Northwestern Medicine®

2024 Community Health Needs Assessment

Northwestern Medicine Valley West Hospital

Your Feedback Makes Us Better

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

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

Foreword

Our Commitment to Equity

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

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

Three pillars of community work

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.

Structural inequities and bias

We elevate initiatives that:

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

Coordination and connection to community resources

We elevate initiatives that:

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

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

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Introduction to the Community Health Needs Assessment

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

Goals of our CHNA

The goals of the CHNA were to:

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

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

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How we achieved our goals

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

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

We identified health needs among people across all:

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

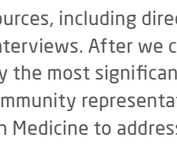
While we assessed information across our entire service area, this report highlights health inequities and needs that disproportionately impact people in communities that have been historically under-resourced and have a higher percentage of people with barriers to health and wellness, such as a lack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

Priority health needs

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

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

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



Addressing identified priority health needs

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

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

Acknowledgments

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

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

Who We Are

Get to know Northwestern Memorial HealthCare

Who we are

Nonprofit | Growing, nationally recognized | World-class care

Who we serve

Rural | Suburban | Urban

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

We are...

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

Our mission

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

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

Improve the health of the communities we serve

How we achieve our mission

As a pillar in the community, Northwestern Medicine Valley West 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 allies that share our vision of building stronger, healthier communities.
- We are a major economic driver in the communities we serve.

About Northwestern Medicine Valley West Hospital

25 beds

Critical access

Located in **DeKalb County**, Illinois

Services: The hospital provides care through a range of emergency, inpatient and outpatient services. Specialty care services include imaging, neurosciences, occupational health, orthopaedics, skilled nursing and rehabilitation services. We are also home to the Homeward Healing Swing Bed Program, a Sleep Health Center and the Bluhm Cardiovascular Institute.

Community: Rural

Northwestern Medicine Valley West Hospital

Located in Sandwich, Illinois, Northwestern Medicine Valley West Hospital is a 25-bed critical access hospital that has served the residents of DeKalb County and the Fox Valley region for more than 70 years. Critical access hospital is a designation given to eligible rural hospitals by the Centers for Medicare & Medicaid Services (CMS). As a critical access hospital in a service area that encompasses parts of DeKalb County, with its federally designated medically underserved areas, Northwestern Medicine Valley West Hospital provides essential services to its rural community and acts as a seamless pathway from critical access to specialty care across the health system. More than 150 physicians are on the hospital medical staff, representing a wide range of specialties. In fiscal year 2023, Northwestern Medicine Valley West Hospital had more than 470 inpatient admissions and nearly 9,000 emergency department visits.

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

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

Defining the Community Service Area

How the Community Service Area was determined

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

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

The defined CSA takes into account populations that are:

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

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

How the Community Service Area is defined

DeKalb, Kendall, LaSalle and Lee Counties, Illinois

6 ZIP codes

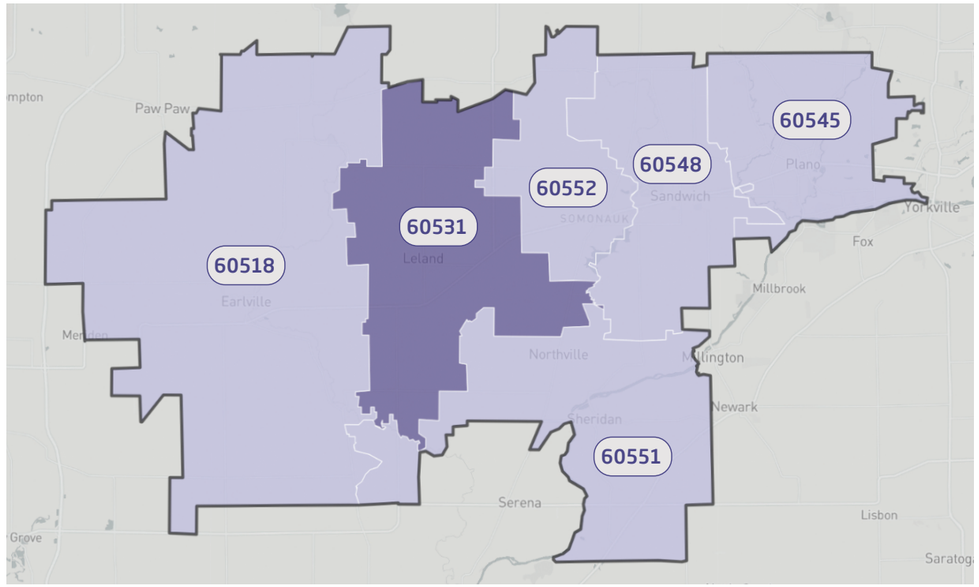
357.9 square miles

40,915 residents

Predominantly **rural**

CSA Cities and ZIP Codes

City	ZIP Code	City	ZIP Code
Earlville	60518	Sandwich	60548
Leland	60531	Sheridan	60551
Plano	60545	Somonauk	60552



Northwestern Medicine Valley West Hospital Community Service Area. The location in dark purple (ZIP code 60531, Leland) has been identified as an under-resourced community by SERI.

Community Service Area map

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

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

Under-resourced areas are concentrated in the middle of the CSA around Leland.

Completing the Assessment

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

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

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

Primary data

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

Community input surveys at a glance

- Conducted from October 2023 to January 2024 by Metopio
- Insights collected from 297 survey participants within the defined CSA
- Intended to gain first-hand information from people who are typically under-represented in the assessment process, including people of color, immigrants, people who identify within the LGBTQ+ community, people with disabilities and people with low income
- Collected from individuals 18 years and older
- Available online or on paper
- Disseminated in English and Spanish
- Seventy-six questions
- Asked about demographic data, community health status, strengths, opportunities for improvement and COVID-19 effects
- Promoted widely through social media, email blasts and in-person events
- Also promoted in collaboration with local community organizations (both paper and online versions)

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

Focus groups at a glance

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

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

Key informant interviews at a glance

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

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

Secondary data

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

- Social Determinants of Health
- Health Conditions
- Health Behaviors

Secondary data sources at a glance

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

Key Findings

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

Who lives in the communities we serve

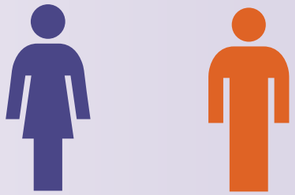
Demographics

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

Population[1]

40,915
residents

Sex[1]



19,044
(46.5%) females

21,871
(53.5%) males

Accurate and complete data for people who are transgender, nonbinary and gender-nonconforming in DeKalb, Kendall, LaSalle and Lee counties is limited.

Age[1]

Age Group	Population in the Hospital's CSA	Percentage in the Hospital's CSA
17 years and younger	8,665	21.2%
18 to 39	12,977	31.7%
40 to 64	13,087	32.0%
65 and older	6,186	15.1%

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

Race and ethnicity[1]

- Majority non-Hispanic white population
- The Hispanic or Latino and Asian populations have grown over the last decade

Race and Ethnicity	Population in the Hospital's CSA	Percentage in the Hospital's CSA
Non-Hispanic White	31,379	76.8%
Hispanic or Latino	6,705	16.4%
Non-Hispanic Black	1,552	3.8%
Two or more races	810	2.0%
Indigenous American	810	2.0%
Asian	430	1.1%

