

Community Health Needs Assessment 2025



Saint Francis Hospital

355 Ridge Ave, Evanston, IL 60202

[Saint Francis Hospital | Best Care in Evanston, IL \(saintfrancisevanston.org\)](https://saintfrancisevanston.org)

Paper copies of this document may be obtained at: Saint Francis Hospital 355 Ridge Ave, Evanston, IL 60202 or via the hospital website: <https://saintfrancisevanston.org>

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Acknowledgements

The 2025 Community Health Needs Assessment (CHNA) uses a systemic, comprehensive data collection and analysis to define priorities for health improvement, creates a collaborative community environment to engage stakeholders, and an open process to listen and understand the health needs of the community served. Saint Francis Hospital is appreciative of all the community organizations and individuals that have shared their knowledge, expertise, and views. A complete description of community partner contributions is included. Our continued collaborative work will promote a healthier and more equitable place to grow, live, work, play, and age.

About Saint Francis Hospital

Founded in 1900, Saint Francis Hospital in Evanston, IL (SFIL), is a 197-bed facility that offers specialized care alongside 24/7 emergency services, including a Level I adult trauma center. Saint Francis Hospital delivers high-quality compassionate care in Cook County to proudly serve the communities of Lincolnwood, Skokie, Evanston and these areas in Chicago: Edgewater (60626), Forest Glen (60646), Rogers Park (60626, 60645), and West Ridge (60645, 60659) as identified as their primary service area.

Saint Francis Hospital is an acute care hospital acquired by Prime Healthcare on March 1, 2025. SFIL is applying to become a 501(c)(3) not-for-profit public charity. Prime Healthcare is an award-winning health system operating 51 hospitals and more than 360 outpatient locations in 14 states, providing over 2.5 million patient visits annually. It is one of the nation's leading health systems with nearly 57,000 employees and affiliated physicians dedicated to providing the highest quality healthcare. Eighteen of the Prime hospitals are members of the Prime Healthcare Foundation.

With a history of delivering quality care, Prime Healthcare was once named by Modern Healthcare as "The fastest growing hospital system" and ranks among the largest for-profit hospital systems in the United States. Prime hospitals have been featured prominently among the "100 Top Hospitals" in the nation 72 times based on quality, and among the "15 Top Health Systems" three times. Prime Healthcare was named as one of America's Greatest Workplaces for 2024 by Newsweek showcasing its environment where diverse backgrounds and identities are valued and celebrated. Its hospitals have garnered over 600 awards from organizations like The Leapfrog Group and U.S. News & World Report and was recognized as a "Top 10 Health System" for health equity and social responsibility by the Lown Institute.

Prime Healthcare believes that exceptional healthcare should be a part of every community and has a proud history of transforming financially distressed hospitals into thriving community assets. Every hospital acquired by Prime Healthcare has been transformed and is now a vital community asset. Our growing family of hospitals across the United States is dedicated to improving healthcare and adding value to the lives of patients, affiliated physicians, staff, and communities. Prime Healthcare believes that "***all healthcare is local.***"

Mission Statement

To deliver compassionate, quality care to patients and better healthcare to communities.

Values

Quality – We are committed to always providing exceptional care and performance.

Compassion – We deliver patient-centered healthcare with compassion, dignity and respect for every patient and their family.

Community – We are honored to be trusted partners who serve, give back and grow with our communities.

Physician-Led – We are a uniquely physician-founded and physician-led organization that allows doctors and clinicians to direct healthcare at every level.

For more information about Prime Healthcare, visit <https://www.primehealthcare.com>

Saint Francis Hospital provides advanced surgical interventions for serious and life-threatening conditions and stands out as a premier destination for specialty services, which encompasses heart care, cancer treatment, stroke management, orthopedics, and women's health. Our facility features a comprehensive range of minimally invasive procedures utilizing robotic-assisted technology, along with imaging and lab tests, all supported by a dedicated inpatient rehabilitation center.

As a not-for-profit organization, Saint Francis Hospital is dedicated to improving the health and well-being of its communities by blending a passion for healing with advanced medical technology to deliver the best possible care to patients.

To assure a thorough understanding of the community's needs and in accordance with the Patient Protection and Affordable Care Act (PPACA) requirement of the tax-exempt hospitals, Saint Francis Hospital is required to conduct a Community Health Needs Assessment (CHNA) and adopt an implementation Strategy (IS) every three years. Requirements for 501(c)(3) hospitals Under the Affordable Care Act are described in Code Section 501(r)(3) and include making the CHNA reports available to the public. In accordance with this requirement, electronic reports of both the CHNA and Implementation Strategy can be found at, <https://saintfrancisevanston.org> and paper versions can be requested from Saint Francis' Administration office.

The 2025 Community Health Needs Assessment was adopted by the Saint Francis Governing Board of Directors on June 18, 2026.

(This report fulfills the requirements of the Internal Revenue Code 501 (r)(3), established within the Patient Protection and Affordable Care Act [PPACA], requiring that nonprofit hospitals conduct CHNAs and adopt an IS every three years).

What is Community Benefit?

Community benefits are programs and services designed to improve health in communities and increase access to health care in response to a demonstrated community need. Community benefit programs seek to achieve at least one of these objectives:

- Improve access to health services,
- Enhance the health of the community,
- Advance medical or health care knowledge,
- Relieve or reduce the burden of government or other efforts. (Source: Catholic Health Association, 2025)

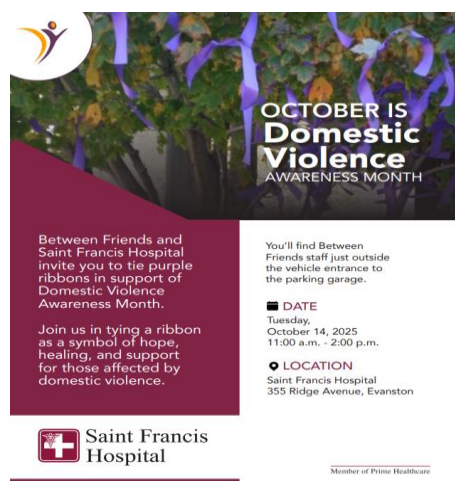
Creating Healthier Communities, Together

Through outreach, programs, health education, donations, free or discounted care, we give back to our communities.

