VILLAGE OF SCHAUMBURG

# A G E N D A

**Health and Human Services Committee**
**Thursday, March 28, 2024**
**7:00 PM - Conference Room B**

---

## CALL TO ORDER

## APPROVAL OF MINUTES

1. February 22, 2024

## NEW BUSINESS

1. Recommendation to Approve Amendment No. 1 and No. 2 to the Residential Refuse and Recycling Collection Services Agreement with Lakeshore Recycling Systems, LLC.
2. Presentation of Phase 1 Report of Schaumburg Community Health Needs Assessment
3. Overview of the Village's Nursing Services Program - Informational

## UNFINISHED BUSINESS

## DEFERRALS

## COMMENTS FROM THE PUBLIC

## ADJOURNMENT

## NEXT VILLAGE BOARD MEETING

April 9, 2024

In compliance with the Americans with Disabilities Act and other applicable Federal and State laws, the meeting will be accessible to individuals with disabilities. Persons requiring auxiliary aids and/or services should contact the Village Manager's Office at 847.923.4705, preferably no later than five days before the meeting.

VILLAGE OF SCHAUMBURG

# AGENDA ITEM SUMMARY

**February 22, 2024**
**3/28/2024**
**Health and Human Services Committee**

Presenter:
Lead Department: Police

***Executive Summary:***

***Recommended Action:***

**ATTACHMENTS:**

| Description | Type |
|---|---|
| H&HS Committee Minutes 20240222 | Minutes |

**HEALTH AND HUMAN SERVICES COMMITTEE**
**Village of Schaumburg**
**Meeting of February 22, 2024 7:00 PM**
**Conference Room B**

---

| | |
|---|---|
| **CALL TO ORDER:** | Chairperson Patel called the meeting to order at 7:00 p.m. |
| **MEMBERS PRESENT:** | Trustee Esha Patel<br>Trustee Mark Madej<br>Trustee Jack Sullivan |
| **OTHERS PRESENT:** | Brian Townsend, Village Manager<br>Bill Wolf, Police Chief<br>Shawn Green, Deputy Police Chief<br>Ryan Franklin, Assistant Director of CDD<br>Chidochashe Baker, Community Planner |
| **OTHERS PRESENT VIA REMOTE:** | |

**APPROVAL OF MINUTES:**

**A motion was made by Trustee Madej to approve the minutes of the meeting of October 26, 2023. Seconded by Trustee Sullivan. Roll call – Trustee Sullivan, Madej and Patel voted aye. No Trustee voted nay. Motion carried unanimously.**

**NEW BUSINESS:**

1. **Recommendation to Approve Modifications to Therapeutic Mental Health Services Delivery Model**

   Chief Wolf reminded the committee that back in August 2023 they were presented a plan to transition away from the Family Counseling Center (FCC) model. An analysis was done at the time that showed most of the people who were going to the FCC had their own insurance and could easily transition to a therapist in the private sector. We contracted with Owens and Associates to provide counseling services to people who wanted to continue their therapies there or could not afford to make the move to private sector. Over this period most people have either finished their counseling or have moved to private providers. Since then, we have not seen a strong need for that service in the community. We have seen some people that are being referred to or coming through our social workers that can't afford private services that are being helped initially with our staff therapist or are being referred to Owens to provide that service.

   Chief Wolf reminded the Committee that we had received a grant for the mobile health unit and that program is up and running and is having great success.

Staff recommends keeping the FCC closed, consider selling the building at 17 E. Schaumburg Rd, and hire a hybrid therapist who could provide therapy but also be another resource to respond with the Mobile Mental Health Crisis Unit.

Trustee Sullivan asked if our current social workers still see people who come in. Chief Wolf responded yes; we currently have social workers who is also a licensed therapist. Anyone who needs longer therapies we are referring out to Owens and Associates to provide that service.

Trustee Sullivan asked if we are eligible for any of the mental health board funds being provided by the Township. Chief Wolf informed him that Kristin Jordan has been in touch with the Township and we are looking into it.

**A motion was made by Trustee Madej to concur with the recommendation to approve the modifications to the village's therapeutic mental health services delivery model and direct staff to explore the disposition of the property at 17 E. Schaumburg Road. Seconded by Trustee Sullivan. Roll call – Trustee Sullivan, Madej and Patel voted aye. No Trustee voted nay. Motion carried unanimously.**

2. **Recommendation to Approve the Community Development Block Grant (CDBG) 2023 Action Plan Amendment**

HUD allows the Village to make minor amendments to the Consolidated Plan and Action Plan administratively. Substantial amendments must go through the public hearing process, which requires a 30-day public comment period and public hearing. Substantial amendments are defined in the Citizen Participation Plan, and required under the following circumstances:

1. To carry out an activity not previously described in the Consolidated Plan or Annual Action Plan
2. To make a substantial change in the purpose, scope, or location of an activity.
3. To increase a project or activity's budget by more than 25%

At the beginning of PY 2023 the Village had a total entitlement balance of $909,527.58. The Revised 2023 Action Plan estimated $145,960.75 in uncommitted prior year funds. These are funds that are not committed to any projects. At the beginning of PY2023 the Village had a total of $217,772.94 in actual uncommitted prior year funds. Because of the additional uncommitted prior year funds available, Staff is proposing to reallocate funds to new and existing projects/programs.

Existing projects that have funding increases:

- The Residential Rehabilitation Loan Program was originally allocated for $100,000 staff is recommending increasing it by $5,000.
- The Barn Renovation was initially allocated $114,000. After working with EPW staff is recommending an additional $46,400 in the amendment.
- Planning and Administration was originally allocated $600. The budget for travel and meeting is increasing by $200 and audit costs are increasing by $25. Staff is recommending increasing it by $225.

New projects not listed in the original action plan:

- Residential Rehabilitation Loan Program – Administration, which is administrated by North West Housing Partnership (NWHP). Staff recommends allocating $15,000 to the administration f the Rehab Program in the 2023 CDBG Action Plan.
- Handy Worker Program, the Village has contracted with a new handy worker for the program and anticipates an increased number of handy work request in plan year 2023. Staff recommends allocating $5,000 for the Handy Worker Program in the 2023 CDBG Action Plan.
- CDBG Sidewalk Replacement – Area 13. Working with EPW it was identified that the area bounded by Schaumburg Rd, Braintree Drive, Amherst Dr and Ellington Dr as the targeted area for sidewalk replacement. Staff is recommending allocating $195,966.

CDBG-CV Programs:
CV-Rental and Mortgage Assistance Programs to date the amount of $42,434.73 for public service-related services. The demand for the Rental Assistance and Mortgage Assistance has decreased, staff is evaluating reallocating funds to other activities that fall within CDBG-CV guidelines.

Staff recommends approval of the Amended 2023 CDBG Action Plan.

**A motion was made by Trustee Madej to concur with the recommendation to approve the 2023 CDBG Action Plan Amendment. Seconded by Trustee Sullivan. Roll call – Trustee Sullivan, Madej and Patel voted aye. No Trustee voted nay. Motion carried unanimously.**

**3. <u>Overview of the Village's Community Development Block Grant (CDBG) Program - Informational</u>**

Brian Townsend began by mentioning there was a request to provide informational items to the committee about services and programs the Village offers. Chidochashe Baker will be doing the presentation about Community Development Block Grant (CDBG) Program.

Annually the US Department of Urban Development allocates CDBG funds to entitlement communities. These are communities that have a population of 50,000 or more. The funds are allocated to provide decent housing, provide suitable living environment, as well as expand economic development. The current allocation for entitlement funds is $375,000 received in total in funds that haven't been spend from previous year is $879,614. For the CDBG CV funds the village received $929,915 and $97,410 remains. $42,000 is allocated towards public service and remaining funds are allocated to economic development programs.

CDBG are required to be used to meet the national objectives. There are three national objectives Low and Moderate income, benefits to prevent slum and blight, and urgent need. 70% of CDBG funds are required to be used to assist low-and moderate-income (LMI) persons. There are four subcategories of LMI benefits activities:

1. Low & Moderate Area (LMA) - These are activities and projects in an area in which 51% of the residents are LMI persons. LMA service areas must be primarily residential. HUD allows an exception to the 51% requirement for communities that have few areas within the jurisdiction that have 51% or more LMI residents. The Village has an adjusted LMA percentage of 42.26%. The Village's annual

CDBG Sidewalk Replacement Program qualifies as a LMA activity. Attached is a copy of the Village's current LMA Map.

2. Low & Moderate Limited Clientele (LMC) - These are activities which benefit a limited clientele. At least 51% of the beneficiaries must be persons whose family income does not exceed the LMI income limit. Limited clientele also includes presumed LMI persons including, abused children, victims of domestic abuse, elderly persons, severely disabled adults, homeless persons, illiterate adults, persons with aids and migrant farm workers. Several public service agencies assisted through the Village's CDBG program qualify as LMC activities. Public facility improvement projects including the Jennings house renovation, the Barn Deck and Ramp project, and the Harbour house renovation also qualify as LMC activities.

3. Low & Moderate Housing (LMH) - These are activities carried out for the purpose of providing or improving permanent residential structures which upon completion will be occupied by LMI households. The village's Residential Rehabilitation and Handy Worker Programs qualify as LMH Activities. Attached is a copy of the 2023 Income limits.

4. Low & Moderate Job Creation and Retention (LMJ) - These are activities designed to create or retain permanent jobs, at least 51 percent of which (computed on a full-time equivalent basis) will be made available to or held by LMI persons. The Village's Small business loan Program qualifies as a LMJ activity.

In order to receive CDBG funds the Village must prepare and submit a Consolidated Plan and subsequent Annual Action Plans for each of the five-program year to HUD.

• The Five-Year Consolidated Plan is a comprehensive planning document that identifies the overall housing and community development needs of the Village, outlines available programs, and resources, and establishes a strategy for prioritizing and addressing these needs. The Village's current Five-Year Consolidated Plan was submitted in 2020 to cover CDBG program years 2020 - 2024. Staff will begin preparation of the next Five-Year Consolidated Plan (2025 - 2029) in October of 2024 for submission in August of 2025.

• An Annual Action Plan is a document that identifies projects and activities the Village plans to accomplish in each program year (PY) to address the priorities and objectives of the Five-Year Consolidated Plan. The village is currently in program year 2023 which began in October of 2023 and will end in September of 2024.

- HUD allows the Village to make minor amendments to the Consolidated Plan and Action Plan administratively. Substantial amendments must go through the public hearing process, which requires a 30-day public comment period and public hearing. Substantial amendments are defined in the Citizen Participation Plan, and required under the following circumstances:
  1. To carry out an activity not previously described in the Consolidated Plan or Annual Action Plan; or
  2. To make a substantial change in the purpose, scope, or location of an activity.
  3. To increase a project or activity's budget by more than 25%.

- The Consolidated Annual Performance and Evaluation Report (CAPER) is a report on the progress in carrying out the Annual Action Plan. The CAPER is designed to provide the jurisdiction an opportunity to assess its annual performance in relationship to meeting its overall five-year Consolidated Plan priorities and objectives.

The current Five-Year Consolidated Plan was presented to the committee:

**Current Five-Year Consolidated Plan (2020 - 2024) Objectives and Goals**

- **Public infrastructure and Public Facility Improvements**: Provide improvements to public infrastructures and public facilities to create a suitable living environment.
    - Goal: Fund a minimum of 10 public facilities, and 5 public infrastructure projects.
    - Current public facilities projects and activities:
        - Jennings House Renovation,
        - The Barn Deck & Ramp Project
        - The Harbour House Renovation
    - Current public infrastructure projects and activities:
        - Annual CDBG Sidewalk Program

- **Affordable Housing**: Provide decent housing through access to affordable housing programs and services.
    - Goal: Assist a minimum of 55 households.
    - Current projects and activities:
        - The Residential Rehab Program: This program offers 0% interest loans to eligible homeowners for necessary home improvements. Priority is given to elderly and disabled homeowners. A maximum loan of $25,000 for a single-family household and $15,000 for a multi-family household is provided to the homeowner and is due in 30 years, whenever the home is sold or there is a change in title.
        - The Handy Worker Program: This program provides grants to elderly and disabled homeowners for minor repairs and ADA improvements. A maximum grant of $500 per household is provided.

- **Public Service Assistance:** Provide assistance to non-housing public services to provide suitable living environments and economic development assistance. * HUD has a cap of 15% of the annual allocation for public service assistance.
    - Goal: Assist 850 residents through public service agencies.
    - Types of public service agencies currently funded:
        - Homeless /Continuum of Care public services
        - Special need public services
        - Non-special needs/non-homeless public services

- **Economic Development**: Create economic development opportunities for the purpose of creating/retaining jobs, assisting low and moderate-income business owners, improving commercial areas, and providing additional services to low- and moderate-income areas.
    - Goal: Assist a minimum of 15 businesses.

  - Current projects and activities:
    - Small Business Loan Program: This program provides eligible applicants with 80% matched, forgivable loans of up to $15,000.

- **Planning and Administration**: Utilize CDBG funds for staff time and necessities to administer the CDBG program. *HUD has a cap of 20% of the annual allocation for Planning and Administration costs.

**A motion was made by Trustee Madej to accept this information regarding Overview of the Village's Community Development Block Grant (CDBG) Program. Seconded by Trustee Sullivan. Roll call – Trustee Sullivan, Madej and Patel voted aye. No Trustee voted nay. Motion carried unanimously.**

**UNFINISHED BUSINESS:**

**DEFERRALS:**

**COMMENTS FROM THE AUDIENCE:**

**ADJOURNMENT:**

**A motion was made by Trustee Sullivan to adjourn the Health and Human Services meeting at 7:33p.m. Seconded by Trustee Madej. Roll call – Trustee Sullivan, Madej and Patel voted aye. No Trustee voted nay. Motion carried unanimously.**

**NEXT VILLAGE BOARD MEETING:** March 12, 2024

Respectfully submitted,
Elizabeth Scanlan, Recording Secretary

VILLAGE OF SCHAUMBURG

# AGENDA ITEM SUMMARY

**Recommendation to Approve Amendment No. 1 and No. 2 to the Residential Refuse and Recycling Collection Services Agreement with Lakeshore Recycling Systems, LLC.**
**3/28/2024**
**Health and Human Services Committee**

Presenter: Adrian Marquez, Engineering and Public Works, Field Services Superintendent
Lead Department: Engineering and Public Works

| Accounts(s): | Budget: | Expense Request: |
|---|---|---|
| 2359010-7274 | $5,152,848.84 | $5,157,710.40 |

The budget status for this request is: Over Budget

Amount Over Budget: $4,861.56

If amount requested is over budget, a detailed explanation of what account(s) the overage will be charged to will be provided in the Executive Summary or attached detail.

***Executive Summary:***

Representatives from the Sarah's Grove Homeowner Association requested that the Village provide the same curbside yard waste pickup service for its 127 townhouse units as single-family homes at Village expense. Sarah's Grove is currently provided the same refuse and recycling removal service as single-family homes. Each multi-family unit has an individual address with an individual backyard. Homeowners are responsible for maintenance of the lawns, bushes and trees planted in their yards. Discussion with Sarah's Grove residents and the refuse contractors indicate that the previous refuse contractor Republic picked up yard waste and Lakeshore Recycling Systems, LLC. (LRS) discontinued this service upon discovering that this particular service was not included in the Village contract.

The Village's refuse disposal provider, LRS, was asked to provide pricing for the collection of yard waste for the Sarah's Grove units. LRS advised that they could charge the same fee as for single-family homes beginning April 1, 2024, on the condition that yard waste is limited to two bags per unit per week. This fee amounts to $38.28 annual cost per unit and was unbudgeted in the FY 24/25 proposed budget.

Providing landscape waste service for Sarah's Grove units will require a first amendment to the Residential Refuse and Recycling Collection Services Agreement approved by the Village Board on February 8, 2022. The amendment shifts 127 units from Multi-family to the Single-family rate. This shift will increase the annual cost to the Village by $4,861.56 to a new total of $5,157,710.40 for FY 24/25. The new pricing table is included in Amendment No. 2 - Exhibit B.

***Recommended Action:***

The Village Manager recommends the Health and Human Services Committee recommend the Village Board approve Amendment No. 1 and No. 2 to the Residential Refuse and Recycling Collection Services Agreement with Lakeshore Recycling Systems, LLC. from Rosemont, IL and approve the required Resolution.

**ATTACHMENTS:**

| Description | Type |
|---|---|
| Resolution | Resolution Letter |
| Amendment No. 1 - Exhibit A | Exhibit |
| Amendment No. 2 - Exhibit B | Exhibit |

**RESOLUTION NO. R-24-**

**A RESOLUTION AUTHORIZING THE VILLAGE MANAGER TO SIGN THE FIRST AND SECOND AMENDMENT TO THE RESIDENTIAL REFUSE AND RECYCLING COLLECTION SERVICE AGREEMENT BETWEEN THE VILLAGE OF SCHAUMBURG AND LAKESHORE RECYCLING SYSTEMS, LLC.**

**WHEREAS,** the Village of Schaumburg previously entered into a five-year franchise agreement with LRS dated to provide residential refuse and recycling services; and

**WHEREAS,** the Village of Schaumburg and LRS wish to allow for the increase or decrease in the number of household units to be served by LRS and paid for by the Village on an annual basis; and

**WHEREAS**, the Village of Schaumburg has requested to move 127 units (Sarah's Grove) from the class of service known as: ***Curbside multi-family residential service plus unlimited recycling collection*** to the class of service known as: ***Curbside single family unlimited residential service plus unlimited recycling and two bags per unit for yard waste collection***.

**WHEREAS,** the corporate authorities have received the amendments, which is attached hereto and marked as Exhibit "A" and "B"; and find that it is in the best interests of the Village of Schaumburg to execute the First and Second Amendments.

**NOW, THEREFORE, BE IT RESOLVED BY THE PRESIDENT AND BOARD OF TRUSTEES OF THE VILLAGE OF SCHAUMBURG:**

**SECTION ONE:** That the Village Manager be and hereby is authorized and directed to execute the attached first and second amendment to the residential refuse and recycling collection service agreement attached as Exhibit "A" and "B".

**SECTION TWO:** That this Resolution shall be in full force and effect after passage and approval as required by law.

**AYES:**

**NAYS:**

**ABSENT:**

**PASSED AND APPROVED** this _____ day of _____, 2024.

_____
Village Manager

ATTEST:

_____
Village Clerk

"EXHIBIT A"

# FIRST AMENDMENT TO THE RESIDENTIAL REFUSE AND RECYCLING COLLECTION SERVICE AGREEMENT

**WHEREAS**, the Village of Schaumburg ("Schaumburg") and LRS of Rosemont, IL ("Contractor") have a Refuse & Recycling Collection Services agreement with the Village of Schaumburg dated May 1, 2022; and

**WHEREAS**, the parties agree that it would be mutually in the best interests to amend that agreement to allow for the increase or decrease in the number of household units to be served by the Contractor and paid for by Schaumburg.

THE PARTIES, THEREFORE, AGREE AS FOLLOWS:

That the contract between Schaumburg and Contractor be amended to add as follows:

Residential Refuse and Recycling Collection Service Costs: The Village and LRS shall on an annual basis review the quantity of services provided by LRS and upon mutual agreement adjust the quantity. The unit costs shall remain in full force and effect.

That all other terms and conditions of the contract shall remain in full force and effect.

DATED THIS_____day of _____, 2024

| Village of Schaumburg | LRS of Rosemont, IL |
|---|---|
| BY: _____ | BY: _____ |
| Village Manager | |

"EXHIBIT B"

SECOND AMENDMENT TO THE RESIDENTIAL REFUSE AND RECYCLING COLLECTION SERVICE AGREEMENT

**WHEREAS**, the Village of Schaumburg ("Schaumburg") and LRS of Rosemont, IL ("Contractor") have a Refuse & Recycling Collection Services agreement with the Village of Schaumburg dated May 1, 2022; and

**WHEREAS**, the Village of Schaumburg and the Contractor desire to execute the First and Second Amendment to the agreement concurrently; and

**WHEREAS**, the Village of Schaumburg has requested to move 127 units (Sarah's Grove) from the class of service known as: ***Curbside multi-family residential service plus unlimited recycling collection*** to the class of service known as: ***Curbside single family unlimited residential service plus unlimited recycling and two bags per unit for yard waste collection***.

THE PARTIES, AGREE TO THE FOLLOWING CHANGES TO THE AGREEMENT:

| Original Contract | Year 1 (2022/2023) | Year 2 (2023/2024) | Year 3 (2024/2025) | Year 4 (2025/2026) | Year 5 (2026/2027) |
|---|---|---|---|---|---|
| | | | | | |
| **TOTAL PER YEAR:** | **$ 4,793,014.92** | **$ 4,993,647.66** | **$ 5,152,848.84** | **$ 5,325,559.74** | **$ 5,505,235.08** |
| | | | | | |
| **Amendment #2** | | | | | |
| 127 Units at Sarah's Grove - Yardwaste Service Add-on | | $ 393.70 | $ 4,861.56 | $ 5,013.96 | $ 5,181.60 |
| **TOTAL PER YEAR:** | | **$ 393.70** | **$ 4,861.56** | **$ 5,013.96** | **$ 5,181.60** |
| **TOTALS:** | | **$ 4,994,041.36** | **$ 5,157,710.40** | **$ 5,330,573.70** | **$ 5,510,416.68** |

**Effective date:** The parties agree that these changes shall be effective April 1, 2024.

That all other terms and conditions of the contract shall remain in full force and effect.

DATED THIS_____day of _____, 2024

Village of Schaumburg

BY: _____
Village Manager

LRS of Rosemont, IL

BY: _____

VILLAGE OF SCHAUMBURG

# AGENDA ITEM SUMMARY

**Presentation of Phase 1 Report of Schaumburg Community Health Needs Assessment**
**3/28/2024**
**Health and Human Services Committee**

| | |
|---|---|
| Presenter: | Andrew S. Buckwinkler; Management Analyst Rachel Sacks; President of Leading Healthy Futures |
| Lead Department: | General Government |

***Executive Summary:***

In FY 22/23, the Village Board authorized the use of up to $75,000 in ARPA (American Rescue Plan Act) funds to conduct a health service needs assessment (HSNA). This assessment aims to identify gaps in health services within the community and develop strategies to address these gaps effectively.

In August 2023, the Village Board authorized staff to award a contract to Leading Healthy Futures for Phase I of this assessment. Phase I included a thorough examination of the existing health services within the Schaumburg to identify any gaps, deficiencies, or areas that require improvement.

To complete this HSNA, the Village of Schaumburg with the support of our consultant, Leading Health Futures (LHF) conducted an assessment utilizing the Mobilizing for Action through Planning and Partnerships (MAPP 2.0) as a framework. This framework was developed by the National Association of County and City Health Officials (NACCHO), MAPP is a Centers for Disease Control and Prevention–approved planning process and one which the Illinois Department of Public Health (IDPH) considers to be an equivalent process for completing a certified local health department's Illinois Project for Local Assessment of Needs (IPLAN). The Village of Schaumburg was not required to use an IPLAN-approved framework to conduct its needs assessment, but elected to do so because MAPP is considered the gold standard for community health needs assessment processes.

The MAPP Framework includes three phases:

1. Build a Community Health Improvement Foundation
2. Tell the Community Story
3. Continuously Improve the Community

Phases 1 and 2 were accomplished through the village's Phase I assessment.

The full report is attached for review, accompanied with a short summary of each assessment conducted. Upon acceptance of the Phase I report, staff will coordinate with Leading Healthy Futures to establish a timeline for Phase II which will utilize support and feedback obtained during Phase I to draft a Health Services Improvement Plan. The anticipated cost of Phase II is $18,900 and is expected to have a duration of six months.

***Recommended Action:***

The Village Manager recommends the Health and Human Services Committee recommend the Village Board accept the Phase 1 report and direct staff to proceed with Leading Healthy Futures to conduct Phase II of the Health Services Needs Assessment.

**ATTACHMENTS:**

| Description | Type |
|---|---|
| Community Health Needs Assessment (Full Report) | Exhibit |
| Health Needs Assessment PowerPoint Presentation | Exhibit |
| Community Context Assessment (Short Report) | Exhibit |
| Community Status Assessment (Short Report) | Exhibit |
| Community Partner Assessment (Short Report) | Exhibit |

# Community Health Needs Assessment

## August 2023 - March 2024


VILLAGE OF SCHAUMBURG

PROGRESS THROUGH THOUGHTFUL PLANNING

## Table of Contents

# I. Executive Summary

The aim of this community health needs assessment is to identify and enhance our understanding of the health needs, as well as assess the existing services and infrastructure available to fulfill these needs, in the Village of Schaumburg and for its residents.

The assessment was led by a project team from the Village of Schaumburg with support from consultant Leading Healthy Futures (LHF), who conducted the assessment in keeping with the Illinois Project for Local Assessment of Needs (IPLAN), which requires such a process every five years for local health departments certified by the Illinois Department of Public Health. The assessment uses the Mobilizing for Action Through Planning and Partnerships 2.0 (MAPP 2.0) process as its framework and structure to understand the community's health status, community members, and the capacity of health and nonprofit partners within the community to improve health for all. Through this process, the village gathered both quantitative data on community health as well as perspectives from health care providers, social service agencies, community groups, and more than 500 individuals who live, work, shop, and play in Schaumburg.

The Village of Schaumburg is home to 79,498 residents, of whom 56% identify as white non-Hispanic and 24% as Asian. Nearly 40% of all residents speak a language other than English at home, with common languages including include Spanish, Polish, Gujarati, Urdu, Hindi, Japanese, and Korean. The village has lower rates of poverty and unemployment than elsewhere in Cook County, and higher levels of educational attainment and rates of health insurance. Many health indicators are better than state and national averages, including those around chronic disease, prenatal health, and pediatric health, though opportunities exist to improve cancer screening rates.

Feedback from community members highlighted the many strengths and assets within the community, including collaborative agencies, parks and green spaces, and access to health care facilities and community services. At the same time, community members also noted barriers to accessing care, including transportation challenges, challenges affording and understanding health insurance, and a level of need for behavioral health services that exceeds current capacity. Housing costs and access to affordable housing were also common challenges. Many community partners have the capacity and skills to fulfill essential public health services, a commitment to equity and community engagement, and are interested in participating in community health improvement activities.

From this assessment, several key cross-cutting strengths, assets, and areas for improvement emerged, including:

- *Community Strengths and Assets:* strong collaboration between government agencies; diverse community; many green spaces; strong business community; strong response to COVID; and many nonprofits and government agencies available to fulfill essential public health services.
- *Social Determinants of Health Facing Residents:* Transportation and public transit barriers; housing cost challenges; language barriers; and challenges accessing, affording, and understanding health insurance.
- *Health and Social Service Capacity and Opportunities for Improvement:* Workforce challenges; growing demand for mental health services and services for older adults, adults with disabilities, and young people; opportunity for more health service facilities, access points, preventive services, and for bringing services closer to residents; and opportunity to increase communication, outreach, and collaboration.

Findings from this assessment affirm that the Village of Schaumburg has a strong infrastructure of social service and health partners that together provide the community with essential public health services. The assessment also pinpointed specific areas where the village has the potential to be a leader in implementing improvements. The project team and its many partners across the community look forward to using this assessment to inform future opportunities to advance some of these areas of improvement and promote access to health and equitable health outcomes for all who live, work, shop, and play in the village.

# II. Introduction and Process

## A. The Village of Schaumburg

The Village of Schaumburg is a full-service home rule municipal corporation located in the northwest corner of suburban Cook County, with a small portion in DuPage County. It is bordered by the municipalities of Elk Grove Village, Rolling Meadows, Palatine, Hoffman Estates, Streamwood, Hanover Park, and Roselle.

Since its incorporation in 1956, the Village of Schaumburg has grown from a population of 130 to what is now the 12th largest community in Illinois, with more than 79,498 residents as of 2017-2021 ACS five-year estimates. Outside the City of Chicago, Schaumburg is the largest center of economic development in the State of Illinois. In addition to the 9.5 million square feet of retail and restaurant space, the Village has over 12 million square feet of office space and 13.5 million square feet of industrial space. With a daytime population of 150,000, thousands of businesses, 30 hotels, over 200 restaurants, a highly educated workforce, superb location and high quality of life, Schaumburg is 'The Place for Business'.

Schaumburg is one of 125 municipalities and 30 townships that are under the jurisdiction of the Cook County Department of Public Health (CCDPH). CCDPH provides services related to communicable disease prevention and control, community epidemiology, emergency preparedness, environmental health, and integrated health support services.

Beyond those services provided by CCDPH, Schaumburg residents and businesses have access to a wide variety of local health services provided by the Village of Schaumburg, Schaumburg Township, other government agencies and divisions such as the Schaumburg Park District and Schaumburg Library, as well as several local private and non-profit service providers. Examples of these services include the following:

- Health inspection programs and services
- Emergency preparedness and response
- Senior services
- General/financial assistance programs
- Nursing services
- Behavioral health services
- Domestic violence services
- Youth and young adult services
- Transportation

## B. Illinois Project for Local Assessment of Needs (IPLAN)

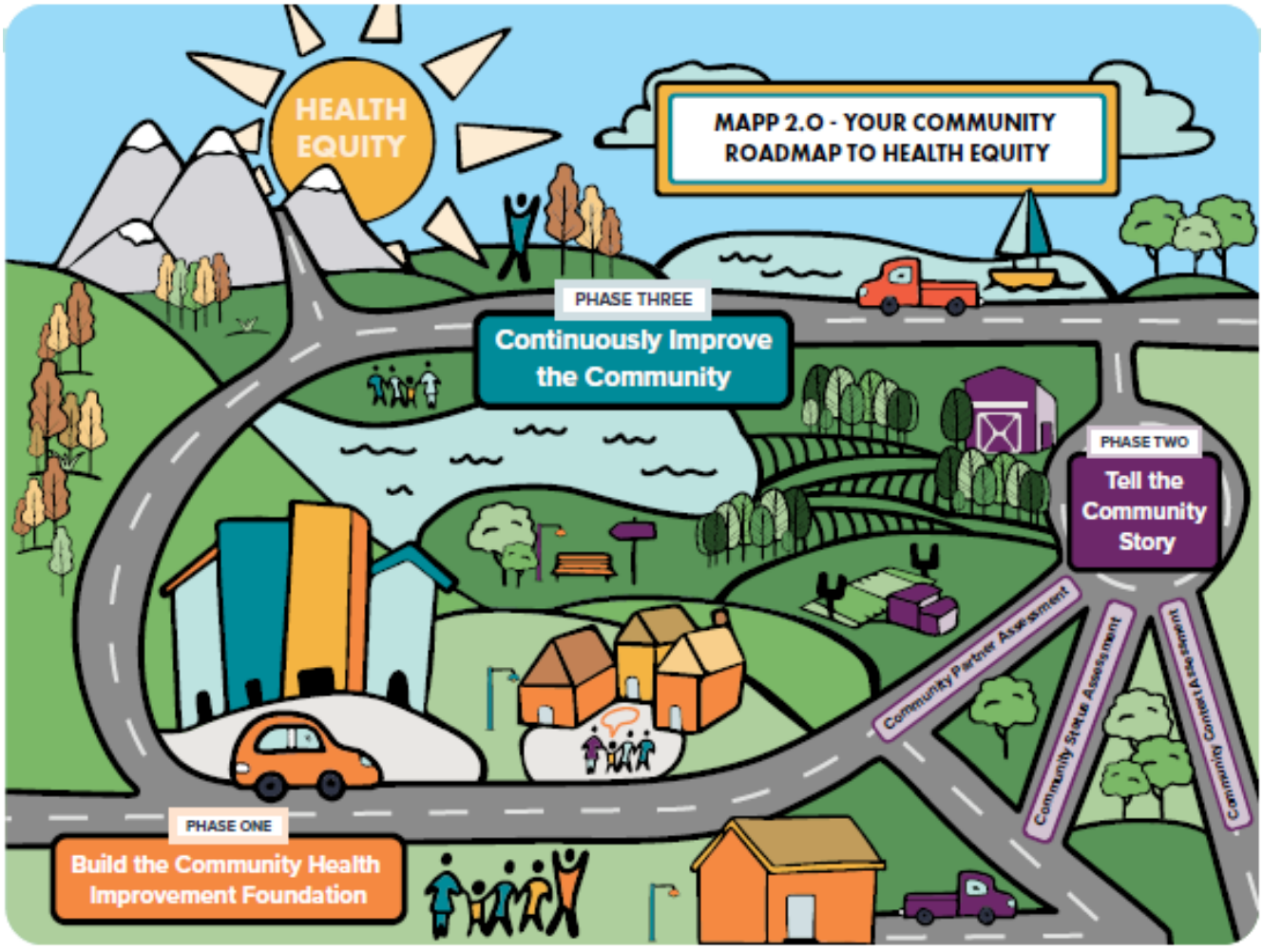
Illinois law requires that, every five years, each local health department complete an Illinois Project for Local Assessment of Needs (IPLAN), which is a community health assessment and health improvement process. This fulfills the requirements of the Illinois Administrative Code, Title 77, Subsection 600.410 for certification for local public health departments by the Illinois Department of Public Health (IDPH). Although the Village of Schaumburg is not a certified local health department, it chose to conduct a community health needs assessment consistent with IPLAN requirements to better understand and improve the health of its residents.

The IPLAN process is grounded in the core functions of public health and incorporates robust participation of community stakeholders. The essential elements of an IPLAN are an organizational capacity assessment, a community health needs assessment, and a community health improvement plan.

## C. The MAPP 2.0 Framework

To complete this community health needs assessment, the Village of Schaumburg and its partners adapted the nationally recognized model Mobilizing for Action through Planning and Partnerships (MAPP). Developed by the National Association of County and City Health Officials (NACCHO), MAPP is a Centers for Disease Control and Prevention–approved planning process and one which IDPH considers to be an equivalent process for completing a certified local health department's IPLAN. The Village of Schaumburg was not required to use an IPLAN-approved framework to conduct its needs assessment, but elected to do so because MAPP is considered the gold standard for community health needs assessment processes.

In 2023, MAPP released MAPP 2.0, an updated framework which seeks to achieve health equity by identifying urgent health issues in a community and aligning community resources.




MAPP involves developing a community-wide vision for health, involving organizations across sectors, assessing both community needs and strengths, and assigning resources to the underlying drivers of inequity. The process includes three phases:

- Phase One: Build the Community Health Improvement Foundation
- Phase Two: Tell the Community Story
- Phase Three: Continuously Improve the Community

## D. Village of Schaumburg Community Health Needs Assessment Process and Timeline

The MAPP 2.0 process begins with Phase One: Build the Community Health Improvement Foundation, which unites partner organizations and people to plan for the activities of the needs assessment. In Schaumburg, this process formally began in August 2023. The village contracted with Leading Healthy Futures (LHF) to support its needs assessment activities, formed a project team of internal village staff from across departments, and identified a diverse list of key external partners and collaborators. An introductory meeting was held in October to welcome community partners, introduce them to the process, and begin to develop a community vision.

Phase Two: Tell the Community Story involved preparation, application, and analysis of three different assessments. This began in Fall 2023 with the gathering and analysis of quantitative data for the Community Status Assessment (CSA), and continued with developing and conducting surveys, focus groups, and interviews for the Community Context Assessment (CCA) and Community Partner Assessment (CPA). In January 2024, the project team hosted a community partner meeting to review the results of the CSA and CCA and to complete the CPA.

This report summarizes Phases One and Two of the MAPP process completed by the village in March 2024.

# III. Phase One: Build the Community Health Improvement Foundation

## PURPOSE

In Phase One of the MAPP 2.0 process, the facilitating organization identifies its stakeholders in the community, establishes its leadership and administrative structure and engages its steering committee, and develops a community vision. This phase unites many different types of partner organizations and stakeholders to plan for and begin to implement MAPP.

