Advocate Health Care

2025

Advocate South Suburban Hospital

Community Health Needs Assessment Report

17800 Kedzie Ave.
Hazel Crest, IL 60429

Letter from Market President

October 2025

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

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

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

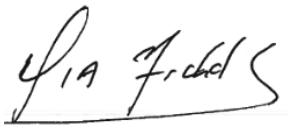
As we close another CHNA cycle, I'm inspired by the profound difference we make each day across our Illinois Division. From groundbreaking research and exceptional clinical care to meaningful patient programs and cutting-edge innovations, our work is driven by the patients, families and communities we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

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

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

Let's move forward toward better health for all.

Together always,



Dia Nichols
President, Illinois Division, Advocate Health

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EXECUTIVE SUMMARY

Advocate South Suburban Hospital is proud to share the 2025 Community Health Needs Assessment (CHNA). As part of Advocate Health, one of the largest nonprofit health systems in the U.S., we are committed to improving the health and well-being of individuals and families across the south Chicagoland area.

To develop this CHNA, we partnered with the Alliance for Health Equity, a coalition of hospitals, health departments and community organizations in Cook County. We also formed a Community Health Council (CHC) made up of local stakeholders, residents and organizations who helped guide the process, review data and select health priorities.

Our service area includes 22 zip codes and nearly 460,000 residents from diverse racial, ethnic and economic backgrounds. This diverse region includes 49.2% African American, 32.3% White, and 13.7% Hispanic residents. While the area is rich in culture and community strength, there are also significant differences in access to resources such as education and income. For example, high school graduation rates range from 77% in Harvey to 99% in Flossmoor, and household income varies from $40,995 in Harvey to $137,651 in Frankfort.

We also look at something called the Hardship Index, which combines different social and economic factors (like unemployment, housing and income) into a single score to show which communities face greater challenges. Harvey, Chicago Heights and Glenwood had the highest hardship scores in the service area, while Frankfort, Tinley Park and Flossmoor had the lowest.

In June 2025, the CHC conducted a prioritization process based on the data presented throughout the assessment process. Based on the council's feedback, mental health and diabetes were identified as the top health priorities to address for the 2025 CHNA cycle.

Advocate South Suburban will use this information to create a 2026-2028 Community Health Implementation Strategy (CHIS). This strategy will outline specific actions and partnerships focused on improving mental health and preventing or managing diabetes. We are proud to already offer a CDC-recognized Diabetes Prevention Program, and we plan to build on that success in the coming years.

We are grateful for the many community partners who helped to shape this report. These efforts are just the beginning. Your voices, your stories and your lived experiences continue to guide the work that we do. Together we can build a healthier future for all who call this community home.

ADVOCATE HEALTH CARE

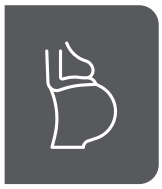
Advocate Health Care is the largest health system in Illinois and a national leader in clinical innovation, health outcomes, consumer experience and value-based care. One of the state's largest private employers, the system serves patients across 11 hospitals, including two children's campuses, and more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

ADVOCATE SOUTH SUBURBAN HOSPITAL

Advocate South Suburban Hospital in Hazel Crest delivers high-quality, compassionate care across more than 50 subspecialties, including advanced cardiac and stroke care, cancer treatment and GI procedures.

We also support the health of our community through free screenings, education and a variety of outreach programs.

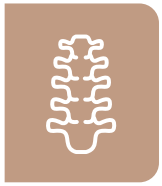
Critical Care



Women's Health

Surgical Care

Cardiovascular



Orthopedics

Primary Care

Cancer Care

2025 COMMUNITY HEALTH NEEDS ASSESSMENT

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

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

Community Definition

For the purposes of this assessment, "community" is defined as Advocate South Suburban Hospital's primary service area (PSA). The PSA encompasses 22 patient zip codes in South Suburban Cook County with parts of Park Forest and Frankfort located in Will County, Illinois. As of the most recent census data estimate (2023), the total population of the communities served by the hospital is 459,812.

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

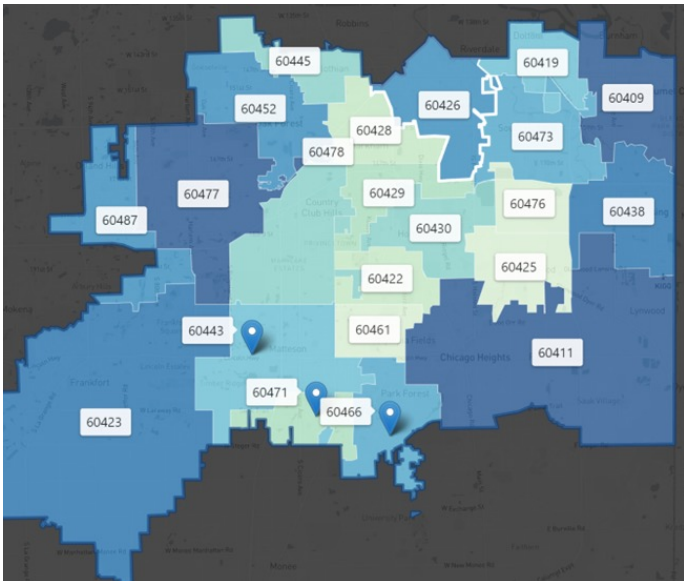


Exhibit 1:
Advocate South Suburban Hospital, Primary Service Area Map
Source: Metopio, 2025

2019-2023 Data Estimates

Population
459,812
Over 5% decrease between 2010 and 2020 Census

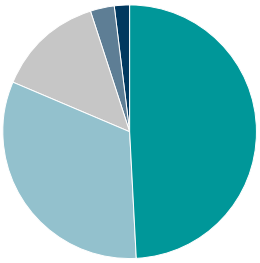
Median Age
39.5 PSA
37.8 Cook County
38.9 Illinois

