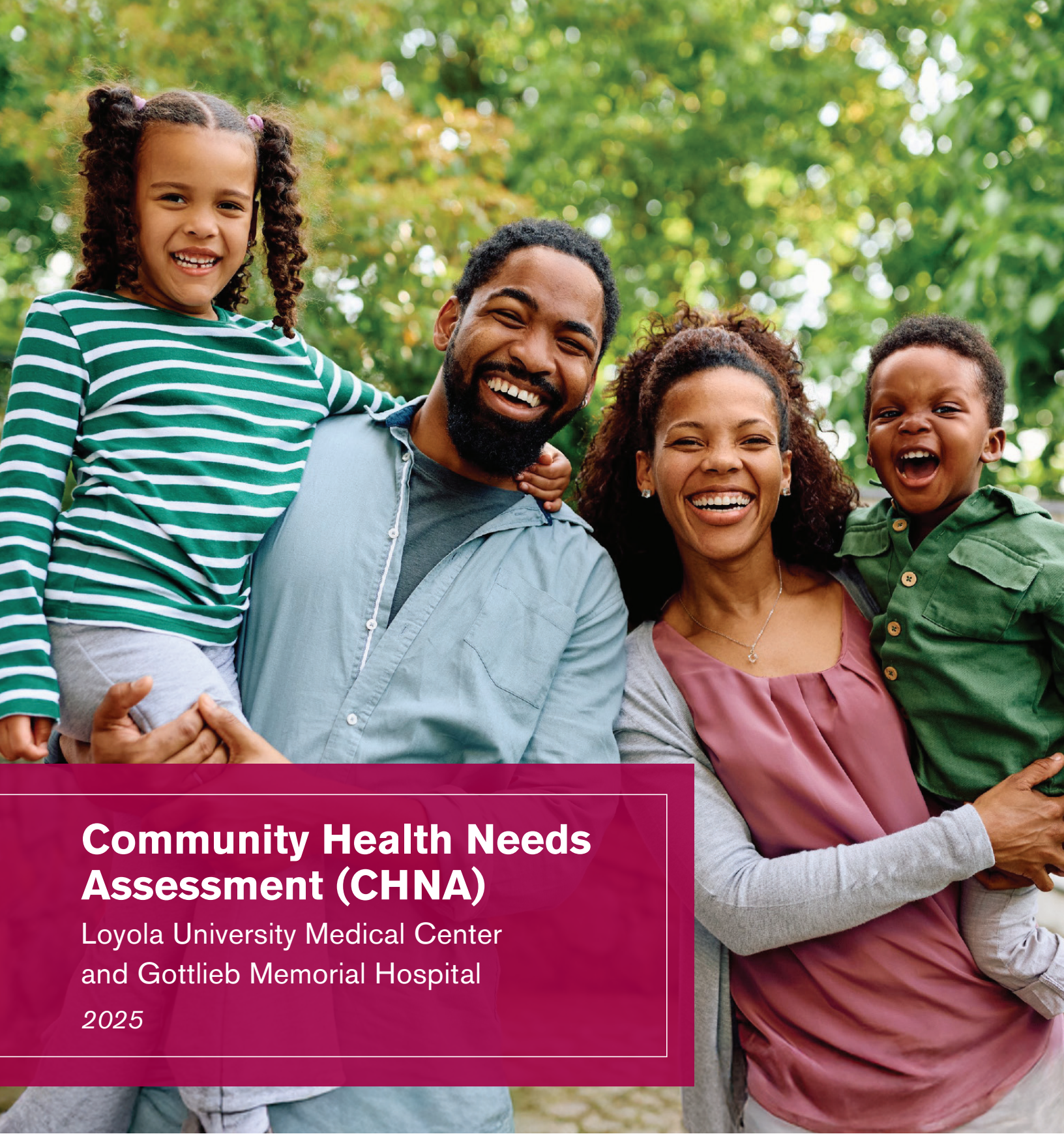


Community Health Needs Assessment (CHNA)

Loyola University Medical Center
and Gottlieb Memorial Hospital

2025

LOYOLA MEDICINE

A Member of Trinity Health

Adopted by Board of Directors on 5/30/2025

Contents

Introduction to Loyola Medicine

Loyola Medicine is a not-for-profit, mission-based, Catholic organization consisting of three hospitals located in the western suburbs of Chicago: Loyola University Medical Center (LUMC) in Maywood, Gottlieb Memorial Hospital (GMH) in Melrose Park, and MacNeal Hospital in Berwyn. All three hospitals are members of Trinity Health. Trinity Health is one of the largest not-for-profit, faith-based health care systems in the nation. It is a family of 127,000 colleagues and more than 38,300 physicians and clinicians caring for diverse communities across 26 states. Nationally recognized for care and experience, the Trinity Health system includes 93 hospitals, 107 continuing care locations, the second largest PACE program in the country, 142 urgent care locations and many other health and well-being services. In fiscal year 2024, the Livonia, Michigan-based health system invested $1.3 billion in its communities in the form of charity care and other community benefit programs.

Loyola University Medical Center (LUMC) is a 547-bed academic medical center that provides comprehensive services, including a center for heart and vascular medicine, a Level 1 trauma center, Illinois's largest burn center, a cancer center, neurosciences, orthopedic surgery, digestive health, the region's largest transplant center, a children's hospital, immediate care, telemedicine and home health care. LUMC discharged 18,767 patients in fiscal year 2024and received 42,094 emergency room visits.

Gottlieb Memorial Hospital (GMH) is a 247-bed hospital that conducts cancer research at the Marjorie G. Weinberg Cancer Center and provides services in metabolic surgery and bariatric care, orthopedics, urology, transitional care, and a child daycare center. In fiscal year 2024, GMH discharged 5,611 patients and received 29,478 emergency visits.

MacNeal Hospital is a 362 -bed teaching hospital. MacNeal has its own Community Health Needs Assessment report on the Loyola Medicine website.

Loyola Medicine also trains the next generation of medical caregivers through its affiliation with Loyola University Chicago's Stritch School of Medicine and Marcella Niehoff School of Nursing. Loyola's other academic partners include Edward Hines Jr. Veterans Hospital, Loyola University Chicago Health Sciences Division, and Loyola University Chicago Center for Translational Research & Education. In the 2024 fiscal year, Loyola Medicine invested $65,940,904 into support for health education and research.

Mission and Core Values

As members of Trinity Health, Loyola University Medical Center and Gottlieb Memorial Hospital are committed to **Trinity Health's mission:**

We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Additionally, Loyola Medicine's core values are: *Reverence, Commitment to Those Experiencing Poverty, Safety, Justice, Stewardship, Integrity*

Intro to the Alliance for Health Equity and Collaborative CHNA

Loyola Medicine is a founding member of the Alliance for Health Equity and has aligned their Community Health Needs Assessment (CHNA) and implementation activities with collaborative members. Founded in 2015, the Alliance for Health Equity (Alliance or AHE) is a partnership between Illinois Public Health Institute (IPHI), hospitals, health departments, and community organizations across Chicago and Suburban Cook County. This initiative is one of the largest collaborative hospital-community partnerships in the country with the current involvement of over 30 nonprofit and public hospitals (Figure 1), six local health departments (Figure 1), and representatives of nearly 100 community organizations. Working through the Alliance, hospitals in Chicago and throughout Cook County aim to make a positive impact on health outcomes by sharing resources and information, cooperating on data collection and analysis, and collaborating on community health improvement strategies. Alliance partners work together to create a county-wide CHNA that is paired with service area specific chapters for each hospital. This allows hospitals to partner on a variety of local and regional health improvement strategies.

Figure 1. Table of Alliance for Health Equity member hospitals and health departments

Alliance for Health Equity Member Hospitals and Health Departments	
▪ Advocate Health Care	▪ Swedish Hospital/Endeavor Health
▪ Ascension	▪ Loyola Medicine/Trinity Health
▪ Cook County Health	▪ UI Health
▪ Insight Chicago	▪ Chicago Department of Public Health
▪ Jackson Park Hospital	▪ Cook County Department of Public Health
▪ Loretto Hospital	▪ Evanston Health & Human Services Department
▪ Northwestern Medicine	▪ Oak Park Health Department
▪ Rush University System for Health	▪ Skokie Health Department
▪ Sinai Health System	▪ Stickney Public Health District
▪ South Shore Hospital	

The 2025 Community Health Needs Assessment is the fourth collaborative CHNA in Cook County, Illinois. Illinois Public Health Institute (IPHI) acts as the backbone organization for the Alliance for Health Equity. IPHI works closely with the planning committee to design the CHNA to meet regulatory requirements under the Affordable Care Act and to ensure close collaboration with the Chicago Department of Public Health (CDPH) and Cook County Department of Public Health (CCDPH) on their community health assessment and community health improvement planning processes. For this CHNA, the Alliance for Health Equity has taken a very intentional approach to build on the previous collaborative CHNA work (2016, 2019, 2022), Healthy Chicago 2025 (2020), and Suburban Cook County WePLAN (2022).

Summary of Collaborative Health Equity Approach to Community Health Needs Assessment

The Alliance documents the health status of communities within Chicago and Suburban Cook County by combining robust public health data and community input with existing research, plans, and assessments. Taken together, the information highlights the systemic inequities that are negatively impacting health. In addition, the CHNA provides insight into community-based assets and resources that could be leveraged or enhanced during the implementation of health improvement strategies.

Between June 2023 and December 2024, the Alliance completed a county-wide CHNA in partnership with other hospitals, the Chicago Department of Public Health, Cook County Department of Public Health, and community organizations. IPHI used data from the county-wide CHNA as well as additional local data to create a service level CHNA for Loyola Medicine. A collaborative, county-wide CHNA was published June 2025.

IPHI worked with the CHNA committee and steering committee to design and facilitate a collaborative, community-engaged assessment. The CHNA process is adapted from the Mobilizing for Action through Planning and Partnerships 2.0 (MAPP 2.0) framework, a community-engaged strategic planning framework that was developed by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). Both the Chicago and Cook County Departments of Public Health use the MAPP 2.0 framework for community health assessment and planning. The MAPP 2.0 framework promotes a system focus, emphasizing the importance of community engagement, partnership development, and the dynamic interplay of factors and forces within the public health system. The Alliance chose this inclusive, community-driven process to leverage and align with health department assessments and to actively engage stakeholders, including community members, in identifying and addressing strategic priorities to advance health equity.

Primary data for the CHNA was collected through three methods:

- Community input surveys;
- Community resident focus groups; and
- Social service provider focus groups.

The community-based organizations engaged in the Alliance for Health Equity represent a broad range of sectors such as workforce development, housing and homeless services, food access and food justice, community safety, planning and community development, immigrant rights, youth development, community organizing, faith communities, mental health services, substance use services, policy and advocacy, transportation, older adult services, health care services, higher education, and many more. All community partners work with or represent communities that are disproportionately affected by health inequities such as communities of color, immigrants, youth, older adults, caregivers, LGBTQIA+, individuals experiencing homelessness or housing instability, individuals living with mental illness or substance use disorders, individuals with disabilities, veterans, and unemployed youth and adults.

Epidemiologists from the Cook County Department of Public Health (CCDPH) and Chicago Department of Public Health (CDPH) and Metopio are invaluable partners in identifying, compiling, and analyzing secondary data for the CHNA. IPHI and the Alliance for Health Equity steering committee worked with CDPH and CCDPH to refine a common set of indicators based on an adapted version of the County Health Rankings and Roadmaps Model. The primary data sources for secondary data were the Cook County Health Atlas, Chicago Health Atlas, and Metopio. A full list of sources is available in the References section. Data for each indicator was pulled from the respective databases and then compared across geography (zip code, service area, county, state, etc.) and various stratifications (race, age, gender, etc.) to identify trends and correlations for each topic area.

Assessment data and findings are organized in following areas:

- An overview of health inequities;
- Mental health and substance use disorders;
- Access to quality health care and community resources;
- Social and structural influencers of health;
- Risk factors, prevention, and management of chronic conditions; and
- Health, economic, and social factors of the COVID-19 pandemic.

The following summary report highlights primary and secondary data related specifically to Loyola Medicine's primary service area. Additional primary and secondary data for Chicago and Suburban Cook County can be found in the countywide CHNA report at allhealthequity.org.

Summary of the 2022 Community Health Needs Assessment

The Alliance for Health Equity conducted a collaborative Community Health Needs Assessment (CHNA) between May 2021 and March 2022. During that time, communities across our county, country, and globe were experiencing profound impacts from the COVID-19 pandemic. The health, economic, and social impacts of the pandemic were strongly present in what was heard from community members as well as healthcare and public health workers over the course of the assessment.

The Alliance and Loyola Medicine gathered community input through focus groups, surveys, and community meetings and combined that with secondary data to determine five priority community health needs.

Priority Community Health Needs – Loyola University Medical Center and Gottlieb Memorial Hospital

1. Mental Health
2. Social and Structural Influencers of Health
3. Community Communication and Community Leader Engagement
4. Access to Healthcare
5. Chronic Disease

From these priorities, a Community Health Implementation Plan (CHIP) was developed to serve as a guide for community health improvement programs for the period from 2022 to 2025.

Executive Summary of the 2025 CHNA

The following summary report highlights significant community health needs and primary and secondary data related specifically to Loyola Medicine's primary service area.

Loyola Medicine engages community members and stakeholders in the CHNA both through the Alliance for Health Equity and through hyperlocal partnerships with coalitions and community groups in the Maywood, Melrose Park, and Berwyn-Cicero area.

Primary data for the Loyola Medicine CHNA was collected through 590 community surveys and 16 focus groups with community residents and social service providers. The primary data was supplemented by secondary data sourced from various partners and databases, including Metopio, public health departments, the CDC, COMPdata, and community health atlases.

This data was used to determine an initial list of priority health needs. This list was brought to a level of deeper engagement of local communities during the phase of prioritizing community health needs. Engagement partners included members from Loyola Medicine's Community Health Needs Advisory Committee (membership listed on page 15). Community meetings were hosted throughout – to review CHNA data and provide input on priorities. This committee will also be involved in the implementation strategy planning process.

The final community health needs priorities were:

1. Mental Health and Substance-Use
2. Access to Community Resources
3. Chronic Conditions
4. Access to Healthcare
5. Child and Adolescent Health
6. Community Safety

The committee recognizes that the social influencers of health play a significant role in the health needs identified as priorities. Consideration of their impact will be addressed through the implementation strategy planning process through root cause analysis.

Contact Information

If you would like more information or have comments/questions on this Community Health Needs Assessment, general contact information is:

Department Contact:
Michelle Peters, Regional Vice President, Community Health & Well-Being Saint Joseph Health System and Loyola Medicine petermic@sjrmc.com

Loyola Medicine Web Links: https://www.loyolamedicine.org/about-us/community-benefit

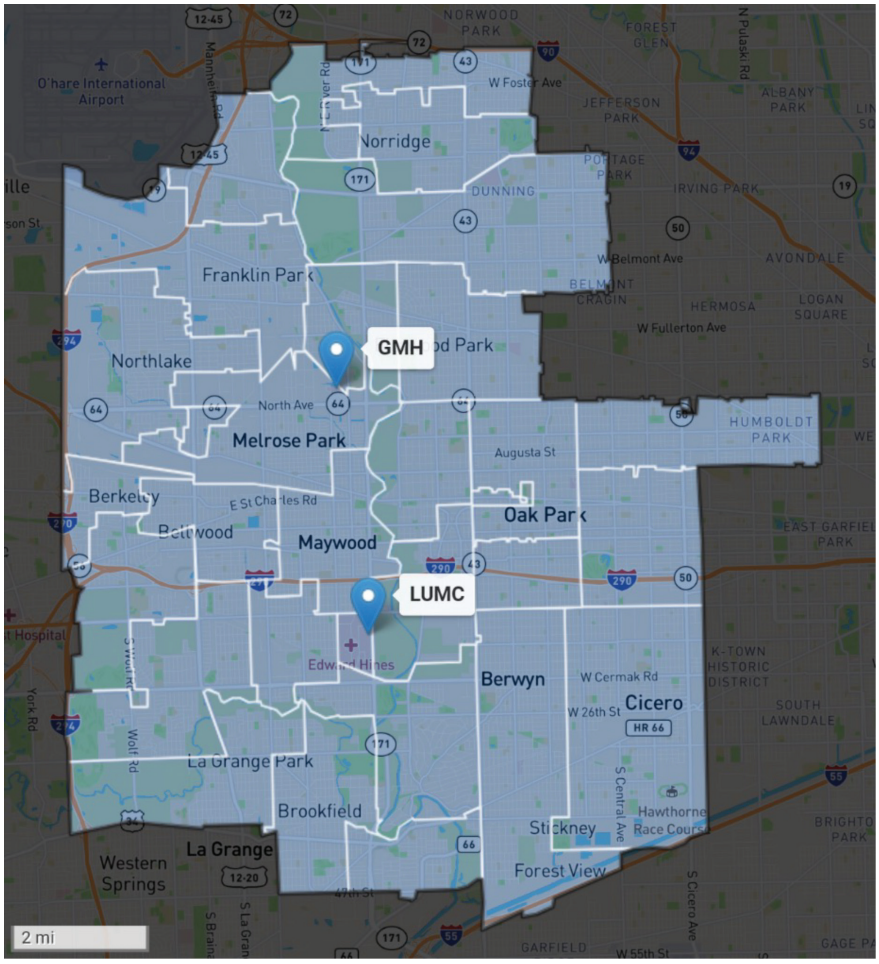
Mailing Addresses:
Community Health & Well-Being
Loyola Medicine at Gottlieb
555 W. North Avenue
Melrose Park, IL 60160
(Paper copies of this report can be requested at Loyola University Medical Center and Gottlieb Memorial Hospital.)

Communities Served

Loyola University Medical Center (Maywood, IL) and Gottlieb Memorial Hospital (Melrose Park, IL) serve a CHNA community service area that includes 30 zip codes in west suburban Cook County and the west side of Chicago. Loyola Medicine defines the CHNA service area as the primary service areas for both hospitals and making sure to include any nearby communities of highest need.

Figure 2. Loyola University Medical Center and Gottlieb Memorial Hospital's primary service area

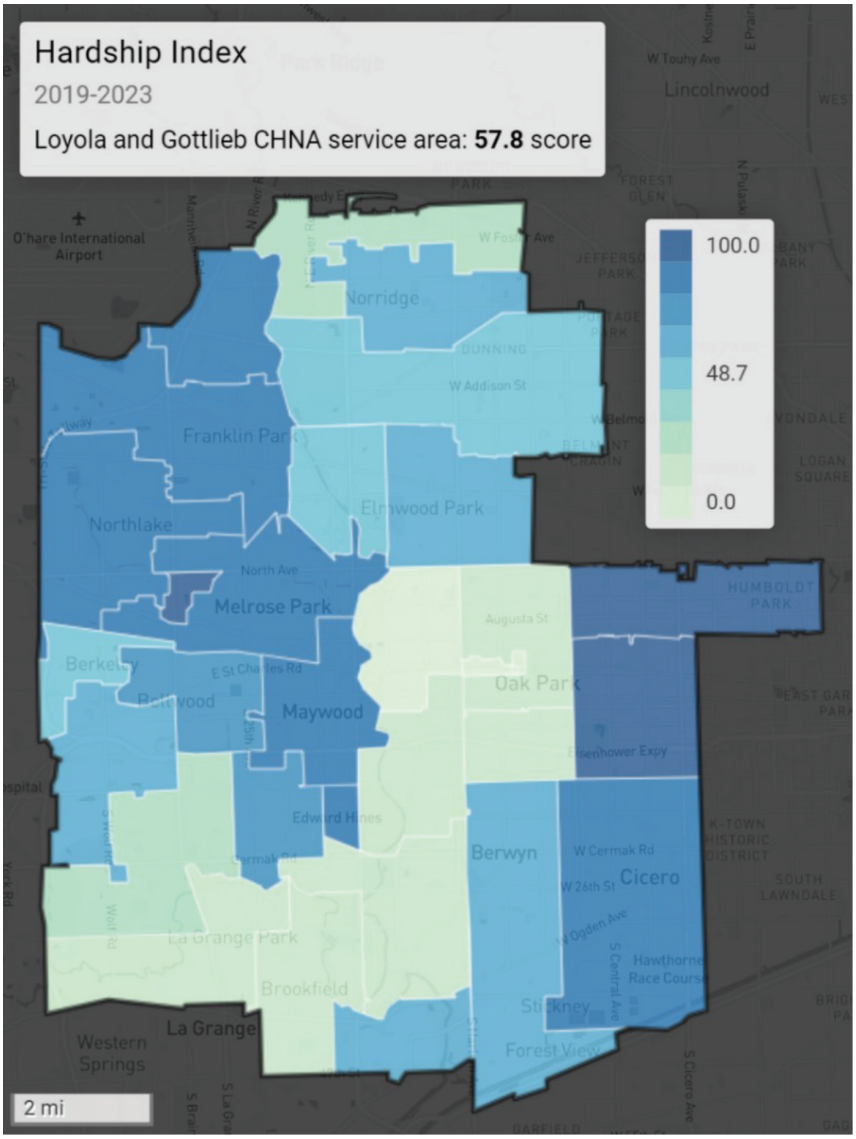
Zip Code	Municipality / Community
60634	Dunning (Chicago)
60656	Norwood Park (Chicago)
60104	Bellwood
60130	Forest Park
60131	Franklin Park
60141	Hines
60153	Maywood
60154	Westchester
60155	Broadview
60160	Melrose Park
60162	Hillside
60163	Berkeley
60164	Northlake
60165	Stone Park
60171	River Grove
60176	Schiller Park
60301	Oak Park
60302	Oak Park
60304	Oak Park
60305	River Forest
60402	Berwyn
60513	Brookfield
60526	La Grange Park
60534	Lyons
60546	Riverside
60644	Austin (Chicago)
60651	Humboldt Park, Austin (Chicago)
60706	Norridge, Harwood Heights
60707	Elmwood Park
60804	Cicero



Economic Hardship Index

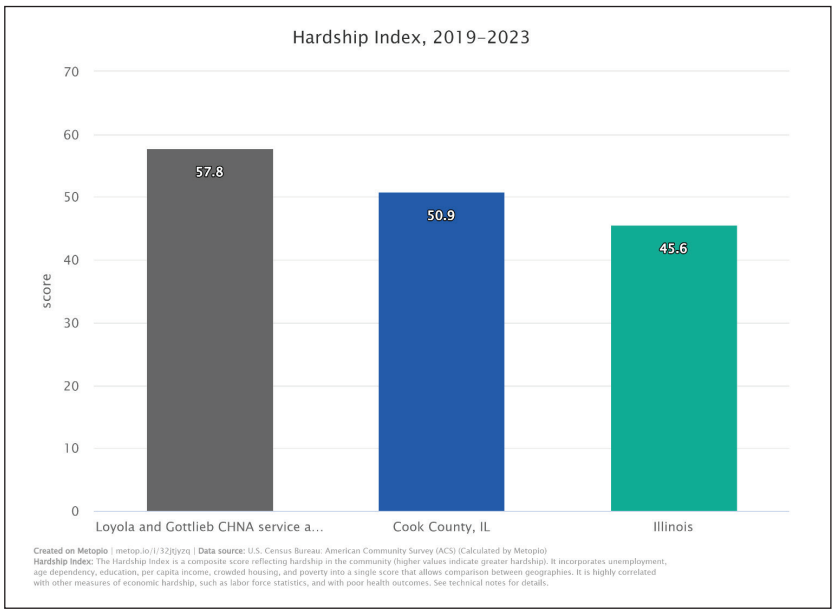
Almost half of communities within Loyola Medicine's service area are classified as high economic hardship communities (Figure 3, Figure 4). Economic hardship is the difficulty resulting from not having enough collective economic resources available within a community (Chicago Department of Public Health, 2023). It incorporates unemployment, age dependency, education, per capita income, crowded housing, and poverty into a single score rated from 1 to 100 – the Hardship Index - that allows comparison between communities (Chicago Department of Public Health, 2023). The higher the score, the greater the community's economic hardship. The average score for Loyola Medicine's service area (57.8) is high compared to the average overall score for Cook County (50.9) (Figure 4). The index is highly correlated with other measures of economic hardship including labor market data and with poor health outcomes (Chicago Department of Public Health, 2023).

Figure 3. Map of Economic Hardship Index scores in the Loyola Medicine service area, 2019-2023



(US Census Bureau, 2024)

Figure 4. Chart comparing Economic Hardship Index scores for Loyola Medicine's service area, Cook County, and Illinois, 2019-2023

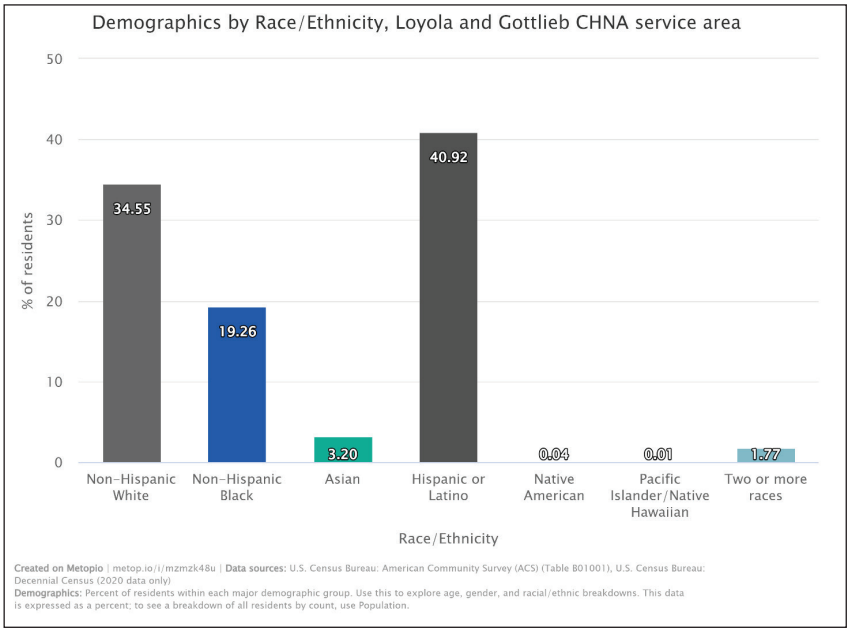


(US Census Bureau, 2024)

Demographics

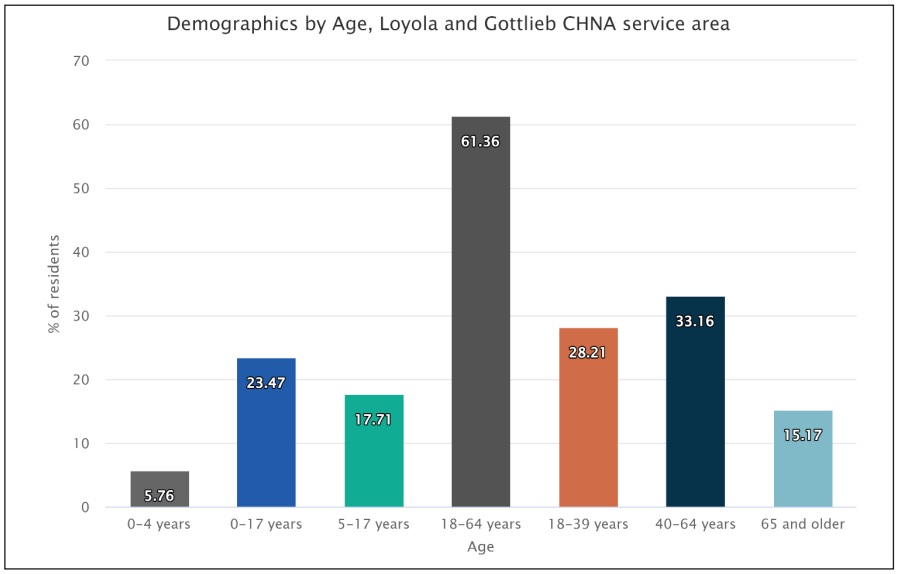
The largest racial and ethnic group within Loyola Medicine's service area is Hispanic or Latino (40.92%) followed by Non-Hispanic White (34.55%), and Non-Hispanic Black (19.26%) (Figure 5). Community members identifying as Asian (3.20%), two or more races (1.77%), Native American (0.04%), and Pacific Islander/Native Hawaiian (0.01%) accounted for about 5% of the service area's overall population (Figure 5). 23.47% of the service area population is children aged 0-17 years (Figure 6). Adults aged 18-64 years comprise 61.36% of the population and seniors aged 65 or older represent 15.17% of the population (Figure 6).

