Stronger Together: Advancing Equity for All

A Community Health Needs Report and Action Plan

FY2022 CHNA + FY2023-2025 CHIP

RUSH University Medical Center
RUSH Oak Park Hospital

RUSH

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◂ On June 6, 2020, RUSH volunteers knelt for 8 minutes and 46 seconds to acknowledge the death of George Floyd in Minneapolis.

The RUSH University System for Health commitment to improving health has been part of our DNA for more than 180 years. Since 2016, that work has focused on achieving racial health equity.

Our mission is to improve the health of the individuals and diverse communities we serve through the integration of outstanding patient care, education, research and community partnerships. And our goal is a nation where everyone has a fair opportunity to attain their full health potential and no one is prevented from achieving that potential.

We know that access to affordable, high-quality, equitable health care is crucial to physical and mental well-being and to overall community wellness. But we also know that clinical care accounts for only a small portion of what contributes to health.

The COVID-19 pandemic has exacerbated health inequities, clearly illustrating how decades of disinvestment in many neighborhoods mean that people have less access to the resources and opportunities we all need for good health. The social conditions in which we're born, live, learn, work and play have an enormous impact on overall well-being. In many neighborhoods, those conditions are shaped by systemic racism and the generational trauma it causes.

Beyond its impact on access to health care, systemic racism affects access to wealth, education, housing, employment, nutrition and overall wellness — everything that communities need to thrive. This helps to explain why COVID-19 hit communities of color so hard — and why removing those obstacles is essential to achieving health equity. In June 2020, RUSH joined 35 other Chicago-area hospitals, health systems and health centers in releasing an open letter that makes it plain: **Racism is a public health crisis.**

In 2016, RUSH launched a health equity strategy aimed at dismantling barriers to good health. This triennial Community Health Needs Assessment (CHNA) and Community Health Implementation Plan (CHIP) is the third such document we have completed since then.

This CHNA and CHIP reflect the pandemic's interruption of some of our initiatives, as well as the necessity of doubling down on our community investments to respond meaningfully to the crisis.

Our health equity strategy laid the groundwork for us to be able to respond quickly and decisively throughout the pandemic. It enabled us to quickly expand our capacity to serve our communities' most excluded members, open our ICUs to patients from the region's safety-net hospitals, serve on the city's Racial Equity Rapid Response team, deepen our commitment to West Side United, provide care for the most systemically excluded populations around the region and become a trusted partner in developing the region's public health preparedness workforce.

We know that achieving health equity is an effort that RUSH can't accomplish alone. We believe that by working in partnership with community members, community-based organizations, other health care providers and government agencies, our efforts will reverberate throughout the communities we serve.

Together, we're focused on locally driven, locally supported strategies for expanding resources and opportunities that will help close the gaps.

Our community work and antiracism work has evolved and accelerated over the last six years — and the pandemic has further sharpened our ability to work together to respond quickly to urgent community needs. Continual, active listening and connections with our community partners keep us informed of what people need, no matter how quickly those needs shift.

These connections are the result of our ongoing work to build authentic relationships and equity-centered programs, outreach and outcomes. In the pages that follow, you'll see how those relationships and the collaborations they inspire are key to the work of RUSH University Medical Center and RUSH Oak Park Hospital to improve health equity.

At RUSH, we believe that all people — no matter where they live — should have equal access to the resources they need to live the safest, healthiest and most fulfilling lives possible.

We want to help people to thrive instead of simply treating the illnesses that result from inequities. Providing everyone with more opportunities to thrive benefits all of us.

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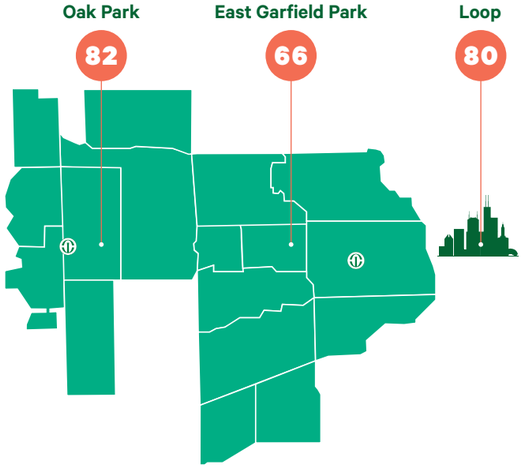
Senior Vice President for Community Health Equity, RUSH University Medical Center

Our imperative for action: The Chicago life expectancy gap and the underlying conditions that drive it

In Chicago's downtown Loop, a baby born today has a life expectancy of 80 years.

In East Garfield Park, a few miles away near RUSH University Medical Center, a baby born today has a life expectancy of just 66 years.



Violence is not the main cause of this 14-year "death gap."

In the neighborhoods most heavily impacted by poverty, systemic racism, lack of educational opportunities and other social determinants of health, the top driver of the gap is chronic disease: heart disease, stroke, cancer, diabetes and obesity.

The data clearly show the inequities: Since 2012, life expectancy has decreased for all Chicagoans except white residents.

The Latinx community saw the largest drop: more than seven years. The Asian American and Pacific Islander (AAPI) community lost almost five years; the Black community lost nearly three years.

And COVID-19 exacerbated every inequity that drives the death gap. Between 2019 and 2020, life expectancy dropped significantly for Black, Latinx and AAPI Chicagoans, while remaining nearly the same for whites. The Black/white life expectancy gap, already the highest in the nation before COVID-19, is now more than 10 years. Black life expectancy has dropped to under 70 in Chicago for the first time in three decades.

In neighborhoods with more equitable access to resources, there are fewer health disparities and people live longer.

Even before the COVID-19 pandemic, each year Chicago recorded more than 3,800 excess deaths among its Black population compared to its white population.

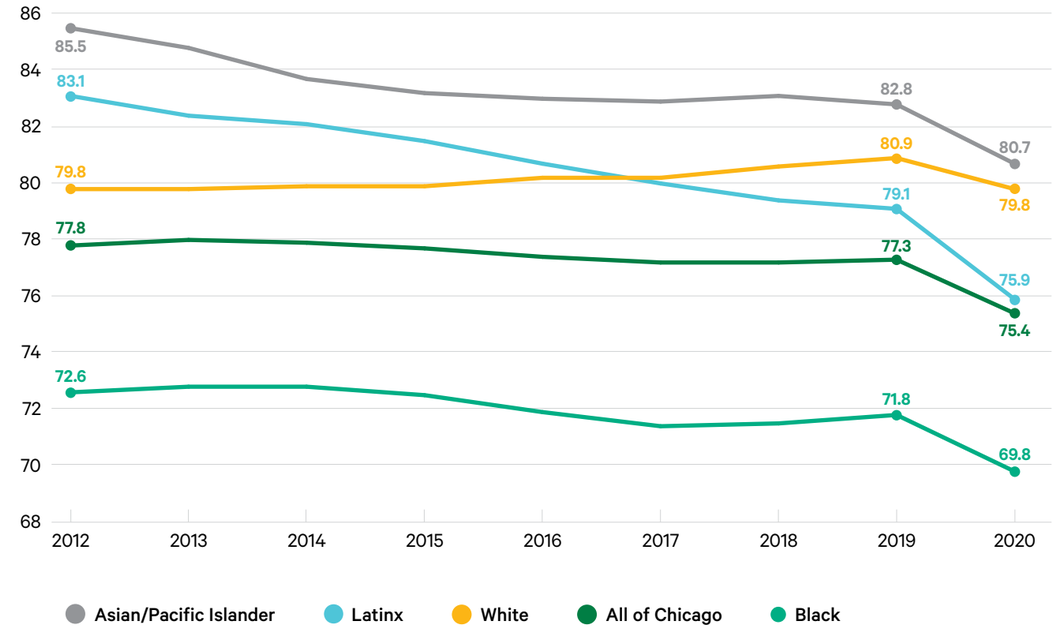
Year after year, more Black Chicagoans have died because of health inequities than the total number of people who died in the World Trade Center attack on 9/11.

