Ascension Alexian Brothers

TY2024 (FY2025) Community Health Needs Assessment
Cook County, Illinois

June 30, 2025

Ascension

The goal of this report is to offer a meaningful understanding of the most significant health needs across the hospital community including Cook County, with emphasis on identifying the barriers to health equity for all people, as well as to inform planning efforts to respond to those needs. Special attention has been given to the needs of individuals and communities who are at increased risk for poor health outcomes or experiencing social factors that place them at risk. Findings from this report can be used to identify, develop, and focus hospital, health system, and community initiatives and programming to better serve the health and wellness needs of the community.

Ascension Alexian Brothers
800 Biesterfield Rd, Elk Grove Village, IL 60007
healthcare.ascension.org
847-437-5500
36-2596381

The tax year 2024 Community Health Needs Assessment report was approved by the Ascension Illinois Quality Board of Directors on May 28, 2025 (2024 tax year), and applies to the following three-year cycle: July 1, 2025 through June 30, 2028. This report, as well as the previous report, can be found at our public website.

We value the community's voice and welcome feedback on this report. Please visit our public website (https://healthcare.ascension.org/chna) to submit your comments.

Table of Contents

Acknowledgements

The tax year 2024 Community Health Needs Assessment (CHNA) represents a true collaborative effort to gain a meaningful understanding of the most pressing health needs across the hospital service area as well as Cook County. Ascension Alexian Brothers is exceedingly thankful to the many community organizations and individuals who shared their views, knowledge, expertise, and skills with us. A complete description of community partner contributions is included in this report. We look forward to our continued collaborative work to promote a healthier, more equitable place to live, work and play.

We would also like to thank you for reading this report, and your interest and commitment to improving the health and well-being of the community.

Executive Summary

The goal of the tax year 2024 Community Health Needs Assessment report is to offer a meaningful understanding of the most significant health needs from the hospital community and across Cook County. Findings from this report can be used to identify, develop, and focus hospital, health system, and community initiatives and programming to better serve the health and wellness needs of the community.

Purpose of the CHNA

As part of the Patient Protection and Affordable Care Act of 2010, all not-for-profit hospitals are required to conduct a community health needs assessment (CHNA) and adopt an implementation strategy (IS) every three years. The purpose of the CHNA is to understand the health needs and priorities, with emphasis on identifying the barriers to health equity, for all people who live and/or work in the communities served by the hospital, with the goal of responding to those needs through the development of an implementation strategy plan.

Community Served

Ascension Alexian Brothers community consists of Elk Grove Village and the surrounding areas. The hospital community primary service area (PSA) is a collection of zip codes where approximately 75% of the hospital patients reside and where we focus our community health improvement efforts. The majority of the hospital PSA is within Cook County. As possible, Alexian Brothers assessed data at the hospital PSA level for the CHNA although community health data is more readily available at the county level, which was also used for some indicators.

Data Analysis Methodology

The tax year 2024 CHNA was conducted from March 2024 to May 2025, and utilized a modified Mobilizing for Action through Planning and Partnership (MAPP) process, which incorporated data from both primary and secondary sources. Community input sources included information provided by groups/individuals, e.g., community members, health care consumers, health care professionals, community stakeholders, and multi-sector representatives. Special attention was given to the needs of individuals and populations who are more marginalized and to unmet health needs or gaps in services. Community input was collected via community survey, community focus groups and from community stakeholders. Secondary data was compiled and reviewed to understand the health status of the community. Measures reviewed included chronic disease, social and economic factors, and healthcare access and utilization trends in the community and were gathered from reputable and reliable sources.

Community Needs

Ascension Alexian Brothers analyzed secondary data of over 75 indicators and gathered community

input through surveys and focus groups to identify the needs of the hospital community. Ascension Alexian Brothers used a phased prioritization approach to determine the most crucial needs for community stakeholders to address. The significant needs are as follows:

- Chronic Disease
- Mental Health & Youth Well-Being
- Healthcare Access & Affordability
- Social Determinants of Health (food insecurity, housing instability and transportation)

Next Steps and Conclusion

Following development and deep review of the CHNA, Ascension Alexian selected the prioritized needs outlined below for its tax year 2024 CHNA Implementation Strategy. The implementation strategy describes how the hospital intends to respond to these prioritized needs throughout the same three-year CHNA cycle: July 1, 2025 - June 30, 2028.

- Chronic Disease
- Mental Health & Youth Well-Being
- Healthcare Access & Affordability
- Social Determinants of Health (food insecurity, housing instability and transportation)

Ascension Alexian Brothers hopes this report offers a meaningful and comprehensive understanding of the most significant needs of the community. The hospital values the community's voice and welcomes feedback on this report; comments or questions can be submitted via Ascension's public website (https://healthcare.ascension.org/chna).

About Ascension

As one of the leading non-profit and Catholic health systems in the United States, Ascension is committed to delivering compassionate, personalized care to all, with special attention to individuals and communities who are at increased risk for poor health outcomes or experiencing social factors that place them at risk.

Ascension

Ascension is one of the nation's leading non-profit and Catholic health systems, with a Mission of delivering compassionate, personalized care to all with special attention to persons living in poverty and those most vulnerable. In FY2024, Ascension provided $2.1 billion in care of persons living in poverty and other community benefit programs. Across 17 states and the District of Columbia, Ascension's network encompasses approximately 128,000 associates, 33,000 affiliated providers, 118 wholly owned or consolidated hospitals, and 34 senior living facilities. Additionally, through strategic partnerships, Ascension holds an ownership interest in 16 other hospitals.

Ascension's Mission provides a strong framework and guidance for the work done to meet the needs of communities across the U.S. It is foundational to transform health care and express priorities when providing care and services, particularly to those most in need.

> **Mission:** Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually-centered, holistic care which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words.

For more information about Ascension, visit https://www.ascension.org.

Ascension Illinois

The rich history of Ascension Illinois began in 1868 when the Alexian Brothers and the Daughters of Charity used their gifts to serve those most in need in the greater Chicago area. The mission is the same but enhanced with today's latest technology to provide innovative advanced care for the most complicated conditions and create opportunities for you and your family to conveniently find care with nearly 700 providers at over 146 locations.Visit www.ascension.org/illinois.

In fiscal year 2024 Ascension Illinois provided over $301 million in community benefit and care for persons living in poverty .

Ascension Alexian Brothers Behavioral Health Hospital

As a Ministry of the Catholic Church, Ascension Alexian Brothers is a non-profit hospital that provides medical care to Elk Grove Village and the surrounding communities. Serving Illinois since 1966, Ascension Alexian Brothers is continuing the long and valued tradition of addressing the health of the people in our community, following in the footsteps of legacy Alexian Brothers, a Roman Catholic order.

Ascension Alexian Brothers is a 329 bed, full service medical facility that provides high-quality, compassionate and family-centered medical care. Ascension Alexian Brothers is a critical care hospital and ER in Elk Grove Village, IL with advanced specialty care services including heart and vascular, neurosurgery, critical care, cancer care, stroke care, orthopedics and women's health.

For more information about Ascension Alexian Brothers, visit:
https://healthcare.ascension.org/locations/illinois/ilchi/elk-grove-village-ascension-alexian-brothers

About the Community Health Needs Assessment

A community health needs assessment is essential for community building, health improvement efforts, and directing resources where they are most needed. CHNAs can be powerful tools with the potential to be catalysts for immense community change.

Purpose of the CHNA

A CHNA is defined as "a systematic process involving the community that identifies and analyzes community health needs and assets to plan and act upon priority community health needs."[1] The process serves as a foundation for promoting the health and well-being of the community by identifying the most pressing needs, leveraging existing assets and resources, developing strategic plans, and mobilizing hospital programs and community partners to work together. This community-driven approach aligns with Ascension Alexian Brothers commitment to offer programs designed to respond to the health needs of a community, with special attention to persons who are medically underserved and at risk for poorer health outcomes because of social factors that put them at increased risk.

Advancing Health Equity

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.[2] Progress toward achieving health equity can be measured by reducing health disparities. Health disparities are particular health differences closely linked with economic, social, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced such obstacles to health based on their race or ethnicity; religion; socioeconomic status; gender identity; sexual orientation; age; cognitive, sensory, or physical disability; geographic location; or other characteristics historically linked to discrimination or exclusion.[3]

Focusing on the root causes that have perpetuated these differences contributes to the advancement of health equity. By identifying the conditions, practices, and policies that perpetuate differences in health outcomes, we can better respond to root causes when pursuing health equity.

Ascension acknowledges that health disparities in our communities go beyond individual health behaviors. Ascension's Mission calls us to be "advocates for a compassionate and just society through our actions and words"; therefore, health equity is a matter of great importance to Ascension.

---

[1] Catholic Health Association of the United States. (2022). *A guide for planning and reporting community benefit, 2022 (p.146)*.

[2] National Center for Chronic Disease Prevention and Health Promotion. (2023, January 4). *Advancing health equity in chronic disease prevention and management*. Center for Disease Control and Prevention (CDC). Retrieved October 11, 2023, from https://www.cdc.gov/chronicdisease/healthequity/index.htm

[3] Braveman, P. (2014). What are health disparities and health equity? We need to be clear. *Public Health Reports*, *129*(Suppl 2), 5-8. https://doi.org/10.1177/00333549141291S203

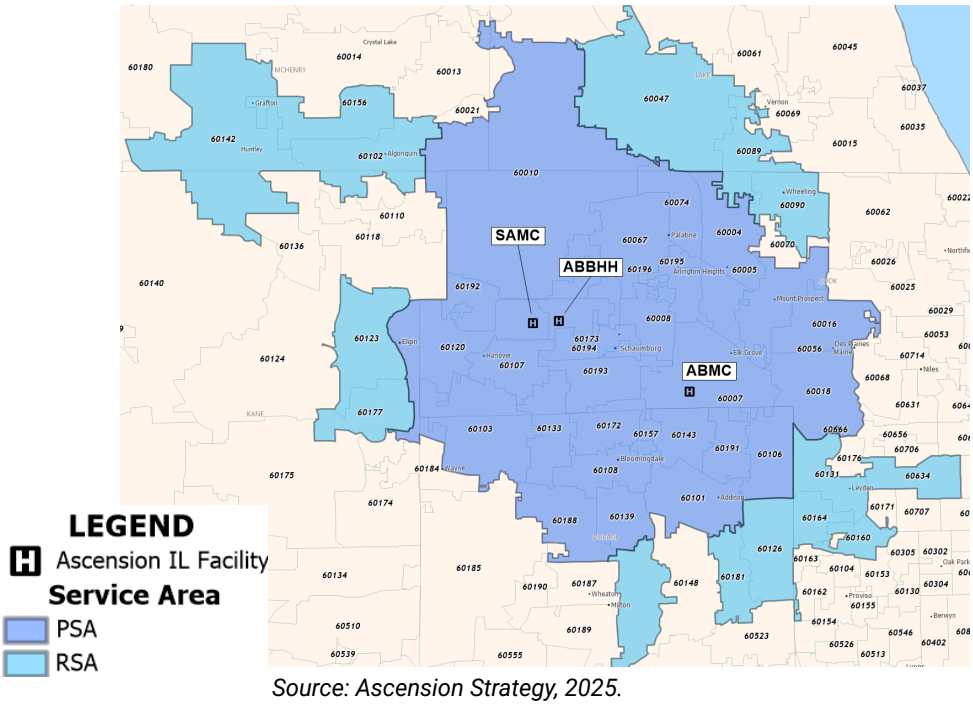
IRS 501(r)(3) and Form 990 Schedule H Compliance

The CHNA also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection and Affordable Care Act of 2010, more commonly known as the Affordable Care Act (ACA). As part of the ACA, all not-for-profit hospitals are required to conduct a CHNA and adopt an implementation strategy every three years. Requirements for 501(c)(3) hospitals under the ACA are described in Code Section 501(r)(3), and include making both current and previous CHNA and implementation strategy reports widely available to the public. In accordance with this requirement, electronic versions of these reports can be accessed at https://healthcare.ascension.org/CHNA, and paper versions can be requested at Ascension Alexian Brothers' administration office.

Community Served and Demographics

Community Served

For the purpose of the tax 2024 CHNA, Ascension Alexian Brothers has defined its community served Elk Grove Village and surrounding Cook County, which includes the majority of the primary service area (PSA). The PSA is where 75% of the hospital inpatients and outpatients reside. The "community served" was defined as such because (a) most of our service area is in each county;(b) most of our assessment partners define their service area at the county level; and (c) most community health data is available at the county level.



Source: Ascension Strategy, 2025.

Cook County includes the major metropolitan area of Chicago as well as 130 surrounding suburban municipalities. Nearly all major industries are offered within Cook County's geography.

Demographic Data

Located in Illinois, Cook County is the second-most-populous county in the United States with a population of 5,185,815. More than 40 percent of all residents of Illinois live within Cook County. Below are demographic data highlights:

- 23.1 percent are Hispanic or Latino (any race) in the PSA, which is less than the rest of Cook County (26.6%)
- The median household income in the PSA ($103,080)is higher in comparison to the county and state median incomes ($76,600 for Cook County $76,700 for Illinois)
- The percent of all ages of people in poverty in the PSA (7.55%) is lower than the county and state (13.29% percent for Cook County; 11.63% percent for Illinois)
- The uninsured rate in the PSA (8.53%) is similar to Cook County but higher than the state (7.79% percent for Cook County; 6.16% percent for Illinois)

Demographic Highlights				
Population				
Indicator	**Hospital PSA**	**Cook County**	**Illinois**	**Description**
Percentage living in rural communities	0.43%	0.1%	13.1%	N/A
Percentage below 18 years of age	22.8%	20.9%	21.6%	N/A
Percentage 65 years of age and over	16.6%	16.2%	17.2%	N/A
Percentage Asian	14.8%	8.3%	6.3%	N/A
Percentage Hispanic	23.1%	26.6%	18.3%	N/A
Percentage non-Hispanic Black	4.2%	22.7%	14.1%	N/A
Percentage non-Hispanic White	55.1%	41.1%	59.5%	N/A
Social and Community Context				
English proficiency households	8.09%	6.68%	4.24%	Proportion of households who speak English “less than well”
Median household income	$103,080	$76,700	$76,700	Income level at which half of households in a county earn more and half of households earn less
Percentage in poverty	7.55%	13%	12%	Percentage of people in poverty
Percentage of uninsured	8.53%	8%	6%	Percentage of population under age 65 without health insurance
Percentage of unemployment	4.39%	5%	4.6%	Percentage of population ages 16 and older unemployed but seeking work

To view additional community demographic data and sources, see Appendix B (Page 42).

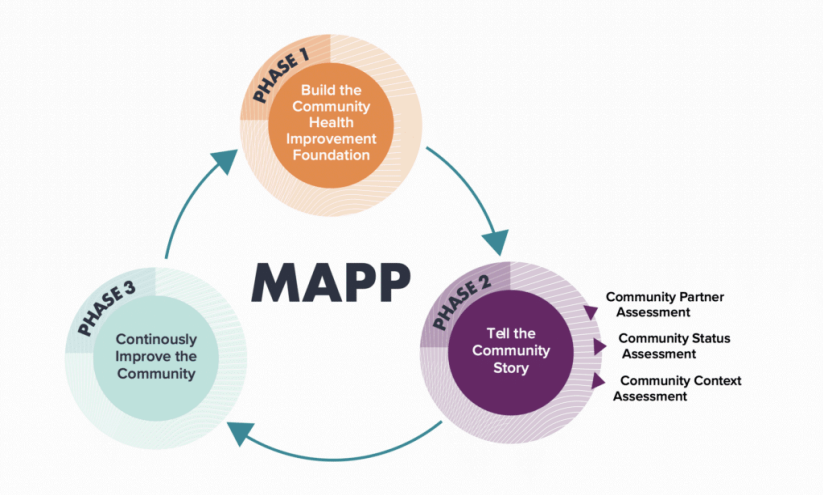
Process and Methods Used

Collaborators

Ascension Alexian Brothers engaged numerous community partner organizations and internal stakeholders to assist with primary data collection and gather input, however, no formal collaborators were engaged to conduct this CHNA. A subscription to vendor, Metopio, was utilized for secondary data collection from its software platform.

Data Collection Methodology

Ascension is committed to using national best practices in conducting the CHNA. In collaboration with various community partners, Ascension Alexian Brothers approach relies on the Mobilizing for Action through Planning and Partnerships (MAPP) model. MAPP is a community-driven, strategic planning framework that assists communities in developing and implementing efforts around the prioritization of public health issues and the identification of resources to address them. A modified MAPP 2.0 model for this iteration of the assessments completing three different assessments[4]:



1. Community Status Assessment (secondary data)
2. Community Partner Assessment (stakeholder or informant input)
3. Community Context Assessment (community input)

Upon completion of the data collection, a review of findings looking for cross-cutting themes was used to determine the significant needs for the community.

Additional Data: Public Health Department Plans

As part of their accreditation process, each health department that serves residents of the city of Chicago as well as surrounding Cook County develops a community health improvement plan every five years. Below is a snapshot of the key themes, priority areas and priority populations of their

[4] Image source MAPP 2.0 User Handbook, National Association of County and City Health Officials, 2023.

improvement plans. This information is used within our identification of significant and priority needs to assure alignment as much as possible with county wide planning.

Chicago Department of Public Health *Healthy Chicago 2025*	
Key Themes: Health equity, collaboration & data driven approaches.	
Priority Areas: Chronic Disease Violence Prevention Substance Use Infectious Disease Infant and Maternal Health Mental Health Partnership	Priority Populations: ● Black Chicagoans ● Communities disproportionately impacted by premature mortality and low life expectancy ● Communities that have historically experienced the most disinvestment

Cook County Department of Public Health *We Plan 2025*	
Key Themes: Structural racism	
Priority Areas: Access to Health Resources Access to Behavioral Health Resources Safe & Healthy Environments Inclusive & Healthy Education Economic Opportunities	Priority Populations: ● Black residents ● Latinx residents ● Asian residents

Summary of Community Input

Community input, also referred to as “primary data,” is an integral part of a community health needs assessment (CHNA) and is meant to reflect the voice of the community. The MAPP framework defines this as the Community Context Assessment (CCA). This input is invaluable for efforts to accurately assess a community's health needs. A concerted effort was made to ensure that the individuals and organizations represented the needs and perspectives of 1) public health practice and research; 2) individuals who are medically underserved, low-income, or considered among the minority populations

served by the hospital; and 3) the broader community at large and those who represent the broad interests and needs of the community served.

Multiple methods were used to gather community input that provided perspectives on selecting and responding to top health issues facing the community. A summary of the process and results is outlined below.

