Advocate South Suburban Hospital Community Health Implementation Strategy

January 1, 2026 - December 31, 2028

Community health improvement is an effective tool for creating a shared vision and supporting a planned and integrated approach to improving health outcomes. The basic premise of community health improvement is that entities identify community health issues, prioritize those that can be addressed, and then develop, implement, and evaluate strategies to address those issues. Tax-exempt hospitals are required to conduct a community health needs assessment (CHNA) and develop an implementation strategy to document how the hospital will address prioritized community health needs. The following outlines a summary of the CHNA process and provides details on how Advocate South Suburban Hospital plans to address their prioritized community health needs.

SUMMARY OF CHNA PROCESS

In 2024, Advocate South Suburban Hospital (Advocate South Suburban) participated with the Alliance for Health Equity collaborative to conduct a Community Health Needs Assessment (CHNA), which consisted of a comprehensive presentation and analysis of both qualitative and quantitative data.

The Advocate South Suburban CHNA relies on two sources of primary data information, gathered through the Alliance for Health Equity partnership:

Community Survey: The community input survey was a qualitative tool designed to understand community health needs and assets with a focus on hearing from community members that are most impacted by health inequities. From February 2024 to October 2024, 120 community input surveys were collected in South Suburban Hospital's service area both on paper and online.

Focus Groups: Seven focus groups were conducted within South Suburban Hospital's service area or included participants living within the service area from January 2024 to October 2024. Hosted by community partners, the focus groups included community residents and local service providers.

Additionally, Advocate Health Care analyzes secondary data, or existing information gathered from various sources, to provide valuable insights and context from the following sources:

Metopio: Advocate Health Care has a contract with Metopio to provide an internet-based data resource for their hospitals. This robust platform offers curated data from public and proprietary sources for information on health behaviors and health risks, health outcomes, health care utilization, demographic, and community-level drivers of health like economic, housing, employment, and environmental conditions. Data for each indicator is presented by race, ethnicity, and gender when the data is available. All data collected through Metopio was quantitative and included data comparisons between county, state and United States data.

County Health Rankings & Roadmaps – Cook County: A program of the University of Wisconsin Population Health Institute and supported by the Robert Wood Johnson Foundation, the County Health Rankings & Roadmaps (CHR&R) provides a snapshot of health for nearly every county in the nation, based on a variety of public health data. CHR&R advocates for an understanding of data and evidence to develop methods to improve health and equity. (County Health Rankings & Roadmaps, About Us, 2024)

The top health issues identified in the Advocate South Suburban Hospital Community Health Needs Assessment were:

- Chronic Conditions
  - » Diabetes
  - » Respiratory issues
  - » Cardiovascular disease
- Substance Use
  - » Alcohol use/binge drinking
  - » Substance use ED visits
- Mental Health
  - » Access to mental health treatment
  - » ED and hospitalizations due to mental health
- Social Drivers of Health - Housing
  - » Housing costs burden
  - » Poverty
- Obesity
  - » Food insecurity
- Unintentional Falls
  - » Age-related physical illness

The top health issues identified were presented to the Advocate South Suburban community health council (CHC), and members were asked to rank the issues based on the following criteria: size and seriousness of the problem; effectiveness of available interventions; available resources to address the health issue; whether the health care system is adequately positioned to address the issue; alignment with a defined community need identified through data; potential for the issue to impact other health and social issues; and the ability to effectively address or impact the issue through collaboration.

Using these criteria, Advocate South Suburban Hospital has prioritized the significant health needs to address in 2026-2028:

Significant Need	Implementation Strategy Selection Reasoning
Mental Health	The community needs assessment identified access to mental health services as a health priority in the hospital's primary service area (PSA). The community health council prioritized mental health as a specific health need to address due to rising rates of emergency department visits, hospitalizations, and the growing demand for local mental health services. This need also reflects the strong connection between mental health and substance use, as many individuals experience both conditions simultaneously and require combined support.
Diabetes	The CHC decided to specifically focus on diabetes from the list of larger chronic conditions. Diabetes prevalence in the hospital's PSA stands at 14.1%, which is considerably higher than the averages seen in Cook County (10.8%) and IL (10.4%). When comparing the percentage of diabetes diagnosed across the PSA landscape, the percentage of adults diagnosed with diabetes across all 22 zip codes increased. Obesity plays a factor in developing diabetes; being overweight or obese may seriously impact a person's health. Extra weight may lead to serious health consequences such as type 2 diabetes, cardiovascular disease, some cancers and other chronic diseases. These conditions could reduce the quality of life and shorten an individual's lifespan.

