and E-Cigarette Use

People Age 18 or Older in the CSA Who Use Tobacco[11]



There is an ongoing gap in Illinois for county-level data on youth health behaviors.

Community Input:[23] Tobacco and E-cigarette Use

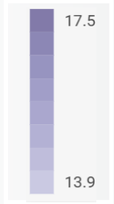
One participant highlighted the challenge of addressing vaping use among students when adults around them are also engaging in similar behaviors, making it difficult for students to understand why they're being told to change their own behavior.

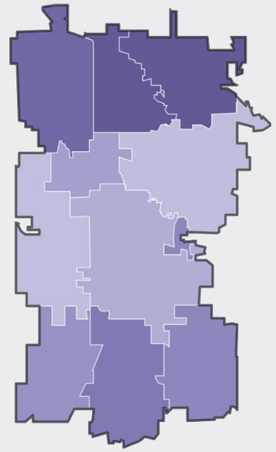
Another participant described a lack of education and regulation surrounding vaping, particularly among younger generations.

Cigarette smoking rate

2021

CSA: **14.8** ±1.3%





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Reflections on our data analysis

Community Health Needs Assessments challenge us to explore data through multiple lenses, including understanding where an issue might be more severe because of community conditions and who might be more impacted because of population characteristics. As the data was collected and analyzed, several themes emerged.

1 RURAL-URBAN DIVIDE

Where you live dramatically determines your life expectancy. The CSA is mostly rural, which can lead to challenges accessing medical care, healthy foods and social services.

2 ACCESSIBILITY

Focus groups noted DeKalb County residents face transportation barriers, including lack of public transit and limited access to ride-hailing services, affecting their ability to access social services.

3 CULTURAL COMPETENCY

Focus groups discussed cultural competency issues in mental health care, particularly for immigrant or first-generation parents who may mistrust medical systems.

4 AFFORDABILITY

The cost of living has been increasing in DeKalb County, and not all residents can afford it, which means they may have to choose between rent, healthy food and medical visits.

5 AGE

Focus groups and survey respondents noted senior care and social isolation among seniors as health concerns in the community.

Significant health needs

Based on local data, benchmark data, the number of people affected and focus group input, we identified the following to be significant health needs within our CSA. Our collaborators considered these needs when identifying which should be priority health needs for Northwestern Medicine to address.

- Access to Health Care
- Behavioral Health
- Cancer
- Cardiovascular Disease
- Diabetes
- Food Access
- Homelessness and Housing
- Obesity
- Substance Use Disorders
- Transportation

Priority Health Needs

Once significant health needs are identified, it is important to engage individuals from a variety of backgrounds to share their insights. This helps ensure that data is being interpreted with the community voice at its core, and guides decisions about which needs should be a priority for Northwestern Medicine.

To that end, Northwestern Medicine Kishwaukee Hospital engaged with community members and organization representatives, along with Northwestern Medicine employees through their Community Engagement Council.

Community Engagement Council

The Community Engagement Council is a diverse group of representatives from across DeKalb County and employees of Northwestern Medicine. Council members are people who have demonstrated a strong, ongoing commitment to improving the health of the communities we serve. Their diverse backgrounds helped ensure we considered a full range of perspectives when prioritizing identified health needs.

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The following community organizations participate on our Community Engagement Council:

Community Organizations	
DeKalb Community Unit School District 428	Kishwaukee College
DeKalb County Community Foundation	Kishwaukee Family YMCA
DeKalb County Health Department	Kishwaukee United Way
DeKalb County Mental Health Board	Northern Illinois University
DeKalb County Regional Office of Education	Opportunity House
Family Service Agency	Suter Company
Greater Family Health	VNA Healthcare
Housing Authority of DeKalb County	Voluntary Action Center
Illinois Department of Public Health	

The following is a list of Northwestern Medicine departments represented and why they were chosen for inclusion.

