RUSH
Rush Copley Medical Center

## Rush Copley Medical Center


# Community Health Needs Assessment 2021

Prepared by Conduent
Healthy Communities Institute

CONDUENT

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# Executive Summary

## Introduction & Purpose

Rush Copley Medical Center is pleased to present its 2021 Community Health Needs Assessment (CHNA). As federally required by the Affordable Care Act, this report provides an overview of the methods and processes used to identify and prioritize significant health needs in Kane County. This CHNA was conducted as a collaborative Community Health Assessment (CHA) and CHNA process. As a part of the Kane Health Counts Collaborative, Rush Copley partnered with Conduent Healthy Communities Institute (HCI) to conduct thier 2021 CHNA.

The goal of this report is to offer a meaningful understanding of the most pressing health needs across Kane County, as well as to guide planning efforts to address those needs. Special attention has been given to the needs of vulnerable populations, unmet health needs or gaps in services, and input from the community. Additionally, a section has been added to this report that focuses on the COVID-19 pandemic and its impact on Kane County.

Findings from this report will be used to identify, develop and target initiatives to provide and connect community members with resources to address these health challenges in Kane County.

## Service Area

The Primary Service Area (PSA) for Rush Copley Medical Center encompasses 18 zip codes total. Five zip codes fall in Southern Kane County: 60505, 60506, 60507, 60538, and 60554, while six zip codes wall in Northern Kendall County: 60512, 60536, 60543, 60545, 60541, and 60560 as illustrated in Figure 1 below. The remining zip codes that comprise the Rush Copley PSA include 60502, 60504, 60503, 60519, 60548, 60552 and 60585 that fall within Kane or Kendall counties and overlap into other Illinois counties including DeKalb, Dupage, LaSalle and Will.

## Demographics

Rush Copley Medical Center's Primary Service Area (PSA) has a population of approximately 383,415 persons. By race, the majority of the population in Rush Copley's PSA identifies as White (67.1%). The Black/African American community makes up 8.2%, followed by Asians comprising 6.2% of the population.

By ethnicity, Rush Copley's PSA has a larger percentage of the population that identifies as Hispanic or Latino (33.5%) compared to Kane and Kendall Counties where 33.2% and 20.4% of the population identifies as Hispanic or Latino respectively.

By age, 27.5% of the population in Rush Copley's PSA are infants, children, or adolescents (age 0-17); another 61.8% are in the age 18 to 64, while 10.7% are age 65 and older.

## Methods for Identifying Community Health Needs

### Secondary Data

The secondary data used in this assessment were obtained and analyzed from Kane Health Counts' Community Dashboard http://www.kanehealthcounts.org/. This includes a comprehensive set of more than 200 community health and quality of life indicators covering over 26 topic areas. Indicator values for Kane County were compared to other counties in Illinois and nationwide to compare health topics and relative areas of need. Other considerations for health areas of need included trends over time, Healthy People 2020 targets, and disparities by age, gender, and race/ethnicity.

### Primary Data: Community Input

The needs assessment was further informed by: (1) focus groups hosted virtually with community members who have a fundamental understanding of Kane County's health needs and represent the broader interests of the community, and (2) a community survey distributed digitally throughout Kane County.

## Summary of Findings

The collaborative CHA/CHNA findings are drawn from an analysis of an extensive set of secondary data (200 indicators from national and state data sources), in-depth primary data from community leaders, non-health professionals, organizations that serve the community at large, vulnerable populations and/or populations with unmet health needs, as well as general members of the Kane County community.

Through a synthesis of the primary and secondary data the following top health needs were determined and listed in rank order from highest to lowest.

1. Mental Health and Mental Disorders
2. Immunizations and Infectious Diseases
3. Substance Abuse
4. Exercise, Nutrition, and Weight
5. Maternal, Fetal, and Infant Health
6. Teen and Adolescent Health
7. Older Adults and Aging
8. Other Chronic Diseases
9. Education
10. Environment
11. Public Safety
12. Transportation

### Disparities

The identification of disparities along race/ethnicity, gender, age, and geographic lines is important for informing and focusing strategies that will address the prioritized health needs. Primary and secondary data revealed significant community health disparities based on race/ethnicity, with Black/African American and Hispanic/Latino populations more negatively impacted than other groups in Kane County.

Furthermore, the data showed that older adults face increased health issues, while populations in certain geographic areas experience higher socioeconomic need and potentially poorer health outcomes.

## Prioritized Areas

On December 8, 2020, more than 70 representative members of the Kane County community came together to learn about the significant health needs identified through primary and secondary data analysis in a virtual session led by consultants from HCI. This session was followed by an online prioritization scoring exercise of each health topic based on how well they met the defined criteria. HCI calculated the results to come up with a ranked list of significant health needs. Kane Health Counts members met on December 15, 2020 to review the ranking while considering the criteria for prioritization. The following four health areas were approved as priority areas to address by the Kane Health Counts Executive Committee on January 15, 2021:

| Prioritized Health Needs |
|---|
| Behavioral Health (Mental Health and Substance Abuse) |
| Access to Health Services |
| Immunizations and Infectious Diseases |
| Exercise, Nutrition, and Weight |

## COVID-19 Impact Snapshot

At the time that Kane Health Counts began its collaborative CHA/CHNA process, Kane County was in the midst of dealing with the COVID-19 pandemic. The CHNA project team looked for additional sources of secondary data and gathered primary data to provide a snapshot of the impact of COVID-19 on Kane County between March 2020 and December 2020. More details of these findings are found in the "COVID-19 Impact Snapshot" section of this report.

## Conclusion

This report describes the process and findings of a comprehensive and collaborative community health assessment for the residents of Kane County, IL. The prioritization of the identified significant health needs will guide the community health improvement efforts of the Kane Health Counts collaborative. Following this process, the collaborative, inclusive of Rush Copley Medical Center, will outline how it plans to address the prioritized health needs.

# Introduction

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The goal of this report is to offer a meaningful understanding of the most pressing health needs across Kane County, as well as to guide planning efforts to address those needs. Special attention has been given to the needs of vulnerable populations, unmet health needs or gaps in services, and input from the community. Additionally, a section has been added to this report that focuses on the COVID-19 pandemic and its impact on Kane County.

Findings from this report will be used to identify, develop and target initiatives to provide and connect community members with resources to address these health challenges in Kane County.

**This report includes a description of:**

- **The community demographics and population served;**
- **The process and methods used to obtain, analyze and synthesize primary and secondary data;**
- **The significant health needs in the community, taking into account the needs of uninsured, low-income, and marginalized groups;**
- **The process and criteria used in identifying certain health needs as significant and prioritizing those significant community needs.**

## Kane Health Counts

In 2011, Kane County Health Department (KCHD) started a Collaborative Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) process. This process aimed to identify health priorities in the community and strategies to address them. Since then, KCHD has joined forces with five local hospitals, AMITA Mercy Medical Center, AMITA Saint Joseph Hospital, Northwestern Medicine Delnor Hospital, Rush Copley Medical Center, and Advocate Aurora Sherman, along with the INC Board, a mental health “708 Board” serving the southern part of Kane County and a number of community partners. This group comes together with a mutual interest in improving the health of Kane County residents. In 2014, this collaborative group was given the name Kane Health Counts.

This comprehensive community health assessment process is conducted every three years to identify the top health priorities Kane County. The Kane Health Counts collaborative works together to plan, implement and evaluate strategies that are in alignment with the identified health priorities. Together, the group strives to make Kane County the healthiest county in Illinois.

## Kane Health Counts Executive Committee Leaders

Tina Link, Manager of Community Outreach, Community Health/Volunteer Services Departments
Advocate Aurora Sherman Hospital

Maria Aurora Diaz, Regional Director of Nursing, Community Health Integration
AMITA Mercy and AMITA St. Joseph Hospitals

Dalila Alegria, Executive Director
INC Board

Karin Podolski, Director, Community Health Services
Northwestern Medicine Delnor Hospital

Alex Pope, Vice President, Philanthropy & Community Engagement
Rush Copley Medical Center

Mariana Martinez, Community Health Outreach Coordinator
Rush Copley Medical Center

## About Rush University System for Health

Driven by discovery, innovation and a deep responsibility for the health of our communities, Rush is a national leader in outstanding patient care, education, research, community partnerships and empowering a new generation of health care providers.

Rush comprises Rush University Medical Center, Rush Copley Medical Center, Rush Oak Park Hospital and Rush University, as well as an extensive providers network and numerous outpatient care facilities.

**Our Vision**
Rush will be the leading academic health system in the region and nationally recognized for transforming health care

**Our Mission**
The mission of Rush is to improve the health of the individuals and diverse communities we serve through the integration of outstanding patient care, education, research and community partnerships.

## About Rush Copley Medical Center

Rush Copley Medical Center, located in Aurora, Illinois, has provided quality health care to the residents of greater Fox Valley for more than 130 years. The 210-bed hospital has been recognized with "A" safety scores from the Leapfrog Group, earned Magnet accreditation from the American Nurses Credentialing Center and is proud to be a designated leader in LGBTQ Healthcare Equality by the Human Rights Campaign Foundation. With nearly 500 physicians on staff in more than 60 specialties, Rush Copley is the destination for excellence in health care with an academic connection to the Rush University System for Health.

**Hospital Leadership**
John Diederich, MA, MBA, FACHE
President and CEO
Rush Copley Medical Center

**Community Benefit Team**

Alexander F. Pope, Vice President/Chief Development Officer
Mariana M. Martinez, CHES® Community Health Outreach

## Primary Service Area

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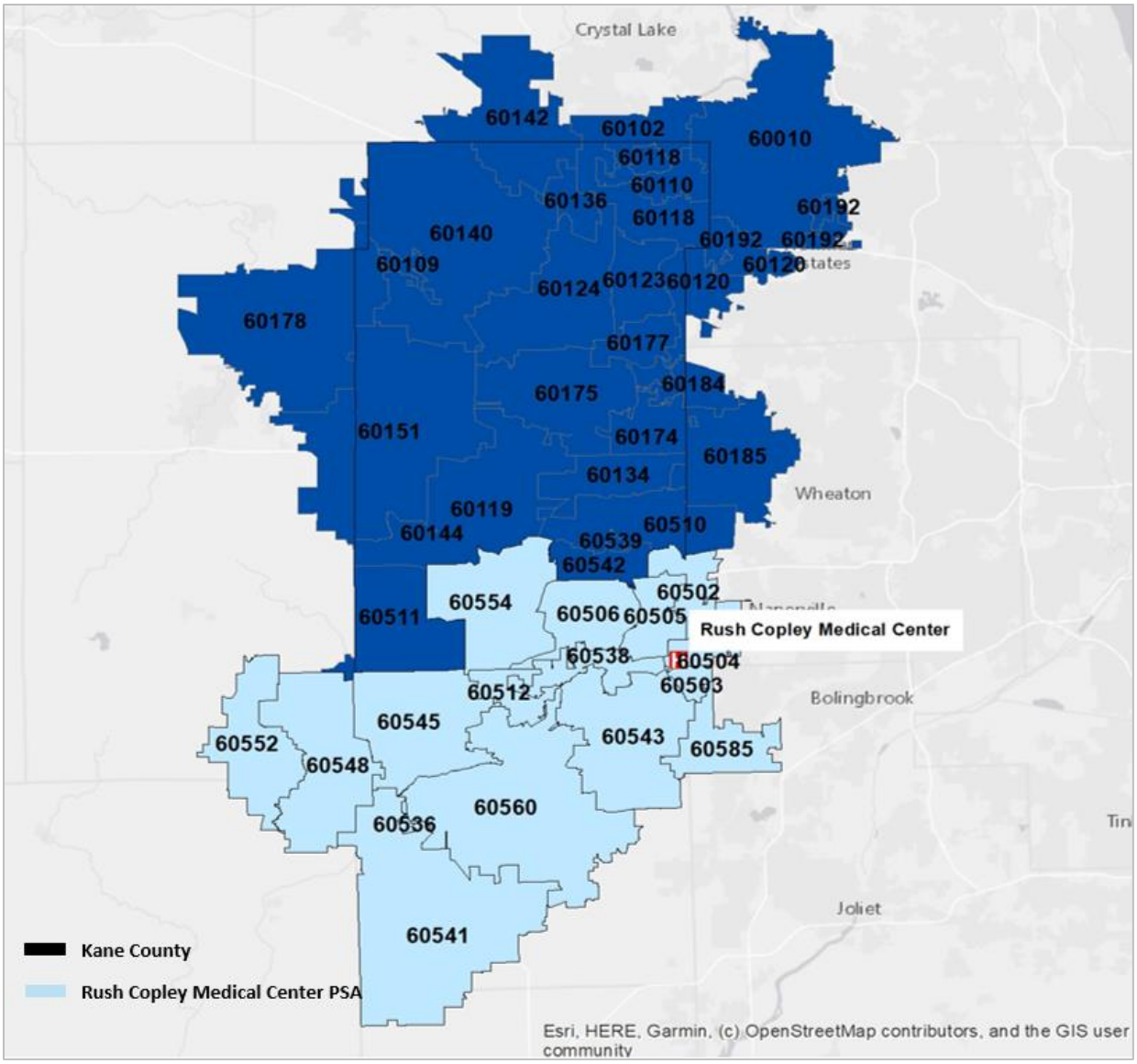
**FIGURE 1. RUSH COPLEY MEDICAL CENTER PRIMARY SERVICE AREA (PSA)**



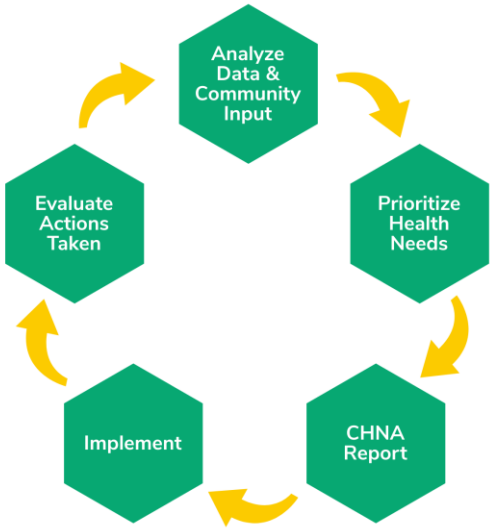
## Consultants

Kane Health Counts collaborative members commissioned Conduent Healthy Communities Institute (HCI) to support report preparation for its 2021 collaborative CHA/CHNA. HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems, and implementing performance evaluation processes. To learn more about Conduent Healthy Communities Institute, please visit https://www.conduent.com/community-population-health. The following HCI team members were involved in the development of this report: Ashley Wendt, MPH – Public Health Consultant, Courtney Kaczmarsky, MPH – Public Health Consultant, Traci Van, Senior Advisor, Zack Flores – Project Coordinator, Era Chaudhry, MPH – Research Associate and Margaret Mysz, MPH – Research Associate.

# Evaluation of Progress Since Prior CHNA

The CHNA process should be viewed as a three-year cycle. An important piece of that cycle is revisiting the progress made on priority health topics set forth in the preceding CHNA. By reviewing the actions taken to address a priority health issue and evaluating the impact those actions have made in the community, it is possible to better target resources and efforts during the next round of the CHNA cycle.

FIGURE 2. THE CHNA CYCLE




## Priority Health Needs from Preceding CHNA

Kane Health Count's Prioritized Health Topics for years 2018-2020 were:

- Behavioral Health
- Chronic Diseases
- Income and Education

### Behavioral Health

| Goal: By 2030, improve the mental health of Kane County residents. | | | |
|---|---|---|---|
| | **Baseline** | **Current** | **Status Update** |
| **Outcome Objective** | | | |
| By August 31, 2021, reduce the number of emergency department visits related to behavioral health by 5.0%. | 108.01 per 10,000 residents | 108 | |
| **Impact Objectives** | | | |
| By Aug. 31, 2020, increase the proportion of adults aware of mental health resources by 15%. | 60.9% | 61.9 % (2018) | Efforts underway to increase traffic to website and coordinate services. |
| By Aug. 31, 2020, reduce the proportion of adults who could not get mental health resources when needed in the past year to 2.5% (or by 11%). | 2.8% | 7.6% (2018) | Team is working to implement online referral source. |
| By Aug. 31, 2020, reduce the proportion of adults that experience "fair" or "poor" mental health by 15%. | 10.5% | 17.8% (2018) | Focus on worksite and primary care contact points to help people with coping skills |

Work to achieve these objectives was implemented in three main areas: Community Collaboration, Public Education, and Service Coordination.

**Community Collaboration:**
In and effort to gain a better understanding of local collaborative efforts related to behavioral health, organizations involved in efforts to reduce the burden of mental health and substance abuse were invited to present to the Kane Health Counts Behavioral Health Task Force at each of their meetings.

**Public Education:**
The community resource web portal was updated in 2019 with the goal of expanding its use. The Behavioral Health Council supported and promoted cross-sector trainings as well that included Lay Person's Guide to Mental Health, Mental Health First Aid (Youth and Adult) and Crisis intervention Training (CIT) and Applied Suicide Intervention Skills Training (ASIST). Finally, in order to increase funding and support for education a Children's Mental Health Initiative grant and a NACCHO Opioid grant were completed and submitted in 2019. Funding for substance use education, parent engagement and provider training were secured through grant funds in 2019 to be implemented in 2020.

**Service Coordination:**
As of the end of 2019, a new web-based referral system was active and on track to be used in 2020. The system being utilized is IRIS and will allow providers to make secure referrals from point to point with tracking at each step of the process. This new system will ensure all strategies in Service Coordination are tracked and about to be met.

## Chronic Diseases

| **Goal: By 2030, reduce chronic disease in Kane County** | | | |
|---|---|---|---|
| | **Baseline** | **Current** | **Status Update** |
| **Outcome Objective** | | | |
| By August 31, 2030, reduce Chronic disease in Kane County | - | - | |
| By August 31, 2021, decrease the number of hospitalizations due to heart disease by 5%. | 66.4 per 10, residents, 2014 | | |
| **Impact Objectives** | | | |
| By August 31, 2021, increase the % of Kane County adults consuming 5+ servings of fruits and/or vegetables a day by 2.5%. | 17.3% (2018) | | |
| By August 31, 2021, decrease the % of Kane County adults reporting no leisure-time physical activity in the past month by 2.5 %. | 27.7%, 2018 | | |

Work to achieve these objectives was implemented in two main areas: 1) Nutrition focusing on increasing access and consumption of healthy foods and 2) Physical Activity focusing on the enhancement of the built environment.

**Nutrition:**
The first strategy for increasing access and consumption of healthy foods was though increasing the availability of healthy foods. Specific activities within this strategy included improving community mapping on the "mapped resources" section of the Kane Health Counts website to include farmers markets, community supported agriculture (CSAs), community gardens, and food pantries. Health messaging to promote eating fresh fruits and vegetables and accessing SNAP benefit registration were also included.

The second strategy to increase access and consumption of healthy foods included improving workplace environments. Specific activities within this strategy included promotion of increased participation in the Kane County workplace recognition program, creating a chronic disease resource toolbox and link on the Kane Health Counts website as well as creating and promoting specific health challenges within the workplace.

**Physical Activity:**
The first strategy for enhancing the built environment was a focus on improving sidewalks. Specific activities within this strategy included: 1) making sidewalks accessible and open for walking and biking, 2) encouraging municipalities and schools to apply for funding opportunities to improve infrastructure, 3) implementation of a bike share/bike rental program in Kane County, and 4) sponsoring a "Walk to School Day" and "Bike to Work Week".

The second strategy for enhancing the built environment was a focus on improving trail systems. One specific activity within this strategy was the addition and upgrade of trail maps and apps to be linguistically appropriate which included the addition of Spanish versions of these resources. Other activities included supporting and promoting physical activities challenges, promoting programs like Gail Borden Walking book club, and promoting bike shop and bike club groups.

The third strategy for enhancing the built environment was an additional focus on workplace environments. One specific activity included creating a toolbox for workplaces to help improve employee health. An additional activity included encouraging workplaces to advocate for bike stations and bike share program stations near their buildings.

The final strategy for enhancing the built environment was a focus on alternative transportation. This included promoting and raising awareness about Ride in Kane to townships and agencies across the county.

## Income and Education

| **Goal: By August 31, 2030, reduce the proportion of Kane County residents living at or below 100% of poverty by 25%.** | | | | |
|---|---|---|---|---|
| | **Baseline** | **Current** | **Target** | **Status Update** |
| **Outcome Objective** | | | | |
| By August 2030, reduce the proportion of Kane County residents living at or below 100% of poverty by 25% | 10.7% SAIPE (2014) | 10.4% (2013-2017) Kane Health Counts | 8.025% | Trending down as desired. |
| By August 31, 2022, improve the 4-year | 3 districts are under 87% | SD131-67% SD129-82% | SD131 72% SD129 87% Elgin | Graduation rates are |

| | | | | |
|---|---|---|---|---|
| graduation rate of all public school districts with a baseline rate <87% by 5 percentage points | SD129 79%<br>SD131 62.8%<br>U-46-Elgin 80.2%<br>Larkin 79.1%<br>Streamwood 87%<br>(Illinois State Board of Education, 2015) | U-46-Elgin 76%,<br>Larkin 73%,<br>Streamwood 86%<br>(2019 figures) | 81% Larkin 78% Streamwood 91% | trending upwards for districts 131 & 129 when compared to the 2013-2014 figures used in the Environmental Scan. U-46 is trending downwards. |
| **Impact Objectives** | | | | |
| By June 30, 2021, demonstrate active, collective community engagement in improving income and education as evidenced by a career exploration communication campaign that involves 50% of middle schools. | None available | - | 50% | Action team has begun Newsflash to begin engaging the middle schools. |

Work to achieve these objectives was implemented through the research, design, and implementation of a career exploration campaign targeting middle school youth and their parents in Kane County.

The first strategy to improve and address challenges with income and education in Kane County focused on engage youth and parents to give input and assistance in developing a middle school career exploration campaign messaging.

The second strategy focused on implementing the career exploration campaign targeting middle school youth and their parents by conducting a series of communication campaign cycles that we evaluate and improve or expand in subsequent cycles.

## Community Feedback from Preceding CHNA & Implementation Plan

Rush Copley's 2018-2020 CHNA and Implementation Plan were made available to the public and open for public comment via their website. No comments were received on either document at the time this report was written.

# Community Health Needs Assessment Methodology

## Overview

Two types of data were analyzed for this CHNA: primary and secondary data. Each type of data was analyzed using a unique methodology. Findings were organized by health topics. These findings were then synthesized for a comprehensive overview of the health needs in Kane County.

## Secondary Data Sources & Analysis

Secondary data used for this assessment were collected and analyzed with the Healthy Communities Institute (HCI) Community Dashboard — a web-based community health platform developed by Conduent Community Health Solutions. The Community Dashboard brings data, local resources, and a wealth of information to one accessible, user-friendly location. It includes over 219 community indicators, hospitalization/ER indicators, and behavioral health indicators covering over 25 topics in the areas of health, determinants of health, and quality of life. The data are primarily derived from state and national public secondary data sources. The value for each of these indicators is compared to other communities, nationally or locally set targets, and to previous time periods.

HCI's Data Scoring Tool® was used to systematically summarize multiple comparisons across the Community Dashboard in order to rank indicators based on highest need. For each indicator, the Kane County value was compared to a distribution of Illinois and US counties, state and national values, Healthy People 2020, and significant trends. Each indicator was then given a score based on the available comparisons. These scores range from 0 to 3, where 0 indicates the best outcomes and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected from other communities, and changes in methodology over time. These indicators were grouped into topic areas for a higher-level ranking of community health needs.

**FIGURE 3: SECONDARY DATA SCORING**

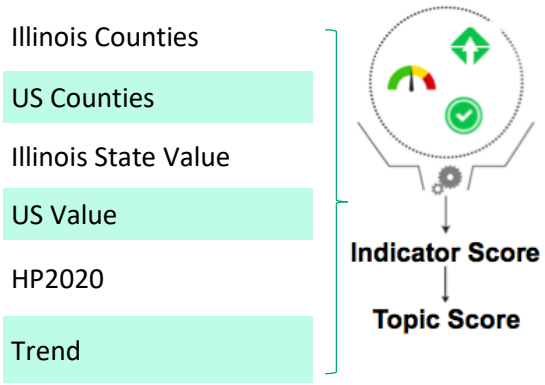



**TABLE 1: SECONDARY DATA TOPIC SCORING RESULTS**

| Health and Quality of Life Topics | Score |
|---|---|
| Other Chronic Diseases | 1.86 |
| Environment | 1.45 |
| Transportation | 1.43 |
| Older Adults & Aging | 1.40 |
| Access to Health Services | 1.38 |
| Immunizations & Infectious Diseases | 1.36 |
| Substance Abuse | 1.35 |
| Maternal, Fetal & Infant Health | 1.32 |
| Education | 1.29 |
| Teen & Adolescent Health | 1.27 |
| Public Safety | 1.25 |

Table 1 shows the health and quality of life topic scoring results for Kane County, with Other Chronic Diseases as the poorest performing topic area, followed by Environment. The top eleven topic areas were those that scored over the 1.25 threshold in data scoring. Health topic areas with fewer than three indicators were considered a data gap. Data gaps were specifically assessed as a part of the key informant interviews to ensure that, where the secondary data fell short, primary data could provide a more accurate picture of that particular health topic area.

Please see Appendix A for further details on the quantitative data scoring methodology.

## Primary Data Collection & Analysis

To expand upon the information gathered from the secondary data, HCI collected community input as well. Primary data used in this assessment consisted of community focus groups and an online community survey that was available in English and Spanish.

Given this CHNA was conducted during the COVID-19 pandemic, primary data collection methods were conducted in a way to maintain social distancing and protect the safety of participants by eliminating in-person data collection.

As a critical aspect of the primary data collection, community members were asked to list and describe resources available in the community. Although not reflective of every resource available in the community, the list can help NMDH build partnerships so as not to duplicate, but rather support existing programs and resources. This resource list is available in Appendix C.

### Focus Groups

The purpose of holding focus groups during the CHNA process is to gain more in-depth information on perceptions, insights, attitudes, experiences, or beliefs from community stakeholders. The data collected through the focus group process provides adjunct information to the quantitative data collection methods in a mixed methods approach. While the data collected is useful in gaining insight into a topic that may be more difficult to gather through other data collection methods, it is important to note that the information collected in an individual focus group is not necessarily representative of other groups.

The project team developed a focus group guide made up of a series of questions and prompts about the health and well-being of residents in Kane County (see Appendix B). Community members were asked to speak to barriers and assets to their health and access to healthcare. Virtual focus groups were hosted across Kane County during October and November 2020. They lasted approximately 60 minutes and were conducted via video conference with a phone only option for those with limited or no access to a reliable device or internet. Trained facilitators implemented techniques to ensure that everyone was able to participates in the discussion. Some focus groups were specifically hosted in Spanish for the Hispanic/Latino community in Kane County. These focus groups were facilitated by bilingual facilitators leveraging the same tool implemented in English only focus groups.

Participants were recruited for the focus group sessions through the Kane Health Counts network of community partner organizations. Specific efforts were made to recruit participants from the African American, Latino/Hispanic, and Senior segments of the Kane County population. Ten focus group sessions were organized between October and November 2020 and although registration was initially strong, sessions had varying levels of attendance. COVID-19 likely had an impact on resident's participation in the focus group sessions. Table 2 provides an overview of the individual sessions as well as number of participants for each of the focus groups.

TABLE 2: KANE COUNTY FOCUS GROUP DISCUSSIONS

| Focus Group Discussion | Number of Sessions | Facilitation Language | Total Community Participants |
|---|---|---|---|
| African American Health | 2 | English | 14 |
| Older Adult/Senior Health | 3 | English | 33 |
| Hispanic/Latino Health | 1 | Spanish | 12 |

** 10 Focus Groups were held, 6 sessions had attendees present*

The project team captured detailed transcripts of the focus group sessions. The text from these transcripts were analyzed using the qualitative analysis program Dedoose®[1]. Text was coded using a pre-designed codebook, organized by themes, and analyzed for significant observations. The findings from the qualitative analysis were combined with the findings from other data sources and incorporated into the Data Synthesis, Prioritized Health Needs, and COVID-19 sections of this report.

### Themes Across All Focus Groups

Table 3 below summarizes the main themes and topics that trended across all or almost all focus group conversations.

TABLE 3: KANE COUNTY FOCUS GROUP THEME SUMMARY

| Main Theme | Sub-topics | Contributing Focus Group(s) |
|---|---|---|
| Exercise, Nutrition and Weight | • Education for parents/families<br>• Children's sedentary lifestyles and nutrition in schools<br>• Health behavior and social environment influence on eating habits; cultural influences | African American and Hispanic/Latino Focus Groups |
| Access to Healthcare Services | • Language barriers<br>• Underinsured and affordability (costs associated with services)<br>• Preventative care for older adults; how to avoid emergent situations by intervening earlier (includes access to medications)<br>• Navigation and education for minority racial or ethnic groups<br>  ○ Lack of focus on men's health in the African American community | All Focus Groups |
| Substance Abuse | • Focus on COVID-19 has diverted attention from drug use issues in the community (ex. heroin/opioid problem) | Older Adults and Hispanic/Latino Focus Groups |

[1] Dedoose Version 8.0.35, web application for managing, analyzing and presenting qualitative and mixed method research data (2018). Los Angeles, CA: SocioCultural Research Consultants, LLC www.dedoose.com

| | | |
|---|---|---|
| | • Teen and adolescent use of substances; social pressure, connection to bullying and self-esteem | |
| Mental Health | • Anxiety and Stress for parents/families with children<br>• Mental health for older adults; impacts of social isolation due to aging issues<br>• Resources in the community; lack of availability and navigation/education about services available | All Focus Groups |

Appendix B provides a more detailed report of the main themes that trended across the individual focus group conversations.

## Community Survey

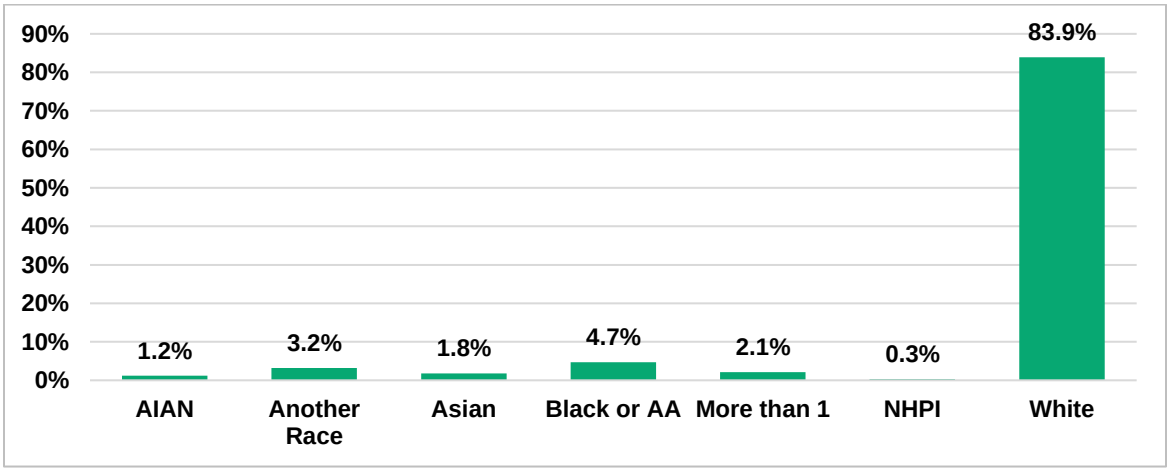
Another form of community input collected was via an online community survey that was available in English and Spanish from October 3, 2020 through November 13, 2020. HCI partnered with Claritas to digitally market, distribute, and collect responses for the community survey. The survey consisted of 47 questions related to top health needs in the community, individuals' perception of their overall health, individuals' access to health care services, as well as social and economic determinants of health. Survey respondents engaged with the community survey through three distinct channels: (1) online panels executed by Claritas, (2) a social media campaign executed by Claritas, and (3) email invites and marketing flyers distributed by Kane Health Counts members and its partner organizations to Kane County residents. To incentivize respondents and thank them for their time, online panelists were offered points or other game currency by the respective panel vendor, set in accordance with the survey length, survey topic, and the relative difficulty of obtaining the required sample, while social media respondents were offered a $5 Amazon gift card. In both cases, only those who qualified and completed the survey were awarded the incentive. Additionally, Kane Health Counts and their community partners marketed and shared the survey across the county for community participation.

The community survey was promoted across Kane County from October 03, 2020 to November 13, 2020. A total of 1,543 responses were collected. The following charts and graphs illustrate the demographics of community survey respondents.

### Demographic Profile of Survey Respondents

As shown in Figure 4, White or Caucasian community members comprised the largest percentage of survey respondents at 83.9%, followed by Black/African American community members at 4.7%.

FIGURE 4: RACE OF COMMUNITY SURVEY RESPONDENTS




Nearly 12.5% of survey respondents identified as Hispanic or Latino, while the majority, 85.6% identified as non-Hispanic/Latino (Figure 5).

FIGURE 5: ETHNICITY OF COMMUNITY SURVEY RESPONDENTS

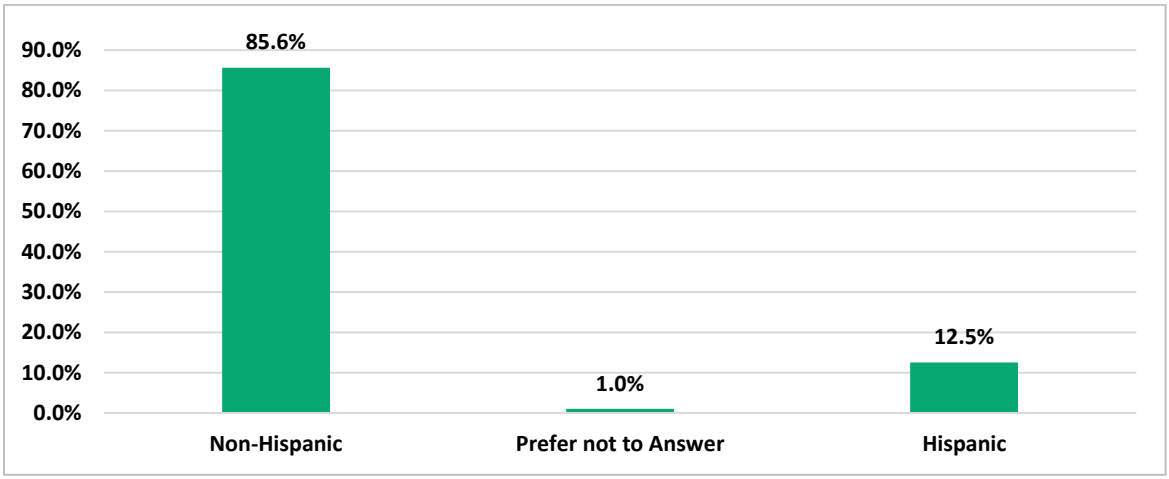
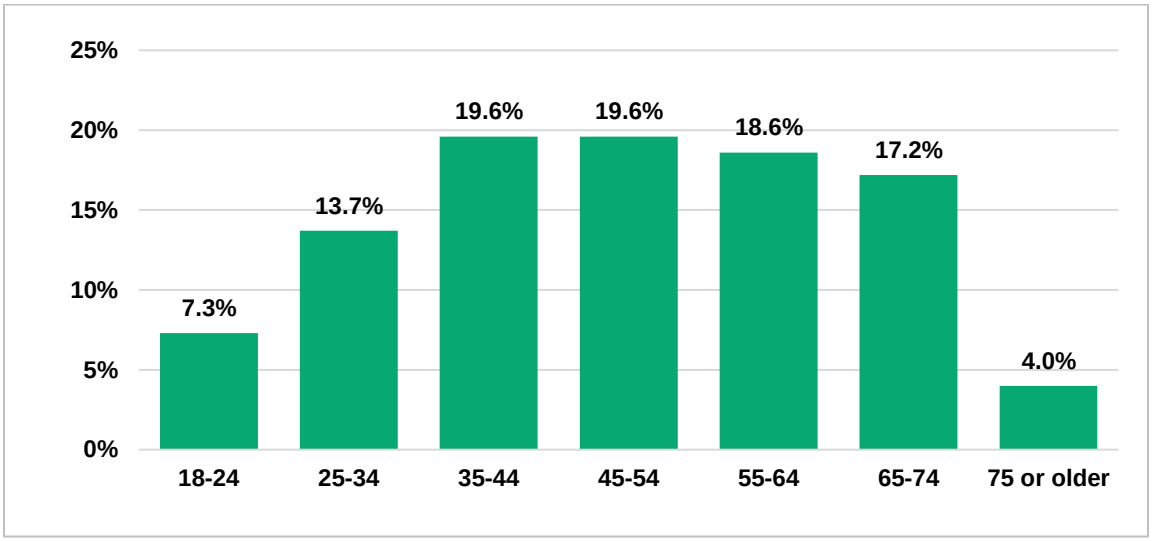


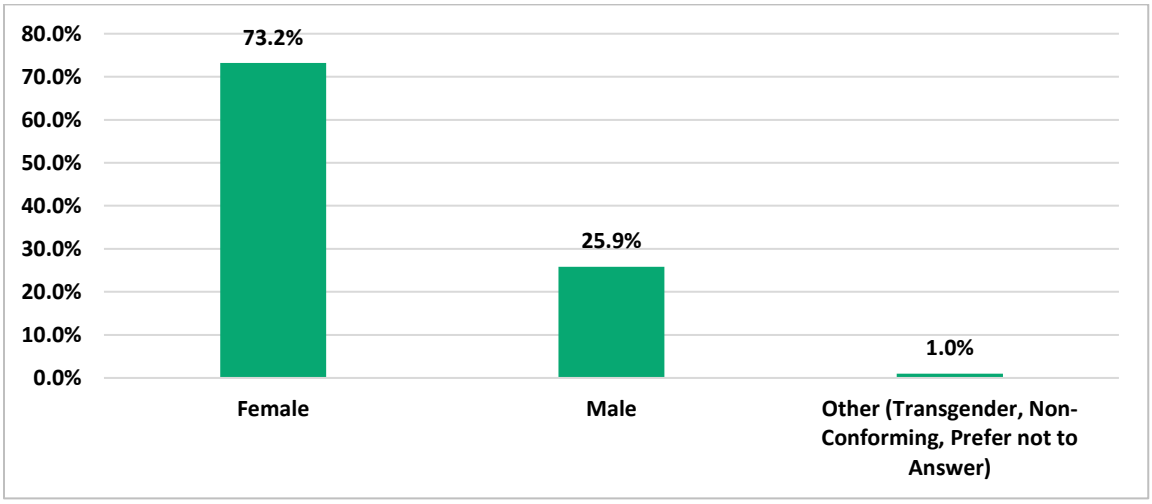

Figure 6 shows the age breakdown of survey respondents. The 35-44 and 45-54 age groups comprised the largest portions of survey respondents, at 19.6% each.

FIGURE 6: AGE OF COMMUNITY SURVEY RESPONDENTS



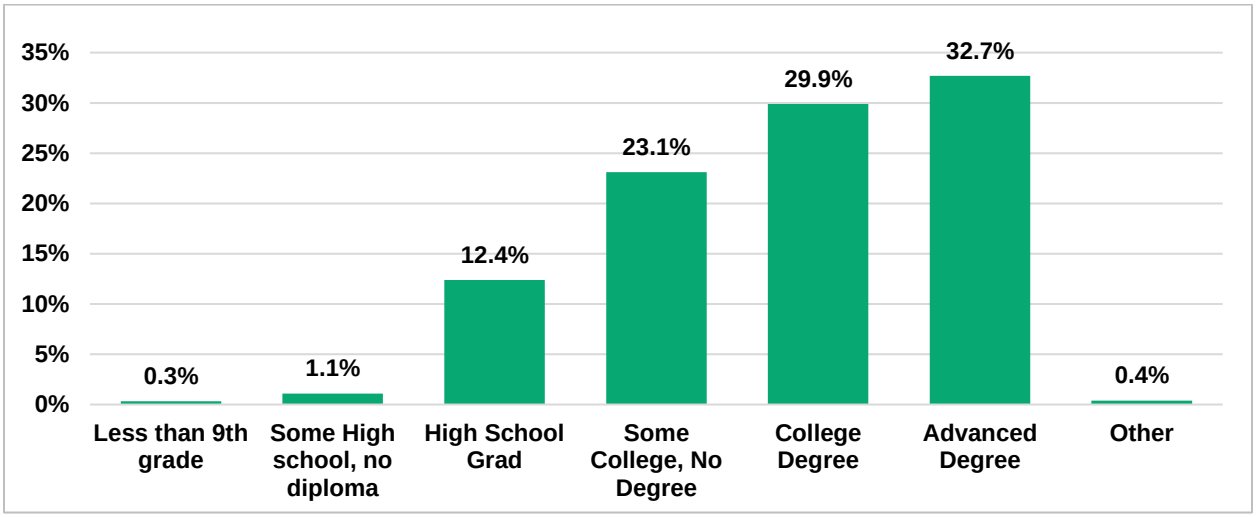

The majority of survey respondents identified as female at 73.2%. An additional 25.9% identified as male, and 1.0% as other (transgender, non-conforming or prefer not to answer), as shown in Figure 7.

FIGURE 7: SEXUAL IDENTITY OF COMMUNITY SURVEY RESPONDENTS




As shown in Figure 8, survey respondents were more likely to have a bachelor's degree or higher (62.6%).

FIGURE 8: EDUCATION OF COMMUNITY SURVEY RESPONDENTS




## Community Survey Analysis Results

To ensure the survey was more representative of the population of Kane County, a weighting procedure was applied. A statistical analysis software (SAS) was used for the analysis. A sample-balancing procedure was used giving each respondent a weight based on respondent-reported demographics within the survey compared to the overall proportion in Kane County[23]. Respondent answers were weighted based on age, education level, sex, and race/ethnicity resulting in 1515 respondents. Survey results moving forward in this report are based on the weighted survey answers (N = 1515).

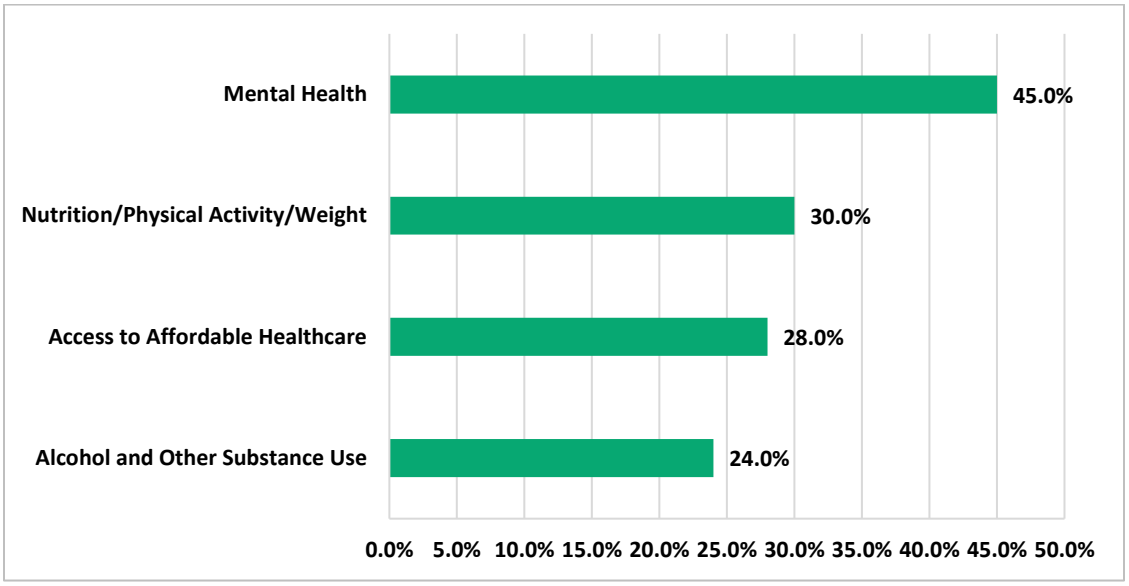
In the survey, participants were asked about important health issues in the community and which were the most important quality of life issues to address in Kane County. The top responses for these questions are shown in Figures 9 and 10. Additionally, questions were included to get feedback about the impact of COVID-19 on the community, which is included in the "COVID-19 Impact Snapshot" section of this report.

Mental health was ranked by survey respondents as the most pressing health problem (45.0% of respondents), followed by Nutrition/ Physical Activity/Weight (30.0%), Access to Affordable Healthcare (28.0%) and Alcohol and Other Substance Use (24.0%).

[2] Izrael, D., S.W. Ball, and M. P. Battaglia. 2017. Tips and Tricks for Raking Survey Data with Advanced Weight Trimming. SESUG SD-62-2017.

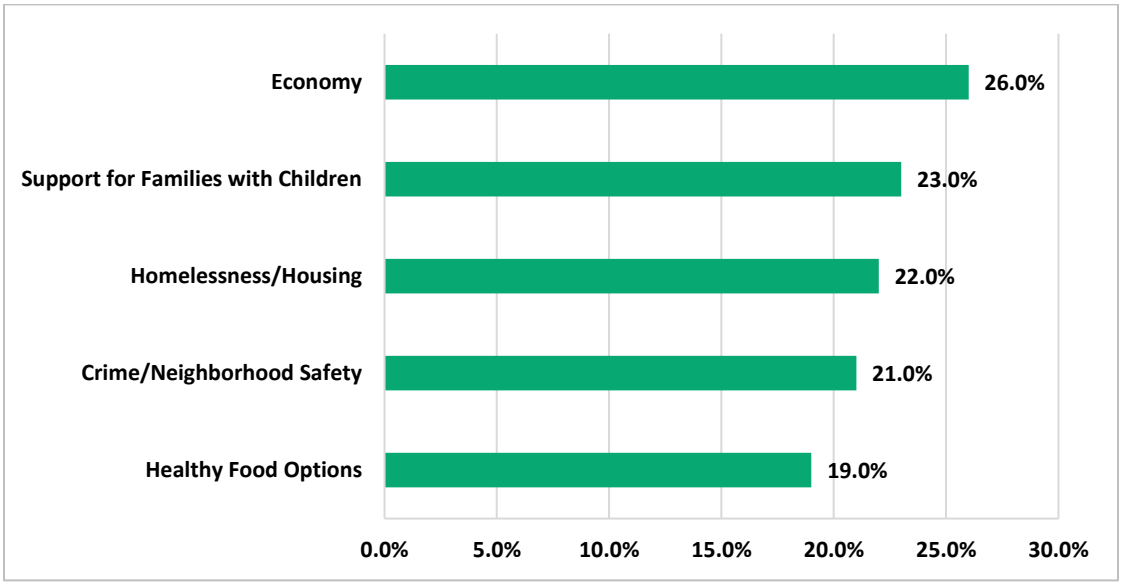
[3] Izrael, D. S.W. Ball, M.P. Battaglia (2016) SAS (9.4) [Source code]. https://www.abtassociates.com/sites/default/files/files/Insights/Tools/rake_and_trim_G4_V5.sas

FIGURE 9: MOST IMPORTANT COMMUNITY HEALTH ISSUES




As shown in Figure 10, Economy was ranked by survey respondents as the most urgent quality of life issue in Kane County (26.0% of survey respondents), followed by Support for Families with Children (23.0%), Homelessness/Housing (22.0%), Crime/Neighborhood Safety (21.0%) and Healthy Food Options (19.0%).

FIGURE 10: MOST URGENT QUALITY OF LIFE ISSUES TO ADDRESS IN KANE COUNTY




## Data Considerations

Several limitations of the data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas,

within each topic there is a varying scope and depth of secondary data indicators and primary data findings.

Regarding the secondary data, some health topic areas have a robust set of indicators, but for others there may be a limited number of indicators for which data is available. The Index of Disparity[4], used to analyze the secondary data, is also limited by data availability from data sources. In some instances, there are no subpopulation data for some indicators, and for others there are only values for a select number of race/ethnic groups.

For the primary data, the breadth of findings is dependent upon who opted to participate in the focus groups. Additionally, the digital community survey was a convenience sample, which means results may be vulnerable to selection bias and make the findings less generalizable. In order to make the survey more representative, a weighting procedure was performed in SAS 9.4. This statistical procedure assigned a weight to each participant based on their unique combination of age, education, sex, race and ethnicity. A smaller weight is given to participants who responded more frequently than expected, while larger weights are given to those that were under-represented, based on the Kane County demographics.

For all data, efforts were made to include a wide a range of secondary data indicators and community member voices.

## Prioritization

In order to better target activities to address the most pressing health needs in the community, Kane Health Counts convened a group of community leaders to participate in a presentation of data on significant health needs facilitated by HCI. Following the presentation and question session, participants were given access to an online link to complete a scoring exercise to rank the significant health needs based on a set of criteria. The process was conducted virtually in order to maintain social distancing and safety guidelines related to the COVID-19 pandemic.

Kane Health Counts joint CHA/CHNA planning committee and the Kane Health Counts Executive Committee reviewed the scoring results of the significant community needs and determined prioritized health needs based on the same set of criteria used in the scoring exercise.

### Process

An open invitation to participate in the Kane Health Counts joint CHA/CHNA data synthesis presentation and virtual prioritization ranking activity was extended across Kane County in the weeks preceding the meeting held on December 8, 2020. A total of 85 individuals representing local hospital systems, health department, educational institutions as well as community-based organizations and non-profits registered for the event. Sixty-five of those registered attended the virtual presentation and of these, 35 submitted feedback to the online prioritization ranking activity. A full list of participants can be found in Appendix B.

On December 8, 2020 over 60 community members from Kane County including members from Kane Health Counts, community partners, and other community leaders were virtually convened. During this meeting, the group reviewed and discussed the results of HCI's primary and secondary data analyses leading to the preliminary significant health needs discussed in detail in the data synthesis portion of this

[4] Pearcy, J. & Keppel, K. (2002). A Summary Measure of Health Disparity. Public Health Reports, 117, 273-280.

report. From there, participants were given three days to access an online link to score each of the significant health needs by how well they met the criteria set forth by Kane Health Counts.

The criteria for prioritization included:

- Scope & Severity: Gauges the magnitude of each health issue.
- Ability to Impact: The perceived likelihood for positive impact on each health issue.

The group also agreed that root causes, disparities, and social determinants of health would be considered for all prioritized health topics resulting from the prioritization.

Participants scored each health area against each criterion on a scale from 1-3 with 1 meaning it did not meet the given criterion, 2 meaning it met the criterion and 3 meaning it strongly met the criterion. In addition to considering the data presented by HCI in the presentation and on the health topic note sheet, participants were encouraged to use their own judgment and knowledge of the community in considering how well a health topic met the criteria.

Completion of the online exercise resulted in a numerical score for each health need that correlated with how well that particular need met the criteria for prioritization. HCI downloaded the online results, calculated the scores, and then ranked the significant health needs according to their topic scores, with the highest scoring health need receiving the highest priority ranking.

## Prioritized Significant Health Needs

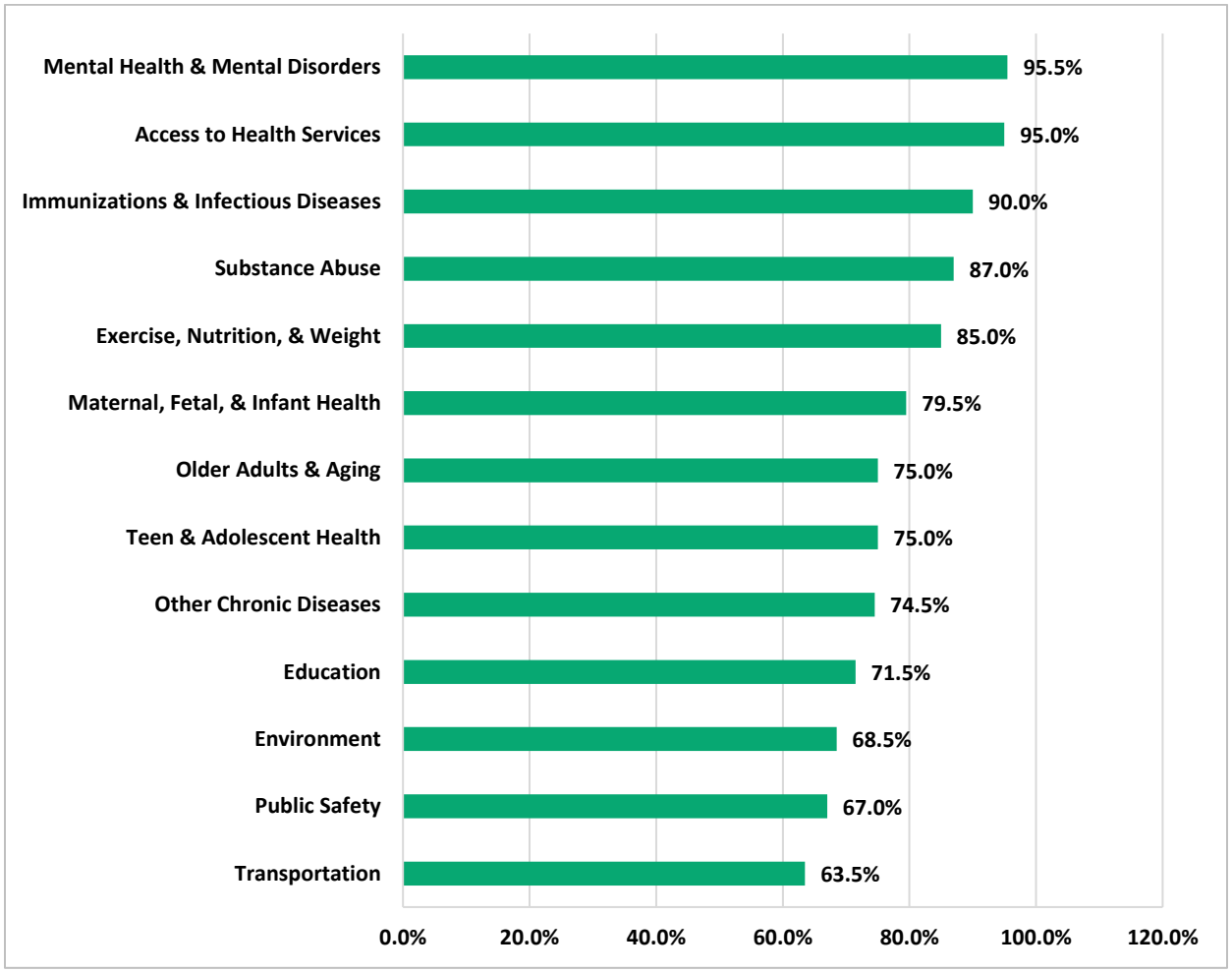
The aggregate ranking can be seen in Figure 11 below. Kane Health Counts' joint CHA/CHNA planning committee and the Kane Health Counts Executive Committee reviewed the scoring results of the significant community needs and determined prioritized health needs based on the same set of criteria used in the scoring exercise. After combining the prioritized health areas of Mental Health and Substance Abuse into the broader category of Behavioral Health, three additional prioritized health needs were included in the final list. The four priority health areas that will be considered for subsequent implementation planning are:

| Prioritized Health Needs |
|---|
| Behavioral Health (Mental Health & Substance Abuse) |
| Access to Health Services |
| Immunizations & Infectious Diseases |
| Exercise, Nutiriton, & Weight |

A deeper dive into the primary data and secondary data indicators for each of these four priority health topic areas is provided later in this report. This information highlights how each issue became a high priority health need for Kane Health Counts. The majority of these health topic areas are consistent with

the priority areas that emerged from the previous CHNA process. Kane Health Counts plans to build upon these efforts and continue to address these health needs in its upcoming Implementation Strategy.

