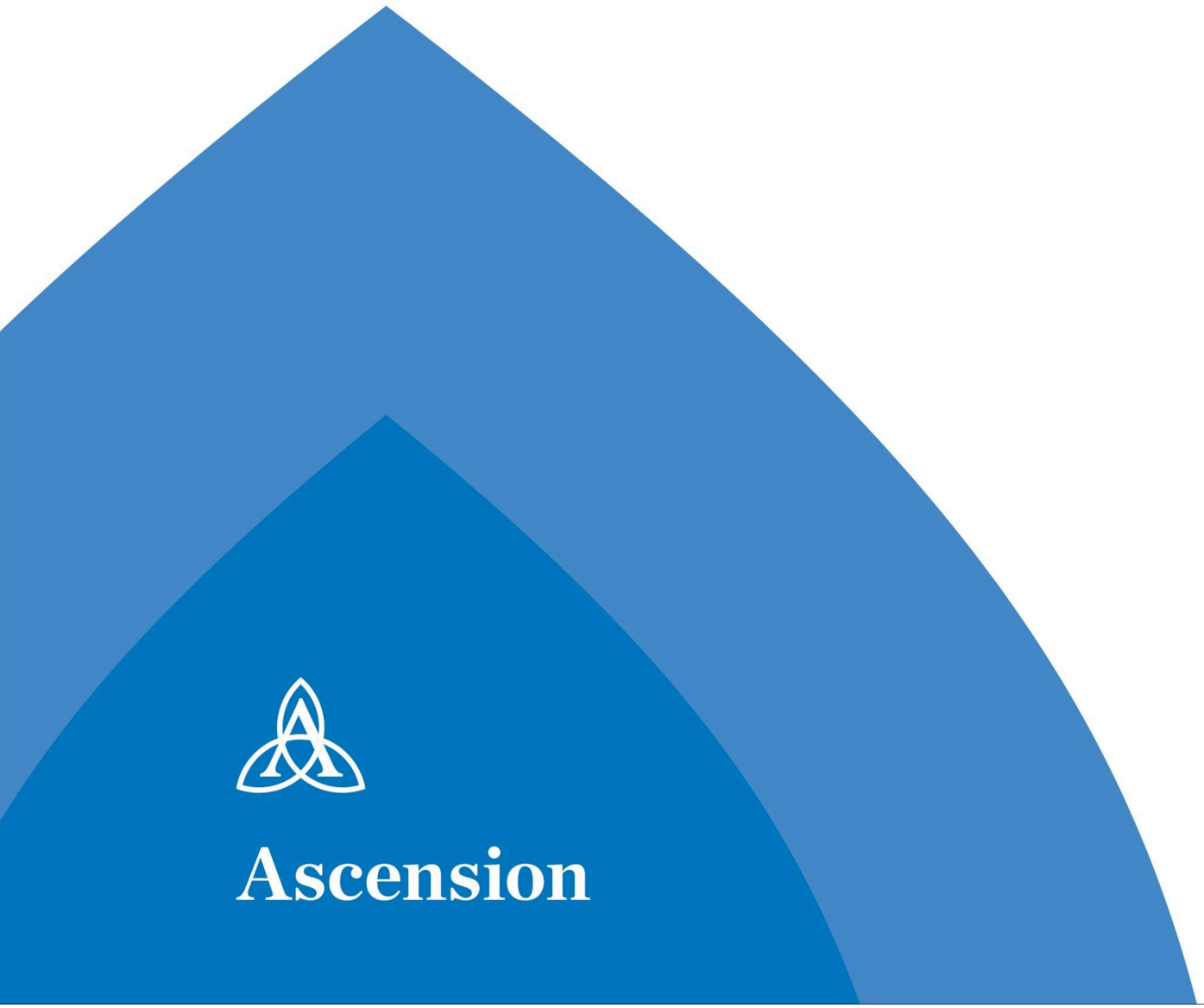
Ascension Saint Alexius

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

June 30, 2025



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.

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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.

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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 Saint Alexius 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 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

Saint Alexis community consists of Hoffman Estates 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, Saint Alexius 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 Saint Alexius 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 Saint Alexius used a phased prioritization approach to determine the most crucial needs for community stakeholders to address. The significant needs are as follows:

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

Next Steps and Conclusion

Following development and deep review of the CHNA, Ascension Saint Alexius 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.

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

Ascension Saint Alexius 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 Saint Alexius

As a Ministry of the Catholic Church, Ascension Saint Alexius is a non-profit hospital that provides medical care to the Village of Hoffman Estates and the surrounding communities. Serving Illinois since 1979, Ascension Saint Alexius 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.

Saint Alexius includes the Women & Children's Hospital on its Hoffman Estates campus as well as 24/7 level II trauma emergency care, advanced surgical care including heart, vascular and orthopedics.

For more information about Ascension Saint Alexius, visit:
https://healthcare.ascension.org/locations/illinois/ilchi/hoffman-estates-ascension-saint-alexius

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 Saint Alexius' 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.

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[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

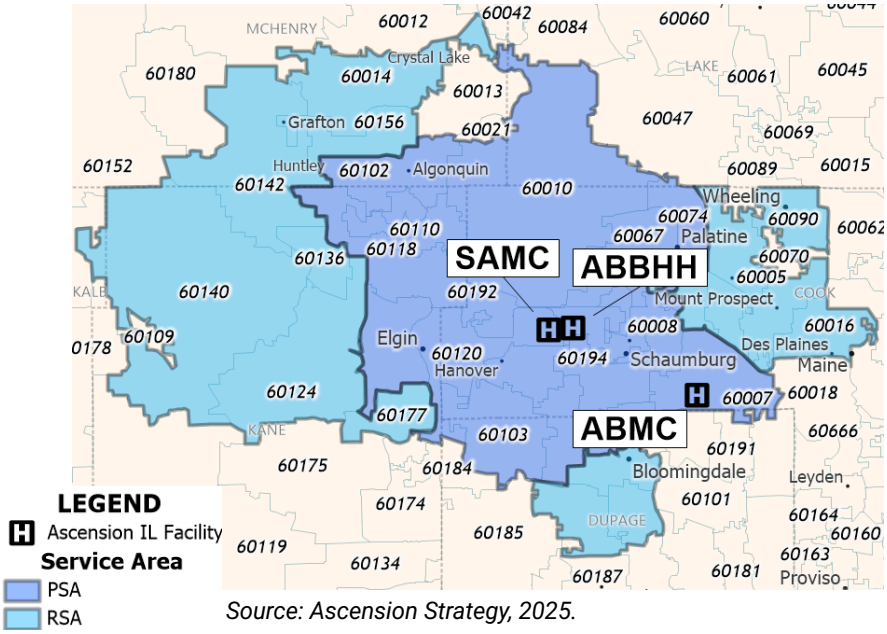
IRS 501(r)(3) and Form 990 Schedule H Compliance

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 Saint Alexius' administration office.

Community Served and Demographics

Community Served

For the purpose of the tax 2024 CHNA, Ascension Saint Alexius has defined its community served Hoffman Estates 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:

- 26.3 percent are Hispanic or Latino (any race) within the PSA, which is similar to the rest of the county (26.6%)
- The median household income is significantly higher in the PSA ($106,146) than 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 is much lower in the PSA (7.81%) compared to the county and state (13.29% percent for Cook County; 11.63% percent for Illinois)

- The uninsured rate for the PSA (8.17%) is less than Cook County and similar to the state (10% percent for Cook County; 8% percent for Illinois)

Demographic Highlights				
Population				
Indicator	**Hospital PSA**	**Cook County**	**Illinois**	**Description**
Percentage living in rural communities	0.79%	0.1%	13.1%	N/A
Percentage below 18 years of age	23.6%	20.9%	21.6%	N/A
Percentage 65 years of age and over	15.3%	16.2%	17.2%	N/A
Percentage Asian	13.3%	8.3%	6.3%	N/A
Percentage Hispanic	26.3%	26.6%	18.3%	N/A
Percentage non-Hispanic Black	4.3%	22.7%	14.1%	N/A
Percentage non-Hispanic White	53.2%	41.1%	59.5%	N/A
Social and Community Context				
English proficiency households	6.91%	6.68%	4.24%	Proportion of households who speak English “less than well”
Median household income	$106,146	$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	7.81%	13%	12%	Percentage of people in poverty
Percentage of uninsured	8.17%	8%	6%	Percentage of population under age 65 without health insurance
Percentage of unemployment	4.55%	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 46).

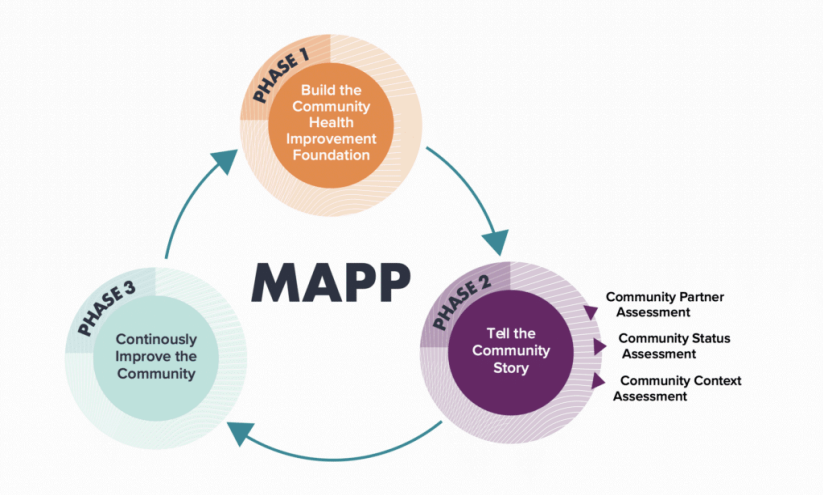
Process and Methods Used

Collaborators

Ascension Saint Alexius 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 Saint Alexius' 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. Four hundred sixty four 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

- A total of 464 respondents participated, with racial and ethnic representation closely aligning with the primary service area.
- 14.2% of respondents were 65+ years old, ensuring senior representation.
- LGBTQ+ representation was slightly above the Illinois state average.
- 91.7% of respondents had at least a high school diploma, and 80% had some higher education.
- 21.4% of respondents earned less than $40K annually, reflecting good representation of lower-income households.
- 12.3% of households spoke a language other than English at home, with Spanish being the most common non-English language (20.5%).
- Health Insurance: 4.7% of respondents were uninsured (lower than Cook County's 10% uninsured rate).
- Self-Reported Health: 79.3% rated themselves as healthy or very healthy; however, Hispanic/Latino respondents reported slightly lower health ratings.

Top Health Concerns

1. Age-related illnesses (44.2%) - Concerns included access to affordable home care, respite services, and specialized support for conditions like Alzheimer's and arthritis.
2. Diabetes (35.1%) - Respondents noted difficulty accessing healthy food options, a lack of weight management programs, and insufficient diabetes education resources.
3. Mental health (33.0%) - Highlighted issues included stress, depression, social media effects, and limited access to culturally competent mental health professionals.
4. Cancers (28.2%) - Respondents emphasized the need for earlier screenings, better oncology services, and more educational programs.
5. Heart disease/stroke (26.9%) - Barriers included lack of preventive education, limited access to screenings, and difficulties affording heart-related medications.

Barriers to Healthcare Access

- Access to Healthcare:
    - Lack of Access (61%) - Major concerns included long wait times for specialist appointments, high costs, and difficulties navigating insurance benefits.
    - Access to mental health services (42%) - Respondents requested more bilingual providers, school-based counseling, and affordable therapy options.
    - Access to community services (41%) - Many emphasized the need for wellness programs, transportation support, and better outreach about existing services.
    - Missed Appointments: 11.8% postponed medical visits due to lack of time (26.9%), cost (18.3%), and work/school conflicts (13.8%).
    - Financial Barriers: High costs for vision insurance, weight-loss drugs, and adult disability services were commonly cited issues.
    - Health Literacy: Respondents expressed difficulty understanding insurance coverage and available benefits.
- Mental Health:
    - 7.8% rated their mental health as poor, and 28.5% rated it as fair or below.
    - Stress and anxiety were common, with financial strain and social media cited as major contributors.
    - A lack of bilingual and culturally competent mental health providers was identified as a key gap.

Social & Community Issues Impacting Health

- Access to healthy food (33%) - High costs of fresh food and inconvenient food pantry hours were primary concerns.

- Affordable housing (21%) - Many cited rising rent costs and a lack of low-income housing options as major stressors affecting overall health.
- Children & Teens:
    - Social Media (40.3%) - Concerns over cyberbullying, misinformation, and excessive screen time impacting mental well-being.
    - Stress (37.1%) - Many youth face academic pressures and household financial instability.
    - Depression (31.3%) - Respondents cited an increased need for school-based mental health support.
    - Bullying (28.4%) - Both in-person and cyberbullying were identified as growing concerns.
    - Vaping/tobacco use (20.0%) - The rise of vaping among teens was seen as a significant health risk.

Open Comments Highlights:

- Access to Care: Long waitlists for adult disability services (average wait of 50 months), need for more home-care options, and more affordable medical services.
- Mental Health: Need for culturally competent mental health professionals, especially for Latino populations, and concerns over the negative impact of social media.
- Health & Wellness: Requests for senior programs, weight-loss programs, affordable exercise options, and holistic health approaches.
- Food Access: High costs of healthy food and inconvenient pantry hours.
- Community Services: Requests for more housing, childcare, transportation, and financial education programs.

Community Recommendations

- **Expand Healthcare Access & Affordability**
    - Increase financial assistance for medical services and prescription medications.
    - Improve insurance literacy programs to help residents navigate healthcare benefits.
- **Strengthen Mental Health Services**
    - Increase availability of bilingual and culturally competent providers.
    - Expand youth mental health programs to address social media and stress-related issues.
- **Improve Health & Wellness Initiatives**
    - Increase funding for senior wellness programs and affordable fitness options.
    - Promote preventive care through screenings and health education.
- **Enhance Food Security & Community Services**
    - Adjust food pantry hours for working families and improve access to fresh food.
    - Increase funding for affordable housing, childcare, and public transportation.

- **Improve Communication & Outreach**
    - Enhance community awareness of available services through multilingual outreach efforts.
    - Provide clear, accessible information about hospital resources and specialty care availability.

