2022
Community Health Needs Assessment Report

Advocate Lutheran General Hospital

1775 Dempster Street

Park Ridge, IL 60068

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December 2022

Thank you for taking the time to learn more about Advocate Lutheran General Hospital's Community Health Needs Assessment (CHNA). Every three years the hospital works with community partners and stakeholders to complete a comprehensive CHNA. The Community Health department is responsible for pulling data from our data platform and for collecting input from the community to gain an in depth understanding of the health assessment of the community. Lutheran General is a member of the Alliance for Health Equity. This is a collaborative of Cook County hospitals, and various community organizations. This collaboration helps to ensure partnership and alignment during the CHNA process. Additionally, Lutheran General has a Community Health Council that provides oversight of the CHNA process and selects the hospital's priority health needs. The process for determining the priority health needs includes comprehensive community data, as well as feedback from constituents. To that end, the Community Health Council selected the following two priorities for the 2022 CHNA:

- Health and Nutrition
- Behavioral Health

We are committed to helping people live well by understanding the needs of the community and implementing culturally appropriate interventions. We also 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 hospital has the honor of working with community partners and leaders to improve the health and wellness of diverse communities across the hospital's service area. With a comprehensive and thorough understanding of our communities' health needs, the hospitals will be well positioned to help people live well and improve the quality of life among individuals, children and families in the communities we are privileged to serve.

Dia Nichols, FACHE
President

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I. Executive Summary

Advocate Lutheran General Hospital (Advocate Lutheran General) completed a comprehensive hospital community health needs assessment (CHNA) process in 2022. This CHNA report describes the process and includes demographic and socioeconomic data for Advocate Lutheran General'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 hospital's PSA. The PSA consists of 25 zip codes in Cook County and three zip codes in Lake County. Demographic and socioeconomic data for the hospital'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 63.11 percent White, 12.66 percent Asian or Pacific Islander, 2.38 percent Black/African American, and 19.57 percent Hispanic or Latino. In addition, the PSA is 51.47 percent female and 48.53 percent male, with a PSA median household income of $90,476.

The hospital's CHC, comprised of hospital 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 hospital'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 Lutheran General's PSA were determined to be:

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

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 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 Lutheran General is a member of The Alliance for Health Equity, a coalition co-founded by Advocate Aurora. 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. Additionally, over 30 nonprofit and public hospitals, seven local health departments and 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 Lutheran General supported the collaborative CHNA process by participating and providing

input in collaborative CHNA meetings and assisting in the recruitment for community focus groups. The primary and qualitative data collected by The Alliance was also used by the hospital to determine the PSA's health needs.

To ensure the hospital 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 Lutheran General Hospital

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, oncology and pediatrics. 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 Lutheran General Hospital

Advocate Lutheran General began serving the community in 1897 and is now a 651-bed not-for-profit health care facility—the eighth largest hospital in Chicagoland and a leading provider in Chicago's North and Northwest Suburbs. Advocate Lutheran General is a tertiary care academic and research hospital and a Level I Trauma Center. The hospital offers a full range of inpatient and outpatient services, as well as a variety of community outreach programs. The hospital employs approximately 1,632 physicians representing 89 specialties, 1,353 nurses and provides medical education to 32 fellows, 200 residents and 900 medical students each year.

As a nationally recognized academic and research hospital, Advocate Lutheran General's patients have access to the most advanced treatment in the areas of cardiology, cancer, neurosciences, orthopedics, pediatrics and women's health. The hospital is also designated as a Resource Hospital, which requires the hospital to provide education and training to emergency medical providers. The hospital has been a Magnet designated hospital for nursing excellence every year since 2010. Advocate Children's is also located on the hospital's campus and provides exceptional pediatric care to the Chicagoland community.

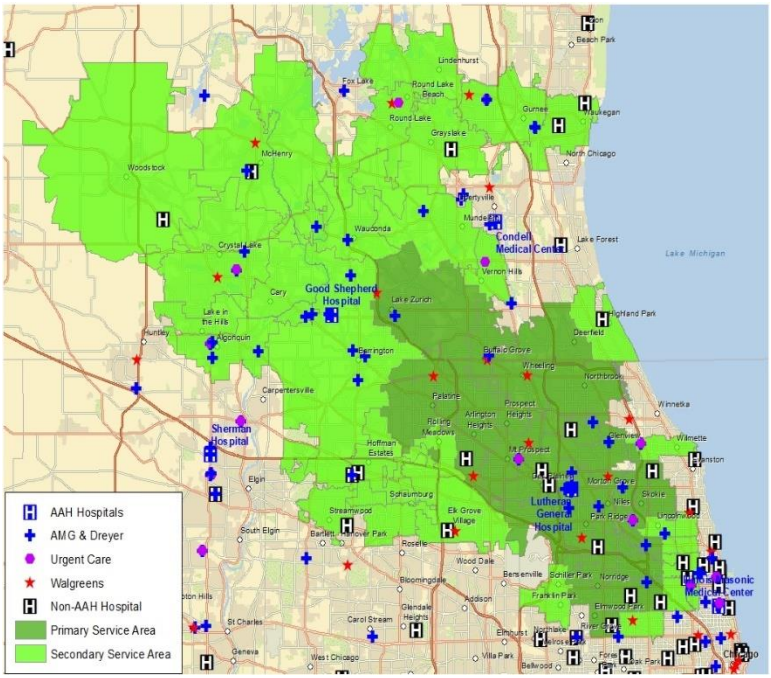
III. 2022 Community Health Needs Assessment

Community Definition

For the 2022 Community Health Needs Assessment (CHNA) cycle, Advocate Lutheran General defined its community as the hospital's primary service area (PSA). This area includes approximately 1,066,255 individuals, which is a slight population increase from the 2019 CHNA (Metopio, American Community Survey). There are 28 zip codes—25 in Cook County and three in Lake County—within the hospital's PSA.

Advocate Lutheran General's PSA includes the following communities: Irving Park/Portage (60641), Elmwood Park (60707), Des Plaines (60018), Dunning (60634), Jefferson Park (60630), Palatine (60074), Harwood Heights (60706), Mount Prospect (60656), Niles (60714), Wheeling (60090), Skokie (60077), Des Plaines (60016), Prospect Heights (60070), Morton Grove (60053), Skokie (60076), Harwood Heights (60056), Norwood Park (60631), Arlington Heights (60005), Forest Glen (60646), Arlington Heights (60004), Palatine (60067), Glenview (60025), Buffalo Grove (60089), Park Ridge (60068), Northbrook (60062), Lake Zurich (60047), Glenview (60026) and Deerfield (60015).

Exhibit 1: Advocate Lutheran General Primary and Secondary Service Area Map 2022



Source: Advocate Aurora Business Development Analytics, 2022

1. Population

The total population for the hospital's PSA is 1,066,255. The largest zip codes/communities in the PSA are Irving Park/Dunning (60634) at 75,694, Irving Park/Portage Park (60641) at 69,354 and Des Plaines (60016) at 61,888. The zip codes/communities with the smallest population are Glenview (60026) at 14,518, Prospect Heights (60070) at 15,840 and Morton Grove (60053) at 25,297.

2. Social Drivers of Health

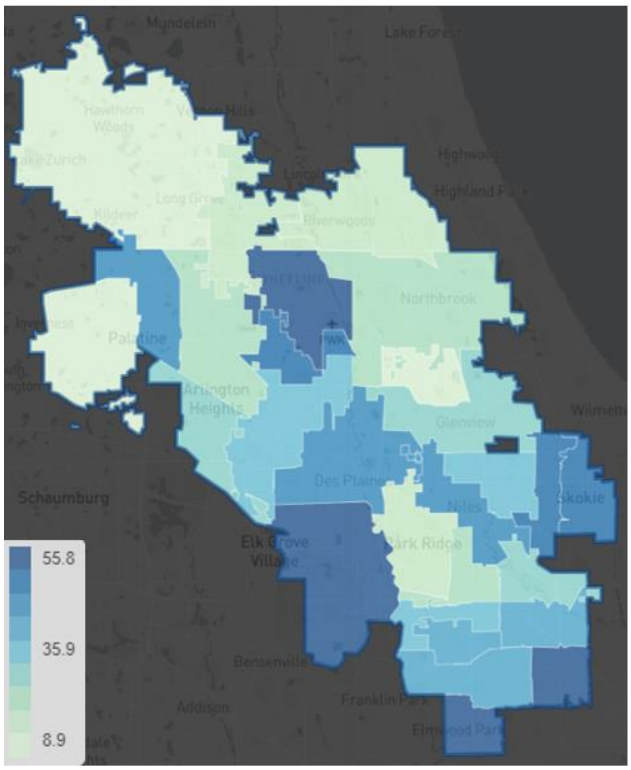
Social Drivers of Health

The hospital's PSA health needs discussed above are strongly influenced by various social factors; this concept is known as social drivers or influencers of health (SDOH). The World Health Organization (WHO) defines social drivers of health as the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. Hospital PSA data shows a relationship between income, race/ethnicity and health outcomes. Hospital PSA communities with lower median household incomes had higher rates of obesity, ED visits and hospitalizations due to chronic diseases and mental health issues (Metopio, 2022). This data is consistent with state and national trends, which indicate poor health outcomes and the risk of chronic disease are greater among those who are low-income with less educational attainment (HealthyPeople2020, 2019). The hospital's CHC recognized the importance of addressing root causes of the health needs above therefore the priority health needs selected will incorporate social drivers of health in Implementation Plan strategies and programs.

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 map below outlines the hardship communities in the PSA.
The darker shaded communities are the highest need with higher hardship scores and the lighter shaded communities have the lower hardship scores. Communities with the highest hardship score and the most need include Irving Park/Portage Park (60641) with a score of 55.8, Des Plaines (60018) with a score of 55.5 and Elmwood Park (60707) with a score of 49. The PSA communities with the least need according to the Hardship Index include Long Grove (60047) with a score of 8.9, Palatine (60067) with a score of 11 and Glenview (60026) with a score of 11.9.

Exhibit 2: Advocate Lutheran General PSA Hardship Index Map by Zip Code 2015-2019



Source: Metopio, American Community Survey, 2022

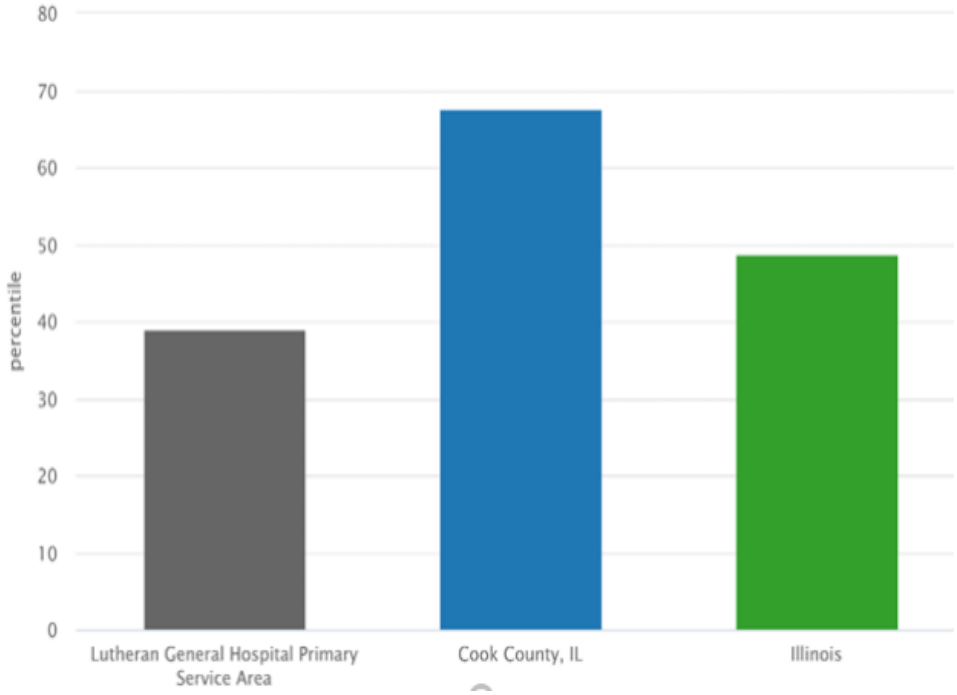
Social Vulnerability Index

The Social Vulnerability Index (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). The SVI includes more social factors in the rankings/score thus providing a more in depth look at each community. To further understand the hospital's communities with the highest need and ensure consideration of all social factors across the Hardship and Social Vulnerability Indexes, the hospital's Community Health Council (CHC) reviewed the Social Vulnerability Index in comparison to the Hardship Index.

The overall SVI for the hospital's PSA is 38.98, which is lower than Cook County at 67.55 and the state at 48.70 (Metopio, Centers for Disease Control, 2022). The highest need communities were Skokie (6007) at 60.59, Irving Park/Portage Park

(60641) at 60.27 and Des Plaines (60018) at 57.37 (Metopio, Centers for Disease Control, 2022). Exhibit 3 shows the overall Social Vulnerability Index for Advocate Lutheran General compared to the county and state.

Exhibit 3: Advocate Lutheran General PSA Social Vulnerability Index Comparison 2018



Source: Metopio, Centers for Disease Control and Prevention (CDC), 2022

3. Demographics

Age and Gender

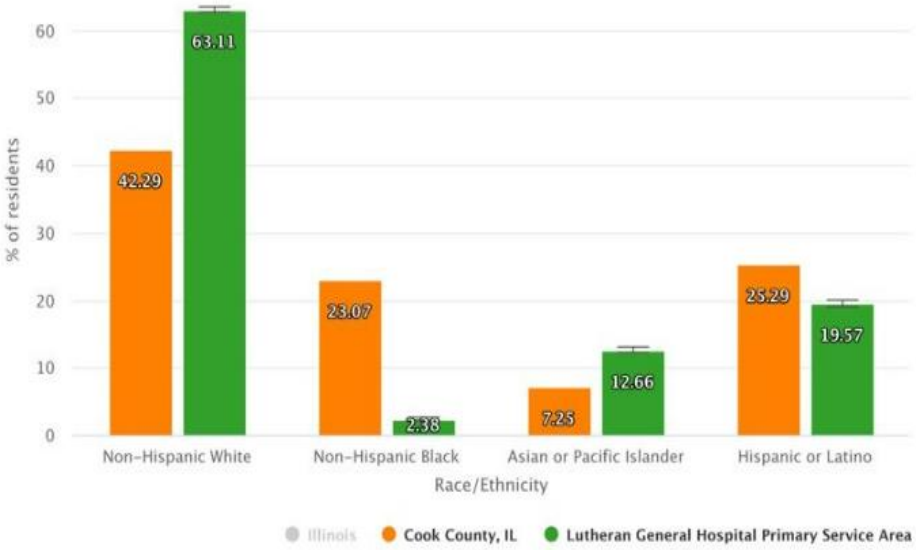
The median age for the population living in Advocate Lutheran General's PSA is 41.9 years (Metopio, American Community Survey, 2022). The largest age group in the hospital's PSA are the adults 40–64 years of age, accounting for 34.62 percent of the PSA followed by the 18–39 year-old age group at 25.73 percent. The male population accounts for 48.53 percent of the PSA while the female population is 51.47 percent of the PSA.