**FIGURE 11: SIGNIFICANT HEALTH NEEDS PRIORITIZATION RESULTS**




## Community Survey Analysis by County Planning Areas

Community survery results for data relevant to the four prioritized health needs were also analyzed by geography for Kane County's North, Central, and South Planning Areas as designated by the Kane County Health Department. The Primary Service Area of Rush Copley within Kane County falls within the South Planning Area. Results of this more focused analysis will be presented in the Data Synthesis Section later in the report.

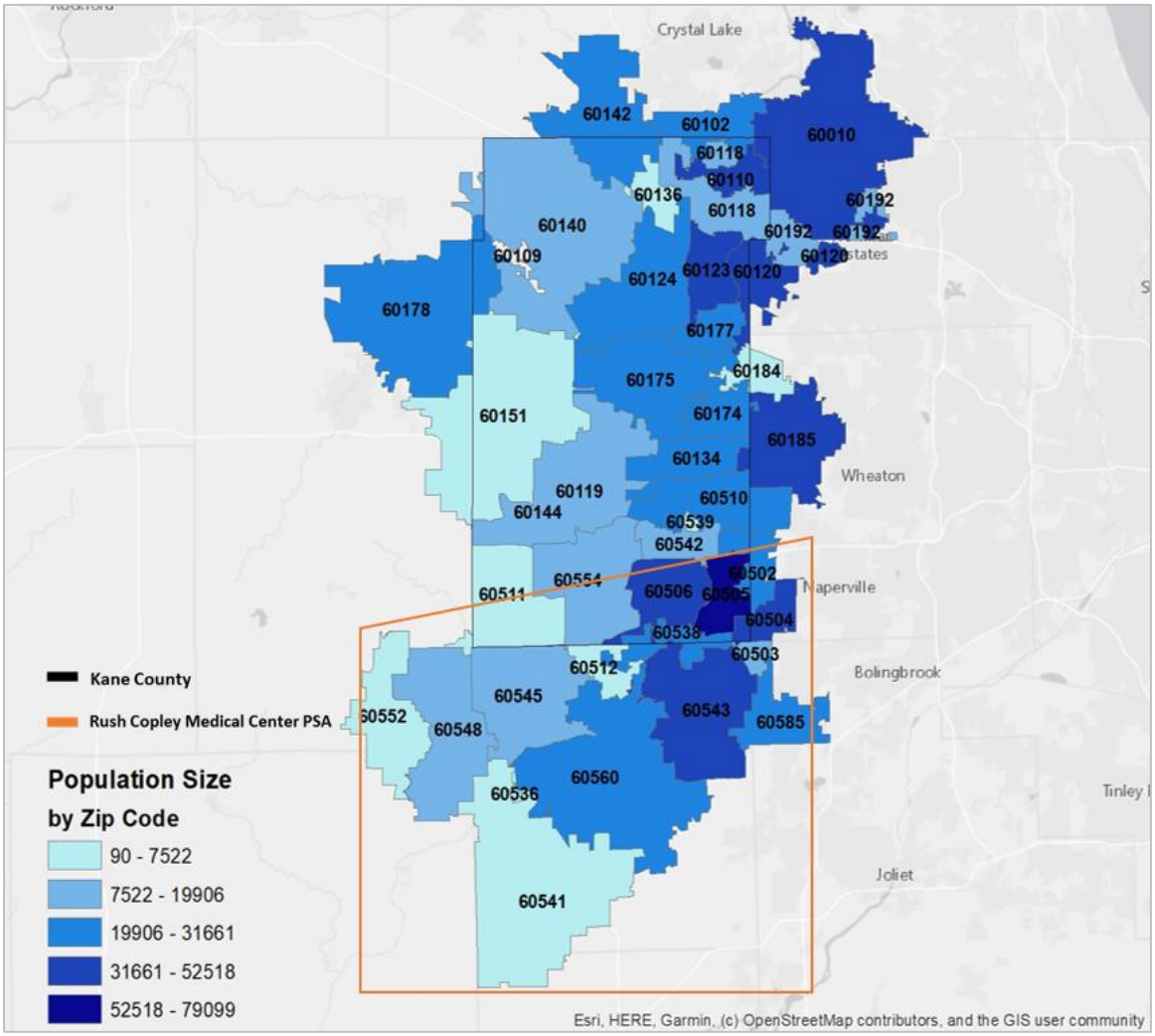
# Demographics

The following section explores the demographic profile of Rush Copley's Primary Service Area (PSA) in comparison to Kane County. The demographics of a community significantly impact its health profile. Different race/ethnic, age and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. All demographic estimates are sourced from Claritas Pop-Facts® (2020 population estimates) and American Community Survey one-year (2019) or five-year (2014-2018) estimates unless otherwise indicated.

## Population

According to the Claritas Pop-Facts 2020 Population Estimates, Rush Copley Medical Center's Primary Service Area (PSA) has a population of approximately 383,415 persons. Figure 12 shows the population size by each zip code within Kane County and Rush Copley Medical Center Primary Service Area with the darkest blue representing the zip codes with the largest population.

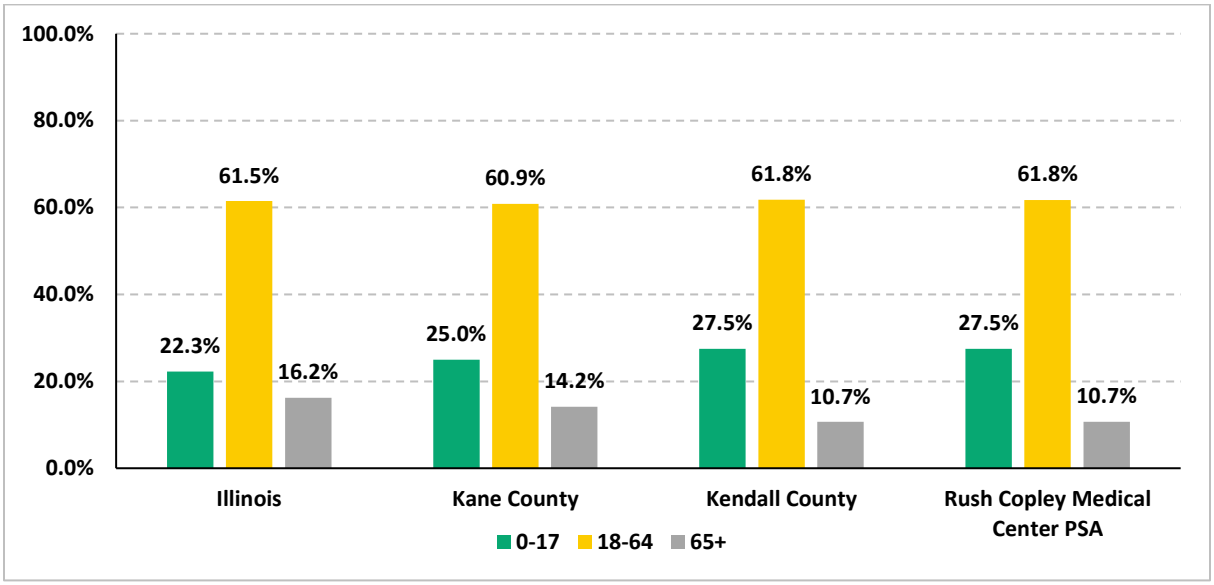
**FIGURE 12. POPULATION SIZE BY ZIP CODE**



## Age

Figure 13 shows the Rush Copley Medical Center PSA population by age group along with Kane County, Kendall County, and Illinois state values. In Rush Copley's PSA, 27.5% of the population are infants, children, or adolescents (age 0-17); another 61.8% are in the age 18 to 64, while 10.7% are age 65 and older.

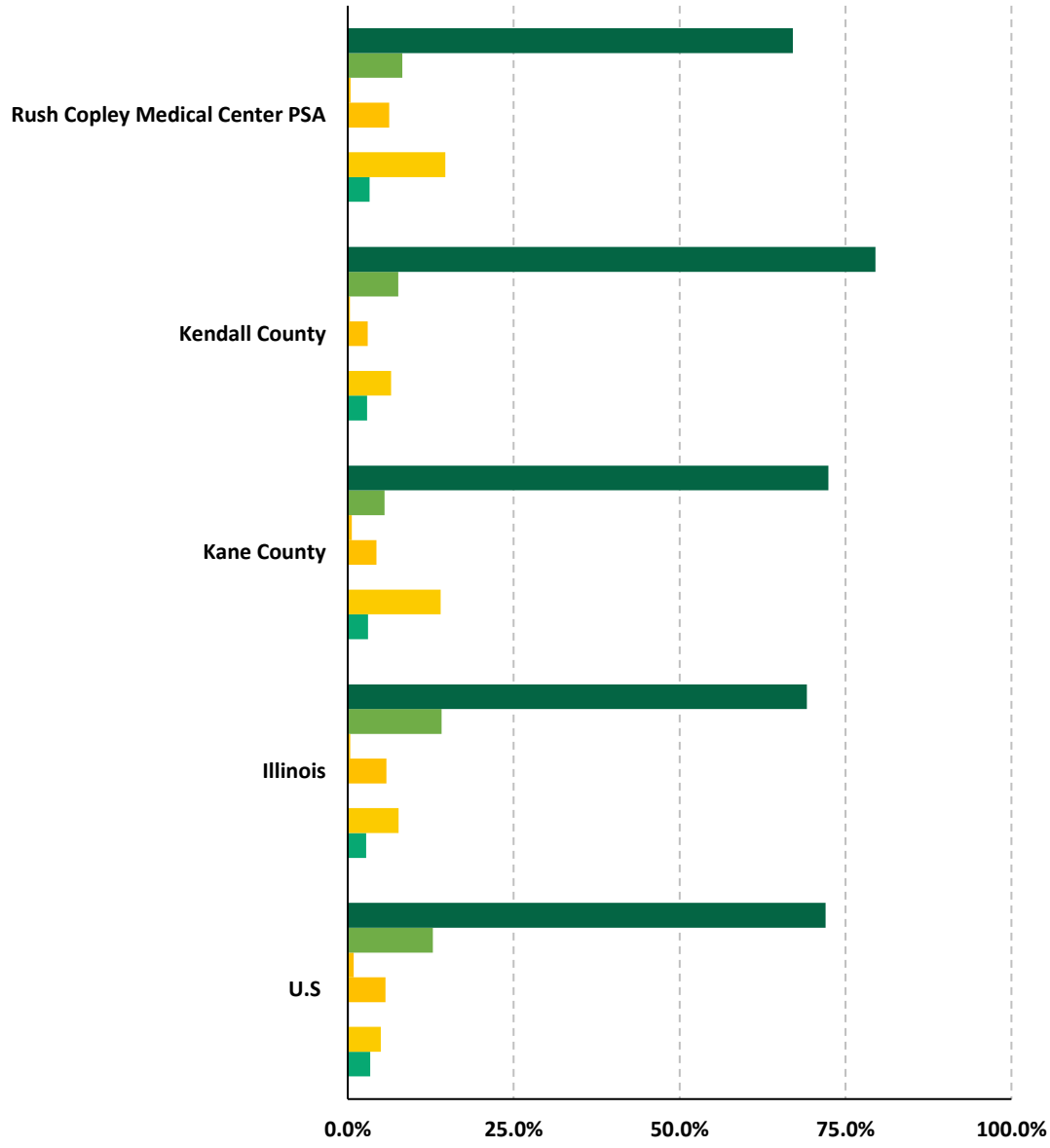
**FIGURE 13. POPULATION BY AGE GROUP**




## Race

The race and ethnicity composition of a population is important in planning for future community needs, particularly for schools, businesses, community centers, health care and childcare. Race and ethnicity data are also useful for identifying and understanding disparities in housing, employment, income, and poverty. The majority of the population in Rush Copley's PSA identifies as White (67.1%) as shown in Figure 14. The Black/African American community makes up 8.2%, followed by Asians comprising 6.2% of the population.

FIGURE 14. POPULATION BY RACE

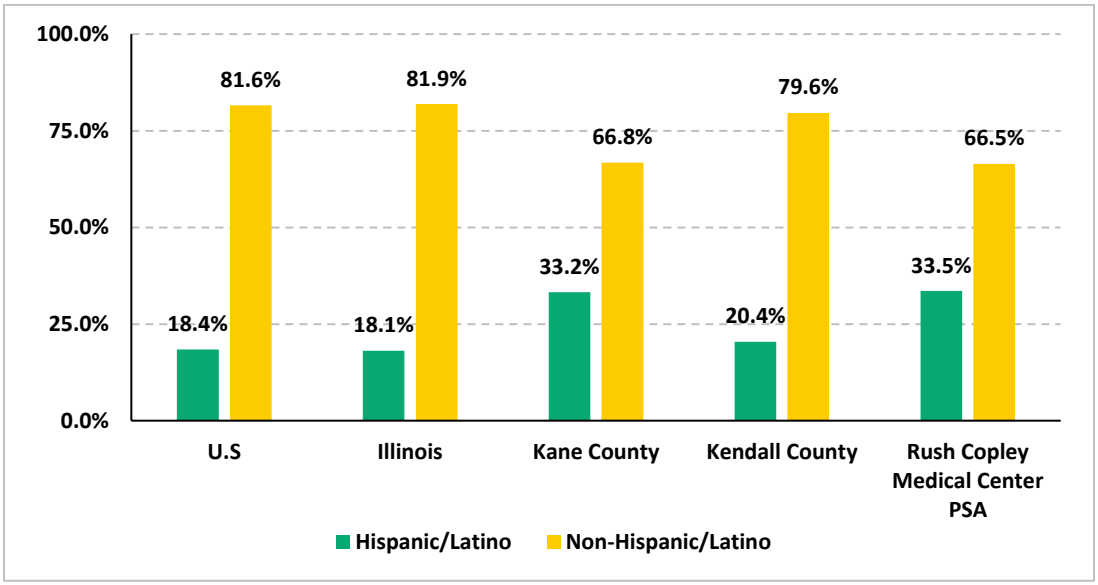



| | U.S | Illinois | Kane County | Kendall County | Rush Copley Medical Center PSA |
|---|---|---|---|---|---|
| White | 72.0% | 69.2% | 72.4% | 79.5% | 67.1% |
| Black/African American | 12.8% | 14.2% | 5.6% | 7.6% | 8.2% |
| American Indian/Alaskan Native | 0.9% | 0.4% | 0.6% | 0.3% | 0.4% |
| Asian | 5.7% | 5.8% | 4.3% | 3.0% | 6.2% |
| Native Hawaiian/Pacific Islander | 0.2% | 0.0% | 0.0% | 0.1% | 0.1% |
| Some Other Race | 5.0% | 7.6% | 14.0% | 6.5% | 14.7% |
| 2+ Races | 3.4% | 2.8% | 3.0% | 2.9% | 3.3% |

## Ethnicity

As shown by Figure 15, 33.5% of the population of Rush Copley Medical Center's PSA identifies as Hispanic or Latino. This is a larger proportion of the population compared to Kane or Kendall Counties.

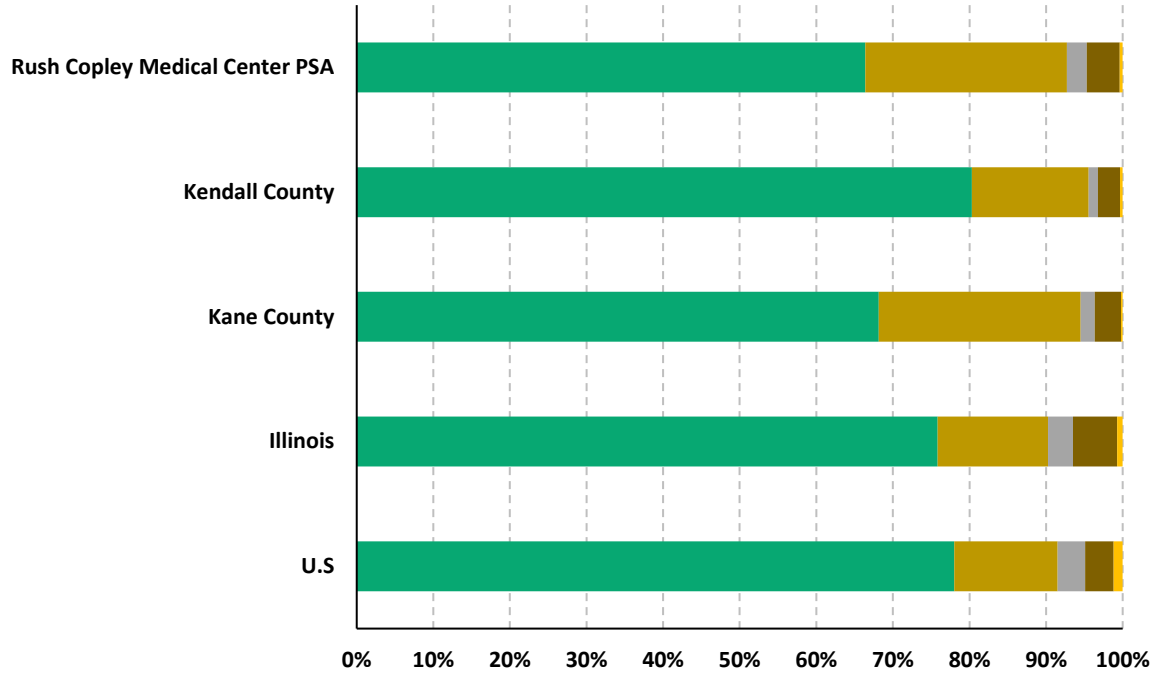
**FIGURE 15. POPULATION BY ETHNICITY**




## Language

Language is an important factor to consider for outreach efforts in order to ensure that community members are aware of available programs and services. Figure 16 shows the population five years and older by language spoken at home. The proportion of the population who speaks English in Rush Copley's PSA is 66.4%. Spanish is the second most common language in the PSA at 26.3%. It is important to note that the percentage of Spanish spoken in Kane and Kendall Counties (26.4% and 15.3% respectively) is comparatively higher than in the state of Illinois (14.4%) and the U.S (13.5%).

FIGURE 16. POPULATION AGE 5+ BY LANGUAGE SPOKEN AT HOME




| | U.S | Illinois | Kane County | Kendall County | Rush Copley Medical Center PSA |
|---|---|---|---|---|---|
| Speak Only English | 78.0% | 75.8% | 68.2% | 80.3% | 66.4% |
| Speak Spanish | 13.5% | 14.4% | 26.4% | 15.3% | 26.3% |
| Speak Asian/Pac Islander Lang | 3.6% | 3.3% | 1.8% | 1.2% | 2.6% |
| Speak Indo-European Lang | 3.7% | 5.7% | 3.5% | 2.9% | 4.3% |
| Speak Other Lang | 1.2% | 0.7% | 0.2% | 0.4% | 0.4% |

## Social & Economic Determinants of Health

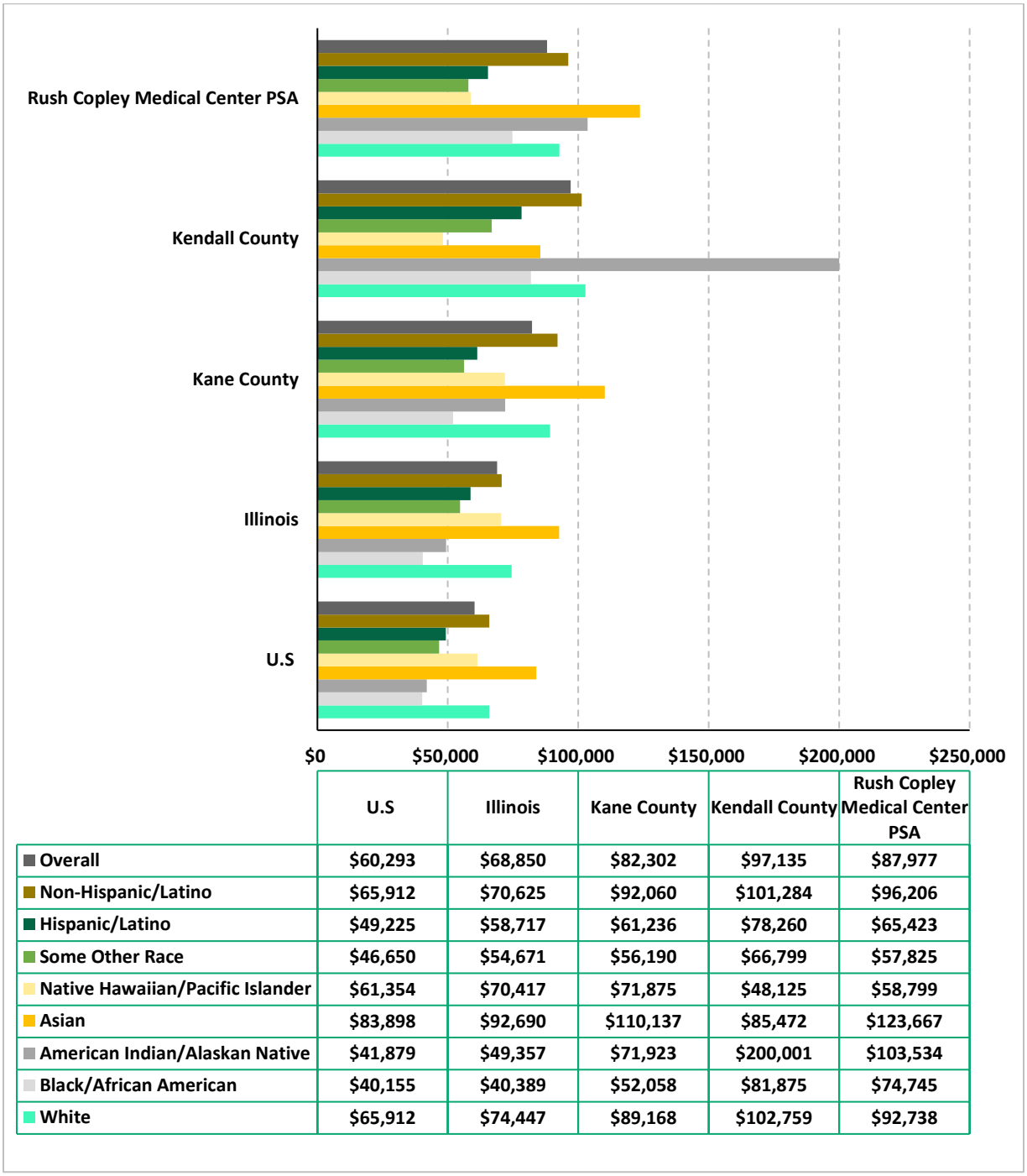
This section explores the economic, environmental, and social determinants of health of Kane County and Rush Copley's PSA. Social determinants are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. It should be noted that county level data can sometimes mask what could be going on at the zip code level in many communities. While indicators maybe strong at the county level, zip code level analysis can reveal disparities.

### Income

Median household income reflects the relative affluence and prosperity of an area. Areas with higher median household incomes are likely to have a greater share of educated residents and lower unemployment rates. Areas with higher median household incomes also have higher home values and their residents enjoy more disposable income.

Figure 17 compares the median household income values for each race in Rush Copley Medical Center's PSA. The overall median household income for the hospital service area is $87,977 which is higher than the overall Kane County, Illinois and U.S. values. Three races – White, Asian, and American Indian/Alaskan Natives – have median household incomes that fall above the overall median value. All other races fall below the overall value.

**FIGURE 17. MEDIAN HOUSEHOLD INCOME BY RACE/ETHNICITY**




| | U.S | Illinois | Kane County | Kendall County | Rush Copley Medical Center PSA |
|---|---|---|---|---|---|
| Overall | $60,293 | $68,850 | $82,302 | $97,135 | $87,977 |
| Non-Hispanic/Latino | $65,912 | $70,625 | $92,060 | $101,284 | $96,206 |
| Hispanic/Latino | $49,225 | $58,717 | $61,236 | $78,260 | $65,423 |
| Some Other Race | $46,650 | $54,671 | $56,190 | $66,799 | $57,825 |
| Native Hawaiian/Pacific Islander | $61,354 | $70,417 | $71,875 | $48,125 | $58,799 |
| Asian | $83,898 | $92,690 | $110,137 | $85,472 | $123,667 |
| American Indian/Alaskan Native | $41,879 | $49,357 | $71,923 | $200,001 | $103,534 |
| Black/African American | $40,155 | $40,389 | $52,058 | $81,875 | $74,745 |
| White | $65,912 | $74,447 | $89,168 | $102,759 | $92,738 |

## Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. A high poverty rate is both a cause and a consequence of poor economic conditions. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased buying power and decreased taxes, poverty is associated with lower quality schools and decreased business survival.

Figure 18 shows the percentage of families living below the poverty level by zip code. The darker blue colors represent a higher percentage of families living below the poverty level. Zip codes 60505, 60545, and 60506 fall within Rush Copley Medical Center's PSA. These zip codes have the highest percentages of families living below the poverty level within the PSA. In comparison to Illinois state (9.2%), the percentage of families living below the poverty level in Kane (7.2%) and Kendall (3.93%) Counties are lower.

**FIGURE 18. FAMILIES LIVING BELOW POVERTY LEVEL BY ZIP CODE**

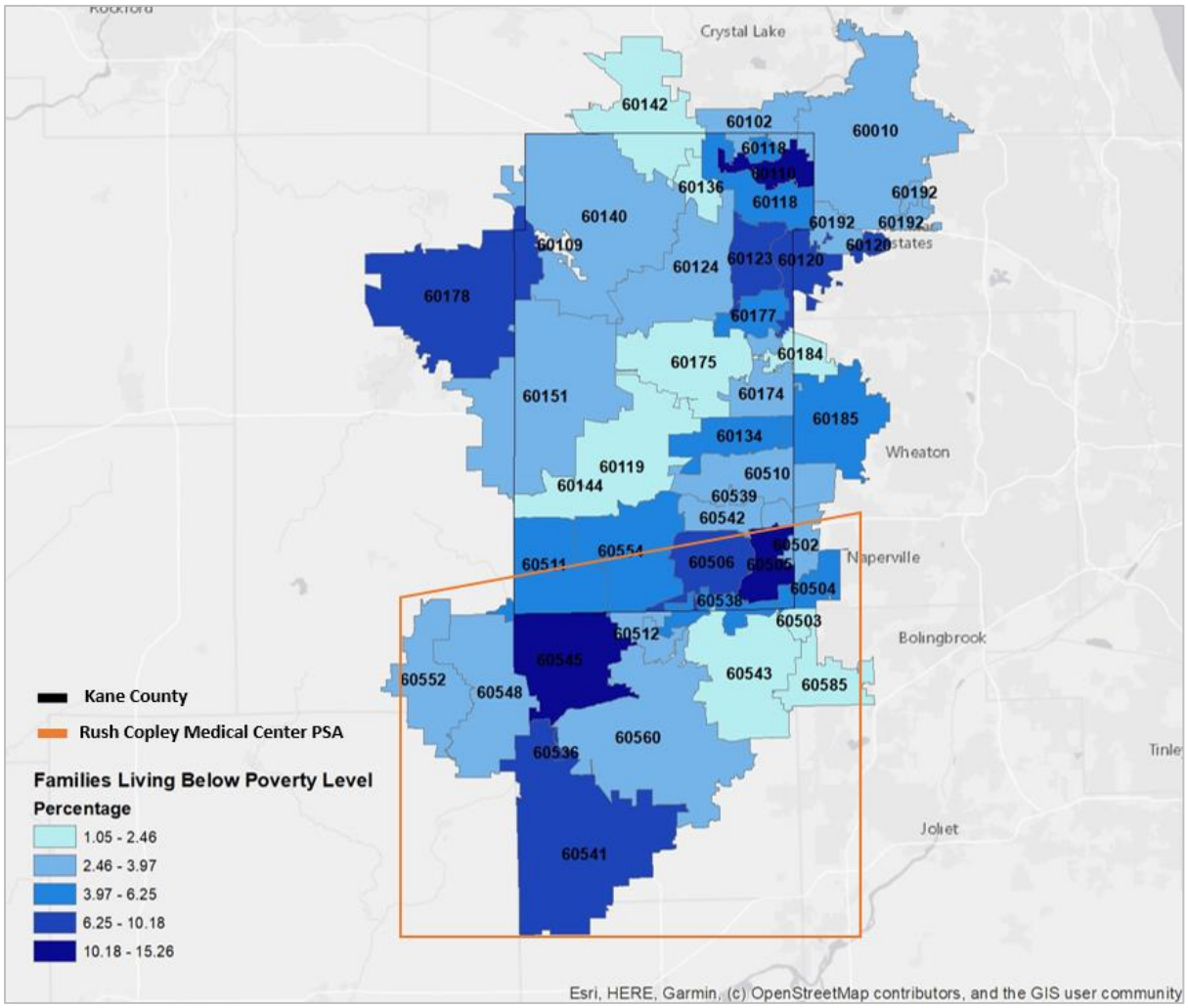
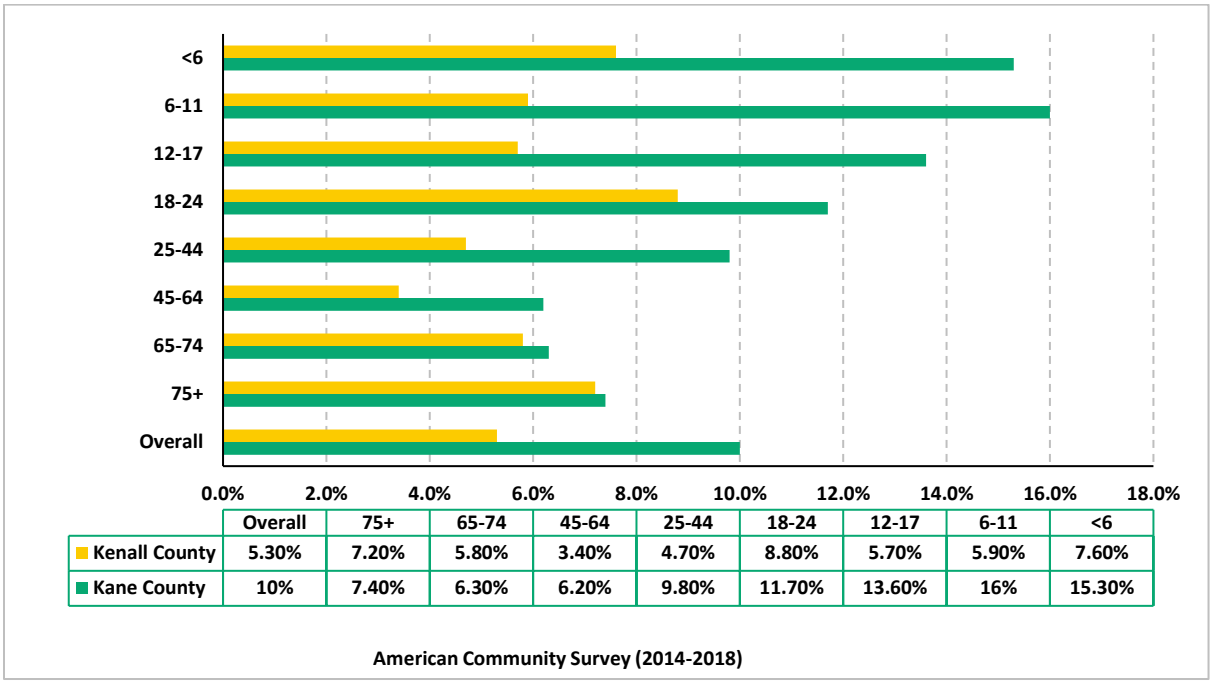


Figure 19 shows the percentage of the population in Kane and Kendall Counties by age who are living below the poverty level. Children and adolescents in Kane County who are less than 18 years old comprise the largest group who are living in poverty.

**FIGURE 19. PEOPLE LIVING BELOW POVERTY LEVEL BY AGE**

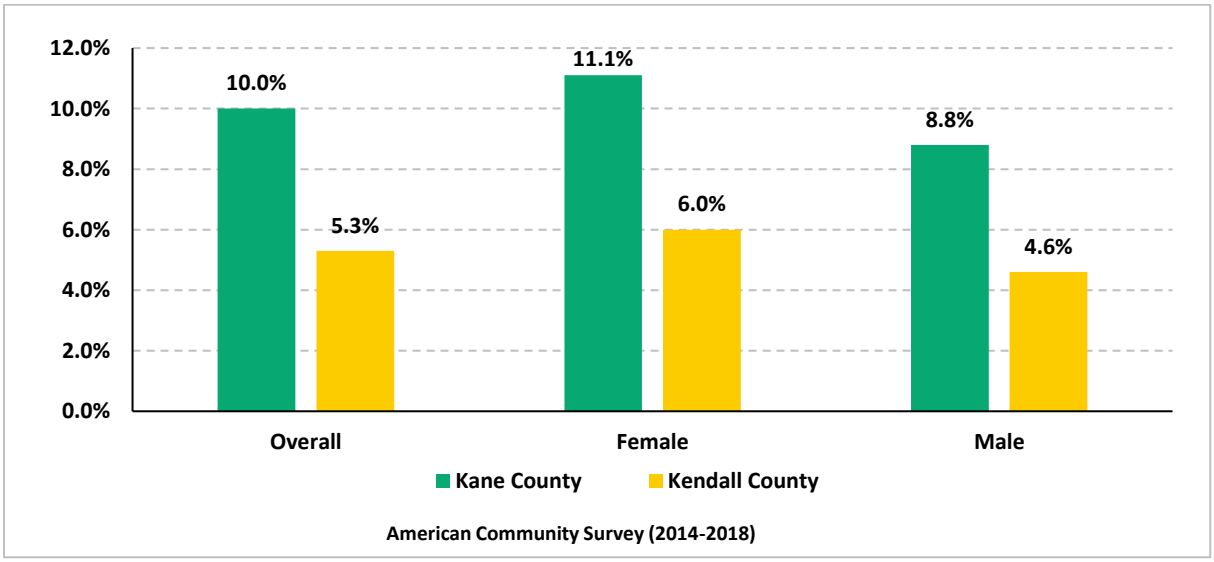



| | Overall | 75+ | 65-74 | 45-64 | 25-44 | 18-24 | 12-17 | 6-11 | <6 |
|---|---|---|---|---|---|---|---|---|---|
| Kenall County | 5.30% | 7.20% | 5.80% | 3.40% | 4.70% | 8.80% | 5.70% | 5.90% | 7.60% |
| Kane County | 10% | 7.40% | 6.30% | 6.20% | 9.80% | 11.70% | 13.60% | 16% | 15.30% |

American Community Survey (2014-2018)

Figure 20 shows the percentage of the population in Kane and Kendall Counties by gender who are living below the poverty level. Females make up a larger percentage of the population in Kane and Kendall Counties who are living in poverty (11.1% and 6.0% respectively).

**FIGURE 20. PEOPLE LIVING BELOW POVERTY LEVEL BY GENDER**



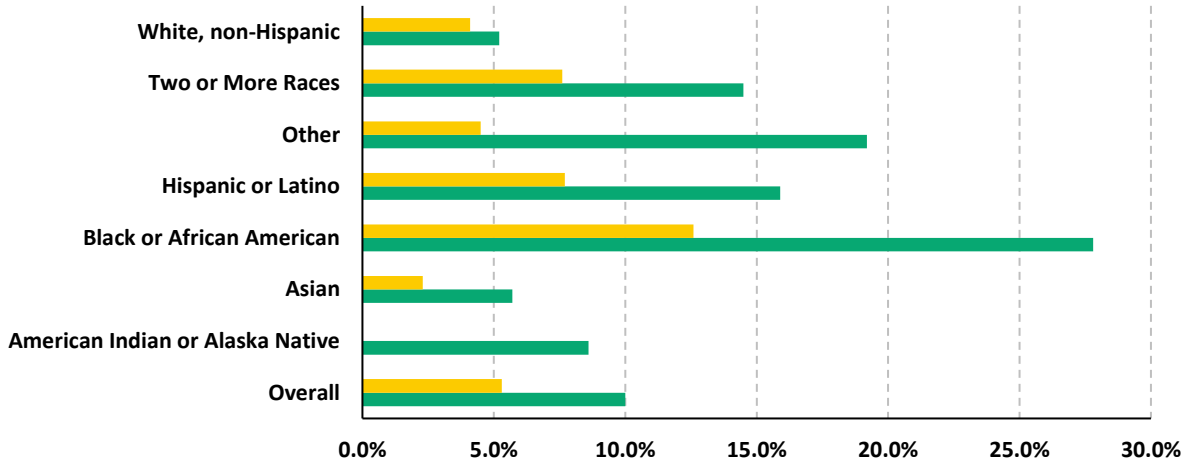

American Community Survey (2014-2018)

Figure 21 shows the percentage of the population in Kane and Kendall Counties by race/ethnicity who are living below the poverty level. The largest racial/ethnic group in Kane County who are living below the

poverty level are those identifying as Black/African American at 27.8% followed by those identifying as "Other" race at 19.2%. Those identifying as Black/African American, Other race, Hispanic/Latino, or as Multi-racial all experience poverty at a higher percentage compared to Kane County at 10.0%.

The largest racial/ethnic group in Kendall County who are living below the poverty level are those identifying as Black/African American at 12.6% followed by those identifying Hispanic or Latino at 7.7% and Two or More Races at 7.6%. Those identifying as Black/African American, Hispanic/Latino, or Multi-racial all experience poverty at a higher percentage compared to Kendall County at 5.3%.

**FIGURE 21. PEOPLE LIVING BELOW POVERTY LEVEL BY RACE/ETHNICITY**



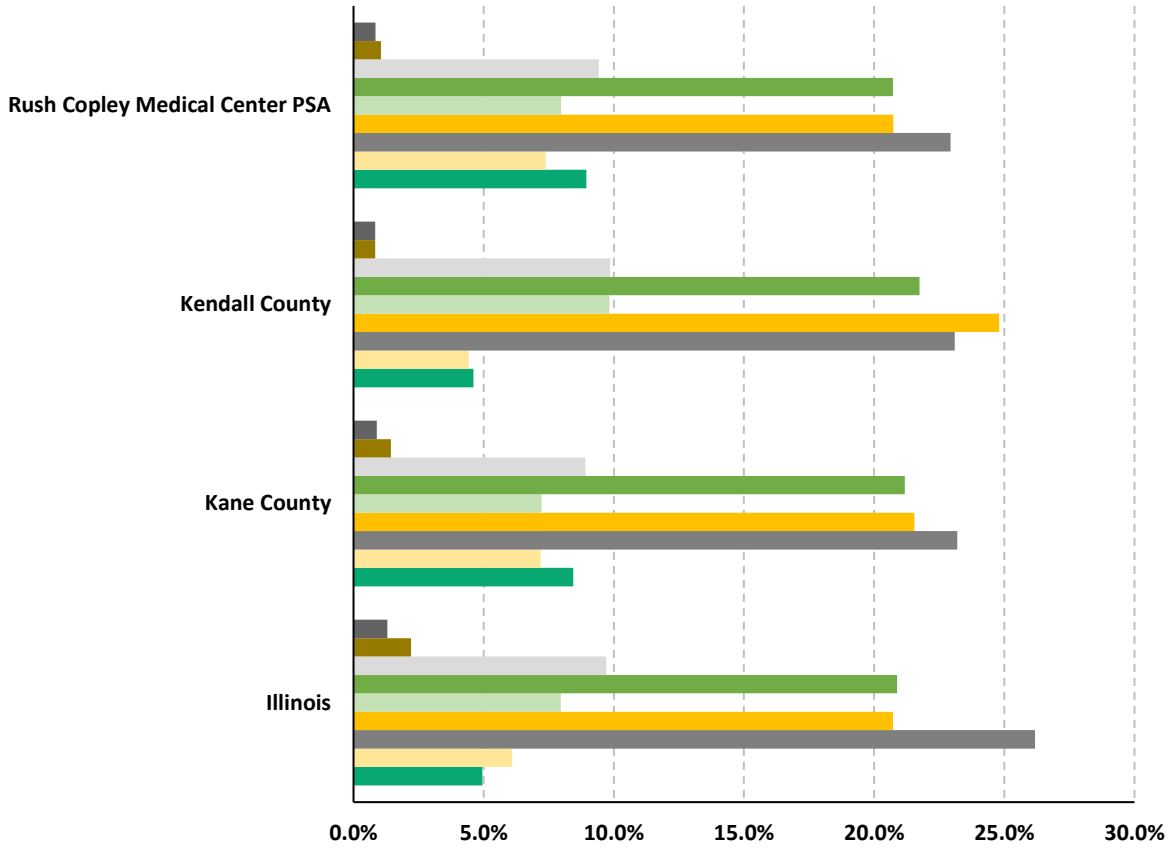

| | Overall | American Indian or Alaska Native | Asian | Black or African American | Hispanic or Latino | Other | Two or More Races | White, non-Hispanic |
|---|---|---|---|---|---|---|---|---|
| Kendall | 5.3% | 0.0% | 2.3% | 12.6% | 7.7% | 4.5% | 7.6% | 4.1% |
| Kane | 10.0% | 8.6% | 5.7% | 27.8% | 15.9% | 19.2% | 14.5% | 5.2% |

American Community Survey (2014-2018)

## Education

Graduating from high school is an important personal achievement and is essential for an individual's social and economic advancement. Graduation rates can also be an important indicator of the performance of an educational system. Having a bachelor's degree or higher opens career opportunities in a variety of fields and is often a prerequisite for higher-paying jobs. Figure 22 shows that Rush Copley's PSA has a slightly lower percentage of people 25 years or older with a bachelor's degree or higher (32.0%) compared to Kane County (32.4%) or Illinois (34.1%).

FIGURE 22. POPULATION 25+ BY EDUCATIONAL ATTAINMENT




| | Illinois | Kane County | Kendall County | Rush Copley Medical Center PSA |
|---|---|---|---|---|
| Doctorate Degree | 1.3% | 0.9% | 0.8% | 0.8% |
| Professional Degree | 2.2% | 1.4% | 0.8% | 1.1% |
| Master's Degree | 9.7% | 8.9% | 9.9% | 9.4% |
| Bachelor's Degree | 20.9% | 21.2% | 21.7% | 20.7% |
| Associate Degree | 8.0% | 7.2% | 9.8% | 8.0% |
| Some College, No Degree | 20.7% | 21.5% | 24.8% | 20.7% |
| High School Grad | 26.2% | 23.2% | 23.1% | 22.9% |
| Some High School, No Diploma | 6.1% | 7.2% | 4.4% | 7.4% |
| Less than 9th Grade | 5.0% | 8.4% | 4.6% | 9.0% |

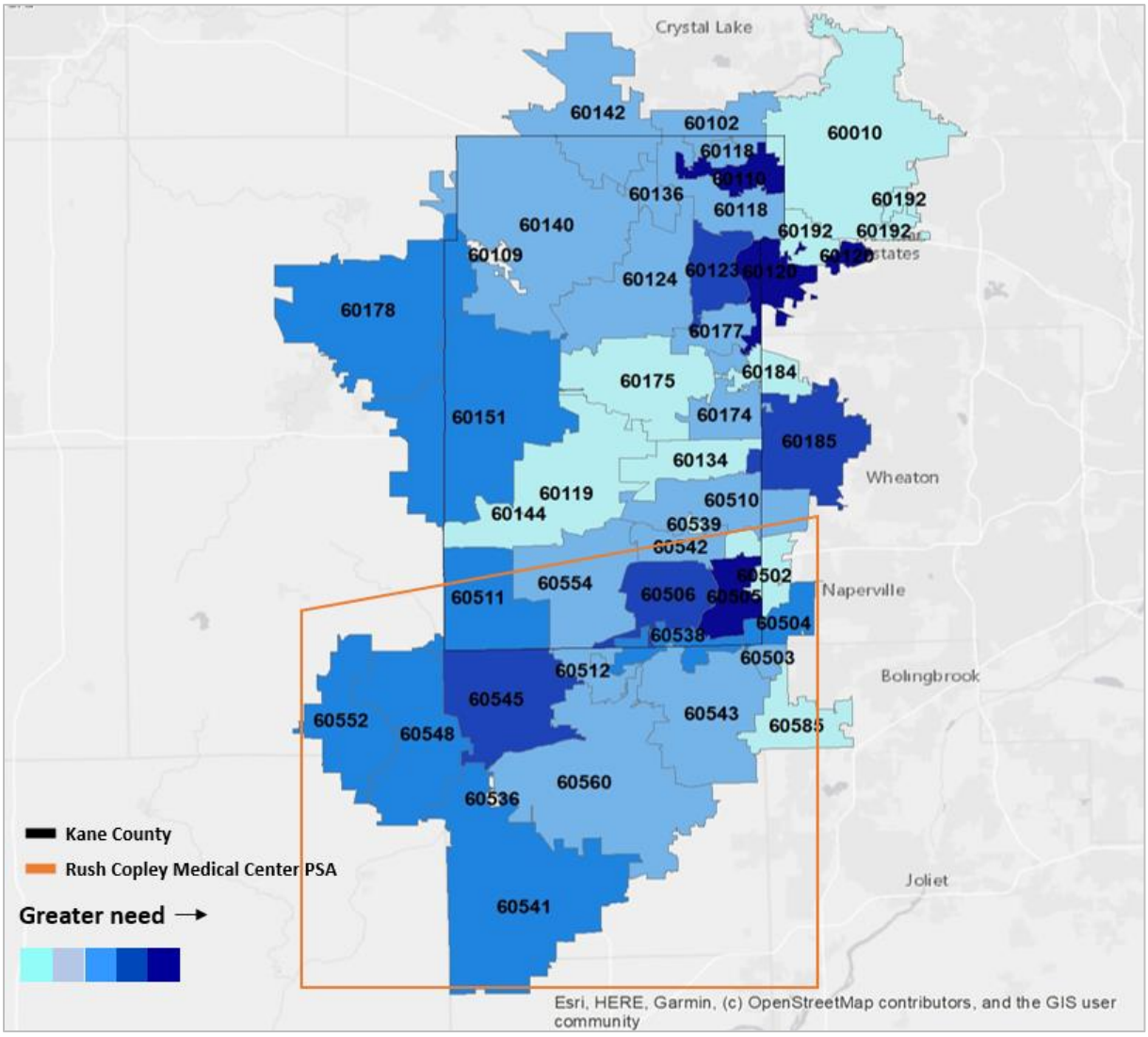
## SocioNeeds Index

Conduent Healthy Communities Institute developed the SocioNeeds Index® to easily identify areas of high socioeconomic need. This index incorporates estimates for six different social and economic determinants of health that are associated with poor health outcomes. The data, which cover income, poverty, unemployment, occupation, educational attainment, and linguistic barriers, are then standardized and averaged to create one composite index value for every zip code in the United States with a population

of at least 200. Zip codes have index values ranging from zero to 100, where higher values are estimated to have the highest socioeconomic need and are correlated with poor health outcomes including preventable hospitalizations and premature death.

Within Kane County, zip codes are ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 23 below. The following zip codes have the highest level of socioeconomic need (as indicated by the darkest shade of blue): 60505, 60506 and 60545. These zip codes fall within Rush Copley Medical Center's PSA. Understanding where there are communities with high socioeconomic need, and associated poor health outcomes, is critical to targeting prevention and outreach activities.

**FIGURE 23. SOCIONEEDS INDEX**



# Data Synthesis

Primary and secondary data were collected, analyzed and synthesized to identify the significant community health needs in Kane County.

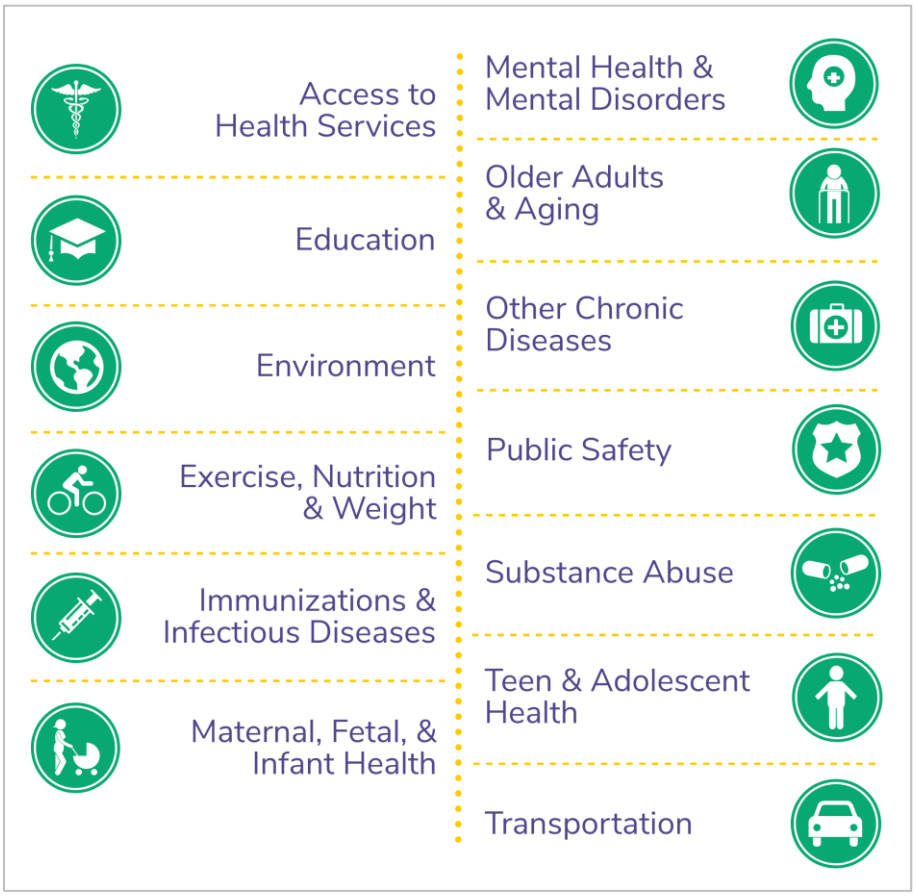
The top health needs identified from data sources were analyzed for areas of overlap. Primary data from focus groups, community survey, FOCA, and Public Health System Assessment as well as Secondary data findings identified 13 areas of greater need. Table 4 shows the final 13 significant health needs, listed in alphabetical order, that were included for prioritization based on the synthesis of all forms of data collected for Kane Health Counts joint CHA/CHNA.

**TABLE 4: HEALTH TOPIC AND DATA COLLECTION**

| Health Topic | Data Source(s) |
|---|---|
| **Access to Health Services** | Secondary Data, Community Survey, Focus Groups, FOCA, PHSA |
| **Education** | Secondary Data, FOCA |
| **Environment** | Secondary Data |
| **Exercise, Nutrition, & Weight** | Community Survey, Focus Groups |
| **Immunizations & Infectious Diseases** | Secondary Data |
| **Maternal, Fetal, & Infant Health** | Secondary Data |
| **Mental Health** | Community Survey, Focus Groups, FOCA |
| **Other Chronic Diseases** | Secondary Data |
| **Older Adults & Aging** | Secondary Data |
| **Public Safety** | Secondary Data |
| **Substance Abuse** | Secondary Data, Community Survey, Focus Groups, FOCA |
| **Teen & Adolescent Health** | Secondary Data |
| **Transportation** | Secondary Data |

Figure 24 below graphically illustrates the final 13 significant health needs, listed in alphabetical order.

**FIGURE 24: HEALTH TOPIC AND DATA COLLECTION**



# Prioritized Significant Health Needs

The following section dives deeper into each of the prioritized health needs in order to understand how findings from secondary and primary data led to the health topic becoming a priority health issue for Kane Health Counts. The four health needs are presented in the order of how they ranked in the prioritization process

## Prioritized Health Topic #1: Behavioral Health (Mental Health & Substance Abuse)

### Behavioral Health: Mental Health

Secondary Data Score: **1.19**

#### Key Themes from Community Input

- Top priority from Community Survey, Focus Group, and Forces of Change Assessment participants
- Mental health care, resources, and available providers are disproportionate to community need

#### Warning Indicators

- Poor Mental Health Days
- Age-Adjusted Hospitalization Rate due to Pediatric Mental Health

### Behavioral Health: Substance Abuse

Secondary Data Score: **1.35**

#### Key Themes from Community Input

- Alcohol and substance abuse were priorities from the Community Survey, Focus Group and Forces of Change Assessment participants

#### Warning Indicators

- Teens who use Alcohol
- Alcohol-Impaired Driving Deaths
- Age-Adjusted ER and Hospitalization Rate due to Adult Alcohol Use
- Liquor Store Density
- Teens who use Marijuana
- Adults who use E-Cigarettes (past 30 days)

## Secondary Data

From the Secondary data scoring results, Behavioral Health was identified as a top health need in Kane County. This health topic includes mental health, mental health disorders, and substance abuse. Using HCI's Secondary Data scoring technique, substance abuse had the fifth highest data score and mental health & mental disorders ranked eleventh. The overall topic scores were 1.35 and 1.19, respectively. Further analysis was done to identify specific indicators of concern across the county. Individual indicators with high data scores within a topic area were categorized as indicators of concern and are listed in Tables 5 and 6 below.

