2025 Community Health Needs Assessment

TABLE OF CONTENTS

Introduction

Founded in 1894, Humboldt Park Health is not-for-profit hospital deeply committed to serving the Humboldt Park community, ensuring access and delivering high-quality, compassionate healthcare. We do so through strong partnerships with our patients and their families, employees, medical staff, and community organizations—both within and beyond the hospital's walls. Building on prior assessments, our 2025 CHNA reflects a continued commitment to a coordinated, community-driven approach to identifying and addressing health needs.

Through this process, Humboldt Park Health, identified and prioritized key health needs within the communities we serve for the 2025–2027 implementation period. Moving forward, Humboldt Park Health will continue to work closely with trusted community partners to leverage existing resources, strengthen partnerships, and implement strategies that address the most pressing health needs of our communities.

Our Hospital

Humboldt Park Health is dedicated to offering the best care for the community. We are a 200-bed safety-net hospital, as well as a full-service professional building with a clinic, two mobile health units (physical & dental) and our new Wellness Center that opened in January of 2025. Humboldt Park Health has an array of medical services that are available, including emergency, acute care, surgical, outpatient clinics, Women's Care Center, GI lab and endoscopy, internal medicine, detox and substance abuse, inpatient and outpatient behavioral health, cardiology and respiratory, imaging, wound care, family medicine and pediatrics, rehabilitative and corporate health services. Humboldt Park Health serves the following communities: Humboldt Park, West Town, East Garfield, West Garfield, Austin, Belmont Cragin, Hermosa, Logan Square, Avondale, Irving Park, Portage Park, and Dunning.

Humboldt Park Health is committed to providing high-quality clinical programs and services that respond to the evolving health needs of the communities it serves. Existing programs are monitored for opportunities to adjust based on the needs of our patients, while new programs are continuously reviewed for possible added services that the community needs. To support this commitment, Humboldt Park Health conducts a Community Health Needs Assessment (CHNA) every three years, informed by both primary and secondary data sources. This process ensures that community health programs, investments, and resources are strategically focused on the most significant health needs as identified by community members and stakeholders, and are aligned with Humboldt Park Health's mission, clinical services, and strategic priorities.

Mission

Humboldt Park Health is committed to advancing health equity and providing high-quality and compassionate healthcare services by partnering with patients and their families, our employees, medical staff, and the communities we serve.

Vision

Humboldt Park Health is the healthcare provider of choice for our communities and caregivers. We strive to be best in class for clinical care, service excellence and employee engagement by following our guiding principle, “Equity Begins at Home.”

Values

Humboldt Park Health leaders, employees and medical staff commit to the following set of values:

RESPECT Supporting all members of our health care team and maintaining the dignity of our patients.

EMPATHY We acknowledge the lived experiences of our patients, their families and our colleagues’ and provide support to meet their needs.

EXCELLENCE Quality of care is free from harm, allows timely access to services, follows best practices, and incorporates our patients’ treatment preferences. Humboldt Park Health commits to providing ongoing opportunities for professional development, competency training, and skill building for staff.

INTEGRITY We are accountable, professional, honest and transparent in all elements of care.

INCLUSIVITY We intentionally incorporate cultural competency, creating a safe and welcoming environment into all areas of the hospital.

At Humboldt Park Health, our mission includes a strong commitment to improving the health of the communities we serve. In addition, the Community Relations Department and Health Equity Committee at Humboldt Park Health work to establish and foster communication between the Hospital and surrounding communities. The department interfaces with a broad range of non-profit, business and community organizations to support initiatives that improve the well-being of the community, addressing health services access, food insecurity, digital equity, transportation insecurity, immigration crisis, and affordable housing issues with our community partners. Members of the community relations staff regularly attend community meetings, health fairs and community events. As a result, they facilitate health-related programs to meet community and patient needs.

Communities We Serve

Humboldt Park's community, as defined for the purposes of the Community Health Needs Assessment includes each of the residential Zip Codes that comprise the hospital's Primary Service Area (PSA). Humboldt Park Health primarily serves eight zip codes in the City of Chicago: 60612, 60622, 60618, 60624, 60639, 60642, 60647, 60651, 60641, 60634. These zip codes encompass twelve community areas in Chicago— Humboldt Park, West Town, East Garfield Park, West Garfield Park, Austin, Belmont Cragin, Hermosa, Logan Square, Avondale, Irving Park, Portage Park, and Dunning.

The total population of Humboldt Park Health's service area is 1,846,088. In the service area, 40% of the population identifies as Hispanic/Latinx and 60% Non-Hispanic. Thirty-five percent of the population identifies as white, 4% Asian, 18% Black/African American, 3% identifies as two or more races, and less than 1% as Native American/Other (Figure 2).

