UChicago Medicine AdventHealth GlenOaks 2025 Community Health Needs Assessment

Extending the Healing Ministry of Christ

UChicago Medicine | AdventHealth

Table of Contents

Letter from Leadership

At AdventHealth, we have a sacred mission of Extending the Healing Ministry of Christ. That obligation goes beyond our hospital walls and permeates into our communities. Our commitment is to address the health care needs of our community with a wholistic focus, one that strives to heal and restore the body, mind and spirit. We want to help our communities get well and stay well.

Every three years, AdventHealth hospitals across the nation complete a Community Health Needs Assessment. During this assessment, we talk and work with community organizations, public health experts, and people like you who understand our communities best. This in-depth look at the overall health of our communities and the barriers to care they experience helps AdventHealth better understand the unique needs in the various communities we serve.

We use this information to create strategic plans that address the issues that impact our communities most. At AdventHealth, we know that a healthy community is not a “one size fits all” proposition—everyone deserves a whole health approach that meets them where they are and supports their individual health journey.

This work would not be possible without the partnership of public health experts, community organizations and countless community members who helped inform this report. Through these ongoing partnerships and collaborative efforts, AdventHealth will continue to create opportunities for better health in all the communities we serve.

In His service,
Kenneth Rose
President and CEO, UChicago Medicine AdventHealth GlenOaks

Our commitment is to address the health care needs of our community with a wholistic focus, one that strives to heal and restore the body, mind and spirit.

Executive Summary

Adventist GlenOaks Hospital dba UChicago Medicine AdventHealth GlenOaks will be referred to in this document as UChicago Medicine AdventHealth GlenOaks or "The Hospital." UChicago Medicine AdventHealth GlenOaks in DuPage County, Illinois conducted a community health needs assessment from February 2024 to June 2025. The goals of the assessment were to:

- Engage public health and community stakeholders, including low-income, minority and other underserved populations.
- Assess and understand the community's health issues and needs.
- Understand the health behaviors, risk factors and social determinants that impact health.
- Identify community resources and collaborate with community partners.
- Publish the Community Health Needs Assessment.
- Use the assessment findings to develop and implement a 2026 – 2028 Community Health Plan based on the needs prioritized in the assessment process.

Community Health Needs Assessment Committee

To ensure broad community input, UChicago Medicine AdventHealth GlenOaks created a Community Health Needs Assessment Committee (CHNAC) to help guide the Hospital through the assessment process. The CHNAC included representation from the Hospital, public health experts and the broad community. This included intentional representation from low-income, minority and other underserved populations.

The CHNAC met two times in 2024. They reviewed primary and secondary data and helped to identify the top priority needs in the community.

See Prioritization Process for a list of CHNAC members.

Data

UChicago Medicine AdventHealth GlenOaks in collaboration with the AdventHealth Corporate Team collected both primary and secondary data. The primary data included community surveys, focus groups, and stakeholder surveys. Secondary data included internal hospital utilization data (inpatient, outpatient and emergency department). This utilization data showed the top diagnoses for visits to the Hospital from 2022 – 2024. In addition, publicly available data from state and nationally recognized sources were used. Primary and secondary data was compiled and analyzed to identify the top eleven needs.

See Process, Methods and Findings for data sources.

Community Asset Inventory

The next step was to create a community asset inventory. This inventory was designed to help the CHNAC understand the existing community efforts being used to address the eleven needs identified from the aggregate primary and secondary data. This inventory was also designed to prevent duplication of efforts.

See Available Community Resources for more.

Selection Criteria

The CHNAC participated in a prioritization process after a data review and facilitated discussion session. The identified needs were then ranked based on clearly defined criteria.

See Prioritization Process for more.

The following criteria were considered during the prioritization process:

A. Impact on Community

What are the consequences to the health of the community of not addressing this issue now?

B. Resources

Are there existing, effective interventions and opportunities to partner with the community to address this issue?

C. Outcome Opportunities

Do interventions addressing this issue have an impact on other health and social issues in the community?

Priorities to Be Addressed

The priorities to be addressed are:

1. Diabetes
2. Mental Health
3. Health Care Access and Quality

See Priorities Addressed for more.

Approval

On March 26, 2025, the UChicago Medicine AdventHealth GlenOaks board approved the Community Health Needs Assessment findings, priority needs and final report. A link to the 2025 Community Health Needs Assessment was posted on the Hospital's website prior to June 30, 2025.

Next Steps

UChicago Medicine AdventHealth GlenOaks will work with the CHNAC to develop a measurable implementation strategy called the 2026–2028 Community Health Plan to address the priority needs. The plan will be completed and posted on the Hospital's website prior to November 15, 2025.

About AdventHealth

UChicago Medicine AdventHealth GlenOaks is part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth strives to heal and restore the body, mind and spirit through our connected system of care. More than 100,000 talented and compassionate team members serve over 8 million patients annually. From physician practices, hospitals and outpatient clinics to skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, whole-person care at more than 50 hospital campuses and hundreds of care sites throughout nine states.

Committed to your care today and tomorrow, AdventHealth is investing in new technologies, research and the brightest minds to redefine wellness, advance medicine and create healthier communities.

In a 2020 study by Stanford University, physicians and researchers from AdventHealth were featured in the ranking of the world's top 2% of scientists. These critical thinkers are shaping the future of health care.

Amwell, a national telehealth leader, named AdventHealth the winner of its Innovation Integration Award. This telemedicine accreditation recognizes organizations that have identified connection points within digital health care to improve clinical outcomes and user experiences. AdventHealth was recognized for its innovative digital front door strategy, which is making it possible for patients to seamlessly navigate their health care journey. From checking health documentation and paying bills to conducting a virtual urgent care visit with a provider, we're making health care easier—creating pathways to wholistic care no matter where your health journey starts.

