City of Hope® | CHICAGO

2024

Implementation Strategy

Contents

Executive Summary

The service area of City of Hope® Chicago is richly diverse in language, culture, religion, race and ethnicities. With this diversity comes a large variation in factors that put individuals at risk for health issues such as cancer and diabetes. Sociocultural factors — for example, the level of education achieved, language spoken at home, racism and cultural biases — can increase or decrease the risk of preventing and treating potentially life-threatening illness. Serving our community and providing programs and services to our residents designed to reduce risk and improve access to health care are paramount to our success as a nonprofit hospital. One way to ensure we do this is by developing a strategy to address the main opportunities identified in our 2024 Community Health Needs Assessment (CHNA).

The Internal Revenue Service, through its 1969 Revenue Ruling 69-545, describes the Community Benefit Standard for charitable tax-exempt hospitals as helping the community in a way that relieved a governmental burden and promoted general welfare. In addition, the Affordable Care Act, enacted in 2010, set forth requirements for nonprofit hospitals under § 501(r) of the Internal Revenue Code. Under this requirement, tax-exempt hospitals are directed to conduct a CHNA and develop an implementation strategy every three years. City of Hope has undertaken a CHNA as required. The CHNA is a primary tool used by City of Hope to determine our community benefit plan, which outlines how we will give back to the community in the form of health care and other services that address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of the community benefit service area.

For this recent CHNA, City of Hope Chicago collected primary data from focus groups and interviews. Secondary data was collected on the leading causes of death, illness, social determinants of health and deeper causes of health inequality. Our Community Benefit team took this data to community stakeholders and asked them, “What does this mean to you? How do you believe that these issues are impacting you and your community? What ideas for solutions do you have for addressing these concerns?” The stakeholders engaged in lively discussion and then prioritized the issues as follows:

1. **Mental Health – Establish mental health partnerships to improve access to resources.**
2. **Access to Care – Development of effective education/advocacy programs and partnerships that increase access to care.**
3. **Housing – Collaborative efforts that support community driven programming around housing insecurity.**
4. **Education – Equipping the community with knowledge about health care access, prevention and available resources.**
5. **Cancer – Working collaboratively with community partners and residents to implement strategies that can reduce the risk of cancer.**

Although addressing these priorities are ambitious, we believe we have formulated a realistic implementation strategy that addresses these issues in a way that makes the most sense for a comprehensive cancer center and research institution. We will continue to seek new pathways to meet the needs of our vulnerable residents and explore innovative strategies that maximize collaborations to build sustainable programs in our local communities. Ultimately, we will provide positive contributions to the collective impact of other hospitals, organizations, schools, churches and government entities in our service area.

We encourage you to take your time reading this plan. Should you have any questions regarding how we plan to implement it, please feel free to contact Katherine Easthon, director Operations and Business Development, City of Hope Chicago - katherine.easthon@coh.org.

Who We Are and Whom We Serve

City of Hope's mission is to make hope a reality for all touched by cancer and diabetes. Founded in 1913 in Los Angeles, City of Hope has grown into one of the largest and most advanced cancer research and treatment organizations in the U.S. and is one of the leading research centers for diabetes and other life-threatening illnesses. With an independent National Cancer Institute-designated comprehensive cancer center at its core, City of Hope brings a uniquely integrated model to patients that spans cancer care, research and development, academics and training, and innovative initiatives. Research and technology developed at City of Hope has been the basis for numerous breakthrough cancer medicines as well as human synthetic insulin