Community Benefit: Investments to Support Those in Need

SFIL's community benefit investments not only support the health and well-being of each person we serve, but the whole community:

- Community Health Services: Free services such as patient education, health screenings, and self-help/support groups as well as donations to support community partners.
- Education and Research: Community education to increase knowledge and awareness of various medical conditions; this helps empower patients to seek earlier interventions when treatment is more effective.
- Care and Services Operated at a Loss: Clinical and social services provided despite financial loss because they need identified needs not met elsewhere in the community.
- Free and Low-cost Care: Financial assistance for those who are uninsured, underinsured, or otherwise unable to pay for their healthcare costs.



Executive Summary

Purpose of the Community Health Needs Assessment (CHNA)

As a part of the Patient Protection and Affordable Care Act of 2010, all not-for-profit hospitals are required to conduct a community health needs assessment (CHNA) and adopt an implementation strategy (IS) every three years. The purpose of the CHNA is to:

- Understand the community's health needs and priorities
- Identify the barriers to health equity in the communities served by the hospital
- Respond to the those identified needs through the implementation strategy plan

Community Served

Saint Francis Hospital delivers high-quality compassionate care in Cook County to proudly serve the communities of Lincolnwood, Skokie, Evanston and these areas in Chicago: Edgewater (60626), Forest Glen (60646), Rogers Park (60626, 60645), and West Ridge (60645, 60659) as defined as their primary service area (PSA) for this CHNA. The primary service and community health data are readily available at the county level.

Data Analysis Methodology

The 2025 CHNA was conducted from September 2024 to October 2025 utilizing the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 assessment tool. MAPP 2.0 enables communities to identify health priorities, develop effective strategies, and mobilize partnerships to improve community health outcomes, empowering communities to create sustainable and equitable solutions for the well-being of the communities served. MAPP 2.0 includes three assessments: Community Partner Assessment (CPA), Community Status Assessment (CSC), and Community Context Assessment (CCA). The CPA is an assessment process that allows all the community partners involved in MAPP to look at their collective capacity as community partners to address health inequities. The CSA is a quantitative assessment aimed at understanding the community's status, including association with social drivers of health. The CCA is a qualitative data assessment tool aimed at harnessing the unique insights, expertise, and perspectives of individuals and communities directly impacted by social systems to improve the functioning and impact of those systems. (Source: National Association of City & County Health Officials [NACCHO], 2024)

Community Needs

Saint Francis Hospital (SFIL) analyzed the all the data from the above assessments, as well as secondary sources including, but not limited to, the American Community Survey, the Decennial Census, the Centers of Disease Control and Prevention, County Health Rankings and Roadmaps, and the Illinois Department of Public Health. Community input was gathered through community surveys to identify the needs. In collaboration with community partners, SFIL used a phased prioritization approach to determine the most crucial needs for community stakeholders to address.

The prioritized needs for the 2025 SFIL's CHNA are:

- Social Driver of Health (SDoH): Food Access & Security
- Social Driver of Health (SDoH): Housing Assistance
- Mental Health/Behavioral Health & Substance Use Support

Next Steps and Conclusion

Following approval of the CHNA, Saint Francis Hospital will develop an implementation strategy plan which will focus on all or a subset of the prioritized needs identified and will describe how the hospital intends to respond to those needs for the next three years.

Saint Francis Hospital hopes this report offers meaningful and comprehensive understanding of the identified community needs. The hospital values the community's voice and welcomes feedback on this report; comment or questions can be submitted via Saint Francis Hospital's website <https://saintfrancisevanston.org>



Community Health Needs Assessment (CHNA) Process

A Community Health Needs Assessment (CHNA) is a systematic process involving non-for-profit hospitals and community partners to identify and analyze community health needs. The process provides a way for prioritizing health needs, and to plan and act upon those needs in an implementation strategy plan. The goal of the CHNA is to improve community health and wellness by connecting research, resources, and people, while complying with Internal Revenue Service guidelines.

Purpose of the CHNA

A CHNA “is a process for determining the needs of a particular community or population through systematic, comprehensive data collection and analysis, and leveraging results to spur community change.” (Source: Community Commons) The process serves as a foundation for promoting the health and well-being of the community by identifying the most pressing needs, leveraging existing assets and resources, developing strategic plans, and mobilizing hospital programs and community partners to work together. This community-drive approach aligns with Saint Francis Hospital’s commitment to offer programs designed to respond to the health needs of a community, with special attention to persons who are medically underserved and at risk for poorer health outcomes because of societal factors that put them at increased risk.

Advancing Health Equity

Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being. Health and health equity are determined by the conditions in which people are born, grow, live, work, play and age, as well as biological determinants. Structural determinants (political, legal, and economic) with social norms and institutional processes shape the distribution of power and resources determined by the conditions in which people are born, grow, live, work, and age. (Source: World Health Organization [WHO], 2025)

Saint Francis Hospital acknowledges that health disparities in our communities go beyond individual health. As part of Prime Healthcare’s Mission “to deliver compassionate, quality care to patients and better healthcare to communities” and part of our Values “we deliver patient-centered healthcare with compassion, dignity, and respect for every patient and their family”, health equity is very important.

Service Area Demographic Analysis

Community Served – Primary Service Area

Saint Francis Hospital located in Evanston, IL delivers high-quality compassionate care in Cook County to proudly serve the communities of Lincolnwood, Skokie, Evanston and these areas in Chicago: Edgewater (60626), Forest Glen (60646), Rogers Park (60626, 60645), and West Ridge (60645, 60659).

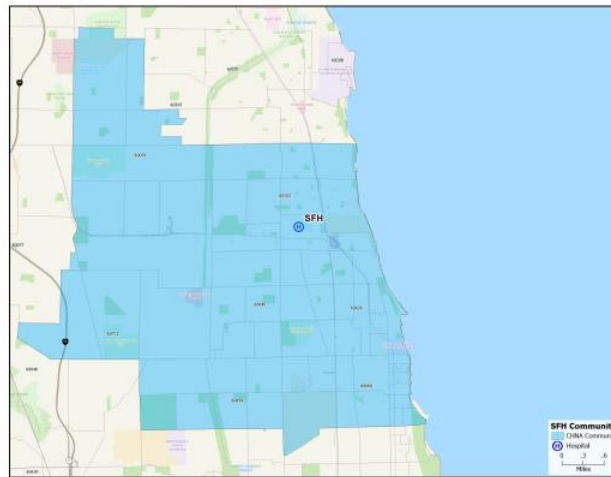


Image 1: Map of Community Served

Demographic data

Saint Francis Hospital is located in the city of Evanston, Illinois, which is part of Cook County. The population of Evanston is 78,100 and is in the northern eastern part of the state of Illinois. Below are demographic data highlights for the Evanston community:

- Evanston's population has grown by nearly 5% over the last decade.
- Evanston's Black and Non-Hispanic White populations have decreased, while representation for all other racial categories has increased.
- The proportion of Evanston residents identifying as Hispanic/Latino has grown 30% over the last 10 years.
- 25% of Evanston residents speak a language other than English, with Spanish being the most common language.
- Evanston's proportion of college educated adults far exceeds that of Illinois and the US, but racial inequities exist with only about a third of Black and Hispanic/Latino adults having at least a bachelor's degree.
- Evanston's poverty rate is 13% with the poverty rate for Black and Hispanic/Latinos exceeding the national average at 18% and 19% respectively.

