2022 Community Health Needs Assessment

NorthShore University HealthSystem

- CHNA Executive Summary
- About our Community
- Key Health Indicators
- Community Input
- Prioritized Health Needs

Evanston Hospital | Glenbrook Hospital | Highland Park Hospital | Skokie Hospital

NorthShore University HealthSystem 2022 CHNA

NorthShore – Edward-Elmhurst Health is a fully integrated healthcare delivery system committed to providing access to quality, vibrant, community-connected care, serving an area of more than 4.2 million residents across six northeast Illinois counties. Our more than 25,000 team members and more than 6,000 physicians aim to deliver transformative patient experiences and expert care close to home across more than 300 ambulatory locations and eight acute care hospitals – Edward (Naperville), Elmhurst, Evanston, Glenbrook (Glenview), Highland Park, Northwest Community (Arlington Heights) Skokie and Swedish (Chicago) – all recognized as Magnet hospitals for nursing excellence. Located in Naperville, Linden Oaks Behavioral Health, provides for the mental health needs of area residents.

NorthShore – Edward-Elmhurst Health desires to continue providing clinical programs and services to meet community health needs, while also pursuing continuous improvement in existing and future programs to improve the overall health of individuals in the communities it serves. As such, hospitals within the NorthShore – Edward-Elmhurst Health system conduct Community Health Needs Assessments (CHNA's) every three years, using primary and secondary data, to ensure community benefit programs and resources are focused on significant health needs as perceived by the community at large, as well as alignment with NorthShore – Edward-Elmhurst Health's mission, services and strategic priorities.

This joint CHNA was conducted by the following hospitals within NorthShore – Edward-Elmhurst Health: Evanston, Glenbrook, Highland Park and Skokie. These four hospitals collectively serve the same communities within NorthShore University HealthSystem (NorthShore). For the remainder of this report "NorthShore" will refer to these four hospitals. Please note that Edward-Elmhurst Health, Swedish Hospital and Northwest Community Healthcare develop and release their own separate CHNAs.

NorthShore University HealthSystem 2022 CHNA

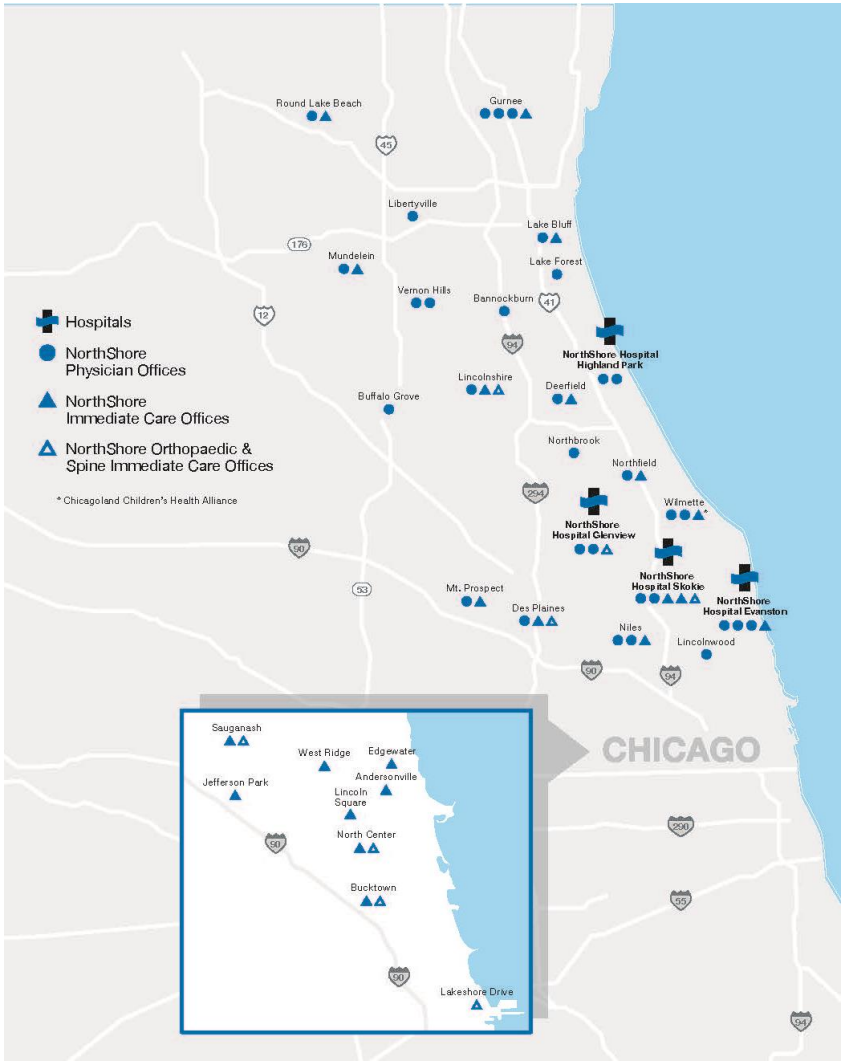
NorthShore has defined its “community” to include 54 zip codes within Lake and Cook Counties in Illinois. Defining the CHNA community similarly to its primary service area will allow NorthShore to more effectively focus its resources to address identified significant health needs, targeting areas of greatest need and health disparities.

NorthShore obtained input from 63 leaders representing public health, major employers, public schools, social services, NorthShore leaders and the community at-large through five focus groups. Primary input was also obtained by conducting an online community health survey distributed to members of the community.

Secondary data was assessed including:

- Demographics (population, age, sex, race)
- Socioeconomic indicators (household income, poverty, unemployment, educational attainment)
- Key health indicators

Information gathered in the above steps was reviewed and analyzed to identify health issues in the community.



NorthShore University HealthSystem 2022 CHNA

The process identified the following health issues listed in alphabetical order:

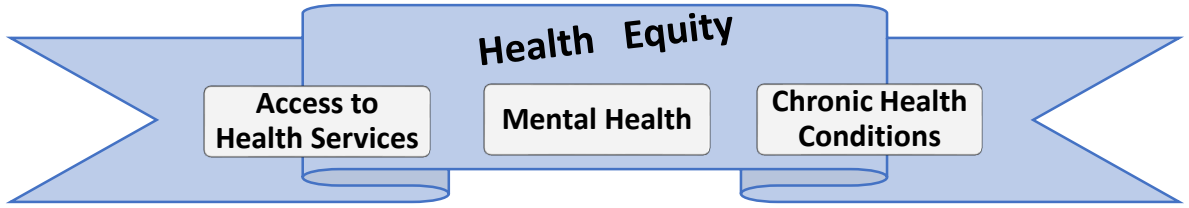
- Access to Health Services (Cost, Language, Navigating Healthcare System)
- Affordability of Healthcare
- Cancer
- Chronic Health Conditions (Diabetes and High Blood Pressure)
- Health Inequity/Discrimination
- Food Insecurity
- Heart Disease
- Health Literacy
- Lack of Affordable Housing
- Maternal and Child Health
- Mental/Behavioral Health
- Obesity
- Poverty
- Preventative Care
- Violence/Safety
- Youth Mental Health/Substance Abuse

Health needs were prioritized with input from a broad base of key NorthShore stakeholders, by utilizing a scoring guide. Representation included:

- Key Stakeholders within Health Equity and/or Diversity, Equity & Inclusion
- Key Stakeholders from NorthShore's Black Leadership Forum
- Key Stakeholders from NorthShore's LGBTQ+ affinity group (True North)
- Key Stakeholders serving Community
- Senior Organization Leaders

A review of existing community benefit and outreach programs was also conducted as part of this process and opportunities for increased community collaboration were explored.

Based on the information gathered through this CHNA and the prioritization process described above, NorthShore University HealthSystem chose the needs below to address over the next three years. Opportunities for health improvement exist in each area. NorthShore University HealthSystem will work to identify areas where NorthShore can most effectively focus its resources to have significant impact and develop an Implementation Strategy for fiscal years ending 2023-2024. It is important to note that Health Equity is woven throughout these areas and will be an integral element of the three priority areas: Access to Health Services, Mental Health and Chronic Health Conditions.

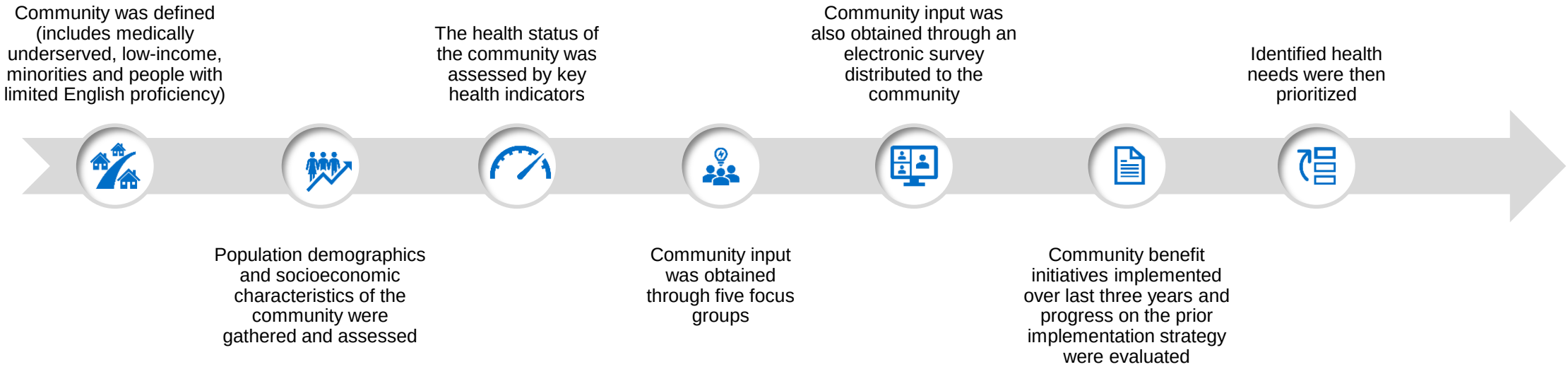


How the Assessment was Conducted

NorthShore conducted a CHNA to support its mission responding to the needs in the community it serves and to fulfill the requirements established by the Patient Protection and Affordable Care Act of 2010 and comply with federal tax-exemption requirements. This is the fourth CHNA conducted by NorthShore. The goals were to:

- ✓ Identify and prioritize health issues and social determinants of health in the NorthShore service area, particularly for vulnerable and under-represented populations.
- ✓ Ensure that programs and services closely match the priorities and needs of the community.
- ✓ Strategically address those needs to improve the health of the communities served by NorthShore facilities.

Based on current literature and other guidance from the United States Department of the Treasury, the following steps were conducted as part of NorthShore's CHNA:



Our Commitment to Address Health Equity and Reduce Health Disparities

Diversity, equity and inclusion is at the core of who we are, being there for our patients and each other with compassion, respect and empathy. We believe that our strength resides in our differences and in connecting our best to provide community-connected healthcare for all. At NorthShore, we:

- See, hear and value all team members and patients
- Connect our best to serve our diverse communities
- Do everything we can to help you achieve your full potential in work, life and health

We commit to ***accelerating***:

Inclusion

The ability to be our authentic self impacts our life, health and happiness. NorthShore is making this a place where all team members and patients feel like they belong.

Opportunity

We are becoming a better reflection of the world we live in, investing in community partnerships and leadership development to enhance diversity across NorthShore.

Health Equity

We are becoming a better reflection of the world we live in, investing in community partnerships and leadership development to enhance diversity across NorthShore.

Direct Actions by NorthShore University HealthSystem:

- Accelerating system-wide strategies for inclusion, opportunity and health equity
- Improving collection and training on REAL data
- IHA Racial Equity In Healthcare Progress Report
- North Region Health Equity Committee
- Integrating heath equity into systemwide quality framework
- Improving collection of social determinants of health indicators
- Implicit bias training for care providers and team members
- Community Investment Fund Partners – investing in community organizations to enhance health and wellbeing, advance health equity and support local economic growth

Acknowledgements

The CHNA for NorthShore supports the organization's mission to *"preserve and improve human life."* This CHNA was made possible because of the commitment toward addressing the health needs in the community. Many individuals across the organization devoted time and resources to the completion of this assessment.

NorthShore would like to thank leaders from the following community organizations who participated in focus groups and interviews and provided valuable information to be used in the assessment:

- Catholic Charities
- Childcare Network of Evanston
- City of Evanston, Health & Human Services
- Community Partners for Affordable Housing
- Erie Evanston/Skokie Health Center
- Evanston Fire & Life Safety Services
- Faith in Action
- Family Service of Glencoe
- Frisbie Senior Center
- Glenview Police Department
- Great Lakes Adaptive Sports Association
- Lake County Health Department
- McGaw YMCA
- Moraine Township
- NAMI Cook County North Suburban
- Niles Township
- Niles Township High School District 219
- North Shore Congregation Israel
- North Shore School District 112
- Northfield Township
- Oakton Community College
- Rosalind Franklin University
- School District 113
- Second Baptist Church
- Skokie Community Foundation
- Skokie Fire Department
- Skokie Library
- The Josselyn Center
- Turning Point
- Village of Glenview - Senior Services
- Village of Skokie Health Department
- Village of Wilmette

This CHNA has been facilitated by Crowe LLP ("Crowe"). Crowe is one of the largest public accounting, consulting, and technology firms in the United States. Crowe has significant healthcare experience including providing services to hundreds of large healthcare organizations. Community health needs assessments and community benefit consulting are provided to hospitals across the country. For more information about Crowe's healthcare expertise visit www.crowe.com/industries/healthcare.

This CHNA has been approved by the NorthShore Board of Directors in 2022.

Written comments regarding the health needs that have been identified in the current CHNA should be directed to:

Jenise Celestin
Director, Community Relations
NorthShore Hospitals
jcelestin@schosp.org
(773) 907-3076

Hania Fuschetto
Manager, Community Relations
NorthShore Glenbrook and Highland Park Hospitals
hfuschetto@northshore.org
(847) 480-2630

Mark Schroeder
Manager, Community Relations
NorthShore Evanston and Skokie Hospitals
mschroeder@northshore.org
(847) 933-6004

Overview of Our Hospitals Included in this CHNA

NorthShore Evanston Hospital - With a history dating back to 1891, Evanston Hospital is a comprehensive acute-care facility and the nucleus of NorthShore University HealthSystem. Evanston Hospital is a leader in cardiac care, cancer care via the NorthShore Kellogg Cancer Center and a variety of surgical specialties. Evanston Hospital is also the regional center for high-risk obstetrics with the Infant Special Care Unit and the Women's Hospital offering the latest technology and a highly trained staff.

Key Specialties
- NorthShore Cardiovascular Institute
- Center for Breast Health
- Infant Special Care Unit (ISCU)
- NorthShore Kellogg Cancer Center
- Level I Trauma Center
- Primary Stroke Center
- Regional Center for High-Risk Obstetrics
- Women's Hospital

NorthShore Glenbrook Hospital - Established in 1977, Glenbrook Hospital is a comprehensive medical center providing advanced diagnostic and therapeutic interventions, as well as superior medical and surgical care for all specialties. In 2011, Glenbrook Hospital opened a new 25,000 square-foot Emergency Department featuring 30 private exam/treatment rooms. A more recent hospital expansion project further enhanced Glenbrook Hospital's ability to meet the healthcare needs of the growing community.

Key Specialties
- NorthShore Cardiovascular Institute
- Center for Breast Health
- Eye and Vision Center
- Gastroenterology
- NorthShore Kellogg Cancer Center
- Level II Trauma Center
- NorthShore Neurological Institute
- NorthShore Orthopaedic Institute
- Primary Stroke Center
- John and Carol Walter Center for Urological Health

Overview of Our Hospitals Included in this CHNA

NorthShore Highland Park Hospital - Founded in 1918, Highland Park Hospital has provided high-quality healthcare and a wide range of clinical programs for the people of Lake County and beyond for over a century. The hospital is the site of the first open-heart surgery in Lake County, and continues to provide a full range of cardiac diagnosis and intervention services. Highland Park Hospital's Kellogg Cancer Center offers the most comprehensive subspecialty care for oncology patients.

Key Specialties

- Adolescent Behavioral Health
- Bariatric Center of Excellence
- NorthShore Cardiovascular Institute
- Center for Breast Health
- Center for Pelvic Health
- Gastroenterology
- NorthShore Kellogg Cancer Center
- Level II Trauma Center
- Primary Stroke Center
- Women's Hospital

NorthShore Skokie Hospital - Skokie Hospital is not only home to Illinois' only specialty hospital dedicated to orthopaedic and spine care, but it also offers emergency and outpatient services to meet the needs of the local community. The Orthopaedic & Spine Institute provides advanced care and is designed for both outpatient and inpatient procedures, including joint replacement, fracture care and complex spine surgeries. Skokie Hospital completed a seven-year, multimillion-dollar renovation and expansion ensuring the hospital continues to provide patients with exceptional medical care for years to come.

Key Specialties

- NorthShore Orthopaedic & Spine Institute
- Comprehensive Emergency Department
- Clinical Cardiology Services
- Comprehensive Outpatient Services that include GI Lab and Outpatient Laboratory
- Mammography
- Outpatient Pharmacy
- Radiology (CAT Scan, MRI, Ultrasound, X-Ray)
- Primary Care and Specialty Care Physician Offices

Who We Serve

NorthShore's patients collectively come from a large geographic area. For purposes of this report, the community served by NorthShore includes 54 zip codes in Lake County, northern Cook County and the north side of Chicago. The map to the right shows the level to which each zip code utilizes NorthShore's services and is based on inpatient, outpatient and emergency room visits. Cities, villages and communities included in the CHNA community are also reflected.

Between October 1, 2020 and September 30, 2021, 85% of NorthShore's inpatient discharges and 81% of its outpatient visits came from patients residing in these 54 zip codes.

CHNA Community:

Includes 54 zip codes within Lake County, northern Cook County and the north side of Chicago

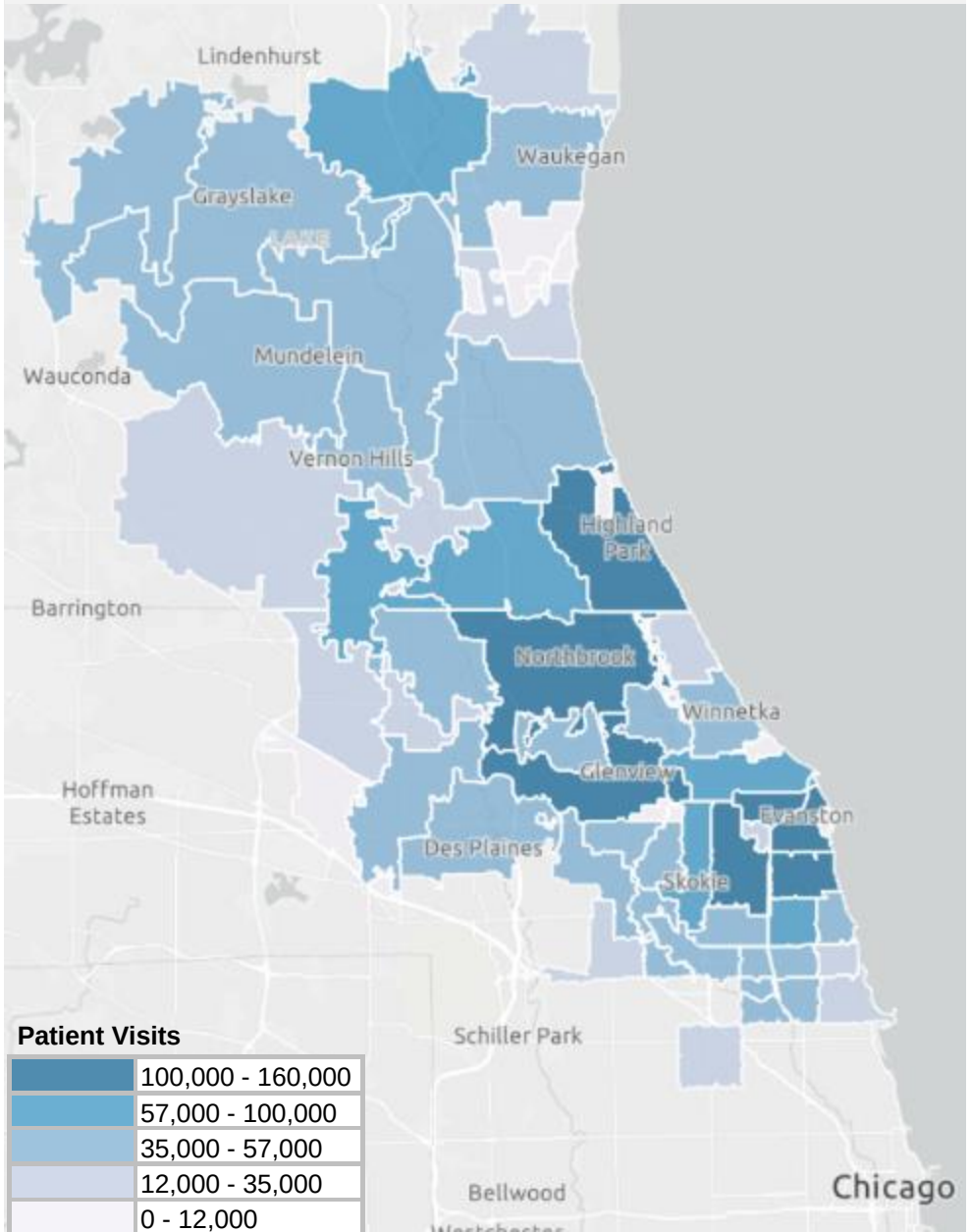
85%

Inpatient Discharges from CHNA Community

81%

Outpatient Visits from CHNA Community

Total Patient Visits – October 1, 2020 to September 30, 2021



Community Overview

Demographic Data

To understand the profile of NorthShore's CHNA community the demographic and health indicator data was analyzed for the population within the defined service area. Data was analyzed for the CHNA community as a whole as well as Lake County, Cook County North Suburbs and Cook-County – Chicago North Side communities.

To provide additional insight into underserved populations, data was further reviewed for zip codes with high economic needs according to Dignity Health's Community Need Index (CNI). Based on demographic and economic statistics, the CNI provides a score for every populated zip code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a zip code with the least need, while a score of 5.0 represents a zip code with the most need. The CNI is strongly linked to variations in community healthcare needs and is a good indicator of a community's demand for a range of healthcare services. Zip codes with a CNI score above 3.4 have higher socioeconomic needs related to factors such as income, education, language, insurance and housing.

The CHNA community has a total population of 1,607,577 according to the U.S. Census Bureau American Community Survey 2015-2019 5-year estimates. The percentage of population by combined race and ethnicity is made up of 58.0% Non-Hispanic White, 19.8% Hispanic or Latino, 12.4% Non-Hispanic Asian, 6.8% Non-Hispanic Black, 2.5% Non-Hispanic Multiple Races and .5% Non-Hispanic some other race. The demographic makeup of the CHNA community is as follows:

$145,116

Average Family Income

50%

People 25+ with a Bachelor's Degree or Higher

10.2%

of people are living in poverty (160,285 persons)

8.08%

Population without Health Insurance Coverage (127,593 persons)

66%

Population 16+ in Civilian Labor Force

8%

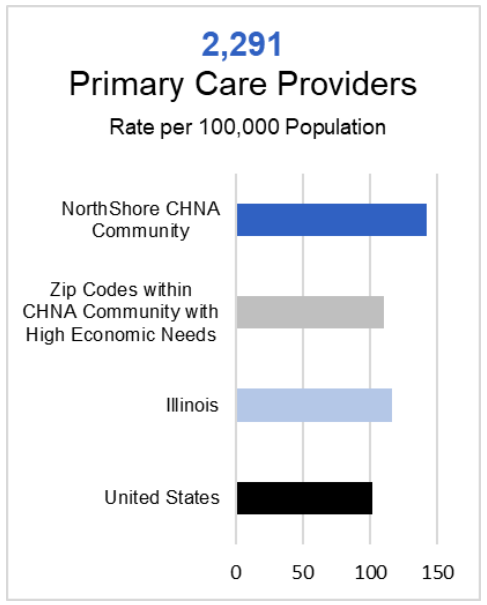
122,423 persons living in Limited English speaking households

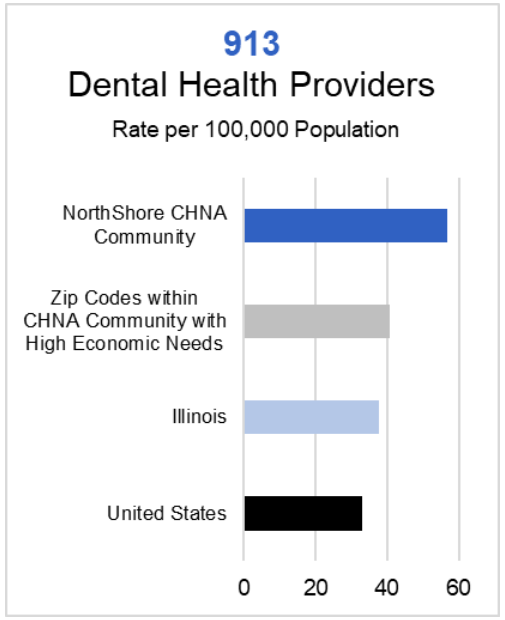
Access to Services

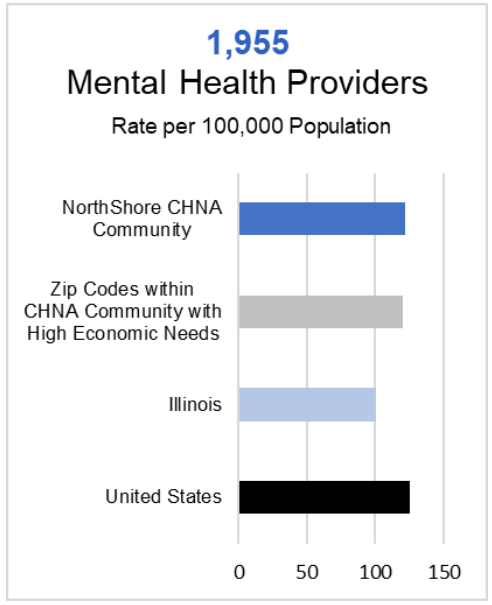
Data Tables

A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians affect access. As shown below, the rate of health care providers within NorthShore's CHNA community is higher than state and national benchmarks. However, the rates of health care providers in zip codes with high economic needs is significantly lower than the rate for the CHNA community as a whole for primary care and dental health providers.

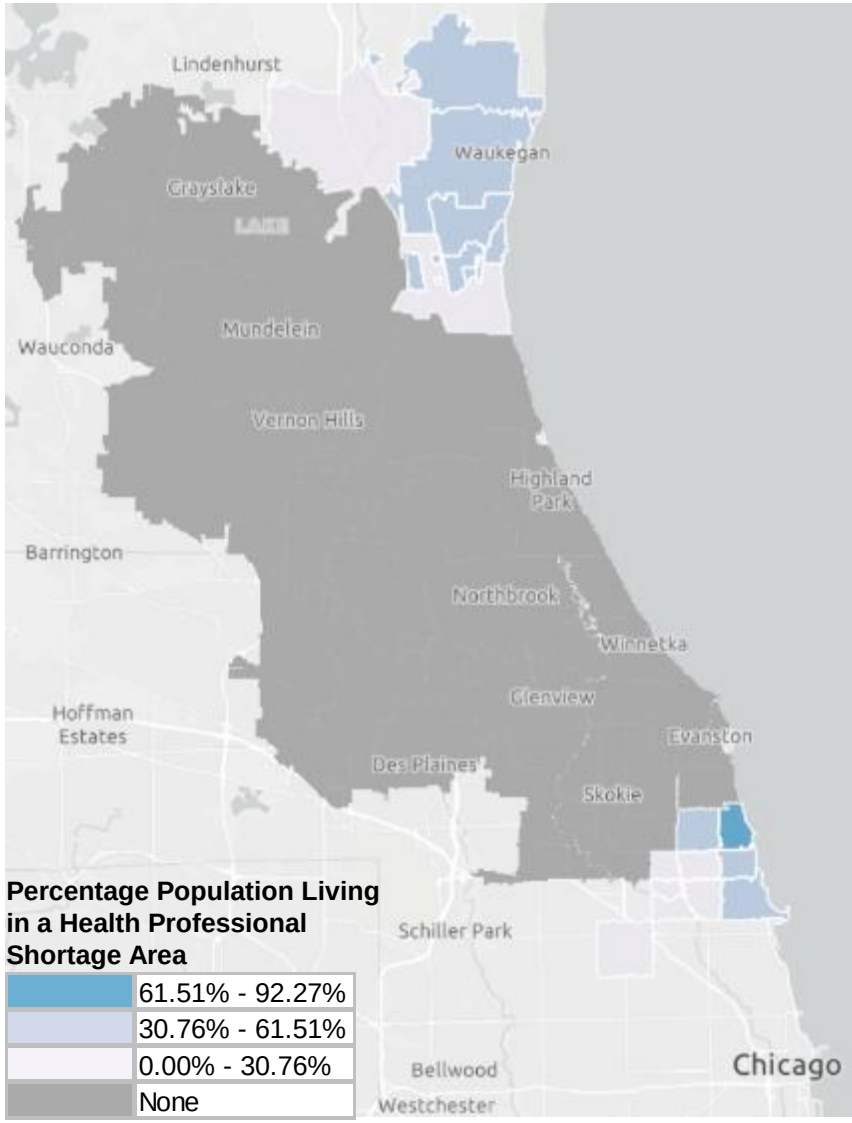
The map to the right reports the percentage of population that is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA). Within the CHNA community, there are 224,611 people living in a HPSA. This represents approximately 13% of the total population.







