Northwestern Medicine®

2025 Community Health Needs Assessment

Northwestern Medicine **Palos Hospital**

Foreword

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 Palos 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 Palos Community Hospital Board of Directors on July 29, 2025, and made available to the public by August 31, 2025. It was created in accordance with federal IRS regulations (26 C.F.R. § 1.501(r)-3).

Our Commitment to Removing Barriers to Better Health

We believe that exceptional care means recognizing the unique circumstances of every patient and team member. We strive to understand and remove obstacles that prevent people from receiving the care, support and opportunities that they need to thrive. This means listening more closely, tailoring our services, and making thoughtful decisions that reflect the realities people face, whether in accessing health care, advancing in their careers or simply being heard. Our commitment to being Better is rooted in doing what is right.

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

Access to Care

We deliver world-class, culturally competent care regardless of ability to pay, race, age, gender, sexuality, or any other social factor, in the communities where our patients live and work.

Economic and Workforce Development

We invest in the communities we serve by employing individuals from a variety of backgrounds and providing innovative training, education and development initiatives that help drive economic growth for under-resourced communities.

Community Engagement

We collaborate with community organizations that provide access to nutritious food, shelter and other essentials, and we support initiatives that reduce violence, address trauma and build safer communities.

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.

Healthcare disparities

We elevate initiatives that:

- Facilitate community engagement and cultivate new relationships
- Address root causes of health in under-resourced communities
- Empower communities through data, education and advocacy
- Ensure Northwestern Medicine is a safe and welcoming environment for all patients

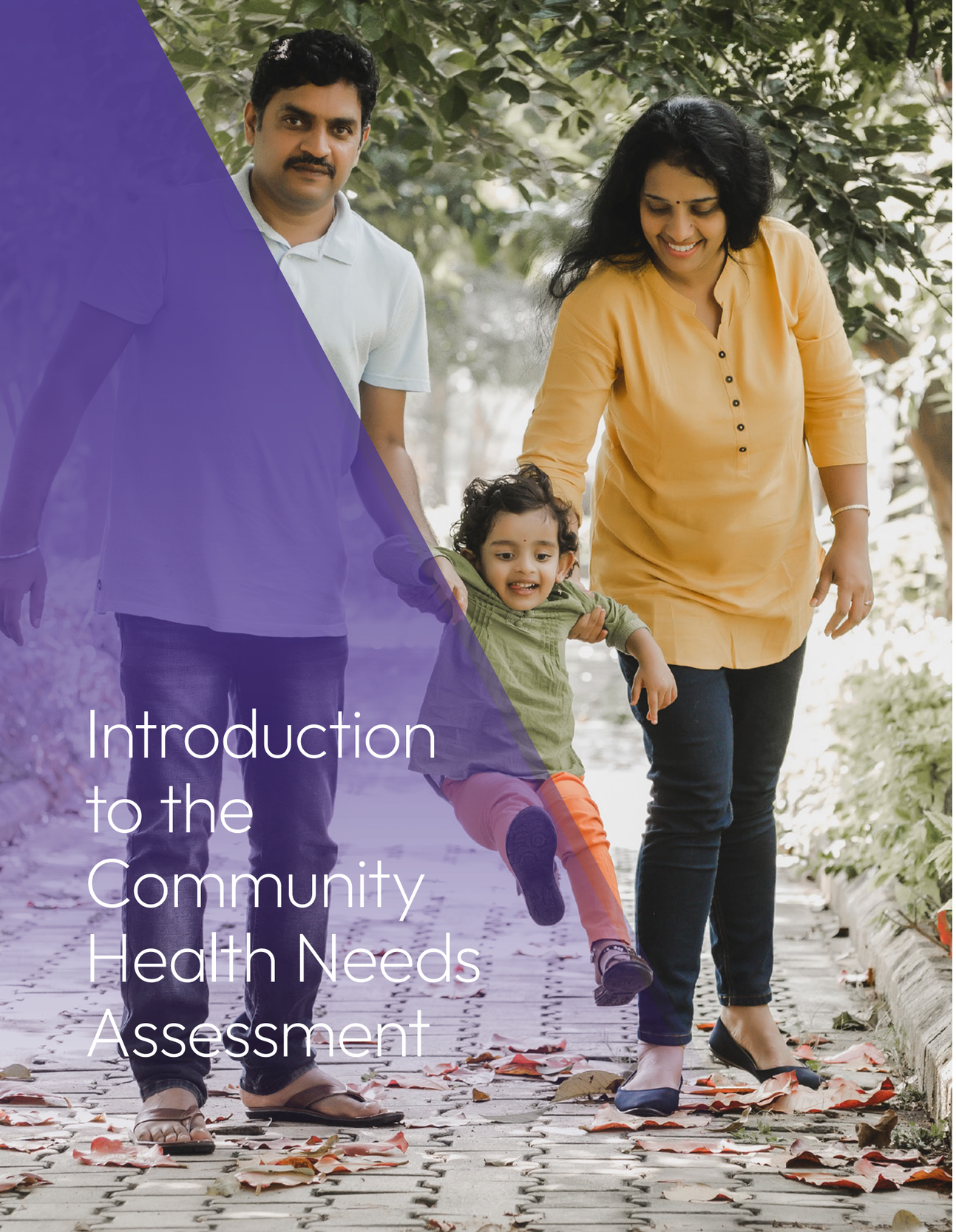
Coordination and connection to community resources

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.

Table of Contents



Introduction to the Community Health Needs Assessment

Since 2012, Northwestern Medicine Palos 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.

How we achieved our goals

For the 2025 CHNA, Palos 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.

We also collaborated with the Alliance for Health Equity (AHE) on the 2025 CHNA. AHE is made up of numerous hospitals working with local health departments and regional and community-based organizations to improve health equality, wellness and quality of life across Chicago and suburban Cook County. The Illinois Public Health Institute acts as the backbone organization for AHE and developed the collaboration so that participating organizations could collaboratively assess community health needs, develop strategies to address needs, and more efficiently share resources and have a greater impact on the larger population residing in Cook County.

Together with Metopio and AHE, we gathered community input from a variety of sources, including surveys, focus groups and in-depth interviews with persons who represent the broad interests of the community. 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
- Ages

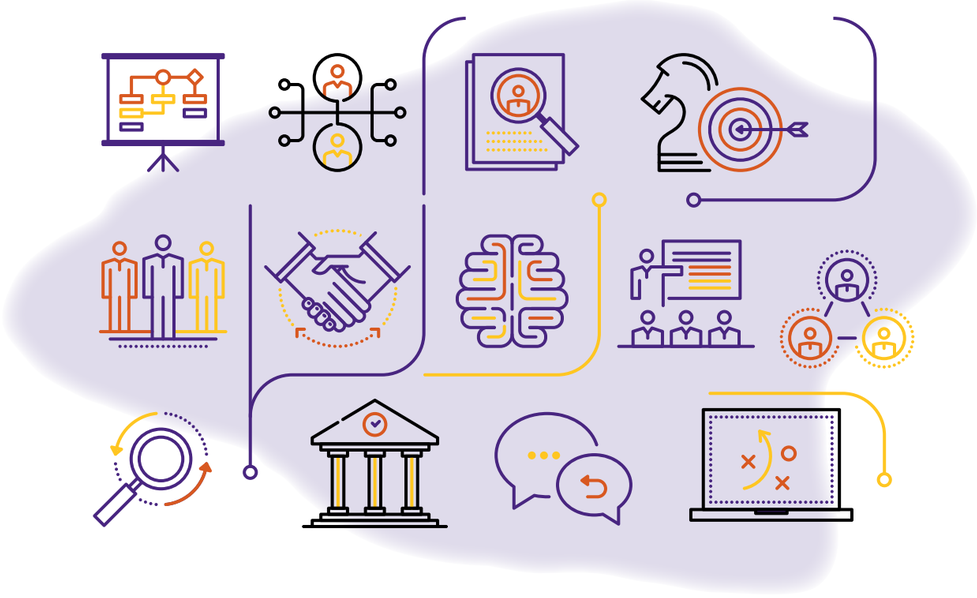
While we assessed information across our entire service area, this report highlights health disparities and needs that disproportionately impact people in communities that have been historically under-resourced and have a higher percentage of people with barriers to health and wellness, such as a lack 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 Palos Hospital in the 2025 CHNA are:

- Access to health care
- Behavioral health
- Cancer



Addressing identified priority health needs

Palos 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 where possible.

> **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 and AHE for their collaboration and significant efforts in the completion of this CHNA.

Who We Are

Get to know Northwestern Memorial HealthCare

Who we are

Northwestern Memorial HealthCare

Northwestern Medicine

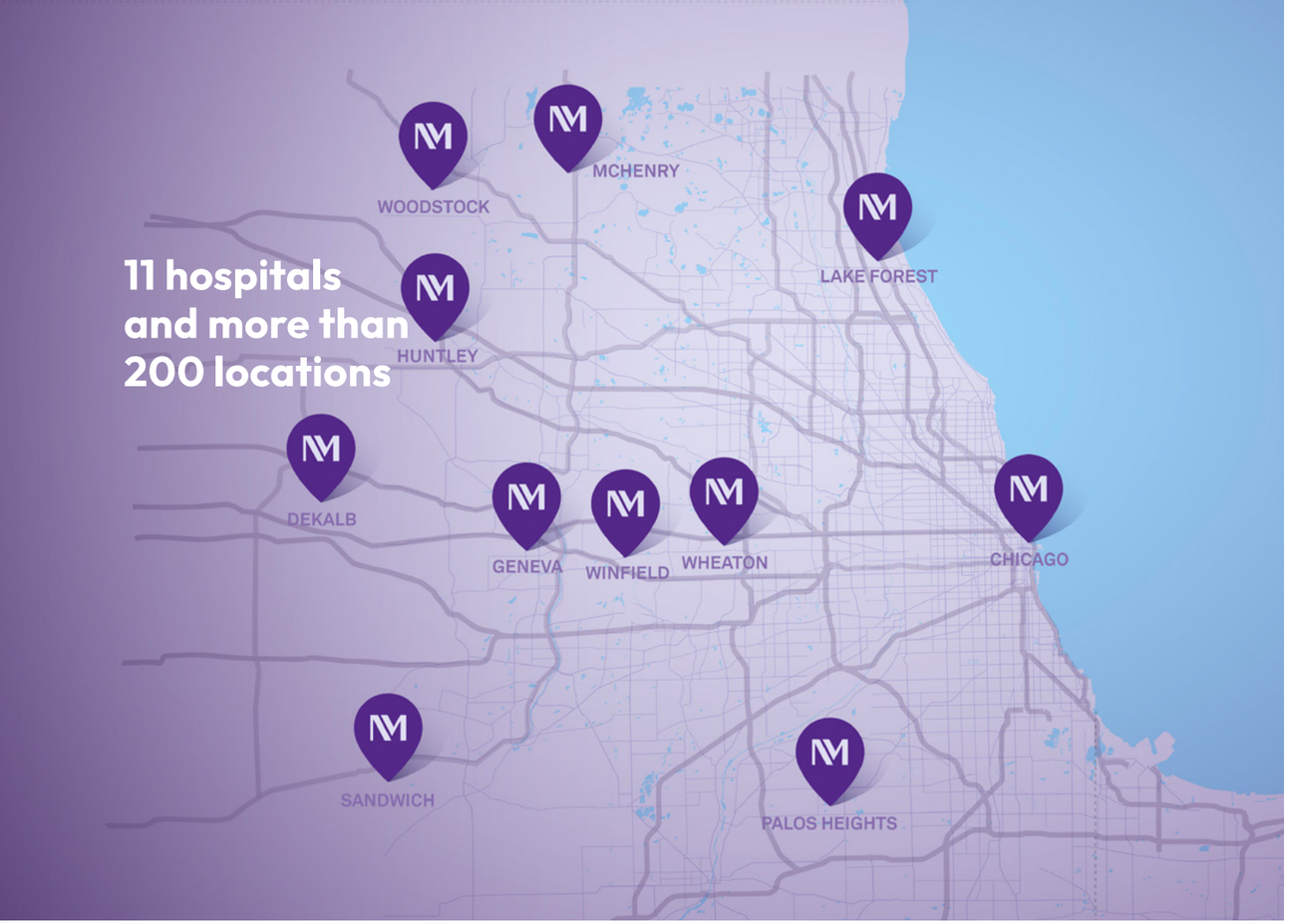
Northwestern University Feinberg School of Medicine

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 drivers 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

BACK TO TABLE OF CONTENTS ▶

About Northwestern Medicine Palos Hospital

How we achieve our mission

As a pillar in the community, Palos 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.

Palos Hospital has a rich history of caring for our community

406 beds

757 physicians

>63,700 emergency department visits

>21,400 inpatient admissions

Acute care

Located in Palos Heights, Illinois

Primary, specialty and emergency care

Data reflects fiscal year 2024.

