Advocate Health Care

2025

Advocate Lutheran General Hospital

Community Health Needs Assessment Report

1775 Dempster St.
Park RIdge, IL 60068

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.

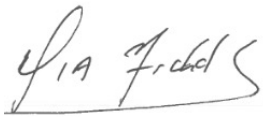
As we close another CHNA cycle, I'm inspired by the profound difference we make each day across our Illinois Division. From groundbreaking research and exceptional clinical care to meaningful patient programs and cutting-edge innovations, our work is driven by the patients, families and communities we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

Letter from Hospital President

October 2025

Thank you for taking the time to learn about the communities served by Advocate Lutheran General Hospital through our Community Health Needs Assessment (CHNA). This report provides a detailed look at the health status and social needs of our service area, helping us deliver safe, high-quality care with compassion and dignity.

Advocate Lutheran General Hospital serves Suburban Cook County and neighboring counties. We are deeply committed to not only exceptional patient care, but also to improving community health through strong partnerships and collaboration.

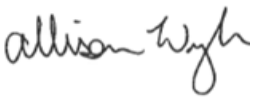
Every three years, we conduct a comprehensive CHNA in partnership with local organizations, stakeholders, and public health departments. This process includes extensive community engagement to ensure the assessment reflects the lived experiences and priorities of those we serve. Input from residents, along with internal and community data sources, forms the foundation of this report. Our Community Health Council also plays a key role by reviewing data, guiding priorities, and offering strategic insight.

For the 2025 CHNA, the Council has identified three priority health areas:

- Mental Health
- Substance Use
- Diabetes

We will implement strategies and interventions that address the root causes of these issues, guided by research, best practices, and evidence-informed approaches. This includes continuing long-standing programs and developing new initiatives.

It is our honor to work alongside community partners, leaders, and residents to improve the health and wellness of the diverse populations we serve. With a data-driven understanding of community needs, Advocate Lutheran General Hospital remains committed to helping people live well and enhancing quality of life across our service area.



Allison Wyler
Senior Vice President of Operations, North Chicago Area
President, Advocate Lutheran General Hospital

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EXECUTIVE SUMMARY

In 2025, Advocate Lutheran General Hospital (Advocate Lutheran General) conducted a Community Health Needs Assessment (CHNA) for its Primary Service Area (PSA), which includes 25 zip codes in Cook County and 3 in Lake County. The CHNA analyzed demographic, socioeconomic, and health data alongside input from the Alliance for Health Equity (surveys and focus groups).

The PSA population is 60.8% White, 20.0% Hispanic/Latino, 13.7% Asian/Pacific Islander, and 3.0% Black/African American, with a median household income of $106,737.

The hospital's Community Health Council (CHC), comprised of hospital leaders and community representatives, guided the 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 CHC identified eight significant health needs: cardiovascular disease, diabetes, respiratory disease, substance and alcohol use, mental health, obesity, food insecurity, and access to care. After prioritization, the **three top health priorities** for the 2025 CHNA were confirmed as:

1. Mental Health
2. Substance Use
3. Diabetes

Cancer, housing and transportation were also noted as important concerns but were not included locally given Advocate Aurora Health's system-wide investments in these areas.

Next Steps

Advocate Lutheran General, 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 LUTHERAN GERNAL HOSPITAL

Advocate Lutheran General Hospital in Park Ridge delivers nationally recognized care in specialties including cardiology, pulmonology, neurology and cancer treatment. As a Level I Trauma Center and teaching hospital, we provide advanced diagnostics, surgical innovation and expert emergency care.

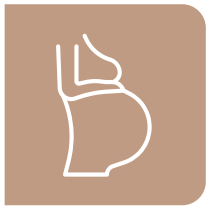
We're also home to Illinois' first stand-alone, hospital-affiliated Cancer Survivorship Center, as well as the Adult Down Syndrome Center, where teens and adults receive holistic care and support.

Level I Trauma Center

Heart & Lung Care

Oncology

Stroke Care



Maternal & Fetal 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, Advocate Lutheran General Hospital defines "community" as its Primary Service Area (PSA). Of the 28 zip codes in the PSA, 25 are in Cook County, while 3 belong to Lake County. The PSA communities have been organized in order from greatest to lowest Hardship Index, and they include: Des Plaines (60018), Skokie (60077), Irving Park/Portage Park (60641), Elmwood Park (60707), Norridge/Harwood Park (60706), Des Plaines (60016), Wheeling (60090), Niles (60714), Prospect Heights (60070), Skokie (60076), Palatine (60074), Irving Park/Dunning (60634), Morton Grove (60053), Mount Prospect (60056), Jefferson Park (60630), Oriole Park (60656), Glenview (60025), Arlington Heights (60004), Arlington Heights (60005), Edison Park/Norwood Park, (60631), Palatine (60067), Glenview (60026), Palatine (60646), Buffalo Grove (60089), Northbrook (60062), Deerfield (60015), Long Grove (60047).

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.

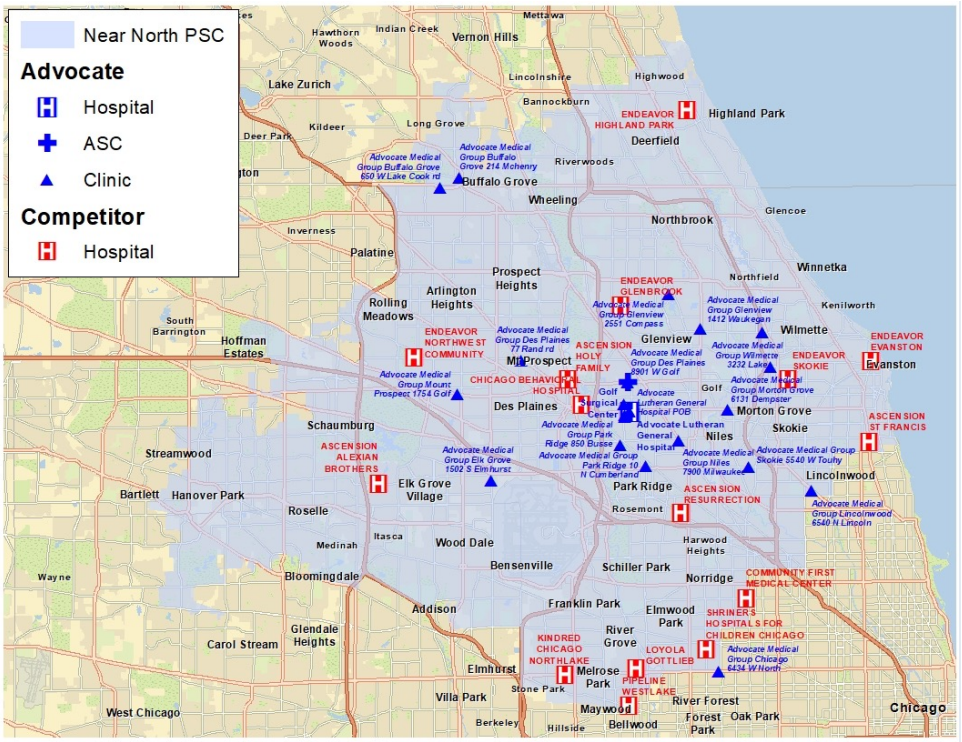


Exhibit 1:
Advocate Luthern General Hospital, Patient Service Area Map
Source: Advocate Health Care, Business Development, 2024

2019-2023 Data Estimates

Population
1,071,183

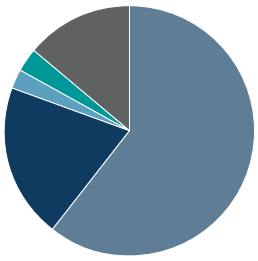
The top three largest communities:
Irving Park/Dunning (60634): 74,418
Irving Park/Portage Park (60641): 67,400
Des Plaines (60016): 60,520

Gender
49.0% Male
51.0% Female

Median Age
42.3 years PSA
41.1 years Males
43.4 years Females

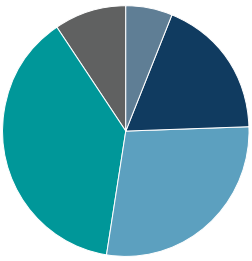
Population by Race/Ethnicity

Non-Hispanic (NH) White	59.9%
Hispanic or Latino	20.5%
Two or More Races	2.7%
Non-Hispanic (NH) Black	3.2%
Asian	13.7%



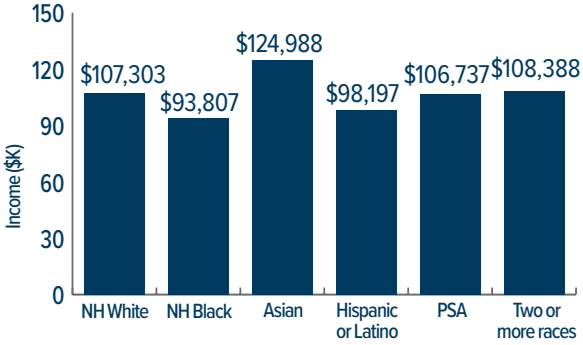
Population by Age Group

Infants 0-4	5.5%
Juveniles 5-17	16.5%
Young Adults 18-39	24.8%
Middle-Age 40-64	34.8%
Seniors 65+	8.3%



Limited English Proficiency Households
9.5% PSA

Income by Race/Ethnicity



Education

High School Graduation Rate
91.3% PSA
88.3% Cook Co
90.2% Illinois

College Graduation Rate
48.9% PSA
41.9% Cook Co
37.1% Illinois

Median Household Income

PSA	Cook Co	Illinois
$106,737	**$81,797**	**$81,702**

Employment
Unemployment rate of population 16+ (2018-2022)

4.5% PSA
7.0% Cook County
5.9% Illinois

Population Living Below Poverty Level:

PSA	Cook County	Illinois
7.6%	**13.3%**	**11.7%**

Household/Family

Single Parent Households
4.54% PSA
6.37% Cook Co
6.06% Illinois

Seniors Living Alone
26.2% PSA

Children under 18
5.5% 0-4 years
22.0% 0-17 years

By Community:
13.5% Irving Park/Portage Park 60641
12.1% Skokie 60077
11.7% Palatine 60074
9.5% Irving Park/Dunning 60634

By Race:
16.8% NH Black
6.7% NH White

By Age:
8.2% 0-4 years
10.2% 5-17 years
8.3% Seniors

Source: Metopio, ACS, 2018-2022 & 2019-2023

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.

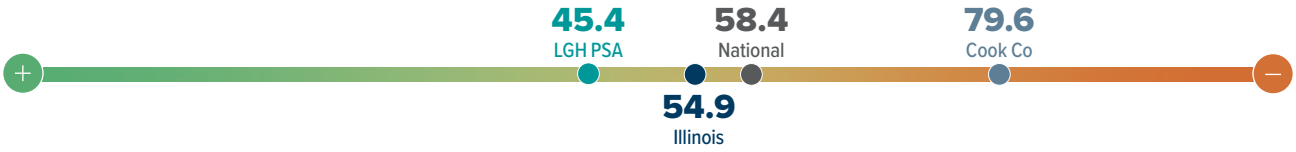
Social Drivers of Health can also cause health differences between groups of people. For example, if someone lives far from a store with healthy food, it's harder for them to eat well. This can lead to health problems like heart disease or diabetes. Just telling people to eat healthy isn't enough - we 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

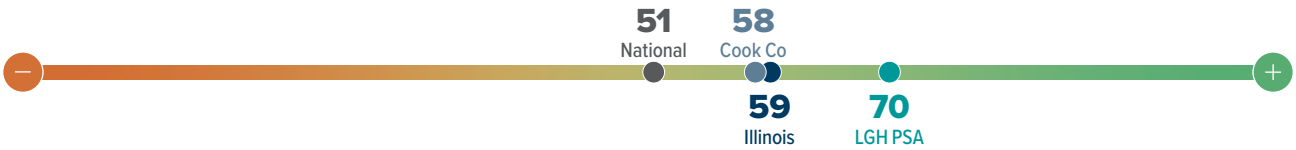
To better understand these factors and identify health inequities in a community, Advocate Health Care has partnered with Metopio, a software company that focuses on how communities are connected through people and places. Metopio's tools use data to show how different factors in each area influence 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 health improvement efforts where they are most needed.

