Advocate Illinois Masonic 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 Illinois Masonic Medical Center plans to address their prioritized community health needs.

SUMMARY OF CHNA PROCESS

In 2025, Advocate Illinois Masonic Medical Center (Advocate Illinois Masonic) conducted 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 Illinois Masonic CHNA relied on the following primary data, gathered through the Alliance for Health Equity partnership:

Community Input Survey and Focus Groups: Primary data collection included survey and focus groups with community members as well as meetings with hospital community advisory councils. In Cook County, 1,880 community input surveys were collected, and 49 focus groups were conducted throughout Chicago and Suburban Cook County. Data collection focused on gathering input from those underrepresented in traditional assessments and was conducted in partnership with community-based organizations.

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

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

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

The top health issues identified in the Advocate Illinois Masonic Medical Center Community Health Needs Assessment were:

- Cardiovascular Disease
- Diabetes
- Respiratory Disease (Asthma & COPD)
- Mental Health
- Substance Use
- Obesity
- Food Insecurity & Access to Healthy Food
- Access to Health Care

Needs Acknowledged (Not Included in the Voting):

- Maternal, Child & Reproductive Health
- Housing
- Cancer

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

Using these criteria, Advocate Illinois Masonic Medical Center has prioritized the significant health needs to address in 2026-2028:

Significant Need	Implementation Strategy Selection Reasoning
Access to Health Care	This need was selected because many residents face significant barriers to health care. Challenges include lack of insurance, high costs, transportation difficulties, and a shortage of providers for specialties. Immigrant communities, older adults, and families with low income are especially impacted, leading to delayed or forgone care. Improving access ensures that all residents can receive the right care at the right time, reducing health disparities and preventing costly emergencies.
Mental Health	This need was selected because mental health is a growing concern in Cook County, with rising rates of depression, anxiety and stress across all age groups. Youth and young adults are particularly vulnerable, as emergency visits for self-harm and behavioral health issues have increased in recent years for these populations. Stigma and lack of awareness often delay people from seeking care until they are in crisis. Expanding access to timely, affordable, and preventative mental health services is critical to protecting long-term community well-being.
Diabetes	This need was selected because diabetes affects many Cook County residents, leading to complications such as kidney disease, vision loss, and cardiovascular issues. Type 2 diabetes is closely tied to lifestyle factors including obesity and physical inactivity, both of which remain concerns in the community. Diabetes prevention and management are critical to the quality of life for residents.

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: Diabetes

IMPACT:
Empower individuals to manage their diabetes effectively by promoting healthy diets, physical activity, and regular monitoring of the condition to reduce disease burden.

DESCRIPTION OF HEALTH NEED DATA:

- In the Alliance for Health Equity survey, 17.3% of community input survey respondents listed diabetes as one of the biggest health issues in the Advocate Illinois Masonic primary service area (PSA).
- Humboldt Park and Belmont Cragin have the highest rates for diagnosed diabetes, and are among the highest emergency department visit rates, and overall diabetes complication hospitalization rates.
- ED utilization for uncontrolled diabetes indicates systematic barriers to preventative care, consistent treatment and education.

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL: CARES Program

- Strategy 1: Expand access to diabetes prevention, diabetes management and family-focused healthy lifestyle programs in Cook County, IL priority communities.
- Strategy 2: Program partners will help implement evidence-based programs tailored to meet the needs of their local communities.
  Source: *Cook County Diabetes Management - Chicago CARES DPP*

STATE: State Health Improvement Plan (SHIP)
Healthy Illinois 2028 Priorities:

- (Chronic Disease) Strategy 2: Decrease preventable chronic disease through nutrition.
  Source: *Healthy Illinois 2028*
- (Chronic Disease) Strategy 4: Increase community-clinical linkages to reduce the incidence and burden of chronic disease.
  Source: *Healthy Illinois 2028*

NATIONAL: Healthy People 2030

- D-06: Increase the proportion of people with diabetes who get formal diabetes education.
  Source: *HP 2030*
- D-01: Increase the proportion of eligible people completing CDC-recognized type 2 diabetes prevention programs.
  Source: *HP 2030*

STRATEGY #1: Increase access to diabetes prevention and self-management programming

Planned Interventions	Collaborative Partners	Intended Outcomes
• Partner with AgeOptions Take Charge of Your Diabetes Self-Management Program • Implement Diabetes Education Empowerment Program DEEP (UIC) • Implement the National Diabetes Prevention Program (DPP) • Provide clinician led presentations on Diabetes awareness to community residents	• American Diabetes Association (ADA) • AgeOptions • University of Illinois Chicago (UIC) • Community-based organizations (CBOs) • Advocate Health Care clinicians and dietitians	• Expanded consistent, community-based diabetes programming to increase access to prevention, education, and support for individuals across the PSA • Improved diabetes-related health outcomes, including reductions in A1C levels, improved weight management, and better disease control, through increased participation in prevention and self-management programs • Strengthened long-term health behaviors and improved diabetes self-management skills

