Community Health Needs Assessment (CHNA)

MacNeal Hospital

2025

LOYOLA MEDICINE

A Member of Trinity Health

Adopted by Board of Directors on 5/30/2025

Contents

Introduction to Loyola Medicine and MacNeal Hospital

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.

MacNeal Hospital provides quality healthcare in the near western suburbs and the City of Chicago. In 1919, Dr. Arthur MacNeal opened his Berwyn home to serve the pioneer community's health care needs. His legacy lives on as a 362 -bed fully accredited teaching hospital in Berwyn, IL. MacNeal Hospital has consistently expanded its scope of care to meet the needs of patients of every age. In fiscal year 2024, MacNeal discharged 9,666 patients and received 51,035 emergency room visits. Comprehensive services provided by MacNeal Hospital include obstetrics, orthopedics, cardiology, cardiac rehabilitation, sports medicine, rehabilitation services, oncology, and emergency care services. MacNeal Hospital offers one of the largest behavioral health services programs in the Chicago area. MacNeal Hospital also provides medical education programs, including the first family medicine residency established in Illinois, which remains one of the largest and most dynamic of its kind.

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. An updated, county-wide CHNA will be released in 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 (Figure 1) 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 MacNeal Hospital 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 – MacNeal Hospital

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

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 MacNeal Hospital'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 MacNeal Hospital CHNA was collected through 423 community surveys and 15 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. Access to Healthcare
4. Chronic Conditions
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

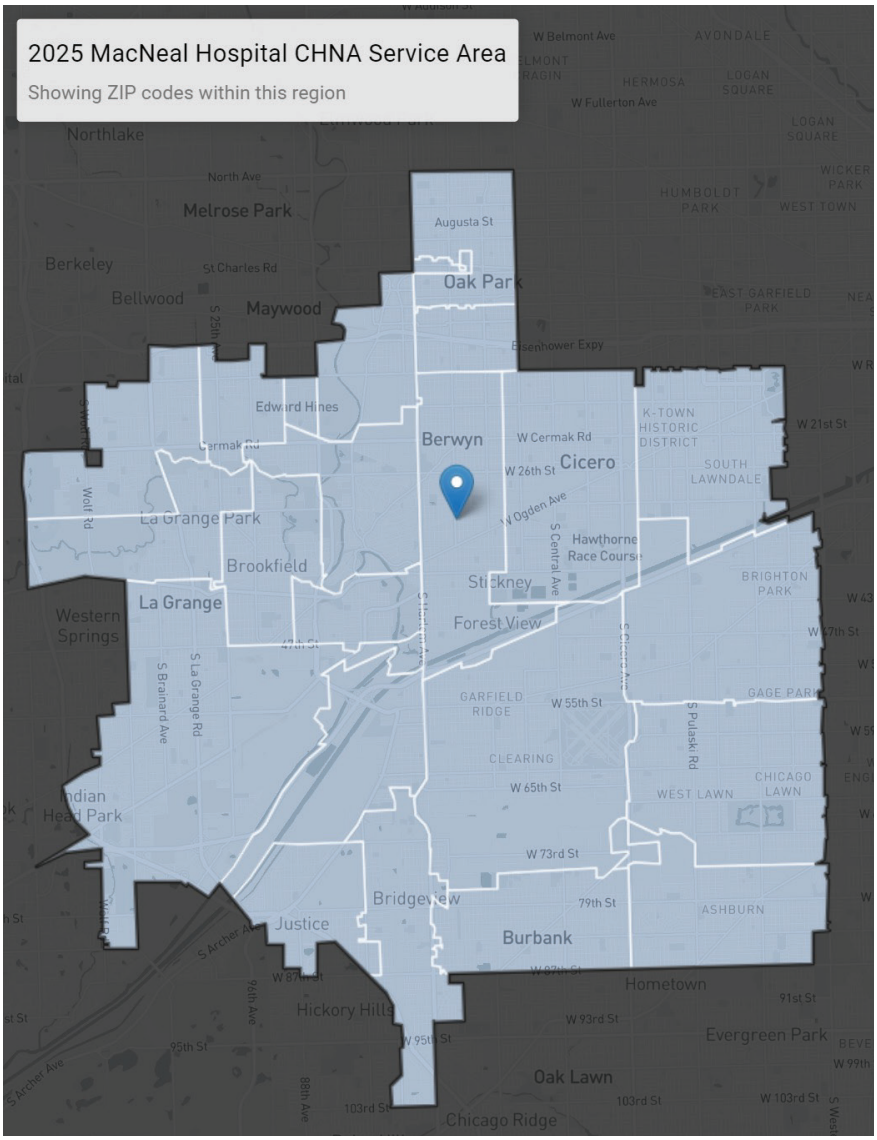
Mailing Address:
Community Health & Well-Being
Loyola Medicine at Gottlieb
555 W. North Avenue
Melrose Park, IL 60160
(Paper copies of this report can be requested at MacNeal Hospital.)

Communities Served

MacNeal Hospital serves a CHNA community service area that includes 23 zip codes in west suburban Cook County and the southwest side of Chicago (Figure 2). Loyola Medicine defines the CHNA service area as the primary service area for the hospital and making sure to include any nearby communities of highest need.

Figure 2. MacNeal Hospital's primary service area

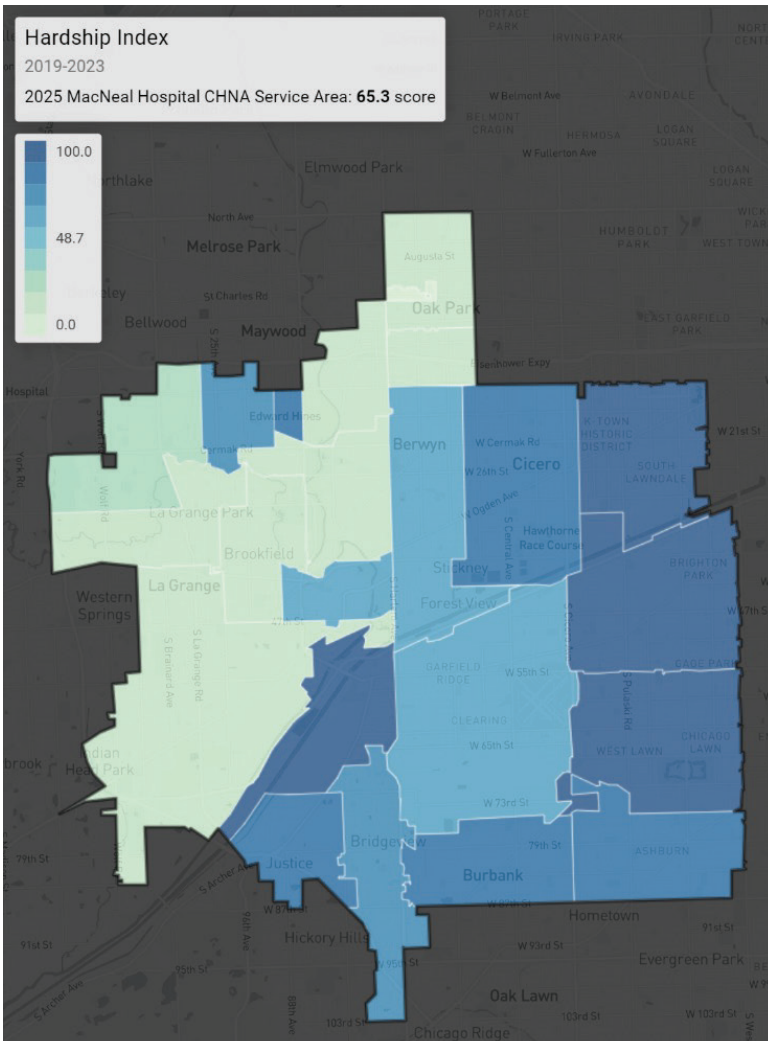
Zip Code	Municipality / Community
60130	Forest Park
60141	Hines
60154	Westchester
60155	Broadview
60301	Oak Park
60302	Oak Park
60304	Oak Park
60402	Berwyn
60455	Bridgeview
60458	Justice
60459	Burbank
60501	Summit Argo
60513	Brookfield
60525	La Grange
60526	La Grange Park
60534	Lyons
60546	Riverside
60623	Chicago
60629	Chicago
60632	Chicago
60638	Chicago
60652	Chicago
60804	Cicero
60534	Lyons
60546	Riverside
60644	Austin (Chicago)
60651	Humboldt Park, Austin (Chicago)
60706	Norridge, Harwood Heights
60707	Elmwood Park
60804	Cicero



Economic Hardship Index

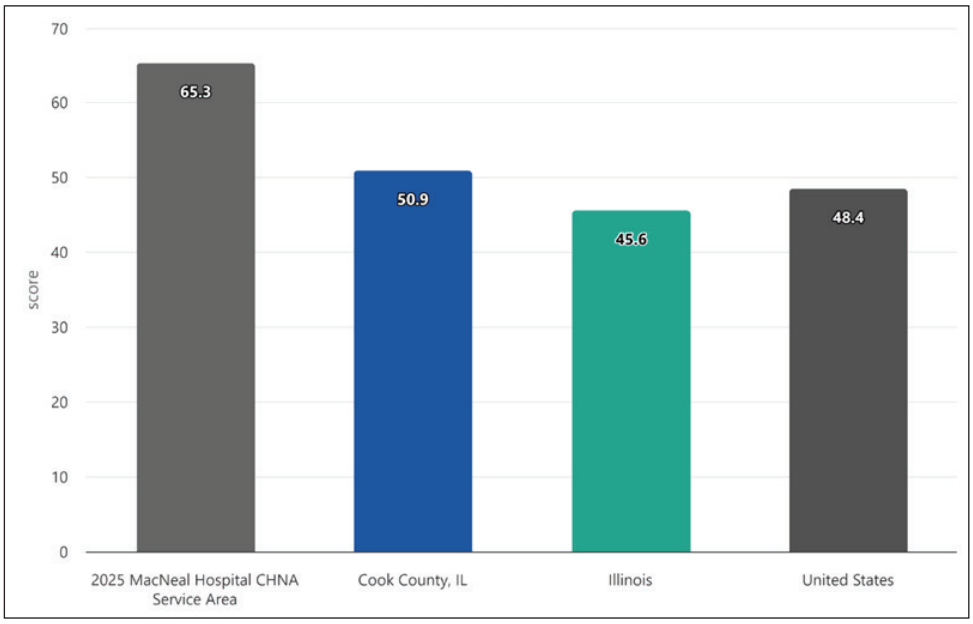
Half of the zip codes within MacNeal Hospital's service area are classified as high economic hardship communities (Figure 4). Economic hardship is the difficulty resulting from not having enough collective economic resources available within a community (Chicago Department of Public Health, 2023). It 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 MacNeal Hospital's service area (65.3) 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 MacNeal Hospital service area, 2019-2023



(US Census Bureau, 2024)

Figure 4. Chart comparing Economic Hardship Index scores for MacNeal Hospital's service area, Cook County, Illinois, and the United States, 2019-2023

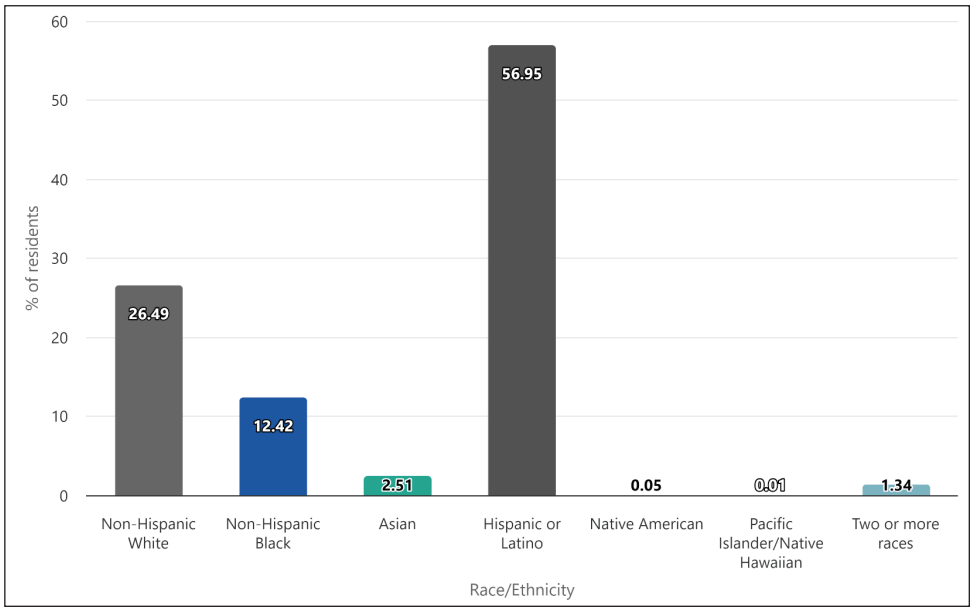


(US Census Bureau, 2024)

Demographics

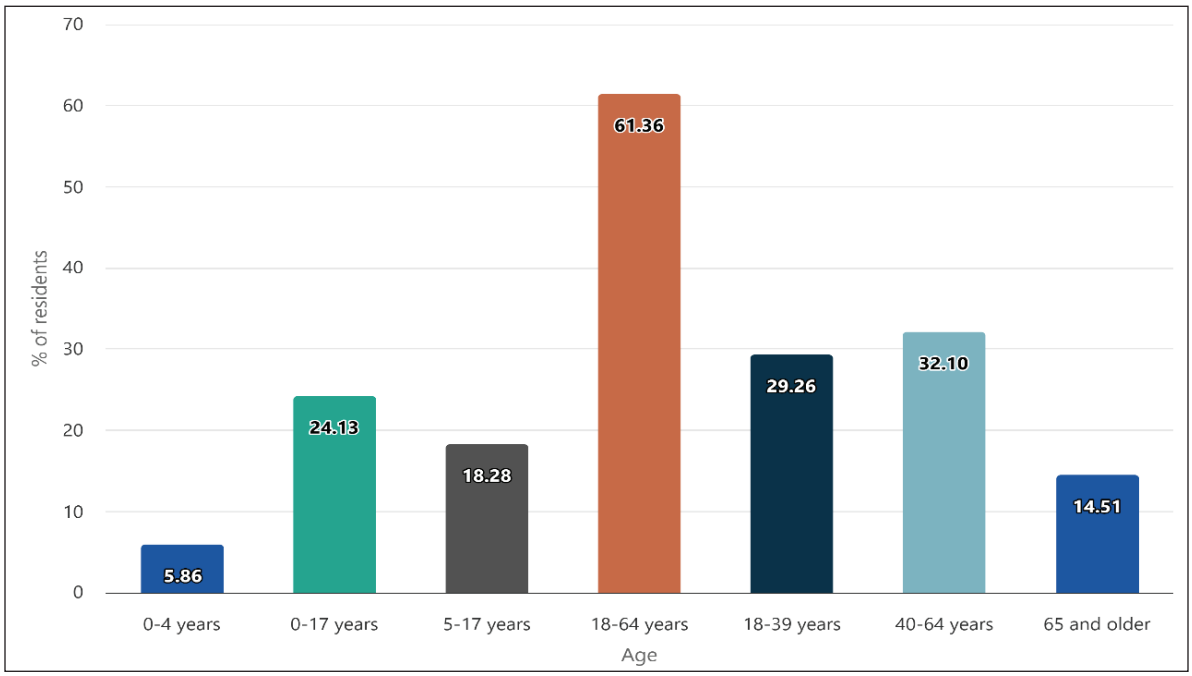
The largest racial and ethnic group within MacNeal Hospital's service area is Hispanic or Latino (56.95%) followed by Non-Hispanic White (26.49%), and Non-Hispanic Black (12.42%) (Figure 5). Community members identifying as Asian (2.51%), two or more races (1.34%), Native American (0.05%), and Pacific Islander/Native Hawaiian (0.01%) accounted for less than 4% of the service area's overall population (Figure 5). 24.13% 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 14.51% of the population (Figure 6).

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



(US Census Bureau, 2024)

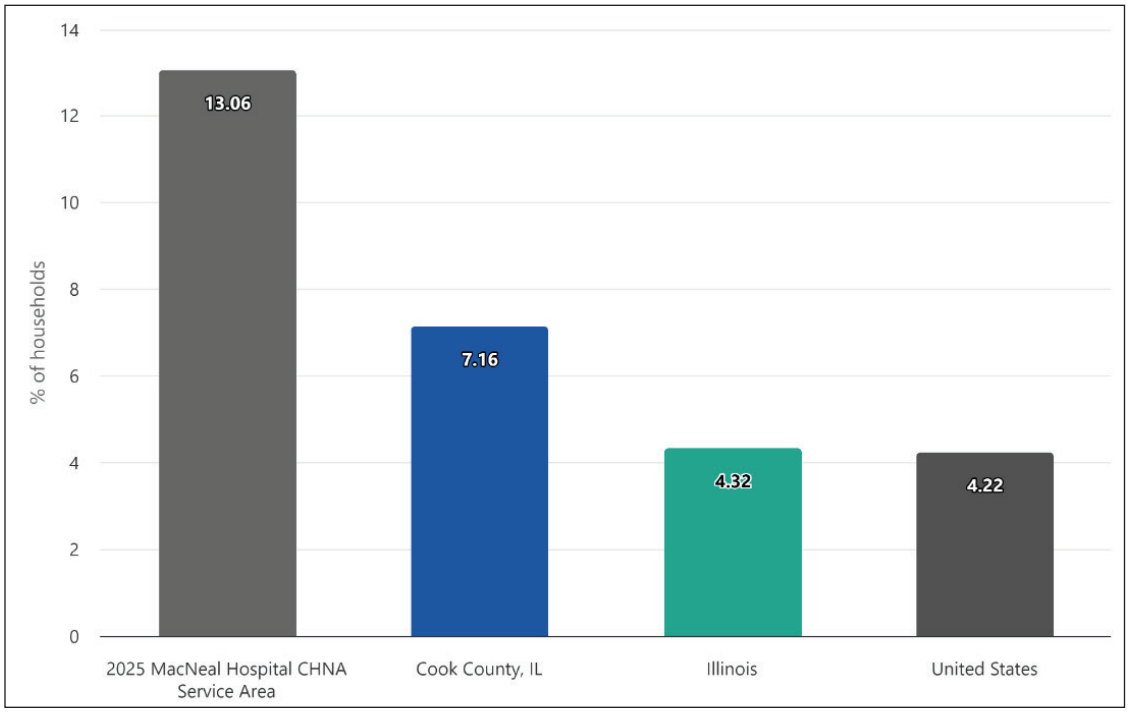
Figure 6. Population of the MacNeal Hospital service area by age, 2019-2023



(US Census Bureau, 2024)

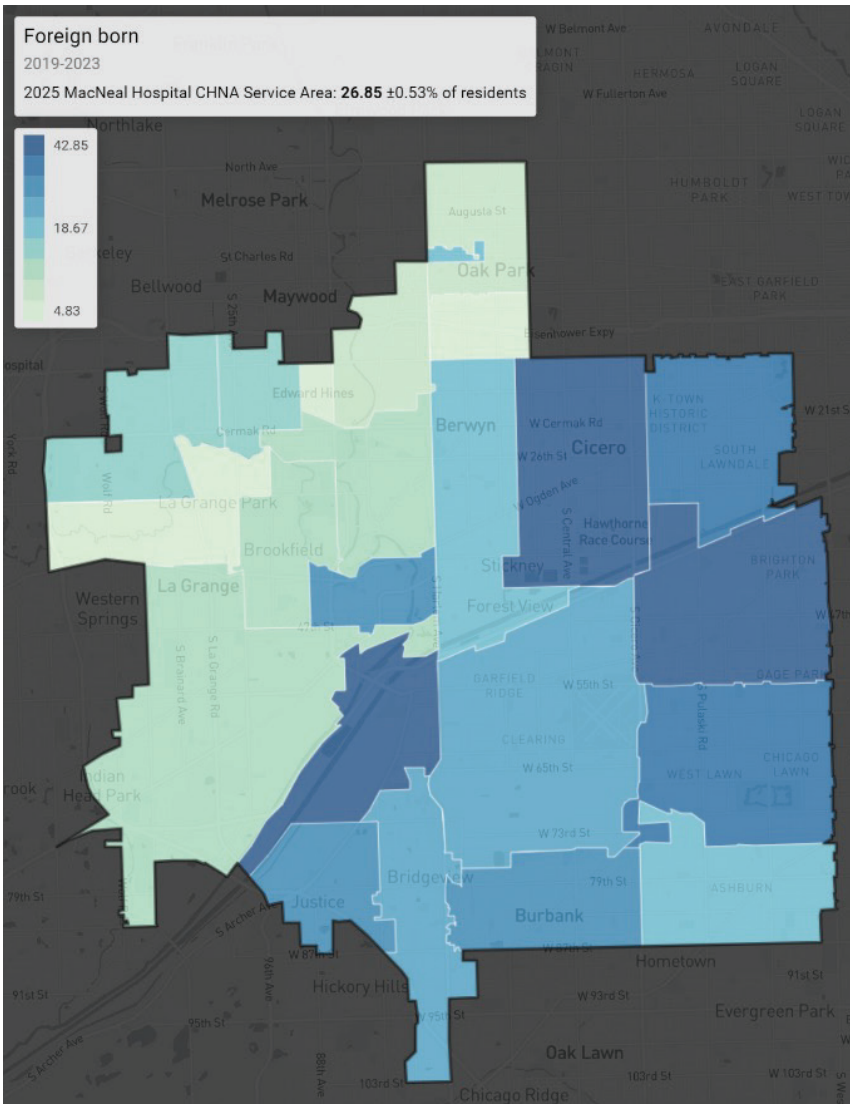
In the MacNeal Hospital service area, a high percentage of households are limited English proficient (13.06%), compared to 7.16% across Cook County and only 4.32% statewide (Figure 7). There is a high percentage of foreign-born individuals in the service area (26.85%) (Figure 8). The zip code with highest percentage of foreign-born individuals is in Archer Heights/ Brighton Park, Chicago (60632) at 42.85% and the lowest percentage in La Grange (60526) at 6.96% (Figure 8).