Language

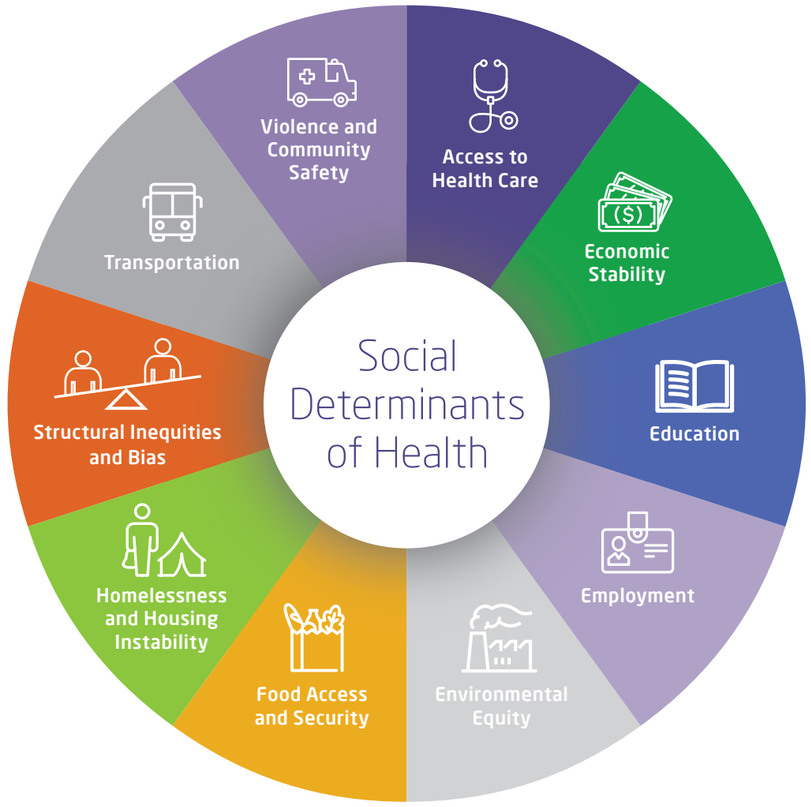
Language skills affect the ability to access, understand and act on health information.

5.7%
of the hospital's CSA residents were not born in the United States (as compared with 14.2% of residents in Illinois)[1]

2.2%
of the hospital's CSA residents speak limited English (as compared with 3.9% of residents in Illinois)[1]

Social determinants of health

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



Access to Health Care

Within the CSA, 43.0% of survey respondents named access to health care as a top community issue, and 44.8% of survey respondents named medication affordability as a top community issue, making up the top two issues of all survey respondents. Access to health care is broadly defined as the "timely use of personal health services to achieve the best health outcomes."[3]

Accessing health insurance is essential for promoting and maintaining health and preventing and managing disease. According to Healthy People 2030, people without insurance are less likely to have a primary care clinician, and they may not be able to afford the healthcare services and medications they need.[4]

Healthcare access and quality can vary greatly between communities. Within the CSA, 4.9% of residents do not have medical insurance, which is two percentage points lower than the state average of 7.0%.[1] Within the CSA, 35.2% of survey respondents said that insurance access and affordability was one of the top concerns in the community.

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

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

"Valley West not having a surgeon on staff ... plays a role in the community because **people still don't know where to go**."[24]

Transportation was a major theme of discussion among focus group participants.

Residents must travel long distances to reach services because of the rural landscape, and walking is not feasible. There are few affordable transportation options.

Focus group participants emphasized that transportation barriers particularly affected older adults, families with young children, pregnant individuals and individuals with disabilities.

Economic Stability

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

Communities in the CSA have significant and concentrated areas of poverty, the highest being in Leland (ZIP code 60531) at 21.1% and the lowest being in Somonauk (60552) at 5.1%.[1]

In Illinois, the median household income is $71,917, which is lower than the CSA's median household income at $80,085. However, when looking at the communities making up the CSA, Earlville (60518) has a lower median household income than the state at $63,551.[1]

Socioeconomic Status	Percentage in the CSA
Persons Living at or Below the Federal Poverty Level	10.2%
Persons Living at or Below 200% of the Federal Poverty Level	24.3%

Below 200% of the Federal Poverty Level | 2018–2022

CSA: **24.3%** ±3.8% of residents

Education

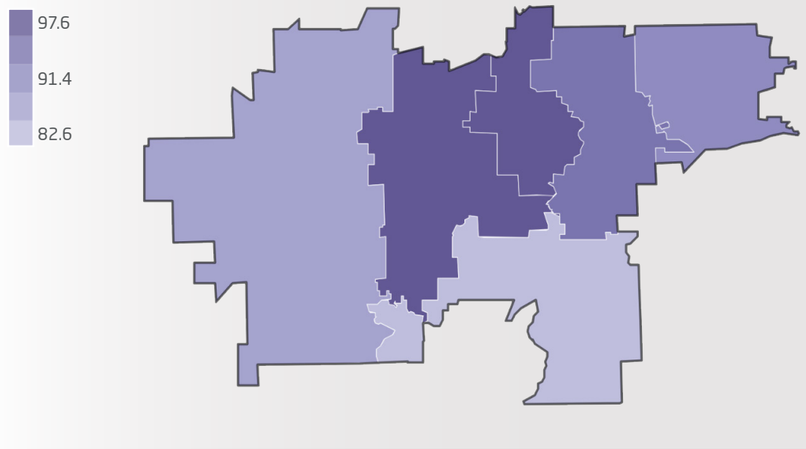
Poverty, unemployment and underemployment are highest among those with less education.[5] A higher level of education is linked to positive health outcomes.

Within the CSA[1]:

- 90.9% of adults 25 years and older have at least a high school diploma (or equivalent).
- That number is 90.1% for the state of Illinois.

High School Graduation Rate | 2018–2022

CSA: **90.9%** ±4.4% of residents



Employment

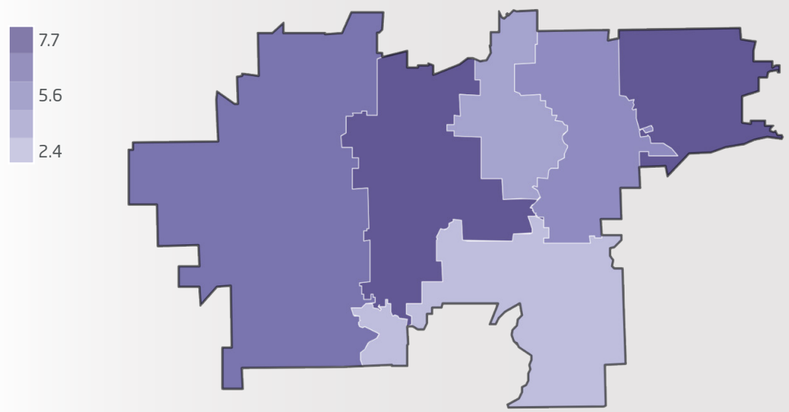
Financial security makes it easier for individuals and families to obtain resources for healthy living and serves as a predictor for positive health outcomes.

From 2018 to 2022[1]:

- The unemployment rate in the CSA averaged 5.7%.
- Leland (60531) had the highest unemployment rate in the CSA at 6.6%.

Unemployment Rate | 2018-2022

CSA: **5.7%** ±1.5% of residents



Environmental Equity

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

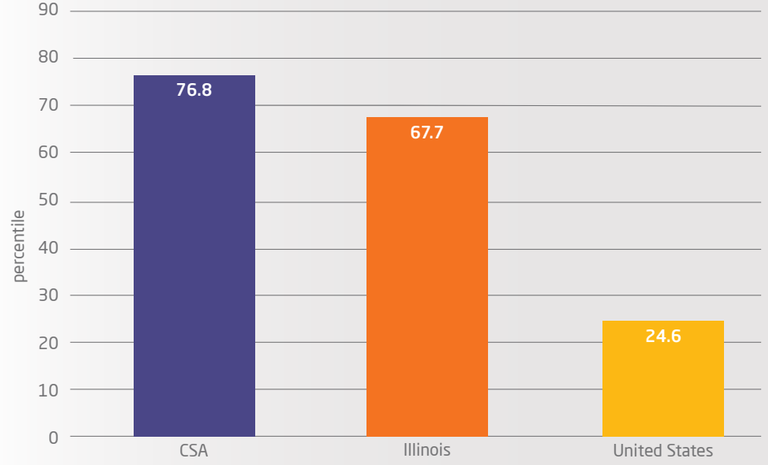
A clean, safe and healthy environment is a significant contributor to the health of individuals and populations. The community environment can affect health outcomes in many ways. Particulate matter is one of the most dangerous pollutants because these particles can penetrate deep into the lungs and cause negative health effects. This includes premature death from cardiovascular disease or lung cancer, and increased health problems such as asthma attacks.

