AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

Community Health Needs Assessment

2024-2025

Contact for Feedback

Questions or comments regarding the Community Health Needs Assessment (CHNA), Evaluation Report, or Strategic Implementation Plan (SIP) can be sent via email to communitybenefit@ingalls.org.

For more information on the CHNA or Community Benefit at UChicago Medicine, please scan the QR code to the right or visit www.uchicagomedicine.org/about-us/community/benefit

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IRS Form 990
Schedule H Compliance

For nonprofit hospitals, a Community Health Needs Assessment also serves to satisfy requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Form 990, Schedule H, the following table cross-references related sections.

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Letter to Our Community

To our community members and partners:

At UChicago Medicine, we believe that everyone deserves the opportunity to live their healthiest life. For more than 20 years, through our Urban Health Initiative, we have worked alongside community members and partners, fellow healthcare providers, public health leaders, and elected officials to better understand and respond to the health needs of our communities.

We are sharing the results of our 2024–2025 Community Health Needs Assessment (CHNA), shaped by the voices, concerns, and priorities of the communities we serve, and grounded in our shared commitment to health equity. By combining public health data, community input, and thoughtful analysis, the CHNA has guided our equity-focused efforts across the South Side and the Southland since 2012.

Our work is also guided by Elevate 2035, UChicago Medicine's 10-year strategic plan that turns our Mission, Vision, and Values into action—focusing on making a difference, committing to excellence, embracing curiosity, taking ownership, and advancing equity. These values shape how we invest in and with the communities we serve.

With the 2024 opening of our multispecialty care center in Crown Point, Indiana, we're also expanding access to care and bringing new investment to support the health of Northwest Indiana communities.

Across all of the communities we serve, we remain deeply committed to finding long-term solutions to complex health challenges and inequities. To our community partners—we're grateful for your insight, energy, and collaboration which make this work possible. We look forward to continuing this journey toward improved health equity, together.

Mark Anderson, MD, PhD
Dean and Executive Vice President for Medical Affairs, University of Chicago

Krista M. Curell, Esq., RN, BSN
President, UChicago Medicine Northwest Indiana

Thomas Jackiewicz
President, University of Chicago Health System

Catina Latham, PhD
Senior Vice President, Community Health Transformation and Chief Equity Officer, Urban Health Initiative

Michael Antoniades
President, UChicago Medicine Ingalls Memorial Hospital

Executive Summary

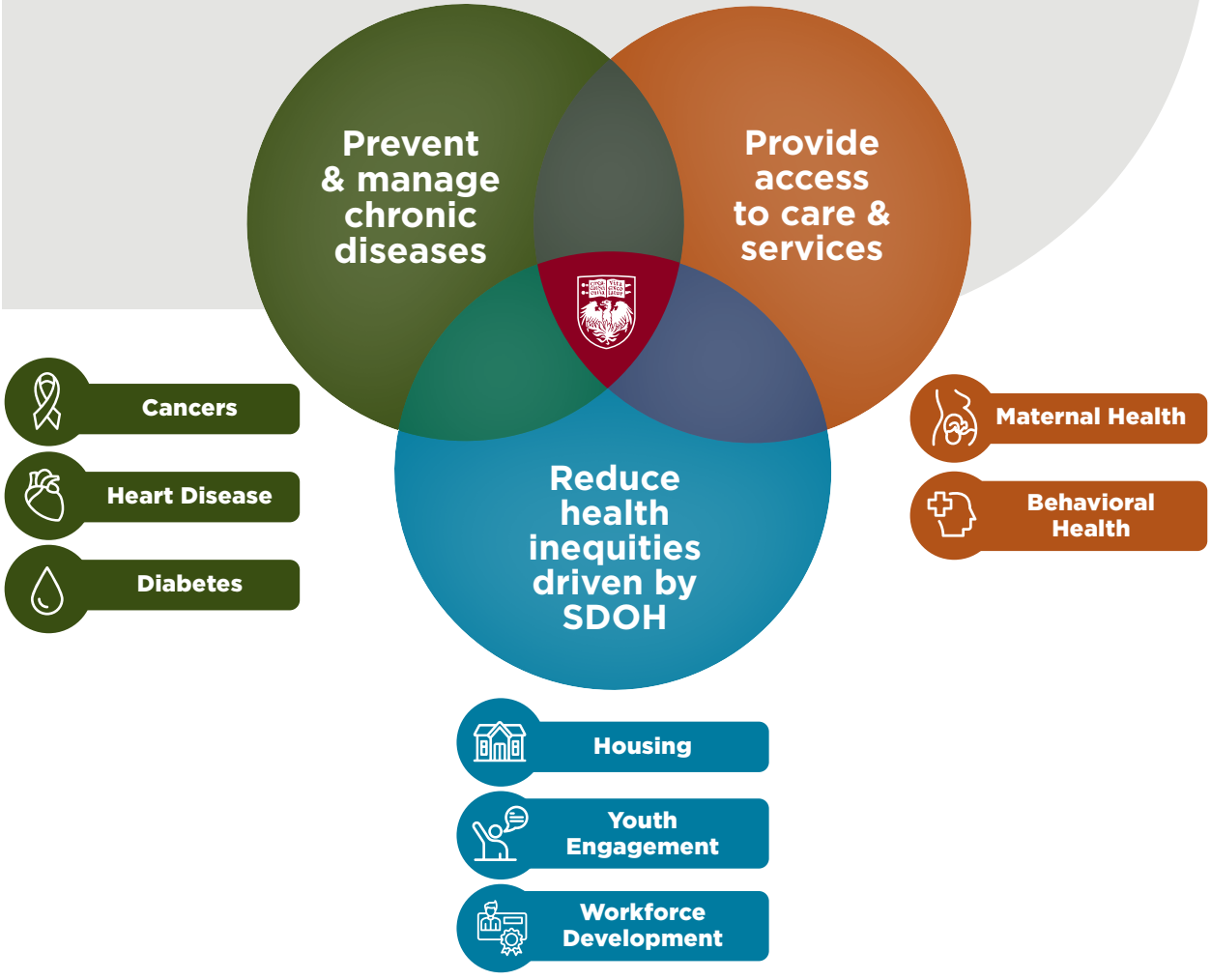
University of Chicago Medicine Ingalls Memorial Hospital (Ingalls Memorial) conducted a Community Health Needs Assessment (CHNA) to identify the areas of greatest need and allocate resources accordingly to improve community health and wellness within the hospital's primary service area (PSA). To complete the 2024–2025 CHNA, Ingalls Memorial partnered with the University of Chicago Medicine (UChicago Medicine) and Metopio, a software and services company grounded in the philosophy that communities are connected through places and people.

The CHNA process involved engagement with multiple stakeholders to prioritize and assess health areas, then collect and interpret the data. Stakeholder groups provided insight and expertise around the indicators to be assessed, the types of community input questions to ask, how to interpret results, and how to prioritize the areas of highest need.

A variety of data sources were used for the CHNA, including community input surveys, focus groups, key informant interviews, and secondary data sources from federal sources, local and state health departments, and community-based organizations.

This report provides a thorough overview of the process that Ingalls Memorial implemented to complete the CHNA, including data collection methods, sources, and the particular context of Ingalls Memorial's PSA. Results of the CHNA can be found within the report.

Based on the findings from the CHNA, Ingalls Memorial identified the following community benefit priorities:



Introduction

The Community Health Needs Assessment (CHNA) is a systematic, data-driven approach to determine health needs in Ingalls Memorial's PSA. Through this process, Ingalls Memorial directly engaged community members and stakeholders to identify the issues of greatest need and the largest obstacles to health. With this direct input from those living in the surrounding communities, Ingalls Memorial can work beyond the hospital's walls. The CHNA drives Ingalls Memorial's programmatic work to address health inequities, build partnerships, develop the workforce, increase access to essential services, and more. The CHNA holds Ingalls Memorial accountable for improving long-term health outcomes in the communities it serves.

Directing resources toward the greatest needs in the community is critical to Ingalls Memorial's work as a nonprofit, safety-net hospital that provides services regardless of a patient's ability to pay.

Since the passage of the 2010 Patient Protection and Affordable Care Act, Section 501(r) of the Internal Revenue Code, Ingalls Memorial has conducted a CHNA every three years. The process Ingalls Memorial used was designed to meet federal requirements and guidelines in Section 501(r), including:

- Clearly defining the community served by the hospital and ensuring that the defined community does not exclude low-income, medically underserved, or minority populations in proximity to the hospital
- Providing a clear description of the CHNA process and methods; community health needs; collaboration, including with public health experts; and a description of existing facilities and resources in the community
- Receiving input from persons representing the broad needs of the community
- Documenting community comments on the CHNA and health needs in the community
- Documenting the CHNA in a written report and making it widely available to the public

This report outlines the CHNA process and summarizes the collected community health needs data. The subsequent SIP will detail strategies designed to address these identified health needs.

Who We Are:
One UChicago Medicine

The **University of Chicago Medicine** is a not-for-profit academic health system based on the University of Chicago campus on the city's South Side. UChicago Medicine unites three organizations to fulfill their shared mission of patient care, research, and education.

- **University of Chicago Health System:** The Health System is anchored by the University of Chicago Medical Center and includes hospitals, outpatient clinics, and physician practices across Chicago, its suburbs, and Northwest Indiana.
- **Biological Sciences Division:** UChicago's largest academic division includes 10 basic science and 14 clinical departments. Research and academic activities sit under the Biological Sciences Division.
- **Pritzker School of Medicine:** UChicago's medical school is co-located on campus, offering students a unique learning environment for education, research collaboration, and community service.

Mission, Vision, Values

UChicago Medicine set out to create guiding principles to unify all UChicago Medicine entities with a shared framework aligned with the values of the University of Chicago. These principles will help UChicago Medicine achieve new heights together in our community.

UChicago Medicine's **Mission** is what drives the organization; it explains why we do what we do and the impact we want to have on society and the world. Our **Vision** is our long-term goal and the ambitious future we want to create. Our **Values** are the guiding principles that inform our actions, behavior, and decisions.

MISSION

As part of the University of Chicago, we pursue globally impactful solutions to seemingly unsolvable challenges. Through our rigorous research, innovative education, and comprehensive care and healing, we collaborate on life-changing advancements that create meaningful results for our community and the world, including a greater, more equitable future for all.

VISION

Together, we can elevate the human experience with knowledge and health care.

VALUES

Commit to Excellence
We contribute our exceptional talents to all we do and empower the same spirit of excellence in others.

Embrace Curiosity
We stay open to new ideas, champion diverse perspectives, and drive a culture of thoughtful risk taking to deliver transformative innovation.

Embody Equity
We identify systemic issues then foster change to drive a more equitable environment inclusive of diverse people, ideas, and fields of science.

Grow Together
We meaningfully collaborate with one another to create something bigger than we could ever achieve alone.

Make a Difference
We lead with heart and compassion in all our interactions. We create positive change in our areas of influence whether expanding scientific inquiry, developing the next generation of leaders, or healing our community.

Take Ownership
We accomplish what we say we will and hold ourselves and one another accountable for our actions.

The Health System

The University of Chicago Health System has a history dating back to 1927. It is known publicly as UChicago Medicine.

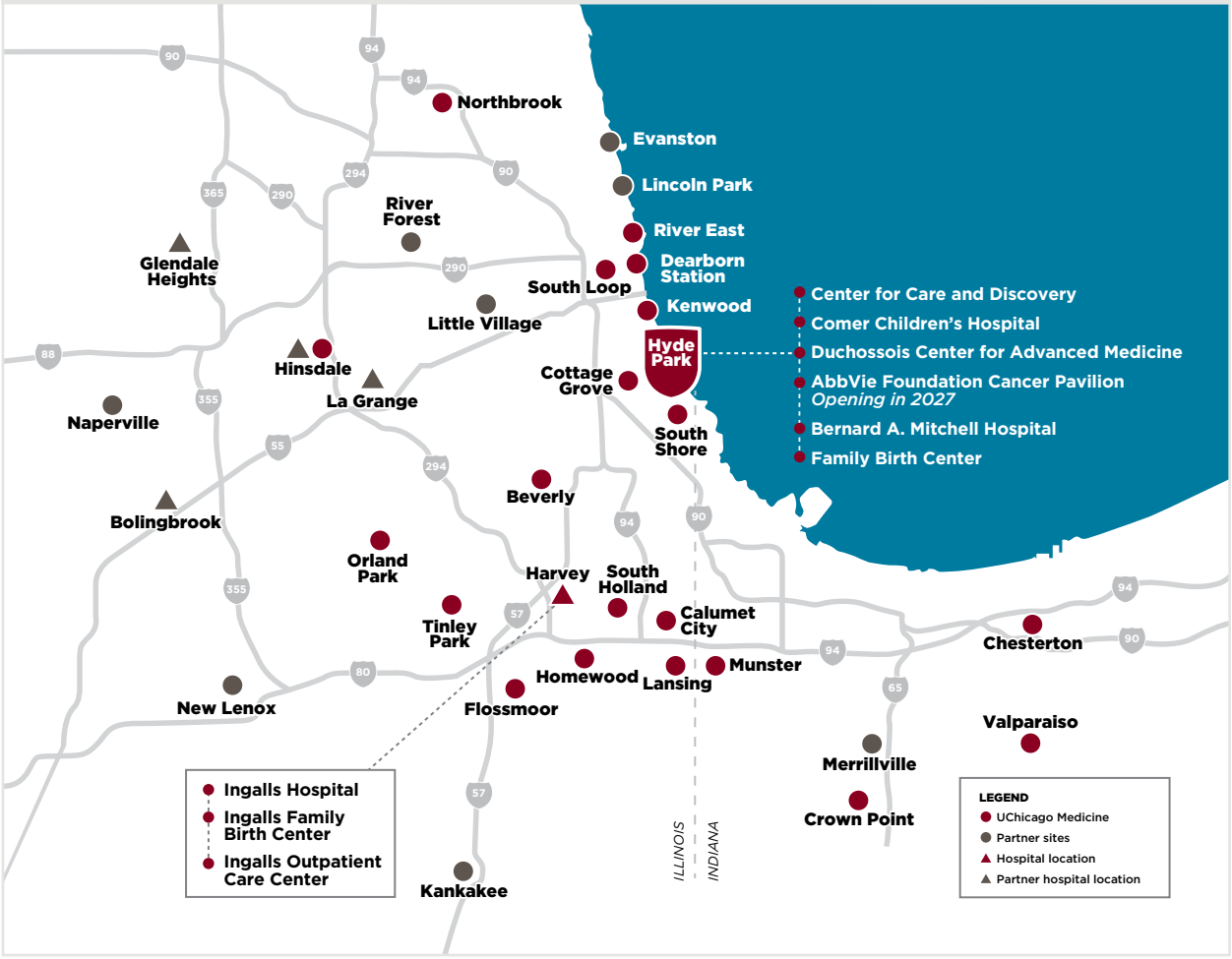
University of Chicago Medical Center
Health System flagship in Hyde Park, serving Chicago's South Side

UChicago Medicine Ingalls Memorial
Serving the Southland & south suburbs

UChicago Medicine AdventHealth
Joint venture serving the western suburbs

UChicago Medicine Crown Point
Multispecialty center & micro-hospital in Northwest Indiana

UChicago Medicine Medical Group
A clinically integrated network of providers affiliated with UChicago Medicine and independent community providers



UChicago Medicine Ingalls Memorial

Serving Chicago's Southland since 1923, Ingalls Memorial is a comprehensive, patient-centered system of care. Ingalls Memorial provides a wide range of services, including orthopedics, cancer care, behavioral health, obstetrics and gynecology, neuroscience, and inpatient and outpatient surgery.

In 2016, UChicago Medicine and Ingalls Memorial joined forces in an alliance that combined a top community hospital in Chicago's south suburbs with one of the country's leading academic medical institutions.

Ingalls Memorial's main campus is located in Harvey, Illinois. Ingalls Memorial has additional facilities of varying sizes and capabilities located throughout the southern suburbs of Chicago.

UChicago Medicine Ingalls Memorial

At a Glance: Fiscal 2024

FACILITIES

1 Inpatient Facility

* Ingalls Memorial Hospital on 37-acre main campus in Harvey
* Joined UCM in 2016

485 Licensed Beds

- **315** Med-Surg
- **25** ICU
- **21** OB-GYN
- **78** Acute/Chronic Mental Illness
- **46** Rehabilitation

4 Ambulatory Care Facilities

* Professional Office Building in Harvey
* Family Care Center at Calumet City*
* Family Care Center at Flossmoor*
* Family Care Center at Tinley Park*

*Locations with 24/7 emergency departments

9 Operating Rooms

PEOPLE

~1,700 Employees

Including:

- **~500** Physicians
- **~500** Nurses (RNs)
- **29** Advanced Practice Providers

VOLUME

- **166,932** Ambulatory Appointments**
- **286,228** Outpatient Encounters
- **3,269** Surgical Cases^
- **8,861** Hospital Admissions
- **73,121** Hospital Patient Days
- **116,828** ED, Urgent Aid Visits
- **493** Births

**Appointments include both onsite and telehealth

^Ingalls Memorial Main OR only, excludes Ambulatory Surgery Center

Asset-Based Community Development

Ingalls Memorial promotes health in the community and provides equitable care in the hospital using Asset-Based Community Development. Asset-Based Community Development (ABCD) is a strategy for sustainable community-driven development that begins with a community's strengths instead of its deficits.

How the ABCD strategy works:

ASSET

Communities identify and mobilize existing, but often unrecognized, assets.

BASED

Individuals, associations, and institutions come together to build based on their assets and further leverage the skills and resources available in the community.

COMMUNITY

Using these identified individual and collective assets, communities respond to needs and create new opportunities.

DEVELOPMENT

Ingalls Memorial executes an ABCD approach through various departments, including:

- **Community Benefit:** tracks and reports community benefit programs and oversees Ingalls Memorial's compliance with 501(r) regulations.
- **Community Relations:** builds relations with community organizations, individuals, and local government to support activities and events in the community.
- **Volunteer Services:** recruits and manages volunteer services at the hospital.

Community Benefit Primary Service Area (PSA)

Following IRS guidelines and 501(r) rules as required by the Affordable Care Act, the Ingalls Memorial community benefit PSA is represented by 13 ZIP codes covering Thornton Township in South Suburban Cook County, Illinois. The PSA has not changed since the 2021-2022 CHNA. While the hospital provides exceptional care to all residents seeking care, Ingalls Memorial will use this report to establish priorities and commit resources that address the most pressing health needs in Thornton Township.

