



COMMUNITY HEALTH NEEDS ASSESSMENT

2019

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Countywide Alliance for Health Equity CHNA:

<https://allhealthequity.org/projects/2019-chna-reports/>

I. Introduction

Founded in 1894, Norwegian American Hospital (NAH) is a safety-net hospital located in the Humboldt Park neighborhood in Chicago. Norwegian American Hospital believes its role as a community health care provider is to treat and cure disease and to promote wellness through health education, prevention, and early intervention. Norwegian American Hospital's mission statement is central to all organizational planning and is a direct reflection of the organization's more than 120-year-old tradition of caring for its neighbors and the families who live in the surrounding communities.

Norwegian American Hospital's Mission, Vision, and Values

Mission:

Norwegian American Hospital provides high quality and compassionate health care services by partnering with patients and their families, our employees, physicians, and the communities we serve.

Vision:

Norwegian American Hospital is the hospital of choice for our communities and our caregivers. We are best in class for clinical care, customer service, employee engagement, access to care and stewardship.

Values:

- Respect: Treat all individuals with courtesy, dignity, and appreciation for their unique needs
- Compassion: Be caring, empathetic, and understanding
- Excellence: Deliver care of the utmost quality and safety with the best outcomes
- Integrity: Adhere to the highest standards of professionalism and ethics in everything we do
- Diversity: Embrace and celebrate the differences among our patients, physicians, employees, and community

Norwegian American Hospital is dedicated to offering the best care for the community in a 200-bed hospital, as well as a full-service professional building, community clinics, and two mobile health units. Norwegian American Hospital has an array of medical services that are available including: emergency, acute care, surgical, outpatient clinics, Women's Center of Excellence, GI lab and endoscopy, internal medicine, detox and substance abuse, cardiology and respiratory, imaging, behavioral medicine, Wound Healing Center, family medicine and pediatrics, physical therapy, and corporate health services.

Norwegian American Hospital Strategic Framework

NAH has structured its capabilities and functional areas to focus on providing the best possible services for its patients.

In addition, NAH's strategic plan is focused on opportunities across the organization's six strategic pillars. These pillars are based on the foundation of NAH's mission and vision and support the organization's goal of being the hospital of choice for our community and caregivers.



Figure 1. Norwegian American Hospital strategic pillars, 2017



The strategic pillars are not aligned with any single functional area but rather focus on the overall key areas for which all NAH staff and caregivers are responsible.

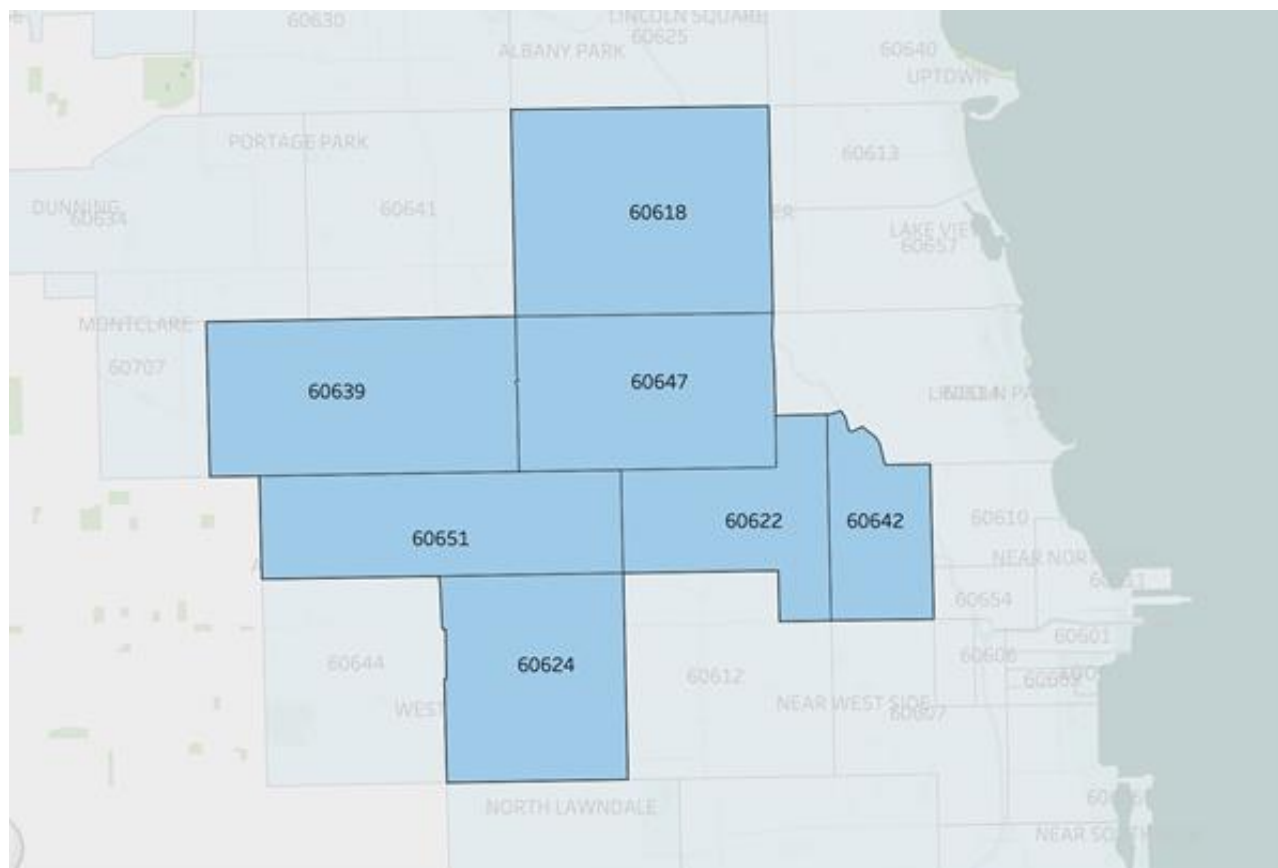
NAH completed a comprehensive strategic plan in 2017, which includes a focus on goals and objectives and improvement targets for each of the organization's six strategic pillars.

Pillar	Goals/Objectives	Improvement Targets
Team	Attract/retain the best physicians, care providers and support staff: inspire & enable them to provide exceptional care	<ul style="list-style-type: none"> • Turn-Over Rate • Agency/Premium Labor Use • Position fill rates/times
Quality	Establish a high-quality culture to drive the best results for our patients and communities	<ul style="list-style-type: none"> • Quality Metrics • Care Quality Performance • Program Awards and Recognition
Community Engagement/Philanthropy	Partner with our patients and communities to fund and promote health and wellness while growing our brand	<ul style="list-style-type: none"> • Active Partnerships • Service Collaborations • Brand Recognition/Perception • Philanthropic Revenue • Donor Expansion/Retention
Resource Management	Optimize resources while enhancing our infrastructure	<ul style="list-style-type: none"> • Financial Performance • Resource Cost and Utilization • Clinical Efficiency • Service Utilization
Growth	Expand the enterprise's clinical footprint and volume	<ul style="list-style-type: none"> • Market Share • Revenue • Key Service Line Volumes • Service Leakage • # Providers by Specialty
Technology & Innovation	Ensure the organization is appropriately evolving to new care models and in the application of new technology	<ul style="list-style-type: none"> • Technology Utilization • Technological Efficacy

Communities Served by Norwegian American Hospital

Norwegian American Hospital (NAH) primarily serves seven zip codes in the City of Chicago: 60618, 60622, 60624, 60639, 60642, 60647, 60651. These zip codes include the following community areas: Austin, Avondale, Belmont-Cragin, East Garfield Park, Hermosa, Humboldt Park, Irving Park, Logan Square, North Center, North Lawndale, West Garfield Park, and West Town. Over 617,000 individuals reside in Norwegian American Hospital's service area. The community members surrounding NAH are very diverse, with 39% identifying as Hispanic/Latinx, 30% African American, 27% White, and 3% Asian. (American Community Survey, 2016 5-year estimates)

Figure 2. Map of Zip Codes Served by Norwegian American Hospital



II. Overview of the Community Health Needs Assessment Process as part of the Alliance for Health Equity Collaborative

Norwegian American Hospital and members of the Alliance for Health Equity (AHE), a collaborative of over 30 hospitals, 7 health departments, and 100 community partners, worked together between March 2018 through March 2019 to conduct a comprehensive Community Health Needs Assessment (CHNA) in Cook County. NAH has served on the Steering Committee for the Alliance for Health Equity since its launch in 2015.

Under the Affordable Care Act, nonprofit hospitals are required to conduct a CHNA every three years that has specific components including:

- a description of the CHNA process, methods, collaborations, prioritized community health needs, and a description of existing facilities and resources in the community;
- input from persons representing the broad needs of the community;
- summary of implementation activities by the hospital since the previous CHNA;
- the CHNA must be posted and made available to the public; and
- the hospital must adopt and submit an implementation strategy to IRS within 4½ months of posting the CHNA.

Summary of our collaborative health equity approach to CHNA

The Alliance for Health Equity's collaborative CHNA combined robust public health data, community input, existing research, existing plans, and existing assessments to document the health status of communities within Chicago and suburban Cook County and to highlight systemic inequities that are negatively impacting health. The CHNA also provided insight into community-based assets and resources that should be supported and leveraged during the implementation of health improvement strategies.

The Alliance for Health Equity completed this collaborative CHNA between March 2018 and March 2019. Primary and secondary data from a diverse range of sources were utilized for robust data analysis and to identify community health needs in Chicago and Suburban Cook County. The Illinois Public Health Institute (IPHI) worked with the CHNA committee and steering committee to design and facilitate a collaborative, community-engaged assessment. As with the 2015-2016 collaborative CHNA, this 2019 CHNA process is adapted from the Mobilizing for Action through Planning and Partnerships (MAPP) model, a community-engaged strategic planning framework that was developed by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). Both the Chicago and Cook County Departments of Public Health use the MAPP framework for community health assessment and planning. The MAPP framework promotes a system focus, emphasizing the importance of community engagement, partnership development, and three types of data--secondary data, community input, and system analysis. AHE chose this inclusive, community-driven process to leverage and align with health department assessments and to actively engage stakeholders, including community members, in identifying and addressing strategic priorities to advance health equity.

Primary data for the CHNA was collected through four methods:

- Community input surveys
- Community resident focus groups and learning map sessions
- Health care and social service provider focus groups
- Two stakeholder assessments led by partner health departments-Forces of Change Assessment and Health Equity Capacity Assessment

Secondary data for the CHNA was compiled and analyzed in partnership with epidemiologists from the Chicago Department of Public Health (CDPH) and Cook County Department of Public Health (CCDPH), IPHI, and member hospitals. The partners worked with the AHE steering committee to select a common set of indicators based on an adapted version of the County Health Rankings and Roadmaps Model. Data was organized in the following categories: overview of health inequities; social and structural determinants of health; mental health and substance use disorders; access to quality health care and community resources; and chronic conditions. Secondary data used in the CHNA were compiled from a range of sources, including the American Community Survey from the U.S Census Bureau, mortality data from the Illinois Department of Public Health, and the Healthy Chicago Survey from the Chicago Department of Public Health. Additional information can be found in Figures 6 and 7 of the full [Alliance for Health Equity CHNA report](#).

In alignment with the purpose, vision, and values, the Alliance for Health Equity prioritizes engagement of community members and community-based organizations as a critical component of assessing and addressing community health needs. Community partners have been involved in the assessment and ongoing implementation process in several ways both in providing community input and in decision-making processes (Figure 5 of Alliance for Health Equity CHNA Report). The community-based organizations engaged in the Alliance for Health Equity represent a broad range of sectors such as workforce development, housing services, food security, community safety, planning, community development, immigrant rights, primary and secondary education, faith communities, behavioral health services, advocacy, policy, transportation, older adult services, health care services, higher education, and many more. All community partners work with or represent communities that are disproportionately affected by health inequities such as communities of color, immigrants, youth, older adults and caregivers, LGBTQ+, individuals experiencing homelessness or housing instability, individuals living with mental illness or substance use disorders, individuals with disabilities, veterans, and unemployed youth and adults.