## PROCESS

As the facilitating organization, the Village of Schaumburg took several steps to plan for the leadership, administrative structure, and infrastructure of a health services needs assessment. The village contracted with Leading Healthy Futures (LHF) to design and lead the assessment process, created an interdepartmental project team of village staff to oversee and provide subject matter expertise and internal perspectives to LHF, and provided the overall leadership and administrative resources to ensure that high-quality assessments could be conducted in Phase Two.

The village project team also helped build relationships with other stakeholders and community partners listed throughout this report. These partners subsequently lent their support and participated in surveys, focus groups, interviews, and community conversations. Additionally, these partners began the process of developing a shared community vision by brainstorming words that described their vision for health and health equity in Schaumburg.

### Village Project Team

Andrew Buckwinkler
Management Analyst
Village of Schaumburg

Kathleen Henkelman
Nursing & Senior Services Supervisor
Village of Schaumburg

Paula Hewson
Assistant Village Manager
Village of Schaumburg

Kristin Jordan
Supervisor of Human Services
Village of Schaumburg

Malgorzata Telichowska
Administrative Intern
Village of Schaumburg

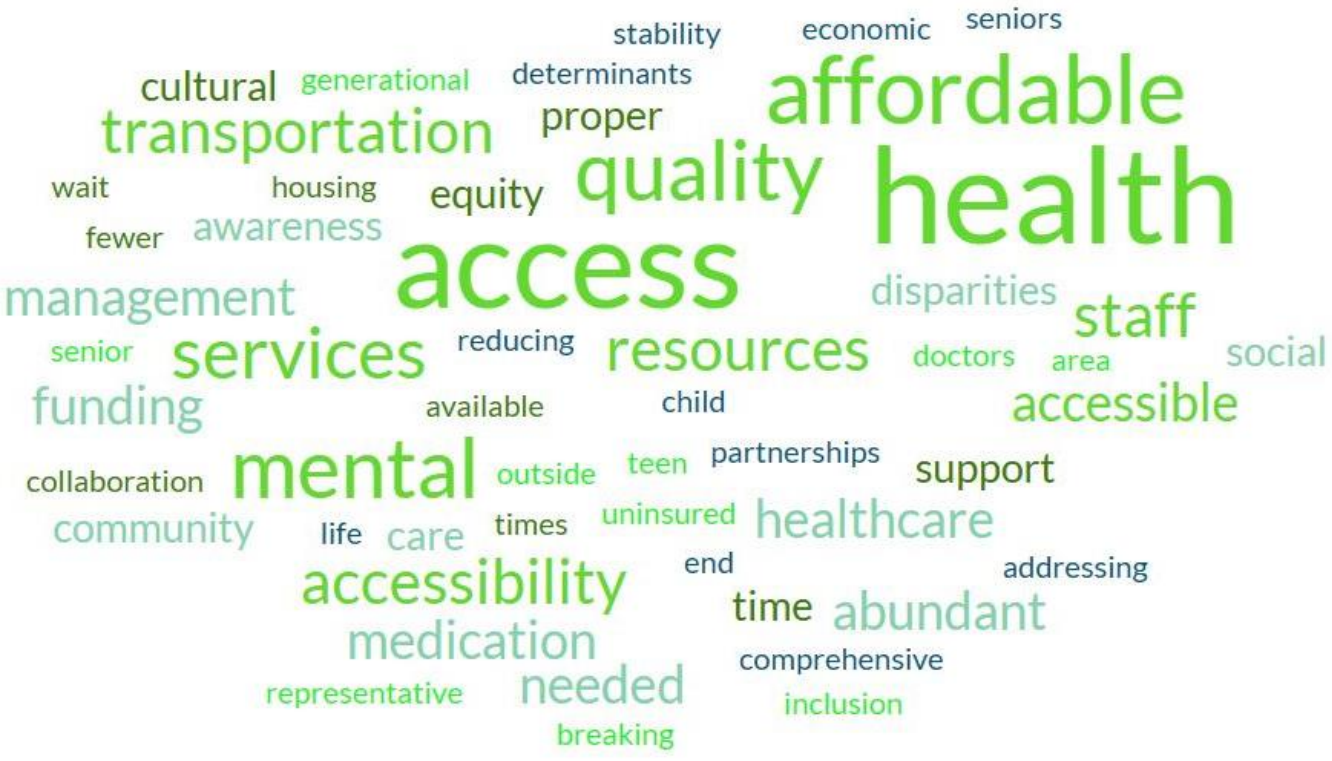
Sharrita Vantrece
Health Supervisor
Village of Schaumburg

### Community Partners

Apna Ghar
Boys & Girls Club of Elgin
Children's Advocacy Center of North and Northwest Cook County
Clearbrook
Greater Family Health
Fellowship Housing
JOURNEY | The Road Home
Kenneth Young Center
Life Span
Northwest CASA
Northwest Community Hospital
Northwest Compass, Inc.
Partners for Our Communities (POC)
Safe From the Start
Schaumburg Business Association
Schaumburg High School
Schaumburg Park District
Schaumburg School District #5411
Schaumburg Township
Schaumburg Township District Library
Schaumburg Township Mental Health Board
Shelter, Inc.
St. Peter Lutheran Church & School
The Bridge Youth and Family Services
The Salvation Army
The SHARE Program

### Vision

Based on brainstorming activities held with partners in October 2023 and January 2024, the word cloud below shows some of the words that described the vision that community partners have for health and health equity in Schaumburg. Key recurring words included access and accessibility, affordable, quality, services, resources, mental health, and transportation.



## IV. Phase Two: Tell the Community Story

In Phase Two of the MAPP 2.0 process, three different assessments are conducted to paint a comprehensive picture of health in the community.

The **Community Status Assessment** collects quantitative data on the status of the community such as demographics, health status, and health inequities. It helps reveal gaps, issues, and inequities across a variety of population and health indicators.

The **Community Context Assessment** uses qualitative data to assess community strengths and assets, built environment, and forces of change. It collects insights, expertise, and views of people and communities affected by social systems and centers on people and communities with lived experience who may be experiencing inequities firsthand.

The **Community Partner Assessment** provides a structure for community partners to look critically at their individual systems, processes, and capacities, and the collective capacity of the system to address inequities and advance health equity.

The Village of Schaumburg, in partnership with LHF and with the support of a variety of community organizations, conducted these three assessments between October 2023 and January 2024. This section summarizes the purpose, methods, and results or findings of each assessment.

## A. Community Status Assessment

### PURPOSE

The Community Status Assessment (CSA) collects quantitative data on the status of the community such as demographics, health status, and health inequities. It helps reveal gaps, issues, and inequities across a variety of indicators. It answers questions like:

- What does the status of the community look like, including key health, socioeconomic, environmental, and quality-of-life outcomes?
- What populations are experiencing inequities across health, socioeconomic, environmental, and quality-of-life outcomes?
- How do systems influence outcomes? Where are the gaps?

### PROCESS

LHF worked with the village project team to identify demographic and health indicators for analysis and to conduct the CSA during September 2023. Data was collected using the most recently available data sets as of September 2023 from the American Community Survey (ACS) 2017–2021 five-year estimates; CDC Wonder; the Behavioral Risk Factor Surveillance System (BRFSS); Youth Risk Behavior Survey (YRBS); Data Resource Center for Child and Adolescent Health; UDS Mapper; Policy Map; Spark Map; CDC PLACES; Cook County Health Atlas; City Health Dashboard; and other publicly available online sources.

At times, the best available data is only available at county or state levels rather than zip code level. In these cases, a standard extrapolation methodology was used to estimate the percent of a population with a certain disease or condition in each zip code. This methodology allows health data only available at the state or county level to be reliably extrapolated down to a smaller geography such as zip code, using data breakouts available by race and ethnicity or age. Extrapolations were either provided by CDC PLACES or conducted by LHF.

The analysis covered zip codes 60173, 60193, 60194, and 60195 (please note that 60196 is also part of the village but does not have any population associated with it) and was compared to relevant benchmarks such as Cook County, Illinois, or national averages as appropriate.

The CSA is organized around the social determinants of health (SDOH). Healthy People 2030, the fifth iteration of the Office of Disease Prevention and Health Promotion's Healthy People Initiative, defined SDOH as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks."[1] There are five domains of SDOH, which are:

1. Social and Community Context
2. Economic Stability
3. Education Access and Quality
4. Health Care Access, Quality, and Disparities
5. Neighborhood and Built Environment


The section on Health Care Access, Quality, and Disparities also describes morbidity, mortality, and other health indicators in the village, including for diabetes, cardiovascular disease, cancer, prenatal and perinatal health, child health, behavioral health, and other health indicators, with comparisons to national and state averages. Health indicators are color-coded based on whether the village is performing better than both the state and nation, in between, or worse than both the state and nation.

## RESULTS

### Community Overview

According to the 2017-2021 ACS five-year estimates, the Village of Schaumburg has a total population of 79,498. More than half (51% or 40,150 individuals) reside in the zip code 60193 and another quarter (26% or 20,467) live in 60194. Due to its vibrant business community, office parks, and major shopping district, nearly 70,000 workers come to Schaumburg from outside the village, nearly as many as the actual population of Schaumburg.[2] This results in a "daytime" population of approximately 150,000.

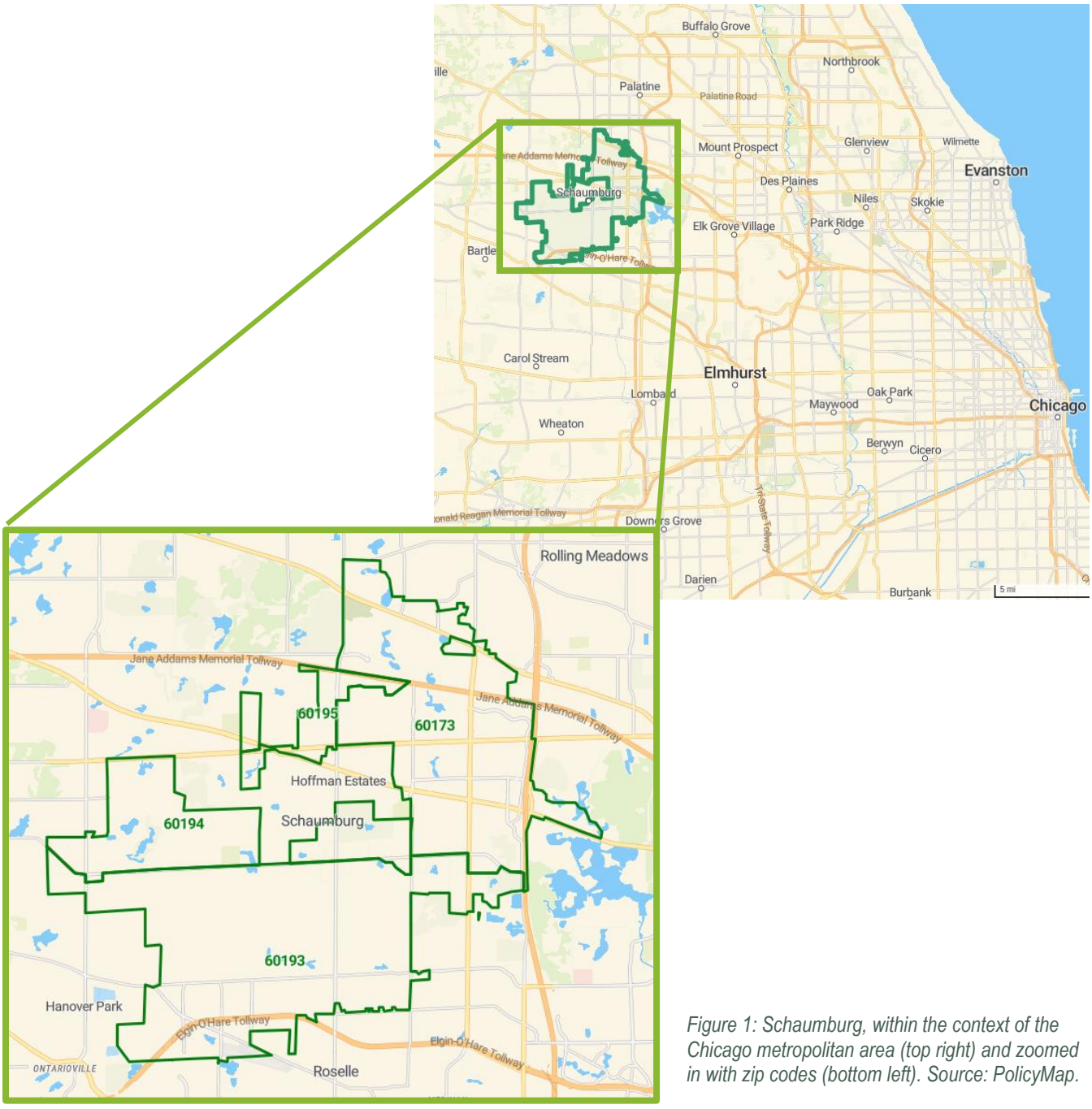



*Figure 1: Schaumburg, within the context of the Chicago metropolitan area (top right) and zoomed in with zip codes (bottom left). Source: PolicyMap.*

## Social and Community Context

*Race/Ethnicity*

The Village of Schaumburg is a racially and ethnically diverse community. A little more than half the population (56%) identifies as white non-Hispanic, which is more than in Cook County but less than in the state of Illinois. Approximately one-quarter (24%) of the population identifies as Asian, which is substantially above the county or state proportion. Another 11% of residents identify as Hispanic/Latino and 6% identify as Black/African American.

At the zip code level, two of Schaumburg's four zip codes have even higher proportions of Asian residents – 42% of residents of 60173 identify as Asian and 52% of 60195 residents do. These zip codes also have the smallest proportion of white residents. The other two zip codes have the highest proportions of Hispanic residents – 14% in 60193 and 9% in 60194 – and higher proportions of white residents as well.

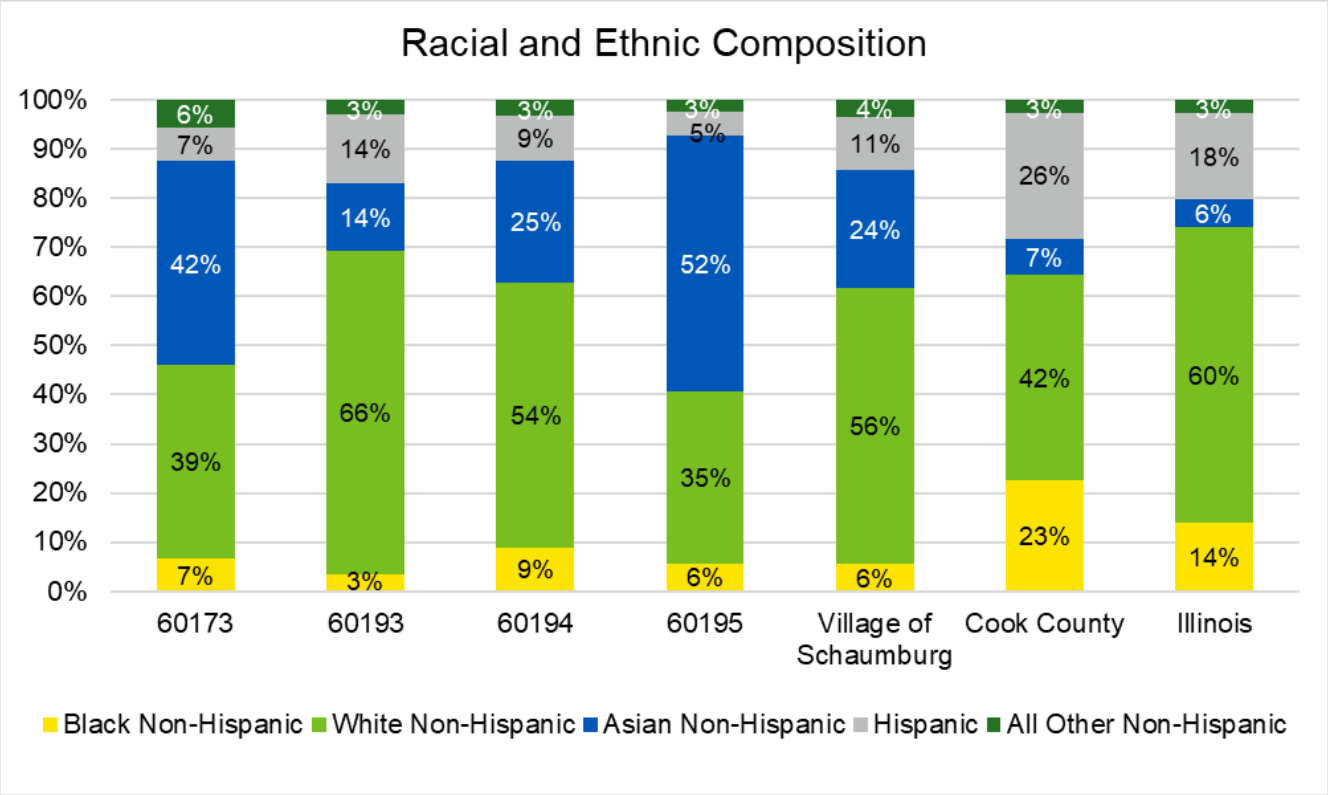



*Figure 2: Racial and ethnic composition of Schaumburg by zip code. Source: 2017-2021 ACS five-year estimates.*

According to a profile of demographic, social, and economic trends in the Village of Schaumburg based on a comparison of the 2010 and 2020 decennial census, the white non-Hispanic share of Schaumburg's population fell from 65% in 2010 to 56% in 2020, while other major groups increased their share of the population. Notably, the Asian population rose from 20% to 26%.[3] This includes not only east Asian populations such as those with roots in China, Japan, and Korea, but also southeast Asian populations such as those with roots in India, Pakistan, and Afghanistan.

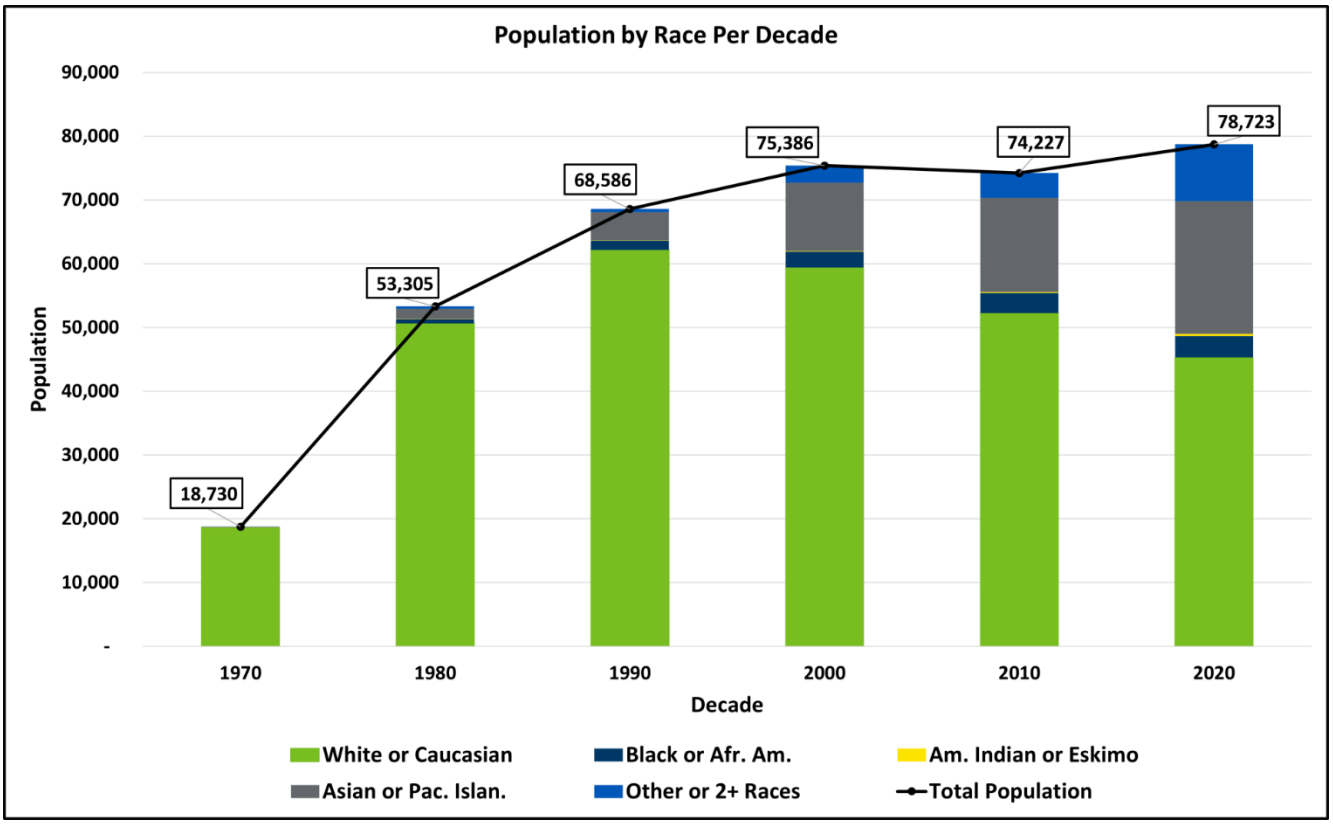



*Figure 3: Population by race per decade in Schaumburg. Source: Village of Schaumburg, based on US Census Bureau data.*

*Age*

Schaumburg overall is relatively similar to Cook County and the state of Illinois in terms of age distribution, with 23% of the population under age 18, 62% of the population between 18 and 64 years of age, and 15% of the population aged 65 years or more.

Notably, the zip code where the majority of the village population lives, 60193, has both a larger proportion of older adults and also a larger proportion of children than either Cook County or the state, and therefore a smaller proportion of working-aged adults. This may reflect the large number of older adults aging in place in the village as well as young families moving into the homes that do vacate; the high rates of homeownership in 60193 (74%) support this. This also aligns with analysis of trends between the 2010 and 2020 Census, which found that there has been a slight increase in both the share of the population that is 0-9 years old and also the share that is 55 years and older.[4]

The two smaller zip codes, 60173 and 60195, have much higher proportions of working-aged adults (71%) and fewer children or older adults. This may align with the higher rates of renters found in 60173 and 60195, where 65% and 70% of residents, respectively, are renters. These renters may be single working-aged adults, couples, and smaller families, compared to the homeowning older adults and families with children in 60193 and 60194.

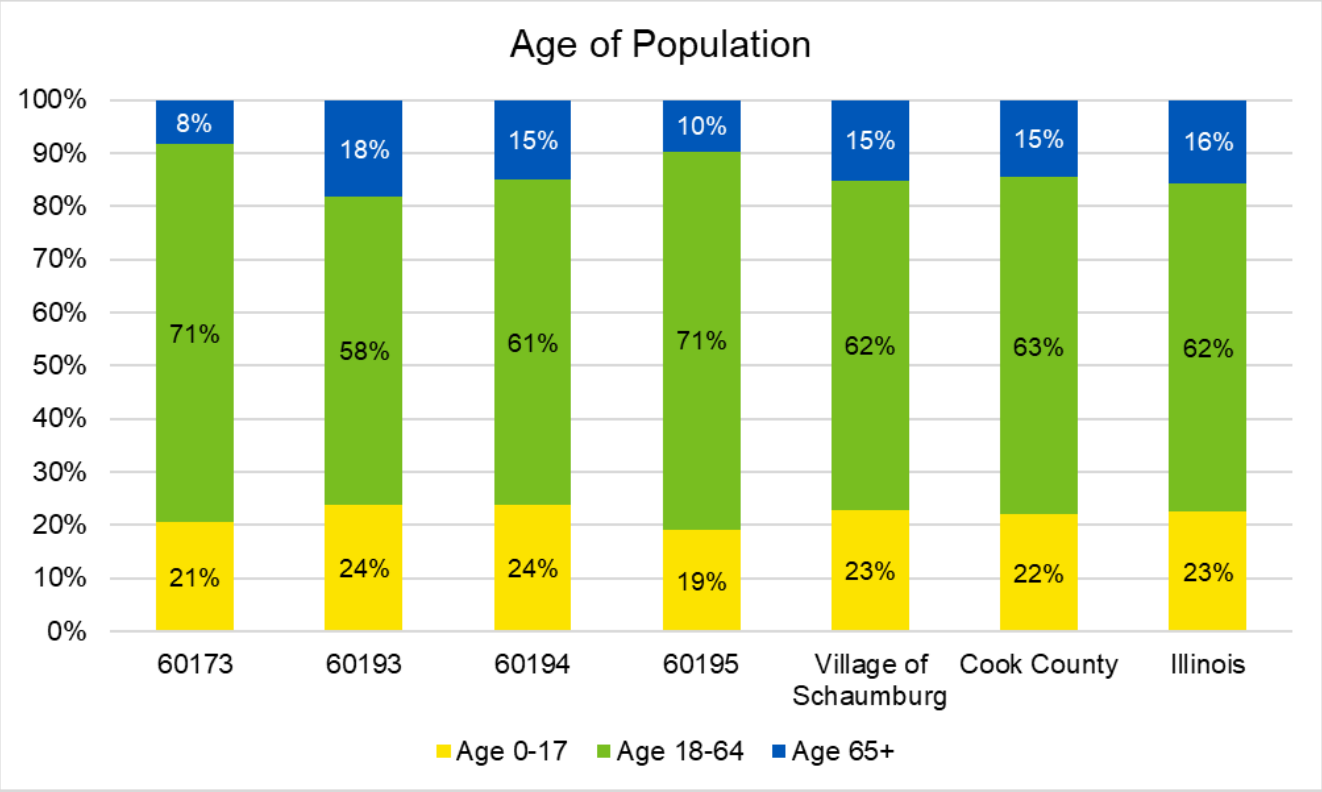



*Figure 4: Age distribution of Schaumburg by zip code. Source: 2017-2021 ACS five-year estimates.*

*International Born*

The Village of Schaumburg has a much larger proportion of immigrant residents than the state of Illinois or even Cook County. A full 30% of residents were born outside the United States, compared to just 21% in Cook County and 14% in Illinois.

The proportion of immigrant community members is highest in 60173 and 60195, where nearly half (47% in each zip code) of the population was born outside the U.S. The smallest proportion of immigrant community members is in 60193, where 23% of the population was born outside the U.S., but even this is higher than the state or county.

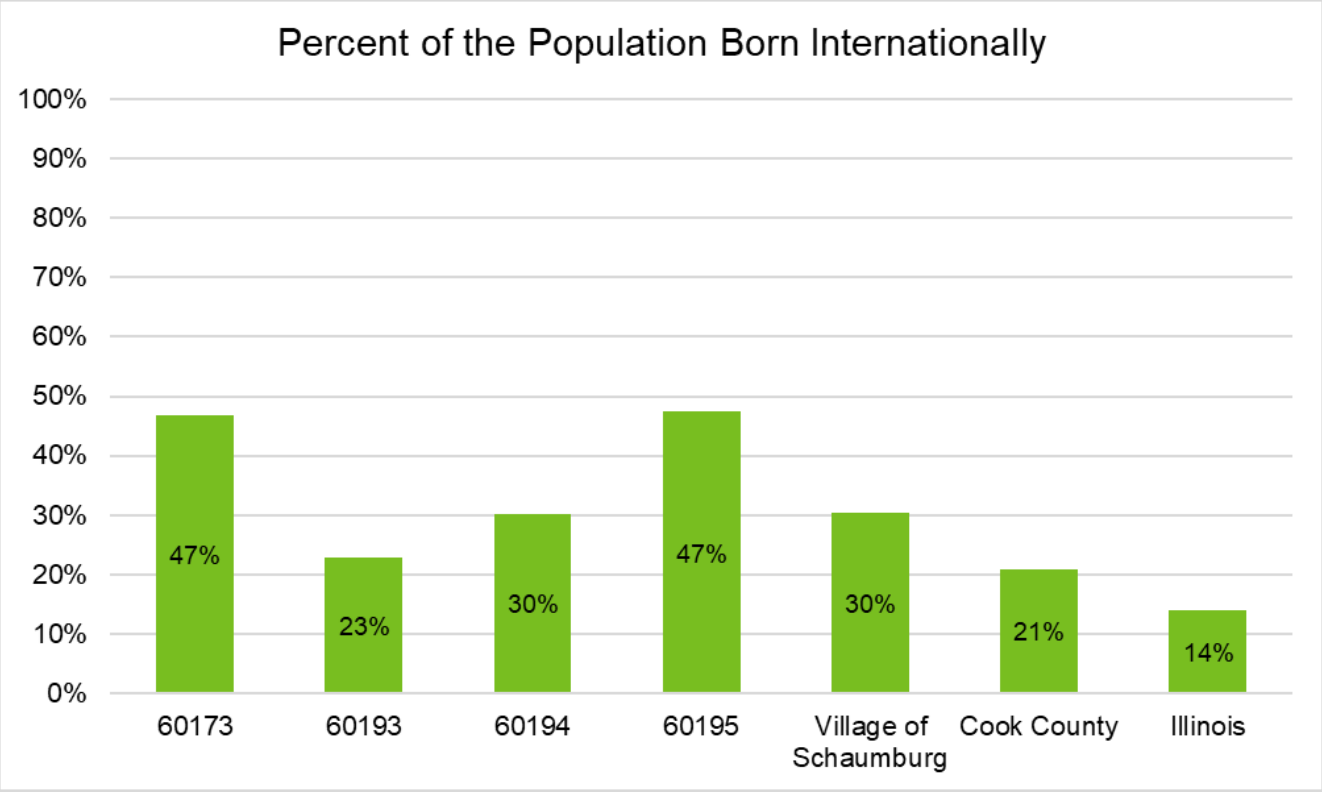



*Figure 5: Percent of Schaumburg population born outside the U.S. by zip code. Source: 2017-2021 ACS five-year estimates.*

As shown on Figure 6, in most census tracts, the most common country of origin for residents born outside the U.S. is India (blue), with a few census tracts where the most common country of origin is Mexico (green). Other common countries of origin include Poland, Japan, the Philippines, China, Korea, Pakistan, and Bulgaria.

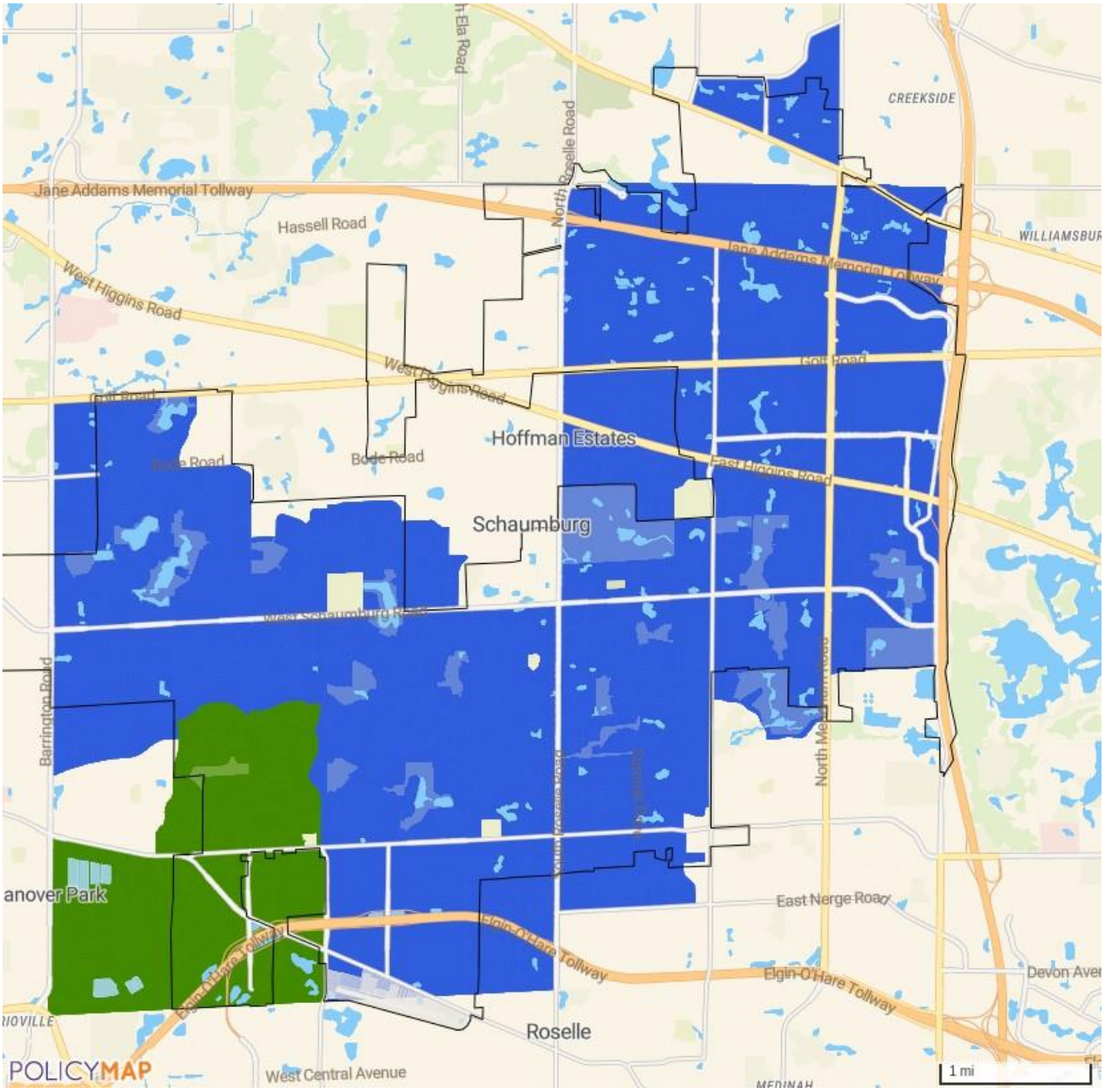



*Figure 6: Predominant country of birth, not including US, by census tract in Schaumburg. Blue represents India and green represents Mexico. Source: PolicyMap, based on ACS 2014-2018 five-year estimates.*

*Language Spoken at Home*

The Village of Schaumburg has a very linguistically diverse population, as nearly 40% of all residents over the age of 5 years speak a language other than English at home, more than in Cook County or Illinois. Overall, 7% of Schaumburg residents speak Spanish at home, 20% speak another Indo-European language at home, and 11% speak an Asian or Pacific Island language at home. This includes both multilingual households that prefer to speak their native language at home and households that have more limited English proficiency.

In 60173 and 60195, more than 50% of residents speak a non-English language at home. This aligns with the zip codes with the highest proportion of residents born outside the U.S. However, it should be noted that in every zip code, more individuals speak non-English languages at home than were born outside the U.S., indicating that many U.S. born residents also speak other languages at home.