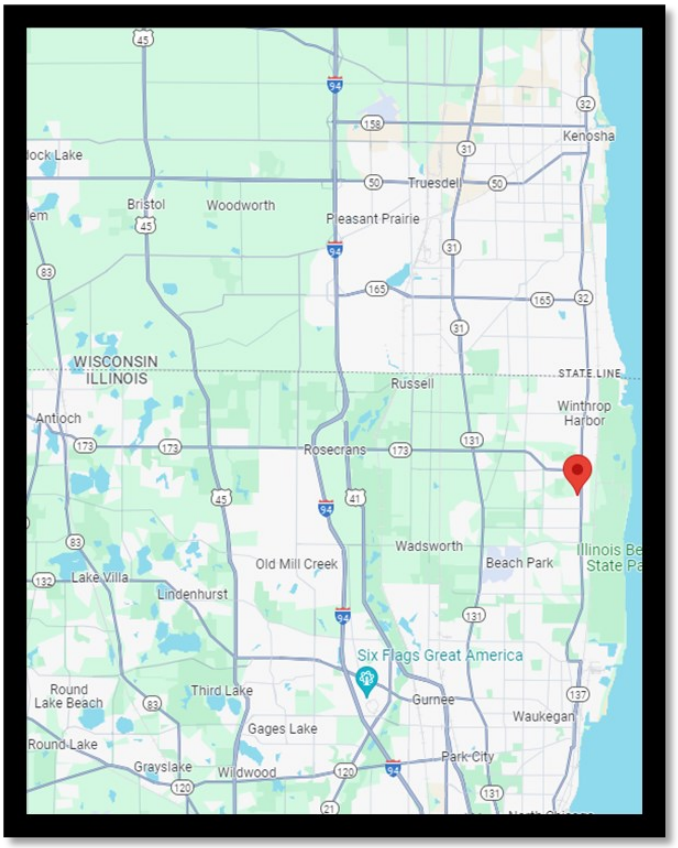
and monoclonal antibodies. As a leader in bone marrow transplantation and immunotherapy, such as CAR T cell therapy, City of Hope's personalized treatment protocols help advance cancer care throughout the world.

With a goal of expanding access to the latest discoveries and leading-edge care to more patients, families and communities, City of Hope's growing national system includes its main Los Angeles campus, a network of clinical care locations across Southern California, a new cancer center in Orange County, California and cancer centers and outpatient facilities in the Atlanta, Chicago and Phoenix areas. City of Hope's affiliated family of organizations include Translational Genomics Research Institute and AccessHope™. Through this national system, more patients will have access to the best of academic medicine in a community environment, including *world-renowned innovation and subspecialist expertise in hematology and bone marrow transplantation, advanced surgical oncology, clinical trials, precision medicine and cellular therapies.*

Upon acquiring Cancer Treatment Centers of America in 2022, City of Hope filed for not-for-profit, tax-exempt status for the newly acquired entities, including City of Hope Chicago. Caring for the vulnerable communities in their catchment area has been a cornerstone of City of Hope's engagement with the community since its origin. Designating community benefit programs as an institutional priority has created meaningful, impactful programs that meet the needs of vulnerable populations in their service area. This institutional commitment is fostering collaboration among City of Hope employees, the local communities, and charitable organizations to participate in activities that benefit the local community.

Service Area

City of Hope Chicago is in Lake County at 2520 Elisha Ave., Zion, IL, 60099. In addition to the main hospital, it manages two outpatient centers in the cities of Skokie and Chicago. The service area reported for this assessment are three counties: Kenosha, McHenry and Lake County with a focus on Northern Lake County and the cities of Waukegan and Zion.



Community Health Needs Assessment Findings

Secondary data analysis yielded a preliminary list of significant health needs, which then informed primary data collection. The primary data collection process (interviews, focus groups and surveys) helped validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations and ascertain community assets to address needs.

The following criteria were used to identify significant health needs:

1. Size of the problem (relative portion of population afflicted by the problem)

2. Seriousness of the problem (impact on individuals, families and communities)

To determine size and seriousness, health indicators identified in the secondary data collection were measured against benchmark data, specifically Illinois rates and Healthy People 2030 objectives, whenever available. Health indicators that performed poorly against one or more of these benchmarks were considered to have met the size or seriousness criteria. Additionally, primary data sources were asked to identify and validate community and health issues. Information gathered from these sources helped determine significant health needs.