**TABLE 5: DATA SCORING RESULTS FOR MENTAL HEALTH & MENTAL DISORDERS**

| SCORE | MENTAL HEALTH & MENTAL DISORDERS | KANE COUNTY | ILLINOIS | U.S. | IL COUNTIES | U.S. COUNTIES | TREND |
|---|---|---|---|---|---|---|---|
| 1.75 | Poor Mental Health Days *(% Adults)* *2010-2014* | 40.5 | | |  | | |
| 1.50 | Age-Adjusted Hospitalization Rate due to Pediatric Mental Health *(hospitalizations/10,000 population)* *2017-2019* | 61.6 | 67.5 | | | | |
| 1.44 | Alzheimer's Disease or Dementia: Medicare Population *(%)* *2017* | 10 | 10.7 | 10.9 |  |  |  |
| 1.44 | Depression: Medicare Population *(%)* *2017* | 16.4 | 16.4 | 17.9 |  |  |  |

TABLE 6: DATA SCORING RESULTS FOR SUBSTANCE ABUSE

| SCORE | SUBSTANCE ABUSE | KANE COUNTY | ILLINOIS | U.S. | IL COUNTIES | U.S. COUNTIES | TREND |
|---|---|---|---|---|---|---|---|
| 2.11 | Teens who Use Alcohol *(%)* *2018* | 46 | 40 | |  | |  |
| 1.89 | Alcohol-Impaired Driving Deaths *(% of MVC deaths)* *2014-2018* | 32 | 32 | 28 |  |  |  |
| 1.83 | Age-Adjusted ER Rate due to Adult Alcohol Use *(hospitalizations/10,000 population)* *2017-2019* | 88 | 87 | |  | | |
| 1.69 | Liquor Store Density *(stores/100,000 population)* *2018* | 11.6 | 10.8 | 10.6 |  |  |  |
| 1.67 | Age-Adjusted Hospitalization Rate due to Adult Alcohol Use *(hospitalizations/10,000 population)* *2017-2019* | 29 | 29.5 | |  | | |
| 1.56 | Teens who Use Marijuana *(%)* *2018* | 24.4 | 26 | |  | |  |

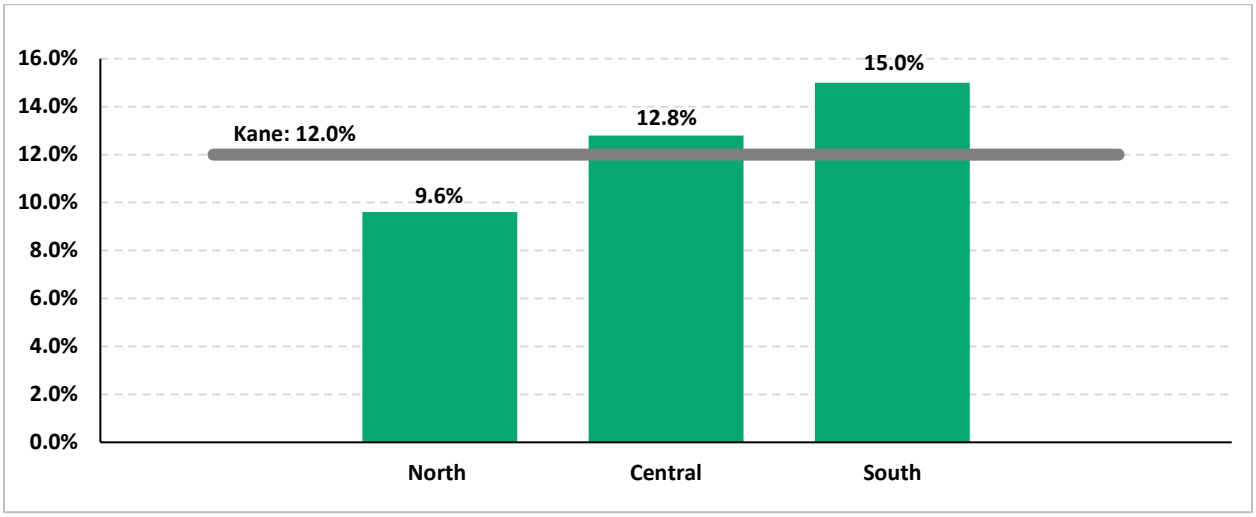
From the secondary data results, there are several indicators in these topic areas that raise concern for Kane County. Compared to other counties in Illinois, Kane County has higher rates of hospitalizations and ER visits due to adult alcohol use. Teen alcohol and marijuana use, although decreasing in recent years, is also higher than most other counties in Illinois. Additionally, Kane County has higher liquor store density than most Illinois and U.S Counties.

## Primary Data

### Mental Health & Mental Disorders

Mental Health and Mental Disorders was a top health need from Community Survey, Focus Group, and Forces of Change Assessment participants. Mental health care, mental health resources, and the availability of mental health providers were frequently cited as disproportionate to community need. Figure 25 shows the percentage of respondents in the North, Central, and South planning areas who reported not being able to access needed mental health services in the past 12 months compared to all respondents from Kane County. The Central and South Planning Areas had a higher percentage of respondents who were unable to access these services (12.8% and 15.0% respectively) compared to Kane County at 12.0%. Overall, respondents reported cost and affordability of receiving care as their biggest barrier to care.

**FIGURE 25: COMMUNITY SURVEY RESPONDENTS REPORTING INABILITY TO ACCESS MENTAL HEALTH SERVICES IN THE LAST 12 MONTHS**




($N_{Kane}$=1,515, $N_{North}$=500, $N_{Central}$=415, $N_{South}$=601)

Focus group participants emphasized the impact of anxiety and stress that parents and families with children are experiencing presently because of COVID-19 restrictions and the ever-evolving options for schooling. Social isolation was another common topic that was discussed during these conversations, specifically mentioning the impact on children, youth, and older adults. Separation from routines and social networks are greatly impacting mental health for these groups. Finally, focus group participants discussed the challenge of accessing mental health services in the community. Cost, availability of appointments, and navigation and/or knowledge about available services were all mentioned as barriers to care.

### Disparities (Access to Mental Health)

Survey responses were also analyzed to identify disparities along race/ethnicity, gender, and age. Table 7 lists respondent groups where a higher percentage of a particular group experienced a greater barrier to mental health care compared to overall Kane County community survey respondents. Higher percentages of respondents identifying as Native American, Black/African American, Native Hawaiian or Pacific Islander, Multi-racial, and Hispanic reported not being able to access mental health care when needed. Additionally, higher percentages of respondents aged 18-54 reported not being able to access mental health care when needed.

This analysis was conducted for the three Kane County Planning Areas as well, but the percentage of the population within each Planning Area who experienced a barrier to care were insufficient in size to result in meaningful results. Further information about barriers to care and disparities can be found in the Other Findings section later in this report.

**TABLE 7. KANE COUNTY COMMUNITY SURVEY RESPONDENT GROUPS WITH SIGNIFICANT RACE/ETHNICITY, AGE OR GENDER DISPARITIES FOR ACCESSING MENTAL HEALTH SERVICES**

| | |
|---|---|
| **Racial Groups** | American Indian/Alaskan Native (AIAN), Black/African American, Native Hawaiian/Pacific Islander (NHPI), Multi-racial, Hispanic |
| **Age Groups** | 45-54, 35-44, 25-34, 18-24 |

*Groups are presented in the order of decreasing disparity, with the group experiencing greater disparity listed first.

> The cases of people suffering from anxiety have increased, it is important to pay attention to mental health. With problems like education, lack of parental care, financial problems and now with the pandemic, people are suffering from more stress and mental problems like anxiety, depression.
> - Focus Group Participant

### Alcohol and Substance Abuse

Alcohol and Substance Abuse were top priorities from the Community Survey, Focus Group and Forces of Change Assessment participants. Focus group participants discussed that the focus on COVID-19 has diverted attention from drug use issues that had been and continue to be present in the community, particularly issues with heroin and opioids. Additionally, focus group participants discussed teen and adolescent use/abuse of illegal substances and the interconnectedness to peer pressure, bullying, and self-esteem.

> Bullying in schools, the sense of belonging of young people. Everyone tries to be like the rest of the other young people and this brings drug addiction problems, alcoholism and many problems for youth.
> - Focus Group Participant

## Prioritized Health Topic #2: Access to Health Services

# Access to Health Services

Secondary Data Score: **1.38**

### Key Themes from Community Input

- Top priority Community Survey, Focus Groups, Forces of Change Assessment as well as Public Health System Assessment participants
- Cost of care is a barrier as well as closings due to Covid
- Lack of funds for needed medication

### Warning Indicators

- Primary Care Provider Rate
- Clinical Care Ranking
- Adults with Health Insurance
- Children with Health Insurance

### Secondary Data

From the secondary data scoring results, access to health services was identified to be a top health need in Kane County. It had the third highest data score of all health topic areas using the data scoring technique, with a score of 1.38. Further analysis was done to identify specific indicators of concern across the county. Individual indicators with high data scores within a topic area were categorized as indicators of concern and are listed in Table 8 below.

**TABLE 8. DATA SCORING RESULTS FOR ACCESS TO HEALTH SERVICES**

| SCORE | ACCESS TO HEALTH CARE | KANE COUNTY | ILLINOIS | U.S. | IL COUNTIES | U.S. COUNTIES | TREND |
|---|---|---|---|---|---|---|---|
| **2.03** | Primary Care Provider Rate *(providers/100,000 population)* *2017* | 40.8 | 80 | |  |  |  |
| **1.75** | Clinical Care Ranking *2020* | 83 | | |  | | |
| **1.67** | Adults with Health Insurance (%) *2018* | 88.2 | 90.1 | 87.5 *HP2020: 100 | | | |
| **1.56** | Children with Health Insurance (%) *2018* | 95.1 | 96.6 | 94.8 *HP2020: 100 | | | |

**HP2020 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2020 represents a Healthy People target to be met by 2020.*

Although Kane County's overall score in this area is relatively low, Kane County falls behind the State of Illinois and other counties for primary care provider rates, clinical care ranking, and adults with health insurance. Of note, the primary care provider rate is decreasing and the percent of adults with health insurance is below both the Illinois state value and the Healthy People 2020 objective.

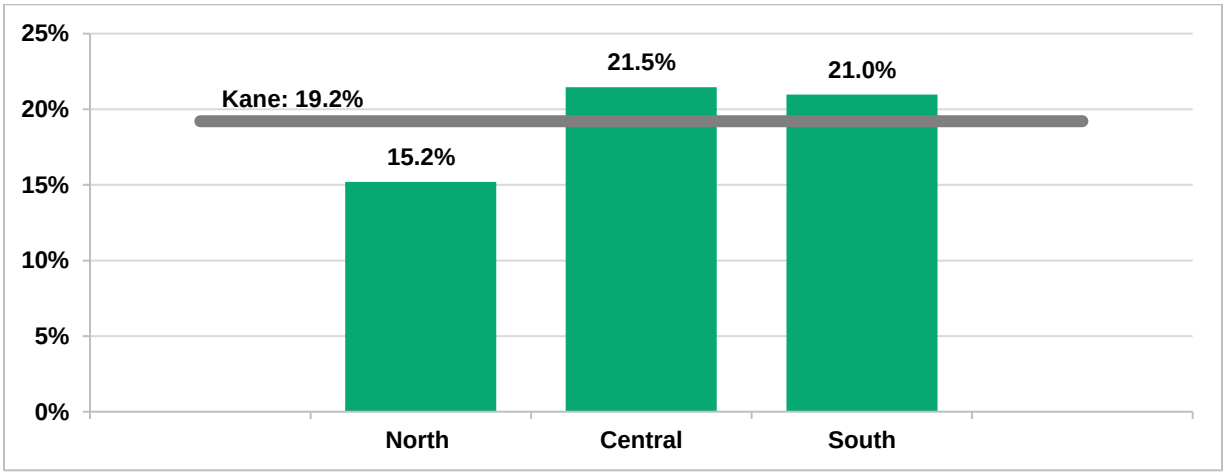
## Primary Data

Access to Health Services was a top health need identified from Community Survey, Focus Group, Forces of Change Assessment as well as Public Health System Assessment participants. Cost of care was a common barrier mentioned across these primary data sources. This included general cost to access care, lack of funds for purchasing needed medication as well as being uninsured or underinsured. Recent health facility closings and delays due to COVID-19 were also specifically mentioned as barriers to accessing care. The need for improved/increased culturally competent, accessible health care offered in languages that are spoken in the community was a theme that surfaced in the primary data as well.

### Barriers and Disparities: Access to Health Services

Figure 26 shows the percentage of respondents in the North, Central, and South planning areas who reported not being able to access needed health services in the past 12 months compared to all respondents from Kane County. The Central and South Planning Areas had a higher percentage of respondents who were unable to access these services (21.5% and 21.0% respectively) compared to Kane County at 19.2%. The Northern Planning Area fell slightly under the Kane County value at 15.2%. Overall, respondents reported cost and affordability of receiving care as their biggest barrier to care. Respondents reported that health providers and/or offices/facilities being closed due to COVID-19 as being a barrier to care as well.

**FIGURE 26: COMMUNITY SURVEY RESPONDENTS REPORTING INABILITY TO ACCESS HEALTH SERVICES IN THE LAST 12 MONTHS**




($N_{Kane}$=1515, $N_{North}$=500, $N_{Central}$=415, $N_{South}$=601)

Table 9 lists respondent groups where a higher percentage of a particular group experienced a greater barrier to health care compared to overall Kane County community survey respondents. Higher percentages of respondents identifying as Native American, Black/African American, or Hispanic reported not being able to access care when needed. Additionally, higher percentages of respondents aged 18-54 reported not being able to access care when needed.

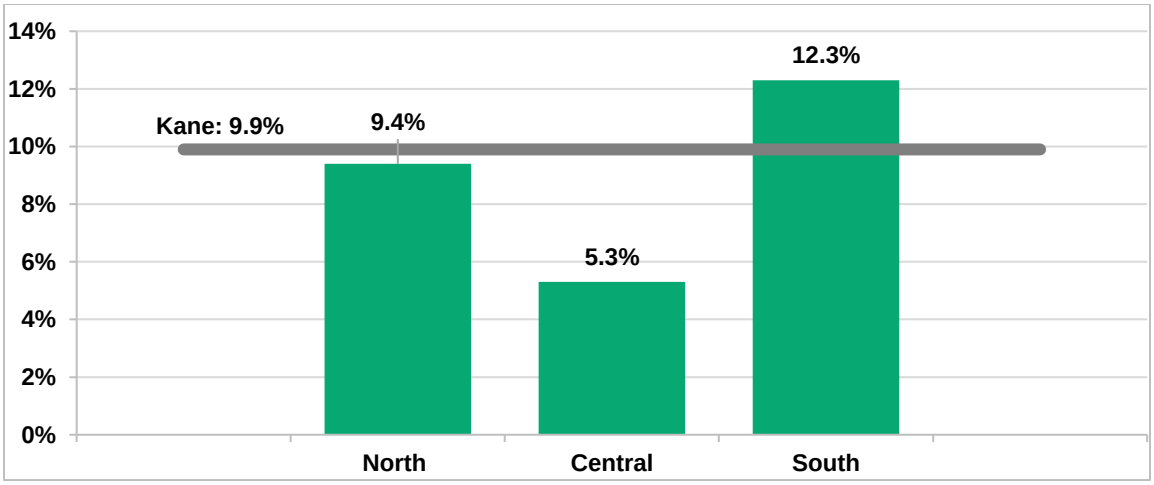
**TABLE 9. KANE COUNTY COMMUNITY SURVEY RESPONDENT GROUPS WITH SIGNIFICANT RACE/ETHNICITY, AGE OR GENDER DISPARITIES FOR ACCESSING HEALTH SERVICES**

| | |
|---|---|
| **Racial Groups** | American Indian/Alaska Native, Black/African American, Hispanic |
| **Age Groups** | 35-44, 45-54, 25-34, 18-24 |

*Groups are presented in the order of decreasing disparity, with the group experiencing greater disparity listed first.

Figure 27 shows the percentage of respondents in the North, Central, and South planning areas who reported not having health insurance or being unsure if they were covered by health insurance compared to all community survey respondents from Kane County. The South Planning Area had a higher percentage of respondents who were uninsured (12.3%) compared to Kane County at 9.9%. The Northern and Central Planning Areas were lower than the Kane County value at 9.4% and 5.3% respectively.

**FIGURE 27: COMMUNITY SURVEY RESPONDENTS SELF REPORTED HEALTH INSURANCE COVERAGE: NO COVERAGE OR UNSURE IF INSURED**

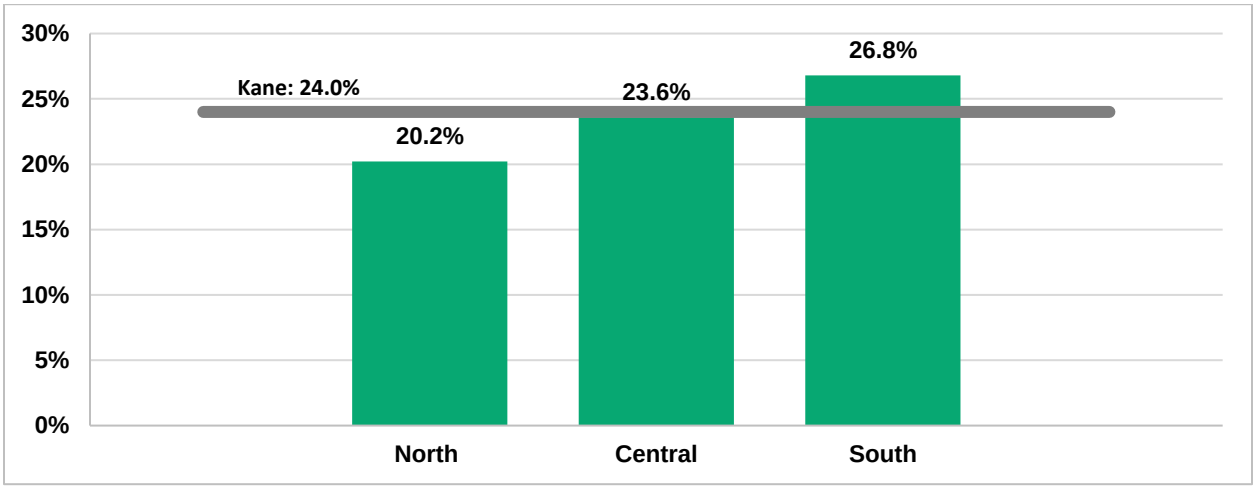



($N_{Kane}$=1515, $N_{North}$=500, $N_{Central}$=415, $N_{South}$=601)

## Barriers and Disparities: Access to Care in the Emergency Room

Figure 28 shows the percentage of respondents in the North, Central, and South planning areas who reported having accessed care in the emergency room (ER) in the past 12 months compared to all community survey respondents from Kane County. The South Planning Area had a higher percentage of respondents who accessed care in the ER (26.8%) compared to Kane County at 24.0%. The Northern and Central Planning Areas were lower than the Kane County value at 23.6% and 20.2% respectively. While the majority of respondents reporting accessing care in the ER did so for an emergency or life-threatening situations (55.6%), a good proportion of respondents reported accessing care in the ER due to their need for care outside of clinic hours or on the weekend when they were unable to access care elsewhere (27.3%).

FIGURE 28: COMMUNITY SURVEY RESPONDENTS SELF REPORTED EMERGENCEY ROOM UTILIZATION: HAVE ACCESSED THE ER IN THE PAST 12 MONTHS




($N_{Kane}$=1515, $N_{North}$=500, $N_{Central}$=415, $N_{South}$=601)

Table 10 lists respondent groups where a higher percentage of a particular group had accessed care in the emergency room (ER) in the last 12 months compared to overall Kane County community survey respondents. A higher percentage of Black/African American, Native American, and those identifying as more than one race reported accessing care in the ER in the last year.

TABLE 10. KANE COUNTY COMMUNITY SURVEY RESPONDENT GROUPS WITH SIGNIFICANT RACE/ETHNICITY, AGE OR GENDER DISPARITIES FOR ACCESSING CARE IN THE ER

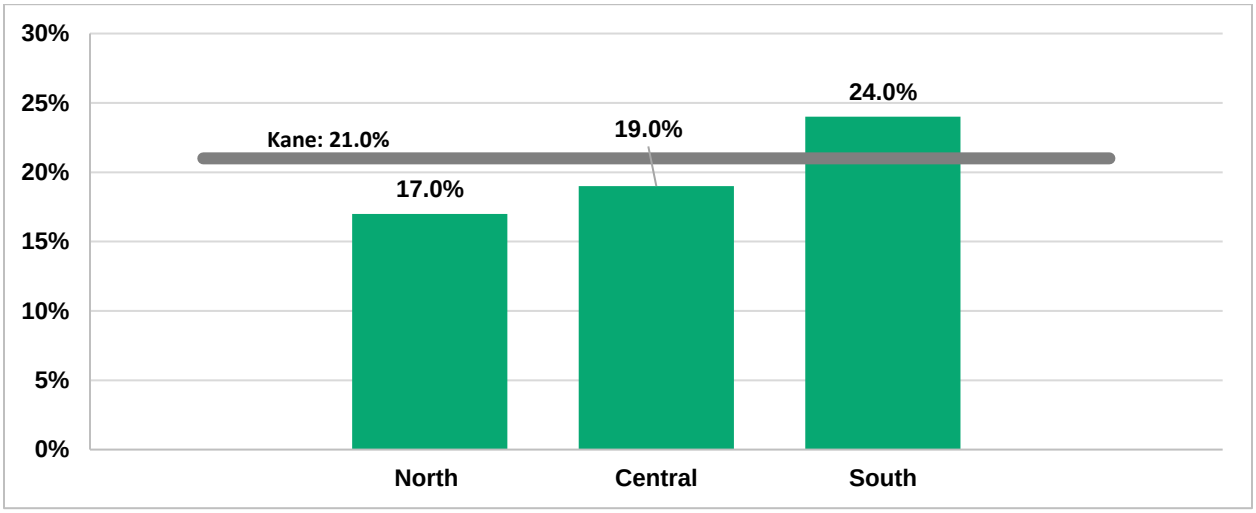
| | |
|---|---|
| **Racial Groups** | American Indian/Alaska Native, Black/African American, Multi-racial |

*Groups are presented in the order of decreasing disparity, with the group experiencing greater disparity listed first.

## Barriers and Disparities: Access to Dental Health Services

Figure 29 below shows the percentage of respondents in the North, Central, and South planning areas who reported not being able to access needed dental health services in the past 12 months compared to all respondents from Kane County. The South Planning Areas had a higher percentage of respondents who were unable to access these services (24.0%) compared to Kane County at 21.0%. The Northern and Central Planning Areas were lower than the Kane County value at 17.0% and 19.0% respectively. Overall, respondents reported cost and affordability of receiving dental care was their biggest barrier to care. Respondents also reported that health providers and/or offices/facilities being closed due to COVID-19 as being a barrier to care. Finally, having no dental insurance was another common barrier to care that was identified.

**FIGURE 29: COMMUNITY SURVEY RESPONDENTS REPORTING INABILITY TO ACCESS DENTAL HEALTH SERVICES IN THE LAST 12 MONTHS**




($N_{Kane}$=1515, $N_{North}$=500, $N_{Central}$=415, $N_{South}$=601)

Table 11 lists respondent groups where a higher percentage of a particular group experienced a greater barrier to dental health services compared to overall Kane County community survey respondents. Higher percentages of respondents identifying as Native American, Black/African American, Multi-racial, Another Race, and Hispanic reported not being able to access dental care when needed.

**TABLE 11. KANE COUNTY COMMUNTY SURVEY RESPONDENT GROUPS WITH SIGNIFICANT RACE/ETHNICITY, AGE OR GENDER DISPARITIES FOR ACCESSING DENTAL HEALTH SERVICES**

| | |
|---|---|
| **Racial Groups** | American Indian/Alaskan Native, Black/African American, Multi-racial, Another Race, Hispanic |

*Groups are presented in the order of decreasing disparity, with the group experiencing greater disparity listed first.

> Lack of health insurance, it is very expensive. There are not many clinics where they charge less or there is more help for the community.
> - Focus Group Participant

## Prioritized Health Topic #3: Immunizations and Infectious Diseases

# Immunizations & Infectious Diseases

Secondary Data Score: **1.36**

### Warning Indicators

- COVID-19 Daily Average Case-Fatality Rate
- HIV Diagnosed Cases
- Overcrowded Households
- Adults with Pneumonia Vaccine
- Chlamydia Incidence Rate
- Syphilis Incidence Rate

### Secondary Data

From the secondary data scoring results, Immunizations & Infectious Diseases were identified to be a top health need in Kane County. It had the fourth highest data score of all health topic areas using the data scoring technique, with a score of 1.36. Further analysis was done to identify specific indicators of concern across the county. Individual indicators with high data scores within a topic area were categorized as indicators of concern and are listed in Table 12.

**TABLE 12. DATA SCORING RESULTS FOR IMMUNIZATIONS & INFECTIOUS DISEASES**

| SCORE | IMMUNIZATIONS & INFECTIOUS DISEASES | KANE COUNTY | ILLINOIS | U.S. | IL COUNTIES | U.S. COUNTIES | TREND |
|---|---|---|---|---|---|---|---|
| 2.50 | COVID-19 Daily Average Incidence Rate *(cases/100,000 population)* *Nov 6,2020* | 84.2 | 79.9 | 47.5 |  |  |  |
| 1.83 | HIV Diagnosed Cases *(# cases)* *2018* | 32 | | | | |  |
| 1.67 | Overcrowded Households *(% of households)* *2014-2018* | 3.7 | 2.5 | |  | |  |
| 1.58 | Adults with Pneumonia Vaccination *(%)* *2010-2014* | 24.4 | | |  | | |
| 1.50 | Chlamydia Incidence Rate *(cases/100,000 population)* *2018* | 407.7 | 604 | 539.9 |  |  |  |
| 1.50 | Syphilis Incidence Rate *(cases/100,000 population)* *2018* | 3.9 | 11 | 10.8 | | |  |

The secondary data reveal that sexually transmitted infections (STIs), specifically syphilis and chlamydia, are on the rise in Kane County. Additionally, Kane county's vaccination rates for pneumonia among adults are among the worst in Illinois. This is particularly worrisome for 2019-2020 and beyond, as COVID-19 cases are increasing in Kane County and throughout the U.S. Overcrowding in households, which has been shown to ease transmission of infectious diseases like COVID-19, is of concern in Kane County as well.

### Primary Data

Concerns related to mental health, health communication, access to care and resources and other barriers to care related to the COVID-19 pandemic were common topics that trended across this Kane County Community Health Needs Assessment. Further exploration of the key primary data findings related to COVID-19 are covered more fully in the Kane County Community Feedback section of the COVID-19 Impact Snapshot later in this report.

> People now are very nervous about going to get their flu shots. There has been a big push for home health care to do in-home flu shots.
> - Focus Group Participant

## Prioritizied Health Topic #4: Exercise, Nutrition, & Weight

### Exercise, Nutrition & Weight

Secondary Data Score: **1.19**

#### Key Themes from Community Input

- Top priority from Community Survey and Focus Groups
- Food security; access to healthy foods and poor nutrition
- Obesity and contribution to chronic disease
- Lack of exercise

#### Warning Indicators

- SNAP Certified Stores
- Children with Low Access to a Grocery Store
- Farmers Market Density
- Fast Food Restaurant Density
- Grocery Store Density
- People with Low Access to a Grocery Store

### Secondary Data

From the secondary data scoring results, Exercise, Nutrition, & Weight was identified to be a top health need in Kane County. It had the twelfth highest data score of all health topic areas using the data scoring technique, with a score of 1.19. Further analysis was done to identify specific indicators of concern across

the county. Individual indicators with high data scores within a topic area were categorized as indicators of concern and are listed in Table 13.

**TABLE 13. DATA SCORING RESULTS FOR EXERCISE, NUTRITION, & WEIGHT**

| SCORE | EXERCISE, NUTRITION, & WEIGHT | KANE COUNTY | ILLINOIS | U.S. | IL COUNTIES | U.S. COUNTIES | TREND |
|---|---|---|---|---|---|---|---|
| 2.11 | SNAP Certified Stores *(stores/1,000 population)* *2017* | 84.2 | 79.9 | 47.5 |  |  |  |
| 1.67 | Children with Low Access to a Grocery Store *(%)* *2015* | 32 | | |  |  | |
| 1.67 | Farmers Market Density *(markets/1,000 population)* *2018* | 3.7 | 2.5 | | | | |
| 1.67 | Fast Food Restaurant Density *(restaurants/1,000 population)* *2016* | 24.4 | | |  |  |  |
| 1.67 | Grocery Store Density *(stores/1,000 population)* *2016* | 0.14 | | |  |  |  |
| 1.50 | People with Low Access to a Grocery Store *(%)* *2015* | 18.5 | | |  |  | |

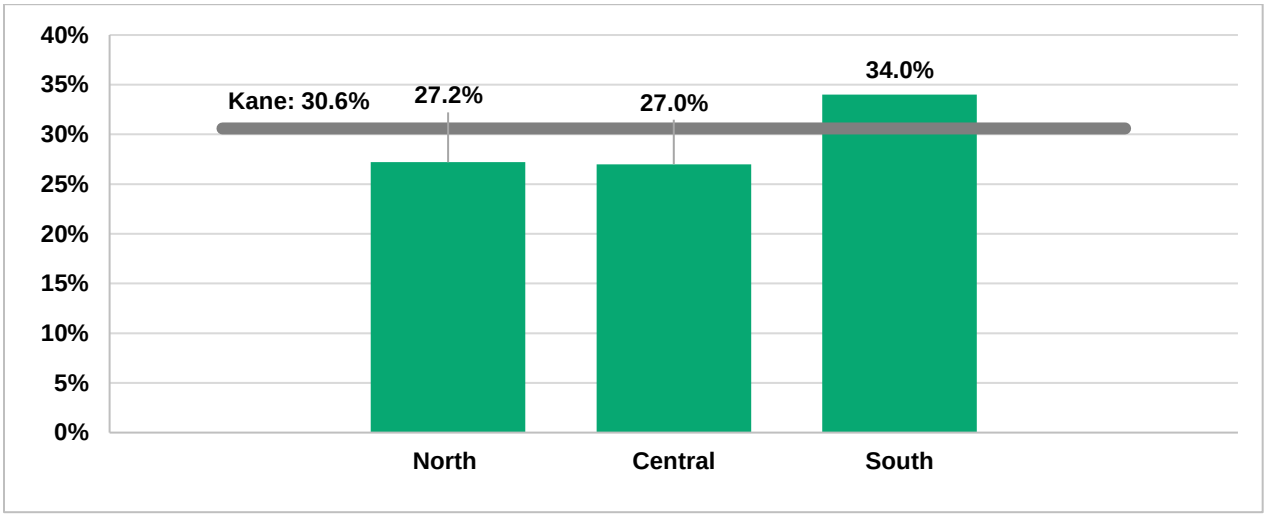
Access to grocery stores and healthy foods are important for decreasing risk of chronic diseases, such as obesity and heart disease, and also help improve mental health. Although the overall topic score for exercise, nutrition, and weight was low for Kane County, Kane County falls behind in some important indicators under this topic. Namely, Kane County is among the worst in Illinois and the U.S. for SNAP certified stores, children with access to grocery stores, and grocery store density.

## Primary Data

Exercise, Nutrition, and Weight was a top health need identified from Community Survey and Focus Group participants. Existing and increasing food insecurity due to COVID-19, access to healthy foods, and poor nutrition were all nutritional themes from primary data. Obesity and its contribution to chronic disease among residents in Kane County was of concern as well. Additionally, sedentary lifestyles and lack of exercise were also common points of discussion.

Figure 30 shows the percentage of respondents in the North, Central, and South planning areas who reported having worried about whether their food would run out before they got money to buy more sometime during the last 12 months compared to all respondents from Kane County. The South Planning Area had a higher percentage of respondents who reported this food insecurity challenge (34.0%) compared to Kane County at 30.6%. The Northern and Central Planning Areas fell under the Kane County value at 27.2% and 27.0% respectively.

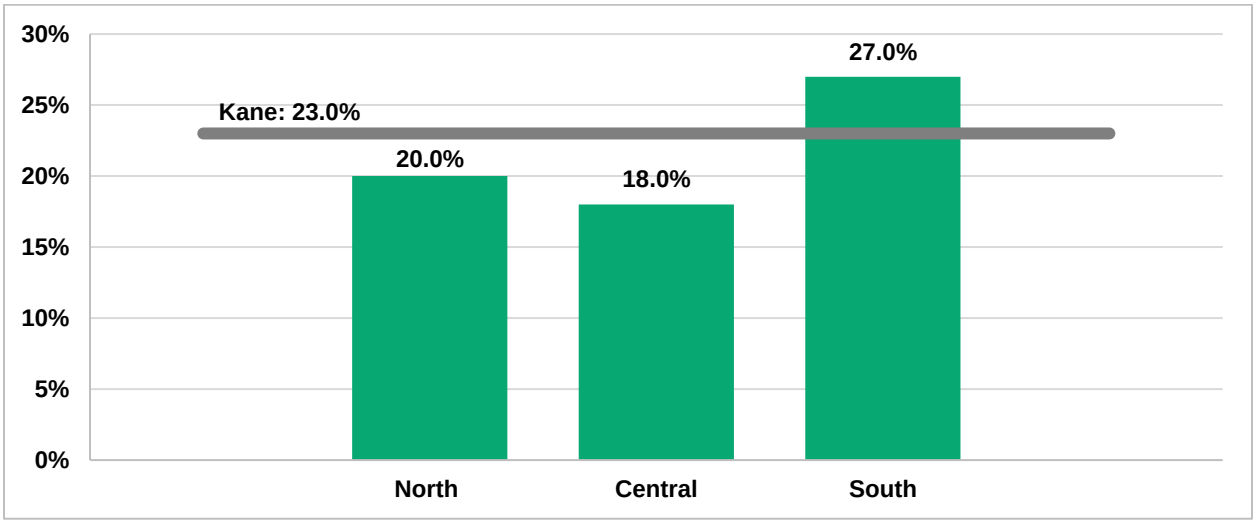
**FIGURE 30: COMMUNITY SURVEY RESPONDENTS REPORTING HAVING WORRIED ABOUT WHETHER THEIR FOOD WOULD RUN OUT BEFORE THEY GOT MONEY TO BUY MORE SOMETIME DURING THE LAST 12 MONTHS**




($N_{Kane}$=1515, $N_{North}$=500, $N_{Central}$=415, $N_{South}$=601)

Figure 31 shows the percentage of respondents in the North, Central, and South planning areas who reported that there was a time during the past 12 months when the food they bought did not last and they did not have money to get more compared to all respondents from Kane County. The South Planning Area had a higher percentage of respondents who reported this food insecurity challenge (27.0%) compared to Kane County at 23.0%. The Northern and Central Planning Areas fell under the Kane County value at 20.0% and 18.0% respectively.

**FIGURE 31: COMMUNITY SURVEY RESPONDENTS REPORTING THAT THERE WAS A TIME DURING THE PAST 12 MONTHS WHEN THE FOOD THEY BOUGHT DID NOT LAST AND THEY DID NOT HAVE MONEY TO GET MORE**

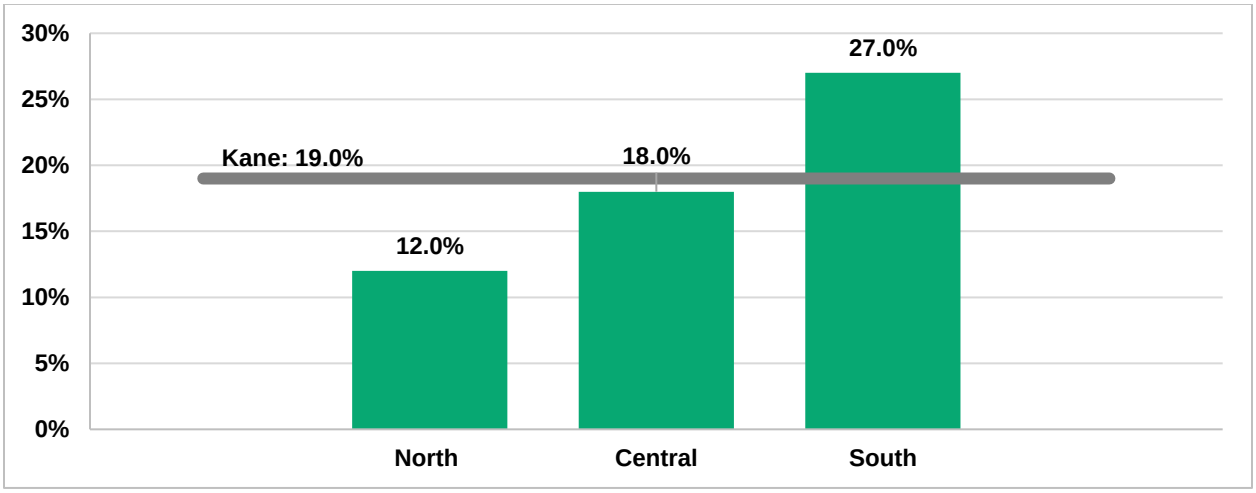



($N_{Kane}$=1515, $N_{North}$=500, $N_{Central}$=415, $N_{South}$=601)

Figure 32 shows the percentage of respondents in the North, Central, and South planning areas who reported that they or someone living in their home received emergency food from a church, a food pantry, or a food bank, or ate in a soup kitchen in the past 12 months compared to all respondents from Kane

County. The South Planning Area had a higher percentage of respondents who accessed these support services (27.0%) compared to Kane County at 19.0%. The Northern and Central Planning Areas fell under the Kane County value at 12.0% and 18.0% respectively.

**FIGURE 32: COMMUNITY SURVEY RESPONDENTS REPORTING THAT THEY OR SOMEONE LIVING IN THEIR HOME RECEIVED EMERGENCY FOOD FROM A CHURCH, A FOOD PANTRY, OR A FOOD BANK, OR ATE IN A SOUP KITCHEN IN THE PAST 12 MONTHS**

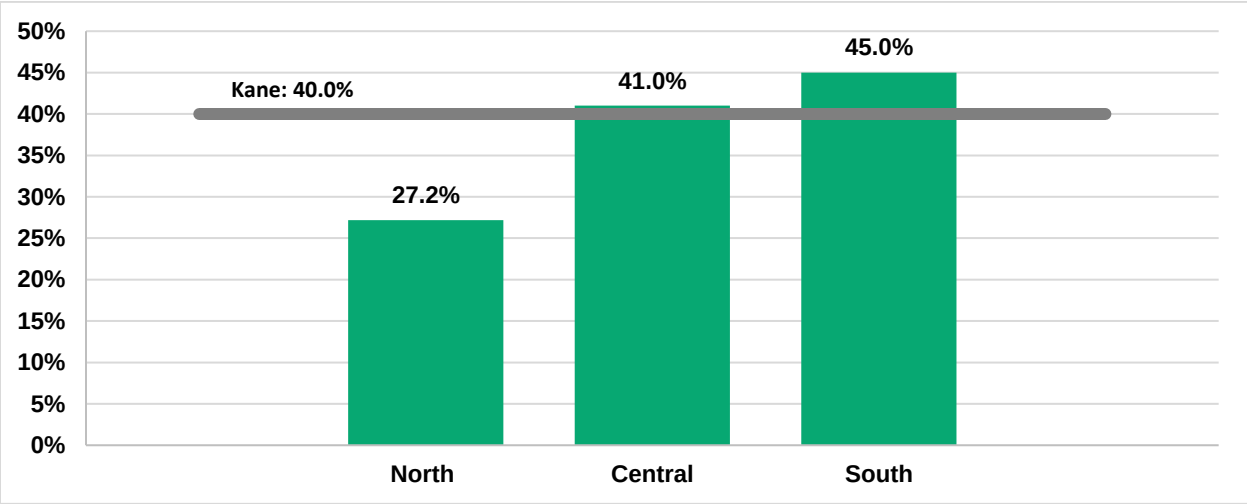



($N_{Kane}$=1515, $N_{North}$=500, $N_{Central}$=415, $N_{South}$=601)

Responses from the community survey indicates that food insecurity impacts a greater number of families living in Kane County who have children living in their home compared to those who did not have children in their home. Figures 30, 31, and 32 below highlight food insecurity among community survey respondents with children in their home by Kane County Planning Areas (North, Central, and South) compared to all survey respondents from Kane County with children in their home.

Figure 33 shows the percentage of respondents with children in their home in the North, Central, and South planning areas who reported having worried about whether their food would run out before they got money to buy more sometime during the last 12 months compared to all respondents from Kane County. The Central and South Planning Areas had a higher percentage of respondents who reported this food insecurity challenge (41.0% and 45.0% respectively) compared to Kane County at 40.0%. The Northern Planning Area fell under the Kane County value at 27.2%.

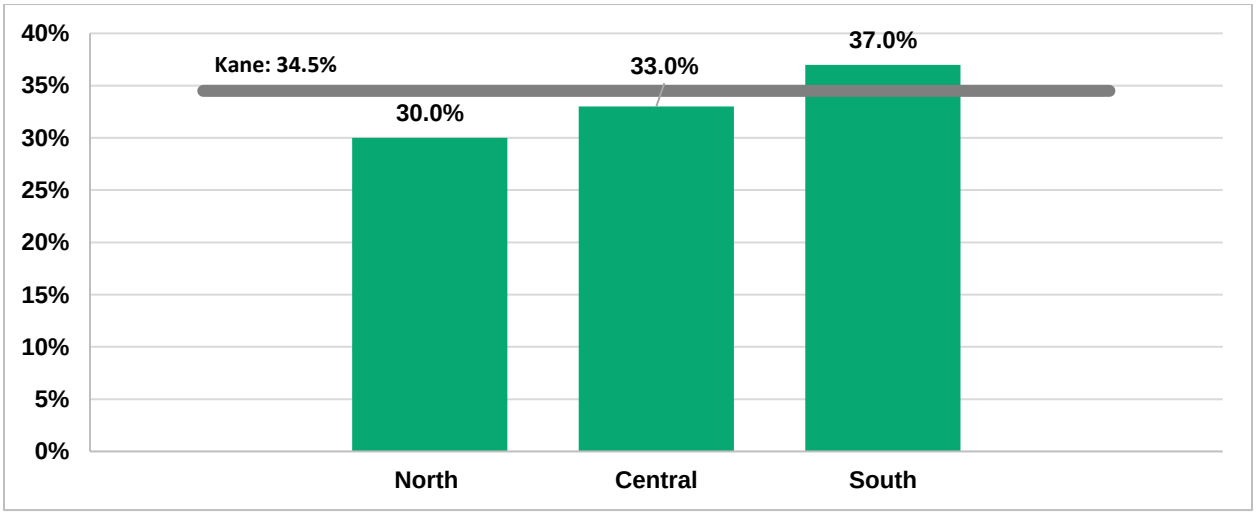
**FIGURE 33: COMMUNITY SURVEY RESPONDENTS WITH CHILDREN IN THEIR HOME WHO REPORTED HAVING WORRIED ABOUT WHETHER THEIR FOOD WOULD RUN OUT BEFORE THEY GOT MONEY TO BUY MORE SOMETIME DURING THE LAST 12 MONTHS**




$N_{Kane}$=677, $N_{North}$=210, $N_{Central}$=181, $N_{South}$=293

Figure 34 shows the percentage of respondents with children in their home in the North, Central, and South planning areas who reported that there was a time during the past 12 months when the food they bought did not last and they did not have money to get more compared to all respondents from Kane County. The South Planning Area had a higher percentage of respondents who reported this food insecurity challenge (37.0%) compared to Kane County at 34.5%. The Northern and Central Planning Areas fell under the Kane County value at 30.0% and 33.0% respectively.

**FIGURE 34: COMMUNITY SURVEY RESPONDENTS WITH CHILDREN IN THER HOME WHO REPORTED THAT THERE WAS A TIME DURING THE PAST 12 MONTHS WHEN THE FOOD THEY BOUGHT DID NOT LAST AND THEY DID NOT HAVE MONEY TO GET MORE**

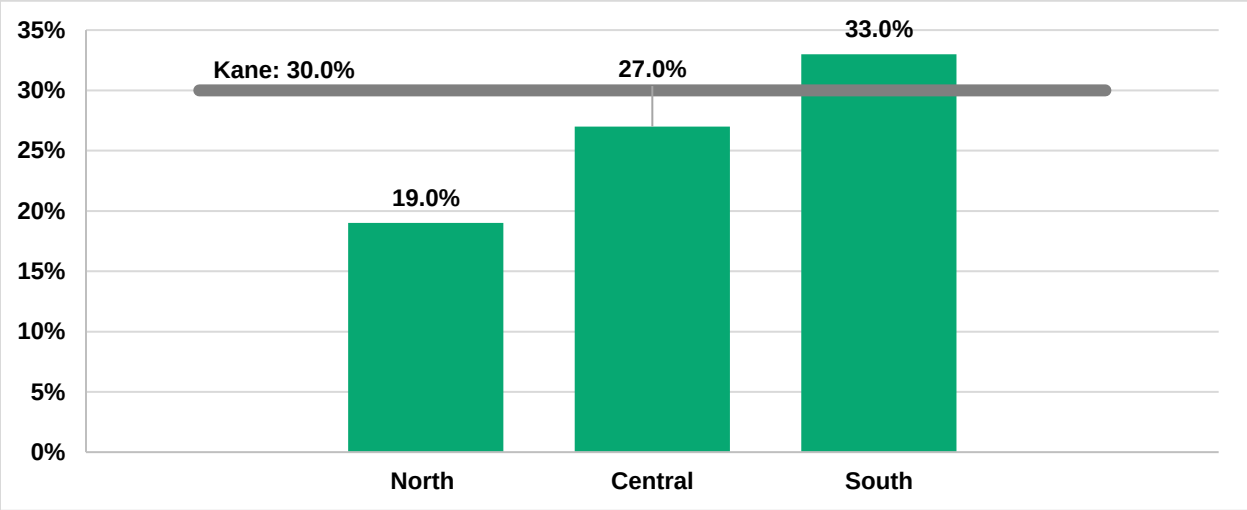



$N_{Kane}$=677, $N_{North}$=210, $N_{Central}$=181, $N_{South}$=293

Figure 35 shows the percentage of respondents with children in their home in the North, Central, and South planning areas who reported that they or someone living in their home received emergency food

from a church, a food pantry, or a food bank, or ate in a soup kitchen in the past 12 months compared to all respondents from Kane County. The South Planning Area had a higher percentage of respondents who accessed these support services (33.0%) compared to Kane County at 30.0%. The Northern and Central Planning Areas fell under the Kane County value at 19.0% and 27.0% respectively.

**FIGURE 35: COMMUNITY SURVEY RESPONDENTS WITH CHILDREN IN THEIR HOME WHO REPORTED THAT THEY OR SOMEONE LIVING IN THEIR HOME RECEIVED EMERGENCY FOOD FROM A CHURCH, A FOOD PANTRY, OR A FOOD BANK, OR ATE IN A SOUP KITCHEN IN THE PAST 12 MONTHS**




$N_{Kane}$=677, $N_{North}$=210, $N_{Central}$=181, $N_{South}$=293

> If you have limited resources, you'll just go to McDonalds. Exercise is another area. Being closed in and moved in very close to each other and not having a broader community really makes the virtual community more of a lifeline and more of an influence.
> - Focus Group Participant

# Non-Prioritized Significant Health Needs

The following significant health needs, presented in alphabetical order, emerged from a review of the primary and secondary data. However, Kane Health Counts will not focus on these topics in their Implementation Strategy.

Key themes from community input are included where relevant for each non-prioritized health need along with the secondary data score and warning indicators.

## Non-Prioritized Health Need #1: Education

### Education

Secondary Data Score: **1.29**

#### Key Themes from Community Input

- Top priority in Forces of Change Assessment
- Impact due to Covid-19
- Unequal access to broadband and technology

#### Warning Indicators

- Student-to-Teacher Ratio
- People 25+ with a High School Degree or Higher

> I agree with the problem of feeding children at school. The solution is to stay on top of school surveys, raise our voice as parents and go talk to the district and talk about the type of food, education, bullying.
> - Focus Group Participant

## Non-Prioritized Health Need #2: Environment

### Environment

Secondary Data Score: **1.45**

**Warning Indicators**

- SNAP Certified Stores
- Recognized Carcinogens Released into the Air
- Annual Ozone Air Quality
- Liquor Store Density
- Children with Low Access to a Grocery Store
- Farmers Market Density
- Fast Food Restaurant Density
- Grocery Store Density
- Overcrowded Households
- Severe Housing Problems

> Health, no exercise. They do not dedicate themselves fully to that. It would be ideal if there were more parks with equipment for sports and exercise.
> - Focus Group Participant

## Non-Prioritized Health Need #3: Maternal, Fetal, & Infant Health

### Maternal, Fetal & Infant Health

Secondary Data Score: **1.32**

**Warning Indicators**

- Preterm Births
- Preterm Labor and Delivery Hospitalizations

## Non-Prioritized Health Need #4: Older Adults & Aging

# Older Adults & Aging

Secondary Data Score: **1.40**

### Warning Indicators

- Atrial Fibrillation: Medicare Population
- Cancer: Medicare Population
- Osteoporosis: Medicare Population
- Rheumatoid Arthritis or Osteoarthritis: Medicare Population
- Stroke: Medicare Population
- Hypertension: Medicare Population
- Hyperlipidemia: Medicare Population

> "Mental health issues which go hand and hand with isolation. It's hard for seniors to get in and get help, there is usually a waiting list to get into these programs."
> - Focus Group Participant

## Non-Prioritized Health Need #5: Other Chronic Dease

# Other Chronic Diseases

Secondary Data Score: **1.86**

### Warning Indicators

- Osteoporosis: Medicare Population
- Rheumatoid Arthritis or Osteoarthritis: Medicare Population

## Non-Prioritized Health Need #6: Public Safety

# Public Safety

Secondary Data Score: **1.25**

### Warning Indicators

- Alcohol Impaired Driving Deaths

## Non-Prioritized Health Need #7: Teen & Adolescent Health

# Teen & Adolescent Health

Secondary Data Score: **1.27**

### Warning Indicators

- Teens Who use Alcohol
- Teens Who use Marijuana

> Younger people are on COVID-19 burn out, some are taking precautions, but some are not. I see elderly people with masks on, but younger people are not being as conscientious about wearing masks and they are taking more risks.
> - Focus Group Participant

## Non-Prioritized Health Need #8: Transportation

# Transportation

Secondary Data Score: **1.43**

### Warning Indicators

- Solo Drivers with a Long Commute to Work
- Mean Travel Time to Work
- Workers Commuting by Public Transportation

> Transportation issue has always been huge. It's a blackhole for money, Riding Kane has worked on it and we have worked on it, but we are a large county; there is a lot of distance between us. It is hard to get around.
> - Focus Group Participant

# Other Findings

Critical components in assessing the needs of a community are identifying barriers to and disparities in health care. Additionally, the identification of barriers and disparities will help inform and focus strategies for addressing the prioritized health needs. The following section identifies barriers and disparities as they pertain to Kane County.

## Barriers to Care

Community health barriers for Kane County were identified as part of the primary data collection. Community survey respondents and focus group participants were asked to identify any barriers to healthcare observed or experienced in the community.

### Transportation

Transportation, while not selected as a Prioritized Health Need by Kane Health Counts through this joint CHA/CHNA process, was still an identified significant health need that scored a 1.43 in the Secondary Data Analysis. Particular indicators of concern from the Secondary Data Analysis included the number of solo drivers who have a long commute to work, the mean travel time to work, as well as the number of workers commuting by public transportation. Additionally, 33% of community survey respondents disagreed or strongly disagreed that public transportation is easily accessible if they needed it. Focus Group participants mentioned that access to transportation was a specific barrier for the elderly population in Kane County.

### Cost, Literacy, and Language Barriers

In general, accessing affordable health care was a common barrier that was discussed whether due to overall cost or being underinsured or uninsured. For community survey respondents that did not receive the care they needed, 35% selected cost as a barrier to seeking the care they needed, while 28% noted that their providers or health care facilities being closed due to COVID-19 was a barrier to their care. Focus Group participants were concerned that low-income community members do not have access to affordable healthcare providers. Focus Group participants added that even when health insurance is available, health literacy issues and language barriers make seeking or renewing healthcare coverage difficult, especially for older adults and immigrant populations.

# Disparities

## Race/Ethnic & Age Disparities

Community health disparities were assessed in both the primary and secondary data collection processes. Table 14 below show secondary data indicators with statistically significant race/ethnicity, age or gender disparity for Kane County Index of Disparity analysis. Disparities should be recognized and considered for implementation planning to mitigate the challenges and barriers often faced along gender, racial, ethnic, or cultural lines.

TABLE 14. INDICATORS WITH SIGNIFICANT RACE/ETHNICITY, AGE OR GENDER DISPARITIES

| Health Indicator | Group Negatively Impacted |
|---|---|
| Age-Adjusted Hospitalization Rate due to Adult Mental Health | American Indian/Alaska Native, Black/African American |
| Age-Adjusted Hospitalization Rate due to Adult Suicide and Intentional Self-Inflicted Injury | American Indian/Alaska Native, Black/African American |
| Age-Adjusted Death Rate due to Suicide | Male |
| Age-Adjusted Drug and Opioid-Involved Overdose Death Rate | Male |
| Age-Adjusted Hospitalization Rate due to Opioid Use | Black/African American and Male |
| Age-Adjusted Hospitalization Rate due to Substance Use | Black/African American and Male |
| Age-Adjusted Death Rate due to Kidney Disease | Male |
| People 65+ Living Below Poverty Level | American Indian/Alaska Native, Black/African American, Hispanic/Latino, Other |

Race and age proved to be a barrier to care among community survey respondents. Among survey respondents, a higher percentage of respondents identifying as Native American, Black/African American, or Hispanic reported not being able to access care when needed. Higher percentages of respondents aged 18-54 also reported not being able to access care when needed. When asked about accessing care in the emergency room, a higher percentage of Black/African American, Native American, and those identifying as more than one race reported accessing care in the ER in the last year. Additionally, a higher percentage of respondents identifying as Native American, Black/African American, Multi-racial, Another Race, and Hispanic/Latino reported not being able to access dental care when needed.

