2025

# Community Health Needs Assessment

## OSF LITTLE COMPANY OF MARY MEDICAL CENTER

Evergreen Park
Cook County

# EXECUTIVE SUMMARY

This Community Health Needs Assessment is a collaborative undertaking by OSF Little Company of Mary Medical Center to highlight the health needs and well-being of residents in the southwest suburb of Evergreen Park, Cook County. This assessment, with the help of collaborative community partners, has identified numerous health issues impacting individuals and families in the OSF Little Company of Mary Medical Center service area. Prevalent themes include demographic composition, disease predictors and prevalence, leading causes of mortality, accessibility to health services, and healthy behaviors.

The results of this study can inform strategic decision-making, directly addressing the community's health needs. It was designed to assess issues and trends affecting the communities served by the collaborative and to understand the perceptions of targeted stakeholder groups.

This study includes a detailed analysis of secondary data to assess the community's health status. Information was collected from numerous secondary sources, both publicly and privately available data. Additionally, primary data were collected for the general population and the at-risk or economically disadvantaged population. Areas of investigation included perceptions of the community health issues, unhealthy behaviors, issues with quality of life, healthy behaviors and access to medical care, dental care, prescription medication, and mental-health counseling. Social drivers of health were also analyzed to understand why certain population segments responded differently.

Ultimately, the collaborative team identified and prioritized the most important health-related issues in the Evergreen Park, Cook County region. They considered health needs based on: (1) magnitude of the issue (i.e., what percentage of the population was impacted by the issue); (2) severity of the issue in terms of its relationship with morbidities and mortalities; and (3) potential impact through collaboration. Using a modified version of the Hanlon Method, two significant health needs were identified and determined to have equal priority:

- **Healthy Behaviors**
- **Access to Healthcare**

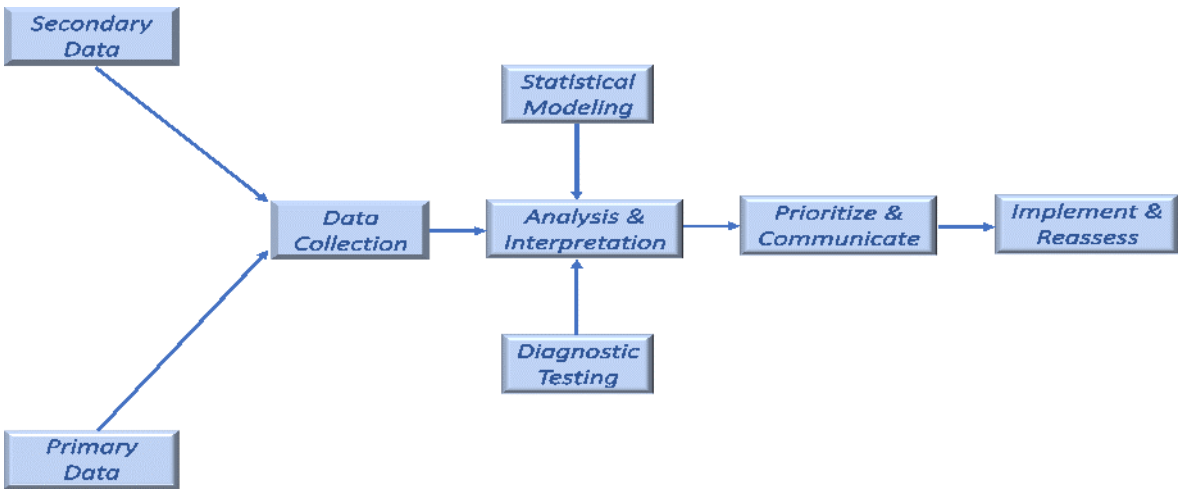
# I. INTRODUCTION

## Background

The Patient Protection and Affordable Care Act (Affordable Care Act), enacted March 23, 2010, introduced new requirements for tax-exempt charitable hospital organizations. These organizations must conduct community health needs assessments and adopt implementation strategies to address the community health needs identified through these assessments. This community health needs assessment (CHNA) includes input from specific individuals who represent the broad interests of the community served by OSF Little Company of Mary Medical Center (OSF LCMMC), including those with special knowledge of or expertise in public health. For this study, a community health needs assessment is defined as a systematic process involving the community to identify and analyze community health needs and assets to prioritize these needs, create a plan, and act upon unmet community health needs. Results from this assessment will be made widely available to the public. This CHNA Report was approved by the OSF HealthCare System's Board of Directors on July 28, 2025.

The structure of the CHNA is based on standards used by the Internal Revenue Service to develop Schedule H, Form 990, designated solely for tax-exempt charitable hospital organizations. The fundamental areas of the community health needs assessment are illustrated below (Figure 1).

*Figure 1*




## Collaborative Team and Community Engagement

To engage the entire community in the CHNA process, a collaborative team of health-professional experts and key community advocates was formed. Members of the team were carefully selected to ensure representation of the broad interests of the community. Specifically, team members included representatives from OSF Little Company of Mary Medical Center, Evergreen Park, Cook County Health Department, and administrators from key community partner organizations. Note that the collaborative team provided input for all sections of the CHNA. Individuals, affiliations, titles, and expertise can be found in APPENDIX 1. MEMBERS OF COLLABORATIVE TEAM. Engagement occurred throughout the

process, resulting in shared ownership of the assessment. The entire collaborative team met in the first and second quarters of 2025. Additionally, numerous meetings were held between the facilitators and specific individuals during the process.

## Definition of the Community

To determine the geographic boundaries for OSF Little Company of Mary Medical Center, analyses were completed to identify what percentage of inpatient and outpatient activity was represented by Evergreen Park, Cook County. Data show that Evergreen Park, Cook County alone represents 72% of all patients for the hospital.

In addition to defining the community by geographic boundaries, this study targets the at-risk population as an area of potential opportunity to improve the health of the community. The at-risk population was defined as those individuals eligible to receive Medicaid based on the State of Illinois guidelines using household size and income level.

## Purpose of the Community Health Needs Assessment

In the initial meeting, the collaborative team defined the purpose of this study. This study aims to equip healthcare organizations, such as hospitals, clinics and health departments, with the essential information needed to develop strategic plans for program design, access, and delivery.

The results of this study will enable healthcare organizations to efficiently allocate limited resources and better manage high-priority challenges. By working together, hospitals, clinics, agencies and health departments will leverage this CHNA to enhance health-care quality in Evergreen Park, Cook County. When feasible, data are assessed longitudinally to identify trends and patterns by comparing with results of the 2022 CHNA and benchmarking them against State of Illinois averages.

## Community Feedback from Previous Assessments

The 2022 CHNA was widely shared with the community to allow for feedback. The hospital posted both a full and summary version on its website, with a feedback link available. Additionally, feedback could be provided via this email: CHNAFeedback@osfhealthcare.org.

Although no written feedback was received by community members via the available mechanisms, verbal feedback from key stakeholders from community-service organizations was incorporated into the collaborative process.

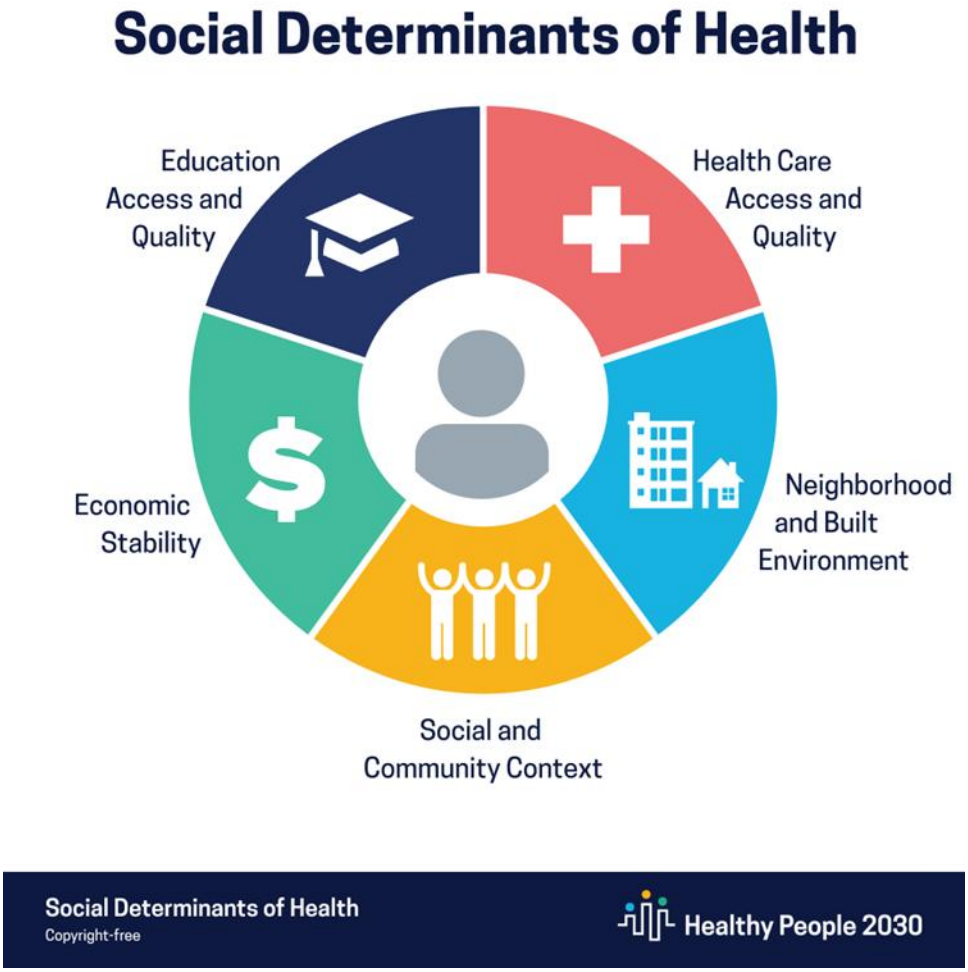
## 2022 CHNA Health Needs and Implementation Plans

The 2022 CHNA for Evergreen Park, Cook County identified four significant health needs: access to care, behavioral health, including mental health and substance use, heart disease, and cancer. Specific actions were taken to address these needs. Detailed discussions of goals and strategies can be found in APPENDIX 2. ACTIVITIES RELATED TO 2022 CHNA PRIORITIZED NEEDS.

# Social Drivers of Health

This CHNA incorporates important factors associated with Social Drivers of Health (SDOH). SDOH are crucial environmental factors, such as where people are born, live, work and play, that affect people's well-being, physical and mental health, and quality of life. Research by the U.S. Department of Health and Human Services, as part of *Healthy People 2030,* identifies five SDOH to include when assessing community health (Figure 2). Note this CHNA refers to social "drivers" rather than "determinants." According to the *Root Cause Coalition*, drivers are malleable, while determinants are not. However, the five factors included in Figure 2 remain the same, regardless of terminology used.

*Figure 2*




Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved November 1, 2024, from https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

The CHNA includes an assessment of SDOH because these factors contribute to health inequities and disparities. Interventions without considering SDOH will have limited impact on improving community health for people living in underserved or at-risk areas.

# II. METHODS

To complete the comprehensive community health needs assessment, multiple sources were examined. Secondary statistical data were used to assess the community profile, morbidity rates, and causes of mortality. Additionally, a study was conducted to examine perceptions of community health-related issues, healthy behaviors, behavioral health, food security, social drivers of health, and access to healthcare.

## Secondary Data Collection

Existing secondary statistical data were first used to develop an overall assessment of health-related issues in the community. Each section of the report includes definitions, the importance of categories, data, and interpretations. At the end of each chapter, there is a section on key takeaways.

Based on several retreats, a separate OSF Collaborative Team used COMPdata Informatics (affiliated with Illinois Health and Hospital Association (IHA)) to identify six primary categories of diseases: age related, cardiovascular, respiratory, cancer, diabetes, and infections. To define each disease category, modified definitions developed by Sg2 were used. Sg2 specializes in consulting for healthcare organizations, and their team of experts includes MDs, PhDs, RNs and healthcare leaders with extensive strategic, operational, clinical, academic, technological, and financial experience.

## Primary Data Collection

In addition to existing secondary data sources, primary survey data were also collected. This section describes the research methods used to collect, code, verify, and analyze primary survey data. Specifically, it covers the research design used for this study: survey design, data collection, and data integrity.

## Survey Instrument Design

Initially, all publicly available health needs assessments in the U.S. were reviewed to identify common themes and approaches to collecting community health needs data. By leveraging best practices from these surveys, a new survey was designed in 2024 for use with both the general population and the at-risk community. To ensure all critical areas were addressed, the entire collaborative team was involved in survey design and approval through several fact-finding sessions. Additionally, several focus groups were used to collect the qualitative information necessary to design survey items. Specifically, for the community health needs assessment, eight specific sets of items were included:

- **Ratings of health issues in the community** – To assess the importance of various community health concerns. Survey items included assessments of topics such as cancer, diabetes, and obesity.
- **Ratings of unhealthy behaviors in the community** – To assess the importance of various unhealthy behaviors. Survey items included assessments of topics such as violence, drug use, and smoking.

- **Ratings of issues concerning well-being** – To assess the importance of various issues relating to well-being in the community. Survey items included assessments of topics such as access to healthcare, safer neighborhoods, and effective public transportation.
- **Accessibility to healthcare** – To assess the degree to which residents could access healthcare when needed. Survey items included assessments of topics such as access to medical, dental, and mental healthcare, as well as access to prescription medication.
- **Healthy behaviors** – To assess the degree to which residents exhibited healthy behaviors. The survey items included assessments of topics such as exercise, healthy eating habits, and cancer screenings.
- **Behavioral health** – To assess community issues related to areas such as anxiety and depression.
- **Food security** – To assess access to healthy food alternatives.
- **Social drivers of health** – To assess the impact that social drivers may have on the above-mentioned areas.

Finally, demographic information was collected to assess the background information necessary to segment markets in terms of the eight categories discussed above. A copy of the final survey is included in APPENDIX 3. SURVEY.

## Sample Size

To identify the potential population, the percentage of the Evergreen Park Village population living in poverty was first identified. Specifically, the Village's population was multiplied by its respective poverty rate to determine the minimum sample size needed to study the at-risk population. The poverty rate for Evergreen Park Village was 5.3%. With a population of 19,498, this yielded a total of 1,033 residents living in poverty in the Evergreen Park Village area.

A normal approximation to the hypergeometric distribution was assumed, given the targeted sample size. The formula used was:

$$n = (Nz2pq)/(E2\ (N-1) + z2\ pq)$$

where:

n = the required sample size

N = the population size

z = the value that specified the confidence interval (use 95% CI)

pq = population proportions (set at .05)

E =desired accuracy of sample proportions (set at +/- .05)

For the total Evergreen Park Village area, the minimum sample size for aggregated analyses (combining at-risk and general populations) was 377. The data collection effort for this CHNA yielded a total of 514

responses. After cleaning the data for "bot" survey respondents, the sample was reduced to 421 respondents. This met the threshold of the desired 95% confidence interval.

To provide a representative profile when assessing the aggregated population for the Evergreen Park Village, Cook County region, the general population was combined with a portion of the at-risk population. To represent the at-risk population as a percentage of the aggregate population, a random-number generator was used to select at-risk cases to include in the general sample. Additionally, efforts were made to ensure that the demography of the sample aligned with population demographics according to U.S. Census data. This provided a total usable sample of 387 respondents for analyzing the aggregate population. Sample characteristics can be seen in APPENDIX 4. CHARACTERISTICS OF SURVEY RESPONDENTS.

## Data Collection

Survey data were collected in the 2nd quarter of 2024. To collect data in this study, two techniques were used. First, an online version of the survey was created. Second, a paper version of the survey was distributed. To be sensitive to the needs of respondents, surveys stressed assurance of complete anonymity. Both the online survey and paper survey were also translated into Spanish.

To specifically target the at-risk population, surveys were distributed at homeless shelters, food pantries, and soup kitchens. Since the at-risk population was specifically targeted as part of the data collection effort, this became a stratified sample, as other groups were not targeted based on their socio-economic status.

It is important to note that the use of electronic surveys to collect community-level data may create a potential for bias from convenience sampling error. To account for potential bias in the community sample, a second control sample of data is periodically collected. This control sample consists of random patients surveyed at the hospital, assuming that patients receiving care represent an unbiased representation of the community. All questions on the patient version of the survey pertaining to access to healthcare are removed, as these questions are not relevant to current patients. Data from the community sample and the control sample are then compared using t-tests and tetrachoric correlations when appropriate. Results show that the community sample did not exhibit any significant patterns of bias. If specific relationships exhibited potential bias between the community sample and the control sample, they are identified in the Social Drivers sections of the analyses within each chapter.

## Data Integrity

Comprehensive analyses were performed to verify the integrity of the data for this research. Without proper validation of the raw data, any interpretation of results could be inaccurate and misleading if used for decision-making. Therefore, several tests were performed to ensure the data were valid. These tests were performed before any analyses were undertaken. Data were checked for coding accuracy using descriptive frequency statistics to verify that all data items were correct. This was followed by analyses of means and standard deviations and comparisons of primary data statistics to existing secondary data.

# Analytic Techniques

To ensure statistical validity, several different analytic techniques were used. Frequencies and descriptive statistics were employed to identify patterns in residents' ratings of various health concerns. Additionally, appropriate statistical techniques were used to identify existing relationships between perceptions, behaviors, and demographic data. Specifically, Pearson correlations, $X^2$ tests and tetrachoric correlations were utilized when appropriate, given the characteristics of the specific data being analyzed.

CHAPTER 1 OUTLINE



# CHAPTER 1: DEMOGRAPHY AND SOCIAL DRIVERS

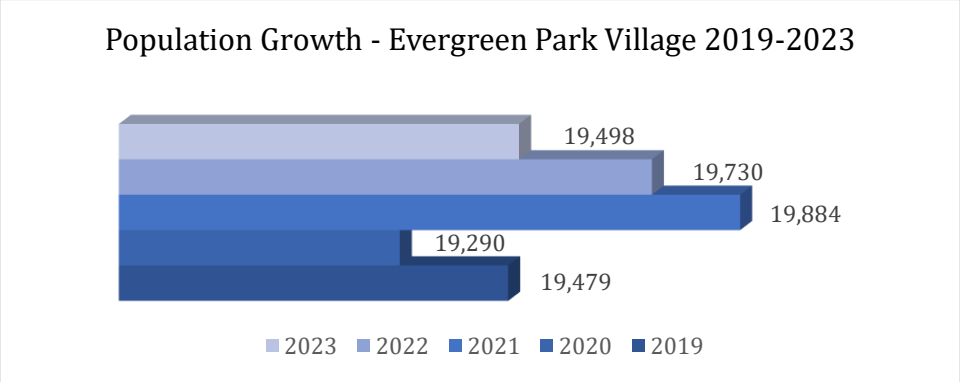
## 1.1 Population

*Importance of the Measure:* Population data characterize individuals residing in Evergreen Park Village. These data provide an overview of population growth trends and build a foundation for further analysis.

## Population Growth

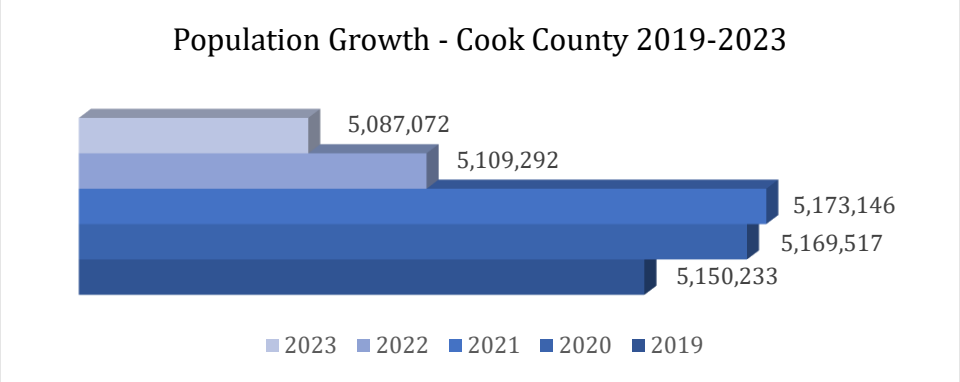
Data from the last census indicate that the population of Evergreen Park Village slightly increased (<0.1%) between 2019 and 2023 (Figure 3). For Cook County, the population decreased 1.2% between 2019 and 2023 (Figure 4).

*Figure 3*




*Source: United States Census Bureau*

*Figure 4*




*Source: United States Census Bureau*

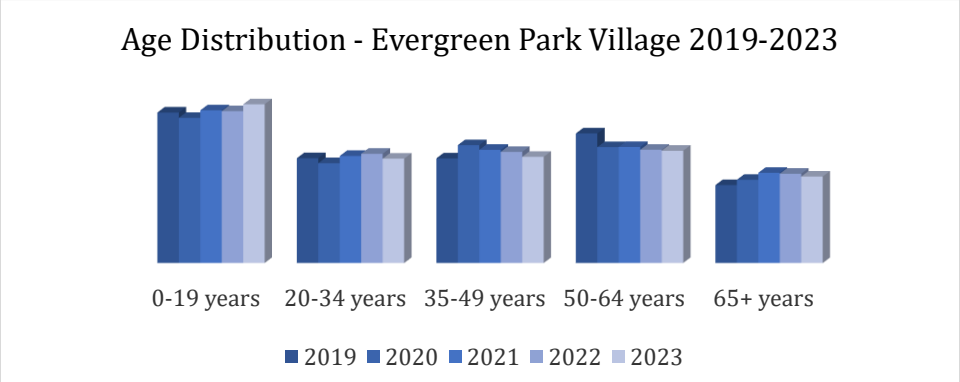
# 1.2 Age, Gender and Race Distribution

*Importance of the Measure:* Population data broken down by age, gender, and race groups provide a foundation to analyze the issues and trends impacting demographic factors, including economic growth and the distribution of healthcare services. Understanding the cultural diversity of communities is essential when considering healthcare infrastructure and service delivery systems.

## Age

As illustrated in Figure 5, the percentage of individuals in Evergreen Park Village in each age group, except two groups, increased over the five-year period from 2019 to 2023. Notably, the 65+ age group increased by 11%, the 0-19 age group increased by 5.5%, and the 35-49 age group increased 1.5% over the same period. Comparatively, those in the 50-64 age group decreased by 13.4% and those in the 20-34 age group declined by 0.5%.

*Figure 5*

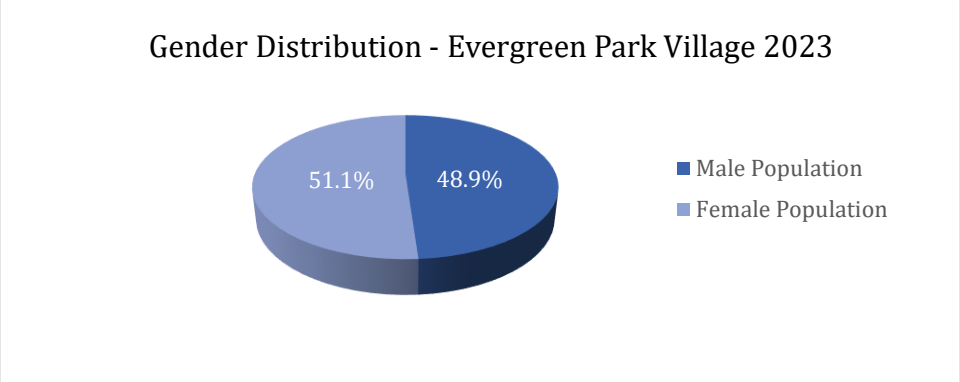



*Source: United States Census Bureau*

## Gender

The gender distribution of Evergreen Park Village residents is relatively equal among males and females (Figure 6).

*Figure 6*

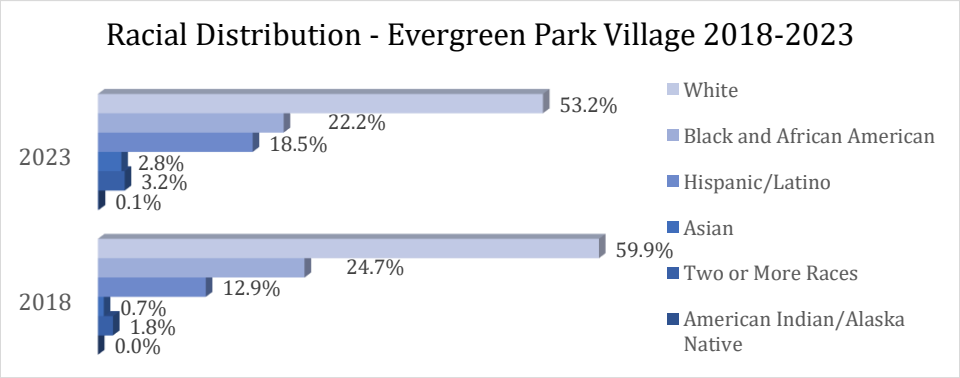



*Source: United States Census Bureau*

## Race

With regard to race and ethnic background, Evergreen Park Village is largely homogenous. However, in recent years, the Village is becoming more diverse. Data from 2023 show that the White ethnicity comprises 53.2% of the population in Evergreen Park Village. The non-White population has been increasing, rising from 40.1% in 2018 to 46.8% in 2023. Within this, Black and African American ethnicity comprises 22.2% of the population, Hispanic/Latino ethnicity comprises 18.5%, multiracial ethnicity comprises 3.2%, Asian ethnicity comprises 2.8%, and American Indian/ Alaska Native ethnicity comprises 0.1% (Figure 7).

