# 2022
# Community Health Needs Assessment Report

## Advocate Illinois Masonic Medical Center

836 W. Wellington Avenue

Chicago, IL 60657

**December 2022**

Thank you for taking the time to learn more about Advocate Illinois Masonic Medical Center's Community Health Needs Assessment (CHNA). Every three years the medical center works with community partners and leaders to complete a comprehensive CHNA. The CHNA is an extensive process and is led by our Community Health department. The process utilizes an online data platform and collects input from the community to gain an in-depth understanding of our communities' health needs. To ensure collaboration, partnership and alignment with community partners and hospitals during the CHNA process, Advocate Illinois Masonic Medical Center is a member of the Alliance for Health Equity, a collaborative of Cook County Hospitals and community organizations. In addition, the medical center has a Community Health Council that provides oversight of the CHNA process and selects the medical center's priority health needs.

Based upon comprehensive community data and feedback, our Community Health Council selected two health priorities for the 2022 CHNA. The priorities selected include the following:

- Health and Nutrition
- Behavioral Health

We understand that creating and sustaining community partnerships to implement evidence-based programming is critical in addressing our communities' health and social needs. We welcome and encourage community feedback regarding the health needs of our community and the CHNA process. A link at the end of the CHNA report will provide you with an opportunity to leave any feedback, comments or ideas. The medical center has the honor of working with community partners and leaders to improve the health and wellness of diverse communities across the medical center's service area. With a comprehensive and thorough understanding of our communities' health needs, the medical center will be well positioned to help people live well and improve the quality of life among individuals, children and families in the communities we serve.

Susan Nordstrom Lopez
President
Advocate Illinois Masonic Medical Center

# Table of Contents


**I. EXECUTIVE SUMMARY 3**

**II. DESCRIPTION OF ADVOCATE HEALTH CARE AND ADVOCATE ILLINOIS MASONIC MEDICAL CENTER 4**

ADVOCATE AURORA HEALTH 4
ADVOCATE ILLINOIS MASONIC MEDICAL CENTER 4

**III. 2022 COMMUNITY HEALTH NEEDS ASSESSMENT 5**

COMMUNITY DEFINITION 5
1. Population 5
2. Social Drivers of Health 5
3. Demographics 7
4. Economics 10
5. Education 11
6. Health Care Resources in the Defined Community 14

HOW THE CHNA WAS CONDUCTED 14
1. Community Health Council 14
2. Purpose and Process 15
3. Data Collection and Analysis 16
4. Data Sources 16

SUMMARY OF CHNA FINDINGS 17
1. Overall Health Status 17
2. Access to Care and Health Care Coverage 18
3. Health Risk Behaviors 20
4. Disease and Chronic Conditions 26

**IV. PRIORITIZATION OF HEALTH-RELATED ISSUES 37**

PRIORITY SETTING PROCESS 37
HEALTH NEED SELECTED 39
HEALTH NEED NOT SELECTED 39

**V. APPROVAL OF COMMUNITY HEALTH NEEDS ASSESSMENT 40**

**VI. VEHICLE FOR COMMUNITY FEEDBACK 40**

COMMUNITY FEEDBACK 40

**VII. EVALUATION OF IMPACT FROM PREVIOUS CHNA 41**

**VIII. APPENDICES 42**

APPENDIX 1: 2022 COMMUNITY HEALTH NEEDS ASSESSMENT DATA SOURCES 42
APPENDIX 2: 2022 HEALTH NEED PRIORITIZATION FORM 44
APPENDIX 3: ALLIANCE FOR HEALTH EQUITY- EQUITY ANALYSIS SURVEY SUMMARY 55

# I. Executive Summary

Advocate Illinois Masonic Medical Center (Advocate Illinois Masonic) completed a comprehensive community health needs assessment (CHNA) process in 2022. This CHNA report describes the process and includes demographic and socioeconomic data for Advocate Illinois Masonic's primary service area (PSA) and key findings regarding the PSA's health status. For the purposes of this report, the "community" was defined as the medical center's PSA. The PSA consists of 21 zip codes in Cook County. Demographic and socioeconomic data for the medical center's PSA was collected and analyzed to obtain a thorough picture of the health and social needs for the PSA. Data collected included primary and secondary, quantitative and qualitative data. Data shows that the hospital's PSA is 48.7 percent Non-Hispanic White, 30.7 percent Hispanic or Latino, 10.3 percent African American, and 7.8 percent Asian or Pacific Islander. In addition, the PSA is 50.2 percent female and 49.8 percent male, with a PSA median household income of $75,577.

The medical center's Community Health Council (CHC), comprised of medical center and community representatives, was essential to completing the CHNA process. The CHC provided oversight of the 2022 CHNA process, reviewing and analyzing data with the support of the hospital's community health department. Under the leadership of the medical center's Director of Community Health, the CHC worked through a prioritization process to determine the key health needs of the PSA. The top nine health needs of Advocate Illinois Masonic's PSA were determined to be:

- Access to Care
- Cancer
- COVID-19
- Diabetes
- Health and Nutrition
- Heart Disease
- Mental Health
- Respiratory Health
- Substance and Alcohol Use

The CHC began the initial stage of prioritization using a prioritization grid that rated each health need using criteria including severity of the health issue, effectiveness of possible interventions and the degree to which community partners are involved in addressing the health issue. After using the prioritization grid to narrow the health needs down from nine to four, the CHC used the tabulation method to vote on the final two health needs. The CHC selected health and nutrition and behavioral health as the priority health needs to be addressed for the medical center's PSA. The CHC also recognized the importance of addressing root causes of health issues, such as social drivers of health, thus Council members decided to ensure the hospital integrated social drivers of health into each of the prioritized health need strategies.

Collaboration with partners is critical to understanding and addressing complex needs of the community. Advocate Illinois Masonic is a member of The Alliance for Health Equity, a coalition co-founded by Advocate Aurora Health. The Alliance membership is comprised of Cook County non-profit and public hospitals, health departments and community-based organizations. Led by a steering committee with facilitation and support from the Illinois Public Health Institute (IPHI), the Alliance aims to impact community health through a collective impact model. This impact begins with a collaborative county-wide CHNA which aligns prioritized health needs and community improvement plans across the county. The Alliance is one of the largest community health improvement coalitions in the country. In addition to over 30 nonprofit and public hospitals and seven local health departments, more than 100 community organizations participated in the 2022 assessment and health improvement action teams. IPHI serves as the backbone organization for the collaborative and the hospitals provide funding for the shared assessment and the development of the community health improvement plan. Advocate Illinois Masonic supported the collaborative CHNA process through participating and providing input in collaborative CHNA meetings and assisting in the recruitment for community focus groups. The

primary, secondary and qualitative data collected by The Alliance was also used by the hospital to determine the PSA's health needs.

To ensure the medical center develops an effective 2022 CHNA Implementation Strategy, the hospital's CHC and Community Health Department will collaborate with community partners and The Alliance to create strategies that address the priority health needs using a collective impact model. Metrics, goals and objectives will be created for each strategy and outcomes will be monitored to track community impact and program effectiveness.

## II. Description of Advocate Health Care and Advocate Illinois Masonic Medical Center

### Advocate Aurora Health

Advocate Aurora Health is one of the 12 largest not-for-profit, integrated health systems in the United States and a leading employer in the Midwest with more than 75,000 employees, including more than 22,000 nurses and the region's largest employed medical staff and home health organization. A national leader in clinical innovation, health outcomes, consumer experience and value-based care, the system serves nearly 3 million patients annually in Illinois and Wisconsin across more than 500 sites of care. Advocate Aurora is engaged in hundreds of clinical trials and research studies and is nationally recognized for its expertise in cardiology, neurosciences, and oncology. To learn more about Advocate Aurora's contributions to the community and how we help people live well, visit Serving Our Community | Advocate Health Care.

### Advocate Illinois Masonic Medical Center

Advocate Illinois Masonic is a 397-bed teaching medical center located on Chicago's North Side. The medical center is one of only five Level I Trauma Centers in Chicago, treating 1,320 trauma patients in 2021 and has one of Chicago's most active emergency departments (EDs) with 38,782 emergency visits in 2021. Advocate Illinois Masonic's Level III Neonatal Intensive Care Unit (NICU) holds the state's highest designation. The medical center is fully accredited by Det Norske Veritas (DNV) and Germanischer Lloyd (Germany) (DNV-GL), with the exception of Outpatient Behavioral Health, which is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), and Laboratory Point of Service Testing, which is accredited by the Joint Commission. Located in the heart of one of the largest Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) communities in the Midwest, the medical center has been recognized by the Human Rights Campaign Healthcare Equality Index as an LGBTQ Healthcare Equity Leader. Advocate Illinois Masonic is also Chicago's only resource coordination medical center, acting as lead for mass disaster communication and coordination.

In 2021, Advocate Illinois Masonic had 1,219 active physicians on staff representing 70 medical specialties. It employed 694 registered nurses. The medical center offers a wide range of medical services and is nationally recognized for its medical expertise, innovative technologies and dedication to patient safety, quality and service. Advocate Illinois Masonic's major services include behavioral health, comprehensive surgical services, emergency and trauma services; cancer care; cardiovascular services; digestive health services; obstetric, midwifery; neonatal intensive care; and neuroscience services. Ambulatory and community health services include primary care; a dentistry program including a mobile dental van; vision services; a deaf and hard of hearing program; the Pediatric Development Center; ear, nose and throat services; urology and urogynecology; physical rehabilitative services; diagnostic imaging services; infusion therapy; pain management; and rheumatology. In addition, the medical center's Creticos Cancer Center launched its first medical center-based food pantry for oncology patients in 2018. Since its inception, the pantry has worked to reduce the incidence of food insecurity for oncology patients.

In 2021, Advocate Illinois Masonic employed 1,974 associates and had 114 volunteers. The medical center trained 391 residents and 331 medical students, it's one of Illinois' largest non-university medical teaching medical centers and is

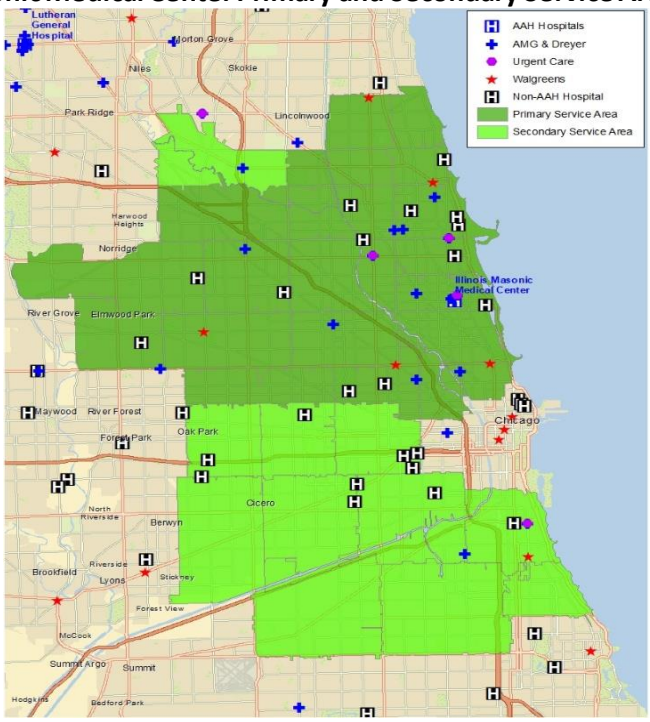
affiliated with the University of Illinois at Chicago Health Sciences Center, Rosalind Franklin University and Midwestern University.

## III. 2022 Community Health Needs Assessment

### Community Definition

For the purposes of this assessment, "community" is defined as the medical center's primary service area (PSA). The PSA consists of 21 communities in Cook County including the communities of Fort Dearborn (60610), North Center (60613), Lincoln Park (60614), Avondale/N. Center (60618), Wicker Park (60622), Ravenswood (60625), Rogers Park (60626), Jefferson Park (60630), Dunning (60634), Belmont Cragin (60639), Uptown (60640), Irving Park/Portage Park (60641), Wicker Park (60642), Avalon Park North (60645), Logan Square (60647), Humboldt Park (60651), Lakeview (60657), West Ridge (60659), Rogers Park (60660), Old Town/Near North Side (60610) and Elmwood (60707 and 60635).

**Exhibit 1: Advocate Illinois Masonic Medical Center Primary and Secondary Service Area Map 2022**




Source: Advocate Aurora Business Development Analytics, 2022

#### 1. Population

The total population for the PSA is 1,214,238 residents (Metopio, 2022). The PSA population slightly increased by 2.40 percent from 2010 to 2020.

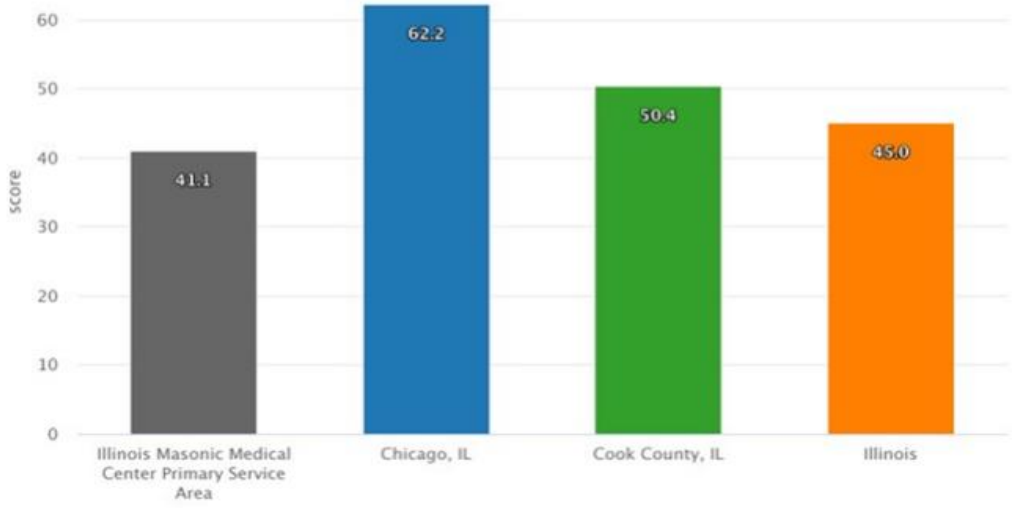
#### 2. Social Drivers of Health

**The Hardship Index**

The Hardship Index is a composite score reflecting hardship in the community (higher values indicate growing hardship). The index incorporates unemployment, age, dependency, education, per capita, income, crowded housing and poverty into a single score that allows for comparison between geographies (Metopio, 2022). To help identify and understand the PSA communities with the highest need, the Community Health Council reviewed hardship scores for each PSA zip

code. The PSA hardship score is 41.1, which is lower than Chicago at 62.2, Cook County at 50.4 and Illinois at 45.0. Communities with the highest hardship score and the most need include Humboldt Park at 83.8, Belmont Cragin at 83.4 and West Ridge at 80.2. The PSA communities with the least need according to the Hardship Index include Lincoln Park at 1.5, Lakeview at 2.2 and Wicker Park at 4.4. The bar graph below in Exhibit 2 shows the Hardship Index score for the PSA, Chicago, Cook County and Illinois.

**Exhibit 2: Advocate Illinois Masonic PSA Hardship Index Comparison 2015-2019**

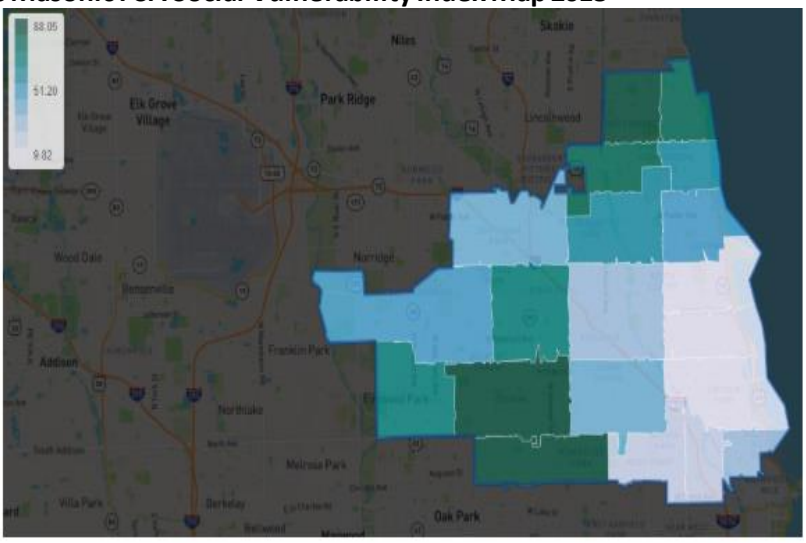



Source: Metopio, American Community Survey, 2022

**Social Vulnerability Index**

To understand the social context that exists in the defined community that deeply influences health, the medical center utilized Metopio's Social Vulnerability Index (SVI). The SVI 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), (Metopio, Centers for Disease Control and Prevention 2022). The PSA communities with the highest SVI include Humboldt Park (60651), Belmont Cragin (60639) and Avalon Park/North (60645).

**Exhibit 3: Advocate Illinois Masonic PSA Social Vulnerability Index Map 2018**



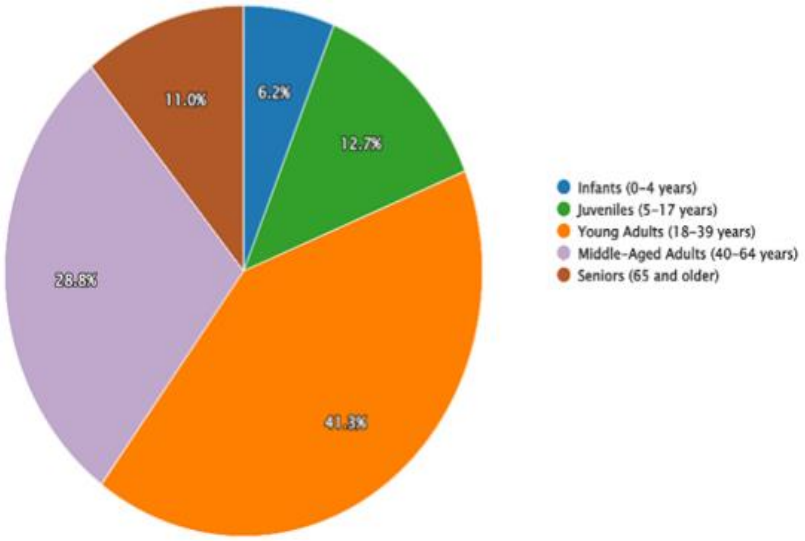

Source: Metopio, Centers for Disease Control and Prevention, 2022

## 3. Demographics

**Age and Sex**

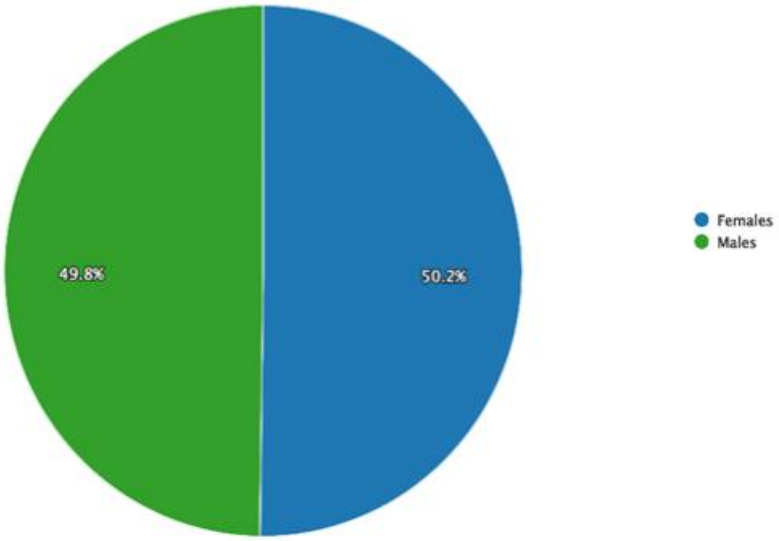
Approximately 18.9 percent of the medical center's PSA is under the age of 18 years old. The 18–39 year-old age group is the largest group at 41.3 percent, followed by the 40-64 year old age group at 28.8 percent. The 65 and older age group is the smallest age group, representing 11 percent of the total population in the PSA. Exhibit 4 displays the population by age group. Females account for 50.2 percent of the population and 49.8 percent of the population is male (Metopio, American Community Survey, 2022).

**Exhibit 4: Advocate Illinois Masonic PSA Population by Age Group 2015-2019**




Source: Metopio, American Community Survey, 2022

**Exhibit 5: Advocate Illinois Masonic PSA Population by Sex 2015-2019**



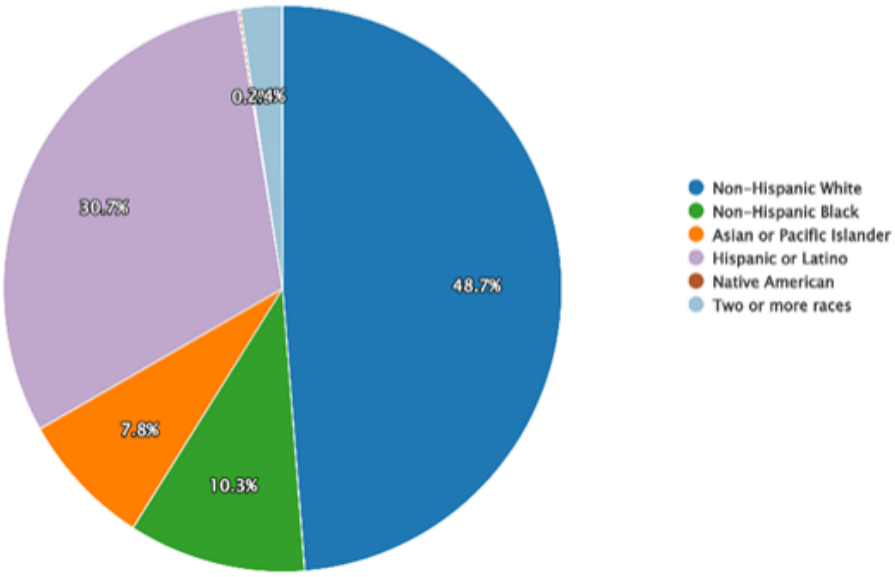

Source: Metopio, American Community Survey, 2022

**Race and Ethnicity**

The demographic data shows that the medical center's PSA is 48.7 percent Non-Hispanic White, 30.7 percent Hispanic or Latino, 10.3 percent Non-Hispanic Black, 7.8 percent Asian or Pacific Islander, 2.4 percent identify as two or more races

and 0.1 percent Native American (Metopio, American Community Survey, 2022). A pie chart showing the racial makeup of the PSA is displayed below in Exhibit 6.

**Exhibit 6: Advocate Illinois Masonic PSA Population by Race/Ethnicity 2015-2019**

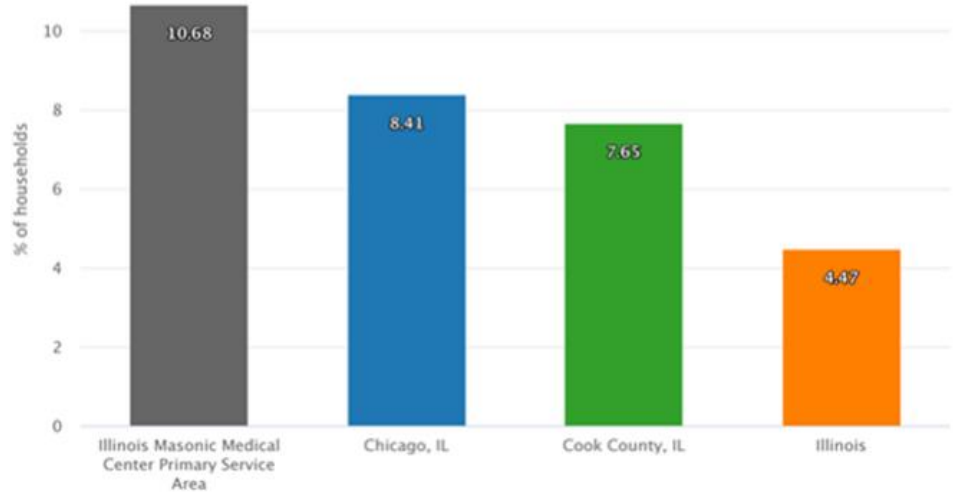



Source: Metopio, American Community Services, 2022

**Language**

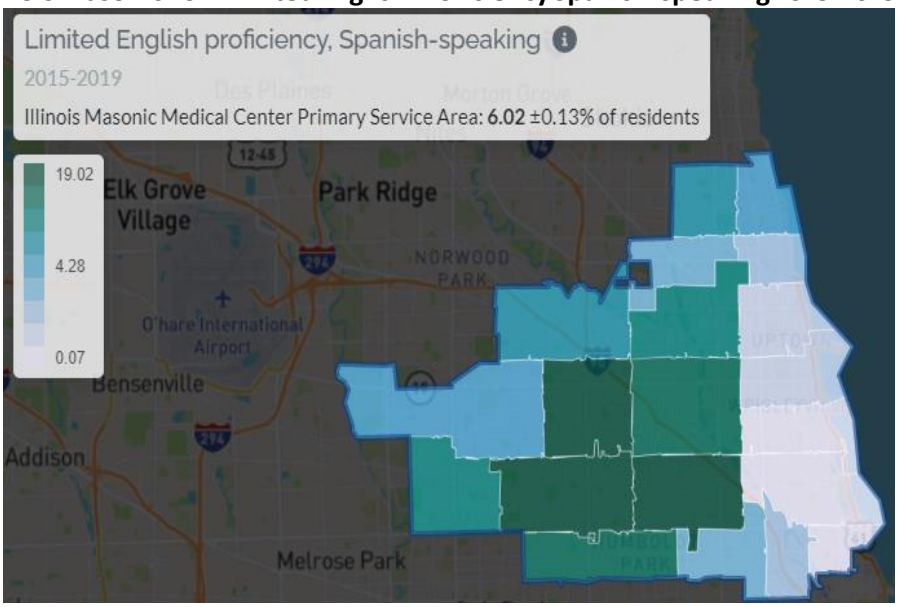
Language and cultural barriers contribute to health disparities experienced by immigrants and non-English speaking communities. Patients with limited English proficiency experience high rates of medical errors and poorer health outcomes. In the PSA, 10.68 percent of households have limited English proficiency, meaning no member 14 years old and older speaks English "very well". Exhibit 7 illustrates the percentage of limited English proficiency households in the PSA. The top five communities in the PSA with the largest percentage of all residents who speak Spanish at home and who do not speak English very well include Belmont Cragin (60639), Logan Square (60647), Irving Park/Portage (60641), Avondale (60618) and Ravenswood (60625). Exhibit 8 shows the darkest green communities as the highest percentage of communities who do not speak English very well. Approximately 10.68 percent of residents in the medical center's PSA do not speak English very well (Metopio, American Community Survey, 2022).

