Ascension Saint Joseph Chicago

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

June 30, 2025

Ascension

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

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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 Joseph 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

Cook County was selected as Ascension Saint Joseph's community served because it is where the majority of the hospital's primary service area (PSA) is contained. As possible data from the hospital's PSA was included but the majority of community health data is readily available at the county level.

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 Joseph analyzed secondary data of over 75 indicators and gathered community input through surveys and focus groups to identify the needs of the hospital community. AscensionSaint Joseph used a phased prioritization approach to determine the most crucial needs for community stakeholders to address. The significant needs are as follows:

- Access to Healthcare & Affordability
- Mental Health & Substance Use Support
- Food Insecurity
- Housing Instability

Next Steps and Conclusion

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

- Access to Healthcare & Affordability
- Mental Health & Substance Use Support
- Food Insecurity
- Housing Instability

Ascension Saint Joseph 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 Joseph

As a Ministry of the Catholic Church, Ascension Saint Joseph is a non-profit hospital that provides medical care to Chicago and the surrounding communities. Serving Illinois since 1869, Ascension Saint Joseph is continuing the long and valued tradition of addressing the health of the people in our community, following in the footsteps of the legacy of the Daughters of Charity. Saint Joseph was the first Catholic hospital in Chicago and is a full service health care facility licensed for 361 beds, located on Chicago's North side.

For more information about Ascension Saint Joseph Chicago, https://healthcare.ascension.org/locations/illinois/ilchi/chicago-ascension-saint-joseph-chicago-at-2900-n-lake-shore-dr

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 Joseph's 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

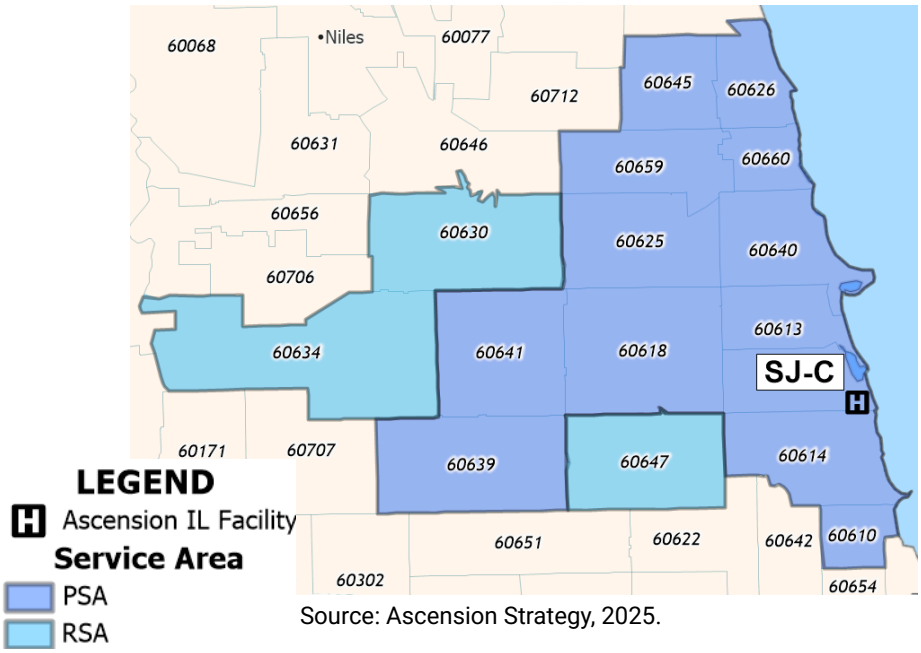
IRS 501(r)(3) and Form 990 Schedule H Compliance

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 Joseph's administration office.

Community Served and Demographics

Community Served

For the purpose of the tax 2024 CHNA, Ascension Saint Joseph has defined its community served as Chicago and surrounding Cook County, which includes the majority of the primary service area. 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. Within the City of Chicago, there are 77 different community neighborhoods. 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:

- There are less children (0-17 years) and older adults (65+ years) within this PSA in comparison to the rest of the county as well as state.

- 28.1 percent are Hispanic or Latino (any race), which is a higher rate than the rest of the county and the state.
- The median household income is higher than the county and state median income ($76,600 for Cook County, $76,700 for Illinois).
- The uninsured rate of the PSA is similar to the rest of Cook County at 10.29%.

Demographic Highlights				
Population				
Indicator	**Hospital PSA**	**Cook County**	**Illinois**	**Description**
Percentage living in rural communities	0.0%	0.1%	13.1%	N/A
Percentage below 18 years of age	17.7%	20.9%	21.6%	N/A
Percentage 65 years of age and over	12.1%	16.2%	17.2%	N/A
Percentage Asian	9.3%	8.3%	6.3%	N/A
Percentage Hispanic	28.1%	26.3%	18.3%	N/A
Percentage non-Hispanic Black	9.0%	22.7%	14.1%	N/A
Percentage non-Hispanic White	49.7%	41.1%	59.5%	N/A
Social and Community Context				
English proficiency households	8.8%	6.68%	4.24%	Proportion of households who speak English “less than well”
Median household income	$87,318	$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	13.07%	13%	12%	Percentage of people in poverty
Percentage of uninsured	10.29%	8%	6%	Percentage of population under age 65 without health insurance
Percentage of unemployment	5.22%	5%	4.6%	Percentage of population ages 16 and older unemployed but seeking work

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

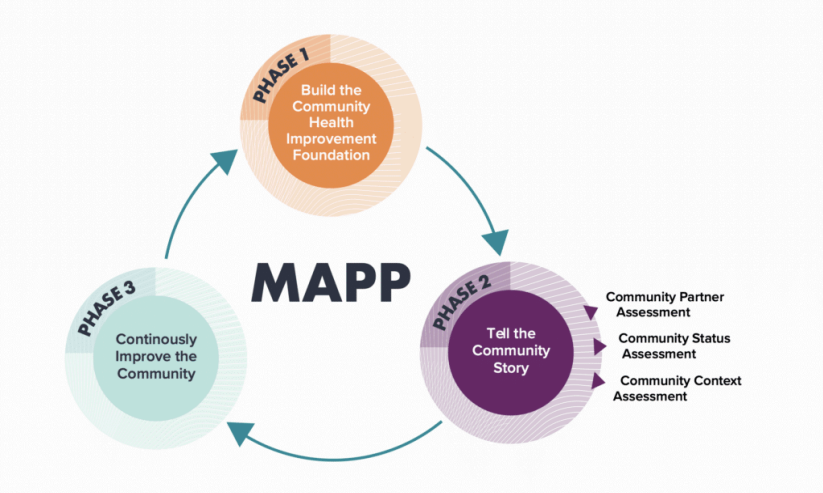
Process and Methods Used

Collaborators

Ascension Saint Joseph 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 Joseph 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 eleven 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

- Overrepresentation of African American/Black respondents (20.7% vs. 10% in the service area).
- Underrepresentation of White (37.5% vs. 48.8%) and Hispanic/Latino (24.6% vs. 29.3%) respondents.
- LGBTQ+ representation: 11.1% identified as LGBTQ+, significantly higher than Illinois' estimated 4.3%.
- Language diversity: 6.3% did not speak English at home; 23.4% spoke Spanish, and 2.4% spoke Polish.

Top Health Concerns

1. Diabetes (36.5%) – The most cited health issue, particularly among Hispanic/Latino (45.5%) and African American/Black (48.2%) respondents.
2. Mental health (35.5%) – A top concern, with Asian respondents identifying it as their #1 issue (44.4%).
3. Heart disease & stroke (34.1%) – Higher concern among Asian (38.9%) and Hispanic/Latino (31.7%) respondents.

4. Age-related illnesses (33.3%) – Notably high among African American/Black (37.6%) and Native American (42.9%) respondents.
5. Cancers (26.5%) – A greater concern for Hispanic/Latino (29.7%) and Asian (33.3%) respondents.

Barriers to Healthcare Access

- 5.4% lack health insurance, lower than Cook County's 10% uninsured rate.
- High appointment barriers: 14.1% skipped care due to cost, 11.9% due to lack of time, and 7.8% due to inconvenient clinic hours.
- Long wait times and lack of specialists contribute to care delays.
- Limited LGBTQ+ healthcare services, including a lack of transgender-affirming care.
- Disparities in healthcare access for low-income and migrant families, with visible gaps between affluent and underserved residents.

Social & Community Issues Impacting Health

- Food insecurity: 24.1% worried about running out of food at least sometimes.
- Safety concerns: 29.6% felt unsafe in their community at least some of the time.
- Child & teen challenges:
    - Social media influence (40.9%)
    - Bullying, including cyberbullying (33.3%)
    - Stress among children and teens (32.8%)
    - Vaping and tobacco use (30.7%)
    - Gun violence (29.2%)

Most Needed Support Services

1. Access to healthcare (51.1%) – A major need across all demographics.
2. Mental health services (45.7%) – Requests for more affordable and culturally competent mental health care.
3. Community services (40.4%) – Greater outreach, support for disadvantaged families, and services for people with disabilities.
4. Access to healthy food (31.6%) – Food insecurity and nutrition programs needed.
5. Affordable housing (20.2%) – Particularly important for low-income families.

Community Recommendations

- **Expand free and culturally competent mental health services**, including Spanish-speaking providers.

- **Increase affordable healthcare access**, including LGBTQ+ affirming services and better outreach about available programs.
- **Improve food security programs** by increasing access to fresh and healthy food.
- **Enhance community engagement** through education, outreach, and support services, including more disability-focused resources.
- **Address disparities in care and social services** by strengthening partnerships between hospitals, nonprofits, and local organizations.

Community Focus Group

A focus group in collaboration with the hospital volunteers was held to gather feedback on the health needs and assets of the community. Ten individuals participated in the focus groups, held in August 2024. Populations represented by participants included older adults.

Key Findings

Community Strengths

- High-quality healthcare services: Participants praised the nurses and physical therapy services, particularly during the pandemic.
- Community engagement with SJH-C: The hospital serves as a gathering point for local residents, including churchgoers and visitors to the café and gift shop.
- Safe and well-connected area: The neighborhood is considered safer and more affluent compared to nearby areas, with excellent public transportation access.

Community Challenges

- Housing affordability: Rising rents and property costs are making the area difficult to afford, particularly for seniors and lower-income residents.
- Geographic limitations: SJH-C's easternmost location makes it harder for residents from other parts of Chicago to access services.
- Safety disparities: While the hospital's immediate surroundings are safe, nearby neighborhoods such as Buena Park experience safety concerns requiring student escorts.

Health & Social Needs

Housing & Transportation

- Homelessness and mental health issues are growing concerns. Participants questioned whether SJH-C collaborates with shelters.

- Migrant community support is needed. Increasing numbers of migrants are seeking assistance, with churches playing a key role.
- Better outreach is needed for available transportation services, such as PACE and other local programs.

Workforce Development

- Positive progress with increased participation from interns, high school students, and nursing students.
- Strong hospital partnerships with Speer Academy, Northside Learning Center, and CPS summer programs, leading to students returning for employment.
- Challenges in public education persist, including large class sizes and teacher shortages.

Access to Care & Insurance Coverage

- Wellness programs and health fairs have declined since COVID-19. Participants emphasized the need to restore health education initiatives like cooking demonstrations, exercise classes, and screenings.
- The cost of care and prescriptions is too high.
- Long wait times:
    - Three weeks for test results and months for specialist appointments.
    - Medicare coverage confusion—seniors struggle with managing costs and coverage.

Mental Health & Substance Use Disorder

- More mental health resources are needed, especially for the homeless. Many residents are unaware of available services.
- Staff training is needed to better direct people to mental health resources.
- Stigma remains a barrier, particularly for older adults. Participants suggested using age-group role models to encourage mental health treatment.
- Substance use treatment gaps due to staffing turnover.

Community Services & Housing Concerns

- Gentrification is pushing out lower-income residents.
- Single Room Occupancy (SRO) developments are reducing affordable housing options.
- Chicago Housing Authority (CHA) buildings nearby are empty and poorly maintained, leaving seniors without adequate housing.

Actionable Recommendations

- **Improve outreach and education** on available health and social services.
- **Expand affordable mental health services**, including for non-severe cases like anxiety and depression.
- **Reinstate wellness programs**, health fairs, and free screenings.
- Address staff turnover and **improve support in addiction recovery services**.
- **Explore partnerships with local food assistance programs** such as Common Pantry and Green City Market to provide food access at the hospital

Community Partner Assessment

An online survey was completed between November 2024-February 2025 by seven 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, Native American/Indigenous/Alaska Native, and Pacific Islander/Native Hawaiian communities.

Key Findings

1. **Community Health Improvement:** 57.1% of organizations have participated in a community health improvement process.
2. **Community Strengths and Weaknesses:** Community partners highlighted the strengths of diversity, commitment to services, and resource availability. However, they noted weaknesses such as lack of education, access to care, economic challenges, limited mental health resources, and security concerns.
3. **Health Concerns:** The most pressing health issues identified were mental health, access to care, social determinants of health (SDOH), community education, cardiovascular disease, and food/nutrition.
4. **Social Issues:** Key social issues include food security, health insurance coverage, poverty, homelessness, employment, and lack of transportation.
5. **Disproportionate Impact:** Populations most impacted by these challenges include the migrant/immigrant community, Latinx/Hispanic, Black/African American, older adults, children, teens, and LGBTQ+ individuals.
6. **Health Drivers and Barriers:** Socioeconomic factors, healthcare access, and affordability were identified as key drivers of health needs, with economic constraints, limited healthcare services, and lack of health education being major barriers.
7. **Healthcare Gaps:** The community faces significant gaps in access to care, social determinants of health programs, and affordable healthcare options.