Unequal access to the social determinants of health leads to the health inequities that fuel the death gap. In 2016, RUSH set out to address the gap by laying out a clear health equity strategy with well-defined initiatives that have measurable outcomes.

Dismantling systemic racism is critical to this work. Devaluing Black and brown lives has led to generations of harm. **If we don't address racism urgently, we won't stop its impact on people's health.**

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care.

Life expectancy of Chicagoans



Source: Illinois Department of Public Health vital records, as analyzed by the Chicago Department of Public Health Office of Epidemiology

"When you examine the life expectancy map of Chicago, residents who live closest to excellent health care at RUSH have had among the worst health outcomes in the city. The answer was not just about providing more health care. If we didn't address the social and structural conditions with the greatest bearing on health outcomes — like poverty, systemic racism, poor educational achievement, food insecurity, housing and safety on Chicago's West Side — we would not achieve our mission of improving health.

These health inequities are unfair, urgent and tied to deeply entrenched poverty. It has never been right that a newborn on Laramie is six times more likely to die in their first year of life than one born in Lincoln Park. We felt that RUSH had a moral and ethical obligation to respond in a different way than we had in the past.

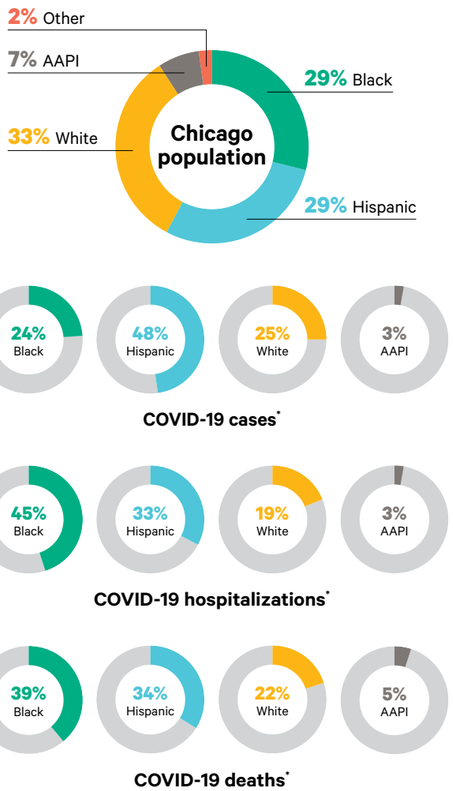
David Ansell, MD, MPH

COVID-19 made health equity gaps worse. But RUSH's actions made a difference.

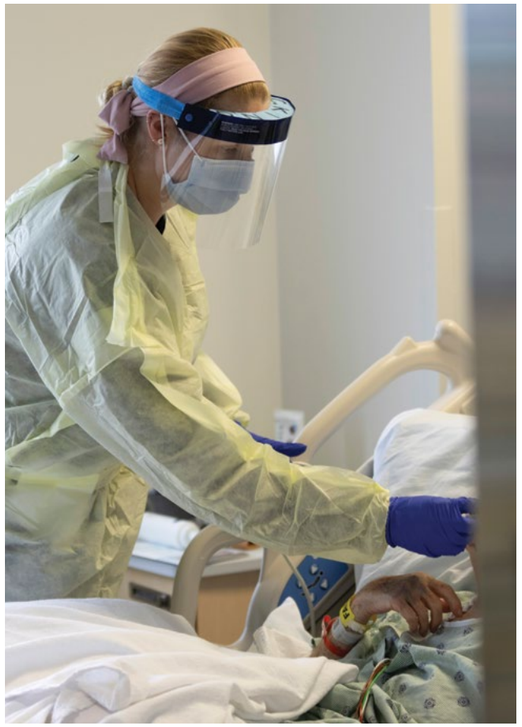
RUSH University Medical Center admitted its first COVID-19 patient on March 5, 2020. Within a month, the disproportionate impact of the virus on Black and Latinx communities became clear throughout the city. In Chicago, just under a third of residents are Black, but 70 of the first 100 Chicagoans who died of COVID-19 were Black.

"Those numbers take your breath away," said Chicago Mayor Lori Lightfoot in early April 2020. "This is a call to action for all of us."

Significant racial disparities in the rates of COVID-19 infection, hospitalization and death continued to emerge as the pandemic raged on.



*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native. Source: Cook County Medical Examiner, 2020



Rather than simply reacting to the pandemic, RUSH took action.

At the peak of the pandemic's first wave, RUSH University Medical Center reached out to the region's safety-net hospitals to offer help and specialized care. We took in more than 100 Black and Latinx transfer patients, all of them on ventilators..

The Medical Center's expert care meant that there were no racial or ethnic disparities in survival rates for these patients; in fact, we posted some of the state's highest overall survival rates. And we took a central role in the community response to COVID-19 (see p. 9 for details).

In 2021, RUSH was the only health system to be awarded the City of Chicago's Medal of Honor for its pandemic response.

Collaboration magnifies impact

Urgent action to fight the reality of the death gap is necessary — but we know that as a single health system, RUSH can't reverse longstanding health inequities on its own.

To make real progress, we coordinate our work with that of other health systems, community residents, nonprofit organizations, government agencies and faith communities. In 2018, we helped create the West Side United collaborative.

We've partnered with the City of Chicago on Healthy Chicago 2025, the city's five-year community health improvement plan that focuses on racial and health equity to close the life expectancy gap. We're an active member of the Alliance for Health Equity, one of the largest collaborative hospital-community partnerships in the country. And our work is aligned with Healthy People 2030, the US Department of Health and Human Services' data-driven objectives to improve health and well-being nationwide over the next decade.

Together, we focus on measurable ways to increase health equity, dismantle systemic racism and close the death gap.

West Side United: From concept to citywide leader in two years

When early COVID-19 data revealed Chicago's racial disparities in infection and death, Mayor Lori Lightfoot called on RUSH University Medical Center and its partner West Side United (WSU) to help lead a Racial Equity Rapid Response Team focused on education, prevention, supportive services, testing and treatment.

RUSH, along with the Cook County Health and Hospitals System, the University of Illinois Hospital & Health Sciences System and other community and health care organizations, established WSU in 2018 as a collaborative focused on coordinating efforts to build community health and economic wellness. Today, nearly 50 organizations and 120 individuals work together in WSU.

In the aftermath of the pandemic's peak, WSU is helping small businesses and community-based organizations stay afloat and working with the Chicago Department of Public Health to support people's access to food, housing and safe neighborhoods. And WSU's trusted team and partners have helped RUSH vaccinate thousands of West Side residents against COVID-19.

Our goal: Shrink the gap.

We can do it. Other cities have.

A 2021 study conducted by Chicago-area researchers and published in the *Journal of the American Medical Association (JAMA) Network Open* examined mortality rates for Black and white populations in the 30 largest U.S. cities.

Nationwide, the mortality rate from all causes was 24% higher among Blacks than among whites. But the rates varied widely among cities: Some, like El Paso, showed little or no difference in death rates between Blacks and whites. In Chicago, the death rate was 65% higher for Black residents than whites.

"Inequities in mortality are not inevitable, and they vary from city to city. If health equity can be achieved in some cities, why not all?" said Fernando De Maio, PhD, a co-author of the study. "Our results are an indication of the toll of structural racism in U.S. society, but they also give us hope that better, and more equitable, patterns of population health are possible."