INGALLS MEMORIAL PRIMARY SERVICE AREA

ZIP Codes and Cities/Municipalities

60406
Blue Island
Dixmoor
Riverdale
Posen

60409
Calumet City
Lansing
Burnham

60419
Dolton

60425
Glenwood

60426
Harvey
Dixmoor
Markham
Phoenix

60429
Hazel Crest
Harvey
East Hazel Crest
Markham

60430
Homewood
Hazel Crest
Thornton

60438
Lansing

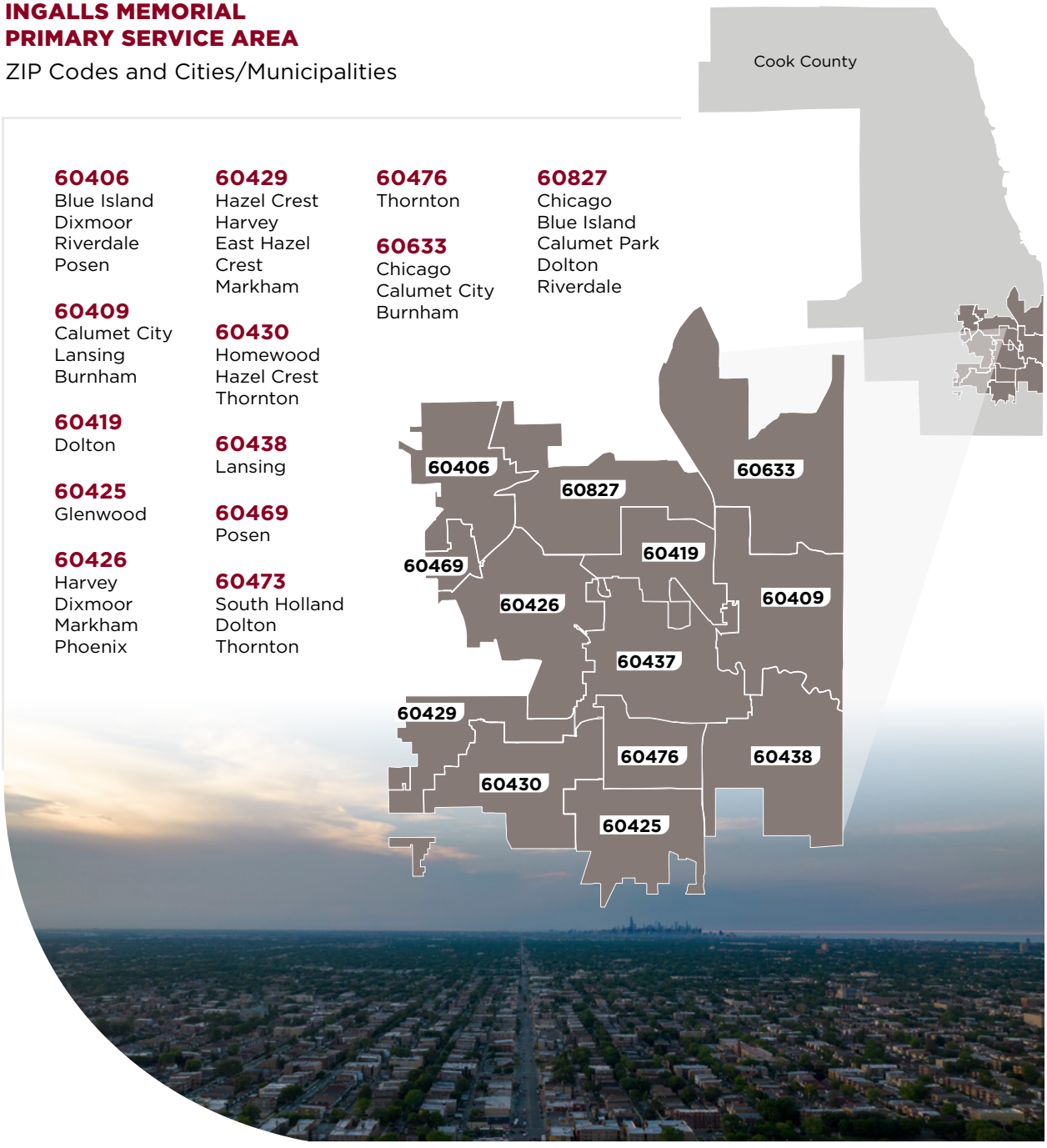
60469
Posen

60473
South Holland
Dolton
Thornton

60476
Thornton

60633
Chicago
Calumet City
Burnham

60827
Chicago
Blue Island
Calumet Park
Dolton
Riverdale



PSA Demographics

The Ingalls Memorial PSA is home to 242,262 residents as of 2020 (U.S. Census Bureau), which has decreased by 4.9% since 2010. The following figures show key demographics for the PSA compared to the county, state, and national averages when applicable.

POPULATION BY RACE/ETHNICITY

UChicago Medicine Ingalls Memorial PSA, 2019-2023

Full Population
242,262
±2,969 residents

Non-Hispanic Black
151,908
±3,977 residents

Non-Hispanic White
35,342
±2,070 residents

Hispanic or Latinx
45,355
±2,874 residents

Asian
2,059
±908 residents

Native American
45
±64 residents

Pacific Islander/Native Hawaiian
50
±99 residents

Two or more races
6,245
±1,088 residents

Created on Metopio | metop.io/i/1r5uc6n2 | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (ACS: Table B01001; Decennial Census: Table P012)
Population: Average population over the time period.

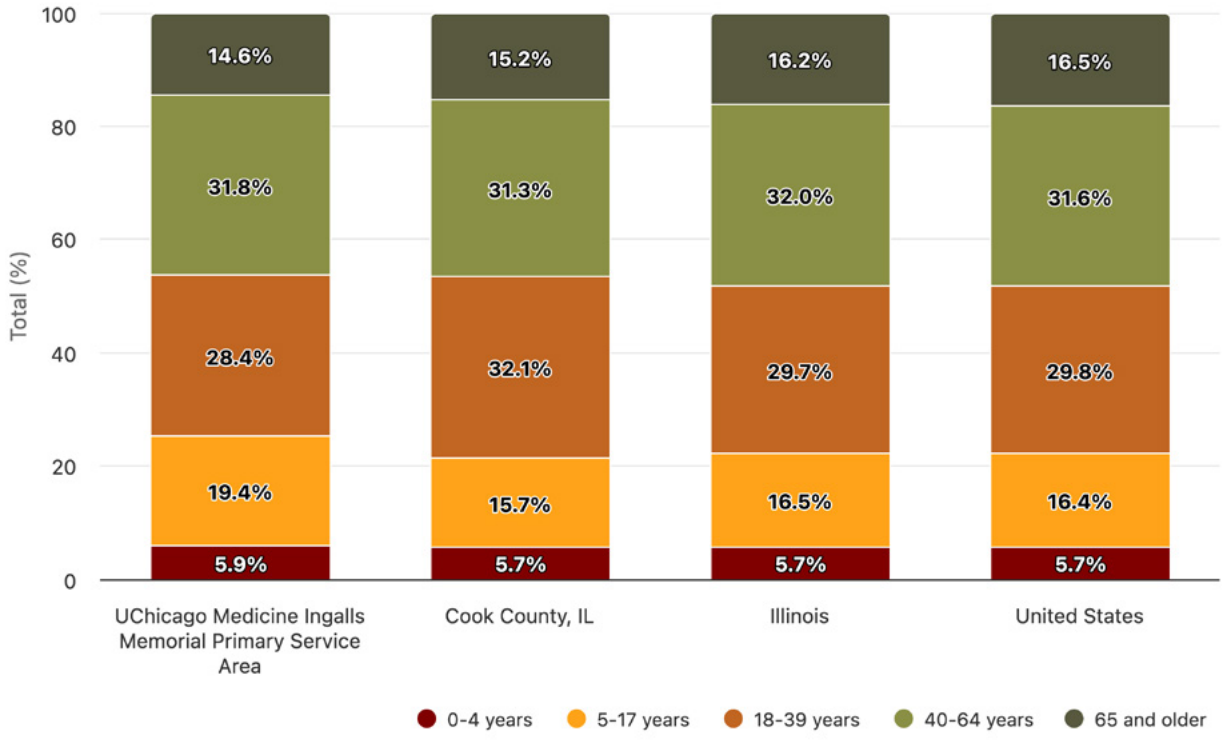
62.9% of the PSA's population is Non-Hispanic Black

18.7% is Hispanic or Latinx

15.2% is Non-Hispanic White

POPULATION BY AGE

UChicago Medicine Ingalls Memorial PSA and comparison, 2018-2022



Created on Metopio | metop.io/i/g13zieae | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (ACS: Table B01001; Decennial Census: Table P012)
Population: Average population over the time period.

31.8% of the PSA's population is 40 to 64-years-old

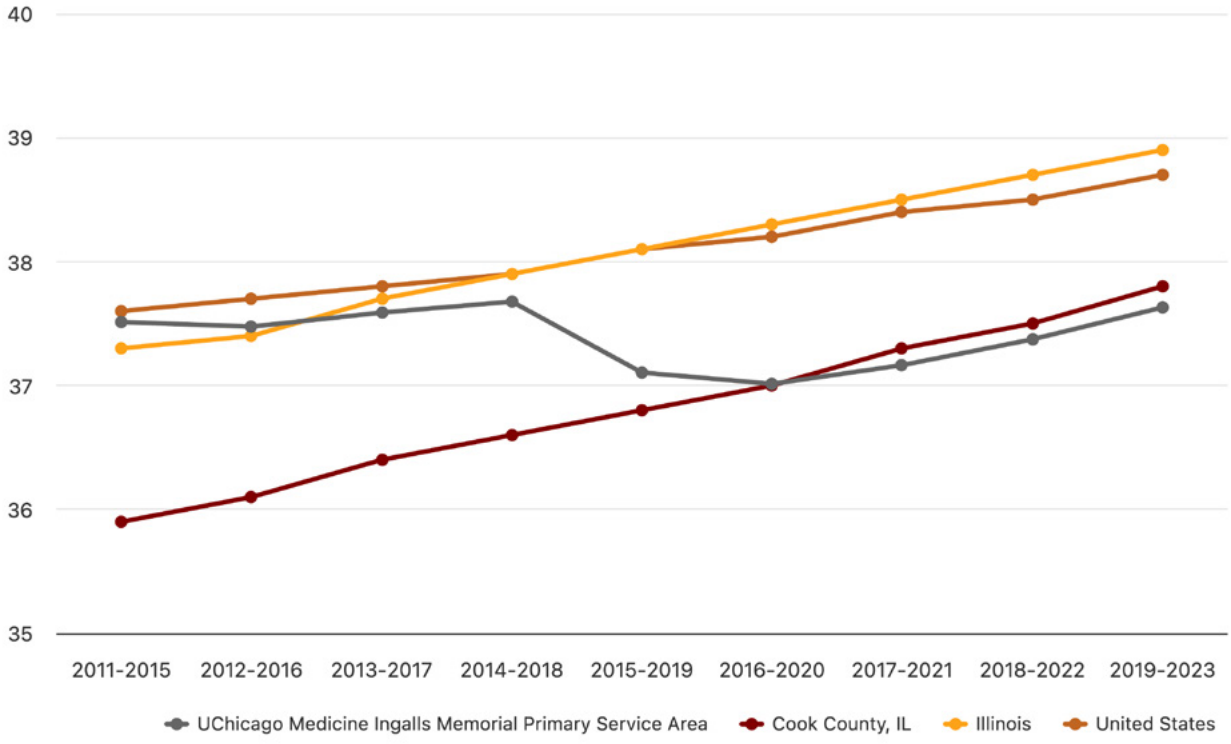
28.4% is 18 to 39-years-old

POPULATION BY SEX

According to the U.S. Census Bureau (2018-2022) American Community Survey (ACS), there are more females (52.2%) than males (42.8%) in the Ingalls Memorial PSA. When the data was collected, the ACS only had two options for sex.

POPULATION BY MEDIAN AGE

UChicago Medicine Ingalls Memorial PSA and comparison



Created on Metopio | metop.io/i/aeox4zsv | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Table B01002)

Median age: The median age represents the age of the "middle" resident, if they were all lined up from youngest to oldest. (Half of all residents are older than this, and half are younger.)

Ingalls Memorial's PSA has not had an overall increase in median age since 2011, but the broader geographic areas have seen increases in age since 2020, and we expect to see an aging population over the next decade.

CHNA Process and Methods

In alignment with UChicago Medicine's Mission, Vision, and Values, engaging both internal and external stakeholders is critical when assessing and addressing community health needs. Ingalls Memorial applied the following parameters when developing the CHNA:

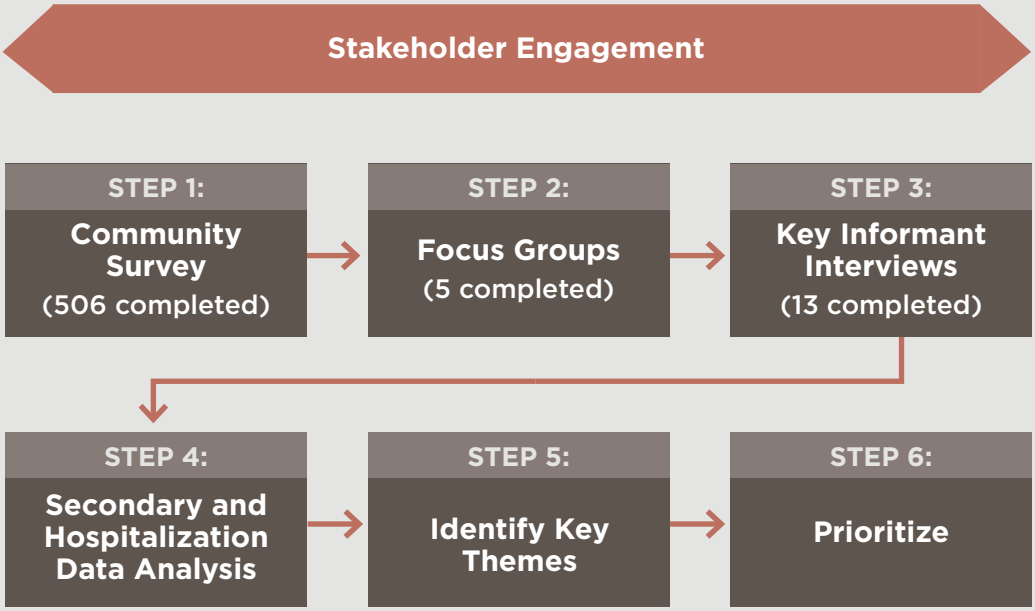
- Built on prior CHNAs from 2021-2022, as well as other local assessments, regional assessments, and plans.
- Contributed to greater understanding and insight into community health needs for ongoing community benefit priorities, including the Ingalls Memorial SIP.
- Leveraged the expertise of community residents, community partners, and key stakeholders, including a broad range of sectors and people disproportionately affected by health inequities.
- Provided an overview of the community health status of a designated area and highlighted data related to health inequities.
- Informed strategies related to population health, connections between community and clinical sectors, anchor institution efforts, policy change, and community partnerships.
- Highlighted health inequities and underlying root causes throughout the report.

For the 2024-2025 CHNA, Ingalls Memorial collaborated with Metopio, a software company with a data visualization platform. Leaders from the Community Benefit team worked with Metopio to guide the strategic direction of the CHNA and engaged various internal committees and workgroups to ensure a broad range of diverse perspectives at Ingalls Memorial. Together, we utilized a variety of primary and secondary data sources to build a robust analysis of the community's health needs. This assessment leverages the following data sources:

- Primary survey data
- Community focus group data
- Detailed key informant interviews
- Claims data
- Secondary data

Once collected and compiled, data were analyzed to compare health needs in Ingalls Memorial's PSA to city, county, state, and national benchmarks. Results were then presented to and reviewed by key stakeholders in the community and across the hospital system.

Detailed methods are described in the figure below:



Stakeholder Engagement

The CHNA process engaged several internal and external groups to collect and interpret data, then use that data to prioritize the health needs of the community. Stakeholder groups and their roles are defined below:

COMMUNITY BENEFIT STEERING COMMITTEE

The Community Benefit Steering Committee is comprised of staff and faculty who provide advice and oversight of UChicago Medicine's community benefit programs, reporting, and CHNA development and execution. The committee is responsible for providing input on the planning and implementation of policies, processes, and programs that support the community benefit function of the Hospital System. The committee meets quarterly and oversees the development and implementation of the CHNA process and reports, as well as the overall Community Benefit strategy.

COMMUNITY ADVISORY COUNCIL (CAC)

Ingalls Memorial's Community Advisory Council (CAC), established in 2020, is another entity that provided input into the 2024-2025 CHNA process. Ingalls Memorial's CAC is a representative group of volunteer members who live and/or work in the Ingalls Memorial PSA. Members of the CAC act as advisors to Ingalls Memorial on issues of interest to the broader community. The CAC is an essential partner as Ingalls Memorial works to achieve its goals related to broader community interests, including access to care and effective community engagement. In this CHNA, the CAC played a key role in providing input to survey questions, identifying community organizations for focus groups, disseminating surveys, and ensuring that we heard from diverse community voices throughout the process.

Data Collection

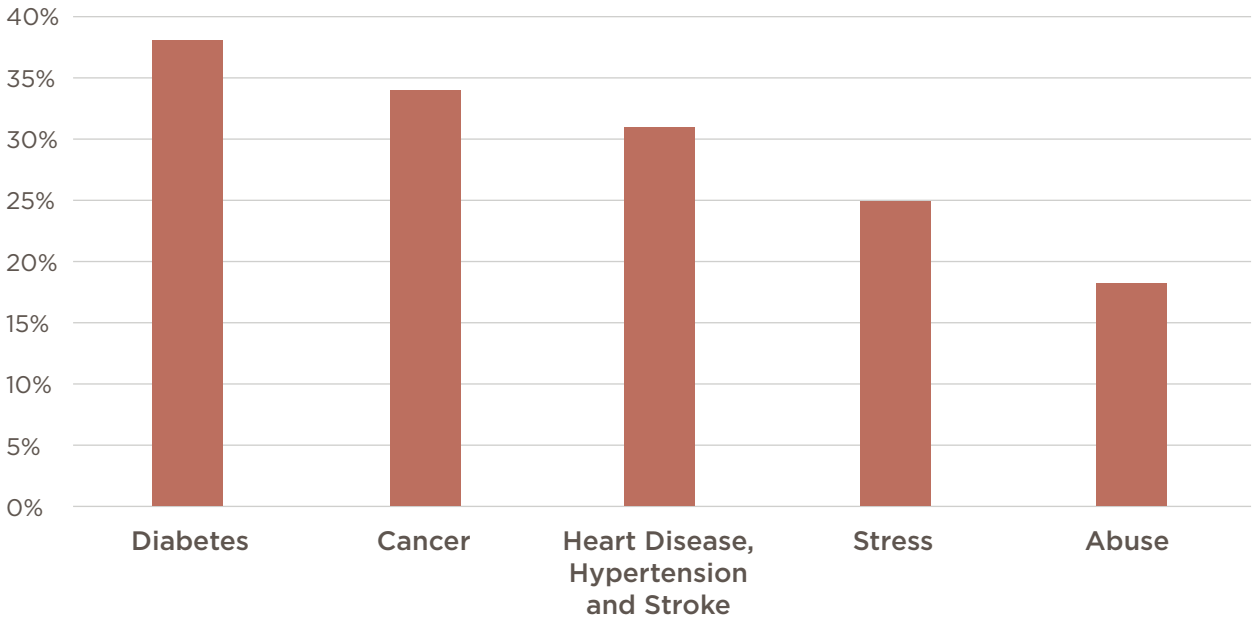
Ingalls Memorial conducted its CHNA process from March 2024 to March 2025 using an adapted process from the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework (NACCHO, 2025). This planning framework is one of the most widely used for CHNAs. It focuses on community engagement, partnership development, and participation from people who are historically excluded from community decision-making processes.

PRIMARY DATA

Community Input Survey at a Glance

- Conducted between July and November 2024
- 506 Ingalls Memorial PSA resident surveys
- Available online or on paper
- Disseminated in English and Spanish, with additional languages available upon request
- Survey topics included healthcare access, top community health issues, and demographics
- 22 questions on the survey
- Survey data was weighted to reflect the demographic makeup of the Ingalls Memorial PSA
- Promoted through community partner events, email lists, and digital and in-person outreach within the hospital

Community Input Survey respondents ranked the top health issues as follows:



Additional community input survey results and demographic data can be found in Appendix 4.

Community Focus Groups at a Glance

Conducted between July and November 2024

Participants were recruited through hospital-community partnerships

Participants were age 12 or older

Conducted four Ingalls Memorial PSA resident focus groups focused on the following population or health issue areas:

- Youth
- Chronic Disease
- Reproductive, Maternal, and Child Health
- Mental Health and Substance Use

Hosted one Healthcare and Social Service Provider focus group with internal hospital staff and external community leaders

Focus groups were held in a semi-structured format and were conducted primarily in person

Key Informant Interviews at a Glance

Conducted between October 2024 and November 2024

Participants were internal Ingalls Memorial leaders and providers

13 key informants were interviewed

Interviews were conducted in a semi-structured format

Respondents were asked to identify the top Social Determinants of Health (SDOH) and health conditions/behaviors in the community

These interviews and focus groups provided valuable qualitative data on the specific health and wellness challenges, resources, and priorities in the community.