Gender
52.2% Male
47.8% Female

Median Age by Gender
36.4 Male
42.0 Female

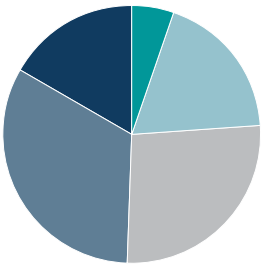
Race/Ethnicity

Non-Hispanic Black	49.2%
Non-Hispanic White	32.2%
Hispanic	13.7%
Two or more races	3.1%
Asian	1.7%



Population by Age Group

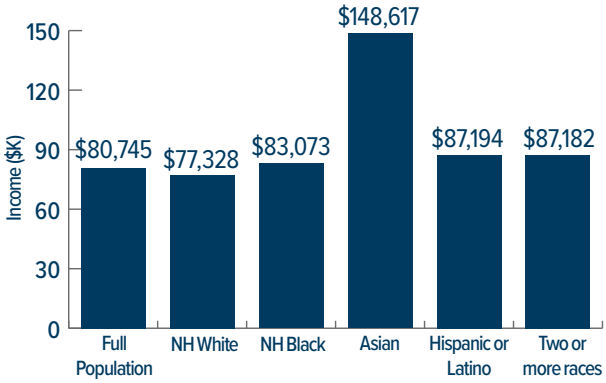
0-4 Years	5.4%
5-17 Years	18.6%
18-39 Years	26.6%
40-64 Years	32.8%
65+ Years	16.6%



Spanish as Primary Language Spoken at Home

9.11% Hospital PSA
18.44% Cook County

Median Household Income by race and ethnicity



Education

High School Graduation Rate

91.71% Hospital PSA
88.34% Cook County

Individuals 25+ with Any Post-Secondary Education

64.29% Hospital PSA
66.16% Cook County

Median Household Income

$80,745 PSA
$81,797 Cook County
$81,702 Illinois

Percent of Population 16+ Unemployed

9.53% Hospital PSA
7.08% Cook County

Population Living Below Poverty Level: 13.82% (PSA)

Communities with Highest Poverty Level

23.82% Harvey 60426
23.28% Calumet City 60409
22.33% Chicago Heights 60411

Household/Family in PSA

9.55% Single Parent Families
30.26% Seniors (65+) Living Alone
24.00% Children under age 18

Children living Below the Poverty Level in PSA

19.79% 0-4 years
19.96% 5-17 years

Seniors living Below the Poverty Level

11.53% Hospital PSA
12.72% Cook County

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

Social Drivers of Health

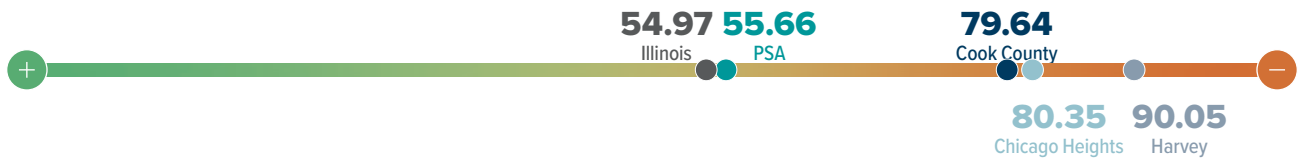
Social drivers of health are the things in our everyday lives that can help us stay healthy or make it harder to be healthy. These include where we live, the food we eat, the schools we go to, the jobs our families have, and whether we can see a doctor when we need to.

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

Social Conditions at a Glance

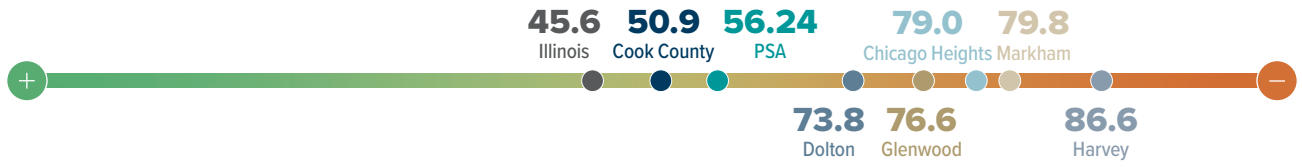
To better understand these factors and identify health inequities in a community, Advocate Health Care has partnered with Metopio, a software company that focuses on how communities are connected through people and places. Metopio's tools use data to show how different factors in each area influence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

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

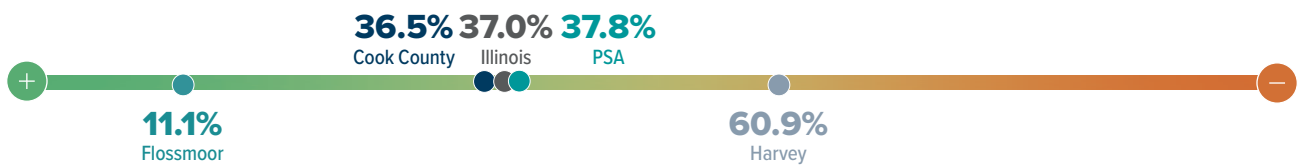


Childhood Opportunity Index (COI) – The COI measures how well neighborhoods support children's healthy growth. Scores range from Very Low (1–19) to Very High (80–100). The hospital PSA score of 44.19 falls within the moderate range, suggesting that children may not have full access to good schools, safe housing, healthy food and jobs. When asked through surveys by The Alliance for Health Equity and Cook County, "What does your community need to be healthy," surveyors indicated activities for teens and youth as its top two priorities.

Hardship Index – The Hardship Index is a measure used to understand the overall economic and social challenges faced by a community. It combines several indicators that reflect conditions that can make life more difficult for residents, especially when it comes to health, income, education, and employment. Higher scores (closer to 100) mean greater hardship and more barriers to health and well-being; lower scores (closer to 0) mean less hardship and more stable conditions for residents.