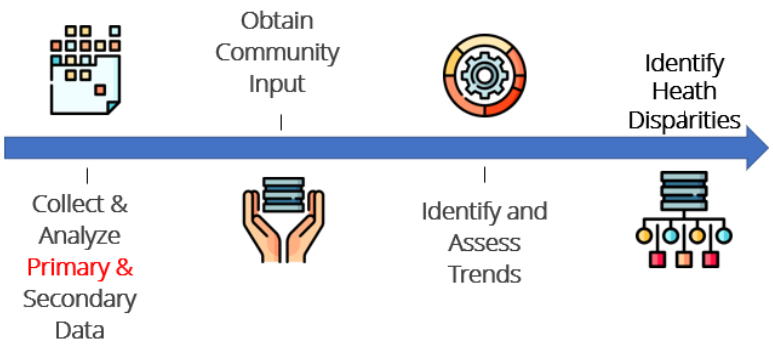
Significant Health Needs

Based in the secondary data collection, the following significant health needs were determined:

- **Access to Care**
- **Cancer**
- **Mental Health**
- **Substance Use/Abuse**
- **Housing**
- **Education**
- **COVID-19**
- **Heart Disease**

Community input on these health needs is detailed throughout the 2023 CHNA report available on City of Hope's Community Benefit website. This year, between February to April 2024, we conducted a total of four focus groups (32 participants) and 27 key informant interviews with stakeholders, who either serve or represent the community, and wove them into the secondary data.

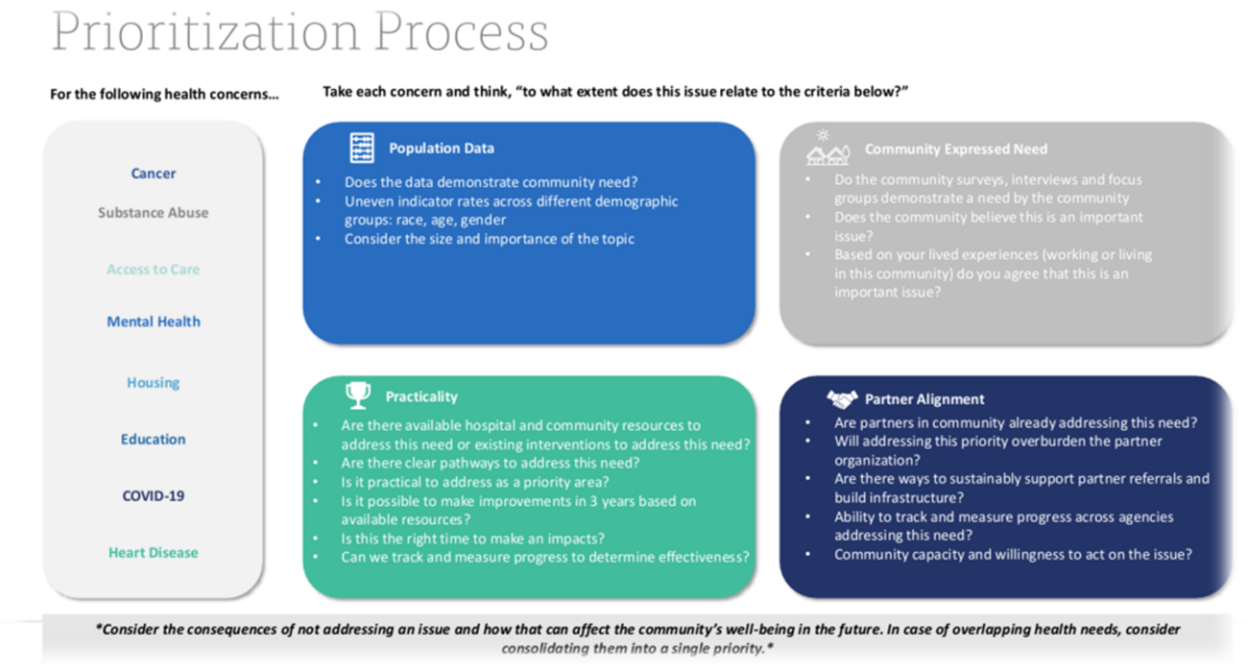
Resources to Address Significant Needs



Through focus groups, surveys and interviews, community stakeholders and residents identified community resources that can help address significant health needs. These resources are presented in the appendix.