Community Health Needs

“When core resources are equitably distributed, basic needs are met and families and communities can thrive.” – Humboldt Park community resident

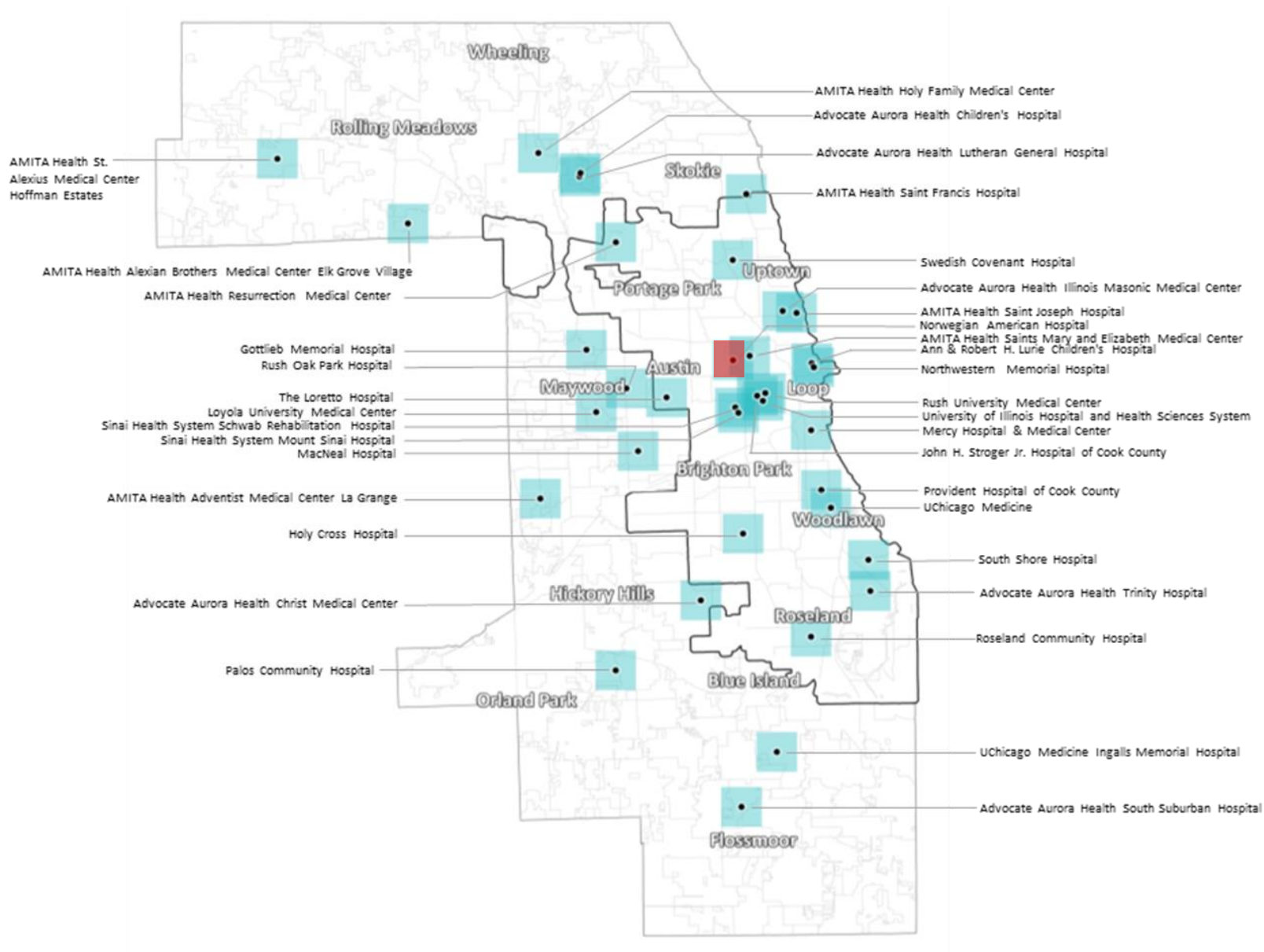
The Alliance for Health Equity CHNA identified six areas of community health needs that different partners are working together to address – (1) social and structural determinants of health, (2) mental health and substance use disorders, (3) chronic conditions, (4) access to care and community resources, (5) maternal and child health, and (6) injury prevention.

Norwegian American Hospital will focus on four needs: Food Access, Transportation, Community Engagement, and Behavioral Health and substance use disorders. More detail about our priority needs is on pages 22-23 of this document.

Figure 3. Alliance for Health Equity - Community Health Focus Areas



Figure 4. Hospitals participating in the Alliance for Health Equity



III. Key Community Health Data and Community Input in communities served by Norwegian American Hospital

The following section highlights primary and secondary data related specifically to the NAH service area.

Community Input Survey

The community input survey was designed to understand the community health needs and assets from community residents. The community input surveys, along with focus group data, informed the priority areas and strategies for community health improvement in Chicago and suburban Cook County. Demographics of the 1,006 survey respondents living within NAH's service area are presented in Table 1.

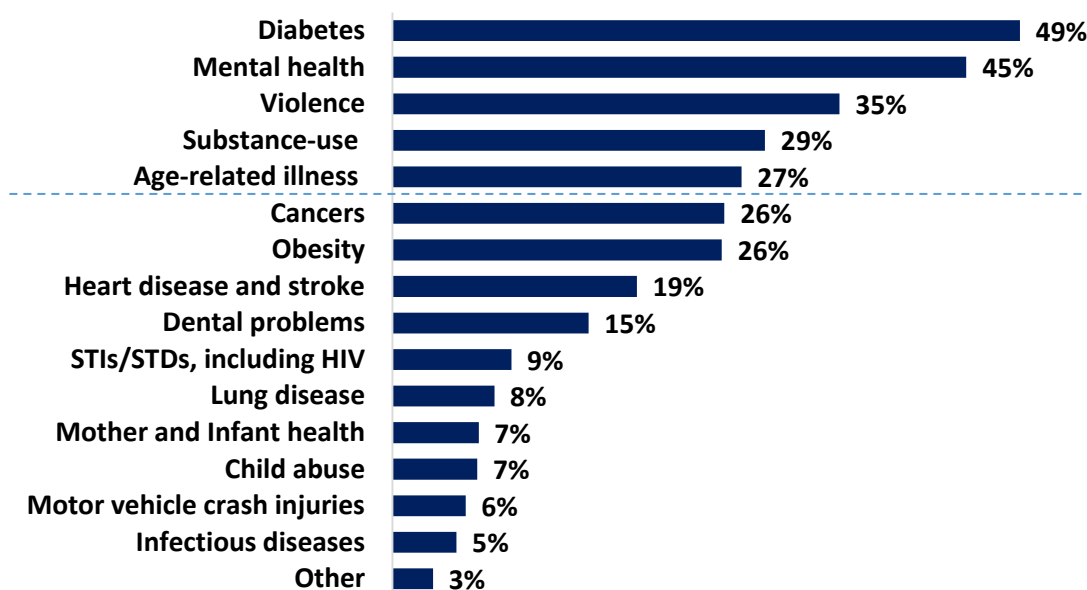
Table 1. Demographics of Community Input Survey Respondents in Norwegian American Hospital Service Area.			
Age (n=959)		Children in the household (n=696)	
18-24	7%	No children in my household	58%
25-34	16%	Child/children age 0-4 in my household	18%
35-44	15%	Child/children age 5-12 in my household	23%
45-54	16%	Child/children age 13-17 in my household	15%
55-64	19%	Anyone in the household have a disability? (n=936)	
65-74	16%	No	62%
75-84	10%	Yes	38%
85 or older	1%	Annual Household Income (n=911)	
Race/Ethnicity (n=943)		Less than \$10,000	29%
Asian	1%	\$10,000 to \$19,999	23%
African American/Black	17%	\$20,000 to \$39,999	17%
Hispanic/Latinx	62%	\$40,000 to \$59,999	13%
White	14%	\$60,000 to \$79,999	7%
Multiracial	5%	\$80,000 to \$99,999	4%
		Over \$100,000	7%

The community survey asked residents about top health issues, top needs for a healthy community, greatest strengths in the community, and what needs to be improved.

As shown in Figure 5, the top health issues identified by respondents in the communities served by NAH were: diabetes, mental health, violence, substance-use, age-related illness, cancers, and obesity. All of these health issues were selected by more than 25% of respondents.

Figure 5. Community Input Survey Data – Top Health Issues

(Note: 982 respondents from the NAH service area answered this question)



As shown in Figure 6, the top needs for a healthy community identified by respondents in the communities served by NAH were: access to healthcare and mental health services, safety and low crime, affordable housing, access to healthy food, and access to community services. All of these health issues were selected by more than 30% of respondents.

Figure 6. Community Input Survey Data – Most Important Factors for a Healthy Community

(Note: 957 respondents from the SCH service area answered this question)

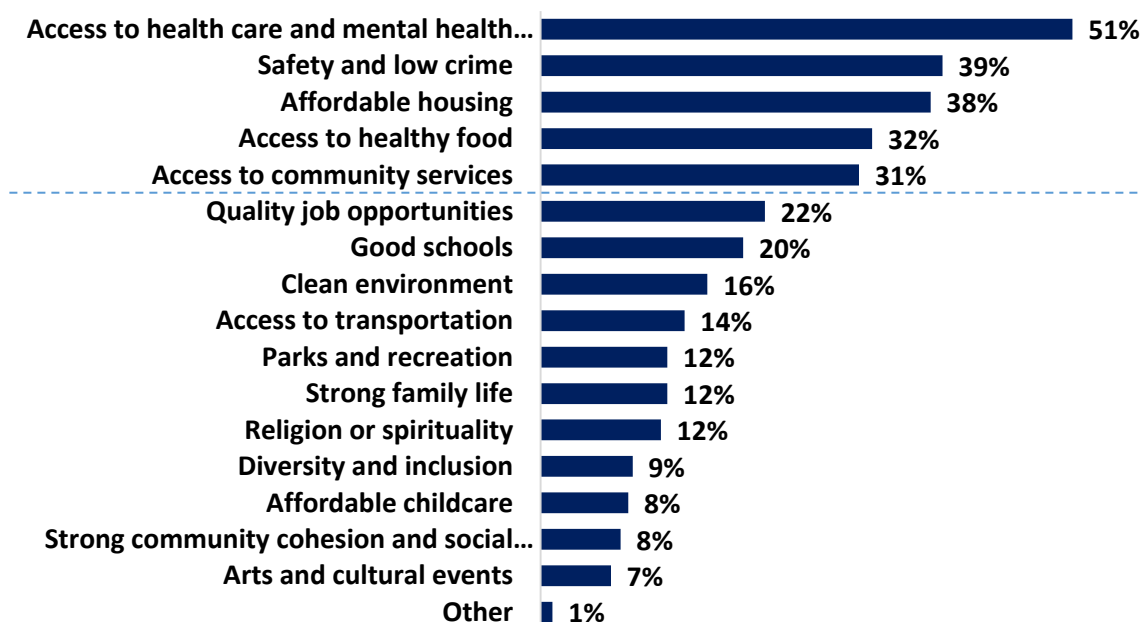


Figure 7. Community Input Survey Data – Greatest strengths and areas for improvement

What are the greatest strengths in the community where you live? (open-ended, n=670)

Responses most commonly related to the following categories:

- Community Cohesion
- Transportation
- Parks and Recreation
- Community Services
- Health Care

“The best thing in HP is that we look out for each other. We have a park for the kids and family to go. We have plenty of transportation.” – Humboldt Park community resident

What is one thing that you would like to see improved in your community? (open-ended, n=613)

Responses most commonly related to the following categories:

- Safety and Low Crime
- Economic Development
- Food Accessibility
- Affordable Housing
- Health Care

Community Focus Groups

Between August 2018 and February 2019, Alliance for Health Equity partners collaborated to conduct a total of 57 focus groups with priority populations such as veterans, individuals living with mental illness, communities of color, older adults, caregivers, teens and young adults, LGBTQ+ community members, adults and teens experiencing homelessness, families with children, faith communities, adults with disabilities, and children and adults living with chronic conditions such as diabetes and asthma.