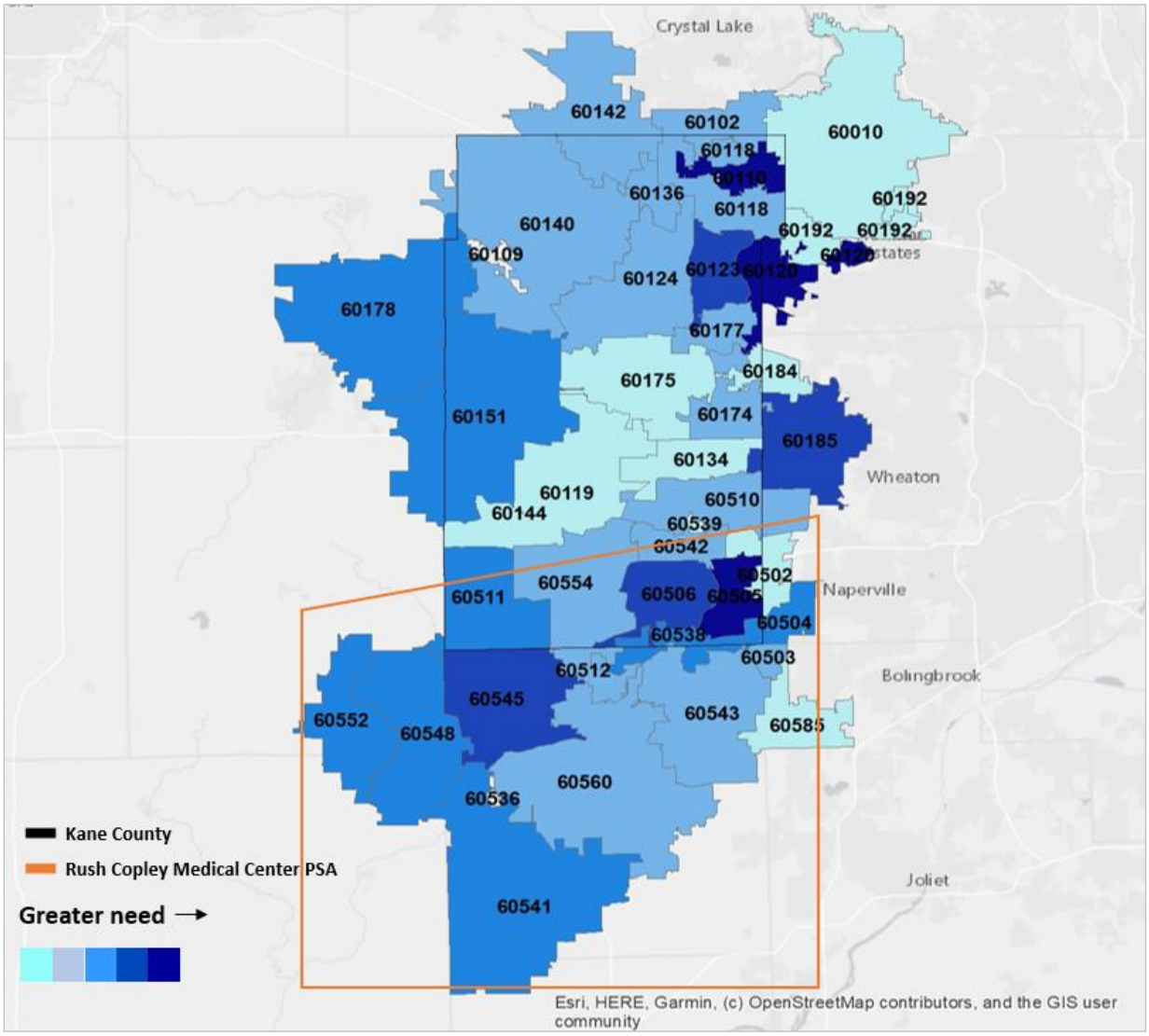
When specifically considering access to mental health services among community survey respondents, a higher percentage of respondents identifying as Black/African American, American Indian/Alaskan Native, those identifying as Multi-racial, and Hispanic/Latino reported not being able to access mental health care when needed. Higher percentages of respondents aged 18-54 reported not being able to access mental health care when needed as well.

Focus Group participants mentioned the health system navigation and health education access for minority racial or ethnic groups being a barrier to equitable care. They also specifically spoke to the lack of focus on men's health topics within the African American community. Additionally, older adults were the age group that focus group participants brought up the most as having more barriers to accessing healthcare and services compared to younger populations. They also mentioned low-income families struggling to access services.

## Geographic Disparities

Geographic disparities were identified using the SocioNeeds Index®. Within Kane County, the following zip codes were identified as having highest socioeconomic need (as indicated by the darkest shade of blue): 60505 (South Planning Area), 60120 (North Planning Area), 60110 (North Planning Area) as shown in Figure 36 below. Zip codes 60505, 60506 and 60545 have the highest level of socioeconomic need among all zip codes within Rush Copley's PSA. Areas of highest socioeconomic need potentially indicate poorer health outcomes for residents in those areas. Because these areas were identified as having the highest socioeconomic need, understanding the population demographics of these communities is equally as important.

**FIGURE 36: SOCIONEEDS INDEX**



# COVID-19 Impact Snapshot

## Introduction

At the time that Kane Health Counts began its collaborative CHA/CHNA process, Kane County and the state of Illinois were in the midst of dealing with the novel coronavirus (COVID-19) pandemic.

The process for conducting the assessment remained fundamentally the same. However, there were some adjustments made during the primary data collection to ensure the health and safety of those participating.

## Pandemic Overview

On March 13, 2020, a U.S. national emergency was declared over the novel coronavirus outbreak first reported in the Wuhan Provence of China in December 2019. Officially named COVID-19 by the World Health Organization (WHO) in February, WHO declared COVID-19 a pandemic on March 11, 2020. Upon completion of this report in February 2021, the pandemic was still very much a health crisis across the United States and in most countries.

## Community Insights

The CHNA project team researched additional sources of secondary data and gathered primary data to provide a snapshot of the impact of COVID-19 on Kane County between March 2020 and January 2021. Findings are reported below.

## COVID-19 Cases and Deaths in Illinois and Kane County

For current cases and deaths due to COVID-19 visit the Illinois Department of Public Health https://www.dph.illinois.gov/covid19 or the Kane County Health Department https://kanehealth.com/

## Vulnerability Index

Beyond looking at what we know about COVID-19 cases and deaths, the Conduent Vulnerability Index is a measure of potential severe illness burden due to COVID-19 by county. Counties are given an index value from 1 (low vulnerability) to 10 (high vulnerability). A county with a high vulnerability score can be described as a location where a higher percentage of COVID-19 cases would result in severe outcomes such as hospitalization or death as comparted a county with a low vulnerability score.

Kane County Index Score: 4 (as of November 8, 2020)


*What does this score mean?*

Kane County's Vulnerability Index Score is 4 out of 10. This means that county residents generally have moderate death rates due to chronic conditions, moderate socio-economic needs, and less than adequate access to healthcare and services to protect themselves from more severe COVID-19 cases and more death.

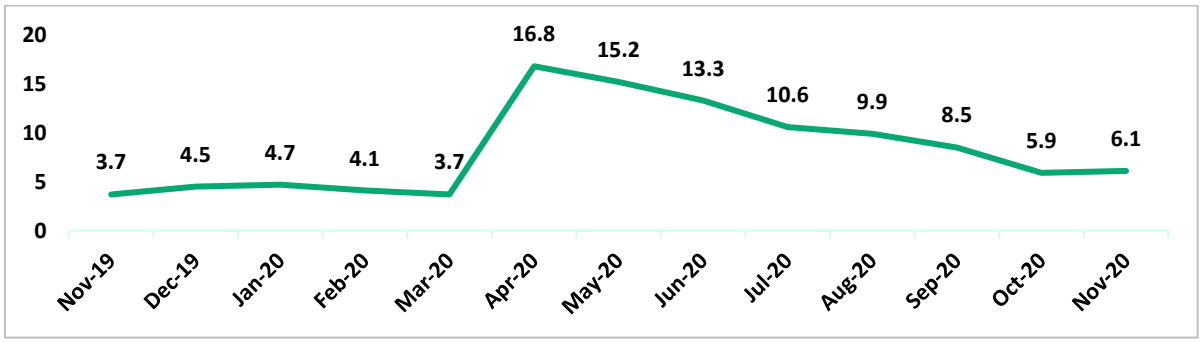
The median Vulnerability Index value in Illinois is 6 out of 10. Kane County's score of 4 indicates their residents have a lower vulnerability than a county with higher rates of chronic disease, risky behavior, and/or low access to health services.

Seventy-six counties meet the inclusion criteria for the model and have calculated Vulnerability Index values.

## Kane County Unemployment Rates

As expected, Kane County's unemployment rates rose in April 2020 when stay at home orders were first in place. As illustrated in Figure 37 below, as Kane and surrounding counties began slowly reopening some businesses in May 2020, the unemployment rate gradually began to go down. As of November 2020, the latest data available at the writing of this report, the county's unemployment rate has still not returned to pre-COVID rates. The county can expect to see variation in unemployment rates based on government response to the pandemic. When unemployment rates rise, there is potential impact on health insurance coverage and health care access if jobs lost include employer-sponsored healthcare.

**FIGURE 37: KANE COUNTY, ILLINOIS UNEMPLOYMENT RATE[5]**




[5] U.S. Bureau of Labor Statistics, Unemployment Rate in Kane County, IL, retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/ILKANE2URN, January 2021.

## Kane County Community Feedback

The Forces of Change Assessment, Public Health System Assessment, focus groups and on-line community survey were used to capture insights and perspectives of the health needs of Kane County. Included in these primary data collection tools were questions specific to COVID-19. Survey respondents were specifically asked about the biggest challenges their households were currently facing due to COVID-19. Of the 1,342 respondents who answered this question:

- 61% Reported not knowing when the pandemic will end
- 42% Reported feeling nervous or anxious
- 37% Reported feeling alone
- 25% Experienced a shortage of sanitation and cleaning supplies
- 24% Had not being able to exercise

Additionally, the information highlighted below summarizes insights from community members who engaged in the various primary data collection methods from September to November 2020 regarding the impact of COVID-19 on their community.

**Access to Health Services:**

- People need to know what services are still available, even if it's virtually
- Continued disparities as it relates to testing and access to care for minorities
- Routine care and testing for those who can't afford it
- Need for better organization of community response

**Social Determinants of Health:**

- Financial and economic impact; increased job loss
- Impact on education
- Challenge/impact of distance learning
- Impact of the pandemic on different racial and ethnic groups in the community
- Impact on frontline workers

**General Impact:**

- COVID-19 fatigue
- Mental health strain caused by physical distancing, especially on seniors and school-aged children and their parents
- Knowing which sources of information to trust to help in your decision making
- Strain on local non-profits

**Positive responses to COVID-19:**

- The turnaround for the tests with pop-up testing sites are helping and getting better
- Collaboration efforts within the county
- The speed at which some services were able to be modified to meet the changing needs due to COVID-19
- Change to virtual services and appointments
- More sense of community
- More family time due to restrictions in place

## Kane County Significant Health Needs and COVID-19 Impact

Each of the four prioritized health needs identified through primary and secondary data and prioritization appeared to worsen throughout the duration of the COVID-19 pandemic according to information gathered through primary data.

### Behavioral Health (Mental Health and Substance Abuse)

- 61% of survey respondents reported not knowing when the pandemic will end
- 42% of survey respondents reported feeling nervous, anxious or on edge due to the COVID-19 pandemic.
- 37% of survey respondents reported loneliness/isolation and the lack of socialization as a major challenge during the COVID-19 pandemic.
- The toll of the pandemic on frontline workers was a frequent topic of discussion

- Mental health strain caused by physical distancing, especially on seniors and school-aged children and their parents
- Impact of the economy and job loss on mental health
- An increase or non-prioritization of alcohol and drug use as resources are diverted to the COVID-19 response

### Access to Health Services

- Cost of accessing care and being uninsured or underinsured were identified as general barriers to care outside of the influence of the COVID-19 Pandemic. Increasing economic strain and job loss which could result in the loss of health insurance through and employer are examples of how the COVID-19 pandemic has exacerbated this barrier to care.
- Health facility closings and delays due to COVID-19 were also identified as barriers to accessing care in primary data.
- Focus Group participants, particularly older adults mentioned that clear and consistent public health messaging about COVID-19 restrictions and guidelines were another common challenge to accessing care. Something as simple as knowing if their own health provider was open and accepting in-person or virtual patients was not clear or easily understood.

### Immunizations and Infectious Diseases

- Improved public health communication is even more crucial as the COVID-19 vaccine rollout continues in Kane County.
- On-going need and concern to maintain other routine vaccine distribution rates particularly among vulnerable populations such as the young and elderly populations.

### Exercise, Nutrition, and Weight

- The inability to exercise was noted by 24% of survey respondents in relation some of the biggest challenges they were facing in their household due to COVID-19.
- Increased food insecurity, even among those who had not experienced food insecurity previously, was noted as one of the major impacts of the COVID-19 pandemic in the community.

## Recommended Data Sources

As local, state, and national data are updated and become available, these data can continue to help inform approaches to meeting existing and developing needs related to the pandemic. Recommended data sources for Kane County are included here:

### National Data Sources

Data from the following national websites are updated regularly and may provide additional information into the impact of COVID-19:

- United States National Response to COVID-19 https://www.usa.gov/coronavirus
- Center for Disease Control: https://www.cdc.gov/
- U.S. Department of Health and Human Services: https://www.hhs.gov/
- Centers for Medicare and Medicaid: https://www.cms.gov/
- U.S. Department of Labor: https://www.dol.gov/coronavirus
- Johns Hopkins Coronavirus Resource Center: https://coronavirus.jhu.edu/us-map
- National Association of County Health Officials: https://www.naccho.org/
- Feeding America (The Impact of the Coronavirus on Food Insecurity): https://www.feedingamerica.org/

### Illinois Data Sources

Data from the following websites are updated regularly and may provide additional information into the impact of COVID-19 in Kane County:

- Illinois Department of Public Health: https://www.dph.illinois.gov/
- Kane County Health Department: https://kanehealth.com/
- Kane Health Counts: http://www.kanehealthcounts.org/

# Conclusion

This joint Community Health Assessment (CHA) and Community Health Needs Assessment (CHNA), conducted for Kane Health Counts used a comprehensive set of secondary and primary data to determine the 13 significant health needs in Kane County, Illinois. The prioritization process identified four top health needs: Behavioral Health (including Mental Health & Substance Abuse), Access to Health Services, Immunizations and Infectious Diseases, and Exercise, Nutrition, and Weight.

The findings in this report will be used to guide the development of the Kane Health Counts Collaborative work plan as well as the Rush Copley's Implementation Strategy which will outline strategies to address identified priorities and improve the health of the community.

Please send any feedback and comments about this CHNA to Questions related to our CHNA and CHIP an be direcete to Alexander F. Pope, Vice President/Chief Development Officer at alexander.pope@rushcopley.com or Mariana M. Martinez, CHES® Community Health Outreach Coordinator at mariana.martinez@rushcopley.com with "CHNA Comments" in the subject line. Feedback received will be incorporated into the next CHNA process.

# Appendices Summary

The following support documents are shared separately on the Rush Copley Medical Center Website https://www.rush.edu/locations/rush-copley-medical-center

## A. Detailed Methodology and Data Scoring Tables (Secondary Data)

A detailed overview of the Conduent HCI data scoring methodology and indicator scoring results from the secondary data analysis.

## B. Community Themes and Strengths Assessment Tools (Primary Data)

Quantitative and qualitative community feedback data collection tools that were vital in capturing community feedback during this collaborative CHA/CHNA:

- Community survey
- Focus Group Guide
- Focus Group Findings Summary

## C. Community Resources

This document highlights existing resources that organizations are currently using and available widely in the community.

## D. Potential Community Partners

The tables in this section highlight potential community partners who were identified during the qualitative data collection process for this collaborative CHA/CHNA.

## E. Local Public Health System Assessment and Forces of Change Assessment Reports

Implementing a Local Public Health System Assessment and Forces of Change Assessment were key components of the MAPP process that contributed to the overall collaborative CHA/CHNA process. Summary reports of key findings from these assessments are included in this appendix.

RUSH

Rush Copley Medical Center

# Rush Copley Medical Center

## APPENDICES: 2021 COMMUNITY HEALTH NEEDS ASSESSMENT

RUSH

Rush Copley Medical Center

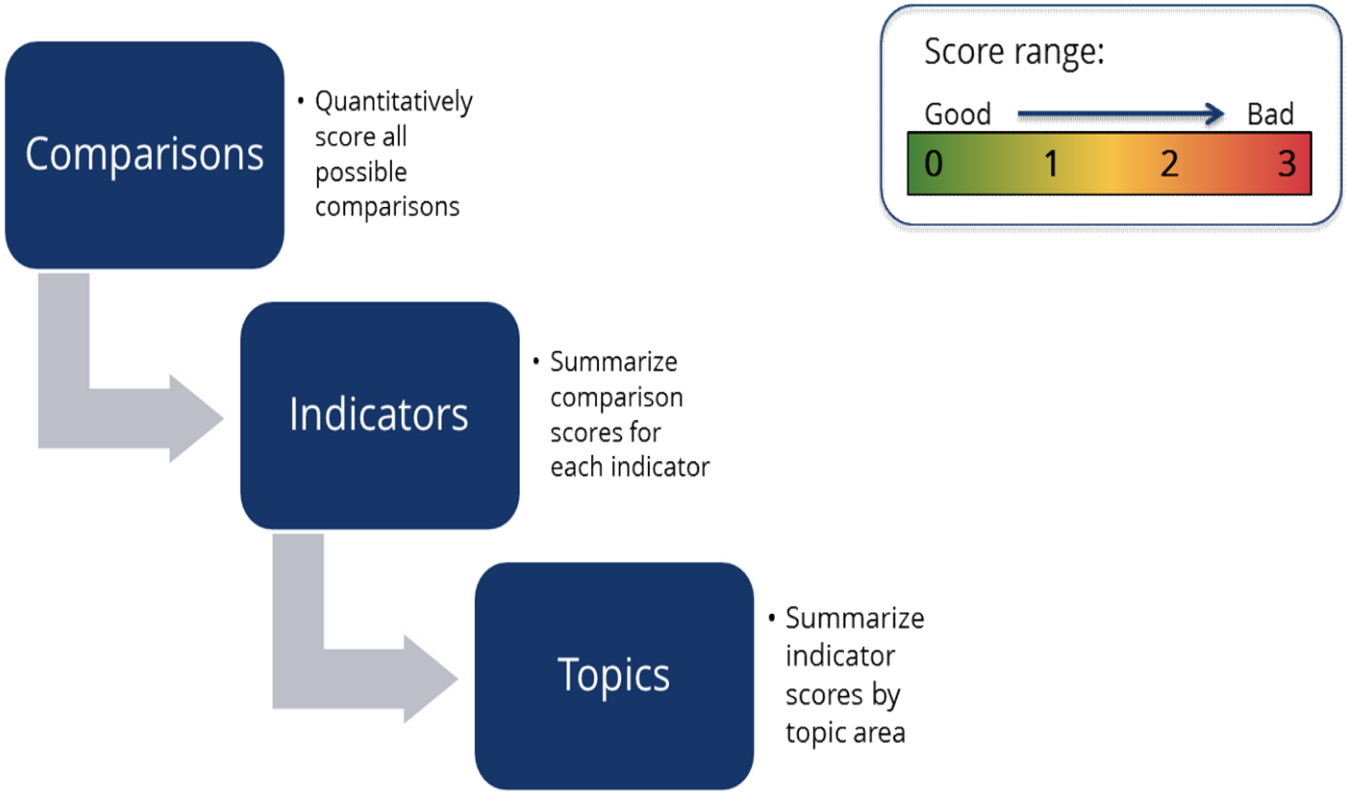
# Appendix A: Detailed Methodology and Data Scoring Tables

SECONDARY DATA: KANE COUNTY

# Conduent Healthy Communities Institute Data Scoring Tool - Methodology

## Scoring Method

Data Scoring is done in three stages:



For each indicator, your county is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time.

Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic.

### Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

**HCI Platform County Distribution Gauge**

### Comparison to Values: State, National, and Targets

Your county is compared to the state value, the national value, and target values. Targets values include the nation-wide Healthy People 2020 (HP2020) goals as well as locally set goals. Healthy People 2020 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

**HCI Platform Compare to State or National Value**

**HCI Platform Compare to Healthy People 2020 Target**

### Trend Over Time

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

### Missing Values

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

### Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated and the indicator is excluded from the data scoring results.

### Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.

### Significant Disparities

When a given indicator has data available for subgroups like race/ethnicity, age or gender–and values for we are able determine if there is a significant difference between the subgroups value and the overall two values with non-overlapping confidence intervals. Only significant differences in which a subgroup is the overall value are identified.

### How to Cite Conduent HCI's Data Scoring Tool

Conduent Healthy Communities Institute (Year). Data Scoring Tool. Title of web site. Retrieved date. URL of website.

Appendix A: Secondary Data Detailed Methodology and Data Scoring Tables

Appendix A: Secondary Data Detailed Methodology and Data Scoring Tables

**Secondary Data Sources**

| Key | Source Title |
|---|---|
| 1 | American Community Survey |
| 2 | American Lung Association |
| 3 | Center for Prevention Research and Development, Illinois Youth Survey |
| 4 | Centers for Disease Control and Prevention |
| 5 | Centers for Medicare & Medicaid Services |
| 6 | Claritas Consumer Profiles |
| 7 | County Health Rankings |
| 8 | Feeding America |
| 9 | Healthy Communities Institute |
| 10 | Illinois Behavioral Risk Factor Surveillance System |
| 11 | Illinois Department of Children and Family Services |
| 12 | Illinois Department of Public Health |
| 13 | Illinois Hospital Association |
| 14 | Illinois State Board of Elections |
| 15 | Illinois State Police |
| 16 | National Cancer Institute |
| 17 | National Center for Education Statistics |
| 18 | National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention |
| 19 | National Environmental Public Health Tracking Network |
| 20 | The Dartmouth Atlas of Health Care |
| 21 | U.S. Bureau of Labor Statistics |
| 22 | U.S. Census - County Business Patterns |
| 23 | U.S. Department of Agriculture - Food Environment Atlas |
| 24 | U.S. Environmental Protection Agency |
| 25 | United For ALICE |

Appendix A: Secondary Data Detailed Methodology and Data Scoring Tables

| SCORE | ACCESS TO HEALTH SERVICES | UNITS | KANE COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| 2.03 | Primary Care Provider Rate | *providers/ 100,000 population* | 40.8 | | 80 | | *2017* | | 7 |
| 1.75 | Clinical Care Ranking | *ranking* | 83 | | | | *2020* | | 7 |
| 1.67 | Adults with Health Insurance | *percent* | 88.2 | 100 | 90.1 | 87.5 | *2018* | | 1 |
| 1.56 | Children with Health Insurance | *percent* | 95.1 | 100 | 96.6 | 94.8 | *2018* | | 1 |
| 1.42 | Non-Physician Primary Care Provider Rate | *providers/ 100,000 population* | 71.3 | | 82.4 | | *2019* | | 7 |
| 0.92 | Dentist Rate | *dentists/ 100,000 population* | 66.3 | | 77.9 | | *2018* | | 7 |
| 0.83 | Adults with Health Insurance: 18+ | *percent* | 92.5 | | 91.5 | 91.3 | *2020* | | 6 |
| 0.83 | Preventable Hospital Stays: Medicare Population | *discharges/ 1,000 Medicare enrollees* | 50.7 | | 54.8 | 49.4 | *2015* | | 20 |
| | | | | | | | | | |
| SCORE | CANCER | UNITS | KANE COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
| 2.44 | Cancer: Medicare Population | *percent* | 9.2 | | 8.9 | 8.2 | *2017* | | 5 |
| 1.39 | Prostate Cancer Incidence Rate | *cases/ 100,000 males* | 104.9 | | 109.1 | 104.5 | *2013-2017* | | 16 |
| 1.06 | Breast Cancer Incidence Rate | *cases/ 100,000 females* | 120.6 | | 133.1 | 125.9 | *2013-2017* | | 16 |
| 1.00 | Oral Cavity and Pharynx Cancer Incidence Rate | *cases/ 100,000 population* | 10.7 | | 12.2 | 11.8 | *2013-2017* | Male (15.8) | 16 |
| 0.81 | Age-Adjusted Death Rate due to Prostate Cancer | *deaths/ 100,000 males* | 17.6 | 21.8 | 20 | 19 | *2013-2017* | | 16 |
| 0.72 | Colorectal Cancer Incidence Rate | *cases/ 100,000 population* | 36.1 | 39.9 | 42.5 | 38.4 | *2013-2017* | | 16 |
| 0.39 | Age-Adjusted Death Rate due to Colorectal Cancer | *deaths/ 100,000 population* | 12.7 | 14.5 | 14.7 | 13.7 | *2013-2017* | | 16 |
| 0.25 | Cervical Cancer Incidence Rate | *cases/ 100,000 females* | 6.2 | 7.3 | 7.7 | 7.6 | *2013-2017* | | 16 |
| 0.17 | Lung and Bronchus Cancer Incidence Rate | *cases/ 100,000 population* | 50.2 | | 63.7 | 58.3 | *2013-2017* | | 16 |
| 0.00 | Age-Adjusted Death Rate due to Breast Cancer | *deaths/ 100,000 females* | 17.1 | 20.7 | 21 | 20.1 | *2013-2017* | | 16 |
| 0.00 | Age-Adjusted Death Rate due to Lung Cancer | *deaths/ 100,000 population* | 33 | 45.5 | 41.1 | 38.5 | *2013-2017* | | 16 |
| | | | | | | | | | |
| SCORE | CHILDREN'S HEALTH | UNITS | KANE COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
| 1.67 | Children with Low Access to a Grocery Store | *percent* | 5.3 | | | | *2015* | | 23 |
| 1.56 | Children with Health Insurance | *percent* | 95.1 | 100 | 96.6 | 94.8 | *2018* | | 1 |
| 1.50 | Age-Adjusted Hospitalization Rate due to Pediatric Mental Health | *hospitalizations/ 10,000 population under 18 years* | 61.6 | | 67.5 | | *2017-2019* | | 13 |
| 1.33 | Age-Adjusted ER Rate due to Pediatric Asthma | *ER visits/ 10,000 population under 18 years* | 51 | | 78.7 | | *2017-2019* | | 13 |
| 1.33 | Age-Adjusted ER Rate due to Pediatric Mental Health | *ER visits/ 10,000 population under 18 years* | 101.5 | | 103.8 | | *2017-2019* | | 13 |
| 1.25 | Age-Adjusted Hospitalization Rate due to Pediatric Asthma | *hospitalizations/ 10,000 population under 18 years* | 5.7 | | 11.8 | | *2017-2019* | | 13 |
| 1.25 | Blood Lead Levels in Children (>=5 micrograms per deciliter) | *percent* | 2.5 | | 3.4 | | *2014* | | 19 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **0.67** | Food Insecure Children Likely Ineligible for Assistance | *percent* | 2 | | 18 | 25 | *2018* | | 8 |
| **0.64** | Substantiated Child Abuse Rate | *cases/ 1,000 children* | 8.1 | | 9.7 | 9.2 | *2015* | | 11 |
| **0.50** | Child Food Insecurity Rate | *percent* | 9.4 | | 12.7 | 15.2 | *2018* | | 8 |
| | | | | | | | | | |
| **SCORE** | **DIABETES** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **1.67** | Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes | *hospitalizations/ 10,000 population 18+ years* | 14.1 | | 15.1 | | *2017-2019* | Male (18.6) | 13 |
| **1.58** | Hospitalization Rate due to Short-Term Complications of Diabetes | *hospitalizations/ 100,000 population 18+ years* | 49.7 | | 67.3 | | *2015* | | 12 |
| **1.50** | Age-Adjusted ER Rate due to Short-Term Complications of Diabetes | *ER visits/ 10,000 population 18+ years* | 2 | | 1.7 | | *2017-2019* | ack (10.5): Male (2. | 13 |
| **1.33** | Age-Adjusted Hospitalization Rate due to Diabetes | *hospitalizations/ 10,000 population 18+ years* | 26.9 | | 31.8 | | *2017-2019* | | 13 |
| **1.33** | Age-Adjusted Hospitalization Rate due to Type 2 Diabetes | *hospitalizations/ 10,000 population 18+ years* | 20.9 | | 23.6 | | *2017-2019* | | 13 |
| **1.25** | Adults with Diabetes | *percent* | 7.5 | | | | *2010-2014* | Male (9.9) | 10 |
| **1.25** | Hospitalization Rate due to Uncontrolled Diabetes | *hospitalizations/ 100,000 population 18+ years* | 13.6 | | 17.4 | | *2015* | | 12 |
| **1.17** | Age-Adjusted ER Rate due to Type 2 Diabetes | *ER visits/ 10,000 population 18+ years* | 28.7 | | 42.3 | | *2017-2019* | Black (109.4), Hispanic / Latino (34.4) | 13 |
| **1.17** | Age-Adjusted Hospitalization Rate due to Short-Term Complications of Diabetes | *hospitalizations/ 10,000 population 18+ years* | 8 | | 10 | | *2017-2019* | Black (25.5) | 13 |
| **1.17** | Age-Adjusted Hospitalization Rate due to Uncontrolled Diabetes | *hospitalizations/ 10,000 population 18+ years* | 4.8 | | 6.6 | | *2017-2019* | | 13 |
| **1.14** | Hospitalization Rate due to Long-Term Complications of Diabetes | *hospitalizations/ 100,000 population 18+ years* | 73.7 | | 105.6 | | *2015* | Male (93.8) | 12 |
| **1.14** | Hospitalization Rate due to Lower-Extremity Amputation among Diabetic Patients | *hospitalizations/ 100,000 population 18+ years* | 8.9 | | 16.5 | | *2015* | | 12 |
| **1.11** | Diabetes: Medicare Population | *percent* | 25.6 | | 27.2 | 27.2 | *2017* | | 5 |
| **1.00** | Age-Adjusted ER Rate due to Diabetes | *ER visits/ 10,000 population 18+ years* | 33.1 | | 48.6 | | *2017-2019* | | 13 |
| **1.00** | Age-Adjusted ER Rate due to Long-Term Complications of Diabetes | *ER visits/ 10,000 population 18+ years* | 4.7 | | 7.2 | | *2017-2019* | Black (21.5) Hispanic / Latino (7.8) | 13 |
| **1.00** | Age-Adjusted ER Rate due to Uncontrolled Diabetes | *ER visits/ 10,000 population 18+ years* | 24.9 | | 30.7 | | *2017-2019* | | 13 |
| | | | | | | | | | |
| **SCORE** | **ECONOMY** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **2.17** | Renters Spending 30% or More of Household Income on Rent | *percent* | 50.4 | | 48.8 | 50.2 | *2014-2018* | | 1 |
| **2.11** | SNAP Certified Stores | *stores/ 1,000 population* | 0.5 | | | | *2016* | | 23 |
| **1.75** | Households that are Asset Limited, Income Constrained, Employed (ALICE) | *percent* | 27.1 | | | | *2017* | | 25 |
| **1.67** | Overcrowded Households | *percent of households* | 3.7 | | 2.5 | | *2014-2018* | | 1 |
| **1.67** | Severe Housing Problems | *percent* | 17.8 | | 17.3 | 19 | *2012-2016* | | 7 |
| **1.67** | Unemployed Workers in Civilian Labor Force | *percent* | 10.6 | | 11.5 | 10.5 | *July 2020* | | 21 |
| **1.42** | Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold | *percent* | 63.9 | | | | *2017* | | 25 |
| **1.42** | Social and Economic Factors Ranking | *ranking* | 30 | | | | *2020* | | 7 |
| **1.33** | Low-Income and Low Access to a Grocery Store | *percent* | 3.8 | | | | *2015* | | 23 |
| **1.25** | Households that are Below the Federal Poverty Level | *percent* | 9 | | | | *2017* | | 25 |
| **1.00** | People 65+ Living Below Poverty Level | *percent* | 6.7 | | 8.8 | 9.3 | *2014-2018* | Black (14.5)<br>American Indian / Alaska Native (12.7)<br>Other Race (19.9)<br>Hispanic / Latino (14.8) | 1 |
| **1.00** | Projected Child Food Insecurity Rate | *percent* | 18.3 | | | | *2020* | | 8 |
| **1.00** | Projected Food Insecurity Rate | *percent* | 12.2 | | | | *2020* | | 8 |
| **0.89** | Students Eligible for the Free Lunch Program | *percent* | 40 | | 46.7 | 41.2 | *2018-2019* | | 17 |
| **0.78** | Households with Cash Public Assistance Income | *percent* | 1.7 | | 2.4 | 2.5 | *2014-2018* | | 1 |
| **0.75** | Persons with Disability Living in Poverty | *percent* | 18.9 | | 26.5 | 26.1 | *2018* | | 1 |
| **0.67** | Food Insecure Children Likely Ineligible for Assistance | *percent* | 2 | | 18 | 25 | *2018* | | 8 |
| **0.50** | Child Food Insecurity Rate | *percent* | 9.4 | | 12.7 | 15.2 | *2018* | | 8 |
| **0.50** | Children Living Below Poverty Level | *percent* | 15 | | 18.1 | 19.5 | *2014-2018* | | 1 |
| **0.50** | Food Insecurity Rate | *percent* | 7.1 | | 10.1 | 11.5 | *2018* | | 8 |
| **0.50** | People Living 200% Above Poverty Level | *percent* | 74.5 | | 70.6 | 68.1 | *2014-2018* | | 1 |
| **0.50** | Per Capita Income | *dollars* | 34924 | | 34463 | 32621 | *2014-2018* | | 1 |
| **0.50** | Persons with Disability Living in Poverty (5-year) | *percent* | 19.1 | | 26.3 | 26.7 | *2014-2018* | | 1 |
| **0.39** | Homeownership | *percent* | 70.1 | | 59.6 | 56.1 | *2014-2018* | | 1 |
| **0.17** | Median Household Income | *dollars* | 76912 | | 63575 | 60293 | *2014-2018* | | 1 |
| **0.17** | People Living Below Poverty Level | *percent* | 10 | | 13.1 | 14.1 | *2014-2018* | | 1 |
| | | | | | | | | | |

Appendix A: Secondary Data Detailed Methodology and Data Scoring Tables

| SCORE | EDUCATION | UNITS | KANE COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| 1.72 | Student-to-Teacher Ratio | *students/ teacher* | 15.7 | | 15 | 16.5 | *2018-2019* | | 17 |
| 1.67 | People 25+ with a High School Degree or Higher | *percent* | 84.1 | | 88.9 | 87.7 | *2014-2018* | | 1 |
| 1.11 | High School Graduation | *percent* | 88.1 | 87 | 85.4 | 85.3 | *2017-2018* | | 7 |
| 0.67 | People 25+ with a Bachelor's Degree or Higher | *percent* | 33.1 | | 34.1 | 31.5 | *2014-2018* | | 1 |
| | | | | | | | | | |
| SCORE | ENVIRONMENT | UNITS | KANE COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
| 2.11 | SNAP Certified Stores | *stores/ 1,000 population* | 0.5 | | | | *2016* | | 23 |
| 1.83 | Recognized Carcinogens Released into Air | *pounds* | 51211 | | | | *2018* | | 24 |
| 1.75 | Physical Environment Ranking | *ranking* | 101 | | | | *2020* | | 7 |
| 1.69 | Annual Ozone Air Quality | *grade* | F | | | | *2016-2018* | | 2 |
| 1.69 | Liquor Store Density | *stores/ 100,000 population* | 11.6 | | 10.8 | 10.6 | *2018* | | 22 |
| 1.67 | Children with Low Access to a Grocery Store | *percent* | 5.3 | | | | *percent* | | 23 |
| 1.67 | Farmers Market Density | *markets/ 1,000 population* | 0 | | | | *2016* | | 23 |
| 1.67 | Fast Food Restaurant Density | *restaurants/ 1,000 population* | 0.6 | | | | *2014* | | 23 |
| 1.67 | Grocery Store Density | *stores/ 1,000 population* | 0.2 | | | | *2014* | | 23 |
| 1.67 | Overcrowded Households | *percent of households* | 3.7 | | 2.5 | | *2014-2018* | | 1 |
| 1.67 | Severe Housing Problems | *percent* | 17.8 | | 17.3 | 19 | *2012-2016* | | 7 |
| 1.61 | Months of Mild Drought or Worse | *months per year* | 7 | | | | *2016* | | 19 |
| 1.61 | Number of Extreme Precipitation Days | *days* | 44 | | | | *2016* | | 19 |
| 1.50 | People with Low Access to a Grocery Store | *percent* | 18.5 | | | | *2015* | | 23 |
| 1.39 | Number of Extreme Heat Days | *days* | 13 | | | | *2016* | | 19 |
| 1.39 | Number of Extreme Heat Events | *events* | 4 | | | | *2016* | | 19 |
| 1.33 | Low-Income and Low Access to a Grocery Store | *percent* | 3.8 | | | | *2015* | | 23 |
| 1.33 | Recreation and Fitness Facilities | *facilities/ 1,000 population* | 0.1 | | | | *2014* | | 23 |
| 1.25 | Annual Particle Pollution | *grade* | A | | | | *2016-2018* | | 2 |
| 1.25 | Blood Lead Levels in Children (>=5 micrograms per deciliter) | *percent* | 2.5 | | 3.4 | | *2014* | | 19 |
| 1.17 | People 65+ with Low Access to a Grocery Store | *percent* | 1.8 | | | | *2015* | | 23 |
| 1.00 | Daily Dose of UV Irradiance | *Joule per square meter* | 2242 | | 2506 | | *2015* | | 19 |
| 1.00 | Households with No Car and Low Access to a Grocery Store | *percent* | 0.9 | | | | *2015* | | 23 |
| 0.67 | Access to Exercise Opportunities | *percent* | 96.4 | | 90.8 | 84 | *2020* | | 7 |
| 0.56 | Food Environment Index | *index* | 9.3 | | 8.6 | 7.6 | *2020* | | 7 |
| | | | | | | | | | |
| SCORE | EXERCISE, NUTRITION, & WEIGHT | UNITS | KANE COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
| 2.11 | SNAP Certified Stores | *stores/ 1,000 population* | 0.5 | | | | *2016* | | 23 |
| 1.67 | Children with Low Access to a Grocery Store | *percent* | 5.3 | | | | *2015* | | 23 |
| 1.67 | Farmers Market Density | *markets/ 1,000 population* | 0 | | | | *2016* | | 23 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.67** | Fast Food Restaurant Density | *restaurants/ 1,000 population* | 0.6 | | | | *2014* | | 23 |
| **1.67** | Grocery Store Density | *stores/ 1,000 population* | 0.2 | | | | *2014* | | 23 |
| **1.50** | People with Low Access to a Grocery Store | *percent* | 18.5 | | | | *2015* | | 23 |
| **1.36** | Adults Who Are Obese | *percent* | 29.9 | 30.5 | | | *2010-2014* | | 10 |
| **1.33** | Low-Income and Low Access to a Grocery Store | *percent* | 3.8 | | | | *2015* | | 23 |
| **1.33** | Recreation and Fitness Facilities | *facilities/ 1,000 population* | 0.1 | | | | *2014* | | 23 |
| **1.25** | Adult Fruit and Vegetable Consumption | *percent* | 18.5 | | | | *2007-2009* | Male (11.5) | 10 |
| **1.25** | Health Behaviors Ranking | *ranking* | 2 | | | | *2020* | | 7 |
| **1.17** | People 65+ with Low Access to a Grocery Store | *percent* | 1.8 | | | | *2015* | | 23 |
| **1.08** | Adults who are Sedentary | *percent* | 18 | 32.6 | | | *2010-2014* | | 10 |
| **1.00** | Households with No Car and Low Access to a Grocery Store | *percent* | 0.9 | | | | *2015* | | 23 |
| **1.00** | Projected Child Food Insecurity Rate | *percent* | 18.3 | | | | *2020* | | 8 |
| **1.00** | Projected Food Insecurity Rate | *percent* | 12.2 | | | | *2020* | | 8 |
| **0.67** | Access to Exercise Opportunities | *percent* | 96.4 | | 90.8 | 84 | *2020* | | 7 |
| **0.67** | Food Insecure Children Likely Ineligible for Assistance | *percent* | 2 | | 18 | 25 | *2018* | | 8 |
| **0.56** | Food Environment Index | *index* | 9.3 | | 8.6 | 7.6 | *2020* | | 7 |
| **0.50** | Child Food Insecurity Rate | *percent* | 9.4 | | 12.7 | 15.2 | *2018* | | 8 |
| **0.50** | Food Insecurity Rate | *percent* | 7.1 | | 10.1 | 11.5 | *2018* | | 8 |
| | | | | | | | | | |
| **SCORE** | **HEART DISEASE & STROKE** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **2.44** | Atrial Fibrillation: Medicare Population | *percent* | 9.7 | | 8.9 | 8.4 | *2017* | | 5 |
| **1.89** | Stroke: Medicare Population | *percent* | 3.9 | | 3.8 | 3.8 | *2017* | | 5 |
| **1.78** | Hypertension: Medicare Population | *percent* | 58.3 | | 58.2 | 57.1 | *2017* | | 5 |
| **1.72** | Hyperlipidemia: Medicare Population | *percent* | 43.2 | | 39.8 | 40.7 | *2017* | | 5 |
| **1.56** | Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke) | *deaths/ 100,000 population* | 36 | 34.8 | 38 | 37.3 | *2016-2018* | | 4 |
| **1.42** | High Cholesterol Prevalence | *percent* | 31.6 | 13.5 | | | *2007-2009* | | 10 |
| **1.33** | Age-Adjusted Hospitalization Rate due to Acute Myocardial Infarction | *hospitalizations/ 10,000 population 18+ years* | 21.8 | | 25.1 | | *2017-2019* | Male (29.9) | 13 |
| **1.33** | Age-Adjusted Hospitalization Rate due to Hypertension | *hospitalizations/ 10,000 population 18+ years* | 6.1 | | 8.1 | | *2017-2019* | Black (24.8) | 13 |
| **1.25** | Risk-Adjusted Hospitalization Rate due to Angina without Procedure | *hospitalizations/ 100,000 population 18+ years* | 4.8 | | 9.4 | | *2014* | | 12 |
| **1.17** | Age-Adjusted Hospitalization Rate due to Heart Failure | *hospitalizations/ 10,000 population 18+ years* | 42.4 | | 61.5 | | *2017-2019* | | 13 |
| **1.14** | Risk-Adjusted Hospitalization Rate due to Heart Failure | *hospitalizations/ 100,000 population 18+ years* | 268.1 | | 378.3 | | *2014* | | 12 |
| **1.14** | Risk-Adjusted Hospitalization Rate due to Hypertension | *hospitalizations/ 100,000 population 18+ years* | 31.9 | | 47.3 | | *2014* | Black (107.6) | 12 |
| **1.08** | High Blood Pressure Prevalence | *percent* | 23 | 26.9 | | | *2007-2009* | | 10 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.00** | Age-Adjusted ER Rate due to Heart Failure | *ER visits/ 10,000 population 18+ years* | 7.9 | | 15.3 | | *2017-2019* | | 13 |
| **1.00** | Age-Adjusted ER Rate due to Hypertension | *ER visits/ 10,000 population 18+ years* | 35.2 | | 61.5 | | *2017-2019* | | 13 |
| **0.89** | Age-Adjusted Death Rate due to Heart Attack | *deaths/ 100,000 population 35+ years* | 50.4 | | 57.4 | | *2018* | | 19 |
| **0.67** | Ischemic Heart Disease: Medicare Population | *percent* | 23.9 | | 26.8 | 26.9 | *2017* | | 5 |
| **0.61** | Heart Failure: Medicare Population | *percent* | 12.3 | | 15.2 | 13.9 | *2017* | | 5 |
| **0.22** | Age-Adjusted Death Rate due to Coronary Heart Disease | *deaths/ 100,000 population* | 65.5 | 103.4 | 83.7 | 92.7 | *2016-2018* | Male (92.5) | 4 |
| | | | | | | | | | |
| **SCORE** | **IMMUNIZATIONS & INFECTIOUS DISEASES** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **2.50** | COVID-19 Daily Average Incidence Rate | *cases per 100,000 population* | 84.2 | | 79.9 | 47.5 | *2020* | | 9 |
| **1.83** | HIV Diagnosed Cases | *cases* | 32 | | | | *2018* | | 12 |
| **1.67** | Overcrowded Households | *percent of households* | 3.7 | | 2.5 | | *2014-2018* | | 1 |
| **1.58** | Adults with Pneumonia Vaccination | *percent* | 24.4 | | | | *2010-2014* | | 10 |
| **1.50** | Chlamydia Incidence Rate | *cases/ 100,000 population* | 407.7 | | 604 | 539.9 | *2018* | | 18 |
| **1.50** | Syphilis Incidence Rate | *cases/ 100,000 population* | 3.9 | | 11 | 10.8 | *2018* | | 18 |
| **1.42** | Adults with Influenza Vaccination | *percent* | 43.3 | 70 | | | *2010-2014* | | 10 |
| **1.42** | Age-Adjusted Hospitalization Rate due to Hepatitis | *hospitalizations/ 10,000 population 18+ years* | 1.4 | | 1.4 | | *2017-2019* | | 13 |
| **1.39** | Lyme Disease Cases | *cases* | 7 | | | | *2016* | | 12 |
| **1.39** | Tuberculosis Cases | *cases* | 15 | | | | *2019* | | 12 |
| **1.33** | Age-Adjusted ER Rate due to Immunization-Preventable Pneumonia and Influenza | *ER visits/ 10,000 population 18+ years* | 33.1 | | 33.9 | | *2017-2019* | | 13 |
| **1.31** | Risk-Adjusted Hospitalization Rate due to Bacterial Pneumonia | *hospitalizations/ 100,000 population 18+ years* | 246.1 | | 252.4 | | *2014* | | 12 |
| **1.25** | Age-Adjusted ER Rate due to Hepatitis | *ER visits/ 10,000 population 18+ years* | 0.4 | | 0.7 | | *2017-2019* | Male (0.5) | 13 |
| **1.17** | Gonorrhea Incidence Rate | *cases/ 100,000 population* | 77.8 | | 198.6 | 179.1 | *2018* | | 18 |
| **1.11** | COVID-19 Daily Average Case-Fatality Rate | *deaths per 100 cases* | 0.7 | | 1.4 | 1.7 | *44141* | | 9 |
| **1.00** | Age-Adjusted ER Rate due to Community Acquired Pneumonia | *ER visits/ 10,000 population 18+ years* | 24.2 | | 32.4 | | *2017-2019* | | 13 |
| **1.00** | Age-Adjusted Hospitalization Rate due to Community Acquired Pneumonia | *hospitalizations/ 10,000 population 18+ years* | 20.1 | | 24 | | *2017-2019* | | 13 |
| **1.00** | Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza | *hospitalizations/ 10,000 population 18+ years* | 5.3 | | 7.1 | | *2017-2019* | | 13 |
| **0.50** | Age-Adjusted Death Rate due to Influenza and Pneumonia | *deaths/ 100,000 population* | 12.9 | | 15.5 | 14.2 | *2016-2018* | | 4 |
| | | | | | | | | | |
| **SCORE** | **MATERNAL, FETAL & INFANT HEALTH** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **1.78** | Preterm Births | *percent* | 11 | 9.4 | 10.7 | | *2018* | | 12 |
| **1.50** | Preterm Labor and Delivery Hospitalizations | *percent* | 3.7 | | 4.1 | | *2017-2019* | | 13 |
| **1.44** | Babies with Low Birth Weight | *percent* | 7.6 | 7.8 | 8.6 | | *2018* | | 12 |
| **0.97** | Teen Births | *percent* | 1 | | 1.1 | 2.8 | *2018* | | 12 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 0.89 | Infant Mortality Rate | *deaths/ 1,000 live births* | 4.9 | 6 | 6.3 | | *2016-2018* | | 12 |
| | | | | | | | | | |
| **SCORE** | **MENTAL HEALTH & MENTAL DISORDERS** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| 1.75 | Poor Mental Health Days | *percent* | 40.5 | | | | *2010-2014* | | 10 |
| 1.50 | Age-Adjusted Hospitalization Rate due to Pediatric Mental Health | *hospitalizations/ 10,000 population under 18 years* | 61.6 | | 67.5 | | *2017-2019* | | 13 |
| 1.44 | Alzheimer's Disease or Dementia: Medicare Population | *percent* | 10 | | 10.7 | 10.9 | *2017* | | 5 |
| 1.44 | Depression: Medicare Population | *percent* | 16.4 | | 16.4 | 17.9 | *2017* | | 5 |
| 1.33 | Age-Adjusted ER Rate due to Pediatric Mental Health | *ER visits/ 10,000 population under 18 years* | 101.5 | | 103.8 | | *2017-2019* | | 13 |
| 1.33 | Age-Adjusted Hospitalization Rate due to Adolescent Suicide and Intentional Self-inflicted Injury | *hospitalizations/ 10,000 population aged 10-17* | 100.5 | | 106 | | *2017-2019* | Female (135.5) | 13 |
| 1.33 | Age-Adjusted Hospitalization Rate due to Adult Mental Health | *hospitalizations/ 10,000 population 18+ years* | 64.7 | | 84.5 | | *2017-2019* | Black (170.7)<br>American Indian / Alaska Native (78.4)<br>Native Hawaiian / Pacific Islander (1061.4) | 13 |
| 1.33 | Age-Adjusted Hospitalization Rate due to Adult Suicide and Intentional Self-inflicted Injury | *hospitalizations/ 10,000 population 18+ years* | 51.3 | | 65.4 | | *2017-2019* | Black (102.5)<br>American Indian / Alaska Native (63.1)<br>Native Hawaiian / Pacific Islander (1001.2) | 13 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.17** | Age-Adjusted ER Rate due to Adult Mental Health | *ER visits/ 10,000 population 18+ years* | 129.1 | | 144.5 | | *2017-2019* | Black (342.2) Native Hawaiian / Pacific Islander (528.3) | 13 |
| **1.00** | Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-inflicted Injury | *ER visits/ 10,000 population aged 10-17* | 80.3 | | 114.5 | | *2017-2019* | Female (112.4) | 13 |
| **1.00** | Age-Adjusted ER Rate due to Adult Suicide and Intentional Self-inflicted Injury | *ER visits/ 10,000 population 18+ years* | 38.1 | | 60 | | *2017-2019* | | 13 |
| **0.78** | Frequent Mental Distress | *percent* | 10.8 | | 11 | 12 | *2017* | | 7 |
| **0.69** | Age-Adjusted Death Rate due to Suicide | *deaths/ 100,000 population* | 8.4 | 10.2 | 11.1 | 13.9 | *2016-2018* | Male (12.8) | 4 |
| **0.61** | Age-Adjusted Death Rate due to Alzheimer's Disease | *deaths/ 100,000 population* | 15.4 | | 25.4 | 30.6 | *2016-2018* | | 4 |
| | | | | | | | | | |
| **SCORE** | **OLDER ADULTS & AGING** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **2.44** | Atrial Fibrillation: Medicare Population | *percent* | 9.7 | | 8.9 | 8.4 | *2017* | | 5 |
| **2.44** | Cancer: Medicare Population | *percent* | 9.2 | | 8.9 | 8.2 | *2017* | | 5 |
| **2.44** | Osteoporosis: Medicare Population | *percent* | 7 | | 6.3 | 6.4 | *2017* | | 5 |
| **2.17** | Rheumatoid Arthritis or Osteoarthritis: Medicare Population | *percent* | 35.7 | | 34.6 | 33.1 | *2017* | | 5 |
| **1.89** | Stroke: Medicare Population | *percent* | 3.9 | | 3.8 | 3.8 | *2017* | | 5 |
| **1.78** | Hypertension: Medicare Population | *percent* | 58.3 | | 58.2 | 57.1 | *2017* | | 5 |
| **1.72** | Hyperlipidemia: Medicare Population | *percent* | 43.2 | | 39.8 | 40.7 | *2017* | | 5 |
| **1.50** | Chronic Kidney Disease: Medicare Population | *percent* | 22.6 | | 24 | 24 | *2017* | | 5 |
| **1.44** | Alzheimer's Disease or Dementia: Medicare Population | *percent* | 10 | | 10.7 | 10.9 | *2017* | | 5 |
| **1.44** | Depression: Medicare Population | *percent* | 16.4 | | 16.4 | 17.9 | *2017* | | 5 |
| **1.39** | Asthma: Medicare Population | *percent* | 4.7 | | 4.9 | 5.1 | *2017* | | 5 |
| **1.28** | Hospitalization Rate due to Hip Fractures Among Males 65+ | *hospitalizations/ 100,000 males 65+ years* | 413.4 | 418.4 | 435 | | *2017-2019* | | 13 |
| **1.17** | People 65+ with Low Access to a Grocery Store | *percent* | 1.8 | | | | *2015* | | 23 |
| **1.11** | Diabetes: Medicare Population | *percent* | 25.6 | | 27.2 | 27.2 | *2017* | | 5 |
| **1.00** | Hospitalization Rate due to Hip Fractures Among Females 65+ | *hospitalizations/ 100,000 females 65+ years* | 652.1 | 741.2 | 762 | | *2017-2019* | | 13 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1.00 | People 65+ Living Below Poverty Level | *percent* | 6.7 | | 8.8 | 9.3 | *2014-2018* | Black (14.5) American Indian / Alaska Native (12.7) Other Race (19.9) Hispanic / Latino (14.8) | 1 |
| 0.72 | People 65+ Living Alone | *percent* | 24.3 | | 28.5 | 26.1 | *2014-2018* | | 1 |
| 0.67 | Ischemic Heart Disease: Medicare Population | *percent* | 23.9 | | 26.8 | 26.9 | *2017* | | 5 |
| 0.61 | Age-Adjusted Death Rate due to Alzheimer's Disease | *deaths/ 100,000 population* | 15.4 | | 25.4 | 30.6 | *2016-2018* | | 4 |
| 0.61 | COPD: Medicare Population | *percent* | 9.5 | | 11.9 | 11.7 | *2017* | | 5 |
| 0.61 | Heart Failure: Medicare Population | *percent* | 12.3 | | 15.2 | 13.9 | *2017* | | 5 |
| | | | | | | | | | |
| **SCORE** | **ORAL HEALTH** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| 1.00 | Age-Adjusted ER Rate due to Dental Problems | *ER visits/ 10,000 population* | 48.1 | | 75.8 | | *2017-2019* | Black (204.7) Native Hawaiian / Pacific Islander (441) | 13 |
| 1.00 | Oral Cavity and Pharynx Cancer Incidence Rate | *cases/ 100,000 population* | 10.7 | | 12.2 | 11.8 | *2013-2017* | Male (15.8) | 16 |
| 0.92 | Dentist Rate | *dentists/ 100,000 population* | 66.3 | | 77.9 | | *2018* | | 7 |
| | | | | | | | | | |
| **SCORE** | **OTHER CHRONIC DISEASES** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| 2.44 | Osteoporosis: Medicare Population | *percent* | 7 | | 6.3 | 6.4 | *2017* | | 5 |
| 2.17 | Rheumatoid Arthritis or Osteoarthritis: Medicare Population | *percent* | 35.7 | | 34.6 | 33.1 | *2017* | | 5 |
| 1.50 | Chronic Kidney Disease: Medicare Population | *percent* | 22.6 | | 24 | 24 | *2017* | | 5 |
| 1.33 | Age-Adjusted Death Rate due to Kidney Disease | *deaths/ 100,000 population* | 16.7 | | 16.9 | 13 | *2016-2018* | Male (22.6) | 4 |
| | | | | | | | | | |
| **SCORE** | **OTHER CONDITIONS** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| 1.75 | Risk-Adjusted Hospitalization Rate due to Perforated Appendix | *hospitalizations/ 1,000 appendicitis admissions 18+ years* | 277.2 | | 373.3 | | *2014* | | 12 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.33** | Age-Adjusted ER Rate due to Headaches | *ER visits/ 10,000 population 18+ years* | 127.7 | | 134.9 | | *2017-2019* | Black (320.9) Native Hawaiian / Pacific Islander (496.6); Female (194.2) | 13 |
| **1.17** | Age-Adjusted Hospitalization Rate due to Dehydration | *hospitalizations/ 10,000 population 18+ years* | 18.1 | | 21.3 | | *2017-2019* | | 13 |
| **1.17** | Age-Adjusted Hospitalization Rate due to Urinary Tract Infections | *hospitalizations/ 10,000 population 18+ years* | 16.8 | | 19.5 | | *2017-2019* | Female (22.1) | 13 |
| **1.14** | Risk-Adjusted Hospitalization Rate due to Urinary Tract Infections | *hospitalizations/ 100,000 population 18+ years* | 139.7 | | 167.9 | | *2014* | Female (168.6) | 12 |
| **1.00** | Age-Adjusted ER Rate due to Dehydration | *ER visits/ 10,000 population 18+ years* | 20.6 | | 27.5 | | *2017-2019* | | 13 |
| **1.00** | Age-Adjusted ER Rate due to Urinary Tract Infections | *ER visits/ 10,000 population 18+ years* | 115.6 | | 132.6 | | *2017-2019* | Female (193.3) | 13 |
| **0.92** | Risk-Adjusted Hospitalization Rate due to Dehydration | *hospitalizations/ 100,000 population 18+ years* | 100.8 | | 139.2 | | *2014* | | 12 |
| | | | | | | | | | |
| **SCORE** | **PREVENTION & SAFETY** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **1.67** | Severe Housing Problems | *percent* | 17.8 | | 17.3 | 19 | *2012-2016* | | 7 |
| **1.33** | Age-Adjusted Hospitalization Rate due to Unintentional Falls | *hospitalizations/ 10,000 population 18+ years* | 55.1 | | 62 | | *2017-2019* | | 13 |
| **1.28** | Hospitalization Rate due to Hip Fractures Among Males 65+ | *hospitalizations/ 100,000 males 65+ years* | 413.4 | 418.4 | 435 | | *2017-2019* | | 13 |
| **1.00** | Age-Adjusted ER Rate due to Unintentional Falls | *ER visits/ 10,000 population 18+ years* | 247.8 | | 304.7 | | *2017-2019* | Black (333.2) Native Hawaiian / Pacific Islander (1310.4) | 13 |
| **1.00** | Death Rate due to Drug Poisoning | *deaths/ 100,000 population* | 14.2 | | 20.6 | 21 | *2016-2018* | | 7 |
| **1.00** | Hospitalization Rate due to Hip Fractures Among Females 65+ | *hospitalizations/ 100,000 females 65+ years* | 652.1 | 741.2 | 762 | | *2017-2019* | | 13 |
| | | | | | | | | | |
| **SCORE** | **PUBLIC SAFETY** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.89** | Alcohol-Impaired Driving Deaths | *percent* | 32 | | 32 | 28 | *2014-2018* | | 7 |
| **1.39** | Domestic Violence Offenses | *offenses* | 1681 | | | | *2018* | | 15 |
| **1.39** | Hate Crime Offenses | *offenses* | 3 | | | | *2018* | | 15 |
| **1.39** | School Crime Incidents | *incidents* | 218 | | | | *2018* | | 15 |
| **1.25** | Age-Adjusted ER rate due to Assault by Firearms | *ER visits/ 10,000 population* | 0.2 | | 0.6 | | *2015-2017* | | 13 |
| **1.25** | Age-Adjusted Hospitalization rate due to Assault by Firearms | *hospitalizations/ 10,000 population* | 0.1 | | 0.4 | | *2015-2017* | | 13 |
| **0.81** | Violent Crime Rate | *crimes/ 100,000 population* | 165.7 | | 403.1 | 386.5 | *2014-2016* | | 7 |
| **0.64** | Substantiated Child Abuse Rate | *cases/ 1,000 children* | 8.1 | | 9.7 | 9.2 | *2015* | | 11 |
| | | | | | | | | | |
| **SCORE** | **RESPIRATORY DISEASES** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **2.50** | COVID-19 Daily Average Incidence Rate | *cases per 100,000 population* | 84.2 | | 79.9 | 47.5 | *44141* | | 9 |
| **1.58** | Adults with Pneumonia Vaccination | *percent* | 24.4 | | | | *2010-2014* | | 10 |
| **1.42** | Adults with Current Asthma | *percent* | 7.6 | | | | *2010-2014* | | 10 |
| **1.42** | Adults with Influenza Vaccination | *percent* | 43.3 | 70 | | | *2010-2014* | | 10 |
| **1.39** | Asthma: Medicare Population | *percent* | 4.7 | | 4.9 | 5.1 | *2017* | | 5 |
| **1.39** | Tuberculosis Cases | *cases* | 15 | | | | *2019* | | 12 |
| **1.33** | Age-Adjusted ER Rate due to Adult Asthma | *ER visits/ 10,000 population 18+ years* | 33.5 | | 45.6 | | *2017-2019* | Black (234.4) | 13 |
| **1.33** | Age-Adjusted ER Rate due to Asthma | *ER visits/ 10,000 population* | 38 | | 54.1 | | *2017-2019* | Black (222.2) | 13 |
| **1.33** | Age-Adjusted ER Rate due to Immunization-Preventable Pneumonia and Influenza | *ER visits/ 10,000 population 18+ years* | 33.1 | | 33.9 | | *2017-2019* | | 13 |
| **1.33** | Age-Adjusted ER Rate due to Pediatric Asthma | *ER visits/ 10,000 population under 18 years* | 51 | | 78.7 | | *2017-2019* | | 13 |
| **1.33** | Age-Adjusted Hospitalization Rate due to Adult Asthma | *hospitalizations/ 10,000 population 18+ years* | 5.5 | | 7.1 | | *2017-2019* | ck (28.2); Female (7 | 13 |
| **1.33** | Age-Adjusted Hospitalization Rate due to Asthma | *hospitalizations/ 10,000 population* | 5.6 | | 8.3 | | *2017-2019* | ck (24.1); Female (7 | 13 |
| **1.31** | Risk-Adjusted Hospitalization Rate due to Bacterial Pneumonia | *hospitalizations/ 100,000 population 18+ years* | 246.1 | | 252.4 | | *2014* | | 12 |
| **1.25** | Age-Adjusted Hospitalization Rate due to Pediatric Asthma | *hospitalizations/ 10,000 population under 18 years* | 5.7 | | 11.8 | | *2017-2019* | | 13 |
| **1.25** | Hospitalization Rate due to COPD or Asthma in Older Adults | *hospitalizations/ 100,000 population 40+ years* | 341.8 | | 516.9 | | *2015* | | 12 |
| **1.14** | Hospitalization Rate due to Asthma in Younger Adults | *hospitalizations/ 100,000 population 18-39 years* | 23.4 | | 49 | | *2015* | Female (31.4) | 12 |
| **1.11** | COVID-19 Daily Average Case-Fatality Rate | *deaths per 100 cases* | 0.7 | | 1.4 | 1.7 | *44141* | | 9 |
| **1.00** | Age-Adjusted ER Rate due to Community Acquired Pneumonia | *ER visits/ 10,000 population 18+ years* | 24.2 | | 32.4 | | *2017-2019* | | 13 |
| **1.00** | Age-Adjusted ER Rate due to COPD | *ER visits/ 10,000 population 18+ years* | 17.3 | | 37.7 | | *2017-2019* | Black (69.3) | 13 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.00** | Age-Adjusted Hospitalization Rate due to Community Acquired Pneumonia | *hospitalizations/ 10,000 population 18+ years* | 20.1 | | 24 | | *2017-2019* | | 13 |
| **1.00** | Age-Adjusted Hospitalization Rate due to COPD | *hospitalizations/ 10,000 population 18+ years* | 24.4 | | 33.2 | | *2017-2019* | | 13 |
| **1.00** | Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza | *hospitalizations/ 10,000 population 18+ years* | 5.3 | | 7.1 | | *2017-2019* | | 13 |
| **0.61** | COPD: Medicare Population | *percent* | 9.5 | | 11.9 | 11.7 | *2017* | | 5 |
| **0.50** | Age-Adjusted Death Rate due to Influenza and Pneumonia | *deaths/ 100,000 population* | 12.9 | | 15.5 | 14.2 | *2016-2018* | | 4 |
| **0.17** | Lung and Bronchus Cancer Incidence Rate | *cases/ 100,000 population* | 50.2 | | 63.7 | 58.3 | *2013-2017* | | 16 |
| **0.00** | Age-Adjusted Death Rate due to Lung Cancer | *deaths/ 100,000 population* | 33 | 45.5 | 41.1 | 38.5 | *2013-2017* | | 16 |
| | | | | | | | | | |
| **SCORE** | **SOCIAL ENVIRONMENT** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **1.89** | Mean Travel Time to Work | *minutes* | 28.9 | | 29 | 26.6 | *2014-2018* | | 1 |
| **1.67** | People 25+ with a High School Degree or Higher | *percent* | 84.1 | | 88.9 | 87.7 | *2014-2018* | | 1 |
| **1.56** | Voter Turnout: General Election | *percent* | 68.1 | | 70.6 | | *2016* | | 14 |
| **1.42** | Social and Economic Factors Ranking | *ranking* | 30 | | | | *2020* | | 7 |
| **1.17** | Single-Parent Households | *percent* | 26.5 | | 32.5 | 33.1 | *2014-2018* | | 1 |
| **0.83** | Adults with Internet Access | *percent* | 96.2 | | 94.4 | 94 | *2020* | | 6 |
| **0.83** | Households with a Computer | *percent* | 93.7 | | 90.7 | 90 | *2020* | | 6 |
| **0.72** | People 65+ Living Alone | *percent* | 24.3 | | 28.5 | 26.1 | *2014-2018* | | 1 |
| **0.67** | People 25+ with a Bachelor's Degree or Higher | *percent* | 33.1 | | 34.1 | 31.5 | *2014-2018* | | 1 |
| **0.64** | Substantiated Child Abuse Rate | *cases/ 1,000 children* | 8.1 | | 9.7 | 9.2 | *2015* | | 11 |
| **0.50** | Children Living Below Poverty Level | *percent* | 15 | | 18.1 | 19.5 | *2014-2018* | | 1 |
| **0.50** | Per Capita Income | *dollars* | 34924 | | 34463 | 32621 | *2014-2018* | | 1 |
| **0.39** | Homeownership | *percent* | 70.1 | | 59.6 | 56.1 | *2014-2018* | | 1 |
| **0.17** | Median Household Income | *dollars* | 76912 | | 63575 | 60293 | *2014-2018* | | 1 |
| **0.17** | People Living Below Poverty Level | *percent* | 10 | | 13.1 | 14.1 | *2014-2018* | | 1 |
| | | | | | | | | | |
| **SCORE** | **SUBSTANCE ABUSE** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **2.11** | Teens who Use Alcohol | *percent* | 46 | | 40 | | *2018* | | 3 |
| **1.89** | Alcohol-Impaired Driving Deaths | *percent* | 32 | | 32 | 28 | *2014-2018* | | 7 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.83** | Age-Adjusted ER Rate due to Adult Alcohol Use | *ER visits/ 10,000 population 18+ years* | 88 | | 87 | | *2017-2019* | Black (148.3) Native Hawaiian / Pacific Islander (370.5): Male (127) | 13 |
| **1.69** | Liquor Store Density | *stores/ 100,000 population* | 11.6 | | 10.8 | 10.6 | *2018* | | 22 |
| **1.67** | Age-Adjusted Hospitalization Rate due to Adult Alcohol Use | *hospitalizations/ 10,000 population 18+ years* | 29 | | 29.5 | | *2017-2019* | White (31.9) Native Hawaiian / Pacific Islander (419.5); Male (42.4) | 13 |
| **1.56** | Teens who Use Marijuana | *percent* | 24.4 | | 26 | | *2018* | | 3 |
| **1.50** | Adults Who Use Electronic Cigarettes: Past 30 Days | *percent* | 4.3 | | 4.2 | 4.4 | *2020* | | 6 |
| **1.42** | Adults who Binge Drink | *percent* | 18.7 | 24.2 | | | *2010-2014* | | 10 |
| **1.42** | Adults who Smoke | *percent* | 14 | 12 | | | *2010-2014* | | 10 |
| **1.42** | Age-Adjusted ER Rate due to Adolescent Alcohol Use | *ER visits/ 10,000 population aged 10-17* | 14 | | 14 | | *2017-2019* | | 13 |
| **1.25** | Age-Adjusted Hospitalization Rate due to Adolescent Alcohol Use | *hospitalizations/ 10,000 population aged 10-17* | 3.5 | | 4.7 | | *2017-2019* | | 13 |
| **1.25** | Health Behaviors Ranking | *ranking* | 2 | | | | *2020* | | 7 |
| **1.17** | Age-Adjusted ER Rate due to Opioid Use | *ER visits/ 10,000 population 18+ years* | 13.5 | | 25.2 | | *2017-2019* | Black (30.2) Native Hawaiian / Pacific Islander (330.8); Male (17.4) | 13 |
| **1.17** | Age-Adjusted ER Rate due to Substance Use | *ER visits/ 10,000 population 18+ years* | 25.3 | | 52.9 | | *2017-2019* | Black (61.3) Native Hawaiian / Pacific Islander (413.7); Male (33.8) | 13 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.17** | Age-Adjusted Hospitalization rate due to Opioid Use | *hospitalizations/ 10,000 population 18+ years* | 5.1 | | 15.2 | | *2017-2019* | Black (10.2) Native Hawaiian / Pacific Islander (523.4); Male (6.4) | 13 |
| **1.17** | Age-Adjusted Hospitalization Rate due to Substance Use | *hospitalizations/ 10,000 population 18+ years* | 7.2 | | 19.2 | | *2017-2019* | Black (16.4) Native Hawaiian / Pacific Islander (551.9); Male (9.2) | 13 |
| **1.00** | Age-Adjusted Drug and Opioid-Involved Overdose Death Rate | *Deaths per 100,000 population* | 14.8 | | 20.5 | 20.7 | *2016-2018* | Male (19.9) | 4 |
| **1.00** | Death Rate due to Drug Poisoning | *deaths/ 100,000 population* | 14.2 | | 20.6 | 21 | *2016-2018* | | 7 |
| **0.67** | Adults Who Used Smokeless Tobacco: Past 30 Days | *percent* | 1.7 | | 1.8 | 2 | *2020* | | 6 |
| **0.67** | Teens who Smoke | *percent* | 4.4 | | 5 | | *2018* | | 3 |
| | | | | | | | | | |
| **SCORE** | **TEEN & ADOLESCENT HEALTH** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **2.11** | Teens who Use Alcohol | *percent* | 46 | | 40 | | *2018* | | 3 |
| **1.56** | Teens who Use Marijuana | *percent* | 24.4 | | 26 | | *2018* | | 3 |
| **1.33** | Age-Adjusted Hospitalization Rate due to Adolescent Suicide and Intentional Self-inflicted Injury | *hospitalizations/ 10,000 population aged 10-17* | 100.5 | | 106 | | *2017-2019* | Female (135.5) | 13 |
| **1.00** | Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-inflicted Injury | *ER visits/ 10,000 population aged 10-17* | 80.3 | | 114.5 | | *2017-2019* | Female (112.4) | 13 |
| **0.97** | Teen Births | *percent* | 1 | | 1.1 | 2.8 | *2018* | | 12 |
| **0.67** | Teens who Smoke | *percent* | 4.4 | | 5 | | *2018* | | 3 |
| | | | | | | | | | |
| **SCORE** | **TRANSPORTATION** | **UNITS** | **KANE COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **2.00** | Solo Drivers with a Long Commute | *percent* | 42.4 | | 41.3 | 36 | *2014-2018* | | 7 |
| **1.89** | Mean Travel Time to Work | *minutes* | 28.9 | | 29 | 26.6 | *2014-2018* | | 1 |
| **1.78** | Workers Commuting by Public Transportation | *percent* | 2.6 | 5.5 | 9.4 | 5 | *2014-2018* | | 1 |
| **1.33** | Workers who Drive Alone to Work | *percent* | 79.7 | | 73.1 | 76.4 | *2014-2018* | | 1 |
| **1.00** | Households with No Car and Low Access to a Grocery Store | *percent* | 0.9 | | | | *2015* | | 23 |
| **0.56** | Households without a Vehicle | *percent* | 4.4 | | 10.8 | 8.7 | *2014-2018* | | 1 |
| | | | | | | | | | |