Chicago's long history of racial segregation and inequities means that our goal will take real, sustained, collaborative effort — but we believe that it is achievable.

Our road map: The RUSH CHNA and CHIP

Every three years, we create a **Community Health Needs Assessment (CHNA)** based on public health data plus input from neighborhood stakeholders like residents, local nonprofits, faith communities and others. This document provides an overview of the health needs of people who live in communities near RUSH University Medical Center and RUSH Oak Park Hospital.

Our **Community Health Implementation Plan (CHIP)** lays out the clear, measurable ways we'll address the needs determined by the CHNA and attack the death gap. At the end of each three-year period, we assess our progress against our CHIP goals.

Where we've been: A 2020-2022 progress report

The impact of COVID-19 and civic unrest in 2020 shifted our focus to many essential needs that weren't explicitly part of our 2019 CHIP — but were critical to community health.

During the COVID-19 pandemic, we took the following actions:

- Partnered with WSU to lead Mayor Lori Lightfoot's Racial Equity Rapid Response Team, focused on education, prevention, supportive services, testing and treatment in majority Black and Latinx neighborhoods
- Convened and led the Chicago Homelessness and Health Response Group for Equity (CHHRGE), a collaborative effort with shelters and providers of health care and social services to address and mitigate the outbreak among people experiencing homelessness
- Launched one of the first mobile COVID-19 testing teams in the city, testing people at risk in homeless shelters, nursing homes and the Cook County Jail
- Performed more than 79,000 COVID-19 tests in shelters and other congregate settings
- Established a respite center at A Safe Haven, with 24-hour clinical staff (from the RUSH University College of Nursing), for more than 1,000 people experiencing homelessness who tested positive
- Established the Center to Transform Health and Housing to provide health care in homeless shelters
- Reached out to the leaders of Chicago's safety-net hospitals and took in COVID-19 transfer patients, many of whom required advanced critical care
- Created a data hub for all of Chicago's COVID-19-related health data, community-based testing and vaccination sites
- Established the virus sequencing lab for the region
- Hired community health workers to assist with contact tracing and connecting people with needed care and resources
- Expanded our RUSH@Home house calls program
- Fed more than 36,000 people in food-insecure neighborhoods
- Launched Connect Chicago in partnership with Esperanza Health Centers and the Chicago Department of Public Health, providing thousands of COVID-19 tests and health screenings
- Served as co-lead with WSU on the West Side Health Equity Zone, the city's initiative to support community organizations taking the lead on strategies that address the root causes of health inequities
- Collaborated with West Side faith communities and community-based organizations to provide vaccine education and stand up vaccine clinics in West Side communities
- Expanded our social work psychotherapy program to provide more than 10,000 mental health therapy sessions to patients and community members in 2021

We convened a multidisciplinary **Racial Justice Action Committee** to develop a road map for addressing institutional racism within RUSH. The committee focuses on ensuring that Black lives matter inside and outside of RUSH's walls and identifying new ways we can all work together to advance social and racial justice alongside health equity.

We launched **Affirm: the RUSH Center for Gender, Sexuality and Reproductive Health** to bridge gaps in care by providing safe, comprehensive, affirming care to LGBTQ+ people and connecting them to the right providers and resources, from behavioral health to specialty care and surgery.

We created our first **Health Equity Report** in 2019 to share what we know about the patients RUSH serves —and examine where we stand in a variety of areas related to health equity. Our 2021 report focused on health equity and our COVID-19 response.

We added two new **school-based health centers (SBHCs)** in Chicago Public Schools, bringing our total to five. SBHCs serve as safety nets, providing primary care and mental health services to those who face barriers to getting care. SBHC teams also engage students in self-care and advocacy, encouraging them to take responsibility for their own health, make healthy choices and promote good health in their families and communities.

We created new **information technology (IT) pathways** programming in the RUSH Education and Career Hub (REACH) to boost educational attainment and economic mobility for underrepresented students in grades 5-12. Our goal: increase the number of students ready to advance to the next level of STEM education and/or enter the workforce with the skills and networks to succeed in IT careers.

The RUSH BMO Institute for Health Equity: Dismantling the causes of disparities

A major step forward for RUSH's health equity work came in 2021 thanks to a $10 million gift from BMO Financial Group to create the RUSH BMO Institute for Health Equity. As the coordinator of health equity initiatives across RUSH, the institute fosters solutions that address the structural and social root causes of poor health in four focus areas: education and workforce development; community-based clinical practice; community engagement; and health equity research.

In 2022, after a national search, RUSH announced the appointment of John A. Rich, MD, MPH, as director of the institute. Rich joins RUSH from the Dornsife School of Public Health at Drexel University, where he was professor of health management and policy and founded the Drexel Center for Nonviolence and Social Justice. Rich will draw from his impressive experience to launch and scale efforts that promote health equity across all dimensions of RUSH's mission.

The RUSH CHIP report card: How we performed on our 2020-2022 goals

We created our 2020-2022 CHIP goals based on what we learned during the 2019 CHNA process. These goals reflect the factors that contribute most directly to the death gap.

Some of the performance metrics that we laid out in 2019 were affected by the COVID-19 pandemic beginning in early 2020. While the pandemic had a significant impact on our ability to provide programming in person, we pivoted to provide many services virtually and expand other initiatives to meet increased needs.

Here's a look at how we've performed against our three-year goals.*

GOAL 1

REDUCE INEQUITIES CAUSED BY THE SOCIAL, ECONOMIC AND STRUCTURAL DETERMINANTS OF HEALTH

STRATEGY Improve K-16 educational outcomes through skills development, internships and industry-recognized credentials

MEASURES	RESULTS
Provide high school and college apprenticeship/ internship programs that serve at least 750 students	**560** students completed paid internship programs (participant numbers were reduced due to COVID-19)
Increase student and family interest and awareness of STEM/health care topics and careers through work-based learning experiences, serving 3,750 students and 459 parents/community members	**11,449** students and **2,059** parents/community members served
Ensure that 75% of all participating high school students are on track to receive an industry-recognized credential	**431** students (**77%** of paid interns) earned an industry-recognized credential

*Data represents Q1 of FY20 through Q3 of FY22

STRATEGY Identify the social determinants of health through screenings, and refer those in need of social services

MEASURES	RESULTS
With West Side ConnectED, roll out the screening tool to RUSH Oak Park Hospital and RUSH Copley Medical Center; screen 30,000 patients/community members and connect them to resources	**38,191** people screened
Integrate social determinants of health screening into community-based programming, connecting with at least 9 partners	Connected with **4** partners before initiative was paused due to COVID-19

STRATEGY Increase local hiring and develop career ladders for employees

MEASURES	RESULTS
Launch 4 career pathway programs, including medical assistant, nursing assistant, nursing and health IT, serving 1,125 people through WSU partner hospitals	**63** RUSH employees served; **152** served through WSU. Funder has provided an additional year to reach the goal because of COVID-19 delays
Work with WSU toward its goal of employing 3,500 West Side community members across six partner hospitals	**2,716** people hired across all hospitals; **876** people hired by RUSH

STRATEGY Increase spending with local businesses

MEASURES	RESULTS
Increase local vendor presence at all 3 hospitals for a total of 9 vendor partnerships (beginning in FY20 for RUSH Oak Park Hospital and in FY21 for RUSH Copley Medical Center)	**18** vendor partnerships
RUSH University Medical Center will aim to increase its FY20 spending with West Side vendors by at least $4.2 million	More than **$8 million** spent

