RUSH
Rush Copley Medical Center

2025 Community Health Needs Assessment

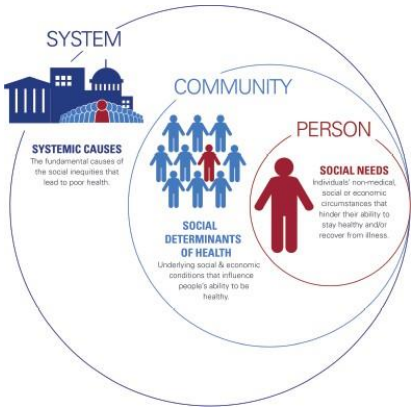
Introduction

Founded in 1886 as Aurora City Hospital, Rush Copley Medical Center has a 139-year history of providing health care services to residents of Aurora and the greater Fox Valley area. While we celebrate the rich diversity of our community, we also recognize that this diversity exists alongside inequities and systemic barriers in health, employment, income and education.

Health is influenced by far more than access to care. In fact, research shows that up to 80% of health outcomes are shaped by social, behavioral and environmental factors. Advancing community health means addressing the broader factors that influence well-being outside of hospital walls.
Rush Copley is committed to being a catalyst for change by working hand-in-hand with residents, community organizations, and local leaders to address health disparities and eliminate barriers to care. Effectively addressing community needs depends on strong, sustained partnerships across sectors.

The Rush Copley Office of Community Engagement is guided by the American Hospital Association's Societal Factors that Influence Health Framework, which drives change at the individual, community and systemic levels.

Rush Copley's strategies are grounded in insights from its Community Health Needs Assessment (CHNA) and Community Health Implementation Plan (CHIP).



Individual/Person. This is Rush Copley's greatest strength and opportunity. Patient-level interventions, at the point of care, can mitigate non-medical social and economic challenges.

Community. As an anchor institution in this community, Rush Copley will lead, convene, collaborate, invest in or support activities that improve the community environment with multi-sector stakeholders. This is our community – where we live, learn, work, play and pray.

Systemic. In partnership with other stakeholders, Rush Copley will work to support and affect policy, system, environmental and cultural changes to achieve widespread impact on societal issues such as racism, sexism, generational poverty, redlining by financial institutions, environmental injustice or educational systems.

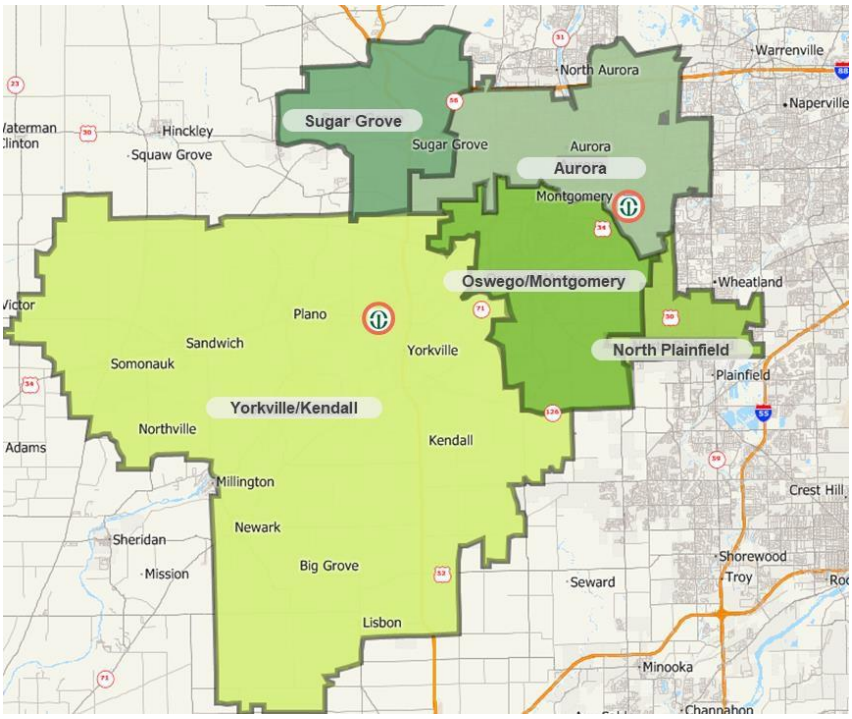
The core of Rush Copley's plan and strategies is derived from its Community Health Needs Assessment and Community Health Improvement Plan.