**Exhibit 7: Advocate Illinois Masonic PSA Limited English Proficiency Households 2015-2019**




Source: Metopio, American Community Survey, 2022

**Exhibit 8: Advocate Illinois Masonic PSA Limited English Proficiency Spanish-speaking 2015-2019**



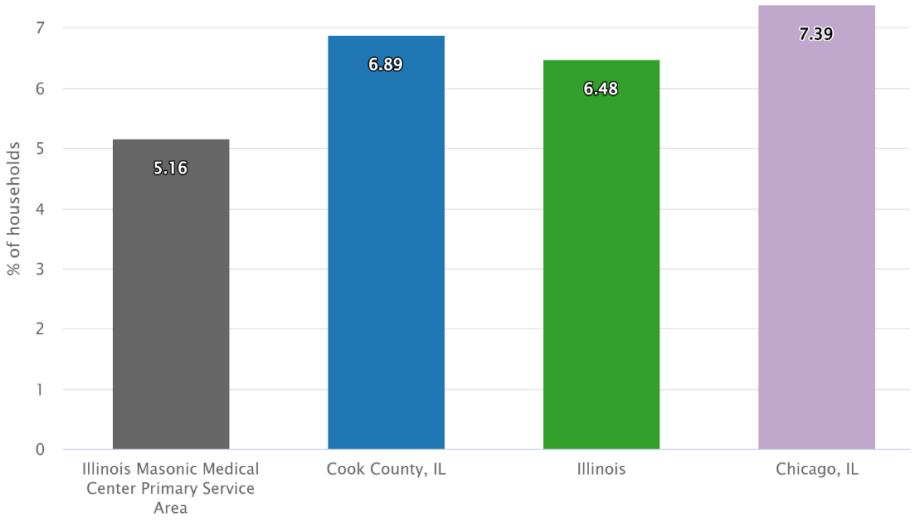

Source: Metopio, American Community Survey, 2022

## Household/Family

### Single parent households

Approximately, five percent of households in the PSA are single parent households meaning the household has children present and are headed by a single parent (mother or father), with no partner present. The top three zip codes with the largest percentage of single-parent households are Division Street (60651) at 12.45 percent of households, Belmont Cragin (60639) at 10.99 percent and West Ridge (60659) at 8.01 percent. Exhibit 9 displays the percentage of single parent households in the medical center's PSA compared to the city of Chicago, the county and the state (Metopio, American Community Survey, 2022).

**Exhibit 9: Advocate Illinois Masonic PSA Single Parent Households 2015-2019**

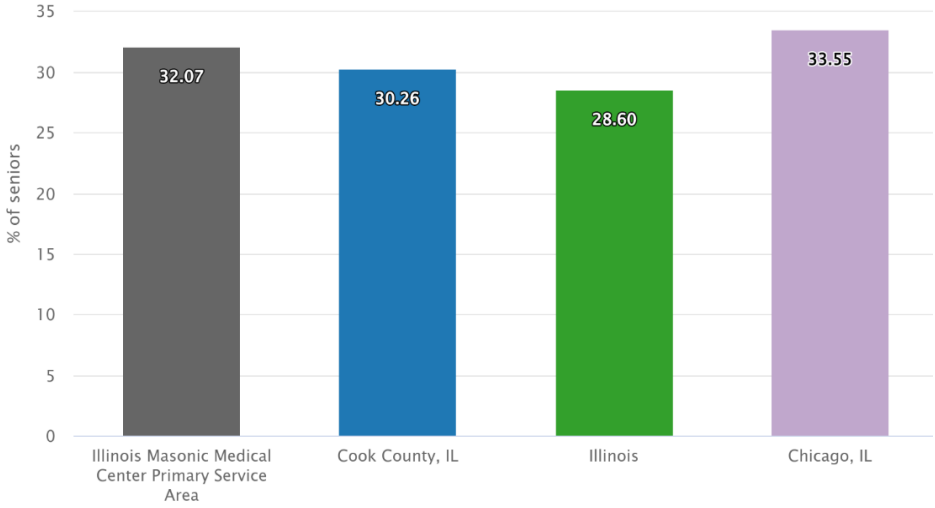



Source: Metopio, American Community Survey, 2022

### Percent of seniors (age 65+) who are living alone

Over 30 percent of the medical center's PSA is over the age of 65 and living alone, which is slightly higher than the county at 30.26 percent, the state at 28.60 percent and slightly lower than the city of Chicago at 33.55 percent.

**Exhibit 10: Advocate Illinois Masonic PSA Seniors Living Alone 2015-2019**




Source: Metopio, American Community Survey, 2022

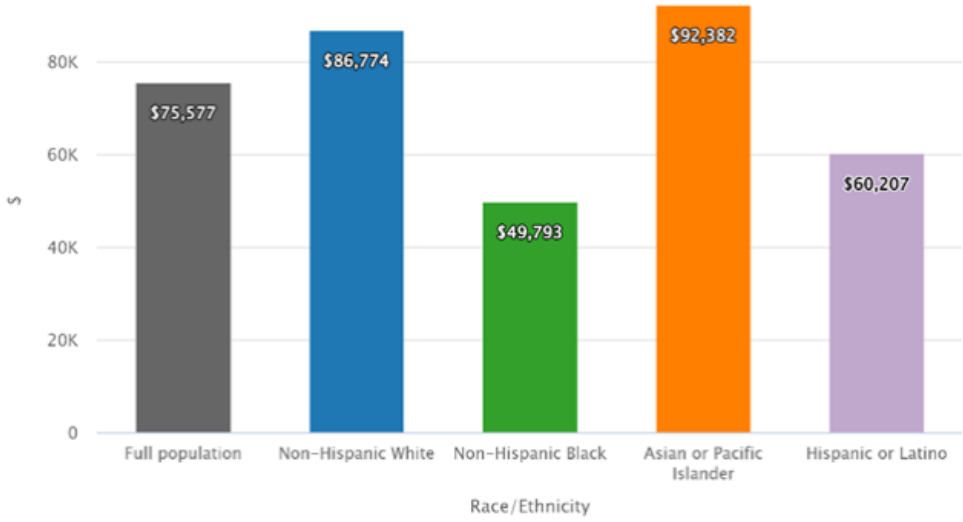
## 4. Economics

**Income**

**Median household income**

The median household income for the PSA is $75,577, which is higher when compared to the city of Chicago, county and state (Metopio, American Community Survey, 2022). There are significant racial and ethnic disparities within the PSA's median household income with the Asian or Pacific Islander population having the highest income of $92,382, followed by the non-Hispanic White population at $86,774. The Hispanic or Latino and Non-Hispanic Black populations had the lowest median household incomes at $60,207 and $49,793 respectively. Exhibit 11 shows the median household income by race/ethnicity. The percentage of individuals and families that live below 200 percent of the poverty level in the PSA is 30.61 percent, which is less than the city of Chicago, county and slightly higher when compared to the state.

**Exhibit 11: Advocate Illinois Masonic PSA Median Household Income by Race/Ethnicity 2015-2019**

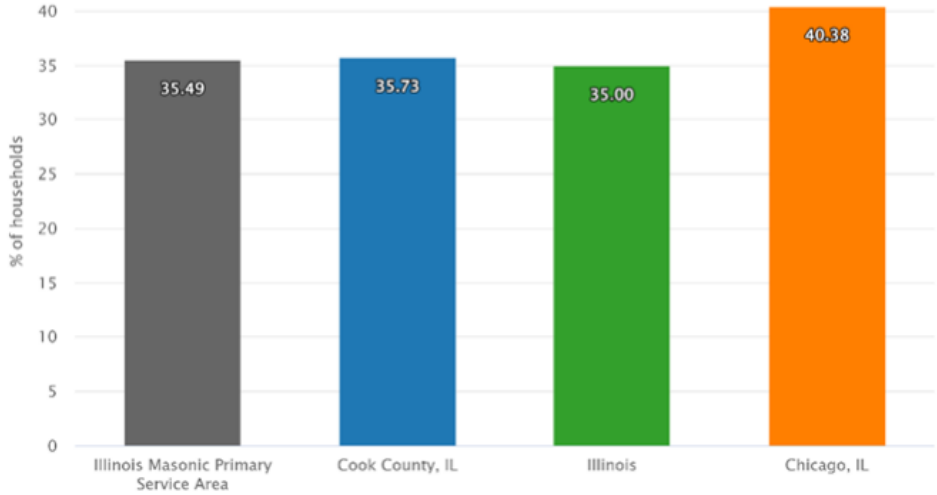



Source: Metopio, American Community Survey, 2022

According to United Way, ALICE stands for Asset Limited, Income Constrained, Employed. ALICE represents households who may be above the poverty line but are still unable to afford the basic necessities of housing, food, childcare, health

care and transportation due to the lack of jobs that can support basic necessities and increases in the basic cost of living. In 2018, 35.49 percent of households in the medical center's PSA were below the ALICE threshold. Exhibit 12 displays the PSA compared to the city of Chicago, county and state. The top three communities whose ALICE threshold is higher than the PSA, county, state and city of Chicago include Division Street (60651) at 57.11 percent, Rogers Park (60626) at 53.59 percent and Belmont Cragin (60639) at 50.11 percent of households, these communities also having the highest percentage of Non-Hispanic Black and Hispanic or Latino populations (Metopio, American Community Survey, 2022).

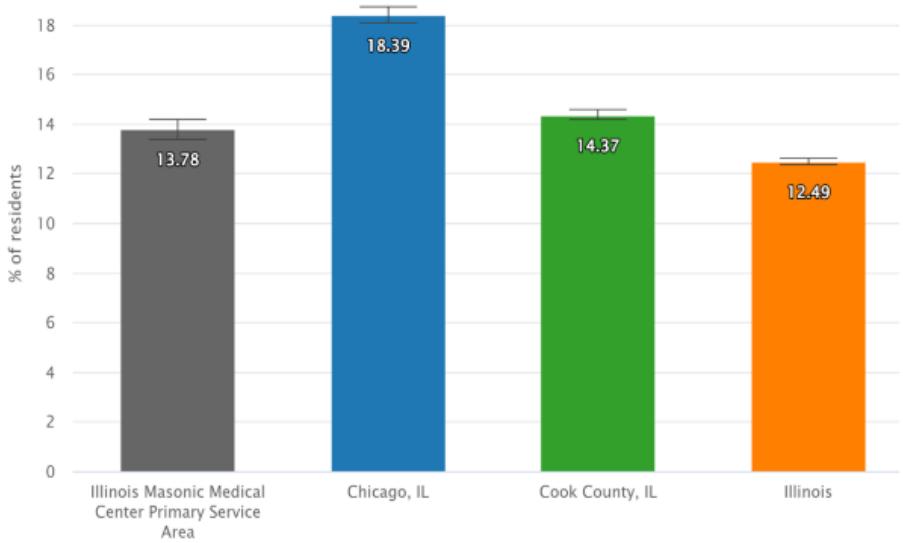
**Exhibit 12: Advocate Illinois Masonic PSA Households below ALICE Threshold 2018**




Source: Metopio, United Way ALICE Data, 2022

The poverty rate in the medical center's primary service area is 13.78 percent of residents, which is less than the city of Chicago at 18.39 percent and the county at 14.37 percent but higher than the state at 12.48 percent. There are racial and ethnic disparities with the Non-Hispanic Black and Hispanic or Latino populations having higher rates of poverty compared to the non-Hispanic White population (Metopio, American Community Survey, 2022).

**Exhibit 13: Advocate Illinois Masonic PSA Poverty Rate 2015-2019**




Source: Metopio, American Community Survey, 2022

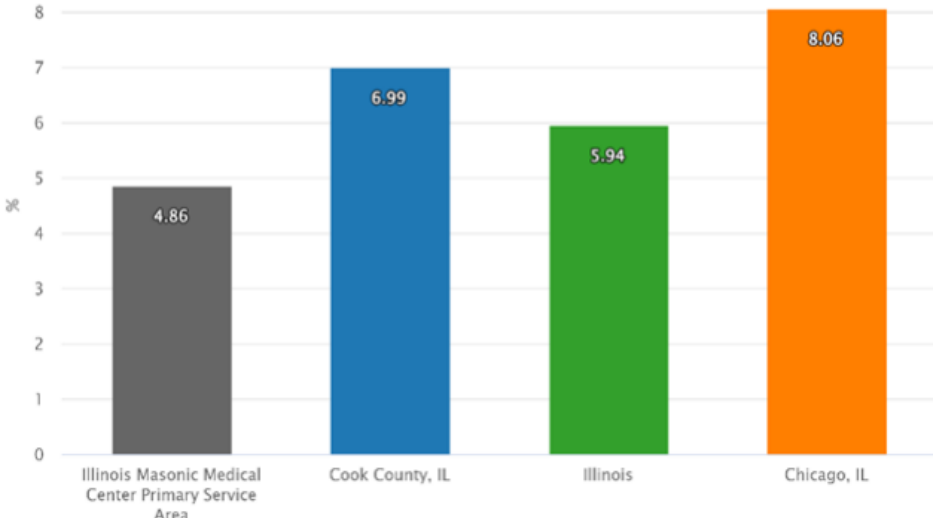
## 5. Education

**Employment and Education**

The unemployment rate in the medical center's PSA is 4.86 percent, which is lower when compared to the city of Chicago, county and state. In the PSA, 70.04 percent of residents 25 years of age and older have a college or graduate/professional degree, which is higher compared to the state at 49.45 percent of residents. Eighty-six-point eighty eight percent of residents 25 and older have a high school diploma. Adults with higher educational attainment live longer and healthier lives compared to their less educated peers. The college graduation rate in the medical center's PSA is at 48.17 percent of residents, which is higher when compared to the city of Chicago at 39.48 percent, the county at 38.81 percent and the state at 34.65 percent.

There is a racial disparity in the college graduation rate in the PSA, with the Asian or Pacific Islander population having the highest college graduation rates across the PSA at 63.91 percent of residents, followed by the Non-Hispanic White population at 60.92 percent of resident in the PSA. The Non-Hispanic Black and Hispanic or Latino populations have the lowest rates in the PSA, the city of Chicago, the county and the state (Metopio, American Community Survey, 2022). Health Exhibits 14-18 shows unemployment and educational attainment rates in the PSA.

**Exhibit 14: Advocate Illinois Masonic PSA Unemployment Rate 2015-2019**

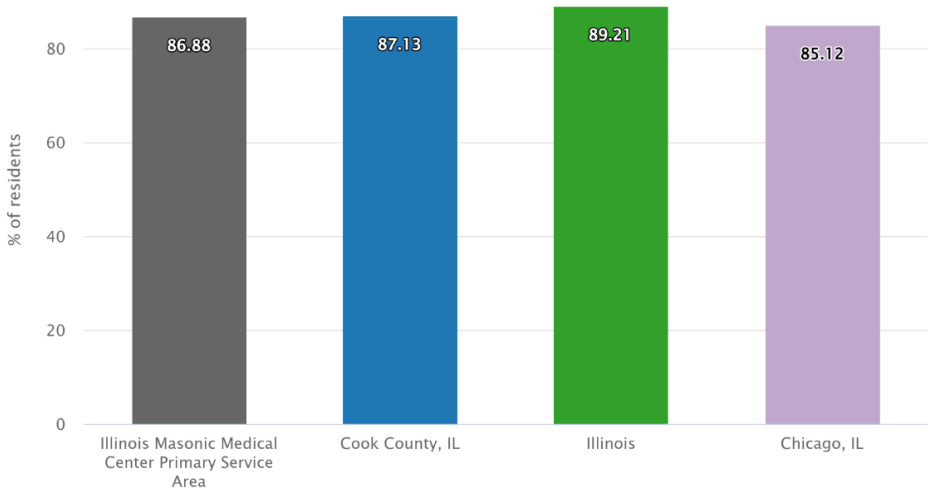



Source: Metopio, American Community Survey, 2022

**Exhibit 15: Advocate Illinois Masonic PSA Unemployment Rate BLS**

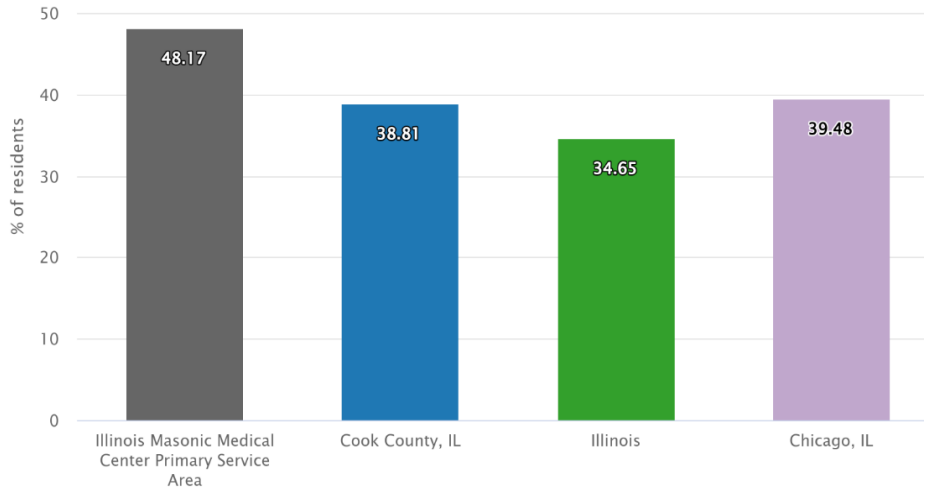
Source: Metopio, Bureau of Labor Statistics: Local Area Unemployment Statistics, 2022

**Exhibit 16: Advocate Illinois Masonic PSA High School Graduation Rate 2015-2019**



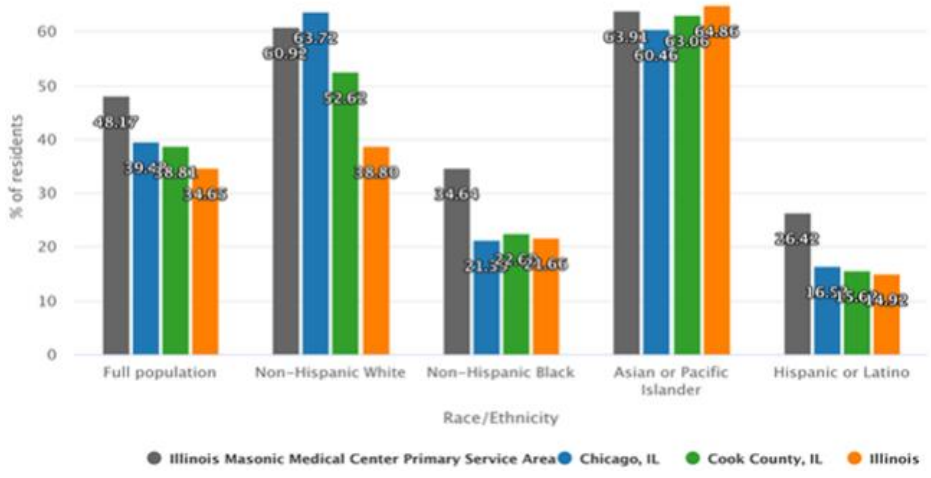

Source: Metopio, American Community Survey, 2022

**Exhibit 17: Advocate Illinois Masonic PSA College Graduation Rate 2015-2019**




Source: Metopio, American Community Survey, 2022

**Exhibit 18: Advocate Illinois Masonic PSA College Graduation Rate by Race/Ethnicity 2015-2019**




Source: Metopio, American Community Survey, 2022

### 6. Health Care Resources in the Defined Community

| Name of Facility | Type of Facility | Location |
|---|---|---|
| Chicago Lakeshore | Hospital | Chicago, IL |
| Kindred-Chicago Lakeshore | Hospital | Chicago, IL |
| Kindred-Chicago North | Hospital | Chicago, IL |
| Methodist Hospital of Chicago | Hospital | Chicago, IL |
| Norwegian American Hospital | Hospital | Chicago, IL |
| Community First Hospital | Hospital | Chicago, IL |
| Ascension Health-Saints Mary and Elizabeth | Hospital | Chicago, IL |
| Ascension Health Saint Joseph Hospital | Hospital | Chicago, IL |
| Swedish Covenant Hospital | Hospital | Chicago, IL |
| Thorek Memorial Hospital | Hospital | Chicago, IL |
| Weiss Memorial Hospital | Hospital | Chicago, IL |
| PPC Wellness | Federally Qualified Health Center | Chicago, IL |
| Prime Care | Federally Qualified Health Center | Chicago, IL |
| Erie Family Health Network | Federally Qualified Health Center | Chicago, IL |
| Near North Health Service Corporation | Federally Qualified Health Center | Chicago, IL |
| Heartland Health Centers | Federally Qualified Health Centers | Chicago, IL |
| Hamdard | Federally Qualified Health Center | Chicago, IL |
| Access Community Health Network | Federally Qualified Health Center | Chicago, IL |
| Howard Brown Health | Federally Qualified Health Center | Chicago, IL |
| Community Health | Free Clinic | Chicago, IL |
| Asian Human Services | Federally Qualified Health Center | Chicago, IL |
| Old Irving Park | Free Clinic | Chicago, IL |

## How the CHNA was Conducted

### 1. Community Health Council

The Community Health Council (CHC) is led by the community health director and is a diverse and multisectoral council comprised of the medical center and community representatives. The Council acts as an advisory body for the medical center's Community Health Department and supports data collection, data review, prioritizing identified health needs and identifying community partners to support the creation and development of the CHNA community h ealth improvement plan. The Council has 21 members of which seven are medical center representatives and 14 members representing community-based organizations. The CHC members representing vulnerable and/or diverse populations are denoted with an asterisk in the CHC member list below. For the 2022 CHNA cycle, the CHC convened several times throughout the year to conduct a comprehensive assessment process. The CHC also participated in the medical center's Forces of Change Assessment (FOCA) which is an exercise to evaluate the strengths, weaknesses, opportunities and threats of the PSA communities. CHC members were also able to share their feedback, comments and recommendations around the health needs of the medical center's PSA.

**2022 CHC Members**

- Acclivus Inc, COO *
- Casa Central, Deputy Director and Senior Community Services *

- Centro Romero, Resource Developer *
- Chicago Police Department 19th District, Officer *
- Chicago Public Health Department, Senior Analyst *
- Community Health, Executive Director *
- Heartland Health Centers, VP Strategy and Development *
- Howard Brown, Director, Data, Evaluation and Epidemiology *
- NAMI Chicago, Chief Integration Officer *
- Northeastern Illinois University, Coordinator, Health Sciences Field Experience Program
- Nourishing Hope, Chief Program Officer *
- Advocate Illinois Masonic, Director, Business Development
- Advocate Illinois Masonic, Director, Transition Support Program
- Advocate Illinois Masonic, Faith Community Nurse
- Advocate Illinois Masonic, Medical Social Worker *
- Advocate Illinois Masonic, Manager, Mission and Spiritual Care
- Advocate Illinois Masonic, Supervisor, Food and Nutrition

**The Alliance for Health Equity**
The Alliance for Health Equity is a coalition of Cook County non-profit and public hospitals, health departments and community-based organizations. The coalition is led by a steering committee of which Advocate Aurora is a member and receives backbone support from the Illinois Public Health Institute (IPHI). IPHI serves as the backbone organization for the collaborative and the hospitals provide funding for the shared assessment and the development of the community health improvement plan.

The Alliance aims to complete a tri-annual comprehensive collaborative CHNA and to develop aligned community health improvement plans. The Alliance is one of the largest CHNA and community health improvement coalitions in the nation. In addition to over 30 non-profit and public hospitals and seven local health departments, more than 100 community organizations participated in the 2022 assessment and health improvement action teams.

The Alliance created and distributed health surveys throughout Cook County, with a focus to survey at risk and ethnically diverse communities. Over 5,000 surveys were completed, providing a picture of community concerns, strengths and health needs through the lens of community members. Primary and secondary data gathering also included multiple focus groups and hospital utilization data, which was analyzed by IPHI staff. IPHI completed The Alliance's CHNA in August 2022.

## 2. Purpose and Process

In August 2021, the medical center's Community Health Department organized a FOCA, which includes questions such as "what is occurring or might occur that affects the well-being of our residents or the local system?" and "what specific threats and opportunities are generated by these occurrences?". The medical center's CHC, additional community organizations and leaders, as well as local municipal representatives were invited to attend the FOCA to provide valuable feedback and insight on the medical center's PSA health needs, social issues, community strengths and opportunities. This primary qualitative data collected from the FOCA was analyzed and utilized to help identify the PSA's health and socioeconomic needs. Key findings and themes were reported back to the CHC.