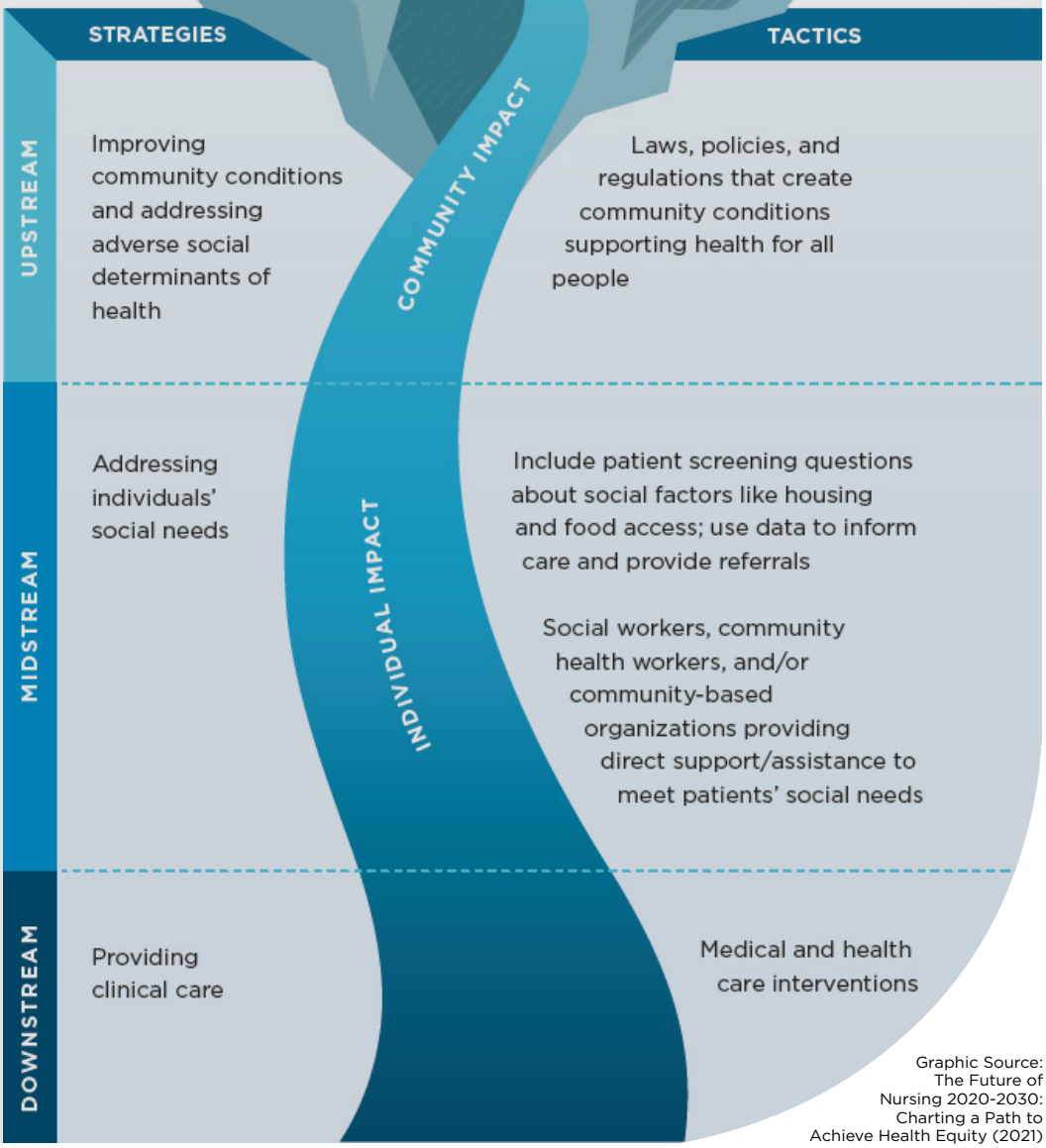
SECONDARY DATA

Ingalls Memorial used common health indicators to understand morbidity and mortality in the Ingalls Memorial PSA, then compared these statistics to county, state, and federal benchmarks. Where possible, Ingalls Memorial used data with stratifications to better explore and articulate health inequities. These health equity indicators were used for key stakeholder review. For a list of secondary data sources, see Appendix 5.

Drivers of Health Inequities

University of Chicago Medicine is focused on understanding the social, structural, and systemic factors that may impact health outcomes. The framework below outlines tactics for achieving health equity that address both the root causes and potential interventions to reduce disparities.

Social Determinants and Social Needs

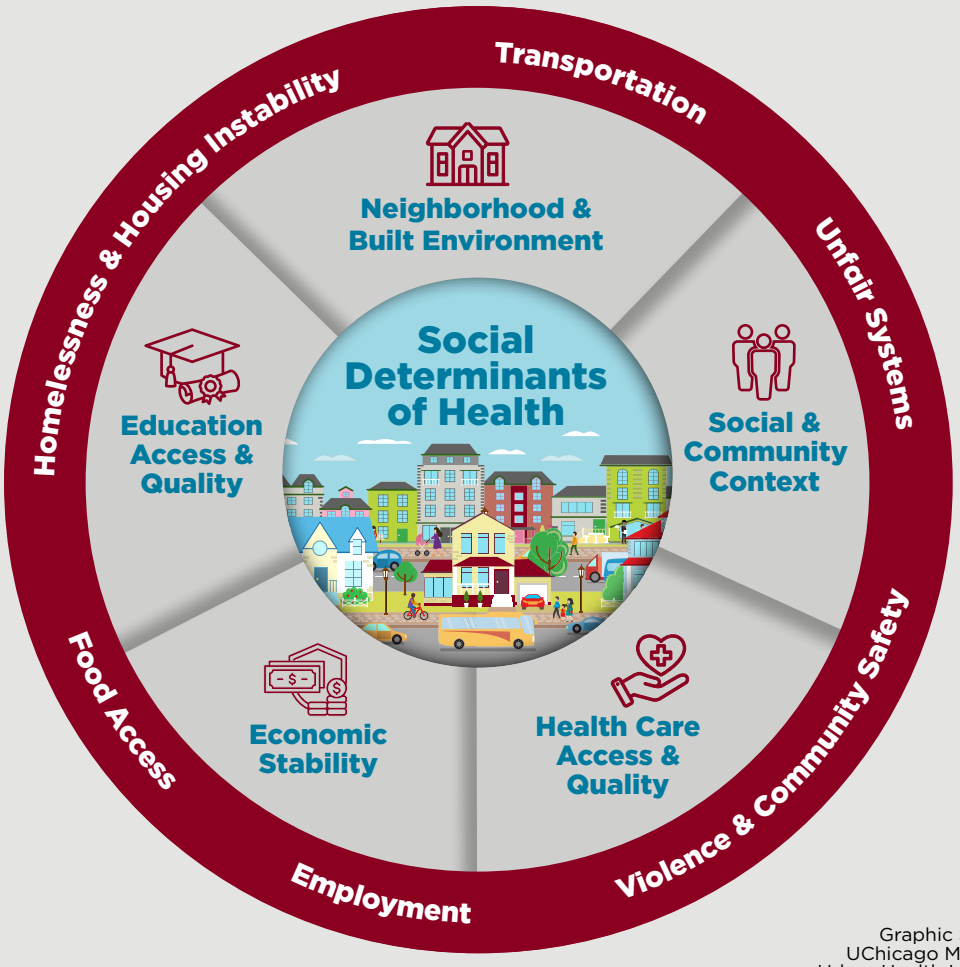


Graphic Source: The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity (2021)

Social Determinants of Health

As defined by the Centers for Disease Control and Prevention (CDC), the Social Determinants of Health (SDOH) are non-medical factors that affect health outcomes. They include the conditions in which people are born, grow, work, live, and age. They also include the broader forces and systems that shape everyday life conditions. SDOH are often linked to a lack of opportunity and resources to protect, improve, and maintain health. The CDC encourages health organizations to address the underlying factors related to key categories of SDOH, including:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

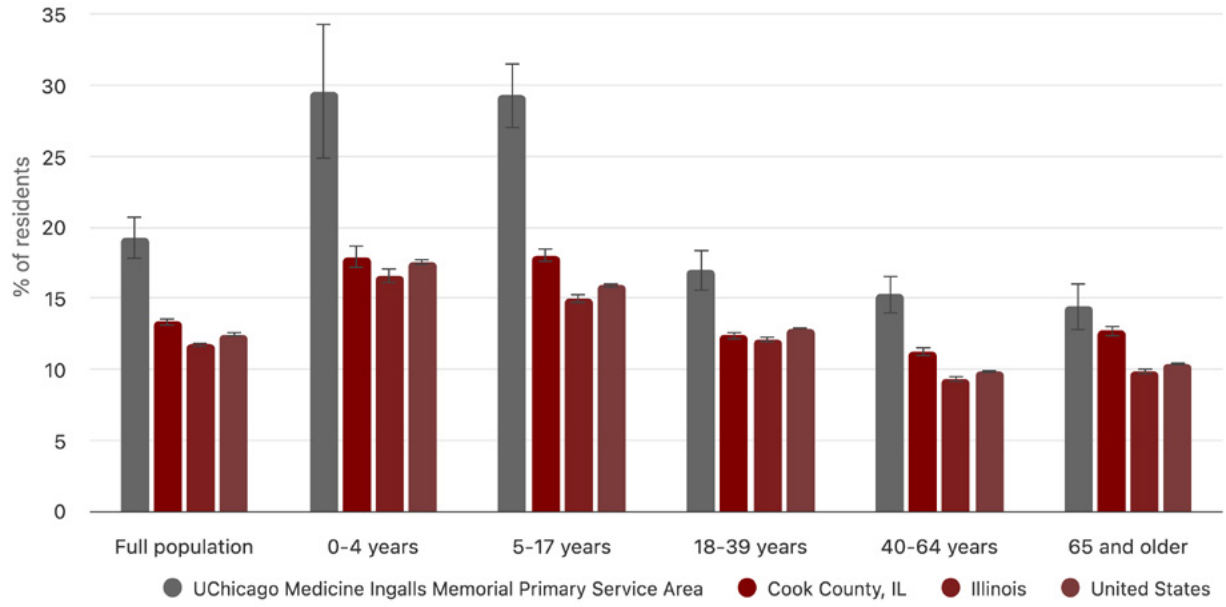


Graphic Source:
UChicago Medicine
Urban Health Initiative
SDOH (2025)

Economic Stability

Economic stability explores the link between an individual's financial resources and their health. To evaluate economic stability, we analyzed indicators such as poverty, income, and employment.

POVERTY RATE BY AGE *UChicago Medicine Ingalls Memorial PSA and comparison, 2019-2023*



Created on Metopio | metop.io/i/81vdp3vd | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Table B17001)
Poverty rate: Percent of residents in families that are in poverty (below the Federal Poverty Level).

As shown in the figure above, the Ingalls Memorial PSA poverty rate (19.25%), or the percent of residents that live below the Federal Poverty Level, is higher, on average, than the rates for Cook County (13.34%) and Illinois (11.72%). The poverty rate in the Ingalls Memorial PSA is highest among people who are 17 years old or younger.

In addition, as shown in the table below, the Ingalls Memorial PSA unemployment rate is higher than the Cook County and Illinois averages. The median household income is also lower than the Cook County and Illinois averages.

> "The cost of housing and salaries don't align."
>
> - Healthcare and Social Service Provider Focus Group Participant

	Ingalls Memorial PSA	Cook County, IL	Illinois
Unemployment Rate % of residents 16 and older	**11.45%**	5.6%	4.7%
Median Household Income	**$60,955**	$80,579	$80,306

Education Access & Quality

Education explores the link between an individual's educational attainment and their health. Key indicators include high school and higher education graduation rates.

As shown in the table below, the high school graduation rate for the Ingalls Memorial PSA is similar to the Cook County and Illinois averages. Higher education and college graduation rates for the Ingalls Memorial PSA are lower than the Cook County and Illinois averages.

	Ingalls Memorial PSA	Cook County, IL	Illinois
High School Graduation Rate % of residents	**88.72%**	88.6%	90.6%
Any Higher Education Rate % of residents	**58.97%**	66.7%	65.3%
College Graduation Rate % of residents	**22.64%**	43.6%	38.3%

> "We have diverse students. They're determined to try to improve their skills and abilities and their economic status."
>
> - Healthcare and Social Service Provider Focus Group Participant

Healthcare Access and Quality

Access to care is a critical component of community health. Community members voiced concerns over significant barriers such as transportation difficulties, lack of insurance, and economic constraints that hinder their ability to access care effectively. These issues are exacerbated in areas described as 'food deserts' and 'maternal health deserts,' where basic services like grocery stores and maternal health facilities are scarce or non-existent.

Focus group participants and key informants described a broad range of challenges faced by different demographic groups, including older adults, those with chronic diseases, and economically disadvantaged populations. They noted the inability to afford medications, the lack of primary care facilities, the closure of local mental health facilities, and the scarcity of outpatient services. Additionally, community members pointed out the crucial need for better coordination of care and enhanced communication between healthcare providers to improve healthcare delivery.

The table below shows the percentage of adults in the Ingalls Memorial PSA who have visited a doctor within the past 12 months for a routine checkup, which is higher than the Cook County and Illinois averages. However, the Primary Care Provider rate per 100,000 residents is significantly lower than the Cook County and Illinois averages. Furthermore, the percentage of Ingalls Memorial residents using Medicaid is higher than the Cook County and Illinois averages, yet the percentage of patients with Medicare coverage is similar.

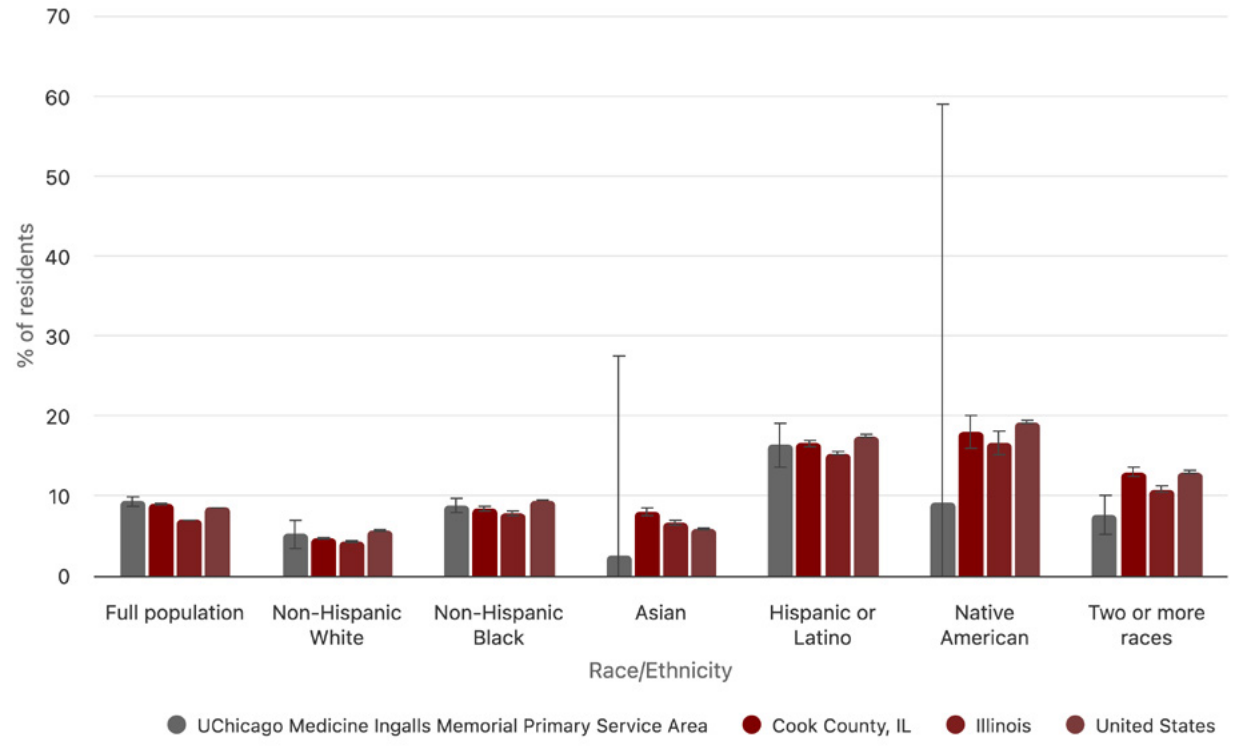
	Ingalls Memorial PSA	Cook County, IL	Illinois
Visited a Doctor for a Routine Checkup % of residents	**78.3%**	74.3%	74.5%
Primary Care Providers Per 100,000 residents	**45.1**	107.4	88.8
Medicaid Coverage % of residents	**33.1%**	22.3%	19.9%
Medicare Coverage % of residents	**17.1%**	16.7%	18.1%
No Vehicle Available % of households	**12.3%**	17.7%	10.8%

> "We have patients who've identified food insecurity and affordability over taking a treatment because they feel that they have to choose."
>
> - Key Informant Participant

The uninsured rate varies significantly across different racial and ethnic groups in the Ingalls Memorial PSA. Non-Hispanic Black and Latinx or Hispanic populations have the highest uninsured rates at 8.6% and 13.7%, respectively. These disparities suggest unequal access to healthcare and highlight the impact of race and ethnicity on insurance coverage within the community.

UNINSURED RATE BY RACE/ETHNICITY

UChicago Medicine Ingalls Memorial PSA and comparison, 2019-2023



Created on Metopio | metop.io/i/ypm6g83n | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Tables B27001/C27001)

Uninsured rate: Percent of residents without health insurance (at the time of the survey).

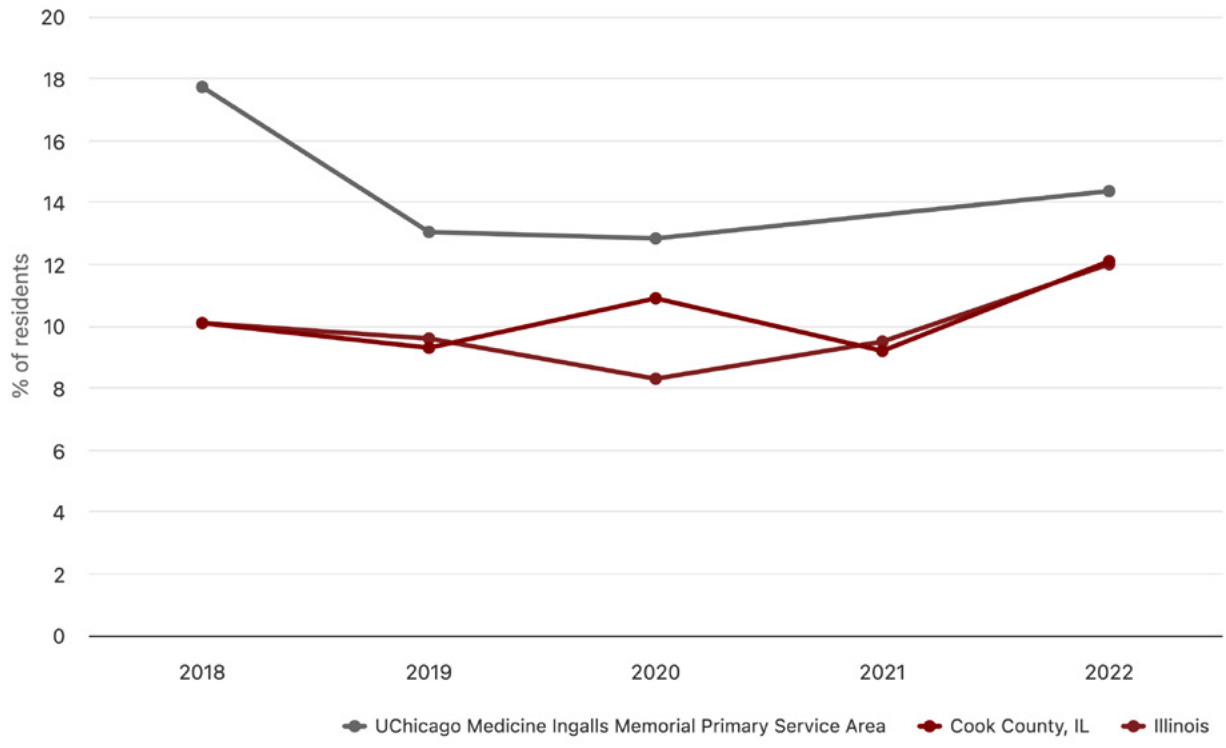
Neighborhood and Built Environment

The built environment refers to the human-made surroundings in which people live, work, and play. The built environment significantly impacts the health and well-being of community members by influencing access to health services, healthy food, and safe living conditions. Many community members face challenges due to a lack of infrastructure that supports healthy lifestyles, such as insufficient access to grocery stores offering fresh foods. Additionally, transportation barriers hinder residents' ability to reach healthcare facilities and access essential services (Metopio).