ALICE Index – ALICE stands for Asset Limited, Income Constrained, Employed. It shows the percent of working households that earn above the poverty line but still can't afford basic needs like housing, food, and child care. *(Source: Metopio, United Way, ALICE Data, 2023)*



How the CHNA Was Conducted

Purpose and Process

Every three years, the federal government requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) to identify key health priorities through comprehensive data collection and analysis. In February 2025, Advocate South Suburban Hospital convened its Community Health Council—comprising hospital staff and community representatives—to review and assess data in order to determine the most pressing health needs within the hospital's primary service area.

Between February and May 2025, the council held four meetings where data was presented on demographics, economics, education, employment, Social Drivers of Health (SDOH), and health indicators. Additionally, partners from the Alliance for Health Equity shared data gathered from local focus groups conducted as part of their CHNA efforts.

On June 17, 2025, during a prioritization meeting, the council voted to focus on two primary health issues: diabetes and mental health. The South Suburban Hospital Governing Council officially approved the 2025 CHNA findings at its meeting on October 21, 2025.

Partnership

In collaboration with numerous stakeholders, the CHC's responsibilities were to oversee the hospital's 2025 CHNA process, including data review and prioritization of health needs and identify health priorities to address in the coming years. Key stakeholders included members from Advocate Health Care, Cook County Department of Public Health, Cook County Sheriff's Department, Alliance for Health Equity, the Village of Hazel Crest and a number of participants from various community organizations.

Data Collection and Analysis

The Alliance for Health Equity completed its fourth Community Health Needs Assessment (CHNA) between June 2023 and December 2024 for Chicago and Suburban Cook County of which Advocate Health Care is a member. The Alliance, which is a collaborative of hospitals, health departments and regional and community-based organizations aims to improve health equity, wellness, and quality of life across Chicago and Suburban Cook County. The report builds on the previous assessments and allows partners to identify strategic priorities that they can collectively address to improve community health.

Data Sources

Alliance for Health Equity Community Surveys – February to October 2024

The community input survey was a qualitative tool designed to understand community health needs and assets with a focus on hearing from community members that are most impacted by health inequities. Community input surveys were collected in South Suburban Hospital's service area.

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

Focus Groups – January to October 2024

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

Metopio

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

County Health Rankings

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

Summary of Findings

Overall Health Status

Overall, Advocate South Suburban Hospital's health outcomes are somewhat comparable to the average in Cook County and in the State of Illinois.

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

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

Mortality - leading causes of death

Top leading causes of death in Cook County:

- Cancer
- Heart Disease
- Accidents
- COVID-19
- Assault

(Cook, Illinois | County Health Rankings & Roadmaps, 2025)

Life Expectancy

The average life expectancy among residents:

- Cook County 77.4 years
- Illinois 77.5 years
- United States 77.1 years

(Cook, Illinois | County Health Rankings & Roadmaps, 2020-2022)

Building on Community Strengths

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

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

40.7% of survey respondents agree that they are ***satisfied with the quality of life*** in their community; **37.3% were neutral** and **12.7% strongly agree.**

Survey respondents identified the following as some as the best things about their community:

- Welcoming and culturally diverse
- Community connections
- Safety and security
- Access to community services such as local business, restaurants, and libraries
- Accessible health services
- Walkability
- Civic engagement
- Cultural and social events
- Outdoor spaces

Data Bright Spots

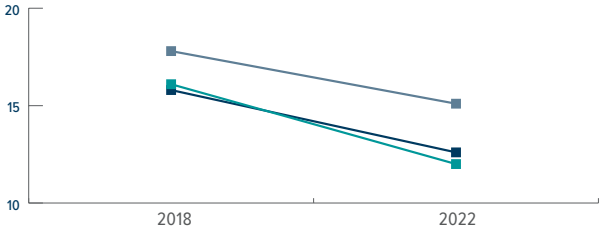
Women in the PSA age 50-74 years are getting their mammogram screenings above the county and state levels: PSA: 76%; County: 74%; State: 73%.

Screenings for cervical and colorectal cancers are conducted at higher rates in the PSA when compared to the county and state.

	Cervical Cancer Screenings	Colorectal Cancer Screenings
County	80%	53%
State	72%	55%
HOSPITAL PSA	**82%**	**61%**

Rate of cigarette smoking shows a decline in the PSA, county and state.

	2018	2022
Hospital PSA:	17.8%	15.1%
County:	16.1%	12.0%
State:	15.8%	12.6%



Emergency Department (ED) visits for substance use have decreased from 1,515.5 (2016-2020) to 1,284.5 (2019-2023) per 100,000 residents.

Identified Significant Needs

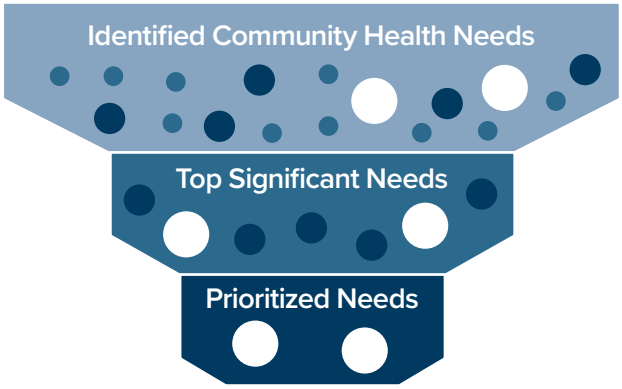
Even with the progress and support in the community, challenges remain. While local programs and services have helped improve health, there are still gaps in care and unmet needs. This section looks at the biggest health concerns found in this assessment and areas where more support is needed to help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

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

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

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

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



Top Health Concerns in Patient Service Area

The following needs listed below represent the significant health needs of the community, based on the information gathered through the assessment process.

