SwedishAmerican Hospital and Medical Center - Belvidere

*Community Health Needs Assessment 2022-2024*

Approved by the Board of Trustees:
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Introduction

About SwedishAmerican Hospital
SwedishAmerican Hospital (SwedishAmerican) is a non-profit tax-exempt 501(c)3 entity that operates two acute care hospitals with a combined total of 373 licensed beds.

SwedishAmerican serves the greater Rockford region, Northern Illinois and Southern Wisconsin. The two hospital facilities include: SwedishAmerican Hospital (SAH), located in Rockford, Illinois in Winnebago County and Medical Center - Belvidere (SAMC), located in Belvidere, Illinois in Boone County. SAH is a teaching hospital that hosts the University of Illinois College of Medicine’s residency program.

Founded in 1911, SwedishAmerican has earned a reputation for its commitment to quality healthcare, including clinical excellence, outcome measurements and placing the needs and concerns of patients first. Many of the services offered include those aimed at improving the health of the community in which it operates with a focus on the elderly and the underserved. SwedishAmerican cares for its patients with:

- A dedicated and caring staff
- A major acute care hospital in Rockford
- A medical center in Belvidere
- The only heart hospital in the region
- The largest regional cancer center
- A network of primary care, immediate care and multi-specialty clinics
- A home healthcare agency
- A full spectrum of outpatient, wellness and education programs

About UW Health
SwedishAmerican Hospital is a subsidiary of UW Health (UWH), an academic medical center located in Madison, Wisconsin. SwedishAmerican is a significant referral area for UWH for tertiary and quaternary services not available at SwedishAmerican.

UWH has a tradition of excellence and innovation in the health sciences. From the first premedical "Special Science" course offered in 1887 through the opening in 1924 of Wisconsin General Hospital and the establishment in 1925 of a full four-year medical degree program at the university, UWH physicians and researchers have pursued their fourfold mission with vision and vigor.

As a healthcare organization, UWH exists for only one reason: their patients and their families. They are at the center of our work and our mission, values and our vision of remarkable healthcare reflect our promise to them. UWH mission is to advance healthcare without compromise through service, scholarship, science and social responsibility.
Community Health Needs Assessment Background

The Community Health Needs Assessment (CHNA) is a systematic data-driven approach to determine the health needs in the service area around SwedishAmerican. The Patient Protection and Affordable Care Act added Section 501(r) to the Internal Revenue Service Code, requiring non-profit hospitals, including SAH and SAMC to conduct a CHNA every three years. The federal requirements and guidelines in Section 501(r) include:

- Clearly defining the community served by the hospital, and ensuring that the defined community does not exclude low-income, medically underserved or minority populations in proximity to the hospital.
- Providing a clear description of the CHNA process and methods, community health needs, collaboration, including with public health experts, and a description of existing facilities and resources in the community.
- Receiving input from persons representing the broad needs of the community.
- Documenting community comment on the CHNA and health needs in the community.
- Documenting the CHNA in a written report and making it widely available to the public.

Collaboration

SAH and SAMC collaborated for the purposes of completing a CHNA. Both hospital facilities define their communities geographically in the same way, serve the same demographic and geographic areas, work with the same community organizations and strategic partners and currently work in the same arenas for community benefit activities. Additionally, SAH and SAMC are part of the same legal entity, SwedishAmerican, and share a leadership team and medical staff.

Executive Summary

Progress Since Previous CHNA & 2022 – 2024 Health Priorities

SwedishAmerican Hospital (SAH) and Belvidere Medical Center (SAMC) have completed this CHNA to identify community health priorities and make decisions on where to commit resources that can most effectively improve overall community health and wellness.

SAH and SAMC partnered with Advis, Inc. (hereinafter Advis), a third-party healthcare consulting firm, to conduct a systematic, data-driven approach to provide a CHNA that incorporated data from both qualitative and quantitative sources. Conducting this CHNA allows SAH and SAMC to better understand the unique needs, concerns and priorities of the community it serves. To complete this CHNA, the Advis team and SwedishAmerican leadership drew upon the 2020 Healthy Community Study conducted by the Rockford Regional Health Council for and internal information for primary data. Secondary data was collected from other agencies and organizations to provide insight into community health needs and priorities, challenges, resources, and potential solutions.
Health needs were identified across all socio-economic groups, races, ethnicities, ages and genders. Special considerations were made to ensure health disparities and the needs of medically underserved and uninsured populations were analyzed. While several health needs were identified throughout the development of this CHNA, SAH and SAMC prioritized health needs with the largest impact on the community as well as those that would be best addressed through a coordinated response from healthcare and community resources.

SAH and SAMC prioritized the following significant health needs, which are a continuation of the priorities from the 2019 CHNA. Below is a list of the identified health priorities for 2022-2024 as well as some of the impacts in these areas from the 2019 CHNA implementation plan:
Cancer
Cancer remains a top health priority for SwedishAmerican as it is a leading cause of death within the SwedishAmerican community service area. The percentage of deaths caused by cancer was 18.4% in Winnebago County and 17% in Boone County.

Since the 2019 CHNA, SwedishAmerican has implemented the following related to cancer care within the community:

- Expanded radiation oncology procedures not yet offered to patients in the service area to include Space OAR Program.
- Met patient education and perception goals for lung cancer clinical indicators.
- Completed National Accreditation Program for Breast Centers (NAPBC) standards, applied for and received accreditation.
- Participated in American Cancer Society “Real Men Wear Pink”.
- Provided keynote speaker at prostate cancer Annual Purple Tea Coalition.
- Provided patient education on aromatherapy for cancer patients, benefits of oncology rehabilitation, palliative care and the anti-inflammatory benefits of spices as a part of Cancer Survivor Week.

Obesity
The issues related to obesity remain two-fold: factors causing the development of obesity and the diseases that result from obesity. As determined through the 2020 Health Community Study and Survey, 12% of the survey participants were obese. Moreover, the survey included a self-assessment of the participants’ weight. Across all samples, “overweight” was the most common answer given by respondents.

According to the CDC, obesity is a leading cause of diabetes, hypertension, high cholesterol and heart diseases.\(^1\) Data indicates that there are high rates of diabetes, hypertension, high cholesterol and heart diseases in Winnebago and Boone Counties.

Since the 2019 CHNA, SwedishAmerican has implemented the following related to Obesity within the community:

- Created Employer Based Clinics (EBC) and Woodward Health Center (WHC).
  - Health Coaching
  - Walk with a coach at WHC
- Referred patients to New Directions weight loss program.
- Utilized Better Life Wellness (BLW) for corporate clients focused on wellness.
- Offered Grocery tours with a registered dietician.
- Offered HRA (health risk assessment) and wellness screenings with corporate clients (aggregate data reports include BMI (body mass index)).
- Held various wellness challenges.
- Prior to COVID restrictions offered Walk with a Doc.
- Ensured that BMI was obtained at every patient visit.
- Established questionnaire regarding activity level/exercise regimen at all wellness visits (pediatrics and adult).

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\(^1\) [https://www.cdc.gov/healthyweight/effects/index.html](https://www.cdc.gov/healthyweight/effects/index.html)
• Recommendations regarding lifestyle included in all assessment/plan for wellness visits (pediatrics and adult).
• EMR reminders for missing cholesterol screening; we start this at age 9 years old (pediatric population) and continue through adulthood.
• Partnership with Diabetes center/nutrition center for additional referrals as needed.

**Tobacco Cessation**
Approximately a quarter of adults in the region are current smokers, an increase from the last time the region was surveyed, but only 3% are regular smokers (smoke every day). The rate of adults in the region who currently smoke cigarettes is higher than the state and national findings, which only shows 15% of the population being current smokers.

Since the 2019 CHNA, SwedishAmerican has implemented the following related to Tobacco Cessation within the community:

• Tobacco use screening at all visits, tobacco cessation encouraged at all wellness visits.
• Provider education regarding Lung Cancer Screening for tobacco use history.
• Provider education regarding smoking cessation counseling.
• EMR reminders regarding need for Abdominal Aortic Aneurysm screening in males’ age 65+ with history of tobacco use.
• EMR reminders for Pneumonia vaccine in all patients with tobacco use.
• Smoking cessation program offered to EBC and BLW corporate clients.

**Poverty and Unemployment**
Approximately 14.6% of the total Winnebago County population lives in poverty, compared to the 11% of population that live in poverty in the State of Illinois. Moreover, both Boone and Winnebago counties have a significantly higher penetration of low-income residents compared to the penetration of low-income residents across the state. Specifically, Winnebago County has a 49.5% rate of penetration of low-income residents, and Boone County has a rate of 43.7% penetration of low-income residents. Comparatively, the State of Illinois has a rate of 38.8%.

Since the 2019 CHNA, SwedishAmerican has implemented the following related to Poverty and Unemployment within the community:

• Provided grants and resources to area non-profits that support unmet, basic needs in our service area such as:
  • $15,000.00 – Provide tutors for struggling students Pre-K to 12 in reading and math.
  • $17,735.00 – Counseling for those who have anxiety, depression, bullying, self-harm and suicide along with childhood trauma and abuse.
  • $6,265.00 – Youth weightlifting outreach which targets at-risk youth who live in poverty, have experienced trauma and struggle with social-emotional well-being.
  • $10,000.00 – Community partnership with Rockford East High School students to provide a new construction trades program.
  • $10,000.00 – Project name “Happy Kids are Healthy Kids” to provide students enrolled in summer camp cooking classes that taught them about making
healthier food options.

- $5,000.00 – Provide 24-hour medical advocacy at hospitals in Winnebago, Boone and Ogle counties. Staff and volunteers provided support, education, referrals and/or clothes to sexual assault survivors.
- $17,500.00 – Equip a home for relational mentoring with at-risk and justice-involved youth, ages 15-23.
- $5,000.00 – Provide field trip enrichment opportunities for inner city children ages 6-16.
- $11,188.65 – Improve the social and emotional well-being of school age kids through physical activity and strength training.
- $10,000.00 – Re-engage youth in outdoor activities that will improve their health and keep them safe and active. Also provides financial assistance to anyone in need that cannot afford the programs, team sports, lessons and camps.
- $6,609.00 – Purchase equipment for education and employment center at homeless shelter to help the unemployed get a job.
- $4,500.00 – Conduct a musical theatre to introduce children of color in poverty the skills learned from participating in musical theatre which offers future career opportunities in this field.
- $12,000.00 – Further development of the Juvenile Justice Ministry program.

**Access to Medical Care**

Access to medical care remains a challenge to the SwedishAmerican community for a wide range of reasons including transportation availability, communication barriers, clinic hours and supply and availability.