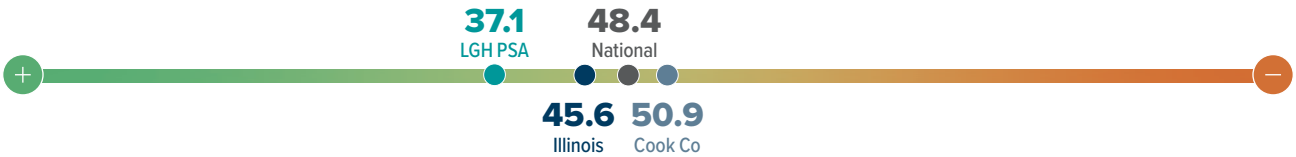
Social Vulnerability Index (SVI) – The Social Vulnerability Index was created to help public health officials and emergency response planners identify and map the communities that will most likely need support before, during, and after a hazardous event, such as a natural disaster, disease outbreak, or chemical spill. SVI indicates relative vulnerability by ranking places on 15 social factors, including unemployment, minority status, and disability, and combining the rankings into a single scale from the 0th percentile (lowest vulnerability) to 100th percentile (highest vulnerability). *(Source: Metopio, CDC, 2022)*



Childhood Opportunity Index (COI) – 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, 2023)*



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. *(Source: Metopio, ACS, U.S. Census Bureau, 2019-2023)*



Communities with the greatest hardship index in the Lutheran General PSA:

Des Plaines 60018	59.9	Des Plaines 60016	54.7
Skokie 60077	58.0	Wheeling 60090	54.6
Irving Park/Portage 60641	56.4	Niles 60714	54.2
Elmwood Park 60707	54.7	Prospect Heights 60070	52.6
Norridge/Harwood Heights 60706	54.7	Skokie 60076	50.1

How the CHNA Was Conducted

The Advocate Lutheran General Community Health Department convenes regularly with the Community Health Council (CHC), which serves in an advisory capacity for the hospital's community health programming, Implementation Strategy, and Community Health Needs Assessment (CHNA). Led by the hospital's Regional Director of Community Health, the CHC includes 11 members, nine from community-based organizations and two from the hospital - representing a range of sectors and expertise.

The CHC played a vital role in supporting the 2025 CHNA through data collection, review, and prioritization of health needs. From January to May 2025, the CHC met virtually five times for 90-minute sessions to provide feedback and engage in meaningful discussion. Community representatives offered critical insight into the needs of underserved populations, while hospital representatives contributed perspectives on patient health trends and resource alignment. Together, members identified health disparities, shared local knowledge on social barriers, and helped pinpoint high-need zip codes within the Primary Service Area (PSA).

Through this collaborative process, the CHC identified three priority health needs for Advocate Lutheran General Hospital: Diabetes Substance Use, and Mental Health. The CHC will continue to meet regularly to help shape Community Health Implementation Strategies.

Purpose and Process

By 2025, Advocate Health Care had established the necessary resources to launch the 2025 Community Health Needs Assessment (CHNA), a process designed to better understand and address the health and social needs of the hospital's Primary Service Area (PSA). As part of this effort, Advocate Health Care maintained a contract with Metopio, a web-based data platform that provides access to a wide range of health and demographic indicators, including hospitalization and emergency department utilization trends. In addition, hospital and system leaders contributed de-identified, aggregated hospital utilization data through the Illinois Hospital Association's COMPdata system to inform the CHNA process.

During the final Community Health Council (CHC) meeting of 2024, the hospital's Community Health team presented the 2025 CHNA timeline and formally outlined expectations for CHC involvement. Council members received official membership letters detailing their roles and responsibilities, along with a comprehensive toolkit to guide participation. The toolkit included space for notetaking, national data on priority health issues, and summaries of the economic burden, long-term impacts, and preventability of each condition. This ensured that council members were well-informed and prepared to engage meaningfully in the upcoming data discussions.

In January 2025, the Community Health team began presenting demographic and socioeconomic data, followed by a series of in-depth presentations on the PSA's top eight identified health needs. After thorough discussion and analysis, CHC members completed a prioritization grid that allowed them to rate each health concern across six distinct criteria. The Community Health team compiled and analyzed these ratings to determine the top priorities. Based on the aggregated results, substance use, mental health, and diabetes were identified as the top three health needs for the 2025 cycle.

Over the next three years, Advocate Lutheran General Hospital's Community Health team will focus its strategic efforts on addressing these three priorities. At the same time, the hospital remains committed to supporting ongoing programs already in place and will remain responsive to any emerging health needs within the community.

Partnership

In addition to the work led by the hospital's Community Health Council, Advocate Lutheran General Hospital actively participates in the Alliance for Health Equity (AHE) committee to help align efforts and support the county's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). To minimize redundancy and overlap, the hospital is also involved with AHE's planning committee, which oversees the community survey efforts that collect qualitative data across the county. AHE is further conducting focus groups to deepen understanding of community needs. Advocate Lutheran Hospital's Community Health team also meets regularly with other non-Advocate hospital systems to foster collaboration and maximize impact in shared zip codes.

Data Collection and Analysis

Multiple data collection strategies were employed to collect data for the CHNA. Our primary data source, Metopio, offers our hospitals over 198 health and demographic indicators, including 38 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 database provides a wealth of county and zip code data comparisons, and a Hardship Index, which helped to visualize vulnerable populations within service areas and counties. Additional data from the Illinois Public Health Institute (IPHI) and the Alliance for Health Equity (AHE) was leveraged to further illustrate the needs of our community. The AHE collaborative facilitated focus groups and collected hundreds of key informant surveys. More information on the survey findings can be found in the appendix of this document.

As indicated, Metopio was a key source of secondary data for the 2025 CHNA. This secondary data was crucial in analyzing the hospital's PSA health needs as the database was the only source that provided such an extensive amount of data specific to the 2025 CHNA's defined community. All data collected through Metopio was quantitative and included data comparisons between PSA communities, counties and the state.

Summary of Findings

Overall Health Status

Overall, Advocate Lutheran General Hospital PSA's health outcomes are comparable to the average county in 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 in the United States

According to the Centers for Disease Control and Prevention (CDC), the leading causes of death, in the US, in order from highest to lowest are: Heart Disease, Cancer, Accidents (unintentional injuries), Stroke, Chronic lower respiratory disease, Alzheimer's Disease, Diabetes, Nephritis (nephrotic syndrome & nephrosis), chronic liver disease (includes cirrhosis) and COVID-19. *(CDC, National Center for Health Statistics, 2023)*

Life Expectancy

- LGH PSA: 81.2 years
- Cook County: 78.5 years
- Illinois: 78.7 years

(Metopio, U.S. Small-Area Life Expectancy Estimates Project (USALEEP), 2010-2015)

Top Health Concerns

Advocate Lutheran General's Community Health team analyzed extensive health data, grouping indicators into broader themes based on health outcomes and health behaviors that correlate to those health outcomes. Our team acknowledges many confounding variables - language barriers, finances, age, medical history, environment, even zip code - affecting health in both direct and indirect ways. We recognize these underlying drivers as the Social Drivers of Health (SDOH).

Building on Community Strengths

Before reviewing the significant health needs, it is important to recognize the assets, support systems, and health improvements within the community. These include hospitals, clinics, community organizations, and programs that help people stay healthy.

This section highlights key organizations and services that support community health, along with improvements that have been made since the last assessment. By understanding existing resources and recent progress, we can build on these strengths and find better ways to address remaining gaps in care.

Data Bright Spots:

- Of the 143 survey respondents near the Lutheran General PSA, 58.6% rated the overall health of their community as "Healthy" or "Very Healthy". When asked about their personal health, only 8.9% selected "Unhealthy" or "Very Unhealthy".
- Of the 143 survey respondents near the Lutheran General PSA, only 17.8% of respondents reported being dissatisfied with the healthcare system in the area.
- The Advocate Lutheran PSA's overall Walkability Index Score is 13.2, putting the PSA in the highest 10% when compared to other areas in Illinois.
- Residents in the PSA are more likely to visit their health care provider and avoid unnecessary emergency department visits. The PSA rate for preventable acute ED visits is in the lowest quartile (10-25%) for the PSA when compared to other zip codes in Illinois.
- The median household income for the PSA is $106,737, putting it in the top quartile (75-90%) when compared to other zip codes in Illinois. Also in the top quartile is the median earnings for workers ($58,041) in the PSA.

Some initatives that seem to be working well in the community are:

- **Strong Public Health Leadership:** The Cook County Department of Public Health and Chicago Department of Public Health are nationally recognized for their programs, policies, and data-driven approaches.
- **The Village of Skokie Health and Human Services Community** (HHS) has also established the Skokie Health Equity Network (SHEN). SHEN is a collaborative group of community stakeholders and residents working to advance identified priorities – IPLAN and CHIP efforts.
- **Diverse and Engaged Community Partnerships:** Collaboration through coalitions like the Alliance for Health Equity (AHE) helps leverage resources and align priorities across sectors.
- The Alliance for Health Equity analysis also identified **key strengths within the PSA**, including strong schools, a safe and clean environment, cultural diversity, accessible community services, outdoor spaces, and active community involvement and support.
- **Community Health Initiatives:** In the PSA, there are many active efforts around chronic disease prevention, maternal and child health, food security, violence prevention, and behavioral health support.
- **Turning Point Behavioral Health** offers crisis support and education outreach, free of charge, through their Mobile Living Room program.
- **JumpStart** is a workforce development program embedded within district 207 Maine East High School in Park Ridge designed to support students with employment opportunities post-graduation.
- **Hospital leadership is strongly involved** in local boards, local chamber of commerce organizations and civic organizations in the PSA.
- The Advocate Lutheran General PSA is home to a large senior population, and the hospital offers an **Older Adult Services program** to support community needs. In addition, there are a wide range of senior services in the area to support our elderly population.

Identified Significant Needs

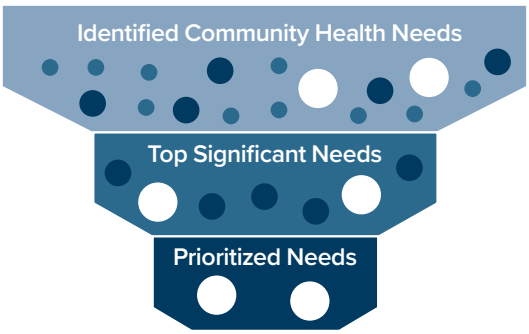
Even with progress and support in the community, challenges remain. While local programs and services have helped improve health, there are still gaps in care and unmet needs. This section looks at the biggest health concerns found in this assessment and areas where more support is needed to help the community stay healthy.

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.



Areas of Opportunity Found Through the Assessment	
Cancer	• Cancer incidence rates • Mammography screenings • Oncologist access
Cardiovascular Disease	• High blood pressure • High cholesterol • Heart attack, heart failure, hypertension, stroke
Diabetes	• Diagnosed with diabetes • Diabetes-related emergencies and hospitalizations • Lower-extremity amputations
Respiratory Diseases (Asthma & (COPD)	• Current asthma • Asthma related complications • Chronic Obstructive Pulmonary Disease • Smoking and e-cigarettes (vaping) • Pneumonia and flu complications
Mental Health	• Poor self-reported mental health • Depression • Mental health related emergencies • Schizophrenia, suicide and self-injury
Substance Use	• Binge drinking • Alcohol and opioid related emergencies and hospitalizations • Drug overdose • Tobacco use
Obesity	• Obesity rates • Adult and childhood obesity • No exercise
Food Insecurity & Access to Healthy Food	• Food insecurity • Poverty and SNAP • Food deserts
Access to Health Care	• Uninsured rates • Young invincibles • Preventable emergencies • Medicare coverage
Transportation & Housing	• Homeownership challenges • No vehicle available • Medical transportation

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

Cancer

SIGNIFICANT NEED

Why is this important? Cancer is a leading cause of death, and addressing it through prevention, early detection, and equitable treatment is critical. Reducing risk factors, such as smoking and unhealthy diets, can help lower incidence. Access to timely screening and care improves outcomes and quality of life for patients.

Significant Need Reasoning

In the Alliance for Health Equity (AHE) survey assessment, 10% of community input survey respondents selected cancer as one of the top three health issues in their community, making it the 11th ranked health need overall. Respondents rated several cancer-related contributing health factors as top priorities, including clean air, safe water, easy access to public transportation, parks and recreational spaces, and the ability to access physical healthcare services within a reasonable amount of time.

Key Findings

- Cook County's colorectal cancer rate is 46.1 cases per 100,000 residents, slightly higher than the PSA's 44.5 cases. Adults 65 and older face much higher rates (163.1 cases per 100,000). The highest rate for PSA diagnoses are in late-stage (27.9 cases per 100,000), followed by regional (18.8), localized (14.5) and distant (9.1) stages.
- The PSA's prostate cancer diagnosis rate is 145.3 cases per 100,000 residents, with most detected early at a localized stage (102.7 cases), indicating strong early detection efforts. The cervical cancer rate for females in the PSA is 7.82 cases per 100,000 residents.
- The PSA's lung cancer diagnosis rate is 54.7 cases per 100,000 residents, slightly lower than Cook (63.1) and Illinois (73.8). Among these, late-stage diagnoses make up 37.3 cases per 100,000, with distant (24.5), regional (12.8), and localized (15.2) following. Adults 65+ have significantly higher rates (255.4 cases per 100,000).

Contributing Factors

- Illinois faces a moderately higher cancer incidence than the national average, influenced by factors such as population density, environmental exposures, and healthcare access disparities.
- Cook County shows slightly lower invasive cancer rates, but PSA positivity remains a concern, reflecting variations in screening practices and community health engagement.
- Prostate cancer is the most diagnosed invasive cancer among men, with significant racial disparities driven by systemic inequities, biological factors, and differences in healthcare utilization.
- Ongoing efforts in surveillance, prevention, and screening are essential to address these disparities and reduce the overall cancer burden across Illinois communities.