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

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

Chronic Conditions

SIGNIFICANT NEED

Why is this important? Six in ten Americans live with at least one chronic disease, such as diabetes, COPD, heart disease or asthma. These and other chronic diseases are the leading causes of death and disability in America, and they are also a leading driver of healthcare costs.

Significant Need Reasoning

27% of AHE survey respondents identified diabetes as the #2 health issue for their communities.

The percentage of adult diabetes in the PSA, county and state consistently increased from 2018 to 2022.

	2018	2022
PSA	11.6%	14.1%
Cook County	10.2%	10.8%
Illinois	9.5%	10.4%

Key Findings

- **Seniors ages 65 and older have the highest ED and hospitalization rates due to Chronic Obstructive Pulmonary Disease (COPD).**
- **Communities with the highest prevalence of COPD: PSA Rate**
  - » Dolton 8.30%
  - » Harvey 8.60%
  - » Markham 8.80%

Diabetes

Diabetes is a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces. Insulin is a hormone that regulates blood glucose. Hyperglycemia, also called raised blood glucose or raised blood sugar, is a common effect of uncontrolled diabetes and over time leads to serious damage to many of the body's systems, especially the nerves and blood vessels. In 2022, 14% of adults aged 18 years and older were living with diabetes, an increase from 7% in 1990. More than half (59%) of adults aged 30 years and over living with diabetes were not taking medication for their diabetes in 2022. (World Health Organization, Diabetes). Diagnosed diabetes presents a significant health challenge, with notable disparities evident from the recent data.

Respiratory Health

Respiratory health is a vital aspect of overall well-being that often goes unnoticed until a problem arises. Understanding the basics of respiratory health, the common diseases and conditions affecting the respiratory system, the connection between respiratory health and overall well-being, and ways to maintain and improve respiratory health are essential for leading a healthy and active life.

Contributing Factors

Chronic diseases can often be prevented by a healthy lifestyle, but those with more money, education, and resources tend to live longer and survive preventable diseases. Lack of these resources leads to worse health and shorter life expectancy, with racial disparities worsening these inequalities. For some, making healthy choices is difficult due to limited access to nutritious food, time constraints, or mental health challenges. External pressures, such as multiple jobs or unstable living conditions, also hinder health. It's essential to recognize that healthy choices and behaviors are not always an easy option, and creating supportive environments is key to improving health for all.

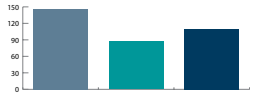
> "We used to have a lot of free health clinics and preventable screening things that would happen a lot, and they would occur, maybe like twice a month. But after COVID, they just never came back."
>
> -Insight from focus group participant

Chronic Conditions *continued*

SIGNIFICANT NEED

Cardiovascular Disease

- Emergency Department Rate due to Heart Failure 2019-2023*
  - » SSH PSA: 146.12
  - » Cook County: 87.31
  - » Illinois: 110.61



- Hospitalization Rate due to Heart Failure*
  - » SSH PSA: 657.3
  - » Cook County: 531.0
  - » Illinois: 449.8

Cerebrovascular Disease (Stroke)

- Emergency Department Rate due to Stroke 2024*
  - » SSH PSA: 85.5
  - » Cook County: 56.5
  - » Illinois: 75.1

- Hospitalization Rate due to Stroke 2024*
  - » SSH PSA: 222.4
  - » Cook County: 221.2
  - » Illinois: 205.1

Hypertension

- Hypertension Emergency Department Rate 2019-2023*
  - » SSH PSA: 865.2
  - » Cook County: 383.2
  - » Illinois: 370.8

- Hypertension Hospitalization Rate 2019-2023*
  - » SSH PSA: 62.1
  - » Cook County: 64.4
  - » Illinois: 52.7

Respiratory Health

Community	COPD Rate	Adult Asthma
Cook County	4.90%	9.20%
Illinois	5.10%	8.90%
HOSPITAL PSA	6.72%	10.56%

HIGHLIGHTED DISPARITIES

Respiratory Health

Per 100,000 residents, females have higher asthma ED visit rates* than males in the PSA and State of Illinois, but males have higher ED visit rates than females in Cook County.

Community	Full Population	Females	Males
Cook County	299.1	292.4	**306.0**
Illinois	243.9	**251.7**	235.6
HOSPITAL PSA	363.3	**374.3**	351.9

Asthma disproportionately affects Non-Hispanic Blacks than any other ethnicity in the hospital PSA, Cook County and state of Illinois when looking at ED and Hospitalization rates, per 100,000 residents.

Community	ED Visit Rate*	Hospitalization*
NH Black	**608.0**	**84.0**
NH White	179.1	**48.3**
Hispanic/Latino	160.0	**33.5**
HOSPITAL PSA	363.3	**54.2**

Diagnosed Diabetes - This elevated rate in the area underscores the need for targeted healthcare interventions and enhanced community support programs to manage and mitigate the impact of diabetes in the region.

Community	Diagnosed Diabetes	Obesity
60419 (Dolton)	**18.4%**	**45.2%**
60428 (Markham)	**18.4%**	**44.0%**
60426 (Harvey)	**18.8%**	**43.9%**
60429 (Calumet City)	**16.8%**	**43.2%**
HOSPITAL PSA	14.1%	38.1%

**per 100,000 residents*

Substance Use

SIGNIFICANT NEED

Why is this important? Substance use – including alcohol and drug use - contributes to preventable health issues and is linked to social and economic issues. Substance misuse is also closely linked to mental health challenges, including depression, anxiety, and trauma-related disorders. These conditions often co-occur, making recovery difficult without proper support.

Significant Need Reasoning

Substance use ranked third amongst the biggest health issues in the community by survey respondents.

23.5% of survey respondents identified substance use as one of the biggest health issues in the PSA.

Secondary data identified adults 18-39 years of age had the highest rates of alcohol use in the PSA for ED visits and hospitalizations.

Secondary data identified adults 18-39 years of age have the highest substance use ED visits.

