Community Health Needs Assessment 2022

OSF Little Company of Mary Medical Center

CHICAGO & COOK COUNTY

OSF
HEALTHCARE

ALLIANCE for HEALTH EQUITY | Hospitals and Communities Improving Health Across Chicago and Cook County
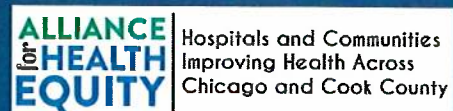
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EXECUTIVE SUMMARY

This Community Health Needs Assessment (CHNA) is a collaborative undertaking between OSF Little Company of Mary Medical Center and the Alliance for Health Equity to highlight the health needs and well-being of residents in 13 zip codes on the south side of Chicago and near southwest suburbs of Cook County. Through this needs assessment, collaborative community partners have identified numerous health issues impacting individuals and families in the OSF Little Company of Mary Medical Center service area.

Several themes are prevalent in this community health needs assessment:

- There are significant health inequities in the communities served by OSF Little Company of Mary Medical Center that are particularly driven by social and structural determinants of health in addition to inequities in access to care and community resources.

- Community members report impacts of the COVID 19 pandemic related to direct health impacts, mental health, social isolation, and economic impacts.

- Heart disease and cancer continue to be leading causes of mortality. Related data on health behaviors and community conditions reveal a number of risk factors that contribute to heart disease and cancer.

- Mental health and substance use disorders are currently high priority health needs strongly identified in community input, and reinforced in secondary data.

Results from this assessment can be used for strategic decision-making purposes as they directly relate to the health needs of the community. The study was designed to assess issues and trends impacting the communities served by OSF Little Company of Mary Medical Center and the Alliance for Health Equity collaborative.

This assessment includes a detailed analysis of secondary data to assess information regarding the health status of the community. In order to perform these analyses, information was collected from numerous secondary sources.

Primary data collection and community engagement have been particularly crucial during this community health needs assessment for two reasons:

1. As OSF Little Company of Mary Medical Center and the Alliance for Health Equity strive to strengthen our work for health equity and racial equity, community engagement is at the core of the work.

2. The most up-to-date data and information about health and social well-being and needs comes from community partners and community members, particularly during the current pandemic when conditions on the ground are changing so fast.

Areas of investigation for primary data collection included perceptions of the community health issues, unhealthy behaviors, issues with quality of life, healthy behaviors and access to medical care, dental care, prescription medications, mental health, substance use, and impacts of the COVID-19 pandemic.

Additionally, demographic characteristics of respondents were utilized to provide insights into why certain segments of the population responded differently. Ultimately, the identification and prioritization of the most important health-related issues in the OSF Little Company of Mary Medical Center service area were identified.

The collaborative team 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; (3) potential impact through collaboration.

Using a modified version of the Hanlon Method, four significant health needs were identified and determined to have equal priority:

- **Access to Care**
- **Behavioral Health, including mental health and substance use**
- **Heart Disease**
- **Cancer**

I. INTRODUCTION

The Patient Protection and Affordable Care Act (Affordable Care Act), enacted March 23, 2010, added new requirements for tax-exempt charitable hospital organizations to conduct community health needs assessments and to adopt implementation strategies to meet the community health needs identified through the assessments. This community health needs assessment (CHNA) takes into account 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. This CHNA was completed in partnership with the Alliance for Health Equity, a collaborative of 35 hospitals partnering with health departments and community based organizations in Chicago and Cook County.[1]

The Alliance for Health Equity and OSF LCMMC carry out a comprehensive community health-needs assessment as a systematic process involving the community, to identify and analyze community health needs and assets in order 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 25, 2022.

If you would like to provide comments to us related to this report, please email us at CHNAFeedback@osfhealthcare.org

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

Figure 1. OSF Community Health Needs Assessment (CHNA) process

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[1] The Alliance for Health Equity's CHNA is available online at https://allhealthequity.org/projects/2022-chna-report/
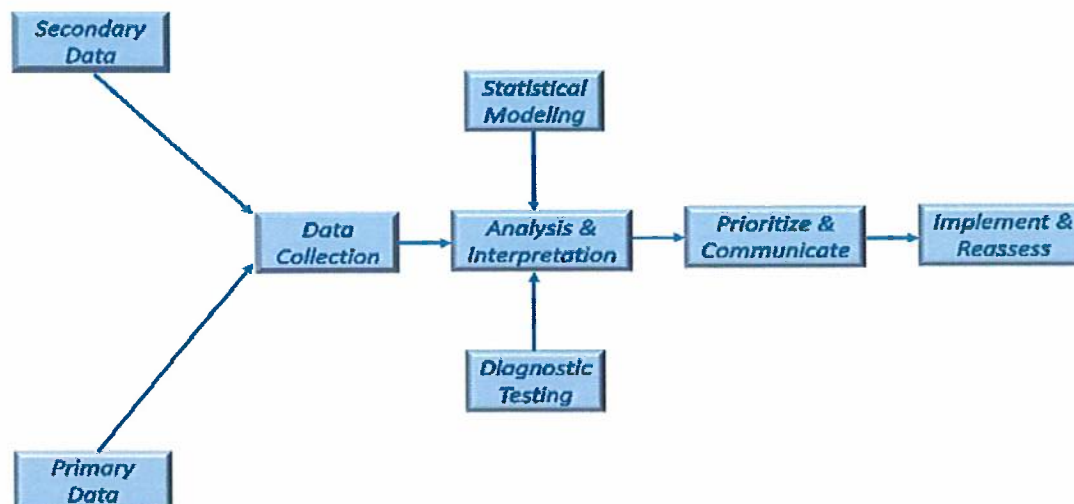
Community Feedback from Previous Assessments

The 2019 CHNA was made widely available to the community to allow for feedback. Specifically, the hospital posted both a full version and a summary version of the 2019 CHNA on its website. While no written feedback was received by individuals from the community via the available mechanism, verbal feedback was provided by key stakeholders from community-service organizations and incorporated as part of the collaborative process.

2019 CHNA Health Needs and Implementation Plans

The 2019 CHNA for Little Company of Mary Medical Center identified five significant health needs. The five health needs from the 2019 CHNA were: Heart Disease and Stroke, Diabetes, Mental Health, Cancer, and Nutrition/Physical Activity/Weight. Specific actions were taken to address these needs. Detailed discussions of goals and strategies to improve these health needs can be seen in APPENDIX 2. Note that numerous challenges associated with the COVID-19 pandemic had significant impact on the activities discussed in Appendix 2.

Social and Structural Determinants of Health

This CHNA incorporates important factors associated with Social and Structural Determinants of Health (SDOH). SDOH are important 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. According to research conducted by the U.S. Department of Health and Human Services, Healthy People 2030 has identified five SDOH that should be included in assessing community health (Figure 2).

Figure 2.

Social Determinants of Health

Social Determinants of Health
Copyright-free
Healthy People 2030

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved January 15, 2022, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Assessment of SDOH is included in the CHNA, as social determinants help contribute to health inequities and disparities. Simply creating interventions without incorporating SDOH will have limited impact on improving community health for people living in underserved or at-risk areas.
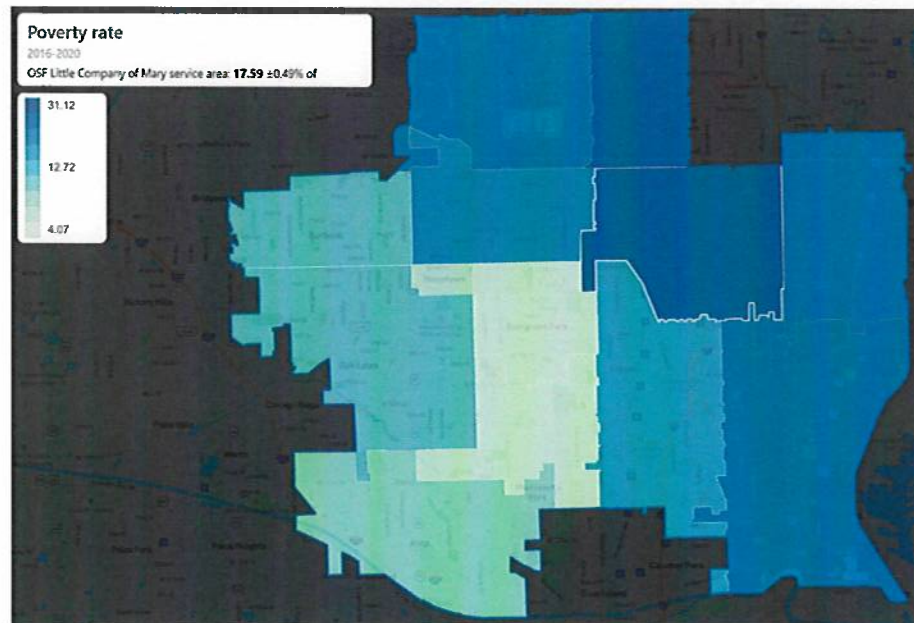
Communities Served

OSF LCMMC's community service area includes 13 zip codes on the south side of Chicago and suburban Cook County.

Communities Served by OSF Little Company of Mary Medical Center*
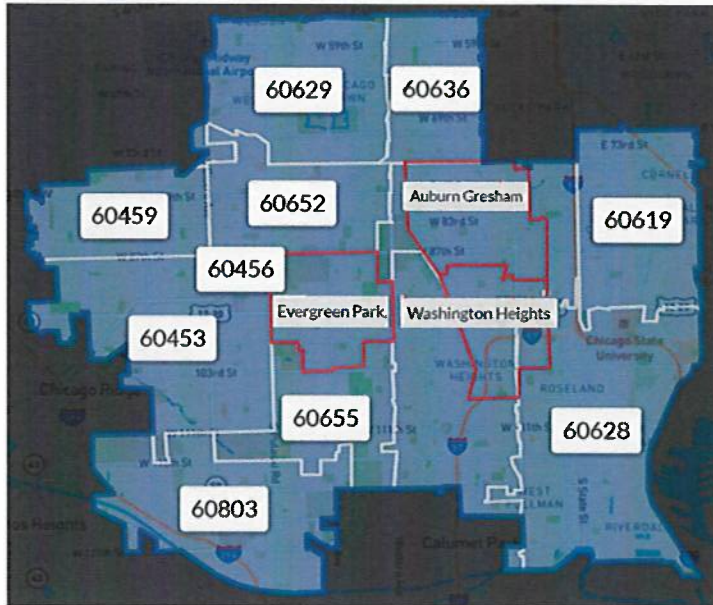
Note: 3 communities of particular focus are highlighted – Auburn Gresham, Washington Heights, and Evergreen Park.

Map of Poverty Rates for the Service Area

The darker shaded zip codes on the map—60636, 60620, 60629, 60619, 60628—experience the greatest health inequities overall in the OSF LCMMC service area.

The 13 zip codes in the OSF LCMMC service area encompass 15 Chicago community areas and 5 suburban municipalities. In addition to defining the community by zip codes, this assessment targets the at-risk population as an area of potential opportunity to improve the health of the community. "At risk population" was defined as those individuals who were eligible to receive Medicaid based on the State of Illinois guidelines using household size and income level.

The 13 zip codes covered by the OSF LCMMC service area are: 60453, 60456, 60459, 60619, 60620, 60628, 60629, 60636, 60643, 60652, 60655, 60803, and 60805. The service area includes 14 Chicago community areas—Avalon Park, Beverly, Burnside, Chatham, Chicago Lawn, Morgan Park, Mount Greenwood, Pullman, Riverdale, Roseland, Washington Heights, West Englewood, West Lawn, and West Pullman.—and 7 suburban towns—Alsip, Bedford Park, Burbank, Evergreen Park, Hometown, Merrionette Park, and Oak Lawn.
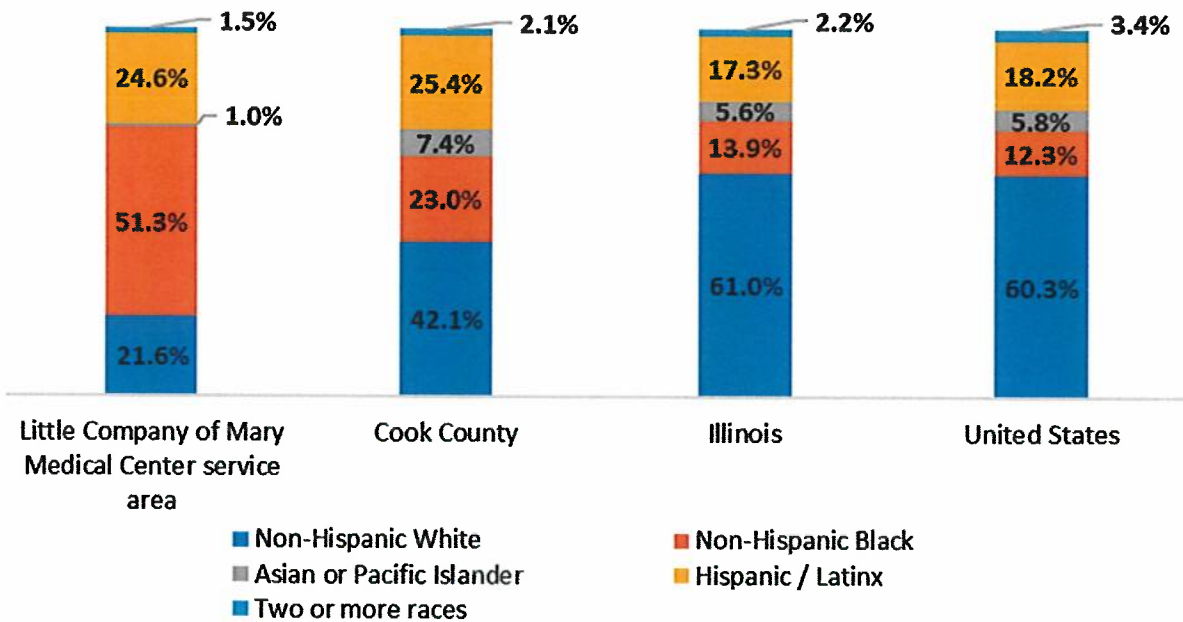
The OSF LCMMC community service area is home to 592,758 community members.

Demographics of the Service Area

Twenty-four percent (24%) of the population in the OSF LCMMC community service area is children and youth under 18, 60% are 18-64, and 16% are older adults over 65.

Fifty-one percent (51%) of the population identifies as Non-Hispanic Black, 25% Hispanic/LatinX, 22% of the population identifies as Non-Hispanic White, 1% Asian, and 2% two or more races. (US Census, American Community Survey, 2016-2020)

Population by Race/Ethnicity, 2016-2020

	Little Company of Mary Medical Center service area	Cook County	Illinois	United States
Two or more races	1.5%	2.1%	2.2%	3.4%
Hispanic / Latinx	24.6%	25.4%	17.3%	18.2%
Asian or Pacific Islander	1.0%	7.4%	5.6%	5.8%
Non-Hispanic Black	51.3%	23.0%	13.9%	12.3%
Non-Hispanic White	21.6%	42.1%	61.0%	60.3%

Legend:
- Non-Hispanic White
- Non-Hispanic Black
- Asian or Pacific Islander
- Hispanic / Latinx
- Two or more races

II. METHODS

This comprehensive community health-needs assessment (CHNA) includes multiple sources. OSF LCMMC conducted the CHNA in collaboration with the Alliance for Health Equity, a countywide collaborative of hospitals, health departments, and community organizations across Chicago and Cook County. Secondary statistical data were used to assess the community profile, social determinants of health, morbidity rates, and causes of mortality. Additionally, primary data were collected through focus groups and surveys. In addition to countywide focus groups and surveys, OSF LCMMC conducted a detailed survey in the LCMMC service area to examine perceptions of community health-related issues, healthy behaviors, behavioral health, food security, social determinants of health and access to healthcare.

Alliance for Health Equity

The Alliance for Health Equity is a collaborative of 35 hospitals working with health departments and regional and community-based organizations to improve health equity, wellness, and quality of life across Chicago and Suburban Cook County. The Alliance for Health Equity conducted a collaborative Community Health Needs Assessment (CHNA) between May 2021 and March 2022, during a time that communities across our county, country, and globe have been experiencing profound impacts from the COVID-19 pandemic. The health, economic, and social impacts of the pandemic are strongly present in what we heard from community members and healthcare and public health workers over the course of the assessment.

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

Community Engagement in CHNA

OSF LCMMC engages community members and stakeholders in the CHNA both through the Alliance for Health Equity and through local partnerships with coalitions and community groups. Specifically, OSF LCMMC partners closely with local social service, primary care, and community development organizations as well as Chicago Department of Public Health and Cook County Department of Public Health for our CHNA and implementation strategies. OSF LCMMC and the Alliance for Health Equity prioritize engagement of

community members and community-based organizations as a critical component of assessing and addressing community health needs.

In order to engage the entire community in the CHNA process, OSF LCMMC created a collaborative team of health-professional experts and key community advocates. Members of the collaborative 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, local Aldermen, and administrators from key community partner organizations. Engagement occurred throughout the entire process, resulting in shared ownership of the assessment. 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.

For the 2022 CHNA, community engagement has been particularly crucial for two reasons:
1. As OSF LCMMC and the Alliance for Health Equity strive to strengthen our work for health equity and racial equity, community engagement is at the core of the work.
2. The most up-to-date data and information about health and social well-being and needs comes from community partners and community members, particularly during the current pandemic when conditions on the ground are changing so fast.

Community partners have been involved in the OSF LCMMC and Alliance for Health Equity's CHNA and ongoing implementation process in several ways. The Alliance for Health Equity's methods of community engagement for the CHNA and implementation strategies include:
- Gathering input from community residents who are underrepresented in traditional assessment and implementation planning processes;
- Partnering with community-based organizations for collection of community input through surveys and focus groups;
- Engaging community-based organizations and community residents as members of implementation committees and workgroups;
- Utilizing the expertise of the members of implementation committees and workgroups in assessment design, data interpretation, and identification of effective implementation strategies and evaluation metrics;
- Working with hospital and health department community advisory groups to gather input into the CHNA and implementation strategies; and
- Partnering with local coalitions to support and align with existing community-driven efforts.

The community-based organizations engaged in the Alliance for Health Equity represent a broad range of sectors such as workforce development, housing and homeless services, food access and food justice, community safety, planning and community development, immigrant rights, youth development, community organizing, faith communities, mental health services, substance use services, policy and advocacy, transportation, older adult services, healthcare services, higher education, and many more. All community partners

work with or represent communities that are disproportionately affected by health inequities such as communities of color, immigrants, youth, older adults and caregivers, LGBTQ+, individuals experiencing homelessness or housing instability, individuals living with mental illness or substance use disorders, individuals with disabilities, veterans, and unemployed youth and adults.

The Alliance for Health Equity 2021-2022 CHNA process for Cook County relied upon input from numerous sources including over 5,200 community input surveys, 43 focus groups, participation from existing AHE workgroups and population data collected by health departments. Where necessary and applicable, existing research provided reliable information in determining county-wide priority health issues. Loyola Medicine partnered with internal experts and the community coalitions to identify priorities by considering multiple factors, including health equity goals, community priorities, urgency, feasibility, existing priorities, and alignment with the existing work of health departments, other hospitals, and community partners.

Secondary Data for the CHNA

OSF LCMMC worked with the Alliance for Health Equity and partners from the Chicago and Cook County Departments of Public Health to identify, compile, and analyze secondary data for the CHNA. Metopio is a cloud-based data atlas and analysis platform that curates publicly-available data for hundreds of health and equity indicators. IPHI and the Alliance for Health Equity steering committee worked with CDPH and CCDPH to refine a common set of indicators that has been used in our previous collaborative CHNAs - based on an adapted version of the County Health Rankings and Roadmaps Model:
- Social and Structural Determinants of Health
- Health Behaviors
- Health Care Delivery System and Clinical Care
- Behavioral Health - Mental Health and Substance Use
- Maternal and Child Health
- Health Outcomes - Birth Outcomes, Morbidity, and Mortality

Primary Data Collection

Focus Groups

The Alliance for Health Equity held 43 in-depth listening sessions countywide between September 2021 and January 2022 with community members and service providers. At least 5 focus groups included community members from the OSF LCMMC service area- Rush community health workers (CHWs), countywide community members who identify as LGBTQIA+, countywide Immigrant and Refugee Service Providers, NAMI countywide focus groups (2), and Primo Center. Below is a summary of the key issues we heard in focus groups with community members. (Figure 4)

Figure 4. Focus Group key takeaways
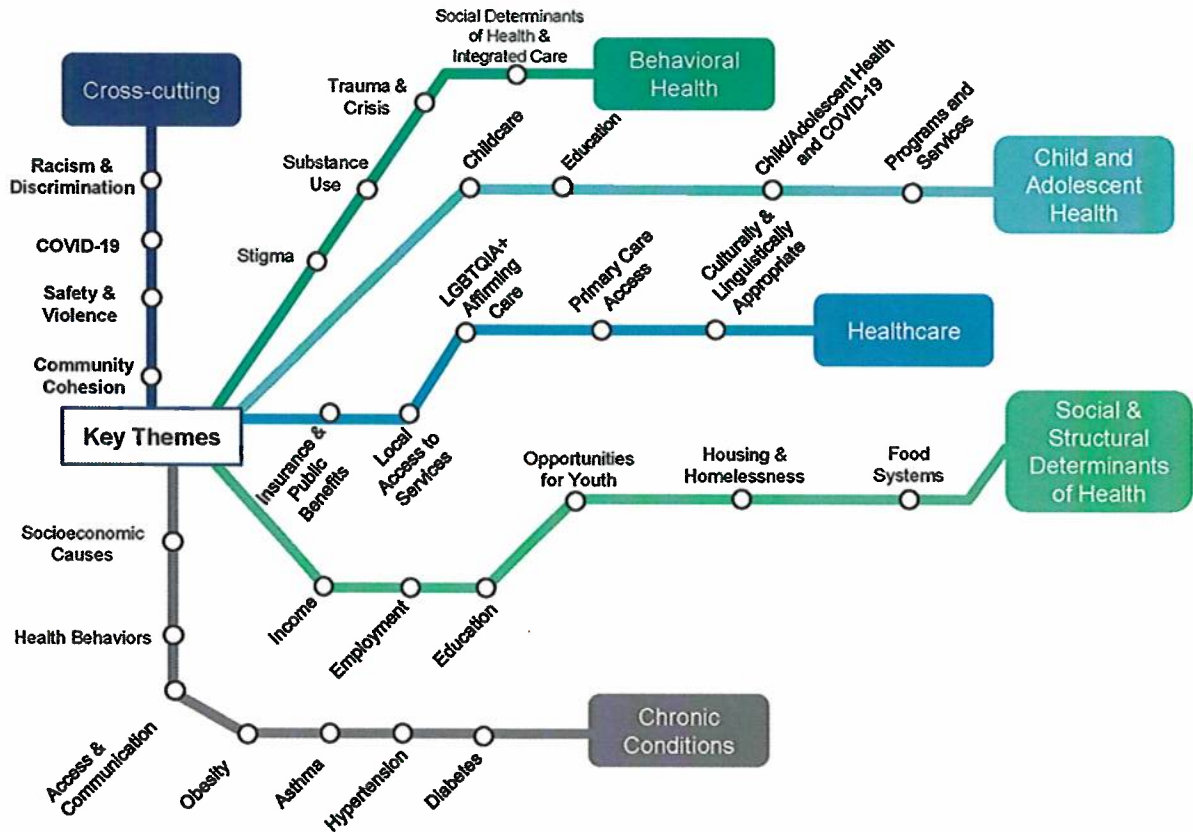
Alliance for Health Equity, community focus groups, 2021

OSF CHNA Survey

OSF LCMMC collected survey data from our local communities using a survey instrument that is used across the OSF health system (Appendix 3). This section describes the research methods used to collect, code, verify and analyze primary survey data. Specifically, we discuss 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 assessed to identify common themes and approaches to collecting community health-needs data. By leveraging best practices from these surveys, the entire collaborative team was involved in survey design/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, viruses (including COVID-19) 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 abuse 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 medications.

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 determinants of health – to assess the impact that social determinants may have on the above-mentioned areas.

Finally, demographic information was collected to assess background information necessary to segment markets in terms of the eight categories discussed above.

Item selection criteria for the final survey included validity, reliability and frequency measures based on responses from the pilot sample. A copy of the final survey is included in Appendix 3.

Sample Size

In order to identify our potential population, we first identified the percentage of the Evergreen Park population that was living in poverty. Specifically, we multiplied the population of the county by its respective poverty rate to identify the minimum sample size to study the at-risk population. The poverty rate for Evergreen Park was 7.2 percent in 2021 (U.S. Census *QuickFacts*, 2021). The population used for the calculation was 19,943, yielding a total 1,436 residents living in poverty in the Evergreen Park area.

We assumed a normal approximation to the hypergeometric distribution given the targeted sample size.

$$n = (Nz^2pq)/(E^2 (N-1) + z^2 pq$$

where:

n = the required sample size

N = the population size

pq = population proportions (set at .05)

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

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

For the total Evergreen Park area, the minimum sample size for aggregated analyses (combination of at-risk and general populations) was 382. The data collection effort for this CHNA yielded a total of 377 usable responses. This exceeded the threshold of the desired 95% confidence interval.

To provide a representative profile when assessing the aggregated population for the Evergreen Park 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 was aligned with population demographics according to U.S. Census data. This provided a total usable sample of 387 respondents for analyzing the aggregate population.

Survey Data Collection

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. In order to be sensitive to the needs of respondents, surveys stressed assurance of complete anonymity. Note that versions of both the online survey and paper survey were translated into Spanish.

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. Note that the at-risk population was defined as those individuals that were eligible to receive Medicaid based on the State of Illinois guidelines using household size and income level. To specifically target the at-risk population, surveys were distributed at homeless shelters, food pantries and soup kitchens. Since we specifically targeted the at-risk population as part of the data collection effort, this became a stratified sample, as we did not specifically target other groups based on their socio-economic status.

Note that use of electronic surveys to collect community-level data may create a potential for bias from convenience sampling error. To recognize for potential bias in the community sample, a second control sample of data was collected. Specifically, the control sample consisted of random patients surveyed at a 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 were removed, as these questions were not relevant to current patients. Data from the community sample and the control sample were 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 a potential for bias between the community sample and the control sample, they are identified in the social-determinants sections of the analyses within each chapter.

Survey 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 that 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 comparison of primary data statistics to existing secondary data.