*Figure 7*



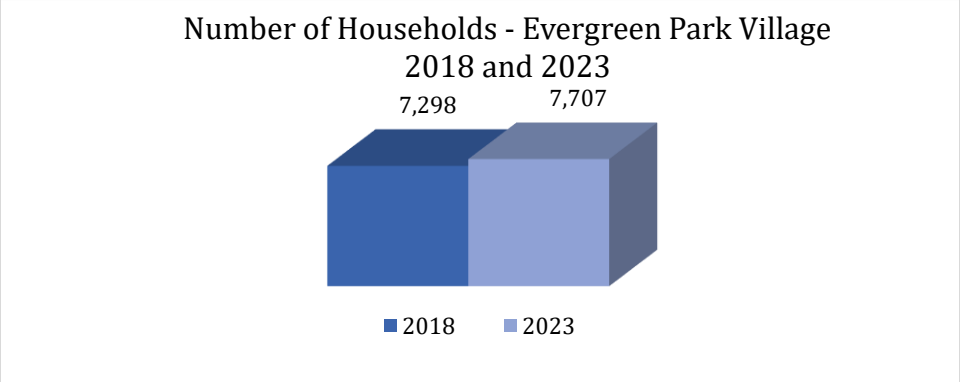

*Source: United States Census Bureau*

# 1.3 Household/Family

*Importance of the Measure:* Families are a vital component of a robust society in Evergreen Park Village, as they significantly impact the health and development of children and provide support and well-being for older adults.

As indicated in the graph below, the number of family households in Evergreen Park Village increased from 2018 to 2023 (Figure 8).

*Figure 8*

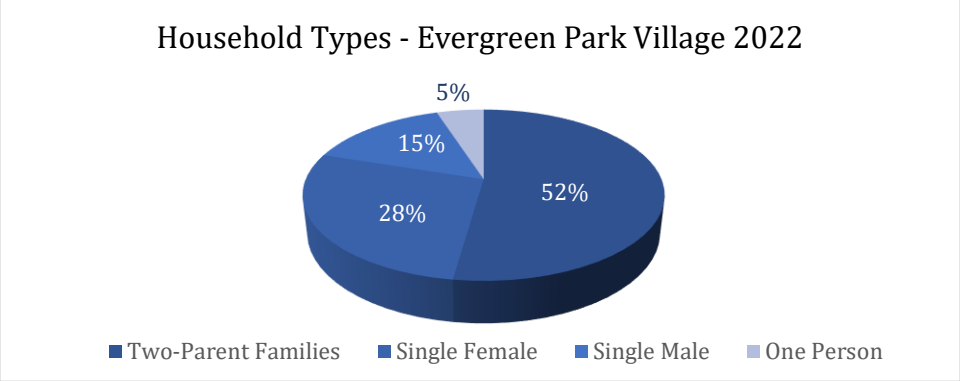



*Source: United States Census Bureau*

## Family Composition

In Evergreen Park Village, data from 2022 show that two-parent families make up 52% of households. One-person households represent 5% of the population, single-female households represent 28%, and single-male households account for 15% (Figure 9).

*Figure 9*

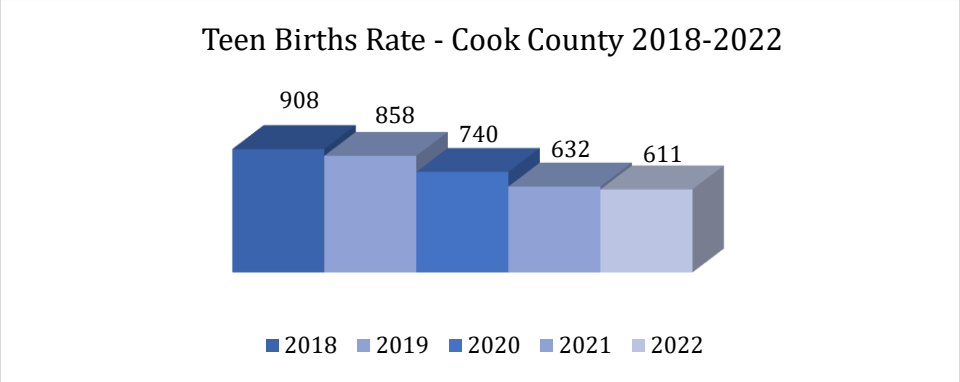



*Source: United States Census Bureau*

## Early Sexual Activity Leading to Births from Teenage Mothers

Cook County has experienced a steady decline in teenage birth count over the five-year period from 2018-2022. In 2018, the teen birth rate was 908, and experienced a continuous decline to 611 in 2022 (Figure 10).

*Figure 10*




*Source: Illinois Department of Public Health*

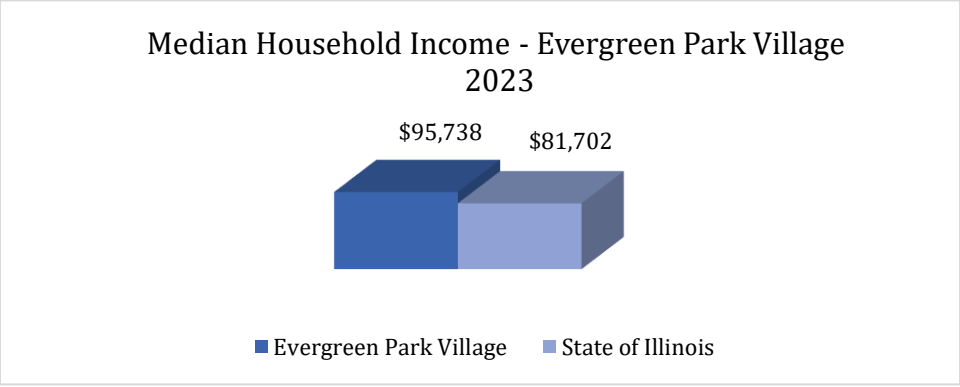
# 1.4 Economic Information

*Importance of the Measure:* Median income divides households into two segments, with one-half of households earning more than the median income and the other half earning less. Because median income is not significantly impacted by unusually high or low-income values, it is considered a more reliable indicator than average income. Living in poverty means lacking sufficient income to meet one's basic needs. Accordingly, poverty is associated with numerous chronic social, health, education, and employment conditions.

## Median Income Level

For 2023, the median household income in Evergreen Park Village ($95,738) was higher than that of the State of Illinois ($81,702) (Figure 11).

*Figure 11*



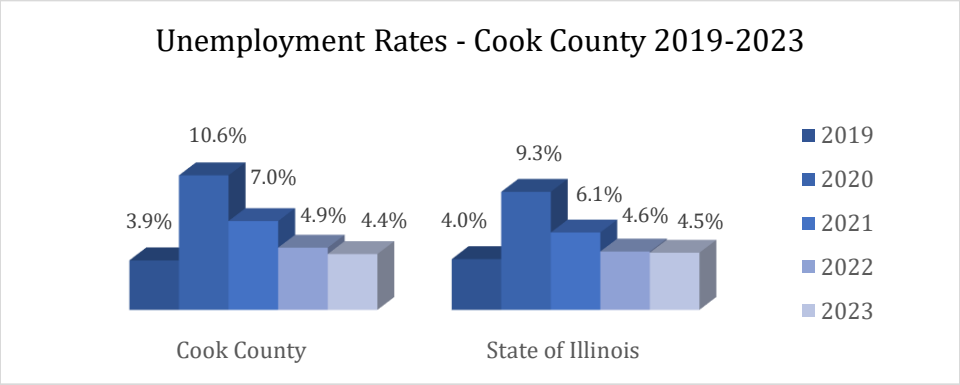

*Source: United States Census Bureau*

## Unemployment

From 2019 through 2023, the Cook County unemployment rate was higher than the State of Illinois unemployment rate. However, in 2019 and 2023, the Cook County rate was lower than the State of

Illinois average (Figure 12). Some of the increase in unemployment in 2020 may be attributed to the COVID-19 pandemic.

*Figure 12*

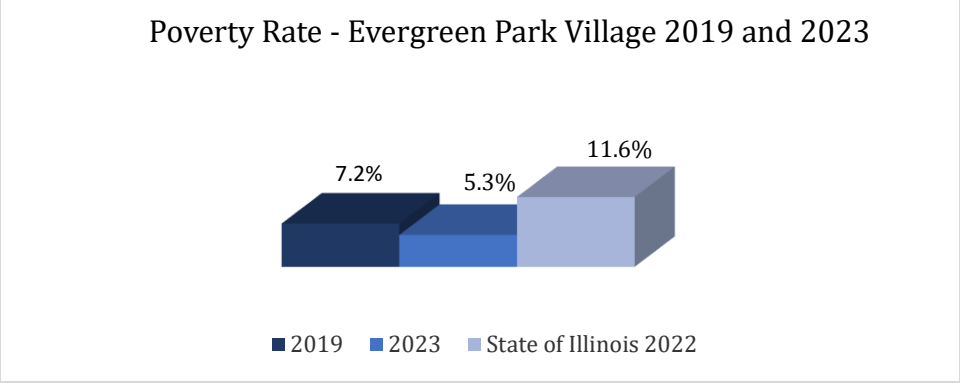



*Source: Bureau of Labor Statistics*

## Individuals in Poverty

In Evergreen Park Village, the percentage of individuals living in poverty decreased from 7.2% in 2019 to 5.3% in 2023. Poverty significantly impacts the development of children and youth. In 2023, the poverty rate for families living in Evergreen Park Village (5.3%) was lower than the State of Illinois poverty rate (11.6%) (Figure 13).

*Figure 13*




*Source: United States Census Bureau*

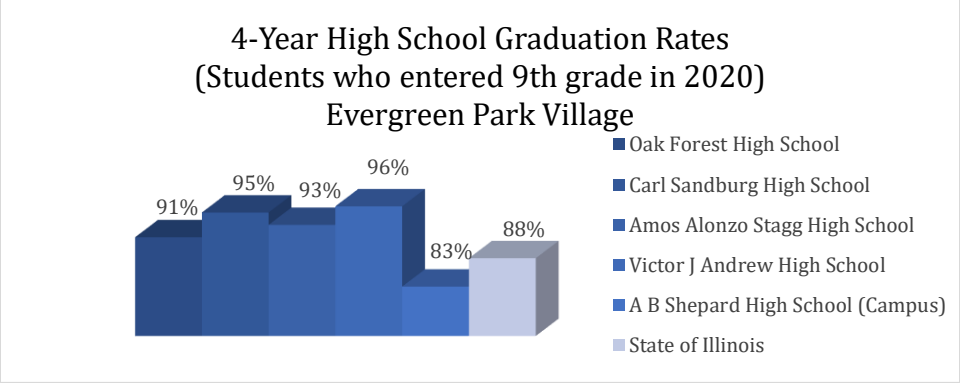
# 1.5 Education

*Importance of the Measure:* According to the National Center for Educational Statistics, "The better educated a person is, the more likely that person is to report being in 'excellent' or 'very good' health, regardless of income." Research suggests that higher educational attainment and greater school success lead to better health outcomes and a higher likelihood of making healthy lifestyle choices. Consequently, years of education are strongly related to an individual's propensity to earn a higher salary, secure better employment, and achieve multifaceted success in life.

# High School Graduation Rates

In 2020, all the school districts in Evergreen Park Village, except A B Shepard High School (Campus), reported high school graduation rates that were higher than the State of Illinois average of 88% (Figure 14).

*Figure 14*

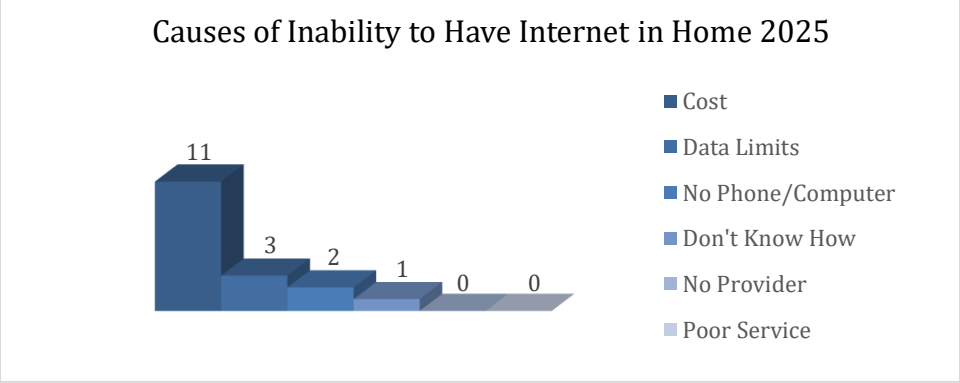



*Source: Illinois Report Card*

# 1.6 Internet Accessibility

Survey respondents were asked if they had Internet access. Of the respondents, 96% indicated they had Internet in their homes. For those who did not have Internet in their home, cost was the most frequently cited reason (11) (Figure 15). Note that these data are displayed in frequencies rather than percentages due to the low number of responses.

*Figure 15*




*Source: CHNA Survey*

## Social Drivers Related to Internet Access

Several factors show significant relationships with an individual's Internet access. The following relationships were found using correlational analyses:

- **Access to Internet** tends to be rated higher for those with higher education and those with higher income. Access to Internet tends to be lower for Black people.

## 1.7 Key Takeaways from Chapter 1

- ✓ POPULATION INCREASED MARGINALLY OVER THE LAST 5 YEARS.
- ✓ POPULATION OVER AGE 65 INCREASED 11%.
- ✓ SINGLE FEMALE HEAD-OF-HOUSEHOLD REPRESENTS 28% OF THE POPULATION. HISTORICALLY, THIS DEMOGRAPHIC INCREASES THE LIKELIHOOD OF FAMILIES LIVING IN POVERTY.

CHAPTER 2 OUTLINE



# CHAPTER 2: PREVENTION BEHAVIORS

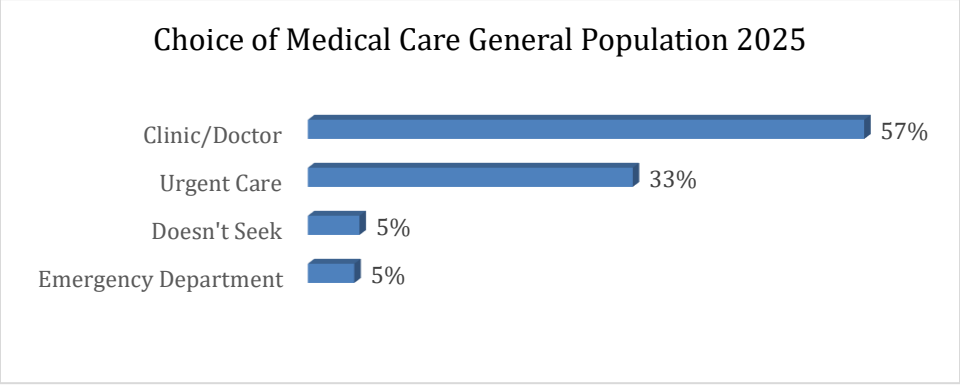
## 2.1 Accessibility

*Importance of the Measure:* It is critical for healthcare services to be accessible. Therefore, accessibility to healthcare must address both the associated financial costs and the supply and demand of medical services.

### Choice of Medical Care

Survey respondents were asked to select the type of healthcare facility they used when sick. Four different options were presented: clinic or doctor's office, urgent-care facility, did not seek medical treatment, and emergency department. The most common response for source of medical care was clinic/doctor's office, chosen by 57% of survey respondents. This was followed by urgent care (33%), not seeking medical attention (5%), and the emergency department at a hospital (5%) (Figure 16).

*Figure 16*




*Source: CHNA Survey*

### *Comparison to 2022 CHNA*

***Clinic/doctor's office decreased from 69% in 2022 to 57% in 2025. Much of this can be attributed to the increase in use of urgent care facilities from 18% in 2022 to 33% in 2025. The use of the emergency department increased from 4% in 2022 to 5% in 2025; however, those not seeking medical care decreased from 8% in 2022 to 5% in 2025.***

## Social Drivers Related to Choice of Medical Care

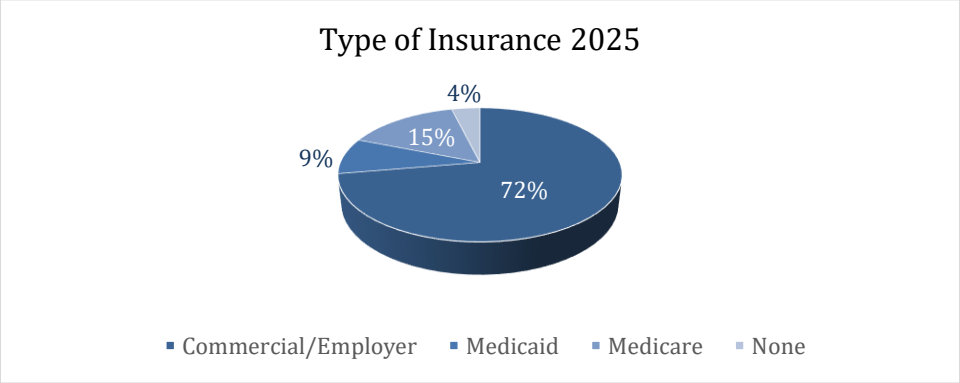
Several factors show significant relationships with an individual's choice of medical care. The following relationships were found using correlational analyses.

- **Clinic/Doctor's Office** tends to be used more often by those with higher income.
- **Urgent Care** tends to be used more often by Black people, those with lower education, those with lower income, and those with an unstable housing environment. Urgent care is used less often by White people.
- **Emergency Department** tends to be used more often by those with an unstable housing environment.
- **Does Not Seek Medical Care** did not have any correlates.

## Insurance Coverage

According to survey data, 72% of the residents are covered by commercial/employer insurance, followed by Medicare (15%) and Medicaid (9%). Four percent of respondents indicated they did not have any health insurance (Figure 17).

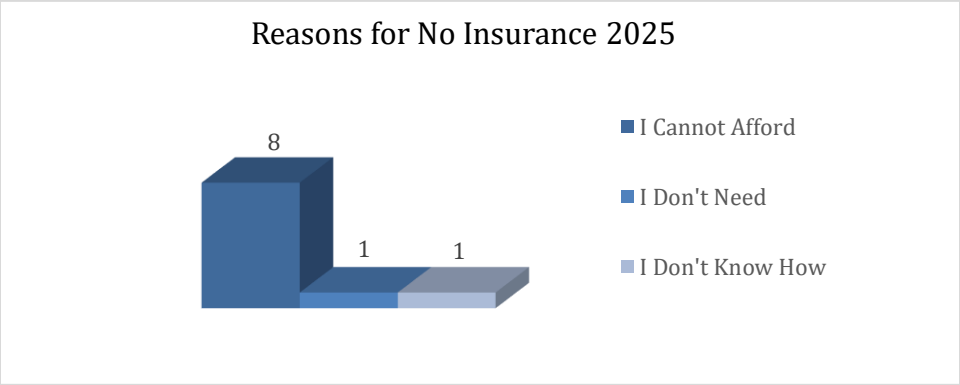
*Figure 17*




*Source: CHNA Survey*

Data from the survey show that for those individuals who do not have insurance, the most prevalent reason was cost (8) (Figure 18). Note that these data are displayed in frequencies rather than percentages given the low number of responses.

*Figure 18*




*Source: CHNA Survey*

## Social Drivers Related to Type of Insurance

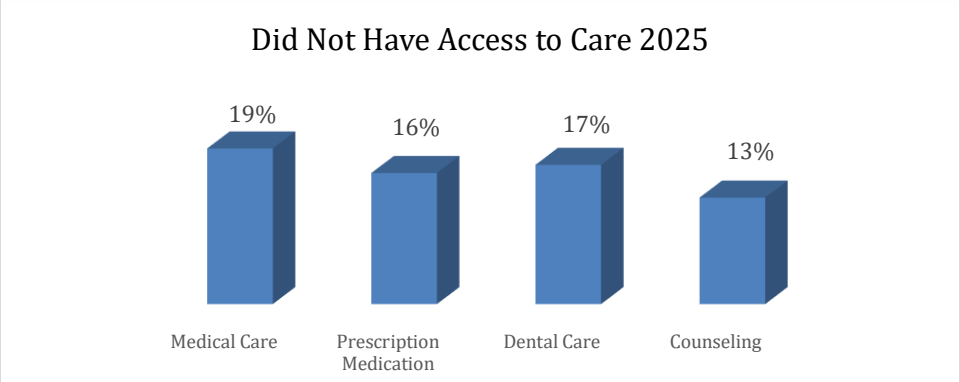
Several characteristics show significant relationships with an individual's type of insurance. The following relationships were found using correlational analyses:

- **Medicare** tends to be used more frequently by older people.
- **Medicaid** tends to be used more frequently by Black people, those with lower education, those with lower income, and those with an unstable housing environment. Medicaid is less often used by White people.
- **Private Insurance** tends to be used more frequently by younger people, White people, those with higher education, and those with higher income.
- **No Insurance** tends to be reported more frequently by those with lower education, those with lower income, and by those with an unstable housing environment.

# Access to Care

In the CHNA survey, respondents were asked, "Was there a time when you needed care but were not able to get it?" Access to four types of care were assessed: medical care, prescription medication, dental care, and counseling. Survey results show that 19% of the population did not have access to medical care when needed; 16% did not have access to prescription medication when needed; 17% did not have access to dental care when needed; and 13% did not have access to counseling when needed (Figure 19).

*Figure 19*




*Source: CHNA Survey*

## Social Drivers Related to Access to Care

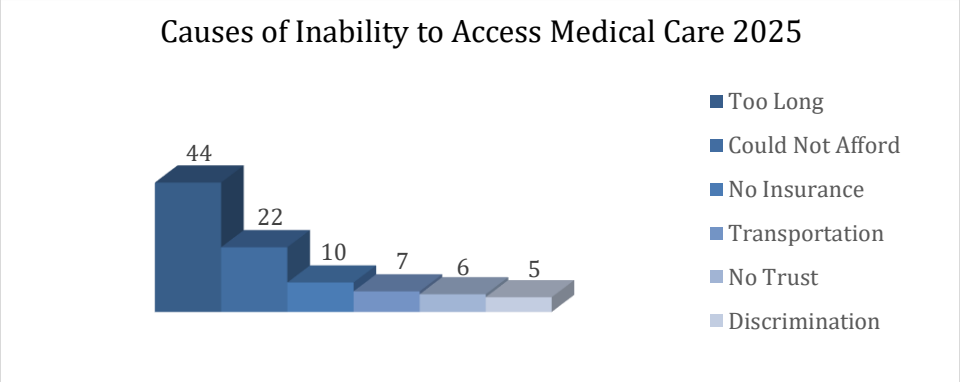
Several characteristics show a significant relationship with an individual's ability to access care when needed. The following relationships were found using correlational analyses. Note correlations including Black and LatinX people should be interpreted with caution, as the number of respondents was relatively low, given the demographics of Evergreen Park.

- **Access to medical care** tends to be rated higher for people with higher income. Access to medical care is rated lower by those with an unstable housing environment.
- **Access to prescription medication** tends to be rated higher for people with higher income. Access to prescription medication is rated lower for those with an unstable housing environment.
- **Access to dental care** tends to be rated higher for older people, White people, those with higher education, and those with higher income. Access to dental care is rated lower for those in an unstable housing environment.
- **Access to counseling** tends to be rated higher for older people and those with higher income. Access to counseling is rated lower for those with an unstable housing environment.

## Reasons for No Access – Medical Care

Survey respondents who reported they were not able to get medical care when needed were asked a follow-up question. Based on frequencies, the leading causes of the inability to gain access to medical care were too long to wait for an appointment (44) and inability to afford the copay (22) (Figure 20).