Figure 7. Chart comparing the percentage of households with limited English proficiency in MacNeal Hospital'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 MacNeal Hospital's service area, 2019-2023

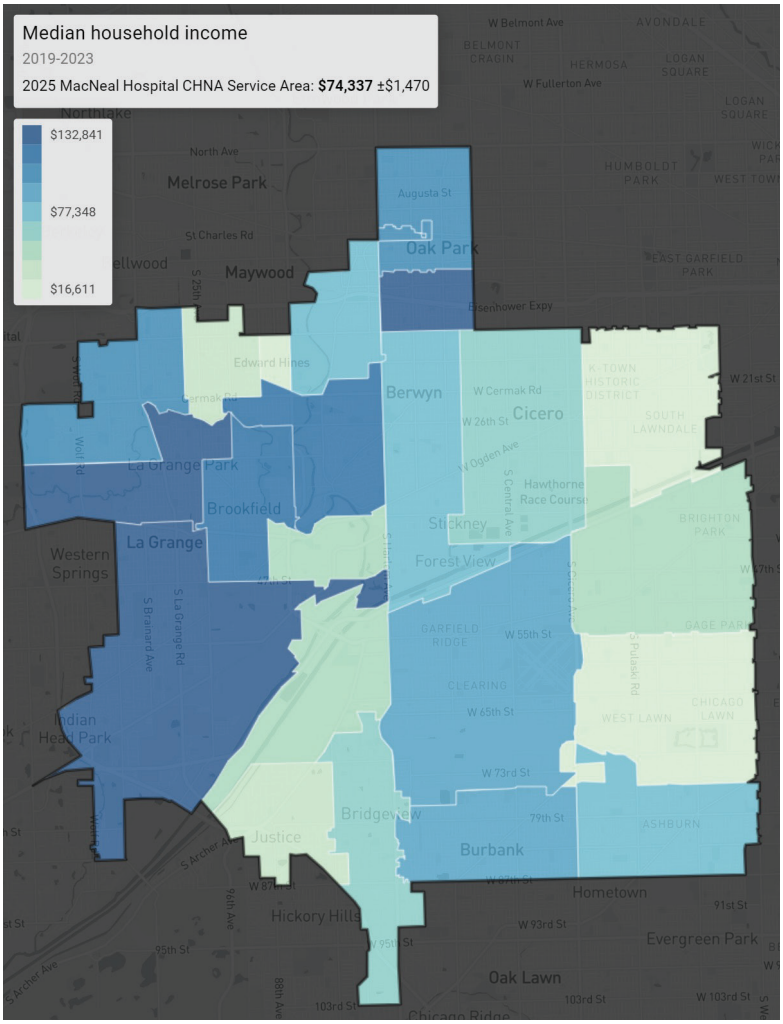


(US Census Bureau, 2024)

MacNeal Hospital's service area includes a high proportion of foreign-born community members

The median household income of people living in MacNeal Hospital's service area ($74,337) is slightly lower than Cook County ($81,797) (US Census Bureau, 2024), but there is wide variation within the service area. Zip code 60304 (Oak Park) has the highest median income of $132,841, while 60623 (North and South Lawndale, Chicago) has the lowest median income of $44,040 (Figure 9). There is a disparity in the racial and ethnic make-up of the two zip codes, highlighting income inequities. 60304 is a majority Non-Hispanic White (60.2%) while 60623 is a majority Hispanic or Latino (68.8%) (Figure 10).

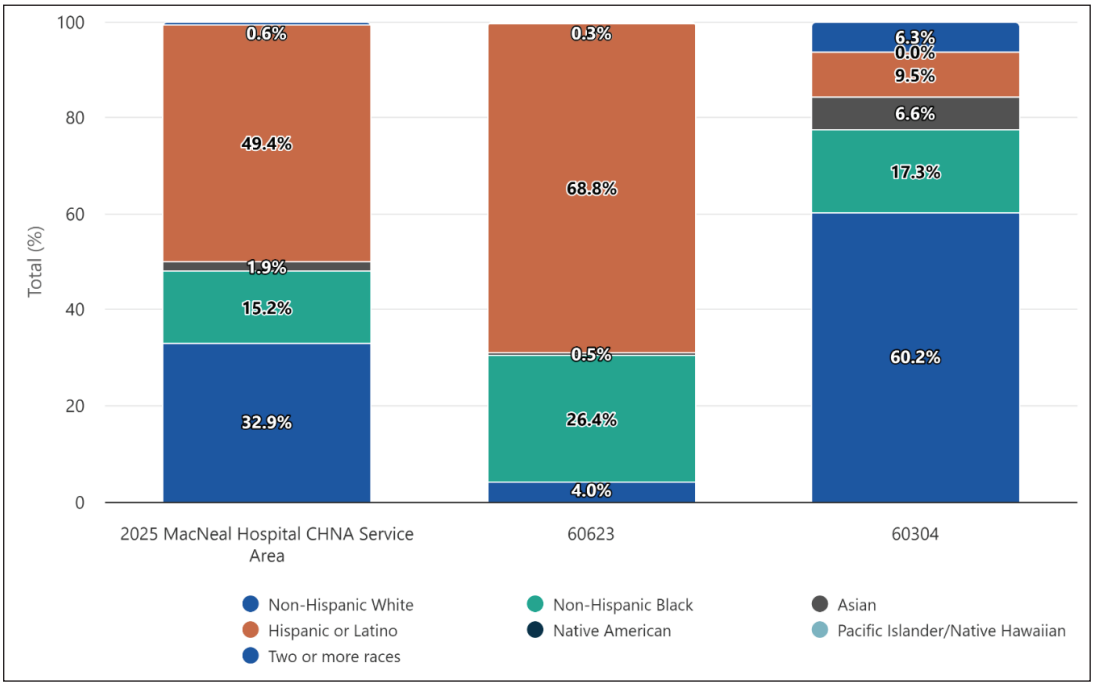
Figure 9. Map of median household income in MacNeal Hospital's service area, 2019-2023



(US Census Bureau, 2024)

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

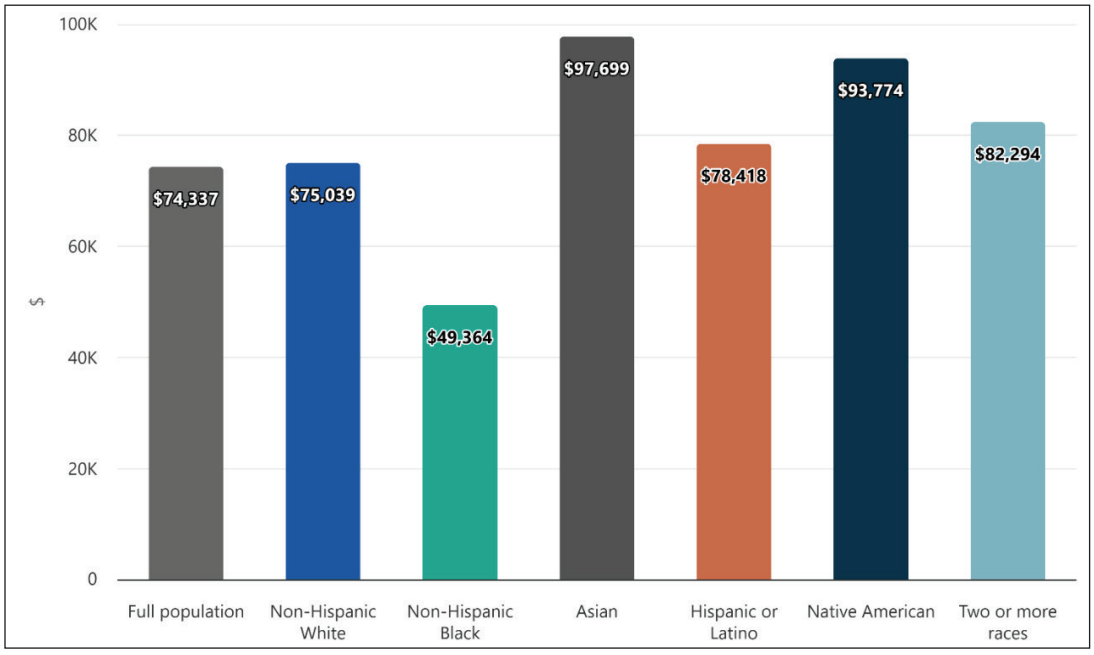
Figure 10. Chart comparing the population by race and ethnicity of the zip codes with the highest and lowest median household income in MacNeal Hospital's service area, 2019-2023



(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 $75,039 and Non-Hispanic Black having a median household income of $49,364 (US Census Bureau, 2024).

Figure 11. Median household income of the MacNeal Hospital 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. Fifteen focus groups with community residents and social service providers were conducted in MacNeal Hospital'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, 423 community input surveys were collected in MacNeal Hospital's service area. A more detailed analysis of the 2024 county-wide survey results will be available at allhealthequity.org in June 2025.

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 ▪ Lakeview Art's Festival ▪ Illinois CHW Summit ▪ Belmont Cragin Elementary Back to School ▪ Latina Expo ▪ Speaker Welsh Annual Back to School Fair	▪ Healing Arts Fair ▪ South Shore Summer Festival ▪ Kelvyn Park Back to School ▪ Taste of Polonia ▪ Over 15 events attended by community health workers
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 Hispanic or Latino (43.7%) followed by Non-Hispanic White (28.6%) and Non-Hispanic Black (27%) (Figure 13). Participants identifying as Asian/Pacific Islander/Native Hawaiian (3.3%), American Indian/Alaskan Native (2.1%), and Middle Eastern/Arab American/Persian (1.4%) accounted for less than 7% of survey respondents (Figure 13). Fourteen percent of the participants are children aged 10-17 years (Figure 14). Adults aged 18-64 comprise 71.9% of the respondents and seniors aged 65 or older represent 13.7% of the respondents (Figure 14).

Figure 13. Race/ethnicity of survey respondents

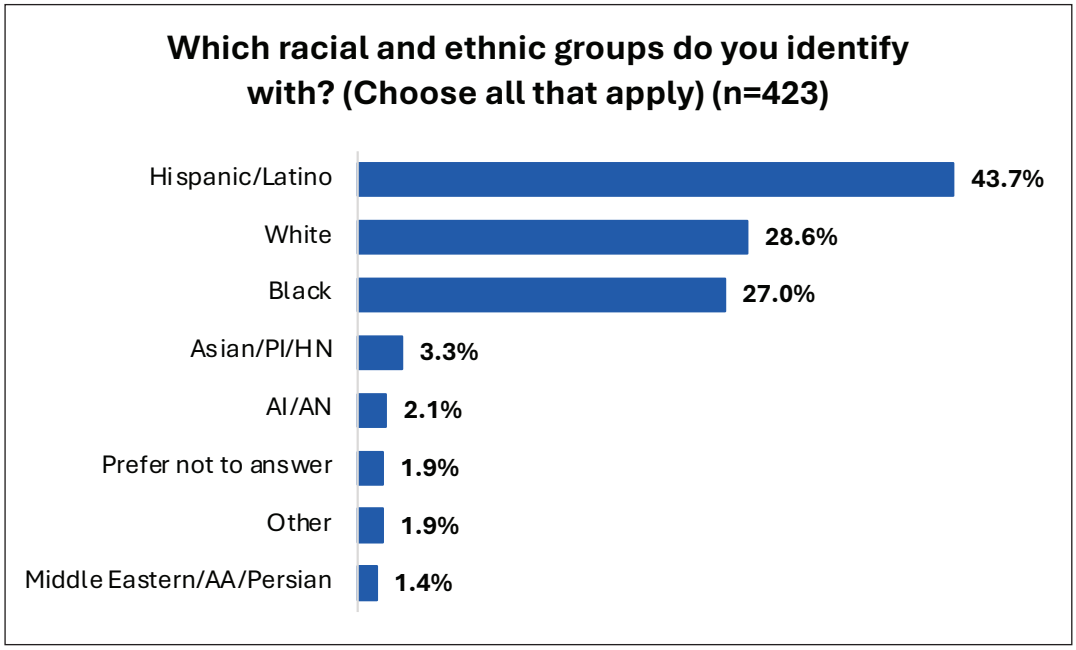
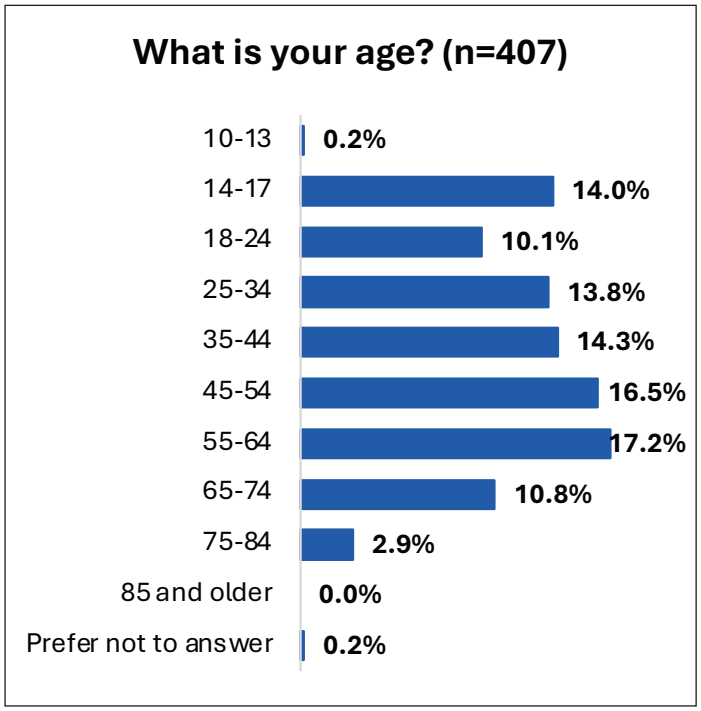


Figure 14. Age of survey respondents



More than half of the survey respondents identify as female (69.8%) in comparison to individuals who identify as male (28.5%) within MacNeal Hospital's service area (Figure 15). A small percentage identify as transgender male (0.5%) and transgender female (0.5%) (Figure 15). Additionally, most of the survey respondents are heterosexual/straight (84.1%) (Figure 16). Participants identifying as gay or lesbian (4.7%) and bisexual (4.7%) accounted for less than 10% of survey respondents (Figure 16).

Figure 15. Gender identity of survey respondents

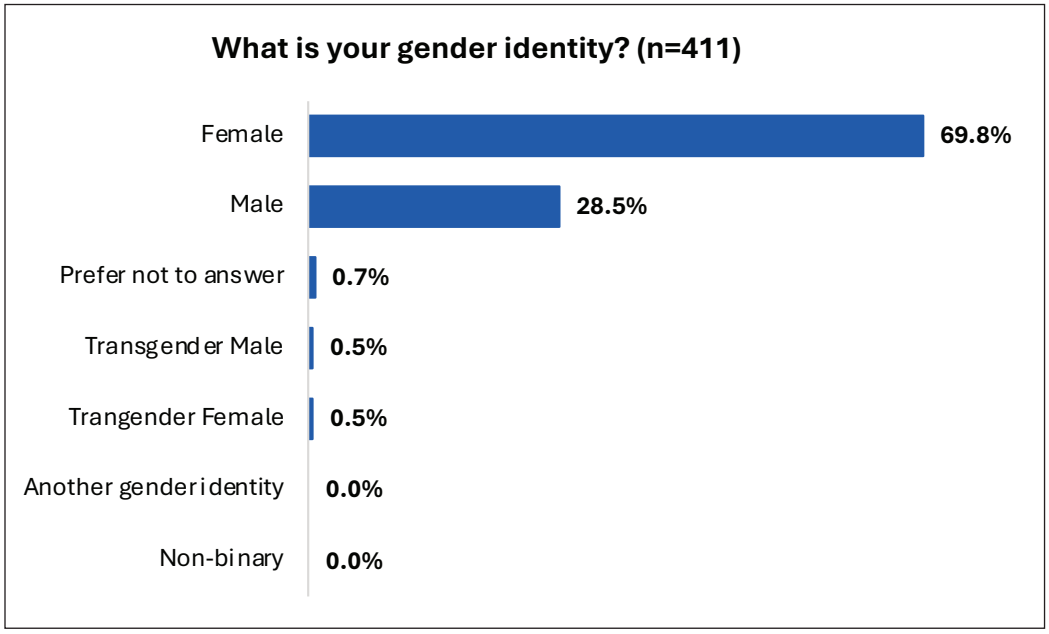
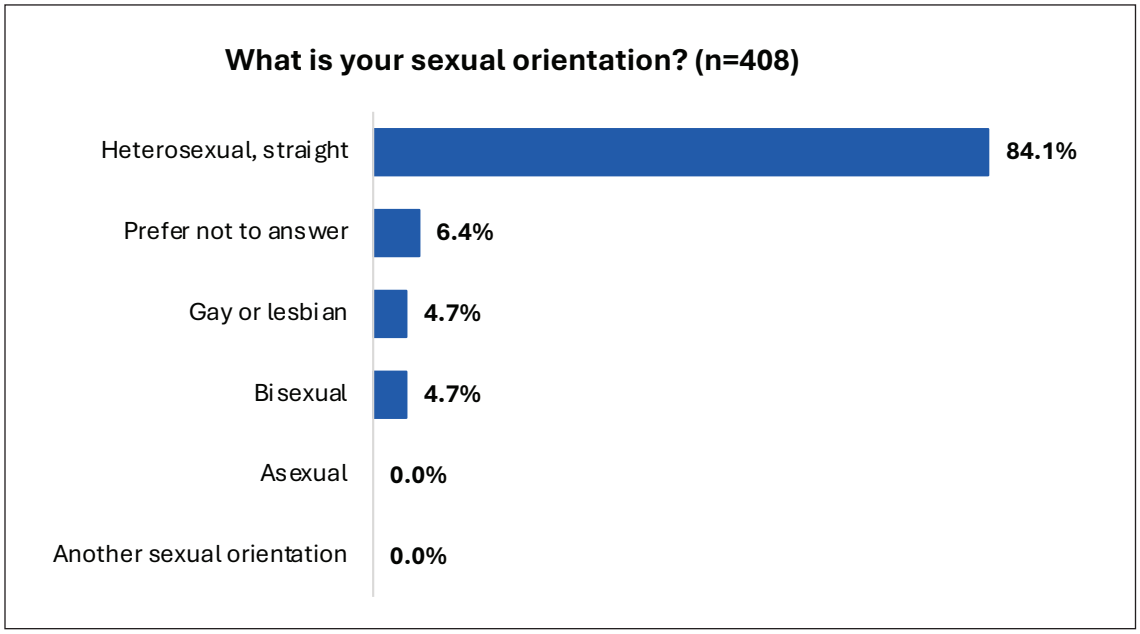
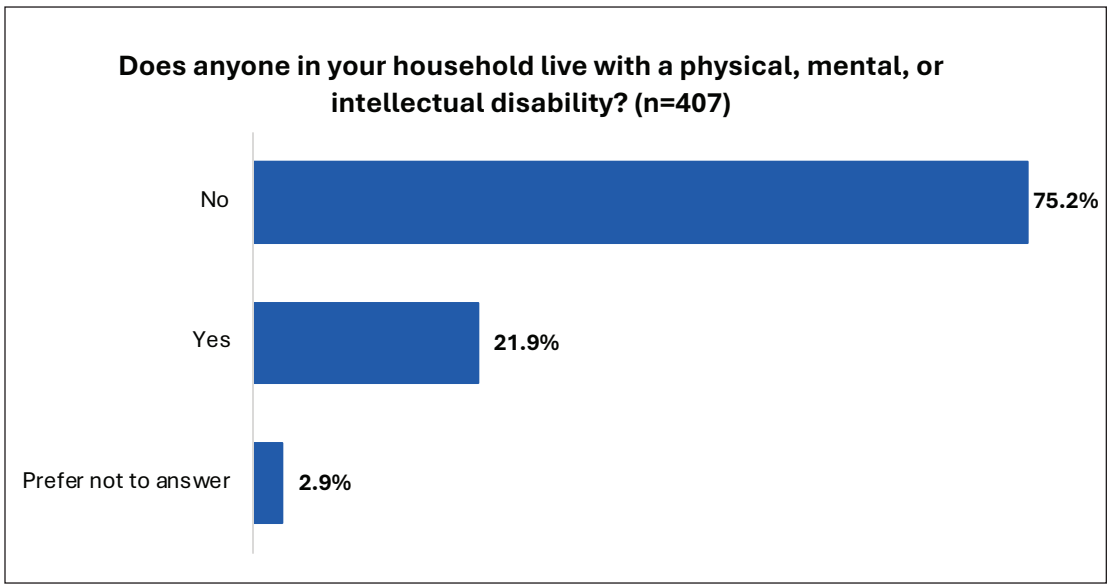


Figure 16. Sexual orientation of survey respondents



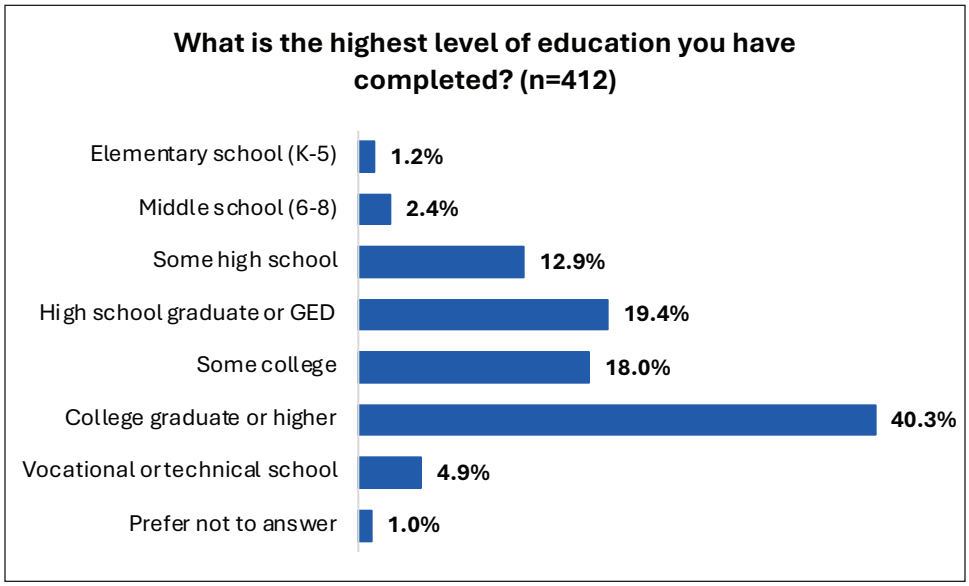
In the survey, 21.9% of respondents reported that someone in their household lives with a physical, mental, or intellectual disability, while 75.2% of respondents reported that they do not have someone in their household with a physical, mental, or intellectual disability (Figure 17).