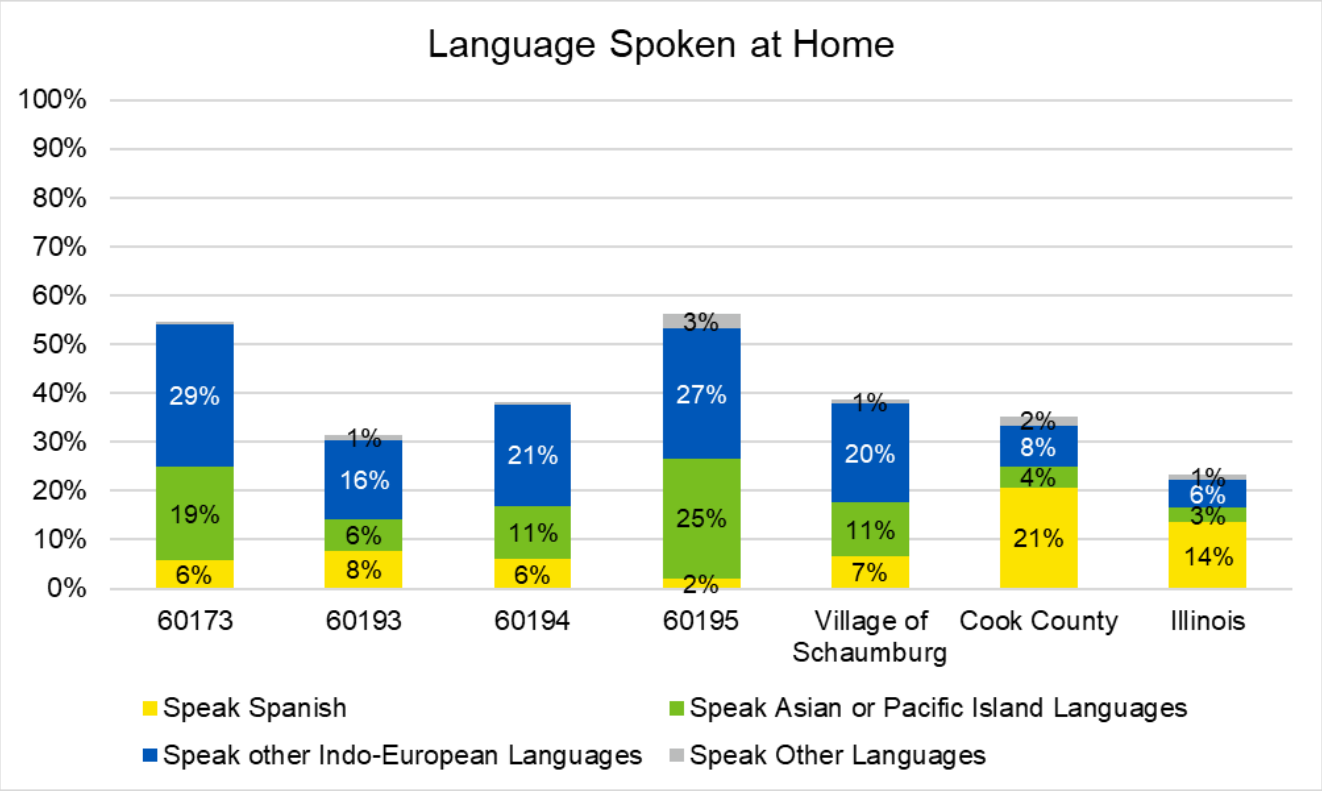



*Figure 7: Languages spoken at home by Schaumburg residents by zip code. Source: 2017-2021 ACS five-year estimates.*

Another key measure is linguistic isolation, defined as households where no person over age 14 speaks English only or English "very well," Between 2010 and 2020, the rate of linguistic isolation fell across all language groups in Schaumburg.[5] This demonstrates that Schaumburg residents are increasingly able to speak English well and are not as linguistically isolated as in the past.

Common languages spoken at home, after English, include Spanish, Polish, Gujarati, Urdu, Hindi, Japanese, and Korean.

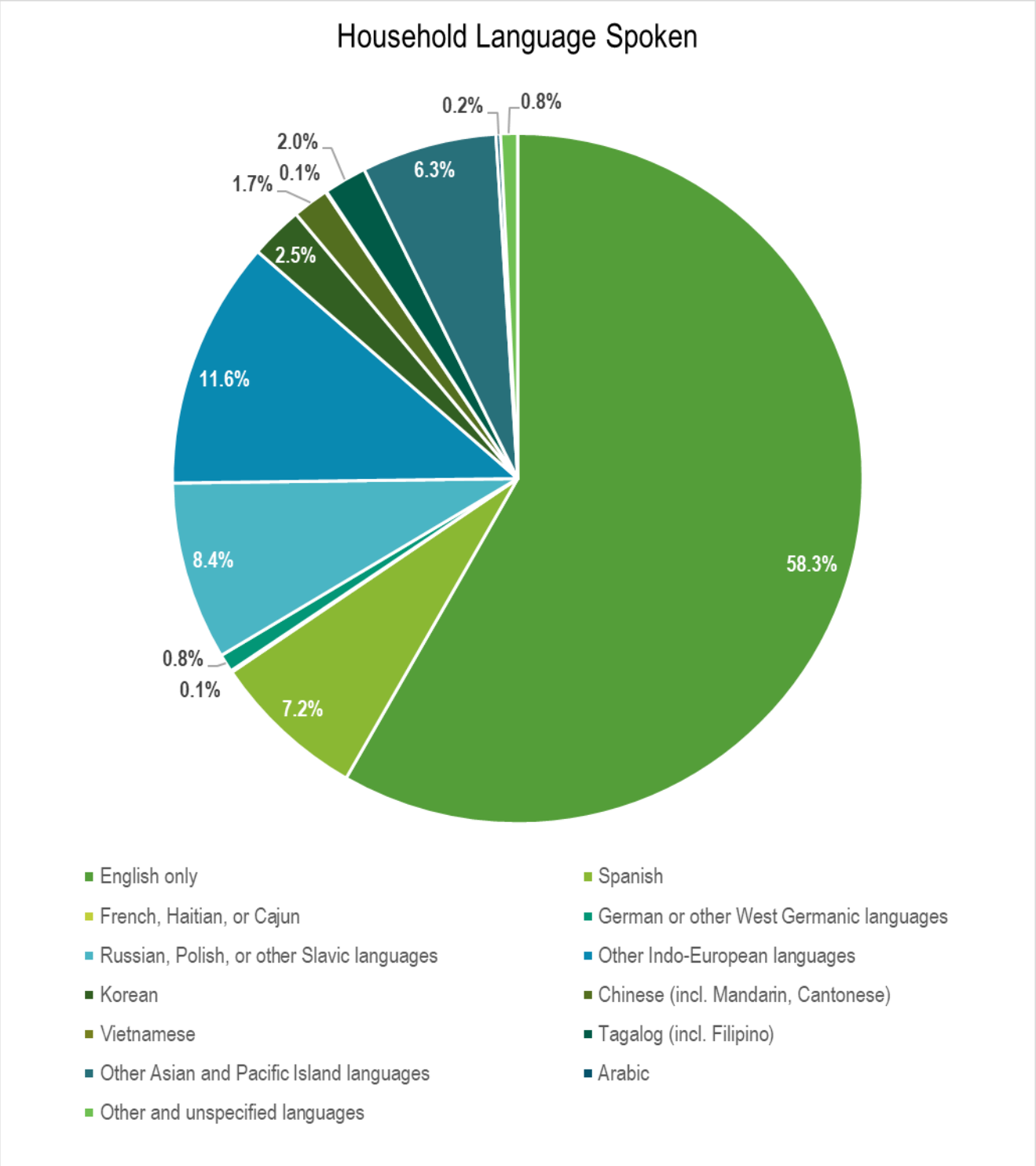



*Figure 8: Languages spoken at home by Schaumburg residents, including English. Source: 2017-2021 ACS five-year estimates.*

The map below shows the most common language group by census tract as of 2019 five-year estimates, with yellow representing Spanish, green representing Polish, orange representing other Indo-European languages such as Gujarati, Hindi, and Urdu, and red representing Japanese.

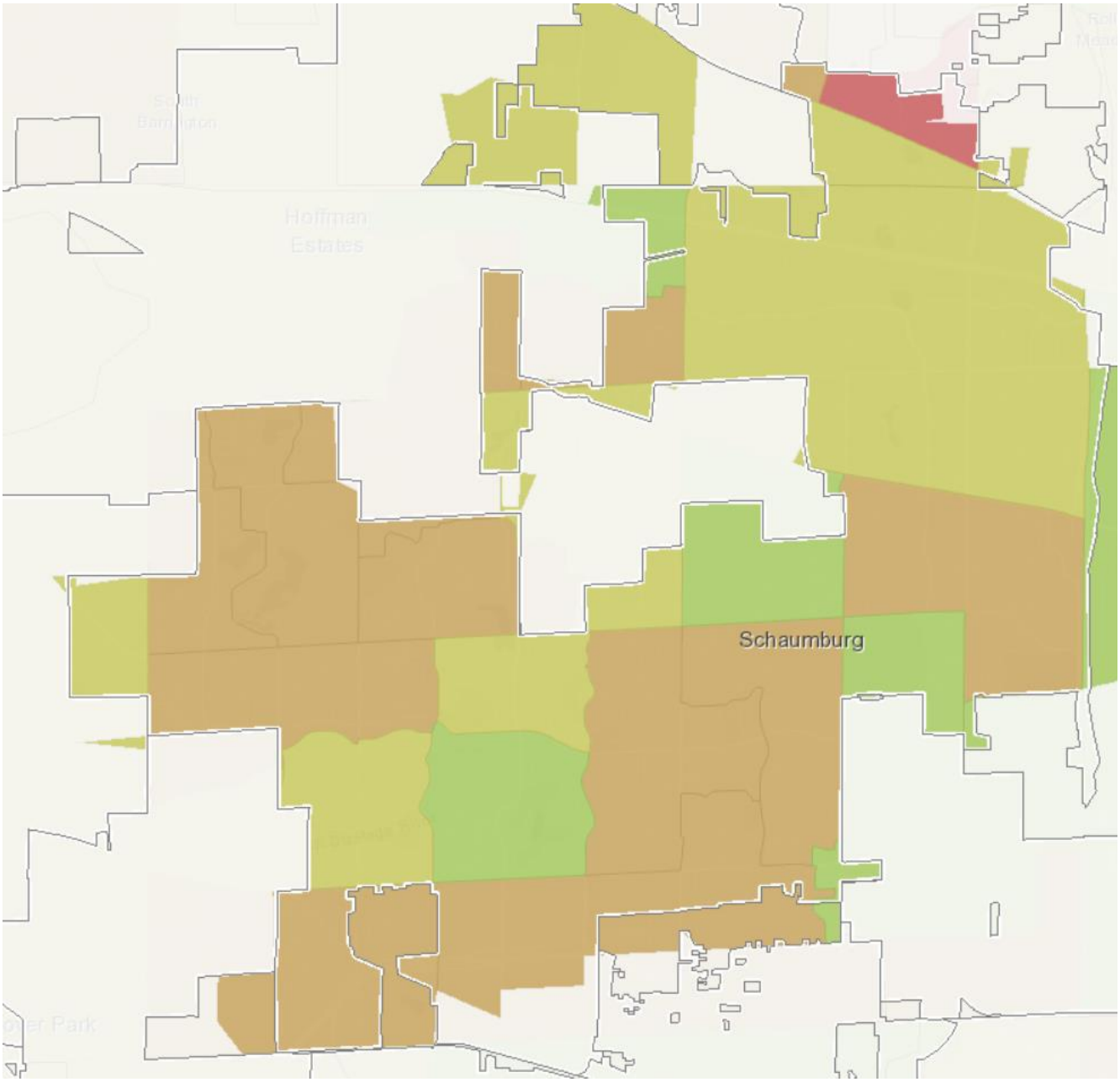



*Figure 9: Predominant language spoken at home, excluding English, by census tract in Schaumburg. Top languages include Spanish (yellow), Polish (green), Gujarati, Hindi, or Urdu (orange), and Japanese (red). Source: SparkMap, based on ACS 2015-2019 five-year estimates.*

## Economic Stability

*Income and Poverty*

Schaumburg experiences less poverty overall than Cook County or the state. A full 85% of residents are living above 200% of the Federal Poverty Level (FPL), a common threshold for many financial assistance programs, compared to only 70% overall in Cook County and 73% in Illinois. In 2024, 200% of the Federal Poverty Level is equivalent to $30,120 for an individual or $62,400 for a family of four.

However, 15% of Schaumburg residents are considered low-income, living under 200% of FPL, and 6% are living in poverty, below 100% of FPL. In Schaumburg's most populous zip code, 60193, more than 17% of residents are living in poverty or low-income.

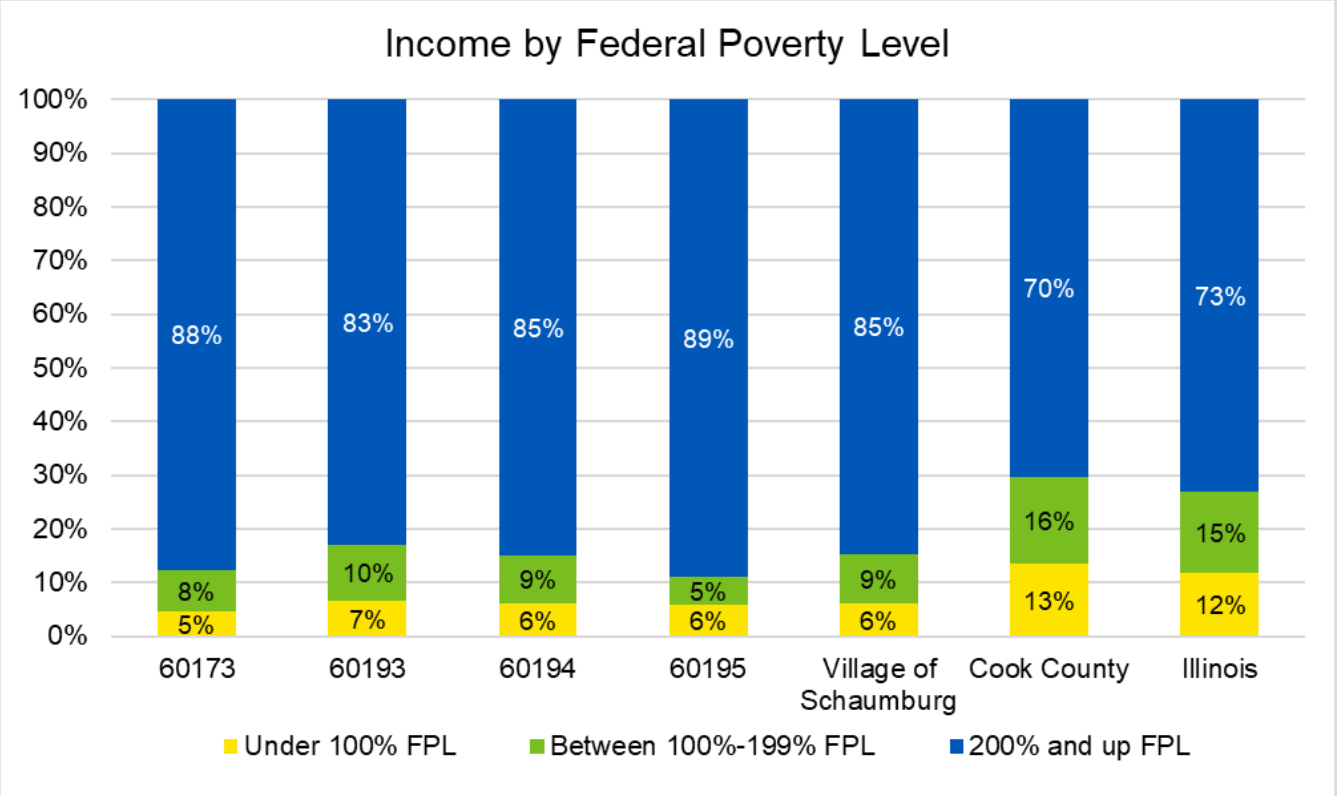



*Figure 10: Income by federal poverty level by zip code in Schaumburg. Source: 2017-2021 ACS five-year estimates.*

Schaumburg households saw their median incomes rise by 4% between 2010 and 2020. While the largest growth in income was seen in Black and Latino households, the highest median household income in 2020 was among Asian households, at $101,593 in 2020.[6]

In general, Schaumburg has less childhood poverty than other communities. According to the City Health Dashboard, Schaumburg had an estimated 6.6% of children in poverty in 2021, compared to an average of 16.9% across other Dashboard cities.[7]

Median household income varies throughout the community. The map below highlights the median household income by Census Block Group, which includes some with median incomes as high as $180,230 and others as low as $54,318.

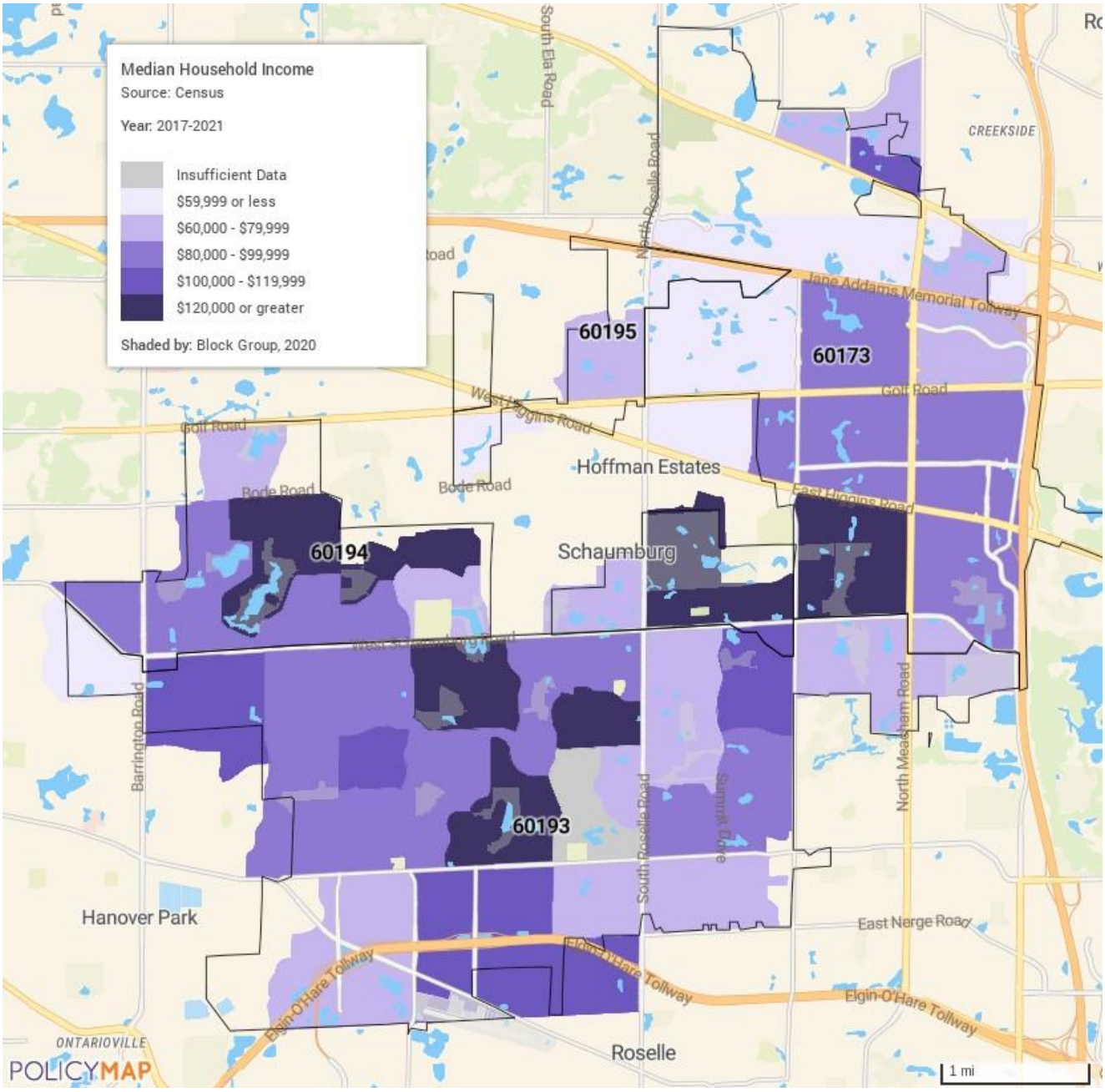



*Figure 11: Estimated median household income by census block group in Schaumburg. Source: PolicyMap, based on ACS 2017-2021 five-year estimates.*

*Unemployment and Occupations*

Like other communities, Schaumburg has seen many swings in unemployment in recent years. For several years prior to the COVID-19 pandemic, the labor market had improved, with unemployment steadily decreasing. The pandemic then caused a significant, unprecedented rise in unemployment, reaching a high of 17.4% in April 2020. This gradually came down, dropping to 2.5% in May 2023.[8]

According to the 2017-2021 ACS five-year estimates shown in the graph below, 3% of the overall Schaumburg population is unemployed, much lower than in Cook County and the state of Illinois. Only 60173 has a higher unemployment rate of 6%. Please note that this data set combines pre-COVID and COVID years, but the pattern of Schaumburg having overall better employment than other US cities is consistently seen in other data sets as well. For example, when looking at 2022 and 2023 monthly data from the Bureau of Labor Statistics as analyzed by the City Health Dashboard, Schaumburg consistently has better employment metrics compared to the average of all cities in the City Health Dashboard's data set (US cities with populations above 50,000).

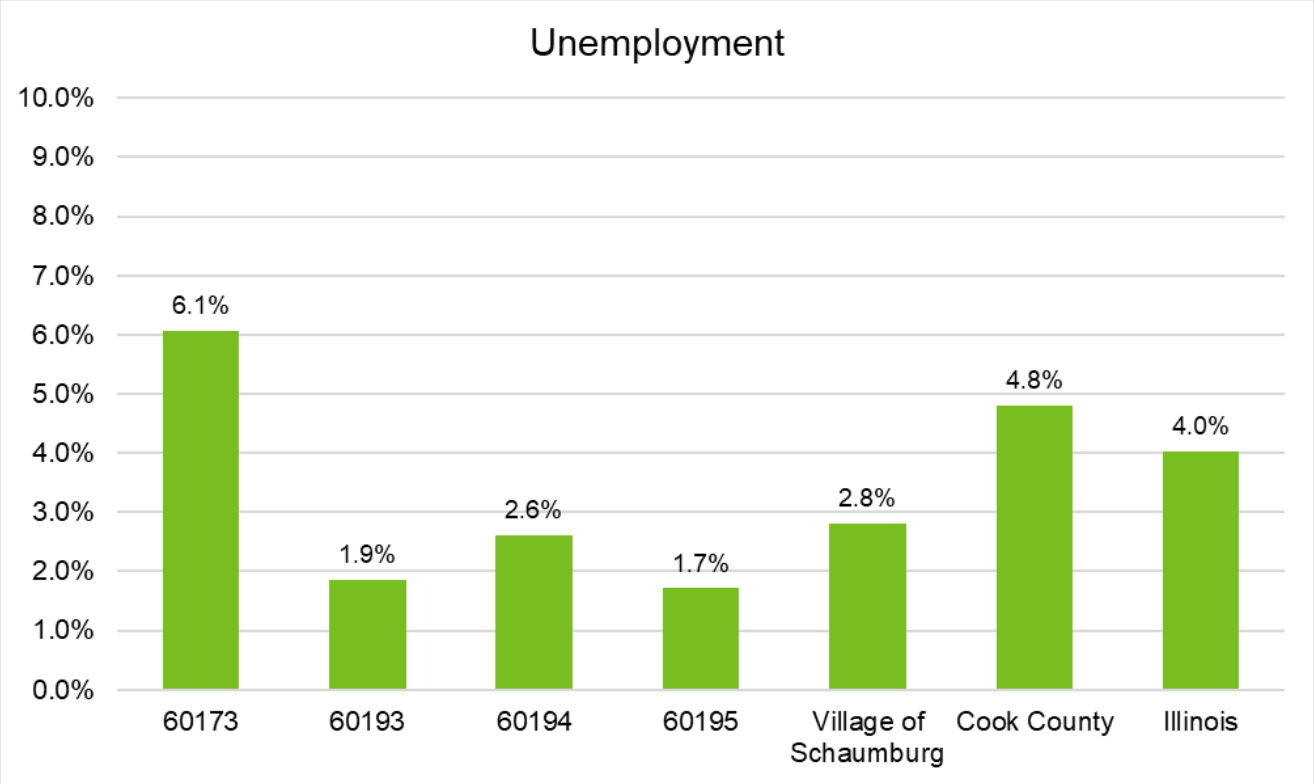



*Figure 12: Unemployment by zip code in Schaumburg. Source: 2017-2021 ACS five-year estimates.*

Trend analysis by Rob Paral and Associates found that the average person coming to work in Schaumburg in 2020 is older than the average worker in 2010. Only 15% of workers were over 55 in 2010, while 23% were over 55 in 2020. People coming to work in Schaumburg are also less likely to be white than a decade ago; 67% of Schaumburg workers in 2010 identified as white, while only 59% in 2020 identify as such.[9] More workers come to Schaumburg for education-related and professional jobs compared to a decade ago, while fewer come for manufacturing, information, or retail trade industries. As of the 2020 Census, the top four industries were:

- Professional, scientific, and management, and administrative and waste management services
- Information and finance and insurance, and real estate and rental and leasing
- Retail trade
- Educational services, and health care and social assistance

## Education Access and Quality

*Educational Attainment*

Schaumburg is a highly educated community, where 50% of residents over age 25 years have a bachelor's degree or higher, compared to just 41% in Cook County and 36% in Illinois. Only 4% of Schaumburg residents over age 25 lack a high school degree, far lower than in Cook County (12%) or Illinois (10%).

The proportion of residents with bachelor's degrees or higher is highest in 60173 and 60195, at 67% and 69% of the population respectively. These are the zip codes with the largest proportion of Asian residents and the largest proportion of individuals living above 200% of the FPL. The smallest proportion of residents with bachelor's degrees is found in 60193, where only 42% of the population has a bachelor's degree, but this still remains higher than Cook County and Illinois.

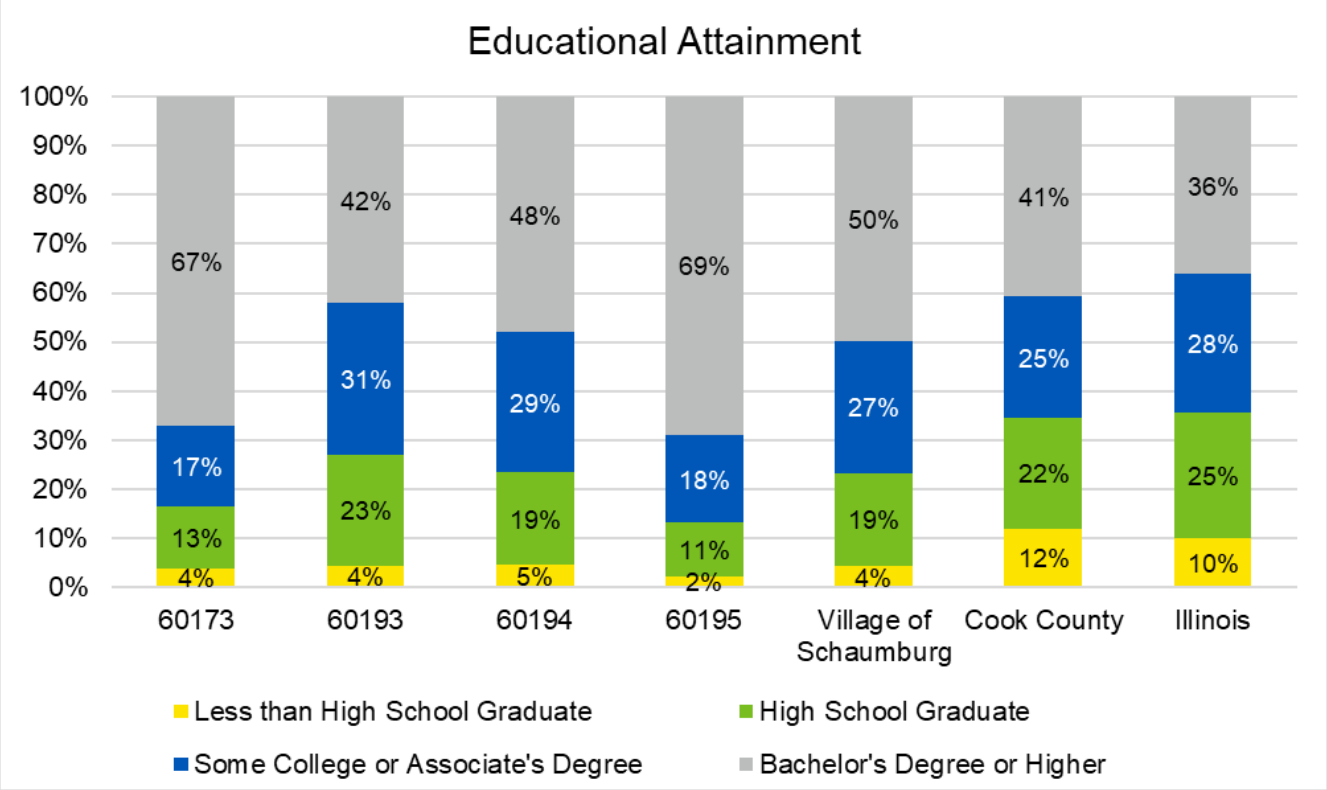



*Figure 13: Highest level of educational attainment among adults 25 years and older by zip code in Schaumburg. Source: 2017-2021 ACS five-year estimates.*

In the decade between the 2010 and 2020 census, Schaumburg residents experienced a notable upward shift in their educational attainment, with the share of residents with a bachelor's degree rising by 7%. Additionally, the share of Schaumburg immigrants with a graduate or professional degree has risen from 21% to 26% over that decade, and 43% of Schaumburg residents from South Central Asia have a graduate or professional degree.[10]

## Neighborhood and Built Environment

*Housing Burden and Homelessness*

Cost of housing is a challenge for some Schaumburg residents. Among homeowners, 23% are considered "housing cost burdened," which means that their housing costs more than 30% of their income. Among renters, 34% are housing cost burdened. These are both better than Cook County, but still mean that one-third of renters in Schaumburg find that their incomes are not keeping pace with the cost of rent.

Renters in 60194 experience the highest housing burden, while the highest housing burden for homeowners is in 60193. The two zip codes that have higher incomes and lower poverty rates experience the lowest housing burden for renters (60173) and for homeowners (60195).

According to trend analysis, the share of Schaumburg households that is housing cost burdened has decreased over the last decade for both renters and homeowners.[11]

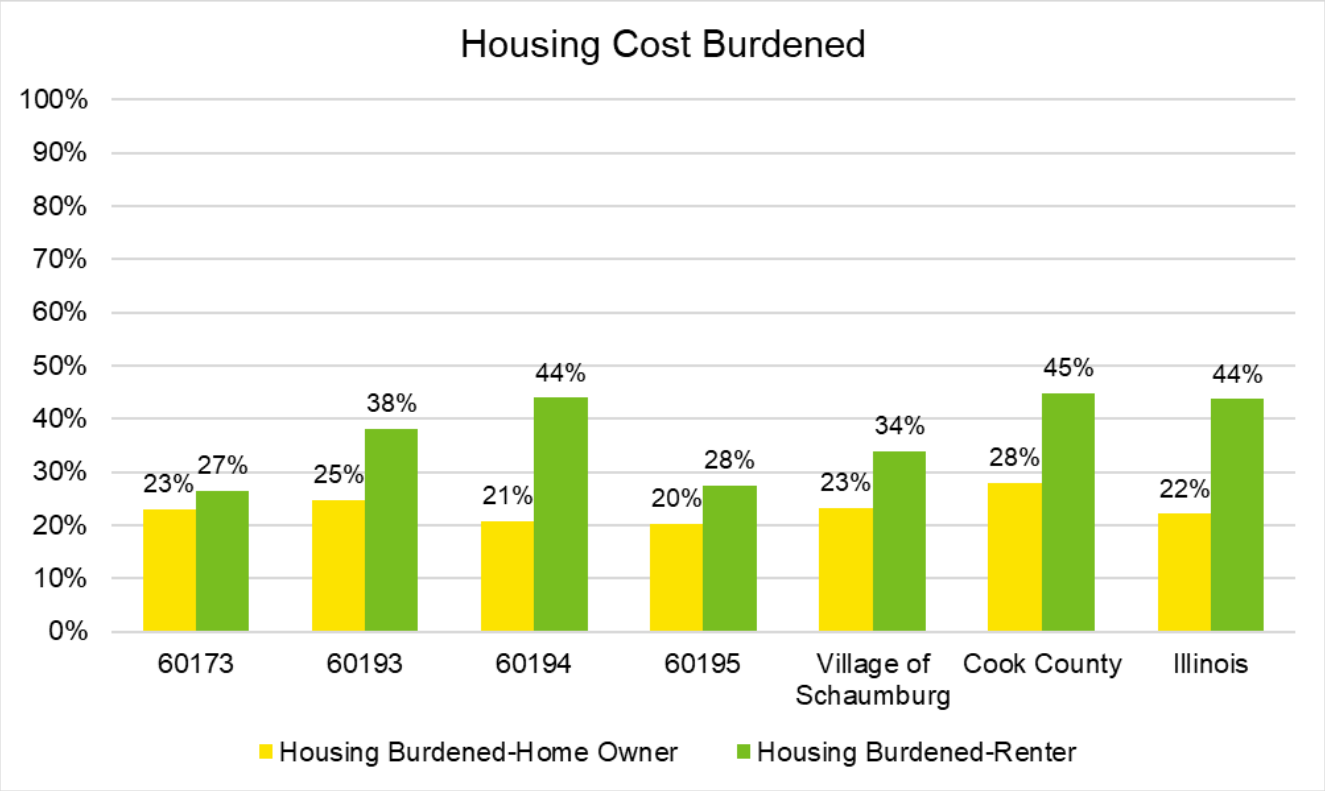



*Figure 14: Percent of housing cost burdened homeowners (yellow) and housing cost–burdened renters (green), or individuals who spend more than 30% of their income on housing, by zip code in Schaumburg. Source: 2017-2021 ACS five-year estimates.*

Housing burden can contribute to people experiencing homelessness. In suburban Cook County, 1,056 individuals were identified as experiencing homelessness in the 2023 Point-in-Time Count, similar to the 1,096 identified in 2022.[12] Many more individuals may be "doubling-up," or temporarily staying at another person's residence, sleeping in cars, or otherwise be transient.

*Roadways and Bikeways*

The Village of Schaumburg is situated at the intersection of three major highways: I-90, I-290, and Illinois 390, seen on the map below. It thus has strong roadway access to the City of Chicago as well as other communities throughout Cook County and the collar counties.

Residents and visitors can also travel around much of the village via bicycle, with numerous bike paths (shown in pink on the map) and bike lanes or routes (shown in blue) that connect different areas of the village, including residential communities, business areas, green spaces, and public transit. Additional bike paths and lanes are planned in the future, as shown by the dotted lines.

