Advocate Health Care



2025

Advocate Christ Medical Center

Community Health Needs Assessment Report

4440 W 95th St.
Oak Lawn, IL 60453

Letter from Division President

October 2025

At Advocate Health, we are redefining care for you, for us, for all. This purpose calls us to see health not just as a service, but as a shared journey. From discovery to everyday moments, everyone plays a vital role.

Our Community Health Needs Assessments (CHNA) are more than just reports. They are roadmaps for our future, centered on strong partnerships that lead to real and lasting solutions.

Throughout the CHNA process, we strive to listen deeply, learn continuously and act boldly to address the changing needs and strengths of our communities. By working together with our community partners, engaging with our neighbors and analyzing local data, we aim to provide the best possible care that extends beyond the walls of our hospitals and clinics.

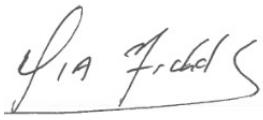
As we close another CHNA cycle, I'm inspired by the profound difference we make each day across our Illinois Division. From groundbreaking research and exceptional clinical care to meaningful patient programs and cutting-edge innovations, our work is driven by the patients, families and communities we serve. Together, we are shaping healthier futures for all.

We are deeply grateful to the many individuals and organizations who contributed to this assessment. Your perspectives and partnership are essential to improving the health and well-being of our communities, and we are proud to stand beside you in this work.

Publishing this CHNA is not the end of the conversation. It's an invitation to keep it going. We welcome your feedback, ideas and suggestions. At the end of this report, you'll find a link where you can share your thoughts on how we can strengthen community programs and strategies to better serve you and your neighbors.

Let's move forward toward better health for all.

Together always,



Dia Nichols
President, Illinois Division, Advocate Health

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EXECUTIVE SUMMARY

In 2025, Advocate Christ Medical Center (Christ) conducted a Community Health Needs Assessment (CHNA) for its Primary Service Area (PSA), which consists of 27 zip codes in Suburban Cook County and Chicago, Illinois. The CHNA analyzed demographic, socioeconomic, and health data alongside input from the Alliance for Health Equity (surveys and focus groups).

The PSA population is 882,555 comprised of 39.3% Non-Hispanic White, 34.6% Hispanic/Latino, 2.7% Asian/Pacific Islander, and 21.3% Non-Hispanic Black/African American, and 1.9% two or more races, with a median household income of $77,186. The median age of residents in the hospital's PSA is 39.1 years.

The hospital created a Community Health Council (CHC) comprised of hospital leaders and community representatives to guide the CHNA process through data review, discussion, and prioritization exercises. Health issues were rated against criteria including severity, urgency, disparities, cost, preventability, and long-term impact.

Key Findings

The assessment identified seven significant health needs: diabetes, substance use, mental health, obesity, food insecurity, community safety and cancer. After prioritization, the three **top health priorities** chosen by the CHC for the 2025 CHNA were confirmed as:

1. Social Drivers of Health - Food Insecurity
2. Behavioral Health
3. Diabetes

Next Steps

Advocate Christ Medical Center in collaboration with community partners, will develop an implementation strategy aligned with these priorities. Using a collective impact model, the strategy will define goals, objectives, and measurable outcomes to monitor community impact and program effectiveness.

ADVOCATE HEALTH CARE

Advocate Health Care is the largest health system in Illinois and a national leader in clinical innovation, health outcomes, consumer experience and value-based care. One of the state's largest private employers, the system serves patients across 11 hospitals, including two children's campuses, and more than 250 sites of care. Advocate Health Care, in addition to Aurora Health Care in Wisconsin and Atrium Health in the Carolinas, Georgia and Alabama, is a part of Advocate Health, the third-largest nonprofit health system in the United States. Committed to redefining care for all, Advocate Health provides nearly $6 billion in annual community benefits.

ADVOCATE CHRIST MEDICAL CENTER

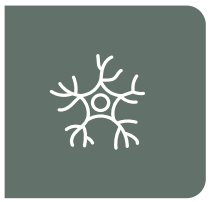
Advocate Christ Medical Center in Oak Lawn is a premier teaching hospital and one of the busiest Level I Trauma Centers in Illinois. As a major referral center for the Midwest, we provide nationally recognized care in cardiology, cancer, neurosciences, orthopedics, women's health and heart and kidney transplantation.

Families choose Christ Medical Center for our highly skilled and compassionate prenatal care, making us the #1 delivery program in the south suburbs. With enhanced services, advanced capabilities, Level III NICU and adjacent Advocate Children's Hospital, we offer the highest level of care for mothers and babies.

Level I Trauma Center

Cardiology

Obstetrics



Neurological Care

Cancer Care

2025 COMMUNITY HEALTH NEEDS ASSESSMENT

A Community Health Needs Assessment (CHNA) is an analysis of the population, resources, services, health care statuses, health care outcomes, and other data within a defined community or service area that helps identify potential health issues being experienced by community members. Every nonprofit hospital is required to complete a CHNA every three years under the Patient Protection and Affordable Care Act (ACA), to demonstrate that a hospital is committed to promoting health.

A CHNA report is designed to inform a wide range of groups to learn more about a community's health and most urgent needs. It is a key tool for promoting health for all, as it lifts the community voice and encourages collaboration between different groups to create focused strategies to address the health needs identified in the CHNA.

Community Definition

For the purposes of this assessment, "community" is defined as Advocate Christ's primary service area (PSA). The PSA is comprised of 27 zip codes in Suburban Cook County and Chicago. As of the most recent five-year data estimates, the total population of the communities served by the hospital is 882,555.

Understanding who lives in a community is an important part of the CHNA process. A community is more than just a place on a map - it's made up of the people who live there, their shared experiences, and their differences. These differences can include things like age, income, education, race or ethnicity, and what people know about health. Learning about these details helps us see what specific health problems people face and what support they may need.

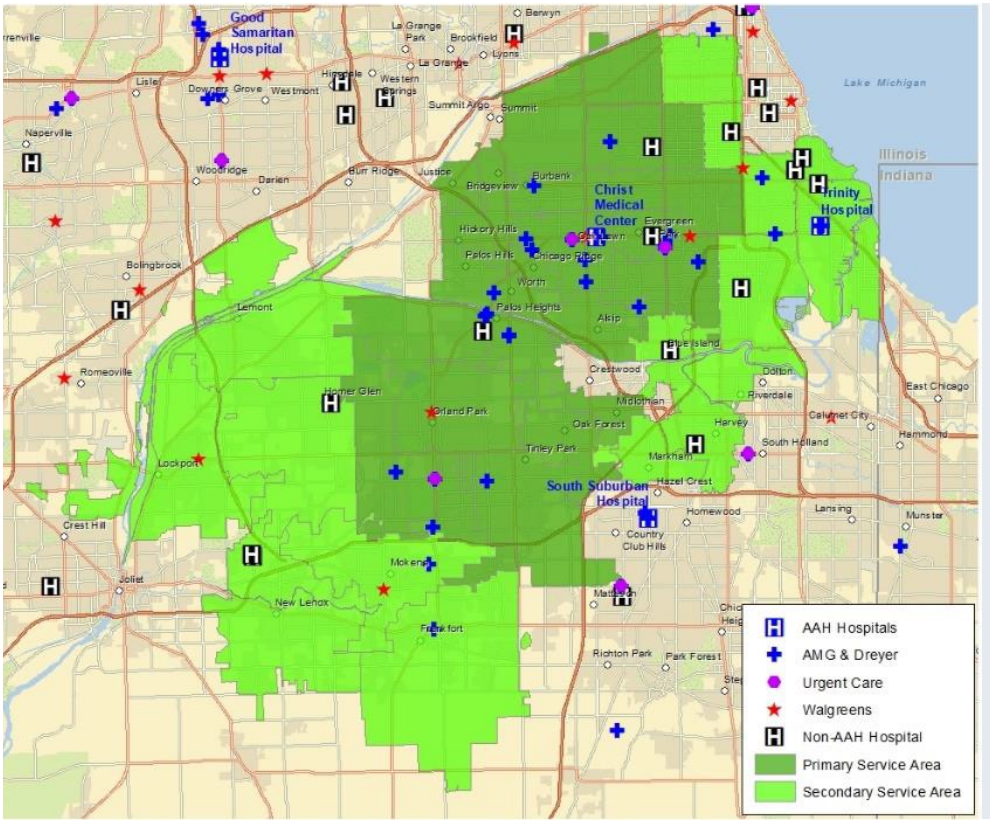


Exhibit 1:
Exhibit 1. Business Development PSA Map, 2025

2019-2023 Data Estimates

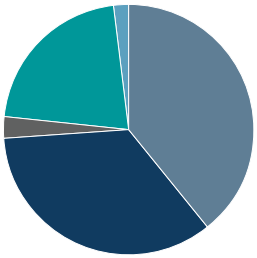
Population
882,555
Decrease of 1.8% from the 2010 and 2020 census.