Figure 17. Household disability status of survey respondents



The largest group of survey respondents are a college graduate or higher (40.3%) followed by high school graduate or GED (19.4%) and some college (18%) (Figure 18). 12.9% of participants completed some high school (Figure 18). Respondents whose highest level of education is elementary school (K-5) (1.2%), middle school (6-8) (2.4%), and vocational or technical school (4.9%) accounted for less than 9% of survey respondents (Figure 18).

Figure 18. Education level of survey respondents



Nearly 21% of survey respondents in MacNeal Hospital's service area have an annual household income of $100,000 or more (Figure 19). 18.7% of participants have an annual household income between $60,000 and $99,999 (Figure 19). An annual household income between $20,000 and $59,999 comprise 28.1% of the respondents, and 10.3% have an annual household income that is less than $20,000 (Figure 19). 69.3% of participants reported that they were employed, whether it was full-time, part-time, and/or self-employed (Figure 20). 14% of survey respondents are students, and 21.6% are not employed or retired (Figure 20).

Figure 19. Household income of survey respondents

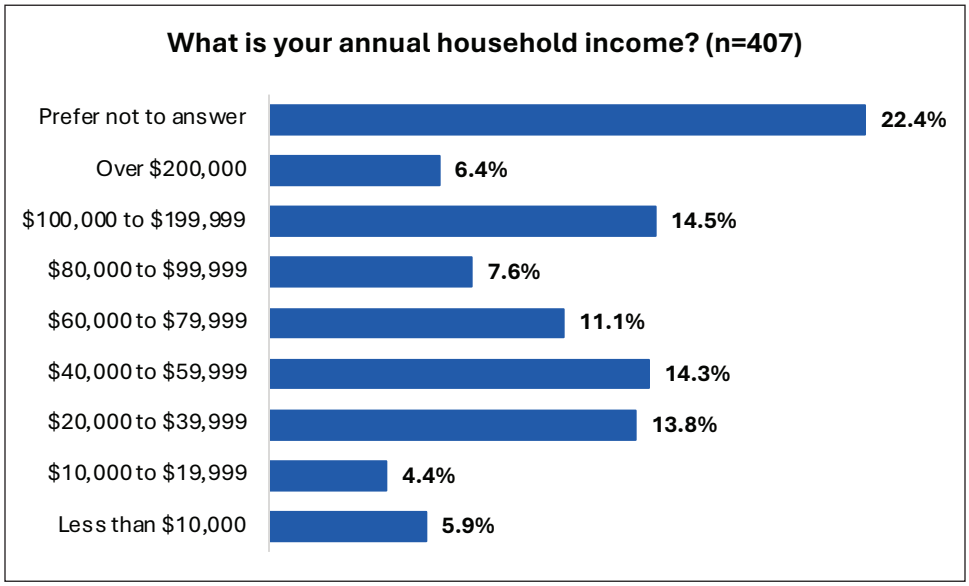
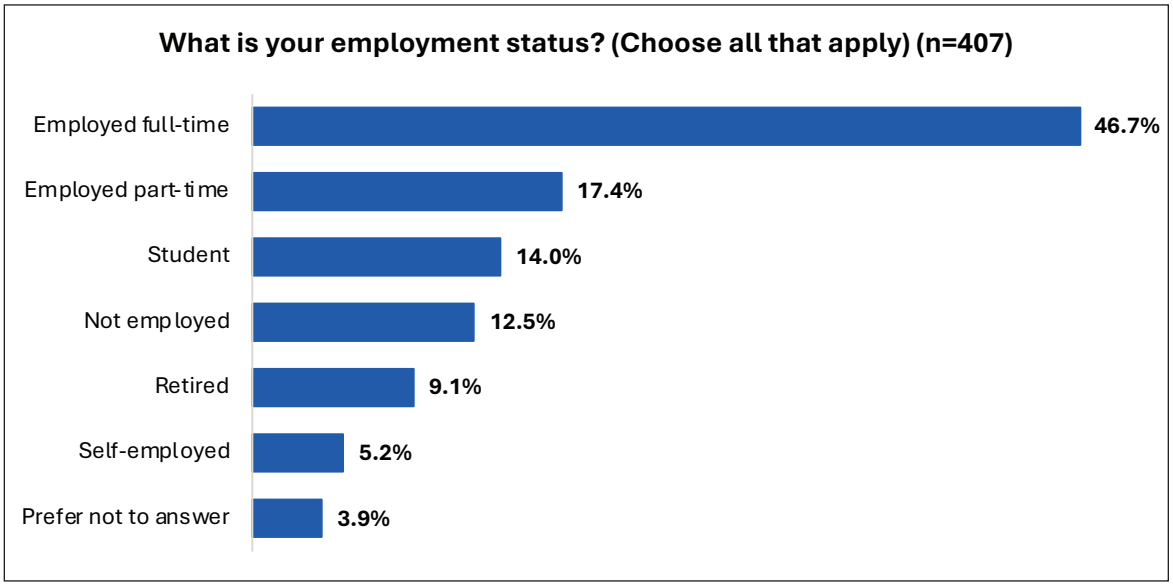


Figure 20. Employment status of survey respondents



Quality of life

In the 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". 40% of respondents rated their communities as "somewhat healthy" and 41% rated "healthy" (Figure 21). Participants were more likely to rate their personal health as better than overall community health with 60% reporting their personal health was "healthy" or "very healthy" (Figure 22). 58% percent of respondents to the survey selected that 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

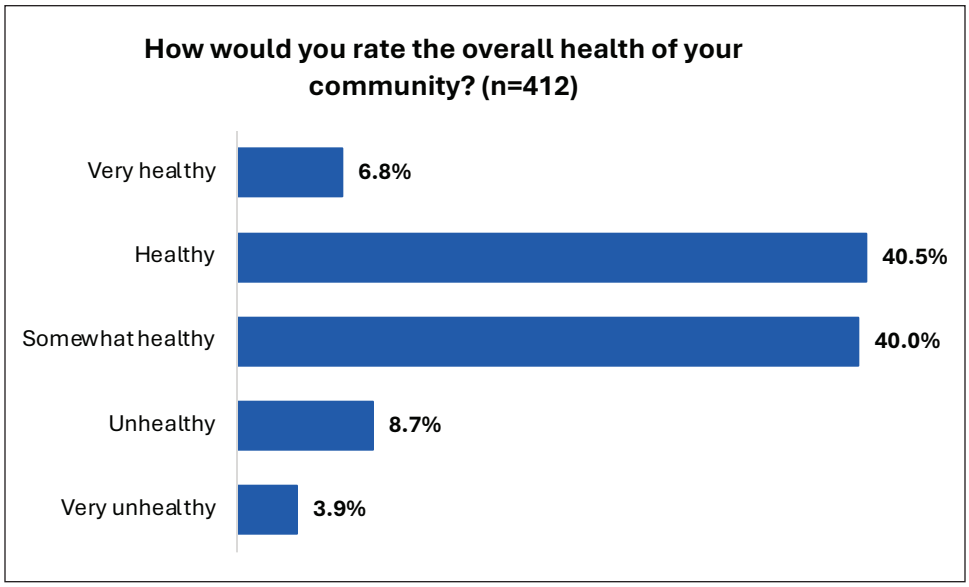


Figure 22. Community input survey responses – personal health

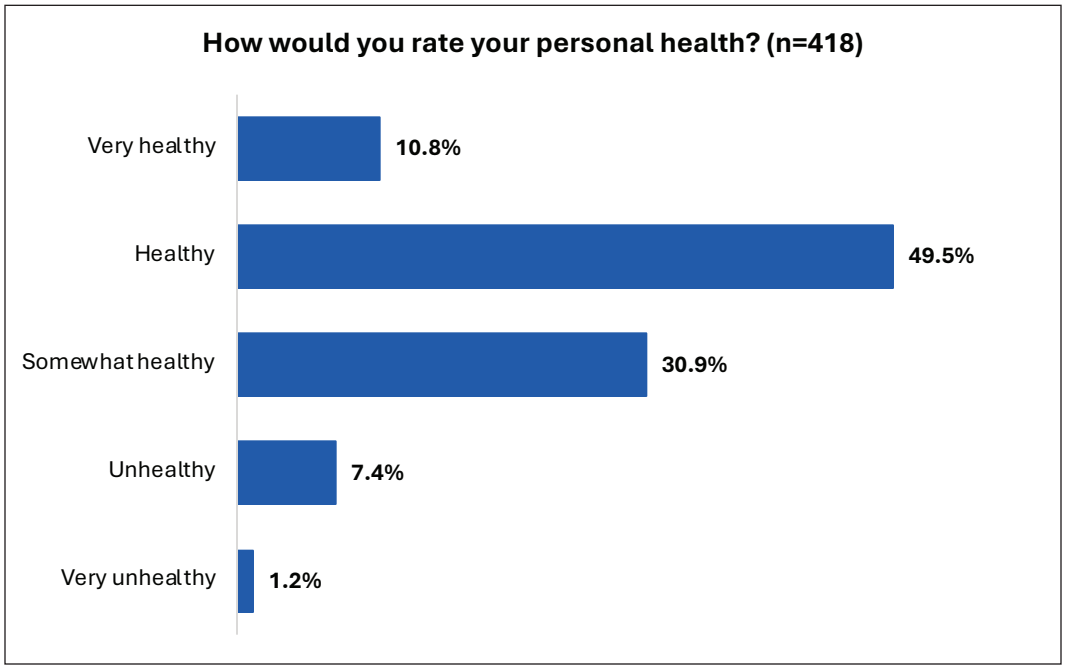
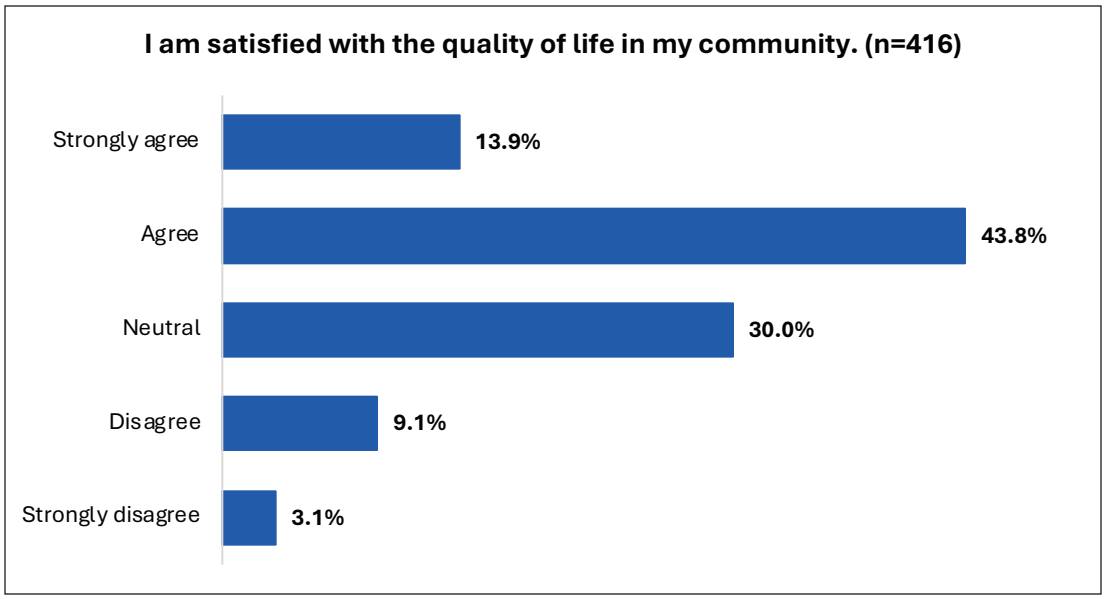


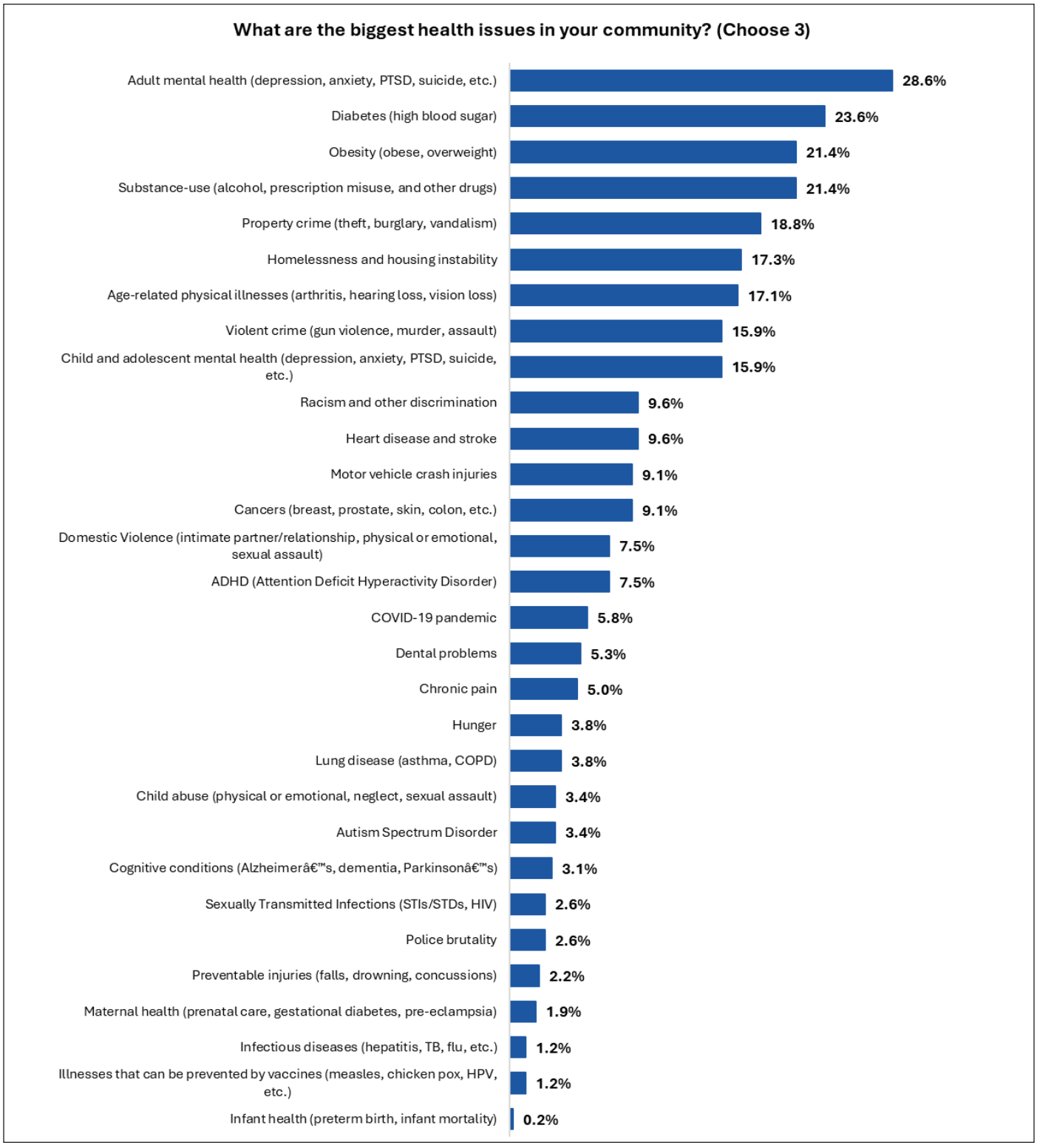
Figure 23. Community input survey responses – quality of life



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 (28.6%), diabetes (23.6%), obesity (21.4%), substance use (21.4%), and property crime (18.8%) being the top five health issues (Figure 24).

Figure 24. Community input survey responses – biggest health issues

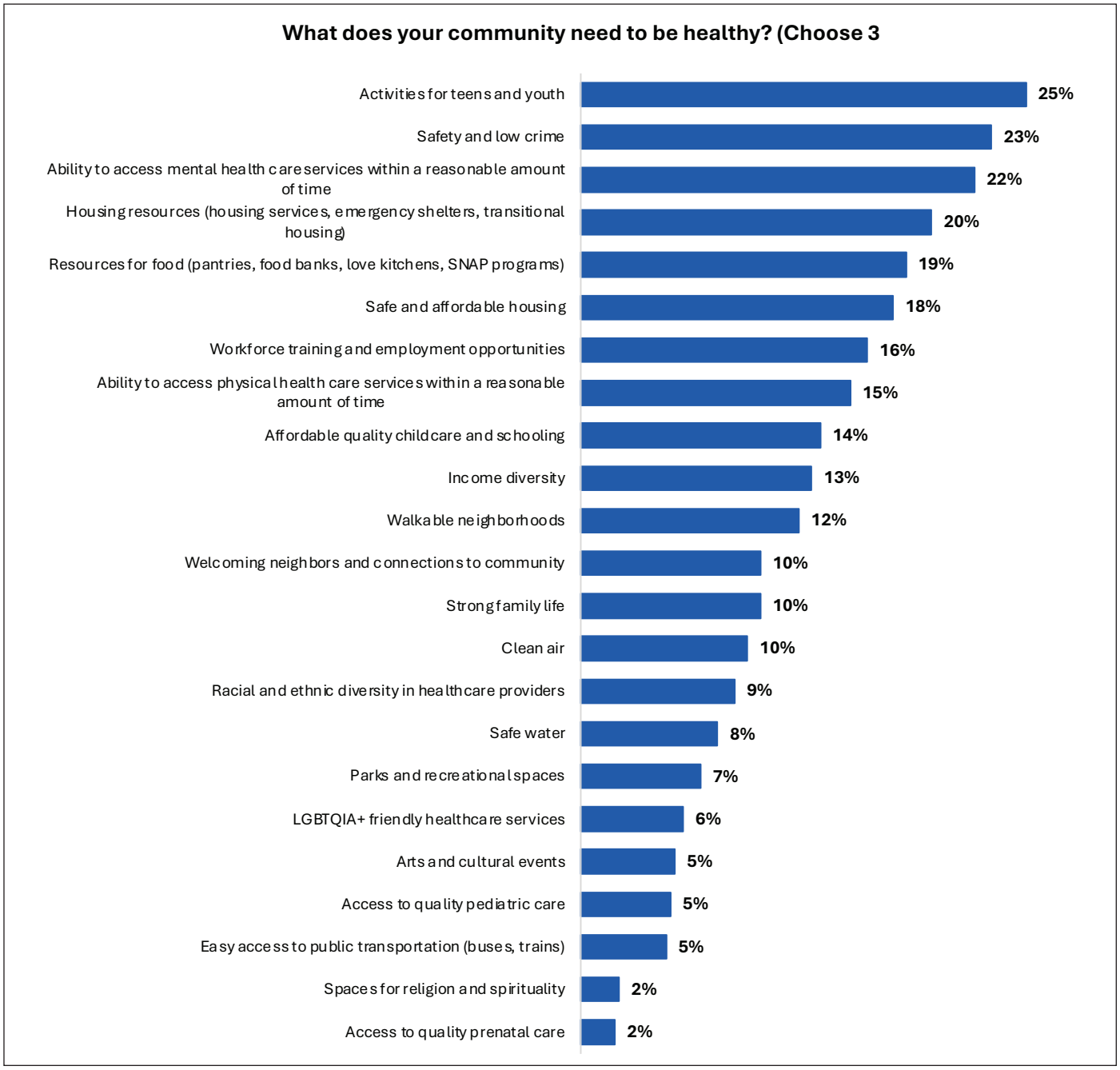


In addition to health priorities, community survey respondents were asked about what was needed to support health improvements in their communities (Figure 25).

The top five health supports identified in the survey included:

1. Activities for teens and youth
2. Safety and low crime
3. Ability to access mental health care services within a reasonable amount of time
4. Housing resources
5. Resources for food

Figure 25. Community input survey responses – biggest health needs



Focus Groups

Fifteen focus groups, totaling over 150 participants, were conducted within MacNeal Hospital'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 MacNeal Hospital service area.