Since the 2019 CHNA, SwedishAmerican has implemented the following related to Access to Medical Care within the community:

- Provided $4 million per year to the University of Illinois College of Medicine family practice residency to educate physicians.
- Provided school physicals to Lincoln School (neighborhood school).
- Partnered with Rockford Fire Department to provide mobile integrated health outreach to community.
- Partnered with local FQHC's (federally qualified health centers) to assure access to hospital services.
- Contracted with all Medicaid Managed Care organizations to assure access to our physicians and hospital for all of the Medicaid population in our service area.
- Set a goal of 48% of new primary care patients seen within 10 days; currently at 45.86%.

**Vulnerable Populations: Hispanic/Latino Population**

The Hispanic and Latino population was identified as particularly vulnerable within the community, and especially impacted by adverse health issues and outcomes. For example, the survey indicated that compared to some other races, Hispanics have higher incidences of high cholesterol, arthritis, obesity and liver disease. Moreover, Hispanic adults were identified as more likely to be current drinkers in the region compared to other races.
Since the 2019 CHNA, SwedishAmerican has implemented the following related to the vulnerable Hispanic and Latino Populations and other underserved populations within the community:

- Created diversity, equity and inclusion committee to address diverse needs of our population – most recent project included providing hair care products to our African American inpatients.
- Participated on Rockford transit committee to make sure our patients have bus access to our hospital from anywhere in Rockford.
- Teamed up with two local hospitals to provide better in-person sign language interpreter access.
- Employed in-person Spanish interpreters.
- Maintain 40 video interpreter computers that provide interpretation in over 200 languages available to the entire hospital.

**Heart Care**
The SwedishAmerican community service area leading causes of death include heart disease, with 21% of deaths in Winnebago County, and 19.3% of deaths in Boone County caused by heart disease.

Since the 2019 CHNA, SwedishAmerican has implemented the following related to Heart Care within the community:

- Created and sustained a Heart Institute: Recruited a complete cardiology team, renovated the clinic space for expansion and increased the number of providers.
- Expanded Cardiac Catheterization Labs.
- Offered full-time pediatric general cardiology services and some pediatric electrophysiology services in Rockford.

**Maternal/Prenatal/Early Childhood Health**
Maternal, Prenatal and Early Childhood health continue to be a top priority for SwedishAmerican as a large portion of the SwedishAmerican diagnoses-related groups from 2019-2021 were related to Pregnancy, Childbirth & the Puerperium, coupled with the fact that Winnebago County has a teen pregnancy rate much higher than the state average.

Since the 2019 CHNA, SwedishAmerican has implemented the following related to Maternal/Prenatal/Early Childhood Health within the community:

- Completed a new patient tower for Women and Children.
- Converted the 10 bed special care nursery to a NICU and added 14 additional NICU beds to offer 24 NICU beds to our patients.
- Offered donor breast milk program including a drop-off site for donors.
- Promoted bonding between birth mom and child with rooming together.
- Supported and educated patients on breastfeeding.
Substance Abuse
The percentage of adults in the region that reported using drugs is around 27%. Adults reporting using/illegally using a wide variety of illicit drugs including marijuana or TCH products, prescription opioids, cocaine, amphetamines and heroin.

Since the 2019 CHNA, SwedishAmerican has implemented the following related to combating substance abuse within the community:

- Implemented state grant for opioid response to create program named Screening, Outreach, Linkage And Referral At SwedishAmerican (SOLARAS).
- SOLARAS has connected with local FQHC’s, mental health providers and substance abuse organizations to create referral source for treatment.
- SOLARAS peer recovery specialists have been hired to assist with warm hand-off from treatment to local support services. Staff participate in warm hand-off meetings and have hired a case manager to assist with community involvement and connectivity to support services.
- SOLARAS staff have created a relationship with Remedies, a local support group for addiction and recovery, to address women’s needs to address housing and violence.
- Collaboration between SOLARAS staff and our Women and Children’s services staff to participate on Opioid committee and develop a screening tool to identify high risk patients and reduce narcotic use after surgery.

The health priorities from the 2019 CHNA are continuing for the 2022-2024 CHNA and SAH and SAMC will develop a three-year implementation plan to address some of the most crucial health needs of the population defined within its community service area. The findings from this CHNA will determine how best to commit resources to address priority health needs that improve the overall health and well-being of its community.
Identification of the Swedish American Community Service Area

Defining the community is a key component of the CHNA process as it determines the scope of the assessment and implementation strategy. The Swedish American Community Service Area (“CSA”) is located approximately 85 miles northwest of Chicago, Illinois and is comprised of both Boone and Winnebago counties.

Figure 1. Swedish American Community Service Area

Per the 2020 Census, Winnebago County has a population of approximately 283,000 residents while Boone County has a population of 53,000 residents. Together this represents a total population of just over 337,000 for the Swedish American CSA, which is approximately 2.7% of the entire population of the State of Illinois.
Table 1. Total Population in the SwedishAmerican Community Service Area vs. State and National Benchmarks

<table>
<thead>
<tr>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnebago County 283,758</td>
</tr>
<tr>
<td>Boone County 53,428</td>
</tr>
<tr>
<td>State of Illinois 12,716,145</td>
</tr>
<tr>
<td>United States 331,449,281</td>
</tr>
</tbody>
</table>

via Census.gov

Boone and Winnebago counties consist of 33 total zip codes. SwedishAmerican determined 83.3% of its patient population from both inpatient, outpatient and emergency department visits in CY2020 and CY2021 resided in one of the 33 zip codes of Boone and Winnebago counties.

Table 2. SwedishAmerican Patient Origin Distribution by Top 20 Zip Codes

<table>
<thead>
<tr>
<th>ZIP Code</th>
<th>Patient Count</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>61008</td>
<td>25,619</td>
<td>9.04%</td>
</tr>
<tr>
<td>61107</td>
<td>22,182</td>
<td>7.83%</td>
</tr>
<tr>
<td>61108</td>
<td>21,752</td>
<td>7.68%</td>
</tr>
<tr>
<td>61109</td>
<td>20,216</td>
<td>7.13%</td>
</tr>
<tr>
<td>61103</td>
<td>17,590</td>
<td>6.21%</td>
</tr>
<tr>
<td>61104</td>
<td>16,462</td>
<td>5.81%</td>
</tr>
<tr>
<td>61101</td>
<td>15,419</td>
<td>5.44%</td>
</tr>
<tr>
<td>61111</td>
<td>15,056</td>
<td>5.31%</td>
</tr>
<tr>
<td>61102</td>
<td>13,941</td>
<td>4.92%</td>
</tr>
<tr>
<td>61115</td>
<td>13,474</td>
<td>4.75%</td>
</tr>
<tr>
<td>61073</td>
<td>11,568</td>
<td>4.08%</td>
</tr>
<tr>
<td>61114</td>
<td>10,928</td>
<td>3.86%</td>
</tr>
<tr>
<td>61072</td>
<td>6,565</td>
<td>2.32%</td>
</tr>
<tr>
<td>61065</td>
<td>6,473</td>
<td>2.28%</td>
</tr>
<tr>
<td>61010</td>
<td>5,901</td>
<td>2.08%</td>
</tr>
<tr>
<td>61068</td>
<td>5,225</td>
<td>1.84%</td>
</tr>
<tr>
<td>61080</td>
<td>4,458</td>
<td>1.57%</td>
</tr>
<tr>
<td>61088</td>
<td>3,600</td>
<td>1.27%</td>
</tr>
<tr>
<td>61016</td>
<td>3,189</td>
<td>1.13%</td>
</tr>
<tr>
<td>61032</td>
<td>3,020</td>
<td>1.07%</td>
</tr>
</tbody>
</table>

via SwedishAmerican Internal Data
The majority of the SwedishAmerican patient population is clustered around the Rockford and Belvidere areas.

Figure 2. SwedishAmerican Patient Origin Heat Map

Process, Methodology and Limitations

Review of Qualitative and Quantitative Data
The Advis team conducted a quantitative data review using previously published community health needs assessments and other reports focused on health in Boone and Winnebago counties. Findings from previous CHNAs and progress reporting on initiatives launched in response were incorporated into project design and analysis in this report where applicable.

Advis used a diverse approach to data collection and analysis. Both qualitative and quantitative measures are drawn from primary and secondary data sources to ensure a comprehensive understanding of the health needs and potential for SwedishAmerican to address those needs in collaboration with community partners.
CHNA development began with collection and examination of quantitative data from secondary sources. Unless otherwise specified all data were accessed from the US Census Bureau, HRSA, CDC Wonder, UDS Mapper, Federal Reserve Economic Data, Definitive Healthcare and National Center for Health Statistics.

The most recent data available from these sources were examined in aggregate and by county across several dimensions, including socio-economic, socio-demographic, health risk behaviors, access to care and clinical outcomes. Advis subsequently obtained internal SwedishAmerican data and conducted various descriptive and quantitative analyses.

**Healthy Community Study**
SwedishAmerican partnered with the Rockford Regional Health Council (RRHC) to complete the 2020 Healthy Community Study (2020 Healthy Community STUDY | Rockford Regional Health Council (rockfordhealth.org). The Rockford Regional Health Council is comprised of steering committee partners from several health and community organizations including the Boone County Health Department, Mercyhealth, OSF, SwedishAmerican Health System, Transform Rockford, United Way of Rock River Valley, University of Illinois College of Medicine Rockford, Department of Family and Community Medicine and the Division of Health Policy and Social Science Research. Data collection was gathered using surveys distributed on paper and digitally. The paper and digital versions of the survey were available in English and Spanish. Respondents included a wide cross section of residents in Boone and Winnebago counties. This cross section includes residents of units operated by the Rockford Housing Authority, Winnebago County Housing Authority and Zion Development; parents/guardians of students in the Harlem School District and Belvidere District 100; a purchased list of email and physical addresses for 13,000 residents of Boone and Winnebago Counties; clients of Crusader Clinic and Northern Illinois Food Bank; and people who learned about the survey on social media platforms. Please see Appendix A for a full description of survey methodology.

**Analysis**
The first stage of the analysis involved comparing community health indicators and various measures of social determinants of health using publicly available secondary data sources. The Advis team compared rates and statistics with those from other State and National sources to identify needs. Additionally, Advis compared these needs to the current SwedishAmerican scope of services and utilization rates to identify various strengths and weaknesses. Primary data from SwedishAmerican provided additional information to supplement the analysis of health needs. Advis calculated patient origin statistics and analyzed facility, service line, payer type and HCPS/CPT code data where applicable. Additionally, Advis used the findings in the Rockford Regional Health Council Healthy Community Study to inform and support all analyses found within this CHNA.