Analytic Techniques

To ensure statistical validity, we used several different analytic techniques. Specifically, frequencies and descriptive statistics were used for identifying patterns in residents' ratings of various health concerns. Additionally, appropriate statistical techniques were used for identification of existing relationships between perceptions, behaviors, and demographic data. Specifically, we used Pearson correlations, x^2 tests and tetrachoric correlations when appropriate, given characteristics of the specific data being analyzed.
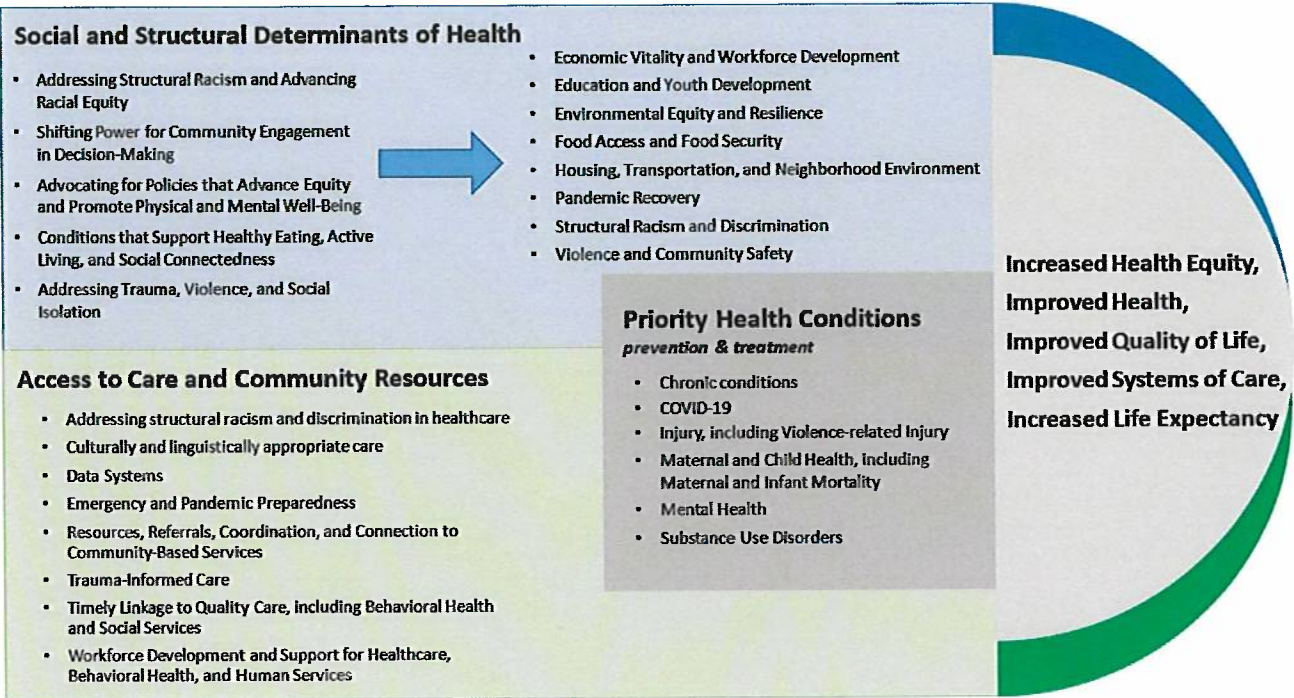
III. SUMMARY OF PRIORITIES

Countywide CHNA Priorities

Through the 2021-2022 countywide Community Health Needs Assessment (CHNA), the Alliance for Health Equity identified the following key health needs across Cook County. (Figure 5)

- **Addressing social and structural determinants of health**
  Issues involving social and structural determinants of health include: (1) addressing structural racism and advancing racial equity, (2) advocating for policies that advance equity and promote physical and mental wellbeing, (3) working towards conditions that support healthy eating and active living, (4) shifting power for community engagement in decision-making, (5) economic vitality and workforce development, (6) education and youth development, (7) food security and food access, (8) housing, transportation, and neighborhood environment, and (9) addressing trauma, violence and social isolation.

- **Improving access to care and community resources**
  Issues involving access to care and community resources include: (1) addressing structural racism and discrimination in healthcare, (2) culturally and linguistically appropriate care, (3) data systems, (4) emergency and pandemic preparedness, (5) resources, referrals, coordination, and connection to community based services, (6) increased timely linkage to appropriate care, including behavioral health and social services, (7) trauma-informed care, (8) workforce development and support for healthcare, behavioral health, and human services workers.

- **Addressing priority health conditions**
  Chronic conditions;
  COVID-19;
  Injury, including violence-related injury;
  Maternal and child health, including maternal and infant mortality;
  Mental health;
  Substance use disorders

Through addressing CHNA priorities, the Alliance for Health Equity seeks to increase health equity, increase life expectancy, improve health, improve systems of care, and improve quality of life.

Alliance for Health Equity – Priority Community Health Needs for Cook County, 2022

Social and Structural Determinants of Health

- Addressing Structural Racism and Advancing Racial Equity
- Shifting Power for Community Engagement in Decision-Making
- Advocating for Policies that Advance Equity and Promote Physical and Mental Well-Being
- Conditions that Support Healthy Eating, Active Living, and Social Connectedness
- Addressing Trauma, Violence, and Social Isolation

- Economic Vitality and Workforce Development
- Education and Youth Development
- Environmental Equity and Resilience
- Food Access and Food Security
- Housing, Transportation, and Neighborhood Environment
- Pandemic Recovery
- Structural Racism and Discrimination
- Violence and Community Safety

Access to Care and Community Resources

- Addressing structural racism and discrimination in healthcare
- Culturally and linguistically appropriate care
- Data Systems
- Emergency and Pandemic Preparedness
- Resources, Referrals, Coordination, and Connection to Community-Based Services
- Trauma-Informed Care
- Timely Linkage to Quality Care, including Behavioral Health and Social Services
- Workforce Development and Support for Healthcare, Behavioral Health, and Human Services

Priority Health Conditions
prevention & treatment

- Chronic conditions
- COVID-19
- Injury, including Violence-related Injury
- Maternal and Child Health, including Maternal and Infant Mortality
- Mental Health
- Substance Use Disorders

**Increased Health Equity,
Improved Health,
Improved Quality of Life,
Improved Systems of Care,
Increased Life Expectancy**

Priority Health Needs - OSF Little Company of Mary Medical Center

Significant Needs Identified and Prioritized

Based on findings from the community survey and focus groups, secondary data analysis, and key informant interviews with internal and external partners, OSF staff along with the collaborative team identified 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, and potential for impact and trends and future forecasts.

In order to prioritize the health needs, OSF staff and the collaborative team used a 2x2 table to consider top community health needs over the course of two meetings in April-May 2022.
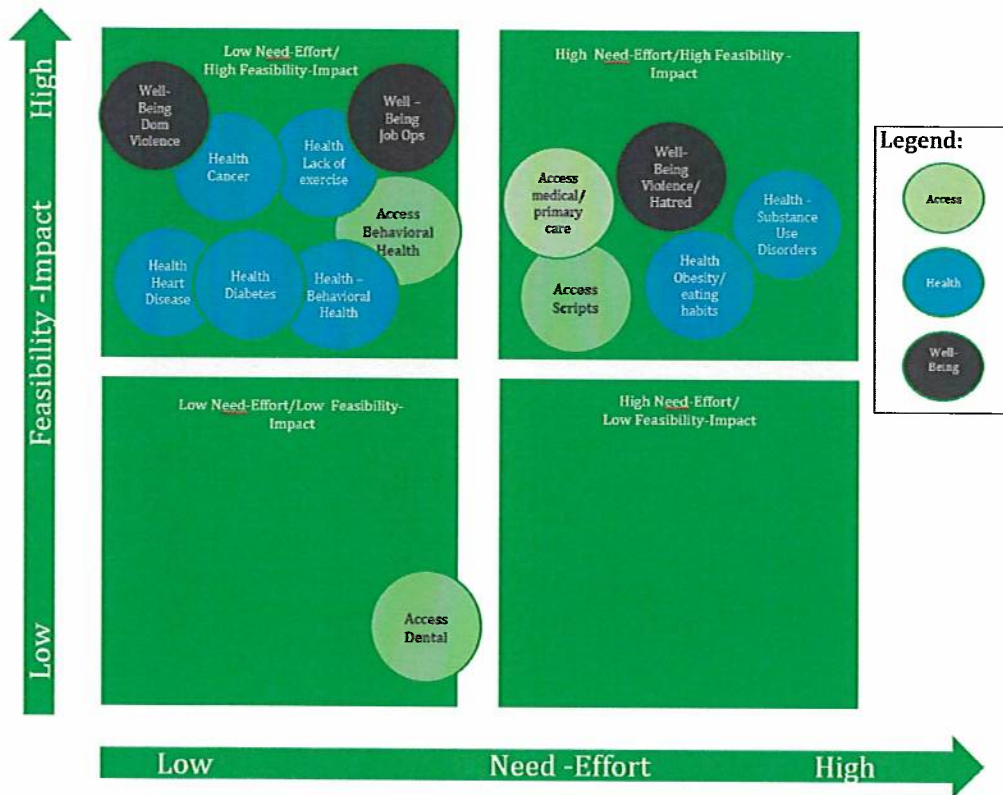
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Using a modified version of the Hanlon Method (as described in Appendix 6), the collaborative team identified four significant health needs as priorities:

- **Access to Care**
- **Behavioral Health, including mental health and substance use**
- **Heart Disease**
- **Cancer**

IV. SOCIAL AND STRUCTURAL DETERMINANTS OF HEALTH

Key Takeaways for Social and Structural Determinants of Health:

- Overall, 17.6% of households in the OSF LCMMC service area are living below the federal poverty level. Over 20% of households experience poverty in Auburn Gresham, Chatham, Riverdale, Roseland, Washington Heights, West Englewood, and West Pullman to less than 6% in Mount Greenwood and Evergreen Park.
- Black community members are much more likely to live below the poverty level than white and Asian community members. Children and adolescents also experience poverty at significantly higher rates than the overall population.
- There are also significant inequities in median household income, ranging from $30,000 in West Englewood to $105,000 in Mount Greenwood.
- Thirteen percent (13%) of the population in the OSF LCMMC service area experienced food insecurity in 2020. Fifty-two percent (52%) of households that have income eligible for SNAP (food stamps) are not receiving SNAP.
- Several communities served by OSF LCMMC have high rates of violent crime compared to Chicago overall (1142.6/100,000) – Greater Grand Crossing (3084.4/100,000), West Englewood (2753.5/100,000), Chatham (2343.2/100,000), and Riverdale (2214.3/100,000) have the highest rates in the service area.
- Homicide mortality in the city of Chicago has increased significantly since 2019 – between 2019 and 2020, the homicide mortality rate Citywide jumped from 14.9/100,000 to 23.5/100,000. Black community members are most affected by homicide mortality, at a rate of 67.3/100,000 compared to 1.6/100,000 for white community members.
- The unemployment rate in the service area is 13%. Eight Chicago community areas within the OSF LCMMC service area have over 15% unemployment whereas other communities in the service area such as Evergreen Park and Mount Greenwood have only about 3% unemployment.
- Eighty-five percent of adults over 25 in the OSF LCMMC have a high school education. The communities with the lowest rates of educational attainment in the service area are communities with larger immigrant populations – Chicago Lawn, West Lawn, West Englewood, and Burbank.
- Thirty eight percent (38%) of households in the OSF LCMMC service area are housing cost burdened, meaning they spend more than 30% of their household income on housing. The communities with the highest rate (49%) are Chicago Lawn, West Englewood, and Greater Grand Crossing.
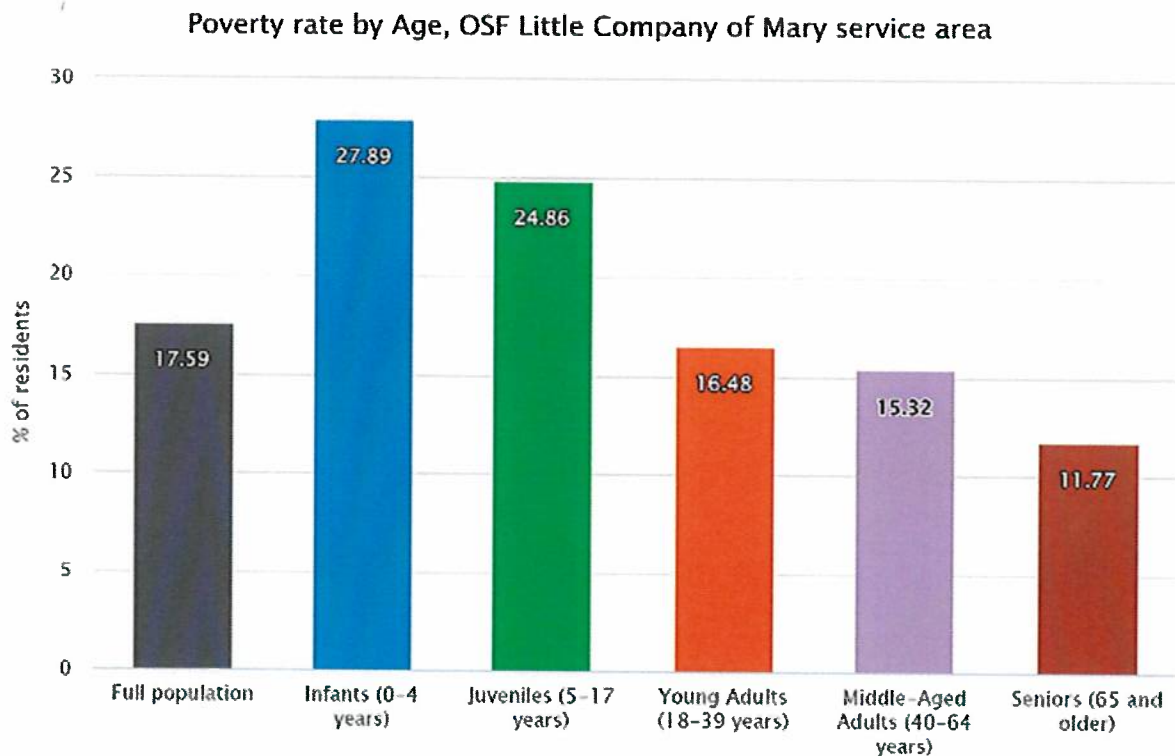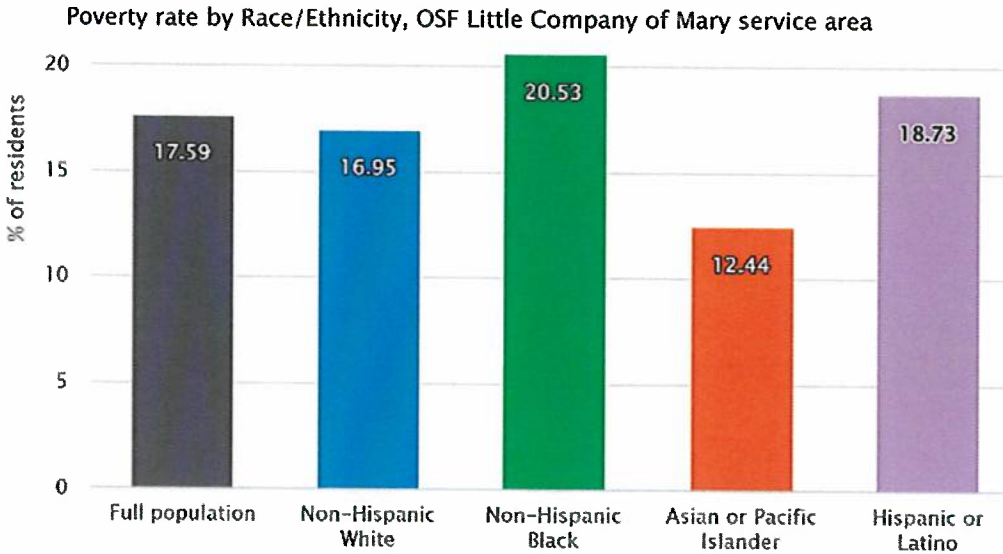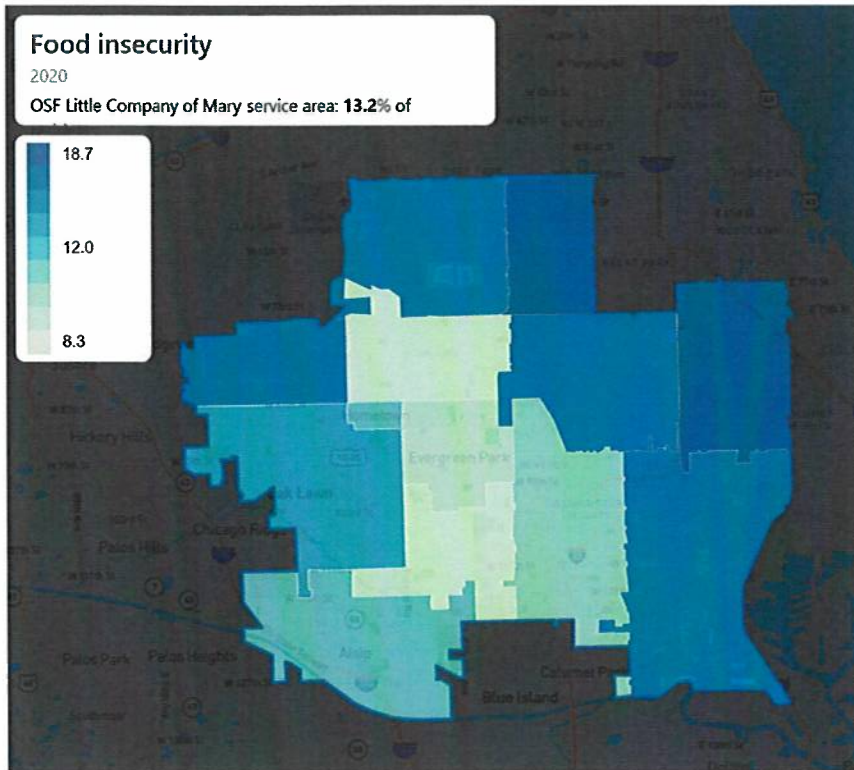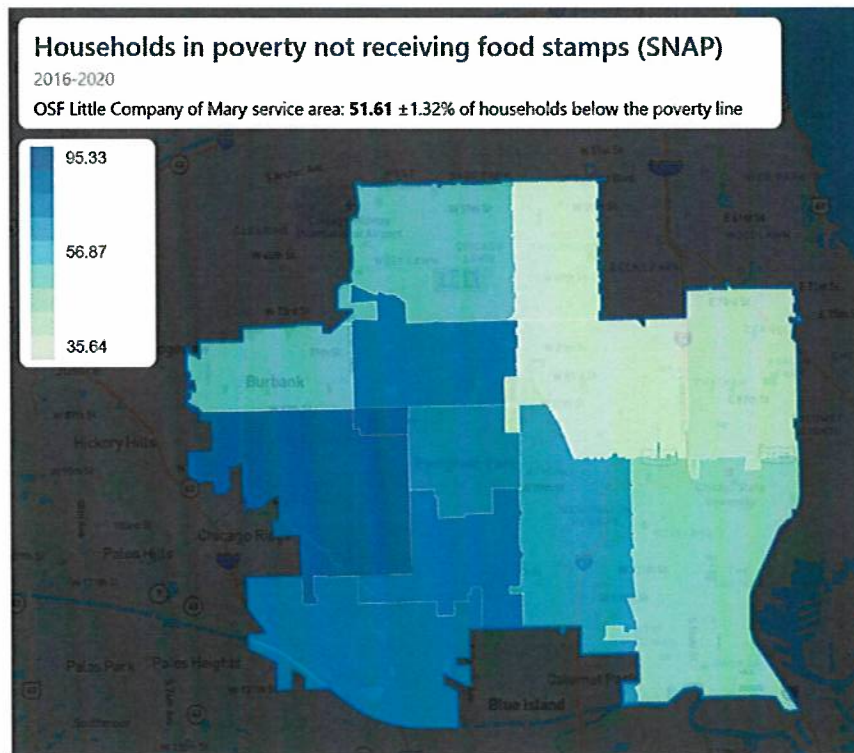
Poverty and Household Income

Overall, 17.6% of households in the OSF LCMMC service area were living below the poverty level as of 2020. There is wide variation in poverty rates across the service area, ranging from over 20% of households in Auburn Gresham, Chatham, Riverdale, Roseland, Washington Heights, West Englewood, and West Pullman to less than 6% in Mount Greenwood and Evergreen Park.

There are also significant inequities in median household income, ranging from less than $30,000 in West Englewood to $105,000 in Mount Greenwood.
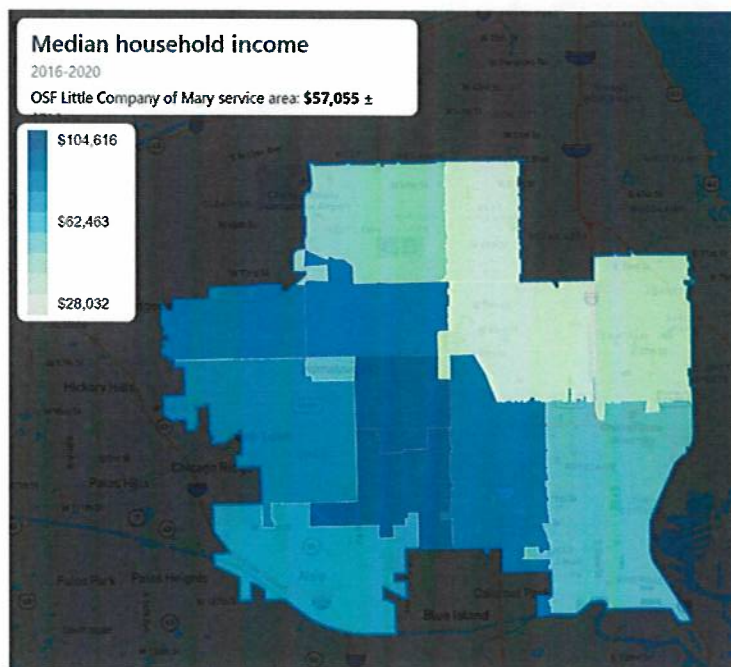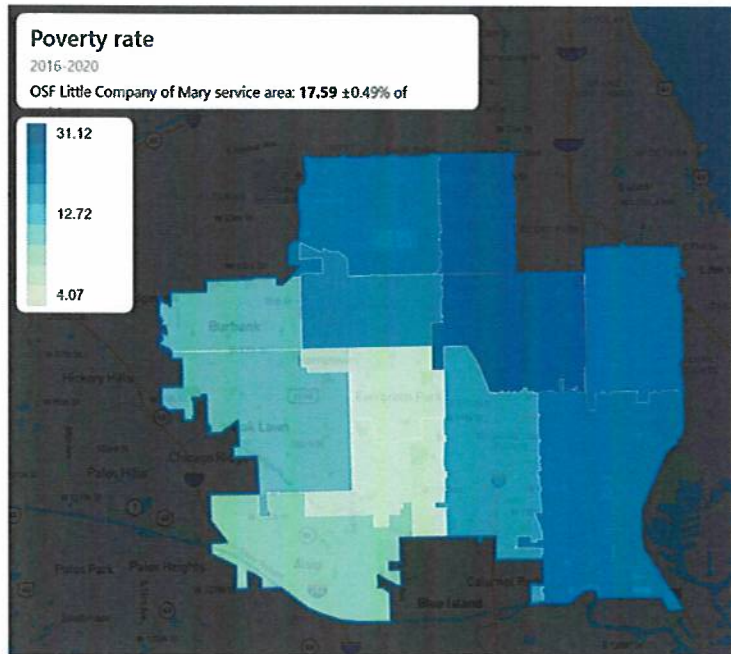
Demographics of Poverty, OSF LCMMC service area

Non-Hispanic Black community members are much more likely to live below the poverty level than white and Asian community members. Children and adolescents also experience poverty at significantly higher rates than the overall population.

Poverty rate by Race/Ethnicity, OSF Little Company of Mary service area

Category	% of residents
Full population	17.59
Non-Hispanic White	16.95
Non-Hispanic Black	20.53
Asian or Pacific Islander	12.44
Hispanic or Latino	18.73

Poverty rate by Age, OSF Little Company of Mary service area

Category	% of residents
Full population	17.59
Infants (0–4 years)	27.89
Juveniles (5–17 years)	24.86
Young Adults (18–39 years)	16.48
Middle-Aged Adults (40–64 years)	15.32
Seniors (65 and older)	11.77

Food Insecurity

Food insecurity
2020
OSF Little Company of Mary service area: **13.2%** of

18.7

12.0

8.3

Thirteen percent (13%) of the population in the OSF LCMMC service area experienced food insecurity in 2020.

Households in poverty not receiving food stamps (SNAP)
2016-2020
OSF Little Company of Mary service area: **51.61** ±1.32% of households below the poverty line

95.33

56.87

35.64

Fifty-two percent (52%) of households that have income eligible for SNAP (food stamps) are not receiving SNAP. This is similar to trends in the City and statewide. In Illinois, 54% of households that are eligible for SNAP are not receiving. Some of the reasons for low enrollment in SNAP are: not realizing they are eligible, not signing up, stigma, immigrants who lack documentation or legal status, and other barriers

Community Safety and Violence

Violent crime rates are only currently available for Chicago communities within the OSF LCMMC service area. Several communities served by OSF LCMMC have rates substantially higher than Chicago overall (1142.6/100,000) – Greater Grand Crossing (3084.4/100,000), West Englewood (2753.5/100,000), Chatham (2343.2/100,000), and Riverdale (2214.3/100,000) have the highest rates in the service area.
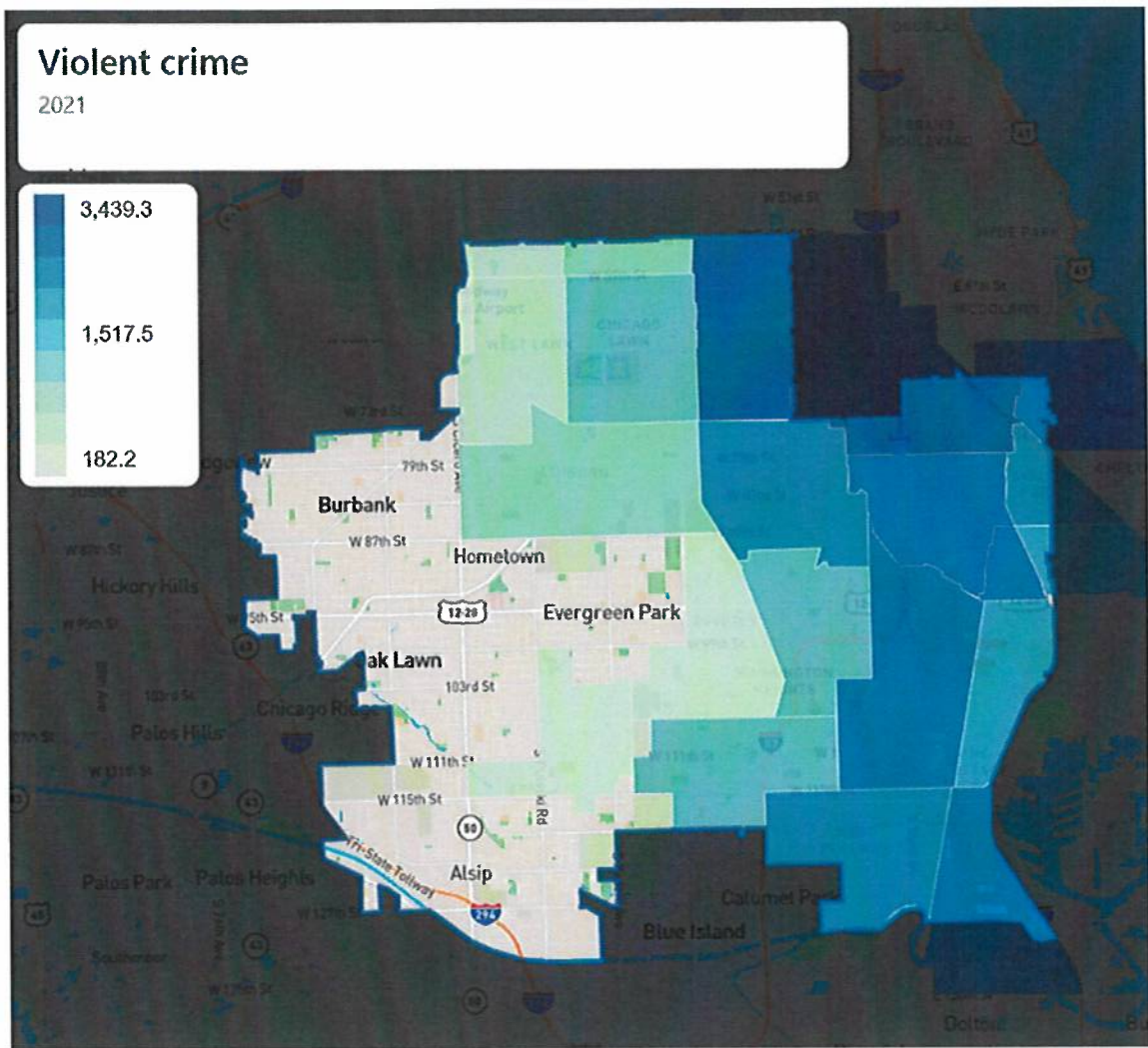
Homicide mortality in the city of Chicago has increased significantly since 2019 – between 2019 and 2020, the homicide mortality rate Citywide jumped from 14.9/100,000 to 23.5/100,000. Black community members are most affected most by homicide mortality, at a rate of 67.3/100,000 compared to 1.6/100,000 for white community members.