Thirty-six focus groups were conducted by IPHI and 21 Learning Map Sessions were led by West Side United with notetaking by IPHI. IPHI developed the focus group questions using resources from existing CHNA toolkits and peer-reviewed studies, in consultation with the CHNA committee and colleagues at partner health departments. Each focus group was hosted by a hospital or community organization. The sessions were approximately 60-90 minutes long with an average of 8-12 participants. A total of 25 learning map sessions/focus groups were conducted with residents living within NAH’s service area (Table 2).

Table 2. Focus group and learning map sessions conducted within NAH’s service area

Learning Map Sessions	
After School Matters (<i>Youth</i>)	Greater Galilee Baptist Church
AMITA Saints Mary and Elizabeth Medical Center	Habilitative Systems
Breakthrough	Kedvale New Mount Zion MB Church
BUILD, Inc. (<i>Youth</i>)	New Moms
By the Hand (<i>Youth</i>)	New Morning Star MB Church
Coalition of Hope	Oakley Square Apartments
CristoRey High School (<i>Youth</i>)	Saint Stephen AME
Deborah’s Place	Temple of Faith MB Church
El Valor (<i>Spanish</i>)	UCAN Community Residents

Enlace Chicago (<i>Spanish</i>)	UCAN (<i>Youth</i>)
Garfield Park Community Council	
Focus Groups	
Alivio Medical Center (<i>Spanish</i>)	
Chicago Public Library – Austin-Irving Park Branch	
New Moms	
Northwest Side Housing Center	
Southwest Organizing Project	

The major themes that arose from focus groups on the West Side included racism; gentrification, displacement, and disinvestment; community resources and community cohesion; social determinants of health; behavioral health; health care; and chronic disease. Additional community input and quotes are highlighted in the secondary data section.

Racism

Issues related to racism permeated many of the focus group conversations. Historical structural racism was linked to past and current patterns of segregation and differential access to resources such as quality schools, affordable safe housing, and healthcare. In addition, exposure to interpersonal and structural racism can be traumatizing for individuals and communities further contributing to health inequities. Focus groups participants emphasized that racism and discrimination in all forms must be addressed if any effort to improve health equity is to be successful.

“It feels like this structural racism is impacting everything. I mean whether we’re talking about the meetings we can attend, whether we’re talking about the properties we can buy because of redlining, whether we’re talking about being able to afford insurance. It really permeates everything from economics to education to even the way that we think.” - Community member from Garfield Park Community Council Learning Map Session

Gentrification, Displacement, and Disinvestment

In almost every focus group, participants highlighted the effects of gentrification, displacement, and disinvestment on the West Side of the city. Focus group participants described how a lack of investment in their communities has led to:

- limited community access to recreational programs, parks, and safe spaces for exercise;
- contracts not given to minority owned businesses;
- fewer job opportunities;
- high rates of unemployment;
- high rates of poverty;
- limited retail and business investment;
- reduced funding for schools; and
- deterioration of the overall built environment.

Participants highlighted that the communities that are being invested in on the West Side are increasing the cost of living and pushing out longtime community members.

“I feel like they’re trying to take everything from us and move us out of places like Wicker Park and West Town.” – Community Resident from Breakthrough Learning Map Session

Community resources and community cohesion

Focus group participants shared that community resources are valuable assets to their communities. Though participants praised the resources in their communities, they expressed barriers to accessing resources such as a lack of easily accessible information about available resources and the cost of programs for children, adolescents, and young adults.

Multiple focus groups mentioned that a shared sense of connection between community members was one of their community's greatest strengths and assets. Several other groups described community cohesion as an essential component of a healthy community. It was emphasized that the knowledge and collective power of communities is often an untapped resource that should be solicited, cultivated, and leveraged in order to develop effective solutions to improve the health and wellbeing of residents.

“They won’t listen to us; we don’t have the formal education. But we have knowledge and understanding and a way of looking at things. I may not be able to use a computer, but we have something they need – wisdom.” – Community Resident from Habilitative System Learning Map Session

Social and Structural Determinants of Health

Socioeconomic inequities were mentioned by several focus groups. Inequities in community economic investment and development, employment opportunities, quality affordable housing, education opportunities, community safety, and food access were highlighted.

Employment

A lack of employment opportunities was one of the most frequently discussed issues among focus group participants. Participants living in the West Side of the city described having the least number of quality job opportunities and employment resources. However certain populations such as those living with mental illness, young adults, homeless individuals, and formerly-incarcerated were highlighted as having significant barriers to employment regardless of their geographic location. Within certain communities, jobs are available, but they are described as lacking benefits, part-time, temporary, and/or low-paying.

Education

The major education-related concerns expressed by focus group participants on the West Side of Chicago included diminishing education opportunities and poor-quality schools. Limited educational opportunities were linked to issues such as higher rates of violence, substance use disorders, and mental illness as well as poorer economic and employment opportunities. Additional education-related concerns included:

- limited or non-existent resources for learning trades;
- a lack of support programs such as quality, low-cost tutoring; and
- the displacement of students due to school closures and district restructuring.

Community Safety

Community safety and violence was mentioned by multiple focus groups in a variety of contexts. The most commonly mentioned safety issues included gun violence, gang activity, drug-related activities, burglaries, and armed robberies. Participants related that the prevalence of violence in their communities has led to health issues such as chronic stress, decreased mental well-being, trauma among children and adults, and decreased physical activity due to a reluctance to exercise in unsafe neighborhoods. Many focus group participants expressed that media's portrayal of the West Side as violent and unsafe area exacerbated negative opinions of the communities and failed to recognize the culture and assets on the West Side.

Food Systems

Participants on the West Sides of the city reported a high proportion of fast food restaurants and limited access to grocery stores selling healthier options. Community members living with chronic diseases such as diabetes explained that living in communities with less access to healthy food options made it more difficult to manage their conditions. Both youth and adults from multiple communities reported that having a healthy diet can be difficult for several other reasons including:

- the cost of healthy foods;
- the need for gardens on the West Side; and
- a lack of knowledge about how to prepare healthy meals.

Housing

As previously mentioned, focus group participants highlighted that gentrification has resulted in rising housing costs and displacement. Additionally, participants described how segregation has led to a concentration of poor-quality housing, poverty, and violence in communities of color.

Behavioral Health

Almost every focus group mentioned behavioral health conditions such as depression, anxiety, and substance use disorders as some of the biggest health priorities in their communities. The major themes that emerged from these discussions included:

- the prevalence of chronic stress among youth and adults in communities;
- a lack of education among youth, adults, and public servants about mental illness and substance use disorders;
- difficulties accessing behavioral health treatment resulting from provider shortages, minimal community-based resources, poor healthcare coverage, financial cost, and policy issues; and
- the impact of stigma on treatment seeking behaviors.

“The wait times to get in to see a psychologist are way too long, and it is very expensive.” -Community Resident from Enlace Learning Map Session

Health Care

Focus group participants on the West Side expressed barriers to accessing quality health care including:

- the complexity of obtaining and keeping public benefit coverage;
- the high cost of some private insurance plans;
- an unequal distribution of health care services and facilities; and
- inequities in health care quality for communities of color and immigrants.

“Most of us don’t have health insurance. You can’t get a mammogram or go to the doctor for checkups. If we had health insurance we would go more often, not just when we are sick.” -Community resident from Oakley Square Apartments Learning Map Session

Chronic Disease

In addition to behavioral health, chronic diseases such as diabetes, obesity, cancer, and asthma were identified as major health priorities for West Side community members. The major themes that were mentioned by participants included:

- social determinants of health such as poverty, limited access to healthy foods, exposure to violence, and housing conditions are both underlying root causes of chronic disease and are barriers to the management of chronic disease;
- education about preventing chronic disease, risk factors, and when to seek medical help is lacking in communities; and
- community groups that share information about resources and support each other with adjusting to healthier lifestyles would be extremely helpful to communities.

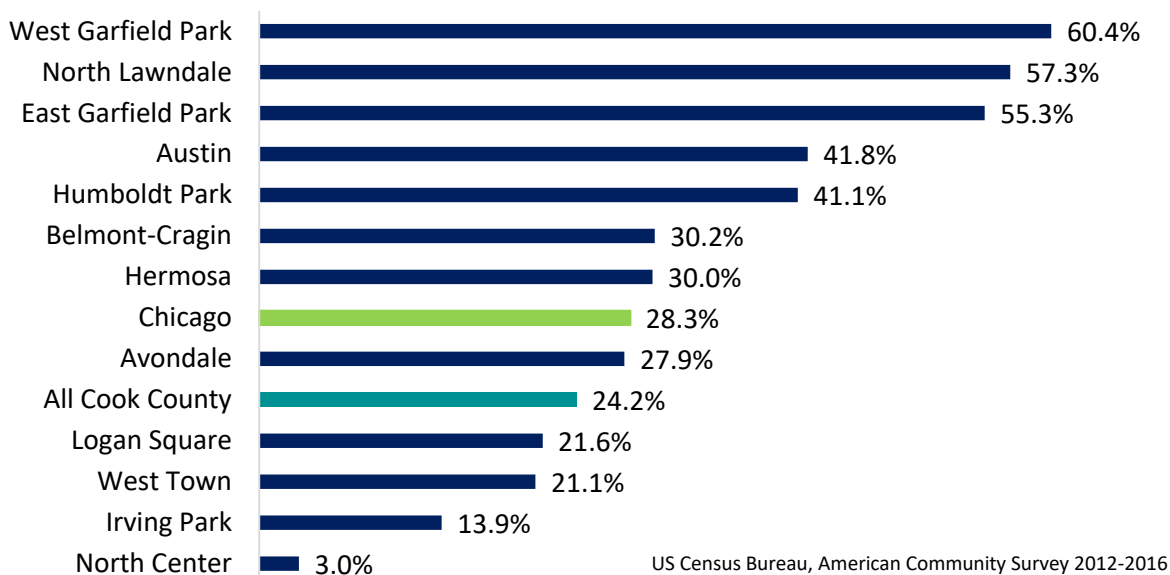
“I know a lot of people who have diabetes because they are eating the wrong food, and don’t have access” -Community resident from By the Hand Learning Map Session

Secondary Data

The following section highlights key data pertaining to social determinants of health including socioeconomic factors, housing, food insecurity, community belonging, and health outcomes. These quantitative data findings are supported by community members' input during focus group sessions.

- **Poverty:** Seven communities in NAH's service area have more than 20% of their population living in poverty, with NAH's home community of Humboldt Park at 30.5%. There is an extreme disparity in poverty rates among the communities of NAH's service area with West Garfield Park having 47.3% while North Center has a poverty rate of 5.1%. Of particular concern from a health perspective, child poverty is very high in the NAH service area. More than half of the children in the communities of West Garfield Park, North Lawndale, and East Garfield Park, are living in households making less than the federal poverty level.