STRATEGY Increase investment in West Side communities

MEASURE	RESULT
Invest $7.5 million in West Side communities through partnership with WSU	**$5.5 million** invested by RUSH

GOAL 2
INCREASE ACCESS TO MENTAL AND BEHAVIORAL HEALTH SERVICES

STRATEGY Conduct community-based trainings — including train-the-trainer programs — in Mental Health First Aid and Spiritual Care

MEASURES	RESULTS
Pilot a West Side health ministry among 5 churches in those communities	Paused during COVID-19; launched pilot in Spring 2022
Conduct Mental Health First Aid training for 500 people	**300** people trained (paused during COVID-19; resumed in Spring 2022)

STRATEGY Increase community screenings and referrals to mental health services

MEASURES	RESULTS
Pilot a faith-based mental health support service across 3 West Side churches	Paused during COVID-19
Provide mental health screenings to 1,000 Chicago Public Schools students through School-Based Health Centers (SBHCs)	**1,197** students screened
Conduct workshops on trauma-informed care, awareness building, and stigma reduction in 5 West Side churches	**6** workshops held, including 2 with representatives from 20 churches

STRATEGY Provide mental health clinical services in community settings through partnerships; support community-based efforts

MEASURES	RESULTS
Partner with 5 West Side schools that do not have SBHCs	Partnered with **21** schools

GOAL 3
PREVENT AND/OR MANAGE CHRONIC CONDITIONS AND RISK FACTORS

STRATEGY Reduce risk factors through assessments, health education/promotion and chronic condition management programs, with a focus on hypertension (e.g., West Side Alive, Live Healthy West Side)

MEASURES	RESULTS
Evaluate current programs and align them across RUSH	In progress
Serve 750 people with programming about chronic conditions (including hypertension) and risk factors; train staff and volunteers from 10 community organizations to offer chronic condition self-management education to 300 people	1,247 people served; 318 people engaged in self-management

STRATEGY Improve access to healthy food

MEASURES	RESULTS
Expand Food is Medicine program across RUSH University Medical Center and RUSH Oak Park Hospital and serve people identified as food-insecure	342 people served
Expand Top Box Foods to 15 community partners in West Side neighborhoods	18 community partners engaged
Continue RUSH Food Surplus Program and donate 60,000 meals	51,438 meals donated
Pilot new access initiatives for food security, including meal delivery	3,311 meals delivered

STRATEGY Develop and deliver community programs to help people stop smoking

MEASURES	RESULTS
Decrease the prevalence of tobacco use in West Side partner agencies by 10% in 3 years	Paused during COVID-19
Bring lung health programming to 5 community-based partners	Paused during COVID-19
Continue local and regional advocacy efforts to promote lung health	Paused during COVID-19

GOAL 4
INCREASE ACCESS TO QUALITY HEALTH CARE

STRATEGY Expand access to primary care medical homes for those with or without insurance, and help people obtain insurance when possible

MEASURES	RESULTS
Talk about primary care and insurance with 85% of patients before they're discharged from a specific unit at RUSH University Medical Center	81% of patients engaged
Refer 1,200 people to CommunityHealth and other partner agencies	354 people referred

STRATEGY Support training and deployment of community health workers

MEASURES	RESULTS
Pilot integration of one community health worker (CHW) into a SBHC to increase access to care for young people and their families	CHW joined Orr Academy/KIPP One in September 2021
Enhance CHW team with 3 local hires and support community-based organizations in their efforts	17 CHWs hired

GOAL 5
IMPROVE MATERNAL AND CHILD HEALTH OUTCOMES

STRATEGY Participate in Live Healthy West Side collaborative, focused on maternal and child health

MEASURE	RESULT
Determine interventions and set baseline measures in the first year; ongoing implementation in the second and third years	Began collaborating in the East Garfield Park Best Babies Zone initiative to improve birth outcomes; convened community advisory team

STRATEGY Support breastfeeding education and promotion programs

MEASURE	RESULT
Continue participation in Baby-Friendly USA, Inc., and provide education and outreach to at least 1,500 parent-baby pairs	**2,170** parent-baby pairs participated in education and outreach

STRATEGY Identify pregnant and parenting people with high Adverse Childhood Experiences (ACEs) scores and connect them to evidence-based home-visiting programs

MEASURES	RESULTS
Provide coordinated referrals for parenting support services to those with those with ACEs ≥ 3	**180** people referred
Implement support service for families with newborns that seeks to support maternal-infant health, family well-being and social needs through a nurse home visit and connections with indicated community resources	**1,500** patients received care
Implement depression screening and linkages to care during new OB visits, postpartum visits and newborn/ infant visits	**98** people referred

Where we are today: The 2022 RUSH University Medical Center and RUSH Oak Park Hospital CHNA*

Individuals, institutions and communities all play key roles in assessing and addressing community health needs.

People who live in neighborhoods are the experts on what's happening locally; they should inform the strategies and resources that could help with the challenges they face.

RUSH's health equity work is guided by the voice of the community: "Nothing about us without us."

How we gathered information for this CHNA

Our most important collaborators on this CHNA are the more than 400 people who participated in 23 focus groups and 17 interviews convened by RUSH, WSU and the Alliance for Health Equity (AHE), along with more than 5,300 other community members who answered a survey. More than 100 community-based organizations that are our partners helped us invite neighbors to focus groups and hosted us in their spaces.

*RUSH Copley Medical Center worked with Kane Health Counts on its own CHNA, using data and community input from people who live in Kane, Kendall, Will and other counties in the RUSH Copley service area. Its CHNA and Community Health Implementation Plan (CHIP) differ slightly from what you'll read here, but the focus on health equity — and the strategies for achieving it — is consistent across the entire RUSH system.

Here's what the discussions of barriers to good health in the RUSH University Medical Center and RUSH Oak Park Hospital service areas looked like.

Themes that came up in virtually every community conversation:

The effects of the COVID-19 pandemic

The pandemic was really a crystallization of the problems and disparities in this city. The poor and undocumented living in the shadows have no rights to speak of. We didn't allow people to get vaccinated as essential workers, and we died. It was a fight, and we died. Our church lost 60 members.

Faith leader, South Lawndale

The impact of gun violence

The sheer number of crimes and violent incidents that the children we serve have experienced…the amount of violence has resulted in repeated trauma for our students, many of whom know someone who has been shot or killed.

Community-based organization volunteer manager, Austin

and overwhelming mental health needs

Mental illness has been such a big issue, especially since COVID. It's not only the physical part of COVID; it's losing jobs, it's the isolation. It took a mental toll, especially on people who had underlying issues. The mental health system wasn't ready.

Food bank volunteer, Oak Park

Data from a number of trusted sources supplemented our conversations. We worked with the AHE to collect and analyze data from a number of sources, including the following:

- American Communities Survey
- Centers for Disease Control and Prevention
- Chicago, Cook County and Illinois departments of public health
- City of Chicago Protect Chicago 77 campaign
- Data compiled by state agencies, including Illinois Department of Healthcare and Family Services, Illinois Department of Human Services, Illinois State Board of Education, Illinois Department of Public Health
- Data from federal sources, including Centers for Medicare and Medicaid Services (data accessed through the Dartmouth Atlas of Health Care), Health Resources and Services Administration and United States Department of Agriculture
- Healthy Chicago Survey
- Hospitalization and emergency department rates (COMPdata) reported by Illinois Health and Hospital Association
- Local data compiled by additional agencies, including Chicago Metropolitan Agency for Planning, Chicago Department of Family and Support Services, Chicago Department of Planning and Development, Housing Authority of Cook County, local police departments
- Local data compiled by community-based organizations, including Greater Chicago Food Depository and Feeding America, Voices of Child Health in Chicago, Healthy Chicago Equity Zones, Mapping COVID-19 Recovery initiative
- Peer-reviewed literature and white papers

This data helped us and our AHE partner organizations identify needs for our CHNAs and create strategies for our CHIPs.