Population Living in a Health Professional Shortage Area

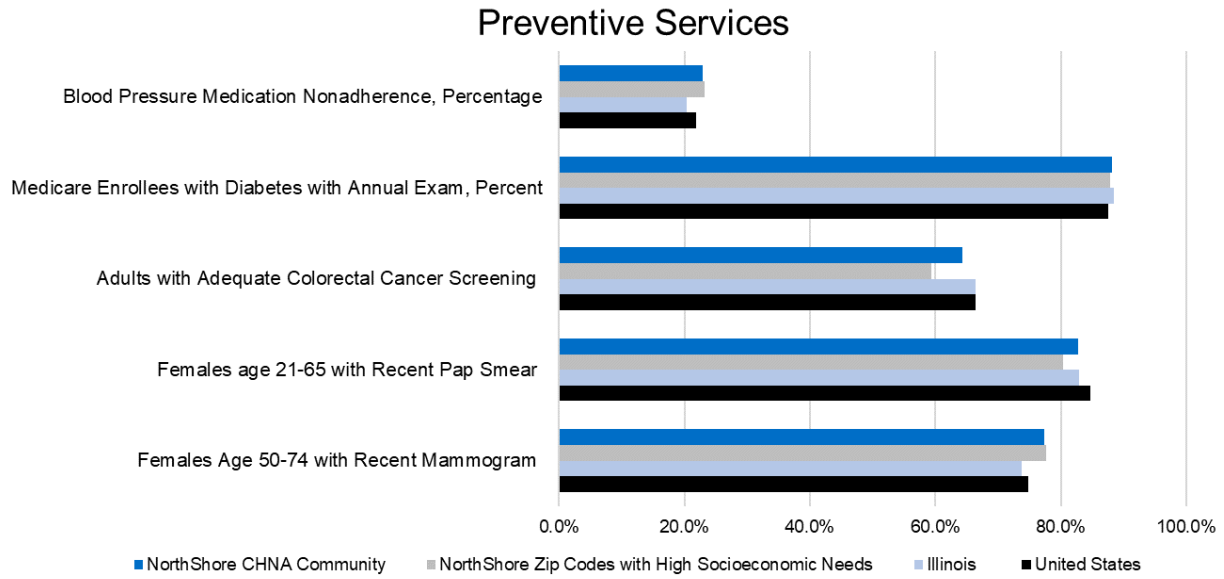


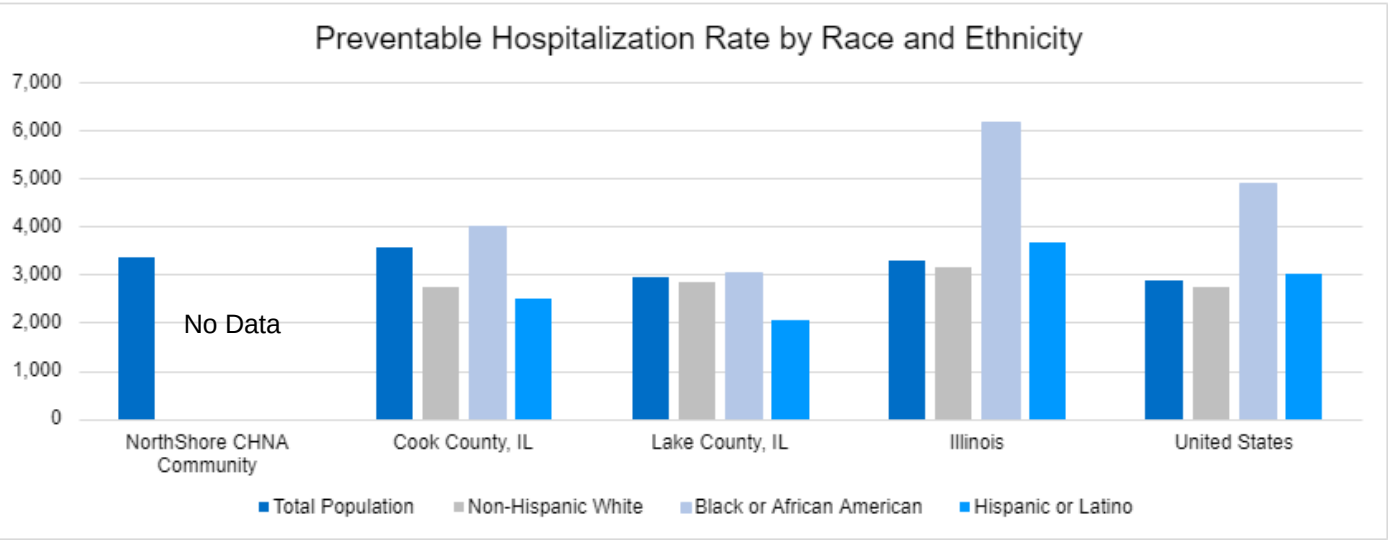
Clinical Preventative Services

Rates of morbidity, mortality, and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests, and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions.

Only **27.4%** of women 65+ in the community are up-to-date with core preventative services compared to the national benchmark of 28.4%.

35.0% of men 65+ in the community are up-to-date with core preventative services compared to the national benchmark of 32.4%.





Preventable hospitalizations include hospital admissions for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection.

- The rate for preventable hospitalizations in the CHNA Community is slightly unfavorable to state and national rates. However, the rate has significantly improved since 2018 .
- Preventable hospitalizations are significantly higher for Black and African American residents compared to Non-Hispanic White and Hispanic or Latino residents.

Data Tables

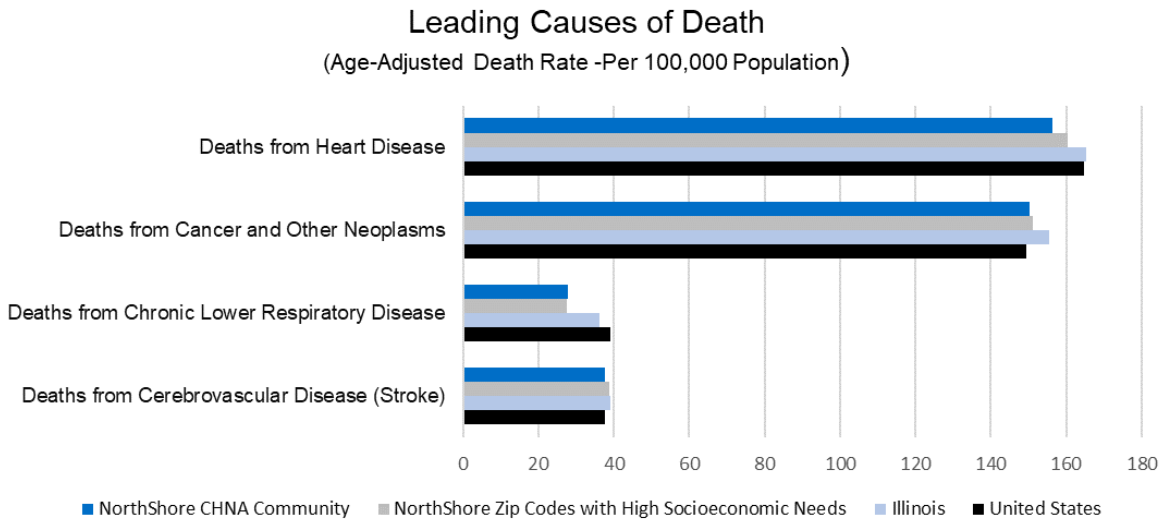
Health Outcomes & Mortality

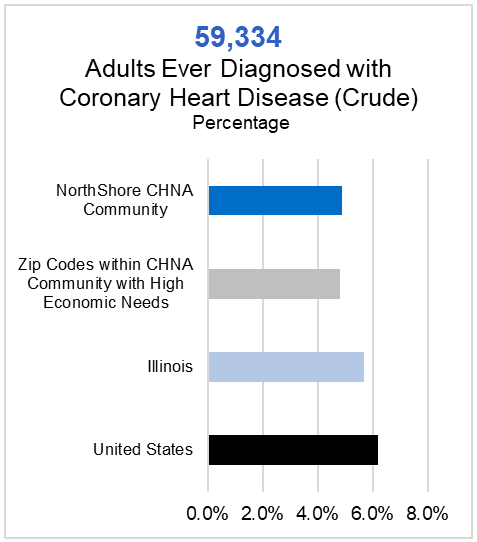
NorthShore's community has a significant number of adults who have been diagnosed with chronic illnesses. The prevalence of chronic diseases in the NorthShore community is favorable to state and national percentages, with slightly higher rates for diabetes in zip codes with high economic needs. Approximately 28% of the population, 339,053 adults, have high blood pressure.

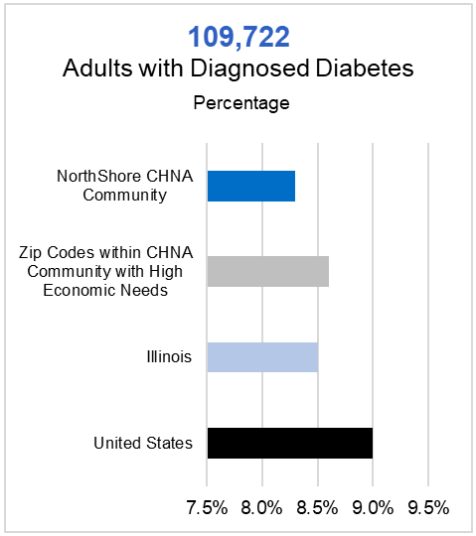
More than 45,000 Medicare beneficiaries have six or more chronic conditions in the community and almost 120,000 Medicare beneficiaries have two or more chronic conditions.

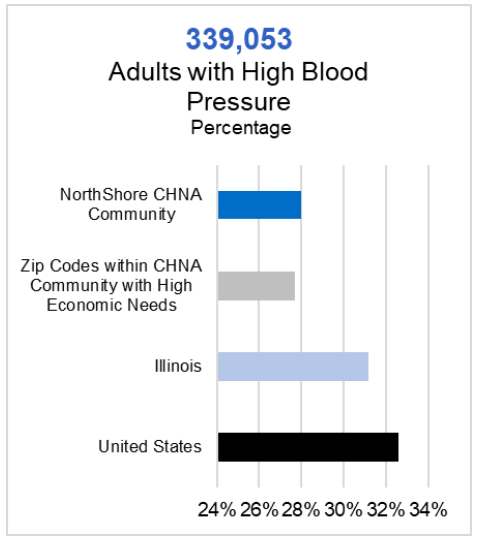
Coronary heart disease, cancer, lung disease and stroke are leading causes of death in the United States. Adjusted death rates for the community are slightly favorable to state and national rates.

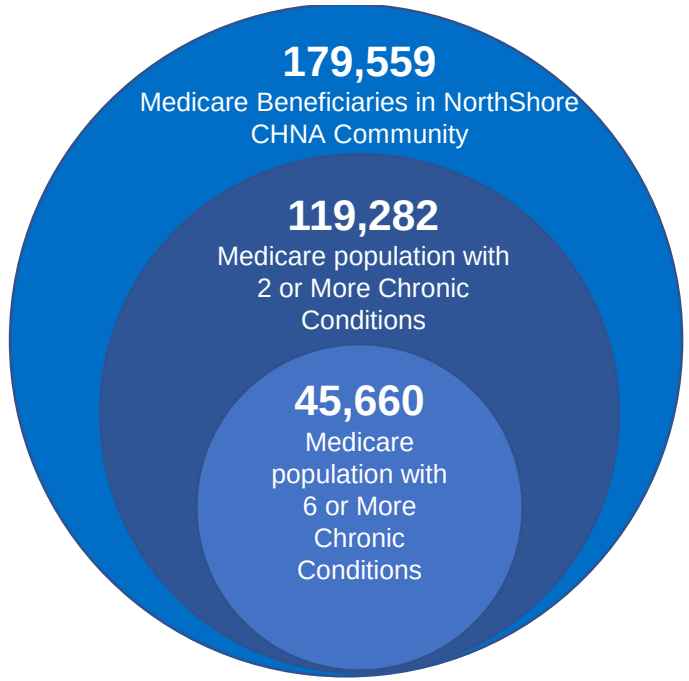
Data Tables











Injury and Violence

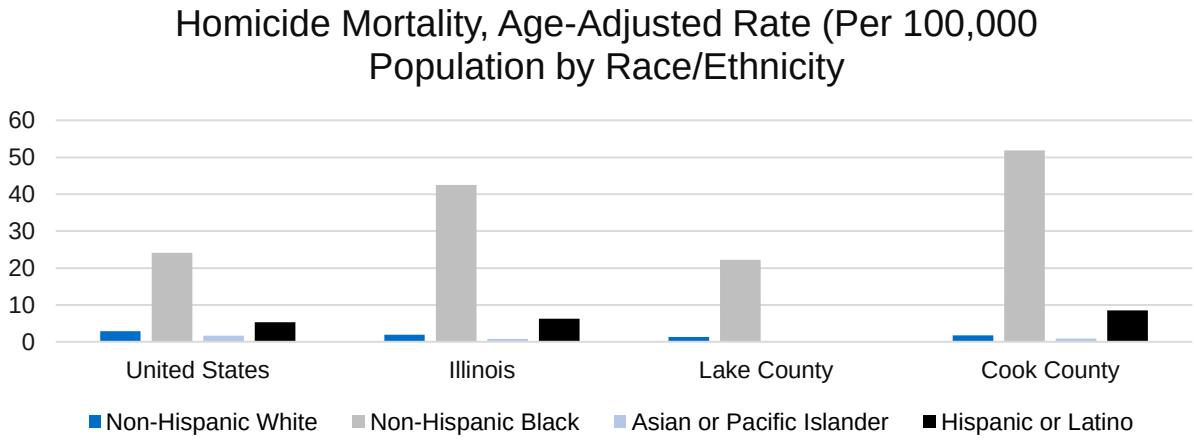
Data Tables

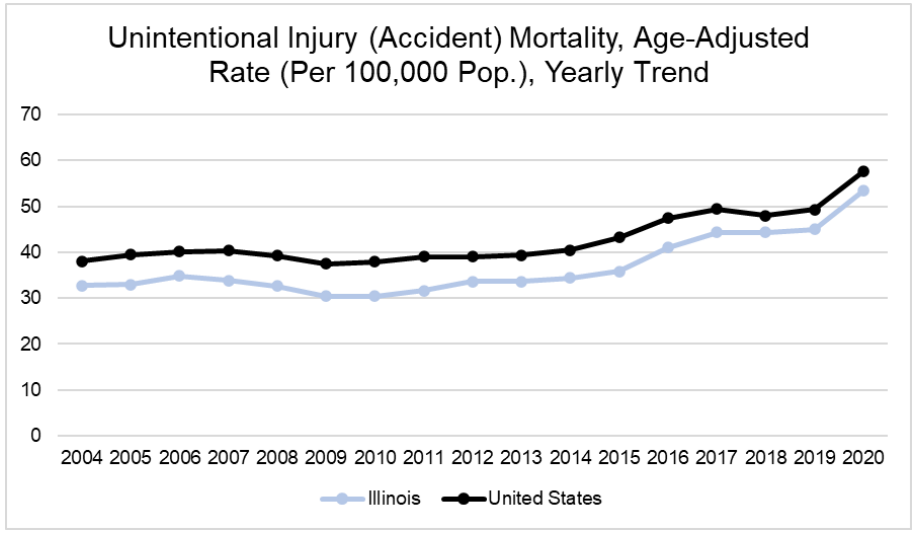
Crime rates are very different for the two counties primarily served by NorthShore with Lake County having favorable rates compared to state and national rates and Cook County having rates higher than state and national rates. The violent crime rate for Cook County is three times the rate of Lake County and significantly higher than state and national rates.

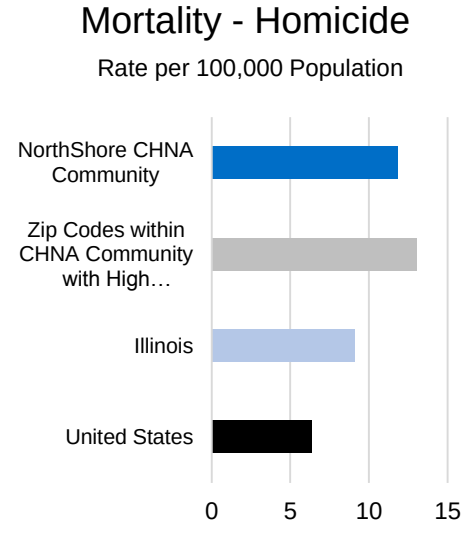
The age-adjusted death rate per 100,000 population for homicide is 11.8 for NorthShore's CHNA community compared to 6.4 for the United States.

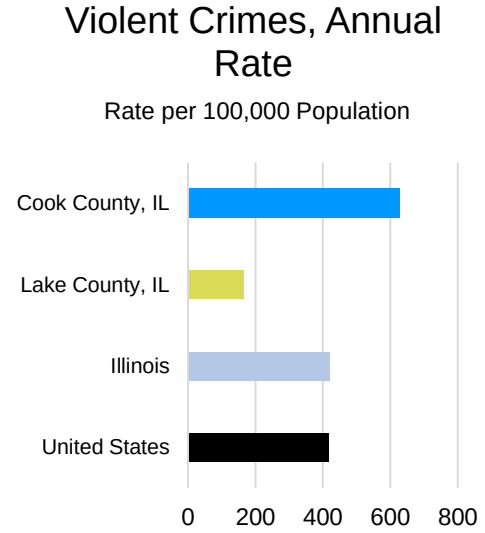
- Nearly 90% of the homicides in the community are male homicides.
- Homicides among Non-Hispanic Black population in Cook County are more than double the national benchmark of 24.1 for Non-Hispanic Black population.

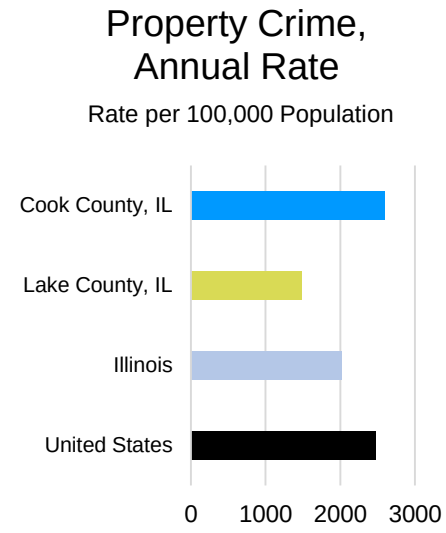
The age-adjusted death rate per 100,000 population for unintentional injury based on the 2016-2020 average is 41.2 compared to the national benchmark of 50.4. Since 2014, the death rate related to unintentional injury has increased significantly for Illinois as well as the United States.









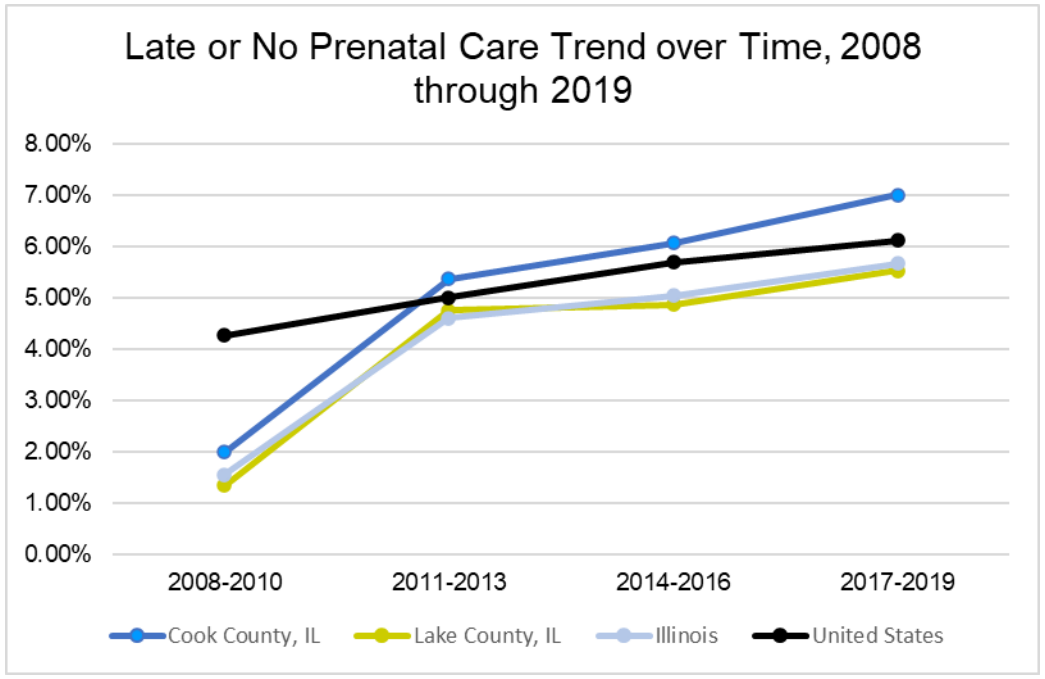


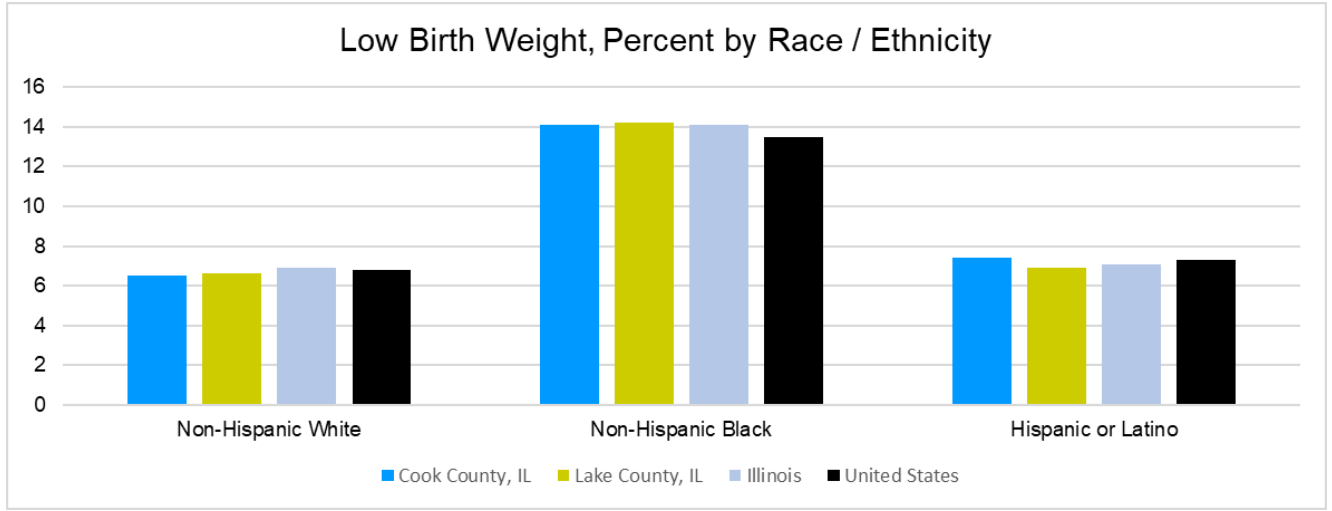
Maternal, Infant and Child Health

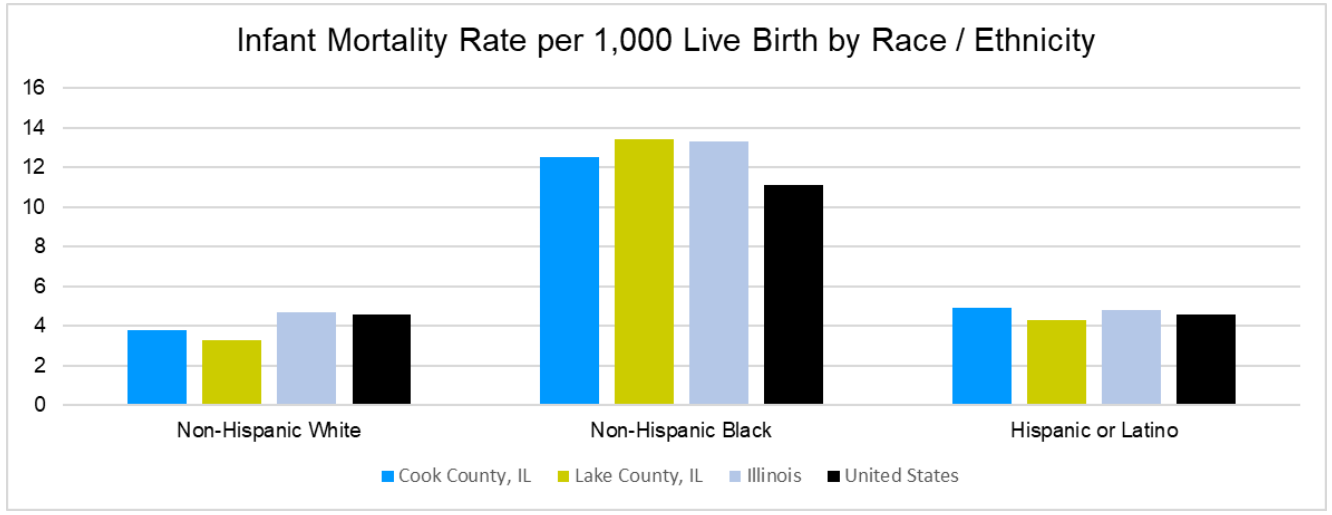
The percentage of births with late or no prenatal care in the community has more than tripled over the last 10 years. Approximately 13,000 births in Cook County and 1,200 births in Lake County had late or no prenatal care between 2017 and 2019. The percentage of births with late or no prenatal care for the CHNA community was 7.01% between 2017 and 2019 which is higher than the national average of 6.12%.

Indicators for Low Birth Weight and Infant Mortality indicate significantly higher rates for Non-Hispanic Black population.

Data Tables







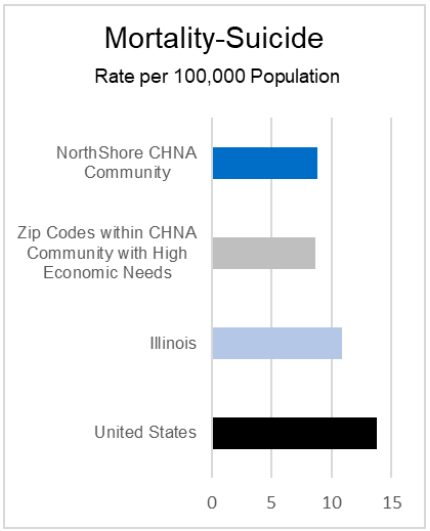
Mental Health

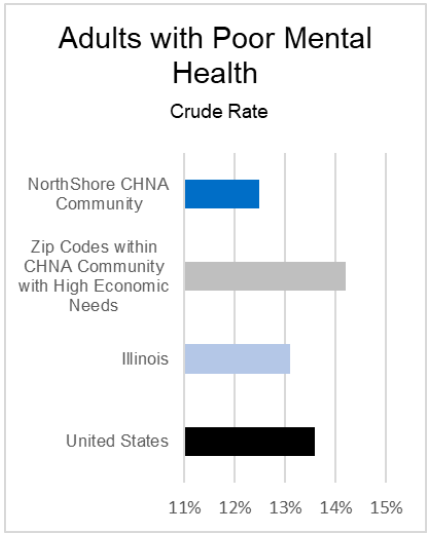
The map to the left reports the percentage of adults (ages 18 years and older) reporting 14 days or more of poor mental health per month. Zip codes with the highest percentages reported include 60088, 60064, 60085 and 60099.

The Illinois Behavioral Health Barometer, measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services, is one of a series of national, regional, and state reports that provide a snapshot of behavioral health in the United States.

A summary of select mental health indicators from the Illinois Behavioral Health Barometer is presented below. Significant increases have occurred from previous surveys for depression, suicide and mental illness among youth.

Data Tables



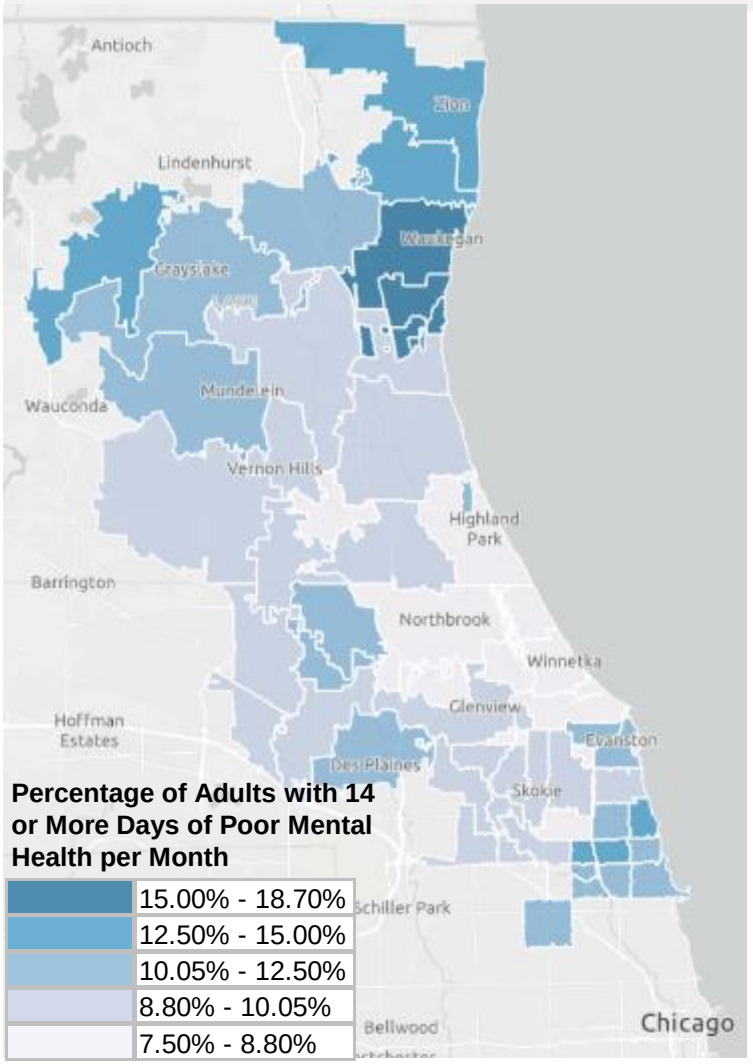


Illinois Behavioral Health Barometer – Youth Mental Health

Prior Survey	2019	
7.5%	15.1%	Among youth aged 12–17 in Illinois, the annual average percentage with a major depressive episode in the past year increased between 2004–2007 and 2016–2019. During 2016–2019, the annual average prevalence of past-year major depressive episode in Illinois was 15.1% (or 145,000), similar to both the regional average (15.2%) and the national average (14.0%).
6.7%	11.1%	Among young adults aged 18–25 in Illinois, the annual average percentage with serious thoughts of suicide in the past year increased between 2008–2010 and 2017–2019. During 2017–2019, the annual average prevalence of past-year serious thoughts of suicide in Illinois was 11.1% (or 145,000), similar to both the regional average (12.2%) and the national average (11.1%).
3.5%	8.7%	Among young adults aged 18–25 in Illinois, the annual average percentage with serious mental illness in the past year increased between 2008–2010 and 2017–2019. During 2017–2019, the annual average prevalence of past-year SMI in Illinois was 8.7% (or 115,000), similar to both the regional average (8.7%) and the national average (7.9%).