Defining the Community Service Area

BACK TO TABLE OF CONTENTS ▶

How the Community Service Area was determined

Palos 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 to address priority health needs, including work with community organizations

The defined CSA considers populations that are:

- Medically underserved
- Low income
- Historically underrepresented, minority populations

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

About the Community Service Area

Northwestern Medicine Palos Hospital Community Service Area

Cook and Will counties, Illinois

26
ZIP codes

299 square miles

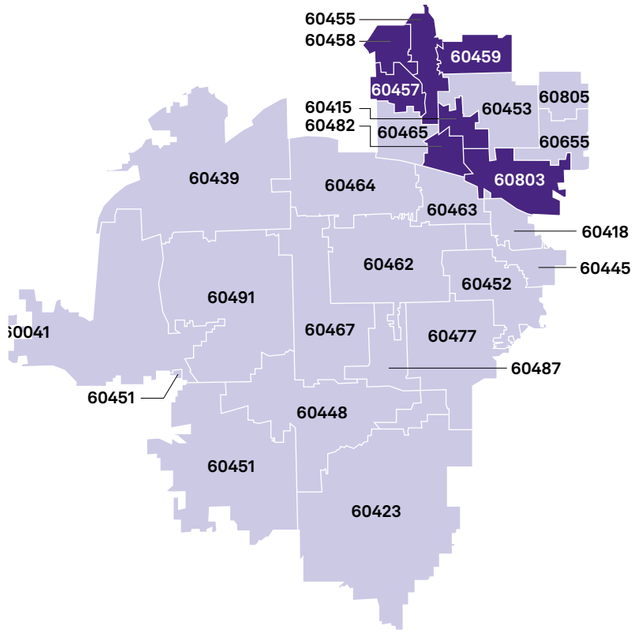
625,423 residents

Predominantly suburban

Community Service Area map

After identifying the CSA, we used the Socioeconomic Resource Index (SERI) to pinpoint areas facing economic challenges. Under-resourced areas are determined using key 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 years or older than 64 years)
- Poverty (income below 200% of the federal poverty level)



Palos Hospital Community Service Area. Locations in dark purple have been identified as under-resourced communities by SERI. Under-resourced areas are concentrated in the northeast corner of the CSA.

Completing the Assessment

Northwestern Medicine performed the CHNA from March 2024 through August 2025. We collaborated with Metopio and AHE on data collection and analysis, and we intentionally built on previous CHNAs.

We conducted surveys, focus groups and in-depth interviews with persons who represent the broad interests of the community. Community input is important for the CHNA because it provides real-time information about community health needs. We also gathered existing data, such as local health statistics.

Taken together, the data allowed us to identify health trends and compare the health needs in the CSA to benchmarks at the city, county, state and national levels.

After we collected the data, it was analyzed and reviewed by community health experts. We then shared the findings with key community collaborators and Palos Hospital employees, who helped identify priority health needs.

Primary data

Collaborating with Metopio and AHE, we gathered information from a variety of sources, including community surveys, focus groups and in-depth interviews with people who represent the broad interests of the community.

This approach helped us gather first-hand information from people in the CSA. The surveys were available online or on paper in English, Spanish and other languages as requested.

Community surveys asked 48 questions about:

- Demographic details of the community
- Top health concerns and community issues
- Access to community resources

Focus groups and key interviews helped us learn about:

- Community strengths and resources available
- Areas of need and opportunities for improvement
- Solutions to identified health needs

Survey, focus group and key interview participants were recruited through hospital community collaborations. Participants consisted of people who are typically underrepresented in the assessment process, including people of color, immigrants, people in the LGBTQ+ community, people with disabilities and people with low incomes.

Collected
1,195
community surveys

Hosted
13
community focus groups and 1 healthcare focus group

Interviewed
8
key community members

Additional information on the survey, focus groups and key interviews can be found in Appendix D.

BACK TO TABLE OF CONTENTS ▶

Secondary data

Secondary data , existing data collected by others, was identified, compiled and analyzed.

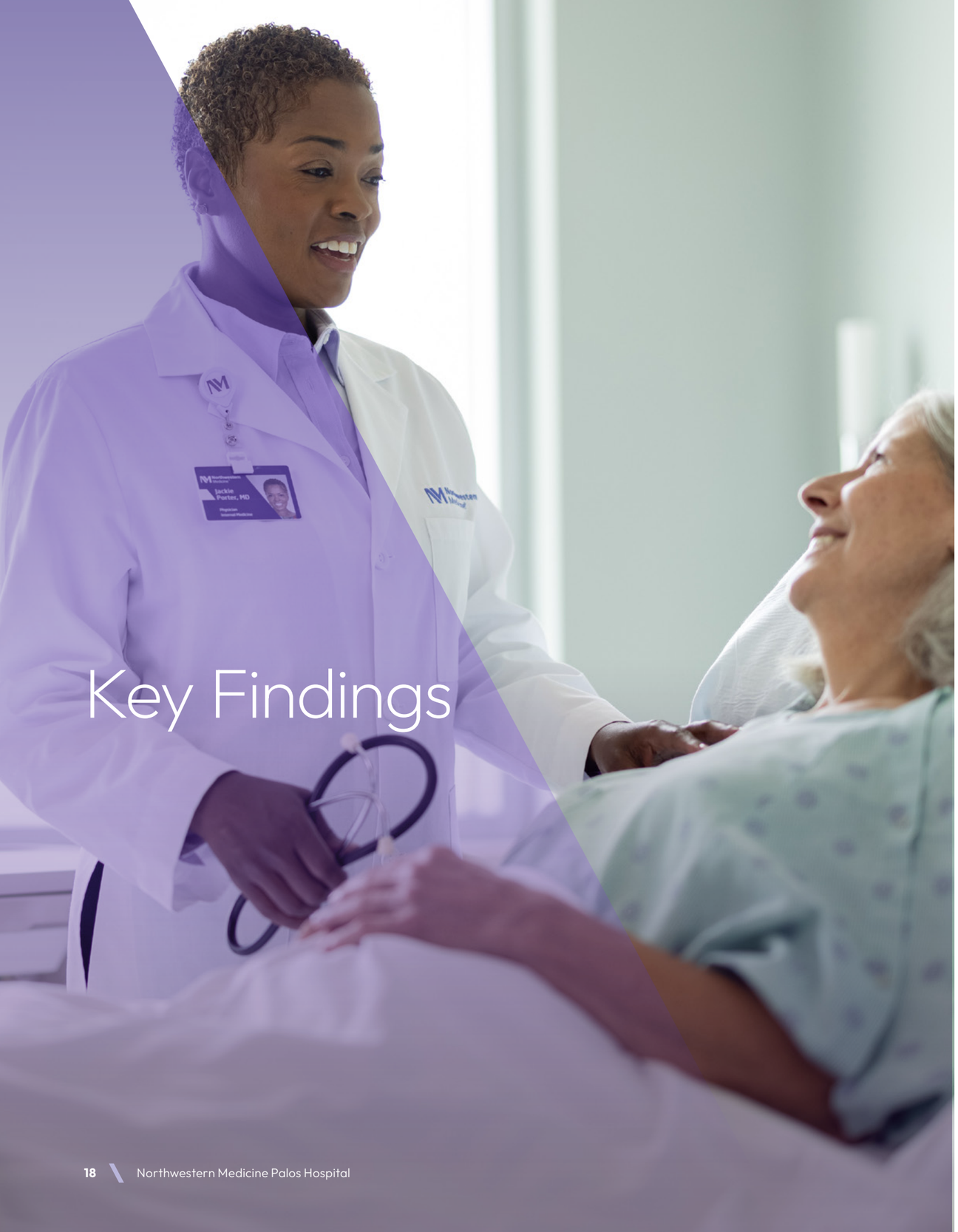
The following key topics were chosen for analysis:

- Social drivers of health
- Health conditions
- Health behaviors

Secondary data sources at a glance

- Peer-reviewed literature, white papers and existing assessments
- Local data compiled by community-based organizations and government agencies
- 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
  - U.S. Census Bureau American Community Survey
  - U.S. Department of Agriculture

Throughout this report, data is presented for the most recent years available for any given source. References are cited to indicate the data sources, which are described or linked in Appendix E.



Key Findings

BACK TO TABLE OF CONTENTS ▶

Who lives in the communities we serve

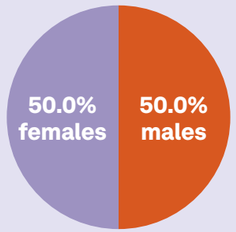
Demographics

Considering the demographic makeup of a community is crucial for shaping community health initiatives to improve health outcomes.

Population[1]

625,423 residents

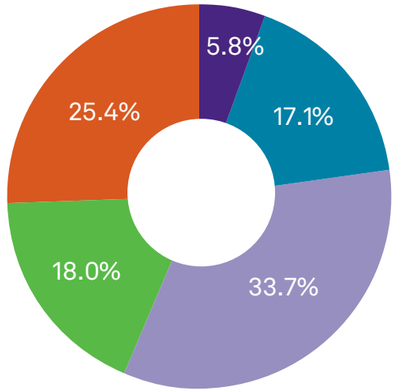
Sex[1]



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

Age[1]

Population by age, 2019-2023



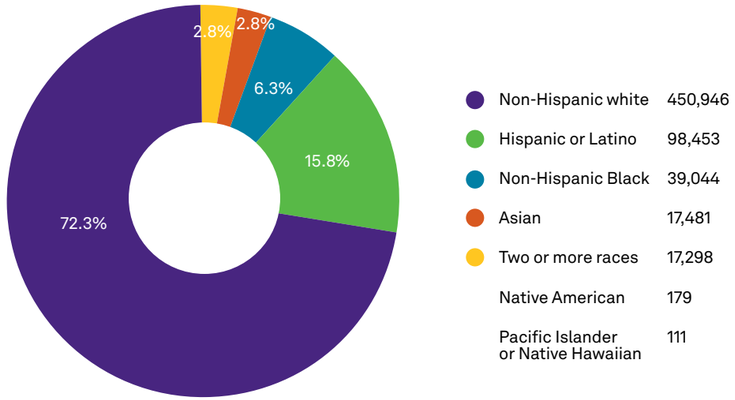
0-4 years	36,318
5-17 years	107,122
18-39 years	158,548
40-64 years	210,841
65 years and older	112,594

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

Race and ethnicity[1]

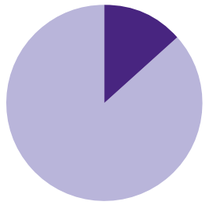
- The population in the CSA is primarily non-Hispanic white.
- However, over the past several years, the non-Hispanic white population has steadily decreased.
- The population identifying as two or more races has increased significantly over the reporting time period.

Population by race and ethnicity, 2019-2023

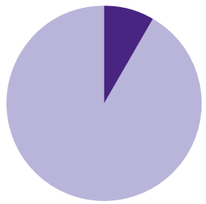


Language

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



13.6%
of CSA residents were not born in the United States
(compared with 14.5% of residents in Illinois)[1]



8.4%
of CSA residents five years and older speak limited English
(compared with 8.8% of residents in Illinois)[1]

Social drivers of health

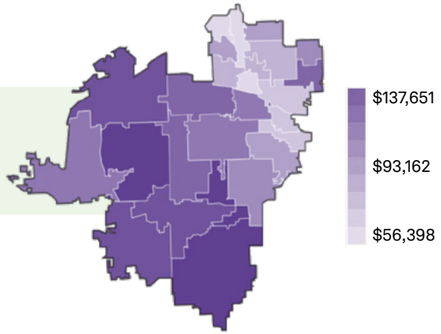
Social drivers of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks. SDOH also contribute to wide health disparities.[2]

Economic stability

Poverty

Poverty is a challenge for many Americans. People experiencing poverty struggle to afford daily necessities such as healthy food and housing. When basic needs are not met, it's harder to maintain good health and prevent illness.[6]

Median household income 2019-2023
Palos Hospital CSA: $100,580 ± $1,660



The median annual household income in the CSA is $100,580, which is higher than the state's median annual household income of $81,702. However, the median annual household income varies widely in the CSA. Frankfort reports a median annual household income of $137,651 (ZIP code 60423), while Worth reports a median annual household income of $56,398 (ZIP code 60482).[1]

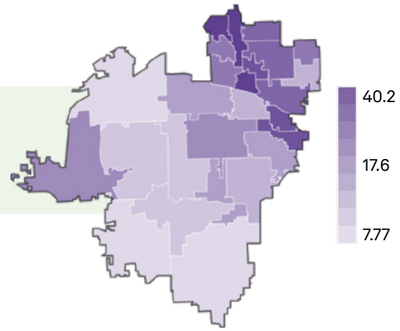
Among survey respondents, **34.0%** report having struggled to pay bills (housing, food, etc.) in the last 12 months.[23]

> "The suburban poor is a whole entire different population."
>
> Focus group participant

Incomes below 200% of federal poverty level

In the CSA, 17.8% of residents have incomes below 200% of the federal poverty level, indicating economic challenges that span various demographics and communities. The data reveals notable disparities, with Justice (ZIP code 60458) and Worth (ZIP code 60482) reporting 40.0% of residents below this income threshold, and Lemont (ZIP code 60439), New Lenox (ZIP code 60451) and Frankfort (ZIP code 60423) reporting less than 10.0%.[1]

Incomes below 200% of poverty level 2019-2023
Palos Hospital CSA: 17.8 ± 0.8% of residents

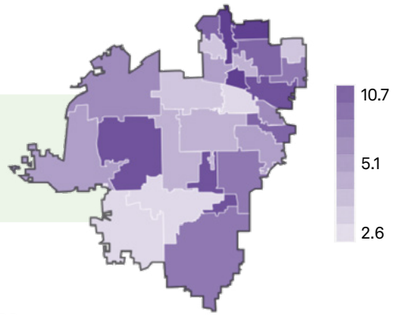


Employment

Employment plays a crucial role in health; stable jobs provide not only income but also benefits such as health insurance and access to a better quality of life.