Figure 1. Map of Humboldt Park Health's CHNA service area

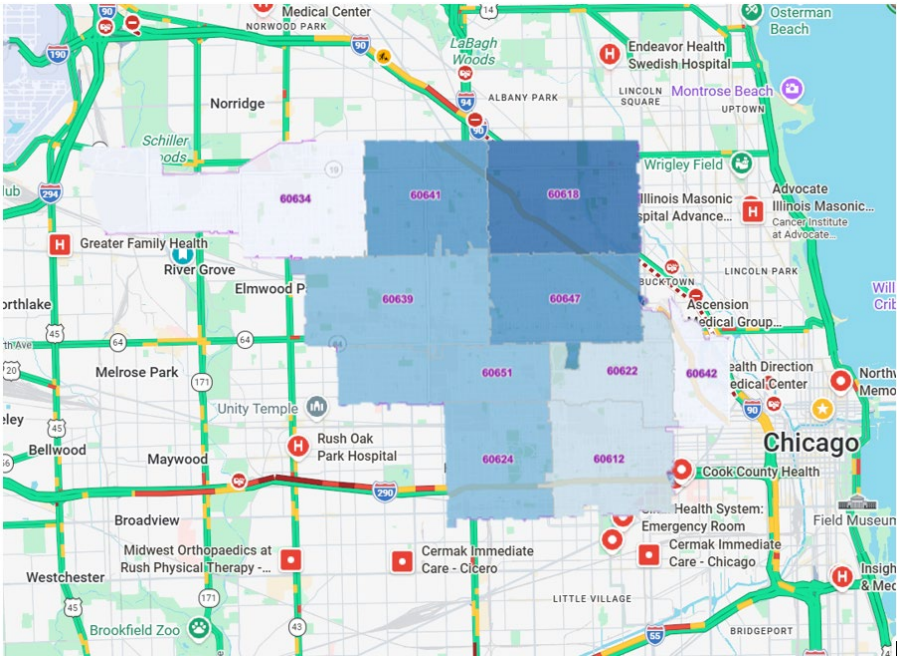
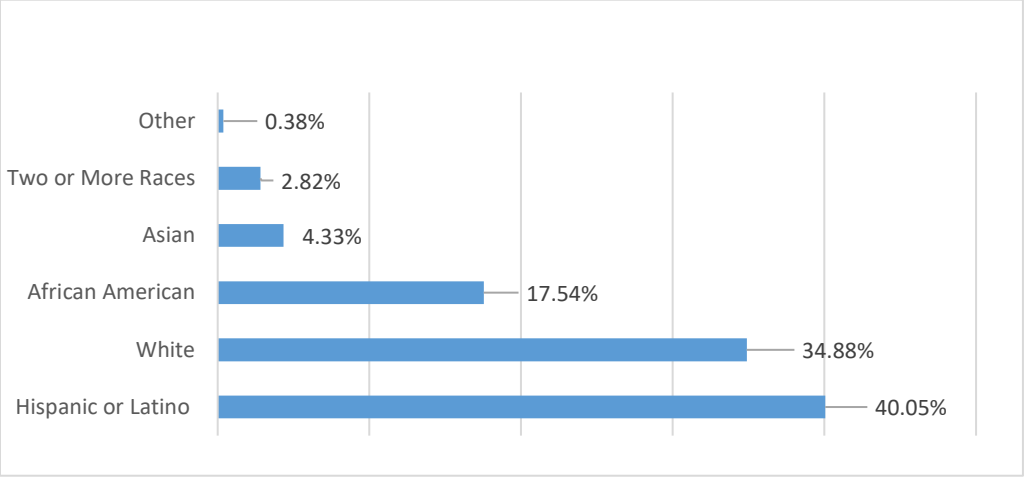


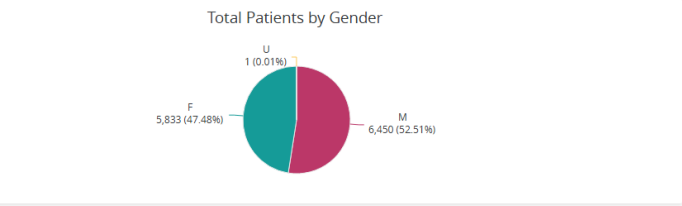
Figure 2. Race and ethnicity in Humboldt Park's service area, 2022-2024