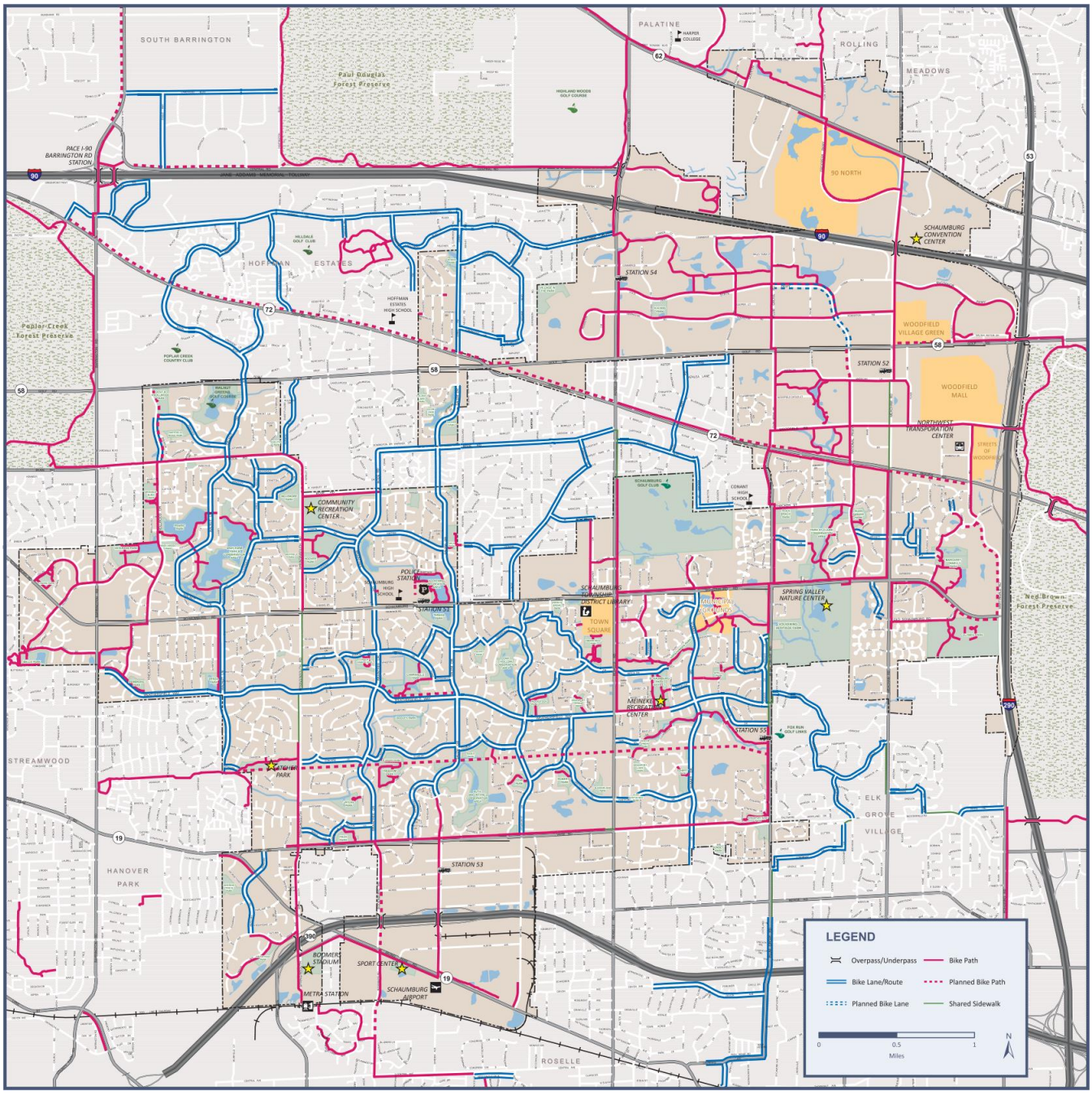



*Figure 15: Roadways, bike paths, and sidewalks in the Village of Schaumburg. Source: Village of Schaumburg.*

*Public Transit and Walking*

For those who do not drive or who lack a vehicle, public transit is available but more limited. As seen below on the map of Metra commuter rail stops and Pace bus stops, Schaumburg is home to the Pace Northwest Transportation Center, where many bus routes connect to one another, making it easy for those outside Schaumburg to access Woodfield Mall, the Schaumburg Convention Center, and other key business locations. However, few bus lines connect areas within Schaumburg, leaving residents without car access facing challenges getting from one side of the village to another. There are also challenges accessing key health care facilities, such as Alexian Brothers Medical Center, which is close to Schaumburg but not connected by any bus line. Despite the many buses that connect at the Transportation Center, Schaumburg has limited rail access, with the only Metra stop in the village being at the far southwest corner, without bus connections. Other nearby Metra stops are in neighboring communities such as Palatine, Arlington Heights, Mount Prospect, Hanover Park, and Roselle.

Shaded in yellow on the map below are several on-demand transit services, but these frequently serve only one or two villages, such as the Arlington Heights-Rolling Meadows On Demand or the Hoffman Estates On Demand services, neither of which serve Schaumburg. Other transit services include Dial-A-Ride Transportation (DART), an on-demand transit service from the Village of Schaumburg and Pace; the Schaumburg Township bus service, which provides door-to-door transportation for seniors and people with disabilities; and the Woodfield Trolly, which is a free shuttle connecting Woodfield-area destinations, hotels, and the Pace Northwest Transportation Center.


*Figure 16: Regional Transportation Authority (RTA) system map of Schaumburg and surrounding communities, with Metra rail system (dark blue lines), Pace bus system (thin colored lines), and on demand transit areas (yellow shading), February 2024. Source: RTA.*

In the Cook County Health Survey (CCHS), 58% of Schaumburg adults said it was easy to walk, scoot, or roll to a transit stop from home. This is just slightly better than the median community in Cook County, where approximately 52% of adults reported it was easy to walk, scoot, or roll to a transit stop from home.[13] Schaumburg also fares well on overall walkability, with a walkability score of 44.8 out of 100 in 2022, compared to an average of 36.6 across other cities in the City Health Dashboard.[14]

*Parks and Green Spaces*

The Village of Schaumburg has exceptional park access. In 2022, it was estimated that 86.8% of residents lived within a 10-minute walk of a park or green space, compared to just 61.5% of residents in City Health Dashboard cities across the nation.[15] The purple shading on the map below indicates portions of Schaumburg's four zip codes that are within a 10-minute walk of a park or green space.

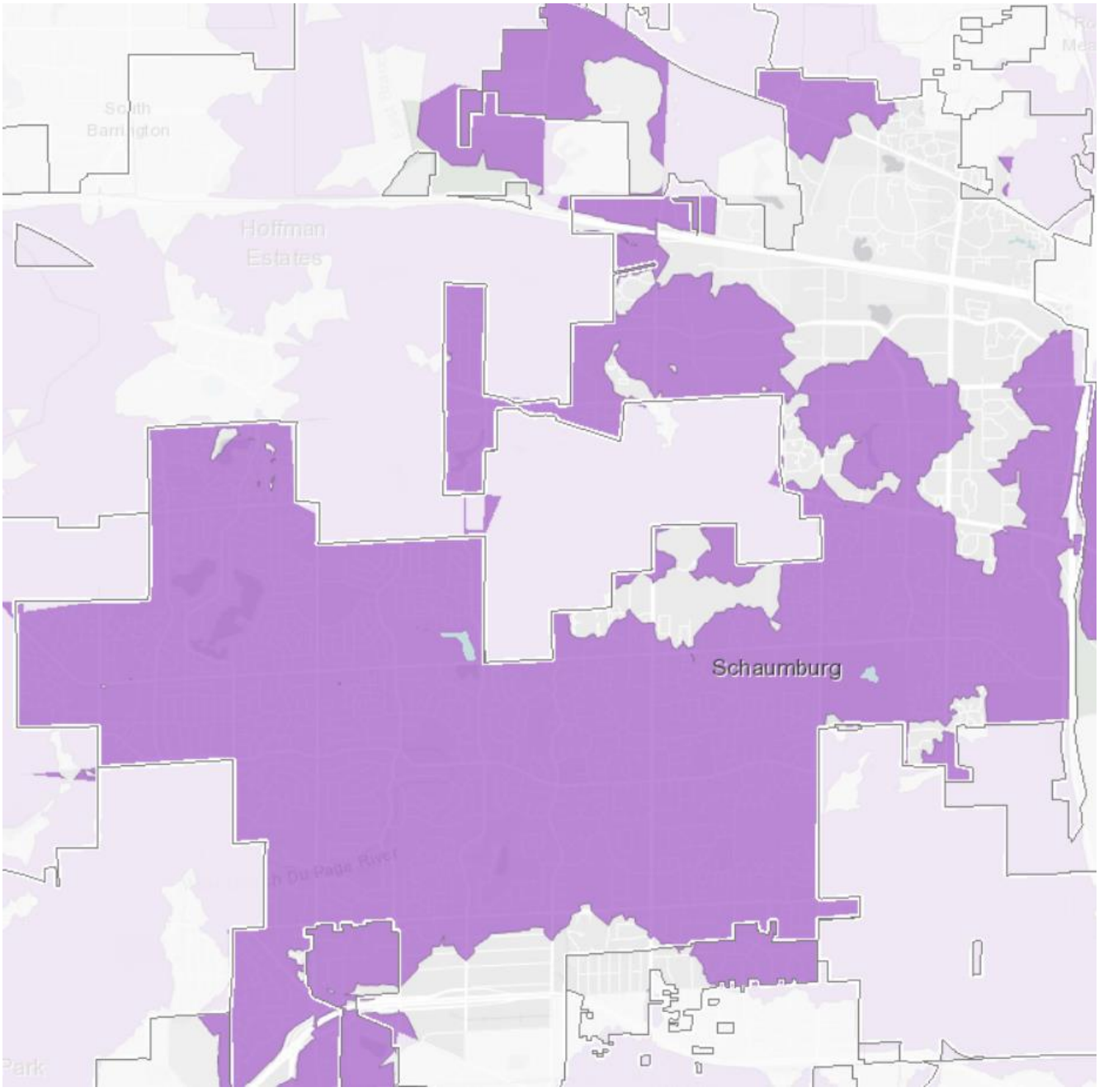



*Figure 17: Areas within a 10-minute walk from a park, 2022. Source: SparkMap, based on Trust for Public Land ParkServe dataset.*

Health Care Access, Quality, and Disparities

*Insurance Status*

Approximately 94% of Schaumburg residents have some form of health insurance, just above the county or state numbers of 92% and 93% respectively. However, there remain 6% of Schaumburg residents who are not insured.

Roughly 10% of Schaumburg residents are on Medicaid or other public insurance, such as the Children's Health Insurance Program (CHIP). Although this is less than in the state or county, it represents an important population when considering access to care. In the most populous zip code of 60193, 15% of residents have Medicaid. The remainder of the insured population has either Medicare or private insurance.

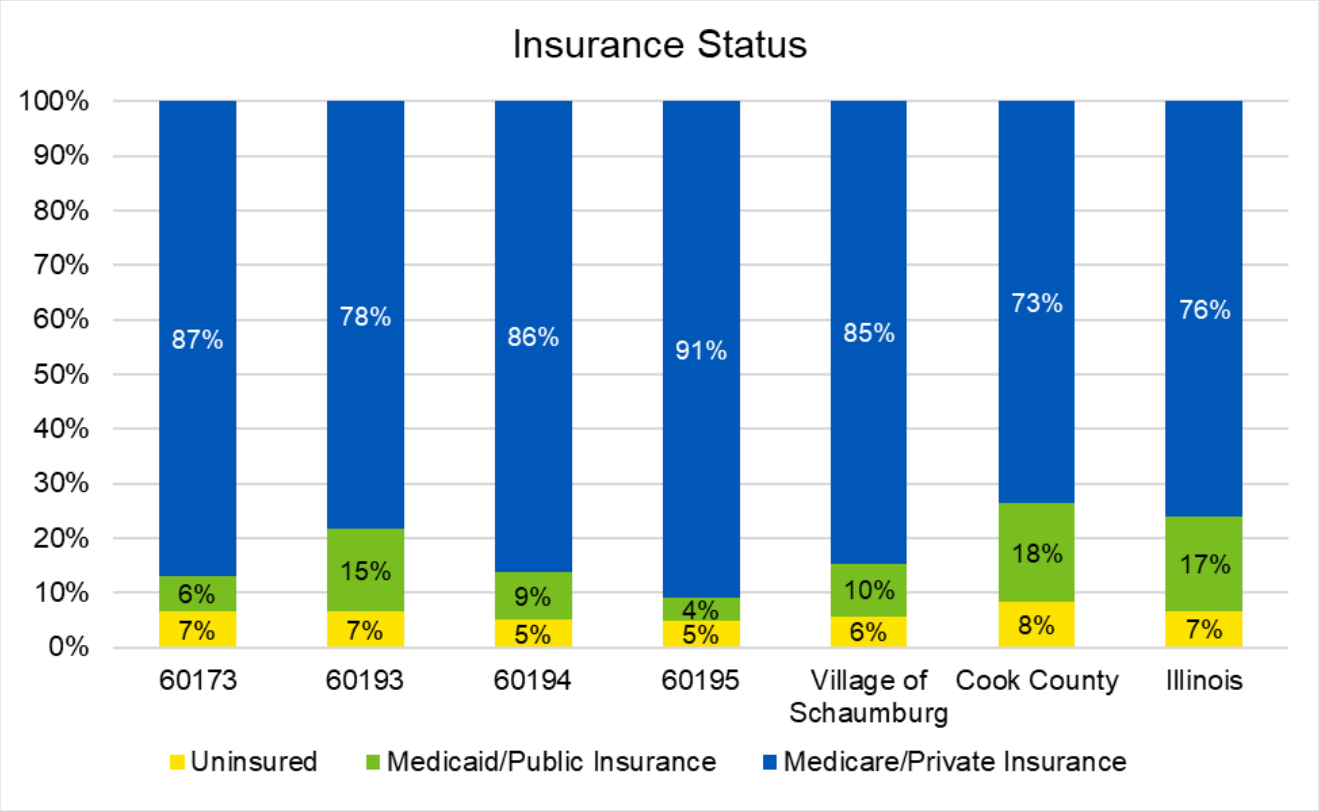



*Figure 18: Insurance status by zip code in Schaumburg. Source: 2017-2021 ACS five-year estimates.*

Insurance status varies across the village. The map below shows the proportion of residents with Medicaid by census tract. As can be seen, census tracts in 60193 and 60194 have higher proportions of residents with Medicaid, reaching as high as 19% in places, which exceeds the Cook County average. Other census tracts have less than 5% of their population that has Medicaid.

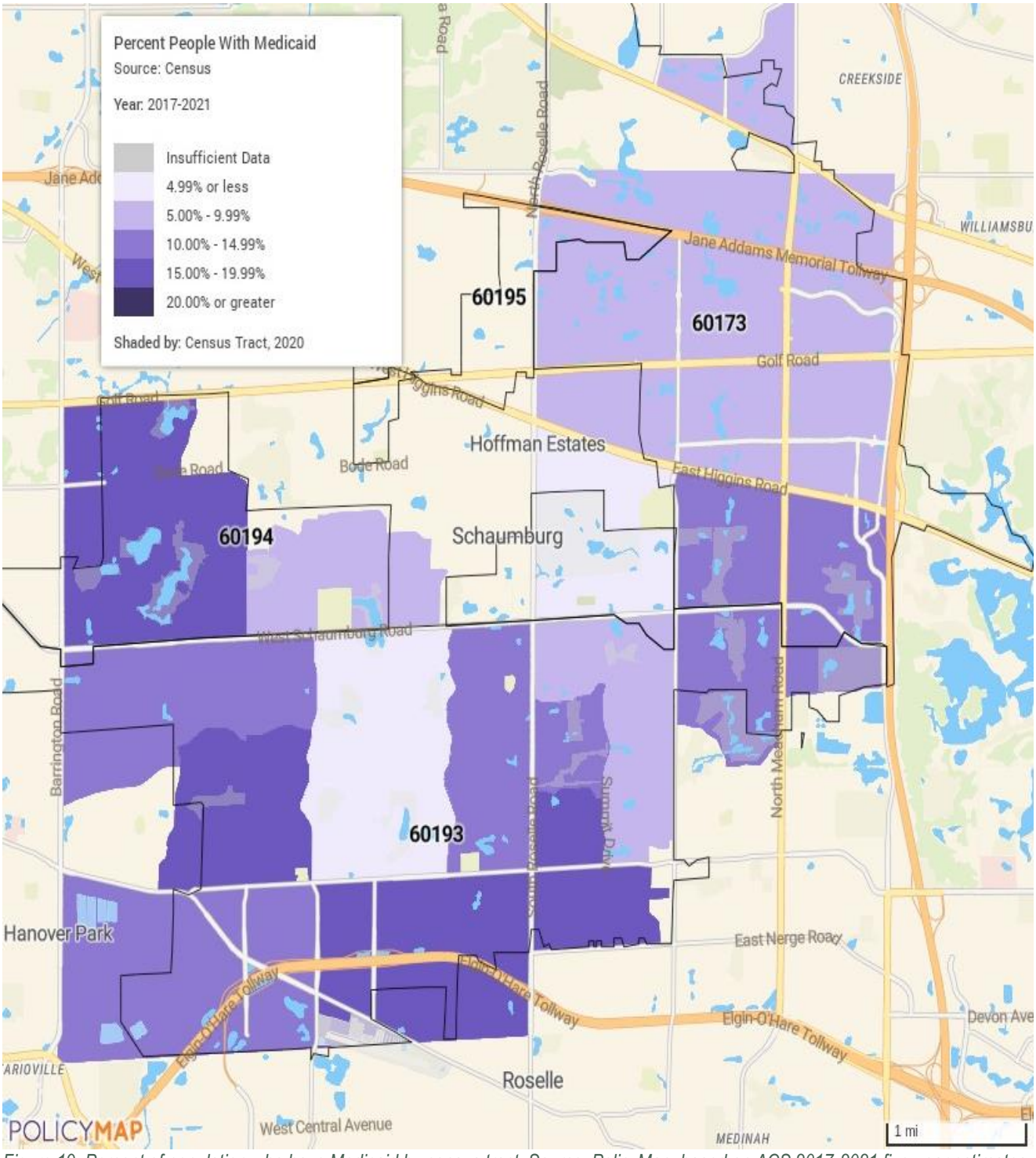



*Figure 19: Percent of population who have Medicaid by census tract. Source: PolicyMap, based on ACS 2017-2021 five-year estimates.*

The map that follows shows the percent of the population that lacks health insurance by census tract. The census tract that makes up 60173 has by far the highest proportion of uninsured residents, at 17%. This is double the county or state average. It should be noted that this zip code also has a very high proportion of residents born outside the U.S., some of whom may not be eligible for various insurance products. It also has a higher proportion of younger, working-aged adults, who are not eligible for Medicare and may not have affordable insurance options or may choose to go without insurance. Other census tracts have as little as 1-3% of the population that is uninsured.

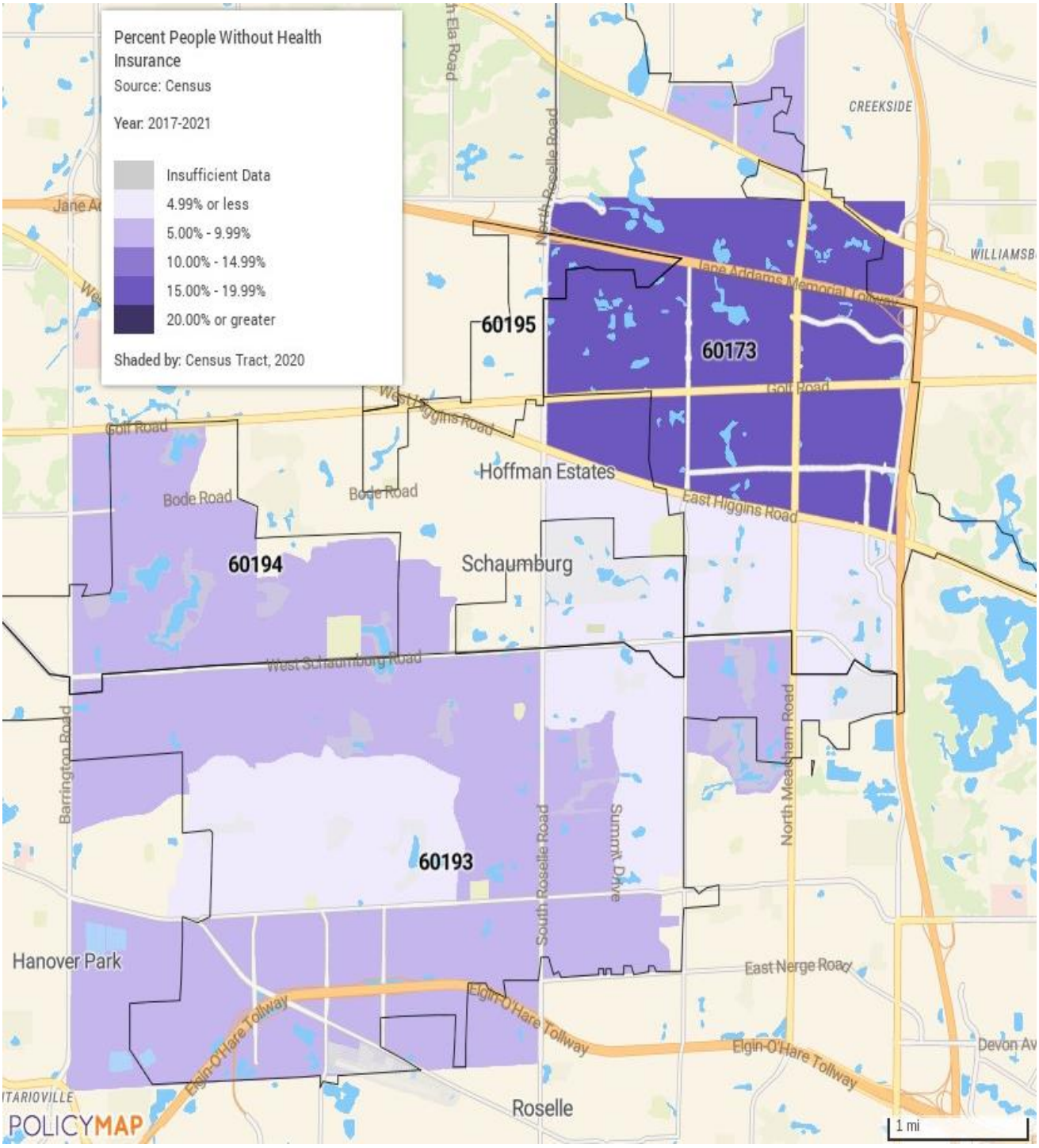



*Figure 20: Percent of population who are uninsured by census tract. Source: PolicyMap, based on ACS 2017-2021 five-year estimates.*

## Health Indicators

*Diabetes and Cardiovascular Disease*

Diabetes and cardiovascular indicators are mixed in Schaumburg. The diabetes prevalence among adults (11%) is slightly elevated compared to the state average (10.8%). However, adult obesity prevalence and high blood pressure prevalence were below the state and national averages.

For mortality, the mortality rate from stroke (47.1 per 100,000) is a little higher than the national average (46.5 per 100,000) but lower than the state average (49.4 per 100,000). Diabetes mortality and heart disease mortality are both lower than the state and national averages.

The one indicator that is elevated compared to both the state and nation is the access measure around cholesterol screening. The proportion of adults that have not had their cholesterol checked in the past 5 years is 15.2%, meaningfully above both the state average of 13.9% and national average of 14.8%.

| Health Indicator | Village of Schaumburg | State Average | National Average |
|---|---|---|---|
| **Diabetes & Cardiovascular Disease** | | | |
| Diabetes prevalence among adults | 11% | 10.8% | 11.8% |
| Diabetes mortality rate (per 100k) | 17.3 | 24.2 | 27.9 |
| Adult obesity prevalence | 26% | 34.2% | 33.9% |
| Adults who have been told they have high blood pressure | 25.4% | 30.0% | 32.4% |
| Adults that have not had cholesterol checked within past 5 yrs | 15.2% | 13.9% | 14.8% |
| Heart disease mortality rate (per 100k) | 195.1 | 207.6 | 204.2 |
| Cerebrovascular (stroke) mortality rate (per 100k) | 47.1 | 49.4 | 46.5 |

*Figure 21: Select estimated diabetes and cardiovascular indicators. Sources: BRFSS, CDC Wonder.*

There are also differences within Schaumburg for some indicators. For example, as noted above, a higher proportion of Schaumburg residents lack a recent cholesterol screening than in other communities. As shown on the adjacent census tract-level map from CDC PLACES, residents of the northeast corner of the village, in the 60173 zip code, have particularly low cholesterol screening rates. This is also the census tract with the highest percent of uninsured residents. Some of these uninsured residents may be ineligible for insurance products due to being foreign-born, while others may be younger adults who choose to go without health insurance due to cost or because they feel it is not necessary.

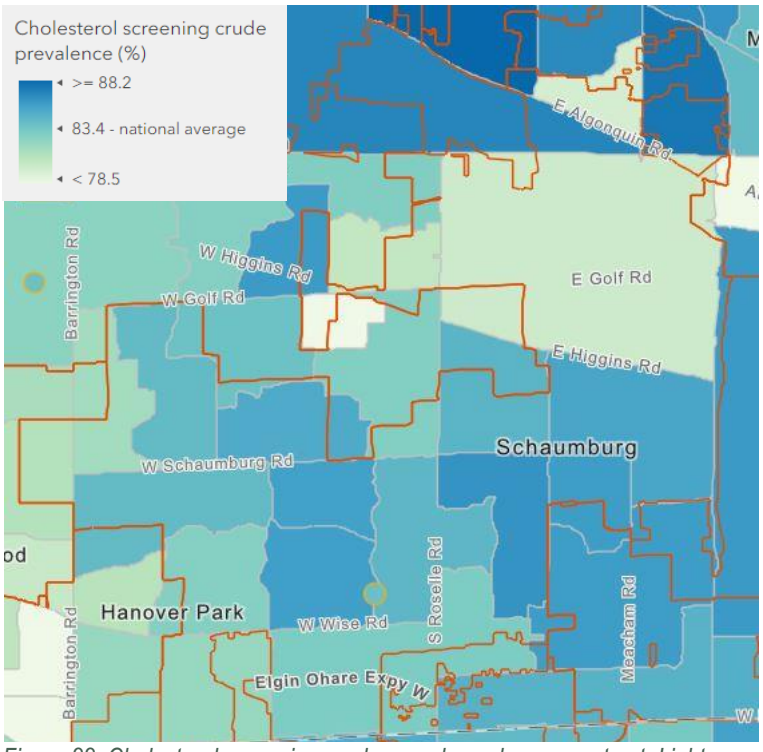



*Figure 22: Cholesterol screening crude prevalence by census tract. Lighter colors denote a lower rate of cholesterol screening. Source: CDC PLACES.*

*Cancer*

In the Village of Schaumburg, several cancer screening measures are elevated compared to the state or nation. Schaumburg has a higher rate of people lacking screenings for cervical cancer screening (Pap tests) and breast/chest cancer (mammograms) than either the state or nation, and a higher rate of lacking colorectal cancer screening than the nation. However, fewer residents lack prostate cancer screening (PSA test) as compared to the state or national averages.

The Village of Schaumburg also has a higher rate of breast/chest cancer mortality, at 14.3 per 100,000, compared to either the state or nation (13.9 and 13.0, respectively). It also experiences elevated colorectal cancer mortality compared to the nation.

| Health Indicator | Village of Schaumburg | State Average | National Average |
|---|---|---|---|
| Cancer | | | |
| No Pap test in the past three years | 28.3% | 27.9% | 22.3% |
| No mammogram in the past two years | 27.3% | 19.9% | 21.7% |
| No PSA (prostate) test in past two years | 66.8% | 69.0% | 68.2% |
| No colorectal screening in past year | 93.1% | 93.5% | 90.7% |
| Breast/chest cancer mortality rate (per 100k) | 14.3 | 13.9 | 13.0 |
| Colorectal cancer mortality (per 100k) | 16.7 | 17.1 | 16.2 |

*Figure 21: Select estimated cancer indicators. Sources: BRFSS, CDC Wonder.*

The adjacent map from CDC PLACES shows differences in cervical cancer screening rates across census tracts. As with cholesterol screening, residents of the northeast corner of the village, in the 60173 zip code, have particularly low rates of cervical cancer screening. Since this is also the census tract with the highest percent of uninsured residents, this may suggest barriers accessing care playing a role in these rates. Individuals without access to insurance – or who have access to insurance but choose to go without due to cost or other factors – may not receive recommended preventive services such as cervical cancer screening.

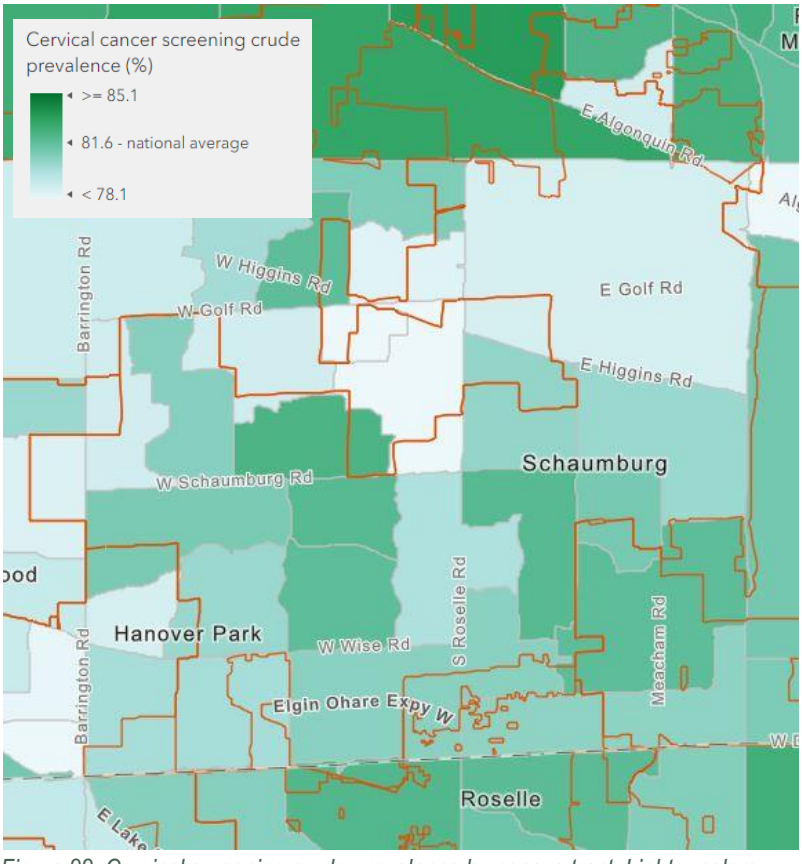



*Figure 22: Cervical screening crude prevalence by census tract. Lighter colors denote a lower rate of cervical cancer screening. Source: CDC PLACES.*

*Prenatal, Perinatal and Pediatric Health*

Schaumburg generally performs well on prenatal and perinatal indicators. As shown below, all listed indicators are better in the village than the state or nation, including low birth weight births, preterm births, infant mortality, birth to teenage mothers, and late entry into prenatal care.

Similarly, Schaumburg fares well on several key pediatric indicators, including percent of children aged 10-17 who are obese and percent of high school students with less than 1 hour of physical activity in the last week.

| Health Indicator | Village of Schaumburg | State Average | National Average |
|---|---|---|---|
| Prenatal, Perinatal, & Pediatric Health | | | |
| Low birth weight (<2500 grams) births | 7.4% | 8.5% | 8.5% |
| Percent of births that are preterm | 9.8% | 10.7% | 10.5% |
| Infant mortality rate per 1,000 | 4.0 | 5.5 | 5.4 |
| Late entry into prenatal care (after first trimester) | 15.1% | 20.0% | 21.2% |
| Births to teenage mothers | 1.0% | 3.4% | 4.0% |
| Percent of children (10-17) who are obese | 13.5% | 16.1% | 17.0% |
| Percent of high school students with less than 1 hour of physical activity in last week | 10.6% | 12.3% | 17.0% |

*Figure 23: Select estimated prenatal, perinatal, and pediatric indicators. Sources: CDC Wonder, Youth Risk Behavior Survey, National Survey of Children's Health.*

*Behavioral Health*

The Village of Schaumburg has more favorable rates than the state or nation on many behavioral health indicators, such as adult depression prevalence, suicide, binge alcohol use, adult smoking rate, and overdose mortality rate. However, as with many self-reported data indicators, behavioral health conditions can be vastly underreported, especially among immigrant communities, due to various factors such as stigma and shame, so caution should be taken in interpretation of these very positive indicators.

Adolescent poor mental health is one behavioral health indicator that is elevated in Schaumburg compared to the state and nation. In the Youth Risk Behavior Survey (YRBS), nearly one-third (30.5%) of Schaumburg adolescents reported stress, anxiety, or depression, compared to 20.5% statewide or 21.8% nationally. Please note that this data is from 2021 and asked about the last 30 days, and thus may be particularly influenced by adolescent experiences during the COVID-19 pandemic; nonetheless, Schaumburg youth had a higher rate of reported poor mental health than youth elsewhere during the same timeframe.

| Health Indicator | Village of Schaumburg | State Average | National Average |
|---|---|---|---|
| Behavioral Health | | | |
| Adults ever told they have a form of depression | 15.2% | 17.0% | 20.5% |
| Adolescent poor mental health (stress, anxiety, depression) | 30.5% | 20.5% | 21.8% |
| Suicide rate | 10.4 | 11.4 | 14.5 |
| Binge alcohol use | 13.7% | 14.8% | 15.4% |
| Adults who currently smoke cigarettes | 10.7% | 12.0% | 14.4% |
| Overdose mortality rate | 20.4 | 23.8 | 23.3 |

*Figure 26: Select estimated behavioral health indicators. Sources: BRFSS, CDC Wonder, YRBS.*

How poorly adults rate their mental health varies across the village. The adjacent Cook County Health Atlas map using CDC PLACES analysis of 2021 BRFSS data shows that in some census tracts, as many as 14% of adult residents have reported 14 or more days in the past 30 days during which their mental health was not good. This is particularly true of census tracts to the west. In other census tracts, only 10% of adult residents have had 14 or more days of poor mental health in the last month.

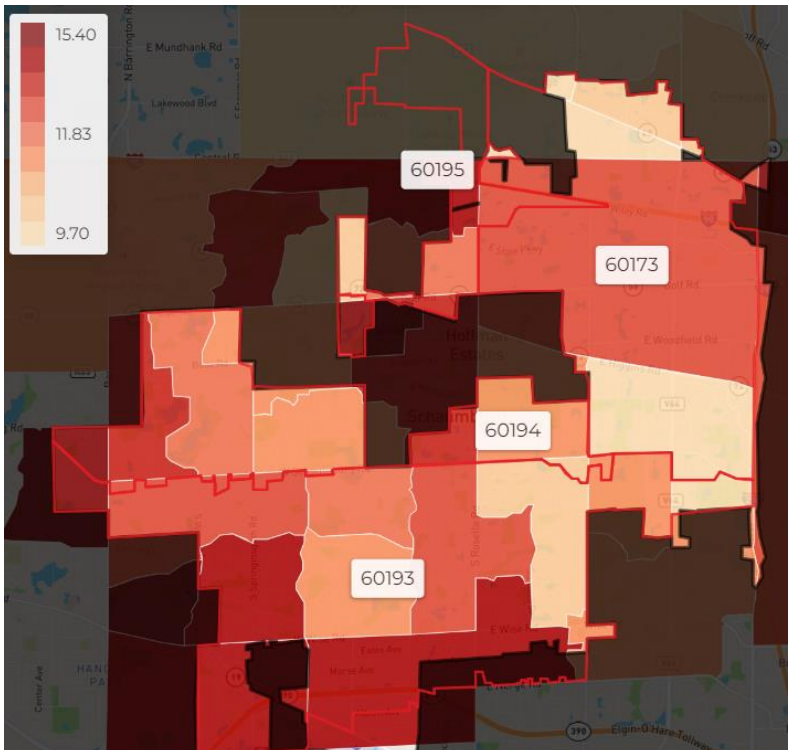



*Figure 27: Percent of adults who report 14 or more days during the past 30 days during which their mental health was not good, by census tract. Darker colors denote higher percent of residents who report that their mental health was not good, 2021. Source: Cook County Health Atlas, based on CDC PLACES.*

*Other Health Indicators*

Several other health indicators are important in the community, including those around asthma, infectious disease, mortality, and access to care. For asthma, Schaumburg's adult asthma prevalence is consistent with that of the state.