In the CSA, particulate matter was estimated in the 77th percentile, which is higher than Illinois in the 67th percentile.[6] This rating is based on the Particulate Matter Environmental Justice Index, in which 0 is the lowest exposure and 100 is the highest exposure.

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

Particulate Matter Environmental Justice Index, 2022

CSA and comparison



Created on Metopio | metop.io/i/8yfzo658 | **Data Source:** Environmental Protection Agency (EPA): EJScreen: Environmental Justice Screening. **Particulate matter Environmental Justice Index:** Weighted index of vulnerability to particulate matter. Measures exposure to PM 2.5 in the air, weighted by population vulnerability and reported as a percentile nationally, where 0 = lowest exposure, and 100 = highest exposure. Weighting by the vulnerability of residents can provide a better estimate of the disproportionate impact of environmental hazards.

Food Access and Security

In the CSA, 26.1% of survey respondents said that access to affordable food was a top concern, and 32.2% of survey respondents said that eating healthy was a top concern.

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

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

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

Community Input:[24] WIC*

One focus group participant mentioned that walking to the nearest WIC clinic would take a long time and may not be safe for expectant mothers in cold weather.

Another focus group participant highlighted the lack of public transportation, making it difficult to access resources like WIC.

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

Focus group participants also highlighted the disparity in access to food and social services in the southern part of the county, particularly for Spanish-speaking populations.

In the CSA, 11.2% of residents experience food insecurity, which is higher than the state at 8.3%. Food insecurity is the highest in Earlville (60518) at 13.9% of residents and the lowest in Plano (60545) at 10.1% of residents.[8]

In addition, 68.1% of residents in the CSA have low food access, meaning that those who live in urban areas live further than a half mile from the nearest supermarket and those who live in rural areas live further than 10 miles from the nearest supermarket.[9]

Community members discussed food insecurity in the area and potential solutions, including Meals on Wheels and Elder Care Services programs.

Among households in the CSA,

8.7%

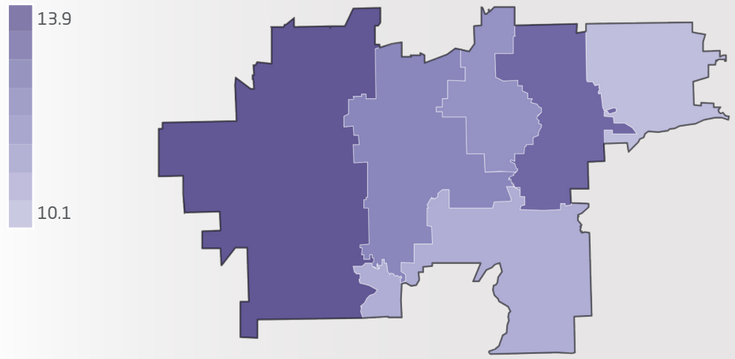
receive Supplemental Nutrition Assistance Program (SNAP)* benefits, which is lower than Illinois at 13.0%.[1]

Food Access and Security (continued)

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.

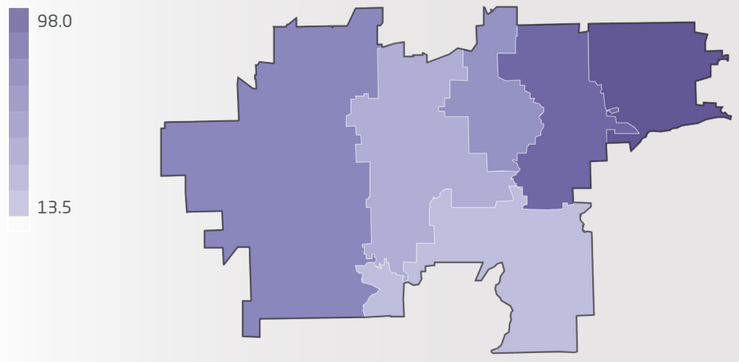
Food Insecurity | 2020

CSA: **11.2%** of residents



Low Food Access | 2019

CSA: **68.1%** of residents



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

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

Homelessness and Housing Instability

In the CSA, 26.1% of survey respondents said access to safe, affordable housing was a top concern. Homelessness was identified as both a root cause and a direct outcome of substance use disorders and chronic disease. Addressing housing issues offers a unique opportunity to address an important SDOH.[2]

In addition, 24.3% of households in the CSA spend more than 30% of their income on housing, classifying them as housing cost burdened.[1] Among households in the CSA, 10.0% are severely housing cost burdened, meaning that they spend more than 50% of their income on housing costs.[1] This significantly affects their ability to pay for other necessities, such as food, transportation and health care.

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

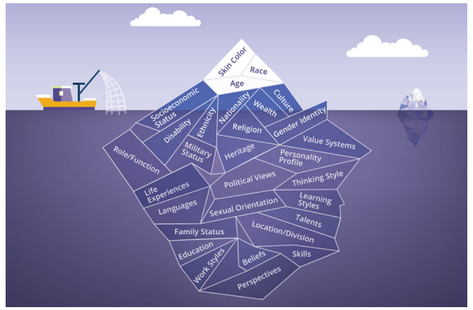
Additionally, focus group participants discussed the inaccessibility to housing for vulnerable populations. One participant noted that the application for affordable housing and internet plans may be too complex for some families to understand. Another participant said that DeKalb County is making strides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

Community Input:[24] Homelessness and Housing Instability

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

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

Structural Inequities and Bias



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

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

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

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

LGBTQ+ Cultural Responsiveness
Providing a safe, affirming environment is essential to welcome patients from the LGBTQ+ community. There is evidence that sexual minorities (LGBTQ+) and transgender or gender-nonconforming patients can have significant difficulty in accessing appropriate care, developing trust in the care team and receiving safe and effective health care throughout their lives.[22]

Community Input:[24] Structural Inequities and Bias

One focus group participant suggested providing cultural competencies training for staff working with youth on gender-affirming health care, to create a comfortable and supportive environment.

Another focus group participant requested training on pronoun usage and awareness for public employees, to improve understanding and inclusivity.

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

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

Structural Inequities and Bias (continued)

Structural Racism

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

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

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

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

Transportation

In the CSA, 31.7% of survey respondents and many focus group participants said that transportation was a top concern in their community. Safe and reliable transportation is essential to accessing healthcare appointments, social services, work, school and grocery stores. A lack of transportation is associated with adverse health outcomes.

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

Community Input:[24] Transportation

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

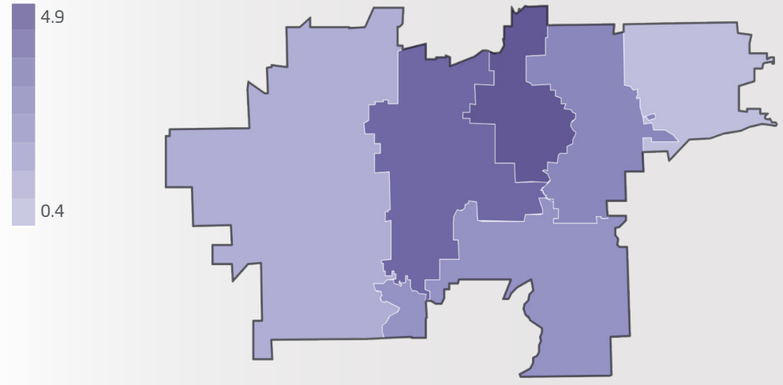
The county does not have a large public transit network, so only 0.3% of residents commute to work by public transportation.[1]

Within the CSA, 2.8% of households have no vehicle available, but that number climbs as high as 4.9% in some rural areas and areas where more residents have low income, especially near Somonauk.[1]

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

No Vehicle Available | 2018-2022

CSA: **2.8%** ±0.7% of households



Violence and Community Safety

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

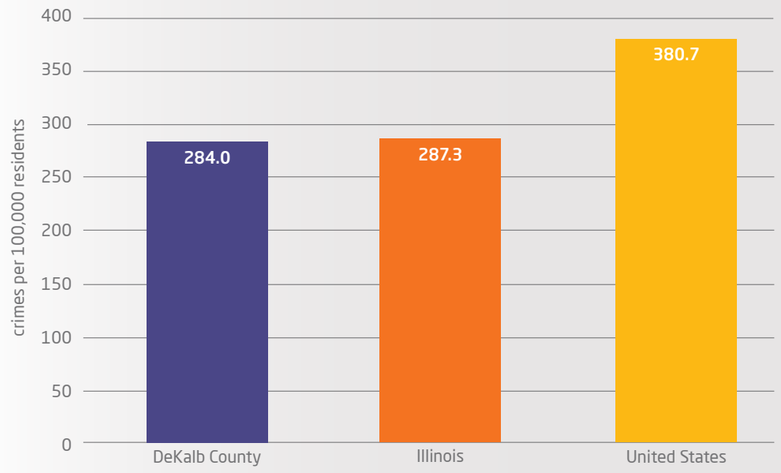
- Concentration of poverty
- Education inequities
- Poor access to health services
- Mass incarceration
- Differential policing strategies
- Generational trauma

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

Within the CSA, 10.0% of survey respondents report that safety is a top concern in the community.