Community Context Assessment (Community Focus Group + Community Survey)

Community Survey

A survey was conducted to gather the perceptions, thoughts, opinions, and concerns of the community regarding health outcomes, health behaviors, social determinants of health, and clinical care for the community. Two hundred eighty three individuals participated in the survey, held between June 2024 and October 2024. The survey contained 28 questions and was distributed to the community through resource sharing, marketing flyers, social media, e-newsletters, at in-person events as well as other channels. The survey was also translated into Spanish and Polish. The data gathered and analyzed provides valuable insight into the issues of importance to the community with findings that reveal significant health disparities, gaps in access to care, and opportunities for improving community health services.

Key Findings

Demographics & Representation

- African American/Black and White respondents were proportionally represented, while Asian respondents were overrepresented (22.3% vs. 12.5%).
- Hispanic/Latino (16.6%) and 65+ year-old respondents (8.1%) were underrepresented compared to the actual community demographic data.
- LGBTQ+ representation was 6.4%, slightly above the state average of 4.3%.
- Unemployment among respondents (2.5%) was lower than the county average (5.0%), indicating possible selection bias in survey participation.

Top Health Concerns

1. Age-related illnesses (43.5%)
2. Diabetes (38.5%) – African American respondents reported significantly higher concerns for diabetes (53.8%) compared to the total population.
3. Mental health concerns (36.7%) – Mental health concerns included long wait times for therapy (8+ weeks), stigma affecting care-seeking behavior, and a need for increased youth services.
4. Hypertension (33.2%) – African American respondents reported significantly higher concerns for hypertension (53.8%) compared to the total population.

5. Heart disease & stroke (29.7%)

Barriers to Healthcare Access & Utilization

- 4.6% of respondents were uninsured, with affordability being a major barrier.
- 27.6% had missed or postponed a medical or therapy appointment, citing reasons such as lack of time (23.0%), high costs (18.7%), and inconvenient clinic hours (12.7%).
- Preventive care utilization was inconsistent among respondents:
    - 81.7% had seen a dentist within the past year, but 12.7% never had a cholesterol screening, and 36.0% never had a colonoscopy.
    - 41.0% of females had a mammogram within the past year, while 26.5% had never had one.
    - Vaccination rates showed gaps, with 13.2% never having received a flu vaccine and 7.4% never receiving a COVID-19 vaccine.

Social & Community Issues Impacting Health

- Food Security: 19.8% of respondents worried about running out of food, with 5.3% worrying all the time.
- Housing: Affordable housing ranked as a top health need, particularly among African American respondents (30.8%).
- Transportation: Medicaid recipients struggle to find specialists in the northwest suburbs, forcing travel to Chicago.
- Youth Issues: Key concerns included social media influence (38.2%), stress (29.6%), depression (27.0%), and bullying (26.3%).

Most Needed Support Services

1. Access to healthcare (61.5%)
2. Access to community services (49.8%)
3. Access to mental health services (44.5%)
4. Access to healthy food (31.1%)
5. Affordable housing (18.7%)

Open Comments Highlights:

- Many Medicaid patients must travel to Chicago for specialized care due to a lack of specialists accepting Medicaid in the northwest suburbs.
- The community requested additional urgent care facilities and free vaccines.
- There was a call for more youth education programs on mental health, substance use, and career pathways.

- Women's health concerns included a need for better education on mammograms, cancer detection, and the importance of seeking second opinions.

Community Recommendations

- **Expand Healthcare Access**
  - Increase Medicaid-accepting specialists in the northwest suburbs to reduce the travel burden.
  - Enhance affordability of healthcare services and medications by expanding assistance programs.
  - Reduce therapy wait times by increasing mental health providers and implementing telehealth options.
- **Strengthen Social Services & Community Programs**
  - Improve access to affordable housing and food security programs.
  - Expand after-school programs and youth mental health initiatives to address depression and stress among children and teens.
  - Develop senior wellness and recreational facilities to support aging community members.
- **Enhance Preventive Care & Health Education**
  - Increase outreach for preventive screenings, including mammograms, colonoscopies, and cholesterol tests.
  - Implement targeted education programs on diabetes and hypertension prevention, particularly for high-risk groups.
  - Promote awareness of existing health and wellness resources through multilingual outreach campaigns.

Community Focus Group

A focus group in collaboration Partners for Our Communities was held to gather feedback on the health needs and assets of the community. Eleven individuals participated in the focus groups, held in July 2024. Populations represented by participants included limited English proficient population; Spanish speaking.

Key Findings

Community Strengths

- Abundance of Resources – Various assistance programs are available, particularly for immigrants.
- Safety – The community is safe and considered safer than Chicago.

- Food Assistance – There is widespread support for food security with growing awareness and accessibility.
- Acceptance of Immigrant Identification – Small policy shifts allow immigrant licenses as valid identification.

Community Weaknesses

- Limited Public Transportation – Only one bus route; many unaware of schedules and stops.
- Workforce Challenges – Lack of nearby jobs and difficulty accessing employment.
- Healthcare Coverage Barriers – Immigration status prevents many from obtaining insurance.

Assessment of Previously Identified Community Needs

- Food Access: Improved due to increased awareness and access, but rising food and gas prices remain a challenge.
- Transportation Support: Unchanged or Worsen as no expansion of routes despite population growth; costs of car ownership are prohibitive.
- Workforce Development: Worsen as employment opportunities for undocumented individuals are limited, with only low-paying options available.
- Access to Care (Insurance & Benefits): Unchanged as majority still lack insurance, face affordability issues, and struggle with understanding available benefits. Dental care remains largely inaccessible.
- Maternal/Child Health: Improved as participants feel adequate support is available.
- Mental Health: Mostly unchanged as services for youth exist but often lapse after age 18. Awareness of mental health signs and symptoms has increased, but more preventive education is needed.

Health & Social Needs Identified

- Health Insurance Enrollment Barriers
- Lack of Access to Dental, Gynecology Services, Vision Care and Primary Care
- Youth Recreation Facilities – Need for safe, engaging spaces for children and teens.
- Disability Support Services – More resources for individuals with special needs.
- Affordable Childcare & After-School Programs – Many parents struggle to find care options.

Disproportionately Affected Populations Identified

- Individuals with Disabilities due to limited transportation and healthcare access.
- People Over 40 due to greater risk of chronic illnesses with limited healthcare access.

Actionable Recommendations

1. **Expand Transportation Options** – Advocate for additional bus routes and better awareness of existing services.
2. **Increase Workforce Development Programs** – Provide more job opportunities and training especially for undocumented community.
3. **Improve Access to Healthcare** – Expand affordable dental, vision, primary care services as well as adult mental health.
4. **Address Community Service Gaps** – Increase after-school programs, disability support, and youth recreation spaces.

Community Partner Assessment

An online survey was completed between November 2024-February 2025 by nine community partners representing a range of organizations, including faith-based organizations, community-based organizations, educational institutions, and healthcare institutions. The survey contained 24 questions and was distributed to key community partners and informants through direct electronic invitation by the hospital. These partners serve diverse populations, with a focus on Black/African American, Latinx/Hispanic, White/Caucasian, Asian/Asian American and Native American/Indigenous/Alaska Native communities.

Key Findings

1. **Community Health Improvement**: Only 11.1% of organizations have participated in a community health improvement process, indicating a significant opportunity for greater involvement.
2. **Demographics and Health Needs**: Community partners serve a wide array of racial and ethnic populations, including White/Caucasian, Black/African American, Latinx/Hispanic, Asian/Asian American, Native American/Indigenous/Alaska Native, and Pacific Islander/Native Hawaiian communities.
3. **Strengths and Weaknesses**: Strengths highlighted include a strong healthcare ecosystem, resource availability, and advocacy efforts. However, weaknesses such as accessibility to care and screenings, food insecurity, lack of awareness of community resources, and staffing shortages were identified as major barriers.
4. **Health Concerns**: Key health issues include food security, obesity, substance use and addiction, mental health (anxiety and depression), maternal and child health, and access to social determinants of health (SDOH) programs.
5. **Social Issues**: The most significant social challenges are food access, lack of insurance, poverty, affordable healthcare, housing instability, stigma around substance abuse treatment, and social justice concerns.

6. **Disproportionate Impact**: The migrant/immigrant community, Latinx/Hispanic, Black/African American, older adults, and LGBTQ+ populations are disproportionately affected by these health and social challenges.
7. **Systemic Drivers**: Socioeconomic factors, healthcare access, affordability, and policy/regulatory changes are identified as key drivers influencing health needs.
8. **Barriers to Access**: Limited healthcare access, economic constraints, low health literacy, cultural/language barriers, and challenges related to SDOH were identified as major obstacles to healthcare access.
9. **Service Gaps**: Gaps in services include nutrition education, detox and addiction recovery, mental health services, housing support, and affordable healthcare options.
10. **Policy and Resource Recommendations**: Respondents recommended policies to improve health education, expand mental health support, reduce healthcare costs, support economic mobility, and increase funding for SDOH programs.
11. **Role of Hospitals**: Hospitals can help reduce disparities by partnering with community organizations, expanding education and outreach, supporting addiction recovery, increasing screenings, improving mental health access, and using technology to expand service accessibility.
12. **Health Service Access**: Community members primarily seek health services at emergency departments (66.6%), local hospitals and clinics (55.5%), immediate care/walk-in clinics (55.5%), and mental health services (55.5%).
13. **Collaboration and Impact**: Organizations collaborate through community health fairs, advocacy efforts, health screenings, coalition work, and policy change lobbying. Successful initiatives include medical advocacy programs, Narcan training, free flu vaccine drives, food pantries, and mental health partnerships.
14. **Effective Communication**: SMS text messaging, in-person communication, social media, and flyers in high-traffic areas were identified as the most effective communication channels.
15. **Community Engagement**: Most respondents (77.7%) reported moderate community engagement, with some noting high levels (22.2%) and low levels (11.1%) of engagement.
16. **Vision for Ideal Collaboration**: Ideal partnerships would involve active collaboration between healthcare institutions and community organizations, increased hospital engagement in public health, workforce development programs, and shared goals for community health initiatives.

To view community input data in its entirety, see Appendix C (Page 45).

Summary of Secondary Data

Secondary data is data that has already been collected and published by another party. Both governmental and non-governmental agencies routinely collect secondary data reflective of the population's health status at the state and county levels through surveys and surveillance systems. Secondary data for this report was compiled from various reputable and reliable sources.

Health indicators in the following categories were reviewed:

- Health outcomes
- Physical environment
- Clinical care
- Social determinants that impact health
- Disparities

A summary of the secondary data collected and analyzed through this assessment is outlined below.

Community Status Assessment

The Community Status Assessment (CSA) for Ascension Alexian Brothers evaluates key health and social determinants impacting the community. Using the Mobilizing Action through Planning and Partnerships (MAPP) framework, this report analyzes health status, economic stability, health behaviors, healthcare access, and environmental factors. The data highlights key disparities and identifies areas for targeted interventions to improve community well-being.

Top Three Health Concerns

1. High Rates of Chronic Diseases
    - The prevalence of cancer, coronary heart disease, and diabetes is higher than county, state, and national averages.
    - Zip codes such as 60191 (Wood Dale) and 60108 (Bloomingdale) have the highest coronary heart disease and diabetes rates, respectively.
2. Mental Health Challenges
    - The percentage of adults reporting poor mental health days is notably high in areas such as Elgin (60120) and Lake Zurich (60074).
    - Mental health provider availability per capita is lower than county, state, and national levels, indicating a need for increased access to services.
3. Health Access & Quality Deficiencies
    - The region has fewer primary care providers and mental health professionals per capita than surrounding areas.
    - The uninsured rate (8.53%) exceeds county, state, and national averages, highlighting financial barriers to care.

Top Three Community Concerns

1. Economic Disparities and Inequality
    a. While the median household income is higher than county and state averages, pockets of poverty persist, particularly in Hanover Park (60133) and Elgin (60120).
    b. The housing cost burden disproportionately affects non-Hispanic Black residents, highlighting inequities in economic stability.

2. Limited English Proficiency
    a. 8.09% of households report limited English proficiency, which is higher than county, state, and national averages.
    b. The highest concentration is in Addison (60101), where 15.55% of households have language barriers, potentially impacting healthcare access and quality.
3. Environmental & Infrastructure Challenges
    a. Certain areas are in close proximity to Superfund (toxic waste) sites, particularly in the western and southwestern regions of the PSA, raising environmental health concerns.
    b. Public transportation access is limited, with only 2.93% of workers relying on it, compared to higher county and state averages, which could hinder employment opportunities and healthcare access.

Disproportionately Affected Populations Identified

- Immigrants/undocumented individuals
- Youth and seniors

This assessment highlights the critical health and community challenges facing the region, emphasizing the need for improved mental health services, chronic disease management, and social support programs to enhance overall well-being.

To view the secondary data and sources in their entirety, see Appendix D (Page 48).

Written Comments on Previous CHNA and Implementation Strategy

Ascension Alexian Brothers' previous CHNA and implementation strategy was made available to the public and open for public comment via the website: https://healthcare.ascension.org/chna. The following is a summary of the comments that were received: Students and community leaders reaching out to inquire about health data for upcoming projects or assignments.

Data Limitations and Information Gaps

Although it is quite comprehensive, this assessment cannot measure all possible aspects of health and cannot represent every possible population within the community. This constraint limits the ability to assess all the community's needs fully.

For this assessment, three types of limitations were identified:

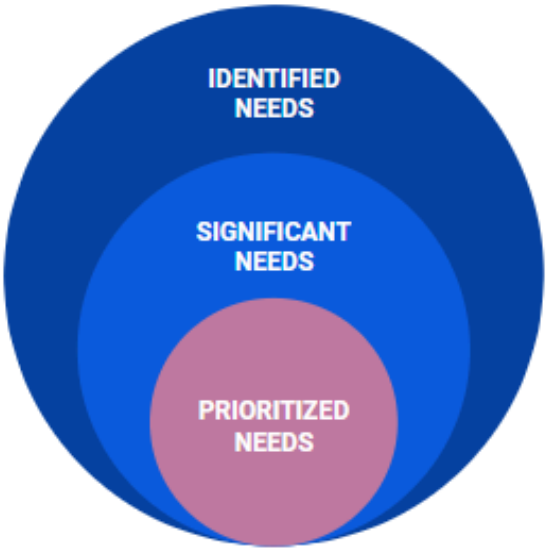
- Some groups of individuals may not have been adequately represented through the community input process that might include persons who are experiencing homelessness, persons who speak other languages other than English, Spanish or Polish.
- Secondary data is limited in a number of ways, including timeliness, reach, and ability to fully reflect the health conditions of all populations within the community.
- An acute community concern may significantly impact a hospital's ability to conduct portions of the CHNA assessment. An acute community concern is defined by Ascension as an event or situation that may be severe and sudden in onset or newly affects a community. Such an event or situation may impact the ability to collect community input, may not be captured in secondary data, and/or can present in the middle of the three-year CHNA cycle. For the tax year 2024 CHNA, the following acute community concerns were identified:
    - No acute community concerns impacted ability to conduct CHNA

Despite the data limitations, Alexian Brothers is confident of the overarching themes and health needs represented through the assessment data. This is based on the fact that the data collection included multiple qualitative and quantitative methods, and engaged the hospital and participants from the community.

Community Needs

Ascension Alexian Brothers analyzed secondary data of over 75 indicators and gathered community input through surveys and focus groups to identify the needs in the hospital community and surrounding Cook County. Ascension Alexian Brothers used a phased prioritization approach to identify the needs.

- First phase: Determine the broader set of **identified needs**.
- Second phase: Narrow identified needs to a set of **significant needs**.
- Third phase: Narrow the significant needs to a set of **prioritized needs** to be addressed in the implementation strategy plan.



Following the completion of the CHNA assessment, Ascension Alexian Brothers will select all, or a subset, of the significant needs as the hospital's **prioritized needs** to develop a three-year implementation strategy. Although the hospital may respond to many needs, the prioritized needs will be at the center of a formal CHNA implementation strategy and corresponding tracking and reporting. The image above portrays the relationship between the needs categories.

Identified Needs

The first phase was to determine the broader set of **identified needs**. Ascension has defined "identified needs" as the health outcomes or related conditions (e.g., social determinants of health) impacting the health status of the hospital community within Cook County. The identified needs were categorized into health behaviors, social determinants of health, length of life, quality of life, clinical care, and systemic issues to develop better measures and evidence-based interventions that respond to the determined condition.[5]

Significant Needs

In the second phase, identified needs were then narrowed to a set of "significant needs" determined most crucial for community stakeholders to address. Ascension Alexian Brothers synthesized and analyzed the data to determine which of the identified needs

[5] Image source National Association of County and City Health Officials, 2023.

were most significant. Ascension has defined **significant needs** as the identified needs deemed most significant to respond to based on established criteria and/or prioritization methods. Data triangulation was used to identify the significant needs of the community as shown in the image above.

Based on the synthesis and analysis of the data, the significant needs for the tax year 2024 CHNA are as follows:

- Chronic Disease
- Mental Health & Youth Well-Being
- Healthcare Access & Affordability
- Social Determinants of Health (food insecurity, housing instability and transportation)

To view healthcare facilities and community resources available to respond to the significant needs, please see Appendix E (Page 82).

The following pages contain a description (including data highlights, community challenges and perceptions, and local assets and resources) of each significant need.

