Advocate Lutheran General Hospital 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 Lutheran General Hospital plans to address their prioritized community health needs.

SUMMARY OF CHNA PROCESS

In 2025, Advocate Lutheran General Hospital (Advocate Lutheran) participated with the Alliance for Health Equity collaborative in Cook County to conduct a Community Health Needs Assessment (CHNA), which consisted of a comprehensive presentation and analysis of both qualitative and quantitative data.

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

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 in 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 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)

Advocate Health Care

Advocate Lutheran General Hospital
1775 Dempster St.
Park Ridge, IL 60068

The top health issues identified in the Advocate Lutheran 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 Lutheran General Hospital team, 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 Lutheran General Hospital has prioritized the significant health needs to address in 2026-2028:

Significant Need	Implementation Strategy Selection Reasoning
Diabetes	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; community resources and existing programs should be put in place to support residents. For this reason, the council recognized diabetes as important and chose to identify it as one of the top three focus areas.
Mental Health	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. Stigma and lack of awareness often delay people from seeking care until they are in crisis. Expanding access to timely, affordable, and preventive mental health services is critical to protecting long-term community well-being.
Substance Use	Substance use continues to pose serious risks in Cook County, with opioid overdoses remaining a leading public health challenge. Alcohol misuse and youth vaping are also concerning trends, impacting both immediate health and long-term outcomes. Many individuals with substance use disorders also face co-occurring mental health conditions, which increases the complexity of care needed. By focusing on prevention, treatment, and recovery support, the community can save lives and reduce the burden on families, schools, and healthcare systems.

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:

By fostering healthier eating habits, increasing physical activity, and supporting regular monitoring, the strategy seeks to promote long-term wellness and stability for individuals at risk or living with diabetes. Through education, community support, and coordinated resources, these efforts empower individuals to take control of their health and improve outcomes across the population.

DESCRIPTION OF HEALTH NEED DATA:

- In the Alliance for Health Equity (AHE) survey assessment, 23.1% of survey respondents (n=143) from the PSA recognized diabetes as the third top health concern.
- Within the PSA, 10.8% of residents aged 18 and older have been diagnosed with diabetes. Several communities carry a disproportionate burden.

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 the National Diabetes Prevention Program (DPP) • Implement Diabetes Education Empowerment Program DEEP • Provide presentations led by health professionals 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 • Deploy mobile health units to provide accessible diabetes screening, education, and follow-up services in communities with gaps to care to reduce barriers to prevention and management of the condition	• American Diabetes Association (ADA) • Age Options • Community Based Organizations (CBOs) • Advocate Lutheran General teammates • Advocate Health Mobile Health team	• 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
- Improved awareness of diabetes risk and prevention resources
- Post satisfaction surveys
- Number of referrals among clinical and community partners
- 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:

Reduce stigma and increase awareness on mental health issues and improve access to care and support options to better promote overall well-being for all community members.

DESCRIPTION OF HEALTH NEED DATA:

- In the Alliance for Health Equity (AHE) survey assessment, 25.2% of survey respondents (n=143) from the PSA recognized adult mental health as the number two health concern.
- Additionally, of the 143 survey respondents, 29.5% highlighted that more access to mental healthcare services was needed for their community to be healthy.
- Non-Hispanic Black residents and young adults have the highest mental health hospitalization rates in the PSA, with children's rates higher than county and state averages. Arlington Heights, Skokie and Irving Park/Portage Park report rates well above the PSA average.
- Youth aged 5–17 and Non-Hispanic Black residents face the highest suicide and self-injury ED visit rates, with females consistently higher than males. Palatine, Prospect Heights and Wheeling show elevated rates for both suicide and self-injury ED visits signaling a need for targeted prevention.

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 the Mobile Living Room (Managed by Turning Point), Ending the Silence (NAMI) and other local programs • Expand Advocate Health's Mental Health Companionship Program in the community • Coordinate the Turning Point Therapy Garden Program	• Turning Point Behavioral Health • NAMI Suburban Cook County • Advocate Lutheran General Resources • Community Based Organizations (CBOs) • Advocate Health's Faith & Health Partnerships Network • 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

PRIORITY: Mental Health (CONTINUED)

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.*

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.*

PRIORITY: Substance Use

IMPACT:

Partner with community-based organizations on expanding substance use treatment, support and prevention education to reduce overdose deaths and substance-related accidents.