Homicide Mortality Rate, Chicago citywide, 2000-2020
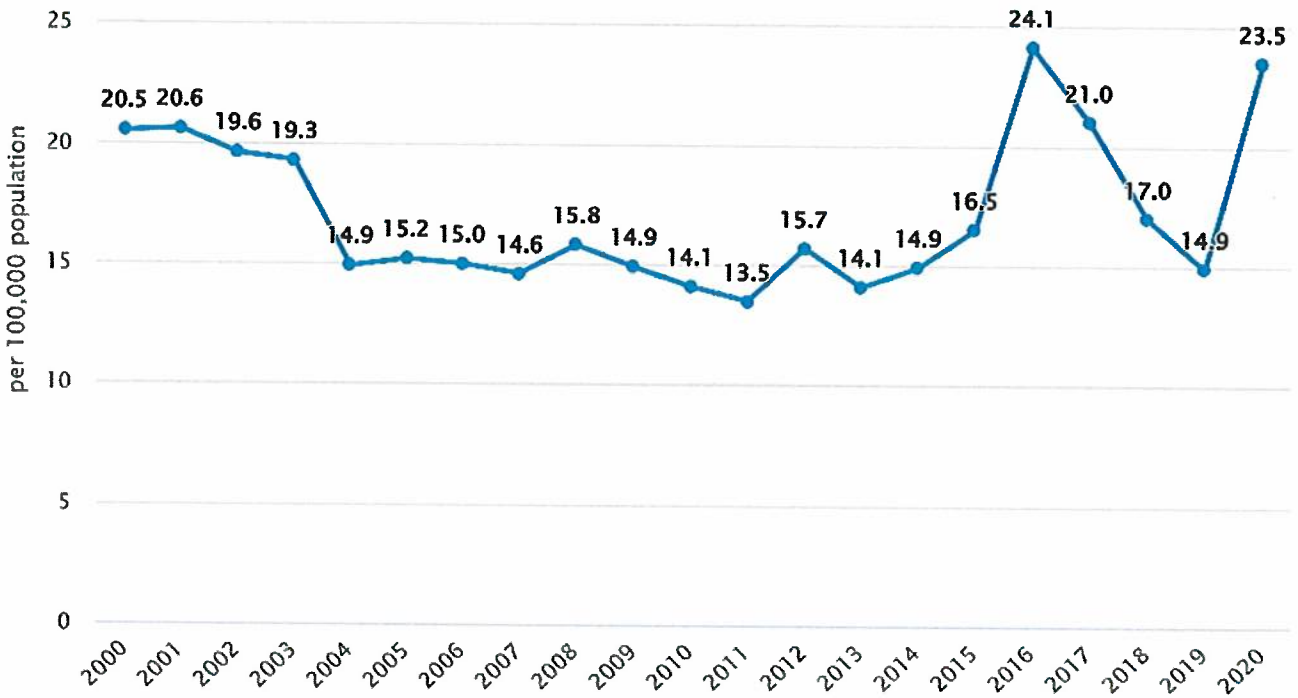
Homicide Mortality Rate, Chicago citywide, by race/ethnicity, 2020
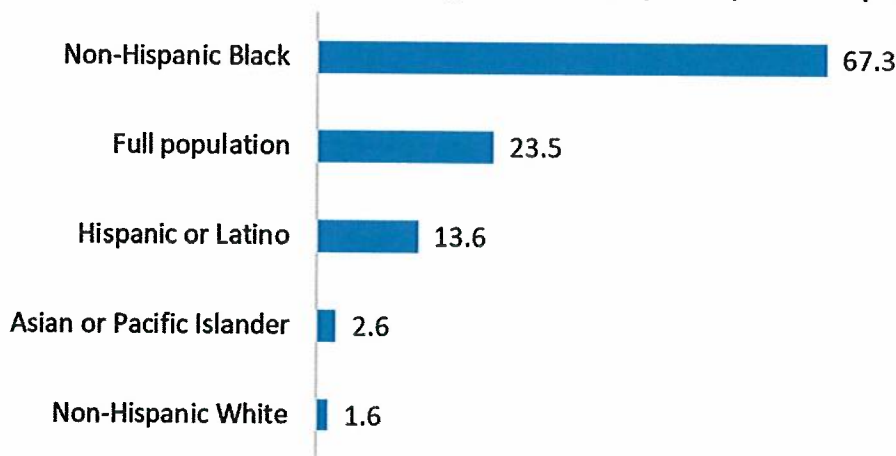
Education and Employment

Eighty-five percent of adults over 25 in the OSF LCMMC have a high school education. The communities with the lowest rates of educational attainment in the service area are communities with larger immigrant populations – Chicago Lawn, West Englewood, and Burbank.
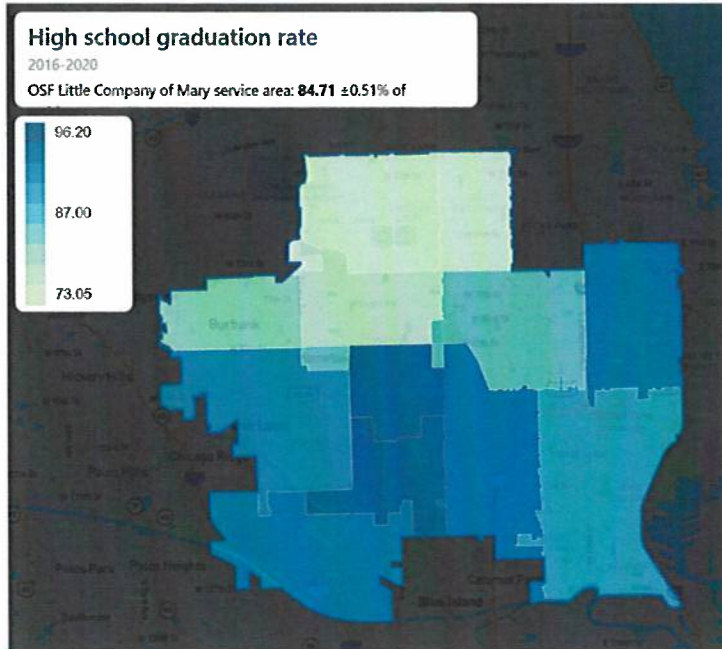
The unemployment rate in the service area is 13%. Within the OSF LCMMC service area, eight Chicago community areas have over 15% unemployment whereas other communities in the service area such as Evergreen Park and Mount Greenwood have only about 3% unemployment.
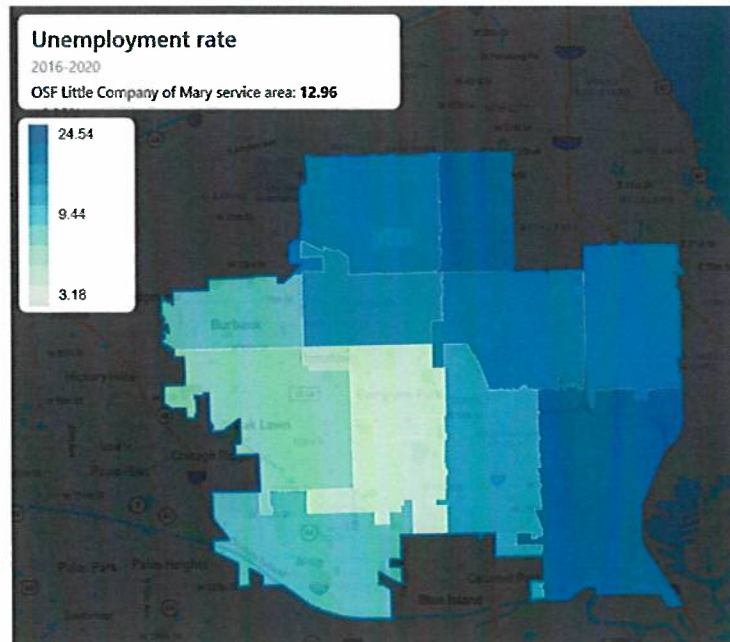
Housing

Thirty eight percent (38%) of households in the OSF LCMMC service area are housing cost burdened, meaning they spend more than 30% of their household income on housing. The communities with the highest rate (49%) are Chicago Lawn, West Englewood, and Greater Grand Crossing.
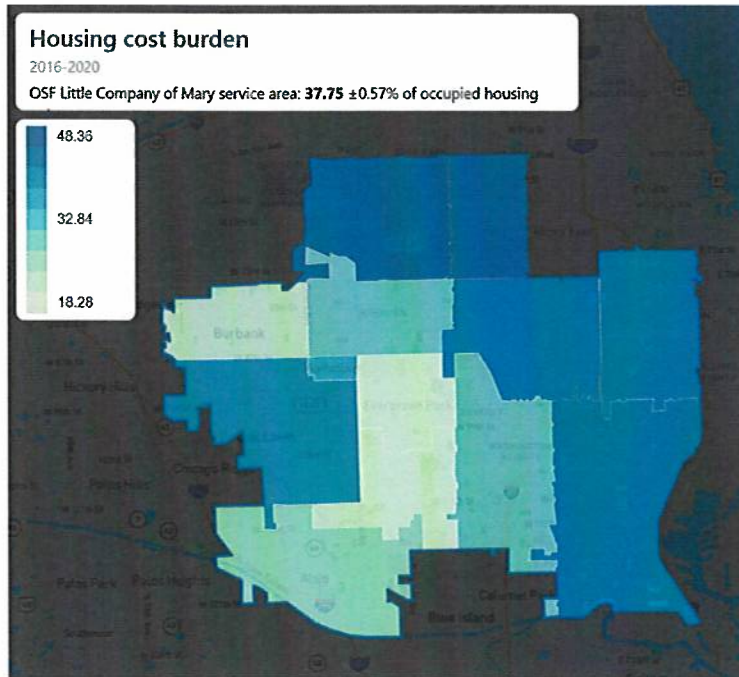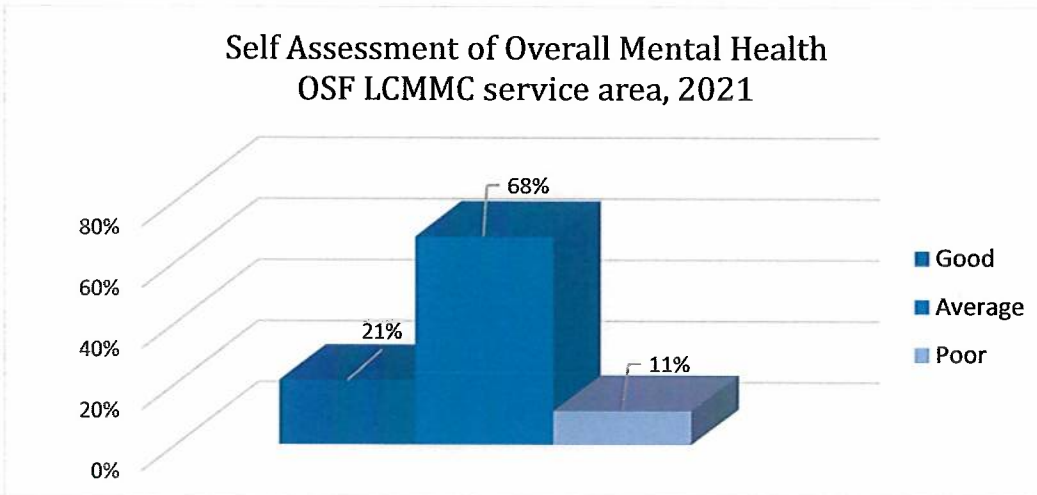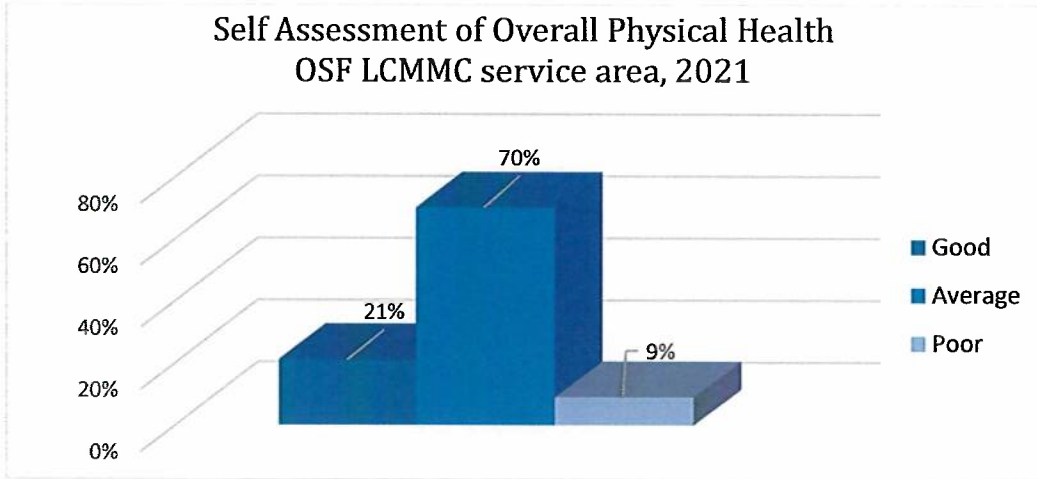

Sixteen percent of renter-occupied units in the service area are Housing Choice Vouchers.
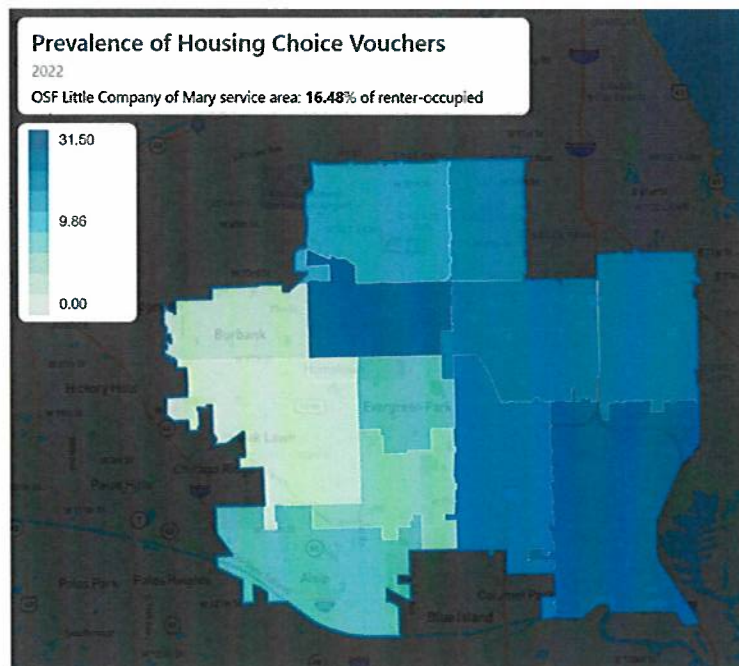
V. HEALTH STATUS

A large majority of CHNA survey respondents reported good or average physical and mental health. Nine percent (9%) of respondents reported poor physical health and 11% reported poor mental health.

**Self Assessment of Overall Physical Health
OSF LCMMC service area, 2021**

**Self Assessment of Overall Mental Health
OSF LCMMC service area, 2021**

Social Determinant Correlates

Several characteristics show a significant relationship with an individual's self-perception of health. The following relationships were found using correlational analyses:

Overall physical health tends to be rated higher by those with higher education and income

Overall mental health tends to be rated higher by older people, Black people and those with higher income. Overall health tends to be rated lower by LatinX people.

VI. ACCESS TO CARE

Key Takeaways for Access to Care:

- As of 2020, 238,138 community members in the OSF LCMMC service area are enrolled in Medicaid.
- Overall, 30% of community members in the OSF LCMMC service area report insurance coverage through Medicaid. This includes over 40% of community members in Auburn Gresham, Chicago Lawn, Greater Grand Crossing, and Riverdale and less than 10% of community members in Beverly, Mount Greenwood, and Evergreen Park.
- 9.2% of community members in the OSF LCMMC service area report being uninsured. Hispanic/LatinX community members have the highest rate of uninsurance in the service area at 13.3%, compared to 7% of white and Asian community members and 7.7% of Black community members.
- As of 2019, 78% of adults in the OSF LCMMC service area reported having been to a primary care provider for a routine checkup (e.g., a general physical exam, not an exam for a specific injury, illness, condition) in the previous year. The communities with the highest proportion of adults reporting routine doctor checkup are Auburn Gresham, Chatham, Roseland, Washington Heights, and West Pullman.
- The overall rate of physicians who see Medicaid enrollees per capita is 85.8 per 100,000, ranging from over 500/100,00 in Evergreen Park and Oak Lawn to less than 10/100,000 in West Englewood, Greater Grand Crossing, and Auburn Gresham.
- 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 medications, dental care and counseling. Survey results show that 15% of the population did not have access to medical care when needed; 15% of the population did not have access to prescription medications when needed; 16% of the population did not have access to dental care when needed; and 14% of the population did not have access to counseling when needed.
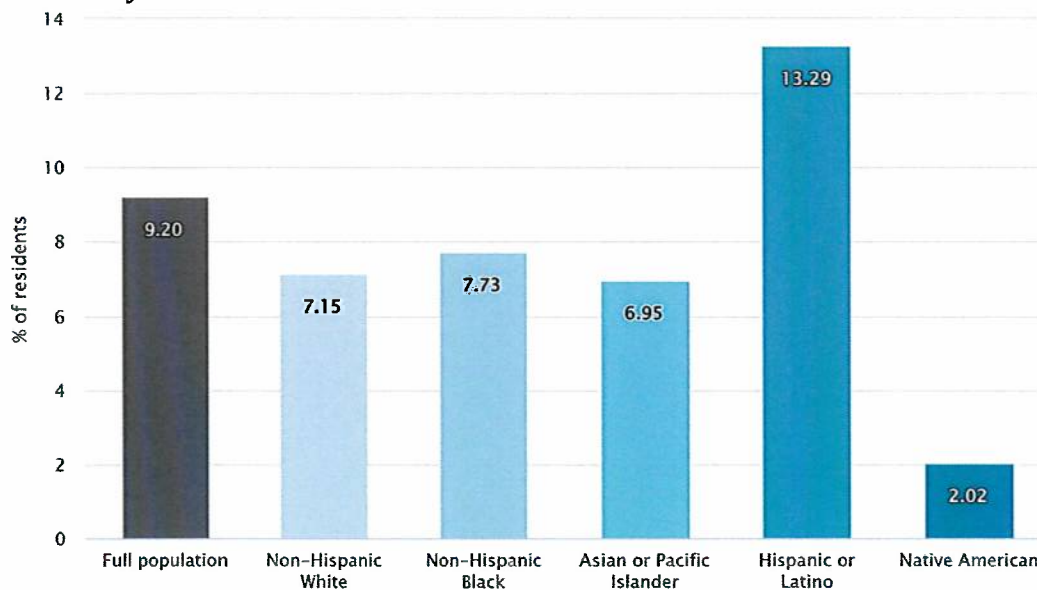
Medicaid

As of 2020, 238,138 community members in the OSF LCMMC service area are enrolled in Medicaid. Overall, 30% of community members in the OSF LCMMC service area report insurance coverage through Medicaid. This includes over 40% of community members in Auburn Gresham, Chicago Lawn, Greater Grand Crossing, and Riverdale and less than 10% of community members in Beverly, Mount Greenwood, and Evergreen Park.

Medicaid coverage
2016-2020
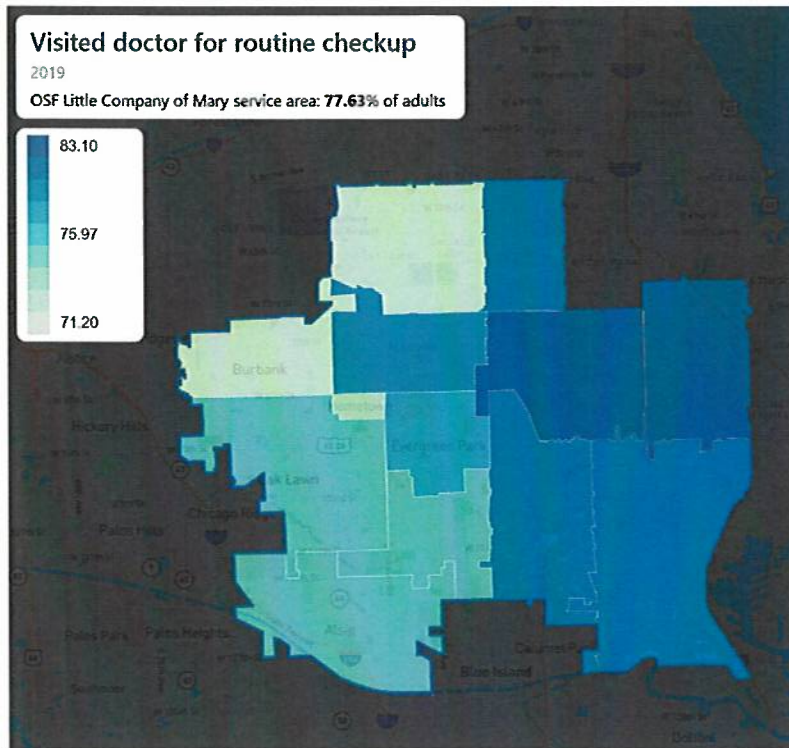OSF Little Company of Mary service area: **29.58** ±0.47% of
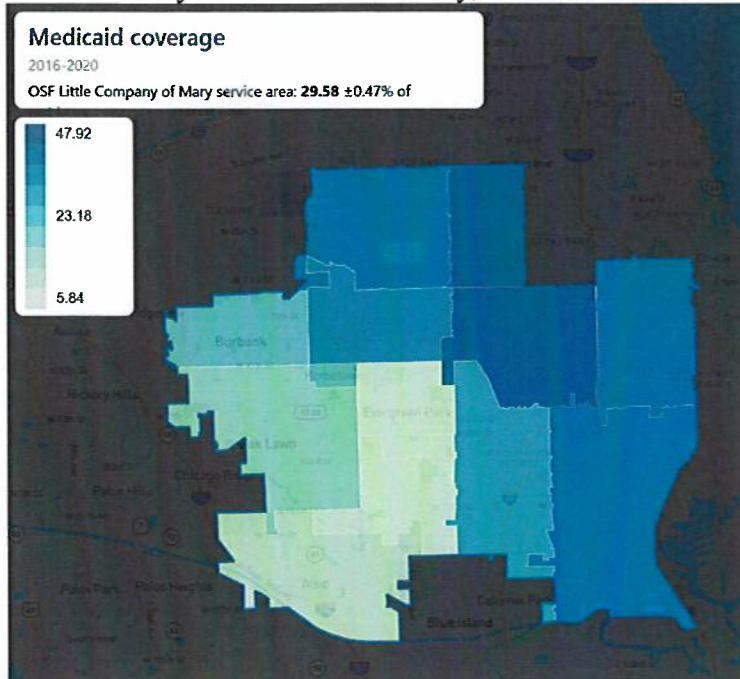
Uninsured Rate, by Race/Ethnicity, OSF LCMMC service area, 2020

Hispanic/LatinX community members have the highest rate of uninsurance in the service area at 13.3%, compared to 7% of white and Asian community members and 7.7% of Black community members.
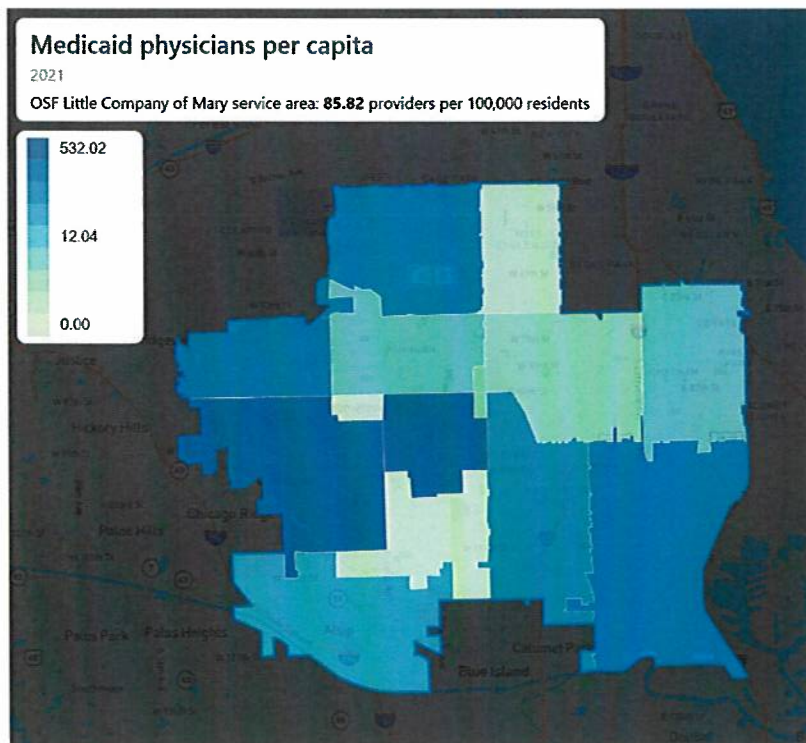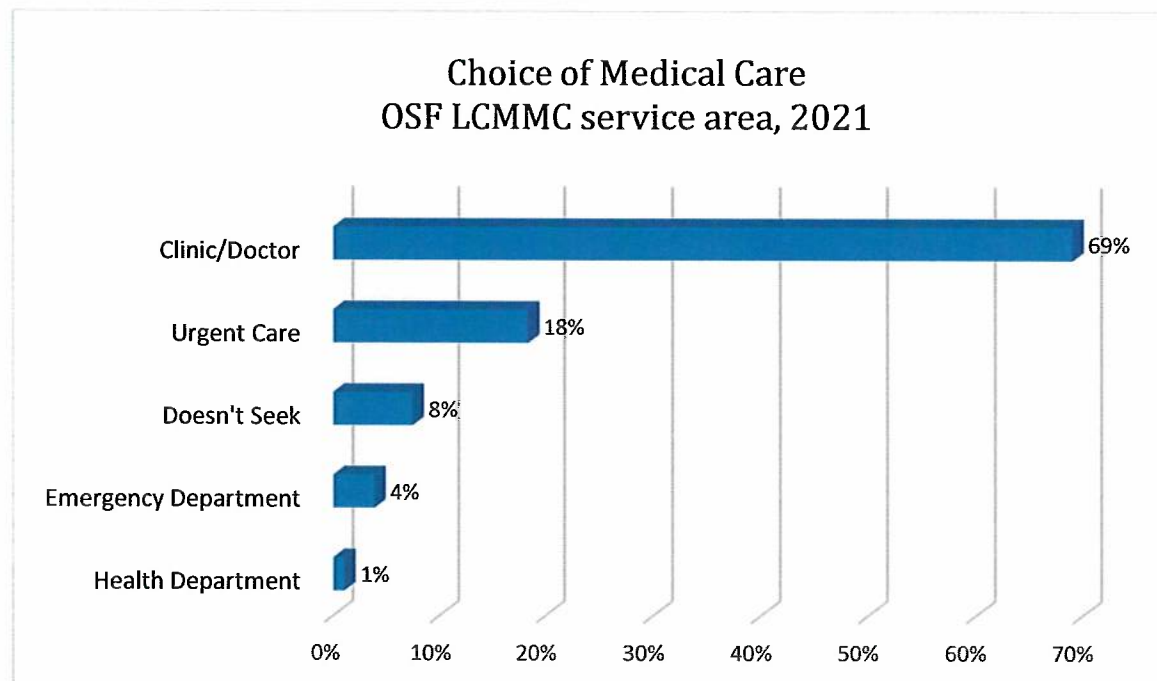
Routine medical care

Visited doctor for routine checkup
2019
OSF Little Company of Mary service area: **77.63%** of adults

83.10

75.97

71.20

As of 2019, 78% of adults in the OSF LCMMC service area reported having been to a primary care provider for a routine checkup (e.g., a general physical exam, not an exam for a specific injury, illness, condition) in the previous year. The communities with the highest proportion of adults reporting routine doctor checkup are Auburn Gresham, Chatham, Roseland, Washington Heights, and West Pullman.