Race and Ethnicity

Demographic data for the hospital's PSA shows that the largest racial/ethnic group is the Non-Hispanic White population at 63.11 percent followed by the Hispanic or Latino population at 19.57 percent (Metopio, American Community Survey, 2022). The third largest racial/ethnic group is the Asian or Pacific Islander population at 12.66 percent followed by the Non-Hispanic Black population at 2.38 percent (Metopio, American Community Survey, 2022). Exhibit 4 shows the PSA population by race/ethnicity. The PSA communities with the largest Hispanic/Latino populations include Irving Park/Portage Park (60641) at 54.61 percent, Elmwood Park (60707) at 39.1 percent and Irving Park/Dunning (60634) at 38.4 percent (Metopio, American Community Survey, 2022).

PSA communities with the largest Asian/Pacific Islander populations include Skokie (60053) at 30.5 percent, Skokie (60077) at 29 percent and Skokie (60076) at 28.8 percent (Metopio, American Community Survey, 2022). Communities with the largest Non-Hispanic Black population include Skokie (60076) at 8.5 percent, Elmwood Park (60707) at 6.9 percent and Skokie (60007) at 5.9 percent (Metopio, American Community Survey, 2022).

Exhibit 4: Advocate Lutheran General PSA Demographics by Race and Ethnicity 2015-2019

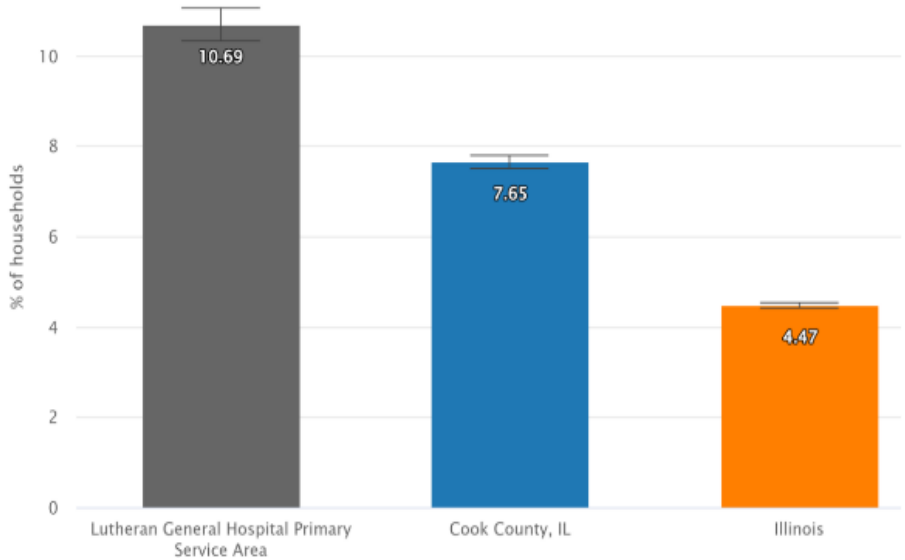


Metopio, American Community Survey, 2022

English Proficiency and Languages Spoken

Approximately 10.69 percent of the PSA is limited in English proficiency, which is higher than Cook County at 7.65 percent and the state at 4.47 percent (Metopio, American Community Survey, 2022). Communities with the largest populations that are limited in English proficiency include: Oriole Park (60656) at 19.4 percent, Skokie (60077) at 16.6 percent, Irving Park/Dunning (60634) at 16.4 percent, Irving Park/Portage Park (60641) at 15.4 percent and Wheeling (60090) at 15.2 percent (Metopio, American Community Survey, 2022). Exhibit 5 shows the rate of limited English proficiency by PSA, county and state. PSA communities with the largest populations that speak an Asian language as the primary language include Morton Grove (60053) at 15.4 percent, Skokie (60077) at 14.5 percent and Buffalo Grove (60089) at 14.2 percent. Communities with the largest populations that speak Spanish as the primary language include Irving Park/Portage Park at 39.9 percent of the population, Elmwood Park (60707) at 28.9 percent and Irving Park/Dunning (60634) at 27.2 percent (Metopio, American Community Survey, 2022).

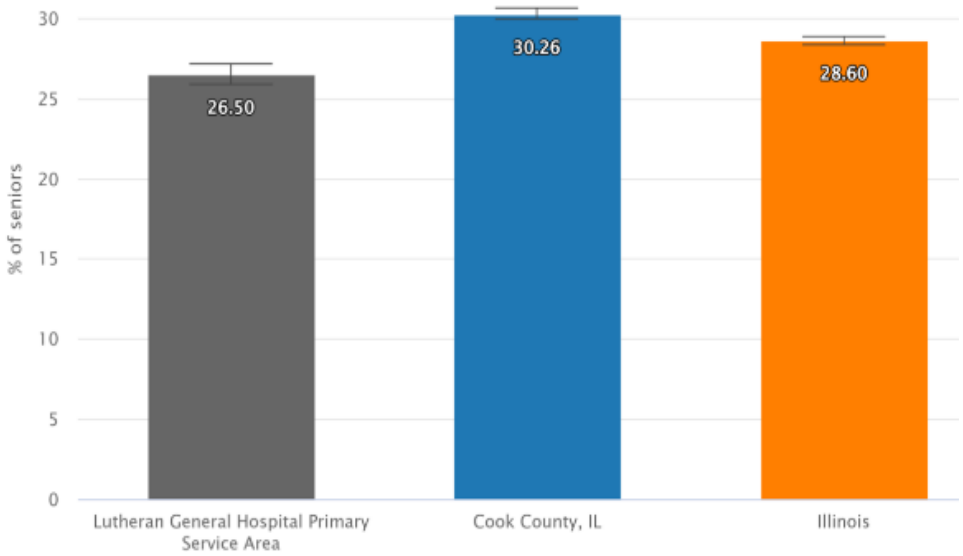
Exhibit 5: Advocate Lutheran General PSA Limited English Proficiency Households Comparison 2015-2019



Source: Metopio, American Community Survey, 2022

Household/Family
In the hospital's PSA 4.41 percent of households are single-parent households, which is lower than Cook County at 6.61 percent and the state at 6.29 percent (Metopio, American Community Survey, 2022). In addition, 4.91 percent of children in the PSA live with one or more grandparent or in a multigenerational household, which is lower compared to Cook County at 9.23 percent and the state at 7.16 percent. The percentage of seniors living alone in the PSA is 26.5 percent, which is lower than Cook County at 30.26 percent and the state at Illinois at 28.6 percent (Metopio, American Community Survey, 2022).

Exhibit 6: Advocate Lutheran General PSA Seniors Living Alone Comparison 2015-2019



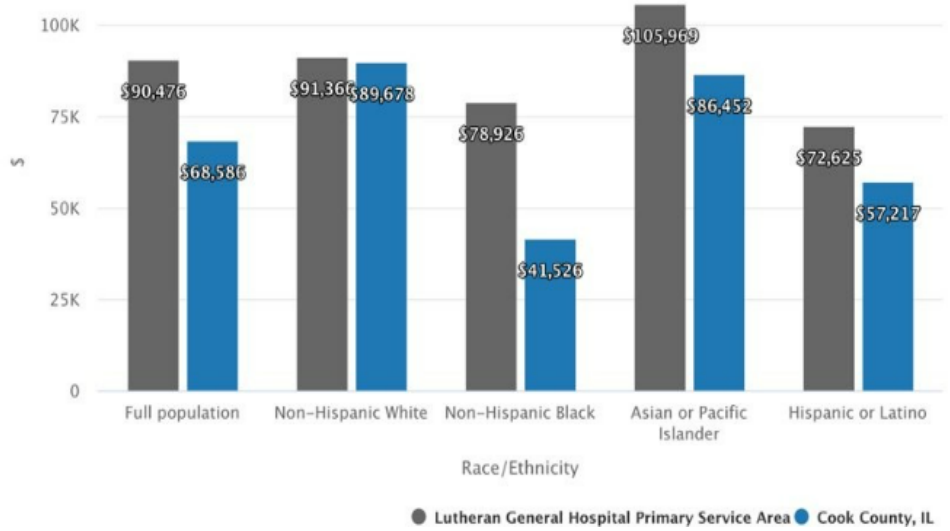
Source: Metopio, American Community Survey, 2022

4. Economics

Income
The median household income for the PSA is high ($90,476) compared to Cook County ($68,586) and Illinois ($69,886) (Metopio, American Community Survey, 2022). There is a significant racial disparity in median household income with the Hispanic/Latino population having the lowest median household income at $72,625 followed by the Non-Hispanic Black population at $78,926. The Non-Hispanic White population ($90,476) and the Asian or Pacific Islander population with a median household income of $105,969, the highest compared to all other racial and ethnic groups. Exhibit 7 depicts the median household income by race/ethnicity at the PSA, county and state level. Deep poverty is defined as individuals and families whose income is less than half of the federal poverty level, in past 12 months income.

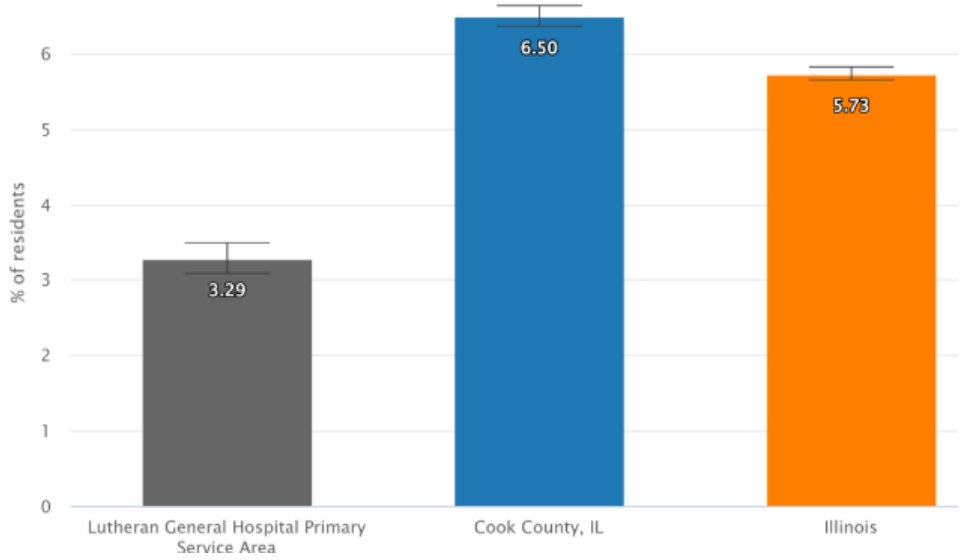
Approximately, 3.29 percent of the PSA lives in deep poverty which is lower than Cook County at 6.5 percent and the state at 5.73 percent (Metopio, American Community Survey, 2022). The communities with the largest population of residents in deep poverty include two zip codes in Des Plaines at 5.13 percent (60018) and 4.96 percent (60016), Palatine (60074) at 4.85 percent, two zip codes in Skokie at 4.6 percent (60077) and 4.56 percent (60076) and Jefferson Park (60630) at 4.47 percent. Exhibit 8 shows deep poverty rates at the PSA, county and state level.

Exhibit 7: Advocate Lutheran General PSA Median Household Income by Race/Ethnicity 2015-2019



Source: Metopio, American Community Survey, 2022

Exhibit 8: Advocate Lutheran General PSA Deep Poverty Comparison 2015-2019

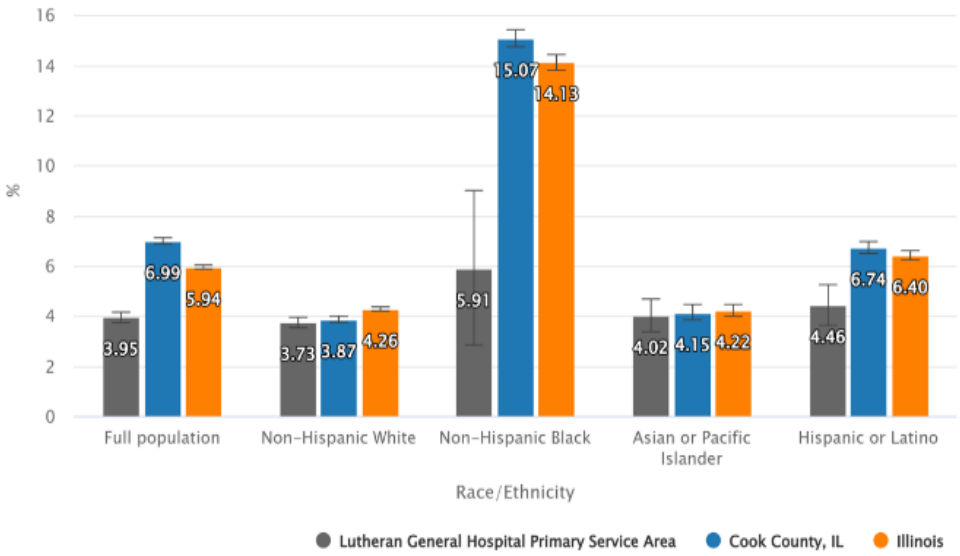


Source: Metopio, American Community Survey, 2022

Employment

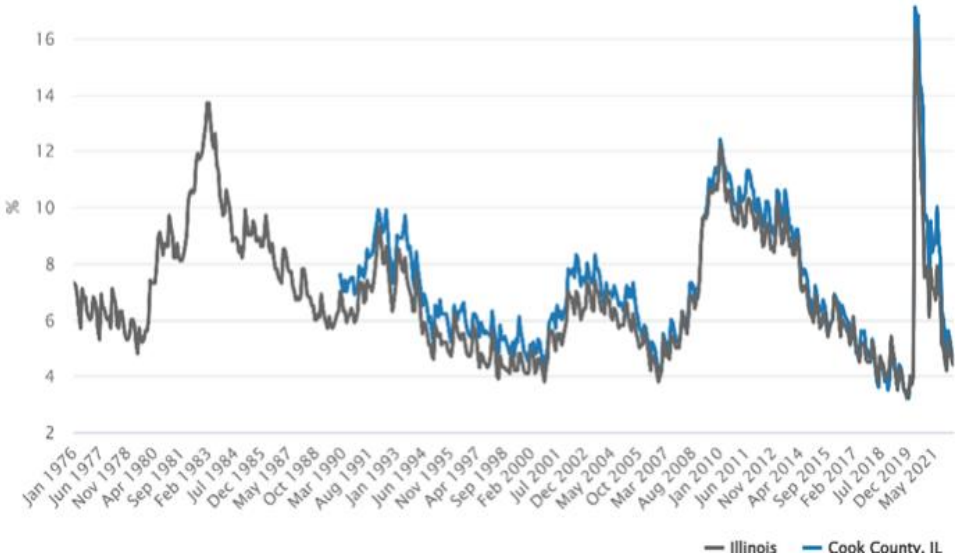
The unemployment rate from 2015-2019 among residents that are of 16 years of age and older in the hospital's PSA was 3.95 percent, which is lower compared to Cook County at 5.54 percent and Illinois at 4.84 percent (Metopio, American Community Survey, 2022). The Non-Hispanic Black populations had the highest rates of unemployment (5.91 percent) during this time period, followed by the Hispanic or Latino population (4.46 percent), the Asian or Pacific Islander population (4.02 percent) and then the Non-Hispanic White population (3.73 percent). The PSA racial/ethnic disparities in unemployment rates are consistent with trends seen at the county and state level. Exhibit 9 shows the 2015-2019 unemployment rates by race/ethnicity at the PSA, county and state level. It is important to note that there was a significant increase in the Cook County unemployment rate from November of 2019 to April of 2020 as a result of the COVID-19 pandemic. Monthly unemployment data was not available at the PSA level so county level data was used as a proxy to examine the affects COVID-19 had on unemployment rates. Exhibit 10 depicts Cook County's unemployment rate from 1976 to 2021. The labor force participation in the PSA is 66.57 percent, which is slightly higher than Cook County at 66.14 percent and the state at 65.24 percent (Metopio, American Community Survey, 2022).