Prioritization of Needs

The significant health needs identified in the process were prioritized with input from the community using the following criteria:



Stakeholder Validation of Prioritized Needs

Community members prioritizing health needs

On July 16, 2024, 10 community members joined City of Hope staff in reviewing the significant needs identified in the recent CHNA. City of Hope's team led both the data presentation and the prioritization process. Using the prioritization criteria above, community members were asked to rate, on a scale of 1 to 4, the importance of the issue and its impact to the community based on Population Data, Community Expressed Need, Practicality and Partners Alignment. Each of the six significant health needs were presented, data was analyzed live, and the community stakeholders had robust conversations about each need and even brainstormed

a few possible solutions or initiatives currently addressing these needs. At the end of each presentation, the stakeholders were asked to rate, individually, their ranking/prioritization of the individual need. Once all eight significant health needs were presented, the rankings from each community member were tallied and the list of 4 highest prioritized needs were presented to them. The stakeholders were then asked to validate the final list of four. As a cancer specialty hospital, we added cancer as the fifth priority for discussion. The stakeholders discussed and aligned on the five listed below:

2024 Stakeholder Prioritized Health Needs

Rank	Health Needs
1	Mental Health and Substance Abuse
2	Access to Care
3	Housing
4	Education
5	Cancer

Although eight areas of need were identified, shared root causes and risk factors allow for combining needs in some cases and overlapping issues in others. Addressing the needs collectively can have a greater impact. For example, social determinants of health are a common thread affecting access to physical and mental health services and individual resilience. Lack of knowledge about accessing services like housing support or food resources hinders thriving. By focusing on five priority areas, we effectively address all eight through their intersections.

No. 1: Mental Health and Substance Abuse – Establish mental health partnerships to improve access to resources

Mental health and substance abuse are top concerns in our community. Members emphasized the need for effective violence de-escalation strategies, often linked to mental health conditions - noting that first responders can diffuse situations but lack resources for follow-up care. The team advocated for early interventions with children and parents. Much like food deserts, our community around City of Hope is a mental health provider desert. This shortage of mental health providers means no after-hours or weekend appointments, widening the access gap. Discussions focused on educating residents and providing resources to reduce

stigma and increase access. Our strength lies in forming mental health partnerships across disciplines to share and leverage resources, improving access for those in need.

Community Input

Strategies to address mental health and substance abuse focused on prevention and partnerships:

- Explore partnerships with mental health professionals to provide services after hours and on the weekends.
- Create mental health pathways through asset mapping for seamless connections to prevention, education, and access resources.
- Identify opportunities to support substance abuse interventions and prevention strategies.

No. 2: Access to Care – Development of effective education/advocacy programs and partnerships that increase access care

Our community members agreed that access to care is a complex issue, but there are promising solutions. Long wait times for primary care often lead people to call the fire department for hospital transport, worsening conditions like diabetes and heart disease. This also diverts emergency responders from other urgent needs. Improving transportation can greatly enhance access.

For specialty care, such as cancer treatment, increasing provider ratios and network breadth can improve screening rates and early detection. Many suggested that by forming progressive partnerships with community organizations, we can develop effective education and advocacy programs. These initiatives will teach people how to access health care, prevent and manage conditions, and ultimately enhance community health and well-being.

Community Input

Looking at solutions to effectively address the access to care challenges of our most vulnerable communities, our community collaborators suggested:

- Engage community health workers and patient navigators to help create pathways that ease the burden of accessing care.
- Recognize that access to care education needs to be addressed at both the community and provider level.
- Ensure that trust is being built by meeting the community where they are, listening to them and creating solutions that are culturally appropriate.

No. 3: Housing – Collaborative efforts that support community driven programming around housing security

While addressing housing might not seem directly relevant for a cancer hospital, it's closely linked to social determinants of health and can contribute to health disparities if overlooked. As one community member suggested, “it’s more impactful to support organizations already tackling housing insecurity rather than solving it ourselves”. The rising number of individuals without secure and affordable housing underscores the need for action.

Though housing insecurity ideas are limited, their importance is clear. The solution lies in a collective effort, bringing together compassionate minds to develop diverse strategies. This involves educating residents, governments, schools, and agencies about housing, connecting people to resources, and supporting organizations working to secure homes for all.

Community Input

A multilayered and collaborative approach is recommended:

- Assess current housing conditions and resources in the area.
- Build sustainable partnerships with local organizations focused on housing.
- Explore additional avenues to support efforts against housing insecurity.

No. 4: Education – Equipping the community with knowledge about health care access, prevention and available resources

This topic emphasizes equipping communities with the knowledge to access resources and adopt preventive behaviors to reduce inequities, rather than focusing on educational attainment. Community members stress that education empowers individuals regarding health care access, prevention, and resources, with a need for culturally competent translations and understanding of health signs and symptoms. Effective communication and cultural competence are crucial.