Source: Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Illinois, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA–20–Baro–19–IL. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

Frequent Mental Distress



Data Source: Centers for Disease Control (CDC), CDC PLACES: Local Data for Better Health (2020)

Nutrition, Physical Activity and Obesity

Healthy diets and physical activity contribute to healthy lifestyles and overall well-being. These factors are relevant because current behaviors are determinants of future health and well-being and these indicators may be linked to significant health issues, such as obesity and poor cardiovascular health.

- Approximately 444,000 persons live in food deserts in the CHNA community.
- Over 13% of the population (214,207 persons) have low food access.
- Over 330,000 persons, or 28% of adults, are obese in the CHNA community. Obesity rates have increased by 7% over the last 15 years.
- 20.4% of adults, age 20 and older, self-report no active leisure time physical activity.

The map to the right reports the percentage of the low-income population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket or large grocery store. The low-income population with low food access in the community is 34,381 with the following zip codes reporting the highest percentages: 60088, 60044, 60031 and 60030.

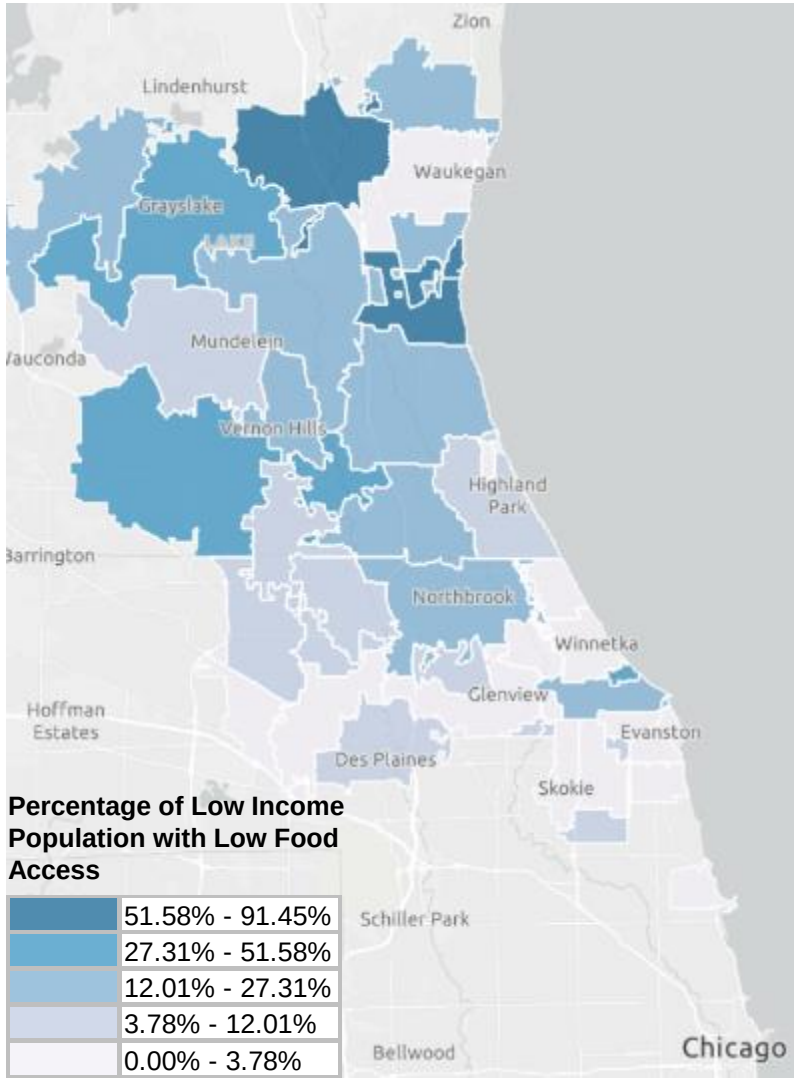
Data Tables

214,207
Food Insecure Population

336,823
Adults with BMI>30 (Obese)

127,854
Students Eligible for Free or Reduced- Price Lunch

Population with Limited Food Access, Low Income Percent by Tract



Physical Environment

The structure of housing and families and the condition and quality of housing units and residential neighborhoods are important because housing issues like overcrowding and affordability have been linked to multiple health outcomes, including infectious disease, injuries, and mental disorders.

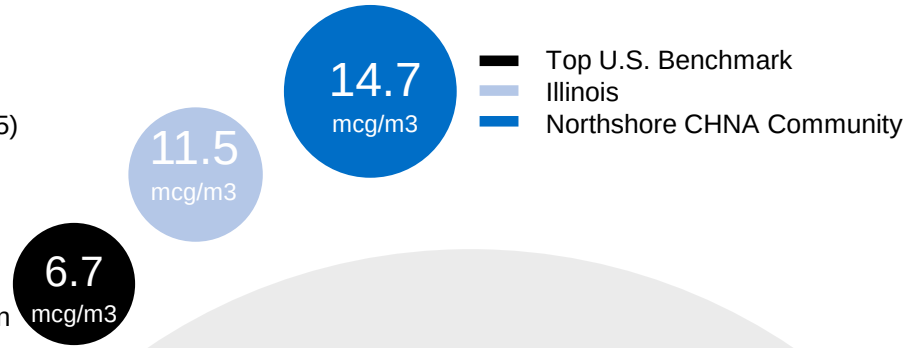
Within the community, 203,874 households, or 34% of households, have housing costs that are 30% or more of the total household income and are classified as “cost-burdened households”.

A large number of seniors in the community, age 65+ live alone. This is important because older adults who live alone may have challenges accessing basic needs, including health needs.

Data Tables

Air Pollution-Fine Particulate Matter-Annual

Air pollution is the percentage of days per year with fine particulate matter 2.5 (PM2.5) levels above the National Ambient air Quality Standard of 35 micrograms pers cubic meter. According to the American Lung Association’s 2022 State of the Air, Chicago, Illinois is ranked 22 for annual particulate pollution out of 202 metropolitan areas.

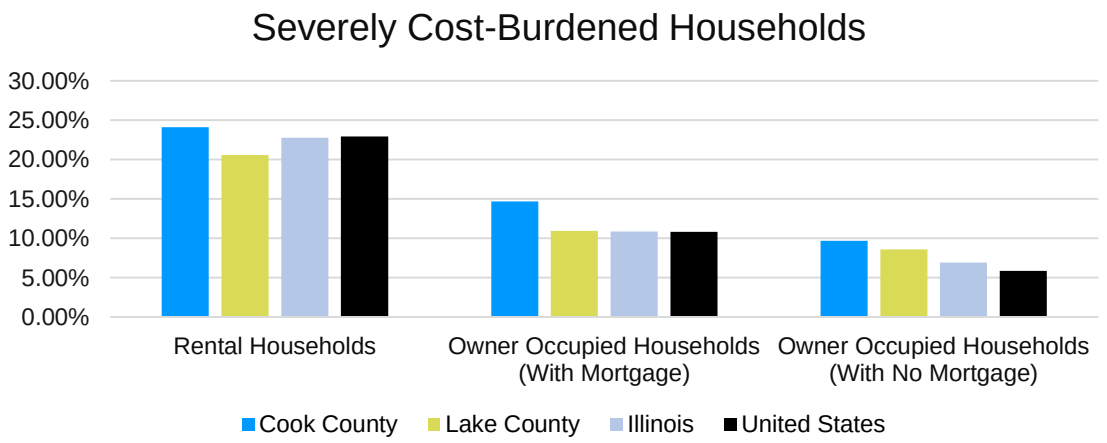


34% of households in the community, 203,874 households, are cost burdened households meaning housing costs exceed 30% of household income. **93,982** households have housing costs that **exceed 50%** of household income.

It is estimated that **13.8%** of households within the community have no or slow internet.

35% housing units have one or more substandard conditions.

69,580 Seniors (age 65+) live alone.



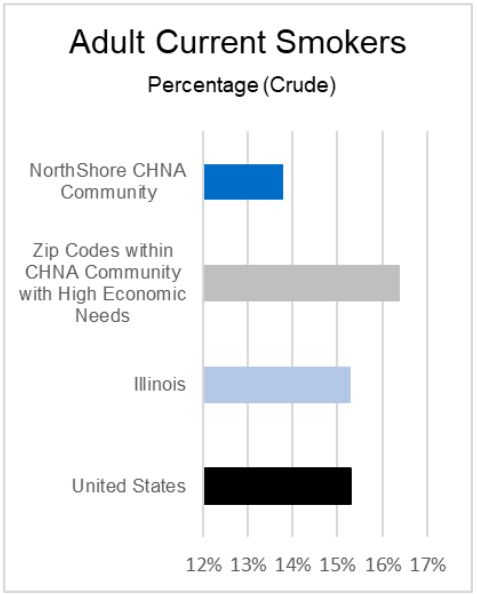
Substance Abuse

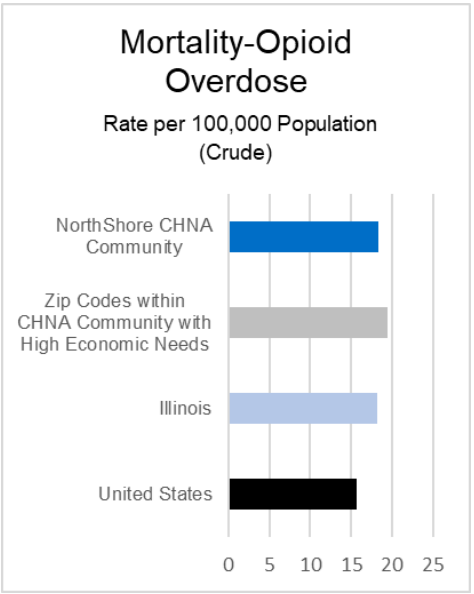
The percentage of adults in the CHNA community who currently smoke is 13.8% and is favorable to state and national benchmarks. The percentage of adults who smoke in zip codes within the CHNA community with high economic needs is slightly higher than the national benchmark.

The 2020 Illinois Youth Survey reports the prevalence of substance use in students from 8th through 12th grade for each county in Illinois. The table below reports the percentage of students who reported alcohol and prescription drugs during the past year and e-cigarettes in the past 30 days. Percentages for 2019 are also shown.

The prevalence of substance use increases significantly from 8th grade to 12, particularly for alcohol and e-cigarettes.

Data Tables





ILLINOIS YOUTH SURVEY

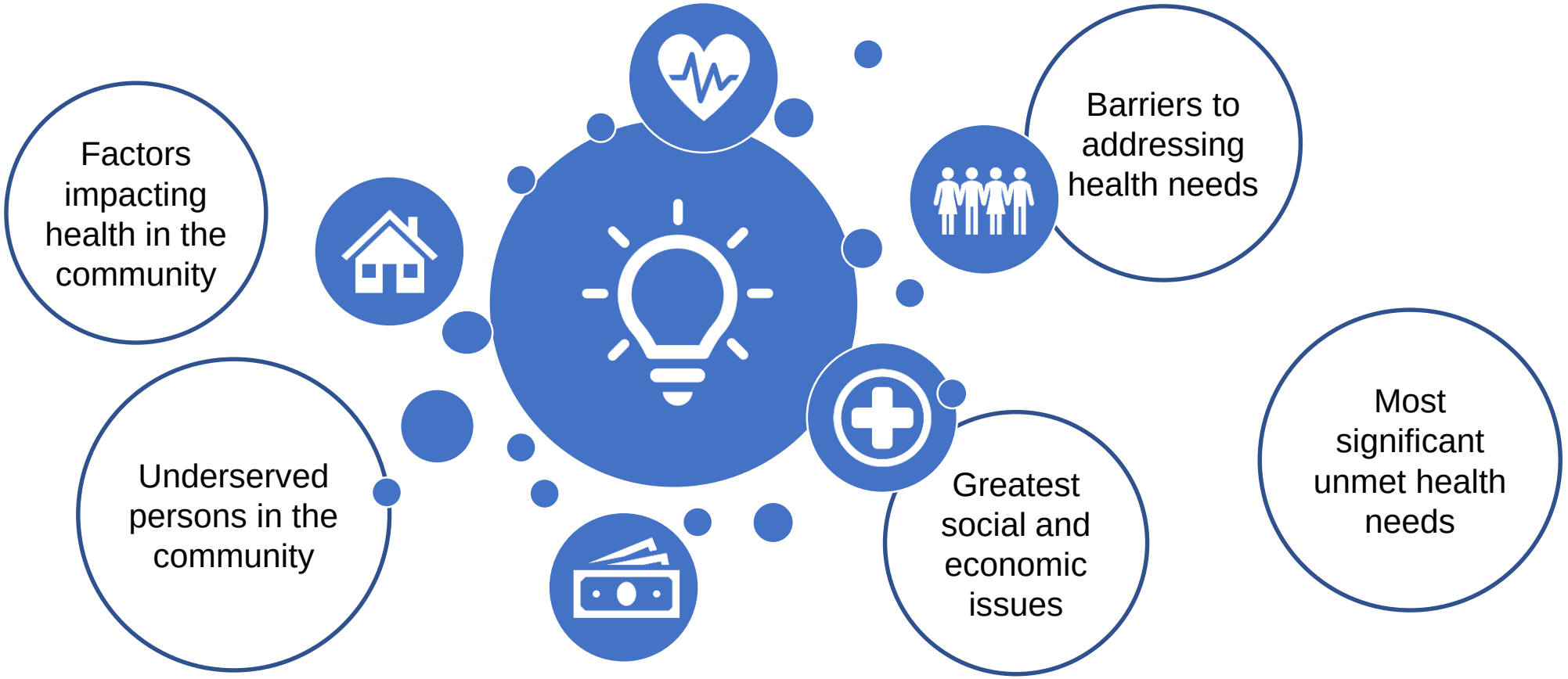
	2019			2020		
	8th Grade	10th Grade	12th Grade	8th Grade	10th Grade	12th Grade
Cook County-Non-Chicago						
Used alcohol during the past year	24%	45%	57%	27%	44%	56%
Used prescription drugs to get high during the past year	1%	3%	6%	1%	2%	3%
Used E-cigarettes in the past 30 days	8%	21%	30%	5%	13%	22%
Lake County						
Used alcohol during the past year	22%	38%	58%	25%	36%	55%
Used prescription drugs to get high during the past year	2%	3%	7%	1%	2%	3%
Used E-cigarettes in the past 30 days	7%	20%	31%	5%	10%	18%

Source: https://iys.cprd.illinois.edu/results/county

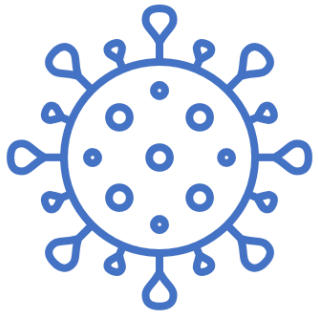
Focus Groups

Written Summary of Focus Groups

NorthShore obtained input from 63 leaders representing public health, major employers, public schools, social services, representatives from the underserved community, NorthShore leaders and the community at-large through five focus groups. Focus groups were conducted throughout January 2022. Focus groups explored multiple areas to identify significant health needs of the community as well as potential ways to address identified needs including the areas below.



Focus Groups



Impact of COVID-19 on Community Health: The COVID-19 pandemic has had significant negative and widespread impact on health within the community. Input from key stakeholders has been provided on how the pandemic influenced related health factors.

Mental Health

The pandemic has stressed and worried nearly everyone and has negatively impacted the economy and housing and caused significant grief and loss. The pandemic is exacerbating mental health issues and making them more obvious and mental health issues and drug abuse are escalating.

Social Isolation

Social isolation resulting from the extended duration of the pandemic (affecting all age groups) was discussed by focus group participants. A sense of belonging has been compromised due to isolation.
There has been an increase in violence among teens due to isolation and lack of supervision.

Financial Impact

The financial impact of the pandemic continues to loom, as people lose their homes and suffer other financial stresses. and the community is seeing the impact of the COVID-19 pandemic on adolescents and young adults.

Physical Health

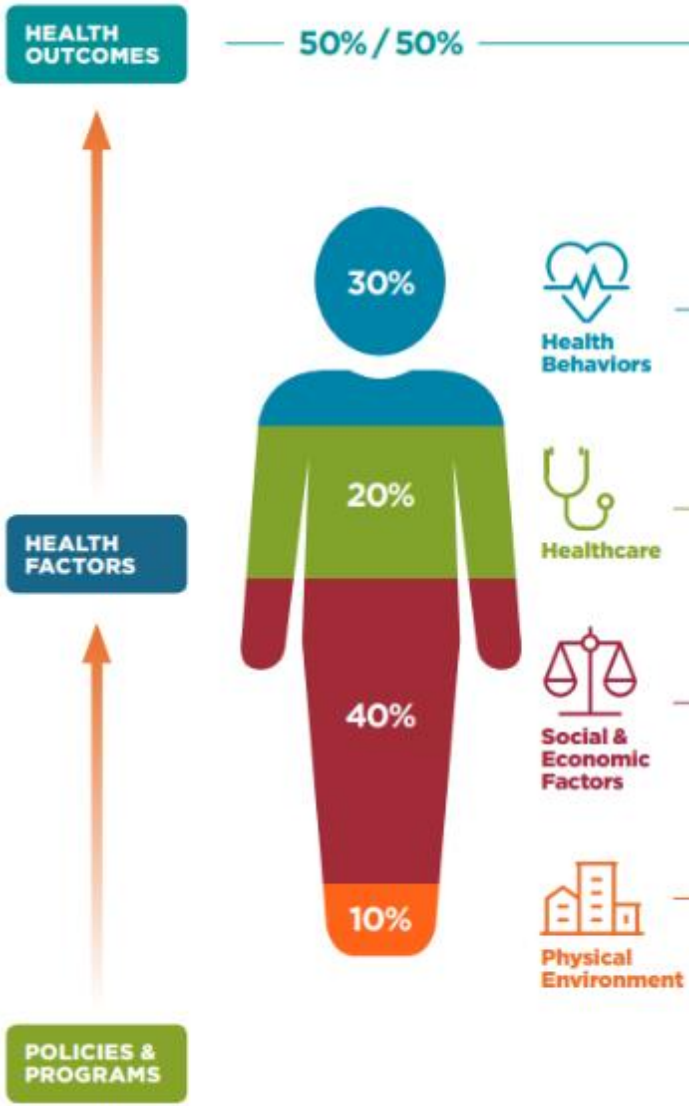
Physical health has declined during the pandemic—due to, among other things, a lack of screening services and delayed health screenings (sometimes even if there are symptoms present). The result of these actions may be late-stage diagnosis and ongoing health issues over a period of years.

Impact on Youth

The fact that youth were out of school for an extended time due to the pandemic has led to numerous issues including an increase in mental health issues and suicide among youth. Teachers have not been able to observe children in the classroom and identify potential healthcare issues due to schools transitioning to in-home learning.

Focus Groups

Written Summary of Focus Groups



Factors Impacting Health in the NorthShore Community

- Certain Members of Community are Not Participating in Healthcare
- Choosing Between Basic Needs and Health Needs
- Delay of Preventative Care
- Distrust of Healthcare System
- Isolation (Youth and Elderly Population)
- Lack of Health Literacy

- Complexity of Healthcare System
- Health Inequity
- Hospital Reimbursement Structure
- Increased Need for Inclusive and Culturally Competent Care
- Lack of Mental Health Providers
- Lack of Statistically Diverse Workforce
- Telehealth

- Economic Disadvantages
- Lack of Access to Resources for Low-Income/Minority Populations
- Poverty
- Structural Racism

- Limited Food Access
- Safe and Affordable Housing

Focus Groups - Most Significant Unmet Healthcare Needs

Written Summary of Focus Groups

Mental Health

- Increased demand for mental health services
- Lack of mental health professionals
- Cost of mental health care

Access to Healthcare; Navigating the Healthcare System

- Insufficient number of medical providers
- Lack of effective communication of health information and available resources
- Patient advocates are needed to:
  - assist with understanding how insurance works and calculating costs
  - educate and direct patients to available social services

Primary and Preventative Care

- Access for uninsured and underinsured
- Medication assistance
- Comprehensive wellness visits

Discrimination/Health Inequity/Mistrust

- Resurgence of discrimination
- Diverse and culturally competent workforce
- Lack of trust in the healthcare system

Housing/Employment/Food Insecurity

- Lack of affordable housing
- Lack of stability with basic needs

Identification of Most Underserved Populations

- People who are low-income, uninsured / underinsured, or homeless
- People with serious mental illness / behavioral health issues
- Members of Black and Brown populations, minority populations and indigenous communities
- Immigrants, undocumented workers and individuals who are not U.S. residents
- LGBTQ+ (including youth)
- Elderly populations
- People with disabilities

Community Survey

In order to develop a broad understanding of community health needs, NorthShore conducted an online community survey from January to February of 2022. The survey was available in English and Spanish. Links to the survey were distributed via e-mail, social media and word of mouth to the community at-large. Signage, including information regarding the community survey and survey links, was posted at community clinics and federally qualified health centers in the CHNA Community. A total of 947 surveys were completed.

Link to Community Survey Summary

Health issues that impact the community most	Cost of Health Care	Mental Health	Obesity/ Overweight	Assistance with Navigating the Healthcare System	High Blood Pressure/Stroke
Weaknesses in the community	Economic Disparities	Racism	Lack of Availability of Mental Health Services	Violence and Safety	Language Barriers to Care
What would improve the quality of life within the community?	More Affordable Housing	Behavioral Health Services	Connections to Resources and Community Agencies	Community Safety	Health Care Access

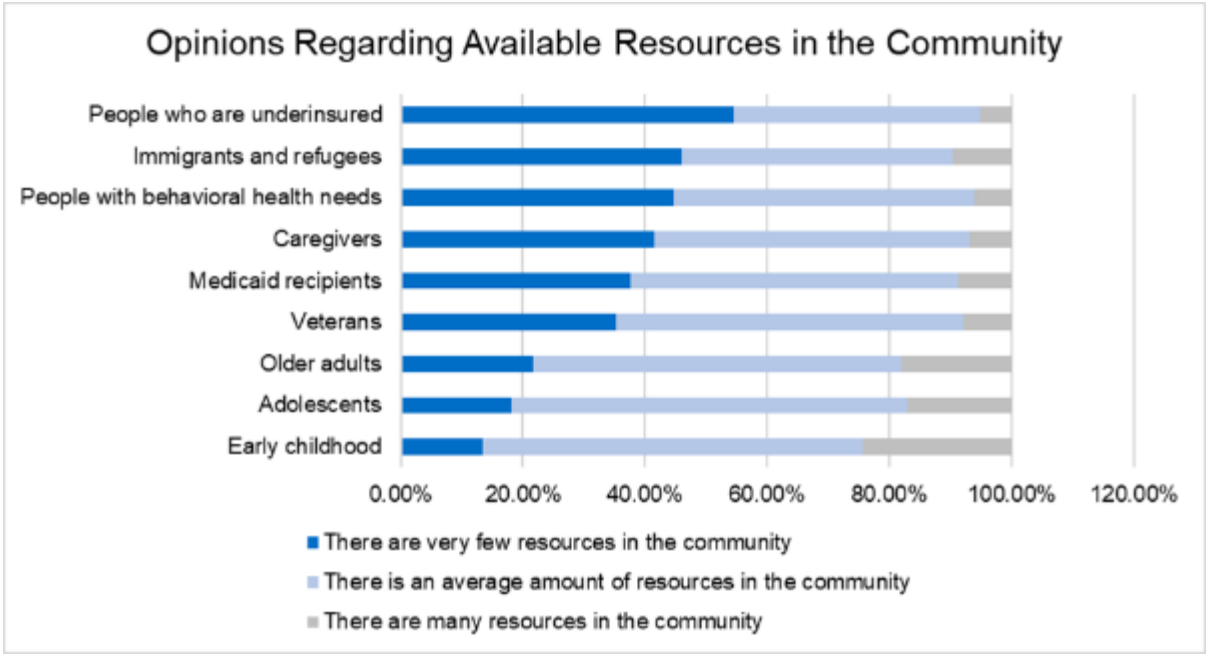
Access to Care Health Outcomes Mental Health Social Determinants of Health

Community Survey

Key Findings

- Almost **65%** of the survey respondents indicated they are always able to visit a doctor when needed.
- Approximately **62%** of the respondents agreed or strongly agreed with eating five fruits and vegetables each day. Significantly less, **35**%, exercise at least 30 minutes a day, five days a week.
- Over **40%** of the respondents indicated there were few resources in the community to assist with health needs of the specific populations below:
  - People who are underinsured
  - Immigrants and refugees
  - People with behavioral health needs
  - Caregivers
- **17%** of the survey respondents indicated transportation to and from doctor appointments is challenging.
- **10%** of the survey respondents disagreed that the housing they lived in was affordable and safe.
- Respondents indicated the biggest source of stress in their daily life was financial stability and relationships.
- The biggest challenges related to the COVID-19 pandemic are mental health and social isolation and juggling work and family.

Available Resources in the Community



Link to Community Survey Summary

Evaluation of the Impact of Actions Taken Since the Last CHNA

Link to Detailed Evaluation of Prior Implementation Strategy

The CHNA is an opportunity for hospitals to do more and be more in the communities they serve. NorthShore provides a broad array of services that provide benefit to the community. Below is a summary of some of NorthShore's significant community benefit programs and services, as well as community partnerships and services available to respond to each priority area. A comprehensive evaluation, including outcomes for each initiative, is provided for each of the four hospitals in Appendix D.

Access to Behavioral Health

- Perinatal Depression Program*
- Perinatal Family Support Center*
- Mental Health First Aid (MHFA)
- Bridges Early Childhood and Adolescent Program*
- Phoenix Program (Adult Mental Health)
- Turning Point Behavioral Health Care Center's "The Living Room" (Mental Health Crisis Support)

Health Literacy and Navigating the Healthcare Environment

- Interpretive Services*
- Partnership with Meridian Health Plan*
- Affordable Care Act/Insurance Exchange Enrollment Support*

NorthShore University HealthSystem

Access and Coordination of Care

- Charity Care (Financial Assistance)*
- Community Health Center*
- Erie Evanston/Skokie Health Center
- Dental Center for Medically Underserved*
- Evanston Township High School Health Center*
- Heartland Community Health Center
- Responding to COVID-19 Pandemic*

Substance Abuse

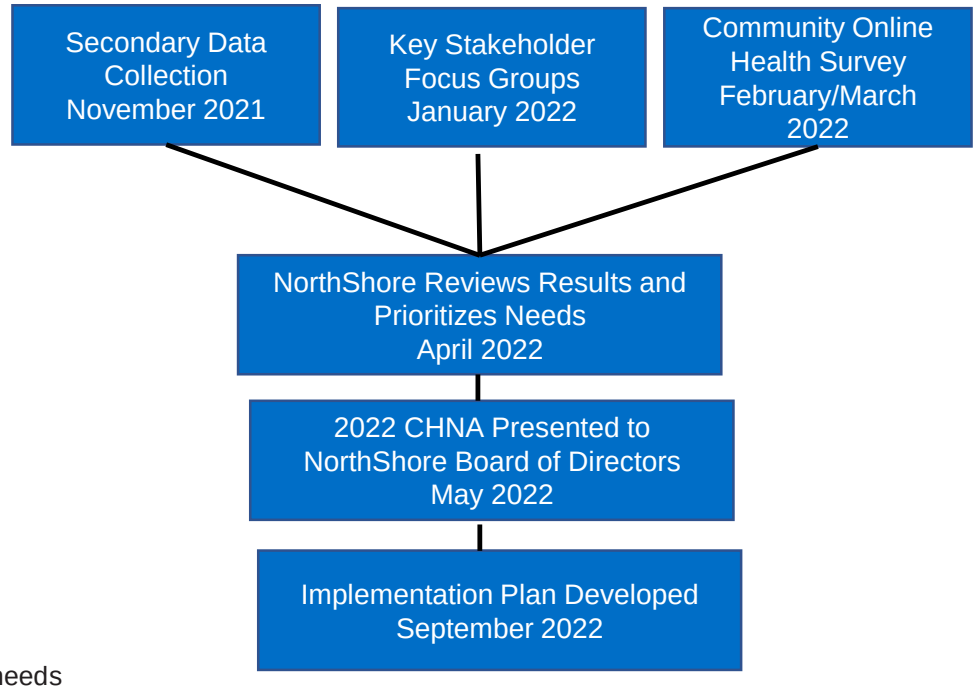
- The Doreen E. Chapman Center*
- Peer Services
- Nicasa
- Lake County Health Department Outpatient Substance Abuse Program

*Community Benefit Programs and Services provided directly by NorthShore

Prioritization of Identified Health Needs

Primary and secondary data was gathered and compiled from November 2021 to March 2022. Based on the information gathered through the CHNA process, the following summary list of needs was identified. Identified health needs are listed in alphabetical order.