Chronic Disease

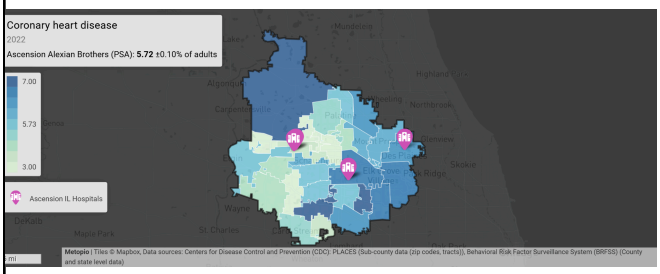
Significance	Populations Most Impacted
Chronic conditions like diabetes, coronary heart disease, and cancer have prevalence rates exceeding county, state, and national averages. These illnesses increase healthcare utilization and can worsen health outcomes if left unmanaged. *Source: U.S. Census Bureau, American Community Survey, 2023. Community Status Assessment (CSA) Alexian Brothers, 2025. Cook County Community Input Survey Data Analysis LEP, 2025.*	• Individuals over 40, who are at higher risk of chronic disease • African American residents, especially for diabetes and hypertension • Residents in zip codes 60191 (Wood Dale), 60120 (Elgin) • Individuals who are uninsured, underinsured or have Medicaid coverage

Community Input Highlights

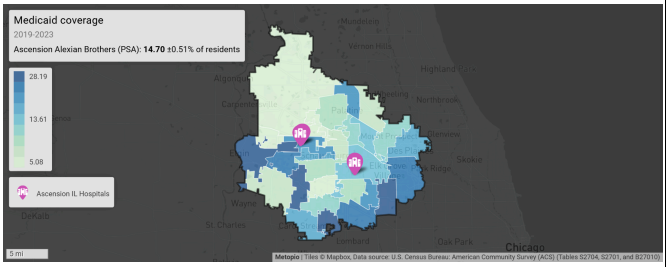
- African American survey respondents report greater concerns for hypertension (53.8%) and diabetes (53.8%) in comparison to the total survey respondents (hypertension 33.2% and diabetes 38.5%).
- 29.7% of survey respondents said heart disease and stroke were a top health concern
- There is a lack of specialists accepting Medicaid in the northwest suburbs was noted by focus group and survey participants, which create travel burdens for care
- Education on managing chronic diseases, including nutrition education, is lacking in low-income areas was noted by community partners
- There is a need for more preventative screenings in the community was noted by community partners and focus group participants as well as targeted education programs on diabetes and hypertension prevention for high-risk groups

Secondary Data Highlights

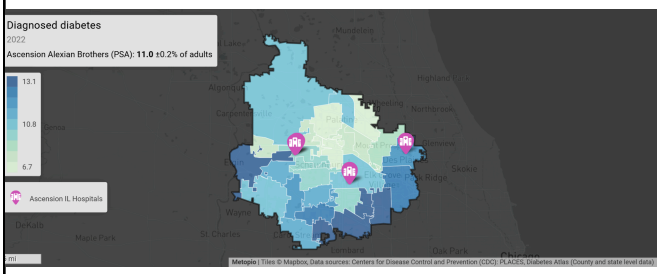
Coronary heart disease affects 5.72% of adults in the PSA, higher than the county and state levels. This heat map shows coronary heart disease is most prevalent in zip code Wood Dale (60191) with 7.0% of adults affected, followed by Bloomingdale (60108) at 6.90%. These findings highlight the geographic disparities and the need for targeted disease management in specific zip codes.	Diabetes is diagnosed in 11.0% of adults in the PSA, higher than the county, state, and national average with some areas in the PSA with elevated risk. The zip code Wood Dale (60191) again shows the highest percentage of diagnosed diabetes at 13.1%. Other high-prevalence areas include Bensenville (12.9%), Addison (12.8%) and Elgin (12.8%). The PSA average was 11.0%, emphasizing concentrated areas of elevated risk requiring focused diabetes support.



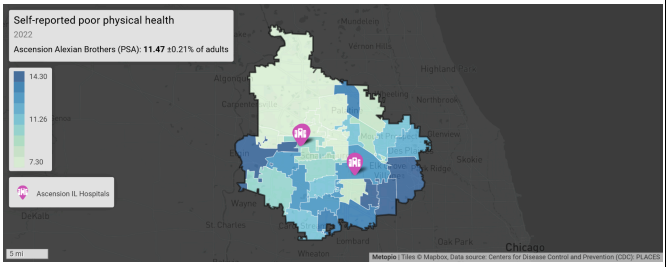
This heat map shows the percentage of residents covered by Medicaid with higher concentrations in the darker shaded areas such as Elgin (60120) with 28.19% of residents with Medicaid coverage and Glendale Heights (60139) 60139 with 23.33% of residents with Medicaid coverage.



Sources: U.S. Census Bureau, American Community Survey, 2023.



This heat map shows self-reported poor physical health with the hospital PSA with Elgin (60120) with the highest percentage of 14.30% followed by Bensenville (60106) with 13.50%. Both of these rates are higher than the PSA average of 11.47%, which is similar to the rest of Cook County as well as Illinois percentages.



Sources: U.S. Census Bureau, American Community Survey, 2023. Centers for Disease Control and Prevention (CDC) PLACES, 2022.

Mental Health & Youth Well-Being

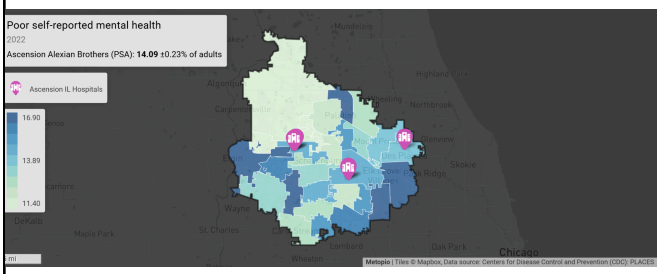
Significance	Populations Most Impacted
Mental health conditions such as anxiety, depression, and stress are major community concerns. Access to care is hindered by stigma, long wait times, and provider shortages, contributing to untreated or worsening mental illness. *Source: U.S. Census Bureau, American Community Survey, 2023. Community Status Assessment (CSA) Alexian Brothers, 2025. Cook County Community Input Survey Data Analysis LEP, 2025.*	• Immigrant and undocumented populations • Latinx/Hispanic and Black/African American populations • Older adults • LGBTQ+ populations • Residents in Elgin (60120), Lake Zurich (60074), Des Plaines (60016 & 60018), Bensenville (60106) and Hanover Park (60133) • Youth and adolescents

Community Input Highlights

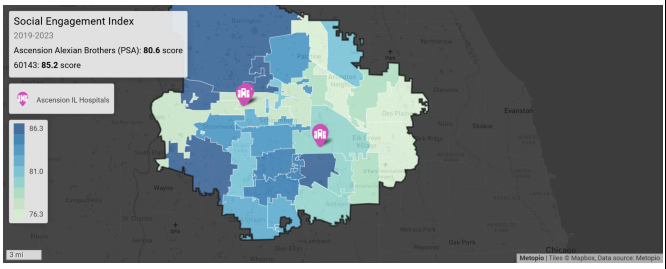
- High concern for depression, anxiety, and addiction in all three assessments
- Mental health concerns (36.7%) included long wait times for therapy (8+ weeks), stigma affecting care-seeking behavior, and a need for increased youth services (especially for stress and depression) in both surveys and focus group participants
- Youth issues identified by survey respondents included key concerts of social media influence (38.2%), stress (29.6%), depression (27.0%), and bullying (26.3%)
- Community partners called for expansion of mental health support through policy and advocacy efforts as well as hospitals to increase collaboration and expand use of technology for mental health and addiction recovery.
- Development of senior wellbeing and recreational facilities are needed to support aging community members was important to survey respondents

Secondary Data Highlights

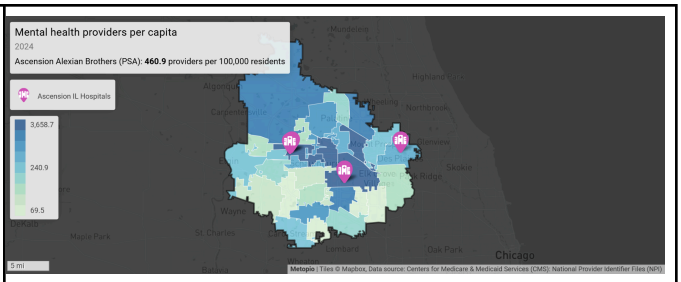
This heat map illustrates the 14.09% of adults in the PSA that reported experiencing 14 or more days of poor mental health in the past month. Rates were highest in Elgin (16.90%) and Lake Zurich (15.80%), highlighting geographic pockets of mental health distress that may require targeted outreach and support services.	The PSA had 460.9 mental health providers per 100,000 residents, which remains below the county, state, and national averages. The availability of providers varies significantly by zip code, with the lower access aligning with the areas of high need and limited insurance coverage, indicating a gap in care infrastructure. Bensenville (60106) has the lowest rate of providers with only 69.5 per 100,000 residents followed by Hanover Park (60133) with 70.4.



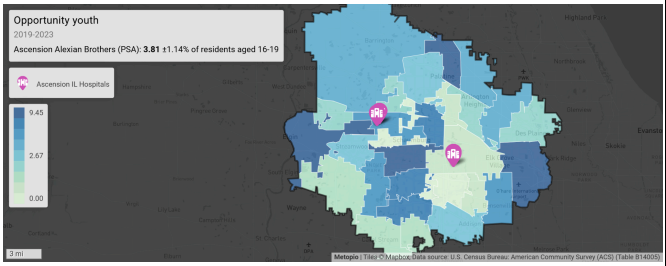
This heat map shows a social engagement index across the hospital PSA. The Social Engagement Index is a composite score measuring elements of civic engagement and social isolation, especially those that are affected by the built environment. It incorporates information about neighborhood resiliency (five-year change in rent prices, how often residents move, and housing vacancy) and barriers to social engagement (opportunity youth, proportion of seniors living alone, residents with cognitive and ambulatory disabilities, limited English proficiency, and residents reporting poor mental health). Higher values indicate more social engagement. Overall the PSA score is 80.6, however, Des Plaines (60016) has the lowest score with 76.3.



Sources: U.S. Census Bureau, American Community Survey, 2023. Metopio, 2023.



This heat map shows youth opportunity across the PSA, which is the percentage of residents aged 16-19 who are neither working nor enrolled in school. Youth who reside in Des Plaines (zip 60018) have the highest opportunity at 9.45% and Elgin (60120) at 8.32% compared to the PSA overall of 3.81%.



Sources: U.S. Census Bureau, American Community Survey, 2023.

Healthcare Access & Affordability

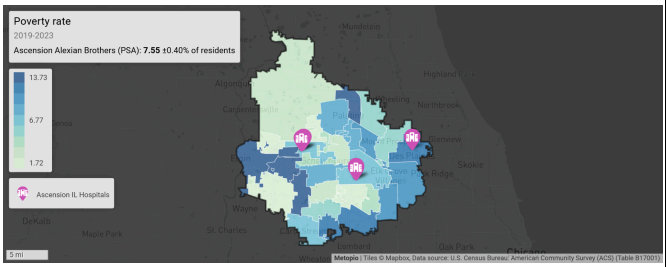
Significance	Populations Most Impacted
A significant portion of the population remains uninsured, underinsured, or faces systemic barriers to healthcare access, leading to poor preventive care (including low rates of screenings and vaccinations) and delayed treatment. *Source: U.S. Census Bureau, American Community Survey, 2023.Community Status Assessment (CSA) Alexian Brothers, 2025.*	• Individuals who are uninsured, underinsured or have Medicaid coverage • Immigrant and undocumented populations • Households with limited English proficiency (8.09% in the PSA, but higher in Elgin and Addison). • Seniors with limited Medicare coverage, especially for specialist care

Community Input Highlights

- 27.6% of survey respondents missed or postponed care due to barriers like lack of time (23.0%), high costs (18.7%), and inconvenient clinic hours (12.7%) were noted by survey respondents
- Most needed support services is access to healthcare (61.5%) by survey respondents
- Preventive care utilization was inconsistent among respondents:
    - 81.7% had seen a dentist within the past year, but 12.7% never had a cholesterol screening, and 36.0% never had a colonoscopy.
    - 41.0% of females had a mammogram within the past year, while 26.5% had never had one.
    - Vaccination rates showed gaps, with 13.2% never having received a flu vaccine and 7.4% never receiving a COVID-19 vaccine.
- Many survey respondents and focus group participants still lack insurance, face affordability issues, and struggle with understanding available benefits
- Barriers include lack of Medicaid-accepting specialists, inconvenient hours, and low awareness of services per community partner assessment
- Women's health concerns included a need for better education on mammograms, cancer detection, and the importance of seeking second opinions
- Community partners said there is a need for more health education including health literacy through multilingual outreach campaigns as well as advocacy to make healthcare including prescriptions more affordable

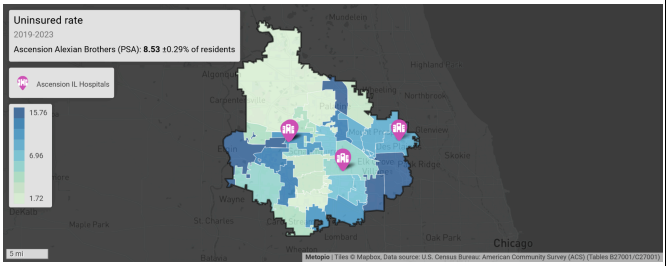
Secondary Data Highlights

7.55% of residents in the PSA live below the poverty line. While this is lower than the county average, certain zip codes such as 60133 Hanover Park and 60120 Elgin, report poverty rates higher. This reveals concentrated areas of economic hardship that may impact healthcare access and outcomes.	Households with limited English proficiency made up 8.09% of the PSA. The southern and eastern areas of the PSA show the highest rates, particularly 60101(Addison) at 15.55%. These language barriers can limit understanding of health services, leading to delayed or missed care.

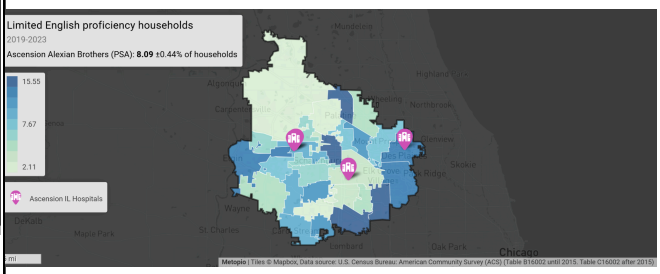


Source: U.S. Census Bureau, American Community Survey, 2023

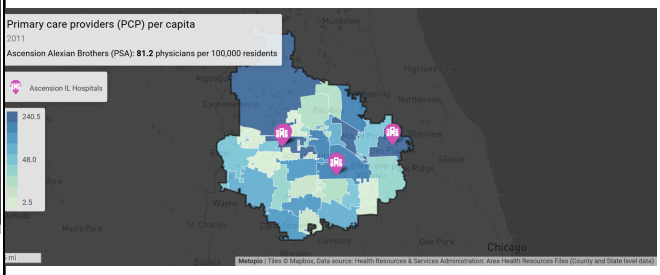
The uninsured rate in the PSA is 8.53%, exceeding county, state, and national averages. High uninsured rates often overlap with provider shortages, creating barriers to affordable care and limiting access to preventive services.



Sources: Centers for Medicare & Medicaid Services (CMS), National Provider Identifier, 2024. U.S. Census Bureau, American Community Survey, 2023.

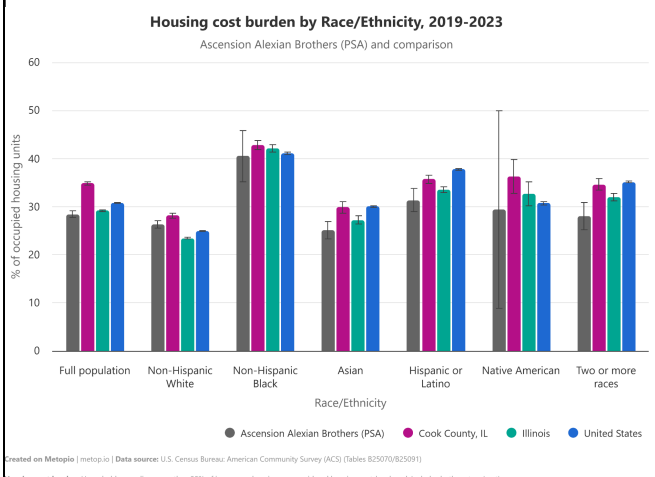


The PSA had 81.2 primary care providers per 100,000 residents, lower than county, state, and national levels. This shortage limits timely access to care, especially for uninsured and underserved residents, and contributes to increased reliance on emergency services and missed opportunities for preventive care.

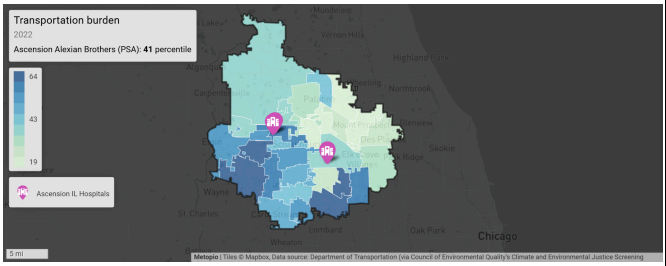


Sources: U.S. Census Bureau, American Community Survey, 2023. Health Resources & Services Administration, Area Health Resources Files, 2021.

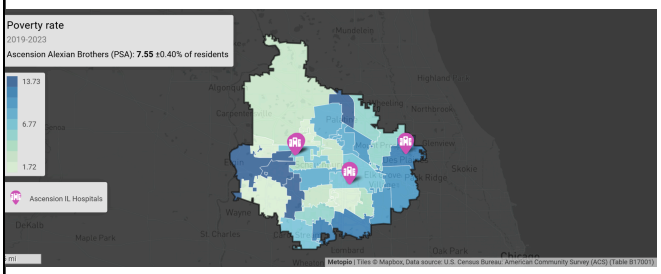
Social Determinants of Health (SDOH)	
Significance	**Populations Most Impacted**
The social determinants of health of housing instability, food insecurity and transportation challenges were identified as top three contributors to poor health outcomes. These barriers disproportionately impact underserved communities. *Source: U.S. Census Bureau, American Community Survey, 2023. Community Context Assessment (CCA) Alexian Brothers, 2025.*	• Low-income households in Addison (60101), Hanover Park (60133), and Elgin (60120) • Migrant & immigrant communities • Latinx/Hispanic and Black/African American populations • Undocumented residents • Persons with disabilities
Community Input Highlights	
• 19.8% of survey respondents worried about running out of food, with 5.3% worrying all the time; food insecurity, mostly due to rising costs, was a top health concern for community partners as well as focus group participants • Medicaid recipients struggle to find specialists in the northwest suburbs, forcing travel to Chicago, which creates transportation barriers to care • Affordable housing ranked as a top health need, particularly among African American respondents (30.8%) on the community input survey • Community partners organizations noted housing instability and food deserts as priority areas for collaboration as well as need for policies to increase funding for all SDoH programs • Transportation challenges impact access to health care, employment and education opportunities per focus group participants	
Secondary Data Highlights	
The chart shows non-Hispanic Black residents in the PSA face the highest housing cost burden, with 40.5% spending over 30% of income on housing. This economic strain impacts stability, stress, and health outcomes, especially for communities already facing structural barriers.	The PSA's overall poverty rate is 7.55%, but certain zip codes such as Hanover Park (60133) at 13.73% and Elgin (60120) at 13.14% exceed this. These pockets of high poverty reflect deep inequities in food access, housing, and healthcare utilization.