In January and February 2022, the medical center's Community Health Department presented demographic and socioeconomic data along with the top nine health needs for the PSA to the CHC. Using qualitative and quantitative data from various sources, the community health team selected and considered health issues as a PSA health need if they met one or more of the following: rates have increased over time, rates of the health issue were higher in the PSA

compared to other geographies and health disparities within the rates of the respective health issue. In addition, the medical center partnered with the Alliance for Health Equity to present social determinant of health data for the PSA.

After a thorough review and analysis of the nine health needs, the CHC utilized a prioritization grid (Appendix 1) to narrow down the nine health needs to the top four. The community health team reviewed and aggregated prioritization grid scores to determine the top four health issues with the highest scores.

After identifying Access to Care, Substance Use, Mental Health and Health and nutrition as the top four health issues, community experts provided a presentation around the barriers and challenges in addressing the health issue, root causes of the health issue and organizations that are working to address the health need in the community. Expert presentations were provided by Community Health— a free clinic in Chicago, the National Alliance on Mental Illness Chicago (NAMI Chicago), Gateway Foundation and Benedictine University School of Public Health. After expert presentations and thorough discussion, CHC members voted on the top and final two health need priorities for the 2022 CHNA.

**Partnership**
The medical center partnered with a diverse group of community-based organizations to conduct the FOCA. The group convened a meeting to discuss the social, economic and health issues/strengths of the medical center's PSA. Various sectors and racial and ethnically diverse community representatives attended the meeting and provided crucial feedback and perspectives on some the community health needs and concerns. Information collected from the FOCA was analyzed and included in the review of the top PSA health needs and prioritization process. Appendix 1 summarizes data collected from the FOCA.

As indicated in the sections above, the medical center also partnered with the Alliance for Health Equity to collect primary qualitative data and present PSA social determinant of health data to the medical center's PSA. The medical center's community health team will also partner with the Alliance for Health Equity to use primary qualitative survey data to inform the Community Implementation Strategy.

## 3. Data Collection and Analysis

Multiple data collection strategies were employed to collect data for the 2022 CHNA. The medical center collaborated with many partners to collect primary and secondary qualitative and quantitative data. Details regarding data sources are listed below.

## 4. Data Sources

**Metopio—Secondary Data**
Metopio provides a web-based data platform for Advocate Aurora's nine hospitals/medical centers. The data platform offered the hospitals/medical centers 198 health and demographic indicators, including 38 hospitalization and emergency room (ER) visit indicators at the primary service area zip code levels. In addition, the platform provides a resource to support community health needs assessments and includes a focused set of community health indicators that allow users to understand what is driving health outcomes in particular neighborhoods. Utilizing the Illinois Hospital Association's COMPdata, Metopio was able to summarize, age adjust and average the hospitalization and ER data for five-time periods from 2019-2022. Metopio also provided a wealth of county and zip code data comparison and data from the American Community Survey. Metopio was a key source for data for the 2022 CHNA. This secondary data was crucial in analyzing Advocate Illinois Masonic's PSA health needs as the database was the only source that provided such an extensive amount of data specific to the defined community. All data collected from Metopio was quantitative and included data comparison between PSA communities, the city of Chicago, Cook County and the state of Illinois. These comparisons were exemplified in the form of various graphs, which provided great insight into the health status of the medical center's PSA in comparison to other counties and communities in Illinois.

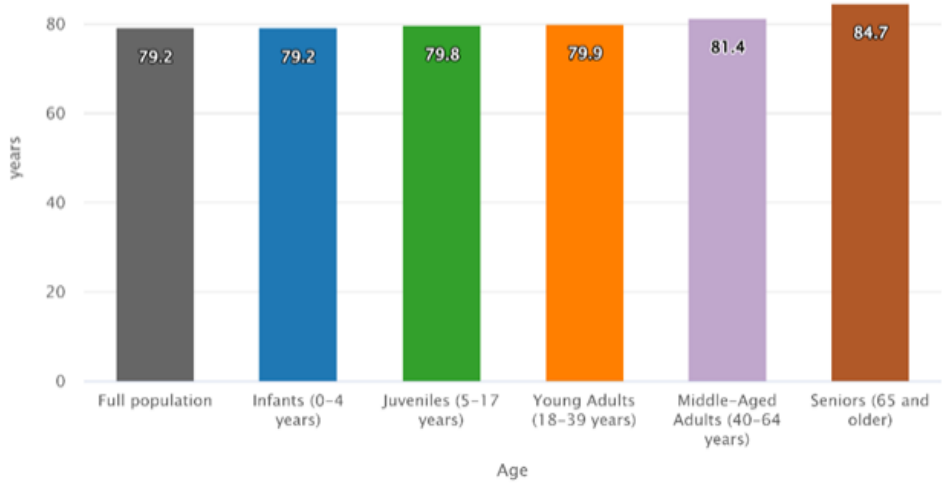
In addition to the FOCA data, primary qualitative data was collected through the Alliance for Health Equity's community survey. Advocate Illinois Masonic's Community Health Department supported the Alliance for Health Equity through community survey distribution and collection. The medical center's community health staff also assisted the Alliance for Health Equity in identifying and conducting outreach to "hard to reach" groups, such as the LGBTQ and undocumented immigrant populations. The survey data will also be used to inform the medical center's Community Implementation Strategy.

## Summary of CHNA Findings

### 1. Overall Health Status

Exhibit 19 displays the PSA's life expectancy at birth and at the start of the specified age bracket. Life expectancy in the medical center's PSA is 79.2 years. Exhibit 20 display's life expectancy by zip code. There are four communities in the medical center's PSA that have the lowest life expectancy. These are also communities with large populations of Non-Hispanic Black and Hispanic or Latino individuals and families. Communities with the lowest life expectancy include Humboldt Park (60651) with a life expectancy of 74.5 years followed by Rogers Park (60626) at 76.8 years, Belmont Cragin (60639) at 77.8 years and Uptown at 77.9 years.

**Exhibit 19: Advocate Illinois Masonic PSA Life Expectancy by Age, 2010-2015**




Source: Metopio, Center for Urban Population Health, 2022

**Exhibit 20: Advocate Illinois Masonic PSA Life Expectancy 2010-2015**

| Community | Zip Code | Life Expectancy |
|---|---|---|
| Jefferson Park | 60630 | 81.2 |
| Fort Dearborn | 60610 | 81.0 |
| North Center | 60613 | 80.8 |
| Avondale/N. Center | 60618 | 80.3 |
| Lakeview | 60657 | 80.3 |
| West Ridge | 60659 | 80.1 |
| Irving Park/Portage Park | 60641 | 79.9 |
| Lincoln Park | 60614 | 79.9 |
| Ravenswood | 60625 | 79.8 |

| | | |
|---|---|---|
| Avalon Park/North | 60645 | 79.6 |
| Dunning | 60634 | 79.4 |
| Logan Square | 60647 | 79.3 |
| Wicker Park | 60622 | 79.3 |
| Rogers Park | 60660 | 79.1 |
| Wicker Park | 60642 | 79.1 |
| Elmwood Park | 60707, 60635 | 78.3 |
| Uptown | 60640 | 77.9 |
| Belmont Cragin | 60639 | 77.8 |
| Rogers Park | 60626 | 76.8 |
| Division Street (Humboldt Park) | 60651 | 74.5 |

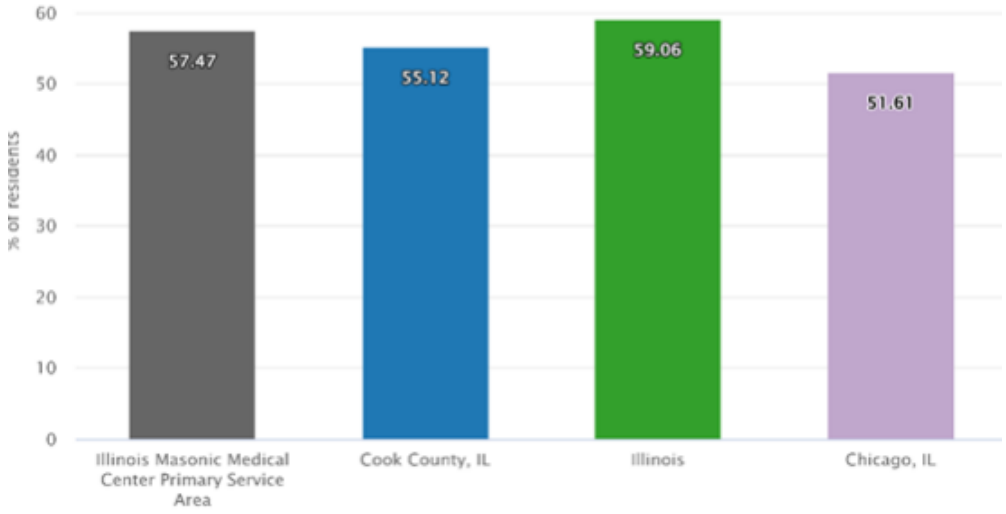
Source: Metopio, Center for Urban Population Health, 2022

## 2. Access to Care and Health Care Coverage

**Health Care Coverage**

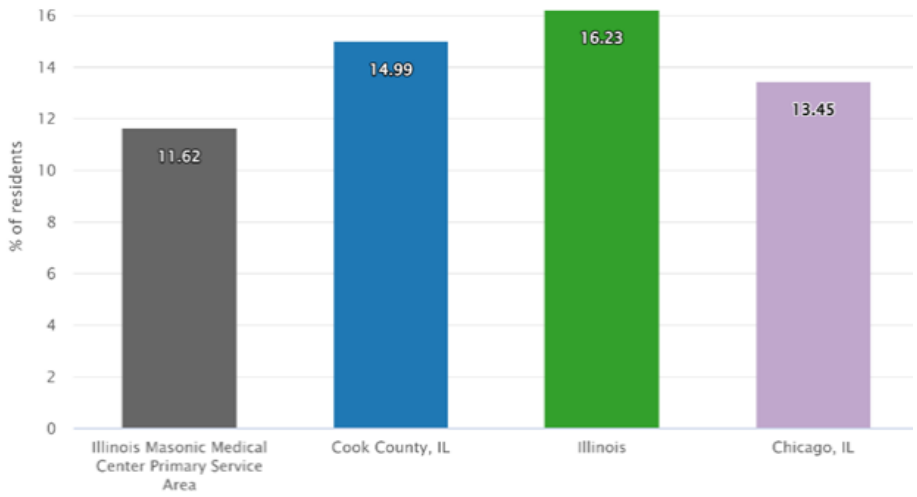
Access to comprehensive, quality health care services---including having insurance, local care options (in your community) and a primary care physician is essential for ensuring quality of life. Health insurance coverage increases the use of preventative services, managing chronic diseases and prevents unnecessary ER visits. Lack of health insurance varies substantially by income, education, age, race and ethnicity. Approximately 57.47 percent of residents in the PSA have employment-based health insurance. Employment-based health insurance is the largest source of health insurance coverage in the PSA, followed by Medicaid at 19.67 percent and Medicare at 11.62 percent. Three communities in the medical center's PSA have the lowest percentage of residents covered by employment-based health insurance. These communities include Belmont Cragin at 39.21 percent, West Ridge at 38.25 percent and Humboldt Park at 33.77 percent. The following Exhibits 21-26 display health care coverage in comparison to the county, state and city of Chicago. These exhibits also show the uninsured rate in the PSA at 9.96 percent, highlighting the racial disparities with the Hispanic and Latino population having the highest uninsured rates at 16.23 percent, followed by the Non-Hispanic Black population at 8.94 percent and then the Asian or Pacific Islander population at 8.32 percent. Belmont Cragin (60639), Humboldt Park (60651), and Irving Park/Portage (60641) have the highest percent of residents who are uninsured.

**Exhibit 21: Advocate Illinois Masonic PSA Employment-Based Health Insurance 2015-2019**



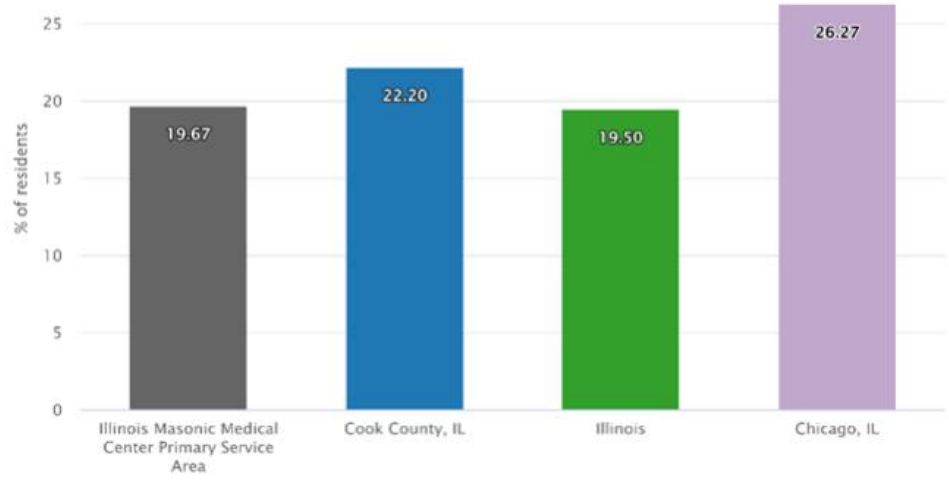

Source: Metopio, American Community Survey, 2022

**Exhibit 22: Advocate Illinois Masonic PSA Medicare Coverage 2015-2019**



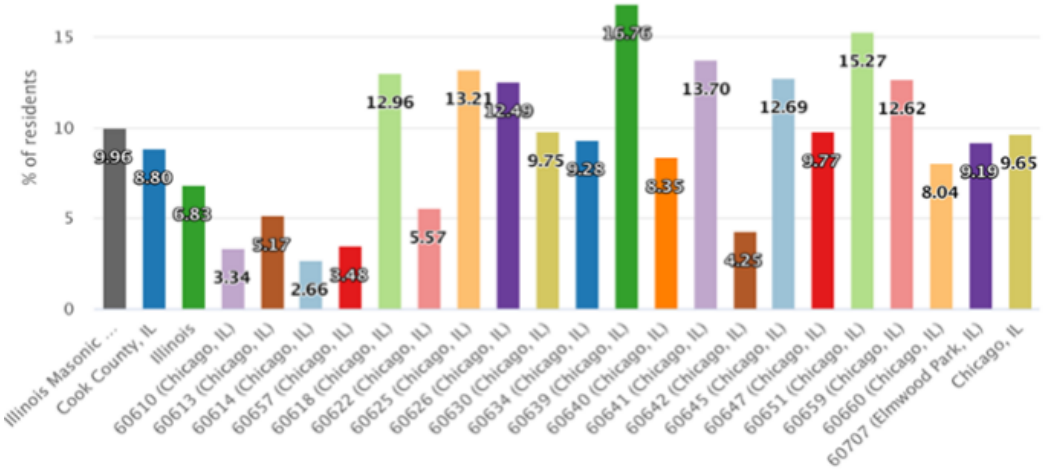

Source: Metopio, American Community Survey, 2022

**Exhibit 23: Advocate Illinois Masonic PSA Medicaid Coverage 2015-2019**



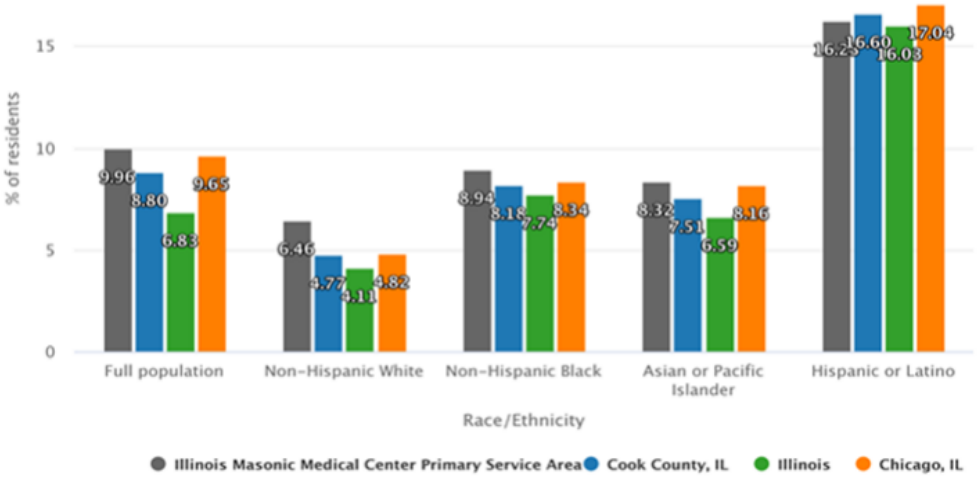

Source: Metopio, American Community Survey, 2022

**Exhibit 24: Advocate Illinois Masonic Uninsured Rate by PSA Zip Codes 2015-2019**



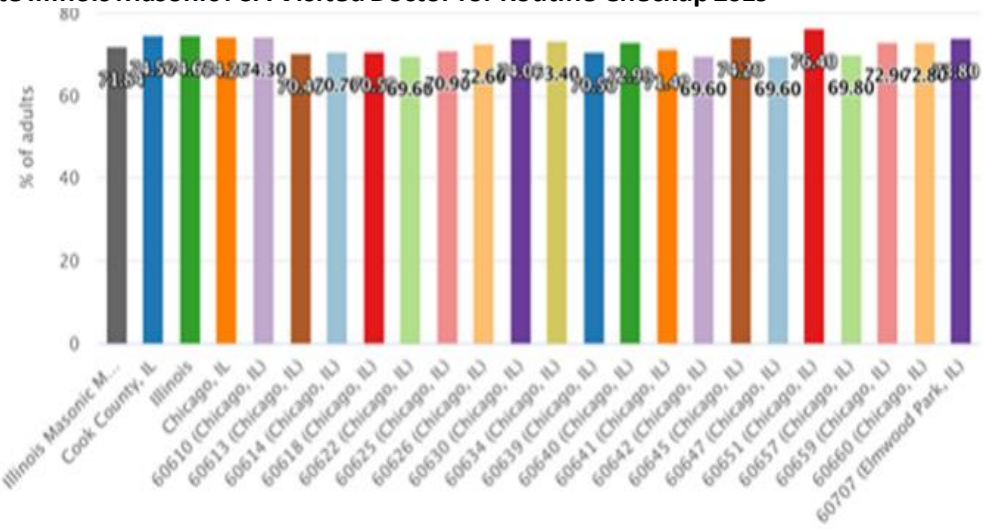

Source: Metopio, American Community Survey, 2022

**Exhibit 25: Advocate Illinois Masonic PSA Uninsured Rate by Race/Ethnicity 2015-2019**




Source: Metopio, American Community Survey, 2022

**Exhibit 26: Advocate Illinois Masonic PSA Visited Doctor for Routine Checkup 2019**




Source: Metopio, Behavioral Risk Factor Surveillance System, 2022

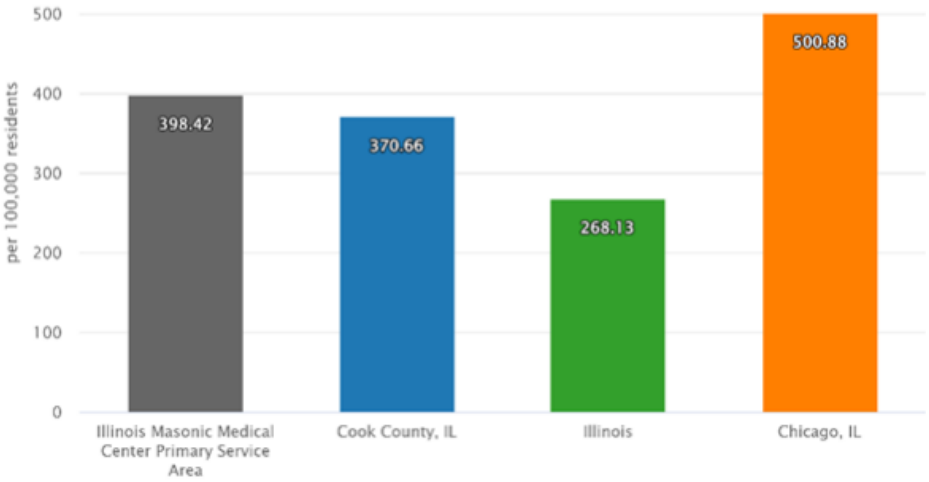
## 3. Health Risk Behaviors

**Substance and Alcohol Use**

The hospitalization rate for substance, alcohol and opioid use continues to increase in the medical center's PSA. From 2016-2020, the substance use hospitalization rate for the PSA was 398.42 per 100,000 residents. The medical center's substance use hospitalization rate is higher than the county at 370.66 per 100,000 residents and significantly higher than the state at 268.13 per 100,000 residents. The city of Chicago's substance use hospitalization rate is 500.88 annual hospital admissions per 100,000 residents, which is higher than the PSA.

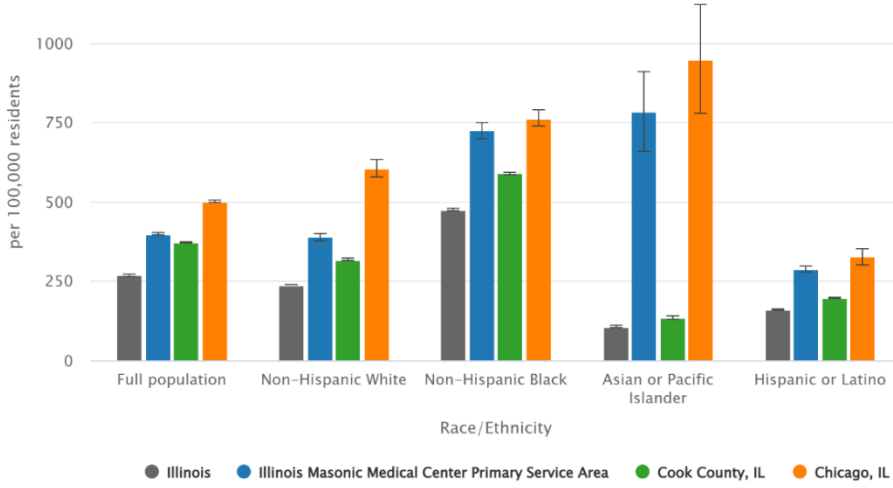
Similarly, alcohol and opioid use hospitalization rates have increased in the PSA. In 2020, the alcohol use hospitalization rate was 175.90 per 100,000 residents in the PSA, which is higher than the city of Chicago and county and significantly higher than the state. There is a racial disparity with the Non-Hispanic White population having the highest rates of hospitalization due to alcohol use (Metopio, IHA COMPdata Informatics, 2022). Exhibits 27-32 show the substance, alcohol and opioid hospitalization rates in the medical center's PSA compared to the city, county and state.