Service Area/Community Needs

The CHNA and CHIP focus specifically on the community served by Rush Copley. That community is defined as the geographic area identified by the contiguous zip codes from which approximately 80% of the hospital's discharged patients reside. The hospital also refers to this geographic area as the Rush Copley Primary Service Area (PSA).

- As seen in the map below, the community served includes all of Aurora and most of Southern Kane and Kendall Counties.
- Includes 17 zip codes and 13 cities/villages.
    - 60506 – Aurora
    - 60505 - Aurora
    - 60504- Aurora
    - 60503 - Aurora
    - 60502 - Aurora
    - 60543 - Oswego
    - 60538 - Montgomery
    - 60560 – Yorkville
    - 60545 – Plano
    - 60548 - Sandwich
    - 60542 - North Aurora
    - 60544 - Plainfield
    - 60564 - Naperville
    - 60585 - Plainfield
    - 60554 - Sugar Grove
    - 60563 - Naperville
    - 60586 - Plainfield
- Covers six counties: Kane, Kendall, DeKalb, LaSalle, DuPage and Will.

The primary service area has a population of over 358,000 residents. There are 49.4% White, 8.4% Black/African American, 0.1% Native American, 7.2% Asian, and 2.7% Two or More Races. Approximately 32.2% of the population is of Hispanic or Latino origin. The median age of the community is 36.3 years.



Rush Copley's Community Health Needs Assessment

Background

The Patient Protection and Affordable Care Act of 2010 requires private, not-for-profit hospitals to conduct a health needs assessment at least once every three years and to adopt an implementation strategy to address the identified community needs. Every three years, Rush Copley completes a comprehensive CHNA process to identify, prioritize and address the top three to five health issues in the communities served. Once priorities are identified, a Community Health Implementation Plan is developed to address those priorities. The CHIP is comprised of actionable initiatives — some already in place, some to be developed, but almost all implemented collaboratively with community partners.

Framework

Rush Copley follows the Association of Community Health Improvement's (ACHI) framework from the American Hospital Association which develops a comprehensive and efficient Community Health Needs Assessment, which is displayed in the graphic to the right.

Methodology

Rush Copley utilizes four key methods used in the data and information collection and analysis component of the assessment process that are critical in developing an accurate picture of the health of the community served.

1) Partnering with the local county (Kane and Kendall) health departments. Rush Copley collaborates with the Kane County and Kendall County health departments, as well as other community partners and other local health providers/experts (including Prime Health Mercy Medical Center, Prime Health Saint Joseph Hospital, Northwestern Medicine Delnor Hospital, Advocate Sherman Hospital, and the INC Mental Health Alliance), to develop and implement

their respective CHAs/CHIPs. Through these collaborations, the hospital actively participated in the identification and prioritization of needs and the development of improvement strategies for key topics that would improve the health and well-being of the residents of the respective counties. In addition, as a part of the Kane Health Counts Collaborative, Rush Copley partnered with Metopio - Health Data Platform to conduct a specific Rush Copley CHNA as a derivative of the Kane County CHA.

2) Community Health Surveys. Rush Copley contracted with Metopio to conduct an online health status survey of adult residents from the community served. The survey questions related to top health needs in the community, individual's perception of their overall health and well-being. It included 91 questions and was available in both English and Spanish to seek resident feedback on the communities' needs. Some 2,691 adult participants responded.

3) Focus Groups and Key Informant Surveys. Thirty key informant interviews, 13 focus groups, 73 community partner assessments. Kane Health Counts Focus Groups and Rush Copley Medical Center focus groups provided unique perspectives of the health needs in the community from community members, patients, health care leaders and experts.