> We used to have a lot of free health clinics and preventative screening things that would happen a lot, and they would occur, maybe, twice a month. But after COVID, they just never came back. It was free breast cancer screenings, and then there was also free vaccines too.
> -Focus Group Participant

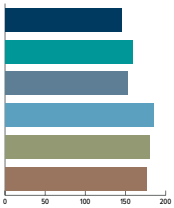
Cancer *continued*

SIGNIFICANT NEED

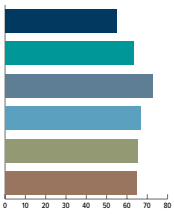
HIGHLIGHTED DISPARITIES

General Cancer Prevalence
PSA: 8.2%
Cook County: 5.9%
IL: 6.6%

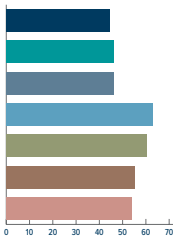
Prostate Cancer* (males)
PSA: 145.33
Cook County: 158.44
IL: 155.36
60067 Palatine: 185.2
60026 Glenview: 180.1
60047 Long Grove: 176.2



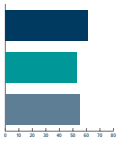
Lung Cancer*
PSA 54.72
Cook County: 63.10
IL: 73.84
60631 Edison Park/Norwood Park: 66.8
60707 Elmwood Park: 65.1
60018 Des Plaines: 64.9



Colorectal Cancer*
PSA: 44.5
Cook County: 46.2
IL: 46.4
60631 Edison Park/Norwood Park: 62.8
60656 Oriole Park: 60.3
60634 Irving Park/Dunning: 55.1
60706 Norridge/ Harwood Heights: 53.8
(Source: Metopio, PLACES, BRFSS, 2022)



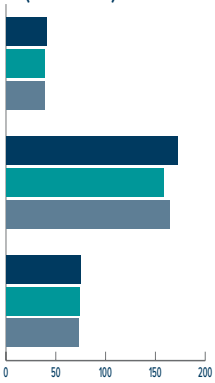
Colorectal Cancer Screening
PSA: 60.92%
Cook County: 52.70%
IL: 55.37%



Non-Invasive Breast Cancer* (females)
PSA: 40.3
Cook County: 38.7
IL: 38.3

Invasive Breast Cancer*
LGH PSA: 172.2
Cook County: 157.8
IL: 164.7

Mammography Screening
PSA: 74.5%
Cook County: 73.85%
IL: 72.7%



Cervical Cancer* (females)
PSA: 7.82
Cook County: 7.76
IL: 7.52
60641 Irving Park Portage Park: 12.7
60630 Jefferson Park: 12.0
60707 Elmwood Park: 9.8
(Source: Metopio, ISCR, 2018–2023)

**Diagnoses/Rates per 100,000 residents*

Cardiovascular Disease

SIGNIFICANT NEED

Why is this important? Heart disease and stroke are major causes of illness and death, making prevention and management essential. Lifestyle changes, like healthy eating, regular exercise, and avoiding tobacco, can significantly reduce risk. Early diagnosis and proper treatment help prevent complications and improve longevity.

Significant Need Reasoning

In the Alliance for Health Equity (AHE) survey assessment, heart disease was mentioned by focus group participants in conjunction with hypertension (high blood pressure) and diabetes, highlighting the interconnectedness of these chronic conditions. They were reported as widespread conditions among adults, often linked to stress, poor diet, and lack of exercise. Limited access to routine checkups and blood pressure management tools were cited as exacerbating issues.

Key Findings

- Heart disease is the leading cause of death in men, women and people of most racial and ethnic groups. To put the severity of this condition into perspective, one person dies every 34 seconds from heart disease; roughly 919,032 people died in 2023 due to heart disease (Source: National Center for Health Statistics, CDC WONDER, 2018-2023).
- Heart failure patterns closely mirror broader heart health disparities. The PSA emergency department (ED) rate is 44.6 visits per 100,000 residents, lower compared to Cook County (87.3) but both are much lower than Illinois (110.6). Communities with higher ED visits also experience higher hospitalization rates - an indicators of delayed or insufficient access to primary care.
- Hypertension contributes heavily to hospital and ED utilization. The overall PSA ED visit rate is 245.8 per 100,000, but Non-Hispanic Black residents are disproportionately impacted, with a rate much higher (589.0). Other groups - including White, Asian, and Hispanic/Latino - report rates under 240.

Contributing Factors

- Heart attack hospitalizations are lower overall in the PSA region, but communities like Irving Park/Dunning, Skokie, Elmwood Park, and Des Plaines show higher rates, which may be influenced by local disparities in access to care and neighborhood stressors.
- Non-Hispanic Black and Hispanic/Latino residents face higher heart failure emergency visit rates, driven by systemic inequities in healthcare access, economic instability, and chronic stress. Older adults (65+) carry the greatest burden, highlighting age disparities.
- Elmwood Park, Norridge/Harwood Heights, and Des Plaines lead in heart failure emergency visits, while hospitalizations peak in Irving Park/Dunning and Elmwood Park—reflecting gaps in outpatient care and social support systems.

Advocate Lutheran General Hospital is committed to meeting the unique needs of diverse communities. Through programs like Community Cardiovascular Care, we offer personalized, culturally tailored services, especially for South Asian patients, led by expert physicians and supported by outreach, education, and research.

Cardiovascular Disease *continued*

SIGNIFICANT NEED

HIGHLIGHTED DISPARITIES

Heart Attack Hospitalizations*
PSA: 163.3
Cook County: 159.8
Illinois: 219.1
60634 Irving Park/Dunning: 219.1
60631 Edison Park/Norwood Park: 205.2
60707 Elmwood Park: 198.6
60077 Skokie: 188.7

Heart Failure ED Visits*
PSA: 44.6
Non-Hispanic Black: 181.2
Adults 65+ 161.6
60707 Elmwood Park: 72.8
60706 Norridge/Harwood Heights: 66.4
60018 Des Plaines: 62.0

Heart Failure Hospitalizations*
PSA: 359.8
Non-Hispanic Black: 672.3
Adults 65+ 1,384.5
60634 Irving Park/Dunning: 513.6
60706 Norridge/Harwood Heights: 513.3
60707 Elmwood Park: 502.5

Hypertension (percent of adults with high blood pressure, 2022)
PSA: 28.9%
60714 Niles: 33.5%
60706 Norridge/Harwood Heights: 31.8%
60077 Skokie: 31.6%
60026 Glenview: 31.4%

Hypertension Hospitalizations*
PSA: 33.8
Non-Hispanic Black: 101.6
Adults 65+ 98.6
60018 Des Plaines: 48.7
60706 Norridge/Harwood Heights: 47.0
60090 Wheeling: 44.5
60707 Elmwood Park: 44.2

Stroke

Stroke ED Visits*
- PSA: 26.5
- Cook County: 49.0
- Illinois: 70.0

Stroke Hospitalizations*
- PSA: 216.9
- Cook County: 238.4
- Illinois: 209.5

Non-Hispanic Black: 328.5
Non-Hispanic White: 247.2
65+ : 738.1
**Stroke risk increases significantly with age*

Diagnosed Stroke by Zip Code (2022)
PSA: 3.0%
60714 Niles: 3.7%
60706 Norridge/Harwood Heights: 3.6%
60077 Skokie: 3.5%
60707 Elmwood Park: 3.4%

**Rates per 100,000 residents*

Diabetes

SIGNIFICANT NEED

Why is this important? 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, 23.1% of survey respondents (n=143) from the PSA recognized diabetes as the third top health concern.

Participants linked diabetes to unhealthy diets high in sugar and processed foods. Many expressed concerns about limited awareness of the importance of diet and exercise in managing the condition.

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.
- When looking at racial and ethnic differences in the U.S., Hispanics report diabetes prevalence at 15.5%, Asian or Pacific Islander at 16.7% and Non- Hispanic White populations at 13.6%. Non-Hispanic Black residents report the highest rate with 17.4%. In Illinois, about 14.7% of adults have been diagnosed with diabetes. (Source: CDC, National Diabetes Report, 2021)
- Within the PSA, 10.8% of residents aged 18 and older have been diagnosed with diabetes. Several communities carry a disproportionate burden.

Contributing Factors

- Limited access to healthcare and insurance leads to delayed diagnoses and poor management of diabetes, increasing the risk of complications like kidney failure, amputations, and cardiovascular disease.
- 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.

> When I first got diagnosed, I barely wanted to sit. It was no way I'm going to check my sugar by taking [it] myself and then take the insulin, and then you got to do it like two, three times a day. So I wasn't taking care of it in the beginning, and I wasn't educated on it. But because of Beyond Hunger, you know I learned a lot about diabetes, how to control it, and how much you should eat, how much you shouldn't eat, what you should or shouldn't eat.
>
> — Beyond Hunger participant

Diabetes *continued*

SIGNIFICANT NEED

HIGHLIGHTED DISPARITIES

	Diagnosed Diabetes	Diabetes ED Visits*	Diabetes Hospitalizations*	Uncontrolled Diabetes ED Visits*	Uncontrolled Diabetes Hospitalizations*	Amputation with Diabetes Hospitalizations*
PSA	10.8%	97	127.1	90.2	29.5	37.6
Cook County	10.8%	231.8	203.9	172.4	48.7	53.7
Illinois	10.4%	223.2	179.0	184.1	39.5	49.8
Skokie (60077)	12.4%					
Niles (60714)	12.4%					
Des Plaines (60018)	12.2%	135.3	205.2	139.6	58.3	67.2
Elmwood Park (60707)	12.1%	179.4	203.4	158.4	47.6	53.9
Morton Grove (60053)	11.9%					
Irving Park/Portage (60641)		162.0	193.4	138.9		54.7
Irving Park/Portage Park (60634)						67.1
Wheeling (60090)					41.3	
Oriole Park (60656)						59.7
NH Black		340.2	333.0	361.9		
NH White			131.6			
Hispanic/Latino				118.7	33.1	47.7
Men		109.7	162.9		33.6	
Women		84.7	92.6			
Age 65+		201.7			81.0	

**Rates per 100,00 residents*

Respiratory Diseases

SIGNIFICANT NEED

Why is this important? Respiratory diseases impact daily life and increase hospitalizations, highlighting the need for prevention, education, and treatment. Environmental factors, such as air quality, play a significant role in disease severity. Proper medication use and management strategies can reduce symptoms and improve quality of life.

Significant Need Reasoning

In the Alliance for Health Equity (AHE) survey assessment, 3% of community input survey respondents rated lung disease as a top health issue in their community. Respiratory-related needs such as clean air, parks and recreational spaces, and access to quality pediatric care were also selected as top community health needs. Eighteen percent of respondents disagreed or strongly disagreed with the statement "my community has clean air and water."

Asthma was described as a significant health concern, particularly for children. Asthma was linked to environmental factors such as neighborhood air quality and housing conditions. Participants shared that asthma-related emergencies often required multiple hospital visits.

Key Findings

- In the U.S., over 28 million people have asthma, equivalent to 1 in 12 people. Of that total, 23 million U.S. adults have asthma. Asthma is more prevalent among Black adults in the U.S and more common in female adults (11%) when compared to male adults (6.8%). Asthma not only affects adults, it is also the leading chronic disease in children, with 4.9 million children (18 and under) having asthma. (Source: AAFA, 2025)
- Similarly to ED rates, the hospitalizations rate for COPD in the PSA (150.3 hospitalizations) are much lower than Cook County (269.0 hospitalizations) and Illinois (252.8 hospitalizations). We continue to observe greater disparities among the Non-Hispanic Black (304.7 hospitalizations) population versus the Non-Hispanic White (169.3 Hospitalizations), Asian (82.6 hospitalizations) and Hispanic or Latino (108.6 hospitalizations) population.

Contributing Factors

- The PSA experiences many asthma-related ED visits. Non-Hispanic Black residents in the PSA have the highest ED visit rate, reflecting a disparity in asthma outcomes. Potential contributing factors may include barriers to accessing inhalers and medications.
- Elmwood Park, Irving Park/Portage Park, and Irving Park/Dunning report the highest asthma ED visit rates within the PSA, indicating localized areas with significant asthma burdens. These are very busy urban communities with many environmental triggers.
- Hospitalizations for asthma rates for the PSA are lower compared to Cook County and Illinois. Age disparities exist, with younger children (0-4 years) typically showing higher hospitalization rates, emphasizing the vulnerability of this group.
- These points highlight important geographic and demographic disparities in asthma outcomes within Cook County and Illinois, signaling areas and populations for targeted public health interventions.