AdventHealth is also an award-winning workplace aiming to promote personal, professional and spiritual growth with its team culture. Recognized by Becker's Hospital Review on its "150 Top Places to Work in Healthcare" several years in a row, this recognition is given annually to health care organizations that promote workplace diversity, employee engagement and professional growth. In 2024, the organization was named by Newsweek as one of the Greatest Workplaces for Diversity and a Most Trustworthy Company in America.

About UChicago Medicine AdventHealth GlenOaks

UChicago Medicine AdventHealth is a connected system of care for every stage of life and health. A shared vision, common values, focus on whole-person health and commitment to making communities healthier unify the system's four hospitals located in Bolingbrook, Glendale Heights, Hinsdale and La Grange. The system also includes nearly 50 primary and specialty practice locations and two multispecialty ambulatory centers. In January 2023, The University of Chicago Medicine and AdventHealth launched a joint venture, bringing academic medicine to the western suburbs. The partnership builds on UChicago Medicine's national reputation for specialty and subspecialty care and AdventHealth's exceptional quality and rich legacy of whole-person care.

UChicago Medicine AdventHealth GlenOaks is a 140- bed, full service medical facility that provides high-quality, compassionate and family-centered medical care to the residents of Glendale Heights and the surrounding communities. UChicago Medicine AdventHealth GlenOaks offers emergency medical services, heart care, lab and imaging services, behavioral medicine services, cancer care and surgical services. UChicago Medicine AdventHealth GlenOaks has earned a number of nationally recognized awards and safety grades including the Joint Commission Certified Primary Stroke Center designation, Level II Trauma Center and American Heart Association/ American Stroke Association's Get With the Guidelines Stroke Silver Plus Quality Achievement Award. It offers a Therapeutic Day School and Transition Program and Hepatitis C Clinic. It is also the only disproportionate share hospital in DuPage County.

UChicago Medicine AdventHealth GlenOaks is a 140-bed, full service medical facility that provides high-quality, compassionate and family-centered medical care to the residents of Glendale Heights and the surrounding communities.

Community Overview

Community Description

Located in DuPage County, Illinois, UChicago Medicine AdventHealth GlenOaks defines its community as the Primary Service Area (PSA), the area in which 75–80% of its patient population lives. This includes eight zip codes across DuPage county and Cook county.

Demographic and community profile data in this report are from publicly available data sources such as the U.S. Census Bureau and the Center for Disease Control and Prevention (CDC), unless indicated otherwise. Data are reported for the Hospital's PSA, unless listed differently. Data are also provided to show how the community compares locally, in the state, and at a national level for some indicators.

Community Profile

Age and Sex

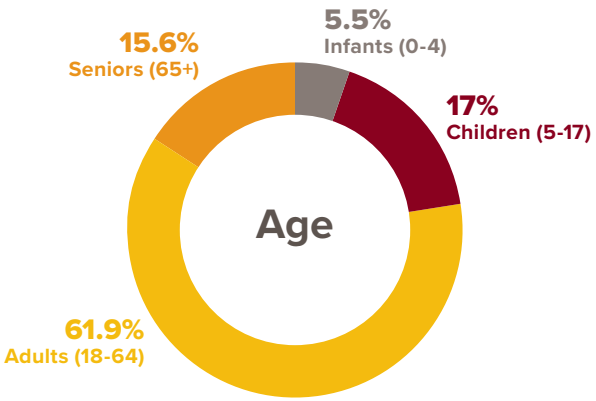
The median age in the Hospital's community is 38.5, slightly lower than that of state which is 39.1 and the US, 39.

Females are the majority, representing 50.5% of the population. Middle aged females, 40–64 are the largest demographic in the community at 16.4%.

Children make up 22.5% of the total population in the community. Juveniles, those five to seventeen, are 17% of that number. The community birth rate is 55.9 births per 1,000 women aged 15–50. This is higher than the U.S. average of 51.1, and higher than that of the state, 50.2. In the Hospital's community, 13.5% of children aged 0–4 and 11.4% of children aged 5–17 are in poverty.

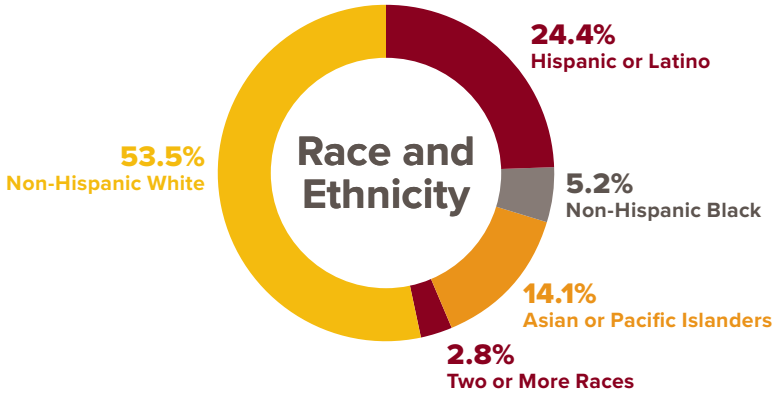
UChicago Medicine AdventHealth GlenOaks defines its community as... the area in which 75–80% of its patient population lives. This includes eight zip codes across DuPage county and Cook county.

Seniors, those 65 and older, represent 15.6% of the total population in the community. Females are 54.8% of the total senior population.



Race and Ethnicity

In the Hospital's community, 53.5% of the residents are non-Hispanic White, 24.4% are Hispanic or Latino, and 14.1% are Asian. Residents who are of non-Hispanic Black represent 5.2% of the population, and two or more races represent 2.8% of the total population.