Figure 5. Population of the Loyola Medicine service area by race and ethnicity, 2019-2023



(US Census Bureau, 2024)

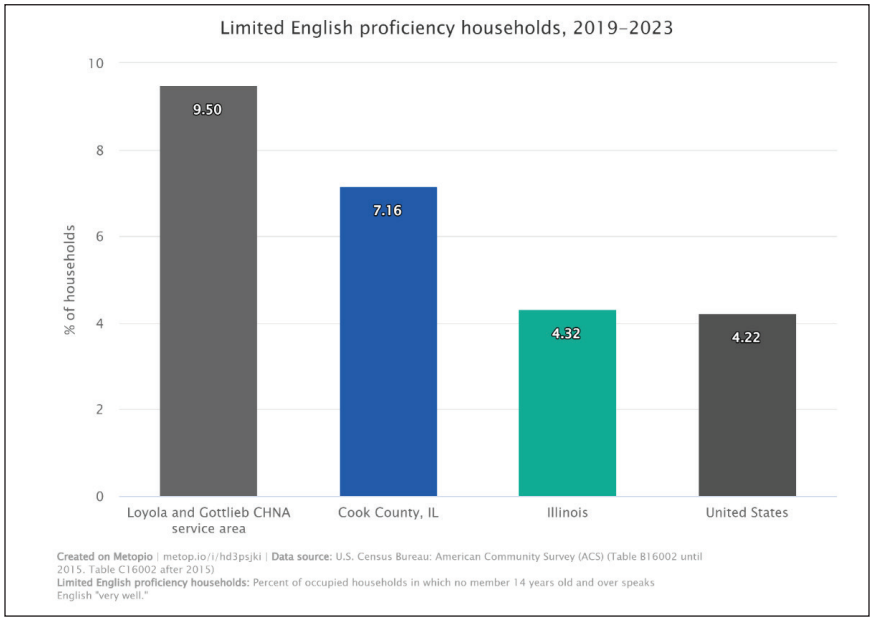
Figure 6. Population of the Loyola Medicine service area by age, 2019-2023



(US Census Bureau, 2024)

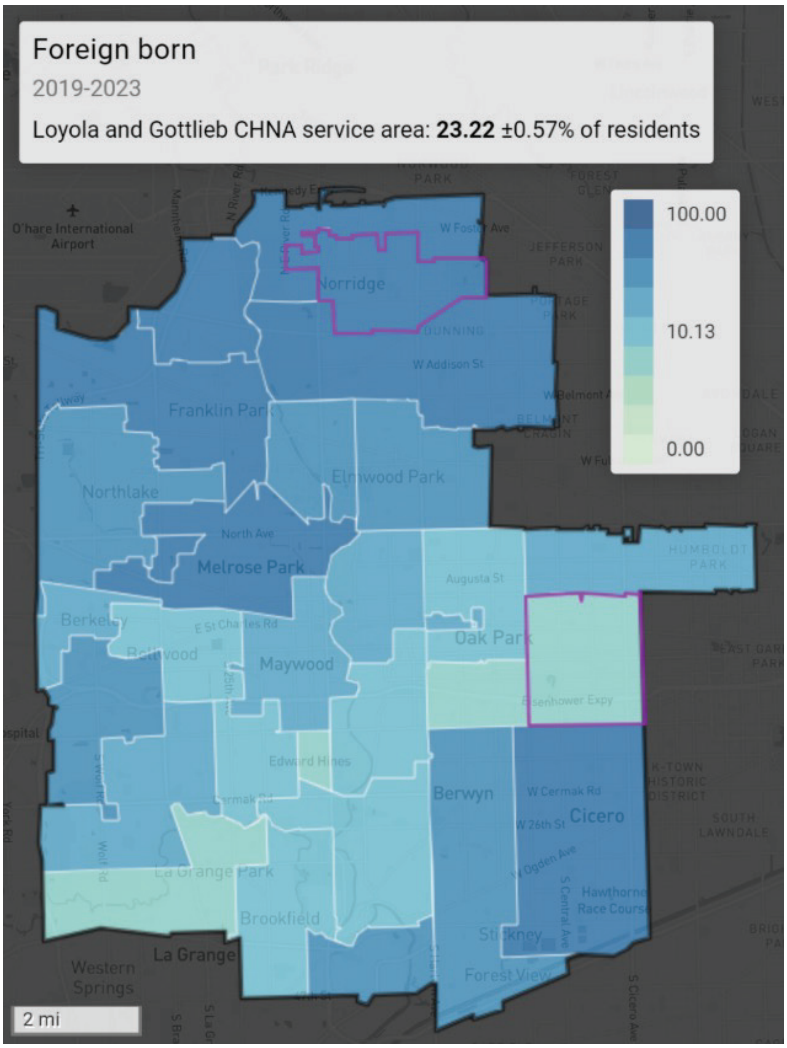
In the Loyola-Gottlieb service area, 9.50% of households are limited English proficient, compared to 7.16% across Cook County and only 4.32% statewide (Figure 7). There is a high percentage of foreign-born individuals in the service area (23.14%) (Figure 8). The zip code with highest percentage of foreign-born individuals is Norridge (60706) at 45.78% and the lowest percentage in Austin, Chicago (60644) at 5.91% (Figure 8).

Figure 7. Chart comparing the percentage of households with limited English proficiency in Loyola Medicine's service area, Cook County, Illinois, and the United States, 2019-2023



(US Census Bureau, 2024)

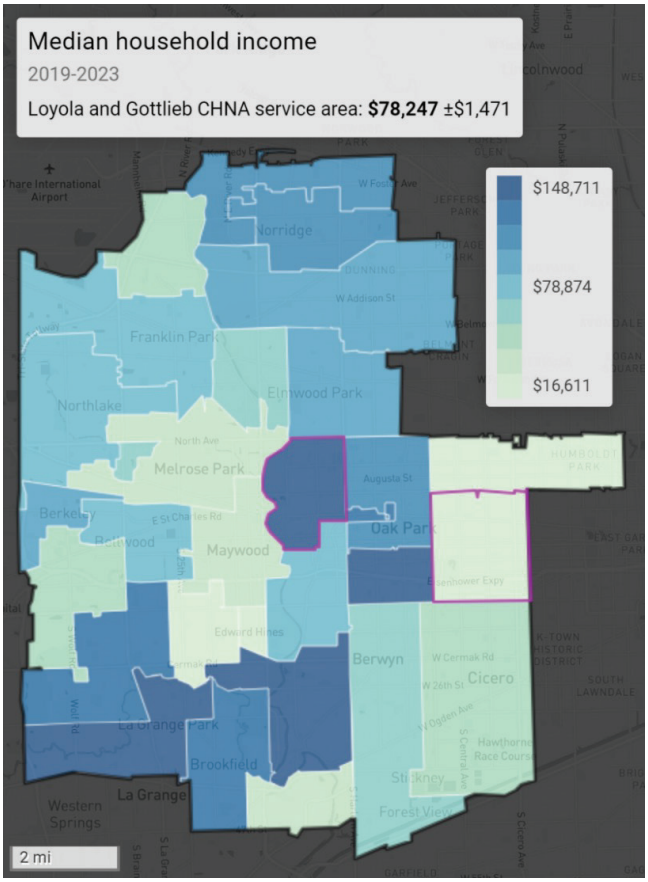
Figure 8. Map of the percentage of residents that are foreign born in Loyola Medicine's service area, 2019-2023



(US Census Bureau, 2024)

The median household income of people living in Loyola Medicine's service area ($78,247) is similar to Cook County ($81,797) (US Census Bureau, 2024), but there is wide variation within the service area. Zip code 60305 (River Forest) has the highest median income of $148,711, while 60644 (Austin, Chicago) has the lowest median income of $37,952 (Figure 9). There is also a disparity in the racial and ethnic make-up of the two zip codes. 60305 is a majority Non-Hispanic White (82.0%) while 60644 is a majority Non-Hispanic Black (78.3%) (Figure 10).

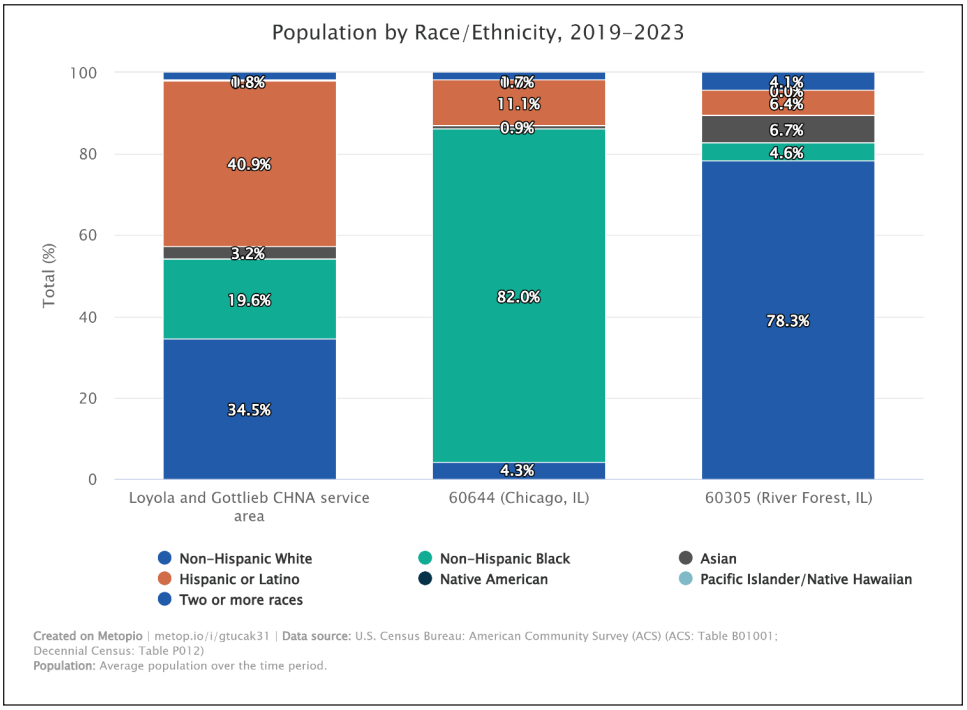
Figure 9. Map of median household income in Loyola Medicine's service area, 2019-2023



In Loyola Medicine's service area, ***Non-Hispanic Black households have the lowest median income by over $20,000****, highlighting racial and ethnic inequities in economic opportunity.*

(*US Census Bureau, 2024)*

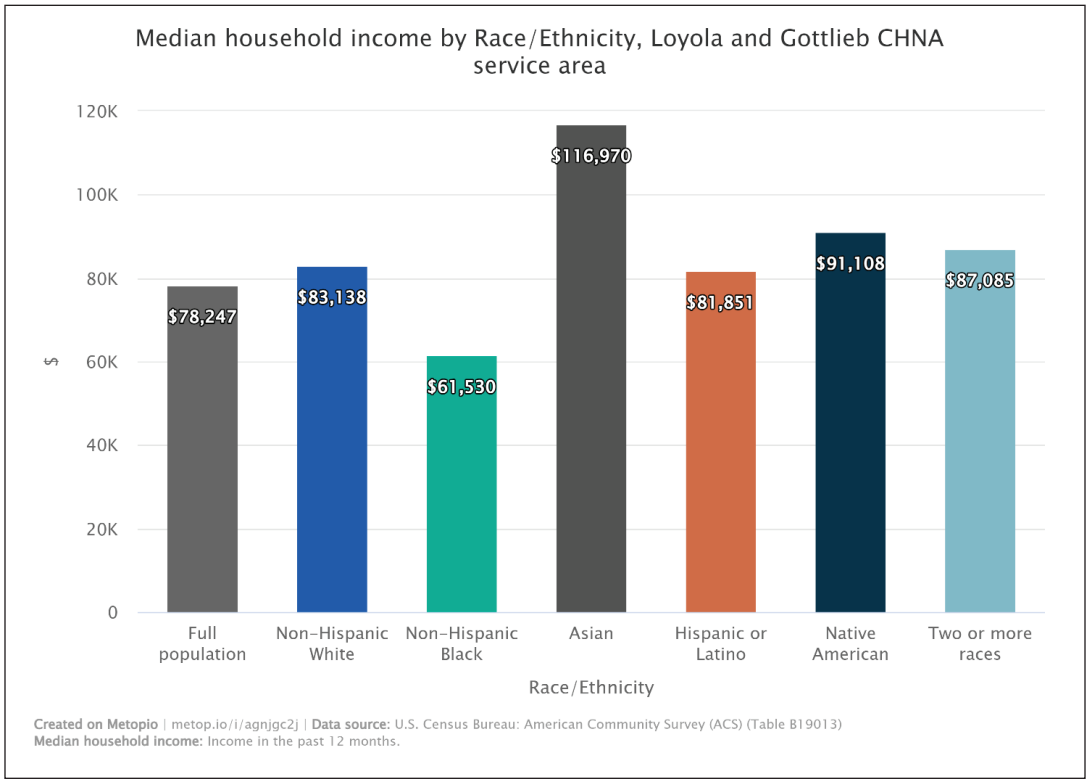
Figure 10. Chart comparing the population by race and ethnicity of the zip codes with the highest and lowest median household income in Loyola Medicine's service area, 2019-2023



(US Census Bureau, 2024)

This aligns with racial and ethnic inequities in median household income for the service area overall, with Non-Hispanic White having a median household income of $83,138 and Non-Hispanic Blacks having a median household income of $61,530 (Figure 11).

Figure 11. Median household income of the Loyola Medicine service area by race/ethnicity, 2019-2023



(US Census Bureau, 2024)

Community Input

Community input is the most valuable data resource in the Alliance for Health Equity CHNA process. First-hand information from communities most impacted by inequities is the most up-to-date data available about community health needs, particularly in the rapidly developing post-COVID-19 surge landscape. The Alliance for Health Equity worked closely with hospital partners and community-based organizations to collect community input data through a community input survey and focus groups. Sixteen focus groups with community residents and social service providers were conducted in Loyola Medicine's service area between January 2024 and October 2024 to review and provide feedback on community health priorities. Community input surveys were collected from February 2024 to October 2024.

Community input is the most valuable data resource in the Alliance for Health Equity CHNA process.

Community Partners

Community partners have been involved in the CHNA and ongoing implementation process in several ways, both in providing community input and in decision-making processes. Ways the Alliance for Health Equity has engaged community partners to assist with community engagement and implementation strategies include:

- Partnering with community-based organizations for collection of community input through surveys and focus groups;
- Engaging community-based organizations and community residents as members of implementation committees and workgroups;
- Utilizing the expertise of the members of implementation committees and workgroups in assessment design, data interpretation, and identification of effective implementation strategies and evaluation metrics;
- Working with hospital and health department community advisory groups to gather input into the CHNA and implementation strategies; and
- Partnering with local coalitions to support and align with existing community-driven efforts.

The community-based organizations engaged in the Alliance for Health Equity represent a broad range of sectors such as workforce development, housing and homeless services, food access and food justice, community safety, planning and community development, immigrant rights, youth development, community organizing, faith communities, mental health services, substance use services, policy and advocacy, transportation, older adult services, health care services, higher education, and many more. All community partners work with or represent communities that are disproportionately affected by health inequities such as communities of color, immigrants, youth, older adults and caregivers, LGBTQIA+, individuals experiencing homelessness or housing instability, individuals living with mental illness or substance use disorders, individuals with disabilities, veterans, and unemployed youth and adults.

Loyola Medicine's FY 2023-2025 Committee Membership

Loyola Medicine's community benefit activities and Community Health and Well-Being department come in contact with many local organizations and participate in ongoing committee discussions attempting to provide justice in the way of caring for those who need it most in our community. Our CHNA is no exception to collaboration. We understand collaboration and partnerships is the most effective avenue for impacting the health of our community. For these reasons, Loyola Medicine's Community Health Needs Advisory Committee contains not only Loyola Medicine colleagues, but also community members with various representations to help us with this process.

Community Health Needs Advisory Committee members:

- **Rebecca Boblett,** Interim CEO and President / COO, West Cook YMCA
- **Jessica Bullock,** Chief Transformation Officer, West Cook YMCA
- **KiShana Ector,** Manager, Community Health & Well-Being, Loyola Medicine
- **LaToya Towns,** Program Director, Quinn Center of St. Eulalia
- **Celene Herrera,** Bilingual Social Services and Outreach Coordinator, Real Foods Collective
- **Alheli Irizarry,** Community Engagement Consultant, Community Catalyst
- **Richard Juarez Sr.,** Executive Director, Solutions for Care
- **Jamie Kucera,** Executive Director/CEO, Pav YMCA
- **Gabriel Lara,** Director of Organizing, Coalition for Spiritual & Public Leadership (CSPL)
- **Kristen Mighty, Ph.D**, Executive Director, Quinn Center of St. Eulalia
- **Edward Miranda,** Community Engagement Manager, Cook County Department of Public Health
- **Marien Casillas Pabellon,** Executive Director, PASO West Suburban Action Project
- **Mandy Peacock, DNP,** Clinical Associate Professor & Director of DNP Project Experiences, Loyola University Chicago
- **Michelle Peters,** Regional Vice President, Community Health & Well-Being, Loyola Medicine and Saint Joseph Health System
- **Mike Rudolph,** Director of Business Development, Riveredge Hospital
- **Erica Sun Rocha,** Senior Coordinator, Community Health & Well-Being, Loyola Medicine and Saint Joseph Health System
- **Nancy Salgado,** Director of Organizing, PASO West Suburban Action Project
- **Lynda Schueler,** Chief Executive Officer, Housing Forward
- **April Tolbert,** Senior Public Health Educator, Cook County Department of Public Health
- **Elizabeth Trevino,** Regional Manager Social Care, Community Health & Well-Being, Loyola Medicine and Saint Joseph Health System
- **Lorenzo Webber,** Executive Board Member, Proviso Partners 4 Health

A combination of these members and other community members participated in the review of the 2025 CHNA results and prioritization of the identified health needs in our communities. The Community Health Needs Advisory Committee will hold Loyola Medicine accountable during this process, serve as guidance for any necessary adaptations, and be actively involved in the development of the strategic action plans for FY2026-2028.

Community Input Survey

The community input survey was a qualitative tool designed to understand community health needs and assets with a focus on hearing from community members that are most impacted by health inequities. Demographic information is included in Figures 13-20. Responses to key questions from community members within the service area are included in Figures 21-25. From February 2024 to October 2024, 592 community input surveys were collected in Loyola Medicine's service area.

Surveys were collected in both paper and online format through various channels. The Alliance leveraged community partnerships to facilitate participation by communities often underrepresented in community assessments. Surveys were collected at focus groups, clinical office visits, community events (Figure 12), and by contracted community partners. The online survey was also shared in email newsletters and on social media.

Figure 12. Community input survey collection partnerships

Community Events	
▪ Black Women's Expo	▪ Healing Arts Fair
▪ Lakeview Art's Festival	▪ South Shore Summer Festival
▪ Illinois CHW Summit	▪ Kelvyn Park Back to School
▪ Belmont Cragin Elementary Back to School	▪ Taste of Polonia
▪ Latina Expo	▪ Over 15 events attended by community health workers
▪ Speaker Welsh Annual Back to School Fair	

Contracted Community Partners

QUINN CENTER OF SAINT EULALIA

WASO West Suburban Action Project

Survey demographics

The largest racial and ethnic group of survey respondents is Black (44%) followed by Hispanic or Latino (28%) and Non-Hispanic White (26%) (Figure 13). Participants identifying as Asian/Pacific Islander/Native Hawaiian (4%), American Indian/Alaskan Native (2%), and Middle Eastern/Arab American/Persian (1%) accounted for 7% of survey respondents (Figure 13). Five percent of the participants are children aged 14-17 years Adults aged 18-64 comprise 73% of the respondents and seniors aged 65 or older represent 22% of the respondents (Figure 14).

Figure 13. Racial and ethnic identities of survey respondents

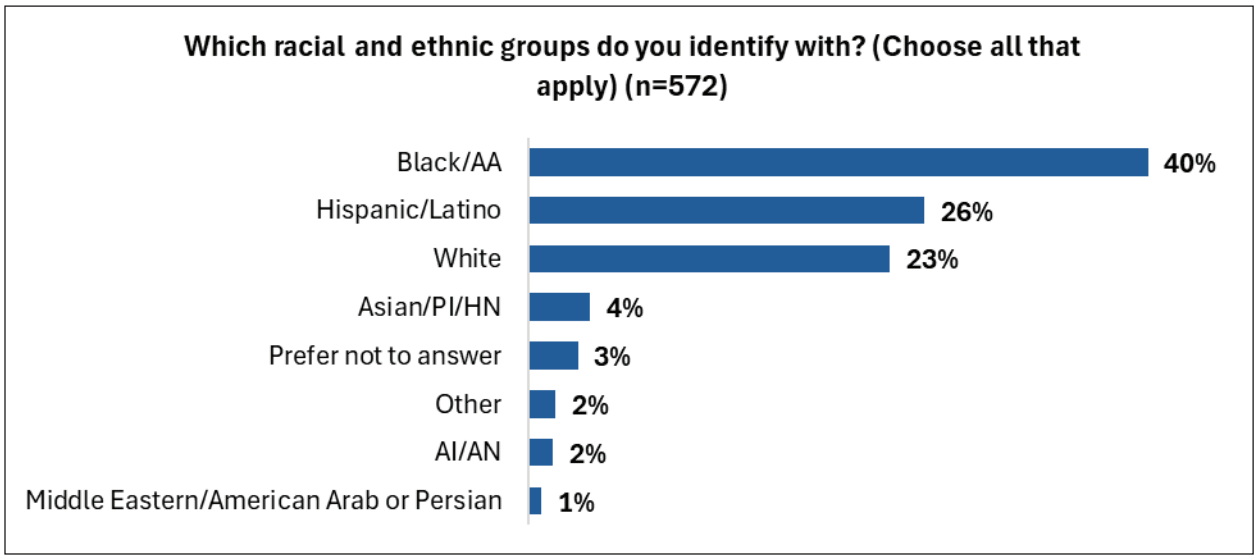
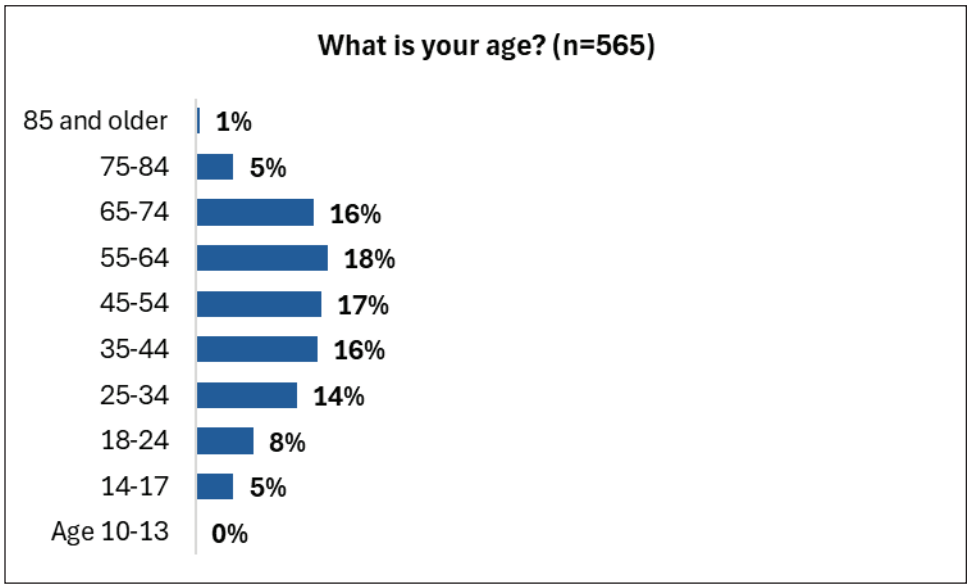


Figure 14. Age distribution of survey respondents



The majority of the survey respondents identify as female (71%) in comparison to individuals who identify as male (26%) within Loyola Medicine's service area (Figure 15). A small percentage identify as transgender female (1%)(Figure 15). Additionally, most of the survey respondents are heterosexual/straight (86%) (Figure 16). Participants identifying as bisexual (4%) and gay or lesbian (3%) accounted for about 7% of survey respondents (Figure 16).

