Advocate Christ Medical Center
Community Health Implementation Strategy

January 1, 2026 - December 31, 2028

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

SUMMARY OF CHNA PROCESS

In 2024, Advocate Christ Medical Center (Advocate Christ) participated with the Alliance for Health Equity collaborative to conduct a Community Health Needs Assessment (CHNA) in Cook County, which consisted of a comprehensive presentation and analysis of both qualitative and quantitative data.

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

Community Survey: The Alliance for Health Equity conducted a community survey designed to understand the community's health needs and assets with a focus on hearing from community members that are most impacted by health inequities. From February 2024 to October 2024, around 260 community surveys were collected specifically within the Advocate Christ primary service area (PSA) online and at focus groups, clinical office visits, community events, and by contracted community partners.

Focus Groups: The Alliance for Health Equity conducted seven focus groups from January 2024 to October 2024. 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.

Additionally, Advocate Christ Community Health staff analyzed secondary data, or existing information gathered from various sources, to provide valuable insights and context from the following sources

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

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

The top health issues identified in the Advocate Christ's Community Health Needs Assessment were:

- Diabetes
- Substance Use
- Mental Health
- Obesity
- Food Insecurity
- Community Safety
- Cancer

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

Using these criteria, Advocate Christ Community Health Council prioritized the following significant health needs to address in 2026-2028:

Significant Need	Implementation Strategy Selection Reasoning
Social Drivers of Health - Food Insecurity	Social drivers of health – such as housing, food access, transportation, education, economic stability – have a significant impact on overall health outcomes. Having regular access to healthy food options like fresh fruits, vegetables, and sources of protein is important for staying healthy. When people do not have regular access to healthy foods, they can develop problems like diabetes, high blood pressure, heart disease, or obesity. Barriers to accessing food may include living far from grocery stores, lacking support from others, or not being able to afford it. The Advocate Christ Community Health Council decided to continue to focus efforts specifically around food security to build on existing initiatives and resources.
Behavioral Health	Behavioral health refers to mental, emotional, and social well-being and includes mental health, substance use, and suicide-related concerns. Mental health and substance misuse are closely connected and are influenced by social and economic factors. These challenges often occur together and may require coordinated, supportive approaches to improve overall well-being. The Community Health Council identified mental health as a 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. The rising rates of both substance use and mental health data suggest that more work needs to be done to address the ever-growing need for additional services, access to programs and support services in our communities.
Diabetes	Diabetes is a condition that affects how the body uses food for energy. When left untreated, it can injure the heart, kidneys, and eyes and cause infections or reduce life expectancy. The Community Health Council selected diabetes as a top health priority based on the data presented in the CHNA and survey results from Alliance for Health Equity (AHE). Diabetes affects many individuals in the community, and proper management and access to care can prevent complications. Education and support are key to empowering individuals to manage their condition effectively. The Community Health staff will continue to address diabetes by implementing the CDC's National Diabetes Prevention Program (DPP) along with other interventions.

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

PRIORITY: Food Insecurity

IMPACT:
Increase access to healthy food for community members, including teammates.

DESCRIPTION OF HEALTH NEED DATA:

- Focus group participants highlighted the prevalence of food deserts, stating that families often rely on processed, low-cost foods that contribute to health issues like obesity and malnutrition.
- From the community survey:
  - » 19% of respondents said improving community health would require improved food resources.
  - » 16.5% of respondents listed resources for food as what the community needs to be healthy.
- In the Christ PSA, 13.2% of residents are faced with food insecurity, which is notably higher than Cook County at 12.1% and the state of Illinois at 12.0%.