**Information Gaps**
Every attempt was made to collect relevant and recent primary and secondary data reflecting the health status and social determinants of health in the SwedishAmerican community. In some cases, the ability of SwedishAmerican to assess all community health needs may have been limited by a lack of existing or recent small area estimate information pertaining to Boone and Winnebago Counties. Additionally, data collection, responses and findings may have been impacted by the COVID-19 pandemic. Advis and SwedishAmerican made efforts to combat any impact from the COVID-19 pandemic through additional data collection and validation as well as altering statistical methods and analyses where applicable.
Analysis

This section explores the demographic, social, economic and health profiles of the SwedishAmerican CSA. The demographics of a community significantly impact its health profile. Different racial, ethnic, age and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts.

Demographic Profile

Individuals between ages 18 and 64 (working-aged adults) constitute 59.4% of the total population in Boone County and 58.7% of the total population in Winnebago County. Of the remaining population, 16.1% are ages 65 and older and 24.5% are under 18 in Boone County, and 18% are ages 65 and older and 23.34% are under 18 in Winnebago County. Overall, the population aged 65 and older in Winnebago County is slightly higher than that of Boone County and even higher than that of the State of Illinois.

Table 3. Age Distribution by County vs State and National Benchmarks

<table>
<thead>
<tr>
<th></th>
<th>Persons under 18 (#)</th>
<th>Persons 18-64 (#)</th>
<th>Persons 65+ (#)</th>
<th>Persons Under 18 (%)</th>
<th>Persons 18-64 (%)</th>
<th>Persons 65+ (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnebago County</td>
<td>86,487</td>
<td>167,500</td>
<td>51,363</td>
<td>23.3%</td>
<td>58.7%</td>
<td>18.0%</td>
</tr>
<tr>
<td>Boone County</td>
<td>13,095</td>
<td>31,748</td>
<td>8,605</td>
<td>24.5%</td>
<td>59.4%</td>
<td>16.1%</td>
</tr>
<tr>
<td>State of Illinois</td>
<td>2,844,377</td>
<td>7,905,317</td>
<td>2,062,814</td>
<td>22.2%</td>
<td>61.7%</td>
<td>16.1%</td>
</tr>
<tr>
<td>United States</td>
<td>73,913,190</td>
<td>202,846,960</td>
<td>54,689,131</td>
<td>22.3%</td>
<td>61.2%</td>
<td>16.5%</td>
</tr>
</tbody>
</table>

via Census.gov
The majority of the population in Boone County identified as White (72%). The next largest race is Hispanic (22%), followed by Black (3%).

Figure 3. Race in Boone County

The majority of the population in Winnebago County identified as White (68%). The next largest races are Hispanic (13%) and Black (13%) followed by Asian (3%) and Other (3%).

Figure 4. Race in Winnebago County
Boone County has a higher Hispanic population than Winnebago County. Both Counties reported slightly lower Hispanic populations than the state and national metrics.

**Table 4. Ethnicity by County vs. State and National Benchmarks**

<table>
<thead>
<tr>
<th></th>
<th>Hispanic Population</th>
<th>Hispanic Population Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boone County</td>
<td>11,879</td>
<td>13.1%</td>
</tr>
<tr>
<td>Winnebago County</td>
<td>37,121</td>
<td>9.9%</td>
</tr>
<tr>
<td>State of Illinois</td>
<td>2,190,696</td>
<td>17.2%</td>
</tr>
<tr>
<td>US Hispanic Population</td>
<td>62,100,000</td>
<td>18.7%</td>
</tr>
</tbody>
</table>

via Census.gov

Boone County has approximately 8,500 individuals with a primary language of Spanish. This represents 16.9% of the population and is significantly higher than Winnebago and State percentages.

**Table 5. Languages by County vs. State and National Benchmarks**

<table>
<thead>
<tr>
<th></th>
<th>Only English</th>
<th>Spanish</th>
<th>Indoeuropean</th>
<th>Asian Pacific</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnebago County</td>
<td>227,035</td>
<td>25,353</td>
<td>5,344</td>
<td>4,248</td>
<td>3,969</td>
</tr>
<tr>
<td>Boone County</td>
<td>40,707</td>
<td>8,515</td>
<td>677</td>
<td>370</td>
<td>113</td>
</tr>
<tr>
<td>State of Illinois</td>
<td>9,207,670</td>
<td>1,596,614</td>
<td>665,950</td>
<td>355,983</td>
<td>134,408</td>
</tr>
</tbody>
</table>

via Census.gov

**Table 6. Language Percentages by County vs. State and National Benchmarks**

<table>
<thead>
<tr>
<th></th>
<th>Only English</th>
<th>Spanish</th>
<th>Indoeuropean</th>
<th>Asian Pacific</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnebago County</td>
<td>85.4%</td>
<td>9.5%</td>
<td>2.0%</td>
<td>1.6%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Boone County</td>
<td>80.8%</td>
<td>16.9%</td>
<td>1.3%</td>
<td>0.7%</td>
<td>0.2%</td>
</tr>
<tr>
<td>State of Illinois</td>
<td>77.0%</td>
<td>13.3%</td>
<td>5.6%</td>
<td>3.0%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

via Census.gov

**Social/Economic Profile**

Boone County has an average per capita income of approximately $51,000, while Winnebago has a slightly lower average per capita income of around $47,000. The per capita income in Boone County is slightly higher than the state average, whereas the per capita income in Winnebago County is slightly lower than the state average of $50,000.
Figure 5. State of Illinois County Per Capita Income Heat Map

via fred.stlouisfed.org
Figure 6. Per Capita Income Boone and Winnebago Counties

Approximately 14.6% of the total Winnebago County population live in poverty. This is significantly higher than the total population living in poverty in Boone County and higher than the population living in poverty across both the state and county.

Table 7. Poverty Rates by County vs. State and National Benchmarks

<table>
<thead>
<tr>
<th></th>
<th>Total Population in Poverty</th>
<th>Percent Poverty - 18 to 64</th>
<th>Percent Poverty - Under 18</th>
<th>Median Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnebago County</td>
<td>14.5%</td>
<td>10.1%</td>
<td>15.5%</td>
<td>$55,310</td>
</tr>
<tr>
<td>Boone County</td>
<td>6.8%</td>
<td>8.6%</td>
<td>12.3%</td>
<td>$70,396</td>
</tr>
<tr>
<td>State of Illinois</td>
<td>11.0%</td>
<td>10.7%</td>
<td>15.3%</td>
<td>$68,428</td>
</tr>
<tr>
<td>United States</td>
<td>11.4%</td>
<td>10.4%</td>
<td>16.1%</td>
<td>$64,994</td>
</tr>
</tbody>
</table>

via Census.gov
Poverty is defined as the percent of low-income residents living below 200% of the Federal Poverty Level in the county. The higher the figure, the more low-income residents. Both Boone and Winnebago counties see a significantly higher penetration of low-income residents vs. the penetration of low-income residents across the state.

Figure 7. Penetration of Low Income by County vs. State
Both Boone County and Winnebago County have lower percentages of the population with high school degrees compared to both state and national percentages. Similarly, both Boone County and Winnebago County have significantly lower percentages of the population with bachelor’s degrees or higher compared to both state and national percentages.

Table 8. Education Rates by County vs. State and National Benchmarks

<table>
<thead>
<tr>
<th></th>
<th>25+ High school graduate or higher</th>
<th>25+ Bachelor's degree or higher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnebago County</td>
<td>87.8%</td>
<td>23.0%</td>
</tr>
<tr>
<td>Boone County</td>
<td>86.7%</td>
<td>24.2%</td>
</tr>
<tr>
<td>State of Illinois</td>
<td>89.7%</td>
<td>35.5%</td>
</tr>
<tr>
<td>United States</td>
<td>88.5%</td>
<td>32.9%</td>
</tr>
</tbody>
</table>

via Census.gov

Winnebago County has a medically underserved area (MUA 7011). The MUA designation is developed by the Health Resources and Services Administration (HRSA) and indicates that a combination of four components exists in the area:

- A low ratio of primary medical care physicians per 1,000 population.
- A high infant mortality rate.
- A high percentage of the population with incomes below the poverty level.
- A high percentage of the population age 65 or over.

**Health Outcomes**

This section explores various health outcomes identified through secondary data sources in the Swedish American CSA. These health outcomes illustrate how the conditions in which people are born, grow, work, live and age ultimately impact individual and community health.

The Swedish American CSA lies within the 40420 (Rockford, IL) Core-Based Statistical Area (“CBSA”). A CBSA is a U.S. geographic area defined by the Office of Management and Budget (OMB) that consists of one or more counties (or equivalents) anchored by an urban center of at least 10,000 people plus adjacent counties that are socioeconomically tied to the urban center by commuting.

The Swedish American CBSA has a Hierarchical Condition Categories (HCC) Risk Score of 1.02. The CMS-HCC risk score for a beneficiary is the sum of the score or weight attributed to each of the demographic factors and HCCs within the model. The CMS-HCC model is normalized to 1.0 (the national average). Beneficiaries would be considered relatively healthy, and therefore less costly, with a risk score less than 1.0. Thus, the beneficiaries in the Swedish American CBSA are considered slightly less healthy and more costly compared to the national average (approximately a 1.09% difference).
Figure 8. CMS-HCC Risk Score Rockford CBSA vs. State

via CMS.gov
Other key findings from across the CBSA include a higher number of emergency department visits per 1,000 beneficiaries compared to the national average. Additionally, the number of emergency department visits and number of acute hospital readmissions at SwedishAmerican make up 1% of all emergency department visits and number of acute hospital readmissions throughout the county. Finally, the hospital readmission rate for the CBSA is consistent with the national average.

Table 9. CBSA Metrics vs. National Benchmarks

<table>
<thead>
<tr>
<th>Metric</th>
<th>Rockford, IL CBSA</th>
<th>National Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Visits</td>
<td>21,375</td>
<td>17,332,356</td>
</tr>
<tr>
<td>Emergency Department Visits per 1000 Beneficiaries</td>
<td>573</td>
<td>535</td>
</tr>
<tr>
<td>Number of Acute Hospital Readmissions</td>
<td>1,504</td>
<td>1,212,308</td>
</tr>
<tr>
<td>Hospital Readmission Rate</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

via Definitive Healthcare (defintivehc.com)

The SwedishAmerican CSA leading causes of death include heart disease, influenza and pneumonia, kidney disease, accidents, chronic lower respiratory diseases, Alzheimer’s, cancer, COVID-19 and diabetes.