*Figure 20*

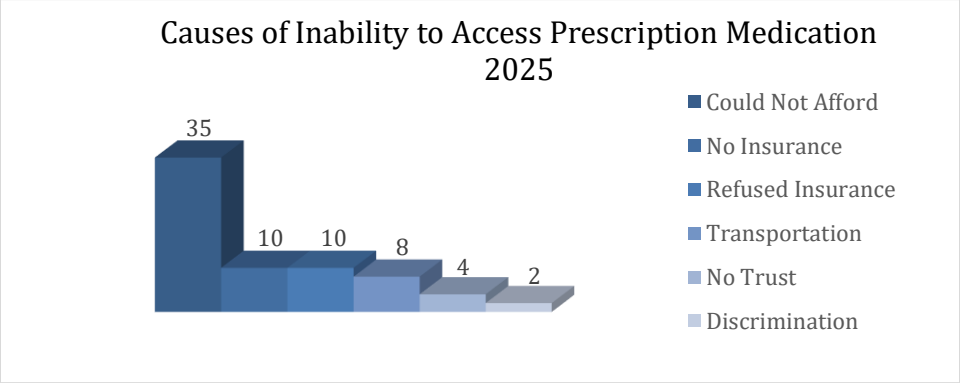



*Source: CHNA Survey*

## Reasons for No Access – Prescription Medication

Survey respondents who reported they were not able to get prescription medication when needed were asked a follow-up question. Based on frequencies, the leading cause of the inability to gain access to prescription medicine was the inability to afford copayments or deductibles (35) (Figure 21).

*Figure 21*

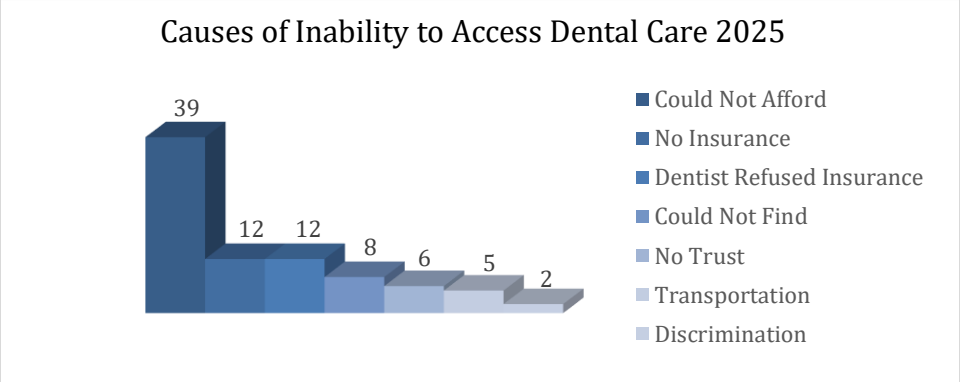



*Source: CHNA Survey*

## Reasons for No Access – Dental Care

Survey respondents who reported they were not able to get dental care when needed were asked a follow-up question. Based on frequencies, the leading cause of the inability to gain access to dental care was the inability to afford copayments or deductibles (39) (Figure 22).

*Figure 22*

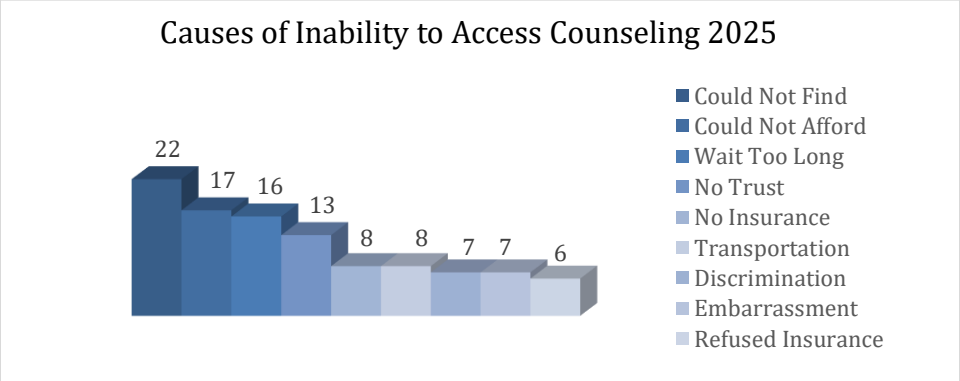



*Source: CHNA Survey*

## Reasons for No Access – Counseling

Survey respondents who reported they were not able to get counseling when needed were asked a follow-up question. Based on frequencies, the leading causes of the inability to gain access to counseling were could not find (22), inability to afford copay or deductible (17), and too long of a wait (16) (Figure 23).

*Figure 23*




*Source: CHNA Survey*

### *Comparison to 2022 CHNA*

***Access to Medical Care – results show a decrease (4%) in those who were able to get medical care.***

***Access to Prescription Medication – results show a slight decrease (1%) in those who were able to get prescription medication.***

***Access to Dental Care – results show a slight decrease (1%) in those who were able to get dental care.***

***Access to Counseling – results show a slight increase (1%) in those who were able to get counseling.***

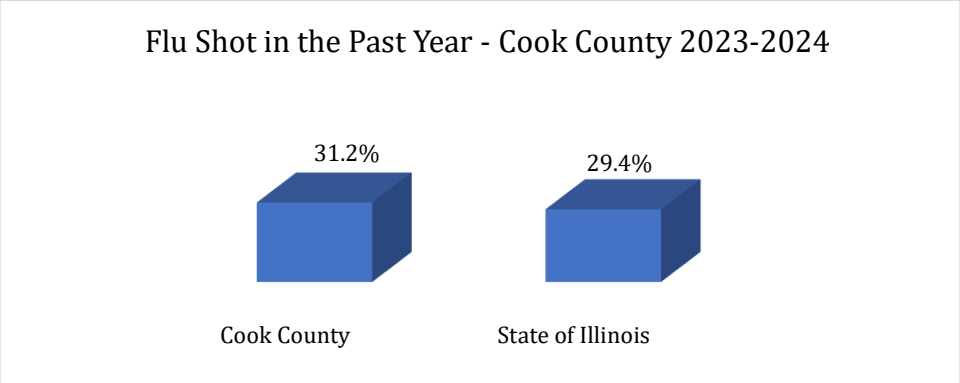
# 2.2 Wellness

*Importance of the Measure:* The overall health of a community is impacted by preventative measures, including immunizations and vaccinations. Preventative healthcare measures, such as getting a flu shot, engaging in a healthy lifestyle, and undertaking screenings for diseases, are essential to combating morbidity and mortality while reducing healthcare costs.

## Frequency of Flu Shots

Figure 24 illustrates that, during the period 2023 to 2024, 31.2% of individuals in Cook County received a flu shot. This vaccination rate surpasses the State of Illinois average, which stands at 29.4%.

*Figure 24*

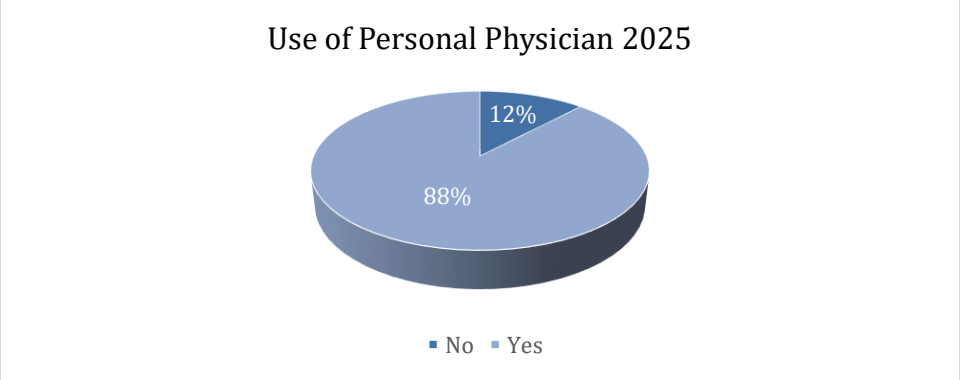



*Source: Illinois Department of Public Health (IDPH)*

# Personal Physician

The CHNA survey asked respondents if they had a personal physician. Having a personal physician suggests that individuals are more likely to get wellness check-ups and less likely to use an emergency department as a primary healthcare service. According to survey data, 88% of residents have a personal physician (Figure 25).

*Figure 25*




*Source: CHNA Survey*

## *Comparison to 2022 CHNA*

***Having a personal physician has increased. Specifically, 86% of residents reported having a personal physician in 2022, compared to 88% in 2025.***

## Social Drivers Related to Having a Personal Physician

Multiple characteristics shows a significant relationship with having a personal physician. The following relationships were found using correlational analyses:

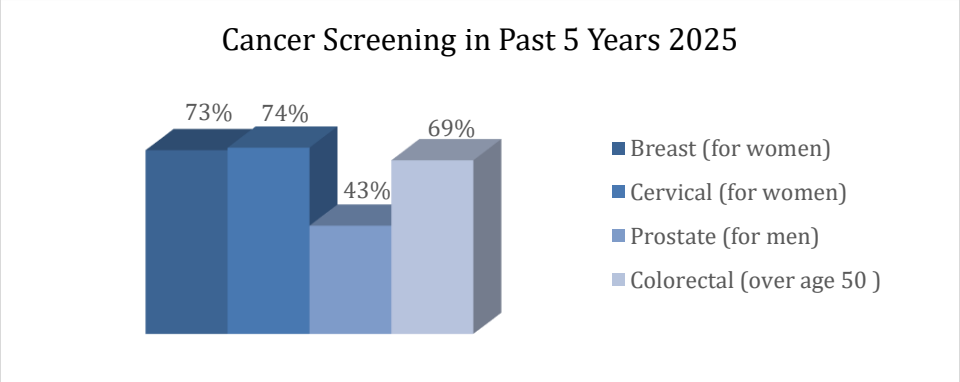
- **Having a personal physician** tends to be more likely for older people and for those who have higher income. Having a personal physician is less likely for those with an unstable housing environment.

# Cancer Screening

Early detection of cancer can greatly improve the probability of successful treatment. In the case of colorectal cancer, early detection of precancerous polyps can prevent cancer. Specifically, four types of cancer screening were measured: breast, cervical, prostate, and colorectal.

Results from the CHNA survey show that 73% of women had a breast screening and 74% had a cervical screening in the past five years. For men, 43% had a prostate screening in the past five years. For women and men over the age of 50, 69% had a colorectal screening in the last five years (Figure 26).

*Figure 26*




*Source: CHNA Survey*

### *Comparison to 2022 CHNA*

***Cancer screening rates in the past five-year period have increased. Specifically, in 2022, 66% of women had a breast screening, compared to 73% in 2025. Similarly, 69% of women had a cervical screening in 2022, compared to 74% in 2025. For men, 38% reported they had a prostate screening in 2022, compared to 43% in 2025. For women and men over the age of 50, 57% had a colorectal screening in 2022, compared to 69% in 2025.***

## Social Drivers Related to Cancer Screenings

Multiple characteristics show significant relationships with cancer screening. The following relationships were found using correlational analyses:

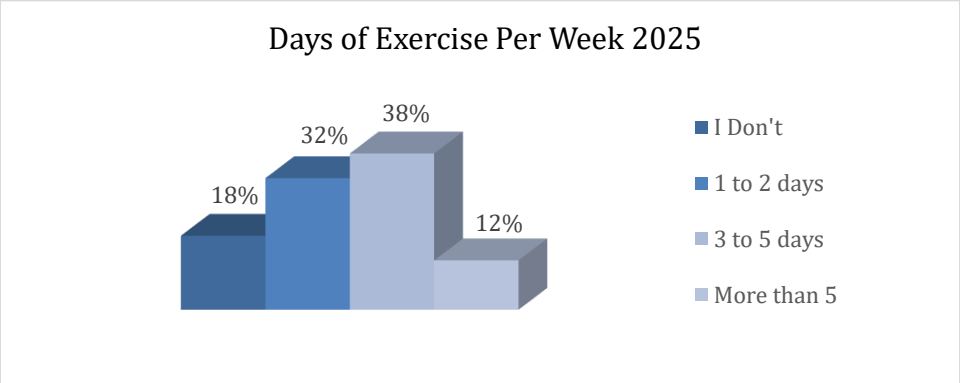
- **Breast screening** tends to be more likely for older women, White women, women with higher education, and women with higher income. LatinX women are less likely to have a breast screening.
- **Cervical screening** tends to be more likely for White women, women with a higher education, and women with higher income. LatinX women and women with an unstable housing environment are less likely to have a cervical screening.
- **Prostate screening** tends to be more likely for older men and men with higher income.
- **Colorectal screening** tends to be more likely for older people, White people, those with higher education, and those with higher income. LatinX people and those with an unstable housing environment are less likely to have a colorectal screening.

# Physical Exercise

A healthy lifestyle, comprised of regular physical activity, has been shown to increase physical, mental, and emotional well-being.

Specifically, 18% of respondents indicated that they do not exercise at all, while the majority (70%) of residents, exercise 1-5 times per week (Figure 27).

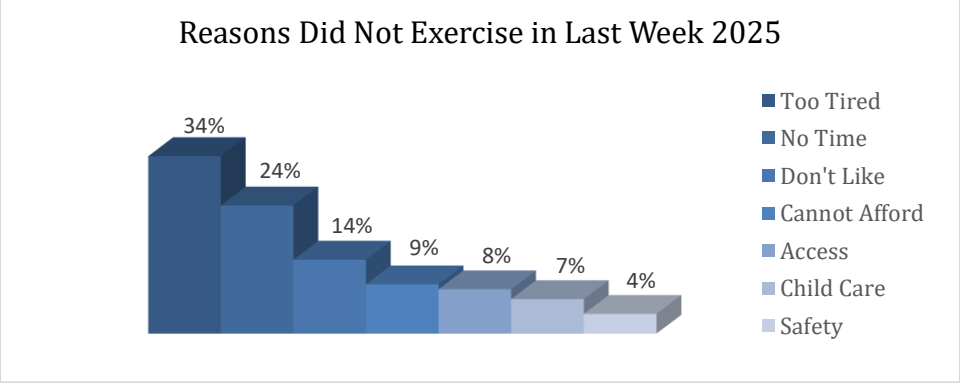
*Figure 27*




*Source: CHNA Survey*

To find out why some residents do not exercise at all, a follow up question was asked. The most common reasons for not exercising are not having enough energy (34%), not having enough time (24%), and a dislike of exercise (14%) (Figure 28).

*Figure 28*




*Source: CHNA Survey*

## *Comparison to 2022 CHNA*

***There has been an increase in exercise. In 2022, 77% of residents exercised, compared to 82% in 2025.***

## Social Drivers Related to Exercise

Multiple characteristics show significant relationships with frequency of exercise. The following relationships were found using correlational analyses:

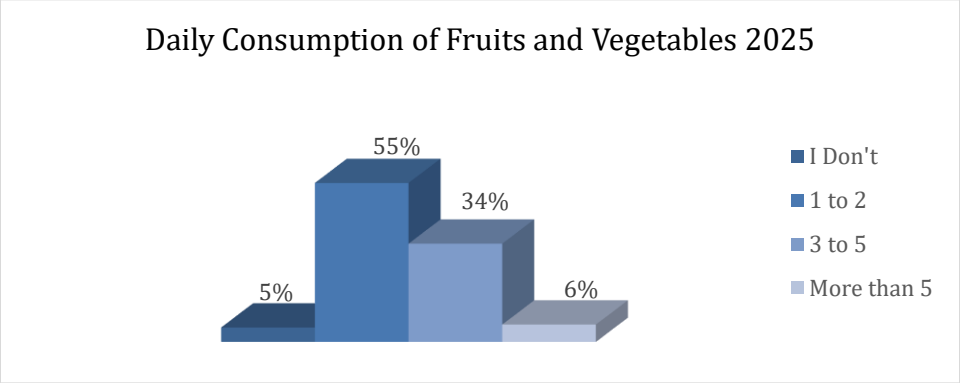
- **Frequency of exercise** tends to be higher among younger people, White people, and those with higher education. Exercise tends to be less likely for Black people.

# Healthy Eating

A healthy lifestyle, comprising a proper diet, has been shown to increase physical, mental, and emotional well-being. Consequently, nutrition and diet are critical to preventative care.

Over half (60%) of residents report no consumption or low consumption (1-2 servings per day) of fruits and vegetables. Notably, only 6% of residents consume five or more servings per day (Figure 29).

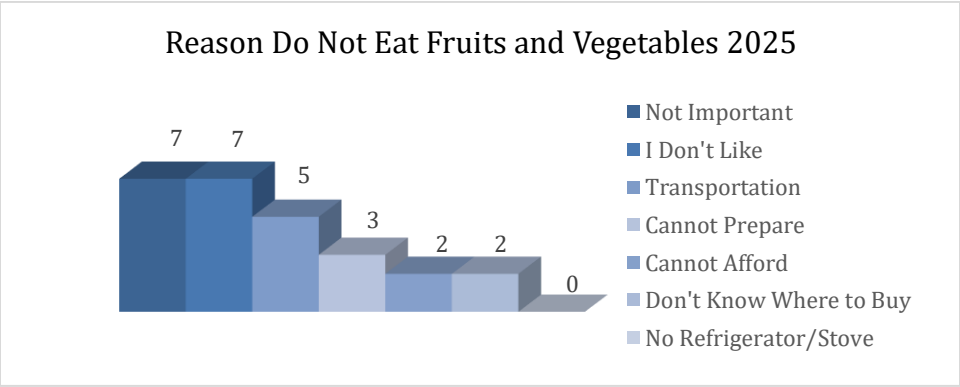
*Figure 29*




*Source: CHNA Survey*

Those individuals who indicated they do not eat any fruits or vegetables were asked a follow up question. The most frequently given reasons for failing to eat more fruits and vegetables were a lack of perceived importance (7) and a dislike of fruits and vegetables (7) (Figure 30). Note that these data are displayed in frequencies rather than percentages due to the low number of responses.

*Figure 30*




*Source: CHNA Survey*

### *Comparison to 2022 CHNA*

***There has been an increase in the frequency of healthy eating. In 2022, 34% of respondents indicated they had three or more servings of fruits and vegetables per day, compared to 40% in 2025.***

## Social Drivers Related to Healthy Eating

Multiple characteristics show significant relationships with healthy eating. The following relationships were found using correlational analyses:

- **Consumption of fruits and vegetables** tends to be more likely for younger people and those people with higher education.

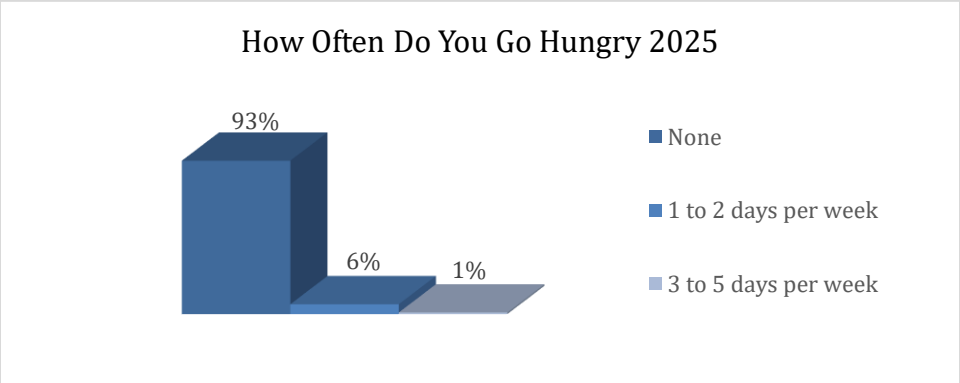
# 2.3 Understanding Food Insecurity

*Importance of the Measure:* It is essential that everyone has access to food and drink necessary for living healthy lives. Food insecurity exists when people don't have physical and economic access to sufficient, safe, and nutritious food that meets their dietary needs for a healthy life.

## Prevalence of Hunger

Respondents were asked, "How many days a week do you or your family members go hungry?" The vast majority of respondents indicated they do not go hungry, however, 6% indicated they go hungry 1-2 days per week and 1% indicated they go hungry 3 to 5 days per week (Figure 31).

*Figure 31*




*Source: CHNA Survey*

## Social Drivers Related to Prevalence of Hunger

Multiple characteristics show significant relationships with hunger. The following relationships were found using correlational analyses:

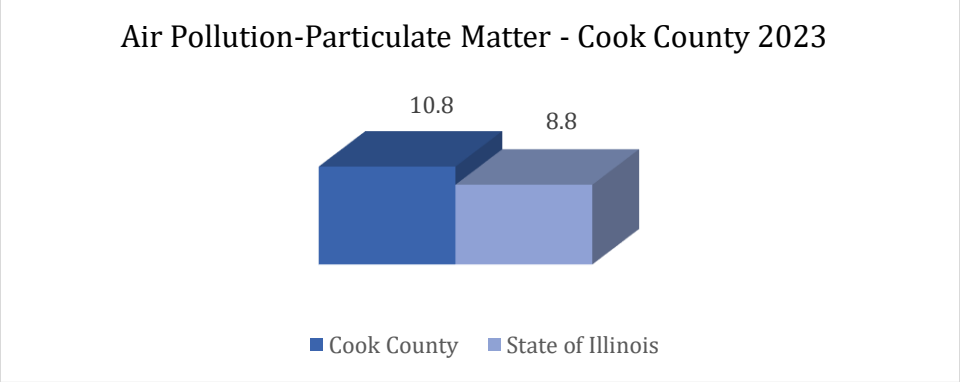
- **Prevalence of hunger** tends to be more likely for those with lower education, those with lower income, and those with an unstable housing environment. Prevalence of hunger tends to be less likely for White people.

# 2.4 Physical Environment

*Importance of the Measure:* According to the County Health Rankings & Roadmaps, Air Pollution - Particulate Matter (APPM) is the average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) in a county. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers. These particles can be directly emitted from sources such as forest fires, or they can form when gases are emitted from power plants, manufacturing facilities and automobiles.

The relationship between elevated air pollution, particularly fine particulate matter and ozone, and compromised health has been well documented. Negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects. The APPM for Cook County (10.8) is higher than the State of Illinois average of 8.8 (Figure 32).

*Figure 32*




*Source: County Health Rankings & Roadmaps*

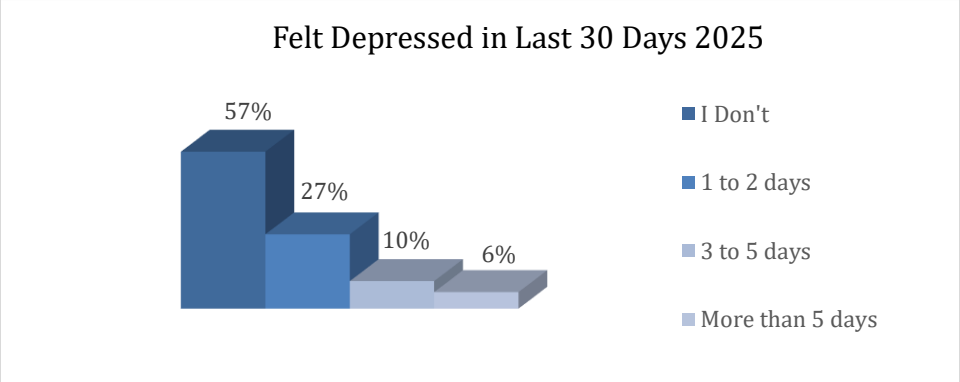
# 2.5 Health Status

*Importance of the Measure:* Self-perceptions of health can provide important insights to help manage population health. These perceptions not only provide benchmarks regarding health status but also offer insights into how accurately people perceive their own health.

## Mental Health

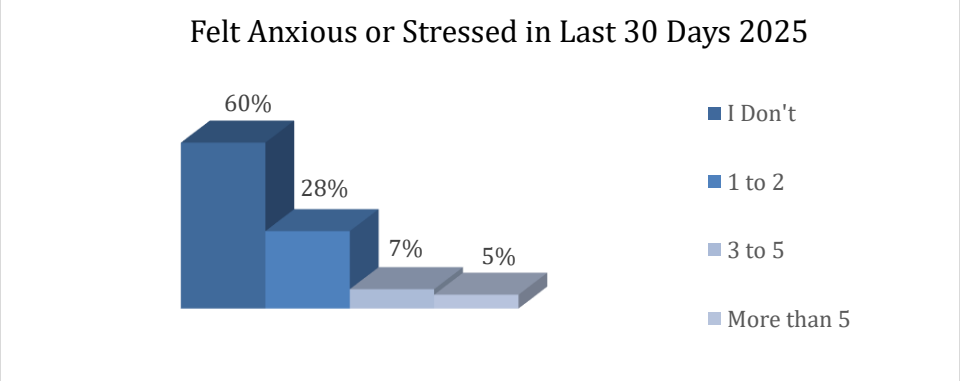
The survey asked respondents to indicate specific issues, such as depression and stress/anxiety. Of the respondents, 57% indicated they did not feel depressed in the last 30 days (Figure 33) and 60% indicated they did not feel anxious or stressed (Figure 34).