Figure 15. Gender identities of survey participants

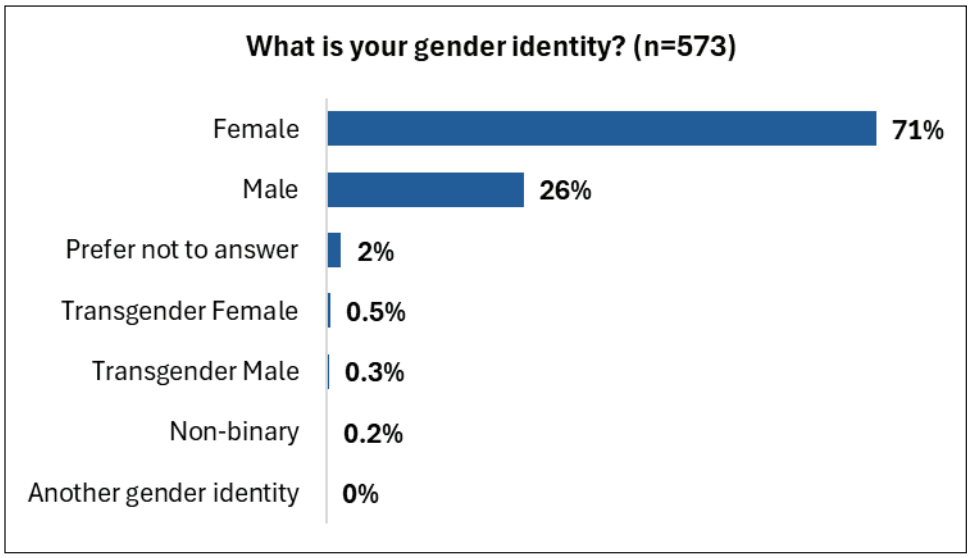
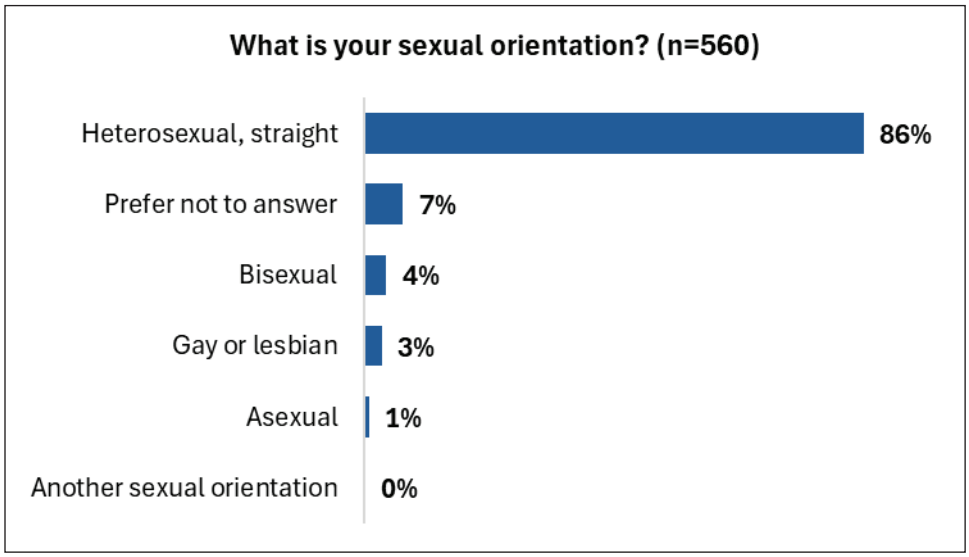
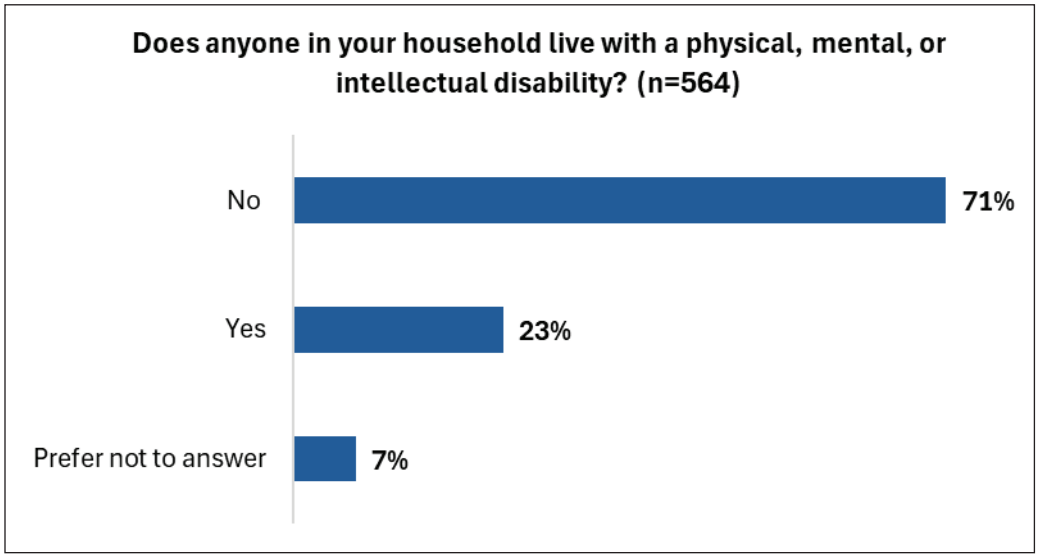


Figure 16. Sexual orientation of survey respondents



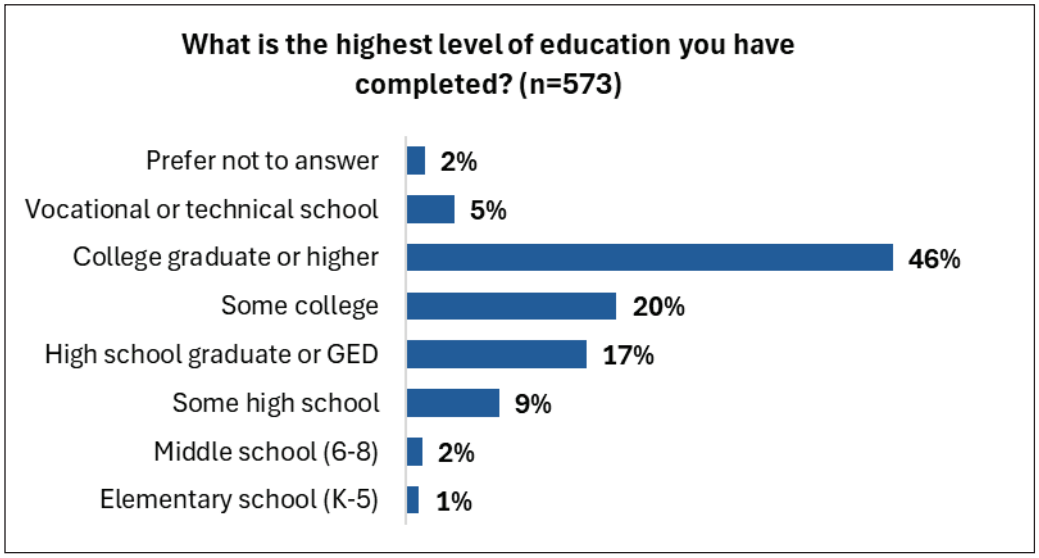
In the survey, 23% of respondents reported that someone in their household lives with a physical, mental, or intellectual disability, while 71% of respondents reported they do not have someone in their household with a physical, mental, or intellectual disability (Figure 17).

Figure 17. Household disability status of survey respondents



The largest group of survey respondents are a college graduate or higher (46%) followed by some college (20%) and high school graduate or GED (17%) (Figure 18). Nine percent of participants completed some high school (Figure 18). Respondents whose highest level of education is elementary school (K-5) (1%), middle school (6-8) (2%), and vocational or technical school (5%) accounted for 8% of survey respondents (Figure 18).

Figure 18. Highest level of education completed among survey respondents



Nineteen percent of respondents in Loyola Medicine's service area have an annual household income of $100,000 or more (Figure 19). Twenty-one percent of participants have an annual household income between $60,000 and $99,999 (Figure 19). An annual household income between $20,000 and $59,000 comprise 26% of the respondents, and 12% have an annual household income that is less than $20,000 (Figure 19). Sixty-nine percent of participants reported that they were employed, whether it was full-time, part-time, and/or self-employed (Figure 20). Six percent of survey respondents are students, and 25% are not employed and/or retired (Figure 20).

Figure 19. Annual household incomes of survey respondents

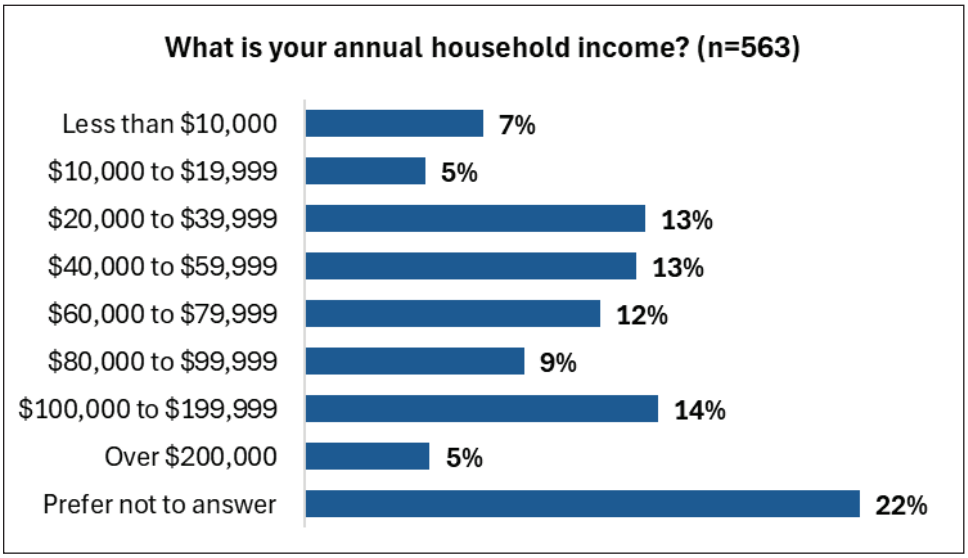
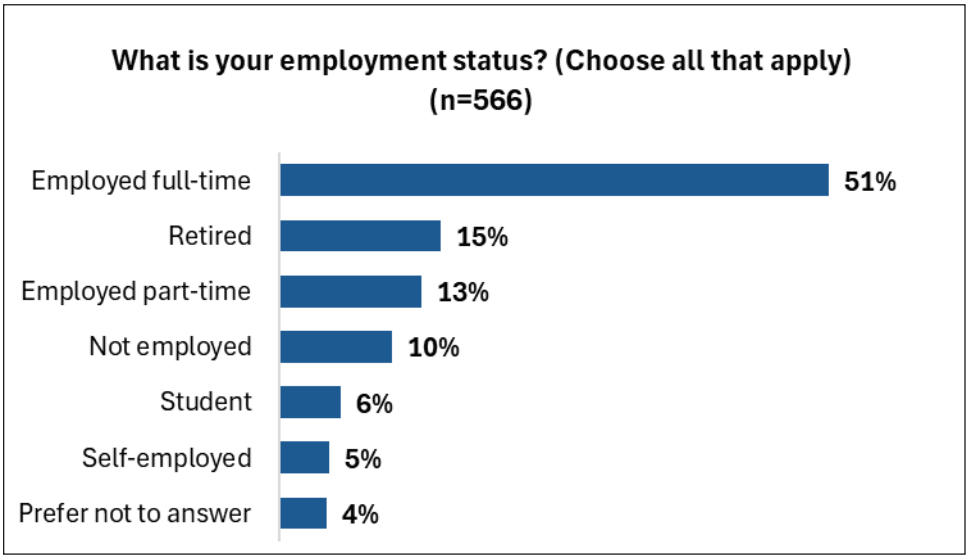


Figure 20. Employment status of survey respondents



Quality of life

In the 2024 survey, participants were asked to rate both the health of their communities and their personal health on a scale from “very unhealthy” to “very healthy”. 43% of respondents rated their communities as “somewhat healthy” (Figure 21). Participants were more likely to rate their personal health as better than overall community health with 62% reporting that their personal health was “healthy” or “very healthy” (Figure 22). 58% percent of respondents to the survey selected they “agree” or “strongly agree” to the statement “I am satisfied with the quality of life in my community” (Figure 23).

Figure 21. Community input survey responses – community health

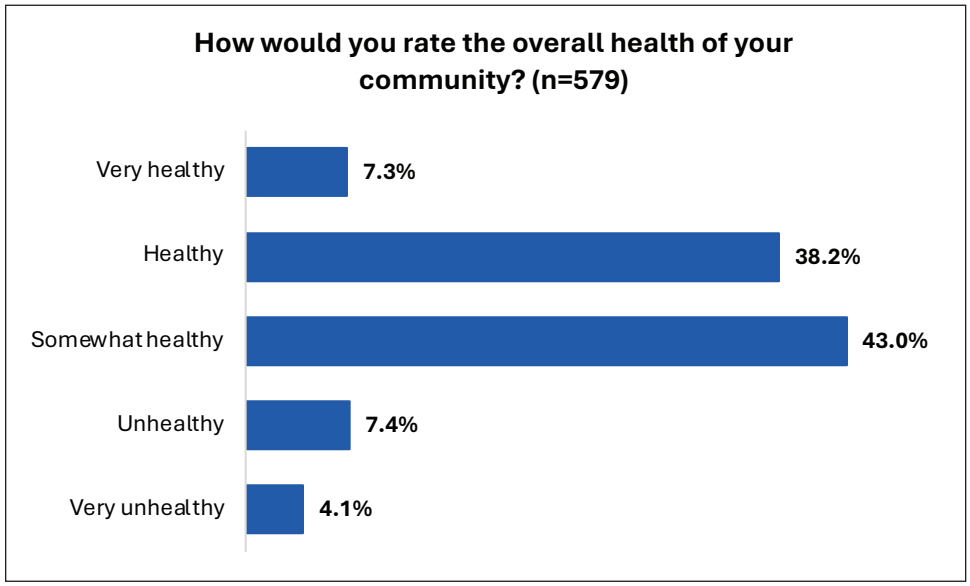


Figure 22. Community input survey responses – personal health

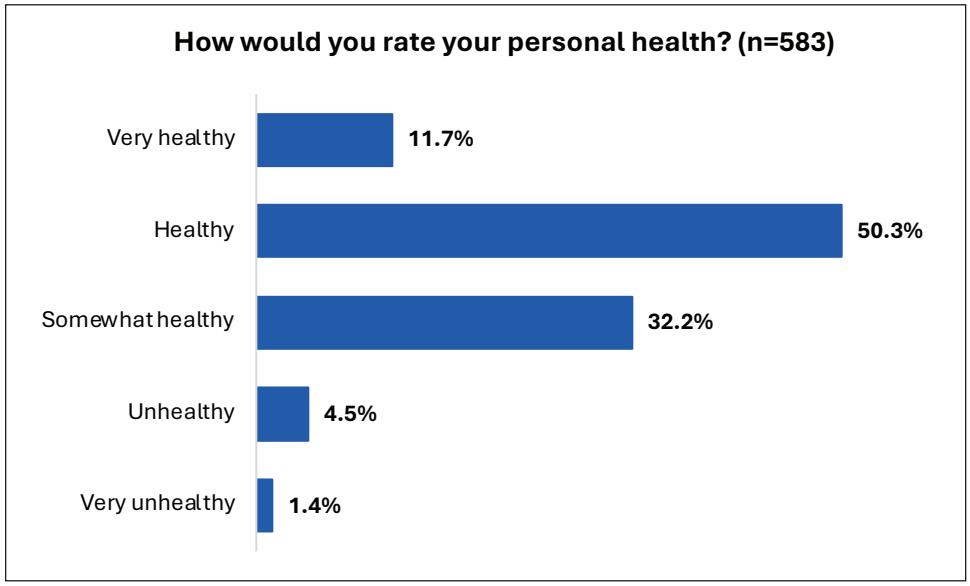
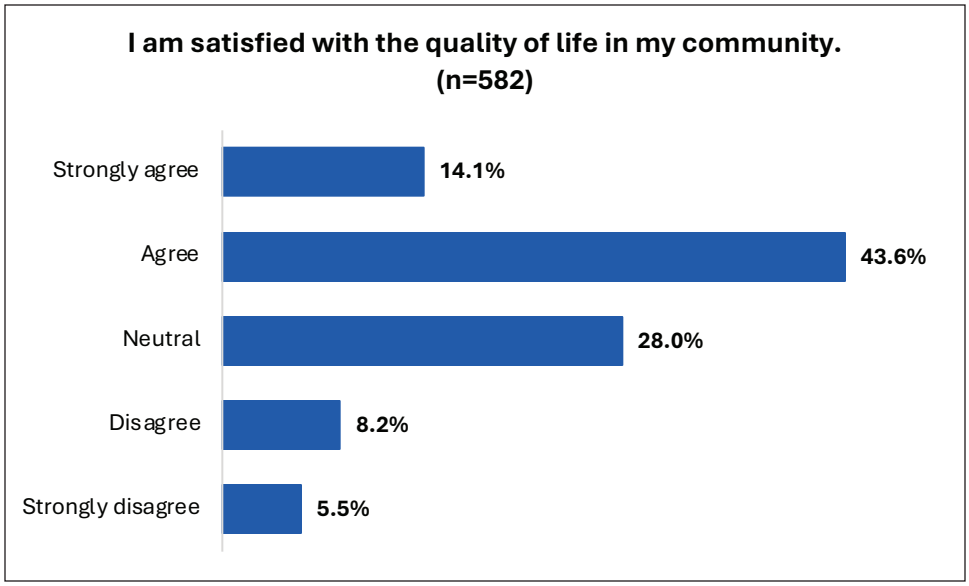


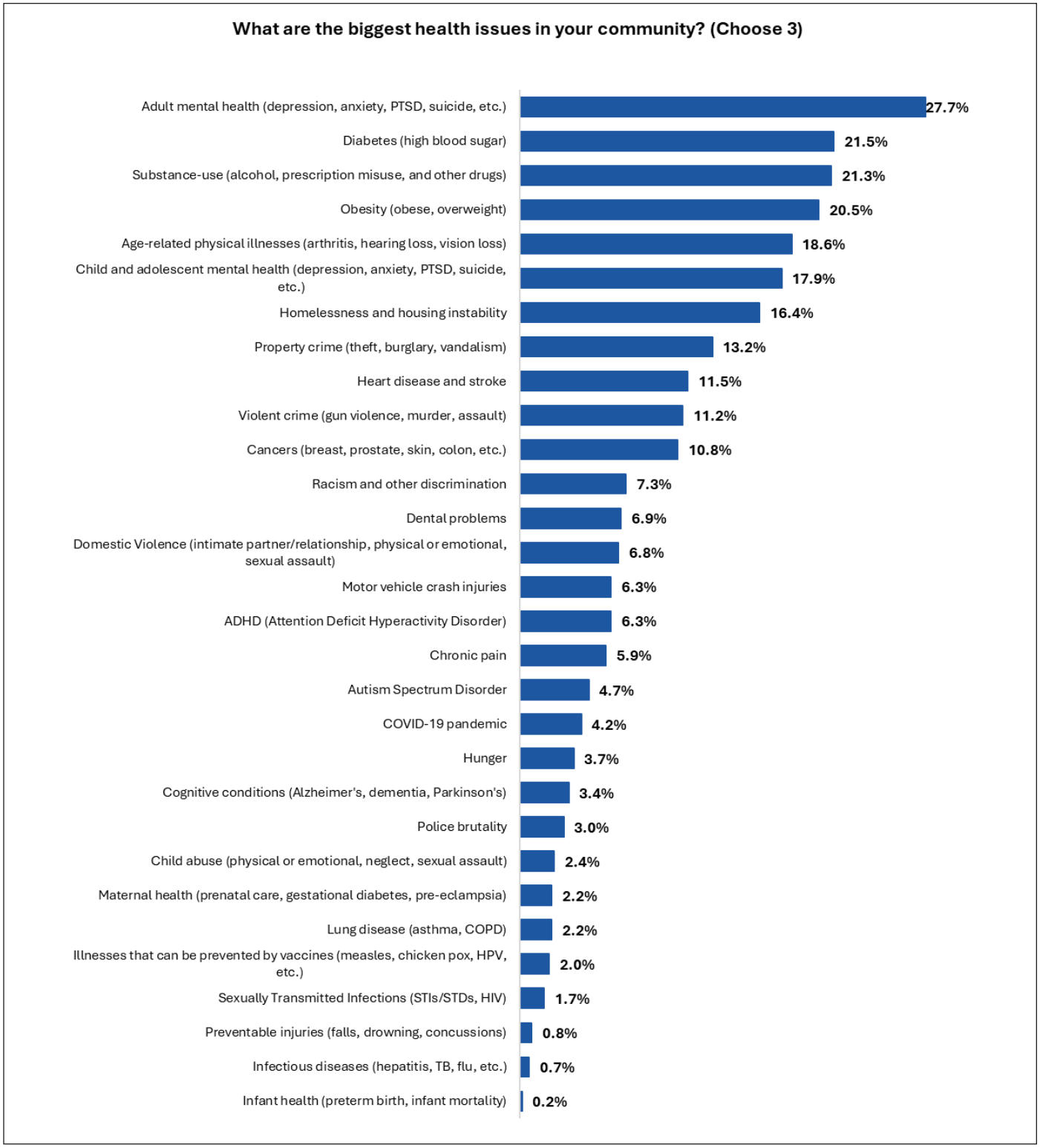
Figure 23. Community input survey responses – quality of life



Community health priorities and needs

The top health needs identified in the community input survey aligned with the overall county results with adult mental health (28%), diabetes (22%), substance use (21%), obesity (21%), and age-related physical illness (19%) being the top five health issues (Figure 24).

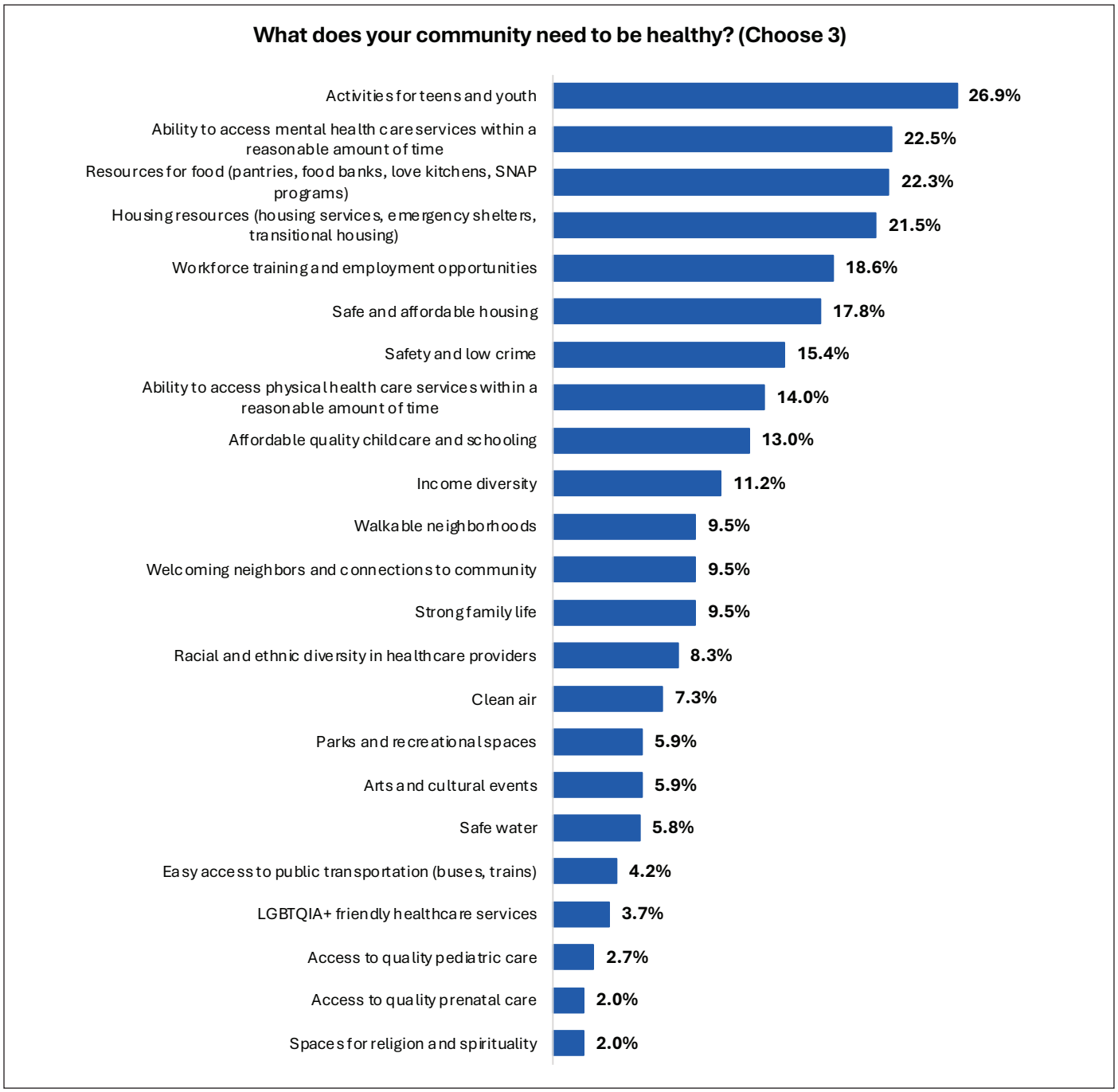
Figure 24. Community input survey responses – biggest health issues



In addition to health priorities, community survey respondents were asked about what was needed to support health improvements in their communities (Figure 25). The top five health supports identified in the survey included:

1. Activities for teens and youth
2. Ability to access mental health services within a reasonable about of time
3. Resources for food (pantries, food banks, love kitchens, SNAP programs)
4. Housing resources (housing services, emergency shelters, transitional housing)
5. Workforce training and employment opportunities

Figure 25. Community input survey responses – biggest health needs



Focus Groups

Sixteen focus groups, totaling over 150 participants, were conducted within Loyola Medicine's service area or included participants living within the service area. Hosted by community partners, the focus groups included community residents and local service providers. Figure 26 lists the partners that hosted focus groups in the Loyola Medicine service area.

Figure 26. Focus group partner organizations that hosted participants living or working within the Loyola Medicine service area

Several themes were identified based on the focus group input collected.

Health issues and challenges:

- Day-to-day stressors
- Lack of healthcare access
- Chronic conditions
- Mental health
- Substance use disorders
- Community safety
- Infrastructure and environment
- Economic challenges
- Child and adolescent health
- Women's health disparities
- COVID-19

Health promoters:

- Positive health behaviors
- Social support systems
- Access to healthy foods
- Outdoor spaces
- Access to community services

Potential Solutions

Focus group participants provided several potential solutions to the community health needs that they identified. More details are provided in the appended focus group report.

Solutions:

- Expansion of community programs
- Improved access to health and community services
- Violence reduction
- Policy and advocacy
- Hospital investment

Several suggestions were made on how hospitals should prioritize investment:

- Coordinated care
- Workforce development
- Community-focused outreach
- Mental health services
- Addressing social influencers of health
- Emergency preparedness and resilience

Focus group findings are integrated throughout the report. The full focus group report is included in Appendix A.

Health Inequities

Health inequities can be defined as differences in the burden of disease, mortality, or distribution of health influencers between different population groups (Centers for Disease Control and Prevention, 2024b; Weinstein et al., 2017). Health inequities can exist across many dimensions such as race, ethnicity, gender, sexual orientation, age, disability status, socioeconomic status, geographic location, and military status.

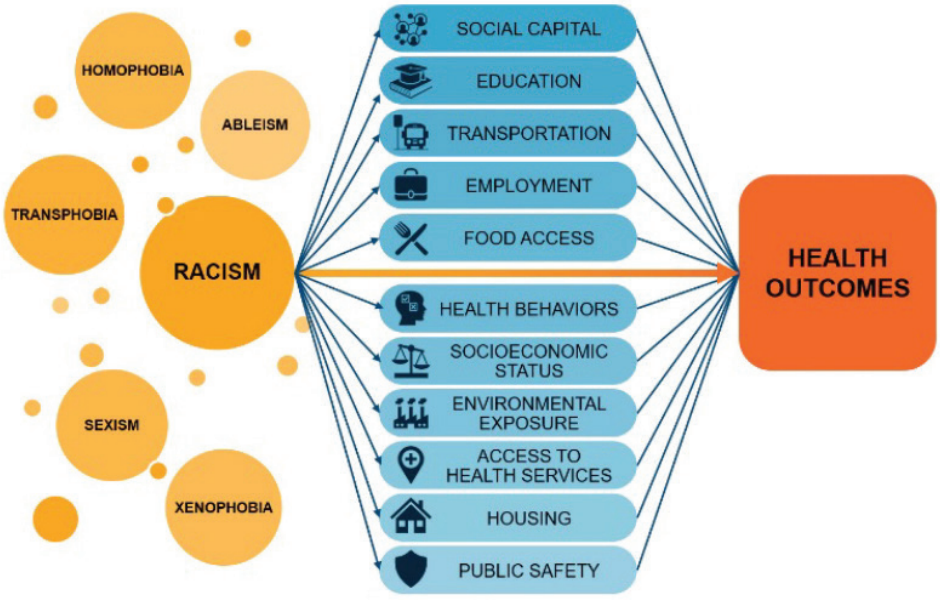
There are four overarching concepts that demonstrate the necessity of addressing health inequities:

1. **Inequities are unjust.** Health inequities result from the unjust distribution of the underlying influencers of health such as education, safe housing, access to health care, and employment.
2. **Inequities affect everyone**. Conditions that lead to health disparities are detrimental to all members of society and lead to loss of income, lives, and potential.
3. **Inequities are avoidable.** Many health inequities stem directly from government policies such as tax policy, business regulation, public benefits, and healthcare funding and can therefore be addressed through policy interventions.
4. **Interventions to reduce health inequities are cost-effective.** Evidence-based public health programs to reduce or prevent health inequities can be extremely cost effective particularly when compared to the financial burden of persistent disparities (Centers for Disease Control and Prevention, 2024b; Weinstein et al., 2017).

Structural Racism

Race and ethnicity are socially constructed categories that have profound effects on the lives of individuals and communities. Racial and ethnic health inequities are the most persistent inequities in health over time in the United States (Weinstein et al., 2017). Racial and ethnic inequities in health are directly linked to racism (Figure 27).

Figure 27. Differences in health outcomes among racial and ethnic groups are directly linked to racism



Source: Boston Public Health Commission's Racial Justice and Health Equity Initiative; available: http://www.bphc.org/whatwedo/health-equity-social-justice/racial-justice-health-equity-initiative/Documents/RJHEI%202015%20Overview%20FINAL.pdf

Loyola Medicine's service area encompasses many of the communities experiencing the highest levels of hardship in Cook County (Figure 28). The area has suffered significant social disruption over the past 100 years along with persistent and pervasive racial and ethnic inequities (Henricks et al., 2018). As a result, community-level violence, poor education opportunities, lack of quality job opportunities, poor quality housing stock, healthcare shortages, and poor health outcomes have been concentrated in Black and Brown communities on the West Side of Chicago and the Far West and Southwest Suburbs.