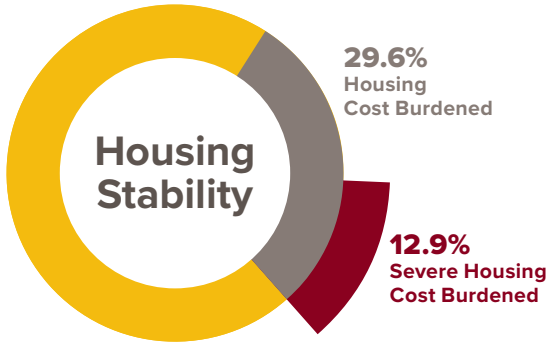
Economic Stability

Income

The median household income in the Hospital's community is $89,404. This is above the median for the state and US. Although above the median, 8.6% of residents live in poverty, the majority of whom are under the age of 18.

Housing Stability

Increasingly, evidence is showing a connection between stable and affordable housing and health.[1] When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more the 50%.



1 Severe housing cost burden* | County Health Rankings & Roadmaps

Education Access and Quality

Research shows that education can be a predictor of health outcomes, as well a path to address inequality in communities.[2] Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

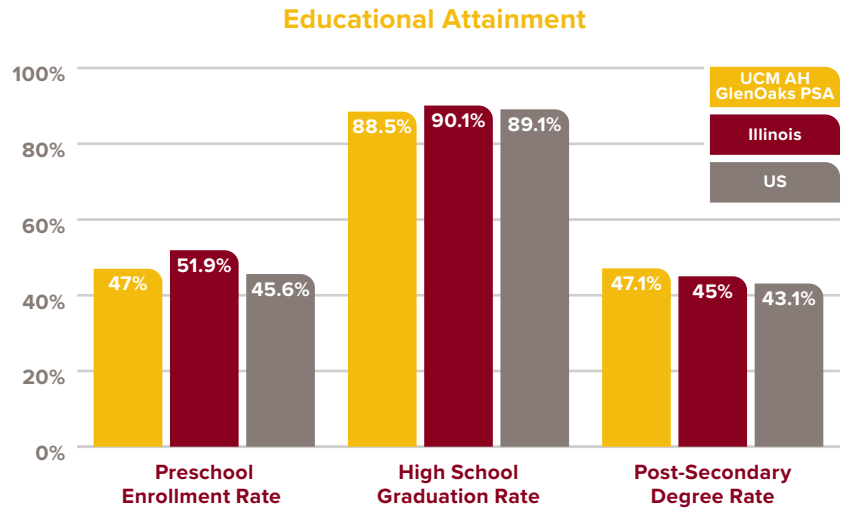
In the Hospital's community, there is a 88.5% high school graduation rate, which is slightly lower than both the state (90.4%) and national average (89.6%). The rate of people with a post-secondary degree is higher (47.1%) in the Hospital's PSA than in both the state (46.1%) and nation (44.5%).

Early childhood education is uniquely important and can improve children's cognitive and social development. It helps provide the foundation for long-term academic success, as well as improved health outcomes. Research on early childhood education programs shows that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings.[3]

2 The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015 | Archives of Public Health | Full Text (biomedcentral.com)

3 Early Childhood Education | U.S. Department of Health and Human Services

In the Hospital's community, 47% of three- and four-year olds were enrolled in preschool. This rate is lower than the state (51.9%) yet higher than the national (45.6%) average; there is a large percentage of children in the community who may not be receiving these early foundational learnings.



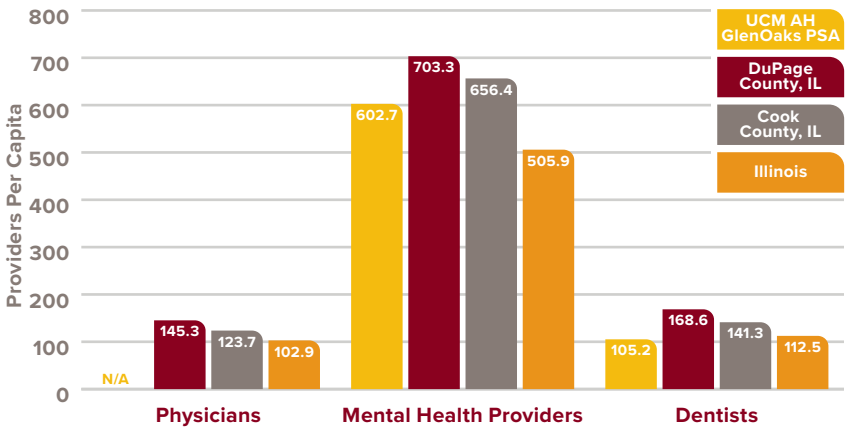
Health Care Access and Quality

In 2022, 12.1% of uninsured community members aged 18 – 64 were found to lack health insurance. Without access to health insurance, these individuals may experience delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people.[4]

Accessing health care requires more than just insurance. There must also be health care professionals available to provide care. When more providers are available in a community access can be easier, particularly for those experiencing transportation challenges. In the counties that the Hospital serves, Cook County has the most care providers available, higher than the state average.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 77.5% of people report visiting their doctor for routine care.