Table 10. Leading Causes of Death by County vs. State Benchmarks

<table>
<thead>
<tr>
<th></th>
<th>Heart Disease (#)</th>
<th>Heart Disease (%)</th>
<th>Influenza and pneumonia (#)</th>
<th>Influenza and pneumonia (%)</th>
<th>Kidney disease (#)</th>
<th>Kidney disease (%)</th>
<th>Accidents (%)</th>
<th>Accidents (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnebago County</td>
<td>732</td>
<td>21.0%</td>
<td>52</td>
<td>1.5%</td>
<td>86</td>
<td>2.5%</td>
<td>6.5%</td>
<td>226</td>
</tr>
<tr>
<td>Boone County</td>
<td>94</td>
<td>19.3%</td>
<td>9</td>
<td>1.8%</td>
<td>9</td>
<td>1.8%</td>
<td>5.9%</td>
<td>29</td>
</tr>
<tr>
<td>State of Illinois</td>
<td>27,466</td>
<td>20.7%</td>
<td>2,430</td>
<td>1.8%</td>
<td>2,651</td>
<td>2.0%</td>
<td>5.4%</td>
<td>7,159</td>
</tr>
</tbody>
</table>

via dph.illinois.gov
Within the CSA, chronic health conditions, particularly cancer, chronic lower respiratory disease, kidney disease and heart disease, were shown to be among the leading causes of death higher than the state average.

Figure 9. Cancer Causes of Death by County vs. State Benchmarks

via dph.illinois.gov
Figure 10. Chronic Lower Respiratory Disease Cause of Death by County vs. State Benchmarks

via dph.illinois.gov
Figure 11. Kidney Disease Cause of Death by County vs. State Benchmarks

Heart Disease Mortality (%)

<table>
<thead>
<tr>
<th>Winnebago County</th>
<th>Boone County</th>
<th>State of Illinois</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.0%</td>
<td>19.3%</td>
<td>20.7%</td>
</tr>
</tbody>
</table>

via dph.illinois.gov
Figure 12. Heart Disease Cause of Death by County vs. State Benchmarks

via dph.illinois.gov
Additionally, it was identified that the teen birth rate in Winnebago County is significantly higher than the State average.

Figure 13. Teen Birth Rate vs. State Average
Other health conditions of note include the fact that the prevalence of diabetes and obesity are approximately equal to or higher than the state averages.

Figure 14. Diabetes Prevalence vs. State Average

via datausa.io
Figure 15. Obesity Prevalence vs. State Average

via datausa.io
Access to primary care remains a challenge within the SwedishAmerican CSA for both Boone and Winnebago counties. While Boone County primary care physicians see an average of 1,847 patients per year (a 3.53% increase from the previous year), Winnebago county primary care physicians see 1,340 patients per year on average (a 4.96% decrease from the previous year). It should be noted that in Winnebago County, dentists see 2,975 patients per year and mental health providers see 2,328 patients per year.

Figure 16. Patient to Primary Care Physician Rations in the SwedishAmerican CSA and neighboring counties
Within the SwedishAmerican CSA, 95% of all outpatient encounters fall into one of the following categories: Pathology and Laboratory Procedures, Medicine Services and Procedures, Cancer Procedures, Radiology Procedures, Surgery, Professional Services, and Evaluation and Management Services. This distribution is consistent with the percentages.

Figure 17. Percentage of Types of Procedures within SwedishAmerican CSA

via dph.illinois.gov
Additionally, SwedishAmerican currently treats patients dealing with the chronic diseases and conditions most prevalent throughout the CSA. An analysis of patient visit data between 2019-2021 shows that approximately 60% of all SwedishAmerican patient visits fall within the following DRG categories:

- Pregnancy, Childbirth & the Puerperium
- Diseases & Disorders of the Circulatory System
- Diseases & Disorders of the Musculoskeletal System and Connective Tissue
- Diseases & Disorders of the Respiratory System
- Endocrine, Nutritional & Metabolic Diseases & Disorders

![Figure 18. Top DRGs and percent of total for SwedishAmerican Patients from 2019-2021](image)

As the figure above demonstrates, SwedishAmerican already does a substantial amount of work to treat and care for patients dealing with some of the chronic conditions and health concerns identified as key priorities for 2022-2024.
As stated above, SwedishAmerican partnered with the Rockford Regional Health Council to complete the 2020 Healthy Community Study. Through qualitative analysis, Advis and SwedishAmerican identified key parts of the 2020 Healthy Community Study for inclusion in this CHNA. The key findings and other supporting information from the Study are contained in the following section.

**The demographics of the 2020 Healthy Community Survey respondents were as follows:**

**Age**
- 31% (30 to 44)
- 38% (46 to 64)
- 18% (65 to 74)

**Race**
- 46% (White)
- 33% (Other)
- 15% (Black or African American)

**Education**
- 20% (high school diploma or GED)
- 26% (graduate or professional degree)

**Living Situation by Type**
- 28% (married couple)
- 21% (single person, living alone)
- 21% (married couple with children)

**Annual Household Income**
- 11% (Less than $10,000)
- 16% ($50,001 - $75,000)
- 14% ($100,001+)
Housing by Type
- 44% (own)
- 29% (rent)
- .5% (homeless)

Employment Status by Type
- Self
  ◇ 9% (self-employed)
  ◇ 21% (full-time job)
  ◇ 14% (not employed, not looking for work)
- Others
  ◇ 9% (self-employed)
  ◇ 28% (full-time job)
  ◇ 4% (not employed, not looking for work)

Zip codes with highest response rates
- Belvidere (61008)
- Rockford (61107)
- Rockford (61103)

It is clear from these demographics that the survey respondents were compromised of a diverse population within the community and represent several different perspectives. Understanding local context and history, it was anticipated that the residents of the region identifying as white in the Report Area would have more access to and options for healthcare. The results of the data analysis reinforced this expectation: there is a racial divide in the report area in terms of access, quality, options and opinion of care. Looking at the data in aggregate, even accounting for the survey population demographics, the white population clearly has greater access to and options for care.

One of the most consistent trends seen throughout the survey was the correlation of education level with adverse health outcomes. The relationship was generally inverse – meaning that lower levels of education were associated with higher levels of disease or poor outcomes – but in many of the relationships, the level of correlation was different in those with an associate degree or higher than the level of correlation in those with some college, but no degree or less. Income had a similar correlation in most areas, most likely because income is correlated with education. For the purposes of this report, we focused on education since education has been proven to result in people getting higher paying jobs.
Figure 19 shows the demographic group with the highest and lowest performing scores in each of the survey items listed below. Blue indicates lowest performing score and green indicates best performing score. Where two or more groups within a demographic category share the highest or lowest score, both are filled in.

**Figure 19. Comparison Findings Between Demographic Groups**
**Chronic Conditions and Disease**
According to the CDC, chronic disease is defined as, “conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both.”

The chronic conditions and diseases most prevalent in the CSA were determined through the survey to be as follows:

1. **High blood pressure, hypertension (20%)**
   Demographic callouts include:
   a. Men
   b. Whites and Asians
   c. Adults age 45 and older, especially those age 45 - 64

2. **High cholesterol (15%)**
   Demographic callouts include:
   a. Men
   b. Whites and Asians; Hispanics more than blacks
   c. Adults age 45 and older, especially those age 45 - 64

3. **Arthritis or rheumatism (14%)**
   Demographic callouts include:
   a. Men
   b. Asians > Whites > Blacks >
   c. Hispanics
   d. Adults age 45 and older

4. **Obesity (12%)**
   Demographic callouts include:
   a. Whites & Hispanics
   b. Men & Women
   c. Adults age 45 - 64

5. **Chronic back pain/disc disorders (10%)**
   Demographic callouts include:
   a. Men
   b. Asians & whites
   c. Adults age 45 – 64 years of age
Survey respondents were asked to report whether they had ever been diagnosed with any of 16 different conditions, in addition to an “other” option. Further analysis of responses regarding the five diseases and/or conditions most prevalent in the region’s total population (all ages), in descending order, are:

1. High blood pressure, hypertension (20%)
2. High cholesterol (15%)
3. Arthritis or rheumatism (14%)
4. Obesity (12%)
5. Chronic back pain or disc disorders (10%)

Respondents were not only asked about their own health and behaviors, they were asked about diseases/conditions and behaviors among all members of their household, including any children. When analyzing survey responses, the five conditions with the highest rates of occurrence were the same among adults as they were among the total population (including those under the age of 18). However, the rates of prevalence were higher among adults than the overall population. This is not surprising since the prevalence of most of these conditions is lower among children than adults. The conditions with the five highest rates of prevalence among adults in the region were:

1. High blood pressure, hypertension (25%)
2. High cholesterol (18%)
3. Arthritis or rheumatism (17%)
4. Obesity (13%)
5. Chronic back pain or disc disorders (12%)

There was a direct relationship between the age of the population group and the prevalence of disease. In other words, the older the group being measured, the higher the prevalence of the condition or disease. This was true for all 16 diseases/conditions being observed except one: asthma. The prevalence of asthma across age groups was highest in those under the age of 18, at about 3%. Among everyone with asthma, out of all four age groups, the one with the highest rate of asthma was 0 - 17-year-olds: 13% of everyone under the age of 18 was diagnosed with asthma. One-third of everyone in the region diagnosed with asthma was under the age of 18.
Each of the conditions and diseases of interest was correlated with one or more different demographics and characteristics. The following relationships were observed with each condition and/or disease:

**Alzheimer’s, dementia or severe memory impairment**
- Whites
- Men
- Adults age 65 and older

**Arthritis or rheumatism**
- Men
- Asians > Whites > Blacks > Hispanics
- Adults age 45 and older

**Asthma**
- Blacks
- Children/people under the age of 18
- Adults age 45 - 64 years old

**Cancer or malignant neoplasms**
- Both men and women
- Asians and whites
- Risk and prevalence increases with age; greatest among adults age 65 and older

**Chronic back pain or disc disorders**
- Men
- Asians and whites
- Adults age 45 - 64 years of age
Chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis and other respiratory problems

- Men
- Whites
- Adults age 45 - 64 years of age (affects almost half of people in this age range)

Chronic digestive or stomach disorders (such as gastroesophageal reflux disease (GERD), reflux or Crohn's disease)

- Men
- Whites and blacks
- Adults age 45 - 64 years of age (affects almost half of people in this age range)

Heart attack, angina or coronary heart disease

- Men
- Adults age 45 and older

High blood pressure, hypertension

- Men
- Whites and Asians
- Adults age 45 and older, especially those age 45 - 64

High cholesterol

- Men
- Whites and Asians; Hispanics more than blacks
- Adults age 45 and older, especially those age 45 - 64
Kidney disease

- Men
- Asians
- Risk and prevalence increase with age; greatest among adults age 65 and older

Liver disease

- Men
- Hispanics
- Adults age 18 – 64, especially those between the ages of 45 - 64

Obesity

- Whites & Hispanics
- Men & women
- Adults age 45 - 64

Stroke

- Men
- Adults age 65 and older

The relationships between race/ethnicity and chronic disease can be observed by using the Disparity Index. The Disparity Ratios demonstrate the long-term impacts of the social determinants of health (SDOH) by showing the differences in rates of disease between blacks and whites or Hispanics and whites, respectively. For example, a Black:White Disparity Ratio for cancer equal to 1 indicates that the rates of cancer are equal between races. A Black:White Disparity Ratio for cancer equal to 2 would indicate that blacks experience cancer at a rate that is double the rate of whites in the region. A Black:White Disparity Ratio for cancer equal to 0.5 would indicate that blacks in the region experience cancer at half the rate of whites. The Disparity Index for Chronic Diseases below is a simple way to compare these rates and is organized in order of greatest to least amount of disparity.
The disparities between whites and Hispanics are clearly not as stark as those between blacks and whites. This indicates that blacks experience more disparity when it comes to chronic disease outcomes than other races/ethnicities.