> Asthma was a huge thing in my family, in NW Indiana, fumes up into south subs, east side. Everyone is affected.
>
> – North River Commission focus group participant

Respiratory Diseases *continued*

SIGNIFICANT NEED

HIGHLIGHTED DISPARITIES

	Current Asthma*	Asthma ED Visits*	Asthma Hospitalizations*	Chronic Obstructive Pulmonary Disease COPD*	COPD ED Visits*	COPD Hospitalizations*
PSA	8.6	144.3	31.7	5.3	151.8	150.3
Cook County	9.2	299.1	52.2	4.9	380.4	269.0
Illinois	8.9	243.9	38.1	5.1	450.9	252.8
Arlington Heights (60005)			46.3			200.6
Des Plaines (60018)				6.2		
Palatine (60074)	9.2	180.0				216.7
Skokie (60076)			42.8		229.0	
Skokie (60077)		172.1			207.8	
Irving Park/Dunning (60634)	9.1	232.4	45.0			
Irving Park/Portage Park (60641)	9.0	259.4	55.0		325.4	252.3
Norridge/Harwood Heights (60706)	9.3			6.9		
Elmwood Park (60707)	9.2	277.0			283.0	218.5
Niles (60714)				6.4		
NH Black		869.9	111.7		544.4	304.7
NH White						169.3
Hispanic					148.3	
Women					166.7	
0-4 years			118.6			
5-17 years			43.2			
40-60						68.2
65 and older			43.6		210.3	304.2

Mental Health

SIGNIFICANT NEED

Why is this important? Mental health affects overall well-being, relationships, and productivity, and access to care and support is vital. Early intervention and treatment can prevent worsening symptoms and improve daily functioning. Reducing stigma and increasing awareness helps communities provide better support for those affected.

Significant Need Reasoning

In the Alliance for Health Equity (AHE) survey assessment, 25.2% of the 143 survey respondents from the PSA recognized adult mental health as the number two health concern. Additionally, of the 139 survey respondents that answered, 29.5% highlighted that more access to mental healthcare services was needed for their community to be healthy.

Key Findings

- The percent of adults that self-reported poor mental health in 2022 for LGH PSA was 13.6%. The highest rates of self-reported poor mental health are in Palatine (15.8%), Irving Park/ Portage (15.8%), 60018 Des Plaines (15.4%) and Dunning (15.4%). The rate in PSA is lower than in Cook County (15.3) and Illinois (16.1)
- While the PSA's mental health ED visit rate is below county and state levels, young adults (18–39) and Non-Hispanic Black residents have the highest rates, often several times greater than other groups. Skokie, Palatine and Elmwood Park face the greatest burden.
- Non-Hispanic Black residents and young adults have the highest mental health hospitalization rates in the PSA, with children's rates higher than county averages. Arlington Heights, Palatine, and Wheeling reported rates well above the PSA average, while Long Grove and Oriole Park have the lowest.
- Youth aged 5–17 and Non-Hispanic Black residents face the highest suicide and self-injury ED visit rates, with females consistently higher than males. Palatine, Prospect Heights and Wheeling show elevated rates for both suicide and self-injury ED visits.

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 LGH PSA is very diverse and serves a large elderly population which requires more attention to environmental trends, social isolation and culturally competent care.
- Every community experiences relationship factors such as the lack of supportive relationships, experiences of bullying, domestic violence, or the loss of loved ones, which can lead to isolation and emotional distress, especially when coping mechanisms are limited.
- Community factors such as living in environments with limited access to mental health care, exposure to violence, or discrimination can compound stress and reduce opportunities for healing and support. There are pockets across the PSA where community factors are more vivid, such as in areas where there are more apartment complexes, crowded housing and poor income is more prevalent.
- 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.

> I've seen a lot of increasing violence. It is a lot of substance abuse and mental health.
>
> Mental health and homelessness are a huge problem
>
> I feel like it's really essential to have something to do with mental health support.
>
> – AHE Focus Group Participants

Mental Health *continued*

SIGNIFICANT NEED

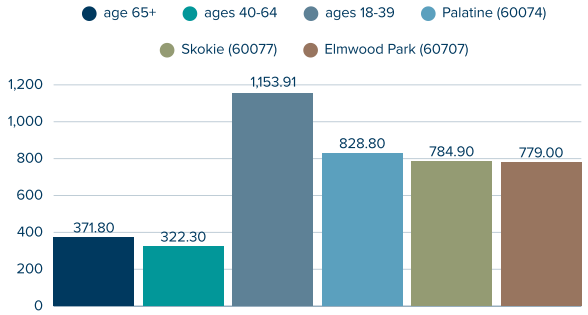
HIGHLIGHTED DISPARITIES

Rates of self-reported poor mental health (% of adult residents)

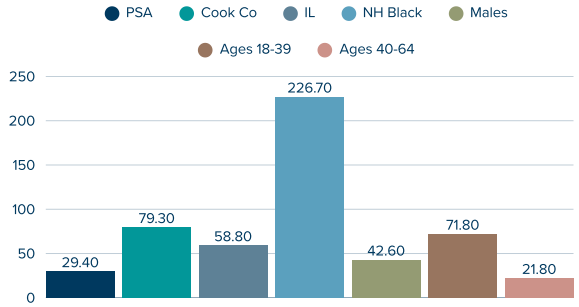
- **PSA: 13.6%**
- **All 28 communities in the PSA reported a rate above 10.6%**
- **Highest: Palatine (60074): 15.8%**

Mental Health ED Visits*

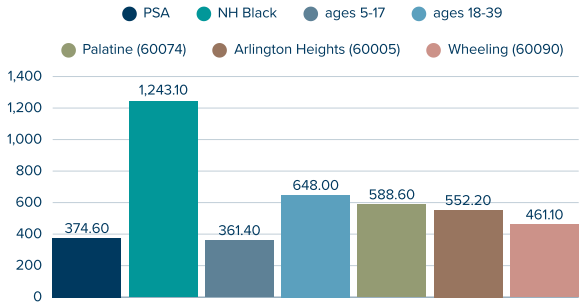
- **Lowest rates are in Glenview (60025) and Deerfield (60015)**



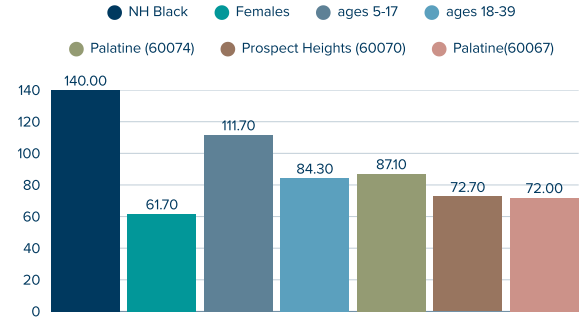
Schizophrenia ED Visits*



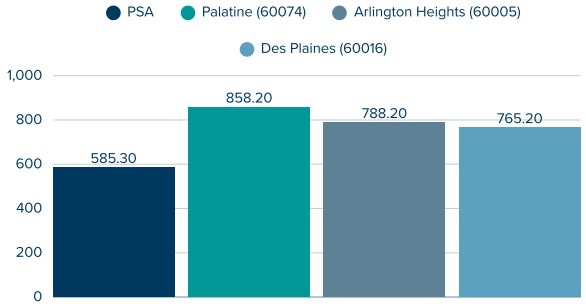
Mental Health Hospitalizations*



Suicide and Self-Injury ED Visits*



Behavioral Health Hospitalizations*



(per 100,000 residents)

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, of the 143 survey participants from the LGH PSA, 14.7% said that substance use was a major health issue in their community; it ranked as the number six biggest health issue.

Key Findings

- In the PSA, we recognize High Binge Drinking rates in certain communities. Irving Park/Portage Park, Oriole Park, Edison Park/Norwood Park, exceed 20 percent binge drinking; Irving Park/Dunning, Norridge/Harwood Heights, Elmwood Park reports alcohol-related ED visits over 500 ED visits per 100,000.
- Alcohol and Opioid disproportionately affect Black residents and young adults. Non-Hispanic Black residents and adults 18–39 and 40-46 years old have the highest ED visit rates for both alcohol and opioids.
- While Opioid impacts all communities in our PSA, we noticed higher rates in key areas. Irving Park/Portage Park, Elmwood Park, Norridge/Harwood Heights show the highest opioid-related ED visits and hospitalizations in the PSA.
- Non-Hispanic Black (1,419.9) have the highest substance use ED rates, followed by White (588), and Hispanics (551.6).

Contributing Factors

- Specific neighborhoods like Irving Park, Portage Park, and Edison Park/Norwood Park show binge drinking rates exceeding 21%, indicating localized patterns of high-risk alcohol use that may be influenced by social norms, access to alcohol, or lack of prevention resources.
- Communities such as Irving Park/Dunning report alcohol-related ED visit rates that surpass county and state averages, suggesting acute health impacts and a strain on emergency services due to excessive alcohol consumption.
- Non-Hispanic Black 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.

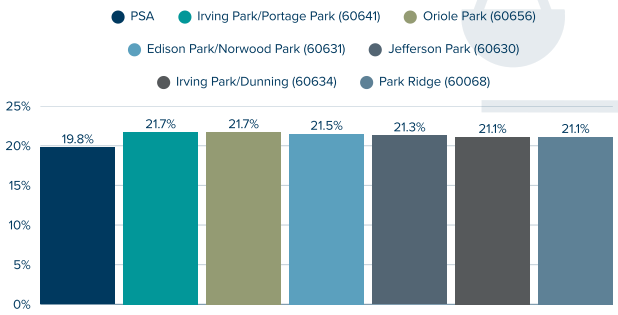
> For my school specifically, substance abuse is a big thing because once in a while, almost like every week, someone from school or someone gets arrested for gun violence or drug use.
>
> – AHE Focus Group Participant
>
> I've seen a lot of increasing violence. It is a lot of substance abuse and mental health.
>
> – AHE Focus Group Participant

Substance Use *continued*

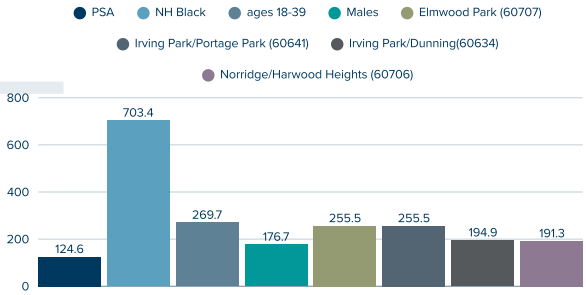
SIGNIFICANT NEED

HIGHLIGHTED DISPARITIES

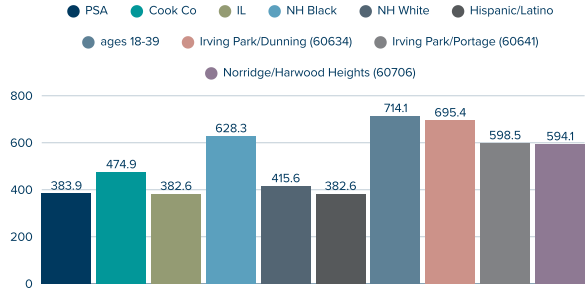
Binge Drinking Rates (% of adults):



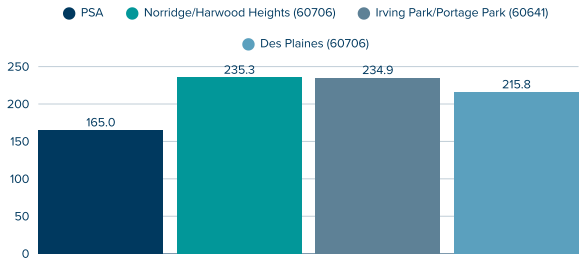
Opioid-Related ED Visits*



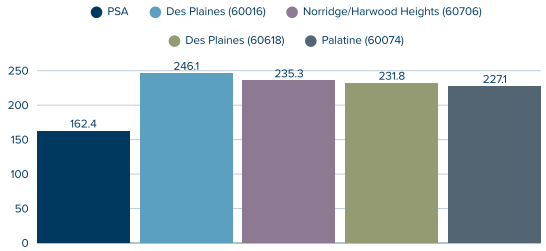
Alcohol-Related ED Visits*



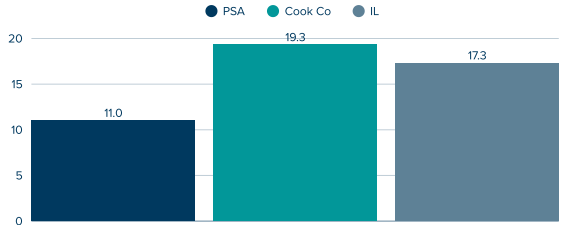
Opioid-Related Hospitalizations*



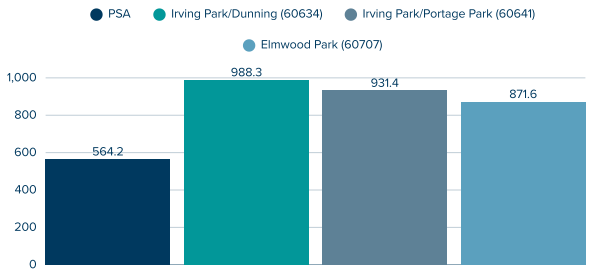
Alcohol-Related Hospitalizations*



Opioid treatment provider access

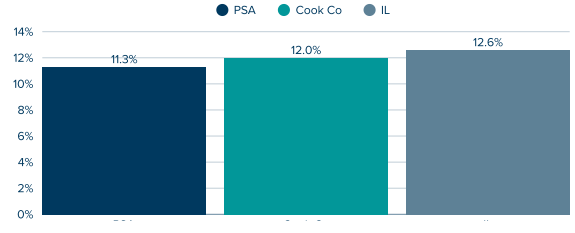


Substance Use ED Visits*



Cigarette Smoking Rates

LG smokers



**(per 100,000 residents)*

Food Insecurity and Access to Healthy Foods

SIGNIFICANT NEED

Why is this important? Lack of reliable access to nutritious food affects health and development, underscoring the need for community support and resources. Food insecurity is linked to poor physical and mental health outcomes. Programs that increase access to healthy foods can improve overall well-being and reduce disparities.