Collaboration is key; we must work together and integrate services to enhance community health. Engaging with communities directly and participating in local events helps address needs and build partnerships. Educational efforts should raise awareness of EBT, WIC, and mental health services, and provide practical support like CPR certification and access to

healthy food. Promoting preventive care, self-advocacy, and youth education can set trends for healthier future generations.

Community Input:

To effectively address health care challenges and reduce health inequities, our community members offer that we focus on enhancing education and awareness, building trust and engagement, promoting self-advocacy and preventive care, addressing social determinants of health, improving provider education and collaboration, and expanding support for youth and families across all identified health needs:

- Ensure educational materials are accurately translated and culturally relevant to avoid misinterpretation and better address diverse needs.
- Provide clear, accessible information about signs and symptoms of cancer and preventive care to avoid overwhelming or creating fear.
- Collaborate with trusted community figures to bridge cultural gaps and build trust in health care recommendations.

No. 5: Cancer – Achieving health equity across the cancer continuum, we aim to work collaboratively with community partners and residents to implement strategies that can reduce the risk of cancer

As a National Cancer Institute-designated comprehensive cancer center, (one of only 57 in the country), City of Hope will continue addressing cancer prevention. Comprehensive cancer centers can translate scientific findings straight from the laboratory to the patient. With a focus on biomedical research through Beckman Research Institute of City of Hope in Duarte, California, and Translational Genomic Research Institute in Phoenix, finding a cure is paramount to our mission. We, therefore, focus on genomic research to ascertain the different cancer incident rates affecting various communities. We also recognize that economic, housing, food insecurity, and mental health issues affect access to care and influence prevention and screening behaviors.

During the prioritization session, concerns were raised about immigrants accessing preventive cancer services, leading to later-stage diagnoses. Additionally, younger women often don't seek care due to perceived low risk. Community listening sessions focused on how City of Hope can be a resource for prevention, education, and screening.

Community Input

Our community views cancer prevention as part of overall health. Instead of isolating cancer, they incorporate it into broader health prevention messaging. Discussing cancer prevention and early detection should include health behaviors that reduce disparities for other conditions like heart disease and diabetes. These ideas are reflected in education suggestions. Specifically for cancer, here are a few of their recommendations:

- Provide culturally competent education about cancer prevention and screenings.
- Extend hours for cancer screening locations.
- Provide nutrition education classes in the community.

No one wants to get cancer. As a world-renowned cancer research institution, we can help deliver cancer education, screening and treatment programs that ultimately save lives.

Greater Zion, Waukegan and Kenosha community members who prioritized the 2024 CHNA results in person.

Plan to Address Needs

City of Hope was pleased to engage with the community members, hear their thoughts regarding the CHNA, prioritize the needs and ideate ways to begin addressing the prioritized needs. City of Hope recognizes the need to partner with the community, to leverage their

expertise, existing programs and infrastructure, brainstorm and align on new ideas, programs, and tactics to address these needs, etc. as we cannot address all these issues alone. We recognize the complexity of the prioritized needs and will approach them using the Public Health Institute's "Five Core Principles" (Figure 1). In planning programs, we will ask how our work will impact vulnerable people, support prevention, create a seamless continuum of care, and empower the community to manage their health. Through this framework, we will design programs and build collaborations to address the identified needs effectively.

Figure 1. Five Core Principles

Collaborations

City of Hope is filled with compassionate individuals dedicated to addressing community needs. We will use these resources to design interventions that target specific issues within our service areas and emphasize the health impact on these targeted groups.

Externally, City of Hope will leverage its relationships with local organizations, schools, universities, governments, other nonprofit hospitals, and dedicated volunteers who serve vulnerable populations. By collaborating with local communities, we can develop system-level approaches that meet the needs of the most vulnerable in culturally appropriate ways. Additionally, involving community stakeholders in planning our community benefit programs and services ensures these initiatives are built on trust and a shared vision. This creates a strong foundation for programs that will thrive within the community we serve.