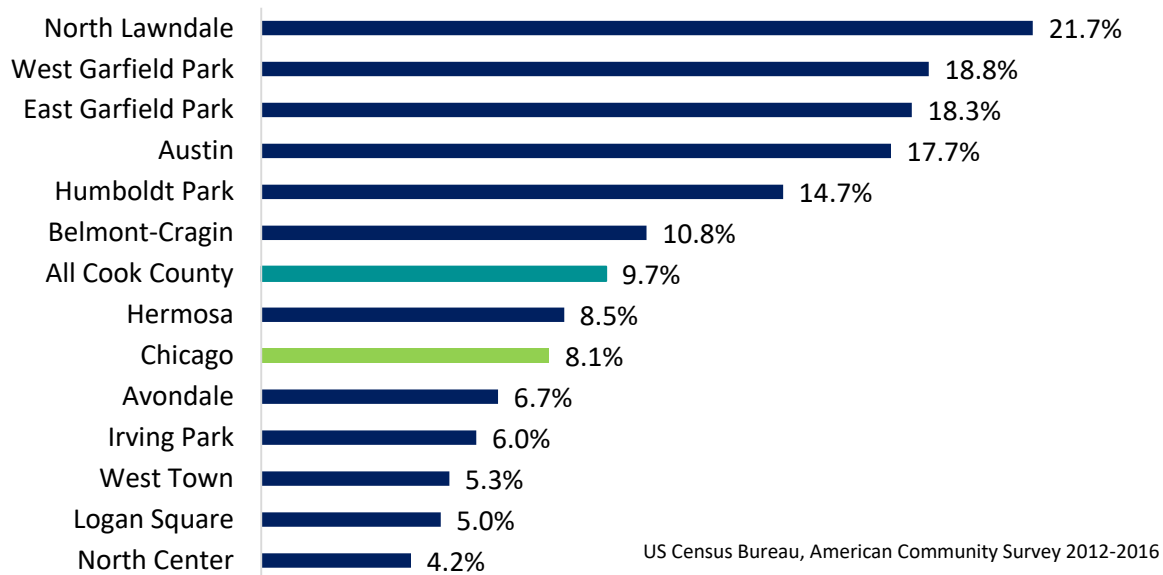
Figure 8. Percentage of Children Living in Poverty (100% FPL), 2012-2016



- **Income and Employment:** North Center, West Town, and Logan Square have the highest median incomes in the NAH service area. Overall, unemployment rates in NAH's service area decreased in every community since the last community health needs assessment, but still vary widely, ranging from 4.2% in North Center to 21.7% in North Lawndale. Four communities – North Lawndale, West Garfield Park, East Garfield Park, Austin, and Humboldt Park – had around or over 15% unemployment over the period of 2012-2016. This was substantially higher than the Cook County and Chicago citywide rates of 9.7% and 8.1%, respectively.

“[We need] access to high paying jobs, access to alternative schools for high school drop-outs or workforce development programs.” – Belmont-Cragin community resident

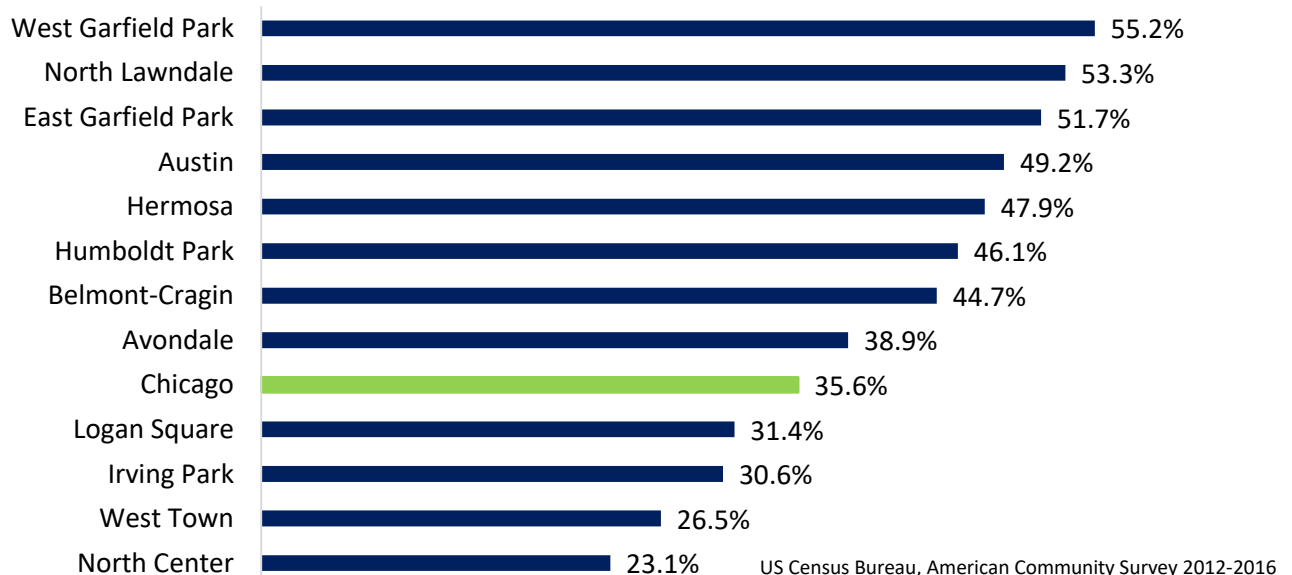
Figure 9. Percentage of unemployed adults 16 years and over in the civilian labor force, 2012-2016



- **Housing:** Being cost-burdened by housing (spending 30% or more of income on housing costs) remains an issue for most residents that NAH serves. The communities of West Garfield Park, North Lawndale, East Garfield Park, and Austin have at least 50% of their population are cost-burdened by housing.

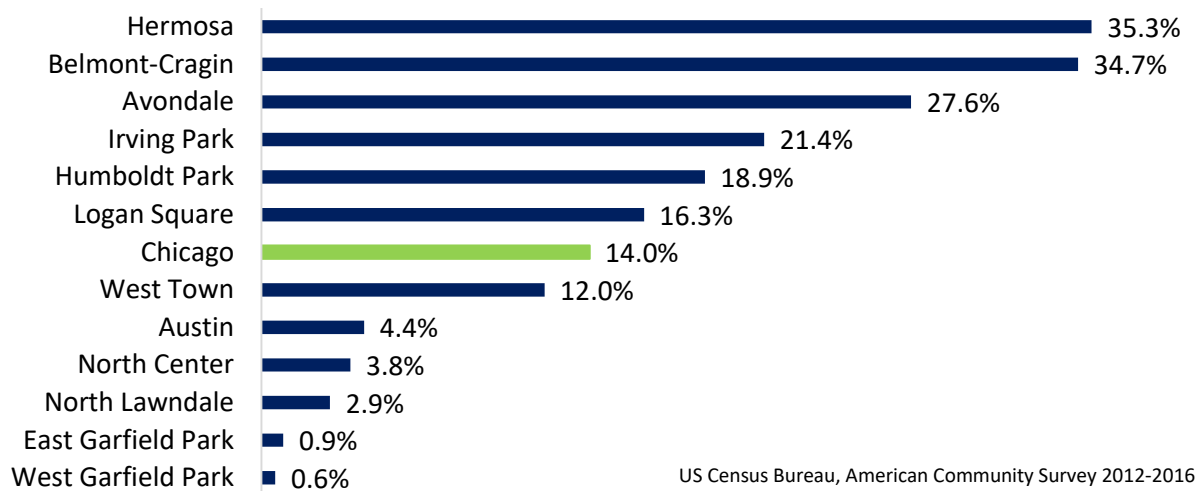
“[I would like to see] affordable housing. Long time minority residents are being forced out due to housing costs and property tax increases.” – Logan Square community resident

Figure 10. Percentage of Households Cost-Burdened by Housing, 2012 -2016



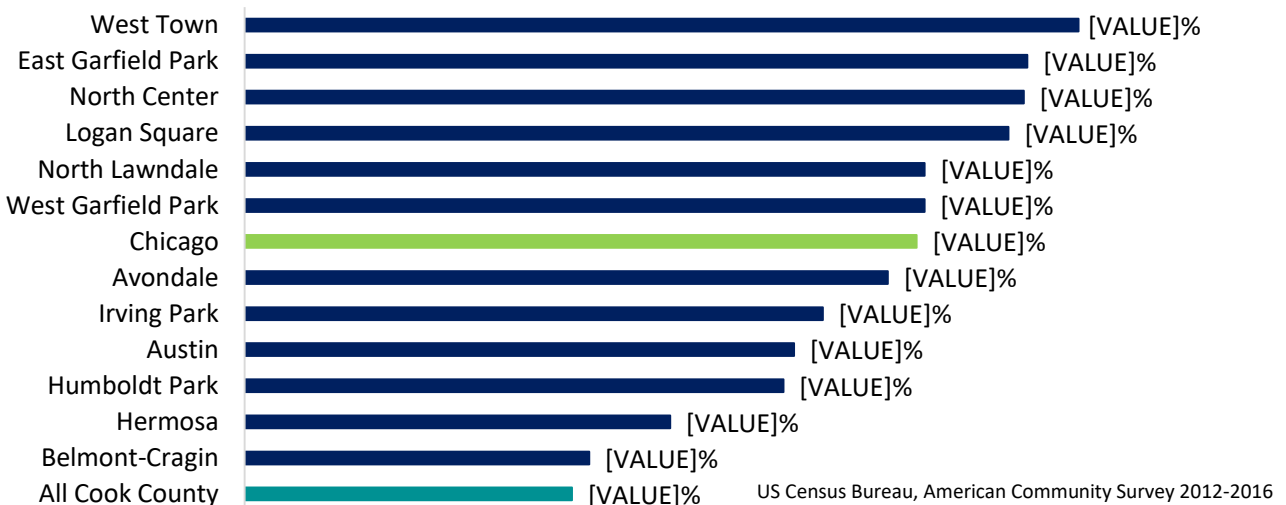
- Limited English-Speaking Households:** Six community areas in the NAH service area have more than 15% of their population in limited English speaking households (persons over five years of age who speak English less than “very well”) with Hermosa (35.3%) and Belmont-Cragin (34.7%) having the highest percentages. Most of these residents speak Spanish as their first language with a sizable minority speaking Polish. There are also a number of communities with large African American populations (West Garfield Park, East Garfield Park, and North Lawndale) with very low numbers of limited English speaking households, pointing to the concentration of new immigrant and limited English speaking households in certain parts of the NAH service area.

Figure 11. Percentage of Limited English-Speaking Households, 2012-2016



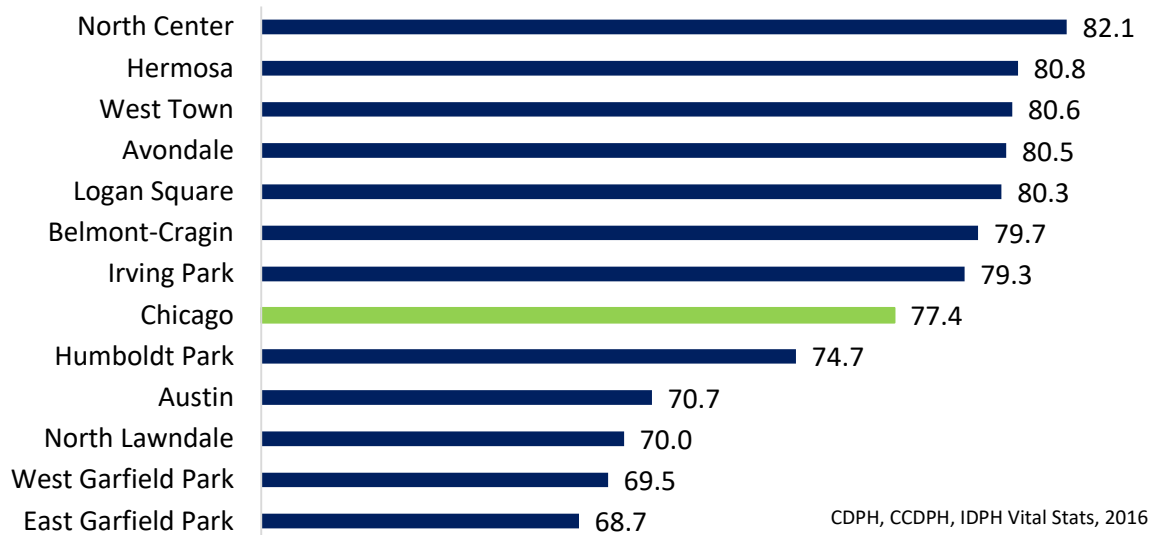
- Commuters Using Active Transportation:** Active transportation (commuting to work by walking, biking, or public transit) is another important social determinant of health. Active transportation varies substantially between the communities in NAH’s service area. Almost half of workers from the West Town community reported using active transportation (47.4%) while Belmont-Cragin and Hermosa have less than 25% of workers who reported using active transportation.