Hospital Department	Knowledge Area
Community Affairs	Community relationships, data and hospital resources
Behavioral Health	Direct patient care
Care Coordination	Coordination of patient care, including medical and social needs
Executive Leadership	Hospital operations and decision making
Medical Staff	Direct patient care
Patient Engagement	Coordination of patient care
Regional Medical Group	Direct patient care

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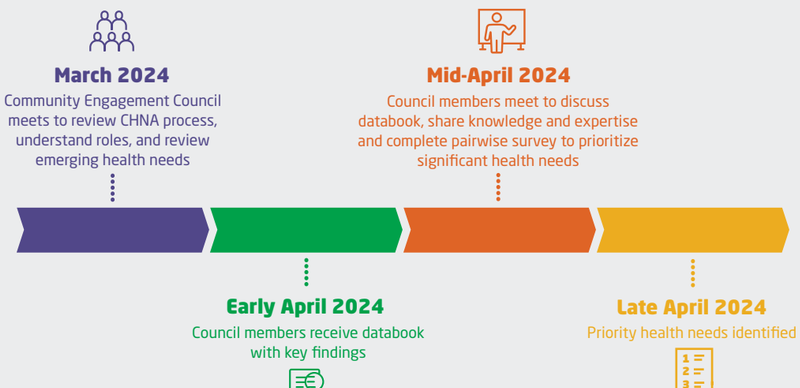
How we chose priority health needs

Following completion of data analysis, leaders from Northwestern Medicine Kishwaukee Hospital convened our Community Engagement Council to review the findings.



The prioritization of health needs took place over a series of meetings with the Community Engagement Council.

- The council convened in March 2024 to receive an overview of the CHNA process, including the data collection process within the defined CSA. In these meetings, council members received a preview of the emerging significant health needs identified through the data analysis.
- In early April 2024, council members were given a databook that highlighted key findings.
- In mid-April 2024, the Community Engagement Council convened again to review the data collected from the community and to prioritize health needs based on data as well as their own knowledge and expertise.
- During this meeting, council members were encouraged to ask questions and offer additional data points based on their areas of expertise. This process was meant to ensure Northwestern Medicine Kishwaukee Hospital was interpreting the data based on the voice of the community.
- Once the data was reviewed, council members participated in a pairwise survey through OpinionX. Through this process, participants were asked to consider multiple prioritization factors.
  - The survey assessed 10 significant health needs.
  - Participants were given two needs at a time and asked to select which was the priority. After making their selection, participants were presented with the next pair and so on.
- After prioritizing the list of top 10 needs, the Community Engagement Council was able to view and compare their results. The idea behind this methodology is to put an emphasis on the community voice while also recognizing that hospital employees are able to provide perspective on what Northwestern Medicine Kishwaukee Hospital can feasibly accomplish over the next three years in this CHNA cycle.

Prioritization Factors Considered to Establish Priority Health Needs

Prioritization Factors	Related Questions
Consequences of Inaction	• What impact would inaction have on individuals and on population health? • Are there other organizations who will act to address the need? • Do the inputs needed to take action create challenges to act in other important areas, recognizing that Northwestern Medicine resources are limited?
Feasibility of Influencing	• What capacity already exists to address the need? Can Northwestern Medicine action add value? • Is there already a foundation for collaboration? Is it local? • Could the role of Northwestern Medicine complement that of other collaborators?
Magnitude and Inequity	• How many people in the community are impacted? • Are there inequalities by race, income or location? • Where is the magnitude the greatest?
Severity and Impact	• How does the need impact health and vitality (focusing on people most impacted by needs related to social determinants of health)?
Trend	• Is there a pattern in the data? • Has the data gotten significantly worse or better over time?

Identified priority health needs

Northwestern Medicine Kishwaukee Hospital has identified three priority health needs in the 2024 CHNA. In selecting priorities, we considered:

- How big the need is in the community
- The capacity and resources available to meet the need
- The suitability of our own expertise to address the need

In particular, priority health needs were selected based on their ability to be addressed through a coordinated response from a range of healthcare and community resources.

Northwestern Medicine Kishwaukee Hospital 2024 Priority Health Needs

Development of a Plan to Address Priority Health Needs

To address the priority health needs identified, Northwestern Medicine Kishwaukee Hospital will continue to work with the community to develop a comprehensive Community Health Implementation Plan (CHIP). The CHIP will detail strategies to address each priority health need as well as anticipated impacts, resources and planned collaborations.*

Northwestern Medicine remains committed to providing culturally informed care that is responsive to the needs of the communities we serve. By creating a CHIP with community organizations, including health and social service organizations, we will develop community-based health initiatives designed to address the identified priority health needs.

This work is ultimately intended to improve health equity, remove health disparities and build healthier communities in alignment with the Northwestern Medicine mission.

Existing resources

We recognize that a significant number of healthcare facilities and organizations within the CSA respond to health needs and support health improvement efforts. A list of resources potentially available to address priority health needs is included in Appendix B.