Medicaid Physicians Per Capita

Medicaid physicians per capita
2021
OSF Little Company of Mary service area: **85.82** providers per 100,000 residents

532.02

12.04

0.00

The overall rate of physicians who see Medicaid enrollees per capita is 85.8 per 100,000, ranging from over 500/100,00 in Evergreen Park and Oak Lawn to less than 10/100,000 in West Englewood, Greater Grand Crossing, and Auburn Gresham.

Survey respondents were asked to select their primary source of healthcare facility used when sick. Six different alternatives were presented, including clinic or doctor's office, emergency department, urgent-care facility, health department, no medical treatment, and other. The most common response for source of medical care was clinic/doctor's office, chosen by 69% of survey respondents. This was followed by urgent care (18%), not seeking medical attention (8%), the emergency department at a hospital (4%), and the health department (1%).

Choice of Medical Care
OSF LCMMC service area, 2021

Category	Value
Clinic/Doctor	69%
Urgent Care	18%
Doesn't Seek	8%
Emergency Department	4%
Health Department	1%

Social Determinant Correlates

Several characteristics 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 women and older people.

**Urgent Care** tends to be used more often by younger people, White people and those with higher income.

Emergency Department tends to be used more often by Black people, those that are less educated, have a lower income and by people with an unstable (e.g. homeless) housing environment.

Do Not Seek Medical Care tends to be selected by men.

Health Department tends to be selected by younger people.

Survey respondents were asked if they have a personal physician, and 86% of respondents indicate they do while 14% did not.

Use of Personal Physician
OSF LCMMC service area, 2021
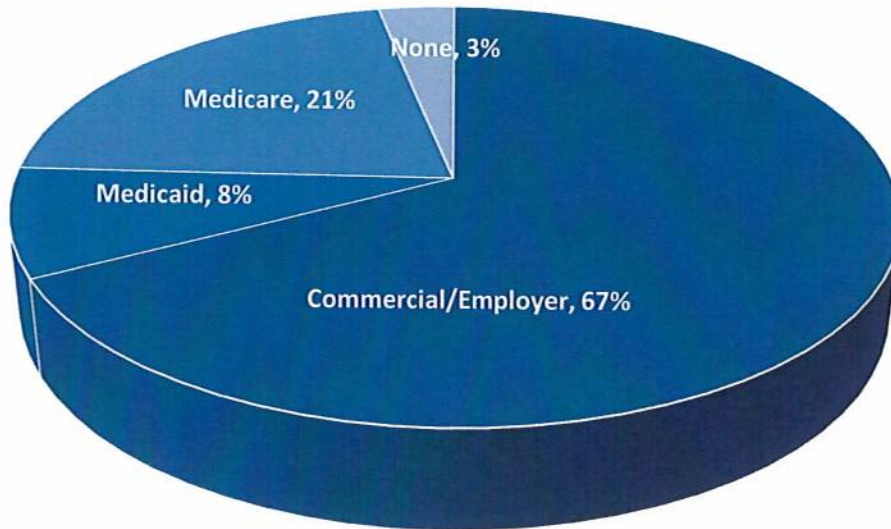
14%

86%

■ No   ■ Yes
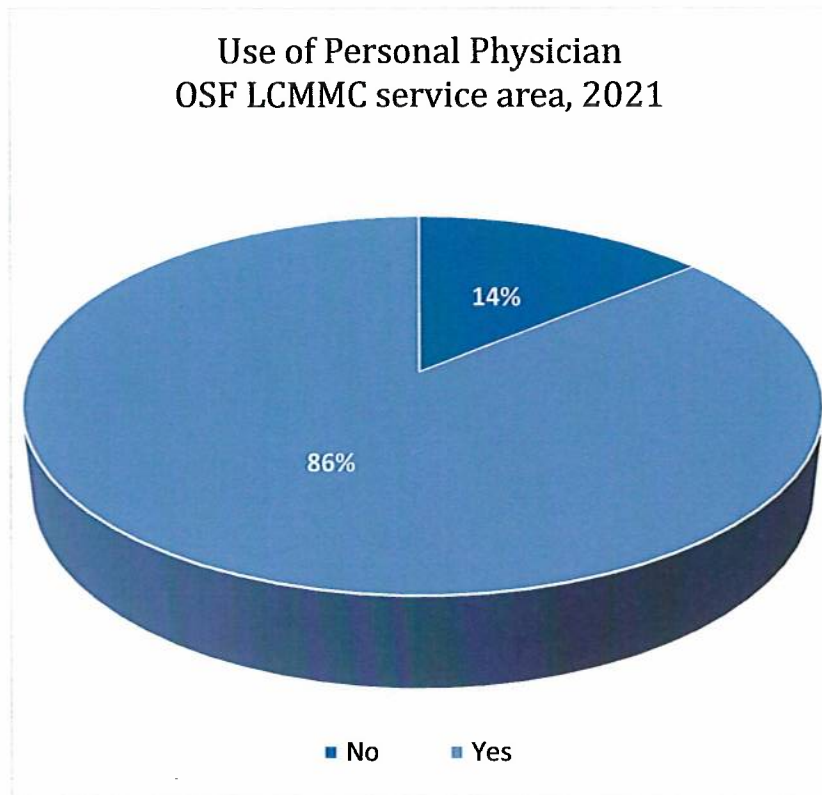
Social Determinant Correlates

One characteristic shows a significant relationship with an individual's likelihood of having a personal physician. The following relationship was found using correlational analyses:

Having a personal physician tends to be rated higher by older people.

Among respondents to the survey, 67% are covered by private insurance, followed by Medicare (21%), Medicaid (8%), and no health insurance (3%).

Type of Insurance
OSF LCMMC Service Area, 2021

None, 3%

Medicare, 21%

Medicaid, 8%

Commercial/Employer, 67%

Social Determinant Correlates

Several characteristics show a significant relationship with an individual's ability to access insurance. The following relationships were found using correlational analyses:
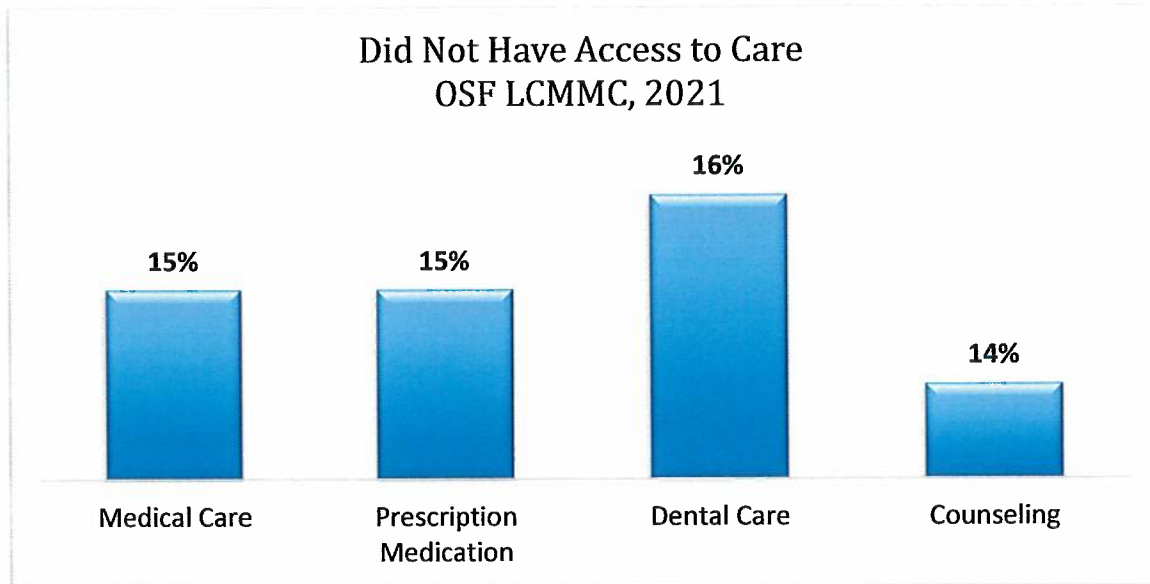
> **Survey respondents with Medicare** tend to be older people, and those with lower education and income.

> **Survey respondents with Medicaid** tend to be those with lower education and income.

> **Survey respondents with Commercial/Employer Insurance** tend to be those with higher education and income. White survey respondents were more likely to have Commercial/Employer Insurance, and Black survey respondents were least likely to have Commercial/Employer Insurance.

> **No Insurance** tends to be reported more often by LatinX people and those with lower education and income.

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 medications, dental care, and counseling. Survey results show that 15% of the population did not have access to medical care when needed; 15% of the population did not have access to prescription medications when needed; 16% of the population did not have access to dental care when needed; and 14% of the population did not have access to counseling when needed.

Did Not Have Access to Care
OSF LCMMC, 2021

Social Determinant Correlates

Several characteristics show a significant relationship with an individual's ability to access care when needed. The following relationships were found using correlational analyses:
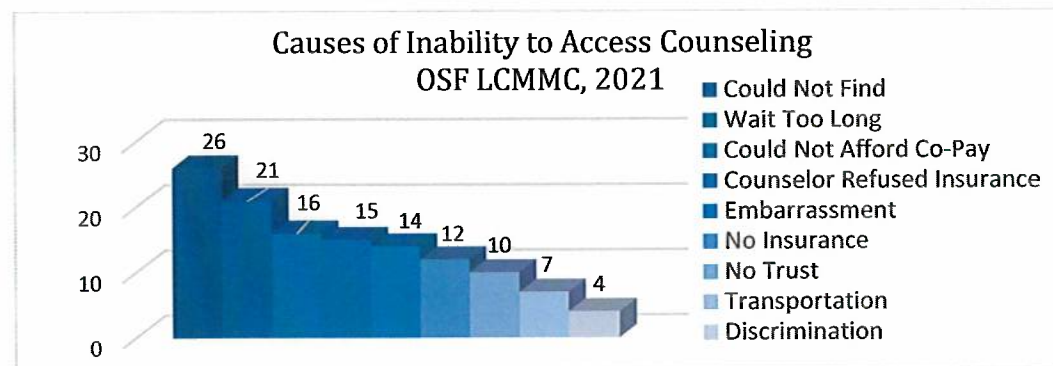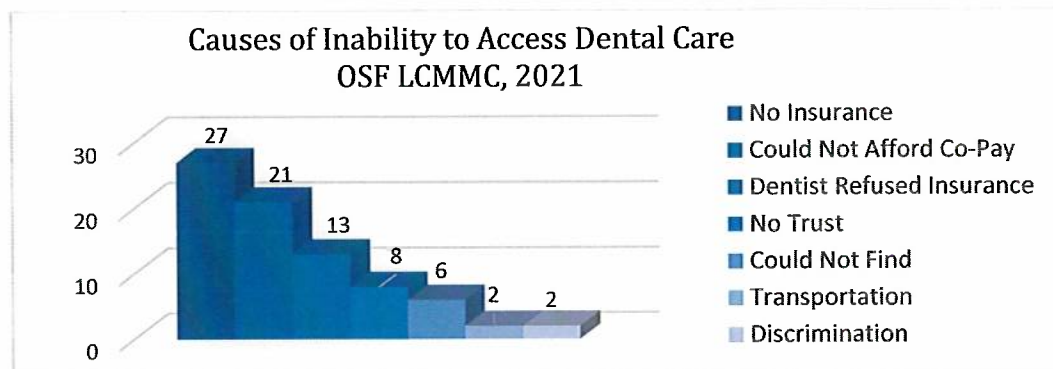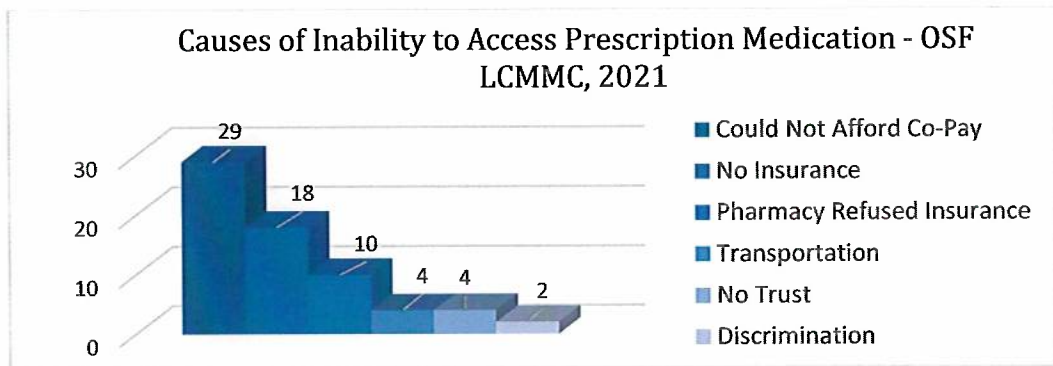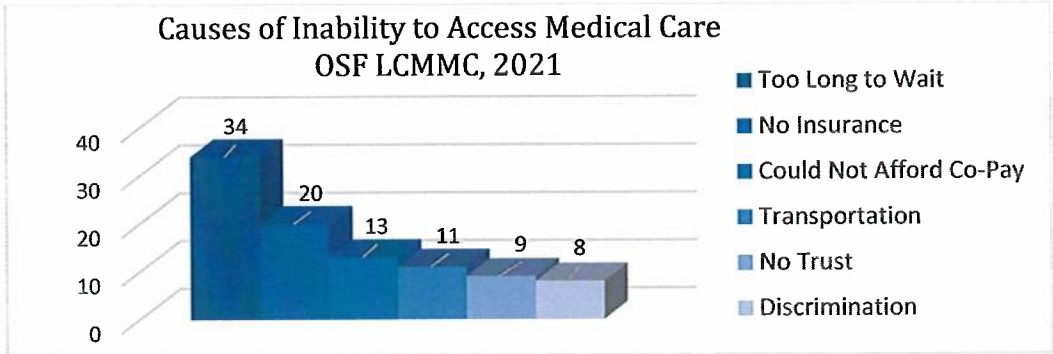
Access to medical care tends to be higher for White people, and those with higher income. Access to medical care tends to be rated lower for LatinX people.

Access to prescription medications tends to be higher for older people, White people, and those with higher education and income. Access to prescription medication tends to be lower for Black people and people with an unstable (e.g., homeless) housing environment.

Access to dental care tends to be higher for White people, those with higher income. Access to dental care tends to be lower for LatinX people.

Access to counseling tends to be rated higher older people. Access to counseling tends to be rated lower for LatinX people and people with an unstable (e.g., homeless) housing environment.

Survey respondents who reported they were not able to get medical care when needed were asked a follow-up question about the causes of not being able to access care. Note that these data are displayed in frequencies rather than percentages given the low number of responses.
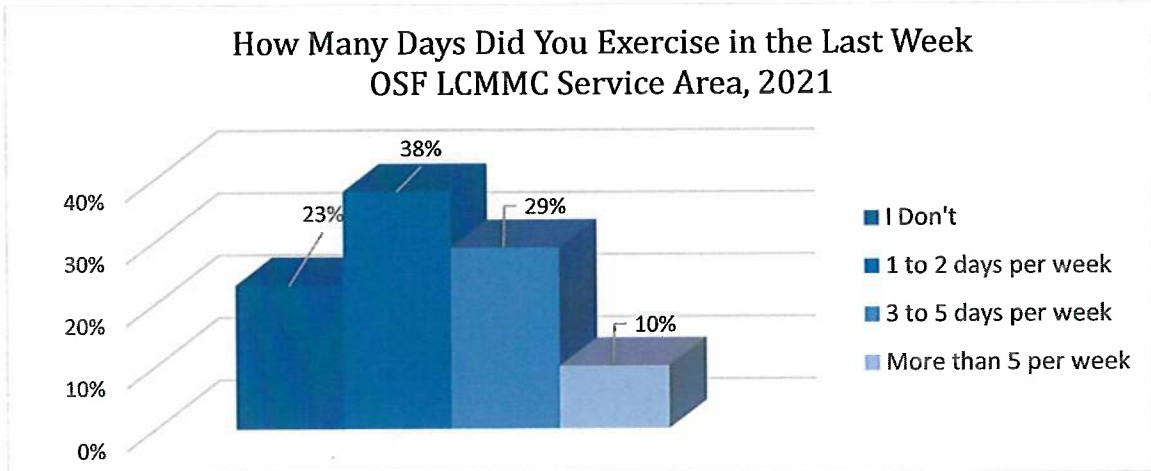
Causes of Inability to Access Medical Care OSF LCMMC, 2021

- Too Long to Wait
- No Insurance
- Could Not Afford Co-Pay
- Transportation
- No Trust
- Discrimination

34, 20, 13, 11, 9, 8

Causes of Inability to Access Prescription Medication - OSF LCMMC, 2021

- Could Not Afford Co-Pay
- No Insurance
- Pharmacy Refused Insurance
- Transportation
- No Trust
- Discrimination

29, 18, 10, 4, 4, 2

Causes of Inability to Access Dental Care OSF LCMMC, 2021

- No Insurance
- Could Not Afford Co-Pay
- Dentist Refused Insurance
- No Trust
- Could Not Find
- Transportation
- Discrimination

27, 21, 13, 8, 6, 2, 2

Causes of Inability to Access Counseling OSF LCMMC, 2021

- Could Not Find
- Wait Too Long
- Could Not Afford Co-Pay
- Counselor Refused Insurance
- Embarrassment
- No Insurance
- No Trust
- Transportation
- Discrimination

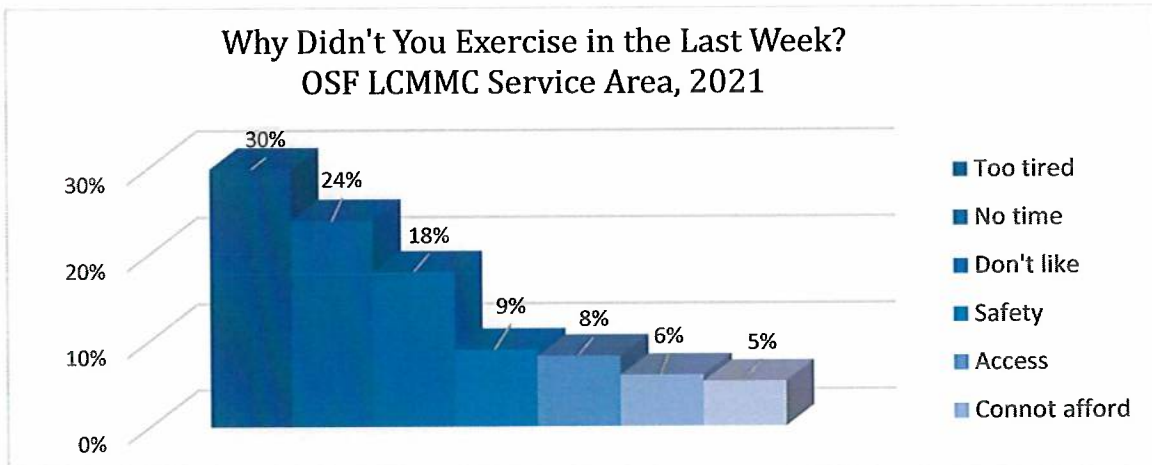26, 21, 16, 15, 14, 12, 10, 7, 4

VII. PREVENTION BEHAVIORS

Key Takeaways for Prevention Behaviors:

- Twenty-three percent (23%) of survey respondents indicated that they do not exercise at all, while 38% of respondents indicated they exercise 1-2 days per week and 29% exercise 3-5 days per week.
- Sixty-two percent (62%) of survey respondents report low consumption (1-2 servings per day) of fruits and vegetables.
- Among survey respondents, 66% of women had a breast screening in the past five years, and 69% of women had a cervical cancer screening. 38% of men had a prostate screening in the past five years. 61% of women and men over the age of 50 had a colorectal screening in the last five years.
- Ninety percent (90%) of survey respondents do not smoke and less than 1% state they smoke or vape more than 12 times per day

Twenty-three percent (23%) of survey respondents indicated that they do not exercise at all, while 38% of respondents indicated they exercise 1-2 days per week and 29% exercise 3-5 days per week.

How Many Days Did You Exercise in the Last Week
OSF LCMMC Service Area, 2021

- ■ I Don't — 23%
- ■ 1 to 2 days per week — 38%
- ■ 3 to 5 days per week — 29%
- ■ More than 5 per week — 10%

If a respondent answered that s/he did not exercise, a follow-up question was asked. The most common reasons for not exercising are too tired (30%) and not having enough time (24%).

Why Didn't You Exercise in the Last Week?
OSF LCMMC Service Area, 2021

- ■ Too tired — 30%
- ■ No time — 24%
- ■ Don't like — 18%
- ■ Safety — 9%
- ■ Access — 8%
- ■ Connot afford — 6%, 5%
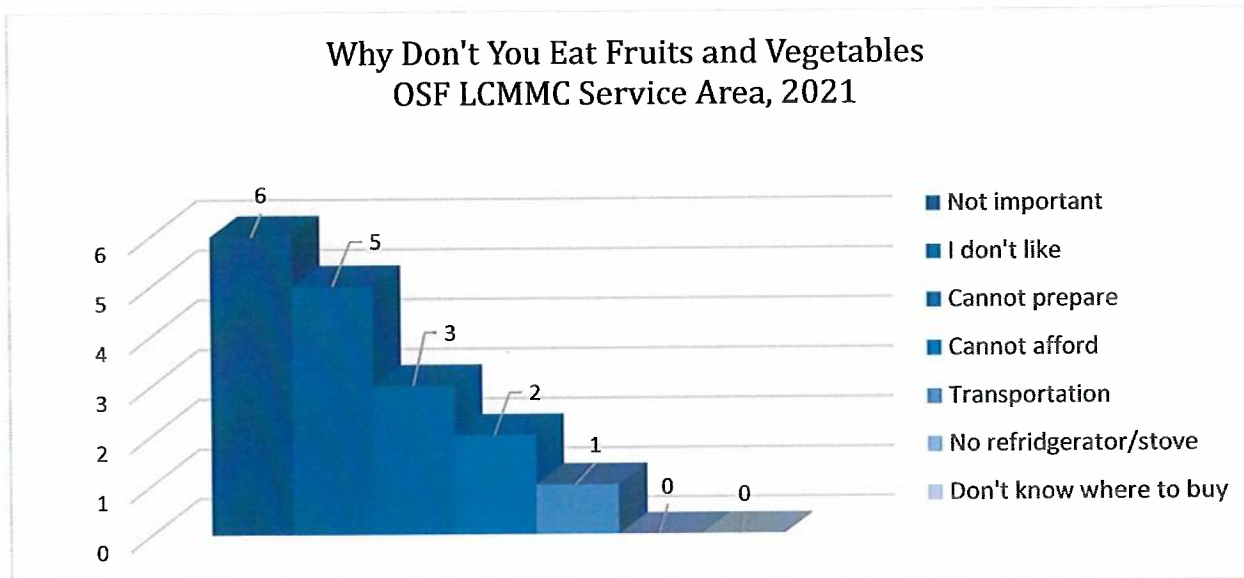
Social Determinant Correlates

Two characteristics show a significant relationship with an individual's exercise frequency. The following relationships were found using correlational analyses:

Frequency of exercise tends to be rated higher people with higher education and higher income.

Sixty-two percent (62%) of survey respondents report low consumption (1-2 servings per day) of fruits and vegetables. Note that the percentage of respondents who consume five or more servings per day is only 4%.