*Figure 33*




*Source: CHNA Survey*

*Figure 34*



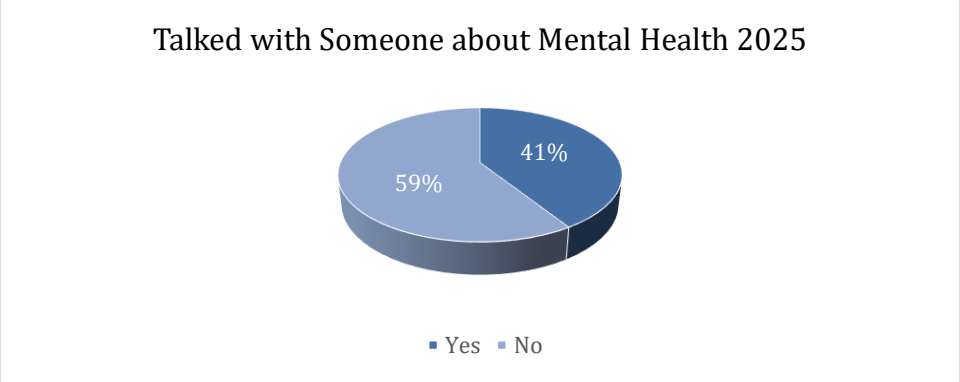

*Source: CHNA Survey*

## *Comparison to 2022 CHNA*

***Results from the 2025 CHNA show an improvement in mental health. In 2022, 53% of respondents indicated they felt depressed in the last 30 days, compared to 43% in 2025. In 2022, 41% indicated they felt anxious or stressed, compared to 40% in 2025.***

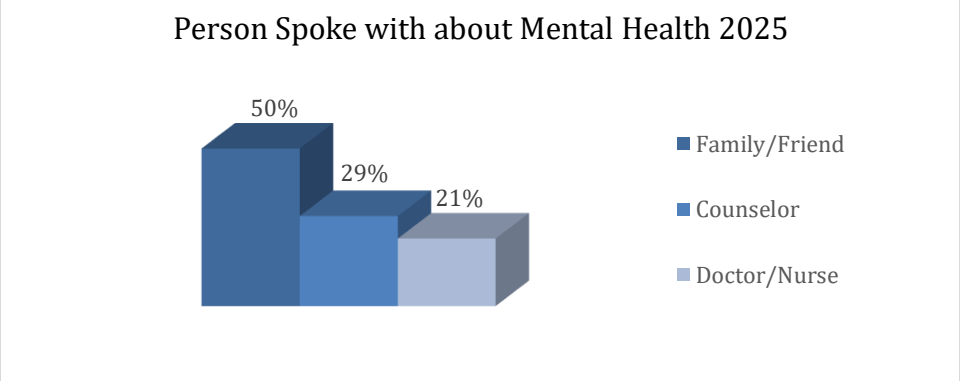
Respondents were also asked if they spoke with anyone about their mental health in the past year. Of the respondents, 41% indicated that they spoke to someone (Figure 35), with the most common response being a family member or friend (50%) (Figure 36).

*Figure 35*




*Source: CHNA Survey*

*Figure 36*




*Source: CHNA Survey*

## Social Drivers Related to Behavioral Health

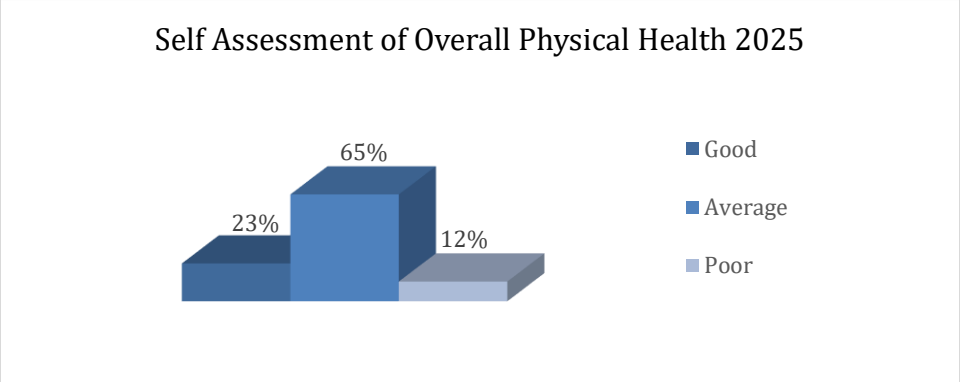
Multiple characteristics show significant relationships with behavioral health. The following relationships were found using correlational analyses:

- **Depression** did not have any correlates.
- **Stress and anxiety** tend to be rated higher for younger people and those with an unstable housing environment.

# Self-Perceptions of Overall Health

In regard to self-assessment of overall physical health, 12% of respondents reported having poor overall physical health (Figure 37).

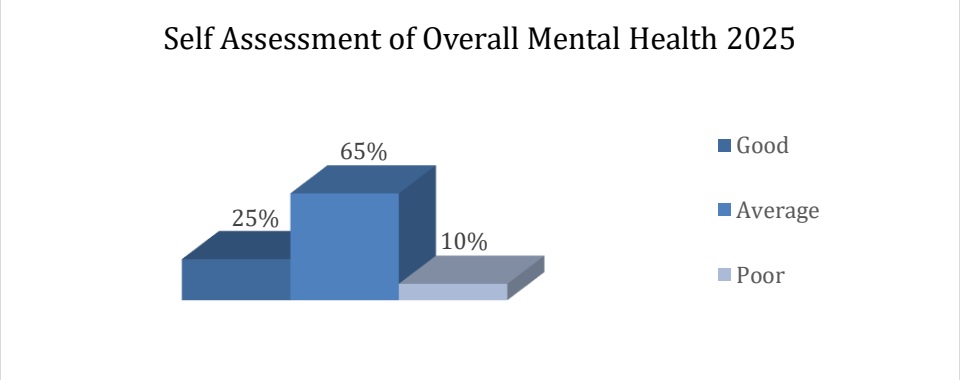
*Figure 37*




*Source: CHNA Survey*

In regard to self-assessment of overall mental health, 10% of respondents stated they have poor overall mental health (Figure 38).

*Figure 38*




*Source: CHNA Survey*

## *Comparison to 2022 CHNA*

***With regard to physical health, more people see themselves in poor health in 2025 (12%), than 2022 (9%). Regarding mental health, slightly less people see themselves in poor health in 2025 (10%), than in 2022 (11%).***

# Social Drivers Related to Self-Perceptions of Health

Multiple characteristics show significant relationships with self-perceptions of health. The following relationships were found using correlational analyses:

- **Perceptions of physical health** tend to be higher for White people, those with higher education, and those with higher income. Perceptions of physical health tend to be lower for Black people and those with an unstable housing environment.
- **Perceptions of mental health** tend to be higher for older people, White people, and those with higher income. Perceptions of mental health tend to be lower for those with an unstable housing environment.

## 2.6 Key Takeaways from Chapter 2

- ✓ THERE WAS A DECREASE IN ACCESS TO MEDICAL CARE, PRESCRIPTION MEDICATION, AND DENTAL CARE.
- ✓ INCREASED UTILIZATION OF URGENT CARE AND USE OF EMERGENCY DEPARTMENT.
- ✓ CANCER SCREENINGS FOR BREAST, CERVICAL, PROSTATE, AND COLORECTAL HAVE INCREASED.
- ✓ HALF OF RESIDENTS DO NOT EXERCISE AT ALL OR ONLY EXERCISE 1 – 2 DAYS PER WEEK, AND THE MAJORITY HAVE A LOW CONSUMPTION OF FRUITS AND VEGETABLES.
- ✓ THERE HAS BEEN AN IMPROVEMENT IN DEPRESSION AND STRESS/ANXIETY, AND SLIGHTLY LESS PEOPLE ARE REPORTING POOR MENTAL HEALTH.
- ✓ ACCESS TO MENTAL HEALTH COUNSELING HAS SLIGHTLY INCREASED, HOWEVER, MORE PEOPLE ARE SPEAKING TO FAMILY/FRIENDS ABOUT MENTAL HEALTH RATHER THAN HEALTHCARE PROFESSIONALS.

CHAPTER 3 OUTLINE



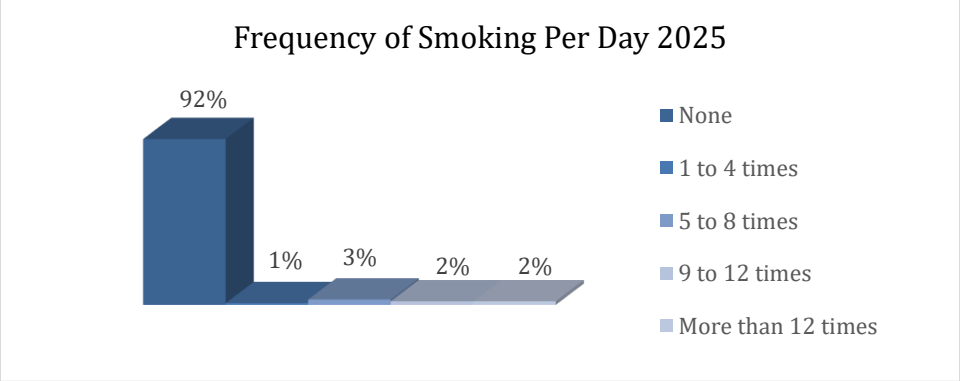
# CHAPTER 3: SYMPTOMS AND PREDICTORS

## 3.1 Tobacco Use

*Importance of the Measure:* To appropriately allocate healthcare resources, a thorough analysis of the leading indicators regarding morbidity and disease must be conducted. In this way, healthcare organizations can target affected populations more effectively. Research suggests that tobacco use facilitates a wide variety of adverse medical conditions.

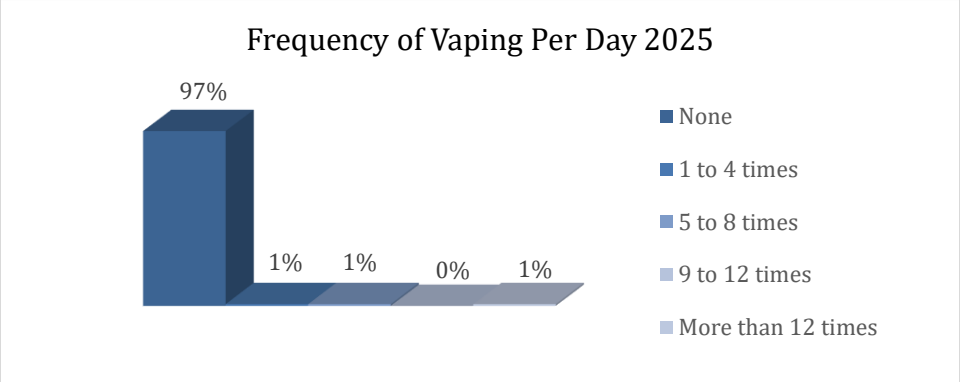
CHNA survey data show 92% of respondents do not smoke, and only 2% state they smoke more than 12 times per day (Figure 39). Additionally, 97% of respondents do not vape, and only 1% state they vape more than 12 times per day (Figure 40).

*Figure 39*




*Source: CHNA Survey*

*Figure 40*




*Source: CHNA Survey*

### *Comparison to 2022 CHNA*

***Results between 2022 and 2025 show a slight improvement in smoking rates, with 10% of people reporting they smoked in 2022, compared to 8% in 2025. Comparatively, those who vape increased. In 2022, 2% of respondents vaped, compared to 3% in 2025. The frequency of those reporting vaping more than 12 times per day accounted for 1% of respondents, up from 0% in 2022.***

## Social Drivers Related to Smoking or Vaping

Multiple characteristics show significant relationships with smoking or vaping. The following relationships were found using correlational analyses:

- **Smoking** did not have any correlates.
- **Vaping** tends to be rated higher by younger people and those with lower income.

# 3.2 Drug and Alcohol Use

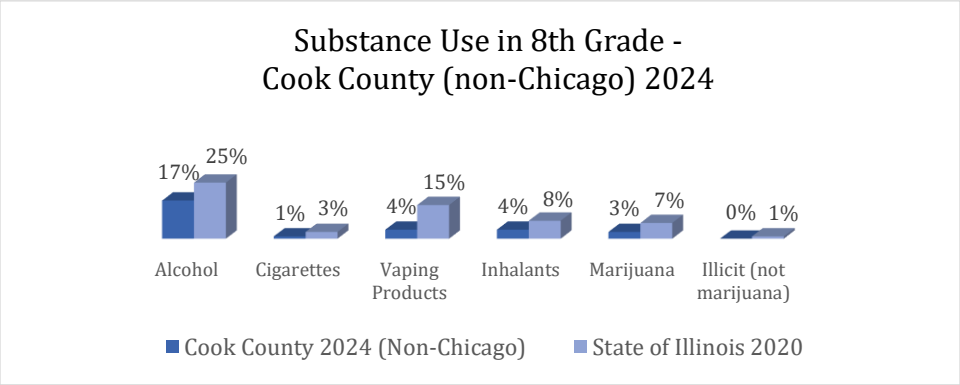
*Importance of the Measure:* Alcohol and drugs impair decision-making, often leading to adverse consequences and outcomes. Research suggests that alcohol is a gateway drug for youth, leading to increased usage of controlled substances in adulthood. Accordingly, the substance use values and behaviors of high school students are a leading indicator of adult substance use in later years.

## Youth Substance Use

Data from the Illinois Youth Survey measures illegal substance use (alcohol, tobacco, and other drugs – including inhalants) among adolescents. Cook County data is reported for 2024, while State of Illinois data is reported for 2020. Figure 41 illustrates Cook County substance use in 8th grade is lower in all categories than State of Illinois substance use in 8th grade.

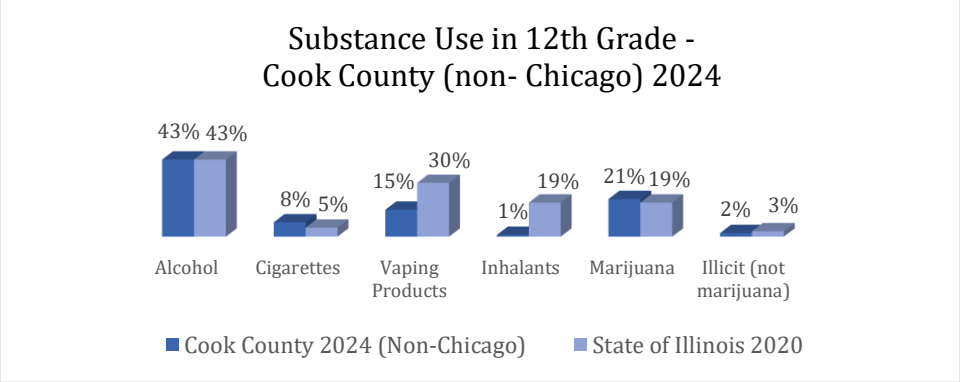
Among 12th graders, the most recent data available for Cook County is 2024 and the State of Illinois data is reported for 2020. These data show Cook County levels are below or at the State of Illinois average in all categories except cigarettes and marijuana (Figure 42).

*Figure 41*




*Source: University of Illinois Center for Prevention Research and Development*

*Figure 42*

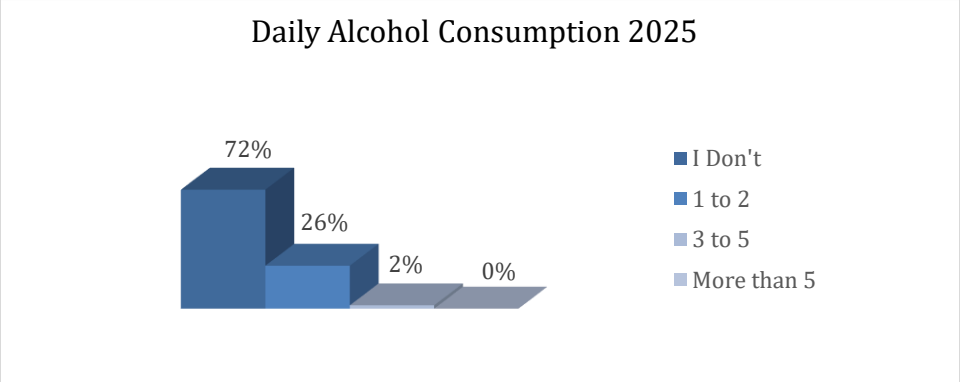



*Source: University of Illinois Center for Prevention Research and Development*

# Adult Substance Use

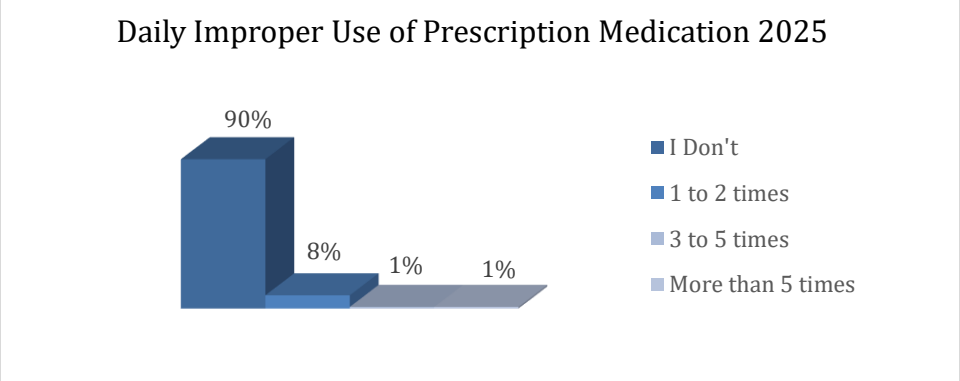
The CHNA survey asked respondents to indicate their usage of several substances. Of respondents, 72% indicated they did not consume alcohol on a typical day (Figure 43). Additionally, 90% indicated they do not take prescription medication improperly, including opioids, on a typical day (Figure 44). Furthermore, 94% indicated they do not use marijuana on a typical day (Figure 45), and 99% indicated they do not use illegal substances on a typical day (Figure 46).

*Figure 43*



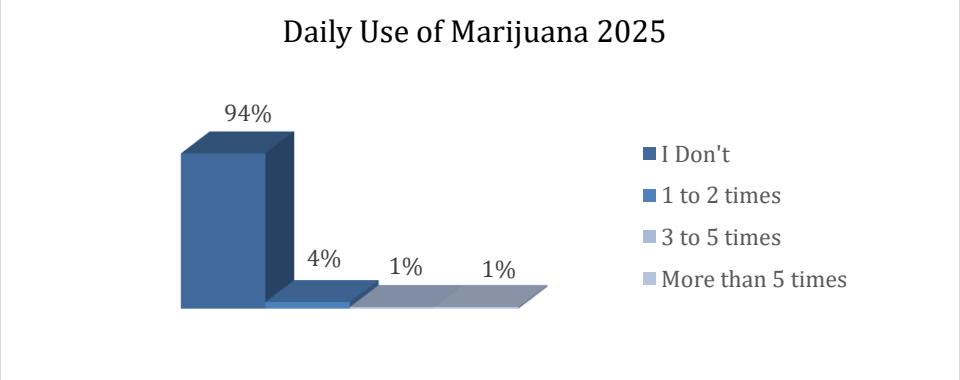

*Source: CHNA Survey*

*Figure 44*



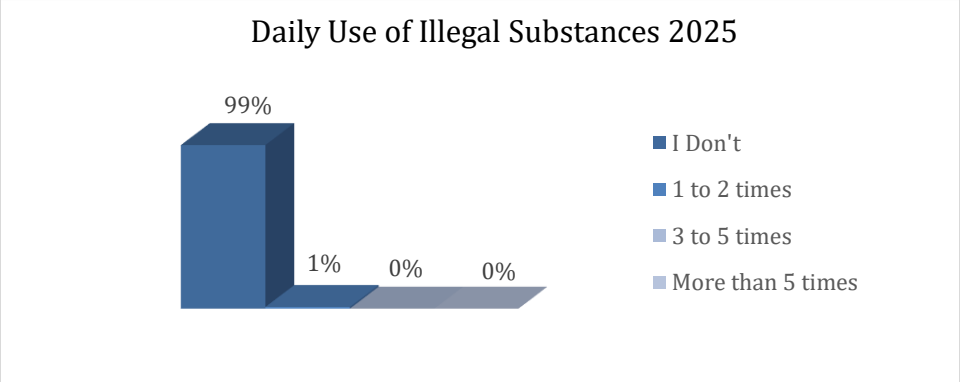

*Source: CHNA Survey*

*Figure 45*




*Source: CHNA Survey*

*Figure 46*




*Source: CHNA Survey*

## Social Drivers Related to Substance Use

Multiple characteristics show significant relationships with substance use. The following relationships were found using correlational analyses.

- **Alcohol use** did not have any significant correlates.
- **Misuse of prescription medication, including opioids** tends to be rated higher for Black people, those with lower education, those with lower income, and those with an unstable housing environment. Misuse of prescription medication, including opioids, tends to be rated lower by White people.
- **Marijuana use** tends to be rated higher for younger people and those with lower income.
- **Illegal substance use** did not have any correlates.

# 3.3 Obesity

*Importance of the Measure:* Individuals who are obese place greater stress on their internal organs, thus increasing their propensity to utilize health services. Research strongly suggests that obesity is a significant problem facing youth and adults nationally, in Illinois, and within Evergreen Park, Cook County. The US Surgeon General has characterized obesity as "the fastest-growing, most threatening disease in America today." According to the Obesity Prevention Initiative from the Illinois General Assembly, 20% of Illinois children are obese.

With children, research has linked obesity to numerous chronic diseases, including Type II diabetes, hypertension, high blood pressure, and asthma. Adverse physical health side effects of obesity include orthopedic problems due to weakened joints and lower bone density. Detrimental mental health side effects include low self-esteem, poor body image, symptoms of depression and suicide ideation. Obesity also impacts educational performance; studies suggest school absenteeism of obese children is six times higher than that of non-obese children.

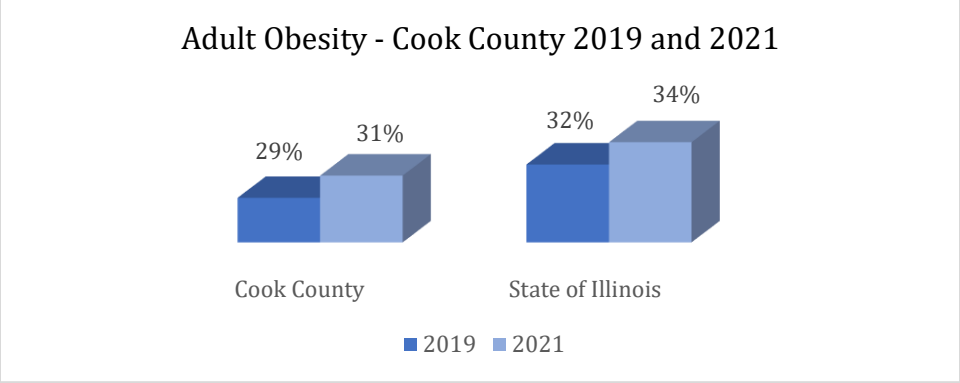
With adults, obesity has far-reaching consequences. Testimony to the Illinois General Assembly indicated that obesity-related illnesses contribute to worker absenteeism, slow workflow, and high worker compensation rates. A Duke University study on the effects of obesity in the workforce noted 13 times more missed workdays by obese employees than non-obese employees. Nationwide, lack of physical activity and poor nutrition contribute to an estimated 300,000 preventable deaths per year.

In Cook County, the number of people diagnosed with obesity has increased overall from 2019 to 2021. Note specifically that the percentage of obese people has increased from 29% to 31%.

Obesity rates in the State of Illinois have increased over the years from 2019 to 2021. Note specifically that the percentage of obese people has increased from 32% to 34% (Figure 47). Obesity is defined as body mass index (BMI) greater than or equal to 30 kg/m2 (age-adjusted).

Additionally, 2025 CHNA survey respondents indicated that being overweight was their most prevalently diagnosed health issue.

*Figure 47*

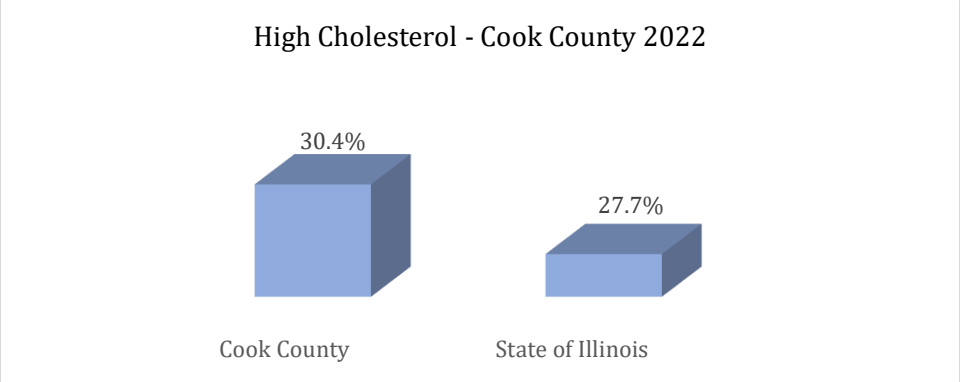



*Source: County Health Rankings & Roadmaps*

# 3.4 Predictors of Heart Disease

Residents in Cook County report a higher prevalence of high cholesterol compared to the State of Illinois average. The percentage of residents who report they have high cholesterol in Cook County (30.4%), compared to the State of Illinois average of 27.7% (Figure 48).