Unemployment rate

Unemployment rate 2018-2022
Palos Hospital CSA: 5.2 ± 0.3%



In the CSA, the overall unemployment rate is 5.2% of residents older than 16 years. The unemployment rates are highest in the communities of Worth (10.7% in ZIP code 60482) and Bridgeview (8.8% in ZIP code 60455).[1]

Highlights

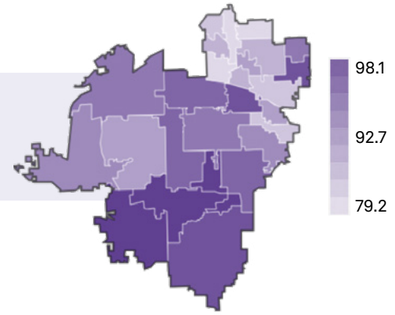
Focus group and key interview participants spoke on economic barriers members of the community face that limit their access to essential resources. Individuals experiencing poverty often have worse health outcomes and greater challenges accessing health care.

Education access and quality

Education is a critical factor in determining health outcomes because it influences opportunities for employment, income and access to resources that promote well-being. Individuals with higher levels of education are more likely to have better health, access to health care and healthier lifestyles.[7]

High school graduation rate

High school graduation rate 2019-2023
Palos Hospital CSA: 92.5 ± 0.9% of residents



The high school graduation rate (percentage of residents 25 years or older with at least a high school degree or GED) in the CSA is 92.5%, which is slightly higher than the state's rate of 90.3%. However, the communities of Burbank and Bridgeview are significantly lower than the state's rate (79.2% in 60459 and 82.7% in 60455, respectively).[1]

Highlights

In our community survey, access to good schools was ranked as an important community issue. Differences in educational attainment contribute to ongoing health disparities. Improving education access and quality is essential for fostering long-term health and well-being.

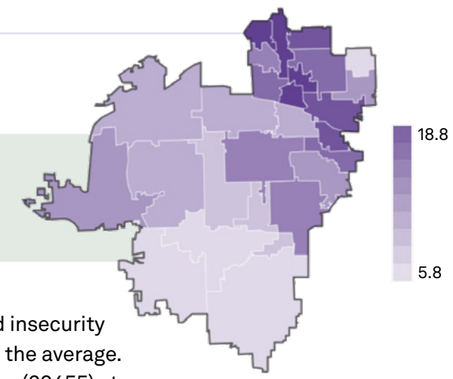
Food access and security

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. A healthy food environment allows people to easily access and afford nutritious foods near where they live. Without this, individuals may have poor diets, increasing the risk of conditions like heart disease, obesity, diabetes and certain cancers. Additionally, lack of food can affect learning and growth and cause both physical and mental health problems.

Among survey respondents, **27.6%** said access to affordable food was an important community issue.[23]

Food insecurity map

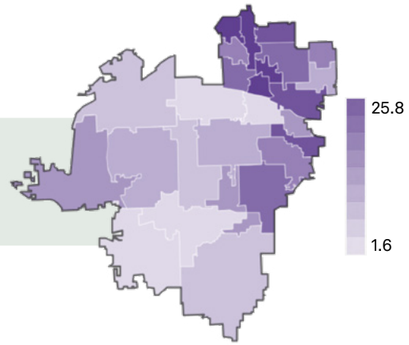
Food insecurity 2022
Palos Hospital CSA: 10.0% of residents



The overall percentage of residents in the CSA experiencing food insecurity is 10.0%. However, several communities report a rate higher than the average. Among those communities are Worth (60482) at 18.8%, Bridgeview (60455) at 16.8% and Justice (60458) at 16.2%.[9]

Food stamps (SNAP) usage*

Food stamps (SNAP) 2019-2023
Palos Hospital CSA: 7.9 ± 0.5% of households



In the CSA, the overall percentage of households receiving SNAP* benefits is 7.9%, which is lower than the state percentage of 13.5%. However, within the CSA, several communities report a much higher percentage of SNAP benefit usage. Among those communities are Justice (60458) at 25.8%, Worth (60482) at 20.1% and Chicago Ridge (60415) at 19.7%.

Highlights

Food access is an important community issue across the CSA. Focus group participants spoke at length about challenges community members face in securing food for their families. Food access is such an important issue that several community organizations spoke about opening their own food pantries to serve their clients or consumers. Ensuring food security can help reduce the risk of chronic diseases, particularly for vulnerable populations.

*SNAP, formerly known as the Food Stamp program, is a federal nutrition program that provides food-purchasing assistance for individuals with low or no income. 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.

> **A lot of families are going without having really healthy nutrition, and healthy nutrition is expensive."**
>
> Focus group participant

Healthcare access and quality

Access to health care is the ability to use health services when needed to achieve the best health outcomes.[3] Healthcare access and quality can vary greatly between communities. Accessing appropriate and timely health care is impacted by:

- Access to health insurance coverage
- Access to health clinics or physicians
- Access to linguistically and culturally appropriate services
- Immigration status

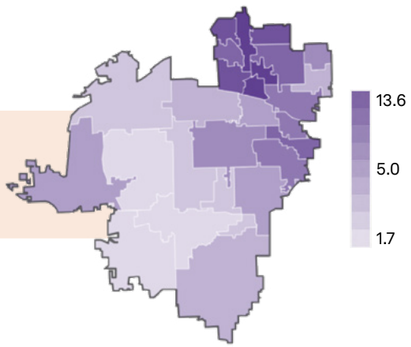
Health insurance

Having health insurance is key to maintaining health and preventing and managing disease. According to Healthy People 2030, people without insurance are less likely to have a doctor, and they may struggle to afford necessary healthcare services and medications.[4]

Among survey respondents, **29.2%** indicated access to affordable insurance was a top challenge in their community.[23]

Within the CSA, 5.6% of residents do not have health insurance. However, in certain communities, that number is much higher. Among those communities are Bridgeview (ZIP code 60455) at 13.6%, Worth (ZIP code 60482) at 13.1% and Chicago Ridge (ZIP code 60415) at 12.4%.[1]

Uninsured rate 2019-2023
Palos Hospital CSA: 5.6 ± 0.3% of households



My brother had a very good job when he was working... when he lost that job, he lost his health insurance."

Focus group participant

Healthcare professionals

Among survey respondents, **39.8%** indicated access to affordable medical professionals was a top challenge in their community.[23]

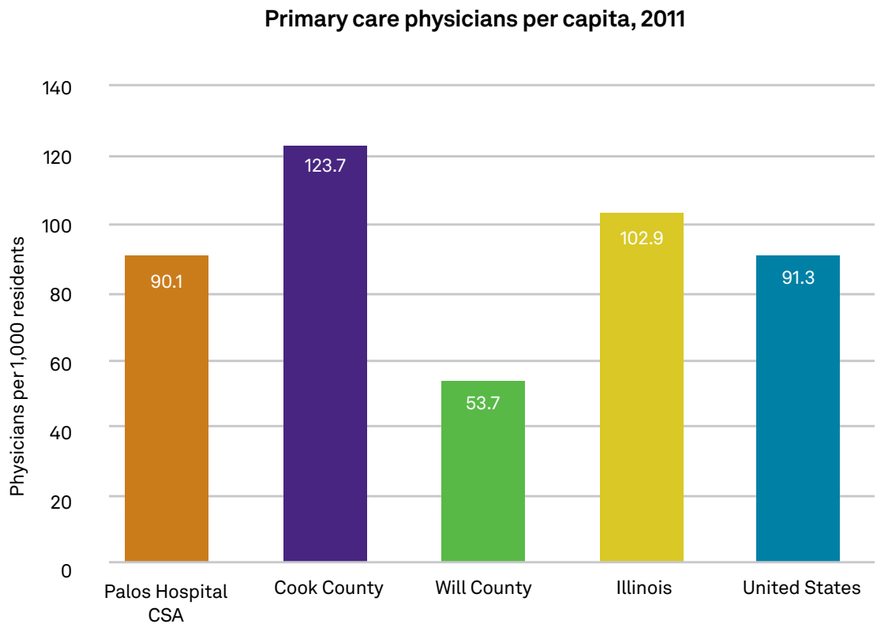
Data analysis considered the primary care physician per capita rate in our community, which is the number of physicians in primary care (general practice, internal medicine, obstetrics and gynecology or pediatrics) per 100,000 residents.

The CSA has an overall rate of 90.1 primary care physicians per 100,000 residents, which is lower than the state's rate of 102.9. When looking closer at specific areas of the CSA, Cook County reports a higher rate, with 123.7 physicians per 100,000 residents. This contrasts sharply with Will County's low rate of 53.7 physicians per 100,000 residents.[5] This discrepancy suggests that residents in Cook County may have better access to healthcare services compared with those in Will County.

Expert observation

"I feel that so many of our patients in the community have logistical challenges in getting to appointments. Telehealth and home visits are essential needs in giving proper care to the community."

Justin Weiner, DO, Pulmonology
Northwestern Medicine



Highlights

Access to health care was discussed at length in most focus groups and key interviews, specifically the challenges involving access to clinicians and insurance. In addition, many focus group and key interview participants spoke about the growing need for clinicians representing a wide variety of cultures, those who speak the language of their patients, but also have cultural awareness.

Twenty-five percent of the population that walks in through my door doesn't have a primary care physician."

Focus group participant

Housing instability

Safe and stable housing is essential for allowing individuals to thrive. Without it, individuals may face increased stress, poor health outcomes and limited access to necessary resources.

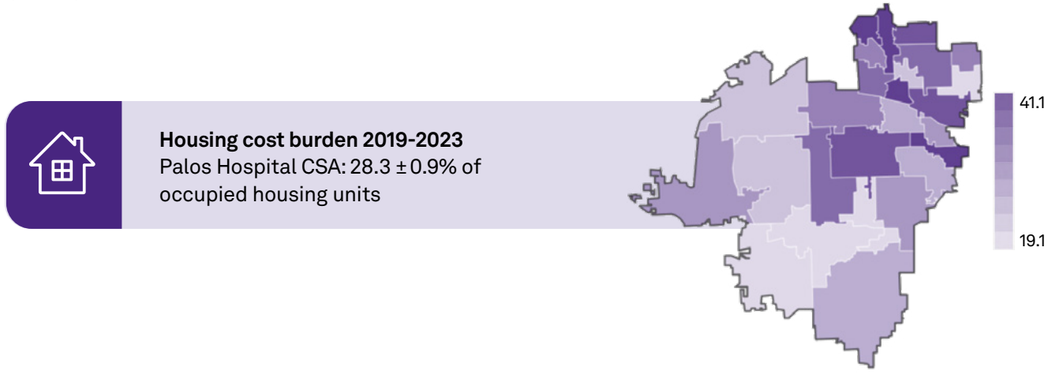
According to **34.4%** of survey respondents, access to affordable and safe housing is a top community issue. Additionally in the survey, when provided the statement

"I am satisfied with the availability of affordable housing in this community,"

24.2% of respondents selected the "agree" answer choice, while 18.9% of respondents selected the "disagree" answer choice.[23]

Households that spend more than 30% of income on housing are considered housing cost-burdened. This includes both renters and owners.

The overall percentage of households considered housing cost-burdened in the CSA is 28.3%. Several communities report a higher percentage, including Justice (60458) at 41.1% and Worth (60482) at 40.1%.[1]



> **Affordable housing, of course, is always a concern, and not only that, but even if you are housed, the cost of living is very high."**
>
> Key interview participant

Highlights

Stable housing is a fundamental need that influences nearly every aspect of life, from health to education. Addressing housing instability is a significant health need in our community based on the increasing housing cost burden and the many times it was mentioned during our focus groups. Breaking this cycle will improve long-term outcomes for individuals and families in our community.

Neighborhood and built environment

A clean, healthy environment is essential for promoting well-being, as the quality of our air, water and neighborhoods directly impacts physical and mental health.

The particulate matter Environmental Justice Index measures exposure to particulate matter in the air and reports that vulnerability as a percentile, with 0 being the lowest exposure and 100 being the highest. Particulate matter is one of the most dangerous pollutants because the particles can penetrate deep into the alveoli of the lungs. Common sources of particulate matter emissions include power plants and industrial facilities.[8]

The overall particulate matter vulnerability percentile in the CSA is 51.6. The percentile in the state of Illinois is 43.7 and the United States is 26.4. Several communities in the CSA report high percentiles as well; two of the highest are Burbank (60459) at 80.4 and Justice (60458) at 79.7.[8]

Highlights

While environmental considerations are important for public health, environmental health did not emerge as a major topic in our community discussions.