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

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

Health issues and challenges:

- Lack of cultural competency in healthcare services
- Barriers to healthcare access
- Chronic conditions
- Mental health
- Substance use disorders
- Social influencers and determinates of health
- Child and adolescent health
- COVID-19

Health promoters:

- Positive health behaviors and wellness programs
- Preventative care
- Transportation and walkability
- Access to community services
- Housing services
- Community safety

Potential Solutions

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

Solutions:

- Expand access to mental health care and substance use treatment
- Expand access to care for children and adolescents
- Support economic stability
- Hospital investment

Several suggestions were made on how hospitals should prioritize investment:

- Infrastructure for integrated services
- Community engagement and staff training
- Mental health and substance use services
- Streamline services
- Safety and community spaces

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 (Centers for Disease Control and Prevention, 2024b; Weinstein et al., 2017).

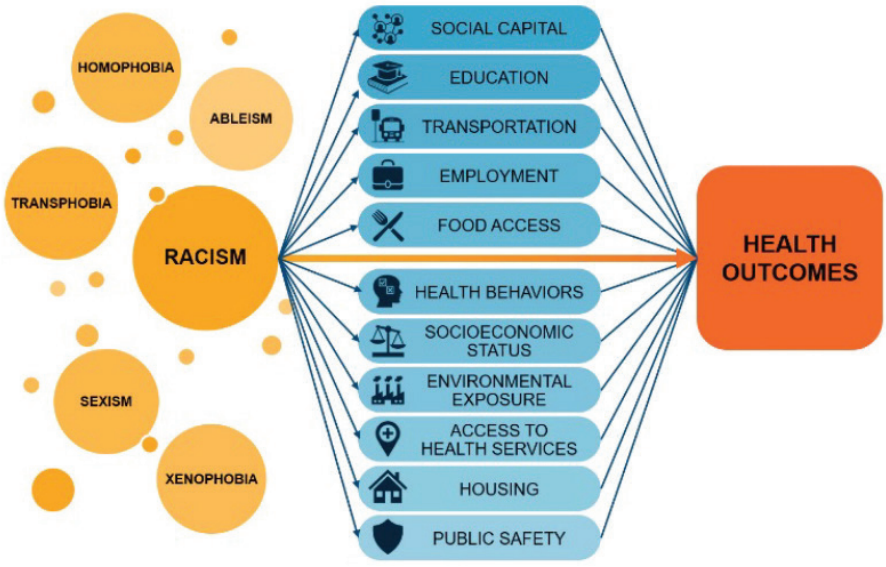
There are four overarching concepts that demonstrate the necessity of addressing health inequities:

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 30).

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

As previously mentioned, MacNeal Hospital's service area encompasses many of the communities experiencing the highest levels of hardship in Cook County (Figure 31). The area has suffered significant social disruption over the past 100 years along with persistent and pervasive racial and ethnic inequities (Henricks et al., 2017). 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 Southwest Suburbs.

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

Zip Code	Hardship Index	Ranking in Cook County (Out of 143)
60301 (Oak Park, IL)	5.8	7
60304 (Oak Park, IL)	16.5	17
60525 (La Grange, IL)	17.4	18
60302 (Oak Park, IL)	18.2	19
60526 (La Grange Park, IL)	18.3	20
60513 (Brookfield, IL)	20.2	25
60546 (Riverside, IL)	22.9	30
60130 (Forest Park, IL)	26.2	39
60154 (Westchester, IL)	30.0	43
60638 (Chicago, IL)	53.6	81
60634 (Chicago, IL)	57.4	91
60402 (Berwyn, IL)	58.6	94
60155 (Broadview, IL)	67.9	104
60455 (Bridgeview, IL)	69.8	105
60459 (Burbank, IL)	71.4	107
60458 (Justice, IL)	71.8	109
60652 (Chicago, IL)	75.7	121
60804 (Cicero, IL)	80.7	129
60501 (Summit, IL)	84.7	132
60629 (Chicago, IL)	86.2	135
60632 (Chicago, IL)	86.6	136
60623 (Chicago, IL)	89.3	138

(US Census Bureau, 2024)

9% of community input respondents in the service area rated racism and other discrimination as a top health issue in their community.

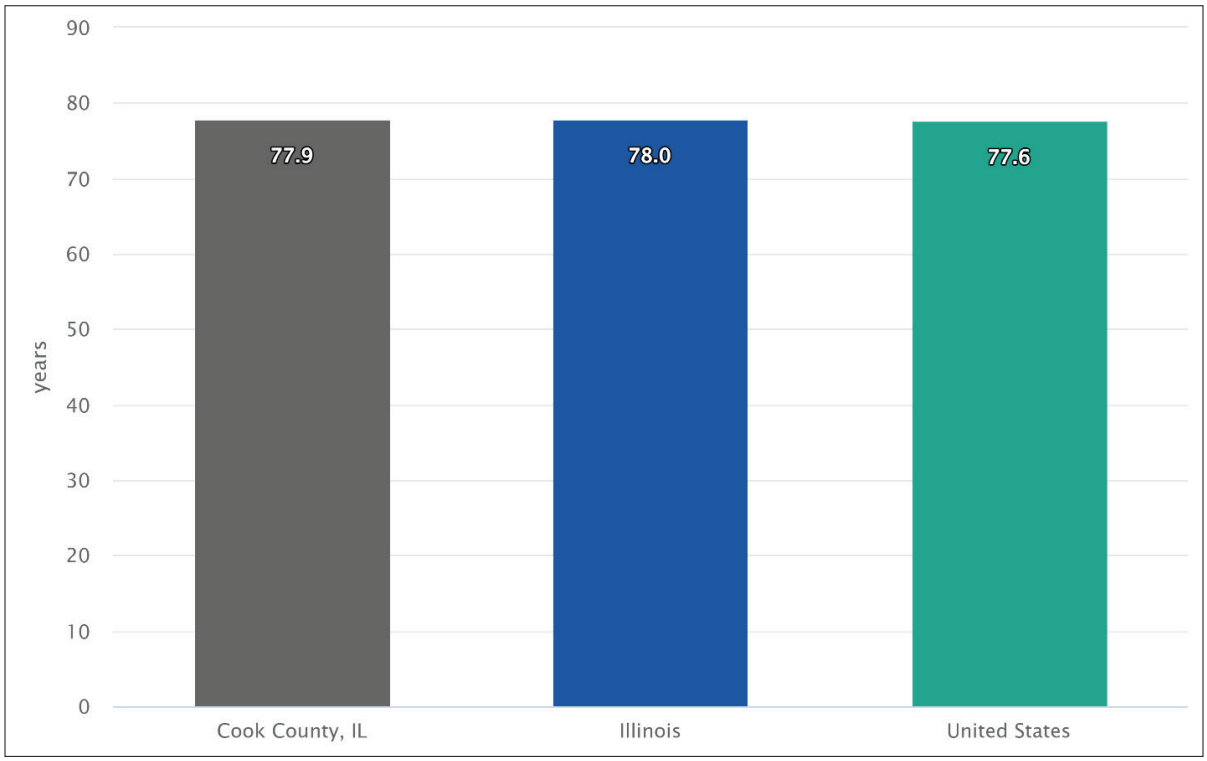
Inequities in mortality

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).

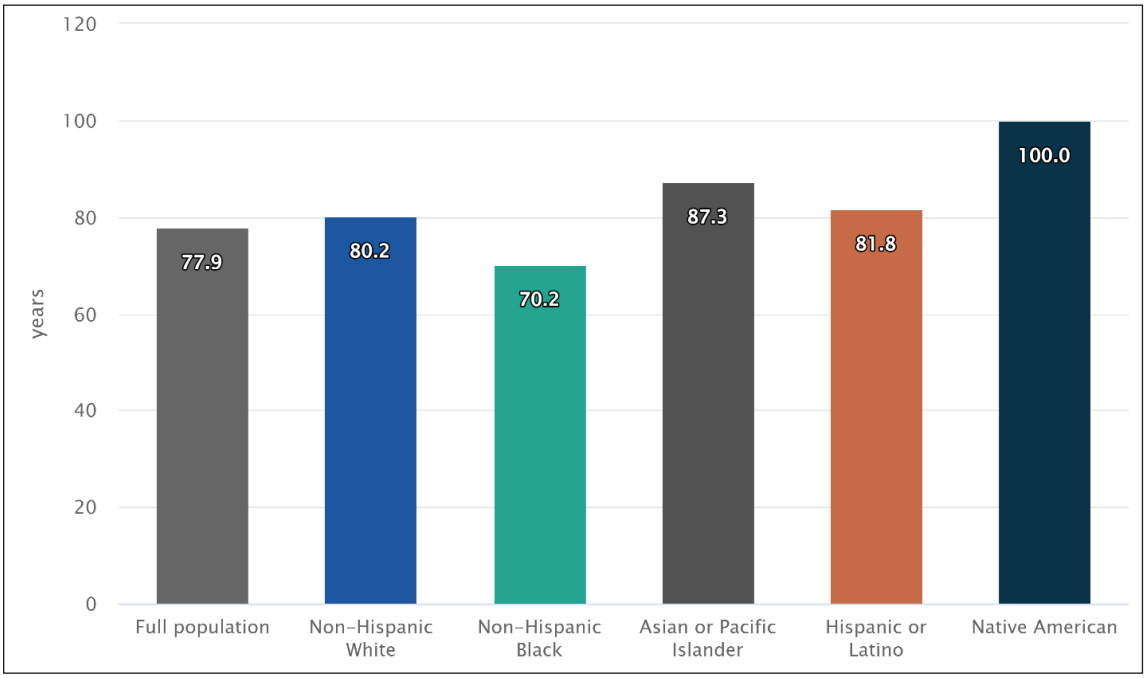
Figure 29. Chart comparing life expectancy in Cook County, Illinois, and the United States, 2019-2021



(Centers for Disease Control and Prevention, 2020a)

The average life expectancy in Cook County (77.9), state (78.0), and national (77.6) 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 while 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



(Centers for Disease Control and Prevention, 2020a)

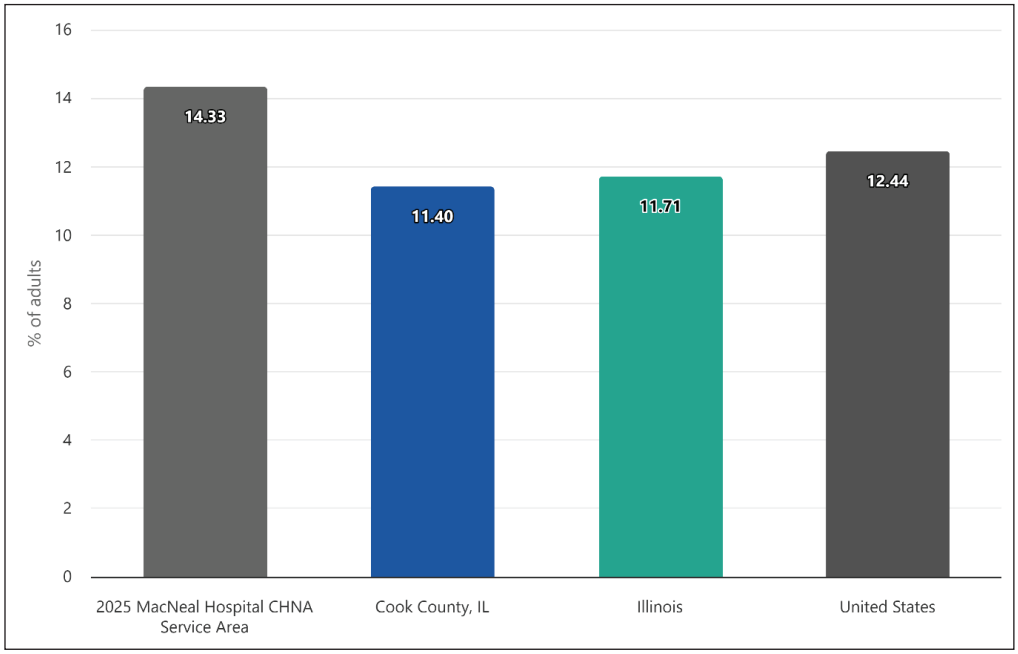
Secondary Data

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 in MacNeal Hospital's service area, Cook County, Illinois, and the United States, 2022



60% of community input survey respondents in the service area 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 MacNeal Hospital's service area are presented in Figure 32.

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

Health Behavior	Date	MacNeal Hospital 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	21%	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	27%	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 MacNeal Hospital's service area are presented in (Figure 33).

Figure 33. Rates of individuals with chronic conditions in MacNeal Hospital's service area

Health condition	Date	MacNeal Hospital Service Area	Cook County	Illinois	United States
Obesity	2022	36%	33%	34%	34%
High blood pressure	2022	30%	29%	29%	30%
Current asthma	2022	10%	9%	10%	10%
Arthritis	2022	23%	21%	23%	23%
Diagnosed diabetes	2022	13%	11%	10%	11%
Chronic obstructive pulmonary disease (COPD)	2022	6%	5%	6%	6%
Diagnosed stroke	2022	3%	3%	3%	3%
Cancer diagnosis rate	2017-2021	477.1 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%

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

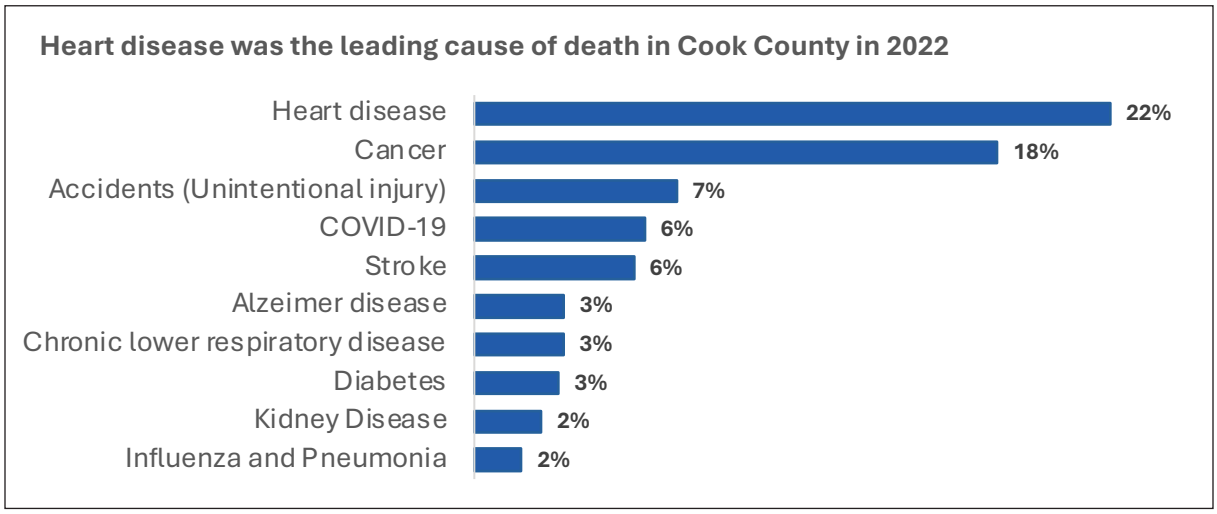
Obesity and high blood pressure (hypertension) are often interconnected risk factors for cardiovascular disease, the leading cause of death in Chicago and the United States. In MacNeal Hospital's service area, 36% of adults reported being obese and 30% reported being diagnosed with high blood pressure (Figure 33).

Diabetes and obesity 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 MacNeal Hospital's service area have some of Chicago's highest rates of heart disease and cancer mortality.

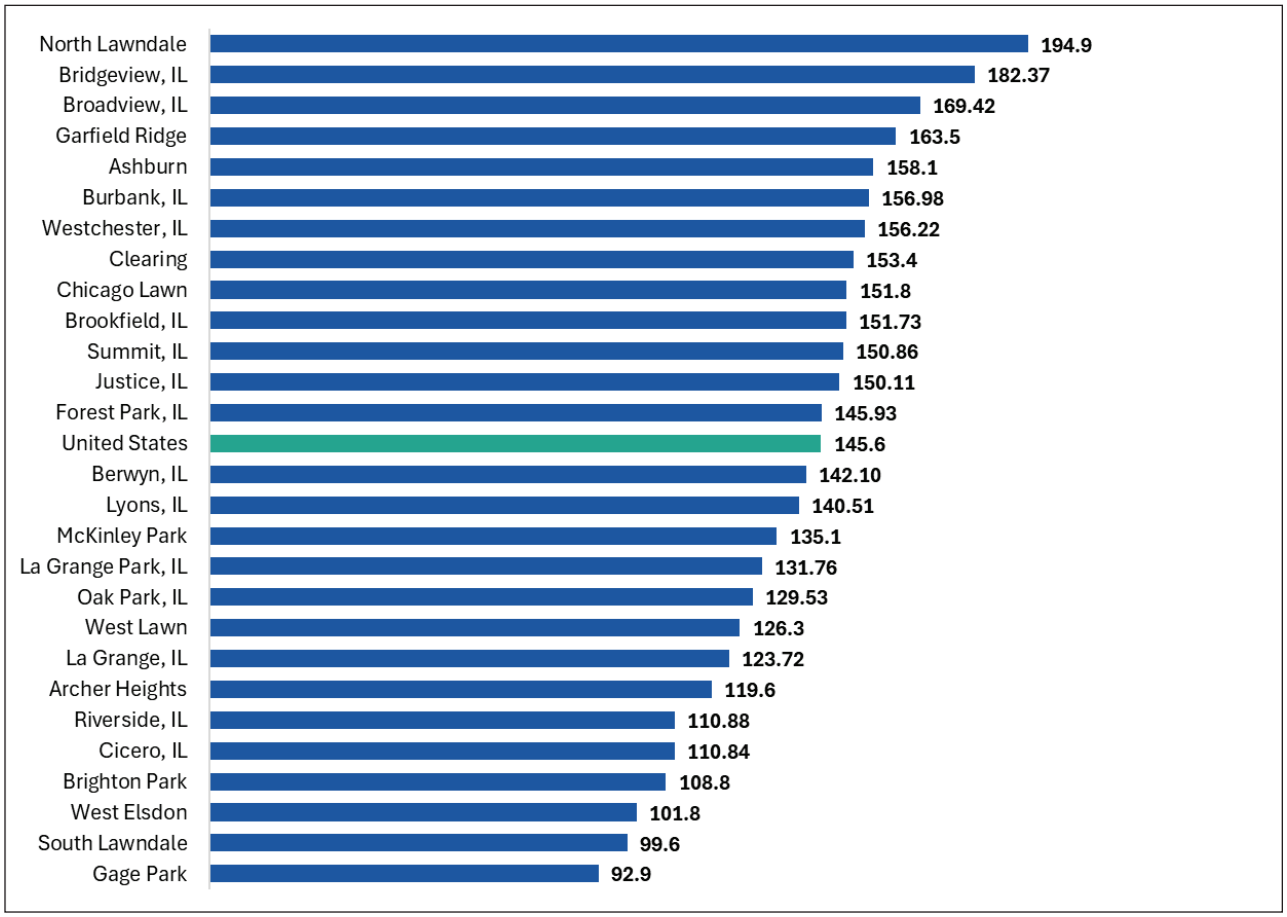
Figure 34. Leading causes of death in Cook County, Illinois, 2022



(Illinois Department of Public Health, 2024)

Some focus group participants noted that preventive screenings and education on cardiovascular health were not widely accessible. Participants described delayed or inaccessible emergency care for acute events like heart attacks.

Figure 35. Cancer mortality rates (per 100,000 population) between communities in the MacNeal Hospital service area and the national rate, 2018-2022



(Illinois Department of Public Health, 2024)

Globally people of African descent have an increased risk of cancer malignancies compared to whites and Asians. Differences in socioeconomic status and health care access play a key role.