Exhibit 9: Advocate Lutheran General PSA Unemployment Rate by Race/Ethnicity 2015-2019



Source: Metopio, American Community Survey, 2022

Exhibit 10: Illinois and Cook County Unemployment Rate (BLS)



Source: Metopio, American Community Survey, 2022

5. Education

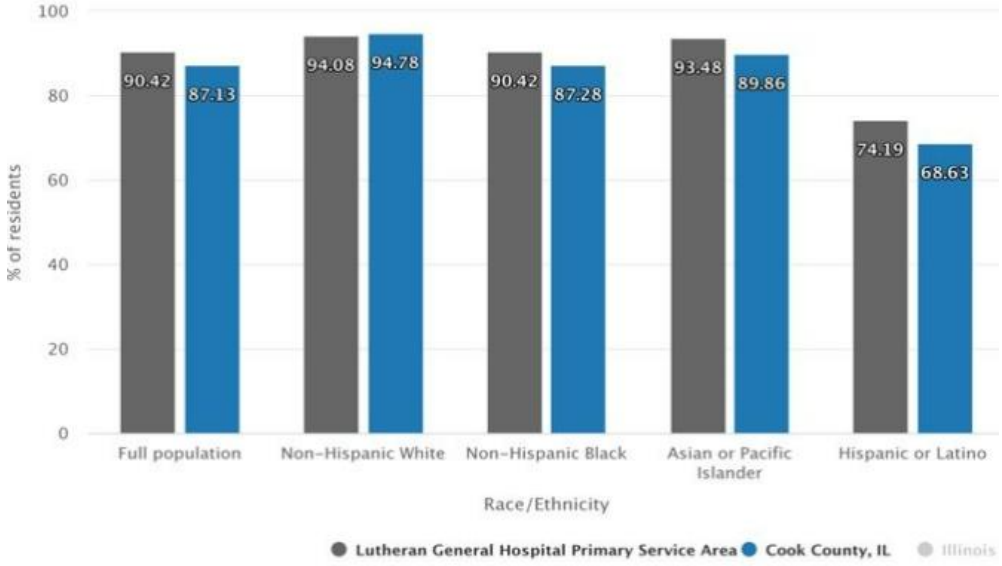
Educational Level

Advocate Lutheran General's PSA educational attainment data was also reviewed and analyzed to gain an in-depth understanding of education levels across the PSA. Educational attainment is one of the most significant influencers of health thus gaining an in depth understanding of education across the PSA was essential. Higher educational attainment has a direct correlation with higher median household incomes and more positive health outcomes. The high school graduation rate for the PSA is 90.42 percent, which is lower than Cook County (93 percent) but higher than Illinois (89.21 percent) (Metopio, American Community Survey, 2022). Furthermore, there is a racial/ethnic disparity in high school graduation rates with the Hispanic or Latino population having significantly lower rates compared to all other races/ethnic groups, followed by the Non-Hispanic Black population at 90.42 percent (Metopio, American Community Survey, 2022). Exhibit 11 below displays the high school graduation rate by race/ethnicity for the PSA, Cook County and

Illinois. The college graduation rate for the PSA is also higher (45.55 percent) compared to Cook County (38.81 percent) and the state (34.65 percent) (Metopio, American Community Survey, 2022).

Additionally, there is a racial/ethnic disparity in college graduation rates with the Hispanic or Latino population having the lowest college graduation rate at 15.62 percent. PSA communities with the lowest college graduation rate include Irving Park/Dunning (60634) at 26.38 percent, Des Plaines (60018) at 26.89 percent and Elmwood Park (60707) at 26.89 percent. These communities also have large Hispanic or Latino populations (Metopio, American Community Survey, 2022).

Exhibit 11: Advocate Lutheran General PSA High School 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
Access Genesis Center for Health and Empowerment	Federally Qualified Health Center	Des Plaines
Oak Street Health	Medicare Clinic	Chicago
Old Irving Park Clinic	Community Clinic	Chicago
Heartland Health Centers	Federally Qualified Health Center	Skokie
Cook County Department of Public Health	Community Clinic	Des Plaines
Ascension Holy Family Medical Center	Hospital	Des Plaines
Ascension Resurrection Medical Center	Hospital	Des Plaines
Shriners Children's Chicago	Hospital	Chicago
Northshore University Health System	Hospital	Glenview
Community First Medical Center	Hospital	Chicago
Northshore University Health System- Glenbrook	Hospital	Glenview
Chicago Behavioral Hospital	Hospital	Des Plaines
Maryville Children's Healthcare Center	Hospital	Chicago

IV. 2022 Community Health Needs Assessment

How the CHNA was Conducted

1. Community Health Council

The Advocate Lutheran General's Community Health Council (CHC) was formed in 2016 and serves in an advisory capacity for the hospital's community health programming, Implementation Strategies and CHNA. The CHC is led by the hospital's regional director of community health and is a multi-sectorial council comprised of hospital leaders and community representatives from community-based organizations. There are a total of 18 CHC members of which 11 are community organization representatives and eight are hospital representatives. Under the direction of the director of community health, the CHC supported the CHNA through data collection, data review and prioritizing identified health needs. The CHC also works with the hospital's Community Health Department to identify community partners for the Community Health Implementation Strategies.

The CHC convened for five two-hour virtual meetings throughout 2021 and 2022 to contribute to the completion of the Advocate Lutheran General CHNA. In addition to the virtual meetings, CHC members were able to send recommendations and feedback electronically. Community representatives provided critical feedback around the health needs of the overall community specifically those related to vulnerable and under-served populations, while hospital representatives provided critical feedback around top patient health issues, hospital resources and confirmation of the hospital health needs alignment with the PSA health needs. Community representatives were also able to provide perspectives from various disciplines and represented the health and social need issues of many vulnerable and marginalized populations within the hospital's PSA.

Both community and hospital representatives engaged in a robust discussion regarding the health needs of the PSA. CHC members were also able to share knowledge regarding social drivers of health and zip codes that had the most health disparities and social barriers.

After thorough data analysis, discussion and expert presentations, the CHC selected the hospital's final health need priorities. The CHC will continue to convene to ensure comprehensive and collaborative Community Implementation Strategies. The affiliation and titles of the Advocate Lutheran General CHC members are listed below. The CHC member affiliations representing at-risk/disparate populations are indicated with an asterisk.

2022 CHC Members

- Governing Council Member, Advocate Lutheran General Hospital
- Rondout School District 72, Superintendent
- Advocate Lutheran General Hospital, Patient Navigator
- Advocate Lutheran General Hospital, Executive Director, Heart Institute
- Access Community Health Network, Cancer Education Program Specialist*
- Park Ridge Police Department, Police Social Worker
- American Heart Association, Communications Director*
- Advocate Lutheran General Hospital, Manager, Outpatient Behavioral Health Services
- Lutheran Social Services, Associate Executive Director*
- National Alliance on Mental Illness – Cook County North Suburban, Executive Director and Program Director*
- Northwest Center, Director, Community Development*
- Advocate Lutheran General Hospital, Director, Transition Support Program
- Advocate Lutheran General Hospital, Public Affairs Coordinator

- Advocate Lutheran General Hospital, Community and Cultural Liaison*
- Advocate Lutheran General Hospital, Coordinator, South Asian Cardiovascular Center
- Skokie School District 69, Community Schools Manager*
- Frisbee Senior Center, President*

2. Purpose and Process

In 2020, Advocate Aurora began organizing resources to implement the 2020-2022 CHNA process—a process developed and completed to better understand and address the health and social needs of the hospital's PSA. The system had a contract with Metopio to provide an internet-based data resource for all Advocate hospitals during the 2020-2022 CHNA cycle. The robust data platform offered over 200 health and demographic indicators including hospitalization and emergency department visit indicators. Hospital and system leadership also provided access to aggregated and de-identified hospital utilization data through the Illinois Hospital Association's COMP data for the Community Health Needs Assessment.

In July of 2021, the hospital's community health team presented the details of the 2022 CHNA process to the hospital's CHC. In August of 2021, the hospital's community health team organized and conducted a Forces of Change Assessment (FOCA)—a process that convenes community leaders and organizers to provide primary qualitative data regarding the health and social needs of the PSA. The FOCA was conducted with the hospital's CHC and additional representatives and leaders from community organizations across various sectors. Following the FOCA with the hospital's CHC and additional community organizations/partners, the hospital's director and coordinator of community health compiled and presented key themes and data points collected from the FOCA to the Community Health Council.

In January of 2022, following the FOCA, the hospital's community health team compiled and presented demographic and socioeconomic data followed by a presentation of the PSA's top nine health needs to the hospital's CHC. After careful review and analysis of the data, the CHC completed a health need prioritization grid that allowed members to rate each health need using five criteria. The hospital's community health team analyzed and aggregated the prioritization grid scores to determine the top four health needs. After careful review and calculation, the community health team identified substance use, mental health, health and nutrition and access to care as the top four health needs.

Following the identification of the top four health needs per the prioritization grid, the community health team identified organizations with expertise in each of the following four health needs. Four experts presented local data including qualitative data on their respective health issue to the CHC. After thorough discussion and analysis, the CHC voted on behavioral health (substance use and mental health) and health and nutrition (access to care, chronic disease prevention and management, food access and physical activity) as the two prioritized health needs. In addition, the hospital's CHC recognized the importance of addressing root causes of the priority health needs therefore council members voted to integrate social influencers/drivers of health into strategies that address priority health needs.

Additional Partnerships
In addition to community representatives on the hospital's CHC, the community health department engaged several community organizations in the 2022 CHNA process. Additional community partners and organizations engaged in the process representing various sectors across the PSA and provided input and feedback regarding the health and social needs of the PSA to ensure thorough completion of the FOCA. The community organizations and partners (outside of the CHC) engaged in the FOCA are listed below.

- Irving Park Community Food Pantry
- Alliance for Immigrant Neighbors
- Turning Point
- Maine Township School District

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, 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.

3. Data Collection and Analysis

Multiple data collection strategies were employed to collect data for the CHNA. In early 2020, Advocate Aurora signed an annual contract with Metopio to provide an internet-based data resource for their 26 hospitals during the 2022 CHNA cycle. This robust platform offered the hospitals 198 health and demographic indicators, including 38 hospitalization and emergency department (ED) visit indicators at the service area and zip code levels. Utilizing the Illinois Hospital Association's COMP data, Metopio was able to summarize, age adjust and average the hospitalization and ED utilization data for several time periods. The Metopio database also provided a wealth of county and zip code data comparisons, and a Hardship Index, which helped to visualize vulnerable populations within service areas and counties.

As indicated, Metopio was a key source of secondary data for the 2022 CHNA. This secondary data was crucial in analyzing the hospital's PSA health needs as the database was the only source that provided such an extensive amount of data specific to the 2022 CHNA's defined community. All data collected through Metopio was quantitative and included data comparisons between PSA communities, counties and the state.

Primary data was also collected through the previously outlined FOCA. Community representatives and leaders representing various sectors across the PSA provided primary qualitative data around the health and social needs of the PSA communities. The data collected from the FOCA provided supplemental information to the quantitative data collected through Metopio and was used to compare and identify health and social needs of the PSA. Data collected through the FOCA was consistent with the quantitative data from Metopio and indicated similar community health needs.

As previously mentioned, the hospital is a member of the Alliance for Health Equity, a collaborative of Cook County hospitals and community organizations. Advocate Lutheran General is an active member of The Alliance and contributes to the collection and analysis of Cook County data for the collaborative CHNA. The hospital utilized components of The Alliance's CHNA data to inform the hospital's CHNA. Advocate Lutheran General utilized the community input surveys and focus group data, collected by The Alliance, to gain a deeper understanding of the community's concerns and perception of health needs and compare data collected to the CHC's FOCA. Advocate Lutheran General will continue working to align the hospital's PSA community health improvement strategies when possible, with that of The Alliance in the pursuit of achieving collective impact. Survey results/responses are included in the appendix.

Exhibit 12: The Alliance for Health Equity Members 2018-2019

Nonprofit Hospital Members	
Advocate Children's	Loyola Medicine-Gottlieb Memorial Hospital
Advocate Christ	Loyola Medicine-Loyola University Medical Center
Advocate Illinois Masonic	Loyola Medicine-MacNeal Hospital
Advocate Lutheran General	Mercy Hospital & Medical Center
Advocate South Suburban	Northwestern Memorial Hospital
Advocate Trinity	Norwegian American Hospital
AMITA Adventist Medical Center, La Grange	Palos Community Hospital
AMITA Alexian Brothers Medical Center, Elk Grove Village	Roseland Community Hospital
AMITA Holy Family Medical Center	Rush Oak Park
AMITA Resurrection Medical Center	Rush University Medical Center
AMITA St. Alexius Medical Center and Alexian Brothers Behavioral Health Hospital	Sinai Health System-Holy Cross Hospital
AMITA Saint Francis Hospital	Sinai Health System-Mount Sinai Hospital
AMITA Saint Joseph Hospital	Sinai Health System-Schwab Rehabilitation Hospital
AMITA Saints Mary and Elizabeth Medical Center	South Shore Hospital
Ann & Robert H. Lurie Children's Hospital-Chicago	Swedish Covenant Hospital
Jackson Park Hospital	University of Chicago Medicine
The Loretto Hospital	University of Chicago Medicine-Ingalls Memorial Hospital
Public Hospital Partners	
Cook County Health-Stroger Hospital	Cook County Health-Provident Hospital
University of Illinois Hospital & Health Sciences System	
Public Health Department Partners	
Chicago Department of Public Health	Evanston Health and Human Services Department
Cook County Department of Public Health	Village of Skokie, Health Department

Source: The Alliance for Health Equity, 2022

4. Data Sources

Multiple data collection strategies were employed to collect data for the CHNA. As indicated in the section above, Advocate Lutheran General collaborated with many partners to collect PSA data. In addition to collecting and analyzing secondary data, the hospital's director of community health worked with the CHC to gather and analyze primary data. Details regarding the hospital's CHNA primary and secondary data sources are listed below.

- Advocate Lutheran General Forces of Change Assessment (primary qualitative)
- Alliance for Health Equity (primary qualitative and secondary quantitative)
- Metopio (secondary quantitative)

Summary of CHNA Findings

1. Overall Health Status

The life expectancy for the hospital's PSA is 81.2 years, which is higher than Cook County at 78.5 years and the state at 78.7 years. The top nine health needs for the hospital's PSA were health and nutrition, cardiovascular disease, diabetes, respiratory disease, mental health, substance use, access to care, cancer and COVID-19.