- Access to Health Services (Cost, Language, Navigating Healthcare System)
- Affordability of Healthcare
- Cancer
- Chronic Health Conditions (Diabetes and High Blood Pressure)
- Health Inequity/Discrimination
- Food Insecurity
- Heart Disease
- Health Literacy
- Lack of Affordable Housing
- Maternal and Child Health
- Mental/Behavioral Health
- Obesity
- Poverty
- Preventative Care
- Violence/Safety
- Youth Mental Health/Substance Abuse

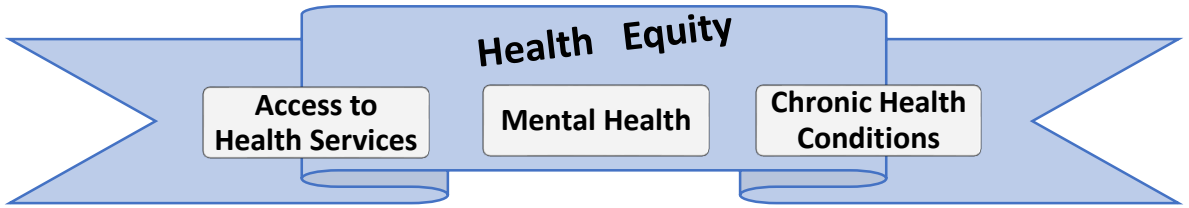


Health needs were prioritized with input from a broad base of key NorthShore stakeholders, by utilizing a scoring guide. See Appendix E for a description of the prioritization process.

Representation included:

- Key Stakeholders within Health Equity and/or Diversity, Equity & Inclusion
- Key Stakeholders from NorthShore's Black Leadership Forum
- Key Stakeholders from NorthShore's LGBTQ+ affinity group (True North)
- Key Stakeholders serving Community
- Senior Organization Leaders

Based on the information gathered through this CHNA and the prioritization process described above, NorthShore chose the needs below to address over the next three years. It is important to note that Health Equity is woven throughout these areas and will be an integral element of the three priority areas: Access to Health Services, Mental Health and Chronic Health Conditions.



Appendix A

Return to Report

Population by Age & Gender

	Age 0-17	Age 18-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65+	Total	Male	Female
NorthShore CHNA Community	**358,942**	**138,986**	**218,669**	**214,392**	**219,762**	**207,797**	**249,029**	**1,607,577**	**794,678**	**812,899**
Cook Chicago North	91,166	39,821	88,575	70,285	60,491	52,163	59,331	461,832	229,840	231,992
Cook North Suburb	143,519	44,658	73,007	81,819	88,574	91,858	123,637	647,072	313,749	333,323
Lake County	124,257	54,507	57,087	62,288	70,697	63,776	66,061	498,673	251,089	247,584
State / National Benchmark										
Illinois	2,891,526	1,192,806	1,770,290	1,644,531	1,672,220	1,656,724	1,942,534	12,770,631	6,272,172	6,498,459
United States	73,429,392	30,646,327	45,030,415	40,978,831	42,072,620	41,756,414	50,783,796	324,697,795	159,886,919	164,810,876

	Age 0-17	Age 18-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65+	Total	Male	Female
NorthShore CHNA Community	**22.3%**	**8.6%**	**13.6%**	**13.3%**	**13.7%**	**12.9%**	**15.5%**	**100.0%**	**49.4%**	**50.6%**
Cook Chicago North	19.7%	8.6%	19.2%	15.2%	13.1%	11.3%	12.8%	100.0%	49.8%	50.2%
Cook North Suburb	22.2%	6.9%	11.3%	12.6%	13.7%	14.2%	19.1%	100.0%	48.5%	51.5%
Lake County	24.9%	10.9%	11.4%	12.5%	14.2%	12.8%	13.2%	100.0%	50.4%	49.6%
State / National Benchmark										
Illinois	22.6%	9.3%	13.9%	12.9%	13.1%	13.0%	15.2%	100.0%	49.1%	50.9%
United States	22.6%	9.4%	13.9%	12.6%	13.0%	12.9%	15.6%	100.0%	49.2%	50.8%

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Population by Ethnicity & Race

Return to Report

	Non-Hispanic/ Latino	Hispanic/ Latino	Total	White	Black	Asian	Other Race	Multiple Races	Total
NorthShore CHNA Community	**1,289,061**	**318,516**	**1,607,577**	**1,134,648**	**113,465**	**201,088**	**105,979**	**52,397**	**1,607,577**
Cook Chicago North	345,952	115,880	461,832	300,395	48,481	54,602	38,903	19,451	461,832
Cook North Suburb	572,188	74,884	647,072	468,721	28,929	106,403	25,252	17,767	647,072
Lake County	370,921	127,752	498,673	365,532	36,055	40,083	41,824	15,179	498,673
State / National Benchmark									
Illinois	10,584,244	2,186,387	12,770,631	9,134,903	1,813,590	698,524	795,168	328,446	12,770,631
United States	266,218,425	58,479,370	324,697,795	235,377,662	41,234,642	17,924,209	19,397,380	10,763,902	324,697,795

	Non-Hispanic/ Latino	Hispanic/ Latino	Total	White	Black	Asian	Other Race	Multiple Races	Total
NorthShore CHNA Community	**80.2%**	**19.8%**	**100.0%**	**70.6%**	**7.1%**	**12.5%**	**6.6%**	**3.3%**	**100.0%**
Cook Chicago North	74.9%	25.1%	100.0%	65.0%	10.5%	11.8%	8.4%	4.2%	100.0%
Cook North Suburb	88.4%	11.6%	100.0%	72.4%	4.5%	16.4%	3.9%	2.7%	100.0%
Lake County	74.4%	25.6%	100.0%	73.3%	7.2%	8.0%	8.4%	3.0%	100.0%
State / National Benchmark									
Illinois	82.9%	17.1%	100.0%	71.5%	14.2%	5.5%	6.2%	2.6%	100.0%
United States	82.0%	18.0%	100.0%	72.5%	12.7%	5.5%	6.0%	3.3%	100.0%

Combined Race and Ethnicity

	Non-Hispanic White	Hispanic/ Latino	Non-Hispanic Asian	Non-Hispanic Black	Non-Hispanic Multiple Races	Some Other Race	Total
NorthShore CHNA Community	**58.0%**	**19.8%**	**12.4%**	**6.8%**	**2.5%**	**.5%**	**100.0%**
Cook Chicago North	49.3%	25.0%	11.7%	10.2%	3.2%	.6%	100.0%
Cook North Suburb	65.2%	11.6%	16.3%	4.3%	2.2%	.4%	100.0%
Lake County	56.9%	25.6%	7.9%	7.0%	2.2%	.4%	100.0%
State / National Benchmark							
Illinois	61.3%	17.1%	5.4%	13.9%	1.9%	.4%	100.0%
United States	60.7%	18.0%	5.5%	12.3%	2.5%	1.0%	100.0%

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Household Income and Poverty

Return to Report

	Percentage of Population Below 100% FPL	Percentage of Population under Age 18 in Poverty	Average Family Income	Percentage of Children Eligible for Free/Reduced Price Lunch
NorthShore CHNA Community	**10.23%**	**12.81%**	**$145,116**	**34.36%**
Cook Chicago North	16.02%	22.13%	$106.504	65.59%
Cook North Suburb	7.42%	8.02%	$160,866	22.93%
Lake County	8.54%	12.89%	$145,311	32.42%
Zip Codes with High Socioeconomic Need	**16.55%**	**23.92%**	**$92,422**	**62.94%**
Cook Chicago North				
60625 - Chicago	13.44%	19.85%	$110,761	70.28%
60626 - Chicago	24.96%	34.17%	$76,881	88.16%
60640 - Chicago	18.95%	24.27%	$118,763	68.43%
60641 - Chicago	10.72%	15.40%	$98,075	81.22%
60645 - Chicago	19.52%	27.44%	$89,624	81.39%
60659 - Chicago	23.49%	36.30%	$78,770	72.13%
60660 - Chicago	15.99%	17.34%	$95,223	75.61%
Cook North Suburb				
60070 - Prospect Heights	9.98%	14.97%	$110,939	21.78%
60077 - Skokie	10.67%	14.24%	$98,592	37.04%
60090 - Wheeling	9.61%	16.52%	$98,390	45.94%
Lake County				
60040 - Highwood	16.79%	29.40%	$113,455	22.21%
60064 - North Chicago	24.24%	32.38%	$58,148	74.14%
60085 - Waukegan	19.84%	28.18%	$63,992	62.20%
60087 - Waukegan	11.18%	19.73%	$77,305	52.68%
State / National Benchmark				
Illinois	12.49%	17.13%	$88,279	48.67%
United States	13.42%	18.52%	$77,263	49.63%

Poverty and Average Family Income Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Free and Reduced Price Lunch Data Source: National Center for Education Statistics, NCES - Common Core of Data. 2019-20. Source geography: Address

Average Family Income
This indicator reports average family income based on the latest 5-year American Community Survey estimates. A family household is any housing unit in which the householder is living with one or more individuals related to him or her by birth, marriage, or adoption. Family income includes the incomes of all family members age 15 and older.

Children Eligible for Free/Reduced Price Lunch
Free or reduced price lunches are served to qualifying students in families with income between under 185 percent (reduced price) or under 130% (free lunch) of the US federal poverty threshold as part of the federal National School Lunch Program (NSLP).

Uninsured Population

Return to Report

Uninsured Population
This indicator reports the percentage of non-institutionalized population are without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Row Labels	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
NorthShore CHNA Community	**1,579,294**	**127,593**	**8.08%**
Cook Chicago North	455,651	48,373	10.6%
Cook North Suburb	640,229	41,102	6.4%
Lake County	483,414	38,118	7.9%
Zip Codes with High Socioeconomic Need	**595,156**	**75,610**	**12.70%**
Cook Chicago North	398,209	46,523	
60625 - Chicago	78,622	10,383	13.2%
60626 - Chicago	48,861	6,101	12.5%
60640 - Chicago	68,009	5,678	8.4%
60641 - Chicago	69,593	9,536	13.7%
60645 - Chicago	46,753	5,934	12.7%
60659 - Chicago	42,425	5,356	12.6%
60660 - Chicago	43,946	3,535	8.0%
Cook North Suburb	81,372	9,880	
60070 - Prospect Heights	15,890	2,213	13.9%
60077 - Skokie	27,454	2,396	8.7%
60090 - Wheeling	38,028	5,271	13.9%
Lake County	115,575	19,207	
60040 - Highwood	5,184	725	14.0%
60064 - North Chicago	15,262	2,699	17.7%
60085 - Waukegan	69,100	12,413	18.0%
60087 - Waukegan	26,029	3,370	13.0%
State / National Benchmark			
Illinois	12,591,483	859,612	6.8%
United States	319,706,872	28,248,613	8.8%

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Population in Limited English Households

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Limited English Households
This indicator reports the percentage of the population aged 5 years and older living in Limited English speaking households. A limited English speaking household is one in which no household member 14 years old and over speaks only English at home, or no household member speaks a language other than English at home and speaks English "very well".

	Total Population Age 5+	Population in Limited English Households	Percentage of Population in Limited English Household
NorthShore CHNA Community	**1,510,707**	**122,423**	**8.1%**
Cook Chicago North	432,354	50,192	11.6%
Cook North Suburb	609,089	46,350	7.6%
Lake County	469,264	25,881	5.5%
Zip Codes with High Socioeconomic Need	**564,095**	**70,141**	**12.4%**
Cook Chicago North	378,123	47,210	12.5%
60625 - Chicago	73,682	10,435	14.2%
60626 - Chicago	47,693	4,511	9.5%
60640 - Chicago	66,453	6,491	9.8%
60641 - Chicago	65,495	7,951	12.1%
60645 - Chicago	42,848	6,524	15.2%
60659 - Chicago	39,463	6,401	16.2%
60660 - Chicago	42,489	4,897	11.5%
Cook North Suburb	76,677	9,886	12.9%
60070 - Prospect Heights	14,652	1,911	13.0%
60077 - Skokie	25,863	3,424	13.2%
60090 - Wheeling	36,162	4,551	12.6%
Lake County	109,295	13,045	11.9%
60040 - Highwood	4,872	539	11.1%
60064 - North Chicago	14,425	1,385	9.6%
60085 - Waukegan	65,118	9,457	14.5%
60087 - Waukegan	24,880	1,664	6.7%
State / National Benchmark			
Illinois	12,003,438	494,435	4.1%
United States	304,930,125	12,982,993	4.3%

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Educational Attainment

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Education
Education metrics can be used to describe variation in population access, proficiency, and attainment throughout the education system, from access to pre-kindergarten through advanced degree attainment. These indicators are important because education is closely tied to health outcomes and economic opportunity.

Row Labels	Total Population Age 25+	Population Age 25+ with No High School Diploma	Population Age 25+ with No High School Diploma, Percent	Population Age 25+ with Bachelor's Degree or Higher, Percent
NorthShore CHNA Community	**1,109,649**	**113,119**	**10.2%**	**49.9%**
Cook Chicago North	330,845	44,869	13.6%	45.9%
Cook North Suburb	458,895	33,966	7.4%	55.2%
Lake County	319,909	34,284	10.7%	46.4%
Zip Codes with High Socioeconomic Need	**418,326**	**67,954**	**16.2%**	**39.9%**
Cook Chicago North	288,145	42,101	14.6%	45.8%
60625 - Chicago	56,639	7,976	14.1%	49.7%
60626 - Chicago	34,717	4,086	11.8%	46.2%
60640 - Chicago	55,212	5,508	10.0%	57.5%
60641 - Chicago	48,896	10,031	20.5%	30.3%
60645 - Chicago	31,252	5,007	16.0%	44.4%
60659 - Chicago	27,817	5,819	20.9%	34.6%
60660 - Chicago	33,612	3,674	10.9%	52.7%
Cook North Suburb	58,655	7,422	12.7%	40.6%
60070 - Prospect Heights	10,731	1,738	16.2%	35.6%
60077 - Skokie	19,992	1,889	9.4%	43.8%
60090 - Wheeling	27,932	3,795	13.6%	40.3%
Lake County	71,526	18,431	25.8%	15.6%
60040 - Highwood	3,509	621	17.7%	38.8%
60064 - North Chicago	9,275	2,791	30.1%	11.6%
60085 - Waukegan	41,686	11,657	28.0%	14.0%
60087 - Waukegan	17,056	3,362	19.7%	16.8%
State / National Benchmark	**229,308,375**	**27,409,303**	**12.0%**	**32.2%**
Illinois	8,686,299	937,042	10.8%	34.7%
United States	220,622,076	26,472,261	12.0%	32.1%

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Areas Affected by a Health Professional Shortage Area (HPSA)

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Areas Affected by a Health Professional Shortage Area
This indicator reports the percentage of the population that is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

	Population Living in an Area Affected by a HPSA	Total Population (5 year estimate)	Percetage of Population Living in an Area Affected by a HPSA
NorthShore CHNA Community	**224,611**	**1,707,425**	**13.2%**
Cook Chicago North	173,797	563,401	30.8%
Cook North Suburb	-	646,880	0.0%
Lake County	50,814	497,144	10.2%
Zip Codes with High Socioeconomic Need	**218,754**	**704,895**	**31.0%**
Cook Chicago North	173,797	505,751	34.4%
60625 - Chicago	12,414	79,773	15.6%
60626 - Chicago	46,266	50,143	92.3%
60640 - Chicago	45,537	131,794	34.6%
60641 - Chicago	9,896	70,361	14.1%
60645 - Chicago	20,800	47,931	43.4%
60659 - Chicago	11,040	42,736	25.8%
60660 - Chicago	27,845	83,013	33.5%
Cook North Suburb	-	81,432	0.0%
60070 - Prospect Heights	-	15,406	0.0%
60077 - Skokie	-	27,186	0.0%
60090 - Wheeling	-	38,840	0.0%
Lake County	44,957	117,712	38.2%
60040 - Highwood	-	5,377	0.0%
60064 - North Chicago	6,821	15,405	44.3%
60085 - Waukegan	27,325	70,322	38.9%
60087 - Waukegan	10,812	26,608	40.6%
State / National Benchmark			
Illinois	3,271,660	12,770,631	25.6%
United States	73,493,673	324,697,795	22.6%

Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. May 2021. Source geography: HPSA

Access to Healthcare Services

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	Dental Care		Mental Care		Primary Care	
	Providers per 100,000 Population	Number of Providers	Providers per 100,000 Population	Number of Providers	Providers per 100,000 Population	Number of Providers
NorthShore Counties	**56.79**	**913**	**121.61**	**1,955**	**142.51**	**2,291**
Cook County, IL	44.85	2,366	107.93	5,684	151.00	7,966
Lake County, IL	52.36	374	95.75	684	103.45	739
State / National Benchmark						
Illinois	37.82	4,846	100.43	12,868	116.25	14,894
United States	33.09	110,751	124.85	417,923	102.27	342,350

Dental Care Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). 2021. Source geography: Address

Mental Care Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). Accessed via County Health Rankings. 2020. Source geography: County

Primary Care Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File. Accessed via County Health Rankings. 2017. Source geography: County

Dental Care
This indicator reports the number of oral health care providers with a CMS National Provider Identifier (NPI). Providers included in this summary are those who list "dentist", "general practice dentist", or "pediatric dentistry" as their primary practice classification, regardless of sub-specialty. Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

Mental Care
This indicator reports the number of mental health providers in the report area as a rate per 100,000 total area population. Mental health providers include psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care. Data from the 2020 Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file are used in the 2021 County Health Rankings.

Primary Care
This indicator reports the number of primary care physicians per 100,000 population. Doctors classified as "primary care physicians" by the AMA include General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs. Physicians aged 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Preventative Services – Core Preventable Services

Return to Report

	Percentage of Males age 65+ Up to Date on Core Preventative Services	Percentage of Females age 65+ Up to Date on Core Preventative Services
NorthShore CHNA Community	**35.0%**	**27.4%**
Cook Chicago North	30.7%	26.8%
Cook North Suburb	35.9%	30.1%
Lake County	37.6%	24.5%
Zip Codes with High Socioeconomic Need	**30.3%**	**25.2**
Cook Chicago North		
60625 - Chicago	31.0%	27.8%
60626 - Chicago	28.0%	24.6%
60640 - Chicago	31.0%	26.9%
60641 - Chicago	29.2%	26.1%
60645 - Chicago	30.3%	26.1%
60659 - Chicago	28.7%	25.5%
60660 - Chicago	30.5%	27.3%
Cook North Suburb		
60070 - Prospect Heights	34.9%	30.1%
60077 - Skokie	33.3%	28.0%
60090 - Wheeling	32.2%	27.6%
Lake County		
60040 - Highwood	36.2%	21.8%
60064 - North Chicago	26.9%	17.3%
60085 - Waukegan	27.8%	17.9%
60087 - Waukegan	34.3%	22.3%
State / National Benchmark		
Illinois	32.9%	29.5%
United States	32.4%	28.4%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2018. Source geography: Tract

Male Preventative Services
This indicator reports the percentage of males age 65 years and older who report that they are up to date on a core set of clinical preventive services. Services include: an influenza vaccination in the past year; a PPV ever; and either a fecal occult blood test (FOBT) within the past year, a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or a colonoscopy within the past 10 years.

Female Preventative Services
This indicator reports the percentage of females age 65 years and older who report that they are up to date on a core set of clinical preventive services. Services include: an influenza vaccination in the past year; a pneumococcal vaccination (PPV) ever; either a fecal occult blood test (FOBT) within the past year, a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or a colonoscopy within the previous 10 years; and a mammogram in the past 2 years.

Preventative Services – Blood Pressure, Diabetes, and Preventable Hospitalizations

Return to Report

	Blood Pressure Medication Nonadherence	Medicare Enrollees with Diabetes with Annual Exam	Preventable Hospitalizations, Rate per 100,000 Beneficiaries
NorthShore Counties	**22.82%**	**88.13%**	**3,375**
Cook County, IL	23.2%	87.3%	3,548
Lake County, IL	19.6%	89.7%	2,946
State / National Benchmark			
Illinois	20.4%	88.8%	3,275
United States	21.8%	87.3%	2,865

Blood Pressure Medication Nonadherence Data Source: Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke . 2018. Source geography: County

Diabetes Annual Exam Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2017. Source geography: County

Preventable Hospitalizations Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2020. Source geography: County

Blood Pressure
This indicator reports the number and percentage of Medicare beneficiaries not adhering to blood pressure medication schedules. Nonadherence is defined having medication coverage days at less than 80%.

Diabetes Annual Exam
This indicator reports the percentage of diabetic Medicare patients who have had a hemoglobin A1c (hA1c) test, a blood test which measures blood sugar levels, administered by a health care professional in the past year. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

Preventable Hospitalizations
This indicator reports the preventable hospitalization rate among Medicare beneficiaries for the latest reporting period. Preventable hospitalizations include hospital admissions for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection. Rates are presented per 100,000 beneficiaries.

Preventative Services – Cancer Screenings

Return to Report

	Adults with Adequate Colorectal Cancer Screening	Females age 21-65 with Recent Pap Smear	Females Age 50-74 with Recent Mammogram
NorthShore CHNA Community	**64.3%**	**82.8%**	**77.3%**
Cook Chicago North	60.4%	81.0%	78.5%
Cook North Suburb	66.7%	83.0%	78.3%
Lake County	64.8%	84.1%	74.9%
Zip Codes with High Socioeconomic Need	**59.3%**	**80.4%**	**77.6%**
Cook Chicago North			
60625 - Chicago	59.6%	80.8%	78.5%
60626 - Chicago	59.0%	80.2%	79.8%
60640 - Chicago	61.3%	82.4%	79.5%
60641 - Chicago	58.3%	81.4%	77.5%
60645 - Chicago	58.8%	79.0%	78.2%
60659 - Chicago	56.4%	75.5%	77.3%
60660 - Chicago	61.8%	81.0%	79.5%
Cook North Suburb			
60070 - Prospect Heights	64.7%	82.0%	77.5%
60077 - Skokie	63.0%	78.7%	77.3%
60090 - Wheeling	61.9%	81.0%	77.2%
Lake County			
60040 - Highwood	62.3%	84.0%	73.9%
60064 - North Chicago	56.9%	79.9%	76.1%
60085 - Waukegan	54.0%	79.5%	74.0%
60087 - Waukegan	62.5%	83.2%	74.0%
State / National Benchmark			
Illinois	64.4%	82.9%	73.7%
United States	66.4%	84.7%	74.8%

Colorectal Cancer Screening
This indicator reports the percentage of adults with adequate colorectal cancer screening.

Pap Smear Screening
This indicator reports the percentage of females age 21–65 years who report having had a Papanicolaou (Pap) smear within the previous 3 years.

Mammogram Screening
This indicator reports the percentage of females age 50-74 years who report having had a mammogram within the previous 2 years.

Colorectal Cancer Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2018.

Pap Smear Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2018.

Mammogram Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2018.

Health Outcomes and Mortality – Cancer Incidence Rates

Return to Report

Cancer Incidence Rates
These indicators report the age adjusted incidence rate (cases per 100,000 population per year) of individuals with cancer adjusted to 2000 U.S. standard population age groups (Under Age 1, 1-4, 5-9, ..., 80-84, 85 and older).

	Breast Cancer Incidence Rate (Per 100,000 Population)	Colorectal Cancer Incidence Rate (Per 100,000 Population)	Lung Cancer Incidence Rate (Per 100,000 Population)	Prostate Cancer Incidence Rate (Per 100,000 Population)
NorthShore CHNA Community	**135.2**	**40.5**	**56.2**	**112.7**
Cook Chicago North	132.2	42.3	57.0	116.0
Cook North Suburb	132.1	42.2	57.0	116.1
Lake County	142.0	36.8	54.2	106.0
State / National Benchmark				
Illinois	133.7	42.1	63.0	111.5
United States	126.8	38.0	57.3	106.2

	Breast Cancer New Cases Annual Average	Colorectal Cancer New Cases Annual Average	Lung Cancer New Cases Annual Average	Prostate Cancer New Cases Annual Average
NorthShore CHNA Community	**1,271**	**714**	**989**	**968**
Cook Chicago North	352	211	285	275
Cook North Suburb	506	303	410	396
Lake County	414	201	293	298
State / National Benchmark				
Illinois	10,389	6,243	9,538	8,174
United States	249,261	143,200	222,811	200,677

Data Source: State Cancer Profiles. 2014-18. Source geography: County

Health Outcomes and Mortality – Chronic Conditions

Return to Report

	Percentage of Adults with Diagnosed Diabetes	Percentage of Adults Ever Diagnosed with Coronary Heart Disease (Crude)	Percentage of Adults with High Blood Pressure
NorthShore CHNA Community	**8.3%**	**4.9%**	**28.0%**
Cook Chicago North	8.9%	4.7%	27.0%
Cook North Suburb	8.8%	5.2%	28.7%
Lake County	7.1%	4.7%	27.9%
State / National Benchmark			
Illinois	8.5%	5.7%	31.2%
United States	9.0%	6.2%	32.6%

Diabetes Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019.
Source geography: County

Coronary Heart Disease and High Blood Pressure Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2019

Diabetes
This indicator reports the number and percentage of adults age 20 and older who have ever been told by a doctor that they have diabetes. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Coronary Heart Disease
This indicator reports the percentage of adults age 18 and older who report ever having been told by a doctor, nurse, or other health professional that they had angina or coronary heart disease.

High Blood Pressure
This indicator reports the percentage of adults age 18 who report ever having been told by a doctor, nurse, or other health professional that they have high blood pressure. Women who were told high blood pressure only during pregnancy and those who were told they had borderline hypertension were not included.

Health Outcomes and Mortality – Mortality

Return to Report

Cancer Deaths
This indicator reports the 2016-2020 five-year average rate of death due to malignant neoplasm (cancer) per 100,000 population.

Heart Disease Deaths
This indicator reports the 2016-2020 five-year average rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population.

Lung Disease Deaths
This indicator reports the 2016-2020 five-year average rate of death due to chronic lower respiratory disease per 100,000 population.

	Cancer Death Rate (Per 100,000 Population)	Heart Disease Death Rate (Per 100,000 Population)	Lung Disease Death Rate (Per 100,000 Population)	Stroke Death Rate (Per 100,000 Population)
NorthShore CHNA Community	**150.4**	**156.4**	**27.8**	**37.7**
Cook Chicago North	152.5	169.2	27.0	41.2
Cook North Suburb	152.5	169.2	27.1	41.2
Lake County	145.7	128.5	29.3	30.1
State / National Benchmark				
Illinois	155.4	165.3	36.1	39.1
United States	149.4	164.8	39.1	37.6

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Injury and Violence – Mortality - Homicide

Return to Report

Mortality - Homicide
This indicator reports the 2016-2020 five-year average rate of death due to assault (homicide) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because homicide rate is a measure of poor community safety and is a leading cause of premature death.

	Five Year Total Deaths, 2016-2020 Total	Unintentional Injury Five Year Total Deaths, 2016-2020 Total
NorthShore Counties	**929**	**11.8**
Cook County, IL	3,986	15.5
Lake County, IL	104	3.1
State / National Benchmark		
Illinois	5,603	9.1
United States	101,419	6.4

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Injury and Violence – Unintentional Injuries

Return to Report

Death due to Unintentional Injury (Accident)
This indicator reports the 2016-2020 five-year average rate of death due to unintentional injury (accident) per 100,000 population.

	Unintentional Injury Death Rate (Per 100,000 Population)	Unintentional Injury Five Year Total Deaths, 2016-2020 Total
NorthShore Counties	**41.2**	**3,417**
Cook County, IL	43.70	11,982
Lake County, IL	35.20	1,242
State / National Benchmark		
Illinois	45.60	30,808
United States	50.40	872,432

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Injury and Violence – Violent Crime and Property Crime

Return to Report

Violent Crime
Violent crime includes homicide, rape, robbery, and aggravated assault.

Property Crime
This indicator reports the rate of property crime offenses reported by law enforcement per 100,000 residents. Property crimes include burglary, larceny-theft, motor vehicle theft, and arson. This indicator is relevant because it assesses community safety.

	Violent Crime		Property Crime	
	Violent Crimes, Annual Rate (Per 100,000 Pop.)	Violent Crimes, 3-year Total	Property Crimes, Annual Rate (Per 100,000 Pop.)	Property Crimes, Annual Average
NorthShore Counties				
Cook County, IL	627.40	99,295	2,587.50	133,275.00
Lake County, IL	165.20	3,385	1,485.10	10,175.00
State / National Benchmark				
Illinois	420.90	162,592	2,022.60	259,698.00
United States	416.00	4,579,031	2,466.10	7,915,583.00

Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2014; 2016. Source geography: County

Maternal, Infant, and Child Care – Infant Deaths, Low Weight Births, Birth Care

Return to Report

	Number of Infant Deaths	Infant Deaths per 1,000 Live Births	Number of Low Birthweight Births	Low Birthweight Births, Percentage	Number of Births with Late/No Care	Births with Late/No Care, Percentage
NorthShore Counties						
Cook County, IL	2,988	6.40	41,105	9.0%	12,978	7.0%
Lake County, IL	244	4.60	4,057	7.7%	12,978	7.0%
State / National Benchmark						
Illinois	12,644	6.20	177,366	8.4%	24,653	5.7%
United States	301,832	5.80	4,440,508	8.2%	697,581	6.1%

Infant Deaths and Low Birthweight Births Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2013-2019. Source geography: County

Births with Late/No Care Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2019. Source geography: County

Infant Deaths
This indicator reports information about infant mortality, which is defined as the number of all infant deaths (within 1 year) per 1,000 live births.