Figure 12. Percentage of workers aged 16 years and older who commute to work by walking, biking, or public transit



- Life Expectancy:** There is about a 13-year disparity in life expectancy among the communities in NAH's service area ranging from 68.7 years in East Garfield Park to 82.1 years in North Center. While the majority of communities in the service area have a greater life expectancy than Chicago overall, residents of Humboldt Park, Austin, North Lawndale, West Garfield Park, and East Garfield Park have substantially lower life expectancy than the City.

Figure 13. Life Expectancy at Birth (in years)



- Maternal and Child Health:** Maternal and child health outcomes vary across NAH's service area, highlighting the overall inequities in health across the communities served by NAH. Percent of births with low birthweight ranges between 6.2% in North Center to 15.8% in East Garfield Park. Similarly, the rate of infant mortality varies between community areas in NAH's service area. Five communities have an infant mortality rate of 10 per 1,000 births or greater. Similar disparities are also seen in teen births.

Figure 14. Low Birthweight (Percent of births with a birthweight less than 2,500 grams among the total number of number of births)

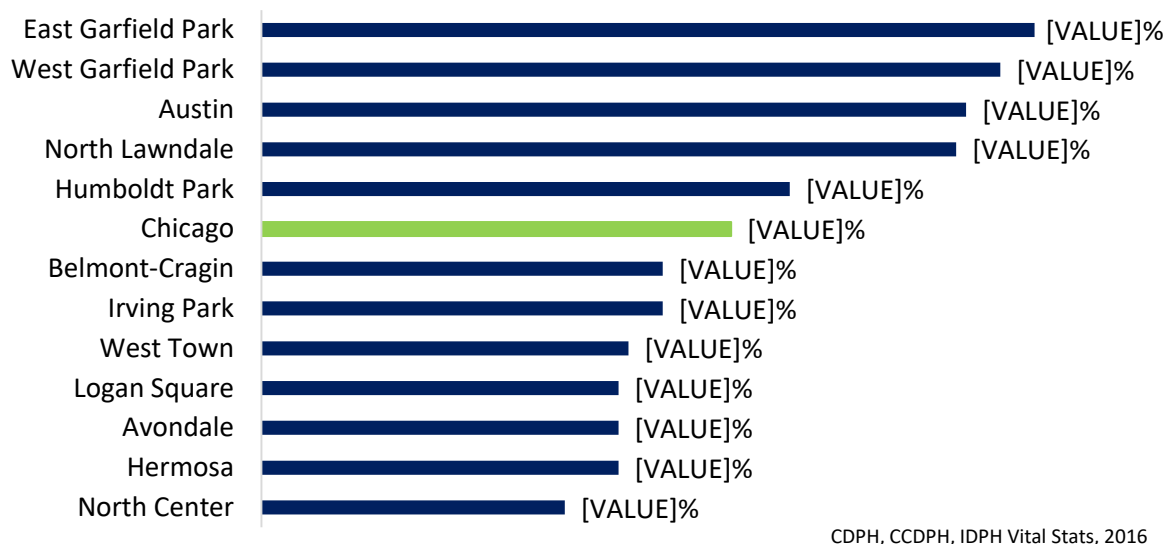


Figure 15. Infant mortality (Number of deaths of infants less than one year old per 1,000 live births)

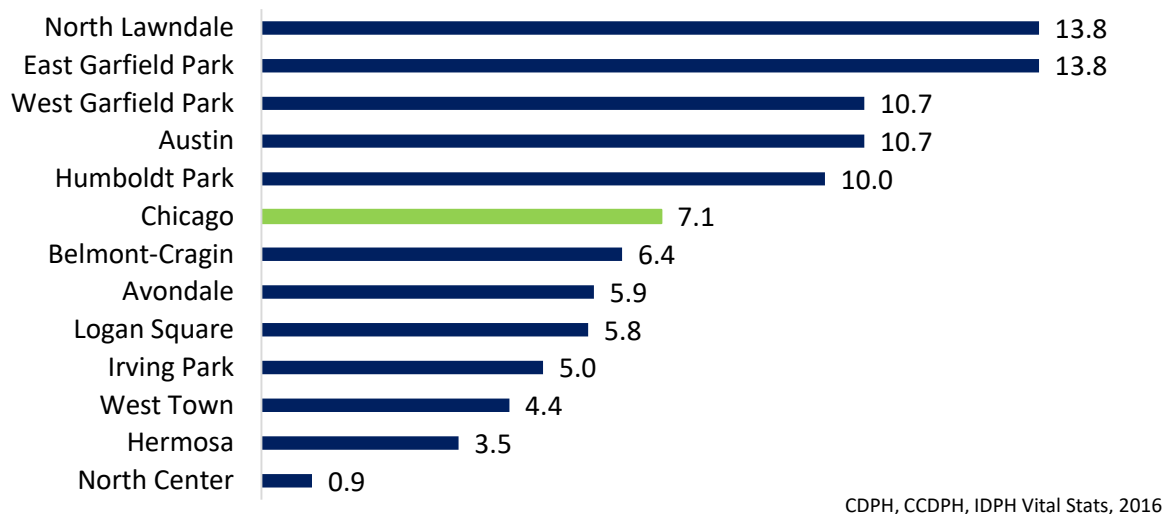
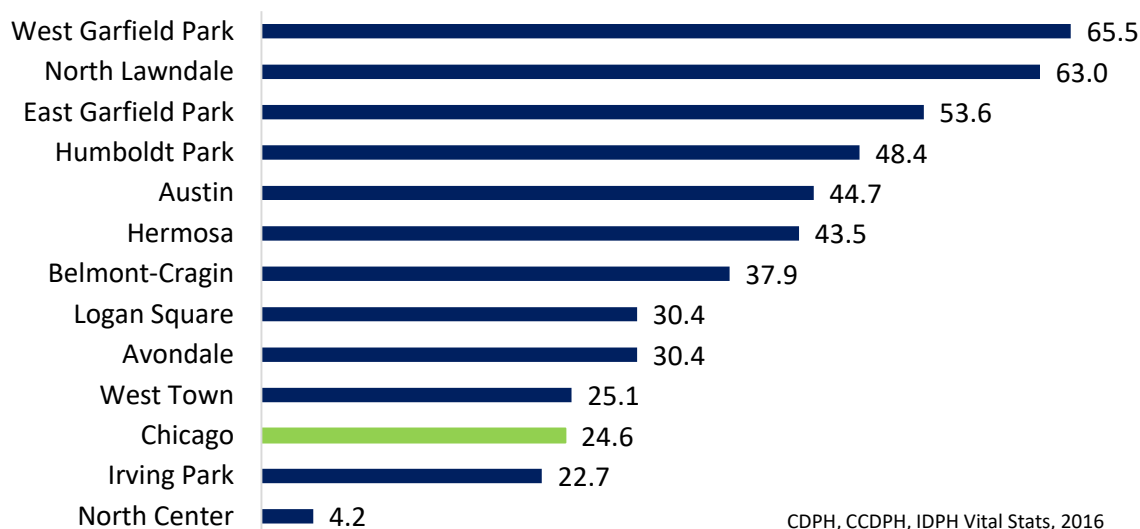


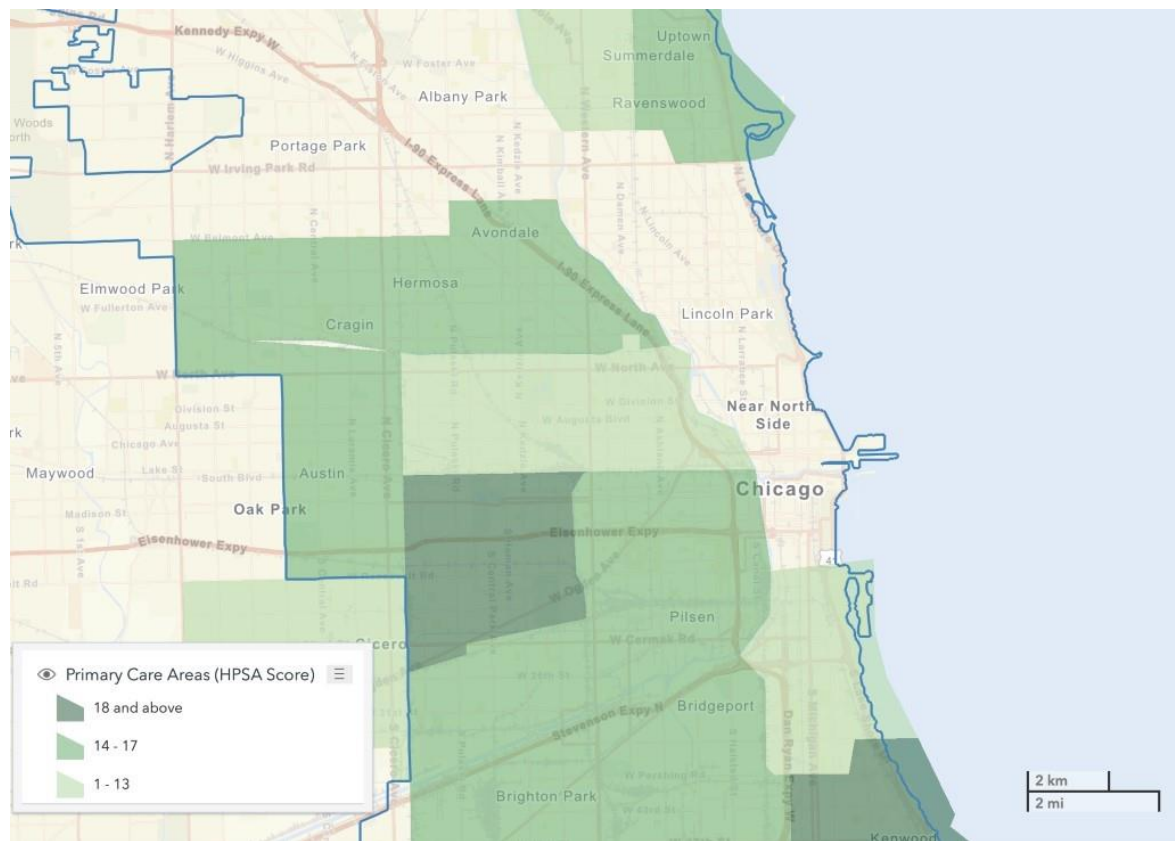
Figure 16. Teen births (Total births where the mother's age is 15-19 years of age at time of delivery per 1,000 population of females aged 15-19 years)