Significant Need Reasoning

In the Alliance for Health Equity (AHE) survey assessment, many communities in Cook County lack affordable access to healthy food. Focus group participants highlighted the prevalence of food deserts, stating that families often rely on processed, low-cost foods that contribute to health issues like obesity and malnutrition. Five percent of community input survey respondents identified hunger as a top health issue in their community. In addition, 19% of respondents said improving community health would require improved food resources.

Key Findings

- While the PSA food insecurity rate (10.4%) is lower than Cook County (12.1%) and Illinois (12%), five communities have a higher percentage than the overall county.
- Irving Park/Portage Park (14.0%), Palatine (12.8%), and Skokie (12.6%) have the highest food insecurity rates in the PSA.
- Some communities, such as Skokie and Irving Park/Portage Park, have high food insecurity but fewer households receive SNAP benefits, suggesting many families struggle financially without assistance.
- Palatine, Des Plaines and Long Grove have the largest populations living in food deserts, highlighting limited access to nutritious and affordable food. In these areas, transportation may be a barrier for families that do not own a car.

Contributing Factors

- Food insecurity is an ongoing problem that is becoming more widespread across many parts of the country; for some regions, the issue is more prevalent.
- Communities of color and single-parent households face higher risks of struggling to get adequate food compared to others, showing clear disparities.
- Certain local areas experience higher rates of food insecurity and have limited access to affordable, healthy food options, often referred to as “food deserts.”
- Despite efforts to assist vulnerable populations, many people experiencing food insecurity do not qualify for federal aid, showing gaps in the current support systems.

> I live in Austin...I want to be healthier...but we don’t have access to it, and then all we have on our blocks is, like, gas stations and chips.
>
> – AHE Focus Group Participant

Food Insecurity and Access to Healthy Foods
continued

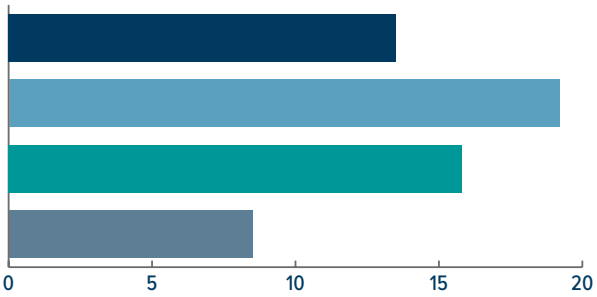
SIGNIFICANT NEED

HIGHLIGHTED DISPARITIES

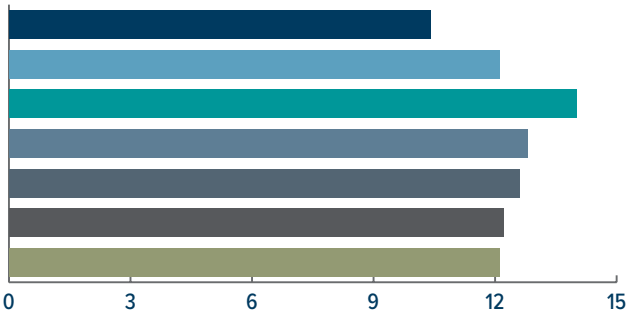
Food Insecurity in the U.S.

- » **National (2023): 13.5%**
- » **Black households: 22.4%**
- » **Hispanic households: 22.7%**
- » **White households: 10.4%**

(Source: USDA ERS, 2022–23)

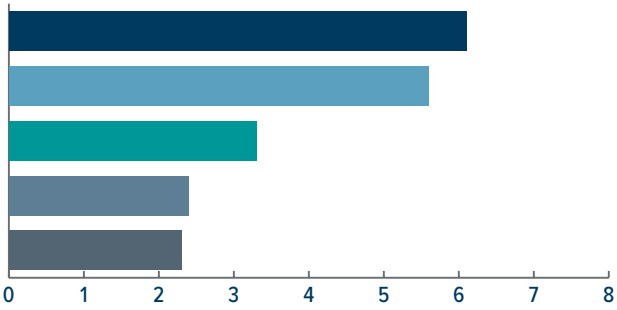


- **Food Insecurity** (% of residents)
  - » **PSA: 10.4%**
  - » **Cook: 12.1%**
  - » **Irving Park/Portage Park (60041): 14.0%**
  - » **Palatine (60074): 12.8%%**
  - » **Skokie (60077): 12.6%**
  - » **Niles (60714): 12.2%**
  - » **Elmwood Park (60707): 12.1%**



- **Food Deserts in the PSA, 2019**
  - » **Des Plaines (60018): 6.1%**
  - » **Palatine (60067): 5.6%**
  - » **Long Grove (60047): 3.3%**
  - » **Wheeling (60090): 2.4%**
  - » **Northbrook (60062): 2.3%**

(Source: Metopio, Food Access Research Atlas, 2019)



Obesity

SIGNIFICANT NEED

Why is this important? Lack of reliable access to nutritious food affects health and development, underscoring the need for community support and resources. Food insecurity is linked to poor physical and mental health outcomes. Programs that increase access to healthy foods can improve overall well-being and reduce disparities.

Significant Need Reasoning

Community input survey respondents highlighted that many communities in Cook County lack affordable access to healthy food and the prevalence of food deserts. Families often rely on processed, low-cost foods, contributing to health issues like obesity and malnutrition. Reduction in programs like SNAP benefits and other financial assistance were described as exacerbating economic hardships

Key Findings

- Across the U.S., adult obesity affects 41.9 percent of the population and youth obesity affects nearly 1 in 5 children. Black (49.9 percent) and Hispanic (45.6 percent) adults experience the highest rates, while Asian adults report the lowest. Among youth, American Indian/Alaska Native (29.6 percent) and Black children (25.2 percent) are most impacted, underscoring persistent racial and ethnic disparities.
- In Cook County, 17.1 percent of adults reported no physical activity in the past month, with women (18.8 percent) more sedentary than men (15.3 percent).
- Obesity rates are highest in 60641 Irving Park/Portage Park (34.0 percent) and 60707 Elmwood Park (33.8 percent), where more than one-quarter of residents also report not exercising. Other communities such as 60634 Irving Park/Dunning (32.8), 60074 Palatine (31.5 percent) and 60018 Palatine (31.5 percent) also face high obesity prevalence. Meanwhile, 60005 Arlington Heights (27.9 percent) and 60016 Des Plaines (27.9 percent) report the lowest rates. These disparities suggest targeted prevention and lifestyle support efforts are most needed in Irving Park/Portage Park and Elmwood Park and similar high-burden areas.

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.
- Efforts to address obesity focus on improving access to healthy food, encouraging exercise, and tackling the underlying social determinants that disproportionately impact certain populations.

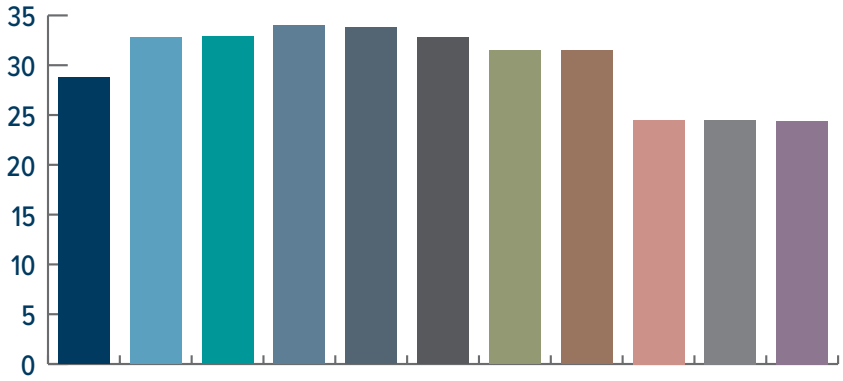
> I live in Austin...I want to be healthier...but we don't have access to it, and then all we have on our blocks is, like, gas stations and chips.
>
> – AHE Focus Group Participant

Obesity *continued*

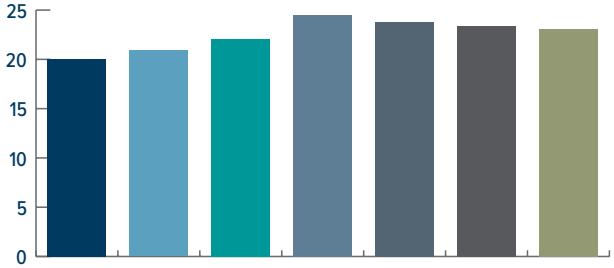
SIGNIFICANT NEED

HIGHLIGHTED DISPARITIES

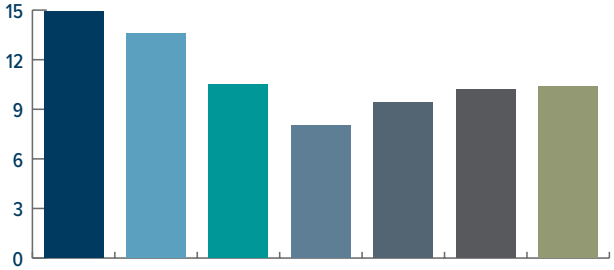
- **Obesity Rates** (% of adult residents)
  - » **PSA: 28.8%**
  - » **Cook County: 32.8%**
  - » **Illinois: 32.9%**
  - » **Irving Park/Portage (60641): 34.0%**
  - » **Elmood Park, IL (60707): 33.8%**
  - » **Irving Park/Dunning (60634): 32.8%**
  - » **Palatine (60074): 31.5%**
  - » **Des Plaines (60018): 31.5%**
  - » **Northbrook (60062): 24.5%**
  - » **Glenview (60026): 24.5%**
  - » **Morton Grove (60053): 24.4%**



- **No Exercise** (% of adult residents)
  - » **PSA: 19.5%**
  - » **Cook County: 20.9%**
  - » **Illinois: 22.1%**
  - » **Des Plaines (60018): 24.5%**
  - » **Irving Park/Portage (60641): 23.8%**
  - » **Elmwood Park (60707): 23.4%**
  - » **Irving Park/Dunning (60634): 23.1%**



- **Walkability Index** (range up to 20-highest)
  - » **PSA: 13.3**
  - » **Cook County: 13.6**
  - » **Illinois: 10.5**
  - » **Long Grove (60047): 8.0**
  - » **Palatine (60067): 9.4**
  - » **Palatine (60074): 10.2**
  - » **Arlington Heights (60004): 10.4**



Access to Care

SIGNIFICANT NEED

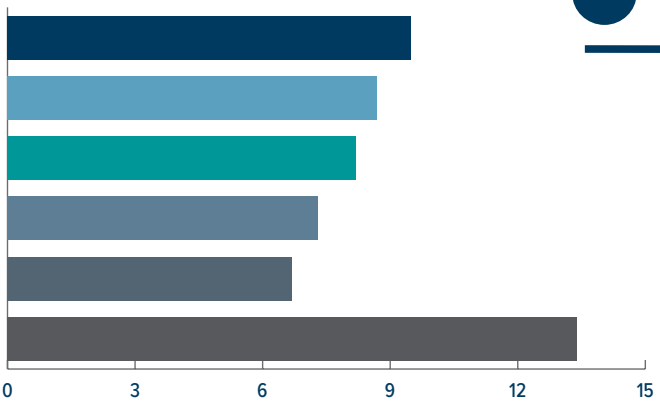
Why is this important? Sometimes people do not get health care services recommended, like cancer screenings, because they do not have a primary care provider. Other times, it is because they live too far from health care providers who offer them. Interventions to increase access to health care professionals and improve communication – in person or remotely – can help more people get the care they need.

Significant Need Reasoning

In the Alliance for Health Equity (AHE) survey assessment, difficulty accessing quality healthcare was frequently cited by both survey respondents and focus group participants as a barrier to health. Easy access to quality mental healthcare and physical healthcare were both selected as top health needs by survey respondents, ranking second and eighth respectively. When asked their agreement with the statement "I am satisfied with the quality of healthcare in my community", a quarter of survey respondents selected "disagree" or "strongly disagree".