Appendix A: Secondary Data Detailed Methodology and Data Scoring Tables

| SCORE | WOMEN'S HEALTH | UNITS | KANE COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| **1.06** | Breast Cancer Incidence Rate | *cases/ 100,000 females* | 120.6 | | 133.1 | 125.9 | *2013-2017* | | 16 |
| **0.25** | Cervical Cancer Incidence Rate | *cases/ 100,000 females* | 6.2 | 7.3 | 7.7 | 7.6 | *2013-2017* | | 16 |
| **0.00** | Age-Adjusted Death Rate due to Breast Cancer | *deaths/ 100,000 females* | 17.1 | 20.7 | 21 | 20.1 | *2013-2017* | | 16 |

| Kane County Health and Quality of Life Topics | Score |
|---|---|
| Other Chronic Diseases | 1.86 |
| Environment | 1.45 |
| Transportation | 1.43 |
| Older Adults & Aging | 1.40 |
| Access to Health Services | 1.38 |
| Immunizations & Infectious Diseases | 1.36 |
| Substance Abuse | 1.35 |
| Maternal, Fetal & Infant Health | 1.32 |
| Education | 1.29 |
| Teen & Adolescent Health | 1.27 |
| Public Safety | 1.25 |
| Heart Disease & Stroke | 1.24 |
| Diabetes | 1.24 |
| Prevention & Safety | 1.21 |
| Mental Health & Mental Disorders | 1.19 |
| Exercise, Nutrition, & Weight | 1.19 |
| Other Conditions | 1.19 |
| Children's Health | 1.17 |
| Respiratory Diseases | 1.15 |
| Economy | 1.01 |
| Oral Health | 0.97 |
| Social Environment | 0.88 |
| Cancer | 0.75 |
| Women's Health | 0.44 |

RUSH

Rush Copley Medical Center

# Appendix A: Data Scoring Tables

SECONDARY DATA: KENDALL COUNTY

| SCORE | ACCESS TO HEALTH SERVICES | UNITS | KENDALL COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| 1.92 | Non-Physician Primary Care Provider Rate | *providers/ 100,000 population* | 32.1 | | 82.4 | | *2019* | | 6 |
| 1.81 | Dentist Rate | *dentists/ 100,000 population* | 36.7 | | 77.9 | | *2018* | | 6 |
| 1.58 | Primary Care Provider Rate | *providers/ 100,000 population* | 37.2 | | 80 | | *2017* | | 6 |
| 1.39 | Adults with Health Insurance | *percent* | 92.9 | 100 | 90.1 | 87.5 | *2018* | | 1 |
| 1.39 | Children with Health Insurance | *percent* | 99.1 | 100 | 96.6 | 94.8 | *2018* | | 1 |
| 1.25 | Clinical Care Ranking | | 22 | | | | *2020* | | 6 |
| 1.06 | Preventable Hospital Stays: Medicare Population | *discharges/ 1,000 Medicare enrollees* | 50.5 | | 54.8 | 49.4 | *2015* | | 19 |
| 0.83 | Adults with Health Insurance: 18+ | *percent* | 93.6 | | 91.5 | 91.3 | *2020* | | 5 |
| | | | | | | | | | |
| SCORE | CANCER | UNITS | KENDALL COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
| 2.75 | Age-Adjusted Death Rate due to Prostate Cancer | *deaths/ 100,000 males* | 25.7 | 21.8 | 20 | 19 | *2013-2017* | | 15 |
| 2.44 | Cancer: Medicare Population | *percent* | 9.3 | | 8.9 | 8.2 | *2017* | | 4 |
| 2.39 | Prostate Cancer Incidence Rate | *cases/ 100,000 males* | 129.3 | | 109.1 | 104.5 | *2013-2017* | | 15 |
| 2.11 | Breast Cancer Incidence Rate | *cases/ 100,000 females* | 136.2 | | 133.1 | 125.9 | *2013-2017* | | 15 |
| 1.78 | Oral Cavity and Pharynx Cancer Incidence Rate | *cases/ 100,000 population* | 13 | | 12.2 | 11.8 | *2013-2017* | Male (19.5) | 15 |
| 1.44 | Colorectal Cancer Incidence Rate | *cases/ 100,000 population* | 42 | 39.9 | 42.5 | 38.4 | *2013-2017* | | 15 |
| 1.28 | Lung and Bronchus Cancer Incidence Rate | *cases/ 100,000 population* | 63.3 | | 63.7 | 58.3 | *2013-2017* | | 15 |
| 0.67 | Age-Adjusted Death Rate due to Lung Cancer | *deaths/ 100,000 population* | 39.3 | 45.5 | 41.1 | 38.5 | *2013-2017* | Male (54.8) | 15 |
| 0.58 | Cervical Cancer Incidence Rate | *cases/ 100,000 females* | 4.8 | 7.3 | 7.7 | 7.6 | *2013-2017* | | 15 |
| 0.44 | Age-Adjusted Death Rate due to Colorectal Cancer | *deaths/ 100,000 population* | 12.1 | 14.5 | 14.7 | 13.7 | *2013-2017* | | 15 |
| 0.00 | Age-Adjusted Death Rate due to Breast Cancer | *deaths/ 100,000 females* | 14.8 | 20.7 | 21 | 20.1 | *2013-2017* | | 15 |

| SCORE | CHILDREN'S HEALTH | UNITS | KENDALL COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| 1.83 | Age-Adjusted ER Rate due to Pediatric Mental Health | *ER visits/ 10,000 population under 18 years* | 117.6 | | 103.8 | | *2017-2019* | | 12 |
| 1.67 | Children with Low Access to a Grocery Store | *percent* | 4.7 | | | | *2015* | | 22 |
| 1.50 | Age-Adjusted Hospitalization Rate due to Pediatric Mental Health | *hospitalizations/ 10,000 population under 18 years* | 63.8 | | 67.5 | | *2017-2019* | Female (82.5) | 12 |
| 1.39 | Children with Health Insurance | *percent* | 99.1 | 100 | 96.6 | 94.8 | *2018* | | 1 |
| 1.33 | Age-Adjusted ER Rate due to Pediatric Asthma | *ER visits/ 10,000 population under 18 years* | 51.1 | | 78.7 | | *2017-2019* | Black (171.3) | 12 |
| 1.25 | Age-Adjusted Hospitalization Rate due to Pediatric Asthma | *hospitalizations/ 10,000 population under 18 years* | 5.8 | | 11.8 | | *2017-2019* | | 12 |
| 1.25 | Blood Lead Levels in Children (>=5 micrograms per deciliter) | *percent* | 0.5 | | 3.4 | | *2014* | | 18 |
| 0.83 | Food Insecure Children Likely Ineligible for Assistance | *percent* | 8 | | 18 | 25 | *2018* | | 7 |
| 0.64 | Substantiated Child Abuse Rate | *cases/ 1,000 children* | 5 | | 9.7 | 9.2 | *2015* | | 10 |
| 0.50 | Child Food Insecurity Rate | *percent* | 6.4 | | 12.7 | 15.2 | *2018* | | 7 |
| | | | | | | | | | |
| SCORE | DIABETES | UNITS | KENDALL COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
| 1.50 | Age-Adjusted ER Rate due to Short-Term Complications of Diabetes | *ER visits/ 10,000 population 18+ years* | 2 | | 1.7 | | *2017-2019* | Male (2.6) | 12 |
| 1.50 | Diabetes: Medicare Population | *percent* | 26.3 | | 27.2 | 27.2 | *2017* | | 4 |
| 1.25 | Adults with Diabetes | *percent* | 8.6 | | | | *2010-2014* | | 9 |
| 1.17 | Age-Adjusted ER Rate due to Diabetes | *ER visits/ 10,000 population 18+ years* | 35.8 | | 48.6 | | *2017-2019* | Black (136.6) Hispanic / Latino | 12 |
| 1.17 | Age-Adjusted ER Rate due to Long-Term Complications of Diabetes | *ER visits/ 10,000 population 18+ years* | 6.3 | | 7.2 | | *2017-2019* | Black (48.3) Hispanic / Latino (9.6) | 12 |
| 1.17 | Age-Adjusted ER Rate due to Type 2 Diabetes | *ER visits/ 10,000 population 18+ years* | 31.9 | | 42.3 | | *2017-2019* | Black (128) Hispanic / Latino (57) | 12 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.17** | Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes | *hospitalizations/ 10,000 population 18+ years* | 11.1 | | 15.1 | | *2017-2019* | | 12 |
| **1.17** | Age-Adjusted Hospitalization Rate due to Type 2 Diabetes | *hospitalizations/ 10,000 population 18+ years* | 13.5 | | 23.6 | | *2017-2019* | Black (52.6) Hispanic / Latino (19) | 12 |
| **1.00** | Age-Adjusted ER Rate due to Uncontrolled Diabetes | *ER visits/ 10,000 population 18+ years* | 24.8 | | 30.7 | | *2017-2019* | Black (74.7) Hispanic / Latino | 12 |
| **1.00** | Age-Adjusted Hospitalization Rate due to Diabetes | *hospitalizations/ 10,000 population 18+ years* | 17.3 | | 31.8 | | *2017-2019* | Black (58.4) Hispanic / Latino | 12 |
| **1.00** | Age-Adjusted Hospitalization Rate due to Short-Term Complications of Diabetes | *hospitalizations/ 10,000 population 18+ years* | 3.9 | | 10 | | *2017-2019* | | 12 |
| **1.00** | Age-Adjusted Hospitalization Rate due to Uncontrolled Diabetes | *hospitalizations/ 10,000 population 18+ years* | 2.4 | | 6.6 | | *2017-2019* | | 12 |
| | | | | | | | | | |
| **SCORE** | **ECONOMY** | **UNITS** | **KENDALL COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **1.89** | SNAP Certified Stores | *stores/ 1,000 population* | 0.4 | | | | *2016* | | 22 |
| **1.61** | Households with Cash Public Assistance Income | *percent* | 2.3 | | 2.4 | 2.5 | *2014-2018* | | 1 |
| **1.61** | Renters Spending 30% or More of Household Income on Rent | *percent* | 46.5 | | 48.8 | 50.2 | *2014-2018* | | 1 |
| **1.58** | Households that are Asset Limited, Income Constrained, Employed | *percent* | 24.1 | | | | *2017* | | 24 |
| **1.33** | Unemployed Workers in Civilian Labor Force | *percent* | 10.1 | | 11.5 | 10.5 | *July 2020* | | 20 |
| **1.25** | Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold | *percent* | 71.1 | | | | *2017* | | 24 |
| **1.25** | Households that are Below the Federal Poverty Level | *percent* | 4.7 | | | | *2017* | | 24 |
| **1.25** | Social and Economic Factors | | 3 | | | | *2020* | | 6 |
| **1.22** | Overcrowded Households | *percent of households* | 1.9 | | 2.5 | | *2014-2018* | | 1 |

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|---|---|---|---|---|---|---|---|---|---|
| **1.00** | Low-Income and Low Access to a Grocery Store | *percent* | 3 | | | | *2015* | | 22 |
| **1.00** | Projected Child Food Insecurity Rate | *percent* | 15.5 | | | | *2020* | | 7 |
| **1.00** | Projected Food Insecurity Rate | *percent* | 9.9 | | | | *2020* | | 7 |
| **1.00** | Severe Housing Problems | *percent* | 12.7 | | 17.3 | 19 | *2012-2016* | | 6 |
| **0.83** | Food Insecure Children Likely Ineligible for Assistance | *percent* | 8 | | 18 | 25 | *2018* | | 7 |
| **0.67** | Per Capita Income | *dollars* | 34423 | | 34463 | 32621 | *2014-2018* | | 1 |
| **0.64** | Persons with Disability Living in Poverty | *percent* | 9.3 | | 26.5 | 26.1 | *2018* | | 1 |
| **0.61** | Students Eligible for the Free Lunch Program | *percent* | 23.2 | | 46.7 | 41.2 | *2018-2019* | | 16 |
| **0.50** | Child Food Insecurity Rate | *percent* | 6.4 | | 12.7 | 15.2 | *2018* | | 7 |
| **0.50** | Food Insecurity Rate | *percent* | 4.8 | | 10.1 | 11.5 | *2018* | | 7 |
| **0.50** | Persons with Disability Living in Poverty (5-year) | *percent* | 12 | | 26.3 | 26.7 | *2014-2018* | | 1 |
| **0.39** | Children Living Below Poverty Level | *percent* | 6.3 | | 18.1 | 19.5 | *2014-2018* | | 1 |
| **0.39** | People 65+ Living Below Poverty Level | *percent* | 6.3 | | 8.8 | 9.3 | *2014-2018* | Black (19.5); Asian (12.5); Other Race (19); Hispanic / Latino (6.7) | 1 |
| **0.39** | People Living 200% Above Poverty Level | *percent* | 81.6 | | 70.6 | 68.1 | *2014-2018* | | 1 |
| **0.39** | People Living Below Poverty Level | *percent* | 5.3 | | 13.1 | 14.1 | *2014-2018* | | 1 |
| **0.17** | Homeownership | *percent* | 80.5 | | 59.6 | 56.1 | *2014-2018* | | 1 |
| **0.17** | Median Household Income | *dollars* | 91764 | | 63575 | 60293 | *2014-2018* | | 1 |
| | | | | | | | | | |
| **SCORE** | **EDUCATION** | **UNITS** | **KENDALL COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **1.83** | Student-to-Teacher Ratio | *students/ teacher* | 15.8 | | 15 | 16.5 | *2018-2019* | | 16 |
| **0.94** | People 25+ with a High School Degree or Higher | *percent* | 92.1 | | 88.9 | 87.7 | *2014-2018* | | 1 |

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|---|---|---|---|---|---|---|---|---|---|
| 0.56 | People 25+ with a Bachelor's Degree or Higher | *percent* | 35.4 | | 34.1 | 31.5 | *2014-2018* | | 1 |
| 0.11 | High School Graduation | *percent* | 95.3 | 87 | 85.4 | 85.3 | *2017-2018* | | 6 |
| | | | | | | | | | |
| **SCORE** | **ENVIRONMENT** | **UNITS** | **KENDALL COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| 2.00 | Grocery Store Density | *stores/ 1,000 population* | 0.1 | | | | *2014* | | 22 |
| 1.89 | SNAP Certified Stores | *stores/ 1,000 population* | 0.4 | | | | *2016* | | 22 |
| 1.78 | Fast Food Restaurant Density | *restaurants/ 1,000 population* | 0.6 | | | | *2014* | | 22 |
| 1.75 | Physical Environment Ranking | | 100 | | | | *2020* | | 6 |
| 1.67 | Children with Low Access to a Grocery Store | *percent* | 4.7 | | | | *2015* | | 22 |
| 1.67 | Farmers Market Density | *markets/ 1,000 population* | 0 | | | | *2016* | | 22 |
| 1.61 | Months of Mild Drought or Worse | *months per year* | 6 | | | | *2016* | | 18 |
| 1.61 | PBT Released | *pounds* | 1.4 | | | | *2018* | | 23 |
| 1.39 | Number of Extreme Heat Days | *days* | 11 | | | | *2016* | | 18 |
| 1.39 | Number of Extreme Heat Events | *events* | 3 | | | | *2016* | | 18 |
| 1.39 | Recognized Carcinogens Released into Air | *pounds* | 0.4 | | | | *2017* | | 23 |
| 1.33 | People with Low Access to a Grocery Store | *percent* | 15.7 | | | | *2015* | | 22 |
| 1.25 | Blood Lead Levels in Children (>=5 micrograms per deciliter) | *percent* | 0.5 | | 3.4 | | *2014* | | 18 |
| 1.22 | Overcrowded Households | *percent of households* | 1.9 | | 2.5 | | *2014-2018* | | 1 |
| 1.17 | Recreation and Fitness Facilities | *facilities/ 1,000 population* | 0.1 | | | | *2014* | | 22 |
| 1.00 | Daily Dose of UV Irradiance | *Joule per square meter* | 2224 | | 2506 | | *2015* | | 18 |
| 1.00 | Households with No Car and Low Access to a Grocery Store | *percent* | 1 | | | | *2015* | | 22 |
| 1.00 | Low-Income and Low Access to a Grocery Store | *percent* | 3 | | | | *2015* | | 22 |
| 1.00 | People 65+ with Low Access to a Grocery Store | *percent* | 1.5 | | | | *2015* | | 22 |
| 1.00 | Severe Housing Problems | *percent* | 12.7 | | 17.3 | 19 | *2012-2016* | | 6 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **0.92** | Liquor Store Density | *stores/ 100,000 population* | 9.4 | | 10.8 | 10.6 | *2018* | | 21 |
| **0.67** | Access to Exercise Opportunities | *percent* | 93.9 | | 90.8 | 84 | *2020* | | 6 |
| **0.56** | Food Environment Index | | 9.4 | | 8.6 | 7.6 | *2020* | | 6 |
| | | | | | | | | | |
| **SCORE** | **EXERCISE, NUTRITION, & WEIGHT** | **UNITS** | **KENDALL COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **2.00** | Grocery Store Density | *stores/ 1,000 population* | 0.1 | | | | *2014* | | 22 |
| **1.89** | SNAP Certified Stores | *stores/ 1,000 population* | 0.4 | | | | *2016* | | 22 |
| **1.78** | Fast Food Restaurant Density | *restaurants/ 1,000 population* | 0.6 | | | | *2014* | | 22 |
| **1.75** | Adults Who Are Obese | *percent* | 34.2 | 30.5 | | | *2010-2014* | | 9 |
| **1.67** | Children with Low Access to a Grocery Store | *percent* | 4.7 | | | | *2015* | | 22 |
| **1.67** | Farmers Market Density | *markets/ 1,000 population* | 0 | | | | *2016* | | 22 |
| **1.58** | Adult Fruit and Vegetable | *percent* | 12.7 | | | | *2007-2009* | | 9 |
| **1.33** | People with Low Access to a Grocery Store | *percent* | 15.7 | | | | *2015* | | 22 |
| **1.25** | Health Behaviors Ranking | | 10 | | | | *2020* | | 6 |
| **1.17** | Recreation and Fitness Facilities | *facilities/ 1,000 population* | 0.1 | | | | *2014* | | 22 |
| **1.08** | Adults who are Sedentary | *percent* | 16.7 | 32.6 | | | *2010-2014* | | 9 |
| **1.00** | Households with No Car and Low Access to a Grocery Store | *percent* | 1 | | | | *2015* | | 22 |
| **1.00** | Low-Income and Low Access to a Grocery Store | *percent* | 3 | | | | *2015* | | 22 |
| **1.00** | People 65+ with Low Access to a Grocery Store | *percent* | 1.5 | | | | *2015* | | 22 |
| **1.00** | Projected Child Food Insecurity Rate | *percent* | 15.5 | | | | *2020* | | 7 |
| **1.00** | Projected Food Insecurity Rate | *percent* | 9.9 | | | | *2020* | | 7 |
| **0.83** | Food Insecure Children Likely Ineligible for Assistance | *percent* | 8 | | 18 | 25 | *2018* | | 7 |
| **0.67** | Access to Exercise Opportunities | *percent* | 93.9 | | 90.8 | 84 | *2020* | | 6 |
| **0.56** | Food Environment Index | | 9.4 | | 8.6 | 7.6 | *2020* | | 6 |
| **0.50** | Child Food Insecurity Rate | *percent* | 6.4 | | 12.7 | 15.2 | *2018* | | 7 |
| **0.50** | Food Insecurity Rate | *percent* | 4.8 | | 10.1 | 11.5 | *2018* | | 7 |

| SCORE | HEART DISEASE & STROKE | UNITS | KENDALL COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| 2.39 | Hyperlipidemia: Medicare | *percent* | 45.8 | | 39.8 | 40.7 | *2017* | | 4 |
| 1.94 | Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke) | *deaths/ 100,000 population* | 38.5 | 34.8 | 38 | 37.3 | *2016-2018* | | 3 |
| 1.61 | Stroke: Medicare Population | *percent* | 3.8 | | 3.8 | 3.8 | *2017* | | 4 |
| 1.56 | Atrial Fibrillation: Medicare | *percent* | 8.9 | | 8.9 | 8.4 | *2017* | | 4 |
| 1.50 | Age-Adjusted ER Rate due to Heart Failure | *ER visits/ 10,000 population 18+ years* | 16.1 | | 15.3 | | *2017-2019* | Black (51.3) Hispanic / Latino | 12 |
| 1.44 | Hypertension: Medicare Population | *percent* | 57.5 | | 58.2 | 57.1 | *2017* | | 4 |
| 1.42 | High Cholesterol Prevalence | *percent* | 30.5 | 13.5 | | | *2007-2009* | | 9 |
| 1.33 | Age-Adjusted Hospitalization Rate due to Acute Myocardial Infarction | *hospitalizations/ 10,000 population 18+ years* | 22 | | 25.1 | | *2017-2019* | Male (29.6) | 12 |
| 1.19 | High Blood Pressure Prevalence | *percent* | 24.9 | 26.9 | | | *2004-2006* | | 9 |
| 1.17 | Age-Adjusted Hospitalization Rate due to Heart Failure | *hospitalizations/ 10,000 population 18+ years* | 39.5 | | 61.5 | | *2017-2019* | | 12 |
| 1.00 | Age-Adjusted ER Rate due to Hypertension | *ER visits/ 10,000 population 18+ years* | 40.1 | | 61.5 | | *2017-2019* | | 12 |
| 1.00 | Age-Adjusted Hospitalization Rate due to Hypertension | *hospitalizations/ 10,000 population 18+ years* | 2.4 | | 8.1 | | *2017-2019* | Black (18.3) | 12 |
| 0.89 | Age-Adjusted Death Rate due to Heart Attack | *deaths/ 100,000 population 35+ years* | 44 | | 57.4 | | *2018* | | 18 |
| 0.89 | Ischemic Heart Disease: Medicare Population | *percent* | 24.5 | | 26.8 | 26.9 | *2017* | | 4 |
| 0.61 | Heart Failure: Medicare Population | *percent* | 12.2 | | 15.2 | 13.9 | *2017* | | 4 |
| 0.22 | Age-Adjusted Death Rate due to Coronary Heart Disease | *deaths/ 100,000 population* | 60.5 | 103.4 | 83.7 | 92.7 | *2016-2018* | Male (97) | 3 |
| | | | | | | | | | |
| SCORE | IMMUNIZATIONS & INFECTIOUS DISEASES | UNITS | KENDALL COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
| 2.33 | COVID-19 Daily Average Incidence Rate | *cases per 100,000 population* | 74.6 | | 79.9 | 47.5 | *44141* | | 8 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.83** | Age-Adjusted ER Rate due to Immunization-Preventable Pneumonia and Influenza | *ER visits/ 10,000 population 18+ years* | 38.7 | | 33.9 | | *2017-2019* | | 12 |
| **1.75** | Adults with Pneumonia Vaccination | *percent* | 22.9 | | | | *2010-2014* | | 9 |
| **1.61** | HIV Diagnosed Cases | *cases* | 3 | | | | *2018* | | 11 |
| **1.58** | Adults with Influenza Vaccination | *percent* | 40.5 | 70 | | | *2010-2014* | | 9 |
| **1.50** | Chlamydia Incidence Rate | *cases/ 100,000 population* | 341.5 | | 604 | 539.9 | *2018* | | 17 |
| **1.42** | Age-Adjusted Hospitalization Rate due to Hepatitis | *hospitalizations/ 10,000 population 18+ years* | 1.3 | | 1.4 | | *2017-2019* | | 12 |
| **1.39** | Tuberculosis Cases | *cases* | 1 | | | | *2019* | | 11 |
| **1.28** | Syphilis Incidence Rate | *cases/ 100,000 population* | 3.2 | | 11 | 10.8 | *2018* | | 17 |
| **1.22** | Overcrowded Households | *percent of households* | 1.9 | | 2.5 | | *2014-2018* | | 1 |
| **1.17** | Age-Adjusted ER Rate due to Community Acquired Pneumonia | *ER visits/ 10,000 population 18+ years* | 30 | | 32.4 | | *2017-2019* | | 12 |
| **1.11** | Gonorrhea Incidence Rate | *cases/ 100,000 population* | 69.7 | | 198.6 | 179.1 | *2018* | | 17 |
| **1.00** | Age-Adjusted Hospitalization Rate due to Community Acquired | *hospitalizations/ 10,000 population 18+ years* | 19.9 | | 24 | | *2017-2019* | | 12 |
| **1.00** | Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza | *hospitalizations/ 10,000 population 18+ years* | 4.7 | | 7.1 | | *2017-2019* | | 12 |
| **0.72** | COVID-19 Daily Average Case-Fatality Rate | *deaths per 100 cases* | 0.3 | | 1.4 | 1.7 | *44141* | | 8 |
| **0.50** | Age-Adjusted Death Rate due to Influenza and Pneumonia | *deaths/ 100,000 population* | 12.3 | | 15.5 | 14.2 | *2016-2018* | | 3 |
| | | | | | | | | | |
| **SCORE** | **MATERNAL, FETAL & INFANT HEALTH** | **UNITS** | **KENDALL COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **1.72** | Preterm Births | *percent* | 11.2 | 9.4 | 10.7 | | *2018* | | 11 |
| **1.22** | Babies with Low Birth Weight | *percent* | 7.5 | 7.8 | 8.6 | | *2018* | | 11 |
| **1.17** | Preterm Labor and Delivery Hospitalizations | *percent* | 3.6 | | 4.1 | | *2017-2019* | | 12 |
| **0.89** | Infant Mortality Rate | *deaths/ 1,000 live births* | 5.4 | 6 | 6.3 | | *2016-2018* | | 11 |
| **0.64** | Teen Births | *percent* | 0.5 | | 1.1 | 2.8 | *2018* | | 11 |

| SCORE | MENTAL HEALTH & MENTAL DISORDERS | UNITS | KENDALL COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| **1.83** | Age-Adjusted ER Rate due to Pediatric Mental Health | *ER visits/ 10,000 population under 18 years* | 117.6 | | 103.8 | | *2017-2019* | | 12 |
| **1.67** | Age-Adjusted Hospitalization Rate due to Adolescent Suicide and Intentional Self-inflicted Injury | *hospitalizations/ 10,000 population aged 10-17* | 116.2 | | 106 | | *2017-2019* | Female (170.4) | 12 |
| **1.58** | Poor Mental Health Days | *percent* | 36.3 | | | | *2010-2014* | | 9 |
| **1.50** | Age-Adjusted Hospitalization Rate due to Pediatric Mental Health | *hospitalizations/ 10,000 population under 18 years* | 63.8 | | 67.5 | | *2017-2019* | Female (82.5) | 12 |
| **1.50** | Depression: Medicare Population | *percent* | 16.3 | | 16.4 | 17.9 | *2017* | | 4 |
| **1.33** | Age-Adjusted Hospitalization Rate due to Adult Suicide and Intentional Self-inflicted Injury | *hospitalizations/ 10,000 population 18+ years* | 44.8 | | 65.4 | | *2017-2019* | White (45) American Indian / | 12 |
| **1.17** | Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-inflicted Injury | *ER visits/ 10,000 population aged 10-17* | 105.9 | | 114.5 | | *2017-2019* | Female (154.1) | 12 |
| **1.17** | Age-Adjusted ER Rate due to Adult Mental Health | *ER visits/ 10,000 population 18+ years* | 120.3 | | 144.5 | | *2017-2019* | | 12 |
| **1.17** | Age-Adjusted Hospitalization Rate due to Adult Mental Health | *hospitalizations/ 10,000 population 18+ years* | 46.3 | | 84.5 | | *2017-2019* | Black (56) American Indian / | 12 |
| **1.00** | Age-Adjusted ER Rate due to Adult Suicide and Intentional Self-inflicted Injury | *ER visits/ 10,000 population 18+ years* | 43.3 | | 60 | | *2017-2019* | | 12 |
| **1.00** | Frequent Mental Distress | *percent* | 10.1 | | 11 | 12 | *2017* | | 6 |
| **0.94** | Alzheimer's Disease or Dementia: Medicare Population | *percent* | 9.2 | | 10.7 | 10.9 | *2017* | | 4 |
| **0.81** | Age-Adjusted Death Rate due to Suicide | *deaths/ 100,000 population* | 9.9 | 10.2 | 11.1 | 13.9 | *2016-2018* | | 3 |
| **0.39** | Age-Adjusted Death Rate due to Alzheimer's Disease | *deaths/ 100,000 population* | 18.6 | | 25.4 | 30.6 | *2016-2018* | | 3 |

| SCORE | OLDER ADULTS & AGING | UNITS | KENDALL COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| **2.44** | Cancer: Medicare Population | *percent* | 9.3 | | 8.9 | 8.2 | *2017* | | 4 |
| **2.39** | Hyperlipidemia: Medicare | *percent* | 45.8 | | 39.8 | 40.7 | *2017* | | 4 |
| **2.28** | Osteoporosis: Medicare Population | *percent* | 6.5 | | 6.3 | 6.4 | *2017* | | 4 |
| **2.17** | Asthma: Medicare Population | *percent* | 5.2 | | 4.9 | 5.1 | *2017* | | 4 |
| **1.83** | Chronic Kidney Disease: Medicare Population | *percent* | 24 | | 24 | 24 | *2017* | | 4 |
| **1.83** | Rheumatoid Arthritis or Osteoarthritis: Medicare Population | *percent* | 33.2 | | 34.6 | 33.1 | *2017* | | 4 |
| **1.61** | Stroke: Medicare Population | *percent* | 3.8 | | 3.8 | 3.8 | *2017* | | 4 |
| **1.56** | Atrial Fibrillation: Medicare | *percent* | 8.9 | | 8.9 | 8.4 | *2017* | | 4 |
| **1.50** | Depression: Medicare Population | *percent* | 16.3 | | 16.4 | 17.9 | *2017* | | 4 |
| **1.50** | Diabetes: Medicare Population | *percent* | 26.3 | | 27.2 | 27.2 | *2017* | | 4 |
| **1.44** | Hypertension: Medicare Population | *percent* | 57.5 | | 58.2 | 57.1 | *2017* | | 4 |
| **1.39** | Hospitalization Rate due to Hip Fractures Among Females 65+ | *hospitalizations/ 100,000 females 65+ years* | 759.9 | 741.2 | 762 | | *2017-2019* | | 12 |
| **1.00** | People 65+ with Low Access to a Grocery Store | *percent* | 1.5 | | | | *2015* | | 22 |
| **0.94** | Alzheimer's Disease or Dementia: Medicare Population | *percent* | 9.2 | | 10.7 | 10.9 | *2017* | | 4 |
| **0.89** | Ischemic Heart Disease: Medicare Population | *percent* | 24.5 | | 26.8 | 26.9 | *2017* | | 4 |
| **0.83** | Hospitalization Rate due to Hip Fractures Among Males 65+ | *hospitalizations/ 100,000 males 65+ years* | 369.2 | 418.4 | 435 | | *2017-2019* | | 12 |
| **0.61** | COPD: Medicare Population | *percent* | 9.6 | | 11.9 | 11.7 | *2017* | | 4 |
| **0.61** | Heart Failure: Medicare Population | *percent* | 12.2 | | 15.2 | 13.9 | *2017* | | 4 |
| **0.39** | Age-Adjusted Death Rate due to Alzheimer's Disease | *deaths/ 100,000 population* | 18.6 | | 25.4 | 30.6 | *2016-2018* | | 3 |
| **0.39** | People 65+ Living Alone | *percent* | 21.4 | | 28.5 | 26.1 | *2014-2018* | | 1 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **0.39** | People 65+ Living Below Poverty Level | *percent* | 6.3 | | 8.8 | 9.3 | *2014-2018* | Black (19.5); Asian (12.5); Other Race (19); Hispanic / Latino (6.7) | 1 |
| | | | | | | | | | |
| **SCORE** | **ORAL HEALTH** | **UNITS** | **KENDALL COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **1.81** | Dentist Rate | *dentists/ 100,000 population* | 36.7 | | 77.9 | | *2018* | | 6 |
| **1.78** | Oral Cavity and Pharynx Cancer Incidence Rate | *cases/ 100,000 population* | 13 | | 12.2 | 11.8 | *2013-2017* | Male (19.5) | 15 |
| **1.00** | Age-Adjusted ER Rate due to Dental Problems | *ER visits/ 10,000 population* | 43.5 | | 75.8 | | *2017-2019* | | 12 |
| | | | | | | | | | |
| **SCORE** | **OTHER CHRONIC DISEASES** | **UNITS** | **KENDALL COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **2.28** | Osteoporosis: Medicare Population | *percent* | 6.5 | | 6.3 | 6.4 | *2017* | | 4 |
| **1.83** | Chronic Kidney Disease: Medicare Population | *percent* | 24 | | 24 | 24 | *2017* | | 4 |
| **1.83** | Rheumatoid Arthritis or Osteoarthritis: Medicare Population | *percent* | 33.2 | | 34.6 | 33.1 | *2017* | | 4 |
| **0.72** | Age-Adjusted Death Rate due to Kidney Disease | *deaths/ 100,000 population* | 13 | | 16.9 | 13 | *2016-2018* | | 3 |
| | | | | | | | | | |
| **SCORE** | **OTHER CONDITIONS** | **UNITS** | **KENDALL COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **1.67** | Age-Adjusted ER Rate due to Dehydration | *ER visits/ 10,000 population 18+ years* | 34.9 | | 27.5 | | *2017-2019* | | 12 |
| **1.67** | Age-Adjusted ER Rate due to Urinary Tract Infections | *ER visits/ 10,000 population 18+ years* | 147.8 | | 132.6 | | *2017-2019* | Female (241.8) | 12 |
| **1.17** | Age-Adjusted Hospitalization Rate due to Urinary Tract Infections | *hospitalizations/ 10,000 population 18+ years* | 17.3 | | 19.5 | | *2017-2019* | Black (83.2) Hispanic / Latino | 12 |
| **1.00** | Age-Adjusted ER Rate due to Headaches | *ER visits/ 10,000 population 18+ years* | 116.4 | | 134.9 | | *2017-2019* | Female (175) | 12 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.00** | Age-Adjusted Hospitalization Rate due to Dehydration | *hospitalizations/ 10,000 population 18+ years* | 11.5 | | 21.3 | | *2017-2019* | | 12 |
| | | | | | | | | | |
| **SCORE** | **PREVENTION & SAFETY** | **UNITS** | **KENDALL COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **1.39** | Hospitalization Rate due to Hip Fractures Among Females 65+ | *hospitalizations/ 100,000 females 65+ years* | 759.9 | 741.2 | 762 | | *2017-2019* | | 12 |
| **1.17** | Death Rate due to Drug Poisoning | *deaths/ 100,000 population* | 16.4 | | 20.6 | 21 | *2016-2018* | | 6 |
| **1.00** | Age-Adjusted ER Rate due to Unintentional Falls | *ER visits/ 10,000 population 18+ years* | 104.5 | | 304.7 | | *2017-2019* | | 12 |
| **1.00** | Age-Adjusted Hospitalization Rate due to Unintentional Falls | *hospitalizations/ 10,000 population 18+ years* | 20.4 | | 62 | | *2017-2019* | | 12 |
| **1.00** | Severe Housing Problems | *percent* | 12.7 | | 17.3 | 19 | *2012-2016* | | 6 |
| **0.83** | Hospitalization Rate due to Hip Fractures Among Males 65+ | *hospitalizations/ 100,000 males 65+ years* | 369.2 | 418.4 | 435 | | *2017-2019* | | 12 |
| | | | | | | | | | |
| **SCORE** | **PUBLIC SAFETY** | **UNITS** | **KENDALL COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **1.61** | Domestic Violence Offenses | *offenses* | 668 | | | | *2018* | | 14 |
| **1.17** | School Crime Incidents | *incidents* | 10 | | | | *2018* | | 14 |
| **0.89** | Alcohol-Impaired Driving Deaths | *percent* | 27.5 | | 32 | 28 | *2014-2018* | | 6 |
| **0.64** | Substantiated Child Abuse Rate | *cases/ 1,000 children* | 5 | | 9.7 | 9.2 | *2015* | | 10 |
| **0.64** | Violent Crime Rate | *crimes/ 100,000 population* | 104.2 | | 403.1 | 386.5 | *2014-2016* | | 6 |
| | | | | | | | | | |
| **SCORE** | **RESPIRATORY DISEASES** | **UNITS** | **KENDALL COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **2.33** | COVID-19 Daily Average Incidence Rate | *cases per 100,000 population* | 74.6 | | 79.9 | 47.5 | *44141* | | 8 |
| **2.17** | Asthma: Medicare Population | *percent* | 5.2 | | 4.9 | 5.1 | *2017* | | 4 |
| **1.83** | Age-Adjusted ER Rate due to Immunization-Preventable Pneumonia and Influenza | *ER visits/ 10,000 population 18+ years* | 38.7 | | 33.9 | | *2017-2019* | | 12 |
| **1.75** | Adults with Pneumonia Vaccination | *percent* | 22.9 | | | | *2010-2014* | | 9 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.58** | Adults with Current Asthma | *percent* | 9.2 | | | | *2010-2014* | | 9 |
| **1.58** | Adults with Influenza Vaccination | *percent* | 40.5 | 70 | | | *2010-2014* | | 9 |
| **1.39** | Tuberculosis Cases | *cases* | 1 | | | | *2019* | | 11 |
| **1.33** | Age-Adjusted ER Rate due to Pediatric Asthma | *ER visits/ 10,000 population under 18 years* | 51.1 | | 78.7 | | *2017-2019* | Black (171.3) | 12 |
| **1.28** | Lung and Bronchus Cancer Incidence Rate | *cases/ 100,000 population* | 63.3 | | 63.7 | 58.3 | *2013-2017* | | 15 |
| **1.25** | Age-Adjusted Hospitalization Rate due to Pediatric Asthma | *hospitalizations/ 10,000 population under 18 years* | 5.8 | | 11.8 | | *2017-2019* | | 12 |
| **1.17** | Age-Adjusted ER Rate due to Adult Asthma | *ER visits/ 10,000 population 18+ years* | 26.3 | | 45.6 | | *2017-2019* | Black (99.6) | 12 |
| **1.17** | Age-Adjusted ER Rate due to | *ER visits/ 10,000 population* | 32.6 | | 54.1 | | *2017-2019* | Black (118.1) | 12 |
| **1.17** | Age-Adjusted ER Rate due to Community Acquired Pneumonia | *ER visits/ 10,000 population 18+ years* | 30 | | 32.4 | | *2017-2019* | | 12 |
| **1.17** | Age-Adjusted Hospitalization Rate due to Adult Asthma | *hospitalizations/ 10,000 population 18+ years* | 3.5 | | 7.1 | | *2017-2019* | Black (21.2) | 12 |
| **1.17** | Age-Adjusted Hospitalization Rate due to Asthma | *hospitalizations/ 10,000 population* | 4.1 | | 8.3 | | *2017-2019* | Black (17.9) | 12 |
| **1.00** | Age-Adjusted ER Rate due to COPD | *ER visits/ 10,000 population 18+* | 22.6 | | 37.7 | | *2017-2019* | | 12 |
| **1.00** | Age-Adjusted Hospitalization Rate due to Community Acquired | *hospitalizations/ 10,000 population 18+ years* | 19.9 | | 24 | | *2017-2019* | | 12 |
| **1.00** | Age-Adjusted Hospitalization Rate due to COPD | *hospitalizations/ 10,000 population 18+ years* | 21.1 | | 33.2 | | *2017-2019* | | 12 |
| **1.00** | Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneumonia and Influenza | *hospitalizations/ 10,000 population 18+ years* | 4.7 | | 7.1 | | *2017-2019* | | 12 |
| **0.72** | COVID-19 Daily Average Case-Fatality Rate | *deaths per 100 cases* | 0.3 | | 1.4 | 1.7 | *44141* | | 8 |
| **0.67** | Age-Adjusted Death Rate due to Lung Cancer | *deaths/ 100,000 population* | 39.3 | 45.5 | 41.1 | 38.5 | *2013-2017* | Male (54.8) | 15 |
| **0.61** | COPD: Medicare Population | *percent* | 9.6 | | 11.9 | 11.7 | *2017* | | 4 |
| **0.50** | Age-Adjusted Death Rate due to Influenza and Pneumonia | *deaths/ 100,000 population* | 12.3 | | 15.5 | 14.2 | *2016-2018* | | 3 |