Available Health Care Providers

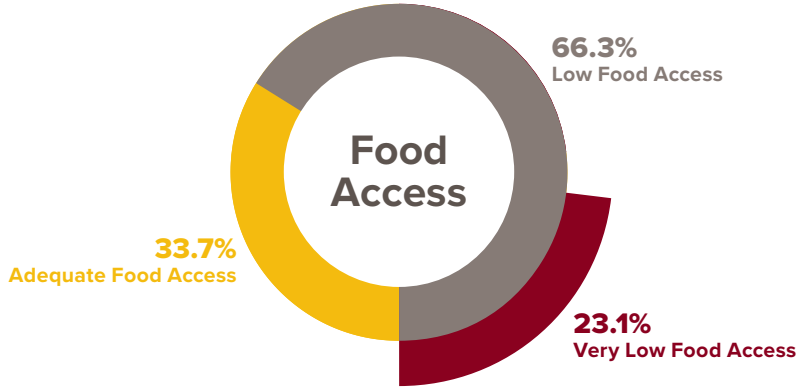


4 Health Insurance and Access to Care | CDC

Neighborhood and Built Environment

Increasingly, a community's neighborhoods and built environment are shown to impact health outcomes. If a neighborhood is considered to have low food access, which is defined as being more than ½ mile from the nearest supermarket in an urban area or ten miles in a rural area, it may make it harder for people to have a healthy diet. A very low food access area is defined as being more than one mile from your nearest supermarket in an urban area or 20 miles in a rural area.

A person's diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet.[5] In the Hospital's community, 66.3% of the community lives in a low food access area, while 23.1% live in a very low food access area.



People who are food insecure, who have reduced quality or food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.[6] Feeding America estimates for 2022[7], showed the food insecurity rate in DuPage County, where the Hospital is located, as 9%.

5 Heart Disease Risk Factors | CDC
6 Facts About Child Hunger | Feeding America
7 Map the Meal Gap 2022 | Feeding America

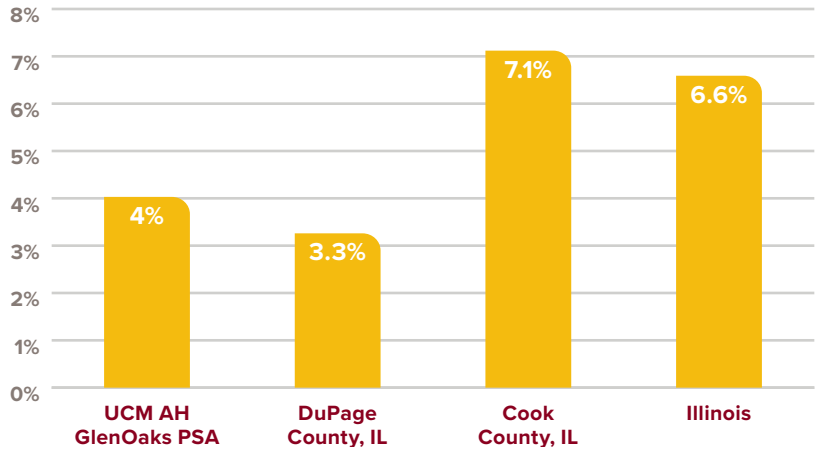
Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and steady employment. In the community, 5.4% of the households do not have an available vehicle.

Social and Community Context

People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being.[8] When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can connect through work, community clubs or others to build their own relationships and social supports. There can be challenges to building these relationships when people don't have connections to create them or there are barriers, like language.

In the community, 4% of youth aged 16-19 were reported as disconnected, meaning they were neither enrolled in school nor working at the time. The county with the highest individual percentage of disconnected youth was Cook County at 5.7%.

Disconnected Youth



Also, in the community 21.9% of seniors (age 65 and older) report living alone and 9.7% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.

8 Social and Community Context - Healthy People 2030 | U.S. Department of Health and Human Services

Social Determinants of Health

According to the CDC, social determinants of health (SDOH) are the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. Social determinants of health are increasingly seen as the largest contributing factor to health outcomes in communities throughout the country.

The Hospital categorized and analyzed SDOH data following the Healthy People 2030 model. This approach was chosen so the Hospital could align its work with national efforts when addressing social determinants of health when possible. For the purposes of CHNA, the Hospital will follow this model for reporting any related data.

The Healthy People 2030 place-based framework outlines five areas of SDOH:

Economic Stability

Includes areas such as income, cost of living and housing stability.

Education Access and Quality

This framework focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.

Health Care Access and Quality

Covers topics such as access to health care, access to primary care and health insurance coverage.

Neighborhood and Built Environment

Includes quality of housing, access to transportation, food security, and neighborhood crime and violence.

Social and Community Context

Focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Process, Methods and Findings

Process and Methods

The Process

The health of people living in the same community can be very different, because there are so many influencing factors. To understand and assess the most important health needs of its unique community and the people in it, the Hospital, solicited input directly from the community and from individuals who represent the broad interests of the community. A real effort was made to reach out to all members of the community to obtain perspectives across age, race and ethnicity, gender, profession, household income, education level and geographic location. The Hospital also collected publicly available and internal hospital utilization data for review.

The Hospital partnered with local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members, to form a Community Health Needs Assessment Committee (CHNAC) to guide the assessment process.

During data review sessions, community members of the CHNAC provided insight on how health conditions and areas of need were impacting those they represented. The CHNAC used the data review and discussion sessions to understand the most important health needs and barriers to health the community was facing and to guide the selection of needs to be addressed in the 2025 CHNA.

A real effort was made to reach out to all members of the community to obtain perspectives across age, race and ethnicity, gender, profession, household income, education level and geographic location.

Community Input

The Hospital collected input directly from the community and from community stakeholders, including individuals working in organizations addressing the needs and interests of the community.

Input was collected through focus groups and two different surveys: the community health survey and the stakeholder survey.

Focus Groups

- Conducted by UChicago Medicine AdventHealth Community Health Team
- Prioritized hearing from community members on the need for more accessible and inclusive healthcare services for marginalized communities.
- Focused on accessibility for medication and healthcare services particularly for the elderly.
- Focus group participants were asked to assist in developing action items to address outreach efforts and concerns in the community.
- Materials for discussions were provided in both English and Spanish

Community Health Survey

- The survey was provided in both English and Spanish to anyone in the community and accessible through weblinks and QR codes.
- Links and QR codes were shared through targeted social media posts and with community partners, including public health organizations. Partners were provided links to the survey, with the request that it be sent to electronic mailing lists they maintained, and, when possible, shared on their own social media channels.
- Paper surveys were given to partners to place at their organizations with the goal of reaching those who might not have access otherwise and who experience barriers to responding electronically. Responses from paper surveys were recorded using survey weblinks.