○ **Medical Professional Shortages:**

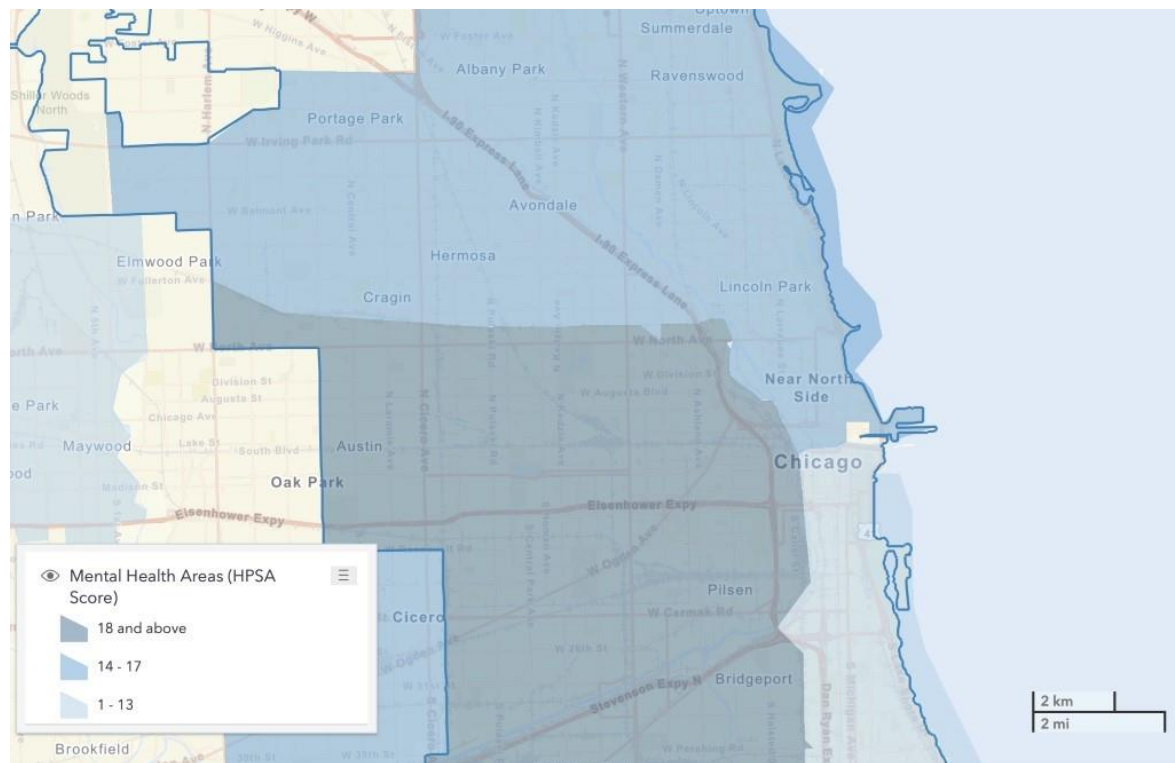
As shown below in figures 17 and 18, the communities of Austin, Logan Square, Humboldt Park, West Town, East Garfield Park, and West Garfield Park have shortages of primary care health professional as seen in the map below. In regard to mental health, all communities in NAH's service area, and Chicago, have mental health professional shortages.

Figure 17. Primary Care Health Professional Shortage Area



Source: <https://data.hrsa.gov/maps/map-tool/>

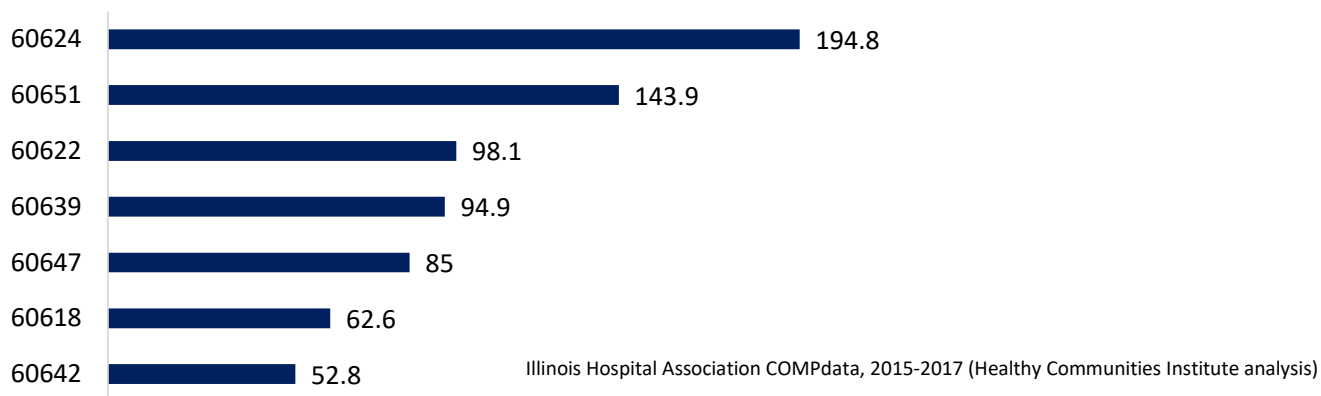
Figure 18. Mental Health Professional Shortage Areas



Source: <https://data.hrsa.gov/maps/map-tool/>

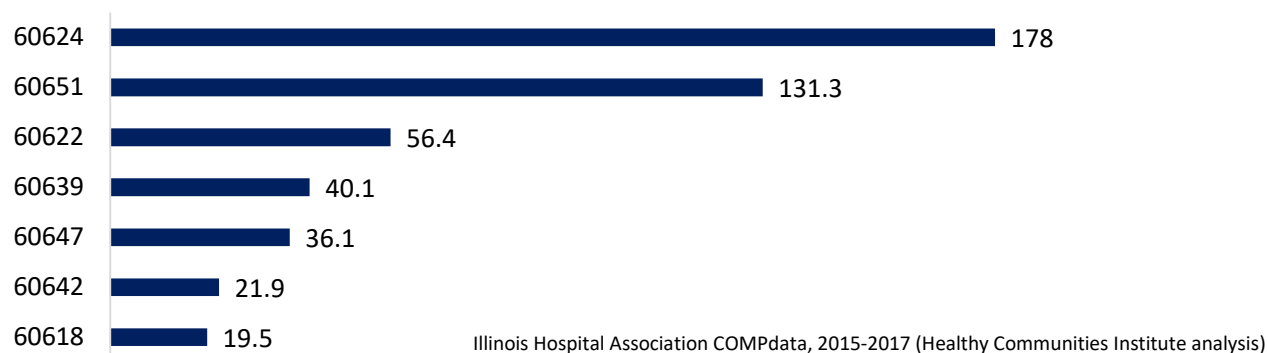
- **Mental Health and Substance Use Disorders:** Mental Health provider shortages are experienced across the NAH service area. The rate of emergency room usage due to mental health varies greatly between zip codes, with the lowest rate being 52.8 per 10,000 in zip code 60642 and the highest being 194.8 per 10,000 in zip code 60624.

Figure 19. Emergency Department (ED) visits due to Mental Health among adults, (age-adjusted rate per 10,000) 2015-2017



The rate of emergency room usage due to substance abuse ranges from 19.5 per 10,000 in zip code 60618 to 178 per 10,000 in zip code 60624. Overall, emergency room usage due to substance abuse has increased since the CHNA cycle from 2016 where the lowest rate was 9.0 per 10,000 in zip code 60642 and the highest rate was 89.6 per 10,000 in zip code 60624.

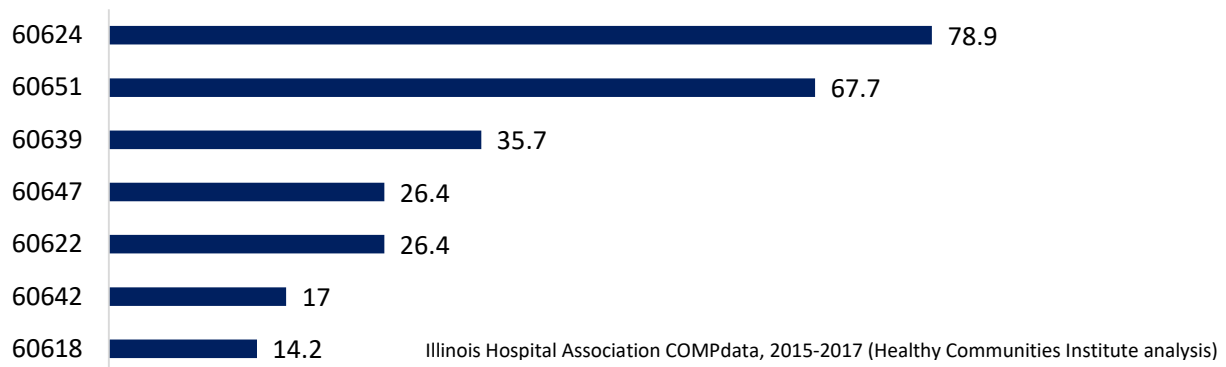
Figure 20. Emergency Department (ED) Rate due to Substance Abuse, (age-adjusted rate per 10,000) 2015-2017



- **Leading Causes of Death and Chronic Disease Risk Factors:**

Heart disease and cancer are the leading age-adjusted causes of mortality across the NAH service area. Rates of obesity and overweight adults in Chicago are similar to national rates; 39.8% of adults reported being overweight, and 30.8% of adults reported obesity in Chicago for the time period between 2015 and 2017. The rate of self-reported diabetes in Chicago is 9.1% of adults, and rates are known to be higher in the areas served by NAH, particularly in Avondale (16.4%) and Austin (14.4%). The rate of emergency department visits due to diabetes varies significantly across NAH's service area, with the lowest rate of 14.2 per 10,000 in the 60618 zip code to the highest rate of 78.9 per 10,000 in 60624 (West Garfield Park.)

Figure 21. Emergency Department (ED) Rate due to Diabetes, (age-adjusted rate per 10,000), 2015 - 2017

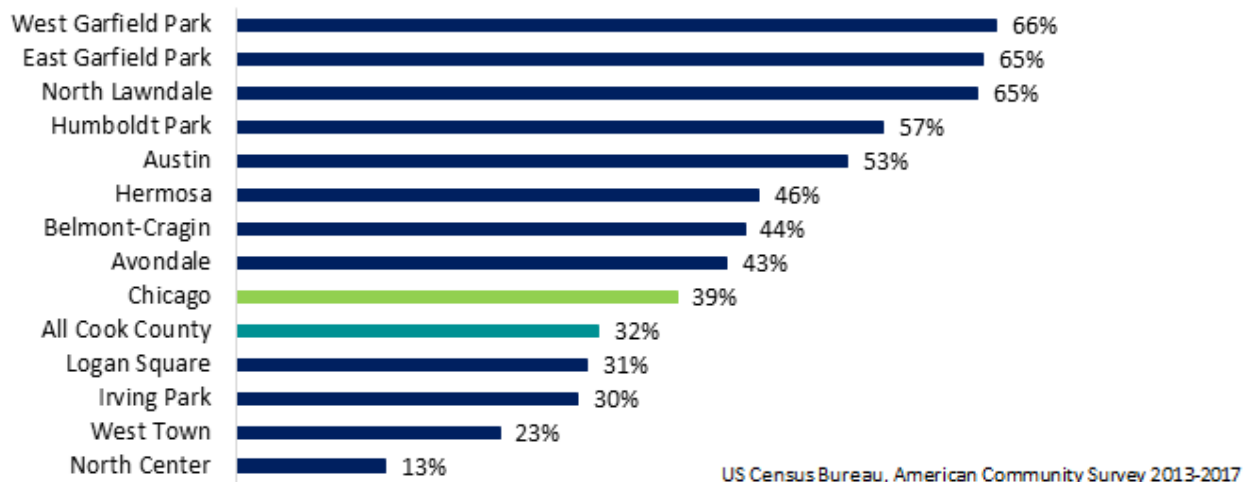


- **Food Insecurity and Food Access:**

Risk of food insecurity disproportionately affects the communities within NAH's service area, with eight communities having higher risk than the citywide average of 39%. West Garfield Park, East Garfield Park, and North Lawndale all have 65% or more risk of food insecurity. North Center has the lowest risk for food insecurity at 13%. Risk of food insecurity is defined as living below 185% of the federal poverty level, in alignment with how the Greater Chicago Food Depository currently measures food insecurity in Chicago communities.

"We have no big grocery stores. They all moved out of our communities, and nothing is within walking distance." – community resident from New Morning Star Learning Map Session

Figure 22. Risk of Food Insecurity. Percent of population living below 185% of the poverty level, 2013 - 2017



- **Health Behaviors Related to Food:** There is a disparity of consumption of the recommended five or more servings of fruits and vegetables among residents of the communities in NAH's service area. Most of the communities that NAH serves have a lower percentage of fruit and vegetable consumption than the citywide percentage of 30.5% with Belmont-Cragin, Humboldt Park, and East Garfield Park reporting the lowest percentages (18.4%, 18.2%, and 17.2% respectively). Seven of the communities in NAH's service area have higher percentages of daily sweetened beverage consumption than the citywide percentage of 25.5% with North Lawndale, East Garfield Park, and Hermosa reporting more than 42%.