Oversight

To maintain our desire to listen to, advocate for and serve as a partner with the community stakeholders throughout our catchment area, City of Hope will convene a Community Benefit Advisory Council that will meet at least four times a year. With a focus on the Five Core Principles (Figure 1 above), we will ensure the council members represent local vulnerable populations or have expertise in the issues of most importance to vulnerable communities (see list below):

- Resident in a local community with a disproportionate percentage of unmet health-related needs
- Knowledge and expertise in primary disease prevention
- Experience working with local nonprofit community-based organizations
- Knowledge and expertise in epidemiology
- Expertise in the analysis of service utilization and population health data

City of Hope will establish a regular internal meeting cadence to plan, coordinate, collaborate and ensure the execution against the Implementation Strategy. As part of this planning, data collection tools will be established to share information and capture staff efforts across the organization that align with the Implementation Strategy. Additionally, City of Hope will report annually on Form 990 and Schedule H to inform the public about our work and its impact on the communities we serve.

Anticipated Impacts on Health Needs

As we consider the five priority areas identified by our community and recognize that each priority has a broad measurable outcome, City of Hope will do our best, given our capabilities to make significant impacts on these priorities to bring about positive changes in our communities. To ensure our work is meaningful, we will draw from the Healthy People 2030 Objectives and suggestions from the community driven strategies:

1. **Mental Health – Establish mental health partnerships to improve access to resources**

Healthy People 2030 Strategies

1.1 Increase the proportion of persons with co-occurring substance use disorders and mental health disorders who receive treatment for both disorders. (MHMD-07)
1.2 Increase quality of life for cancer survivors. (C-R01)
1.3 Reduce anxiety and depression in family caregivers of people with disabilities. (DH-D01)
1.4 Increase the proportion of people who get a referral for substance use treatment after an emergency department visit. (SU-D02)
1.5 Increase the proportion of homeless adults with mental health problems who get mental health services. (MHMD-R01)

Community Driven Strategies

1.6 Explore partnerships with mental health professionals to provide services after hours and on the weekends.
1.7 Create mental health pathways through asset mapping for seamless connections to prevention, education, and access resources.
1.8 Identify opportunities to support substance abuse interventions and prevention strategies.

2. **Access to Care – Development of effective education/advocacy programs and partnerships that increase access care**

2.1 Increase the proportion of adults who get recommended evidence-based preventive health care. (AHS-08)
2.2 Reduce the proportion of people who can't get medical care when they need it. (AHS-04)

2.3 Increase the proportion of people with health insurance. (AHS-01)

Community Driven Strategies

2.4 Engage community health workers to help educate about how to access care.
2.5 Recognize that access to care education needs to be addressed at both the community and provider level.
2.6 Ensure that trust is being built by meeting the community where they are, listening to them and creating solutions that are culturally appropriate.

3. Housing– Collaborative efforts that support community driven programming around housing security

3.1 Reduce the proportion of families that spend more than 30 percent of income on housing. (SDOH-04)

Community Driven Strategies

3.2 Assess current housing conditions and resources in the area.
3.3 Build sustainable partnerships with local organizations focused on housing.
3.4 Explore additional avenues to support efforts against housing insecurity.

4. Education – Equipping the community with knowledge about health care access, prevention and available resources

4.1 Increase the proportion of adults who health care provider checked their understanding. (HC/HIT-01)
4.2 Decrease the proportion of adults who report poor communication with their health care provider. (HC/HIT-02)
4.3 Increase the proportion of adults who health care providers involved them in decisions as much as they wanted. (HC/HIT-03)
4.4 Increase the proportion of adults with limited English proficiency who say their providers explain things clearly. (HC/HIT-D11)
4.5 Increase the health literacy of the population. (HC/HIT-R01)
4.6 Increase the proportion of adults who talk to friends or family about their health. (HC/HIT-04)
4.7 Increase the proportion of people who discuss interventions to prevent cancer with their providers. (C-R02)
4.8 Increase the proportion of emergency messages in the news stories that include steps for reducing personal health threats. (HC/HIT-D03)
4.9 Increase the number of community organizations that provide prevention services. (ECBP-D07)

Community Driven Strategies

4.10 Ensure educational materials are accurately translated and culturally relevant to avoid misinterpretation and better address diverse needs.
4.11 Provide clear, accessible information about signs and symptoms of cancer and preventive care to avoid overwhelming or creating fear.