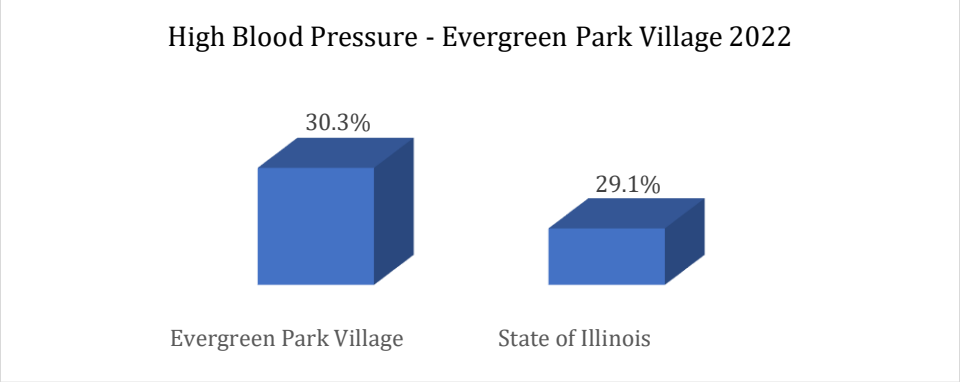
*Figure 48*




*Source: Stanford Data Commons*

With regard to high blood pressure, Evergreen Park Village (30.3%) has a higher percentage of residents with high blood pressure, compared to the State of Illinois as a whole (29.1%) (Figure 49).

*Figure 49*




*Source: Stanford Data Commons*

# 3.5 Key Takeaways from Chapter 3

- ✓ SUBSTANCE USE AMONG 8TH GRADERS IS LOWER THAN STATE OF ILLINOIS AVERAGES WHILE CIGARETTE AND MARIJUANA USE AMONG 12TH GRADERS IS HIGHER THAN STATE OF ILLINOIS AVERAGES.
- ✓ WHILE LOWER THAN THE STATE OF ILLINOIS AVERAGES, ALMOST ONE-THIRD OF RESIDENTS ARE OBESE.
- ✓ RISK FACTORS FOR HEART DISEASE ARE SLIGHTLY HIGHER THAN STATE OF ILLINOIS AVERAGES.
- ✓ VAPING HAS SLIGHTLY INCREASED.
- ✓ 10% OF SURVEY RESPONDENTS INDICATED THEY MISUSE PRESCRIPTION MEDICATION, INCLUDING OPIOIDS, ON A DAILY BASIS.

CHAPTER 4 OUTLINE



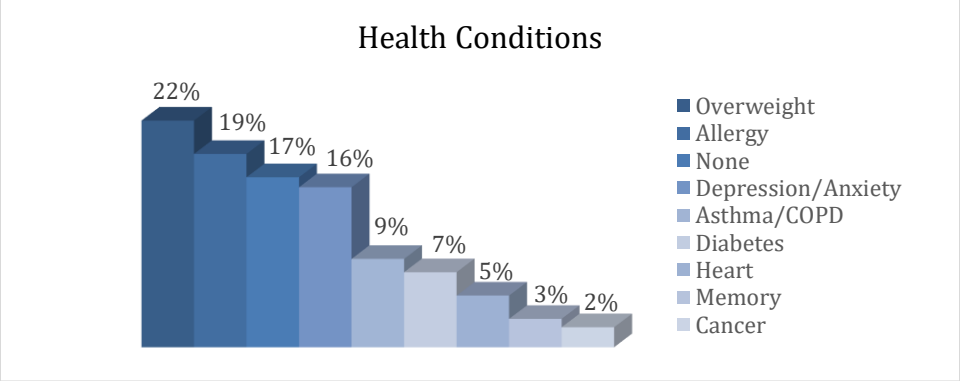
# CHAPTER 4: MORBIDITY AND MORTALITY

Given the lack of recent disease/morbidity data from existing secondary data sources, much of the data used in this chapter was manually gathered from OSF Little Company of Mary Medical Center hospital-level data using COMPdata Informatics. Note that hospital-level data only show hospital admissions and do not reflect outpatient treatments and procedures.

## 4.1 Self-Identified Health Conditions

Survey respondents were asked to self-identify any health conditions. The highest rated health conditions were being overweight (22%), allergies (19%), and depression/anxiety (16%). Often percentages for self-identified data are lower than secondary data sources (Figure 50).

*Figure 50*




*Source: CHNA Survey*

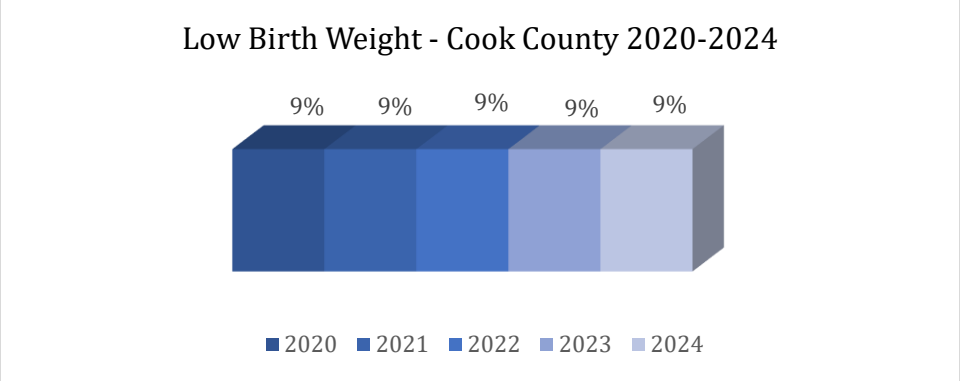
# 4.2 Healthy Babies

*Importance of the Measure:* Regular prenatal care is vital for producing healthy babies and children. Screening and treatment for medical conditions, as well as identifying and intervening in behavioral risk factors associated with poor birth outcomes, are crucial. Research suggests that women who receive adequate prenatal care are more likely to have better birth outcomes, such as full-term and normal-weight babies.

## Low Birth Weight Rates

Low birth weight rate is defined as the percentage of infants born below 2,500 grams (5.5 pounds). Very low birth weight rate is defined as the percentage of infants born below 1,500 grams (3.3 pounds). In contrast, the average newborn weighs about 7 pounds. The percentage of babies born with low birth weight in Cook County has remained relatively constant at 9% over the period from 2020 to 2024 (Figure 51).

*Figure 51*




*Source: County Health Rankings & Roadmaps*

# 4.3 Cardiovascular Disease

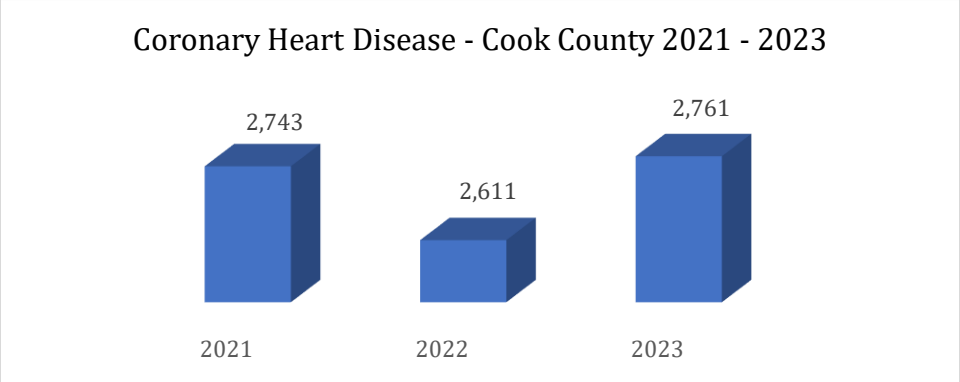
*Importance of the Measure:* Cardiovascular disease encompasses all diseases of the heart and blood vessels, including ischemic (also known as coronary) heart disease, cerebrovascular disease, congestive heart failure, hypertensive disease, and atherosclerosis.

## Coronary Heart Disease

Coronary Heart Disease, sometimes-called atherosclerosis, can slowly narrow and/or harden the arteries throughout the body. Coronary artery disease is a leading cause of death for Americans. Most of these deaths resulting from heart attacks caused by sudden blood clots in the heart's arteries.

The number of cases of coronary atherosclerosis complications at Cook County area hospitals have increased overall from 2021 through 2023, with a more significant drop in 2022 (Figure 52).

*Figure 52*

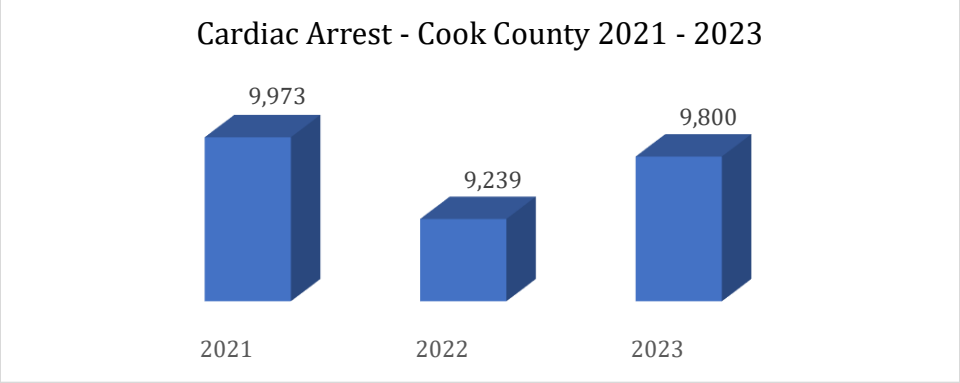



*Source: COMPdata Informatics*

## Cardiac Arrest

Cases of dysrhythmia and cardiac arrest at Cook County area hospitals decreased overall between 2021 and 2023, with a more significant drop in cases during 2022 (Figure 53).

*Figure 53*

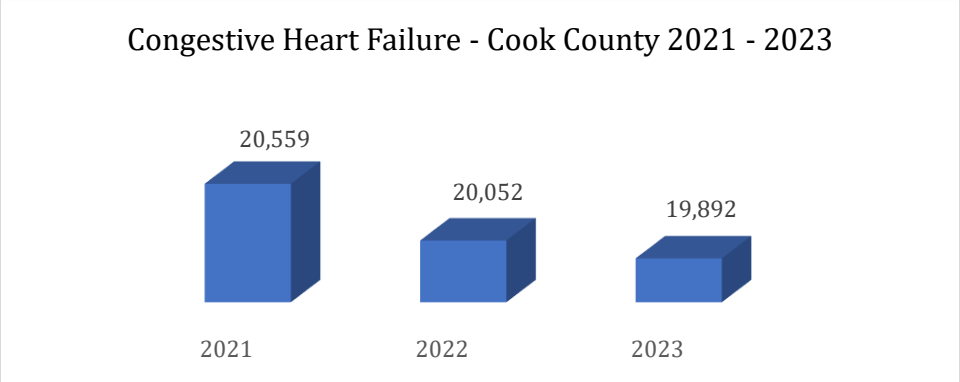



*Source: COMPdata Informatics*

## Heart Failure

The number of treated cases of heart failure at Cook County area hospitals decreased from 20,559 in 2021 to 19,892 in 2023 (Figure 54).

*Figure 54*

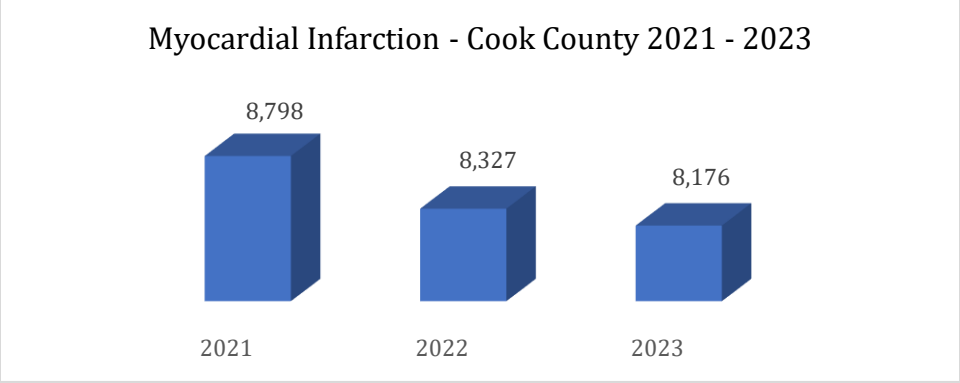



*Source: COMPdata Informatics*

## Myocardial Infarction

The number of treated cases of myocardial infarction at area hospitals in Cook County decreased from 8,798 in 2021 to 8,176 in 2023 (Figure 55).

*Figure 55*

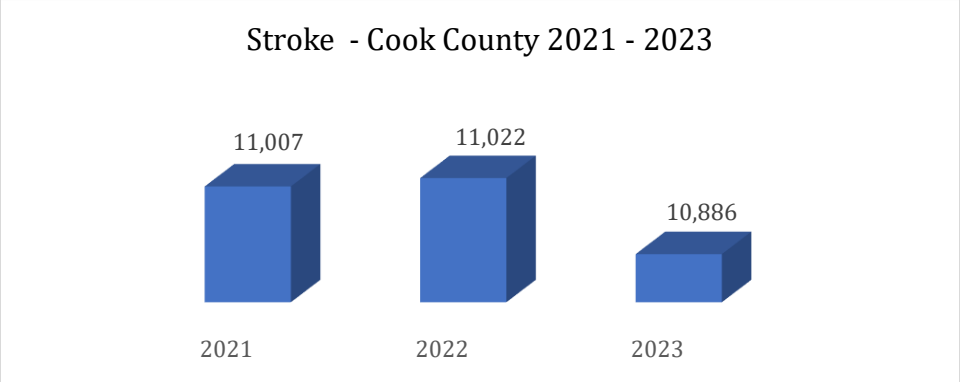



*Source: COMPdata Informatics*

## Strokes

The number of treated cases of stroke at Cook County area hospitals fluctuated between 2021 and 2023. Cases increased from 11,007 in 2021 to 11,022 in 2022. The number of cases then decreased to 10,886 in 2023 (Figure 56).

*Figure 56*



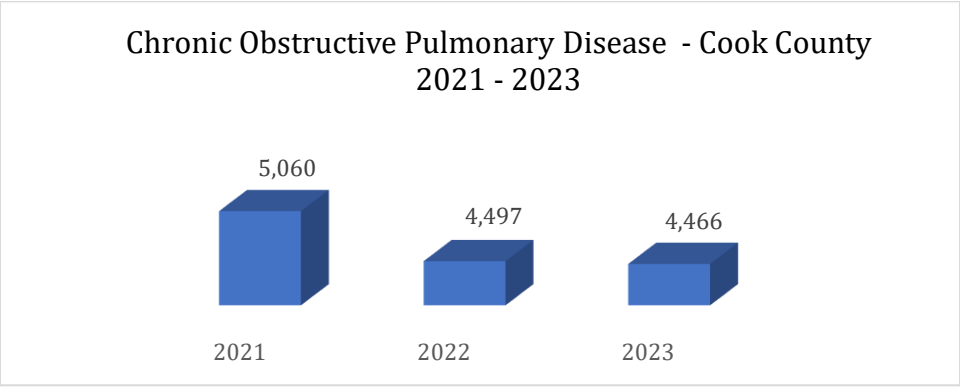

*Source: COMPdata Informatics*

# 4.4 Respiratory

*Importance of the Measure:* Diseases of the respiratory system include acute upper respiratory infections such as influenza, pneumonia, bronchitis, asthma, emphysema, and Chronic Obstructive Pulmonary Disease (COPD). These conditions are characterized by breathlessness, wheezing, chronic coughing, frequent respiratory infections, and chest tightness. Many respiratory conditions can be successfully controlled with medical supervision and treatment. However, children and adults who do not have access to adequate medical care are likely to experience repeated serious episodes, trips to the emergency room and absences from school and work. Hospitalization rates illustrate the worst episodes of respiratory diseases and serve as a proxy measure for inadequate treatment.

Treated cases of COPD at Cook County area hospitals decreased from 5,060 in 2021 to 4,466 in 2023 (Figure 57).

*Figure 57*



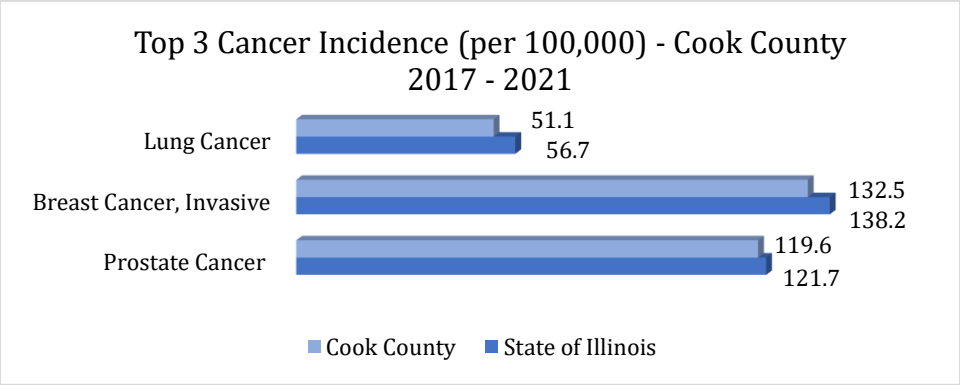

*Source: COMPdata Informatics*

# 4.5 Cancer

*Importance of the Measure:* Cancer is caused by the abnormal growth of cells in the body, and many causes of cancer have been identified. Generally, each type of cancer has its own symptoms, outlook for cure, and methods for treatment. Cancer is one of the leading causes of death in Cook County.

For the top three prevalent cancers in Cook County, comparisons are illustrated in the graph that follows (Figure 58). Specifically, lung, breast, and prostate cancer rates are lower than the State of Illinois cancer rates between the years 2017 and 2021.

*Figure 58*



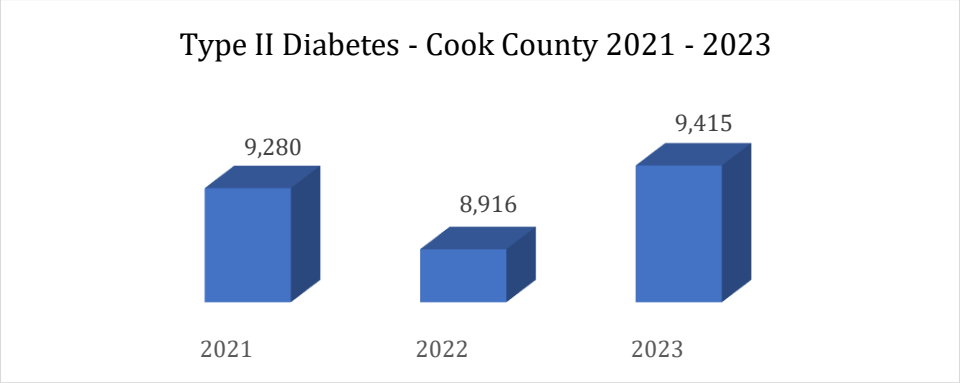

*Source: Illinois Department of Public Health*

# 4.6 Diabetes

*Importance of the Measure:* Diabetes is the leading cause of kidney failure, adult blindness, and amputations and it is a leading contributor to strokes and heart attacks. It is estimated that 90-95% of individuals with diabetes have Type II diabetes (previously known as adult-onset diabetes), while only 5-10% of individuals with diabetes have Type I diabetes (previously known as juvenile diabetes).

Inpatient cases of Type II diabetes from Cook County have fluctuated between 2021 and 2023, with an overall increase in cases from 9,280 in 2021 to 9,415 in 2023 (Figure 59).

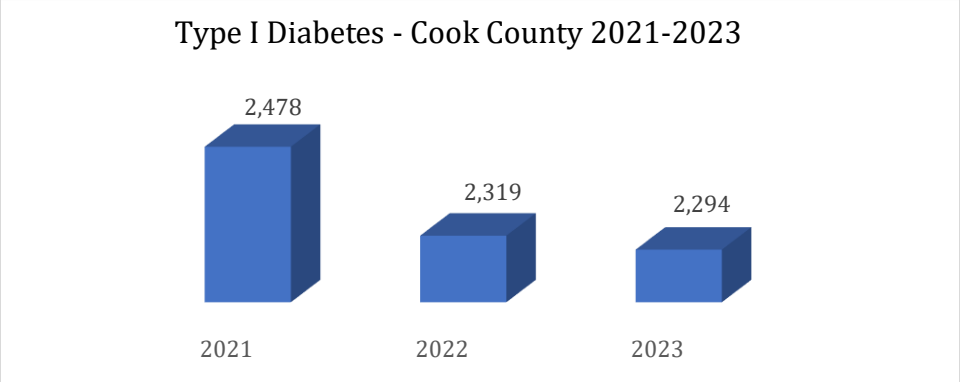
*Figure 59*




*Source: COMPdata Informatics*

Inpatient cases of Type I diabetes show a decrease from 2,478 in 2021 to 2,294 in 2023 in Cook County (Figure 60). Note that hospital-level data only show hospital admissions and do not reflect out-patient treatments and procedures.

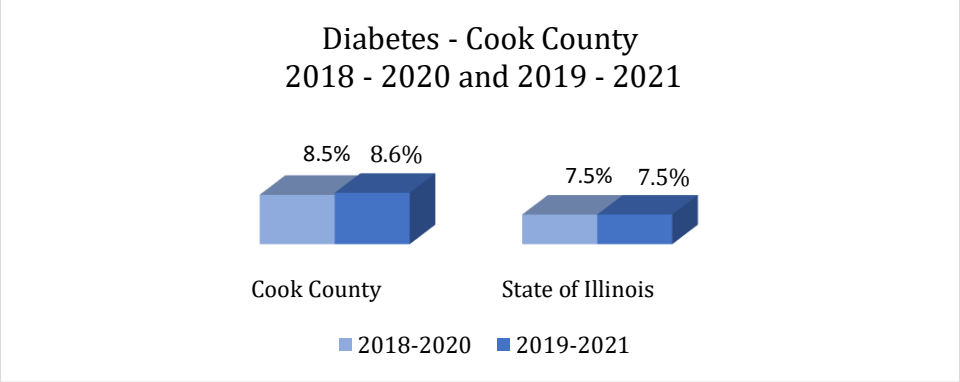
*Figure 60*




*Source: COMPdata Informatics*

Data show that 8.6% of Cook County residents have diabetes during the period from 2019 to 2021 (Figure 61), which is higher than the State of Illinois average (7.5%).

*Figure 61*




*Source: Center for Disease Control (CDC)*

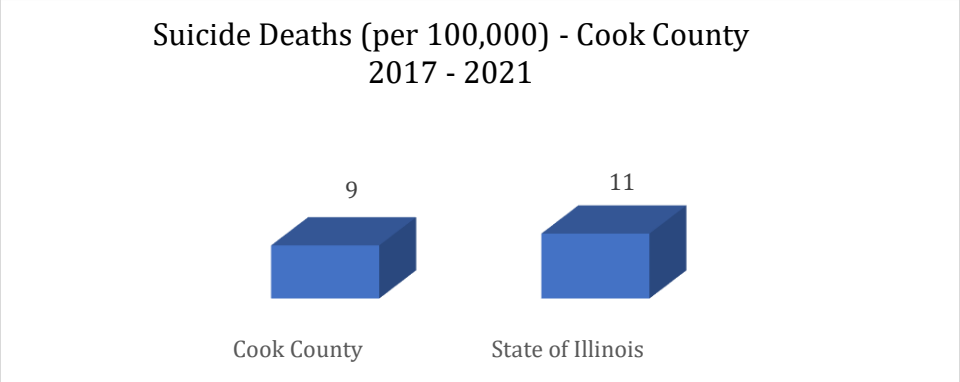
# 4.7 Injuries

*Importance of the Measure:* Suicide is intentional self-harm resulting in death. These injuries often indicate serious mental health problems requiring the treatment of other trauma-inducing issues.

## Suicide

The number of suicides in Cook County indicates lower incidences compared to the State of Illinois averages, with approximately 9 per 100,000 people in Cook County between 2017 and 2021 (Figure 62).

*Figure 62*




*Source: Illinois Department of Public Health*

# 4.8 Mortality

*Importance of the Measure:* Presenting data that focuses on causes of mortality provides an opportunity to define and quantify which diseases are causing the most deaths.

The leading causes of death in the State of Illinois and Cook County are similar as a percentage of total deaths in 2022. Diseases of the heart are the cause of 22.1% of deaths, cancer is the cause of 19.2% of deaths, and COVID-19 is the cause of 6.1% of deaths in Suburban Cook County (Table 1).