*The CHIP will also specify significant health needs identified through the CHNA that we did not prioritize, together with the reason that they will not be addressed.

Northwestern Medicine roles

To address the priority health needs, Northwestern Medicine Kishwaukee Hospital can serve in a variety of roles.

Civic Leader

- Collaborator/convener
- Employer
- Advocate
- Funder

Educator

- Training
- Youth programs
- Health promotion
- Knowledge transfer

Researcher

- Medical/biomedical research
- Community-based evaluation
- Outcomes data
- Proof of concept

Care Provider

- Financial assistance
- Medicaid
- Safety net collaborator

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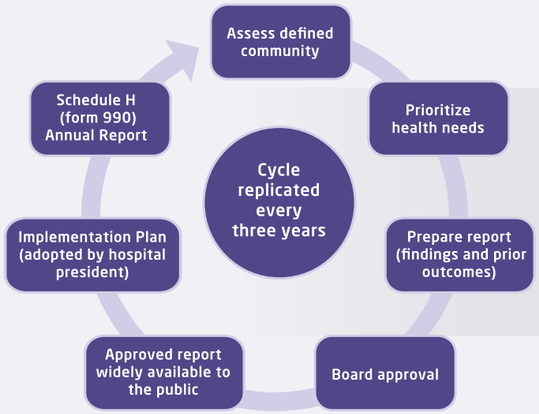
Appendix A: Evaluation of Impact

Actions taken to address Northwestern Medicine Kishwaukee Hospital 2021 priority health needs

The last CHNA Northwestern Medicine Kishwaukee Hospital was completed in 2021. We worked with Conduent Healthy Communities Institute to determine significant health needs through a comprehensive assessment that included analysis of community voice, data and the potential health impact of a given issue.

Our community councils met to identify priority health needs for the CSA based on CHNA findings. In selecting priorities, Northwestern Medicine Kishwaukee Hospital considered the following criteria:

- Consequences of Inaction
- Feasibility of Influencing
- Magnitude of Inequity
- Severity and Impact
- Trend



The final step before beginning a new CHNA report is evaluating the impact of the strategies started as a result of the previous CHNA.

Through the 2021 CHNA process, Northwestern Medicine Kishwaukee Hospital identified three priority health needs to be addressed through collaborative planning and coordinated action with organizations that impact health services in the community:

1. Access to Health Care and Community Resources
2. Mental Health and Substance Use Disorders
3. Chronic Disease

The hospital and key community organizations collaborated to address the identified priority health needs. This Evaluation of Impact report summarizes progress of community strategies outlined in the hospital's 2021 CHIP. This evaluation shows change over time and indicates how well these strategies addressed the priority health needs of the community.

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Priority Health Need 1: Access to Health Care and Community Resources

Goal: Improve access to quality health care and community resources to help ensure that under-resourced populations in the CSA have the services and support needed to live healthy lives.

Priority Health Need Strategy 1.1: Community Engagement: Support efforts that increase access to healthcare services and community resources by investing in resources and collaborating with community-based organizations.

Through an organized approach to connect with community organizations, Northwestern Medicine Kishwaukee Hospital contacted a number of agencies to learn more about the services they provide and share knowledge to identify and support access to health care issues.

In addition, there was a planned approach to increase programs and initiatives focused on promoting access to care, especially with low-income and under-resourced communities.

Impact of Strategy

We engaged with the following organizations to provide support in the form of staff time:

- Safe Passage
- University Village Collaborative
- Opportunity House
- Hope Haven

These community collaborations allowed us to increase access, and improve efficiency and quality in coordinating care among all of the settings in our CSA. These examples demonstrate the variety of ways we can enhance the work of organizations that are already making an impact for patients in the community.

Priority Health Need Strategy 1.2: Federally Qualified Health Center and Clinical Community Collaboration: Align with the system-level approach to better serve the uninsured and underinsured populations through clinical community relationships.

In collaboration with Federally Qualified Health Centers and free and charitable clinics, Northwestern Medicine Kishwaukee Hospital used third-party software to assess the numbers of patients who sought medical care in the Emergency Department (ED) and inpatient setting.

In FY22, 103 self-identified patients from Aunt Martha's received care in the ED. Additionally, 849 self-identified patients from VNA Health Care visited the ED. Thirty-nine patients from VNA Health Care were admitted to inpatient care.