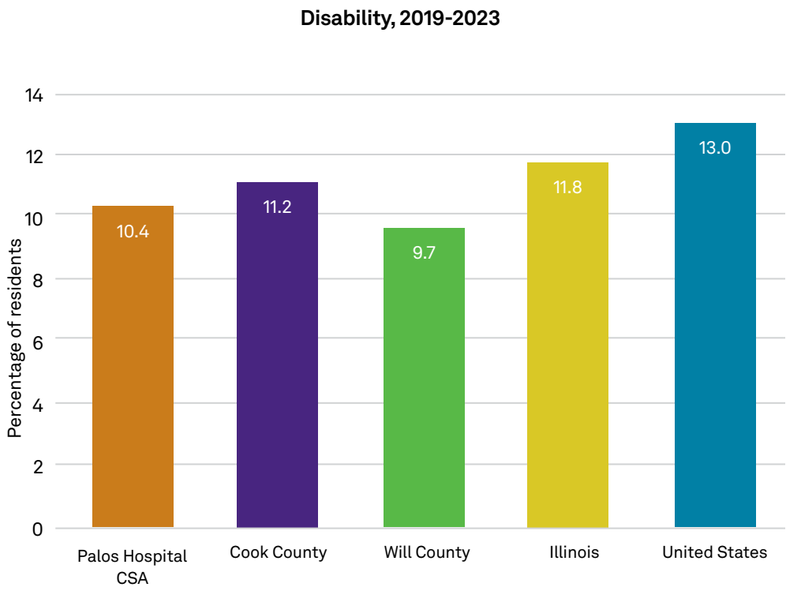
Social and community context

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.

Disability cultural responsiveness

A physical or mental impairment is considered a disability when it limits how someone goes about their daily life: when it affects how they hear or walk, for example, or how they communicate, learn or work. The Americans With Disabilities Act (ADA) is the federal civil rights law that defines disability and guarantees that people with disabilities have the same opportunities as everyone else.[10]

Northwestern Medicine provides reasonable accommodations to patients, companions and employees with disabilities when requested. These are provided at no cost to ensure good care, effective communication and compliance with disability rights laws (such as the ADA).



In the CSA, 10.4% of residents identify as having a disability, which is similar to comparisons.[1]

LGBTQ+ cultural responsiveness

Providing a safe, affirming environment is essential to welcome patients from the LGBTQ+ community. There is evidence that patients who are members of sexual minority groups 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.[11]

Healthcare disparities

Medically underserved communities often lack access to:

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

Highlights

A common theme shared among focus group and key interview participants was the need for access to key resources for all community members.

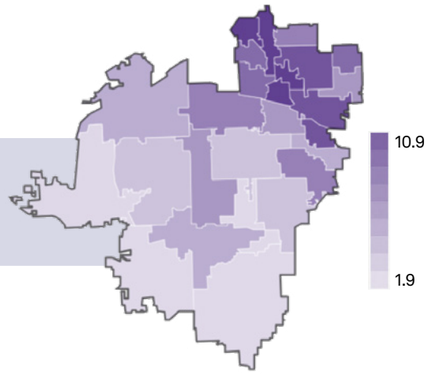
Transportation

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.

Among survey respondents, **22.5%** say access to transportation is an important community issue.[23] Additionally, respondents say lack of transportation is a barrier to accessing basic needs such as food shopping and attending medical appointments.

In the CSA, 4.8% of households have no vehicle available. Several communities report a higher percentage, including Chicago Ridge (60415) at 10.9% and Bridgeview (60455) at 9.9%.[1]

No vehicle available 2019-2023
Palos Hospital CSA: 4.8 ± 0.4%
of households



> **If the client doesn't have a car, they need transportation with public transportation. If the client isn't disabled or not older than 60, I believe they're not eligible for free transportation."**
>
> Key interview participant

Highlights

Residents struggle with limited public transportation options, which impacts their access to healthy food, gyms and parks for physical activity, and healthcare services.

Violence and safety

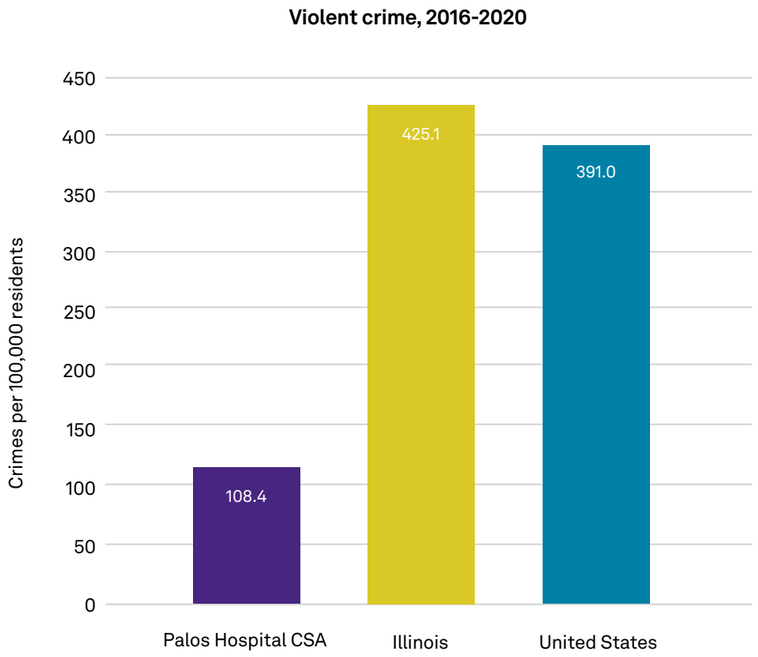
Any person can be affected by crime and violence either by experiencing it directly or indirectly, such as witnessing violence or property crimes in their community or hearing about crime and violence from other residents.[12]

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

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

Among survey respondents, **29.9%** say feelings of safety and low crime are needed for a community to be healthy. Additionally, **65.9%** of respondents feel their community is a safe place to live.[23]

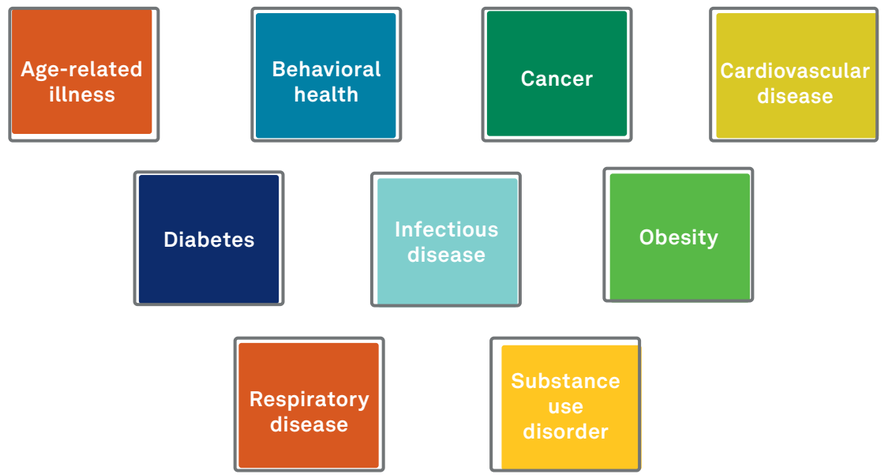
Crimes related to violence are reported as a yearly rate per 100,000 residents. Violent crimes include homicide, criminal sexual assault, robbery, aggravated assault, and aggravated battery. In the CSA, the rate of violent crime is significantly lower than the state and national rates.[13]



Highlights

Community safety was not frequently discussed in focus groups or key interviews. When it was mentioned, participants referenced low crime rates and a feeling of safety in their environment.

Health conditions



In our community survey, respondents were asked:

> "On a scale from 1 to 5, with 5 being Very Healthy and 1 being Very Unhealthy, how would you rate the overall health of your community?"

The average overall response on the 5-point scale was 3.7. The highest value was 4, reported by non-Hispanic Black respondents. The lowest value was 3.5, reported by Middle Eastern, Arab American or Persian respondents.[23]

Overall, estimates of disease burden in the CSA are similar to those reported for the state of Illinois.

Health condition[15]	CSA	Illinois
Obesity	32.7%	34.4%
High blood pressure	30.9%	29.1%
Diabetes	10.7%	10.4%
Asthma	9.4%	9.5%
Cancer (diagnosis rate per 100,000 residents)	608.4	573.2

Life expectancy in the CSA

Life expectancy is an important way to measure the overall health of a community. It helps us understand how long people live now compared with how long people lived in the past and shows the effects of big changes like diseases or lack of resources in the community.

In the CSA, there is a 7.3-year gap between the community with the highest life expectancy (Orland Park) and the lowest life expectancy (Chicago Ridge).[17]

Overall life expectancy in the CSA:

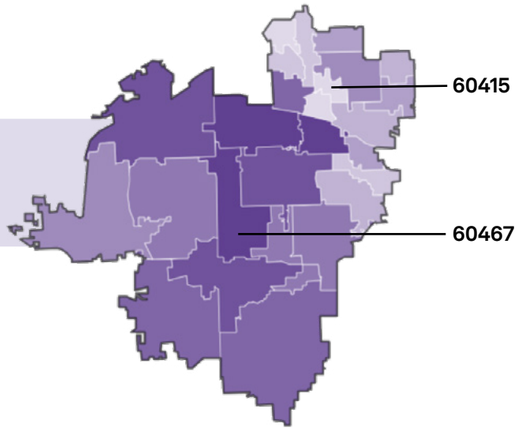
79.0 years

Lowest life expectancy: Chicago Ridge (60415)

74.8 years

Highest life expectancy: Orland Park (60467)

82.1 years



Life expectancy 2010-2015
Palos Hospital CSA:
79.0 ± 0.3 years

Age-related illness

In the survey of residents in the CSA, **26.1%** of respondents indicated age-related illness (specifically Alzheimer's disease and dementia) was an important health issue.[23] For the purposes of this report, age-related illness includes:

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

Alzheimer's disease mortality: annual deaths per 100,000 residents[18]

Cook County: **25.9**

Will County: **25.2**

Illinois: 26.2

Arthritis[14,15]

CSA: **26.5% of adults**

Illinois: 23.0% of adults

Vision difficulty[1]

CSA: **1.8% of adults**

Illinois: 2.2% of adults

Hearing difficulty[1]

CSA: **3.1% of adults**

Illinois: 3.0% of adults

> **We do get a population of senior-aged patients who have advanced dementia or Alzheimer's."**
>
> **Key interview participant**

Highlights

Age-related illness was not heavily discussed in focus groups or key interviews. Care for our senior population was discussed in terms of the need for housing and transportation, and the high cost of prescriptions.

Behavioral health

Behavioral health disorders are common and affect people of all demographics. They affect how we think, feel and act, and also influence how we handle stress, relate to others and make choices. In our community, behavioral health challenges are a growing concern and addressing them is key to improving overall health.

Among survey respondents, **44.0%** indicated adult mental health is a top health-related challenge within the community.[23]

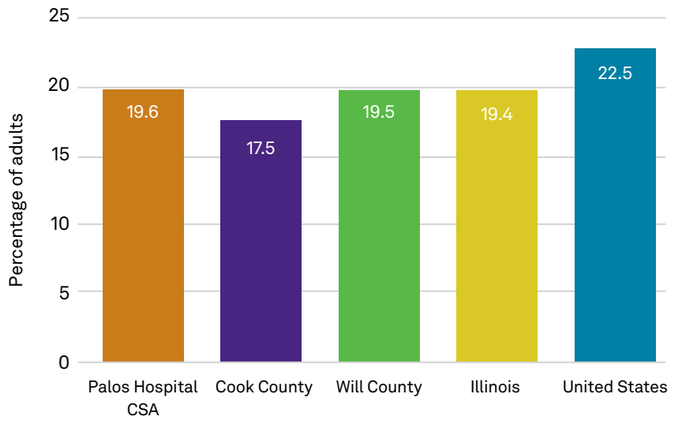
Additionally, **34.0%** of survey respondents indicated adolescent mental health is a top community health-related challenge.[23]

Also, **18.8%** of survey respondents reported at some point in the past 12 months they needed behavioral health care. Of those respondents, 33.9% did not receive behavioral health care, and the following were the most common reasons.[23]

- They were put on a waitlist.
- They didn't know where to get services.
- They could not afford the cost.