**Figure 20. Chronic Disease Disparity Index**

![Graph showing chronic disease disparity index between Black-White and Hispanic-White disparity ratios.](image)

*via Rockford Regional Health Council Healthy Community Study*

**Behavioral Health**

Approximately 60% of survey respondents answered the survey questions about mental and behavioral health. The self-reported zip codes were varied, indicating no clear tie between neighborhood and willingness to discuss mental or behavioral health concerns. However, self-reported drug and alcohol use were higher in 61104, 61102 and 61115 – each of these communities is known to have lower median household incomes and lower levels of education than the rest of the CSA.

This suggests that there may be a relationship between behavioral health and one of the characteristics prevalent in all of these areas. Interestingly, there was a trend in skipping certain questions; white respondents selected “prefer not to answer” far less frequently on questions related to substance use than all other racial groups. Additionally, those with less than a high school degree and women reported prescription drug use more often.
Of the respondents, just over 60% answered the behavioral and mental health questions. Of the total population:

- Approximately one quarter (27%) reported at least one mental illness or behavioral health issue
- 30% of respondents were male and 70% were female

The region’s rates are comparable to State and National findings, which show that 1 in 5 adults have been diagnosed with depression or a related disorder. Of those that responded, the disorders with the highest rates among adults of all ages were:

- Anxiety (19%)
- Depression (17%)
- Post-traumatic stress disorder (PTSD) (7%)
- Attention-deficit disorder (ADD)/ Attention-deficit hyperactivity disorder (ADHD) (6%)
- Bipolar disorder (manic-depressive) (6%)

**Description of Health Status**

The survey sought to determine the general health status of residents throughout the region by asking survey respondents to rate their own health. Overall, the highest percentage of respondents across all survey samples (23%) described their health as “okay”, or a 3 out of 5 on a simple Likert scale. Only 11% described their health as excellent. Less than 1% of the total sample described their health as “poor”, regardless of race, income or education level. In fact, 6 of the 8 (75%) groups surveyed had no respondents who described their health as “poor”.

**Description of Weight**

This survey also included a self-assessment of participant weight. Across all samples, “overweight” was the most common answer given by respondents and made up 44% of the total. Within the total sample, 51% of the Random sample rated themselves as overweight. Of the total sample, 40% of respondents reported their weight as just about right. According to the CDC, the prevalence of obesity is significantly higher among adults living in rural counties (34%) than among those living in metropolitan counties (29%). The findings held true for adults in most sociodemographic categories, including age, sex and household income. While this finding does not correlate directly with the Rockford Region, there are similarities. Urban, suburban and rural groups with a wide range of income levels comprise the Rockford Region’s population as well.

The region is not unlike the U.S. as whole in regard to weight. Only 10% of the total sample identified as obese. While overweight and obese both mean having more body fat than is considered healthy, obese refers to a higher amount of body fat than overweight. This percentage does not correlate with national data available from the CDC. Nationally, 42% of the population was considered obese in 2017-2018. This indicates obesity may be
under-reported by the RRHC survey sample. Among other reasons, the Health Community researchers believe that obesity is actually higher, as, the fitness opportunities available from community resources such as park districts, forest preserve districts and YMCA branches in Boone and Winnebago counties are not always widely utilized by all segments of the population.

Just 3% of the total sample described themselves as “underweight”. This is the same percentage as those who have a high school diploma or GED. This could indicate a relationship, or it could be tied to housing status or income. 10% of those within the total sample that reported being underweight also reported an income of $10,001-$15,000 and 5% of these were renters. 29% of those who said they were underweight also reported being homeless. These respondents do not have easy access to food at all, let alone a healthy diet.

Body weight was assessed in two different ways. One way was a subjective measure that prompted survey respondents to assess their own weight by asking, in general, how would you describe your weight? The other measure was more objective, and that asked them whether they, or anyone else in their household, had ever been told that they were obese by a medical professional. Since a trained professional would have an understanding of the diagnostic criteria for obesity, we believe this would be a valid measure for prevalence of obesity. Since weight is a sensitive topic that many people do not feel comfortable discussing and a very subjective characteristic, and a person’s perception of their own weight can vary greatly from one person to the next, asking about this both ways provides a way to cross-reference responses to assess the level of variance between the types of assessment. The subjective measure was asked first and gave respondents four options to classify their weight: underweight, about the right weight, overweight, and obese, as well as a fifth option, prefer not to answer for those that were not comfortable sharing this information. Approximately half of all respondents classified their own weight as either overweight or obese.

**Figure 21. Responses to Question, “In General, How Would You Describe Your Weight?”**

via Rockford Regional Health Council Healthy Community Study
The second measure of body weight, the number of people that have been told by a doctor that they meet the criteria for obesity, also asked for the ages of any people characterized as obese. This was expected to be considerably lower than the rate of people that self-identified as overweight or obese, as the criteria were far narrower. In total, around 13% of people had been told that they were obese by a doctor at some point. Of those that said yes, nearly half were between 45 – 64 years old. An additional 1 out of 5 that said yes were 65 or older, and another 1 out of 5 were 18 – 44 years old. The rates observed both differ from the statewide rates, which were split roughly into thirds, between obese, overweight and normal weight people, with a small percentage (less than 2%) classified as underweight. The differences can mostly be attributed to a higher rate of people classifying themselves as overweight instead of obese with the remainder of the difference coming from those classifying themselves as about the right weight (normal) instead of overweight or obese.

The adults in the region that are obese are usually:
- Women
- Generally, more highly educated

The adults in the region that are overweight are usually:
- Women
- Less educated

This is interesting, specifically because of the trends in education level. While the trend among obese adults is less clear and similar to that seen between behavioral health and education level, among overweight adults, there is a clear inverse relationship. Overweight and obese adults also tend to report higher rates of certain adverse health conditions and comorbidities, including:

- Activity limitations
- Asthma, COPD, emphysema and chronic bronchitis
- Fair or poor physical health
- Heart attack, angina or coronary heart disease, or stroke
- Kidney disease

**Difficulty with Daily Activities**
The survey sought to determine difficulties residents reported with daily activities due to physical and behavioral health. Walking or climbing stairs was the most common daily activity associated with physical health problems, with 26% of the total sample reporting this as a problem. This could be related to the percentages of those who self-reported as overweight (44%) or obese (10%) as well as other factors such as age and specific health conditions.

At 23%, exercising was the next most common daily activity linked with health problems. Again, this could be related to age, specific health problems or simply a lack of regular, physical activity and the largely sedentary lifestyle of the regional and national population.

Over half (53%) reported they did not have difficulty with daily activities due to mental health or substance abuse.
**Frequency of Care**
The survey also measured the frequency of self-reported routine medical care. Most respondents (68%) reported that they had seen a doctor for a check-up in the last 12 months, demonstrating that overall, residents in the region have good access to regular medical care, regardless of factors such as income, race or education level.

**Routine Dental Care**
Frequency of routine dental care was measured as well. Most people (58%) reported seeing a dentist for a check-up in the last 12 months. The next highest percentage (18%) said they had seen a dentist in the last 1-2 years. Though over half of the sample had seen both a doctor and a dentist for routine care within the last 12 months, a lower percentage had seen a dentist, indicating a gap in affordable dental care and/or insurance. Furthermore, some dental care covered under private insurance is not covered under public insurance at the same level and may result in some people going without regular care. The gap between those who had seen a dentist in the last two years and those who had seen one in the last 3-5 years was smaller; 13% said they had seen a dentist within the last 3-5 years.

**Figure 22. Routine Dental Care Breakdown**

![Pie chart showing frequency of dental care](image)

via Rockford Regional Health Council Healthy Community Study
Prevalence of Cigarette Smoking
Approximately a quarter of adults in the region are current smokers, an increase from the last time the region was surveyed, but only 3% are regular smokers (smoke every day). Most of the smokers that responded chose not to specify how often they smoke. Almost three quarters of people (71%) said that they have never smoked.

The rate of adults in the region who currently smoke cigarettes is higher than the state and national findings, which only shows 15% of the population being current smokers. The rates of Winnebago County adults and Boone County adults who currently smoke cigarettes are similar. The majority of smokers are:

- White
- More educated

Prevalence of Alcohol Use
According to the survey responses, slightly more than half (53%) of adults in the region are current drinkers (drank at least one alcoholic beverage in the past month) and 42% are non-drinkers (drank no alcoholic beverages in the past month). The percentage of adults in the region who are current drinkers is more favorable than the state rate (61%) and is similar to the national rate (56%). The adults in the region more likely to be current drinkers are:

- Male
- White or Hispanic
- Higher income
- More educated

Men in the region tend to be more frequent drinkers than women, but the difference is relatively small. Of the adult population in the region, 3% binge drink (have 4 or more (women)/5 or more (men) drinks on any single occasion during the past month) and 48% do not (49% declined to answer). Women binge drink more than men (5%), with only 2% of men binge drinking. So, while the survey results found that men drink more often, women drink more heavily on the occasions they do drink.