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. Nine 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

- Community Resources: Residents recognize the availability of community resources, particularly through Partners for Our Communities, though access can be limited by eligibility requirements.
- Food Assistance: Many participants acknowledged the effectiveness of local food pantries, churches, and schools in providing food support.
- Healthcare Access: Participants appreciated the quality of doctors and hospitals, particularly for maternal care and surgeries.

Community Challenges

- Healthcare Coverage & Affordability:
    - High insurance costs limit access to medical services.
    - Many residents struggle to afford necessary medications and dental care.
    - Eligibility for healthcare assistance remains unclear to many.
- Transportation Support:
    - Public transportation options are limited.
    - Car ownership is expensive, creating mobility challenges.
- Workforce Development:
    - Limited job opportunities for undocumented individuals.
    - Wage increases have not kept pace with the rising cost of living.

Health & Social Needs Identified

- Healthcare Gaps:

  - Dental and vision care remain unaffordable.
  - Continued need for mental health services.
  - Diabetes management and prevention efforts.
- Lacking Community Services:
  - Support for individuals with special needs.
  - Affordable childcare and after-school programs.
  - Playgrounds and affordable sports programs for children.

Disproportionately Affected Populations Identified

- Immigrants/undocumented individuals
- Youth and seniors

Actionable Recommendations

- **Expand Healthcare Access & Affordability**
  - Advocate for expanded insurance options and clearer communication about eligibility.
  - Develop a program to subsidize medication and dental care for low-income residents.
- **Improve Transportation Solutions**
  - Explore subsidized public transit passes for low-income individuals.
  - Enhance community ride-share or shuttle programs.
- **Strengthen Workforce Development Initiatives**
  - Provide job training and employment support, especially for undocumented individuals.
  - Advocate for fair wages and affordable living solutions.
- **Enhance Community Support Services**
  - Increase funding for affordable childcare and after-school programs.
  - Develop outreach programs for seniors needing food and healthcare assistance.
  - Expand mental health services, particularly for Spanish-speaking individuals.
- **Improve Communication & Awareness of Available Resources**
  - Create a centralized, multilingual resource directory for healthcare, job training, and food assistance.
  - Organize workshops to educate residents on navigating insurance and healthcare systems.

Community Partner Assessment

An online survey was completed between November 2024-February 2025 by thirteen community partners representing a range of organizations, including 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 Process**: 46.1% of organizations reported participation in a community health improvement process, suggesting there is room for greater engagement in coordinated health efforts.
2. **Demographics and Health Needs**: Community partners serve diverse populations, with a significant representation of Black/African American (84.6%), Latinx/Hispanic (84.6%), White/Caucasian (76.9%), Asian/Asian American (61.5%), and Native American/Indigenous/Alaska Native (46.1%) groups. Health concerns such as food insecurity, mental health issues (anxiety, depression, and stress), diabetes, obesity, chronic diseases, and domestic violence-related traumatic brain injuries were cited as key priorities.
3. **Community Strengths and Weaknesses**: Respondents noted strengths such as community collaboration, diversity, and the availability of basic services and resources. However, the community faces critical weaknesses, including limited access to affordable care, housing insecurity, and economic disparities.
4. **Health and Social Issues**: The most pressing health issues identified include food insecurity, mental health challenges, chronic diseases, and access to social determinants of health (SDOH) programs. Major social issues include unemployment, housing instability, discrimination (racism and sexism), limited healthcare access, poverty, and transportation challenges. The populations most affected by these issues include the Latinx/Hispanic, migrant/immigrant, and Black/African American communities, as well as older adults, children, and individuals with disabilities.
5. **Barriers to Access**: Economic constraints, limited healthcare services, and cultural/language barriers were the main obstacles to healthcare access. Lack of education and inadequate insurance coverage also present significant challenges to accessing care.
6. **Service Gaps**: Key health service gaps identified include mental health services, affordable and preventative care, dental and vision services, health education, outreach for non-English-speaking communities, and primary care for uninsured individuals. Respondents also emphasized the need for more flexible appointment scheduling and senior services.
7. **Policy and Resource Recommendations**: Community partners called for policies to improve access to services, address social determinants of health, expand Medicaid coverage, enhance mental health services, and improve transportation. Additionally, respondents advocated for policies supporting immigrant populations and the expansion of preventative care programs.
8. **Role of Hospitals**: Hospitals were seen as key players in reducing health disparities. They could support the community by screening for food insecurity, providing mental health screenings, offering educational workshops, providing cultural competency training for staff, and partnering with local organizations to enhance social services. Hospitals should also focus on supporting

research into diseases like Alzheimer's and leveraging hospital staff for community engagement.

9. **Health Service Access**: Individuals primarily seek health services at local hospitals and clinics (76.9%), immediate care/walk-in clinics (69.2%), and emergency departments (61.5%).
10. **Collaboration and Initiatives**: Organizations collaborate through events, educational workshops, community health fairs, mental health training, free screenings, and flu shot campaigns. Successful initiatives include Rx Mobile Market, food pantries, Dementia committees, Narcan training, back-to-school events, and digital outreach programs.
11. **Effective Communication Channels**: SMS text messaging, social media, flyers, and in-person communication were identified as the most effective methods for reaching the community. Direct mail, word of mouth, and active communication with schools also play a role in community outreach.
12. **Community Engagement**: Most respondents (84.6%) rated community engagement as moderate, with some reporting high (23%) and low (7.6%) engagement levels.
13. **Vision for Ideal Collaboration**: Respondents envisioned an ideal partnership involving continued funding, leveraging hospital staff and facilities, student contributions, workforce development, and mutual benefits. They also emphasized the importance of sustaining programs such as GiGiFIT and expanding food insecurity screenings.

To view community input data in its entirety, see Appendix C (Page 49).

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 Saint Alexius 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. Mental Health and Access to Care
    - The mental health provider rate is lower than county and national averages, indicating limited access to services.
    - Self-reported poor mental health days are highest in Elgin (60120, 60123), Carpentersville (60110), and Palatine (60074).
2. High Rates of Chronic Diseases
    - Diabetes and obesity rates are consistent with county and state averages but show pockets of concern in areas like Elgin (60120, 60123).
    - Cancer diagnosis rates are slightly lower than county and state levels but remain a significant health burden.
3. Limited Preventive Health Screenings
    - Colorectal cancer and mammogram screening rates are below Healthy People 2030 targets.
    - The teen birth rate (13.47 per 1,000) exceeds county, state, and national averages, with the highest rates in Streamwood (60107).

Top Three Community Concerns

1. Economic Disparities and Food Insecurity
    - While the median household income is higher than county and state averages, pockets of food insecurity and poverty persist.
    - The highest food insecurity rates are in Elgin (60120 – 13.1%), Palatine (60074 – 12.8%), and Hanover Park (60133 – 12.2%).
2. Language Barriers and Education Challenges
    - 6.91% of households have limited English proficiency, exceeding state and national averages.
    - The highest concentrations are in Palatine (60074 – 14.28%) and Schaumburg (60173 – 12%), impacting healthcare access and communication.
3. Infrastructure and Housing Cost Burden
    - Public transportation use is low, at 2.26%, limiting access to employment and healthcare.

- Housing costs disproportionately affect non-Hispanic Black (35.67%) and Hispanic (32.43%) populations, creating economic strain.
- Public transportation use (23.01%) is higher than county and state levels, highlighting reliance on transit for 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 52).

Written Comments on Previous CHNA and Implementation Strategy

Ascension Saint Alexius' 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:

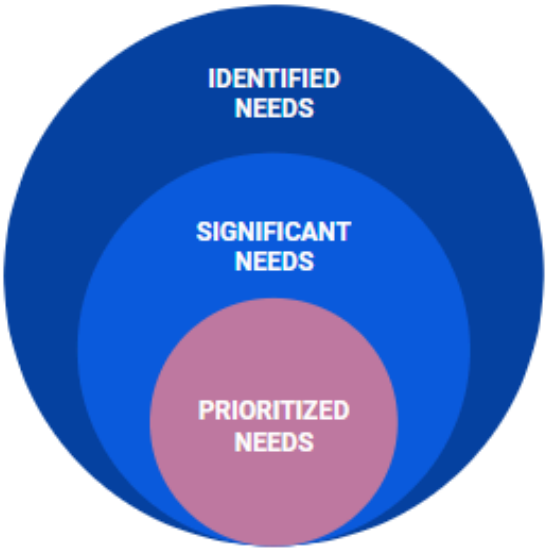
- No acute community concerns impacted ability to conduct CHNA

Despite the data limitations, Saint Alexius 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 Saint Alexius 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 Saint Alexius 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 Saint Alexius 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 Saint Alexius synthesized and analyzed the data to determine which of the identified needs were most significant. Ascension has defined **significant needs** as the

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

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:

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

To view healthcare facilities and community resources available to respond to the significant needs, please see Appendix E (Page 85).

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

Healthcare Access & Affordability

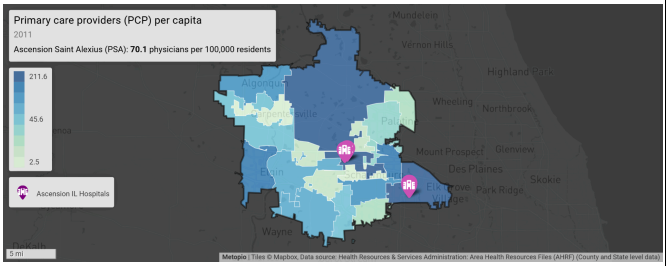
Significance	Populations Most Impacted
Individuals in the community face major barriers in obtaining necessary medical care including lack of affordable medical care (including dental and vision) and medications, difficulties navigating insurance, and long wait times for specialists. *Source: U.S. Census Bureau, American Community Survey, 2023. Community Context Assessment (CSA) Saint Alexius/ABBHH, 2025. Cook County Community Input Survey Data Analysis LEP, 2025.*	• Residents in Elgin (60120, 60123) and Palatine (60074) • Uninsured or underinsured residents • Low-income individuals unable to afford out-of-pocket healthcare costs • Seniors with limited Medicare coverage, especially for specialist care • Immigrant and undocumented populations • Persons with disabilities • Limited English proficiency households

Community Input Highlights

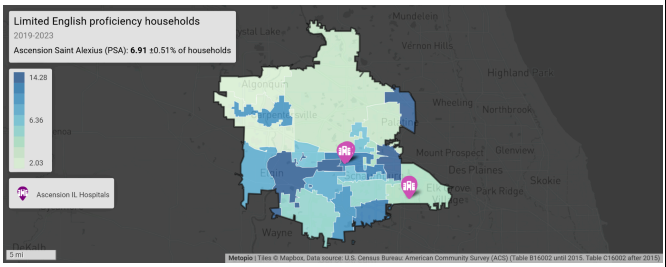
- 61% of community survey respondents cited lack of access to care as a major issue that includes concerns for long wait times for specialist appointments, high costs, and difficulties navigating insurance benefits
- 11.8% of survey respondents postponed medical visits due to lack of time (26.9%), cost (18.3%), and work/school conflicts (13.8%)
- Survey respondents said long wait lists for services, especially for adult disability services, is a barrier
- Respondents expressed difficulty understanding insurance coverage and available benefits
- Community partners noted barriers such as economic constraints, limited healthcare services, and cultural/language challenges for individuals in the community
- Community partners said hospitals play a critical role in bridging gaps in healthcare access and reducing health disparities including advocating for expanded insurance options
- Focus group participants said high insurance costs limit access to medical services including necessary medications and dental services, while many are unclear about their eligibility for healthcare coverage

Secondary Data Highlights

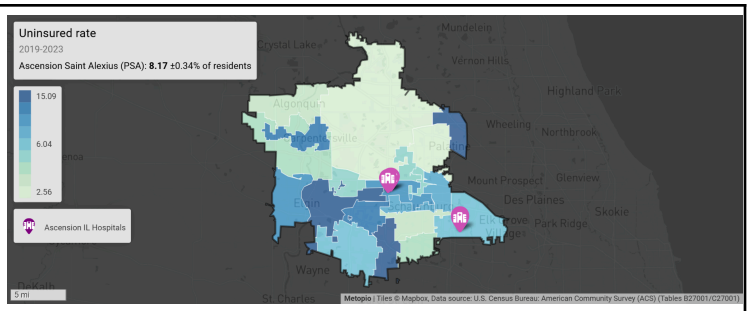
The PSA had 70.1 primary care providers per 100,000 residents, lower than county, state, and national levels. This shortage limits timely access to care, especially for uninsured and underserved residents, and contributes to increased reliance on emergency services and missed opportunities for preventive care.	The uninsured rate in the PSA is 8.17%, 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. The highest percentages of uninsured individuals live within Elgin (60120) 15.09% and Palatine (60074) 14.96%.



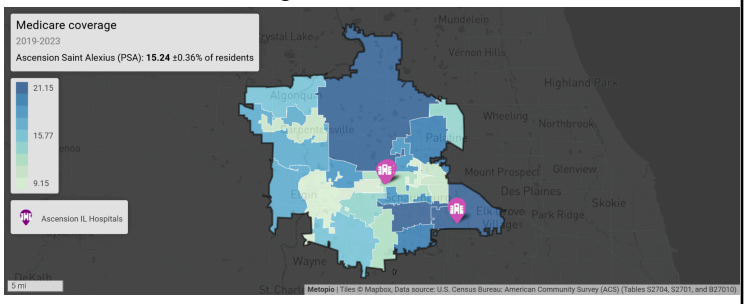
This map shows where the greatest concentration of limited-English proficient households are located within the PSA, which is also where the shortage of primary care providers is higher. The PSA has 6.91% of households with limited-English proficiency with areas such as Elgin (60120) at 10.41%, Schaumburg (60173) at 12% and Palatine (60074) at 14.28%

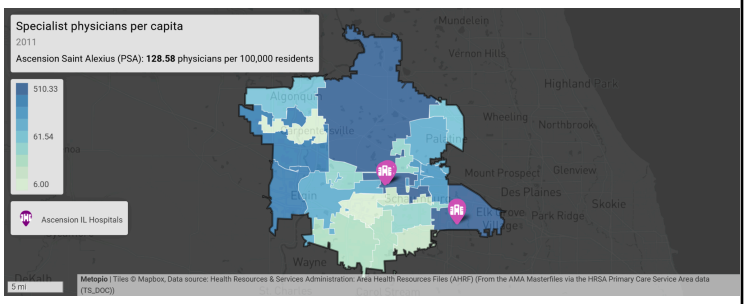


Sources: Health Resources & Services Administration, Area Health Resources Files, 2021. U.S. Census Bureau, American Community Survey, 2023.