Gender
49.1% Male
50.9% Female

Median Age
39.1 years PSA
37.3 years Males
41.0 years Females

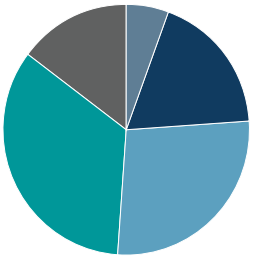
Population by Race/Ethnicity

Non-Hispanic White	39.3%
Hispanic or Latino	34.6%
Asian	2.7%
Non-Hispanic Black	21.3%
Two or More Races	1.9%



Population by Age Group

Infants 0-4	5.9%
Juveniles 5-17	17.4%
Young Adults 18-39	27.7%
Middle-Age 40-64	32.1%
Seniors 65+	16.9%



Spanish as Primary Language Spoken at Home
26.8% PSA
18.4% Cook County

Median Household Income
$77,186 Christ PSA
$81,797 Cook County
$81,702 Illinois

Household/Family
Single Parent Households
6.6% PSA
6.4% Cook County
6.1% Illinois

Seniors Living Alone
30.4% PSA

Children Under Age 18
23.4% PSA

Education
High School Graduation
85.3% PSA

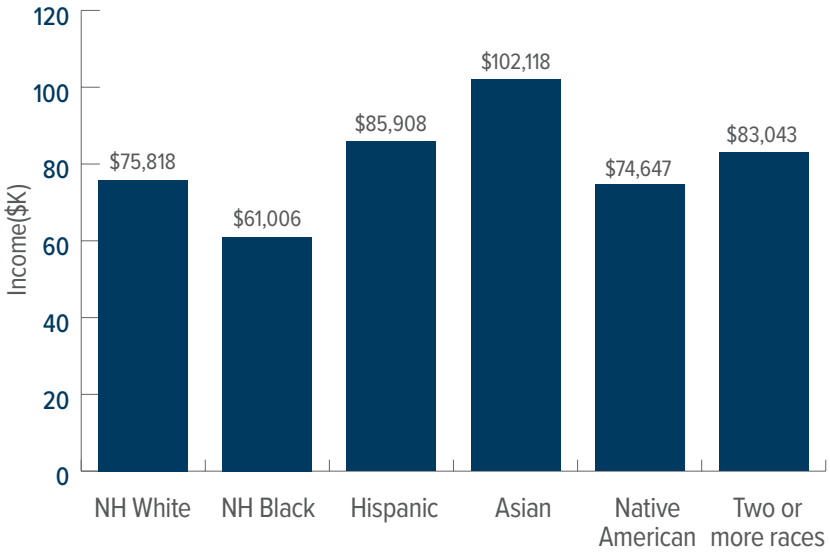
College Degree or Highger
25.8% PSA

People Living Below 200% of the Poverty Level
29.9% PSA total
28.7% Cook County

Poverty Rate by Age
18.9% 0-4 years
17.4% 5-17 years
11.4% Seniors

Employment
Unemployment Rate of Population 16+
(2018-2022)
9.2% PSA

Median Household Income by Race/Ethnicity



Source: Metopio, American Community Survey, 2019-2023 & 2018-2022

Social Drivers of Health

Social drivers of health are the things in our everyday lives that can help us stay healthy or make it harder to be healthy. These include where we live, the food we eat, the schools we go to, the jobs our families have, and whether we can see a doctor when we need to.

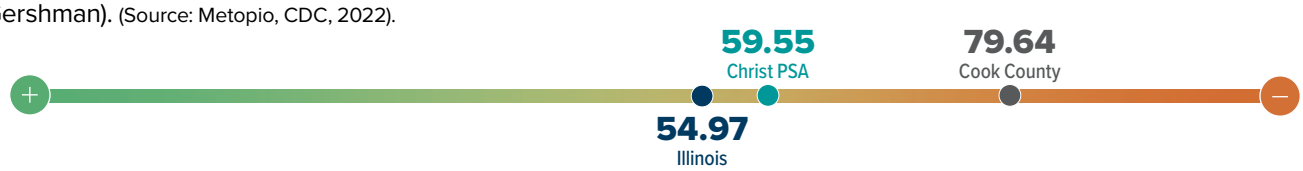
Social Drivers of Health can also cause health differences between groups of people. For example, if someone lives far from a store with healthy food, it's harder for them to eat well. This can lead to health problems like heart disease or diabetes. Just telling people to eat healthy isn't enough - we need to make sure they have what they need to make healthy choices. That's why people who work in health, schools, housing, and transportation must work together to help everyone live a healthy life.

Social Conditions at a Glance

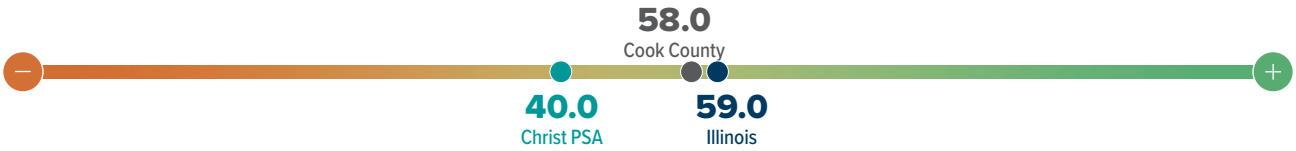
To better understand these factors and identify health inequities in a community, Advocate Health Care has partnered with Metopio, a software company that focuses on how communities are connected through people and places. Metopio's tools use data to show how different factors in each area influence health. It uses the latest data to create visual tools that focus on specific communities and hospital service areas.

The following section contains descriptions of three important indices found in Metopio. These indices combine various data points to compare areas in the community, helping to identify disparities caused by social factors that impact health. By doing this, it can better focus on health improvement efforts where they are most needed.

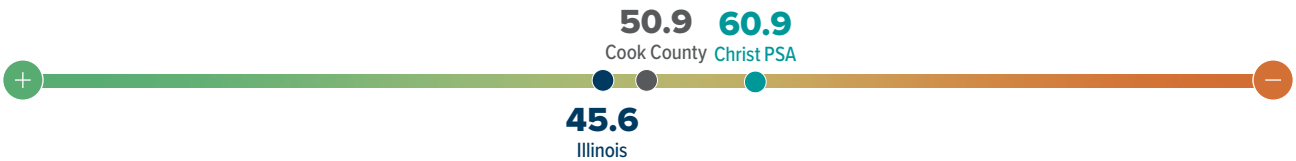
Social Vulnerability Index (SVI) – The Social Vulnerability Index (SVI) shows how vulnerable a community is based on 15 social factors like unemployment, disability, and minority status to help identify and map the communities that will most likely need support before, during, and after a hazardous event. Scores range from 0 (least vulnerable) to 100 (most vulnerable). Communities with the highest SVI: 60636 (West Englewood), 60629 (Chicago Lawn), and 60620 (Auburn Gershman). (Source: Metopio, CDC, 2022).



Childhood Opportunity Index 3.0 – Childhood Opportunity Index 3.0 is a composite index that captures neighborhood resources and conditions that matter for children's healthy development, scored as Very Low (1-19), Low (20-39), Moderate (40-59), High (60-79), and Very High (80-100). *(Source: Metopio, Diversitydatakids.org, 2017–2021).*



Hardship Index – The Hardship Index is a composite score reflecting hardship in the community (higher values indicate greater hardship). It incorporates unemployment, age dependency, education, per capita income, crowded housing, and poverty into a single score that allows comparison between geographies. It is highly correlated with other measures of economic hardship, such as labor force statistics, and with poor health outcomes. Communities with the highest hardship index: 60632 (Archer Heights) at 86.6, 60629 (Chicago Lawn) at 86.2. *(Source: Metopio, U.S. Census Bureau, ACS, 2018–2022).*



ALICE Households– ALICE stands for Asset Limited, Income Constrained, Employed. It shows the percent of working households that earn above the poverty line but still can't afford basic needs like housing, food, and child care. (*Source: Metopio, United Way, ALICE Data, 2022)*

How the CHNA Was Conducted

Purpose and Process

Every three years, the federal government requires not-for-profit hospitals to conduct a community health needs assessment (CHNA). This CHNA is intended to identify key health needs and issues through systematic, comprehensive data collection and analysis. In April 2025, Advocate Christ convened its community health council members, comprised of hospital staff and community members to review data to make informed decisions on the health needs that will be addressed in the hospital's primary service area over the next three years. Data was presented over a period of four meetings during April, May, June, and July 2025 that included topics on demographics, economics, education, employment, Social Drivers of Health (SDOH) and health indicators. Partners from the Alliance for Health Equity also presented similar data based on results from focus group meetings held in the hospital's PSA as part of its assessment process. During the prioritization meeting held on September 18, 2025, council members voted to select the needs to address in the hospital PSA for the 2025 CHNA and the 2026-2028 implementation plan. The needs selected were Social Drivers of Health/Food Insecurity and Diabetes. The Advocate Christ Governing Council approved the 2025 CHNA findings at its November 11, 2025 meeting.

Partnership

In conducting this CHNA, Advocate Christ Medical Center partnered with several key stakeholders and community partners that include:

- Advocate Christ Medical Center Community Health Council
- Advocate Christ Medical Center Governing Council
- Alliance to End Homelessness in Suburban Cook County
- Alliance for Health Equity
- BEDS Plus
- Cook County Department of Public Health
- Illinois Public Health Institute
- Metopio
- Pathlights
- Respond Now
- Superior Ambulance

In addition to initiatives led by the hospital's Community Health Council, Advocate Christ Medical Center maintains active involvement with the Alliance for Health Equity (AHE) committee to coordinate efforts and support the county's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). To reduce redundancy and ensure efficiency, the hospital also participates in AHE's planning committee, which manages community survey initiatives to collect qualitative data throughout the county.

Data Collection and Analysis

Advocate Christ referenced the Cook County community assessment report to supplement other hospital and public health data pulled for the hospital CHNA, secondary data, and primary data including community surveys distributed online and focus groups. Metopio was a key source of data for the 2025 Advocate Christ CHNA. This secondary data was crucial in analyzing the hospital's PSA health needs as the database was the only source that provided extensive data specific to the PSA. All data collected through Metopio was quantitative and included data comparisons between PSA, counties in Illinois, the state of Illinois, and United States data, when available.

Data Collection and Analysis

Metopio

Advocate Health Care continues its relationship with Metopio to provide an internet-based data resource for its eleven hospitals during the 2025 CHNA cycle. This platform offers the hospitals a multitude of health and demographic indicators, including hospitalization and emergency department (ED) visit indicators at the service area and zip code levels. Utilizing the Illinois Hospital Association's COMPdata, Metopio was able to summarize, age adjust and average the hospitalization and ED utilization data for several time periods. The Metopio platform also provides a wealth of county and zip code data comparisons, and Hardship Indices, which helped to visualize vulnerable populations within the service area and Cook County.

Community Surveys – February to October 2024

The Alliance for Health Equity conducted a community input survey designed to understand community health needs and assets with a focus on hearing from community members that are most impacted by health inequities. From February 2024 to October 2024, 255 community input surveys were collected in Advocate Christ's service area.