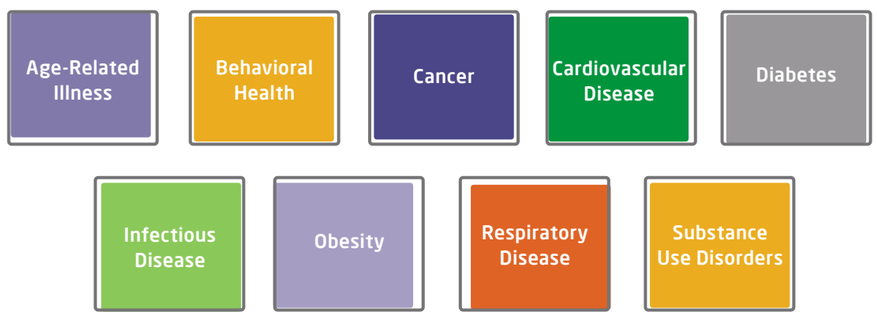
The rate of violent crime in DeKalb County is **284.0 cases per 100,000 residents,** which is lower than the United States average at 380.7 and similar to the Illinois average at 287.3.[11]

Violent Crime, 2022
DeKalb County, Illinois and comparison



Created on Metopio | metop.io | **Data sources:** Federal Bureau of Investigation: Crime Data Explorer, Chicago Police Department: crime data portal (for Illinois)
Violent crime: Crimes related to violence (yearly rate). Includes homicide, criminal sexual assault, robbery, aggravated assault, battery.

Health conditions



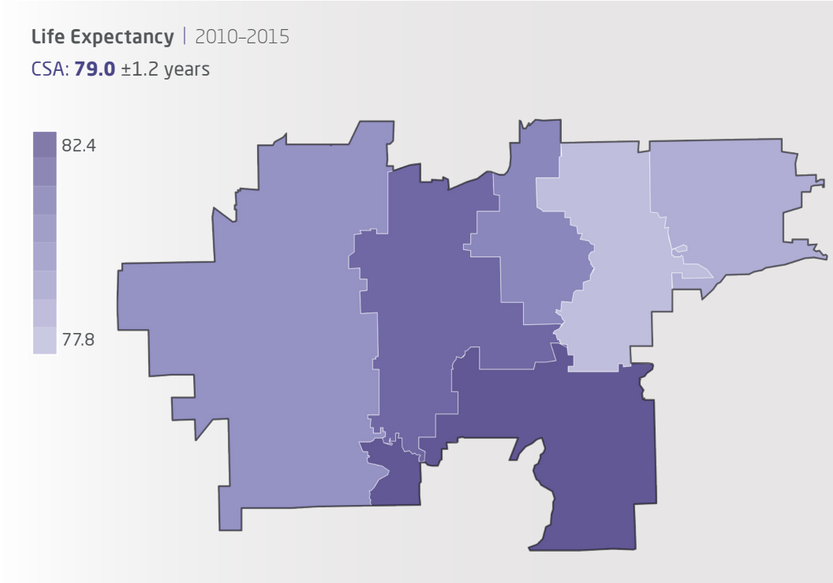
Overall, estimates of disease burden in the CSA are similar or slightly higher than those reported for the state of Illinois.

Health Condition[12]	Prevalence in the CSA	Prevalence in Illinois
Obesity	35.7%	33.6%
High Blood Pressure	29.7%	29.0%
Diabetes	9.0%	9.8%
Asthma	9.8%	9.5%
Cancer (diagnosis rate)	590.4 per 100,000 residents	570.7 per 100,000 residents

Life expectancy in the CSA

Life expectancy is a core measure of the overall health of a community. It allows for comparisons between generations and to understand the long-term impact of macro changes in community conditions, such as an epidemic or systemic poverty and a lack of access to resources. In the hospital's CSA, there is a four-year gap between the community with the highest life expectancy (Sheridan) and the lowest life expectancy (Sandwich).[13]

- Overall life expectancy in the CSA: 79.0 years
- Lowest life expectancy: 77.8 years in Sandwich (60548)
- Highest life expectancy: 82.4 years near Sheridan (60551)



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Age-Related Illness

Within the CSA, age-related illness (especially Alzheimer's) emerged as an important health issue through the community input survey. For the purposes of this report, age-related illness includes:

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

Alzheimer's Disease Mortality
Annual Deaths per 100,000 Residents[14]

DeKalb County: **33.7**
LaSalle County: **38.9**
Kendall County: **21.7**
Lee County: **26.8**
Illinois: 25.9

Arthritis[12]

CSA: **22.3% of adults**
Illinois: 20.4% of adults

Vision Difficulty[1]

CSA: **1.2% of adults**
Illinois: 2.1% of adults

Hearing Difficulty[1]

CSA: **3.0% of adults**
Illinois: 3.0% of adults

Behavioral Health

Mental health disorders are common and affect people of all demographics. Conditions like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders.

Within the CSA, **adult and adolescent mental health** were **two of the top health-related challenges** in the community according to survey respondents.

Focus group participants highlighted the following needs:

- Improved access to treatment, including more mental health workers and adequate emergency room care for mental health crises
  - There are 44.4 mental health professionals per 100,000 residents in the CSA, which is significantly lower than Illinois at 334.4 mental health professionals per 100,000 residents.[15]
- Improved continuity of care for individuals transitioning from hospital to home
- Increased mental health services for youth

Community Input:[24] Behavioral Health

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

"Behavioral health care and physical health care really need to pay attention: a lot of the people we work with come in looking one way, and it turns out that it's a result of trauma in their life. And we're at a point now where a lot of people have had that experience of trauma. So I think trauma-informed [care] or at least trauma awareness always needs to be a part of what we're talking about."

- Focus Group Participants

Behavioral Health (continued)

The suicide and self-injury hospitalization rate in the CSA is 31.7 per 100,000, which is lower than the state at 45.6, and has been declining since 2016.[16]

Suicide Mortality
Annual Deaths per 100,000 Residents[14]

DeKalb County:	Kendall County:	LaSalle County:	Lee County:
15.3	**10.4**	**17.1**	**19.8**

Illinois: 10.9

As of 2021, 20.7% of adults in the CSA reported having been diagnosed with depression.[12]

- 15.6% of residents have poor self-reported mental health[12]
- 17.0% of residents report having low social-emotional support[12]
- 17% of survey respondents reported needing mental health treatment
  - 75% of those survey respondents received the treatment they needed

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

Cancer

Among survey respondents in the CSA, **32.6% of community input survey respondents identified cancer as an important health need in the community**. This made cancer the third highest in the list of most important health needs. Focus group participants identified inadequate access to health services, insurance issues and environmental factors as contributors to the prevalence of cancer in the community.