Source: City of Evanston, 2022 EPLAN (Evanston Project for the Local Assessment of Needs)

SFIL Demographic Highlights						
Population						
Indicator	Evanston	Trend	Cook County	Illinois	United States	Description
Population	78,110		5,087,072	12,549,689	341,500,000	
Race/ Ethnicity						
Asian	10%		8.30%	6.30%	5.82%	
Black	16%		22.40%	14.00%	12.36%	
Hispanic/Latino	11%		17.00%	19.00%	20.00%	
Non-Hispanic White	57%		40.60%	58.80%	63.44%	
American Indian/Alaskan Native	>1%		0.80%	0.60%	0.88%	
Native Hawaiian/Pacific Islander	>1%		0.10%	0.10%	0.19%	
Two or More Races	5%				6.60%	
All Other Races	>1%				10.71%	
Age Groups						
% Below 18 Years of Age	20%		20.70%	21.60%	23.70%	
% 65 and Older	16%		16.60%	17.60%	16.90%	
Social and Community Context						
English Proficiency	7%		7%	4%		Proportion of community members who speak English "less than well".
Median Household Income	\$78,904		\$80,500	\$80,300	\$77,700	The income where half of households in a county earn more and half of households earn less.
Children in Poverty	8.70%		17%	15%	16%	Percentage of people under age 18 in poverty
Percentage of Uninsured	5.40%		10%	8%	10%	Percentage of population under 65 without health insurance.
High School Completion	81%		88%	90%	89%	Percentage of adults ages 25 and over with a high school diploma or equivalent.
Some College	14%		74%	71%	68%	percentage of adults ages 25-44 with some post-secondary education.
Percentage of Unemployment	4.20%		4.40%	4.50%	3.60%	Percentage of population ages 16 and older unemployed but seeking work.

Sources: City of Evanston, 2022 EPLAN (Evanston Project for the Local Assessment of Needs) and County Health Rankings & Roadmaps, Cook County, IL, 2025.

The top five industries in Evanston are: Education; Professional, Scientific, and Technical Services; Healthcare; Retail; and Finance & Insurance.

Cook County, Illinois has significant Jewish populations, particularly in North Shore suburbs, Lincolnwood and Skokie, as well as West Rogers Park (Chicago).



The Chicago Center's Annual Health & Safety Fair

Process and Methods Utilized

Saint Francis Hospital is committed to using national best practices in conducting the CHNA. In collaborating with various community partners, SFIL relies on the Mobilizing Action through Planning and Partnerships (MAPP) 2.0 assessment tool. MAPP is a community-driven, strategic planning framework that assists communities in developing and implementing efforts around the prioritization of resources to address them. MAPP 2.0 enables communities to identify health priorities, develop effective strategies, and mobilize partnerships to improve community health outcomes, empowering communities to create sustainable and equitable solutions for the well-being of the communities served. MAPP 2.0 includes three assessments:

1. Community Partner Assessment (CPA) - stakeholder or informant input
2. Community Status Assessment (CSA) - secondary data
3. Community Context Assessment (CCA) - community input

The CPA is an assessment process that allows all the community partners involved in MAPP to look at their collective capacity as community partners to address health inequities. The CSA is a quantitative assessment aimed at understanding the community's status, including association with social drivers of health. The CCA is a qualitative data assessment tool aimed at harnessing the unique insights, expertise, and perspectives of individuals and communities directly impacted by social systems to improve the functioning and impact of those systems. (Source: National Association of City & County Health Officials [NACCHO], 2023)



Photo received from the National Association of County and City Health Officials at https://www.pathlms.com/naccho/courses/29122/video_presentations/192977

Community Partner Assessment (CPA)

A community partner assessment that included both a survey and forum was conducted by Saint Francis Hospital's Community Health department to understand the community's perception of the needs based on key stakeholder's experiences and feedback from

clients/patients. The online survey was completed by eleven community partners, and the in-person forum had six community members representing a diverse range of organizations, including educational institutions, economic development groups, community-based organizations, and the technology sector. These partners serve varied racial and ethnic populations, such as Black/African American, Latinx/Hispanic, White/Caucasian, Asian/Asian American, Pacific Islander/Native Hawaiian, and Native American/Indigenous/Alaska Native communities.

Key Findings:

1. *Community Health Improvement:* Only 36.3% of organizations have participated in a community health improvement process.
2. *Demographics and Needs:* Community partners emphasized the strong diversity and commitment of the hospital community. The most pressing health issues include mental health, social determinants of health (housing, education, and workforce), and chronic conditions like heart disease, stroke, and obesity.
3. *Social Issues:* The top social challenges identified were food access, homelessness, healthcare access, and racial equity/injustice.
4. *Disproportionate Impact:* Specific populations, particularly migrant/immigrant, Black/African American, and Latinx/Hispanic communities, are most affected by health and social inequities.
5. *Health Drivers and Barriers:* Key factors influencing health needs include healthcare access and affordability, socioeconomic conditions, demographic changes, and environmental factors. Barriers include economic constraints, limited healthcare access, and cultural/language barriers.
6. *Healthcare Gaps:* The community is seen as lacking affordable and accessible healthcare, particularly in mental health, preventative services, and dental care.
7. *Collaborative Efforts:* Community partners highlighted the need for increased partnerships, community programming, and cross-sector communications to address health and social challenges. Notable successful initiatives include The Living Room and community-led events.
8. *Preferred Communication:* Personal referrals from trusted sources are the most effective way to communicate health information. Community partners were divided on whether technology (social media/texting) or in-person events with hard-copy resources are more effective.
9. *Community Engagement:* The majority of community partners reported moderate (54.5%) to low (36.3%) community engagement.
10. *Vision for Collaboration:* Partners see an ideal collaboration focusing on increased access to healthcare, improved communication, and a stronger presence in schools.

Conclusion: The survey results underline the importance of strengthening partnerships, addressing healthcare access and affordability, and engaging in community-driven initiatives to improve health outcomes. The insights shared by community partners highlight critical areas for

targeted action, particularly in the areas of mental health, social determinants of health, and equity.