(Özdemir & Dotto, 2017)

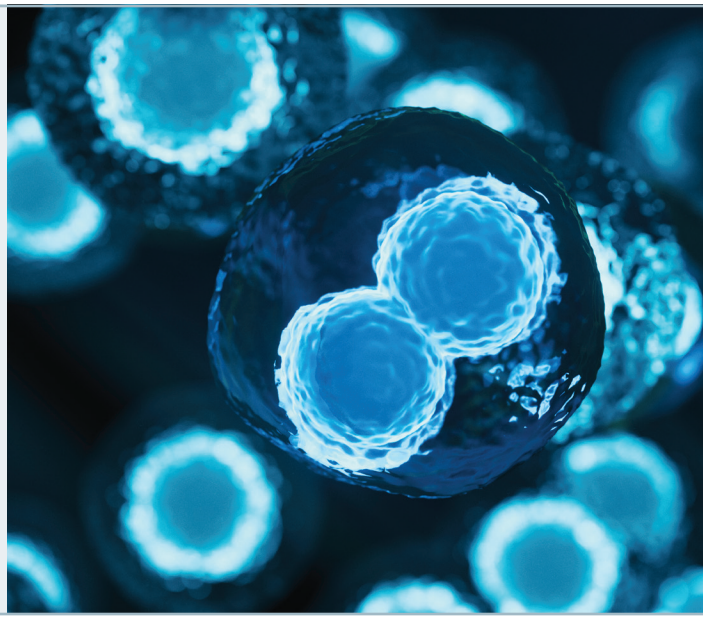
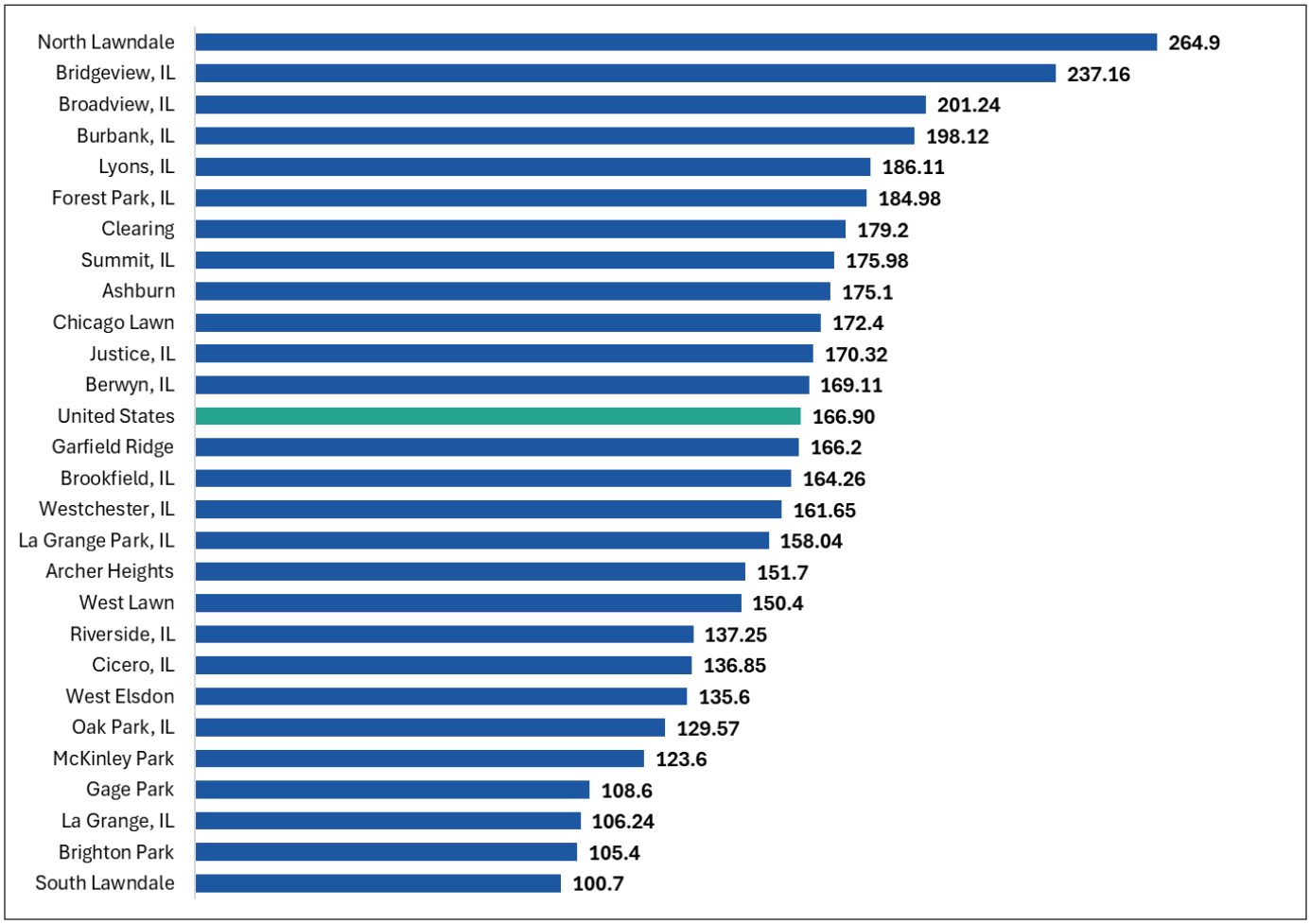


Figure 36. Chart comparing heart disease mortality rates (per 100,000 population) between communities in the MacNeal Hospital service area and the national rate, 2018-2022



Source: (Illinois Department of Public Health, 2024)

Maternal and child health

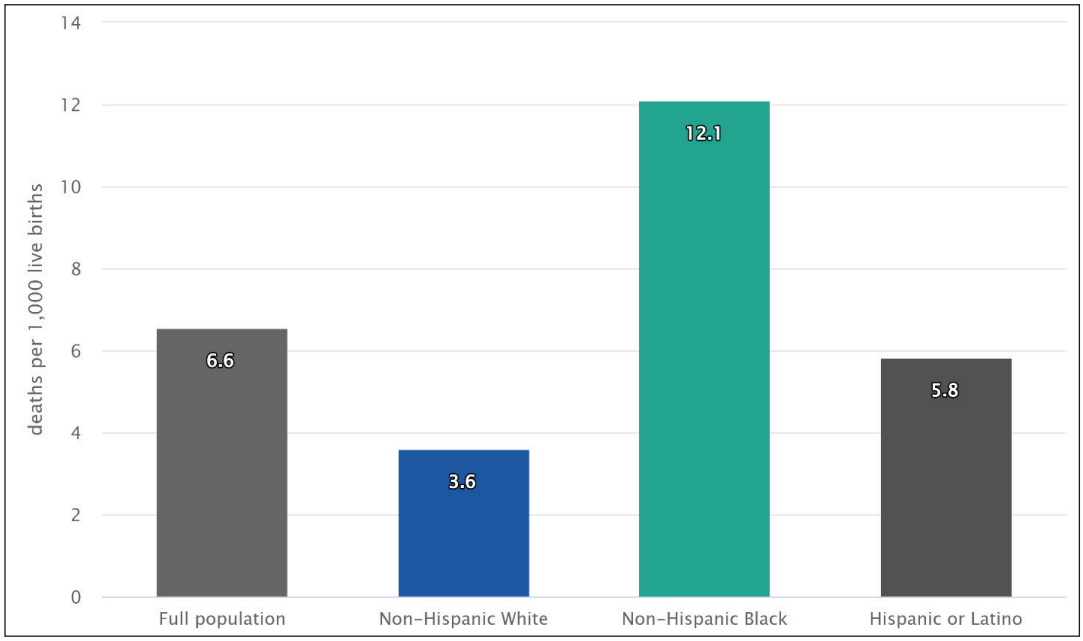
Maternal health is defined as the health of women during pregnancy, childbirth, and in the postpartum period (Bennet et al., 2023). This period is a critical time for women's health since they typically have more interaction with and access to health care services (Bennet et al., 2023). In addition, 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. 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).

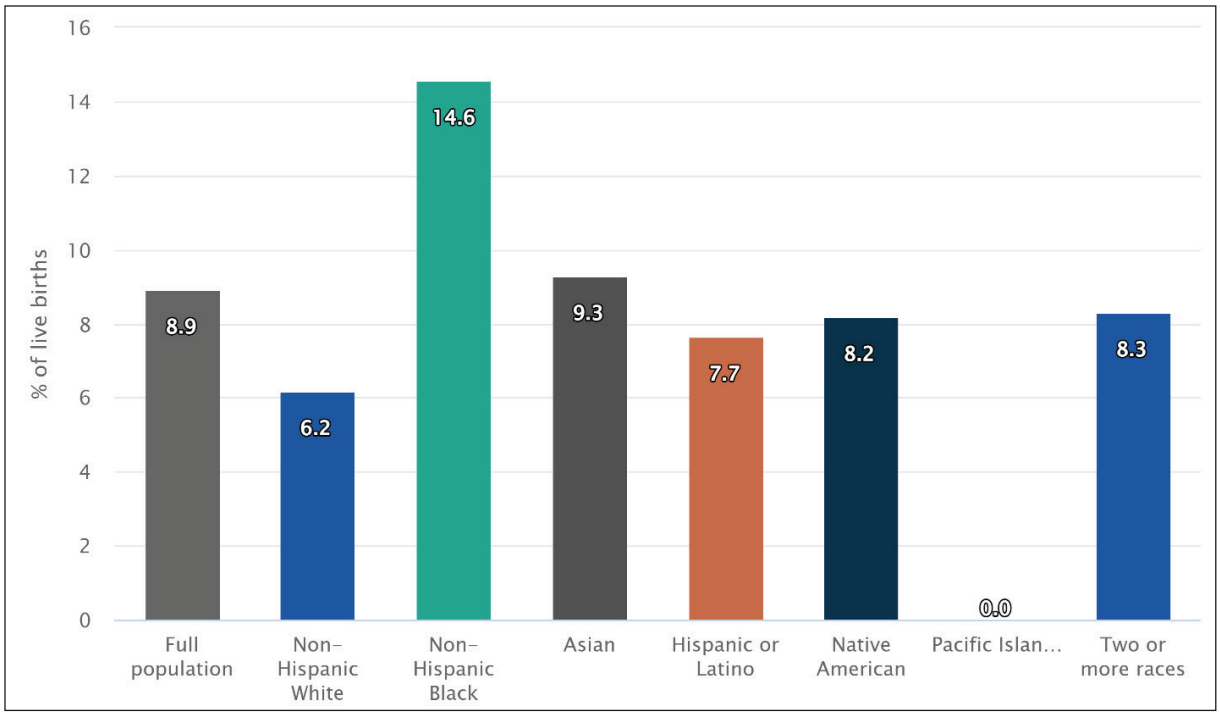
The infant mortality rate in Cook County (6.6 per 1,000 live births) is comparable to the state and national rates (Centers for Disease Control and Prevention, 2020b). Within the county, there are inequities between different racial and ethnic groups. Infant mortality rates for Non-Hispanic Black infants (12.1) are more than double that of Hispanic or Latino infants (5.8 per 1,000 lives births) and three times that of Non-Hispanic white infants (3.6 per 1,000 live births) (Figure 37). 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 38, Figure 39).

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



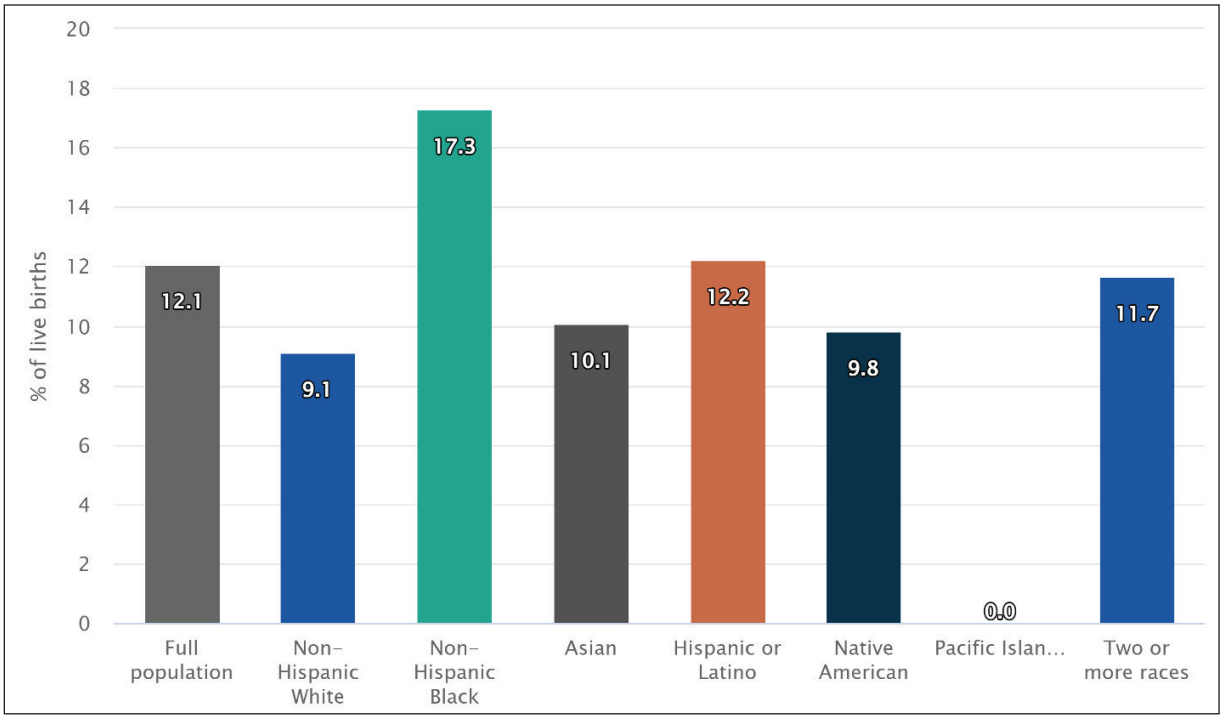
(Illinois Department of Public Health, 2024)

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



(Centers for Disease Control and Prevention, 2020b)

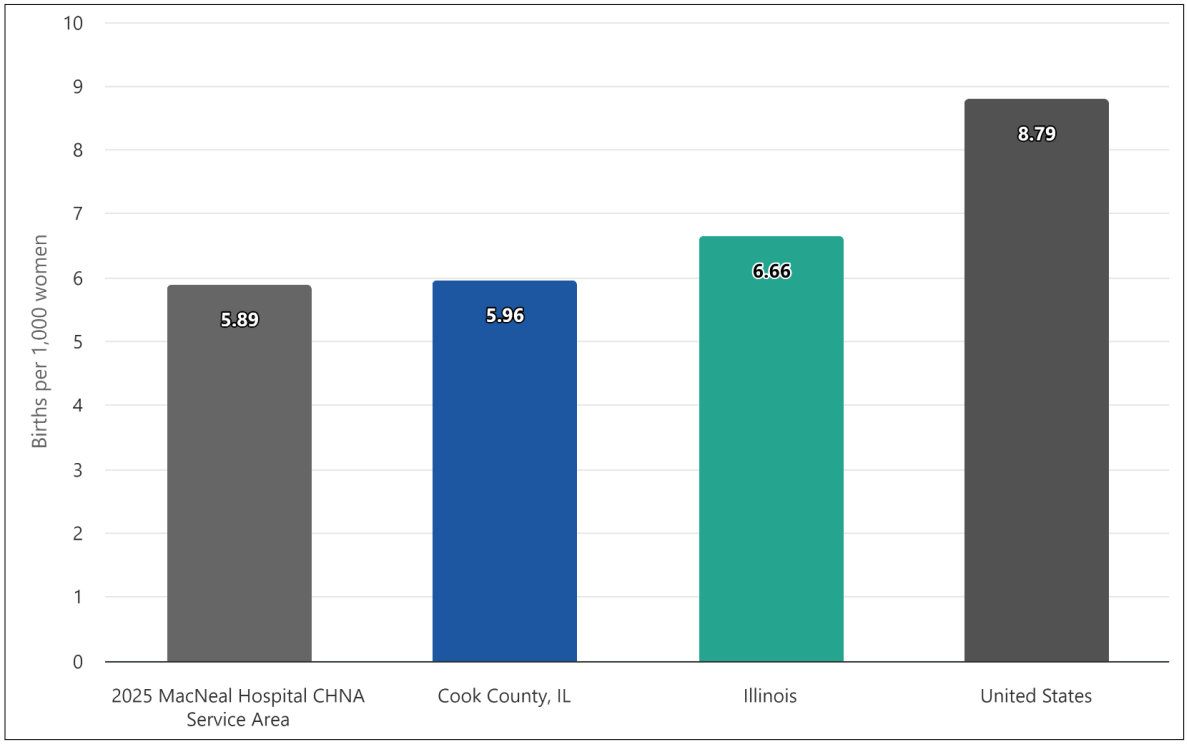
Figure 39. Preterm birth rates by race and ethnicity in Cook County, 2018-2022



(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 MacNeal Hospital's service area is 5.9 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 MacNeal Hospital's service area, Cook County, Illinois, and the United States, 2019-2023

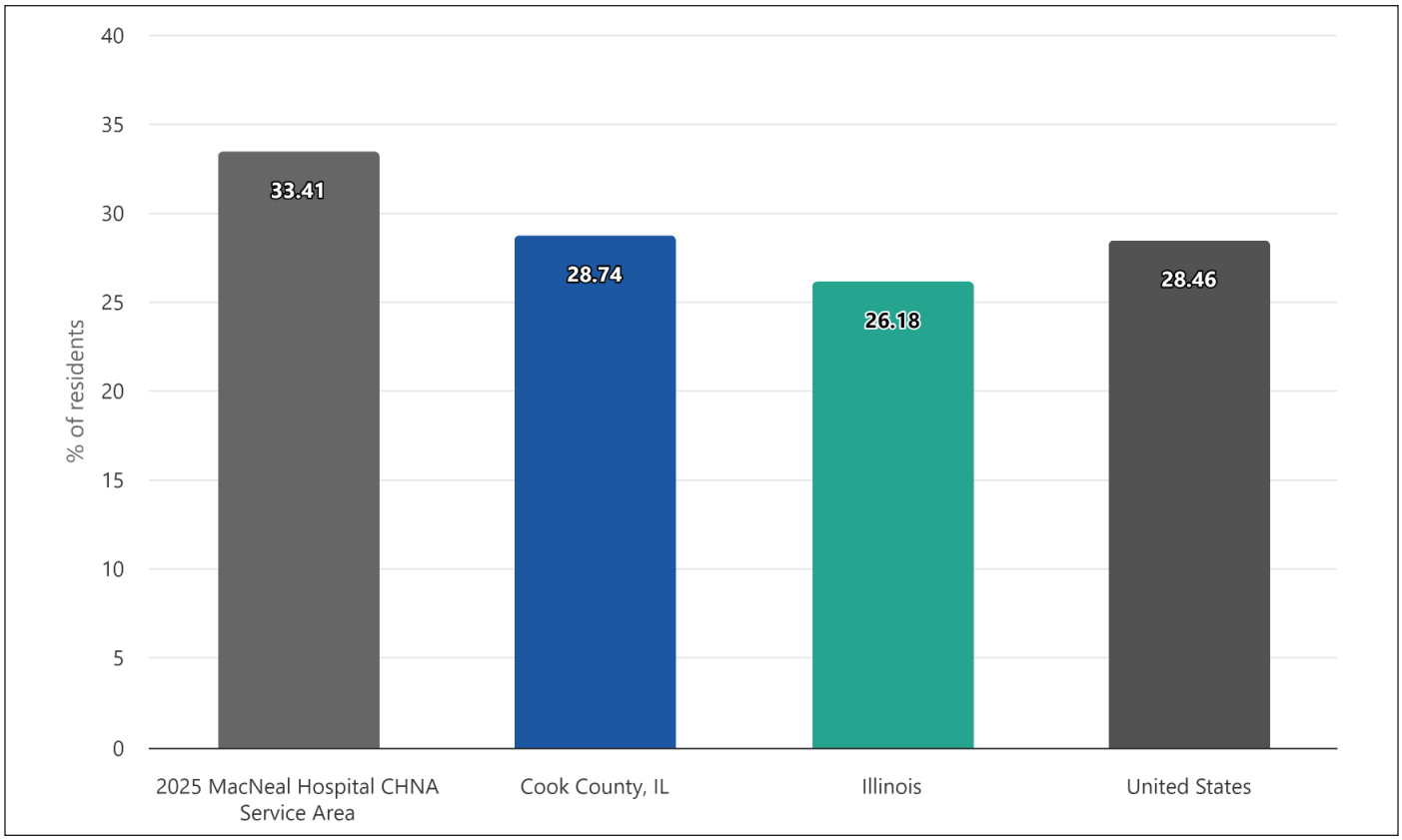


Social Determinates of Health

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 MacNeal Hospital'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 MacNeal Hospital'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 40% (US Census Bureau, 2024).

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



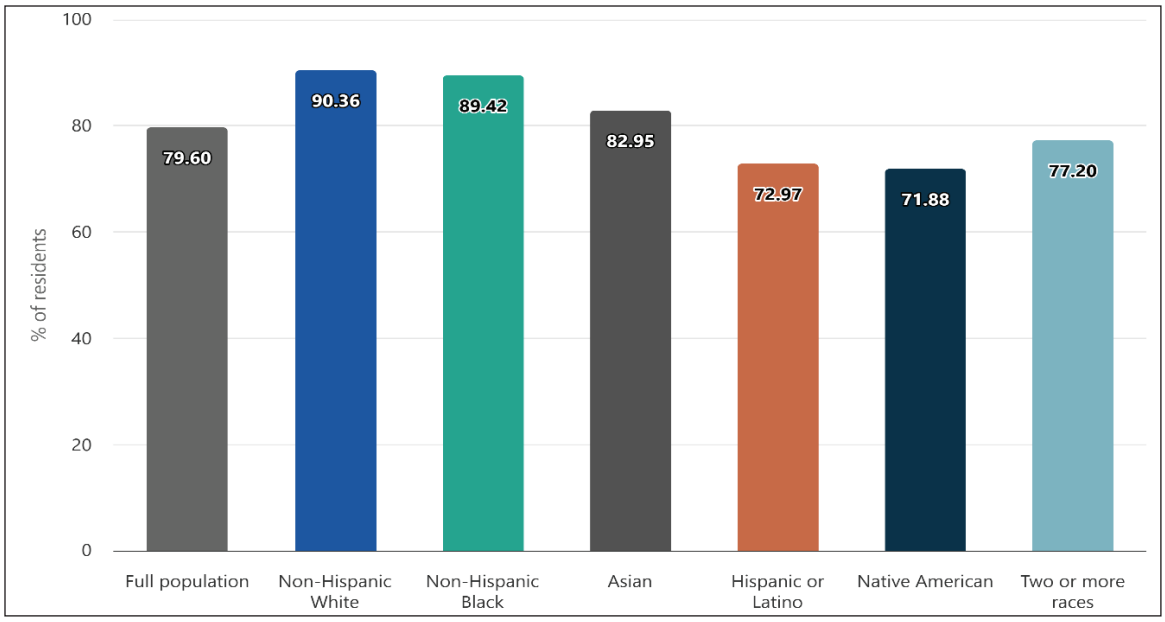
(US Census Bureau, 2024)

Focus group participants described how many families struggle to afford basic necessities, including food, housing, and healthcare. This economic strain exacerbates health inequities.

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 MacNeal Hospital's service area (80%) 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 MacNeal Hospital's service area, 2019-2023



(US Census Bureau, 2024)

Focus group participants explained that lower levels of education were linked to reduced job opportunities, lower incomes, and poorer health outcomes.