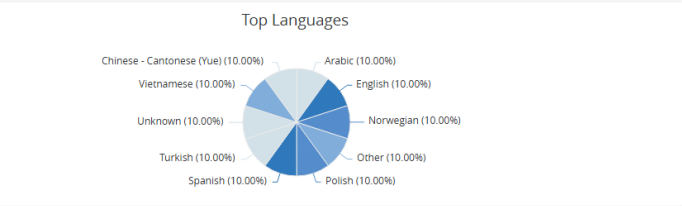


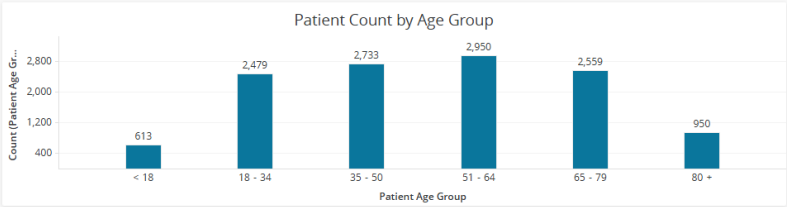
US Census, American Community Survey, 2022-2024

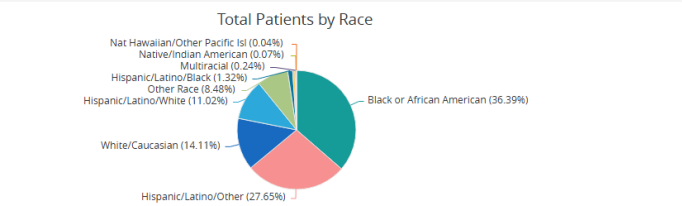
Humboldt Park Health's Patient Population

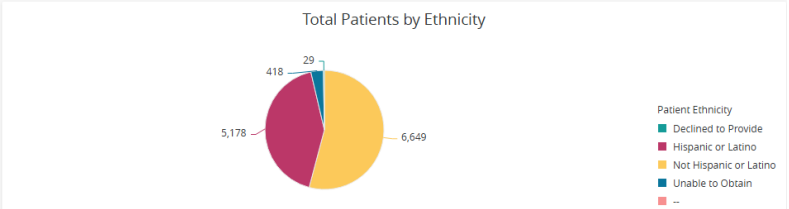
Compared to our service area the population shows a higher ratio of Black/African American identified persons of thirty-seven percent with Hispanic/Latino at twenty-eight percent and Caucasian at fourteen percent.