Community Status Assessment (CSA)

The Community Status Assessment (CSA) is compiled of relevant indicators to help understand the status of the community focused on social determinants of health, health status, behaviors, outcomes, systems of power, privilege, and oppression. As possible, data was collected from the primary service area (PSA) zip codes of the hospital community to compare to the county, state and national data as well as relevant Healthy People 2030 benchmarks.

Disease & Injury Indicators

The cancer diagnosis rate is significantly lower in the hospital's PSA compared to county and state rates. Coronary heart disease and diagnosed diabetes rates are both higher than county and state rates. The low birth rate of infants is lower than county, state, and national rates. The percentage of adults with obesity is lower than the county, state, and national percentages.

Topic	Saint Francis (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Cancer diagnosis rate <i>per 100,000 residents</i> 2017-2021	508.91	547.69	573.24	444.40	n/a
Coronary heart disease % of adults 2022	5.46	5.10	5.37	5.82	n/a
COVID-19 case rate <i>cumulative cases per 100,000 population</i> Mar 2023	–	29,479.86	31,887.08	32,217.47	n/a
Diagnosed diabetes % of adults 2022	11.2	10.8	10.4	10.8	n/a
HIV prevalence <i>people per 100,000</i> 2022	–	595.8	338.8	386.6	n/a
Low birth weight % of live births 2020-2022	6.5	8.9	8.5	8.5	n/a

Motor vehicle traffic mortality <i>deaths per 100,000</i> 2022	–	8.9	10.0	12.9	10.1
Obesity <i>% of adults</i> 2022	30.4	32.8	34.4	33.8	n/a
Sexually transmitted infection prevalence <i>cases per 100,000</i> 2022	–	1,720.9	1,139.5	1,113.6	n/a

Economic Stability Indicators

The food insecurity rate is higher than the county, state, and national level. The median selected monthly owner costs (SMOC) are significantly higher in the hospital than state and national level. The percentage of occupied housing units is drastically lower than the county, state, and national rates. The poverty rate is much higher than the county, state, and national rates.

Topic	Saint Francis (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Food insecurity <i>% of residents</i> 2022	13.8	12.1	12.0	13.3	n/a
Median selected monthly owner costs (SMOC) <i>dollars</i> 2019-2023	\$1,733	\$1,602	\$1,366	\$1,320	n/a
Owner occupied <i>% of occupied housing units</i> 2019-2023	47.07	57.81	67.37	65.24	n/a
Median household income <i>dollars</i> 2019-2023	\$78,578	\$80,579	\$80,306	\$77,719	n/a
Poverty rate <i>% of residents</i>	14.05	13.29	11.63	12.46	8.00

2019-2023					
Unemployment rate (BLS) % Nov 2024	–	5.3	4.8	4.0	n/a

Evanston has only 3% of the population in suburban Cook County but has 8.7% of the suburban Cook population who are experiencing homelessness, according to federal and state governments, and homeless advocacy organizations. The population numbers come from the U.S. Census Bureau for 2023.

Education & Quality of Life Indicators

The percentage of toddlers (3-4 years) enrolled in Preschool is lower than the county, state, and national level. The percentage of households with limited English proficiency is notably higher than the county, state, and national level.

Topic	Saint Francis (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
High school graduation rate % of residents 2019-2023	89.70	88.55	90.55	89.78	n/a
Preschool enrollment % of toddlers ages 3-4 3-4 years, 2019-2023	47.60	49.97	52.25	48.45	n/a
Limited English proficiency households % of households 2019-2023	9.03	6.68	4.24	4.36	n/a

Health Behavior Indicators

The percentage of adults that binge drink is similar to that of the county and state. The percentage of adults that completed colorectal cancer screening is higher than both the county and state. The cigarette smoking rate is similar to county and state rates, but lower than national rates.

Topic	Saint Francis (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Binge drinking % of adults 2022	19.62	20.80	20.37	18.58	25.40
Colorectal cancer screening % of adults 2022	57.36	52.70	55.37	58.85	68.30
No exercise % of adults 2022	21.1	20.9	21.5	23.7	21.8
Mammography use % of adults Female, 2022	73.75	73.80	73.02	75.65	80.30
Cigarette smoking rate % of adults 2022	12.7	12.0	13.5	14.6	n/a
Teen birth rate <i>Births per 1,000 women, female under 18 yrs</i> 2019-2023	—	10.16	7.88	8.48	31.40
Few fruits and vegetables % of adults 2009	—	75.90	77.50	76.14	n/a

Health Status Indicators

Life expectancy is higher than the county, state, and national expectancy. The percentage of adults with poor self-reported mental health and physical health is similar to the county, state, and national percentages.

Topic	Saint Francis (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Life expectancy years 2019-2021	79.7	77.9	78.0	76.1	n/a
Poor self-reported mental health % of adults 2022	15.12	15.30	16.11	17.35	n/a
Poor self-reported physical health % of adults 2022	11.70	11.40	11.71	12.44	n/a
Fair or poor self-reported health % of adults 2022	17.56	17.50	17.00	17.87	n/a

Health Access & Quality Indicators

The availability of dentists is lower in the PSA than in the rest of the county. The mental health providers per capita is lower than the county and national level. The primary care providers (PCP) per capita is lower than the county, state, and national level. The uninsured rate is significantly higher than the county, state, and national rates.

Topic	Saint Francis (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Dentists per capita <i>dentists per 100,000 residents</i> 2024	116.0	141.3	112.5	105.2	n/a
Mental health providers per capita <i>providers per 100,000 residents</i> 2024	601.9	656.4	505.9	602.7	n/a
Primary care providers (PCP) per capita <i>physicians per 100,000 residents</i> 2021	85.5	107.4	88.8	89.6	n/a
Uninsured rate % <i>of residents</i> 2019-2023	10.62	7.79	6.16	7.93	n/a

Mortality Indicators

There is no PSA level data available for this set of indicators.

Topic	Saint Francis (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
COVID-19 mortality <i>deaths per 100,000 2022</i>	–	54.6	45.5	44.5	n/a
Drug overdose mortality <i>deaths per 100,000 2022</i>	–	41.98	29.98	32.57	20.70
Heart disease mortality <i>deaths per 100,000 2022</i>	–	202.1	166.6	167.2	n/a
Motor vehicle traffic mortality <i>deaths per 100,000 2022</i>	–	8.9	10.0	12.9	10.1
Unintentional injury mortality <i>deaths per 100,000 2022</i>	–	67.9	57.2	66.0	43.2
Cancer mortality <i>deaths per 100,000 2022</i>	–	164.1	145.1	142.3	122.7
Suicide mortality <i>deaths per 100,000 2022</i>	–	9.8	11.7	14.0	42.6

Neighborhood & Built Environment Indicators

The walkability index of the hospital community is remarkably higher than the county, state, and national level. The percentage of residents experiencing food insecurity is higher than the county, state, and national rates. The housing cost burden is much higher than the county, state, and national level. The percentage of workers 16 years or older that take public transportation to work is drastically higher than the county, state, and national level. The percentage of households with internet access is slightly lower than the county, state, and national percentages.