Key Findings

Age-adjusted ED rate due to alcohol use*

- » PSA 345.6
- » Cook County 474.9
- » Illinois 390.6

Age-adjusted hospitalization rate due to alcohol use*

- » PSA 112.4
- » Cook County 157.9
- » Illinois 136.3

Adults who drink excessively

- Binge drinking in the hospital PSA, county and state demonstrate a continual increase since 2020.
  - » PSA: 18.1%
  - » Cook County 20.8%
  - » Illinois 18.4%

Age-adjusted ED rate due to substance use*

- » PSA 1,284.5
- » Cook County 956.4
- » Illinois 718.9

Age-adjusted hospitalization rate due to substance use*

- » PSA: 177.0
- » Cook County 261.7
- » Illinois 209.6

Age-adjusted emergency department rate for opioid use *

- » PSA: 182.1
- » Cook County 357.4
- » Illinois 225.4

*per 100,000 residents

(Metopio, IHA COMP data Informatics, 2019-2023)

Contributing Factors

While substance misuse is a health behavior – actions and habits that individuals choose to engage in – there is more to it than a simple choice. Health behaviors are influenced by social drivers of health (SDOH) and are often closely tied to mental health issues, making it hard for individuals from certain groups or with mental health diagnoses to abstain from using drugs or alcohol. Substance use can be used for coping with problems in life and can become an addiction, changing the brain's structure and function, affecting an individual's ability to control their behavior.

HIGHLIGHTED DISPARITIES

Communities with the highest rates for binge drinking

Oak Forest	Tinley Park	South Holland	Frankfort
22.5%	21.7%	20.2%	20.1%

- Males, non-Hispanic whites and adults 18-39 years have the highest ED visit rates for binge drinking.
- Middle-aged adults (40-64 years) had the highest hospitalization rates due to alcohol use for the PSA.

Age-adjusted ED rate due to alcohol use*

- » Male visit rates 527.6
- » Female visit rates 171.7

Mental Health

SIGNIFICANT NEED

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

Significant Need Reasoning

In a series of focus group meetings with the Alliance for Health Equity and Cook County, mental health was ranked among the top five health issues.

Focus group findings identified access to treatment, mental health crises and connections between mental health and other determinants of health as core themes in the community.

In the PSA, young adults (18-39 years) have the highest ED visit and hospitalization rates due to mental health; this same age group has the highest rate of hospitalization for suicide and self-injury.

Key Findings

- Since 2020, self-reported poor mental health in the PSA has increased by 30%.
- In the hospital PSA, the mental health providers per capita continually increased from 276.8 per 100,000 residents in 2021 to 478.5 in 2025.

> My mental health was shot so I went to the hospital to get help with housing and got no resources.
> - AHE focus group respondent

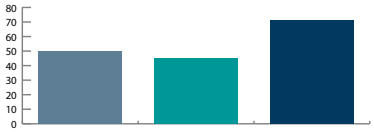
Contributing Factors

When SDOHs are lacking or unequal, they can create barriers to care and recovery.

- Barriers can include:
  - » Economic instability
  - » Lack of access to quality health care
  - » Unstable housing or homelessness
  - » Low education attainment
  - » Health literacy
  - » High crime/violence
  - » Discrimination/exclusion

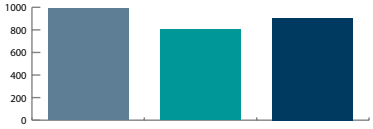
Suicide and intentional self-inflicted injury ED rate*

- » **PSA:** 50.48
- » **Cook County** 45.4
- » **Illinois** 71.81



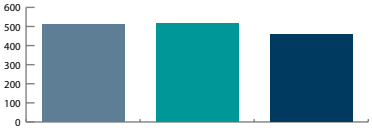
Age-adjusted ED rates due to mental health*

- » **PSA:** 991.34
- » **Cook County** 805.38
- » **Illinois** 906.27



Age-adjusted hospitalization rates due to mental health*

- » **PSA:** 512.9
- » **Cook County** 514.2
- » **Illinois** 458.3



**per 100,000 residents*

HIGHLIGHTED DISPARITIES

- Young adults (18–39 years) have the highest ED visit and hospitalization rates for mental health.
- This age group also has the highest hospitalization rates for suicide and self-injury.

Communities with the highest percentage of adults who felt their mental health was not good for 14 or more days within a month include:

- » Harvey (60426) 19.0%
- » Markham (60428) 18.8%
- » Calumet City (60409) 18.7%
- » Dolton (60419) 18.7%
- » Chicago Heights (60411) 18.3%

Social Drivers of Health - Housing

SIGNIFICANT NEED

Why is this important? Affordable housing means having a safe and stable place to live that doesn't cost more than an individual or family can afford. High housing costs, frequent moves, or fear of eviction can affect mental health and even physical well-being. Problems in living spaces like mold, bugs, peeling paint, drafts and energy inefficiencies, and too many people in one space can also impact health.

Significant Need Reasoning

27.6% of survey respondents identified housing resources for the community to be healthy. 16.4% of survey respondents identified safe and affordable housing for the community to be healthy.

Research demonstrates that people experiencing homelessness are at an increased risk and severity of many acute and chronic health conditions. Many chronic age-related conditions affect people experiencing homelessness 10-20 years earlier than the general population, often resulting in premature death. (IDPH, U of I Chicago: Illinois Homelessness Mortality and Morbidity Report, Suburban Cook County).

Although data was not available at the zip code level in the hospital PSA, the point in time count for Suburban Cook County in 2024 identified 1,188 people as homeless.

HIGHLIGHTED DISPARITIES

Home ownership rates in the PSA show various differences across racial and ethnic groups. Non-Hispanic White residents have the highest rates of homeownership, while Non-Hispanic Black residents have significantly lower rates. The same can be said at the county and state levels.