When comparing drinking patterns between racial and ethnic groups, the relationship is not straightforward. First, there are more whites and Hispanics that say they drink than whites and Hispanics that don’t. Conversely, there are more blacks that say they don’t drink than blacks that do. When it comes to the number of drinks consumed in each instance, the Disparity Index shows that whites typically have fewer drinks on the days they drink than blacks, and the blacks that drink are more frequently heavy drinkers (drink 4 or more drinks per day). However, it is difficult to say how reliable the statistics regarding black drinking rates are because the refusal rate for this series of questions is so high. Of all of the black respondents, over 15% skipped the question or chose prefer not to answer (only 3% of whites and 7% of Hispanics did the same).
Prevalence of Drug Use
The percentage of adults in the region that report using drugs is around 27%. Of those that report using substances, the rates among adults are represented in Figure 23.

Figure 23. Drug Use Breakdown

- Marijuana or THC products: 37.46%
- Prescription Opioids: 15.12%
- Cocaine/Crack: 7.22%
- Amphetamines: 5.50%
- Heroin: 5.15%
- Withdrawal Medications: 4.81%
- Barbiturates: 1.37%
- LSD, etc.: 1.03%

via Rockford Regional Health Council Healthy Community Study

Of the adults in the region:

- Women are more frequently willing to disclose substance use than men.
- Women more frequently report use of marijuana than men.
- Women report using prescription opioids and withdrawal relieving products about twice as frequently as men.
- Men report use of heroin slightly more than women.
Adults in 61104 reported a much higher rate of marijuana use, 17% compared to rates between 3% and 6% in other zip codes of significance. The only other zip code with rates anywhere near this was in 61115, where the rate was just under 10%. Adults 65 or older (8%) and those with annual household incomes of less than $25,000 (8%) are more likely to have used prescription narcotics every day in the past month.

It appears that those with lower levels of education have higher levels of substance use for almost all substances with a few exceptions:

- People with less than a high school diploma/GED had higher than expected levels of cocaine/crack use (the highest rate of use), rates that did not fall within the expected trend line of education and cocaine use. They also had higher than expected levels of amphetamine use, which fell outside the trend line of education level and use.

- Those with graduate/professional degrees did not conform to the trend that other educational levels had for marijuana use (12%).

- Hallucinogen use did not appear to be associated with education level.

**Conclusion**

Building on the previous CHNAs, SwedishAmerican worked with its leadership and the community to prioritize health issues for SwedishAmerican’s next three years of community programming. Partnering with Advis, SwedishAmerican reviewed data from the previous CHNA as well as other health outcome and community profile data to inform the key health priorities. Ultimately, SwedishAmerican determined the following as the health priorities for 2022-2024:

- Cancer
- Obesity
- Smoking Cessation
- Poverty and Unemployment
- Access to Medical Care
- Vulnerable Populations: Hispanic/Latino Population
- Heart Care
- Maternal/Prenatal/Early Childhood Health
- Substance Abuse
APPENDIX

Appendix A – Healthy Community Study Survey Methodology

Per the 2020 Rockford Regional Health Council Healthy Community Study:

SURVEY METHODOLOGY

Survey Design
The survey was conducted using a mixed methodology design with three distinct distribution modalities. The first modality was email/physical mail. Initially, the survey was planned to be conducted primarily as an electronic survey sent to a random sample of emails matched with physical addresses. The list of survey recipients was purchased from a third-party data vendor, which was selected based on the richness of the dataset offered. The vendor is an original source for data, generating information through proprietary websites and websites of its trusted partners (Acxiom being the primary single source). The core demographic information used to cull the list to match regional demographics is overlaid from the major credit and service bureau agencies and the data was derived from a multitude of sources, including the following:

- Magazine and newspapers subscriptions
- Software registration
- Municipal directories
- Internet connections
- Telephone and machine hookups
- Memberships
- Internet connections and searches
- Attendee registers
- Website registrations
- DBAs
- Incorporations
- Yellow page and business white page
- Directories
- Internet searches
- Most recent government records
- Postal service information
- County courthouse records
- National change of address
- Secretary of State data
- ZIP+4 carrier route
- Licensing boards
- Delivery sequence files

The sample was culled to mirror the demographics of the region and to intentionally oversample minority groups in order to compensate for the known differences between races/ethnicities in their propensity to complete surveys. The survey was initially sent out at the beginning of February with weekly follow-up reminders to those that had not responded. The initial distribution of the survey sample was sent to 12,960 email recipients. The survey link was resent three times, and ultimately, 3,147 of these were unable to be delivered, primarily because of the spam filters of the

1 Personal communication, ExactData- email with P. Green, dated March 13, 2020
recipients. Unfortunately, due to the large number of emails sent, the only practical way to send the mailing was by using a third party system, whose emails are frequently sent to recipients’ “junk” folders. This is evidenced by the open rate of the messages, which differed with each mailing and ranged between 183 and 1,080.

To encourage response rates, an incentive was added to the project to provide $5 in an e-gift card or Paypal payment to the respondent, and a reminder postcard was sent to the physical addresses on file, highlighting the incentive available. Ultimately, throughout the entire survey period, which was open from the beginning of February until the end of March, 468 responses were received, 84 of which were partially completed.

On the same timeline, the second modality, in-person distribution of paper surveys were given to three different cohorts: households of third grade students, households of public housing residents and households of participants in “pop-up events”, targeted activities in which researchers set up tables in public areas known to have high-traffic of hard-to-survey populations, such as patients of Crusader Clinic, the region’s Federally-Qualified Health Center (FQHC). The totals for each of these cohorts are included in Appendix C. Incentives were used during these activities as well.

The sample referred to as the “Outreach sample” or “Pop-up sample” includes responses from events from the following pools of respondents:

- Crusader Clinic patients (Broadway, West State, Brookside and North 2nd Street locations)
- KFACT volunteers
- Northern Illinois Food Bank, Mobile Food Pantry event in Winnebago County

Paper surveys were distributed to the first cohort, the families of all third grade students in two school districts in the region, Harlem Unit School District 122 (in Winnebago County) and Belvidere School District 100 (in Boone County). These surveys were sent home with students from each class, along with an introductory letter that explained the survey and included instructions. Teachers were also given paper reminders that were to be sent home with students halfway through the survey period to encourage more parents to participate.

The second cohort, participating housing authorities, included Rockford Housing Authority (RHA), Winnebago County Housing Authority (WCHA) and Zion Development. The surveys were distributed by staff at each housing organization with simultaneous “pop-up events” planned, in which research staff were available to assist respondents in filling out surveys and offered incentives including $5 gift cards and refreshments. This did seem to be an effective strategy when working with housing staff and including incentives at the events. Use of incentives was done at the recommendation of the housing authority staff, and was implemented after doing a trial at a couple of different sites with no incentives. As predicted by housing authority staff, there was little to no response or willingness from
residents to participate without incentivizing the survey. The events all offered, in exchange for a completed survey, an entry into a drawing with a chance to win a Visa Gift card. Participation from this population was vital to the survey design, as it was one of the major methods of oversampling minority and low-income populations to ensure the survey was representative of the demographics of the region and included those that typically are hard to survey.

The largest events planned were multiple survey collection events planned during Rockford Housing Authority’s mandatory resident meetings, at which all scattered site (Section 8) residents were required to attend. This would have provided a captive audience and allowed researchers to explain the benefits of completing the survey, which we believe would have increased the response rate dramatically. Unfortunately, days before the events were set to occur, the global Coronavirus pandemic began to cause deaths in exponentially increasing numbers, and the state’s “Stay-at-Home” order, which included a ban of gatherings larger than 10 people was enacted, resulting in the meetings (and pop-up events) being canceled. This resulted in a massive decrease in the participant pool. At the same time, Governor Pritzker also ordered the cancellation of school throughout the state. This was just prior to the planned collection date of the school cohort’s paper surveys, and this major disruption resulted in a drastically reduced response rate from school participants.

It was at this time, in order to obtain enough responses to conduct a generalizable analysis, the project design was changed to include a Facebook promotion of the survey, open to any participants with a link. The link was shared through the Region 1 Planning Council page, the Rockford Regional Health Council page and the personal pages of researchers and associates. Researchers also opted to use Facebook’s “boost post” option, which prioritizes the post when displaying on individual’s News Feeds, moving the post toward the top of the feed to increase the likelihood that the post will be seen by potential participants. The cost was negligible, around $30. Incentives were used for this sample as well, with a $5 reward offered to any participant who finished the survey. Interestingly, only a small fraction of the nearly 1,300 Facebook participants that took part in the survey (less than 100) completed the email process to claim the incentive. Ultimately, these sampling methods produced:

- Random sample: 468 responses
- Housing authority samples: 165 responses
- School sample: 124 responses
- Pop-up event sample: 191 responses
- Facebook sample: 729 responses2

Given the difficulties encountered while gathering responses and the unprecedented barriers involved, we believe the number of responses gathered was an excellent response.

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2 The full total of Facebook responses was 1,226, but a number of responses were determined to be invalid, as they were “bot” responses completed by a non-local apparently automated source. These responses were excluded from the sample.
IMPACTS OF COVID-19 ON THE REGION AND SURVEY

The 2020 Healthy Community Study’s planning period (which began at the end of 2019) and implementation overlapped with one of the most significant events of our lifetime. The COVID-19 pandemic, also known as the Coronavirus pandemic, refers to the global outbreak of Coronavirus disease 2019, or COVID-19, an illness caused by a virus known as “severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).” First identified in Wuhan, China, in December of 2019, the virus spread quickly, and after almost 8,000 cases were confirmed in 19 countries, the World Health Organization (WHO) declared the outbreak a public health emergency of international concern on January 30, 2020.

Only two months later, in the span of two weeks, we saw a 13-fold increase in the number of cases outside China, and the number of affected countries tripled, leading the WHO to declare COVID-19 a global pandemic on March 11. As of this printing, there have been more than 5.9 million cases of COVID-19 reported in nearly 190 countries and territories worldwide, resulting in over 364,000 deaths.

In assessing the epidemiological threat posed by an infectious disease, two of the most important questions to answer are:

- How contagious is it (or, put another way, how easily is it spread)?
- How deadly is it (or, of all the people infected, how many die as a result)?

COVID-19’s level of transmissibility has been difficult to measure, since many people that become infected are asymptomatic or presymptomatic carriers, meaning they have no symptoms, but they can still spread the virus. The most recent data estimates that of all cases (whether diagnosed or not), between 5 – 80% are asymptomatic.