In FY23, 45 self-identified patients from Aunt Martha's received care in the ED. Additionally, 833 self-identified patients from VNA Health Care visited the ED. Thirty-two patients from VNA Health Care patients were admitted to inpatient care.

Impact of Strategy

Providing and supporting these organizations ensured that our most vulnerable patients received and had access to adequate and timely care, and overall improved patient outcomes.

Priority Health Need Strategy 1.3: Health Screenings: Support efforts to increase access to health screenings by investing in resources and collaborating with community-based organizations such as the Women Matter program.

Breast health education provided information on breast cancer risk factors, current screening guidelines and what individuals can do to reduce risk. Comprehensive review of program content was completed in the calendar year 2023 (CY23), and revisions were made to the evaluation to capture appropriate information on knowledge gained. Breast health education classes delivered by a certified lactation counselor taught participants about breast health, breast cancer prevention and screenings.

Educational initiatives focusing on prevention and age-appropriate screening were implemented. Post-program evaluations were completed to measure outcomes and increase in knowledge.

Impact of Strategy

- Six educational programs that reached 47 participants were provided in CY23.
- There was a 36.0% increase in overall knowledge on the information presented at the completion of the program.

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Priority Health Need Strategy 1.4: Community Benefit Donations and Grants: Provide funding through the Community Benefit donations and grants process to strategies and organizations that address access to healthcare services and community resources.

In FY22 and FY23, Northwestern Medicine Kishwaukee Hospital awarded a community grant to Voluntary Action Center (VAC). VAC has provided transportation and nutrition services to DeKalb County residents for more than 45 years. Grant funding awarded to VAC supports transportation services and meal delivery to homebound and senior populations through Meals on Wheels.

TransVAC offers transportation services to senior citizens, persons with disabilities and the general public to and from community facilities and resources for purposes of accessing and receiving wrap-around services. MedVAC provides transportation to and from medical appointments outside of DeKalb County. In FY22, TransVAC and MedVAC provided 39,903 rides for DeKalb County residents.

Northwestern Medicine Kishwaukee Hospital also provided funds to the Sycamore Park District to support fitness programming for families, youth and adults, inspire healthy habits and raise awareness about wellness services. The funds helped provide access to the district's programs and services to qualified individuals at a reduced cost or no cost.

Impact of Strategy

Over the past few years, access to health care for the county has increased significantly through the financial support of high-quality, trusted community organizations.

Priority Health Need 2: Chronic Disease

Goal: Improve access to educational and behavioral modification programs as well as healthy food options to help reduce the risk of chronic disease.

Priority Health Need Strategy 2.1: Health Screenings: Provide no-cost biometric screenings and educational sessions to the community. Provide no-cost blood pressure screenings and education about cardiovascular disease. Offer strategies to help people eat healthier, maintain a healthy weight and increase physical activity.

Northwestern Medicine Kishwaukee Hospital continued to provide community education related to chronic disease in the areas of evidence-based primary interventions (disease prevention, health promotion), secondary interventions (screenings) and tertiary interventions (programs for individuals affected with a chronic disease to promote an optimum state of wellness). This acute care for chronic disease and chronic disease management was offered to all individuals regardless of their ability to pay.

Impact of Strategy

Community-based screenings help identify people with unmanaged high blood pressure. They also reinforce awareness of heart disease and the importance of measures to prevent or manage it. Patients screening positive for high blood pressure were given information on how to manage it. They were encouraged to follow treatment plans provided by their clinicians and, where necessary, they were referred to a primary care site.

- Blood pressure screenings: FY22, 21 clinics, 233 people screened; FY23, 43 clinics, 445 people screened; FY24 so far, 11 clinics, 110 people screened.
- Know Your Numbers: FY22, 6 clinics, 35 people screened; FY23, 2 clinics, 15 people screened.
- Bluhm Cardiovascular Institute screenings for peripheral arterial disease: FY22, 8 screening events with 11 participants; FY23, 9 screening events with 21 participants; FY24 so far, 4 screening events with 13 participants.

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Priority Health Need Strategy 2.2: Leishman Center for Culinary Health: Expand access to educational and behavioral modification programs (such as healthy diet and cooking programs) to reduce the risk of chronic disease.

The Leishman Center for Culinary Health offers a variety of natural, whole-foods cooking classes designed to help participants make simple changes for a healthier lifestyle. The philosophy of the Leishman Center is focused around eating real food, which supports a mission of tackling chronic illness, disease and obesity.