Surveys were collected in both paper and online format through various channels. The Alliance leveraged community partnerships to facilitate participation by communities often underrepresented in community assessments. Surveys were collected at focus groups, clinical office visits, community events, and by contracted community partners. The online survey was also shared in email newsletters and on social media.

Focus Groups – January to October 2024

Seven focus groups were conducted within Christ Hospital's service area or included participants living within the service area. Hosted by community partners, the focus groups included community residents and local service providers. Focus groups covered several different priority populations and topics including education, housing, social services, advocacy, community and economic development, workforce development, food insecure individuals and families, adults with disabilities, Black/African American individuals, young people of color, and older adults.

Summary of Findings

Overall Health Status

Overall, Advocate Christ PSA's health outcomes are comparable to the average county in the state of Illinois.

However, many disparities - or differences in outcomes - exist between groups of populations in nearly every social and health issue, especially for Black, Indigenous and People of Color (BIPOC) populations. These disparities are often caused by barriers that these communities face. Health inequities are the unfair differences in health that can be avoided, measured and are often linked to injustice (AMA, 2021).

As you look at the data in the following sections, it is important to remember that these health issues are connected to many of these broader social and environmental factors.

Mortality - Leading Causes of Death

According to the Illinois Department of Health, heart disease, cancer, accidents, COVID-19 and stroke are the five leading causes of death (IDPH, 2022).

(Source, IDPH, Website data - Deaths 2022.xlsx)

Life Expectancy

The average life expectancy among residents:

- Christ PSA: 77.8 years
- Cook County 78.5 years
- Illinois 78.7 years
- United States 78.7 years

Metopio, U.S. Small-Area Life Expectancy Estimates Project (USALEEP), 2010-2015
County Health Rankings and Roadmaps, Cook Illinois, 2025

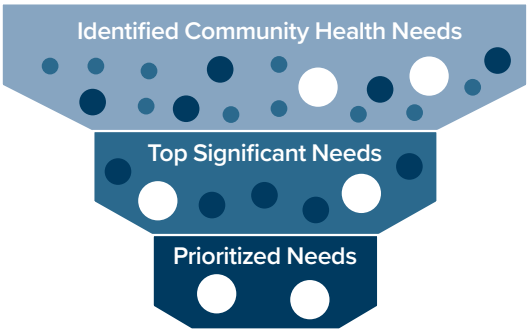
Identified Significant Needs

The following health needs section reviews parts of health such as health outcomes, social factors, and health behaviors.

- **Health outcomes** are the results of how healthy people are. This includes how many people in our community are affected by long-term illnesses, and the differences we see between groups of people.
- **Social factors** include things like income, education, jobs, and access to healthcare.
- **Health behaviors** are the choices people make, like what they eat and how much they move, and are often shaped by where people live and what is normal in their community.

Community input is important during this CHNA process, as it helps us decide which problems to focus on first. A health need is seen as important, or significant, if it's a big concern for the community, matches public health goals, and is backed up by data.

From the list of significant needs, we choose a smaller group of prioritized needs. These are the needs we will focus on first, in a very targeted way. This helps us make a plan to improve community health in the best way possible.



Advocate Christ service area top health issues	
Diabetes	• Diagnosed with diabetes • Diabetes-related emergencies and hospitalizations • Lower-extremity amputations
Obesity	• Obesity rates • Adult and childhood obesity • No exercise
Substance Use	• Binge drinking • Alcohol and opioid related emergencies and hospitalizations • Drug overdose • Tobacco use
Mental Health	• Poor self-reported mental health • Depression • Mental health related emergencies • Schizophrenia, suicide and self-injury
Cancer	• Leading cause of death • Diagnosed with cancer
Food Insecurity	• Food Insecurity • Povery and SNAP • Food Deserts
Community Safety	• Violent crime • Unintentional falls

The following pages summarize the top identified needs – also known as significant needs - from the CHNA process.

Diabetes

SIGNIFICANT NEED

Why is this important? Diabetes is a condition that makes it hard for your body to use food for energy. When someone has diabetes, too much sugar stays in the blood. If they don't take care of it, it can hurt their heart, kidneys, eyes, cause bad infections or reduce life expectancy.

Diabetes affects millions worldwide, and proper management and access to care can prevent complications. Promoting healthy diets, physical activity, and regular monitoring helps reduce disease burden. Education and support are key to empowering individuals to manage their condition effectively.

Significant Need Reasoning

In the Alliance for Health Equity (AHE) survey assessment, 24.4% of survey respondents from the PSA (n=258) recognized diabetes as a top health concern.

Participants linked diabetes to unhealthy diets high in sugar and processed foods and a lack of access to quality food resources such as grocery stores, food banks and SNAP programs.

Key Findings

- In the United States, an estimated 38.4 million people are living with diabetes, representing about 11.6% of the total population. Diabetes is the eighth leading cause of death nationwide and contributes to roughly $412.9 billion in medical costs each year.
- In Cook County, about 10.8% of adults have been diagnosed with diabetes. Within the PSA, 13.1% of residents aged 18 and older have been diagnosed with diabetes.
- When looking at racial and ethnic differences, Non-Hispanic Blacks report the highest diabetes hospitalization rate at 403.89, followed by Non-Hispanic White population at 310.70.

Contributing Factors

- Economic instability and poverty restrict access to healthy food, medications, and diabetes management tools, contributing to poor glycemic control and higher complication rates. In our PSA, the communities experiencing greater hardship are also experiencing diabetes related complications.
- Low education levels and health literacy affect individuals' ability to understand and manage their condition, resulting in missed screenings, improper medication use, and reduced engagement in preventive care.
- Neighborhood and environmental factors, such as lack of safe spaces for physical activity, poor housing conditions, and limited access to nutritious food exacerbate diabetes risks and outcomes, especially in underserved communities.

> I want to eat like protein, vegetables and fruits, but they don't have any of that.
>
> – AHE Focus Group Participant

Sources: American Diabetes Association, Statistics About Diabetes, 2023
Metopio, PLACES, CDC , 2022

Diabetes *continued*

SIGNIFICANT NEED

HIGHLIGHTED DISPARITIES

Indicator	Christ PSA	Cook Co	Illinois	Insight/Disparity
Diagnosed Diabetes (% of adults)	13.1%	10.8%	10.4%	Highest zip codes: 60636: 19.8% 60620: 19.0% 60643: 15.7%
ED Visits*	218.1	211.2	214.5	Highest zip codes: 60620: 413.8 60636: 522.5 60445: 397.2 Demographic: NH-Black: 454.3 Men: 235.0 Adults 65+: 381.4
Hospitalizations*	239.5	202.8	178.8	Highest zip codes: 60620: 426.2 60636: 474.7 60643: 320.4 Demographic: NH-Black: 403.8 NH White: 310.7 Men: 284.6
Short-Term Complication Hospitalizations*	84.4	74.6	71.9	Demographic: NH-Black: 177.8 Men: 97.3 Young Adults 18-39: 115.3
Long-Term Complication Hospitalizations*	157.0	1130.2	112.1	Demographic: NH-Black: 231.6 Men: 203.5 Adults 65+: 339.4
Uncontrolled Diabetes ED Visits*	177.2	169.5	182.7	Highest zip codes: 60620: 353.5 60629: 238.7 60632: 173.5 Demographic: NH Black: 360.2 NH White: 186.2 Men: 190.8
Uncontrolled Diabetes Hospitalizations*	55.2	46.1	37.8	Highest zip codes: 60620: 96.5 60629: 70.5 60453: 61.2 Demographic: NH Black: 118.4 Men: 59.7 Adults 65+: 141.9
Lower-Extremity Amputation Hospitalizations*	70.9	54.4	51.2	Highest zip codes: 60620: 94.7 60629: 87.0 60453: 72.7 Demographic: NH Black: 130.8 Men: 107.4 Adults 65+: 155.3

Sources: PLACES, CDC, 2022
Metopio, IHA COMPdata Informatics, 2020-2024

**Rates per 100,000 residents*

Obesity

SIGNIFICANT NEED

Why is this important? Being overweight or obese may seriously impact a person's health. Extra weight may lead to serious health consequences such as cardiovascular disease, type 2 diabetes, some cancers, and other chronic diseases. These conditions could reduce quality of life and shorten the individual's lifespan.

Significant Need Reasoning

In the Alliance for Health Equity (AHE) survey assessment, 22.9% of survey respondents from the PSA (n=258) recognized obesity as the third highest community health concern.

County-wide, 18% of respondents in AHE survey selected obesity as a top health concern.

Key Findings

- In the PSA, 25.1% of the population does not engage in regular exercise.
- Numerous zip codes in the PSA have much higher rates of obesity than in the county and state.

Contributing Factors

- Geographic differences are notable, with some communities and states showing consistently higher obesity levels, often linked to lifestyle and socioeconomic factors.
- Areas with higher obesity rates frequently report lower levels of physical activity and limited walkability, contributing to the problem.

  Community's Walkability Index *(Values range from 1 to 20 with 20 being most walkable)*
  PSA: 13.06
  Cook: 13.61
  IL: 10.56
  » 60638: 14.43
  » 60632: 14.20
  » 60638: 13.88
  » 60629: 13.51
  » 60453: 13.70
- Efforts to address obesity focus on improving access to healthy food and encouraging exercise.

HIGHLIGHTED DISPARITIES

Obesity

PSA: 35.7%
Cook County: 32.8%
Illinois: 32.9%
60636: 46.9%
60620: 44.7%
60629: 39.8%
60643: 38.5%
60632: 36.7%

No Exercise

PSA: 25.1%
Cook County: 20.9%
Illinois: 22.1%
60636: 36.6%
60629: 31.8%
60632: 31.4%
60620: 30.3%

> And grocery shopping is like way harder to do since they'll run out of supplies quickly.
>
> – AHE Focus Group Participant

Sources: Metopio, BRFSS, PLACES, 2022
Metopio, EPA, 2024

Substance Use

SIGNIFICANT NEED

Why is this important? Alcohol and drug misuse has a large impact on public health, mental well-being, and community stability. Substance misuse contributes to preventable health issues like liver disease, cardiovascular problems, and overdose deaths, while also being linked to social and economic issues.