*Table 1*

| Top 5 Leading Causes of Death for all Races by County & State of Illinois, 2022 | | |
|---|---|---|
| Rank | **Suburban Cook County** | **State of Illinois** |
| 1 | Diseases of Heart (22.1%) | Diseases of Heart (21.8%) |
| 2 | Malignant Neoplasm (19.2%) | Malignant Neoplasm (19.2%) |
| 3 | COVID-19 (6.1%) | Accidents (6.1%) |
| 4 | Cerebrovascular Disease (6.0%) | COVID-19 (5.8%) |
| 5 | Accidents (5.5%) | Cerebrovascular Disease (5.4%) |

*Source: Illinois Department of Public Health*

# 4.9 Key Takeaways from Chapter 4

- ✓ LUNG, BREAST, AND PROSTATE CANCER RATES IN COOK COUNTY ARE SLIGHTLY LOWER THAN STATE OF ILLINOIS AVERAGES.
- ✓ SUICIDE RATES IN COOK COUNTY ARE LOWER THAN STATE OF ILLINOIS AVERAGE.
- ✓ DIABETES RATES ARE SLIGHTLY INCREASING AND ARE HIGHER IN COOK COUNTY THAN THE STATE OF ILLINOIS AVERAGES.
- ✓ HEART DISEASE AND CANCER ARE THE LEADING CAUSES OF MORTALITY IN SUBURBAN COOK COUNTY.

CHAPTER 5 OUTLINE



# CHAPTER 5: PRIORITIZATION OF HEALTH-RELATED ISSUES

In this chapter, the most critical health-related needs in the community are identified. To accomplish this, community perceptions of health issues, unhealthy behaviors, and issues related to well-being were first considered. Key takeaways from each chapter were then used to identify important health-related issues in the community. Next, a comprehensive inventory of community resources was completed, and finally, the most significant health needs in the community were prioritized.

Specific criteria used to identify these issues included: (1) magnitude in the community; (2) severity in the community; and (3) potential for impact to the community.

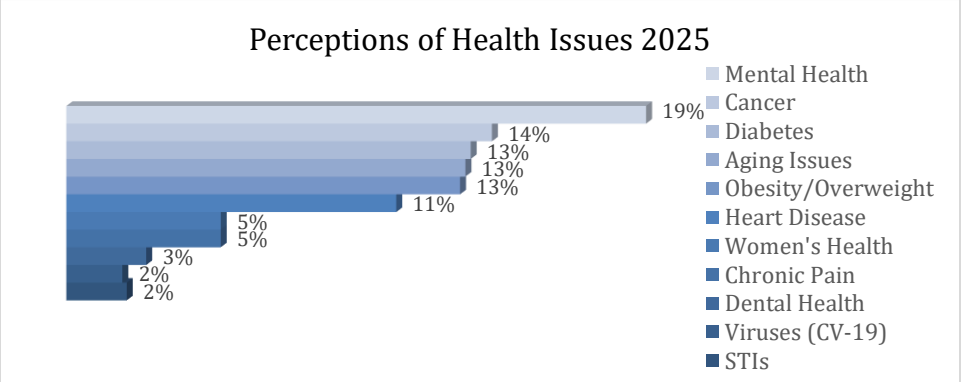
## 5.1 Perceptions of Health Issues

The CHNA survey asked respondents to rate the three most important health issues in the community from 11 different options.

The highest-rated health issue was mental health (19%), followed by cancer (14%), diabetes (13%), aging issues (13%), obesity (13%), and heart disease (11%) (Figure 63).

Note that perceptions of the community were accurate in some cases. For example, mental health issues are significant, and cancer is a leading cause of death. The survey respondents accurately identified these as important health issues. However, some perceptions were inaccurate. For instance, while heart disease is a leading cause of mortality, it is ranked relatively low.

*Figure 63*

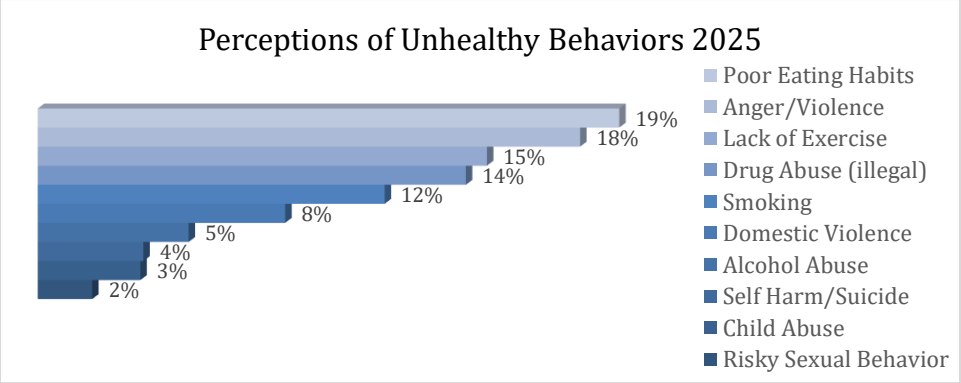



*Source: CHNA Survey*

# 5.2 Perceptions of Unhealthy Behaviors

Respondents were asked to select the three most important unhealthy behaviors in the community out of a total of 10 choices. The highest rated unhealthy behaviors were poor eating habits (19%), anger/violence (18%), lack of exercise (15%), drug abuse (illegal) (14%), and smoking (12%) (Figure 64).

*Figure 64*



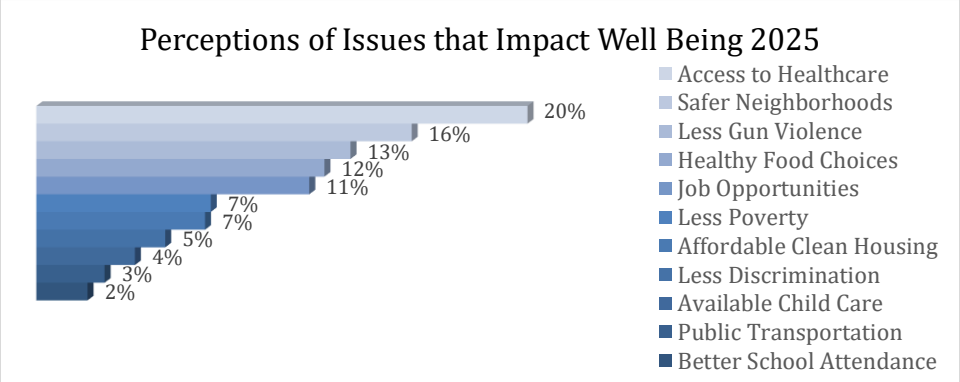

*Source: CHNA Survey*

# 5.3 Perceptions of Issues Impacting Well Being

Respondents were asked to select the three most important issues impacting well-being in the community from a total of 11 choices.

The highest-rated issue impacting well-being was access to healthcare (20%), followed by safer neighborhoods (16%), less gun violence (13%), healthy food choices (12%), and job opportunities (11%) (Figure 65). Access to healthcare was significantly higher than other categories based on t-tests between sample means.

*Figure 65*




*Source: CHNA Survey*

# 5.4 Summary of Community Health Issues

Based on the findings from the previous analyses, a chapter-by-chapter summary of key takeaways is used to provide a foundation for identifying the most important health-related issues in the community. Considerations for identifying key takeaways include magnitude in the community, strategic importance to the community, existing community resources, potential for impact, and trends and future forecasts.

**Demographics (Chapter 1) –** Three factors were identified as the most important areas of impact from the demographic analyses:

- Population increased
- Population over age 65 increased
- Single female head-of-house-household represents 28% of the population

**Prevention Behaviors (Chapter 2) –** Five factors were identified as the most important areas of impact from the chapter on prevention behaviors:

- Increase use in urgent care and emergency department
- Decrease access to medical care, prescription medication, and dental care
- Cancer screenings have increased
- Exercise and healthy eating behaviors
- Depression and stress/anxiety

**Symptoms and Predictors (Chapter 3) –** Five factors were identified as the most important areas of impact from the chapter on symptoms and predictors:

- Vaping
- Cigarettes and marijuana among young people
- Obesity
- Risk factors for heart disease
- Opioid use

**Morbidity and Mortality (Chapter 4) –** Two factors were identified as the most important areas of impact from the chapter on morbidity/mortality behaviors:

- Diabetes rates are increasing
- Heart disease and cancer are the leading causes of mortality

## Potential Health-Related Needs Considered for Prioritization

Before the prioritization of significant community health-related needs was performed, results were aggregated into 8 potential categories. Based on similarities and duplication, the 8 potential areas considered are:

- **Aging Issues**
- **Access to Healthcare**
- **Healthy Behaviors – Nutrition and Exercise**
- **Behavioral Health, Including Depression, Anxiety/Stress, Suicide**
- **Obesity**
- **Substance Use, Particularly Misuse of Prescription Medication**
- **Cancer**
- **Diabetes**

# 5.5 Community Resources

After summarizing potential categories for prioritization in the Community Health Needs Assessment, a comprehensive analysis of existing community resources was performed to identify the efficacy to which these 8 health-related areas were being addressed. A resource matrix can be seen in APPENDIX 5. RESOURCE MATRIX relating to the 8 health-related issues.

There are numerous forms of resources in the community. They are categorized as recreational facilities, county health departments, community agencies, and area hospitals/clinics. A detailed list of community resources and descriptions appears in APPENDIX 6. DESCRIPTION OF COMMUNITY RESOURCES.

# 5.6 Significant Needs Identified and Prioritized

In order to prioritize the previously identified dimensions, the collaborative team considered health needs based on: (1) magnitude of the issues (e.g., what percentage of the population was impacted by the issue); (2) severity of the issues in terms of their relationship with morbidities and mortalities; (3) potential impact through collaboration. Using a modified version of the Hanlon Method, as seen in

APPENDIX 7: PRIORITIZATION METHODOLOGY, the collaborative team identified two significant health needs and considered them equal priorities:

- **Healthy Behaviors**
- **Access to Healthcare**

# HEALTHY BEHAVIORS – NUTRITION, EXERCISE, AND SUBSEQUENT OBESITY

Healthy behaviors, such as a balanced diet consisting of whole foods and physical exercise, are critical for both physical and mental well-being. Healthy behaviors can have substantial influence in reducing the risk of numerous health issues and these behaviors contribute to increased longevity and improved quality of life. Nationwide, lack of physical exercise and poor nutrition contribute to an estimated 300,000 preventable deaths per year.

**NUTRITION.** Almost two-thirds (60%) of residents in Evergreen Park report no consumption or low consumption (1-2 servings per day) of fruits and vegetables per day. Note that the percentage of residents who consume five or more servings per day is only 6%. The most prevalent reasons for failing to eat more fruits and vegetables were lack of importance and dislike.

**EXERCISE.** A healthy lifestyle, comprised of regular physical activity and balanced diet, has been shown to increase physical, mental, and emotional well-being. Note that 18% of respondents indicated that they do not exercise at all, while the majority (70%) of residents exercise 1-5 times per week. The most common reasons for not exercising were not having enough energy (34%) and not enough time (24%).

**OBESITY.** In Evergreen Park, the percentage of obese people has increased from 29% in 2019 to 31% in 2021. This is slightly lower than the State of Illinois average, where obesity rates have increased from 32% in 2019 to 34% in 2021. In the 2025 CHNA survey, respondents indicated that obesity was the third most important health issue and was rated as the most prevalently diagnosed health condition. Research strongly suggests that obesity is a significant problem facing youth and adults nationally, in Illinois, and within Evergreen Park. The U.S. Surgeon General has characterized obesity as "the fastest-growing, most threatening disease in America today." According to the Obesity Prevention Initiative from the Illinois General Assembly, 20% of Illinois children are obese. With children, research has linked obesity to numerous chronic diseases including Type II diabetes, hypertension, high blood pressure and asthma. Adverse physical health side effects of obesity include orthopedic problems due to weakened joints and lower bone density. Detrimental mental health side effects include low self-esteem, poor body image, symptoms of depression and suicide ideation. Obesity impacts educational performance as well; studies suggest school absenteeism of obese children is six times higher than that of non-obese children. With adults, obesity has far-reaching consequences. Testimony to the Illinois General Assembly indicated that obesity-related illnesses contribute to worker absenteeism, slow workflow, and high worker

compensation rates. A Duke University study on the effects of obesity in the workforce noted 13 times more missed workdays by obese employees than non-obese employees.

# ACCESS TO CARE

**PRIMARY SOURCE OF HEALTHCARE.** The CHNA survey asked respondents to identify their primary source of healthcare. While 57% of respondents identified clinic/doctor's office as the primary source of care and 33% of respondents identified urgent care as the primary source of care, 5% of respondents indicated they do not seek healthcare when needed and similarly 5% identified the emergency department as a primary source of healthcare. Note that not seeking healthcare had no significant correlates. Selection of an emergency department as the primary source of healthcare tends to be rated higher by those in an unstable housing environment.

**ACCESS TO MEDICAL CARE, PRESCRIPTION MEDICATIONS, DENTAL CARE AND MENTAL-HEALTH COUNSELING.** Survey results show that 19% of the population did not have access to medical care when needed; 16% of the population did not have access to prescription medications when needed; 17% of the population did not have access to dental care when needed; and 13% of the population did not have access to counseling when needed. The leading causes of not getting access to care when needed were cost and too long of a wait.

# III. APPENDICES

# APPENDIX 1. MEMBERS OF COLLABORATIVE TEAM

Members of the Collaborative Team consisted of individuals with special knowledge of and expertise in the healthcare of the community. Individuals, affiliations, titles and expertise are as follows:

**Dr. Charlene Bermele** has been a dedicated leader in higher education at Saint Xavier University for over 20 years. A registered nurse with more than 40 years of experience, she serves as Dean of the College of Nursing, Health Sciences, and Business.

Charlene earned her Doctorate of Nursing Practice from Loyola University Chicago, focusing her research on domestic violence support for pregnant individuals. As a Certified Nurse Educator, she brings an extensive teaching background to her role, fostering the next generation of health care professionals.

A resident of Evergreen Park for over 35 years, Charlene has cultivated strong collaborative ties with OSF HealthCare Little Company of Mary Medical Center, actively contributing to various Community Outreach Hospital Boards.

**Kelly Burke, Mayor of Evergreen Park,** has lived in Evergreen Park for 27 years alongside her husband, Terry, and their three children. She currently serves as State Representative of the 36th District, where she holds the role of Assistant Majority Leader, focusing on state budget, higher education, health care, and pension issues.

Her legislative work includes significant contributions to Illinois' budget, education funding, pensions, public safety, telecommunications, and family law. As a founding member of the House Democratic Women's Caucus, she actively promotes policies that support women’s leadership. Locally, she is deeply engaged with the community, hosting town hall meetings, meeting with constituents, and organizing events such as basketball tournaments and the popular "Yoga in the Park" at 50 Acre Park during the summer.

Kelly earned her B.A. from the University of Illinois at Urbana-Champaign and her J.D. from the John Marshall Law School. She is an attorney at the Evergreen Park-based firm Odelson & Sterk.

Before serving as a state representative, Kelly worked at Saint Xavier University for six years. She also served two terms on the Evergreen Park Library Board, where she held the position of president. She remains involved with the library through the library foundation.

In 2012, Kelly was selected to participate in the inaugural class of the Edgar Fellows program at the University of Illinois, an initiative led by former Gov. Jim Edgar to foster bipartisan leadership across Illinois. She also serves as an adjunct professor at Loyola University Law School.

Kelly has been a committed volunteer in Evergreen Park for many years, particularly through her work with Most Holy Redeemer Parish. She has served on the Women's Guild board, founded a Mock Trial program for grade school students, coached youth sports, and helps prepare meals for the Su Casa shelter. Additionally, she is an advisory board member of the Women's Bar Foundation and volunteers with the Restorative Justice program at Leo High School.

**Elaine Grande** was appointed Executive Director by Pathlights' Board of Directors on May 30, 2022. She has more than 30 years of successful leadership experience and is only the third Executive Director in the nonprofit's 50-year history.

Grande has spent more than 23 years with the nonprofit, working across every department including specialist and supervisory roles in Advocacy & Benefits, Housing, and Care Coordination. Prior to her promotion to Executive Director, she led all Pathlights program and services as Director of Program Development.

As Executive Director, Grande oversees all operations for the 501(c)3 human service organization providing comprehensive community services to more than 16,000 individuals in Palos, Lemont, Orland, Worth, Bremen and Rich Townships of Illinois. She leads a team of 70+ staff, collaborates with the Board and Advisory Council, guides strategic planning, financial management and fundraising, ensures program quality and works with the community, legislators, regulatory agencies, and volunteers and representatives of the not-for-profit sector to promote policies that encourage a healthy aging community and address the needs impacting different constituencies.

A native of Ireland, Grande lives in Oak Forest, IL with her husband, two daughters and son. She is a graduate of Dublin Institute of Technology (D.I.T) and has experience living and working in Ireland, the United Kingdom, Germany, and the U.S.

**Tracy Jendruczek** joined OSF Little Company of Mary Medical Center in November 2022 as Vice President of Surgical and Procedural Services. In this role, she oversees surgical and procedural operations, along with Radiology, Cardiology, and Laboratory services.

Tracy holds a Bachelor of Business Administration (BBA) in Finance and a Master's in Health Administration (MHA), both from the University of Iowa, as well as a Master of Business Administration (MBA) from North Central College.

Before joining OSF LCMMC, Tracy held various leadership positions in Radiology and Surgical and Procedural Services within academic medical centers and community hospitals across Chicagoland. She is also actively involved in the community, serving on a local board and previously holding the position of Treasurer on a swim team board.

**Tim Kelleher** has served as Director of Entity Finance since the OSF HealthCare merger in February 2020. He originally joined Little Company of Mary in 2015 and was promoted to Chief Financial Officer in 2018.

Before his tenure at Little Company of Mary, Tim worked in audit at Deloitte & Touche from 2009 to 2015. He is a licensed CPA and holds a bachelor's degree in accounting from Centenary College of Louisiana, as well as a master's degree in accounting from The University of Notre Dame.

Kathleen Kinsella joined Little Company of Mary Hospital and Healthcare Centers in November 2018 as Chief Operating Officer, serving as the LCMH Executive Sponsor for the OSF integration. Following the retirement of Dr. John Hanlon, she was named President of Little Company of Mary Medical Center in July 2020.

Kathleen holds a Bachelor of Science in Health and Safety Education from the University of Illinois at Urbana-Champaign and a Master's in Health Administration from the University of St. Francis.

Before joining LCMH, she held various leadership positions, including Chief Administrative Officer, Senior Vice President, and President, across acute care facilities, ambulatory practices, and consulting firms, specializing in organizations in transition.

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**Eileen Knightly,** RN, serves as Vice President and Chief Nursing Officer at OSF HealthCare Little Company of Mary Medical Center. In this role, she leads nursing operations, driving Key Results and ensuring superior clinical outcomes. Working alongside the leadership team, she establishes quality standards, develops policies and procedures, and oversees staffing levels through ongoing continuing education programs.

Eileen has held numerous nursing leadership roles throughout her career in Chicago. She served as Director of the Hematology Oncology Clinic at UI Health from 2016 to 2019 and previously held the position of Vice President of Oncology, Women, and Children's Services at Mercy Hospital and Medical Center, where she dedicated 36 years of service in various roles.

Beyond her hospital leadership, Eileen has been deeply involved in community health initiatives. For 18 years, she has served as Vice President of Equal Hope and was a founding member of the Metropolitan Breast Cancer Task Force in Chicago, advocating for improved breast cancer care and equity.

Eileen earned her Bachelor of Science in Nursing from Saint Xavier University and later completed her Master of Science in Health Care Administration.

**Sara Lesnicki** serves as Regional Director of Quality and Safety at OSF HealthCare, supporting OSF Little Company of Mary and St. Francis Hospital in Escanaba, MI. She assumed this role in January 2025, bringing over 25 years of healthcare experience with expertise in performance improvement, patient safety, and operational excellence. Sara leads strategic initiatives to enhance healthcare quality and uphold the highest standards of safety across the organization.

Before joining OSF HealthCare, Sara held multiple leadership positions at RUSH Copley Medical Center in Aurora, where she made significant contributions in trauma care, risk management, and quality improvement. Her efforts consistently led to measurable gains in patient outcomes and institutional efficiency.

Sara earned both her Bachelor of Science and Master of Science in Nursing from St. Francis. She is deeply committed to continuous improvement and passionate about mentoring healthcare professionals to reach their full potential. Her collaborative leadership style fosters engagement and empowers teams to drive meaningful change.

**Dr. Keith Moss** serves as Vice President and Chief Medical Officer at OSF Little Company of Mary Medical Center in Evergreen Park. His academic journey began at the University of Chicago, where he completed his undergraduate studies, followed by graduate work at the University of Pittsburgh, earning a Master's degree in the History and Philosophy of Science.

After spending time in academia, Dr. Moss pursued his medical degree at the University of Illinois College of Medicine, graduating in 1999. He completed his Internal Medicine residency at Rush University from 1999 to 2002 and later practiced as an internist in private practice in the Kankakee area.

Dr. Moss transitioned into healthcare leadership, becoming Chief Medical Information Officer (CMIO) at Riverside Healthcare in 2013. He went on to serve as Chief Medical Officer (CMO) and CMIO at Riverside from 2015 to 2022. From 2022 to 2024, he held the position of Vice President and Chief Medical Officer at BJC Memorial Hospitals in Belleville and Shiloh, Illinois.

Dr. Moss joined OSF HealthCare in 2024, bringing a wealth of experience in clinical leadership, medical informatics, and patient-centered care.

**Thomas O'Malley** has dedicated more than 36 years to education, serving most recently as superintendent at Evergreen Park Community High School (EPCHS). He joined EPCHS in 2017after a distinguished career in District 228, where he held leadership roles as teacher, assistant principal, Director of Services, Director of Finance, and Assistant Superintendent.

Inspired by his father's teaching career and coaching at EPCHS, Thomas was drawn to education and leadership, following in his family's footsteps. Raised on Chicago's South Side, he deeply values the close-knit community of Evergreen Park and takes pride in being an EPCHS Mustang.

His educational background includes a Bachelor of Science in Business Education from Eastern Illinois University, a Master of Science in Education from Chicago State University, and a Master of Science in Administration from Governors State University. He also completed the Chief School Business Officials Certification and pursued a Doctoral Program in Administrative Leadership at Aurora University.

In addition to collaborative team members, the following facilitators managed the process and prepared the Community Health Needs Assessment. Their qualifications and expertise are as follows:

**Michelle A. Carrothers (Coordinator)** is currently the Vice President of Strategic Reimbursement for OSF Healthcare System, a position she has served in since 2014. She serves as a Business Leader for the Ministry Community Health Needs Assessment process. Michelle has over 35 years of health care experience. Michelle obtained both a Bachelor of Science Degree and Master of Business Administration Degree from Bradley University in Peoria, IL. She attained her CPA in 1984 and earned her Fellow of the Healthcare Financial Management Association Certification (HFMA) in 2011. Currently, she serves on the National Board of Examiners for HFMA. Michelle serves on various Peoria Community Board of Directors and Illinois Hospital Association committees.

**Dawn Tuley (Coordinator)** is a Strategic Reimbursement Senior Analyst at OSF Healthcare System. She has worked for OSF Healthcare System since 2004 and acts as the coordinator for 15 Hospital Community Health Needs Assessments. In addition, she coordinates the submission of the Community Benefit Attorney General report and the filing of the IRS Form 990 Schedule H since 2008. Dawn holds a Master of Healthcare Administration from Purdue University and is certified in Community Benefit. Dawn has been a member of the McMahon-Illini Chapter of the Healthcare Financial Management Association (HFMA) for over twelve years. She has served as the Vice President, President-Elect, and two terms as the Chapter President on the board of Directors. She has earned a silver, bronze, gold, and Medal of Honor from her work with the McMahon-Illini HFMA Chapter. She is currently serving as a director on the board.

**Dr. Laurence G. Weinzimmer, Ph.D. (Principal Investigator)** is the Caterpillar Inc. Professor of Strategic Management in the Foster College of Business at Bradley University in Peoria, IL. An internationally recognized thought leader in organizational strategy and leadership, he is a sought-after consultant to numerous Fortune 100 companies and not-for-profit organizations. Dr. Weinzimmer has authored over 100 academic papers and four books, including two national bestsellers. His work appears in 15 languages, and he has been widely honored for his research accomplishments by many prestigious organizations, including the Academy of Management. Dr. Weinzimmer has served as principal investigator for numerous community assessments, including the United Way, Economic Development Council, and numerous hospitals. His approach to Community Health Needs Assessments was identified by the Healthcare Financial Management Association (HFMA) as a Best-in-Practice methodology. Dr. Weinzimmer was contracted for assistance in conducting the CHNA.

# APPENDIX 2. ACTIVITIES RELATED TO 2022 CHNA PRIORITIZED NEEDS

Four major health needs were identified and prioritized in the Evergreen Park, Cook County 2022 CHNA. Below are examples of the activities, measures, and impact during the last three years to address these needs.