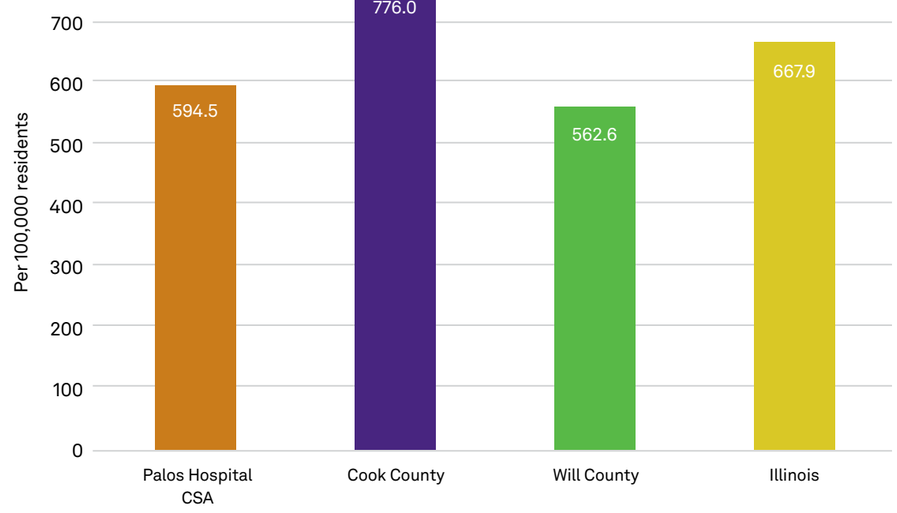
Depression rates among adults 18 years and older vary across different regions, reflecting distinct community challenges and needs in behavioral health support. The CSA and Will County report depression prevalence close to 20.0%, similar to the state's rate of nearly 20.0%, but slightly higher than Cook County's rate of 17.5% and lower than the national average of 22.5%.[15]

Depression, 2022



The behavioral health hospitalization rates across various regions present a notable disparity. The CSA reports the lowest rate at 594.5 annual hospital admissions per 100,000 residents, contrasting sharply with Cook County, which has a higher rate at 776.0 annual hospital admissions per 100,000 residents. The behavioral health hospitalization rate includes hospital admissions for mental health and substance use and is reported for adults 18 years and older.[19]

Behavioral health hospitalization rate, 2019-2023



Highlights

Behavioral health is an urgent need in our community. Focus group and key interview participants spoke at length about the need for more resources to address behavioral health issues, such as improved access to behavioral health professionals and increased insurance coverage for behavioral health treatments.

Mental health, of course, is always an area where there's still a stigma. Thankfully, it's easing over the years."

Key interview participant

Cancer

Cancer affects many individuals and families from all walks of life. Analyzing and reporting diagnosis rates, mortality rates and screening rates can influence local health policies, enhance public awareness programs and help target interventions.

Among survey respondents, 41.0% identified cancer as an important health-related challenge in their community.[23]

Cancer diagnosis rates (per 100,000 residents)[16]

	CSA	Illinois
All invasive cancers	608.4	573.2
Invasive breast cancer (females)	174.6	161.5
Colorectal cancer	49.6	46.3
Lung cancer	75.6	72.6
Prostate cancer (males)	163.2	144.9
Other cancers	177.2	169.4

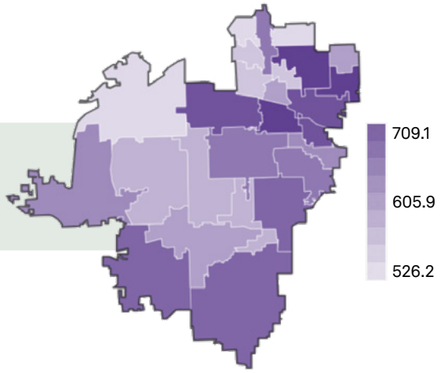
The overall cancer diagnosis rate in the CSA is 608.4 diagnoses per 100,000 residents, but the rate also varies greatly across the CSA. Rates are highest in Palos Heights (60463) at 709.1 diagnoses per 100,000 residents and in Oak Lawn (60453) at 654.6 diagnoses per 100,000 residents. The lowest rates are reported in Burbank (60459) at 553.3 diagnoses per 100,000 and Justice (60458) at 526.2 diagnoses per 100,000 residents.[16]

Cancer, various forms of cancer, has been a huge issue in our community."

Key interview participant

Cancer diagnosis rate

Cancer diagnosis rate 2017-2021
Palos Hospital CSA: 608.4 ± 7.2 per 100,000 residents



Prevention and screening in the CSA vs. Illinois

73.6%
of females aged 50-74 years had a mammography screening within past two years[14,15]

Illinois: 73.0%

81.7%
of females aged 21-65 years had a Pap smear within previous three years[14,15]

Illinois: 81.0%

62.1%
of residents aged 50-75 years had a colorectal cancer screening*[14,15]

Illinois: 55.4%

Highlights

Though not widely raised in early discussions, cancer emerged as a top community concern through this assessment process.

*Full description of data: Percentage of resident adults aged 50-75 years who report having had (1) a fecal occult blood test (FOBT) within the past year, (2) a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or (3) a colonoscopy within the past 10 years.

Cardiovascular disease

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

According to **30.5%** of survey respondents, cardiovascular disease is one of the top health issues in their community.[23]

Rates of high blood pressure[14,15]

CSA: 30.9%

Illinois: 29.1%

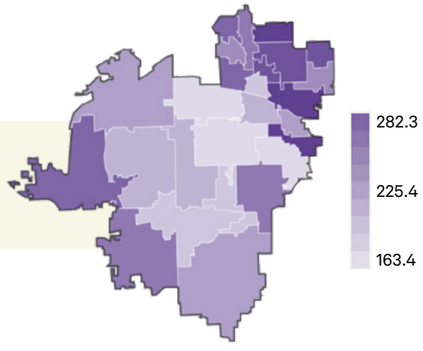
Rates of high cholesterol[14,15]

CSA: 31.7%

Illinois: 28.2%

Stroke hospitalization

Stroke hospitalization rate 2019-2023
Palos Hospital CSA: 229.0 ± 5.0 per 100,000 residents

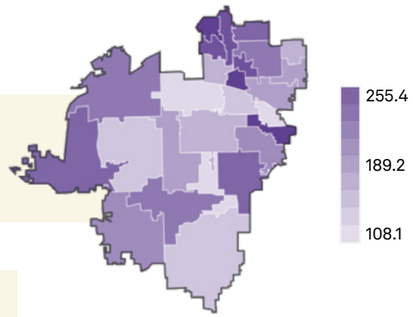


The stroke hospitalization rate varies widely across the CSA, with the overall rate being 229.0 hospital admissions per 100,000 residents. Communities where the rate is highest are Alsip (282.3 admissions in ZIP code 60803), Midlothian (279.1 admissions in ZIP code 60445) and Burbank (272.3 admissions in ZIP code 60459).[19]

Heart attack hospitalization

The heart attack hospitalization rate also varies widely across the CSA, with the overall rate being 194.6 hospital admissions per 100,000 residents. Communities where the rate is highest are Justice (255.4 admissions in ZIP code 60458), Worth (251.6 admissions in ZIP code 60482) and Midlothian (247.5 admissions in ZIP code 60445).[19]

Heart attack hospitalization rate 2019-2023
Palos Hospital CSA: 194.6 ± 4.6 per 100,000 residents



Heart disease mortality:
annual deaths per 100,000 residents[18]

Cook County:
201.5

Will County:
165.2

Illinois: 166.7

Stroke mortality:
annual deaths per 100,000 residents[18]

Cook County:
50.0

Will County:
42.1

Illinois: 40.8

Highlights

Cardiovascular disease was not a topic discussed heavily in focus groups or key interviews even though nearly one-third of survey respondents indicated it was a top health concern. The stroke mortality rate for both Cook and Will counties is higher than the state's rate, and the heart disease mortality rate for Cook County is also higher than the state's rate.

> **Heart attacks — I see a lot of those — and strokes, too. They're just so common around here."**
>
> **Key interview participant**

Diabetes

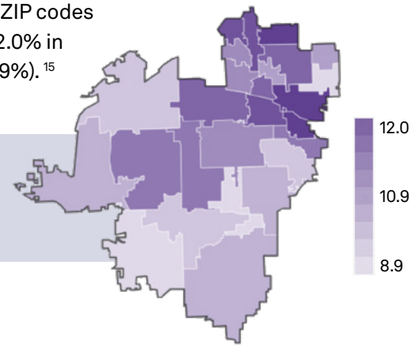
Diabetes is a complex disease that can ultimately lead to heart disease, stroke, kidney failure, foot ulcers and damage to the eyes. Tailored health interventions and community education programs can help manage and mitigate the impact of diabetes, aiming to enhance the overall well-being and health of residents.

In the survey of CSA residents, **23.4%** listed diabetes as a top health issue in the community.[23]

Diagnosed diabetes

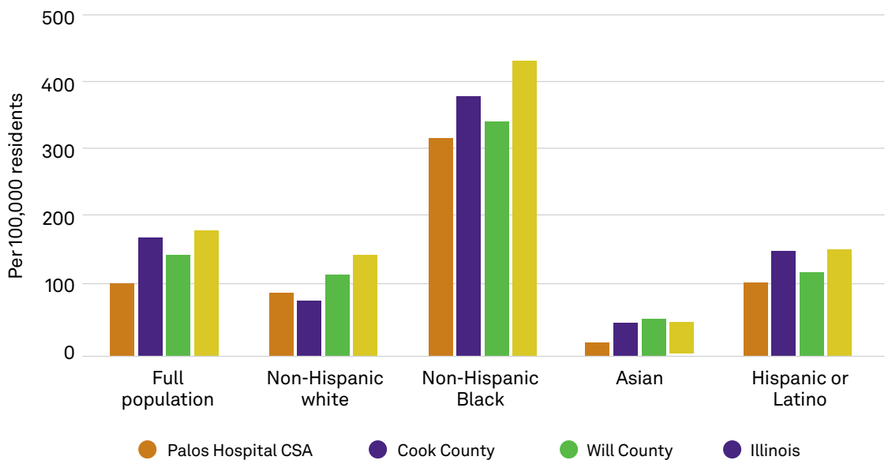
Diagnosed diabetes is a significant health concern across various regions. The overall diagnosed diabetes rate in the CSA is 10.7% of resident adults, which is similar to the state's rate of 10.4%. The range of rates reported in ZIP codes across the CSA is also similar, with the highest rate in Crestwood (12.0% in ZIP code 60418) and the lowest rate in Chicago's ZIP code 60655 (8.9%). [15]

Diagnosed diabetes rate 2022
Palos Hospital CSA: 10.7 ± 0.2% of adults

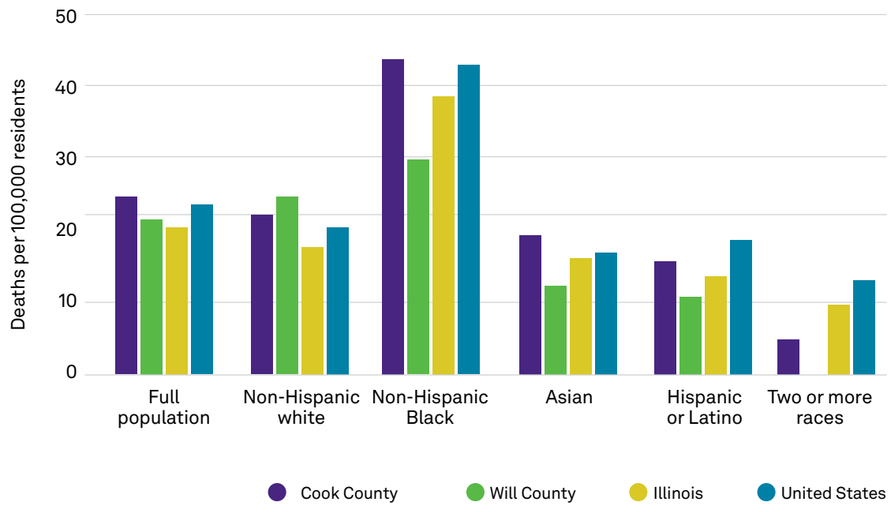


Data reveals significant disparities in rates of emergency department visits for uncontrolled diabetes across different racial and ethnic groups in Illinois. Specifically, non-Hispanic Black populations face the highest rates, with 319.2 emergency department visits per 100,000 residents in the CSA.[19] Furthermore, non-Hispanic Black populations also face the highest diabetes mortality rates, with Cook County reporting a mortality rate of 43.6 annual deaths per 100,000 residents (with an underlying cause of diabetes).[18]

Uncontrolled diabetes emergency department visit rate by race and ethnicity, 2019-2023



Diabetes mortality by race and ethnicity, 2018-2022



Highlights

While diabetes diagnosis rates are similar across the CSA, the stark contrast between racial and ethnic groups is apparent when reporting mortality rates.

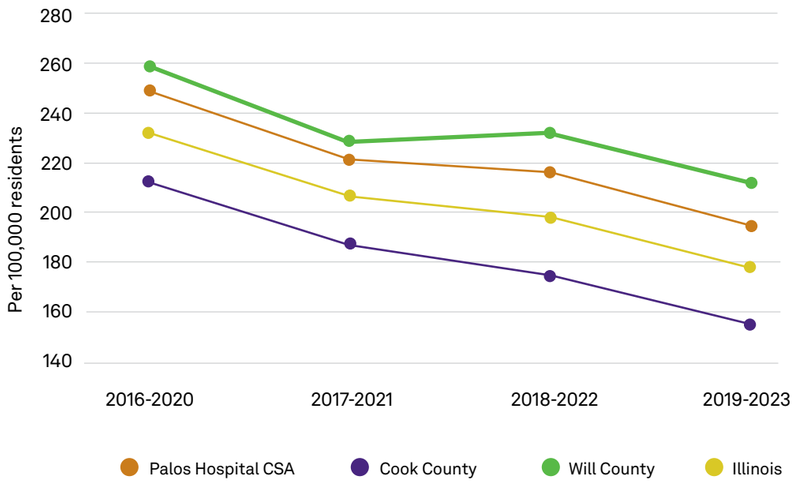
> **Diabetes is often seen as a consequence of obesity."**
>
> Focus group participant

Infectious disease

The assessment of infectious diseases includes a review of sexually transmitted infections (STIs), pneumonia and influenza (flu).