This map shows where the medicare recipients reside within the PSA. As seniors referenced concerns with specialist availability in the PSA, areas such as Roselle (60172) and Hoffman Estates (60192), have fewer specialists (see map below) but higher levels of seniors with Medicare coverage.





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

Mental Health & Youth Well-Being

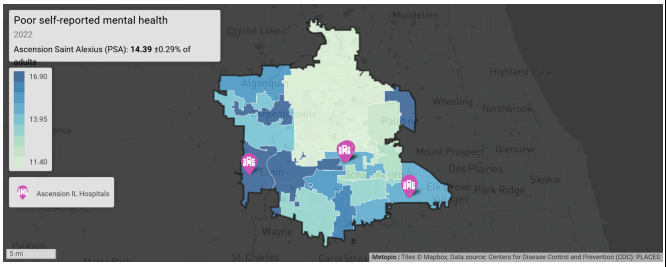
Significance	Populations Most Impacted
Mental health concerns, including depression and anxiety, were frequently identified as top health priorities. The PSA has a lower mental health provider rate, particularly bilingual and culturally competent professionals, compared to county and national levels, creating significant barriers to care. Social media impact, stress, depression, bullying, vaping, and lack of school-based mental health support are pressing youth concerns. *Source: U.S. Census Bureau, American Community Survey, 2023. Community Status Assessment (CSA) Saint Alexius/ABBHH, 2025. Cook County Community Input Survey Data Analysis LEP, 2025.*	• Residents in Elgin (60120, 60123), Carpentersville (60110) and Palatine (60074) • Low-income residents with limited insurance coverage • Youth, adolescents and young adults facing high levels of stress • Seniors experiencing social isolation • Limited English proficiency households

Community Input Highlights

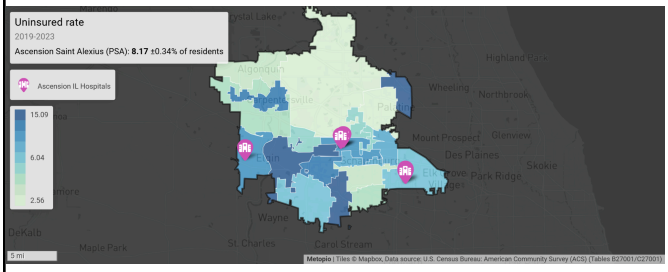
- Mental health was a top concern (33.0%) in community surveys with 42% cited difficulty accessing mental health services; community partners also expressed that mental health challenges was one of the most pressing community issues
- Survey respondents said more bilingual providers, school-based counseling and affordable therapy options were needed to increase access to mental health services
- Community partners reported that mental health conditions (stress, anxiety, depression) were a major concern, alongside gaps in services for non-English speakers
- 40.3% of respondents cited social media as a major concern for youth
- 37.1% reported high stress levels among youth due to academic and financial pressures
- Community partners highlighted teen birth rates exceeding county, state, and national averages, particularly in Streamwood in which secondary data supported that indicator (PSA teen birth rate of 13.47 teen births per 1,000 births; Streamwood 31.80 teen births per 1,000 births).
- Youth mental health challenges are rising, with depression, bullying, and stress as major concerns.

Secondary Data Highlights

This map highlights the prevalence of poor self-reported mental health across the PSA. Areas with darker shades indicate higher levels of reported mental distress, emphasizing regions where residents may need additional mental health services and support. Self-reported poor mental health days are highest in Elgin (60120: 16.90%, 60123: 15.80%), Carpentersville (60110: 16.40%) and Palatine (60074: 14.39%).

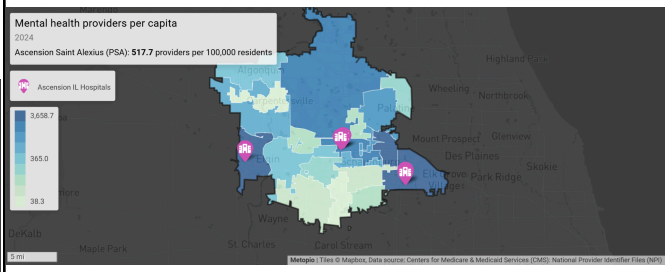


The map shows the percentage of residents in the PSA who lack health insurance. Higher uninsured rates in certain regions suggest financial barriers to accessing healthcare, including mental health services, reinforcing the need for expanded coverage and affordability initiatives.

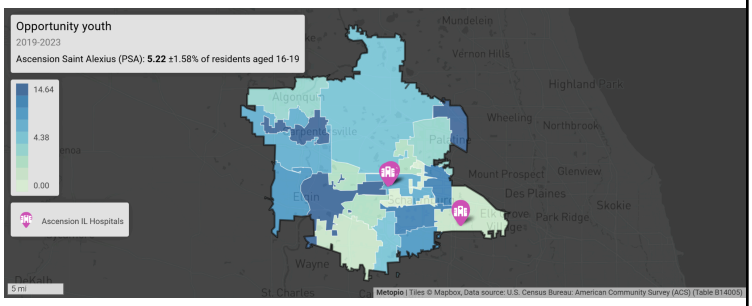


Sources: U.S. Census Bureau, American Community Survey, 2023.

Limited access to mental health care due to lower provider-to-population ratio. The map illustrates the distribution of mental health providers per 100,000 residents within the PSA. Lighter areas suggest fewer available providers (Carpentersville lowest with 38.3 providers per 100,000), indicating potential service gaps and barriers to mental healthcare access.



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 Carpentersville (zip 60110) have the highest opportunity at 14.64% compared to the PSA overall of 5.22%.



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

Chronic Disease

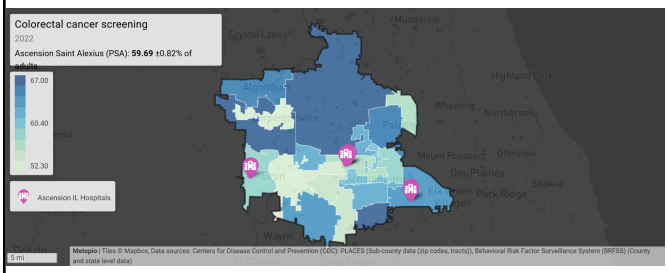
Significance	Populations Most Impacted
Chronic diseases such as diabetes, obesity, and heart disease were identified as key health concerns. The prevalence of diabetes in Elgin (60120: 12.8%, 60123: 12.3%) is higher than state and national averages. Preventive health screenings, including colorectal cancer and mammograms, fall below Healthy People 2030 targets. *Source: U.S. Census Bureau, American Community Survey, 2023. Community Status Assessment (CSA) Saint Alexius/ABBHH, 2025. Cook County Community Input Survey Data Analysis LEP, 2025.*	• Residents in Elgin (60120, 60123) and Carpentersville (60110) • Low-income residents with limited access to preventive care • Individuals over 40, who are at higher risk of chronic disease • Limited English proficiency households • Individuals who are uninsured, underinsured or have Medicaid coverage

Community Input Highlights

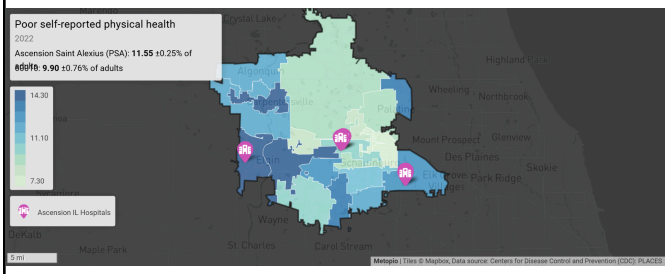
- Diabetes (35.1%) and heart disease/stroke (26.9%) were top health concerns on the community input survey
- Respondents noted difficulty in managing chronic diseases due to healthcare access barriers as well as difficulty accessing health food options, diabetes education resources, screenings and heart-related medications
- Access to community services (41%) was emphasized by respondents including the need for wellness programs (including weight loss, nutrition and fitness), transportation support, and better outreach about existing services
- Community partners emphasized the importance of early detection programs and community screenings as well as the need for more flexible appointment scheduling and increased senior services programs for the aging population
- Community partners said lack of education on health issues including information that is culturally appropriate increases health risks
- Focus groups participants said there is need for diabetes management and prevention efforts in the community, especially bilingual offerings

Secondary Data Highlights

The map illustrates colorectal cancer screening rates across the PSA, with an overall rate of 59.69%. However, certain areas, such as Elgin (52.3%) and Carpentersville (53.1%), have lower screening rates, suggesting opportunities for increased outreach and education.

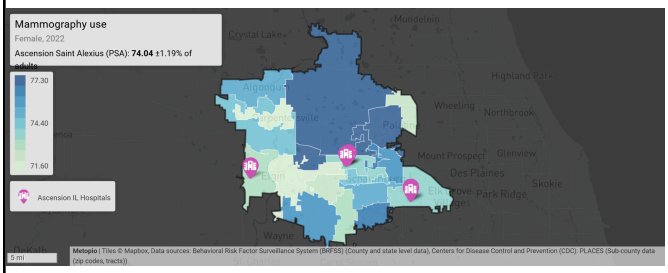


This heat map highlights self-reported poor physical health within the PSA, with 11.55% of adults reporting poor health. Some areas show rates as high as 14.3%, reinforcing the need for better access to primary and preventive healthcare services.

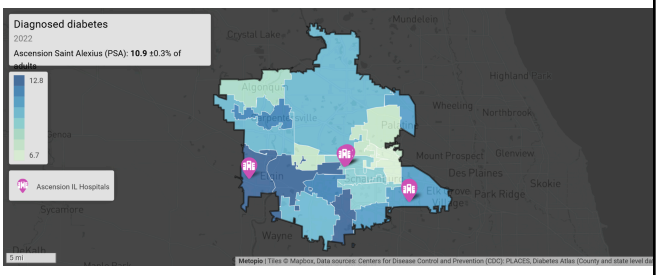


The obesity heat map shows that 31.5% of adults in the PSA are classified as obese. The western edge of the PSA has the highest obesity rates, signaling a need for improved access to healthy food, physical activity programs, and obesity-related healthcare services.

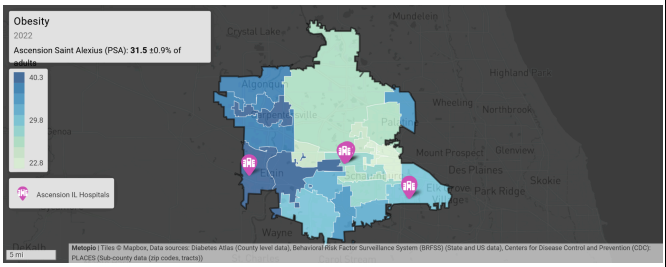
The mammography use heat map shows that 74.04% of women in the PSA have received a mammogram. However, areas such as Elgin and Carpentersville have lower rates (71.6%), indicating potential barriers to screening access and the need for increased awareness campaigns.



The heat map highlights the prevalence of diagnosed diabetes across the PSA. While the overall rate for the area is 10.9%, certain regions, such as Elgin (60120: 12.8%) and (60123: 12.3%), experience higher rates. These findings indicate the need for targeted diabetes prevention and management efforts.



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



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

Social Determinants of Health

Significance	Populations Most Impacted
The social determinants of health of food insecurity and housing instability challenges were identified as top two contributors to poor health outcomes. These barriers disproportionately impact underserved communities. Despite a higher median household income in the PSA, food insecurity remains a pressing issue, particularly in Elgin, Palatine, and Hanover Park. Access to affordable and nutritious food is a barrier for many, impacting chronic disease rates. Rising housing costs and economic disparities contribute to housing instability, especially for low-income renters. In addition, a high percentage of households in the PSA spend over 30% of their income on housing, indicating a significant cost burden. *Source: U.S. Census Bureau, American Community Survey, 2023. Community Context Assessment (CCA) Saint Alexius/ABBHH, 2025. Cook County Community Input Survey Data Analysis LEP, 2025.*	• Households in Elgin, Palatine, and Hanover Park • Low-income families relying on food assistance programs • Individuals with chronic illnesses needing access to healthier foods • Low-income renters at risk of eviction and seniors with fixed incomes • Individuals and families experiencing housing instability • African American/Black and Hispanic/Latino households facing the highest housing cost burdens • Immigrant and migrant communities

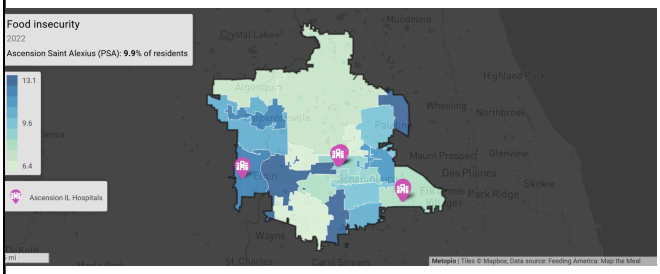
Community Input Highlights

- 33% of survey respondents cited food insecurity was a top concern in community surveys, particularly in areas with high poverty rates
- High costs of fresh food and inconvenient food pantry hours were primary barriers noted by survey respondents for access healthy food
- Community partners noted food insecurity as the most pressing health issue. Partners expressed concern over affordability and access to fresh and nutritious foods for families managing chronic illnesses and relying on food assistance programs
- Similarly, focus group participants said rising food costs continue to pose a challenge despite knowledge of various food assistance programs in the community
- Community partners emphasized economic disparities as a major challenge impacting access to basic needs and that hospitals could play a role in addressing food insecurity through screenings and partnerships.
- 21% of survey respondents cited housing affordability as a major concern and stressor with rising rent and housing costs were frequently cited as a major issue for low-income families and seniors living on fixed incomes
- Survey respondents shared concerns about eviction risks and a lack of affordable housing options

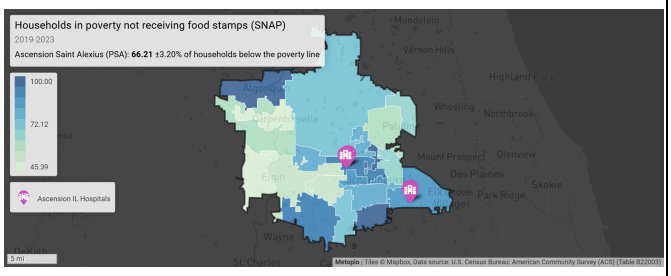
- Focus group participants said the rising cost of living has not been reflected in wage increases
- Community partners identified housing insecurity as a significant social issue affecting health
- Housing instability contributes to economic disparities and healthcare challenges

Secondary Data Highlights

The map highlights food insecurity across the PSA, with Elgin (13.1%), Palatine (12.8%), and Hanover Park (12.2%) showing the highest levels in comparison to 9.9% for the PSA. These areas face greater food access challenges and may benefit from targeted interventions.