Within the CSA, 6.2% of adults report having had cancer. The mortality rate is 167.4 deaths per 100,000 residents for DeKalb County, 145.6 for Kendall County, 187.3 for LaSalle County and 180.8 for Lee County. This is higher than Illinois, with a death rate of 150.0 per 100,000 residents.[14]

Cancer Diagnosis Rates[17]

	CSA	Illinois
All invasive cancers	590	571
Invasive breast cancer (females)	173	161
Colorectal cancer	50	47
Lung cancer	78	73
Prostate cancer (males)	139	142
Other cancers	177	168

Prevention and Screening Rates in the CSA vs. Illinois[12]

76.1%
of females aged 50-74
had a mammography screening in 2020
Illinois: 74.9%

81.8%
of females aged 18-64
had a Pap smear in 2020
Illinois: 81.0%

65.9%
residents aged 50-75
had a colorectal cancer screening in 2020
Illinois: 67.4%

Cardiovascular Disease

Heart disease represents the leading cause of morbidity and mortality in the CSA.[14] The burden of cardiovascular disease was uniformly evident across the county.

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

Rates of High Blood Pressure[12]
CSA:
29.7%
Illinois: 29.0%

Rates of High Cholesterol[12]
CSA:
31.5%
Illinois: 28.2%

The stroke hospitalization rate in the CSA is significantly lower than the state's: 126.1 per 100,000 residents compared with 218.0 per 100,000 residents in Illinois. When stratifying by race and ethnicity, the rate is lower for the non-Hispanic white population when compared with the state (145.6 vs. 214.4).[16]

The heart attack hospitalization rate in the CSA is 106.7 per 100,000 residents, which is also significantly lower than Illinois (165.8). When stratified by sex, males are disproportionately impacted, and that remains consistent at the state level.[16]

Heart Disease Mortality
Annual Deaths per 100,000 Residents[14]

DeKalb County: **155.6**
LaSalle County: **185.4**
Kendall County: **123.7**
Lee County: **184.8**
Illinois: 165.3

Stroke Mortality
Annual Deaths per 100,000 Residents[14]

DeKalb County: **39.3**
LaSalle County: **39.3**
Kendall County: **39.7**
Lee County: **37.3**
Illinois: 39.1

Making sure people who experience a cardiovascular emergency – such as stroke, heart attack or cardiac arrest – get timely recommended treatment is essential to reduce the risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.[4]

Diabetes

In the survey of the CSA residents, 20.0% listed diabetes as the most important health need in the community, placing it in the top 10 health concerns, and 8.7% of survey respondents have been told they have prediabetes.

Prevalence of Diabetes[12]
CSA:

9.0% of adults

Illinois: 9.8%

Like many health conditions and exposures, diabetes rates were higher in the western side of the CSA, around Earlville. A lack of access can also be a contributing factor to poorer outcomes.

There were 143.1 Type 2 diabetes hospitalizations per 100,000 residents in the CSA, which was lower than the Illinois average at 176.4.[16] The emergency department visit rate for people with uncontrolled diabetes was 20.2 per 100,000 in the CSA, which was also lower than the Illinois average at 42.4.[16]

Infectious Disease

Review of infectious disease data primarily focused on rates of sexually transmitted infections (STIs), influenza and COVID-19.

The STI prevalence for DeKalb County is
813.3 per 100,000 residents
compared with 1,161.4 in Illinois.[18]

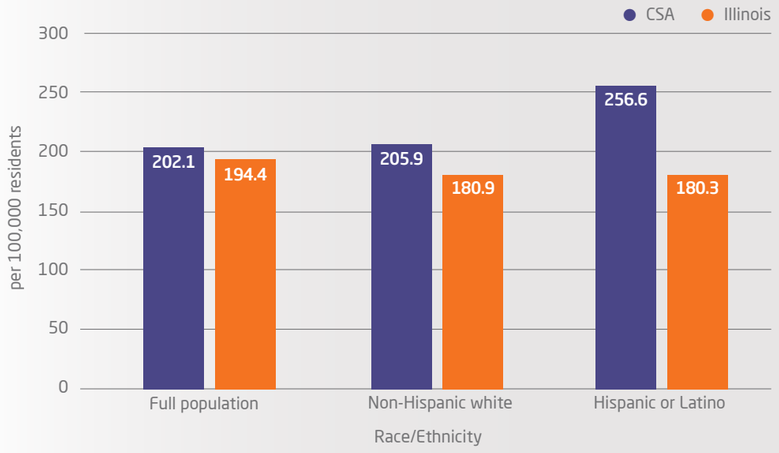
Only 25.9% of survey respondents reported ever receiving a test for human papillomavirus infection.

The pneumonia and influenza hospitalization rate in the CSA in 2022 was 195.2 per 100,000 residents, which was slightly higher than the state at 176.3.[16] A total of 35.5% of survey respondents reported that they received a flu vaccine in the last 12 months.

Regarding COVID-19, the hospitalization rate in the CSA was 267.7 per 100,000 residents in 2022, which was slightly higher than the state average of 245.9.[16]

In 2021, the COVID-19 vaccination rate was 59.7% of residents, which was lower than the Illinois and United States averages at 77.9% and 79.7%, respectively.[19] Among the survey respondents from the CSA, 79.9% reported having received at least one COVID-19 vaccine shot.

COVID-19 Hospitalizations by Race/Ethnicity, 2018-2022
CSA and Comparison



Created on Metopio | metop.io/i/mnghj8bz | **Data sources:** Wisconsin Health Association Information Center (WHAIC) (Calculated by Metopio), Illinois Health and Hospital Association COMPdata Informatics (Calculated by Metopio)
COVID-19 hospitalization rate: Annual hospital admissions for COVID-19 per 100,000 residents. Risk-adjusted by age and sex. All hospitals, all payers based on patient residence.

Obesity

Obesity is linked to many serious health problems, including:

- Cancer (some types)
- Heart disease
- Stroke
- Type 2 diabetes

Obesity is a common health condition in the CSA.

Rates of Obesity[12]

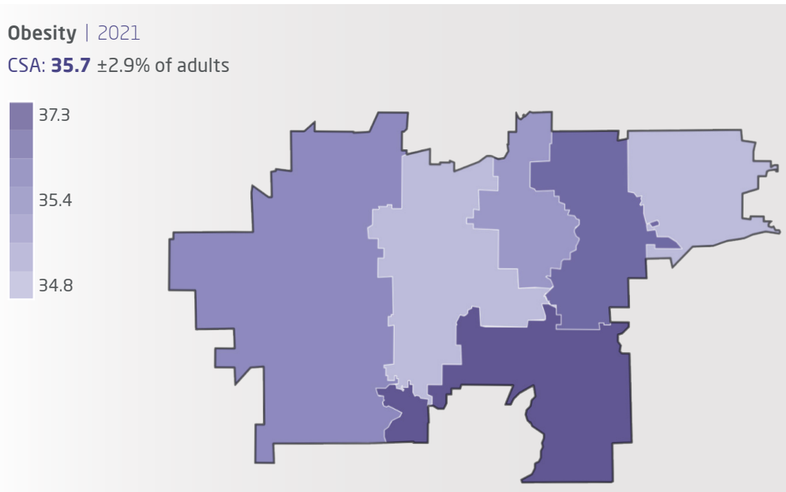
CSA:

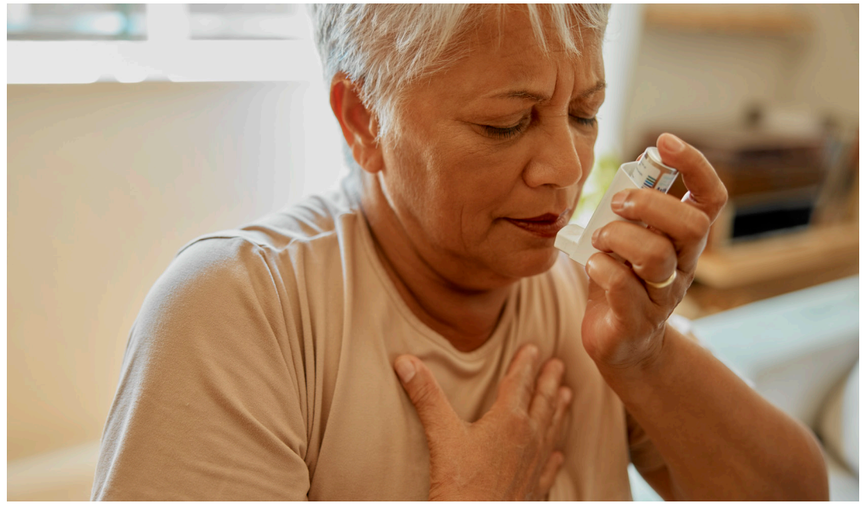
35.7% of adults

Illinois: 33.6%

Among community input survey respondents, obesity ranked fourth in the list of most important health needs affecting the community.