4) Extensive Secondary Data Analysis. Rush Copley accessed 40+ local, state and national sources of health data and information. These data indicators aligned and compared to the FY13, FY16, FY19, FY22 CHNAs and Healthy People 2030 data and goals. These data sources can be found here.

This entire (16- to 18-month) process is overseen and facilitated by the Office of Community Engagement. Once the research was complete and all input gathered, a collaborative steering committee, with health care and community expertise, guided the development of the CHNA and CHIP. In evaluating the many community priorities, that steering committee considers the following *Needs Identification Criteria*:

1. The severity of the indicator/problem
2. The magnitude of the indicator/problem
3. A high need among vulnerable populations

And when determining which priorities to address, the following *Needs Prioritization Criteria* are considered:

1. The community's capacity to act on the issue, including any economic, social, cultural or political considerations
2. The likelihood or feasibility of having a measurable impact on the issue
3. The current community resources that are already focused on an issue
4. Whether the issue is a root cause of other problems

Information Sources

The hospital used the most current and up-to-date data available to identify the health needs of the community. The table below includes the data sources used in the assessment.

Primary Sources	Secondary Sources	
• Online Community Health Survey - Metopio Community Health Survey • Focus Groups - Kane Health Counts - *Food Access* - *Housing* - *Providers/Caregivers* - *Adult Health (2)* - *Maternal Child Health* - *Senior Health (2)* - *Behavioral Health – providers* - *Behavioral Health – community members* - Rush Copley Kendall County, Spanish - Rush Copley Care Managers - Rush Copley Patient Family Advisory Council (PFAC) • Online Key Informant/Stakeholder Surveys - Kane Health Counts - RCMG Physicians and Advanced Practice Providers • Written comments regarding the most recent CHNA and Implementation Strategy, however, no public comments were received regarding the posted draft of the assessment on the hospital's website.	• Advisory Board • Association for Community Health Improvement (ACHI) • Center for Applied Research and Environmental Systems (CARES) • Centers for Disease Control & Prevention (CDC), Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention • Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS) • Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics • Centers for Disease Control & Prevention, PLACES: Local Data for Better Health • Community Commons • County Health Rankings and Roadmaps • Drug Abuse Warning Network, www.samhsa.gov • ESRI ArcGIS Map Gallery • Fit Kids 2020 Plan (Kane County) • IHA COMPdata • Illinois Department of Public Health • Illinois Behavioral Risk Factor Surveillance System • Illinois Department of Public Health State Cancer Registry • Illinois Department of Human Services • Healthy People 2030	• Kane County Health Department • Kane County Community Health Assessments and supportive reports 2011, 2016, 2018 • Kane County Community Health Improvement Plan 2012-2016, 2017-2020, 2021-2024 • Kendall County Health Department • Kendall County IPLANs 2011-2016, 2016-2021 • National Cancer Institute, State Cancer Profiles • National Institute on Drug Abuse • The Neilsen Company • RCMC FY2013, FY2016, FY2019, and FY 2022 CHNAs • RCMC internal data systems • RealtyTrac • Robert Wood Johnson Foundation • US Census Bureau, American Community Survey • US Census Bureau, County Business Patterns • US Census Bureau, Decennial Census • US Department of Agriculture, Economic Research Service • US Department of Health & Human Services • US Department of Health & Human Services, Health Resources and Services Administration (HRSA) • US Department of Health & Human Services, The Office of Minority Health • US Department of Justice, Federal Bureau of Investigation • US Department of Labor, Bureau of Labor Statistics • Walkscore.com • World Health Organization • Various additional articles and community reports

Information Sources and Gaps

While an extensive amount of data was gathered and analyzed, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. Identified data gaps include:

- Limited data for the community served was available for many of the health needs topics by demographic subgroups and socio-economic subgroups (i.e., race, ethnicity, age, gender, income, education attainment, homeless, etc.).
- Very limited to no data was available for undocumented residents in the community.
- While this assessment was designed to provide a comprehensive and broad picture of the health of the overall community, several medical conditions are not specifically addressed.
- The online survey analysis demonstrated limitations on community representation among specific populations group (Black and African populations, Hispanic and Latino populations, and men)

• To address most of the data gaps mentioned above, the hospital asked questions regarding health disparities in the community through focus groups and online key informant/stakeholder surveys facilitated by or on behalf of the hospital.