For each prioritized health need, the hospital plans to commit resources, which may include staff time, information technology systems, outreach, promotions and educational materials, funding, medical supplies, and other resources as available.

PRIORITY: Mental Health

IMPACT: Increase access, education and availability of mental health resources in the Advocate South Suburban PSA.

DESCRIPTION OF HEALTH NEED DATA:

- In the South Suburban Hospital Primary Service Area, the rate of fair or poor self-reported health stands at 16.5%, which is higher compared to Cook County, and the State average, which are 15.3%, and 16.1% respectively.
- The rate of self-reported poor mental health in the PSA has increased 26% since 2020.
- The mental health emergency department visit rate in the PSA of 991.34 per 100,000 residents is higher than the county rate of 805.38 and state rate of 906.27 per 100,000 residents.
- Young adults aged 18-39 years had the highest emergency department visit rate in the PSA at 1,958.5 per 100,000 residents. This rate is significantly higher than the county and state rates of 1,382.16 and 1,604.06 respectively.
- Also, notably high emergency department visit rates were for children aged 5-17 years in the PSA at 970.98 per 100,000 residents. The rate was higher than the county rate of 881.67, but lower than the state rate of 1,074.23.

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL: Advocate Health
- Access to mental health services within Advocate Health
- Referrals to community partners

STATE: Illinois State Health Improvement Plan
- Increase community interventions to improve prevention and linkage to care

NATIONAL: Healthy People 2030
- Improve mental health
- 988 Suicide & Crisis Lifeline

STRATEGY #1: Improve mental health among young adults

Planned Interventions	Collaborative Partners	Intended Outcomes
• Deploy screening tools for identifying students at an increased risk for poor outcomes • Incorporate NAMI's Ending the Silence program to educate families and youth in mental health awareness • Collaborate on launching a creative art therapy program with one of the potential partners	• Cook County Sheriff's Department (high school program) • Local high school parent-teacher associations • NAMI – Ending the Silence program • American Foundation for Suicide Prevention	• Increased mental health literacy • Increased awareness for parents and high school students on mental health • Improved coping skills and resilience among students • Increased emotional expression and resilience • Reduction in ED visits for mental health crisis

Measures

- Number of attendees at community events
- Percent of participants that indicated increased knowledge

**Impact measures are subject to change depending on the direction of each intervention.*

PRIORITY: Mental Health (CONTINUED)

STRATEGY #2: Provide trauma-informed and resilience training for community and teammates

Planned Interventions	Collaborative Partners	Intended Outcomes
• Implement training for staff on trauma-informed care approaches and resilience building to support colleagues and empower staff with patient interactions • Develop quarterly new teammate education to focus on mental health • Develop a program that includes education, skill-building and community support	• Behavioral health professionals (ASSH) • NAMI • Faith and Health Partnership department • New teammate orientation department • American Foundation for Suicide Prevention	• Improved mental health literacy • Increased staff confidence in managing stress • Improved support for patient's mental health • Reduced absenteeism • Healthier coping skills and reduced anxiety

Measures

- Number of programs hosted
- Number of teammates who participate in programs offered
- Percent of participants that indicated increased knowledge

**Impact measures are subject to change depending on the direction of each intervention.*

PRIORITY: Diabetes

IMPACT: Reduce the prevalence and impact of diabetes by strengthening prevention, early detection, and evidence-based disease management efforts.