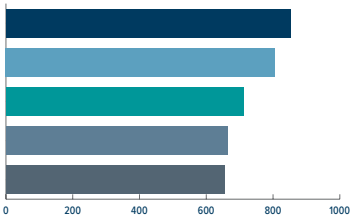
HIGHLIGHTED DISPARITIES

- **Uninsured Rates** (% of adult residents)
  - » **PSA: 7.8%**
    Of these, an estimated 38,039 are uninsured non-citizens
  - » **Cook County: 8.9%**
  - » **Prospect Heights (60070): 18.5%**
  - » **Des Plaines (60018): 15.4%**
  - » **Palatine (60074): 15.0%**
  - » **Wheeling (60090): 13.6%**
  - » **Irving Park/Portage Park (60641): 13.4%**
  - » **Deerfield 2.3%**
  - » **Ages 19–39: 12.8%**
  - » **Hispanic or Latino: 13.2%**
  - » **Males: 8.5%**
  - » **Females: 7.1%**
  - » *Communities with higher insurance rates also report more frequent routine checkups with doctors*



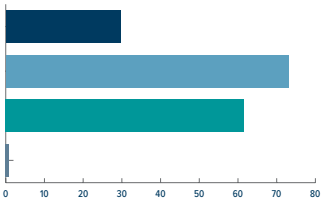
- **Preventable chronic ED Visits***
  - » **Elmwood Park (60707): 851.8**
  - » **Irving Park/Portage Park (60641): 805.8**
  - » **Irving Park/Dunning (60634): 710.9**
  - » **Skokie (60076): 664.4**
  - » **Skokie (60077): 655.6**

(Metopio, PLACES, BRFSS, 2022).



- **Types of coverage rates in the PSA**
  - » **29.6% of residents are covered by public insurance (Medicare 17.8%, Medicaid 13.7%)**
  - » **73.0 % have private health insurance.**
  - » **61.5% have employer-based coverage.**
  - » **0.88% are covered by VA Health Care**

(Metopio, ACS, 2019–2023)



> We used to have a lot of free health clinics and preventative screening things that would happen a lot, and they would occur, maybe, twice a month. But after COVID, they just never came back. It was free breast cancer screenings, and then there was also free vaccines too.
> – AHE Focus Group Participant

> 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.
> – AHE Focus Group Participant

(Rates per 100,000 residents)

Access to Care *continued*

SIGNIFICANT NEED

Key Findings

- Thousands of residents in the PSA lack adequate health insurance, creating significant barriers to accessing appropriate health care.
- Communities facing greater socioeconomic hardships such as higher unemployment, lower education levels, lower per capita income, crowded housing, and higher poverty—also experience reduced access to health coverage and quality health services. This contributes to preventable emergency department visits and hospitalizations.
- 10 percent of adults in the Lutheran General PSA are uninsured. Among racial and ethnic groups, Hispanic/Latino and Native American adults have the lowest insurance coverage
- Most residents (73%) have private health insurance, primarily through employers (61.5%), while nearly 30% rely on public programs like Medicare and Medicaid. A small portion (0.88%) is covered by VA Health Care, highlighting the need for inclusive health strategies that support both privately and publicly insured populations.

Contributing Factors

- A significant portion of adults in the population remain uninsured, often due to factors like eligibility gaps, affordability issues, or lack of awareness of coverage options.
- Uninsured adults tend to be younger and disproportionately belong to lower-income households, reflecting socioeconomic barriers to obtaining health insurance.
- Demographic disparities exist, with higher uninsured rates observed among racial and ethnic minorities, highlighting systemic challenges in access to healthcare coverage.
- The lack of insurance coverage among adults can lead to delayed or foregone medical care and financial hardship from medical costs, underscoring the importance of policy efforts aimed at expanding coverage and outreach.

Health Care Resources in the Defined Community

Name of Facility	Type of Facility	Location
Advocate Children's in PR	Hospital	Park Ridge
Endeavor Health Northwest Community Hospital	Hospital	Arlington Heights
Endeavor Health Evanston Hospital	Hospital	Evanston
Endeavor Health Glenbrook Hospital	Hospital	Glenview
Endeavor Health Skokie Hospital	Hospital	Skokie
Community First Medical Center	Hospital	Belmont Cragin
Ascension Alexian Brothers	Hospital	Elk Grove Village
PCC Salud Family Health Center	Federally Qualified Health Center	Belmont Cragin
Greater Family Health	Federally Qualified Health Center	Franklin Park / Des Plaines / Wheeling / Palatine /
ACCESS Genesis Cener for Health and Empowerment	Federally Qualified Health Center	Des Plaines
Prime Care Health	Federally Qualified Health Center	Belmont Cragin
Erie Evanston/Skokie Health Center	Federally Qualified Health Center	Evanston
Old Irving Park Community Clinic	Free Clinic	Irving Park
Village of Skokie, Health Department	Public Health Department	Skokie
Cook County Department of Public Health	Public Health Department	Cook County/Arlington Heights
Evanston Health and Human Services Department	Public Health Department	Evanston

Transportation & Housing

SIGNIFICANT NEED

Why is this important? Transportation and housing are fundamental social drivers of health. Reliable transportation ensures access to basic needs, while lack of it can lead to missed appointments, isolation, and increased stress. Similarly, safe and affordable housing provides a foundation for physical and mental health; poor housing conditions or housing insecurity can cause illnesses, injuries, and chronic stress. Together, these factors shape health outcomes and contribute to disparities across communities.

Significant Need Reasoning

- Access to public transportation and other active transportation methods is especially important for Cook County residents, as a higher percentage of households lack a vehicle compared to the national average.
- Focus group participants described how unreliable or unavailable public transit and specialized medical transport services make it difficult for residents without personal vehicles to access healthcare, and also noted that the cost of transportation can be an additional burden.
- In the Alliance for Health Equity (AHE) survey assessment, 25.1% of respondents list homelessness and housing instability as the second biggest health issue in the community, and 25.6% of respondents listed safe and affordable housing as the third leading resource the community needs to be healthy. Almost half (49%) of the survey respondents in the PSA are dissatisfied with the availability of affordable housing.

Key Findings

- In 2022, about 76,375 Chicagoans experienced homelessness, including more than 20,000 children.
  (Source: Chicago Coalition to end Homelessness, 2025)
- Percentage of Walkable neighborhoods in the PSA: 10.8%.
- Ease of access to public transportation: 5.6%.
- Chicago and Cook County have higher rates of active transportation (walking, biking, and public transportation) to work compared to the United States overall. In Cook County, 18% of residents aged 16 or older use active transportation for commuting, while in Chicago, more than 25% rely on active transportation for their work commute.

> The closest specialist is miles away, and if you don't have a car, it's almost impossible to get there.
> –AHE Focus Group Participant

> Mental health and homelessness is a huge problem.
> –AHE Focus Group Participant

Contributing Factors

- Public transportation is relied upon by many in this PSA. Lack of funding and maintenance of public transportation disrupts citizens from getting to where they need to be for their employment, education, health and much more.
- Transportation limits many from accessing preferable jobs opportunities, school districts, and health providers.
- Citizens who are low income are more likely to stay low income if they have no means of transportation or access to stable housing.

HIGHLIGHTED DISPARITIES

- Commuters taking public transportation to work (percentage of workers 16 years and older)
  - » PSA: 19.2%
  - » Cook County: 12.9%
  - » Illinois: 6.3%
- Households with no vehicle available
  - » PSA: 26.6%
  - » Cook County: 17.9%
  - » Illinois: 10.9%

The housing cost burden (households spending more than 30% of income on housing) is notably higher for Black and Hispanic or Latino populations in the PSA compared to the overall population in Cook County and Illinois.

PRIORITIZATION OF HEALTH-RELATED ISSUES

PRIORITY SETTING PROCESS

Advocate Lutheran General's Community Health Department presented data to the hospital's CHC on the top eight health needs in the hospital's Primary Service Area (PSA). The CHC reviewed and discussed the data to ensure a clear understanding of all indicators and reports.

Top health needs were identified using several criteria:

- Whether rates increased or decreased over time
- Whether rates were higher than county and/or state averages
- Whether significant health disparities existed within the issue

Top Health Needs Presented to the Community Health Council for Voting

1. Cardiovascular Disease
2. Diabetes
3. Respiratory Disease (Asthma & COPD)
4. Mental Health
5. Substance Use
6. Obesity
7. Food Insecurity & Access to Healthy Food
8. Access to Health Care

Needs Acknowledged (Not Included in the Voting)

9. Cancer
10. Transportation & Housing

The Council engaged in discussion around the eight health needs, which led to the first prioritization phase of the CHNA. Members were asked to complete a prioritization grid (see appendices for more details), rating each health need against the following criteria:

Severity: How serious is the issue? Does it cause significant harm or disability?

Urgency: Does it require immediate attention? Is it time-sensitive?

Impact on Quality of Life: How much does it affect daily activities, mental health, or overall well-being?

Cost of Treatment/Intervention: What are the financial costs for individuals and the system?

Preventability: Can it be prevented or reduced through lifestyle changes, interventions, or screening?

Potential for Long-Term Consequences: Will it lead to lasting health problems, complications, or disabilities?

Significant Health Needs Selected

Each member received an Excel spreadsheet to score health issues on a scale 1-5 (5= highest). The sheet automatically totaled scores, with the highest indicating the greatest priority. Members had several weeks to complete scoring, review their notes, and revisit the data presented.

The Community Health Department collected and analyzed the grids to aggregate the scores. The results were presented back to the CHC, and the top three priority health needs were identified. Cancer and housing were not included in the grid because Advocate Health already dedicates significant resources to these issues. The Council recognized these system-level commitments and agreed they are already being prioritized with ongoing strategies in development.

Using these criteria, the following significant health needs were chosen as priorities to address in the 2026-2028 implementation strategy:

Mental Health

Mental health is a growing concern in Cook County, with rising rates of depression, anxiety, and stress across all age groups. Youth and young adults are particularly vulnerable, as emergency visits for self-harm and behavioral health issues have increased in recent years. Stigma and lack of awareness often delay people from seeking care until they are in crisis. Expanding access to timely, affordable, and preventive mental health services is critical to protecting long-term community well-being.

Substance Use

Substance use continues to pose serious risks in Cook County, with opioid overdoses remaining a leading public health challenge. Alcohol misuse and youth vaping are also concerning trends, impacting both immediate health and long-term outcomes. Many individuals with substance use disorders also face co-occurring mental health conditions, which increases the complexity of care needed. By focusing on prevention, treatment, and recovery support, the community can save lives and reduce the burden on families, schools, and healthcare systems.

Diabetes

Diabetes affects many Cook County residents, leading to complications such as kidney disease, vision loss, and cardiovascular issues. Type 2 diabetes is closely tied to lifestyle factors including obesity and physical inactivity, both of which remain concerns in the community. Diabetes prevention and management are critical; community resources and existing programs are already in place to support residents. The council recognized diabetes as an important need that requires continued attention.

HEALTH NEEDS NOT SELECTED

Cancer

Cancer remains a significant health issue in Cook County, with breast, lung, and prostate cancers among the most frequently diagnosed. While mortality rates have improved due to early detection and treatment advances, disparities still exist across racial and socioeconomic groups. Preventive screenings and lifestyle changes are critical to reducing cancer's impact. The council acknowledged cancer as an important concern but did not select it as a top priority given stronger community capacity and resources already in place to address it. Advocate Lutheran Hospital's Cancer Survivorship Center provides extensive support and resources and continues to support programs as part of their commitment to our community.

Cardiovascular Disease

Cardiovascular disease is a leading cause of death in Cook County and nationwide. Risk factors such as high blood pressure, high cholesterol, and poor diet contribute significantly to heart-related illnesses. Residents who lack access to regular preventive care may not be screened or treated early, increasing risk for heart attack or stroke. While still a major health challenge, the council determined that cardiovascular disease would not be a primary focus since it is already addressed through ongoing health initiatives and prevention programs and will continue to support this priority.

Respiratory Disease

Respiratory diseases such as asthma and COPD continue to impact residents, particularly children, older adults, and those exposed to poor air quality. Emergency department visits for asthma remain higher among some racial and ethnic minority groups, reflecting ongoing disparities. Preventive care, medication management, and environmental improvements can help reduce the burden of respiratory illness. The council acknowledged this as an issue but chose not to prioritize it at this time, given the relative capacity of current health programs to address respiratory needs.

Obesity

Obesity remains a public health concern in Cook County, with long-term impacts on diabetes, heart disease, and overall quality of life. Childhood obesity in particular poses risks for future health outcomes and healthcare costs. While obesity prevention is important, it is already integrated into many school- and community-based wellness programs. The council determined that while addressing obesity is critical, it did not rise to the level of being selected as a top focus area for this cycle.

Access to Health Care

Many residents face significant barriers to health care in Cook County. Challenges include lack of insurance, high costs, transportation difficulties, and a shortage of behavioral health providers. Immigrant communities, older adults, and families with low incomes are especially impacted, leading to delayed or forgone care. We also recognize that political decisions at the federal, state and local levels can significantly influence available resources and shape residents' access to health care. Improving access ensures that all residents can receive the right care at the right time, reducing health disparities and preventing costly emergencies. The council recognized this as an important need, but the hospital already addresses it in daily operations and did not prioritize it as a separate need.

Food Insecurity

Food insecurity persists for some Cook County residents, despite some areas of wealth and existing resources. Families with low income, single parents, and older adults often struggle to afford healthy foods, which directly impacts chronic disease risk. Local organizations and food pantries have been instrumental in meeting immediate needs, but long-term solutions remain necessary. The council recognized food insecurity as a pressing issue but did not select it as a top focus area, choosing instead to elevate broader access-to care strategies. Although this was not selected as a priority, Advocate Illinois Masonic's community health team will continue supporting the programs in place, such as the hospital pantry program and community.