8. **Policy and Resource Needs:** Community partners called for improved access to care and SDOH programs, community education campaigns, revised Medicaid eligibility, reduced co-pays, and the development of user-friendly digital tools.
9. **Hospital Role:** Hospitals were seen as vital in offering diverse communication channels, expanding community outreach, providing digital tools for accessibility, and connecting with social service providers to organize educational and preventative services.
10. **Health Service Access:** The majority of individuals in the community seek health services at emergency departments (85.7%), immediate care/walk-in clinics (71.4%), and local hospitals/clinics (57.1%).
11. **Collaboration and Impact:** Community partners collaborate through community events, joint initiatives, education, and partnerships with hospital staff. Successful initiatives include food pantries, health fairs, mental health awareness campaigns, and transportation programs.
12. **Effective Communication:** SMS text messaging, email outreach, social media, in-person seminars, and flyers in high-traffic areas were identified as the most effective communication channels.
13. **Community Engagement:** The majority of respondents (85.7%) felt the community had moderate engagement, with 28.5% indicating high engagement.
14. **Ideal Collaboration:** An ideal partnership would involve coordinated marketing, outreach initiatives, collaboration across sectors to meet community needs, and effective communication about available resources and services.

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

Summary of Secondary Data

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

Health indicators in the following categories were reviewed:

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

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

Community Status Assessment

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

Top Three Health Concerns

1. High Prevalence of Chronic Diseases
    - Diabetes rates are significant in 60639 (14.7%) and 60659 (12.9%), surpassing national levels.
    - Obesity rates in 60639 (38.9%) and 60641 (34.0%) indicate a need for prevention programs.
2. Elevated Binge Drinking Rates
    - 23.17% of adults engage in binge drinking, exceeding county, state, and national averages.
    - Highest rates are concentrated in 60657 (28.6%), requiring targeted awareness campaigns.
3. Healthcare Access Barriers
    - Uninsured rate (10.29%) is higher than county, state, and national levels.
    - Limited primary care provider availability (94.3 per 100,000) affects access to preventive care.

Top Three Community Concerns

1. Food Insecurity and Economic Disparities
    - Food insecurity (13.5%) is above county and state averages.
    - High poverty rates exist in 60640 (18.73%) and 60626 (17.74%), affecting overall health outcomes.
2. Housing Affordability and Cost Burden
    - Owner-occupied housing (40.77%) is lower than state and national rates.
    - High housing cost burden (35.87%) disproportionately impacts Pacific Islander/Native Hawaiian (54.30%) and Black (43.15%) communities.
3. Environmental and Infrastructure Concerns
    - High proximity to Superfund (toxic waste) sites, especially in 60610 (3.974 km).

- Public transportation use (23.01%) is higher than county and state levels, highlighting reliance on transit for healthcare access.

This report underscores the need for enhanced chronic disease management, improved healthcare access, and targeted community support programs to address disparities and improve quality of life in the Ascension Saint Joseph Chicago service area.

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

Written Comments on Previous CHNA and Implementation Strategy

Ascension Saint Joseph's 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:

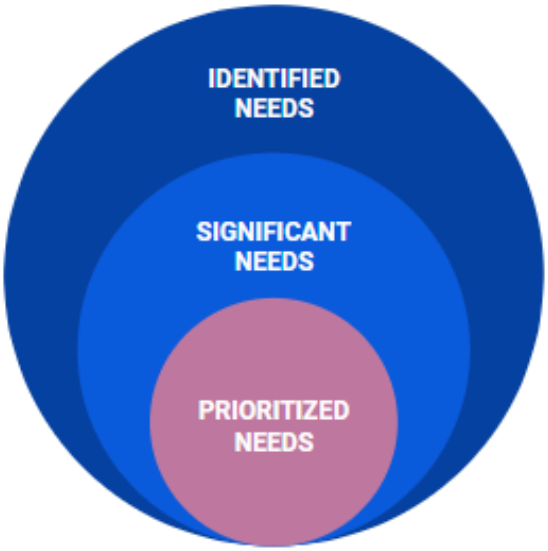
- Some groups of individuals may not have been adequately represented through the community input process that might include persons who are experiencing homelessness, persons who speak other languages other than English, Spanish or Polish.
- Secondary data is limited in a number of ways, including timeliness, 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 Joseph 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 Joseph analyzed secondary data of over 75 indicators and gathered community input through surveys and focus groups to identify the needs in Cook County. Ascension Saint Joseph 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 Joseph 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 Joseph 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:

- Access to Healthcare & Affordability
- Mental Health & Substance Use Support
- Food Insecurity
- Housing Instability

To view healthcare facilities and community resources available to respond to the significant needs, please see Appendix E (Page 84).

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

Access to Healthcare & Affordability

Significance	Populations Most Impacted
A significant portion of the community lacks adequate health insurance, which limits their ability to access primary and specialty care services. Many residents rely on emergency rooms for care due to affordability and provider shortages in their neighborhoods. *Source: Community Status Assessment (CSA) Saint Joseph Chicago, 2025. 2021 CHNA Ascension Saint Joseph Chicago, 2021. Cook County Community Input Survey Data Analysis LEP, 2025.*	• Uninsured or underinsured residents • Residents within 60639 zip code (Belmont Cragin) • Low-income individuals unable to afford out-of-pocket healthcare costs • Seniors with limited Medicare coverage, especially for specialist care • Immigrant & migrant populations with language or legal barriers to insurance enrollment

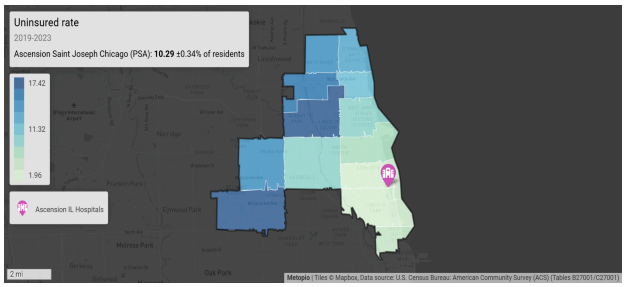
Community Input Highlights

- 51.1% of total survey respondents identified access to healthcare as their top needed support
- Emergency department use is high (85.7%) among survey respondents due to lack of accessible care alternatives with many delaying or avoiding necessary medical care:
    - 14.1% skipped care due to cost, 11.9% due to lack of time, and 7.8% due to inconvenient clinic hours
- There are disparities in healthcare access for low-income and migrant families, with visible gaps between affluent and underserved residents within the PSA geography; there are Limited LGBTQ+ healthcare services, including a lack of transgender-affirming care
- Black/African American survey respondents ranked access to healthcare at top needed support (43.5%), and Hispanic/Latino (52.5%)
- Concerns about high prescription costs, lack of affordable care options, long wait times for specialists, and Medicare confusion among seniors were noted in the focus group
- The geographic location of the main SJ-C campus makes it hard for residents from other parts of Chicago to access services was noted in the focus group
- Community partners named access to care and health insurance coverage as top health and social issues for the community with access and affordability as key drivers
- Community partners felt hospitals play vital role in expanding community outreach, providing digital solutions and connecting with social service partners to collaborate on educational and preventative services

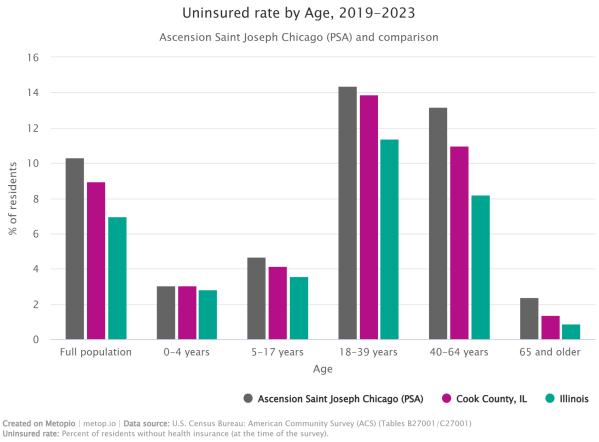
Secondary Data Highlights

Uninsured rate (10.29%) is higher than county, state, and national levels. A heat map of the hospital PSA reveals that the highest uninsured rates are concentrated in the northern and	The uninsured rate varies significantly by race and ethnicity. Pacific Islander/Native Hawaiian (19.08%) and Hispanic or Latino (19.20%) residents have the highest uninsured rates, surpassing county and state

western areas. The zip code 60639 has an uninsured rate of 17.42%.

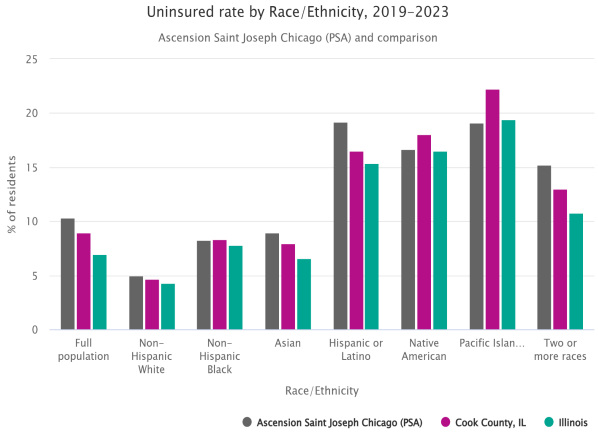


Men in the PSA have higher uninsured rates (11.2%) compared to women, reflecting potential differences in employment types, access to benefits, or healthcare-seeking behaviors. Additionally, younger adults face higher uninsured rates, with 18-39 year-olds experiencing the highest percentage (14.35%). This indicates a gap in coverage for working-age adults, potentially due to cost barriers or lack of employer-sponsored insurance.

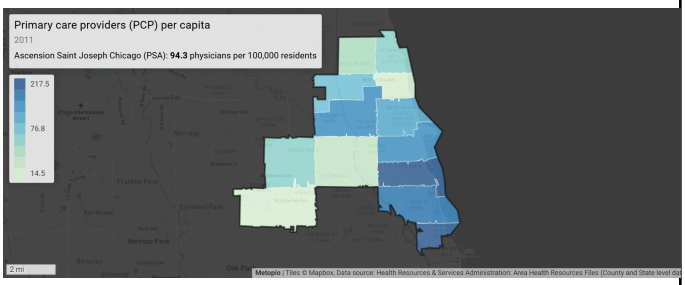


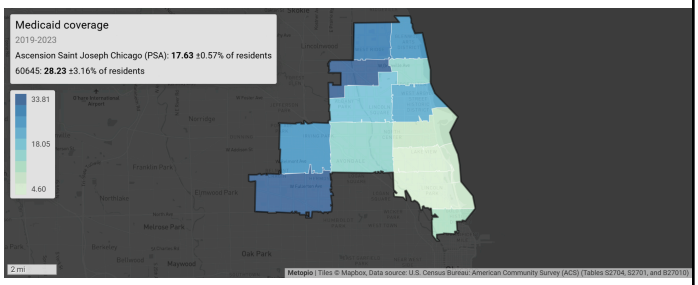
Sources: U.S. Census Bureau, American Community Survey, 2023.

averages. This suggests a need for targeted outreach and support for these communities.



The availability of primary care providers is concentrated in the eastern part of the hospital PSA creating access issues for those residing in other parts of the PSA including those who reside in areas with higher percentages of residents with Medicaid coverage (see second heat map).





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

Mental Health & Substance Use Support

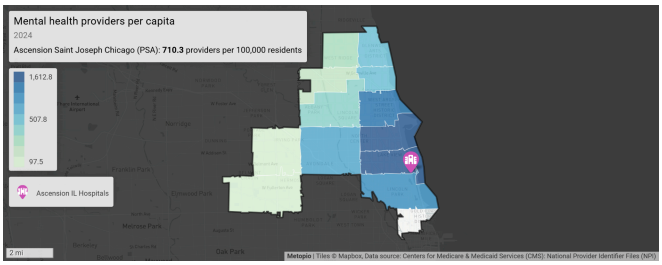
Significance	Populations Most Impacted
Mental health concerns, including depression, anxiety, PTSD, and suicide as well as substance misuse were frequently reported as top health concern affecting the community. Limited access to mental health care, high levels of stress, and economic hardship were identified as barriers to overall well-being. Stigma and workforce shortages also limit access. *Sources: Community Status Assessment (CSA) Saint Joseph Chicago 2025. Cook County Community Input Survey Data Analysis LEP, 2025.*	• Low-income residents with limited insurance coverage • Residents within 60639 zip code (Belmont Cragin) • Seniors experiencing isolation and mental health decline • Adolescents and young adults facing stress and anxiety • Uninsured and underinsured individuals • Persons experiencing homelessness • Black/African American, Asian, LGBTQ+ communities

Community Input Highlights

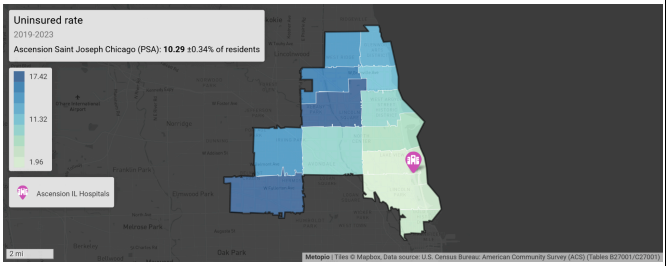
- 35.5% of survey respondents identified mental health as a top health issue; 44.4% of Asian respondents said mental health was the top health issue for the community
- 45.7% of survey respondents reported a need for better access to mental health services
- Community focus groups emphasized a lack of culturally competent mental health providers, particularly for non-English speakers and marginalized populations whereas survey respondents said more affordable mental health services were needed as well as culturally competent care
- 42.4% of Black/African American survey respondents and 45.5% of Hispanic/Latino respondents prioritized access to mental health services
- Limited mental health services cited as a key barrier, with hospitals needing to increase outreach and education on available resources to help with stigma reduction.
- Community partners said mental health was the most pressing health concern of the community

Secondary Data Highlights

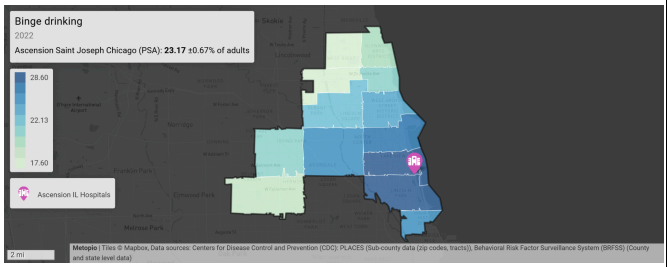
The heat map below shows the mental health provider availability for the hospital PSA. While the overall rate of mental health providers for the PSA is higher than the county, state and nation rates, there are geographical disparities that exist. Providers are most concentrated on the eastern portions of the service area creating access issues for those that reside in the western part of the service area. Those that reside in the western part of the service area also are less likely to be insured (second heat map).	A heat map shows the concentration of binge drinking to be highest in the eastern and southern portions of the hospital PSA with the highest percentage in 60657 (28.6%).