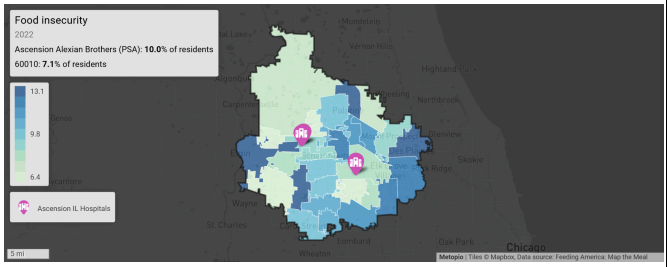
This heat map shows the transportation burden across the PSA, which is at the 41st percentile as a region. A measure of transportation insecurity that takes into account average relative cost and time spent on transportation relative to all other tracts. Streamwood (60107) has the highest percentile of 64th within the hospital PSA.



Sources: U.S. Census Bureau, American Community Survey, 2023. Department of Transportation via Council of Environmental Quality's Climate and Environmental Justice Screening Tool, 2022.



Similarly, this map of food insecurity shows some of the same communities most in need: Elgin (60120) with 13.1% and Hanover Park (60133) with 12.2% of their residents with uncertain access to adequate food. The PSA as a whole has 10.0% food insecurity.



Sources: U.S. Census Bureau, American Community Survey, 2023. Feeding America, Map the Meal, 2022.

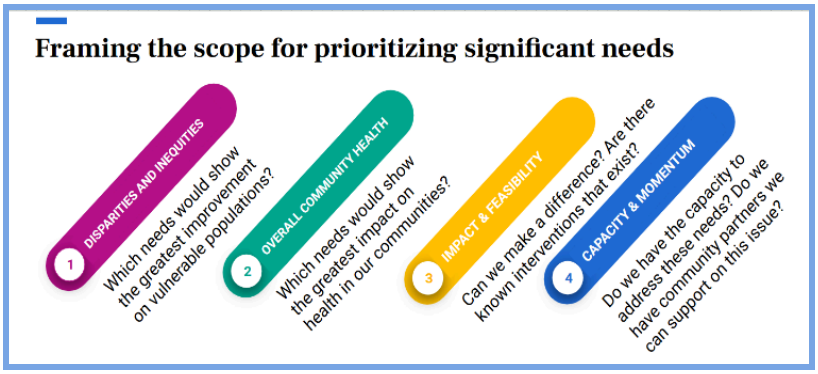
Next Steps

In the third phase, which will take place following the completion of the community health needs assessment as outlined in this report, Ascension Alexian Brothers will narrow the significant needs to a set of prioritized needs. Ascension defines "prioritized needs" as the significant needs that the hospital has prioritized to respond to through the three-year CHNA implementation strategy. The implementation strategy will detail how Ascension Alexian Brothers will respond to the prioritized needs throughout the three-year CHNA cycle: July 1, 2025 - June 30, 2028. The implementation strategy will also describe why certain significant needs were not selected as prioritized needs to be addressed by the hospital.

Prioritized Needs

In the third phase, significant needs were further narrowed to a set of "prioritized needs." Ascension defines **prioritized needs** as the significant needs that the hospital has prioritized to respond to through the three-year CHNA implementation strategy. In framing the scope for prioritizing significant needs, the following criteria were used as discussion:

- Disparities & Inequities: Which needs would show the greatest improvement on vulnerable populations?
- Overall Community Health: Which needs would show the greatest impact on health in our communities?
- Impact & Feasibility: Can we make a difference? Are there known interventions that exist?
- Capacity & Momentum: Do we have the capacity to address these needs? Do we have community partners we can support on this issue?



Based on discussion and feedback, hospital senior leadership as well as the market community leaders selected the prioritized needs outlined below for its tax year 2024 CHNA implementation strategy:

- **Chronic Disease *(Diabetes, Obesity, Heart Disease - Chronic Conditions)***: Chronic conditions like diabetes, coronary heart disease, and cancer have prevalence rates exceeding county, state, and national averages. These illnesses increase healthcare utilization and can worsen health outcomes if left unmanaged. African American survey respondents report greater concerns for hypertension (53.8%) and diabetes (53.8%). 29.7% of survey respondents said heart disease and stroke were a top health concern. There is a lack of specialists accepting Medicaid in the northwest suburbs, which create travel burdens for care. Education on managing/preventing

chronic diseases, including nutrition education, is lacking in low-income areas as noted by community partners.

- **Mental Health & Youth Well-Being (*Mental Health - Quality of Life)***: Mental health conditions such as anxiety, depression, and stress are major community concerns. Access to care is hindered by stigma, long wait times, and provider shortages, contributing to untreated or worsening mental illness.High concern for depression, anxiety, and addiction in all three assessments. Mental health concerns (36.7%) included long wait times for therapy (8+ weeks), stigma affecting care-seeking behavior, and a need for increased youth services (especially for stress and depression). Development of senior wellbeing and recreational facilities are needed to support aging community members was important to survey respondents. Community partners called hospitals to increase collaboration and expand use of technology for mental health and addiction recovery.
- **Healthcare Access & Affordability *(Access to Care - Clinical Care)***: A significant portion of the population remains uninsured, underinsured, or faces systemic barriers to healthcare access, leading to poor preventive care (including low rates of screenings and vaccinations) and delayed treatment. 27.6% of survey respondents missed or postponed care due to barriers like lack of time (23.0%), high costs (18.7%), and inconvenient clinic hours (12.7%). Most needed support services is access to healthcare (61.5%) by survey respondents. Preventive care utilization was inconsistent among respondents with opportunities for colonoscopy, mammography, cholesterol screening & flu vaccines. Barriers include lack of Medicaid-accepting specialists; needs for multilingual health education, women's programs & affordable medications noted.
- **Social Determinants of Health *(Income - SDoH & Housing - SDoH)***: The social determinants of health of housing instability, food insecurity and transportation challenges were identified as top three contributors to poor health outcomes. These barriers disproportionately impact underserved communities. 19.8% of survey respondents worried about running out of food, mostly due to rising costs. Medicaid recipients struggle to find specialists in the northwest suburbs, forcing travel to Chicago, which creates transportation barriers to care. Affordable housing ranked as a top health need, particularly among African American respondents (30.8%). Community partners noted housing instability and food deserts as priority areas; Transportation challenges impact access to health care, employment and education opportunities.

Needs That Will Not Be Addressed

All of the significant needs were selected for prioritization to be addressed in this CHNA cycle.

Summary of Impact of the Previous CHNA Implementation Strategy

An important piece of the three-year CHNA cycle is revisiting the progress made on priority needs set forth in the preceding CHNA. By reviewing the actions taken to respond to the prioritized needs and evaluating the impact those actions have made in the community, it is possible to better target resources and efforts during the next CHNA cycle.

Ascension Alexian Brothers' previous CHNA implementation strategy was completed in October 2022 and responded to the following priority health needs:

- Food Access & Food Insecurity
- Transportation
- Housing
- Resources, Referrals, Coordination, and Connection to Community-Based Services
- Timely Linkage to Quality Care
- Workforce Development
- Maternal & Child Health
- Mental Health
- Substance Use Disorders
- Chronic Conditions

Highlights from the **Ascension Alexian Brothers'** previous implementation strategy include:

- 69,915 pounds of food provided to the community through programs and partnerships
- 2,045 rides provided for individuals identified as needing transportation assistance
- 524 individuals provided with housing assistance through programs and partnerships
- 16,951 preceptor hours provided for highschool and college students
- 1,055 referrals were made from Ascension's Neighborhood Resource Directory
- 1,371 individuals were provided with Public Health Insurance Assistance enrollment services
- 1,817 counseling sessions for youth were provided by supporting local partnerships
- 62% of individuals that screened positive for substance used disorders agreed to receive treatment through Warm Handoff program services

Written input received from the community and a report on the actions taken to respond to the significant health needs prioritized in the tax year 2021CHNA implementation strategy can be found in Appendix F (Page 85).

Approval

To ensure Ascension Alexian Brothers efforts meet the needs of the community and have a lasting and meaningful impact, the tax year 2024 CHNA was presented and approved by the Ascension Illinois Quality Board of Directors on May 28, 2025. Although an authorized body of the hospital must adopt the CHNA and implementation strategy reports to be compliant with the provisions in the Affordable Care Act, adoption of the reports also demonstrates that the board is aware of the findings from the CHNA, endorses the health needs identified, and supports the strategies developed to respond to those needs.

Conclusion

Ascension Alexian Brothers hopes this report offers a meaningful and comprehensive understanding of the most significant needs of the hospital community including Cook County. This report will be used by internal stakeholders, nonprofit organizations, government agencies, and other Ascension Alexian Brothers community partners to guide the implementation strategies and community health improvement efforts as required by the Affordable Care Act. The tax year 2024 CHNA will also be available to the broader community as a useful resource for further health improvement efforts.

As a Catholic health ministry, Alexian Brothers is dedicated to spiritually centered, holistic care that sustains and improves the health of not only individuals but the communities it serves. With special attention to those who are underserved and marginalized, we are advocates for a compassionate and just society through our actions and words. Ascension Alexian Brothers is dedicated to serving patients with compassionate care and medical excellence, making a difference in every life we touch. The hospital values the community's voice and welcomes feedback on this report. Please visit Ascension's public website (https://healthcare.ascension.org/chna) to submit any comments or questions.

Appendices

Table of Contents

Appendix A: Definitions and Terms

Catholic Health Association of United States (CHA) "is recognized nationally as a leader in community benefit planning and reporting."[3] The definitions in Appendix A are from the CHA guide *Assessing and Addressing Community Needs, 2015 Edition II,* which can be found at chausa.org.

Community Focus Groups

Group discussions with selected individuals. A skilled moderator is needed to lead focus group discussions. Members of a focus group can include internal staff, volunteers and the staff of human service and other community organizations, users of health services and members of minority or disadvantaged populations.

Community Forums

Meetings that provide opportunities for community members to provide their thoughts on community problems and service needs. Community forums can be targeted toward priority populations. Community forums require a skilled facilitator.

Demographics

Population characteristics of your community. Sources of information may include population size, age structure, racial and ethnic composition, population growth, and density.

Key Stakeholder Interviews

A method of obtaining input from community leaders and public health experts one-on-one. Interviews can be conducted in person or over the telephone (including computer/video calls). In structured interviews, questions are prepared and standardized prior to the interview to ensure consistent information is solicited on specific topics. In less structured interviews, open-ended questions are asked to elicit a full range of responses. Key informants may include leaders of community organizations, service providers, and elected officials. Individuals with special knowledge or expertise in public health may include representatives from your state or local health department, faculty from schools of public health, and providers with a background in public health. Could also be referred to as Stakeholder Interviews.

Medically Underserved Populations

Medically underserved populations include populations experiencing health disparities or that are at risk of not receiving adequate medical care because of being uninsured or underinsured or due to geographic, language, financial, or other barriers. Populations with language barriers include those with limited English proficiency. Medically underserved populations also include those living within a

hospital facility's service area but not receiving adequate medical care from the facility because of cost, transportation difficulties, stigma, or other barriers.

Surveys

Used to collect information from community members, stakeholders, providers, and public health experts for the purpose of understanding community perception of needs. Surveys can be administered in person, over the telephone, or using a web-based program. Surveys can consist of both forced-choice and open-ended questions.

[3] Catholic Health Association of the United States. (2015). *Assessing & Addressing Community Health Needs, 2015 Edition II*.

Appendix B: Community Demographic Data and Sources

The tables below provide further information on the community's demographics. The descriptions of the data's importance are largely drawn from the County Health Rankings & Roadmaps website. For additional data see Appendix D: Secondary Data and Sources.

Population

Why it is important: The composition of a population, including related trends, is important for understanding the community context and informing community planning.

Population	Hospital PSA	Cook County	Illinois	U.S.
Total	907,501	5,087,072	12,549,689	334,914,896
Male	49.6%	48.9%	49.5%	49.6%
Female	50.4%	51.1%	50.5%	50.4%

Sources: County Health Rankings & Roadmaps. (2024). https://www.countyhealthrankings.org/health-data/illinois/cook?year=2024; American Community Survey (ACS). (2023).

Population by Race and Ethnicity

Why it is important: The racial and ethnic composition of a population is important in understanding the cultural context of a community. The information can also be used to better identify and understand health disparities.

Race or ethnicity	Hospital PSA	Cook County	Illinois	U.S.
Asian	14.8%	8.3%	6.3%	6.3%
Non-Hispanic Black / African American	4.2%	22.7%	14.1%	12.6%
Hispanic / Latino	23.1%	26.3%	18.3%	19.1%
American Indian or Alaska Native	0.1%	0.8%	0.6%	1.3%
Non-Hispanic White	55.1%	41.1%	59.5%	58.9%

Sources: County Health Rankings & Roadmaps. (2024). https://www.countyhealthrankings.org/health-data/illinois/cook?year=2024; American Community Survey (ACS). (2023).

Population by Age

Why it is important: The age structure of a population is important in planning for the future of a community, particularly for schools, community centers, healthcare, and child care. A population with more youths will have greater education and childcare needs, while an older population may have greater healthcare needs.

Age	Hospital PSA	Cook County	Illinois	U.S.
Ages 0-17	22.8%	20.9%	21.6%	21.7%
Ages 65+	16.6%	16.2%	17.2%	17.3%

Sources: County Health Rankings & Roadmaps. (2024). https://www.countyhealthrankings.org/health-data/illinois/cook?year=2024; American Community Survey (ACS). (2023).

Income

Why it is important: Median household income and the percentage of children living in poverty, which can compromise physical and mental health, are well-recognized indicators. People with higher incomes tend to live longer than people with lower incomes. In addition to affecting access to health insurance, income affects access to healthy choices, safe housing, safe neighborhoods, and quality schools. Chronic stress related to not having enough money can have an impact on mental and physical health as well. ALICE, an acronym for Asset Limited, Income Constrained, Employed, are households that earn more than the U.S. poverty level but less than the basic cost of living for the county. Combined, the number of poverty and ALICE households equals the total population struggling to afford basic needs.

Income	Hospital PSA	Cook County	Illinois	U.S.
Median household income	$103,080	$76,600	$76,700	$74,800
ALICE Households	27.56%	35.48%	37.00%	42.00%
Poverty	7.55%	13.29%	11.63%	12.46%

Sources: County Health Rankings & Roadmaps. (2024). https://www.countyhealthrankings.org/health-data/illinois/cook?year=2024; American Community Survey (ACS). (2023).

Education

Why is it important: There is a strong relationship between health, lifespan, and education. In general, as income increases, so does lifespan. The relationship between more schooling, higher income, job opportunities (e.g., pay, safe work environment), and social support helps create opportunities for healthier choices.

Income	Hospital PSA	Cook County	Illinois	U.S.
High school diploma	89.54%	88.55%	90.55%	89.78%
Associate's degree or higher	67.53%	66.69%	65.5%	63.84%

Sources: County Health Rankings & Roadmaps. (2024). https://www.countyhealthrankings.org/health-data/illinois/cook?year=2024; American Community Survey (ACS). (2023).

Insured/Uninsured

Why it is important: Lack of health insurance can have serious health consequences due to lack of preventive care and delays in care that can lead to serious illness or other health problems.

Income	Hospital PSA	Cook County	Illinois	U.S.
Uninsured	8.53%	7.79%	6.16%	7.93%
Medicaid Coverage	14.70%	22.31%	19.88%	21.31%

Source: American Community Survey (ACS). (2023).

Appendix C: Community Input Data and Sources

Community focus groups

The following questions were discussed with participants of the community focus group conducted with the volunteer department that was integral in the recruitment efforts for the focus group.

1. In your view, what are the top 3 strengths of the community?
2. In your view, what are the top 3 weaknesses of the community?
3. In the hospital's previous community health needs assessment, (insert need) was identified. (a) Has this issue improved, worsened or remained the same? (b) In your opinion, does it remain a significant or great need?
4. What are the most important health issues you see in the community besides the needs we just discussed?
5. What specific populations, if any specifically, are disproportionately affected by the mentioned issues?
6. What health services are lacking in the community?
7. What community services are lacking in the community?

Community survey

Conducted electronically via Google Form, the community survey was comprised of the following key questions:

- What are the 3 most important health problems in your community?
    - What is needed to support the 3 most important health problems you chose above?
- During the past 12 months, have you missed or postponed medical or therapy (i.e. behavioral health counseling) appointments?
    - If yes to the previous question, what were the reasons you postponed or missed health care appointments (check all that apply)?
- On a scale from 1-5 with 1 being not healthy and 5 being very healthy, how would you rate your overall health?
- On a scale from 1-5 with 1 being not healthy and 5 being very healthy, how would you rate the overall health of people in your neighborhood?
- On a scale from 1-5 with 1 being not healthy and 5 being very healthy, how would you rate your mental and emotional health in general in the past 12 months?
- "How long has it been since you...Had your teeth cleaned by dentist or dental hygienist]"
- "How long has it been since you...[Had healthcare exam or physical]"
- "How long has it been since you...[Had a mammogram]"
- "How long has it been since you...[Had a colonoscopy]"
- "How long has it been since you... [Had a cholesterol screening]"

- "How long has it been since you...[Had your blood sugar measured]"
- "How long has it been since you...[Had a flu vaccine]"
- "How long has it been since you...[Had a COVID-19 vaccine]"
- Do you feel safe in your community?
- In the past 12 months, were you worried whether food would run out before you could get more?
- How big of a problem do you feel the following issues are for children and teens in your neighborhood? Select an answer for each statement

Key stakeholder survey

Ascension Illinois reached out to more than 30 organizations and agencies in the community with an invitation to participate in the key stakeholder surveys. Through this process, nine completed surveys were collected from different types of organizations including schools/educational institutions, non-profit organizations, grassroots organizations and health providers including:

Christus Victor Lutheran Church
Kenneth Young Center
WINGS Program, Inc.
Gateway Foundation
William Rainey Harper College
Advocatia Solutions, Inc.
Sharing Notes
Ascension Illinois

Conducted electronically via Google Form, the key stakeholder survey was comprised of the following key questions:

- In your view, what are the top three strengths of the community?
- In your view, what are the top three weaknesses of the community?
- What are the most important health issues you see in the community?
- What are the most important social issues you see in the community?
- What specific populations, if any, are disproportionately affected by the mentioned issues?
- What drivers are impacting the top health needs?
- What barriers are impacting the top health needs?
- What health services are lacking for the people in the communities you serve?
- What policies or resources are needed to help address the top health needs?
- How could hospitals in your community potentially improve health or reduce health disparities beyond traditional health care?