Stakeholder Survey

- Participants were asked to provide input on health, and barriers to health, that they saw in the community.
- Surveys were sent to individuals working at community organizations, including public health organizations, that work to improve the health and well-being of the community.
- Efforts were focused on stakeholders who represent or serve underserved, underrepresented communities that are lower income, and are more likely to be impacted by the social determinants of health.

Public and Community Health Experts Consulted

A total of nine stakeholders provided their expertise and knowledge regarding their communities, including:

Name	Organization	Services Provided	Populations Served
Dr. Joseph R. William, Superintendent	Queen Bee School District 16	Education/youth services, Food assistance, Mental health, Health care/public health	Infant, Children, Adolescents; LGBTQIA+; Parents or Caregivers; People with disabilities; Women; Homeless; Low income
Doug Flint, Village Administrator	Village of Glendale Heights	Government provided services	General public
Kara Murphy, President	DuPage Health Coalition	Nonprofit/social service, Public health, Community organization, Health and wellness	Elderly; People with disabilities; Women; Low income; General public; LGBTQIA+; Uninsured, Immigrants
David Roth, Executive Director	DuPage Federation on Human Services Reform	Community planning, language access and public benefits access	We serve organizations that provide and influence human services
Joel Jara, Community Relationships Coordinator	DuPage Health Coatlion	Health care/public health, Education/youth services, Mental health	Low income; Women; General public
Vladimir Radivojevic, Former CEO, President	UChicago AdventHealth GlenOaks	Health care/public health, Education/youth services, Mental health, Behavioral health, Food assistance	LGBTQIA+; Elderly; People with disabilities; Women; Low income; Veterans; General public; Parents or Caregivers; Homeless
Becky McFarland, Population Health Coordinator	DuPage County Health Department	Health care/public health, Education/youth services, Mental health, Behavioral health, Food assistance, Benefits Navigation	Infant, Children, Adolescents; LGBTQIA+; Elderly; Parents or Caregivers; People with disabilities; Women; Homeless; Low income; Veterans; General public
Jose Luis Gutierrez, Director	Casa Michoacan DuPage	Health care/public health, Housing, Domestic violence, Mental health, Food assistance, Employment assistance, Financial support, Education/youth services	Infant, Children, Adolescents; LGBTQIA+; Elderly; Parents or Caregivers; People with disabilities; Women; General public
Catherine Lynott, Executive Director	The Outreach House	Food assistance, Financial support	General public; Low income; Infant, Children, Adolescents; Elderly; Women; Homeless; Veterans

Secondary Data

To inform the assessment process, the Hospital collected existing health-related and demographic data about the community from public sources. This included data on health conditions, social determinants of health and health behaviors.

The most current publicly available data for the assessment was compiled and sourced from government and public health organizations including:

- US Census Bureau
- Centers for Disease Control and Prevention
- Feeding America
- County Health Rankings
- The State Health Department
- National Cancer Institute

Hospital utilization data for uninsured or self-pay patients who visited the Hospital for emergency department, inpatient or outpatient services in 2022 – 2024 was also used in the assessment. The top ten diagnosis codes were provided by the the AdventHealth Information Technology team

The Findings

To identify the top needs, the Hospital analyzed the data collected across all sources. At the conclusion of the data analysis, there were eleven needs that rose to the top. These needs were identified as being the most prevalent in the community and frequently mentioned among community members and stakeholders.

The significant needs identified in the assessment process included:

Cancer

Cancer is a disease in which some of the body's cells grow uncontrollably and spread to other parts of the body. Cancer can start almost anywhere in the human body, which is made up of trillions of cells. Normally, human cells grow and multiply (through a process called cell division) to form new cells as the body needs them. When cells grow old or become damaged, they die, and new cells take their place. Sometimes this orderly process breaks down, and abnormal or damaged cells grow and multiply when they shouldn't. These cells may form tumors, which are lumps of tissue. Tumors can be cancerous or not cancerous (benign).

Diabetes

Diabetes is a group of diseases characterized by high blood sugar. When a person has diabetes, the body either does not make enough insulin (type 1) or is unable to properly use insulin (type 2). When the body does not have enough insulin or cannot use it properly, blood sugar (glucose) builds up in the blood. Prediabetes is a condition in which blood sugar is higher than normal but not high enough to be classified as diabetes.

Heart Disease and Stroke

Cardiovascular disease generally refers to conditions that involve narrowed or blocked blood vessels that can lead to a heart attack, chest pain (angina) or stroke. Other heart conditions, such as those that affect your heart's muscle, valves or rhythm, also are considered forms of heart disease.

Mental Health

Mental illnesses are conditions that affect a person's thinking, feeling, mood or behavior, such as depression, anxiety, bipolar disorder or schizophrenia. Such conditions may be occasional or long-lasting (chronic) and affect someone's ability to relate to others and function each day. Mental health includes our emotional, psychological and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Drug and Alcohol Use

Healthy People 2030 focuses on preventing drug and alcohol misuse and helping people with substance use disorders get the treatment they need. Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Physical Activity

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active—like providing access to community facilities and programs—can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

Tobacco Use

Tobacco smoking is the practice of burning tobacco and ingesting the smoke produced. Smoking leads to disease and disability and harms nearly every organ of the body. Additionally, smoking causes cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Smoking also increases risk for tuberculosis, certain eye diseases, and problems of the immune system, including rheumatoid arthritis.

Economic Stability

People with steady employment are less likely to live in poverty and more likely to be healthy, but many people have trouble finding and keeping a job. People with disabilities, injuries, or conditions like arthritis may be especially limited in their ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy.