2. Access to Care and Health Care Coverage

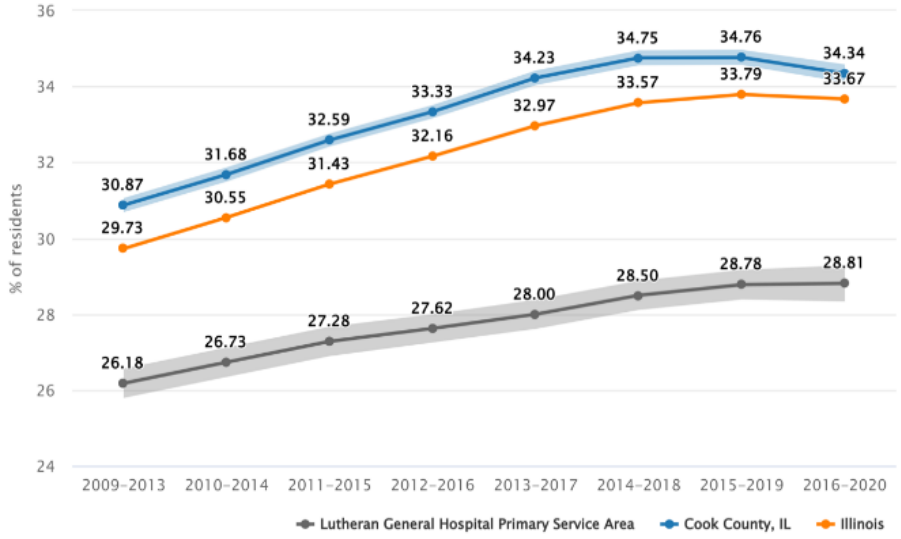
One of the main barriers to achieving positive health outcomes is an individual's access to primary care. Health screenings and preventative visits decrease significantly if individuals are uninsured or underinsured resulting in poor chronic disease management and late-stage diagnosis. Transportation and proximity to care are also factors that influence the ability to access primary care. Interventions to increase access to health care professionals and improve communication – in person or remotely – can help more people access primary care.

Health Care Coverage

Approximately 14.72 percent of adults in the hospital's PSA have no health insurance, which is less than Cook County at 21.10 percent and the state at 18.23 percent (Metopio, Behavioral Risk Factor Surveillance System, 2022). The communities in the PSA with the largest percentage of uninsured adults include Irving Park/Portage Park (60641) at 24.3 percent, Des Plaines (60018) at 21.9 percent, Elmwood Park (60707) at 19.8 percent, Wheeling (60090) at 19. 3 percent and Irving Park/Dunning at 19.3 percent. These communities are also some of the most racially/ethnically diverse zip codes in the PSA. The number of non-citizens who are uninsured in the PSA is 36,593 residents (Metopio, American Community Survey, 2022). The number of non-citizen uninsured is not a rate therefore it cannot be compared to the county or state but can provide insight into a vulnerable population with very limited access to healthcare resources and services. The percentage of PSA residents with public health insurance is 28.78 percent, which is less than Cook County at 34.76 percent and the state at 33.79 percent (Metopio, American Community Survey, 2022).

Exhibit 13 shows the percentage of residents with public health insurance for the PSA, county and state. Medicare is federal health insurance supported and funded by the federal government, it provides health insurance to many seniors and those with disabilities. In the PSA, 17.27 percent of residents receive Medicare coverage, which is more than Cook County at 15.32 percent and the state at 16.23 percent (Metopio, American Community Survey, 2022).

Exhibit 13: Advocate Lutheran General PSA Public Health Insurance 2009-2020

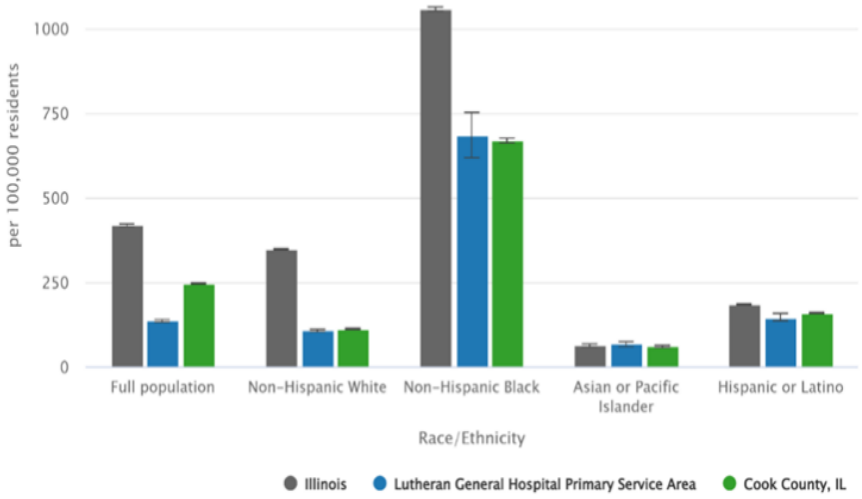


Source: Metopio, American Community Survey, 2022

Unmet Dental Needs

Dental problems emergency department visit rates also indicate a lack of access to health and dental services. The emergency dental rate for the PSA is 136.54 per 100,000 residents, which is less than Cook County at 246.57 and the state at 419.51 per 100,000 residents (Metopio, IHA COMP data Informatics, 2022). There is a racial/ethnic disparity with the Non-Hispanic Black population having the highest rates (684.46 per 100,000 residents) compared to the White (108.24 per 100,000 residents), Asian or Pacific Islander (67.24 per 100,000 residents) and Hispanic or Latino (145.65 per 100,000 residents) populations. This disparity is also persistent at the county and state level with the Non-Hispanic Black population having the highest rates. The communities in the PSA with the highest rates of dental problem emergency department visits include Skokie (60076) at 252.15 per 100,000 residents, Skokie (60077) at 234.27 per 100,000 and Irving Park/Portage Park (60641) at 219.04 per 100,000 residents. These communities also have some of the largest Non-Hispanic Black populations in the PSA, which further illustrates the racial/ethnic disparity in dental emergency department visits. Exhibit 14 below, shows the dental problems emergency department visit rates by race/ethnicity for the PSA, county and state.

Exhibit 14: Advocate Lutheran General PSA Dental Problems Emergency Department Visit Rate by Race/Ethnicity 2017-2021



Source: Metopio, IHA COMPdata Informatics, 2022

3. Health Risk Behaviors

Health and Nutrition

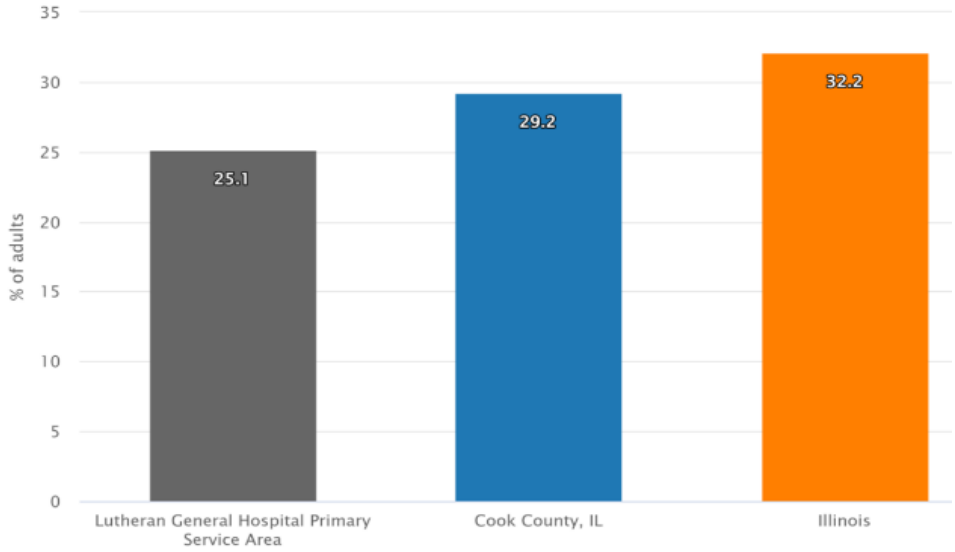
The overall quality of life at the individual and community level is dependent on various factors such as access to healthy affordable food, the ability to be physically active in the community and nutrition. These factors are not only essential in overall quality of life but also important in maximizing positive health outcomes thus increasing life expectancy across communities. Social drivers of health also have a strong influence on quality of life and the factors listed above. For example, if an individual is unemployed or low-income, they are less likely to have access to healthy affordable foods and more likely to feel unsafe or uncomfortable being physically active in the community where they reside. Addressing issues like access to affordable healthy foods, physical activity and nutrition are also critical in increasing proper chronic disease management and chronic disease prevention.

Approximately 25.1 percent of adults in the hospital's PSA are obese, which is slightly lower than Cook County at 29. 2 percent and the state at 32.2 percent (Metopio, Behavioral Risk Factor Surveillance System, 2022). The PSA communities with the highest rates of obesity include Long Grove (60047) at 29.6 percent, Irving/Portage Park (60641) at 28.5 percent, Deerfield (60015) at 28.4 percent and Elmwood Park (60707) at 28.4 percent. With the exception of Long Grove (60047), the communities with the highest rates of obesity are also communities with higher hardship scores. Exhibit 15

shows the obesity rates for the PSA, county and state. A lack of exercise is highly correlated with increased obesity. In communities with high rates of violent crime, there are higher rates of lack of exercise due to safety and high rates of community violence. Approximately 21.5 percent of adults in the PSA reported not exercising in the past month that were surveyed; the PSA rate is lower compared to Cook County (24.2 percent) and the state (24.6 percent) (Metopio, Behavioral Risk Factor Surveillance System, 2022). Exhibit 16 displays the rates of no exercise for the PSA, county and state. The PSA communities with higher rates of no exercise include Des Plaines (60018) at 26.6 percent, Irving Park/Portage Park (60641) at 26.2 percent, Elmwood Park (60707) at 25.4 percent and Irving Park/Dunning (60634) at 24.6 percent. PSA communities with higher rates of no exercise also had higher rates of obese adults.

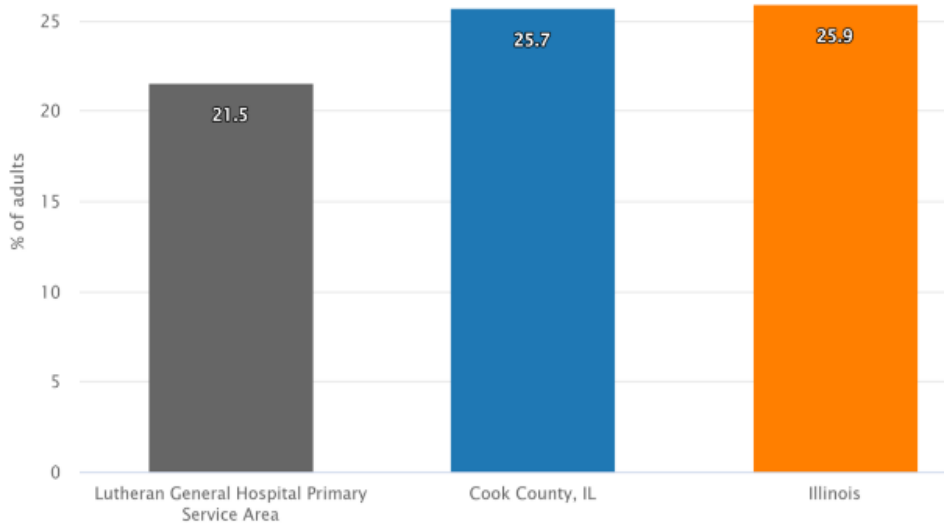
The percentage of adults in the PSA reporting poor physical health is 10.68 percent, which is lower than Cook County at 11.6 percent and the state at 11.5 percent (Metopio, Behavioral Risk Factor Surveillance System, 2022). The communities in the PSA with higher rates of self-reported poor physical health include Des Plaines (60018) at 12.7 percent, Norridge/Harwood Heights at 12.5 percent, Elmwood Park (60707) at 12.4 percent and Niles (60714) at 12.3 percent.

Exhibit 15: Advocate Lutheran General PSA Obesity Comparison 2019



Source: Metopio, Behavioral Risk Factor Surveillance System, 2022

Exhibit 16: Advocate Lutheran General PSA No Exercise 2019



Source: Metopio, Behavioral Risk Factor Surveillance System, 2022

Substance and Alcohol Use

In the United States, fifty percent of people 12 and older have used illicit drugs at least once (National Center for Drug Abuse Statistics, 2022). More than 932,000 people in the US have died since 1999 from drug overdose (National Center for Drug Abuse, 2022). Over 85 percent of people 18 years and older have reported that they drank alcohol at some point in their lifetime (National Institute on Alcohol Abuse and Alcoholism, 2022). In 2019, over 25 percent of people ages 18 and older reported that they engaged in binge drinking in the past month (National Institute on Alcohol Abuse and Alcoholism, 2022). Furthermore, in 2020, the number one cause of death among those aged 20-24 was unintentional injury of which most were caused by poisonings related to certain drugs, including narcotics and hallucinogens (Very Well Health, 2022).

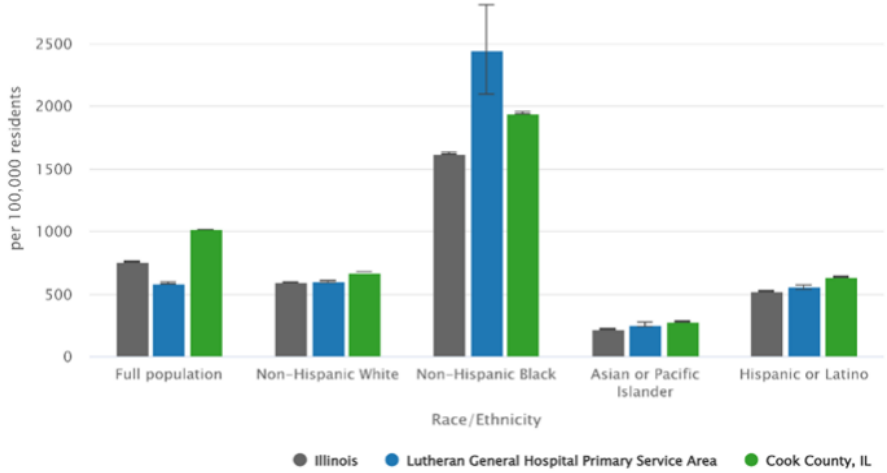
The PSA rate of emergency department visits due to substance use is 578.88 per 100,000 residents, which is lower than Cook County at 992.53 per 100,000 residents and the state at 753.65 per 100,000 residents Metopio, IHA COMPdata Informatics, 2022). There is a racial/ethnic disparity in substance use emergency department visit rates with the Non-Hispanic Black population having the highest rates in the PSA at 2,445.95 compared to the Non-Hispanic White (595.93 per 100,000 residents), Hispanic or Latino (552.46 per 100,000 residents) and Asian or Pacific Islander (253.35 per 100,000 residents) populations. This disparity is consistent with data at the county level with the Non- Hispanic Black populations having the highest rates. The graph in Exhibit 17 shows the rates of substance use emergency department visit rates by race/ethnicity for the PSA, county and state.