- In your community, where do individuals typically seek access to health and wellness services?
- How does your organization currently collaborate with other community stakeholders to address health and social issues?
- Can you identify any successful community-led initiatives or programs that have positively impacted health outcomes?
- In your experience, what communication channels are most effective in reaching diverse segments of the community with health information?
- How do you perceive the level of community engagement in existing health and social programs?
- How do you envision the ideal partnership between your organization and the hospital in addressing community health needs?

Appendix D: Secondary Data and Sources

The Community Status Assessment (CSA) of the Mobilizing Action through Planning and Partnerships (MAPP) framework is compiled of relevant indicators to help understand the status of the community focused on social determinants of health, health status, behaviors, outcomes, systems of power, privilege, and oppression. As possible, data was collected from the primary service area (PSA) zip codes of the hospital community to compare to the county, state and national data as well as relevant Healthy People 2030 benchmarks.

How to Read These Charts

Primary Service Area (PSA) vs. County vs. state: Describes how the PSA's most recent data for the health issue compares to the county average and state average.

Healthy People 2030: A national benchmark data set created by the Center for Disease Control (CDC) to improve health decade by decade.

Trends: As available for the PSA, data is color coded to reflect the following trends:

- Red: The measure is worsening.
- Green: The measure is improving.
- Empty: There is no data trend to share, or the measure has remained the same.

United States (U.S.): Describes how the county's most recent data for the health issue compares to the U.S.

Topic: Explains what the indicator measures, the unit of measurement as well as year or year-range of data collection. Many times for a year-range, it is the last year available that is used.

N/A: Not available or not applicable. There might not be available data for the community on every measure. Some measures will not be comparable.

Stratifications & Heat Mapping: After each set of indicators, a series of heat maps and stratified charts were created to dig deeper into certain data points. Heat maps of the hospital PSA highlight where health or social conditions are worse geographically by zip code. As available, stratifications of data by sex, gender or ethnicity is displayed.

Community Status Assessment (CSA)
Ascension Alexian Brothers 2025

The Community Status Assessment (CSA) of the Mobilizing Action through Planning and Partnerships (MAPP) framework is compiled of relevant indicators to help understand the status of the community focused on social determinants of health, health status, behaviors, outcomes, systems of power, privilege, and oppression. As possible, data was collected from the primary service area (PSA) zip codes of the hospital community to compare to the county, state and national data as well as relevant Healthy People 2030 benchmarks.

Disease & Injury Indicators

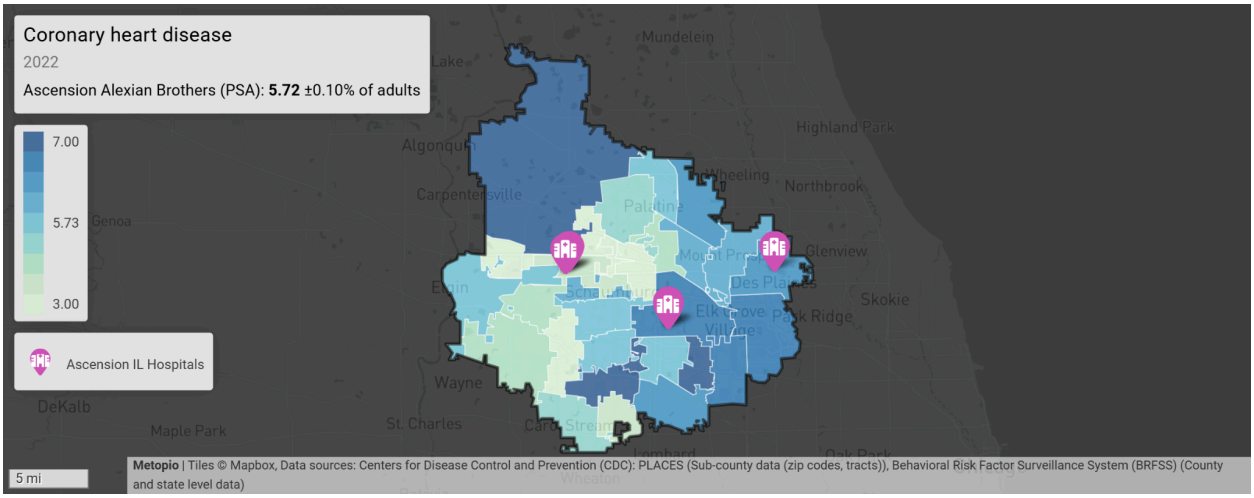
The cancer diagnosis rate is higher than the county and national rate. The percentage of adults with coronary heart disease is higher than the county and state percentages. The rate of adults diagnosed with diabetes is higher than the county, state, and national rate. The percentage of live births with low birth weight is lower than the county, state, and national percentages. The adult obesity rate is significantly lower than the county, state, and national rate.

Topic	Ascension Alexian Brothers (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Cancer diagnosis rate *per 100,000 residents* 2017-2021	**550.87**	547.69	573.24	444.40	n/a
Coronary heart disease *% of adults* 2022	**5.72**	5.10	5.37	5.82	n/a
COVID-19 case rate	–	29,479.86	31,887.08	32,217.47	n/a

cumulative cases per 100,000 population Mar 2023					
Diagnosed diabetes *% of adults* 2022	**11.0**	10.8	10.4	10.8	n/a
HIV prevalence *people per 100,000* 2022	–	595.8	338.8	386.6	n/a
Low birth weight *% of live births* 2020-2022	**6.1**	8.9	8.5	8.5	n/a
Motor vehicle traffic mortality *deaths per 100,000* 2022	–	8.9	10.0	12.9	10.1
Obesity *% of adults* 2022	**29.8**	32.8	34.4	33.8	n/a
Sexually transmitted infection prevalence *cases per 100,000* 2022	–	1,720.9	1,139.5	1,113.6	n/a

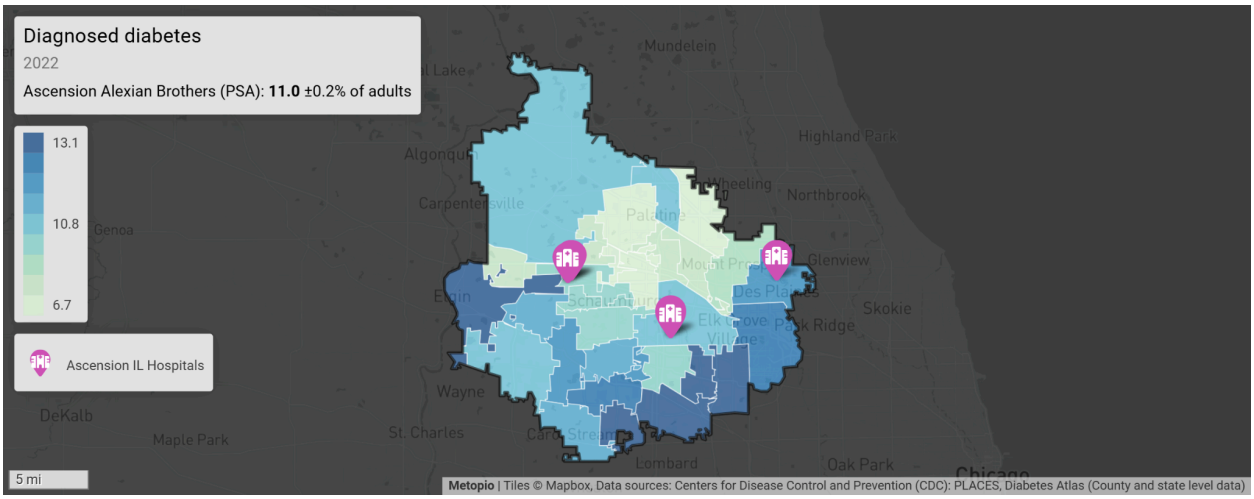
Stratifications & Heat Mapping

A heat map of the percentage of adults with coronary heart disease shows the zip code 60191 (Wood Dale) with the highest prevalence at 7.00% followed by 60108 (Bloomingdale) at 6.90%.



A heat map of the percentage of adults diagnosed with diabetes shows the 60191(Wood Dale) zip code to have the highest percentage at 13.1%. Other zip codes with higher rates of diagnosed diabetes:

Zip Code - Community	% of diagnosed diabetes
60106 Bensenville	12.9%
60101 Addison	12.8%
60139 Glendale Heights	12.8%
60120 Elgin	12.8%
60108 Bloomingale	12.7%


Diagnosed diabetes
2022
Ascension Alexian Brothers (PSA): 11.0 ±0.2% of adults
13.1
10.8
6.7
Ascension IL Hospitals
Mundelein
Highland Park
Algonquin
Wheeling
Northbrook
Carpentersville
Palatine
Glenview
Elgin
Des Plaines
Skokie
Park Ridge
Genoa
Wayne
DeKalb
Maple Park
St. Charles
Lombard
Oak Park
5 mi
Metopio | Tiles © Mapbox, Data sources: Centers for Disease Control and Prevention (CDC): PLACES, Diabetes Atlas (County and state level data)

Economic Stability Indicators

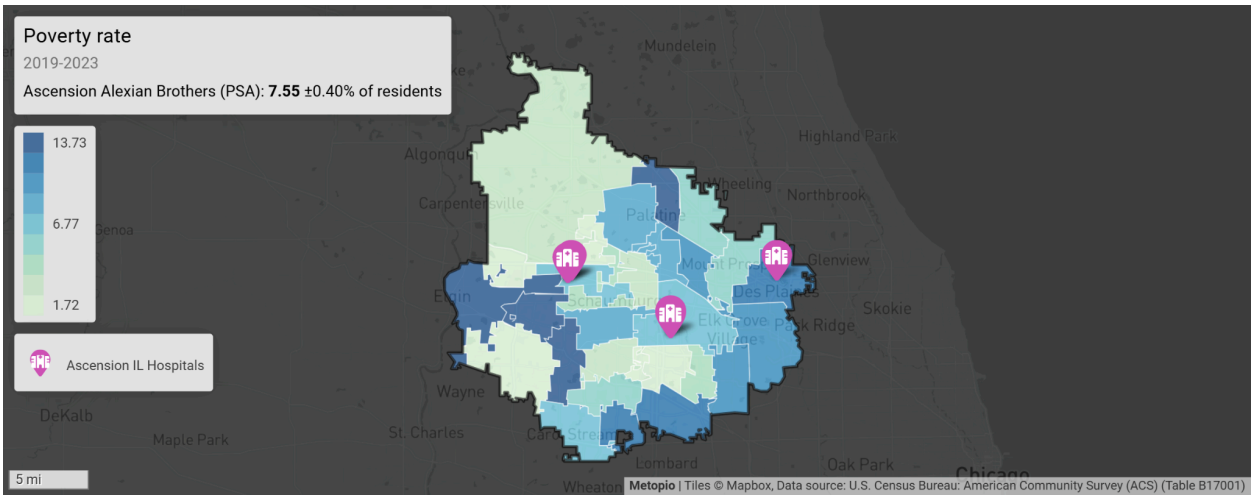
The median selected monthly owner costs (SMOC) is higher than the county, state, and national level.The percentage of owner occupied housing is drastically higher than the county, state, and national percentages. The median household income is notably higher than the county, state, and national level. Similarly, the poverty rate is much lower than the county, state, and national rate.

Topic	Ascension Alexian Brothers (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Median selected monthly owner costs (SMOC) 2019-2023	**$1,742**	$1,602	$1,366	$1,320	n/a
Owner occupied *% of occupied housing units* 2019-2023	**72.00**	57.81	67.37	65.24	n/a
Median household income 2019-2023	**$103,080**	$80,579	$80,306	$77,719	n/a
Poverty rate *% of residents* 2019-2023	**7.55**	13.29	11.63	12.46	8.00
Unemployment rate (BLS) *%* Nov 2024	–	5.3	4.8	4.0	n/a

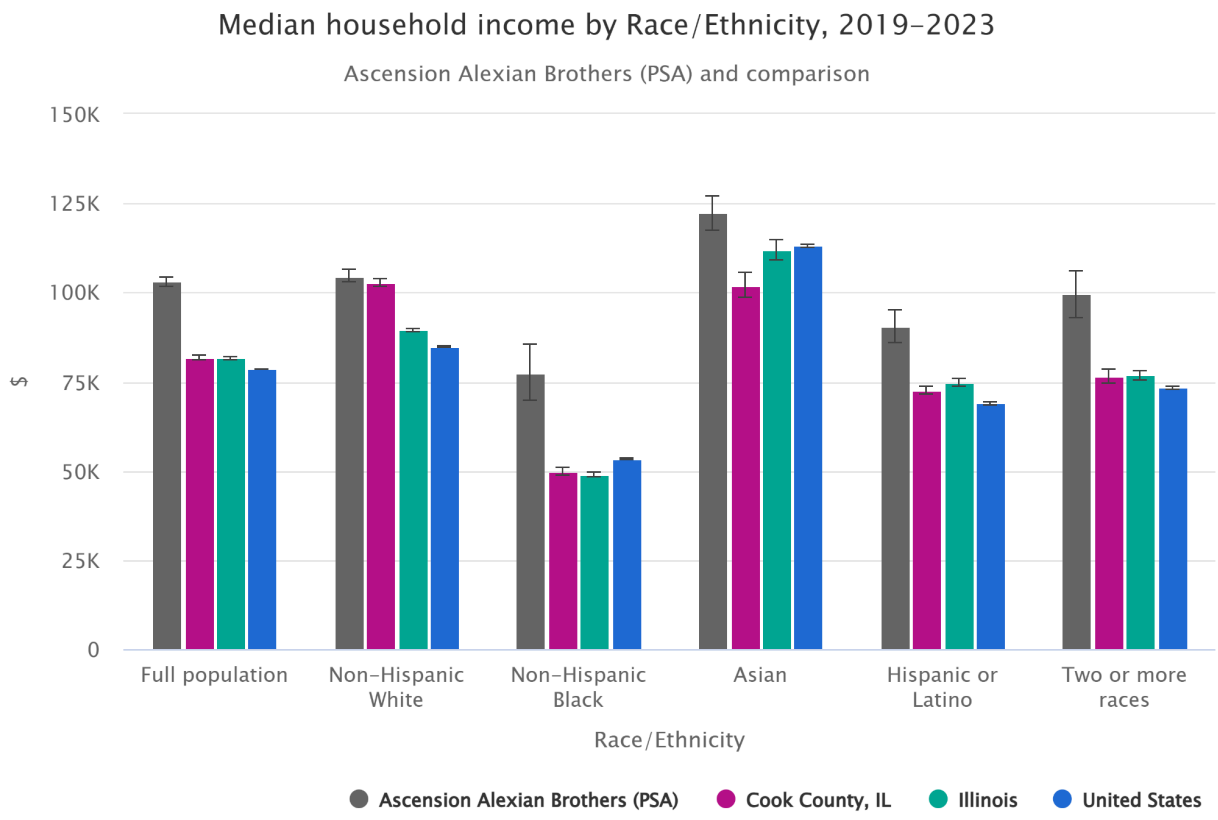
Unemployment rate (BLS) % Nov 2024	–	5.3	4.8	4.0	n/a

Stratifications & Heat Mapping

While the poverty rate for the PSA is much lower in comparison to county, state and national averages, there are pockets of inequities within the PSA. The following zip codes have the highest poverty rates within the PSA: 60133 Hanover Park (13.73%) and 60120 Elgin (13.14%).



The stratification of median household income by race/ethnicity shows a greater income across all races and ethnicities in comparison to county, state and national averages.



Created on Metopio | metop.io | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Table B19013)
Median household income: Income in the past 12 months.

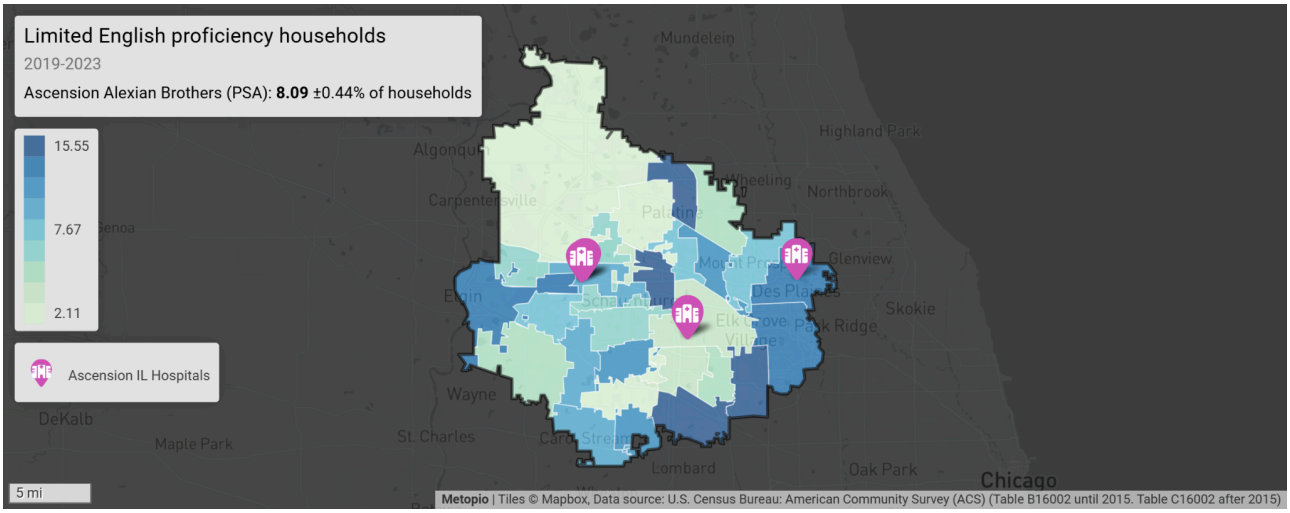
Education & Quality of Life Indicators

The limited English proficiency in households is considerably higher within the PSA than the county, state, and national levels.

Topic	Ascension Alexian Brothers (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
High school graduation rate *% of residents* 2019-2023	89.54	88.55	90.55	89.78	n/a
Preschool enrollment *% of toddlers ages 3-4* 3-4 years, 2019-2023	**50.57**	49.97	52.25	48.45	n/a
Limited English proficiency households *% of households* 2019-2023	**8.09**	6.68	4.24	4.36	n/a

Stratifications & Heat Mapping

A heat map shows the concentration of limited-English proficiency households to be highest in the southern and eastern portion of the hospital PSA with the highest percentage in 60101 Addison (15.55%).