By increasing its virtual classes, the Leishman Center has expanded access to educational and behavioral modification programs (such as healthy diet and cooking lessons).

Impact of Strategy

- FY22: 133 classes were held with 1,315 participants;
- FY23: 214 classes were held with 1,696 participants;
- FY24 so far: 103 classes have involved 2,482 participants.

Priority Health Need Strategy 2.3: Food Security and Access: Farmers Market Coupon Program: Foster collaborations with community-based organizations to increase access to fresh fruits and vegetables.

The farmers market coupon program was discontinued during the time frame because of a lack of participation and vendors willing to support the program. Instead, Northwestern Medicine Kishwaukee Hospital pivoted to provide additional funding to support DeKalb County Community Gardens and Barb Food Mart.

In FY22, volunteers helped maintain the 2-acre garden and harvest produce at DeKalb County Community Gardens. The produce was used on the Grow Mobile, a refrigerated truck, which delivers fresh produce and non-perishable foods throughout DeKalb County. DeKalb County Community Gardens was able to use funds in other ways since part of the produce came from Northwestern Medicine Kishwaukee Hospital. Educational classes were held for community members to attend and learn about gardening and healthy eating. Fresh produce from the community garden was provided to individuals who are food insecure, local food pantries, and other social services. The vegetables and fruits that were grown and distributed were chemical-free.

In FY23, the produce from the community garden and Northwestern Medicine Valley West Hospital garden helped diversify offerings at local pantry distributions and provide healthy items to neighbors facing food insecurity. DeKalb County Community Gardens also hosted monthly educational classes in collaboration with the University of Illinois Extension office to teach local children about growing their own food. The gardens also served as community gathering places and helped strengthen friendships in the area.

Impact of Strategy

- DeKalb County Community Gardens hired a part-time staff member to create educational classes and coordinate volunteers.
- From the community garden, DeKalb County Community Gardens harvested and donated more than 2,000 pounds of produce to local pantries.
- The DeKalb County Community Gardens/ Northwestern Medicine Valley West Hospital garden produced more than 1,000 pounds.
- More than 5,001 individuals benefited from the funding.

Priority Health Need Strategy 2.4: Community Benefit Donations and Grants: Provide funding through the Community Benefit donations and grants process to strategies and organizations that address chronic disease.

In FY22, Northwestern Medicine Kishwaukee Hospital provided funding to Sycamore Park District to offer high-quality, accessible programming about increasing physical activity and preventing chronic disease. Their programs strived to engage community members around increased awareness and wellness resources.

In FY23, Northwestern Medicine Kishwaukee Hospital provided funding to support the LIVESTRONG program at Kishwaukee Family YMCA. Kishwaukee Family YMCA is dedicated to youth development, healthy living and social responsibility. The LIVESTRONG program is offered at no cost to cancer survivors who have finished their cancer treatment. It is designed to help participants develop their own physical fitness program and to support emotional well-being through a supportive community of other survivors and their families.

In addition, Northwestern Medicine Kishwaukee Hospital program staff offered Know Your Numbers, a biometric screening that gives participants results of a blood glucose screening, among other health indicators.

Impact of Strategy

- Through the Sycamore Park District, community members were able to participate in minimal or no-cost recreational and wellness programs.
- Kishwaukee Family YMCA offered two sessions of the LIVESTRONG program.
- In FY23, two Know Your Numbers biometric screenings were offered, reaching 15 participants.

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Priority Health Need 3: Mental Health and Substance Use Disorders

Goal: Improve access to mental health and substance use disorder resources to help ensure under-resourced populations in the CSA have the services and support needed to get appropriate treatment.

Priority Health Need Strategy 3.1: Ben Gordon Center: The Living Room: Provide a calm and safe environment in which guests can resolve crises without intensive intervention.

At The Living Room at Northwestern Medicine Ben Gordon Center, any DeKalb County resident 18 years or older can speak with a trained peer recovery support specialist. There is no cost, and no appointment is needed to visit.

Impact of Strategy

The Living Room has hosted the following visitors:

- FY22: 465 clients, 572.6 combined hours.
- FY23: 967 clients, 1056 combined hours.
- FY24 so far: 339 clients, 308.69 combined hours.

Priority Health Need Strategy 3.2: Mental Health Training and Education: Educate the community on how to identify, understand and respond to the signs of mental illnesses and substance use disorders. Increase awareness of negative attitudes and beliefs around mental health.