In the hospital's PSA, the opioid-related emergency department visit rate is 137.36 per 100,000 residents, which is lower than Cook County at 342.83 per 100,000 residents and the state at 236.19 per 100,000 residents (Metopio, IHA COMPdata Informatics, 2022). There is a racial/ethnic disparity in opioid-related emergency department visit rates with the Non-Hispanic Black population having the highest rate at 650.77 per 100,000 residents, which is significantly higher than the Non-Hispanic White (150.03 per 100,000 residents), Hispanic or Latino (111.45 per 100,000 residents) and the Asian or Pacific Islander (100.84 per 100,000 residents) populations. This disparity is consistent in the county and state rates with the Non-Hispanic Black population having the highest rates. Exhibit 18 displays the opioid-related emergency department visit rates by race/ethnicity for the PSA, county and state. The rate of opioid-related emergency visit rates are highest amongst the PSA's young adult (18-39 years of age) population with a rate of 260.75 per 100,000 residents. PSA Communities with the highest rates include Elmwood Park (60707) at 274.2 per 100,000 residents, Irving Park/Portage Park (60641) at 236.6 per 100,000 residents and Irving Park/Dunning (60634) at 220.7 per 100,000 residents.

The alcohol emergency department visit rate for the PSA is 578.88 per 100,000 residents, which is lower than the county at 518.91 per 100,000 residents and the state at 413.49 per 100,000 residents. There is a racial and ethnic disparity in rates with the Non-Hispanic Black population having the highest rate for the PSA, county and state followed by the Non-Hispanic White, Hispanic or Latino and Asian or Pacific Islander populations. Detailed data regarding the alcohol use emergency department visit rate by race and ethnicity for the PSA, county and state is outlined below in Exhibit 19.

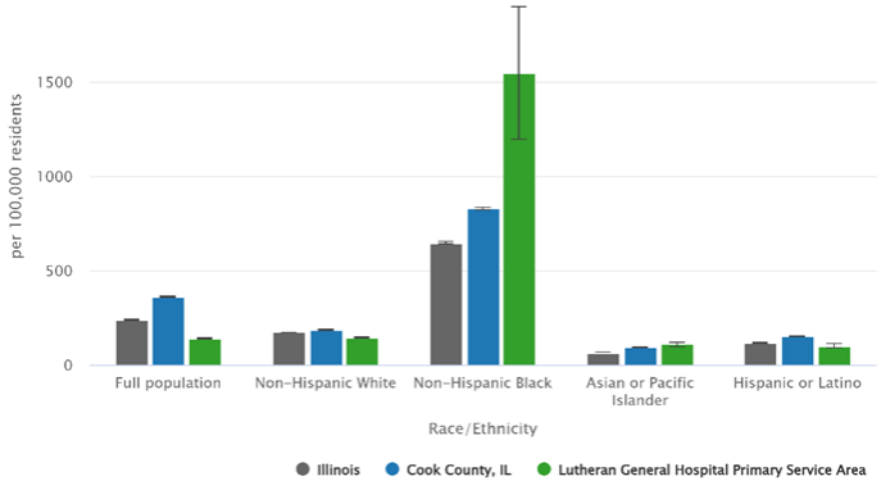
Binge drinking rates have also increased in the PSA going from 21.09 percent of adults in 2018 to 22.29 percent of adults in 2019 (Metopio, CDC, 2022). There are several communities that have higher rates of binge drinking including, Palatine (60074) at 24.6 percent, Palatine (60067) at 24.1 percent and Irving Park/Portage Park (60641) at 24.1 percent. Exhibit 20 shows the binge drinking rates for the PSA from 2014-2019.

Exhibit 17: Advocate Lutheran General PSA Substance Use Emergency Department Visit Rate by Race/Ethnicity 2017-2019



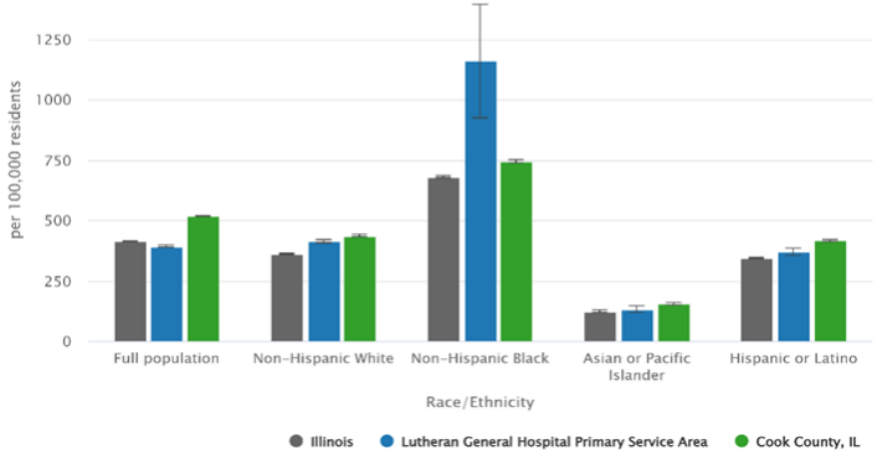
Source: Metopio, IHA COMPdata Informatics, 2022

Exhibit 18: Advocate Lutheran General PSA Opioid-related Emergency Department Visit Rate by Race and Ethnicity 2017-2021



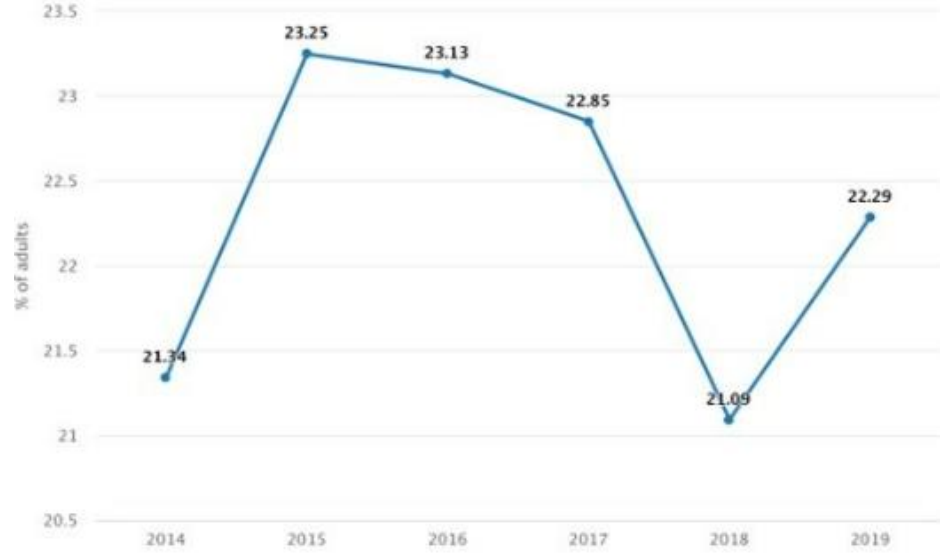
Source: Metopio, IHA COMPdata Informatics, 2022

Exhibit 19: Advocate Lutheran General PSA Alcohol Use Emergency Department Visit Rate by Race and Ethnicity 2017-2021



Source: Metopio, IHA COMPdata Informatics, 2022

Exhibit 20: Advocate Lutheran General PSA Binge Drinking 2014-2019



Source: Metopio, CDC, 2022

Mental Health

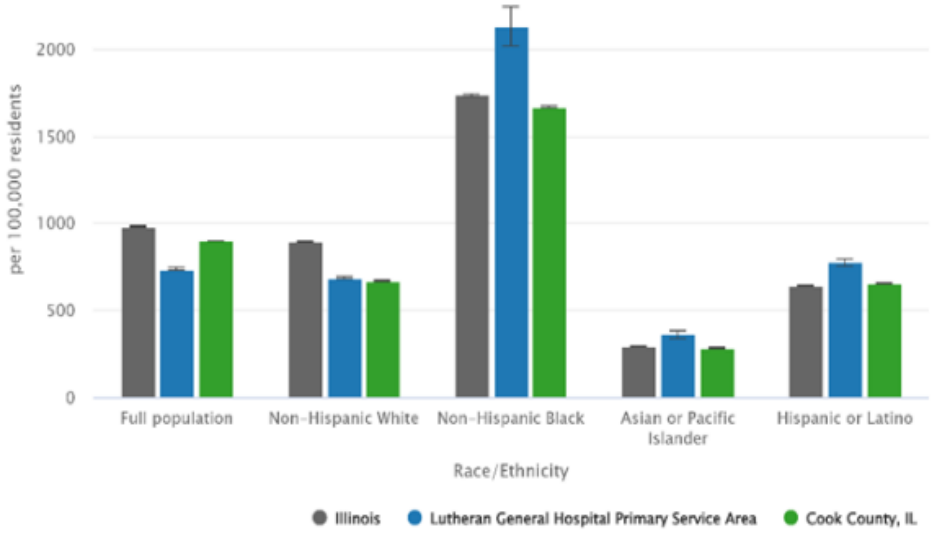
According to the National Alliance on Mental Illness (NAMI) one in five adults experience mental illness each year (NAMI, 2022). One in 20 adults in the U.S. experience serious mental illness each year (National Alliance on Mental Illness, 2022). In addition, 50 percent of all lifetime mental illness begins by age 14, and 75 percent by age 24 (National Alliance on Mental Illness, 2022). In the U.S., suicide is the second leading cause of death among people aged 10-34. The pandemic has exacerbated mental health issues and crises. In 2019, 11 percent of adults experienced symptoms of anxiety disorder and/or depressive disorder, by 2021 the rate almost quadrupled to 41 percent (National Alliance on Mental Illness, 2022).

The mental health emergency department visit rate for the PSA is 730.8 per 100,000 residents, which is lower than Cook County at 917.12 and the state at 981.67 per 100,000 residents (Metopio, IHA COMP Informatics, 2022). There is a racial/ethnic disparity in the rate of mental health emergency department visits with the Non-Hispanic Black population having the highest PSA rate at 2,129.40 per 100,000 residents; this rate is almost double compared to the second highest rate among the Hispanic or Latino population at 775.44 per 100,000 residents (Metopio, IHA COMP Informatics, 2022). More details regarding the mental health emergency department visit rates by race/ethnicity for the PSA, county and state are depicted below in Exhibit 21. The mental health hospitalization rate for the PSA is 419.41 per 100,000 residents, which is lower than the county at 639.99 per 100,000 residents and the state at 514.73 per 100,000 residents (Metopio, IHA COMP Informatics, 2022). There is a racial/ethnic disparity in mental health hospitalization rates with the Non-Hispanic Black population having the highest PSA rate at 1,339.15 per 100,000 residents, which is higher compared to the Non-Hispanic White population at 430.58 per 100,000 residents, the Hispanic or Latino population at 353.13 per 100,000 residents and the Asian or pacific Islander population at 297.68 per 100,000 residents. Furthermore, there are several communities with higher rates compared to the overall PSA. These communities include Arlington Heights (60005) at 597.7 per 100,000 residents, Palatine (60074) at 557.5 per 100,000 residents, Skokie (60076) at 541.9 per 100,000 residents and Palatine (600067) at 526.9 per 100,000 residents.

The suicide and self-inflicted injury emergency department visit rate for the PSA is 29.25 per 100,000 residents, which is lower than Cook County at 48.88 per 100,000 residents and the state at 74.83 per 100,000 residents (Metopio, COMP data Informatics, 2022). Similar to mental health and substance use emergency department visit rates, there is a racial/ethnic disparity in suicide and self-inflicted emergency department visit rates with the Non-Hispanic Black population having the highest rate (131.24 per 100,000 residents) compared to all other racial and ethnic groups. Exhibit

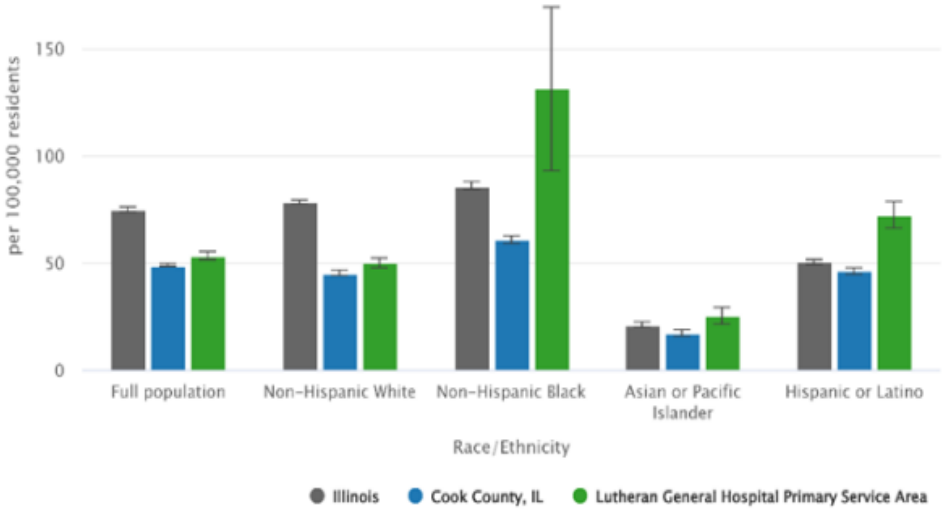
22 shows the rate of suicide and self-inflicted injury emergency department visits by race/ethnicity. The communities in the PSA with the highest rate of emergency department visits due to suicide and self-inflicted injury include Palatine (60074) at 53.5 per 100,000 residents, Palatine (60067) at 50.4 per 100,000 residents and Irving Park/Portage Park (60641) at 46 per 100,000 residents.

Exhibit 21: Advocate Lutheran General PSA Mental Health Emergency Department Visit Rate by Race/Ethnicity 2017-2021



Source: Metopio, IHA COMPdata Informatics, 2022

Exhibit 22: Advocate Lutheran General PSA Suicide and self-injury Emergency Department Visit Rate by Race and Ethnicity 2017-2021



Source: Metopio, IHA COMPdata Informatics, 2022

4. Disease and Chronic Conditions

Cancer

Cancer is one of the leading causes of death worldwide, accounting for nearly 10 million deaths in 2020, or nearly one in six deaths (World Health Organization, 2022). The most common cancers are breast, lung, colon and rectum and prostate cancers (World Health Organization, 2022). Around one-third of deaths from cancer are due to tobacco use,

high body mass index, alcohol consumption, low fruit and vegetable intake and lack of physical activity (World Health Organization, 2022). The cancer diagnosis rate for the PSA is 664.07 per 100,000 residents, which is higher than Cook County at 522.52 per 100,000 residents and the state at 531.12 per 100,000 residents. The non-invasive breast cancer diagnosis rate is 39.55 per 100,000 residents, which is higher than Cook County at 37.92 per 100,000 residents and 37.37 per 100,000 residents. The oral cancer diagnosis rate for the PSA (17.36 per 100,000 residents) is also higher than Cook County (13.62 per 100,000 residents) and the state (14.43 per 100,000 residents). The rates of lung cancer diagnosis are higher in the PSA (77.29 per 100,000 residents) compared to Cook County (68.70 per 100,000 residents) and the state (74.39 per 100,000 residents) (Metopio, Illinois Department of Public Health, 2022). Additionally, the PSA colorectal cancer diagnosis rate is higher (62.07 per 100,000 residents) compared to Cook County (50.07 per 100,000 residents) and the state (48.69 per 100,000 residents). The chart below in exhibit 23 shows the diagnosis rate of various cancers for the PSA, county and state.