Community feedback indicates a pressing need for improvements in several areas of the built environment. Issues such as food insecurity, inadequate healthcare facilities, and poor access to primary care are significant. There have been efforts to address these challenges, such as the introduction of mobile health services and food pantries, expansion of healthcare facilities, and partnerships with community health centers. However, residents still struggle to access these services due to physical and logistical barriers.

FOOD INSECURITY

UChicago Medicine Ingalls Memorial PSA and comparison



Created on Metopio | metop.io/i/xotqxznv | **Data source:** Feeding America: Map the Meal Gap

Food insecurity: Percentage of the population experiencing food insecurity at some point. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food, as represented in USDA food-security reports. 2020 data is a projection based on 11.5% national unemployment and 16.5% national poverty rate.

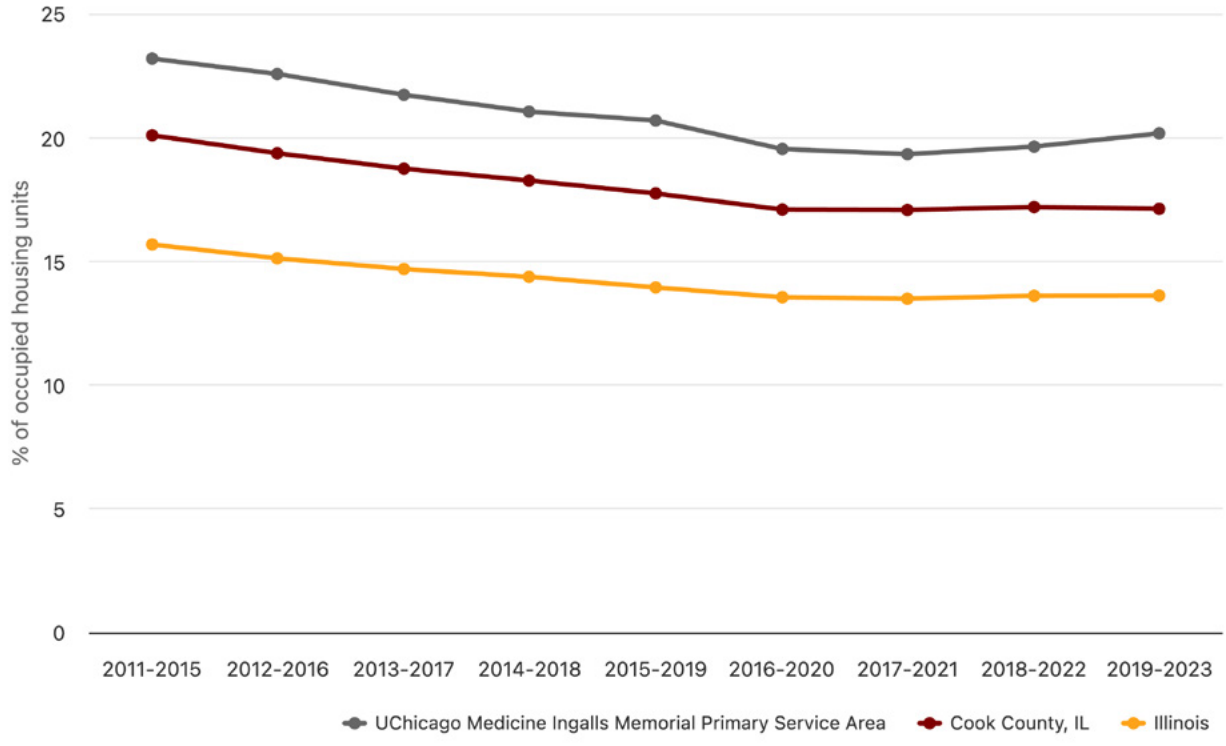
A higher percentage of adults in the Ingalls Memorial PSA experience food insecurity, compared to the Cook County, Illinois, and United States averages. Food insecurity is defined by Feeding America as uncertain or limited access to food.

> “I like how they’re paying more attention to the physical aspects of it, like the roads. They’re fixing the roads now. They’re adding new buildings.”
>
> - Youth Focus Group Participant

Focus group participants also noted challenges related to safe and affordable housing. The graph below shows the percentage of housing units experiencing a Severe Housing Cost Burden (households spending more than 50% of their income on housing costs). Within Ingalls Memorial PSA, there is a higher percentage of households with this burden than at the county or state level.

SEVERE HOUSING COST BURDEN

UChicago Medicine Ingalls Memorial PSA and comparison



Created on Metopio | metop.io/i/o9ekz4x1 | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Tables B25070/25091)

Severe housing cost burden: Households spending more than 50% of income on housing are considered severely housing cost-burdened. Includes both renters (rent) and owners (mortgage and other owner costs). For renters, costs include any utilities or fees that the renter must pay, but do not include insurance or building fees.

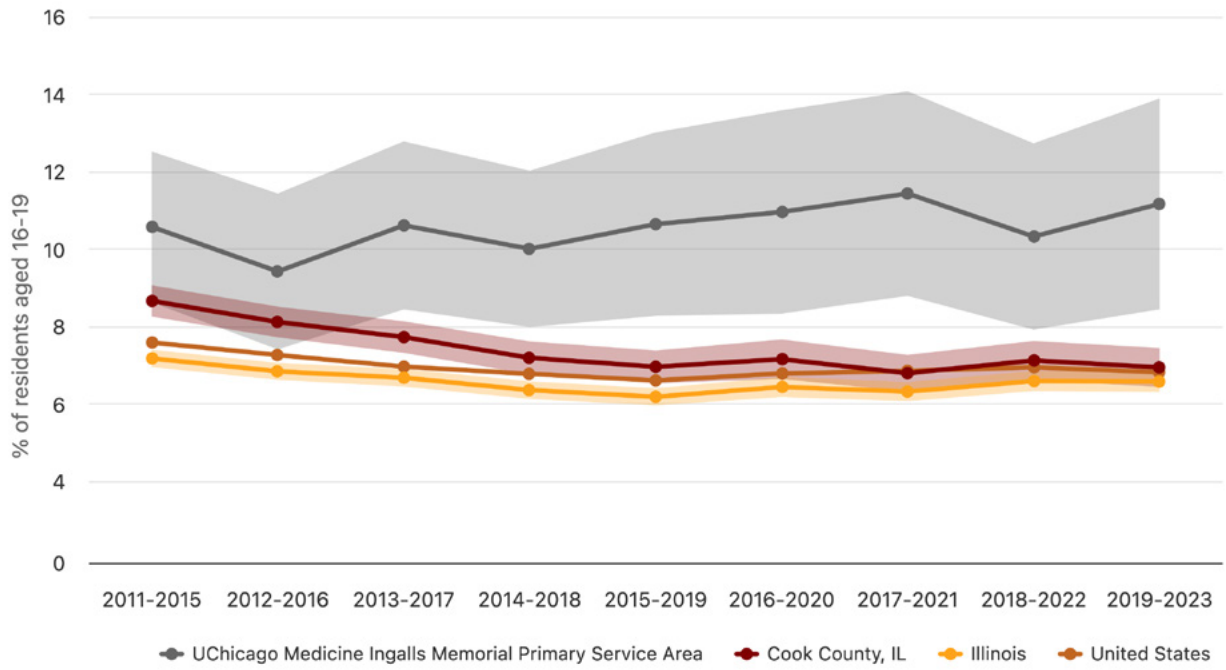
Social and Community Context

Social and community factors significantly influence healthcare access and outcomes, impacting the availability and quality of medical services across different communities. Socio-economic disparities can lead to differences in the quality of care received, as well as in the health outcomes of various demographic groups. Addressing these socio-economic barriers is crucial for improving health equity and ensuring that all community members have access to necessary healthcare services.

Community members voiced recurring themes, including concerns about affordability, inadequate transportation, and other socio-economic barriers. These barriers not only hinder access to routine healthcare but also affect patients' ability to manage chronic conditions or access emergency healthcare services. Financial limitations force many to make difficult choices between essential needs such as food and medication, further complicating their health situations. Community members also noted a shortage of local jobs, increasing transportation time and costs. Economic challenges directly affect the community's ability to improve their living conditions and access health resources. Additionally, the shortage of mental health providers and necessary support for chronic illness management underscores the need for comprehensive healthcare services that are accessible and affordable to all community members.

OPPORTUNITY YOUTH

UChicago Medicine Ingalls Memorial PSA and comparison



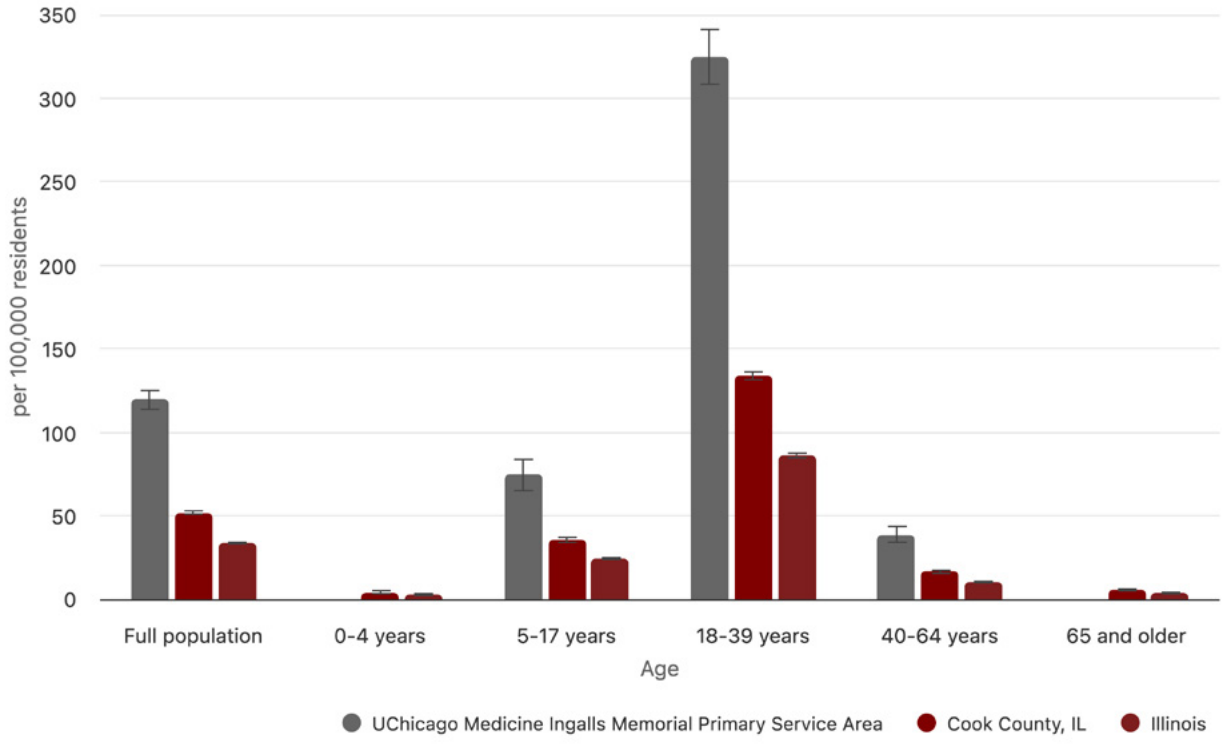
Created on Metopio | metop.io/i/fasyrnj2 | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Table B14005)

Opportunity youth: Percent of residents aged 16-19 who are neither working nor enrolled in school.

Opportunity Youth is defined as residents 16-19 who are neither working nor enrolled in school. The percentage of opportunity youth in the Ingalls Memorial PSA is higher than the Cook County, Illinois, and United States averages.

ASSAULT BY FIREARMS EMERGENCY DEPARTMENT VISIT RATE BY AGE

UChicago Medicine Ingalls Memorial PSA and comparison, 2019-2023

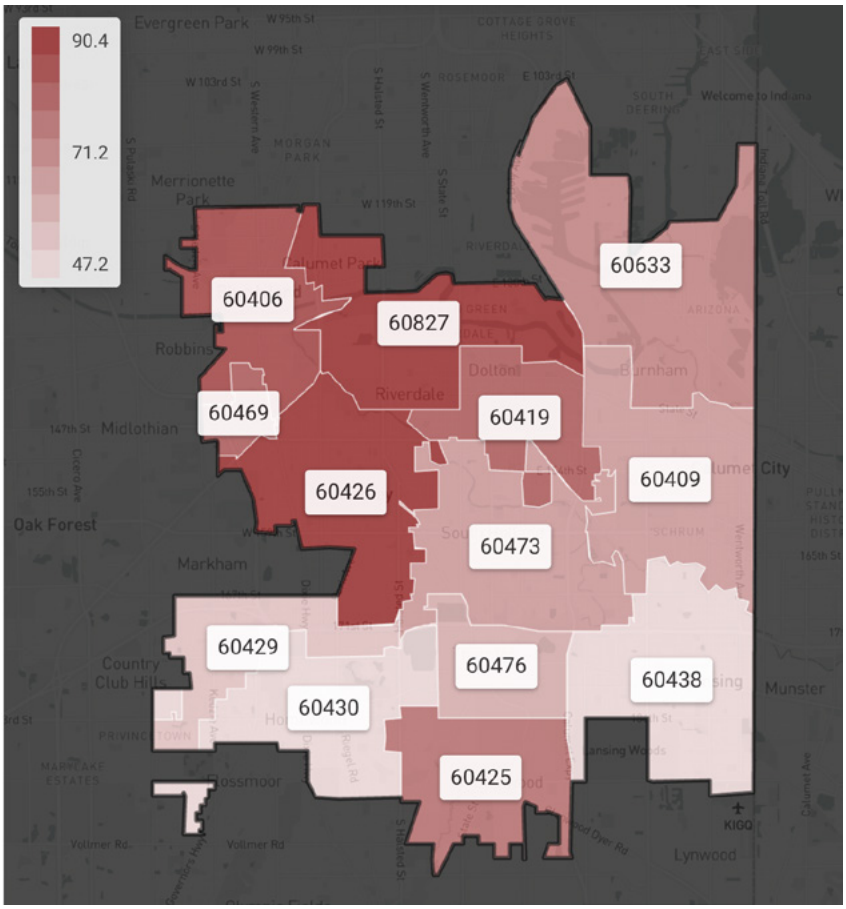


Created on Metopio | metop.io/i/77eqt5bk | **Data source:** IHA COMPdata Informatics (Calculated by Metopio)

Assault by firearms emergency department visit rate: Annual emergency department visits for assaults with firearms per 100,000 residents. Risk-adjusted by age and sex. All hospital providers, all payers, based on patient residence.

The Ingalls Memorial PSA assault by firearms emergency department visit rate remains significantly higher than the Cook County and Illinois rates. The rate is highest among individuals 18-39 years old.

> "There's been a lot of violence going on outside of the school, which we have to deal with."
>
> - Youth Focus Group Participant



HARDSHIP INDEX

UChicago Medicine Ingalls Memorial PSA

One way to measure adversity in a community is through the Hardship Index. The Hardship Index is a composite score reflecting hardship in the community (higher values indicate more significant hardship). It incorporates unemployment, age dependency, education, per capita income, and crowded housing. Higher scores are correlated with poor health outcomes.

As shown in the map on the left, the Hardship Index for Ingalls Memorial is highest in the 60426 and 60827 ZIP codes.

Health Conditions and Mortality

During this CHNA cycle, Ingalls Memorial identified obesity, cancers, heart disease, diabetes, maternal health, and behavioral health as significant health conditions in the community.

CHNA Findings

Chronic Diseases

Chronic diseases such as heart disease, diabetes, and cancer pose significant challenges to community health. These conditions often require long-term management and can lead to reduced quality of life for affected individuals and substantial healthcare costs. Community members expressed concerns about the high incidence of chronic diseases in their neighborhoods. In addition, they noted related issues: access to necessary healthcare services, including medication, healthy food, and preventative care; the need for better management of these diseases through improved diet and exercise; and regular screenings to identify diseases early and reduce their impact.

Community members shared various experiences and observations about the challenges associated with chronic diseases. They note high rates of readmissions for conditions like congestive heart failure, often linked to poor dietary habits, and the lack of access to preventative care, which results in patients seeking help only when their condition becomes severe. They highlighted the benefits of successful community programs like the Food as Medicine initiative and free food offerings for oncology patients.

- Obesity
- Cancers
- Heart Disease
- Diabetes
- Maternal Health
- Behavioral Health

> “We see a lot of patients with chronic disease, like stroke and heart disease, who come in with pretty significant disease by the time they come in.”
>
> - Key Informant Participant

There is a clear need for more comprehensive services that address the wide spectrum of chronic diseases and their complications, particularly in underserved populations. Community members noted an urgent need to address chronic diseases through better outreach, education, and resources that help patients manage conditions more effectively and prevent severe outcomes. An emphasis on screenings, such as diabetes and cancer, and the integration of behavioral health programs indicate a comprehensive approach to tackling the multifaceted challenges of chronic diseases in the community.

As seen in the table below, the Ingalls Memorial PSA has higher rates of most chronic conditions than Cook County. Most notably, respondents highlighted diabetes, obesity, heart disease (stroke, high blood pressure, coronary heart disease), and cancer.

	Ingalls Memorial PSA	Cook County, IL
Asthma % of residents	**11.2%**	9.2%
Arthritis % of residents	**27.7%**	21.3%
Cancer % of residents	**5.8%**	5.9%
Coronary Heart Disease % of residents	**6.6%**	5.1%
High Cholesterol % of residents	**29.9%**	27.4%

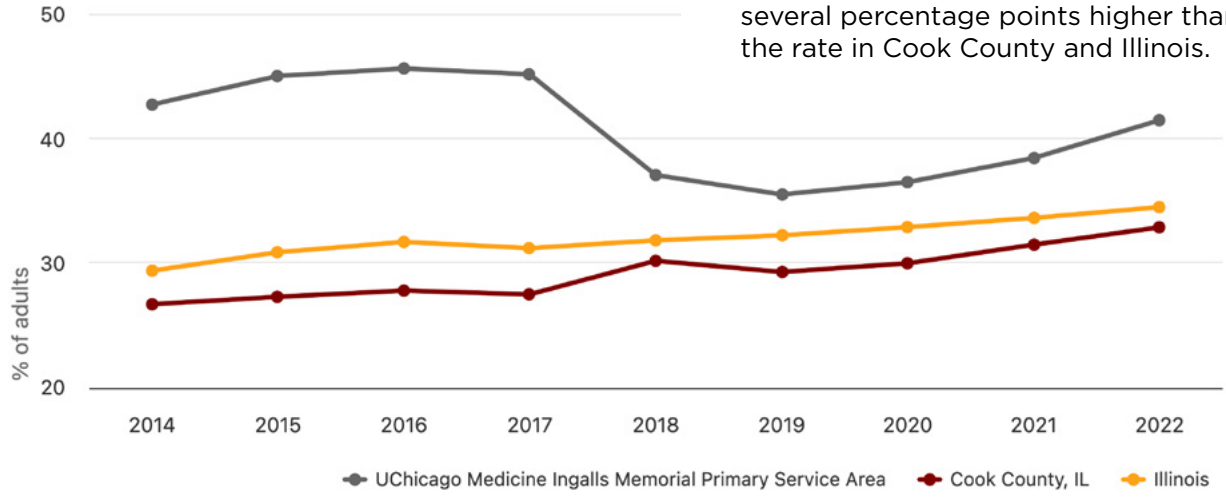
	Ingalls Memorial PSA	Cook County, IL
Chronic Kidney Disease % of residents	**3.5%**	2.9%
Diabetes % of residents	**16.1%**	10.8%
High Blood Pressure % of residents	**38.9%**	28.6%
Obesity % of residents	**41.4%**	32.8%
Stroke % of residents	**4.9%**	3.0%

Source: Centers for Disease Control and Prevention (CDC) PLACES Data, 2022

OBESITY

UChicago Medicine Ingalls Memorial PSA and comparison

The obesity rate for adults is 41.4% in the Ingalls Memorial PSA, which is several percentage points higher than the rate in Cook County and Illinois.