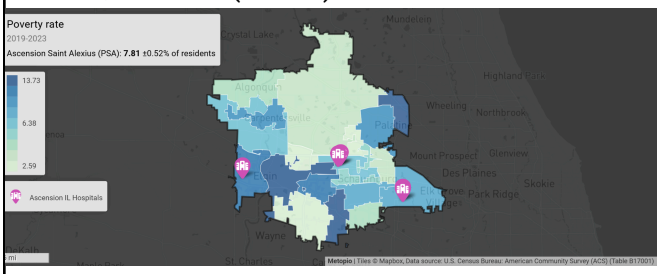


This map displays households in poverty that are not receiving food stamps (SNAP). 66.21% of households in poverty within the PSA are not enrolled in this benefit, which is higher than the rest of the county and state. This signifies a need for community education and enrollment to this benefit for those households particularly in Algonquin (60102) 84.34% & Roselle (60172) 83.64%.

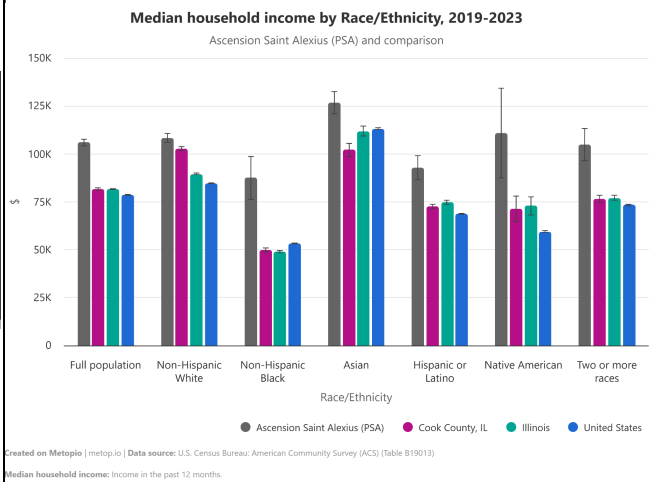


The poverty rate across the PSA is 7.81%, but varies by region. Higher poverty concentrations in the western and southern portions of the PSA overlap with areas experiencing greater housing cost burdens, indicating financial hardship that

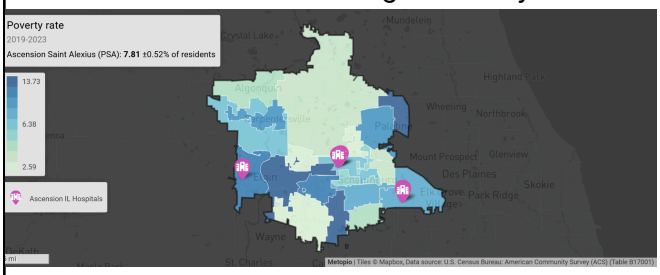
Poverty rates in the PSA align closely with food insecurity. The highest poverty levels are in the same regions struggling with food access, reinforcing the economic barriers many residents face: Elgin (60120) 13.14%; Hanover Park (60133) 13.73%; Palatine (60074) 11.75%.



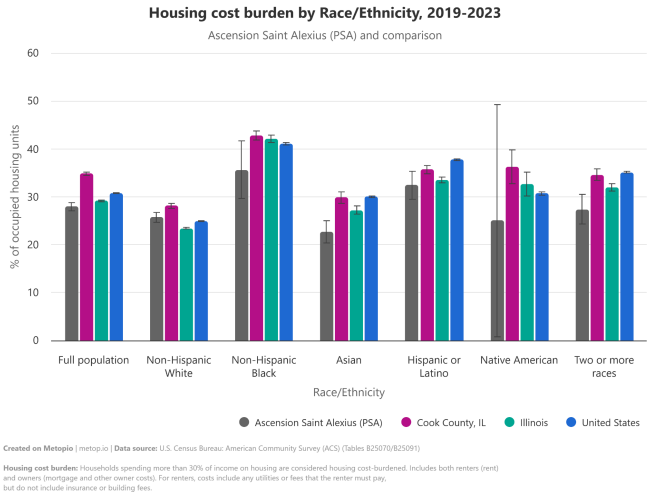
This chart shows median income levels by race/ethnicity, revealing significant economic disparities. Non-Hispanic Black households have the lowest median income at $87,504 within the PSA. These lower incomes correlate with the groups that are most affected by housing cost burden, reinforcing how income inequality impacts housing affordability.



could increase risk of housing insecurity.

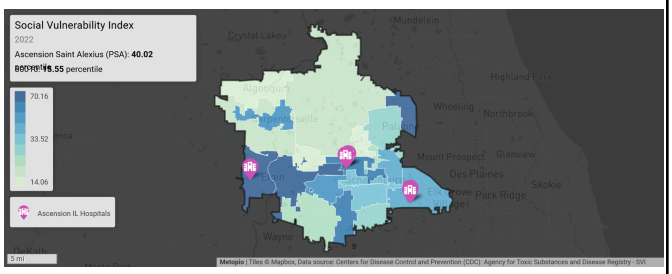


This bar chart illustrates the percentage of households by race/ethnicity spending over 30% of income on housing. Housing cost burdens disproportionately affect Hispanic (32.43%) and Non-Hispanic Black (35.67%) in the PSA. These disparities suggest a disproportionate financial strain among communities of color, contributing to increased housing instability.



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

This heat map displays the Social Vulnerability Index across the PSA. Although the PSA as a whole has a lower index (40.02) than the broader county, there are pockets of higher vulnerability evident, especially in zip codes 60123 Elgin (70.16), 60120 Elgin (66.99), and 60074 Palatine (56.05). These areas may face increased risks related to housing instability due to economic and social disparities.



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

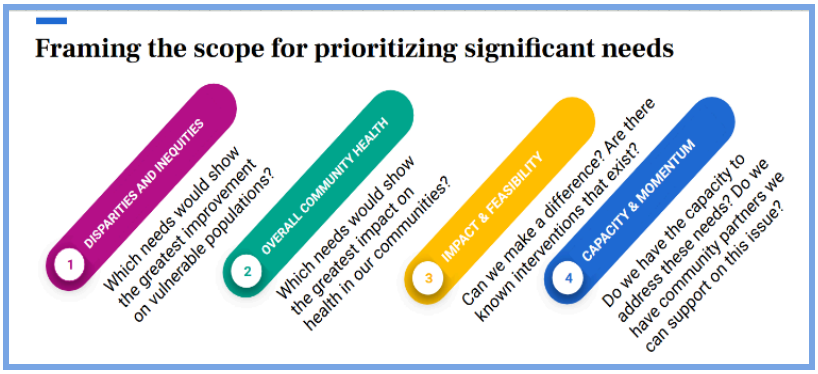
Next Steps

In the third phase, which will take place following the completion of the community health needs assessment as outlined in this report, Ascension Saint Alexius 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 Saint Alexius 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:

- **Healthcare Access & Affordability *(Access to Care - Clinical Care)***: Individuals in the community face major barriers in obtaining necessary medical care including lack of affordable medical care (including dental and vision) and medications, difficulties navigating insurance, and long wait times for specialists. 61% of community survey respondents cited lack of access to care as a major issue that includes concerns for long wait times for specialist appointments, high costs, and difficulties navigating insurance benefits. Participants said high insurance costs limit access to medical services including necessary medications and dental services, while many are unclear about their eligibility for healthcare coverage. Community partners noted barriers

such as economic constraints, limited healthcare services, and cultural/language challenges for individuals in the community.

- **Mental Health & Youth Well-Being (*Mental Health - Quality of Life*):** Mental health concerns, including depression and anxiety, were frequently identified as top health priorities. The PSA has a lower mental health provider rate, particularly bilingual and culturally competent professionals, compared to county and national levels, creating significant barriers to care. Social media impact, stress, depression, bullying, vaping, and lack of school-based mental health support are pressing youth concerns. Mental health was a top concern (33.0%) in community surveys with 42% cited difficulty accessing mental health services & lack of school-based counseling; community partners also expressed that mental health challenges were one of the most pressing community issues, especially services for Limited English Proficient individuals. 40.3% of respondents cited social media as a major concern for youth; 37.1% reported high stress levels among youth due to academic and financial pressures. Community partners highlighted teen birth rates exceeding county, state, and national averages, particularly in Streamwood.
- **Chronic Disease *(Diabetes, Obesity, Heart Disease - Chronic Conditions):*** Chronic diseases such as diabetes, obesity, and heart disease were identified as key health concerns. The prevalence of diabetes in Elgin (60120: 12.8%, 60123: 12.3%) is higher than state and national averages. Preventive health screenings, including colorectal cancer and mammograms, fall below Healthy People 2030 targets. Diabetes (35.1%) and heart disease/stroke (26.9%) were top health concerns on the community input survey. Respondents noted difficulty in managing chronic diseases due to healthcare access barriers as well as difficulty accessing health food options, diabetes education resources, screenings and heart-related medications. Access to community services (41%) was emphasized by respondents including the need for wellness programs (including weight loss, nutrition and fitness including senior & bilingual offerings), transportation support, and better outreach about existing services.
- **Social Determinants of Health *(Income - SDoH & Housing - SDoH):*** The social determinants of health of food insecurity and housing instability challenges were identified as top two contributors to poor health outcomes. These barriers disproportionately impact underserved communities. Food insecurity remains a pressing issue, particularly in Elgin, Palatine, and Hanover Park. Access to affordable and nutritious food is a barrier for many, impacting chronic disease rates. Rising housing costs and economic disparities contribute to housing instability. 33% of survey respondents cited food insecurity a top concern, particularly in areas with high poverty rates. Community partners noted food insecurity as the most pressing health issue. Partners expressed concern over affordability and access to fresh and nutritious foods for families managing chronic illnesses and relying on food assistance programs. Survey respondents shared concerns about eviction risks and a lack of affordable housing options; 21% of survey respondents cited housing affordability as a major concern and stressor; Focus group participants said the rising cost of living has not been reflected in wage increases.

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 Saint Alexius' previous CHNA implementation strategy was completed in October 2022 and responded to the following priority health needs:

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

Highlights from **Ascension Saint Alexius's** previous implementation strategy include:

- 82,990 pounds of food provided to the community through programs and partnerships
- 2,771 rides provided for individuals identified as needing transportation assistance
- 516 individuals provided with housing assistance through programs and partnerships
- 16,013 preceptor hours provided for college students
- 4,575 referrals were made from Ascension's Neighborhood Resource Directory
- 5,472 individuals served through ED Annex Clinical Support Initiative
- 4,210 community health screenings offered through Community Wellness Program

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 88).

Approval

To ensure Ascension Saint Alexius' efforts meet the needs of the community and have a lasting and meaningful impact, the tax year 2024 CHNA was presented to the Ascension Illinois Quality Board of Directors for approval and adoption 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 Saint Alexius 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 Saint Alexius 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, Saint Alexius 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 Saint Alexius 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	609,538	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	13.3%	8.3%	6.3%	6.3%
Non-Hispanic Black / African American	4.3%	22.7%	14.1%	12.6%
Hispanic / Latino	26.3%	26.3%	18.3%	19.1%
American Indian or Alaska Native	0.1%	0.8%	0.6%	1.3%
Non-Hispanic White	53.2%	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	23.6%	20.9%	21.6%	21.7%
Ages 65+	15.3%	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	$106,146	$76,600	$76,700	$74,800
ALICE Households	26.99%	35.48%	37.00%	42.00%
Poverty	7.81%	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	89.23%	88.55%	90.55%	89.78%
Associate's degree or higher	67.26%	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	8.17%	7.79%	6.16%	7.93%
Medicaid Coverage	14.88%	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, thirteen completed surveys were collected from different types of organizations including schools/educational institutions, non-profit organizations, grassroots organizations and health providers including:

Northern Illinois Food Bank
Partners for Our Communities
WINGS Program, Inc.
Fellowship Housing Corporation
GiGi's Playhouse, Inc.
William Rainey Harper College
Advocatia Solutions, Inc.
Sharing Notes
Hoffman Estates Chamber of Commerce & Industry
Greater Chicago Food Depository

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 Saint Alexius 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

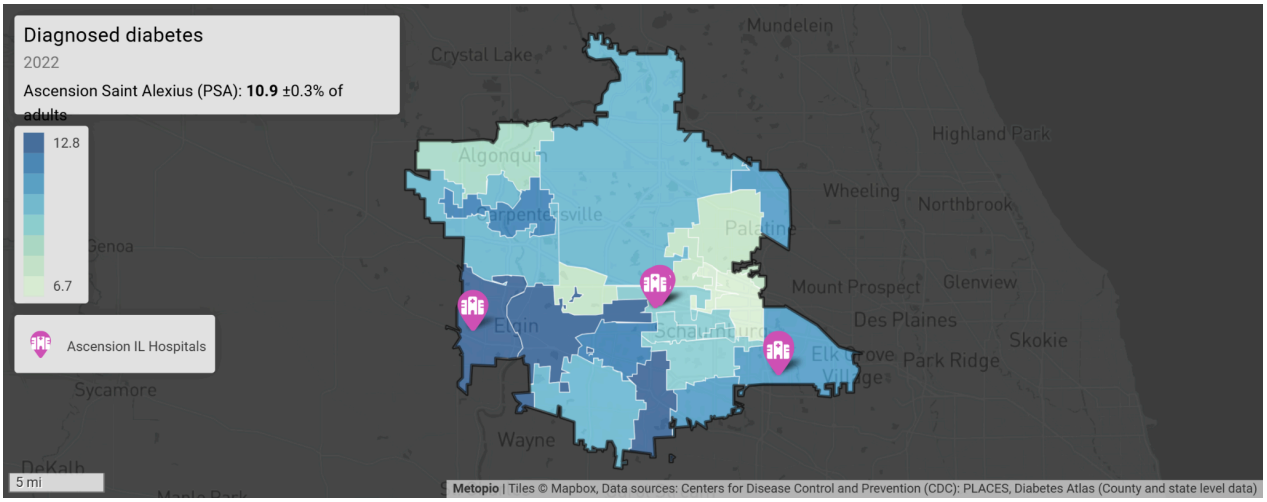
The cancer diagnosis rate is lower than the county and state rates. The percentage of adults with coronary heart disease and diagnosed diabetes rates are similar to the county, state and national percentages. Low birth weight rates are significantly lower in comparison to county, state and national levels. The percentage of adults with obesity is lower than the county, state, and national percentages.