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





Respiratory Disease

Lung diseases did not emerge as a high priority in surveys and focus groups conducted in the CSA. Rates of asthma and chronic obstructive pulmonary disease (COPD) in the CSA are very similar to the state average.

Rates of Asthma[12]

CSA:

9.8%

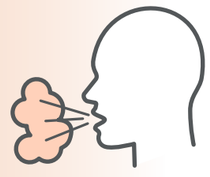
Illinois: 9.5%

Rates of COPD[12]

CSA:

6.1%

Illinois: 5.6%



Substance Use Disorders

A substance use disorder is a complex condition. If use of a substance cannot be controlled and continues despite harmful consequences and impairment in day-to-day functioning, it is termed *substance use disorder.*[20]

The COVID-19 pandemic not only highlighted the increasing burden of substance use disorders, but it also led to an increase in substance use. As of June 2020, the Centers for Disease Control and Prevention estimated that 13% of people in the United States started or increased substance use to cope with the stress and uncertainty of the pandemic.[21]

Drug Overdose Mortality Rate

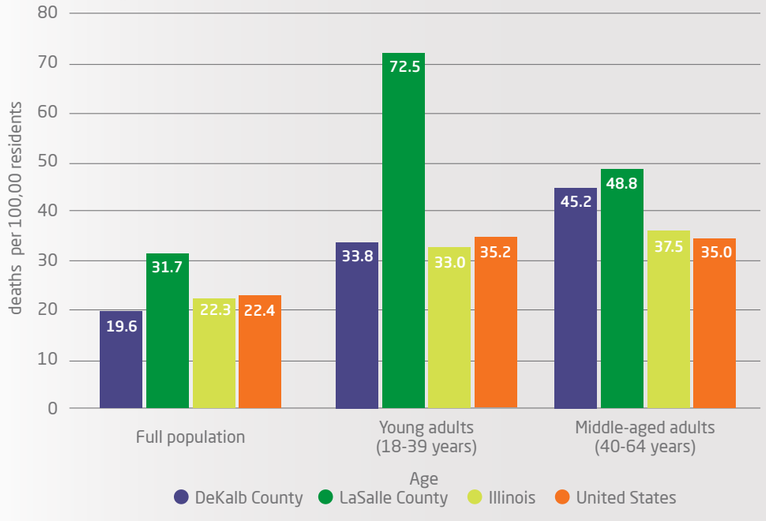
Annual Deaths per 100,000 Residents[14]

DeKalb County:	Kendall County:	LaSalle County:	Lee County:
19.6	**15.0**	**31.7**	**15.5**

Illinois: 22.3

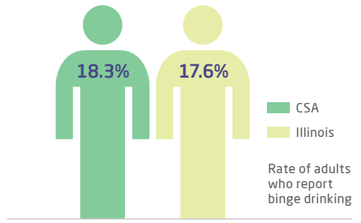
Drug Overdose Mortality Rate by Age, 2016-2020

DeKalb County and comparison



Created on Metopio | metop.io/i/vwd86ss3 | **Data sources:** Chicago Department of Public Health (Epidemiology Department: Chicago community area level, only in IL), Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC Wonder)
Drug overdose mortality: Deaths per 100,000 residents due to drug poisoning (such as overdose), whether accidental or intentional. The increase during the 2010s is largely due to the opioid overdose epidemic, but other drugs are also included here. Age-adjusted.

Substance Use Disorders (continued)



The CSA has a binge drinking rate at 18.3% of adults, which is slightly higher than Illinois (17.6% of adults).[12]

Among survey respondents in the CSA, 12.6% believed that substance use is a challenge within the community.

Community Input:[24] Substance Use Disorders

One participant mentioned that vaping has become prevalent in middle school, with some students starting as young as fifth grade.

E-cigarette and marijuana use are major concerns among high schoolers, with nicotine vaping being the most common and marijuana use also on the rise despite its legalization for those over 21.

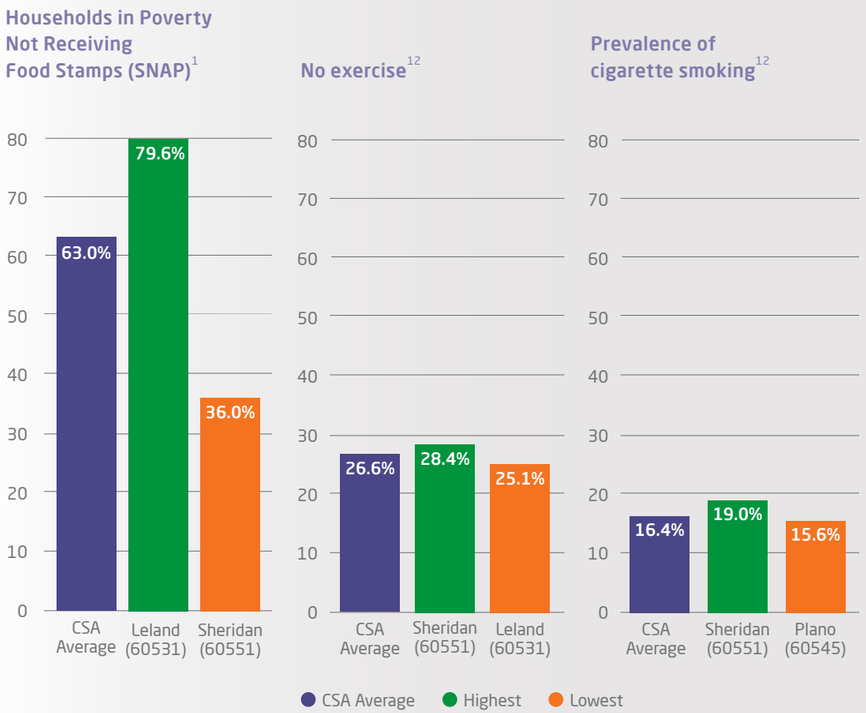
One participant said that drinking has become more accessible and easier to conceal among younger kids in their area, with the availability of sweet-tasting alcohol and lack of adult supervision at parties.

Some focus group participants said that the lack of ID checks at local stores and events makes it easier for minors to purchase alcohol and e-cigarette products without detection.

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.[23]

Health Behaviors by ZIP Code in the CSA (Adults)



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

Nutrition

Eating healthy was considered a challenge by 33.2% of survey respondents, and access to affordable food was considered a challenge by 26.1% of survey respondents.

Some people do not have the information they need to choose healthy foods, while others do not have access to healthy foods or cannot afford to buy enough food. In fact, 4,817 residents in the CSA live in food deserts.[9]

Many communities across the CSA, particularly in more rural areas, have a high level of food insecurity. 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.

Community Input:[24] Nutrition

A nutritionist suggested expanding services to the Medicaid population, offering one-on-one counseling and cooking classes.

11.2% of CSA residents are food insecure[8]

Illinois: 8.3%

8.7% of CSA households receive SNAP benefits[1]

Illinois: 13.0%

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, **29.4% participated in any form of exercise in the past month, and 70.6% did not exercise at all.** Guidelines recommend at least 150 minutes of moderate aerobic activity per week.

Personal, social, economic and environmental factors all play a role in physical activity levels among youth, adults and older adults. Among survey respondents, 14.1% stated that they cannot afford the fees to exercise. Six percent of survey respondents do not have access to an exercise facility, and 1.6% do not have access to childcare while they exercise.