**Exhibit 27: Advocate Illinois Masonic PSA Substance Use Hospitalization Rate 2016-2020**



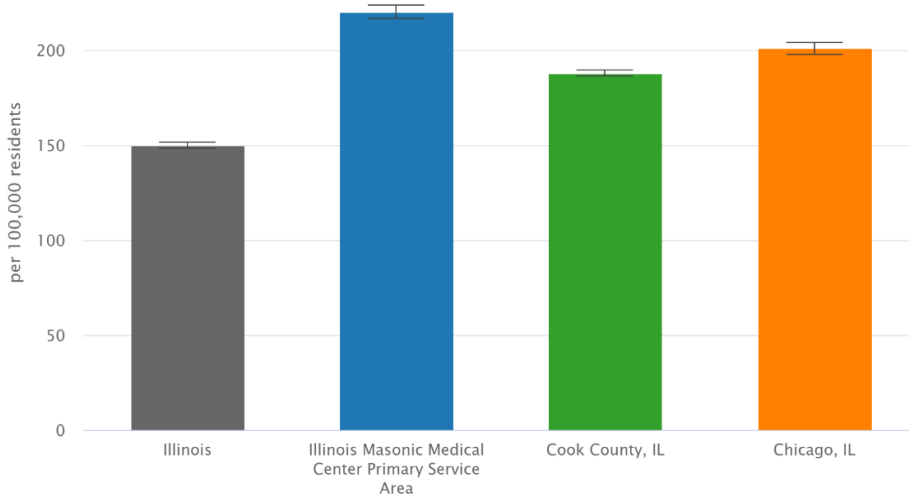

Source: Metopio, IHA COMPdata Informatics, 2022

**Exhibit 28: Advocate Illinois Masonic PSA Substance Use Hospitalization Rate by Race/Ethnicity 2016-2020**



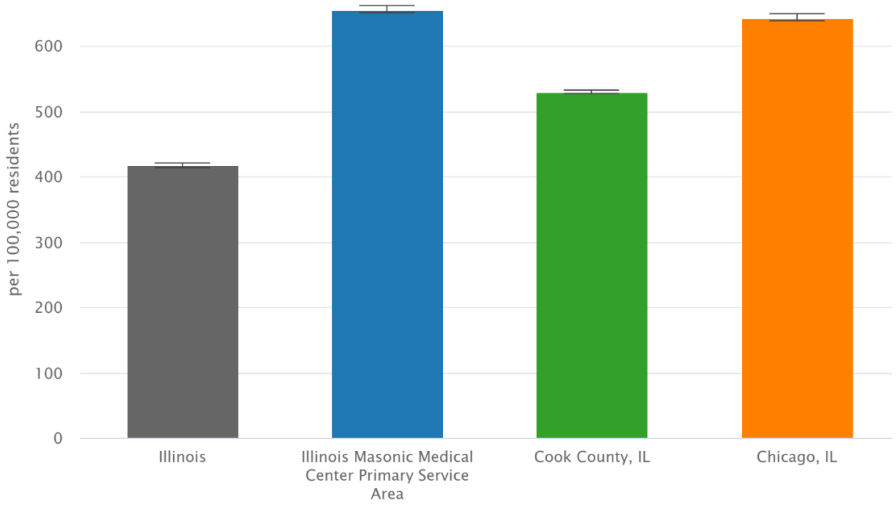

Source: Metopio, IHA COMPdata Informatics, 2022

**Exhibit 29: Advocate Illinois Masonic PSA Alcohol Use Hospitalization Rate 2016-2020**



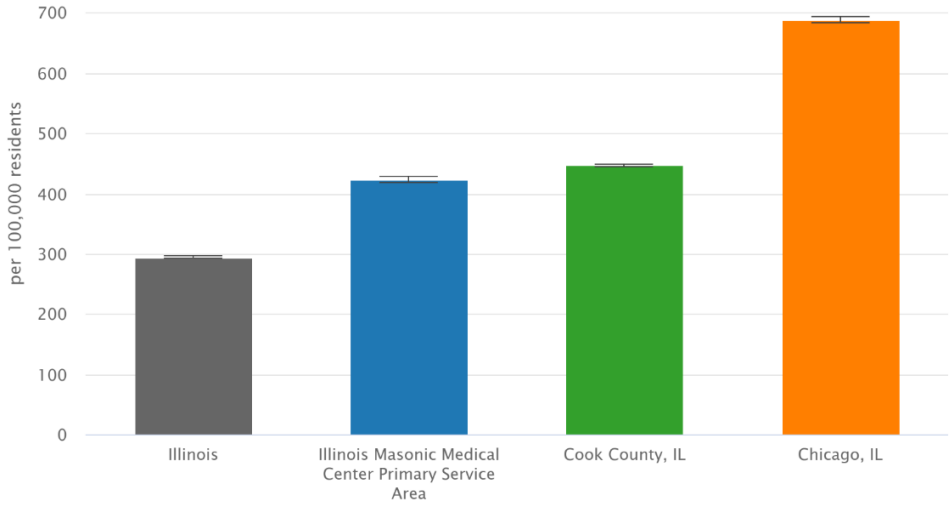

Source: Metopio, IHA COMPdata Informatics, 2022

**Exhibit 30: Advocate Illinois Masonic PSA Alcohol Use Emergency Department Visit Rate 2016-2020**



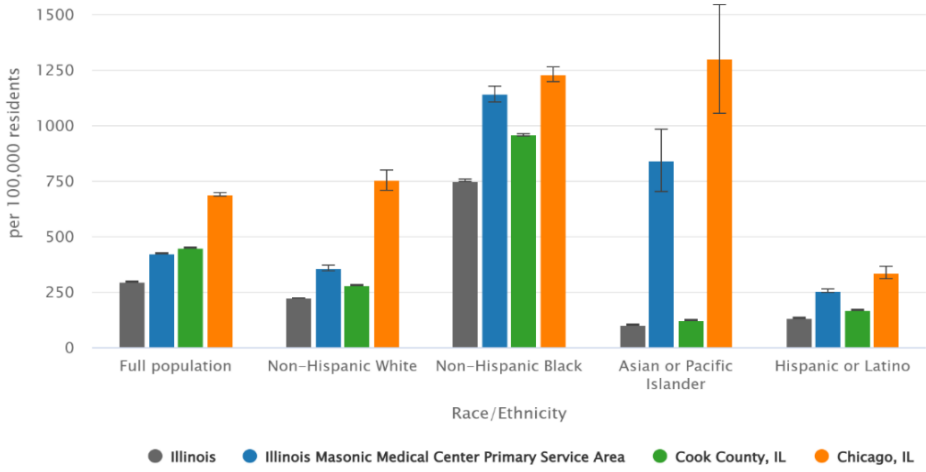

Source: Metopio, IHA COMPdata Informatics, 2022

**Exhibit 31: Advocate Illinois Masonic PSA Opioid-related Hospitalization Rate 2016-2020**




Source: Metopio, IHA COMPdata Informatics, 2022

**Exhibit 32: Advocate Illinois Masonic PSA Opioid-related Hospitalization Rate by Race/Ethnicity 2016-2020**




Source: Metopio, IHA COMPdata Informatics, 2022

**Health and Nutrition**

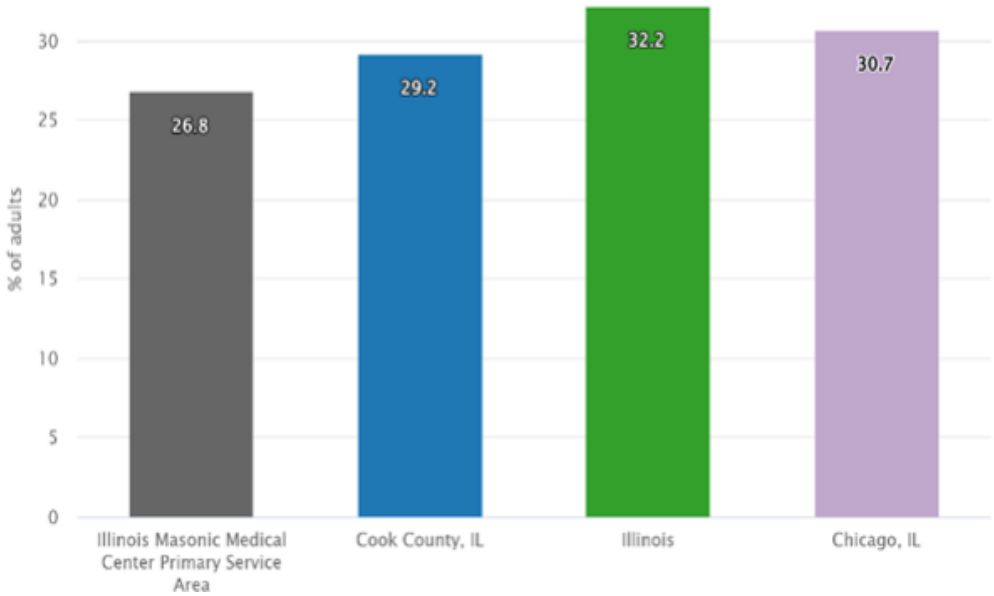
Obesity, nutrition and physical activity are strong indicators and leading causes of many preventable diseases such as diabetes, stroke, heart disease and some cancers. The availability of affordable, fresh food and safe places to be physically active affects an individuals' ability to exercise, eat a healthy diet and maintain a healthy body weight. According to the State of Obesity 2021: Better Policies for a Healthier America, systemic inequalities and socioeconomic factors contribute to higher rates of obesity among certain racial and ethnic populations. Black/African American adults had the highest level of adult obesity nationally followed by Hispanic/Latino adults. Approximately 32.4 percent of adults are obese, making Illinois the 23rd highest in obesity out of 51 U.S. states. In the PSA, 26.8 percent of adults (aged 18 and older) are obese. The PSA with the highest rates of obesity include Humboldt Park (60651) at 38.6 percent, Belmont Cragin (60639) 34.1 percent and Rogers Park (60626) at 29.6 percent. Approximately 23.1 percent of adults in the PSA reported answering "no" to the following question: "during the past month, other than your regular job, did you participate in any physical activities or exercises such as running, golf, gardening or walking for exercise".

Food insecurity, Supplemental Nutrition Assistance Program (SNAP) benefits and access to affordable fruits and vegetables are additional indicators that relate to obesity and nutrition. In 2020, the PSA's food insecurity rate was 14.5 percent, which is a four percent increase from 2018. The PSA communities with the highest rates of food insecurity include Rogers Park (60626) at 19.8 percent, West Ridge (60659) at 19.2 percent and Uptown (60640) at 18.8 percent. Exhibit 36 shows the drastic increase in food insecurity rates in the PSA.

In the PSA, 12.67 percent of households receive food stamps (SNAP), which is less than the city of Chicago at 18.26 percent and Cook County at 14.57 percent and almost equivalent to the state at 12.76 percent. The Non-Hispanic Black, Hispanic or Latino and the Asian or Pacific Islander populations have the highest percentage of households receiving SNAP benefits.

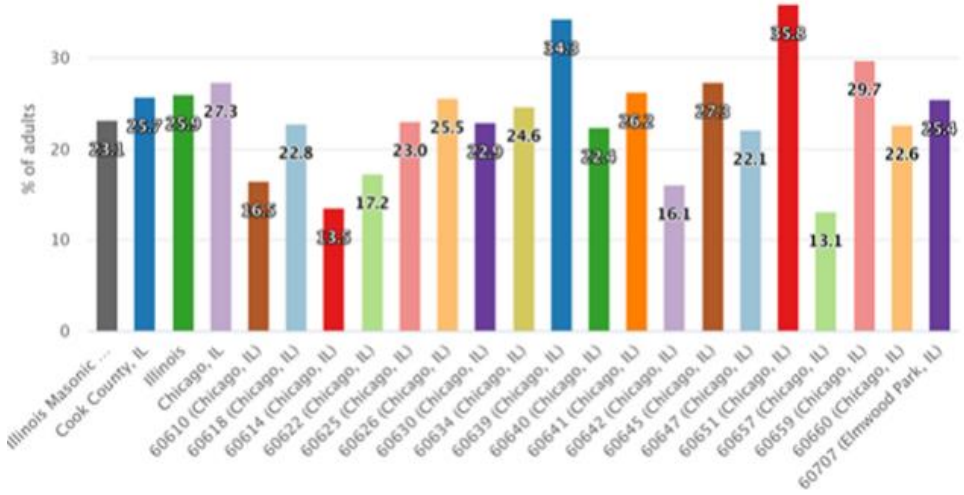
Insufficient sleep is associated with numerous chronic diseases and conditions, such as diabetes, cardiovascular disease, hypertension, obesity and depression. Insufficient sleep is also associated with the onset of these conditions and poses important implications for their management and outcomes. In the PSA, 34.67 percent of adults sleep less than seven hours a night, which is almost equivalent to Illinois at 34.96 percent.

**Exhibit 33: Advocate Illinois Masonic PSA Obesity 2019**



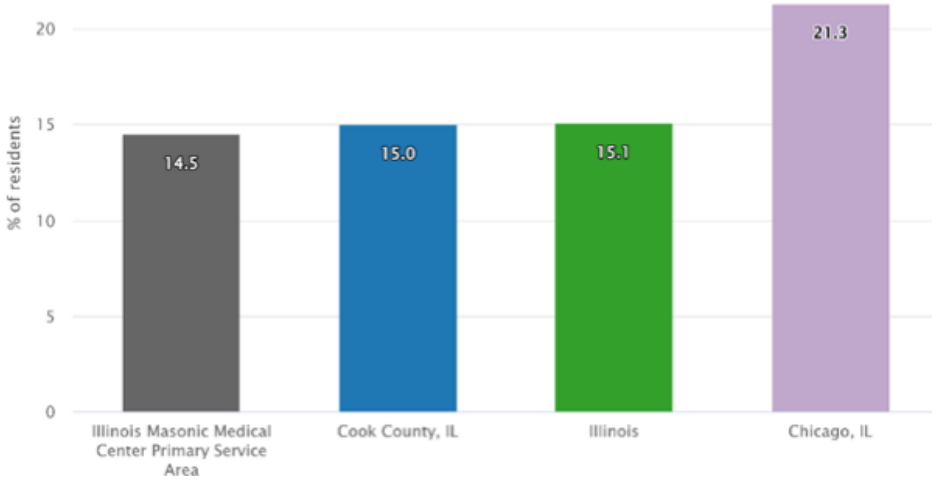

Source: Metopio, Behavioral Risk Factor Surveillance System, 2022

**Exhibit 34: Advocate Illinois Masonic PSA No Exercise 2019**



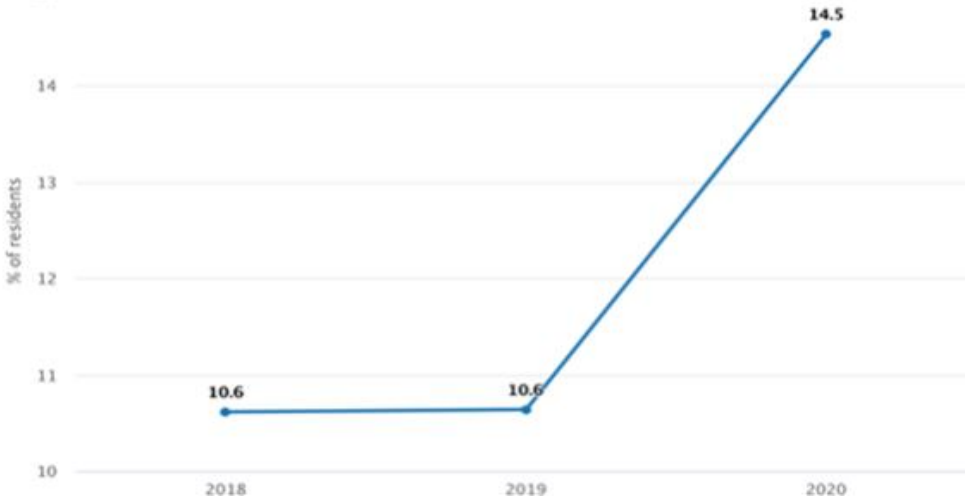

Source: Metopio, Behavioral Risk Factor Surveillance System, 2022

**Exhibit 35: Advocate Illinois Masonic PSA Food Insecurity 2020**



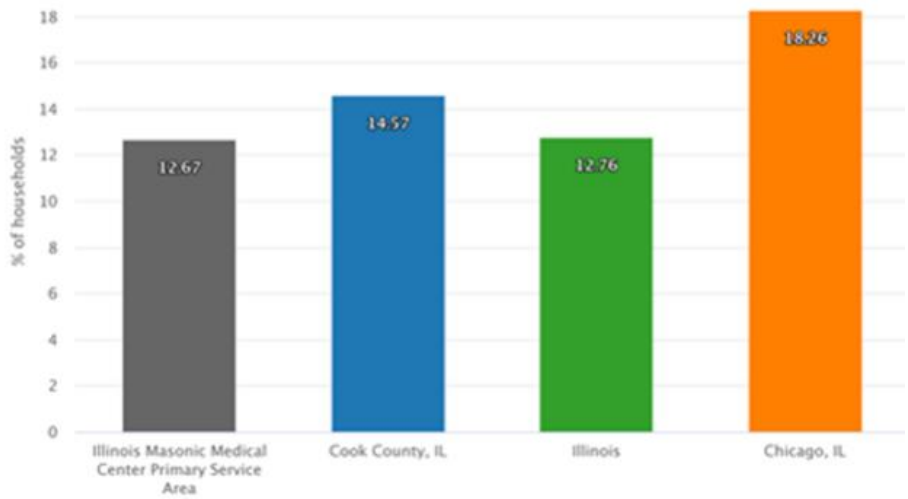

Source: Metopio, Feeding America, 2022

**Exhibit 36: Advocate Illinois Masonic PSA Food Insecurity 2020**



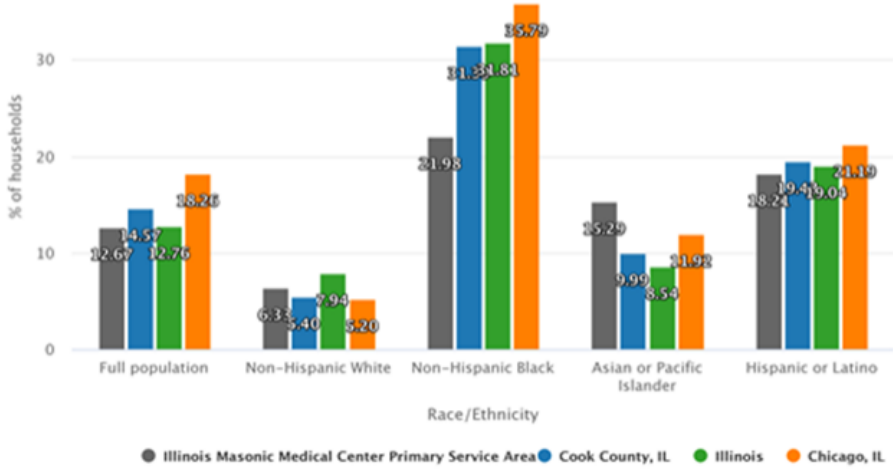

Source: Metopio, Feeding America, 2022

**Exhibit 37: Advocate Illinois Masonic PSA Food Stamp (SNAP) 2019**



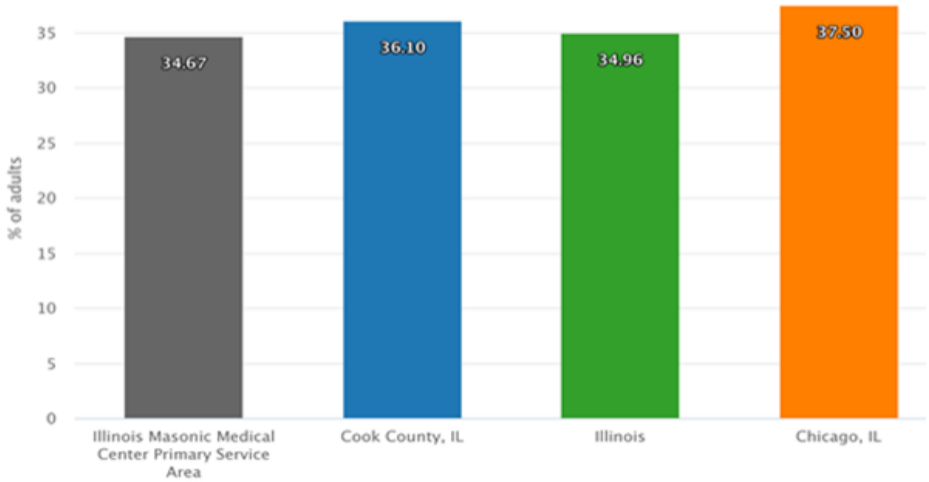

Source: Metopio, American Community Survey, 2022

**Exhibit 38: Advocate Illinois Masonic PSA Food Stamp (SNAP) by Race/Ethnicity 2019**




Source: Metopio, American Community Survey, 2022

**Exhibit 39: Advocate Illinois Masonic PSA Sleeping Less than 7 Hours 2018**



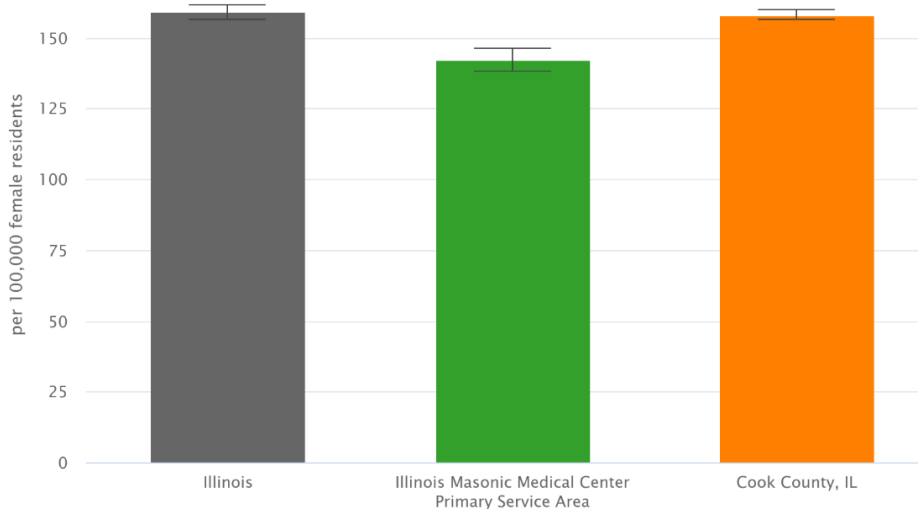

Source: Metopio, American Community Survey, 2022

## 4. Disease and Chronic Conditions

**Cancer**

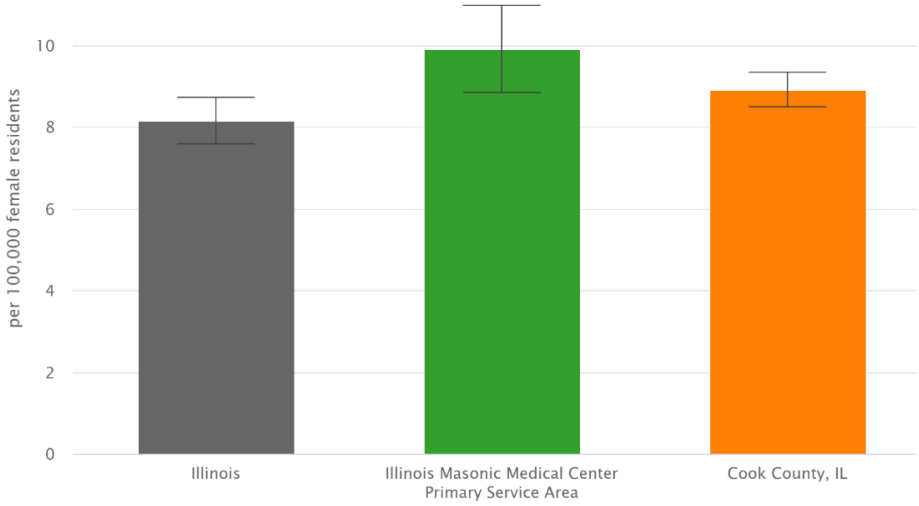
Cancer was identified as a health need for the PSA due to the severity of the disease and high incidence and prevalence rates. The invasive breast cancer diagnosis rate was 142.23 per 100,000 female residents, which is slightly lower than Cook County at 158.14 and the state at 159.20 per 100,000 female residents. The cervical cancer diagnosis rate is 9.91 per 100,000 female residents, which is higher than the county at 8.91 and noticeably higher than the state at 8.14 per 100,000 female residents. Compared to the invasive breast cancer diagnosis rate, young adults 18-39 years have higher rates of cervical cancer in the PSA. Colorectal cancer rates in the PSA are at 59.91 per 100,000 residents, which is higher when compared to the county and the state. In addition, colorectal rates are highest in seniors aged 65 and older when compared to other age groups in the medical center's PSA. The PSA has slightly higher rates of lung cancer compared to the county and state. The medical center's PSA males have higher rates of lung cancer compared to females, which is consistent across the county and state. Leukemia and lymphoma diagnosis rates in the PSA are higher compared to the county and state. The leukemia and lymphoma diagnosis rate in the PSA is 44.33, the county is at 39.47 and the state is at 40.27 percent per 100,000 residents. Exhibits 40-45 display graphs of cancer diagnosis rates in the PSA.