For infectious disease, Schaumburg has a slightly higher flu and pneumonia death rate than the nation but comparable to the state. The village's flu vaccination rate in 2023, at 25.2% of adults, was also comparable to that of all of suburban Cook County (25.8%).[16]

Schaumburg has a much lower rate of unintentional injury death than the state or nation, at only 39.3 deaths per 100,000 population This includes things like motor vehicle accidents and falls. Schaumburg also has a lower overall all-cause age-adjusted death rate than either the state or nation, which aligns with the lower rates of unintentional injury deaths, suicides, infant mortality, and deaths from diabetes and heart disease noted earlier in this report.

| Health Indicator | Village of Schaumburg | State Average | National Average |
|---|---|---|---|
| Other Health Indicators | | | |
| Adult asthma prevalence | 8.6% | 8.7% | 9.8% |
| Flu and pneumonia death rate (per 100k) | 18.5 | 18.7 | 16.5 |
| Unintentional injury death rate (per 100k) | 39.3 | 50.7 | 54.9 |
| Age-adjusted death rate (per 100k) | 806.0 | 819.8 | 826.3 |
| Adults who have delayed or not sought care due to cost | 8.8% | 10.8% | 10.1% |
| Adults without a visit to a dental clinic during the past year | 31.4% | 31.6% | 33.3% |
| Percent of high school students with no visit to a dentist in last year | 17.8% | 23.8% | 24.1% |

*Figure 24: Select estimated behavioral health indicators. Sources: BRFSS, CDC Wonder, YRBS.*

For access to care indicators, fewer adults have delayed care or not sought care due to cost in Schaumburg than in the state or nation. A similar pattern is seen with oral health care, where the percent of adults without a visit to a dental clinic in the past year is better than the state or nation, and the percent of high school student with no visit to a dentist in the last year is substantially better than the state or nation.

## B. Community Context Assessment

### PURPOSE

The Community Context Assessment (CCA) uses qualitative data to assess community strengths and assets, built environment, and forces of change. It collects insights, expertise, and views of people and communities with lived experience who may be experiencing inequities firsthand. It answers questions like:

- What strengths and assets do community members have that contribute to health?
- How does the built environment impact health and health inequities?
- What access to care gaps or barriers exist? Who is most affected?
- What changes are occurring in the community that affect health? Who is most affected?
- How has COVID-19 affected the community? What have health departments done well or not well to help?

### PROCESS

The village project team and LHF gathered qualitative data on community perceptions through three methodologies.

First, a community survey for local Schaumburg residents was conducted from October through December 2023. The survey was available in five languages: English, Spanish, Polish, Gujarati, and Hindi. It was primarily completed online but able to be completed on paper as needed. The survey was distributed via the village's website and flyers utilizing QR codes, which offered direct links to the survey in each language, and was promoted in the village's weekly newsletter, on Village Hall's Marquee sign and information screen, and via flyer distribution throughout village facilities and with community partners. Survey questions covered health insurance, school and work, home, quality of life, health needs, and community needs. The survey totaled 25 questions in length. In total, 480 total survey responses were received in four languages, with 463 responses (96%) from residents of the four Schaumburg zip codes.

**Self-identified demographics of survey respondents**

96% Schaumburg residents (all four zip codes), 3% adjacent zip codes

81% white, 8% Asian, 4% Latino/a/x, 2% Black/African American

73% female, 25% male, 1% other

44% age 65 and older, 56% mix of other ages from 18 to 64

Survey responses received in English, Polish, Gujarati, and Spanish

It should be noted that the survey was a self-reported survey conducted by a self-selected convenience sample of individuals in contact with the village or its partners, not a controlled random sample of the entire population. As such, it is important to note that convenience samples are vulnerable to hidden and systemic biases, where the sample results may differ from results that would be derived from the entire population. It is therefore unknown how responses in this survey may differ from the whole village population. Despite such limitations, the survey provides valuable insight into community members' perspectives and perceived needs.

As a second methodology, subject matter expert interviews were conducted in October and November 2023 with individuals recommended by the village project team as having knowledge of and perspectives on the health needs of the community. These experts included representatives from village leadership, sister agencies, and community partners. In total, LHF conducted 12 individual or paired phone interviews with a total of 13 people.

Finally, LHF facilitated four focus groups in October and November 2023 to gather insights from populations whose perspectives were vital to include. These groups were older adults, teens, business owners, and direct service providers in the health, mental health, and disability sectors. The groups also functioned as "member checking," allowing for discussion of themes emerging from other data. In total, 40 individuals participated in a focus group.

The CCA is organized around the guiding questions above, with survey responses and common emergent themes from interviews and focus groups woven together. Where themes are listed, the number in parentheses represents the number of different conversations out of the 16 in which this theme emerged.

RESULTS

## Community Strengths and Assets

*Village and Organizational Strengths and Assets*

Some of the most common themes around community strengths and assets that emerged from interviews and focus groups were around the strengths of the village and other local government institutions and agencies such as the township and park district. Recurring themes include:

- Township offers many services, such as its food pantry, transportation, tax help, new Mental Health Board and forthcoming funding, and other services (n=8)
- Village, township, and park district all are strong and collaborate well (n=8)
- Many resources and programs exist for seniors, the Senior Center/the Barn is an asset (n=7)
- Village does a great job with its services around nutrition, mental health counseling, nursing, loan closet, health education and promotion (n=6)
- Park district is an asset (e.g., playgrounds, gym facilities, classes); also YMCA, athletic association (n=6)
- Schaumburg library is a community asset, a positive for kids, and was valuable during COVID (n=4)
- New mental health crisis van, crisis response social workers are assets that help with village police response (n=5)
- Village cares about its seniors, people with disabilities, victims of domestic violence, and is more proactive about caring for underserved than many other communities (n=4)
- Police department and social work team at the village are compassionate, work in close partnership with social service partners and other agencies (n=4)

*Broader Community Strengths and Assets*

There were also several emergent themes surrounding the broader community's assets, including the natural and built environment and the overall residents. These include:

- Strong vibrant business community, job opportunities, tourism (n=5)
- Tolerant community that respects diversity, has many ethnic resources and foods, and that generally welcomes everyone (n=4)
- Schaumburg is higher income, employment is good, most people are insured, minority population is better off than in some communities, more infrastructure and resources (n=4)
- Bike and walking paths throughout village, walking groups, improvements to bike paths (n=4)
- Green spaces, parks, creek, nature pathways, flowers, retention ponds are assets, calming (n=4)
- Schaumburg has very good schools, people move to Schaumburg because of the schools and quality special education programs, schools have good rapport with social services (n=3)
- Safe community, clean, well-lit, good for walking (n=3)
- Lighting and streets improvements have made community safer, though still need more (n=3)
- The mall is big, is a good place for teens to hang out, is still doing well even when other malls aren't, though not at its former glory (n=3)

## Built Environment

*Housing*

Housing was a major concern across both the community survey and the interviews and focus groups. When asked if in the past 5 years they were worried about losing their home or apartment, 15% of community survey respondents (68/451) said they had been. Among respondents under age 65 years, 20% had been worried about losing their home, and respondents over age 65 were statistically more likely to say they have not been worried about losing their home or apartment. Though not statistically significant due to overall low numbers, a higher proportion of Black respondents said they were worried about losing their home or apartment than other racial/ethnic groups.

Q13: In the last 5 years, have you been worried about losing your home or apartment?

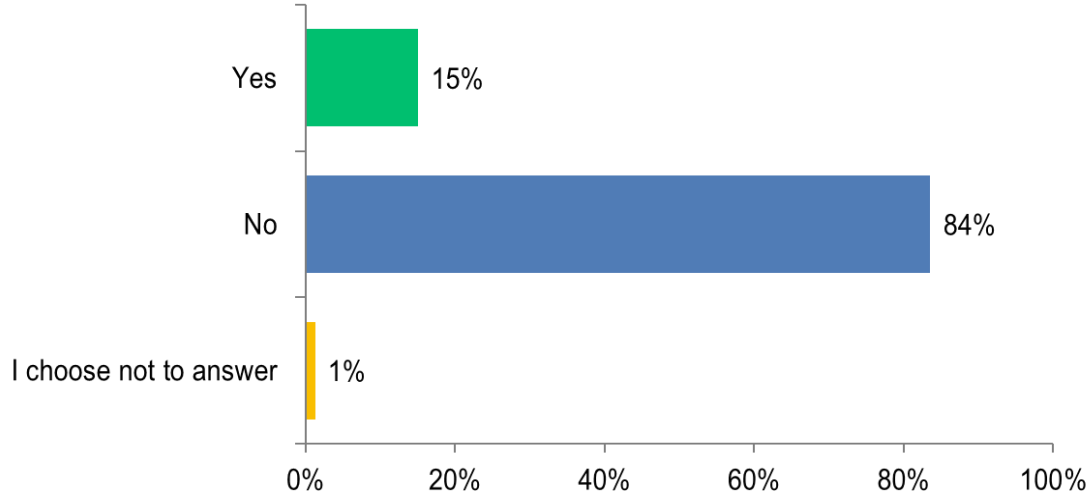



*Figure 25: Community survey responses to the question: "in the last 5 years, have you been worried about losing your home or apartment?" n=451*

Many interviews and focus group conversations also discussed housing-related concerns. Recurring themes around housing centered on some of the gaps in availability, affordability, and accessibility, including:

- Affordability, cost of living, inflation, gentrification, income disparities, "nothing is cheap" (n=9)
- Limited affordable housing, HUD housing, landlords don't want to take vouchers, people who work in Schaumburg have to live outside Schaumburg to afford it (n=8)
- Homelessness, transience, limited shelters/long waits for shelter (n=7)
- Housing for seniors is a challenge, many are on a fixed income, barriers to seniors affording housing, housing is not accessible for seniors (too many stairs), seniors can't maintain their homes (n=6)
- Limited supportive housing/assisted living, limited group homes, not enough resources for adults with disabilities whose parents are aging, waiting lists for assisted living (n=6)
- People in apartments/condos get forgotten about, priced out, discriminated against, seen as "undesirable," evicted for higher paying tenants, limited options for low-income (n=5)
- Many hotels exist in Schaumburg but few will work to house homeless individuals, village policy allows only 28 day stays, need more bridge or transitional housing (n=3)

Two of the top recommendations for the village emerging from these conversations focused on housing:

- Village needs more multi-family housing and more units that lower- and middle-income families can afford; should consider zoning changes and vacant building use to make that happen (n=7)
- Village could be leader in addressing affordable housing, working with alliance on homelessness, create wraparound services, group housing, push landlords to have more affordable units (n=4)

*Transportation*

Transportation was another top concern about the built environment present in nearly every qualitative conversation. Two major overarching themes around transportation and inequities or gaps in access to transportation emerged in more than half the conversations:

- Transportation in general is a challenge and a barrier to getting care, not everyone (seniors, parents, immigrants) drives or has a vehicle, need more transportation options for qualifying/low-income (n=11)
- Public transit and paratransit are better than other suburbs (transit hub) but still very limited (dial-a-ride, Pace); doesn't go outside the village limits in most cases, doesn't go to mental health drop-in centers, often have to wait for hours, runs at limited times/days, need more transit or shuttles for older adults (n=9)

*Community Safety*

Although Schaumburg was generally regarded as fairly safe, a small number of survey respondents did express concerns about safety on questions about safety at home and neighborhood safety. Three qualitative conversations also brought up concerns about increasing crime, fights, shootings, and homicides (3 of 16).

Q14: Within the past year, have you felt unsafe at home, such as being afraid of someone in your household?

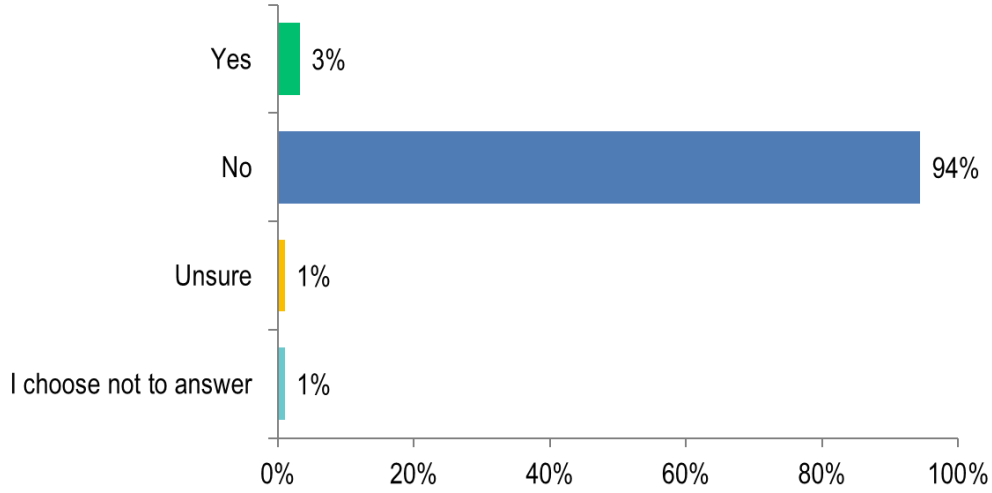



*Figure 26: Community survey responses to the question: "Within the past year, have you felt unsafe at home, such as being afraid of someone in your household?" n=451*

Q15: Do you feel safe in your neighborhood?

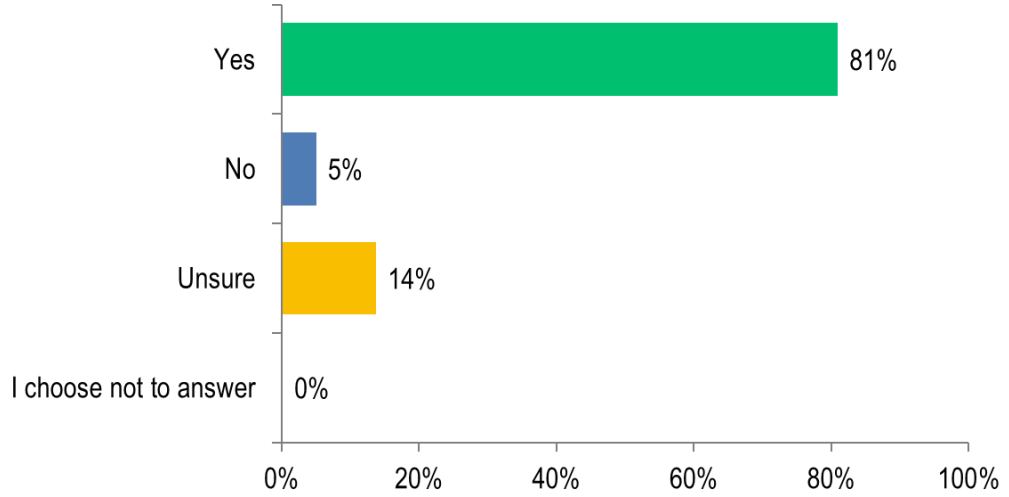



*Figure 27: Community survey responses to the question: "Do you feel safe in your neighborhood?" n=451*

## Access to Care Gaps and Barriers

*Access to Health Care and Insurance*

When asked if they or their household members had been unable to get any of the following when it was really needed, more than 70% of community survey respondents had not had any difficulty buying what they needed. However, for those that did have difficulty accessing items when they were needed, the top items they had difficulty accessing related to health services. These included health care, including medical, dental, and vision (9% of all respondents, or 38/425), mental health support (7% or 28/425), or medicine or medications (6% or 25/425). Other commonly reported needs included food (5%), transportation (5%), and open-ended responses related to services for seniors.

Q18: In the past year, have you or any household members been UNABLE to get any of the following when it was REALLY NEEDED? Please check all that apply.

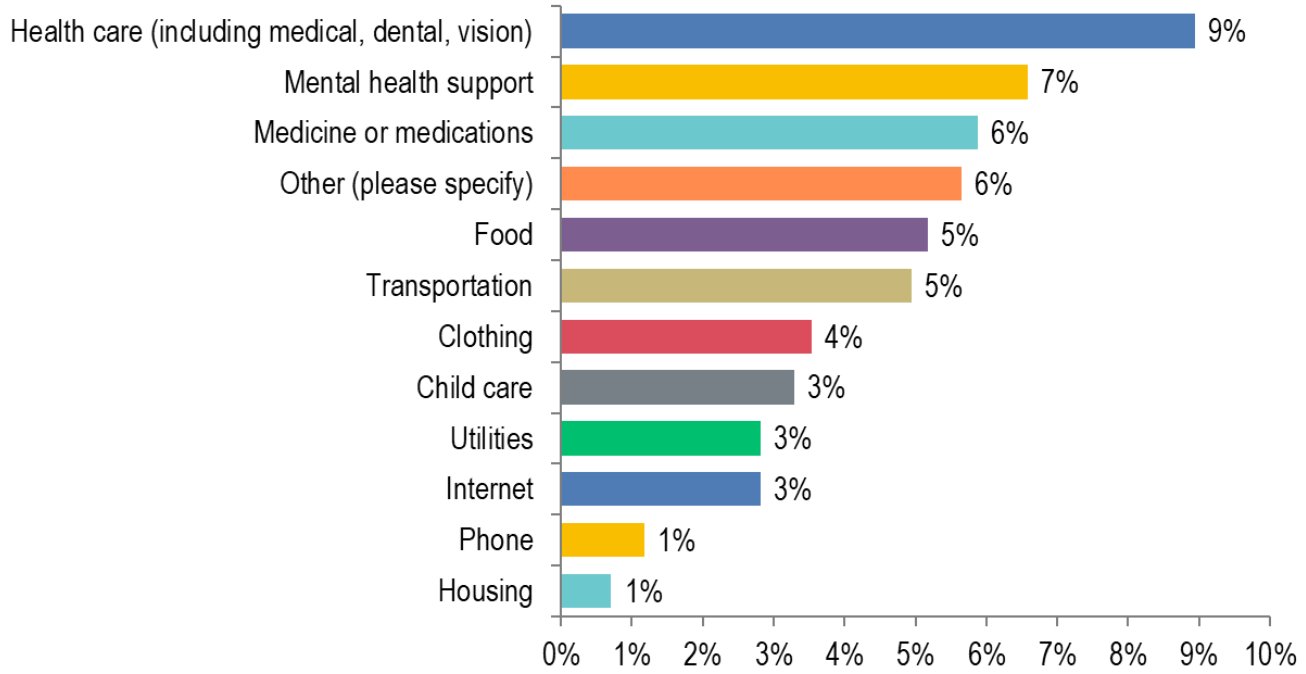



*Figure 28: Community survey responses to the question: "In the past year, have you or any household members been UNABLE to get any of the following when it was REALLY NEEDED?" n=425*

Both community survey respondents and qualitative conversation participants emphasized that insurance and cost barriers associated with insurance were some of the main barriers to care. This is a particularly complex challenge to address at the local level, given that health insurance access and health plan costs are frequently dictated by employers or by state or national entities, not local ones. Common themes around insurance and cost barriers that emerged from qualitative conversations included:

- Cost of care, affording insurance, high deductibles, high office bills, insurance can limit access to specific facilities or specialists (n=11)
- Need more prescription access, need more reduced cost medications, pharmaceuticals are expensive, high deductibles and copays for medications (n=9)
- Many people are uninsured/underinsured, immigrants and service workers may lack insurance and therefore delay care due to costs (n=6)
- Need more resources on how to understand insurance, your Medicare options, supplements/Advantage plans (n=4)

These themes aligned with what community survey respondents reported as barriers to accessing care. When asked what keeps people in the community from seeing a medical provider, the top responses were costs are too much (62%) and lack of health insurance (43%).

Some variation existed by age and insurance, with respondents under age 65 statistically more likely to say time off work was a barrier compared to those over 65, and those with Medicare more likely to identify lack of transportation as a barrier than respondents with private insurance.

Q25: What keeps people in your community from seeing a medical provider (doctor, dentist, nurse, etc.)? Please choose the top THREE.

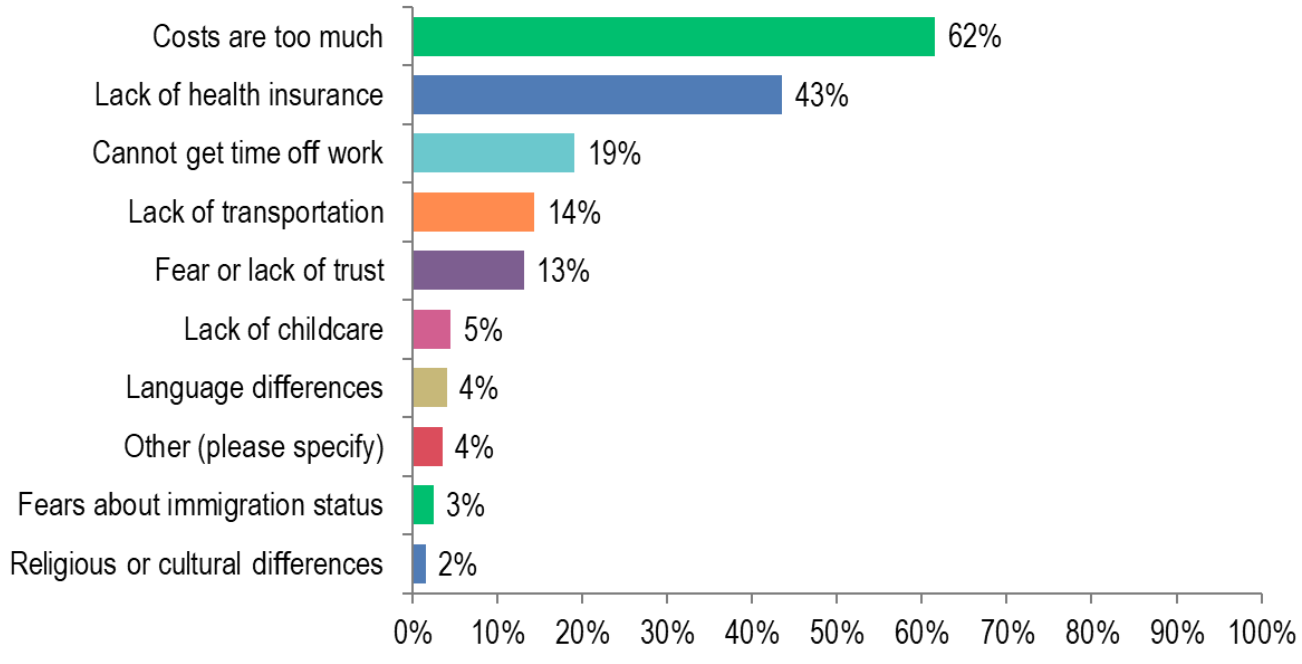



*Figure 29: Community survey responses to the question: "What keeps people in your community from seeing a medical provider (doctor, dentist, nurse, etc.)?" n=398*

Qualitative themes also aligned with survey respondents' challenges with their own insurance. Although 46% of respondents reported that they have no problems with their insurance, among those who did, the top problems were that the plan does not cover needed services (23%), monthly payments or bills from visits are too expensive (20%), medications are not covered or are too expensive (16%), and it is confusing (10%).

There were some differences depending on the insurance type the respondent had. Compared with people on Medicare, respondents with private insurance were statistically more likely to report problems with the cost of monthly payments or bills from visits, and with being confused by their plans. Respondents with Medicare were more likely to have problems with the plan covering services they need.

Q7: What problems do you experience with your insurance? Please check all that apply.

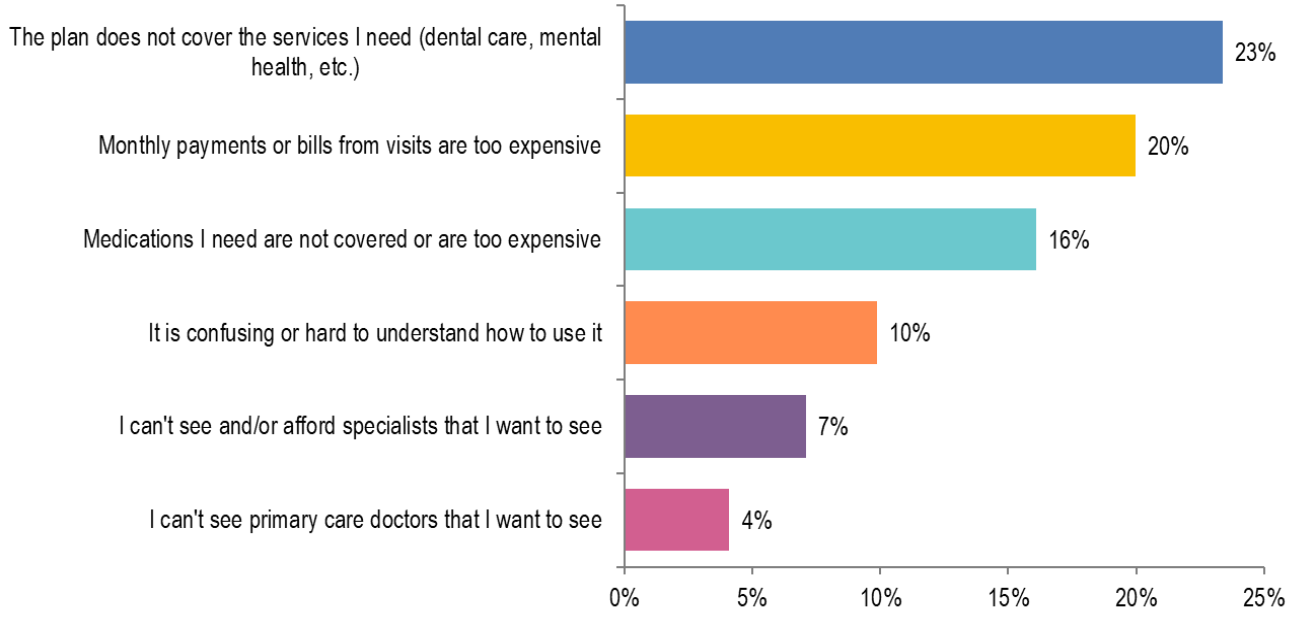



*Figure 30: Community survey responses to the question: "What problems do you experience with your insurance?" n=466*

*Mental Health and Substance Use Disorder Service Needs*

Another key set of themes across qualitative conversations centered on mental health, psychiatric health, substance use disorders, and other behavioral health needs. Participants expressed concern with both the great needs around mental health as well as the barriers to accessing mental health resources. Themes included:

- Psychiatric needs, mental health needs, mental health medication needs, insufficient safety net mental health resources (n=9)
- Stigma/shame with accessing care, getting help, especially around mental health and especially with immigrants (n=9)
- Overall mental health and suicide in the community - people are isolated, struggling silently, lonely, depressed, lots of crisis needs, needs for veterans (n=8)
- Drug and opioid use disorders are a problem, fentanyl is a problem and is in other drugs, need for fentanyl test strips (n=3)
- Co-morbidities, medical issues get ignored during mental health/substance use disorder crisis - sores on feet, wounds, necrosis, trauma needs for mental health patients (n=3)

When asked what keeps people in the community from seeking mental health care, community survey respondents pointed to both similar and different barriers compared to those for medical care. The top reported barrier to seeking mental health care was costs are too much (48%), followed by do not know where to go or how to access services (35%), lack of health insurance (33%), and fear, stigma, or lack of trust (31%).

Respondents in their 40s and 50s were statistically more likely to select costs as a barrier compared to those over age 65. Respondents 49 and under were also more likely to select time off work and childcare as barriers compared to those over 65. Similarly, compared to those with Medicare, those with private insurance were more likely to say costs are too much or have challenges getting time off work.

Q24: What keeps people in your community from seeking mental health care? Please choose the top THREE.

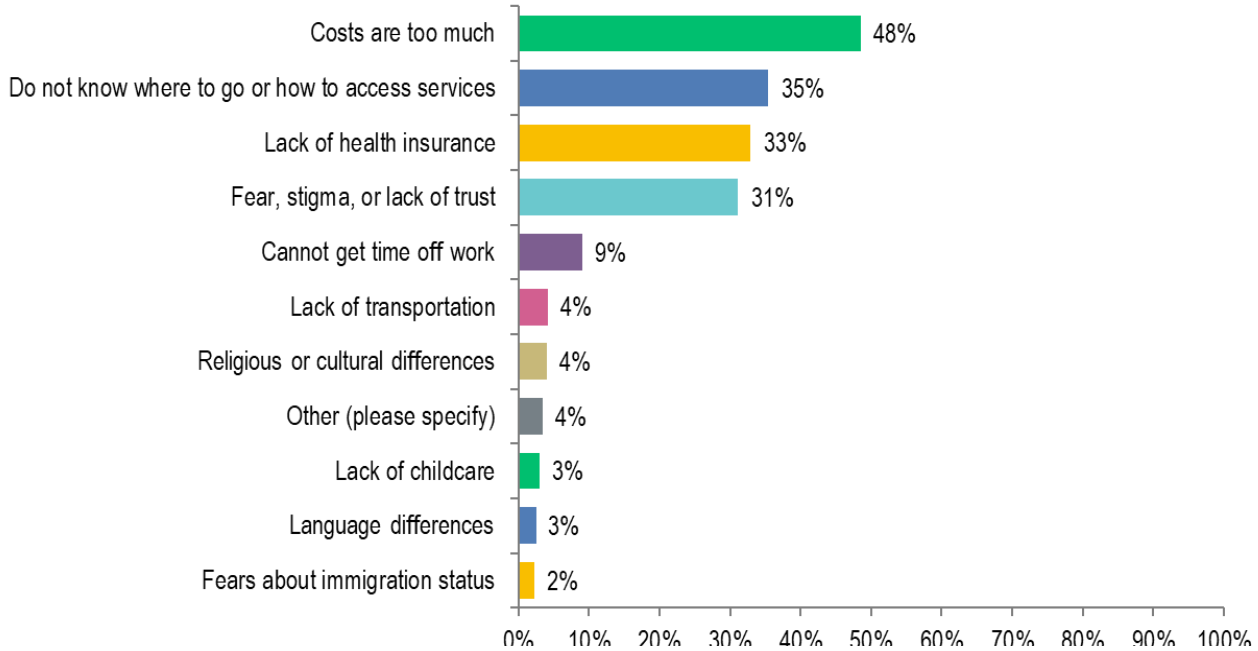



*Figure 31: Community survey responses to the question: "What keeps people in your community from seeking mental health care?" n=398*

*Availability of Health Facilities, Providers, and Services*

Another key aspect of access to care is access to health facilities and providers. Qualitative conversations highlighted some of the assets in Schaumburg around health facilities and locations, including:

- Proximity to many health facilities/resources: hospitals, retail clinics, urgent care, outpatient centers (n=7)
- New healthcare facilities coming to Schaumburg soon – Lurie outpatient, cancer treatment, Duly, small and large centers (n=4)

However, other themes emerged around gaps, shortcomings, and challenges in health facilities and workforce:

- Lack of providers, specialists, healthcare workforce burnout, people leaving field or retiring, hard to find providers, not diverse enough workforce to find appropriate providers (n=7)
- Mental health/behavioral health workforce challenges – smaller organizations can't compete on salary with hospitals, not enough social workers, not enough psychiatry, not enough bilingual mental health/behavioral health staff (n=7)
- No safety net clinics/community health centers/Federally Qualified Health Centers/free clinics in Schaumburg, few doctors work on a cash basis (n=5)
- No hospital in Schaumburg, though several nearby (n=3)
- Not enough vision services/vision care, especially for kids; need for eye doctors (n=3)

When asked for the top three health or social services that the community needs more of, the top choices for community survey respondents included care for elderly adults (33%) and counseling for depression, anxiety, family problems, etc. (27%). Other key services the community needs included psychiatric care (14%), care for people with disabilities (14%), health education (13%), and dental health (13%). Younger respondents were more likely to select services in other languages, counseling for mental health, and childcare as needed in the community. Older respondents were more likely to select care for elderly adults and services for those experiencing homelessness.

Q23: What are the top three health or social services that your community needs more of? Please choose up to three.

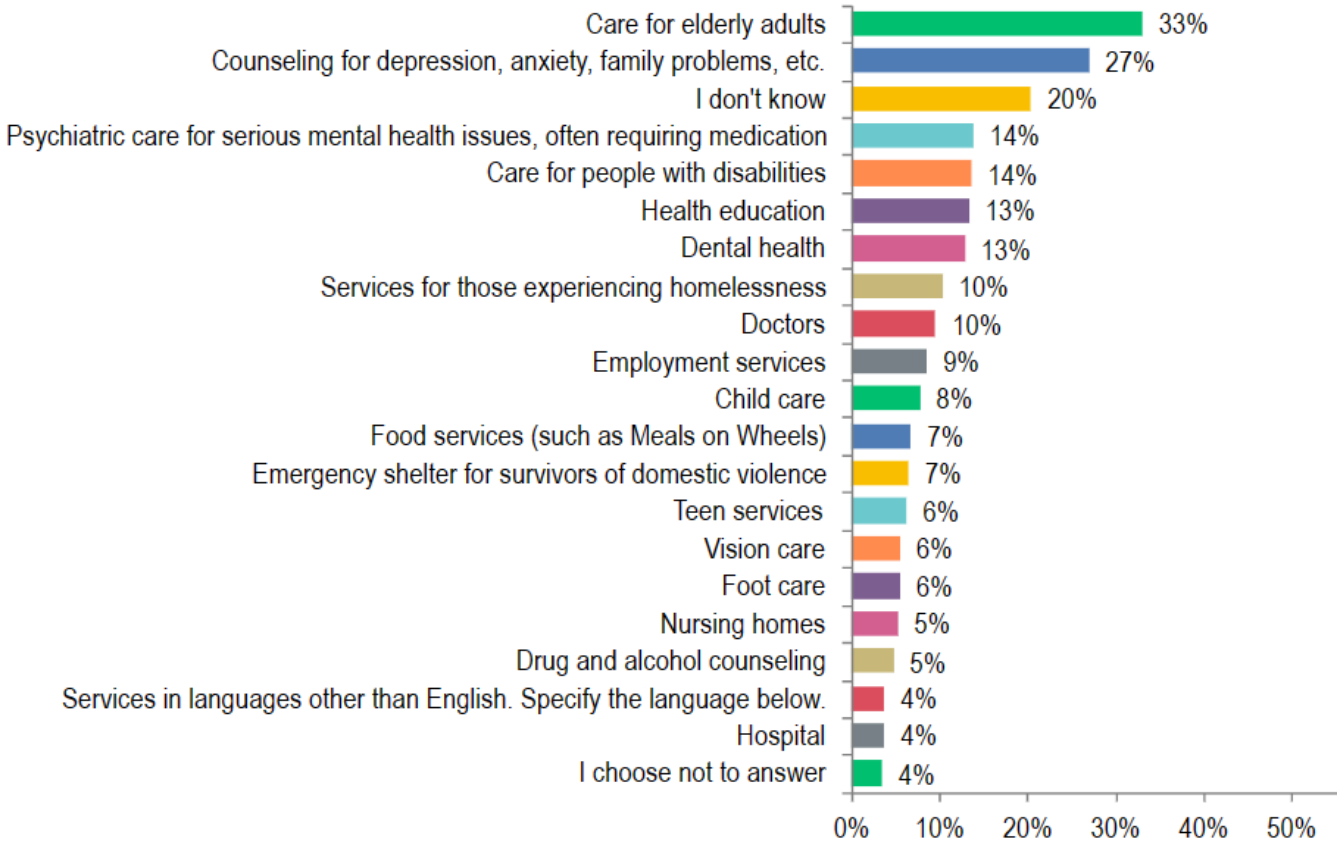



*Figure 32: Community survey responses to the question: "What are the top three health or social services that your community needs more of?" n=398*

## COVID-19 and Public Health Response

Interviews and focus groups included questions around how the COVID-19 pandemic has affected the community and what health departments and other institutions did well or not well as part of the COVID-19 response effort. On the whole, participating stakeholders felt the response to COVID went well in Schaumburg:

- Local COVID response went well generally, no specific concerns regarding response from health department (CCDPH), nothing specific to change, no specific criticism, not sure what came from what level of government (n=8)
- Community came together, lots of food, supplies, PPE, tests distributed, would be nice to still have (n=7)
- County provided information during COVID, regular calls, very helpful; other agencies (CDC, etc.) provided information (n=4)

Not all stakeholders shared this perspective on the response in Schaumburg. There did emerge some themes that were more critical or pointed out shortcomings in the local COVID response:

- Needed a manual/guide, a clearer plan, more written communications, more townhalls with public (n=4)
- Would have liked to see community have greater confidence in/understanding of decisions during COVID, more buy-in from restaurants, more flexibility for village to make own decisions (n=3)
- Perception that county focused more on other communities and that county services were not readily available within a reasonable distance of Schaumburg during COVID (n=3)

Additionally, several themes pointed to the lasting impact that COVID has had in the community:

- Rates of anxiety, trauma, post-traumatic stress disorder, depression, grief, hopelessness due to COVID, not enough therapy available for this (n=4)
- Many people with losses during COVID, widowed, orphaned, lost friends, many people who died, lost homes or stability due to losing loved ones, staff who put lives on the line (n=4)
- Pivot to telehealth during COVID helped address some barriers to care - transportation, childcare, seniors learned to use electronics (n=3)

## Forces of Change

Qualitative conversations highlighted a variety of demographic changes that the Schaumburg community is seeing and that may affect the health services and initiatives that will be needed in the future. Some of these forces of change include:

- Community is getting more diverse – more Indian, Polish, more people of color, more recent immigrants - fewer white residents (n=8)
- Increasing refugee/asylee needs, increasing migration, undocumented immigrant challenges, need for a long-term solution/housing/asylum (n=5)
- More languages spoken, need for services is Spanish, Polish, and other languages, need for crisis workers who are bilingual, not enough ESL support (n=5)
- Younger generations are more diverse, more mixed income, more renters, not the same population as 15-20 years ago (n=5)
- More seniors than ever, seniors are a big part of the community, more older seniors than ever (75+, not 60+), people aging in place and staying longer, not enough services to meet their needs (n=5)
- Very multigenerational community, grandparents raising grandkids, age diversity, younger people need to know about services for older people and vice versa (n=3)

## Recommendations for Village of Schaumburg

Finally, many qualitative conversations pointed to the Village of Schaumburg potentially playing a role in closing gaps and driving future community health improvement. In addition to the housing-focused recommendations on page 37, other recommended solutions emerging from focus groups and interviews included:

- More awareness of village services, more visibility, more promoting what is available, more health fairs, more literature/newsletters about the many resources, targeted mailings (n=8)
- Village could expand existing services – nursing, screenings/referrals, vaccines, mental health care (n=7)
- Village could give funds to organizations already doing this work, e.g., grantmaking/subcontracting (n=4)
- Village could convene/coordinate social service partners around mental health, housing (n=3)
- Village could get more health facilities into town – urgent care, labs, outpatient, dialysis, Federally Qualified Health Centers (FQHCs), alternative medicine providers, birthing centers, device manufacturers (n=3)

## C. Community Partner Assessment

### PURPOSE

The Community Partner Assessment (CPA) provides a structure for community partners to look critically at their individual systems, processes, and capacities, and the collective capacity of the system to address inequities and advance health equity. It answers questions like:

- Who is involved in MAPP? Who else needs to be involved?
- What capacities, skills, and strengths does each organization bring that could contribute to improving community health? Where are there gaps in fulfilling the essential public health services?