Limited English proficiency households
2019-2023
Ascension Alexian Brothers (PSA): 8.09 ±0.44% of households
15.55
7.67
2.11
Ascension IL Hospitals
Mundelein
Highland Park
Algonquin
Wheeling
Northbrook
Carpentersville
Glenview
Elgin
Des Plaines
Skokie
Park Ridge
Wayne
DeKalb
Maple Park
St. Charles
Lombard
Oak Park
Chicago
5 mi
Metopio | Tiles © Mapbox, Data source: U.S. Census Bureau: American Community Survey (ACS) (Table B16002 until 2015. Table C16002 after 2015)

Health Behavior Indicators

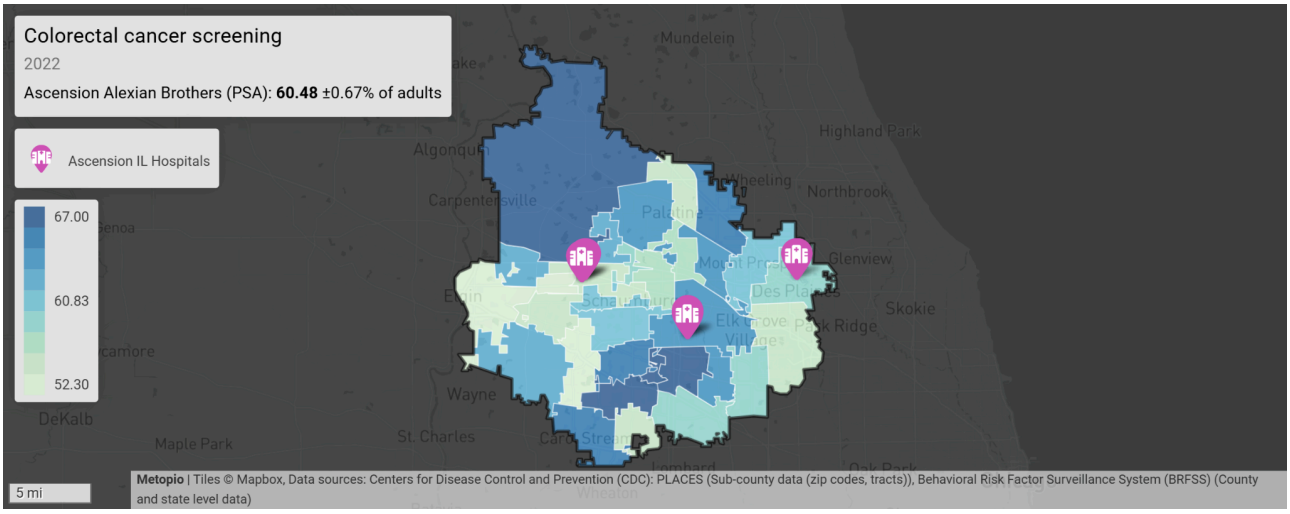
The percentage of adults that binge drink is lower than the county and state percentages as well as the Healthy People 2030 goal. The rate of adults that receive colorectal screening is higher than the county, state, and national rate. The Mammography use rate is similar in comparison to other rates, but lower than the Healthy People 2030 rate. The teen birth rate is higher than the county, state, and national rate, but significantly lower than the Healthy People 2030 rate.

Topic	Ascension Alexian Brothers (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Binge drinking *% of adults* 2022	**19.77**	20.80	20.37	18.58	25.40
Colorectal cancer screening *% of adults* 2022	**60.48**	52.70	55.37	58.85	68.30
No exercise *% of adults* 2022	20.5	20.9	21.5	23.7	21.8
Mammography use *% of adults* Female, 2022	74.18	73.80	73.02	75.65	80.30
Cigarette smoking rate *% of adults* 2022	12.0	12.0	13.5	14.6	n/a

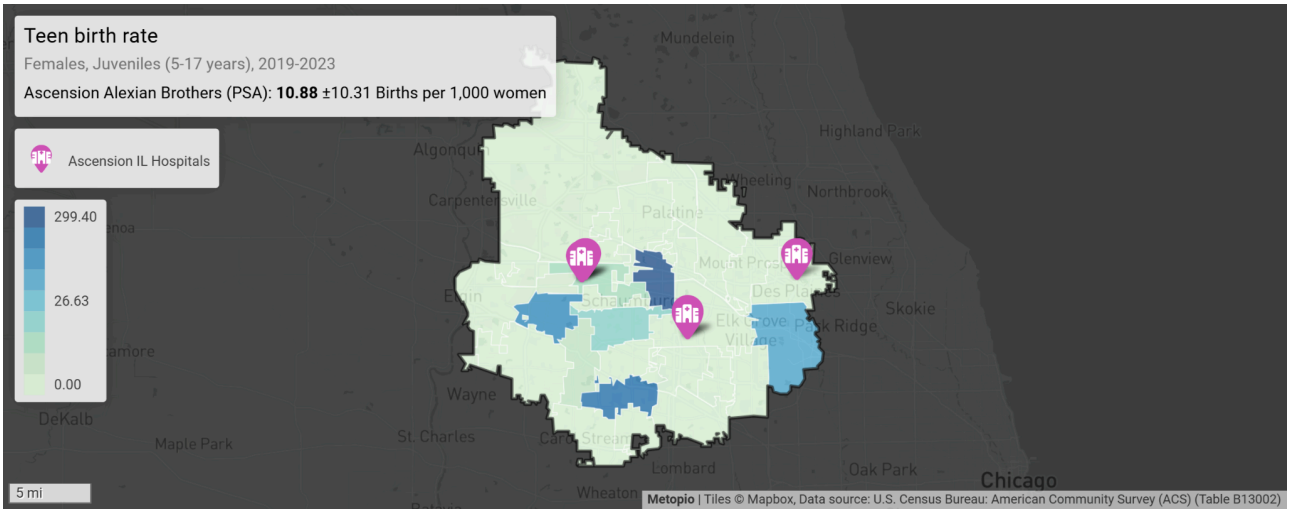
Teen birth rate *Births per 1,000 women, female under 18 yrs* 2019-2023	**10.88**	10.16	7.88	8.48	31.40
Few fruits and vegetables *% of adults* 2009	--	75.90	77.50	76.14	n/a

Stratifications & Heat Mapping

The heat map shows the colorectal cancer screening rate across the PSA. The zip codes with the greatest opportunity to increase screening rates are: 60120 Elgin (52.30%) 60133 Hanover Park (55.80%).



The heat map shows the teen birth rates among the zip codes within the PSA. The zip codes with the highest teen birth rate are as follows: 60108 Bloomingdale (64.59 per 1,000); 60107 Streamwood (31.80 per 1,000). The zip code 60173 (Schaumburg) reports 299.40 per 1,000, which has been removed as an inaccurate outlier.


Teen birth rate
Females, Juveniles (5-17 years), 2019-2023
Ascension Alexian Brothers (PSA): 10.88 ±10.31 Births per 1,000 women
Ascension IL Hospitals
299.40
26.63
0.00
Mundelein
Highland Park
Algonquin
Wheeling
Northbrook
Carpentersville
Palatine
Glenview
Elgin
Schaumburg
Des Plaines
Skokie
Elk Grove Village
Park Ridge
Wayne
DeKalb
Maple Park
St. Charles
Lombard
Oak Park
Chicago
Wheaton
5 mi
Metopio | Tiles © Mapbox, Data source: U.S. Census Bureau: American Community Survey (ACS) (Table B13002)

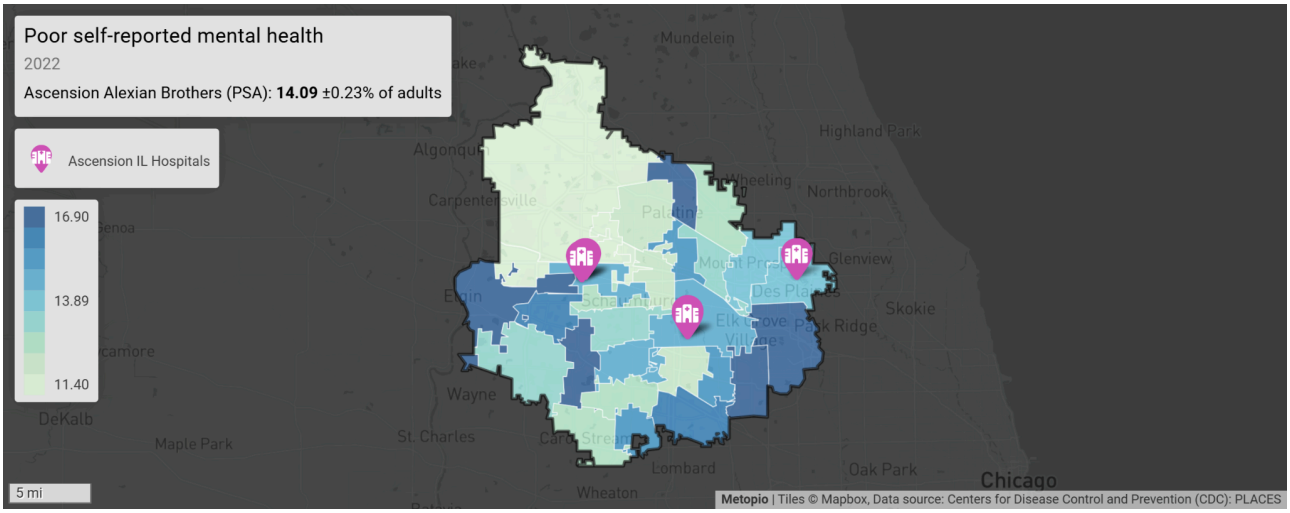
Health Status Indicators

The life expectancy is higher than the county, state, and national level. The percentage of adults with poor self-reported mental health is lower than the county, state, and national percentages. The percentage of adults with fair or poor self-reported health is lower than the county, state, and national percentages.

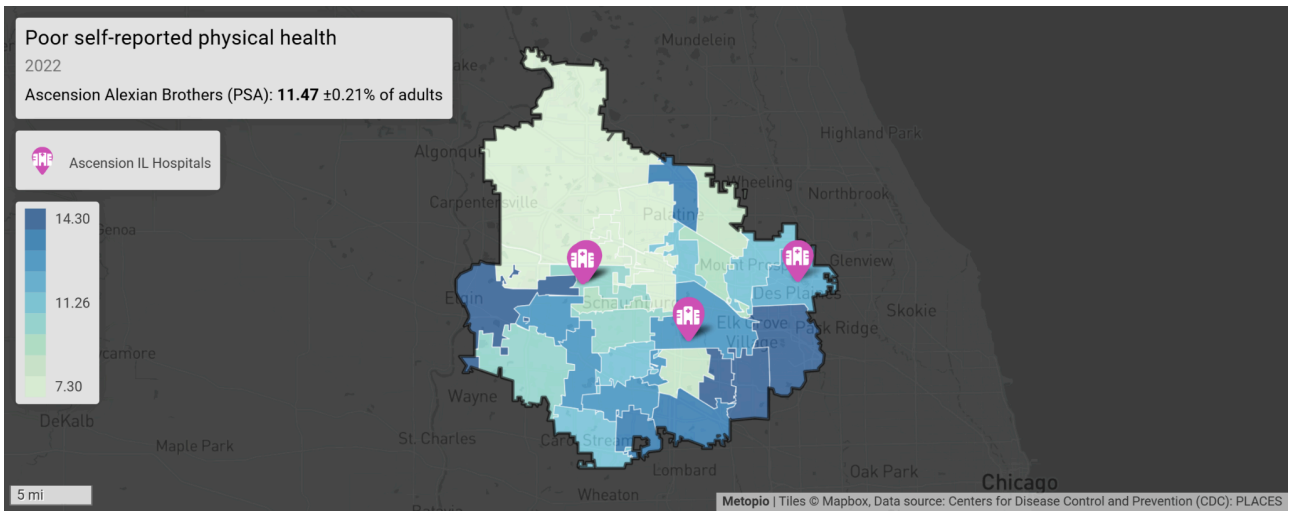
Topic	Ascension Alexian Brothers (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Life expectancy *years* 2019-2021	**80.8**	77.9	78.0	76.1	n/a
Poor self-reported mental health *% of adults* 2022	**14.09**	15.30	16.11	17.35	n/a
Poor self-reported physical health *% of adults* 2022	**11.47**	11.40	11.71	12.44	n/a
Fair or poor self-reported health *% of adults* 2022	**16.32**	17.50	17.00	17.87	n/a

Stratifications & Heat Mapping

The heat map shows the rates of percent of resident adults aged 18 and older who report 14 or more days during the past 30 days during which their mental health was not good. There are pockets of higher inequities by zip code that exist in the PSA including zip code 60120 Elgin (16.90%) and 60074 Lake Zurich (15.80%).



Similarly the heat map below shows percent of resident adults aged 18 and older who report 14 or more days during the past 30 days during which their physical health was not good, with pockets the higher inequities of in zip codes 60120 Elgin (14.30%) and 60106 Bensenville (13.50%).



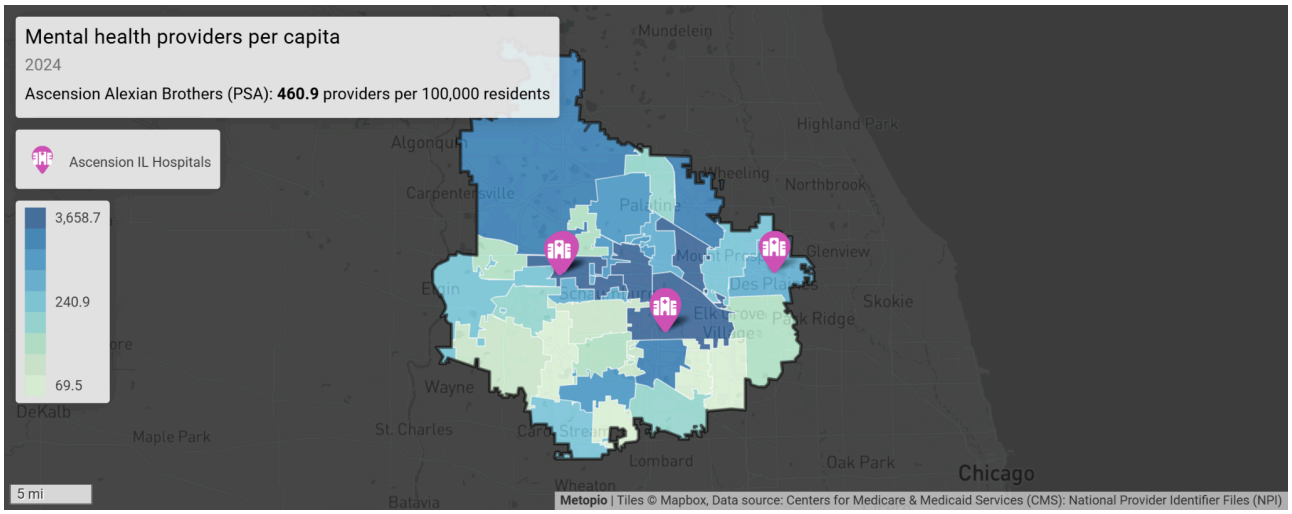
Health Access & Quality Indicators

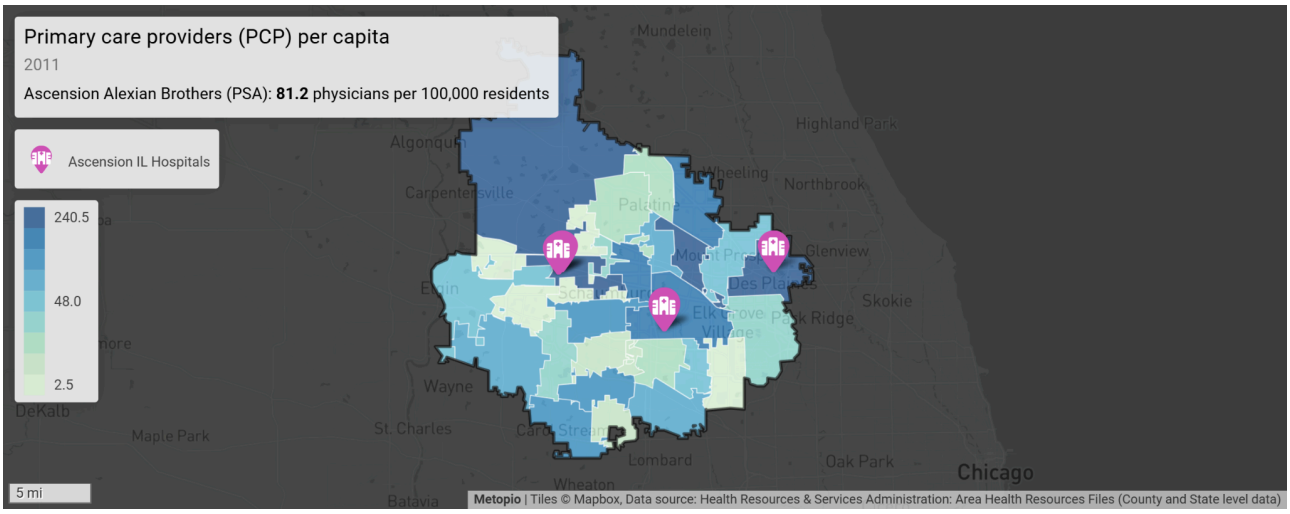
The number of dentists per capita is higher than the county, state, and national level. The amount of mental health providers and primary care providers (PCP) per capita, are both lower than the county, state, and national level. The uninsured rate is higher than the county, state, and national rate.

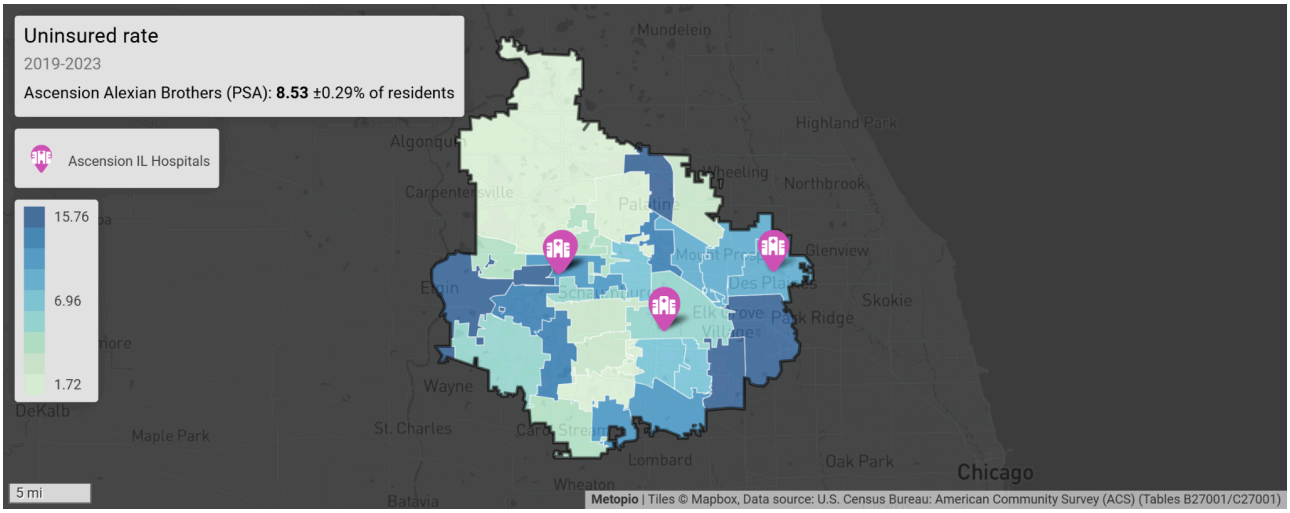
Topic	Ascension Alexian Brothers (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Dentists per capita *dentists per 100,000 residents* 2024	**157.2**	141.3	112.5	105.2	
Mental health providers per capita *providers per 100,000 residents* 2024	**460.9**	656.4	505.9	602.7	
Primary care providers (PCP) per capita *physicians per 100,000 residents* 2021	**81.2**	107.4	88.8	89.6	
Uninsured rate *% of residents* 2019-2023	**8.53**	7.79	6.16	7.93	

Stratifications & Heat Mapping

The first two heat maps show the provider rate per capita for both mental health and primary care, which are nearly identical in the darker areas with more populated access to care opportunities. The third heat map below shows the rate of residents who are uninsured, which correlates with areas that have less providers and also have higher rates of residents who are uninsured.