Existing Health Care Facilities and Resources

The table below outlines existing facilities and resources available to address the significant health needs identified in this report. This list is not exhaustive, but rather it includes those resources identified while conducting this Community Health Needs Assessment.

Service	Health Care Facility and Resource	
Health Care Facilities and Providers	• Aunt Martha's Health and Wellness • Advocate Outpatient Center – Aurora • Independent Physicians/Providers • Prime Healthcare Mercy Medical Center • Rush Copley Medical Center • Valley West Community Hospital • VNA Health Care • Community Health Partnership: Aurora Medical and Dental Clinic • Aurora Christian Healthcare	• Dental Offices • Drug Store Based Clinics • Planned Parenthood - Aurora Health Center • Open Door Health Centers of Illinois • Long-term care facilities such as Alden of Waterford and Tillers • Palliative care professionals such as AccentCare Hospice Seasons • Waterford Place Cancer Resource Center • Home health agencies
Mental and Behavioral Health	• Association for Individual Development (AID) • Aunt Martha's Health and Wellness • Northwestern Behavioral Health Services • Communities in Schools Aurora • Advocate Outpatient Center – Aurora • Ecker Center for Mental Health • Elderday Center • Family Counseling Services • Gateway Foundation – Aurora • Family Service Association of Greater Elgin • Hope for Tomorrow, Inc. • Kendall County Health Department Mental and Substance Abuse Treatment Clinicians	• Mutual Ground, Inc. • Prime Healthcare Mercy Medical Center • Prime Healthcare St. Joseph Hospital (Elgin) • Senior Services Associates • TriCity Family Services • VNA Health Care • Suicide Prevention Services • Linden Oaks Behavioral Health • Rosecrance • National Alliance on Mental Health Illness (NAMI) South Kane, DeKalb, and Kendall • 988 Suicide & Crisis Hotline
Other Agencies, Programs and Resources	• City of Aurora • Compañeros en Salud/ Partners in Health • Aurora African American Health Coalition • Fit for Kids Program • Healthy Living Council • Kane County Health Department • Kendall County Health Department • Women, Infants and Children (WIC) Program • Aurora Primary Care Consortium • 708 INC Board • Local park districts such as Fox Valley Park District and Oswego Park District • Local Fitness Clubs/Centers • Local K-12 School Programs • Local Colleges and Universities • Local Law Enforcement Agencies and EMS • Local Nutritionists • Senior Services Associations • Kendall Area Transit (KAT) • PACE Bus • American Cancer Society	• American Diabetes Association • Local Grocery Stores and Food Panties • Northern IL Food Bank • Fox Valley United Way • Kane Kares • Public Libraries such as Aurora, Oswego and Yorkville, Plano Public Libraries • Public and Private Sports programs • Worksite Wellness Programs • 211 Call Center • Community Resource Team Aurora • Kendall County Interagency Council • Plano Area Alliance Supporting Student Success (PAASSS) • Community Organizing and Family Issues (COFI)

Section: Where We've Been: 2022 CHNA and FY23-25 CHIP

Rush Copley conducted its last CHNA in FY22 and developed a subsequent CHIP FY23-FY25. Here are those previously identified and prioritized health needs:

Identified Community Health Needs
1. **Access to Health Services:** Leverage patient and community-driven data to advance health Equity.
2. **Behavioral Health** (includes mental health and substance abuse): Increase awareness on behavioral health conditions and navigation of behavioral health services in the community. Continue to focus on reducing the misuse of opioids and opioid-related deaths.
3. **Chronic Disease:** Health Behaviors and Management: Reduce health behaviors related to chronic health conditions and increase management of chronic diseases in the community.
4. **Inequities in vulnerable populations:** Reduce inequities caused by the social, economic and structural determinants of health.