4.12 Collaborate with trusted community figures to bridge cultural gaps and build trust in healthcare recommendations.
4.13 Attending local events to understand and address community needs directly.
4.14 Educate patients on how to advocate for themselves and understand their health needs.
4.15 Offer workshops and programs on preventive care tailored to specific communities.
4.16 Provide practical resources that improve access to resources like EBT and WIC, and ensure they are affordable and accessible.
4.17 Promote healthy, affordable food options and educate on cost-effective healthy eating.
4.18 Ensure healthcare providers are educated in cultural sensitivity and effective communication.
4.19 Collaborate with organizations and agencies to offer integrated services and avoid working in isolation.
4.20 Create educational and recreational programs for children that focus on prevention and healthy living.
4.21 Provide resources and workshops for parents on proactive health management and making healthier choices.
4.22 Partner with organizations to provide certifications, such as hands-only CPR, and other health-related training.
4.23 Ensure that mental health first aid and substance use treatment resources are readily available and well-publicized.
4.24 Tailor messaging to use culturally appropriate language and messaging to promote exercise and health activities.
4.25 Develop outreach strategies with clear accessible communication plans to ensure families know how to access different levels of health care and available resources.

5. Cancer – Achieving health equity across the cancer continuum, we aim to work collaboratively with community partners and residents to implement strategies that can reduce the risk of cancer.

Healthy People 2030 Strategies

5.1 Reduce the overall cancer death rate. (C-01)
5.2 Increase the proportion of females who get screened for breast cancer. (C-05)
5.3 Reduce prostate cancer death rate. (C-08)
5.4 Increase the proportion of females who get screened for breast cancer. (C-05)
5.5 Increase the proportion of adults who get screened for lung cancer. (C-03)
5.6 Increase the number of community organizations that provide prevention services. (ECBP-D07)
5.7 Increase the proportion of adolescents who get the recommended doses of the HPV vaccine. (IDD-08)

Community Driven Strategies

5.8 Culturally competent education about cancer prevention and screenings.
5.9 Extend hours for cancer screening locations.
5.10 Provide nutrition education classes in the community.

Yearly, our Community Benefit Advisory Council will assist City of Hope in prioritizing strategies with the same lens they used to prioritize the health needs in the CHNA (e.g., Population Data, Community Expressed Need, Practicality and Partners Alignment). We will develop more specific outcome measures as programs are planned and delivered.

Needs Not Addressed

As a specialty hospital, City of Hope is not equipped to address every need as some issues fall outside our areas of focus. While prioritizing the significant needs in our catchment area, we combined needs as much as possible to encompass social determinants of health and root causes of health disparities that are closely linked to cancer and diabetes risk factors. We will adhere to the Five Core Principles to guide all programs and services, ensuring we remain focused on communities with the greatest unmet health needs.

Conclusion

City of Hope is committed to being a good steward and offering assistance to make measurable impact within the communities we serve. We view community benefit as an initiative in which the entire organization can engage. As such, our community benefit process is designed to empower each department to manage its own planning and delivery of programs and services. The Community Benefit Department will serve as the central hub for collecting all reportable work, providing structure and guidance throughout the year and ensuring the voice of the community is a key component to the work we do. At the end of the fiscal year, this department, in collaboration with our stakeholders, will compile the yearly report for the community.

City of Hope is dedicated to strengthening relationships within the communities where we work and serve. We are particularly focused on meeting the needs of our vulnerable residents. We

aim to maximize community collaborations and create sustainable change, making positive contributions alongside other hospitals, organizations, schools, churches, and government entities in our service area.

Thank you for reading our 2024-2027 Implementation Strategy. Written comments on this report can be submitted to Katherine Easthon via katherine.easthon@coh.org.