Northwestern Medicine Kishwaukee Hospital addresses part of its training goal by offering the Mental Health First Aid (MHFA) course to the CSA. This course is designed to increase awareness and decrease stigma related to mental health.

Other education goals include sharing information in the community about naloxone, a medication approved by the Food and Drug Administration to rapidly reverse the effects of an opioid overdose. Additional community education is provided through National Alliance on Mental Illness (NAMI) presentations, Crisis Intervention Team (CIT) training, Nutrition and Exercise for Wellness and Recovery (NEW-R) programs for people with mental illnesses, and employment groups. Personnel from Northwestern Medicine Kishwaukee Hospital serve on task forces for Juvenile Justice Council, Youth Service Providers, Networking for Families, and Shelter Plus Care.

Impact of Strategy

- MHFA course: FY22, seven sessions with 38 participants; FY23, seven sessions with 121 participants.
- Naloxone education and distribution: FY23: four events training more than 40 individuals.
- Community Education through NAMI, CIT Training, NEW-R and the Employment Group: FY22, 15 programs and 128 people; FY23, 20 programs and 197 people; FY24 so far: 8 programs and 21 people.
- DeKalb County Mental Health Response Line: FY22, 987 calls; FY23: 827 calls; FY24 so far: 259 calls.
- Task Force: FY22, 38.25 hours; FY23, 50 hours; FY24 so far: 26 hours.

Priority Health Need Strategy 3.3: Community Benefit Donations and Grants: Provide funding through the Community Benefit donations and grants process to strategies and organizations that address mental health or substance use disorders.

CASA DeKalb County serves as the voice for children in DeKalb County who have experienced abuse or neglect and are involved in the court system through no fault of their own. Northwestern Medicine Kishwaukee Hospital provided funding that was used for recruitment costs, training costs and staff support for the summer and fall 2022 pre-service training classes for new advocates and continuing education classes for current advocates. It costs approximately $2,500 to train and support each volunteer.

Impact of Strategy

- CASA DeKalb County trained seven new advocates and offered continued training for 20 current advocates.

Priority Health Need Strategy 3.4: Drug Education and Safety Services: Raise awareness and educate the community about the potential for abuse of medications while providing a safe, convenient and responsible way of disposing of prescription drugs.

Drug take-back programs provide an opportunity for members of the community to safely dispose of unused opioids and other prescription medications. Northwestern Medicine Kishwaukee Hospital worked with the following local law enforcement offices: DeKalb Police Department, DeKalb County Sheriff's Office, Kingston Police Department, Sandwich Police Department and Sycamore Police Department. Individuals can safely dispose of unwanted, unused or expired medication in either permanent drug take-back boxes or during events held on National Drug Take Back Day.

Impact of Strategy

The following amounts of unwanted, unused, or expired medication was disposed of throughout DeKalb County:

- FY22: 169.8 pounds.
- FY23: 96.9 pounds.
- FY24 so far: 60.0 pounds.

Priority Health Need Strategy 3.5: Tobacco Cessation Education and Resources: Offer educational programs and referral services (such as Courage to Quit and referrals to the Illinois Tobacco Quitline) to encourage tobacco cessation.

Northwestern Medicine Kishwaukee Hospital offered no-cost educational programs and referral services to encourage tobacco cessation. The programs included multisession classes from Courage to Quit and Catch My Breath and were led by Northwestern Medicine community health educators. The Illinois Tobacco Quitline is a no-cost resource to help people quit smoking or other e-cigarette or tobacco use.

Impact of Strategy

- FY22: Twelve classes of Catch My Breath were held with 170 participants. There were two referrals made to the Illinois Tobacco Quitline.
- FY23: Ten classes of Catch My Breath were held with 118 participants. Five classes of Courage to Quit had 13 participants.

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Appendix B: Resources Available to Address Significant Health Needs

The following healthcare facilities and community organizations may be available to address significant health needs identified in this CHNA.