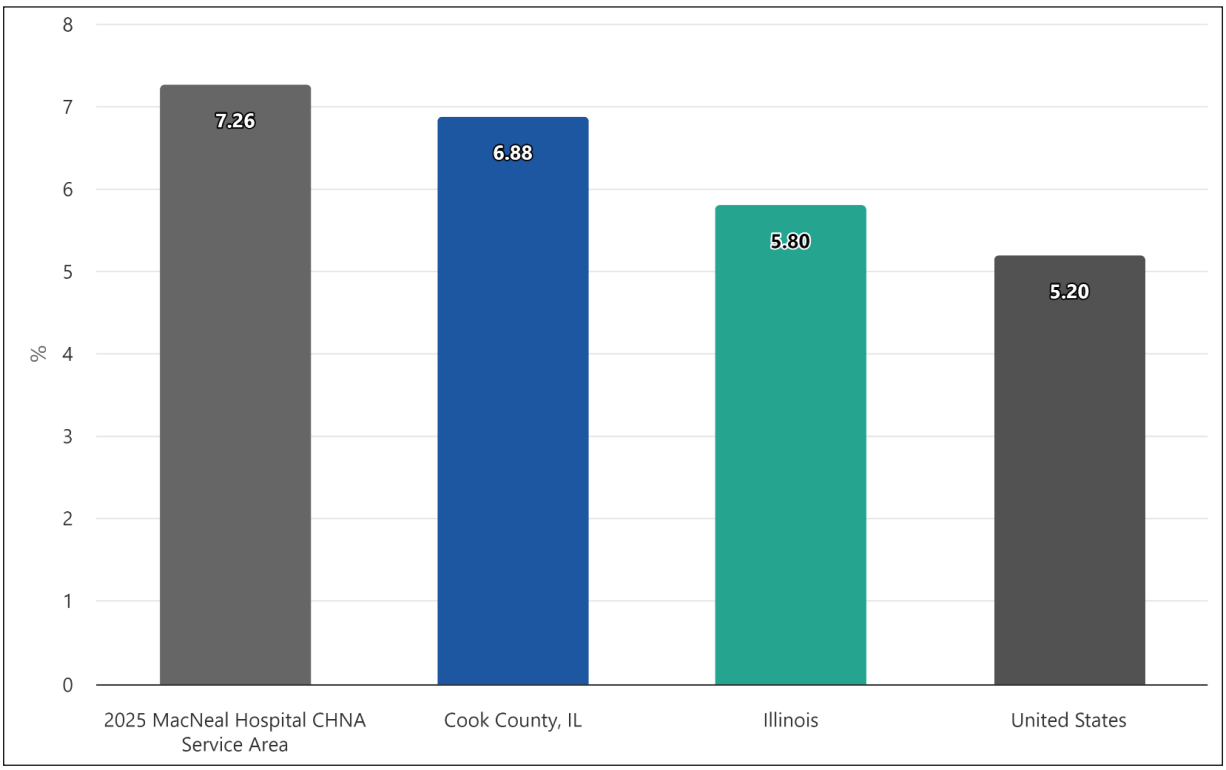
A lack of health education in schools was also noted as a missed opportunity for early prevention and awareness.

Participants noted a lack of access to education and vocational training as a barrier to securing higher-paying jobs.

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 higher than the county, state, and nation (Figure 43). Within the service area, unemployment rates vary widely, with more than a 7% difference between the zip codes with the highest (10.5%) and lowest (3.1%) unemployment (Figure 43).

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



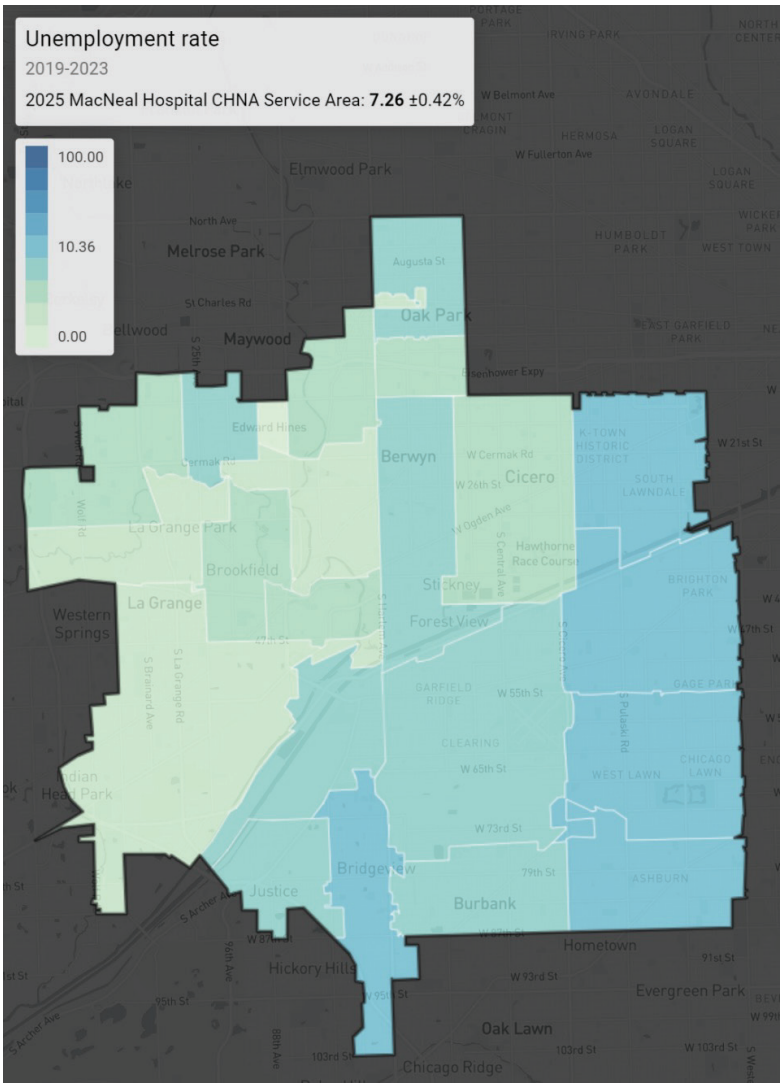
(US Census Bureau, 2024)

Focus group participants highlighted a lack of jobs offering health insurance or benefits.

A lack of flexible work schedules prevents individuals from attending medical appointments or focusing on preventative care.

Many participants stated that low wages make it difficult to afford healthcare, healthy food, and stable housing. Some participants described how working multiple jobs to make ends meet exacerbates stress. Individuals with criminal records face significant obstacles to obtaining stable employment.

Figure 44. Map of unemployment rates in the MacNeal Hospital 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.

> *I find that there's a big problem if you've been out of the workforce for a while to get back into it.*
>
> *– NAMI Metro Suburban focus group participant*

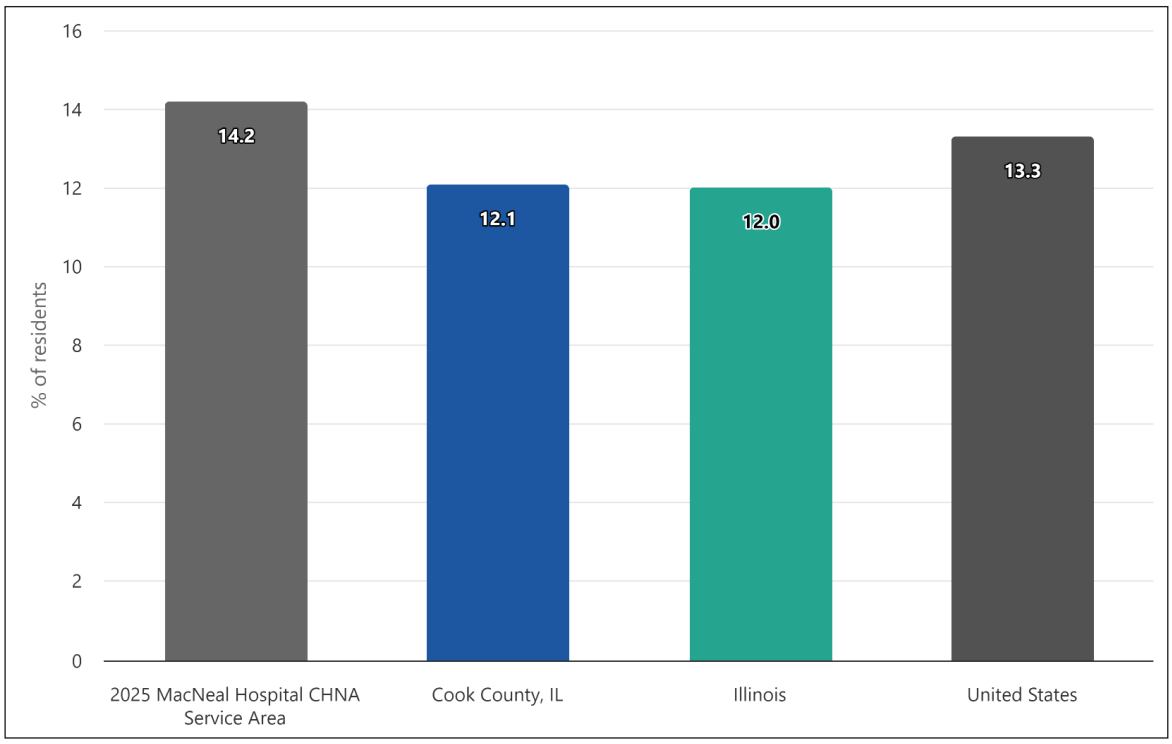
Food access and food security

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*

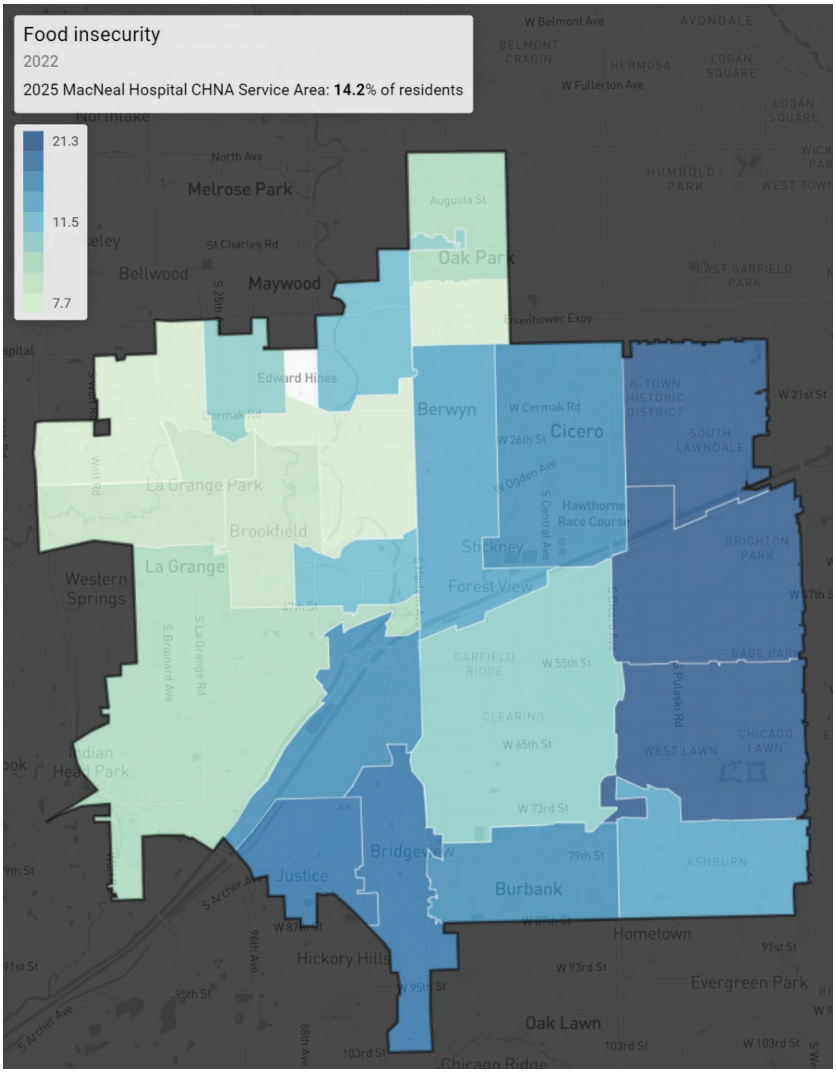
Food insecurity in the MacNeal Hospital service area (14.2%) is comparable to the rate for the nation (13.3%) and slightly higher than the county (12.1%) and state (12.0%) (Figure 45). However, as with other indicators, food access varies widely within the service area. Westchester has the lowest percentage of food insecure residents (7.7%) and North and South Lawndale, Chicago, which has the highest percentage (21.3%) (Figure 46).

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



(Feeding America, 2022)

Figure 46. Map of food insecurity in MacNeal Hospital's service area, 2022



(Feeding America, 2022)

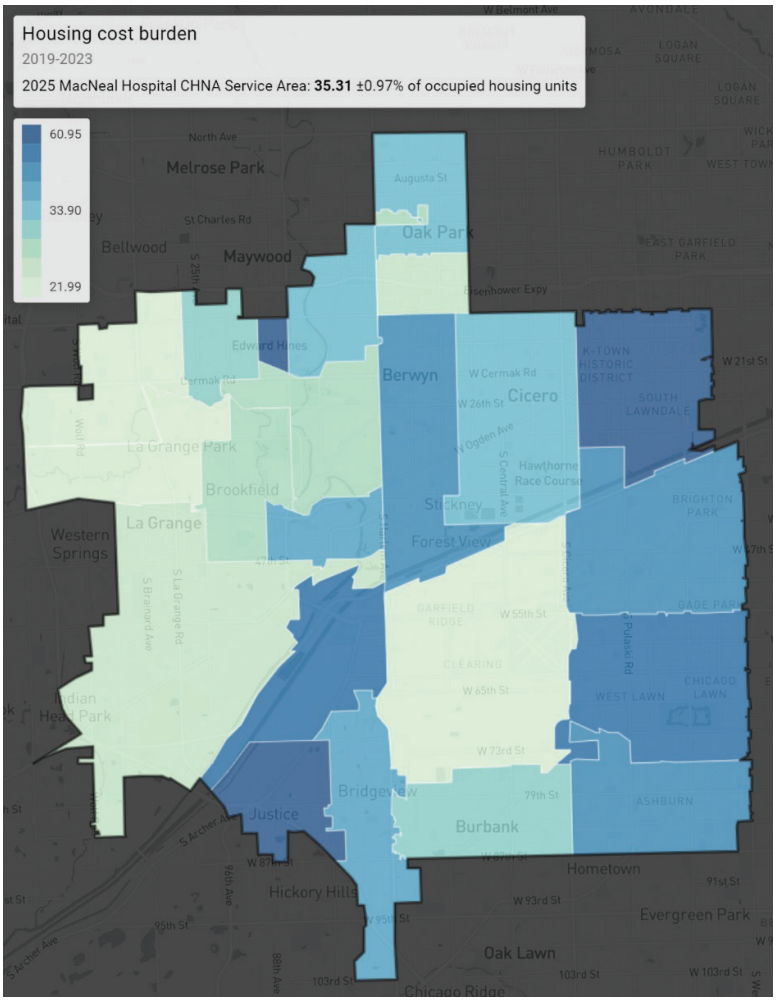
Housing

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 MacNeal Hospital's service area are considered housing cost burdened, meaning they spend more than 30% of their income on housing costs. North and South Lawndale, Chicago (47%), and Justice (41%) 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 MacNeal Hospital's service area, 2019-2023



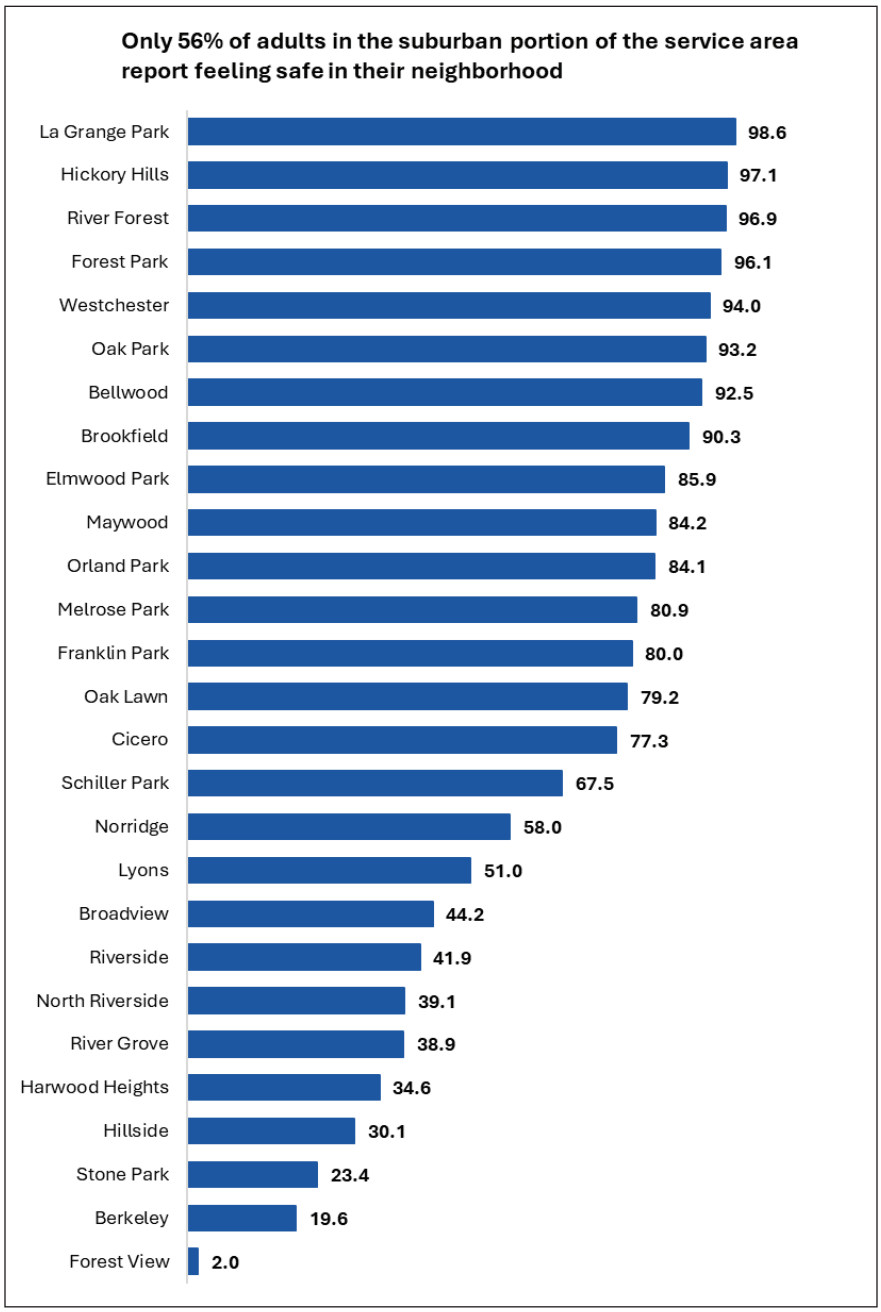
(US Census Bureau, 2024)

Housing resources was the third highest ranked health need *by community input survey respondents in the service area.*

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 suburban portion of MacNeal Hospital's service area only 56% of the population reports feeling safe in their neighborhood "all of the time" or "most of the time" and in some communities, it is less than 2% (Figure 48).

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



Source: (Cook County Department of Public Health, 2023)

52% of community input respondents in the service area reported that 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

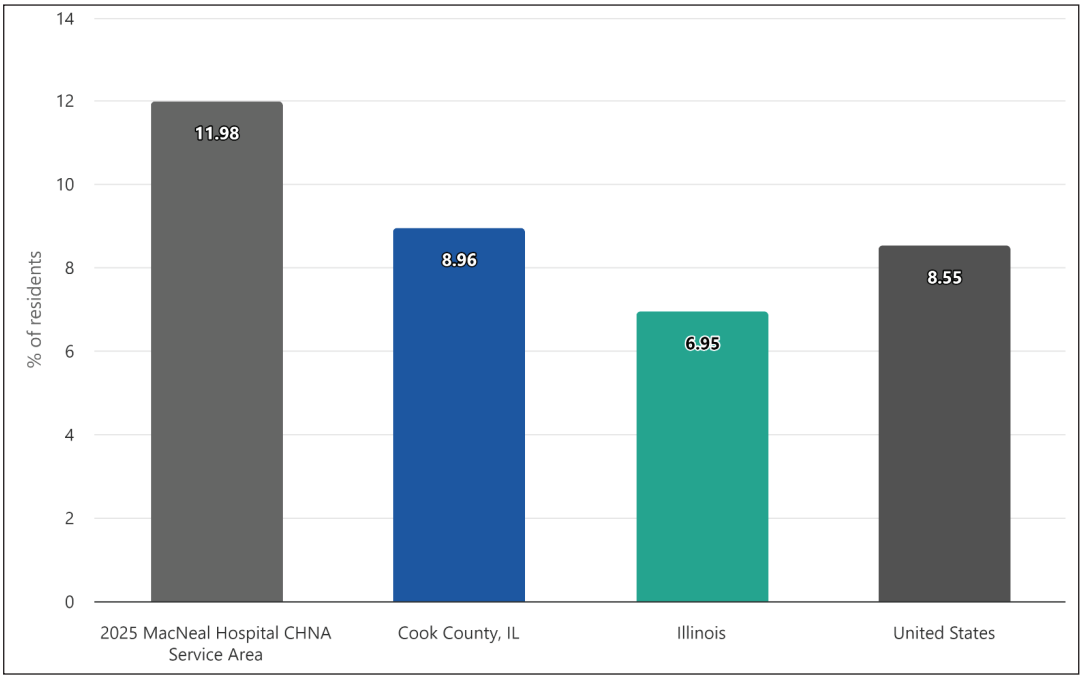
Focus group participants described how high rates of violence in some neighborhoods contribute to chronic stress and limit outdoor physical activity or social engagement.