Transportation & Housing

Affordable housing in the PSA has become scarce as the years progress and many residents face housing cost burden as well as homelessness. Additionally, many residents in the PSA rely on public transportation to get to where they need to be. Lack of access to transportation as well as lack of maintenance create issues for residents who need to arrive to work, school, doctor appointments and many more important destinations. Although these are both important issues, these are not priorities that are feasible or sustainable for the hospital to address on its own. These require federal assistance, and these issues would be better addressed through collective impact led by the government.

APPROVAL OF COMMUNITY HEALTH NEEDS ASSESSMENT

The director of community health provided an update presentation to the hospital Governing Council on August 11th, 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. On October 10, 2025, the Lutheran General Governing Council fully approved the findings of the 2025 Advocate Lutheran General CHNA Report. The Advocate Health Care Network Board approved the Advocate Lutheran General 2025 CHNA Report at the Division level on December 10, 2025.

VEHICLE FOR COMMUNITY FEEDBACK

Community Feedback

If you would like to provide feedback or have any questions, please send an email to us at: AHC-CHNAReportCmtyFeedback@aah.org

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

Priority #1: Behavioral Health:

Over the past two years, Advocate Lutheran General Hospital has advanced community behavioral health efforts through education, prevention, and collaboration. The hospital strengthened its partnership with the Turning Point in Skokie to support the Living Room program, which provides mental health services for those in crises. Support is provided through training and workshops from Turning Points Living Room staff. The Community Health team provided turning point with a grant to support in their endeavors to maintain and expand their community garden that is used for nutritious and therapeutic purposes for the participants. Advocate Lutheran General Hospital also partnered with Onward Neighborhood House's Welcoming Center for Immigrant and Refugees in the Belmont Cragin community, to increase access to behavioral health services for immigrant and under insured individuals. The partnership has increased access to individual, couple and family psychotherapy in the community.

To further build community capacity, the hospital hosted and offered multiple Mental Health First Aid training courses for health professionals in the area as well as for any professionals who encounter citizens in mental health crises. These training courses inform and educate professionals on how to handle these crises as well as what steps to take to prevent them and minimize stigma.

Priority #2: Health and Nutrition

Advocate Lutheran General Hospital has continued to advance health promotion, disease prevention, and food security initiatives through education, partnerships, and innovative programming. The Advocate Lutheran General Hospital-Based Pantry was created in December of 2020 to serve food insecure patients. Since the inception of the program, the pantry has served 270 individuals. In 2024, the pantry served a total of 167 patients with 2,505 pounds of food distributed and continues to expand into multiple departments within Advocate Lutheran General Hospital. The program has successfully expanded to into nine service lines within the hospital as well as with Skokie Health and Human Services. Advocate Lutheran General also partnered with the Frisbee Senior Center in Des Plaines to offer a five-week, Brain Health lecture series for their members. The lecture series focused on increasing brain health promotion. Health professionals such as stroke coordinators, memory care providers and older adult services presented each week a different topic relating to brain health as well as dementia/Alzheimer's care/prevention. For each week, there were around 30-35 participants.

Lastly, Advocate Lutheran General Hospital continues to partner with Skokie School District 69 to implement the Healthy Schools Produce program for families that screened positive for food insecurity. The program offers fresh produce for 50 families per event; a total of 9 food distributions were organized in 2024. The program also includes 5 healthy eating workshops and cooking demonstrations that are led by an Advocate dietitian. The program creates a family-friendly environment and enables both students and parents to work together.

Together, these efforts underscore Advocate Lutheran General's commitment to building healthier communities by addressing nutrition, chronic disease prevention, and the social determinants of health.

Exhibit 1: Prioritization Tool Instructions (Voting Methodology)

The tool below outlines the methodology used for council members to select the top health priorities.

1. Prioritization Factors

This health issue prioritization tool is intended to help assess and prioritize health concerns based on factors like severity, urgency, impact, and preventability. Below is a framework that we will use to rank and prioritize health issues based on these key criteria.

- Severity: How serious is the health issue? Does it cause significant harm or disability?
- Urgency: Does the health issue require immediate attention? Is it time-sensitive?
- Impact on Quality of Life: How much does the issue affect daily activities, mental health, or overall well-being?
- Cost of Treatment/Intervention: What are the financial costs associated with addressing the issue (both individual and system-wide)?
- Preventability: Can the health issue be prevented or mitigated through lifestyle changes, interventions, or screening?
- Potential for Long-Term Consequences: Will the issue lead to long-term health problems, complications, or disabilities?

2. Assign Weights to Each Criterion

Determine how important each criterion is relative to others. Assign a weight (e.g., 1-5) to each. Assigning a number weight to a topic or issue involves quantifying its importance, severity, or impact in a way that can be used for comparison, prioritization, or decision-making. The health issues have already been assigned a weight in the excel template, same weight as below.

Criterion Weight:

- Severity 5
- Urgency 4
- Impact on Quality of Life 4
- Cost of Treatment.....3
- Preventability 4
- Potential for Long-Term Consequences 5

3. Rate Each Health Issue

Each council member will have their own excel spread sheet and he/she will rate each health issue on a scale of 1-5 (5 being the highest) for each criterion. The excel sheet will automatically add the total for each section. Highest score indicates highest priority.

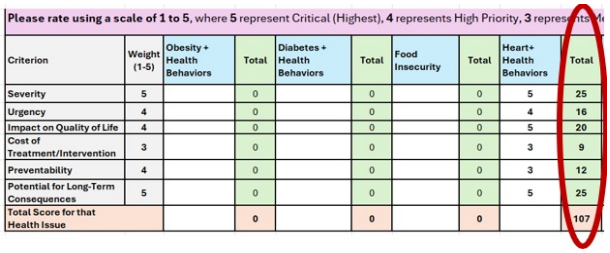
4. Calculate the Total Score

The excel spreadsheet will take the rating by the weight assigned to each criterion, then sum the results for each health issue.

Example Below for Heart Disease:

- Severity .....(5 x 5) = 25
- Urgency .....(4 x 4) = 16
- Impact on Quality of Life .....(4 x 5) = 20
- Cost of Treatment..... (3 x 3) = 9
- Preventability..... (4 x 3) = 12
- Potential for Long-Term Consequences .....(5 x 5) = 25

Total: 107



Please rate using a scale of 1 to 5, where **5** represent Critical (Highest), **4** represents High Priority, **3** repres

Criterion	Weight (1-5)	Obesity + Health Behaviors	Total	Diabetes + Health Behaviors	Total	Food Insecurity	Total	Heart+ Health Behaviors	Total
Severity	5		0		0		0	5	25
Urgency	4		0		0		0	4	16
Impact on Quality of Life	4		0		0		0	5	20
Cost of Treatment/Intervention	3		0		0		0	3	9
Preventability	4		0		0		0	3	12
Potential for Long-Term Consequences	5		0		0		0	5	25
Total Score for that Health Issue			0		0		0		107

5. Rank the Health Issues

After calculating the total scores, rank the health issues from highest to lowest. This gives you a prioritized list based on the criteria. The excel spreadsheet will automatically calculate the total for your voters, they just need to enter their rating for each category.

6. Review and Adjust

After reviewing the rankings, make sure they reflect the priorities of your specific context (e.g., for a particular

community, healthcare system, or population). Adjust the weights or ratings if needed to better align with local needs or available resources.

This tool provides a structured way to prioritize health issues based on objective criteria, helping you focus on those that require immediate attention or have the greatest impact on health outcomes. You can adapt the criteria and weights based on your specific needs (e.g., community health, healthcare budget, disease burden).

Exhibit 2: Health Priority Facts

In addition to robust data presentation, council members received a overview of the economic burden, long-term consequences and preventability for each health priority presented.

Health Priority	Economic Burden		Long-Term Consequences	Preventability
Obesity + Health Behaviors	Obesity + Health Behaviors: $170 billion Adult Obesity Facts | Obesity | CDC	Annual Cost: Approximately $170 billion in direct medical costs in the U.S. Obesity-related health behaviors (such as poor diet and lack of exercise) contribute heavily to chronic conditions like heart disease and diabetes, raising the overall costs.	Increases risk of chronic diseases (heart disease, diabetes, cancer), reduced life expectancy, mental health issues, limited mobility, and high healthcare costs.	Preventability: **Highly preventable** Maintaining a balanced diet, regular physical activity, and avoiding unhealthy behaviors (e.g., excessive screen time, sedentary lifestyle) can prevent obesity. Public health initiatives focusing on nutrition education and access to healthy foods are also key.
Diabetes + Health Behaviors	Diabetes + Health Behaviors: $412.9 billion $412.9 Billion in Health Care Dollars |ADA	Annual Cost: The total cost of diabetes in the U.S. is estimated at $412.9 billion annually, with a significant portion of that coming from medical care related to poor health behaviors (poor diet, sedentary lifestyle). Direct medical costs: About $237 billion. Lost productivity: About $90 billion.	Increases risk of chronic diseases (heart disease, diabetes, cancer), reduced life expectancy, mental health issues, limited mobility, and high healthcare costs.	Preventability: **Highly preventable** Maintaining a balanced diet, regular physical activity, and avoiding unhealthy behaviors (e.g., excessive screen time, sedentary lifestyle) can prevent obesity. Public health initiatives focusing on nutrition education and access to healthy foods are also key.
Food Insecurity	Food Insecurity: $160 billion Health Care Costs Associated with Food Insecurity	Annual Cost: The economic cost of food insecurity in the U.S. is estimated at $160 billion annually. This includes healthcare costs due to increased risk for chronic conditions like diabetes, heart disease, and mental health issues that are exacerbated by lack of access to nutritious food.	Chronic health issues (obesity, diabetes, malnutrition), developmental delays in children, mental health problems, and economic strain.	Preventability: **Partially preventable** While food insecurity often arises from broader economic and social factors, addressing poverty, improving access to nutritious foods, and strengthening social safety nets can reduce its impact. Community-based solutions like food banks and assistance programs are crucial in mitigating food insecurity.
Heart Health + Health Behaviors	Heart Health + Health Behaviors: $219 billion Forecasting the Economic Burden American Heart Association	Annual Cost: Heart disease and associated health behaviors (e.g., smoking, poor diet, lack of exercise) contribute to an estimated $219 billion annually in healthcare costs in the U.S. Direct medical costs: Around $150 billion. Lost productivity: About $70 billion.	Increased risk of heart disease, stroke, chronic heart failure, premature death, and reduced quality of life.	Preventability: **Highly preventable** Many heart conditions are preventable through regular exercise, healthy eating (low salt, low saturated fat), avoiding smoking, and managing stress. Lifestyle modifications can significantly reduce the risk of heart disease, especially when adopted early in life.

Health Priority	Economic Burden		Long-Term Consequences	Preventability
Asthma/ COPD	**Asthma/COPD: $80 billion** **The Economic Impact That Asthma Has on the Economy and Families**	Annual Cost: The total cost for asthma and chronic obstructive pulmonary disease (COPD) in the U.S. is estimated at $80 billion annually. Direct medical costs: About $50 billion. Lost productivity: Around $30 billion.	Permanent lung damage, respiratory infections, reduced mobility, chronic disability, and early death.	Preventability: **Partially preventable** Asthma cannot be entirely prevented, but its triggers (e.g., tobacco smoke, pollution) can be managed to reduce severity. COPD (primarily caused by smoking) is largely preventable through smoking cessation and reducing exposure to environmental pollutants.
Access to Health Care	**Access to Health Care: $93 billion** **NIH: Access**	Annual Cost: Poor access to healthcare can result in higher healthcare costs overall, both for individuals and the healthcare system. The U.S. spends $93 billion annually on preventable hospitalizations and emergency room visits that could have been avoided with adequate access to primary care and preventive services.	Delayed diagnoses, worsening of chronic conditions, higher mortality, increased healthcare costs, and health inequities.	Preventability: **Partially preventable** Access to healthcare is influenced by policy, geography, and socioeconomic factors. Expanding healthcare coverage, improving public health infrastructure, and reducing socioeconomic disparities can enhance access. While systemic changes are required, improving education about healthcare options and navigating insurance can also help.
Mental Health + Health Behaviors	**Mental Health + Health Behaviors: $225 billion** **Statistics - National Insti-tute of Mental Health (NIMH)**	Annual Cost: Mental health disorders (such as depression, anxiety, and related behaviors like substance abuse) contribute to about $225 billion annually in lost productivity and healthcare costs. Poor health behaviors, such as smoking or lack of exercise, can exacerbate mental health conditions, raising overall costs.	Chronic mental health disorders, physical health deterioration, increased substance abuse, decreased productivity, and social isolation.	Preventability: **Partially preventable** Mental health disorders have both genetic and environmental causes. While not all are preventable, promoting mental wellness through stress management, social support, and early intervention can reduce the onset or severity of conditions. Avoiding substance abuse and maintaining good physical health can help prevent some mental health issues.
Substance Use + Health Behaviors	Substance Use + Health Behaviors: $740 billion NIDA.NIH.GOV | National Institute on Drug Abuse (NIDA)	Annual Cost: The economic burden of substance use disorders (including alcohol and drug use) in the U.S. is estimated to be $740 billion annually. This includes healthcare costs, lost productivity, and criminal justice costs.	Addiction, chronic health problems (liver disease, cancer), mental health disorders, injury or death, and social and economic hardship.	Preventability: **Highly preventable** Substance use disorders are largely preventable through education, early intervention, and public health initiatives focusing on the dangers of substance use. Avoiding early exposure to substances, strong family and community support systems, and providing access to mental health resources can prevent or reduce substance abuse.