- Percent of occupied housing units
  - » **PSA** 73.61%
  - » **Cook County** 57.51%
  - » **Illinois** 66.84%
- Owner Occupied by Race/Ethnicity in PSA
  - » **Non-Hispanic White** 82.74%
  - » **Non-Hispanic Black** 62.11%
  - » **Asian** 77.43%
  - » **Hispanic/Latino** 80.97%
  - » **Native American** 71.72%
  - » **Two or More Races** 76.04%
- Rent-burdened *(renters spending 30% or more of household income on rent)*
  - » **PSA** 50.2%
- Households without a vehicle
  - » **PSA** 7.8%
  - » **Harvey (60426)** 20.0%
  - » **Calumet City (60409)** 14.2%
  - » **Hazel Crest (60429)** 13.7%
  - » **Chicago Heights (60411)** 11.6%

Key Findings

- 73.6% of housing is owner-occupied in the PSA.
- The number people living in shelters and other facilities in the PSA rose from 1,413 in 2010 to 1,803 in 2020. (U.S. Census Bureau).
- Mean travel time to work
  - » **PSA:** 33 minutes
  - » **Cook County:** 32 minutes

Contributing Factors

- Income, education, and access to resources are crucial to home ownership. Rising home prices, gentrification, and lack of affordable housing options can put homeownership out of reach for many families.
- Barriers and Challenges:
  - » Economic stability
  - » Financial literacy
  - » Affordability
  - » Safe community
  - » Good schools
  - » Low crime

> With the cost of housing these days, I don't know how anyone can afford it around here.
>
> -Focus group participant

Obesity

SIGNIFICANT NEED

Why is this important? Being overweight or obese may seriously impact a person's health. Extra weight may lead to serious health consequences such as cardiovascular disease, type 2 diabetes, some cancers, and other chronic diseases. These conditions could reduce quality of life and shorten the individual's lifespan. Having regular access to healthy food options like fresh fruits, vegetables, and meat is important for staying healthy and at a healthy weight. Reasons some people have a hard time getting food may include living far from grocery stores, lacking support from others, or not being able to afford it.

Significant Need Reasoning

In a survey conducted by the Alliance for Health Equity, hunger was ranked among the top 10 health issues for the community.

15.5% of survey respondents identified resources for food as a need for the community to be healthy.

Key Findings

- Obesity rates increased 4% from 2018 to 2022.
- All communities in the PSA have obesity rates of more than 30%.
- 11.5% of residents in the PSA are food insecure.
- 17.13% of households in the PSA receive food stamps; however, households in poverty not receiving food stamps is 56.74%.
- There is strong and consistent evidence that obesity management can delay the progression from prediabetes to type 2 diabetes and is highly beneficial in treating type 2 diabetes. In people with type 2 diabetes and overweight or obesity, modest weight loss improves glycemia and reduces the need for glucose-lowering medications, and greater weight loss substantially reduces A1C and fasting glucose and may promote sustained diabetes remission American Diabetes Association.

Contributing Factors

- Sedentary lifestyle
- Access to exercise opportunities
- Lack of grocery stores and access to affordable healthy foods
- Lack of knowledge on how/where to find resources (food pantries)
- Limited transportation
- High rent burden

> It's hard to eat healthy on a limited budget. I don't get that much money in food stamps.
> -Focus Group Participant

HIGHLIGHTED DISPARITIES

- **More than 50% of communities in the PSA surpass the average hospital PSA obesity rate of 38.1%**
  - » PSA 38.1%
  - » Cook County 32.8%
  - » Illinois 32.9%
- **2024 Cook County IL Youth Survey – Obese Range**
  - » 12th graders 8%
  - » 10th graders 8%
  - » 8th graders 10%
- **Food Insecurity:**
  (Households with limited or uncertain access to adequate food)
  - » **60426 (Harvey)** **18.4%**
  - » **60428 (Markham)** **15.8%**
  - » **60411 (Chicago Heights)** **16.4%**
  - » **60429 (Hazel Crest)** **15.3%**
- **Adults With No Exercise:**
  - » **60426 (Harvey)** **33.8%**
  - » **60428 (Markham)** **31.9%**
  - » **60419 (Dolton)** **30.3%**

Unintentional Falls

SIGNIFICANT NEED

Why is this important? Falls are a major concern in healthcare environments, leading to serious injuries, longer hospital stays, and in some cases, even fatalities. Preventing falls is a crucial part of patient safety efforts in hospitals, nursing homes, and other healthcare facilities, and in the community. With the right protocols in place, most falls can be avoided, improving patient outcomes and reducing the risks associated with injury.

Source: Fall Prevention Foundation

Significant Need Reasoning

Age-related physical illnesses were identified as a top health issue in the hospital PSA, as identified through surveys conducted by the Alliance for Health Equity.

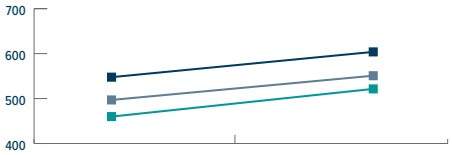
Key Findings

- The unintentional fall ED rate indicated continued increases since 2020 for the PSA, county and state.
- The ED visit rate for unintentional falls in the hospital PSA of 1,910 per 100,000 residents exceed the county rate of 1,800 per 100,000. This rate is less than the state rate of 2,053.8 per 100,000.

CONCERNING TREND

- **Unintentional Fall Hospitalization Rate:**
  (Per 100,000 residents)

	2016-2020	2020-2024
» **Hospital PSA:**	**459.88**	**521.47**
» **Cook County:**	**496.9**	**550.8**
» **Illinois:**	**547.6**	**603.8**



Contributing Factors

- **Age-related factors:** Older adults are particularly vulnerable to falls due to conditions like muscle weakness, balance issues, and cognitive impairments.
- **Medications:** Medications that cause dizziness, confusion, or sedation are often linked to increased fall risk. These can include blood pressure medications, pain relievers, and sedatives.
- **Cognitive impairments:** Patients with conditions like dementia or delirium may struggle with confusion or memory issues, making them more prone to accidents.
- **Physical conditions:** Illnesses that impair strength, mobility, or coordination, such as strokes or fractures, can heighten the likelihood of falls.
- **Environmental hazards:** Hospitals and other healthcare settings can have environmental factors such as wet floors, uneven surfaces, or inadequate lighting that increase the risk of a fall.