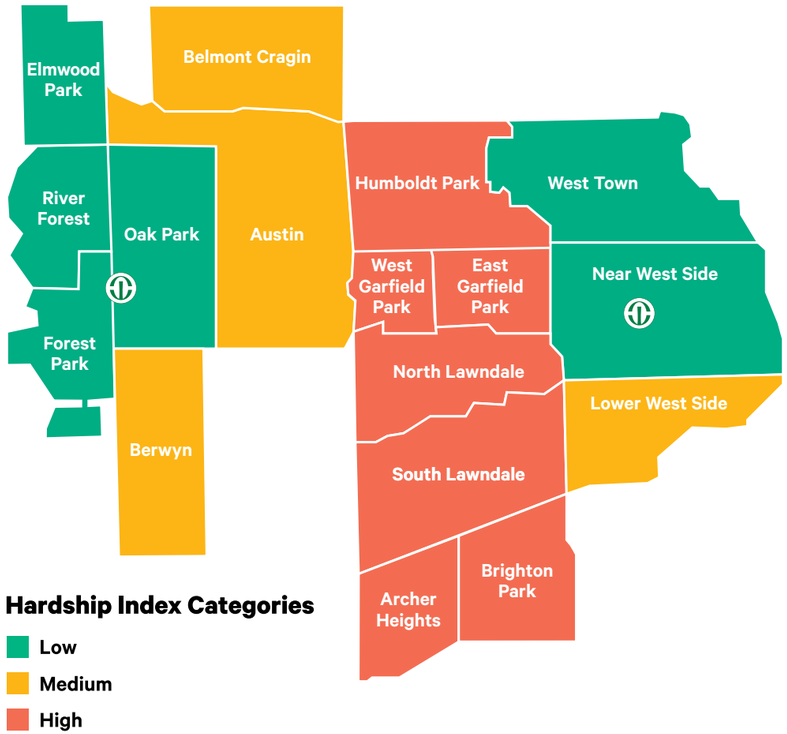
We've added five new communities to this year's CHNA:

In Chicago	In the suburbs
Archer Heights	Berwyn
Belmont Cragin	Elmwood Park
Brighton Park	

We chose these communities after reviewing RUSH University Medical Center and RUSH Oak Park Hospital patient data and asking our partners in community-based organizations about their perception of the needs in their areas.

This map of where people experience the most hardship in the RUSH service area is based on six factors from the American Community Survey.

- The number of people under age 18 and over age 64
- The percentage of housing with more than one person per room
- Poverty
- Per capita income
- Unemployment
- No high school diploma



We always want to talk about solutions alongside challenges.

Our CHIP goals, starting on p. 56 and updated for fiscal years 2023 through 2025, show our plans for addressing concerns and suggestions that we heard from neighborhood residents and identified in public health data.

For example, in the city's 2020 Healthy Chicago Survey, 10% of Chicago adults surveyed said they were experiencing "serious psychological distress," up from 7% in 2018.

But the percentage of city residents ages 18 to 29 experiencing serious distress in 2020 is nearly double the city average, at 18%. And in every focus group we held, mental health concerns were a major concern for community members.

To address this critical issue, we've significantly expanded our CHIP goal No. 2, "Improve access to mental and behavioral health services." We're committed to providing 10,000 therapy sessions to referred patients, linking community members and CPS students to mental health resources, increasing telehealth access to therapy and building a pipeline to increase the number of mental health providers of color.

"My wish list? Bring in quality grocery stores, that's No. 1 on my list. Fitness centers, job training that places people in jobs where they can earn a decent living, affordable housing. Make sure internet connectivity is free to everyone. And we need a lot of education and better support for young mothers of small children.

Community manager
West Side nonprofit housing

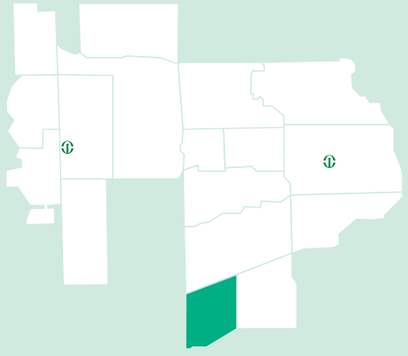
Public health data sources

Because it takes time for government agencies to collect, analyze and share data, the data in the neighborhood profiles that follow reflects a range of time periods. Different information is presented for suburban communities, since city and county survey questions differ. Percentages are rounded.

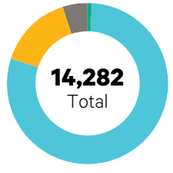
Population, unemployment, individual poverty, child poverty	American Community Survey, US Census Bureau (2016-2020)
COVID-19 positivity and mortality rates	Chicago Health Atlas, Illinois Department of Public Health, Cook County Department of Public Health (2020)
COVID-19 vaccination rates	Chicago Health Atlas, Illinois Department of Public Health, Protect Chicago 77 (2022)
Perceptions of neighborhood safety	Chicago Health Atlas, Healthy Chicago Survey (2020-2021)
Life expectancy at birth	Chicago Department of Public Health (2020), Cook County Department of Public Health (2017)
Early and adequate prenatal care (city)	Chicago Health Atlas, Healthy Chicago Survey (2017)
Late or no prenatal care (suburbs)	Cook County Department of Public Health (2013-2017)
Diabetes prevalence, obesity, hypertension	Chicago Health Atlas, Healthy Chicago Survey, CDC's PLACES (2016-2021)
Servings of fruits and vegetables	Chicago Health Atlas, CDC's Behavioral Risk Factor Surveillance System (2020-2021)
Hardship index	American Community Survey (2016-2020)

Archer Heights*

60632



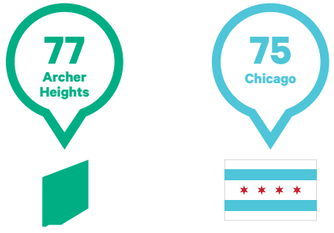
Race/Ethnicity†



1% Black
80% Hispanic/Latino
15% White
5% AAPI
<1% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy



COVID-19

Positivity rate
13%

Mortality rate
.16%

Vaccination rate
80%

"Mental health is certainly an issue. There's a fallacy that stigma is the primary reason for not accessing care, but that's far down the list. Lack of health insurance is at the top of the list. And many of our households are not English-proficient. We have to provide services in easily understandable ways."