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/

Organization	Website
Cardiovascular Disease	https://www.heart.org/en/ https://www.advocatehealth.com/health-services/advocate-heart-institute
Diabetes	https://diabetes.org/ https://community.beyondtype2.org/ https://thresholds-health.org/
Respiratory Disease (Asthma & COPD)	https://cookcountyhealth.org/services/pulmonary-lung-health https://lungfessions.com/
Mental Health	https://www.tpoint.org/ https://cookcountypublichealth.org/mental-health-and-substance-use/ https://www.advocatehealth.com/health-services/behavioral-health-care/resources https://www.nami.org/affiliate/illinois/nami-cook-county-north-suburban/
Substance Use	https://www.gatewayfoundation.org/programs-services/programs/addiction-therapy-services/ https://illinoisaddictionhelp.org/cook-county/ https://www.gatewayfoundation.org/
Obesity	https://www.uchicagomedicine.org/conditions-services/weight-management https://iphionline.org/iapo/
Food Insecurity & Access to Healthy Food	https://extension.illinois.edu/food/find-food-illinois https://www.chicagosfoodbank.org
Access to Health Care	https://www.d214.org/Page/3736 https://communityhealth.org/ https://www.oipcc.org/
Cancer	https://www.cancer.org/about-us/local/illinois.html https://www.gildasclubchicago.org/get-support/resources/
Housing & Transportation	https://www.shelterlistings.org/county/il-cook-county.html https://evictionhelpillinois.org/ https://ilaging.illinois.gov/benefitsaccess/ride-free-transit-benefit.html

Appendix 3: References

References	
Demographics	• Metopio, American Community Survey (ACS), 2019-2023
Cancer	• Mammography: Metopio, Behavioral Risk Factor Surveillance System (BRFSS) (for state and MSA), PLACE, 2022 • Cancer Diagnosis Rate: Metopio, Illinois State Cancer Registry (ISCR), 2018-2022 • Oncologist: Metopio, National Provider Identifier Files (NPI), 2025
Cardiovascular Disease	• World Health Organization, 2021 • National Center for Health Statistics, CDC WONDER, 2018-2023 • United Health Foundation, CDC, 2018–2023 • NEPHTN, 2021; CDC, 2018–2020 • Metopio, IHA COMPdata, 2019–2023
Diabetes	• CDC, National Diabetes Report, 2021 • Metopio, PLACES Diabetes Atlas, 2022 • Metopio, IHA COMPdata, 2019–2023 • Alliance for Health Equity, Survey Data, 2024
Respiratory Disease (Asthma & COPD)	• National Center for Health Statistics. NHIS Adult Summary Health Statistics. Accessed April 16, 2025. https://data.cdc.gov/d/25m4-6qqq. National Center for Health Statis-tics. NHIS Child Summary Health Statistics. Accessed April 16, 2025. https://data.cdc.gov/d/wxz7-ekz9Ferrante, G., & La Grutta, S. (2018). The Burden of Pediatric Asthma. Frontiers in Pediatrics, 6. https://doi.org/10.3389/fped.2018.00186 • AAFA Asthma Facts and Figures, April 2025 • Metopio, IHA COMPdata, 2019–2023 • Metopio, PLACES BRFSS, 2022
Mental Health	• Metopio, IHA COMPdata, 2019–2023 • Alliance for Health Equity, Survey Data, 2024
Substance Use	• Metopio, IHA COMPdata, 2019–2023 • Metopio, SAMHSA, 2024 • Alliance for Health Equity, Survey Data, 2024
Food Insecurity & Access to Healthy Food	• https://www.feedingamerica.org/research/map-the-meal-gap • U.S. Department of Agricul-ture (USDA): The USDA regularly publishes food insecurity statistics through its Eco-nomic Research Service (ERS). The Household Food Security in the United States report includes data at the state level. Website: https://www.ers.usda.gov/topics/food-security/ • Illinois Department of Human Services (IDHS): They offer information and data related to food assistance programs in Illinois. Website: https://www.idhs.state.il.us/ • Metopio, Map the Meal Gap, 2022 • Metopio, American Community Survey, 2018-2022 • Metopio, Food Access Research Atlas, 2019
Obesity	• Metopio, BRFSS, PLACES, 2022 • Metopio, Behavioral Risk Factor Surveillance System (BRFSS), 2022 • Metopio, American Community Survey (ACS), 2018-2022 • Alliance for Health Equity, Survey Data, 2024 • Agency for Toxic Substances and Disease Registry - Environmental Justice Index, 2022 • Impact DuPage, CDC, 2021 • The State of Obesity, 2024, SOO-2024-FINAL-R-Sept-12.pdf
Access to Health Care	• Metopio, Behavioral Risk Factor Surveillance System (BRFSS), 2022 • Metopio, Ameri-can Community Survey (ACS), 2019-202 • Metopio, IHA COMPdata, 2019–2023 • Metopio, PLACES, BRFSS, 2019–2023
Maternal, Child & Reproductive Health	• CDC, National Vital Statistics System, 2023 • CDC, National Center for Health Statistics, National Vital Statistics System, mortality data file, 2023 • Metopio, Maternal Hardship Index, 2016-2023
Housing	• Metopio, American Community Survey (ACS), 2018-2022 • Alliance for Health Equity, Survey Data, 2024

Appendix 4: Additional Data

Alliance for Health Equity PSA Survey Analysis:

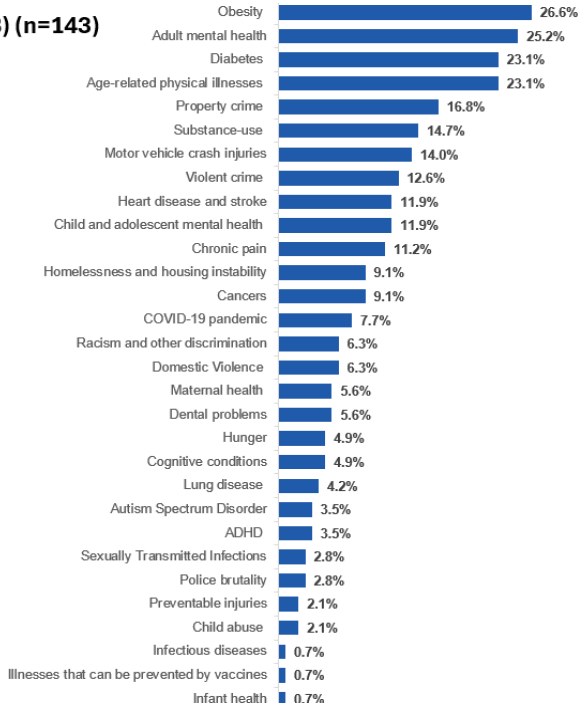
What are the biggest health issues in your community? (Choose 3) (n=143)

Advocate Lutheran service area top health issues

1. Obesity
2. Adult mental health
3. Diabetes
4. Age-related physical illness
5. Property crime

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 Lutheran service area top health needs

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

Cook County top health needs

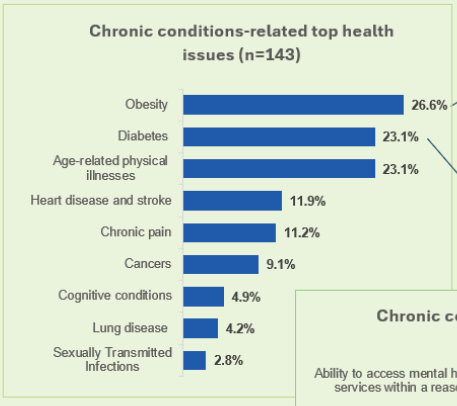
1. Activities for teens and youth
2. Access to mental healthcare services
3. Housing resources
4. Safety and low crime
5. Safe and affordable housing

10

"We used to have a lot of free health clinics and preventative screening things that would happen a lot, and they would occur, maybe, twice a month. But after COVID, they just never came back. It was free breast cancer screenings, and then there was also free vaccines too."

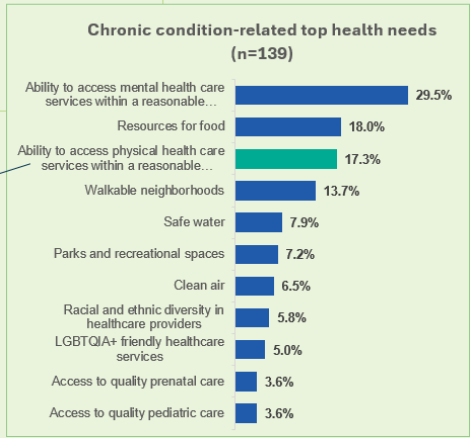
Chronic Conditions

In both the focus groups and survey, community members in the Advocate Lutheran service area chose chronic conditions a top health need in their community.



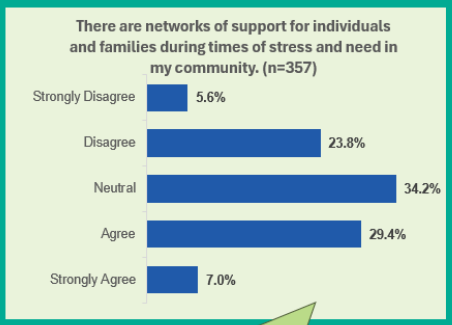
County-wide, 19% of respondents selected obesity as a top health concern.

County-wide, 22% of respondents selected diabetes as a top health concern.

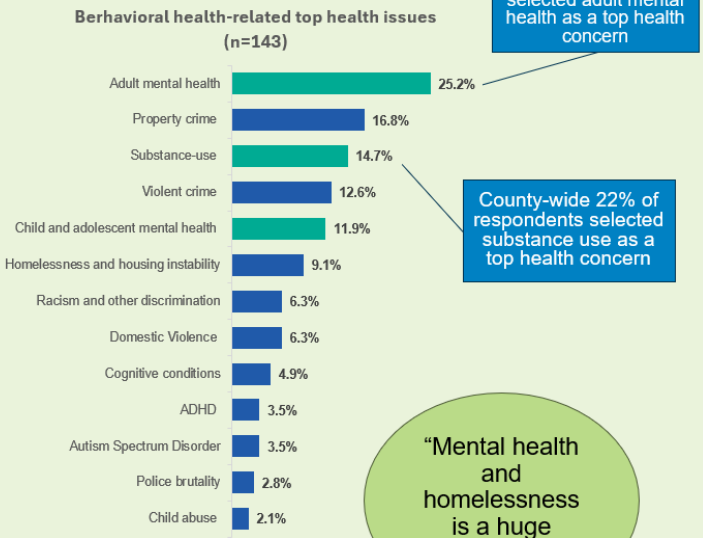


County-wide, 16% of respondents selected access to physical health care as a top health need

Mental Health and Substance Use



"I've seen a lot of increasing violence. It is a lot of substance abuse and mental health."



County-wide, 26% of all respondents selected adult mental health as a top health concern

County-wide 22% of respondents selected substance use as a top health concern

"Mental health and homelessness is a huge problem."

Alliance for Health Equity PSA Survey Analysis:

Summary of Focus Group Findings

Core Themes

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

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

Healthcare
- Several factors influence access
  - Ease of access to health clinics
  - Insurance coverage
  - Culturally appropriate services
- Several additional healthcare needs discussed
  - Behavioral health services
  - Engagement in primary care
  - Building trust with communities
  - Better communication about resources
  - Transportation to appointments
  - Diverse healthcare workforce

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

"I used to live...a few blocks from the United Center, and there was a laundromat that had to close down because of COVID. And so now people don't have any place to wash their clothes."

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

Summary of Focus Group Findings

Core Themes

"I feel like in our community, there is some similar opportunities to get the help provided for you, but not a lot of people know"

"I don't have cable, I have antennae tv, and I can't get the communication from Cook County, Illinois from them."

Community safety
- Several factors contribute to violence in communities
  - 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 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
  - Passing information through local organizations
  - Mail

"I'd love to be able to take a bus and go to the library for a program and not have to think about the or when I can't drive. That's a wish list item"

"For my school specifically, substance abuse is a big thing because once in a while, almost like every week, someone from school or someone gets arrested for gun violence or drug use."

"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."

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
  - Community investment
  - Improved infrastructure
  - Environmental health
  - Health education courses

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

"I feel like it's really essential to have something to do with mental health support."

"I live by the 606, so me and my sisters go and walk that's where my family helps us to be active."

"I live in Austin...I want to be healthier...but we don't have access to it, and then all we have on our blocks is, like, gas stations and chips."

"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."

Advocate Health Care®

Thank You

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