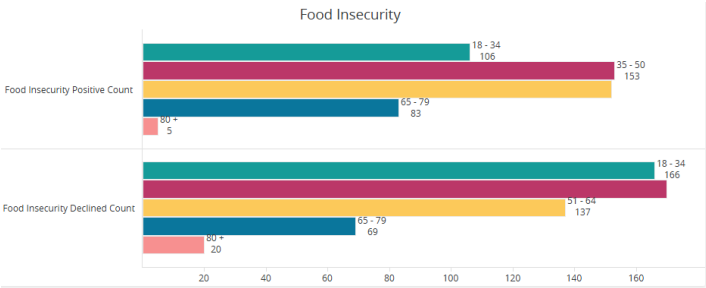


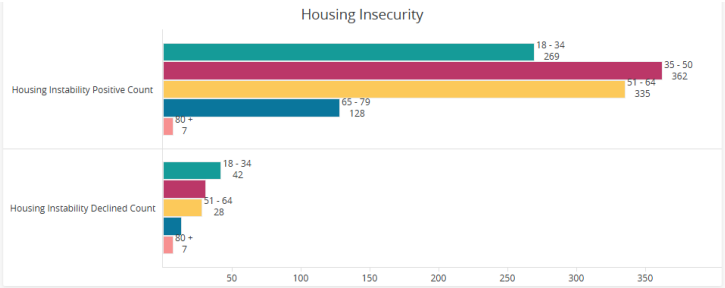


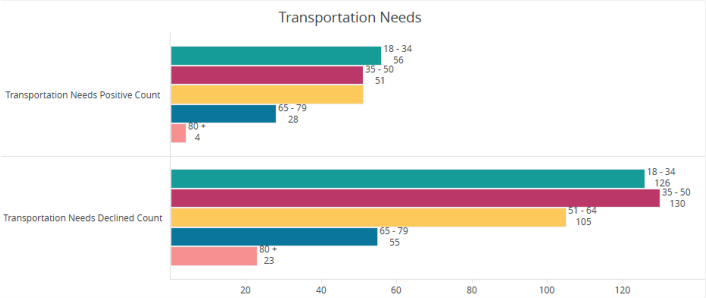


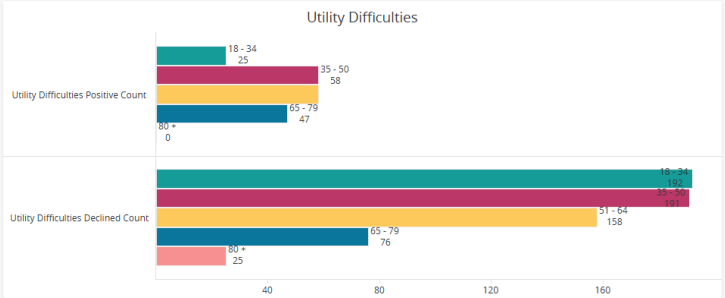
Social Determinants of Health

During triage at Humboldt Park Health, each patient is asked a series of questions to determine additional services and resources that may be needed. These are also entered into the system for data tracking used to determine needed programs.









Humboldt Park Health Community Needs Action Plan: Addressing Priority Health Conditions (2023–2025)

In consideration of the top health priorities identified through the CHNA process and taking into account hospital resources and overall alignment with the hospital's mission, goals and strategic priorities it was determined that Humboldt Park Health would focus on developing and/or supporting strategies and initiatives to improve:

Addressing priority health conditions:

- Chronic conditions
- Maternal and child health, including maternal and infant mortality
- Mental health
- Substance use disorders

Goal: To improve health outcomes and reduce disparities related to chronic diseases, maternal and child health, mental health, and substance use disorders through targeted, community-centered strategies, including mobile and dental health services.

1. Chronic Conditions (Diabetes, Hypertension, Heart Disease, Obesity)

Objectives:

- Reduce preventable hospitalizations and emergency visits for chronic disease complications.
- Increase community-based education and early screening for chronic disease prevention.

Key Actions:

- **Launch a Chronic Disease Self-Management Program (CDSMP):** Evidence-based workshops for adults living with chronic illnesses.
- **Screening and referrals to address Social Determinants of Health (SDOH):**
- Provide education to patients admitted for Diabetes, Heart Disease and Depression around the importance of Nutrition, Physical Activity & Weight Management
- Provide referrals and support for outpatient diabetes patients to prevent hospital admission
- Partner with local organizations, to help in coordinating care and or access to social services to help in addressing any positive social determinants of health finding.
- **Expand Community Health Worker (CHW) Outreach:** CHWs to conduct screenings for hypertension and diabetes at community events and primary care clinics.
- **Healthy Eating and Active Living Initiative:** Partner with local organizations to offer free fitness classes and nutrition education at Humboldt Park Health.
- **Mobile Health Services for Pediatric and Adult Populations:** Deploy mobile units to provide screenings, immunizations, and health education in underserved neighborhoods.

Timeline: 2023 –2025
Partners: Greater Chicago Food Depository, YMCA, UIC College of Nursing, Wellness West Collaborative including Access Health Care Network, Infant Welfare Society, Near North, Prime Care. Also American Medical Association and American Heart Association. Several Mental Health Community Agencies that also collaborate thru the Wellness West.

---

2. Maternal and Child Health (Including Maternal and Infant Mortality)

Objectives:

- Decrease maternal and infant mortality rates in high-risk populations.
- Improve access to prenatal, perinatal, postnatal, and pediatric preventive care.

Key Actions:

- Provide onsite access to Maternal Fetal Medicine care at Humboldt Park Health to minimize travel for patients.
- **Expand Pediatric Mobile Health Services:** Utilize mobile units to deliver well-child visits, immunizations, developmental screenings, and health education directly in neighborhoods with low pediatric visit rates.
- **Enhance Access to Lactation Consultants and Parenting Classes:** Provide ongoing education to improve breastfeeding rates and early childhood development.
- **Mobile Dental Health Services for Children:** Provide preventive dental care, including fluoride treatments, sealants, and oral hygiene education through mobile units targeting schools and community centers.

Timeline: 2023 – 2025
Partners: March of Dimes, Chicago Public Schools, Wellness West Collaborative including Access Health Care Network, Infant Welfare Society, Near North, Prime Care. Also American Medical Association and American Heart Association. Several Mental Health Community Agencies that also collaborate thru the Wellness West., Local FQHCs

---

3. Mental Health

Objectives:

- Expand access to culturally competent mental health services.
- Reduce stigma and normalize mental health conversations in the community.

- Provide coordinated care to improve outcomes of patients who seek services for mental health and substance use disorders.
- Reduce recidivism for opioid use disorder and mental health disorders such as depression, anxiety, and bipolar disorder.