Figure 28. Table comparing Hardship Index score between zip codes in the Loyola Medicine service area, 2019-2023

Zip Code	Hardship Index	Ranking in Cook County (Out of 180)
60305 (River Forest, IL)	5.4	14
60301 (Oak Park, IL)	8.6	18
60304 (Oak Park, IL)	15.9	31
60526 (La Grange Park, IL)	16.7	33
60302 (Oak Park, IL)	16.8	34
60513 (Brookfield, IL)	19.8	42
60130 (Forest Park, IL)	21.5	45
60546 (Riverside, IL)	25.8	55
60154 (Westchester, IL)	27.0	60
60656 (Chicago, IL)	31.8	69
60634 (Chicago, IL)	43.9	84
60706 (Chicago, IL)	47.8	91
60707 (Elmwood Park, IL)	49.1	94
60162 (Hillside, IL)	54.5	108
60171 (River Grove, IL)	54.7	109
60534 (Lyons, IL)	59.0	118
60402 (Berwyn, IL)	60.8	122
60163 (Berkeley, IL)	61.6	124
60155 (Broadview, IL)	66.4	129
60141 (Maywood, IL)	68.9	134
60104 (Bellwood, IL)	69.8	137
60131 (Franklin Park, IL)	70.0	138
60176 (Schiller Park, IL)	73.7	146
60164 (Northlake, IL)	73.8	147
60160 (Melrose Park, IL)	74.8	150
60153 (Maywood, IL)	77.1	155
60804 (Cicero, IL)	79.5	158
60651 (Chicago, IL)	83.1	164
60165 (Stone Park, IL)	86.5	170
60644 (Chicago, IL)	92.2	179

(US Census Bureau, 2024)

7% of community input respondents in the service area rated racism and other discrimination as a top health issue in their community.

Focus group participants identified prejudice and racism as a day-to-day stressor

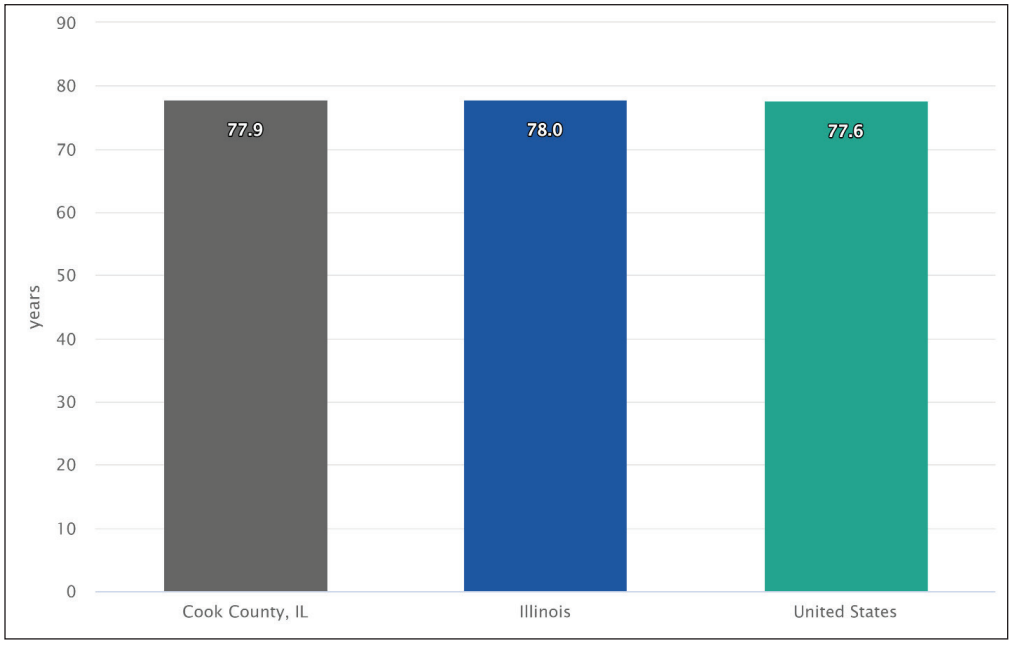
Inequities in mortality

Race-specific mortality records dating as far back as the 1800s indicate that Black individuals in the U.S. have higher rates of mortality compared to white individuals (Benjamins et al., 2021). Although some mortality gaps have narrowed over time, these disparities remain critical markers of injustice (Benjamins et al., 2021).

Life Expectancy

Life expectancy is the average number of years an individual is expected to live. During the COVID-19 pandemic, the U.S. experienced its largest decline in life expectancy since the 1920s decreasing 2.7 years between 2019 and 2021. The pandemic also worsened existing racial inequities in life expectancy and mortality in the U.S. The largest declines in life expectancy were experienced by American Indian and Alaskan Natives (6.6 years) followed by Hispanic (4.2 years) and Black people (4.0 years). The declines were largely due to COVID-19 and reflect the disproportionate burden of excess deaths and premature deaths among people of color (Hill & Artiga, 2023).

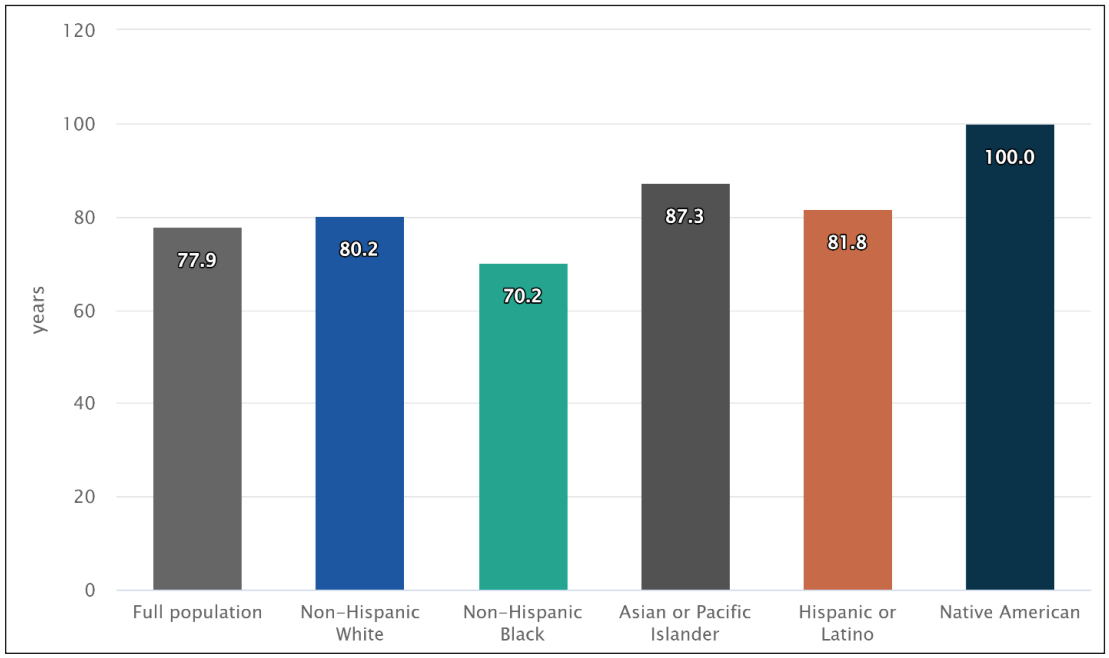
Figure 29. Chart comparing life expectancy in Cook County, Illinois, and the United States, 2019-2021



(National Center for Health Statistics, 2021)

The average life expectancy in Cook County (77.9 years), state (78.0 years), and national (77.6 years) are comparable (Figure 29). However, when looking at Cook County by race/ethnicity, there are inequities. Native Americans have the highest life expectancy at 100.0 years although this is likely an overestimation due to small population size. Asian and Pacific Islanders have the second highest life expectancies (87.3 years) and Non-Hispanic Black individuals have the lowest at 70.2 years (Figure 30).

Figure 30. Chart comparing life expectancy in Cook County by Race/Ethnicity, 2019-2021



(National Center for Health Statistics, 2021)

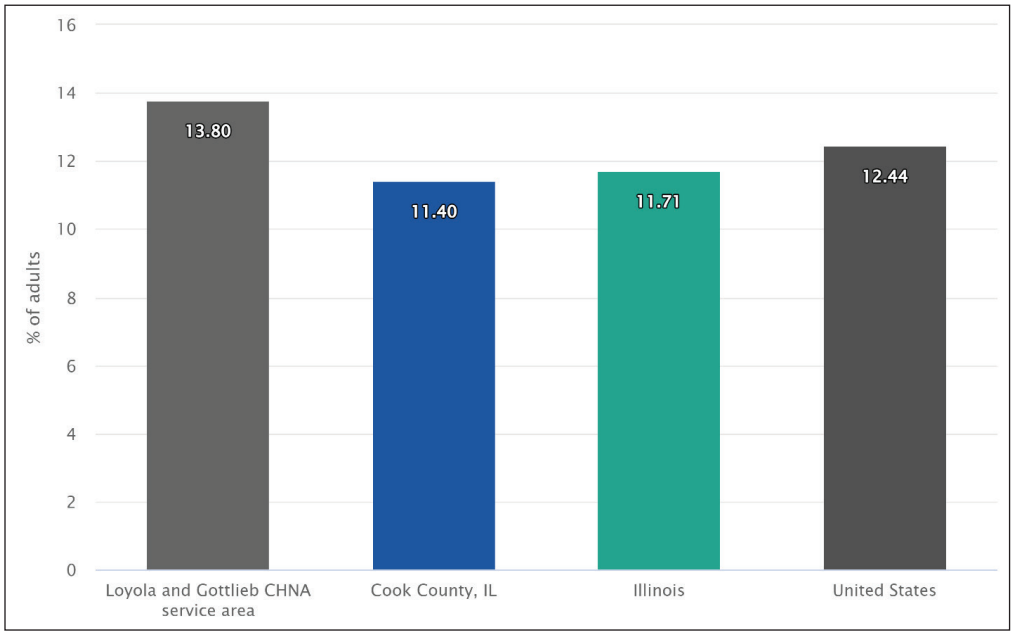
Secondary Data

Secondary data provides insight into the current health status of communities. The following are key highlights of data related to overall health, health behaviors, chronic disease, social influencers of health, and mental health. When available, population and geographic comparisons are included.

Overall Health

Existing research indicates that self-reported health remains an important predictor of mortality (Wuorela et al., 2020). The measure integrates biological, mental, social, and cultural aspects of a person (Wuorela et al., 2020). The percentage of individuals reporting poor overall physical health is slightly higher in the service area than in the city, state, and nation (Figure 31). High rates of poor self-reported physical health such as those within the service area are connected to high rates of hardship and poor health outcomes.

Figure 31. Chart comparing the percentage of adults reporting poor physical health, Cook County, Illinois, and the United States, 2022



(Centers for Disease Control and Prevention, 2024a)

62% of community input survey respondents rated their personal health as "healthy" or "very healthy"

Health Behaviors

Four key health behaviors that are strongly correlated with chronic disease outcomes are smoking, physical activity, alcohol consumption, and sufficient daily sleep. Some communities in Cook County face significant barriers to engaging in preventative health behaviors such as access to safe exercise spaces, access to healthy affordable foods, and access to mental health and substance use disorder treatment. Health behaviors for communities in Loyola Medicine's service area are presented in Figure 32.

Figure 32. Table of key health behaviors impacting chronic disease outcomes in Loyola Medicine's service area

Health Behavior	Date	Loyola Medicine Service Area	Cook County	Illinois	United States
Cigarette smoking rate Percent of resident adults aged 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days. Age-standardized.	2022	15%	12%	14%	15%
Binge drinking Percent of adults aged 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days. Alcohol use is likely seriously underreported, so these estimates are an extreme lower bound on actual binge drinking prevalence.	2022	20%	21%	20%	19%
Sleeping less than 7 hours Percent of resident adults aged 18 and older who report usually getting insufficient sleep (<7 hours for those aged ≥18 years, on average, during a 24-hour period)	2022	37%	36%	36%	37%
No exercise Percent of resident adults aged 18 and older who answered "no" to the following question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"	2022	25%	21%	22%	24%

(Centers for Disease Control and Prevention, 2024a)

> *I'm taking walks with the family – low-hanging fruit. It doesn't require any money, commitment, but it does require a safe space.*
>
> *- West Cook YMCA Focus Group Participant*

Chronic Conditions

A chronic condition is an ongoing physical or mental health condition that lasts a year or more, requires ongoing medical attention, and/or limits activities of daily living. Worldwide and in the United States chronic diseases are the leading cause of disability and death. Chronic conditions such as heart disease, stroke, cancer, diabetes, arthritis, asthma, and poor mental health create a significant health and economic cost for individuals and communities. Prevention and management of chronic conditions can significantly reduce the burden of these diseases on individuals and society. The percentage of individuals with common chronic conditions in Loyola Medicine's service area are presented in Figure 33.

Figure 33. Rates of individuals with chronic conditions in Loyola Medicine's service area

Health condition	Date	Loyola Medicine Service Area	Cook County	Illinois	United States
Obesity	2022	36%	33%	34%	34%
High blood pressure	2022	31%	29%	29%	30%
Current asthma	2022	10%	9%	10%	10%
Arthritis	2022	24%	21%	23%	23%
Diagnosed diabetes	2022	13%	11%	10%	11%
Chronic obstructive pulmonary disease (COPD)	2022	6%	5%	6%	6%
Diagnosed stroke	2022	4%	3%	3%	3%
Cancer diagnosis rate	2017-2021	522.4 per 100,000 residents	547.7 per 100,000 residents	573.2 per 100,000 residents	444.4 per 100,000 residents
Coronary heart disease	2022	6%	5%	5%	6%
Chronic kidney disease	2022	3%	3%	3%	3%

(Centers for Disease Control and Prevention, 2024a; Illinois Department of Public Health, 2021)

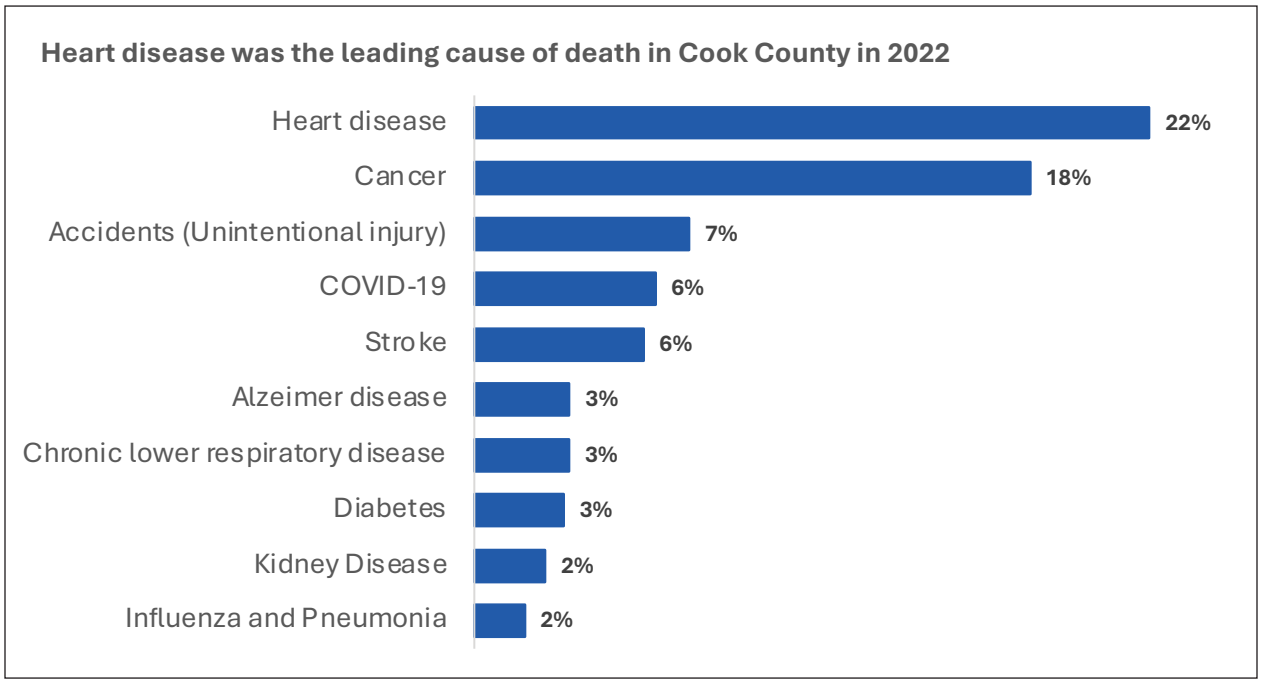
Obesity and high blood pressure (hypertension) are often interconnected risk factors for cardiovascular disease, the leading cause of death in Chicago and the United States. In Loyola Medicine's service area, 36% of adults reported being obese and 31% reported being diagnosed with high blood pressure.

Diabetes, obesity, and age-related physical illnesses were among the top 5 health issues *chosen by community input survey respondents.*

Mortality

The top five leading causes of death in Cook County were heart disease, cancer, accidents (unintentional injury), COVID-19, and stroke (Figure 34). The geographic distributions of heart disease and cancer mortality are presented in Figure 35 and Figure 36. Communities in Loyola Medicine's service area have some of Chicago's highest rates of heart disease and cancer mortality.

Figure 34. Leading causes of death in Cook County, Illinois, 2022

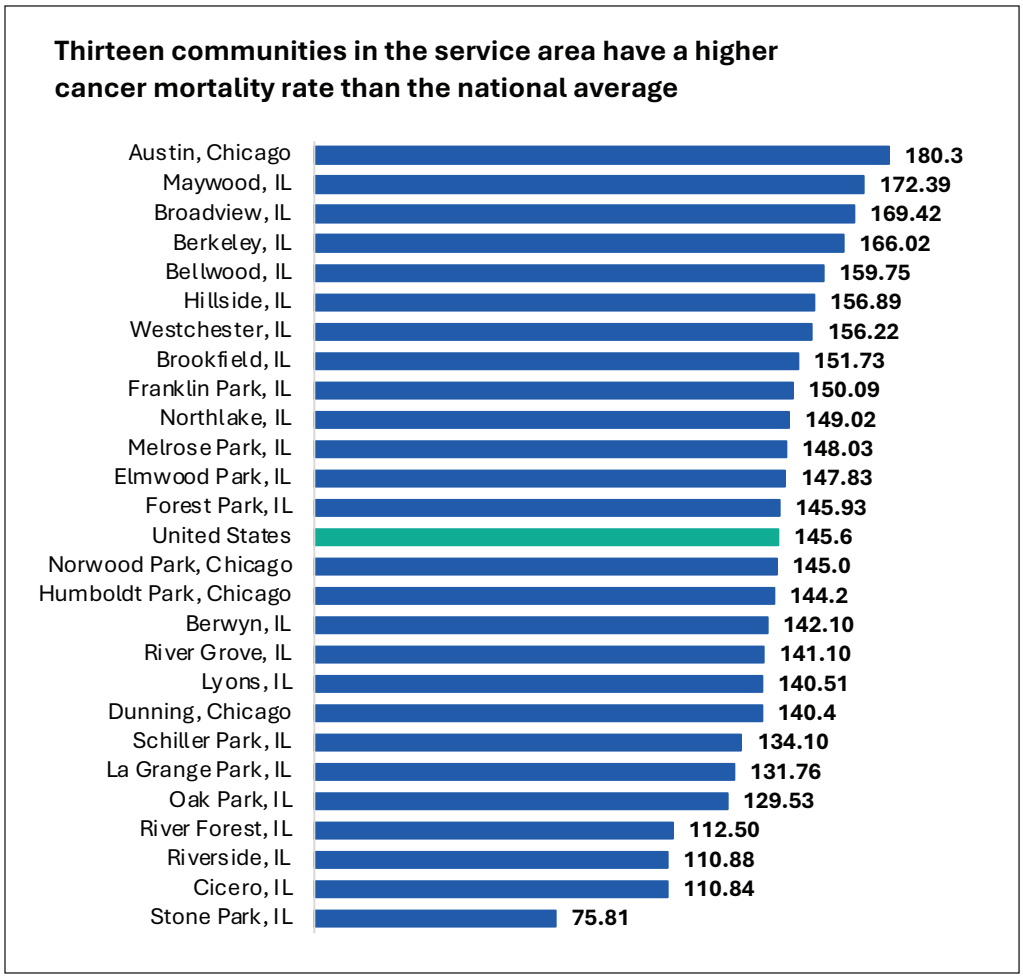


Source: (Illinois Department of Public Health, 2024b)

Hypertension was noted as a prevalent issue by focus group participants and often linked to stress, poor diet, and lack of preventative healthcare.

Cardiovascular conditions were tied to systemic issues, such as lack of exercise opportunities in some neighborhoods and limited access to affordable healthcare.

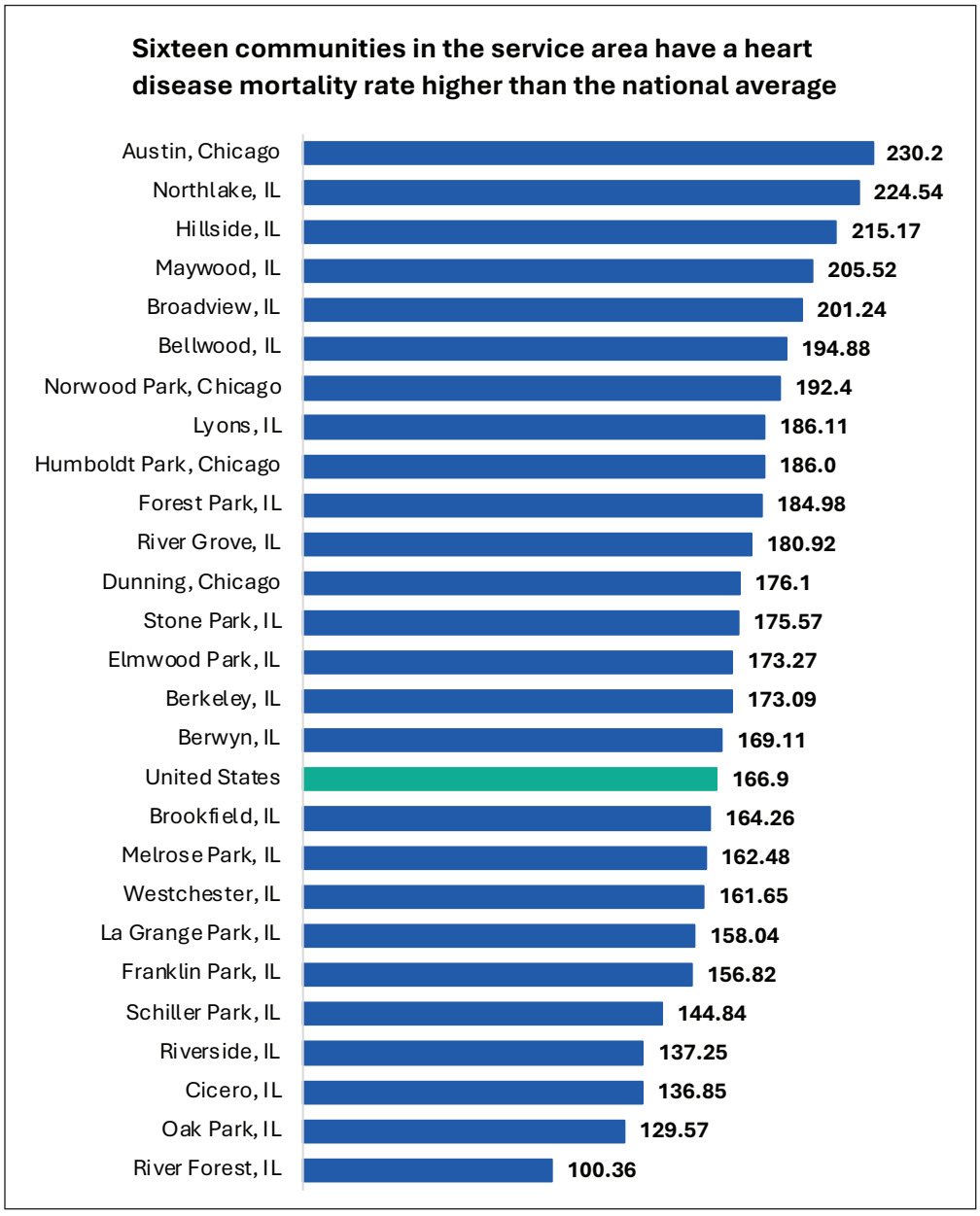
Figure 35. Chart comparing cancer mortality rates (per 100,000 population), 2018-2022



Source: (Illinois Department of Public Health, 2024a)

Within the service area, focus group participants highlighted a lack of access to preventative care programs, screenings, and comprehensive health education.

Figure 36. Chart comparing heart disease mortality rates (per 100,000 population) between communities in the Loyola Medicine service area and the national rate, 2018-2022



Source: (Illinois Department of Public Health, 2024a)

Maternal and child health

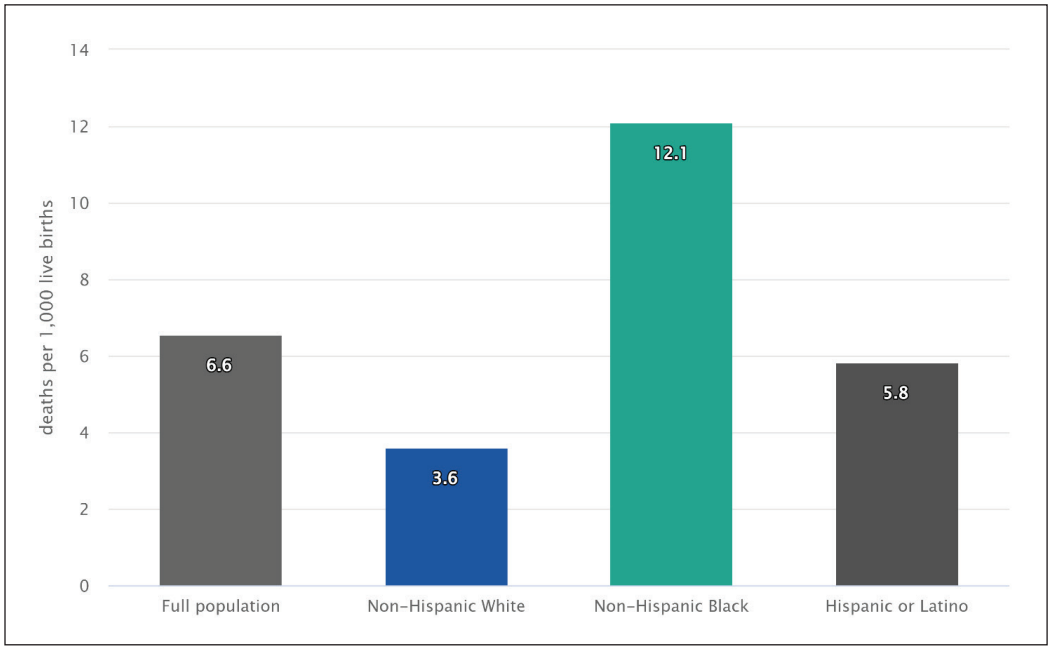
Maternal health is defined as the health of women during or after pregnancy (Bennet et al., 2023). This period is a critical time for women's health since they typically have more interaction with and access to health care services (Bennet et al., 2023). In addition, pregnancy provides an opportunity to identify, treat, and manage underlying chronic conditions to improve a woman's overall health (Bennet et al., 2023).

Severe pregnancy complications (maternal morbidity) and mortality are used on an international level to judge the overall health status of a country, state, or community (Bennet et al., 2023). Since the year 2000, maternal mortality rates in the United States have been increasing even though the global trend has been the opposite (MacDorman et al., 2016). In addition, vast maternal health disparities exist between racial and ethnic groups (Bennet et al., 2023). The persistent nature of racial and ethnic disparities in maternal health indicate that inequities are due to more than just access to health care but include factors such as poverty, quality of education, health literacy, employment, housing, childcare availability, and community safety (Bennet et al., 2023)

In a 2023 report, a Maternal Mortality Review Committee found that in Illinois between 2018-2020, Black women were almost twice as likely to die of pregnancy-related conditions than their white counterparts (Bennet et al., 2023). The report also found that the gap in pregnancy-related deaths between Black and white women has narrowed, but not due to improved health outcomes for Black women (Bennet et al., 2023). Instead, it is an effect of worsening conditions for white women, especially due to mental health conditions, including substance use disorder and suicide (Bennet et al., 2023). Discrimination was cited as a contributing factor in 50% of pregnancy-related deaths among Black women (Bennet et al., 2023). From 2018-2020, 90% of pregnancy-related deaths in Illinois were found to have had either a "Good Chance" or "Some Chance" of being preventable (Bennet et al., 2023).