Daily Consumption of Fruits and Vegetables
OSF LCMMC Service Area, 2021
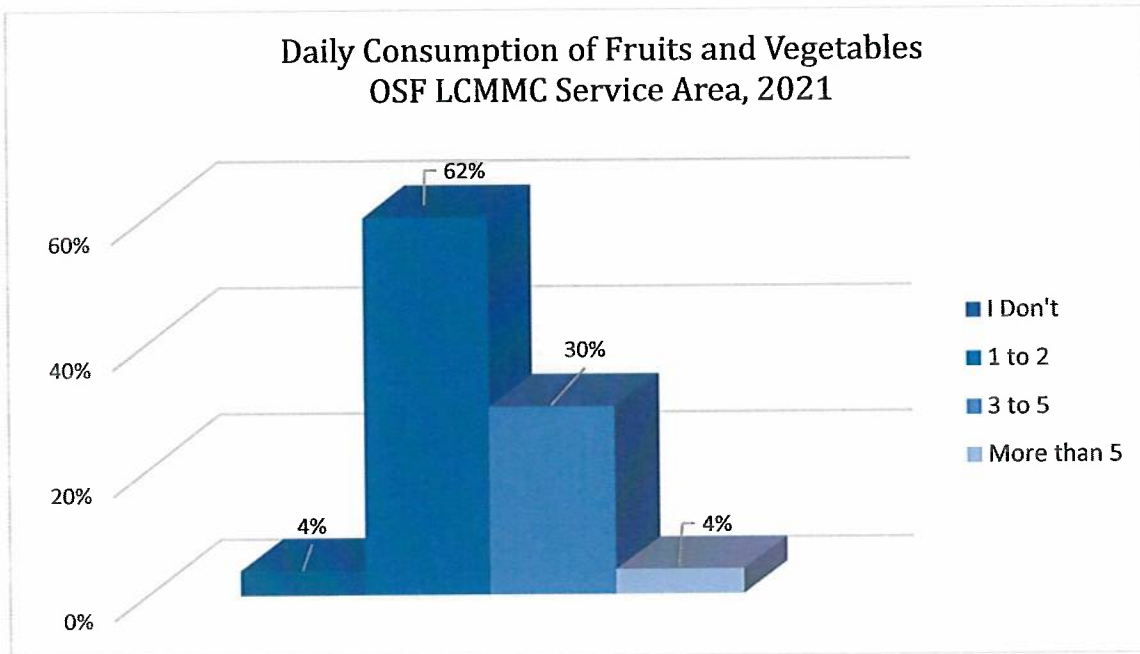
If a respondent answered that s/he did not eat fruits and vegetables, a follow-up question was asked about why they don't eat fruits and vegetables. Due to the small number of respondents that don't eat any fruits or vegetables, the data below are presented as COUNTS (frequencies) rather than percentages.

Why Don't You Eat Fruits and Vegetables
OSF LCMMC Service Area, 2021

Ninety-one percent (91%) of survey respondents report that a grocery store is their primary source of food.

Primary Source of Food
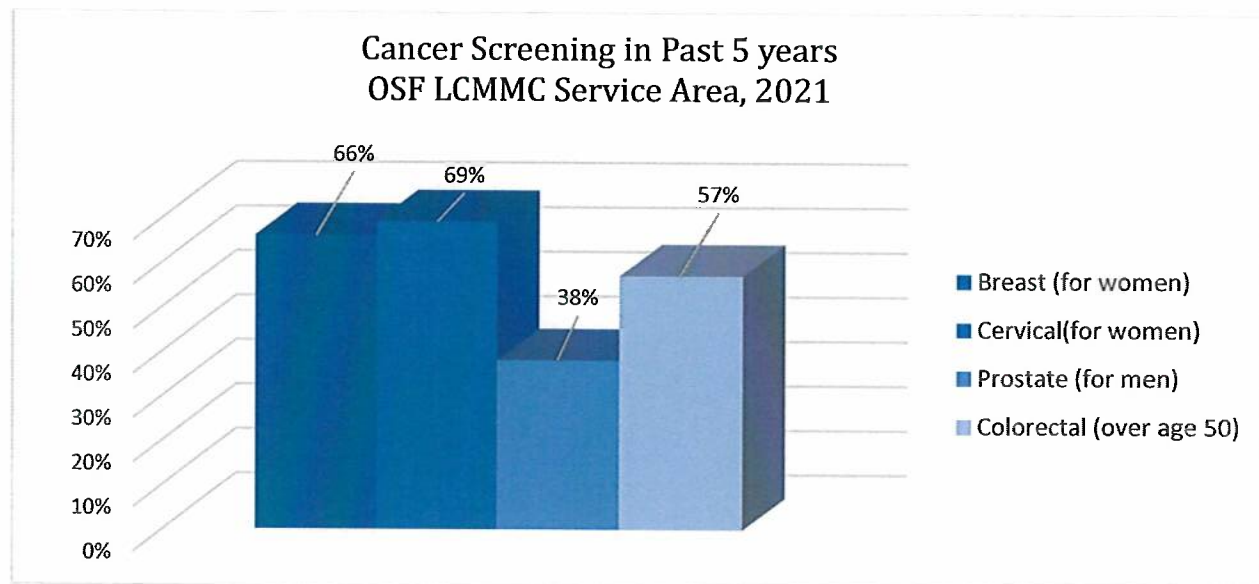OSF LCMMC Service Area, 2021
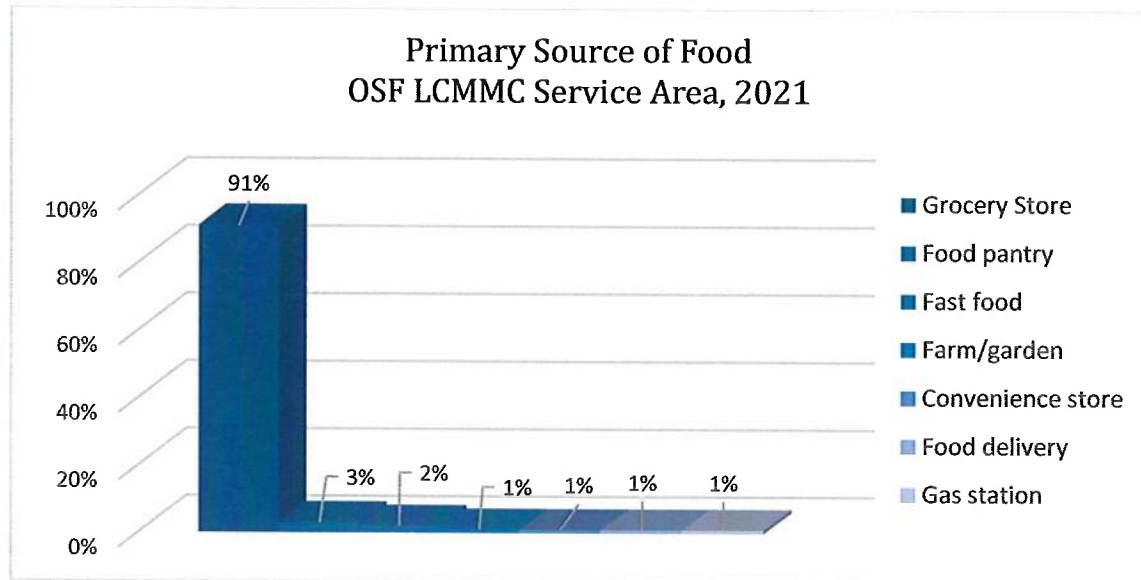
Social Determinant Correlates

The following relationships were found using correlational analyses:

Frequency of eating fruits/vegetables tends to be rated higher by older people, and those with higher education and higher income.

Among survey respondents, 66% of women had a breast screening in the past five years, and 69% of women had a cervical cancer screening. 38% of men had a prostate screening in the past five years. 61% of women and men over the age of 50 had a colorectal screening in the last five years.

Cancer Screening in Past 5 years
OSF LCMMC Service Area, 2021

- Breast (for women) — 66%
- Cervical (for women) — 69%
- Prostate (for men) — 38%
- Colorectal (over age 50) — 57%

Social Determinant Correlates

Several characteristics show a significant relationship with cancer screenings. The following relationships were found using correlational analyses:
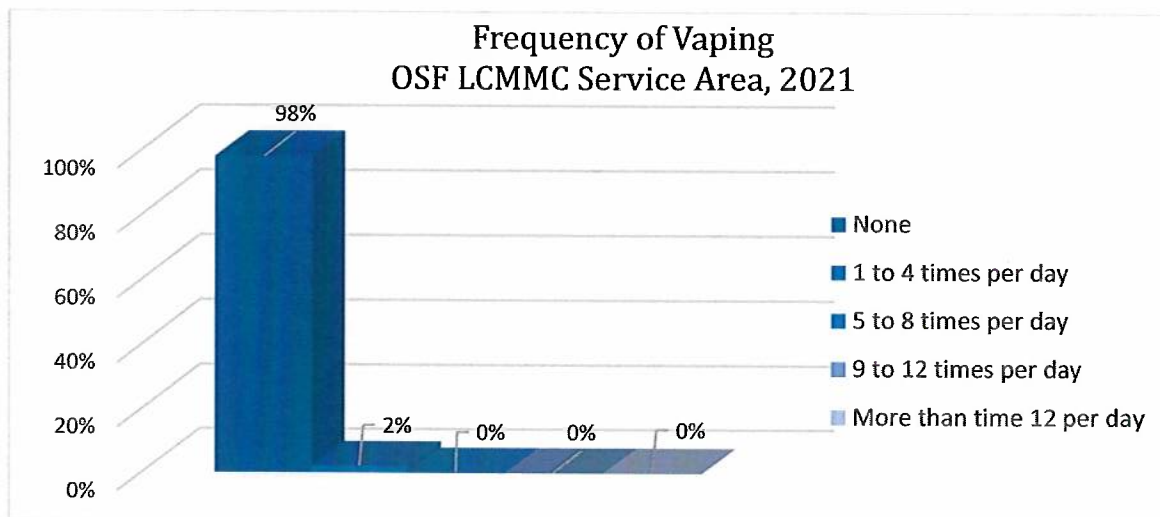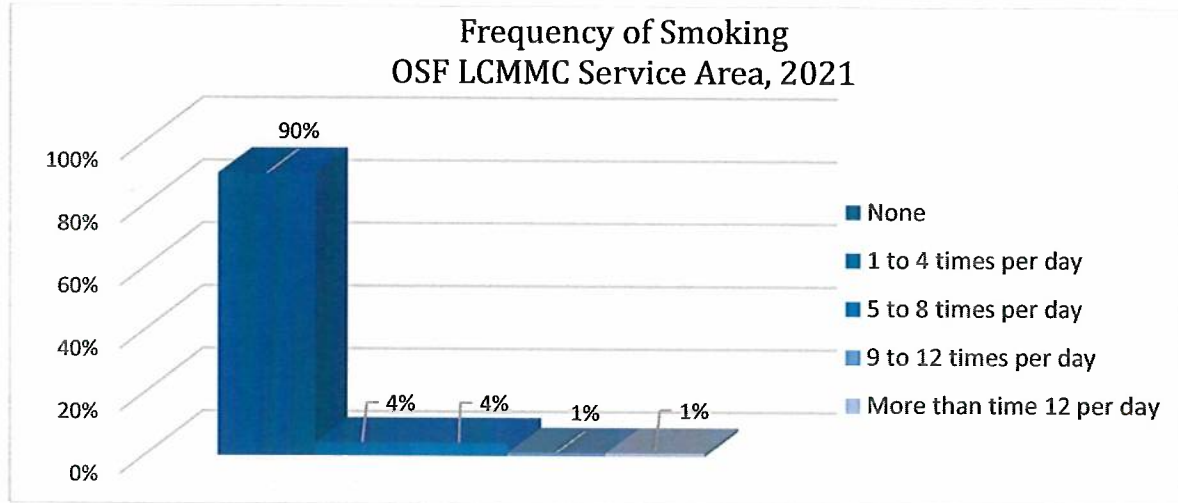
> **Frequency of breast exams** tends be rated higher by older women, and those with higher income. Frequency of breast exams tends to be rated lower by LatinX women and those with an unstable (e.g. homeless) housing environment.

> **Frequency of cervical exams/pap smears** tends be rated higher by younger women, White women, those with higher education and income.

> **Frequency of prostate exams** tends be rated higher by older men and those with higher income.

> **Frequency of colorectal exams** had no significant correlates.

Ninety percent (90%) of survey respondents do not smoke and less than 1% state they smoke or vape more than 12 times per day

Frequency of Smoking
OSF LCMMC Service Area, 2021

- None
- 1 to 4 times per day
- 5 to 8 times per day
- 9 to 12 times per day
- More than time 12 per day

Frequency of Vaping
OSF LCMMC Service Area, 2021

- None
- 1 to 4 times per day
- 5 to 8 times per day
- 9 to 12 times per day
- More than time 12 per day

Social Determinant Correlates

Several characteristics show a significant relationship with frequency of smoking and vaping. The following relationships were found using correlational analyses:

Frequency of smoking tends be rated higher by those with lower education and income and those with an unstable (e.g. homeless) housing environment.

Frequency of vaping tends be rated higher by LatinX people, and those with an unstable (e.g. homeless) housing environment.
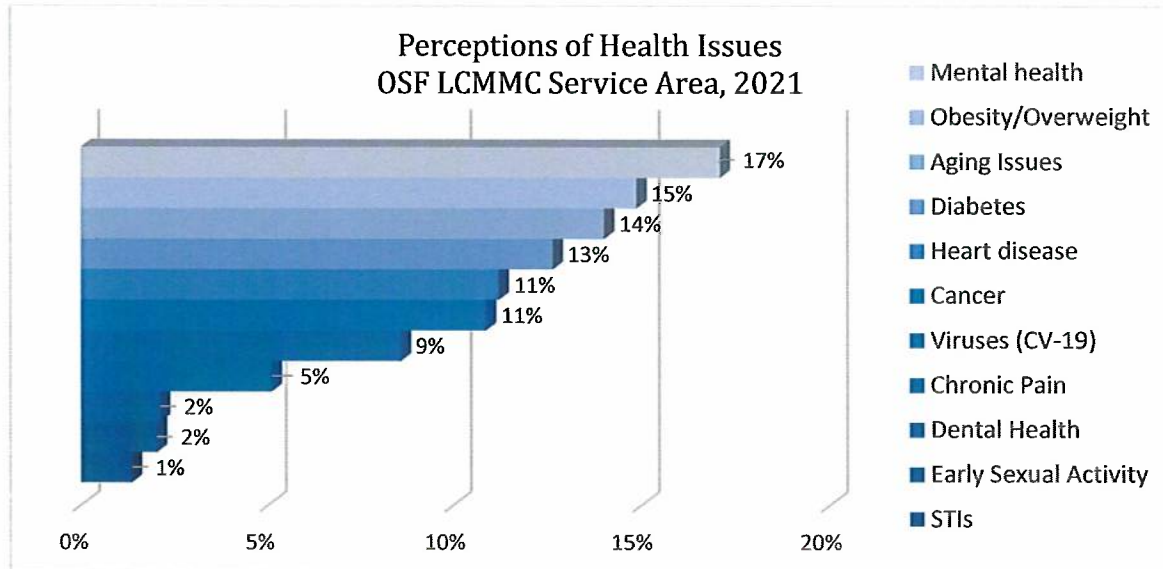
VIII. MENTAL HEALTH & SUBSTANCE USE DISORDERS

Key Takeaways for Mental Health and Substance Use Disorders

- Mental Health was the highest rated health need among respondents to the OSF CHNA survey in the Little Company of Mary Medical Center service area (n=387)
- Community members from the Little Company of Mary Medical Center service area (n=233) who responded to the Alliance for Health Equity community input survey, identified mental health as the top health need in their community.
- As of 2019, 15% of community members in the OSF LCMMC service area self-reported "poor" mental health and 18% reported having depression. (source: Behavioral Risk Factor Surveillance Survey (BRFSS)) Local, state, and national analyses also show that stress and mental health conditions have increased during the COVID-19 pandemic.
- In Chicago, the rate of self-reported "serious psychological distress" increased from 6.6% in 2018 to 10% in 2020. Among communities in the OSF LCMMC service area, 16.6% of residents in Chicago Lawn reported serious psychological distress, 15% in Auburn-Gresham, and 14.6% in Chatham.
- Mental illness (in particular bipolar and depressive disorders) and Substance use disorders (especially alcohol and opioid use disorders) are 2 of the top 3 most frequent and resource-intensive diseases driving hospitalizations for Medicaid enrollees (analysis by the University of Illinois at Chicago (UIC) for HFS Healthcare Transformation Collaboratives, focused on south and west Chicago and Cook County)
- As of 2019, 20% of community members in the OSF LCMMC service area reported drinking at levels considered to be binge drinking. (source: Behavioral Risk Factor Surveillance Survey (BRFSS))
- Opioid overdoses increased significantly from 2019 to 2020 across both Chicago and suburban Cook County. There were 487 opioid-involved overdose deaths in suburban Cook County in 2020, a 36% increase from 2019. There were 1062 opioid-involved overdose deaths in Chicago in 2020, a 50% increase from 2019.
- Citywide opioid overdose mortality in 2020 was 39.2 per 100,000. Within the OSF LCMMC service area, several communities have substantially higher rates: Auburn-Gresham (58.0), Roseland (59.8), Chatham (75.5), and West Englewood (78.4).
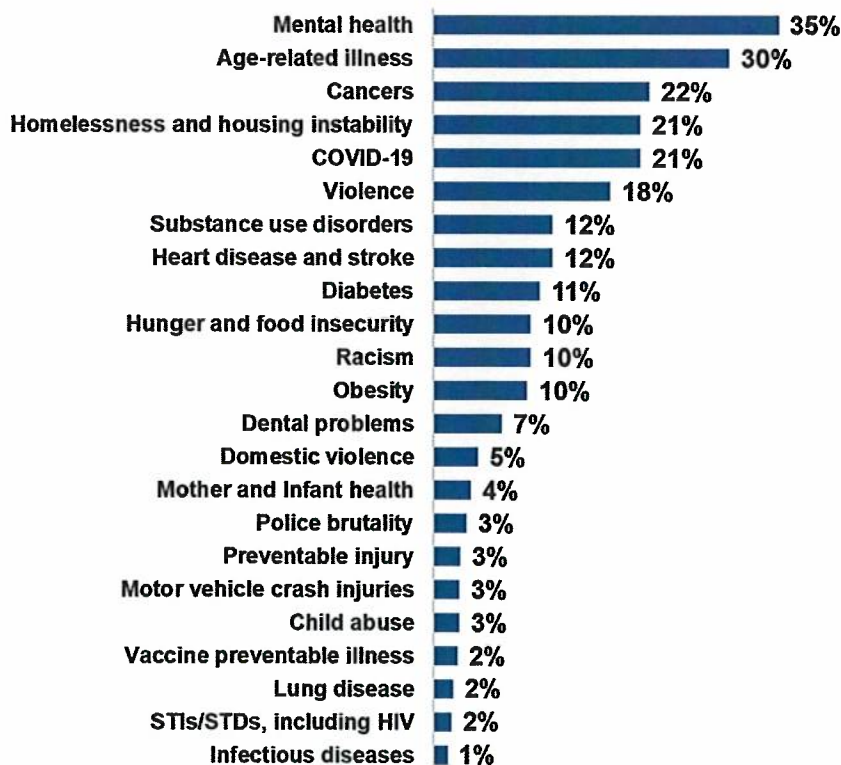
Mental Health was the highest rated health need among respondents to the OSF CHNA survey in the Little Company of Mary Medical Center service area (n=387).

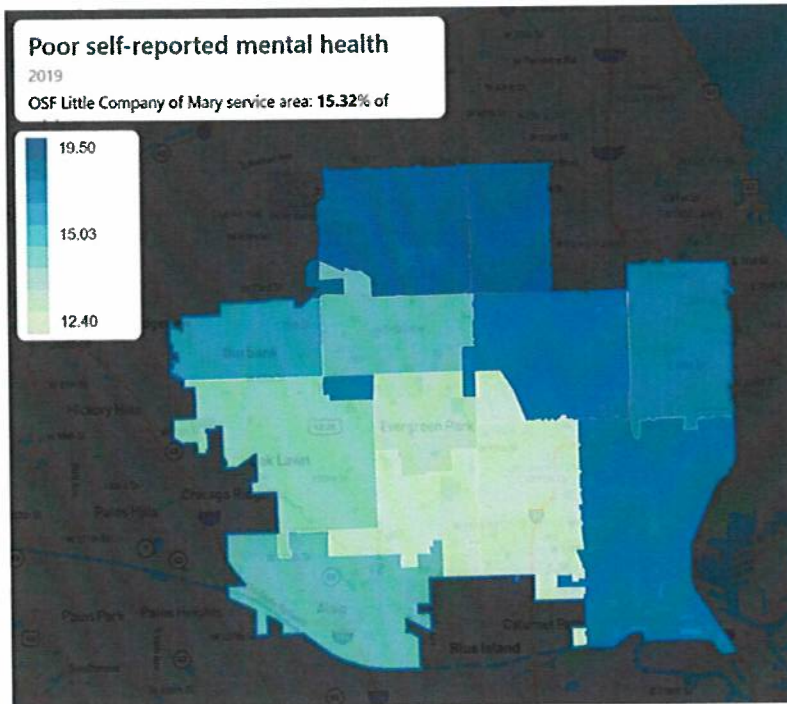### OSF LCMMC CHNA Survey, Perceptions of Health Issues

Perceptions of Health Issues
OSF LCMMC Service Area, 2021

Mental health — 17%
Obesity/Overweight — 15%
Aging Issues — 14%
Diabetes — 13%
Heart disease — 11%
Cancer — 11%
Viruses (CV-19) — 9%
Chronic Pain — 5%
Dental Health — 2%
Early Sexual Activity — 2%
STIs — 1%

Similarly, community members from the Little Company of Mary Medical Center service area (n=233) who responded to the Alliance for Health Equity community input survey, identified mental health as the top health need in their community.

Alliance for Health Equity Survey, 2021, Most Important Health Needs in your Community (N=233 respondents from LCMMC service area)

Mental health — 35%
Age-related illness — 30%
Cancers — 22%
Homelessness and housing instability — 21%
COVID-19 — 21%
Violence — 18%
Substance use disorders — 12%
Heart disease and stroke — 12%
Diabetes — 11%
Hunger and food insecurity — 10%
Racism — 10%
Obesity — 10%
Dental problems — 7%
Domestic violence — 5%
Mother and Infant health — 4%
Police brutality — 3%
Preventable injury — 3%
Motor vehicle crash injuries — 3%
Child abuse — 3%
Vaccine preventable illness — 2%
Lung disease — 2%
STIs/STDs, including HIV — 2%
Infectious diseases — 1%

Self-reported "Poor" Mental Health, 2019, OSF LCMMC service area

As of 2019, 15% of community members in the OSF LCMMC service area self-reported "poor" mental health. Communities with higher rates included West Englewood (19%), Chicago Lawn (18%), Greater Grand Crossing (18%), Auburn Gresham (17%), and West Pullman (15%).

Centers for Disease Control and Prevention (CDC) PLACES survey data, 2019

Self-reported Depression, 2019, OSF LCMMC service area
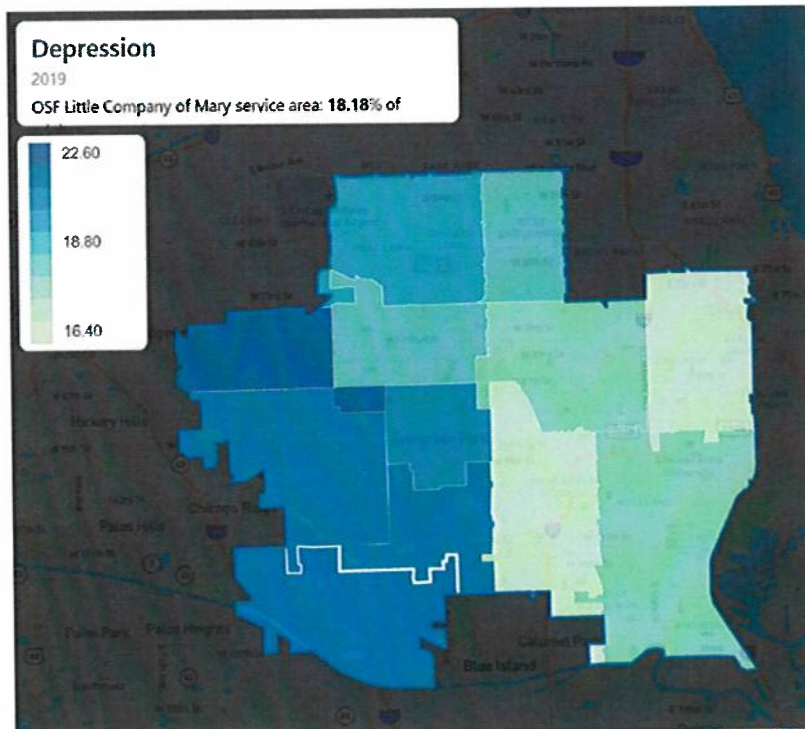
As of 2019, 18% of community members in the OSF LCMMC service area reported experiencing depression. Communities with higher rates included Burbank, Alsip, Chicago Lawn, West Englewood, and Riverdale.

Centers for Disease Control and Prevention (CDC) PLACES survey data, 2019

Local, state, and national analyses also show that stress and mental health conditions have increased during the COVID-19 pandemic.