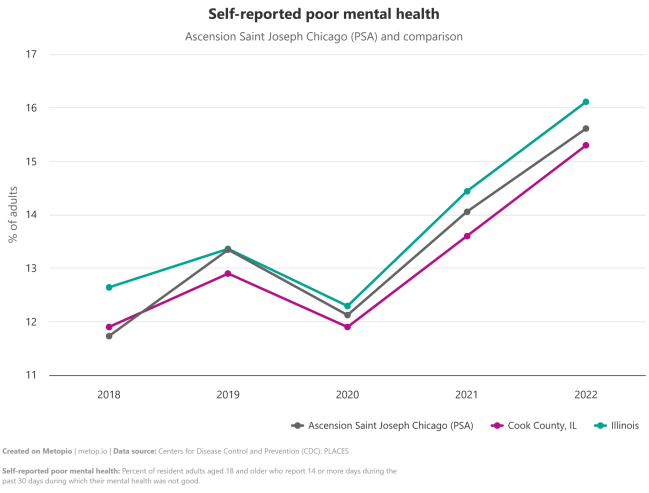
A heat map shows the northern and western portions of the hospital PSA with the highest rates of adults who are uninsured or without health insurance. The zip code 60639 has 17.42% uninsured residents. Those persons who are underinsured or uninsured face significant barriers to all forms of health services.



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



Self-reported poor mental health for the PSA is lower than the Illinois rate, but higher than the rest of Cook County, The rate has also been increasing in the last five years displayed (2018-2022).



Source: Centers for Disease Control & Prevention (CDC) Places, 2022.

Food Insecurity

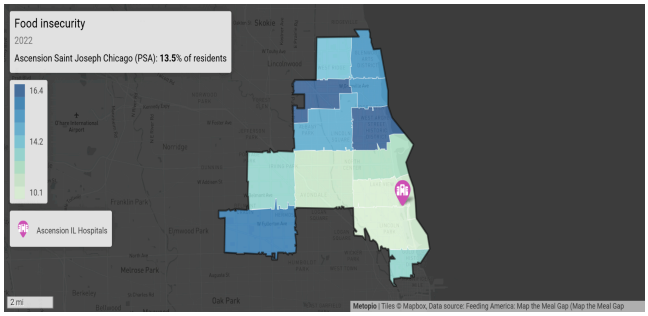
Significance	Populations Most Impacted
Food insecurity remains a significant issue, affecting physical and mental health outcomes. Limited access to affordable, nutritious food contributes to chronic conditions like diabetes and heart disease. *Sources: Cook County Community Input Survey Data Analysis, 2025. Community Status Assessment (CSA) Saint Joseph Chicago 2025.*	● Low-income families struggling to afford nutritious meals ● Senior residents on fixed incomes ● Children relying on school meal programs ● Immigrant and migrant communities ● Residents within 60639 zip code (Belmont Cragin) and 60640 zip code (Uptown)

Community Input Highlights

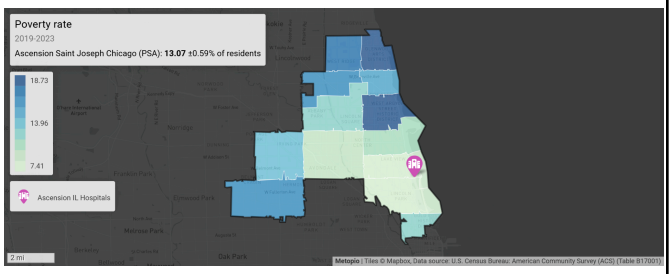
- 55% of survey respondents ranked hunger and food insecurity as a top concern while 24.1% worried about running out of food at least sometimes
- 44.6% of Hispanic/Latino respondents prioritized access to healthy food on the community input survey and 38.8% of Black/African American respondents identified food insecurity as a primary issue
- 31.6% of survey respondents said more nutrition and food insecurity programs are needed in the community especially those that increase access to fresh and healthy foods
- Food, nutrition and food insecurity were named as top health and social issues by community partners with economic constraints a key barrier for the issue
- Collaboration with food pantries was named by community partners as a successful method to engage with the community

Secondary Data Highlights

The map highlights food insecurity across Ascension Saint Joseph Chicago's service area, showing varying levels of need, with some regions experiencing significantly higher food access challenges. Food insecurity (13.5%) is above county and state averages within the PSA. The heat map of the percentage of population experiencing food insecurity shows areas further north (zip code 60659: 15.8%; 60640: 16.4%) and west (60639: 15.6%) with the PSA having greater levels.

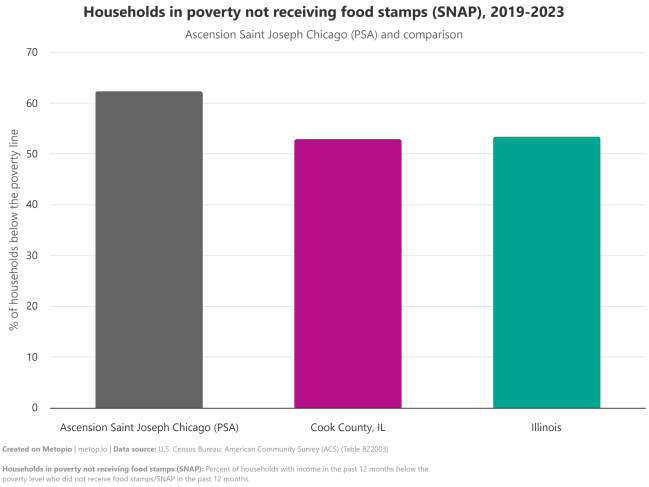


Poverty levels and access to food are linked. The heat map of the percent of families that are in poverty (below the Federal Poverty Level) similarly shows areas further north (60640: 18.73%; 60626: 17.74%) and west (60639: 16.4%) in the PSA having the greater levels.



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

This chart displays households in poverty that are not receiving food stamps (SNAP). 62.29% 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.



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

Housing Instability

Significance	Populations Most Impacted
Housing instability and homelessness contribute to poor health outcomes, including increased rates of mental illness, substance use, and chronic disease. Many residents face housing insecurity due to rising housing costs, gentrification and limited affordable housing options including senior housing. *Source: Community Status Assessment (CSA) Saint Joseph Chicago, 2025. 2021 CHNA Ascension Saint Joseph Chicago, 2021.*	• Individuals experiencing chronic homelessness • Families living in temporary shelters • Low-income renters at risk of eviction • Seniors on fixed incomes • Native American and Pacific Islander residents • Black/African American residents • Hispanic/Latino residents • Residents within 60639 zip code (Belmont Cragin) and 60626 zip code (Rogers Park) • Immigrant and migrant communities

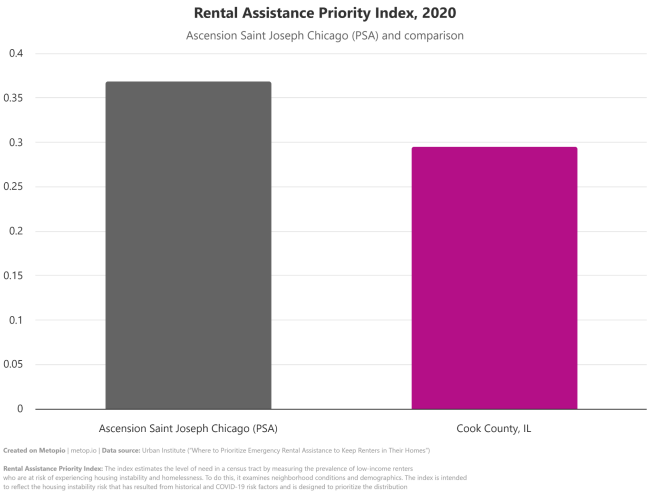
Community Input Highlights

- 45% of respondents identified homelessness and housing instability as a major concern
- 29.4% of Black/African American respondents and 16.8% of Hispanic/Latino respondents ranked affordable housing as a top priority
- Community partners linked unstable housing to worsening health conditions; focus group participants said homelessness and mental health issues are growing community concerns
- Emergency shelters are at capacity, leaving many without stable housing per community partners
- Gentrification is pushing out lower-income residents including seniors leaving many without adequate housing per focus group participants
- Homelessness was named as top social community concern by community partners

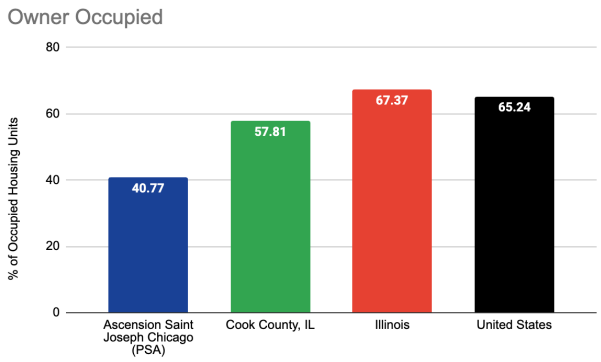
Secondary Data Highlights

Over 35% of households in the Ascension Saint Joseph PSA are cost-burdened, a higher rate than Cook County, Illinois, and the U.S.. Rental assistance programs and affordable housing initiatives could help alleviate this burden.This chart displays the racial disparities in housing cost burden across the hospital PSA, Cook County, and Illinois. The populations most affected by housing costs are Pacific Islander/Native Hawaiian (54.30%) Native American (48.91%), and non-Hispanic Black (43.15%) emphasizing the need for affordable housing solutions to prevent financial strain and displacement.	Homeownership in the Ascension Saint Joseph Chicago PSA (40.77%) is much lower than the county, state, and national averages. This demonstrates greater vulnerability to rent increases, eviction, and displacement.

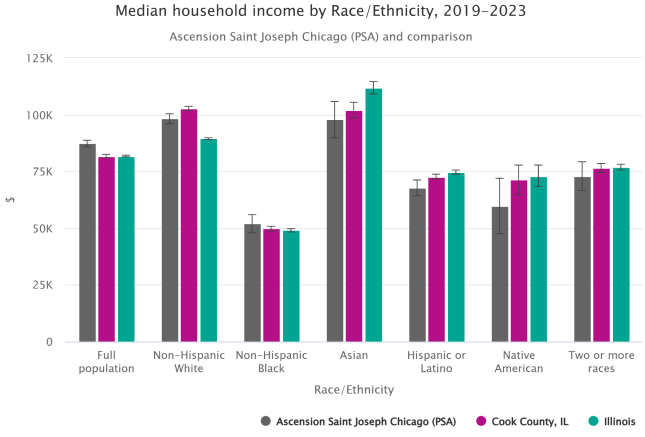
The rental assistance priority index estimates the level of need in a census tract by measuring the prevalence of low-income renters who are at risk of experiencing house instability and homelessness. The rental assistance priority index is higher in the hospital PSA than the rest of Cook County indicating higher risk for homelessness.

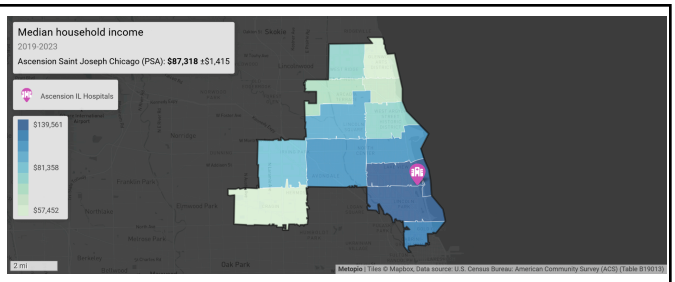


Source: U.S. Census Bureau, American Community Survey, 2023. Urban Institute, 2020.



A stratification chart of median household income by race and ethnicity shows disparities. The non-Hispanic White and Asian races have the highest median household incomes of $98,264 and $98,000 respectively. The Native American population and Non-Hispanic Black population have the lowest median household incomes of $59,609 and $51,960 respectively. The heat map below shows the median household income by zip code within the PSA. There are geographical disparities in income within zip codes 60626 ($57,452) and 60639 ($59,710) having the lowest median household income.





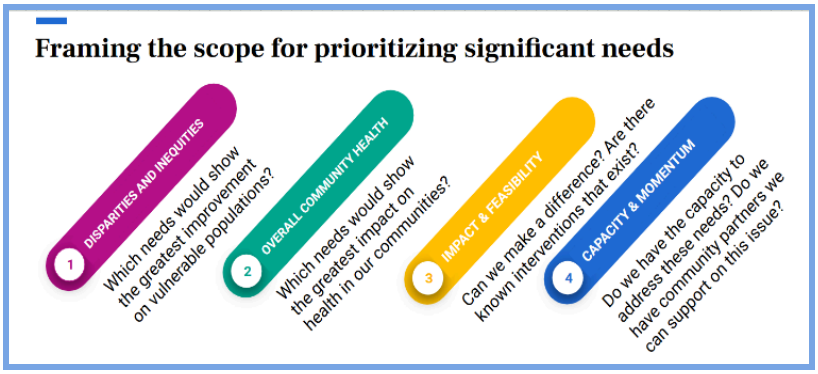
Sources: U.S. Census Bureau, American Community Survey, 2023.