### PROCESS

The village project team and LHF first held a virtual community partner welcome meeting in October 2023 to bring together community partners from across the public health landscape, provide an opportunity for them to learn more about the needs assessment, and launch a community partner assessment survey. The village invited a wide variety of partner organizations in the health and human services sectors that serve Schaumburg residents, including social service nonprofits, health care entities, mental health and substance use providers, faith-based organizations, senior service providers, and municipal departments.


*Figure 33: The 10 Essential Public Health Services (EPHS). Revised 2020 by the Public Health National Center for Innovations (PHNCI) and the de Beaumont Foundation. Image from CDC.*

The community partner assessment survey was open online from October through December 2023 and received 27 total responses, primarily from leadership or senior management from nonprofit organizations serving Schaumburg. The survey itself was adapted from a sample MAPP 2.0 survey developed by NACCHO. It included questions about each partner organization, who they serve and what they focus on, the community health improvement needs they see in their work, their organizational commitment to equity, their interest in being part of MAPP, their capacities to support community health improvement, and their specific capacities around the 10 Essential Public Health Services (EPHS). The updated 2020 version of the EPHS framework was used, which puts equity at the center of all 10 EPHS (see Figure 37).

A facilitated in-person meeting was held on January 16, 2024, in which participating community partners heard preliminary findings about community needs from the CSA and CCA, reflected on the results of the community partner assessment survey, and worked in small groups to weigh in on gaps and barriers based on these findings.

The CPA is organized around the guiding questions above, with highlights from both the community partner assessment survey and from the discussion and synthesis with partners in-person in January 2024.

RESULTS

## Community Partners and Involvement in Community Health Improvement

*Community Partner Agencies and Their Focus*

Partner agencies responding to the survey came from many different sectors:

- 73% were nonprofit organizations, but agencies self-identified as many different provider types, including social service provider, mental health provider, housing provider, government agency, school, faith-based organization, hospital, clinic, and emergency response agency.
- 61% focus on health issues, largely a combination of mental health, primary care and chronic disease management, healthy living and nutrition, health prevention, and immunization.

Partner agencies report working with many underserved populations, including:

- 92% work with populations that speak English as a second language
- 88% work with immigrants
- 75% work with people with disabilities
- 71% work with transgender, non-binary, and other members of the LGBTQIA+ community
- 58% work with refugees
- 50% work with asylum seekers

Partner agencies report many categories of work, with the top nine as follows:

- 78% work on mental health care
- 70% work on human services
- 57% work on family well-being
- 52% work on food access and affordability
- 48% work on education
- 48% work on housing
- 43% work on transportation
- 39% work on LGBTQIA+ discrimination/equity
- 39% work on racial justice

Partner agencies focus on all five social determinants of health (see page 9) but focus the most on economic stability, such as working on poverty, employment, food security, and housing. 65% of respondents reported focusing on economic stability a lot, 26% focusing on it a little, and only 9% (2/23) not focusing on it at all.

Q11: How much does your organization focus on each of these topics? For each one, select a lot, a little, not at all, or unsure.

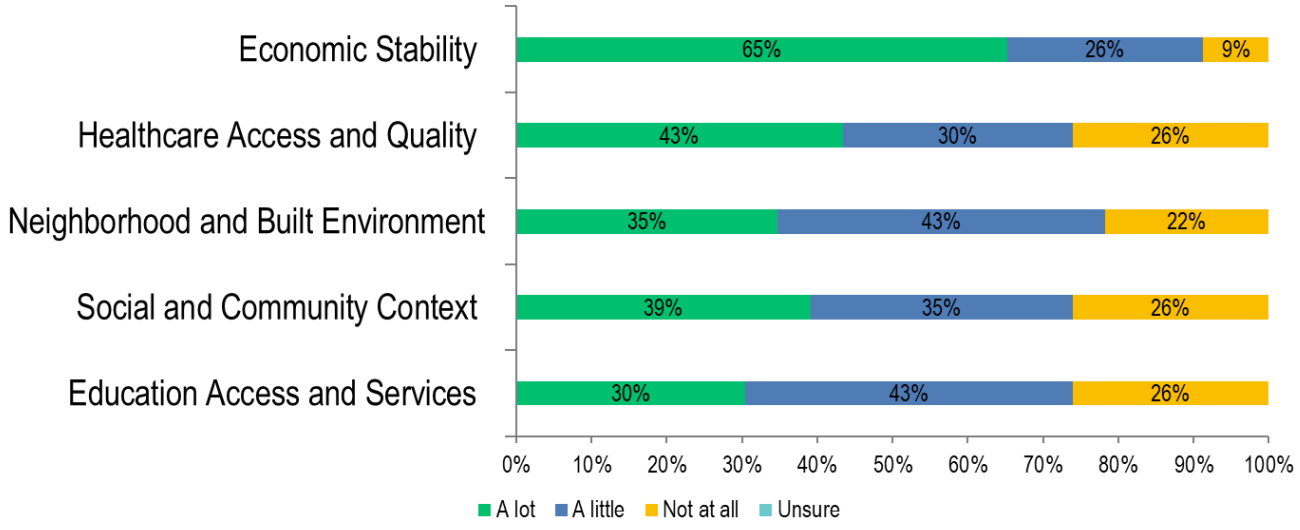



*Figure 34: Partner survey responses to the question: "How much does your organization focus on each of these topics?" n=23*

*Interest and Involvement in Community Health Improvement Partnership*

In the survey, partners were asked several questions about their past involvement and their future interest in being a part of a community health improvement partnership and process like MAPP. Key findings included:

- 50% said their organization has participated in a community heath improvement process, while 12% said their organization had not.
- 54% said their organization had participated in or facilitated community-led decision-making around policies, actions, or programs, while 15% said their organization had not.
- The number one reason organizations were interested in joining a community health improvement partnership was to deliver programs effectively and efficiently and avoid duplicated efforts (72%). This was followed by creating long term, permanent social change (48%), pooling resources (40%), and increasing communication among groups (40%).
- Organizations were also interested in participating in a community health initiative to improve conditions for their members or constituents (33%), build connections to other organizations (21%), and build connections to communities with lived experience (17%).

Q6: What are your organization's top three interests in joining a community health improvement partnership?

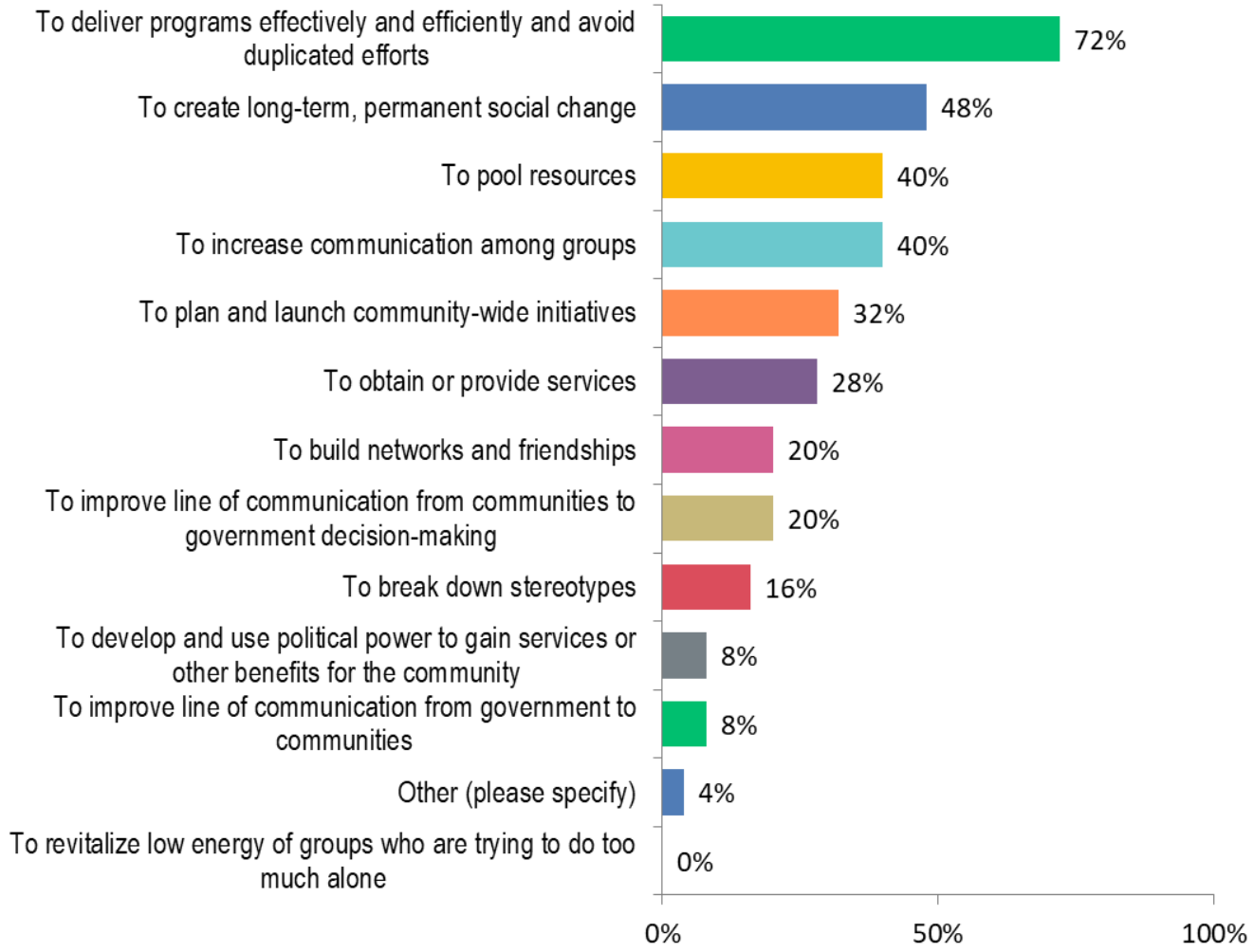



*Figure 35: Partner survey responses to the question: "What are your organization's top three interests in joining a community health improvement partnership?" n=25*

*Partner Perceptions of Community Health Improvement Needs*

Partner agencies were asked what groups of people need more services available in the community and could select their organization's top three. The top eight groups that emerged were:

- Individuals with limited English proficiency (75%)
- Immigrants, refugees, asylum seekers (70%)
- Individuals who are unhoused (65%)
- Children or teens (55%)
- Individuals with disabilities and their caregivers (55%)
- Older adults (50%)
- Individuals who identify as Hispanic/Latinx (50%)
- Individuals who identify as LGBTQIA+ (50%)

Partners were also asked to select the top 10 greatest challenges in the community, whether or not their organization directly worked on those. Many of the top selected challenges mirrored findings from the CSA and CCA, with the top nine as follows:

- Mental health care access (95%)
- Poverty or affordability of basic needs (85%)
- Housing stability or affordability (85%)
- Food security (70%)
- Unemployment or underemployment (65%)
- Transportation (65%)
- Childcare or early childhood education access (60%)
- Primary care access (55%)
- Health insurance coverage (55%)

Regarding the greatest barriers to community members accessing health services, the top three barriers selected by partners were costs (80%), lack of transportation (75%), and insurance barriers (70%), followed by language differences (50%), lack of childcare (45%), and fear or lack of trust (40%). These also aligned with findings from other assessments.

Q25: What are the greatest barriers to community members accessing health services, social services, or other needed services that your organization observes? Please check your organization's top three.

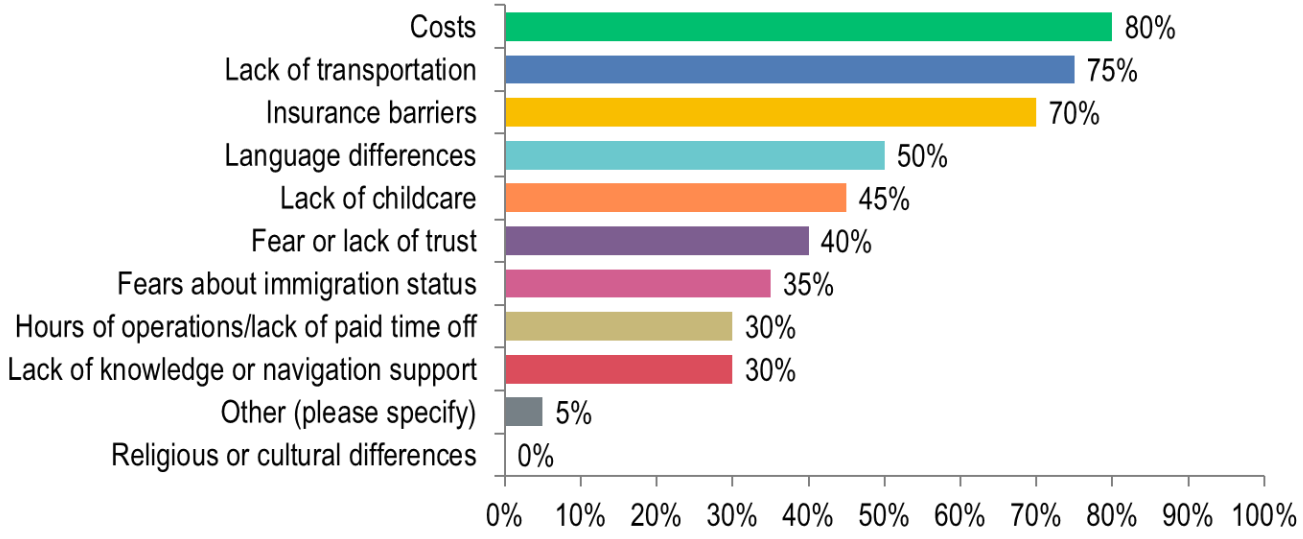



*Figure 36: Partner survey responses to the question: "What are the greatest barriers to community members accessing health services, social services, or other needed services that your organization observes?" n=20*

## Capacities of Community Partners and Gaps in Essential Public Health Services

*Partner Capacities, Skills, and Strengths*

As part of understanding organizational strengths and capacities, partners were asked about organizational equity practices. Key findings include that:

- 91% of responding organizations have at least one person in their organization dedicated to addressing diversity, equity, and inclusion internally.
- 74% have a team dedicated to advancing equity in the organization.
- 70% have advancing equity or addressing inequities in all or most of their staff job requirements.
- Not as many organizations have at least one person dedicated to addressing inequities *externally* in the community. Only 30% of responding organizations reported that their organization has this.

To accomplish their work, strategies that partners most commonly used included providing social and health services (90%), using communications (80%), and engaging in alliance and coalition building (70%), research and policy analysis (65%), and leadership development (65%). Few partners use voter engagement, movement building, arts and culture, narrative change, campaigns, organizing, or litigation as their main strategies.

Q21: Which of the following strategies does your organization use to do your work? (check all that apply)

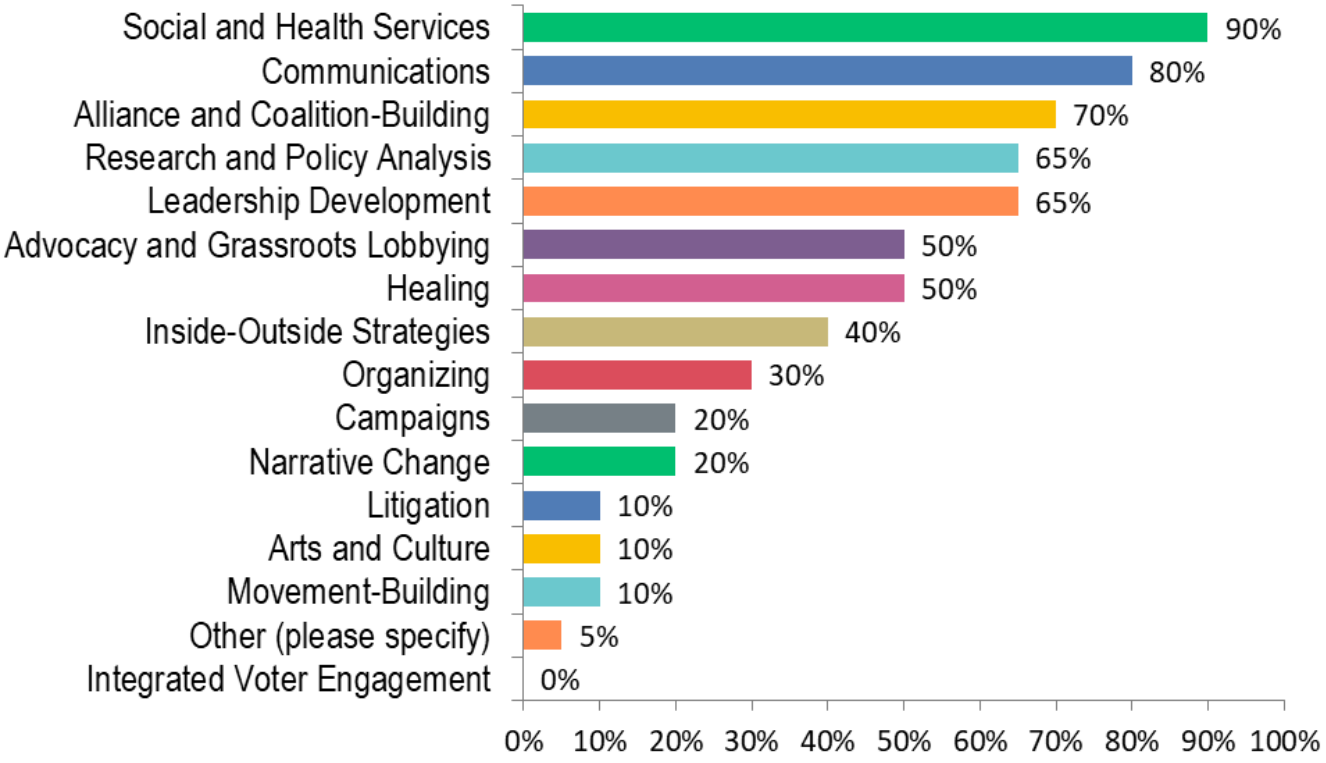



*Figure 37: Partner survey responses to the question: "Which of the following strategies does your organization use to do your work?" n=20*

Partner organizations were also asked if they had sufficient capacity to do their work, and only 20% felt they did while 70% felt they did not and 10% were unsure. In open-ended comments, many partners noted that they have experienced funding cuts and that insufficient funding has resulted in insufficient staff capacity and wait lists. One noted that in nonprofits, there is never enough funding.

*Fulfillment of Essential Public Health Services*

Partner agencies were asked a question structured around the 10 Essential Public Health Services, which are a set of activities that public health systems undertake to protect and promote the health of all people in all communities (see Figure 37 on page 47). These activities can be done by different organizations throughout the community, including nonprofit organizations, schools, faith institutions, mental health agencies, community health centers, emergency responders, neighborhood groups, employers, and more (see Figure 42).


*Figure 38: The local public health system, from MAPP 2.0.*

What emerged is that several essential public health services are being done by most partners that responded to this question, including communication and education (100%), community engagement and partnerships (81%), and access to care (76%). Other essential public health services are being fulfilled by some partners, including workforce (52%), policies, plans, and laws (48%), and evaluation and research (43%). Few partners who took the survey regularly fulfill the essential public health services of legal and regulatory authority (14%) or investigation of hazards (19%).

Q18: Please select whether your organization regularly does the following activities. (check all that apply)

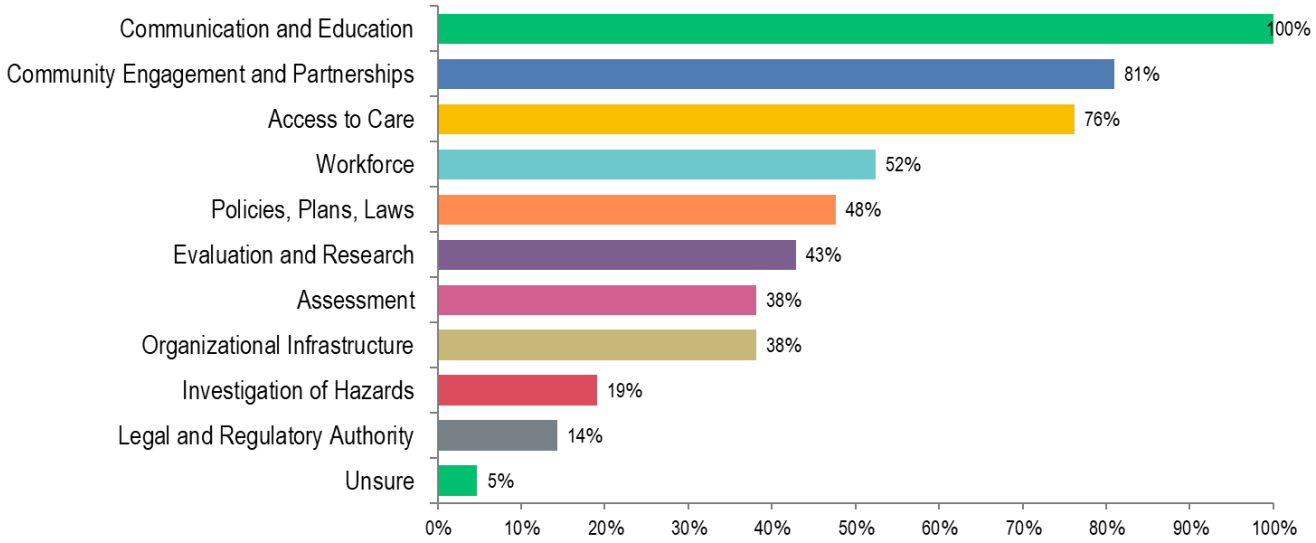



*Figure 39: Partner survey responses to the question around fulfillment of the 10 essential public health services: "Please select whether your organization regularly does the following activities." n=21*

One observation made during the January 2024 community partner meeting was that while there are a wide variety of organizations serving Schaumburg residents and located in close proximity to Schaumburg, comparatively few agencies are actually located within the village itself. Organizations may have a perception that there is less need in Schaumburg and that the village, township, and park district are able to meet existing needs, and therefore not located within the village. Opportunities may exist to bring additional services in proximity to residents, whether through new sites within the village, mobile services, or transportation to existing sites just outside the village.

*Capacities to Support Community Health Improvement*

Partners were asked about other types of capacities, strengths, and skills their organization brings to community health improvement activities. Regarding assessment and data collection practices, key findings included:

- 55% of responding organizations conduct assessments of some kind, while 20% do not.
- All organizations collect some kind of data, primarily demographic data about clients or members (89%), access and utilization data about services provided and to whom (63%), and evaluation, performance management, or quality improvement information about services and programs offered (63%).
- 47% of organizations collect data on social determinants of health and 42% collect data on health status.
- Only 26% of organizations collect data on health behaviors and just 11% (2 respondents) said their organization is collecting data about systems of power, privilege, and oppression.
- The most common form of data collected was surveys (75%), followed by feedback forms (45%), interviews (40%), data tracking systems (40%), electronic health records (25%), and focus groups (20%). Few organizations are using methods like videos or photovoice or participatory research methods.

Partners were asked about their community engagement practices, including where they fall along the spectrum of community engagement to community ownership (see figure 44 below). Findings included:

- Approximately half of partners are less far along the spectrum from community engagement to ownership. 47% of partners typically inform the community and 5% consult the community.
- Nearly half of organizations are further along the spectrum from community engagement to ownership. 11% involve the community, 26% collaborate with the community, and 5% defer to the community.
- Partners use many different community engagement methods, but most often use social media (74%), customer or patient satisfaction surveys (68%), presentations (68%), and community forums/events (68%).
- 84% of responding partners say that most of their organization's publicly available materials are translated into other languages.


*Figure 40: Spectrum of community engagement to ownership. From MAPP 2.0 Power Primer.*

Finally, partners were asked about what types of policy and advocacy work they do. Most organizations develop close relationships with elected officials (68%), educate decision-makers and respond to their questions (58%), and respond to requests from decision-makers (53%). Fewer partners report engaging in strategies like voter outreach, legal advocacy, building capacity of impacted communities, and writing or developing policy.

## D. Triangulating and Summarizing the Three Assessments

Across all three assessments, several cross-cutting themes emerged that reflect issues faced by the community. Based on triangulation of the CSA, CCA, and CPA, as well as feedback from community partners that participated in the January 2024 meeting, the following cross-cutting themes were identified:

### Community Strengths and Assets

- Collaboration between government agencies (village, township, etc.) is strong
- Diverse, tolerant community
- Robust green spaces, parks, recreation opportunities
- Strong business community, high education, and low unemployment
- Strong response to COVID within community
- Many nonprofits and government agencies fulfilling essential public health services

### Social Determinants of Health Facing Residents

- Transportation barriers and limited access to public transit
- Housing and affordable housing challenges
- Language barriers due to wide and increasing diversity of languages
- Unique challenges for foreign-born residents
- Challenges accessing, affording, and understanding health insurance
- Stigma around accessing services, especially mental health services and especially among immigrants

### Health and Social Service Capacity and Opportunities for Improvement:

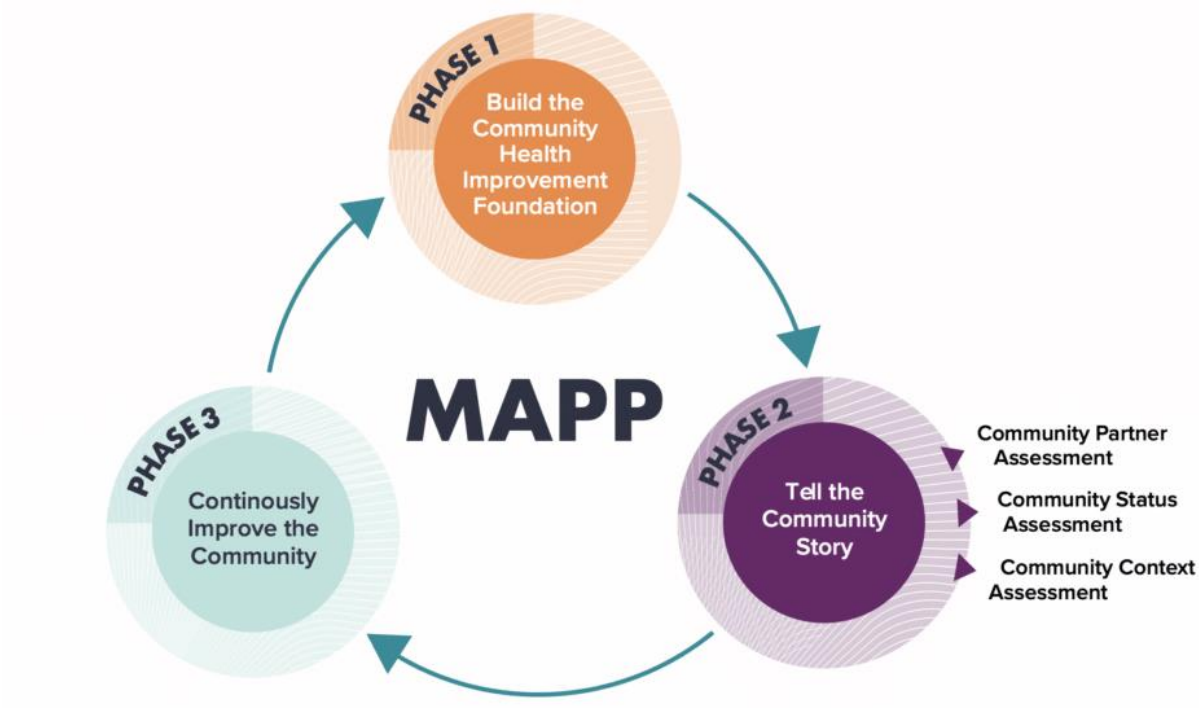
- Growing demand for mental health and psychiatric services
- Growing demand for services for older adults and for adults with disabilities
- Opportunity to increase preventive services such as chronic disease and cancer screening
- Opportunity to increase services for young people and collaboration with schools
- Workforce challenges like high turnover, insufficient practitioners, lack of bilingual providers
- Although many nonprofits serve Schaumburg, few are located within the village
- Opportunity for more health services facilities and points of access for health services within the village, in order to bring key health services in closer proximity to residents
- Opportunity to increase communication, outreach, education, and information about available services
- Opportunity to increase collaboration between nonprofits and partners serving the village

## V. Conclusion

Results from this community health needs assessment affirm that the Village of Schaumburg is a community with many strengths and assets, including a robust infrastructure of social service and health partners that together provide the community with essential health services. There are also many opportunities to further improve access to care and be ever-more responsive to the needs of residents. Cross-cutting themes that emerged from across all three assessments conducted include:

- *Community Strengths and Assets:* strong collaboration between government agencies; diverse community; many green spaces; strong business community; strong response to COVID; and many nonprofits and government agencies available to fulfill essential public health services.
- *Social Determinants of Health Facing Residents:* Transportation and public transit barriers; housing cost challenges; language barriers; and challenges accessing, affording, and understanding health insurance.
- *Health and Social Service Capacity and Opportunities for Improvement:* Workforce challenges; growing demand for mental health services and services for older adults, adults with disabilities, and young people; opportunity for more health service facilities, access points, preventive services, and for bringing services closer to residents; and opportunity to increase communication, outreach, and collaboration.

The Village of Schaumburg can play a leading role in addressing these identified needs, leveraging opportunities for improvement, and encouraging community solutions. Based on the findings in this report, the village will determine whether and when they will embark on Phase Three of the MAPP 2.0 process, which centers on prioritizing issues, defining strategies, and developing a formal Community Health Improvement Plan to improve health access and outcomes for the whole community. The themes and findings in this report can also be used to inform future planning by other partners and stakeholders in the broader Schaumburg community who share a desire to promote access to health and equitable health outcomes for all who live, work, shop, and play in the village.