Measures

- Number of diabetes prevention/self-management programs offered
- Number of participants enrolled in the programs
- Pre/post assessment and self-reported increase in confidence (managing blood sugar, healthy food choices, exercises, etc.)
- Improvement in A1C, weight and blood pressure (clinical or self-reported)

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

PRIORITY: Diabetes (CONTINUED)

STRATEGY #2: Establish a diabetes collaborative to expand screening, improve referrals, and support early detection

Planned Interventions	Collaborative Partners	Intended Outcomes
• Establish a Diabetes Prevention & Care Coordination Action Team that supports Lutheran General and Illinois Masonic • Develop a network of resources and providers to increase access to prevention of diabetes, promotion and management	• American Diabetes Association (ADA) • Age Options • Community Based Organizations (CBOs) • Advocate Illinois Masonic teammates	• Improved referral pathways and follow through to prevention and care services • Reduced delays in diagnosis and initiation of care • Stronger coordination and communication among clinical and community partners • Earlier identification of prediabetes and diabetes

Measures

- Number of implemented activities that support diabetes programming
- Number of education and workshops provided
- Number of attendees for each session
- Number of referrals among clinical and community partners

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

PRIORITY: Access to Health Care

IMPACT:
Expand access to ensure people receive preventative, primary, and timely care, reducing the prevalence and severity of chronic and acute conditions.

DESCRIPTION OF HEALTH NEED DATA:

- In focus groups, participants mentioned it is hard to navigate insurance coverage and what treatments are paid for, and which are out-of-pocket. Additionally, they added it gets more stressful because employment is tied to their health insurance.
- The uninsured rate for the PSA (9.9%) is higher when compared to the Cook County (8.9%) and state (6.9%) rate.

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL: Cook County Policy Roadmap 2024-2027

- Reduce health inequities by addressing the racial disparities, social, physical and economic conditions that impact health. (*Strategy 1.2*) Reduce barriers to accessing health services for all residents through assessment, education, outreach, and advocacy. ***Source:*** Policy Roadmap 2024-2027 FINAL
- Improve access to and integration models of high-quality, responsive healthcare. *(Strategy 2.3*) Explore and support innovative models of care that increase access and expand ability to serve historically marginalized residents. ***Source:*** Policy Roadmap 2024-2027 FINAL

STATE: State Health Improvement Plan (SHIP)
Healthy Illinois 2028 Priorities:

- (Chronic Disease) *Strategy 4*: Increase community-clinical linkages to reduce the incidence and burden of chronic diseases.
- (COVID-19 and Emerging Diseases) *Strategy 3*: Strengthen public health system infrastructure and coordination to prepare for and respond to communicable disease threats, improving equitable access to needed services.
  Source: *Healthy Illinois 2028*

NATIONAL: Healthy People 2030

- Strategy AHS 04: Reduce the proportion of people who can't get medical care when they need it.
  Source: *HP 2030*

STRATEGY #1: Enhance internal care coordination and strengthen community resources in Findhelp to advance enterprise goals related to social drivers of health

Planned Interventions	Collaborative Partners	Intended Outcomes
• Expand Advocate Health's Findhelp Trusted Partnership • Improve internal and external coordination of care for patients with an increased risk for poor health outcomes by expanding Epic Care Link Expansion	• Community-based organizations (CBOs) • Advocate's Social Health department • Advocate Illinois Masonic's Care Management	• Increased number of trusted partners within Advocate Health's trusted partnership network to support trusted referrals • Increased number of closed loop referrals to community-based organizations

Measures

- Number of active community-based organizations (CBOs) in Findhelp
- Number of newly enrolled trusted partners in Findhelp
- Number of internal and external trainings offered to support Findhelp expansion
- Percentage of referrals resulting in a resolved or partially resolved social need

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

PRIORITY: Access to Health Care (CONTINUED)

STRATEGY #2: Enhance access to resources that support social drivers of health and individual care

Planned Interventions	Collaborative Partners	Intended Outcomes
• Coordinate and strengthen access to CommunityHealth Clinic rides • Promote equitable access to care and community support by reducing barriers to care and increasing access to services such as insurance enrollment support, food insecurity resources, and other essential community-based services for residents and Advocate patients • Manage a Community Health Worker (CHW) program • Leverage mobile health units staffed with healthcare professionals to provide screenings, care navigation and referrals, and health education to increase access to timely and appropriate healthcare services within the community	• CommunityHealth Clinic • Onward House • Old Irving Park Community Center • Other Free clinics and Federally Qualified Health Centers (FQHC) • Advocate Health's Care Management team • Advocate Health Mobile Health team	• Improved care access and continuity • Increased number of underinsured residents who successfully attend medical appointments through reliable transportation support • Decreased missed and delayed care • Reduced transportation-related no-show rates among underinsured residents through targeted transportation assistance • Strengthened food security and health outcomes • Expanded onsite food pantry to consistently support food-insecure patients • Improved stability and care navigation • Expanded internal and external services that address social determinants of health (SDOH) needs, including food, insurance, housing, and financial assistance

Measures

- Number of riders enrolled
- Number of rides provided
- Number of individuals connected to primary care and/or follow-up appointment
- Increased percentage of secured appointments post discharge
- Number of food-insecure patients served through the onsite food pantry program
- Year over year 20% increase in pantry utilization
- Number of people served through the mobile health units
- Number of partner sites
- Number of screenings provided

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

PRIORITY: Mental Health

IMPACT:

Promote early intervention and treatment to prevent worsening symptoms and improve daily functioning. Reduce stigma and increase awareness to help communities provide better support for those affected.