Significant Need Reasoning

In the Alliance for Health Equity (AHE) survey assessment, 22.1% of survey participants from the Christ PSA (n = 258) said that substance use was a major health issue in their community; it ranked as the fourth biggest health issue.

Key Findings

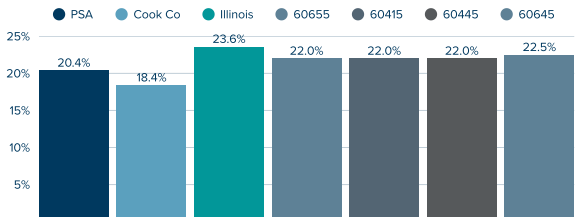
- Alcohol use emergency department visit rates are higher in the Christ PSA compared to Illinois. The highest alcohol emergency department rates are observed among individuals aged 18-39, with rates of 646.31 in the PSA compared to 401.5 for the full population.
- Alcohol and opioid use disproportionately affect White residents and young adults. Non-Hispanic White residents and adults 18–39 and 40-64 years old have the highest ED visit rates for both alcohol and opioids.
- Notably, the highest substance use ED rate is for Non-Hispanic White individuals in Cook County at 2,029.9 visits per 100,000 residents, which is higher than the rates for other racial and ethnic groups. In contrast, the Hispanic/Latino population has the lowest rate at 431.0.

Contributing Factors

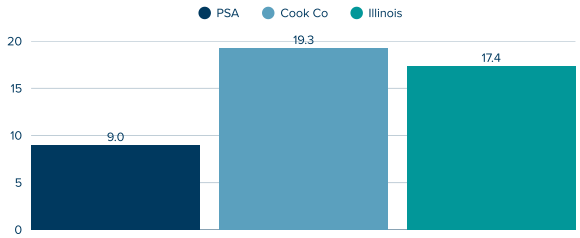
Non-Hispanic White adults and individuals aged 18–39 experience disproportionately high rates of alcohol-related ED visits, pointing to systemic inequities, cultural factors, and possibly gaps in targeted prevention or treatment services.

Alcohol-related hospitalizations across the PSA reflect the chronic nature of substance use issues and the need for sustained public health interventions, especially in high-burden areas and among vulnerable populations.

Cigarette Smoking Rate of Adults



Opioid Treatment Provider Access*



> And it's like kind of been all over the news recently where a lot of people are experiencing health issues just because of substance abuse.
> – AHE Focus Group Participant

Sources: Metopio, BRFSS & PLACES, CDC, 2022
Buprenorphine Practitioner Locator SAMHSA, 2024

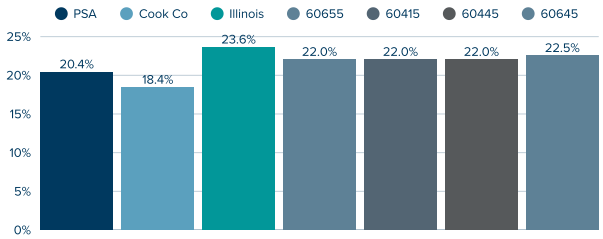
**Providers per 100,000 residents*

Substance Use *continued*

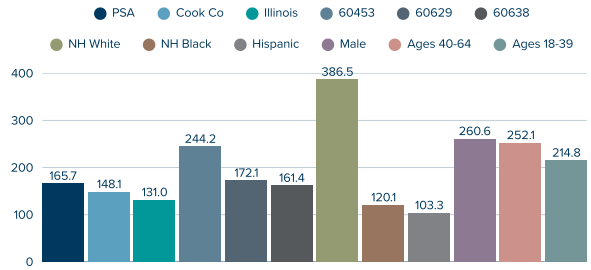
SIGNIFICANT NEED

HIGHLIGHTED DISPARITIES

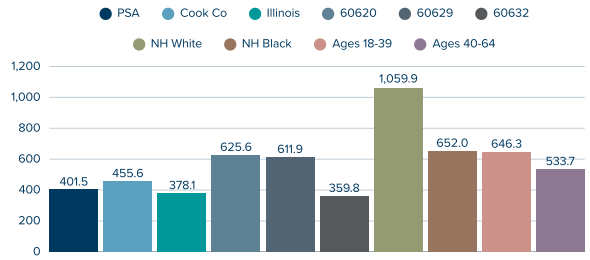
Binge Drinking Rates (% of adults):



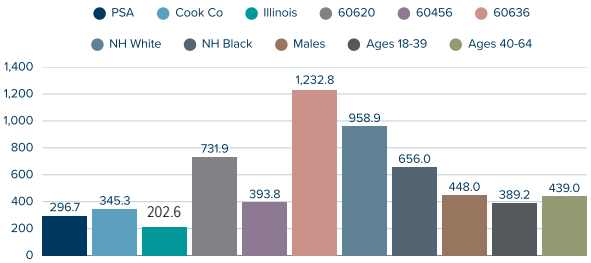
Alcohol-Related Hospitalizations*



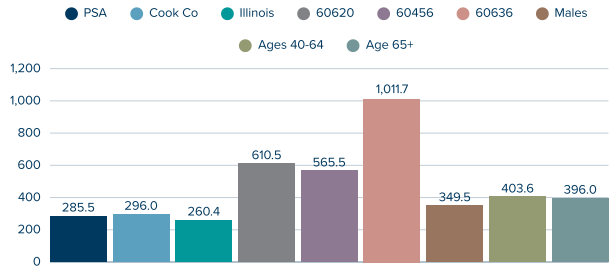
Alcohol-Related ED Visits*



Opioid-Related ED Visits*



Opioid-Related Hospitalizations*



Sources: Metopio, BRFSS & PLACES, CDC, 2022
Metopio, IHA COMPdata, 2020–2024

**Rates per 100,000 residents*

Mental Health

SIGNIFICANT NEED

Why is this important? Mental Health: This includes emotional, psychological, and social well-being. Mental health influences how we manage stress, build relationships, make decisions, and engage with all areas of our lives. Mental health is not just the absence of a mental health condition but also the ability to thrive. (CDC, 2025).

Significant Need Reasoning

In the Alliance for Health Equity (AHE) survey assessment, 21.7% of survey respondents from the PSA (n=258) recognized adult mental health as the fifth health concern.

Additionally, of the 258 survey respondents, 14% highlighted that child and adolescent mental health resources were needed for their community to be healthy.

23.5% of the AHE respondents recognized the ability to access mental health care services within a reasonable amount of time as a community need.

Key Findings

- The Christ PSA has the lowest average mental health treatment facilities per capita at 1.33 compared to cook county 1.79 and Illinois 2.18 per 100,000 residents.
- There are only 12 mental health treatment facilities with 2,341 mental health providers covering the 27 zip codes in the Christ PSA, compared to Cook County (29,381) and Illinois (58,275).
- Suicide and self-injury ED visits are highest among youth ages 5-17 years of age and Non-Hispanic White residents; rates are higher amongst females (57.6) compared to Males (33.9).
- Data presents the Schizophrenia emergency department visit rate across different racial and ethnic groups in various locations. The highest rates are observed among Black individuals in the Christ PSA (238.1) and Cook County (267.6).

Contributing Factors

- Individual Factors such as depression, anxiety, substance use, and chronic pain can deeply affect emotional well-being. Personal history of trauma or previous suicide attempts also significantly increase vulnerability. The Christ PSA is very diverse and serves a large elderly population which requires more attention to environmental trends, social isolation and culturally competent care.
- Community-level influences - like residing in neighborhoods that lack sufficient mental health services, face frequent violence, or experience discrimination - can intensify stress and limit access to necessary support and healing resources. Within the PSA, these challenges are particularly evident in certain areas, especially where apartment complexes and densely populated housing are common, and where economic hardship is widespread.
- Broader issues like poverty, unemployment, systemic racism, and cultural stigma around mental illness can create barriers to care and increase feelings of hopelessness or despair.

> Mental health and homelessness is a big issue
> – AHE Focus Group Participant

Sources: Metopio, SAMHSA, 2024
Metopio, NPI, CMS, 2024
Metopio, IHA COMPdata, 2020–2024

Mental Health *continued*

SIGNIFICANT NEED

HIGHLIGHTED DISPARITIES

	Mental Health ED Visits*	Mental Health Hospitalizations*	Self-reported Poor Mental Health	Schizophrenia ED Visits*	Suicide and Self-Injury ED Visits*	Behavioral Health Hospitalizations*	Behavioral Health ED Visits*
PSA	743.0	416.4	16.65%	68.8	45.9	668.6	1,546.4
Cook County	762.8	488.0	15.3%	80.4	45.0	726.1	1,675.0
Illinois	862.7	438.6	16.11%	59.4	70.4	634.4	1,552.5
60620	1,171.9	820.1			58.5	1,119.6	2,692.5
60643	962.3	683.4			46.6	920.5	1,919.0
60453	723.5					693.7	
60629	664.3		18.6%				1,701.8
60638	621.0				46.4		
NH Black	1,539.4	927.8		230.0	67.5	1,207.1	3,003.8
NH White	1,647.0	1,179.1			89.4	1,819.3	3,676.9
Asian		1,269.5				1,146.4	
Men	799.5	460.0		102.9		840.7	1,999.4
Women	688.6				57.6		
5-17 years	751.8				106.5		
18-39 years	1,433.1	720.4		169.6	73.6	1,058.0	
40-60						698.5	
65 and older							

Sources: Metopio, IHA COMPdata, 2020–2024
Metopio, PLACES, 2022

**Rates per 100,000 residents*

Cancer

SIGNIFICANT NEED

Why is this important? Cancer is a disease where certain cells in the body grow and divide in an uncontrolled way. Unlike normal cells, these abnormal cells don't stop growing when they should. They can form lumps (called tumors), damage nearby tissues, and sometimes spread to other parts of the body.

Significant Need Reasoning

Secondary data shows higher rates of mortality for breast and colorectal cancers in the county, with significant disparities.