Education Access and Quality

People with higher levels of education are more likely to be healthier and live longer. Healthy People 2030 focuses on providing high-quality educational opportunities for children and adolescents—and on helping them do well in school. Children from low-income families, children with disabilities, and children who routinely experience forms of social discrimination—like bullying—are more likely to struggle with math and reading.

Health Care Access and Quality

Many people in the United States don't get the health care services they need. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Interventions to increase access to health care professionals and improve communication—in person or remotely—can help more people get the care they need.

Neighborhood and Built Environment—Food Security

Food security exists when all people, at all times, have physical and economic access to sufficient safe and nutritious food that meets their dietary needs and food preferences. A lack of food security has been linked to negative health outcomes in children and adult, as well as potentially causing trouble for children in schools.

Priorities Selection

The CHNAC through data review and discussion, narrowed the health needs of the community to a list of three. Community partners on the CHNAC represented the broad range of interests and needs, from public health to the economic, of underserved, low-income and minority people in the community. During the fall of 2024, the CHNAC met to review and discuss the collected data and select the top community needs.

Members of the CHNAC included:

Community Members

- Joseph R. Williams, Superintendent, Queen Bee School District 16
- Richard Veenstra, Mayor, Village of Addison
- Jennifer Fabian, Executive Director, People's Resource Center
- Kara Murphy, President and CEO, DuPage Health Coalition
- Meg Thompson, Director of Strategic Initiatives, DuPage Health Coalition
- Abdullah Ansari, Operations Manager, ICNA Relief
- Scott Austgen, VP of Programs, DuPage PADS

AdventHealth Team Members

- Dru Lazarra, Regional Director, Behavioral Health Services, UChicago Medicine AdventHealth
- Bob Honest, Finance Director, UChicago Medicine AdventHealth GlenOaks
- Debra Ayanian, Chief Nursing Officer, UChicago Medicine AdventHealth GlenOaks
- Derek Cazeau, Executive Director, Hospital Services
- Heather Hoffman, Regional Director, Clinical Integration, UChicago Medicine AdventHealth
- Armand Krikorian, MD, Chief Medical Officer, UChicago Medicine AdventHealth GlenOaks
- Kimberly Gillette, Case Management Director, UChicago Medicine AdventHealth GlenOaks
- Vladimir Radivojevic, Former President | CEO, UChicago Medicine AdventHealth

Community partners on the CHNAC represented the broad range of interests and needs, from public health to the economic, of underserved, low-income and minority people in the community.

GlenOaks

- Renante Gomez, Chaplain Manager, UChicago Medicine AdventHealth GlenOaks
- Kyle Glass, Regional Chief Financial Officer, UChicago Medicine AdventHealth
- Fabiola Zavala, Regional Director, Community Health, UChicago Medicine AdventHealth

Public Health Experts

- Adam Forker, Executive Director, DuPage County Health Department
- Rebecca McFarland, Population Health Coordinator, DuPage County Health Department

Prioritization Process

To identify the top needs the CHNAC participated in a prioritization session. During the session, the data behind each need was reviewed, followed by a discussion of the need, the impact it had on the community and the resources available to address it. CHNAC members then ranked the needs via an online survey.

The CHNAC (n=12) were asked to select the three needs they thought the Hospital should address in the community.

The following criteria were considered during the prioritization process:

A. Impact on Community

What are the consequences to the health of the community of not addressing this issue now?

B. Resources

Are there existing, effective interventions and opportunities to partner with the community to address this issue?

C. Outcome Opportunities

Do interventions addressing this issue have an impact on other health and social issues in the community?

The following needs rose to the top during the CHNAC's discussion and prioritization session. The needs receiving the most votes were considered the highest priority by the CHNAC.

Top Identified Needs	# of Votes	% of Responses
Mental Health	11	91.7%
Healthcare Access and Quality	7	58.3%
Diabetes	6	50%
Drug and Alcohol Use	5	41.7%
Heart Disease and Stroke	2	16.7%
Neighborhood and Built Environment—Food Security	2	16.7%
Cancer	1	8.3%
Physical Activity	1	8.3%
Economic Stability	1	8.3%
Tobacco Use	0	0%
Education Access and Quality	0	0%

Available Community Resources

As part of the assessment process, a list of resources or organizations addressing the top needs in the community was created. Although not a complete list, it helped to show where there were gaps in support and opportunities for partnership in the community when the CHNAC chose which priorities to address.

Top Needs	Current Community Programs		Current Hospital Programs
Cancer	• Wellness House — Cancer Support Group • DuPage Health Coalition — Breast Health Navigator	• Illinois Breast and Cervical Cancer Program (VNA)	• Inpatient Oncology Services • Open Arms (free mammograms)
Diabetes	• Riverwalk Adult Day Services — Adult Day Services • DuPage Health Coalition Take Charge of Your Diabetes	• VNA Diabetes Program • VNA Get Well Kitchen	• Medication Therapy Management Clinic • Medical Mission Clinic — Lifestyle Medicine
Heart Disease and Stroke	• Access Fit DuPage • Young Hearts for Life	• Everyday Hero CPR	• Congestive Heart Failure Clinic • Cath Lab • Outpatient Cardiac Testing • Medication Therapy Management Clinic
Mental Health	• DuPage County Health Department — Crisis Phone Support, 988 • DuPage County Health Department Outpatient Services • NAMI DuPage County — WRAP (Wellness Recovery Action Plan) • NAMI DuPage County — Parent Support Groups • Suicide Prevention Services of America — Counseling • SamaraCare Counseling — Adult Counseling Support Services	• NAMI DuPage County — Suicide Loss Connections Support Group • Madrigal Consulting and Counseling, LLP — Counseling Services • Lutheran Social Services of Illinois (LSSI) — Counseling and Therapy Services • Living Room (NAMI Dupage County) • Peer Counseling (NAMI DuPage County)	• Adolescent Program (mental health) • Adult Program (mental health) • Behavioral Health Collaborative Care Model • UChicago Medicine AdventHealth GlenOaks School and Transition Program
Drug and Alcohol Use	• Adult and Teen Challenge Illinois — Audrey Ephraim Women's Center • Way Back Inn — Gambling Addiction Services • Renz Addiction Counseling Center — Addiction Services • Breaking Free Inc — Comprehensive Drug and Alcohol Evaluations • New Age Services Corporation — Opioid Addiction Treatment (OATS)	• Thresholds — Substance Use Treatment • Healthcare Alternative Systems – Wheaton • Haymarket • Serenity House — Addison • Gateway • VNA Healthcare — MAT • Stonybrook • DuPage County Health Department Narcan Program	• Inpatient Medical Detox Program • New Day Center (Substance Misuse and Dual-Diagnosis Treatment)