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL: Advocate Health Care Food Security
- Advocate Health Care Food Farmacy Program

STATE: IDPH Illinois State Physical Activity and Nutrition Program - Illinois Public Health Institute
- Increase access to nourishing foods

NATIONAL: Healthy People 2030
- Reduce household food insecurity and hunger

STRATEGY #1: Continue implementing food support for patients and promoting sustainability

Planned Interventions	Collaborative Partners	Intended Outcomes
• Continue offering Food Farmacy program • Work with Food and Nutrition on collaborating food purchasing from Cristina Foods to promote sustainability • Create a teammate-facing food program • Increase knowledge of food resources available in the community	• Advocate Medical Group (AMG) • Top Box • Cristina Foods • AH Food Sustainability Task Force • Good Shepherd Smart Farm • Food Farmacy • Volunteer Services • FindHelp	• Increased access to healthy foods for community members • Increased knowledge of food resources available in community • Reduced food waste, positively impacting the environment

Measures

- Number of patients enrolled in program
- Number of teammates enrolled
- Number of boxes distributed
- Pounds of food distributed

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

PRIORITY: Food Insecurity (CONTINUED)

STRATEGY #2: Collaborate to expand healthy food availability within the community

Planned Interventions	Collaborative Partners	Intended Outcomes
• Increase knowledge of food resources available in community • Mobilize system resources through investments and community service with food organizations • Participate in locally led coalitions to better support the food environment	• Community-based organizations in FindHelp • Faith-based organizations • Alliance for Health Equity	• Decreased barriers for teammates in need to access food • Increased knowledge of food resources available in community

Measures

- Number of referrals provided to community food pantries
- Funds donated / hours of staff time provided
- Progress updates

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

PRIORITY: Behavioral Health

IMPACT:

Improve the behavioral health status of the Advocate Christ Medical center PSA residents by ensuring access to mental health resources.

DESCRIPTION OF HEALTH NEED DATA:

- In the Alliance for Health Equity (AHE) survey assessment, 22.1% of the participants said that substance use was a major health issue in their community; it ranked as the fourth biggest health issue.
- Alcohol use emergency department visit rates are significantly higher in the Christ PSA compared to Cook County and Illinois overall, with rates of 646.31, 732.22, and 658.75 respectively. The highest rates are observed among individuals aged 18-39. Overall, the rates for all age groups in the Christ PSA exceed those of Cook County and Illinois.
- Of AHE survey respondents, 23.5% recognized the ability to access mental health care services within a reasonable amount of time as a community need.
- Among adult residents ages 18 and older, 16.7% report 14 or more days during the past 30 days during which their mental health was not good. This is slightly higher than the Illinois rate of 16.1% and the Cook County rate of 15.3%.
- In the PSA, the behavioral health hospitalization rate due to mental health is 668.6 per 100,000 residents. This is higher than the Illinois rate of 634.4 per 100,000 residents and the Cook County rate.

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL: Access to Behavioral Health Services

- Advocate Trauma Recovery Center
- Mental Health and Substance Use - Cook County Department of Public Health

STATE: Regional Behavioral Health Strategic Plan | Cook County Health

- Implement a public health approach that emphasizes trauma-informed strategies for mental and behavioral health, substance use, and community safety

NATIONAL: Healthy People 2030

Health Conditions and Behavioral Health, Improve Mental Health and Mental Disorders

- Increase social and community support

STRATEGY #1: Improve mental health awareness through community collaborations

Planned Interventions	Collaborative Partners	Intended Outcomes
• Partner on educational speaking engagements to reduce behavioral health stigma and increase mental health awareness • Strengthen partnership with AH Faith and Health's Mental Health First Aid (MHFA) trainings • Support local coalitions and community organizations that address substance use and mental health across the Christ PSA • Offer Mental Health Lunch and Learns to support staff mental health	• Faith-Based Institutions • Cook County Sheriff's Department • Envision Community-Based Organizations in the PSA • American Society for Suicide Prevention • Fraternities and Sororities • AAH Faith & Health Partnerships	• Improved coordination of system-wide efforts to support mental and behavioral health needs • Increased capacity for teammate social support and resiliency among individuals with behavioral health concerns in the PSA • Improved community and clinical linkages to address the non-clinical needs of individuals with behavioral health concerns

Measures

- Number of participants attending workshops
- Number of new programs or interventions developed in partnership with local community-based organizations
- Hours of staff time contributed to coalitions
- Number of staff impacted by mental health support offerings
- Number of attendees at workshops
- Pre and post assessments; post evaluation percentage of participants who are adequately prepared to address mental health issues during patient care
- Attendance at Lunch and Learns

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

PRIORITY: Behavioral Health (CONTINUED)