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.

The rate of uninsured residents in the service area (12%) is higher than the uninsured rate for the county (9%), state (7%), and country (9%) (Figure 50). Within the service area, Cicero has the highest uninsured rate at 19% followed by North and South Lawndale, Chicago (18%) and West Lawn/ Chicago Lawn, Chicago (16%) (Figure 51).

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



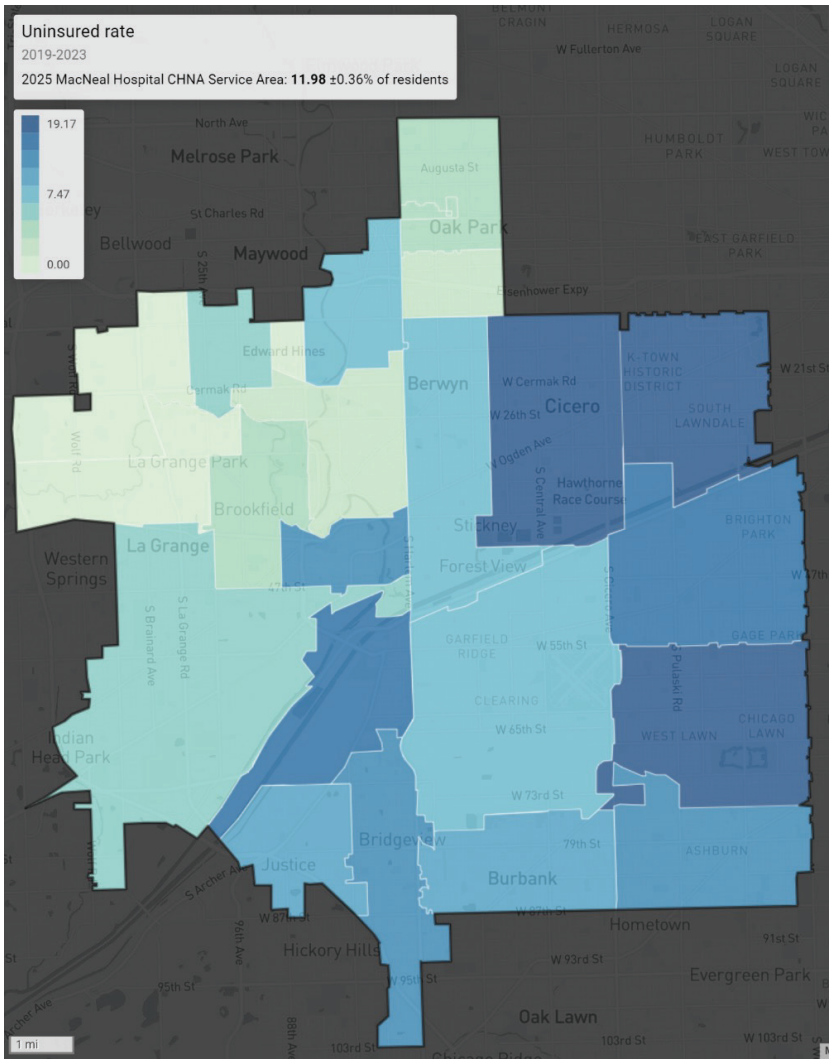
(US Census Bureau, 2024)

The expense of medical visits, treatments, and medications was frequently cited as a primary obstacle to care by focus group participants. Several participants reported being uninsured or underinsured, leading to delayed care or avoidance of medical services altogether.

Co-pays, deductibles, and non-covered services added to the financial strain, particularly for low-income families.

Some participants reported a lack of available doctors accepting Medicaid or offering sliding scale fees.

Figure 51. Map of the uninsured rate in the MacNeal Hospital service area, 2019-2023



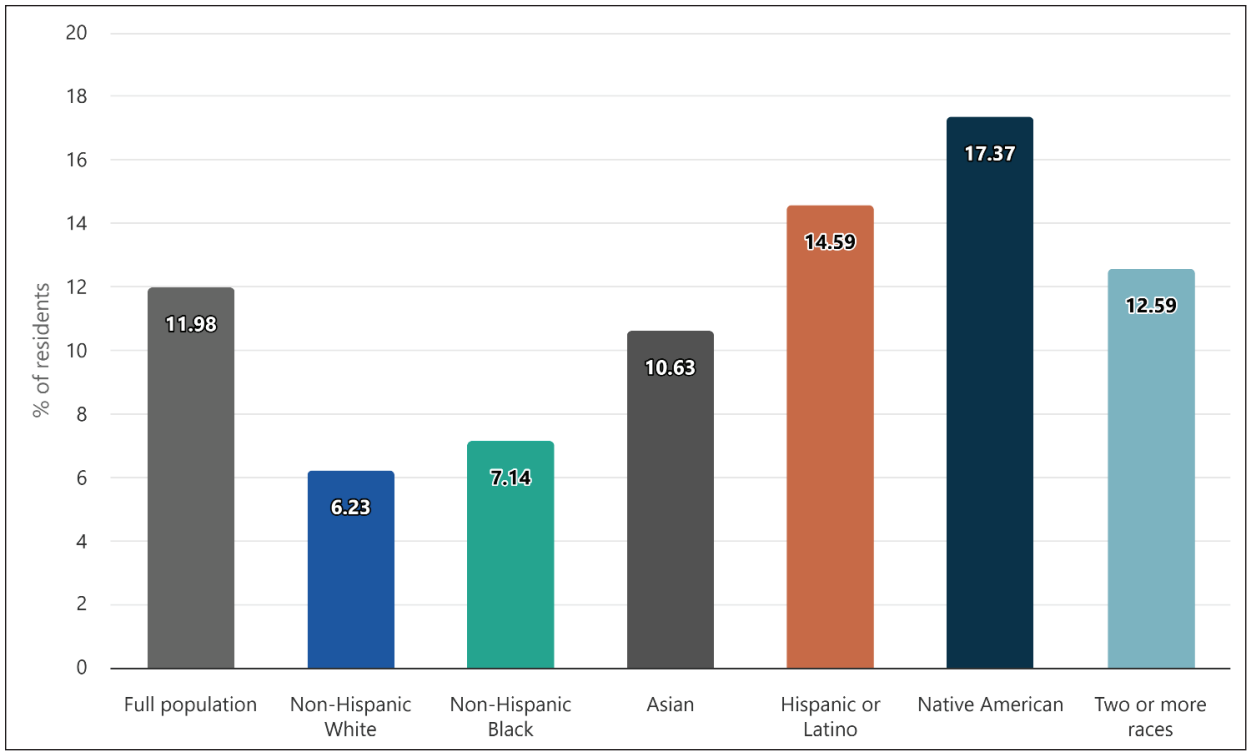
(US Census Bureau, 2024)

Focus group participants described how the complexity of navigating healthcare systems, including scheduling, paperwork, and insurance processes, discouraged individuals from seeking care. Immigrants and undocumented individuals faced additional hurdles due to legal and identification requirements.

In addition to geographic inequities in insurance coverage, there are racial and ethnic inequities in uninsured rates as well. In MacNeal Hospital's service area, Native Americans (17%) have the highest uninsured rate followed by Hispanic Latinos (15%) and two or more races (13%) (Figure 52). Non-Hispanic Whites (6%) and Non-Hispanic Black (7%) 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 MacNeal 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)

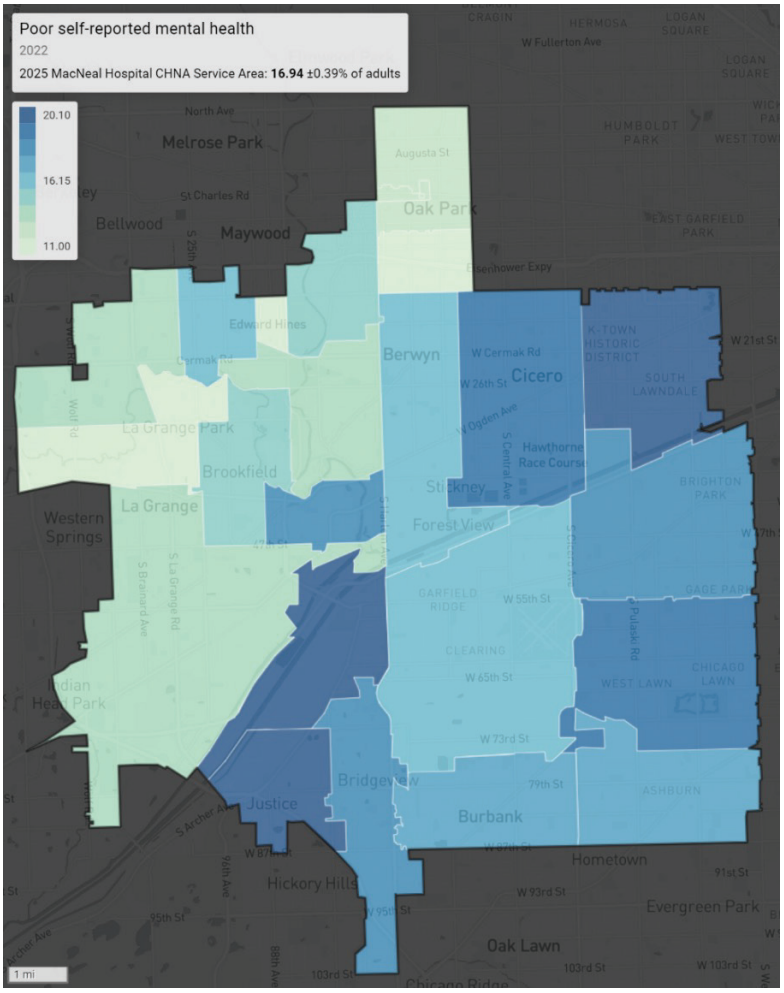
Mental health and substance use disorders

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 MacNeal Hospital'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 17% 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 North and South Lawndale, Chicago (20%) 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 MacNeal Hospital 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.***

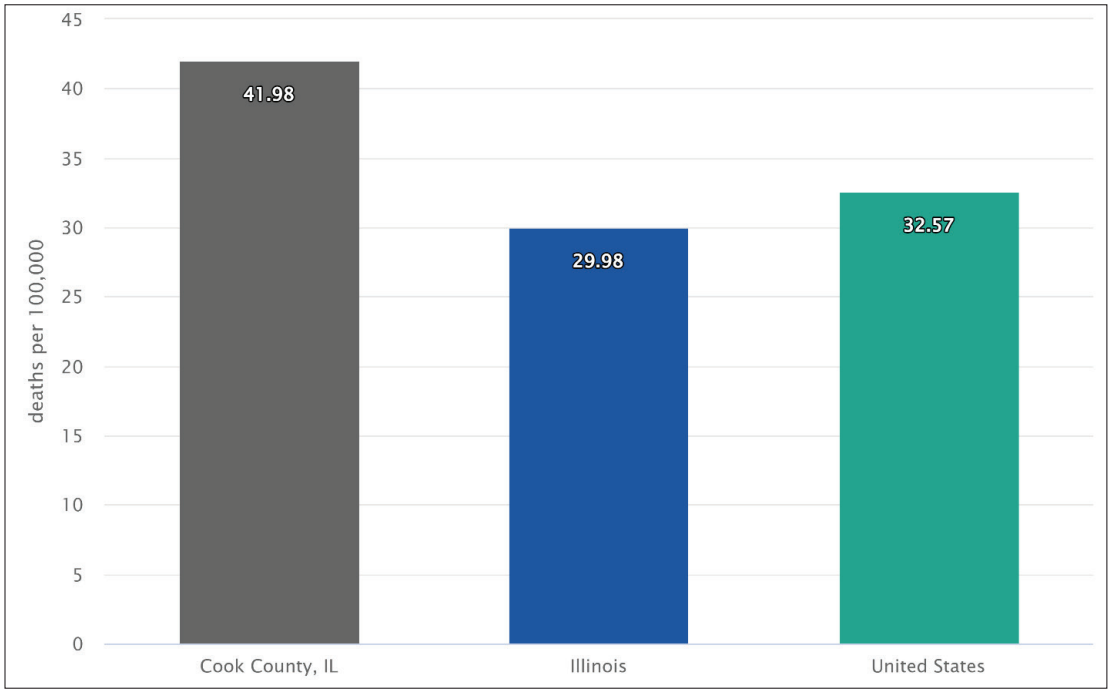
Drug and alcohol use

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*

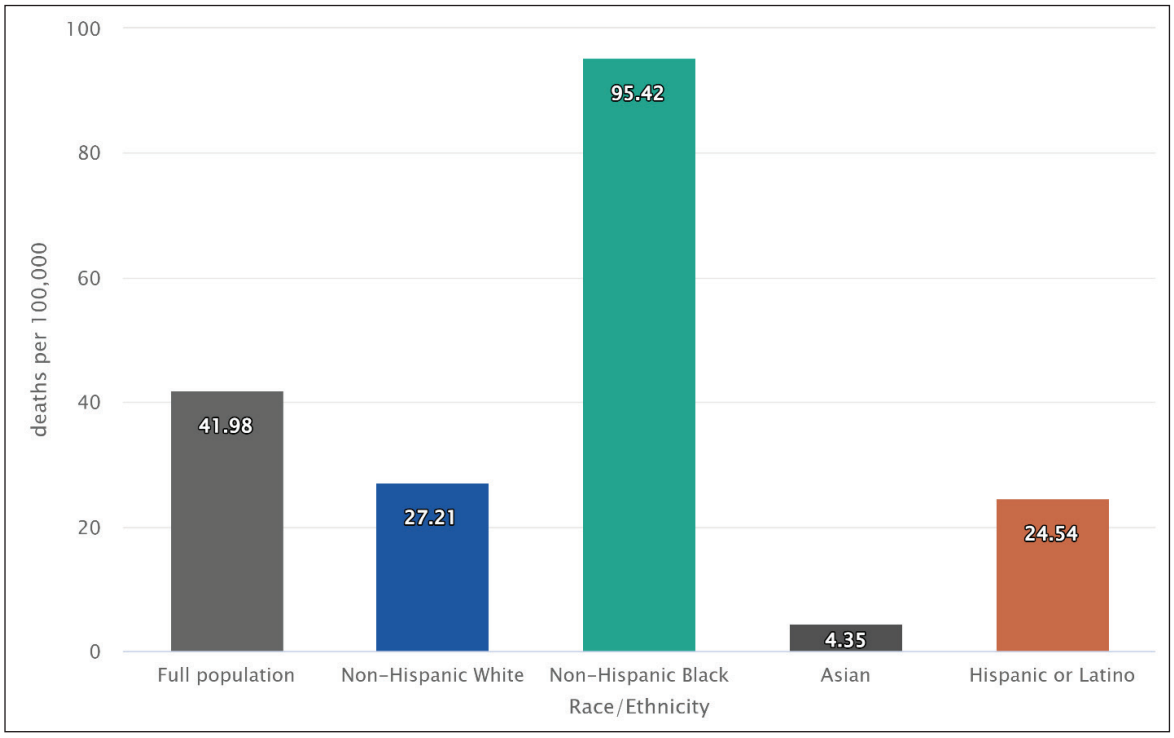
Cook County has a higher rate of drug overdose mortality (42%) than both Illinois (30%) and the United States (33%) (Figure 54). As previously stated, the COVID-19 pandemic disproportionately affected Black communities. In 2022, the drug overdose mortality rate for Non-Hispanic Black residents (95.4)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



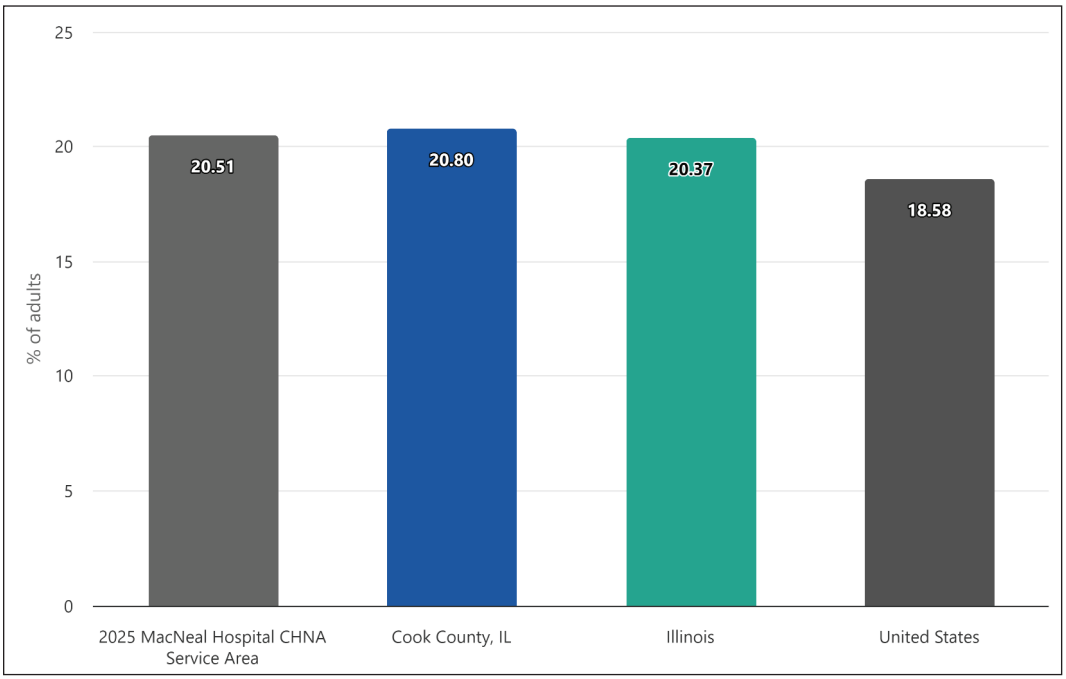
(Centers for Disease Control and Prevention, 2020a)

Substance use, particularly alcohol, opioids, and recreational drugs, was identified as a growing concern in many neighborhoods. Focus group participants connected substance use to stress, unemployment, and lack of access to mental health resources.

In addition, participants raised concerns about increasing substance use among young people, driven by peer pressure, lack of recreational activities, and exposure to trauma.

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 (21%) 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 MacNeal Hospital 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

(Illinois Department of Public Health, 2022)

Substance use was ranked as the fourth most significant health issue *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 improve mental health, MacNeal Hospital (MNH) 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.

Additionally, MNH's Trauma and Sexual Assault Nurse Examiner (SANE) clinical coordinator facilitated free community trainings to empower bystanders to help in a bleeding emergency before professional medical help arrives. Trainings were facilitated in both English and Spanish.

In FY25, MNH partnered with Youth Crossroads, a non-profit community-based organization whose mission is to act in the best interest of youth, guiding them through life's challenges, and inspiring them to discover new opportunities for personal development, healthy relationships, and positive community involvement, to offer a conference for youth serving individuals and educators focused on trauma-informed care. The Building Future Success in Youth Conference had 92 attendees, and 18 individuals were able to apply for CEU's. 100% of those surveyed indicated that the overall content was appropriate to their level of training and that the information learned could be applied to their practice or work. 97% felt the teaching methods were effective and the visual aids, handouts and oral presentations clarified content. Approximately 95% felt that presenters were knowledgeable on the subject matter presented, the material was effective, and the presenters answered questions effectively and were responsive to questions, comments and opinions.

MNH continued to increase social connectedness and build trust among vulnerable populations and in communities of color by hosting a local chapter of Walk with a Doc, an international 501(c3) non-profit organization. Led by physicians and residents from MacNeal's Family Medicine Clinic, this free walking program fosters relationship and trust between providers and community members and increases health awareness. During the past 3 years, over 250 community members engaged in at least one of 15 monthly opportunities offered. Thanks to community collaboration an indoor

MacNeal Hospital 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.

space was secured for use when weather was unfavorable, thereby increasing the regularity of connection.

MNH participated in health care advocacy on behalf of the communities served. Efforts included policy change on COVID-19 response, improved public health infrastructure, expanded access to care, lengthened maternal health coverage, enhanced mental and behavioral health support, amplified efforts to curb gun violence, and secured additional resources to address homelessness. It included state legislator discussions in collaboration with our lobbyists and the Illinois Hospital Association.

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 are awaiting certification due to changing state standards, which have been in the works for 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 MNH Surplus Project was established in March 2021 to provide nutritional health and eliminate food insecurity and waste by distribution of surplus food from the hospital cafeteria to create food access and address food insecurity. Over the past 3 years, the hospital cafeteria's food surplus project partnered with Housing Forward to deliver over 4,000 meals to a local homeless organization, Sojourner House medical respite facility.

MNH continued to address housing insecurity through its collaboration with housing partner Housing Forward who offers transitional housing to those in need. MacNeal Hospital physicians provided free medical care for an average of 17 patients and 10 households annually who were experiencing homelessness and in need of medical respite care at Sojourner House. Additionally, The Medical Respite Committee, consisting of MNH leadership and external partners addressing homelessness, continued to meet monthly to discuss patient updates regarding physical and psychological needs/barriers, transitional housing opportunities for the patients, and growth and funding opportunities.

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.

MacNeal Hospital (MNH) 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 were the most pressing, under-addressed and within its ability to influence. MNH did not address the following health needs:

Community Communication and Leader Engagement – MNH did not directly address this need because our community stakeholder feedback did not indicate it was the most urgently needed. MNH leadership and staff currently participate in community coalitions, including board appointment with the Berwyn Development Corporation, and community events within the MNH service area and will continue to participate in these efforts.