Exhibit 23: Advocate Lutheran General PSA Cancer Diagnosis Rates 2014-2018

Topic	Lutheran General Hospital Primary Service Area	Cook County, IL	Illinois
Cancer diagnosis rate per 100,000 residents, 2014-2018	664.07 ± 6.42	522.52 ± 2.41	531.12 ± 3.35
Non-invasive breast cancer diagnosis rate per 100,000 female residents, 2014-2018	39.55 ± 1.94	37.92 ± 0.89	37.37 ± 1.24
Invasive breast cancer diagnosis rate per 100,000 female residents, 2014-2018	166.98 ± 3.95	158.14 ± 1.82	159.20 ± 2.57
Cervical cancer diagnosis rate per 100,000 female residents, 2014-2018	8.37 ± 1.13	8.91 ± 0.43	8.14 ± 0.58
Oral cancer diagnosis rate per 100,000 residents, 2014-2018	17.36 ± 1.04	13.62 ± 0.39	14.43 ± 0.55
Lung cancer diagnosis rate per 100,000 residents, 2014-2018	77.29 ± 2.19	68.70 ± 0.88	74.39 ± 1.25
Nervous system cancer diagnosis rate per 100,000 residents, 2014-2018	8.80 ± 0.76	6.33 ± 0.26	6.94 ± 0.38
Colorectal cancer diagnosis rate per 100,000 residents, 2014-2018	62.07 ± 1.96	50.07 ± 0.75	48.69 ± 1.01
Prostate cancer diagnosis rate per 100,000 male residents, 2014-2018	116.58 ± 3.36	137.70 ± 1.80	129.85 ± 2.36

Source: Metopio, Illinois Department of Public Health, Illinois State Cancer Registry, 2022

Respiratory Disease

Asthma and chronic obstructive pulmonary disease (CODP) are significant public health burdens. Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing (Healthy People 2020, 2022). Approximately one in 12 people have asthma and the numbers are increasing every year (CDC, 2022). 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).

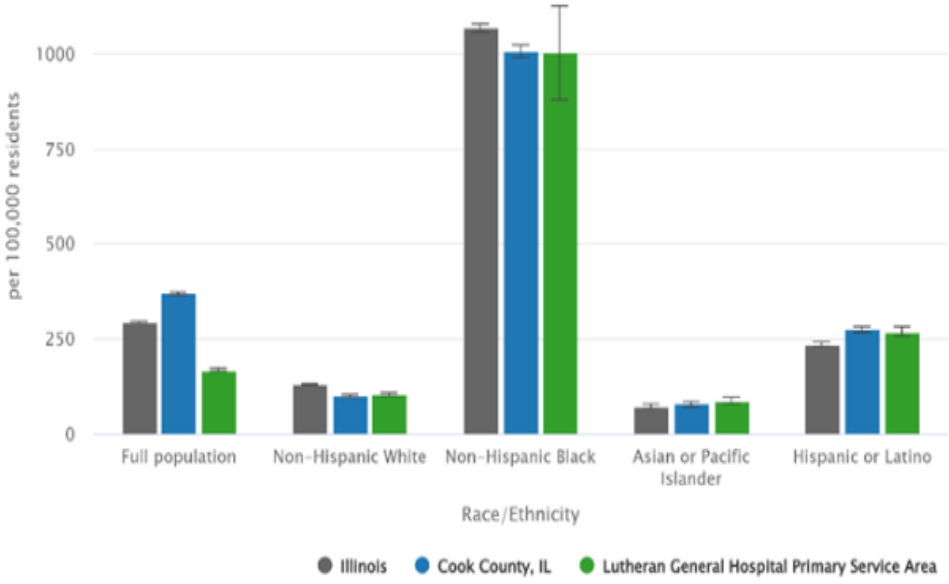
The PSA asthma emergency department visit rate is 168.34 per 100,000 residents, which is lower than Cook County at 369.38 and the state at 292.71 per 100,000 residents (Metopio, IHA COMPdata Informatics, 2022). There is a racial/ethnic disparity with the PSA's Non-Hispanic Black populations having the highest rate (1,001.21 per 100,000 residents) compared to all other racial and ethnic groups. Exhibit 24 displays the asthma emergency department visit rates for the PSA, county, state by race/ethnicity. There are several PSA communities that have higher rates of asthma

emergency department visits compared to the overall PSA. Communities with the highest rates include Irving Park/Portage Park (60641) at 346.5 per 100,000 residents, Elmwood Park (60707) at 337.8 per 100,000 residents and Irving Park/Dunning (60634) at 273.5 per 100,000 residents (Metopio, IHA COMPdata Informatics, 2022).

The COPD emergency department visit rate for the PSA is 224.71 per 100,000 residents, which is lower than Cook County at 562.46 and the state at 611.83 per 100,000 residents. Although the PSA rate is lower, there is a racial/ethnic disparity with the Non-Hispanic Black population having a significantly higher rate at 1,092.98 per 100,000 residents compared to the Hispanic/Latino population at 250.28 per 100,000 residents, the Non-Hispanic White population at 218.24 per 100,000 residents and the Asian or Pacific Islander population at 106.86 per 100,000 residents (Metopio, IHA COMPdata Informatics, 2022). This disparity is also persistent at the county and state level with the Non-Hispanic Black population having the highest rates. Exhibit 25 shows the COPD emergency department visit rate for the PSA, county and state by race and ethnicity. PSA communities with the highest rates of COPD emergency department visits include Irving Park/Portage Park (60641) at 506.8, Irving Park/Dunning (60634) at 367.8 per 100,000 residents, Elmwood Park (60707) at 355.9 per 100,000 residents and Jefferson Park (60630) at 329.5 per 100,000 residents.

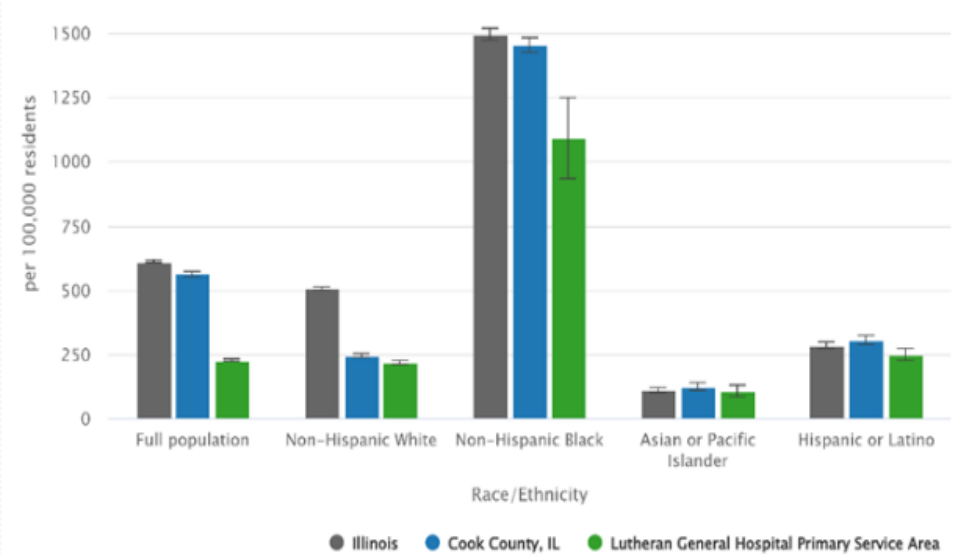
The pneumonia/flu emergency department visit for the PSA is 370.46 per 100,000 residents, which is less than the county at 590.05 per 100,000 residents and the state at 567.30 per 100,000 residents (Metopio, IHA COMPdata Informatics, 2022). There is a racial/ethnic disparity with the Non-Hispanic Black population having the highest rates at the PSA (938.22 per 100,000 residents), county (779.28 per 100,000 residents) and state (981.06 per 100,000 residents) level. The Hispanic or Latino population has the second highest rates by PSA- 597.37, Cook County- 611.63, Illinois- 657.29 per 100,000 residents). Exhibit 26 shows details of the pneumonia/flu emergency department visit rates by race/ethnicity for the PSA, county and state. PSA communities with the highest rates include Irving Park/Portage Park (60641) at 574.4 per 100,000 residents, Skokie (60076) at 562.3 per 100,000 residents, Skokie (60077) at 551.6 per 100,000 residents, Elmwood Park (60707) 496.9 per 100,000 residents.

Exhibit 24: Advocate Lutheran General PSA Asthma Emergency Department Visit Rate by Race and Ethnicity 2016-2020



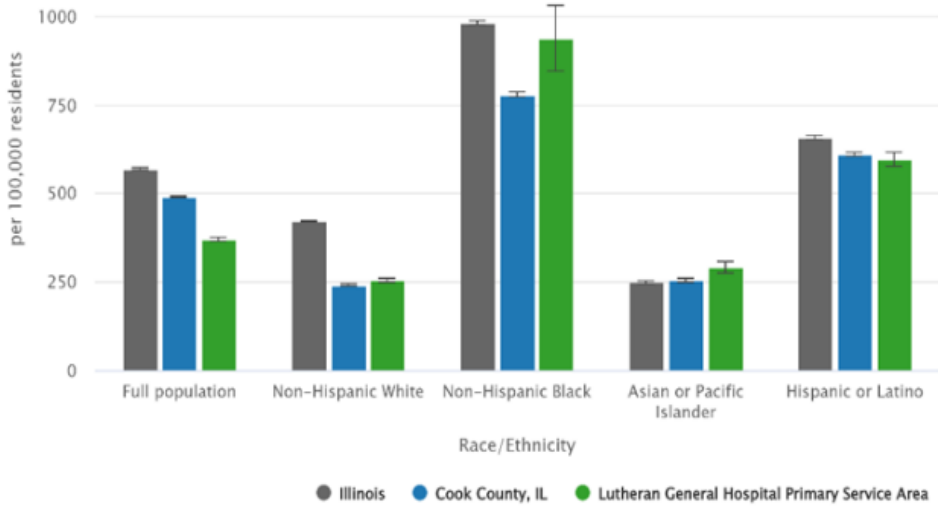
Source: Metopio, IHA COMPdata Informatics, 2022

Exhibit 25: Advocate Lutheran General PSA COPD Emergency Department Visit Rate by Race and Ethnicity 2016-2020



Source: Metopio, IHA COMPdata Informatics, 2022

Exhibit 26: Advocate Lutheran General PSA Pneumonia/flu Emergency Department Visit Rate by Race and Ethnicity, 2016-2020



Source: Metopio, IHA COMPdata Informatics, 2022

Diabetes

Diabetes is a chronic health condition that affects how the body turns food into energy. Diabetes is the 7th leading cause of death in the Unites States (CDC, 2022). More than 37 million people in the Unites States have diabetes, and one in five of them don't know they have it (CDC, 2022). Ninety-six million adults in the United States have pre-diabetes and one in eight do not know they have it (CDC, 2022).

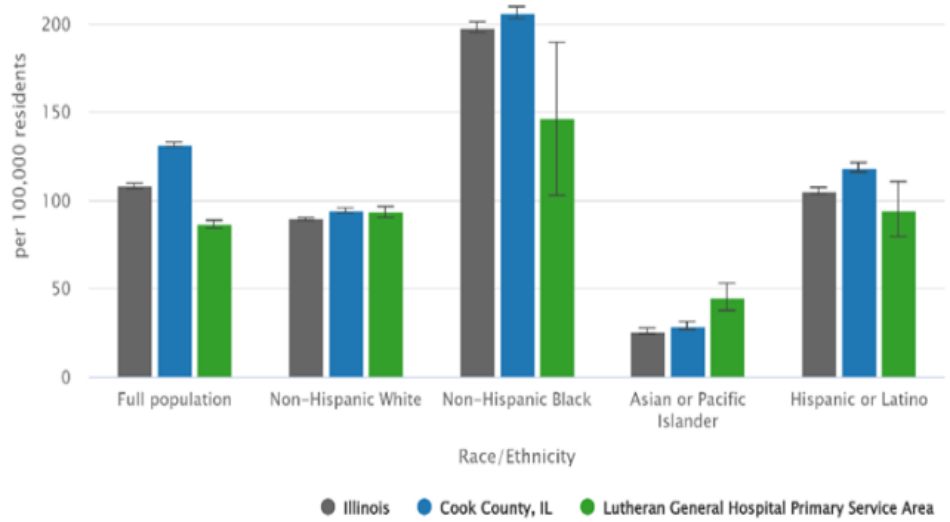
The percentage of adults 18 years and older diagnosed with diabetes in the hospital's PSA is 8.7 percent, which is lower than Cook County at 10.6 percent and the state at 10.1 percent (Metopio, Diabetes Atlas, 2022). The type 2 diabetes hospitalization rate for the PSA is 115.33 per 100,000 residents, which is lower than Cook County at 205.79 per 100,000 residents and the state at 160.67 per 100,000 residents (Metopio, IHA COMPdata Informatics, 2022). There is a racial/ethnic disparity in the PSA with the Non-Hispanic Black population having the highest type 2 diabetes hospitalization rate at 432.69 per 100,000 compared to the Hispanic or Latino population at 144.19 per 100,000

residents, the Non-Hispanic White population at 114.92 per 100,000 residents and the Asian or Pacific Islander population at 57.86 per 100,000 residents.

Exhibit 27 shows the percentages of type two diabetes hospitalization rate for the PSA, county and state. The communities in the PSA with the highest diabetes type two hospitalization rates include Elmwood Park (60707) at 206.6 per 100,000 residents, Irving Park/Portage Park (60641) at 197.2 per 100,000 residents, Des Plaines (60018) at 180.5 per 100,000 residents and Niles (60714) at 153.3 per 100,000 residents.

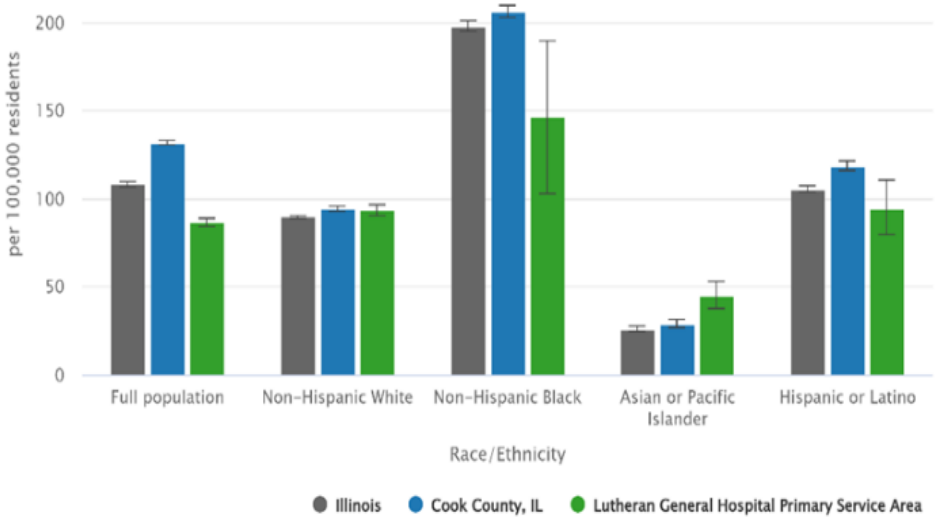
The diabetes long-term complication emergency department visit rate for the PSA is 17.01 per 100,000 residents, which is lower than Cook County at 131.67 and the state at 108.18 per 100, 000 residents. Similar to the aforementioned chronic diseases, there is a racial/ethnic disparity in the diabetes long-term complication rate for the PSA, county and state. In the PSA, the Non-Hispanic Black population has the highest rate at 146 per 100,000 residents, followed by the Hispanic and Latino population at 94.78 per 100,000 residents. More details regarding the diabetes long-term complications hospitalization rate by race ethnicity is included in exhibit 28.