| SCORE | SOCIAL ENVIRONMENT | UNITS | KENDALL COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| 2.61 | Mean Travel Time to Work | *minutes* | 33.7 | | 29 | 26.6 | *2014-2018* | | 1 |
| 1.25 | Social and Economic Factors | | 3 | | | | *2020* | | 6 |
| 1.22 | Voter Turnout: General Election | *percent* | 71.9 | | 70.6 | | *2016* | | 13 |
| 0.94 | People 25+ with a High School Degree or Higher | *percent* | 92.1 | | 88.9 | 87.7 | *2014-2018* | | 1 |
| 0.83 | Adults with Internet Access | *percent* | 97.4 | | 94.4 | 94 | *2020* | | 5 |
| 0.83 | Households with a Computer | *percent* | 95.4 | | 90.7 | 90 | *2020* | | 5 |
| 0.67 | Per Capita Income | *dollars* | 34423 | | 34463 | 32621 | *2014-2018* | | 1 |
| 0.64 | Substantiated Child Abuse Rate | *cases/ 1,000 children* | 5 | | 9.7 | 9.2 | *2015* | | 10 |
| 0.61 | Single-Parent Households | *percent* | 20.5 | | 32.5 | 33.1 | *2014-2018* | | 1 |
| 0.56 | People 25+ with a Bachelor's Degree or Higher | *percent* | 35.4 | | 34.1 | 31.5 | *2014-2018* | | 1 |
| 0.39 | Children Living Below Poverty Level | *percent* | 6.3 | | 18.1 | 19.5 | *2014-2018* | | 1 |
| 0.39 | People 65+ Living Alone | *percent* | 21.4 | | 28.5 | 26.1 | *2014-2018* | | 1 |
| 0.39 | People Living Below Poverty Level | *percent* | 5.3 | | 13.1 | 14.1 | *2014-2018* | | 1 |
| 0.17 | Homeownership | *percent* | 80.5 | | 59.6 | 56.1 | *2014-2018* | | 1 |
| 0.17 | Median Household Income | *dollars* | 91764 | | 63575 | 60293 | *2014-2018* | | 1 |
| | | | | | | | | | |
| SCORE | SUBSTANCE ABUSE | UNITS | KENDALL COUNTY | HP2020 | Illinois | U.S. | MEASUREMENT PERIOD | HIGH DISPARITY | Source |
| 1.50 | Adults Who Use Electronic Cigarettes: Past 30 Days | *percent* | 4.3 | | 4.2 | 4.4 | *2020* | | 5 |
| 1.50 | Adults Who Used Smokeless Tobacco: Past 30 Days | *percent* | 2.4 | | 1.8 | 2 | *2020* | | 5 |
| 1.42 | Adults who Binge Drink | *percent* | 20.2 | 24.2 | | | *2010-2014* | | 9 |
| 1.42 | Age-Adjusted Hospitalization Rate due to Adolescent Alcohol Use | *hospitalizations/ 10,000 population aged 10-17* | 4.6 | | 4.7 | | *2017-2019* | | 12 |
| 1.33 | Age-Adjusted ER Rate due to Adult Alcohol Use | *ER visits/ 10,000 population 18+ years* | 48.6 | | 87 | | *2017-2019* | Male (64.4) | 12 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.33** | Age-Adjusted Hospitalization Rate due to Adult Alcohol Use | *hospitalizations/ 10,000 population 18+ years* | 19.1 | | 29.5 | | *2017-2019* | Male (26) | 12 |
| **1.33** | Age-Adjusted Hospitalization rate due to Opioid Use | *hospitalizations/ 10,000 population 18+ years* | 6.9 | | 15.2 | | *2017-2019* | | 12 |
| **1.28** | Teens who Use Alcohol | *percent* | 36 | | 40 | | *2018* | | 2 |
| **1.25** | Age-Adjusted ER Rate due to Adolescent Alcohol Use | *ER visits/ 10,000 population aged 10-17* | 7.9 | | 14 | | *2017-2019* | | 12 |
| **1.25** | Health Behaviors Ranking | | 10 | | | | *2020* | | 6 |
| **1.17** | Age-Adjusted ER Rate due to Opioid Use | *ER visits/ 10,000 population 18+ years* | 10.3 | | 25.2 | | *2017-2019* | Male (15) | 12 |
| **1.17** | Age-Adjusted Hospitalization Rate due to Substance Use | *hospitalizations/ 10,000 population 18+ years* | 8.4 | | 19.2 | | *2017-2019* | | 12 |
| **1.17** | Death Rate due to Drug Poisoning | *deaths/ 100,000 population* | 16.4 | | 20.6 | 21 | *2016-2018* | | 6 |
| **1.08** | Adults who Smoke | *percent* | 8.6 | 12 | | | *2010-2014* | Male (14.3); Female | 9 |
| **1.00** | Age-Adjusted Drug and Opioid-Involved Overdose Death Rate | *Deaths per 100,000 population* | 16.4 | | 20.5 | 20.7 | *2016-2018* | | 3 |
| **1.00** | Age-Adjusted ER Rate due to Substance Use | *ER visits/ 10,000 population 18+ years* | 20.3 | | 52.9 | | *2017-2019* | Male (29.3) | 12 |
| **1.00** | Teens who Smoke | *percent* | 1.8 | | 5 | | *2018* | | 2 |
| **1.00** | Teens who Use Marijuana | *percent* | 9.4 | | 26 | | *2018* | | 2 |
| **0.92** | Liquor Store Density | *stores/ 100,000 population* | 9.4 | | 10.8 | 10.6 | *2018* | | 21 |
| **0.89** | Alcohol-Impaired Driving Deaths | *percent* | 27.5 | | 32 | 28 | *2014-2018* | | 6 |
| | | | | | | | | | |
| **SCORE** | **TEEN & ADOLESCENT HEALTH** | **UNITS** | **KENDALL COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **1.67** | Age-Adjusted Hospitalization Rate due to Adolescent Suicide and Intentional Self-inflicted Injury | *hospitalizations/ 10,000 population aged 10-17* | 116.2 | | 106 | | *2017-2019* | Female (170.4) | 12 |
| **1.28** | Teens who Use Alcohol | *percent* | 36 | | 40 | | *2018* | | 2 |
| **1.17** | Age-Adjusted ER Rate due to Adolescent Suicide and Intentional Self-inflicted Injury | *ER visits/ 10,000 population aged 10-17* | 105.9 | | 114.5 | | *2017-2019* | Female (154.1) | 12 |
| **1.00** | Teens who Smoke | *percent* | 1.8 | | 5 | | *2018* | | 2 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.00** | Teens who Use Marijuana | *percent* | 9.4 | | 26 | | *2018* | | 2 |
| **0.64** | Teen Births | *percent* | 0.5 | | 1.1 | 2.8 | *2018* | | 11 |
| | | | | | | | | | |
| **SCORE** | **TRANSPORTATION** | **UNITS** | **KENDALL COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **2.61** | Mean Travel Time to Work | *minutes* | 33.7 | | 29 | 26.6 | *2014-2018* | | 1 |
| **2.61** | Solo Drivers with a Long Commute | *percent* | 51.2 | | 41.3 | 36 | *2014-2018* | | 6 |
| **1.89** | Workers who Drive Alone to Work | *percent* | 83.8 | | 73.1 | 76.4 | *2014-2018* | | 1 |
| **1.56** | Workers Commuting by Public Transportation | *percent* | 2.8 | 5.5 | 9.4 | 5 | *2014-2018* | | 1 |
| **1.00** | Households with No Car and Low Access to a Grocery Store | *percent* | 1 | | | | *2015* | | 22 |
| **0.83** | Households without a Vehicle | *percent* | 2 | | 10.8 | 8.7 | *2014-2018* | | 1 |
| | | | | | | | | | |
| **SCORE** | **WOMEN'S HEALTH** | **UNITS** | **KENDALL COUNTY** | **HP2020** | **Illinois** | **U.S.** | **MEASUREMENT PERIOD** | **HIGH DISPARITY** | **Source** |
| **2.11** | Breast Cancer Incidence Rate | *cases/ 100,000 females* | 136.2 | | 133.1 | 125.9 | *2013-2017* | | 15 |
| **0.58** | Cervical Cancer Incidence Rate | *cases/ 100,000 females* | 4.8 | 7.3 | 7.7 | 7.6 | *2013-2017* | | 15 |
| **0.00** | Age-Adjusted Death Rate due to Breast Cancer | *deaths/ 100,000 females* | 14.8 | 20.7 | 21 | 20.1 | *2013-2017* | | 15 |

| Health and Quality of Life Topics | Score |
|---|---|
| Transportation | 1.75 |
| Other Chronic Diseases | 1.67 |
| Oral Health | 1.53 |
| Cancer | 1.44 |
| Access to Health Services | 1.40 |
| Immunizations & Infectious Diseases | 1.34 |
| Older Adults & Aging | 1.33 |
| Environment | 1.32 |
| Other Conditions | 1.30 |
| Heart Disease & Stroke | 1.26 |
| Respiratory Diseases | 1.25 |
| Children's Health | 1.22 |
| Mental Health & Mental Disorders | 1.22 |
| Exercise, Nutrition, & Weight | 1.20 |
| Substance Abuse | 1.20 |
| Diabetes | 1.18 |
| Maternal, Fetal & Infant Health | 1.13 |
| Teen & Adolescent Health | 1.13 |
| Prevention & Safety | 1.07 |
| Public Safety | 0.99 |
| Women's Health | 0.90 |
| Economy | 0.89 |
| Education | 0.86 |
| Social Environment | 0.78 |

RUSH

Rush Copley Medical Center

# Appendix B: Community Themes and Strengths Assessment Tools

PRIMARY DATA

## Survey Instructions

**Welcome to the Kane Health Counts community health survey. The information collected in this survey will allow community organizations across the county to better understand the health needs in your community. The knowledge gained will be used to implement programs that will benefit everyone in the community. We can better understand community needs by gathering the voices of community members like you to tell us about the issues that you feel are the most important.**

**REMINDER: You must be 18 years old or older to complete this survey. We estimate that it will take 10 minutes to complete. Survey results will be available and shared broadly in the community within the next year. The responses that you provide will remain anonymous and not attributed to you personally in any way. If you have any questions, please contact Stacy Zeng by email at ZengStacy@co.kane.il.us or Louise Lie at LieLouise@co.kane.il.us. Thank you very much for your input and your time!**

**Your participation in this survey is completely voluntary. Please note that by clicking the forward button below you are agreeing to have the following data collected:**

- **Your responses to survey questions and form fields**
- **Your IP address**
- **The date and time when you took the survey or submitted the form**
- **Information about the type of device you are taking the survey from (phone/tablet/desktop/OS and browser version)**

1. In what zip code do you live?

2. Are you of Hispanic or Latino origin or descent?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

3. What race best describes you?

- ◯ American Indian or Alaska Native
- ◯ Asian or Asian American
- ◯ Black or African American
- ◯ Native Hawaiian or other Pacific Islander
- ◯ White or Caucasian
- ◯ More than one race
- ◯ Another race
- ◯ Prefer not to answer

## Health in Your Community

**In this survey, “community” refers to the major areas where you live, shop, play, work, and get services.**

4. How would you rate your community as a healthy place to live? (Select one)

◯ Very Unhealthy ◯ Unhealthy ◯ Somewhat Healthy ◯ Healthy ◯ Very Healthy

5. In the following list, what do you think are the **three** most important “health problems” in your community? (Those problems that have the greatest impact on overall community health.)

- ☐ Auto Immune Diseases (multiple sclerosis, Crohn's disease, etc.)
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease and Stroke
- ☐ Respiratory/Lung Diseases (asthma, COPD, etc.)
- ☐ Chronic Pain
- ☐ Access to Affordable Health Care Services (doctors available nearby, wait times, services available nearby, takes insurance)
- ☐ Quality of Health Care Services Available
- ☐ Mental Health and Mental Disorders (anxiety, depression, suicide)
- ☐ Nutrition, Physical Activity, and Weight
- ☐ Other (please specify)

  _____

- ☐ Oral Health and Access to Dentistry Services (dentists available nearby)
- ☐ Sexual and Reproductive Health (family planning services, sexually transmitted diseases/infections, etc.)
- ☐ Alcohol and Other Substance Use
- ☐ Tobacco Use (including e-cigarettes, chewing tobacco, etc.)
- ☐ Injury and Violence
- ☐ Older Adults and Aging (hearing/vision loss, arthritis, etc.)
- ☐ Maternal and Infant Health
- ☐ Children's Health
- ☐ Teen & Adolescent Health

6. In your opinion, which of the following would you most like to see addressed in your community? (Select Up to 3)

- [ ] Crime and neighborhood safety (robberies, shootings, other violent crimes)
- [ ] Domestic violence prevention (intimate partner, family, or child abuse)
- [ ] Injury prevention and traffic safety (traffic safety, drownings, bicycling and pedestrian accidents)
- [ ] Homelessness and unstable housing
- [ ] Transportation
- [ ] Emergency Preparedness
- [ ] Air and water quality
- [ ] Food insecurity or hunger
- [ ] Healthy food options - restaurants, stores, or markets
- [ ] Parks and walking paths
- [ ] Bike lanes
- [ ] Disbility accessible sidewalks and other structures
- [ ] Economy and job availability
- [ ] Education and schools (Pre-K to 12th grade)
- [ ] Access to higher education (2-year or 4-year degrees)
- [ ] Senior services (over 65)
- [ ] Support for families with children (child care, parenting support)
- [ ] Social isolation
- [ ] Other (please specify)

## Access to Health Services

7. Below are some statements about ***health care services*** in your community. Please rate how much you agree or disagree with each statement.

| | Strongly Agree | Agree | Feel Neutral | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| There are good quality health care services in my community. | ○ | ○ | ○ | ○ | ○ |
| There are affordable health care services in my community. | ○ | ○ | ○ | ○ | ○ |
| I am connected to a primary care doctor or health clinic that I am happy with. | ○ | ○ | ○ | ○ | ○ |
| I can access the health care services that I need within a reasonable time frame and distance from my home or work. | ○ | ○ | ○ | ○ | ○ |
| I know where to find the health care resources or information I need when I need them. | ○ | ○ | ○ | ○ | ○ |

8. How would you rate your own personal health in the past 12 months? (Select one)

- ◯ Very Unhealthy
- ◯ Unhealthy
- ◯ Somewhat Healthy
- ◯ Healthy
- ◯ Very Healthy

9. Do you currently have a health insurance plan/health coverage?

- ◯ Yes
- ◯ No
- ◯ I don't know

10. Which type(s) of health plan(s) do you use to pay for your health care services? (Select all that apply)

- ☐ Medicaid
- ☐ Medicare
- ☐ Insurance through an employer (HMO/PPO) - either my own or partner/spouse/parent
- ☐ Insurance through the Health Insurance Marketplace/Obama Care/Affordable Care Act (ACA)
- ☐ Private Insurance I pay for myself (HMO/PPO)
- ☐ Indian Health Services
- ☐ Veteran's Administration
- ☐ COBRA
- ☐ I pay out of pocket/cash
- ☐ Other (please specify)

* 11. In the past 12 months, was there a time that you needed ***health care services*** but <u>did not</u> get the care that you needed?

- ◯ Yes
- ◯ No - I got the services that I needed
- ◯ Does not apply - I did not need health care services in the past year

12. Select the top reason(s) that you did not receive the ***health care services*** that you needed in the past 12 months. (Select all that apply)

- [ ] Cost- too expensive/can't pay
- [ ] No insurance
- [ ] Lack of transportation
- [ ] Language barrier
- [ ] Hours of operation did not fit my schedule
- [ ] Wait is too long
- [ ] No doctor is nearby
- [ ] Office/service/program closed due to COVID-19
- [ ] Insurance not accepted
- [ ] Cultural/religious reasons
- [ ] Other (please specify)

* 13. In the past 12 months, was there a time that you needed ***dental or oral health services*** but did not get the care that you needed?

- ( ) Yes
- ( ) No - I got the services that I needed
- ( ) Does not apply - I did not need dental/oral health services in the past year

14. Select the top reason(s) that you did not receive the ***dental or oral health services*** that you needed in the past 12 months. (Select all that apply)

- [ ] Cost- too expensive/can't pay
- [ ] No insurance
- [ ] Lack of transportation
- [ ] Language barrier
- [ ] Hours of operation did not fit my schedule
- [ ] Wait is too long
- [ ] No doctor is nearby
- [ ] Office/service/program closed due to COVID-19
- [ ] Insurance not accepted
- [ ] Cultural/religious reasons
- [ ] Other (please specify)

* 15. In the past 12 months, was there a time that you needed or considered seeking ***mental health services or alcohol/substance abuse treatment*** but did not get services?

- ◯ Yes
- ◯ No - I got the services that I needed
- ◯ Does not apply - I did not need services in the past year

16. Select the top reason(s) that you did not receive ***mental health services or alcohol/substance use treatment***. (Select all that apply)

- ☐ Cost- too expensive/can't pay
- ☐ No insurance
- ☐ Lack of transportation
- ☐ Hours of operation did not fit my schedule
- ☐ Other (please specify)
- ☐ Language barrier
- ☐ Wait is too long
- ☐ No doctor is nearby
- ☐ Office/service/program closed due to COVID-19
- ☐ Insurance not accepted
- ☐ I did not know how treatment would work
- ☐ I worried that others would judge me
- ☐ Cultural/religious reasons

* 17. In the past 12 months, did you go to a hospital Emergency Department (ED)?

- ◯ Yes
- ◯ No – I have not gone to the hospital ED

18. Please select the number of times you have gone to the ED in the past 12 months.

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6 or more

19. What were the main reasons that you went to the ED instead of a doctor's office or clinic? (Select any that apply)

- [ ] After clinic hours/weekend
- [ ] Emergency/Life-threatening situation
- [ ] I don't have a regular doctor/clinic
- [ ] Long wait for an appointment with my regular doctor
- [ ] I do not have health insurance
- [ ] Needed food, shelter, or other resources
- [ ] Concerns about cost or co-pays
- [ ] Other (please specify)

* 20. How many children (under age 18) currently live in your home? (Select one)

- ( ) None
- ( ) 1
- ( ) 2
- ( ) 3
- ( ) 4
- ( ) 5
- ( ) 6 or more

## Children's Health

**The following questions refer to children under 18 that live in your home.**

21. Which type(s) of health plans(s) do children in your home have to cover the costs of health care services? (Select all that apply)

- [ ] Medicaid/Children's Health Insurance Program (CHIP)
- [ ] Medicare
- [ ] Insurance through an employer (HMO/PPO) - either my own or partner/spouse
- [ ] Insurance through the Health Insurance Marketplace/Obama Care/Affordable Care Act (ACA)
- [ ] Private Insurance I pay for myself (HMO/PPO)
- [ ] Other (please specify)
- [ ] Indian Health Services
- [ ] Veteran's Administration
- [ ] COBRA
- [ ] None - I pay out of pocket/cash

22. Have the children (under 18) in your home experienced any of the following health issues? (Select all that apply)

- [ ] No, the child/children have not faced any health issues
- [ ] Childhood disabilities/special needs
- [ ] Allergies
- [ ] Asthma
- [ ] Autoimmune diseases
- [ ] Injuries or accidents that required immediate medical care (ex. sports injuries, bicycle accidents)
- [ ] Behavior Challenges/Mental Health
- [ ] Heart Disease or other heart conditions
- [ ] Cancer
- [ ] Child/children overweight
- [ ] Child/children underweight
- [ ] Other (please specify)

- [ ] Birth-related (ex. low birth weight, premature, prenatal)
- [ ] Child abuse/child neglect
- [ ] Diabetes/Pre-diabetes/High blood sugar
- [ ] Hearing and /or vision
- [ ] Nervous system disorders
- [ ] Stroke
- [ ] Drug or alcohol use
- [ ] Using tobacco, e-cigarettes, or vaping
- [ ] Teen pregnancy
- [ ] Sexually Transmitted Disease

* 23. In the past 12 months, was there a time when children in your home needed ***medical care or other health related services*** but did not get the services that they needed?

- ( ) Yes
- ( ) No - they got the services that they needed
- ( ) Does not apply - the child/children did not need services

## Children's Health

24. Which of the following services were the children in your home not able to get in the past 12 months when they needed them? (Select all that apply)

- [ ] Well child visit/check-up
- [ ] Scheduled vaccination(s)
- [ ] Prescription medications
- [ ] Sick visit/urgent care visit
- [ ] Emergency care services
- [ ] Routine care/treatment for ongoing or chronic condition – ex. allergies, respiratory conditions, diabetes
- [ ] Nutrition services
- [ ] Dental care (routine cleaning or urgent care)
- [ ] Mental health services
- [ ] Alcohol or other substance abuse treatment
- [ ] Services for Special Needs
- [ ] Other (please specify)

25. Select the top reason(s) that children in your home did not get the medical/health care services that they needed in the past 12 months. (Select all that apply)

- [ ] Cost- too expensive/can't pay
- [ ] No insurance
- [ ] Lack of transportation
- [ ] Not able to take off work for an appointment
- [ ] Language barrier
- [ ] Other (please specify)
- [ ] Wait is too long
- [ ] No doctor is nearby
- [ ] Office/service/program closed due to COVID-19
- [ ] Insurance not accepted
- [ ] Cultural/religious reasons

## Employment and Education

26. Below are some statements about ***employment and education*** in your community. Please rate how much you agree or disagree with each statement.

| | Strongly Agree | Agree | Feel Neutral | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| There are plenty of jobs available for those who are over 18 years old. | ○ | ○ | ○ | ○ | ○ |
| There are plenty of jobs available for those who are 14 to 18 years old. | ○ | ○ | ○ | ○ | ○ |
| There are job trainings or employment resources for those who need them. | ○ | ○ | ○ | ○ | ○ |
| Childcare (daycare/pre-school) resources are affordable and available for those who need them. | ○ | ○ | ○ | ○ | ○ |
| The K-12 schools in my community are well funded and provide good quality education. | ○ | ○ | ○ | ○ | ○ |
| Our local University/Community College provides quality education at an affordable cost. | ○ | ○ | ○ | ○ | ○ |

* 27. Which of the following categories ***best reflects*** your current employment status? (Select one)

- ○ Employed, working full-time
- ○ Employed, working part-time
- ○ Homemaker/Work in the Home
- ○ Not employed, looking for work
- ○ Not employed, NOT looking for work
- ○ Retired
- ○ Student

## Employment and Education

28. What is the main reason(s) you are not working? (Select any that apply)

- [ ] Ill or disabled, not able to work
- [ ] Furloughed or temporarily unemployed
- [ ] Cannot find work
- [ ] Other (please specify)
- [ ] Taking care of family member
- [ ] Need more training

## Housing and Transportation

29. Below are some statements about ***housing and transportation*** in your community. Please rate how much you agree or disagree with each statement.

| | Strongly Agree | Agree | Feel Neutral | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| There are affordable places to live in my community. | ○ | ○ | ○ | ○ | ○ |
| Streets in my community are typically clean and buildings are well maintained. | ○ | ○ | ○ | ○ | ○ |
| I feel safe in my own neighborhood. | ○ | ○ | ○ | ○ | ○ |
| Crime is not a major issue in my neighborhood. | ○ | ○ | ○ | ○ | ○ |
| Public Transportation is easy to get to if I need it. | ○ | ○ | ○ | ○ | ○ |

30. What transportation do you use most often to go places? (Select one)

- ○ I drive my own car
- ○ I walk
- ○ I ride a motorcycle or scooter
- ○ Someone drives me
- ○ I use medical transportation/specialty van transport
- ○ Other (please specify)
- ○ I ride a bicycle
- ○ I take a car ride service (Uber/Lyft)
- ○ I take a bus
- ○ I take a taxi car service
- ○ Hitchhike

31. Which of the following categories **best** reflects your current living situation? (select one)

- ◯ Live alone in a home (house, apartment, condo, trailer, etc.)
- ◯ Live in a home with another person such as a partner, sibling(s), or roommate(s)
- ◯ Live-in single-family home that include a spouse or partner AND a child/children under age 25
- ◯ Live in a multi-generational home (home includes grand-parents or adult children over age 25)
- ◯ Multi-family home (more than one family lives in the home)
- ◯ Live in an assisted living facility (such as a nursing home)
- ◯ Temporarily staying with a relative or friend
- ◯ Staying in a shelter or are homeless (living on the street)
- ◯ Living in a tent, recreational vehicle (RV), or couch-surfing

* 32. Does your current housing situation meet your needs?

◯ Yes ◯ No

## Housing and Transportation

33. What issues do you have with your current housing situation? (Select all that apply)

- ☐ Too small /crowded
- ☐ Problems with other people
- ☐ Unsafe, high-crime
- ☐ Too run down or unhealthy environment (ex. mold, lead)
- ☐ Rent/facility is too expensive
- ☐ Other (please specify)
- ☐ Mortgage is too Expensive
- ☐ Too far from town/services
- ☐ Current housing is temporary, need permanent housing
- ☐ Need supportive and/or assisted living

## Housing and Transportation

34. In the ***past 2 years***, was there a time when you (and your family) were living on the street, in a car, or in a temporary shelter?

- ◯ Yes, ***1 or 2 times*** in the past 2 years
- ◯ Yes, ***3 or more times*** in the past 2 years
- ◯ No

35. In the ***past 12 months***, has the utility company shut off your service for not paying your bills?

◯ Yes ◯ No ◯ Does not apply - I do not pay utility bills

36. Are you worried or concerned that in the ***next 2 months*** you (and your family) may not have stable housing that you own, rent, or stay in as part of a household?

◯ Yes ◯ No

## Access to Healthy Food and Physical Activity Resources

37. Below are some statements about ***access to food and resources*** in your community. Please rate how much you agree or disagree with each statement.

| | Strongly Agree | Agree | Feel Neutral | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| We have good parks and recreational facilities. | ◯ | ◯ | ◯ | ◯ | ◯ |
| There are good sidewalks or trails for walking safely. | ◯ | ◯ | ◯ | ◯ | ◯ |
| It is easy for people to get around regardless of abilities. | ◯ | ◯ | ◯ | ◯ | ◯ |
| The air and water quality are good in my community. | ◯ | ◯ | ◯ | ◯ | ◯ |
| Affordable healthy food options are easy to purchase at nearby grocery stores or farmer’s markets. | ◯ | ◯ | ◯ | ◯ | ◯ |
| In my neighborhood it is easy to grow/harvest and eat fresh food from a home garden. | ◯ | ◯ | ◯ | ◯ | ◯ |
| Local restaurants serve healthy food options. | ◯ | ◯ | ◯ | ◯ | ◯ |

38. In the ***past 12 months***, did you worry about whether your food would run out before you got money to buy more?

◯ Often ◯ Sometimes ◯ Never

39. In the ***past 12 months***, was there a time when the food that you bought just did not last, and you did not have money to get more?

◯ Often ◯ Sometimes ◯ Never

40. In the ***past 12 months***, did you or someone living in your home receive emergency food from a church, a food pantry, or a food bank, or eat in a soup kitchen?

◯ Often ◯ Sometimes ◯ Never

## Corona Virus (COVID-19)

**During this time, we understand that COVID-19 has impacted everyone's lives, directly and indirectly. We would like to know how these recent events have impacted you and your household to better understand how our community has been affected overall.**

**REMINDER: This is an anonymous survey. If you or anyone in your household has questions or concerns related to COVID-19, information is available at www.kanehealth.com. If you need assistance finding local resources and support services, please call 211.**

41. We know the COVID-19 pandemic is challenging in many ways. Please select from the following list the issues that are the biggest challenge for your household right now. (select all that apply)

- ☐ Household member(s) have COVID-19 or COVID-like symptoms (fever, shortness of breath, dry cough)
- ☐ Access to basic medical care
- ☐ Access to emergency medical services
- ☐ Access to prescription medications
- ☐ A shortage of food
- ☐ A shortage of healthy food
- ☐ A shortage of sanitation and cleaning supplies (e.g., toilet paper, disinfectants, etc.)
- ☐ Options for child care services/lack of child care support
- ☐ Not being able to exercise
- ☐ Feeling alone/isolated, not being able to socialize with other people
- ☐ Feeling nervous, anxious, or on edge
- ☐ Not knowing when the pandemic will end/not feeling in control
- ☐ Household members not getting along
- ☐ Lack of technology to communicate with people outside of my household (e.g. internet access, computer, tablet, etc.)
- ☐ Lack of skills to use technology to communicate
- ☐ Unsheltered or homeless
- ☐ Lack of access to facilities to maintain hygiene

## Demographics

**Please answer a few final questions about yourself so that we can see how different types of people feel about these local health issues.**

42. What is your age?

- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75 or older
- Prefer not to answer

43. To which gender identity do you most identify?

- Female
- Male
- Other identification (optional)
- Transgender Female
- Transgender Male
- Gender Non-Conforming
- Prefer not to answer

44. What is the highest level of education you have completed?

- Did not attend school
- 1st grade
- 2nd grade
- 3rd grade
- 4th grade
- 5th grade
- 6th grade
- 7th grade
- 8th grade
- 9th grade
- 10th grade
- 11th grade
- Graduated from high school
- 1 year of college
- 2 years of college
- 3 years of college
- Graduated from college
- Some graduate school
- Completed graduate school

45. What is your total household income?

- Less than $20,000
- $20,000 to $34,999
- $35,000 to $49,999
- $50,000 to $74,999
- $75,000 to $99,999
- $100,000 to $149,999
- $150,000 or More
- Prefer not to answer

46. What language do you mainly speak at home?

- ○ American Sign Language (ASL)
- ○ Arabic
- ○ English
- ○ French
- ○ Laotian
- ○ Spanish
- ○ Uzbek
- ○ Vietnamese
- ○ Some other language (please specify)

47. Do you identify with any of the following statements? (Select all that apply)

- ☐ I have a disability
- ☐ I am a Veteran
- ☐ I am part of the LGBTQ+ community
- ☐ I am an immigrant or refugee
- ☐ Prefer not to answer
- ☐ I do not identify with any of these

**INTRODUCTION**

{Introduce Yourself and Others on the Team.}

{"Let's get started…I will read this first part because it is really important to cover all of the topics and I want to make sure not to miss anything."}

**Opening Script:** Thank you for taking the time to speak with us to support the Kane Health Counts Community Health Assessment. We anticipate that this discussion will last no more than 45 minutes. You have been invited to take part in this focus group because of your experience living or working in Kane County. The focus of our Community Health Assessment is how to improve health in the community and understand what challenges people living within Kane County area facing in regards to their health. We are going to ask a series of questions related to health issues in the community specifically focused on children and adolescent health. We hope to get through as many questions as possible and hear each of your perspectives as much as time allows.

For this discussion group, I will invite you to share as much or little as you feel comfortable sharing with the others in the group. The results of this assessment will be made available to the public. We will be taking notes on your responses, but your names will not be associated with any direct quotes. Your identity will be kept confidential, so please share your honest opinions.

We do have a few ground rules for this virtual discussion that I would like to review with you. It is important that everyone has a chance to be heard, so we ask that only one person talks at a time (most important ground rule for today). You may also mute yourself when you are not speaking to cut down on background noise. Finally, please respect the opinions of others, as the point of the discuss is to collect various points of view. And remember, there are no right or wrong answers, so please share freely and openly.

Does anyone have any questions before we get started?

Okay, let's get started by going around and introducing ourselves. Please tell everyone your first name, what community you live in, and if you are interested in sharing, your involvement in the community (could be your job or work for example).

{Introductions}

Thank you for introducing yourselves. Now we will get started with our discussion.

**COVID-19 QUESTION**

1. **We know that COVID-19 has significantly impacted everyone's lives. What have you seen as the biggest challenges in Kane County during this time?**
   [Probe 1: Which groups of people are having the hardest time right now?]
   [Probe 2: How have you seen these challenges being addressed, if at all?]

**GENERAL HEALTH QUESTIONS**

{For the next set of questions, I would like for you to think about the health of the community in Kane County before Covid-19}

2. **What is the most critical health related problem that residents are facing in your community that you would change or improve?**
   [*Probe 1: Why do you think this is the most critical health issue? What do you think is the cause if this problem in your community?]*
   [*Probe 1: What would you do to address this problem? What is needed to address this problem?]*

3. **Are there groups in your community that are facing particular health issues or challenges? Which groups are these?**
   [*Probe: Are these health challenges different if the person is a particular age, or gender, race or ethnicity? Or lives in a certain part of the county for example?*

4. **From the health issues and challenges we've just discussed, which do you think are the hardest to overcome?**
   *[Probe: Are some of these issues more urgent or important than others? If so, why?]*

5. **What do you think causes residents to be healthy or unhealthy in your community?**
   [*Probe 1: What types of things influence their health, to make it better or worse?]*
   [*Probe 2: What might prevent someone from accessing care for these health challenges? Examples could include lack of transportation, lack of health insurance coverage, doctor's office hours, language or cultural barriers, etc.]*

6. **What resources are available for residents in your community?**
   *[Probe 1: Are there specific community organizations or agencies that you see taking a strong leadership role for improving the health of particular groups in your community?]*
   [*Probe 2: Do you see residents taking advantage of them? Why or why not?]*
   [*Probe 3: What additional programs and resources do you think are needed to best meet the needs of residents in Kane County?]*

**CLOSING QUESTION**

{I have one more question as we close out our discussion today.}

7. **Can you think of any other ways we could improve the health of residents in the community that we have not already talked about today?**
   *[Probe: Is there anything else you would like to add that we haven't discussed?]*

**CONCLUSION**

{Review the summary points and key takeaways from discussion}

{Check if note taker needs any clarification}

***CLOSURE SCRIPT***: Thank you very much for your time and willingness to share your experiences with us today. We will include your comments in our data to describe how health can be improved for residents

in your community. Please remember, your name will not be connected to any of the comments you made today. Please let us know if you have any questions or concerns about this.

I also wanted to let you know that we are currently conducting an online Kane Health Counts Community Health Survey that is a part of the Community Health Needs Assessment process. If you would be interested in participating in the survey or willing to help share the link with your organization, community partners, friends, or family who live, work, or play in Kane County, it would be greatly appreciated. We will send you a follow-up email thanking you for your participation today and will include more information about the community survey with a link.

# Kane Health Counts
# Kane County: Focus Group Analysis Results

Kane Health Counts conducted focus groups to gain deeper insights about perceptions, attitudes, experiences, or beliefs held by community members about their health. The data collected through the focus group process provides adjunct information to the quantitative data collection methods in a mixed methods approach. While the data collected is useful in gaining insight into a topic that may be more difficult to gather through other data collection methods, it is important to note that the information collected in an individual focus group is not necessarily representative of other groups.

The project team developed a focus group guide made up of a series of questions and prompts about the health and well-being of residents in Kane County. Community members were asked to speak to barriers and assets to their health and access to healthcare. Virtual focus groups were hosted across Kane County during October and November 2020. They lasted approximately 60 minutes and were conducted via video conference with a phone only option for those with limited or no access to a reliable device or internet. Trained facilitators implemented techniques to ensure that everyone was able to participates in the discussion. Some focus groups were specifically hosted in Spanish for the Hispanic/Latino community in Kane County. These focus groups were facilitated by bilingual facilitators leveraging the same tool implemented in English only focus groups.

Participants were recruited for the focus group sessions through the Kane Health Counts network of community partner organizations. Specific efforts were made to recruit participants from the African American, Hispanic/Latino, and Senior segments of the Kane County population. Ten focus group sessions were organized between October and November 2020 and although registration was initially strong, sessions had varying levels of attendance. COVID-19 likely had an impact on resident's participation in the focus group sessions. Table 1 provides an overview of the individual sessions as well as number of participants for each of the focus groups.

**TABLE 1: KANE COUNTY FOCUS GROUP DISCUSSIONS**

| Focus Group Discussion | Number of Sessions | Facilitation Language | Total Community Participants |
|---|---|---|---|
| African American Health | 2 | English | 14 |
| Older Adult/Senior Health | 3 | English | 33 |
| Hispanic/Latino Health | 1 | Spanish | 12 |

* *10 Focus Groups were held, 6 sessions had attendees present*

The project team captured detailed transcripts of the focus group sessions. The text from these transcripts were analyzed using the qualitative analysis program Dedoose®[1]. Text was coded using a pre-designed

[1] Dedoose Version 8.0.35, web application for managing, analyzing and presenting qualitative and mixed method research data (2018). Los Angeles, CA: SocioCultural Research Consultants, LLC www.dedoose.com

codebook, organized by themes, and analyzed for significant observations. The findings from the qualitative analysis were combined with the findings from other data sources and incorporated into the Data Synthesis, Prioritized Health Needs, and COVID-19 sections of this report.

## Themes Across All Focus Groups

Table 2 below summarizes the main themes and topics that trended across all or almost all focus group conversations.

**TABLE 2. KANE COUNTY FOCUS GROUP THEME SUMMARY**

| Main Theme | Sub-topics: Concerns, issues, and barriers | Contributing Focus Group(s) |
|---|---|---|
| Exercise, Nutrition and Weight | • Need for improved/additional education for parents/families<br>• Children's sedentary lifestyles and nutrition in schools<br>• Health behavior and social environment influence on eating habits; cultural influences | African American and Hispanic/Latino Focus Groups |
| Access to Healthcare Services | • Language barriers<br>• Underinsured and affordability (costs associated with services)<br>• Preventative care for older adults; how to avoid emergent situations by intervening earlier (includes access to medications)<br>• Navigation and education for minority racial or ethnic groups<br>  ○ Lack of focus on men's health in the African American community | All Focus Groups |
| Substance Abuse | • Focus on COVID-19 has diverted attention from drug use issues in the community (ex. heroin/opioid problem)<br>• Teen and adolescent use of substances; social pressure, connection to bullying and self-esteem | Older Adults and Hispanic/Latino Focus Groups |
| Mental Health | • Increased anxiety and Stress for parents/families with children<br>• Need for mental health for older adults; impacts of social isolation due to aging issues<br>• Lack of resources in the community; lack of availability and navigation/education about services available | All Focus Groups |

## Summary of African American Sessions

The majority of participants in these sessions resided in the Aurora, Illinois area.

**COVID-19 Impact**: Participants were interested in gaining more information about the local impact of COVID-19. They noted that they felt that they were more informed about what is happening in larger metropolitan areas across the US than what was happening locally in their community. One of the top concerns raised by participants was the potential for increases in mental health issues in the community due to the preventative restrictions in place to contain the spread of COVID-19. The primary causes for this increased concern for mental health participants raised were:

- Social isolation - limiting and reducing social interactions
- Feeling nervous and lots of unknowns about COVID-19
- Job loss and worry about the local economic impact

Inequities in access to testing for minority community members was also raised by participants as a top priority issue:

> *"For example, if you go and get testing for free you get results in 3-5 days, if you go and pay for tests with Cadillac health insurance at your doctor's office, you get the results much quicker. Another example, if I am working and I am the primary bread winner in my home, if I get a positive test result what do I do, when I find out that I am positive what do I do. If there is no support after testing what do I do. The majority of people that are testing positive are minorities and there is nothing that is put in place. If we really care about everyone being safe, then we need to make the adequate accommodations."*

Participants also were concerned that with the prioritization of COVID-19 and that there could be a negative impact on other chronic conditions and access to health and social services. Contributing to the concerns about social isolation and access to services were the many programs, events, and services that had been cancelled due to the preventative COVID-19 measures such as the fresh fruit/produce truck stopped serving the community over the summer, multiple health fairs were cancelled, charity walk/runs were cancelled, homeless intake paused at times, a church mental health initiative was paused indefinitely, and all in-person church meetings/activities were stopped.

> *"What happens if you need food and you don't have a car? How do you stand in line at the food pantry? Even though there is a lot of effort put in, more can be done especially at the organization level."*

> *"This year, members of the Fox Valley Faith and Health Network, and the African American community in general, were unable to participate in the Gospel Run scheduled to be held around the lakefront in Chicago. Instead, a number of us participated in the virtual walk. Secondly, we collaborate with the American Cancer Association to raise breast cancer awareness and to raise funds for the association. This year, we didn't have our usual walk event; however, we continue to strive to raise funds for the association. Last, but not least, we were unable to hold our annual health fair."*

A few participants noted that they had recently started to notice fatigue in the community with COVID-19 restrictions and worried that people may not be taking preventative measures as seriously as they had earlier in the pandemic (ex. mask-wearing). Multiple participants with children shared their

concerns about not knowing how this would impact children long-term. They shared the challenges they were having with keeping the children engaged and active, while also balancing their own time with other obligations (ex. work, home, etc.). An unexpected positive impact of COVID-19 participants noted was an increased interest in exercise and staying active since the COVID-19 restrictions were put in place.

> *"There is an increased interest in exercise. I have found myself riding bikes, playing sports, and hopscotch with the kids so that the kids get their required 30-45 minutes a day."*

*Additional health concerns in the community:*

**Nutrition – Health Behaviors and Social Environment:** Participants discussed the connection in their community between healthy eating and the importance of the social environment and modeling healthy behaviors. Inequities in access to healthy food options was also brought up as a barrier to healthy eating in the African American Community. Participants felt that while there are programs or services to increase healthy eating and access to healthy foods, there may be stigma in the community preventing those who may need them from utilizing those programs and services.

> *"Culture and tradition drive a lot of what we have been eating. People are turning to vegan diets, trying to be more intentional about their food choices. What we are hearing about how we look at food and deciding that I am not going to do that anymore. The culture changes because we are changing the culture one person at a time. I have had to change and be more intentional about my choices not just for me but for my children and grandchildren and setting an example."*

> *"It is about 'mindset', sometimes I know I can do better but I don't always. There is an inequality of having healthy choices, but we also need to be showing examples of healthy eating consistently. We need to change our conditioning."*

> "Programs through the state are trying to address nutrition through food programs, but some people have too much pride to use those services."

Access to Services – Minority race/ethnicity: A portion of the discussion focused on access to services for minority groups in the community. One participant raised the issue that policies that have an impact on health and well-being often times are designed for those who have access to certain resources.

> *"There are continued disparities as it relates to testing and access to care for minorities...We continue to see minorities as an afterthought, we put policies and procedures in place that work for the [well off] families with a house/fence. Most people especially in Aurora do not live that way."*

**Men's Health:** Another important topic of discussion was Men's Health in the African American community. Men's Health was raised in the context of preventative health services and chronic diseases. Participants agreed that diabetes, cancer, and heart disease were major issues in the community and that more could be done to outreach to men to encourage wellness check-ups and seek preventative health services (ex. cancer screenings).

> *"There is a heavy focus on women's health issues. We do a lot for women but neglect the men in the community. We need to make sure that they get their checkups. There needs to be just as much emphasis on the men as we put on women's health issues."*

## Summary of Older Adults/Senior Sessions

The majority of participants in these sessions resided in the Elgin and Aurora, Illinois area.

**COVID19 Impact:**

- Quality of Life – Social Environment

  *"Able to be being around people, that's the only thing we want. Everything is isolated. Even in the senior building their community is closed. They can't even go there. The zoom is not doing a lot and that's what we want, to get back there and meet."*

  *"I have concern right now is that my nephew son passed away yesterday because of Covid-19. I want to go to his funeral, but I am afraid to go because specially he is died of covid-19. Also, I don't know whether my nephew also has it. What did you do when members of your families die of that disease and you want to go the funeral, but you are afraid because you don't want to hug them?"*

  *"I think isolation has been taking longer than expected. It's taken the toll on us one way or the other. No matter how busy you try to stay busy or positive, it's just been dragging on for too long. And now it's like if it's ever going to end. We reached to end on how to combat it. These last few days weather is being so really really nice. It's been exceptionally nice, and we have enjoyed it by sitting outside and just passes the time outside and it's not going to last. As winters comes on it's going to be hard on all of us and it's really challenging right now to get ourselves to keep going. I try to keep busy day in and day out but sometimes it's just not working."*

    - Mental Health

  *"I wanted to say for sometimes because we are keeping quarantine is not something we used to. I don't drive. It picks my depression up."*

    - Transportation
- Health Behaviors – Fear/Stigma, knowledge/navigation
- Access to Healthcare Services

*Additional health concerns in the community:*

- Substance Abuse (not an older adults issue):

  *"The community was talking about heroin, since covid we haven't heard a word about heroin. We were having a dangerous mix of drugs that was killing our young people. The community was talking about mental health issues, the craziness of this disease has changed the communication. Now all we hear about is covid."*

- Access to Health Services - Health Care Costs including medications and preventative care:

  *"Ability to have regular check-ups, seniors tend not to do that, they wait until somethings really wrong with them before they go. Also concerned about medications because they are frugal beyond belief, they will cut the medicine in half and there is a lot of self-*

*medicating going on. This was an issue before Covid. Patients stop taking medication due to cost."*

*"Our business is helping people with dementia, how do you pay for the care you need when you have dementia? Are people better off in their homes or in communities where you have nurses? I don't know if because of covid and with so many people working from home, it could be that people are being taken care of by their household in 2-3 generation homes. I just got two emergency calls for two people who want to move in today. One family said their loved one, for the last 4 months, has lived with them and now they can't do it anymore. This would've been someone who would have moved their mom into a nursing home before covid but now we only hear about the crisis part because they are waiting and keeping them home until there's a crisis."*

- Mental Health (age related due to isolation):

  *"Mental health issues which go hand and hand with isolation. It's hard for seniors to get in and get help, there is usually a waiting list to get into these programs."*

  *"Would like to see more mental health services and intergenerational activities so that younger people can learn from the seniors because they have a lot of information. These are hard to arrange given conflicting schedules, but it brings a sense of life and adventure to see the kids and it's important for the kids to learn the living history that the seniors represent."*

- Older Adults as a Vulnerable Population:

  *"Depends on their race, a lot of systemic inequality that goes on. Certain populations are better served than others, so this makes a difference in terms of what you have access to. It's also important for a community to value their community members, seniors are often the least valued piece now. They are all focused on kids and their futures but not about the seniors who built the community. Seniors are not treated well in the community, are not valued, and the Covid pandemic has shown that."*

## Summary of Spanish Language Session

**COVID19 Impact:**

- Social Environment and Isolation for Children
- Support for parents/people with children – school/education

*Additional health concerns in the community:*

- Exercise, Nutrition, and Weight; adults and children:

  *"Lack of educating parents that it [technology] is not the first option that one has to use to entertain children. We must eliminate a sedentary lifestyle and be more active because that is why there is a lot of childhood diabetes, obesity and bullying for being chubby."*

  *"There is not much information about children's parts. Money is invested in other things not so important, but not so much for the feeding of children or in programs that educate*

*parents on how to improve nutrition, emotional education and in what way we can help our children to improve their self-esteem."*

- Substance Abuse; specifically, teen and adolescent use:

  *"Bullying in schools, the sense of belonging of young people. Everyone tries to be like the rest of the other young people and this brings drug addiction problems, alcoholism and many problems for the youth."*

- Access to Healthcare Services – language barriers and costs:

  *"Limited by language, they don't go because they don't know English. Information needs to be provided in both languages. Nepalese staff are added to the community and their barrier is language, Syrian children. There are a variety of races and they will not seek help because they are uncomfortable with the language. They also do not go for little flexibility in the schedule."*

  *"Lack of health insurance, it is very expensive. There are not many clinics where they charge less or there is more help for the community."*

- Mental Health – stress and anxiety:

  *"The cases of people suffering from anxiety have increased, it is important to pay attention to mental health. With problems like education, lack of parental care, financial problems and now with the pandemic, people are suffering from more stress and mental problems like anxiety, depression."*

  *"If there was more support for us mothers, such as some kind of therapy that encourages us, give us help in many ways."*

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# Appendix C: Community Resources

## Kane County Community Resources

Increased collaboration and broader county-wide collaboration during the 2021 CHA/CHNA process established stronger relationships across Kane County. There are existing resources that organizations are currently using and available widely in the community:

### State and Local Sources

Fox Valley United Way
https://www.foxvalleyunitedway.org/

Illinois Department of Public Health
https://www.dph.illinois.gov/

Kane County 211
https://www.navigateresources.net/path/

Kane County Health Department
https://kanehealth.com/

Kane County Government
https://www.countyofkane.org/

Kane Health Counts
http://www.kanehealthcounts.org/

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# Appendix D: Potential Community Partners

## Potential Community Partners

The following list highlights potential community partners who were identified during the collaborative Kane Health Counts CHA/CHNA.