Low Birthweight Births
This indicator reports the percentage of live births where the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.). These data are reported for a 7-year aggregated time period.

Births with Late/No Care
This indicator reports the percentage of women who did not obtain prenatal care until the 7th month (or later) of pregnancy or who didn't have any prenatal care, as of all who gave birth during the three-year period from 2017 to 2019. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

Mental Health – Adult Mental Health

Return to Report

	Adults with Poor Mental Health. Percent (Crude)	Crude Suicide Death Rate (Per 100,000 Population)	Suicide Five Year Total, 2016-2020
NorthShore CHNA Community	**12.5%**	**9.1**	**723**
Cook Chicago North	13.6%	8.8	196
Cook North Suburb	11.2%	8.8	283
Lake County	13.1%	9.8	244
Zip Codes with High Socioeconomic Need	**14.2%**	**9.0**	**277**
Cook Chicago North			172
60625 - Chicago	13.2%	8.8	34
60626 - Chicago	15.5%	8.8	22
60640 - Chicago	13.1%	8.8	29
60641 - Chicago	13.7%	8.8	31
60645 - Chicago	14.3%	8.8	20
60659 - Chicago	15.0%	8.8	17
60660 - Chicago	13.7%	8.8	19
Cook North Suburb			28
60070 - Prospect Heights	12.5%		
60077 - Skokie	11.6%	8.8	12
60090 - Wheeling	12.9%	8.8	16
Lake County			77
60040 - Highwood	13.5%		29
60064 - North Chicago	17.3%		
60085 - Waukegan	16.9%	9.9	35
60087 - Waukegan	14.7%	9.9	13
State / National Benchmark			
Illinois	13.1%	11.3	7,178
United States	13.6%	14.3	233,972

Poor Mental Health
This indicator reports the percentage of adults age 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.

Suicides
This indicator reports the 2016-2020 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population.

Poor Mental Health Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2019. Source geography: Tract

Suicide Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Nutrition, Physical Inactivity Obesity – Food Environment

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		Food Desert		Low Food Access		SNAP Authorized Retailers	
	Total Population (2010)	Food Desert Population	Food Desert Population, Percent	Population with Low Food Access	Population with Low Food Access, Percent	Total SNAP-Authorized Retailers	SNAP-Authorized Retailers per 10,000 Population
NorthShore CHNA Community	**1,591,962**	**444,335**	**27.9%**	**214,207**	**13.5%**	**908**	**5.83**
Cook Chicago North	448,191	-	0.0%	-		290	6.62
Cook North Suburb	645,110	141,081	21.9%	50,220	7.8%	318	5.04
Lake County	498,661	303,254	60.8%	163,987	32.9%	300	6.14
Zip Codes with High Socioeconomic Need	**592,362**	**32,757**	**5.5%**	**20,147**	**3.4%**	**428**	**7.46**
Cook Chicago North	392,373	-	0.0%	-		277	7.25
60625 - Chicago	78,651	-	0.0%	No Data		52	6.59
60626 - Chicago	50,139	-	0.0%	No Data		42	8.51
60640 - Chicago	65,790	-	0.0%	-		45	7.40
60641 - Chicago	71,663	-	0.0%	No Data		42	5.82
60645 - Chicago	45,274	-	0.0%	No Data		45	10.13
60659 - Chicago	38,104	-	0.0%	No Data		35	9.28
60660 - Chicago	42,752	-	0.0%	No Data		16	4.13
Cook North Suburb	80,459	10,296	12.8%	6,795	8.4%	36	4.81
60070 - Prospect Heights	16,001	3,920	24.5%	2,143	13.4%	5	3.58
60077 - Skokie	26,825	-	0.0%	84	0.3%	14	5.32
60090 - Wheeling	37,633	6,376	16.9%	4,568	12.1%	17	4.92
Lake County	119,530	22,461	18.8%	13,352	11.2%	115	9.86
60040 - Highwood	5,431	-	0.0%	3	0.1%	1	1.94
60064 - North Chicago	15,407	4,502	29.2%	4,802	31.2%	14	9.07
60085 - Waukegan	71,714	2,306	3.2%	1,496	2.1%	75	10.78
60087 - Waukegan	26,978	15,653	58.0%	7,051	26.1%	25	9.46
State / National Benchmark							
Illinois	12,830,632	1,242,939	9.7%	2,589,942	20.2%	9,294	7.38
United States	308,745,538	39,074,974	12.7%	68,611,398	22.2%	248,526	7.47

Food Deserts
This indicator reports the number of neighborhoods in the report area that are within food deserts. The USDA Food Access Research Atlas defines a food desert as any neighborhood that lacks healthy food sources due to income level, distance to supermarkets, or vehicle access.

Low Food Access
This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store.

SNAP Authorized Retailers
This indicator reports the number of SNAP-authorized food stores as a rate per 10,000 population. SNAP-authorized stores include grocery stores as well as supercenters, specialty food stores, and convenience stores that are authorized to accept SNAP (Supplemental Nutrition Assistance Program) benefits.

Food Desert and Low Food Access Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019. Source geography: Tract
SNAP Authorized Retailers Data Source: US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator. Additional data analysis by CARES. 2021. Source geography: Tract

Nutrition, Physical Inactivity Obesity – Obesity and Physical Activity

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		Obesity		Physical Activity	
	Population Age 20+	Adults with BMI > 30.0	Adults with BMI > 30.0, Percent	Adults with No Leisure Time Physical Activity	Adults with No Leisure Time Physical Activity, Percent
NorthShore CHNA Community	**1,205,036**	**336,823**	**27.95%**	**246,045**	**20.42%**
Cook Chicago North	352,243	93,697	26.60%	73,971	21.00%
Cook North Suburb	494,582	132,446	26.78%	103,763	20.98%
Lake County	358,211	110,680	30.90%	68,311	19.07%
State / National Benchmark					
Illinois	9,523,557	2,673,824	28.08%	2,043,592	21.43%
United States	243,082,729	67,624,774	27.82%	54,200,862	22.60%

Obesity Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019. Source geography: County

Physical Activity Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019. Source geography: County

Obesity
This indicator reports the number and percentage of adults aged 20 and older self-report having a Body Mass Index (BMI) greater than 30.0 (obese). Body mass index (weight [kg]/height [m]2) was derived from self-report of height and weight. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Physical Activity
This indicator is based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?" This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as obesity and poor cardiovascular health.

Physical Environment – Cost Burdened Households

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	Total Households	Cost Burdened Households (30%)	Percentage of Cost Burdened Households	Households with No or Slow Internet, Percent	Substandard Housing Conditions, Percent
NorthShore CHNA Community	**599,588**	**203,874**	**34.0%**	**13.8%**	**34.8%**
Cook Chicago North	186,255	72,967	39.2%	19.1%	40.4%
Cook North Suburb	243,191	78,543	32.3%	12.3%	32.8%
Lake County	170,142	52,364	30.8%	10.3%	31.5%
Zip Codes with High Socioeconomic Need	**233,127**	**92,973**	**39.9%**	**18.2%**	**41.3%**
Cook Chicago North	163,259	66,507	40.7%	19.1%	42.1%
60625 - Chicago	29,668	10,895	36.7%	16.4%	37.8%
60626 - Chicago	22,995	10,700	46.5%	21.2%	48.6%
60640 - Chicago	35,466	13,721	38.7%	19.8%	38.4%
60641 - Chicago	24,557	9,411	38.3%	20.2%	39.5%
60645 - Chicago	16,004	6,681	41.7%	18.9%	44.1%
60659 - Chicago	13,485	6,482	48.1%	17.1%	51.2%
60660 - Chicago	21,084	8,617	40.9%	19.6%	42.8%
Cook North Suburb	30,212	11,215	37.1%	14.3%	39.1%
60070 - Prospect Heights	5,625	2,088	37.1%	17.3%	42.1%
60077 - Skokie	10,146	3,938	38.8%	14.1%	38.9%
60090 - Wheeling	14,441	5,189	35.9%	13.3%	38.1%
Lake County	39,656	15,251	38.5%	17.4%	40.1%
60040 - Highwood	1,897	775	40.9%	17.5%	45.2%
60064 - North Chicago	5,108	2,130	41.7%	21.6%	43.6%
60085 - Waukegan	23,235	9,462	40.7%	18.4%	42.5%
60087 - Waukegan	9,416	2,884	30.6%	12.9%	31.2%
State / National Benchmark					
Illinois	4,846,134	1,468,277	30.3%	17.3%	30.8%
United States	120,756,048	37,249,895	30.8%	17.3%	31.9%

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Cost Burdened Households
This indicator reports the percentage of the households where housing costs are 30% or more total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels. The following zip codes have the highest percentage of households with severe cost burden of housing.

Internet Access
This indicator reports the percentage of households who either use dial-up as their only way of internet connection, or have internet access but don't pay for the service, or have no internet access in their home, based on the 2014-2019 American Community Survey estimates.

Substandard Housing
This indicator reports the percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%. Selected conditions provide information in assessing the quality of the housing inventory and its occupants. This data is used to easily identify homes where the quality of living and housing can be considered substandard.

Physical Environment – Environment and Housing

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	Percent Population within 1/2 Mile of a Park	Percent Population Using Public Transit for Commute to Work	Percentage of Days Exceeding Ozone Standards	Average Daily Ambient Ozone Concentration
NorthShore CHNA Community	**52%**	**14.4%**	**0.9%**	**165.5**
Cook Chicago North	29%	30.0%	2.0%	250.6
Cook North Suburb	60%	10.2%	0.6%	155.7
Lake County	63%	4.7%	0.0%	133.8
Zip Codes with High Socioeconomic Need	**37%**	**23.7%**	**1.6%**	**214.55**
Cook Chicago North				
60625 - Chicago	23%	33.4%	3.0%	382.1
60626 - Chicago	10%	41.7%	2.1%	278.9
60640 - Chicago	34%	45.4%	2.6%	329.5
60641 - Chicago	55%	20.7%	2.6%	328.7
60645 - Chicago	10%	18.6%	1.7%	224.6
60659 - Chicago	21%	16.7%	1.4%	186.2
60660 - Chicago	11%	40.8%	1.8%	238.2
Cook North Suburb				
60070 - Prospect Heights	86%	2.7%	0.0%	83.6
60077 - Skokie	73%	8.5%	1.0%	133.6
60090 - Wheeling	47%	3.3%	0.0%	187.9
Lake County				
60040 - Highwood	42%	9.7%	0.0%	35.3
60064 - North Chicago	54%	4.8%	0.0%	113.9
60085 - Waukegan	50%	4.7%	0.0%	333.7
60087 - Waukegan	66%	1.3%	0.0%	147.5
State / National Benchmark				
Illinois	59%	9.5%	0.0%	36.1
USA	46%	5.0%	0.3%	37.9

Living Near a Park
This indicator reports the percentage of population living within 1/2 mile of a park. This indicator is relevant because access to outdoor recreation encourages physical activity and other healthy behaviors.

Public Transit
This indicator reports the percentage of population using public transportation as their primary means of commuting to work. Public transportation includes buses or trolley buses, streetcars or trolley cars, subway or elevated rails, and ferryboats.

Living Near a Park Data Source: Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network. 2015. Source geography: Tract

Public Transit Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Substance Abuse – Adult Alcohol and Tobacco Use

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	Percentage of Adults Binge Drinking in the Past 30 Days	Percentage of Adult Current Smokers
NorthShore CHNA Community	**21.9%**	**13.8%**
Cook Chicago North	23.3%	15.5%
Cook North Suburb	21.7%	12.3%
Lake County	20.7%	14.2%
Zip Codes with High Socioeconomic Need	**22.3%**	**16.4%**
Cook Chicago North		
60625 - Chicago	25.0%	14.4%
60626 - Chicago	23.7%	17.0%
60640 - Chicago	24.3%	14.9%
60641 - Chicago	24.1%	15.8%
60645 - Chicago	20.4%	17.2%
60659 - Chicago	19.8%	18.8%
60660 - Chicago	24.3%	14.9%
Cook North Suburb		
60070 - Prospect Heights	23.2%	14.4%
60077 - Skokie	19.2%	13.6%
60090 - Wheeling	23.0%	15.1%
Lake County		
60040 - Highwood	20.3%	14.8%
60064 - North Chicago	18.1%	20.8%
60085 - Waukegan	19.0%	20.0%
60087 - Waukegan	19.8%	17.0%
State / National Benchmark		
Illinois	20.4%	15.3%
United States	16.7%	15.3%

Adult Alcohol Use
This indicator reports the percentage of adults age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

Adult Tobacco Use
This indicator reports the percentage of adults age 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

Alcohol Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2019. Source geography: Tract

Tobacco Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2019. Source geography: Tract

Substance Abuse – Opioid Overdose

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Opioid Overdose
This indicator reports the 2016-2020 five-year average rate of death due to opioid drug overdose per 100,000 population. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because opioid drug overdose is the leading cause of injury deaths in the United States, and they have increased dramatically in recent years.

	Unintentional Injury Death Rate (Per 100,000 Population)	Opioid Overdose Five Year Total Deaths, 2016-2020 Total
NorthShore Counties	**18.4**	**1,480**
Cook County, IL	21.6	5,809
Lake County, IL	10.7	340
State / National Benchmark		
Illinois	18.2	11,559
United States	16.0	256,428

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System.
Accessed via CDC WONDER. 2016-2020. Source geography: County

Appendix B – Summary of Focus Groups

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Five focus groups were conducted during the month of January, 2022. Four focus groups were comprised of leaders representing public health, major employers, public schools, social services, NorthShore leaders and the community at-large. A fifth focus group was conducted with leaders from public health.

Focus groups explored multiple areas to identify significant health needs of the community as well as potential ways to address identified needs. The areas included 1.) factors impacting health in the community; 2.) greatest unmet health needs; 3.) health status in the community; 4.) barriers to addressing health needs, 5.) underserved groups, and 6.) greatest economic social issues.

This section of the report summarizes what the key stakeholders said without assessing the credibility of their comments.

1. Factors Impacting Health in the Community

Focus group participants were first asked to generally indicate what is impacting health within the community. Some positive factors were mentioned by focus group participants that have improved health within the community, including the great health and education resources in the community, increases in research leading to better care, improvement in telehealth and technology, great not-for-profit organizations that collaborate on issues (which has improved from the past), and a high vaccination status (in general, including COVID). However, numerous negative factors were cited by focus group participants included the following:

a. COVID-19 Pandemic

Numerous focus group participants believed that the COVID-19 pandemic has significantly negatively impacted health within the community and that the impact is widespread. The pandemic has stressed and worried nearly everyone and has negatively impacted the economy and housing and caused significant grief and loss. Social isolation resulting from the extended duration of the pandemic (affecting all age groups) was discussed by focus group participants. A sense of belonging has been compromised due to isolation. The financial impact of the pandemic continues to loom, as people lose their homes and suffer other financial stresses. Mental health issues and drug abuse are escalating, and the community is seeing the impact of the COVID-19 pandemic on adolescents and young adults.

The pandemic has also made it more difficult for individuals to take care of chronic health conditions. Focus group participants noted that physical health has declined during the pandemic—due to, among other things, a lack of screening services and delayed health screenings (sometimes even if there are symptoms present). The result of these actions may be late-stage diagnosis and ongoing health issues over a period of years. Additionally, people were forced to put healthy lifestyles on hold (such as going to the gym) and to find other ways to proactively manage health when resources were closed or reallocated due to the pandemic.

It was noted by one focus group participant that the pandemic has created a “moment of crisis” for children. The fact that youth were out of school for an extended time due to the pandemic has led to numerous issues, including an increase in mental health issues and suicide, an inability to observe children in the classroom and identify potential healthcare issues, and an increase in violence due to lack of supervision. Furthermore, staffing shortages in the classroom due to the pandemic has negatively impacted quality of life. Lastly, work-life changes in the family have impacted childcare in many homes.

In general, the pandemic is exacerbating numerous healthcare issues and making them more obvious.

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b. Mental Health

Focus group participants mentioned that the mental and social wellbeing of the community continues to be a struggle – which has been exacerbated by the pandemic – and that mental health ultimately affects physical health. Isolation caused by the pandemic and by winter weather contributes to mental health issues. Many people are lonely and do not have a sense of belonging. People need community for mental strength. The stigma associated with mental health must be addressed. While the pandemic has been a time that calls for increased mental health therapy and psychosocial support, access to these resources has been limited, especially for youth.

c. Economic Disadvantages

For certain members of the population, a lack of financial security negatively impacts their health. This is true for those individuals who live in poverty—especially those who experience intergenerational poverty. Many in the community are experiencing employment and education challenges. Focus group participants noted that the economically disadvantaged population is growing, and that healthcare costs, housing costs, and early childcare costs are rapidly rising. Due to financial constraints, individuals sometimes make decisions that negatively impact physical and mental wellbeing (for example, they must decide on whether to pay for medication or food). Some lack insurance coverage due to unemployment or underemployment. For the underinsured, knowing what insurance will pay impacts preventative care.

d. Housing / Food / Safety

There were several aspects of housing mentioned by focus group participants that impact health within the community. First, there are vast disparities within the community and segregation of housing, rather than an integrated community. Second, it was mentioned that housing has a significant impact on health, and that research shows the great impact that housing stability, quality, and affordability, and the neighborhood in which one lives, has on individual health outcomes. Third, housing can create an unsafe physical environment, for example, when lead pipes are present in the home.

Food insecurity was raised by focus group participants as a negative factor impacting community health.

Regarding safety, a general collapse of civility was discussed. Because interactions among people have worsened (compared to 20 years ago), people are not as willing to help each other, resulting in many people feeling unsafe.

e. Fractured Healthcare System

One focus group participant referred to a “fractured health system” where there are disparities in treatment and access, and part of the community is not even participating in healthcare. For example, there are many people without access to healthcare, such as the middle-income population, who have a hard time accessing specialists and mental health providers. Also, there are long wait times for appointments and issues with scheduling appointments due to an overwhelmed system creating a scheduling backlog. Even getting to an appointment can be challenging for some individuals, as there is a lack of affordable escorted transportation for individuals who cannot afford caregivers (for those who need services beyond a traditional taxi).

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Navigating the healthcare system was also discussed by focus group participants—specifically, that navigating the health system is extremely complicated, even for those in the healthcare system. For example, people are unsure of who to call, when to call, where to follow through, etc. Focus group participants pointed out that there is a lack of onsite health advocates—people who can interpret healthcare "speak" to common persons, especially in the senior population. Also, help is needed navigating uninsured and underinsured individuals through the healthcare system by communicating available financial resources.

Focus group participants discussed the prohibitive cost of healthcare services and prescription drugs. With the cost of healthcare being high, there is a lack of education of the availability of affordable healthcare options and a need for better transparency of fee structures. Oftentimes, people do not understand healthcare costs. Thus, even if health issues are identified, there may be a lack of access to follow-up care due to prohibitive cost.

Another aspect of the healthcare system that needs addressed is understaffing of healthcare institutions, a workforce shortage, and provider burnout. As healthcare workers continue to experience stress, employers should address employee wellness.

Another aspect of the healthcare system that needs addressed is how hospitals are compensated by payors.

Furthermore, racism, implicit bias, homophobia, and ageism are present within the healthcare system, leading to unequal access to healthcare. Also, there is a lack of providers with whom patients can connect, such as psychiatrists of color. Immigration status is also an issue that impacts an individual's willingness to access healthcare because individuals are unsure if they can seek treatment.

Communication of healthcare information to the community through social media has been very positive in some respects, but there is also a lot of misinformation circulating, which hospitals are working to combat. Varying levels of health literacy exist throughout the community.

f. Schools / Childcare Resources

Because of remote learning, youth is a population that has been missed within our healthcare system during the pandemic. Many children are primarily interacting through social media; however, they need more face-to-face social and emotional interaction, and gaps have been broadened.

Focus group participants noted that in Illinois there has been a loss of available adolescent beds and resources, and there are insufficient resources to respond to the needs of this population.

g. Fear / Lack of Trust of the Healthcare System

Focus group participant indicated that there is an "unhealthy skepticism of public leaders" in the community, particularly in certain groups of color. This lack of trust instills fear in people and makes them withdraw. One root cause of the lack of trust mentioned by a focus group participant was previous illegal medical practices experimented on African Americans. At the present time, that lack of trust is leading to mistrust of vaccines. Generally, there is a hesitancy or reluctance to get healthcare, to go to the hospital, to get vaccinations, etc. among certain groups of color.

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2. Greatest Unmet Health Needs

a. Mental Health / Behavioral Health

Focus group participants mentioned access to mental health/behavioral health services (including for youth and adolescents, and including therapy and psychosocial support), among the greatest unmet health needs within the community. If people present at the emergency department, they are often screened out at this level. Access is a challenge, as providers are booked for months, and there is a lack of available beds. Increases are seen in suicides, post-natal depression, and families dealing with added stressors and anxiety.

b. Physical Health

Physical health was mentioned by focus group participants as one of the greatest unmet health needs, as people are not seeking preventative care. The cause may be due to a variety of reasons, including economic circumstances, lack of transportation, high cost (including medication costs), lack or insurance, or lack of knowledge. Furthermore, preventative screenings are hard to access for certain populations, such as uninsured adults. Federally Qualified Health Centers do not have access to certain preventative screening services in-house (such as colonoscopy and mammogram). Also, people may delay preventative care due to the pandemic or other concerns. There must be a greater focus on preventative care, health maintenance and physicals. It was noted by one focus group participant that the sense of overwhelm in the healthcare system impacts workers and is stemming people from wanting preventative care, so the system is becoming crisis oriented. Vaccines in the most vulnerable communities are needed. There is needed focus on overall wellness of people and communities holistically (mind, body, spirit). People must be educated on where and how they can get help (for example, the location of food pantries)—and it is important to distinguish between a lack of resources and a lack of awareness of resources. Dignity and self-respect come into play (some people may not want to seek help), as well as some people using resources that they may not need as much as others. An increased social services network is needed so that people can find availability of services and have one-stop care.

c. Access to Healthcare

Access to healthcare was also mentioned by focus group participants as one of the greatest unmet healthcare needs. There must be continued affordability and access to services. While great strides have been made in providing community-level programs, more work is needed. There are continued access challenges for the undocumented and those with Medicaid—for example, NorthShore does not accept Medicaid in primary care clinics. This creates a segregated healthcare system for those individuals. Access to supportive care and resources is also needed, as well as more healthcare options, to improve the quality of healthcare.

Resources to assist individuals navigate the complex healthcare system are needed (such as navigating the preauthorization process), as there is a lack of understanding in that regard, especially among the elderly. Language barriers must be overcome, and resources must be current (address outdated websites, etc.)

Health education and awareness in disease prevention and care is lacking as well as health literacy. More classes and support groups are needed in the community. Access to correct information is needed—and educating people on how to determine what information is true or false, and what sources they can trust.

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d. Lack of Healthcare Providers

A lack of healthcare providers (including primary care physicians) was mentioned as one of the greatest unmet health needs, both in general and among diverse providers, as well as a lack of specialty providers in free/reduced cost clinics. No-shows may be causing a lack of offerings due to capacity in some instances. It was noted that a lack of diverse providers impacts communication with patients and fails to combat the lack of trust.

e. Under-Resourced Populations and Structural Racism

Under-resourced populations include Black/African American, Latino, medical refugees, recent immigrants, and persons with disabilities. The healthcare system must acknowledge structural racism and must be designed to address these barriers. Gender-affirming care is needed for pediatric and adolescent patients.

f. Social Determinants of Health

Safe, stable, and affordable housing were mentioned by focus group participants as some of the greatest unmet health needs in the community (including housing for individuals after discharge), as well as food insecurity, education, and unemployment.

3. Whether Health of the Community Improved, Declined or Stayed the Same

Whenever asked whether the health of the community has improved, declined, or stayed the same over the past few years, most respondents believed that health is declining. Some specifically indicated that mental health is declining. Some specified that health has improved for the insured and wealthy but declined for the poor and uninsured.

The pandemic was cited as a primary cause of the decline for several reasons—isolation has led to increased drug use and mental and behavioral health issues, people are not seeking care (including preventative care) for fear of COVID, and statistically there is an increased rate of death. Also, college-age students and young adults have felt the effects of the pandemic and experienced anxiety. Also due to the pandemic, poverty has increased, people have lost jobs and health insurance, and education has been permanently altered. Also, burnout has impacted all industries, and has impacted available healthcare services. The pandemic has also uncovered disparities among minority patient populations, and exposed segregation and discrimination (including Black and Latino populations), conditions which have existed for decades. Pandemic healthcare difficulties have also exposed a declining safety net that has existed for a long time, as there is a decreased ability to help underserved communities. The pandemic has also compromised basic resources such as access to workout facilities. The decline has created an environment that is reactive, versus focusing on the long-term.

Focus group participants noted that a few good things may have come from the pandemic. For example, one positive factor is the recognition of integrated needs (mental health, physical health, and financial health) needing to be addressed at all levels. Also, communication has improved due to need.

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4. Barriers to Addressing Health Needs

Focus group participants mentioned the following barriers to addressing health needs within the community and noted that strong leadership support to solve the issues and challenges is needed.

a. Mental Health Resources

Focus group participants indicated that many more therapists, nurses, and technicians are needed to serve mental health patients. The pandemic has caused "pandemic fatigue" – burnout and complacency depending on the circumstances and ability to access resources. The new reality or sense of "normal" is causing uncertainty in people's daily lives and is causing people to become scared, confused, or to feel unsettled. Isolation brought on by the pandemic is also a barrier.

The stigma surrounding mental healthcare still exists and is a barrier to tapping into services. Also, the virtual environment of accessing mental healthcare services due to the pandemic is a barrier. In the healthcare treatment context, virtual meetings dehumanize some of the interactions.

The structure of the mental health system is a barrier, as it is based on a "band-aid approach" versus a wholistic approach.

b. Lack of Healthcare Providers

Focus group participants noted that there is a lack of healthcare providers—especially mental health providers with immediate availability (all age groups). There is a shortage of primary care providers and preventative care options. Also, more providers are needed that patients can identify with (more providers of color are needed), and there is a lack of a strategic plan and/or pipeline to match diverse providers to patients.

Focus group participants noted that "community-based primary care" is needed. Healthcare is needed in places that are easier for people to access, and more community clinics would respond to this need. With the overcrowding of facilities and provider offices, the fear of COVID is deterring people from seeking care. Furthermore, scheduling and availability are limited.

Staffing shortages and pandemic burnout (on the provider side) were also discussed by focus group participants. There is a lack of providers and support professionals, and many have left the industry. This situation is causing high turnover, long hours, and much stress for those who work in healthcare, and there are currently many open positions. Healthcare organizations must offer a work environment that prioritizes employee care and allows employees to take the time off work for their own healthcare.

c. Poverty

Focus group participants observed that there is a lot of unemployment and poverty in the community, and people who do not have financial resources often do not prioritize health and have limited resources and services available to them. Also noted was that there is a lack of healthcare information distributed to this population. Finally, many people do not have resources for medications. Given these factors, there is a general sense that systems/resources are unable to keep people safe and protected.

d. Complexity of Healthcare System

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Focus group participants noted that the complexity of the healthcare system is a barrier to addressing the healthcare needs within the community. First and foremost, focus group participants discussed the difficulty of navigating the healthcare system in general. People do not know where to sign up for insurance, how their insurance works, or how to navigate the healthcare system. People are unfamiliar with Federally Qualified Health Centers and what care is available there. People question what services exist, how to find providers, how to get to provider locations and access the services, and who will pay for their care. People need to know how to navigate the healthcare system—ambassadors or navigators are needed to help people know how or where to get help. This would give people a sense of mastery over the requirements that must be met to understand the healthcare system and get the help they need.

Focus group participants discussed the current lack of temporary/transitional services available within the community. Essentially, there are not places for people to land, and there is a long wait for services to assist people with mental health, housing, food, and employment. Fulfilling the need for downstream resources is important because providing these services will decrease the need for resources in the future. Medicare/Medicaid do not provide a complete chain of help for people. There is a decrease in supporting services due to low funding and high demand. Focus group participants noted that, while there are a lot of ideas, a lack of funding exists.

Finally, focus group participants noted that a significant barrier to addressing the health needs of the community is the compensation model of healthcare providers (which is based on cash versus care).

e. Access to Healthcare

Focus group participants discussed how “access to healthcare” is a barrier to addressing health needs within the community. Numerous factors negatively impact access to healthcare.

Focus group members noted that the high cost of healthcare is a barrier, as well as a lack of insurance, a lack of understanding of insurance, and a decreasing number of medical facilities that will treat patients without insurance. Within the community, there is little awareness and knowledge regarding health issues and awareness of available programs, a lack of primary care, and long wait times for appointments. The Community Health Center was mentioned, although focus group participants noted that there is a lack of knowledge of or access to the center, and that the center is the only point in the system accommodating underserved populations.

Healthcare is particularly difficult to access for those individuals who lack residency. Undocumented persons are not able to access services as there is a fear of being turned away and subject to legal action impacting residency. One focus group participant noted that it is impossible to access primary care if you are uninsured or undocumented—and that you have no choice but to use the emergency room.