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 Joseph 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 Joseph 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:

- **Access to Healthcare & Affordability** *(Access to Care - Clinical Care): A significant portion of the hospital community lacks adequate health insurance, which limits their ability to access primary and specialty care services. Many residents rely on emergency rooms for care due to affordability and provider shortages. 51.1% of total survey respondents identified access to healthcare as top needed support; Emergency department use is high (85.7%) due to lack of accessible care alternatives among respondents. Concerns about high prescription costs, lack of affordable care options, long wait times for specialists, and Medicare confusion among seniors were noted.*

Community partners named access to care and health insurance coverage as top health and social issues for the community with access and affordability as key drivers

- **Mental Health & Substance Use Support** *(Mental Health - Quality of Life & Substance Misuse - Health Behaviors) Mental health concerns, including depression, anxiety, PTSD, and suicide as well as substance misuse were frequently reported as top health concern affecting the community. Limited access to mental health care, high levels of stress, and economic hardship were identified as barriers to overall well-being. Stigma and workforce shortages also limit access. 35.5% of survey respondents identified mental health as a top health issue & 45.7% of respondents reported a need for better access to mental health services. Community input emphasized a lack of affordable and culturally competent mental health providers, particularly for non-English speakers and marginalized populations. Limited mental health services cited as a key barrier, with hospitals needing to increase outreach and education on available resources to help with stigma reduction.*
- **Food Insecurity** *(Income - SDoH) Food insecurity remains a significant issue, affecting physical and mental health outcomes. Limited access to affordable, nutritious food contributes to chronic conditions like diabetes and heart disease. 55% of respondents ranked hunger and food insecurity as a top concern. 44.6% of Hispanic/Latino respondents and 38.8% of Black/African American respondents prioritized access to healthy food as a key community need. Food insecurity (13.5%) in the PSA is above county and state averages with varying needs across the area. 31.6% of survey respondents said more nutrition and food insecurity programs are needed in the community especially those that increase access to fresh and healthy foods*
- **Housing Instability** *(Housing - SDoH) Housing instability and homelessness contribute to poor health outcomes, including increased rates of mental illness, substance use, and chronic disease. Many residents face housing insecurity due to rising housing costs, gentrification and limited affordable housing options including senior housing. 45% of respondents identified homelessness and housing instability as a major concern. 29.4% of Black/African American respondents and 16.8% of Hispanic/Latino respondents ranked affordable housing as a top priority. Community partners & focus group participants linked unstable housing to worsening health conditions including mental health issues. Emergency shelters are at capacity, leaving many without stable housing while gentrification pushes out lower-income residents especially seniors.*

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

- Transportation
- Economic Vitality and Workforce Development
- Resources, Referrals, Coordination, and Connection to Community-Based Services
- Timely Linkage to Quality Care, including Behavioral Health and Social Services
- Mental Health
- Substance Use Disorders

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

- 852 rides provided for individuals identified as needing transportation assistance
- 7,325 preceptor hours provided for highschool and college students
- 4,575 referrals were made from Ascension's Neighborhood Resource Directory
- 1,699 individuals were provided with Public Health Insurance Assistance enrollment services
- 97% of individuals that screened positive for substance used disorders received access to narcan treatment

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

Approval

To ensure Ascension Saint Joseph' s 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 Joseph 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 Joseph community partners to guide the implementation strategies and community health improvement efforts as required by the Affordable Care Act. The tax year 2024 HNA will also be available to the broader community as a useful resource for further health improvement efforts.

As a Catholic health ministry, Saint Joseph 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 Joseph 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	809,121	5,087,072	12,549,689	334,914,896
Male	49.5%	48.9%	49.5%	49.6%
Female	50.5%	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	9.3%	8.3%	6.3%	6.3%
Non-Hispanic Black / African American	9.0%	22.7%	14.1%	12.6%
Hispanic / Latino	28.1%	26.3%	18.3%	19.1%
American Indian or Alaska Native	0.1%	0.8%	0.6%	1.3%
Non-Hispanic White	49.7%	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	17.7%	20.9%	21.6%	21.7%
Ages 65+	12.1%	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	$87,318	$76,600	$76,700	$74,800
ALICE Households	32.73%	35.48%	37.00%	42.00%
Poverty	13.07%	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	88.9%	88.55%	90.55%	89.78%
Associate's degree or higher	73.94%	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	10.29%	7.79%	6.16%	7.93%
Medicaid Coverage	17.63%	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, seven completed surveys were collected from different types of organizations including schools/educational institutions, non-profit organizations, grassroots organizations and health providers including:

Nourishing Hope
City Colleges of Chicago-Malcolm X College School of Nursing
Sharing Notes
North Grand High School (CPS)
Community Health
Advocatia Solutions Inc.

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 Joseph Chicago 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 for the PSA is lower than the county and state rates. The percentage of adults with coronary heart disease and diagnosed diabetes is lower than the county, state, and national levels. The low birth rate percentage is significantly lower than the county, state, and national rate. The adult obesity rate is also lower than the county, state, and national rates.

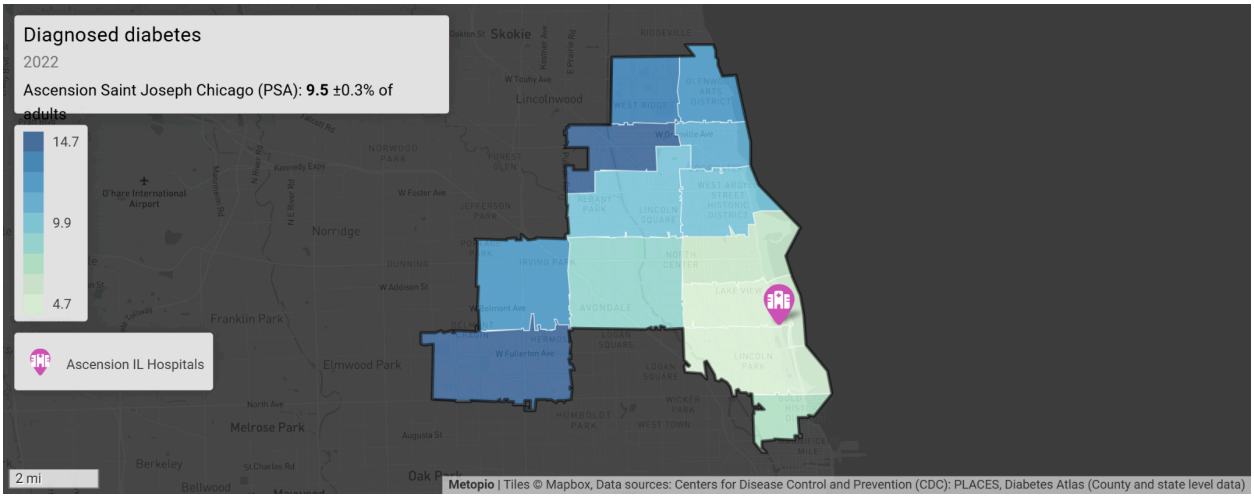
Topic	Ascension Saint Joseph Chicago (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Cancer diagnosis rate *per 100,000 residents* 2017-2021	**494.51**	547.69	573.24	444.40	n/a
Coronary heart disease *% of adults* 2022	**4.46**	5.10	5.37	5.82	n/a

COVID-19 case rate *cumulative cases per 100,000 population* Mar 2023	–	29,479.86	31,887.08	32,217.47	n/a
Diagnosed diabetes *% of adults* 2022	**9.5**	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* 2022	**6.0**	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	**30.7**	32.8	34.4	33.8	n/a

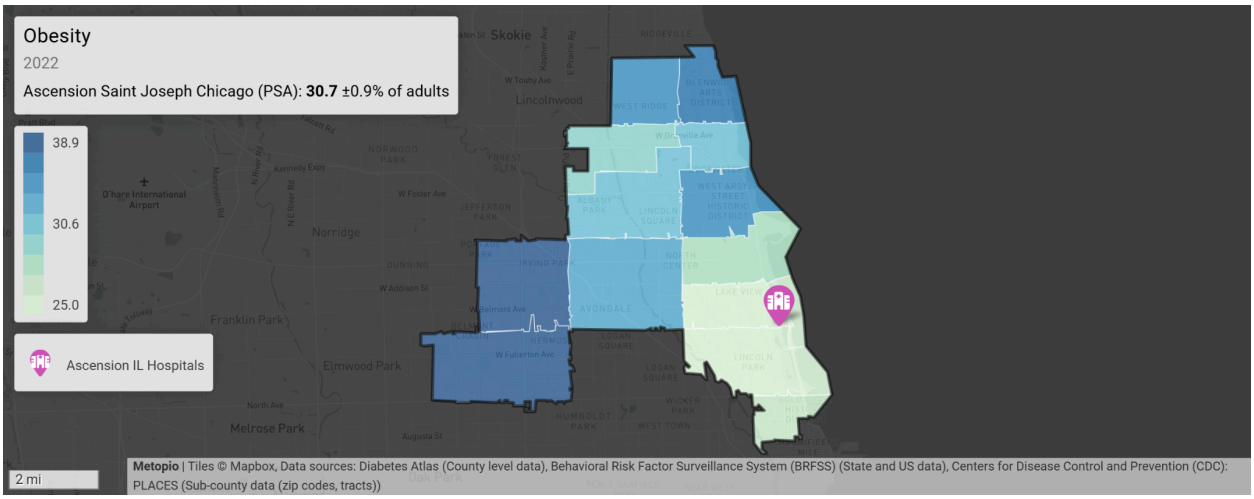
Sexually transmitted infection prevalence *cases per 100,000* 2022	–	1,720.9	1,139.5	1,113.6	n/a

Stratifications & Heat Mapping

The heat map of percentage of adults with diagnosed diabetes shows areas further north (zip code 60659: 12.9%) and west (60639: 14.7%) with the PSA having greater levels.



The heat map of the percentage of adults with obesity shows areas further north (zip code 60626: 33.9%) and west (zip codes: 60641: 34.0%; 60639: 38.9%) within the PSA having greater levels.


Obesity
2022
Ascension Saint Joseph Chicago (PSA): 30.7 ±0.9% of adults
38.9
30.6
25.0
Ascension IL Hospitals
Skokie
Lincolnwood
Norridge
Franklin Park
Elmwood Park
Melrose Park
O'hare International Airport
2 mi
Metopio | Tiles © Mapbox, Data sources: 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))

Economic Stability Indicators

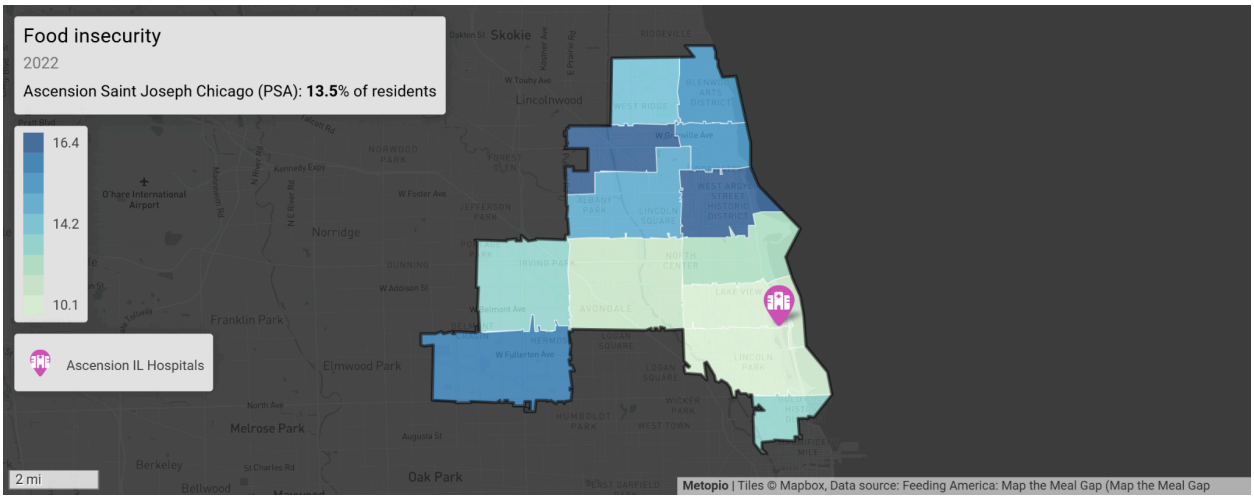
The food insecurity rate is higher in the PSA than the county, state, and national rates. The median selected monthly owner costs is drastically higher than the county, state, and national level. The percentage of owner occupied housing units is notably lower than the county, state, and national percentages. The poverty rate is higher than the state and national rate, but lower than the rest of the county.

Topic	Ascension Saint Joseph Chicago (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Food insecurity *% of residents* 2022	**13.5**	12.1	12.0	13.3	n/a
Median selected monthly owner costs (SMOC) *dollars* 2019-2023	**$2,301**	$1,602	$1,366	$1,320	n/a
Owner occupied *% of occupied housing units* 2019-2023	**40.77**	57.81	67.37	65.24	n/a
Median household income *dollars* 2019-2023	**$87,318**	$80,579	$80,306	$77,719	n/a
Poverty rate *% of residents* 2019-2023	**13.07**	13.29	11.63	12.46	8.00

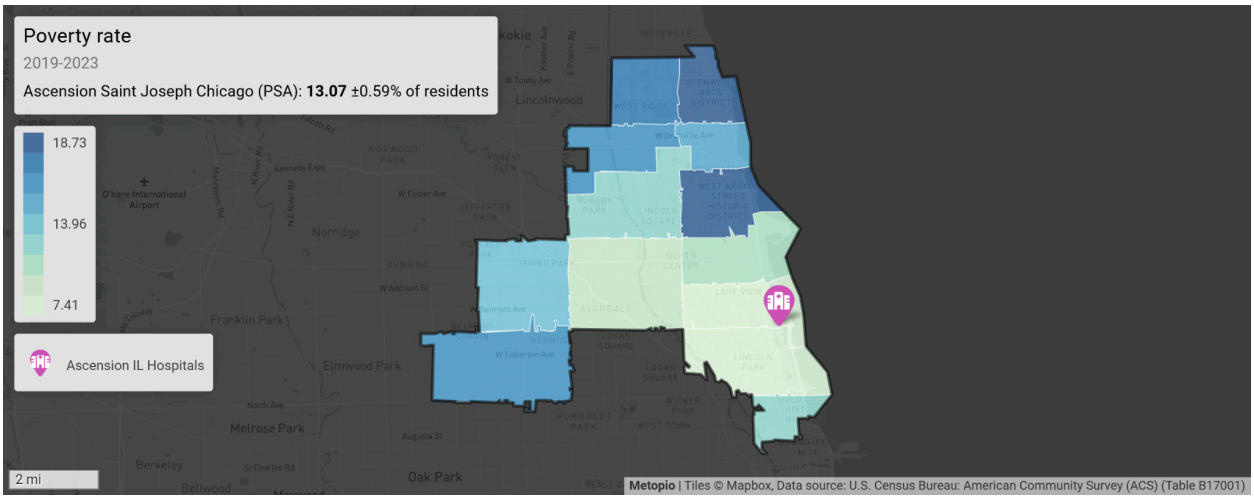
Unemployment rate (BLS) % Nov 2024	--	5.3	4.8	4.0	n/a