**Exhibit 40: Advocate Illinois Masonic PSA Invasive Breast Cancer Diagnosis Rate 2014-2018**



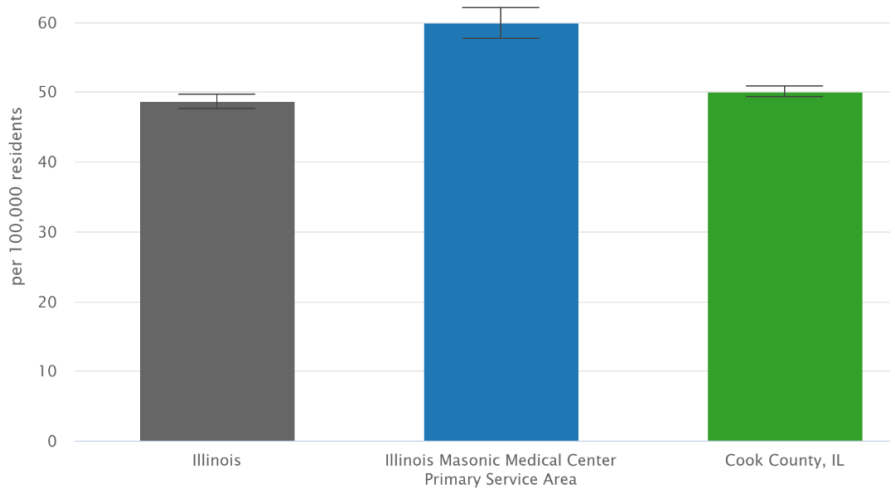

Source: Metopio, National Cancer Institute, 2022

**Exhibit 41: Advocate Illinois Masonic PSA Cervical Cancer Diagnosis Rate 2014-2018**



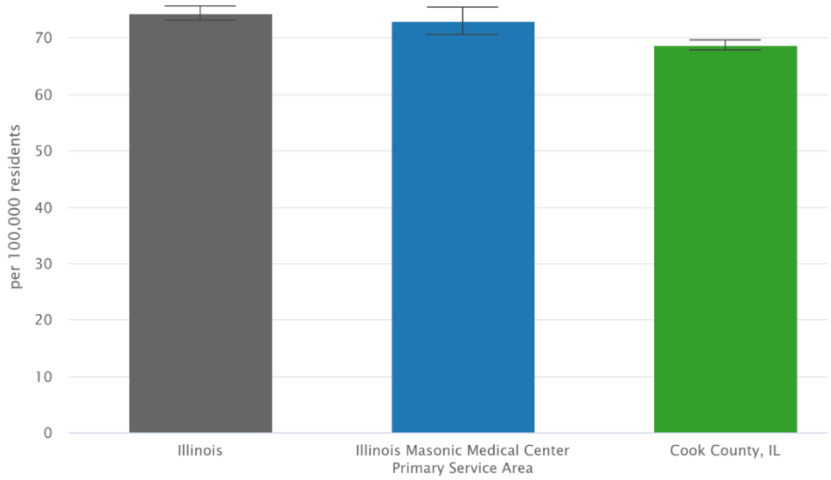

Source: Metopio, National Cancer Institute, 2022

**Exhibit 42: Advocate Illinois Masonic PSA Colorectal Cancer Diagnosis Rate 2014-2018**



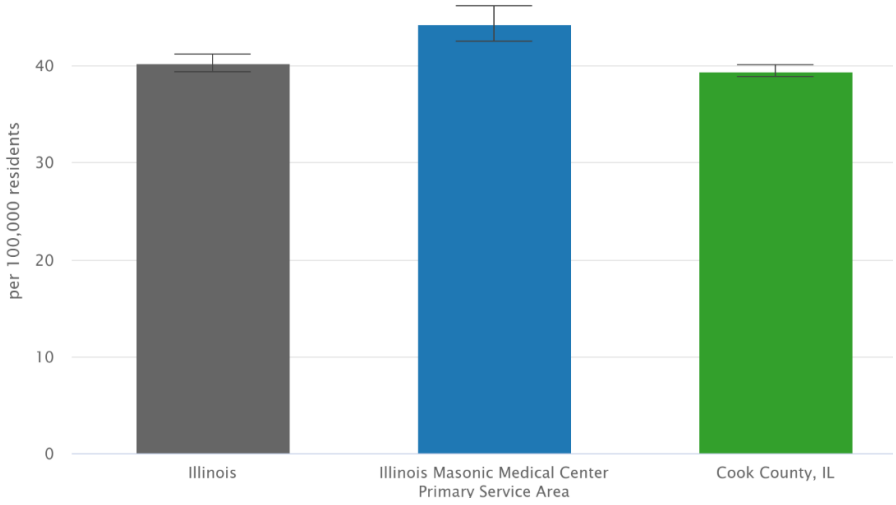

Source: Metopio, National Cancer Institute, 2022

**Exhibit 43: Advocate Illinois Masonic PSA Lung Cancer Diagnosis Rate 2014-2018**



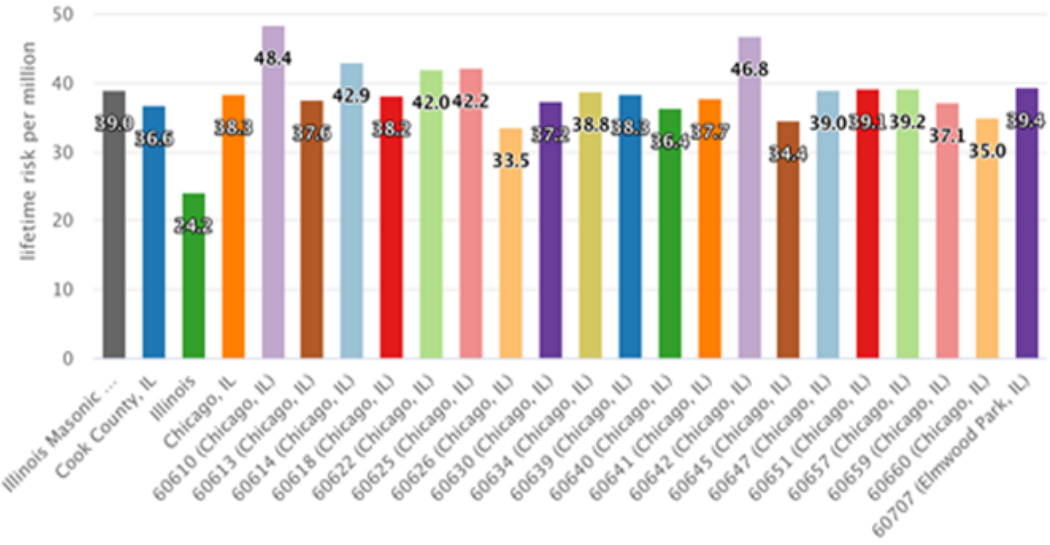

Source: Metopio, National Cancer Institute, 2022

**Exhibit 44: Advocate Illinois Masonic PSA Leukemia and Lymphoma Diagnosis Rate 2014-2018**




Source: Metopio, National Cancer Institute, 2022

**Exhibit 45: Advocate Illinois Masonic PSA Lifetime Inhalation Cancer Risk 2020**



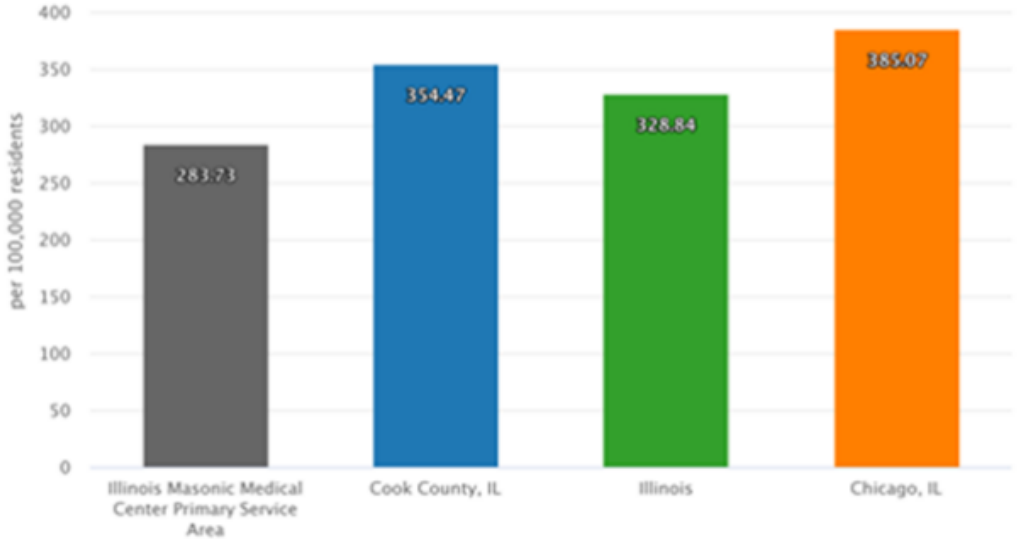

Source: Metopio, Environmental Protection Agency, 2022

**Heart Disease**

Cardiovascular disease (CVD) a group of heart and blood vessel disorders, are the number one cause of death and disability globally. Hypertension or high blood pressure is a leading risk factor for CVD and causes over 10 million deaths worldwide. In addition, heart disease is the leading cause of death for men, women, and people of most racial and ethnic groups in the United States.

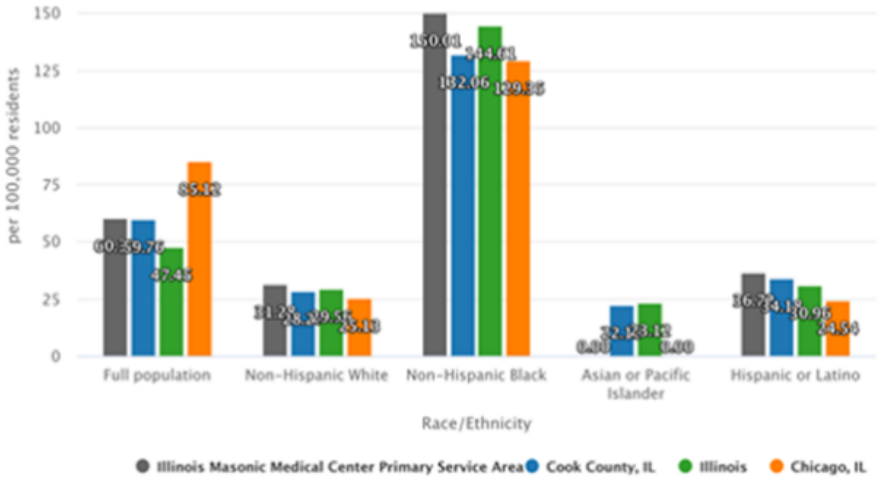
The PSA hypertension emergency department visit rate is 238.73 per 100,000 residents, which is lower than Chicago at 385.07, the county at 354.74 and the state at 328.84 per 100,000 residents. The PSA hospitalization rate due to heart failure is 424.57 per 100,000 residents, which is lower than Chicago at 616.47, the county at 489.06 but higher than the state at 408.17 per 100,000 residents. Racial and ethnic disparities continue to be prevalent with the Non-Hispanic Black population having the highest rates across the PSA, county and state.

**Exhibit 46 Advocate Illinois Masonic PSA Hypertension Emergency Department Visit Rate 2020**



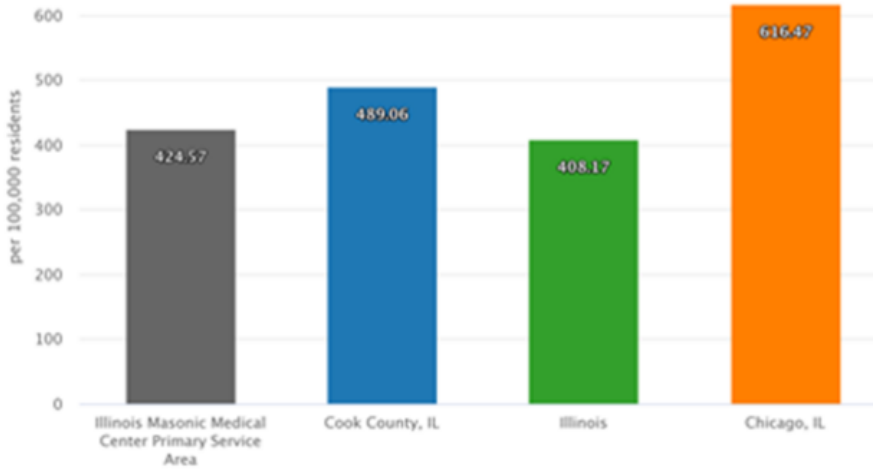

Source: Metopio, IHA COMPdata Informatics, 2022

**Exhibit 47: Advocate Illinois Masonic PSA Hypertension Hospitalization Rate by Race/Ethnicity 2020**



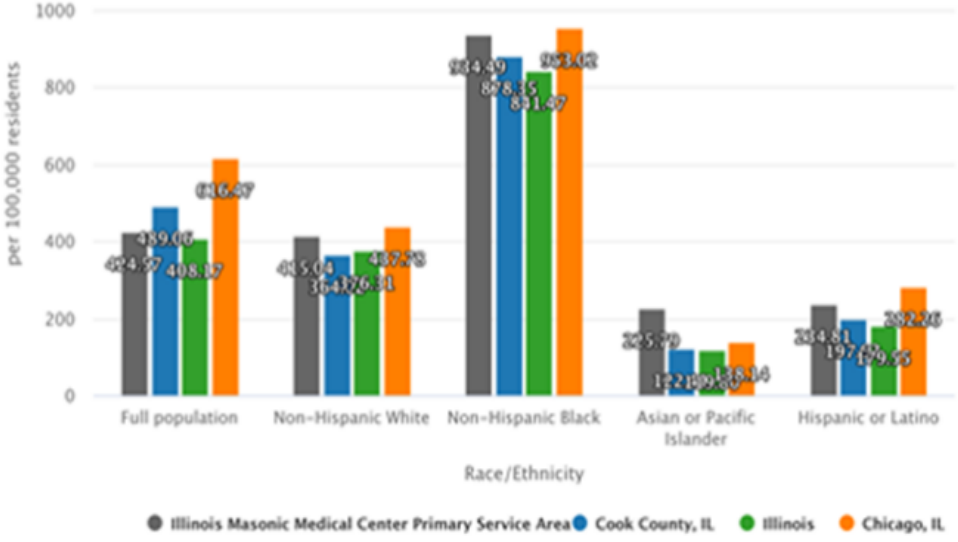

Source: Metopio, IHA COMPData Informatics, 2022

**Exhibit 48: Advocate Illinois Masonic PSA Heart Failure Hospitalization Rate 2020**




Source: Metopio, IHA COMPData Informatics, 2022

**Exhibit 49: Advocate Illinois Masonic PSA Heart Failure Hospitalization Rate by Race/Ethnicity 2020**




Source: Metopio, IHA COMPdata Informatics, 2022

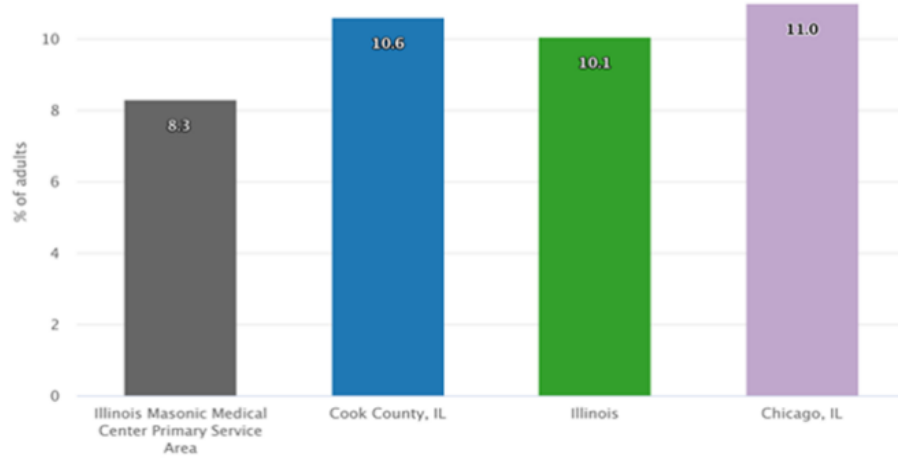
**Diabetes**

In Illinois, approximately 1.3 million adults have diabetes, but roughly 341,000 of these individuals do not know they have diabetes. It is estimated that 84 million Americans have prediabetes, of which 3.6 million live in Illinois. Diabetes is the seventh leading cause of death nationally and in Illinois, according to the Illinois Department of Public Health. Individuals with diabetes are at an increased risk for health disease, stroke, blindness, kidney failure, dental disease and lower extremity amputations. Diabetes and its complications occur among all ages, racial and ethnic groups.

In the PSA, 8.3 percent of residents in the medical center's PSA are diagnosed with diabetes. Diagnosed diabetes is most prevalent in Humboldt Park (60651), Belmont Cragin (60639), and West Ridge (60659), with rates that are significantly higher than the overall PSA, county, state and city of Chicago. The type 2 diabetes hospitalization rate in the PSA is at 192.64 per 100,000 residents, which is lower than Chicago at 269.72 and Cook County at 204.23 but higher than the state at 164.20 per 100,000 residents.

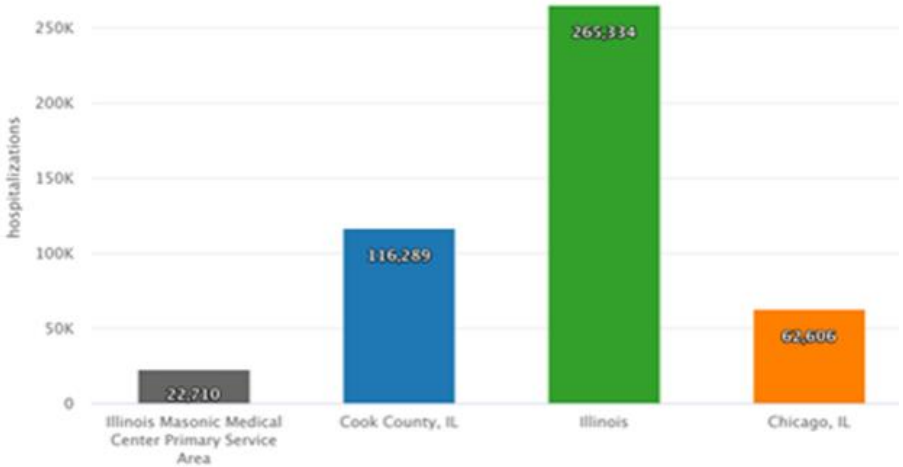
The uncontrolled diabetes hospitalizations are highest in the city of Chicago with a rate of 72.01 per 100,000 residents. In the medical center's PSA, the uncontrolled diabetes hospitalizations rate is 47.57 per 100,000 residents which is less than Cook County at 50.41 but more than the state at 39.02 per 100,000 residents. Non-Hispanic Blacks have the highest rates of type 2 diabetes and uncontrolled diabetes hospitalization rates across the PSA, county, state and city of Chicago, again highlighting racial and ethnic disparities.

**Exhibit 50: Advocate Illinois Masonic PSA Heart Failure Hospitalization Rate by Race/Ethnicity 2020**



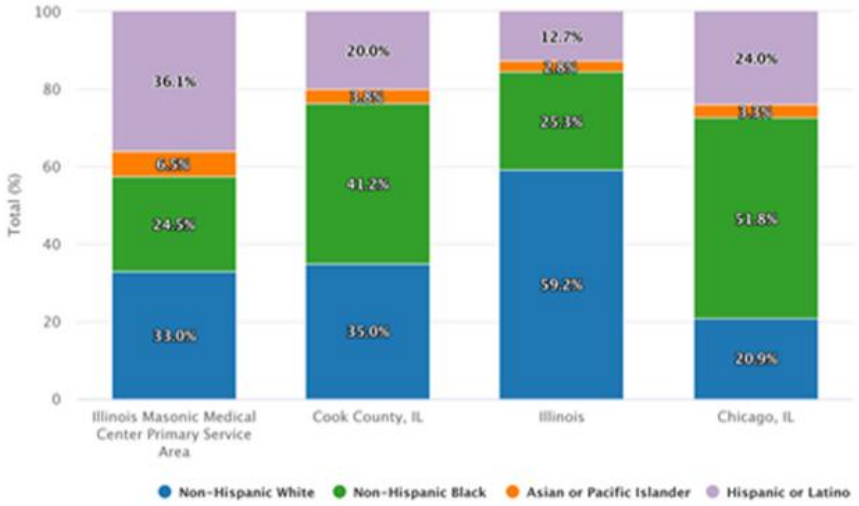

Source: Metopio, IHA COMPData Informatics, 2022

**Exhibit 51: Advocate Illinois Masonic PSA Presence of Diabetes (Hospitalizations) 2020**



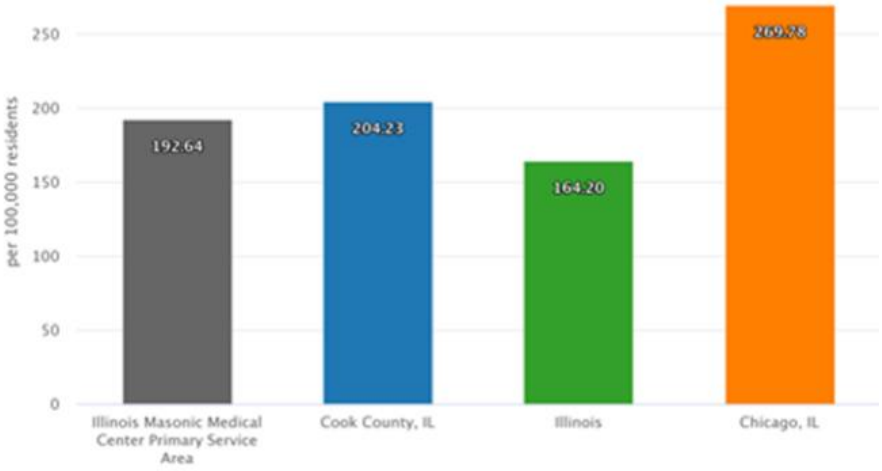

Source: Metopio, IHA COMPData Informatics, 2022

**Exhibit 52: Advocate Illinois Masonic PSA Heart Failure Hospitalization Rate by Race/Ethnicity 2020**



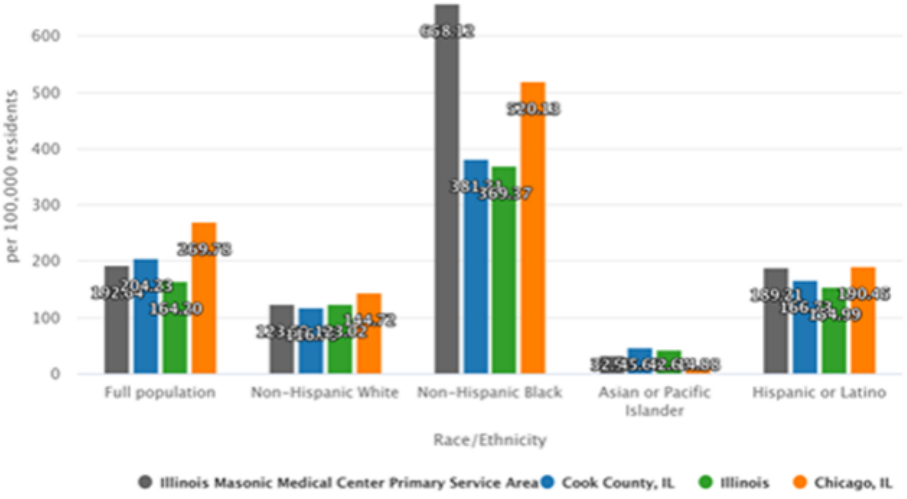

Source: Metopio, IHA COMPData Informatics, 2022

**Exhibit 53: Advocate Illinois Masonic PSA Type 2 Diabetes Hospitalization Rate 2020**



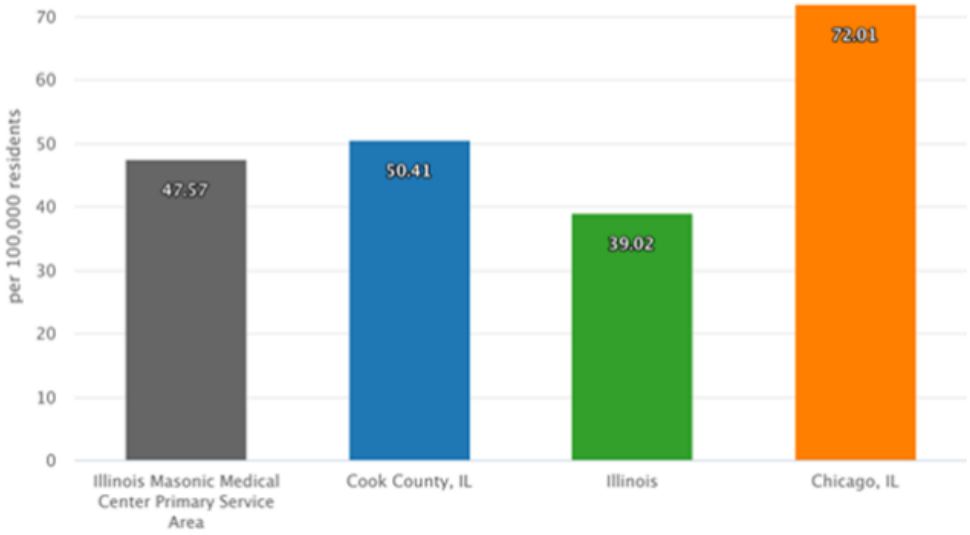

Source: Metopio, IHA COMPData Informatics, 2022

**Exhibit 54: Advocate Illinois Masonic PSA Type 2 Diabetes Hospitalization Rate by Race/Ethnicity 2020**



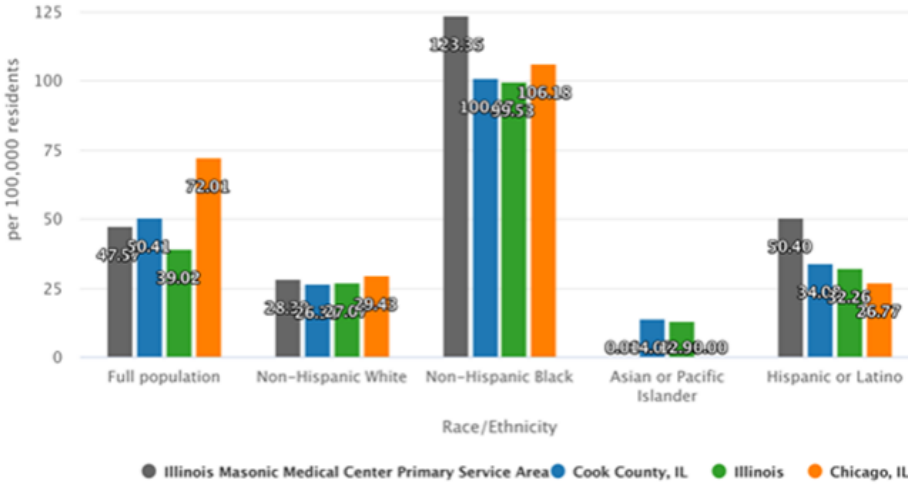

Source: Metopio, IHA COMPData Informatics, 2022

**Exhibit 55: Advocate Illinois Masonic PSA Type 2 Diabetes Hospitalization Rate 2020**




Source: Metopio, IHA COMPData Informatics, 2022

**Exhibit 56: Advocate Illinois Masonic PSA Type 2 Diabetes Hospitalization Rate by Race/Ethnicity 2020**




Source: Metopio, IHA COMPData Informatics, 2022

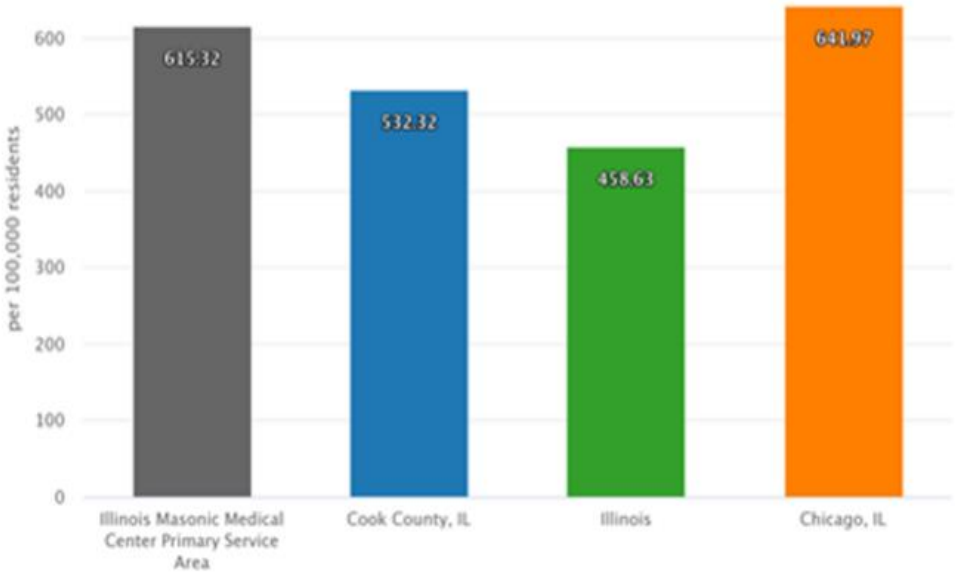
**Mental Health**

Mental health affects all areas of life and is an increasing issue across many communities in the U.S. including the medical center's PSA. It is estimated that during the pandemic, the overall mental health of the US population declined. According to research published in the Journal of Racial and Ethnic Health Disparities, given higher rates of COVID-19 infections and deaths experienced by communities of color along with greater exposure to pandemic related stressors (e.g., unemployment, food insecurity), we expect that the decline in mental health during the pandemic was more pronounced among Black, Hispanic and Asian adults, with these groups also having less access to mental health services. In addition, the Centers for Disease Control and Prevention states, some groups have disproportion ately high rates of suicide when specifically looking at race/ethnicity, sex and age groups.