According to focus group participants, transportation systems and routes to healthcare services are not available in suburban areas. Transportation for persons with physical disabilities is a barrier—and there currently is no such transportation. Financial and safety barriers also exist. People may be able to find transportation to the hospital, but not for follow-up visits or referrals from the emergency room. People also need transportation to pharmacies to get their medications.

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Finally, focus group participants discussed the issues of health literacy and technological ability. Information is changing so fast that it is hard to keep up, and attention must be paid to information versus misinformation. Technological ability is a barrier, however. One focus group participant asked, if people do not know how to use the technology, how are they going to access information and care? It was noted that there is too much emphasis on technology for a population that is not proficient in the use of technology.

f. Social Determinants of Health

Focus group participants noted that job opportunities are needed within the community with livable wages, as well as job-training programs and workforce training, so people can get the resources they need. Affordable housing is also needed, and people do not have resources for food. Childcare is also needed within the community, because obtaining childcare impacts the ability to make healthcare appointments (for example, women with young children scheduling mammograms).

g. Diversity and Inclusion

Focus group participants noted that different populations within the community face different levels of opportunities and challenges. For example, language access for non-English speaking populations is a problem (for example, electronic medical records are only produced in English), and healthcare institutions must commit to being anti-racist/diverse and be able to deliver information through language barriers and provide it to a diverse community. One participant noted that antisemitism, racism, all the “isms” and phobias are heightened in the current environment and will play a large role going forward, and that there must be a commitment to serve everyone in the community. Another participant noted that, while there may be improvements in some parts of the city, there is historic disinvestment in Black neighborhoods. Focus group participants commented that within the community there is a cultural/historical distrust of the healthcare system and of the government, along with disparities in care, and that the gap is widening.

h. Other

There were several other barriers to addressing health needs within the community discussed by the focus group participants. Discussion was held regarding barriers experienced by the elderly population. To that end, the “digital divide” was mentioned – that there is a technology gap for certain populations – and how to make technology accessible and understandable by certain populations. Also, technology/internet access is needed. With an aging society and life expectancy increasing, it is important for the elderly to be able to navigate the healthcare system and to be able to remain independent. Also, the elderly need hearing and vision services, and more time with their physicians.

Focus group participants also discussed a shortage of childcare and day programs for children within the community, day patient spots, and the ability for youth and teens to receive assistance across the board. One barrier in this regard has been space.

Finally, focus group participants discussed the need for people to understand how to take care of themselves through preventative care, healthy eating, and exercise.

5. Underserved Groups

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Focus group participants were asked to identify who are the most underserved groups within the community. An overarching theme discussed by focus group participants was that it must be understood that underserving a subset of the population impacts the overall health of the *entire community*. The following were identified by focus group participants as the most underserved groups within the community:

People who are low-income, uninsured/underinsured, or homeless, and other traditionally marginalized groups, are underserved. Medical care is expensive, and people in this group think they cannot afford doctors or medications. This population may not know how to navigate healthcare system. There are disparities in treatment, and differing treatment based on insurance plans. People in this group may be bypassing regular healthcare and may be unable (or afraid) to access care. The pandemic has created less access to help for these individuals.

People with serious mental illness/behavioral health issues are also underserved. These individuals often have no political power or voice within the community.

Members of Black and Brown populations, minority populations, and indigenous communities are underserved. There is a history of systemic racism and overall lack of equality among these populations. Relationships with these populations need to be reframed, and the lack of diversity in the healthcare system must be addressed. Children need to be exposed to different professions at an early age, and programs must be established in schools to teach children about medical professions. Also, healthcare provider education is needed to teach cultural education and communication skills and empathy to healthcare providers as well as how to combat mistrust (which must be addressed through targeted education and meeting individuals where they are located).

Immigrants, undocumented workers, and individuals who are not U.S. residents are underserved. Language barriers exist, and these individuals may experience fear and feel as though they are “in the shadows.” Characteristic of this group is a lack of representation in government and feeling like they have no voice politically.

People with disabilities are underserved and are often overlooked and sidelined. Many people in this group do not have the resources to become independent.

Numerous other populations were identified by focus group participants as being underserved within the community, including the elderly (especially those without an advocate, caregiver, or family), children and disconnected youth, young adults, LGBTQ (including youth), the uneducated (communications may not meet their needs), those who do not have access to technology or who are unable/unsure how to use technology, single moms with children, the “sandwiched” population (the generation between children and aging population who often take no time for themselves for mental health), those who need access to vaccines and boosters (currently, the system is not “friendly”), frontline workers who suffer from exhaustion, and NorthShoreConnect users (as there are significant disparities for those who access the system).

6. Greatest Economic Social Issues

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Focus group participants were asked to identify the greatest social economic issues within the community. The following issues were discussed by focus group participants:

Poverty – Poverty has widespread effects and impacts one's ability to access proper food and affordable housing. Often there is a significant lag time when submitting applications for federal or state resources—for example, people may have utilities shut off before they obtain help. There are numerous causes of poverty, including intergenerational poverty and fixed income constraints for older generations.

Mental Health – Currently, there is high demand for mental health services, but a low supply of providers and resources, and stigmas still exist around the need for mental health support.

Access to Healthcare – Access to healthcare is hindered by many obstacles—including the cost of care (even for those who are insured), obtaining insurance, and the coordination of deductibles and costs. New families or people that are new to the community are unsure of what to do and where to go for assistance.

Health Literacy – Health literacy is an issue among various populations due to language differences and different levels of education. Also, if parents have low health literacy and are unaware of health matters, their children may suffer as a result.

Safe and Affordable Housing – Safe and affordable housing is an important issue, along with environmental matters that come into play if people have mold or lead in their household. People must sometimes wait for years to have home repairs competed. One focus group participant noted that 49.5% of the county residents pay more than 30% of income for housing.

Employment – Employment is challenging for many people for various reasons, including difficulty navigating employment sites/online job boards, lack of skills, and lack of mentorship. While there are many open positions, there is a lack of qualified candidates to fill those positions. Thus, emphasis must be placed on how to train people to fill positions, workforce development, getting into schools to increase awareness of healthcare careers, and recognizing that the "typical" college path is not needed. Employment is also challenging for people with disabilities.

Racism and Cultural Differences – Racism and cultural differences prevent opportunities for people to advance economically. It helps people to see people that look like themselves—there is safety in that, and it makes people feel like they can bring their full self.

Other – Other economic social issues raised by focus group participants include transportation, drugs, and the uncertainty of COVID and what it means in our daily lives.

7. Most Significant Unmet Healthcare Needs (and How to Address Those Needs)

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Focus group participants were first asked to identify the most significant unmet healthcare needs within the community, and then to discuss how to address those health needs. Their responses are summarized below.

a. Mental Health

Description of Health Need: Focus group participants identified mental health as one of the most significant unmet healthcare needs of the community—in general, affecting all populations—from childhood diagnosis to adult depression and medication, and at all levels. Demand for mental health services has increased for a variety of reasons, including stressors related to the pandemic and resulting loneliness, isolation, frustration, and helplessness. There is a lack of mental health professionals, and mental health services are expensive and economically out of reach, even with insurance. Low reimbursement rates also an issue for providers. While state legislators have been focusing on mental health, demand and strain are outweighing what has been accomplished, and it is still difficult for people to get the kind of care they need. Addressing mental health needs is very important because proper mental health care helps individuals from a physical health perspective, too.

How to Address: A common theme focus group participants raised to address mental health within the community is to rework the model of care make the services more accessible to people. Ideas to make services more accessible included establishing mental health clinics in the middle of residential areas; expanding mental health services into schools (for example, Evanston High School has a social worker); expanding telehealth services and mobile clinics; expanding real-time tools to assist people in a mental health crisis (such as hotlines); and integrating mental health screenings into wellness visits. Additionally, people need assistance overcoming the cost of accessing mental health services. Access to care is made difficult by the fact that public assistance is not accepted by most mental health providers.

Training was also raised as a fundamental means to address mental health, including culturally relevant mental healthcare training on a community level, increasing public awareness of mental health concerns and communication of care, mental health first aid training (for example, the mental health first aid training program at the Josselyn Center), and training lay populations to bring education to the community. A proactive approach in supporting mental wellbeing was suggested, such as by engaging friends, parents, teachers of children to help identify mental health issues and improve the network around youth.

Focus group participants discussed the need for an expanded and diversified workforce and increased pipeline of mental health service providers, initiatives to assist the immediate need with acute care, and retooling the system for long-term mental health care. Mental health care providers are faced with inadequate breaks and increasing restrictions, and there is a heavy focus on seeing more patients, resulting in less time spent with patients (which raises trust and ethical concerns).

b. Access to Healthcare; Navigating the Healthcare System

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Description of Health Need: Focus group participants noted that access to healthcare is being hindered in various ways. First, there are not enough healthcare providers and staff. Many people are leaving the profession or supplementing their income (especially primary care providers). Second, there is a lack of effective communication of health information and resources to the community. While there may be information and resources to help those in need, people need confidence and support to better access the information and find resources. Third, people have difficulty navigating the healthcare system and many are "falling through the cracks" (particularly the elderly). Patient advocates are needed to help people figure out the costs of care, how their insurance works, what community social services are available, and where to go to receive services. People who do not understand technology may need assistance and support that is not computer based.

How to Address: Focus group participants next discussed how to improve access to healthcare and navigation of the healthcare system.

As to a shortage of healthcare providers and staff, focus group participants had various recommendations, including creating a Workforce Development Task Force, exposing youth to health knowledge and medical professions in school and developing a progressive curriculum, and mentoring people to go into the medical field. In the workplace, the need to reduce workload and stress for healthcare workers was discussed, along with considering financial rewards to incentivize healthcare workers to remain in their role (although it was recognized that for some people financial incentives not worth it compared to stress of the profession).

As to a lack of effective communication of health information and resources to the community, a recommendation was made to focus on making sure that the community knows about available services and resources and to reconsider the how health information is getting out to community members in need of assistance. For example, it was also mentioned that people may not be aware of certain rebate programs.

As to difficulty navigating the healthcare system, more robust care navigation assistance is needed to help people find safety net services/resources. Oftentimes, services/resources exist but people are not aware of what is available. Investment in a healthcare navigation program is needed to effect real change. More social workers, patient navigators, and patient ambassadors are needed because they are familiar with the healthcare system and can identify gaps. One focus group participant suggested creating a career path for people to act as consultants on insurance—potentially a government office that people could go for help with insurance. If people lose insurance or find out that their insurance is no longer accepted, healthcare providers should give a list of resources to people, so they do not fall through the cracks.

c. Primary and Preventative Care

Description of Health Need: Better access to primary care is needed, particularly for the uninsured and underinsured, as it is known that poverty contributes to health problems remaining unaddressed. Medication assistance is also needed, with a focus on diabetes and long-term medication management, especially in the senior population. Thorough and complete wellness visits are needed for more effective preventative care, and visits need to be more comprehensive. Also, there is an imbalance of focus on body health versus brain health. Finally, people need to better understand healthy life skills, including healthy eating habits.

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How to Address: Focus group participants discussed the need for better access to primary care within the community. Numerous suggestions were made, including to expand or add locations to NorthShore's Community Health Center, create new or expanded collaborations among organizations that target underserved communities (such as Erie Family Health Centers), increase mobile services within communities (including for dental and preventative services), innovate school-based services models (such as by expanding clinic hours to accommodate parents getting flu shots in the evening), improve access to healthcare for NorthShore employees, and improve access to providers at NorthShore to get as many people seen as possible (including through same-day appointments).

As to addressing preventative care, numerous focus group participants emphasized the importance of providers taking the time to understand what patients need, which would involve increasing the length of time of wellness visits (especially in youth). Also, physicians need to spend more time to help manage and coordinate care. Consideration should be given to utilizing technologies to obtain input from the patients, and then actually responding to that input by following through on next steps (which is currently lacking). Preventative care in youth can be bolstered through parenting classes and programs that help parents model good health and wellbeing. Furthermore, expanded outreach to young adults at colleges and high schools regarding health literacy should be considered. To that end, suggestions included speaking at schools and sending providers into schools, establishing means to see healthcare providers outside of a healthcare setting, and leveraging social media.

Focus group participants suggested that creating better access to primary and preventative care may require taking a step back and getting back to basics, and essentially rebuilding healthcare programs and redetermining priorities. Also, influential organizations within the community should engage in advocacy efforts and use their voices to make healthcare more affordable. The power of insurance companies must be balanced with the power of providers to be able to make decisions that benefit patients and the community.

d. Discrimination / Health Inequity / Mistrust

Description of Health Need: Focus group participants discussed a resurgence of discrimination in this country. Those feeling the brunt of this discrimination are impacted the health needs described in this report. The community lacks access to providers with whom patients can identify, as well as a statistically diverse and culturally competent workforce that matches the geographical area of care. Also, healthcare inequities exist within the healthcare system and there is a lack of inclusive care. Focus group participants also discussed a general lack of trust in the healthcare system and noted that a healthcare system is needed that puts patients first and that is welcoming and fosters engagement, access, and trust.

How to Address: Focus group participants emphasized the need to combat discrimination within the healthcare system. Patients need healthcare providers to whom they can relate (including clinical and administrative staff) – providers that look like them – and they need providers that will meet them where they are. To improve diversity among healthcare providers, the community must develop a diverse talent pipeline, and start early to develop these careers. Suggestions included considering a middle/high school mentorship program to foster these careers and recruiting with an intentional focus on diversity at every level of the organization. Also, healthcare providers must commit to hiring and training people of color—for all levels of jobs, from low-level to executive level, and should also look at their own workforce to elevate or groom people of color for positions of authority and decision-making. Diversity of clinical and administrative staff would help develop trust in the community.

Focus group participants also discussed the need for intentional education of providers on the importance of cultural competency and implicit racial biases (for providers and administration). This step can help build trust with vulnerable communities and lead to better healthcare outcomes.

Community healthcare must include population-focused programs that offer inclusive care. To that end, it is important for NorthShore to understand who is in its service area, and to ensure all patient voices and experiences are represented. Welcoming spaces must be created for all people (regardless of culture, language, etc.) This may involve the utilization of community healthcare workers (not clinicians, but rather people who can interface with clinicians). Marketing communications must be in all relevant languages, and efforts must be made to identify language barriers and provide interpreter services.

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To combat discrimination, health inequity, and mistrust, there must be community collaboration that includes key partners. There are numerous organizations that need to be included in the dialogue about issues and solutions, and all groups must be represented, including immigrants, Muslims, LGBTQ, etc. Also, community organizations can use their buying power to show support for black and brown and other minority-owned businesses within the community.

e. Housing / Employment / Food Insecurity

Description of Health Need: Focus group participants observed the need for access to home ownership and for people to experience stability and wealth within the community. More affordable housing is needed, as well as more multi-unit housing. There is a great need for stability in people's lives, especially given the challenges brought on by the pandemic, which compromised mental health outcomes, children's wellbeing, employment, food security, and more.

How to Address: Focus group participants supported an increase in the supply of affordable housing within the community. Also, an emphasis on employment was suggested, perhaps utilizing partnerships to guarantee employment upon completion of a certification or degree program. Also, food pantry deliveries to seniors in need was suggested.

Within the discussion of significant health needs and how to best address those needs, it was mentioned that no single group can "do it alone," and that the community working together will have the greatest impact on addressing health needs, such as through Community-Connected Care, an organization that helps those within the community who need healthcare services and that is funded by philanthropic support from generous community partners.

Appendix B – Summary of Focus Groups: Public Health Department Input

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Public health officials from the City of Evanston Department of Health, Lake County Health Department, and the Village of Skokie Health Department were interviewed to obtain additional input on the health needs of the community. The officials were asked three questions regarding community health, their responses to which are summarized as follows.

First, the officials were asked for their input regarding the most significant health needs within the community and their thoughts on recommended strategies for how to address those needs.

Mental health was cited as a significant health need for numerous reasons, including the unwillingness of providers to accept Medicaid or Medicare, a lack of available inpatient mental health care, a lack of psychiatry providers (including a lack of diverse providers), the stigma surrounding seeking mental health treatment, and a lack of means to better identify and refer individuals with mental health needs. Suggestions to address the need for mental health services in the community include mental health first aid training and establishing a mental health “living room” program. A mental health “living room” model aims to have a dedicated building for mental health living rooms, which offer people experiencing a mental health crisis a calm and safe environment.

Access to healthcare was also mentioned as a significant health need. Access to healthcare is hindered by numerous factors, including a lack of insurance, the high cost of care, staffing and resource constraints (due to retirements and people leaving the industry), and high volume and long wait times to obtain help. The officials stated that all healthcare services should be accessible to everyone. Several suggestions were made to address this health need, including better identifying patients and improving referrals (which requires an investment in digital technology and investment in resources to which individuals are referred), helping channel people to other resources rather than going through emergency rooms, and continuing to utilize telehealth (which has helped capacity by decreasing the no-show rate and improving continuity of care).

Other significant health needs mentioned by the officials included a lack of trust in the healthcare system (especially among the African American community), the challenge of moving primary care diagnoses to specialty care, intergenerational poverty, nutrition, and inactive lifestyles. Social determinants of health that need addressed within the community include education (particularly how education is funded), the ability to earn a living wage, better housing, and food.

Second, the officials were asked for their input regarding health disparities within the community and their thoughts on what populations in the community are most underserved. Individuals at lower socio-economic levels experience health disparities within the community, and a guaranteed income program was instituted in Evanston to help individuals who have experienced extreme hardships during the pandemic. Undocumented residents also experience health disparities. While there is some governmental funding, the number of undocumented residents within the community is unknown and resources are limited. Undocumented residents may have a fear of seeking healthcare and may be unable to access care once diagnosed or when they become sick. Minority populations within the community—including African American, Brown, and Hispanic communities—experience health disparities. Structural racism must be addressed, as well as the ability for minorities to earn a living wage. Many essential workers were unable to work from home during the pandemic. Because they needed income, they were forced to go into the workplace, which increased their likelihood of exposure to COVID, leading to more deaths and infections. Individuals who speak English as a second language, or those who do not speak English at all (including immigrants, South Asians, and Middle Eastern populations) experience health disparities within the community, and deeper connections must be made with these communities. The elderly population also experiences health disparities in the community, as long-term care facilities are not investing in disease prevention (as seen with COVID). Also, individuals with mental health needs experience health disparities in the community.

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Third, the officials were asked their opinion regarding emerging health needs within the community. Poor diet and lack of exercise were discussed, with contributing factors including socio-economic status, the digital environment, and the pandemic. Another emerging health need discussed was negativity or hesitancy toward vaccines, especially given the threat of other infectious diseases and the future of COVID-19. Lessons learned from COVID may inform future responses to emerging new infectious diseases. There is a need for resources, staffing, and funding (particularly an increased investment in prevention). While improving public health infrastructure is important, the current trend is reduced governmental funding as states try to find a COVID exit strategy. While it is hard to predict the future, it is important to build off lessons learned from COVID. Additional emerging health issues identified by the officials include coordination and intake processes to help individuals in the health care system, and crime and violence. Evanston is seeking to put programs and initiatives in place to keep youth engaged and away from crime and violence.

Appendix C – Community Survey Summary

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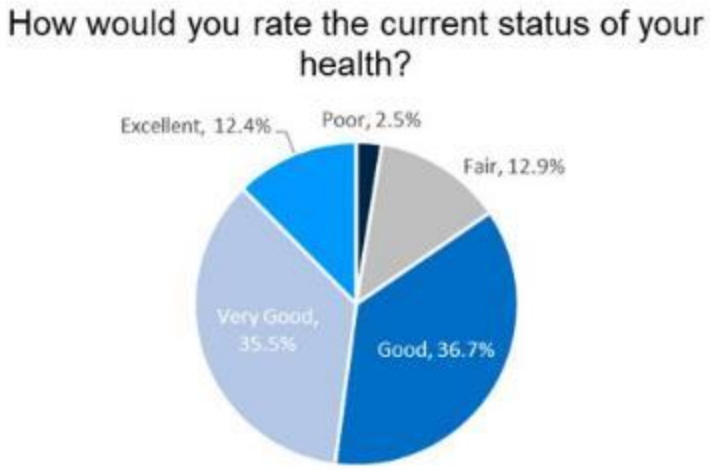
In order to develop a broad understanding of community health needs, NorthShore conducted a community survey during February and March of 2022. A link to the survey was distributed via e-mail, social media and word of mouth to the community at-large. A total of 947 surveys were completed.

- The majority of respondents were White/Caucasian (76%), 9% identified as Hispanic or Latino, 7% of the respondents identified as Asian, and 4% identified as Black or African American. The remaining 4% identified with other racial or ethnic identities.
- Respondents by age group were as follows:
- Age Group Percent of Total Respondents
  18-34 7%
  35-44 15%
  45-54 23%
  55-64 21%
  65+ 34%
- Females represented 78% of the respondents while males represented 21%. The remaining 1% of respondents identified as other genders or chose not to answer.

Given the reported demographics above, care should be taken with interpreting the survey results. The ethnicities, ages and gender of survey respondents do not match demographics for the CHNA Community. Specifically, the survey reached more whites and more females compared to demographic information for the community. Additionally, the majority of survey respondents were adults, aged 55+.

Survey respondents were asked to rate the current status of their health. The majority of the respondents indicated the status of their health was good.



Almost **65%** of the survey respondents indicated they are always able to visit a doctor when needed. When asked for about the reasons why they are unable to visit a doctor when needed, respondents indicated the fact that doctors are not taking new patients, limited appointments are available and/or appointments are not available for months, inability to afford the doctor visit, and getting time off work as primary reasons why they could not visit the doctor when needed. The majority of respondents, over **74%,** have had a routine physical in the last year.

Respondents indicated the biggest source of stress in their daily life was financial stability and relationships. In addition, respondents indicated the biggest challenges related to the COVID-19 pandemic were mental health and social isolation and juggling work and family.

Appendix C – Community Survey Summary

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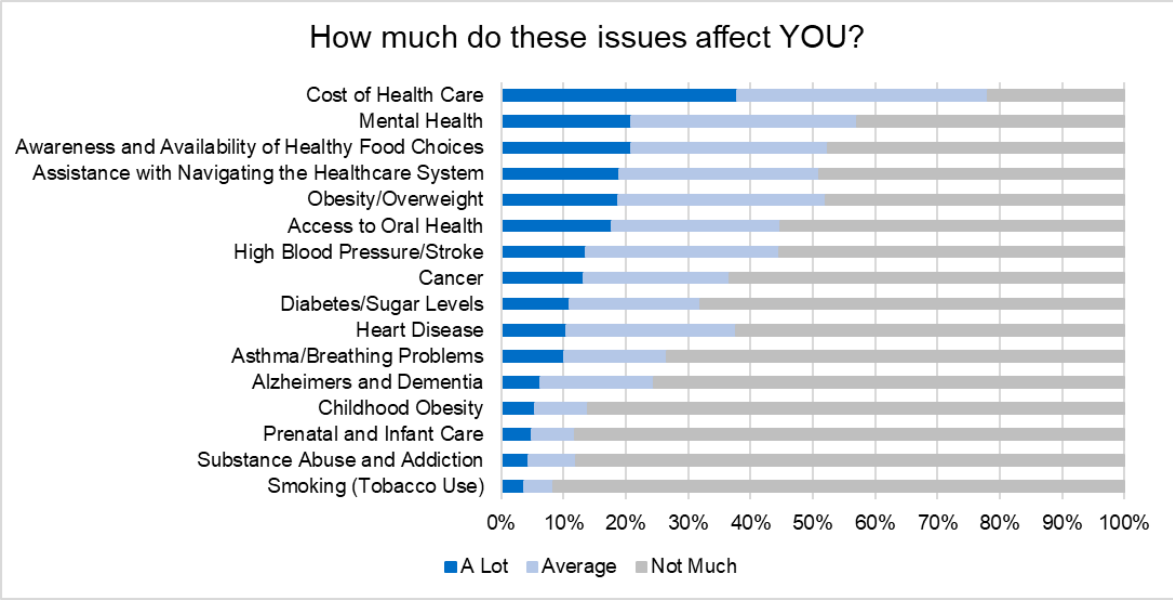
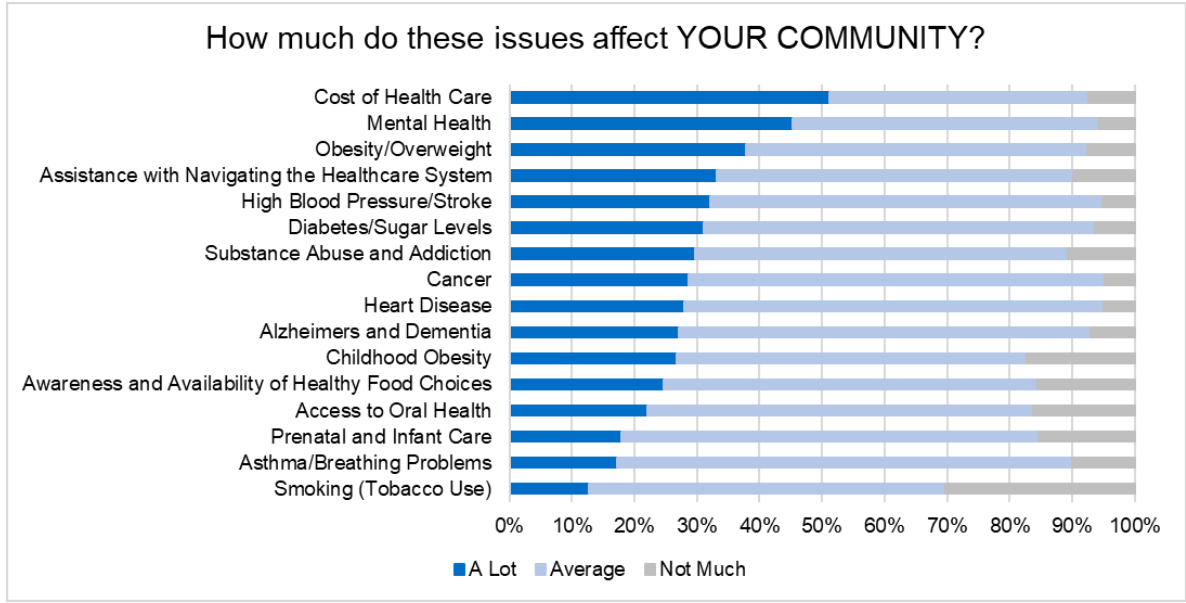
When asked "How much do these health issues affect YOU?" cost of health care, mental health, awareness and availability of healthy food choices and assistance with navigating the healthcare system were the issues that affected respondents most.

When asked to rate how the same issues impacted the community, respondents identified cost of health care, mental health, obesity and assistance with navigating the healthcare system as the issues that affected the community most. The charts below summarize all of the responses to these questions.





Appendix C – Community Survey Summary

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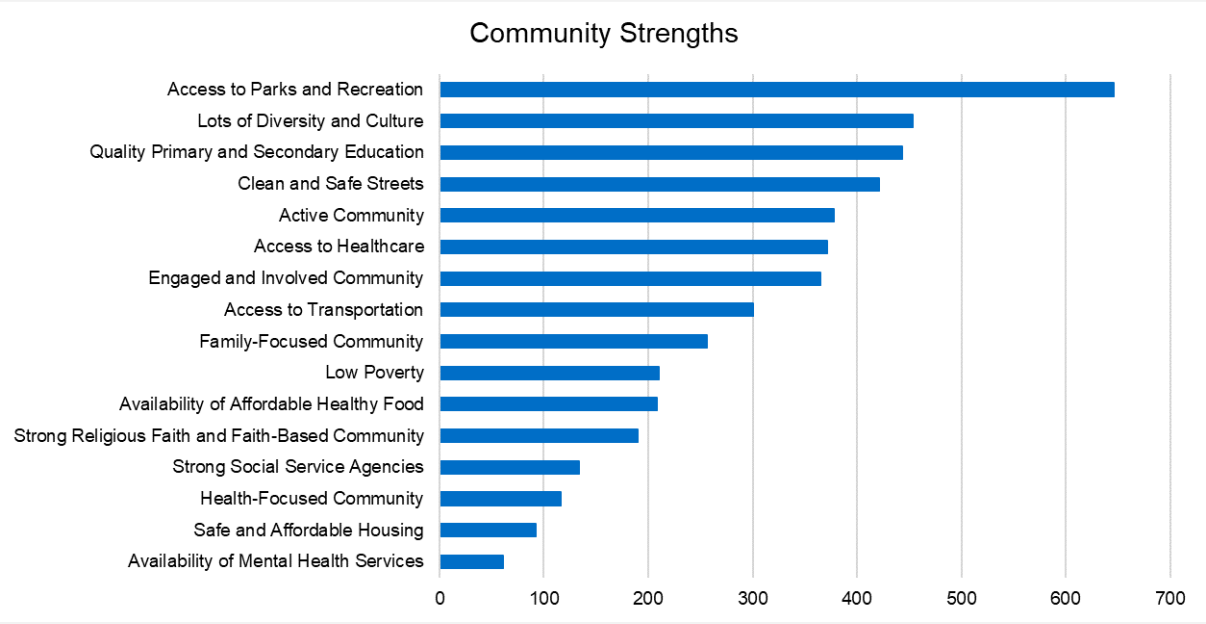
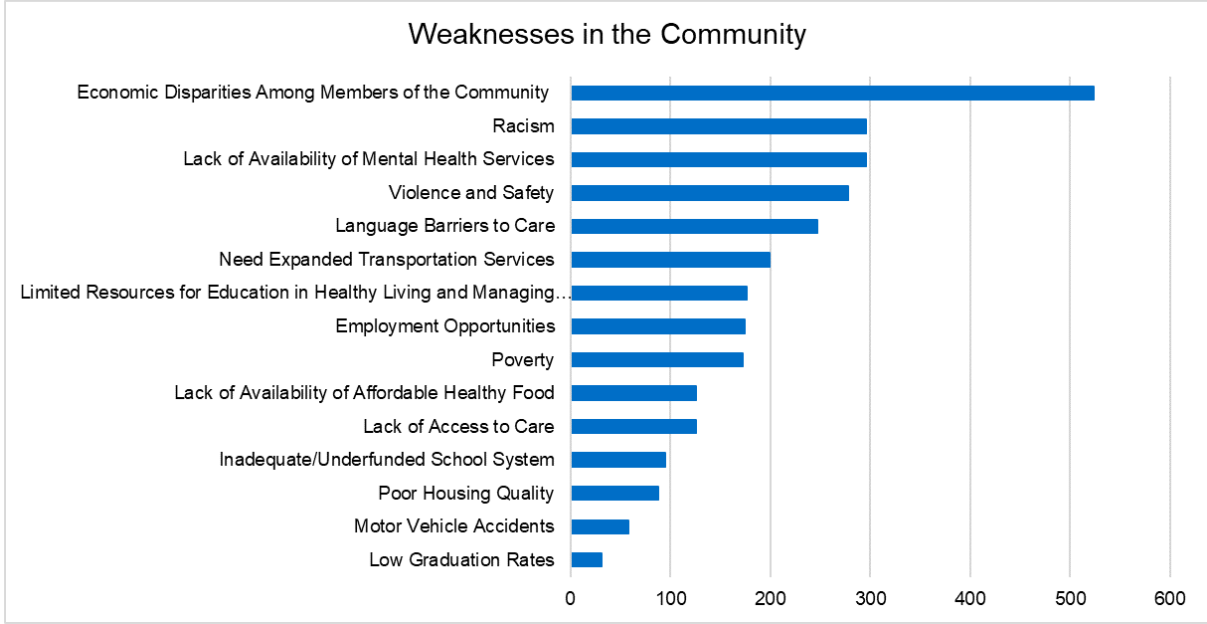
The survey asked the following two questions:

- What do you believe are the current STRENGTHS of your community?
- What do you believe are the WEAKNESSES in your community?