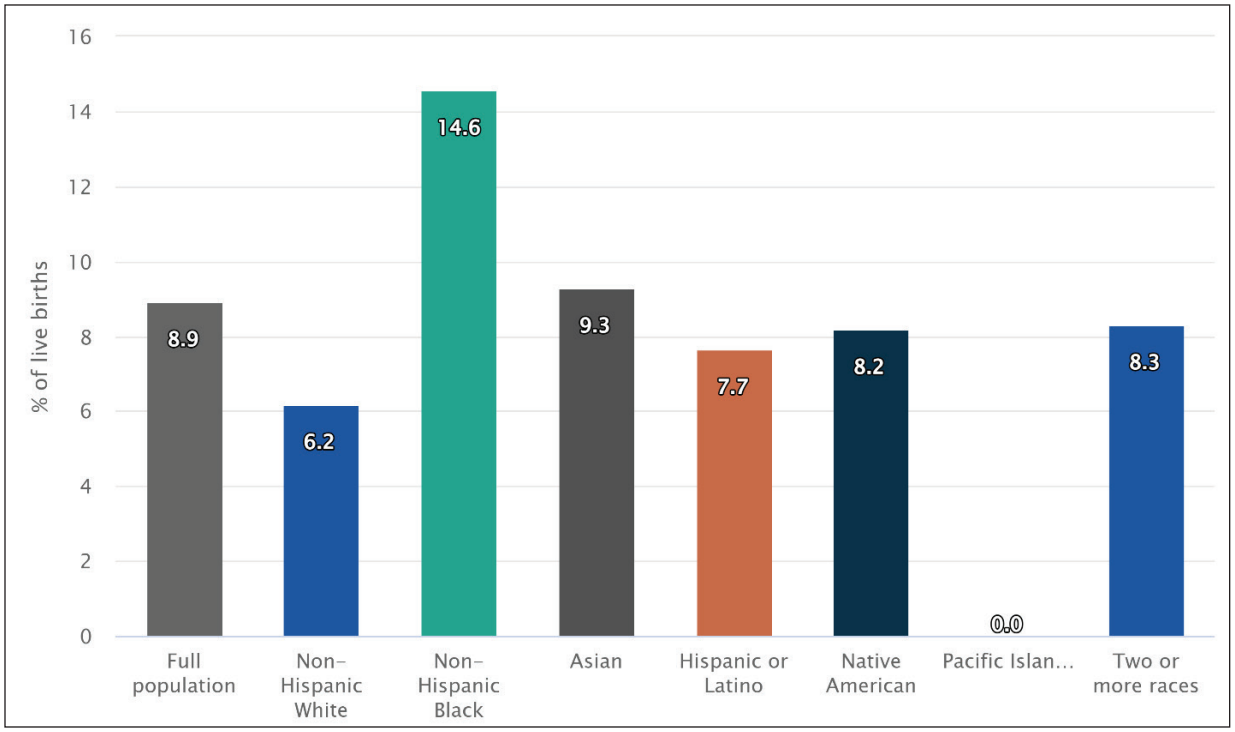
The infant mortality rate in Cook County (6.6) is comparable to the state and national rates (Centers for Disease Control and Prevention, 2020b). Within the county, there are inequities between different racial and ethnic groups. Infant mortality rates for Non-Hispanic Black infants (12.1) are more than double that of Hispanic or Latino infants (5.8) and three times that of Non-Hispanic White infants (3.6) (Figure 31). Other risk factors for poor infant health outcomes such as low-birth weight and preterm births also show inequities between racial/ethnic groups in Cook County (Figure 37, Figure 38).

Figure 37. Infant mortality rates (per 1,000 live births) by race and ethnicity in Cook County, 2015-2019



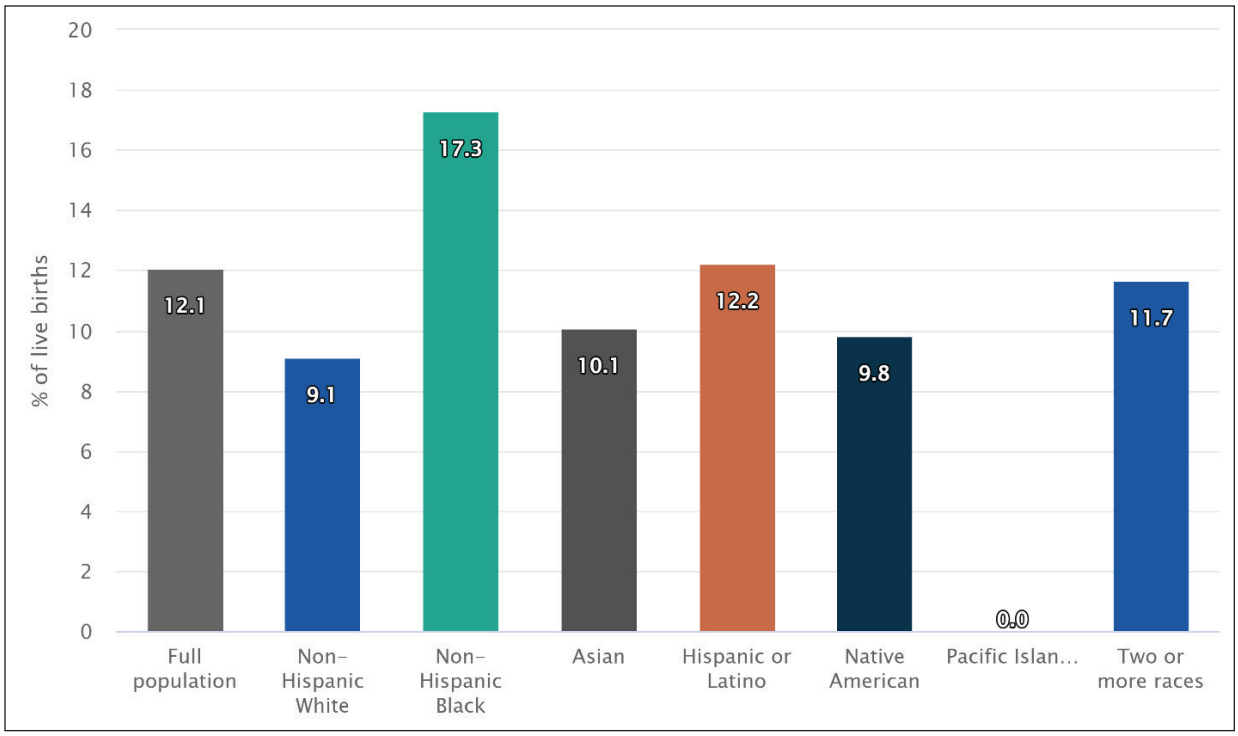
(Centers for Disease Control and Prevention, 2020b)

Figure 38. Low birth weight rates by race and ethnicity in Cook County, 2018-2022



(Centers for Disease Control and Prevention, 2020b)

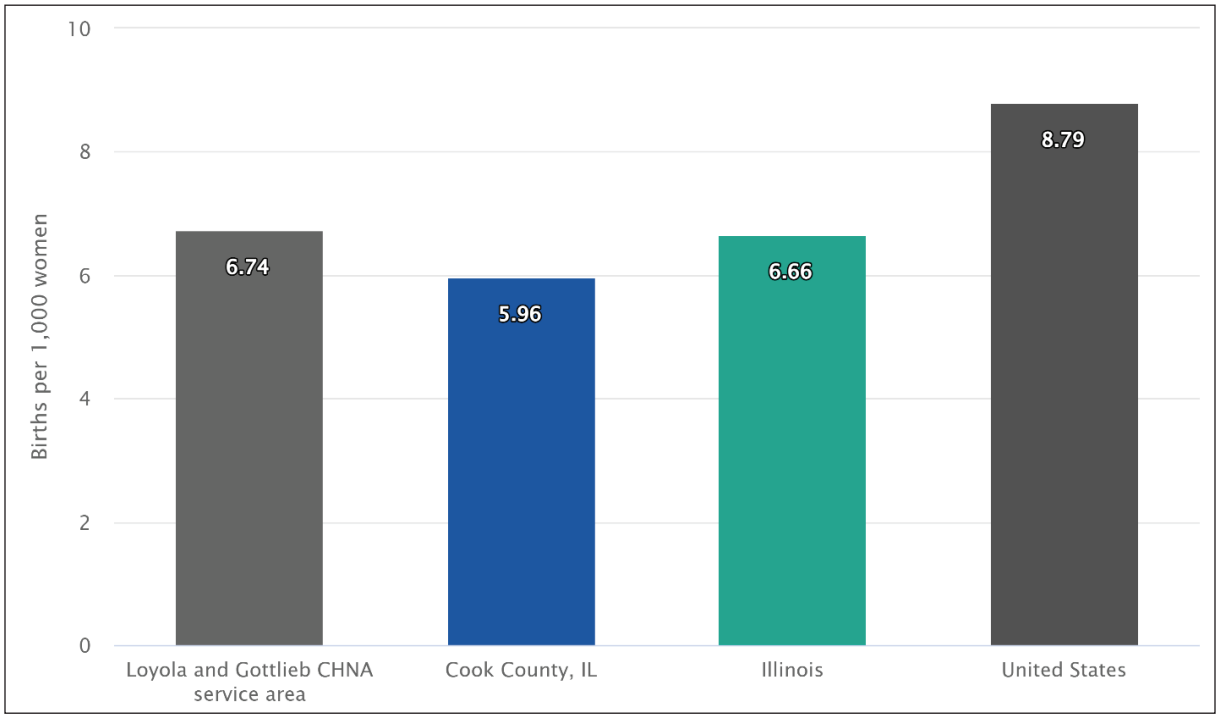
Figure 39. Preterm birth rates by race and ethnicity in Cook County, 2018-2022



(Centers for Disease Control and Prevention, 2020b)

Preterm birth and low birthweight are more likely among infants born to adolescent mothers. The teen birth rate for Loyola Medicine's service area is 6.7 births per 1,000 women compared to 6.0 births per 1,000 women in Cook County, and 6.7 births per 1,000 women in Illinois (Figure 40). The county findings are consistent with overall population trends of high inequities in health outcomes among women and infants of color.

Figure 40. Chart comparing teen birth rates (per 1,000 women) of Loyola Medicine's service area, Cook County, Illinois, and the United States, 2019-2023



(Centers for Disease Control and Prevention, 2020b)

Among focus group participants, there was a significant call for greater awareness and resources dedicated to women's health issues such as endometriosis, menopause, and maternal health.

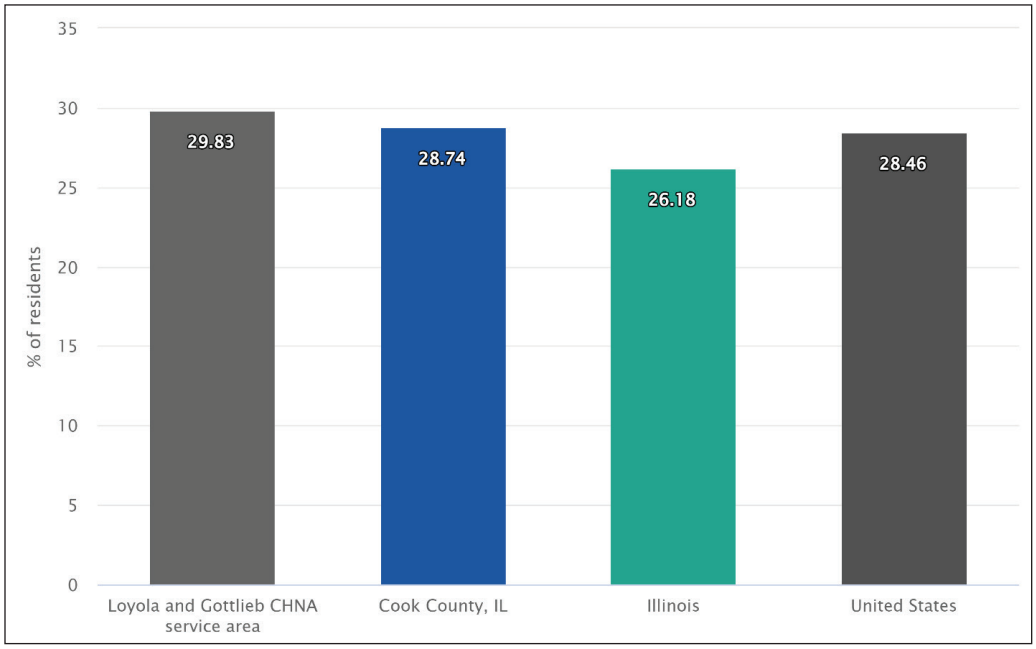
Participants expressed concerns about higher maternal and child mortality rates among Black and Brown families. In addition, participants highlighted a lack of access to women's health services including pre- and post-natal care and maternal mental health services.

Social Influencers of Health

Social influencers of health such as poverty, limited access to healthy foods, exposure to violence, limited access to healthcare, and housing conditions are both underlying root causes of chronic disease and are barriers to the management of chronic disease. Communities within Loyola Medicine's service area face significant inequities related to the social influencers of health.

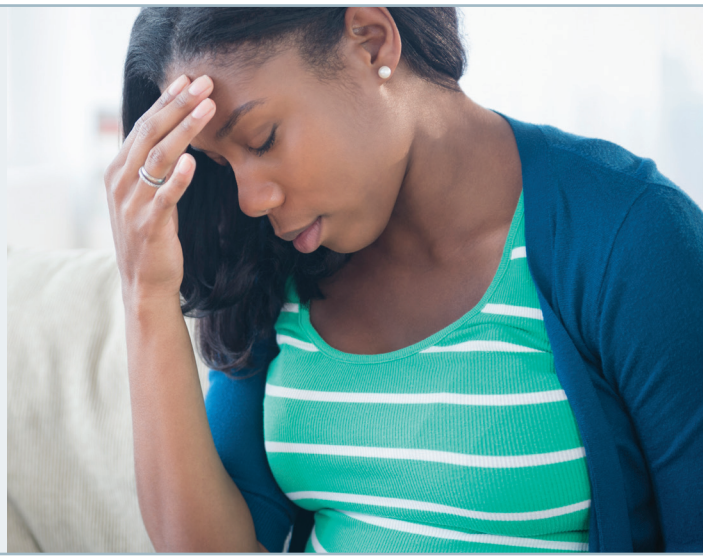
Healthy People 2020 highlights that communities with high rates of poverty are at increased risk for mental illness, chronic disease, higher mortality, and lower life expectancy. The percentage of residents within Loyola Medicine's service area living at or below 200% of the Federal Poverty Level is high (Figure 41). For some zip codes, the percentage of residents living at or below 200% of the Federal Poverty Level is more than 50% (US Census Bureau, 2024).

Figure 41. Chart comparing the percentage of residents below 200% of the Federal Poverty Level in Loyola Medicine's service area, Cook County, Illinois, and the United States, 2019-2023



(US Census Bureau, 2024)

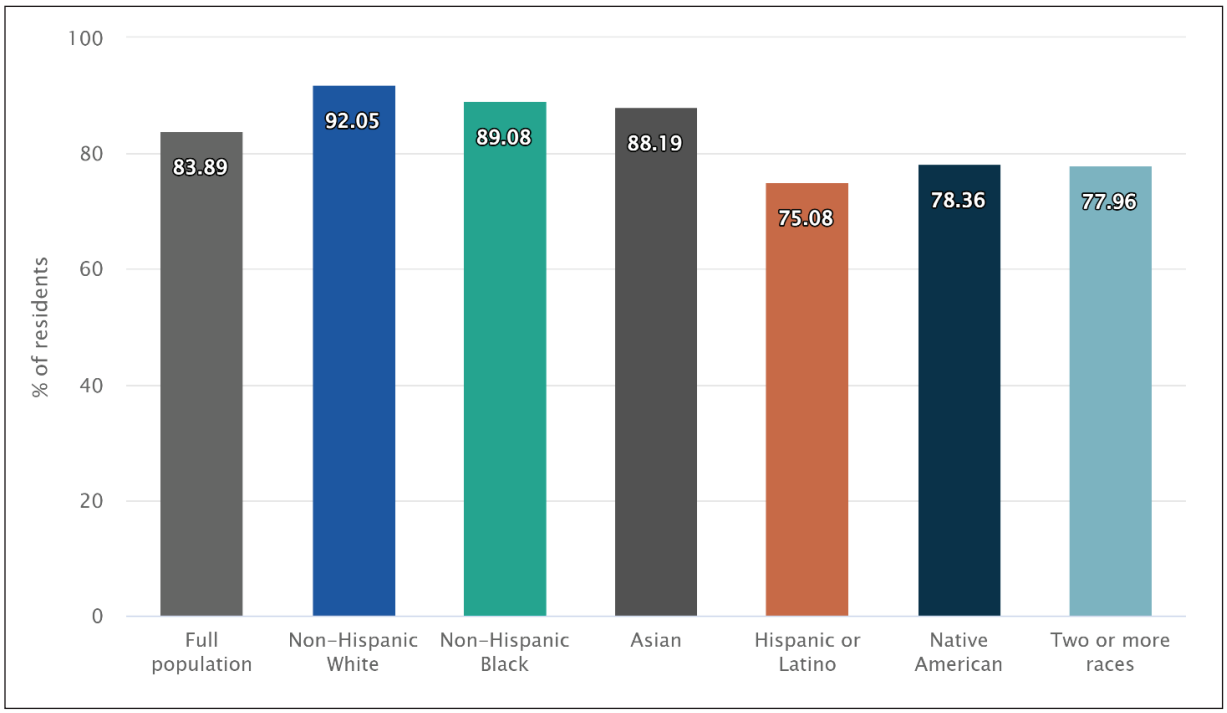
Focus group participants noted that economic instability leads to stress, anxiety, and worsened health conditions due to delayed or unaffordable care.



Education

Education is an important determinant of health because poverty, unemployment, and underemployment are highest among those with lower levels of educational attainment. High school graduation rates in Loyola Medicine's service area (84%) are lower than rates for the county (88%), state (90%) and nation (89%) (US Census Bureau, 2024). High school graduation rates vary by race and ethnicity with Native American and Hispanic or Latino residents having the lowest rates in the service area (Figure 42).

Figure 42. High school graduation rates by race and ethnicity in Loyola Medicine's service area, 2019-2023



(*US Census Bureau, 2024)*

Focus group participants expressed dissatisfaction with the quality of education in some schools.

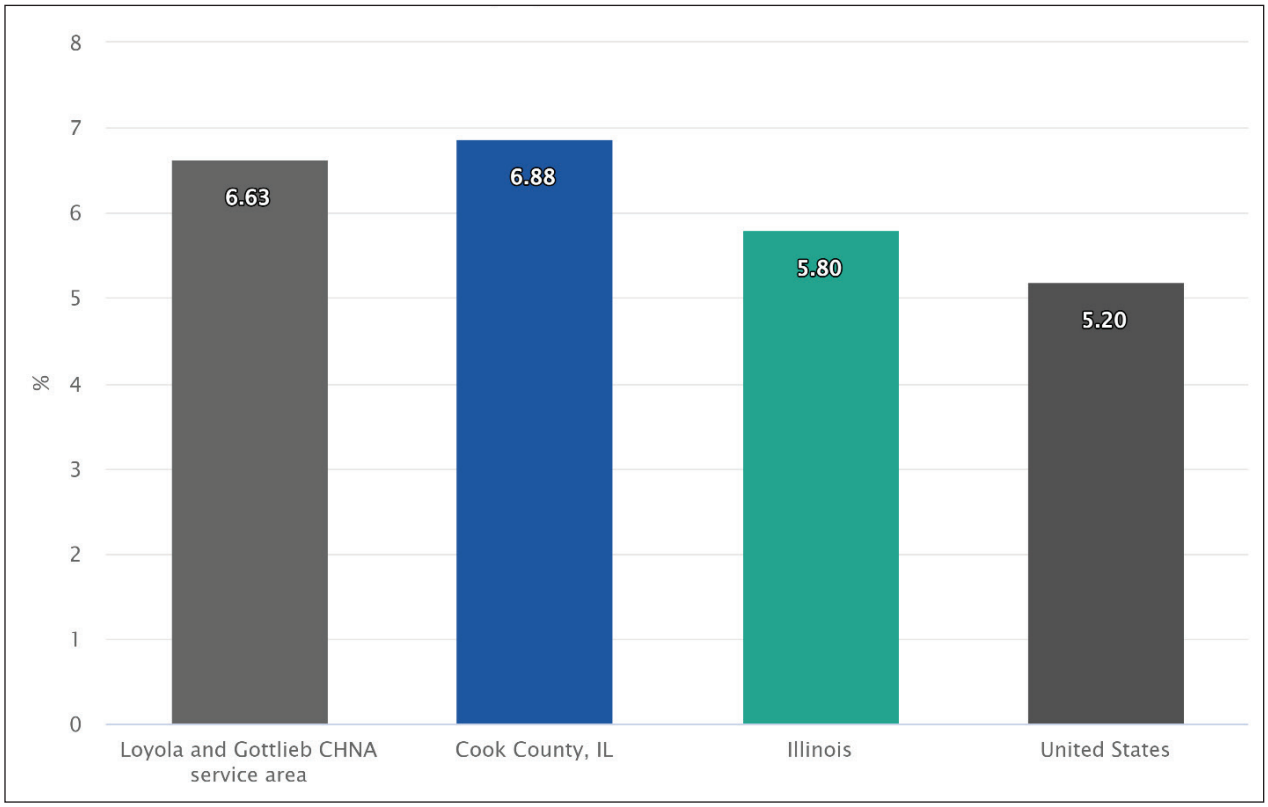
They noted that key subjects like history, music, art, and home economics were no longer part of the curriculum. Concerns were raised about schools passing students without adequately preparing them, leading some parents to send their children to schools outside their communities for better education.

Schools with limited wraparound services, such as counseling and extracurricular activities, were seen as failing to meet students' holistic needs.

Unemployment

Unemployment and underemployment can create financial instability, which influences access to health care services, insurance, healthy foods, stable quality housing, and other basic needs. The unemployment rate for the service area is comparable to the county, but higher than the state and nation (Figure 43). Within the service area, unemployment rates vary widely, with an almost 17% difference between the zip codes with the highest (19.1%) and lowest (2.4%) unemployment (Figure 44).

Figure 43. Chart comparing the unemployment rate in Loyola Medicine's service area, Cook County, Illinois, and the United States, 2019-2023

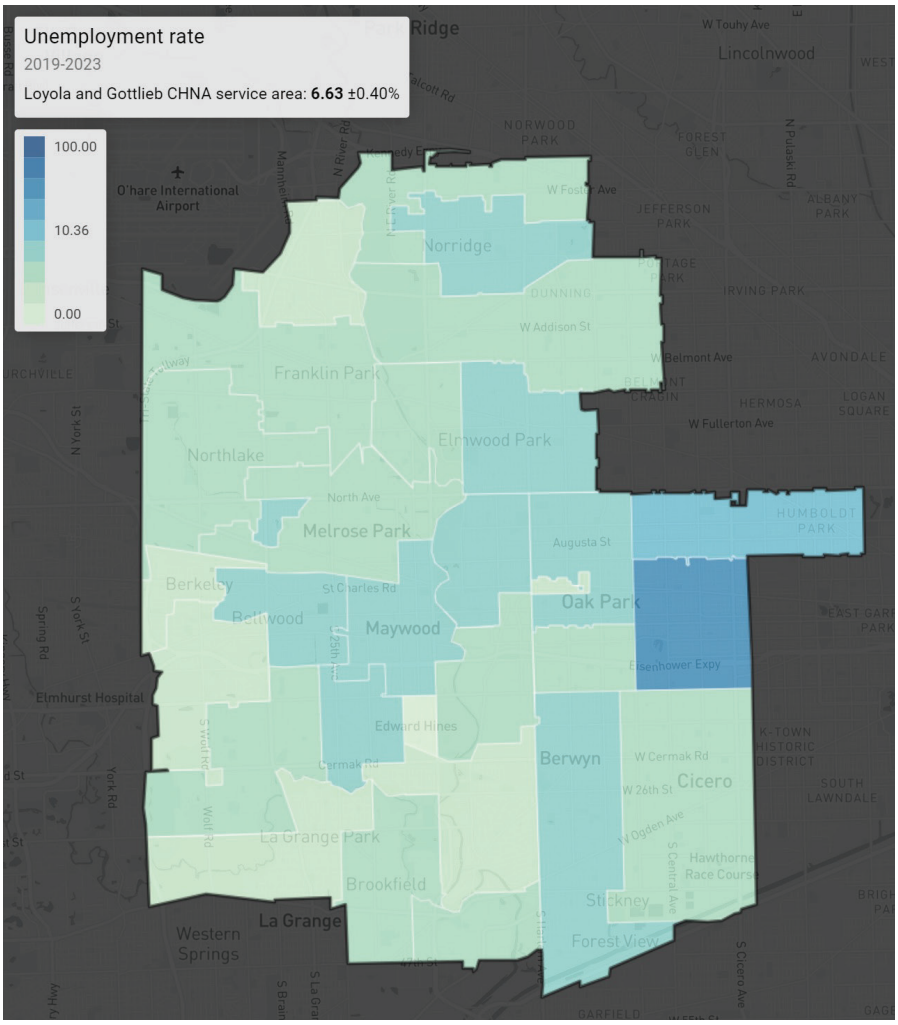


(US Census Bureau, 2024)

Limited job opportunities and high unemployment were mentioned by focus group participants, especially for marginalized populations. Participants highlighted challenges like low wages, insufficient full-time positions, and barriers for young adults entering the workforce.

Several participants criticized the reliance on employment for healthcare coverage as this system excludes unemployed or underemployed individuals. Young adults face challenges transitioning to independence due to a lack of financial literacy and job opportunities.

Figure 44. Map of unemployment rates in the Loyola and Gottlieb service area, 2019-2023



(US Census Bureau, 2024)

As previously stated, education and employment can have a significant influence on access to healthcare and health outcomes among youth and adults. Workforce development is a strategy that has the potential to improve both education and employment outcomes within marginalized communities experiencing poor health outcomes (Perez-Johnson & Holzer, 2021; Pittman et al., 2021). Community input clearly indicates that improved quality educational opportunities and quality job opportunities are important for decreasing poverty and improving health within Chicago communities.

Community input survey respondents in the service area ***ranked "workforce training and employment opportunities" as the fifth most significant health need.***

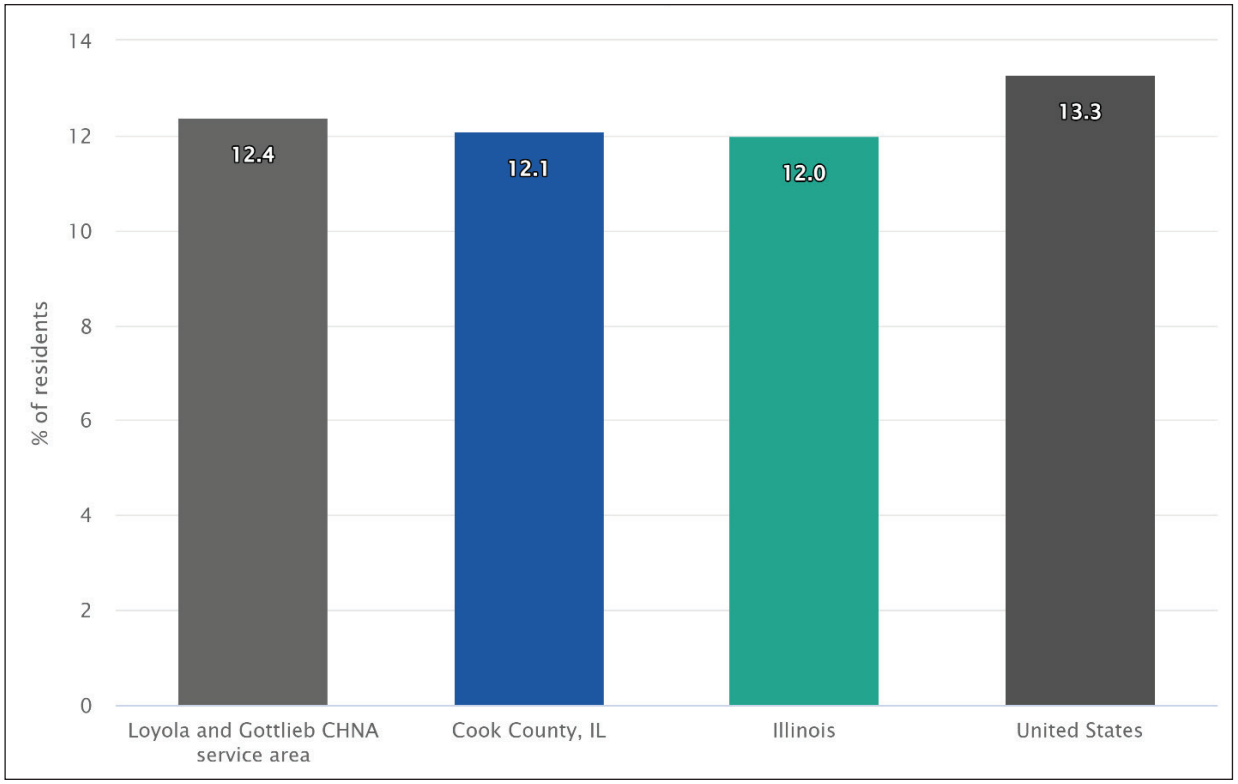
Food access and food security

Food access and food security are major contributors to health. In areas with lower access to fresh, healthy foods there are higher rates of negative health outcomes such as obesity and diabetes. Historically, food access has been lower in majority communities of color due to racist policies such as discriminatory banking practices, redlining, and disinvestment.