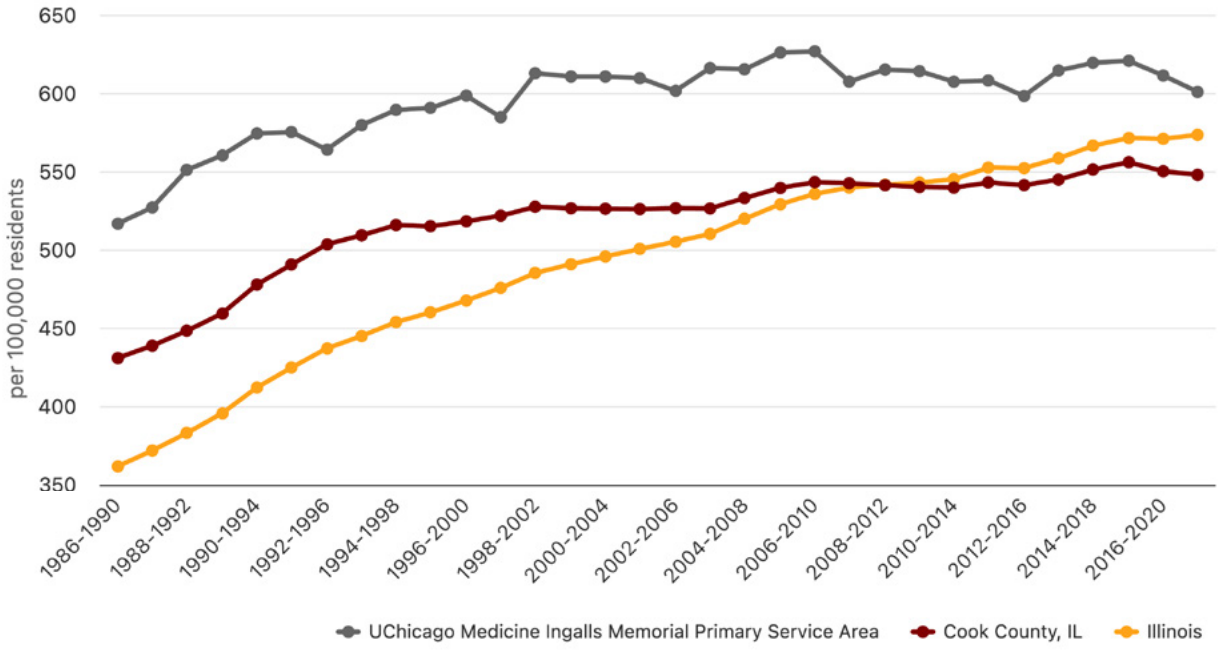


Created on Metopio | metop.io/i/n19yhcq5 | **Data sources:** Diabetes Atlas (County level data), Behavioral Risk Factor Surveillance System (BRFSS) (State and US data), Centers for Disease Control and Prevention (CDC): PLACES (Sub-county data (zip codes, tracts))
Obesity: Percent of resident adults aged 18 and older who are obese (have a body mass index (BMI) ≥30.0 kg/m² calculated from self-reported weight and height). Excludes those with abnormal height or weight and pregnant women.

The annual diagnosis rate for all invasive cancers in the Ingalls Memorial PSA is higher than in Cook County and Illinois.

CANCER DIAGNOSIS RATE

UChicago Medicine Ingalls Memorial PSA and comparison

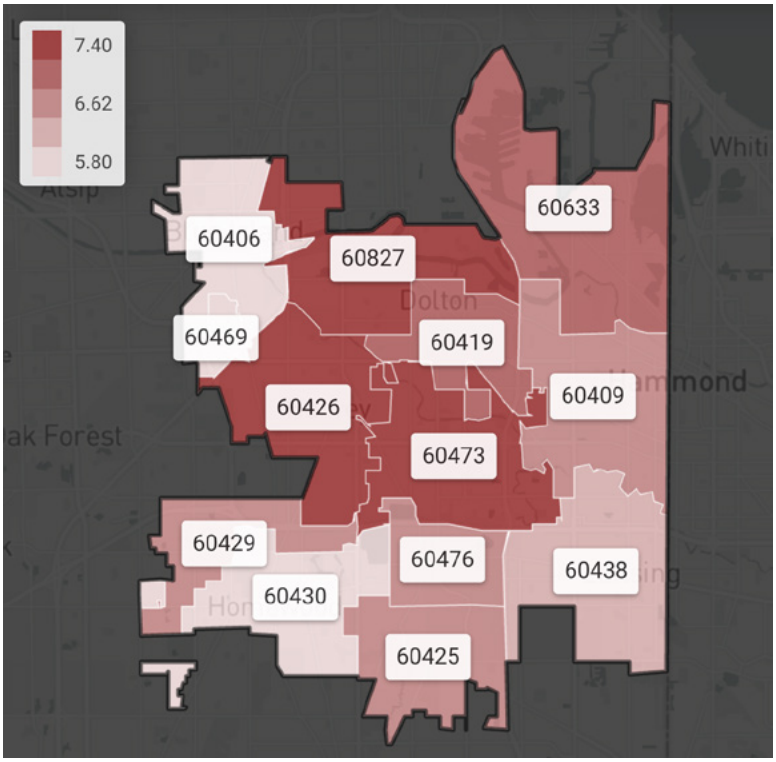


Created on Metopio | metop.io/i/f7pyf6d9 | **Data sources:** National Cancer Institute (NCI): State Cancer Profiles (WI: racial stratifications only) (Everywhere except IL), Illinois Department of Public Health (IDPH): Illinois State Cancer Registry (Calculated by Metopio) (Only in IL)
Cancer diagnosis rate: Annual diagnosis rate for all invasive cancers. Does not include pre-cancerous diagnoses such as breast cancer in situ or urinary cancer in situ. All ages, risk-adjusted.

HEART DISEASE

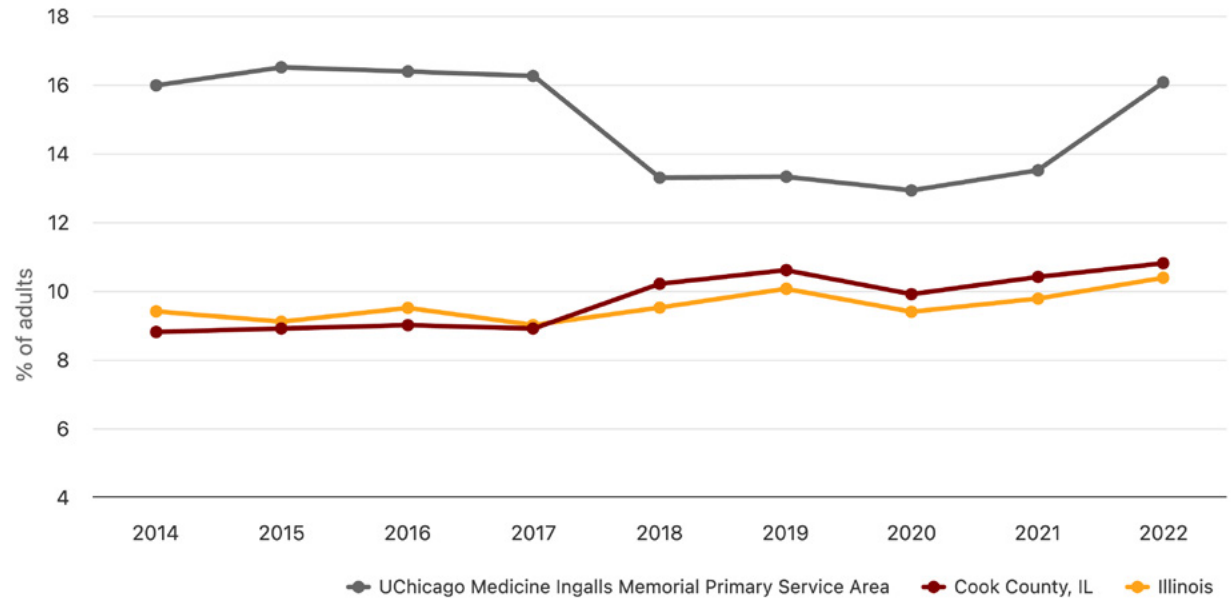
UChicago Medicine Ingalls Memorial PSA, 2022

The prevalence of coronary heart disease in the Ingalls Memorial PSA is higher than the prevalence in Cook County. The rates are highest in the 60827, 60426, and 60473 ZIP codes.



DIAGNOSED DIABETES

UChicago Medicine Ingalls Memorial PSA and comparison



Created on Metopio | metop.io/i/wgijf7mn | **Data sources:** Centers for Disease Control and Prevention (CDC): PLACES, Diabetes Atlas (County and state level data before 2017)
Diagnosed diabetes: Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have diabetes, other than diabetes during pregnancy. Data for counties and states are age-adjusted. Data for zips, tracts and smaller layers are raw.

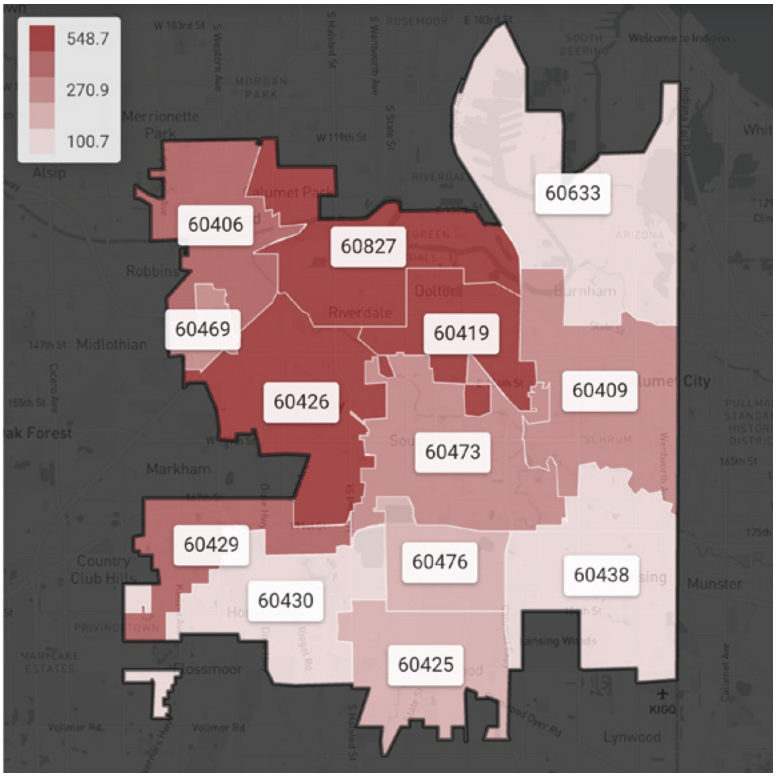
The rate of diagnosed diabetes is higher in the Ingalls Memorial PSA than in Cook County and Illinois.

DIABETES HOSPITALIZATION

UChicago Medicine Ingalls Memorial PSA, 2019-2023

The diabetes hospitalization rate is higher in the Ingalls Memorial PSA than in Cook County and Illinois.

The rates are highest in the 60827, 60419, and 60426 ZIP codes.



Maternal Health

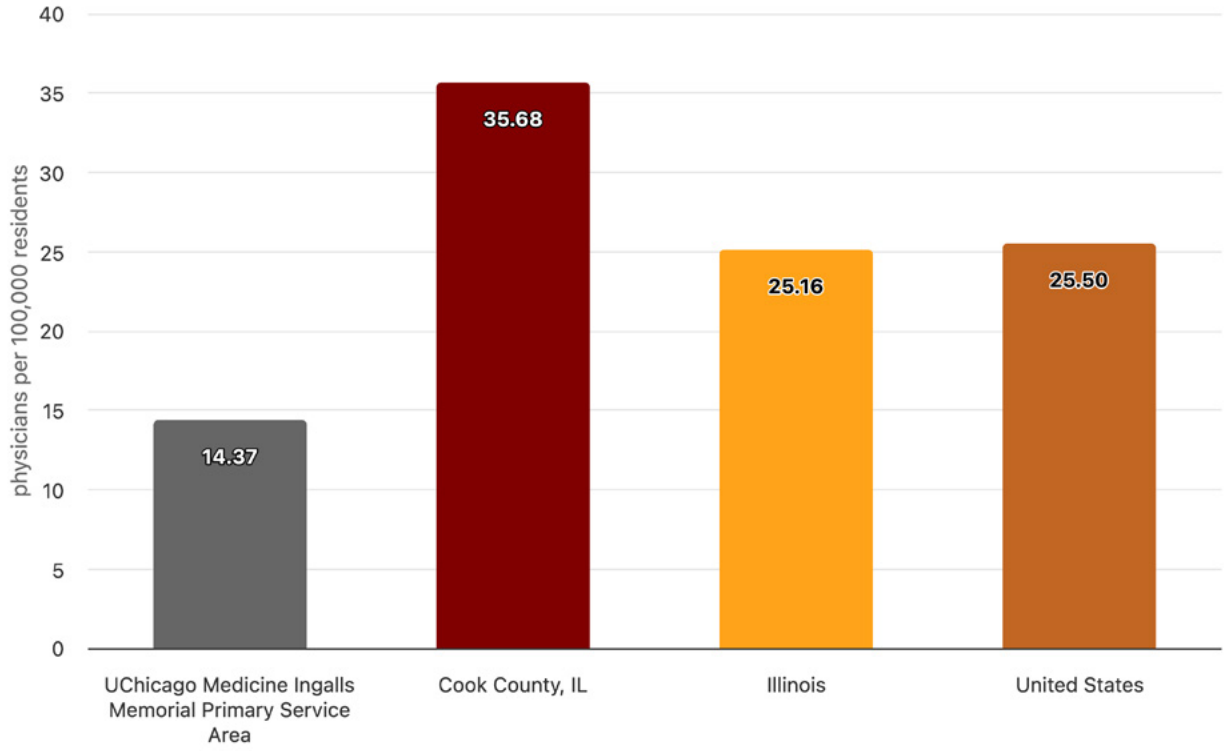
Maternal health is a critical aspect of community health. To improve health outcomes for children and women during pregnancy, childbirth, and the postpartum period, we need better integration of obstetric services to support high-risk patients, the establishment of maternal mortality programs, and the creation of programs like Ingalls Memorial's Healthy Baby Network that provide resources and support to at-risk mothers. The Ingalls Memorial PSA also faces challenges such as maternal care deserts, limited prenatal care, and disparities in maternal mortality rates among different racial groups.

Community members and healthcare providers are actively discussing the strengths and gaps in maternal and child health services. They highlight the successful aspects of existing programs, such as strong maternal health programs and innovative approaches like drive-through baby showers. However, they also point out significant challenges, such as the high proportion of pregnancies with little or no prenatal care and the closure of labor and delivery units in certain areas. The efforts to expand services and improve access to prenatal care and maternal health resources are crucial to addressing these issues.

> "It's almost a labor and delivery desert in the Southland; hospitals are closing these units."
>
> - Maternal, Child and Infant Health Focus Group Participant

OBSTETRICS & GYNECOLOGY PHYSICIANS PER CAPITA

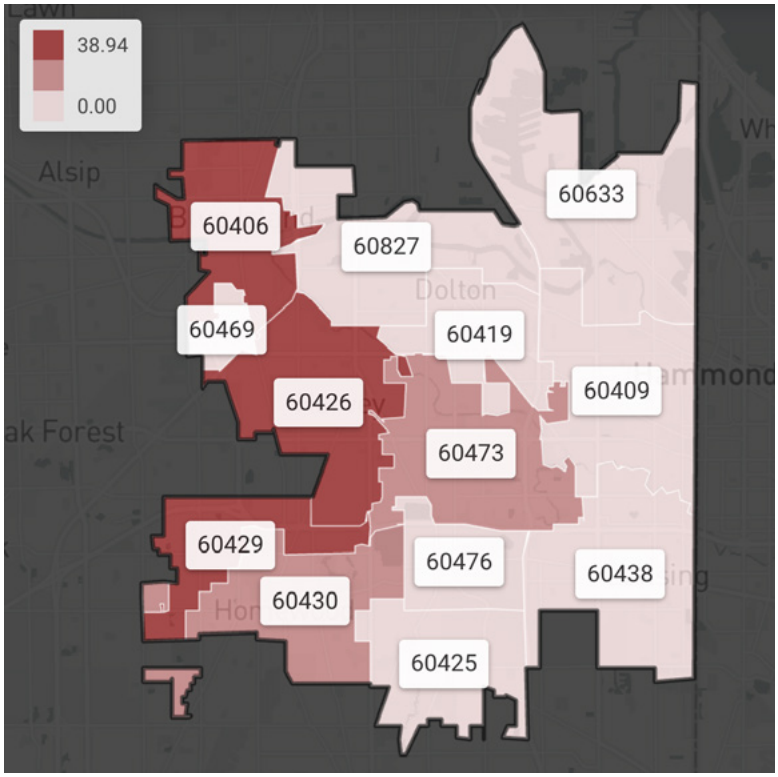
UChicago Medicine Ingalls Memorial PSA and comparison, 2024



Created on Metopio | metop.io/i/as4ps9i5 | **Data source:** Centers for Medicare & Medicaid Services (CMS): National Provider Identifier Files (NPI)

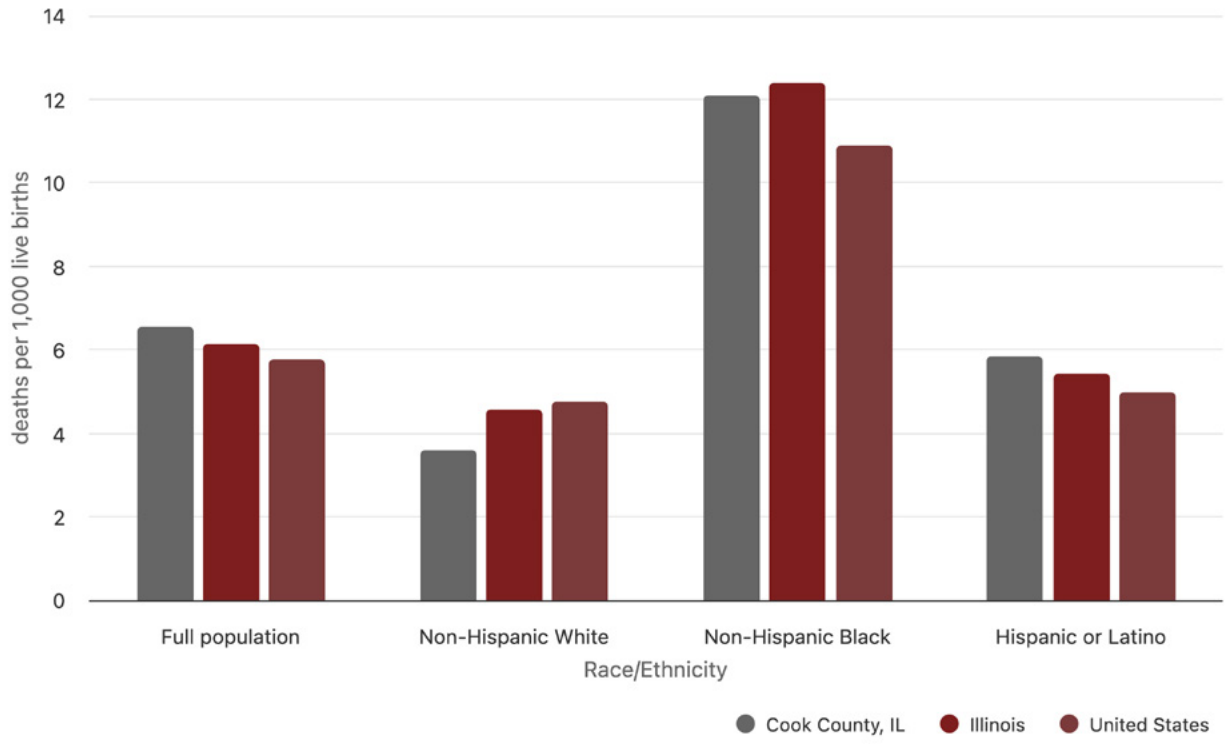
Obstetrics & gynecology physicians per capita: An obstetrician/gynecologist possesses special knowledge, skills and professional capability in the medical and surgical care of the female reproductive system and associated disorders.