Topic	Saint Francis (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Walkability Index 2024	14.60	13.61	10.56	9.47	n/a
Housing cost burden % of occupied housing units 2019-2023	37.22	34.44	29.37	31.86	n/a
Particulate matter PM 2.5) concentration $\mu\text{g}/\text{m}^3$ 2020	8.709	9.304	8.457	6.927	n/a
Public transportation to work % of workers 16 years and older 2019-2023	16.88	13.40	6.60	3.53	n/a
Proximity to Superfund (toxic waste) sites distance-weighted sites 2024	0.535	0.298	0.097	0.094	n/a
Travel time to work over one hour % of workers 2019-2023	13.34	13.10	10.10	8.90	n/a
Drinking water non-compliance violations 2023	0	0	0	2	n/a
Internet access % of households 2019-2023	93.80	94.91	94.64	94.77	n/a

Social & Community Context Indicator

The percentage of children (0-17 years) living with their grandparents is considerably lower than the county, state, and national level. The social vulnerability index is higher than the state and national index.

Topic	Saint Francis (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Social membership associations <i>number per 10,000 people 2021</i>	--	7.12	9.72	9.09	n/a
Violent crime (cases) <i>Crimes 2023</i>	879	981	203,184	4,058,660	n/a
Children living with grandparents <i>% of children, 0-17 yrs 2019-2023</i>	4.88	10.35	7.80	8.10	n/a
Social Vulnerability Index <i>Percentile 2022</i>	66.83	79.64	54.97	58.40	n/a
Voter participation rate (Presidential) <i>% of voting-age citizens 2020</i>	--	57.27	61.13	63.05	n/a

Systems of Power, Privilege & Oppression Indicators

The area's deprivation index is lower than the county, state, and national level. The point in time eviction rate is lower than the county, state, and national rate. The Gini index of income inequality is lower than that of the county, state, and national level.

Topic	Saint Francis (PSA)	Cook County, IL	Illinois	United States	Healthy People 2030
Area Deprivation Index 2022	43.55	46.12	53.70	47.50	n/a
Correctional facilities census <i>Persons</i> 2020	70	6,598	61,605	2,055,412	n/a
Eviction rate <i>% renter-occupied households</i> Oct 2024	0.46	1.06	1.52	2.12	n/a
Gini index of income inequality 2019-2023	0.459	0.501	0.481	0.483	n/a
Labor force participation <i>% of residents 16 and older</i> 2019-2023	66.59	66.96	65.39	63.82	n/a
Voter participation rate (Presidential) <i>% of voting-age citizens</i> 2020	—	57.27	61.13	63.05	n/a

Source: All the above data was extracted from Metopio, a partnership when a part of Ascension. See References

Community Context Assessment: Executive Summary

Community Input Survey

This report presents the findings from a community health survey conducted by Saint Francis Hospital to assess health needs, barriers to care, and other relevant social determinants affecting residents. A total of 402 respondents participated in the survey, representing diverse demographic groups within the hospital's primary service area.

Key Findings:

Demographics of Respondents

- The survey sample overrepresented African American/Black (24.1% vs. 13.6% in the community) and Asian (12.9% vs. 9.9%) populations, while White respondents were underrepresented (35.8% vs. 50.5%).
- 31.1% of respondents were 65 or older, ensuring strong representation of older adults.
- 9.7% identified as LGBTQ+, exceeding Illinois estimated 4.3%.
- A higher proportion of respondents (77.4%) had some higher education compared to the service area (72.6%).
- 2.7% were unemployed, lower than Cook County's 5.0% unemployment rate.
- 6.0% did not speak English at home, with Spanish (16.7%) and Polish (1.2%) being the most common non-English languages.

Health Status and Needs

- ⌘ Top Health Concerns:
 1. Diabetes (38.1%)
 2. Mental health issues (34.3%)
 3. Heart disease & stroke (32.8%)
 4. Age-related illnesses (32.6%)
 5. Hypertension (27.4%)
- ⌘ Stress-related concerns such as financial insecurity, violence, and high healthcare costs were frequently mentioned in open comments.
- ⌘ Mental health was particularly emphasized among Native American (50%) and African American/Black (38.1%) respondents.
- ⌘ 4.5% of respondents rated their own health as poor or not healthy.

Healthcare Access & Utilization

- ⌘ Insurance Coverage: 5.0% of respondents lacked health insurance, a lower rate than Cook County's 10%.
- ⌘ Missed Appointments: 23.4% postponed or missed medical appointments due to time constraints (12.9%), cost (12.4%), and lack of transportation (6.7%).
- ⌘ Preventive Care:
 - ⌘ 83.1% had a routine healthcare exam within the past year.

- ☞ 34.1% never had a colonoscopy.
- ☞ 24.4% of women never had a mammogram.

Needed Community Support

- ☞ Top 5 Needed Supports:
 1. Access to healthcare (52.0%)
 2. Access to mental health services (46.3%)
 3. Access to community services (42.8%)
 4. Access to healthy food (30.1%)
 5. Affordable childcare (19.2%)
- ☞ Financial assistance for medical bills and concerns over high housing costs were common themes in open comments.

Social Determinants of Health

- ☞ Community Safety: 22.6% of respondents felt unsafe in their community at least some of the time.
- ☞ Food Insecurity: 26.7% worried about running out of food at least sometimes.
- ☞ Children & Teens: social media (39.6%) and bullying (36.3%) were identified as major concerns.

Community Forum

Location: Second Baptist Church

Participants: 6 community members (populations participating: 55+ years old, Black/African American)

Community Strengths

Faith & Spirituality

- Faith plays a central role in community resilience and mental health healing.

Community Agency & Influence

- Residents feel they have a voice and influence within their community.

Integration of Spirituality & Mental Health

- Faith-based approaches help address mental health challenges.

Community Challenges/Opportunities

Housing Affordability & Economic Strain

- High housing costs force residents, including college students, to sacrifice spending on healthy food.
- Inflation has significantly increased food prices, impacting community food programs.
- Middle-class families also struggle to access healthy food, facing stigma when seeking assistance.