Top Needs	Current Community Programs		Current Hospital Programs
Physical Activity	• North Suburban YMCA — Community Recreation Services • Access Fit DuPage	• Addison Parks and Recreation • Glendale Heights HUB	
Tobacco Use	• Illinois Tobacco Quitline		• Medication Therapy Management Clinic
Economic Stability	• TCA Health, Inc. — SNAP Program • DuPage Pads — Supportive Housing, Shelter Assistance During Coronavirus Outbreak • Community and Economic Development Association of Cook County, Inc — Hanul Family Alliance Chicago — Low-income Home Energy Assistance Program (LIHEAP)	• People's Resource Center — Financial Assistance and Social Services • The Salvation Army Des Plaines Corps Community Center — Homelessness Prevention and Emergency Assistance Programs	
Education Access and Quality	• Women Empowered for Tomorrow NFP • Kids Above All — Youth Foster Care Program • Easterseals DuPage and Fox Valley — Family Services Program	• Firman Community Services — Maternal Child Health (MCH) Case Management Program • DuPage County AOK Early Childhood	• UChicago Medicine AdventHealth GlenOaks School and Transition Program
Health Care Access and Quality	• DuPage Health Coalition, Access DuPage, Silver Access, Dispensary of Hope, Navigators • DuPage County Health Department	• ICNA Relief • VNA Healthcare • Access Community Network • World Relief	• Medication Therapy Management Clinic • Medical Mission Clinic
Neighborhood and Built Environment — Food Securit	• Northside Housing and Supportive Services — Emergency Shelter Program • Sanad Social Services — Sanad "Pay It Forward" Center • Connections for the Homeless — Drop-In Services • Beyond Hunger — SNAP Application Assistance • Oasis Senior Advisors — Naperville — Senior Housing Advising	• Covenant Faith Church of God — Food Pantry • Saint Blase Church — Food Pantry • Hanover Township — Warming and Cooling Center • ICNA Relief • Neighborhood Food Pantries • Northern Illinois Food Bank	• Hospital Micro-Pantry and Mobile Food Pantries in collaboration with Northern Illinois Food Bank

The Hospital will focus its efforts on initiatives which address health care access and have an equity-based lens and approach.

Priorities Addressed

The priorities to be addressed include:

Diabetes

In the Hospital's community, 11.8% of residents have a prevalence of diabetes, which is higher than the state average of 10.4%. According to the community survey, more than 23% of respondents have reported having diabetes. Diabetes was highest among community survey respondents who identified as Black or African American. When addressing diabetes as a priority, the Hospital can work collaboratively with organizations already addressing this issue to promote prevention activities over the next three years.

Mental Health

According to secondary data, 16.8% of residents in the Hospital's PSA have depression. According to the community survey, more than 10% of respondents have been diagnosed with a depressive disorder, and more than 10% have been diagnosed with an anxiety disorder. Stakeholders also chose mental health as one of the top health conditions affecting the community. Awareness and the need to address mental health disorders has been growing in the country. Including mental health as a priority, the Hospital can align to local, state and national efforts for resources and to create better outcomes opportunities over the next three years.

Health Care Access and Quality

In the Hospital's community, 7.24% of residents do not have health insurance. Cook county had the highest rate of uninsured, with 9% of residents. According to the community survey, more than 35% of respondents said they needed to see a doctor in the past 12 months but weren't able to due to cost. Stakeholders also mentioned difficulty accessing care due to long wait times for appointments and low provider availability further exacerbating the issue. Focus group participants also highlighted lack of insurance and affordability as barriers to seeking care. The Hospital will focus its efforts on initiatives which address health care access and have an equity-based lens and approach. The Hospital will also work with others who are addressing this priority.

Priorities Not Addressed

The priorities not to be addressed include:

Cancer

In the Hospital's community, 7.3% of residents have cancer, which is higher than the state average of 6.5%. Only 3% of community survey respondents have been diagnosed with cancer. When asked if they were up to date on preventative cancer screenings, 65% of survey respondents said yes. The Hospital did not select this need as a priority, as it is not positioned to directly address this in the community at large.

Heart Disease and Stroke

In the Hospital's community, 29.6% of residents have high cholesterol, while 28% of residents have high blood pressure. According to community survey, 25% of respondents reported having high blood pressure, and only 4% of respondents reported having coronary heart disease. While the CHNAC was in agreement that this is an important issue, they agreed that the Hospital was better positioned to focus on other issues based on current available resources.

Drug and Alcohol Use

In the Hospital's community, 18.8% of residents binge drinking, with Cook County (20.8%) surpassing the state average (20.4%). According to community survey, 12% of respondents reported taking prescription medication for non-medical reasons. Stakeholders also chose drug and alcohol use as a top health behavior of concern in the community. Drug and alcohol use has been a growing concern in the country. However, the Hospital believes other organizations are better positioned to address this need in the community and will support those efforts.

