Principles for Community Health Care Report

Humboldt Park Health Foundation
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Mission:
To raise funds to support Humboldt Park Health as a vital safety net hospital, improving the health and well-being of our neighbors through investment in high-quality patient care, technology, and community health initiatives.

At Humboldt Park Health, we believe that access to high-quality healthcare is a fundamental right. As a safety-net hospital serving one of Chicago's most diverse and medically vulnerable communities, our mission extends beyond clinical care to address the social and economic factors that impact health. This report outlines our principles and programs designed to improve community health through innovation, collaboration, and equity.

Humboldt Park Health (HPH), a 200-bed safety-net hospital, serves predominantly low-income, uninsured, and underinsured populations across Chicago's west and northwest neighborhoods, including Humboldt Park, West Town, East Garfield, and Austin. The community is 40% Hispanic/Latinx and 28% Black/African American, with a median household income of $45,000 and high rates of chronic conditions such as diabetes and cardiovascular disease.

Based on community health assessments and Social Determinants of Health (SDOH) screenings, HPH has implemented targeted strategies to increase access to care: developing a 103-unit affordable housing complex to address housing instability and partnering with the Greater Chicago Food Depository for food bank enrollment to operate a monthly food pantry distributing over 300 bags. Transportation barriers are mitigated through five hospital-operated vans, and cancer care access is expanded through collaborations with City of Hope Cancer and federally qualified health partners (FQHCs) for breast, cervical, and colon cancer screenings. Additionally, HPH launched a sliding-scale Wellness Center and deployed mobile health units to deliver preventive services, chronic disease education, and mental health screenings directly in high-need neighborhoods.

HPH actively engages high-risk and underserved populations through community health needs assessments, patient surveys, and direct feedback from advisory boards composed of local leaders and caregivers. These insights inform program design, such as tailoring mobile health services to include asthma education and diabetes management based on identified gaps. The hospital also leverages screening tools like Hunger Vital Sig and SDOH questionnaires during patient encounters to capture real-time data on food insecurity, housing instability, and transportation needs, ensuring interventions are responsive to community priorities.

To strengthen continuity of care, HPH collaborates with a network of providers and community-based organizations. Key partnerships include City of Hope Cancer for oncology services, Equal Hope for breast and cervical cancer screening, and local FQHCs to streamline colonoscopy referrals. Through Wellness West, HPH connects patients to housing resources via community navigators, while partnerships with the Greater Chicago Food Depository address food insecurity. Behavioral health integration and insurance enrollment support are provided through wraparound services linked to HPH programs, ensuring that vulnerable populations receive comprehensive, coordinated care beyond the hospital setting.

Examples of our Community-oriented programs:

Example 1: The Care-A-Van Program (Mobile Health Units)

The Care-A-Van program exemplifies a community-oriented approach by delivering essential preventive medical services directly to children and adolescents in high-need Chicago zip codes. These neighborhoods are predominantly low-income, where access to preventive care is limited, making this program a critical resource. By bringing care into neighborhoods rather than requiring families to travel, the program removes barriers to access and builds trust within the community. It provides health education and preventive services, including vaccinations, physical and oral exams, screenings for diabetes, lead, hemoglobin, hearing, vision, and asthma, as well as nutritional planning. The program also connects pediatric patients to wraparound services such as behavioral health, insurance enrollment support, and the HPH food pantry.

Number of clients served: 1,032
Total amount budgeted by your organization for the program: $243,091.72
Percent that program budget is of total agency budget: 35%
Percent of program budget that is directly reimbursed by third party payers: 0%
Percent of program budget that is covered by public/private grants: 80%

Example 2: Diabetes/Food Insecurity Program
The Diabetes/Food Insecurity Program was implemented by Humboldt Park Health from July 2020 to May 2021 to address health disparities among adults with Type 2 diabetes who screened positive for food insecurity.

Leveraging the hospital's drive-through COVID-19 testing site, the program screened 275 high-risk individuals using the Hunger Vital Sign tool. Most participants were Hispanic/Latino (76%) and Spanish-speaking (65%), reflecting local demographics where Puerto Ricans face a 21% diabetes rate. The initiative provided three nutrition education sessions and distributed 103 nutritious food bags and portion plates to support healthier eating habits.

Number of clients served: 450
Total amount budgeted by your organization for the program: $150,000
Percent that program budget is of total agency budget: 10%

Percent of program budget that is directly reimbursed by third party payers
Percent of program budget that is covered by public/private grants:15%

Humboldt Park Health remains committed to advancing health equity and improving outcomes for the communities we serve. Through strategic partnerships, targeted programs, and a deep understanding of social determinants of health, we continue to break down barriers to care and create pathways for healthier lives.