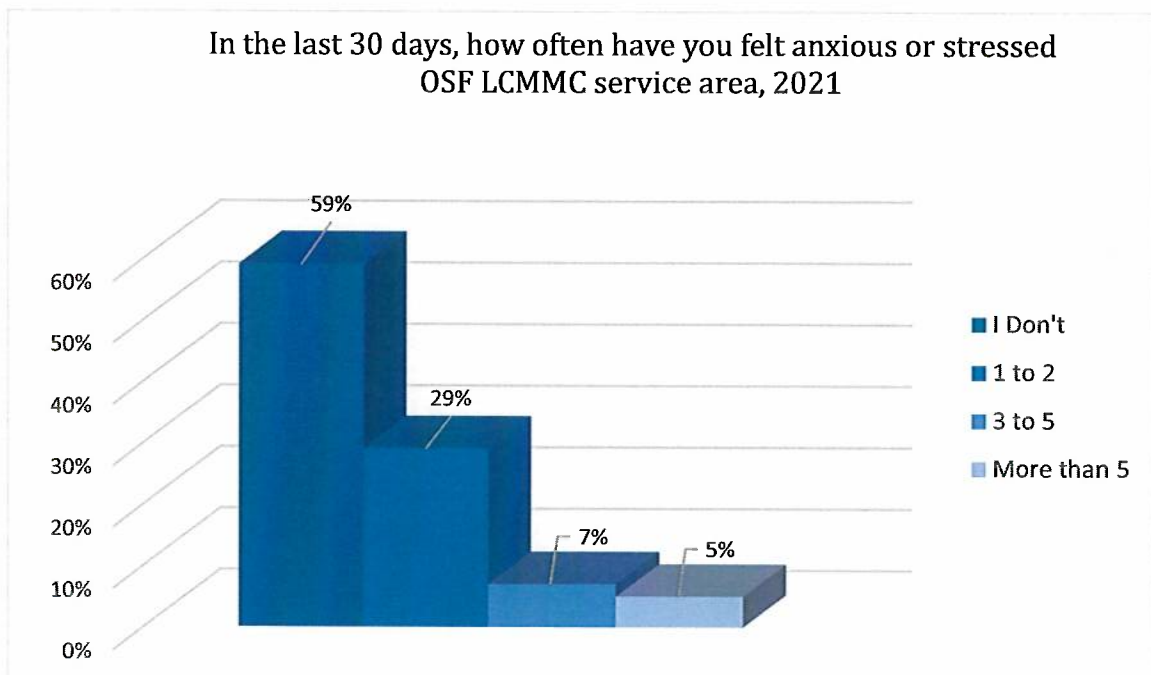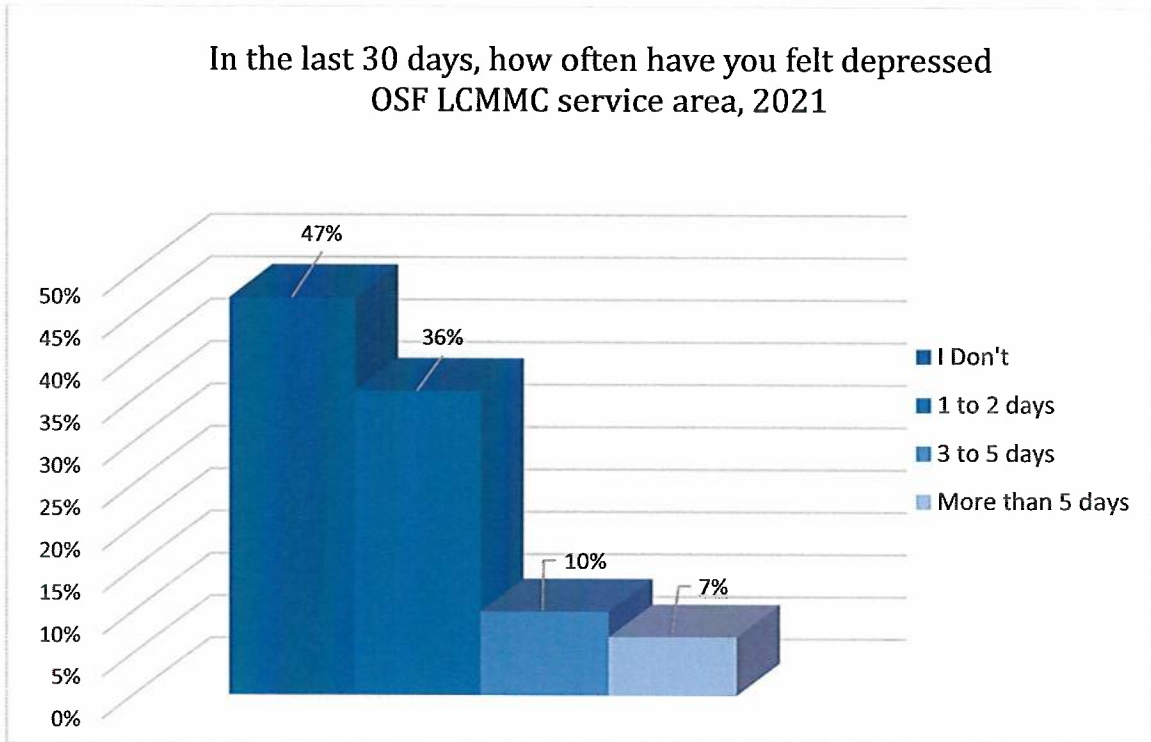**Serious psychological distress rate, Chicago, 2014-2021**
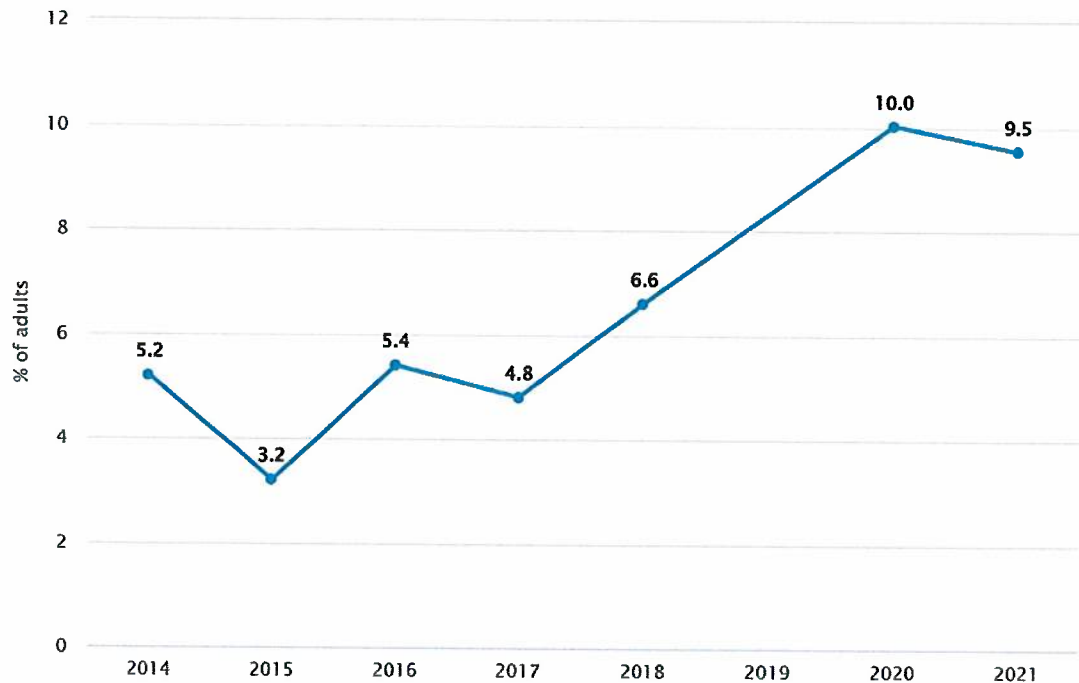
Created on Chicago Health Atlas | chicagohealthatlas.org | Data source: Chicago Department of Public Health, Healthy Chicago Survey
Serious psychological distress rate: Percent of adults who reported serious psychological distress based on how often they felt nervous, hopeless, restless or fidgety, depressed, worthless, or that everything was an effort in the past 30 days.
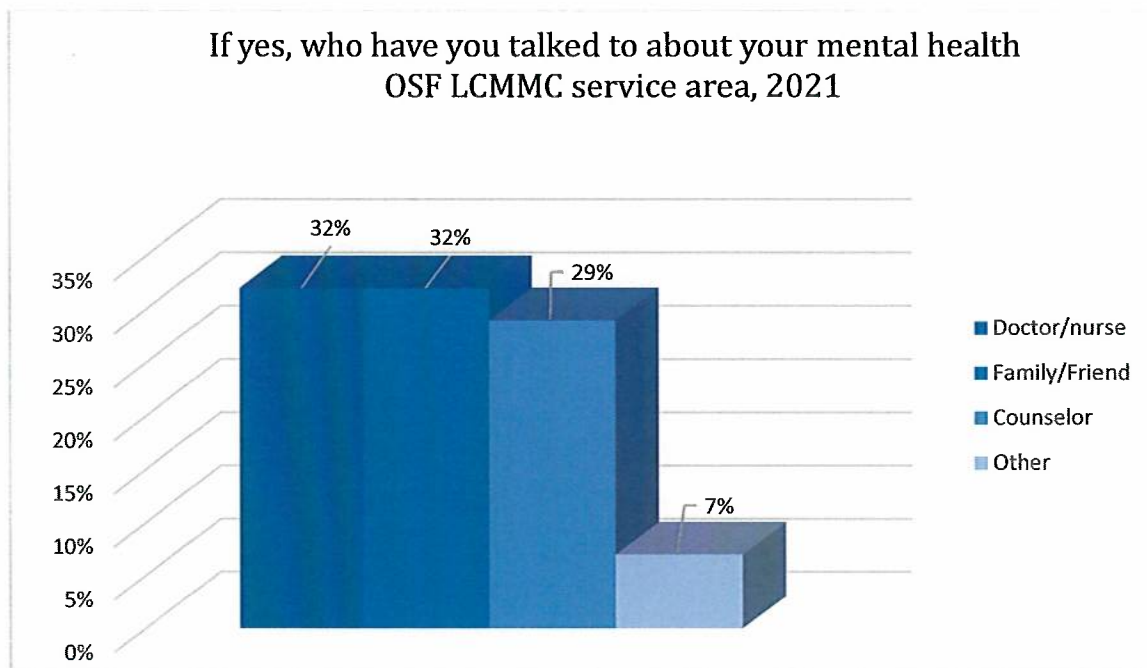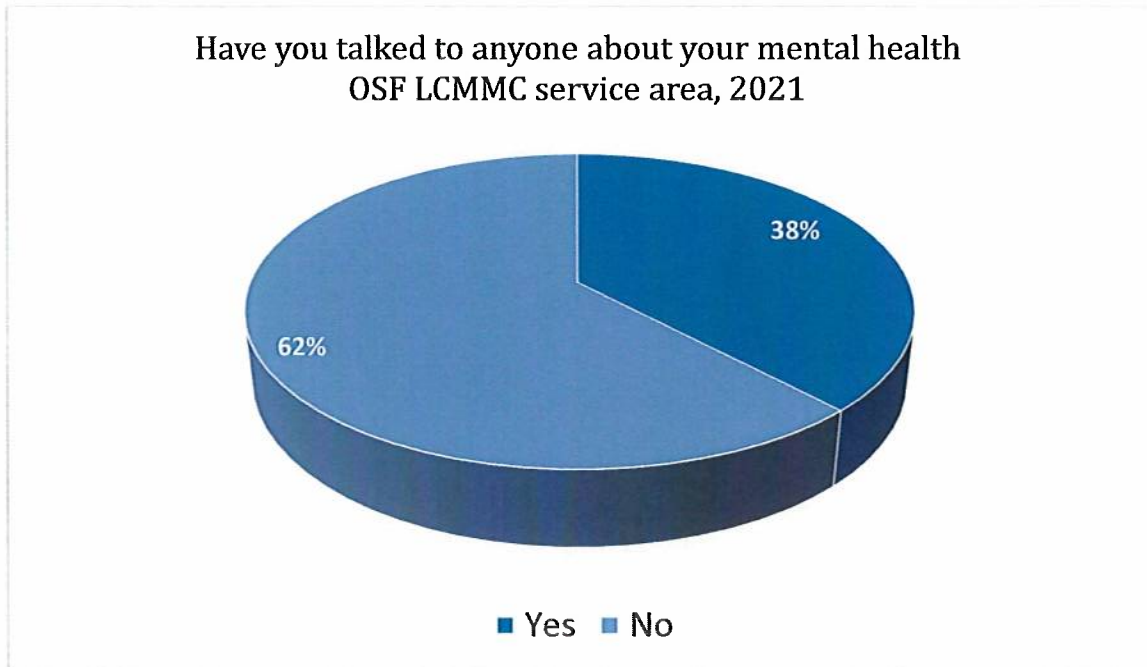
In Chicago, the rate of self-reported "serious psychological distress" increased from 6.6% in 2018 to 10% in 2020.

Among communities in the OSF LCMMC service area, in 2020-2021, 16.6% of residents in Chicago Lawn reported serious psychological distress, 15.0% in Auburn-Gresham, and 14.6% in Chatham.

The CHNA survey asked respondents to indicate specific issues, such as depression and stress/anxiety. Of respondents, 53% indicated they had felt depressed within the last 30 days and 41% indicated they had felt anxious or stressed within the last 30 days.

In the last 30 days, how often have you felt depressed OSF LCMMC service area, 2021

47%
36%
10%
7%

- I Don't
- 1 to 2 days
- 3 to 5 days
- More than 5 days

In the last 30 days, how often have you felt anxious or stressed OSF LCMMC service area, 2021

59%
29%
7%
5%

- I Don't
- 1 to 2
- 3 to 5
- More than 5

Respondents were asked if they spoke with anyone about their mental health in the past year. Of respondents, 38% indicated that they spoke to someone. Respondents who indicated they had spoken with someone were split across doctor/nurse (32%), family/friend (32%), and counselor (29%).

Have you talked to anyone about your mental health
OSF LCMMC service area, 2021

38%

62%

■ Yes ■ No

If yes, who have you talked to about your mental health
OSF LCMMC service area, 2021

32% 32% 29%

7%

■ Doctor/nurse
■ Family/Friend
■ Counselor
■ Other

Alcohol use

Binge Drinking

As of 2019, 20% of community members in the OSF LCMMC service area reported drinking at levels considered to be binge drinking within the previous 30 days. Binge drinking is defined as five or more drinks (men) or four or more drinks (women) on an occasion.
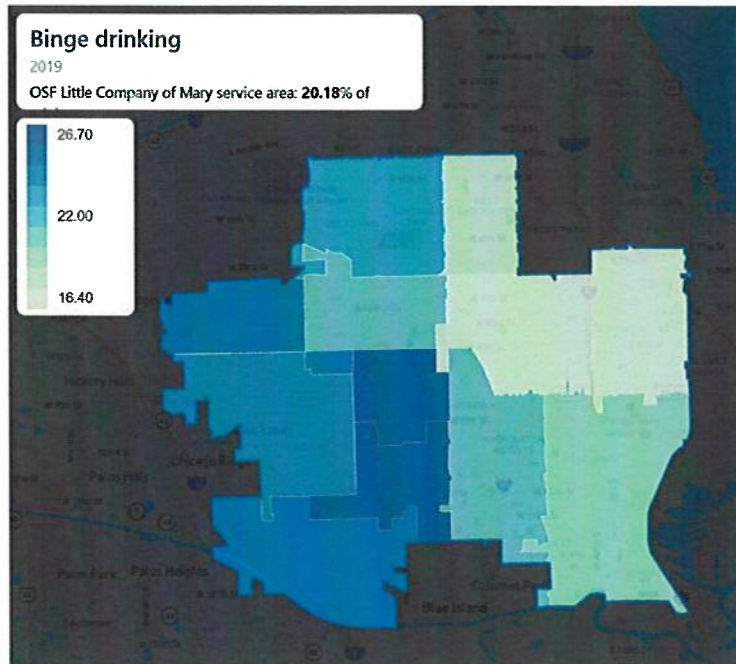
CHNA survey respondents were asked how many alcoholic drinks they have on a typical day. 4% said over 3, 22% said 1-2 drinks, and 74% said 0 alcoholic drinks.
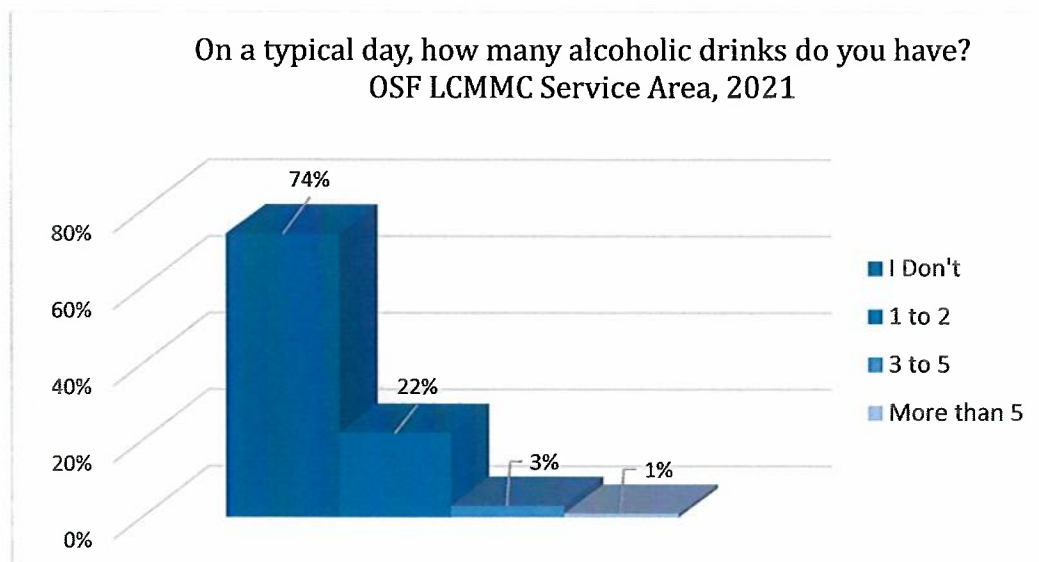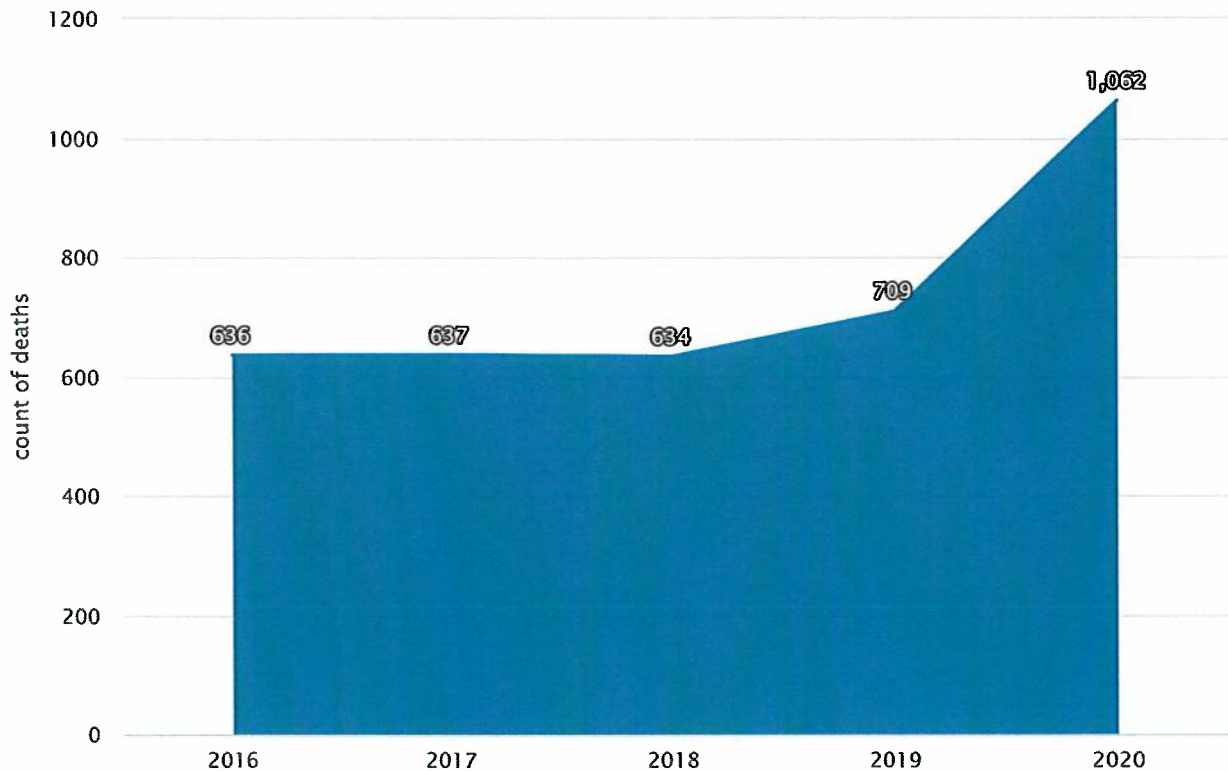
Opioid Overdoses

Opioid overdoses increased significantly from 2019 to 2020 across both Chicago and suburban Cook County.

There were 487 opioid-involved overdose deaths in suburban Cook County in 2020, a 36% increase from 2019.
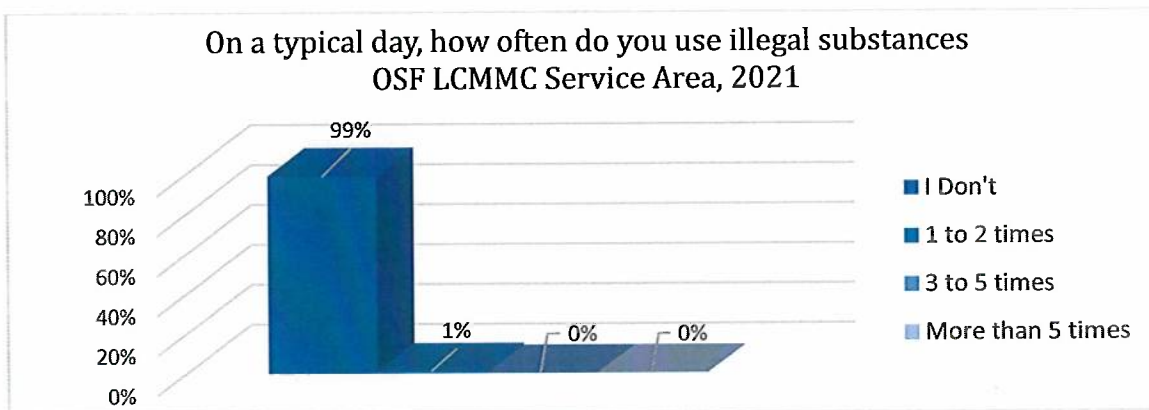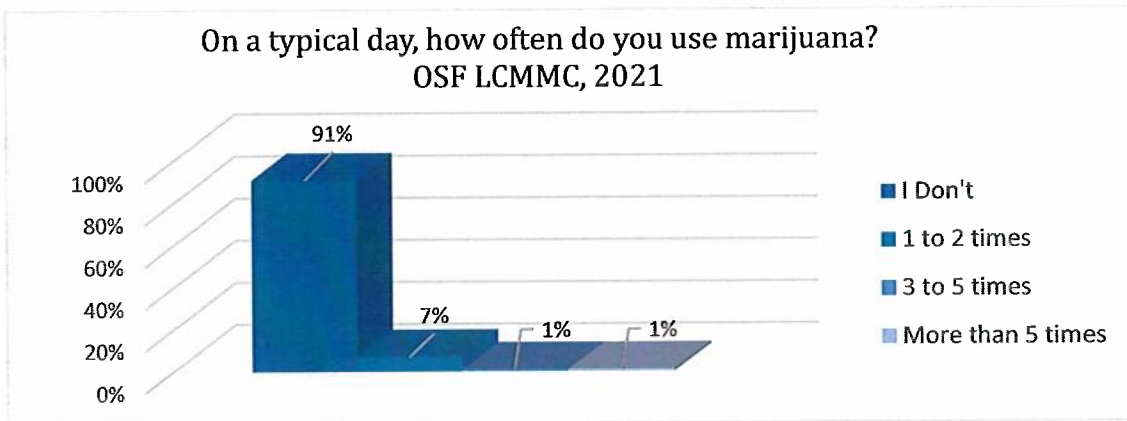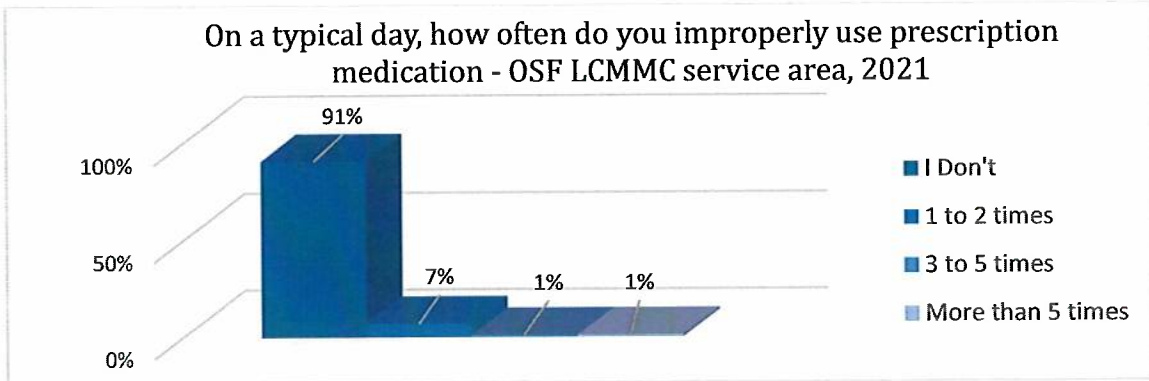
There were 1062 opioid-involved overdose deaths in Chicago in 2020, a 50% increase from 2019.

Opioid-involved Overdose Deaths, Chicago citywide

Citywide opioid overdose mortality in 2020 was 39.2 per 100,000. Within the OSF LCMMC service area, several communities have substantially higher rates: Auburn-Gresham (58.0), Roseland (59.8), Chatham (75.5), and West Englewood (78.4).

Among survey respondents, the large majority reported <u>not</u> using drugs: 91% reported they don't improperly use prescription medication, 91% reported they do not use marijuana, 99% reported not using illegal substances,

On a typical day, how often do you improperly use prescription medication - OSF LCMMC service area, 2021

- I Don't
- 1 to 2 times
- 3 to 5 times
- More than 5 times

91%, 7%, 1%, 1%

On a typical day, how often do you use marijuana?
OSF LCMMC, 2021

- I Don't
- 1 to 2 times
- 3 to 5 times
- More than 5 times

91%, 7%, 1%, 1%

On a typical day, how often do you use illegal substances
OSF LCMMC Service Area, 2021

- I Don't
- 1 to 2 times
- 3 to 5 times
- More than 5 times

99%, 1%, 0%, 0%

Social Determinant Correlates

Several characteristics show a significant relationship with an individual's behavioral health. The following relationships were found using correlational analyses:

Depression tends to be rated higher by younger people.

Anxiety tends to be rated higher by younger people, LatinX people, those with lower education and income and those with an unstable (e.g. homeless) housing environment.

Frequency of alcohol consumption tends to be rated higher by younger people.

Frequency of misuse of prescription medication tends to be rated higher by those with lower income, and those with an unstable (e.g. homeless) housing environment.