Stratifications & Heat Mapping

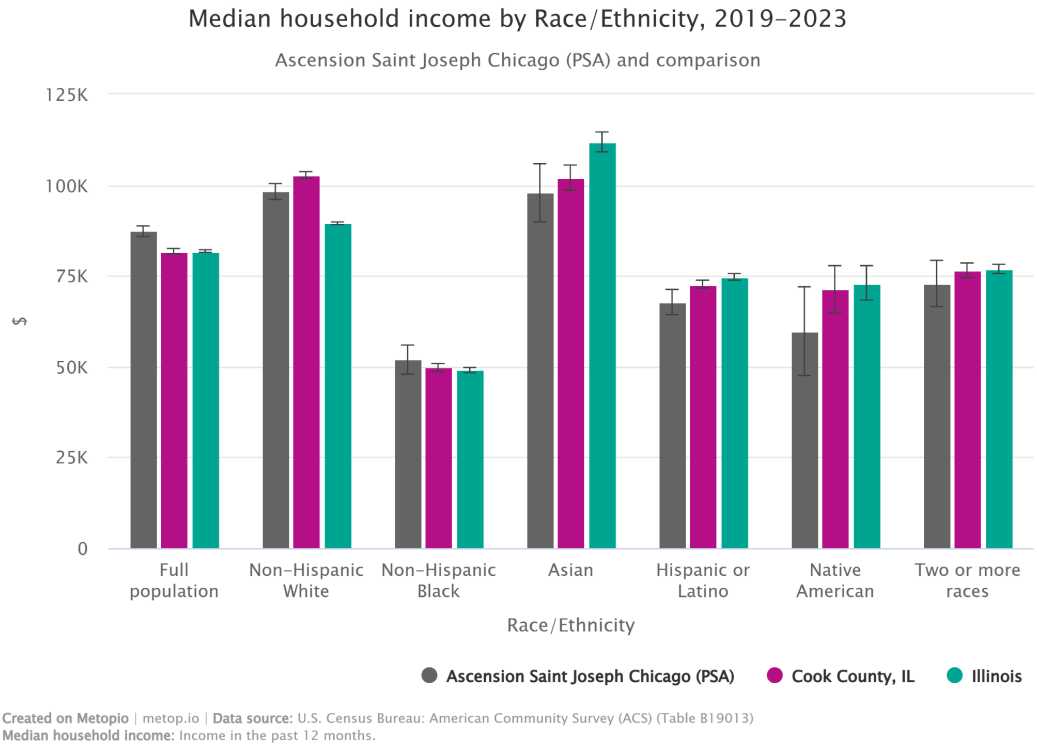
The heat map of the percentage of population experiencing food insecurity shows areas further north (zip code 60659: 15.8%; 60640: 16.4%) and west (60639: 15.6%) with the PSA having greater levels.



The heat map of the percent of families that are in poverty (below the Federal Poverty Level) similarly shows areas further north (60640: 18.73%; 60626: 17.74%) and west (60639: 16.4%) in the PSA having the greater levels.



A stratification chart of median household income by race and ethnicity shows disparities. The non-Hispanic White and Asian races have the highest median household incomes of $98,264 and $98,000 respectively. The Native American population and Non-Hispanic Black population have the lowest median household incomes of $59,609 and $51,960 respectively.



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.

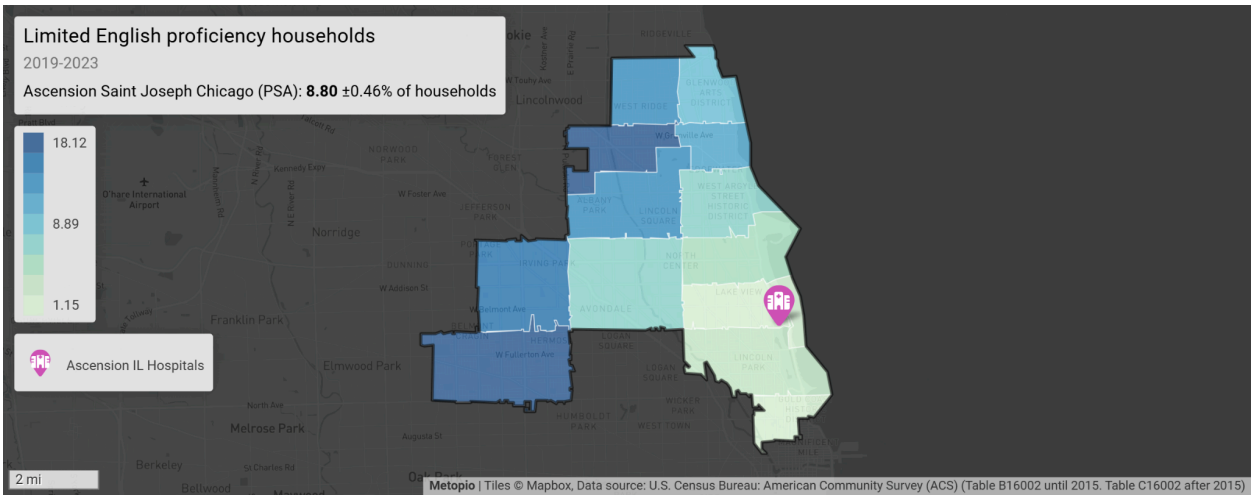
Education & Quality of Life Indicators

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

Topic	Ascension Saint Joseph Chicago (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
High school graduation rate *% of residents* 2019-2023	88.94	88.55	90.55	89.78	n/a
Preschool enrollment *% of toddlers ages 3-4* 3-4 years, 2019-2023	**58.12**	49.97	52.25	48.45	n/a
Limited English proficiency households *% of households* 2019-2023	**8.80**	6.68	4.24	4.36	n/a

Stratifications & Heat Mapping

A heat map shows the concentration of limited-English proficiency households to be highest in the north and western portions of the hospital PSA with the highest percentage in 60639 (18.12%).



Health Behavior Indicators

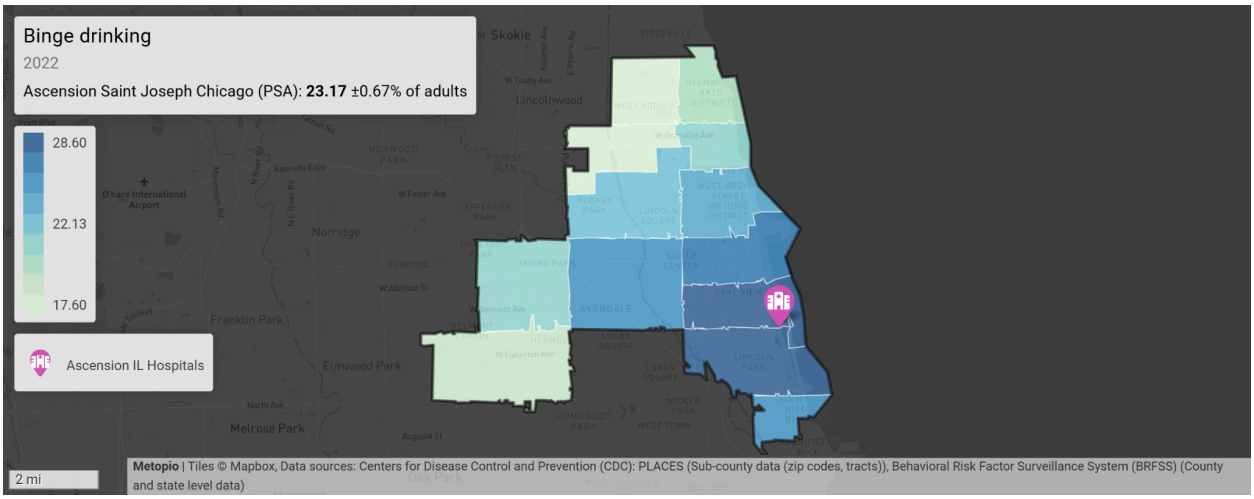
The percentage of adults that binge drink is significantly higher in the PSA than the county, state, and national percentage. The percentage of adults that have received colorectal cancer screening is higher than the county and state level. The rate of adults that do not exercise and receive mammograms is similar to county, state, and national rates. The cigarette smoking rate in the PSA is lower than the county, state, and national rate. The teen birth rate is remarkably lower than the county, state, and national rates.

Topic	Ascension Saint Joseph Chicago (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Binge drinking *% of adults* 2022	**23.17**	20.80	20.37	18.58	25.40
Colorectal cancer screening *% of adults* 2022	**56.99**	52.70	55.37	58.85	68.30
No exercise *% of adults* 2022	**19.5**	20.9	21.5	23.7	21.8

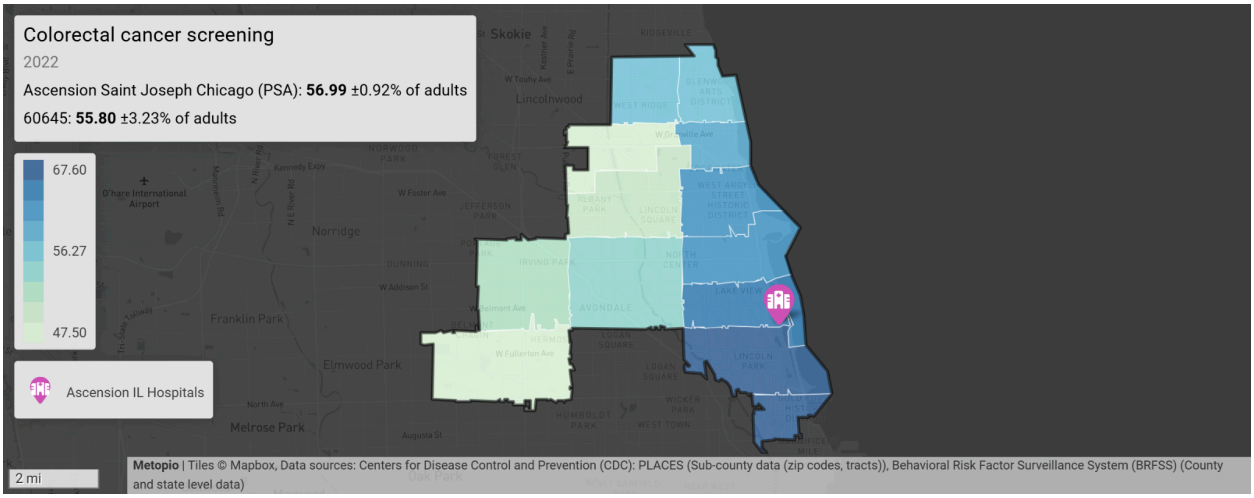
Mammography use *% of adults, female* 2022	**74.46**	73.80	73.02	75.65	80.30
Cigarette smoking rate *% of adults* 2022	**11.7**	12.0	13.5	14.6	n/a
Teen birth rate *Births per 1,000 women, female under 18 yrs* 2019-2023	**2.61**	10.16	7.88	8.48	31.40
Few fruits and vegetables *% of adults* 2009	--	75.90	77.50	76.14	n/a

Stratifications & Heat Mapping

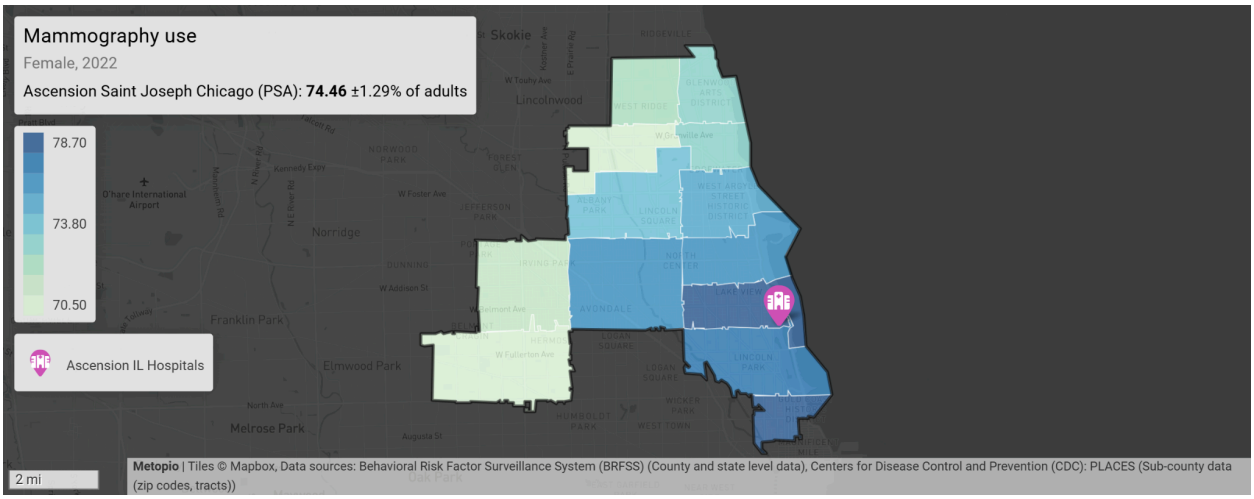
A heat map shows the concentration of binge drinking to be highest in the eastern and southern portions of the hospital PSA with the highest percentage in 60657 (28.6%).