1. Access to Health Services: Leverage patient and community-driven data to advance health equity.

- Implementation of a pilot program in Family Medicine Residency Clinic focused on data collection on Sexual Orientation and Gender Identity (SOGI). Clinicians received a two-part series educational workshop focused on the importance of and how to collect SOGI data in the office setting. Non-clinical staff received LGBTQ+ affirming care training.
- Implementation of Rush Health Equity Strategic Plan across Rush.
- Provided 1,021 diabetes sessions to uninsured/underinsured patients.
- Collaborated with local State Representative and community-based organizations and hosted two health care enrollment events for immigrant adults. Benefit enrollment specialist helped over 60 residents apply for Health Benefits for Immigrant Adults (HBIA) and Health Benefits for Immigrant Senior (HBIS) programs.
- Hosted three community CPR and AED classes for community members to become certified in CPR and AED. Trainings were hosted in Spanish and one in English. A total of 85 community members participated.
- Twenty-four AEDs were provided to non-profit organizations within the Rush Copley Medical Center service area.
- Participated in local community health improvement collaboratives:
    - Kane Health Counts Executive Committee
    - Kane County Action Team Access to Health Services
    - Kane County Health Department Partners in Health Committee
    - Kendall County Interagency Council

2. Behavioral Health (includes mental health and substance abuse): Increase awareness on behavioral health conditions and navigation of behavioral health services in the community. Continue to focus on reducing the misuse of opioids and opioid-related deaths.

- Implemented partnership in FY25 with Gateway Foundation and Rush Copley Medical Center that served 130 patients. A Gateway Engagement Specialist supports Rush Copley's Emergency Services Department and in-patient departments to coordinate warm handoffs for substance abuse treatment centers and follow up with a recovery coach.
- The Association for Individual Development's Mental Crisis Response Team provided education to Rush Copley care management and medical group leadership and held another educational session specific to family medicine providers.
- Launched in mid-FY25 in partnership with the Kane County Health Department, a naloxone dispensing machine was installed in the Rush Copley emergency department waiting area. Provided 288 kits of naloxone to the community.
- Continue to monitor opioid dashboards and reports to track and benchmark opioid use.
- Participate in local community health improvement collaboratives:
    - Kane Health Counts Executive Committee
    - Kane County Opioid Task Force
    - Kane County Behavioral Health Council
    - Rush University System for Health Opioid Workforce
    - Kendall County Mental Health Stakeholders Committee

3. Chronic Disease: Health Behaviors and Management: Reduce health behaviors related to chronic health conditions and increase management of chronic diseases in the community.

- Rush Copley hosted a seven-week walking program, Rush Walk for Wellness. The program's goal was to increase physical activity among participants. There were 40 attendees in-person and 405 hybrid participants across Rush.
- Continued partnership with VNA Health Care, a local Federally Qualified Healthcare Center, to provide Walk with a Doc program at the indoor track at Rush Copley Healthplex, a bimonthly walking program open to patients, community members and employees. In FY24 further partnered by aligning Rush Walk for Wellness with VNA Health Care's Walk with a Doc program.
- Partnered with the Aurora Public Library to host Period Party, an educational workshop focused on menstrual cycles. The program was held three times with over 45 participants.
- Rush Copley hosted Cancer Thriving and Surviving, a seven-week evidence-based program to support participants in their ability to manage their health and maintain an active and fulling life.
- Continued engagement of the Alive Faith Network with three churches from the greater Aurora area participating in the Keeping it Movin' community-based research project.
- Assisted in coordinating, supporting and participating in the Compañeros en Salud Health Festival, Aurora African American Health Fair, Waubonsee Community College's Pride Palooza, Aurora Area Interfaith Food Pantry Community Resource Fair, Fox Valley Community Services Health Fair with over 600 attendees. Participants received health screenings, community resources, and health-related presentations from health care professionals.
- Stroke educational coordinator provided stroke education at local food pantry and Spanish interpretation was provided by the community health outreach coordinator. Additionally, a pharmacist from Rush Copley provided education on the importance of medication review. Over 200 community members educated.
- Participate in local community health improvement collaboratives:
    - Kane Health Counts Executive Committee