Topic	Ascension Saint Alexius/ABBHH (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Cancer diagnosis rate *per 100,000 residents* 2017-2021	**545.16**	547.69	573.24	444.40	n/a
Coronary heart disease *% of adults* 2022	5.56	5.10	5.37	5.82	n/a
COVID-19 case rate	–	29,479.86	31,887.0	32,217.47	n/a

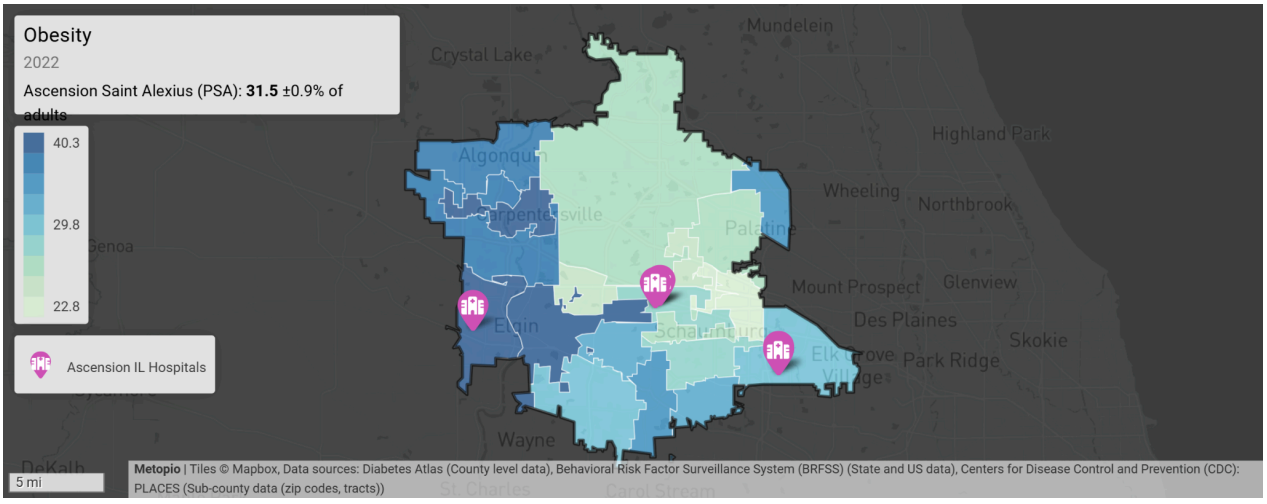
cumulative cases per 100,000 population Mar 2023					
Diagnosed diabetes *% of adults* 2022	10.9	10.8	10.4	10.8	n/a
HIV prevalence *people per 100,000* 2022	–	595.8	338.8	386.6	n/a
Low birth weight *% of live births* 2020-2022	**6.1**	8.9	8.5	8.5	n/a
Motor vehicle traffic mortality *deaths per 100,000* 2022	–	8.9	10.0	12.9	10.1
Obesity *% of adults* 2022	**31.5**	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

The heat map shows the rates of diagnosed diabetes across the PSA. While the average rate for the PSA is similar to county, state and national rates, there are pockets within the PSA with greater rates of known diabetes such as 60120 Elgin (12.8%) and 60123 Elgin (12.3%).



The heat map below shows the rates of adult obesity within the PSA. The areas along the western edge of the PSA have great levels of obesity.



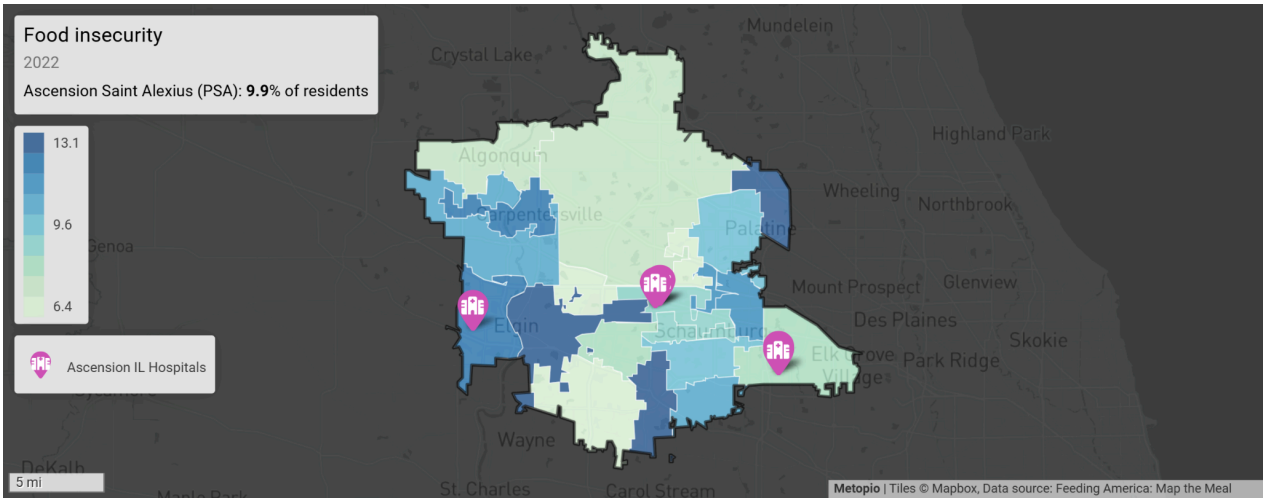
Economic Stability Indicators

The food insecurity rate is lower than the county, state, and national rate. The median selected monthly owner costs (SMOC) is significantly higher than the county, state, and national costs. The median household income is drastically higher than the county, state, and national level. The poverty rate is much lower than the county, state, and national rate.

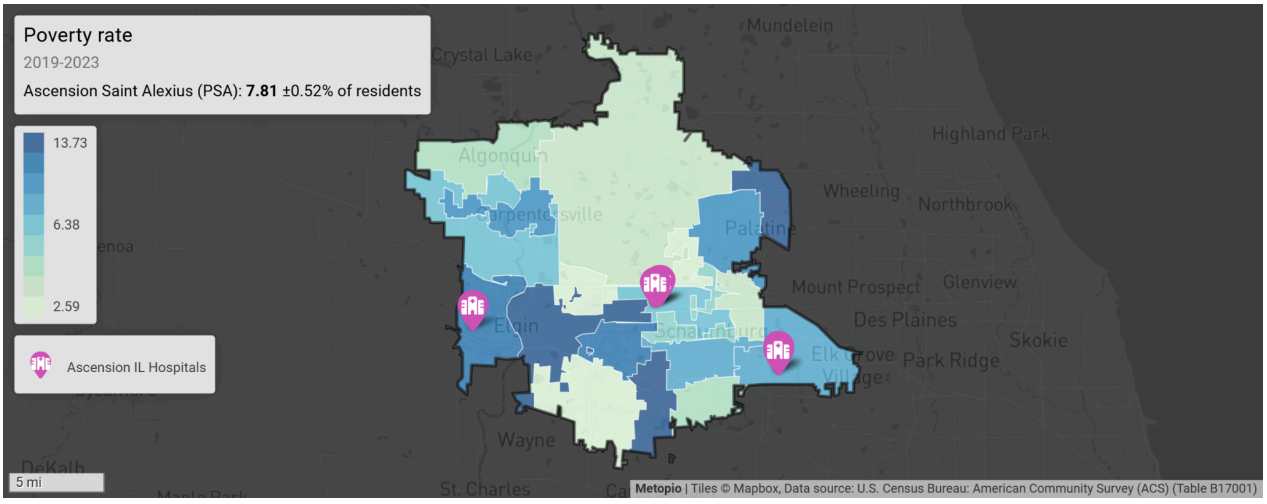
Topic	Ascension Saint Alexius/ ABBHH (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Food insecurity *% of residents* 2022	**9.9**	12.1	12.0	13.3	n/a
Median selected monthly owner costs (SMOC) 2019-2023	**$1,800**	$1,602	$1,366	$1,320	n/a
Owner occupied *% of occupied housing units* 2019-2023	**74.52**	57.81	67.37	65.24	n/a
Median household income 2019-2023	**$106,146**	$80,579	$80,306	$77,719	n/a
Poverty rate *% of residents* 2019-2023	**7.81**	13.29	11.63	12.46	8.00
Unemployment rate (BLS) *%* Nov 2024	–	5.3	4.8	4.0	n/a

Stratifications & Heat Mapping

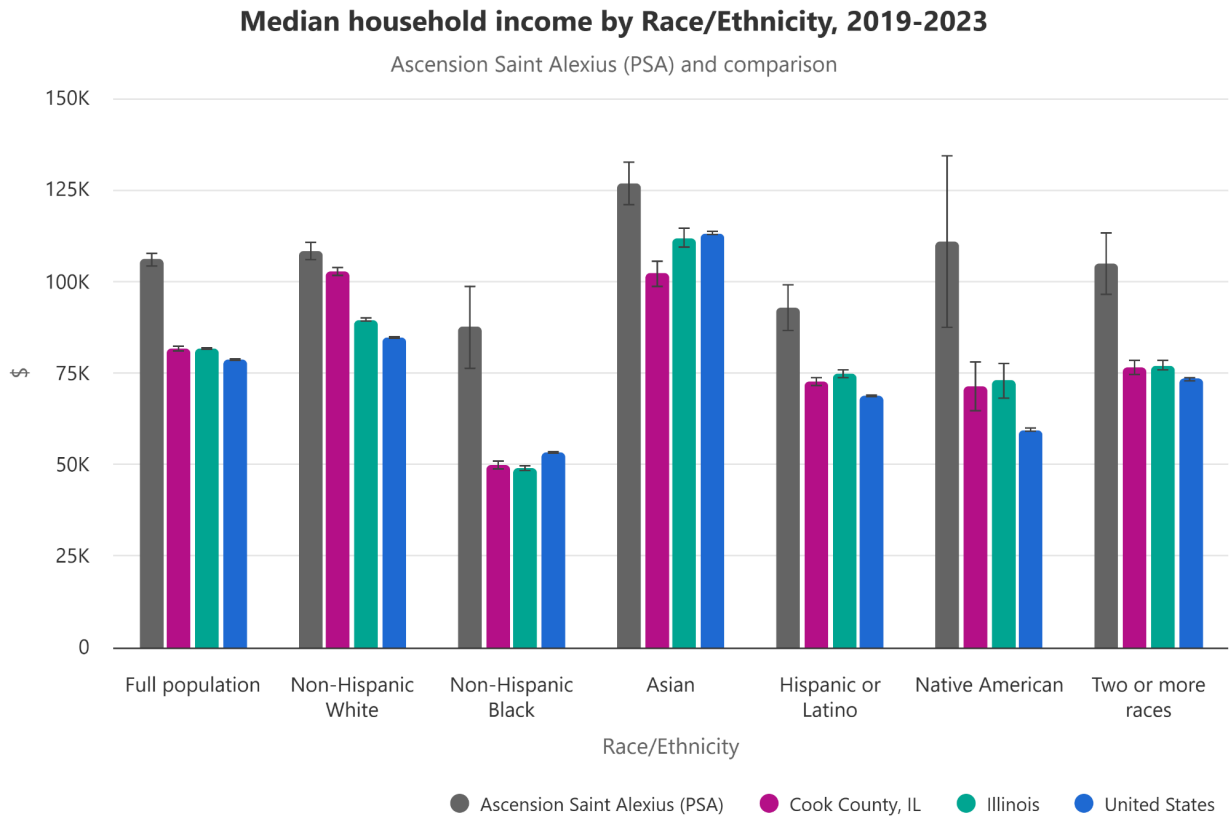
The heat map shows the rates of food insecurity across the PSA. There are geographic disparities that exist specifically in 60120 Elgin (13.1%), 60074 Palatine (12.8%) and 60133 Hanover Park (12.2%).



Similarly, the heat map of the poverty rates across the PSA are nearly identical to the areas where food insecurity exists.



The stratified chart shows the median household income by race/ethnicity with the PSA, county, state and nation. The population with the lowest median household is the non-Hispanic Black population ($87,504).



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.

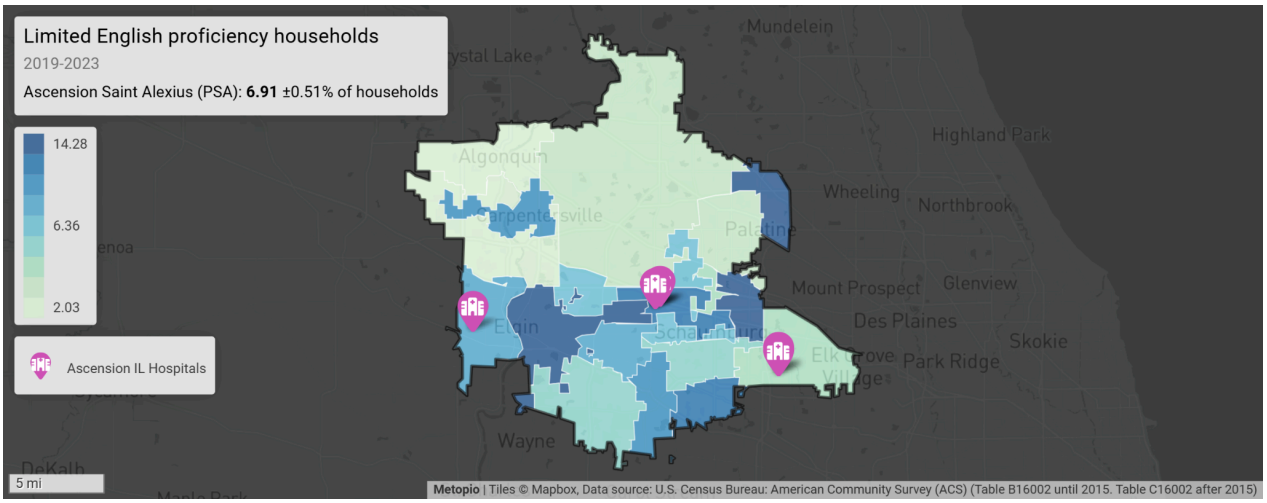
Education & Quality of Life Indicators

The percentage of toddlers (ages 3-4) enrolled in preschool is higher than the county and national percentages. The percentage of households with limited English proficiency is higher than the county, state, and national level.