- **6** grocery stores
- **1** childcare center
- **6** health care and **0** mental health facilities
- **2** pharmacies
- **5** public parks
- **7** public and private schools

*denotes new CHNA community in 2022

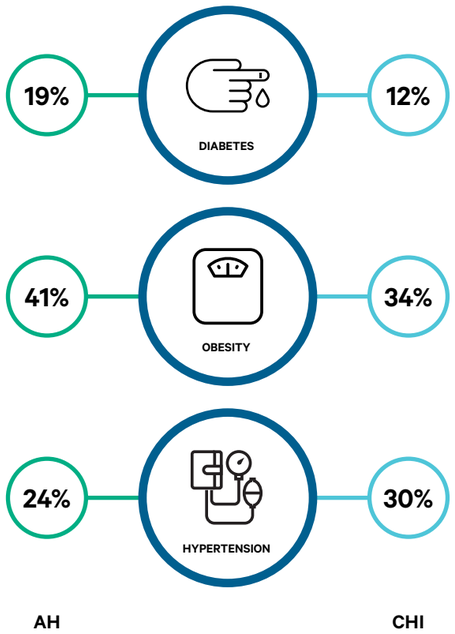
Unemployment

Moms getting good prenatal care

People who feel safe in their community

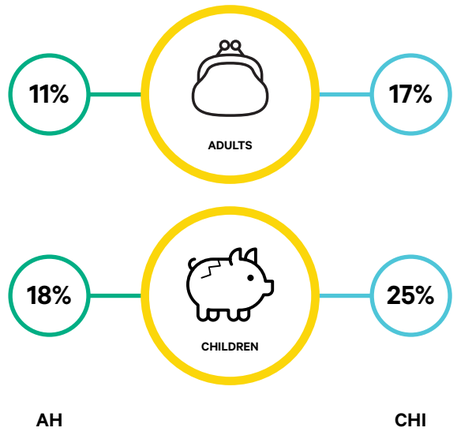
Adults eating enough fruits & vegetables

People with chronic conditions that contribute to the life expectancy gap



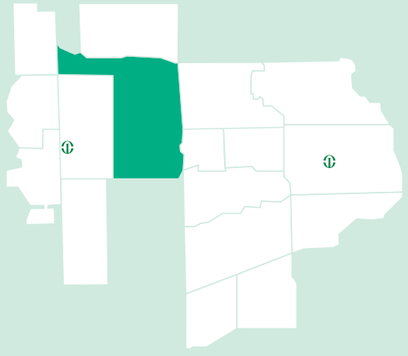
"We have a lot of young people in our community, a lot of intergenerational families living together. That presents challenges for pandemic safety, but brings us many good things."

People living in poverty

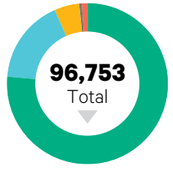


Austin

60651, 60644

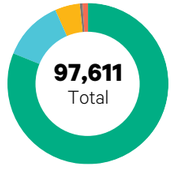


Race/Ethnicity†



TODAY

76% Black
17% Hispanic/Latino
5% White
<1% AAPI
1% Other

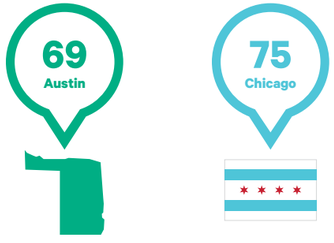


2019 CHNA

82% Black
13% Hispanic/Latino
5% White
<1% AAPI
1% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy

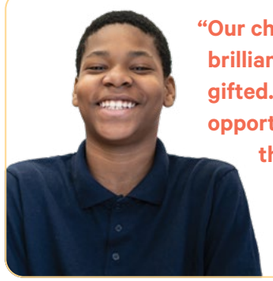


COVID-19

Positivity rate
8%

Mortality rate
.22%

Vaccination rate
61%



"Our children are really brilliant, talented, gifted. With the right opportunities, you see them shine."

- **11** grocery stores
- **15** childcare centers
- **3** health care and **8** mental health facilities
- **3** pharmacies
- **18** public parks
- **29** public and private schools

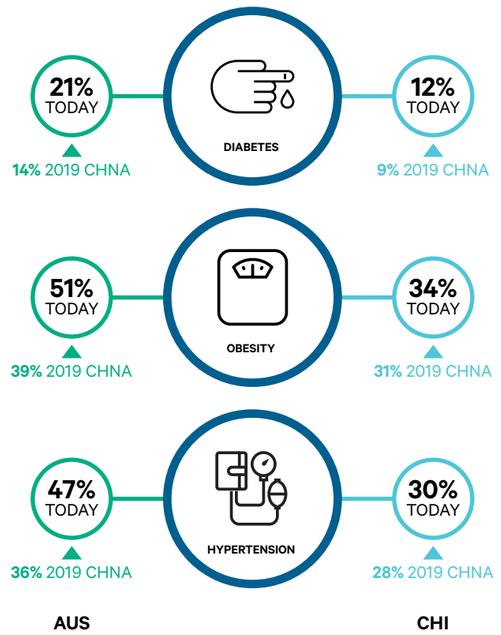
Unemployment

Moms getting good prenatal care

People who feel safe in their community

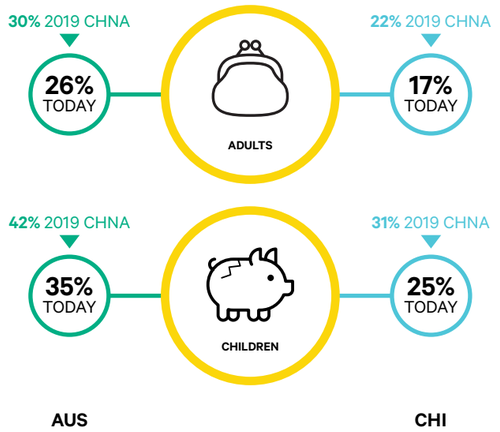
Adults eating enough fruits & vegetables

People with chronic conditions that contribute to the life expectancy gap



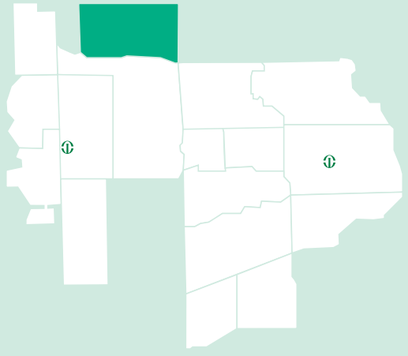
"We need more education on preventing disease instead of trying to cure it when it's too late — like the lack of good, nutritious food and what that does to you."

People living in poverty

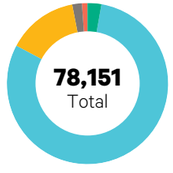


Belmont Cragin*

60639

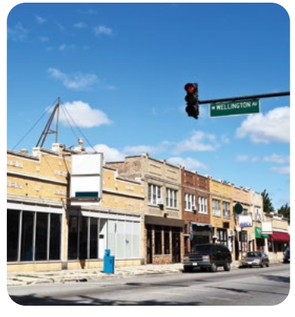


Race/Ethnicity†

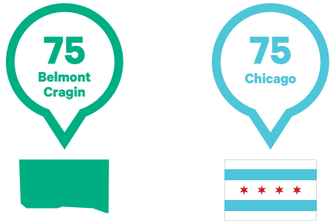


3% Black
80% Hispanic/Latino
14% White
2% AAPI
1% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native



Life expectancy



COVID-19

Positivity rate
13%

Mortality rate
.22%

Vaccination rate
77%

"When we want to see change, we unite. There are plenty of resources that are open and available. It is so much different than other communities. Here, people let you know where the resources are, unlike other places I've lived."