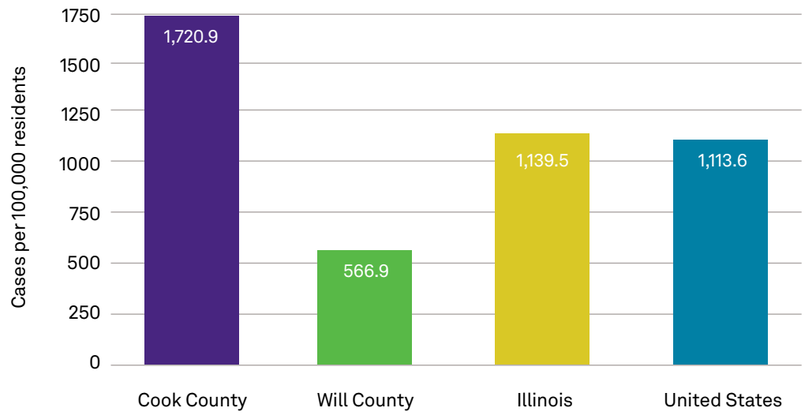
Among survey respondents, **60.9%** say they received a flu vaccine in the past 12 months.[23]

Pneumonia/flu hospitalization rates over time



The annual pneumonia/flu hospitalization rate for the CSA is 194.8 hospital admissions per 100,000 residents, which is higher than the state's rate of 177.6 admissions. However, the CSA's rate has declined over the past several years.[19]

Sexually transmitted infection incidence, 2022



The rate of sexually transmitted infection in Cook County is 1,720.9 cases per 100,000 residents and in Will County is 566.9 cases per 100,000 residents. This rate includes cases of chlamydia, gonorrhea, syphilis and HIV/AIDS. More than half of the cases are from chlamydia.[20]

Highlights

Even though only 60.9% of survey respondents report receiving the flu vaccine, the pneumonia/flu hospitalization rate has trended downward over the past several years.

Data shows a significant difference in sexually transmitted infection prevalence between Cook and Will counties. Additionally, Cook County reports a significantly higher infection rate than all other comparisons.

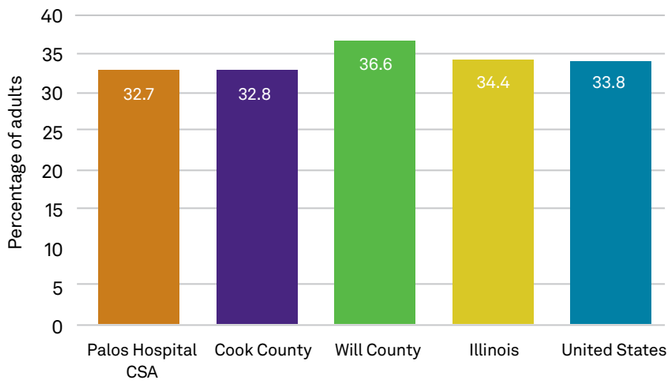
Obesity

Obesity can contribute to the development of health conditions such as diabetes and heart disease. Managing obesity has a positive impact on the overall health of the individual and the community as a whole. Obesity is defined by a number called the body mass index, which is calculated using weight and height. An individual has obesity when their body mass index is 30 or more.

Among survey respondents, **30.5%** believe obesity to be a top health-related challenge within the community.[23]

The overall rate of obesity in adults in the CSA is 32.7%, which is similar to other measures. The rates in ZIP codes across the CSA ranges from Lockport at the highest (37.5% in ZIP code 60441) to Palos Park at the lowest (27.9% in ZIP code 60464).[14,15]

Obesity, 2022



Highlights

While the rate of obesity in the CSA is similar to other comparisons, it still is a health concern that can have negative impacts on the overall health of individuals. Obesity wasn't specifically discussed among focus group and key interview participants, but the general topic of community health was discussed as it relates to accessing physicians to address health concerns.

"It's going to be very interesting how we address the whole crisis of obesity."

Key interview participant

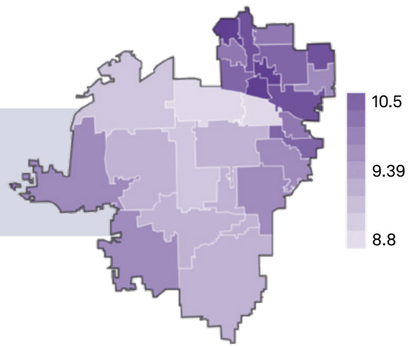
Respiratory disease

Respiratory disease includes the conditions of asthma and chronic obstructive pulmonary disease (COPD).

Among survey respondents, **10.3%** indicated lung diseases were a top community health concern.[23]

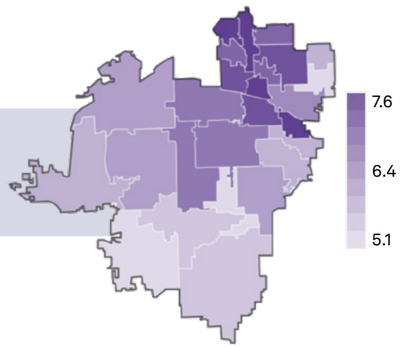
In the CSA, 9.4% of adults report having an asthma diagnosis, which is similar to the state's rate of 9.5%. The highest rates in the CSA are in the communities of Justice (10.5% in ZIP code 60458), Worth (10.1% in ZIP code 60482) and Chicago Ridge (10.0% in ZIP code 60415).[14,15]

Current rates of asthma 2022
Palos Hospital CSA: 9.4 ± 0.2% of adults



In the CSA, 6.2% of adults report receiving a diagnosis of COPD, emphysema or chronic bronchitis, which is slightly higher than the state's rate of 5.4%. The highest rates within the CSA are in the communities of Worth (7.6% in ZIP code 60482), Bridgeview (7.5% in ZIP code 60455) and Crestwood (7.4% in ZIP code 60418). [14,15]

Current rates of COPD 2022
Palos Hospital CSA: 6.2 ± 0.1% of adults



Highlights

Focus group and key interview participants did not speak about lung disease in the community. Data shows that of lung disease is similar across the CSA and is also similar within the state.

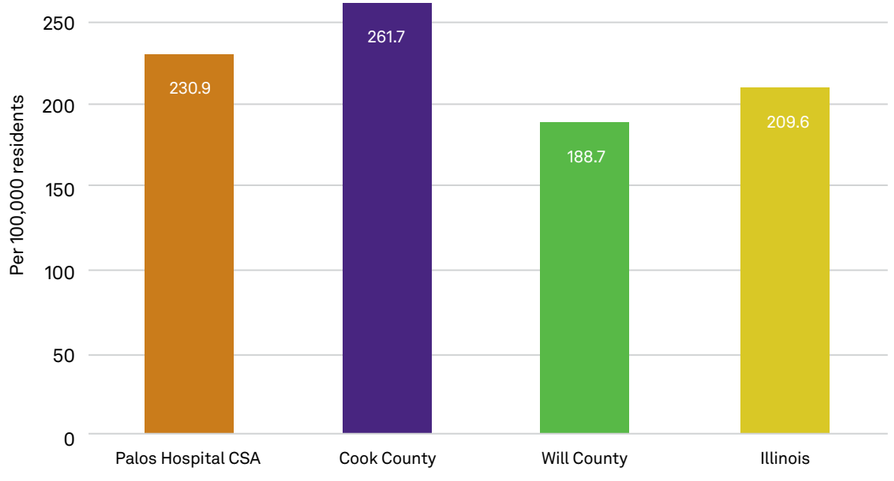
Substance use disorder

A substance use disorder is when someone cannot control their use of a substance, even though it causes harm and makes it hard to function in daily life.

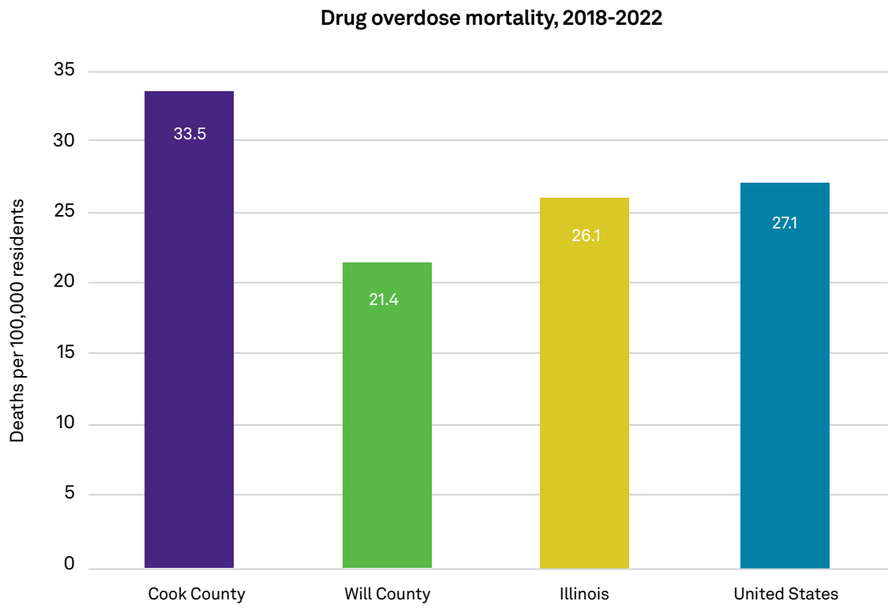
According to **19.8%** of survey respondents, substance use disorder is a top health-related challenge in their community.[23]

Cook County has the highest rate of substance use hospitalizations among comparisons at 261.7 admissions per 100,000 residents. Substance use includes the use of controlled substances such as alcohol, heroin, methadone, cocaine, hallucinogens and other substances.[19]

Substance use hospitalization rate, 2019-2023



Cook County has the highest rate of drug overdose mortality among comparisons at 33.5 deaths per 100,000 residents.[18]



Highlights

Substance use disorder is a top concern within the CSA. Focus group and key interview participants spoke in detail about the need for more resources within their communities to help individuals experiencing substance use challenges, as well as behavioral health challenges.

> **We struggle to get [substance use patients] inpatient placement when needed and outpatient."**
>
> **Focus group participant**

Health behaviors

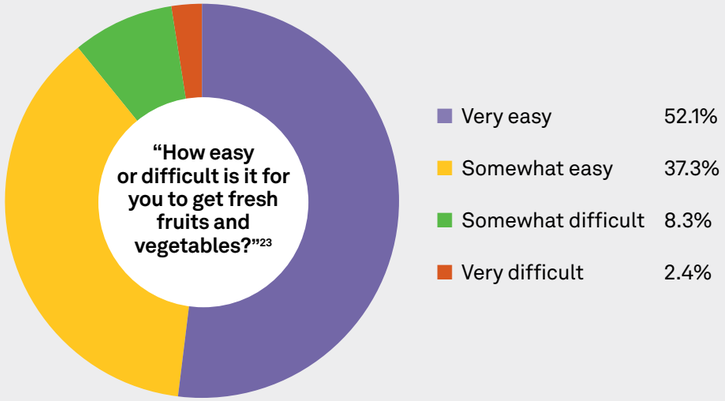
Research has shown that a person's health is not solely defined by their socioeconomic status or available resources. In fact, a person's health is greatly influenced by their health behaviors such as food choices, physical activity and substance use.[21]

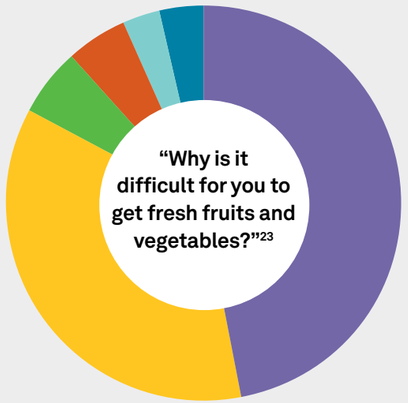
Nutrition

Access to affordable food was considered an important community issue by **27.6%** of survey respondents in the CSA.[23] 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.

The community survey asked:





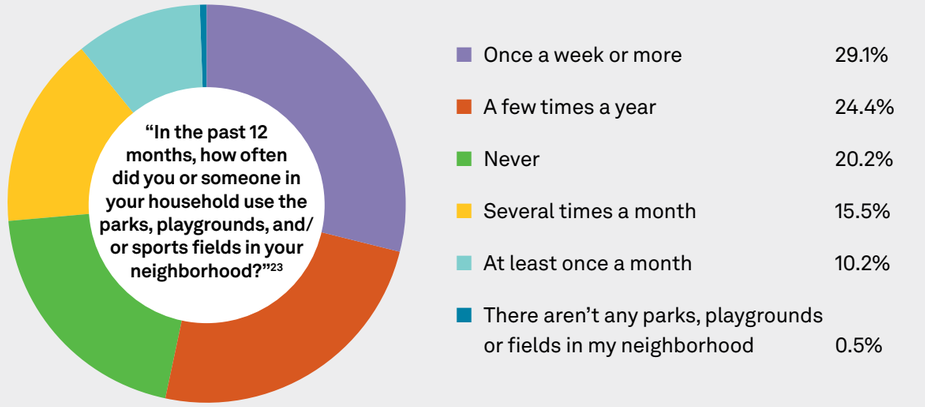
Physical activity

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, **68.1%** reported exercising at some point within the past month.[23] 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. 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.