For residents who cannot afford gym memberships or exercise equipment for their home, they may look to the neighborhood's parks, playgrounds or sports fields to exercise. However, 11.5% of survey respondents state that there aren't any parks, playgrounds or fields in their neighborhood, so that severely limits their ability to exercise.

Understanding barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Tobacco and Electronic-Cigarette Use

In the CSA, 16.4% of adults reported having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.[12]

Among survey respondents,
15.0% reported ever using an e-cigarette.

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

Community Input:[24] Tobacco and E-Cigarette Use

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

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

Reflections on our data analysis

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

1 ACCESSIBILITY

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

2 RURAL-URBAN DIVIDE

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

3 CULTURAL COMPETENCY

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

4 AFFORDABILITY

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

5 AGE

Focus groups and survey respondents noted senior care and social isolation among seniors as health concerns in the community. Age is an important stratification when prioritizing populations.

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 the Northwestern Medicine Valley West Hospital CSA. Our collaborators considered these needs when identifying which should be priority health needs for Northwestern Medicine to address.

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

Priority Health Needs

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

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

Community Engagement Council

The Community Engagement Council is a diverse group of representatives from across the hospital's 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 diverse backgrounds helped ensure we considered a full range of perspectives when prioritizing identified health needs.

The following community organizations participate on our Community Engagement Council:

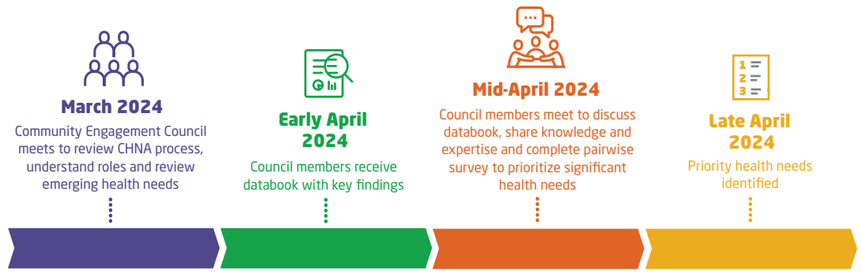
Community Organizations	
DeKalb Community Unit School District 428	Kishwaukee College
DeKalb County Community Foundation	Kishwaukee United Way
DeKalb County Health Department	Kishwaukee Family YMCA
DeKalb County Mental Health Board	Northern Illinois University
DeKalb County Regional Office of Education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

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

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

How we chose priority health needs

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



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

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

Prioritization Factors Considered to Establish Priority Health Needs

Prioritization Factors	Related Questions
Consequences of Inaction	• What impact would inaction have on individuals and on population health? • Are there other organizations who will act to address the need? • Do the inputs needed to take action create challenges to act in other important areas, recognizing that Northwestern Medicine's 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 allies?
Magnitude and Inequity	• How many people in the community are impacted? • Are there inequalities by race, income or location? • Where is the magnitude the greatest?
Severity and Impact	• How does the need impact health and vitality (focusing on people most impacted by needs related to social determinants of health)?
Trend	• Is there a pattern in the data? • Has the data gotten significantly worse or better over time?

Identified priority health needs

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

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

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

Northwestern Medicine Valley West Hospital 2024 Priority Health Needs

Development of a Plan to Address Priority Health Needs

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

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

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

Existing resources

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

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

Northwestern Medicine roles

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

Civic Leader

- Collaborator/convener
- Employer
- Advocate
- Funder

Educator

- Training
- Youth programs
- Health promotion
- Knowledge transfer

Researcher

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

Care Provider

- Financial assistance
- Medicaid
- Safety net collaborators

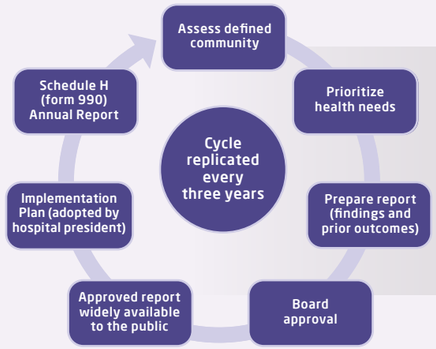
Appendix A: Evaluation of Impact

Actions taken to address Northwestern Medicine Valley West Hospital 2021 priority health needs

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

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

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



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

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

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

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

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

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

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

In fiscal year 2022 (FY22) and FY23, Northwestern Medicine Valley West Hospital supported efforts that increased access to healthcare services and community resources by investing in resources and collaborating with community-based organizations. Through an organized approach to connect with community organizations, we contacted several agencies to learn more about the services they provide and share knowledge to identify and support access to healthcare issues.

In addition, there was a planned approach to increase programs and initiatives focused on promoting access to care, especially in low-income and under-resourced communities. We worked with community organizations that provide access to nutritious food, shelter and other essentials to help build stronger and healthier communities.

Impact of Strategy

We engaged with organizations that included:

- Equine Dreams
- Fox Valley Family YMCA
- Sandwich Education Foundation
- United Way of DeKalb County

Fox Valley Family YMCA was able to expand its support to members by offsetting membership fees for individuals who were not able to pay the full fee to participate in its programs and services. Additionally, funding support contributed to staff education to provide classes and programs focused on chronic disease prevention for adults. With this support, Fox Valley Family YMCA was able to focus effort on chronic disease prevention. Fox Valley Family YMCA reported that during this time frame, they recorded an increase in attendance by 13% and repeat visits by 5% over the previous year.

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

In FY22, Northwestern Medicine Valley West Hospital, in collaboration with Federally Qualified Health Centers and free and charitable clinics, assessed a number of patients who sought medical care in the Emergency Department (ED) and inpatient setting. During the time frame, 16 self-identified patients from Aunt Martha's received care in the ED. Additionally, 467 self-identified patients from VNA Health Care used the Northwestern Medicine Valley West Hospital ED. Eight patients from VNA Health Care were admitted to inpatient care.

Impact of Strategy

Providing and supporting these organizations ensured that our most vulnerable patients received and had access to adequate and timely care. Doing this provided these patients with an opportunity for improved outcomes.

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

The Northwestern Medicine Valley West Hospital CHNA also indicated that the age-adjusted death rate due to breast cancer in DeKalb County was higher than state and national values. Further, the county value of 28.4 deaths per 100,000 female patients did not meet the Healthy People 2020 target of 20.7 deaths per 100,000, and the rate was increasing significantly. Offering people with little or no insurance coverage access to no-cost or reduced-cost mammograms will help increase screening rates.

Impact of Strategy

As a result of these efforts, five women received free mammograms through the Women Matter program.

Breast health education provided information on breast cancer risk factors, current screening guidelines and what individuals can do to reduce risk. Comprehensive review of program content was completed in calendar-year 2023 (CY23), and revisions were made to the evaluation to capture appropriate information on knowledge gained. Educational initiatives focusing on prevention and age-appropriate screening were implemented.

Breast health education classes delivered by a certified lactation counselor taught participants about breast health, breast cancer prevention and screenings at the following:

- CY22: Two presentations had six participants.
- CY23: Four presentations had 20 participants.

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

Open Door Rehabilitation Center provides services for adults with intellectual and developmental disabilities to enrich their quality of life. Open Door Rehabilitation Center offers day program, residential and intermittent services. Their client population has physical health challenges due to their disabilities, and programs are designed to help their clients make healthier choices and give them opportunities for activities that improve their health.

Fox Valley Community Services is a service agency for older adults that was established in 1972. Their mission is to assist seniors to remain in their own home; improve and enrich vital, independent living; enhance dignity and self-respect; and encourage participation in community life. The Adult Day Services program is staffed by a registered nurse and nurses' aides to provide client care and offer respite to caregivers.

Impact of Strategy

- FY22: Support given to Open Door Rehabilitation Center funded opportunities for clients to access and participate in a number of outings and activities in the community.
- FY23: Funding given to Fox Valley Community Services maintained public access to the facility and sustained the Adult Day Services and support groups for individuals with multiple sclerosis and Alzheimer's disease.