Category	Resource	Description	Link
Health Care	Northwestern Medicine Valley West Hospital	Critical care hospital	nm.org
	Greater Family Health	Federally Qualified Health Center	greaterfamilyhealth.org
	Northwestern Medicine Ben Gordon Center	Behavioral health services	nm.org
Nonprofit, Faith-Based Organizations	New Hope Missionary Baptist Church	Church	newhopeofdekalb.org
	Salem Lutheran Church	Church	slcsycamore.org/outreach
Social Service Organizations	Barb Food Mart	Food pantry	barbfoodmart.com
	DeKalb County Community Gardens	Food pantry	dekalbgardens.org
	Opportunity House	Services for persons with intellectual and developmental disabilities	ohinc.org
	Voluntary Action Center	Services that address the basic transportation and nutrition needs of the community	vacdk.org
Education	Sycamore School District 427	School district	syc427.org
	DeKalb Community Unit School District 428	School district	dist428.org
	Northern Illinois University	University	niu.edu
Government-Based Organizations	DeKalb County Health Department	Health department	health.dekalbcounty.org
	DeKalb County Government	County government	dekalbcounty.org

Appendix C:
Timeline for the 2024 CHNA for Northwestern Medicine Kishwaukee Hospital

Phase	Description	Date
Assessment and Analysis	Overall	October 2023 to April 2024
	Community input survey	October 2023 to January 2024
	Focus groups	January to February 2024
	Key informant interviews	March to April 2024
Prioritization	Overall	April 2024
	Community Engagement Council	April 11, 2024
Approval	Kishwaukee Community Hospital Board of Directors	July 30, 2024
Report Made Widely Available to the Public	Website	August 31, 2024
	Paper copy available at no charge on request	August 31, 2024
Public Comment	Northwestern Medicine Kishwaukee Hospital 2024 CHNA	August 31, 2024, through August 31, 2030
	Northwestern Medicine Kishwaukee Hospital 2021 CHNA	August 31, 2021, through August 31, 2027

Appendix D:
A Closer Look at Data

Community Input Summary

Metopio collected 1,683 survey responses from people in the CSA. The following issues were selected as the most important health challenges in the community by 25.0% or more of the survey respondents:

1. Adult mental health (43.0%)
2. Adolescent mental health (36.0%)
3. Obesity (32.0%)
4. Cancer (29.0%)

The following factors that support improvements in health needs were selected by 25% or more of the survey respondents:

1. Access to health care (39.0%)
2. Medication affordability (38.0%)
3. Affordable, safe housing (36.0%)
4. Insurance access and affordability (31.0%)
5. Elder care (28.0%)
6. Food access (27.0%)
7. Transportation (25.0%)

Metopio facilitated five focus groups in the CSA and conducted 10 key informant interviews. Focus groups took place with priority populations such as individuals living with mental illness, people of color, older adults, caregivers, teens and young adults, people from sexual minority groups, families with children, faith communities and adults with disabilities.

Most focus groups were 90 minutes long with an average of 10 participants. Groups were conducted virtually using the Zoom platform or in person. A trained facilitator moderated each session. Sessions were recorded, and recordings were stored securely on a server at Metopio.

Key informant interviews lasted 30 minutes and were done with a trained interviewer. Sessions were held over the Zoom platform. Notes were captured in a Word document.

The following themes were identified during focus group sessions and key informant interviews for the hospital CSA:

Accessibility

- Access to behavioral health care
- Transportation needs for medical appointments and other common locations
- Limited availability of appointment times

Rural-Urban Divide

- Access challenges due to limited public transportation and other affordable options
- Long distances to nearest medical facilities, grocery stores and gyms

Cultural Competency

- Stigma around receiving addiction treatment, specifically for Hispanic or Latino communities
- Linguistically and culturally competent care

Affordability

- Cost of living
- Cost of care and medications

Age

- Substance use among youth
- Lack of education for youth on substance use and healthy living
- Social isolation among older adults
- Better coordination of care needed for older adults