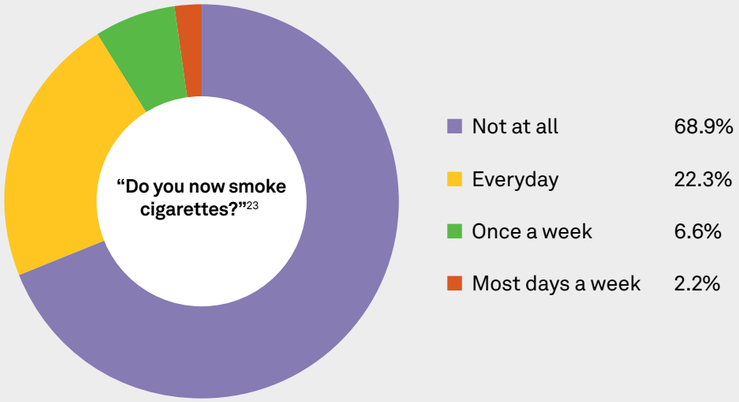
The community survey asked:



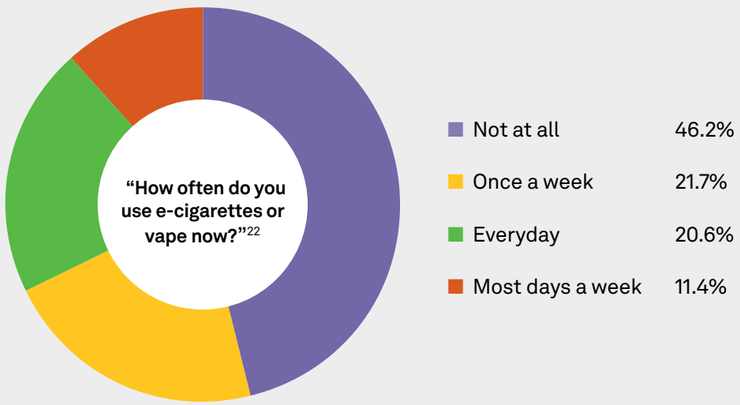
Tobacco and electronic cigarette use

Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases and many types of cancer.[22]

The community survey asked:



The community survey asked:



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
- Housing instability
- Obesity
- Substance use disorder

BACK TO TABLE OF CONTENTS

Priority Health Needs

Community Engagement Council

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, Palos Hospital engaged with community members and organization representatives along with Northwestern Medicine employees through their Community Engagement Council.

The Community Engagement Council includes representatives from across the CSA 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 different backgrounds helped us consider a full range of perspectives when prioritizing identified health needs.

The following community organizations participate on our Community Engagement Council:

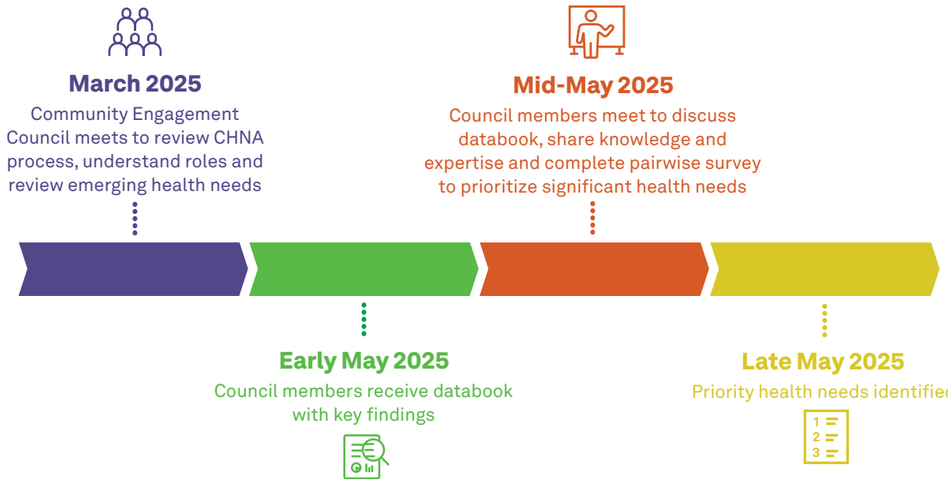
Arab American Family Services	NAMI South Suburbs of Chicago
Beds Plus	Northwestern Medicine
Bremen High School District 228	Pathlights
Crisis Center for South Suburbia	Sertoma Star Services
Inner-City Muslim Action Network (IMAN)	South Suburban Joy Emporium
Moraine Valley Community College	Together We Cope

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

Hospital department	Knowledge area
Cardiology	Direct patient care
Community Affairs	Community relationships, data and hospital resources
Executive Leadership	Hospital operations and decision making
Hematology/Oncology	Direct patient care
Home Health	Direct patient care
Medical Staff	Direct patient care
Quality	Supports patient care
Regional Medical Group	Direct patient care
Social Work	Direct patient care
Strategy	Hospital operations and decision making

How we chose priority health needs

Following completion of data analysis, leaders from Palos 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 2025 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 May 2025, council members were given a databook that highlighted key findings.
- In mid-May 2025, 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 Palos 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 nine 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 nine 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 Palos Hospital can feasibly accomplish over the next three years in this CHNA cycle.

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 disparity	▸ How many people in the community are impacted? ▸ Are there disparities 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 drivers of health)?
Trend	▸ Is there a pattern in the data? ▸ Has the data gotten significantly worse or better over time?

Identified priority health needs

Palos Hospital has identified three priority health needs in the 2025 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 Palos Hospital 2025 priority health needs

Development of a Plan to Address Priority Health Needs

To address the priority health needs identified, Palos 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, reduce 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, Palos Hospital can serve in a variety of roles.

Civic leader

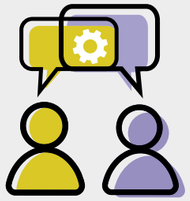
- Collaborator/convener
- Employer
- Advocate
- Funder

Researcher

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

Educator

- Training
- Youth programs
- Health promotion
- Knowledge transfer



Carer

- Financial assistance
- Medicaid
- Safety net collaborator

Appendix A

Evaluation of Impact

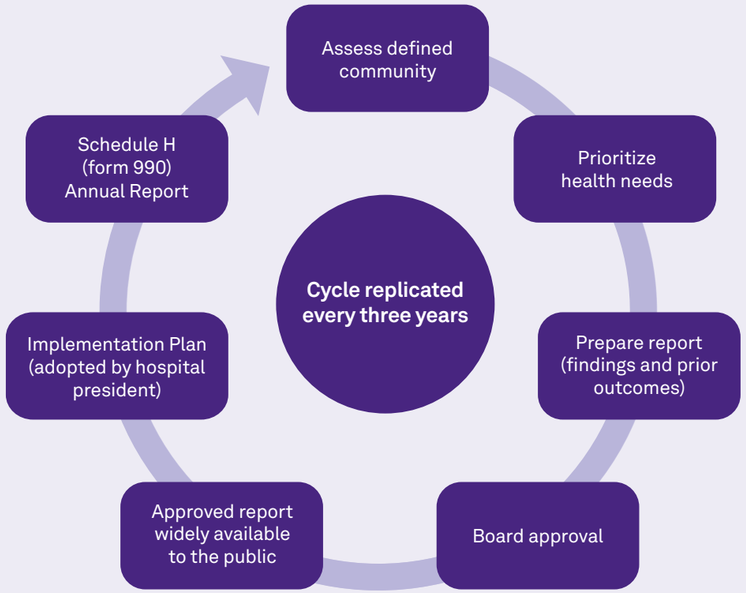
Actions taken to address Northwestern Medicine Palos Hospital 2022 priority health needs

The last CHNA completed for Palos Hospital was in 2022. We worked with AHE 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, Palos Hospital considered the following criteria:

- Consequences of inaction
- Feasibility of influencing
- Magnitude of disparity
- 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 2022 CHNA process, Palos 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. Behavioral health
2. Culturally and linguistically appropriate care
3. Food access and security

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

Priority health need 1: Behavioral health

Goal: Improve access to and utilization of behavioral health services within the Palos Health CSA.

Strategy 1.1: Resources: Improve access to behavioral health support services through the expansion of community-based programs.

Palos Hospital collaborated with community organizations to offer evidence-based wellness programs, such as Mental Health First Aid. We also collaborated with the Palos Heights Police Department and the U.S. Drug Enforcement Agency to offer medication disposal events as well as training on and doses of Narcan.

Examples of organizations and strategies funded:

- NAMI South Suburbs of Chicago: Expanding participation in community events to share information to reduce stigma and connect individuals to resources available to address behavioral health challenges.
- Crisis Center for South Suburbia: Supporting counseling for individuals experiencing domestic violence and their family members.
- Arab American Family Services: Preparing office space to launch behavioral health services.

Because of the resources provided and the work of the community collaborations, these relationships have the potential to grow and continue to expand offerings within the community to meet needs.

Impact of Strategy
Palos Hospital offered the Mental Health First Aid program to the community to increase awareness and reduce stigma related to mental health

- In FY23, ten classes were offered with 318 participants.
- In FY24, two classes were offered with 41 participants.
- So far in FY25, one class has been offered with 11 participants.

To address substance-use challenges, Palos Hospital participated in the National Drug-Take Back Day twice a year, collecting more than 250 pounds of medications and distributing 22 doses of Narcan from FY23 through FY25.

In FY25, Palos Hospital installed a Narcan distribution machine on the Orland Park campus. More than 80 doses have been distributed via the machine.

Palos Hospital provided funding to support community agencies via the Community Benefit Competitive Grant process. This process resulted in the following awards:

- FY23: Five grants totaling $198,000.
- FY24: Seven grants totaling $596,589.
- FY25: Grant recipients are being selected.

Strategy 1.2: Education: Expand behavioral health preventive and educational resources in collaboration with community organizations.

This strategy focused on supporting the work of the local chapter of the National Alliance on Mental Illness (NAMI) by providing resources to host a support group for friends and family of individuals facing behavioral health issues.

Impact of Strategy
Palos Hospital hosted more than 24 NAMI support group meetings with an average attendance of eight people. This strategy demonstrated how the donation of time in a conference room allowed a community organization to expand their reach to bring a support group to an additional community.

Strategy 1.3: Training: Expand behavioral health training and education for home health certified nursing assistants (CNAs).

The Palos Hospital Home Health CNAs, as well as some office staff, participated in the Mental Health First Aid program. This strategy was implemented to give tools to CNAs visiting patients in their homes for identifying common signs and symptoms of mental health and substance use challenges. Program participants learn:

- Common signs and symptoms of substance use challenges
- How to interact with a person in crisis
- How to connect a person with help
- Expanded content on trauma, substance use and self-care

Impact of Strategy
Palos Hospital Home Health patients interact with caregivers who are better prepared to help individuals in need of behavioral health care.

Strategy 1.4: Access: Pilot a collaborative care model by embedding a social worker in a primary care practice to co-manage behavioral health issues and facilitate additional referrals to behavioral health practitioners as needed.

The collaborative behavioral healthcare program (CBHP) adds a layer of care to the primary care setting for screening and addressing behavioral health issues early. Early access to this care may prevent issues from escalating into a behavioral health crisis. Palos Hospital's primary care practices launched the program on in 2024.

Impact of Strategy
Between September 1, 2024, and January 15, 2025, 11,025 patients received basic screening for anxiety and depression; more than 1,300 of those patients were given additional screenings. Two hundred sixty-one unique patients were eligible for the CBHP. There have been 52 patients referred to the program, and 15 have been connected to additional support to address general anxiety and/or depression.

Priority health need 2: Culturally and linguistically appropriate care

Goal: Promote inclusion for Palos Hospital patients and employees by offering training, programming and translations appropriate for communities served within the Palos Hospital CSA.

Strategy 2.1: Programming: Increase culturally and linguistically appropriate programs, including educational opportunities, cooking demonstrations, health screenings and opportunities to receive a flu vaccination in collaboration with community organizations.

By working with community-based organizations, we increased trust among under-resourced communities and provided basic health information and screenings to empower individuals to work toward a healthier lifestyle. Community-based screenings helped identify people with unmanaged high blood pressure as well as increased awareness of heart disease and the importance of measures to prevent or manage it. Patients who screened 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 when necessary, they were referred to a primary care site.

Impact of Strategy
Palos Hospital provided a variety of programs to two organizations, Mosque Foundation Food Pantry (MFFP) and Arab American Family Services (AAFS), which predominantly serve Arab American individuals in the Palos Hospital CSA.