- Kane County Health Department Partners in Health Committee
- Kane County Health Department's Action Team on Nutrition, Exercise and Weight
- Compañeros en Salud/Partners in Health
- Aurora African American Health Coalition
- Kendall County Interagency Council

4. Inequities in Vulnerable Populations: Reduce inequities caused by the social, economic, and structural determinants of health

- Social Determinants of Health (SDoH) Screening implemented in all departments throughout Rush Copley Medical Center. In June of 2024 Rush transitioned from NowPow to the Unite Us platform. A list of local resources generated by Unite Us based on patient's zip code and added to the patient's After Visit Summary. Rush Copley has reached and surpassed the goal of 85% of in-patient patients screened for SDoH.
- Rush Copley participated in the FY24 Will County Continuum of Care, 100 Day Challenge, focused on improving support to homeless community members in Will, Kendall and Grundy counties.
- Rush Copley is the regional traffic safety resource center for suburban Cook and six collar counties (Lake, DuPage, McHenry, Kane, Kendall and Will). A total of 209 new technicians were certified in child passenger safety technician courses, and 48 technicians were recertified. There were 154 individuals trained for technical skills building classes. Rush Copley hosted car seat education classes and checks for caregivers; a total of 311 people were educated.
- Car seat education and appropriate car seat for child presentation – partnered with Rush Copley care management team, VNA, Meridian Health, County Care, Headstart Programs, ECHO Family Services, Aunt Martha's, and the local school districts to identify families in need of car seats with no means to afford one. A total of 344 car seats were distributed after caregivers received the necessary education for the car seat in their vehicle. Car seat distribution for agencies: 146 agencies with certified car seat technicians on staff received five car seats to be distributed to families in their area in need. Overall, 2,284 car seats were distributed to low-income families and agencies that have certified child passenger safety technicians on staff.
- Teen driver safety presentations were held across 22 high schools, where mini safety fairs were conducted for health, physical education and driver's education classes, reaching a total of 2,943 students. Senior Driving Safety Presentations– two presentations were given for Senior Drivers at TRIAD groups totaling 51 participants.
- Rush Copley Promise Pantry, a partnership between Rush Copley and Loaves and Fishes Community Service, provided over 3,116 Promise Pantry bags to Rush Copley patients who screened positive for food insecurity. Each Promise Pantry bag provides 10 pounds of shelf stable food items which equates to over 46,400 pounds of food provided to patients.
- Rush Copley administration team participated in three volunteer opportunities with Loaves and Fishes Community Services at St. Therese Church in Aurora which served over 400 community members. Additionally, 81 nurses volunteered across three local pantries with food distribution and stocking of food panty items as well as a clean-up day at Waubonsie Lake Park in the Fox Valley Park District.

- Participate in local community health improvement collaboratives:
    - Kane Health Counts Executive Committee
    - Kane County Health Department's Action Team on Access to Health Services
    - Kane County Health Department's Action Team on Nutrition, Exercise and Weight
    - Kendall County Interagency Council

2025 CHNA Priorities and FY2026-2028 CHIP

Identified and Prioritized Health Needs
Rush Copley identified the following as the top health needs in the community to be addressed in the implementation strategy:

Identified Community Health Needs	
	1. **Access to Care** Improve access to care by leveraging strategic partnerships and hospital-based programs to connect individuals with essential health services and community resources.
	2. **Behavioral Health** (includes mental health and substance abuse) Enhance access to substance use and mental health services by building strong partnerships with community-based behavioral health organizations to deliver coordinated and accessible care.
	3. **Chronic Disease: Lifestyle Behavior Change and Chronic Disease Management** Promote healthy lifestyle behaviors and strengthen chronic disease management by empowering individuals with education, resources and support to prevent and manage long-term health conditions.
	4. **Inequities Caused by the Social, Economic and Structural Determinants of Health** Reduce health inequities by addressing the social, economic and structural factors that impact well-being, through targeted interventions and community partnerships.

Rush Copley developed and adopted an implementation strategy to address these community health needs. The CHNA and Implementation Strategies were approved and adopted by the hospital's Board of Directors on June 4, 2025.