> *Our community doesn't feel deserving of high-quality food.*
>
> *– Loyola Community Benefit Council Focus Group Participant*

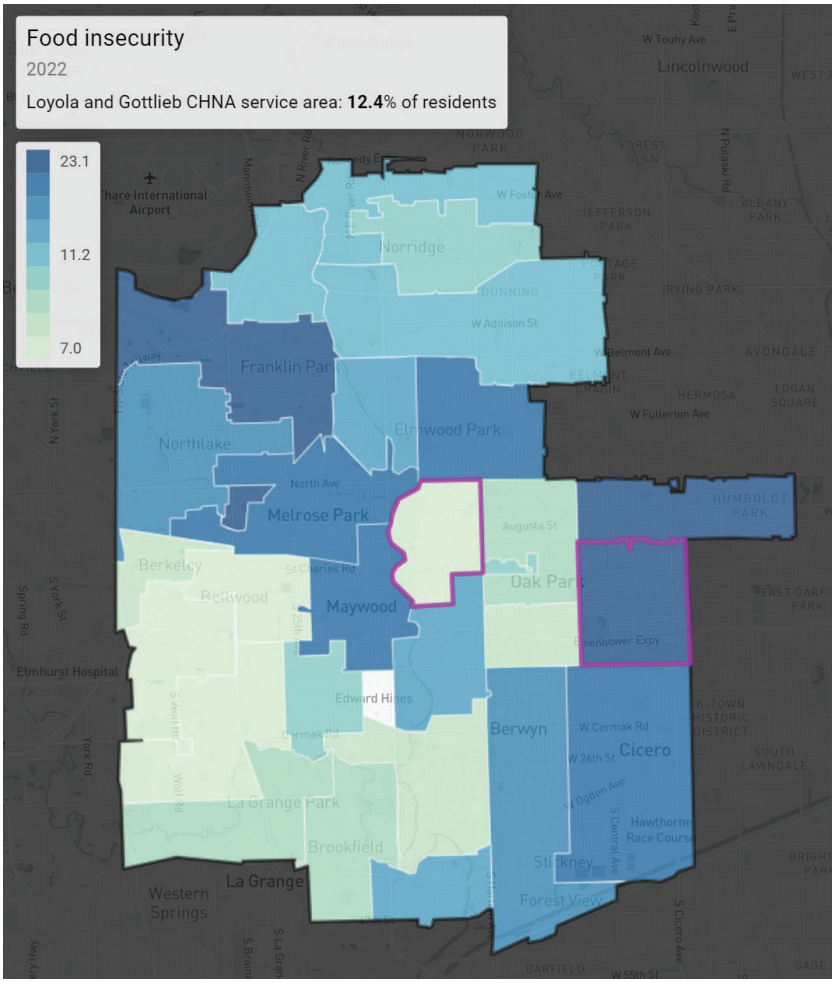
Food insecurity in the Loyola Medicine service area (12.4%) is lower than the rate for the nation (13.3%) and comparable to the county (12.1%) and state (12.0%) (Figure 45). However, as with other indicators, food access varies widely within the service area. River Forest has the lowest percentage of food insecure residents (7.0%) and Austin, Chicago, which has the highest percentage (23.1%) (Figure 46).

Figure 45. Chart comparing food insecurity in the Loyola Medicine service area, Cook County, Illinois, and the United States, 2022



(Feeding America, 2022)

Figure 46. Map of food insecurity in Loyola Medicine's service area, 2022



Source: (Feeding America, 2022)

Access to healthy food was a challenge for focus group participants, with high costs cited as a barrier for low-income families. Participants mentioned that it is cheaper to buy unhealthy fast food than fresh produce due to high food costs.

Reductions in programs like SNAP benefits and other financial assistance were described as exacerbating economic hardships.

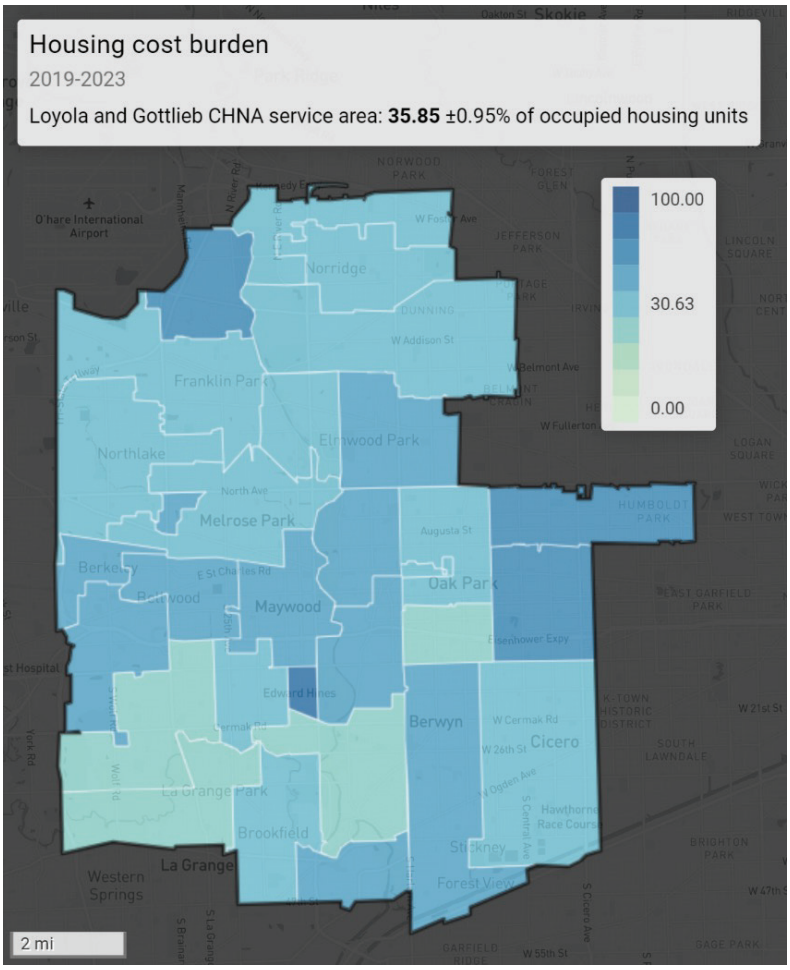
Housing

Housing can serve as an opportunity for many people in this country, offering a pathway to better health, education, and business. However, for some people, housing (or the lack thereof) provides a significant path to health inequities that have been sustained for decades due to systemic racism.

Focus group participants emphasized that the cost of living is higher post-pandemic, rent doubling and housing prices increasing dramatically, but salaries are still the same.

Thirty-six percent of households in Loyola Medicine's service area are considered housing cost burdened, meaning they spend more than 30% of their income on housing costs. Maywood (61%), Austin, Chicago (49%), Humboldt Park (46%), and Schiller Park (43%) have the highest percentages of cost burdened households (Figure 47). In addition, 17% of households in the service area are considered severe housing cost burdened, meaning they spend more than 50% of their household income on housing costs alone (US Census Bureau, 2024).

Figure 47. Map of housing cost burdened households in Loyola Medicine's service area, 2019-2023



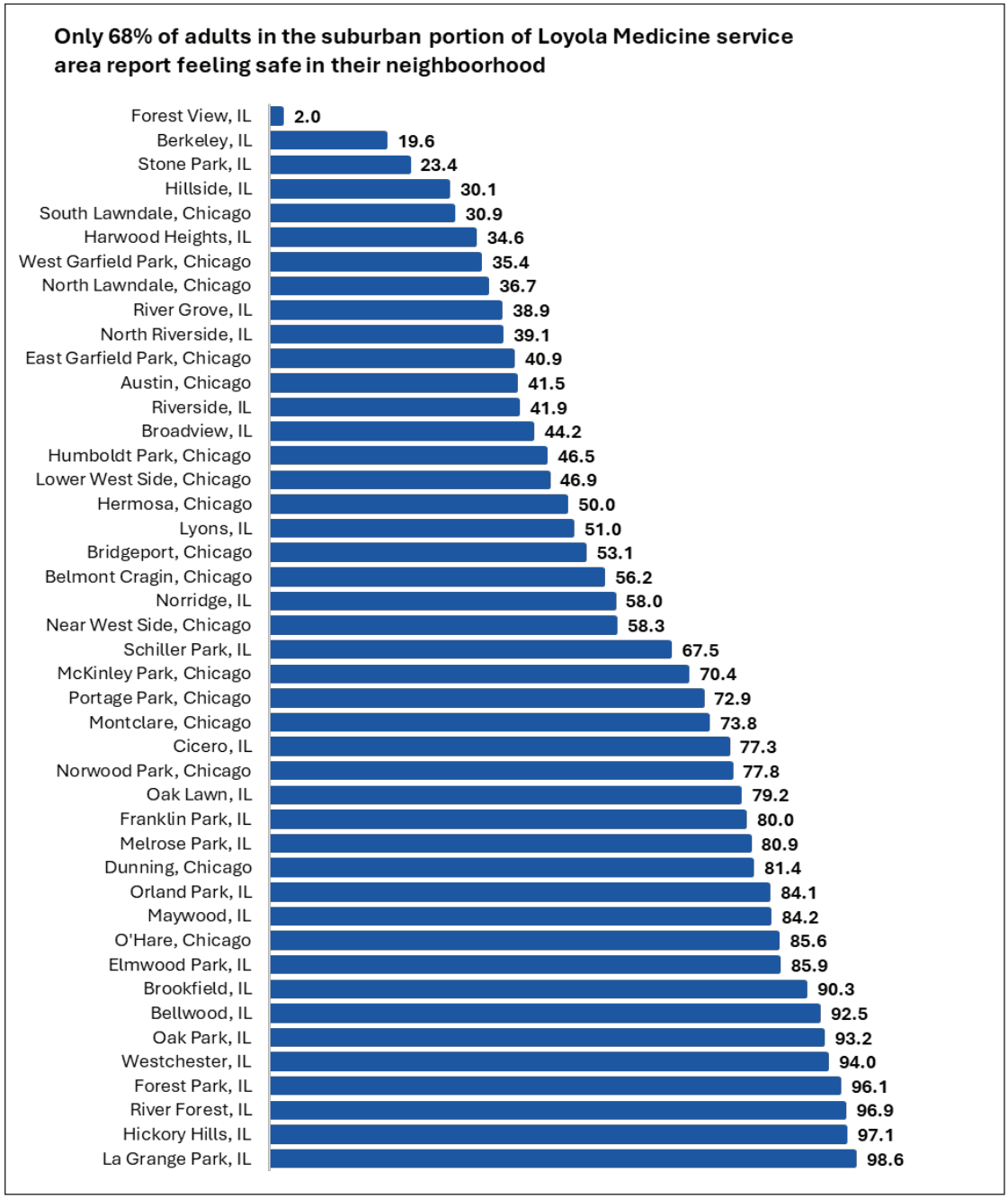
(US Census Bureau, 2024)

1 in 5 community input survey respondents selected housing resources as a top health need.

Community safety and violence

The root causes of community violence are multifaceted but include issues such as the concentration of poverty, education inequities, poor access to health services, mass incarceration, differential policing strategies, and generational trauma. Research has established that exposure to violence has significant impacts on physical and mental well-being. In addition, exposure to violence in childhood has been linked to trauma, toxic stress, and an increased risk of poor health outcomes across the lifespan. Violence also has a negative impact on the socioeconomic conditions within communities that contribute to the widening of disparities. In the suburbs in Loyola Medicine's service area only 68% of adults reports feeling safe in their neighborhood "all of the time" or "most of the time" and in some communities, it is as low as 20% (Figure 48).

Figure 48. Chart comparing the percentage of adults who report feeling safe in their neighborhood between suburbs in the Loyola Medicine service area, 2023



(Cook County Department of Public Health, 2023)

55% of community input survey responded reported they agree or strongly agree with the statement "my community is a safe place to live".

Firearm-related and homicide mortality are complex issues that disproportionately affect communities of color in the U.S. Factors such as the concentration of poverty, disinvestment, low rates of home ownership, and a lack of neighborhood-based resources have all been linked to higher rates of gun violence, homicide, and other violent crimes in communities of color. Cook County has higher homicide mortality and firearm-related mortality rates than both Illinois and the United States (Figure 49).

*The homicide mortality rate in Cook County is **more than double** the national rate.*

Figure 49. Table comparing homicide mortality rates and firearm-related mortality rates in Cook County, Illinois, and the United States, 2018-2022

	Homicide mortality rate (per 100,000 deaths)	Firearm-related mortality rate (per 100,000 deaths)
Cook County	18.2	19.6
Illinois	10.9	14.4
United States	7.7	14.2

Source: (Centers for Disease Control and Prevention, 2020a)

Focus group participants stated that constant exposure to unsafe environments led to stress, anxiety, and fear among community members. Participants expressed frustration about the normalization of unsafe conditions, particularly for children growing up in high-crime areas.

Safety concerns discouraged residents from engaging in outdoor activities or using public spaces, reducing opportunities for community connection and other positive health behaviors.

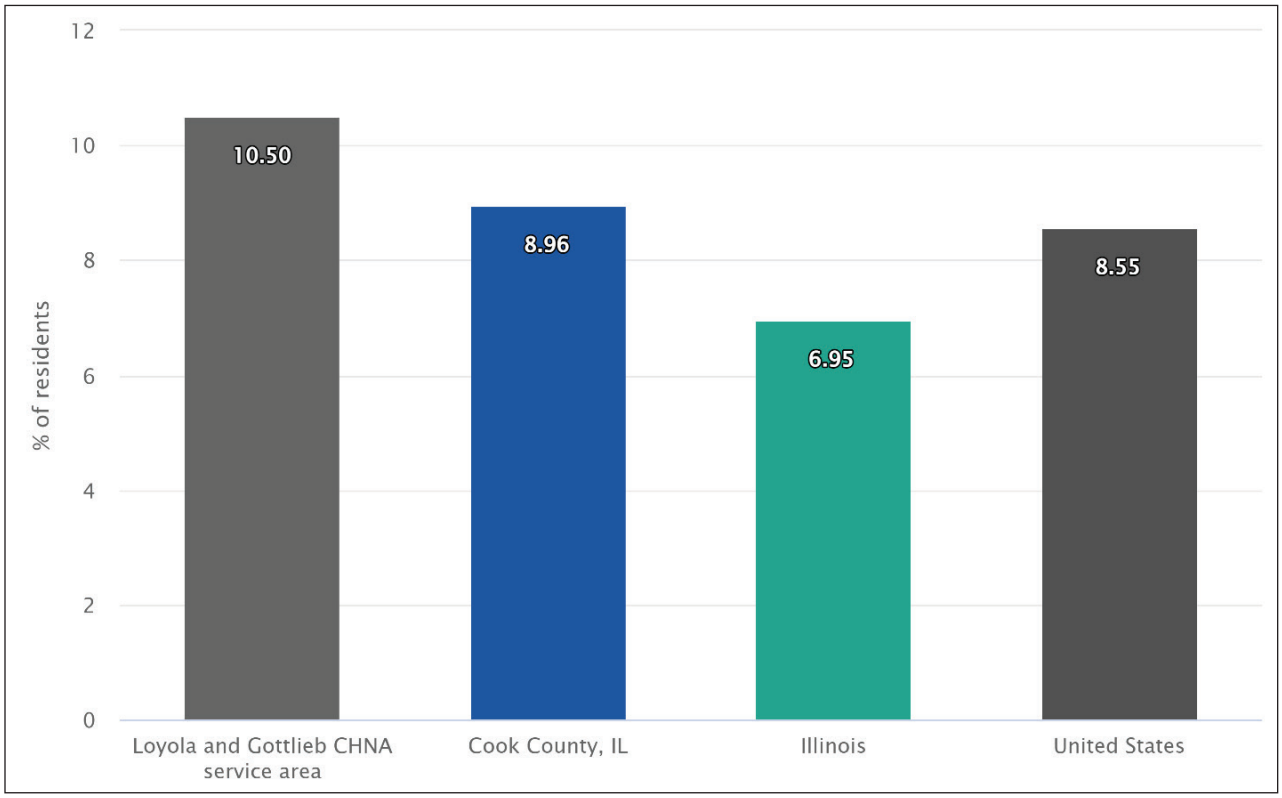
Access to healthcare

There are several complex factors that influence access to health care including proximity; affordability; availability, convenience, accommodation, and reliability; quality and acceptability; openness and approachability; and cultural responsiveness and appropriateness. Insurance coverage is associated with improved access to health services and better health monitoring.

> *My main struggle is getting timely appointments with specialists. We just got my son diagnosed with autism… I made his appointment in June of last year. He didn't get to go see the doctor until December.*
>
> *- A House in Austin Focus Group Participant*

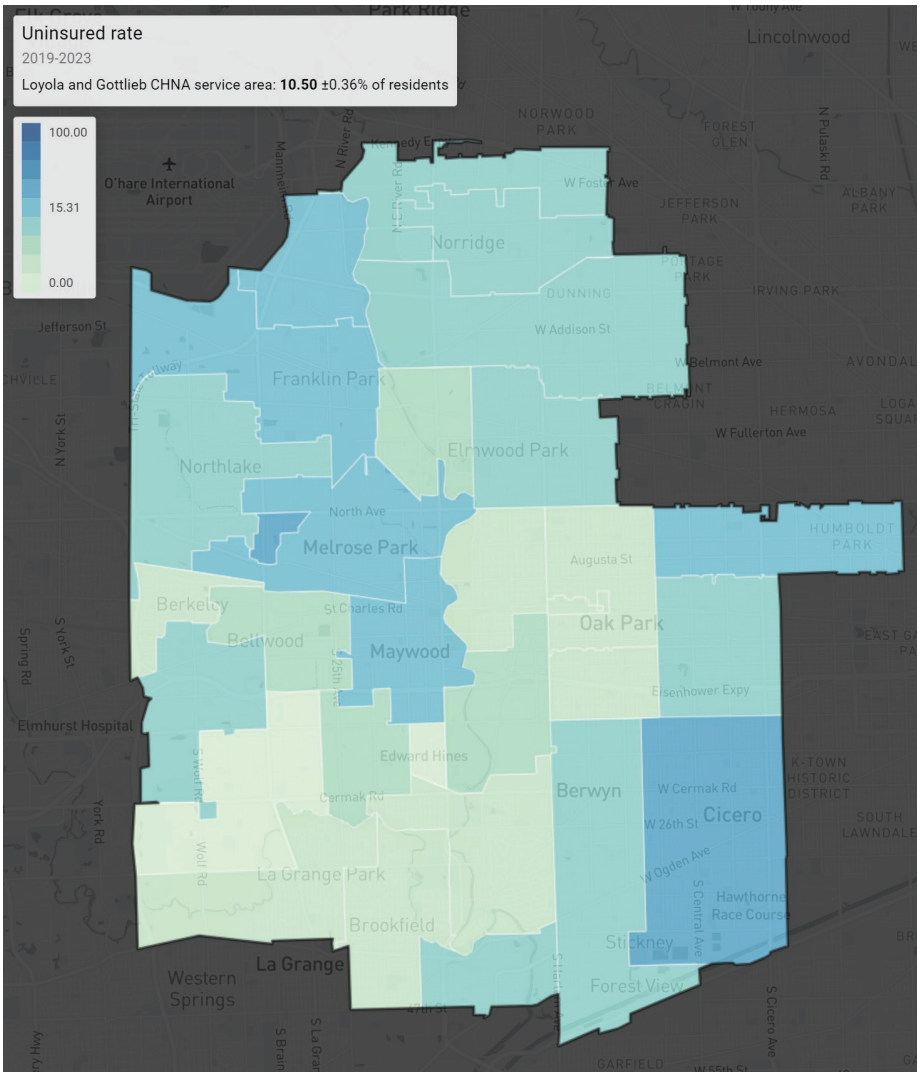
The rate of uninsured residents in the service area (11%) is higher than the uninsured rate for the county (9%), state (7%), and country (9%) (Figure 50). Within the service area, Stone Park has the highest uninsured rate at 23% followed by Cicero (19%) and Austin/Humbolt Park, Chicago (18%) (Figure 51).

Figure 50. Chart comparing the uninsured rate in Loyola Medicine's service area, Cook County, Illinois, and the United States, 2019-2023



(US Census Bureau, 2024)

Figure 51. Map of the uninsured rate in the Loyola Medicine service area, 2019-2023

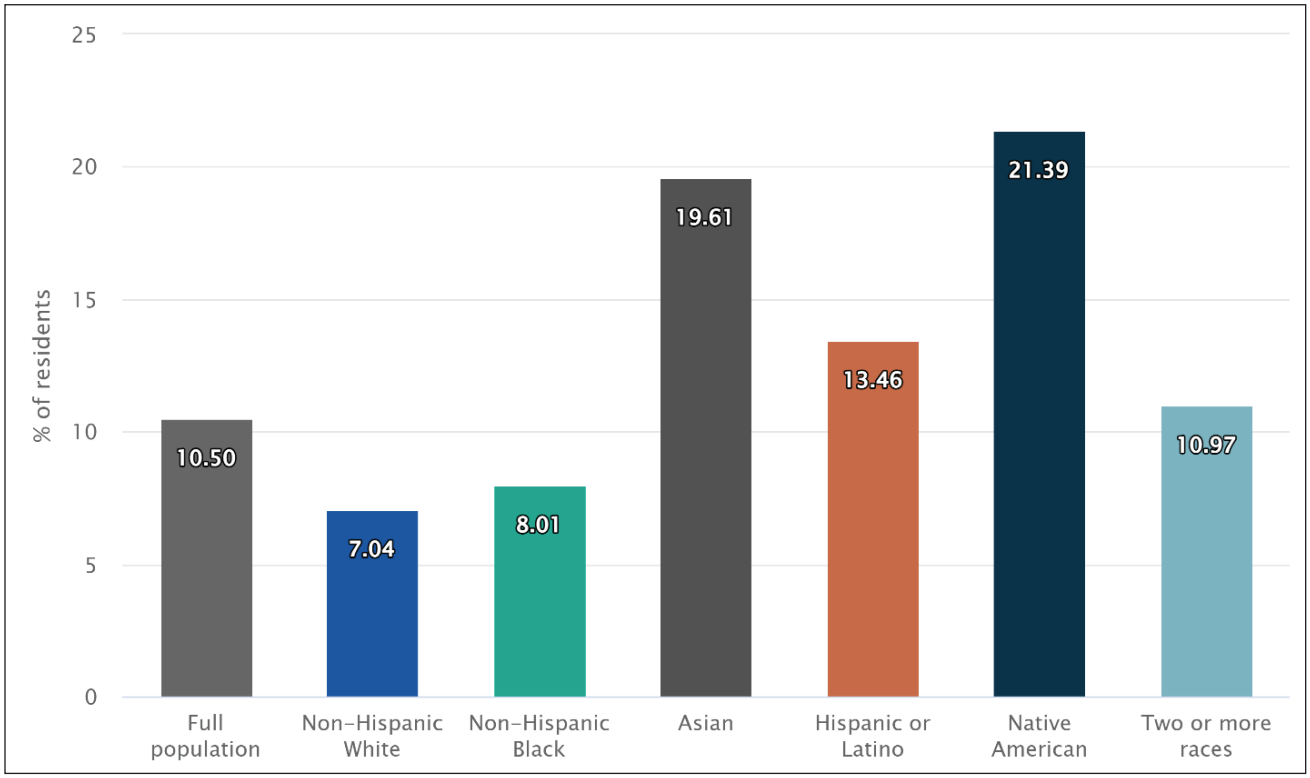


(US Census Bureau, 2024)

In addition to geographic inequities in insurance coverage, there are racial and ethnic inequities in uninsured rates as well. In Loyola Medicine's service area, Native Americans (21%) have the highest uninsured rate followed by Asians (20%) and Hispanic Latinos (13%) (Figure 47). Non-Hispanic Whites (7%) and Non-Hispanic Blacks (8%) have uninsured rates that are lower than average for the service area (Figure 52).

*Native Americans in the service area are uninsured at rates **three times** that of Non-Hispanic Whites.*

Figure 52. Uninsured rate by race and ethnicity in the Loyola Medicine service area, 2019-2023



(US Census Bureau, 2024)

As previously mentioned, access to healthcare is tied to affordability, particularly the affordability of health insurance (National Academies of Sciences, Engineering, and Medicine, 2018). Financial barriers to care, particularly among low-income people and the uninsured, have been greater in the United States than in other high-income countries (Davis & Ballreich, 2014; Squires & Anderson, 2015).

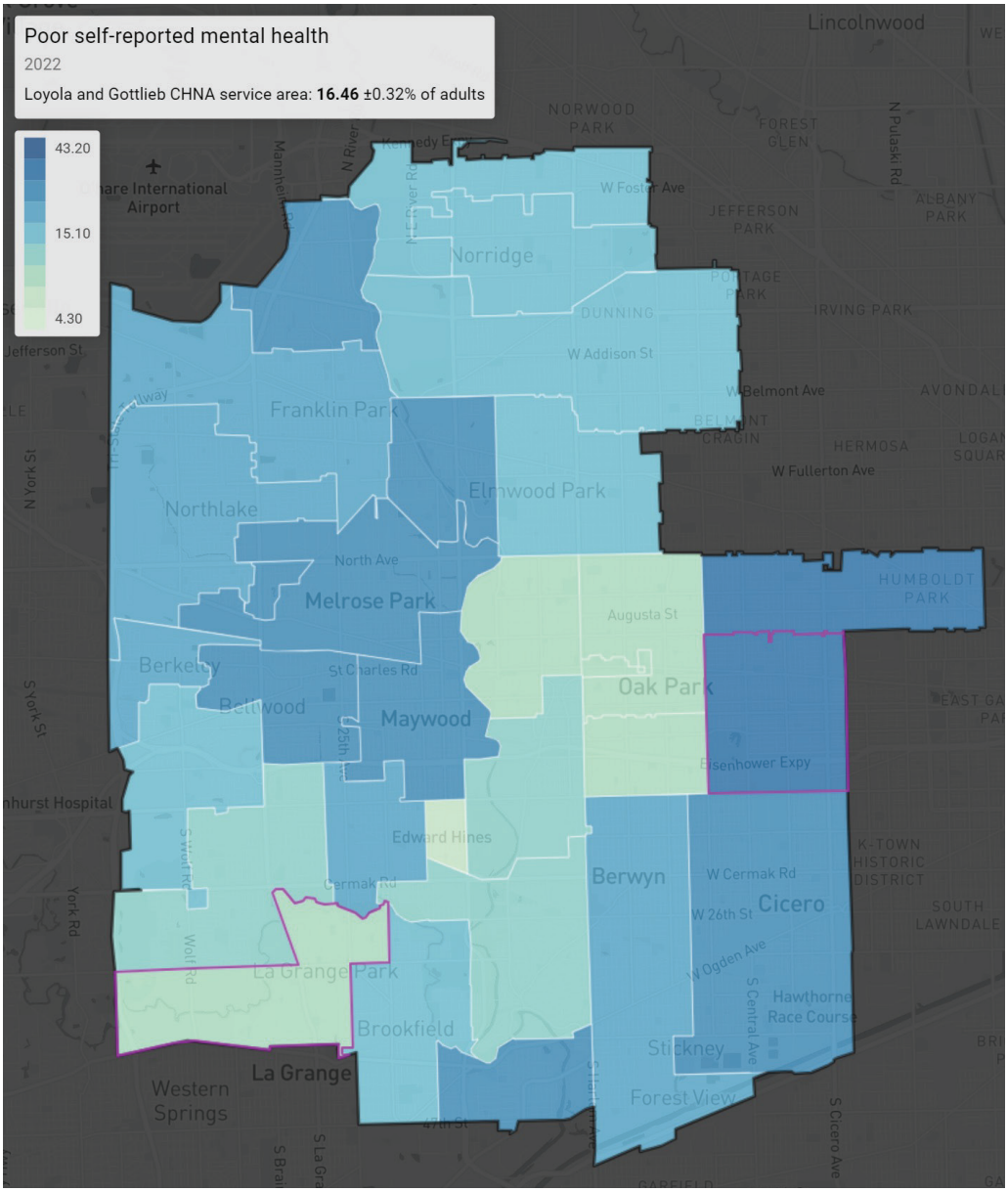
Mental health and substance use disorders

The World Health Organization states that mental health is an integral and essential component of overall health and wellbeing (World Health Organization, 2022). Mental health continues to be a top priority for communities in Cook County including those within Loyola Medicine's service area.