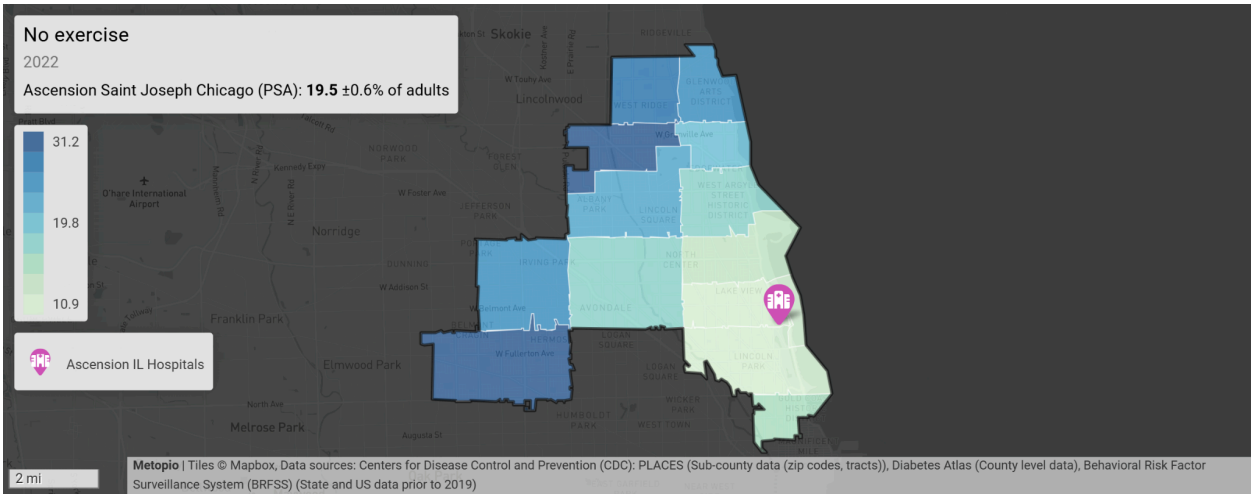
The heat map shows more residents in the eastern and southern portions of the PSA are obtaining colorectal cancer screenings. Only 47.5% of residents in the western zip code of 60639 obtained the screenings whereas 67.60% of residents in the southeastern zip code of 60610 obtained the screenings.



The heat map shows more residents in the eastern and southern portions of the PSA are obtaining mammograms. The zip codes with the highest use are 60610 (78.70%) and 60657 (78.0%). The zip code with the lowest use is 60639 (70.50%).



The heat map shows the percentage of adults with no exercise among the PSA zip codes. Those who live in eastern zip codes such as 60657 report 10.9% with no exercise whereas those that live in the west zip code of 60639 report 31.2% with no exercise.



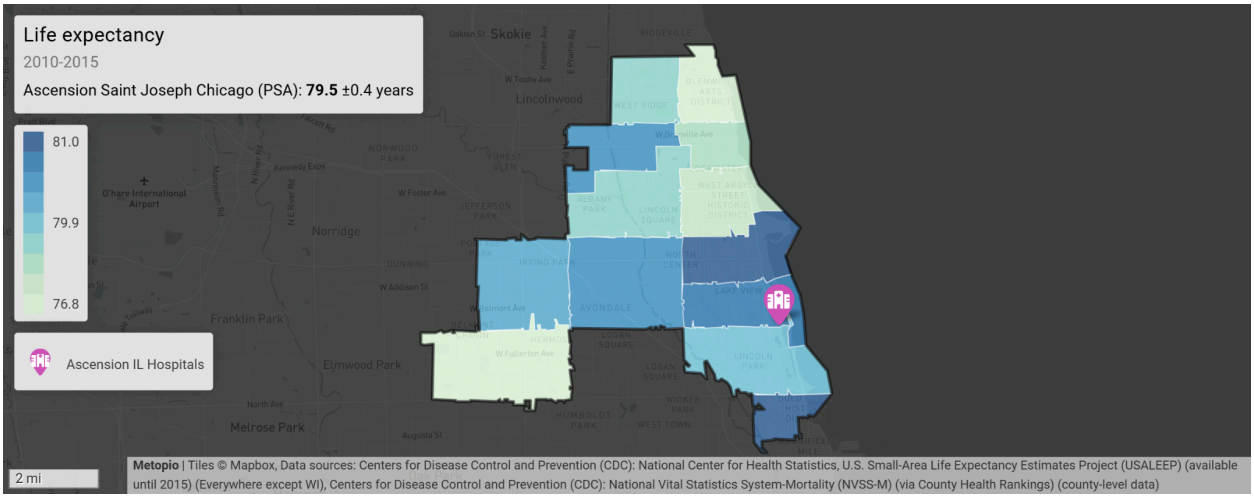
Health Status Indicators

The life expectancy is higher than the county, state, and national life expectancy. The poor self-reported mental health in adults is similar to the state and national levels. The poor self-reported physical health in adults is lower than the county, state, and national level. The fair or poor self-reported health in adults is lower than the county, state, and national level.

Topic	Ascension Saint Joseph Chicago (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Life expectancy *years* 2019-2021	**79.5**	77.9	78.0	76.1	n/a
Poor self-reported mental health *% of adults* 2022	**15.61**	15.30	16.11	17.35	n/a
Poor self-reported physical health *% of adults* 2022	**10.86**	11.40	11.71	12.44	n/a
Fair or poor self-reported health *% of adults* 2022	**16.47**	17.50	17.00	17.87	n/a

Stratifications & Heat Mapping

A heat map shows varied life expectancy across the hospital PSA. The highest life expectancy are residents from the 60610 zip code of 81.0 years. The lowest life expectancy are residents from the 60629 zip code of 76.8 years.



Health Access & Quality Indicators

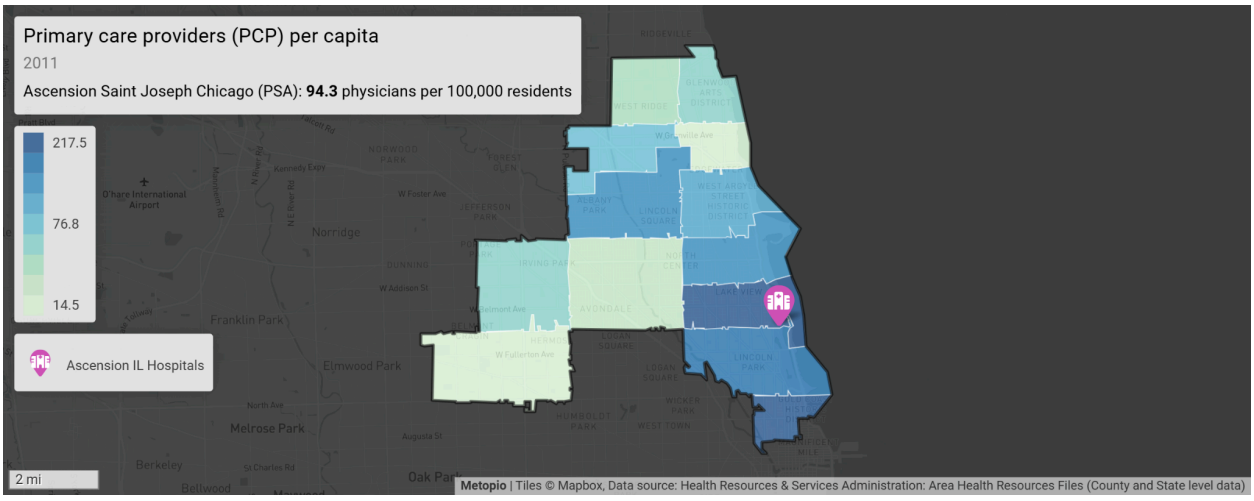
The mental health providers per capita is significantly higher than the county, state, and national levels. The availability of primary care providers (PCP) is less than the rest of the county, but higher than the state and national levels. The uninsured rate is crucially higher than the county, state, and national rate.

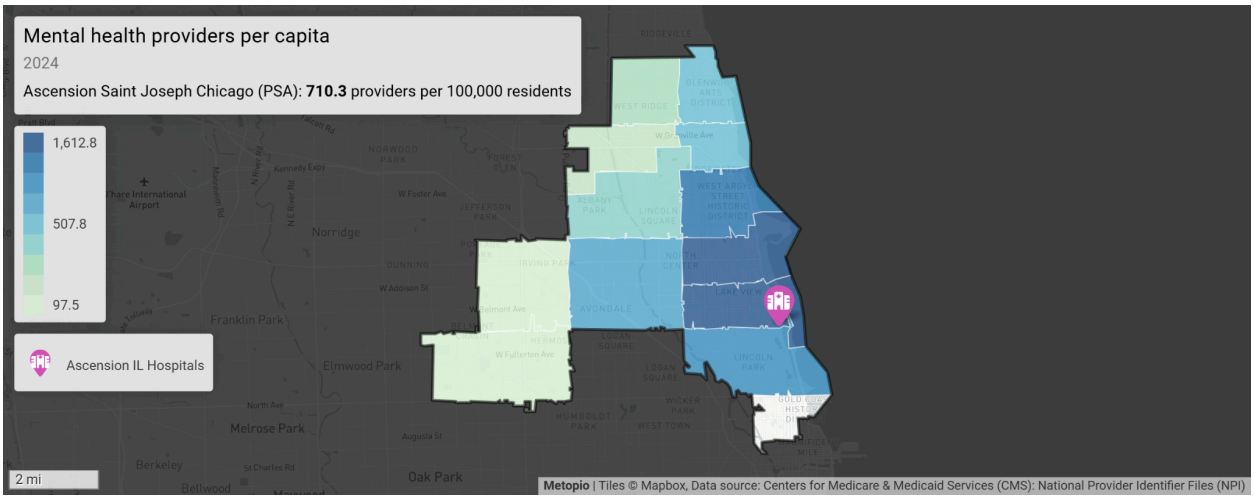
Topic	Ascension Saint Joseph Chicago (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Dentists per capita *dentists per 100,000 residents* 2024	121.4	141.3	112.5	105.2	n/a
Mental health providers per capita	**710.3**	656.4	505.9	602.7	n/a

providers per 100,000 residents 2024					
Primary care providers (PCP) per capita *physicians per 100,000 residents* 2021	**94.3**	107.4	88.8	89.6	n/a
Uninsured rate *% of residents* 2019-2023	**10.29**	7.79	6.16	7.93	n/a

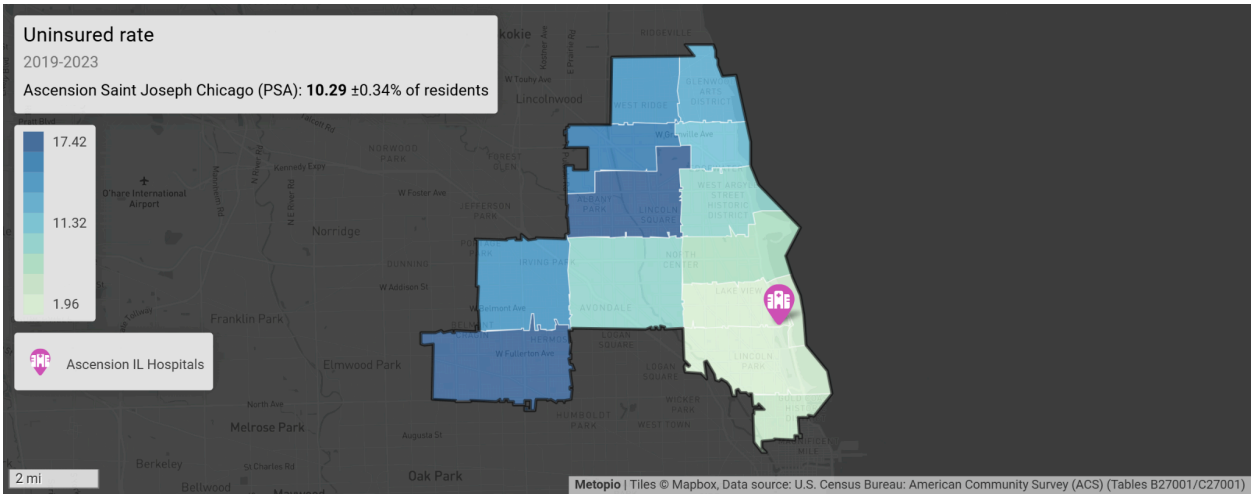
Stratifications & Heat Mapping

The following two heat maps of provider availability within the hospital PSA are nearly identical with the majority of the providers in the eastern portions of the service area.