Key Actions:

- **Integrate Behavioral Health into Primary Care Settings:** Embed behavioral health consultants in primary care and pediatric clinics.
- **Mental Health First Aid Training:** Train community members, educators, and faith leaders to recognize and respond to mental health crises.
- **Peer-Led Support Groups:** Establish bilingual support groups for anxiety, depression, and trauma survivors.
- **Mental Health Mobile Unit Days:** Offer pop-up counseling and mental health screenings, including services for youth through pediatric mobile units.

Timeline: 2023 – 2025
Partners: Internal: Health Equity Committee, Community Advisory Council, Medical Stabilization Unit, Emergency Department, External: Collaborative Bridges, Community Counseling Centers of Chicago, Habilitative Systems Inc., Family Guidance Center, Bobby E., Wright, and Hartgrove, NAMI Chicago, Thresholds, Chicago Department of Public Health,

---

4. Substance Use Disorders

Objectives:

- Expand access to harm reduction programs and substance use treatment services.
- Prevent overdose deaths and improve recovery support for individuals with substance use disorders.
- Provide coordinated care to improve outcomes of patients who seek services for mental health and substance use disorders.
- Reduce recidivism for opioid use disorder and mental health disorders such as depression, anxiety, and bipolar disorder.

Key Actions:

- **Establish a Medication-Assisted Treatment (MAT) Program:** Provide outpatient services for opioid use disorder, including Suboxone and Methadone.
- **Harm Reduction and Naloxone Distribution Program:** Partner with street outreach organizations to distribute naloxone kits and offer safe use education.
- **Develop a Recovery Navigator Program:** Employ certified recovery specialists to guide patients through treatment and recovery resources.

Timeline: 2023 – 2025
Partners: Internal: Health Equity Committee, Community Advisory Council, Medical Stabilization Unit, Emergency Department, External: Collaborative Bridges, Community Counseling Centers of Chicago, Habilitative Systems Inc., Family Guidance Center, Bobby E., Wright, and Hartgrove,

---

Anticipated Impact of Community Needs Action Plan

1. **Improved Chronic Disease Outcomes**
    - Increased control of diabetes and hypertension in the community.
    - Reduced hospital readmissions and avoidable emergency department visits related to chronic conditions.
    - Improved community knowledge of healthy lifestyle behaviors.
2. **Enhanced Maternal and Child Health**
    - Reduction in maternal and infant mortality, particularly among high-risk populations.
    - Increased access to prenatal and pediatric preventive care.
    - Improved breastfeeding rates and early childhood development milestones.
3. **Expanded Access to Mental Health Services**
    - Greater utilization of mental health services among underserved populations.
    - Reduced stigma and increased community resilience through mental health education.
    - Decreased behavioral health-related ED visits.
4. **Reduction in Substance Use and Overdose Deaths**
    - Increased access to treatment and harm reduction resources.
    - Reduced opioid overdose deaths through expanded naloxone distribution and education.
    - Improved recovery success rates through peer support and recovery navigation services.

Impact Measures by Priority Area

Priority Area	Key Metrics	Target Outcomes by 2025
Chronic Conditions	A1C control rates, BP control, ED visits	+15% A1C improvement, 15% reduction in readmissions
Maternal & Child Health	Maternal/Infant mortality, prenatal visit rates, pediatric immunizations	10% reduction in maternal/infant mortality, 20% increase in immunization rates
Mental Health	Number of mental health visits, ED visits for mental health crises	20% reduction in mental health ED readmissions
Substance Use Disorders	Naloxone kits distributed, MAT enrollment, overdose deaths	1,000 naloxone kits distributed, 15% reduction in overdose deaths

Mobile Health Services	Pediatric mobile unit visits, dental screenings	1,500 children served annually via dental mobile unit; 20% increase in pediatric visits

Evaluation Plan

1. Data Collection Methods:

- Electronic Health Records (EHR) analysis for clinical metrics (A1C, BP control, hospital readmissions).
- Community Health Worker and Mobile Unit activity logs.
- Surveys and focus groups to assess community satisfaction and program effectiveness.
- Tracking of program participation rates (e.g., prenatal classes, MAT enrollments, mental health workshops).

2. Evaluation Timeline:

- **Quarterly**: Monitor operational metrics (number of visits, program participation, naloxone distributions).
- **Biannually**: Conduct outcome reviews with the Community Advisory Board.
- **Annually**: Comprehensive review of health outcomes and report to hospital leadership

3. Responsible Parties:

- **Evaluation Lead:** Chief Operating Officer
- **Data Analysis Support:** Quality Improvement and Analytics Teams
- **Stakeholder Oversight:** Community Advisory Board, Hospital Executive Team

4. Continuous Quality Improvement (CQI):

- Use Plan-Do-Study-Act (PDSA) cycles to refine programs based on real-time feedback and outcomes data.