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Appendix E: References

1. U.S. Department of Commerce. (2022). *U.S. Census Bureau 2018-2022 American Community Survey 5-year Estimates.* U.S. Department of Commerce. https://www.census.gov/newsroom/press-kits/2022/acs-5-year.html.
2. Centers for Disease Control and Prevention. (2022). *Social Determinants of Health.* Centers for Disease Control and Prevention. https://www.cdc.gov/chronicdisease/programs-impact/sdoh.htm.
3. Millman, M. (1993). *Access to Health Care in America.* Institute of Medicine (US) Committee on Monitoring Access to Personal Health Care Services. https://www.ncbi.nlm.nih.gov/books/NBK235882/.
4. U.S. Department of Health and Human Services. (2023). *Healthy People 2030.* U.S. Department of Health and Human Services. https://health.gov/healthypeople.
5. McGill, N. (2016). Education attainment linked to health throughout lifespan: Exploring social determinants of health. The Nation's Health (1971), 46(6), 1.
6. Environmental Protection Agency. (2020). *Particulate Matter Environmental Justice Index.* Environmental Protection Agency. Accessed through Metopio.
7. U.S. Food and Nutrition Service. (2022). *About WIC.* About WIC | Food and Nutrition Service (usda.gov).
8. Feeding America. (2020). *Map the Meal Gap.* Feeding America. Accessed through Metopio.
9. Krieger, N. (2014). *Discrimination and health inequities.* International Journal of Health Services, 44(4), 643-710. doi:10.2190/HS.44.4.b.
10. Federal Bureau of Investigation. (2021). *FBI Crime Data Explorer.* Accessed through Metopio.
11. Centers for Disease Control and Prevention. (2021). *PLACES.* Accessed through Metopio.
12. National Center for Health Statistics. (2020). U.S. *Small-area Life Expectancy Estimates Project - USALEEP.* Centers for Disease Control and Prevention. Accessed through Metopio.
13. Centers for Disease Control and Prevention. (2022). *Mortality Statistics.* National Vital Statistics System-Mortality. Accessed through Metopio.
14. Illinois Health and Hospital Association (IHA). (2022). *COMPdata Informatics.* Calculated by Metopio.
15. Illinois Department of Public Health (IDPH). (2015-2019). *Illinois State Cancer Registry.* Calculated by Metopio.
16. Centers for Disease Control and Prevention (CDC). (2021). *National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: Atlas Plus.* http://healthindicators.gov.

17. Illinois Department of Public Health. (2022). *COVID-19 Vaccines*. Accessed through Metopio.

18. American Psychiatric Association. (2023). *What Is a Substance Use Disorder?* https://www.psychiatry.org/patients-families/addiction-substance-use-disorders/what-is-a-substance-use-disorder.

19. Abramson, A. (2021). *Substance use during the pandemic*. American Psychological Association. https://www.apa.org/monitor/2021/03/substance-use-pandemic#:~:text=According%20to%20the%20Centers%20for,emotions%20related%20to%20COVID%2D19.

20. U.S. Department of Agriculture. (2019). Food Access Research Atlas. Accessed through Metopio.

21. Bass B, Nagy H. (2023) Cultural Competence in the Care of LGBTQ Patients. StatPearls Publishing. ncbi.nlm.nih.gov/books/NBK563176/.

22. Institute of Medicine (US) Committee on Health and Behavior: Research, Practice, and Policy. (2001). Health and Behavior: *The Interplay of Biological, Behavioral, and Societal Influences.* National Academies Press (US). ncbi.nlm.nih.gov/books/NBK43732/.

23. Community input represents information and beliefs obtained from CHNA focus groups and from persons representing the broad interests of the community, including people who are uninsured, have low incomes and belong to certain minority groups.

Appendix F: Disclaimers

Information gaps

Northwestern Medicine Kishwaukee Hospital made efforts to comprehensively collect and analyze CHNA data to assess the health of the community. However, there are limitations to consider while reviewing the findings.

- Data is presented for the most recent years available for any given source. Due to variations in data collection timeframes across different sources, some datasets are not available for the same time spans.
- Data availability ranges from census track to national geographies. The most relevant localized data is reported.
- There are persistent gaps in data for certain community health issues, such as homelessness, behavioral health, crime, environmental health and education.

Northwestern Medicine is investigating strategies for addressing information gaps for future assessment and implementation processes.

Public dissemination

The Northwestern Medicine Kishwaukee Hospital 2024 CHNA report is available to the public at no charge and can be accessed in the following ways:

Online: nm.org/about-us/nm-community-impact/reports

Phone: 312.926.2301 (TTY: 711)

Email: communityhealth@nm.org

In person: Please visit the main customer service desk at:

Northwestern Medicine Kishwaukee Hospital
1 Kish Hospital Drive
DeKalb, Illinois 60115

Public comment

As of May 2024, Northwestern Medicine Kishwaukee Hospital had not received comments from the public. Northwestern Medicine will continue to use its website as a tool to encourage public comments and ensure that these comments are considered in the development of future CHNAs.

Extensive input from the broader community was gathered through surveys and focus groups for this report. This input, in conjunction with any public comments received, was considered when identifying and prioritizing the significant health needs of the community.

Northwestern Medicine Kishwaukee Hospital welcomes comments from the public regarding the CHNA. Please submit comments to communityhealth@nm.org, and include your name, organization (if applicable) and any feedback you have regarding the CHNA process or findings.

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