Food Security & Access

- Food insecurity persists, particularly among children who lose access to subsidized school meals in the summer.
- Rising costs for soup kitchens and food pantries limit their ability to serve quality food.
- Leftover grocery store food donations are not always nutritious or high-quality.

Workforce Development

- Workforce development programs are well advertised but remain insufficient in addressing community needs.

Healthcare Access & Insurance Barriers

- Many residents are unaware of existing healthcare resources, including the Neighborhood Resource Directory.
- Insurance policies are restrictive, making it difficult to access care without severe or life-threatening conditions.
- Long wait times (up to six weeks) for doctor appointments to limit access to timely care.
- Certain doctors still do not accept Medicare, further reducing available options.

Mental Health & Substance Use Treatment

- ⌘ Lack of Proper Crisis Response: Mental health issues often result in police intervention rather than specialist care, leading to unnecessary incarcerations.
- ⌘ Insurance Limitations: Many insurance policies only cover severe cases, leaving those with moderate conditions untreated.
- ⌘ Need for Specialized Support: Participants emphasized the need for mental health professionals to be involved in crisis response at police calls and in jails.

Actionable Recommendations

1. *Increase Awareness of Healthcare Resources:* Improve outreach and education on the availability of the Neighborhood Resource Directory.
2. *Address Insurance Barriers:* Advocate for policy changes that allow coverage of moderate mental health and substance use disorders before they escalate.
3. *Enhance Food Security Initiatives:* Expand community food programs and increase accessibility for middle-class families struggling with affordability.
4. *Improve Crisis Response:* Train and deploy mental health specialists for emergency situations to reduce unnecessary incarceration.

Conclusion & Recommendations

Both the community input survey and focus group input highlights significant health and social challenges within the Saint Francis Hospital community. Chronic diseases, mental health concerns, health care access, food insecurity, safety concerns and stress are top priorities from the community input received. Expanding access to affordable healthcare, enhancing mental health services, and addressing social determinants like housing, safety and food security will be critical in improving community well-being. Addressing these concerns will require a combination of policy advocacy, improved resource distribution, and expanded community programs.

Data Limitations and Information Gaps

Although this assessment is comprehensive, it cannot measure all the possible aspects of health and cannot represent every possible population within the communities that Saint Francis serves. This assessment began when Saint Francis Hospital was under Ascension Healthcare, but on March 1, 2025, Ascension transferred ownership to Prime Healthcare. This constraint limits the ability to assess all the community's needs fully. For this assessment, three types of limitations were identified:

- Some groups of individuals may not have been adequately represented through the community input process that might include persons who are experiencing homelessness, persons who speak other languages other than English and Spanish.
- Secondary data is limited in a number of ways, including timeliness, reach, and ability to fully reflect the health conditions of all populations within the community.
- An acute community concern may significantly impact a hospital's ability to conduct portions of the CHNA assessment. Such an event or situation may impact the ability to collect community input, may not be captured in secondary data, and/or can be present in the middle of the three-year CHNA cycle. For the 2025 CHNA, there were no acute community concerns impacting the ability to conduct CHNA.

Despite the data limitations, Saint Francis Hospital is confident of the overarching themes and health needs represented through the assessment data. This is based on the fact that the data collection included multiple qualitative and quantitative methods and engaged the hospital and participants from the community.

Results of the CHNA: Prioritized Health Needs

Prioritization Criteria

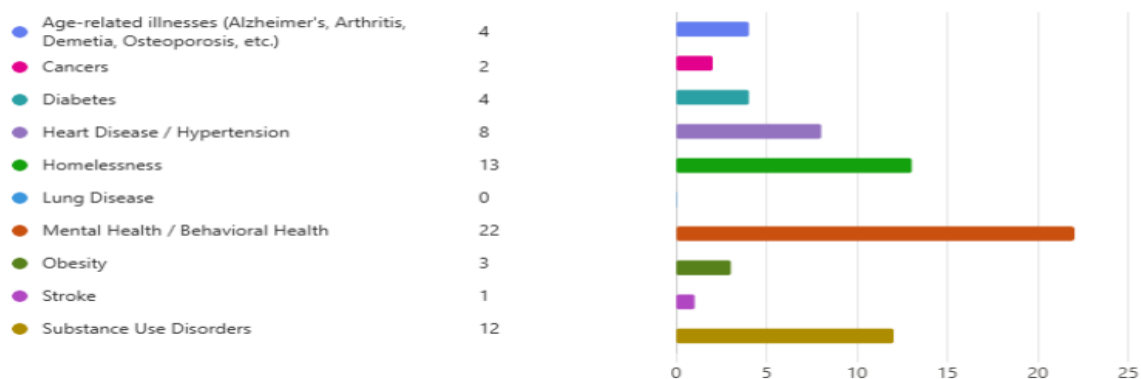
The hospital leadership reviewed the community health information and used the criteria below to prioritize the health needs in the community. The top three needs were selected that will make an impact, are ready with capacity for interventions, and can align with existing or new community partners via Microsoft Forms Survey. Framing the scope for prioritizing significant needs included:

Disparities & Inequities	Which need would show the greatest improvement in vulnerable populations?
Overall Community Health	Which need would show the greatest impact on health in our communities?
Impact & Feasibility	Can we make a difference? Are there known interventions that exist?
Capacity & Momentum	Do we have the capacity to address these needs? Do we have community partners we can support on this issue?

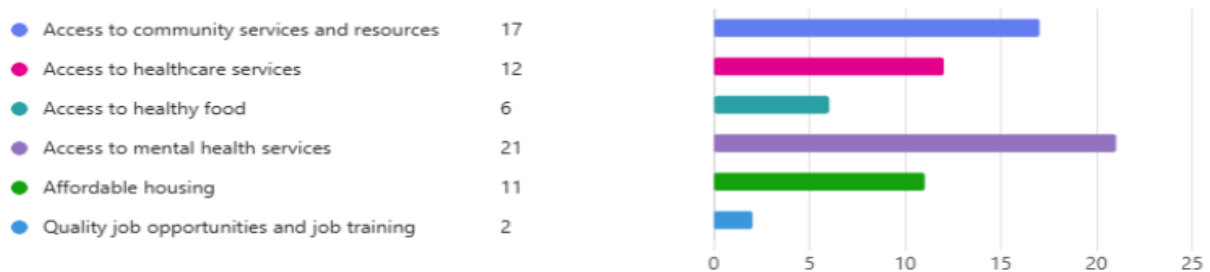
1. Which Social Determinants of Health (SDoH) do you feel SFIL can make an impact on? (Select your top three) (0 point)