The number of obstetrics and gynecology physicians per 100,000 residents in the Ingalls Memorial PSA is lower than the number in Cook County, Illinois, and the United States.



INFANT MORTALITY BY RACE/ETHNICITY

Cook County, IL and comparison, 2015-2019



Created on Metopio | metop.io/i/r9z1f26q | **Data sources:** Health Resources & Services Administration: Maternal and Child Health Bureau (MCHB) (3-year data), Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Natality (NVSS-N) (CDC Wonder; counties
Infant mortality: Rate of postneonatal deaths (in the first year of life). Stratifications by race/ethnicity are of the mother.

Infant mortality rates vary across different racial and ethnic groups, as depicted in the chart. In Cook County, IL, the overall infant mortality rate is 6.56 per 1,000 live births, which is slightly higher than the statewide rate of 6.15 and the national rate of 5.77. The Non-Hispanic Black population experiences the highest infant mortality rate in Cook County, IL, at 12.08.

Behavioral Health

Behavioral health encompasses a range of mental health and substance use issues that significantly affect individuals and communities. In the current context, there are notable challenges in addressing behavioral health, particularly the lack of access to adequate care and the shortage of mental health providers. These challenges are exacerbated by unaddressed SDOH, which hinder individuals' ability to access necessary services. Furthermore, it is crucial to integrate behavioral health services with other community institutions like schools, but these partnerships are still developing.

Focus group participants and key informants noted a growing awareness of and need for behavioral health services within the community. Initiatives to improve access to these services include securing grants, partnering with local institutions, and expanding facilities. However, challenges remain, particularly in emergency departments where behavioral health issues are often treated due to the lack of proper outpatient care.

> "I think mental health is such a huge thing, and I think people are literally crying out for help at this point."
>
> - Key Informant Interview

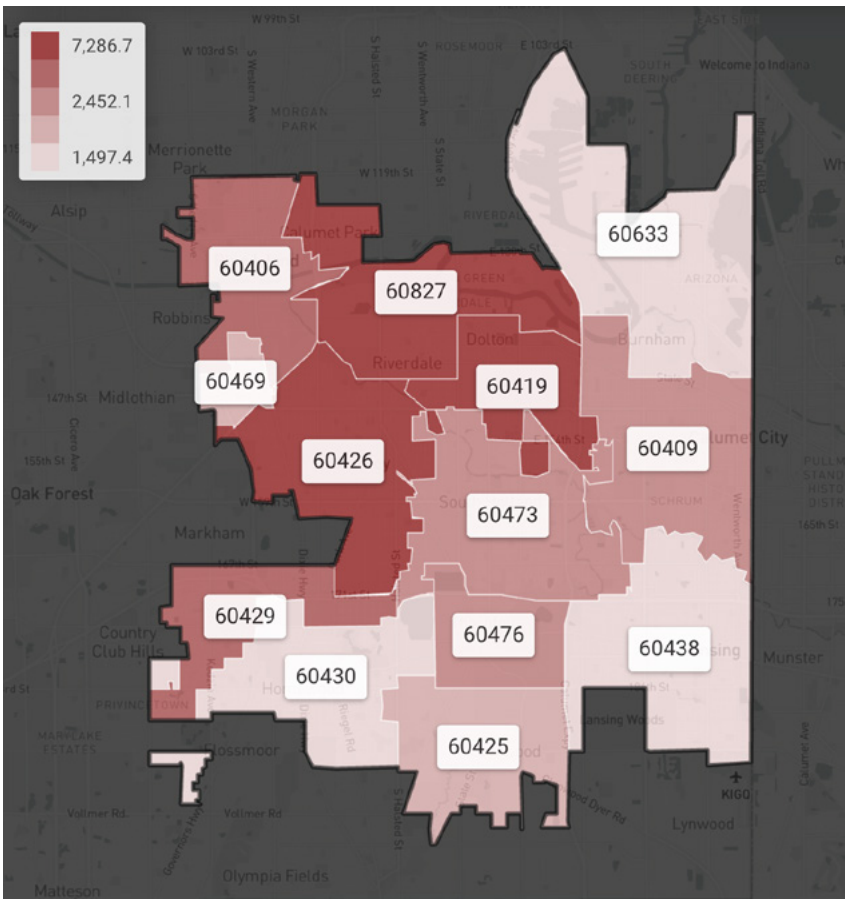
Condition	Ingalls Memorial PSA	Cook County, IL	Illinois
Poor self-reported mental health % of adults	**17.9%**	15.3%	16.1%
Suicide and self-injury emergency department visit rate Per 100,000 residents	**41.1**	45.9	72.0
Behavioral health emergency department visit rate Per 100,000 residents	**3,096.5**	1,761.8	1,625.2
Alcohol use emergency department visit rate Per 100,000 residents	**465.5**	474.9	390.6
Mental health emergency department visit rate Per 100,000 residents	**1,201.3**	805.4	906.3
Substance use emergency department visit rate Per 100,000 residents	**1,895.2**	956.4	718.9

BEHAVIORAL HEALTH EMERGENCY DEPARTMENT VISIT RATE

UChicago Medicine Ingalls Memorial PSA, 2019-2023

The Ingalls Memorial PSA behavioral health emergency department visit rate is higher than the rate in Cook County and Illinois per 100,000 residents.

The rate is highest in the 60827, 60426, and 60419 ZIP codes.

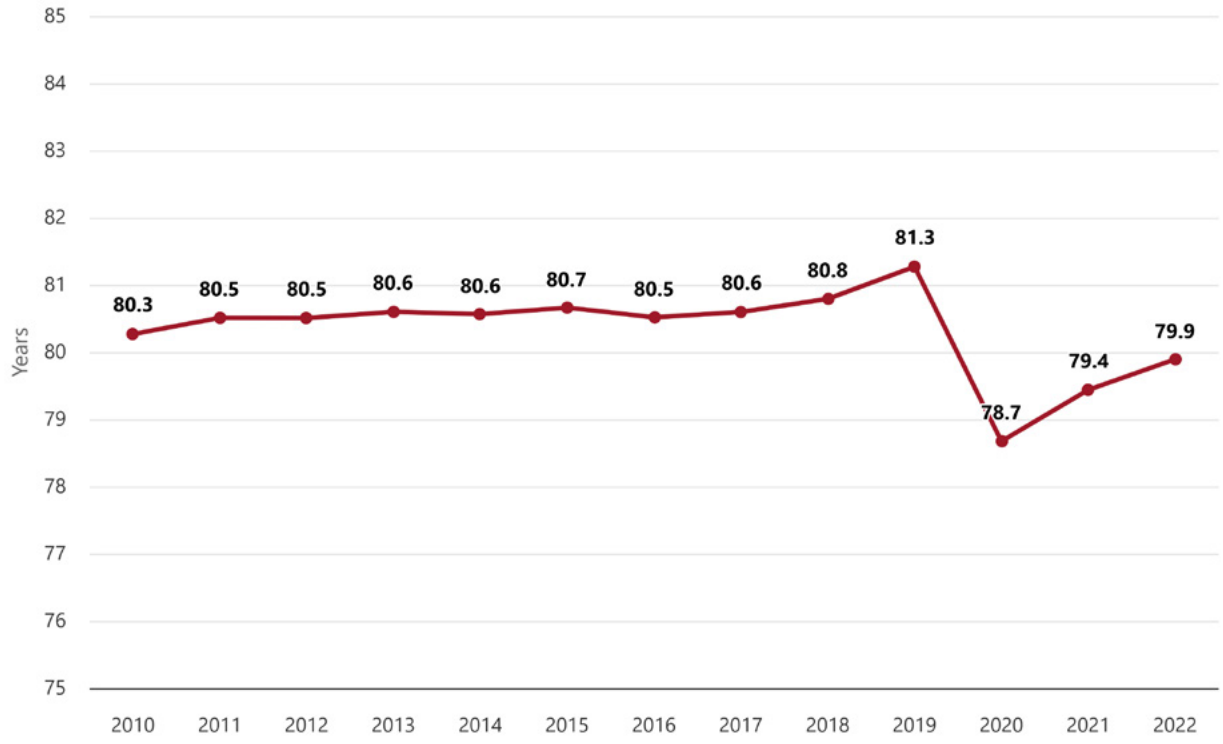


Life Expectancy and Mortality

As shown in the graph below, life expectancy in suburban Cook County experienced a sharp decrease in 2020 but has been increasing since 2021.

LIFE EXPECTANCY

Suburban Cook County, All Time Periods



Created on Cook County Health Atlas | cookcountyhealthatlas.org | **Data source:** Illinois Department of Public Health (IDPH) Vital Records

Life expectancy: The average number of years a person may expect to live.

Conclusion

Prioritization of Health Needs

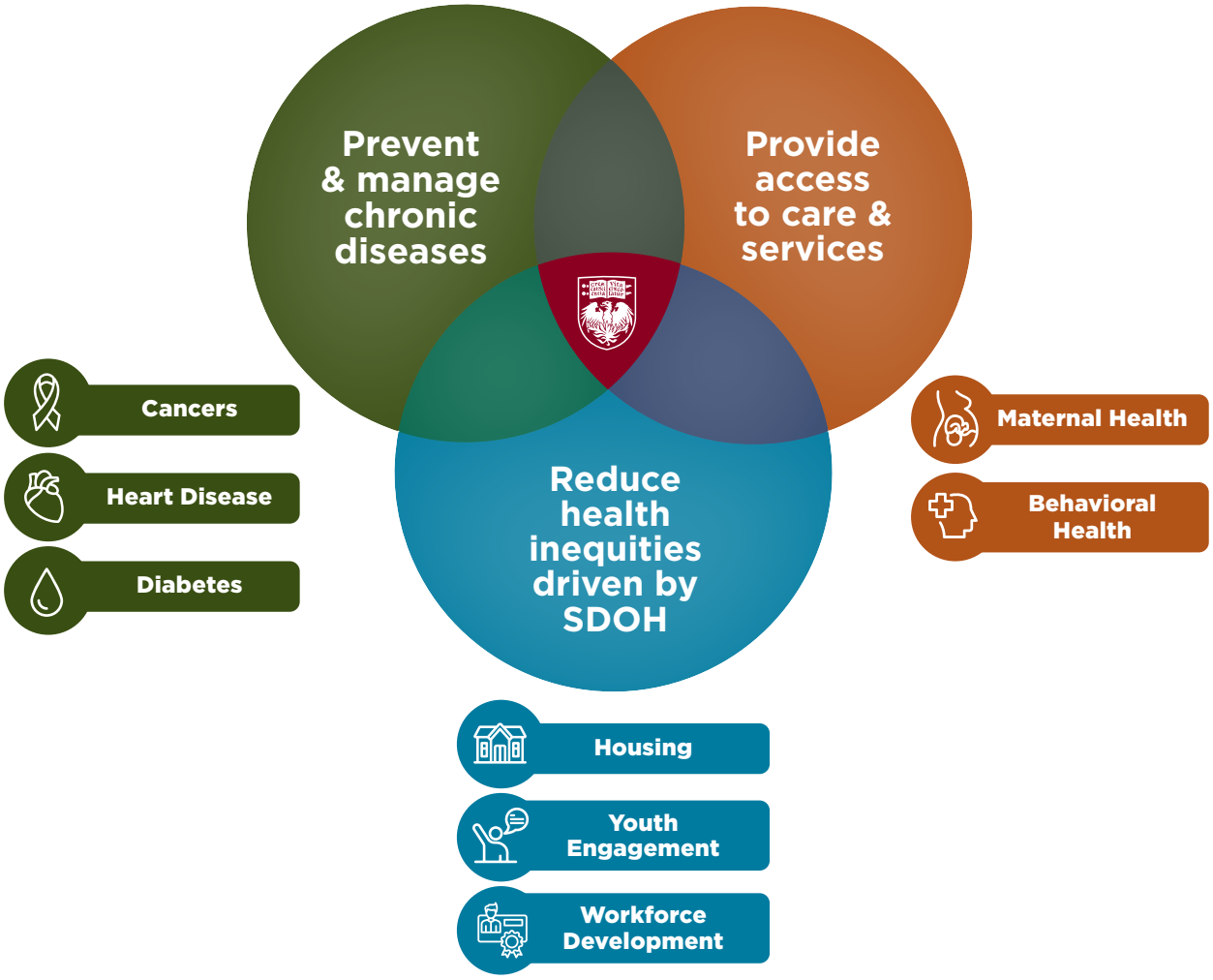
Building on the past four CHNAs, the Community Health Needs Assessment Workgroup collaborated with internal and external stakeholders to prioritize health issues for Ingalls Memorial's community benefit programming for fiscal years 2026 through 2028. These stakeholders were strategically selected for their understanding of community perspectives, community-based health engagement, and community health education efforts.

Using the CHNA as a foundational tool, the process used a multifaceted approach to prioritize health issues.

- **Prioritization:** First, internal and external stakeholders reviewed new data, comparing Ingalls Memorial's PSA health outcome data to health outcome data from prior CHNAs. The health issues that had worse outcomes than previous years were slated for consideration. The group narrowed the priorities down using a multi-voting approach.
- **Refinement:** Next, internal stakeholders reviewed the prioritized health issues, comparing them to the community benefit priorities identified in the previous cycle.
- **Selection**: Lastly, the group defined the proposed priority framework for Ingalls Memorial's next three years of community benefit programming (FY 2026-2028).

The framework for community benefit priorities expanded from the 2021-2022 CHNA. The current priorities are organized into three domains, outlined on the following page.

- Prevent and manage chronic diseases
- Provide access to care and services
- Reduce health inequalities driven by SDOH



This framework matches the 2021-2022 CHNA and includes five of the priority areas from the FY 2023-2025 Ingalls Memorial SIP: heart disease, diabetes, cancers, maternal health, and workforce development. In the FY 2023-2025 SIP, mental health and food insecurity were also selected as priority areas. Access to food remains an overarching factor that affects all health domains. Although it was removed as a priority, Ingalls Memorial will continue its current efforts to address this area. Furthermore, since obesity is linked to some chronic diseases, Ingalls Memorial will address chronic diseases by including strategies that also tackle obesity. This cycle, the mental health priority was broadened to behavioral health to include behaviors and lifestyle factors. The hospital will continue to support existing programs that invest resources toward sustaining positive outcomes.

Safety was a topic of discussion; however, after gathering feedback from various stakeholders, it was not chosen as a priority area. Currently, the hospital lacks sufficient resources, specialized knowledge, and skills to address this issue directly. Nevertheless, safety will be integrated into other priority areas, such as reducing violence through teen programs and workforce development. Additionally, the hospital will support and collaborate with community organizations that effectively address safety concerns whenever feasible.

These three domains and eight corresponding priorities will serve as the designated issue areas for official reporting and are the principal concerns that Ingalls Memorial's community benefit efforts will target. They are the result of rigorous data collection and analysis in partnership with the community. These domains represent a coordinated strategy to create long-term health and prosperity in the community.

Next Steps

The results of this CHNA will be used to develop and refine health policy, programs, and partnerships that are responsive to the identified needs, ensuring that Ingalls Memorial continues to be a powerful promoter of health equity and quality of life in the community.

Following the publishing of the CHNA report, Ingalls Memorial will advance efforts to align and integrate the many voices and ideas heard during the data collection and analysis process. Ingalls Memorial will engage and collaborate with the community partners on the development of the FY 2026-2028 SIP. By maintaining a commitment to an evidence-based approach and community engagement, Ingalls Memorial will strive to exceed the health expectations of those it serves.

Adoption by the Board

UChicago Medicine Board of Directors Government and Community Relations Committee received the 2024-2025 CHNA report, FY 2023-2025 Evaluation Report, and FY 2026-2028 SIP for review and formally approved all documents in May 2025.

Appendix 1

Community Resources in the Hospital's Primary Service Area

Ceda Center for Community Action
53 E 154th St.
Harvey, IL 60426
708-339-3610

Thornton Township Food and General Assistance Center
15340 Page Ave.
Harvey, IL 60426
708)-596-6040

Family Christian Health Center
31 W. 155th St.
Harvey, IL 60426
708-596-5177

The Cancer Support Center
2028 Elm Road
Homewood, IL 60430
708-798-9171

Restoration Ministries, Inc.
253 E. 159th St.
Harvey, IL 60426
708-333-3370

Aunt Martha's Harvey Health Outreach Center
15420 Dixie Hwy.
Harvey, IL 60426
877- 692-8626

Anew
P.O. Box 937
Homewood, IL 60430
708-794-2140
Hotline number: 708-335-3028

You Matter 2
2218 Hutchison Road
Room 22
Flossmoor, IL 60422
708-996-0871

Harvey Neighborhood Network
CO: Restoration Ministries
253 E. 159th St.
Harvey, IL 60426
www.harveyneighborhoodnetwork.org

TSA Health
13336 S Baltimore Ave.
Chicago, IL 60633
773-995-6300

Christian Community Health Center
364 Torrence Ave.
Calumet City, IL 60409
773-233-4100

Christian Community Health Center
901 Sibley Blvd.
South Holland, IL 60473
773-233-4100

Appendix 2

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

Community Benefit Evaluation Report

FY 2023-2025

Table of Contents

Introduction

UChicago Medicine Ingalls Memorial Hospital (Ingalls Memorial) has a long history of community-based programming designed to improve the health and vitality of residents living within the Ingalls Memorial Primary Service Area (PSA) in the South Suburbs of Chicago.

Ingalls Memorial has focused its efforts on specific community benefit priority areas informed by the **Community Health Needs Assessment (CHNA)** and its **Strategic Implementation Plan (SIP)**.

Evaluation Report Purpose

This report looks back on Ingalls Memorial's collective efforts to address each community benefit priority area from the previous CHNA cycle. It provides a comprehensive summary of the work Ingalls Memorial and community partners undertook to address the 2021-2022 CHNA community benefit priority areas, as outlined in the FY 2023-2025 Ingalls Memorial SIP.

Ingalls Memorial recognizes that achieving community-level impact requires collaboration with the community and its people. Ingalls Memorial includes community partners at every phase of program development and implementation, ensuring community health programming centers the voices of those served.

This report demonstrates Ingalls Memorial's reach and impact across its PSA, learning from the experience and strategies implemented over the past three years or more. Although there are limitations in quantifying impact (e.g., program turnover, inconsistent program reporting, adaptations of programs), Ingalls Memorial has included key process and outcome measures as a snapshot of the collective impact on the Ingalls Memorial PSA community benefit priority areas.