Physical Activity

In the Hospital's community, 21.7% of residents have not exercised in the past 30 days, which is slightly higher than the state average of 21.5%. According to community survey, 11% of respondents reported zero exercise in the past 30 days. The Hospital did not perceive the ability to have a measurable impact on the issue within the three years allotted for the Community Health Plan with the current resources available to the community and the Hospital at this time.

Tobacco Use

In the Hospital's community, 12.1% of residents smoke cigarettes, which is close to the state average of 13.5%. According to community survey, 3% of respondents smoke cigarettes, and 2% vape or use e-cigarettes. The Hospital believes other organizations in the community are better positioned to address this need in the community, therefore it was not selected to be addressed.

Economic Stability

In the Hospital's community, 5.2% of residents are unemployed and actively seeking employment. According to community survey, 21% of community survey respondents are worried about stable housing in the next two months. Stakeholders indicated living wage and affordable housing were two concerns impacting the health of the community. While the CHNAC was in agreement that this is an important issue, they agreed that the Hospital does not have the resources to effectively address this issue in the community.

Education Access and Quality

In the Hospital's community, 88.5% of residents have at least a high school diploma which is slightly below the state average of 90.4% of residents. Preschool enrollment in the Hospital's PSA is also below the state average. The Hospital did not select this need as a priority, as it is not positioned to directly address this in the community at large.

Neighborhood and Built Environment — Food Security

In the Hospital's community, 10.1% of households received food stamps (SNAP), while 62.7% in poverty do not receive food stamps (SNAP). According to community survey, 17% of respondents said they ate less than they should due to cost in the past 12 months.

The neighborhood and built environment (food security) need in the community is significant, however, the CHNAC did not perceive the ability to have a measurable impact on the issue within the three years allotted for the Community Health Plan with the current resources available to the community and the Hospital at this time. While the CHNAC was in agreement that this is an important issue, they agreed that the Hospital was better positioned to focus on other issues based on current available resources.

Next Steps

The CHNAC will work with the Hospital and other community partners to develop a measurable Community Health Plan for 2026 – 2028 to address the priority needs. For each priority, specific goals will be developed, including measurable outcomes, intervention strategies and the resources necessary for successful implementation.

Evidence-based strategies will be reviewed to determine the most impactful and effective interventions. For each goal, a review of policies that can support or deter progress will be completed with consideration of opportunities to make an impact. The plan will be reviewed quarterly, with an annual assessment of progress. A presentation of progress on the plan will also be presented annually to the Hospital board.

A link to the Community Health Plan will be posted on AdventHealth.com prior to November 15, 2025.

Community Health Plan

2023 – 2025 Community Health Plan Review

The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually. The following is a summary of progress made on our most recently adopted plan. The full evaluation is available upon request.

Priority 1: Prevention and Management of Serious Illness

In the 2022 CHNA, the Hospital addressed Prevention and Management of Serious Illness as a priority. This includes addressing social determinants of health and awareness of equity issues, chronic disease and serious illness.

Access to Care and Chronic Disease

In 2020, 6.6% of community members aged 18-64 were found to not have health insurance. A lack of health insurance can lead to delayed care, resulting in more serious health conditions and increased treatment costs. Since adopting the plan, the Hospital has offered two medical mission clinics and two safety fairs providing health screenings and education to over 600 community members and connected them to community resources to address health and social needs. In addition, UChicago Medicine AdventHealth GlenOaks has provided financial support to the DuPage Health Coalition and through their Silver Access program provided financial assistance help to families purchasing insurance through the ACA Healthcare Marketplace. Since 2023, 1,166 individuals have benefited from this program.

The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually.

Prevention can reduce the risk for diseases and serious illness, while appropriate disease management can improve an individual's health outcomes and quality of life. The Hospital has provided educational information on health equity, diabetes and sepsis on social media having had over 18,000 impressions and having an average reach of 220 per post. One Take Charge of Your Diabetes program was offered in collaboration with DuPage Health Coalition.

Food Insecurity

In 2020 Feeding America estimated the food insecurity rate in the Hospital's community as 9.8%. To address this the Hospital has supported the ICNA Relief Food Pantry, which in 2023, provided food to 10,000 individuals who were food insecure. The Hospital also collaborated with Northern Illinois Food Bank to provide Mobile Food Pantries that have served over 1,240 families in Glendale Heights. Additionally, the Hospital has a micro-pantry located onsite that provides food and supplies to families that are food insecure. Approximately 630 individuals have been supported with the micro-pantry since 2023.

Priority 2: Mental Health and Substance Use

Mental Health and Substance Use was also a priority. During the assessment, 54% of community survey respondents believed mental health issues were in the top three health concerns in DuPage County. Twenty-two percent, believe drug use to also be in the top three health concerns in DuPage County. The Hospital has focused on increasing referrals to mental health community-based organizations. In 2024, 348 patients were referred to mental health community-based services. The Hospital also collaborated with the National Alliance on Mental Illness (NAMI) to provide a mental health first aid training to ten faith leaders. In 2024, the Hospital participated in the DuPage Mental Health Summit that brought together approximately 200 community stakeholders to learn about services and support systems for mental health substance use treatment and engaged in discussions about stigma. The Hospital was part of a panel discussion that spoke about initiatives to support mental health and promote wellness.

2022 Community Health Needs Assessment Comments

We posted a link to the most recently-conducted CHNA and the most recently adopted implementation strategy, 2023 Community Health Plan on our hospital website as well as on AdventHealth.com prior to May 15, 2023 and have not received any written comments.

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CHNA Approved by the Hospital board on: March 26, 2025

For questions or comments, please contact
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