DESCRIPTION OF HEALTH NEED DATA:

- In the PSA, binge drinking rates in certain communities are high, with Irving Park/Portage Park, Oriole Park, Edison Park/ Norwood Park, exceed 20% binge drinking.
- Non-Hispanic Black residents and adults 18–39 and 40-46 years old have the highest ED visit rates for both alcohol and opioids.
- While Opioid impacts all communities in our PSA, Irving Park/Portage Park, Elmwood Park, Norridge/Harwood Heights show the highest opioid-related ED visits and hospitalizations in the PSA.
- Non-Hispanic Black (1,419 per 100,000 residents) have the highest substance use ED rates, followed by Asians (587) and Hispanics (551). Males in the PSA also have higher ED rates at 808.

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL: Northern Cook County (NCC) ROSC Coalition Report

- Strategy 1: NCC will develop a plan to harmonize the barriers that individuals with substance use disorder face in trying to receive treatment by June 2028.
- Strategy 2: Strengthen Peer Leadership and Community-Based Supports By June 2028

Source: *Peer Services ROSCFY26 Strategic Plan*

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 2: Reduce mortality due to mental health conditions and substance use disorders through harm reduction and preventative care strategies.

Source: *Healthy Illinois 2028*

NATIONAL: Healthy People 2030

- Strategy 1: Reduce the proportion of adults who used drugs in the past month
- Strategy 2: Reduce drug overdose deaths
- Strategy 3: Reduce overdose deaths involving opioids

Source: *Drug and Alcohol Use - Healthy People 2030 | odphp.health.gov*

STRATEGY #1: Deepen partnerships with local organizations to expand substance use education and support resources for internal and external professionals

Planned Interventions	Collaborative Partners	Intended Outcomes
• Expand access to substance use training for both health professionals and non-health professionals • Assess opportunities to expand or introduce programming through initiatives such as SBIRT, training, Narcan availability, etc.	• Gateway Foundation • PEER Services • Federally Qualified Health Centers (FQHC) • Local Schools • Advocate Lutheran General Behavioral Health Team • Advocate Lutheran General Care Management • Community Based Organizations	• Reduced substance related harm and emergency events • Increased provider competency and confidence in addressing substance use • Strengthened workforce capacity across care settings • Increased use of evidence-based prevention and intervention strategies • Improved early screening, referral, and harm reduction • Expanded overdose prevention and response capacity

PRIORITY: Substance Use (CONTINUED)

Measures

- Number of professional trainings offered
- Number of professionals trained
- Percentage increase in self-reported knowledge from pre to post surveys
- Percentage of participants reporting increased preparedness

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

STRATEGY #2: Strengthen and expand substance use education and support resources to improve awareness, early intervention, and support in the community

Planned Interventions	Collaborative Partners	Intended Outcomes
• Support harm reduction programs in the community, such as the SBIRT Program, Narcan education, alcohol misuse support and prevention • Align with the Recovery Oriented System of Care (ROSC) Council • Expand the number of Advocate trusted substance use partners in Findhelp to strengthen community referrals	• PEER Services • Skokie Health & Human Services • Local Community Based Organization (CBOs) • Advocate Lutheran General teammates	• Increased access to equitable harm reduction and overdose prevention resources • Improved alignment with community-led efforts to strengthen local capacity and impact • Improved linkage to treatment and recovery support post-hospital discharge

Measures

- Number of harm reduction and overdose prevention programs offered
- Number of substance use agencies enrolled as trusted partners in Findhelp
- Percent increase in self-reported knowledge from pre to post surveys
- Percent of participants reporting increased preparedness

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

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.

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 cardiovascular disease, respiratory disease, obesity, food insecurity, access to health care, maternal, child and reproductive health, housing, and cancer. These needs, while also important, are not addressed in this CHIS due to factors such as limited hospital resources, the presence of existing initiatives led by other organizations, 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 April 13, 2026, and additionally approved by the Advocate Health Care Network Board on May 5, 2026.