Further complicating the matter, testing has been an issue, particularly in the U.S. National testing got off to a slow start, first by defective federal test kits, then a lack of federal approval for non-government test kits, next, by restrictive eligibility criteria that limited access to testing, all of which obscured the extent of the outbreak. These are just a few of the factors that have made an accurate count of cases impossible to obtain, without which, we can only estimate the extent of infection in the population.

The preferred measure for doing so is an estimate of the basic reproduction number (or R0, pronounced “R-Naught”) of COVID-19, which essentially tells us the expected number of cases that will be spread from one case, assuming no one in the population is immune.

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3 “Naming the coronavirus disease (COVID-19) and the virus that causes it”, World Health Organization (WHO).
Figure B1 shows the estimated R0’s of some well-known infectious diseases.

The most contagious transmissible virus ever discovered, Measles, is shown at the top; it remains infective for up to two hours in an airspace and is so contagious that if one person has it, 90% of nearby non-immune people will also become infected. Smallpox is in the middle, and is moderately contagious, spread through inhalation, usually of droplets from sneezes or coughs, within six feet of an infected person, and through direct contact with infected fluids or contaminated objects. Influenza subtype H1N1 (a subtype of influenza A whose best known strains were responsible for both the deadly 1918 Spanish Flu pandemic and the 2009 swine flu pandemic) is at the bottom, as the least contagious (relatively). Much like COVID-19, the circumstances such as failure to acknowledge the magnitude of the threat and population travel patterns, contributed to the spread of the virus. As contagious as it was, it still falls below COVID-19 on the R0
scale which, studies indicate, has an R0 of 5.7. Establishing an exact rate of death for COVID-19 has been impossible due to the vast number of asymptomatic and presymptomatic carriers who contract and spread the disease but, since they never know they have it, don’t seek medical attention and thus, are not counted in the total count of cases. However, best estimates based on Johns Hopkins University statistics put the global death-to-case ratio at 6.1%. Although the disease is not particularly deadly compared to diseases like Ebola, which has a case fatality ratio of 67%, it does produce extremely severe symptoms for many that have it.

The two most common symptoms are fever and dry cough, but can also include many other symptoms (see Figure B2), further complicating our ability to accurately determine the number of cases. Of those that do develop symptoms, 1 in 5 become more seriously ill. These symptoms include difficulty breathing, chest pain/pressure and can later include pneumonia, acute respiratory distress syndrome, sepsis, septic shock and kidney failure.

COVID-19 may not pose the threat of death to most who get it, but it poses a great threat to society. In any pandemic, there are many risks, both on the individual level and on a societal level. The number of inpatient hospital beds in any community is limited, even in those with the best healthcare providers. Since there is no vaccine or cure for COVID-19, it is estimated that 20 – 80% of the population will be infected by the time the pandemic runs its course. Even conservatively estimating (40%), that would be almost 100 million Americans, 20 million of whom would probably be hospitalized, over 4 million of whom would need ICU care. If no actions were taken to slow the spread, the pandemic would have spread like wildfire through the population in 3 – 6 months. Even if hospitals could free up half of their beds by canceling elective procedures, we would still need between 200 – 500% of the beds we have to meet that need.

This would cause a collapse in our medical system and result in a drastically higher rate of mortality. In order to avoid this, we have had to take non-pharmaceutical interventions (NPIs) to do what is called...
“flattening the curve” in order to buy the healthcare system time to “raise the line” (shown in Figure B3). NPIs are used to reduce the speed of disease spread in pandemics to allow researchers time to develop a cure or vaccine and include things like hand washing, wearing face masks, self-isolation of those who may be exposed, and what is known as social distancing (also called physical distancing). Social distancing refers to a set of NPIs that aim to reduce the spread of infection through a community-level effort to maintain at least six feet of distance between people and reduce the number of physical contacts people have with others. To work, these measures must be done community-wide, by everyone and consistently.

The first case was confirmed on January 20. Although the federal government declared a public health emergency January 31, the only nationwide NPI implemented at the time was a limited travel ban from certain countries. Confusion only further facilitated the spread as some federal officials told the media that there was little chance of the virus spreading through the community, while officials from many states where they were seeing indications that it already was, (including Illinois, where the 2nd U.S. case was confirmed) attempted to sound the alarm, pleading with residents to implement NPIs like social distancing before the disease spread uncontrollably.

Unfortunately, the U.S. did not heed this warning and in March, got a preview of how steep the climb in cases could be without the entire country implementing protective measures. On March 9, after confirming it’s 11th case, the Governor of Illinois announced a statewide disaster proclamation. Two days later, that number had more than doubled, marking the start of a number of event cancellations, and after two more days, it had doubled again, prompting a two week statewide closure of schools and casinos. Winnebago County confirmed its first case on March 15, 1 of 93 in the state, the same day the Governor restricted public gatherings to 50 people or less, while some businesses across the country began closing and moving to telework. Two days later, COVID-19 claimed its first life in Illinois. Unfortunately, not everyone took the pandemic this seriously and continued to ignore the recommendations made to slow the spread.

By March 21, just over a week later, as the state totals continued to soar to over 750 cases and six deaths, the Governor issued the first executive order (referred to as the “stay at home order”) requiring all Illinoisans to remain in their homes except for “non-essential travel”, shutting down all non-essential workplaces (except telework). Five days later, the U.S. number of confirmed cases rose to over 82,000, more than any other country on the planet, with 2,538 of these in Illinois and nine deaths. In those five days alone, Illinois’s new daily case confirmations went from over 100, to 200, then 300, then 600.

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On April 11, 2020, the U.S. became the country with the highest official death toll for COVID-19, with over 20,000 deaths.\footnote{Shumaker, Lisa (April 11, 2020). “U.S. coronavirus deaths top 20,000, highest in world exceeding Italy: Reuters tally”. Reuters. Retrieved May 28, 2020.} By then, on April 30, the Illinois Governor extended the lockdown for an additional month. Although other countries that have controlled the disease and even brought the number of new cases near zero have done so through four main strategies: Early and decisive action, national lockdowns, clear communication and information sharing and widespread community-wide testing, including for those without symptoms.

Unfortunately, the U.S. has failed on all of these and, while testing criteria have become a bit better, we’re still not testing nearly enough, and the federal government has not reported any plans to do so. This means that this will be one of the (if not the) most significant health concerns of at least the next year, and will influence the health care and public health systems in almost every way possible. While the survey did not include questions about the issue, due to the intervals of the HCS survey (since it wasn’t included in this one and may not be in the next, depending on how long it persists and the survey timing), the authors felt it important to include an overview of the events: even if the pandemic’s resurgences have ended by the time the next survey is conducted, we thought we would be remiss not to include it and emphasize the importance of using all of this as context when viewing the results of the survey, particularly when using them for policy decisions over the next 1-2 years (at minimum).

COVID-19 has impacted the planned implementation of the 2020 Healthy Community Survey primarily by lowering the expected survey response rate. Residents in the Report Area were less eager to complete public surveys for several reasons, whether due to general fear of contracting the illness through close contact with others causing reluctance to fill out surveys in person), or from factors related to job loss, caring for sick or at-risk loved ones or school-age children, or from, increased working hours for essential goods and service providers, to name a few.
Additionally, a number of key staff were needed to assist with the emergency response efforts throughout the region. While project team members worked long hours to ensure that the survey remained a top priority in addition to the pandemic response, this resulted in a serious strain on resources. This strain, when compounded with the other COVID-19-related disruptions to the original work plan, necessitated both project design alterations and the scaling down of certain planned portions of the survey and report, in order to ensure that the project could still be completed by the original deadline.

However, RPC was able to attain the intended response rate from the original scope nonetheless by rapidly adjusting our collection tactics. This was primarily achieved by two revisions:

- Incentivizing survey participation with $5 gift cards to Wal-Mart, McDonalds or Walgreens.
- Increasing awareness of the survey by “boosting” the survey through a post on Region 1 Planning Council’s Facebook page.

Boosting the Facebook post was particularly useful after the shelter-in-place order was implemented, preventing further in-person survey collection. Residents stuck at home without work or working from home had more time to engage with social media platforms and were actively thinking about health and health care providers as national, state and local media reminded viewers of the increasing toll COVID-19 had and is continuing to take on the community. This aspect likely made the public more predisposed to engage with health-system related content. Ultimately, a very minor financial investment in this Facebook post resulted in over 22% of all survey responses.

We will probably never know how much COVID-19 impacted survey collection and the resulting data from the 2020 Healthy Community Study; however, by acting quickly and making adjustments to the survey design based on public sentiment at the time, we believe we were still able to successfully conclude the survey despite the unprecedented circumstances that many thought would be insurmountable.

**ANALYSIS**

Before being able to analyze any survey data, individual surveys had to be consolidated within our survey system, SurveyGizmo. Our random online sample and Facebook sample were done directly within SurveyGizmo by respondents, but any paper surveys collected at outreach events or through the housing authorities required manual data entry to convert the surveys into the online system.

This resulted in three separate samples of hundreds of responses. Survey data for analysis was exported in two ways:

1. Through the SurveyGizmo services, which was largely a report of response counts.
2. Exported as raw data into an Excel file, with each row being a response and each column being a question or portion of a question.
For basic descriptive statistics of counts and averages, the first method of reporting response counts was used. For any demographic analysis, or analysis that required the comparison of responses (see Survey Analysis – Demographic Observations), the raw data had to be used. However, when exporting into raw data, only completed surveys were able to export, whereas the response count report exported all answers, including answers from partial surveys. For this reason, sample sizes varied slightly between questions depending on the type of export. We did find a work-around for this issue for certain types of questions, allowing for responses from partially-completed surveys to be included, so certain questions, specifically those relating to chronic and behavioral health conditions, have a different sample size (n). Further, for certain questions, respondents were asked for information pertaining to themselves as well as the other members of their households. For these questions, there are two different n’s: one of respondents, one of households. In these instances, when discussing these results, we specify which “n” we are referring to. In our analysis, we focused primarily on reporting percentages of recorded responses for the respective sample size, to avoid confusion. In both cases, survey samples were combined into spreadsheets for analysis.

**DESCRIPTIVE DATA**

The type of analysis for each survey question was dependent on the type of question being analyzed. For many questions, for which results could be shown by simple descriptive statistics, tables of responses and percentages of those responses as a portion of the total was sufficient. Some questions which had few responses such as yes or no questions were better shown as pie-charts and other figure types.

This analysis was similar to past Healthy Community Surveys and made the most sense for ease of understanding and analysis.