In the medical center's PSA, mental health and access to mental health continues to be a barrier for individuals to live and maintain a healthy life. In the PSA, 13.44 percent of adult residents 18 and older self-reported having mental health that wat not good. The PSA's rate is higher when compared to the county at 12.90 percent and the state at 13.36 percent of adult residents. The PSA's mental health hospitalization rate is 615.32 per 100,000 residents and highest among Non-Hispanic Black and Asian or Pacific Islander populations.

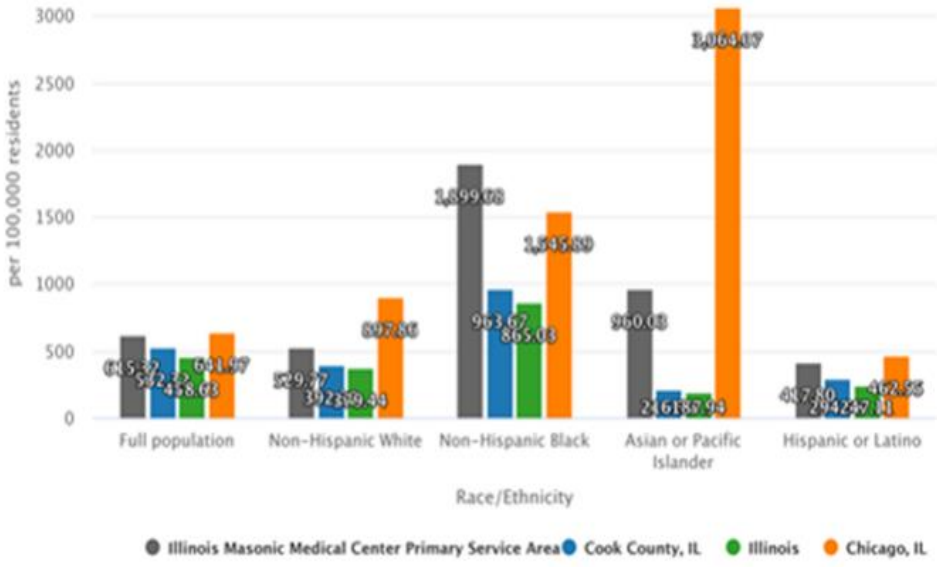
The prevalence rate of depression in the medical center's PSA is also high at 18.71 percent compared to Chicago at 18.30 percent and Cook County at 17.30 percent. Additionally, the PSA's schizophrenia hospitalization rate is high at 224.02 per 100,000 residents compared to Cook County at 172.72 per 100,000 residents and Illinois at 103.79 per 100,000 residents. Furthermore, there is a racial/ethnic disparity in schizophrenia hospitalization rates with the Non-Hispanic Black population having the highest rate for the PSA at 1,109.58 per 100,000 residents followed by the Asian or Pacific Islander population at 282.98 per 100,000 residents. The PSA racial/ethnic disparity in schizophrenia hospitalization rates is consistent with Chicago, Cook County and Illinois rates with the Non-Hispanic Black population having the highest rates.

**Exhibit 57: Advocate Illinois Masonic PSA Mental Health Hospitalization Rate 2020**



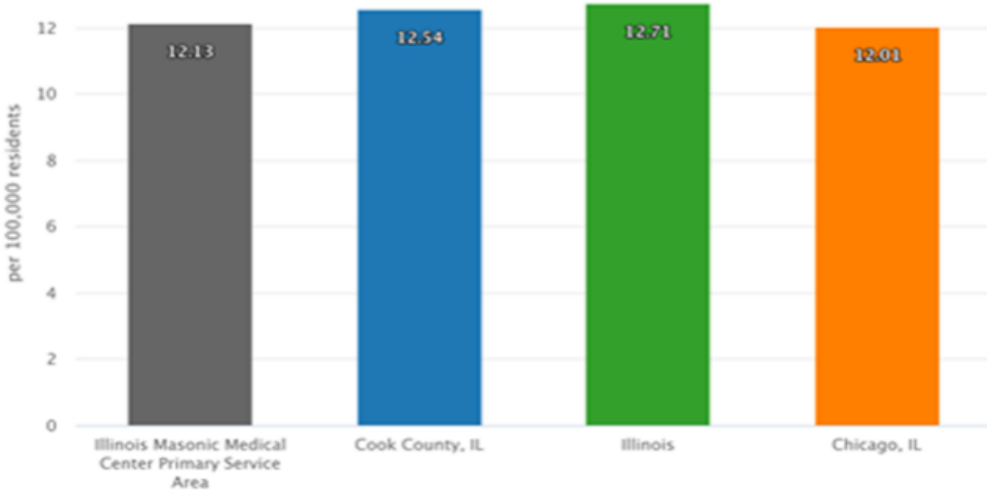

Source: Metopio, IHA COMPdata Informatic, 2022

**Exhibit 58: Advocate Illinois Masonic PSA Mental Health Hospitalization Rate by Race/Ethnicity 2020**



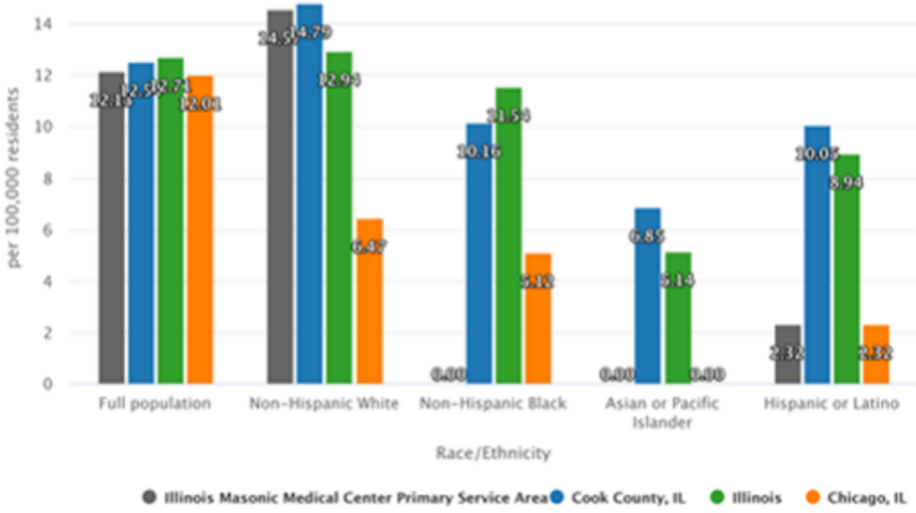

Source: Metopio, IHA COMPdata Informatic, 2022

**Exhibit 59: Advocate Illinois Masonic PSA Suicide and Self Injury Hospitalization Rate 2020**



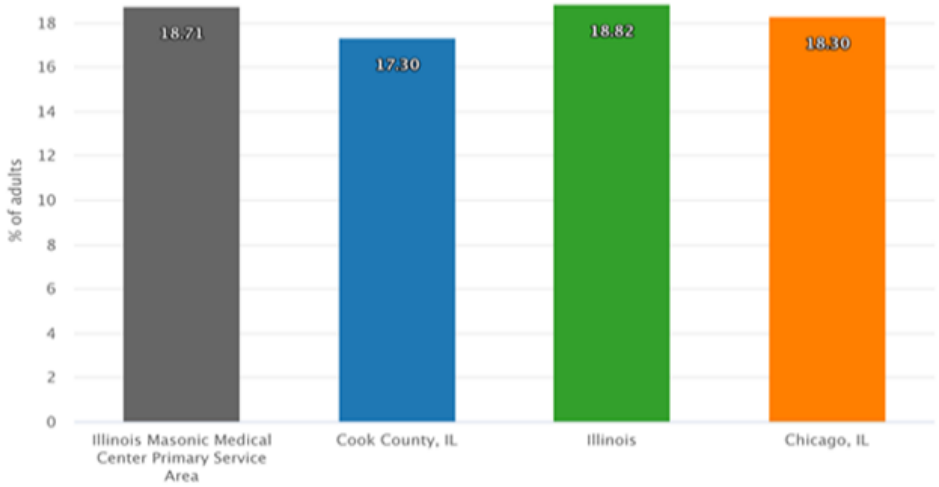

Source: Metopio, IHA COMPdata Informatic, 2022

**Exhibit 60: Advocate Illinois Masonic PSA Suicide and Self Injury Hospitalization Rate 2020**



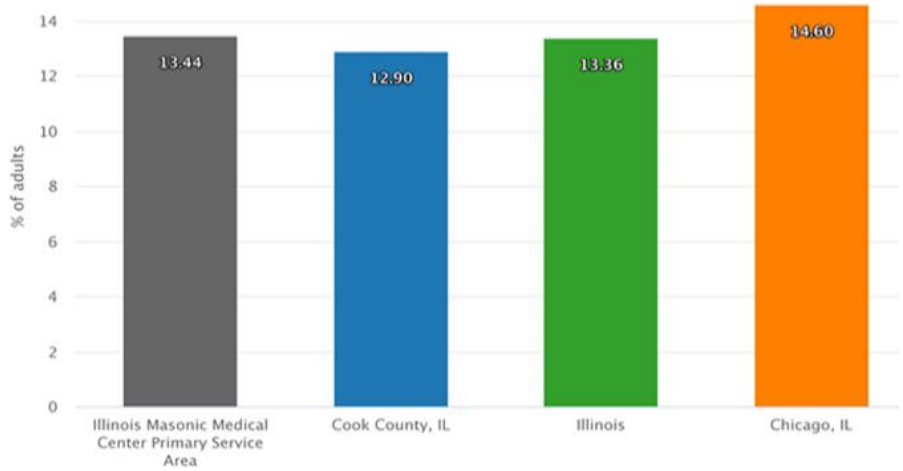

Source: Metopio, IHA COMPdata Informatic, 2022

**Exhibit 61: Advocate Illinois Masonic PSA Depression 2019**




Source: Metopio, IHA COMPdata Informatic, 2022

**Exhibit 62: Advocate Illinois Masonic PSA Poor Self-Reported Mental Health 2019**




Source: Metopio, IHA COMPdata Informatic, 2022

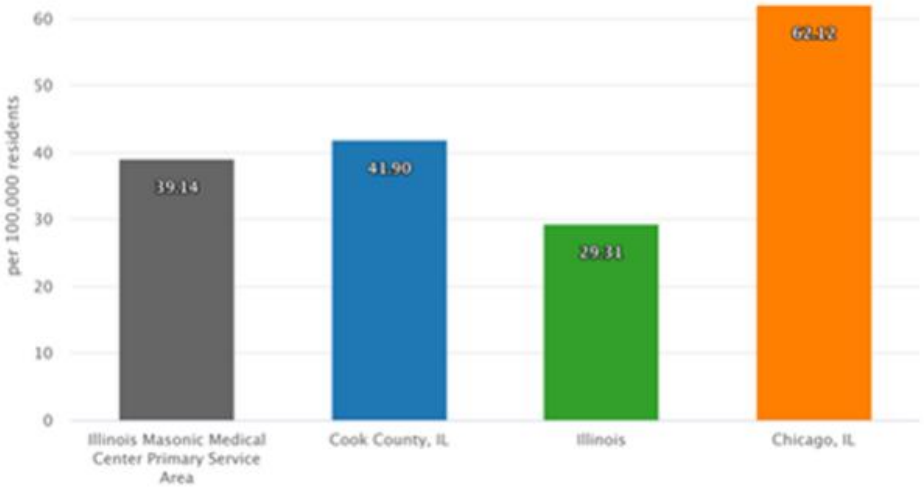
**Respiratory Health**

Asthma is a chronic condition that affects the airways and the lungs. About one in 13 people in the United States has asthma, according to the Centers for Disease Control and Prevention. COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. COPD affects more than 15 million Americans and more than 150,000 Americans die of COPD each year (CDC, 2022).

The PSA's asthma hospitalization rate is 39.14 per 100,000 residents, which is significantly lower compared to the city of Chicago at 62.12, the county at 41.90 and the state at 29.31 per 100,000 residents. There is a racial/ethnic disparity in asthma hospitalization rates with the Non-Hispanic Black population having a significantly higher rate (91.36 per 100,000 residents) compared to the overall PSA and all other racial/ethnic groups.

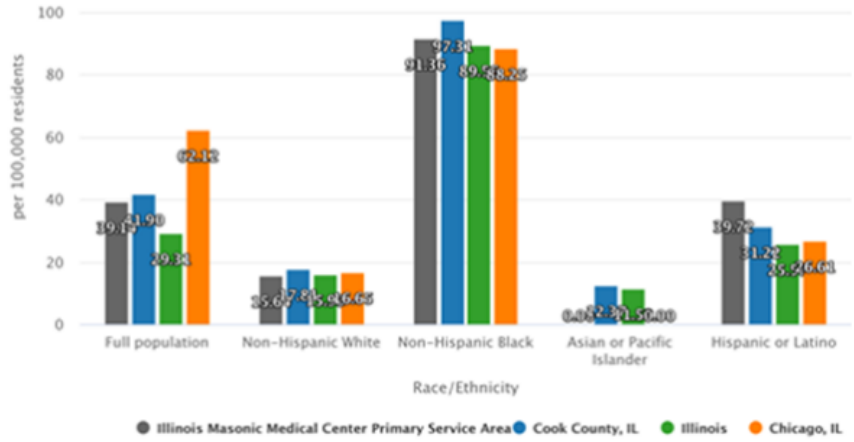
The COPD hospitalization rate in the medical center's PSA is 279.568 per 100,000 residents, which is lower than Chicago at 420.64 and Cook County at 310.89 but higher than the state's rate at 275.53 per 100,000 residents (Metopio, COMPdata Informatics, 2022). Similar to asthma hospitalization rates, there is a racial/ethnic disparity in the PSA COPD hospitalization rates with the Non-Hispanic Black population having the highest rate at 819.42 per 100,000 residents compared to the Hispanic or Latino population at 301.74 per 100,000, the Non-Hispanic White population at 265.93 and the Asian or Pacific Islander population at 90.8 per 100,000 residents.

**Exhibit 63: Advocate Illinois Masonic PSA Asthma Hospitalization Rate 2020**



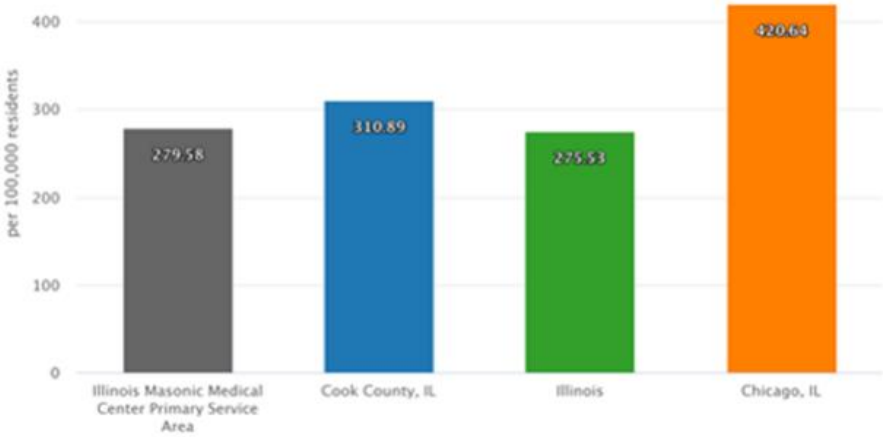

Source: Metopio, IHA COMPdata Informatics, 2022

**Exhibit 64: Advocate Illinois Masonic Asthma Hospitalization Rate by Race/Ethnicity, 2020**



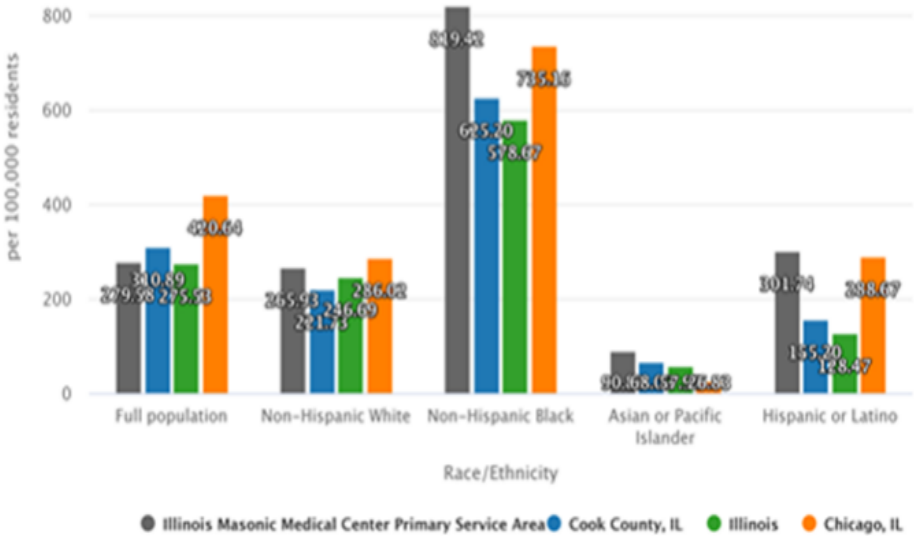

Source: Metopio, IHA COMPdata Informatics, 2022

**Exhibit 65: Advocate Illinois Masonic PSA COPD Hospitalization Rate 2020**




Source: Metopio, IHA COMPdata Informatics, 2022

**Exhibit 66: Advocate Illinois Masonic PSA COPD Hospitalization Rate by Race/Ethnicity 2020**




Source: Metopio, IHA COMPdata Informatics, 2022

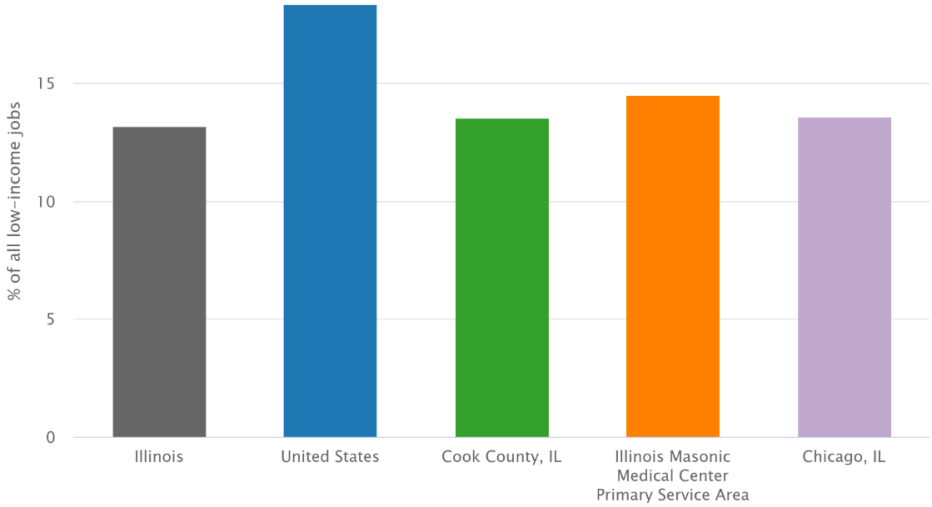
**COVID-19**

The Covid-19 pandemic brought profound changes to the way people work, communicate, learn, play, eat, socialize and receive health care. COVID-19 raced across the American landscape bringing illness, suffering, economic struggle and death to people across all racial, ethnic and socioeconomic groups. COVID-19 shined an even brighter light on the health inequities experienced by low-income communities and communities of color. Notably, communities of color were disproportionately affected by the disease, its many difficult side effects and higher death rates. Covid-19 continues to be a priority and as a health care system, we are proactively working with public health professionals and clinical experts to educate and improve health outcomes in our communities.

The COVID-19 risk factor score predicts risk of all fatalities from COVID-19, built using data on chronic disease prevalence, hospitalization, and mortality as well as demographic characteristics. Higher scores indicate a greater predicted risk. There are five communities that have a risk factor score higher than the overall PSA. These communities also have the highest number of COVID-19 cases. The PSA communities with the highest COVID-19 risk factor score include Belmont Cragin (60639), Humboldt Park (60651), Rodgers Park (60626) and Irving Park/Portage Park (60641).

COVID-19 also had a major impact on employment rates with many low-wage employees and" non-essential" individuals losing employment during an extended period of time. The low-income jobs lost to COVID-19 indicator provided the percentage of all low-income (less than $40,000 per year) jobs lost to COVID-19. In the hospital's PSA, 14.49 percent of low-income jobs were lost due to COVID-19, which is higher than Chicago at 13.57 percent, Cook County at 13.54 percent and the state at 13.17 percent (Metopio, Urban Institute, 2022). The graph below in exhibit 29 shows the percentage of low-income job loss due to COVID-19 at the PSA, county, state and national level.

**Exhibit 67: Advocate Illinois Masonic PSA Low-Income Jobs Lost to COVID-19 (2020)**




Source: Metopio, Urban Institute, 2022

## IV. Prioritization of Health-Related Issues

### Priority Setting Process

Advocate Illinois Masonic's Community Health Department presented data to the medical center's CHC for the top nine health needs in the medical center's PSA. The data was reviewed and discussed by the CHC to ensure thorough understanding of all data indicators and reports. The top health needs presented to the Council are listed below.

1) Access to Care

2) Cancer
3) COVID-19
4) Diabetes
5) Health and Nutrition
6) Heart Disease
7) Mental Health
8) Respiratory Health
9) Substance and Alcohol Use

Council members were able to ask questions and engage in a robust discussion around the top nine health needs, which led to the first prioritization phase of the CHNA. The CHC members were asked to complete a prioritization grid (Appendix 2), which required each member to rate the nine health needs based on the following criteria:

- Size of the health need—This was determined through ED, hospitalization, prevalence and incidence data.
- Seriousness of the health issue—Several questions were taken into consideration to rate the seriousness of the health issue including:
    1) What is the importance of health issue to the community?
    2) Does health issue impact the quality of life?
    3) What are the hospitalization and mortality rates caused by the health issue?
- Effectiveness of available interventions—The CHC considered several questions to determine the effectiveness of the health need interventions including:
    1) Are prevention programs effective in preventing the health issue?
    2) Do interventions for the health issue have the ability to improve/impact other health issues?
    3) Do treatment programs effectively address the health issue?
- Resources available to address the health issue
- Existing community partners working on the problem
- Meets a defined community need as identified through data
- Potential for health issue to impact other health issues
- Ability to impact the health issue through demonstrable outcomes and collaboration

The hospital's Community Health Department collected the prioritization grids to conduct analysis and to aggregate the health need scores (listed below). The aggregated scores for each health need were presented to the CHC and the four health needs with the highest scores were selected for community expert presentations to assist the CHC in selecting the final two health need priorities. COVID-19 was not included in the prioritization grid due to Advocate Aurora Health's significant and continuing commitment to address the health issue. The Council recognized the significant impact and resources the health care system already had in place and felt this health issue was already prioritized and would continue to be prioritized as long as the disease was a health issue/need in the medical center's service area.

<u>Prioritization Grid Results</u>

- Access to health care: 257
- Mental Health: 272
- Substance and Alcohol Use: 262
- Health and Nutrition: 278
- Heart Disease: 252
- Respiratory Disease: 229
- Cancer: 249
- Diabetes: 250

After careful review of data and extensive discussion about the top four health needs (access to health care, mental health, substance/alcohol use and health and nutrition) the Community Health Department had experts from the community presented on each of the top four health issues. Community experts/organizations that presented included the National Alliance on Mental Illness (NAMI Chicago), Community Health (free community clinic), Gateway Foundation and Benedictine University. Each presentation consisted of health disparities, root causes, community resources, gaps in resources, and most affected communities/populations. Following presentations, the Council engaged in an in-depth discussion and the hospital's Community Health Department called for a second vote to narrow the health needs from the top four to the final two 2022 CHNA health priorities. The Council voted for: 1) Health and Nutrition; and 2) Behavioral Health as the hospital's final two health need priorities for the 2022 CHNA. Additionally, the Council decided to include access to care in the health and nutrition priority because of the significant impact access to primary care has on an individual's overall health, wellness and nutrition. The Council also decided to combine substance and alcohol use with mental health to form Behavioral Health as a final priority.