Exhibit 27: Advocate Lutheran General PSA Type 2 Diabetes Hospitalization Rate by Race and Ethnicity 2016-2020



Source: Metopio, IHA COMPdata Informatics, 2022

Exhibit 28: Advocate Lutheran General PSA Diabetes Long-term Complications hospitalization Rate by Race and Ethnicity 2017-2021



Source: Metopio, IHA COMPdata Informatics, 2022

Cardiovascular Disease

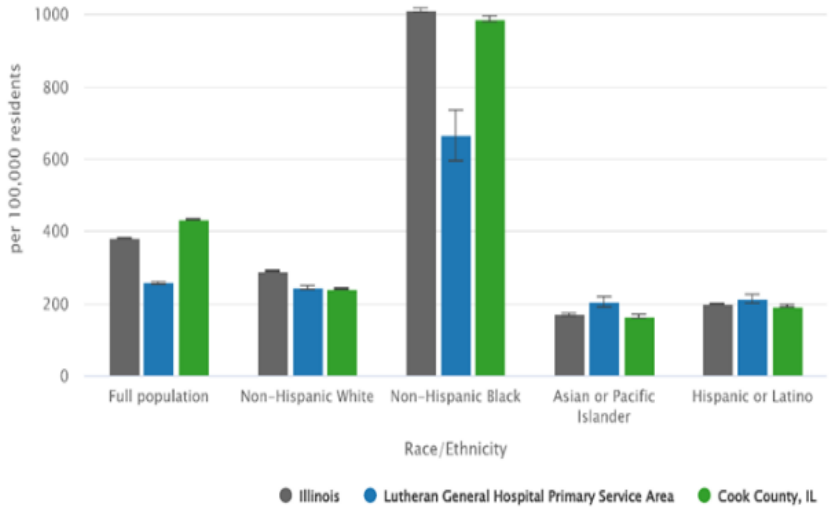
Cardiovascular disease is another leading cause of death globally, taking an estimated 17.9 million lives each year (World Health Organization, 2022). Cardiovascular diseases are a group of disorders of the heart and blood vessels and include coronary heart disease, cerebrovascular disease, rheumatic heart disease and other conditions. More than four out of five cardiovascular disease deaths are due to heart attacks and strokes and one third of these deaths occur prematurely in people under 70 years of age (World Health Organization, 2022).

In the hospital's PSA, the hypertension emergency department visit rate is 251.94 per 100,000 residents, which is less than Cook County at 446 per 100,000 residents and the state at 380.44 per 100,000 residents. There is a racial/ethnic disparity in hypertension emergency department visit rates with the Non-Hispanic Black population having the highest rate at 665.65 per 100,000 residents, followed by the Non-Hispanic White population at 243.33 per 100,000 residents, the Hispanic or Latino population at 212.50 per 100,000 residents and the Asian or Pacific Islander population at 204.17 per 100,00 residents. The racial/ethnic disparity persists at the county and state level with the Non-Hispanic Black population having significantly higher rates compared to all other racial/ethnic groups. Exhibit 29 shows the hypertension emergency department visit rate for the PSA, county and state by race/ethnicity. The PSA communities with the highest rates include Skokie (60077) at 371.4 per 100,000 residents, Skokie (60076) at 345.7 per 100,000 residents, Palatine (60074) at 306.8 per 100,000 residents and Elmwood Park (60707) at 303.4 per 100,000 residents.

The heart attack hospitalization rate for the PSA is 188.96 per 100,000 residents which is more than Cook County at 178.16 per 100,000 residents and the state at 172.41 per 100,000 residents (Metopio, IHA COMPdata Informatics, 2022). Similar to the hypertension emergency department visit rates, there is a racial/ethnic disparity in heart attack hospitalization rates with the Non-Hispanic Black population having a higher rate compared to all other racial and ethnic groups. Exhibit 30 shows details of the heart attack hospitalization rates by race/ethnicity for the PSA, county and state. There are several communities with high rates of heart attack hospitalization compared to the overall PSA. Edison Park/Norwood Park (60631) has a rate of 302.3 per 100,000 residents followed by Irving Park/Dunning (60634) at 284.5 per 100,000 residents and Norridge/Hardwood Heights (60706) at 244.5 per 100,000 residents.

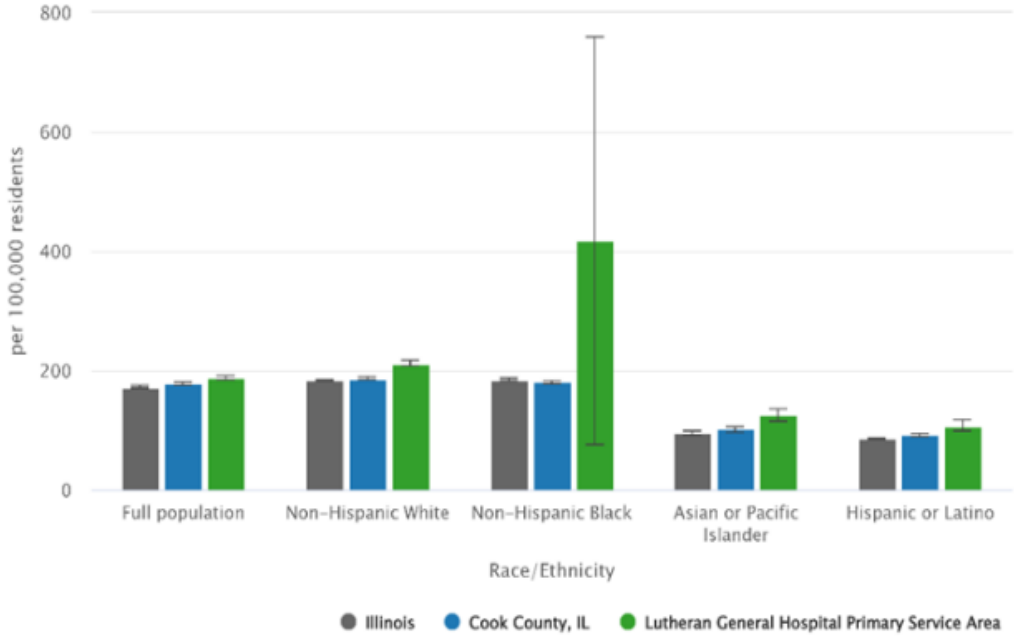
The stroke emergency department visit rate for the PSA is 24.75 per 100,000 residents, which is lower than the county at 49.50 and the state at 69.91 per 100,000 residents. The Non-Hispanic Black population has the highest rate for the PSA at 36.26 per 100,000 residents. There are several communities that have significantly higher rates compared to the overall PSA, they include Elmwood Park (60707) at 56.2, Irving Park/Dunning (60634) at 43.6 per 100,000 residents and Irving Park/Portage Park (60641) at 40.6 per 100,000 residents.

Exhibit 29: Advocate Lutheran General PSA Hypertension Emergency Department Visit Rate by Race and Ethnicity 2017-2021



Source: Metopio, IHA COMPdata Informatics, 2022

Exhibit 30: Advocate Lutheran General PSA Heart attack Hospitalization Rate by Race and Ethnicity 2017-2021



Source: Metopio, IHA COMPdata Informatics, 2022

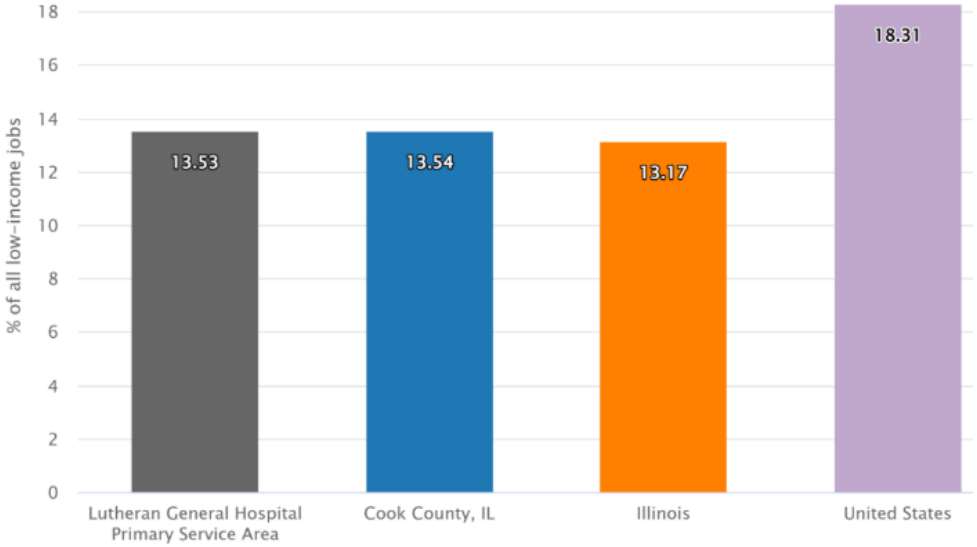
Impact of COVID-19

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 Irving Park/Dunning (60634), Irving Park/Portage (60641), Des Plaines (60016), Jefferson Park (60630), Mount Prospect (60056) and Elmwood Park (60707) (Metopio, UIC School of Public Health, 2022). After analyzing additional data, the Community Health team identified a correlation between the number of COVID-19 cases and vaccination rates. The PSA communities with lower vaccination rates had the highest number of COVID-19 cases, while the communities with higher vaccination rates had the lowest number of COVID-19 cases.

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, 13.53 percent of low-income jobs were lost due to COVID-19, which is equivalent to Cook County 13.54 percent and higher than the state at 13.17 percent (Metopio, Urban Institute, 2022) . The graph below in exhibit 31 shows the percentage of low-income job loss due to COVID-19 at the PSA, county, state and national level.

Exhibit 31: Advocate Lutheran General PSA Low-income Jobs Lost to COVID 19 2020



Source: Metopio, Urban Institute, 2022

V. Prioritization of Health-Related Issues

Priority Setting Process

Advocate Lutheran General's Community Health Department presented data to the hospital's CHC for the top nine health needs in the hospital'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.

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

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'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 hospital's service area.

Prioritization Grid Results

- Access to health care: 288
- Mental Health: 326
- Substance and Alcohol Use: 299
- Health and Nutrition: 308
- Cardiovascular Disease: 282
- Respiratory Disease: 280
- Cancer: 274
- Diabetes: 279

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 present on each of the top four health issues. Community experts/organizations that presented included the National Alliance on Mental Illness (NAMI Cook County North Suburban), Advocate Aurora Health's Transition Support Program Director, 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 votes 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 Needs Selected

Health and Nutrition
Health and nutrition was chosen as one of the two health need priorities due to the many chronic diseases and health issues that are related to poor nutrition, physical inactivity and overall unhealthy lifestyle choices. Moreover, the Council also identified health and nutrition due to the large impact this issue has on quality of life and overall health outcomes in the PSA. The Council also recognized the impact lack of access to health care has on disease prevention and management thus access to health care is included in the health and nutrition priority.

Behavioral Health
The behavioral health priority includes mental health and substance/alcohol use. Although mental health received a higher score compared to substance/alcohol use, the hospital's CHC considered the strong correlation between substance use and mental health, making it essential for the hospital to address both health issues in tandem. The rate of mental health issues and substance use have continued to increase in the PSA over time and the COVID-19 pandemic has exacerbated the health issue(s). Data and hospitalization rates also indicate that there is a great need for expansion of behavioral health services such as mental health services, substance use disorder treatment, housing and preventative programming.

Health Need Not Selected

Cardiovascular Disease
Although cardiovascular disease was not selected as a priority, the hospital is committed to decreasing the rate of cardiovascular disease through 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 Lutheran General 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.

Cancer
Cancer was identified as a health need for the hospital's PSA but was not selected as a priority due to the many cancer services and programs offered by the hospital's Cancer Center. In addition, the hospital's Community Health Department partners with the hospital's Cancer Center to support community-focused cancer prevention programs, including health and nutrition centered interventions. The hospital also works closely with the American Cancer Society to provide other cancer related services and support, such as wigs, support groups and other services.

Asthma/Respiratory Disease
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 operates 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 member of Advocate Aurora, Advocate Lutheran General has and will continue to dedicate a substantial number of resources, including but not limited to medical supply, PPE, COVID-19 testing, medical services and treatment for those with COVID-19 and community-focused interventions 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 be the backbone of emergency health outbreaks and also provide crucial and critical care to the community. AAH including Advocate Lutheran General will continue to make COVID-19 a priority through its commitment to improve access to testing and provide quality care for those diagnosed with the disease.

VI. Approval of Community Health Needs Assessment

The director of community health provided a copy of the CHNA to each hospital Governing Council member in advance of the October 2022 Council meeting. Governing Council members were able to review the CHNA document in its entirety before the meeting. The hospital'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 October 17, 2022, the Advocate Lutheran General Governing Council fully approved the 2022 Advocate Lutheran General Hospital CHNA Report. The Advocate Health Care Network Board approved the Advocate Lutheran General 2022 CHNA Report at the system level on December 31, 2022.

VII. Vehicle for Community Feedback

Community Feedback

SCAN ME

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

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.

VIII. Evaluation of Impact from Previous CHNA

Health Lifestyles
The CHC chose obesity/healthy lifestyles for the 2019 CHNA due to the many chronic diseases and health issues that are related to poor nutrition and physical inactivity. Moreover, the CHC recognized the large impact this issue has on quality of life and overall health outcomes in the PSA. Implementation activity and outcomes in 2021 are as follows.
Advocate Lutheran General partnered with the Irving Park Food Pantry to implement the LGH Pantry Pilot Program as part of our strategy to address Food Insecurity (FI) and obesity. The LGH Hospital-Based Food Pantry program officially

launched in October of 2021. From January 2021 to December 2021, the program identified and served over 70 patients. All patients reported at least one or more existing health conditions.

In 2021, Advocate Lutheran General partnered with Produce Alliance and Belmont-Cragin Early Childhood Center to establish a Pop-up Pantry for local residents. Through this partnership, our team was able to distribute over 6,000 boxes; roughly 186,000 pounds of food was distributed to food insecure communities. From February through the end of April, the program offered weekly access to healthy food.

Additionally, Advocate Lutheran General partnered with Skokie School District 69 to implement a Pop-up Produce Market for families that screened positive for food insecurity. The program offered fresh produce for 50 families per event, a total of four events were organized at the end of 2021. A dietitian was also onsite to offer health education to families.

Behavioral Health

The CHC selected behavioral health as a priority, including mental health and substance/alcohol use in the 2019 CHNA. Data and hospitalization rates indicated that there is a great need for expansion of behavioral health services, such as mental health services, substance use disorder treatment, housing and preventative programming. Implementation plan activities and outcomes for 2021 are as follows:

To address an identified need, Advocate Lutheran General's community health team partnered with Sertoma Centre to implement two, Mental Health First Aid (MHFA) trainings for Advocate Lutheran General's Emergency Medical Service (EMS) department and local health professionals. A total of 40 hospital and community health professionals were trained, in person, by two MHFA instructors from the Sertoma Centre. The two training courses included fire fighters, paramedics, fire chiefs, dispatchers, tele communicators and other health professionals.