DESCRIPTION OF HEALTH NEED DATA:

- Rogers Park, Uptown and Humboldt Park have the highest mental health emergency department (ED) visits and Hospitalization rates in the PSA.
- The Non-Hispanic Black population has over three times higher rates of mental health ED and hospitalization rates in the PSA.
- There are high rates of seniors living alone in the community (Uptown 54%, Rogers Park 43%, Lakeview 52%); social isolation is a risk factor for mental health issues.

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL: Healthy Chicago 2025 Strategic Plan:

- Strategy 1: Hyperlocal marketing campaigns to drive connection to and continuance of treatment among people with SMI.
  Source: *Pg. 50 Healthy Chicago 2025 Strategic Plan*
- Strategy 2: Mental health promotion and early prevention through community screenings and referrals.
  Source: *Pg. 50 Healthy Chicago 2025 Strategic Plan*

Chicago Department of Public Health, Cook County Policy Roadmap 2024-2027:

- Strategy 1: Improve access to and integration of high-quality, responsive healthcare.
- Strategy 2: Enhance access to high-quality mental healthcare, trauma-informed services and substance use disorder care. ***Source***: *Policy Roadmap 2024-2027 FINAL*

STATE: State Health Improvement Plan (SHIP) Healthy Illinois 2028 Priorities:

- (Mental Health and Substance Use Disorder) Strategy 1: Improve the mental health and substance use disorder (SUD) system's infrastructure to support and strengthen prevention and treatment.
- (Mental Health and Substance Use Disorder) Strategy 4: Improve the resilience and recovery capital of communities experiencing violence.
  Source: *Healthy Illinois 2028*

NATIONAL: U.S Centers for Disease Control and Prevention (CDC) Mental Health Strategy

- Strategy 1: Promote Well-being
- Strategy 2: Improve Access to Supports and Opportunities
  Source: Protecting the Nation's Mental Health | Mental Health | CDC

STRATEGY #1: Advance community partnerships to enhance the co-delivery of adult and youth mental health education and support programs

Planned Interventions	Collaborative Partners	Intended Outcomes
• Promote Community-centered Programming, including Ending the Silence (NAMI), Mental Health First Aid (MHFA) and other local programs • Expand Advocate Health's Mental Health Companionship program in the community • Align with the Cook County Office of BH's Strategic Plan to support access to community focused programming	• Turning Point Behavioral Health • NAMI Cook County • Advocate Illinois Masonic Resources • Community Based Organizations (CBOs) • Advocate Health's Faith & Health Partnerships Network • Cook County Office of Behavioral Health • Alliance for Health Equity (AHE)	• Improved timely access to care by closing gaps in availability and utilization of mental health services within the PSA • Reduced preventable emergency department use by ensuring individuals experiencing mental health crises receive appropriate, earlier intervention and community-based care • Increased engagement and help-seeking behavior by providing supportive services that normalize mental health care and reduce stigma among patients and residents

Measures

- Number of participants served
- Number of programs offered in the PSA (internal and external)
- Percentage increase in self-reported comfort, awareness, and willingness to seek mental health support from pre to post surveys

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

PRIORITY: Mental Health (CONTINUED)

STRATEGY #2: Broaden access to high-quality mental health resources to support the ongoing learning and resilience of professionals

Planned Interventions	Collaborative Partners	Intended Outcomes
• Expand the Mental Health Companionship program for professionals • Strengthen community partnerships to expand mental health training for professionals including MHFA, Motivational Interviewing, Trauma Informed Care, and other best practices • Align with the Cook County Office of BH's Strategic Plan to support access to professional programming	• Alliance for Health Equity (AHE) • Advocate Health's Faith & Health Partnerships Network • Cook County Office of Behavioral Health • PEER Services	• Expanded partnerships with behavioral health experts (including internal partners), schools, faith-based organizations, community-based organizations, and public health agencies to co-design and deliver mental health training • Improved alignment with regional efforts to expand mental health services and resource coordination

Measures

- Number of programs offered
- Number of participants supported
- Percentage increase in self-reported knowledge from pre to post surveys

**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, cardiovascular disease, food insecurity, and maternal, child and reproductive health, obesity, respiratory disease, and substance use. These needs are not addressed in this CHIS due to factors including limited hospital resources, the presence of existing initiatives led by other organizations, and a determination that the hospital is not best positioned to lead efforts in these areas at this time. Advocate Health will continue to collaborate with community partners and share resources, when appropriate, to support progress on these needs within the community.

Adoption of the Implementation Strategy

The Community Health Implementation Strategy report was adopted by the governing council on April 24, 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.