2. What do you feel are the three most important health issues in SFIL's communities? (0 point)



3. What do you feel is needed to support the three health issues that you selected above? (0 point)



There were 23 responses out of 44 with a 52% response rate. Based on the analysis of the data and discussion with leadership, the top three most significant prioritized community health needs were identified as follows:

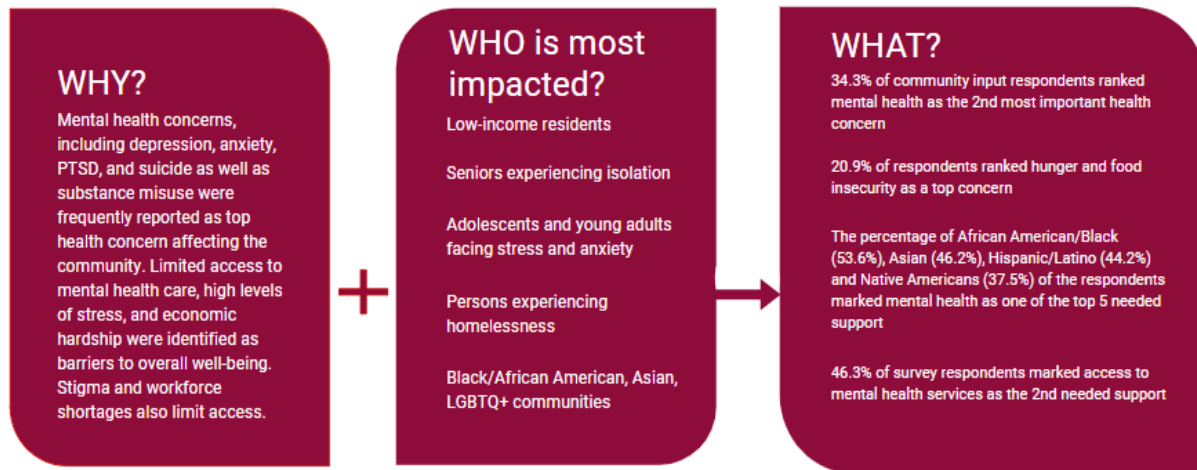
Food Access & Security



Housing Assistance



Mental Health/Behavioral Health & Substance Use Support



Stop by our new Living Room bungalow in Evanston

311 Elmwood Ave., Evanston

On the south end of the campus of St. Francis Hospital. (See map on this page.)

OPEN HOUSE on Weds. 10/1/2025, 9:30-11:30 a.m. in celebration of the Evanston Living Room's one-year birthday! Please stop by for coffee, sweets, and info about our free crisis services.

The Living Room provides professional peer support for adults in crisis, offered at no charge.

12 p.m. – 8 p.m. daily. No appointments needed, just walk in.

847.933.0051, TTY: 711

Click [HERE](#) for information on other services.

Immediate support, when you need it, free of charge.

In the Living Room, trained recovery support specialists with personal experience in managing the challenges of mental illness collaborate with licensed therapists to provide crisis intervention, support, and mentoring. To offer a wide range of supports, Turning Point has partnered with trusted colleague organizations, PEER Services and Impact Behavioral Health Partners, to also offer employment assistance and support for substance use concerns.



Next Steps

Following the completion of the community health needs assessment as outlined in this report, Saint Francis Hospital will respond to these prioritized needs through the three-year CHNA Implementation Strategy (IS) plan. The Implementation Strategy (IS) Plan will detail how Saint Francis Hospital will respond to the prioritized needs throughout the three-year CHNA cycle. The Implementation Strategy (IS) Plan will also describe why certain significant needs were not selected as prioritized needs to be addressed by the hospital.

CHNA/Implementation Strategies Recommendations

Prioritized Need	Strategy	Strategy Source	SFIL Role	Anticipated Impact
Social Determinants of Health (SDoH): Food Access & Security	Food Access Assistance	• Micro-pantry • Food Drives • Local Food Pantry Support and Partnerships	Increase food access assistance for food insecure individuals Provide financial support to community-based organizations for food assistance (Greater Chicago Food Depository-Produce Mobile, local churches, Connections for the Homeless, Howard & Evanston Community Center)	Total Number Individuals Served: TBD Total Pounds of Food Provided: TBD Total Meals Provided: TBD Total Percentage of Community Investment: TBD
Social Determinants of Health (SDoH): Housing Assistance	Housing Assistance	Local Housing Support and Partnerships	Provide financial support to transitional housing community-based organization (i.e., Connections for the Homeless, etc.)	Total Number of Individuals Served: TBD Total Percentage of Community Investment: TBD
Behavioral Health/Mental Health Substance Use Support	Access to Mental Health Resources & Services Substance Use Disorder (SUD)	Local MH/BH & SUD Assistance Support and partnerships	Continue to provide a program for patients in need of SUD treatment Community education and outreach Provide financial support to community-based organization (PEER, Trilogy, Impact BH Partners, Between Friends, etc.)	Total Number of Individuals Screened for SUD: TBD Total Number of Individuals Served: TBD Total Percentage of Community Investment: TBD

Summary of the Impact of the Previous CHNA Implementation Strategy Plan

An important piece of the three-year cycle is revisiting the progress made on priority needs in the preceding CHNA. By reviewing the actions taken to address the significant needs and evaluating the impact those actions have made in the community, it is possible to better target resources and efforts during the next CHNA cycle. As mentioned, the preceding assessment was under Ascension Healthcare, but on March 1, 2025, Ascension transferred ownership to Prime Healthcare.

Saint Francis' previous CHNA Implementation Strategy included these priority health needs: Food Access & Security, Workforce Development, Access to Care and Community Resources, and Mental Health/Behavioral Health. Highlights include:

- Over 1,000 food items were collected annually for the Howard & Evanston Community Center.
- Local food access support for Greater Chicago Food Depository, American Cancer Society's Food Insecurity Program, and Second Baptist Church's Soup Kitchen & Food Pantry.
- Over 1,000 high school and college students were provided opportunities to engage with health care professionals, giving 12,491.34 hours of their time.
- For Access to Care & Community Resources, the Neighborhood Resource Directory and Advocata Enrollment Benefits program made 485 referrals, community residents with 3,767 searches for resources and 21 eligible applicants connected to healthcare services.
- In partnership with PEER Services and Trilogy, SFIL provides a warm hand-off program for substance use disorder patients in need of services and treatments. There were 377 patients referred and 39 Narcan kits distributed.