HIGHLIGHTED DISPARITIES

Older adults, ages 65 and older have the highest ED visit and hospitalization rates for unintentional falls.

Communities with the highest rates of ED visits for unintentional falls per 100,000 residents include:

Community	Rate per 100,000 Residents
Hazel Crest	2,721.7
Harvey	2,635.1
Park Forest	2,469.3
Markham	2,371.6
CC Hills	2,363.6
HOSPITAL PSA	1,910.8

PRIORITIZATION OF HEALTH-RELATED ISSUES

PRIORITY SETTING PROCESS

The Community Health department of Advocate South Suburban Hospital researched and presented data that highlighted the demographics, economics, education, employment, social drivers of health (SDOH) and the prevalent health issues in the hospital's PSA to its Community Health Council from February through May 2025. In April 2025, The Alliance for Health Equity also presented data to the council members that proved to have very similar findings. Data presented during the four-month meetings included:

- Cancer
- Cardiovascular Disease
- Demographics
- Dental Health
- Diabetes
- Food Insecurity and Access to Healthy Foods
- Hardship Index
- Housing
- Mental Health
- Obesity
- Respiratory Health
- Sexually Transmitted Infections
- Social Drivers of Health
- Substance Abuse
- Unintentional Falls

In June 2025, a prioritization meeting was held with the council to vote on the health needs to address as part of the hospital's 2025 community health needs assessment process. Council members were presented with the top six health needs from which to select the health priorities to address. They were asked to vote on two priorities. Those needs were:

- Mental Health
- Chronic Conditions:
  - Cardiovascular Disease
  - Diabetes
  - Respiratory Health
- Substance Use
- Obesity
- Social Drivers of Health - Housing
- Unintentional Falls

The community health council considered the below criteria when voting:

The CHC selected mental health and diabetes as the specific priority areas to focus on for the 2026-2028 implementation strategy cycle.

Mental Health

The community needs assessment identified access to mental health services as a health priority in the PSA.

The community health council identified mental health as the specific priority health need due to rising rates of emergency department visits, hospitalizations, and the growing demand for local mental health services. This need also reflects the strong connection between mental health and substance use, as many individuals experience both conditions simultaneously and require combined support.

Diabetes

The CHC decided to specifically focus on diabetes from the list of larger chronic conditions. Diabetes prevalence in the hospital PSA stands at 14.1%, which is considerably higher than the averages seen in Cook County (10.8%) and IL (10.4%). Upon further investigation and when comparing the percentage of diabetes diagnosed across the PSA landscape, the percentage of adults diagnosed with diabetes across all 22 zip codes increased. Obesity also plays a factor in developing diabetes. Being overweight or obese may seriously impact a person's health. Extra weight may lead to serious health consequences such as type 2 diabetes, cardiovascular disease, some cancers, and other chronic diseases. These conditions could reduce quality of life and shorten the individual's lifespan.

Advocate South Suburban implements the CDC's National Diabetes Prevention Program for the community and patients. Continuing and expanding upon this program empowers individuals to take control of their health.

HEALTH NEEDS NOT SELECTED

Cardiovascular Health

Advocate South Suburban Hospital, through the Advocate Heart Institute, provides a comprehensive range of cardiovascular services, including screening, diagnosis, treatment, education, and long-term care management. These services are fully integrated into the hospital's routine clinical operations and are delivered consistently as part of standard patient care. Given the ongoing and embedded nature of these efforts, cardiovascular health was not identified as a separate priority area in this CHNA.

Obesity

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

Respiratory Health

Respiratory health was not selected as a priority health need to address as the hospital already provides many services and programs to address asthma, COPD and other respiratory health issues. Advocate South Suburban Hospital offers comprehensive, multi-disciplinary services for lung and respiratory care, including the treatment of asthma. The respiratory care department provides inpatient and outpatient respiratory care services to help patients achieve a better quality of life.

Substance Use

Substance use was not identified as a priority health need due to the limited availability of substance abuse services within Advocate Health Care in Illinois. While South Suburban Hospital does offer medically managed withdrawal services and level-of-care assessments conducted by substance use counselors, we also provide peer support specialists who help connect patients with community-based treatment resources. Recognizing that substance use remains a significant health concern, Advocate Health Care is committed to strengthening partnerships with specialized community agencies to better address this need.

Social Drivers of Health - Housing

Social drivers of health, specifically housing, has a significant impact on overall health outcomes. Although these factors are essential, they were not selected as a distinct focus area in this CHNA. Instead, they are recognized as underlying influences that affect all identified health priorities. The hospital continues to address these needs through existing programs, strategic partnerships, and efforts to connect individuals with supportive resources.

Unintentional Falls

While unintentional falls – particularly among older adults – are an important public health concern, they were not selected as a health need to address in this CHNA. The hospital currently addresses fall prevention through ongoing clinical practices, including routine fall risk assessments, patient education, and care coordination for at-risk individuals. Because these efforts are already integrated into patient care and existing safety protocols, the need for additional community-level intervention was not identified during the assessment process.

APPROVAL OF COMMUNITY HEALTH NEEDS ASSESSMENT

Teammates from the Community Health department presented the CHNA to the hospital's governing council on October 21, 2025 for validation of the CHNA findings and priorities. The Advocate Health Care Board approved the report on December 10, 2025.

VEHICLE FOR COMMUNITY FEEDBACK

Community Feedback

If you have any questions or comments on the CHNA, please send an email to us at: AHC-CHNAReportCmtyFeedback@aah.org.