**DEMOGRAPHIC OBSERVATIONS**

Working with RIPC, RRHC identified certain questions that were a priority to them and other health partners for analyzing demographic trends. These questions and the responses therein were deemed useful to policy discussions regarding social determinants of health in our community (discussed elsewhere in this report). In order to examine these questions and compare them to demographic groups self-reported by respondents, survey data on complete responses were exported as raw response data from our survey system (SurveyGizmo), and cross tabulations of demographic data for each identified question were created using conditional sorting formulas. Tests of significance were run on this data. By and large, education, age and income were the most significant results.

This analysis was time consuming and required additional preliminary cleaning of the data. Additionally, while this data is the most vulnerable to issues of external validity, our survey demographics were fairly representative of the community, with a slight oversample of minority and low-income communities through our pop-up event group.
## Appendix B – Community Health Resources

**The following resources were identified within the SwedishAmerican CSA to address inpatient care needs:**

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>City</th>
<th>Type of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>OSF-St. Anthony Medical Center</td>
<td>Rockford</td>
<td>Full-Service Hospital</td>
</tr>
<tr>
<td>Mercyhealth Javon Bea Hospital-Riverside</td>
<td>Rockford</td>
<td>Full-Service Hospital</td>
</tr>
<tr>
<td>Mercyhealth Javon Bea Hospital-Rockton</td>
<td>Rockford</td>
<td>Full-Service Hospital</td>
</tr>
<tr>
<td>SwedishAmerican Hospital</td>
<td>Rockford</td>
<td>Full-Service Hospital</td>
</tr>
<tr>
<td>SwedishAmerican Medical Center/Belvidere</td>
<td>Belvidere</td>
<td>Full-Service Hospital</td>
</tr>
<tr>
<td>Van Matre Encompass Health Rehabilitation Hospital</td>
<td>Rockford</td>
<td>Rehabilitation Hospital</td>
</tr>
</tbody>
</table>

**The following resources were identified within the SwedishAmerican CSA to address outpatient care needs for adults:**

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>City</th>
<th>Type of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crusader Community Health</td>
<td>Rockford</td>
<td>Primary Care</td>
</tr>
<tr>
<td>Crusader Community Health</td>
<td>Belvidere</td>
<td>Primary Care</td>
</tr>
<tr>
<td>Crusader Community Health - Woodward Campus</td>
<td>Rockford</td>
<td>Primary Care</td>
</tr>
<tr>
<td>OSF - Center for Health - Belvidere</td>
<td>Belvidere</td>
<td>Specialty, including screenings</td>
</tr>
<tr>
<td>OSF - Center for Health - Rock Cut</td>
<td>Loves Park</td>
<td>Primary Care</td>
</tr>
<tr>
<td>OSF - Cherry Valley</td>
<td>Cherry Valley</td>
<td>Primary Care</td>
</tr>
<tr>
<td>OSF - Fertility Care Center - Rockford</td>
<td>Cherry Valley</td>
<td>Fertility Care</td>
</tr>
<tr>
<td>OSF - Guilford Square</td>
<td>Rockford</td>
<td>Primary Care</td>
</tr>
<tr>
<td>OSF - Illinois Neurological Institute</td>
<td>Rockford</td>
<td>Neurology</td>
</tr>
<tr>
<td>OSF - Joslin Diabetes Center Affiliate at OSF HealthCare</td>
<td>Rockford</td>
<td>Diabetes</td>
</tr>
<tr>
<td>OSF - Outpatient Palliative Care</td>
<td>Rockford</td>
<td>Palliative Care</td>
</tr>
<tr>
<td>OSF - PromptCare and primary care - Rock Cut</td>
<td>Loves Park</td>
<td>Primary Care</td>
</tr>
<tr>
<td>OSF - PromptCare (UrgentCare) Southridge</td>
<td>Rockford</td>
<td>Primary Care</td>
</tr>
<tr>
<td>OSF - Rehabilitation</td>
<td>Rockford</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>OSF - Rehabilitation</td>
<td>Belvidere</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>OSF - Rockford Cardiovascular Associates</td>
<td>Rockford</td>
<td>Cardiology</td>
</tr>
<tr>
<td>OSF - Roxbury Family Medicine</td>
<td>Rockford</td>
<td>Primary Care</td>
</tr>
<tr>
<td>OSF - Saint Anthony - Ambulatory Care Center</td>
<td>Rockford</td>
<td>Ambulatory Care Center</td>
</tr>
<tr>
<td>OSF - Specialty Clinic Guilford Square</td>
<td>Rockford</td>
<td>Home Health, Hospice, Elderly Care</td>
</tr>
<tr>
<td>OSF - Springcreek</td>
<td>Rockford</td>
<td>Primary Care</td>
</tr>
<tr>
<td>OSF - Surgical Group - Rockford</td>
<td>Rockford</td>
<td>Surgery</td>
</tr>
<tr>
<td>OSF - Wal-Mart Clinic (Northridge Drive)</td>
<td>Rockford</td>
<td>Primary Care</td>
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<td>OSF - Wal-Mart Clinic (Walton Street)</td>
<td>Rockford</td>
<td>Primary Care</td>
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<td>OSFMG - Belvidere Primary Care</td>
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<td>Primary Care</td>
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<td>OSFMG - Cosmetic and Reconstructive Plastic Surgery</td>
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<td>Cosmetic</td>
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<td>OSFMG - Endocrinology and Diabetes</td>
<td>Rockford</td>
<td>Endocrinology</td>
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<td>OSFMG - OB/GYN Garrett Lane</td>
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<td>Obstetrics/Gynecology</td>
</tr>
<tr>
<td>OSFMG - Orthopedics</td>
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</tr>
<tr>
<td>OSFMG - Pulmonology</td>
<td>Rockford</td>
<td>Pulmonology</td>
</tr>
<tr>
<td>Mercyhealth Physicians - Winnebago</td>
<td>Winnebago</td>
<td>Primary Care</td>
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<td>SAMG Stateline Clinic &amp; Immediate Care</td>
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<td>SAMG SwedishAmerican Immediate Care</td>
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<td>UIC - The F.W. Shappert University Primary Care Clinic</td>
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<td>UIC - University Outreach Services at Rochelle</td>
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<td>UIC - Women and Children’s Center</td>
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The following resources were identified within the SwedishAmerican CSA to address outpatient care needs for Children:

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<th>City</th>
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<tbody>
<tr>
<td>Crusader Community Health</td>
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<td>Crusader Community Health - Loves Park</td>
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<td>Primary Care</td>
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<tr>
<td>Crusader Community Health - Woodward Campus</td>
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<td>OSF - Children’s Hospital of Illinois - Rockford</td>
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<td>OSF - Rock Cut Pediatrics</td>
<td>Loves Park</td>
<td>Primary Care</td>
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<td>OSF - Wal-Mart (Children 18 months and older)</td>
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<tr>
<td>OSF - Wal-Mart Walton (Children 18 months and older)</td>
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<td>Primary Care</td>
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<tr>
<td>Rockford Ambulatory Surgery Center</td>
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<td>Outpatient Surgery</td>
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<td>Ronald McDonald Care Van-travels to 5 counties</td>
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<td>SAMG - Rock Valley Pediatrics</td>
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<tr>
<td>SAMG SwedishAmerican Immediate Care</td>
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<td>Immediate Care</td>
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<td>UIC - Rockford Primary Care Clinic, Belvidere Site</td>
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<td>Primary Care</td>
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<td>UIC - University Outreach at Rochelle</td>
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<tr>
<td>UIC - Women and Children’s Health Center</td>
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The following resources were identified within the SwedishAmerican CSA to address mental health needs:

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<td>Rockford Memorial Behavioral Health</td>
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<td>Inpatient Mental Health Treatment</td>
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<td>Rosecrance Belvidere Clinic</td>
<td>Belvidere</td>
<td>Outpatient adult mental health &amp; substance abuse</td>
</tr>
<tr>
<td>Rosecrance Berry Campus</td>
<td>Rockford</td>
<td>Child and teen mental health treatment</td>
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<tr>
<td>Rosecrance Greendale Recovery House</td>
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<td>Substance Abuse Treatment</td>
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<tr>
<td>Rosecrance Griffin Williamson Campus</td>
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<td>Inpatient Drug Abuse Treatment</td>
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<td>Rosecrance Harrison Campus</td>
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<tr>
<td>Rosecrance Mulberry Center</td>
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<td>Crisis Stabilization</td>
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<td>Rosecrance Ware Center</td>
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<td>Outpatient Mental Health Treatment</td>
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<td>SwedishAmerican Behavioral Health Resources</td>
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<td>Outpatient Mental Health Treatment</td>
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<td>SwedishAmerican Center for Mental Health (main campus)</td>
<td>Rockford</td>
<td>Inpatient and Outpatient Mental Health Treatment</td>
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<tr>
<td>University Psychiatric Services (UIC affiliate)</td>
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<td>Outpatient Mental Health Treatment</td>
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</table>
Appendix C – Survey Respondent Demographics

Figure C1
Gender, 2020

Figure C2
Age, 2020

Figure C3
Race, 2020
Education by Type, 2020

- Graduate or Professional Degree: 332
- Bachelor's Degree: 180
- Associate's Degree or Technical Degree: 198
- Some College, no Degree: 235
- High School Diploma or GED: 249
- Less than High School: 73
Figure C6

Annual Household Income by Group, 2020

- Less than $10,000: 116
- $10,001 - $15,000: 73
- $15,001 - $20,000: 53
- $20,001 - $25,000: 49
- $25,001 - $35,000: 67
- $35,001 - $50,000: 133
- $50,001 - $75,000: 163
- $75,001 - $100,000: 149
- $100,001 +: 148
- Don't know/Not sure: 84
Figure C8

Age Groups by Household, 2020

- Ages (0–12): 483
- Ages (13–17): 205
- Ages (18–29): 212
- Ages (30–44): 253
- Ages (45–64): 248
- Ages (65–74): 162
- Ages (75+): 90
Figure C9

Employment Status (Self and Others) by Type, 2020

- Self-employed, full time: Self - 178, Others - 115
- Full-time job only: Self - 428, Others - 353
- Part-time job only: Self - 135, Others - 92
- 2 or more jobs: Self - 72, Others - 67
- Work seasonally or part of year: Self - 95, Others - 34
- Unemployed, looking for work: Self - 59, Others - 48
- Homemaker: Self - 65, Others - 85
- Student: Self - 74, Others - 274
- Retired: Self - 271, Others - 187
- Disabled: Self - 195, Others - 74
- Not employed, not looking: Self - 272, Others - 44
- Other: Self - 13, Others - 21