The survey provided predetermined responses that could be selected from the list. Respondents were instructed to mark up to five selections. Below is a summary of strengths and weaknesses identified.





Appendix C – Community Survey Summary

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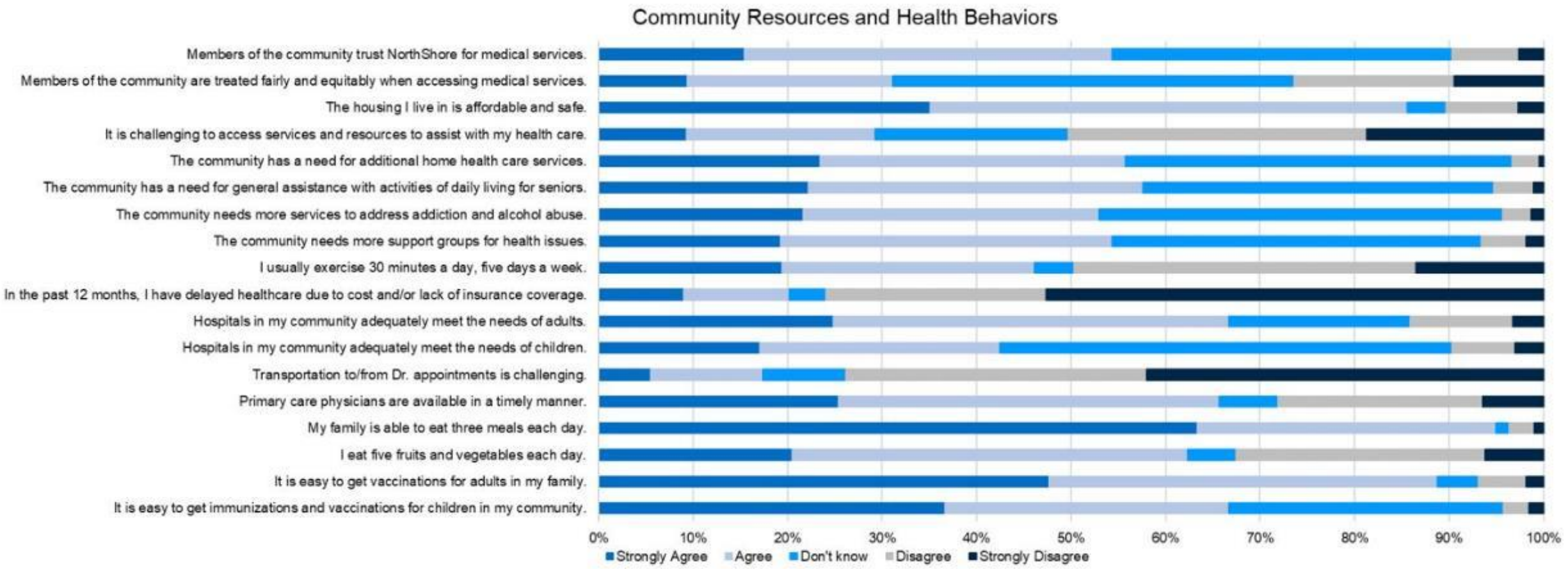
Below is summary of the survey results regarding specific statements regarding community resources and health behaviors. Key findings are summarized on the following page.



Appendix C – Community Survey Summary

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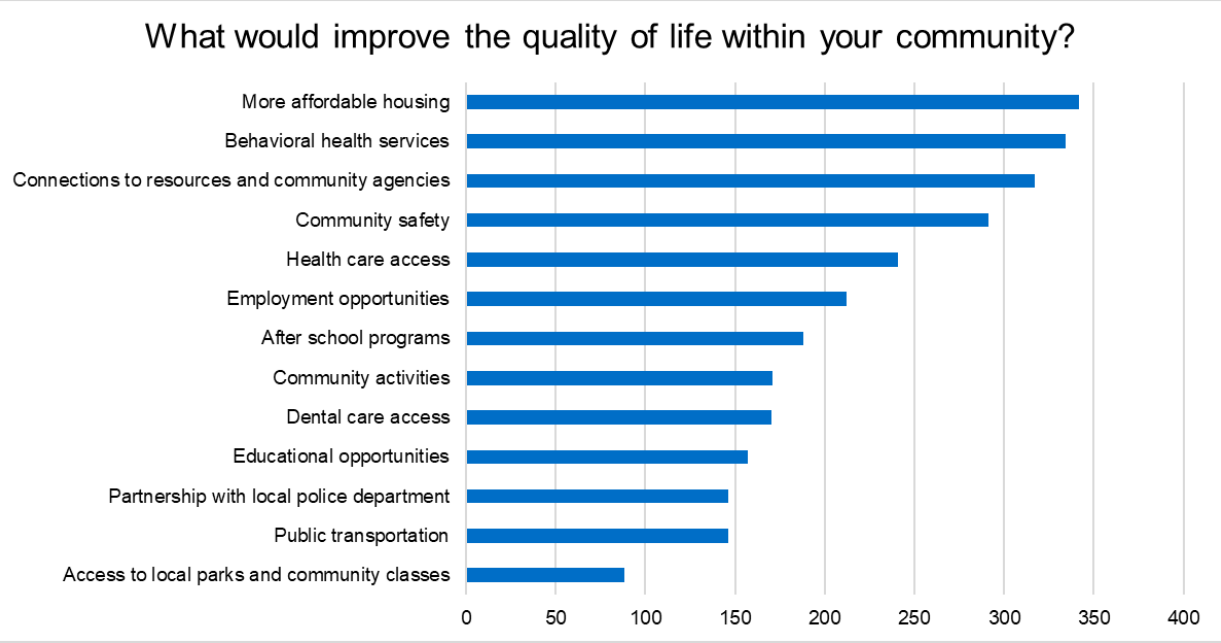
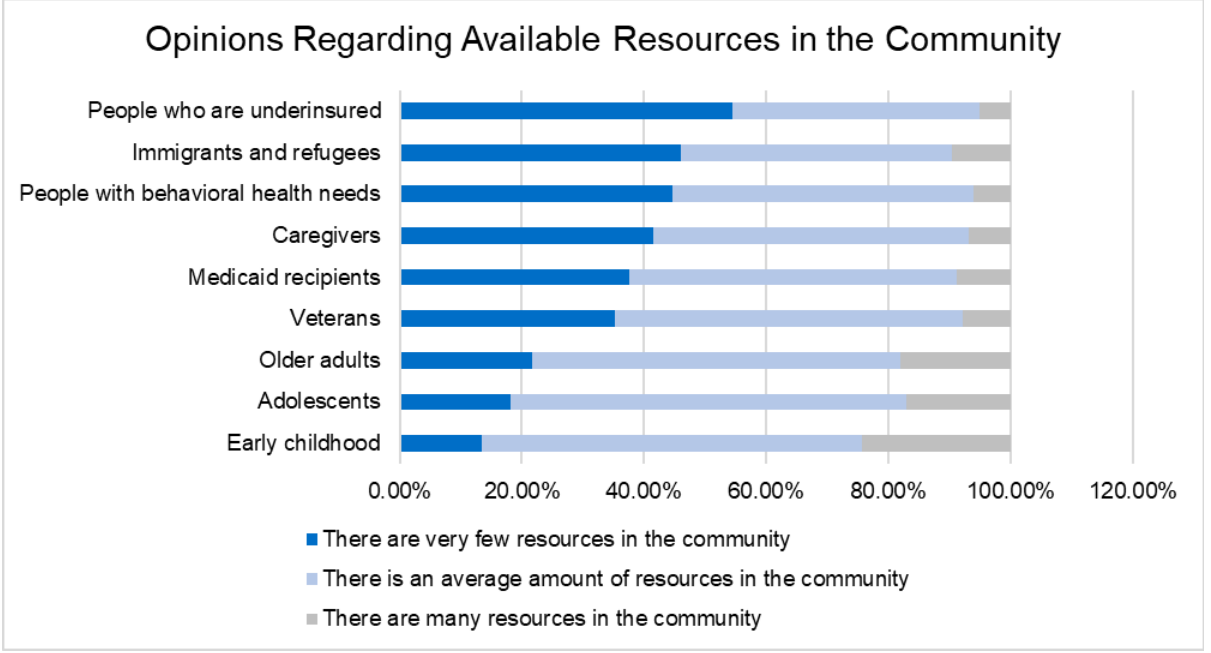
Community Resources and Health Behaviors – Key Findings

- Approximately **62%** of the respondents agreed or strongly agreed with eating five fruits and vegetables each day. Significantly less, **35**%, exercise at least 30 minutes a day, five days a week.
- **17%** of the survey respondents indicated transportation to and from doctor appointments is challenging.
- **10%** of the survey respondents disagreed that the housing they lived in was affordable and safe.





Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA

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Evaluation of the Impact of Actions Taken Since the Last CHNA

NorthShore University HealthSystem (NorthShore) implements a three-fold strategy to address the identified health needs of the communities that it serves as follows:

1. Community benefits programs and partnerships will address a need identified in the CHNA (CHNA) conducted by NorthShore. If an identified health need is not to be addressed by NorthShore, rationale will be provided.

2. Community benefits programs, initiatives and partnerships will address a need requested by the community.

3. Community benefits programs, initiatives and partnerships will be aligned with the guiding principles outlined in Advancing the State of the Art of Community Benefits for Nonprofit Hospitals. The guiding principles are: Disproportionate Unmet Health-Related Needs; Primary Prevention; Seamless Continuum of Care; and, Build Community Capacity and Community Collaboration.

NorthShore places priority on providing community benefits and services in the communities located nearest to our hospitals, where we believe we have the greatest capacity and responsibility to serve.

Community health needs data is used in NorthShore's annual planning processes. Stakeholder participation is critical and influences NorthShore's prioritization and execution of its community benefits programs. In addition, collaboration with local leadership allows NorthShore to detect urgent and growing needs that may be under-represented or absent from aggregate data, in a timely and effective manner. Lastly, collaboration with local leaders has facilitated the development of programs and partnerships to provide real time solutions to critical health challenges.

Overview of Anticipated Impact: For the fiscal year 2019 CHNA and Implementation Strategy Plan, NorthShore evaluated the anticipated impact of the initiatives listed for each hospital outlined in the strategic plan by collecting data on how many individuals utilized components of the initiative. Measurement of the impact also assessed by gathering ongoing feedback from the hospitals' Community Advisory Committees, senior leadership and physician leadership.

In accordance with Internal Revenue Code §501(r) and final regulations outlined in §1.501(r)-3(b)(6)(i)(F), NorthShore presents the following review and evaluation of implementation activities carried out over the past three years related to the fiscal year 2022 CHNA and Implementation Strategy (2019-2020).

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA

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Priority Health Needs Identified in 2019 Implementation Strategy Plan

Based on the review and analysis by NorthShore's leadership, the following health issues were determined as priority health needs, divided into "External Factors Impacting Community Health" and "Disease Conditions," which NorthShore addressed over the past three years.

External Factors Impacting Community Health (rank order):

- Access to Behavioral Health
- Health Literacy and Navigating the Healthcare Environment
- Access and Coordination of Care (affordability, education, transportation, specialty care, cultural competency)
- Substance Abuse

Disease Conditions (rank order):

- Behavioral Health (mental health and substance abuse, psychiatry and community based services)
- Chronic Risk Factors (prevention and management of obesity, tobacco use, hypertension)
- Alzheimer's/Dementia (prevention, management, caregiver support, long-term care)
- Oral Health
- Diabetes
- Cardiovascular Disease and Stroke
- Cancer
- Lung Health
- Maternal and Child Health (infant mortality, low birth weight)

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA

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Key Initiatives to Address Identified Health Priorities

The following health issues were identified as priority health needs addressed since the previous Implementation Strategy Plan of 2019. Below are key initiatives throughout the NorthShore system that addressed those needs.

Access to Behavioral Health

- **Perinatal Depression Program** identified women who are suffering from perinatal depression and offered referrals for women who may need additional help. The program screened women for perinatal depression during and after their pregnancy and offered a 24/7 crisis hotline for women and their family members who may have found themselves in an emergent situation. All services were provided free of charge. *The Perinatal Family Support Center responded to more than **600 referrals** annually.*

- The **Perinatal Family Support Center** provided a wide array of services free of charge to women and their families who experienced challenges related to pregnancy, birth, prematurity or perinatal loss. Services were provided in both inpatient and outpatient settings and included groups, sibling tours and a literacy program in the child and adolescent clinic. *The Perinatal Family Support Center responded to more than **1,500 referrals** annually.*

- NorthShore collaborated with The Josselyn Center to develop a pilot program that provided virtual **Mental Health First Aid** (MHFA) training in NorthShore's service area. The collaboration consisted of community based programs on how to identify and respond to mental health emergencies. *In its first year, 2020, a total of **six** MHFA sessions were conducted that trained a total of **120 participants**.*

- **Bridges Early Childhood and Adolescent Program** provided comprehensive, multidisciplinary mental health intervention and direct care to insured and uninsured children between the ages of three and 18 living in NorthShore communities.

- The **Phoenix Program** served adult community residents with chronic and persistent mental illnesses, as well as community patients without sufficient financial resources to afford outpatient psychiatric care.

- NorthShore provided substantial financial support for **Turning Point Behavioral Health Care Center's** innovative **"The Living Room"** project provided psychiatric respite care for patients dealing with mental health issues. The unique program, supported by Skokie Hospital, uses peer counselors (adults in recovery from their own mental health challenges) and reports a 98% success rate in keeping in-crisis patients out of hospital emergency rooms.

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Health Literacy and Navigating the Healthcare Environment

- **Interpretive Services** provided comprehensive, in-person and telephonic translation and interpretation services for patients and family members who received medical treatment at any of the NorthShore facilities. *NorthShore provided over **$4 million** worth of interpretive services.*

- NorthShore is one of the partners in a **Value Based Contract** that served the Medicaid population managed in partnership by Meridian Health Plan. NorthShore coordinated care and the quality programs designed to improve access and ensure high quality care for a Medicaid population. *NorthShore coordinates care and the quality programs designed to improve access and ensure high quality care for a Medicaid population of approximately **6,000 patients** annually.*

- NorthShore's certified application counselors assisted patients and the public with questions about enrollment in the insurance exchange (**Affordable Care Act/Insurance Exchange Enrollment**).

Access and Coordination of Care

- **Charity Care** (free or discounted care) was provided to all NorthShore patients who qualified based upon federal poverty guidelines. *Charity care was provided to over **57,000 patients** valued at over **$58 million**.*

- The **Community Health Center** at Evanston Hospital provided medical care to adults who lack private medical insurance. Medical services included, but were not limited to: Primary Care, Obstetrics/Gynecology, General Surgery, Orthopedics, Diabetes Education and Podiatry. *Evanston Hospital's Community Health Center provided care for **10,005 adult patients** with **29,019 visits**.*

- NorthShore provided primary, mental and dental care services to under/uninsured patients of the **Erie Evanston/Skokie Health Center** and community. *Over **2,000** Erie Evanston/Skokie Health Center client received specialty care services at NorthShore on an annual basis.*

- The **Dental Center** at Evanston Hospital provided primary dental care services and special consultations for medically underserved adult patients, pre-screenings for cardiovascular patients, management for oral complications in oncology patients and refractory dental problems. *Annually, the Dental Center served approximately **10,500 underserved individuals**.*

- **Evanston Township High School Health Center** is a school-based health clinic funded by NorthShore, which provided physical exams, immunizations, treatment of acute and chronic illnesses, individual counseling, health education, gynecological care, and support groups to students whose parents allow them to enroll in the health center. *An average of **900 ETHS students** made **3,500 visits** to the Health Center annually.*

- NorthShore responded to the **COVID-19 pandemic** by providing ongoing and updated safety and vaccine information to the public through numerous communication channels including virtual meetings with organizations and community leaders. The organization provided free vaccinations in several community settings and donated personal protective equipment (PPEs) to community organizations.

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Substance Abuse

- **The Doreen E. Chapman Center** at Evanston Hospital, provided chemical dependency services to adults 18 years and older and their families. The Chapman Center offered effective, coordinated services to individuals who have addiction and a co-occurring psychiatric illness or chronic pain. *An average of **350 patients** received care on an annual basis.*

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Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Comprehensive List of Initiatives by NorthShore Hospital Pavilions

The table below lists the initiatives based out of the **Evanston Hospital** campus, which addressed the health needs identified in the NorthShore 2019 CHNA.

Implementation Strategy Plan Activities/Initiatives/Events and Programs Reporting:

1. Initiatives identified by named hospital are managed from that site
2. Corporate/System initiatives are applied to all four NorthShore hospitals
3. Financial contributions to community organizations correlate as indirect impact to identified community health needs

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
NorthShore collaborated with The Josselyn Center to develop a sustainable program to provide virtual **Mental Health First Aid (MHFA)** training in NorthShore's service area. The collaboration consisted of community based programs on how to identify and respond to mental health emergencies.	Access and Coordination of Care Behavioral Health		A total of **six** MHFA sessions were conducted that trained a total of **120** participants. The long term goal of the partnership is to train additional instructors to meet the increased demands from community organizations during the next implementation strategy cycle.
The **Community Health Center** provided medical care to adults and children who lack private medical insurance. Medical services include, but are not limited to: Primary Care, Obstetrics/Gynecology, General Surgery, Orthopedics, Diabetes Education and Podiatry.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	Evanston Hospital's Community Health Center provided care for **10,005** adult patients with **29,019** visits.
Emergency Departments within NorthShore are staffed 24/7 with physicians, nurses and technicians who are trained to respond to medical emergencies. Evanston Hospital provides Level 1 trauma services.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health	On an annual basis, the Emergency Departments at NorthShore had approximately **118,500** patient visits.

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Initiative	Community Health Need Assessed	Outcomes/Individuals Served
Evanston Hospital's Emergency Department provided **Care for Sexual Assault Patients** from ED nurses who received specialized education and training and provide survivors of sexual assault with comprehensive medical-forensic care.	Access and Coordination of Care Behavioral Health Community Request	Over the last three years, 155 individuals received care from a nurse examiner trained in supporting sexual assault patients.
The **Dental Center** provided primary care dental services and special consultations for medically underserved adult patients, pre-screenings for cardiovascular patients, management for oral complications in oncology patients and refractory dental problems.	Access and Coordination of Care Chronic Disease Risk Factors Cancer Diabetes Oral Health	Annually, the Dental Center served approximately 10,500 underserved individuals.
The **Cardiovascular Institute** provided comprehensive cardiology services, with combined expertise of cardiologists and cardiac surgeons working together to provide patients with exceptional heart care including cardiac imaging, cardiovascular surgery, clinical cardiology, electrophysiology, heart failure, interventional cardiology and a women's heart program.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore hospitals had an average of **123,000** cardiology procedures each year including open-heart surgeries, coronary interventions, echocardiograms, and stress tests.
The **Primary Stroke Center** follows national standards and guidelines that include an Acute Stroke Team for rapid diagnosis and treatment. A team of neurologists plans to staff the center 24 hours a day, 7 days a week.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore maintains Primary Stroke Centers at each hospital with an Acute Stroke Team available 24 hours a day, seven days a week, for rapid diagnosis and treatment.
The **Kellogg Cancer Center** provided comprehensive, compassionate cancer care and treatments for oncology patients and their families. Our collaborative cancer treatment model focuses on each patient's individual needs, providing medical, surgical, radiation, psychological and emotional care.	Access and Coordination of Care Cancer	The Kellogg Cancer Centers at Evanston, Glenbrook, and Highland Park Hospitals had an average of **92,000** patient visits each year.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Gastroenterology (GI) Department** provided a full complement of services including early diagnosis and prevention of colorectal, esophageal, pancreatic cancer, Inflammatory Bowel Disease and other GI conditions.	Access and Coordination of Care Cancer	NorthShore hospitals had an average of **38,000** GI procedures each year including colonoscopies, endoscopies, and advanced therapeutics.
The **Division of Pulmonary, Allergy and Critical Care Medicine** provided consultative services, diagnosis, and treatment of all aspects of lung disease in adults including allergy, asthma, lung cancer, bronchiectasis, COPD, cystic fibrosis, pulmonary fibrosis, persistent cough, shortness of breath, lung infections, and other diseases of the lung.	Access and Coordination of Care Chronic Disease Risk Factors Cancer Lung Health	The NorthShore Division of Pulmonary, Allergy, and Critical Care had an average of **23,000** patient visits each year.
The **Division of Endocrinology, Diabetes and Metabolism** provided consultative services, diagnosis and management of diseases of the endocrine system. The program offers a multidisciplinary approach to diabetes, gestational diabetes and those requiring insulin pumps. The staff consists of physicians, nurses, dietitians and certified diabetes educators who work together for diabetes management.	Access and Coordination of Care Chronic Disease Risk Factors Diabetes	The NorthShore Division of Endocrinology, Diabetes and Metabolism had an average of **26,500** patient visits each year.
The **Neurological Institute** provided therapies to slow brain aging to reduce the risk for Alzheimer's disease and other aging brain disorders include medical, physical, cognitive, dietary and integrative approaches.	Access and Coordination of Care Alzheimer's/Dementia	NorthShore Neurological Institute had an average of **138,000** patient visits each year.
The **Maternal Health** department at Evanston Hospital provided comfortable, high-tech birthing facilities.	Access and Coordination of Care Maternal and Child Health	NorthShore Maternal Health Department saw an average of **3,500** patients per year.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Pediatric Rehabilitation Clinic** provided a wide array of outpatient services for young patients (from birth through adolescence) with special needs. A team of licensed physical, occupational and speech therapists specializing in pediatric care provide one-on-one individualized treatment as well as group classes to help patients achieve or regain functional skills.	Access and Coordination of Care Maternal and Child Health	NorthShore's Pediatric Rehabilitation Clinic saw an average of **9,000** patients per year.
The Perinatal Depression Program identifies women suffering from perinatal depression and offers referrals for women who may need additional help. The program screened women for perinatal depression during and after their pregnancy and offers a 24/7 crisis hotline for women and their family members who may find themselves in an emergent situation. All services are provided free of charge.	Access and Coordination of Care Behavioral Health Maternal and Child Health	The Perinatal Family Support Center responded to more than **600** referrals annually.
The **Perinatal Family Support Center** provided a wide array of services free of charge to women and their families experiencing challenges related to pregnancy, birth, prematurity or perinatal loss. Services are provided in both inpatient and outpatient settings and include groups, sibling tours and a literacy program in the Child and Adolescent Clinic.	Access and Coordination of Care Behavioral Health Maternal and Child Health	The Perinatal Family Support Center responded to more than **1,500** referrals annually.
Child Passenger Safety & Injury Prevention Services provided one-on-one training to new parents on proper car seat placement, harness placement and infant/child safety.	Maternal and Child Health Community Request	On average, **20** child passenger safety inspections were offered on an annual basis.
Interpretive Services provided comprehensive, in-person and telephonic translation and interpretation services for patients and family members receiving medical treatment at any of the NorthShore facilities.	Access and Coordination of Care Community Request	Over the last three years, over **$4,000,000** was provided for interpretive services.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
The **Medication Assistance Program** provided assistance with the cost of prescriptions for patients of the Community Health Center.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer Diabetes Lung Health		NorthShore provided an average of **27,000** prescriptions per year to approximately **2,300** low-income patients.
NorthShore provided **Healthcare Services** to patients of the **Erie Evanston/Skokie Health Center**, a Federally Qualified Health Center by providing primary, mental and dental care services to under and uninsured patients in the community.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer Diabetes	Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	Over **2,000** Erie Evanston/Skokie Health Center clients received specialty care services at NorthShore on an annual basis.
NorthShore provided **Financial Support** to a variety of national and local non-profit organizations that supports NorthShore's mission to preserve and improve human life and to help NorthShore connect with the communities it serves. Fund allocations are focused to those organizations who address an identified health need in our communities.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	Over the last three years, NorthShore donated a total of **$ 5.5 million** to an average of **80** organizations per year.
Inpatient and intensive outpatient **Mental Health Services** were provided for adults and children along a continuum of care including group, individual and family services.	Access and Coordination of Care Behavioral Health		On a yearly average, NorthShore provided mental health services that included **3,000** intake calls. In addition, over **3,700** emergency department crisis visits occurred with an additional **3,500** crisis hotline calls.
The Bridges Early Childhood and Adolescent Program provided comprehensive, multidisciplinary mental health intervention and direct care to insured and uninsured children between the ages of 3 and 17 living in the Evanston community.	Access and Coordination of Care Behavioral Health		The program focused on comprehensive, multidisciplinary mental health intervention and direct care to insured and uninsured children between the ages of 3 and 17 living in the Evanston community. The Bridges team also treated children in other communities surrounding NorthShore.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
MRW LIFE: Living in the Future Cancer Survivorship Program provided cancer patients with individualized cancer treatment summaries along with recommendations for long-term and late effects of cancer treatment; recovery for post treatment and healthy lifestyle recommendations.	Cancer		The LIFE program provided more than **2,000** cancer treatment summaries for Kellogg Cancer Center patients in the last three years.
Health Education Programs were provided through Evanston Hospital.	Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore provided **555** health education programs in its service area to more than **10,000** individuals.
Experts from Evanston Hospital provided **Speaking Engagements** to organizations throughout the NorthShore service area. Presentations range from health related topics to issues relevant to communities and hospitals.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore provided an average of **50** speaking engagements in its service area to nearly **2,200** individuals per year.
Staff members, from Evanston Hospital, participated in community **Health Fairs** throughout the year.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Lung Health Maternal and Child Health Community Request	NorthShore participated in **24** health fairs over the last three years.
Health Screenings were provided through Evanston Hospital, as well as in NorthShore's service area.	Chronic Disease Risk Factors Cardiovascular Disease/Stroke Cancer Diabetes Community Request		NorthShore provided on average **100** health screenings in its service area to nearly **1,300** individuals per year.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
Evanston Hospital addressed health needs through **Employee Volunteerism** opportunities by collaborating with diverse local community agencies and assisting with civic and social service programs and initiatives.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore employees volunteer to carry out community service projects that met community needs and promoted goodwill. Countless charitable organizations and schools benefited from the generosity and hard work of NorthShore volunteers.
Rethink Your Drink is a public education campaign to increase public awareness about the negative health impact of consuming sugar-sweetened beverages. NorthShore served as a financial sponsor and program partner with the City of Evanston's Public Health Department in the campaign's planning, implementation and measurement.	Chronic Disease Risk Factors Cardiovascular Disease/Stroke Diabetes Maternal and Child Health Community Request		A NorthShore physician was available to conduct lessons and provide staff training on the health impact of sugar-sweetened beverages. Additionally, NorthShore purchased filtered water bottle refilling stations at Willard and Chute Elementary schools.
Evanston Township High School Health Center is a school-based health clinic, funded and staffed by NorthShore. NorthShore provided services including: physical exams, immunizations, treatment of acute and chronic illnesses, individual counseling, health education, gynecological care and support groups to students whose parents allow them to enroll in the health center.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Diabetes Lung Health Community Request		An average of **900** ETHS students made **3,500** visits to the Health Center annually.
Evanston Township High School Health Center Wellkits program is a clinic-based, healthy weight program at the school-based health center at Evanston Township High School. A NorthShore physician manages the program and dedicates at least five hours of work per week. The program is based upon six evidence-based goals that improve weight and overall health. Overweight and obese students are identified by clinic and school staff and asked to participate in the program.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke Diabetes		An estimated 50 students per year participate in the program. Additionally, a NorthShore physician collaborates with the physical education department to adopt components of Wellkits into the freshman curriculum of approximately **45** students.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
NorthShore provided a **Nurse Practitioner at Evanston/Skokie School District 65** to provide specific health care services one day per week for the students. The nurse makes in-school visits in addition to seeing students at the Evanston Township High School Health Center.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Diabetes Community Request	Over a three-year period, the nurse made an average of **275** student visits per year.
Connections for Pregnant & Parenting Teens partnered with a consortium of agencies to network and share resources to provide education and assistance to pregnant and parenting teens.	Access and Coordination of Care Behavioral Health Maternal and Child Health	NorthShore provided services to nearly **50** teenagers and their families on an annual basis.
NorthShore assisted the **Cancer Wellness Center, Northbrook** through financial contributions and presenters for programs and services that addressed the needs of cancer patients, cancer survivors, family members and caregivers.	Access and Coordination of Care Behavioral Health Cancer	NorthShore Kellogg Cancer Center donated more than **$7,500** to Cancer Wellness to sustain programs and services.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Glenbrook Hospital)

Comprehensive List of Initiatives by NorthShore Hospital Pavilions

The table below lists the initiatives based out of the **Glenbrook Hospital** campus, which addressed the health needs identified in the NorthShore 2019 CHNA.