"I would like to see better access to good food and quality health care in the neighborhood." – Austin community resident

Figure 23. Percentage of adults who reported eating five or more servings of fruits and vegetables (combined) daily

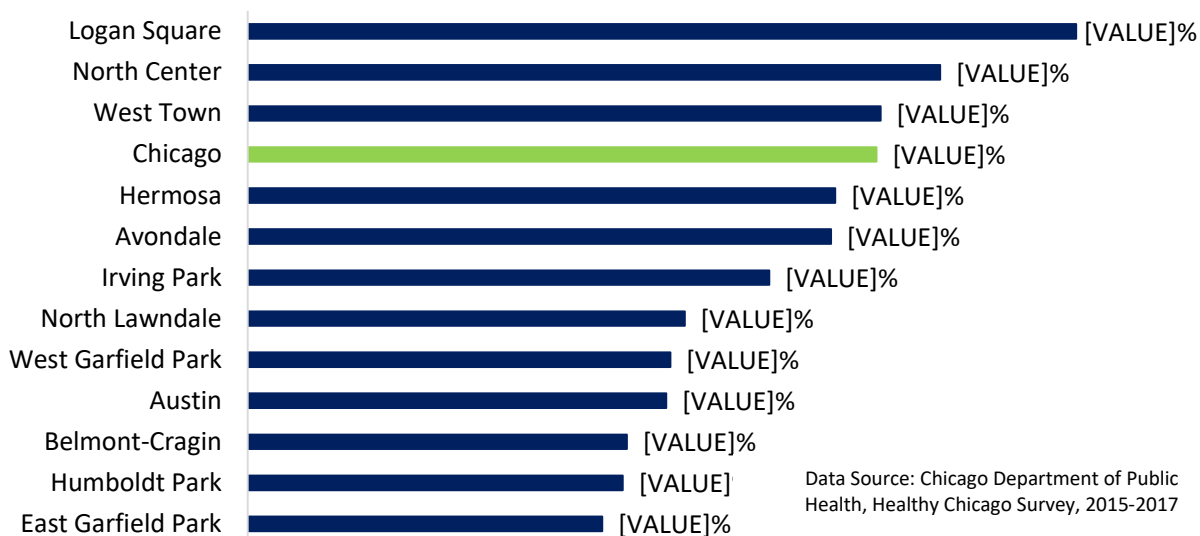
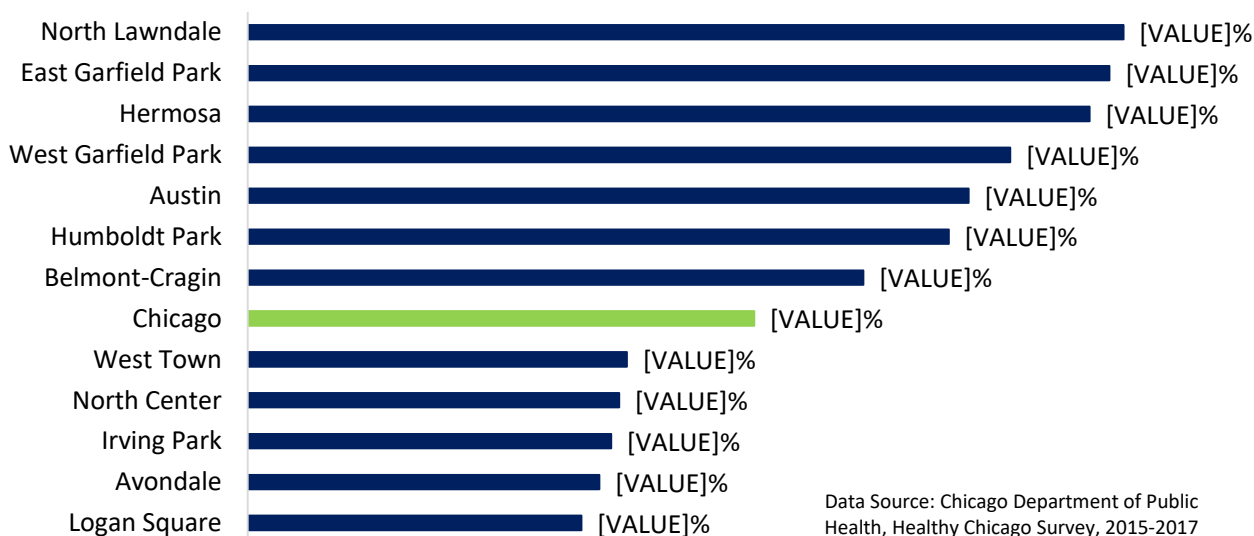
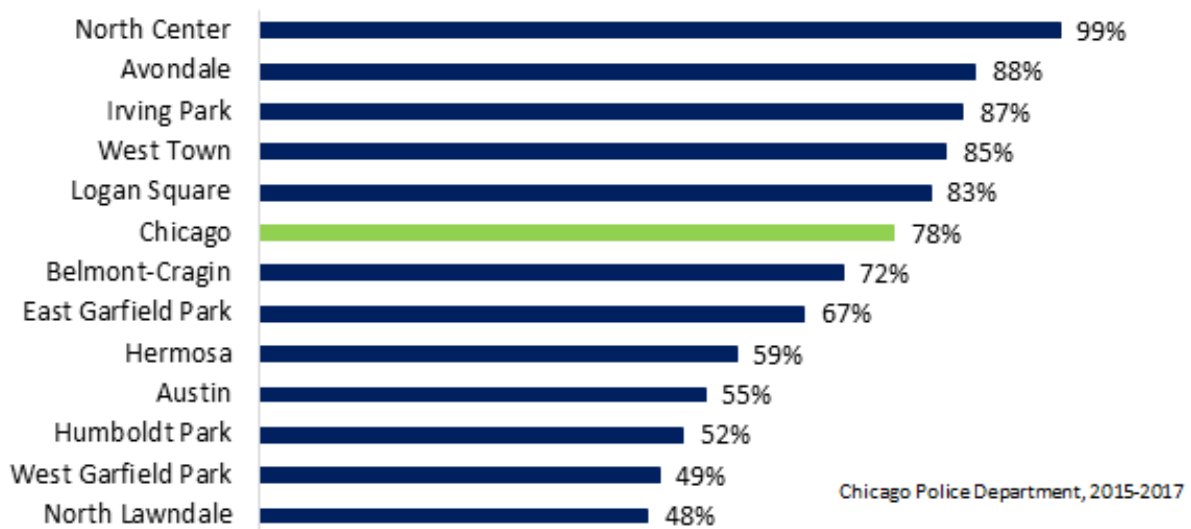


Figure 24. Percentage of adults who drank soda or pop or other sweetened drinks like sweetened iced tea, sports drinks, fruit punch or other fruit-flavored drinks at least once per day in the past month



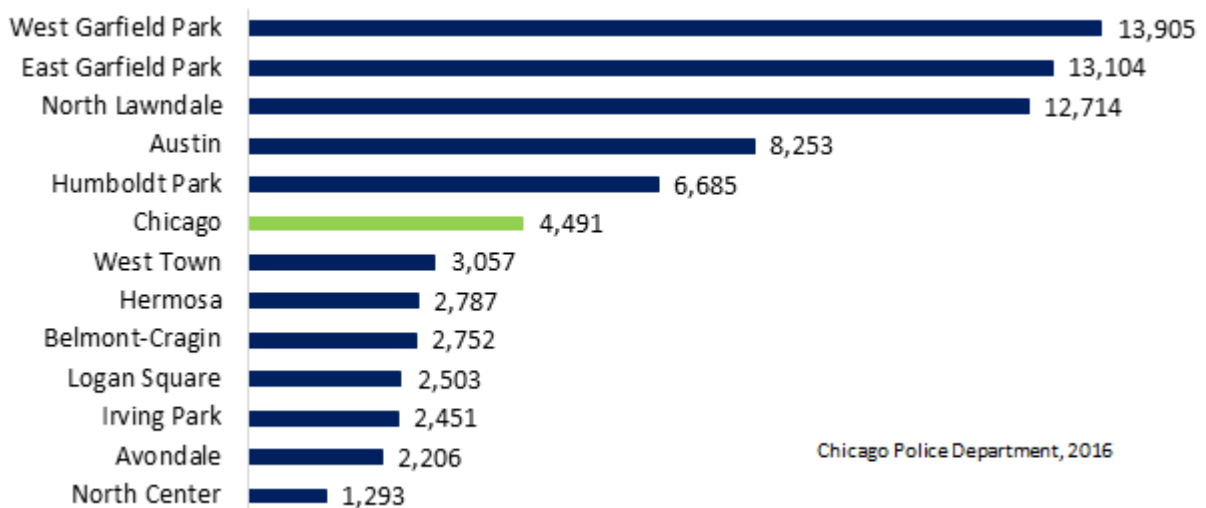
- **Community Safety and Violence:** Communities around NAH's service area report a wide range of perceived neighborhood safety. Almost 100% of people in North Center report feeling safe in their neighborhood most or all of the time while less than half of the people in West Garfield Park and North Lawndale report feeling safe most or all of the time. There is an extreme disparity in the rates of violent crimes in the communities of NAH's service area. The rate of violent crimes in West Garfield Park is more than 10.5 times higher than the rate in North Center. The rates of violent crime in West Garfield Park, East Garfield Park, and North Lawndale are more than 2.5 times higher than the citywide rate.

Figure 26. Estimated Percent of Adults who Report Feeling Safe in their neighborhood all of the time or most of the time, 2015 - 2017



“Since there’s no jobs in the community they find it easier to gang bang than to travel 2 hours for minimum wage.” – Community resident from Southwest Organizing Project focus group

Figure 27. Community areas with the highest and lowest violent crime rates (per 100,000 population) in Norwegian American Hospital's service area*

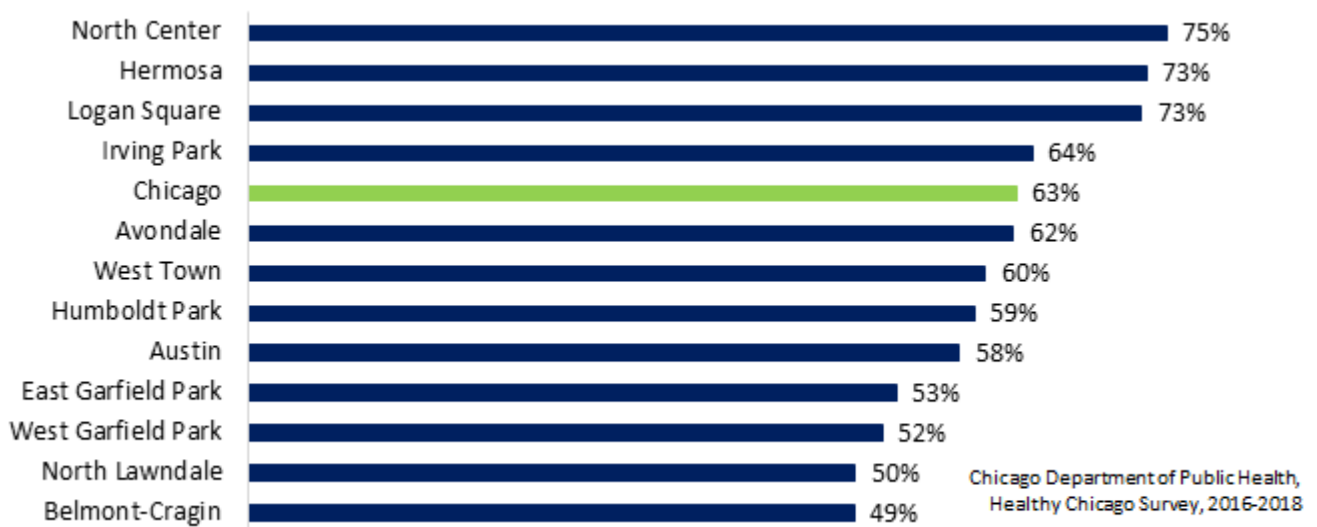


- **Community Belonging/Engagement:** Overall, around 50% or more people in the communities within NAH's service report a sense of community belonging. The communities of North Center, Hermosa, Logan Square, and Irving Park report a higher percentage than the citywide average of 63%.