Community Asset Inventory

This list of community assets and resources is relative to the most significant issues that can help improve the health of the community and assist with implementation of the plan that will accompany this report. This asset inventory is not exhaustive and may have inadvertently omitted community resources.

Food Access & Security

COMMUNITY PARTNER	PROGRAM NAME	COMMUNITY NEED	AFFILIATED HOSPITAL AND DESCRIPTION
American Cancer Society	Food Insecurity Program	SDoH: Food Access & Nutrition	SFH: Provide support to the American Cancer Society with a cash donation for individuals and families that are food insecure.
Connections for the Homeless	Food Pantry	SDoH: Food Access & Nutrition	SFH: Collaboration with Connections for the Homeless to provide financial support and an annual food drive for their local food pantry for those in need and are homeless.
City of Evanston: Parks & Recreation – Levy Senior Center	Aging Well Conference	SDoH: Community Safety	SFH: Provide cash donation support for various events at the Levy Senior Center.
Evanston Chamber of Commerce	MashUp	SDoH: Economic Stability	SFH: Provide cash donation support for various events at the chamber.
Greater Chicago Food Depository	Produce Mobile	SDoH: Food Access & Nutrition	SFH: Collaboration with Greater Chicago Food Depository and local churches to provide volunteer support with monthly food distribution and food assistance efforts with a cash donation.
Howard and Evanston Community Center	Food Pantry	SDoH: Food Access & Nutrition	SFH: Collaboration with Howard and Evanston Community Center to provide annual Thanksgiving food drive support for their local food pantry for those in need.
Second Baptist Church St. Luke's Church Ebenezer AME Church First Church of God Christian Life center	Food Pantry AED Donations and Training	SDoH: Food Access & Nutrition SDoH: Community Safety	SFH: Collaboration with Second Baptist Church to provide financial support for their local food access programs with a cash donation for those in need. Provided eight AEDs to various AA churches in Evanston (listed). Community Hand-only CPR & AED training provided to Second Baptist Church.
NAACP Evanston Branch	Freedom Fund	SDoH: Racism/Health Equity	SFH: Provide cash donation support for the NAACP Evanston Branch annually.
YWCA Northshore – Evanston	Race Against Hate	SDoH: Racism/Health Equity	SFH: Provide cash donation annually to support the Race Against Hate event.

Workforce Development

COMMUNITY PARTNER	PROGRAM NAME	COMMUNITY NEED	AFFILIATED HOSPITAL AND DESCRIPTION
ATS Institute of Technology	Clinical Rotation Site	Workforce Development	SFH: Provide support for ATS Institute of Technology nursing students - hospital serves as a clinical rotation site for nursing students.
Chamberlain University	Clinical Rotation Site	Workforce Development	SFH: Provide support for Chamberlain University nursing students - hospital serves as a clinical rotation site for nursing students.
DePaul University	Clinical Rotation Site	Workforce Development	SFH: Provide support for DePaul University nursing students - hospital serves as a clinical rotation site for nursing students.
Loyola University	Clinical Rotation Site	Workforce Development	SFH: Provide support for Loyola University nursing students - hospital serves as a clinical rotation site for nursing students.
Malcolm X University	Clinical Rotation Site	Workforce Development	SFH: Provide support for Malcolm X University nursing students - hospital serves as a clinical rotation site for nursing students.
Oakton Community College	Clinical Rotation Site	Workforce Development	SFH: Provide support for Oakton Community College nursing students - hospital serves as a clinical rotation site for nursing students.
ETHS (Evanston Township High School) & CPS (Chicago Public High Schools)	High School Student Interns	Workforce Development	SFH: Provide support for high school students who are interested in healthcare careers.

Access to Care & Community Resources

COMMUNITY PARTNER	PROGRAM NAME	COMMUNITY NEED	AFFILIATED HOSPITAL AND DESCRIPTION
A Silver Lining Foundation	Buy a Mom-a-Mammogram	Access to Care	SFH: Partnership with A Silver Lining Foundation to provide screening and diagnostic services to uninsured and underinsured individuals in need of mammography services.
CommunityHealth	Free Clinic Services	Access to Care	SFH: Provide support with cash donations to CommunityHealth which is a free clinic for all Chicago low-income residents to receive services.
Find Help	Community Resources	Access to Care	SFH: Provide support to internal staff and external partners to find free or reduced-cost resources like food, housing, financial assistance, health care, and more. SDoH screenings and referrals included.
The Chicago Center	Community Resources	Access to Care	SFH: Provide support to The Chicago Center's annual community event with various resources.



Mental Health/Behavioral Health

COMMUNITY PARTNER	PROGRAM NAME	COMMUNITY NEED	AFFILIATED HOSPITAL AND DESCRIPTION	
Between Friends	Domestic Violence	Behavioral Health	SFH: Provide support to Between Friends for their efforts to prevent domestic violence and end the cycle of abuse by equipping our communities with the tools necessary for everyone to feel safe and equal in their relationships.	
Impact Behavioral Health Partners	Supportive Housing, BH	Behavioral Health	SFH: Provide support to Impact BH Partners to develop and champion opportunities for people with serious mental illness by providing comprehensive services in housing, employment, and clinical support so that each person can live as independently as possible.	
PEER Services	Warm Handoff Services Program	Behavioral Health & Substance Use Disorder	SFH: Partnership with PEER/Trilogy Services to provide warm handoff services in the ED. This is a referral from ED to PEER/Trilogy Services to provide substance use disorder services post discharge.	
Trilogy Services	Warm Handoff Services Program	Behavioral Health & Substance Use Disorder	SFH: Partnership with PEER/Trilogy Services to provide warm handoff services in the ED. This is a referral from ED to PEER/Trilogy Services to provide substance use disorder services post discharge.	
Turning Point Behavioral Health	The Living Room, BH Services	Behavioral Health	SFH: Partnership with Turning Point to provide the Living Room and other mental health services. The walk-in program welcomes adults in crisis who seek safety and solutions in a calm and comfortable space.	

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Saint Francis Hospital Best Care in Evanston, IL
State public health departments (via KIDS COUNT, https://datacenter.kidscount.org), Health Resources & Services Administration: Maternal and Child Health Bureau (MCHB) (3-year data), Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Nativity (NVSS-N) (Via CDC Wonder Health Indicators Warehouse (through 2014) and via CDC Wonder (2016-2020 data averages))
The Eviction Lab at Princeton University: Estimating Eviction Prevalence across the United States, Cook County Sheriff's Office of Research (Monthly data in Chicago)
The New York Times (based on reports from state and local health agencies), Various state health departments (COVID dashboards)
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