Frequency of use of marijuana tends to be rated higher by younger people, and those with an unstable (e.g. homeless) housing environment.
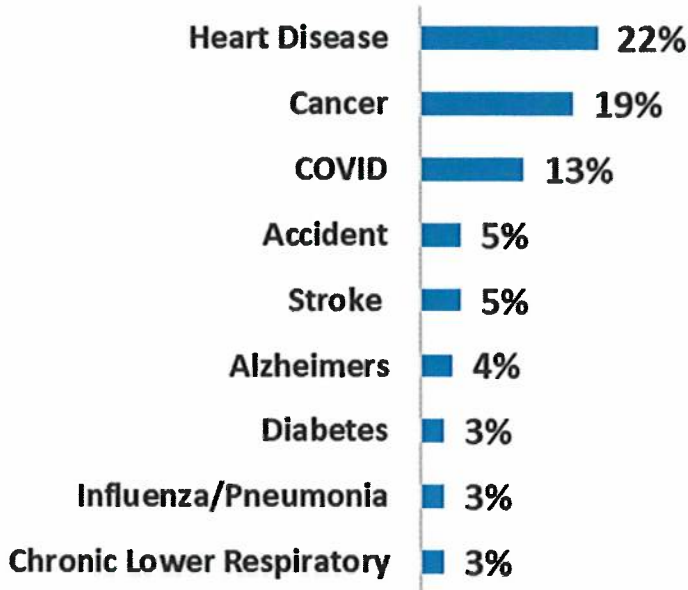
IX. MORBIDITY AND MORTALITY

Key Takeaways for Morbidity and Mortality:

- The leading causes of death in Chicago and Suburban Cook County are heart disease, cancer, COVID, accidents (drug overdose, car crashes, etc.), and stroke.
- CHNA survey respondents were asked to self-identify any health conditions. The most common responses were overweight (29%) and allergies (23%) followed by mental health (12%), diabetes (11%), and asthma/COPD (10%).
- Thirty-seven percent (37%) of community members in the OSF LCMMC service area report having high blood pressure (hypertension), and 14% report being diagnosed with diabetes.
- Six percent (6%) of adults in the OSF LCMMC service area report having been diagnosed with coronary heart disease.
- Six percent (6%) of adults in the OSF LCMMC service area report having had cancer.
- The cancer diagnosis rate in the OSF LCMMC service area is 709.6/100,000. The lung cancer diagnosis rate is 81.9/100,000, colorectal cancer diagnosis rate is 55.9/100,000, prostate cancer diagnosis rate is 165.0/100,000, breast cancer diagnosis rate is 37.5/100,000, and cervical cancer diagnosis rate is 11.6/100,000.
- Data on the average stage of cancer at diagnosis shows that community members on the south side of Chicago are diagnosed at a substantially later stage compared to community members in suburban communities in the OSF LCMMC service area.
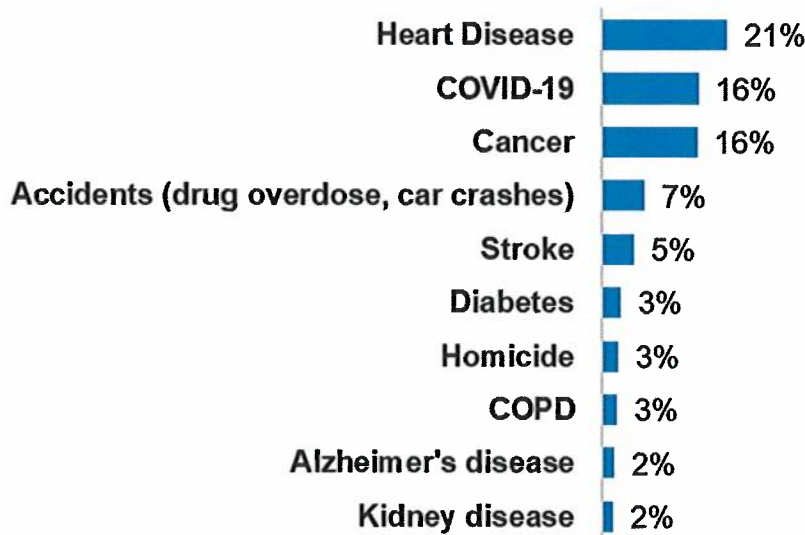
The leading causes of death in Chicago and Suburban Cook County are heart disease, cancer, COVID, accidents (drug overdose, car crashes, etc.), and stroke.

**Leading causes of death in Suburban Cook County, 2020**

Cause	Percentage
Heart Disease	22%
Cancer	19%
COVID	13%
Accident	5%
Stroke	5%
Alzheimers	4%
Diabetes	3%
Influenza/Pneumonia	3%
Chronic Lower Respiratory	3%

Illinois Department of Public Health, Division of Vital Records, 2020

Leading causes of death in Chicago, 2020

| Cause	Percentage
Heart Disease	21%
COVID-19	16%
Cancer	16%
Accidents (drug overdose, car crashes)	7%
Stroke	5%
Diabetes	3%
Homicide	3%
COPD	3%
Alzheimer's disease	2%
Kidney disease	2%

CDPH Office of Vital Records, Analyzed by CDPH Office of Epidemiology

CHNA survey respondents were asked to self-identify any health conditions. The most common responses were overweight (29%) and allergies (23%) followed by mental health (12%), diabetes (11%), and asthma/COPD (10%).
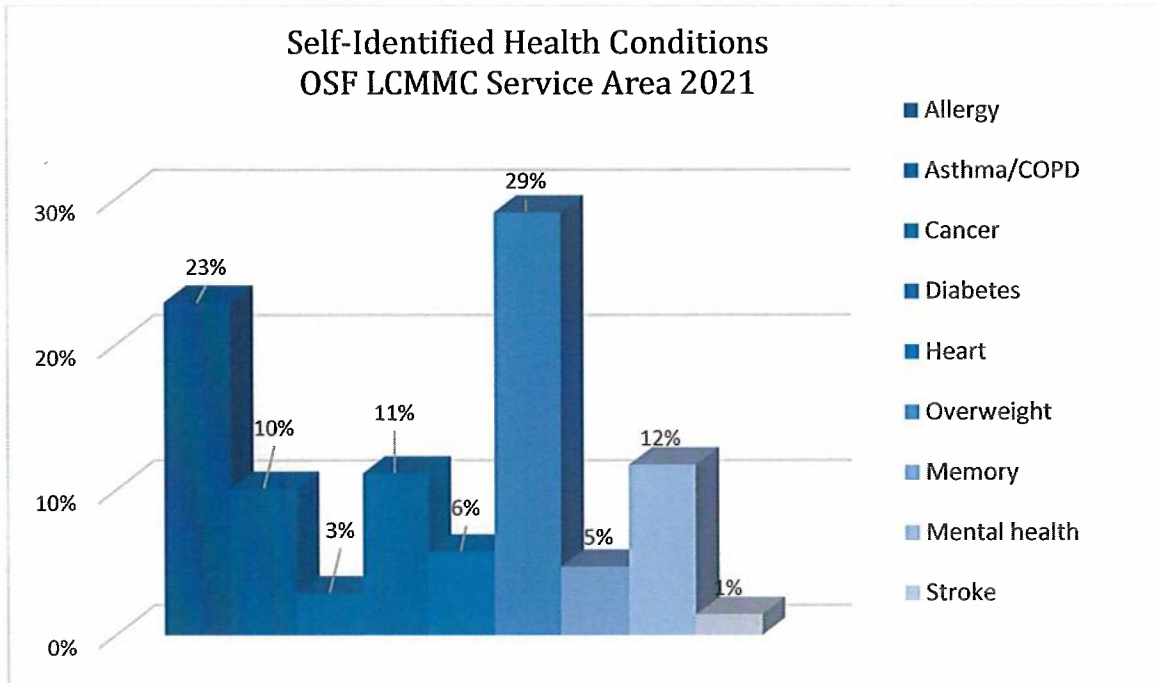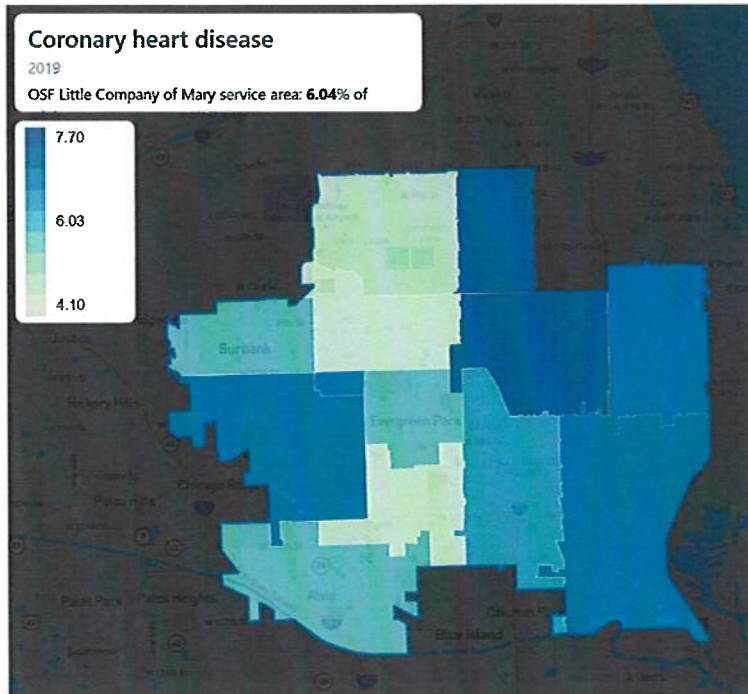

Thirty-seven percent (37%) of community members in the OSF LCMMC service area report having high blood pressure (hypertension), and 14% report being diagnosed with diabetes.
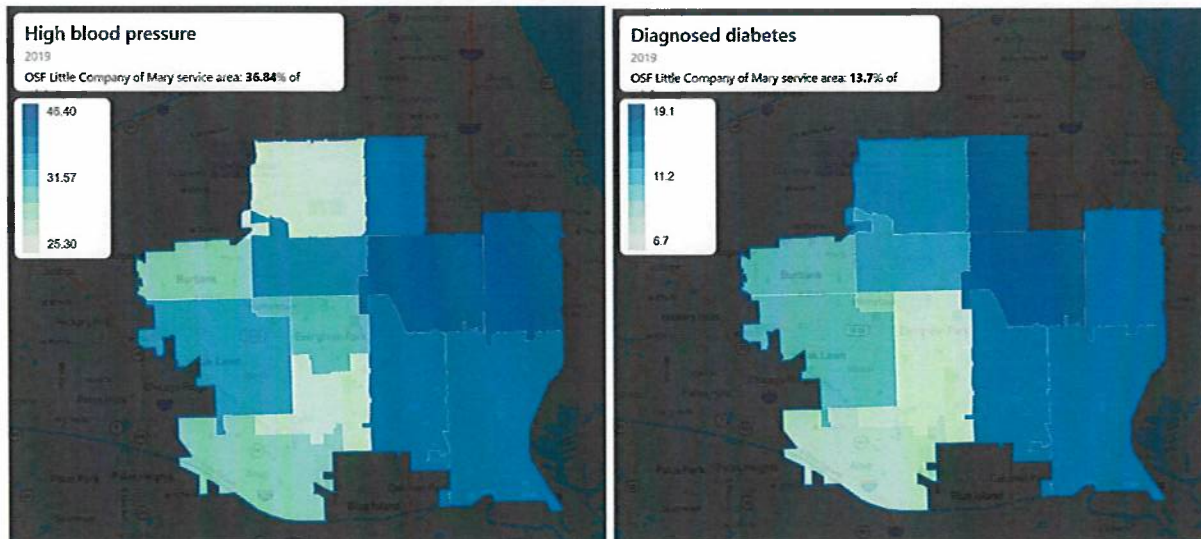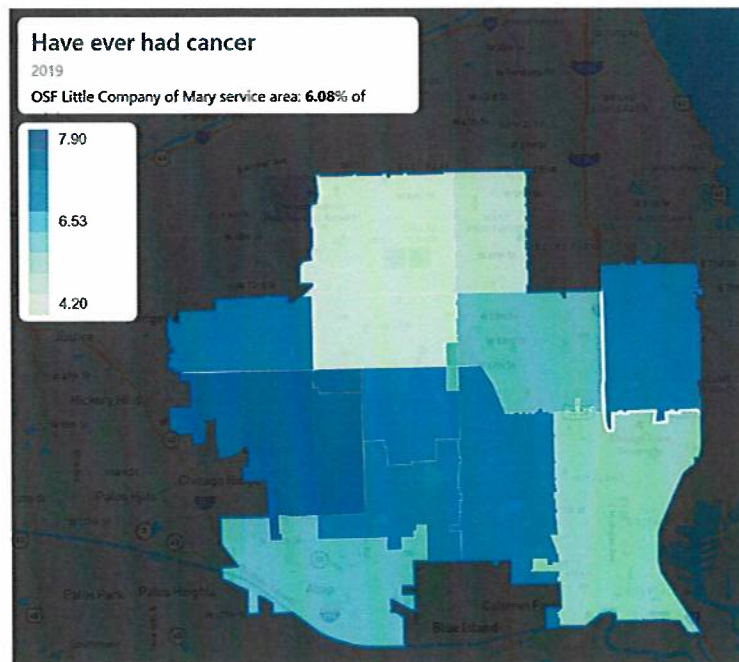

Centers for Disease Control and Prevention, 2019

Six percent (6%) of adults in the OSF LCMMC service area report having been diagnosed with coronary heart disease.

Six percent (6%) of adults in the OSF LCMMC service area report having had cancer.

The cancer diagnosis rate in the OSF LCMMC service area is 709.6/100,000. The lung cancer diagnosis rate is 81.9/100,000, colorectal cancer diagnosis rate is 55.9/100,000, prostate cancer diagnosis rate is 165.0/100,000, breast cancer diagnosis rate is 37.5/100,000, and cervical cancer diagnosis rate is 11.6/100,000.

Data on the average stage of cancer at diagnosis shows that community members on the south side of Chicago are diagnosed at a substantially later stage compared to community members in Evergreen Park and other suburban communities in the OSF LCMMC service area.

Cancer diagnosis rate
2014-2018
OSF Little Company of Mary service area: **709.64** ±5.70 per 100,000

800.13
740.94
555.59

Average stage of cancer at diagnosis
2014-2018
OSF Little Company of Mary service area: **1.82**

1.94
1.81
1.68
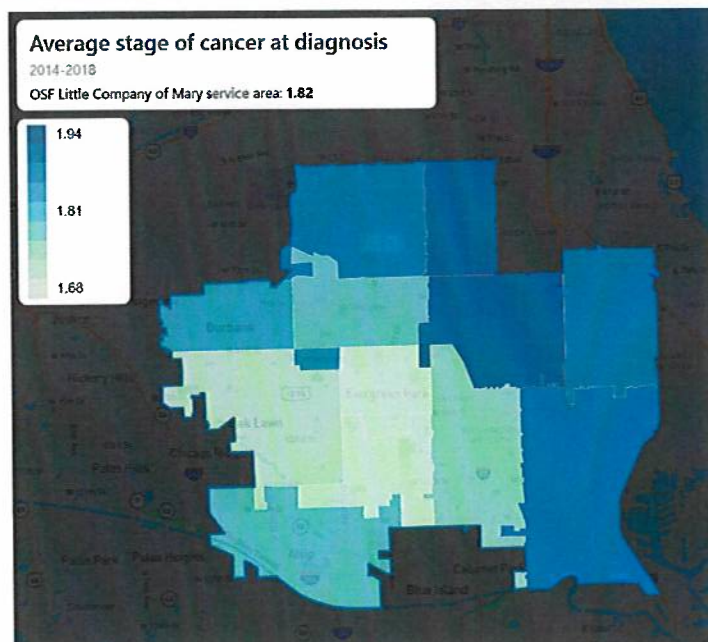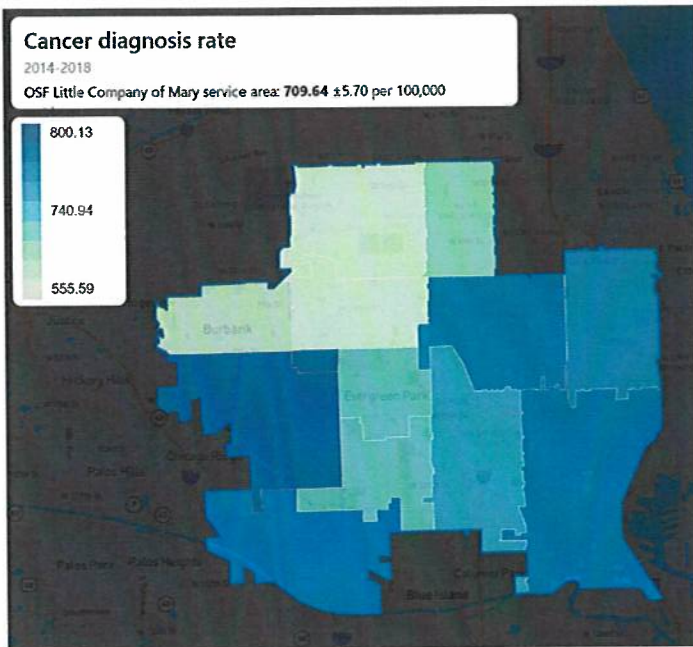
Additional data on morbidity and mortality are included in the Alliance for Health Equity's Cook County CHNA (Appendix 7 and online at https://allhealthequity.org/projects/2022-chna-report/).

X. PERCEPTIONS OF HEALTH ISSUES

The CHNA survey asked respondents to select the most important health issue in the community. Respondents had a choice of 11 different options.
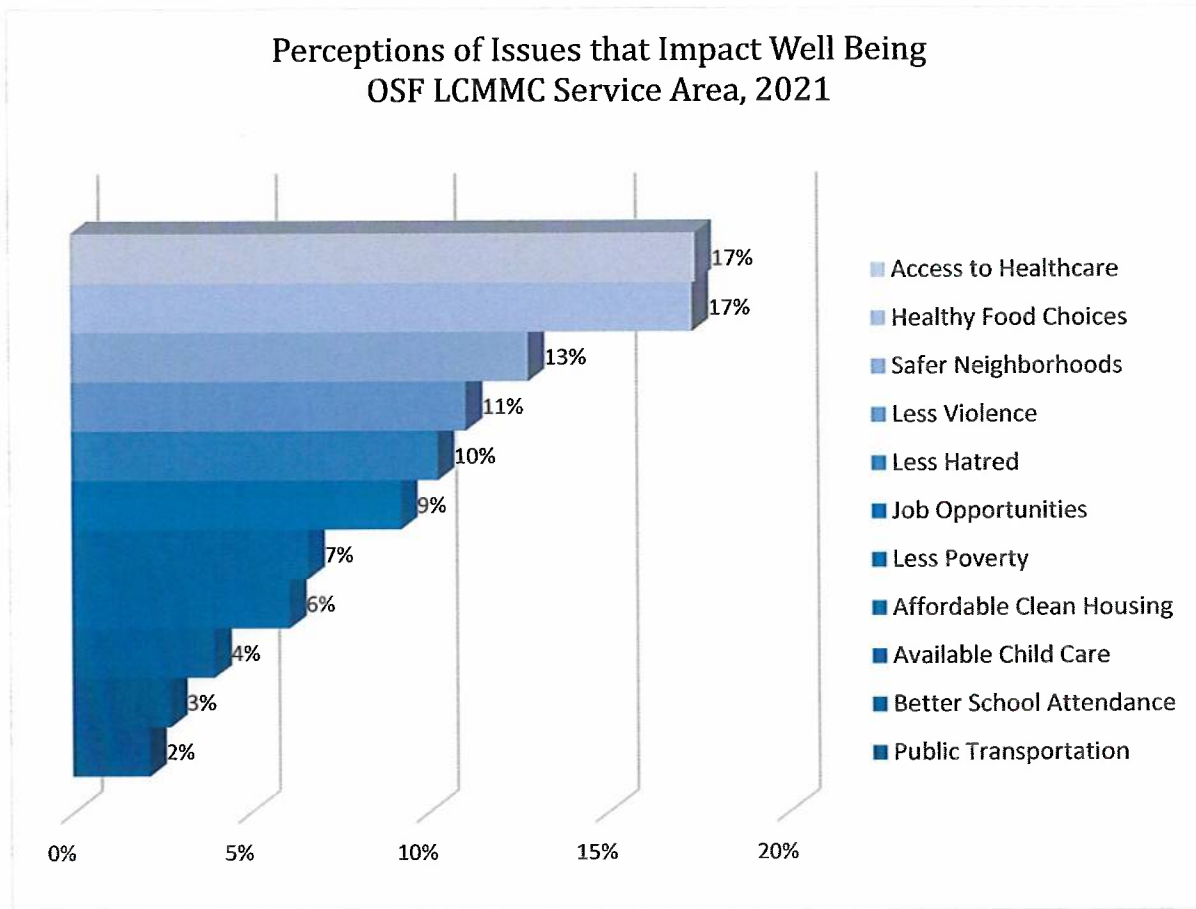
The health issue that rated highest was mental health (17%), followed by obesity/overweight (15%), aging issues (14%), diabetes (13%), heart disease (11%), cancer (11%) and viruses, CV-19 (9%).

Perceptions of Health Issues
OSF LCMMC Service Area, 2021

Category	Percentage
Mental health	17%
Obesity/Overweight	15%
Aging Issues	14%
Diabetes	13%
Heart disease	11%
Cancer	11%
Viruses (CV-19)	9%
Chronic Pain	5%
Dental Health	2%
Early Sexual Activity	2%
STIs	1%
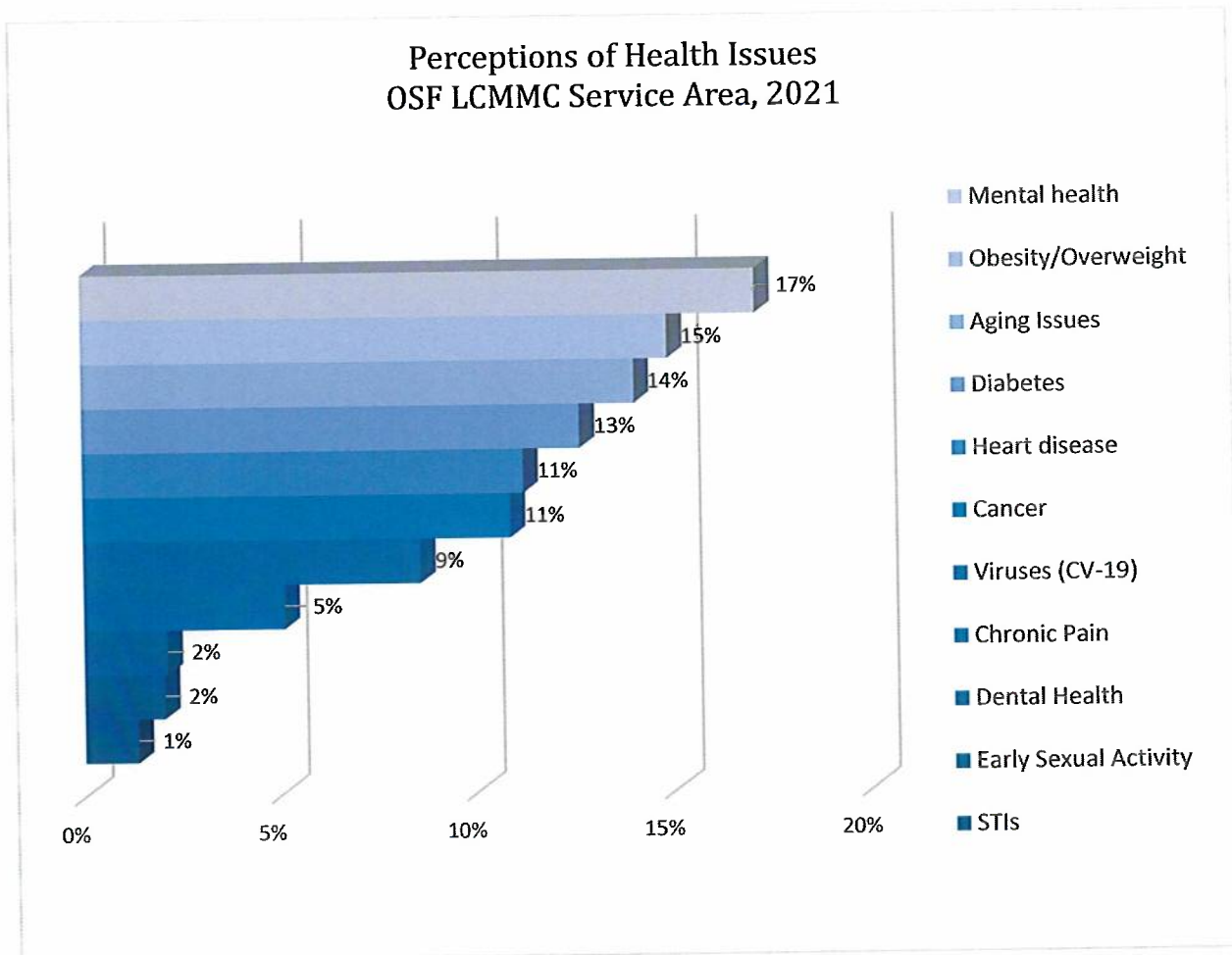
CHNA survey respondents were asked to select the three most important unhealthy behaviors in the community out of a total of 10 choices. The five unhealthy behaviors that rated highest were poor eating habits (18%), alcohol abuse (18%) drug abuse (illegal) (17%), lack of exercise (14%), and anger/violence (14%).

Perceptions of Unhealthy Behaviors
OSF LCMMC Service Area, 2021

Behavior	Percentage
Poor Eating Habits	18%
Alcohol Abuse	18%
Drug Abuse (illegal)	17%
Lack of Exercise	14%
Anger/Violence	14%
Domestic Violence	7%
Smoking	6%
Drug abuse (legal)	4%
Child Abuse	3%
Risky Sexual Behavior	1%
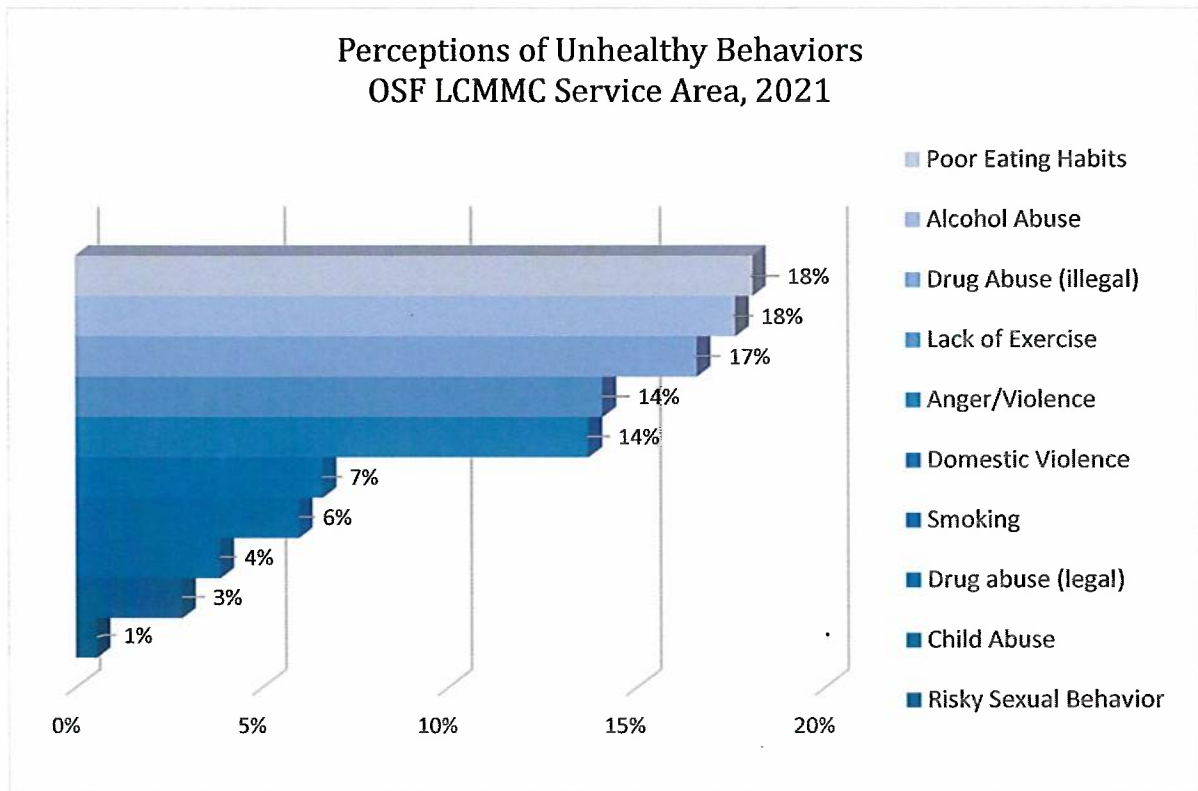
CHNA survey respondents were asked to select the three most important issues impacting well-being in the community out of a total of 11 choices. The issues impacting well-being that rated highest were access to healthcare (17%), healthy food choices (17%), safer neighborhoods (13%), less violence (11%), and less hatred (10%).