> *I feel like it's really essential to have something to do with mental health support. We need more free and easy access to programs.*
>
> *- UIC Champions Focus Group Participant*

The rate of poor self-reported mental health in the service area is 16% which is comparable to rates for the county (15%), state (16%), and nation (17%) (Centers for Disease Control and Prevention, 2024a). However, there is considerable geographic variation in these rates. The lowest rate is in La Grange Park (12%) and Austin, Chicago (21%) has the highest rate of poor self-reported mental health (Figure 53).

Figure 53. Map showing the percentage of adults reporting poor mental health in the Loyola Medicine service area, 2022



Source: (Centers for Disease Control and Prevention, 2024a)

Community input survey respondents in the service area ***ranked adult mental health as the most significant health issue in their community.***

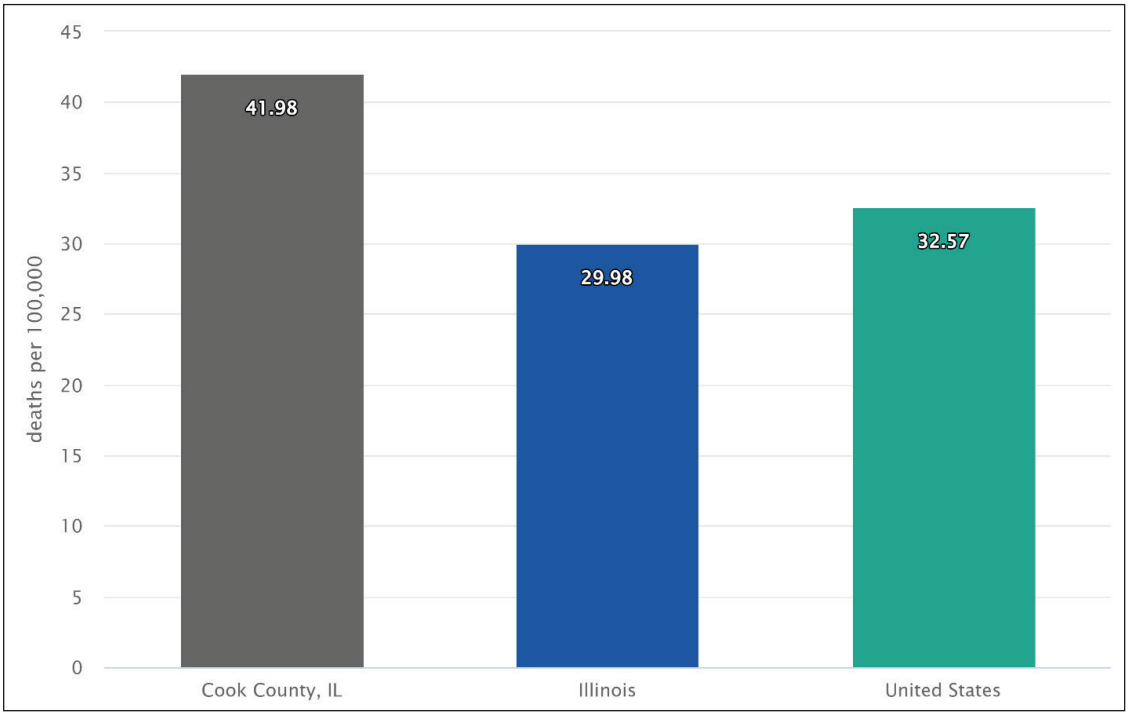
Drug and alcohol use

Before the start of the COVID-19 pandemic, opioid overdose and drug-related deaths were steadily increasing in the city and county. In March of 2020, the rates of opioid overdose mortality and drug-related deaths began to skyrocket (Ghose et al., 2022; National Center for Health Statistics, 2024). This trend is expected to continue with synthetic opioids such as fentanyl continuing to accelerate mortality rates (National Center for Health Statistics, 2024). Within these populations, children, teenagers, and young adults have experienced some of the most dramatic increases in drug overdose mortality.

> *For my school specifically, substance abuse is a big thing because once in a while, almost like every week, someone from school or someone gets arrested for gun violence or drug use.*
>
> *- UIC Champions Focus Group Participant*

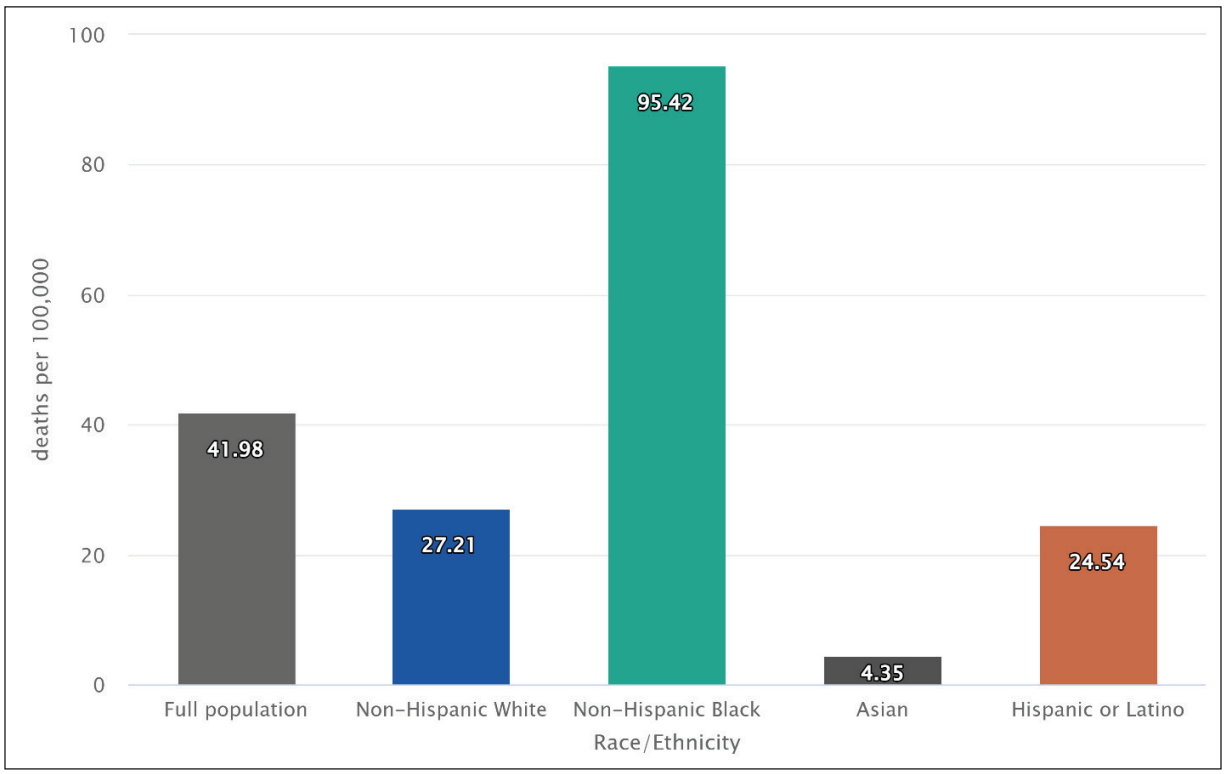
Cook County has a higher rate of drug overdose mortality (42%) than both Illinois (30%) and the United States (33%) (Figure 54). As previously stated, the COVID -19 pandemic disproportionately affected Black communities. In 2022, the drug overdose mortality rate for Non-Hispanic Black residents (95.4) was more than three times that of Non-Hispanic White residents (27.2) in Cook County (Figure 55).

Figure 54. Chart comparing the drug overdose mortality rate (per 100,000 population) of Cook County, Illinois, and the United States, 2022



(Centers for Disease Control and Prevention, 2020a)

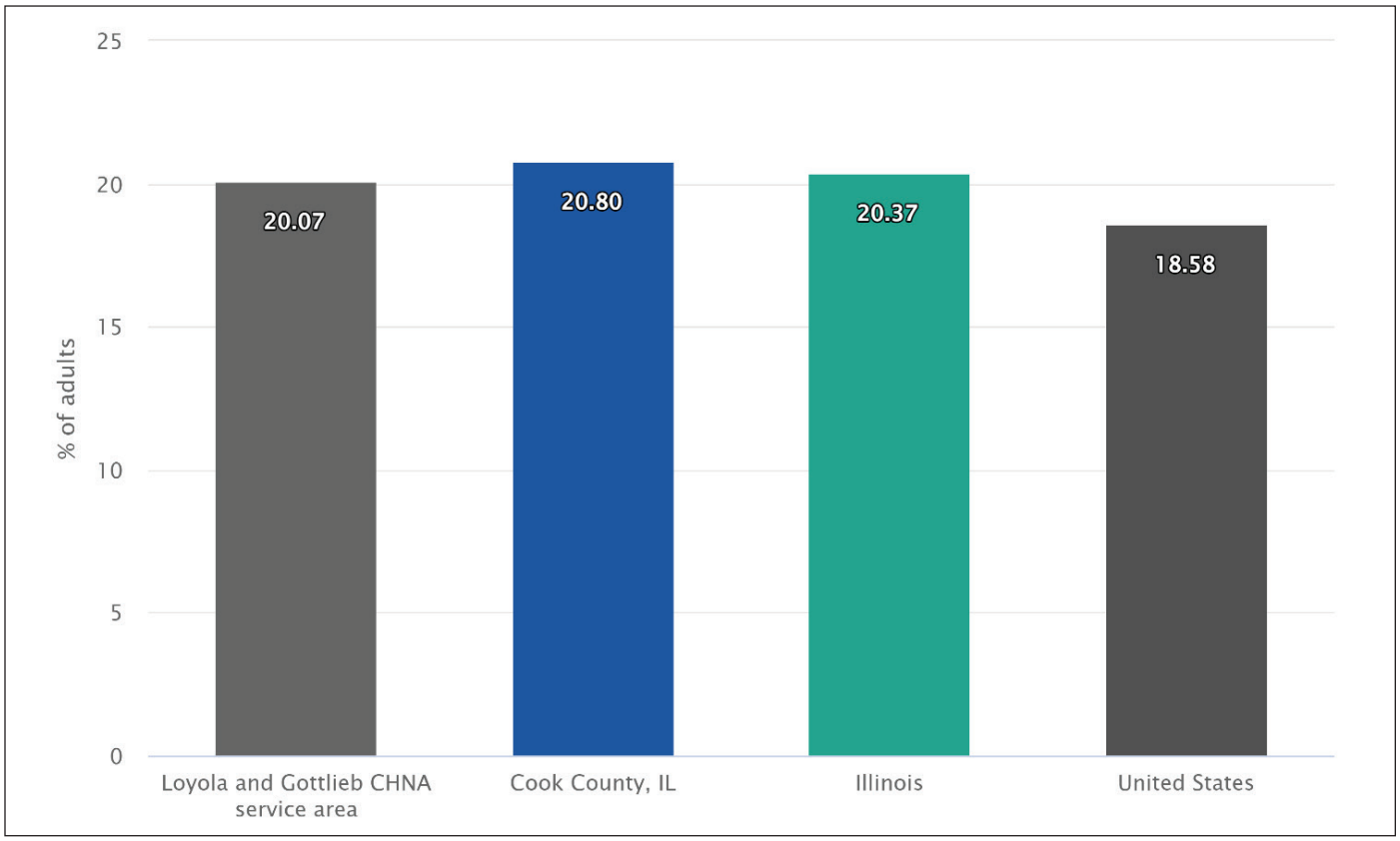
Figure 55. Drug overdose mortality rate (per 100,000 residents) in Cook County by race and ethnicity, 2022



(Centers for Disease Control and Prevention, 2020a)

In addition to increases in drug overdoses, emerging evidence indicates that alcohol-related issues such as binge drinking increased as a result of the pandemic (Grossman et al., 2020). Those experiencing COVID-19 related stress were more likely to increase alcohol consumption (National Center for Health Statistics, 2024). The binge drinking rate in the service area (20%) is comparable to the county (21%), state (20%), and country (19%) (Figure 56). Within Cook County, there is an inequity in the alcohol-related emergency department visit rate and alcohol-related hospitalization rates between different racial and ethnic groups. The emergency department visit rate for Black individuals is almost double that of white individuals (Figure 57). The hospitalization rate for white individuals is almost double that of Black and Hispanic individuals (Figure 57).

Figure 56. Chart comparing binge drinking rates in the Loyola Medicine service area, Cook County, Illinois, and the United States, 2022



(Centers for Disease Control and Prevention, 2024a)

Figure 57. Alcohol-related emergency department visit and hospitalization rates by race/ethnicity, Cook County and Illinois, 2022

	Alcohol-related emergency department visit rate (per 10,000 residents)	**Alcohol-related hospitalization rate** (per 10,000 residents)
White	45.2	22.3
African American/Black	84	13.7
Hispanic/Latino	59.1	13.4
Total	60	17.8

Source: (Illinois Department of Public Health, 2022)

Substance use was ranked as the third most significant health issue
in by community input survey respondents in the service area.

Updates on Implementation Activities from 2022 CHNA

Previously, the 2022 CHNA revealed several needs. The top significant health needs were:

1. Mental Health
2. Social and Structural Influencers of Health
3. Community Communication and Community Leader Engagement
4. Access to Healthcare
5. Chronic Disease

The previous CHNA provided contact information soliciting comments or concerns regarding both the CHNA and implementation strategies; Loyola Medicine did not receive any written comments.

Over the past three years, Loyola Medicine has implemented strategic action plans designed to fulfill these significant community needs.

To address mental health, Loyola Medicine engaged in the second round of Transforming Community Initiatives (TCI), which launched in January 2022, as an innovative health system/community partner collaborative supported by funding and technical assistance. This collaborative engages Trinity Health, its Regional Health Ministries, community-based organizations and residents to advance health and racial equity in nine of Trinity Health communities whose populations are 40% or more black or Latino residents who are experiencing high poverty and other vulnerabilities.

Quinn Center of St. Eulalia was selected to lead the work addressing youth mental health in Maywood, IL, and a Loyola University Chicago Clinical Assistant Professor and Nurse Practitioner was appointed as the Project Manager of TCI. Maywood's community assets, strengths, and opportunities were mapped, youth listening sessions were completed, with a total of 92 participants, and the Perceptions and Behavior Youth Survey was administered to local organizations to establish a baseline for work plan development. In FY24, a multi-sector collaborative consisting of two entities, a Youth Advisory Board and an Advisory Council, totaling over 20 members, was formed. Together, a root-cause analysis was conducted, and a work plan began to create a "Safe Space" for youth in the community. TCI core members, led by the multi-sector collaborative, are continuing to work cohesively in FY25 to make this vision a reality.

Additionally, Loyola Medicine collaborated with the National Alliance On Mental Illness (NAMI) Metro Suburban to offer Mental Health First Aid trainings for over 25 individuals from Loyola Medicine's Community Health & Well-Being staff and community agencies. These trainings empowered attendees to take a trauma-informed approach to the social services they offer and built their capacity to best serve our communities. Loyola Medicine also worked to ensure cultural inclusiveness through two trainings during FY23. 100% of Loyola's workforce, holding positions in management or above, completed an extensive anti-racism course and over 90% of the general workforce completed cultural competency training.

Loyola Medicine staff also actively participate in the Loyola Stands Against Gun Violence Committee, a gun violence initiative that includes an interdisciplinary group of educators and health care professionals who collaborate to address and advocate against gun violence within the community. As a supportive action, LUMC's Trauma and Injury prevention educators participated in 60 community events reaching nearly 900 individuals. Events focused on car seat safety, the dangers of drunk driving, prevention of gun violence, and responding to trauma related injuries by educating the community how to Stop the Bleed.

Loyola Medicine collaborated with the National Alliance On Mental Illness (NAMI) Metro Suburban to offer Mental Health First Aid trainings for over 25 individuals from Loyola Medicine's Community Health & Well-Being staff and community agencies.

Furthermore, Gottlieb Memorial Hospital (GMH) supported the work of Sarah's Inn, a social service organization for families affected by domestic violence, through the in-kind donation of space for weekly support groups. Lastly, Loyola Medicine continued its commitment to patients who are uninsured or underinsured at the Access to Care Clinic at Loyola's Maywood Primary Care Clinic. In addition to primary care, the clinic expanded to provide free and low-cost mental health counseling sessions to patients.

To improve the social and structural influencers of health, Loyola Medicine addressed the Social Determinants of Health by utilizing Community Health Workers (CHW's) to screen patients for social needs (food, housing, health care, and employment). Patients who screened positive were provided resources or connected to community-based organizations or government agencies for further assistance. This referral process was strengthened through the embedding of Trinity Health's social needs into the electronic medical record, allowing the care team to share resources in an electronic format with patients. In FY24, our CHW team significantly increased the rates of screenings completed, from 20% in FY23 to 70% in FY24. This feat was accomplished through a grant award, increasing our team of 3 to 18, including the hiring of culturally and linguistically appropriate staff. To adequately address the needs of our communities, several of the new hires spoke Spanish and one spoke Polish. CHW's are strategically placed in clinics, where the percentage of patients on Medicaid or uninsured is high, in the emergency department, and in the centralized office, to manage referrals from across the health system. 11 of the 18 CHWs at Loyola Medicine have been certified through Sinai Urban Health Institute (SUHI). Seven need to be certified; however, certification has been paused due to the changing standards for certification in Illinois, which have been in review for over a year. Loyola Medicine's expanded CHW team now responds to over 2,600 referrals per year.

Loyola Medicine addressed the prevention of diabetes through The National Diabetes Prevention Program (DPP). The DPP, branded Fresh Start at Loyola Medicine, is an evidence-based wellness program that helps people at risk for type 2 diabetes to lower their risk through behavior modification. Targeted audiences for the program included vulnerable populations, those who identified as African American or Hispanic, men, and colleagues. Seven cohorts have been launched since FY23 and have been delivered in-person or virtually based on participant preference. Cohorts were offered in both English and Spanish, and a new self-paced virtual option for participants was also offered. Additionally, a referral pathway was created to two area YMCAs, thanks to state funding, to facilitate increased program participation among qualified individuals whose schedule restricted them from attending one of our cohorts. To further support the success of the program, Loyola Medicine hired a DPP Lifestyle Coach who was cross-trained as a Community Health Worker, allowing all participants to be screened for Social Influencers of Health (SIOH) and any identified needs to be addressed.

Loyola Medicine also increased awareness and utilization of Trinity Health's Community Resource Directory (CRD). CRD is a database for the broader community linking those in need to local free resources and program. This was done by holding an overview session of the tool for 50 community partners. Those agency's work have the potential to be posted on the site. Loyola Medicine shared access to the database with community ambassadors and distributed flyers and window clings with the QR code and webpage in multiple languages to community-based organizations that serve populations most likely to need the listed resources. Additionally, direct distribution of the CRD was made to the community at 100 events reaching nearly 1,600 individuals per year.

The DPP, branded Fresh Start at Loyola Medicine, is an evidence-based wellness program that helps people at risk for type 2 diabetes to lower their risk through behavior modification.

Loyola Medicine participated in collaborative work with the Illinois Public Health Institute by serving on both the Food is Medicine Subcommittee and the Food Access and Nutrition Security Workgroup. To address the needs of the local community, bi-lingual recipe cards, featuring nutrients such as kale and tomatoes, were also distributed to area food pantries and at community events attended by Loyola Medicine. The LUMC Food Surplus Project was established in response to the pandemic to provide nutritional healthy food and eliminate food insecurity and waste by distributing surplus food from the hospital cafeteria to create access and address food insecurity. The hospital's cafeteria food surplus was delivered to the Edward Hines, Jr. VA hospital. In the past 3 years, LUMC has donated and delivered over 14,000 meals.

In the last three years, Loyola Medicine has sought to increase the number of diverse local hires and improve access to living wage jobs by hosting 134 job fairs. Available positions were for a variety of departments including transportation, food and nutrition, pharmacy technicians, nurses, patient care teams, and community health workers. In FY24, collaborative partners in the community began discussions with Loyola Medicine regarding how this work could be expanded into communities of greatest need for economic advancement. As a result, Loyola Medicine hosted it's first community-based job fair, inviting other employers who offer living wages within the county to partner along side them in recruiting for entry level positions. 119 job seekers attended the event hosted at the American Job Center located in Maywood, IL. Within the week, Loyola Medicine had extended 14 offers for open entry level positions.

Loyola Medicine acknowledges the wide range of priority health issues that emerged from the CHNA process and determined it could effectively focus on only those health needs which are the most pressing, under-addressed and within its ability to influence. Loyola Medicine did not address the following health needs:

Community Communication and Leader Engagement - Loyola Medicine did not directly address this need because our community stakeholder feedback did not indicate it was the most urgent need. Loyola Medicine leadership and staff currently participate in community coalitions, serve on local and regional board, including appointment within the Illinois Hospital Association (IHA), and community events within their service area and will continue to participate in these efforts.

Access to Health Care - Loyola Medicine continued to provide services that include the Child Advocacy Program, which evaluates and counsels children referred due to suspected abuse or neglect; the Oral Health Center, which provides dental services visits; EMS classes for ambulances and local municipal fire departments, including NARCAN (Naloxone HCI) training; the federal Ryan White Program for people living with HIV/AIDS who need medical care but cannot afford it; and palliative and spiritual care. Via Access to Care, a nonprofit organization, Loyola Medicine provided subsidized clinical services, including dental, palliative, and primary care, community health, screening programs and support groups staffed by clinicians. Since 2012, Loyola Medicine has provided free or significantly discounted care to low-income and undocumented patients at the Access to Care Clinic at Loyola's Maywood Primary Care Clinic, the largest primary care site within Access to Care's network, and through its Enrollment Assistance program.

Chronic Disease - Loyola Medicine did not directly address this need due to competing priorities; however, nearly 250 individuals have received chronic disease screening over the past 3 years by participating in two free events hosted by Loyola Medicine. One such event provided free heart and vascular screenings and health promotion education to women in our service area, including smoking cessation information and counseling by a physical therapist and/or dietician. All women who attended were provided blood pressure, electrocardiogram (ECG), and cholesterol screenings, and those with specific risk factors were also provided peripheral artery disease (PAD) and abdominal aortic aneurysm (AAA) screenings at no-cost to them. Participants with abnormal results were counseled one-on-one by a vascular surgeon and/or cardiologist, and residents were available for any general questions from any participant. Additionally, Loyola Medicine annually hosts their See, Test, Treat event, which provides free cervical and breast cancer screenings for women ages 30-64 who are uninsured.

Loyola Medicine's past efforts to address the needs of the community were met with success and there is no doubt future endeavors will do the same. While not able to fulfill every need identified through the CHNA, Loyola Medicine will make every effort to align the defined and redefined priorities with its mission.

Conclusion

Prioritization of Top Health Needs

The priority areas for the FY2026-2028 implementation strategy from the 2025 CHNA were developed through conversations regarding the results from the primary data collection, in conjunction with other activities and resources existing in the community. The conversations began in December 2024 and continued through April 2025. Combining primary data collection from quantitative information from the survey and qualitative information from focus groups, the Community Health Needs Advisory Committee was able to heed and reaffirm the community members' top health needs. Additionally, the members were able to speak on behalf of their representation in other committees and organizations, in conjunction with available secondary health statistics, to develop an approach to improving services most critical to our community members.

Initial meetings to discuss the primary data collection results allowed for open discussion on a number of priority areas. Many of the initial priority areas contained several of the same underlying health concerns.

Review of data sources and community input were used to determine potential priority areas. Potential priority areas were evaluated based on the recommended priority areas brought forth by the survey and focus groups. The Community Health Needs Advisory Committee recommended the following six focus areas:

Mental Health and Substance-Use - Participants in the focus groups raised numerous concerns related to mental health, highlighting a range of conditions, challenges, and systemic barriers. Specific mental health conditions mentioned included depression, anxiety, chronic stress, PTSD, Bipolar disorder, and ADHD. Challenges that were highlighted included limited access to services, stigma, lack of appropriate crisis intervention, social isolation, and multiple gaps in community level care. Youth, older adults, and the LGBTQIA+ community were described as priority populations. 28% of survey respondents reported adult mental health as an issue and 18% of respondents reported child and adolescent mental health as a top health issue. Additionally, access to mental health care was cited by 22% of respondents as a top health need for the Loyola-Gottlieb service area.

Participants in the focus groups shared significant concerns regarding substance use disorders and their impacts on individuals and communities. In addition, participants discussed barriers to treatment such as stigma and lack of resources. Populations highlighted as experiencing specific challenges included youth, immigrants, and people experiencing homelessness. 21% of survey participants indicated this was one of the biggest health issues within their community.

Reducing day-to-day stressors (including language and cultural barriers, social isolation, mental health, and economic challenges), encouraging positive health behaviors, increasing social support systems, and increasing activities for teens and youth (the top health need recorded among survey respondents) were also measured as potential solutions to improving mental health and reducing substance-use and misuse.

Access to Community Resources - Participants emphasized the availability of various community-based services that contribute to health and well-being. These services and programs included but were not limited to community centers, student programs, food pantries, senior transportation services, and faith-based initiatives. Housing resources (identified by 21% of survey respondents) and workforce training and employment opportunities (identified by 19% of survey respondents) were other assets mentioned as necessary to improve the health and well-being of the Loyola-Gottlieb service area. Participants also mentioned the presence of stores and markets offering healthy food options in addition to food pantries and community-supported food programs being crucial for community health; 22% of survey respondents also identified this need.

Chronic Conditions - Chronic conditions like diabetes, heart disease, asthma, arthritis, chronic pain, obesity, HIV and mental health conditions were mentioned by focus group participants. Participants linked these conditions to systemic issues such as delayed or inadequate care, financial burdens, and lifestyle and environmental factors. The top three chronic conditions identified by survey respondents were diabetes, obesity, and age-related physical illness (arthritis, hearing loss, and vision loss).

Access to Healthcare - Participants in the focus groups highlighted several interconnected challenges related to healthcare access including affordability of care, availability of services, communication challenges, healthcare navigation, quality of care, lack of coordinated care, and geographic barriers. These issues reflect systemic barriers and individual struggles in navigating the healthcare system. They also raised particular concern for women's health disparities, access to mental health care services, and child and adolescent health.

Child and Adolescent Health - Participants raised specific concern for child and adolescent health needs. Challenges raised included the accessibility and affordability of childcare, school quality, rising mental health needs, lack of community spaces, technology (as a challenge and as a solution), safety concerns, food insecurity, and support for families with special needs. The top reported health need among survey respondents, activities for teens and youth, is directly influenced by the reported lack of community spaces and safety concerns sited. Health promoters for this focus area also included the encouragement of positive health behaviors and social support systems, and the reduction of youth mental illness and substance-use.