This report can be viewed online at Advocate Health Care's Community Health Needs Assessment Report webpage via the following link: https://www.advocatehealth.com/hospital-chna-reports-implementation-plans-progress-reports. A paper copy of this report may also be requested by contacting the hospital's Community Health Department.

EVALUATION OF IMPACT FROM PREVIOUS CHNA

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

Mental Health

To address mental and behavioral health, Advocate South Suburban Hospital collaborated with local partners and internal teams – including the Trauma Recovery Center and Faith and Health Partnerships – to offer a wide range of community-based education, support and training programs.

Community Partners included:

- Body by Ivory
- National Alliance for Mental Illness
- Southland Police Departments
- Southland Rise
- St. Mark Missionary Baptist Church
- Victory Apostolic Church
- Village of Hazel Crest

Key Community Events/Programs Offered

- Resource Fairs
- DICE Task Force Intervention Meetings
- Mental Health First Aid Training
- Trauma Faith Resilience Training
- Clergy Support Groups
- Companionship Training

1,390 lives were touched through the services offered.

Obesity

In response to rising obesity rates and related chronic conditions, the hospital implemented three targeted programs aimed at prevention education and access to healthy food:

Healthy Living Food Farmacy Program

In partnership with the Greater Chicago Food Depository, Top Box Foods and Christina Foods, the Food Farmacy helps patients with chronic conditions and individuals may be experiencing food insecurity. Patients receive fresh produce twice a month and protein accompaniment once a month.

- Total patient visits: 6,447 (rolling total)
- Total pounds of food distributed: 147,151 lbs.

Live Well Eat Well

This after-school program targets children ages 10-14 to promote healthy eating habits. Led by a lifestyle coach and supported by a local chef, participants engage in food preparation and cooking lessons. The program runs from September through May.

- 152 students have participated since the program launched

National Diabetes Prevention Program

This evidence-based, year-long program is designed to help adults with prediabetes reduce their risk of developing type 2 diabetes. It focuses on weight loss, physical activity and improved nutrition. A1c is another metric but was not always tracked.

- Six cohorts - Average retention rate across all cohorts is 80.5%
- Average weight loss for all cohorts is 4 pounds
- 166 participants completed the year-long program over six cohorts
- Participants now have access to fresh produce from the Food Farmacy program

Summary

Over this CHNA period, Advocate South Suburban Hospital and its partners have made progress toward addressing mental health and obesity in the community. These efforts reflect a strong commitment to prevention, education and reducing health disparities through local engagement and sustainable programming.

APPENDICES

Appendix 1: 2025 Community Health Needs Assessment Data Sources

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

Appendix 2: Community Resources Available for Significant Needs

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

Behavioral Health: Mental Health, Alcohol and Substance Use

Organization	Website	Contact
Grande Prairie Services	www.gpsbh.org	708-799-2200
Trinity Services	www.trinityservices.org	708-981-3370
The Link & Option Center	www.link-option.com	708-331-8111
Sertoma Star Services	https://sertomastar.org/	708-748-1951
Aunt Martha's, Chicago Heights	www.auntmarthas.org	877-692-8686
Gateway Foundation	https://www.gatewayfoundation.org/	877-505-4673
HRDI	www.hrdi.org	773-863-1452
NAMI of South Suburbs of Chicago	www.namisouthsuburbsofchicago.com	708-852-9126

Chronic Conditions, Obesity, Food Security

Organization	Website	Contact
American Diabetes Association	www.diabetes.org	1-800-DIABETES
Centers for Disease Control	www.cdc.gov	
Respiratory Health Association	https://resphealth.org/	1-888-880-LUNG (5864)
American Lung Association	www.lung.org/	1-800-LUNGUSA (586-4872)
Greater Chicago Food Depository	https://www.chicagosfoodbank.org/	773-247-3663
Hazel Crest Community Church Food Pantry	https://hazelcrestumc.org/food-pantry/	708-335-4500
Together We Cope Food Pantry	www.togetherwecope.com	708-633-5040

Housing

Organization	Website	Contact
Respond Now	www.respondnow.org	708-755-4357
South Suburban PADS	www.sspads.org	708-550-4411

Unintentional Falls

Organization	Website	Contact
Chicago Department of Family and Support Services	https://www.chicago.gov/city/en/depts/fss/provdrs/senior.html	312-744-4016
National Council on Aging	https://www.ncoa.org/professionals/health/center-for-healthy-aging/national-falls-prevention-resource-center/	

Appendix 3: References

ALICE Index: (Source: Metopio, United Way ALICE Data), ALICE Report - United Way of Illinois

American Diabetes Association: American Diabetes Association

Behavioral Health, CDC: About Behavioral Health | Mental Health | CDC

County Health Rankings: www.countyhealthrankings.org/about-us

Diabetes, World Health Organization: World Health Organization, Diabetes

Housing: Illinois Homelessness Mortality and Morbidity

Life Expectancy: Cook, Illinois | County Health Rankings & Roadmaps

Mental Health: World Health Organization, Mental Health

Metopio, American Community Survey (ACS); U.S. Census Bureau, 2019-2023

Metopio, Behavioral Risk Factor Surveillance System (BRFSS), 2022

Metopio, Map the Meal Gap; Feeding America, 2022

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

Metopio, United States Diabetes Surveillance System; Centers for Disease Control and Prevention (CDC), 2022

Metopio, Wisconsin Hospital Association Information Center (WHAIC), 2019-2023

Mortality – leading causes of death: Source, IDPH, Website data - Deaths 2022.xlsx

Social Drivers of Health: Social Determinants of Health - Healthy People 2030 | odphp.health.gov

Social Vulnerability Index: Source: Metopio, CDC, 2022

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

U.S. Census Bureau. (2019-2023). American Community Survey

Understanding Fall Risks in Healthcare Settings. Fall Prevention Foundation, 2025

Advocate Health Care®

Thank You

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