Topic	Ascension Saint Alexius/ ABBHH (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
High school graduation rate *% of residents* 2019-2023	89.23	88.55	90.55	89.78	n/a
Preschool enrollment *% of toddlers ages 3-4* 2019-2023	**51.20**	49.97	52.25	48.45	n/a
Limited English proficiency households *% of households* 2019-2023	**6.91**	6.68	4.24	4.36	n/a

Stratifications & Heat Mapping

The heat map shows the households with limited English proficiency across the PSA. The areas with greatest limited proficiency are 60074 Palatine (14.28%) and 60173 Schamburg (12%),


Limited English proficiency households
2019-2023
Ascension Saint Alexius (PSA): 6.91 ±0.51% of households
14.28
6.36
2.03
Ascension IL Hospitals
Mundelein
Highland Park
Wheeling
Northbrook
Mount Prospect
Glenview
Des Plaines
Skokie
Park Ridge
Elgin
Wayne
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

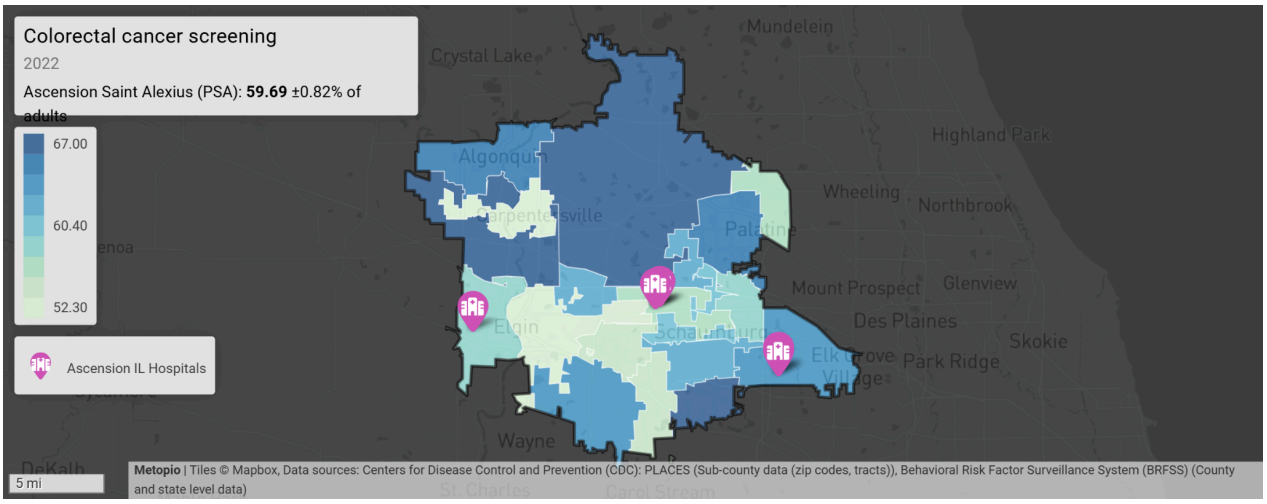
The percent of adults who report binge drinking is well below the Healthy People 2030 benchmark. The percentage of adults that have received colorectal cancer screening or mammograms is below the Healthy People 2030 benchmark. The teen birth rate is notably higher than the county, state, and national rates.

Topic	Ascension Saint Alexius/ ABBHH (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Binge drinking *% of adults* 2022	**19.66**	20.80	20.37	18.58	25.40
Colorectal cancer screening *% of adults* 2022	**59.69**	52.70	55.37	58.85	68.30
No exercise *% of adults* 2022	20.7	20.9	21.5	23.7	21.8
Mammography use *% of adults, female* 2022	**74.04**	73.80	73.02	75.65	80.30
Cigarette smoking rate *% of adults* 2022	12.2	12.0	13.5	14.6	n/a

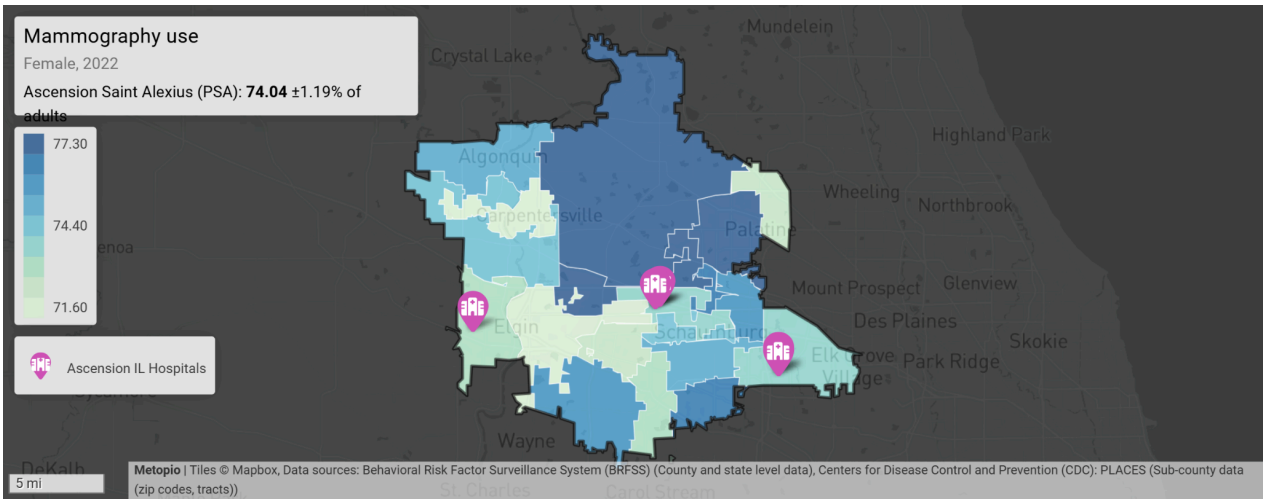
Teen birth rate *Births per 1,000 women, female under 18 yrs* 2019-2023	**13.47**	10.16	7.88	8.48	31.40
Few fruits and vegetables *% of adults* 2009	n/a	75.90	77.50	76.14	n/a

Stratifications & Heat Mapping

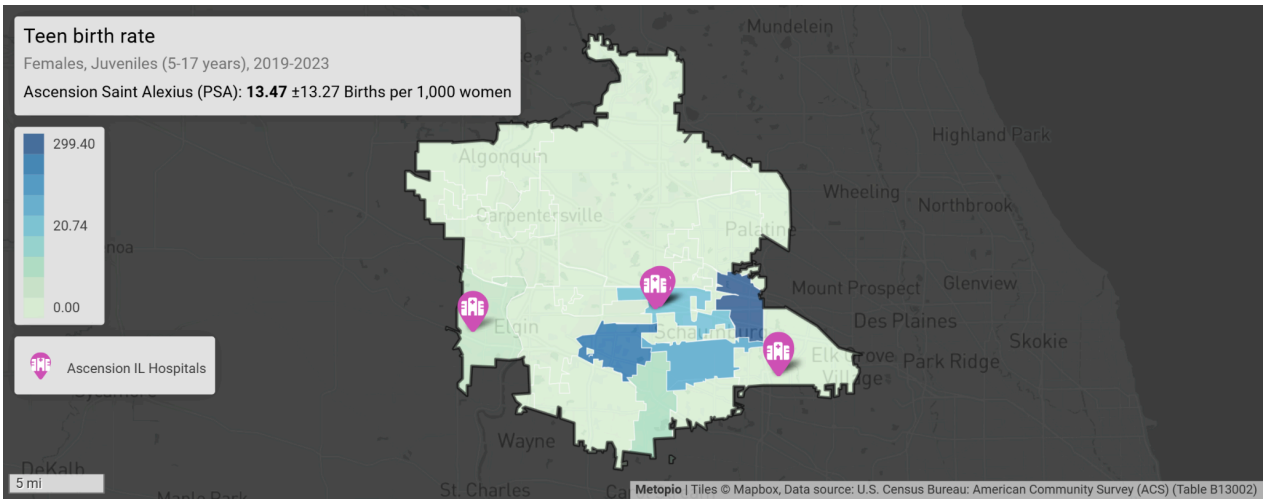
The heat map shows the percentages of adults obtaining a colorectal cancer screening within the PSA. The areas with greatest opportunities to increase screenings is 60120 Elgin (52.30%) and 60110 Carpentersville (53.10%)



The heat map below shows the percentages of women obtaining their mammogram with the PSA. The areas with the greatest opportunities to increase use are the same as colorectal screenings 60120 Elgin (71.60%) and 60110 Carpentersville (71.60%).



The heat map below shows the teen birth rates among the zip codes within the PSA. The zip code with the highest teen birth rate is 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.



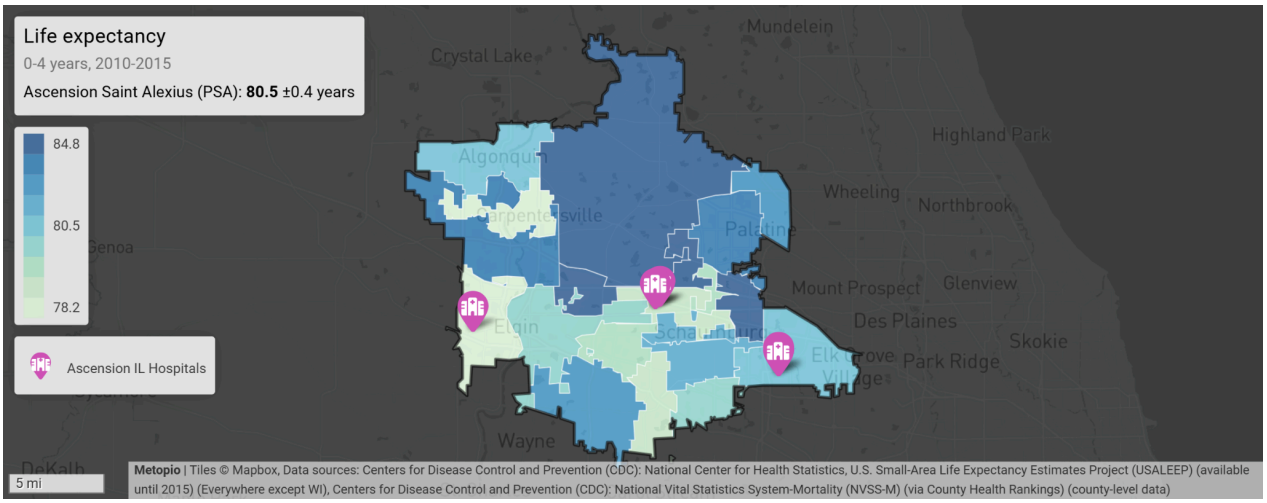
Health Status Indicators

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

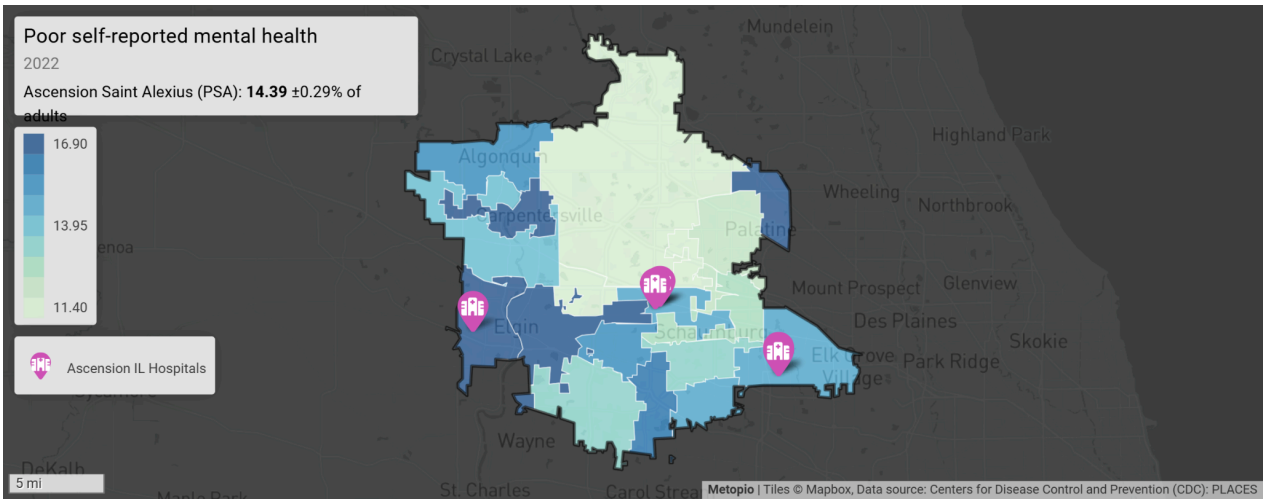
Topic	Ascension Saint Alexius/ ABBHH (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Life expectancy *years* 2019-2021	**80.6**	77.9	78.0	76.1	n/a
Poor self-reported mental health *% of adults* 2022	**14.39**	15.30	16.11	17.35	n/a
Poor self-reported physical health *% of adults* 2022	**11.55**	11.40	11.71	12.44	n/a
Fair or poor self-reported health *% of adults* 2022	**16.54**	17.50	17.00	17.87	n/a

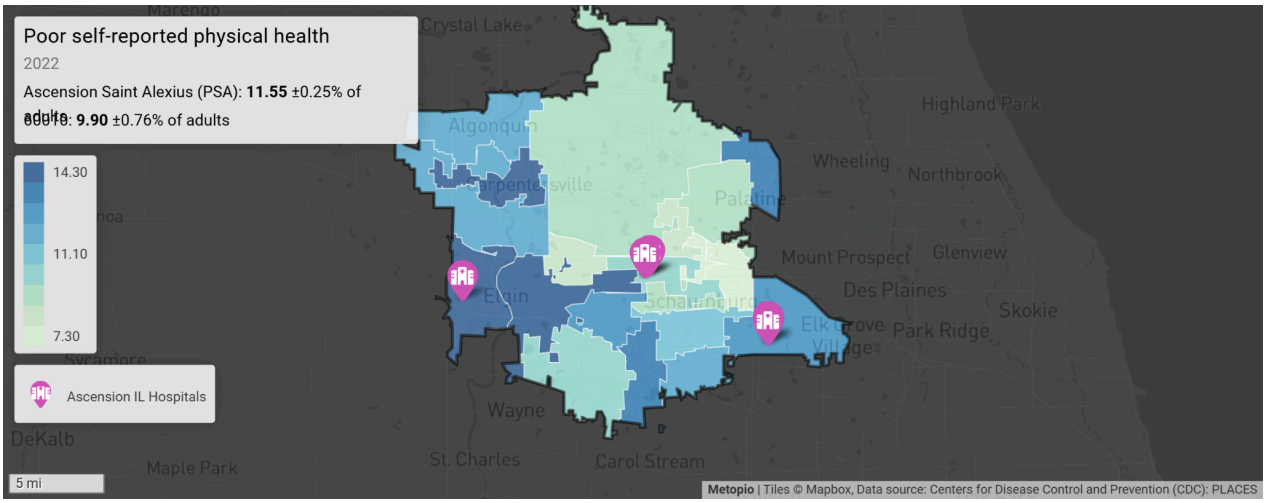
Stratifications & Heat Mapping

The heat map shows the life expectancy across the PSA. The community with the highest life expectancy is 60192 Hoffman Estates (84.8 years). The community with the lowest life expectancy is 60123 Elgin (78.2 years).