Community Safety - Participants raised numerous concerns about community safety, describing its multifaceted impact on health, well-being, and quality of life. Key areas of discussion included gun violence, gang activity, substance use and safety impacts, homelessness and public perceptions, public spaces, public transportation safety, police presence, youth safety, and the mental and economic impacts associated in areas that are less safe.

Specific infrastructure and environmental concerns mentioned included: poorly lit streets, abandoned buildings, and lack of community centers as factors that increased crime and reduced safety; unsafe pedestrian and bike areas posing physical dangers to residents; and health impacts, such as poor air quality and environmental hazards linked to increased risk of respiratory and chronic diseases, lack of access to parks and green spaces limiting opportunities for physical activity and contributing to obesity, and limited recreational spaces leading to social isolation.

The committee recognizes that the social influencers of health play a significant role in the health needs identified as priorities. Consideration of their impact will be addressed during the implementation strategy planning process through root cause analysis.

Lessons Learned

Loyola Medicine and the Alliance for Health Equity took an equity centered, collaborative approach to the 2025 CHNA. Through a combination of community input data and secondary quantitative data, the CHNA has centered the voices of the community, particularly those in the priority communities. By oversampling target populations who have been historically silenced, the CHNA hopes to provide insight into the needs and concerns of these communities to maximize the effectiveness of community-based programs.

Loyola Medicine and the Alliance for Health Equity will continue to evaluate our CHNA process, looking to improve accessibility and reach of community input gathering methods as well as refining the secondary data collection process to best amplify the community voice. The framework of the CHNA will remain largely the same to allow for evaluation of the impact of community programming and continue to center health equity.

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Appendix A: Summary of Loyola-Gottlieb Focus Group Input

Sixteen focus groups were conducted within Loyola Gottlieb hospitals' service area or included participants living within the service area. The groups were hosted in partnership with community-based organizations.

Focus group host organizations included:

- A House in Austin
- Bethel New Life Inc.
- Beyond Hunger
- Housing Forward
- Life is Work Resource Center
- Living Word Christian Center
- LUHS Community Advisory Committee
- National Alliance on Mental Illness (NAMI) – Metro Suburban
- Neighborhood United Methodist Church
- Oak Park Area Lesbian and Gay Association+ (OPALGA+)
- The Douglas Center
- University of Illinois Chicago, Champions Program
- West Cook YMCA
- West Side Health Authority
- Youth Crossroads

Focus group themes were broken into five overarching categories.

Community descriptions - Statements that participants used to describe their communities.

Health issues and challenges - Community health issues and challenges related to the AHE priorities.

Health promoters - Factors that help individuals and communities be healthy.

Solutions - Solutions to health issues and challenges discussed by participants.

Vision for the future - Improvements that participants would like to see in their communities over the next 3-5 years.

Key findings within each of the themes are summarized in the sections that follow.

Community Descriptions

Definition: Statements that participants used to describe their communities

Purpose: To categorize participant responses to questions asking them to describe their communities. To generate a list of community assets.

Table 1. Community descriptions – Summary findings

Theme	Summary
Welcoming and inclusive atmosphere	▪ Diversity was frequently mentioned, with residents appreciating the acceptance of different cultures, backgrounds, and lifestyles. ▪ The tight-knit nature of neighborhoods was emphasized. People often know their neighbors, and a sense of camaraderie was evident in day-to-day interactions. ▪ Community events and gatherings play a significant role in fostering this bond and encouraging resident engagement.
Safety and security	Feeling safe in their neighborhoods was a recurring theme, with several participants noting the ability to walk around safely at night. Well-lit streets, frequent garbage collection, and visible law enforcement contribute to a feeling of safety and cleanliness in public spaces for some.
Accessible resources and services	Many participants appreciated the availability of services and resources, particularly those supporting families. Access to town halls, public services, and community-focused activities was noted as a benefit. Libraries were appreciated for providing free access to books, technology, and internet services. They also serve as venues for community workshops and educational programs. Churches, mosques, synagogues, and other places of worship also provide social support and host community outreach programs.
Accessible health services	Access to nearby clinics, hospitals, and mental health services is crucial for residents. Many appreciated the availability of urgent care centers and specialized health services within their communities.
Walkability	Walkable neighborhoods with accessible amenities like parks, libraries, and local businesses were highlighted.
Civic engagement	Active participation in local events, town halls, and community initiatives stood out as a key strength. Many participants expressed pride in their communities' ability to come together, emphasizing that this culture of civic engagement is a defining strength of their neighborhoods. Beyond formal events, participants also highlighted informal acts of civic engagement, such as helping neighbors, sharing resources, and maintaining open lines of communication within their blocks.
Cultural and social events	Cultural diversity was paired with opportunities to engage in cultural and community events, enriching the social togetherness of the area. Artistic and cultural inclusivity helped define the character of some neighborhoods.
Outdoor spaces	Parks were a frequently mentioned community highlight. Residents often use these spaces for recreational activities, exercise, and socializing. Parks were highlighted as a hub for community events.

Health issues and challenges

Definition: Community health issues and challenges related to the AHE priorities.

Purpose: To categorize the types of health issues and challenges mentioned by participants.

Table 2. Health issues and challenges – Summary findings

Theme	Summary
Day-to-Day stressors	Language and cultural barriers, social isolation, mental health, and economic challenges were highlighted by participants as daily challenges.

Lack of healthcare access	Participants in the focus groups highlighted several interconnected challenges related to healthcare access. These issues reflect systemic barriers and individual struggles in navigating the healthcare system.
	▪ **Affordability of care:** The high cost of healthcare and limitations in insurance coverage were underlying factors preventing people from accessing timely and adequate care.
	▪ **Availability of services:**
	  ▪ **Long wait times:** Excessive wait times to see specialists were a recurring concern.
	  ▪ **Inadequate emergency services:** Stories of delayed emergency responses and insufficient ambulance services were shared.
	  ▪ **Preventative care shortages:** A lack of preventive care programs, such as routine screenings and health education, was also noted, which contributed to unmanaged chronic conditions.
	▪ **Communication challenges:** Non-English-speaking participants reported significant difficulties communicating with healthcare providers. Even when interpreters were present, participants felt that their concerns were not fully understood or accurately conveyed. Language barriers delayed diagnoses and appropriate treatments, adding to the stress and health risks faced by individuals and families.
	▪ **Healthcare navigation:** Many participants, especially younger populations, older populations, immigrants, and non-English speakers struggled to navigate the complexity of the healthcare system. This included identifying the right providers, understanding eligibility for services, and dealing with bureaucratic hurdles.
	  ▪ Priority populations, including the homeless and LGBTQIA+ individuals, faced additional challenges in accessing care. For instance, transgender individuals reported difficulties finding providers knowledgeable about or willing to address their specific healthcare needs.
	▪ **Quality of care:** Participants noted disparities in the quality of care received, with marginalized groups feeling overlooked or dismissed. Some expressed frustration at a lack of empathy from healthcare providers.
	▪ **Lack of coordinated care:** Poor coordination among providers and inadequate follow-up care led to delays in treatment and unresolved health concerns.
	▪ **Geographic barriers:** Participants from certain suburban areas highlighted disparities in healthcare infrastructure compared to urban centers. This included fewer healthcare facilities and longer distances to reach care.

Chronic conditions	Chronic conditions like diabetes, heart disease, asthma, arthritis, chronic pain, obesity, HIV and mental health conditions were mentioned by participants. Participants linked these conditions to systemic issues such as delayed or inadequate care, financial burdens, and lifestyle and environmental factors.
	▪ **Diabetes**:
	  ▪ Diabetes was frequently highlighted as a widespread issue, particularly in communities with limited access to healthy food and preventive care.
	  ▪ Participants discussed difficulties managing the condition due to financial constraints, limited access to medications, and inadequate education on disease management.
	▪ **Hypertension and heart disease:**
	  ▪ Hypertension was noted as a prevalent issue, often linked to stress, poor diet, and lack of preventive healthcare.
	  ▪ Cardiovascular conditions were tied to systemic issues, such as lack of exercise opportunities in some neighborhoods and limited access to affordable healthcare.
	▪ **Asthma:** Asthma was described as a significant health concern, particularly for children. It was brought up in relation to environmental factors, such as air quality and housing conditions.
	▪ **Arthritis**: Arthritis was mentioned in relation to long wait times for specialists. Delays in treatment were linked to compounded pain and reduced mobility.
	▪ **Chronic pain**: Associated with conditions like arthritis and other musculoskeletal disorders. Participants described a lack of adequate pain management options.
	▪ **Obesity**: Highlighted as both a health condition and a contributing factor to other chronic diseases, such as diabetes and cardiovascular issues. Barriers to healthy food access and safe spaces for exercise were seen as underlying causes.
	▪ **HIV**: HIV was identified as a significant health issue in some communities. Participants also referenced health inequities tied to systemic racism, with Black and Hispanic individuals facing stereotypes and barriers in accessing equitable care.

Mental health conditions	Participants in the focus groups raised numerous concerns related to mental health, highlighting a range of conditions, challenges, and systemic barriers. Specific mental health conditions mentioned included depression, anxiety, chronic stress, PTSD, Bipolar disorder, and ADHD. Challenges that were highlighted included limited access to services, stigma, lack of appropriate crisis intervention, social isolation, and multiple gaps in community-level care. Youth, older adults, and the LGBTQIA+ community were described as priority populations. ▪ **Access to mental health services:** Participants described significant barriers to accessing mental health care, including difficulty finding in-network providers, long wait times for appointments, lack of nearby facilities (particularly in under resourced communities), and inadequate Medicaid coverage for day programs or residential care. ▪ **Stigma:** Stigma around mental health, particularly in Black and immigrant communities, was seen as a major barrier to seeking help. Participants noted many people avoid acknowledging their mental health issues due to fear of judgment. ▪ **Crisis intervention:** The lack of appropriate crisis intervention services was a recurring theme. Participants highlighted the absence of trauma-informed care in emergency settings. The Cook County Jail was identified as a major mental health facility, reflecting systemic gaps in community-based care. ▪ **Social isolation:** Both youth and older adults reported feelings of loneliness and isolation, compounded by the pandemic and a lack of community spaces for connection. ▪ **Community-level care:** Participants described a lack of preventive mental health interventions, with most care being accessed only during crises. Limited local facilities and the need to travel long distances for services were significant obstacles, especially for residents without reliable transportation. ▪ **Youth mental health:** Young people were described as particularly vulnerable to mental health challenges, including those exacerbated by social media and technology use. LGBTQ+ youth faced unique challenges, such as finding inclusive support spaces and navigating mental health concerns related to identity and transition. ▪ **Depression:** Participants reported personal struggles with depression. Postpartum depression was mentioned as a significant, underdiagnosed issue, with participants noting a lack of education and awareness about its symptoms and impact. ▪ **Anxiety:** Social anxiety was frequently mentioned, particularly among youth and young adults, with many attributing increased anxiety levels to the pandemic and the challenges of social reintegration. General anxiety was linked to systemic stressors like financial instability and navigating healthcare systems. ▪ **Post-Traumatic Stress Disorder (PTSD):** Some participants shared personal experiences of PTSD, often rooted in past trauma, dysfunctional family dynamics, or adverse life events. They emphasized the need for trauma-informed care. ▪ **Bipolar Disorder and ADHD**: Individuals mentioned other specific diagnoses like bipolar disorder and neurological conditions such as ADHD. Support groups, such as NAMI, were noted as helpful resources for coping.

Substance use disorders	Participants in the focus groups shared significant concerns regarding substance use disorders and their impacts on individuals and communities. In addition, participants discussed barriers to treatment such as stigma and lack of resources. Populations highlighted as experiencing specific challenges included youth, immigrants, and people experiencing homelessness. ▪ **Community impacts:** Substance abuse was repeatedly tied to increasing violence, including gun violence. Participants expressed concerns about the safety of neighborhoods, especially for children. Participants noted issues with substance use in public spaces, such as people smoking or using drugs on public transportation, further contributing to a sense of insecurity. ▪ **Health impacts:** Participants described the physical and mental toll of substance abuse on individuals, including health crises and struggles with addiction recovery. Substance abuse was also associated with co-occurring mental health issues, such as depression and suicidal ideation. ▪ **Barriers to treatment:** ▪ **Stigma:** Participants mentioned the stigma associated with addiction, which prevents many individuals from seeking help or acknowledging their struggles. ▪ **Access to resources:** A lack of accessible recovery programs and mental health facilities was identified as a significant barrier. Programs like "Roads to Recovery" were mentioned but seen as insufficient for the level of need in communities. ▪ **Youth and adolescents**: Substance abuse among youth was frequently highlighted, with mentions of drug use and arrests related to gun violence and substance abuse at schools. Participants noted an increase in youth being diverted to alternative schools due to substance-related issues. ▪ **People experiencing homelessness:** Substance abuse was closely linked to homelessness in many communities. Participants described how individuals with substance use disorders often end up on the streets due to a lack of resources or support. ▪ **Immigrant communities:** Substance use issues were noted among some immigrant populations, with concerns about vulnerability to gang influence and drug-related activities.

Community safety	Participants raised numerous concerns about community safety, describing its multifaceted impact on health, well-being, and quality of life. ▪ **Gun violence:** Gun violence emerged as one of the most pressing safety concerns across communities. Participants reported frequent shootings in some neighborhoods, creating an atmosphere of fear, especially for children and families. The connection between gun violence and substance abuse, gangs, and economic disparities was frequently noted. ▪ **Gang activity:** Gang activity was highlighted as a critical issue in some neighborhoods, contributing to violence, drug distribution, and unsafe streets. ▪ **Substance use and safety impacts:** Substance abuse was closely linked to safety concerns in multiple ways. Participants in some communities described public spaces being dominated by individuals using drugs or drinking alcohol, creating a sense of unease. Homeless individuals struggling with substance use disorders were often viewed as both victims of systemic neglect and sources of safety concerns for others. ▪ **Homelessness and public perceptions:** Many participants expressed empathy for homeless individuals but also noted that their presence, especially in groups, created fear in certain settings. The lack of support systems for homeless individuals, particularly for mental health and substance use treatment, was seen as a root cause of safety concerns. ▪ **Public spaces:** Safety concerns were heightened during nighttime hours, with participants describing unsafe streets due to inadequate lighting and increased criminal activity after dark as well as fear of walking in public spaces, especially for women, children, and the elderly. ▪ **Public transportation safety:** Participants described safety issues on public transportation, including drug use, smoking, and sleeping on buses and trains. Participants also mentioned concerns about harassment and violence on transit systems, particularly during late hours. ▪ **Police presence:** Policing was a polarizing issue. Some participants expressed concerns about insufficient police presence in high-crime areas, leading to unchecked violence and criminal activity. Others criticized overly aggressive policing practices, particularly racial profiling, which led to mistrust and fear among community members ▪ **Youth safety:** Schools were seen as both safe havens and sites of concern, with reports of substance abuse, fights, and gun violence involving students. Lack of safe recreational spaces for youth was noted as a contributing factor to their involvement in unsafe behaviors, such as gang activity and substance use. ▪ **Mental health impact:** ▪ Constant exposure to unsafe environments led to stress, anxiety, and fear among community members. Participants expressed frustration about the normalization of unsafe conditions, particularly for children growing up in high-crime areas. ▪ Safety concerns discouraged residents from engaging in outdoor activities or using public spaces, reducing opportunities for community connection and other positive health behaviors. ▪ **Economic impact:** Businesses avoid high-crime areas, limiting economic opportunities and perpetuating cycles of poverty and unsafe conditions

Infrastructure and environmental concerns	Several environmental issues impacting health were mentioned by participants. ▪ **Community safety:** Participants mentioned poorly lit streets, abandoned buildings, and lack of community centers as factors that increased crime and reduced safety. Unsafe pedestrian areas, such as intersections without proper crossings, posed physical dangers to residents. ▪ **Lack of green space:** ▪ Participants from lower-income neighborhoods noted a lack of well-maintained parks and recreational areas for children and families. Many parks that once had community centers and facilities (e.g., woodshops and basketball courts) now lack services and upkeep. ▪ Youth and young adults expressed frustration about the lack of outdoor activities and spaces designed for their age group. ▪ **Pollution:** Participants in some communities noted higher levels of industry compared to other neighborhoods. Increased truck traffic and industrial activity raised concerns about air quality and pollution. Some neighborhoods faced controversies around businesses relocating, such as scrapyards or dumps, which residents feared would exacerbate environmental concerns. ▪ **Active transportation:** Many communities lack infrastructure like protected bike lanes, leading to safety issues. Participants reported incidents of students being hit by cars due to poorly designed bike paths. Public infrastructure for biking and walking is underfunded, with limited areas for secure bike parking. ▪ **Environmental policy:** Participants criticized perceived public corruption and stagnation in leadership, leading to poor environmental decision-making. For instance, concerns were raised about policies allowing forest destruction and other environmental damage. Poor urban planning and insufficient investment in green and public spaces perpetuate disparities in environmental quality. ▪ **Health impacts:** ▪ Poor air quality and environmental hazards were linked to increased risk of respiratory and chronic diseases. ▪ Participants described how lack of access to parks and green spaces limits opportunities for physical activity, contributing to obesity and related health conditions ▪ Limited recreational spaces lead to social isolation, particularly for young adults and families. In addition, poor environmental conditions in lower-income areas were connected to reinforced feelings of neglect and inequity among residents.

Economic challenges	Participants highlighted various economic challenges that impact their day-to-day lives, health outcomes, and overall community well-being. ▪ **Inequities in development:** Participants described visible disparities in housing and economic development across neighborhoods. Some areas receive significant investment, while others remain neglected. ▪ **Cost of living:** The cost of living, particularly for essentials like food, healthcare, and housing, was a major concern. ▪ Seniors expressed frustrations over high out-of-pocket healthcare expenses, even with insurance. ▪ Participants on fixed incomes, such as Social Security Disability Insurance (SSDI), highlighted difficulties in meeting basic needs due to rising costs and stagnant benefits. ▪ Property taxes and other economic pressures force middle-class families to leave their communities once children grow up. ▪ **Housing affordability:** ▪ **Rising housing costs:** Participants reported sharp increases in rent and property prices, with wages remaining stagnant. Gentrification was highlighted as a driver of unaffordable housing. ▪ Lack of affordable housing was cited as a root cause of homelessness. Participants noted that many homeless individuals are in "survival mode," without access to stable housing or preventive healthcare. Long waiting lists for housing assistance programs like Section 8 vouchers were common, with limited availability compounding the issue. ▪ **Food instability:** Access to healthy food was a challenge, with high costs cited as a barrier for low-income families. Participants mentioned that it is cheaper to buy unhealthy fast food than fresh produce due to high food costs. ▪ Reductions in programs like SNAP benefits and other financial assistance were described as exacerbating economic hardships. ▪ **Employment challenges:** Limited job opportunities and high unemployment were mentioned, especially for marginalized populations. Participants highlighted challenges like low wages, insufficient full-time positions, and barriers for young adults entering the workforce. Several participants criticized the reliance on employment for healthcare coverage as this system excludes unemployed or underemployed individuals. Young adults face challenges transitioning to independence due to a lack of financial literacy and job opportunities. ▪ **Health impacts:** ▪ Economic instability contributes to stress, anxiety, and exacerbation of chronic conditions due to delays in care or unaffordable treatments. ▪ High housing costs and gentrification are displacing long-term residents, disrupting social ties and community cohesion.

Child and adolescent health	▪ **Accessibility and affordability of childcare**: Childcare was described as prohibitively expensive. Participants highlighted insufficient financial aid or support for working parents balancing childcare and other expenses.
	▪ **School quality:** Participants expressed dissatisfaction with the quality of education in some schools.
	  ▪ Participants noted that key subjects like history, music, art, and home economics were no longer part of the curriculum. Concerns were raised about schools passing students without adequately preparing them, leading some parents to send their children to schools outside their communities for better education.
	▪ Schools with limited wraparound services, such as counseling and extracurricular activities, were seen as failing to meet students' holistic needs.
	▪ **Rising mental health needs:**
	  ▪ Children and adolescents were described as struggling with increased mental health challenges, including anxiety and loneliness, particularly after the pandemic.
	  ▪ LGBTQIA+ youth faced additional mental health concerns related to identity acceptance and bullying, with limited support systems available.
	  ▪ Participants noted a lack of accessible mental health programs for youth and insufficient awareness about existing services.
	▪ **Lack of community spaces:** A recurring theme was the absence of safe spaces for young people to socialize and participate in activities. Parks and community centers were often underfunded or lacked programming for youth.
	▪ **Technology:** Technology was described as both a solution and a challenge. While it provides entertainment, participants highlighted concerns about its overuse, with children spending excessive time on screens instead of engaging in outdoor or social activities.
	▪ **Safety concerns:**
	  ▪ Participants reported unsafe biking and walking infrastructure near schools.
	  ▪ Concerns about over-policing of youth in schools and communities were frequently mentioned. Participants linked these practices to criminalization and lack of support for adolescents.
	▪ **Food insecurity:** Access to healthy food for children was highlighted as a challenge. Many families resorted to cheaper, unhealthy options due to the high costs of nutritious food.
	▪ **Support for families with special needs:**
	  ▪ Support services for children with autism were described as having long waiting lists, leaving families struggling to find timely assistance.
	  ▪ Parents with special needs children often required additional support such as respite services but faced barriers accessing it.

Women's health disparities	There was a significant call for greater awareness and resources dedicated to women's health issues such as endometriosis, menopause, and maternal health. Participants expressed concerns about higher maternal and child mortality rates among Black and Brown families. In addition, participants highlighted a lack of access to women's health services including pre- and post-natal care and maternal mental health services.

COVID-19	▪ **Ongoing health issues:**
	  ▪ Participants mentioned lingering health issues after contracting COVID-19, such as loss of taste and smell, sinus problems, and chronic fatigue.
	  ▪ The pandemic underscored disparities in healthcare access, with some communities struggling to find preventive and primary care services.
	▪ **Prevention:** While participants noted continued use of masks and precautions, there was variability in adherence, with some expressing a need for ongoing vigilance and others downplaying its significance.
	▪ **Economic impacts:** COVID-19 exacerbated economic challenges, with many participants citing job losses and financial instability during the pandemic. Post-pandemic rent increases and reduced SNAP benefits further strain households.
	▪ **Mental health impacts:**
	  ▪ The pandemic intensified feelings of loneliness and isolation, especially among older adults, adolescents, young adults, and individuals living alone.
	▪ Participants reported heightened levels of anxiety, depression, and social awkwardness post-pandemic. The sudden halt of in-person interactions and reliance on virtual connections disrupted social skills and emotional well-being.

Health promoters

Definition: Factors that help individuals and communities be healthy.

Purpose: To categorize the factors within communities that help people to be healthy and identify essential existing resources.

Table 3. Health promoters – Summary findings

Theme	Summary
Positive health behaviors	Community members discussed their proactive steps to maintain health, such as staying active, adopting healthy diets, and participating in sports.
Social support systems	Social support systems such as having strong community connections, belonging to inclusive faith communities, supportive families, and community services such as drop-in centers were highlighted as supporting health in communities.
Access to healthy foods	Participants mentioned the presence of stores and markets offering healthy food options as well as food pantries and community-supported food programs as crucial for community health.
Outdoor spaces	Parks, trails, and outdoor community events were mentioned as promoting health within communities that had access to them.
Access to community services	Participants emphasized the availability of various community-based services that contribute to health and well-being. These services and programs included community centers, student programs, food pantries, senior transportation services, and faith-based initiatives.

Solutions

Definition: Solutions to health issues and challenges discussed by participants.

Purpose: To develop community-informed and community-driven strategies for addressing community health challenges.

Table 4. Solutions – Summary findings

Theme	Summary
Expansion of community programs	Community members emphasized the importance of creating and enhancing "outside-of-school" programs for children and teens, providing safe and engaging environments to support youth development. Suggestions included after-school activities, mentorship programs, and sports initiatives to keep young people engaged and reduce exposure to risky behaviors.
Improved access to health and community services	▪ Participants highlighted the need for increased access to affordable and comprehensive health services, particularly urgent care and specialized treatment options. ▪ Strengthening existing community resources, such as food distribution programs and free counseling services, was also a recurring theme. ▪ Mobile health clinics and outreach efforts were proposed to serve underserved areas effectively. ▪ Respondents advocated for culturally sensitive healthcare services that respect the diverse backgrounds of Cook County residents.
Violence reduction	Community safety emerged as a significant concern, with recommendations for programs targeting violence reduction. Collaborative efforts between health departments, law enforcement, and community organizations were seen as vital for addressing root causes of violence.
Policy and advocacy	Participants identified gaps in policies that could be addressed to improve health outcomes, such as better funding for public health initiatives and equitable access to care. Strengthened collaboration between hospitals, health departments, and community leaders was seen as a critical step in driving meaningful change
Hospital investment priorities	Participants called for hospitals to prioritize investments in several areas. **Coordinated care:** Fragmentation in healthcare services was a recurring concern, especially for individuals with chronic conditions or complex medical needs. ***Recommendations:*** ▪ Implement systems to improve communication between different care providers such as primary care providers and specialists. This includes the development of technology platforms, such as integrated electronic health records, to share patient information across facilities securely and efficiently. ▪ Expand care navigation programs where healthcare workers guide patients through the healthcare system, helping them access appropriate services and follow treatment plans.

Hospital investment priorities (continued)	**Workforce development:** There is a shortage of culturally competent and community-focused healthcare professionals in underserved areas. ***Recommendations:*** ▪ Investment in training programs to recruit and retain healthcare workers from diverse backgrounds, reflecting the communities they serve. Including establishing partnerships with local schools, colleges, and vocational programs to create pipelines for future healthcare workers ▪ Providing continuing education and certifications for existing staff in areas such as cultural competency, trauma-informed care, and advanced clinical skills. **Community-focused outreach:** Many residents face barriers accessing hospital services, particularly in low-income or geographically isolated areas. ***Recommendations:*** ▪ Investments in community health workers, who could bridge gaps between healthcare systems and community residents, were frequently mentioned. ▪ Expand mobile health clinics and satellite locations to bring services like screenings, vaccinations, and chronic disease management closer to the community. ▪ Partner with community organizations to host regular health fairs and educational workshops to raise awareness of available services. ▪ Develop tailored programs to address the specific needs of priority populations, such as seniors, youth, LGBTQIA+ youth, and individuals with disabilities. **Mental health services:** A lack of focus on prevention and mental health was noted as a significant gap in hospital services. ***Recommendations:*** ▪ Invest in mental health infrastructure, including outpatient clinics, telehealth services, and crisis intervention programs. ▪ Create integrated care models where mental health services are available alongside primary and specialty care to reduce stigma and increase utilization. **Addressing social determinants of health:** The social and economic conditions in many communities contribute to poor health outcomes. ***Recommendations:*** ▪ Invest in programs addressing food insecurity, housing stability, and transportation challenges to enable residents to access care more effectively. ▪ Establish partnerships with local organizations to provide resources such as job training, educational programs, and legal aid. **Emergency preparedness and resilience:** The COVID-19 pandemic underscored the need for hospitals to be better prepared for public health emergencies. ***Recommendations:*** ▪ Develop community resilience programs that educate residents on emergency preparedness and connect them to resources during disasters.

Vision for the future

Definition: Improvements that participants would like to see in their communities over the next 3-5 years.

Purpose: To further refine community-identified health priorities, to create a list of action-oriented next steps for hospitals and health departments seeking to improve community health and inform the development of metrics for evaluating health improvement strategies.

Table 5. Vision for the future – Summary findings

Theme	Summary
Safety and respect	Participants expressed a significant desire for reduced violence and an increase in mutual respect among community members.
Access to opportunities	Participants mentioned the need for more resources and opportunities like those available in other communities. Specific mentions included programs fostering healthcare career pathways, cultural representation, and community engagement.
Youth development	A recurring theme was the importance of creating programs and activities for youth to engage them positively and provide alternatives to detrimental activities.
Representation	Many participants emphasized the importance of seeing people from their community in prominent roles, particularly in healthcare and other fields, to inspire the next generation.
Community cohesion	Participants envisioned a stronger sense of community, supported by accessible services, shared goals, and cultural enrichment.

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