- African American Cultural Board
- African American Sororities and Fraternities "The Divine Nine"
- AgeGuide Northeastern IL
- American Cancer Society
- Association for Individual Development
- Aunt Martha's Health & Wellness
- Aurora Food Pantry
- Blue Cross and Blue Shield of Illinois
- BPS District 101
- Bridging The Gap of Aurora, Inc.
- City of Aurora, IL
- Community Advocacy Awareness Network
- Community Foundation of the Fox River Valley
- District 129
- Ecker Center for Behavioral Health
- Fox Valley Community Services
- Fox Valley Montessori School
- Fox Valley United Way - SPARK Early Childhood Collaboration
- Gail Borden Public Library
- Grand Victoria Foundation
- Hesed House
- Kane County 211
- Kane County Development and Community Services Department
- Kane County Juvenile Justice Council
- Kane County Regional Office of Education
- Kids Above All
- Leaders In Transformational Education
- Main Baptist Church
- Mutual Ground
- NAMI-KDK
- Rudnicki Consulting Services
- Save One Life Foundation
- School District U-46
- Senior Services Associates
- Streamwood Behavioral Health Center
- Sugar Grove United Methodist Church
- The Church of Jesus Christ of Latter-day Saints
- Tri City Health Partnership
- TriCity Family Services
- Two Rivers Head Start Agency
- VNA Health Care
- Waubonsee Community College
- World Relief Chicagoland
- Xilin Association

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# Appendix E: Local Public Health System Assessment & Forces of Change Assessment Reports

KANE COUNTY HEALTH DEPARTMENT

KANE Health Counts
UNITY FOR A HEALTHY COMMUNITY

*Kane County*

# Local Public Health System Assessment 2020

Prepared by Conduent
Healthy Communities Institute

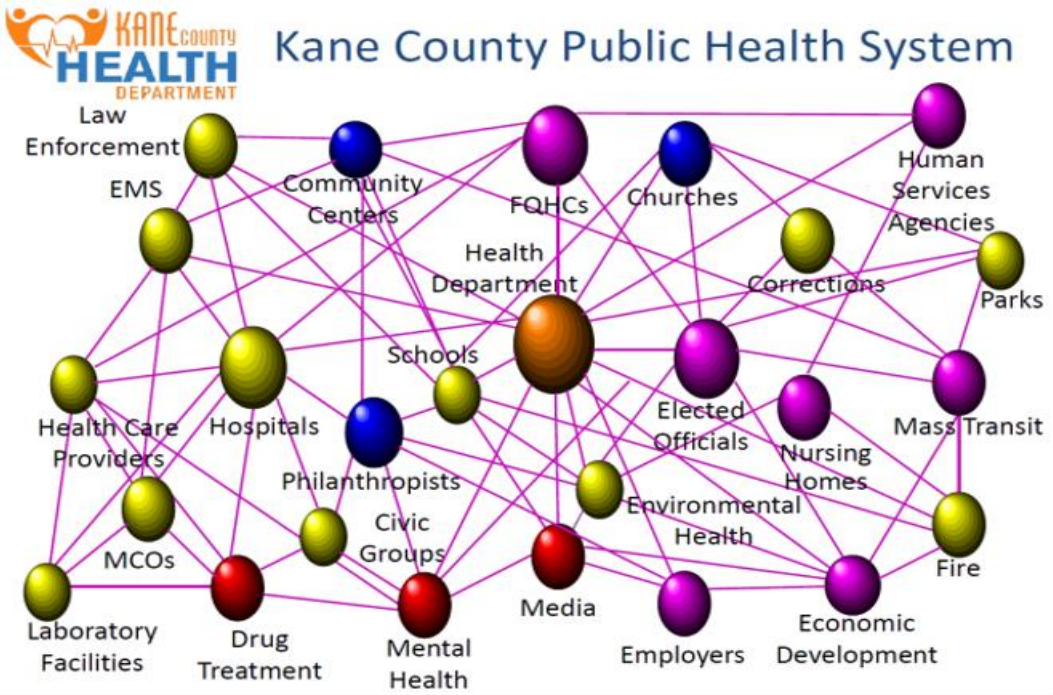
CONDUENT

# Kane County Local Public Health System Assessment 2020

## Background

In September and October 2020, Kane County Public Health Department and its Kane Health Counts partners engaged in an assessment of the health of Kane County utilizing the Mobilizing Action for Planning and Partnerships (MAPP) collaborative process. The MAPP model for community health assessment and planning includes four different assessments that provide a comprehensive picture of health in an area.

To complete the Local Public Health System Assessment (LPHSA) of MAPP, Kane utilized the National Public Health Performance Standards (NPHPS) Local Public Health System Performance Assessment Instrument Version 3. The LPHSA helps to describe how well the public health system works together to deliver the 10 Essential Public Health Services (Essential Services) and opportunities for improvement. These Essential Services are utilized in the field to describe the scope of public health and listed in the "Assessment Framework" section of this report.




## Assessment Framework

The LPHSA measures the collective efforts of the public health system. The instrument is framed around the 10 Essential Public Health Services framework, which was developed in 1994 by a federal working group and serves as the description of activities that public health systems should undertake in all communities. These include:

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, Educate and empower people about health issues

4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable
8. Assure a competent public health and personal healthcare workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

In mid-September 2020, after Kane County had launched its LPHSA process, updates to the 10 Essential Public Health Services were announced through the "The Futures Initiative." This resulted in a revised version of the 10 Essential Public Health Services that centers on equity and incorporates concepts relevant to current and future public health practice.

In response to these updates, the LPHSA discussions held as part of the assessment process, included additional questions to draw attention to the focus of health equity in current and future public health practice.

## Assessment Approach

Kane County commissioned Conduent Healthy Communities Institute (HCI) to assist with this LPHSA and author this report. Conduent Healthy Communities Institute's mission is to improve the health and environmental sustainability of cities, counties and communities through services and technology. HCI support hospitals and health departments in meeting their community health assessment requirements.

To complete this LPHSA, Conduent HCI conducted included four distinct online surveys and facilitated conversations, each focusing on two to three Essential Services.

Kane Health Counts members reached out to colleagues, partners and other community organizations involved in the public health system to encourage them to take the surveys and invited them to participate in the follow up live discussions. Representatives from various sectors of the public health system participated including Kane County Health Department, local hospitals and health systems, mental and behavioral health, education, substance abuse treatment, local government, housing, transportation, local nonprofit and faith-based organizations.

Each discussion included 7-11 stakeholders from various sectors within Kane County's public health system. Conversations were led by a facilitator with support from a content expert and notetaker from Conduent Healthy Communities Institute (HCI).

| Essential Service Topics | Survey Live Dates | Number of Respondents | Discussion Date | Number of Participants |
|---|---|---|---|---|
| **Monitor, Diagnose and Investigate (ES1, ES2)** | 9/14/20 - 9/25/20 | 31 | 10/1/20 | 8 |
| **Inform, Educate and Empower (ES3, ES4, ES7)** | 9/14/20 - 9/25/20 | 28 | 10/6/20 | 10 |
| **Policy, Planning and Regulations (ES 5, ES6)** | 9/14/20 - 9/30/20 | 20 | 10/8/20 | 11 |
| **Workforce, Research and Evaluation (ES8, ES9, ES10)** | 9/14/20 - 9/30/20 | 18 | 10/13/20 | 7 |

The discussions included a brief overview of MAPP and purpose of the LPHSA. Participants were then led through a discussion focused on the Kane County public health system covering the following topics: review of survey results, discussion of current activities, health equity considerations, strengths, weaknesses, and near and long-term improvement opportunities for each Essential Service. Notes were captured live during the online discussions and shown through the "share screen" feature of Microsoft Teams. This process allowed participants to ensure their thoughts were captured accurately and request adjustments to the notes in real time as needed.

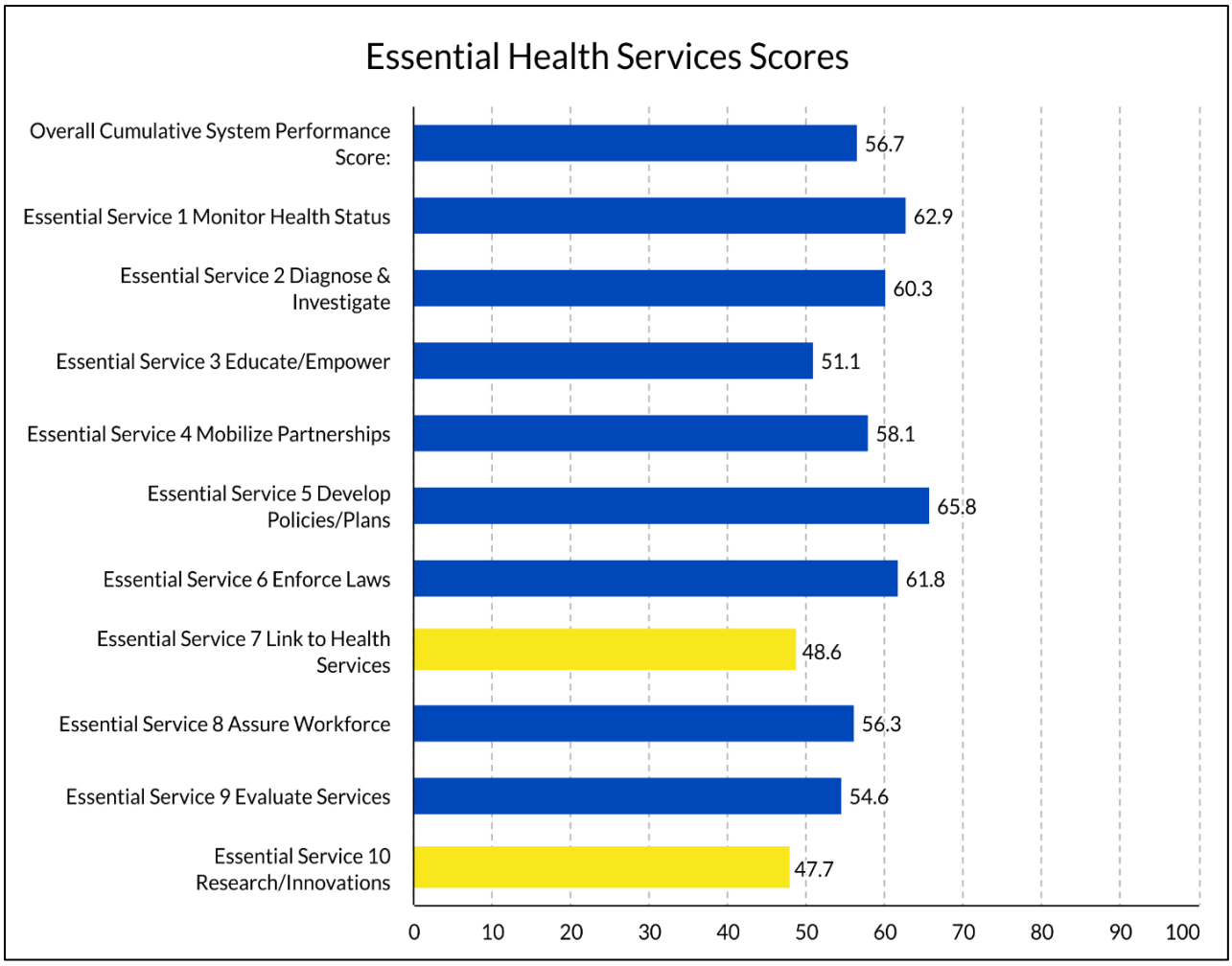
## Survey Scoring

Each Essential Service was scored by participants to assess public health system performance on the components of each service. Respondents were asked to rate "at what level does Kane County's public health system" conduct each Essential Service standard and activities using the following scale:

| | |
|---|---|
| **Optimal Activity (76-100%)** | The public health system is doing absolutely everything possible for this activity and there is no room for improvement. |
| **Significant Activity (51-75%)** | The public health system participates a great deal in this activity and there is opportunity for minor improvement. |
| **Moderate Activity (26-50%)** | The public health system somewhat participates in this activity and there is opportunity for greater improvement. |
| **Minimal Activity (1-25%)** | The public health system provides limited activity and there is opportunity for substantial improvement. |
| **No Activity (0%)** | The public health system does not participate in this activity at all. |

## Essential Health Service Survey Scores and Ranking

Based on survey responses, Essential Services 1, 2, 3, 4, 5, 6, 8, and 9 fell into the "Significant Activity" range for activity. Scores for Essential Services 7 and 10 put those services into the "Moderate Activity" range. The overall score for the system was 56.7, placing it in the "Significant Activity" range.




The following table includes the score for each Essential Service as well as the overall ranking from highest to lowest based on survey results.

| Summary of Scores and Ranking | | | |
|---|---|---|---|
| **ES** | **Essential Public Health Services Description** | **2020 Score** | **Overall Ranking** |
| **1** | Monitor health status to identify community health problems | 62.9 | 2nd |
| **2** | Diagnose and investigate health problems and health hazards in the community | 60.3 | 4th |
| **3** | Inform, educate and empower people about health issues | 51.1 | 8th |

| | | | |
|---|---|---|---|
| **4** | Mobilize community partnerships to identify and solve health problems | 58.1 | 5th |
| **5** | Develop policies and plans that support individual and community health efforts | 65.8 | 1st |
| **6** | Enforce laws and regulations that protect health and ensure safety | 61.8 | 3rd |
| **7** | Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable | 48.6 | 9th |
| **8** | Assure a competent public health and personal healthcare workforce | 56.3 | 6th |
| **9** | Evaluate effectiveness, accessibility, and quality of personal and population-based health service | 54.6 | 7th |
| **10** | Research for new insights and innovative solutions to health problems | 47.7 | 10th |
| **Overall LPHS Performance Score:** | | **57.7** | |

## Essential Service Assessment Results

The following sections offer detail by Essential Service including:

- Essential Service definition and standards
- Survey results describing level of activity
- Summary of current activities and strengths, weaknesses, and opportunities

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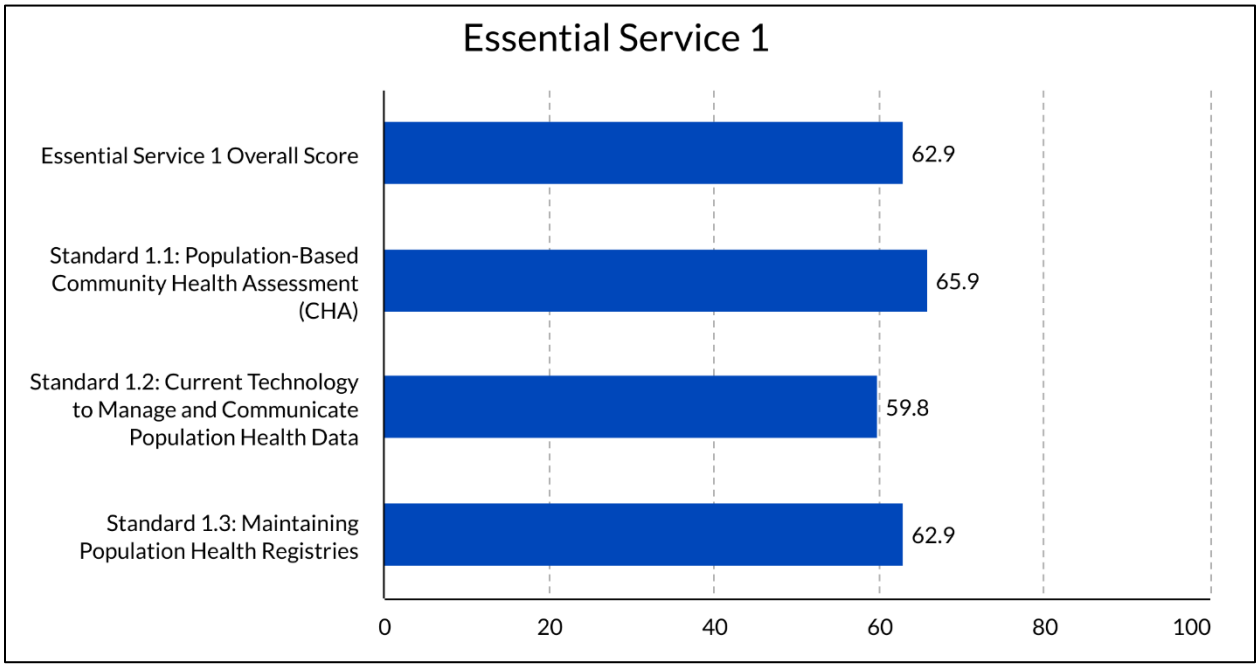
## Essential Service 1: Monitor Health Status to Identify Community Health Problems

Essential Service 1 is composed of the following standards:

- 1.1: Population-Based Community Health Assessment (CHA)
- 1.2: Current Technology to Manage and Communicate Population Health Data
- 1.3: Maintaining Population Health Registries

## Survey Results




The overall score for Essential Service 1 (ES 1) based on responses by 31 survey responses was 62.9 and ranked 2nd highest among scores for the 10 Essential Services. This puts this Essential Service in the "Significant Activity" range indicating that Kane County's public health system "participates a great deal in this activity and there is opportunity for minor improvement." Individual scores for the standards making up ES 1 all scored in the "Significant Activity" range.

## Essential Service 1 Current Activities Summary

To better understand Essential Service 1 performance in Kane County, an online group discussion was held on October 1, 2020. Eight stakeholders participated in the discussion including representation from Kane County Health Department, local hospital systems, and mental health services. Participants reviewed the ES 1 survey results and then engaged in discussions about current activities for the service. Based on these activities, participants then identified what they thought to be strengths, weaknesses, short-term improvement opportunities, and long-term improvement opportunities.

***Note:*** *The information captured in this table is based on what participants are aware of and may not be comprehensive for Kane County.*

**Standard 1.1, Population-Based Community Health Assessment (CHA) (Score: 65.9, Significant Activity).** This standard explores the extent to which the local public health system regularly assesses the health of the community, updates the CHA, and promotes the use of the CHA among community members and partners. Participants shared that over the past 15 years, Kane County has conducted a community health needs assessment that includes focus groups

and community input with Kane Health Department leading efforts. Noted as important in these efforts was the ability to stratify target areas for the county.

**Standard 1.2, Current Technology to Manage and Communicate Population Health Data (Score: 59.8, Significant Activity).** This standard explores the performance of the local public health system in using technology and methods to combine, analyze, and show data for health and public health data. Kane Health Counts (www.kanehealthcounts.com) was identified as a key community resource that includes priority areas, data, and dashboards that track community progress. The platform is leveraged for health centers conducting needs assessments and grant funding. In addition, most hospitals have tracking systems in electronic health records (EHR) that include social determinants of health data. To address the 2020 COVID-19 pandemic, participants noted that Kane County Health Department has tracked and displayed county information about COVID-19 and disproportionately affected communities on a dashboard available on a public website.

**Standard 1.3, Maintaining Population Health Registries (Score: 62.9, Significant Activity).** This standard explores the extent to which data are regularly collected to update population health registries and the extent to which data from these health registries is used to inform the community health assessment and other health analyses. Participants noted that Kane County maintains vital records, reportable diseases, and hospital surveillance through several systems: Influenza Illness Surveillance System, hospital discharge surveillance system, Illinois National Electronic Data Surveillance System for tracking reportable disease, Illinois Vital Records Surveillance System, Cancer Registry, and ESSENCE system for Syndromic Surveillance. Other systems tracking prevention and risk include Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE), Adverse Pregnancy Outcomes Registry System (APORS), and Healthy Homes and Lead Poisoning Surveillance System (HHLPSS). Behavioral health and prevention are tracked through the Red Cap system for collecting information related to mental health concerns and a Narcan distribution database. County metrics for COVID-tracking is conducted through the Illinois Department of Public Health.

| **ES 1: Monitor Health Status to Identify Community Health Problems<br>Current Activities Summary Table** | |
|---|---|
| • Health Department-led CHNA and CHA process<br>• United funding sources to address substance use disorder, mental health and developmental disabilities<br>• COVID-19 tracking – monitoring what's happening in the county, and which populations are disproportionally affected | • Healthy Homes and Lead Poisoning Surveillance System (HHLPSS)<br>• Essence for Syndromic Surveillance<br>• Hospital Discharge Surveillance System<br>• Adverse Pregnancy Outcomes Registry System (APORS)<br>• Community health centers data system<br>• Opioid Taskforce database<br>• Narcan distribution database |

| | |
|---|---|
| • Kane County Influenza Illness Surveillance System<br>• Illinois Vital Records Surveillance System<br>• Cancer Registry | • IDPH county metrics for COVID-19<br>• Red Cap collecting mental health concerns |

### Essential Service 1 Strengths, Weaknesses, and Opportunities

Considering the standards that make up ES 1 and what they know to be currently in place, participants identified strengths, weaknesses and opportunities for Kane County, which are summarized below.

| **Strengths** |
|---|
| • Ability to dissect COVID data and look at how specific groups are being affected<br>• Real-time data available for the county<br>• Strong healthcare system including the health department, hospitals, physicians and Federally Qualified Health Centers<br>• Syndromic surveillance to quickly identify unusual clusters |
| **Weaknesses** |
| • Unable to stratify some data at a granular level (demographic, geographic)<br>• Great resources in the community, but silos exist<br>• Medicare numbers aren't readily accessible |
| **Near-Term Improvement Opportunities** |
| • Put together a children's mental health dashboard (monitor suicide ideation)<br>• Improve the framework to get information out to municipalities<br>• Dig deeper into specific groups within the community to understand health issues/needs<br>• Develop a tracking system for specialty care needs for underserved/uninsured population<br>• Launch chronic disease portal (in development) |
| **Long-Term Improvement Opportunities** |
| • Improve ability to track chronic disease across the community<br>• Engage directly with communities most affected by mental and physical health issues |

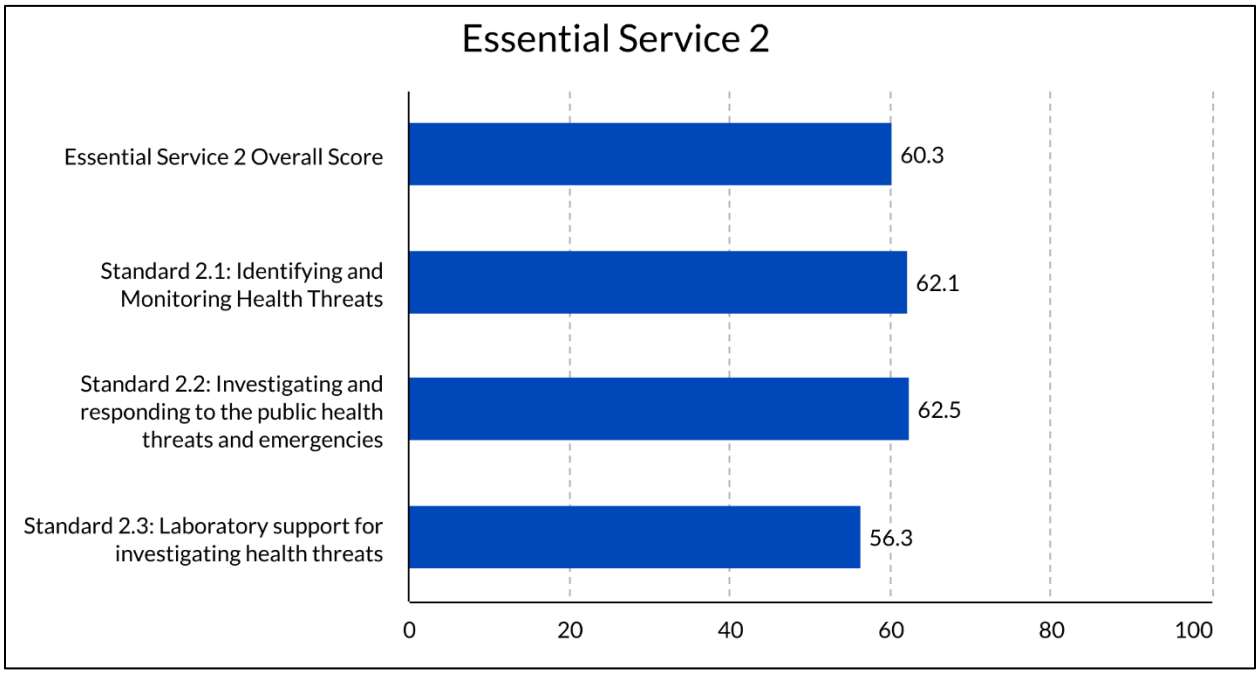
## Essential Services 2: Diagnose and investigate health problems and health hazards in the community

Essential Service 2 is composed of the following standards:

- 2.1: Identifying and Monitoring Health Trends

- 2.2: Investigating and Responding to Public Health Threats and Emergencies
- 2.3: Laboratory Support for Investigating Health Threats

## Survey Results




The overall score for Essential Service 2 (ES 2) based on responses by 31 survey responses was 60.3 and ranked 4th highest among scores for the 10 Essential Services. This puts this Essential Service in the "Significant Activity" range indicating that Kane County's public health system "participates a great deal in this activity and there is opportunity for minor improvement." Individual scores for the standards making up ES 2 all scored in the "Significant Activity" range.

## Essential Service 2 Current Activities Summary

To better understand Essential Service 2 performance in Kane County, an online group discussion was held on October 1, 2020. Eight stakeholders participated in the discussion including representation from Kane County Health Department, local hospital systems, and mental health services. Participants reviewed the ES 2 survey results and then engaged in discussions about current activities for the service. Based on these activities, participants then identified what they thought to be strengths, weaknesses, short-term improvement opportunities, and long-term improvement opportunities.

***Note:*** *The information captured in this table is based on what participants are aware of and may not be comprehensive for Kane County.*

**Standard 2.1, Identifying and Monitoring Health Trends (Score: 62.1, Significant Activity).** This standard explores the performance of the local public health system monitor and identify outbreaks, disasters, emergencies, and other emerging threats to public health. Participants

described a responsive and timely surveillance system with reportable diseases submitted through the Illinois Department of Public Health (IDPH) electronic reporting disease system. With Illinois' National Electronic Disease Surveillance System (I-NEDSS), Kane County can look at data in real time and address clusters. The use of Salesforce for contract tracing was described as a helpful tool. Participants indicated that the health department is effective in testing, monitoring, and containing outbreaks including those around measles, tuberculosis, lead, and legionella. To address the 2020 COVID-19 pandemic, participants expressed that Kane County Health Department has done a good job of working with businesses in addressing local outbreaks.

**Standard 2.2, Investigating and Responding to Public Health Threats and Emergencies (Score: 62.5, Significant Activity).** This standard explores the performance of the local public health system in collecting and analyzing data on public health threats and responding to emergencies. Participants shared that collaboration between hospitals and the health department in identifying potential outbreaks has been efficient and effective. Hospital infection control practitioners alert the health department as they become aware of public health outbreaks or threats. Kane County Health Department was noted as working well with communities to address concerns. Other partners involved in collaborative response efforts include schools, business, federally qualified health centers (FQHCs), private practices, and others. The local emergency response program under the Sheriff's Office includes a designated coordinator at the health department. Participants expressed that communications related to public health threats and emergencies to be helpful and inclusive of key partners. Hospital emergency medical services staff are in contact with the health department and work with municipalities. Examples of successful communication included the ability to receive personal protective equipment (PPE) in a streamlined manner during recent civil unrest and a mass shooting event.

**Standard 2.3, Laboratory Support for Investigating Health Threats (Score: 56.3, Significant Activity).** This standard explores the performance of the local public health system in collecting and analyzing data on public health threats and responding to emergencies. The survey results put laboratory support for investigating health threats in the significant range with a score of 56.3. Participants noted that laboratory services have been constrained by budgets and force local laboratories to be dependent on free laboratory services by the state.

| ES 2: Diagnose and Investigate Health Problems and Health Hazards<br>Current Activities Summary Table | |
|---|---|
| • Health Department providing COVID-19 contract tracing for business – using Salesforce<br>• Testing and monitoring process for disease outbreaks (e.g., Covid-19, measles, TB, Lead) | • Good Health Department and hospital collaboration through infection control practitioners<br>• IDPH electronic reporting disease system<br>• Process in place for submitting reportable disease to the health department |

| | |
|---|---|
| • INEDSS - able to look at data in real time and address any clusters identified | • Emergency response program under the Sheriff's Office |

## Essential Service 2 Strengths, Weaknesses, and Opportunities

Considering the standards that make up ES 2 and what they know to be currently in place, participants identified strengths, weaknesses and opportunities for Kane County, which are summarized below.

| **Strengths** |
|---|
| • Able to build on successful response to previous disease outbreaks for COVID-19<br>• Good collaboration between organizations in the public health system<br>• Active medical reserve corps used for investigating and responding to health issues<br>• Opioid Surveillance System – including law enforcement and other community agencies<br>• County workgroup focused on families for inclusion, diversity & equity<br>• Children's mental health data available through three behavior health providers to get insights about difference diagnoses and identify trends |
| **Weaknesses** |
| • Disconnect between providers and mental health agencies<br>• Rural western part of the community faces access issues<br>• Lack of adequate local laboratory services for COVID-19 testing – dependent on the state to provide free testing<br>• No local health department community health center |
| **Near-Term Improvement Opportunities** |
| • Build trust with immigrant community to reduce fear and improve engagement (challenges came up in COVID-19 response)<br>• Laboratory support: opportunities to partner in order to build capacity and bring more lab services into the community<br>• Utilize emergency response to COVID-19 to learn and improve processes<br>• Proactively prepare for and debrief outbreaks in order to enhance emergency services and response |
| **Long-Term Improvement Opportunities** |
| • Rethink engagement and services during a time where people are more isolated and disconnected from their providers<br>• Better coordination between mental health agencies to enhance access to services during a pandemic or other health emergencies<br>• Focus on response to the homeless/houseless population's health needs |

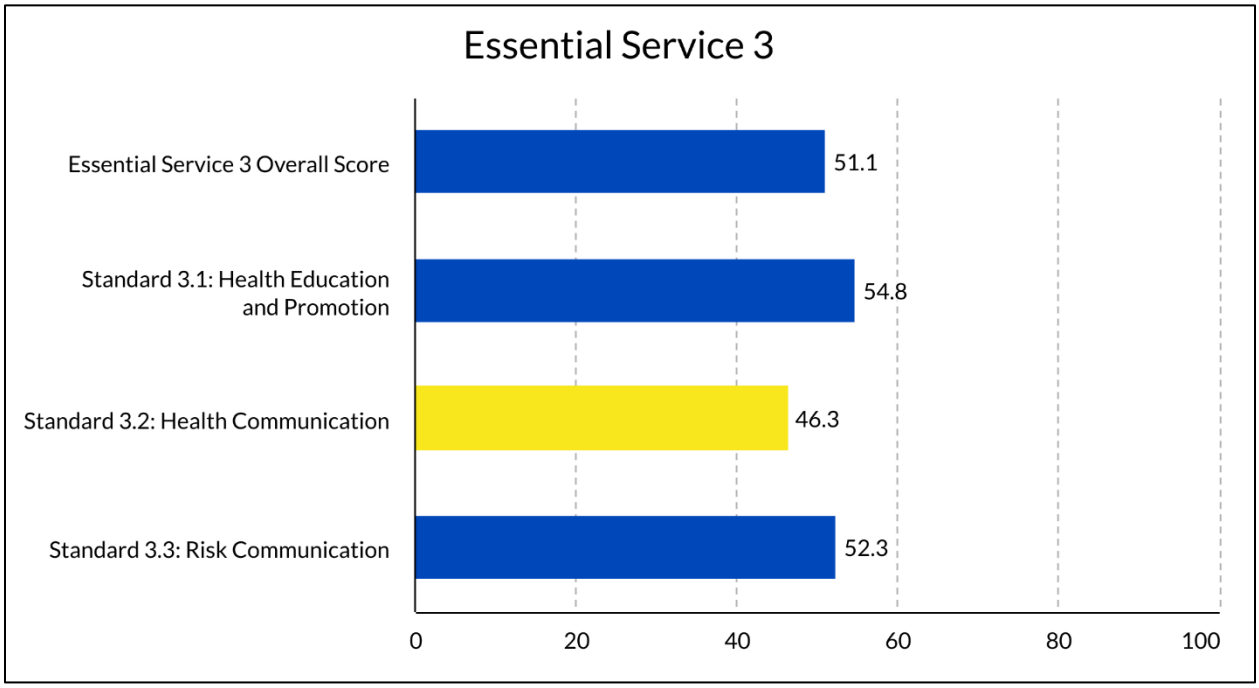
- Collaborate with providers to address chronic health conditions in the community
- Expand health services into the rural, western part of the community to better monitor health conditions
- Find ways to engage the African American community to identify and address health disparities (this community makes up a smaller percent of the population, but bears the brunt of the diseases)
- Focus on immigrant, Latinx, migrant works and refugee populations for targeted outreach
- Address social determinants of health through collaboration across the local health system to proactively address needs before they become issues

## Essential Services 3: Inform, educate and empower people about health issues

Essential Service 3 is composed of the following standards:

- 3.1: Health Education and Promotion
- 3.2: Health Communication
- 3.3: Risk Communication

### Survey Results




The overall score for Essential Service 3 (ES 3) based on responses by 28 survey responses was 51.1 and ranked 8th highest among scores for the 10 Essential Services. This puts this Essential

Service in the "Significant Activity" range indicating that Kane County's public health system "participates a great deal in this activity and there is opportunity for minor improvement." Individual scores for standards 3.1 and 3.3 were also in the "Significant Activity" range. Standard 3.2 scored 46.3, putting it in the "Moderate Activity" range indicating that the local public health system "somewhat participates in this activity and there is opportunity for greater improvement."

## Essential Service 3 Current Activities Summary

To better understand Essential Service 3 performance in Kane County, an online group discussion was held on October 6, 2020. Ten stakeholders participated in the discussion including representation from Kane County Health Department, local hospital systems, non-profit organizations, schools, and universities. Participants reviewed the ES 3 survey results and then engaged in discussions about current activities for the service. Based on these activities, participants then identified what they thought to be strengths, weaknesses, short-term improvement opportunities, and long-term improvement opportunities.

***Note:*** *The information captured in this table is based on what participants are aware of and may not be comprehensive for Kane County.*

**Standard 3.1, Health Education and Promotion (Score: 54.8, Significant Activity).** This standard explores the extent to which the local public health system provides policy makers, stakeholders, and the public with health information and recommendations for policies; and coordinates and engages the community in health promotion and education activities. Participants shared that there is a range of activities in this area. Kane County Health Department distributes newsletters via email and on their website on a range of topics. System partners conduct health promotion through health fairs, community health workers and nursing, which can help reach vulnerable populations. Elected officials work collaboratively with the health department and hospital systems for health promotion. Information and resources are shared by community partners through community meetings with diverse organizations.

**Standard 3.2, Health Communication (Score: 46.3, Moderate Activity).** This standard explores the extent to which the local public health system uses health communication strategies to contribute to healthy living including developing health communication plans for media and public relations, using relationships with media, and conducting spokespersons training on public health issues. Kane County Health Department public health information communicates with media. Kane Health Counts (www.kanehealthcounts.org) also acts as a resource for the media, showing data and priorities for the county. System partners coordinate with Spanish-language media for outreach to the Spanish-speaking community.

**Standard 3.3, Risk Communication (Score: 52.3, Significant Activity).** This standard explores the local public health system performance in using health risk communications strategies including developing an emergency communications plan; ensuring systems are in place for

rapid response; and providing crisis response training. Participants shared that health care agencies are able to connect quickly and work together well in response to emergencies. Kane County's emergency preparedness coordinator helps to gather information and collaborates with the Kane County Health Department and Kane County Sheriff's Office at the county level and local Emergency Medical Services agencies.

| ES 3: Inform, Educate and Empower People About Health Issues<br>Current Activities Summary Table | |
|---|---|
| • Newsletters available in print and on Health Department and other websites on a variety of topics (e.g. vaccine awareness, mental health, emergency preparedness, lead testing) – mostly available in English, some also in Spanish<br>• Reflejo publication – information for Hispanic/Spanish-speaking community<br>• Kane Health Count site has links to partners' health information<br>• Faith Nursing Program (Amita)<br>• Community education and outreach departments/service lines in each health system<br>• Community meetings to share resources and training opportunities | • Annual African American Health Fair<br>• Compañeros en Salud health festivals for uninsured and underinsured<br>• Municipalities work collaboratively with the Health Department to distribute health related information<br>• Health Department has a Public Information Officer on staff<br>• Interagency Health Advisory Committee meets monthly and disseminates health information as needed<br>• Northern IL Public Health Committee focuses on public health emergency response<br>• Each health system has an Emergency Preparedness Coordinator in place |

## Essential Service 3 Strengths, Weaknesses, and Opportunities

Considering the standards that make up ES 3 and what they know to be currently in place, the participants identified strengths, weaknesses and opportunities for Kane County, which are summarized below.

| Strengths |
|---|
| • Strong collaboration between agencies and municipalities to respond to community needs (e.g., COVID)<br>• Hospitals and the Health Department have good relationships with schools to get information distributed<br>• FQHCs provide primary care to uninsured and underinsured including health education<br>• Health systems collaborate on some health education for the community<br>• Population health is more integrated and mainstream in the public health system<br>• COVID-19 increased awareness of how social determinants of health impact people |

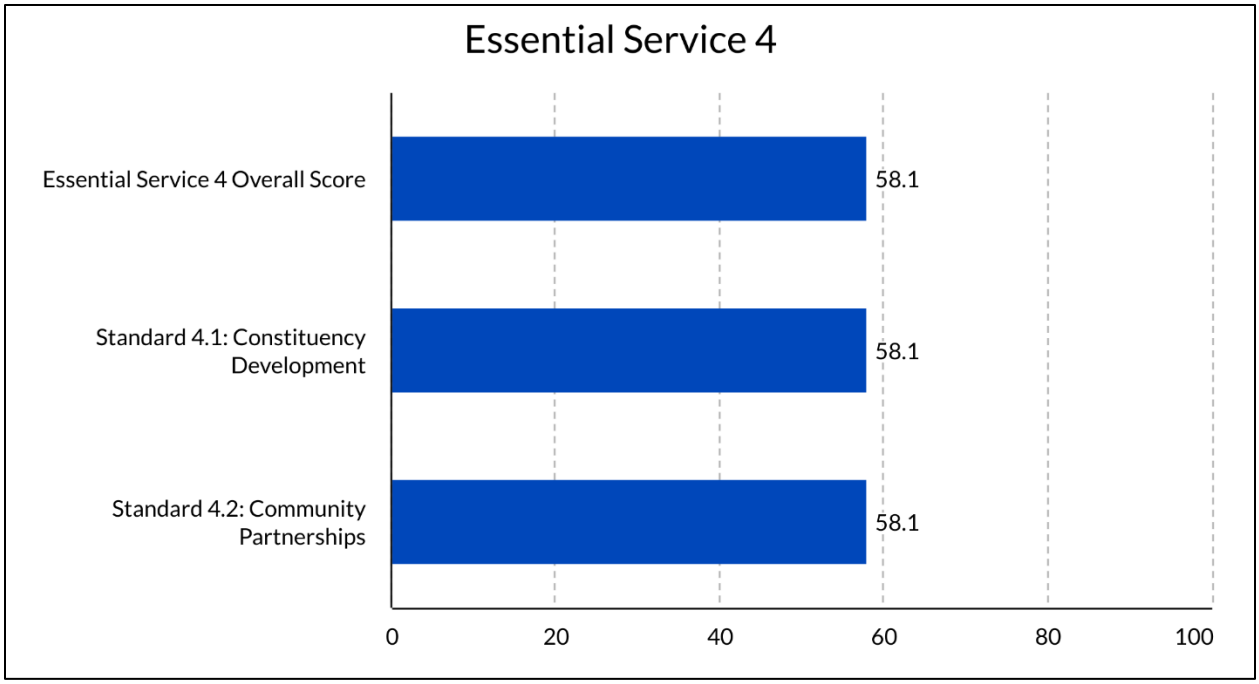
| Weaknesses |
| --- |
| • Not able to adequately address needs of vulnerable populations such as homeless<br>• Limited collaboration with FQHCs through Kane Health Counts<br>• Lack of bicultural/bilingual mental health services<br>• An automatic process is not in place to consider, integrate cultural competency<br>• Shortage of psychiatric services<br>• Gap in childcare services and reaching at-risk families during COVID |
| **Near-Term Improvement Opportunities** |
| • Increase collaboration across health agencies on community education and outreach<br>• Create intentional engagement with homeless residents to address health needs<br>• Increase access to specialty care for uninsured and underinsured<br>• Engage with FQHCs through Kane Health Counts and the CHIP<br>• Leverage potential avenues of funding that are accessible to FQHCs<br>• Investigate other channels to get information out to community beyond email and websites |
| **Long-Term Improvement Opportunities** |
| • Extend support for homeless community members to help them get back on their feet (e.g., support services, shelters, mental health counseling, addiction treatment, housing, GED, job training)<br>• Partner with the business community to integrate homeless back into the work environment<br>• Address restrictions within community programs that limit access to services based on a person's past<br>• Increase availability of mental health services including psychiatric care in the community<br>• Offer bicultural and bilingual mental health services |

## Essential Services 4: Mobilize community partnerships to identify and solve health problems

Essential Service 4 is composed of the following standards:

- 4.1: Constituency Development
- 4.2: Community Partnerships

### Survey Results




The overall score for Essential Service 4 (ES 4) based on responses by 28 survey responses was 58.1 and ranked 5th highest among scores for the 10 Essential Services. This puts this Essential Service in the "Significant Activity" range indicating that Kane County's public health system "participates a great deal in this activity and there is opportunity for minor improvement." Individual scores for the standards making up ES 4 all scored in the "Significant Activity" range.

## Essential Service 4 Current Activities Summary

To better understand Essential Service 4 performance in Kane County, an online group discussion was held on October 6, 2020. Ten stakeholders participated in the discussion including representation from Kane County Health Department, local hospital systems, non-profit organizations, schools, and universities. Participants reviewed the ES 4 survey results and then engaged in discussions about current activities for the service. Based on these activities, participants then identified what they thought to be strengths, weaknesses, short-term improvement opportunities, and long-term improvement opportunities.

***Note:*** *The information captured in this table is based on what participants are aware of and may not be comprehensive for Kane County.*

**Standard 4.1, Constituency Development (Score: 58.1, Significant Activity).** This standard explores the local public health system performance in identifying and involving a wide range of community partners and providing opportunities to contribute to community health. Participants described successful community engagement and collaboration efforts including countywide activities that have been sustained over time, with task teams that bring these partnerships to life. Past initiatives have engaged with the community through open forums

and townhalls. Involvement from multiple agencies to partner with the Mayor's collaborative to push anti-smoking initiative forward was an example of efforts in this area.

**Standard 4.2, Community Partnerships (Score: 58.1 Significant Activity).** This standard explores the extent to which the local public health system establishes community partnerships and strategic alliances to provide a comprehensive approach to community health improvement; establishes a broad-based community health improvement committee; and assesses the impact of these efforts. Participants described a wide range of community partnerships that included different regions of Kane County as well as different topical areas. Kane Health Counts was cited as a partnership that includes many representatives from different organizations including libraries, hospitals, mental health board, behavioral clinics, schools from pre-school through universities, local municipalities, businesses, and government agencies. Other strong community partnerships include the Kane County System of Care, A-OK (All Our Kids), Human Service Council, and Compañeros en Salud.

| ES 4: Mobilize Community Partnerships to Identify and Solve Health Problems Current Activities Summary Table | |
|---|---|
| • Community engagement and collaboration process (assessment) has been sustained over past 12 years<br>• Action teams are in place including the Health Department and other partners<br>• Kane Health Counts community collaborative with representation from much of the public health system<br>• Kane County System of Care (Children's Mental Health Grant)<br>• All Our Kids Early Childhood Network – early childhood education<br>• Kane County 211 | • Collaborative efforts among multiple agencies and organizations<br>• The Majors' Collaborative includes multiple agencies and organizations that share information and support informed decision making about marijuana<br>• Work Group for Inclusion, Diversity and Equity – information provided for entire community<br>• Human Service Council focused on Greater Elgin area<br>• Resource Council of Behavioral Health<br>• Substance use services and providers collaborate and partner on warm handoffs between clients |

## Essential Service 4 Strengths, Weaknesses, and Opportunities

Considering the standards that make up ES 4 and what they know to be currently in place, the participants identified strengths, weaknesses and opportunities for Kane County, which are summarized below.

| Strengths |
|---|

- Strong relationships between organizations exist in the community that help support reactive efforts to meet health needs as they come up
- Kane Health Counts members have deep knowledge of groups in county and who to pull into collaboration efforts
- Mental Health Council broadened to include behavioral health
- Strong funding community that pool resources and work together to support organizations providing basic health needs during COVID – 19
- Free breakfast and lunch meals offered to elementary schools in Kane County
- The Health Department's Home Isolation Strike Team was mobilized to assist anyone isolated during COVI-19 with food and supplies
- Libraries are valued partners in getting messages out to the community
- Park District provides services in the community and work collaboratively with others
- Evaluation process in place related to community assessments with regular progress reports from Action Teams

**Weaknesses**

- COVID-19 has revealed areas of need to be strengthened (e.g., homelessness, housing, food insecurity, unemployment)
- Food insecurity response is slower than it should be
- Limited resources for the Home Isolation Strike Team
- Community tends to be more "reactive" than "proactive"

**Near-Term Improvement Opportunities**

- Focus on different regions of the county and unique needs of those regions to be more strategic with efforts
- Reach out to organizations not currently collaborating with the public health system to engage them in efforts
- Focus on priorities that emerged due to COVID-19
- Connect with 211 and the resources associated with it
- Reach out to the growing Laotian population in Elgin
- Partner with food security programs and organizations
- Involve more senior services, assisted living, independent housing, senior housing groups with community health efforts
- Promote grant opportunities from the hospitals and other funders in the community to a wide variety of organizations to enhance reach of funding
- Target collaboration with the faith community, currently engagement is intermittent

**Long-Term Improvement Opportunities**

- Work with larger funders and policy makers to address needs and have greater impact

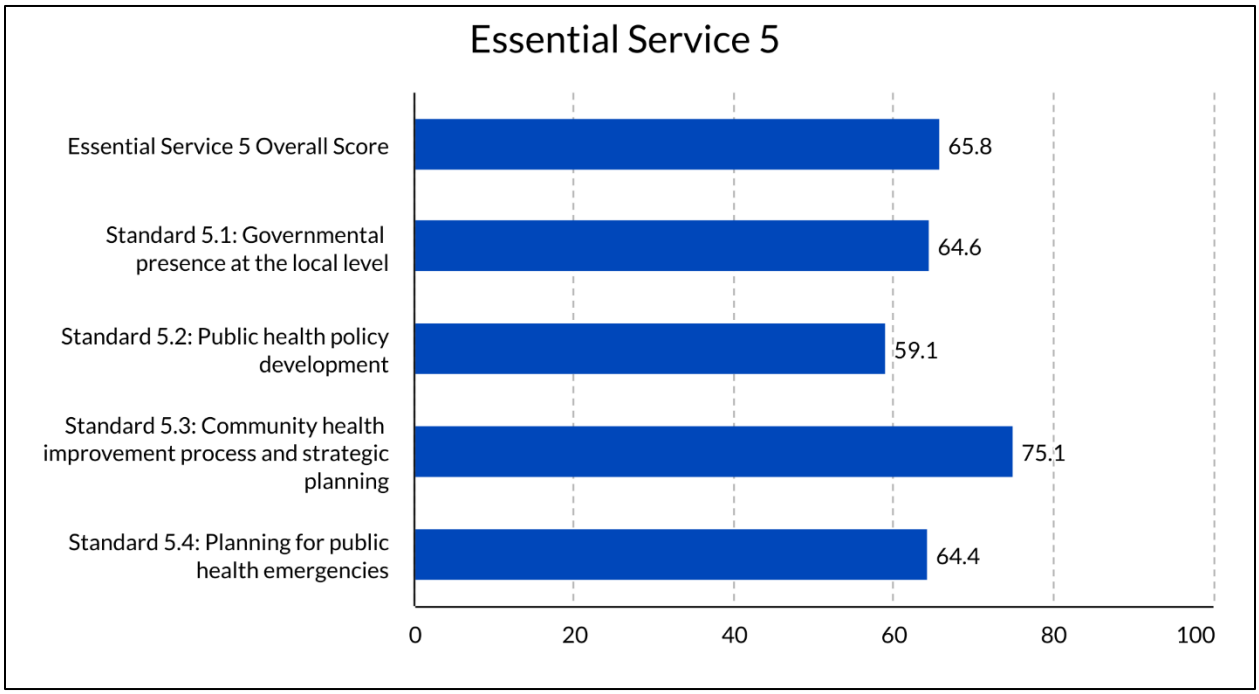
- Engage the Park District in collaborative efforts to meet community needs, especially in the rural communities
- Partner more with schools (public and private) at all levels to address health issues

## Essential Services 5: Develop policies and plans that support individual and community health efforts

Essential Service 5 is composed of the following standards:

- 5.1: Governmental Presence at the Local Level
- 5.2: Public Health Policy Development
- 5.3: Community Health Improvement Process and Strategic Planning

### Survey Results




The overall score for Essential Service 5 (ES 5) based on responses by 20 survey responses was 65.8 and ranked highest among scores for the 10 Essential Services. This puts this Essential Service in the "Significant Activity" range indicating that Kane County's public health system "participates a great deal in this activity and there is opportunity for minor improvement." Individual scores for the standards making up ES 5 all scored in the "Significant Activity" range.

### Essential Service 5 Current Activities Summary

To better understand Essential Service 5 performance in Kane County, an online group discussion was held on October 8, 2020. Eleven stakeholders participated in the discussion including representation from Kane County Health Department, local hospital systems, mental health services, and non-profit organizations, and schools. Participants reviewed the ES 5 survey results and then engaged in discussions about current activities for the service. Based on these activities, participants then identified what they thought to be strengths, weaknesses, short-term improvement opportunities, and long-term improvement opportunities.

***Note:*** *The information captured in this table is based on what participants are aware of and may not be comprehensive for Kane County.*

**Standard 5.1, Governmental Presence at the Local Level (Score: 64.6, Significant Activity).** This standard explores the extent to which the local public health system regularly supports the work of the local health department to ensure the 10 Essential Public Health Services are provided; sees that the local health department is accredited; and ensures the local health department receives appropriate resources. Participants were pleased to share that Kane County was the first local health department in the state to be accredited by the Public Health Accreditation Board (PHAB) and earned reaccreditation in November 2019. PHAB's initial accreditation assesses a health department's capacity to carry out the ten Essential Public Health Services; manage an effective health department; and maintain strong and effective communications with the governing entity. Becoming reaccredited shows the health department's continued improvement and advancement thereby becoming increasingly effective at improving the health of the population they serve.

**Standard 5.2, Public Health Policy Development (Score: 59.1, Significant Activity).** This standard explores the local public health system performance in contributing to public health policies; alerts policymakers and the community of the possible public health impacts of policies; and reviews existing policies at least every three to five years. Participants shared coordinated efforts by the partner organizations that include Kane County Health Department, municipalities, state work groups and regional consortiums. Partners have worked together on a range of policy issues including those related to smoking, legalization of marijuana, COVID-19, and substance use including opioids.

**Standard 5.3, Community Health Improvement Process and Strategic Planning (Score: 75.1, Significant Activity).** This standard explores the extent to which the local public health system establishes a community health improvement plan (CHIP) with broad-based participation; develops strategies to achieve identified CHIP objectives; and connects its organization strategic plans with the CHIP. Kane Health Counts is a broad-based partnership that leads completion of Kane County's CHIP every three years. Kane County uses the Mobilizing Action for Planning and Partnerships (MAPP) process to complete its CHIP. Kane Health Counts includes an Executive Committee that meets every two months and action teams meeting monthly. An annual meeting is organized with the community to share the status of goals and objectives. Information is also shared on the Kane Health Counts website (www.kanehealthcounts.org)

including reports, objectives, and other updates about implementation of the CHIP. The CHIP is conducted every three years to be in alignment with hospital partners cycles; partner organizations including local hospital systems utilize the CHIP to align priorities and strategies.

**Standard 5.4, Planning for Public Health Emergencies (Score: 64.4, Significant Activity).** This standard explores the performance of the local public health system in supporting a workgroup to develop and maintain preparedness and response plans; developing a plan for its use; and testing and revising the plan, at least every two years. Participants shared that there is ongoing work with the Emergency Medical Services, law enforcement, and hospital partners to responds to emergencies including environmental hazards and civil unrest. Regular exercises are completed with after action reports to determine areas of improvement. Plans are updated annually and shared with relevant departments.

| ES 5: Develop Policies and Plans that Support Individual and Community Health Efforts Current Activities Summary Table | |
|---|---|
| • Health Department and municipalities work together on policies to ensure guidelines are appropriate and followed (e.g., smoking, legalization of marijuana)<br>• Local and statewide coordination related to Opioid and substance use policies<br>• Kane County Opioid Task Force and state work groups including local Health Department officers<br>• Northern IL Public Health Consortium - 17 local HDs representing 80% state of IL<br>• Hospitals' strategic planning process addresses community priorities based on resources and strengths<br>• Hospitals, municipalities and school districts work together to address chronic diseases<br>• Increased focus on supporting family caregivers of older adults<br>• Health Department, nine township boards, three municipal boards and developmental disabilities boards partner on strategic planning related to goals and objectives to address mental health needs | • Kane County Health Department re-accredited by PHAB in November 2019 for 5 years<br>• Collaborative community health needs assessment process in place every three years using MAPP process<br>• Annual meeting with the community<br>• Action Teams meet regularly (monthly); pull together community and sectors together based on objectives<br>• Executive Committee meetings (every 2 months); oversees goals, review updates, collaborate, determine if pivot is needed<br>• Annual meeting with community to share status of goals and objectives, report on outcomes that have occurred<br>• Kane Health Counts website is updated with Action Team activities<br>• Hospital implementation strategies aligned with county activities and based on findings from the assessment<br>• Coordinated emergency operations plans updated annually by county; Health Department is involved |

## Essential Service 5 Strengths, Weaknesses, and Opportunities

Considering the standards that make up ES 5 and what they know to be currently in place, the participants identified strengths, weaknesses and opportunities for Kane County, which are summarized below.