The heat maps below reflect self-reported poor mental health and physical health. The maps are nearly identical showing the greatest opportunity to improve in zip codes 60120 Elgin, 60123 Elgin, 60110 Carpentersville and 60074 Palatine.




Poor self-reported physical health
2022
Ascension Saint Alexius (PSA): 11.55 ±0.25% of adults
County: 9.90 ±0.76% of adults
14.30
11.10
7.30
Ascension IL Hospitals
5 mi
Crystal Lake
Algonquin
Highland Park
Wheeling
Northbrook
Mount Prospect
Glenview
Des Plaines
Skokie
Park Ridge
Elgin
Wayne
DeKalb
Maple Park
St. Charles
Carol Stream
Metopio | Tiles © Mapbox, Data source: Centers for Disease Control and Prevention (CDC): PLACES

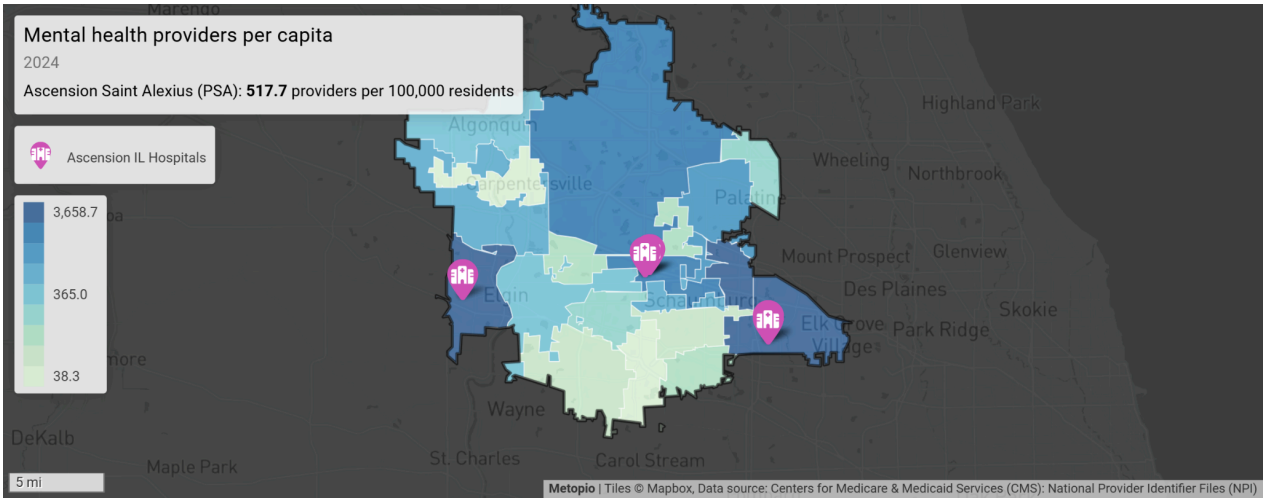
Health Access & Quality Indicators

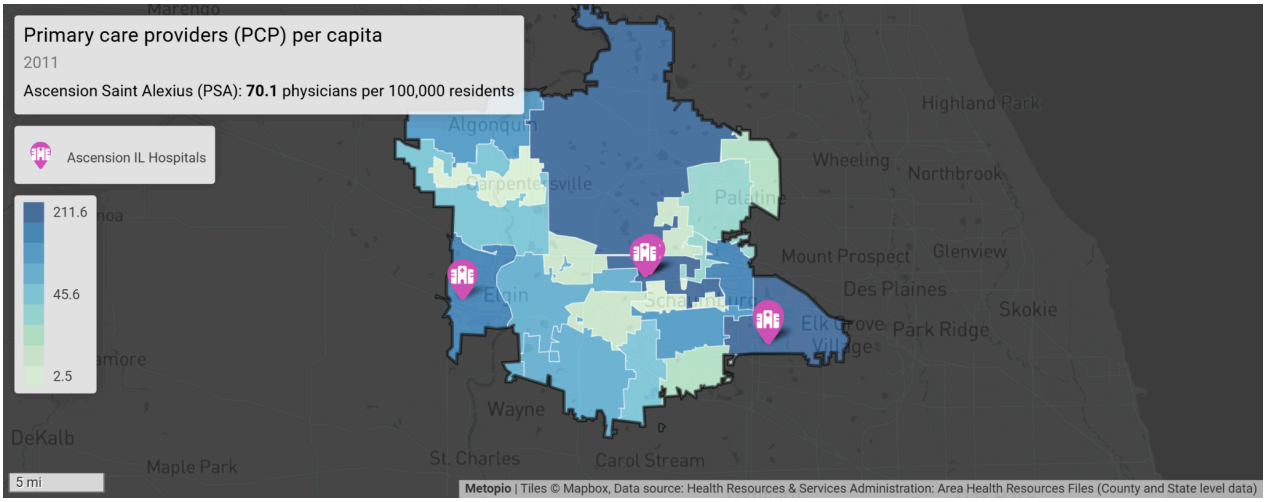
The mental health providers per capita is lower than the county and national level. The primary care providers per capita is crucially lower than the county, state, and national level. The uninsured rate is higher than the county, state, and national rate.

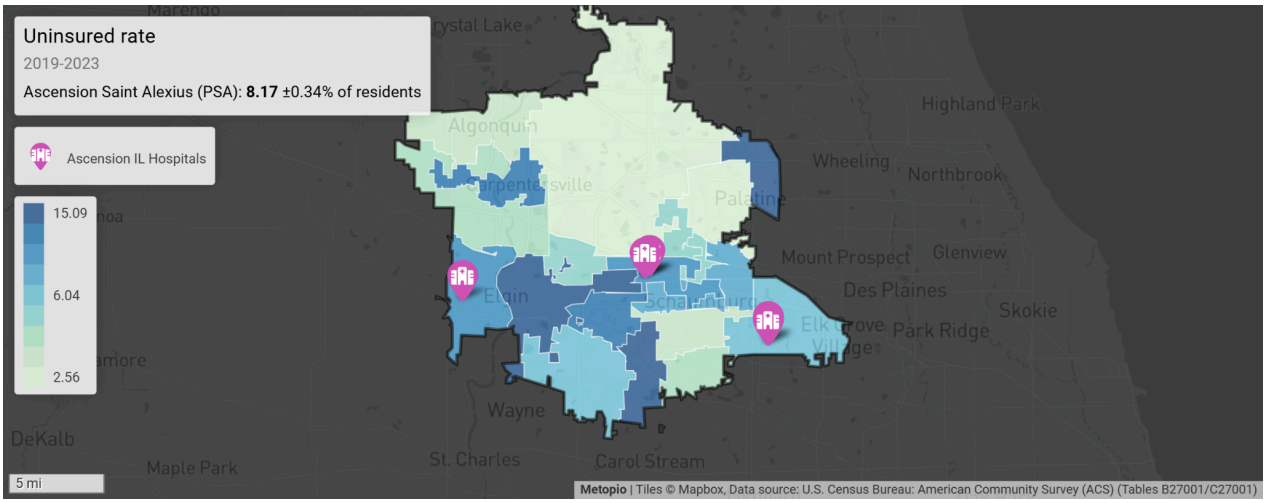
Topic	Ascension Saint Alexius/ ABBHH (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Dentists per capita *dentists per 100,000 residents* 2024	**143.1**	141.3	112.5	105.2	n/a
Mental health providers per capita *providers per 100,000 residents* 2024	**517.7**	656.4	505.9	602.7	n/a
Primary care providers (PCP) per capita *physicians per 100,000 residents* 2021	**70.1**	107.4	88.8	89.6	n/a
Uninsured rate *% of residents* 2019-2023	**8.17**	7.79	6.16	7.93	n/a

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 Saint Alexius (PSA): 8.17 ±0.34% of residents
Ascension IL Hospitals
15.09
6.04
2.56
Highland Park
Wheeling
Northbrook
Algonquin
Mount Prospect
Glenview
Des Plaines
Skokie
Park Ridge
Elgin
Wayne
DeKalb
Maple Park
St. Charles
Carol Stream
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 Saint Alexius/ ABBHH (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* 2022	–	164.1	145.1	142.3	122.7

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

Neighborhood & Built Environment Indicators

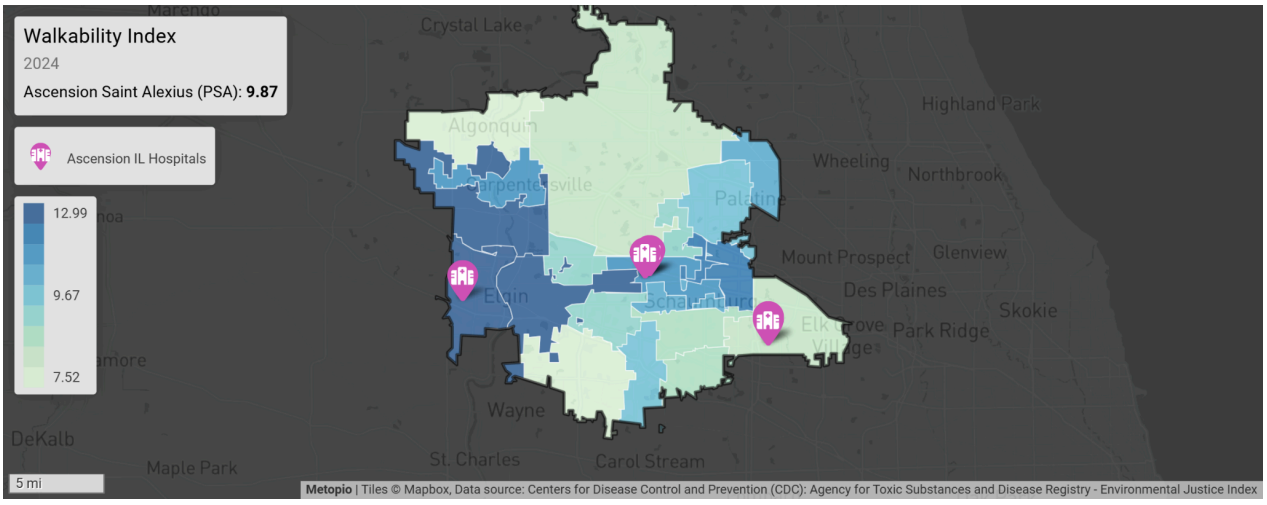
The percentage of workers (16 years and older) that take public transportation to work is lower than the county, state, and national percentages. Similarly, the walkability index is lower than the county and state levels.

Topic	Ascension Saint Alexius/ ABBHH (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Walkability Index 2024	**9.87**	13.61	10.56	9.47	n/a
Housing cost burden *% of occupied housing units* 2019-2023	**27.97**	34.44	29.37	31.86	n/a
Particulate matter (PM 2.5) concentration *µg/m3* 2020	8.994	9.304	8.457	6.927	n/a
Public transportation to work *% of workers 16 years and older* 2019-2023	**2.26**	13.40	6.60	3.53 .	n/a
Proximity to Superfund (toxic waste) sites *distance-weighted sites* 2024	**0.069**	0.298	0.097	0.094	n/a

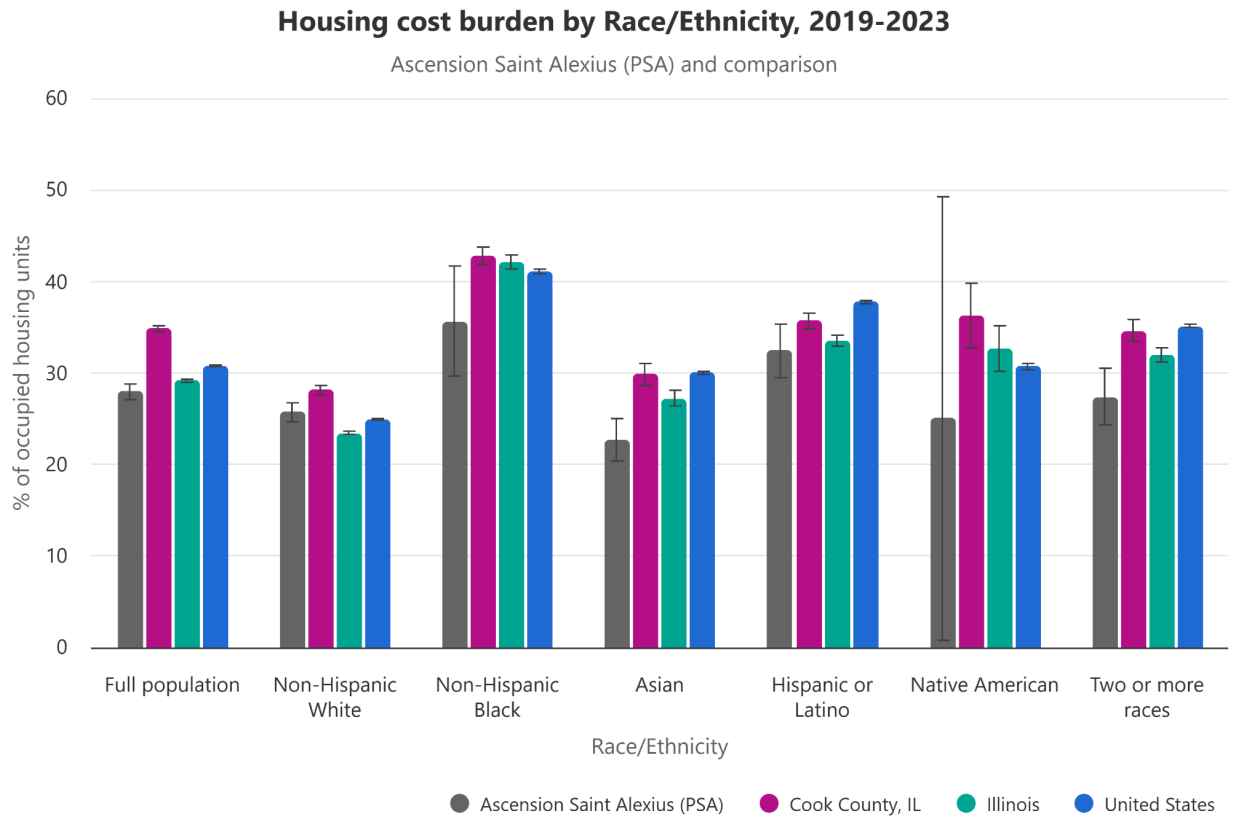
Travel time to work over one hour *% of workers* 2019-2023	**9.80**	13.10	10.10	8.90	n/a
Drinking water non-compliance *violations* 2023	0	0	0	2	n/a
Internet access *% of households* 2019-2023	**95.66**	94.91	94.64	94.77	n/a

Stratifications & Heat Mapping

The heat map reflects the walkability of communities within the PSA. A community's ranking of walkability is based on intersection density, proximity to transit, diversity of businesses and density of housing. The communities with the lowest index are 60103 Bartlett (7.52) and 60102 Algonquin (8.01).