- **10** grocery stores
- **12** childcare centers
- **7** health care and **7** mental health facilities
- **8** pharmacies
- **6** public parks
- **18** public and private schools

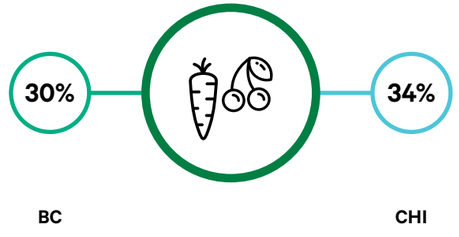
*denotes new CHNA community in 2022

Unemployment

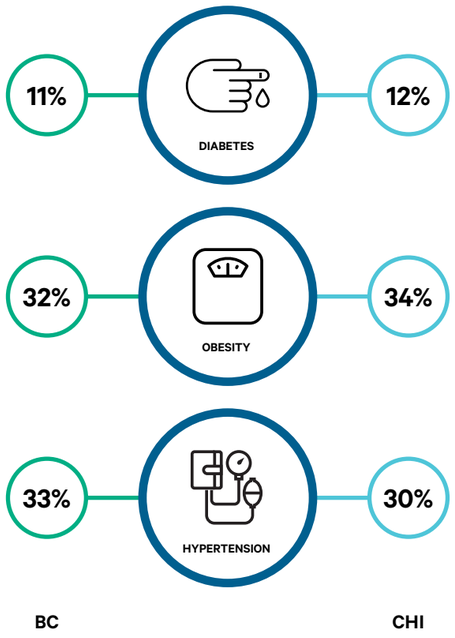
Moms getting good prenatal care

People who feel safe in their community

Adults eating enough fruits & vegetables

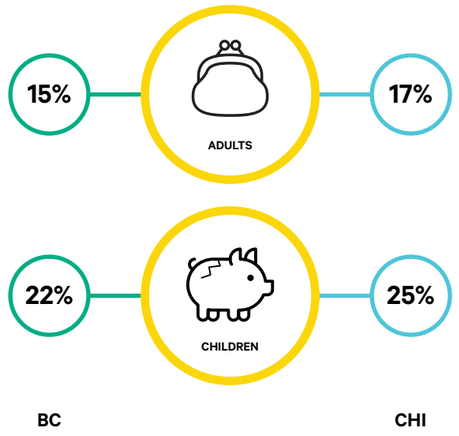


People with chronic conditions that contribute to the life expectancy gap



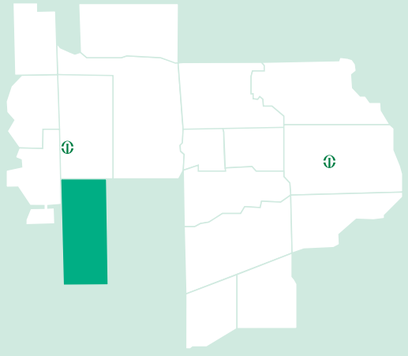
"Due to community violence, it's hard to be healthy. It's not just about having a park, but about people feeling safe and comfortable letting our kids out late."

People living in poverty

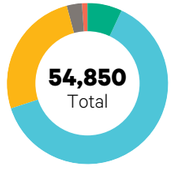


Berwyn*

60402

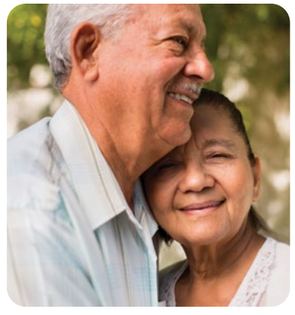


Race/Ethnicity†

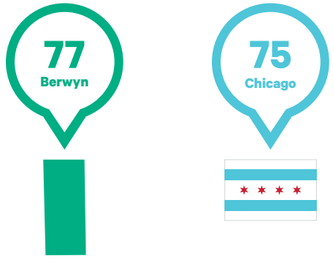


- 7% Black
- 63% Hispanic/Latino
- 26% White
- 3% AAPI
- 1% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native



Life expectancy



COVID-19

Positivity rate
20%

Mortality rate
.16%

Vaccination rate
63%

Necessary for a healthy community, according to focus group participants:

- Access to healthy foods
- Access to resources
- Inclusion of youth in community decisions
- Good jobs with living wages in our own neighborhood
- Recreational green spaces

- **8** grocery stores
- **18** childcare centers
- **9** health care and **7** mental health facilities
- **5** pharmacies
- **11** public parks
- **21** public and private schools

*denotes new CHNA community in 2022

Unemployment

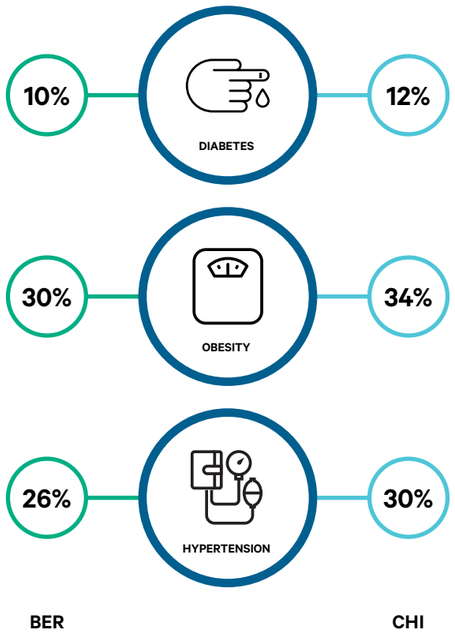
Moms getting late or no prenatal care

"We were unprepared for virtual school and virtual education. It was very challenging for students: impacted their social skills, impacted their mental health, affected their confidence when going back to school."

Top health concerns of focus group participants:

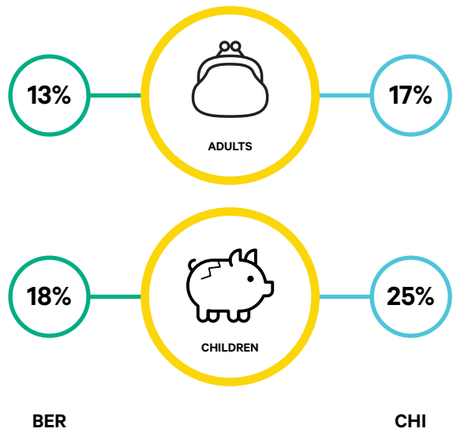
- Community safety
- Substance use disorders, especially opiates
- Mental health
- Diabetes
- Hypertension

People with chronic conditions that contribute to the life expectancy gap



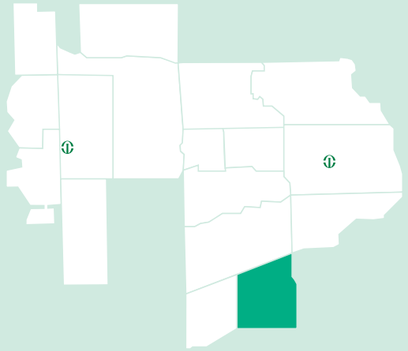
"There's lots of strong culture in the community — people coming together to support immigrants and other Latino community members."

People living in poverty

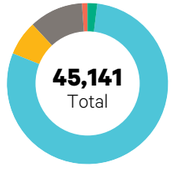


Brighton Park*

60632



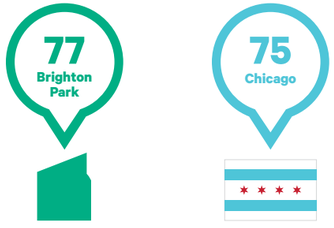
Race/Ethnicity†



2% Black
80% Hispanic/Latino
7% White
11% AAPI
1% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy



COVID-19

Positivity rate
11%

Mortality rate
.17%

Vaccination rate
76%

"I'm seeing so many organizations coming together at family events like Día del Niño celebrations to promote things like financial literacy, rental and gas assistance, health centers, COVID testing. That collaboration has been meaningful to see. That's what a safety net is meant to be for families."