Key Findings

- Breast cancer mortality rates vary significantly across different regions. In Cook County, the rate is notably higher than both the state and national averages.
- There are numerous disparities in cancer outcomes, particularly for Non-Hispanic Black individuals.
- Christ PSA overall cancer rates are slightly higher than Cook County, with colorectal cancers in the PSA detected most commonly in late stage.
- Mammography screening rates and colorectal screening rates in Cook County and the PSA are similar compared to Illinois.
  - » Mammography screening: Medicare population:
    - ◊ Cook County: 35%
    - ◊ Illinois: 37%
  - » Mammography screening (Female):
    - ◊ Christ PSA: 73.3%
    - ◊ Cook: 73.8%
    - ◊ Illinois: 72.7%
  - » Colorectal Cancer Screening:
    - ◊ Christ PSA: 57.0%
    - ◊ County: 52.7%
    - ◊ Illinois: 55.4%

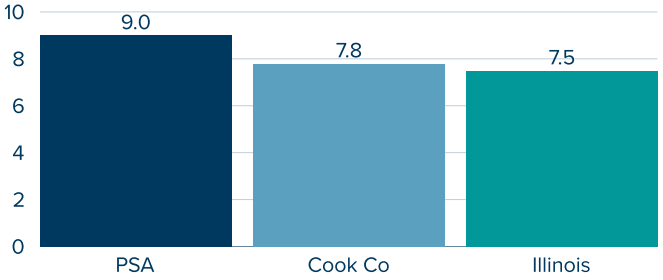
Contributing Factors

- Timely access to oncology care is critical for early diagnosis, effective treatment, and improved survival outcomes. Without it, patients face delays that can significantly affect their prognosis and quality of life.
  - » In the Christ PSA, there are 8.97 oncologist physicians per capita. In contrast, several zip codes in Cook County, including 60632 and 60620, have no oncologist physicians per capita.
- Specialist access is concentrated in affluent areas like 60453 (Oak Lawn) while many ZIP codes report no oncologists at all. Geographic inequities, transportation barriers, and insurance coverage limitations contribute to uneven cancer care across the PSA.
- Lung cancer diagnosis rates in Christ PSA are below the state average overall, but some ZIP codes like 60620 and 60453 face significantly higher burdens. Risk is elevated by factors such as tobacco use, environmental exposures, and gaps in early detection, particularly among older adults.
- The Inhalation Cancer Risk Environmental Justice Index data for the Christ PSA and 60453 zip code show elevated risk indices, indicating a significant environmental justice concern.

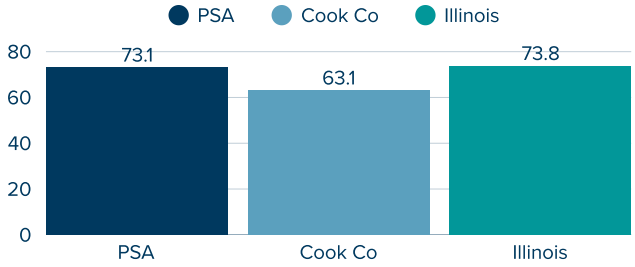
Sources: Metopio, Mapping Medicare Disparities, CMS, 2023
Metopio, BRFSS, 2022
Metopio, EPA, 2019

SUMMARY OF CANCER DIAGNOSIS

Cervical Cancer Diagnosis* (females)
PSA: 9.0
Cook County: 7.8
IL: 7.5
(Source: Metopio, Illinois State Cancer Registry, Ilinois Department of Public Health (IDPH), 2018–2022)

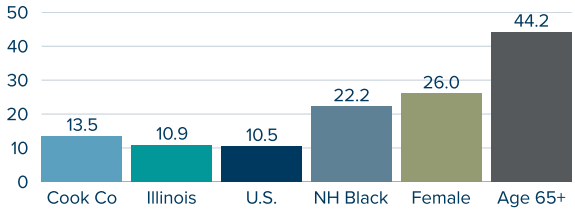


Lung Cancer Diagnosis*
PSA 73.11
Cook County: 63.10
IL: 73.84
(Source: Metopio, NCI, IDPH, 2018-2022)

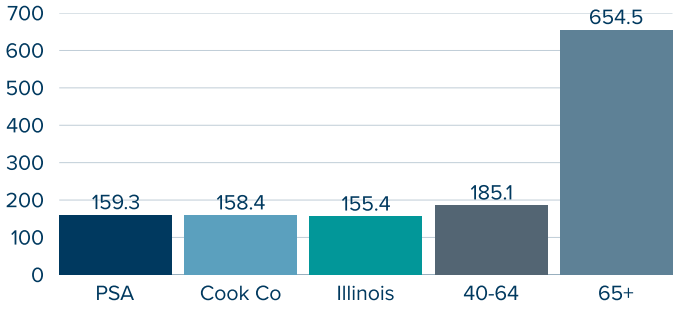


HIGHLIGHTED DISPARITIES

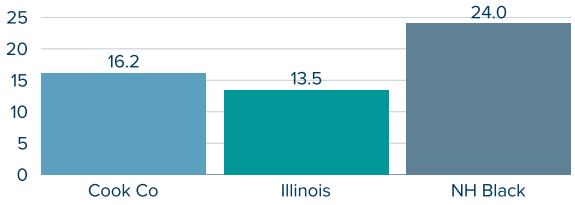
Breast Cancer Mortality* (females)
Cook County: 13.5
IL: 10.9
U.S.: 10.5
NH Black: 22.2
Female: 26.0
Age 65+: 44.2
(Source: Metopio, 2019–2023)



Prostate Cancer Diagnosis* (males)
PSA: 159.6
Cook County: 158.4
IL: 155.4
40-64 years: 185.1
65 and older: 654.5
(Source: Metopio, NCI, IDPH, 2018–2022)



Colorectal Cancer Mortality*
Cook County: 16.2
IL: 13.5
NH Black: 24.0



**Rates per 100,000 residents*

Community Safety (Violent Crime & Unintentional Falls)

SIGNIFICANT NEED

Why is this important? Community safety means making sure people feel safe in their neighborhoods, schools and public spaces. It includes preventing injuries, helping survivors of violence and working with first responders to improve their ability to respond to emergencies. Feeling safe supports better physical and mental health.

Experiencing violence, sexual assault and other forms of trauma can have harmful and lasting effects for individuals, families and communities. The impact goes beyond immediate harm and can include long-term physical impacts, mental health issues, health behavior risks, and financial costs. The chronic stress associated with feeling unsafe can cause anxiety, depression and fear of violence. It can keep people indoors, limiting access to social encounters, exercise, or even healthy foods options

Significant Need Reasoning

Violent crime ranked as the second top biggest health issues by survey respondents.

24% of survey respondents reported violent crime being the biggest health issue in their community.

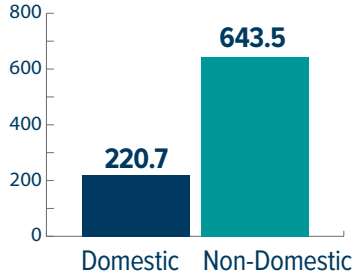
28.6% of survey respondents reported activities for teens and youth are needed, and 25% of survey respondents reported safety and low crime are needed for their community to be healthy.

Key Findings

- Unintentional fall rates in the Christ PSA indicates a higher incidence of fall related emergency and hospitalizations compared to county and state averages. The White population has the highest hospitalization rate, significantly higher than the overall population rate. This disparity indicates a need for targeted interventions to address fall risk and prevention measures in the PSA.
- While crime rates have varied over time, the violent crime and homicide rates in the PSA are generally higher than in the county and state.

Violent Crime Victim Type

(Metopio, FBI, CPD, 2019-2023)



Contributing Factors

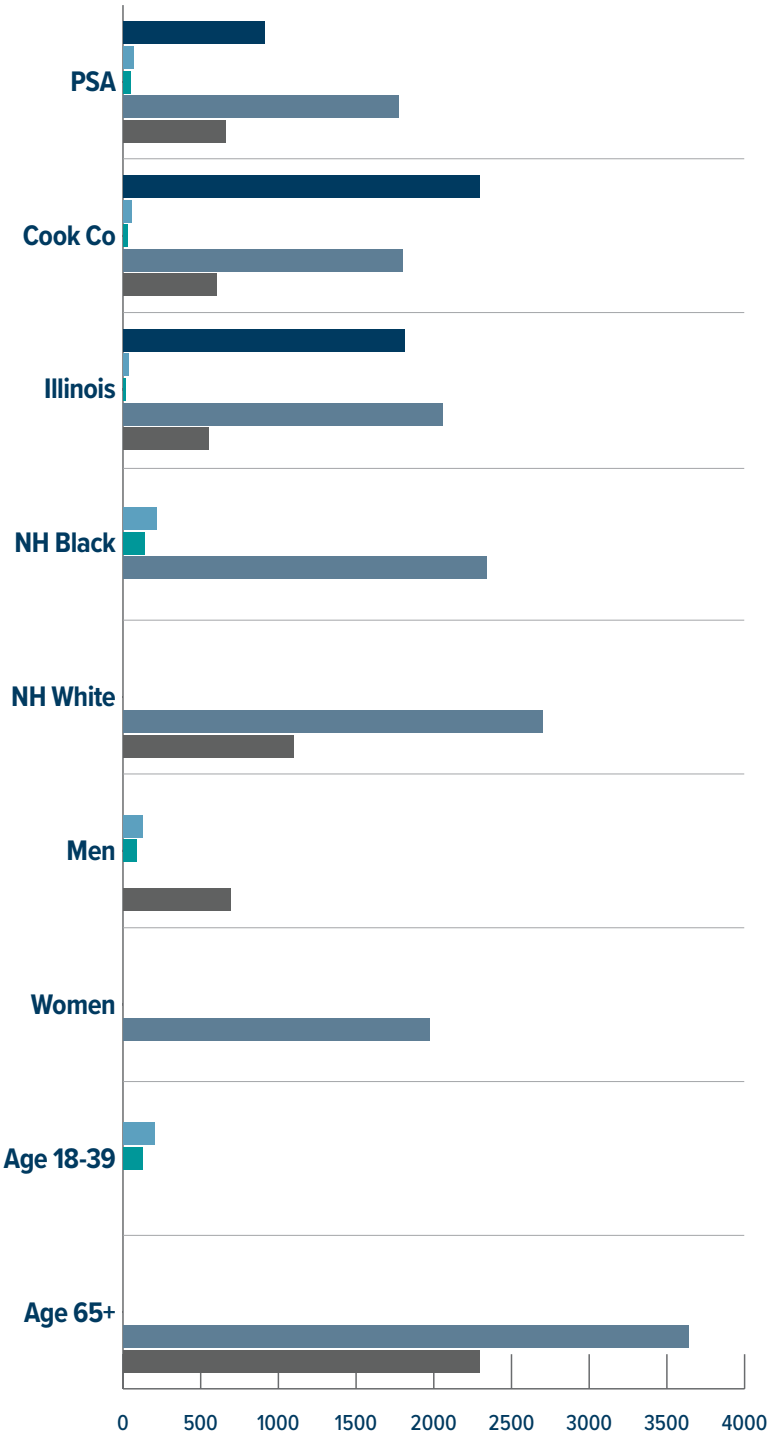
Safety is shaped by many factors, including the social, economic, and environmental makeup of the community. A strong sense of connection among residents, strong support systems in place and trusting leaders and public safety workers tend to make communities safer. Age-related health conditions in older adults such as arthritis and neurological issues caused by certain medications can contribute to unintentional falls, especially when combined with unsafe environments, impaired mobility, and balance difficulties.