## References


[1] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Social Determinants of Health. Accessed at https://health.gov/healthypeople/priority-areas/social-determinants-health
[2] Rob Paral and Associates. Demographic, Social and Economic Trends in Schaumburg: A profile of the Village of Schaumburg based on Census Bureau data. September 19, 2022. Accessed at https://arcg.is/0biur0
[3] Rob Paral and Associates. Demographic, Social and Economic Trends in Schaumburg: A profile of the Village of Schaumburg based on Census Bureau data. September 19, 2022. Accessed at https://arcg.is/0biur0
[4] Rob Paral and Associates. Demographic, Social and Economic Trends in Schaumburg: A profile of the Village of Schaumburg based on Census Bureau data. September 19, 2022. Accessed at https://arcg.is/0biur0
[5] Rob Paral and Associates. Demographic, Social and Economic Trends in Schaumburg: A profile of the Village of Schaumburg based on Census Bureau data. September 19, 2022. Accessed at https://arcg.is/0biur0
[6] Rob Paral and Associates. Demographic, Social and Economic Trends in Schaumburg: A profile of the Village of Schaumburg based on Census Bureau data. September 19, 2022. Accessed at https://arcg.is/0biur0
[7] City Health Dashboard. Children in Poverty in 2021, Schaumburg. Data from ACS 2017-2021 five-year estimate. Accessed at https://www.cityhealthdashboard.com/IL/Schaumburg
[8] City Health Dashboard. Unemployment – Current, City-Level, Schaumburg. Data from Local Area Unemployment Statistics, U.S. Bureau of Labor Statistics. Accessed at https://www.cityhealthdashboard.com/IL/Schaumburg
[9] Rob Paral and Associates. Demographic, Social and Economic Trends in Schaumburg: A profile of the Village of Schaumburg based on Census Bureau data. September 19, 2022. Accessed at https://arcg.is/0biur0
[10] Rob Paral and Associates. Demographic, Social and Economic Trends in Schaumburg: A profile of the Village of Schaumburg based on Census Bureau data. September 19, 2022. Accessed at https://arcg.is/0biur0
[11] Rob Paral and Associates. Demographic, Social and Economic Trends in Schaumburg: A profile of the Village of Schaumburg based on Census Bureau data. September 19, 2022. Accessed at https://arcg.is/0biur0
[12] HUD Office of Policy Development and Research. 2007-2023 Point-In-Time Estimates by CoC. Annual Homelessness Assessment Report, December 2023. Accessed at https://www.huduser.gov/portal/datasets/ahar/2023-ahar-part-1-pit-estimates-of-homelessness-in-the-us.html
[13] Cook County Health Atlas. Ease of walking to transit stop rate (CCHS). Accessed at https://cookcountyhealthatlas.org
[14] City Health Dashboard. Walkability, Schaumburg. Data from Walk Score. Accessed at https://www.cityhealthdashboard.com/IL/Schaumburg
[15] City Health Dashboard. Park Access in 2022, Schaumburg. Data from Park-Serve. Accessed at https://www.cityhealthdashboard.com/IL/Schaumburg
[16] Cook County Health Atlas. Flu vaccination rate (CCHS). Accessed at https://cookcountyhealthatlas.org

VILLAGE OF SCHAUMBURG

PROGRESS THROUGH THOUGHTFUL PLANNING

# Community Health Needs Assessment

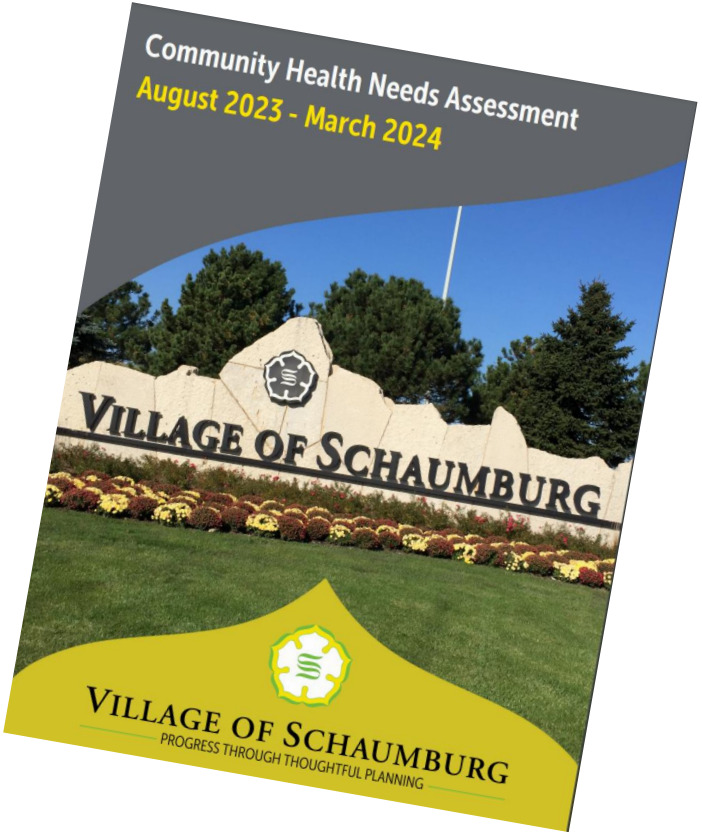
Health and Human Services Committee Presentation

March 28, 2024

# Purpose of Needs Assessment

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

- To identify and enhance our understanding of the health needs of Village of Schaumburg residents
- To assess the existing services and infrastructure available to fulfill these needs



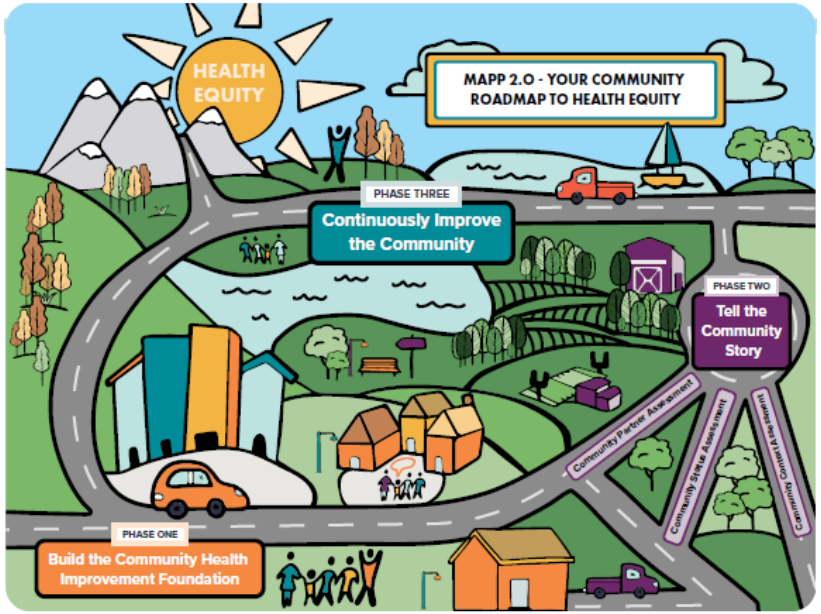
# OVERVIEW OF PROCESS

# Framework Used: MAPP 2.0

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

## Mobilizing through Action for Planning and Partnerships 2.0

- Phase One: Build the Community Health Improvement Foundation
- Phase Two: Tell the Community Story
  - Community Status Assessment
  - Community Context Assessment
  - Community Partner Assessment
- Phase Three: Continually Improve the Community



# Three Community Assessments in MAPP 2.0

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

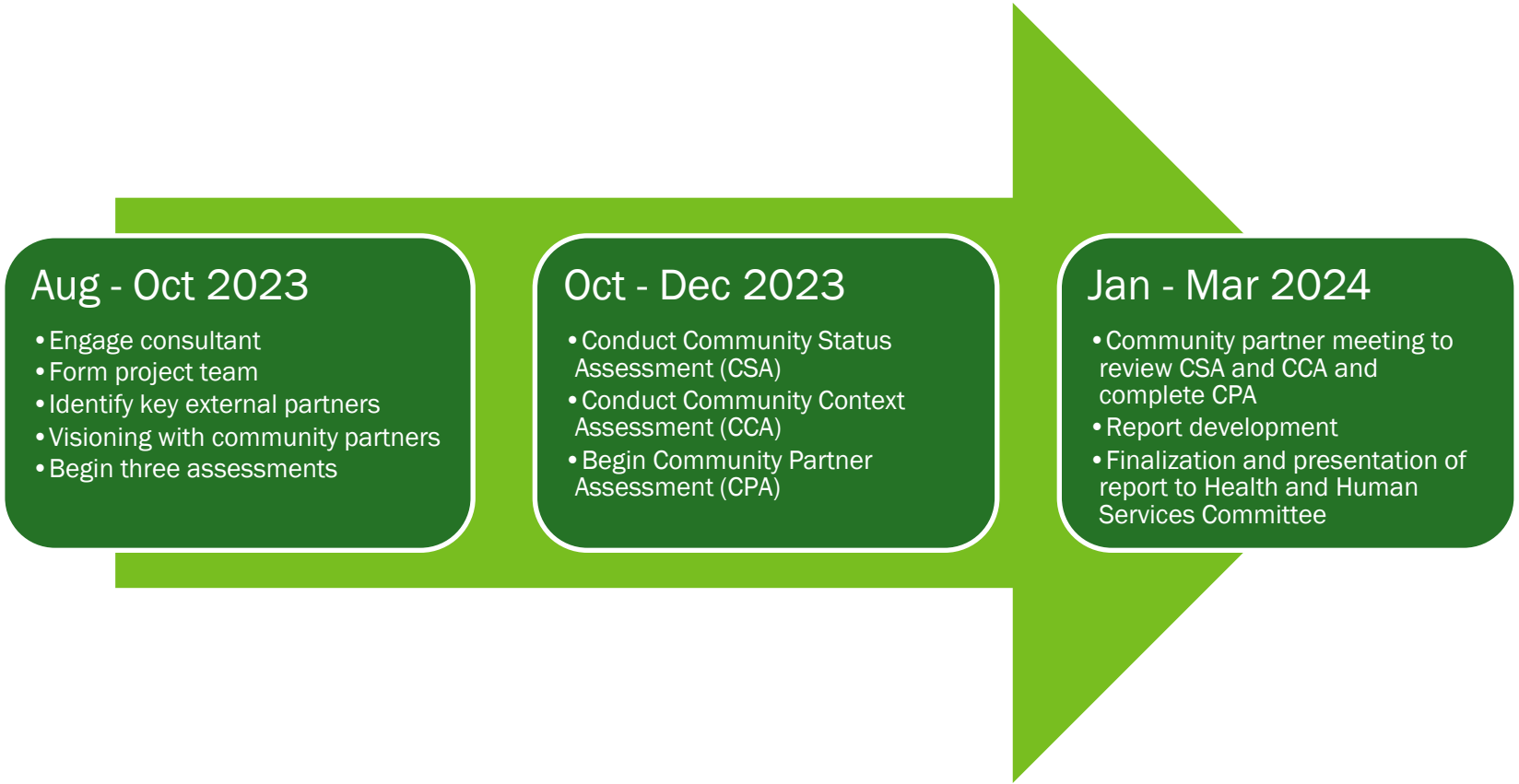
Community Status Assessment (CSA)

Community Context Assessment (CCA)

Community Partner Assessment (CPA)

# Needs Assessment Process and Timeline

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING



# KEY THEMES AND FINDINGS

# Community Strengths and Assets

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

- Strong collaboration between government agencies
- Green spaces
- Diverse community
- Strong business community
- Strong response to COVID
- Many nonprofits and government agencies

# Social Determinants of Health Facing Residents

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

- Transportation and public transit barriers to and from health service providers
- Housing cost challenges
- Language barriers
- Challenges accessing, affording, and understanding health insurance

# Health Service Capacity and Improvement Areas

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

- Workforce challenges
- Growing demand for mental health services
- Growing demand for services for older adults, adults with disabilities, and young people
- Opportunity for more health service facilities, preventive services, and services closer to residents
- Opportunity to increase communication, outreach, and collaboration

# Key Areas to Focus Efforts to Improve Health

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

**Transportation** – to and from health service providers

**Education** – in health insurance, available services, and translation

**Collaboration** – between existing service providers to improve efficiencies

# QUESTIONS

# VILLAGE OF SCHAUMBURG

PROGRESS THROUGH THOUGHTFUL PLANNING

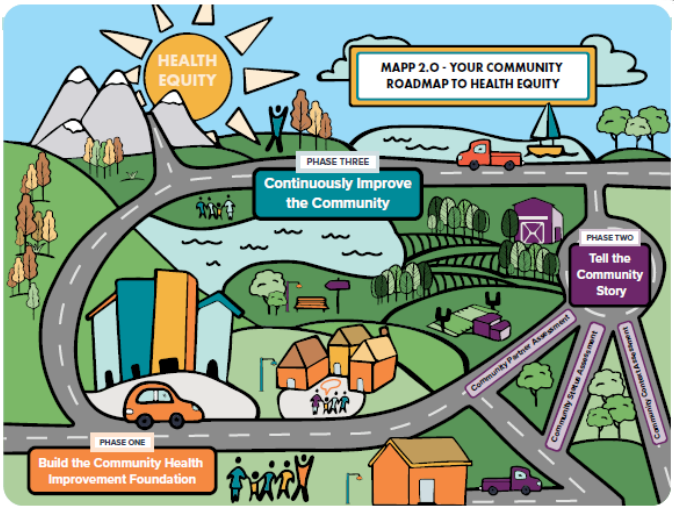
# Thank you!

# Village of Schaumburg
# Community Context Assessment Summary

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

## PURPOSE

In the Mobilizing for Action through Planning and Partnerships 2.0 (MAPP 2.0) process, Phase Two: Tell the Community Story involves conducting three different assessments to paint a comprehensive picture of health in the community.




The Community Context Assessment (CCA) uses qualitative data to assess community strengths and assets, built environment, and forces of change. It collects insights, expertise, and views of people and communities with lived experience who may be experiencing inequities firsthand. It answers questions like:

- What strengths and assets do community members have that contribute to health?
- How does the built environment impact health and health inequities?
- What access to care gaps or barriers exist? Who is most affected?
- What changes are occurring in the community that affect health? Who is most affected?
- How has COVID-19 affected the community? What have health departments done well or not well to help?

## PROCESS

The Village of Schaumburg project team used several methods to gather community perspectives. The first was an online community survey conducted between October and December 2023. The survey was available in five languages: English, Spanish, Polish, Gujarati, and Hindi. Survey questions covered health insurance, school and work, home, quality of life, health needs, and community needs. A total of 480 survey responses were received in four languages, with 463 responses (96%) from residents of the four Schaumburg zip codes.

As a second methodology, subject matter expert interviews were conducted in October and November 2023 with individuals recommended by the village project team as having knowledge of and perspectives on the health needs of the community.

Finally, LHF facilitated four focus groups in October and November 2023 to gather insights from populations whose perspectives were vital to include. These groups were older adults, teens, business owners, and direct service providers in the health, mental health, and disability sectors.

### Self-identified demographics of survey respondents

Self-identified demographics of survey respondents

96% Schaumburg residents (all four zip codes), 3% adjacent zip codes

81% white, 8% Asian, 4% Latino/a/x, 2% Black/African American

73% female, 25% male, 1% other

44% age 65 and older, 56% mix of other ages from 18 to 64

Survey responses received in English, Polish, Gujarati, and Spanish

## RESULTS

Common themes emerged from the survey, interviews, and focus groups around the strengths and assets of the community, including collaborative agencies, parks and green spaces, and access to health care facilities and community services. Themes also emerged around barriers in housing, transportation, access to health care and insurance, behavioral health needs, and availability of health facilities, providers, and services. Key findings are summarized here.

# Village of Schaumburg
# Community Context Assessment Summary

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

## Community Strengths and Assets

- Strengths of village and other government agencies, including their strong collaboration, many resources and services, and proactive approach to caring for underserved populations.
- Natural and built environment as assets, including robust green spaces, parks, bike paths, recreation opportunities.
- Strong, vibrant business community, job opportunities, and tourism as well as tolerant community of residents.

## Built Environment

- **Housing:** 15% of community survey respondents said they had been worried about losing their home or apartment. A majority of interviews and focus groups discussed housing-related concerns and gaps in availability, affordability, and accessibility, especially housing for seniors, adults with disabilities, and low-income individuals and families.
- **Transportation:** Transportation in general is a challenge and a barrier to getting care, as not everyone drives or has a vehicle. Public transit and paratransit are better than other suburbs but still very limited in where they go and when. More transit or shuttles options are needed for seniors, low-income people, and others.
- **Community Safety:** Schaumburg is generally regarded as safe. Some participants did express safety concerns.

## Access to Care Gaps and Barriers

- **Access to Health Care and Insurance:** In the last year, 9% of survey respondents reported that they or their family were unable to get medical, dental, or vision care when it was needed, 7% were unable to get mental health support, and 6% were unable to get medications. When asked what keeps people in the community from seeing a medical provider, the top responses were costs are too much (62%) and lack of health insurance (43%).
- **Insurance Challenges:** While many survey respondents experience no problems with their insurance, 23% say their plan does not cover the services they need, 20% say monthly payments or bills from visits are too expensive, 16% say medications are not covered or are too expensive, and 10% say it is confusing. Insurance and cost barriers associated with insurance were also highlighted by qualitative conversation participants.
- **Mental Health and Substance Use Disorder Services:** There are many mental health, psychiatric health, and substance use disorder needs, yet barriers exist in accessing care for these needs. When asked what keeps people from seeking mental health care, the top reported barriers were costs are too much (48%), do not know where to go or how to access services (35%), lack of health insurance (33%), and fear, stigma, or lack of trust (31%).
- **Availability of Health Facilities, Providers, and Services:** There are many health facilities in close proximity to Schaumburg, though fewer within the village. Workforce challenges like burnout, shortages of some provider types, and insufficient bilingual providers can make it hard to have enough access and availability.

## COVID-19 and Public Health Response

- Participating stakeholders largely felt the response to COVID went well in Schaumburg. The community came together, and the county and other agencies (CDC, etc.) provided information.
- Others pointed out shortcomings in the local COVID response, including wishing for greater flexibility for the village to make its own decisions, and perceiving county services as not readily available within a reasonable distance.
- COVID has also had a lasting impact on the community, including high rates of anxiety, trauma, post-traumatic stress disorder, depression, and grief, and the many people with losses of loved ones or stability during COVID.

## Forces of Change

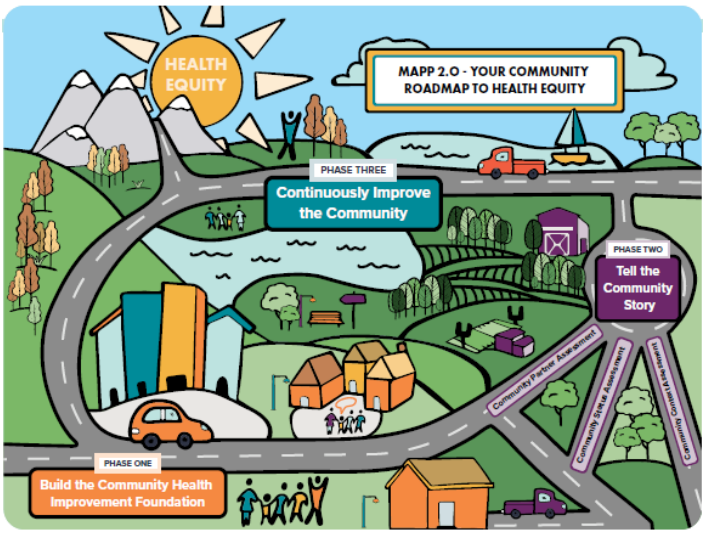
- Qualitative conversations highlighted a variety of demographic changes that the community is seeing and that may affect the services and initiatives that will be needed in the future, including increasing community diversity, increasing immigration, more languages spoken, and an aging population with more seniors aging in place in Schaumburg.

# Village of Schaumburg
# Community Status Assessment Summary

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

## PURPOSE

In the Mobilizing for Action through Planning and Partnerships 2.0 (MAPP 2.0) process, Phase Two: Tell the Community Story involves conducting three different assessments to paint a comprehensive picture of health in the community.




The Community Status Assessment (CSA) collects quantitative data on the status of the community to reveal gaps, issues, and inequities across a variety of indicators. It answers questions like:

- What does the status of the community look like?
- What populations experience inequities across health, socioeconomic, environmental, and quality-of-life outcomes?
- How do systems influence outcomes? Where are the gaps?

## PROCESS

LHF worked with the Village of Schaumburg project team to identify demographic and health indicators for analysis and to conduct the CSA during September 2023. Data was collected using the most recently available data sets as of September 2023 from the American Community Survey (ACS) 2017–2021 five-year estimates; CDC Wonder; the Behavioral Risk Factor Surveillance System (BRFSS); Youth Risk Behavior Survey (YRBS); Data Resource Center for Child and Adolescent Health; UDS Mapper: Policy Map; CDC PLACES; Cook County Health Atlas; and other publicly available online sources.

The analysis covered zip codes 60173, 60193, 60194, and 60195, and compared to relevant benchmarks such as Cook County, Illinois, or national averages as appropriate.

## RESULTS

The CSA is organized around five domains of social determinants of health (SDOH), which are:

1. Social and Community Context
2. Economic Stability
3. Education Access and Quality
4. Neighborhood and Built Environment
5. Health Care Access, Quality, and Disparities


The section on Health Care Access, Quality, and Disparities also describes morbidity, mortality, and other health indicators in the village, including for diabetes, cardiovascular disease, cancer, prenatal and perinatal health, child health, behavioral health, and other health indicators, with comparisons to national and state averages.

Highlights of the CSA are described in this summary.

# Village of Schaumburg
# Community Status Assessment Summary

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

## Social and Community Context

- **Race and Ethnicity:** Slightly more than half the population (56%) identifies as white non-Hispanic (more than in Cook County but less than in the state). One-quarter (24%) of the population identifies as Asian, which is substantially above the county or state. Another 11% of residents identify as Hispanic/Latino and 6% identify as Black/African American.
- **Age**: The zip code where the majority of the village population lives, 60193, has both a larger proportion of older adults and also a larger proportion of children than either Cook County or the state, and therefore a smaller proportion of working-aged adults. Two smaller zip codes, 60173 and 60195, have higher proportions of working-aged adults (71%).
- **International Born**: 30% of residents were born outside the U.S., compared to just 21% in Cook County and 14% in Illinois. The proportion of immigrant community members is highest in 60173 and 60195, where nearly half (47% in each zip code) of the population was born outside the U.S.
- **Language**: The Village of Schaumburg has a very linguistically diverse population, as nearly 40% of all residents over the age of 5 years speak a language other than English at home, more than in Cook County or Illinois. In 60173 and 60195, more than 50% of residents speak a non-English language at home.

## Economic Stability

- **Income**: 15% of Schaumburg residents are considered low-income, living under 200% of FPL. 6% are living in poverty, below 100% of FPL.

## Education Access and Quality

- **Education**: Schaumburg is a highly educated community, where 50% of residents over age 25 years have a bachelor's degree or higher, compared to just 41% in Cook County and 36% in Illinois.

## Health Care Access, Quality, and Disparities

- **Health Insurance**: 94% of Schaumburg residents have some form of health insurance. However, that leaves 6% of Schaumburg residents who are not insured. Roughly 10% of residents are on Medicaid or other public insurance.
- **Diabetes and Cardiovascular Disease:** 15.2% of adults have not had their cholesterol checked in the past 5 years, compared to the state average of 13.9% and national average of 14.8%.
- **Cancer**: Compared to the state or nation, Schaumburg has a higher rate of people lacking mammograms, screenings for cervical cancer, and colorectal cancer screening. Rates of breast/chest cancer mortality are also elevated.
- **Prenatal, Perinatal, and Pediatric Health**: Schaumburg generally fares well on prenatal, perinatal, and pediatric indicators, such as low birth weight births, preterm births, infant mortality, and key pediatric health measures.
- **Behavioral Health**: 30.5% of Schaumburg adolescents reported stress, anxiety, or depression, compared to 20.5% statewide and 21.8% nationally. In some census tracts, as many as 14% of adult residents have reported 14 or more days in the past 30 days during which their mental health was not good.
- **Other Health Indicators**: Schaumburg has a much lower rate of unintentional injury death than the state or nation, and. a lower overall all-cause age-adjusted death rate.

## Neighborhood and Built Environment

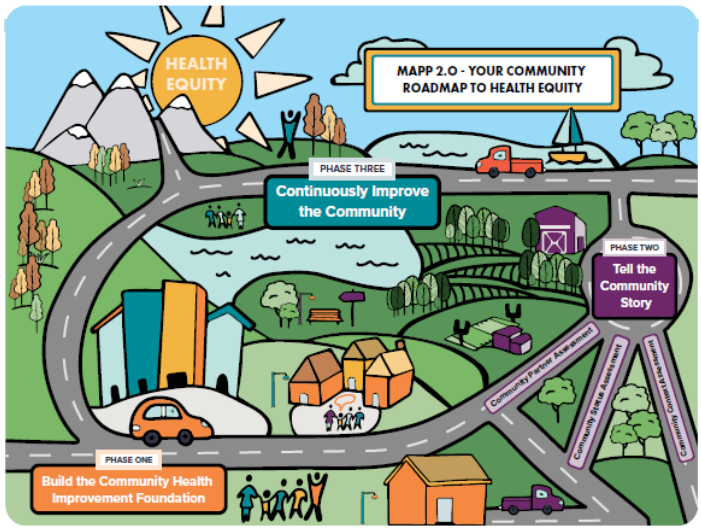
- **Housing Cost:** Among homeowners, 23% are considered "housing cost burdened," which means that their housing costs more than 30% of their income. Among renters, 34% are housing cost burdened.
- **Roadways and Bikeways:** The village sits at the intersection of three major highways and has numerous bike baths.
- **Public Transportation and Walking:** Public transit is available but can be limited. 58% of Schaumburg adults say it is easy to walk, scoot, or roll to a transit stop from home. Schaumburg also fares well on overall walkability.
- **Parks and Green Spaces:** The Village of Schaumburg has exceptional park access, with 86.8% of residents estimated to live within a 10-minute walk of a park or green space.

# Village of Schaumburg
# Community Partner Assessment Summary

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

## PURPOSE

In the Mobilizing for Action through Planning and Partnerships 2.0 (MAPP 2.0) process, Phase Two: Tell the Community Story involves conducting three different assessments to paint a comprehensive picture of health in the community.




The Community Partner Assessment (CPA) provides a structure for community partners to look critically at their individual systems, processes, and capacities, and the collective capacity of the system to address inequities and advance health equity. It answers questions like:

- Who is involved, or needs to be involved, in MAPP?
- What capacities, skills, and strengths does each organization bring to improving community health?
- Where are there gaps in fulfilling essential public health services?

## PROCESS

The village project team and LHF held a virtual community partner welcome meeting in October 2023 to bring together community partners from across the public health landscape, provide an opportunity for them to learn more about the needs assessment, and launch a community partner assessment survey.

The community partner assessment survey was open online from October through December 2023 and received 27 total responses, primarily from leadership or senior management from nonprofit organizations serving Schaumburg.

A facilitated in-person meeting was held on January 16, 2024, in which participating community partners heard preliminary findings about community needs from the CSA and CCA, reflected on the results of the community partner assessment survey, and worked in small groups to weigh in on gaps and barriers based on these findings.


*The 10 Essential Public Health Services (EPHS). Revised 2020 by the Public Health National Center for Innovations (PHNCI) and the de Beaumont Foundation. Image from CDC.*

## RESULTS

The CPA is organized around the guiding questions above, with highlights from both the community partner assessment survey and from the discussion and synthesis with partners in-person in January 2024. Highlights of the CPA are described in this summary.

# Village of Schaumburg
# Community Partner Assessment Summary

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

## Community Partners and Involvement in Community Health Improvement

- **Participating Partners:** Partner agencies responding to the survey came from many different sectors. 73% were nonprofit organizations, and 61% focus on health. Partners work in the areas of mental health care, human services, family well-being, food access/affordability, education, housing, transportation, LGBTQIA+ discrimination/equity, and racial justice.
- **Involvement in Community Health Improvement Partnership:** 50% of partners said their organization has participated in a community heath improvement process, and 54% said their organization had participated in or facilitated community-led decision-making. 72% said the reason they were interested in joining a community health improvement partnership was to deliver programs effectively and efficiently and avoid duplicated efforts, followed by creating long term, permanent social change (48%), pooling resources (40%), and increasing communication among groups (40%).
- **Populations Needing More Services:** According to partner agencies, the populations who need more services available in the community include individuals with limited English proficiency (75%), immigrants, refugees, asylum seekers (70%), individuals who are unhoused (65%), children or teens (55%), individuals with disabilities and their caregivers (55%), older adults (50%), individuals who identify as Hispanic/Latinx (50%), and individuals who identify as LGBTQIA+ (50%).
- **Greatest Community Challenges:** The greatest challenges in the community selected by partners included mental health care access (95%), poverty or affordability of basic needs (85%), housing stability or affordability (85%), food security (70%), unemployment or underemployment (65%), transportation (65%), childcare or early childhood education access (60%), primary care access (55%), and health insurance coverage (55%).
- **Greatest Barriers to Community Members Accessing Health Care:** The top three barriers to community members accessing health services selected by partners were costs (80%), lack of transportation (75%), and insurance barriers (70%), followed by language differences (50%), lack of childcare (45%), and fear or lack of trust (40%).

## Capacities of Community Partners and Gaps in Essential Public Health Services

- **Equity Practices:** 91% of responding organizations have at least one person in their organization dedicated to addressing diversity, equity, and inclusion internally.
- **Strategies and Skills:** To accomplish their work, partners utilize strategies like providing social and health services (90%), using communications (80%), engaging in alliance and coalition building (70%), research and policy analysis (65%), and leadership development (65%).
- **Organizational Capacity:** Only 20% of responding partners felt they have sufficient capacity to do their work, while 70% felt they did not have sufficient capacity and 10% were unsure. Funding was a noted challenge.
- **Fulfillment of Essential Public Health Services:** Several essential public health services are being done by most responding partners, including communication and education (100%), community engagement and partnerships (81%), and access to care (76%). Other essential public health services are being fulfilled by some partners, including workforce (52%), policies, plans, and laws (48%), and evaluation and research (43%). Few partners who took the survey fulfill the services of legal and regulatory authority (14%) or investigation of hazards (19%).
- **Data and Assessment Capacities:** 55% of responding organizations conduct assessments of some kind. All organizations collect some kind of data, using data collection methods such as surveys, feedback forms, interviews, data tracking systems, electronic health records, and focus groups.
- **Community Engagement Practices:** Partners vary in terms of their depth of community engagement. 11% involve the community, 26% collaborate with the community, and 5% defer to the community for decision making. Community engagement methods also vary and include social media, surveys, presentations, and community events.
- **Language:** 84% of partners say that most of their publicly available materials are translated into other languages.

VILLAGE OF SCHAUMBURG

# AGENDA ITEM SUMMARY

**Overview of the Village's Nursing Services Program - Informational**
**3/28/2024**
**Health and Human Services Committee**

Presenter: Kathy Henkelman, Supervisor | Nursing & Senior Services
Lead Department: Fire

***Executive Summary:***

At the request of Trustee Patel, village staff has prepared an overview presentation of the, Nursing Services component of the Nursing & Senior Services Division to the Health & Human Services Committee. The Senior Services functions will be presented in May as requested. This will describe the various services the division provides to the residents, as well as report the increases in volumes over the past years. Additionally, it will discuss the volunteer programs coordinated by the Nursing & Senior Services Supervisor and the committees in which she is involved and their respective purposes and functions.

***Recommended Action:***

Informational.

**ATTACHMENTS:**

| Description | Type |
|---|---|
| Nursing & Senior Services Division Analysis/Scope of Services 2024 | Exhibit |
| HHS NSS 2024 Report Presentation Summary | Exhibit |

**Village of Schaumburg**
**Nursing & Senior Services Division**
**Analysis/Scope of Services 2024**

Current Programs:

1. Nursing
    a. In-home nursing visits
    b. Consultations
    c. Memory Screening
    d. Wellness clinics
    e. Community education/outreach
    f. Sharps Collection
    g. Partnership with community agencies
        i. Kenneth Young Center
        ii. Private Agencies
        iii. Schaumburg Park District
        iv. Schaumburg Library
2. Lending Program
3. Senior Center – separate report deferred to May 2024
4. Volunteer Management
    a. MRC
        i. Special Health Needs Registry
        ii. Community Education/Engagement
    b. OASIS – Older Adult Services In Schaumburg
5. Committees
    a. Public Health Advisor
    b. Healthy U
    c. Support Our Seniors Council
    d. Hazardous Homes Task Force
    e. Community Health Needs Assessment
    f. Senior Advisory Council
    g. Northwest Municipal Nurses
    h. Money Management Advisory Board
    i. Blood Program Committee
    j. Board of Health
    k. Committee on Aging
6. Summary
7. Case studies
    a. JB
    b. SW
    c. DM

## 1. Nursing Care

The Nursing & Senior Services (NSS) is a division of the Village of Schaumburg Fire Department. Current staffing consists of 2 full-time secretaries that are public facing at our nursing office on Schaumburg Rd. They operate the busy lending closet, as well as provide administrative support. At the Barn Senior Center we have a full-time Senior Services Coordinator who manages our very popular senior activity & meal program. Moving between both facilities is our full-time Nursing & Senior Support Assistant. This position's main function is providing program assistance at the Barn as the attendance continues to grow and is also responsible for cleaning returned equipment. I am full-time and currently have one part-time nurse to provide care to the residents referred to us. There is a vacant part-time nursing position as well. While nurses care for people of all ages, we know that the senior population is in more need of nursing services as a whole – which is why the pairing of Nursing with Senior Services is ideal. That being said, seniors are a part of families, groups and of course, our community. The majority of our clients are older adults, but we also serve adults with disabilities. Our current age range is 34-97 years old. What follows is an update on our current services.

### a. In-home nursing visits

Referrals for patients come to Nursing in a number of ways. Internally we hear from those who interact with the public, including EMS/Fire, Police and The Barn (Senior Center) personnel. Externally we are contacted by local physician offices, hospital discharge planners, community-based agencies serving both the disabled as well as the elderly, neighbors, family members and finally the prospective client themselves. Concern for a resident's welfare in regard to their health is the impetus behind these communications made to us. Currently the division employs a full-time Nursing Supervisor and part-time Community Health Nurse (CHN) who investigate and respond to these referrals. Prior to April 2020 we employed a full-time CHN. Due to her departure and subsequent COVID hiring freeze, we have intermittently had 1 or 2 part-time CHNs at any given time. While our staffing has fluctuated, our volumes have only increased. I have inserted graphs after the services we measure to illustrate this.

Our first step in response to these referrals is to have a nurse place a call to the resident and/or family member to gather information. These consultations will allow the nurse to assess whether the resident is in need of simple guidance that can be managed via phone/email or whether a home visit is indeed necessary.

If the resident is receptive to a home visit, a nurse will visit to speak to the prospective client, assess his/her health as well as their environment and introduce the possibility of creating a relationship with nursing. The goal is to aid in the care of their illness or disability, with the hopes of promoting their health and preventing further illness. We do this by direct nursing care,

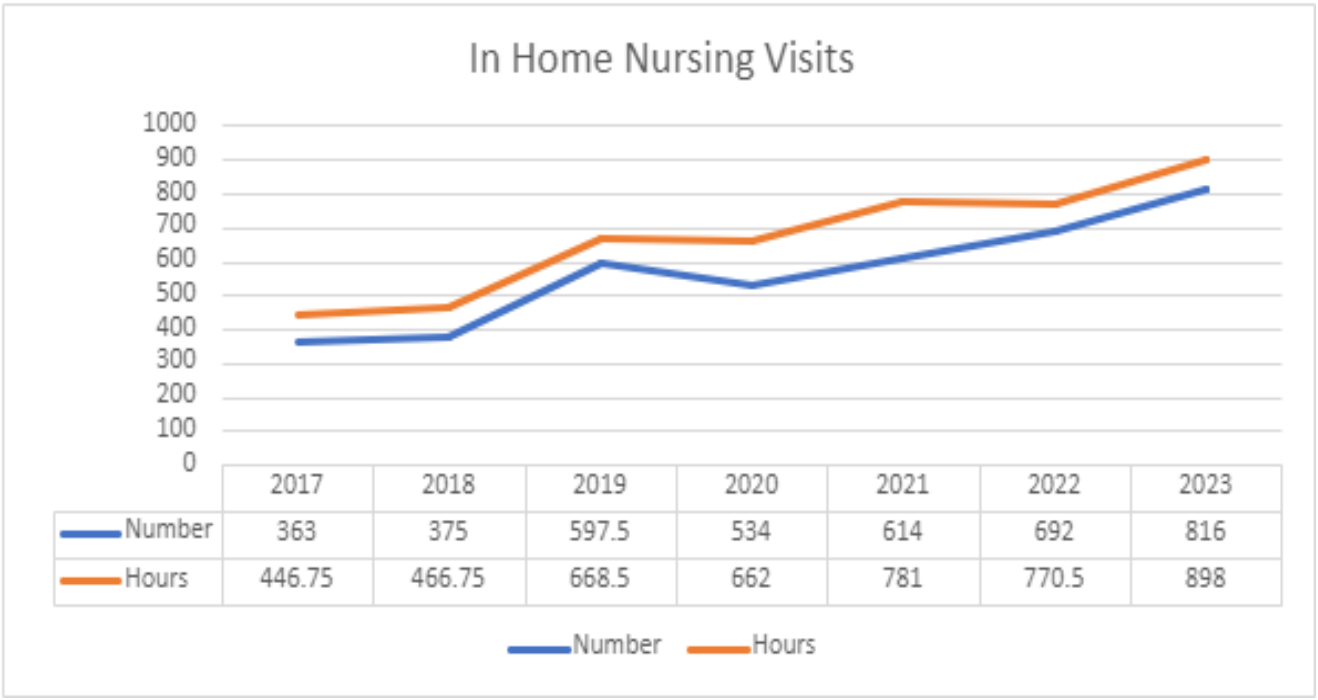
as well as navigation to community services of which the client/family may not be aware. For some of our clients, a home visit from a nurse is the beginning of a connection to the outside world beyond their four walls. A number of our clients are for all intents and purposes "alone". A fulfilling part of our mission is to become their support and advocate. This service and our entire division truly make the Village of Schaumburg distinctive. By providing this care we can enable the resident to remain in an independent living situation longer and safer. However, when this is no longer possible, we also guide and assist the family/resident to more supportive living environments that are in line with the increased care required as well as their financial situation.

In-home nursing visits are approximately 45-120 minutes per visit providing:

- Medication management (filling pill organizers, ensuring appropriate amounts of medications are on hand, ordering refills, contact with physicians regarding possible changes needed)
- Physical assessment (vital signs, review of symptomatology or changes in condition)
- Navigation of the healthcare system (translating lab/diagnostic results; clarification with healthcare providers regarding client's possible misinterpretation of instructions or changes to healthcare regimen)
- Environmental issues (hazardous home sites – involving coordination with social services and health division staff)
- Medical equipment needs

Over the past 5 years I have enjoyed providing this rare and important service. I often hear from residents who make remarks about how Schaumburg is a great place to live because of the nursing and senior services provided.