Perceptions of Issues that Impact Well Being
OSF LCMMC Service Area, 2021

Issue	Percentage
Access to Healthcare	17%
Healthy Food Choices	17%
Safer Neighborhoods	13%
Less Violence	11%
Less Hatred	10%
Job Opportunities	9%
Less Poverty	7%
Affordable Clean Housing	6%
Available Child Care	4%
Better School Attendance	3%
Public Transportation	2%

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:

PARTICIPANT	BIO	AGENCY
AJ Querciagrossa	AJ Querciagrossa has held multiple positions since joining OSF Healthcare System (Peoria, IL) in 1995. Since June 2020, AJ serves as the Chief Executive Officer of OSF's Metro Region (Chicago, IL). Prior to that role he was named the Executive Sponsor for the integration of Little Company of Mary to OSF HealthCare and served as the President of OSF Home Care & Post-Acute Services for the Ministry. AJ has great passion and expertise in employee and patient engagement and has presented in numerous venues. He looks forward to continuing and expanding Catholic Healthcare within the Southside of Chicago. AJ resides in Palos Heights, IL with his wife, Kristen and has three grown children. AJ received his bachelors' degree in pharmacy from St. Louis College of Pharmacy (St. Louis, MO) in 1988 and a Masters' degree in management in 2013 from the University of St. Francis (Joliet, IL). He completed his MBA in 2014 also from the University of St. Francis (Joliet, IL). AJ enjoys traveling, swimming, and being outdoors.	OSF Healthcare
Kathleen Kinsella	Ms. Kinsella joined Little Company of Mary Hospital and Healthcare Centers in November, 2018 as Chief Operating Officer and was the LCMH Executive Sponsor for the OSF integration. Upon the retirement of Dr. John Hanlon, Kathleen was named President of Little Company of Mary Medical Center in July, 2020. Kathleen has her BS from the University of Illinois at Urbana-Champaign in Health and Safety Education and her MS in Health Administration from the University of St. Francis. Prior to joining LCMH, she held various leadership positions (Chief Administrative Officer, Senior Vice President and President) in acute care facilities, ambulatory practices and consulting firms focusing on organizations in transition.	OSF Healthcare

| Howard B. Brookins | Alderman Howard B. Brookins was elected in April 2003 and is currently serving his second term in the 21st Ward. Alderman Brookins follows a lineage of politics in the footsteps of his father, Former Senator Howard B. Brookins Sr. Alderman Brookins has a distinguished career serving in holding past capacities of Assistant Public Defender, Assistant States Attorney and Special Assistant Attorney General. Alderman Brookins is currently a partner with Brookins and Wilson Law Firm.

Alderman Brookins is a graduate of Mendel Catholic High School, Southern Illinois Carbondale and Northern Illinois University. He is an active member with a number of committees and organizations to include Trinity United Church of Christ, Prince Hall Mason Eureka Lodge #64, Board of Directors Community Media Workshop, Board of Directors Northern Illinois Alumni, Alpha Phi Alpha and the 9100 South Union Block Club.

Howard Brookins is a long time resident of the City of Chicago and is committed to improving the quality of life for the area he serves. In conducting business, Alderman Brookins does so with integrity and is fair and equitable.

Alderman Brookins has addressed key issues on crime, economic development and employment opportunities. Within his first term, he has promoted events in the community to address community needs and to build trust and rapport. He has shown dedication and commitment to his constituents by being a listening ear to their concerns and an avenue to brainstorm ideas.

Alderman Brookins Jr. is a devoted husband to Ebonie Taylor-Brookins and proud father of Howard B. Brookins III and Harihson Bilal Brookins. | Alderman 21st Ward |
| David Moore | In less than a year, David Moore has won two elections to represent the 17th Ward. First, becoming alderman on February 24, 2015 and Democratic committeeman on March 15, 2016. The Englewood resident possesses a rare combination of corporate experience, political savvy and passion for progressive change. Through his work as a community organizer and in several campaigns, he has connected with | Alderman 17th Ward |

people and issues in every corner of the ward he has resided in for nearly 40 years.

A native Chicagoan, Moore spent his childhood in the Robert Taylor Homes, before moving to the Auburn-Gresham community. Upon completing Simeon Vocational High School, he graduated Western Illinois University with a dual major in accounting and operations management. He earned an MA with emphasis in government studies at Loyola University-Chicago.

Moore established a successful accounting career in the private sector at several Fortune 500 companies, as well as with Chicago's Department of Aviation and Housing Authority. Most recently, he served as an assistant to the commissioner of the Cook County Board of Review, coordinating the Faith-based Community Initiative.

His work in the public sector exposed him to nearly every aspect of government management, including hands-on experience with cost-benefit analysis, budgeting, strategic planning, directing inter-agency teams, and projecting the impact of initiatives related to such issues as urban renewal, affordable housing, land use, public works, and transportation. He oversaw projects for redeveloping the South Loop, creating job-training sites and identifying employment opportunities for low-income residents.

Moore traces his "call" to public service back to his days as an 11-year-old walking the 17th Ward with his uncle, an assistant precinct captain. Years later, David became precinct captain of the ward's Democratic Organization. He worked on behalf of local neighborhoods in several capacities, most notably successful voter registration drives, assisting officials shut down drug houses and common-sense gun legislation. He also played key roles in city, state and national elections.

As alderman, Moore believes his first priority will be to tackle traditionally neglected areas in the 17th Ward–from severe unemployment and school closings, foreclosed homes and abandoned buildings, to street and sidewalk improvements and tree trimming. He believes such challenges deserve the attention of a full-time alderman, whom he considers the "front line" for facilitating progress in Chicago neighborhoods.

He sits on six city council committees: Economic, Capital, and Technology Development, Housing and Real Estate, Human Relations, License and Consumer

	Protection, Rules & Ethics and Zoning, Landmarks and Building Standards. Moore is the proud father of Alexandria Moore and son of Elizabeth Lee—known for generously giving her time to 17th Ward residents and causes. The community recognizes him as a man of integrity, as well as for his volunteer work particularly with seniors, students and those involved with drug abuse. He is a member of the National Forum for Black Public Administrators and Rainbow PUSH Coalition. He serves on the board of the Kodero Hunter "MVP" Foundation and as a deacon of his long-time religious home, Fellowship Missionary Baptist Church.	
Veleda Simpson	Veleda currently serves as a Regional Library Director for Chicago Public Library and has an extensive career in the library field. For close to 25 years, she has performed several roles in the profession as a Branch Services Administrator, Children's Librarian, Elementary School Media Specialist, and Law Firm Reference Librarian. She has also been active in ALA and was elected to the Executive Board of the Ethnic and Multicultural Information Exchange Round Table (EMIERT) Member-At-Large for 2016-2018. Veleda is a proud double HBCU alum having earned an MLS from Clark Atlanta University and a BA from Hampton University. She has significant experience in grant writing, has been awarded, and managed several grants throughout her library career. Veleda's lifelong passion is underrepresented children and parents in urban communities; she has done significant work to create programs and resources to improve the education and experiences of these communities. Veleda grew up in Atlanta, GA on the heels of the Civil Rights Movement and was raised in a community that preached education, equality, and justice as our inalienable rights. In 2017, Veleda founded a Chicago nonprofit organization, Project Higher Ed, which is committed to helping Chicago area African American students and families to establish strategic pathways to and through college.	Chicago Public Library

	Veleda is a south side Chicago resident with her husband Byron. They have a blended family of four young adult children.	
Carlos Nelson	Carlos Nelson is the Chief Executive Officer of the Greater Auburn Gresham Development Corporation (GAGDC) having joined the upstart organization in 2003. He is a mechanical engineer and certified project manager focusing on construction and real estate development. Carlos has been a long-time stakeholder in the Auburn Gresham community; a community he has been a part of all his life, a place where his grandparents have resided since 1963. While working in Chicago's Loop as an engineer and living near 79th & Racine during the 1980's and 90's, Carlos had a strong desire to help people in need. He tutored in the Cabrini Green Tutoring Program, then in April 2002 became more involved in his own community. He began volunteering for the newly formed not-for-profit organization whose executive director left in December 2002 to relocate to Michigan, Carlos accepted the position of Executive Director in January 2003, leaving corporate America behind. Carlos often says that he 'has not worked a day since 2003 as working to rebuild his people and community is not working at all.' And joyfully proclaims,"not many people are blessed to do what God put them on earth to do."	Greater Auburn Gresham Development Corporation
Cindy Deuser	Cindy Deuser, Director Quality & Safety – Ms. Deuser has served as Director of Quality & Safety since integration in 2020. Ms. Deuser has been part of the Little Company of Mary family for most of her career. She has been a Quality and Safety professional for greater than 30 years. Prior to integration she was the Vice President Performance Improvement from 2014-2020, and Director of Quality Resources from 2003-2014. She received a Bachelor of Science in Nursing in 1986 from Lewis University and Masters of Science in Healthcare Administration in 2013. She has her Certification as a Professional in Patient Safety (CPPS).	OSF Healthcare
Tim Kelleher	Mr. Kelleher has served as Director of Entity Finance since the merger in February 2020. Mr. Kelleher originally joined Little Company of Mary in 2015 and was promoted to Chief Financial Officer in 2018. Prior	OSF Healthcare

	to joining Little Company, he worked in audit at Deloitte & Touche from 2009 – 2015. He is a licensed CPA and holds a Bachelor's Degree in Accounting from Centenary College of Louisiana and a Master's Degree in Accounting from The University of Notre Dame.	
Lauren Hull	Lauren Hull, MHSA, Vice President of Surgical and Procedural Services for OSF HealthCare Little Company of Mary Medical Center. Lauren most recently served as Chief Operating Officer at Porter Health Care System in Valparaiso, Indiana. Prior to that she was with Hospital Corporation of America (HCA) in the Central West Texas Division over OR Performance Improvement and then at Henrico Doctors Hospital in Richmond, VA as the VP of Surgical Services and Associate COO. She spent the first 7 years of her Career at the University of Chicago Medicine in various roles. Lauren received her Bachelor of Science in Biology with a minor in chemistry from Baldwin-Wallace College in Berea, Ohio. She went on to earn her Master of Health Services Administration from Xavier University in Cincinnati, Ohio.	OSF Healthcare
Eileen Knightly	Eileen Knightly, RN, is the vice president and chief nursing officer of OSF HealthCare Little Company of Mary Medical Center. In this role, Eileen is accountable for leading the nursing operations at OSF Little Company of Mary to achieve Key Results and drive superior clinical outcomes. Together, with other members of the leadership team, Eileen establishes quality standards and develops policies and procedures for the nursing staff. She ensures that adequate staffing levels are maintained through the development of continuing education programs. Prior to that, Eileen served in a variety of nursing leadership roles throughout her career in Chicago. Eileen was Director of the Hematology Oncology Clinic for UI Health from 2016 to 2019. Prior to that Eileen served as Vice President of Oncology, Women and Children's Services at Mercy Hospital and Medical Center. Eileen served many roles at Mercy for 36 years. For 11 years Eileen has served as Vice President of Equal Hope and was a founding member of the Metropolitan Breast Cancer Task Force in Chicago.	OSF Healthcare

	Eileen received her Bachelor of Science in nursing from Saint Xavier University where she went on to earn a Master of Science in health care administration.	
William P. Walsh, MD	Dr. Walsh grew up near by and his parents still live approximately one mile from the hospital. On staff at OSF Little Company of Mary since 2001, he came to Little Company of Mary after completing his emergency medicine residency at OSF St Francis Medical Center. Board Certified in Emergency Medicine, he worked full time clinically in the Emergency Department until 2008, when he took on the role of Assistant Medical Director. Bill then served as the President Elect and President of the Medical Staff from 2014-2018. In 2018 Bill took on the role of Medical Director of the Emergency Department. In 2019 he became the CMIO in preparation for the conversion to EPIC. In the Fall of 2019 Bill became the Chief Medical Officer as the hospital prepared to integrate with OSF HealthCare and has remained in that capacity. Dr Walsh resides in Chicago with his wife and two children.	OSF Healthcare
Jess Lynch	Jess Lynch, MCP, MPH is Program Director for the Alliance for Health Equity at Illinois Public Health Institute. The Alliance for Health Equity is a collaborative of over 30 hospitals partnering with health departments and community based organizations across Chicago and Cook County. Jess' work focuses on advancing health equity and social justice. She has worked on a range of topics including food systems and policy, housing and community development initiatives, labor rights for domestic workers, healthcare system reform, and climate change adaptation. In her current role, Jess works with healthcare providers, public health, and community based organizations across Chicago and Cook County. Jess has worked in public health and community development in Illinois, California, and El Salvador.	Alliance for Health Equity / Illinois Public Health Institute

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 Masters of Business Administration Degree from Bradley University in Peoria, IL. She attained her CPA in 1984 and has earned her Fellow of the Healthcare Financial Management Association Certification 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.

Amy M. Krantz, MSW (Coordinator) is currently the Manager of Strategic Reimbursement for OSF Healthcare System, a position she has served in since 2017. She serves as coordinator for the Community Health Needs Assessment process for the OSF Little Company of Mary Medical Center as well as an expert resource for community health and value based programs. Amy has 25 years of health care experience as a practitioner and manager. She obtained both a Bachelor of Arts Degree in Sociology and a Master of Social Work Degree, from the University of Iowa.

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 best sellers. 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 2019 CHNA PRIORITIZED NEEDS

Five major health needs were identified and prioritized in Little Company of Mary Medical Center 2019 CHNA. Below are examples of the activities, measures and impact during the last three years to address these needs.

The team identified fourteen significant health needs and five were prioritized all to be addressed in the Community Health Needs Implementation Strategy.

- Heart Disease and Stroke
- Diabetes
- Mental Health
- Cancer
- Nutrition, Physical Activity and Weight

1. **Heart Disease and Stroke**
   Goal: Focus on residents living in the LCMMC primary service and current and future clients of the Health Education Center. Increase opportunities for blood pressure screening and education.

   Strategies and Objectives: Strategy: Enhance opportunity for BP screening at Health Education Center events on and off campus.

   1. Heath Education Center will provide free Blood Pressure screening twice per week at the hospital.
      a. For the first two quarters of 2021, the Medical Center continued to be challenged due to high COVID numbers, which limited the events we could participate in.

   2. Incorporate Blood Pressure screening into all lab-screening programs.
      a. As COVID numbers declined we began to be more comfortable doing community events.

2. **Diabetes**
   Goal: Goal: Increase the number of people who had their blood glucose tested in the past three years.

   Strategies and Objectives: Increase opportunities for community members to have their blood glucose checked.

   1. Add information about this program to the already established Diabetes Toolkit program.
      a. Due to COVID, our outreach was limited due to many events not taking place.

   2. Offer optional blood sugar (glucose) screening in conjunction with established weekly blood

pressure screening clinics.
  a. Focused work on establishing a support group for diabetic patients.

3. **Mental Health**
    Goal: Increase the awareness of mental health within the community and educate the consumer on the availability of resources.

    Strategies and Objectives: Increase channels for communicating mental health issues by collaborating with community partners to increase awareness and access to resources.

    1. Produce a Facebook Live event to include two (2) counselors discussing MH issues.

    2. OSF LCMMC on-boarded an additional full time Licensed Clinical Social Worker in the ambulatory care setting to expand capacity to allow for the delivery of individual therapy.

    3. Offer a stress-management lecture to include admin/CNA & Avantara Care Center, Evergreen Park.

    4. Co-produce a webinar series with St. Xavier University and Mother McAuley High School to increase awareness among student populations and resources in community.

    5. The Behavioral Health Department initiated a multidisciplinary performance improvement team to enhance the assessment, collaboration and care delivery model utilized within the Emergency Department in order to safely, effectively & efficiently meet the increasingly complex and expanding psychiatric and chemical dependency needs of the community.

    6. Produce a pocket guide to mental health resources.

    7. The Behavioral Health Department Clinical Supervisor appointed OSF LCMMC site leader for a Ministry wide initiative to strengthen the organization's response to the management of patient aggressive behavior. A key element of this initiative is the formalized process for the multidisciplinary team's (inclusive of Public Safety, Administrative Supervisor, Pastoral Care, Behavioral Health and a care team designee) response to a Control Alert.

    8. The Behavioral Health Department continues to collaborate with the Business Development Specialist to participate in the orientation of new primary care and specialty services providers. This partnership provides an overview of Behavioral Health Services and direct access to a Behavioral Health Liaison.

    9. LCMH Emergency Department renovation to include four (4) treatment rooms designed to accommodate patients who present with behavioral health issues.

    10. LCMH Public Safety Department to offer twenty (20) 4-hour de-escalation team trainings to directly care LCMH employees.

11. The OSF Metro Region Navigator provides continuous community outreach to local and external providers to assist with patient linkage to care, treatment, and services. The Navigator provides information and access to Silver Cloud, an anonymous web based platform that helps individuals manage stress, depression and anxiety. Silver Cloud is provided to the community at no cost.

4. **Cancer**

Goal: Increase community awareness of, and access to, screenings for top three cancers (colorectal, female breast, prostate).

Strategies and Objectives: Increase number of participants in cancer-awareness and prevention event each year by 20%.

1. Identify individuals at high risk for colorectal cancer: Implement colon cancer risk stratification survey to be administered to all participants in HEC screening programs.

2. Set the framework for the screening colonoscopy program.

3. Virtual presentation at Oak Street Health Clinic in April 2021 to promote Breast health and stress the importance of screening.

4. Provide three physician-led programs for colorectal cancer awareness and screening updates.

5. In June 2021, Navigators participated in the Evergreen Park Senior fair, promoted importance of timely cancer screening, and shared services provided by OSF LCMMC.

6. Continue a self-referral colonoscopy screening program.

7. In September 2021, Navigators participated in the OSF LCMMC 22nd annual Golf classic at Midlothian Country Club promoting timely cancer screening and shared services provided by OSF LCMM.

8. Plan ACS awareness event to cover three top cancers.

9. In November 2021, Navigators attended Cancer Prevention Event at Hyde Park Academy High School promoting self-breast exam and breast cancer screenings.

10. In November 2021, RN participated in the Great American Smoke out as our prevention event. Education on smoking cessation was distributed.

5. **Nutrition, Physical Activity and Weight**

Goal: To encourage our employees to lose weight and make healthier nutrition choices.

Strategies and Objectives: Continue and expand current program offerings that encourage weight loss and healthy eating opportunities.

1. Time Out For Wellness Weight Loss Challenge. Team Walking Challenge.

2. Expanded healthy lifestyle choices for lunch and dinner in hospital cafeteria, like Farmers Fridge.

3. Weight loss physician began in April of 2021 and is to get the Surgical Weight Loss patients into programs for maintaining weight loss.

4. Hypnosis for weight loss.

5. Launch "Walk with the Doc" program at Evergreen Park Farmer's market Implement Weightwatchers weekly workplace meeting.

APPENDIX 3. SURVEY INSTRUMENT

Evergreen Park

2021 COMMUNITY HEALTH-NEEDS ASSESSMENT SURVEY

1. 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
- ☐ Early sexual activity
- ☐ Heart disease/heart attack
- ☐ Mental health issues (including depression, anger)
- ☐ Obesity/overweight
- ☐ Sexually transmitted infections
- ☐ Viruses (including COVID-19)

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 abuse (illegal drugs)
- ☐ Drug abuse (legal drugs)
- ☐ Lack of exercise
- ☐ Poor eating habits
- ☐ Risky sexual behavior
- ☐ 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
- ☐ Healthy food choices
- ☐ Job opportunities
- ☐ Less hatred & more social acceptance
- ☐ Less poverty
- ☐ Less violence
- ☐ 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? (Please choose only one answer).

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

If you don't seek medical attention, 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.
☐ Couldn't afford to pay my co-pay or deductible.   ☐ 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.
☐ Couldn't afford to pay my co-pay or deductible.   ☐ 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
☐ Couldn't afford to pay my co-pay or deductible.   ☐ 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.
☐ Couldn't afford to pay my co-pay or deductible   ☐ 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 the last WEEK how many times did you participate in exercise, (such as jogging, walking, weight-lifting, fitness classes) that lasted 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.
☐ Can't afford the fees to exercise.
☐ Don't have access to an exercise facility.
☐ Safety issues.

☐ Don't like to exercise.
☐ Don't have child care while I exercise.
☐ Too tired.

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 - 5 servings   ☐ More than 5 servings

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
☐ It is not important to me
☐ Don't know how to prepare fruits/vegetables
☐ Don't know where to buy fruits/vegetables

☐ Don't like fruits/vegetables
☐ Can't afford fruits/vegetables
☐ Don't have a refrigerator/stove

5. Where is your primary source of food? (Please choose only one answer).

☐ Grocery store   ☐ Fast food   ☐ Gas station   ☐ Food delivery program
☐ Food pantry   ☐ Farm/garden   ☐ Convenience store

6. 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 #8: Smoking.

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

7. If you identified any conditions in Question #6, how often do you follow an eating plan to manage your condition(s)?

☐ Never   ☐ Sometimes   ☐ Usually   ☐ Always

Smoking

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

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

Vaping

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

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

GENERAL HEALTH

10. 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.). _____

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

12. How many days a week do you or your family members go hungry?
☐ None ☐ 1–2 days ☐ 3-5 days ☐ More than 5 days

13. 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

14. 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

15. In the last YEAR have you talked with anyone about your mental health?
☐ Yes (please answer #16) ☐ No (please go to #17)

16. If you talked to anyone about your mental health, who was it?
☐ Doctor/nurse ☐ Counselor ☐ Family/friend ☐ Other _____

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

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

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

20. 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

21. Do you feel safe where you live? ☐ Yes ☐ No

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

Breast/mammography exam	☐ Yes	☐ No	☐ Not applicable
Prostate exam	☐ Yes	☐ No	☐ Not applicable
Colonoscopy/colorectal 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 county do you live in?

☐ Cook   ☐ 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   ☐ Other _____

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   ☐ Other: _____

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   ☐ Other: _____

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. If you answered that you have housing, does your house have:

☐ leaking roof   ☐ mold   ☐ heat   ☐ air conditioning
☐ running water   ☐ rodents ☐ lead   ☐ electricity   ☐ Internet

13. How many people live with you? _____

14. How often do you communicate with people you care about and feel close to? (For example, talking, texting, meeting with friends/family?)

☐ Less than once per week   ☐ 1–2 times per week   ☐ 3 - 5 times per week   ☐ More than 5 times per week

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. SURVEY RESPONDENT DEMOGRAPHICS

Survey Gender - OSF LCMMC Service Area, 2021

23%   1%

76%

■ Women   ■ Men   ■ Non-Binary

Sexual Preference - OSF LCMMC Service Area, 2021

95%

■ Heterosexual

■ Queer

■ Lesbian

■ Gay

1%   1%   1%   2%

■ Bisexual

Survey Age - OSF LCMMC Service Area, 2021

Legend: Under 20, 21 to 35, 36 to 50, 51 to 65, Over 65

Values: 0%, 23%, 29%, 27%, 21%

Survey Race/Ethnicity - OSF LCMMC Service Area, 2021

Legend: White, Black, Latino, Multirace, Other

Values: 57%, 27%, 10%, 3%, 2%

Survey Education - OSF LCMMC Service Area, 2021

Legend:
- Less than High School
- Some high School
- High school
- Some college
- Associate's Degree
- Certificate
- Bachelor's Degree
- Graduate Degree

Values: 1%, 2%, 11%, 18%, 12%, 5%, 33%, 19%

Survey Living Arrangements
OSF LCMMC Service Area, 2021

Legend:
- Homeless
- Have housing-worried
- Have housing, not worried

Values: 5%, 9%, 85%

Number of People in Household
OSF LCMMC Service Area, 2021

Legend:
- People in household 1
- People in household 2
- People in household 3
- People in household 4
- People in household 5
- People in household 6 or more

Values: 12%, 27%, 24%, 24%, 8%, 5%

APPENDIX 5: COMMUNITY RESOURCES

Resource	Access to Care	Behavioral Health	Heart Disease	Cancer
18th Ward (Alderman Derrik Curtis)	X	X	X	X
19th Ward (Alderman Matthew O'Shea)	X	X	X	X
21st Ward (Alderman Howard Brookins)	X	X	X	X
95th Street Business Association / 95th St Farmers Market			X	X
ACCESS Community Health Network	X	X	X	X
Acclivus	X	X		
Age Options	X	X	X	X
Alliance for Health Equity	X	X	X	X
American Cancer Society	X			X
American Heart Association	X		X	
Arab American Family Services	X	X		
Beds Plus	X	X		
Beverly Arts Center				
Blue Door Neighborhood Center	X	X	X	X
Catholic Charities South-Southwest	X	X	X	X
Chicago Department of Public Health	X	X	X	X
Chicago Family Health Center	X	X	X	X
Chicago Park District			X	X
Christian Community Health Center	X	X	X	X
Communities Partnering For Peace (CP4P)	X	X	X	X
Cook County Department of Public Health	X	X	X	X
Esperanza Health Centers	X	X	X	X
Evergreen Park Library	X	X		
Family Guidance	X	X		
Greater Auburn Gresham Development Corporation	X	X	X	X
Greater Chatham Initiative	X	X	X	X

Greater Chicago Food Depository			X	X
Grow Greater Englewood			X	X
Howard Brown Health Center	X	X	X	X
HRDI	X	X		
Humana Neighborhood Center	X		X	X
IMAN	X	X	X	X
NAMI Chicago	X	X		
Oak Street Health	X	X	X	X
Pat's Pantry	X	X	X	X
Phalanx Family Services	X	X	X	X
Resident Association of Greater Englewood	X	X	X	X
South Shore Works	X	X		
Southwest Organizing Project (SWOP)	X	X	X	X
Thresholds	X	X		
Trilogy	X	X		
UCAN	X	X		
United Way	X	X	X	X
Urban Growers Collective			X	X
Village Pantry				

APPENDIX 6: PRIORITIZATION METHODOLOGY

Strategy Grid Prioritization Of Community Health Issues

Step 1. Select criteria- the two broad criteria that were most relevant and utilized were 'Need and Feasibility'

Step 2. Create a grid – a grid was set up with four quadrants and 'Need' broad criteria was assigned to one axis and 'Feasibility' broad criteria was assigned to the other axis.

Step 3. Label quadrants – based upon the axes, each quadrant was labeled as one of the following: High Need/High Feasibility, High Need/Low Feasibility, Low Need/High Feasibility, Low Need/Low Feasibility.

Step 4. Categorized & Prioritize – Need that were identified through the survey were then placed in the appropriate quadrant based on the designation by the collaborative team. High Need/High Feasibility needs ranked the highest in order of priority.

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

APPENDIX 7: ALLIANCE FOR HEALTH EQUITY COUNTYWIDE CHNA

The full Cook County-wide Alliance for Health Equity Community Health Needs Assessment (CHNA) report is available online at www.allhealthequity.org