The CHNA Report, Data and Information Book, and Implementation Strategy are helpful community resources and are widely available to the public at Rush Copley CHNA.

1. Access to Care	
Goal 1: Improve access to care by leveraging strategic partnerships and hospital-based programs to connect individuals with essential health services and community resources.	
Strategies	
1.1	Increase access to care and support for people managing diabetes and heart failure.
1.2	Provide access to postpartum support group for parents in the community.
1.3	Improve health literacy and the care experience for Limited English Proficiency (LEP) patients through clear, culturally and linguistically appropriate communication.
1.4	Increase CPR and AED readiness by expanding access to Heartsaver CPR training and automated external defibrillators (AED).
1.5	Strengthen partnerships with Federally Qualified Health Centers (FQHCs) to enhance access to care and community health outcomes.
1.6	Participate in local community health improvement collaborative(s).

2. Behavioral Health	
Goal 2: Enhance access to substance use and mental health services by building strong partnerships with community-based behavioral health organizations to deliver coordinated and accessible care.	
Strategies	
2.1	Increase patient access to and awareness of substance abuse treatment through outreach and referral pathways.
2.2	Maintain and promote a Naloxone dispenser in the Emergency Department to ensure access to harm reduction resources.
2.3	Pilot an initiative to increase access to warm handoffs for mental health services within the primary care setting.
2.4	Establish a partnership with an internet-based referral system to enhance warm handoffs to mental health agencies and improve care coordination.
2.5	Participate in local community health improvement collaborative(s).

3. Chronic Disease: Lifestyle Behavior Change and Chronic Disease Management	
Goal 3: Promote healthy lifestyle behaviors and strengthen chronic disease management by empowering individuals with education, resources and support to prevent and manage long-term health conditions.	
Strategies	
3.1	Incorporate chronic disease care manager into hospital settings to improve care coordination, reduce readmissions and support better outcomes for patients with long-term conditions.
3.2	Increase chronic disease management through community-based chronic disease programs.
3.3	Improve engagement in lifestyle behavior programs focused on prevention and reduction of risk for metabolic health conditions.
3.4	Participate in local community health improvement collaborative(s).

4. Inequities Caused by the Social, Economic and Structural Determinants of Health	
Goal 4: Reduce health inequities by addressing the social, economic and structural factors that impact well-being, through targeted interventions and community partnerships.	
Strategies	
4.1	Screen for social determinants of health to connect patients with resources, reduce health disparities and foster healthier communities.
4.2	Increase access to transportation resources to patients and provide warm handoff to community-based programs.
4.3	Provide real-time access to food resources for patients who screen positive for food insecurity, enabling timely support and reducing the impact of hunger on health outcomes.
4.4	Strengthen community impact by fostering employee engagement through meaningful volunteer experiences that support local needs.
4.5	Increase access to educational opportunities for youth in the community, with a focus on fostering interest and exposure to careers in health care and contribute to community well-being.
4.6	Participate in local community health improvement collaborative(s).

Significant Health Needs and Health Indicators Not Addressed

Several community health needs were assessed but ultimately not prioritized as significant in the final analysis. These included areas where data indicated lower severity or prevalence, limited impact on vulnerable populations, or where existing community resources were already effectively addressing the issue. In addition, some needs were not elevated as immediate priorities due to limited capacity for measurable improvement or lack of alignment with the hospital's strategic focus.

- Food Access
- Housing
- Maternal and Child Health
- Built Environment: Green space and transportation

Public Comment

Rush Copley Medical Center's Community Health Needs Assessment and Community Health Implementation Plan can be accessed by the public by visiting https://www.rush.edu/about-us/rushcommunity/chnachip-reports-and-cbr/rush-copley-chna-report. For more information or to provide public comment on our CHNA, please contact:

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Conclusion

This joint Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP), was completed through an extraordinarily collaborative effort. As an anchor in this community, Rush Copley stands committed to serving the health needs well beyond the walls of our hospital and offices.

Coming together is a beginning, staying together is progress, and working together is success.
-Henry Ford