## 1. Access to Care

***Goal 1:*** *Expand access to low-acuity health care in the OSF LCMMC service area.*

1. Strengthened executive leadership support for the Auburn Gresham Development Corporation
    a. The CNO maintained membership on an additional neighborhood community board

2. Expanded maternal fetal medicine (MFM) outreach to local Federally Qualified Health Centers (FQHCs)
    a. 421 patients served from local FQHC clinics
    b. 212 deliveries facilitated through MGM services

## 2. Behavioral Health, including Mental Health and Substance Use

***Goal 1:*** *Increase community awareness of mental health and educate consumers on available resources in the OSF LCMMC service area. Support providers in accessing mental health resources in the community.*

1. Conducted behavioral health education annually
    a. Nine community events provided mental health education

2. Administered SDOH Mental Health Screenings
    a. 36,450 screenings completed

3. Offered Behavioral Health Navigation Services
    a. 1,512 referrals provided

4. Promoted behavioral health awareness through public relations channels (social media, press releases, and community outreach)
    a. 19 occurrences, including social media posts, portal updates, and event promotions

***Goal 2:*** *Increase community awareness of substance use and educate consumers on the available resources.*

1. Promoted the free drug disposal drop box available in the OSF LCMMC lobby through quarterly social media posts and information distribution at community events
    a. Four campaigns completed

2. Provided a secured drug take-back receptacle for the disposal of unneeded or expired medications, located in the main lobby of OSF LCMMC
    a. 235 pounds collected

## 3. Heart Disease

***Goal 1:*** *Improve heart health by educating patients about high blood pressure and its management in the OSF LCMMC service area.*

1. Increased blood pressure screenings and education opportunities within the service area
    a. Eight events held

2. Expanded heart risk assessments in the Metro service area
    a. 80 total assessments completed (with 10 participants per event for blood pressure screenings)

## 4. Cancer

***Goal 1:*** *Improve breast health for women in the OSF LCMMC service area.*

1. Promoted Cancer Screening Health Risk Assessments (HRAs) (breast)
    a. 9,393 screening mammography exams performed, reflecting a 7% year-over-year increase

2. Expanded Cancer Integrative Therapy Services
    a. Hosted four Lunch and Learn events with 24 total participants.
    b. Provided 2,368 integrative therapy encounters in 2024
    c. Supported oncology patients with dedicated LCSW services, totaling 1,134 encounters throughout the year:
        - Q1 = 239 encounters
        - Q2 = 323 encounters
        - Q3 = 332 encounters
        - Q4 = 240 encounters 2024 LCSW encounters = 1,134

# APPENDIX 3. SURVEY

## 2024 COMMUNITY HEALTH-NEEDS ASSESSMENT SURVEY

### INSTRUCTIONS

We want to know how you view our community, and other factors that may impact your health. We are inviting you to participate in a research study about community health needs. Your opinions are important! This survey will take about 12 minutes to complete. All of your individual responses are anonymous and confidential. We will use the survey results to better understand and address health needs in our community.

## COMMUNITY PERCEPTIONS

1. What would you say are the three (3) biggest **HEALTH ISSUES** in our community?

- ☐ Aging issues, such as Alzheimer's disease, hearing loss, memory loss, arthritis, falls
- ☐ Cancer
- ☐ Chronic pain
- ☐ Dental health (including tooth pain)
- ☐ Diabetes
- ☐ Heart disease/heart attack
- ☐ Mental health issues, such as depression, anxiety
- ☐ Obesity/overweight
- ☐ Sexually transmitted infections
- ☐ Viruses, such as COVID-19 or flu
- ☐ Women's health, such as pregnancy, menopause

2. What would you say are the three (3) most **UNHEALTHY BEHAVIORS** in our community?

- ☐ Angry behavior/violence
- ☐ Alcohol abuse
- ☐ Child abuse
- ☐ Domestic violence
- ☐ Drug use
- ☐ Lack of exercise
- ☐ Poor eating habits
- ☐ Risky sexual behavior
- ☐ Self harm/suicide
- ☐ Smoking/vaping (tobacco use)

3. What would you say are the three (3) most important factors that would improve your **WELL-BEING**?

- ☐ Access to health services
- ☐ Affordable healthy housing
- ☐ Availability of child care
- ☐ Better school attendance
- ☐ Good public transportation
- ☐ Less gun violence
- ☐ Job opportunities
- ☐ Less poverty
- ☐ Less race/ethnic discrimination
- ☐ Safer neighborhoods/schools

## ACCESS TO CARE

**The following questions ask about your own health and health choices. Remember, this survey will not be linked to you in any way.**

### Medical Care

1. When you get sick, where do you go most often? (Please choose only one answer).

- ☐ Clinic/Doctor's office
- ☐ Urgent Care Center
- ☐ Emergency Department
- ☐ I don't seek medical care

If you don't seek medical care, why not?

☐ Fear of Discrimination ☐ Lack of trust ☐ Cost ☐ I have experienced bias ☐ Do not need

2. In the last YEAR, was there a time when you needed medical care but were not able to get it?

- ☐ Yes (please answer #3)
- ☐ No (please go to #4: Prescription Medicine)

3. If you were not able to get medical care, why not? (Please choose all that apply).

- ☐ Didn't have health insurance.
- ☐ Too long to wait for appointment.
- ☐ Cannot afford
- ☐ Didn't have a way to get to the doctor
- ☐ Fear of discrimination
- ☐ Lack of trust

## Prescription Medicine

4. In the last YEAR, was there a time when you needed prescription medicine but were not able to get it?

- ☐ Yes (please answer #5)
- ☐ No (please go to #6: Dental Care)

5. If you were not able to get prescription medicine, why not? (Please choose all that apply).

- ☐ Didn't have health insurance
- ☐ Pharmacy refused to take my insurance or Medicaid
- ☐ Cannot afford
- ☐ Didn't have a way to get to the pharmacy
- ☐ Fear of discrimination
- ☐ Lack of trust

## Dental Care

6. In the last YEAR, was there a time when you needed dental care but were not able to get it?

- ☐ Yes (please answer #7)
- ☐ No (please go to #8: Mental-Health Counseling)

7. If you were not able to get dental care, why not? (Please choose all that apply).

- ☐ Didn't have dental insurance
- ☐ The dentist refused my insurance/Medicaid
- ☐ Cannot afford
- ☐ Didn't have a way to get to the dentist
- ☐ Fear of discrimination
- ☐ Lack of trust
- ☐ Not sure where to find available dentist

## Mental-Health Counseling

8. In the last YEAR, was there a time when you needed mental-health counseling but could not get it?

- ☐ Yes (please answer #9)
- ☐ No (please go to next section – HEALTHY BEHAVIORS)

9. If you were not able to get mental-health counseling, why not? (Please choose all that apply).

- ☐ Didn't have insurance
- ☐ The counselor refused to take insurance/Medicaid
- ☐ Cannot afford
- ☐ Embarrassment
- ☐ Didn't have a way to get to a counselor
- ☐ Cannot find counselor
- ☐ Fear of discrimination
- ☐ Lack of trust
- ☐ Long wait time.

## HEALTHY BEHAVIORS

**The following questions ask about your own health and health choices. Remember, this survey will not be linked to you in any way.**

## Exercise

1. In a typical WEEK how many times do you participate in exercise, (such as jogging, walking, weight-lifting, fitness classes) that lasts for at least 30 minutes?

☐ None (please answer #2) ☐ 1 – 2 times ☐ 3 - 5 times ☐ More than 5 times

2. If you answered "none" to the question about exercise, why didn't you exercise in the past week? (Please choose all that apply).

☐ Don't have any time to exercise
☐ Don't like to exercise
☐ Can't afford the fees to exercise
☐ Don't have child care while I exercise
☐ Don't have access to an exercise facility
☐ Too tired
☐ Safety issues

## Healthy Eating

3. On a typical DAY, how many **servings/separate portions** of fruits and/or vegetables did you have? An example would be a banana (but not banana flavored pudding).

☐ None (please answer #4) ☐ 1 - 2 servings ☐ 3 - 4 servings ☐ 5 servings or more

4. If you answered "none" to the questions about fruits and vegetables, why didn't you eat fruits/vegetables? (Please choose all that apply).

☐ Don't have transportation to get fruits/vegetables
☐ Don't like fruits/vegetables
☐ It is not important to me
☐ Can't afford fruits/vegetables
☐ Don't know how to prepare fruits/vegetables
☐ Don't have a refrigerator/stove
☐ Don't know where to buy fruits/vegetables

5. Please check the box next to any health conditions that you have. (Please choose all that apply).
If you don't have any health conditions, please check the first box and go to question #6: Smoking.

☐ I do not have any health conditions
☐ Diabetes
☐ Depression/anxiety
☐ Allergy
☐ Heart problems
☐ Stroke
☐ Asthma/COPD
☐ Overweight
☐ Cancer
☐ Memory problems

## Smoking

6. On a typical DAY, how many cigarettes do you smoke?

☐ None ☐ 1 - 4 ☐ 5 - 8 ☐ 9 - 12 ☐ More than 12

## Vaping

7. On a typical DAY, how many times do you use electronic vaping?

☐ None ☐ 1 - 4 ☐ 5 - 8 ☐ 9 - 12 ☐ More than 12

## GENERAL HEALTH

8. Where do you get most of your health information and how would you like to get health information in the future? (For example, do you get health information from your doctor, from the Internet, etc.). _____

_____

9. Do you have a personal physician/doctor? ☐ Yes ☐ No

10. How many days a week do you or your family members go hungry?

☐ None ☐ 1–2 days ☐ 3-5 days ☐ More than 5 days

11. In the last 30 DAYS, how many days have you felt depressed, down, hopeless?

☐ None ☐ 1–2 days ☐ 3 – 5 days ☐ More than 5 days

12. In the last 30 DAYS, how often has your stress and/or anxiety stopped you from your normal daily activities?
☐ None ☐ 1–2 days ☐ 3 - 5 days ☐ More than 5 days

13. In the last YEAR have you talked with anyone about your mental health?
☐ No ☐ Doctor/nurse ☐ Counselor ☐ Family/friend

14. How often do you use prescription pain medications not prescribed to you or use differently than how the doctor instructed on a typical DAY?
☐ None ☐ 1–2 times ☐ 3-5 times ☐ More than 5 times

15. How many alcoholic drinks do you have on a typical DAY?
☐ None ☐ 1–2 drinks ☐ 3-5 drinks ☐ More than 5 drinks

16. How often do you use marijaunia on a typical DAY?
☐ None ☐ 1–2 times ☐ 3-5 times ☐ More than 5 times

17. How often do you use substances such as inhalants, ecstasy, cocaine, meth or heroin on a typical DAY?
☐ None ☐ 1–2 times ☐ 3-5 times ☐ More than 5 times

18. Do you feel safe in your home? ☐ Yes ☐ No

19. Do you feel safe in your neighborhood? ☐ Yes ☐ No

20. In the past 5 years, have you had a:

| | | | |
|---|---|---|---|
| Breast cancer screening/mammogram | ☐ Yes | ☐ No | ☐ Not applicable |
| Prostate exam | ☐ Yes | ☐ No | ☐ Not applicable |
| Colon cancer screening | ☐ Yes | ☐ No | ☐ Not applicable |
| Cervical cancer screening/pap smear | ☐ Yes | ☐ No | ☐ Not applicable |

## Overall Health Ratings

21. My overall physical health is: ☐ Below average ☐ Average ☐ Above average
22. My overall mental health is: ☐ Below average ☐ Average ☐ Above average

## INTERNET

1. Do you have Internet at home? For example, can you watch Youtube at home?

☐ Yes (please go to next section – BACKGROUND INFORMATION) ☐ No (please answer #2)

2. If don't have Internet, why not? ☐ Cost ☐ No available Internet provider ☐ I don't know how ☐ Data limits ☐ Poor Internet service ☐ No phone or computer

## BACKGROUND INFORMATION

1. What city/village do you live in?

☐ Evergreen Park ☐ Other

2. What is your Zip Code? _____

3. What type of health insurance do you have? (Please choose all that apply).

☐ Medicare ☐ Medicaid/State insurance ☐ Commercial/Employer

☐ Don't have (Please answer #4)

4. If you answered "don't have" to the question about health insurance, why **don't** you have insurance? (Please choose all that apply).

☐ Can't afford health insurance ☐ Don't need health insurance

☐ Don't know how to get health insurance

5. What is your gender? ☐ Male ☐ Female ☐ Non-binary ☐ Transgender ☐ Prefer not to answer

6. What is your sexual orientation? ☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer ☐ Prefer not to answer

7. What is your age? ☐ Under 20 ☐ 21-35 ☐ 36-50 ☐ 51-65 ☐ Over 65

8. What is your racial or ethnic identification? (Please choose only one answer).

☐ White/Caucasian ☐ Black/African American ☐ Hispanic/LatinX

☐ Pacific Islander ☐ Native American ☐ Asian/South Asian

☐ Multiracial

9. What is your highest level of education? (Please choose only one answer).

☐ Grade/Junior high school ☐ Some high school ☐ High school degree (or GED)

☐ Some college (no degree) ☐ Associate's degree ☐ Certificate/technical degree

☐ Bachelor's degree ☐ Graduate degree

10. What was your household/total income last year, before taxes? (Please choose only one answer).

☐ Less than $20,000 ☐ $20,001 to $40,000 ☐ $40,001 to $60,000

☐ $60,001 to $80,000 ☐ $80,001 to $100,000 ☐ More than $100,000

11. What is your housing status?

☐ Do not have ☐ Have housing, but worried about losing it ☐ Have housing, **NOT** worried about losing it

12. How many people live with you? _____

13. Prior to the age of 18, which of the following did you experience (check all that apply):

☐ Emotional abuse ☐ Physical abuse ☐ Sexual abuse

☐ Substance use in household ☐ Mental illness in household ☐ Parental separation or divorce

☐ Emotional neglect ☐ Physical neglect ☐ Incarcerated household member

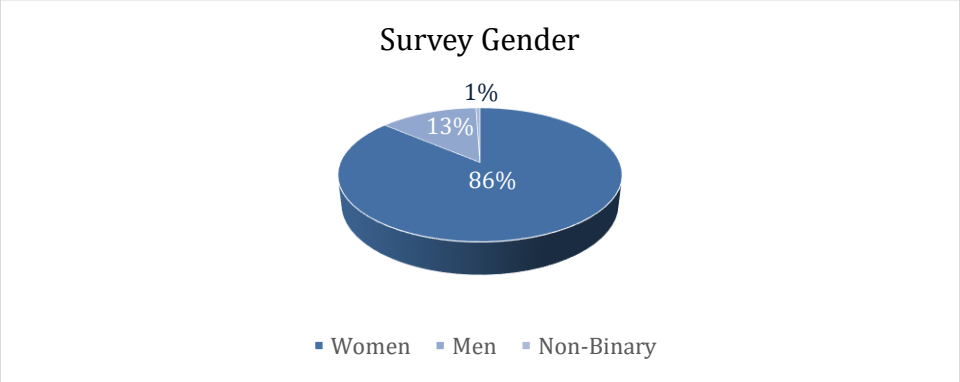
☐ Mother treated violently

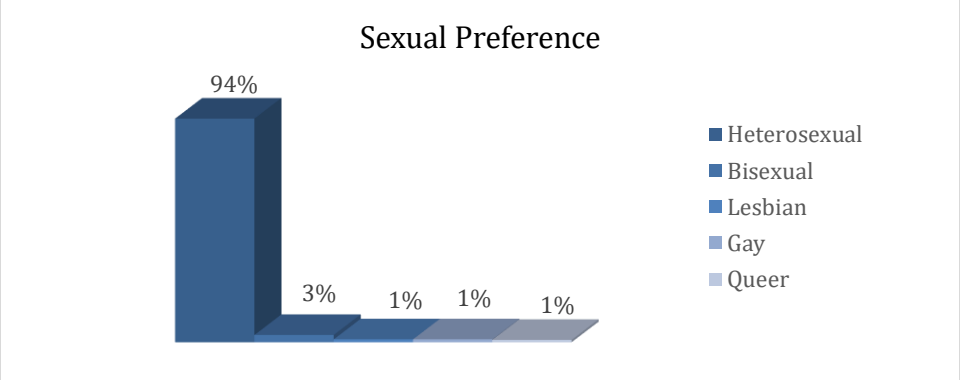
Is there anything else you'd like to share about your own health goals or health issues in our community?

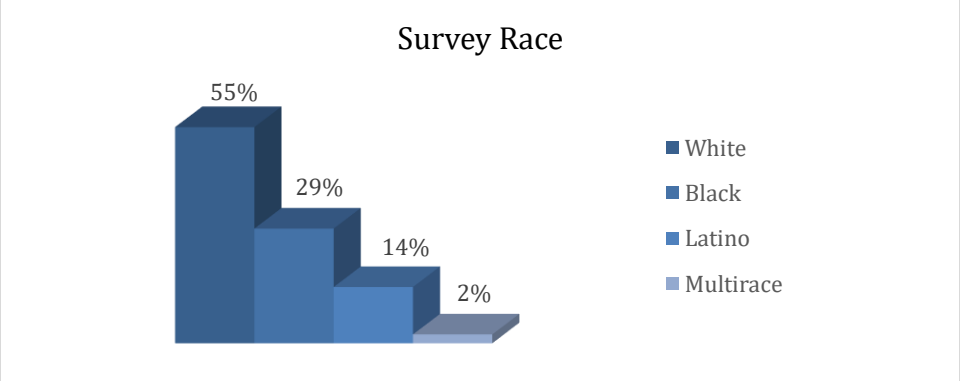
_____

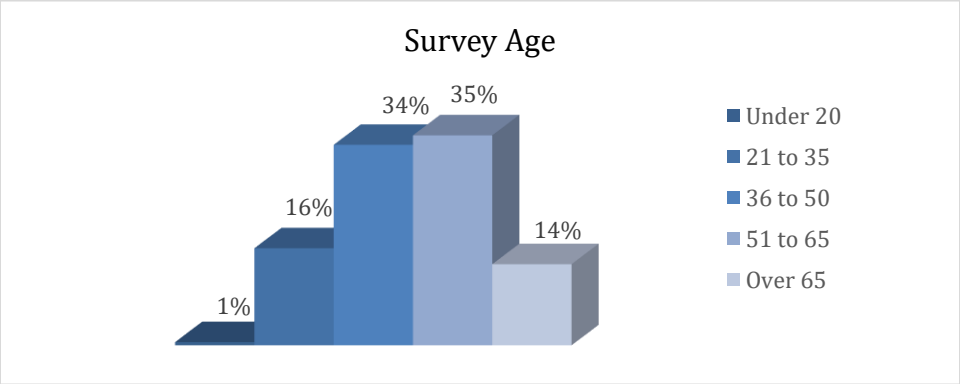
**Thank you very much for sharing your views with us!**

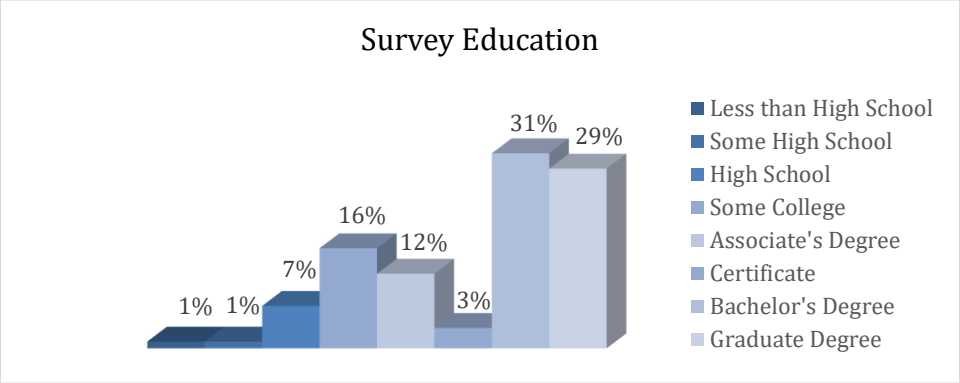
# APPENDIX 4. CHARACTERISTICS OF SURVEY RESPONDENTS 2025

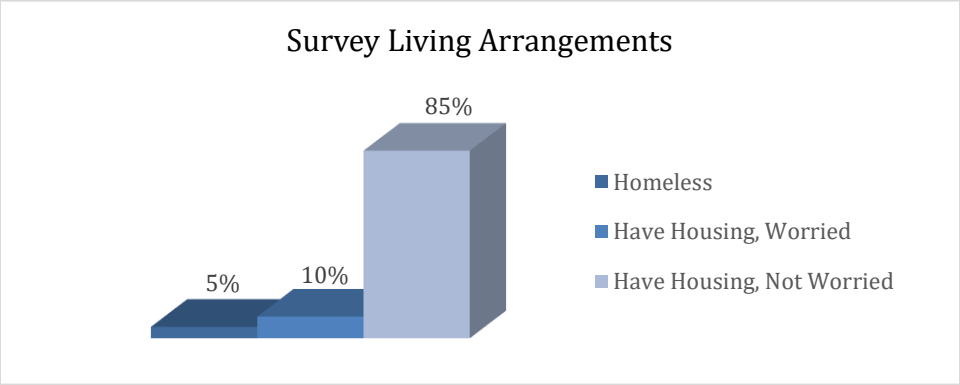


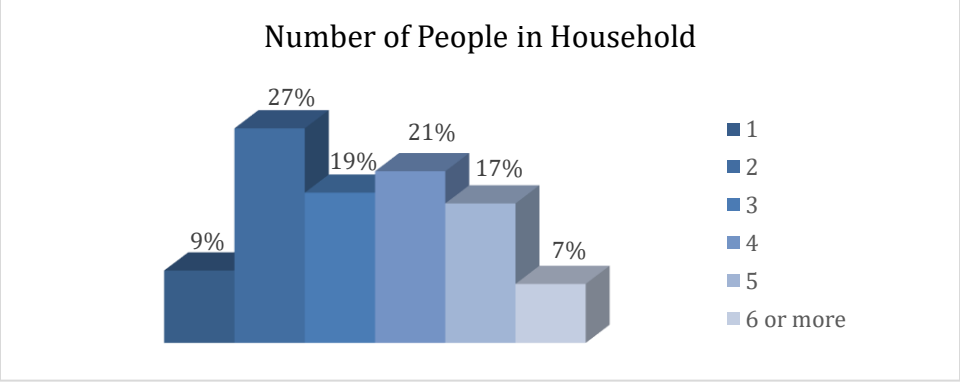



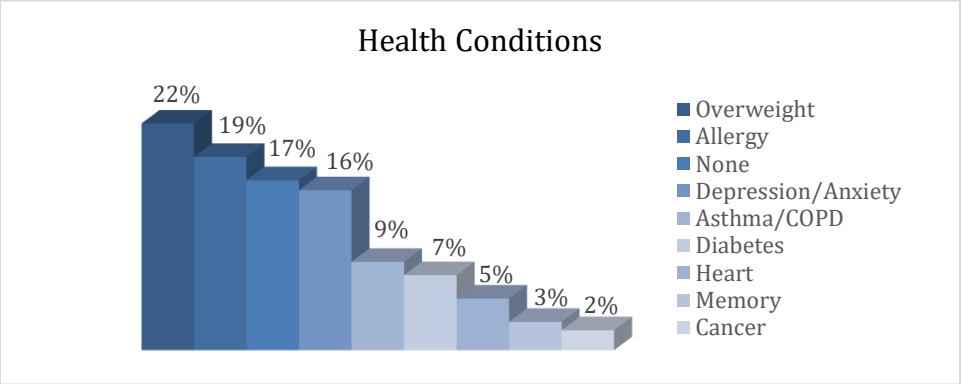



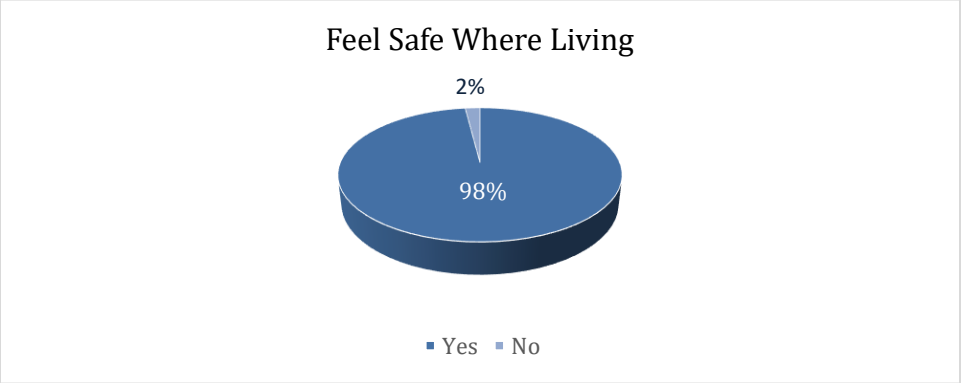

Survey Age
1%
16%
34%
35%
14%
Under 20
21 to 35
36 to 50
51 to 65
Over 65

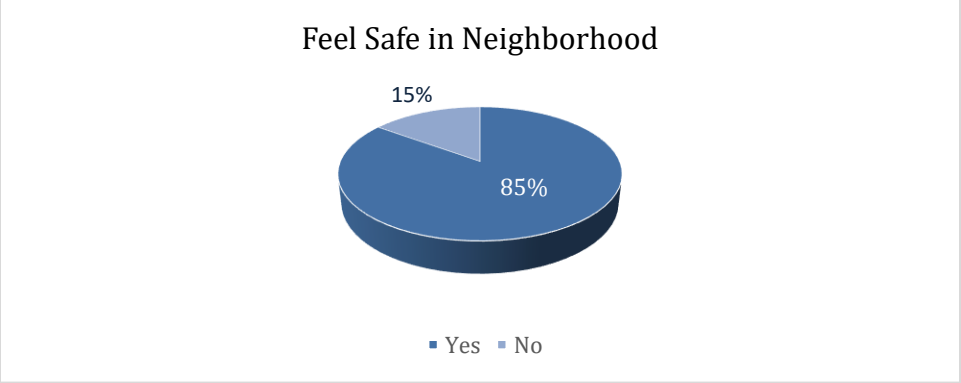

Survey Education
1%
1%
7%
16%
12%
3%
31%
29%
Less than High School
Some High School
High School
Some College
Associate's Degree
Certificate
Bachelor's Degree
Graduate Degree