Ingalls Memorial's Primary Service Area

Ingalls Memorial's PSA focuses on the 13 ZIP codes of Thornton Township. The Ingalls Memorial PSA includes the following cities/municipalities: the Harvey, Riverdale, Dolton, Dixmoor, Phoenix, Hazel Crest, East Hazel Crest, Markham, Homewood, Burnham, Hegewisch, and South Deering communities of Chicago, as well as Posen, South Holland, Calumet City, Lansing, Glenwood, Blue Island, Calumet Park, and Thornton.

INGALLS MEMORIAL PRIMARY SERVICE AREA

ZIP Codes and Cities/Municipalities

60406
Blue Island
Dixmoor
Riverdale
Posen

60409
Calumet City
Lansing
Burnham

60419
Dolton

60425
Glenwood

60426
Harvey
Dixmoor
Markham
Phoenix

60429
Hazel Crest
Harvey
East Hazel Crest
Markham

60430
Homewood
Hazel Crest
Thornton

60438
Lansing

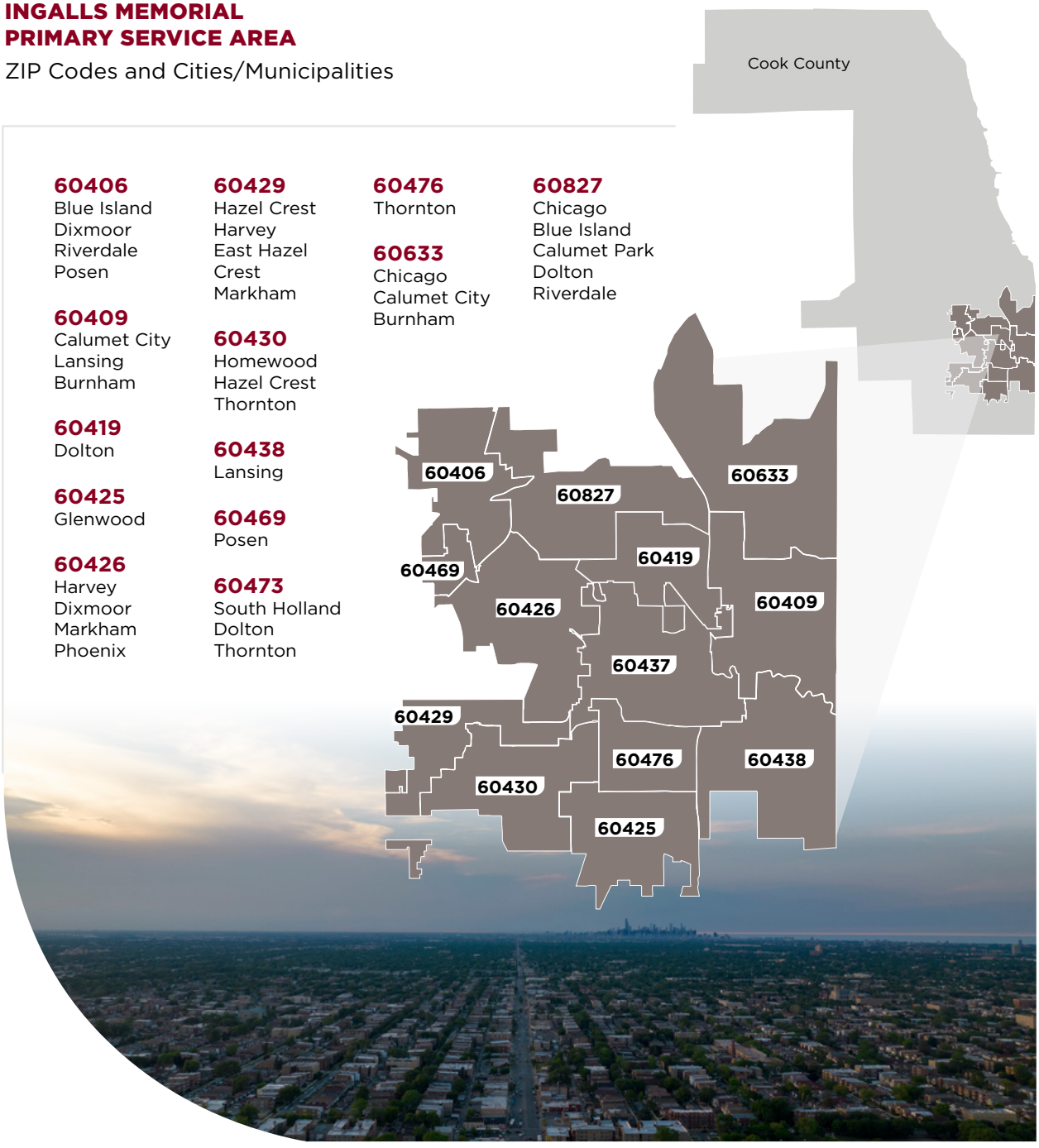
60469
Posen

60473
South Holland
Dolton
Thornton

60476
Thornton

60633
Chicago
Calumet City
Burnham

60827
Chicago
Blue Island
Calumet Park
Dolton
Riverdale



Looking Back: Community Benefit Priority Areas for FY 2023-2025

Ingalls Memorial identified **seven community benefit priority areas** to focus on during FY 2023-2025: Heart Disease, Diabetes, Cancers, Maternal Health, Mental Health, Food Insecurity, and Workforce Development.

To maximize impact and recognize intersecting strategies, these were further organized under three domains:

- Prevent and manage chronic diseases
- Provide access to care and services
- Reduce inequities caused by Social Determinants of Health (SDOH)*

Prevent and manage chronic diseases	Provide access to care and services	Reduce inequities caused by Social Determinants of Health
Heart Disease	Maternal Health	Food Insecurity
Diabetes	Mental Health	Workforce Development
Cancers		

**Social Determinants of Health (SDOH) are non-medical factors that influence a person's health and well-being. To learn more about SDOH, see Drivers of Health Inequities on page 24 of the Ingalls Memorial 2024-2025 CHNA.*

Evaluation Report Methods

This report compiles qualitative and quantitative data collected from a wide array of stakeholders, including data from community benefit grantees, program operations and evaluation data, and community event logs.

Report Data Sources

Identified programs and services shared process and outcome metrics that demonstrated progress toward Ingalls Memorial's goals. Programs addressing community benefit priority areas internally, as well as those implemented by partner organizations, were required to incorporate one or more strategies listed in the FY 2023-2025 Ingalls Memorial SIP, which allowed the CHNA workgroup to aggregate specific results across all programs.

Because of the varied program structures and approaches, the workgroup defined two areas under which to organize data sources and reporting mechanisms. This helped demonstrate comprehensive impact in the Ingalls Memorial PSA.

Community-based partners
Community based programs provide data on progress towards goals and objectives. These data include process and outcome level measures, often captured through activity logs, standard or customized designed reporting templates, surveys, and qualitative reports

Ingalls Memorial departments and programs
Multiple Ingalls Memorial department staff collaborate with internal stakeholders to track program activities and services, capturing process-level data.

The CHNA workgroup organized data from identified programs and services, aggregated them under corresponding priority health domains, and reported the aggregate results to demonstrate impact.

Report Development

Using the process outlined on the previous page, the CHNA workgroup was able to evaluate the breadth and impact of initiatives on the FY 2023-2025 community benefit priority domains and their areas of focus.

For established or completed programs, this report includes both process and outcome measures. For ongoing or early-stage programs, it includes process measures. Unless a statistical test is noted, outcome measures (change in knowledge or behavior) presented are pre-post percent changes for which statistical significance cannot be assessed.

Report Findings

Prevent and Manage Chronic Diseases

Building on the FY 2023-2025 Strategic Implementation Plan (SIP) and prior SIPs, Ingalls Memorial continued to collaborate with community-based organizations and community health centers to implement programs that addressed chronic diseases. Ingalls Memorial focused its efforts on the following chronic diseases: **diabetes, heart disease, and cancers.**

Goal: **Reduce the impact of heart disease, diabetes, and cancers by increasing focus on prevention, treatment, and support**

Strategies:

1. ***Increase community education activities that focus on heart disease, diabetes, and cancer prevention and screenings.***

   Leverage existing programs and resources, including Community Health Workers and internal clinical staff, to provide education on managing and preventing chronic diseases.

2. ***Increase opportunities, via partnerships, for in-person and/or virtual events that support the prevention and management of chronic diseases.***

   Leverage the Ingalls Memorial Dietetic Internship program, the Ingalls Memorial Community Impact Grant Program, and community partner organizations to provide community-based education and/or programming that addresses heart disease, diabetes, and cancer prevention and management.

3. ***Expand access to primary care medical homes.***

   Expand existing programming and resources, like Community Health Workers, to help people connect to primary care homes and tackle identified barriers to care.

Chronic Disease Programs

INGALLS MEMORIAL CANCER CARE AND RESEARCH

Cancer remains a leading health concern within the Ingalls Memorial PSA, highlighting the need for more awareness, early detection, and prevention. Many cancers, like lung, breast, colon, and prostate, can be reduced through risk factor education and regular screenings, but barriers such as limited access to care, cost, and low awareness create inequities in early diagnosis and treatment.

Ingalls Memorial has focused on community initiatives that raise cancer awareness, promote healthy habits, and link residents to research, screening, and treatment services. Working with healthcare and community partners, the team of dedicated staff aims to reduce cancer incidence and improve health outcomes through targeted education, screening events, and advocacy efforts. These efforts align with national guidelines to ensure individuals receive timely information and access to life-saving preventive services.

Strategy 1: *Increase community education activities that focus on heart disease, diabetes, and cancer prevention and screenings.*

Strategy 2: *Increase opportunities, via partnerships, for in-person and/or virtual events that support the prevention and management of chronic diseases.*

Results

In 2023, Ingalls Memorial supported two major cancer events to educate and empower the community. Ingalls Memorial collaborated with Covenant United Church of Christ, in partnership with the American Cancer Society, to host *The Cancer Symposium: A Day of Healing, Health, and Hope*. The event welcomed over 150 attendees and focused on early detection, lifestyle modifications, and the latest screening recommendations. Participants discussed smoking cessation, physical activity, weight management, and other preventive measures.

Later in 2023, Homewood Farmers Market hosted a breast cancer screening event, providing critical screening services with on-site 2D and 3D mammograms. Ingalls Nurse Navigators also educated attendees and assisted with follow-up care, bridging gaps in accessibility and affordability. In 2024, Ingalls Memorial held three additional events with partners. This work ensured residents connected with screening opportunities, ongoing clinical trials, and essential cancer care resources.

Through these five events, Ingalls Memorial strengthened community engagement, increased access to screenings, and reinforced the importance of early detection. By prioritizing education and preventive care, the hospital continues to advance its mission of reducing cancer disparities and improving health outcomes in the Ingalls Memorial PSA.

2 events hosted in 2023, including a Cancer Symposium focused on early detection, healthy lifestyles, and cancer prevention with 150 attendees and the Homewood Farmers Market Breast Cancer Screening with 2D and 3D mammograms, nurse navigation, and follow-up support.

3 events hosted in 2024 focused on cancer risk factor education, advances in detection and treatments, and behavioral strategies for prevention, reaching 343 total attendees.

Collaborating organizations included Robert H. Lurie Cancer Center, UIC Cancer Center, Covenant United Church of Christ, Barbara W. Smith Family of Life Center, and the American Cancer Society.

*Data Timeframe: July 1, 2022 – December 31, 2024

Community Affairs Department
BETTER2KNOW BRUNCH: BREAST & LUNG SCREENING EVENT

In November 2024, the Community Affairs department hosted the Better2Know Brunch event to increase access to free cancer and health screenings. Held in partnership with local organizations and the Ingalls Memorial Cancer Care and Research department, the event created a welcoming space for attendees to connect with health resources and take proactive steps toward wellness.

Strategy 1: *Increase community education activities that focus on heart disease, diabetes, and cancer prevention and screenings.*

Strategy 2: *Increase opportunities, via partnerships, for in-person and/or virtual events that support the prevention and management of chronic diseases.*

Results

15 community members attended

2 mammogram appointments scheduled

9 on-site HIV and glucose screenings given

*Data Timeframe: July 1, 2022 – December 31, 2024

Community Affairs Department
PHYSICAL ACTIVITY SERIES

The Ingalls Memorial Community Affairs department also hosted a series of physical activity events to help community members prevent and manage chronic diseases. These physical activity events aimed to improve cardiovascular health, support weight management, and support diabetes management.

Strategy 2: *Increase opportunities, via partnerships, for in-person and/or virtual events that support the prevention and management of chronic diseases.*

Results

21 physical activity events offered in person and virtually

Event exercise activities included cardio drumming, hip hop cardio, walking club, virtual hip hop cardio party, virtual cardio dance, sunrise stretch online yoga, and tone and release.

*Data Timeframe: July 1, 2022 – December 31, 2024

COMPLIMENTARY NUTRITION STATION PROGRAM

The Complimentary Nutrition Station Program at Ingalls Memorial helps address food insecurity among oncology patients and community members affected by a cancer diagnosis who face barriers to care. This program provides free, nutritious food to patients and their families, recognizing the vital link between nutrition and health during treatment and recovery.

To better support those with limited transportation, the **Food Brigade Program** launched in October 2023, delivering groceries directly to patients' homes. Additionally, for nearly three years, the program has collaborated with the American Cancer Society to receive 60 easily microwaveable Factor meals weekly. These meals are distributed to treatment patients and others facing food insecurity, offering a convenient and nutritious solution for those with limited food access.

Strategy 2: *Increase opportunities, via partnerships, for in-person and/or virtual events that support the prevention and management of chronic diseases.*

Results

6,157 individuals served through Complimentary Nutrition Stations

38,750 pounds of food distributed

Launched the Food Brigade program in October 2023 to deliver groceries and Factor microwaveable meals to patients and families

*Data Timeframe: July 1, 2022 – December 31, 2024

Dietetic Internship Community Talks (DICT)
DIETETIC INTERNSHIP PROGRAM

The Ingalls Memorial Dietetic Internship Program has provided supervised practice experience to dietetic interns pursuing their licensure for more than 40 years. Over the 18-month program, interns must complete 1,236 supervised practice hours and offer request-based community talks called “Nutrition to Go.” Interns present interactive, informative sessions on a variety of food and nutrition topics.

Strategy 1: *Increase community education activities that focus on heart disease, diabetes, and cancer prevention and screenings.*

Strategy 2: *Increase opportunities, via partnerships, for in-person and/or virtual events that support the prevention and management of chronic diseases.*

Results

15 community talks hosted on topics like nutritional needs for chronic illness and nutritional literacy

600+ community members reached

Established Nutrition to Go partner sites at libraries, churches, community centers, and local country clubs

86.4% of survey respondents were satisfied with the information delivered

81.2% of survey respondents reported that they were more likely to improve their eating behaviors after attending a talk

*Data Timeframe: July 1, 2022 – December 31, 2024

LIAISONS IN CARE COMMUNITY HEALTH WORKER PROGRAM (LINC)

The Liaisons in Care Community Health Worker (LinC) Program at Ingalls Memorial addresses health inequities by hiring Community Health Workers (CHWs) to improve patient care across Chicago's Southland region. CHWs serve as trusted connectors, helping Ingalls Memorial patients navigate the healthcare system, manage chronic conditions, and access critical SDOH resources such as food, housing, and transportation.

CHWs play an essential role at Ingalls Memorial, serving asthma and cardiology patients. As part of a patient's care team, CHWs link patients to continued care and SDOH resources, facilitating access to services and advocating for quality patient care.

Strategy 1: *Increase community education activities that focus on heart disease, diabetes, and cancer prevention and screenings.*

Strategy 3: *Expand access to primary medical homes.*

Results

83 cardiology patients enrolled LinC

32 asthma patients enrolled in LinC

*Data Timeframe: July 1, 2022 – December 31, 2024

CHOOSE HEALTHIER, BALANCE YOUR LIFE: WELLNESS PROGRAM

The Choose Healthier, Balance Your Life program launched in June 2024 to promote healthier lifestyles and support chronic condition management among residents of Thornton Township. The program focused on increasing access to wellness resources, building participants' health knowledge and skills, and fostering a supportive environment for sustained lifestyle changes. Program topics included behavioral health, fitness, and chronic disease management, with a specific emphasis on heart disease and diabetes.

Strategy 1: *Increase community education activities that focus on heart disease, diabetes, and cancer prevention and screenings.*

Strategy 2: *Increase opportunities, via partnerships, for in-person and/or virtual events that support the prevention and management of chronic diseases.*

Results

13 participants in workshops and monthly telehealth coaching

4 specialized presentation sessions

Free fitness opportunities and incentives, including blood pressure cuffs, wellness journals, and affirmation t-shirts

On average, participants lost **9.8 lbs** through the program

100% satisfaction ratings for the program across all participants

*Data Timeframe: June - October, 2024

Provide Access to Care and Services

Building upon the 2020-2022 and 2023-2025 SIPs, Ingalls Memorial continued community-based collaborations and internal programming to address prenatal care, education, and access. Community outreach programming included enrolling patients in the Healthy Baby Network, a unique network of local health care providers, retailers, government agencies, schools, and community organizations that work together to coordinate prenatal care, education, and social services for pregnant women. Ingalls Memorial also worked to improve access to mental health care services in the Southland.

Goal: Increase access to maternal and mental health services in the Southland

Strategies:

1. Increase the number of individuals who have access to maternal and mental health services.

- Provide no-cost mental health and maternal health training and educational materials to the community.
- Identify community partners who provide mental health services and resources.

2. Reduce the number of individuals who present to the ED with unaddressed mental health needs.

Increase community screenings and referrals to mental health services.

3. Reduce the number of pregnant individuals who present to the ED and are discharged without prenatal resources.

Increase outreach to at-risk populations to link them to maternal and mental health services and resources.

Maternal and Mental Health Programs

HEALTHY BABY NETWORK (HBN)

The Healthy Baby Network (HBN) is managed by Ingalls Memorial and partially funded by the Ingalls Memorial Development Foundation. This community outreach program includes a unique network of local healthcare providers, retailers, government agencies, schools, and community organizations that work together to coordinate prenatal care, education, and social services for pregnant women. HBN is a no-cost service, and each patient is assessed for programs that provide medical, nutritional, and/or financial assistance. Qualifying patients are enrolled in public benefits and provided support by HBN's dedicated coordinator.

Strategy 1: *Increase the number of individuals who have access to maternal and mental health services.*

Results

266 patients accessed maternal health services

31 outreach activities were conducted

3,500 educational materials were given to patients

138 referrals were made

31 maternal health training sessions were conducted

97% of referred patients successfully accessed prenatal care services

*Data Timeframe: July 1, 2022 – December 31, 2024

BEHAVIORAL HEALTH DEPARTMENT

The Behavioral Health department at Ingalls Memorial is committed to bridging the gap between mental health services and the community. The department provides education, outreach, and direct engagement with the community to reduce stigma, increase awareness, and connect individuals to essential resources. In response to growing community interest in mental health education and services, the department developed the **"Behavioral Health in the Community"** program to provide accessible information and support. Beyond education, the department remains committed to offering outpatient services and resources and strengthening partnerships with local organizations to enhance mental health support.

Strategy 1: *Increase the number of individuals who have access to maternal and mental health services.*

Results

Attended **45** community events, including community tabling, educational workshops, speaking engagements, and direct consultations

*Data Timeframe: July 1, 2022 – December 31, 2024

COMMUNITY AFFAIRS DEPARTMENT

The Community Affairs department at Ingalls Memorial fosters strong relationships with community organizations and residents. Through strategic partnerships and programming, the department supports activities and events aligned with the SIP. These initiatives enhance community well-being by addressing critical health topics, with a particular emphasis on mental health and wellness. Through these initiatives, the Community Affairs department has provided education and resources to support emotional resilience and stress management and has encouraged open conversations about reducing mental health stigma and promoting proactive wellness practices.