Appendix

Community Resources

Community stakeholders identified resources potentially available to address the identified community needs. This is not a comprehensive list of all available resources. For additional resources refer to:

Lake County — www.unitedwayoc.org/how-we-are-doing-more/get-help-211/

Kenosha County — 211 Wisconsin (communityos.org)

McHenry County — Dial 2-1-1 | get connected. get help. | United Way of Greater McHenry County (uwmchenry.org)

Significant Health Needs	Community Resources
Mental Health	• NAMI Lake County • Catholic Charities – Behavioral Health • Lake County Health Department – Mental Health First Aid • Lake County Health Department – Young Mental Health First Aid • Lake County Health Department – Mental Health Crisis Care • NICASA Behavioral Health Services • AMITA Health Alexian Center for Mental Health • Captain James A Lovell Federal Health Care Center • Thresholds – Intensive Outreach for Mental Health • Josselyn Center • Willow House • Global Executive Council Services – Walk in Behavioral Health Clinic • Independence Center
Access to Care	• Erie Family Health Center • Lake County Health Department – Zion Health Center • Lake County Health Department - North Shore Health Center • Lake County Health Department - Grand Avenue Health Center • Arosa Liv home – In-Home Care • Hanul Family Alliance – Home Care Program • LHC Illinois Home Health Care • Equal Hope • YWCA Metropolitan Chicago – Health and Human Services Program • Illinois Department of Insurance – Get Covered Illinois • Illinois Department of Human Services – Medicaid • Rosalind Franklin University Health Clinics – Community Care Connection • Waukegan Township – Senior Health Insurance Program (SHIP)
Chronic Disease	• Lake County Health Department – Zion Health Center

Significant Health Needs	Community Resources
	• Lake County Health Department - North Shore Health Center • Lake County Health Department - Grand Avenue Health Center • Need2Know Lake County Program • Rosalind Franklin University Health Clinics – Community Care Connection • YWCA Metropolitan Chicago – Health and Human Services • Greater Family Health – Primary Health Care • Rosalind Franklin University Health Clinics – Interprofessional Community Clinic • Waukegan Public Library Health Literacy Program • Mano a Mano – Healthy Families Program • Age guide Northeastern Illinois • Roberti Community House – Community Health Support
Cancer	• Cancer Wellness Center • YWCA Metropolitan Chicago • CancerCare Co-Payment Assistance • Cancer Hope Network • GO2 Foundation for Lung Cancer • National Children's Cancer Society • City of Hope Cancer Fighters
Unintentional Injury	• NorthShore University Health System Immediate Care sites • Northwestern Medicine – Emergency Center • Vista Health System • Catholic Charities Emergency Assistance Program • Waukegan Township – Emergency Assistance • Mano a Mano
Food Insecurity	• Adelante Center for Entrepreneurship – Post Pantry • Beth AM • Catholic Charities Shreiber Center • Church of the Holy Spirit Food Pantry • CSBG Food Pantry • Cool Ministries Food Pantries • First Presbyterian Church of Libertyville Food Pantry • Holy Family Episcopal Church – RX Mobile Pantry • Hope Center Food Pantry • Northern Illinois Food Bank – Food Pantry Locator • Family Resource Center of Zion • Keeping Families Covered - Formula • Mother's Milk Bank of the Western Great Lakes • First United Methodist Church – Free Meal Program • Most Blessed Trinity Soup Kitchen • Saint Anastasia Soup Kitchen • Shiloh Baptist Church – Soup Kitchen • St. Vincent de Paul of Chicago • Illinois Department of Human Services – Food stamps/SNAP • Lake County Health Department WIC

Significant Health Needs	Community Resources
Social Determinants of Health	• City of Lake Forest Dickinson Hall Senior Center • Catholic Charities • Wings of Mercy, Inc • Eldercare – transportation services • Home Instead Senior Care – Transportation Program • Lake County Government Division of Transportation • Ride Lake County – Transportation • Seniors Alone Guardianship & Advocacy Services • Warren Township Transportation Program • Waukegan Township – Patricia A. Jones Center Senior Activity Center • United Way of Lake County • Zion Township • Waukegan Township • Community Partners for Affordable Housing • Kindred Life Ministries • Allendale Association – Residential Services • Lake County Haven – Shelter and Transitional Housing • PADS Lake County Programs and Services • Pioneer Center for Human Services • Lake County Housing Authority • Waukegan Housing Authority • A Safe Place – Permanent Supportive Housing • Assisi Homes of Gurnee – Senior Housing Program • Community Partners for Affordable Housing (CPAH) • Illinois Housing Search • Waukegan Public Library – Wi-Fi Access • Zion Benton Public Library – Wi-Fi Access

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