## Health Need Selected

**Health and Nutrition**
Health Lifestyles was chosen as one of the two health need priorities due to many chronic diseases and health issues that are related to poor nutrition and physical activity. The physical environment of a community such as availability of affordable, fresh food and safe places to be physically active affect residents' ability to exercise, eat a healthy diet, and maintain a healthy body weight.

**Behavioral Health**
Behavioral health was selected as the other health priority. This health priority includes mental health and substance/alcohol use. The rates of mental health issues and substance use are continuing to increase over time, and it's anticipated that the impact will be severe due to the implications of COVID-19.

**Social Drivers of Health**
COVID-19 exposed the devastating impact social and economic factors can have on one's health and in many low-income communities of color. The CHC identified SDOH as a crucial component of addressing the root causes of the prioritized health needs and key to improving the overall health and quality of life in the PSA. The CHC voted to integrate SDOH into Health and Nutrition and Behavioral Health instead of having a SDOH stand alone as a health need.

## Health Need Not Selected

**Access to Health Care**
The Council, Community Health Department and medical center are aware that access to health care is a critical need for the medical center's PSA. Access to health care need will be addressed within the health and nutrition, behavioral health and social drivers of health strategies.

**Cancer**
Cancer was identified as a health need for the medical center but was not selected as a priority due to the many cancer services and programs offered by the medical center's Creticos Cancer Center (CCC). The Community Health Department partners with the CCC to provide access to healthy and fresh produce and address cancer screening interventions within low income and hard to reach communities.

**Respiratory Health**
Asthma was identified as a health need but not selected as the recommended health priority by the CHC due to the lack of community partners and the ineffectiveness/availability of asthma prevention programs in the PSA. Advocate Children's has two Ronald McDonald Care Mobiles (RMCM) which provide care to low-income children in the hospital's

PSA who experience barriers to receiving primary health care. The staff of the mobile units also provide asthma education to pediatric patients served by the RMCM.

**COVID-19**
As a part of the Advocate Aurora Health system, Advocate Illinois Masonic will continue to dedicate a substantial number of resources, including but not limited to medical supply, PPE, COVID-19 testing, medical services, community-focused interventions and treatment to address the ongoing COVID-19 pandemic. In the event of a pandemic and/or major health crisis, the CHC recognized that hospitals are called to serve as the backbone to addressing emergency health outbreaks and provide crucial and critical care to the community. Advocate Illinois Masonic will continue to make COVID-19 a priority through its commitment to improve access to testing, vaccine administration and quality care for those diagnosed with the disease.

**Heart Disease**
Although heart disease was not selected as a priority, the hospital is committed to decreasing the rate of heart disease by addressing and prioritizing health and nutrition. National data maps from the CDC indicate that higher heart disease and stroke death rates occur in states that also have higher obesity rates. The CHC decided it was more beneficial to prioritize health and nutrition because of its impact on reducing the risk for cardiovascular disease, including hospitalizations and ER visits due to various cardiovascular diseases and related health issues. Advocate Aurora Health also addresses cardiovascular disease through the hospital's many Advocate Heart Institute programs.

**Diabetes**
While the CHC acknowledges diabetes is a health issue, the CHC decided to address diabetes prevention and management through the health and nutrition priority, which will include interventions and partnerships to address nutrition and physical inactivity—key elements of diabetes prevention and management.

## V. Approval of Community Health Needs Assessment

The director of community health provided a copy of the CHNA to each medical Governing Council member in advance of the November 2022 Council meeting. Governing Council members were able to review the CHNA document in its entirety before the meeting. The medical center's director and coordinator of community health presented the CHNA document including the assessment process and selected health need priorities to the Council. Following the presentation, Council members were able to discuss findings, ask questions and comment. On November 22, 2022, the Advocate Illinois Masonic Medical Center Governing Council fully approved the 2022 Advocate Illinois Masonic Medical Center CHNA Report. The Advocate Health Care Network Board approved the Advocate Illinois Masonic 2022 CHNA Report at the system level on December 16, 2022.

## VI. Vehicle for Community Feedback

### Community Feedback

Advocate Illinois Masonic welcomes all feedback regarding the 2022 Community Health Needs Assessment. Any member of the community wishing to comment on this report, can click the link below to complete the CHNA feedback form. Questions will be addressed and will also be considered during the next CHNA cycle.
Feedback Link: Advocate Aurora Health CHNA Feedback

**SCAN ME**

**If you experience any issues with the link to our feedback form or have any other questions, please email Elvis Munoz at Elvis.munoz@aah.org**

This report can be viewed online at Advocate Health Care's Community Health Needs Assessment Report webpage via the following link: Hospital CHNA Reports Implementation Plans Progress Reports | Advocate Health Care

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

## VII. Evaluation of Impact from Previous CHNA

**Healthy Lifestyles**
The CHC chose healthy lifestyles as one of the two health need priorities due to the many chronic diseases and health issues that are related to poor nutrition and physical activity. Implementation activity and outcomes in 2021 are as follows.

In 2021 Advocate Illinois Masonic implemented pop- up farmers markets that served over 20,000 pounds of fresh produce and shelf stable foods to 1,320 individuals and families in the food desert communities. In partnership with Produce Alliance and community-based organizations, the medical center served over 9,000 USDA Farmers to Families produce boxes totaling over 300,000 pounds of food.

In 2021, the medical center's hospital-based food pantry distributed over 140 non-perishable food bags and 312 fresh produce boxes to over 120 food insecure patients.

In partnership with Avondale Faith and Health Collaborative, the Advocate Illinois Masonic Community Health Department participated in three Avondale Restorative Justice Community Court (ARJCC) peace circles. One participant from ARJCC peace circle successfully completed the Mental Health First Aid training.

Additionally, the Transition Support Program aims to increase access to primary care for low income and uninsured patients. The Community Health Department will continue to partner with the Transition Support Program in 2021.

**Behavioral Health**
The Advocate Illinois Masonic Medically Integrated Community Crisis Support (MICCS) program aims to increase access to mental health services and medication. In 2021, the program served 68 individuals receiving intensive case management through MICCS.

Advocate Illinois Masonic also runs an injection clinic for those with mental illness. In 2021, despite the pandemic, the clinic served 91 individuals.

In medical center's First Access program aims to increase access to behavioral health services. Due to COVID-19, the program operated in a hybrid model to link patients from the hospital, emergency department (ED), consult, inpatient psych and Advocate primary care to outpatient remote services. In 2021, 1,828 patients were linked to outpatient remote services.

Advocate Illinois Masonic's behavioral health team staffed the Call4Calm line, a phone line developed during COVID-19 for those struggling with mental health issues or illness. The program received 60 calls of which seven were referred to First Access for additional support.

To address increasing needs for mental health programming, the medical center implemented two Mental Health First Aid trainings. The medical center partnered with the LGBTQ Lakeview Chamber of Commerce and hosting an internal training for clinical staff in 2021, providing a training for a total of 43 individuals.

**Social Drivers of Health**
In 2021, Advocate Illinois Masonic placed four individuals directly into long term permanent housing and one individual was placed in transitional housing through the Flexible Housing Pool program. The program provides permanent housing to the medical center's patients who are homeless and have high hospital readmission rates.

In 2021, the medical center's Community Health and Advocate Aurora Workforce Development teams collaborated to provide 11 individuals in high-risk communities with hands on experience through an externship. Two externs were hired and obtained permanent employment in the Advocate Aurora Health system.

Advocate Aurora partnered with Acclivus, an organization focused on community safety, to provide violence intervention services to 218 patients admitted to the emergency department due to domestic and or community violence. Patients also received an assessment and referrals to social and health services.

**Community Health Accolades**
Since 2017, Advocate Masonic Illinois Medical Center has partnered with Nourishing Hope (formerly known as Lakeview Pantry) to implement the medical center's hospital-based food pantry and community pop-up pantries for patients, individuals and families who are low-income and or food insecure. To address the increased need during the pandemic, Illinois Masonic Medical Center's Community Health team expanded the hospital-based food pantry to the medical center's team members and community partners. Since 2020 Nourishing Hope (formerly known as Lakeview Pantry) and Illinois Masonic Medical Center have worked to distribute over 18,000 pounds of food to over 800 food insecure individuals and families. The Feeding Hope Award and recognition is due to the medical center's commitment to improving health equity through increasing access to healthy food.

The Community Health Department also has a long-standing partnership with Grover Cleveland Elementary School, a school with a large population of low-income, immigrant and Latino populations. In 20211, the medical center's Community Health Department was awarded the Friends of Cleveland award for going above and beyond to provide access to healthy foods to students, families, and staff at Grover Cleveland Elementary School.

The medical center was awarded $250k from the NFL Foundation through their Social Justice Grant. The grant is intended to serve high-risk communities experiencing health disparities exacerbated by COVID-19. Through this grant the medical center developed workforce development and food security programs.

**Link to previous Progress Reports**
More details about Advocate Illinois Masonic Medical Center's 2020-2022 Implementation Plan strategies and progress can be found online within the Advocate Illinois Masonic Medical Center immc-chip-2021-final.pdf (advocatehealth.com).

## VIII. Appendices

## Appendix 1: 2022 Community Health Needs Assessment Data Sources

Advocate Aurora Business Development Analytics, 2022
Advocate Aurora Health – EpicHB 2021

Centers for Disease Control and Prevention, July 15, 2022. Retrieved from cdc.gov; July 7, 2022. Retrieved from cdc.gov

National Alliance on Mental Illness, January 1, 2022. Retrieved from https://www.nami.org/Home; July 1, 2022.

Illinois Department of Public Health, Heart Disease and Stroke, 2022. Retrieved from dph.illinois.gov).

The Alliance for Health Equity, Community Health Needs Assessment for Chicago and Suburban Cook, 2022; The Alliance for Health Equity, Focus Groups, 2022; and

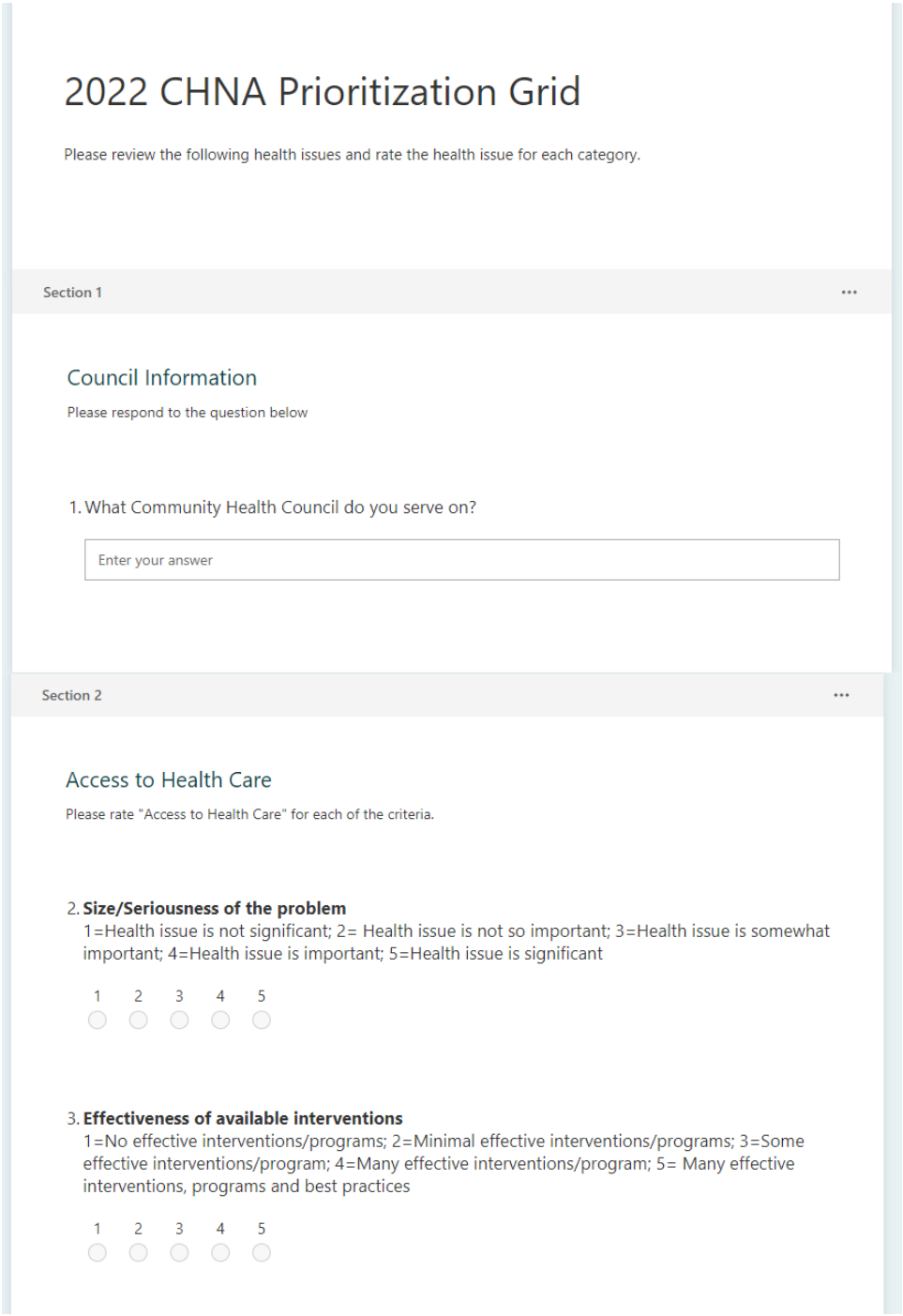
The Alliance for Health Equity, Community Input Survey, 2022. All three documents accessible at https://allhealthequity.org/projects/2019-chna-reports/

Mental Health America, The State of Menta Health in America 2022

Metopio. Accessed via a contract with Advocate Aurora Health. Website is unavailable to the public. The following data sources were accessed through the portal:
American Community Survey, 2015-2019, 2016-2020
Behavioral Risk Factor Surveillance System, 2019
Centers for Disease Control and Prevention, 2018
Centers for Disease Control and Prevention WONDER, 2015-2019, 2016-2020
Centers for Medicare and Medicaid Services, National Provider Identifier, 2021
Chicago Department of Public Health, 2016-2020
Diabetes Atlas, 2019
Feeding America, 2020
FBI Crime Data Explorer, 2016-2020
Health Resources and Services Administration, 2018
Illinois Department of Public Health, 2014-2018, 2021
IHA COMPdata Informatics, 2016-2020
Illinois State Cancer Registry, 2014-2018
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2018
National Vital Statistics System-Mortality, 2016-2020
PLACES, 2015-2019
UIC School of Public Health, 2020, 2021
United Way ALICE Data, 2018
USDA, 2019

Trust for America's Health, The State of Obesity: Better Policies for a Healthier America, 2021

## Appendix 2: 2022 Health Need Prioritization Form



2022 CHNA Prioritization Grid

Please review the following health issues and rate the health issue for each category.

Section 1

Council Information

Please respond to the question below

1. What Community Health Council do you serve on?

Enter your answer

Section 2

Access to Health Care

Please rate "Access to Health Care" for each of the criteria.

2. **Size/Seriousness of the problem**
1=Health issue is not significant; 2= Health issue is not so important; 3=Health issue is somewhat important; 4=Health issue is important; 5=Health issue is significant

1 2 3 4 5

3. **Effectiveness of available interventions**
1=No effective interventions/programs; 2=Minimal effective interventions/programs; 3=Some effective interventions/program; 4=Many effective interventions/program; 5= Many effective interventions, programs and best practices

1 2 3 4 5

4. **Amount of resources to address the health issue**
   1=No resources to address the health issue; 2=Very few resources to address the health issue; 3=Some resources to address the health issue; 4=There are a variety of resources to address health issue; 4= Resources to address health issue are plentiful and abundant

   1 2 3 4 5

5. **Health care system adequately addresses the health issue**
   1=Health care system addresses and has a strong impact on the health issue; 2=Health care system addresses health issue adequately; 3=Health care system somewhat addresses the health issue; 4= Health care system minimally addresses the health issue; 5=Health care system does not address the health issue

   1 2 3 4 5

6. **Meets a defined community need as identified through data**
   1=Data shows there is no health issue; 2=Data shows there may be a potential community need; 3=Data shows a minor need in the community; 4=Data shows issues related to health disparities and health equity; 5=Data shows a large community need with disparities and equity issues

   1 2 3 4 5

7. **Potential for issue to impact other health and social issues**
   1=No potential to impact other health issues; 2=Minimal potential to impact other health issues; 3=Potential to impact other health issues; 4=Strong potential to impact other health issues; 5=Addressing health issue has significant impact on other health/social issues/needs

   1 2 3 4 5

8. **Ability to effectively address or impact health issue through collaboration**
   1=No ability to address health issue through collaboration; 2=Potential ability to address health issue through collaboration; 3=Ability to address/impact health issue through collaboration; 4=Strong impact through collaboration; 5=Significant and effective impact through collaboration

   1 2 3 4 5

Section 3

## Mental Health

9. **Size/Seriousness of the problem**
   1=Health issue is not significant; 2= Health issue is not so important; 3=Health issue is somewhat important; 4=Health issue is important; 5=Health issue is significant

   1 2 3 4 5

10. **Effectiveness of available interventions**
    1=No effective interventions/programs; 2=Minimal effective interventions/programs; 3=Some effective interventions/program; 4=Many effective interventions/program; 5= Many effective interventions, programs and best practices

    1 2 3 4 5

11. **Amount of resources to address the health issue**
    1=No resources to address the health issue; 2=Very few resources to address the health issue; 3=Some resources to address the health issue; 4=There are a variety of resources to address health issue; 4= Resources to address health issue are plentiful and abundant

    1 2 3 4 5

12. **Health care system adequately addresses the health issue**
    1=Health care system addresses and has a strong impact on the health issue; 2=Health care system addresses health issue adequately; 3=Health care system somewhat addresses the health issue; 4= Health care system minimally addresses the health issue; 5=Health care system does not address the health issue

    1 2 3 4 5

13. **Meets a defined community need as identified through data**
    1=Data shows there is no health issue; 2=Data shows there may be a potential community need; 3=Data shows a minor need in the community; 4=Data shows issues related to health disparities and health equity; 5=Data shows a large community need with disparities and equity issues

    1 2 3 4 5

14. **Potential for issue to impact other health and social issues**
    1=No potential to impact other health issues; 2=Minimal potential to impact other health issues; 3=Potential to impact other health issues; 4=Strong potential to impact other health issues; 5=Addressing health issue has significant impact on other health/social issues/needs

    1 2 3 4 5

15. **Ability to effectively address or impact health issue through collaboration**
1=No ability to address health issue through collaboration; 2=Potential ability to address health issue through collaboration; 3=Ability to address/impact health issue through collaboration; 4=Strong impact through collaboration; 5=Significant and effective impact through collaboration

1 2 3 4 5

Section 4

## Substance Use

16. **Size/Seriousness of the problem**
1=Health issue is not significant; 2= Health issue is not so important; 3=Health issue is somewhat important; 4=Health issue is important; 5=Health issue is significant

1 2 3 4 5

17. **Effectiveness of available interventions**
1=No effective interventions/programs; 2=Minimal effective interventions/programs; 3=Some effective interventions/program; 4=Many effective interventions/program; 5= Many effective interventions, programs and best practices

1 2 3 4 5

18. **Amount of resources to address the health issue**
1=No resources to address the health issue; 2=Very few resources to address the health issue; 3=Some resources to address the health issue; 4=There are a variety of resources to address health issue; 4= Resources to address health issue are plentiful and abundant

1 2 3 4 5

19. **Health care system adequately addresses the health issue**
1=Health care system addresses and has a strong impact on the health issue; 2=Health care system addresses health issue adequately; 3=Health care system somewhat addresses the health issue; 4= Health care system minimally addresses the health issue; 5=Health care system does not address the health issue

1 2 3 4 5

20. **Meets a defined community need as identified through data**
1=Data shows there is no health issue; 2=Data shows there may be a potential community need; 3=Data shows a minor need in the community; 4=Data shows issues related to health disparities and health equity; 5=Data shows a large community need with disparities and equity issues

1 2 3 4 5

21. **Potential for issue to impact other health and social issues**
1=No potential to impact other health issues; 2=Minimal potential to impact other health issues; 3=Potential to impact other health issues; 4=Strong potential to impact other health issues; 5=Addressing health issue has significant impact on other health/social issues/needs

1 2 3 4 5

22. **Ability to effectively address or impact health issue through collaboration**
1=No ability to address health issue through collaboration; 2=Potential ability to address health issue through collaboration; 3=Ability to address/impact health issue through collaboration; 4=Strong impact through collaboration; 5=Significant and effective impact through collaboration

1 2 3 4 5

Section 5

## Health, Wellness and Nutrition

23. **Size/Seriousness of the problem**
1=Health issue is not significant; 2= Health issue is not so important; 3=Health issue is somewhat important; 4=Health issue is important; 5=Health issue is significant

1 2 3 4 5

24. **Effectiveness of available interventions**
1=No effective interventions/programs; 2=Minimal effective interventions/programs; 3=Some effective interventions/program; 4=Many effective interventions/program; 5= Many effective interventions, programs and best practices

1 2 3 4 5

25. **Amount of resources to address the health issue**
1=No resources to address the health issue; 2=Very few resources to address the health issue; 3=Some resources to address the health issue; 4=There are a variety of resources to address health issue; 4= Resources to address health issue are plentiful and abundant

1 2 3 4 5

26. **Health care system adequately addresses the health issue**
1=Health care system addresses and has a strong impact on the health issue; 2=Health care system addresses health issue adequately; 3=Health care system somewhat addresses the health issue; 4= Health care system minimally addresses the health issue; 5=Health care system does not address the health issue

1 2 3 4 5

27. **Meets a defined community need as identified through data**
1=Data shows there is no health issue; 2=Data shows there may be a potential community need; 3=Data shows a minor need in the community; 4=Data shows issues related to health disparities and health equity; 5=Data shows a large community need with disparities and equity issues

1 2 3 4 5

28. **Potential for issue to impact other health and social issues**
1=No potential to impact other health issues; 2=Minimal potential to impact other health issues; 3=Potential to impact other health issues; 4=Strong potential to impact other health issues; 5=Addressing health issue has significant impact on other health/social issues/needs

1 2 3 4 5

29. **Ability to effectively address or impact health issue through collaboration**
1=No ability to address health issue through collaboration; 2=Potential ability to address health issue through collaboration; 3=Ability to address/impact health issue through collaboration; 4=Strong impact through collaboration; 5=Significant and effective impact through collaboration

1 2 3 4 5

Section 6

## Cardiovascular/Heart Disease

30. **Size/Seriousness of the problem**
1=Health issue is not significant; 2= Health issue is not so important; 3=Health issue is somewhat important; 4=Health issue is important; 5=Health issue is significant

1 2 3 4 5

31. **Effectiveness of available interventions**
1=No effective interventions/programs; 2=Minimal effective interventions/programs; 3=Some effective interventions/program; 4=Many effective interventions/program; 5= Many effective interventions, programs and best practices

1 2 3 4 5

32. **Amount of resources to address the health issue**
1=No resources to address the health issue; 2=Very few resources to address the health issue; 3=Some resources to address the health issue; 4=There are a variety of resources to address health issue; 4= Resources to address health issue are plentiful and abundant

1 2 3 4 5

33. **Health care system adequately addresses the health issue**
1=Health care system addresses and has a strong impact on the health issue; 2=Health care system addresses health issue adequately; 3=Health care system somewhat addresses the health issue; 4= Health care system minimally addresses the health issue; 5=Health care system does not address the health issue

1 2 3 4 5

34. **Meets a defined community need as identified through data**
1=Data shows there is no health issue; 2=Data shows there may be a potential community need; 3=Data shows a minor need in the community; 4=Data shows issues related to health disparities and health equity; 5=Data shows a large community need with disparities and equity issues

1 2 3 4 5

35. **Potential for issue to impact other health and social issues**
1=No potential to impact other health issues; 2=Minimal potential to impact other health issues; 3=Potential to impact other health issues; 4=Strong potential to impact other health issues; 5=Addressing health issue has significant impact on other health/social issues/needs

1 2 3 4 5

36. **Ability to effectively address or impact health issue through collaboration**
1=No ability to address health issue through collaboration; 2=Potential ability to address health issue through collaboration; 3=Ability to address/impact health issue through collaboration; 4=Strong impact through collaboration; 5=Significant and effective impact through collaboration

1 2 3 4 5

Section 7

## Respiratory Health/Disease

37. **Size/Seriousness of the problem**
1=Health issue is not significant; 2= Health issue is not so important; 3=Health issue is somewhat important; 4=Health issue is important; 5=Health issue is significant

1 2 3 4 5

38. **Effectiveness of available interventions**
1=No effective interventions/programs; 2=Minimal effective interventions/programs; 3=Some effective interventions/program; 4=Many effective interventions/program; 5= Many effective interventions, programs and best practices

1 2 3 4 5

39. **Amount of resources to address the health issue**
1=No resources to address the health issue; 2=Very few resources to address the health issue; 3=Some resources to address the health issue; 4=There are a variety of resources to address health issue; 4= Resources to address health issue are plentiful and abundant

1 2 3 4 5

40. **Health care system adequately addresses the health issue**
1=Health care system addresses and has a strong impact on the health issue; 2=Health care system addresses health issue adequately; 3=Health care system somewhat addresses the health issue; 4= Health care system minimally addresses the health issue; 5=Health care system does not address the health issue