DESCRIPTION OF HEALTH NEED DATA:

- Diagnosed diabetes presents a significant health challenge across various regions, with notable disparities evident from the recent data. The hospital PSA reports a diabetes prevalence of 14.1%, which is considerably higher than the averages seen in Cook County and Illinois at 10.8% and 10.4%, respectively.
- The uncontrolled diabetes rates in the hospital PSA of 239.38 per 100,000 residents is higher than both Cook County and Illinois at 172.4 and 184.1, respectively
- In the PSA, Non-Hispanic Blacks have the highest uncontrolled diabetes emergency department visit rate of 339.43 per 100,000 residents – far greater than Non-Hispanic Whites of 178.22 per 100,00 residents and Hispanics/Latino at 164.64 per 100,000 residents.
- In the PSA, Non-Hispanic Blacks have the highest uncontrolled diabetes hospitalization rate of 76.7 per 100,000 residents, more than double Non-Hispanic Whites of 36.0 per 100,000 residents.

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL: Advocate Health

- Advocate Health Food Farmacy Program
- Advocate South Suburban Diabetes Prevention Program

STATE: Illinois State Health Improvement Plan

- Increase community-clinical linkages to reduce the incidence and burden of chronic diseases

NATIONAL: Healthy People 2030

- Increase the proportion of eligible people completing CDC-recognized type 2 diabetes prevention programs

STRATEGY #1: Sustain the CDC-recognized National Diabetes Prevention Program

Planned Interventions	Collaborative Partners	Intended Outcomes
• Maintain CDC recognition status • Deliver the year-long lifestyle change curriculum through trained lifestyle coaches • Offer in-person, virtual, and hybrid participation options • Improve participation in the "Group Me" meetings to encourage accountability through peer support	• Centers for Disease Control and Prevention (CDC) • Lifestyle Coach	• Improved blood glucose control among participants • Reduced emergency department visits and diabetes-related complications • Strengthened community capacity to sustain long-term health improvements

Measures

- Continued receipt of the CDC Full-Plus Recognition status
- Number of participants enrolled per cohort
- Program outcomes including:
  - » Achieve at least 60% participant retention at 6 months
  - » Achieve at least 50% participant retention at 12 months
  - » At least 50% of participants will achieve 5% body weight loss
  - » Participants will average 150 minutes of physical activity per week by month 6
  - » At least 40% of participants with baseline elevated HbA1c reduce their A1c level
- Number of participants in Group Me meetings; tracked improvements

**Impact measures are subject to change depending on the direction of each intervention.*

PRIORITY: Diabetes (CONTINUED)

STRATEGY #2: Increase access to diabetes prevention through community linkages

Planned Interventions	Collaborative Partners	Intended Outcomes
• Partner with community-based organizations for outreach and education • Deploy mobile health units to provide accessible diabetes screening, education, and follow-up services in communities with gaps to care to reduce barriers to prevention and management of the condition • Increase access to affordable, nutritious foods in the community to promote healthy lifestyles and reduce the risk of chronic disease (including diabetes)	• Advocate Medical Group (AMG) physicians • Lifestyle Coach • Community Organizations • Advocate Health Mobile Health team • Food Farmacy	• Increased participation in preventive programs • Increased knowledge in preventing diabetes • Earlier identification of prediabetes and diabetes • Reduced food-related barriers that contribute to risk of developing chronic diseases including diabetes

Measures

- Number of partner organizations / number of education sessions
- Number of people served through the mobile health units
- Number of partner sites
- Number of screenings provided
- Number of attendees to Food Farmacy
- Pounds of food distributed

**Impact measures are subject to change depending on the direction of each intervention.*

Needs Not Addressed

This Community Health Implementation Strategy focuses on the above priority health needs selected by the hospital based on community input, available resources, and alignment with organizational and community partner capacity. The Community Health Needs Assessment (CHNA) also identified additional significant health needs, including cardiovascular disease, obesity, respiratory issues, social drivers of health - housing, substance use, and unintentional falls. These needs, while also important, are not addressed in this CHIS due to factors such as limited hospital resources, the presence of existing initiatives, or a determination that the hospital is not best positioned to lead efforts in these areas at this time. Advocate Health will continue to collaborate with community partners and share resources, when appropriate, to support progress on these needs within the community.

Adoption of the Implementation Strategy

The Community Health Implementation Strategy report was adopted by the governing council on April 21, 2026, and additionally approved by the Advocate Health Care Network Board on May 5, 2026.

Note: Plans to address selected CHNA priorities are dependent upon resources and may be adjusted on an annual basis to best address the health needs of our community.