Uninsured rate
2019-2023
Ascension Alexian Brothers (PSA): 8.53 ±0.29% of residents
Ascension IL Hospitals
15.76
6.96
1.72
Mundelein
Highland Park
Algonquin
Wheeling
Northbrook
Carpentersville
Glenview
Elgin
Skokie
Park Ridge
Wayne
DeKalb
Maple Park
St. Charles
Lombard
Oak Park
Chicago
Wheaton
Batavia
5 mi
Metopio | Tiles © Mapbox, Data source: U.S. Census Bureau: American Community Survey (ACS) (Tables B27001/C27001)

Mortality Indicators

No PSA data available.

Topic	Ascension Alexian Brothers (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
COVID-19 mortality *deaths per 100,000* 2022	–	54.6	45.5	44.5	n/a
Drug overdose mortality *deaths per 100,000* 2022	–	41.98	29.98	32.57	20.70
Heart disease mortality *deaths per 100,000* 2022	–	202.1	166.6	167.2	n/a
Motor vehicle traffic mortality *deaths per 100,000* 2022	–	8.9	10.0	12.9	10.1
Unintentional injury mortality *deaths per 100,000* 2022	–	67.9	57.2	66.0	43.2
Cancer mortality *deaths per 100,000*	–	164.1	145.1	142.3	122.7

2022					
Suicide mortality *deaths per 100,000* 2022	–	9.8	11.7	14.0	42.6

Neighborhood & Built Environment Indicators

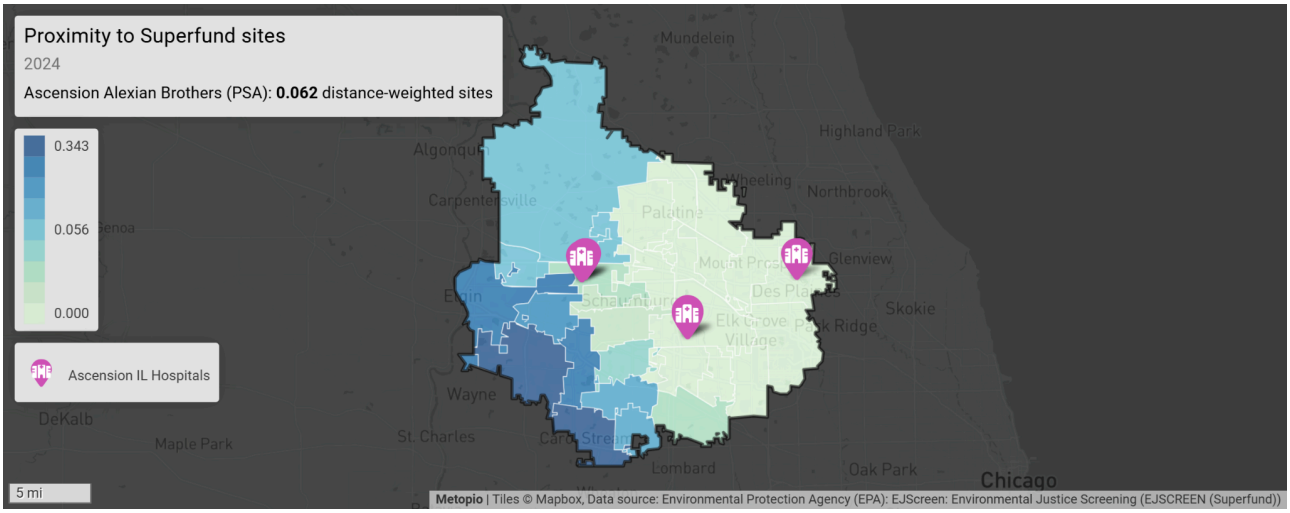
The housing cost burden is lower than the county, state, and national level. The percentage of workers (16 years or older) that take public transportation to work is exceptionally higher than the county, state, and national percentages. The percentage of households with internet access is higher than the county and state level.

Topic	Ascension Alexian Brothers (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Walkability Index 2024	10.45	13.61	10.56	9.47	n/a
Housing cost burden *% of occupied housing units* 2019-2023	**28.40**	34.44	29.37	31.86	n/a
Particulate matter (PM 2.5) concentration *µg/m3* 2020	**9.011**	9.304	8.457	6.927	n/a
Public transportation to work *% of workers 16 years and older* 2023	**2.93**	6.60	3.53	2.93	n/a
Proximity to Superfund (toxic waste) sites *distance-weighted sites*	**0.298**	0.097	0.094	0.062	n/a

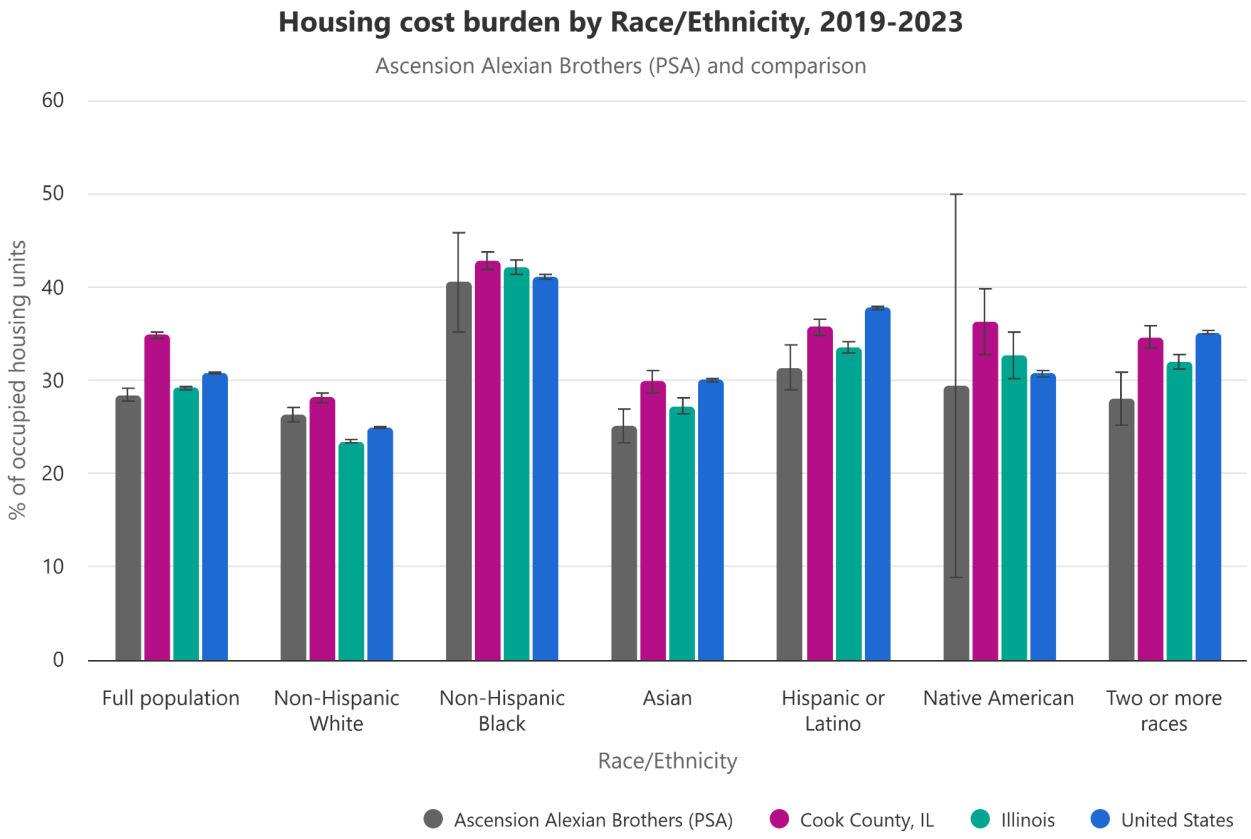
2024					
Travel time to work over one hour *% of workers* 2023	**13.10**	10.10	8.90	9.48	n/a
Drinking water non-compliance *violations* 2023	0	0	2	0	n/a
Internet access *% of households* 2023	**94.91**	94.64	94.77	95.24	n/a

Stratifications & Heat Mapping

The heat map shows the zip codes with the closest proximity to Superfund (toxic waste) sites with the hospital PSA. The western and southwestern zip codes have closer proximity to Superfund sites.



The chart below shows the housing cost burden by race/ethnicity for those residing within the hospital PSA. The population most affected by housing costs are non-Hispanic Black (40.5%).



Created on Metopio | metop.io | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Tables B25070/B25091)

Housing cost burden: Households spending more than 30% of income on housing are considered housing cost-burdened. Includes both renters (rent) and owners (mortgage and other owner costs). For renters, costs include any utilities or fees that the renter must pay, but do not include insurance or building fees.

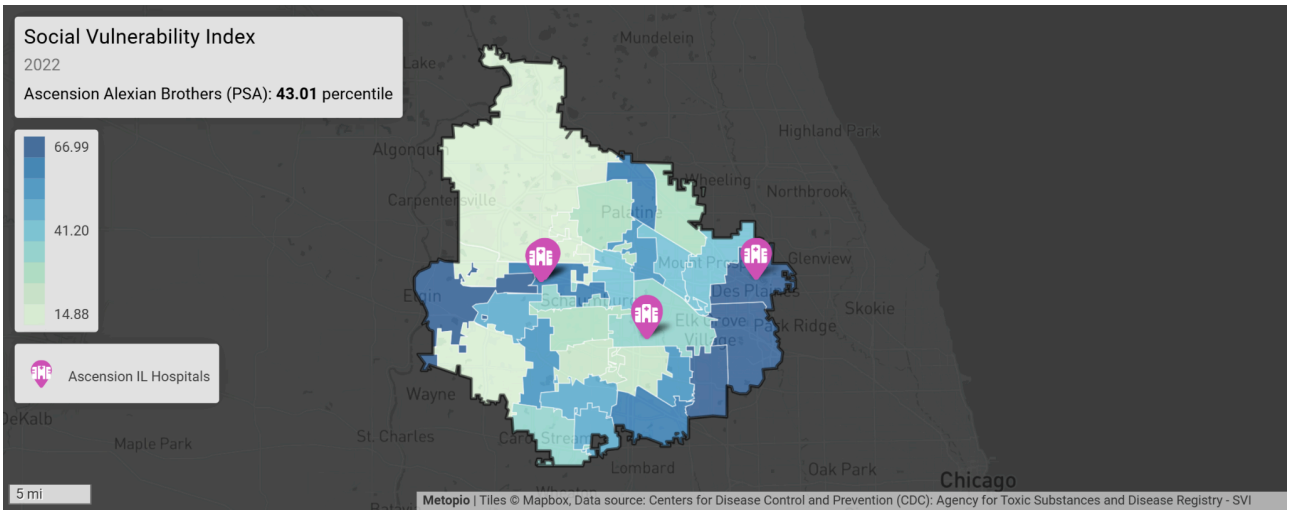
Social & Community Context Indicators

The percentage of children (0-17 years old) living with their grandparents is much lower than the county, state, and national percentages. The social vulnerability index is lower than the county, state, and national level, but geographical disparities exist.

Topic	Ascension Alexian Brothers (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Social membership associations *number per 10,000 people* 2021	--	7.12	9.72	9.09	n/a
Violent crime (cases) *crimes* 2023	--	981	203,184	4,058,660	n/a
Children living with grandparents *% of children, 0-17 yrs* 2019-2023	**5.60**	10.35	7.80	8.10	n/a
Social Vulnerability Index *percentile* 2022	**43.01**	79.64	54.97	58.40	n/a
Voter participation rate (Presidential) *% of voting-age citizens* 2020	–	57.27	61.13	63.05	n/a

Stratifications & Heat Mapping

A heat map shows the social vulnerability index (SVI) for the PSA. As a whole the PSA index is much lower in comparison to the rest of the county. However, there are pockets of greater disparity with the PSA including zip code 60120 Elgin (66.99 index) and 60106 Bensenville (66.94 index).



Systems of Power, Privilege & Oppression Indicators

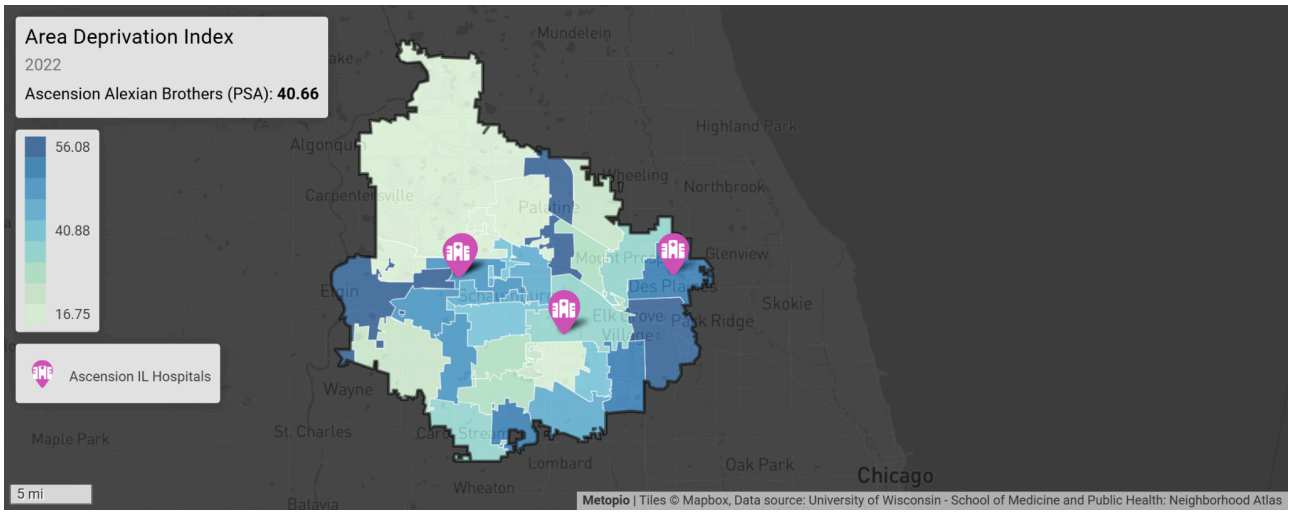
The area deprivation index is lower than the county, state, and national indexes, but geographical disparities exist. The Gini index of income inequality is lower than the county, state, and national level. The percentage of residents (16 and older) that participate in the labor force is higher than the county, state, and national percentages.

Topic	Ascension Alexian Brothers (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Area Deprivation Index 2022	**40.66**	46.12	53.70	47.50	n/a
Correctional facilities census *persons* 2020	132	6,598	61,605	2,055,412	n/a
Eviction rate *% of renter-occupied households* 2018	1.12	1.06	1.52	2.12	n/a
Gini index of income inequality 2019-2023	**0.407**	0.501	0.481	0.483	n/a
Labor force participation *% of residents 16 and older* 2019-2023	**68.66**	66.96	65.39	63.82	n/a

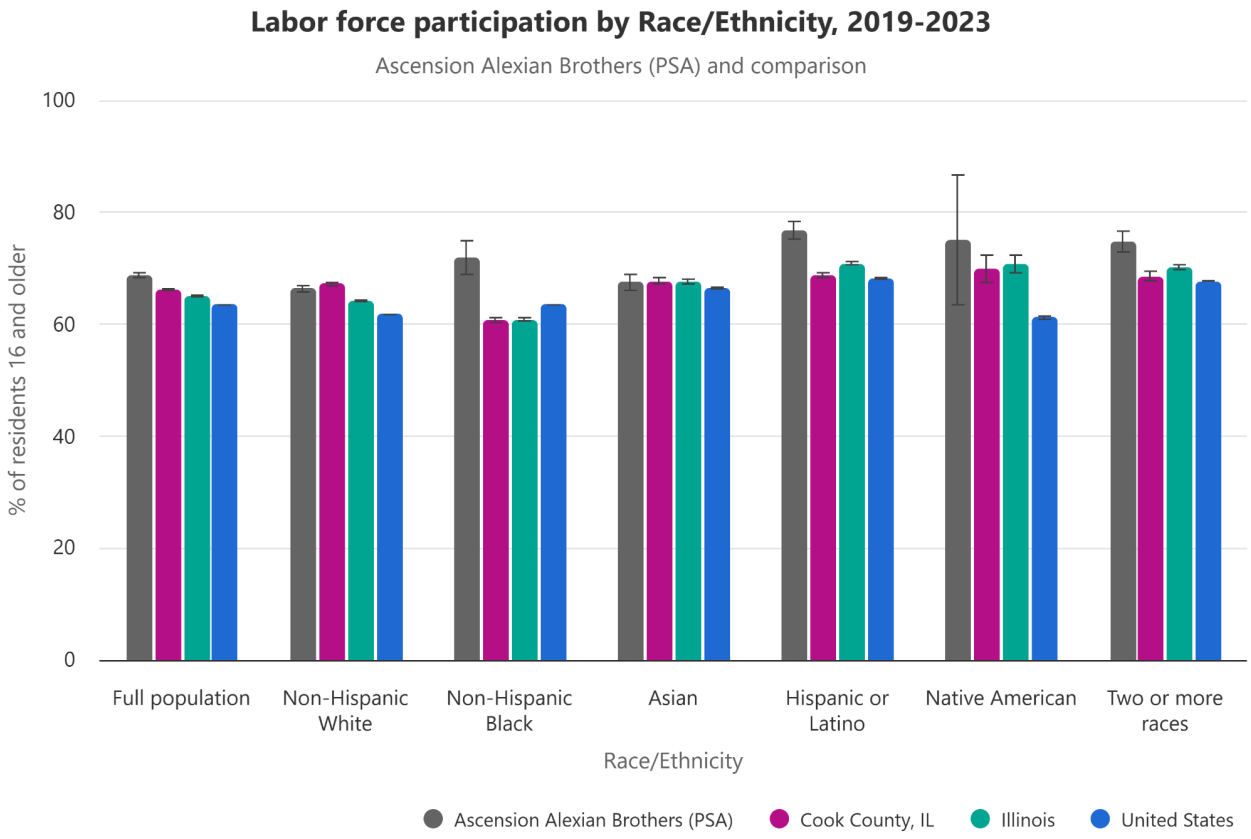
Voter participation rate (Presidential) *% of voting-age citizens* 2020		57.27	61.13	63.05	n/a

Stratifications & Heat Mapping

Similar to the social vulnerability index (SVI), the area deprivation index (ADI) for the PSA is lower in comparison to the rest of the county as well as state and national levels. The ADI is a ranking of communities by socioeconomic disadvantage. However, there are pockets of greater disparity geographically within the PSA including zip code 60120 Elgin (56.08 index) and 60018 Des Plaines (50.47 index).