Because it is difficult to capture the value that the nurses bring to the residents, I have provided 3 case studies at the back of this packet that will illustrate this.




| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|
| Number | 363 | 375 | 597.5 | 534 | 614 | 692 | 816 |
| Hours | 446.75 | 466.75 | 668.5 | 662 | 781 | 770.5 | 898 |

### b. Consultations

For those residents or employees who feel they need some help from nursing, but can and want to travel to our office, we are happy to see them in our treatment room for a confidential visit. In-office we:

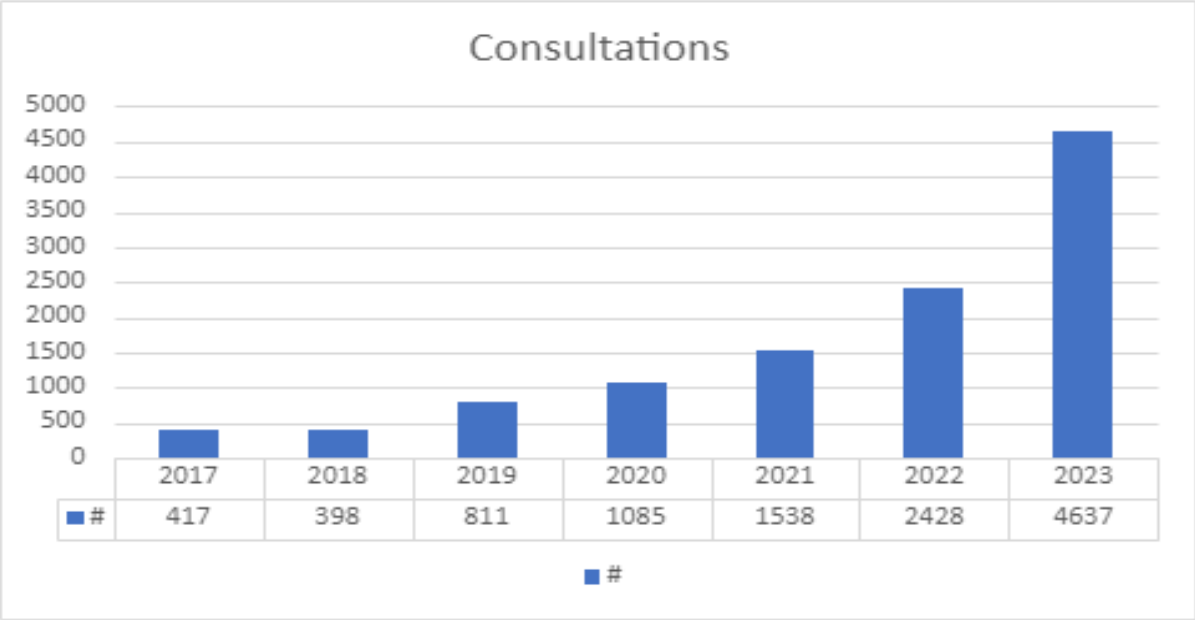
- Administer regular injections prescribed by a resident's physician
- Assess blood pressure and other vital signs
- Provide blood sugar readings
- Memory screening
- Healthcare advice

For those consultations that do not require in-person interaction we provide:

- Phone conversations/emails/texts with residents; family members; physicians; VOS service providers (Fire, Police, Social Services, Health); and community-based agencies regarding client status/needs
- Research regarding resident/client needs
- Connection to support services (caregivers, in-home visiting physicians, meals)

These consultations provide us the opportunity to interact and educate about a variety of health issues that are either particularly topical or the client brings up to the nurse. Some clients are facing a health concern for themselves or a family member about which they want information and/or advice. It is our pleasure to research options in the community and to share these with clients. This connection, whether it takes place in person or remotely, is an important one for those who do not know where to turn when questions come up. The corporatization of

healthcare has made it difficult to contact a live person directly. Websites can be difficult to navigate or inaccessible and do not necessarily offer the answers one is looking for. We offer a personal service that is invaluable to many, especially when faced with worries concerning health.




### c. Memory Screening

Nursing offers memory screening for community members through a program affiliated with the Alzheimer's Foundation of America. Two different assessments are provided with instant scoring and recommendations. We also offer a wide variety of literature regarding dementia, Alzheimer's disease, as well as general memory health. These are offered in office by appointment, however these same cognitive assessments, if needed could be provided in the home to an existing in-home client. This is a service for those who have concerns about their memory but have not been evaluated by a physician for this issue. A preliminary look into the issue if you will – assuring those who do not have anything serious going on, while being a possible early warning sign for those that may be developing Alzheimer's – the 6th leading cause of death, killing more people than breast cancer and prostate cancer combined.

### d. Wellness Clinics

Our wellness clinics offer the older population in our community a chance to interact with a nurse and have their vital signs and/or blood sugar assessed on a monthly basis. We meet the people where they live and/or gather – common areas of the senior independent living buildings in town as well as The Barn. During the VOS Farmer's Market season, we also position ourselves at a booth at the market on occasion. With a large local health system eliminating their community health program in October of 2019, this became an even more relevant service. We

also welcome VOS employees to make an appointment to be seen individually in our office for these services.

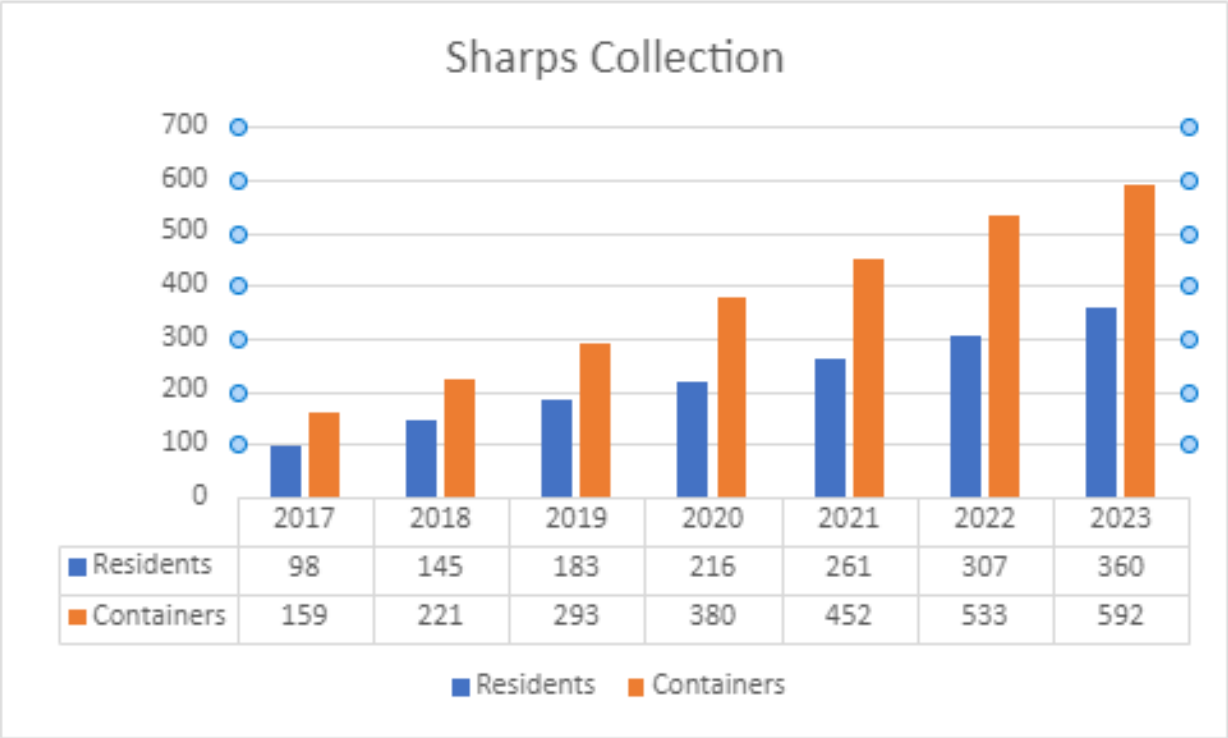
### e. Community Education

I have provided education to the community as requested by community groups, or as a part of the multiple committees I belong to (see 5. Committees). Some examples of independent requests have come from:

- Schaumburg Bank & Trust
- GFWC - Northwest Suburban Conference
- Philanthropic Women's Organization - Schaumburg chapter
- Seko Logistics – Women in Leadership group

### f. Sharps Collection

The NSS office offers the community a safe way to dispose of sharps (used needles) that they may utilize for a medical condition. We collect full personal sharps containers and utilize an independent medical disposal company to remove them from our locked closet once we have filled the large containers that they provide for us. This offers safety, satisfaction, and peace of mind to our community. In October 2023 we secured a grant from the Illinois Environmental Protection Agency to cover the costs we incur with the disposal company, as well as the ability to purchase and distribute new/empty sharps disposal containers to residents as they bring in their full ones.




### g. Partnership with Community Agencies

#### i. Kenneth Young Center

The Kenneth Young Center (KYC) provides 2 main service lines – Older Adult (OA) and Mental Health. We often refer clients to the OA program at KYC as they provide valuable services through the Illinois Department of Aging's Care Coordination Program that complement the services that we are able to provide. KYC OA also has hospital-based liaisons that now provide us with referrals of seniors being discharged back into Schaumburg that are at risk. We are then able to connect with these residents early on in their discharge to prevent potential decline once one is back in the home and may need extra support to keep them safe.

#### ii. Private Agencies

There are many private entities in the immediate area that provide services needed by our clients. We partner with certain members of this specific business community to provide education to the community and are thus able to assess their quality and commitment to our residents. This is important as we are then comfortable when referring residents for services that they provide which include: caregiving; hospice; home-health; navigation to long-term care facilities (assisted, memory, skilled); elder law and home modifications. We maintain a list of these agencies with whom residents known to us have had successful working relationships with and are then able to help others have a starting point.

#### iii. Schaumburg Park District

The division partners with the senior program/coordinator at the park district for events on a regular basis. Also, each summer we partner with the SPD to provide poison control education to their summer pre-school camp attendees. This is a lovely way to engage with the other end of the spectrum in the community. We also provide goodie bags for the children to take home that also have our division's information flyer to increase awareness of our services.

#### iv. Schaumburg Library

The Schaumburg Library's Senior Services Coordinator and I have worked together to create kits that can be borrowed, which contain books as well as other materials. Topics include Stay Sharp (memory activities); Fall Prevention; Stroke Recovery; Caregiving Resources. We also host the library facilitated "Barn Book Club" at the NSS office and I arranged for a lending cart filled with books, DVDs, etc. to be placed in the office that is widely utilized by those coming to borrow medical equipment.

### 2. Lending Program

The lending program that operates out of the NSS office provides the community with safety and convenience through a wide variety of durable medical equipment (DME) on a short-term basis for a cash deposit that is refunded upon return of DME. Our two secretaries manage an inventory of over 800 assistive devices with 20 unique item types. These are offered for a loan of 90 days at a time. This service is invaluable to those having surgery, a disabled relative visiting/needing to travel or an opportunity for someone to try specific pieces of equipment in order to see if it is one worthy of purchasing. As an expression of gratitude for this service, the cash deposit is often donated back to the program. This provides funds for us to purchase new equipment when certain items have reached the end of usefulness. We also receive donations in the form of equipment/medical supplies. If we deem something unsuitable for our program, we pay it forward with a donation to Project Cure, https://projectcure.org/ an organization whose mission is stated here: *"Project C.U.R.E. identifies, solicits, collects, sorts and distributes medical supplies and services according to the imperative needs of the world."* We began tracking clients new to the loan closet services in 2020 shortly after my arrival to VOS.


### 3. Senior Center

The Senior Center affectionately known as The Barn provides the division's third service line and is considered a second home to many older adults in the area. Information on this program will be presented at the May HHS meeting as requested and will therefore be deferred at this time.

### 4. Volunteer Management

#### a. Medical Reserve Corps

The Medical Reserve Corps (MRC) is a national network of volunteers, organized locally to improve the health and safety of their communities. The MRC network comprises approximately 300,000 volunteers in roughly 800 community-based units located throughout the United States and its territories.

MRC volunteers include medical and public health professionals, as well as other community members without healthcare backgrounds. MRC units engage these volunteers as well as local and state-level partners to strengthen public health, improve emergency response capabilities, and build community resiliency. MRC units prepare for and respond to natural disasters, as well as other emergencies affecting public health.

The Village of Schaumburg MRC was established in 2012 and the Nursing & Senior Services Supervisor has been their coordinator since inception. We currently have 17 members on the

roster, with some members being more active than others. Our most recent response to an emergency in the community was to provide support for those affected by the Emerald Village fire in July 2023. Many of the volunteers came out to deliver food to displaced residents at hotels, as well as escorting and assisting residents when they were initially allowed back into their units briefly post-fire to gather up essential belongings. In the past, the MRC was invaluable during COVID-19 as they assisted with the large-scale vaccination clinics held at the Schaumburg Convention Center as well as remote/drive-up food pantry operations when The Barn was closed to the public.

#### i. Special Needs Registry

The MRC also provides support by processing the annual mailings sent to residents that are registered in the VOS Special Needs Registry database. This GIS map identifies the households of residents who due to a medical condition would prevent them from self-evacuating in an emergency/disaster situation. This in turn would allow us to contact the residents to determine if first responders were needed to assist in their evacuation. The yearly mailing asks whether the resident wishes to continue to be a part of the database and/or if there have been any changes to their information. Periodically, we advertise the ability to complete an initial registration through VOS electronic and print publications. I maintain the database by adding new residents and removing those who have either moved away from the village or who have passed away. Currently there are close to 300 residents in the database – with the last mailing sent out in mid-February 2024.

#### ii. Community Education/Engagement

The education and engagement of the community regarding topics related to emergency preparedness as well as staffing first-aid stations for events like marathons have historically been a large part of the activity base for the VOS MRC. Each year we provide an information table at the Public Safety Open House in October and have participated in several severe weather presentations presented to the community. When the MRC is not responding to emergencies or engaging with the community, they are training to be prepared.

### b. Older Adult Services In Schaumburg (OASIS)

A newer volunteer service that is in relatively early stages, OASIS aims to connect volunteers with lonely seniors via friendly phone calls and/or in-person engagement. Currently we have 7 volunteers serving 9 seniors. This has been a difficult program to grow, but I have received 2 recent new volunteer applications.

## 5. Committees

### a. Public Health Advisor

The Public Health Advisor committee is made up of internal VOS members, with representatives from NSS, Fire, Police, HR, Community Development, Social Work and EPW. The committee is chaired by our Public Health Advisor, Dr. Tighe Zimmers. This group meets quarterly to discuss current public health topics and field questions individual departments may have, as well as highlight new programs and improvements in this vein at VOS. This is a good way for multiple departments to come together to understand and become aware of any public health concerns throughout the village. I am the VOS point person for this committee.

**b. Healthy U**

I was appointed chairperson of the Healthy U committee in March of 2022. This group, which has representatives from each VOS department has a mission statement to promote and provide opportunities to the employees to enhance personal wellbeing through utilization of the five essentials of wellbeing. The five pillars of health we focus on are: Career; Community; Financial; Physical and Social. Since taking over as chair I have produced a monthly e-newsletter that is sent to all employees with information and events related to the five pillars mentioned above. In February of 2024 we started a new program - "Lunch n' Learn" - at which we will present a topic/event of interest to employees. Our inaugural event was attended by 30 employees and was recorded to provide access for those that could not attend live.

**c. Support Our Seniors Council**

This committee is made up of VOS staff from Fire and Police working alongside other community service agencies like the township, library, Kenneth Young Center as well as private entities that provide services for older adults. We work to put on 2 presentations per year that address safety issues and crime prevention. Examples include how to avoid scams, dementia resources/case study, legal and social implications of preparing for the future, and the very popular fashion show of uniforms worn by workers that may come to one's door.

**d. Hazardous Homes Task Force**

Members of Police, Fire and Community Development have recently come together to work on the challenge of hoarding and unsafe homes. As a team we can impact both the physical dwelling as well as the person behind it.

**e. Community Health Needs Assessment**

I am a core member of this large project taken on by the village with the consultants at Leading Healthy Futures.

**f. Senior Advisory Council**

This group is made up of seniors who represent the attendees at the Barn. They raise money to fund donations to non-profits, make decisions about day-to-day activities held in the senior program, as well as plan and deliver special events. I serve in an advisory capacity.

### g. Northwest Municipal Nurses

Each quarter, this group of municipal nurses meets to share the experiences and programs they are delivering to their residents as well as how to overcome barriers met, to learn from each other in order to improve our individual services. Members: Hanover Township, Schaumburg Township, Mt. Prospect, Arlington Heights, Hoffman Estates. These are the only nursing programs in our immediate area and all function differently, with only 3 of them providing in-home visits and none of them providing oversight to their senior center if they have one.

### h. Money Management Advisory Board

The Kenneth Young Center maintains a volunteer corps of citizens in the financial field who offer their time to assist seniors and adults with disabilities who have limited income manage their finances. KYC asked me to be a part of the board to advise on certain aspects of their respective clients as well as collaborate regarding potential clients that I serve who may be good candidates for their program. This board meets quarterly.

### i. Blood Program Committee

The Blood Program Committee consists of residents who are charged with planning, coordinating, and promoting blood drives within the village. They currently work with Vitalant – an area blood donation center – to facilitate the operation of blood drives. I am the village liaison for this committee and an NSS secretary takes minutes and keeps records. Our drives have been held at The Barn most recently, but I have coordinated a move to a local church as scheduling conflicts at The Barn were becoming more frequent. This move has created opportunities for me to partner with EPW regarding sign creation/adaptation for the event as well as with Communications to inform the public about the change of venue. There are currently 6 resident members plus the representative from Vitalant. This is a very active and engaged committee with a clear purpose and defined role.

### j. Board of Health

The Board of Health (BOH) is a resident committee which currently has 6 members. Two of these members are physicians, another has a background as a Physical Therapist, 2 pharmacists, and the last is a journalist representing a small local media outlet. VOS members include the Health Supervisor from CDD, the Nursing Supervisor who is the village liaison to the committee and an NSS secretary serves to take minutes and keep records. This group meets 6 times a year or every other month, however due to a lack of agenda items brought forth from the committee we have not met since July 2023.

### k. Committee On Aging

The Committee on Aging is a 10 member, very active committee which plans educational and social events for older adults as well as produces a hard copy resource guide for the seniors in the

community. Our Senior Services Coordinator is the VOS liaison to this committee, and I attend regularly as well to advise. This committee meets every other month and definitely does important work.

## 6. Summary

As evidenced above, the growth in our program and services has been consistent and the data shown on the graphs is summarized below. All growth is from 2017 – 2023, unless otherwise noted.

- In-home Nursing Visits have increased 125% in number and 101% in time spent
- Consultations have increased 1,011%
- Sharps collection has increased 267% (residents) and 272% (containers collected)
- We began tracking new Loan Closet clients in 2020 and have seen an increase of 81%

There is no question that the primary demographic we serve is growing as illustrated by the links below. Additionally, I have worked diligently to increase the visibility of our programs to residents in a variety of forums. This division creates a distinction in the services provided by the municipality to its most vulnerable residents. It also helps to reduce 911 calls and prevent injury/illness.

https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-population-grew.html

https://www.census.gov/library/stories/2019/12/by-2030-all-baby-boomers-will-be-age-65-or-older.html

## 7. Case Studies

### a. #1 JB

JB is a 74-year-old African American male who was referred to Nursing from EMS on 1/4/2022. He called me just after paramedics left his apartment, as they had given him my business card. John suffered a ruptured appendix after which he developed septic shock and spent 1 month in the hospital, 2 weeks in rehab and then moved to skilled care for 2 months. During his initial hospital stay he developed necrotic fasciitis which required extensive surgical intervention, leaving him with a large deep wound on his upper right anterior thigh. At the time of my initial visit, he was using a wheelchair and was able to transfer to commode and hospital bed, all of which were in place in his apartment. At discharge from Symphony on 1/1/22 he was given 4 paper prescriptions for several high blood pressure medications, a blood thinner and a pain

medication. A home health nurse (HHRN) first visited JB on 1/4/2022 and his blood pressure was 190/100. As this is a critically high level, the HHRN called 911. When EMS measured his BP, it was 160/98. John was adamant about not going back to the ER as he feared he would end up back in a nursing home. He simply needed his prescriptions filled as he had not taken them for 3 days. As this is not a service that home health provides, she was unable to assist him with this task. She also stated that he was being non-compliant, and that she would have to check with her supervisor as to whether or not they would continue to serve him. JB lives alone and has no support system. After his phone call, I went to JB's home, picked up his prescriptions and had them filled at Walgreens. While I was at the home picking up the prescriptions, a social worker from his home health company arrived with groceries. She informed me that he would be receiving wound care from nursing, physical therapy, and bathing assistance. I requested that she advise the agency that JB was not being non-compliant, but required specific support which I would provide. This ensured that he was able to continue HH services which were greatly needed. Upon returning to the apartment, I gave JB his medications and waited until his blood pressure continued to normalize. I returned the next morning with a transfer bench for his shower and pill boxes to establish medication management. He was very appreciative and cooperative. Prior to this hospitalization, JB was completely independent.

Over time I collaborated with his home health team and then eventually his hospice care team to allow him to remain in the home rather than be placed in a facility. By working hard to regain his ability to walk with a walker/cane, he was discharged from hospice in October 2022 and the hospital bed was removed from his living room. I established a home visiting physician for him, and I work with this physician ongoing to advise on status and determine changes needed in medications and/or dosage. Of particular issue is his high blood pressure and heart failure issues, of which he had an exacerbation of in December 2023. By working with his physician and changes in medication, this has resolved. I deliver his medications to him and set up his pill trays every 2 weeks. Due to his homebound status, I also deliver frozen meals and food pantry items from the Barn when I visit to provide medication management. Over the 2 years, I have also accessed items from the loan closet and delivered them to him. These services have been life changing and lifesaving per JB, as he said if he had to go back to the skilled care facility, he would not have found life worth living.

None of the services I provide would have been covered by home health or hospice when he was eligible for their services. Now that he is no longer receiving this care, I am his connection to the outside world. Had EMS not provided JB with my contact information, he would most likely have been a frequent caller to 911 or possibly would have simply passed away alone in his home due to not wanting to return to the hospital.

**b. #2 SW**

SW is a 60-year-old Caucasian male with serious mental illness and multiple co-morbidities including diabetes, high blood pressure and high cholesterol. I was referred on 10/31/2023. SW lives alone and had a significant foot fracture causing him to be hospitalized for surgical intervention and subsequent rehabilitation at a skilled nursing facility. Upon arriving home, his

home health company declined to serve him due to the overwhelming accumulation of trash and pests found in his apartment. I was contacted by Kenneth Young Center to determine if I could serve him in some capacity. As the Hazardous Homes Task Force had recently been formed, I knew the avenue I needed to explore. I reached out to Sharrita, the VOS Health Supervisor. She contacted ServiceMaster and I contacted Adult Protective Services. The four of us made a joint visit to SW's apartment. What we found was exactly as described by the home health company.

Because I could not work in SW's current environment, I gathered medication bottles that were strewn about as I sifted through the trash that filled the apartment and came up with what I thought were all of his medications. I brought him to the lobby and found a quiet corner to speak with him. It was apparent that Steven struggled to care for himself even prior to his injury. His only relative is an elderly father living in Arizona. He does not drive and struggles to manage his medication. He has a psychiatrist and a therapist in Arlington Heights. This practice is also the designated payee for his social security disability payments. He had a part-time job in a restaurant prior to his injury, but now is unable to work as he is using a walker and wearing a boot on his injured foot. I contacted his primary care physician and his psychiatrist to verify his medications and after several attempts we came up with a correct list. I then set about to organizing the massive number of bottles that I had collected. Some of them were no longer applicable, but most were. In the end, I determined that SW takes 47 pills per day. There was no doubt he was mis-managing his meds. I provided pill trays and organized them appropriately.

We worked with ServiceMaster to get the apartment cleaned and I contacted SW's insurance (a managed Medicaid plan) that provides the benefit of a caregiver, and established service for 12 hours per week over 3 days. I gave him a donated shower chair from the loan closet so that he could bathe safely and fixed his broken walker. I provided him with donated bedding as his mattress was bare and a private agency in town donated his share of the cost of ServiceMaster, with KYC paying the remainder. I also obtained a home BP cuff for him and instructed him on monitoring this in the home. I continue to help him navigate the healthcare system, the transportation systems as well as fill his pill trays every 2 weeks. The caregiver he was assigned is wonderful and has organized his home and is helping him keep it clean and teaching him how to keep it clean. She also shops and cooks for him. This is a very vulnerable adult who needs to have oversight. I brought Adult Protective Services out with me on my last visit (2/22/24) and she was impressed with the progress made and sustained. Our services have kept this man out of a skilled care facility, decreasing the cost of his care considerably and increasing his quality of life.

**c. #3 DM**

DM is a 34-year-old Indian female who sustained traumatic injuries in July 2023 in a motor vehicle accident, leaving her with paraplegia. I received a referral from DM's sister-in-law on February 14, 2024, as DM had recently returned home after extensive hospitalization, rehabilitation, and skilled care stays. She lives with extended family in Schaumburg who are helping care for her. She attends day rehabilitation at the Shirley Ryan facility in Arlington Heights 5 days a week for 3 hours each visit. The family is looking for help in bathing and

changing DM to provide them some respite and I have provided them with private caregiving agency referrals. After exploring possible benefits that she might be eligible for with my contacts who work for state and federal agencies, I was confronted with the barrier of her residency status. She is not a citizen or an immigrant but is a dependent on her husband who is here on an HIB work visa. This leaves her with only a private pay option for caregiving, which is quite costly, and the family has limited financial resources. More importantly, DM has an indwelling urinary catheter that needs changing every 6 weeks. This regular change is paramount in preventing infection. I began working with Shirley Ryan staff and her husband's insurance company that she is covered under via his employer. I managed to get an order from her physician and supplies ordered via her insurance that should be delivered to the home. With the physician order and supplies, I am quite capable of providing this service to her. As there is no other entity able to do so, she is quite fortunate that our division services exist. I am also working to get her urology visit moved up from the summer to sooner as she will need to be followed closely by that specialty. This case is new and definitely a challenge as many factors fall outside my typical patient profile. Thankfully I am confident in this technical skill and do not anticipate any problems.

# VILLAGE OF SCHAUMBURG

PROGRESS THROUGH THOUGHTFUL PLANNING

## Nursing & Senior Services

### 2024 Health & Human Services Update

# Nursing & Senior Services

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

**One Division**

- We are a division of the Fire Department

**Two Locations**

Nursing & Senior Services Office
- 746 E. Schaumburg Road

The Barn Senior Center
- 231 Civic Drive

**Three Service Lines**

- Nursing Services
- Loan Closet
- Senior Programming

# Nursing & Senior Services

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

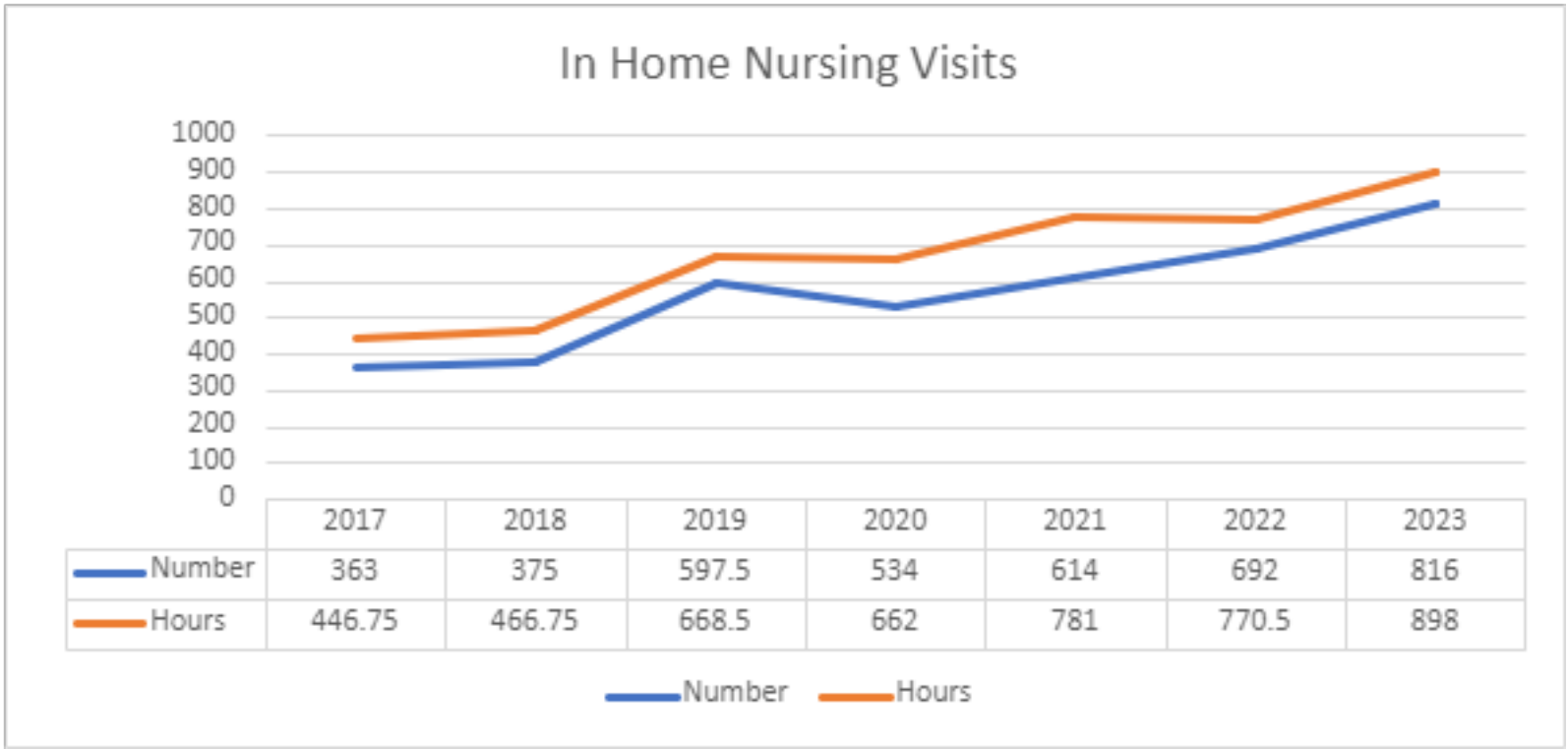
## Nursing

- Staffing – 1 FT Supervisor, 1 PT Comm Health RN, 1 Open PT CHRN
- In-home nursing visits
  - Wide base for referrals
  - Medication Management
  - Limited nursing procedures
  - Physical/Environmental Assessment
  - Medical Equipment
  - Navigation/Connection/Support & Advocacy
  - 2017-2023 – 125%/101% increase

*Residency Requirement – VOS Resident or Employee*

# In-Home Nursing Visits

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING




| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|
| Number | 363 | 375 | 597.5 | 534 | 614 | 692 | 816 |
| Hours | 446.75 | 466.75 | 668.5 | 662 | 781 | 770.5 | 898 |

# Nursing & Senior Services

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

## Nursing

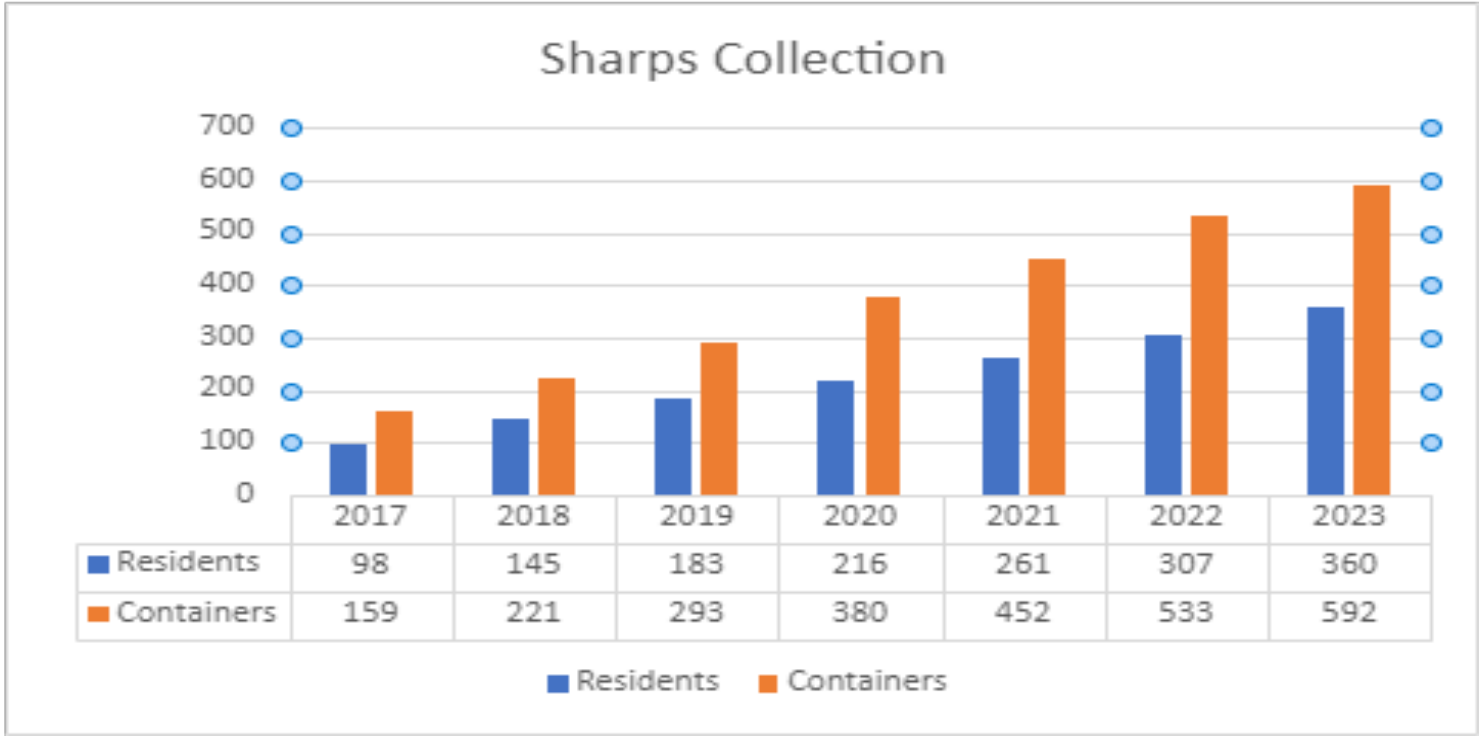
- Consultations
  - In-office – injections, blood pressure/sugar
  - Phone/email - advice, referrals, research, connection
  - 2017-2023 – 1,011% increase
- Memory Screening
- Wellness Clinics
- Community education/outreach
- Sharps Collection
  - 2017-2023: 267% increase in residents, 272% increase containers collected
  - IEPA grant
- Partnership – community agencies

# Consultations

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

# Sharps Collection

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING



# Nursing & Senior Services

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

## Lending Program

- 90-day loans – cash deposit refunded (donated)
- Limited donations of equipment/supplies accepted & paid forward
- Project Cure
- 2020-2023 – new loan clients increased 81%

*Residency Requirement – Schaumburg Township Resident or VOS Employee*

# New Loan Closet Clients

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

## Volunteer Management

- Medical Reserve Corps (MRC)
  - Special Health Needs Registry
  - Community Education/Engagement
- Older Adult Services In Schaumburg (OASIS)
  - Friendly phone calls → Possible in-person visits

# Nursing & Senior Services

VILLAGE OF SCHAUMBURG
PROGRESS THROUGH THOUGHTFUL PLANNING

## Committees

- Public Health Advisor
- Healthy U
- Support Our Seniors Council
- Hazardous Homes Task Force
- Community Health Needs Assessment
- Senior Advisory Council
- Northwest Municipal Nurses
- Money Management Advisory Board
- Blood Program Committee
- Board of Health
- Committee on Aging

# THANK YOU!