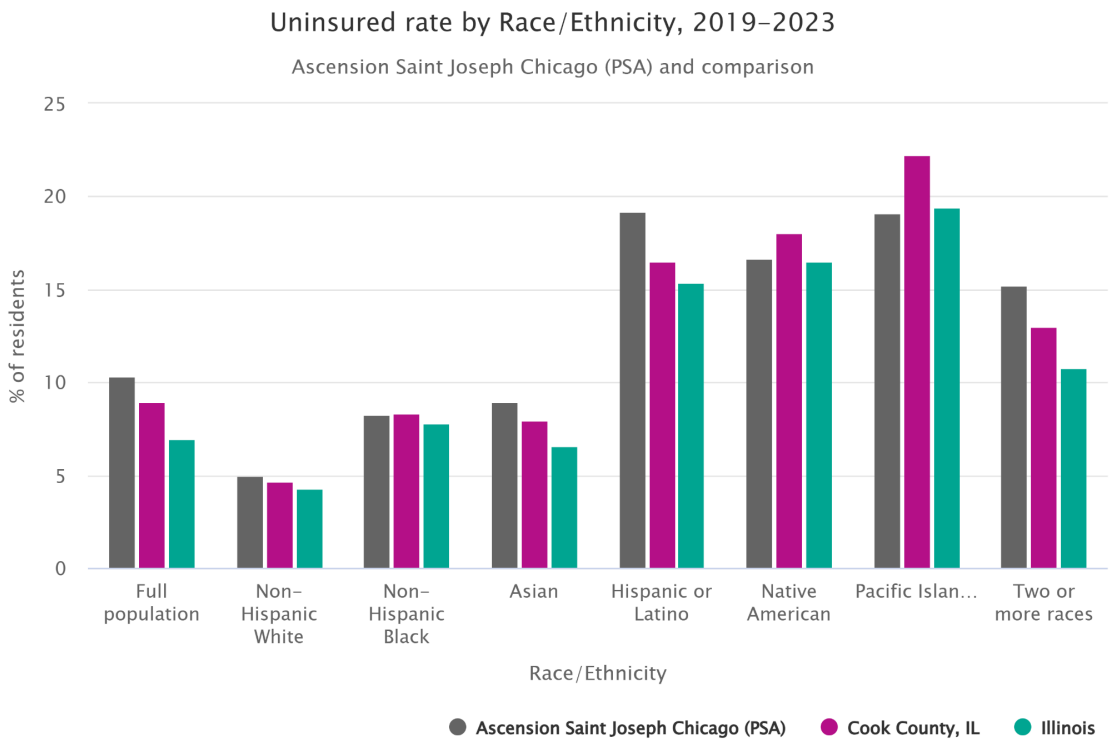




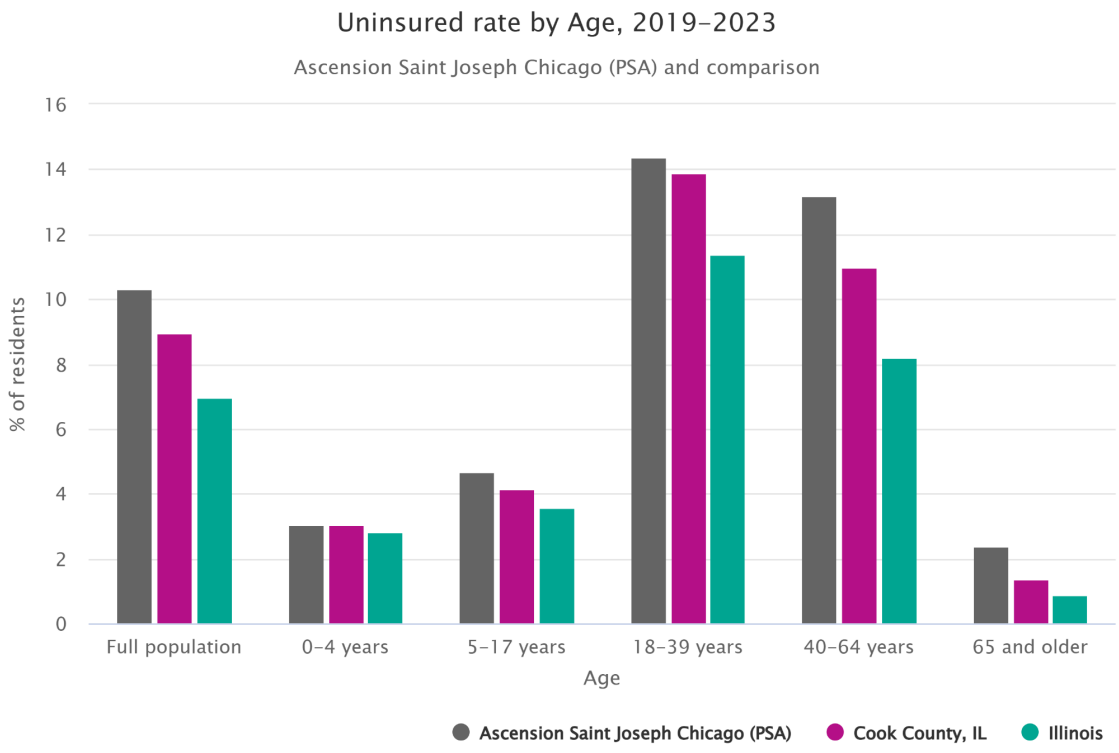
A heat map shows the northern and western portions of the hospital PSA with the highest rates of adults who are uninsured or without health insurance. The zip code 60639 has 17.42% uninsured residents.



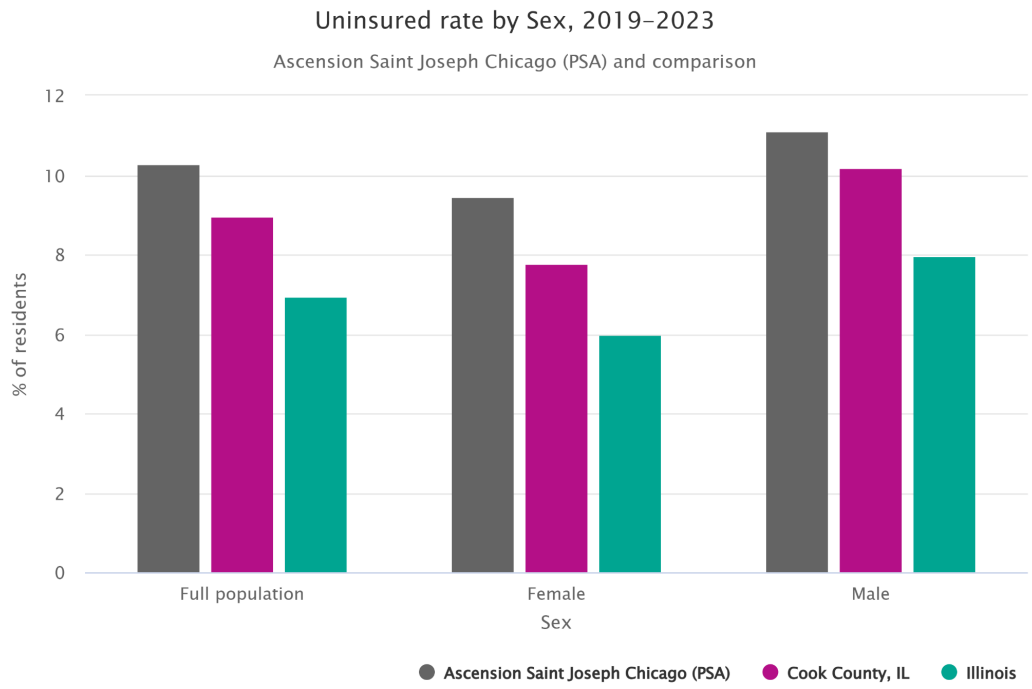
A stratification chart shows the Pacific Island/Native Hawaiian (19.08%) and Hispanic or Latino (19.20%) populations have the highest rates of adults who are uninsured. Also more males in the PSA (11.2%) and those aged 18-39 years (14.35%) are more likely to be uninsured.



Created on Metopio | metop.io | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Tables B27001/C27001)
Uninsured rate: Percent of residents without health insurance (at the time of the survey).



Created on Metopio | metop.io | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Tables B27001/C27001)
Uninsured rate: Percent of residents without health insurance (at the time of the survey).



Created on Metopio | metop.io | Data source: U.S. Census Bureau: American Community Survey (ACS) (Tables B27001/C27001)
Uninsured rate: Percent of residents without health insurance (at the time of the survey).

Mortality Indicators

There is no PSA level data available for this set of indicators.

Topic	Ascension Saint Joseph Chicago (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 showing for 2018-2022.	42.6

Neighborhood & Built Environment Indicators

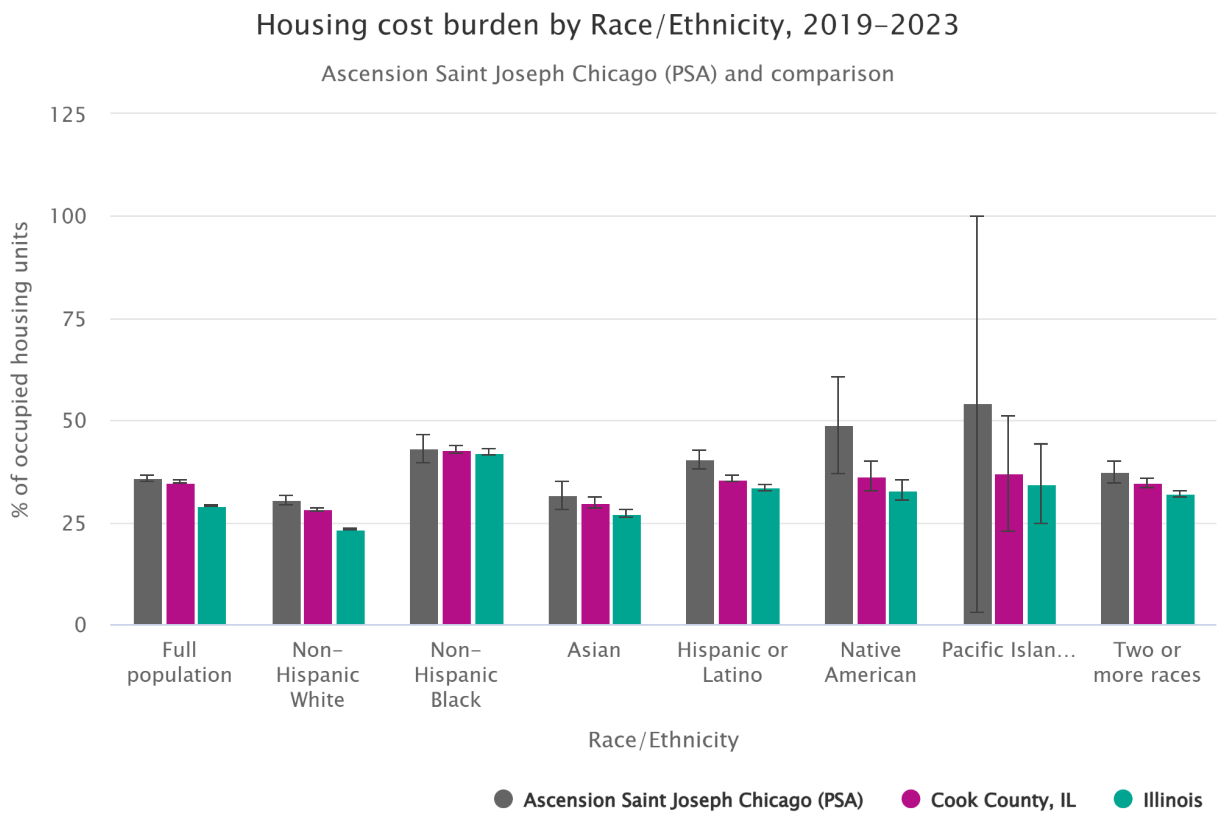
The walkability index and percent who take public transportation to work is higher in the PSA than the county, state, and national level. The housing cost burden is higher than the county, state, and national level. The proximity to a toxic waste site(s) is higher in the PSA than the county, state and national levels. Time spent commuting to work is slightly lower than the rest of the county, but higher than state and national averages.

Topic	Ascension Saint Joseph Chicago (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Walkability Index 2024	**14.90**	13.61	10.56	9.47	n/a
Housing cost burden *% of occupied housing units* 2019-2023	**35.87**	34.44	29.37	31.86	n/a
Particulate matter (PM 2.5) concentration *µg/m3* 2020	8.960	9.304	8.457	6.927	n/a
Public transportation to work *% of workers 16 years and older* 2019-2023	**23.01**	13.40	6.60	3.53	n/a

Proximity to Superfund (toxic waste) sites *distance-weighted sites* 2024	**0.883**	0.298	0.097	0.094	n/a
Travel time to work over one hour *% of workers* 2019-2023	**12.95**	13.10	10.10	8.90	n/a
Internet access *% of households* 2019-2023	93.65	94.91	94.64	94.77	n/a

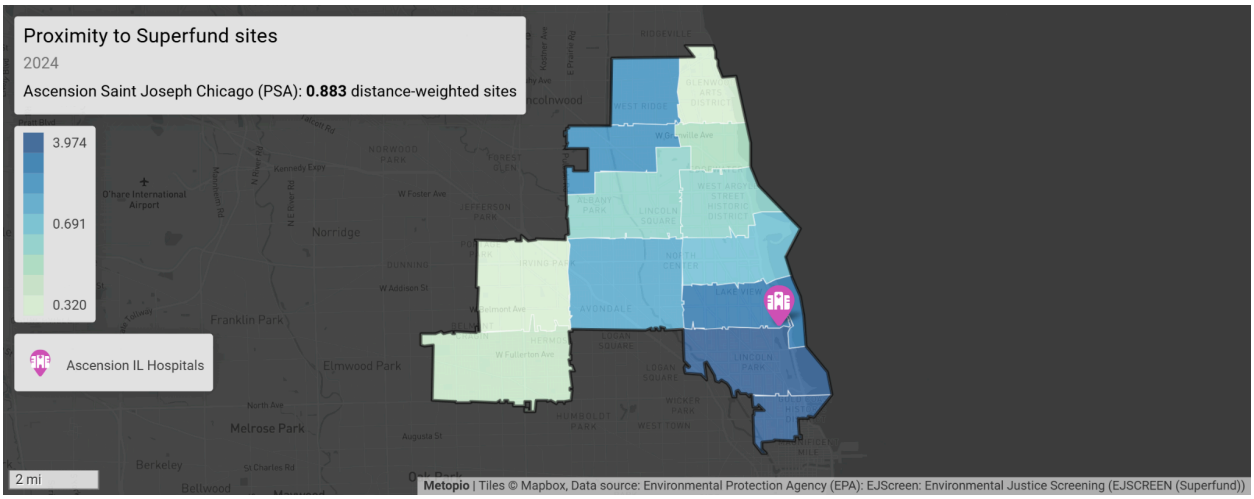
Stratifications & Heat Mapping

The chart below shows the housing cost burden by race/ethnicity for those residing with the hospital PSA. The populations most affected by housing costs are Pacific Islander/Native Hawaiian (54.30%) Native American (48.91%), and non-Hispanic Black (43.15%).



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.

A heat map shows the zip codes within the PSA that are in closer proximity to Superfund (toxic waste) sites. The zip code 60610 has the highest proximity at 3.974 (km).


Proximity to Superfund sites
2024
Ascension Saint Joseph Chicago (PSA): 0.883 distance-weighted sites
3.974
0.691
0.320
Ascension IL Hospitals
2 mi
Metopio | Tiles © Mapbox, Data source: Environmental Protection Agency (EPA): EJScreen: Environmental Justice Screening (EJSCREEN (Superfund))

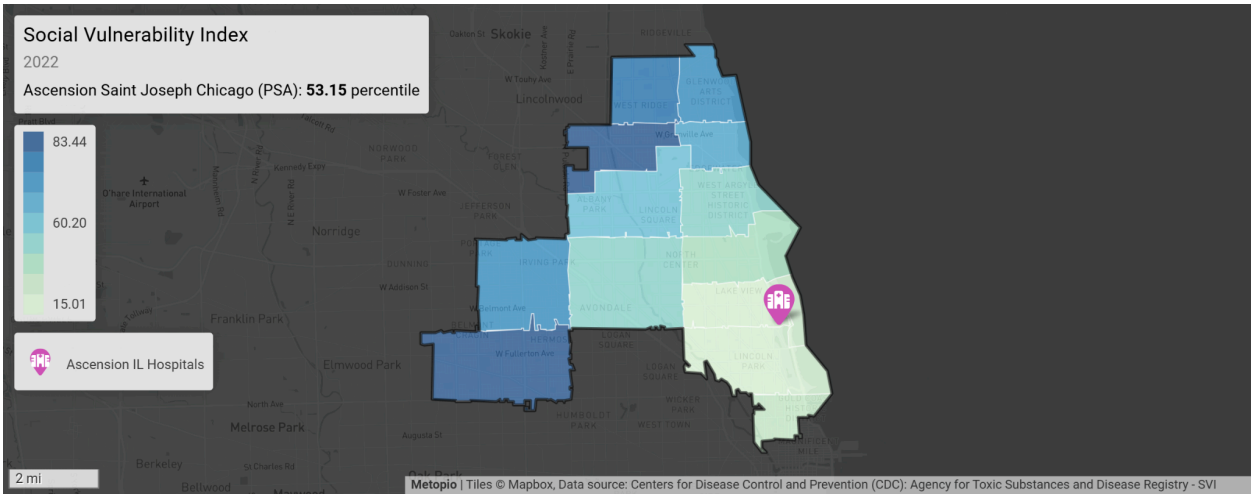
Social & Community Context Indicators

The percentage of children (0-17 years old) living with their grandparents is much lower than the county, state, and national percentage. The social vulnerability index is significantly lower in the PSA than the county, state, and national level.