- Barriers & Challenges
  - » Lack of economic opportunity
  - » Inaccessible community resources
  - » Lack of violence awareness programs in schools
  - » Stigma for accusers
  - » Lack of community engagement
  - » Lack of “outside of school” programs for youth

Community Safety (Violent Crime & Unintentional Falls) *continued*

SIGNIFICANT NEED

HIGHLIGHTED DISPARITIES



GRAPH LEGEND

- Violent Crime*
- Assault by Firearms ED Visits*
- Assault by Firearms Hospitalizations*
- Unintentional Fall ED Visit*
- Unintentional Fall Hospitalizations*

**Rates per 100,000 residents*

Sources: Metopio,FBI and CPD crime data portal 2023
Metopio, FBI, CPD, 2019-2023
Metopio,IHA COMPdata, 2020-2024

Food Security

SIGNIFICANT NEED

Why is this important? Having regular access to healthy food options like fresh fruits, vegetables, and meat is important for staying healthy. When people do not have regular access to healthy foods, they can develop problems like diabetes, high blood pressure, heart disease, or obesity. Reasons some people have a hard time getting food may include living far from grocery stores, lacking support from others, or not being able to afford it.

Significant Need Reasoning

Secondary data shows that in the Christ PSA, 13.2% of the residents are faced with food insecurity, which is notably higher than Cook County 12.1% and the state of Illinois 12.0%.

16.5% of AHE survey respondents listed resources for food as what the community needs to be healthy.

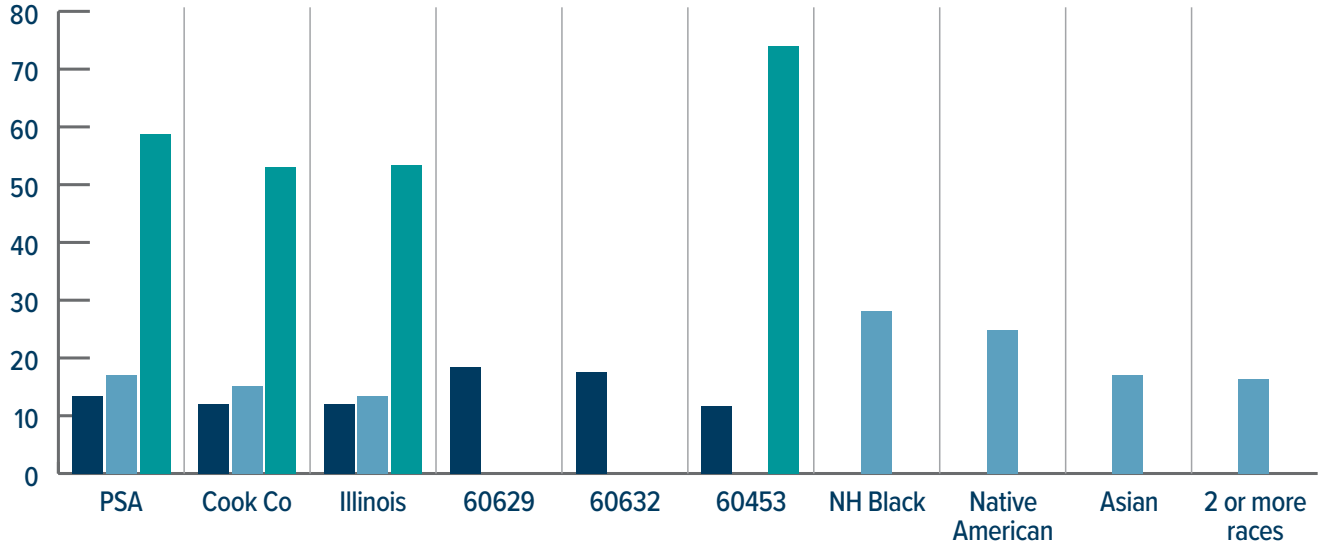
Key Findings

- Low food access significantly impacts communities in the Christ PSA. A notable 51.5% of residents are considered to have low access to food, defined solely by distance, a figure that is much higher compared to 38.65% in Cook County.
- 17.1% of households in the Christ PSA receive food stamps; 58.7% households in poverty are not receiving food stamps.

Contributing Factors

- Lack of grocery stores
- Lack of knowledge on how/where to find resources (food pantries)
- Limited transportation

HIGHLIGHTED DISPARITIES



GRAPH LEGEND

● **Food Insecurity** ● **Households Receiving Food Stamps (SNAP)** ● **Households in poverty not receiving food stamps**

> And grocery shopping is like way harder to do since they'll run out of supplies quickly.
> –AHE Focus Group Participant
>
> Transportation is something that has become really difficult.
> – AHE Focus Group Participant

PRIORITIZATION OF HEALTH-RELATED ISSUES

PRIORITY SETTING PROCESS

Advocate Christ's Community Health department reviewed data from primary and secondary sources. The data highlighted the prevalent health issues within the medical center's PSA. After reviewing medical center data, the Alliance data and other data sources, the most significant health issues were summarized and presented to the medical center's CHC for prioritization. Data presented to the CHC targeted the following significant health conditions for Advocate Christ's PSA:

- Cancer
- Cardiovascular Disease
- Demographics
- Diabetes
- Hardship Index
- Maternal Fetal and Infant Care
- Mental Health
- Obesity
- Respiratory Health
- Sexually Transmitted Infections
- Social Determinants of Health
- Substance Abuse
- Unintentional Falls

In September 2025, a prioritization meeting was held with the council to vote on health needs to be addressed as part of the hospital's community health needs assessment process. Council members were presented with the top health needs from which to select the health priorities to address.

Additional primary data was reviewed in this CHNA to add community safety, with a focus on violent crime. The Community Health Council selected Social Drivers of Health - Food Insecurity, Diabetes and Behavioral Health as priority areas to focus on for the 2026-2028 implementation strategy cycle.

HEALTH NEEDS SELECTED

Social Drivers of Health - Food Security

Social drivers of health - such as housing, food access, transportation, education, economic stability - have a significant impact on overall health outcomes. Social drivers of health impact people's health and their wellbeing. While there are many SDOH that have need of addressing, the Advocate Christ team has decided to continue to focus efforts around food insecurity, as there are concerning trends, and it is an area that has dedicated resources. The hospital will strive to continue the momentum they currently have to impact outcomes.

Behavioral Health

Behavioral health, which includes mental health and substance abuse, was selected as another health priority. Mental health and substance use often co-occur. The Community Health Council identified mental health as a priority health need due to rising rates of emergency department visits, hospitalizations, and the growing demand for local mental health services. This need also reflects the strong connection between mental health and substance, as many individuals experience both conditions simultaneously and require combined support. The rising rates of both substance use, and mental health data suggest that more work needs to be done to address the ever-growing need of additional services, access to programs and support services in our communities.

The CHC has recommended strengthening our interventions that address both health issues. Mental health and substance use issues of individuals impacted by trauma will continue to be addressed through the Advocate Trauma Recovery Center. The high rates of Emergency Department (ED) visits and hospitalization due to mental health issues will continue to be addressed through employing coping mechanisms and resilience training. Examples include Mental Health First Aid trainings and trauma-informed workshops.

Diabetes

Diabetes remains a significant health concern. Diabetes was selected as the number one health priority by our AHE survey respondents. Christ PSA reports a diabetes diagnosis rate of 13.1%, which is notably higher compared to Cook County (10.8%) and Illinois (10.4%). Upon further investigation and when comparing the percentage of diabetes diagnosed across the PSA landscape, the percentage of adults diagnosed with diabetes across all 27 zip codes has increased since 2020. Hospitalization and emergency department (ED) visits are indicative of poorly controlled chronic diseases and a lack of access to routine preventive care.

This elevated rate within the service area suggests a critical need for targeted diabetes management and intervention programs to mitigate the impact on local community health. As a result, the Advocate Christ's CHC decided that diabetes initiatives in this service area are still needed and continue to be a burden for residents.

HEALTH NEEDS NOT SELECTED

Obesity

Although obesity is a significant health issue, it was not prioritized as a separate focus area in this CHNA. Because obesity, diabetes and healthy eating are closely related, Advocate Christ Medical Center is addressing these needs through existing programs. These include the CDC National Diabetes Prevention Program, the Healthy Eating Food Farmacy, and the Love Your Heart/Trust the Process program, all of which support healthy lifestyle changes. Given these ongoing efforts, additional focus on obesity as its own category was not identified as necessary during this assessment.