Implementation Strategy Plan Activities/Initiatives/Events and Programs Reporting:

1. Initiatives identified by named hospital are managed from that site
2. Corporate/System initiatives are applied to all four NorthShore hospitals
3. Financial contributions to community organizations correlate as indirect impact to identified community health needs

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
NorthShore collaborated with The Josselyn Center to develop a sustainable program to provide virtual **Mental Health First Aid (MHFA)** training in NorthShore's service area. The collaboration consisted of community based programs on how to identify and respond to mental health emergencies.	Access and Coordination of Care Behavioral Health		A total of **six** MHFA sessions were conducted that trained a total of **120** participants. The long term goal of the partnership is to train additional instructors to meet the increased demands from community organizations during the next implementation strategy cycle.
Emergency Departments within NorthShore are staffed 24/7 with physicians, nurses and technicians who are trained to respond to medical emergencies. Glenbrook Hospital provides Level 2 trauma services.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health	On an annual basis, the Emergency Departments at NorthShore had approximately **118,500** patient visits.
Glenbrook Hospital's Emergency Department maintained a program to support **care for sexual assault** patients from ED nurses who received specialized education and training and provided survivors of sexual assault with comprehensive medical-forensic care.	Access and Coordination of Care Behavioral Health Community Request		Over the last three years, **155** individuals received care from a nurse examiner trained in supporting sexual assault patients.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Glenbrook Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Cardiovascular Institute** provided comprehensive cardiology services, with combined expertise of cardiologists and cardiac surgeons working together to provide patients with exceptional heart care including cardiac imaging, cardiovascular surgery, clinical cardiology, electrophysiology, heart failure, interventional cardiology and a women's heart program.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore hospitals had an average of **123,000** cardiology procedures each year including open-heart surgeries, coronary interventions, echocardiograms, and stress tests.
The **Primary Stroke Center** follows national standards and guidelines that include an Acute Stroke Team for rapid diagnosis and treatment. A team of neurologists plans to staff the center 24 hours a day, 7 days a week.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore maintains Primary Stroke Centers at each hospital with an Acute Stroke Team available 24 hours a day, seven days a week, for rapid diagnosis and treatment.
The **Kellogg Cancer Center** provided comprehensive, compassionate cancer care and treatments for oncology patients and their families. Our collaborative cancer treatment model focuses on each patient's individual needs, providing medical, surgical, radiation, psychological and emotional care.	Access and Coordination of Care Cancer	The Kellogg Cancer Centers at Evanston, Glenbrook, and Highland Park Hospitals had an average of **92,000** patient visits each year.
LIFE: Living in the Future Cancer Survivorship Program provided cancer patients with individualized cancer treatment summaries along with recommendations for long-term and late effects of cancer treatment; recovery for post treatment and healthy lifestyle recommendations.	Cancer	The LIFE program provided more than **2,000** cancer treatment summaries for Kellogg Cancer Center patients in the last three years.
The **Gastroenterology (GI) Department** provided a full complement of services including early diagnosis and prevention of colorectal, esophageal, pancreatic cancer, Inflammatory Bowel Disease and other GI conditions.	Access and Coordination of Care Cancer	NorthShore hospitals had an average of **38,000** GI procedures each year including colonoscopies, endoscopies, and advanced therapeutics.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Glenbrook Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Division of Pulmonary, Allergy and Critical Care Medicine** provided consultative services, diagnosis, and treatment of all aspects of lung disease in adults including allergy, asthma, lung cancer, bronchiectasis, COPD, cystic fibrosis, pulmonary fibrosis, persistent cough, shortness of breath, lung infections, and other diseases of the lung.	Access and Coordination of Care Chronic Disease Risk Factors Cancer Lung Health	The NorthShore Division of Pulmonary, Allergy, and Critical Care had an average of **23,000** patient visits each year.
The **Division of Endocrinology, Diabetes and Metabolism** provided consultative services, diagnosis and management of diseases of the endocrine system. The program offers a multidisciplinary approach to diabetes, gestational diabetes and those requiring insulin pumps. The staff consists of physicians, nurses, dietitians and certified diabetes educators who work together for diabetes management.	Access and Coordination of Care Chronic Disease Risk Factors Diabetes	The NorthShore Division of Endocrinology, Diabetes and Metabolism had an average of **26,500** patient visits each year.
The **Neurological Institute** provided therapies to slow brain aging to reduce the risk for Alzheimer's disease and other aging brain disorders include medical, physical, cognitive, dietary and integrative approaches.	Access and Coordination of Care Alzheimer's/Dementia	NorthShore Neurological Institute had an average of **138,000** patient visits each year.
The **Pediatric Rehabilitation Clinic** provided a wide array of outpatient services for young patients (from birth through adolescence) with special needs. A team of licensed physical, occupational and speech therapists specializing in pediatric care provide one-on-one individualized treatment as well as group classes to help patients achieve or regain functional skills.	Access and Coordination of Care Maternal and Child Health	NorthShore's Pediatric Rehabilitation Clinic saw an average of **9,000** patients per year.
The Perinatal Depression Program identifies women suffering from perinatal depression and offers referrals for women who may need additional help. The program screened women for perinatal depression during and after their pregnancy and offers a 24/7 crisis hotline for women and their family members who may find themselves in an emergent situation. All services are provided free of charge.	Access and Coordination of Care Behavioral Health Maternal and Child Health	The Perinatal Family Support Center responded to more than **600** referrals annually.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Glenbrook Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
Interpretive Services provided comprehensive, in-person and telephonic translation and interpretation services for patients and family members receiving medical treatment at any of the NorthShore facilities.	Access and Coordination of Care Community Request		Over the last three years, over **$4,000,000** was provided for interpretive services.
NorthShore provided **Financial Support** to a variety of national and local non-profit organizations that support NorthShore's mission to preserve and improve human life and to help NorthShore connect with the communities it serves. Fund allocations were focused to those organizations who addressed an identified health need in our communities.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	Over the last three years, NorthShore donated a total of **$ 5.5 million** to an average of **80** organizations per year
The **Eye and Vision Center** hosted ophthalmology clinics for medically underserved clients referred through the Community Health Center at Evanston Hospital, providing a spectrum of pediatric and adult vision services.	Access and Coordination of Care		The Eye & Vision Center provides approximately **$780,000** in free services to medically underserved patients per year.
Experts from Glenbrook Hospital provided **Speaking Engagements** to organizations throughout the NorthShore service area. Presentations ranged from health related topics to issues relevant to communities and hospitals.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore provided an average of **50** speaking engagements in its service area to nearly **2,200** individuals per year.
Staff members, from Glenbrook Hospital, participated in community **Health Fairs** throughout the year.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Lung Health Maternal and Child Health Community Request	NorthShore participated in **24** health fairs over the last three years.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Glenbrook Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
Health Screenings were offered at Glenbrook Hospital, as well as in NorthShore's service area.	Chronic Disease Risk Factors Cardiovascular Disease/Stroke Cancer Diabetes Community Request		NorthShore provided on average **100** health screenings in its service area to nearly **1,300** individuals per year.
Glenbrook Hospital addressed health needs through **Employee Volunteerism** opportunities by collaborating with diverse local community agencies and assisting with civic and social service programs and initiatives.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore employees volunteer to carry out community service projects that met community needs and promoted goodwill. Countless charitable organizations and schools benefited from the generosity and hard work of NorthShore volunteers.
NorthShore assisted the **Cancer Wellness Center, Northbrook** through financial contributions and presenters for programs and services that addressed the needs of cancer patients, cancer survivors, family members and caregivers.	Access and Coordination of Care Behavioral Health Cancer		NorthShore Kellogg Cancer Center donated more than **$7,500** to Cancer Wellness to sustain programs and services.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Highland Park Hospital)

Comprehensive List of Initiatives by NorthShore Hospital Pavilions

The table below lists the initiatives based out of the **Highland Park Hospital** campus, which addressed the health needs identified in the NorthShore 2019 CHNA.

Implementation Strategy Plan Activities/Initiatives/Events and Programs Reporting:

1. Initiatives identified by named hospital are managed from that site
2. Corporate/System initiatives are applied to all four NorthShore hospitals
3. Financial contributions to community organizations correlate as indirect impact to identified community health needs

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
NorthShore collaborated with The Josselyn Center to develop a sustainable program to provide virtual **Mental Health First Aid (MHFA)** training in NorthShore's service area. The collaboration consisted of community based programs on how to identify and respond to mental health emergencies.	Access and Coordination of Care Behavioral Health		A total of **six** MHFA sessions were conducted that trained a total of **120** participants. The long term goal of the partnership is to train additional instructors to meet the increased demands from community organizations during the next implementation strategy cycle.
Emergency Departments within NorthShore are staffed 24/7 with physicians, nurses and technicians who are trained to respond to medical emergencies. Highland Park Hospital provides Level 2 trauma services.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health	On an annual basis, the Emergency Departments at NorthShore had approximately **118,500** patient visits.
Highland Park Hospital's Emergency Department maintains a program to support **Care for Sexual Assault Patients** from ED nurses who received specialized education and training and provide survivors of sexual assault with comprehensive medical-forensic care.	Access and Coordination of Care Behavioral Health Community Request		Over the last three years, **155** individuals received care from a nurse examiner trained in supporting sexual assault patients.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Highland Park Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Cardiovascular Institute** provided comprehensive cardiology services, with combined expertise of cardiologists and cardiac surgeons working together to provide patients with exceptional heart care including cardiac imaging, cardiovascular surgery, clinical cardiology, electrophysiology, heart failure, interventional cardiology and a women's heart program.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore hospitals had an average of **123,000** cardiology procedures each year including open-heart surgeries, coronary interventions, echocardiograms, and stress tests.
The **Primary Stroke Center** follows national standards and guidelines that include an Acute Stroke Team for rapid diagnosis and treatment. A team of neurologists plans to staff the center 24 hours a day, 7 days a week.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore maintains Primary Stroke Centers at each hospital with an Acute Stroke Team available 24 hours a day, seven days a week, for rapid diagnosis and treatment.
The **Kellogg Cancer Center** provided comprehensive, compassionate cancer care and treatments for oncology patients and their families. Our collaborative cancer treatment model focuses on each patient's individual needs, providing medical, surgical, radiation, psychological and emotional care.	Access and Coordination of Care Cancer	The Kellogg Cancer Centers at Evanston, Glenbrook, and Highland Park Hospitals had an average of **92,000** patient visits each year.
MRW LIFE: Living in the Future Cancer Survivorship Program provides cancer patients with individualized cancer treatment summaries along with recommendations for long-term and late effects of cancer treatment; recovery for post treatment and healthy lifestyle recommendations.	Cancer	The LIFE program provided more than **2,000** cancer treatment summaries for Kellogg Cancer Center patients in the last three years.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Highland Park Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **MRW Leadership Board** of Highland Park Hospital provided philanthropic support for breast cancer screenings for vulnerable and underserved community members.	Cancer	The MRW Leadership Board raised funds to provide **188** breast cancer screenings for clients of Lake County Health Department's Community Health Center.
The **Gastroenterology (GI) Department** provided a full complement of services including early diagnosis and prevention of colorectal, esophageal, pancreatic cancer, Inflammatory Bowel Disease and other GI conditions.	Access and Coordination of Care Cancer	NorthShore hospitals had an average of **38,000** GI procedures each year including colonoscopies, endoscopies, and advanced therapeutics.
The **Division of Pulmonary, Allergy and Critical Care Medicine** provided consultative services, diagnosis, and treatment of all aspects of lung disease in adults including allergy, asthma, lung cancer, bronchiectasis, COPD, cystic fibrosis, pulmonary fibrosis, persistent cough, shortness of breath, lung infections, and other diseases of the lung.	Access and Coordination of Care Chronic Disease Risk Factors Cancer Lung Health	The NorthShore Division of Pulmonary, Allergy, and Critical Care had an average of **23,000** patient visits each year.
The **Division of Endocrinology, Diabetes and Metabolism** provided consultative services, diagnosis and management of diseases of the endocrine system. The program offers a multidisciplinary approach to diabetes, gestational diabetes and those requiring insulin pumps. The staff consists of physicians, nurses, dietitians and certified diabetes educators who work together for diabetes management.	Access and Coordination of Care Chronic Disease Risk Factors Diabetes	The NorthShore Division of Endocrinology, Diabetes and Metabolism had an average of **26,500** patient visits each year.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Highland Park Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Neurological Institute** provided therapies to slow brain aging to reduce the risk for Alzheimer's disease and other aging brain disorders include medical, physical, cognitive, dietary and integrative approaches.	Access and Coordination of Care Alzheimer's/Dementia	NorthShore Neurological Institute had an average of **138,000** patient visits each year.
The **Maternal Health** department at Highland Park Hospital provided comfortable, high-tech birthing facilities.	Access and Coordination of Care Maternal and Child Health	NorthShore Maternal Health Department saw an average of **1,300** patients per year.
The **Pediatric Rehabilitation Clinic** provided a wide array of outpatient services for young patients (from birth through adolescence) with special needs. A team of licensed physical, occupational and speech therapists specializing in pediatric care provide one-on-one individualized treatment as well as group classes to help patients achieve or regain functional skills.	Access and Coordination of Care Maternal and Child Health	NorthShore's Pediatric Rehabilitation Clinic saw an average of **9,000** patients per year.
The Perinatal Depression Program identifies women suffering from perinatal depression and offers referrals for women who may need additional help. The program screened women for perinatal depression during and after their pregnancy and offers a 24/7 crisis hotline for women and their family members who may find themselves in an emergent situation. All services are provided free of charge.	Access and Coordination of Care Behavioral Health Maternal and Child Health	The Perinatal Family Support Center responded to more than **600** referrals annually.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Highland Park Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
Experts from Highland Park Hospital provided **Speaking Engagements** to organizations throughout the NorthShore service area. Presentations ranged from health related topics to issues relevant to communities and hospitals.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore provided an average of **50** speaking engagements in its service area to nearly **2,200** individuals per year.
Staff members, from Highland Park Hospital, participated in community **Health Fairs** throughout the year.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Lung Health Maternal and Child Health Community Request	NorthShore participated in **24** health fairs over the last three years.
Health Screenings were offered at Highland Park Hospital, as well as in NorthShore's service area.	Chronic Disease Risk Factors Cardiovascular Disease/Stroke Cancer Diabetes Community Request		NorthShore provided on average **100** health screenings in its service area to nearly **1,300** individuals per year.
Highland Park Hospital addressed health needs through **Employee Volunteerism** opportunities by collaborating with diverse local community agencies and assisting with civic and social service programs and initiatives.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore employees volunteer to carry out community service projects that met community needs and promoted goodwill. Countless charitable organizations and schools benefited from the generosity and hard work of NorthShore volunteers.
NorthShore assisted the **Cancer Wellness Center, Northbrook** through financial contributions and presenters for programs and services that addressed the needs of cancer patients, cancer survivors, family members and caregivers.	Access and Coordination of Care Behavioral Health Cancer		NorthShore Kellogg Cancer Center donated more than **$7,500** to Cancer Wellness to sustain programs and services.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Skokie Hospital)

Comprehensive List of Initiatives by NorthShore Hospital Pavilions

The table below lists the initiatives based out of the **Skokie Hospital** campus, which addressed the health needs identified in the NorthShore 2019 CHNA.

Implementation Strategy Plan Activities/Initiatives/Events and Programs Reporting:

1. Initiatives identified by named hospital are managed from that site
2. Corporate/System initiatives are applied to all four NorthShore hospitals
3. Financial contributions to community organizations correlate as indirect impact to identified community health needs

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
NorthShore collaborated with The Josselyn Center to develop a sustainable program to provide virtual **Mental Health First Aid (MHFA)** training in NorthShore's service area. The collaboration consisted of community based programs on how to identify and respond to mental health emergencies.	Access and Coordination of Care Behavioral Health		A total of **six** MHFA sessions were conducted that trained a total of **120** participants. The long term goal of the partnership is to train additional instructors to meet the increased demands from community organizations during the next implementation strategy cycle.
Emergency Departments within NorthShore are staffed 24/7 with physicians, nurses and technicians who are trained to respond to medical emergencies. Skokie Hospital provides Level 2 trauma services.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health	On an annual basis, the Emergency Departments at NorthShore had approximately **118,500** patient visits.
Skokie Hospital's Emergency Department provided **Care for Sexual Assault Patients** from ED nurses who received specialized education and training and provide survivors of sexual assault with comprehensive medical-forensic care.	Access and Coordination of Care Behavioral Health Community Request		Over the last three years, **155** individuals received care from a nurse examiner trained in supporting sexual assault patients.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Skokie Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Cardiovascular Institute** provided comprehensive cardiology services, with combined expertise of cardiologists and cardiac surgeons working together to provide patients with exceptional heart care including cardiac imaging, cardiovascular surgery, clinical cardiology, electrophysiology, heart failure, interventional cardiology and a women's heart program.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore hospitals had an average of **123,000** cardiology procedures each year including open-heart surgeries, coronary interventions, echocardiograms, and stress tests.
The **Primary Stroke Center** follows national standards and guidelines that include an Acute Stroke Team for rapid diagnosis and treatment. A team of neurologists plans to staff the center 24 hours a day, 7 days a week.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore maintains Primary Stroke Centers at each hospital with an Acute Stroke Team available 24 hours a day, seven days a week, for rapid diagnosis and treatment.
The **Gastroenterology (GI) Department** provided a full complement of services including early diagnosis and prevention of colorectal, esophageal, pancreatic cancer, Inflammatory Bowel Disease and other GI conditions.	Access and Coordination of Care Cancer	NorthShore hospitals had an average of **38,000** GI procedures each year including colonoscopies, endoscopies, and advanced therapeutics.
The **Division of Pulmonary, Allergy and Critical Care Medicine** provided consultative services, diagnosis, and treatment of all aspects of lung disease in adults including allergy, asthma, lung cancer, bronchiectasis, COPD, cystic fibrosis, pulmonary fibrosis, persistent cough, shortness of breath, lung infections, and other diseases of the lung.	Access and Coordination of Care Chronic Disease Risk Factors Cancer Lung Health	The NorthShore Division of Pulmonary, Allergy, and Critical Care had an average of **23,000** patient visits each year.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Skokie Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Division of Endocrinology, Diabetes and Metabolism** provided consultative services, diagnosis and management of diseases of the endocrine system. The program offers a multidisciplinary approach to diabetes, gestational diabetes and those requiring insulin pumps. The staff consists of physicians, nurses, dietitians and certified diabetes educators who work together for diabetes management.	Access and Coordination of Care Chronic Disease Risk Factors Diabetes	The NorthShore Division of Endocrinology, Diabetes and Metabolism had an average of **26,500** patient visits each year.
The **Neurological Institute** provides therapies to slow brain aging to reduce the risk for Alzheimer's disease and other aging brain disorders include medical, physical, cognitive, dietary and integrative approaches.	Access and Coordination of Care Alzheimer's/Dementia	NorthShore Neurological Institute had an average of **138,000** patient visits each year.
The **Pediatric Rehabilitation Clinic** provided a wide array of outpatient services for young patients (from birth through adolescence) with special needs. A team of licensed physical, occupational and speech therapists specializing in pediatric care provide one-on-one individualized treatment as well as group classes to help patients achieve or regain functional skills.	Access and Coordination of Care Maternal and Child Health	NorthShore's Pediatric Rehabilitation Clinic saw an average of **9,000** patients per year.
The **Perinatal Depression Program** identifies women suffering from perinatal depression and offers referrals for women who may need additional help. The program screened women for perinatal depression during and after their pregnancy and offers a 24/7 crisis hotline for women and their family members who may find themselves in an emergent situation. All services are provided free of charge.	Access and Coordination of Care Behavioral Health Maternal and Child Health	The Perinatal Family Support Center responded to more than **600** referrals annually.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Skokie Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
Interpretive Services provided comprehensive, in-person and telephonic translation and interpretation services for patients and family members receiving medical treatment at any of the NorthShore facilities.	Access and Coordination of Care Community Request		Over the last three years, over **$4,000,000** was provided for interpretive services.
NorthShore provided **Healthcare Services** to patients of the **Erie Evanston/Skokie Health Center**, a Federally Qualified Health Center by providing primary, mental and dental care services to under and uninsured patients in the community.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	Nearly **1,400** Erie Evanston/Skokie Health Center clients received specialty care services at NorthShore on an annual basis.
NorthShore provide **Financial Support** to a variety of national and local non-profit organizations that supports NorthShore's mission to preserve and improve human life and to help NorthShore connect with the communities it serves. Fund allocations are focused to those organizations who address an identified health need in our communities.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	Over the last three years, NorthShore donated a total of **$ 5.5 million** to an average of **80** organizations per year.
The **Eye and Vision Center** hosted ophthalmology clinics for medically underserved clients referred through the Community Health Center at Evanston Hospital, providing a spectrum of pediatric and adult vision services.	Access and Coordination of Care		The Eye & Vision Center provides approximately $**780,000** in free services to medically underserved patients per year.
MRW LIFE: Living in the Future Cancer Survivorship Program provided cancer patients with individualized cancer treatment summaries along with recommendations for long-term and late effects of cancer treatment; recovery for post treatment and healthy lifestyle recommendations.	Cancer		The LIFE program provided more than **2,000** cancer treatment summaries for Kellogg Cancer Center patients in the last three years.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Skokie Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
Health Education Programs were provided through Skokie Hospital.	Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore provided **555** health education programs in its service area to more than 10,000 individuals.
Experts from Skokie Hospital provided **Speaking Engagements** to organizations throughout the NorthShore service area. Presentations range from health related topics to issues relevant to communities and hospitals.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore provided an average of **50** speaking engagements in its service area to nearly **2,200** individuals per year.
Staff members, from Evanston Hospital, participated in community **Health Fairs** throughout the year.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Lung Health Maternal and Child Health Community Request	NorthShore participated in 24 health fairs over the last three years.
Health Screenings were offered through Skokie Hospital, as well as in NorthShore's service area.	Chronic Disease Risk Factors Cardiovascular Disease/Stroke Cancer Diabetes Community Request		NorthShore provided on average **100** health screenings in its service area to nearly **1,300** individuals per year.
Evanston Hospital addresses health needs through **Employee Volunteerism** opportunities by collaborating with diverse local community agencies and assisting with civic and social service programs and initiatives.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore employees volunteer to carry out community service projects that met community needs and promoted goodwill. Countless charitable organizations and schools benefited from the generosity and hard work of NorthShore volunteers.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Skokie Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
Rethink Your Drink is a public education campaign to increase public awareness about the negative health impact of consuming sugar-sweetened beverages. NorthShore is a financial sponsor and program partner with the Village of Skokie's Public Health Department in the campaign's planning, implementation and measurement.	Chronic Disease Risk Factors Cardiovascular Disease/Stroke Diabetes Maternal and Child Health Community Request	The Village of Skokie's Health Department promoted the Rethink Drink campaign through various promotional vehicles, community events and at schools.
NorthShore assisted the **Cancer Wellness Center, Northbrook** through financial contributions and presenters for programs and services that addressed the needs of cancer patients, cancer survivors, family members and caregivers.	Access and Coordination of Care Behavioral Health Cancer	NorthShore Kellogg Cancer Center donated more than $7,500 to Cancer Wellness to sustain programs and services.
NorthShore provided a **Nurse Practitioner at Evanston/Skokie School District 65** to provide specific health care services one day per week for the students. The nurse makes in-school visits in addition to seeing students at the Evanston Township High School Health Center.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Diabetes Community Request	Over a three-year period, the nurse made an average of **275** student visits per year.

Appendix E – Description of NorthShore's Prioritization Process

Using findings obtained through the collection of primary and secondary data, NorthShore completed an analysis to identify community health needs. This process identified 16 health needs listed below.

- Access to Health Services (Cost, Language, Navigating Healthcare System)
- Affordability of Healthcare
- Cancer
- Chronic Health Conditions (Diabetes and High Blood Pressure)
- Health Inequity/Discrimination
- Food Insecurity
- Heart Disease
- Health Literacy
- Lack of Affordable Housing
- Maternal and Child Health
- Mental/Behavioral Health
- Obesity
- Poverty
- Preventative Care
- Violence/Safety
- Youth Mental Health/Substance Abuse

To facilitate prioritization of identified health needs, a ranking process was used. Health needs were ranked based on the following five factors. Each factor received a score between 0 and 5.

1) **How many people are affected by the issue or size of the issue?** For this factor, ratings were based on the percentage of the community who are impacted by the identified need. The following scale was utilized: >25% of the community= 5; >15% and <25%=4; >10% and <15%=3; >5% and <10%=2 and <5%=1.

2) **What are the consequences of not addressing this problem?** Identified health needs which have a high death rate or have a high impact on chronic diseases received a higher rating.

3) **The impact of the problem on vulnerable populations.** Needs identified which pertained to vulnerable populations were rated for this factor.

4) **How important the problem is to the community.** Needs identified through community focus groups and the community survey were rated for this factor.

5) **Prevalence of common themes.** The rating for this factor was determined by how many sources of data (leading causes of death, health outcomes and factors and primary data) identified the need.

Appendix E – Description of NorthShore's Prioritization Process

In addition, 28 NorthShore stakeholders provided input by rating each health need for each of the following statements using a scale of 1 to 6.

1. NorthShore has the expertise and resources available to address the identified health need.
2. I believe a successful intervention on this health topic could make a real impact on this health issue.
3. There are There are existing or available opportunities to partner with other community organizations to address this health need. existing or available opportunities to partner with other community organizations to address this health need.

The summary table of rankings is provided below.

	CHNA Five-Factor Ranking						Input from NorthShore Stakeholders (Average Score)				
Identified Health Need	How Many People Are Affected by the Issue?	How Significant are the Consequences of Not Addressing the Problem?	How Significant is the Impact on Vulnerable Populations? (Health Equity)	How Important is it to the Community?	How Many Sources Identified the Need? (Focus Groups, Survey, Secondary	Subtotal	NorthShore has the expertise and resources available to address the identified health need.	I believe a successful intervention on this health topic could make a real impact on this health issue.	There are There are existing or available opportunities to partner with other community organizations to address this health need. existing or available opportunities to partner with other community organizations to address this health need.	NorthShore Stakeholder Subtotal	Total Score
Health Inequity/Discrimination	5	3	5	4	2	19	4	5.39	4.77	14.16	**33.16**
Lack of Affordable Housing	5	3	3	5	3	19	2.26	4.04	4.36	10.66	**29.66**
Access to Health Services (Cost, Language, Navigating Healthcare System)	5	4	5	2	2	18	4.61	5.7	5	15.31	**33.31**
Obesity	5	5	3	3	2	18	4.96	4.91	4.77	14.64	**32.64**
Affordability of Healthcare	2	4	5	5	2	18	3.96	4.74	4.64	13.34	**31.34**
Mental/Behavioral Health	3	4	3	4	3	17	4.57	5.52	5.32	15.41	**32.41**
Chronic Health Conditions (Diabetes and High Blood Pressure)	5	5	4	1	2	17	5.43	4.27	5.18	14.88	**31.88**
Preventative Care	5	3	3	3	2	16	5.52	5.43	5.27	16.22	**32.22**
Youth Mental Health/Substance Abuse	4	3	3	3	3	16	4.61	5.13	4.91	14.65	**30.65**
Health Literacy	5	3	3	3	2	16	4.17	5.22	5	14.39	**30.39**
Food Insecurity	5	5	4	0	2	16	2.91	4	4.91	11.82	**27.82**
Poverty	3	4	5	0	2	14	2.74	3.65	4.45	10.84	**24.84**
Heart Disease	2	5	3	0	1	11	5.48	5.13	5.09	15.7	**26.7**
Maternal and Child Health	2	3	4	0	1	10	5.3	5.52	5.27	16.09	**26.09**
Violence/Safety	1	2	3	2	2	10	3.22	3.96	4.36	11.54	**21.54**
Cancer	1	5	2	0	1	9	5.39	4.87	5	15.26	**24.26**

Limitations and Information Gaps

Return to Report

As with all data collection efforts, there are several limitations related to the assessment's research methods that should be acknowledged. Years of the most current data available differ by data source. In some instances, 2021 may be the most current year available for data, while 2014 may be the most current year for other sources. Likewise, survey data based on self-reports, such as the Behavioral Risk Factor Surveillance Survey (BRFSS), should be interpreted with particular caution. In some instances, respondents may over or under report behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked.

In addition, respondents may be prone to recall bias – that is, they may attempt to answer accurately, but they remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys analyzed in this CHNA benefit from large sample sizes and repeated administrations, enabling comparison over time. Similarly, while the qualitative data collected for this study provide valuable insights, results are not statistically representative of a larger population due to nonrandom recruiting techniques and a small sample size. Data were collected at one point in time and among a limited number of individuals.

Therefore, findings, while directional and descriptive, should not be interpreted as definitive.