1 2 3 4 5

41. **Meets a defined community need as identified through data**
1=Data shows there is no health issue; 2=Data shows there may be a potential community need; 3=Data shows a minor need in the community; 4=Data shows issues related to health disparities and health equity; 5=Data shows a large community need with disparities and equity issues

1 2 3 4 5

42. **Potential for issue to impact other health and social issues**
1=No potential to impact other health issues; 2=Minimal potential to impact other health issues; 3=Potential to impact other health issues; 4=Strong potential to impact other health issues; 5=Addressing health issue has significant impact on other health/social issues/needs

1 2 3 4 5

43. **Ability to effectively address or impact health issue through collaboration**
1=No ability to address health issue through collaboration; 2=Potential ability to address health issue through collaboration; 3=Ability to address/impact health issue through collaboration; 4=Strong impact through collaboration; 5=Significant and effective impact through collaboration

1 2 3 4 5

Section 8

## Cancer

44. **Size/Seriousness of the problem**
1=Health issue is not significant; 2= Health issue is not so important; 3=Health issue is somewhat important; 4=Health issue is important; 5=Health issue is significant

1 2 3 4 5

45. **Effectiveness of available interventions**
1=No effective interventions/programs; 2=Minimal effective interventions/programs; 3=Some effective interventions/program; 4=Many effective interventions/program; 5= Many effective interventions, programs and best practices

1 2 3 4 5

46. **Amount of resources to address the health issue**
1=No resources to address the health issue; 2=Very few resources to address the health issue; 3=Some resources to address the health issue; 4=There are a variety of resources to address health issue; 4= Resources to address health issue are plentiful and abundant

1 2 3 4 5

47. **Health care system adequately addresses the health issue**
1=Health care system addresses and has a strong impact on the health issue; 2=Health care system addresses health issue adequately; 3=Health care system somewhat addresses the health issue; 4= Health care system minimally addresses the health issue; 5=Health care system does not address the health issue

1 2 3 4 5

48. **Meets a defined community need as identified through data**
1=Data shows there is no health issue; 2=Data shows there may be a potential community need; 3=Data shows a minor need in the community; 4=Data shows issues related to health disparities and health equity; 5=Data shows a large community need with disparities and equity issues

1 2 3 4 5

49. **Potential for issue to impact other health and social issues**
1=No potential to impact other health issues; 2=Minimal potential to impact other health issues; 3=Potential to impact other health issues; 4=Strong potential to impact other health issues; 5=Addressing health issue has significant impact on other health/social issues/needs

1 2 3 4 5

50. **Ability to effectively address or impact health issue through collaboration**
1=No ability to address health issue through collaboration; 2=Potential ability to address health issue through collaboration; 3=Ability to address/impact health issue through collaboration; 4=Strong impact through collaboration; 5=Significant and effective impact through collaboration

1 2 3 4 5

Section 9

## Diabetes

51. **Size/Seriousness of the problem**
1=Health issue is not significant; 2= Health issue is not so important; 3=Health issue is somewhat important; 4=Health issue is important; 5=Health issue is significant

1 2 3 4 5

52. **Effectiveness of available interventions**
1=No effective interventions/programs; 2=Minimal effective interventions/programs; 3=Some effective interventions/program; 4=Many effective interventions/program; 5= Many effective interventions, programs and best practices

1 2 3 4 5

53. **Amount of resources to address the health issue**
1=No resources to address the health issue; 2=Very few resources to address the health issue; 3=Some resources to address the health issue; 4=There are a variety of resources to address health issue; 4= Resources to address health issue are plentiful and abundant

1 2 3 4 5

54. **Health care system adequately addresses the health issue**
1=Health care system addresses and has a strong impact on the health issue; 2=Health care system addresses health issue adequately; 3=Health care system somewhat addresses the health issue; 4= Health care system minimally addresses the health issue; 5=Health care system does not address the health issue

1 2 3 4 5

55. **Meets a defined community need as identified through data**
1=Data shows there is no health issue; 2=Data shows there may be a potential community need; 3=Data shows a minor need in the community; 4=Data shows issues related to health disparities and health equity; 5=Data shows a large community need with disparities and equity issues

1 2 3 4 5

56. **Potential for issue to impact other health and social issues**
1=No potential to impact other health issues; 2=Minimal potential to impact other health issues; 3=Potential to impact other health issues; 4=Strong potential to impact other health issues; 5=Addressing health issue has significant impact on other health/social issues/needs

1 2 3 4 5

57. **Ability to effectively address or impact health issue through collaboration**
1=No ability to address health issue through collaboration; 2=Potential ability to address health issue through collaboration; 3=Ability to address/impact health issue through collaboration; 4=Strong impact through collaboration; 5=Significant and effective impact through collaboration

1 2 3 4 5

## Appendix 3: Alliance for Health Equity- Equity Analysis Survey Summary

ALLIANCE for HEALTH EQUITY | Hospitals and Communities Improving Health Across Chicago and Cook County

# COMMUNITY HEALTH NEEDS ASSESSMENT

## COMMUNITY SURVEY - SUMMARY REPORT

June
2022
Survey Report

ILLINOIS PUBLIC HEALTH INSTITUTE

www.allhealthequity.org

ALLIANCE for HEALTH EQUITY | Hospitals and Communities Improving Health Across Chicago and Cook County

2022 Community Health Needs Assessment

# Community Input Survey – Key Findings from Equity-Focused Analysis

**Data collected September 2021 – December 2021**

Between September 2021 and December 2021, Alliance for Health Equity partners collected over 5,200 community input surveys from individuals ten or older living in Chicago and Suburban Cook County. The surveys were available online in English and Spanish. In addition, surveys were collected in paper format at focus groups and select in-person events. The survey asked participants about the health status of their communities, community strengths, opportunities for improvement, priority health needs, and COVID-19 impacts. Hospitals, community-based organizations, and health departments distributed the surveys with the intention of gaining insight from priority populations that have been historically excluded in assessment processes. Survey data were analyzed by our partners at Sinai Urban Health Institute (SUHI) using STATA.

The intention of the community input survey was to complement existing surveys such as the Healthy Chicago Survey and CDC PLACES. IPHI and the CHNA planning committee took the following steps to develop the survey tool:

1. Illinois Public Health Institute (IPHI) drafted a survey based on a review of six existing survey tools as well as peer-reviewed standards for survey development.
2. CHNA committee members provided feedback on survey questions.
3. IPHI incorporated revisions from the CHNA committee members and partner organizations with survey expertise.
4. A Spanish translation of the survey was created by Heartland Alliance Health's Cross Cultural Interpreting Services.
5. The survey tool was uploaded into the web-based survey platform Alchemer and paper versions were created for in-person events.
6. The online survey was tested on Microsoft Windows and MacOS desktop platforms as well as Android and iOS mobile platforms before public release.

The final survey tool included 24 questions – two multi-select questions about health priorities and needs; five open-ended questions about community strengths, resources, and needs; four questions about COVID-19 impacts, recovery, and vaccine access; one question about access to help; two questions related to ZIP code and community of residence; and ten demographic questions.

Through the community input survey and focus groups, the Alliance for Health Equity is focused on hearing voices of community members most impacted by inequities through the community input survey including communities of color, immigrants, youth, older adults and caregivers, LGBTQ+, individuals experiencing homelessness or housing instability, individuals living with mental health conditions or substance use disorders, individuals with disabilities, veterans, and unemployed youth and adults. Given some of the challenges with collecting surveys during the COVID-19 pandemic–in particular not being able to distribute paper surveys as we have in the past–the overall demographics of survey respondents skewed more high-income, older, and less Black and Latine/Hispanic respondents (overall demographic tables are presented at the end of this summary document). Therefore, the Alliance for Health Equity undertook a more in-depth equity-focused analysis of the responses by various subpopulations of survey respondents. The analysis was led by Sinai Urban Health Institute (SUHI).

The purpose of this equity-focused analysis is to highlight the responses of priority groups that are most impacted by inequities. Here we present responses from eight priority groups: **Households with children, youth and young adult respondents, respondents that identified as LGBTQ+, Black/African American respondents, Latine/Hispanic respondents, Spanish-language respondents, respondents with lower educational attainment, and households that include an individual with a disability.**

**Overall survey responses (n=5405)**

| | |
|---|---|
| Most important community health needs (each respondent ranked 3) | Top 6:<br>1. Age-related illness<br>2. Mental health<br>3. COVID-19<br>4. Homelessness and housing<br>5. Cancer<br>6. Violence |
| Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3) | Top 6:<br>1. Mental health services access<br>2. Healthcare access<br>3. Community service access<br>3. Safety and low crime<br>4. Affordable housing<br>5. Healthy food access<br>6. Activities for teens and youth |
| Household Experiences due to the COVID-19 Pandemic (each respondent could select all that apply) | Top 6:<br>Lack of Control, Not Knowing when the Pandemic will End (56%)<br>Feeling nervous, anxious, or on edge (53%)<br>Feeling alone or isolated, Not being able to socialize with other People (51%)<br>Stress regarding employment status (29%)<br>Reduced pay and hours (22%)<br>Loss of employment (20%)<br>Death of family members or friends (20%)<br><br>For all respondents, psychological impacts were the top household experiences reported during the COVID-19 pandemic. In addition to the psychological impacts, employment-related impacts were among the most common household experiences reported, followed by experiencing loss of family members or friends. |

**Households with children (n=1285)**

| | | |
|---|---|---|
| Most important community health needs (each respondent ranked 3) | Top 5:<br>1. Mental health<br>2. COVID-19<br>3. Age-related illness<br>4. Homelessness and housing<br>5. Cancer | While the top 5 health needs were similar for respondents from households with and without children, several health needs had statistically significant differences between groups in the *magnitude* of average ranked importance. |
| Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3) | Top 5:<br>1. Mental health services access<br>2. Healthcare access<br>3. Community service access<br>4. Activities for teens and youth<br>4. Safety and low crime<br>5. Affordable housing | |
| Household Experiences due to the COVID-19 Pandemic (each respondent could select all that apply) | Top 5:<br>1. Feeling nervous, anxious, or on edge (56%)<br>2. Lack of Control, Not Knowing when the Pandemic will End (52%)<br>3. Feeling Alone or isolated, Not being able to Socialize with Other People (47%)<br>4. Stress regarding employment status (36%)<br>5. Reduced pay and hours (30%) | The top household experiences were similar for households with and without children. |

**Youth and young adult respondents (n=248)**

Youth under 18 (n=94)

| | | |
|---|---|---|
| Most important community health needs (each respondent ranked 3) | Top 5:<br>1. COVID-19<br>2. Age-related illness<br>2. Mental health<br>4. Child Abuse<br>5. Violence | |
| Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3) | Top 5:<br>1. Healthcare access<br>2. Mental health services access<br>3. Community service access<br>4. Activities for teens and youth<br>5. Healthy food access | |
| Household Experiences due to the COVID-19 Pandemic (each respondent could select all that apply) | Top 5:<br>1. Lack of Control, Not Knowing when the Pandemic will End (37%)<br>2. Sick household members (32%)<br>3. Feeling nervous, anxious, or on edge (30%)<br>4. Loss of employment (28%)<br>5. Reduced pay and hours (24%) | For all respondents, regardless of age group, psychological impacts were the top household experiences reported during the COVID-19 pandemic. For younger respondents, in addition to the psychological impacts, employment-related impacts were among the most common household experiences reported. |

Young adults 18-24 (n=154)

| | | |
|---|---|---|
| Most important community health needs (each respondent ranked 3) | Top 5:<br>1. COVID-19<br>2. Mental health<br>3. Age-related illness<br>4. Homelessness and housing<br>5. Diabetes<br>5. Violence | |
| Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3) | Top 5:<br>1. Healthcare access<br>2. Mental health services access<br>3. Community service access<br>4. Affordable housing<br>5. Healthy food access | |
| Household Experiences due to the COVID-19 Pandemic (each respondent could select all that apply) | Top 5:<br>1. Feeling nervous, anxious, or on edge (53%)<br>2. Lack of Control, Not Knowing when the Pandemic will End (52%)<br>3. Feeling Alone or isolated, Not being able to Socialize with Other People (44%)<br>4. Reduced pay and hours (40%)<br>5. Stress regarding employment status (38%) | For all respondents, regardless of age group, psychological impacts were the top household experiences reported during the COVID-19 pandemic. For younger respondents, in addition to the psychological impacts, employment-related impacts were among the most common household experiences reported. |

**Respondents that identified as LGBTQ+ (n=457)**

| | | |
|---|---|---|
| Most important community health needs (each respondent ranked 3) | Top 5:<br>1. Mental health<br>2. Homelessness and housing<br>3. COVID-19<br>4. Age-related illness<br>5. Racism and other discrimination | For the LGBTQ+ group, racism and other discrimination was the 5th top priority. There were significant differences between groups in the magnitude of importance for age-related illness, housing instability, mental health, and racism and other discrimination health needs. |

| | | |
|---|---|---|
| Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3) | Top 5:<br>1. Mental health services access<br>2. Healthcare access<br>3. Community service access<br>4. Affordable housing<br>5. Safety and low crime | |
| Household Experiences due to the COVID-19 Pandemic (each respondent could select all that apply) | Top 5:<br>1. Lack of Control, Not Knowing when the Pandemic will End (66%)<br>2. Feeling nervous, anxious, or on edge (64%)<br>3. Feeling Alone or isolated, Not being able to Socialize with Other People (61%)<br>4. Stress regarding employment status (39%)<br>5. Loss of employment (26%) | While the top household experiences for those identifying as LGBTQ+ were similar to those identifying as heterosexual, cisgender, those identifying as LGBTQ+ reported a significantly higher frequency of psychological impacts and stress related to employment status. |

**Black/African American respondents (n=633)**

| | | |
|---|---|---|
| Most important community health needs (each respondent ranked 3) | Top 5:<br>1. Mental health<br>2. Age-related illness<br>3. COVID-19<br>4. Homelessness and housing<br>5. Violence<br>6. Racism and other discrimination | The top 5 health needs were relatively similar among different racial/ethnic groups; however, the magnitude of importance varied across groups. Comparing Black respondents to overall respondents, there were significant differences around the magnitude of importance of Racism and Discrimination, Homelessness and housing, Dental problems, and Diabetes. |
| Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3) | Top 5:<br>1. Mental health services access<br>2. Healthcare access<br>3. Community service access<br>4. Affordable housing<br>5. Healthy food access<br>5. Safety and Low Crime | |
| Household Experiences due to the COVID-19 Pandemic (each respondent could select all that apply) | Top 5:<br>1. Lack of Control, Not Knowing when the Pandemic will End (49%)<br>2. Feeling Alone or isolated, Not being able to Socialize with Other People (44%)<br>3. Feeling nervous, anxious, or on edge (43%)<br>4. Death of Family Members or Friends (28%)<br>5. Stress regarding employment status (27%) | As was the case across respondents overall and in stratified assessment, the top household experiences by racial/ethnic group clustered around psychological impacts and employment-related impacts; however, the frequency of these experiences varied by the racial/ethnic group of the respondent. In addition, Black, Latinx, Indigenous (interpret with caution due to sample size), and Two or More Race/Ethnicity respondents were twice as likely as white respondents to report the death of family members or friends. |

**Latine/Hispanic respondents (n=606)**

| | | |
|---|---|---|
| Most important community health needs (each respondent ranked 3) | Top 5:<br>1. Mental health<br>2. Age-related illness<br>3. COVID-19<br>4. Homelessness and housing<br>4. Diabetes<br>5. Cancer | The top 5 health needs were relatively similar among different racial/ethnic groups; however, the magnitude of importance varied across groups. Comparing Latine/Hispanic respondents to overall respondents, there were significant differences |

| | | |
|---|---|---|
| | | around the magnitude of importance of Dental problems, Diabetes, Racism and Discrimination, and Homelessness and housing. |
| Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3) | Top 5:<br>1. Mental health services access<br>2. Healthcare access<br>3. Community service access<br>4. Activities for teens and youth<br>5. Safety and low crime<br>6. Affordable housing<br>6. Healthy food access | |
| Household Experiences due to the COVID-19 Pandemic (each respondent could select all that apply) | Top 5:<br>1. Lack of Control, Not Knowing when the Pandemic will End (49%)<br>2. Feeling Alone or isolated, Not being able to Socialize with Other People (44%)<br>3. Feeling nervous, anxious, or on edge (43%)<br>4. Death of Family Members or Friends (28%)<br>5. Stress regarding employment status (27%) | As was the case across respondents overall and in stratified assessment, the top household experiences by racial/ethnic group clustered around psychological impacts and employment-related impacts; however, the frequency of these experiences varied by the racial/ethnic group of the respondent. In addition, Black, Latinx, Indigenous (interpret with caution due to sample size), and Two or More Race/Ethnicity respondents were twice as likely as white respondents to report the death of family members or friends. |

**Spanish-language respondents (n=145)**

| | | |
|---|---|---|
| Most important community health needs (each respondent ranked 3) | Top 5:<br>1. Age-related illness<br>2. Mental health<br>3. Cancers<br>4. Dental problems<br>5. Homelessness and housing | The top health needs were overall similar between respondents who took the English and Spanish surveys; however, there were significant differences between groups in the magnitude of importance of different health needs (housing instability and cancer). COVID-19 and dental problems also showed significant differences between groups in the magnitude of their importance, with COVID-19 ranking in the top 5 for English survey respondents and Dental problems in the top 5 for Spanish survey respondents. |
| Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3) | Top 5:<br>1. Mental health services access<br>2. Community service access<br>3. Healthcare access<br>4. Activities for teens and youth<br>5. Healthy food access | |
| Household Experiences due to the COVID-19 Pandemic | Top 5:<br>1. Stress regarding employment status (49%)<br>2. Reduced pay and hours (47%)<br>3. Loss of employment (39%)<br>4. Feeling nervous, anxious, or on edge (37%)<br>4. Sick household members (37%)<br>5. Death of family members or friends (36%) | Among English-speaking respondents, psychological impacts were the top household experiences reported during the COVID-19 pandemic; however, among Spanish-speaking respondents, employment-related impacts were the top household experiences reported during the COVID-19 pandemic. In addition, Spanish-speaking respondents were over twice as likely to report that someone in their |

| | | |
|---|---|---|
| | | household experienced employment-related impacts than English-speaking respondents. Spanish-speaking respondents were also over twice as likely to report that the death of a family member or friend was a COVID-19 impact compared to English-speaking respondents. |

**Respondents with lower educational attainment (n=457)**

High School Diploma or Equivalent (n=297)

| | | |
|---|---|---|
| Most important community health needs (each respondent ranked 3) | Top 5:<br>1. Age-related illness<br>2. Mental health<br>2. COVID-19<br>3. Cancers<br>4. Diabetes<br>5. Homelessness and housing | |
| Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3) | Top 5:<br>1. Community service access<br>2. Healthcare access<br>3. Mental health services access<br>4. Safety and low crime<br>5. Activities for teens and youth<br>5. Healthy food access | |
| Household Experiences due to the COVID-19 Pandemic | Top 5:<br>1. Lack of Control, Not Knowing when the Pandemic will End (40%)<br>2. Feeling Alone or isolated, Not being able to Socialize with Other People (36%)<br>3. Feeling nervous, anxious, or on edge (33%)<br>4. Stress regarding employment status (32%)<br>5. Loss of employment (31%) | Among the top household experiences for respondents with lower educational attainment was loss of employment. Respondents with higher educational attainment reported that their households experienced psychological impacts more frequently compared to households of respondents with lower educational attainment, although this category of responses was the top rated household experience for all groups. |

Less than high school (n=168)

| | | |
|---|---|---|
| Most important community health needs (each respondent ranked 3) | Top 5:<br>1. Age-related illness<br>2. COVID-19<br>3. Cancer<br>4. Mental health<br>5. Homelessness and housing<br>5. Dental problems<br>5. Diabetes | |
| Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3) | Top 5:<br>1. Community service access<br>2. Healthcare access<br>3. Mental health services access<br>4. Activities for teens and youth<br>5. Healthy food access | |
| Household Experiences due to the COVID-19 Pandemic | Top 5:<br>1. Feeling nervous, anxious, or on edge (38%)<br>2. Lack of Control, Not Knowing when the Pandemic will End (34%) | Among the top household experiences for respondents with lower educational attainment was loss of employment. Respondents with higher educational |

| | | |
|---|---|---|
| | 3. Feeling Alone or isolated, Not being able to Socialize with Other People (33%)<br>4. Stress regarding employment status (31%)<br>4. Reduced pay and hours (31%)<br>4. Loss of employment (31%) | attainment reported that their households experienced psychological impacts more frequently compared to households of respondents with lower educational attainment, although this category of responses was the top rated household experience for all groups. |

**Household includes individual with a disability (n=870)**

| | | |
|---|---|---|
| Most important community health needs (each respondent ranked 3) | Top 5:<br>1. Mental health<br>2. Age-related illness<br>3. COVID-19<br>4. Homelessness and housing<br>5. Cancer | The top 5 health needs were similar for respondents from households with and without individuals with a disability. Among the top 5 health needs, there were significant differences between groups in the magnitude of importance of mental health needs. |
| Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3) | Top 5:<br>1. Mental health services access<br>2. Healthcare access<br>3. Community service access<br>4. Affordable housing<br>5. Safety and low crime | |
| Household Experiences due to the COVID-19 Pandemic | Top 5:<br>1. Feeling nervous, anxious, or on edge (58%)<br>2. Feeling Alone or isolated, Not being able to Socialize with Other People (57%)<br>3. Lack of Control, Not Knowing when the Pandemic will End (56%)<br>4. Stress regarding employment status (38%)<br>5. Loss of employment (28%) | The top experiences were similar for households with and without someone who had a disability. However, households with an individual who had a disability were more likely to report sick household members, ongoing illness, and death of family/friends than households without an individual who had a disability. |

## Overall Survey Demographics

**DEMOGRAPHICS - COMMUNITY INPUT SURVEY RESPONDENTS**

| Years Lived in Community (N=5,095)* | N | Percent |
|---|---|---|
| 0 to <2 Years | 315 | 6.2 |
| 3 to <5 Years | 741 | 14.5 |
| 5 to <10 Years | 743 | 14.6 |
| 10 to <20 Years | 1112 | 21.8 |
| 20 Years or More | 2184 | 42.9 |

**310 (5.7% of 5,405 total sample) did not respond or provided a number >85 years and are not included in table.*

| Respondent Identified as LGBTQ+* (N=4,816)** | N | Percent |
|---|---|---|
| No | 4305 | 89.4 |
| Yes | 511 | 10.6 |

**Includes individuals who identified as transgender female, transgender male, non-binary, or another gender*

**589 (10.9% of 5,405 total sample) excluded because responses were missing or they selected prefer not to*

| Race/Ethnicity (N=5,044)* | N | Percent |
|---|---|---|
| White Only | 3030 | 60.1 |
| African American/Black Only | 673 | 13.3 |
| Latino(a)/Hispanic Only | 642 | 12.7 |
| Asian Only | 274 | 5.4 |
| American Indian or Alaskan Native Only | 8 | 0.2 |
| Middle Eastern, Arab American, or Persian Only | 103 | 2.0 |
| Pacific Islander or Hawaiian Native Only | 10 | 0.2 |
| Other Only** | 15 | 0.3 |
| Two or More Race/Ethnicities | 289 | 5.7 |

**361 (6.7% of 5,405 total sample) did not respond or said prefer not to answer and are not included in table.*

***Examples of other responses included: Jewish, North African, East African, West Indian*

| Educational Attainment (N=5,256)* | N | Percent |
|---|---|---|
| Less than High School | 189 | 3.6 |
| High School Diploma or Equivalent | 322 | 6.1 |
| Some College** | 843 | 16.0 |
| College Graduate or Higher | 3,902 | 74.2 |

**149 (2.8% of 5,405 total sample) did not respond or said prefer not to answer and are not included in table.*

***Includes those who attended vocational or technical school.*

| Annual Household Income (N=4,028)* | N | Percent |
|---|---|---|
| Less than $20,000 | 379 | 9.4 |
| $20,000 to $39,999 | 438 | 10.9 |
| $40,000 to $59,999 | 456 | 11.3 |
| $60,000 to $79,999 | 452 | 11.2 |
| $80,000 to $99,999 | 458 | 11.4 |
| $100,000 to $199,999 | 1,069 | 26.5 |
| Over $200,000 | 776 | 19.3 |

**1,377 (25.5% of 5,405 total sample) did not respond or said prefer not to answer and are not included in table.*

| Age of Respondents (N=5,278)* | N | Percent |
|---|---|---|
| Younger than 18 years | 98 | 1.9 |
| 18 to 24 | 162 | 3.1 |
| 25 to 34 | 651 | 12.3 |
| 35 to 44 | 812 | 15.4 |
| 45 to 54 | 837 | 15.9 |
| 55 to 64 | 979 | 18.6 |
| 65 to 74 | 1116 | 21.1 |
| 75 and older | 623 | 11.8 |

**127 (2.4% of 5,405 total sample) did not respond or said prefer not to answer and are not included in table.*

| Household includes Children (Aged <18 Years) (N=5,405)* | N | Percent |
|---|---|---|
| No | 4033 | 74.6 |
| Yes | 1372 | 25.4 |

**If respondent did not respond, it was assumed that there were no children in the house*

| Household includes Young Adults (Aged 18-24 Years) (N=5,405)* | N | Percent |
|---|---|---|
| No | 4643 | 85.9 |
| Yes | 762 | 14.1 |

**If respondent did not respond, it was assumed that there were no children in the house*

| Household includes Individual with a Disability (N=5,086)* | N | Percent |
|---|---|---|
| No | 4,170 | 82.0 |
| Yes | 916 | 18.0 |

**319 (5.9% of 5,405 total sample) did not respond or said prefer not to answer and are not included in table.*