"...the neighbors we have, we look out for."

- Community resident from Austin-Irving Park Chicago Public Library focus group

Figure 25. Percentage of adults who reported that they strongly agree or agree that they really feel part of their neighborhood, 2016 – 2018



IV. Priority Community Health Needs, 2019-2022

Norwegian American Hospital will focus on increasing access to care for community residents. This will be met in the following four areas: Access to food, access to healthcare services and full service care within NAH and in community settings, access to health and wellness within the community and access to behavioral health and substance use disorders.

NAH will address the concerns of the community in the following ways:

Access to food:

- Screen patients for food insecurities both in inpatient and outpatient care areas
- Host food pantries with glucose screenings
- Partner with the Greater Chicago Food Depository and other organizations to increase impact
- Participate in community garden
- Give educational resources regarding diabetes and food

Access to healthcare services:

- Provide no cost transportation to patients to and from their homes and healthcare facilities
- Offer ADA accessible vehicles for health transportation

Access to community health resources:

- Send team into the community to provide health services to adults, children and young people at no cost

- Provide coats, socks, toys, car seats and other basic need items at designated events
- Work with over 80 community partners
- Link patients with community resources

Access to behavioral health and substance use disorders care:

- Expand outpatient services for behavioral health and substance use disorders
- Provide inpatient care
- Expand youth and community development and resources through Mental Health First Aid
- Provide screening, brief intervention and referral to treatment through Substance Abuse and Mental health Services Administration (SAMSHA) grant with 6 other Illinois hospitals
 - In collaboration with the Illinois Department of Human and Family Services (HFS), increase warm handoff services that allow patients to move directly from the hospital to a medical treatment program, dramatically reducing the risk for relapse or overdose and improving the odds for success

A special thank you to the NAH Foundation for assisting in program expansion through grant funding.

V. Progress Addressing Needs Identified in 2016 CHNA

- **Need: Improving social, economic, and structural determinants of health while reducing social and economic inequities**
 - FY18:
 - Food
 - Initiated food insecurity screenings
 - Provided 186 recipients with food
 - Clothing and Basic Needs
 - Maintained a patient closet of clothing items to be distributed to those in need
 - Coat drive- Provided over 130 free coats to children in need
 - Hosted Farmer's Market
 - Hosted a Car Seat event for our patients, in collaboration with Lurie Children's
 - Economic Stability and Employment
 - NAH is the largest employer in the Humboldt Park area
 - Attended and hosted job fairs and other events
 - Expanded the Family Medicine Residency Program to train the next generation of doctors to provide quality, compassionate care to underserved communities
 - Provided training on health equity in our residency program and to primary care providers
 - Increased wages for nurses and environmental services staff
 - Presumptively qualify patients for Medicaid
 - Provided \$1.3M of presumptive charity care
 - Patient and Family Advisory Council
 - Elicit feedback and input from patients, families and community members
 - Transportation
 - Transportation Vehicles – 3 vans dedicated to driving patients door-to-door to and from the hospital

- Provided 3900 rides, totaling 31,000 miles in FY19
- Language Assistance Services and Hearing
 - Providing quality care in the patient's preferred language plays a critical role for the health and wellness of the patient and clinical outcomes. Of the patients seen in 2018, 45% were of Hispanic/Latinx descent.
- **Need: Improving mental health and decreasing substance use disorders**
 - Behavioral Health and Trauma Informed Care
 - Began the journey of becoming an integrated health home to provide more holistic and quality care for our patients with chronic medical and behavioral health needs
 - Conducted training and certification for sexual assault nurse examiners (SANE) nurses
 - Initiated a SANE certified exam room for sexual assault survivors
 - Opioid Task Force
 - Initiated to address the growing concerns of opioid and substance use in the community
 - Initiated warm handoff to approximately 80 patients with substance use disorders
- **Need: Preventing and reducing chronic disease (focused on risk factors – nutrition, physical activity, etc)**
 - FY18:
 - Diabetes Learning Center:
 - NAH's primary service area includes one of the highest incidence of diabetes in the country (12% vs. 8% nationally)
 - In response to community needs, NAH fully activated a comprehensive diabetes care center in 2017 (certified by the American Diabetes Association) with licensed, trained physician specialists and other clinical staff (such as registered diabetes nurses and educators) to provide all critical services in a single point of care model, including: endocrinology; nephrology; nutrition counseling and education; podiatry; ophthalmology, and other key services
 - The Center has allowed allow NAH to maximize diabetes prevention and early detection efforts, as well as provide an effective model for helping individuals with diabetes manage their disease and maximize their health status over the long term
 - The Diabetes Center achieved significant outcomes in 2017,
 - 85% of patients decreased their A1C level.
 - 81% of hypertensive patients have decreased their blood pressure to below <140/90 mmHg.
 - 69% of patients with elevated LDL levels experienced a decrease in value.
 - Additional healthy lifestyles programs
 - Participated in Muevete, an event aimed at walking/moving 10,000 steps Walking – 10,000 steps Muevete
 - Breast cancer screening – mammograms at reduced cost
 - HPV initiative- NAH in citywide initiative on increase HPV rates with American Cancer Society, EverThrive, CDPH, CPS, and Mobile Care Chicago.
 - FY17:
 - Initiated healthy lifestyle choices shared decision making tool for children and young people who's BMI was 85% or higher

- FY16:
 - Ortho:
 - NAH serves a primarily Medicaid population which often has difficulty accessing basic orthopedic services
 - As a result, in December of 2016, NAH established a weekly orthopedic clinic designed to provide a range of orthopedic services, primarily to patients with Medicaid and the uninsured
 - The clinic takes both scheduled and “walk-in” patients to optimize access
 - The clinic provides orthopedic treatment, casting, consults, podiatry and chiropractic treatments, as well as a direct linkage to radiological and physical therapy services to provide a comprehensive, single visits services to individuals who otherwise would not have access to this type of care
 - 80-100 patients are seen each week in the clinic
 - STI Task Force
 - According to the CDC, Cook County has the second highest rates in the country for chlamydia and gonorrhea, with greater inequity on the West side. As a result, a task force was created to address these concerns and devise a strategic plan for community outreach.
 - Community Forum in March 2019: Presented hospital major milestones and goals; proactively engaged the community for valuable insights
- **Need: Increasing access to care and community resources**
 - Care-A-Van – Award-winning Mobile Health Unit
 - The Care-A-Van program provides no-cost health services to children and young people at schools, daycares, and organizations in the community
 - Partners with 80 different sites/organizations to provide services at convenient locations in the community
 - Services include school and sports physicals, immunizations, lead and hemoglobin testing, as well as hearing, vision, diabetes and tuberculosis screenings
 - FY18:
 - Expanded services for FY2018 include: sexual and reproductive health services, fluoride varnish and basic dental exams
 - Full implementation of electronic medical records to improve coordination across the continuum of care
 - Provided over 13,900 services and 4,400 referrals; completed almost 3,000 medical appointments
 - 98% of children and young adults (≥ 10 years old) who received services indicated the Care-A-Van staff listened to them
 - Community Affairs
 - Partnered with approximately 20 sites/organizations in FY 18 to provide no-cost health screenings to adults
 - Completed the following screenings: 1,000 for diabetes, over 150 for blood pressure and approximately 620 for cholesterol; provided 1,113 referrals for ongoing care

- Coordinated events internally, including but not limited to annual community forum, legislative luncheon, informational tables and informational workshops
- NAH Primary Care Clinics (located within community partner clinics)
 - NAH works with a number of community health and social service providers in the community
 - These organizations serve clients with various psychosocial and health needs, such as mental illness, homelessness, substance use, etc. that make it difficult to access primary care services
 - NAH has developed a model to co-locate a weekly primary care clinic within the community partner sites, thereby bringing primary care services to individuals who otherwise may not receive basic primary or preventative care
 - Through these clinics NAH also provides direct linkage to its other services to ensure a continuum of care to these individuals
 - Partnerships with New Life Covenant Church, Healthcare Alternative Systems (HAS) and Association House.
- Norwegian American Hospital has established numerous partnerships, collaborative programs and associations with a number of FQHCs to increase the Hospital's ability to provide services to community members. FQHCs include:
 - PCC Community Wellness Centers
 - Near North Health Centers
 - Erie Health Centers
 - Access Community Health Centers
 - Mile Square Health Clinics
 - Programs include but are not limited to:
 - Behavioral Health services
 - Screening programs, such as mammography
 - OB and midwifery services
 - Residency programs
 - Inpatient resources for clinic patients
- Hurricane Maria -- Puerto Rico Relief Effort
 - Sent medical teams to Puerto Rico to assist in the care of residents
 - Donated supplies and services; served as a collection center
 - Provided medical services when people arrived to Chicago from the island
 - Delivered resources, screenings and job opportunities at the Humboldt Park Fieldhouse Welcoming Center

In addition to the above initiatives, NAH continues to respond to the needs of the community through other inpatient and outpatient services:

Outpatient Services:

- | | |
|-----------------------------------|--|
| • Emergency Department | • Pain clinic |
| • Comprehensive Diabetes Center | • Occupational Medicine/Corporate Health |
| • Vision Center | • Women's Health Center |
| • Podiatry | • Comprehensive Breast Program |
| • Wound Clinic – 25th anniversary | • Urology |
| • Orthopedic Clinic | • GI lab |

- Oncology
- Obstetrics/Gynecology
- Neurology
- Pulmonology
- Primary Care Clinics
- Laboratory
- Imaging
- Physical Therapy

Inpatient Services:

- Medical/Surgical
- Cardiovascular
- Telemetry
- OB/GYN
- Orthopedics
- Oncology
- Mother/Baby
- Neurology
- Pulmonology
- Intensive Care
- Behavioral (Acute, General, Geriatric)
- Medical Detox
- Pulmonology
- Intensive Care
- Behavioral (Acute, General, Geriatric)
- Medical Detox

Other initiatives:

- NAH joined other Illinois Health and Hospital Association members to minimize patient harm as a result of the opioid epidemic
- Exclusive partnership with Saint George's Medical School for Family Medicine Residency Program.
- Partnership with M. Scholl College of Podiatric Medicine for medical students and residents
- In addition, NAH collaborates with local colleges for clinical rotations for nursing, radiology, and pharmacy.
- Puerto Rican Cultural Center
 - HIV/AIDS and STI testing; Counseling; Substance Abuse Treatment; Case Management; Infectious Disease Referrals
- Illinois Coalition of Mobile Health Clinics Association
 - NAH participates in quarterly meetings with Mobile Programs across the state of Illinois. The goal is to learn from each other's programs, minimize duplication of services and maximize quality care.
- Donated Community Space and Financial Sponsorships
 - NAH also provided financial sponsorship to assist other community healthcare providers, social service agencies and organizations.
 - The hospital also lends community space on occasion for our partners.
- Volunteer Services
 - Volunteers also support the work that we do in the community. In FY2018, we had 3,414 volunteer hours logged, estimated to provide a total value of \$38,316. Volunteers assisted with multiple projects at the hospital and with community programs.

VI. Conclusion

NAH is dedicated to delivering strong outcomes and compassionate care that lead to lasting change. NAH believes that its community-based approach to the delivery of health care services is the key to achieving its mission.

Through this collaborative community-engaged CHNA process, we have identified four strategic community health equity needs that we will focus on for implementation activities: Food access, Transportation, Community engagement, and Behavioral health and substance use disorders.

Norwegian American Hospital continues to participate in the countywide Alliance for Health Equity and in many local partnerships for community health improvement.

This Community Health Needs Assessment was approved by the Norwegian American Hospital Board of Trustees on March 2, 2020.

Signed: _____

Printed Name: _____

Board Title: _____

To comment on this CHNA or to request more information or paper copies of the CHNA, please contact Jacqueline Soto-Herrera at jsoto@nahospital.org.