STRATEGY #2: Improve awareness of alcohol and substance use services, resources, and risk reduction options

Planned Interventions	Collaborative Partners	Intended Outcomes
• Increase awareness of availability of free Naloxone and other materials for community members to reduce risk of overdose deaths • Navigate patients to appropriate services and resources to promote recovery from substance use • Explore opportunities to support drug take back initiatives, to decrease the number of unused medications available in the community	• AH Faith & Health Partnerships • First Breath program • FindHelp • Community Health Workers • Mobile Health	• Increased knowledge related to alcohol and substance use • Increased coordination to local community support services • Reduced medication available in community to decrease misuse • Decreased overdose deaths

Measures

- Number of referrals
- Number of Naloxone distributions
- Number of events supported / partnerships supported
- ED related admissions due to alcohol and substance use

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

PRIORITY: Diabetes

IMPACT:
Increase access to healthy produce, provide education and healthy cooking resources for people living with diabetes or at risk for diabetes in the Advocate Christ PSA.

DESCRIPTION OF HEALTH NEED DATA:

- In the Alliance for Health Equity (AHE) survey assessment, 24.4% of survey respondents recognized diabetes as top health concern.
- Participants linked diabetes to unhealthy diets high in sugar and processed foods, and a lack of access to quality food resources such as grocery stores, food banks, and SNAP programs.
- Within the Christ PSA, 12.6% of residents aged 18 and older have been diagnosed with diabetes. which is considerably higher than the averages seen in Cook County, IL, and Illinois at 10.8%, 10.4%, respectively.
- Hospitalization rates for diabetes are 239.5 per PSA population, again higher than Cook County (202.8) and Illinois (178.8), with Non-Hispanic Black residents facing the greatest hospitalization burden.

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL:

- Advocate Christ Medical Center Diabetes Prevention Program
- Expansion of AH Live Well Eat Well healthy cooking and eating program for youth
- Cook County Health Improvement Plan (WePlan 2025)

STATE: IDPH Illinois State Physical Activity and Nutrition Program - Illinois Public Health Institute

- Increase access to nourishing foods

NATIONAL: Healthy People 2030

- Increase the proportion of eligible persons completing Centers for Disease Control and Prevention (CDC)-recognized lifestyle change programs

STRATEGY #1: Offer evidence-based lifestyle education for patients in community settings

Planned Interventions	Collaborative Partners	Intended Outcomes
• Continue offering Prevent T2 diabetes prevention program for patients, with an emphasis on weight reduction • Partner with AMG physicians to screen and refer patients to the program	• AMG physicians referring participants to DPP program • LKC Health and Wellness DPP lifestyle coach	• Decreased weight of participants by 5% • Reduced emergency department visits and diabetes-related complications

Measures

- Number of participants
- Program outcomes including:
  - » Achieve at least **60% participant retention** at 6 months.
  - » Achieve at least **50% participant retention** at 12 months.
  - » At least **50% of participants** will achieve 5% body weight loss.
  - » Participants will average **150 minutes of physical activity per week** by month six.
  - » At least **40% of participants** with baseline elevated HbA1c reduce their A1c level.

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

PRIORITY: Diabetes (CONTINUED)

STRATEGY #2: Build community awareness and education of diabetes prevention through healthy living

Planned Interventions	Collaborative Partners	Intended Outcomes
• Introduce AH Live Well Eat Well healthy cooking instruction classes for youth to prevent chronic diseases • Provide students in the healthy eating program with fresh produce and recipes provided by the Food Farmacy • Support community efforts on health education, prevention, and management of diabetes	• Faith Based Organizations • Community Based Organizations • Food Farmacy • LKC Health & Wellness	• Increased number of nutrition education and cooking demonstrations • Increased participant nutrition knowledge

Measures

- Number of students enrolled in healthy cooking program / percent enrolled in Food Farmacy
- Pre- and post- test of participation knowledge
- Number of community events / number of participants
- Progress updates

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

Needs Not Addressed

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

Adoption of the Implementation Strategy

The Community Health Implementation Strategy report was adopted by the governing council on March 16, 2026, and additionally approved by the Advocate Health Care Network Board on May 5, 2026.

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