Cancer

Cancer was not identified as a prioritized health concern by the Community Health Council, given that Advocate Health is already allocating substantial resources to this area. While the Council acknowledged the significance of cancer, it also recognized the existing system-level initiatives and concurred that comprehensive strategies are presently underway to address these needs. Advocate Health will continue to focus on expanding our education/prevention efforts, support our screening programs, and improve access to our cancer services, treatment, and clinical trials.

Advocate Christ is proud to house a satellite location for Gilda's Club. Gilda's Club provide a safe and welcoming space where people can come together, share their stories, and find support from others who truly understand. Recognizing the need for free resources for men, women, teens and children, Advocate Christ Cancer Institute provides diagnosis, treatment and support to thousands of cancer patients and sees more than 2,000 newly diagnosed cases each year.

Community Safety

Although nearly a quarter (24%) of participants in the Alliance for Health Equity (AHE) survey ranked violent crime as the second most pressing health concern in the area, it was not chosen as a dedicated priority in the Community Health Needs Assessment (CHNA). While violence affects every community, it is most prevalent in low-income neighborhoods predominantly inhabited by people of color. The underlying causes of community violence are complex and include concentrated poverty, disparities in education, limited access to healthcare, high rates of incarceration, differing law enforcement practices, and generational trauma (Centers for Disease Control and Prevention, 2022).

To address this issue, Advocate Health Care's Trauma Recovery Center has partnered with UChicago Medicine's Violence Recovery Program through the Southland RISE initiative. This collaborative effort focuses on strengthening long-term trauma recovery and supporting victims of violence in Chicago's South Side and surrounding communities. Since Southland RISE is already an established part of the hospital's operations, the CHNA did not identify the need for additional focus on violent crime at this time.

APPROVAL OF COMMUNITY HEALTH NEEDS ASSESSMENT

The director of Community Health presented the CHNA to the hospital's Governing Council on November 17, 2025. Governing Council members learned about the process and the selected priorities. In addition, council members were informed that a copy of the CHNA would be provided later in the year for their review and approval. The Advocate Health Care Board approved the report on December 10, 2025.

VEHICLE FOR COMMUNITY FEEDBACK

Advocate Christ Medical Center welcomes all feedback regarding the 2025 Community Health Needs Assessment. Any member of the community wishing to comment on this report can email us: AHC-CHNAReportCmtyFeedback@aah.org. Questions will be addressed and will also be considered during the next CHNA cycle.

This report can be viewed online at Advocate Health Care's Community Health Needs Assessment Report webpage via the following link: https://www.advocatehealth.com/hospital-chna-reports-implementation-plans-progress-reports

A hardcopy of this report may also be requested by contacting the hospital's Community Health Department.

EVALUATION OF IMPACT FROM PREVIOUS CHNA

The 2022-2025 CHNA identified mental/behavioral health and obesity as the primary health priorities for the hospital PSA. Complete outcome date is not yet available at the time of this report as the 2025 program year is still in progress. However, significant community engagement and program implementation efforts have taken place.

Mental Health

To address mental and behavioral health, Advocate Christ Medical Center's Community Health team, in partnership with local community organizations, our Faith and Health Partnerships and Trauma Recovery Center have participated in the following mental health activities:

In 2023, the Trauma Recovery Center provided 4,656 individual therapy sessions, 7,311 Individual Counseling Sessions, and 425 inpatient behavioral health visits. In 2024, the Trauma Recovery Center provided 5,352 individual therapy sessions, 8,276 Individual Counseling Sessions, and 1,239 inpatient behavioral health visits. Since 2023, the Trauma Recovery Center (TRC) was involved in 36 community training courses and offered 4 trainings to the community regarding TRC services.

In 2023 Advocate Christ partnered with team members from the AAH Faith and Health Partnerships to conduct 41 total events that focused on mental health education. The workshops and trainings in the community include Mental Health First Aid Training, Companionship Training and Peer Support Group trainings, which reached 480 people. In 2024, Advocate Christ partnered with team members from the AAH Faith and Health Partnerships to conduct 45 total events in the South Chicagoland area that focused on mental health education. The workshops and training in the community include Mental Health First Aid Training, Companionship Training and Peer Support Group trainings, which reached 343 people. Since 2023, the Community Health Workers (CHWs) at Advocate Christ provided 64 mental/behavioral health referrals for community members.

To address hypertension, blood pressure, and mental health needs, the Community Health team partnered with Body by Ivory Fitness Gym in Fall 2024 to launch the Love Your Heart/Trust the Process program. This initiative implements the Love Your Heart curriculum, focusing on managing hypertension and lowering blood pressure, while also supporting mental health through a series of workshops alongside its six-month fitness schedule. The program is designed to emphasize the connections between physical activity, hypertension, and mental well-being. To date, this program has served 50 members.

Obesity

Advocate Christ has continued to advance health promotion, disease prevention, and food security initiatives through implementation of Food Farmacy and the National Diabetes Prevention Program (NDPP). Over the past two years we have implemented the NDPP program to address obesity in Advocate Christ Primary Service Area.

National Diabetes Prevention Program

This evidence-based, year-long program is designed to help adults with prediabetes reduce their risk of developing type 2 diabetes. It focuses on weight loss, physical activity and improved nutrition. In 2023, there were 2 cohorts for the Diabetes Prevention Program (DPP) supporting a total of 26 graduates. The participants spent an average of 224 physical activity minutes for the entire cohort. A total of 8 participants met the 5% weight loss goals. A total of 23 participants lost or maintained their weight. Thirty-six percent of participants who enrolled in the program met their nutrition and weight loss goals.

In 2024, there were 3 cohorts for the Diabetes Prevention Program (DPP), supporting a total of 64 participants enrolled, with 26 graduating. The participants spent an average of 224 average physical activity minutes for the entire cohort. A total of 8 participants met the 5% weight loss goals. A total of 23 participants lost or maintained their weight. Thirty-six percent of participants who enrolled in the program met their nutrition and weight loss goals.

Advocate Christ's Food Farmacy

In 2023, Advocate Christ partnered with Greater Chicago Food Depository to expand the Food Farmacy to the Christ PSA offering fresh produce and recipes for recipients who are food insecure. In 2023, the Food Farmacy provided fresh produce to 120 individuals through a total of 180 visits. Advocate Christ's Food Farmacy was featured in the Chicago Tribune

https://www.chicagotribune.com/2023/11/14/advocate-health-care-fresh-foodservice-allows-physicians-to-prescribe-a-healthy-diet/

In 2024, the program partnered with Cristina Foods and Top Box Foods to provide fresh produce and protein to patients who are experiencing food insecurity or cardiometabolic diseases. Patients received fresh produce twice a month; and a protein accompaniment (chicken, fish or ground turkey) once a month.

In 2024 the program distributed over 79,460 pounds of food, serving 3,973 patients. The program's success was highlighted at the GATHER gala fundraising event where proceeds supported health equity in the communities that we serve. Enclosed is the video testimonial that was highlighted at the gala: https://youtu.be/hyjq6CmR3GY?si=5-kJ6yTzsq4T-Yxn

In 2024, the Food Farmacy partnered with the LiveWell Mobile Health Van to provide 228 blood pressure, glucose and BMI screenings to 76 Food Farmacy Participants.

Summary

Over this CHNA period, Advocate Christ Medical Center and its partners have made progress toward addressing mental health and obesity in the community. These efforts reflect a strong commitment to prevention, education and reducing health disparities through local engagement and sustainable programming. Final outcome data will be available following the conclusion of the CHNA cycle.

Appendix 1: 2025 Community Health Needs Assessment Data Sources

To view the Alliance for Health Equity CHNA report, which includes summaries of the community feedback, descriptions of the data collection methods and the members of the collaborative, along with the full survey reports, visit: https://www.allhealthequity.org/chna

Appendix 2: Community Resources Available for Significant Needs

The resources under each significant need are not a complete list. For more community resources, visit: https://advocateauroracommunity.org/

Behavioral Health (Mental Health and Substance Use)

Organization	Website	Contact
Trauma Recovery	www.advocatehealth.com	708-684-4393
Sertoma Star Services	https://sertomastar.org/	708-371-9700
NAMI Chicago	www.namichicago.com	833-626-4244
Advocate Behavioral Health	https://www.advocatehealth.com/health-services/behavioral-health-care	
Respond Now	www.respondnow.org	708-755-4357
BEDS Plus	www.beds-plus.org	708-354-0858
NAMI of South Suburbs of Chicago	www.namisouthsuburbsofchicago.com	708-852-9126
HRDI	www.hrdi.org	773-863-1452

Obesity and Diabetes

Organization	Website	Contact
American Diabetes Association	www.diabetes.org	1-800-DIABETES
PCC South Family Health Center	https://www.pccwellness.org/locations/pcc-south-family-health-center/	
Advocate Diabetes Endocrinology	https://www.advocatehealth.com/health-services/diabetes-endocrinology	
Illinois Alliance to Promote Opportunities for Health	https://iphionline.org/iapo/	

Food Insecurity

Organization	Website	Contact
Greater Chicago Food Depository	www.chicagosfoodbank.org	773-247-3663
FindHelp	www.findhelp.org	
Find Food Illinois	www.extension.illinois.edu/food/find-food-illinois	

Community Safety (Violent Crime)

Organization	Website	Contact
Chicago Police Department – Community Outreach	https://www.chicagopolice.org/community-policing-group/community-liaisons-outreach/	815-334-4585

Cancer

Organization	Website	Contact
Chicago Police Department – Community Outreach	https://www.chicagopolice.org/community-policing-group/community-liaisons-outreach/	
Advocate Cancer Institute	https://www.advocatehealth.com/health-services/cancer-institute	
Gilda's Club	https://www.gildasclubchicago.org/locations/detail/advocate-christ-medical-center-and-advocate-childrens-hospital-oak-lawn/	

Appendix 3: References

Metopio. Accessed via a contract with Advocate Aurora Health. Website is unavailable to the public. The following data sources were accessed through the portal:

American Community Survey, 2019-2023, 2020-2024./

Behavioral Risk Factor Surveillance System, 2021, 2022

Centers for Disease Control and Prevention, 2022

Centers for Disease Control and Prevention, WONDER, 2022

Centers for Medicare and Medicaid Services, National Provider Identifier, 2021

Diabetes Atlas, 2022

Diversitydatakids.org, 2017-2021

Feeding America, 2022

FBI Crime Data Explorer, 2017-2021

Health Resources and Services Administration, 2021

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2021

National Vital Statistics System-Mortality, 2018-2022

National Vital Statistics System-Natality, 2016-2020

PLACES, 2022

United Way ALICE Data, 2022

USDA, 2019

U.S. Opioid Dispensing Rate Maps, 2022

Other Resources:

American Diabetes Association, Statistics About Diabetes, 2023

The Alliance for Health Equity, Community Health Need Assessment, 2025: CHNA | Community Health Needs Assessment for the City of Chicago and Suburban Cook County — The Alliance for Health Equity

CDC. Racial and Ethnic Differences in Social Determinants of Health and Health-Related Social Needs Among Adults — Behavioral Risk Factor Surveillance System, United States, 2022: https://www.cdcgov/mmwr/volumes/73/wr/mm7309a3.htm

Appendix 4: Additional Data

Alliance for Health Equity PSA Survey Analysis:

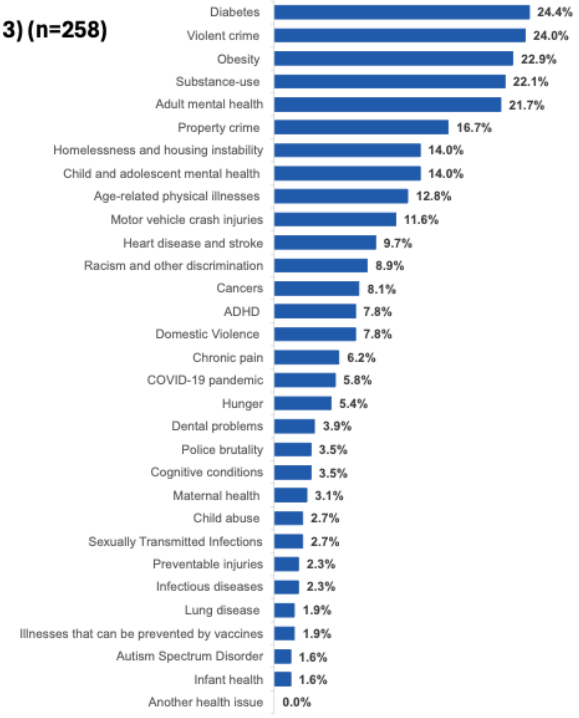
What are the biggest health issues in your community? (Choose 3) (n=258)

Advocate Christ service area top health issues

1. Diabetes
2. Violent crime
3. Obesity
4. Substance use
5. Adult mental health

Cook County top health issues

1. Adult mental health
2. Diabetes
3. Substance use
4. Obesity
5. Homelessness and housing instability



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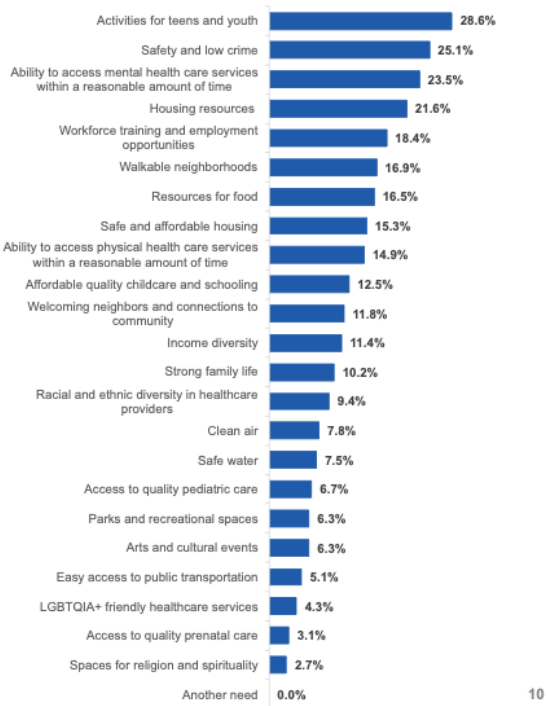
What does your community need to be healthy? (Choose 3) (n=139)

Advocate Christ service area top health needs

1. Activities for teens and youth
2. Safety and low crime
3. Access to mental healthcare services
4. Housing resources
5. Workforce training and employment

Cook County top health needs

1. Activities for teens and youth
2. Access to mental healthcare services
3. Housing resources
4. Safety and low crime
5. Safe and affordable housing



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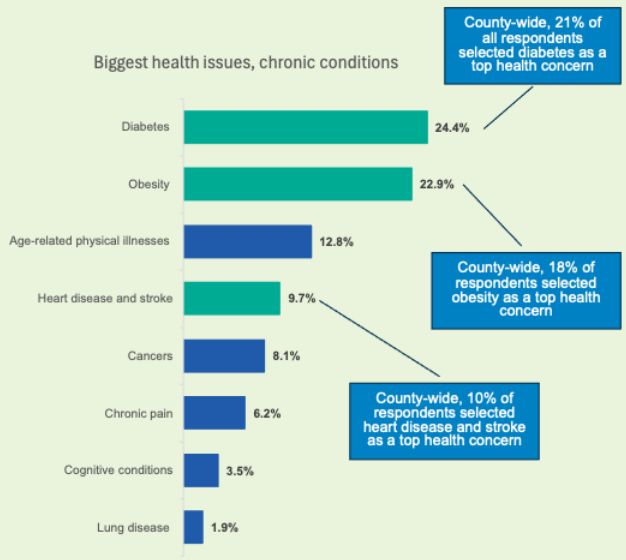
Diabetes, Obesity & Cardiovascular disease



"We had decided to live here because it was close to healthcare, but now it is far away. The ambulance only goes to two hospitals and there are issues."

Chronic health conditions

- Several health behaviors and social determinants are contributing to chronic disease
- Impacts of COVID-19 infection

"I want to eat like protein, vegetables and fruits, but they don't have any of that."

I am satisfied with the availability of fresh and healthy foods in my community. — **50.8%** agree or strongly agree

My community has clean air and water. — **55.0%** agree or strongly agree

I am satisfied with the healthcare system in my community. — **39.7%** agree or strongly agree

Summary of focus group findings

Core Themes

Child and adolescent health

- Programs and services needed
  - After-school programs
  - Recreation centers
  - Health Education
- Childcare
- Education
- Youth mental health crises

"Just like maybe community things that kids can get into. That way they're not just on the streets or bored."

Chronic health conditions

- Several health behaviors and social determinants are contributing to chronic disease
  - Impacts of COVID-19 infection
  - Lack of health education in preventive care

COVID-19

- COVID-19 impacts:
  - Local businesses closed down
  - Health clinics that happened pre-COVID do not exist

Healthcare

- Several factors influence access
  - Ease of access to health clinics
  - Insurance coverage and public benefits
  - Immigration status
  - Culturally appropriate services
- Lack of empathy among healthcare professionals
- Long ED wait times
- Several additional healthcare needs discussed
  - Behavioral health services
  - Engagement in primary care
  - Expanded use of CHWs
  - Building trust with communities
  - Better communication about resources
  - Transportation to appointments
  - Diverse healthcare workforce

"I feel like diversity is the thing that can be improved out there a bit, because maybe the departments I've seen so far, but there aren't that many Black or Brown people working there, and I feel like that could go a long way in like patient interactions."

Summary of focus group findings

Core themes

Community safety

- Several factors contribute to violence in communities
- Lack of economic opportunity
  - Inaccessible community resources
  - Lack of "outside of school" programs for youth
- Police involvement is not helpful
- Substance use disorders
- Lack of behavioral health treatment and need for greater mental health awareness
- Lack of infrastructure investment in roads and public safety measures
- Lack of public transportation access

Community cohesion and leadership

- Community cohesion is important for healthy communities
- Roles of communities in solutions
  - Trusted community liaisons for sharing information
- Coordination between programs and services needs improvement

Community communication

- Communication about resources is ineffective
- In-person communications
  - Community events
  - Trusted messengers
  - Passing information through local organizations
  - Mail

"Services are there... but the issue is getting the word out, getting people to trust it, and increasing the amount of services that you can provide."

"A lot of people still don't use the internet."

"Information shouldn't just stay in this community, whether that's sending out envelopes or having gatherings that bring other communities in and then they [the hospitals] have like, some nurses or doctors talk to people."

Summary of focus group findings

Core themes

Social and structural determinants of health

- Some of the most discussed needs included:
  - Access to affordable housing
  - Access to healthy foods and grocery stores
  - Affordable childcare
  - Quality education
  - Economic opportunity and community investment
  - Improved infrastructure
  - Health education courses

"And grocery shopping is like way harder to do since they'll run out of supplies quickly."

"Given the park in my neighborhood, it's really easy to just go outside and do anything like sports-related with friends or sometimes they have organized recreational baseball."

"Transportation is something that has become really difficult."

Behavioral Health

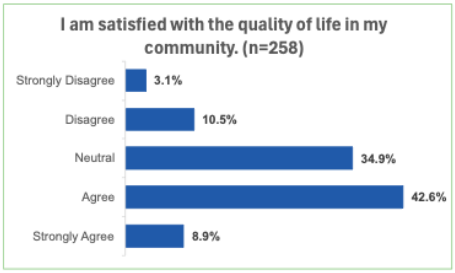
- Wholistic integrated care
- Substance use
- Mental health crises
- Access to treatment
- Connections between mental health and other determinants of health
- Positive health behaviors

"Mental health and homelessness is a big issue."

"And it's like kind of been all over the news recently where a lot of people are experiencing health issues just because of substance abuse."

Community assets

- **What are the best things about communities?**
  - Friendly people
  - Schools
  - Community events
  - Clean and safe community
  - Diversity
  - Access to community services
  - Outdoor space
  - Community involvement and support



Advocate Health Care

Thank You

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