Topic	Ascension Saint Joseph Chicago (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	3,633	981	203,184	4,058,660	n/a
Children living with grandparents *% of children, 0-17 yrs* 2019-2023	**5.81**	10.35	7.80	8.10	n/a
Social Vulnerability Index *percentile* 2022	**53.15**	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 60639 (83.44 index) and 60659 (82.66 index).



Systems of Power, Privilege & Oppression Indicators

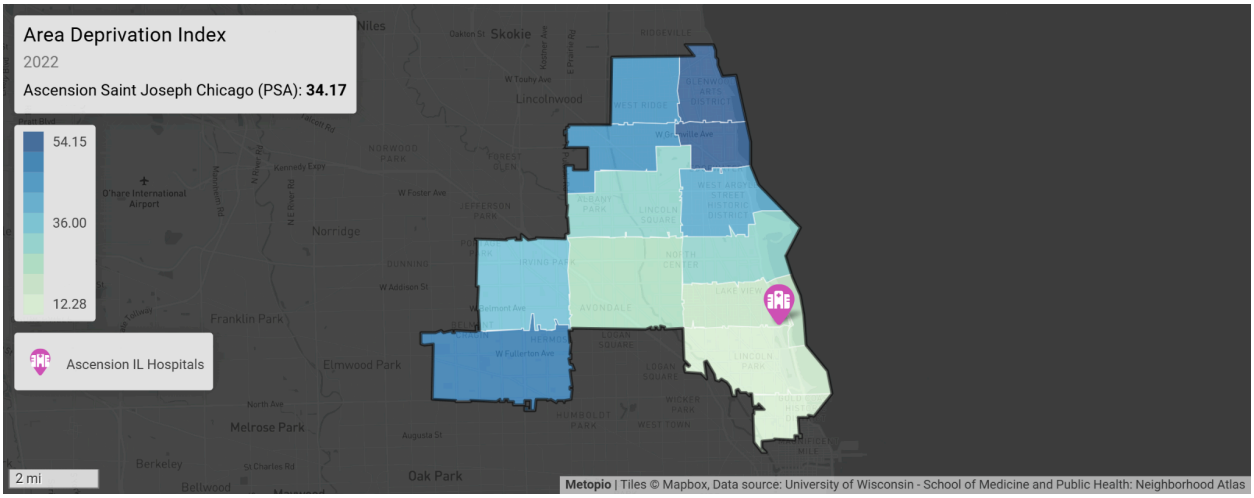
The area deprivation index is significantly lower than the county, state, and national level. The eviction rate is drastically lower than the county, state, and national rate. The percentage of residents 16 and older that are participating in the labor force is higher than the county, state, and national percentage.

Topic	Ascension Saint Joseph Chicago (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Area Deprivation Index 2022	**34.17**	46.12	53.70	47.50	n/a
Correctional facilities census *persons* 2020	100	6,598	61,605	2,055,412	n/a
Eviction rate *% of renter-occupied households* Oct 2024	**0.22**	1.06	1.52	2.12	n/a
Gini index of income inequality 2019-2023	0.484	0.501	0.481	0.483	n/a
Labor force participation *% of residents 16 and older* 2019-2023	**72.87**	66.96	65.39	63.82	n/a

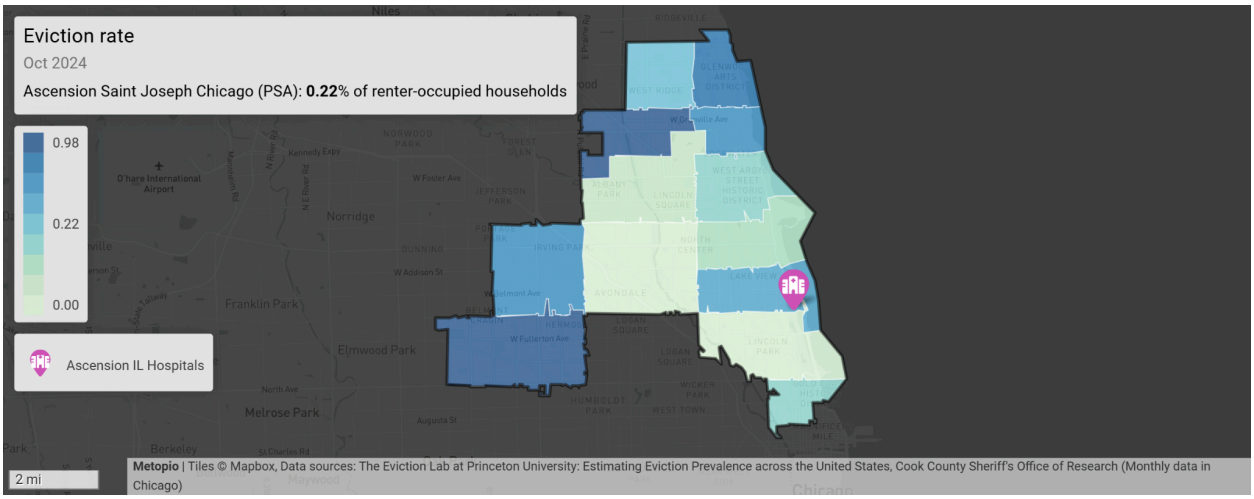
Voter participation rate (Presidential) *% of voting-age citizens* 2020	–	57.27	61.13	63.05	n/a

Stratifications & Heat Mapping

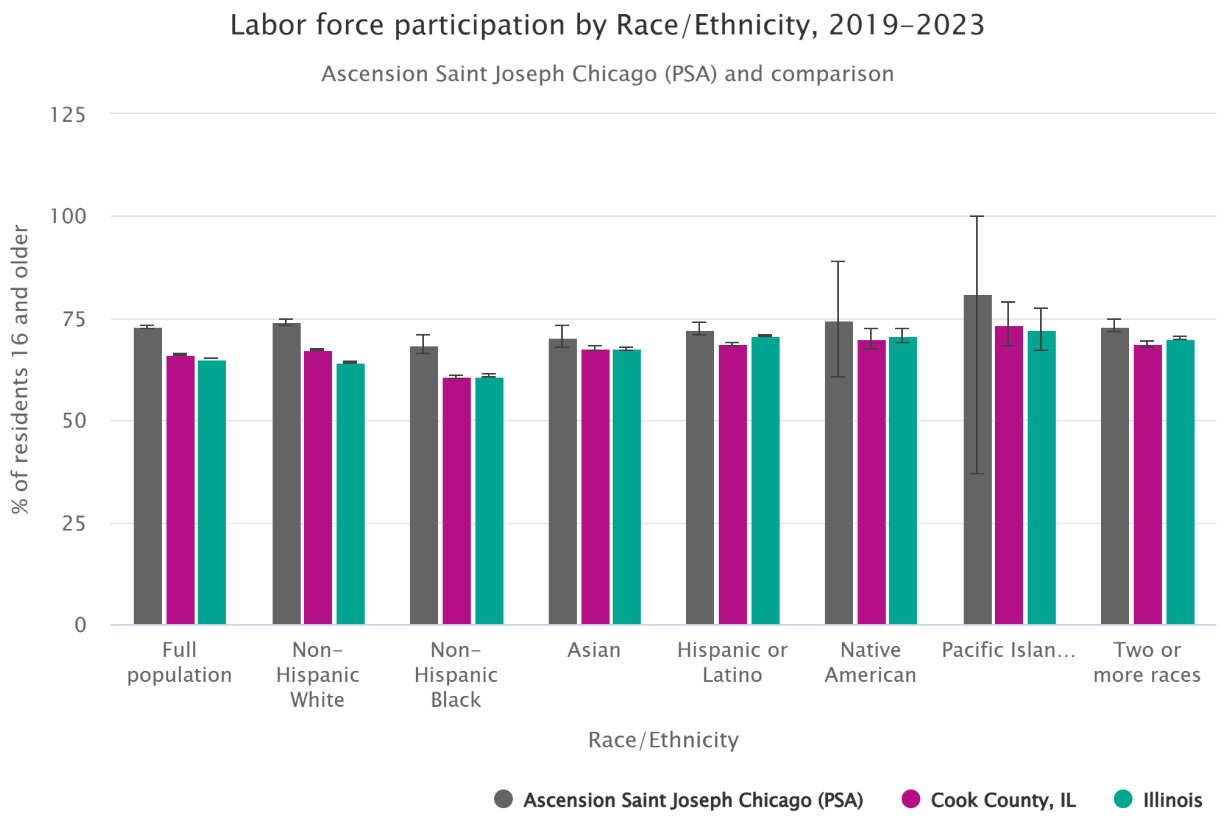
Similar to the social vulnerability index (SVI), the area deprivation index (ADI) for the PSA is lower in comparison to the rest of the county as well as state and national levels. The ADI is a ranking of neighborhoods by socioeconomic disadvantage. However, there are pockets of greater disparity geographically within the PSA including zip code 60626 (54.15 index) and 60660 (52.12 index).



The heat map shows the eviction rate (rentals) among the zip codes in the PSA. The zip codes with highest evictions include .98% (zip code 60659) and .53% (zip code 60639).



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 include Pacific Islander/Native Hawaiian (81.21%) and Native American (74.72%).



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 Joseph 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.

Access to Healthcare & Affordability

Organization	Phone	Website
Advocatia	312.584.1212	www.coverage.312Help.com
Lederman Family Health Center	773.395.9900	www.communityhealth.org
Community Health at Onward House	773.395.9900	www.communityhealth.org
Neighborhood Resource Illinois	N/A	www.neighborhoodresourceceil.org

Mental Health & Substance Use Support

Organization	Phone	Website
Ascension Behavioral Health Hospital	800.432.5005	www.healthcare.ascension.org
Ascension Saint Joseph - Chicago	773.665.3000	www.healthcare.ascension.org
Ascension Saint Joseph Harborview Recovery Center	773.665.6509	www.healthcare.ascension.org
Ascension Behavioral Health Hospital	800.432.5005	www.ascension.org

Food Insecurity

Organization	Phone	Website
Common Food Pantry	773.327.0553	www.commonpantry.org
Greater Chicago Food Depository	773.247.3663	www.chicagosfoodbank.org

Housing Instability

Organization	Phone	Website
Homelessness Prevention Call Center	“311” or 312.744.5000	
EHARC (Emergency Homeless Assessment and Response Center	“311”	

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

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

- Transportation
- Economic Vitality and Workforce Development
- Resources, Referrals, Coordination, and Connection to Community-Based Services
- Timely Linkage to Quality Care, including Behavioral Health and Social Services
- Mental Health
- Substance Use Disorders

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 Joseph Chicago's** previous implementation strategy include:

- 852 rides provided for individuals identified as needing transportation assistance
- 7,325 preceptor hours provided for highschool and college students
- 4,575 referrals were made from Ascension's Neighborhood Resource Directory
- 1,699 individuals were provided with Public Health Insurance Assistance enrollment services
- 97% of individuals that screened positive for substance used disorders received access to narcan treatment

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 Determinants of Health: Housing & Transit (Transportation Assistance)

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

Lyft and Uber Concierge Services
 	
Provide access to transportation assistance services for patients and community residents that have been screened for transportation barriers and connect them to services.
	Completed	• **Process Measures:**
		  • **Total Number of Individuals Screened for Transportation Needs**: 852+
		  • **Total Number of Rides Provided:** 852
		  ○ Lyft Concierge: 852

Social and Structural Determinants of Health (SDoH: Education) 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**: 815 ○ High School: 57 ○ College (Nursing): 758 • **Total Number of Preceptor Hours:** 7,325.04 ○ High School: 461 ○ College (Nursing): 6,864.04

Access to Care and Community Resources (Access to Care)

Action(s) taken	Status of action(s)	Results
Neighborhood Resource Directory: FindHelp! Increase access to community resources and community-based services for the Ascension Saint Joseph Chicago 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
Action(s) taken	**Status of action(s)**	**Results**
Public Health Insurance Assistance Enrollment Continue to provide assistance for individuals identified as potentially eligible for public health insurance coverage by facilitating their application for government-sponsored healthcare coverage.	**Completed**	• **Process Measure:** • **Total Applications:** 73 ○ **Medicaid:** 68 ○ **SNAP:** 23 ○ **Total Number of Individuals Engaged & Educated:** 1,699

Action(s) taken	Status of action(s)	Results
Patient Navigator in the Emergency Department Provide free navigation services for patients in need of follow up care, a medical provider, or other health related social needs.		• **Process Measure:** • **Total Number of Individuals Served:** 9,878 • **Total Number of Patients Offered Assistance:** 12,742 **Please Note: Patient Navigator in the ED program sunsetted FY24.*

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

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

Mental Health Education and Awareness
 	
Provide mental health first aid (MHFA) training program.
	Completed	• **Process Measures:**
		  • **Number of Trainings Offered:** 3
		  • **Number of Individuals Trained:** 15
		**Please Note: Mental Health First Aid Program sunsetted FY24.*

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

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

Warm Handoff Program
 	
Provide a warm hand-off program for patients in need of access to Substance Use Disorder (SUD) treatment.
	Completed	• **Process Measures:**
		  • **Total Number of SUD Screenings:** 39
		  • **Total Number of Individuals that Received Narcan:** 38