At MFFP, Palos Hospital offered monthly blood pressure screenings with education about hypertension and stroke risk:

- In FY23, 11 blood pressure clinics were held with 204 total participants; 153 of those participants (76.8%) had readings considered high risk and were advised to seek additional medical intervention.
- In FY24, nine blood pressure clinics were held with 162 participants; 104 (66.2%) were considered high risk.
- So far in FY25, one blood pressure clinic has been held with 11 participants, and 10 (90.0%) of those had readings considered high risk.

In addition to blood pressure screenings, annual influenza vaccinations were administered. Nearly 100 healthy Middle Eastern recipes (appropriate for people with diabetes) were distributed, including the spices needed to make healthy meals with ingredients frequently available from the MFFP.

Palos Hospital collaborated with AAFS to provide the following:

- In FY25, heart health education was given to 32 clients and 16 were screened for hypertension. Of the 16 screened, seven participants screened with stage 2 hypertension and one was in crisis.
- Palos Hospital provided Mental Health First Aid classes to AAFS employees.
- In FY23 and FY24, Palos Hospital provided influenza vaccinations at an annual event, resulting in a total of 15 participants receiving a vaccine..
- In FY25, a Palos Hospital registered dietitian nutritionist gave a presentation on healthy eating to 32 pregnant women or new mothers through the AAFS-hosted Women, Infants and Children (WIC) program.

To allow screening and vaccination participants to maintain their preferred level of modesty Palos Hospital used a privacy screen for participants that may prefer not to reveal their arm in public.

With the Illinois Coalition for Immigrant and Refugee Rights, Palos Hospital provided financial support in FY23 and FY24 to fund classes to educate individuals new to the U.S. about getting medical care.

Strategy 2.2: Training: Promote inclusion by educating staff members on the key components of delivering care while being sensitive to unique cultures, customs and religions.

Through education, Palos Hospital team members gained a better understanding of customs and a faith different from their own, creating a more welcoming setting for all patients. For example, working with Arab American Family Services (AAFS), Palos Hospital leaders learned about Middle Eastern culture.

Impact of Strategy
During FY25, more than 80 leaders at Palos Hospital learned about Islam and Middle Eastern culture from presentations led by one of the founders of AAFS. Two additional presentations are slated for caregivers in the Mother/Baby unit and the Home Health division.

Emergency Department physicians and employees received training and a supply of hijabs to offer to female patients. In an emergency, women may arrive at the hospital without their head covering because it was damaged or lost.

Strategy 2.3: Access: Assess most commonly spoken languages and identify patient materials to be translated into those languages.

Palos Hospital performed an audit of the languages used by patients, finding that Arabic is the second most common language after English. The inpatient guide has been translated into Arabic and made available to patients. A newly convened committee is reviewing additional materials for translation to other languages.

Impact of Strategy
Arabic-speaking patients and their families now receive the same information as those who speak English or Spanish.

Priority health need 3: Food access and security

Goal: Improve access to healthy and affordable food options and nutrition education for communities within the Palos Hospital CSA.

Strategy 3.1: Access: Ensure safe storage of unused food for use by a community partner that addresses needs related to homelessness.

Palos Hospital has a collaborative relationship with BEDS Plus, a housing organization that serves southwest suburban Cook County. The hospital implemented a program that rescues nutritious food from the hospital's cafeteria that may otherwise go to waste and delivers it to BEDS Plus shelter locations.

Impact of Strategy
During FY23, FY24 and FY25, Palos Hospital provided more than 150 trays of food to BEDS Plus. BEDS Plus served this food to their guests. The relationship with BEDS Plus has expanded over time, and in FY25, Palos Hospital employees now regularly volunteer for the housing organization.

Strategy 3.2: Access: Implement electronic medical record screening tool to connect patients with local agencies that assist with food resources.

During FY23, Palos Hospital primary care practices introduced the electronic medical record screening tool. Patients seen at those practices are screened for needs related to social drivers of health (SDOH). Individuals who screen positive for a need receive a call from a community health worker, who tells them about resources available in the CSA.

Impact of Strategy
Since the launch of this program, 879 patients have been screened, with 166 identifying as food insecure. Of those patients, 49 were successfully contacted and given information about resources available within the community.

Strategy 3.3: Access: Promote access to food and support nutrition education through funding in collaboration with community organizations.

Palos Hospital provided funding through the Community Benefit Competitive Grant process as well as donations to address food access and security.

Examples of the organizations and strategies funded include the following:

- The Hope Center: Growing and providing fresh vegetables to clients experiencing food insecurity every 28 days, year-round, by using aquaponic and hydroponic equipment.
- Moraine Valley Community College: Providing food to students experiencing food insecurity with a pantry they constructed.
- Mosque Foundation Food Pantry: Rescuing food donated from area restaurants and stores as well as delivering food to clients unable to drive to pantry with vehicle purchased with funding.

Impact of Strategy
The Community Benefit Competitive Grant process resulted in the following awards:

- FY23: Three grants and three donations totaling $126,500.
- FY24: Six grants totaling $260,900.
- FY25: Grant recipients are being selected.

Over the last few years, the financial support provided by Northwestern Medicine enhanced the availability of nutritious foods to residents experiencing food insecurity.

BACK TO TABLE OF CONTENTS ▶

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	American Cancer Society	Breast cancer screening	cancer.org
	BRIA Health Services	Breast cancer support	briahs.com/location/palos-hills-strive-center-for-rehabilitation
	Lemont Nursing and Rehabilitation Center	Nursing home and rehabilitation center	lemontcenter.com
	Northwestern Medicine Palos Hospital	Health system	nm.org
	Smith Crossing	Nursing home and rehabilitation center	smithcrossing.org
Social service organizations	BEDS Plus	Housing	beds-plus.org
	Caring Patriots	Veteran assistance	caringpatriots.org
	Crisis Center for South Suburbia	Family crisis centers	crisisctr.org
	Elim Christian Services	Disability services	elimcs.org
	Gigi's Playhouse	Disability services	gigisplayhouse.org
	Orland Township Food Pantry	Food access	orlandtownship.org/about-the-food-pantry

Category	Resource	Description	Link
Social service organizations	Palos Heights Farmers Market	Food access	palosheights.org/273/farmers-market
	Pathlights	Aging assistance and disability services	pathlights.org
	Sleep in Heavenly Peace	Housing	shpbeds.org
	Together We Cope	Housing and food	togetherwecope.org
	VKMI Hattie B. Williams Food Pantry	Food access	chicagosfoodbank.org/locations/vkmi-hattie-b-williams-food-pantry
	Arab American Family Services	Comprehensive social service assistance	aafsil.org
	The Bridge Teen Center	Youth programs	thebridgeteencenter.org
Behavioral health services	Sertoma Star Services	Behavioral health services	sertomastar.org
	Metropolitan Family Services	Behavioral health services	metrofamily.org

BACK TO TABLE OF CONTENTS ▶

Appendix C

CHNA Timeline and Community Details

Timeline for the Palos Hospital CHNA

Phase	Description	Date
Assessment and analysis	Overall	March 2024 to March 2025
	Community input survey	March 2024 to December 2024
	Focus groups	February to March 2025
	Key interviews	February to March 2025
Prioritization	Overall	May 2025
	Community Engagement Council	May 28, 2025
Approval	Palos Community Hospital Board of Directors	July 29, 2025
Report made widely available to the public	Website	August 31, 2025
	Paper copy available at no charge on request	August 31, 2025
Public comment	Northwestern Medicine Palos Hospital 2025 CHNA	August 31, 2025, through August 31, 2031
	Northwestern Medicine Palos Hospital 2022 CHNA	August 31, 2022, through August 31, 2028

Community Details

CSA cities and ZIP codes

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

BACK TO TABLE OF CONTENTS ▶

Appendix D

A Closer Look at Data

Community input survey

The survey was shared widely through social media, email blasts and in-person events in collaboration with community organizations. Metopio and AHE collected 1,195 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 (44.0%)
2. Cancer (41.0%)
3. Adolescent mental health (34.0%)
4. Obesity (30.5%)
5. Heart disease (30.5%)
6. Alzheimer's disease, dementia (26.1%)

The following factors that support improvements in health needs were selected by 25.0% or more of the survey respondents:

1. Access to health care and affordable medical care professionals (39.8%)
2. Medication affordability (37.6%)
3. Access to care for older adults (35.1%)
4. Affordable, safe housing (34.4%)
5. Eating healthy (31.6%)
6. Insurance access and affordability (29.2%)
7. Access to affordable food (27.6%)
8. Safety (27.2%)

Community focus groups and key interviews

We facilitated 13 focus groups in the CSA and conducted eight key interviews with persons representing the interests of the community. 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 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.

We thank the community members and the following community organizations that participated in focus groups and key interviews:

- Arab American Family Services
- City of Palos Heights
- Moraine Valley Community College
- Pathlights
- Stickney Township Public Health District
- VKMI Hattie B. Williams Food Pantry

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

Access to health care

- Better coordination of care needed for older adults
- Cost of care and medications
- Limited availability of appointment times
- Linguistically and culturally competent care
- Transportation needs for medical appointments and other common locations

Behavioral health and substance use disorder

- Access to behavioral health care
- Stigma around receiving behavioral health care
- Substance use among youth

Community health

- Cost of food, housing and other necessities
- Limited public transportation and other affordable options
- Long distances to nearest medical facilities and grocery stores
- Social isolation among older adults

Appendix E

References

1. U.S. Census Bureau. (2019–2023). *American community survey*. U.S. Department of Commerce. Accessed through Metopio.
2. Office of Disease Prevention and Health Promotion. (n.d.). Social determinants of health. *Healthy People 2030*. U.S. Department of Health and Human Services. odphp.health.gov/healthypeople/priority-areas/social-determinants-health
3. Millman, M. (1993). *Access to health care in America*. Institute of Medicine (US) Committee on Monitoring Access to Personal Health Care Services. ncbi.nlm.nih.gov/books/NBK235882/
4. Office of Disease Prevention and Health Promotion. (n.d.). Health care access and quality. *Healthy People 2030*. U.S. Department of Health and Human Services. health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality
5. Area Health Resources & Services Administration. (2022). *Area health resource files*. U.S. Department of Health and Human Services. Accessed through Metopio.
6. Office of Disease Prevention and Health Promotion. (n.d.). Economic stability. *Healthy People 2030*. U.S. Department of Health and Human Services. odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability
7. Centers for Disease Control and Prevention. (2022, May 17). *Social determinants of health (SDOH)*. U.S. Department of Health & Human Services. from cdc.gov/socialdeterminants/index.htm
8. Environmental Protection Agency. (2024). *EJScreen: Environmental Justice Screening.* Accessed through Metopio.
9. Feeding America. (2022). *Map the meal gap*. Feeding America. Accessed through Metopio.
10. Americans With Disabilities Act of 1990, 42 U.S.C. § 12101 et seq. (1990). ada.gov/pubs/adastatute08.htm
11. Bass B, Nagy H. (2023) *Cultural competence in the care of LGBTQ patients*. StatPearls Publishing. ncbi.nlm.nih.gov/books/NBK563176/
12. Hartinger-Saunders, R. M., Rine, C. M., Nochajski, T., & Wieczorek, W. (2012). Neighborhood crime and perception of safety as predictors of victimization and offending among youth: A call for macro-level prevention and intervention models. *Children and Youth Services Review*, 34(9), 1966–1973.
13. Federal Bureau of Investigation. (2023). *FBI crime data explorer*. Federal Bureau of Investigation. Accessed through Metopio.
14. Centers for Disease Control and Prevention. (2022). *Behavioral risk factor surveillance system.* U.S. Department of Health and Human Services. Accessed through Metopio.
15. Centers for Disease Control and Prevention. (2022). *PLACES*. U.S. Department of Health and Human Services. Accessed through Metopio.
16. Illinois Department of Public Health. (2017–2021). *Illinois state cancer registry*. Illinois Department of Public Health. Accessed through Metopio.
17. National Center for Health Statistics. (2020). *U.S. small-area life expectancy estimates project – USALEEP*. Centers for Disease Control and Prevention. Accessed through Metopio.
18. Centers for Disease Control and Prevention. (2018–2022). *National vital statistics system-mortality*. U.S. Department of Health and Human Services. Accessed through Metopio.
19. Illinois Health and Hospital Association. (2019–2023). *COMPdata informatics*. Illinois Health and Hospital Association. Calculated by Metopio.
20. Centers for Disease Control and Prevention. (2022). *National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: Atlas Plus*. Accessed through Metopio.
21. 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/
22. Office of Disease Prevention and Health Promotion. (n.d.). Tobacco use. *Healthy People 2030*. U.S. Department of Health and Human Services. odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/tobacco-use
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 Palos 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. Because of variations in data collection time frames 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 2025 CHNA report for Northwestern Medicine Palos Hospital is available to the public at no charge.

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 Palos Hospital
12251 South 80th Avenue
Palos Heights, Illinois 60463

Public comment

As of May 2025, Northwestern Medicine Palos 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 Palos 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.

Northwestern Medicine®

Northwestern Medicine Palos Hospital
12251 South 80th Avenue
Palos Heights, Illinois 60463
708.923.4000

TTY for those who are deaf or hard of hearing: 711

nm.org

For healthcare information at your fingertips, download the MyNM® app today.

Download on the App Store | GET IT ON Google Play

25-1921/0525