Advocate Lutheran General Hospital also partners with Turning Point in Skokie to support the Living Room program, which provides mental health services for those in crises. Support is provided through trainings and workshops for Turning Points Living Room staff.

Advocate Lutheran General also worked with Gateway Foundation—an organization specializing in substance use disorder treatment—to establish a partnership agreement for a treatment linkage program in the hospital's emergency department.

Social Drivers of Health (SDOH)

Social Drivers of Health (SDOH). Social drivers of health affect a wide range of health conditions, may contribute to adverse health outcomes and are commonly the root cause of poor health outcomes; therefore, Advocate Lutheran General and Advocate Children's selected social drivers of health as a priority health need for the PSA. Advocate Lutheran General implements several strategies to address the SDOH priority, these strategies and 2021 outcomes are listed below.

Advocate Lutheran General continued to work with District 207 schools in 2021 to offer paid internships and hands on experience. The hospital's community health team has partnered with JumpStart, a youth employment program that provides paid work experience for at-risk youth in District 207. The program focuses on developing youth's work readiness skills while providing academic support. The hospital provides internship placement for students and the hospital's community health team works closely with the career advisors to ensure proper orientation and expand internal opportunities for interns. Advocate Lutheran General's community health team provided two orientations to JumpStart students placed in internships at Lutheran General Hospital. Seven students completed the orientation and were placed in paid internships with Advocate Lutheran General's Food and Nutrition department.
In partnership with Maine East School District 207 and Advocate Lutheran General's Licensed Clinical Social Worker, a one hour, stress management workshop was held for local high school students. The program focused on stress management in the workplace and offered coping strategies.

More details about Advocate Lutheran General's 2020-2022 Implementation Plan strategies and progress can be found online within the Advocate Lutheran General 2021 Community Implementation Plan (CHIP) Progress Report.

IX. 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).

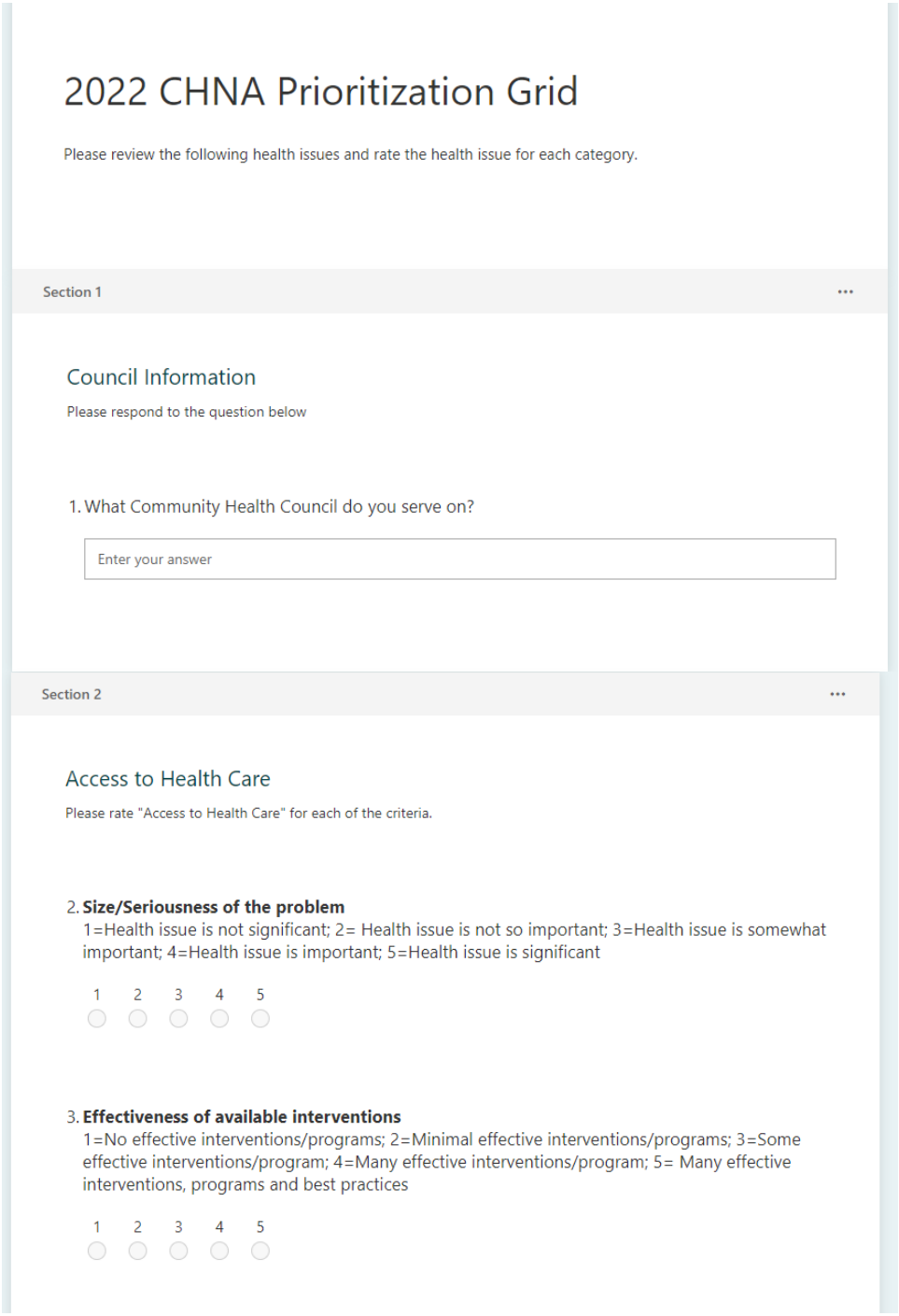
The Alliance for Health Equity, Community Health Needs Assessment for Chicago and Suburban Cook, 2022; The Alliance for Health Equity, Focus Groups, 2022; and
The Alliance for Health Equity, Community Input Survey, 2022. All three documents accessible at
https://allhealthequity.org/projects/2019-chna-reports/

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

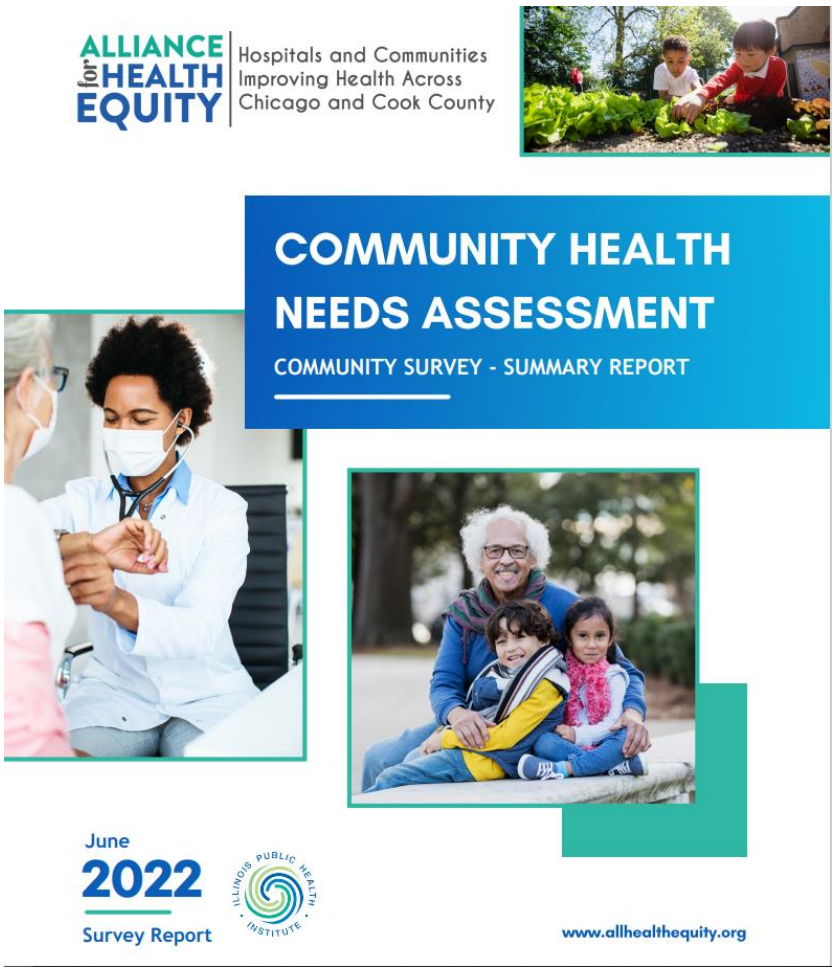
56. **Potential for issue to impact other health and social issues**
1=No potential to impact other health issues; 2=Minimal potential to impact other health issues; 3=Potential to impact other health issues; 4=Strong potential to impact other health issues; 5=Addressing health issue has significant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

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: 1. Age-related illness 2. Mental health 3. COVID-19 4. Homelessness and housing 5. Cancer 6. Violence
Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3)	Top 6: 1. Mental health services access 2. Healthcare access 3. Community service access 3. Safety and low crime 4. Affordable housing 5. Healthy food access 6. Activities for teens and youth
Household Experiences due to the COVID-19 Pandemic (each respondent could select all that apply)	Top 6: Lack of Control, Not Knowing when the Pandemic will End (56%) Feeling nervous, anxious, or on edge (53%) Feeling alone or isolated, Not being able to socialize with other People (51%) Stress regarding employment status (29%) Reduced pay and hours (22%) Loss of employment (20%) Death of family members or friends (20%) 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: 1. Mental health 2. COVID-19 3. Age-related illness 4. Homelessness and housing 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: 1. Mental health services access 2. Healthcare access 3. Community service access 4. Activities for teens and youth 4. Safety and low crime 5. Affordable housing	
Household Experiences due to the COVID-19 Pandemic (each respondent could select all that apply)	Top 5: 1. Feeling nervous, anxious, or on edge (56%) 2. Lack of Control, Not Knowing when the Pandemic will End (52%) 3. Feeling Alone or isolated, Not being able to Socialize with Other People (47%) 4. Stress regarding employment status (36%) 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: 1. COVID-19 2. Age-related illness 2. Mental health 4. Child Abuse 5. Violence	
Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3)	Top 5: 1. Healthcare access 2. Mental health services access 3. Community service access 4. Activities for teens and youth 5. Healthy food access	
Household Experiences due to the COVID-19 Pandemic (each respondent could select all that apply)	Top 5: 1. Lack of Control, Not Knowing when the Pandemic will End (37%) 2. Sick household members (32%) 3. Feeling nervous, anxious, or on edge (30%) 4. Loss of employment (28%) 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: 1. COVID-19 2. Mental health 3. Age-related illness 4. Homelessness and housing 5. Diabetes 5. Violence	
Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3)	Top 5: 1. Healthcare access 2. Mental health services access 3. Community service access 4. Affordable housing 5. Healthy food access	
Household Experiences due to the COVID-19 Pandemic (each respondent could select all that apply)	Top 5: 1. Feeling nervous, anxious, or on edge (53%) 2. Lack of Control, Not Knowing when the Pandemic will End (52%) 3. Feeling Alone or isolated, Not being able to Socialize with Other People (44%) 4. Reduced pay and hours (40%) 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: 1. Mental health 2. Homelessness and housing 3. COVID-19 4. Age-related illness 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: 1. Mental health services access 2. Healthcare access 3. Community service access 4. Affordable housing 5. Safety and low crime	
Household Experiences due to the COVID-19 Pandemic (each respondent could select all that apply)	Top 5: 1. Lack of Control, Not Knowing when the Pandemic will End (66%) 2. Feeling nervous, anxious, or on edge (64%) 3. Feeling Alone or isolated, Not being able to Socialize with Other People (61%) 4. Stress regarding employment status (39%) 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: 1. Mental health 2. Age-related illness 3. COVID-19 4. Homelessness and housing 5. Violence 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: 1. Mental health services access 2. Healthcare access 3. Community service access 4. Affordable housing 5. Healthy food access 5. Safety and Low Crime	
Household Experiences due to the COVID-19 Pandemic (each respondent could select all that apply)	Top 5: 1. Lack of Control, Not Knowing when the Pandemic will End (49%) 2. Feeling Alone or isolated, Not being able to Socialize with Other People (44%) 3. Feeling nervous, anxious, or on edge (43%) 4. Death of Family Members or Friends (28%) 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: 1. Mental health 2. Age-related illness 3. COVID-19 4. Homelessness and housing 4. Diabetes 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: 1. Mental health services access 2. Healthcare access 3. Community service access 4. Activities for teens and youth 5. Safety and low crime 6. Affordable housing 6. Healthy food access	
Household Experiences due to the COVID-19 Pandemic (each respondent could select all that apply)	Top 5: 1. Lack of Control, Not Knowing when the Pandemic will End (49%) 2. Feeling Alone or isolated, Not being able to Socialize with Other People (44%) 3. Feeling nervous, anxious, or on edge (43%) 4. Death of Family Members or Friends (28%) 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: 1. Age-related illness 2. Mental health 3. Cancers 4. Dental problems 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: 1. Mental health services access 2. Community service access 3. Healthcare access 4. Activities for teens and youth 5. Healthy food access	
Household Experiences due to the COVID-19 Pandemic	Top 5: 1. Stress regarding employment status (49%) 2. Reduced pay and hours (47%) 3. Loss of employment (39%) 4. Feeling nervous, anxious, or on edge (37%) 4. Sick household members (37%) 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: 1. Age-related illness 2. Mental health 2. COVID-19 3. Cancers 4. Diabetes 5. Homelessness and housing	
Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3)	Top 5: 1. Community service access 2. Healthcare access 3. Mental health services access 4. Safety and low crime 5. Activities for teens and youth 5. Healthy food access	
Household Experiences due to the COVID-19 Pandemic	Top 5: 1. Lack of Control, Not Knowing when the Pandemic will End (40%) 2. Feeling Alone or isolated, Not being able to Socialize with Other People (36%) 3. Feeling nervous, anxious, or on edge (33%) 4. Stress regarding employment status (32%) 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: 1. Age-related illness 2. COVID-19 3. Cancer 4. Mental health 5. Homelessness and housing 5. Dental problems 5. Diabetes	
Actions Needed to Support Improvements in Community Health Needs (each respondent ranked 3)	Top 5: 1. Community service access 2. Healthcare access 3. Mental health services access 4. Activities for teens and youth 5. Healthy food access	
Household Experiences due to the COVID-19 Pandemic	Top 5: 1. Feeling nervous, anxious, or on edge (38%) 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%) 4. Stress regarding employment status (31%) 4. Reduced pay and hours (31%) 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: 1. Mental health 2. Age-related illness 3. COVID-19 4. Homelessness and housing 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: 1. Mental health services access 2. Healthcare access 3. Community service access 4. Affordable housing 5. Safety and low crime	
Household Experiences due to the COVID-19 Pandemic	Top 5: 1. Feeling nervous, anxious, or on edge (58%) 2. Feeling Alone or isolated, Not being able to Socialize with Other People (57%) 3. Lack of Control, Not Knowing when the Pandemic will End (56%) 4. Stress regarding employment status (38%) 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.*