Access to Health Care – MNH did not directly address this need because stakeholders did not determine this was the most urgently needed. MNH continues their commitment to serving uninsured and underinsured patients by providing Enrollment Assistance and through the Access to Care Clinic.

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.

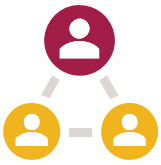
Initial meetings to discuss the primary data collection results allowed for open discussion on a number of priority areas. Many of the initial priority areas contained several of the same underlying health concerns.

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 challenges sited included the prevalence of chronic stress, stigma, and treatment barriers. 28% of survey respondents reported adult mental health as an issue and 16% 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 MacNeal 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, youth substance use, co-occurrence with mental health conditions, and criminalization being a harmful approach to recovery. 21% of survey participants indicated this was one of the biggest health issues within their community.

Increasing activities for teens and youth (the top health need recorded among 25% of survey respondents) was measured as potential solution to improving mental health and reducing substance-use and misuse in the communities within the MacNeal service area.



Access to Community Resources - Survey respondents identified the following resources as needed in their communities: activities for teens & youth (25%), housing resources (20%), and resources for food (18%). Focus groups participants highlighted essential support such as utility bill assistance, farmers' markets and food pantries, local support groups and recovery programs for overcoming addiction, housing-focused initiatives, positive health behaviors and wellness programs for those of all ages. Transportation and walkability also emerged as a significant resource in community health and well-being.

Chronic Conditions - Chronic conditions like diabetes, heart disease, asthma, and obesity, 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. 20% of survey respondents identified diabetes as a top health issue in their community and 21% identified obesity. Some participants mentioned staying up to date with doctor visits and preventive screenings as part of their routine; a privilege that helped them remain healthy. Ensuring children and adults in their households were vaccinated was also highlighted as an important protective measure.

Access to Healthcare - Participants in the focus groups highlighted several interconnected challenges related to healthcare access. Lack of cultural competency in healthcare services including lack of multilingual services, insensitive or judgmental attitudes, exclusion of marginalized groups and under-representation in the health care workforce were specifically cited as barriers to equitable access. Additionally, financial barriers, geographic and transportation barriers, long wait times, difficulties navigating healthcare, and technology were cited as barriers to access for the general community. Particular concern was raised for child and adolescent health warranting it be it's own focus area.

Child and Adolescent Health - Participants raised specific concern for child and adolescent health needs. Challenges raised included limited availability of services, financial barriers, mental health concerns, substance use, food security, lack of physical activity, housing, community violence, sexual and reproductive health, school environments, and the need for youth-friendly services. The need for positive health behaviors and wellness programs was cited as a critical need to maintain the health and well-being of youth in the community among focus group participants; this was further reinforced by the 25% of survey respondents identifying a need for activities for youth and teens.

Community Safety - Participants raised numerous concerns about community safety, describing its multifaceted impact on health, well-being, and quality of life. 18% of survey respondents reported property crime as the biggest health issue in the MacNeal service area and 23% of survey respondents identified the need for safety and low crime in order for their community to be healthy. Participants viewed safety as a combination of low crime rates, strong community ties, and accessible public spaces. Many participants highlighted the ability to walk freely and engage in outdoor activities without fear as a significant asset. Some participants mentioned that a visible police presence contributes to a sense of security, particularly in public spaces. However, in some focus groups, participants shared feelings of mistrust toward law enforcement, which can undermine the effectiveness of safety measures. Well-lit streets and public spaces were seen as critical for encouraging outdoor activities and fostering community interactions. Conversely, poorly maintained infrastructure, such as broken sidewalks, abandoned properties, and inadequate lighting, were seen as contributing to safety concerns. Additionally, investing in youth programs and recreational spaces was seen as a preventive measure against crime.

The committee recognizes that the social influencers of health play a significant role in the health needs identified as priorities. Focus groups discussions included the influence of economic stability, employment barriers, educational attainment, poor food access, housing insecurity, environmental hazards, community safety, limited public transport, and systemic racism. Consideration of these issues and 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 MacNeal Hospital Focus Group Input

Fifteen focus groups were conducted within MacNeal's service area or included participants living within the service area. Focus groups were hosted in partnership with community-based organizations.

Focus group host organizations included:

- A House in Austin
- Bethel New Life Inc.
- Beyond Hunger
- Brighton Park Neighborhood Council
- Living Word Christian Center
- LUHS Community Advisory Committee
- National Alliance on Mental Illness (NAMI) – Metro Suburban
- Oak Park Area Lesbian and Gay Association+ (OPALGA+)
- The Douglas Center
- UCAN Chicago
- University of Illinois Chicago, Champions Program
- West Cook YMCA
- 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 environment and cultural diversity	▪ Participants highlighted the welcoming nature of their neighborhoods, emphasizing a strong sense of community where people feel connected and supported. ▪ Residents praised the diverse nature of their communities, emphasizing the presence of people from varied cultural, ethnic, and linguistic backgrounds. ▪ Some participants described the presence of culturally diverse shops, restaurants, and activities, enriching the community experience. This includes international cuisines, multicultural events, and spaces where diversity is celebrated.
Community connection	▪ Some participants likened their neighborhoods to "one big family," highlighting strong interpersonal relationships and neighborly bonds. ▪ Communities were often portrayed as places where residents look out for one another.
Safety	▪ Participants viewed safety as a combination of low crime rates, strong community ties, and accessible public spaces. ▪ Many participants highlighted the ability to walk freely and engage in outdoor activities without fear.
Access to services	▪ Easy access to community and professional resources was described as a significant benefit in some communities. ▪ Communities were described as having diverse resources, ranging from restaurants and businesses to recreational and wellness facilities. ▪ The ability to walk or use public transportation to access services was frequently highlighted.

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
Chronic conditions	▪ **Diabetes**: Diabetes was described as one of the most prevalent chronic conditions in communities. Participants mentioned difficulties in accessing regular care and maintaining consistent treatment plans. Some participants noted the lack of community-based education on managing diabetes through diet, exercise, and routine checkups. ▪ **Hypertension (High blood pressure):** Affordability and availability of medications were noted as significant challenges for managing hypertension. Participants highlighted limited knowledge about preventive measures, particularly for at-risk groups. ▪ **Heart disease:** Some participants noted that preventive screenings and education on cardiovascular health were not widely accessible. Some participants described delayed or inaccessible emergency care for acute events like heart attacks. ▪ **Asthma and respiratory issues:** Poor air quality, proximity to industrial areas, and housing conditions were cited as contributors to respiratory conditions. Limited access to inhalers and other essential medications for management were described as challenges. ▪ **Obesity:** Participants highlighted limited availability of healthy food options in certain neighborhoods, high cost of nutritious foods, and limited opportunities for physical activity as factors contributing to obesity. Obesity was mentioned as a contributing factor to diabetes, heart disease, and joint problems.
Lack of cultural competency in healthcare services	▪ **Lack of multilingual services**: Many participants expressed difficulty accessing healthcare due to limited availability of interpreters or healthcare providers who speak their native language. Miscommunication during appointments led to misunderstandings about diagnoses, treatments, and medication instructions. ▪ **Insensitive or judgmental attitudes**: Some participants reported feeling judged or misunderstood when discussing health issues, especially regarding dietary habits or family dynamics rooted in cultural traditions. Treatment recommendations often failed to consider cultural preferences, such as traditional healing practices or food customs, resulting in low adherence to prescribed care plans. ▪ **Exclusion of marginalized groups**: Undocumented individuals and non-English speakers felt particularly excluded from mainstream healthcare services. Historical mistreatment and systemic inequities have led to mistrust in healthcare institutions among some communities. ▪ **Representation**: Participants advocated for a healthcare workforce that reflects the racial, ethnic, and linguistic diversity of the community. In addition, they emphasized the need for healthcare providers to receive training on cultural relevance and bias.

Barriers to healthcare access	▪ **Financial barriers:** The expense of medical visits, treatments, and medications was frequently cited as a primary obstacle to care. Several participants reported being uninsured or underinsured, leading to delayed care or avoidance of medical services altogether. Co-pays, deductibles, and non-covered services added to the financial strain, particularly for low-income families. Some participants reported a lack of available doctors accepting Medicaid or offering sliding scale fees. ▪ **Geographic and transportation barriers:** Residents in some neighborhoods lacked nearby healthcare facilities, forcing them to travel long distances for care. Certain areas were described as having no primary care providers, pharmacies, or specialty clinics. Public transit options were often unreliable or unavailable, especially for elderly and disabled individuals. ▪ **Long wait times:** Participants noted difficulty scheduling timely appointments, often waiting weeks or months for primary or specialty care. Due to long wait times elsewhere, many relied on emergency rooms for non-urgent issues, leading to overcrowding and inadequate care. ▪ **Healthcare navigation difficulties:** The complexity of navigating healthcare systems, including scheduling, paperwork, and insurance processes, discouraged individuals from seeking care. Immigrants and undocumented individuals faced additional hurdles due to legal and identification requirements. ▪ **Technology barriers:** Limited access to the internet and technology prevented some residents from using telehealth services. Older adults and those unfamiliar with digital platforms struggled to navigate online appointment systems or patient portals.
Mental health challenges	▪ **Chronic stress:** Participants reported high levels of stress, anxiety, and depression across communities, often exacerbated by financial instability, housing insecurity, and violence. Chronic stress was linked to other health conditions such as hypertension and cardiovascular diseases. ▪ **Stigma:** Mental health stigma remains a major barrier to seeking care, particularly in communities of color, immigrant populations, and among men. Participants noted cultural taboos against discussing mental health or seeking therapy. ▪ **Treatment barriers:** A shortage of mental health providers, especially those who are culturally competent or offer care in multiple languages, limits access. Long wait times for appointments and the high cost of therapy were frequently cited. Participants frequently mentioned insufficient funding for community-based mental health and addiction programs.

Substance use challenges	▪ **Prevalence:** Substance use, particularly alcohol, opioids, and recreational drugs, was ▪ identified as a growing concern in many neighborhoods. Participants connected substance use to stress, unemployment, and lack of access to mental health resources. ▪ **Youth substance use:** Concerns were raised about increasing substance use among young people, driven by peer pressure, lack of recreational activities, and exposure to trauma. ▪ **Treatment barriers:** Stigma around addiction prevents individuals from seeking help. Participants highlighted the limited availability of rehabilitation centers and affordable treatment programs. A lack of support systems for families dealing with mental health or substance use issues compounds the problem. ▪ **Co-occurrence with mental health conditions:** Many participants noted that mental health challenges and substance use often co-occur, creating complex barriers to recovery. ▪ **Criminalization:** Criminalization of substance use, rather than offering treatment-focused solutions, was identified as a harmful approach.
Social influencers and determinants of health	Focus group participants highlighted various social determinants of health that deeply influence the ability of individuals and communities to achieve and maintain good health. These challenges include economic instability, housing insecurity, education access, and broader systemic inequities. ▪ **Economic stability:** Many families struggle to afford basic necessities, including food, housing, and healthcare. This economic strain exacerbates health inequities. ▪ **Employment barriers:** There is a lack of jobs offering health insurance or benefits. A lack of flexible work schedules prevents individuals from attending medical appointments or focusing on preventative care. Many participants stated that low wages make it difficult to afford healthcare, healthy food, and stable housing. Some participants described how working multiple jobs to make ends meet exacerbates stress. Individuals with criminal records face significant obstacles to obtaining stable employment. ▪ **Educational attainment:** Lower levels of education were linked to reduced job opportunities, lower incomes, and poorer health outcomes. A lack of health education in schools was also noted as a missed opportunity for early prevention and awareness. Participants noted a lack of access to education and vocational training as a barrier to securing higher-paying jobs. ▪ **Poor food access:** Limited access to affordable, nutritious food contributes to chronic conditions like obesity and diabetes. Food deserts were cited as a particular concern in certain neighborhoods. ▪ **Housing insecurity:** Several participants reported living in unsafe, overcrowded, or unstable housing conditions, leading to stress and negative health outcomes. Some participants mentioned struggling to afford utilities like electricity and water. Homelessness was described as a major issue in many communities. ▪ **Environmental hazards:** Poor air and water quality, especially in industrial areas, contribute to respiratory issues like asthma. ▪ **Community safety:** High rates of violence in some neighborhoods contribute to chronic stress and limit outdoor physical activity or social engagement. ▪ **Limited public transit:** Inadequate or unreliable public transportation restricts access to healthcare facilities, healthy food options, and employment opportunities. Participants noted that travel expenses, such as bus fares or gas, are prohibitive for low-income families. ▪ **Systemic racism:** Participants connected health disparities to historical inequities in housing, employment, and education. They highlighted how insufficient safety net programs leave priority populations unsupported.

Child and adolescent health	▪ **Limited availability of services:** Participants noted a lack of pediatric specialists, particularly in underserved areas. Long wait times for appointments and limited after-hours care were barriers for working parents. ▪ **Financial barriers:** Families without insurance or with limited coverage often delay or avoid seeking care for their children. Low rates of routine checkups and vaccinations were mentioned, particularly among immigrant families and those facing economic hardship. ▪ **Mental health concerns:** Stress, anxiety, and depression were frequently mentioned as prevalent among youth. Contributors included academic pressure, social media influence, and exposure to trauma, such as community violence or family instability. A lack of mental health education and culturally competent counseling options creates barriers to addressing these issues. Participants emphasized the need for more school-based mental health services. ▪ **Substance use:** Participants expressed concern about increasing exposure to drugs and alcohol among adolescents, often linked to stress and peer pressure. ▪ **Food security:** Many children and adolescents face inconsistent access to healthy meals, with reliance on school meal programs as a primary source of nutrition. Participants linked poor diets to rising rates of childhood obesity and related conditions, such as diabetes. ▪ **Lack of physical activity:** Limited access to safe recreational spaces and organized sports programs was highlighted as a barrier to physical fitness. Screen time and sedentary lifestyles were noted as contributing factors. ▪ **Housing:** Children living in unstable housing situations or experiencing homelessness face significant health risks, including developmental delays and exposure to environmental hazards. ▪ **Community violence:** Exposure to violence, including gun violence, was reported as a source of trauma and fear for many children and adolescents. This trauma was described as negatively impacting mental health, academic performance, and overall development. ▪ **Sexual and reproductive health:** Participants noted gaps in education and services related to sexual health, including access to contraception and information about sexually transmitted infections (STIs). ▪ **School environments:** Participants highlighted the need for more comprehensive health education in schools, including topics on nutrition, mental health, and substance use prevention. Limited availability of school nurses and counselors was a significant concern, especially in low-income areas. Participants described how bullying and social pressures, exacerbated by social media, contribute to mental health challenges and risk behaviors. ▪ **Youth friendly health services:** Participants noted that many health services are not tailored to the unique needs of adolescents, leading to gaps in care.

COVID-19	▪ **Delays in care:** Participants reported delays in routine medical care, including preventive services, chronic disease management, and elective procedures, due to the strain on healthcare systems. Delays in care during the pandemic have worsened chronic conditions for many individuals, potentially leading to long-term health complications. ▪ **Economic impacts:** The pandemic led to widespread unemployment and income instability, especially for families reliant on hourly wages or informal work. Many families faced increased difficulty affording and accessing nutritious food, exacerbating health disparities. Eviction moratoriums provided temporary relief, but participants expressed fears about long-term housing insecurity. ▪ **Mental health impact:** Participants expressed concern about the lasting mental health effects of the pandemic, particularly for youth who experienced significant disruptions in education and social development. ▪ **Telehealth expansion:** The rapid adoption of telehealth services, while not without challenges, improved access for some individuals, particularly those with mobility issues or transportation barriers. ▪ **Resilience:** Participants highlighted grassroots efforts to provide food, financial assistance, and mental health support during the pandemic. However, the pandemic highlighted systemic vulnerabilities, with participants calling for stronger safety nets to address future public health crises.

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
Access to community services	▪ Participants frequently mentioned organizations like the Salvation Army, which provides essential support such as utility bill assistance. ▪ Participants noted the importance of eating fresh fruits and vegetables and appreciated community resources like farmers' markets and food pantries. ▪ Beyond formal services, participants emphasized the role of informal community networks in providing support. ▪ Local support groups and recovery programs were appreciated for helping individuals overcome addiction.
Housing services	▪ Housing-focused initiatives, like the Housing Forward program, were praised for their efforts in addressing homelessness and providing stable housing solutions.
Community safety	▪ Some participants mentioned that a visible police presence contributes to a sense of security, particularly in public spaces. However, in some focus groups, participants shared feelings of mistrust toward law enforcement, which can undermine the effectiveness of safety measures ▪ Well-lit streets and public spaces were seen as critical for encouraging outdoor activities and fostering community interactions. Poorly maintained infrastructure, such as broken sidewalks, abandoned properties, and inadequate lighting, contributes to safety concerns. ▪ Investing in youth programs and recreational spaces was seen as a preventive measure against crime.
Positive health behaviors and wellness programs	▪ Accessibility to community health services and programs was seen as critical. Several participants pointed to wellness programs and therapy services as examples of initiatives that help them maintain their physical and mental health. ▪ Activities such as meditation, yoga, and journaling were mentioned as ways to reduce stress and promote mental health. ▪ Many participants shared their routines of walking for fitness and enjoyment, especially in neighborhoods with accessible sidewalks and parks. ▪ Youth and adult involvement in sports leagues and recreational activities were commonly mentioned as ways to stay active and connected. ▪ Participants shared stories of reducing or quitting harmful habits such as smoking to improve their health.
Preventative care	Some participants mentioned staying up to date with doctor visits and preventive screenings as part of their routine. Ensuring children and adults in their households were vaccinated was highlighted as an important protective measure.
Transportation and walkability	Walkability emerged as a significant factor in community health. Participants valued neighborhoods where they could access essential services, such as grocery stores and health clinics, without needing a car.

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
Expand access to mental health care and substance use treatment	▪ **Integrated care models:** Develop programs that address both mental health and substance use simultaneously. ▪ **Community-based resources:** Increase funding for local mental health clinics and support groups. Offer more peer-led initiatives to reduce stigma and build trust. ▪ **Affordable care:** Expand access to low-cost therapy, counseling, and addiction treatment. Provide mobile units or telehealth options for underserved areas. ▪ **Education:** Promote mental health awareness campaigns to reduce stigma. ▪ **Decriminalization:** Advocate for decriminalizing substance use and increasing focus on rehabilitation and recovery.
Expand access to care for children and adolescents	▪ **Increase availability of healthcare services:** Increase availability of pediatric and adolescent-focused healthcare providers in underserved areas. Provide mobile clinics and telehealth options to reach families with transportation or scheduling challenges. Increase access to tailored youth-friendly healthcare. ▪ **Enhance school-based services:** Invest in school-based health centers that provide physical, mental, and preventive care. Train educators and staff to recognize and address mental health and trauma-related issues. Create safe spaces and activities for youth, such as after-school programs and mentorship initiatives. ▪ **Prevention-focused programs:** Develop programs focused on childhood nutrition, physical activity, and mental health awareness. Offer free or low-cost health education workshops for families.
Support economic stability	▪ **Job training:** Expand vocational and skills-based programs to prepare individuals for higher-paying, stable jobs. ▪ **Policy and advocacy:** Push for policies ensuring minimum wages that reflect the cost of living in Cook County. Strengthen regulations for workplace safety and advocate for mandatory paid sick leave. Encourage employers to offer flexible schedules, particularly for parents and caregivers. ▪ **Re-entry support:** Participants recommended more targeted programs for justice-involved individuals.

Hospital investment priorities	▪ **Infrastructure for integrated services:** Establish "one-stop-shop" facilities offering a wide range of services, including mental health care, substance use treatment, preventive care, and childcare. Co-locate resources such as food pantries, housing services, and counseling to reduce the burden on individuals needing to navigate multiple systems. ▪ **Community engagement and staff training:** Invest in training healthcare providers on trauma-informed care and motivational interviewing to enhance patient-provider interactions and trust. Encourage healthcare staff, including students, to participate in community service projects to build stronger connections with local residents. Recruit and train diverse staff, such as Spanish-speaking professionals, mental health crisis workers, and representatives from underrepresented groups, including young Black men. Provide resources that make community health work appealing and accessible to diverse demographics, including scholarship opportunities for underrepresented groups. ▪ **Mental health and substance use services:** Expand access to mental health services, including immediate crisis intervention, psychiatric facilities, and medication management. Integrate mental health and substance use services with broader community support systems, acknowledging intersecting issues such as homelessness and socioeconomic disparities. ▪ **Streamline services**: Streamline appointment systems to reduce wait times and simplify processes for individuals in need of urgent care. Consider leveraging technology to create unified electronic records systems that integrate hospital services with community-based resources. ▪ **Safety and community spaces:** Invest in initiatives that improve community safety, such as better lighting, reliable water quality, and safe public spaces for residents. Support programs that promote community cohesion and provide gathering spaces for young adults and families.

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 reduced violence	Participants emphasized a desire for safer communities with reduced violence. This includes fostering an environment where residents feel secure and free to engage in daily activities without fear.
Respectful communities	Many expressed a wish for stronger community bonds characterized by mutual respect and understanding. This includes bridging gaps between different cultural, social, and economic groups.
Opportunities for growth	Participants envisioned increased opportunities, particularly for youth, through initiatives like educational programs, skill development workshops, mentorship opportunities, and recreational activities that inspire and prepare the next generation.
Resource availability	There is a strong call for better access to resources—be it healthcare, housing, education, or community support systems.
Community-led development	Participants recommended greater involvement of residents in decision-making processes and partnerships with local organizations to drive sustainable community improvements.

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