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Priority Health Need 2: Chronic Disease

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

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

Know Your Numbers is an evidence-based approach to increasing community awareness of cardiovascular disease. Better prevention and the management of high cholesterol, high blood pressure or diabetes to help lower the risk for heart disease is a key component of the Know Your Numbers biometric screening appointments. Unfortunately, due to changes in leadership and oversight of federal laboratory regulations, the program was not offered during FY22. Know Your Numbers resumed in the fourth quarter of 2023.

Impact of Strategy

- FY22: Four blood pressure clinics were offered in the CSA, which provided screening for 62 participants. Of those screened, 40% of patients had blood pressure greater than 120/80 mm Hg, which is the upper limit of the normal range.
- FY23: Nine blood pressure clinics in the CSA provided screening for 142 participants. One Know Your Numbers event was held with 21 participants.
- FY24: So far, there have been two blood pressure clinics with 70 participants and one Know Your Numbers event with 11 participants.

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

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

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

Impact of Strategy

- FY22: A total of 133 classes were held with 1,315 participants.
- FY23: A total of 214 classes were held with 1,696 participants.
- FY24: So far, a total of 103 classes have involved 2,482 participants.

Priority Health Need Strategy 2.3: Community Benefit Donations and Grants: Provide funding through the Community Benefit donations and grants process to strategies and organizations that address chronic disease.

A beneficiary of community donations from Northwestern Medicine Valley West Hospital is DeKalb County Community Gardens, whose mission is to address hunger and food insecurity in DeKalb County. Established in 2012, DeKalb County Community Gardens seeks to empower residents to choose healthy and sustainable foods through education and participation.

The organization maintains more than 15 acres of community garden space and a garden located on the campus of Northwestern Medicine Valley West Hospital. Community residents are encouraged to participate in the planting and harvesting of the gardens. In addition to produce, participants in the program receive education and healthy recipes and learn how to cook and store produce.

Impact of Strategy

- FY22: Funding supported the community garden space and distribution of produce to community members through the Grow Mobile, a mobile food pantry program.
- FY23: Funding supported the hospital campus garden. The harvest included more than 1,000 pounds of produce, which was shared with the community.

Priority Health Need 3: Mental Health and Substance Use Disorders

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

Priority Health Need Strategy 3.1: Mental Health Training and Education: Educate the community on how to identify, understand and respond to the signs of mental illnesses and substance use disorders. Increase awareness of negative attitudes and beliefs around mental health.

Part of the public education goal is achieved by increasing the proportion of DeKalb County organizations who complete the Mental Health First Aid (MHFA) course. This course is designed to increase awareness and decrease stigma related to mental health.

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

Impact of Strategy

- MHFA Course: FY22, one class with nine participants; FY23, seven classes with 121 participants.
- Naloxone education and distribution: FY23, two events training more than 30 individuals.
- Community Education through NAMI, CIT Training, NEW-R and the Employment Group: FY22, 15 programs and 128 people; FY23, 20 programs and 197 people; FY24 so far, eight programs and 21 people.
- DeKalb County Mental Health Response Line: FY22, 987 calls; FY23, 827 calls; FY24 so far, 259 calls.
- Task force: FY22, 38.25 hours; FY23, 50 hours; FY24 so far, 26 hours.

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Priority Health Need Strategy 3.2: Drug Education and Safety Services: Raise awareness and educate the community about the potential for abuse of medications while providing a safe, convenient and responsible way of disposing of prescription drugs.

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

Impact of Strategy

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

- FY22: 169.75 pounds.
- FY23: 96.9 pounds.
- FY24: 60 pounds so far.

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

Northwestern Medicine Valley West Hospital provides funding to the Sandwich Police Department to support their D.A.R.E. program. The D.A.R.E. program is a fifth-grade, classroom-based teaching opportunity that empowers students to respect others and choose to lead lives free from violence, substance use and other dangerous behaviors.

Northwestern Medicine Valley West Hospital works with Behavioral Health Services and Northwestern Medicine Ben Gordon Center to provide a calm and safe environment called The Living Room, where visitors can resolve crises without intensive intervention. At The Living Room, any DeKalb County resident 18 years or older can speak with a trained peer recovery support specialist. There is no cost, and no appointment is needed to visit.

Impact of Strategy

- FY22: Funding for the D.A.R.E. program resulted in education provided to about 300 students.
- FY23: There were 967 visits to The Living Room and 429 unique clients.

Priority Health Need 4: Older Adults and Aging

Goal: Improve access to quality resources, focusing on isolation and loneliness, to help ensure older adults in the CSA have the services and support needed to live healthy lives.

Priority Health Need Strategy 4.1: Community Benefit Donations and Grants: Provide funding through the Community Benefit donations and grants process to strategies and organizations that address the needs of older adults and aging.

Northwestern Medicine Valley West Hospital provides funding to support organizations whose primary focus is older adults and aging. Fox Valley Community Services offers nutrition programming developed and led by staff from Northwestern Medicine's Leishman Center for Culinary Health.

Another program at Fox Valley Community Services is Adult Day Services, which offers a safe alternative for care so an older family member is not left alone when their caregiver must go out. The program is a source of nutrition, transportation, exercise and overall support for the senior population. Funding provided by Northwestern Medicine Valley West Hospital supports staff education and training for Certified Dementia Practitioners credentialing.

Impact of Strategy

- FY22: Educators delivered two virtual programs with six participants to clients of Fox Valley Community Services.
- FY23: The Adult Day Services program was restructured to use new research methods and create an environment that is conducive to clients with Alzheimer's disease and other dementia-related illnesses. The site provides support to 20 seniors each week on average.

Appendix B: Resources Available to Address Significant Health Needs

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

Category	Resource	Description	Link
Health Care	Northwestern Medicine Kishwaukee Hospital	Hospital	nm.org
	Greater Family Health	Federally Qualified Health Center	greaterfamilyhealth.org
Nonprofit, Faith-Based Organizations	Saint Paul the Apostle Catholic Church	Church	saintpaulscc.net
Social Service Organizations	DeKalb County Community Gardens	Food pantry	dekalbgardens.org
	Fox Valley Community Services	Services to help older adults live active, independent lives	fvoas.org
	Open Door Rehabilitation Center	Rehabilitation center for adults with intellectual and developmental disabilities	odrc.org
Education	Sandwich Community Unit School District 430	School district	sandwich430.org
	Plano Community Unit School District 88	School district	plano88.org
Government-Based Organizations	DeKalb County Health Department	Health department	health.dekalbcounty.org
	DeKalb County Government	County government	dekalbcounty.org

Appendix C: Timeline for the 2024 CHNA for Northwestern Medicine Valley West Hospital

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

Appendix D: A Closer Look at Data

Community Input Summary

Community Input Survey

Metopio collected 297 survey responses from people in the CSA. The following issues were selected as the most important health needs in the community by 25% or more of the survey respondents:

1. Adult mental health (34.8%)
2. Heart disease (33.0%)
3. Cancer (32.6%)
4. Obesity (31.3%)
5. Alzheimer's disease (27.8%)
6. Adolescent mental health (26.1%)

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

1. Medication affordability (44.8%)
2. Access to health care (43.0%)
3. Insurance access (35.2%)
4. Eating healthy (32.2%)
5. Transportation (31.7%)
6. Elder care (31.7%)
7. Safe, affordable housing (26.1%)
8. Access to affordable food (26.1%)

Community focus groups and key informant interviews

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

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

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

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

Accessibility

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

Rural-Urban Divide

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

Cultural Competency

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

Affordability

- Cost of living
- Cost of care and medications

Age

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

Appendix E: References

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

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24. 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 Valley West 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 2024 CHNA report for Northwestern Medicine Valley West Hospital is available to the public at no charge and can be accessed in the following ways:

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

Phone: 312.926.2301 (TTY: 711)

Email: communityhealth@nm.org

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

Northwestern Medicine Valley West Hospital
1302 North Main Steet
Sandwich, Illinois 60548

Public comment

As of May 2024, Northwestern Medicine Valley West 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 Valley West 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.

Notes:

Northwestern Medicine Valley West Hospital
1302 North Main Street
Sandwich, Illinois 60548
815.786.8484

nm.org

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