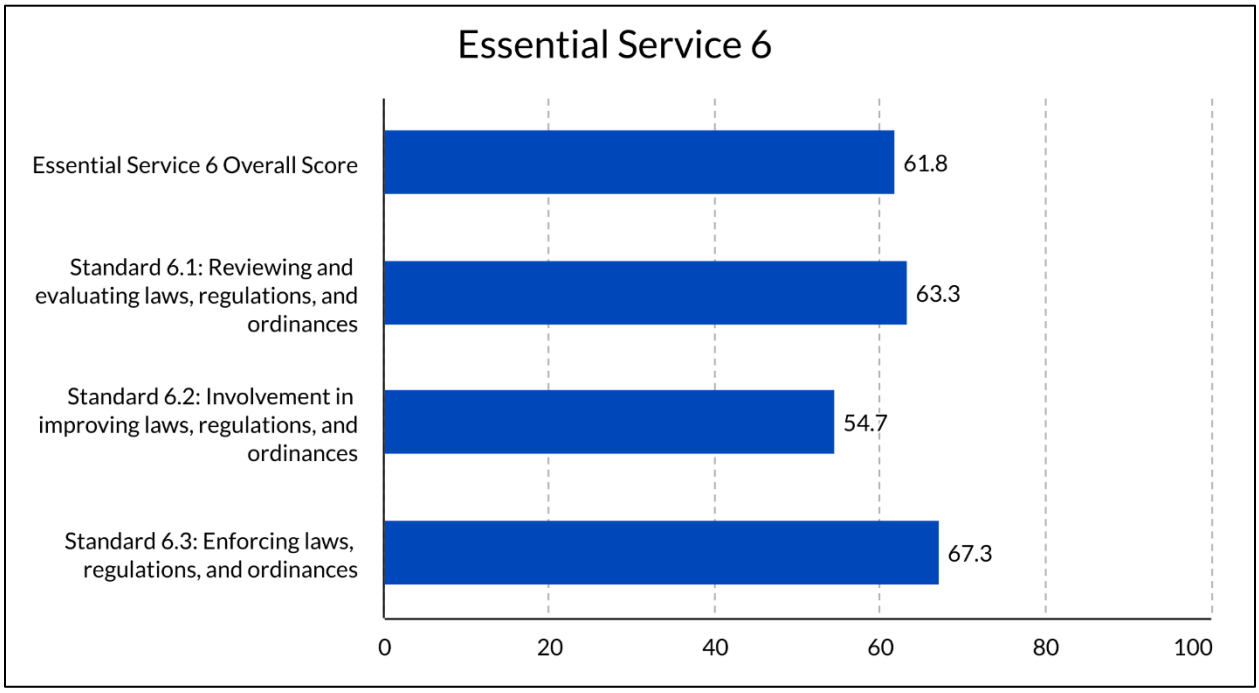
| **Strengths** |
|---|
| • Exceptional collaboration with community partners; willingness to share data and information to identify biggest needs, think outside of the box and be mobile<br>• Children's Health Grant Community Implementation Team – representation, input and participation from diverse populations (parents, professionals)<br>• Additional funding received for mental health services in southern end of the county<br>• Research project with Northern IL University to assess lead in homes using well water<br>• 24 elected officials (covering 500 square miles of county) participate in different groups and annual meetings; very involved in different priority areas |
| **Weaknesses** |
| • Federal guidelines not always aligned with state guidelines related to COVID-19<br>• Health Department created by 1985 resolution rather than referendum so have to rely heavily on grant funding to cover 45% of its budget |
| **Near-Term Improvement Opportunities** |
| • Seek Health Department referendum to enhance ability to more successfully address needs in community and direct resources towards needs verse spending time to chase grants and being bound by deliverables outlined in grants<br>• Emergency services partnership with faith-based organizations and businesses during COVID-19 and other emergencies to address emerging needs (e.g., food, housing)<br>• Increase intentional engagement and partnership with community members to get feedback, especially from communities most affected by COVID-19<br>• Go where communities are in most needs (immigrants, refugees); bring services and opportunities to them, meet them where they're more comfortable |
| **Long-Term Improvement Opportunities** |
| • Keep social determinants of health (income, education, food security, housing/rent) at forefront of policies and programs developed<br>• Focus on big picture – not just physical and mental health, but also environmental factors (air, water, lead) that have a long-term, systemic influence on health<br>• Increase communication with elected officials (local, state, federal) to share input that may influence policies<br>• Incorporate ACEs trauma-informed policies in workplaces and schools |

## Essential Services 6: Enforce laws and regulations that protect health and ensure safety

Essential Service 6 is composed of the following standards:

- 6.1: Reviewing and Evaluating Laws, Regulations, and Ordinances
- 6.2: Involvement in Improving Laws, Regulations, and Ordinances
- 6.3: Enforcing Laws, Regulations, and Ordinances

### Survey Results




The overall score for Essential Service 6 (ES 6) based on responses by 20 survey responses was 61.8 and ranked 3rd highest among scores for the 10 Essential Services. This puts this Essential Service in the "Significant Activity" range indicating that Kane County's public health system "participates a great deal in this activity and there is opportunity for minor improvement." Individual scores for the standards making up ES 6 all scored in the "Significant Activity" range.

### Essential Service 6 Current Activities Summary

To better understand Essential Service 6 performance in Kane County, an online group discussion was held on October 8, 2020. Eleven stakeholders participated in the discussion including representation from Kane County Health Department, local hospital systems, mental health services, and non-profit organizations, and schools. Participants reviewed the ES 6 survey results and then engaged in discussions about current activities for the service. Based on these activities, participants then identified what they thought to be strengths, weaknesses, short-term improvement opportunities, and long-term improvement opportunities.

***Note:*** *The information captured in this table is based on what participants are aware of and may not be comprehensive for Kane County.*

**Standard 6.1, Reviewing and Evaluating Laws, Regulations, and Ordinances (Score: 63.3, Significant Activity).** This standard explores the local public health system performance in identifying public health issues that should be addressed through laws and regulations; reviewing laws and regulations with public health impact; having access to legal counsel for technical assistance; and involving governing entities in reviewing and developing public health laws and regulations. Participants noted that Kane County's Health Advisory Committee provides advice to the Kane County Health Department and Board of Health in matters related to public health policies and strategic initiatives. The Health Advisory Committee is composed of designated roles including nurse, dentist, physician, and community leaders. The County Board's Legislative Committee provides a process in which any department, including public health, can bring forth bills that need support; these are placed on an agenda for review and decision from the County's perspective.

**Standard 6.2, Involvement in Improving Laws, Regulations, and Ordinances (Score: 54.7, Significant Activity).** This standard explores the performance of the local public health system in identifying local public health issues inadequately addressed in existing laws and regulations; participating in changing existing laws and regulations to protect and promote public health; providing technical assistance in drafting language for proposed changes or new laws and regulations; and evaluating the effects of policies and regulations. The health department shared that it participates in the Northern Illinois Public Health Consortium to review public health related legislation and encourage local and state officials to support policies that improve public health. Local hospitals and Federally Qualified Health Centers engage in review and advocacy at state and federal levels through government relations departments. Hospitals also participate in the Illinois Hospital and Health Association, which supports integrated policy efforts. Many partners participate in public health advocacy through formalized process through trade associations that coordinate responses to regional and state laws. Participants described coordinated activities around policy including efforts to promote public health policy included efforts related to for smoke-free Kane ordinances and to a separate campaign to help educate community members about the impact of a new marijuana law.

**Standard 6.3, Enforcing Laws, Regulations, and Ordinances (Score: 67.3, Significant Activity).** This standard explores the performance of the local public health system in identifying organizations with authority to enforce public health laws; ensuring that a local health department has authority to act in public health emergencies; ensuring that enforcement activities are conducted; informing and educating about relevant laws; and evaluating compliance with public health laws. Participants identified that Kane County's various departments are responsible for local public health and safety code enforcement including those related to restaurant inspections, communicable disease control such as tuberculosis,

and water quality. Memoranda of Understanding and relationships are developed to ensure enforcement of school policies related to food-borne illnesses and communicable diseases.

In response to the COVID-19 in 2020, Kane County Health Department has worked with state offices to coordinate rules and guidelines around the pandemic. Participants reported divided experience related to enforcement of COVID-19 mitigation including those related to physical distancing and face coverings.

| ES 6: Enforce Laws and Regulations that Protect Health and Ensure Safety<br>Current Activities Summary Table | |
|---|---|
| • Hospitals have government relations departments with local representation that focus on state/federal advocacy efforts<br>• Health Department has Health Advisory Committee<br>• Legislation is passed through Legislative Committee or Northern IL Public Health Consortium, which concentrate on public health related legislation<br>• Hospitals partner with IL Hospital and Health Association to support/oppose various bills<br>• Advocacy efforts in place through AMITA, Health Department and American Cancer Society<br>• Public health lobbying – formalized process through trade association; collaborate on monthly basis on bills and legislations that may affect the community<br>• County Board has legislative committee where any department including public health can bring forth bills that need support; placed on agenda for review and decision making | • FQHCs advocacy and legislation efforts in place<br>• EMS advocacy and legislative bodies with fire and law enforcement<br>• Public health seeks out partners for support on specific bills<br>• MOU and relationships established between public health and schools; collaborate with school nurses and superintendents on school surveillance (e.g., flu season, absenteeism, link to food-borne illnesses)<br>• Work group created (local representatives) to share guidelines and interventions; weekly meeting with State Board of Education and public health to review guidelines and discuss interventions for schools; school toolkit created to help navigate issues (e.g., quarantine, isolation)<br>• Code enforcement is part of county (e.g., food, water, infectious disease)<br>• Legal process for enforcing codes includes vetting through State Attorney Office, opening for public comments, education |

## Essential Service 6 Strengths, Weaknesses, and Opportunities

Considering the standards that make up ES 6 and what they know to be currently in place, the participants identified strengths, weaknesses and opportunities for Kane County, which are summarized below.

| Strengths |
|---|

- Outstanding collaboration between Health Department and community
- Community engagement in enforcement and sharing complaints/input on major and minor violations happening through website/designated number, email, mail, voice mail, and direct calls to staff, elected officials, sheriff's office
- During COVID, Health Department met with churches, chambers of commerce, homeless shelters, schools to share information on guidelines and supportive services
- Advocacy for mental health including parity laws (e.g., insurance coverage for mental health along with physical health insurance opportunities)
- Advocacy for older adults and other vulnerable population impacted by COVID-19

**Weaknesses**

- Enforcement is difficult when law enforcement and/or the community is not on board
- Divided experience with enforcing COVID-19 related orders
- No clear guidance provided through Governor's reopening phases and IL public health on older adult facilities
- Disparities experienced by essential workers (e.g., service workers, manufacturing plants) not able to isolate from families, take time off from work or work from home during COVID-19
- Lack of good infection control plans in nursing homes
- Minority populations disproportionality affected by COVID-19; Hispanic population with highest rates and African American population with highest mortality
- Limited test kits revealed who was being tested for COVID at the start of the pandemic - mostly those with access to health care (predominately White community members)

**Near-Term Improvement Opportunities**

- Collaborate more on defining guidelines and guidance for older adults during an event like the COVID-19 pandemic
- Increase collaboration between individual agencies to work on mental health advocacy efforts together
- Identify where populations are and how to get information out to them quickly and safely

**Near-Term Improvement Opportunities**

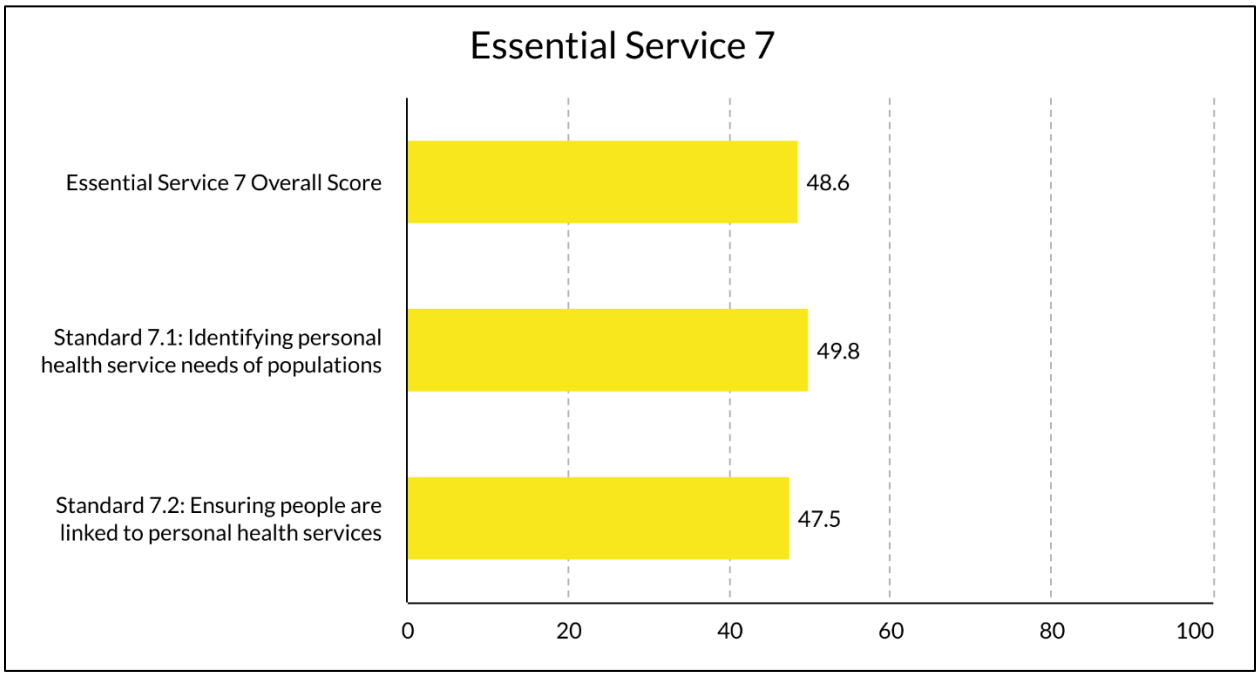
- Increase continuity and alignment with State Attorney, law enforcement, hospitals and Health Department in enforcing laws and ordinances; put politics aside and see what can be done for community collectively; need to come together and deliver cohesive/unified message to community

## Essential Services 7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

Essential Service 7 is composed of the following standards:

- 7.1: Identifying Personal Health Service Needs of Populations
- 7.2: Ensuring People are Linked to Personal Health Services

## Survey Results




The overall score for Essential Service 7 (ES 7) based on responses by 28 survey responses was 48.6 and ranked 9th highest among scores for the 10 Essential Services. This puts this Essential Service in the "Moderate Activity" indicating that Kane County's public health system "somewhat participates in this activity and there is opportunity for greater improvement." Individual scores for the standards making up ES 7 all scored in the "Moderate Activity" range.

## Essential Service 7 Current Activities Summary

To better understand Essential Service 7performance in Kane County, an online group discussion was held on October 6, 2020. Ten stakeholders participated in the discussion including representation from Kane County Health Department, local hospital systems, non-profit organizations, schools, and universities. Participants reviewed the ES 7 survey results and then engaged in discussions about current activities for the service. Based on these activities, participants then identified what they thought to be strengths, weaknesses, short-term improvement opportunities, and long-term improvement opportunities.

***Note:*** *The information captured in this table is based on what participants are aware of and may not be comprehensive for Kane County.*

**Standard 7.1, Identifying Personal Health Service Needs of Populations (Score: 49.8, Moderate Activity).** This standard explores the performance of the local public health system in identifying groups who have trouble accessing personal health services and unmet needs; defining roles and responsibilities for partners in responding to unmet needs; and understanding reasons for people not getting health services they need. Participants shared a variety of activities to better understand the needs of the population and gaps in services. Community health needs assessments conducted by hospitals included questions about access to services, primary care, health insurance, and mental health. Kane County Health Department conducted surveys and focus groups with parents and youth to better understand unmet needs and barriers to health and mental health services for children and families. A health equity and diversity survey was conducted with providers to better understand mental health needs in the community. Data on Kane Health Counts (www.kanehealthcounts.org) shares information on gaps in services including mental health services, and shows breakouts by race/ethnicity, age, and location.

**Standard 7.2, Ensuring People are Linked to Personal Health Services (Score: 47.5, Moderate Activity).** This standard explores the performance of the local public health system in connecting people to organizations providing personal health services taking into account unique needs of different populations; helping people sign up for public benefits; and coordinating the delivery of personal health and social services to ensure care. Participants highlighted activities conducted by multiple partners in the local public health system linking populations to needed services. Community health workers in emergency departments connect patients to needed services including FQHCs, housing, mental health, and resources for food. Agreements with Federally Qualified Health Centers (FQHCs) and hospitals are established such that hospitals cover services at no or low cost for individuals who cannot afford them. FQHCs also have health promoters and migrant programs that assist with Medicaid enrollment. Leased offices in rural areas provide easier access to mental health services. The local 211 screens individuals for needs and connects them to agencies and services. Family Focus, a local nonprofit, connects individuals with SNAP benefits and other resources as needed. Finally, the county public health system advocates for access to care on local and state levels including Medicaid coverage of mental health.

| ES 7: Mobilize Community Partnerships to Identify and Solve Health Problems Current Activities Summary Table | |
|---|---|
| • Community health workers in ER departments connect patients to other services (e.g., FQHCs, housing, mental health services, food)<br>• Office space is leased in two rural areas for agencies to provide mental health services | • Health equity and diversity survey was conducted with providers to understand mental health needs in community<br>• Health Department surveys conducted with parents and focus groups with youth to better understand barriers to children and family mental health services |

| | |
|---|---|
| to the community, so people don't have to go to Aurora and Elgin to get services<br>• 211 phone line provides referral to services<br>• East side of Aurora has food pantry in high school building and an FQHC mobile site to provide services to students<br>• Agreements between FQHCs and hospitals - if there are services that the clinic can't take care of, hospitals will cover those services at low cost or free | • Resources established in the community to assist with Medicaid and safety net program enrollment (e.g., FQHC health promoters, community health workers in hospitals, Family Focus – social service agency that offers assistance)<br>• Advocacy efforts are in place at the local and state levels to have Medicaid cover mental health services |

## Essential Service 7 Strengths, Weaknesses, and Opportunities

Considering the standards that make up ES 7 and what they know to be currently in place, the participants identified strengths, weaknesses and opportunities for Kane County, which are summarized below.

| **Strengths** |
|---|
| • Information pushed out through schools for dental programs and family services<br>• Intentional focus on having resources translated in Spanish<br>• Bilingual mental health providers in the community<br>• Telemedicine and telehealth<br>• Opioid efforts - numbers tracked, harm reduction<br>• Health fair in southern region of county focuses on African American community members<br>• AMITA faith nurses in churches<br>• Health Department focuses on infant mortality |
| **Weaknesses** |
| • Quality of translation of health materials is not consistent<br>• Community members' lack of education or knowledge about resources in area (e.g. people making 911 calls to get prescription assistance)<br>• Technology challenges for community members and specific populations such as low income<br>• Lack of bilingual mental health providers – long wait lists |
| **Near-Term Improvement Opportunities** |
| • Create intentional efforts to translate materials from community health centers and other organizations serving the refugee population in Kane County |

- Train healthcare providers and mental health staff in addressing needs of LBGTQ community
- Use the new Opioid Coordinator at the Health Department to revitalize efforts of the steering committee focused on programs that address opioid addiction
- Target interventions to specifically address needs of the African American population
- Increase representation within Kane Health Counts to sectors within the public health system that are missing

**Long-Term Improvement Opportunities**

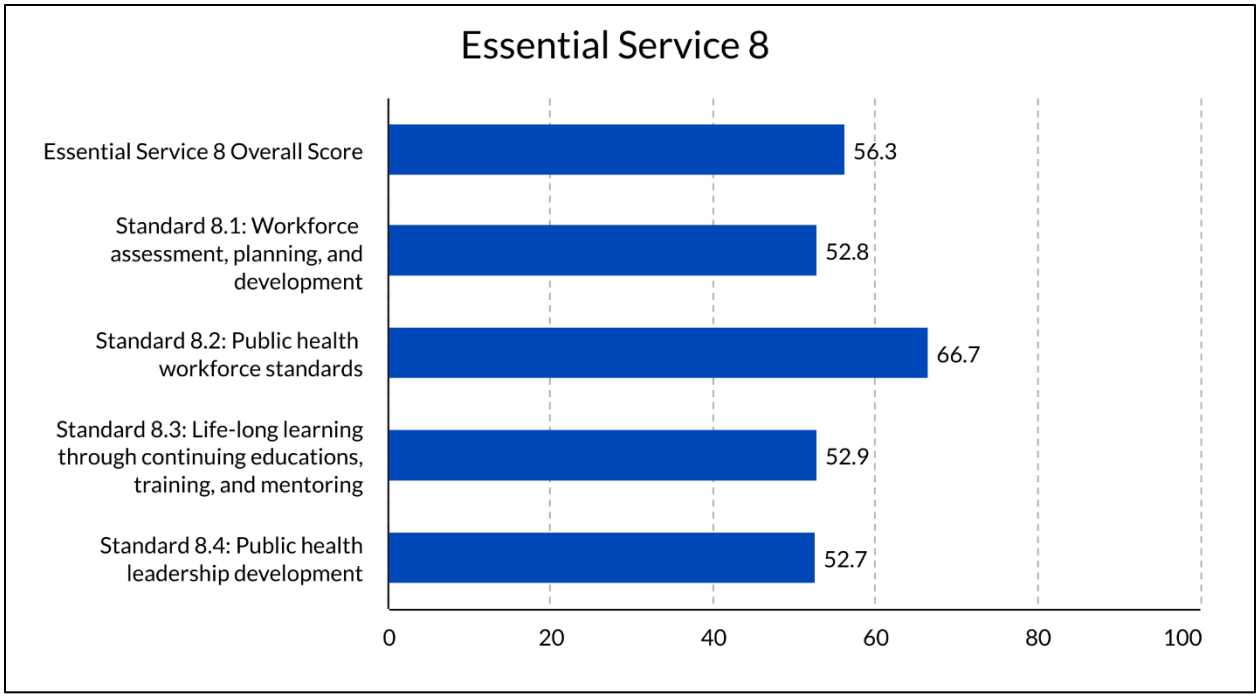
- Recruit for bilingual mental health therapists and staff
- Identify strategies to reach community members through telehealth and address technological challenges/barriers
- Strategies to enhance specialty care services for FQHC patients
- Collaborate with independent physicians to open up panels to community members without commercial insurance
- Better identify barriers preventing people from accessing services (e.g., transportation, finances, insurance coverage)
- Tap into research and innovation at major medical centers in the Chicago area to leverage locally
- Develop a process to integrate referrals and create a feedback loop between ED community health workers, providers, and social service providers
- Create a planning group of local health systems' CEOs and strategists to focus on where collaboration can occur outside of competition

## Essential Services 8: Assure a competent public health and personal health care workforce

Essential Service 8 is composed of the following standards:

- 8.1: Workforce Assessment, Planning and Development
- 8.2: Public Health Workforce Standards
- 8.3: Life-Long Learning through Continuing Education, Training, and Mentoring
- 8.4: Public Health Leadership Development

### Survey Result




The overall score for Essential Service 8 (ES 8) based on responses by 18 survey responses was 56.3 and ranked 6th highest among scores for the 10 Essential Services. This puts this Essential Service in the "Significant Activity" range indicating that Kane County's public health system "participates a great deal in this activity and there is opportunity for minor improvement." Individual scores for the standards making up ES 8 all scored in the "Significant Activity" range.

## Essential Service 8 Current Activities Summary

To better understand Essential Service 8 performance in Kane County, an online group discussion was held on October 13, 2020. Seven stakeholders participated in the discussion including representation from Kane County Health Department, local hospital systems, non-profit organizations, and mental health services. Participants reviewed the ES 8 survey results and then engaged in discussions about current activities for the service. Based on these activities, participants then identified what they thought to be strengths, weaknesses, short-term improvement opportunities, and long-term improvement opportunities.

***Note:*** *The information captured in this table is based on what participants are aware of and may not be comprehensive for Kane County.*

**Standard 8.1, Workforce Assessment, Planning and Development (Score: 52.8, Significant Activity).** This standard explores the extent to which the local public health system assesses, reviews, and shares information about the local public health system workforce assessment. Participants shared that the Kane County Health Department conducts a workforce assessment and creates a plan that looks at its existing workforce including strengths and needs using the public health core competencies. The workforce development plan is aligned with requirements

by the Public Health Accreditation Board. Hospital systems also engage in regular efforts to assess the workforce and needs for training.

**Standard 8.2, Public Health Workforce Standards (Score: 66.7, Significant Activity).** This standard explores the performance of the local public health system in ensuring that the workforce have required certificates, licenses, and education; developing and maintaining job standards; and basing hiring and performance reviews in public health competencies. Participants shared the different standards in place across different organizations and how they are monitored. Health department job descriptions and annual evaluations include responsibilities and duties outlined by Public Health Core Competencies. Hospital systems have a defined process for creating job descriptions and identifying necessary competencies for positions. Hospitals hold annual skills competencies where employees demonstrate skills; these efforts are consistent with requirements for accreditation by the Joint Commission.

**Standard 8.3, Life-Long Learning through Continuing Education, Training, and Mentoring (Score: 52.9, Significant Activity).** This standard explores the performance of the local public health system in encouraging lifelong learning by identifying education and training needs; providing ways for developing core public health skills; developing incentives for training; and creating and supporting collaborations between organizations to support training and education. Participants shared that there are many opportunities for continuing education including healthcare workforce CEs and certifications. Kane Health Department and hospitals have tuition reimbursement to help incentivize continuous education and training. Partnerships between the health department and health systems provide internship and volunteer opportunities for students in public health, healthcare, and behavioral health fields.

**Standard 8.4, Public Health Leadership Development (Score: 52.7, Significant Activity).** This standard explores the performance of the local public health system in providing broad access to leadership development; creating a shared vision of community health; ensuring that organizations and individuals have opportunities to provide leadership; and providing opportunities for leadership development that reflect the diversity of the community. Participants shared that the system does collaborate across organizations to ask about specific needs to contribute to a shared vision. There are coaching and mentoring program that assist with career and leadership development. Partners also shared programs that fostered diversity and inclusion in the workforce. Various Human Resource departments use an equity lens across the system. Partners described efforts for diversity at the board and leadership level, however some also noted that leadership retention can be a challenge.

| ES 8: Assure a Competent Public Health and Personal Health Care Workforce Current Activities Summary Table | |
|---|---|
| • Healthcare workforce programs for Continuing Education | • Hospitals have in process in place for workforce assessment planning twice a |

| | |
|---|---|
| • Collaboration between behavioral health providers and local university for internships (Masters and undergrad)<br>• High school student volunteer program through local hospitals to expose students to job opportunities beyond traditional clinical roles of doctors and nurses<br>• Partnership between organizations for Point of Distribution sites around the county<br>• Medical Reserve Corp volunteers help with food insecure community members<br>• Kane County Health Department Workforce Development Plan: looks at existing workforce, current strengths and needs, alongside public health core competencies to drive workforce development strategy<br>• Health Department job descriptions include responsibilities/duties as well as demonstrated skill and knowledge; annual reviews evaluate against job description requirement as well as public health core competencies | year looking at opportunities for openings and productivity<br>• Hospitals have defined process for job descriptions, competencies, trainings, etc. that follow accreditation requirements from the Joint Commission<br>• The Health Department, hospitals and some community-based organizations offer tuition reimbursement programs for employees<br>• Various coaching and mentoring programs are in place in the community related to health system positions<br>• Hospital and Health Department offer certifications<br>• Health Department offers clinical rotations for the nursing program students focused community health<br>• Advocate Aurora focuses on diversity and inclusion within workforce development and recruitment<br>• A local funder works with community agencies to understand needs related to workforce recruitment and development to guide future funding |

## Essential Service 8 Strengths, Weaknesses, and Opportunities

Considering the standards that make up ES 8 and what they know to be currently in place, the participants identified strengths, weaknesses and opportunities for Kane County, which are summarized below.

| **Strengths** |
|---|
| • The public health system utilizes data from the community assessments to understand where needs are and focus workforce development efforts<br>• Diversity of community served is considered and cultural competence training is provided for staff<br>• Discovery Program helps introduce high school students to careers in healthcare<br>• Alignment Collaborative for Education provides resources/materials on different topics including healthcare careers tailored to high school students |

- Parent Café's: Health Department community engagement strategy to get parent feedback on health-related issues; some are targeted specifically for minority or underserved communities
- Advocate Health participated in racial discussion to share stories and foster discussion
- Focus on LGBTQ community

**Weaknesses**

- County is challenged with recruiting diverse leadership for paid positions as well as volunteer board service
- Southern end of the county is challenged with retaining leadership and availability of leadership workforce pool
- It's challenging to recruit diverse (race/ethnicity, gender, age) board members for community boards
- Not enough of the younger population involved with leadership development or board service
- Transportation barriers for some populations in the county so they can't access needed services (e.g., health, social, employment, school)
- Lack of bilingual staff, therapists and psychiatrists

**Near-Term Improvement Opportunities**

- Make healthcare workforce continuing education classes available to a cross-sector of employees in the health system
- Look for more collaboration opportunities for education and training across the county
- Work with Kane County HR Department to create Health Department specific polices related to job performance evaluation that embeds public health core competencies
- Create strategies to recruit younger people to get involved in leadership positions (e.g. serve on boards of local organizations)
- Expand the Discovery Program to reach more high school-aged students
- Target recruitment efforts for bilingual therapists and psychiatrists to meet growing need
- Expand outreach through Alignment Collaborative for Education to include middle school students and look for other opportunities to engage this age group
- Use partnership between organizations for Point of Distribution sites around the county for mass vaccination events

**Long-Term Improvement Opportunities**

- Develop long-term, county-wide staffing plans to staff healthcare based on population changes (e.g., getting older)
- Focus provider recruitment efforts on specialty care shortages

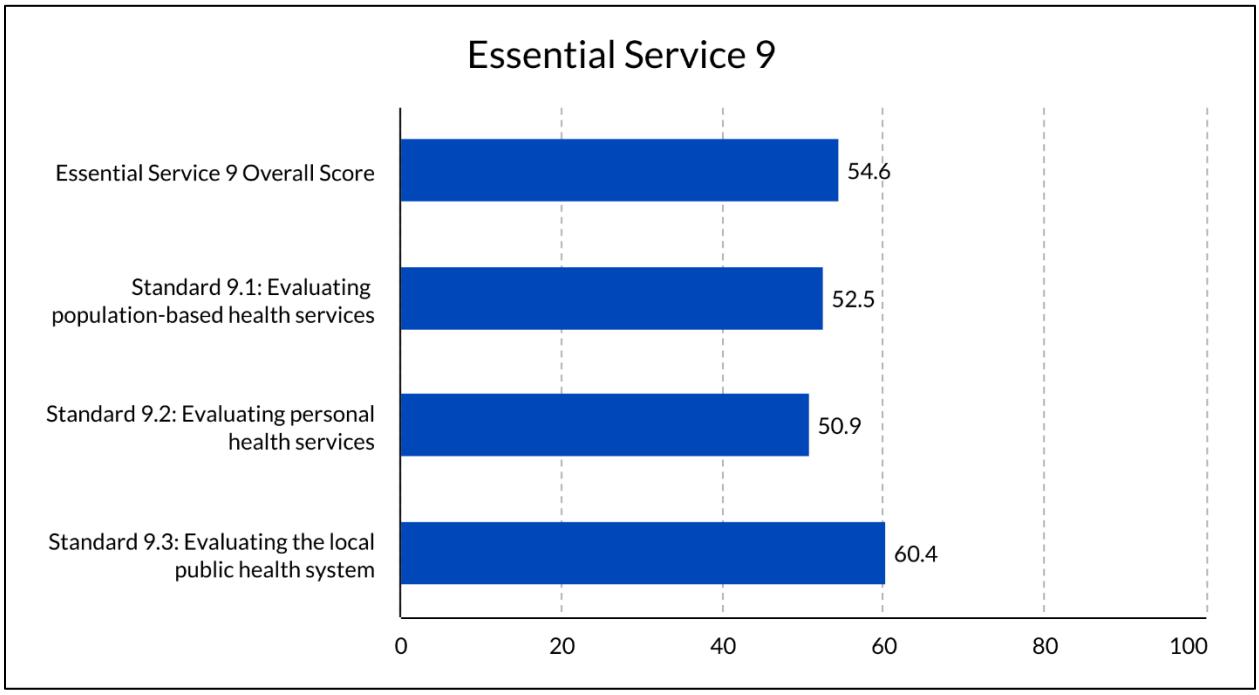
- Collaborate on development and implementation of training for health system staff specific to LGBTQ community
- Include cultural competency in all training for public health system employees

## Essential Services 9: Evaluate effectiveness, accessibility, and quality of personal and population-based health services

Essential Service 9 is composed of the following standards:

- 9.1: Evaluating Population-Based Health Services
- 9.2: Evaluating Personal Health Services
- 9.3: Evaluating the Local Public Health System

### Survey Results




The overall score for Essential Service 9 (ES 9) based on responses by 18 survey responses was 54.6 and ranked 7th highest among scores for the 10 Essential Services. This puts this Essential Service in the "Significant Activity" range indicating that Kane County's public health system "participates a great deal in this activity and there is opportunity for minor improvement." Individual scores for the standards making up ES 9 all scored in the "Significant Activity" range.

### Essential Service 9 Current Activities Summary

To better understand Essential Service 9 performance in Kane County, an online group discussion was held on October 13, 2020. Seven stakeholders participated in the discussion

including representation from Kane County Health Department, local hospital systems, non-profit organizations, and mental health services. Participants reviewed the ES 9 survey results and then engaged in discussions about current activities for the service. Based on these activities, participants then identified what they thought to be strengths, weaknesses, short-term improvement opportunities, and long-term improvement opportunities.

***Note:*** *The information captured in this table is based on what participants are aware of and may not be comprehensive for Kane County.*

**Standard 9.1, Evaluating Population-Based Health Services (Score: 52.5, Significant Activity).** This standard explores the performance of the local public health system in evaluating the effectiveness of population-based health services, which are aimed at disease prevention and health promotion for the entire community. Participants shared that population-based health services are typically aligned through strategies identified through Kane Health Counts, which identifies strategies to meet needs found in community health assessments. Participants identified a range of population-based health services through Kane County Health Department including those addressing children's mental health, tobacco prevention, opioid abuse, immunizations, and others. These programs are initiated based on alignment with identified needs through Kane Health Counts or Kane County Health Department's mission or strategic plan. The health department evaluates programs through measures of outputs, outcomes, satisfaction surveys, and pre-post tests. Community Benefit departments at hospitals also study the effectiveness of their programs to evaluate their community impact.

**Standard 9.2, Evaluating Personal Health Services (Score: 50.9, Significant Activity).** This standard explores the extent to which the local public health system evaluates the accessibility, quality, and effectiveness of personal health services; uses technology to improve quality of care; and uses findings to improve services. Participants shared that both hospitals and the health department regularly evaluate the quality and effectiveness of services by looking at outcomes and patient experience services.

**Standard 9.3, Evaluating the Local Public Health System (Score: 60.4, Significant Activity).** This standard explores the performance of the public health system as a whole, including identifying organizations to contribute to the 10 Essential Public Health Services; evaluating of the public health system; assessing how well organizations are coordinating services; and using results to improve the system. Kane County evaluates the performance of the local public health system through the Local Public Health System Assessment (LPHSA). This assessment is conducted with partners across the public health system to describe how well the public health system works together to deliver the 10 Essential Public Health Services.

**ES 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services**
**Current Activities Summary Table**

| | |
|---|---|
| • Hospital patient experience surveys look at the quality, effectiveness of services<br>• Health Department has an evaluation system to follow up with clients to rate services provided<br>• Health Department surveys restaurants related to code enforcement<br>• Specific effort to target churches through community health workers for feedback about services needed<br>• Health Department workgroup for diversity and inclusion (open to health professionals, youth, community members) utilized survey to Identify problem areas and will have additional follow-up surveys in community with metrics to measure progress toward goals | • Pre and post-tests in place for various certifications<br>• Hospitals focus on gathering outcomes data to show impact of community programs<br>• Community funders require outputs and outcomes from grantees to evaluate efficacy of programs and determine if funding is making an impact<br>• Kane Health Counts has a process to review stated objectives and strategies to determine what has been completed and where work is still needed<br>• Kane County has many different public health programs funded through grants and they have built in evaluation based on the grant requirements |

## Essential Service 9 Strengths, Weaknesses, and Opportunities

Considering the standards that make up ES 9 and what they know to be currently in place, the participants identified strengths, weaknesses and opportunities for Kane County, which are summarized below.

| **Strengths** |
|---|
| • Collaborative community and health system that works together to support each other in addressing needs<br>• Assessment process includes community input through interviews and focus groups |
| **Weaknesses** |
| • Community residents are not taxed to support the Health Department like in other communities, so the Health Department has to rely on grant funds to support much of their efforts<br>• Health Department must rely on grant funding and the grant deliverables don't always match up with identified community needs |
| **Near-Term Improvement Opportunities** |
| • Put in place an evaluation of outreach efforts<br>• Pull in more diverse agencies/municipalities into action groups and Kane Health Counts |

- Improve communication between community organizations about health promotion efforts going on in the community

**Long-Term Improvement Opportunities**

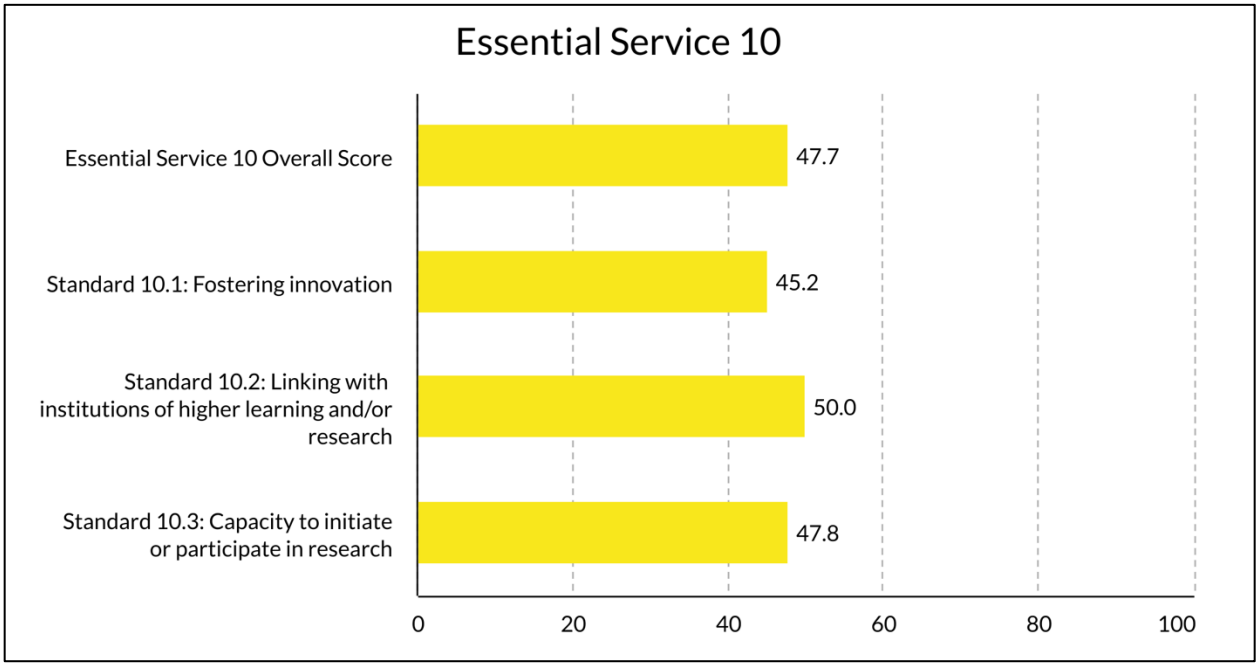
- Help community partners to educate their teams about outcomes and evaluation
- Look at the salaries for the Health Department in comparison to other health professions/areas to anticipate challenges in filling positions when pay scales are so different

## Essential Services 10: Research for new insights and innovative solutions to health problems

Essential Service 10 is composed of the following standards:

- 10.1: Fostering Innovation
- 10.2: Linking with Institutions of Higher Learning and/or Research
- 10.3: Capacity to Initiate or Participate in Research

### Survey Results




The overall score for Essential Service 10 (ES 10) based on responses by 18 survey responses was 47.7 and ranked 10th among scores for the 10 Essential Services. This puts this Essential Service in the "Moderate Activity" range indicating that Kane County's public health system "somewhat participates in this activity and there is opportunity for greater improvement." Individual scores for the standards making up ES 10 all scored in the "Moderate Activity" range.

## Essential Service 10 Current Activities Summary

To better understand Essential Service 10 performance in Kane County, an online group discussion was held on October 13, 2020. Seven stakeholders participated in the discussion including representation from Kane County Health Department, local hospital systems, non-profit organizations, and mental health services. Participants reviewed the ES 10 survey results and then engaged in discussions about current activities for the service. Based on these activities, participants then identified what they thought to be strengths, weaknesses, short-term improvement opportunities, and long-term improvement opportunities.

***Note:*** *The information captured in this table is based on what participants are aware of and may not be comprehensive for Kane County.*

**Standard 10.1, Fostering Innovation (Score: 45.2, Moderate Activity).** This standard explores the extent to which the public health system provides staff with time and resources to conduct studies to test new solutions, suggest ideas for new research, keep up current best practices in public health, and encourage community participatory research. Participants shared that the work of Kane Health Counts Action Teams has helped to foster some innovation and best practices and has potential to do more. Participants were pleased to share several innovative projects including a mobile health clinic to help reduce Emergency Department visits and unnecessary hospital visits. Another innovative project mentioned utilized volunteers from the Medical Reserve Corps (MRC) to bring lead testing in unincorporated areas of Kane County.

**Standard 10.2, Linking with Institutions of Higher Learning and/or Research (Score: 50.0, Moderate Activity).** This standard extent to which the local public health system establishes relationships and partnerships with colleges, universities, and other research organizations. Participants shared that there are existing partnerships with local universities and hospitals. Kane County participates in the Nurse Family Partnership, which is a national evidence-based program.

**Standard 10.3, Capacity to Initiate or Participate in Research (Score: 47.8, Moderate Activity).** This standard explores the extent to which the local public health system collaborates with researchers, supports research with necessary resources, shares findings with the community, and evaluates research efforts. Participants indicated that system partners try to bring research to different areas and more could be done. Partners do utilize social media to increase awareness of research opportunities among community members.

| ES 10: Research for New Insights and Innovative Solutions to Health Problems Current Activities Summary Table | |
|---|---|
| • Advocate Sherman partnered with state of IL on innovation: only hospital (1st in state) to have mobile integrated health | • Northwestern Medicine draws research into different areas of Kane County; use social media to make community members aware of opportunities |

| | |
|---|---|
| clinic to help reduce ER visits, unnecessary hospital visits<br>• Children's mental health grant includes evaluation of children health outcomes being conducted by Child & Family Health research team; results of this evaluation help to fuel innovation | • Kane Cares: Nurse Family Partnership (national research) program<br>• Share findings with community members via publications and social media |

### Essential Service 10 Strengths, Weaknesses, and Opportunities

Considering the standards that make up ES 10 and what they know to be currently in place, the participants identified strengths, weaknesses and opportunities for Kane County, which are summarized below.

| **Strengths** |
|---|
| • COVID created a unique way of coming together in ways that we wouldn't have before and helped forge new relationships<br>• Several large healthcare organizations in the county |
| **Weaknesses** |
| • Constraints of grant restrictions may not necessarily foster innovation |
| **Near-Term Improvement Opportunities** |
| • Add an innovation focus to Kane Health Counts Action Teams<br>• Collaborate between health system providers to understand and develop materials would be helpful for discussing vaccines with hesitant parents<br>• Look at research more strategically and seek to collaborate with universities and hospitals<br>• Become more adept at reaching audiences (especially younger populations) through social media |
| **Long-Term Improvement Opportunities** |
| • Look at what resources can be leveraged across hospitals and the public health system to support research and foster innovation |

## Conclusion

Kane County's Local Public Health System Assessment revealed a strong and well-functioning public health system with significant activity in completing the vast majority of the 10 Essential Public Health Services. The survey results combined with the insights captured during the follow up survey discussions reveal that the Kane County public health system is built on a

foundation of trust, a spirit of collaboration and a commitment to share resources to address identified needs.

The assessment revealed key areas of excellence for Kane County. The public health system includes a strong surveillance and monitoring system with timely submissions of disease information, coordination with state and national systems, and communication with local health and community providers. The local system's emergency preparedness efforts were noted for its efficiency in planning and execution, and communication with local hospitals, municipalities, and community partners. The public health system includes strong partnerships across many organizations. Kane Health Counts was consistently mentioned as providing leadership for collaboration around community health assessment and planning. Kane County Health Department was identified as a pillar for public health activities in the county, showing its commitment to the 10 Essential Public Health Services with attainment of accreditation and reaccreditation through the Public Health Accreditation Board.

Conversations throughout the assessment process underscored system partners concerns for local communities who may be more vulnerable to current and future health and public health threats. These include, but are not limited to, rural communities, African American communities, Latinx communities, those experiencing homelessness, immigrant and refugee communities, and LGBTQ communities. The county's public health system currently includes many practices to support diversity, equity, and inclusion. However more work in outreach and inclusion of these many communities was identified as a need to strengthen the system. Workforce development and more linguistically and culturally appropriate materials and practices were also expressed as efforts that could broaden the public health system's impact for vulnerable populations, especially in linking to personal health care services.

The COVID-19 pandemic and activities around civil unrest in 2020 exposed many of the strengths and areas for improvement for Kane County's public health system. COVID-19 further emphasized the disparities based on race, income, housing, and employment as well as needs for behavioral health services that existed prior to the pandemic. Emergency response systems were lauded by partners for efficient and effective communications across system partners. Community engagement efforts by the health department and other partners were also a highlight. However, difficulty implementing public health orders to mitigate spread of COVID-19 showed the need for clear guidance at the policy level and buy-in from policy makers, community members, and law enforcement.

The Local Public Health System Assessment showed that the Kane County public health system has built deep trust among current partners and a true spirit of collaboration. Some areas for broader collaboration that could benefit the system included workforce development, evaluation, and research and innovation. While individual agencies showed efforts in these areas, sharing findings and coordination of planning efforts across the system could help better inform future efforts and direct resources. The near and long-term opportunities identified and summarized in this report provide ideas for future strategic planning to improve the health

system's ability to deliver the 10 Essential Public Health Services and improve Kane County's public health system.

*Kane County*

# Forces Of Change Assessment 2020

Prepared by Conduent
Healthy Communities Institute

# Kane County Forces of Change Assessment Summary Report

## Background:

In 2020, Kane County Health Department and its Kane Health Counts partners conducted a comprehensive assessment of the health of Kane County. They used the Mobilizing Action for Planning and Partnerships (MAPP) model for community health assessment and planning.

The Focus of Change Assessment (FOCA) is one of four different assessments in the MAPP model that provides a comprehensive picture of health in the area. The FOCA focuses on identifying forces, otherwise considered trends, factors, or events, that are impacting health in Kane County and the opportunities and threats associated with these forces.

## Assessment Framework:

The following four categories were used as a framework for the assessment, with participants identifying and discussing forces within each of these categories of influence:

- Political
- Economic
- Technological
- Social

## Assessment Approach:

Kane Health Counts members helped to identify stakeholders with unique knowledge of and experience with the public health system to participate in four separate, one-hour online discussions centered on the four categories noted above.

Stakeholders represented a variety of public health system sectors including:

| | |
|---|---|
| Public Health | Higher Education |
| Hospitals/Health Systems | Local Cities |
| Mental Health | School Districts |
| Behavioral Health/Substance Abuse | Community Based / Social Services Organizations |

Online discussions were held as follows:

| Discussion Category | Date | Number of Participants |
|---|---|---|
| Political | 9/9/20 | 10 |
| Economic | 9/10/20 | 10 |
| Technology | 9/15/20 | 11 |
| Social | 9/17/20 | 10 |

Each discussion included stakeholders from Kane County as well as a neutral facilitator, content expert and note taker from Conduent Healthy Communities Institute (HCI). All participants received a Forces Work Sheet to pre-populate and send to HCI prior to their participation in the online discussion. HCI used information from the work sheets to develop an initial list of forces and pre-populate the discussion note sheet to start off each discussion.

The discussions included a brief overview of MAPP and purpose of the FOCA. Participants were then led through each of the forces populated on the note sheet and asked to provide their insights and perspectives as to:

- Clarification of the force (if needed)
- Addition of additional forces (if needed)
- Opportunities associated with each force
- Threats associated with each force

Notes were captured live during the online discussions and shown through the "share screen" feature of Microsoft Teams. This process allowed participants to ensure their thoughts were captured accurately and give them the chance to request adjustments to the notes in real time if needed.

## Analysis:

Following the FOCA, HCI representatives with experience in primary data analysis reviewed notes from the discussion and identified cross-cutting themes that transcend political, economic, technology, and social forces of change. Racial and economic disparities emerged out of each of the themes as communities of color and low-income community members were often cited as being most impacted by the threats discussed and being able to benefit by the opportunities identified.

## Cross Cutting Themes:

This section includes a table summarizing opportunities and threats identified for each cross-cutting theme and a brief summary of the main points brought up by participants in the discussions about each theme.

### COVID-19 Pandemic

| Opportunities | Threats |
|---|---|
| • Innovation and technology to provide services, reach hard-hit populations<br>• Targeted, culturally competent and linguistically appropriate messaging<br>• Increased access to mental/behavioral health | • Racial disparities and impact on different populations<br>• Limited stimulus money for businesses, elevated unemployment rates<br>• Record-level state and local budget deficits – CARES Act falls short of meeting needs |

| | |
|---|---|
| • Renewed focus and interest in physical fitness and exercise at home<br>• Community organizations working together to meet needs | • Impact of physical distancing on mental health<br>• Strain on local not-for-profits |

Not surprisingly, the COVID-19 pandemic was top of mind with each of the discussion groups. The impact of the pandemic on different racial and ethnic groups in the community was seen as both a threat as well as an opportunity to target efforts with culturally appropriate messaging. The mental health strain caused by physical distancing, especially on seniors and school-aged children and their parents, was universally noted as a concern. As the pandemic continues, the economic toll on businesses, local budgets and the workforce is considered a major threat to the well-being of the community. The CARES Act has been beneficial to some businesses, but not as far reaching as needed. Although there continues to be uncertainty around when a vaccine might be widely available and when the pandemic will end, the situation has fostered collaboration and innovation within the community.

## K-12 Education

| Opportunities | Threats |
|---|---|
| • Distance learning – students and teachers connect virtually<br>• Students increase independent learning skills<br>• Enhanced technology skills by both students and teachers<br>• Hybrid learning options<br>• Students can work at their own pace<br>• Address food insecurities for families<br>• More attention being paid to capital investments in technology | • Elevated stress experienced by students, parents and teachers<br>• Decreased social interactions<br>• Inconsistent parent engagement<br>• Unequal access to technology infrastructure – communities of color and low-income families have the least access<br>• Inability for teachers to fulfill their roles as mandated reporters to keep kids safe<br>• Strain on budgets – families and schools<br>• Burden on parents to work and also manage online education for their children<br>• Potential data privacy issues with online educational platforms |

Education and the changes necessary due to the COVID-19 pandemic occupied much of the discussions. Focusing on students of the K-12 education system, the benefits as well of pitfalls of distance learning were addressed. Technology to support learning outside the classroom represents both access to education and a challenge to teachers and students. Physical distancing, which is a driver of online education, keeps students and teachers safe from exposure to the virus, but denies them the opportunity for more meaningful engagement and

learning through in-person social interaction. Access to the needed infrastructure for successful distance learning, such as adequate internet speed and computers, often depend on the geographic region where the student lives, their racial/ethnic background and the economic status of their family.

## Access to Health Care including Mental/Behavioral Health

| Opportunities | Threats |
|---|---|
| • Increased use of telemedicine<br>• Payers reimbursing for more telemedicine visits<br>• FQHCs (Federally Qualified Health Centers) expanding into providing mental health services<br>• Mental health counseling/therapy expanding outside clinician office into community | • Technological access for underserved communities<br>• Lack of access for uninsured/underinsured populations<br>• Transportation barriers to get to in-person appointments<br>• Increased need for mental and behavioral health<br>• Patients do not have money to pay for needed medications<br>• Potential data privacy issues with more use of telemedicine |

Noting the connection of overall physical health and mental health to individual and community well-being, participants called out access to health care (including mental and behavioral health) as a theme that must be considered for future community health planning. There was energy and excitement around the expanded use of telemedicine to meet both primary care and mental health needs, but simultaneous acknowledgement that disparities exist between community members with access to technology/telemedicine, and those without. Additionally, transportation issues and lack of funds for medication are barriers to health. Expansion of mental health services (such as counseling and therapy into community places like churches, libraries and senior centers) will create expanded access to these vital service needs.

## Rising Poverty and Disparities

| Opportunities | Threats |
|---|---|
| • Work with communities that need services and support to enhance engagement and tailor interventions<br>• Promote trade programs and publicize job services in the community – apprenticeship positions pay students while they learn | • Gap between jobs vs. skills needed in the workforce<br>• Lack of affordable housing<br>• Digital divide between "the haves and the have nots" – low-income and minority populations impacted the most<br>• Low-paying jobs do not cover rent/necessities for living |

| | |
|---|---|
| • Local colleges offering classes/degrees/certifications to prepare the workforce<br>• Use data to better understand how certain communities and populations in the county are being impacted<br>• Target students to teach life skills such as personal finance<br>• Develop safe parks and walking paths<br>• Targeted interventions and policies to address communities facing disparities<br>• Create all-inclusive housing facilities for families to live and stay together<br>• Strong entrepreneurial skills in Latinx community | • Increase in homelessness – not enough shelters<br>• Workers that are not eligible for unemployment benefits – unable to provide for their families during the pandemic<br>• Unhealthy nutrition options – food deserts<br>• Lack of physical activity due to unsafe neighborhoods<br>• Low literacy levels of Latinx parents |

Participants viewed rising poverty and disparities in the community from the lens of "the haves and the have nots." Low-paying jobs, unaffordable housing and limited access to services are realities and threats facing low-income residents and communities of color. Providing the younger generation with higher education options as well as trade school programs is considered a step toward moving people out of generational poverty. Community organizations providing services for impacted populations can enhance their engagement and success by not just working "in" communities but working "with" communities. Advocacy efforts can be concentrated in high-risk neighborhoods to bring housing, education, employment, and healthy food options to help improve overall quality of life.

## Social Unrest and Black Lives Matter

| Opportunities | Threats |
|---|---|
| • Listen to the community<br>• Criminal justice reform<br>• Educate on bias and racism<br>• Enhance community engagement specifically with youth and members of the Black and Latinx communities<br>• Address health disparities which were highlighted by the COVID-19 pandemic<br>• The health system can be a leader in convening community dialogue and addressing issues | • Health and economic disparities based on race/ethnicity<br>• Broken immigration system<br>• Mistrust in healthcare<br>• Mistrust of police and government by community members<br>• Misunderstanding of minority communities<br>• Racial profiling<br>• Upcoming election<br>• Inconsistent State vs. Federal policies |

Social unrest and the Black Lives Matter movement were characterized in discussions as a wake-up call for community leaders. Economic and health disparities have long impacted communities of color. Recent events are further highlighting social injustices, particularly in the black community. Proactive engagement with different community groups, fueled by "active listening" by those in positions of power, are considered opportunities to channel energy to positively impact the community as a whole and invite to the table community members that have been oppressed. The upcoming presidential election is exacerbating the level of angst in communities due to a bipartisan divide, and the seeming inability of political leaders to work together. No matter who wins the election, the President will have to address a mounting federal deficit, which strains state and local leaders' abilities to invest in their communities to make needed changes.

## Conclusion:

The cross-cutting themes identified by the FOCA participants represent issues that will have implications for the local health system and the community of Kane County. As Kane Health Counts and other collaborative community efforts move forward with planning strategies to address community needs and improve the quality of life for all Kane County residents, solutions should take into consideration these cross-cutting themes.