The chart below shows the housing cost burden by race/ethnicity for those residing within the hospital PSA. The populations most affected by housing costs are non-Hispanic Black (35.67%) and Hispanic or Latino (32.43%).



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.

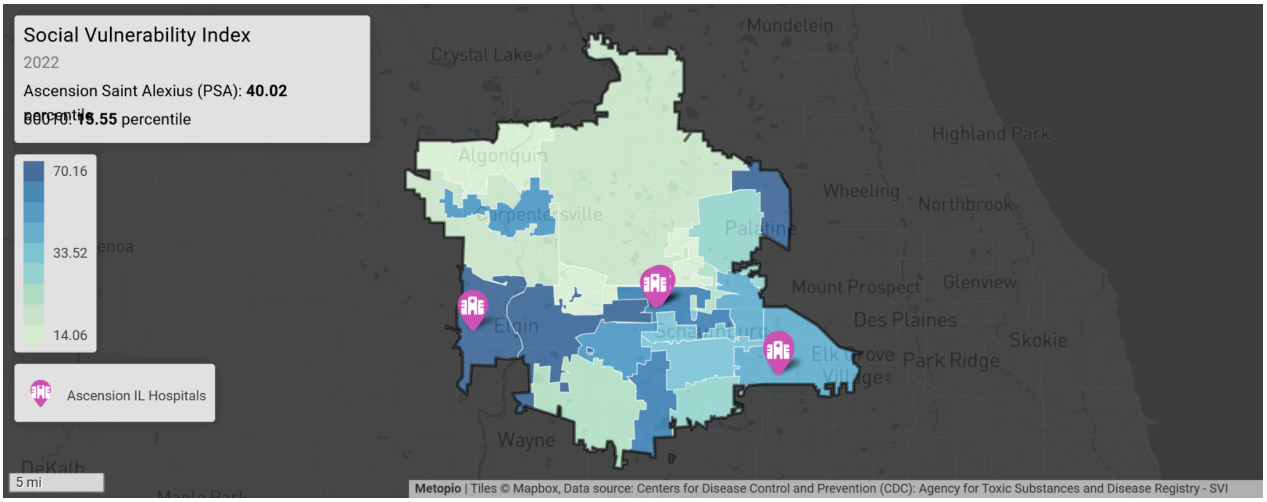
Social & Community Context Indicators

The percentage of children (0-17 years) living with their grandparents is 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 Saint Alexius/ ABBHH (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	**6.52**	10.35	7.80	8.10	n/a
Social Vulnerability Index *percentile* 2022	**40.02**	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 60123 Elgin (70.16 index), 60120 Elgin (66.99 index) and 60074 Palatine (56.05).



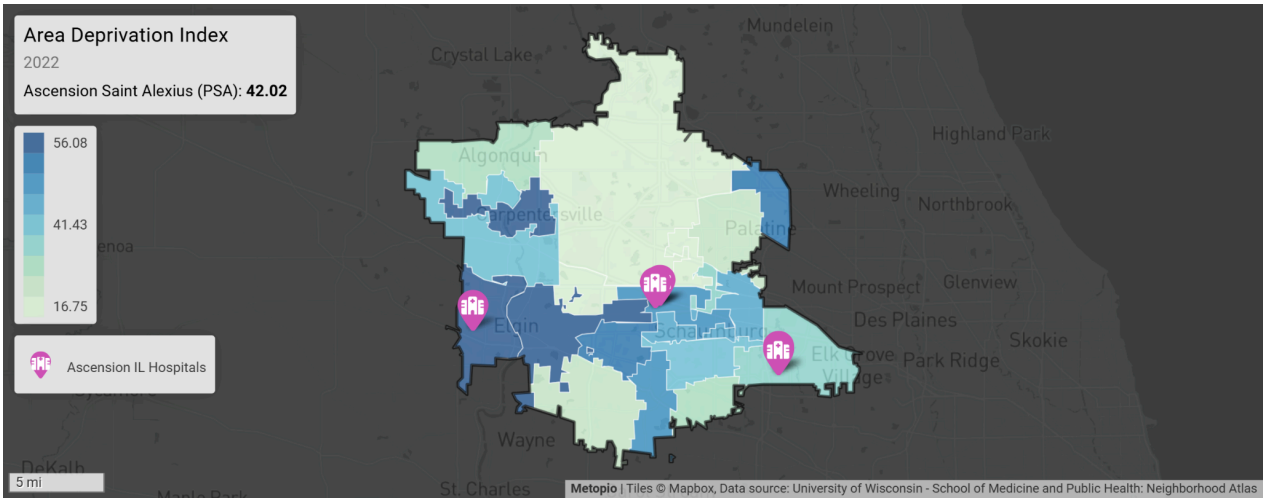
Systems of Power, Privilege & Oppression Indicators

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.

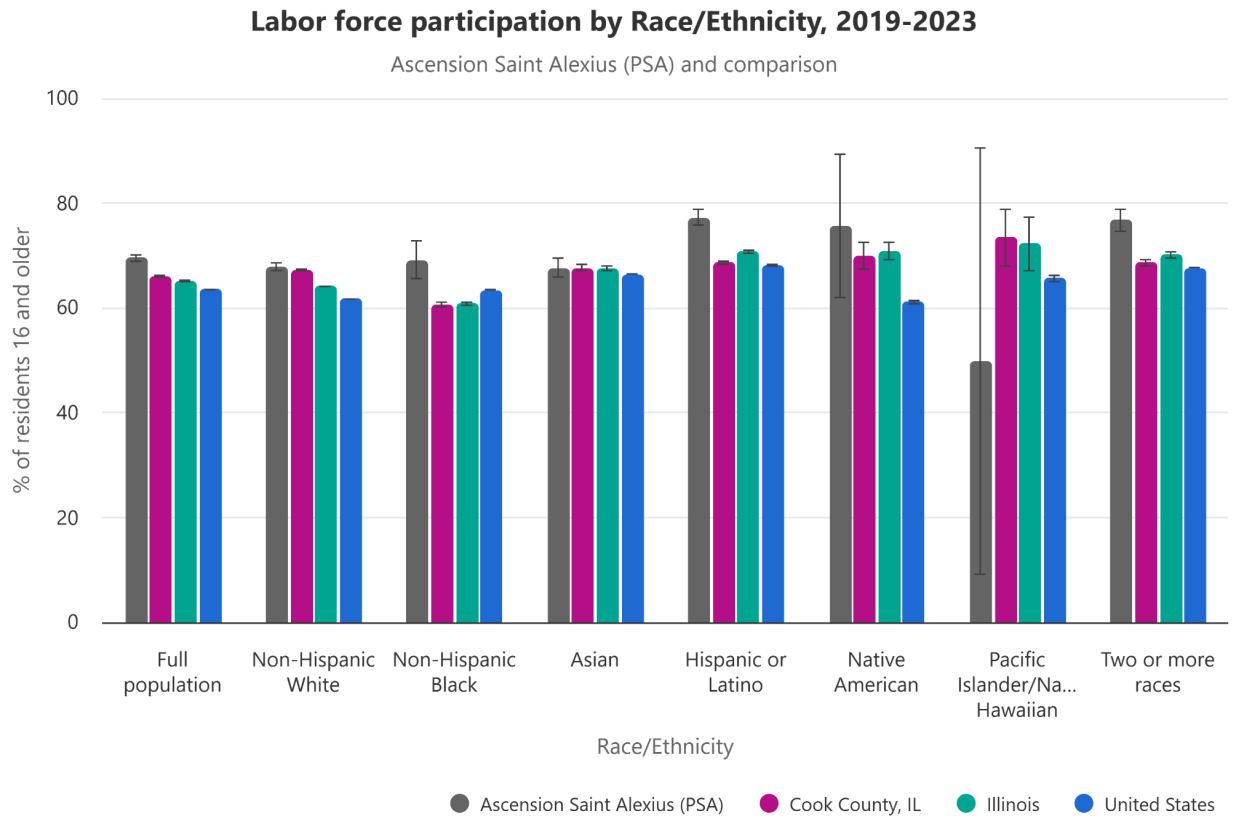
Topic	Ascension Saint Alexius/ ABBHH (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Area Deprivation Index 2022	**42.02**	46.12	53.70	47.50	n/a
Correctional facilities census *persons* 2020	99	6,598	61,605	2,055,412	n/a
Eviction rate *% of renter-occupied households* 2018	**1.44**	1.06	1.52	2.12	n/a
Gini index of income inequality 2019-2023	**0.400**	0.501	0.481	0.483	n/a
Labor force participation *% of residents 16 and older* 2019-2023	**69.57**	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), 60123 Elgin (55.73 index) and 60110 Carpentersville (52.91 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 (77.30%) and individuals with two or more races (76.84%).



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 Saint Alexius 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.

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 Bartlett	630.716.7500	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
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

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

Chronic Disease

Organization	Phone	Website
Ascension Saint Alexius 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 Diabetes Care Elk Grove	224.273.5148	www.healthcare.ascension.org
Ascension Medical Group Illinois Primary Care Schaumburg	847.985.9390	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
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
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

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

Organization	Phone	Website
Greater Chicago Food Depository	773.247.3663	www.chicagosfoodbank.org
Northern Illinois Food Bank	630.443.6910	www.solvehungertoday.org
Hanover Township Food Pantry	630.540.9085	www.hanover-township.org
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
Willow Creek Care Center	224.512.2600	www.willowcreekcarecenter.org

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

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

- Food Access and Food Insecurity
- Transportation
- Housing
- Resources, Referrals, Coordination, and Connection to Community-Based Services
- Timely Linkage to Quality Care, including Behavioral Health and Social Services
- Workforce Development
- Maternal and Child Health
- Mental Health
- 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 Saint Alexius's** previous implementation strategy include:

- 82,990 pounds of food provided to the community through programs and partnerships
- 2,756 rides provided for individuals identified as needing transportation assistance
- 516 individuals provided with housing assistance through programs and partnerships
- 16,013 preceptor hours provided for college students
- 4,575 referrals were made from Ascension's Neighborhood Resource Directory
- 5,472 individuals served through ED Annex Clinical Support Initiative
- 4,210 community health screenings offered through Community Wellness Program

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 Saint Alexius community residents.	**Completed**	**Process Measures:** • **Total Individuals Served:** 3,850 • **Total Number of Meals Provided:** 64,622 • **Total Pounds of Food Provided:** 76,500 • **Total Produce Mobile Events:** 34

Micro Pantry Increase food access assistance for food insecure individuals for Ascension Saint Alexius community residents.	**Completed**	**Process Measures:** • **Total Pounds of Food Provided**: 6,490 • **Total Meals Provided**: 5,566 • **Total Food Drives:** 9
Local Food Pantry Support and Partnerships Increase food access assistance for food insecure individuals for Ascension Saint Alexius community residents.	**Completed**	**Process Measures:** • **Total Cash Donations:** $27,500 • **Total Partnerships:** 7 • **Total Food Pantry Support Volunteer Hours**: 68

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**: 2,763
		• **Total Number of Rides Provided:** 2,756
		  ○ Lyft Concierge: 2,249
		  ○ Uber Concierge: 507

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:** $30K • **Total Individuals Served:** 516 • **Total Number of Families Served:** 129

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 Saint Alexius community.	**Completed**	**Process Measures:** • **Total Number of Programs Available:** 4,940 • **Total Number of Searches Within the Directory:** 19,728 • **Total Number of Sessions:** 7,578 • **Total Number of Referrals Made:** 4,575 • **Total Number of Persons Trained:** 95

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 Measure:**
		• **Total Number of Individuals Provided with Public Health Insurance Coverage Enrollment Services:** 1,371
		• **Total Applications:** 73
		  ○ **Medicaid:** 68
		  ○ **SNAP:** 23
		  ○ **Total Number of Individuals Engaged & Educated:** 1,699

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**: 2,912
		  ○ Nursing: 13,530
		  ○ Other: 1,630
		• **Total Preceptor Hours:** 16,013
		  ○ Nursing: 13,530
		  ○ Other: 2,482

Access to Mental Health Resources and Services

Action(s) taken	Status of action(s)	Results
Emergency Department (ED) Annex Clinical Support Initiative Increase access to mental health assessments, services, education and resources through ED Annex Clinical Support Initiative.	**Completed**	**Process Measure:** • **Total Number of Individuals Served:** 5,472

Maternal and Child Health Resources and Services

Action(s) taken	Status of action(s)	Results
Social Determinants of Health (SDoH) Screening	**Completed**	During the Implementation Strategy cycle, work plans were created to screen birthing patients on health related social needs and provide staff education. Implementation is still underway.

PREM (Patient Related Experience Measure) Tool	**Completed**	During the Implementation Strategy cycle, work plans were created to screen birthing patients on health related social needs and provide staff education. Implementation is still underway.

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 Saint Alexius community residents.	**Completed**	**Process Measures:** • **Total Number of Health Education Occurrences:** 10,790 • **Total Number of Community Health Screenings:** 4,210