Strategy 1: *Increase the number of individuals who have access to maternal and mental health services.*

Results

Organized **6** major events to address mental health and wellness needs in the community

Event topics included:
- Stress Less, Live More – For Women Only
- Health and Wellness Fair
- Put Yourself on Your "To Do" List
- Work/Life Balance: Is This a Myth?
- Mental Health Spring Series
- Hour of Power: Mental Wellness Post COVID-19
- Self-Care is Essential
- Mental Well-Being: It's Okay Not to be Okay

*Data Timeframe: July 1, 2022 – December, 2023

Reduce Inequities Caused by Social Determinants of Health (SDOH)

During this cycle, Ingalls Memorial addressed specific SDOH barriers through initiatives that enhance food security and economic opportunity. Efforts include facilitating programs that connect individuals to food resources and job opportunities, strengthening community partnerships, and aligning efforts with Ingalls Memorial's community health improvement plans.

Additionally, SDOH-related services are woven throughout other priority areas—for example, the Complementary Nutrition Station provides food items to cancer patients, and programs such as Dietetic Community Talks offer education on healthy eating.

Goal: Reduce inequities caused by SDOH, focused on food access and workforce development

Strategies:

1. ***Demonstrate innovative programs and services that support both food access points and workforce development opportunities.***
   - Identify the need for food access through screenings and refer those in need to services.
   - Improve access to healthy food.

2. ***Foster relationships with community partners and external stakeholders to address food access and workforce development.***
   - Increase local hiring.
   - Develop regular communication with emergency feeding programs in the Ingalls Memorial PSA.

3. ***Create collected plans with internal and external stakeholders that support the execution of Ingalls Memorial's community health improvement plans.***
   - Develop career advancement plans for employees.
   - Develop plans to partner with community organizations to provide workforce development and hiring opportunities.

SDOH Programs

COMMUNITY SCHOLARSHIPS

Community Scholarships is a program funded by the Ingalls Memorial Development Foundation in collaboration with Thornton Township. It provides scholarships to graduating high school seniors and university students. Additionally, the foundation supports scholarships for Ingalls Memorial employees and their children, reinforcing its investment in the community, since many recipients also reside within the Ingalls Memorial PSA. By funding essential healthcare services and educational opportunities, the Ingalls Memorial Development Foundation continues to advance its mission of improving the health and prosperity of the community it serves.

Strategy 1: *Demonstrate innovative programs and services that support both food access points and workforce development opportunities.*

Strategy 2: *Foster relationships with community partners and external stakeholders to address food access and workforce development.*

Results

$95,050 in scholarships awarded to 105 community members

$105,850 awarded to 173 children of Ingalls Memorial employees

Since the program's inception in 2001, Ingalls Memorial Development Foundation has invested over **$3.29 million** in scholarships, supporting more than 2,000 students pursuing higher education

*Data Timeframe: Fall 2022 - Fall 2024

WORKFORCE DEVELOPMENT

The Ingalls Memorial Development Foundation has invested over $20,000 in the workforce development initiative, reinforcing its mission to create sustainable economic and career pathways for local students and residents. Three students from Thornton High School District 205 became the first cohort to complete a workforce development internship program at Ingalls Memorial. This initiative, designed to provide hands-on experience and career exposure, reflects the foundation's commitment to strengthening the local workforce pipeline.

Strategy 1: *Demonstrate innovative programs and services that support both food access points and workforce development opportunities.*

Strategy 2: *Foster relationships with community partners and external stakeholders to address food access and workforce development.*

Results

3 students became the first cohort to complete a workforce development internship program, gaining hands-on experience and career exposure

*Data Timeframe: Fall 2022 - Fall 2024

Community Impact Grants

The Community Impact Grant program at Ingalls Memorial supports local organizations tackling key health and SDOH needs in Chicago's Southland region. Since 2022, these grants have funded innovative, community-led initiatives focused on chronic disease prevention, food insecurity, youth development, access to care, and violence prevention.

Grantees, including health centers, schools, advocacy groups, and service agencies, have provided services like fresh produce distribution, cancer screenings, youth mentoring, and transportation for justice-involved youth. Many partnerships have continued over multiple grant cycles, showing lasting impact and strong community support.

The following programs received funding between 2022 and 2024:

Barbara W. Smith Life Center

Total Awarded: $15,000 (2022)

The Barbara W. Smith Life Center is dedicated to enriching the lives of young people, adults, and seniors in South Suburban Cook County. In collaboration with Black farmers, the Center **distributed over 350 cancer care bags** containing fresh vegetables to community members affected by cancer. The program also provided gift cards for food and transportation, and offered free nutrition, cooking, and physical activity classes to support individuals battling cancer.

Cancer Support Center

Total Awarded: $68,000 (2022–2024)

The Cancer Support Center's program builds on the *Kick It Cancer* initiative, expanding its reach to further address the cancer crisis in the Ingalls Memorial PSA. Leveraging insights from *Kick It Cancer*, the program continues its focus on barriers to cancer prevention and treatment, such as fear, limited awareness, and inadequate access to care. It uses a multifaceted strategy that includes outreach, education, and support for those affected by cancer, aiming to reduce cancer-related health inequities and improve survival outcomes.

Cook County Southland Juvenile Justice Council

Total Awarded: $5,000 (2023)

The Cook County Southland Juvenile Justice Council collaborated with local police, school districts, and probation departments to implement diversion programs for young people. The grant provided safe transportation for justice-involved youth to access restorative justice programs, youth employment initiatives, and other community-based programs aimed at personal and professional growth.

South Suburban PADS – The Emergency Shelter Program

Total Awarded: $50,000 (2023–2024)

South Suburban PADS is dedicated to preventing and ending homelessness in Chicago's south suburbs. Their *Emergency Shelter Program* provided secure overnight lodging, free meals prepared by volunteers, case management, transportation assistance, and other supportive services to unhoused individuals and families.

Thornton Township High School – Urban Farming Program

Total Awarded: $10,424 (2022)

Launched in 2015, the *Thornton Urban Farmers* program teaches students basic agricultural skills to promote food sovereignty, build community, increase biodiversity, and enhance self-reliance. The initiative ensures democratic access to healthy food choices and addresses issues related to food deserts as a means to manage chronic diseases.

TCA Health – Fresh Rx Program

Total Awarded: $50,000 (2023–2024)

The *Fresh Rx Program* through TCA Health addresses food insecurity and chronic illness by delivering monthly boxes of healthy food to 100 medically at-risk seniors and individuals living with diabetes, hypertension, and other food-related health conditions. The program also aims to influence health outcomes through nutrition education and care coordination.

Your Career Tapestry

Total Awarded: $50,000 (2023–2024)

Your Career Tapestry is a nonprofit organization dedicated to helping young people reach goals, foster meaningful relationships, and expand opportunities through a variety of programs and services. Focusing on under-resourced students ages 12–19, the program teaches young people skills to successfully navigate high school and make informed decisions about future education and career options. The program emphasizes both academic achievement and career exploration.

KidFest

Total Awarded: $87,014 (2022–2024)

KidFest is an annual community event hosted by Ingalls Memorial that provides free physical exams, vaccinations, and health resources to school-aged children as they prepare for the upcoming school year. In partnership with Family Christian Health Center and other community organizations, KidFest helps reduce barriers to care in a fun, family-friendly environment. This annual event continues to grow in its impact, supporting health equity by making essential services accessible to underserved families.

Conclusion

UChicago Medicine Ingalls Memorial is committed to working with local partners to address the needs of the broader Southland community. By actively listening to community members in the PSA, Ingalls Memorial will continue to address priority health needs and strengthen its existing services to ensure residents receive the highest quality of care. Ingalls Memorial will monitor each program regularly and adjust its programming accordingly. Plans for the next three years of Ingalls Memorial community benefit programming are outlined in the Ingalls Memorial FY 2026–2028 Strategic Implementation Plan.

Appendix 3

Community Input Survey

Community Health Needs Survey

Welcome to the Community Health Needs Survey for the UChicago Medicine Ingalls Memorial

This survey will only take about 5 minutes. We will ask you questions about the health needs of your community.

The information from the survey will help us:

- Find health problems that affect the people in our community
- Better understand the needs for our community
- Work together to find a solution

The survey is voluntary and you do not have to take part. You can also skip any questions you do not want to answer or stop the survey at any time.

The answers you give are very important to us. **Your answers will be private** (we will not know who gave the answers) and we will protect the information you are giving.

Your Information	
Your home zip code:	How many years you lived here:
What town or neighborhood do you live in?	

What do you like best about where you live? (List up to 3 things)
1.
2.
3.

Community Health Needs Survey

Community Health Problems

What do you see as the **most important health problems** in your area? Choose up to 5. **Make an X next to your 5 choices.**

	Abuse such as child abuse, emotional abuse, physical abuse, neglect, sexual assault, domestic violence, intimate partner violence
	Access to healthy food items
	Age-related illness such as arthritis, hearing or vision loss, Alzheimer's or dementia
	Cancers
	Chronic pain
	Dental disease
	Diabetes (high blood sugar)
	Family planning (birth control)
	Heart disease, hypertension (high blood pressure), and stroke
	Homelessness and housing
	Lung disease such as asthma or chronic obstructive pulmonary disease (COPD)
	Mental health such as depression, anxiety, suicide, post-traumatic stress disorder (PTSD)
	Mother and infant health
	Obesity
	Racism and other discrimination
	Sexually Transmitted Infections (STIs and STDs), including Human Immuno-deficiency virus (HIV) and acquired immuno-deficiency syndrome (AIDS)
	Substance-use such as alcohol, tobacco, prescription misuse, and other drugs
	Stress
	Violence such as community violence, homicide, aggravated assault, shootings and car jackings
	Other: Please give example

Community Health Needs Survey

Questions About Community

What do you think are the **most important things for a healthy community?**
Check up to 5 choices.

- ☐ Activities for teens and youth
- ☐ Affordable childcare
- ☐ Affordable healthy foods such as fresh fruits and vegetables
- ☐ Affordable housing
- ☐ Arts and cultural events
- ☐ Cancer screening (testing) and ways to lessen risk for cancer such as mammogram, colonoscopies, Pap smears, or HPV vaccine
- ☐ Clean streets and neighborhood
- ☐ Community services such as resources for housing
- ☐ Fitness (gym or place to work out)
- ☐ Getting good services no matter my race, gender, or where I live
- ☐ Good schools (caring, supportive, good resources)
- ☐ Health support services for conditions such as diabetes, cancer, or heart disease. This could include support for diet, weight management, quitting smoking, and end of life care.
- ☐ Health care such as being able to make appointments
- ☐ Healthy family life and relationships
- ☐ Inclusive and equal care for all people no matter their race, gender identity or sexual orientation (LGBTQ)
- ☐ Job training and good paying jobs
- ☐ Life skill trainings such as cooking and how to budget
- ☐ Mental health services
- ☐ Parks and recreation
- ☐ Preventive ways to improve health
- ☐ Racial equity
- ☐ Religion or spirituality
- ☐ Safety and low crime
- ☐ Strong sense of community and social networks (caring neighbors, sense of belonging)
- ☐ Technology (internet, computers)
- ☐ Transportation
- ☐ Other:_____

What changes do you want to see in the area where you live?

Community Health Needs Survey

Questions About You

What is your age?

_____

How do you identify yourself?

- ☐ Male
- ☐ Female
- ☐ Transgender man female-to-male (FTM)
- ☐ Transgender woman male-to-female (MTF)
- ☐ Genderqueer
- ☐ Gender non-conforming (Not only male or female)
- ☐ Other gender group Please describe: _____
- ☐ Do not want to answer

Check one of the following that best represents how you think of yourself:

- ☐ Straight or heterosexual
- ☐ Lesbian or gay
- ☐ Bisexual
- ☐ Queer
- ☐ Pansexual
- ☐ Questioning
- ☐ Do not know
- ☐ Other, please describe: _____
- ☐ Do not want to answer

What racial and ethnic groups do you identify with? (check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian or Mideast Asian
- ☐ Black or African-American
- ☐ Hispanic or Latino/Latina
- ☐ More than one race
- ☐ Do not know
- ☐ White-Caucasian
- ☐ Do not want to answer

Is a language other than English spoken in your home? ☐ Yes ☐ No

If Yes: What languages other than English are spoken in your home?

_____

What is the highest level of education you have completed?

- ☐ Less than high school
- ☐ Some high school
- ☐ High school graduate or graduate equivalency degree (GED)
- ☐ Vocational or technical school
- ☐ Some college
- ☐ College graduate
- ☐ Advanced degree (such as MS, MEd, MSW, MD, PhD, JD, etc.)

Community Health Needs Survey

Questions About Your Household

What kind of place do you live in?

- ☐ Own my home
- ☐ Rent my home
- ☐ Living in emergency or transitional shelter
- ☐ Living outside (Not a shelter, car, tent or abandoned building)
- ☐ Living with a friend or family
- ☐ Other: _____

How many people, including yourself, live in your household? Please count people who spend most of their time living in your household. Please give the number of people in each age group. If none, please enter 0.

Adults, 18 years of age or older: _____

Children, 11-17 years old: _____

Children, 6-10 years old: _____

Children, 1-5 years old: _____

Children, less than 1 year old: _____

Are you or anyone in your household a veteran? ☐ Yes ☐ No

Do you or anyone in your household have a disability? (have a condition of the body or mind that greatly limits their activities and caring for themselves)

☐ Yes ☐ No

What is the yearly household income? This is the total income of all the people in the home who financially help. Total before taxes are taken out.

- ☐ Less than $10,000
- ☐ $10,001 to $20,000
- ☐ $20,001 to $30,000
- ☐ $30,001 to $40,000
- ☐ 40,001 to $50,000
- ☐ $50,000 to $75,000
- ☐ $75,001 to $100,000
- ☐ $100,001 to $150,000
- ☐ $150,001 to $200,000
- ☐ $200,001 or more
- ☐ I don't know
- ☐ Prefer not to answer

Community Health Needs Survey

Questions about Your Health

Do you see a medical or healthcare professional on a regular basis?
(Sometimes called a primary care provider)

☐ Yes ☐ No

Have you ever had any cancer screenings? (tests for cancer) ☐ Yes ☐ No

If yes, check all that apply:

- ☐ Mammogram: breast (within past 1 to 2 years)
- ☐ Cervical: Pap smear or HPV test (within past 3 to 5 years)
- ☐ HPV vaccine for yourself, child, or grandchild
- ☐ Colonoscopy: Colon or intestinal screening for cancer (within 10 years)
- ☐ Home stool: Poop test (within past 1 year)
- ☐ Prostate cancer screening
- ☐ Lung cancer screening (if you have used tobacco products)
- ☐ Other (please describe): _____

If no, please explain why not:

- ☐ I am too young for any cancer screenings
- ☐ Did not know when or at what age to have the screenings
- ☐ No time to do this
- ☐ No transportation
- ☐ Conflicts with my work or cannot get time off
- ☐ No insurance
- ☐ Not covered by insurance
- ☐ Fear of pain
- ☐ Fear of bad results
- ☐ Fear of side effects
- ☐ I do not have a reason. I want to learn more about cancer testing.

Appendix 4

Additional Community Input Survey Results

Race/Ethnicity

60.6% Black
16.9% White
16.6% Latinx or Hispanic
2.7% Did not disclose
1.5% Two or more
1.3% Unknown
0.4% Asian

Age

34.6% 18-39
41.3% 40-64
20.1% 65+
4.0% Did not disclose

Gender

55.8% Female
43.1% Male
0.8% Did not disclose
0.2% Gender non-conforming (Not only male or female)
0.0% Transgender female-to-male (FTM) or male-to-female (MTF)

Sexual Orientation

86.9% Straight or heterosexual
6.1% Did not disclose
3.2% Bisexual
1.2% Do not know
0.6% Lesbian or gay
0.6% Questioning
0.6% Queer
0.3% Pansexual

Note: Percentages may not total 100 due to rounding.

Household Status

59.9% Own my home
26.0% Rent my home
10.4% Living with a friend or family
1.3% Other
1.7% Did not disclose
0.5% Living outside (Not a shelter, car, tent, or abandoned building)
0.2% Living in emergency or transitional shelter

Education

27.5% Some college
26.1% College graduate
23.2% High school graduate or graduate equivalency degree (GED)
11.4% Advanced degree (such as MS, MEd, MSW, MD, PhD, JD, etc.)
5.4% Some high school
4.5% Vocational or technical school
1.4% Did not disclose
0.5% Less than high school

Household Income

9.2% Less than $10,000
8.0% $10,001 to $20,000
10.3% $20,001 to $30,000
11.1% $30,001 to $40,000
0.2% $40,001 to $50,000
7.6% $40,001 to $50,000
14.0% $50,001 to $75,000
9.8% $75,001 to $100,000
11.0% $100,001 to $150,000
5.1% $150,001 to $200,000
1.9% $200,001 or more
9.9% Did not disclose
1.7% I don't know

ZIP Code Counts

Number of survey respondents	Respondent ZIP code	Number of survey respondents	Respondent ZIP code	Number of survey respondents	Respondent ZIP code
94	60426	**40**	60430	**30**	60633
59	60409	**38**	60406	**15**	60425
56	60827	**37**	60419	**7**	60469
48	60438	**33**	60429	**4**	60476
45	60473				

"What do you think are the most important things for a healthy community?"

57% **Activities for teens and youth**

50% **Affordable housing**

46% **Affordable healthy foods such as fruits and vegetables**

36% **Clean streets and neighborhood**

34% **Affordable childcare**

Appendix 5

Secondary Data Sources & Limitations

Secondary Data Sources

- Local data compiled by government agencies:
  - Chicago Police Department
  - Chicago Department of Public Health
  - Cook County Sheriff's Office of Research

- Illinois Health and Hospital Association/COMPdata:
  - Hospitalization and emergency department rates

- State agencies:
  - Illinois Department of Healthcare and Family Services
  - Illinois Department of Human Services
  - Illinois State Board of Education
  - Illinois Department of Public Health

- Federal sources:
  - Annie E. Casey Foundation: Kids Count
  - Behavioral Risk Factor Surveillance System (BRFSS)
  - Centers for Disease Control and Prevention: PLACES project, Diabetes Atlas, National Vital Statistics System-Natality, and Environmental Justice Index
  - Centers for Medicare and Medicaid Services
  - Environmental Protection Agency (EPA): Environmental Justice Screening
  - Federal Bureau of Investigation: FBI Crime Data Explorer
  - Feeding America
  - Health Resources and Services Administration
  - March of Dimes
  - The Eviction Lab at Princeton University
  - United States Department of Agriculture
  - United States Department of Housing and Urban Development
  - U.S. Census Bureau American Community Survey

Data Needs and Limitations

Ingalls Memorial and Metopio made substantial efforts to comprehensively collect, review, and analyze primary and secondary data. However, there are limitations to consider when reviewing CHNA findings:

- Population health and demographic data are often delayed in their release, and data are presented for the most recent years available for any given data source.
- Variability in the geographic level at which data sets are available (ranging from census tract to statewide or national geographies) presents an issue, particularly when comparing similar indicators collected at disparate geographic levels. Whenever possible, we have reported the most relevant localized data.
- Due to variations in geographic boundaries, population sizes, and data collection techniques for suburban and city communities, some datasets are not available for the same periods or at the same level of localization throughout the county.
- Gaps and limitations persist in data systems for certain community health issues, such as mental health and substance use disorders for both youth and adults, crime reporting, environmental health statistics, and education outcomes. Additionally, these data are often collected and reported from a deficit-based framework that contributes to systemic bias.
- Survey data was collected using convenience sampling, which could lead to selection bias. As a response, survey data was weighted to reflect the PSA population.
- Focus group locations were selected based on partner availability.
- Any data that includes the time period of the COVID-19 pandemic and its resulting data collection disruptions can produce challenges in accuracy and relevance. Community members may have reported or experienced significantly different economic or health situations based on when the data was collected during that time period.

With this in mind, Ingalls Memorial, Metopio, and all stakeholders were deliberate in discussing these limitations throughout the development of the CHNA and the selection of the FY 2026-2028 community benefit priority areas.