A stratified chart shows the labor force participation (16 years+) by race/ethnicity for the PSA. The populations with the highest participation in the PSA Hispanic or Latino (76.8%) and Native American (75.04%).



Created on Metopio | metop.io | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Tables B23025, B23001, and C23002)
Labor force participation: Percent of residents 16 and older who are currently employed, enlisted in the armed forces, or actively seeking employment.

Sources

Data was extracted from Metopio from the following sources:

National Cancer Institute (NCI): State Cancer Profiles (WI: racial stratifications only) (Everywhere except IL), Illinois Department of Public Health (IDPH): Illinois State Cancer Registry (Calculated by Metopio) (Only in IL)

Centers for Disease Control and Prevention (CDC): PLACES (Sub-county data (zip codes, tracts)), Behavioral Risk Factor Surveillance System (BRFSS) (County and state level data)

The New York Times (based on reports from state and local health agencies), Various state health departments (COVID dashboards)

Centers for Disease Control and Prevention (CDC): PLACES, Diabetes Atlas (County and state level data)

Centers for Disease Control and Prevention (CDC): National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: Atlas Plus

State public health departments (via KIDS COUNT, https://datacenter.kidscount.org), Health Resources & Services Administration: Maternal and Child Health Bureau (MCHB) (3-year data), Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Natality (NVSS-N) (Via CDC Wonder Health Indicators Warehouse (through 2014) and via CDC Wonder (2016-2020 data averages))

Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) (Only in IL)

Diabetes Atlas (County level data), Behavioral Risk Factor Surveillance System (BRFSS) (State and US data), Centers for Disease Control and Prevention (CDC): PLACES (Sub-county data (zip codes, tracts))

Centers for Disease Control and Prevention (CDC): National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: Atlas Plus (Via http://healthindicators.gov)

Feeding America: Map the Meal Gap (Map the Meal Gap 2020)

U.S. Census Bureau: American Community Survey (ACS) (Table B25088)

U.S. Census Bureau: American Community Survey (ACS) (Table B25003)

U.S. Census Bureau: American Community Survey (ACS) (Table B19013)

US Department of Housing and Urban Development (HUD): Annual Homeless Assessment Report (AHAR)

U.S. Census Bureau: American Community Survey (ACS) (Table B17001)

US Department of Agriculture (USDA) - Economic Research Service: Food Environment Atlas (Before 2015), US Department of Agriculture (USDA) - Food and Nutrition Service: Child Nutrition Tables (After 2019)

Bureau of Labor Statistics (BLS): Local Area Unemployment Statistics

U.S. Census Bureau: American Community Survey (ACS) (Table B15002)

U.S. Census Bureau: American Community Survey (ACS) (Table B14003)

U.S. Census Bureau: American Community Survey (ACS) (Table B16002 until 2015. Table C16002 after 2015)

Centers for Disease Control and Prevention (CDC): PLACES (Sub-county data (zip codes, tracts)), Behavioral Risk Factor Surveillance System (BRFSS) (County and state level data)

Centers for Disease Control and Prevention (CDC): PLACES (Sub-county data (zip codes, tracts)), Behavioral Risk Factor Surveillance System (BRFSS) (County and state level data)

Centers for Disease Control and Prevention (CDC): PLACES (Sub-county data (zip codes, tracts)), Diabetes Atlas (County level data), Behavioral Risk Factor Surveillance System (BRFSS) (State and US data prior to 2019)

Behavioral Risk Factor Surveillance System (BRFSS) (County and state level data), Centers for Disease Control and Prevention (CDC): PLACES (Sub-county data (zip codes, tracts))

Centers for Disease Control and Prevention (CDC): PLACES (Sub-county data (zip codes, tracts) for 2014 - present), Dwyer-Lindgren, Mokdad, et al. (Population Health Metrics, 2014) (Data modeled from BRFSS for years 1996-2012), Behavioral Risk Factor Surveillance System (BRFSS) (2013 data)

U.S. Census Bureau: American Community Survey (ACS) (Table B13002)

Behavioral Risk Factor Surveillance System (BRFSS)

Centers for Disease Control and Prevention (CDC): Youth Risk Behavior Surveillance System (YRBSS)

Centers for Disease Control and Prevention (CDC): Youth Risk Behavior Surveillance System (YRBSS)

Centers for Disease Control and Prevention (CDC): National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project (USALEEP) (available until 2015) (Everywhere except WI), Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (via County Health Rankings) (county-level data)

Centers for Disease Control and Prevention (CDC): PLACES

Centers for Disease Control and Prevention (CDC): PLACES

Behavioral Risk Factor Surveillance System (BRFSS) (Pre-2017 data), Centers for Disease Control and Prevention (CDC): PLACES (2019 data), The University of Wisconsin Population Institute (2020 County Health Rankings & Roadmaps)

Health Resources & Services Administration: Area Health Resources Files (County and State level data), Centers for Medicare & Medicaid Services (CMS): National Provider Identifier Files (NPI)

Centers for Medicare & Medicaid Services (CMS): National Provider Identifier Files (NPI)

Health Resources & Services Administration: Area Health Resources Files (County and State level data)

U.S. Census Bureau: American Community Survey (ACS) (Tables B27001/C27001)

Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Natality (NVSS-N)

Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (via CDC Wonder)

Chicago Department of Public Health (Epidemiology Department: Chicago community area level) (Only in IL), Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC Wonder)

Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) (Only in IL)

Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov)

Chicago Department of Public Health (Epidemiology Department: Chicago community area level data only) (Only in IL), Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (county, state, and US data)

Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) (Only in IL)

Chicago Department of Public Health (via Chicago Health Atlas)

Centers for Disease Control and Prevention (CDC): Agency for Toxic Substances and Disease Registry - Environmental Justice Index

US Department of Agriculture (USDA) - Economic Research Service: Food Access Research Atlas

U.S. Census Bureau: American Community Survey (ACS) (Tables B25070/B25091)

Feeding America: Map the Meal Gap (Data captured via County Health Rankings), US Department of Agriculture (USDA) - Economic Research Service: Food Environment Atlas (Data captured via County Health Rankings)

Centers for Disease Control and Prevention (CDC): PLACES, Behavioral Risk Factor Surveillance System (BRFSS), U.S. Census Bureau: American Community Survey (ACS)

Environmental Protection Agency (EPA): EJScreen: Environmental Justice Screening (EJSCREEN)

U.S. Census Bureau: American Community Survey (ACS) (Table B08301)

Environmental Protection Agency (EPA): EJScreen: Environmental Justice Screening (EJSCREEN (Superfund))

Trust for Public Land: ParkScore Rankings

U.S. Census Bureau: American Community Survey (ACS) (Table S0801)

Environmental Protection Agency (EPA): EJScreen: Environmental Justice Screening

U.S. Census Bureau: American Community Survey (ACS) (Table B28002)

County Health Rankings

Chicago Police Department: Chicago crime data portal (Data within Chicago) (Only in IL), Federal Bureau of Investigation: FBI Crime Data Explorer (County, state, and city level data)

U.S. Census Bureau: American Community Survey (ACS) (Table B10002)

Centers for Disease Control and Prevention (CDC): Agency for Toxic Substances and Disease Registry - SVI Data

Assorted election data sources compiled by Tony McGovern, U.S. Census Bureau: American Community Survey (ACS) (Table B05003)

University of Wisconsin - School of Medicine and Public Health: Neighborhood Atlas

U.S. Census Bureau: Decennial Census (SF1 P42)

The Eviction Lab at Princeton University: Estimating Eviction Prevalence across the United States, Cook County Sheriff's Office of Research (Monthly data in Chicago)

U.S. Census Bureau: American Community Survey (ACS) (Table B19083)

U.S. Census Bureau: American Community Survey (ACS) (Tables B23025, B23001, and C23002)

County Health Rankings

Appendix E: Health Care Facilities and Community Resources

As part of the CHNA process, Ascension Alexian Brothers has cataloged resources available in the hospital community that respond to the significant needs identified in this CHNA. Resources may include acute care facilities (hospitals), primary and specialty care clinics and practices, mental health providers, and other non-profit services. State and national resources can also provide information regarding programs that can better serve the needs of a person experiencing a specific problem.

The resources listed under each significant need heading are not intended to be exhaustive.

Chronic Disease

Organization	Phone	Website
Ascension Alexian Brothers Community Health	N/A	www.healthcare.ascension.org
Ascension Medical Group Illinois Primary Care Hoffman Estates	847.882.2400	www.healthcare.ascension.org
Ascension Medical Group Illinois Primary Care Elk Grove Village	847.981.3500	www.healthcare.ascension.org
Ascension Medical Group Illinois Primary Care Schaumburg	847.985.9390	www.healthcare.ascension.org
Ascension Medical Group Illinois Diabetes Care Elk Grove	224.273.5148	www.healthcare.ascension.org
Ascension Medical Group Illinois Heart & Vascular	847.981.3680 or 847.427.7262	www.healthcare.ascension.org
Ascension Pharmacotherapy Clinics		www.healthcare.ascension.org
Hoffman Estates Park District	847.885.7500	www.heparks.org
Schaumburg Park District	847.985.2115	www.parkfun.com
Village of Schaumburg	847.895.4500	www.villageofschaumburg.com
Village of Elk Grove Township	847.437.0300	www.elkgrovetownship.com
Village of Hoffman Estates	847.882.9100	www.hoffmanestates.org

Mental Health & Substance Use Support

Organization	Phone	Website
Ascension Alexian Brothers Behavioral Health Hospital	800.432.5005	www.healthcare.ascension.org
Ascension Illinois-Foglia Family Foundation Residential Treatment Center	855.383.2224	www.healthcare.ascension.org
Ascension Illinois Center for Mental Health Arlington Heights	847.952.7460	www.healthcare.ascension.org
Gateway Foundation	877.326.3133	www.gatewayfoundation.org
Kenneth Young Center - Elk Grove Village	847.524.8800	www.kennethyoung.org
NAMI Schaumburg	847.431.8745	www.namischaumburgarea.org
National Hispanic Suicide Prevention Network	224.248.6956	www.nhspn.org

Healthcare Access & Affordability

Organization	Phone	Website
Advocatia	312.584.1212	www.coverage.312Help.com
Neighborhood Resource Illinois	N/A	www.neighborhoodresourceceil.org
Ascension Medical Group Illinois Primary Care Hoffman Estates	847.882.2400	www.healthcare.ascension.org
Ascension Medical Group Illinois Primary Care Elk Grove Village	847.981.3500	www.healthcare.ascension.org
Ascension Medical Group Illinois Primary Care Schaumburg	847.985.9390	www.healthcare.ascension.org
Greater Family Health - Palatine	844.599.3700	www.greaterfamilyhealth.org
Greater Family Health - Streamwood	844.599.3700	www.greaterfamilyhealth.org
Greater Family Health - Hanover Park	844.599.3700	www.greaterfamilyhealth.org

Social Determinants of Health (food Insecurity, housing, transportation)

Organization	Phone	Website
Greater Chicago Food Depository	773.247.3663	www.chicagosfoodbank.org
Christus Victor Lutheran Church Food Pantry	847.437.2666	www.cvlutheran.org
Elk Grove Township Food Pantry	224.265.611	www.elkgrovetownship.com
Palatine Township Food Pantry	847.358.6700	www.palatinetownship-il.gov
Schaumburg Township Food Pantry	847.884.0030	www.schaumburgtownship.org
Neighborhood Resource Illinois	N/A	www.neighborhoodresourceceil.org
Fellowship Housing	847.882.2511	www.fhcmoms.org
Little Sisters of the Poor St. Joseph Home for the Elderly	847.358.5700	www.littlesistersofthepoorpalatine.org
Lyft Concierge Services	N/A	www.lyft.com

Appendix F: Evaluation of Impact from the Previous CHNA Implementation Strategy

Ascension Alexian Brothers' previous CHNA implementation strategy was completed in October 2022 and responded to the following priority health needs:

- Food Access & Food Insecurity
- Transportation
- Housing
- Resources, Referrals, Coordination, and Connection to Community-Based Services
- Timely Linkage to Quality Care
- Workforce Development
- Maternal & Child Health
- Mental Health
- Substance Use Disorders
- Chronic Conditions

The tables below describe the actions taken during the tax year 2021 CHNA implementation strategy cycle to respond to each priority need.

Highlights from **Ascension Alexian Brother's** previous implementation strategy include:

- 69,915 pounds of food provided to the community through programs and partnerships
- 2,045 rides provided for individuals identified as needing transportation assistance
- 524 individuals provided with housing assistance through programs and partnerships
- 16,951 preceptor hours provided for college students
- 1,055 referrals were made from Ascension's Neighborhood Resource Directory
- 1,371 individuals were provided with Public Health Insurance Assistance enrollment services
- 1,817 counseling sessions for youth were provided by supporting local partnerships
- 62% of individuals that screened positive for substance used disorders agreed to receive treatment through Warm Handoff program services

Note: At the time of the report publication, the third year of the cycle will not be complete. The hospital will accommodate for that variable; results from the last year of this cycle will be reported and attached to the 2024 IRS Form 990/Schedule H.

Social and Structural Determinants of Health: Food Access Assistance

Action(s) taken	Status of action(s)	Results
Produce Mobile Increase food access assistance for food insecure individuals for Ascension Alexian Brothers community residents.	**Completed**	**Process Measures:** • **Total Individuals Served:** 3,450 • **Total Number of Meals Provided:** 58,866 • **Total Pounds of Food Provided:** 64,455 • **Total Produce Mobile Events:**34
Micro Pantry Increase food access assistance for food insecure individuals for Ascension Alexian Brothers community residents.	**Completed**	**Process Measures:** • **Total Pounds of Food Provided**: 5,460 • **Total Meals Provided**: 4,550
Local Food Pantry Support and Partnerships Increase food access assistance for food insecure individuals for Ascension Alexian Brothers community residents.	**Completed**	**Process Measures:** • **Total Cash Donations:** $23,500 • **Total Partnerships:** 34 • **Total Food Pantry Support Volunteer Hours**: 81

Social and Structural Determinants of Health: Transportation Assistance

Action(s) taken	Status of action(s)	Results

Lyft and Uber Concierge Services
Provide transportation services for patients and community residents
	Completed	**Process Measures:**
		• **Total Number of Persons Screened for Transportation Needs**: 2,045+
		• **Total Number of Rides Provided:** 2,045
		  ○ Lyft Concierge: 1,447
		  ○ Uber Concierge: 598

Social and Structural Determinants of Health: Housing Assistance

Action(s) taken	Status of action(s)	Results
Local Housing Assistance Support and Partnerships Provide support to transitional housing community based organizations.	**Completed**	**Process Measures:** • **Total Cash Donations:** $70K • **Total Individuals Served:** 524 • T**otal Number of Families Served:** 131

Access to Community Resources

Action(s) taken	Status of action(s)	Results
Ascension Neighborhood Resource Directory Increase access to community resources and community-based services for the Ascension Alexian Brothers community.	**Completed**	**Process Measures:** • **Total Searches:** 1,005

Public Health Insurance Coverage Enrollment Services

Action(s) taken	Status of action(s)	Results

Public Health Insurance Assistance Enrollment Services
Provide public health insurance coverage enrollment services.
	Completed	**Process Measures:**
		• **Total Number of Individuals Provided with Public Health Insurance Coverage Enrollment Services:** 1,371
		• **Total Applicants:** 48
		  ○ Medicaid:45
		  ○ SNAP: 14

Workforce Development

Action(s) taken	Status of action(s)	Results

College Student Practicums/Internships/Clinical Rotations
Provide Opportunities for Students to engage with health care professionals
	Completed	**Process Measures:**
		• **Total Number of Students Served**: 1,466
		  ○ Nursing: 1,398
		  ○ Other: 68
		• **Total Preceptor Hours:** 16,951.33
		  ○ Nursing: 14,631.13
		  ○ Other: 2,119.40

Prevention and Treatment of Priority Health Conditions: Mental Health (Mental & Behavioral Health)

Action(s) taken	Status of action(s)	Results
Mental Health Services Partnership Kenneth Young Center Provide access to mental health services for youth	**Completed**	**Process Measures:** • **Total Number of Individuals Served:** 549 • **Total Number of Sessions Offered:** 1,815
Mental Health First Aid Trainings Provide mental health first aid trainings to the community	**Completed**	**Process Measures:** • **Total Number of Individuals Trained:** 29 • **Total Number of Community Partners Trained:** 44

Prevention and Treatment of Priority Health Conditions: Substance Use Disorders (Mental & Behavioral Health)

Action(s) taken	Status of action(s)	Results
Warm Handoff Program Provide a warm hand-off program for patients in need of access to Substance Use Disorder (SUD) treatment.	**Completed**	**Process Measures:** • **Total Number of SUD Screenings:** 639 • **Total Number of Individuals that Accepted Referral:** 126 (20%) • **Total Number of Individuals that Kept Appointment:** 78 (62%)

Chronic Condition Screening, Education and Awareness

Action(s) taken	Status of action(s)	Results
Community Wellness Program Provide access to health screening services and health education for Ascension Alexian Brothers community residents.	**Completed**	**Process Measures:** • **Total Number of Health Education Occurrences:** 9,226 • **Total Number of Community Health Screenings:** 703