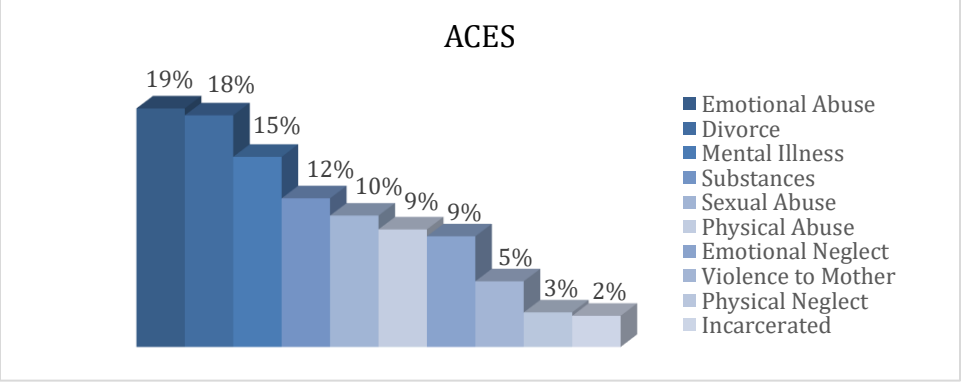

Survey Living Arrangements
5%
10%
85%
Homeless
Have Housing, Worried
Have Housing, Not Worried


Number of People in Household
9%
27%
19%
21%
17%
7%
1
2
3
4
5
6 or more


Health Conditions
22%
19%
17%
16%
9%
7%
5%
3%
2%
Overweight
Allergy
None
Depression/Anxiety
Asthma/COPD
Diabetes
Heart
Memory
Cancer


Feel Safe Where Living
2%
98%
Yes
No


Feel Safe in Neighborhood
15%
85%
Yes
No


ACES
19%
18%
15%
12%
10%
9%
9%
5%
3%
2%
Emotional Abuse
Divorce
Mental Illness
Substances
Sexual Abuse
Physical Abuse
Emotional Neglect
Violence to Mother
Physical Neglect
Incarcerated

# APPENDIX 5. RESOURCE MATRIX

| Resource | Aging Issues | Access to Healthcare | Healthy Behaviors - Prevention and Screenings | Behavioral Health | Obesity | Substance Use | Cancer | Diabetes |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| 18th Ward (Alderman Derrik Curtis) | 1 | 2 | 2 | 1 | 2 | 1 | 1 | 1 |
| 19th Ward (Alderman Matthew O'Shea) | 1 | 2 | 2 | 1 | 2 | 1 | 1 | 1 |
| 21st Ward (Alderman Ronnie Mosley) | 1 | 2 | 2 | 1 | 2 | 1 | 1 | 1 |
| 95th Street Business Association/ 95th St Farmers Market | 1 | 1 | 3 | 1 | 3 | 1 | 1 | 2 |
| ACCESS Community Health Network | 2 | 3 | 2 | 3 | 2 | 2 | 2 | 2 |
| Acclivus | 1 | 2 | 2 | 3 | 1 | 2 | 1 | 1 |
| Age Options | 3 | 2 | 2 | 2 | 2 | 1 | 1 | 2 |
| Alliance for Health Equity | 2 | 3 | 2 | 2 | 2 | 2 | 1 | 2 |
| American Cancer Society | 1 | 2 | 2 | 1 | 1 | 1 | 3 | 1 |
| American Heart Association | 1 | 2 | 3 | 1 | 2 | 1 | 1 | 2 |
| Arab American Family Services | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 1 |
| Beds Plus | 2 | 2 | 1 | 3 | 1 | 2 | 1 | 1 |
| Beverly Arts Center | 1 | 1 | 2 | 2 | 1 | 1 | 1 | 1 |
| Blue Door Neighborhood Center | 2 | 3 | 3 | 2 | 3 | 2 | 2 | 3 |
| Catholic Charities South-Southwest | 3 | 3 | 2 | 2 | 2 | 2 | 1 | 2 |
| Chicago Department of Public Health | 2 | 3 | 3 | 3 | 3 | 3 | 2 | 3 |
| Chicago Family Health Center | 2 | 3 | 2 | 3 | 2 | 2 | 2 | 3 |

| Resource | Aging Issues | Access to Healthcare | Healthy Behaviors - Prevention and Screenings | Behavioral Health | Obesity | Substance Use | Cancer | Diabetes |
|---|---|---|---|---|---|---|---|---|
| **Chicago Park District--Local location** | 2 | 1 | 3 | 1 | 3 | 1 | 1 | 2 |
| **Christian Community Health Center** | 2 | 3 | 2 | 3 | 2 | 3 | 2 | 3 |
| **Communities Partnering For Peace (CP4P)** | 1 | 1 | 2 | 3 | 1 | 2 | 1 | 1 |
| **Cook County Department of Public Health** | 2 | 3 | 3 | 3 | 3 | 3 | 2 | 3 |
| **Esperanza Health Centers** | 2 | 3 | 3 | 3 | 2 | 2 | 2 | 3 |
| **Evergreen Park Library** | 2 | 1 | 2 | 2 | 1 | 1 | 1 | 1 |
| **Family Guidance** | 1 | 2 | 2 | 3 | 1 | 3 | 1 | 1 |
| **Greater Auburn Gresham Development Corporation** | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 2 |
| **Greater Chatham Initiative** | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 2 |
| **Greater Chicago Food Depository** | 2 | 2 | 3 | 2 | 3 | 1 | 1 | 2 |
| **Grow Greater Englewood** | 1 | 1 | 3 | 2 | 3 | 1 | 1 | 2 |
| **Howard Brown Health Center** | 2 | 3 | 3 | 3 | 2 | 2 | 2 | 2 |
| **HRDI** | 1 | 2 | 2 | 3 | 1 | 3 | 1 | 1 |
| **Humana Neighborhood Center** | 3 | 3 | 3 | 2 | 3 | 1 | 1 | 3 |
| **IMAN** | 2 | 3 | 3 | 3 | 2 | 2 | 1 | 2 |
| **NAMI Chicago** | 1 | 2 | 2 | 3 | 1 | 2 | 1 | 1 |
| **Oak Street Health** | 3 | 3 | 2 | 2 | 2 | 1 | 2 | 3 |
| **Pathlights** | 3 | 2 | 2 | 2 | 2 | 1 | 1 | 2 |
| **Pat's Pantry** | 2 | 1 | 2 | 1 | 2 | 1 | 1 | 2 |
| **Phalanx Family Services** | 2 | 2 | 2 | 3 | 2 | 2 | 1 | 2 |
| **Resident Association of Greater Englewood** | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 2 |

| Resource | Aging Issues | Access to Healthcare | Healthy Behaviors - Prevention and Screenings | Behavioral Health | Obesity | Substance Use | Cancer | Diabetes |
|---|---|---|---|---|---|---|---|---|
| **South Shore Works** | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 2 |
| **Southwest Organizing Project (SWOP)** | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 2 |
| **Thresholds** | 1 | 2 | 2 | 3 | 1 | 3 | 1 | 1 |
| **Trilogy** | 1 | 2 | 2 | 3 | 1 | 3 | 1 | 1 |
| **UCAN** | 2 | 2 | 2 | 3 | 2 | 2 | 1 | 1 |
| **United Way** | 2 | 3 | 2 | 2 | 1 | 2 | 1 | 1 |
| **Urban Growers Collective** | 1 | 1 | 3 | 2 | 3 | 1 | 1 | 2 |
| **Village Pantry** | 2 | 1 | 2 | 1 | 2 | 1 | 1 | 2 |

*(1)= low; (2)= moderate; (3) = high, in terms of degree to which the need is being addressed

# APPENDIX 6. DESCRIPTION OF COMMUNITY RESOURCES

**19th Ward (Alderman Matthew O'Shea)**
The Chicago 19th Ward, currently represented by Alderman Matthew O'Shea, is a legislative district in the city. The 19th Ward in Chicago, also known as the Mount Greenwood and Beverly community areas, is a closely knit, diverse, and community-oriented neighborhood. It's characterized by being safe and highly educated, with a strong emphasis on community events and civic engagement.

**21st Ward (Alderman Ronnie Mosley)**
The 21st Ward in Chicago, Illinois, is a city ward represented by Alderman Mosley. Alderman Mosley's primary goal is to ensure the ward's thriving by focusing on community engagement and continuous improvement. He also serves as Vice-Chair of the Committee on Economic, Capital & Technology Development and is a member of other city council committees. The ward website provides information about community activities and services provided by the office.

**95th Street Business Association/ 95th St Farmers Market**
The 95th Street Beverly Hills Business Association is contracted with the City of Chicago to manage Special Service Area Number 4, a stretch of 95th Street that extends from Western Avenue to Ashland. The Association provides a range of valuable services to the SSA businesses, including promotional support, maintenance of the public way, safety and other functions. The city requires all SSA administrators to share their financial records.

**ACCESS Community Health Network**
ACCESS Community Health Network (ACCESS) is a network of community health centers (CHCs) that provide primary and preventive care in the Chicagoland area. It focuses on serving low-income individuals and families, especially in vulnerable communities. ACCESS offers a wide range of services, including adult and senior care, pediatric care, behavioral health services, and support services like food assistance and access to medications through the 340B program.

**Acclivus**
Acclivus, Inc. supports community health and well-being for populations at risk for violence and other negative health outcomes. Acclivus provides evidence-based violence prevention and reduction programming in partnership with community-based grassroots organizations, community leaders, hospitals, and other stakeholders. Funds will support Acclivus' hospital intervention programming, community-based violence prevention programming, and subawards to communities for direct services.

**AgeOptions**
AgeOptions is a nonprofit organization connecting adults aged 60 and over and those who care about them with resources and services that allow them to live their lives to the fullest while remaining in their homes and communities for as long as they are able.

**Alliance for Health Equity**
The Alliance for Health Equity (AHE) is a collaborative hospital-community partnership in Chicago and Cook County dedicated to improving health outcomes and promoting health equity. It brings together hospitals, community-based organizations, and local health departments to address social and structural determinants of health, promote capacity building, and advocate for policy changes. AHE works through various initiatives, including Community Health Needs Assessments (CHNAs), to understand the needs of the community and develop shared plans for addressing health disparities.

**American Cancer Society**
The American Cancer Society (ACS) is a leading cancer-fighting organization dedicated to ending cancer as we know it, for everyone. They achieve this through research, advocacy, and patient support, aiming to improve the lives of people with cancer and their families by helping to prevent, detect, treat, and survive the disease.

**American Heart Association**
The American Heart Association (AHA) is a nonprofit organization dedicated to fighting heart disease and stroke, the two leading causes of death globally. Founded in 1924, it's the oldest and largest voluntary organization in the US focused on this cause. The AHA's mission is to be a relentless force for a world of longer, healthier lives.

**Arab American Family Services**
Arab American Family Services (AAFS) is a non-profit organization in South Suburban Chicagoland that provides social services to Arab American communities. AAFS focuses on building understanding between Arab Americans and the mainstream American culture, addressing myths and taboos that may hinder access to services. They offer a range of programs, including case management, mental health support, immigration services, and disability assistance, with a particular focus on providing cultural and linguistical sensitive services.

**Beds Plus**
BEDS Plus offers a range of services for individuals experiencing homelessness and at risk of homelessness in Southwest Suburban Cook County, IL. Their services focus on emergency needs, preventing homelessness, and providing supportive housing to facilitate independent living. These services include shelter, eviction prevention, medical respite, and street outreach, along with wraparound services like employment support and financial literacy.

**Beverly Arts Center**
The Beverly Arts Center (BAC) is a not-for-profit cultural and educational institution located in Chicago's Beverly and Morgan Park community. It offers a variety of arts programs and events in dance, visual arts, music, film, and theater, serving the Chicago metro area. The BAC is also a popular venue for events, offering spaces for meetings, celebrations, and more.

**Blue Door Neighborhood Center**
The Blue Door Neighborhood Center (BDNC) is a community-based health and wellness hub, operated by Blue Cross and Blue Shield of Illinois. It offers free programs and services, including health education, low-impact fitness classes, and connections to community resources. The centers are in Chicago's Pullman, Morgan Park, and South Lawndale neighborhoods.

**Catholic Charities South-Southwest**
Catholic Charities serves individuals and families in need in the South and Southwest regions of Cook County, IL, offering a range of services including crisis assistance, food and basic needs, housing, and support for mothers and families. They also focus on homelessness prevention, mental health support, and senior care.

**Chicago Department of Public Health**
The Chicago Department of Public Health offers a comprehensive range of services to protect and improve the health of Chicago residents. These services include direct clinical care, community-based programs, and public health initiatives focused on prevention, health equity, and addressing social determinants of health.

**Chicago Family Health Center**
Chicago Family Health Center (CFHC) is a network of community health centers providing affordable, comprehensive healthcare services in Chicago's South Side. CFHC offers a wide range of services including primary care, dental care, behavioral health, and support services. They aim to provide high-quality care to all, regardless of ability to pay or immigration status.

**Chicago Park District--Local Bradley (Josephine) Park**
The Chicago Park District is a municipal park and recreation agency responsible for managing over 600 parks, playgrounds, and green spaces across the city, encompassing over 8,800 acres. It's one of the largest municipal park systems in the nation, offering a wide range of recreational and cultural activities. The district also oversees various amenities like beaches, pools, museums, and conservatories.

**Christian Community Health Center**
Christian Community Health Center (CCHC) is a Federally Qualified Health Center (FQHC) and 501(c)3 non-profit organization that provides comprehensive primary medical, dental, behavioral health, and supportive services. They aim to address the healthcare and social service needs of the communities they serve.

**Communities Partnering for Peace (CP4P)**
Communities Partnering 4 Peace (CP4P) is a collaborative initiative in Chicago, convened by Metropolitan Family Services, aimed at reducing gun violence and improving community safety. It brings together various outreach and restorative justice organizations to provide comprehensive, evidence-based, and trauma-informed services. CP4P focuses on community engagement, working with local organizations, and offering services and case management to individuals at risk of or impacted by gun violence.

**Cook County Department of Public Health**
The Cook County Department of Public Health (CCDPH) is a government agency responsible for protecting and improving the health of residents in suburban Cook County, Illinois. It achieves this through a variety of means, including regulatory enforcement, monitoring and responding to health threats, policy development, public health research, and numerous programs and initiatives. The CCDPH also works to foster partnerships within the community**.**

**Esperanza Health Centers**
Esperanza Health Centers is a Federally Qualified Health Center (FQHC) that provides bilingual, culturally appropriate primary and specialty care, behavioral health, and wellness services. They operate multiple clinics on Chicago's Southwest Side, serving medically underserved and primarily Latino communities. Their mission is to improve health equity and reduce barriers to care, offering services regardless of immigration status, insurance, or ability to pay.

**Evergreen Park Library**
Neighborhood library with resources for all ages, including DVDs, study rooms, and events.

**Family Guidance**
A Family Guidance Center, often called FGC, is a behavioral health organization that provides treatment and prevention services for individuals and families dealing with substance use disorders, mental health conditions, and related problems. These centers offer a range of services, including medication-assisted treatment, counseling, and support groups, often with a focus on recovery and long-term well-being.

**Greater Auburn Gresham Development Corporation**
The Greater Auburn Gresham Development Corporation’s mission is to foster and promote revitalization of the community by designing and implementing programs that improve the community’s economic viability; increase availability of quality housing to people of different income levels, while maintaining and improving existing affordable housing; and enhance delivery of social services, particularly to senior citizens.

**Greater Chatham Initiative**
The Greater Chatham Initiative is an organization charged with developing and driving the implementation of a comprehensive strategy to revitalize the Chatham, Auburn Gresham, Avalon Park and Greater Grand Crossing neighborhoods on Chicago’s south side. The Greater Chatham Initiative was born from a comprehensive plan for

economic growth and neighborhood vitality (The Plan). Our mission is to strategically invest (consistent with The Plan) in the Chicago communities of Chatham, Greater Grand Crossing, Avalon Park, and Auburn Gresham so they can re-emerge as communities of opportunity and choice.

**Greater Chicago Food Depository**
As the food bank for Cook County, the Greater Chicago Food Depository distributes food to individuals and families through a network of approximately 700 pantries, soup kitchens, shelters and community programs.

**Grow Greater Englewood**
Grow Greater Englewood is a 501(c)(3) social enterprise that works with residents and developers to create sustainable local food economies, green businesses, and land sovereignty to empower residents to create wellness and wealth.

**Howard Brown Health Center**
Howard Brown Health is an organization that focuses on providing health care for people within the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community in several areas throughout the city of Chicago. They are one of the largest health care and research organizations primarily caring for the LGBTQ community in the United States.[1] In addition to healthcare, they also provide a variety of services that include housing, jobs, food, education and more through the Broadway Youth Center and Brown Elephant Resale Shops, which Howard Brown owns.

**HRDI**
HRDI, a subsidiary of Friend Health, is a community behavioral health center that provides a comprehensive array of prevention, intervention and treatment services to address various mental health, substance use, and community health concerns. Anchored on Chicago's South Side, HRDI clinics have provided support to underserved communities since 1974. We use evidenced based (as well as evidenced informed) models of care to empower individuals, families and communities to improve their quality of life, regardless of their ability to pay.

**Humana Neighborhood Center**
The Humana Neighborhood Center located at 9522 S Western Ave, Evergreen Park, IL 60805 is permanently closed.

**IMAN**
The Inner-City Muslim Action Network (IMAN) is a community organization that fosters health, wellness and healing in the inner-city by organizing for social change, cultivating the arts, and operating a holistic health center.

**NAMI Chicago**
Since 1979, NAMI Chicago has fought for families and individuals impacted by mental health conditions. We promote community wellness, break down barriers to mental health care and provide support and expertise for families, professionals and individuals in Chicago and beyond.
Mental health affects everyone, no matter who they are or where they are from. That's why NAMI Chicago is committed to showing up for everyone in our community—whether it's Chicago's first responders, students and school staff, a person on the other end of the phone, or in the community, meeting individuals where they are.

**Oak Street Health**
Oak Street Health is a network of primary care centers primarily serving older adults on Medicare. They focus on providing comprehensive, coordinated care, and preventive healthcare services. Oak Street Health's website indicates they are a value-based care model, meaning they are paid per patient rather than per service, and they assume the full financial risk of their patients.

**Pathlights**
Pathlights has been helping guide communities along the path to aging for 46 years. More than 16,000 individuals in 35 communities throughout the Southwest Suburbs of Cook County use its services annually. The nonprofit helps guide adults 60 years+, adults with disabilities, their caregivers, families, and friends by providing resources, advocacy, programs and services needed to remain living in the community. Services include home-delivered meals and safety checks, in-home services, support groups, education, and Respite for caregivers, protection from abuse, access to benefits for health insurance, SNAP, transportation, and property tax savings, assistance needed for safe transition from hospitals or skilled nursing facilities, shared housing, and general information about resources.

**Pat's Pantry**
Pat's Pantry is a food pantry in collaboration with Mt. Greenwood Community Church in memoriam of Patrick Turney. Pat's Pantry, through volunteers, envisions and cultivates a hunger free community by feeding families in need.

**Phalanx Family Services**
Phalanx offers wrap-around services to participants to help bridge the gap of financial barriers that may prevent individuals from being successful as they transition into work activity, training, and employment. We also assist families in crisis providing financial assistance to help stabilize housing.

**Resident Association of Greater Englewood**
R.A.G.E. is more than an organization—we are the voice of Englewood. We strategize, organize, and mobilize to address challenges head-on while fostering relationships between residents, public officials, and local businesses. For over a decade, R.A.G.E. has remained committed to uplifting Englewood. Through advocacy, resource-sharing, and direct action, we continue to prove that when residents take the lead, real progress follows. Where others see problems, we see opportunity.

**South Shore Works**
South Shore Works is an independent, dedicated consortium of individuals, entities, and institutions committed to the revitalization of the South Shore community in every aspect. Its primary strategy is to harness the abundance of talent and expertise in the neighborhood to participate in the design and implementation of a strategic plan that will result in a safe, economically viable, aesthetically beautiful, culturally well community.

**Southwest Organizing Project (SWOP)**
The Southwest Organizing Project's (SWOP) mission is to build a broad-based organization of Christian, Muslim and Jewish faith institutions, local schools and other institutions in Southwest Chicago, which will enable families to exercise common values, determine their own future and connect with each other to improve life in their neighborhoods.

**Thresholds**
Thresholds is fighting to transform the lives of people living with mental illnesses and substance use disorders. We break cycles of poverty and unemployment. We are path breaking in our innovative research and advocacy. We also make opportunities. Opportunities for housing, employment, and recovery. Opportunities for families to reconnect. Above all we make hope possible.

**Trilogy**
For more than 50 years, Trilogy has provided people across Chicago and beyond with support to recover from mental illness and move toward stability. We provide our clients with an array of essential services and ongoing support so that they can live independently and thrive in our community.

**UCAN**
Provides education coaching, family development, therapy, and clinical consultation to youth in care who are pregnant and parenting**.**

**Urban Growers Collective**
Urban Growers Collective is a Black- and women-led agriculture nonprofit in Chicago. We aim to address inequities and structural racism in the food system and in communities of color.
The UGC team cultivates eight urban farms on 11 acres of land, predominantly on Chicago's South Side. These farms are production-oriented, and offer opportunities for staff-led education, training, and leadership development. Our produce is available at farmers markets, in our Collective Supported Agriculture program, and via our Fresh Moves Mobile Market buses.

**Village Pantry**
The Village Pantry Coalition Inc. is a Non-Profit 501c3 Tax Exempt Organization serving Evergreen Park. The Village Pantry Coalition was established by a coalition of Churches, Representatives of Village Administration, Community Organizations and Evergreen Park residents to HELP Evergreen Park residents who may find themselves needing temporary food assistance in an emergency situation caused by unemployment, illness, fire, etc. Since opening in September, 1981, the Village Pantry has served over 5,500 families, distributing food valued in excess of $620,000.

# APPENDIX 7: PRIORITIZATION METHODOLOGY

**5-Step Prioritization of Community Health Issues**

**Step 1.** Review Data for Potential Health Issues

**Step 2.** Briefly Discuss Relationships Among Issues

**Step 3.** Apply "PEARL" Test from Hanlon Method[1]

Screen out health problems based on the following feasibility factors:

***Propriety*** – Is a program for the health problem appropriate?

***Economics*** – Does it make economic sense to address the problem?

***Acceptability*** – Will a community accept the program? Is it wanted?

***Resources*** – Is funding available for a program?

***Legality*** – Do current laws allow program activities to be implemented?

**Step 4.** Use Voting Technique to Narrow Potential Issues

Prioritize Issues. Use a weighted-scale approach (1-5 scale) to rate remaining issues based on:

**1. Magnitude** – size of the issue in the community. Considerations include, but are not limited to:

- Percentage of general population impacted
- Prevalence of issue in low-income communities
- Trends and future forecasts

**2. Severity** – importance of issue in terms of relationships with morbidities, comorbidities and mortality. Considerations include, but are not limited to:

- Does an issue lead to serious diseases/death
- Urgency of issue to improve population health

**3. Potential for impact through collaboration** – can management of the issue make a difference in the community?

Considerations include, but are not limited to:

- Availability and efficacy of solutions
- Feasibility of success

[1] "Guide to Prioritization Techniques." National Connection for Local Public Health (NACCHO)