- **6** grocery stores
- **6** childcare centers
- **9** health care and **12** mental health facilities
- **3** pharmacies
- **2** public parks
- **14** public and private schools

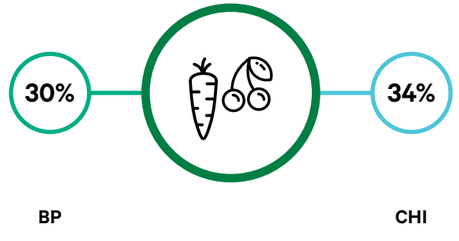
*denotes new CHNA community in 2022

Unemployment

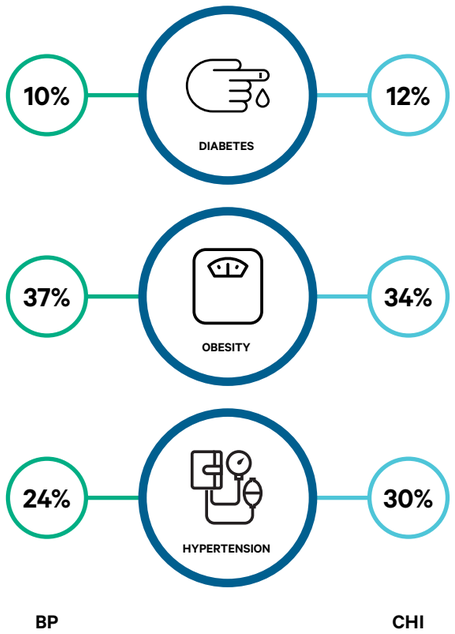
Moms getting good prenatal care

People who feel safe in their community

Adults eating enough fruits & vegetables

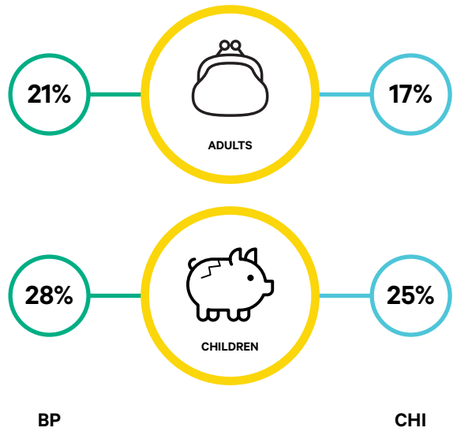


People with chronic conditions that contribute to the life expectancy gap



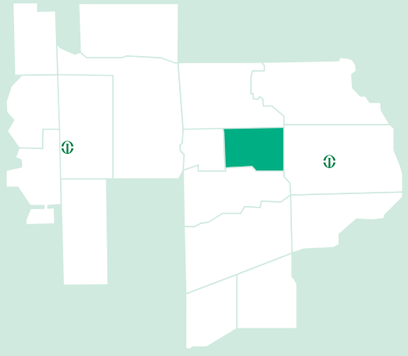
"We've seen a real increase in young families seeking basics: baby formula, diapers. That's not something there's funding for, but these are the real needs."

People living in poverty

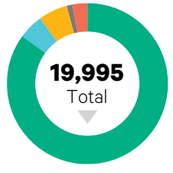


East Garfield Park

60624

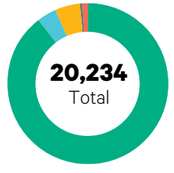


Race/Ethnicity†



TODAY

85% Black
5% Hispanic/Latino
6% White
1% AAPI
3% Other

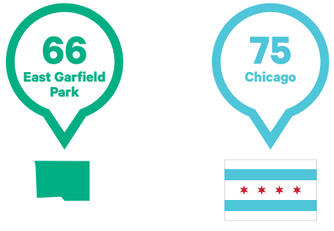


2019 CHNA

90% Black
4% Hispanic/Latino
5% White
<1% AAPI
1% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy



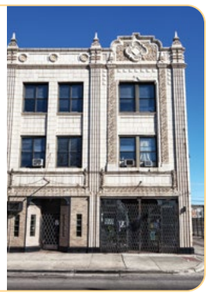
COVID-19

Positivity rate
7%

Mortality rate
.15%

Vaccination rate
58%

"We need quality grocery stores, fitness centers, job training, affordable housing, internet connectivity, safe day cares."



- **26** grocery stores
- **4** childcare centers
- **4** health care and **7** mental health facilities
- **1** pharmacy
- **12** public parks
- **10** public and private schools

Unemployment

EGP CHI

Moms getting good prenatal care

EGP CHI

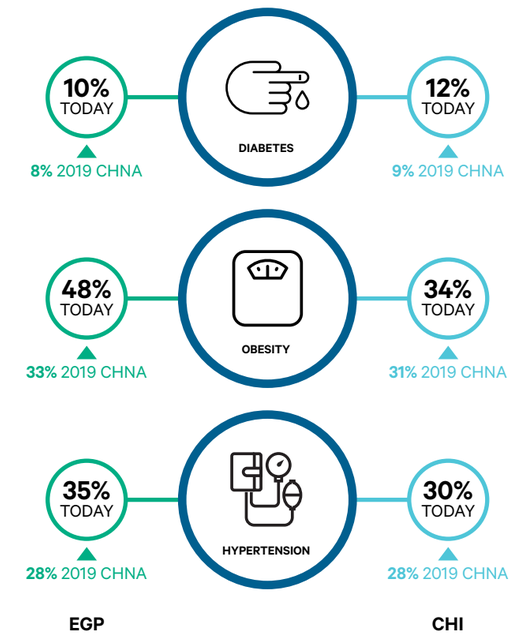
People who feel safe in their community

EGP CHI

Adults eating enough fruits & vegetables

EGP CHI

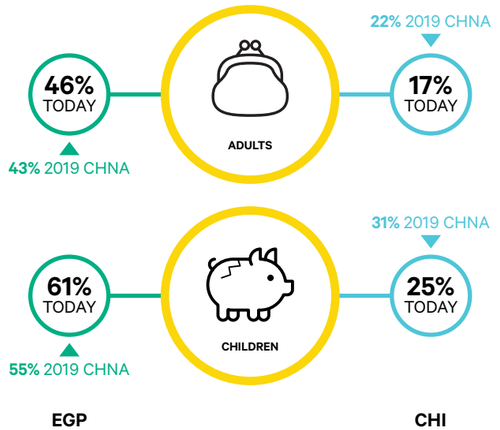
People with chronic conditions that contribute to the life expectancy gap



EGP CHI

"People stay in Garfield so long because they grew up here. It feels like home. And a lot of people want to leave the community better than they found it."

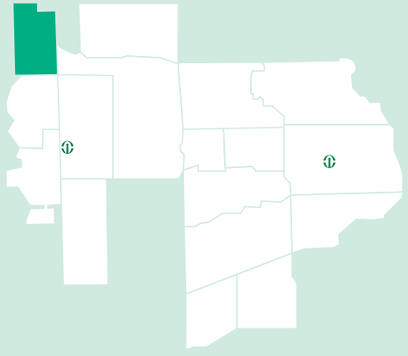
People living in poverty



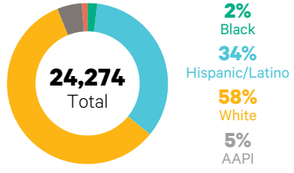
EGP CHI

Elmwood Park*

60707



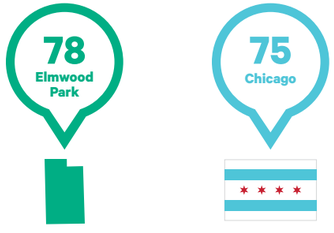
Race/Ethnicity†



2% Black
34% Hispanic/Latino
58% White
5% AAPI
1% Other

†Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy



COVID-19

Positivity rate
24%

Mortality rate
.16%

Vaccination rate
62%

Necessary for a healthy community, according to focus group participants:

- Eating healthy
- Safety: being able to walk around knowing that you're not going to be attacked
- Youth activity
- COVID-19 vaccines
- Physical activity

- **5** grocery stores
- **4** childcare centers
- **7** health care and **4** mental health facilities
- **2** pharmacies
- **8** public parks
- **5** public and private schools

*denotes new CHNA community in 2022

Unemployment

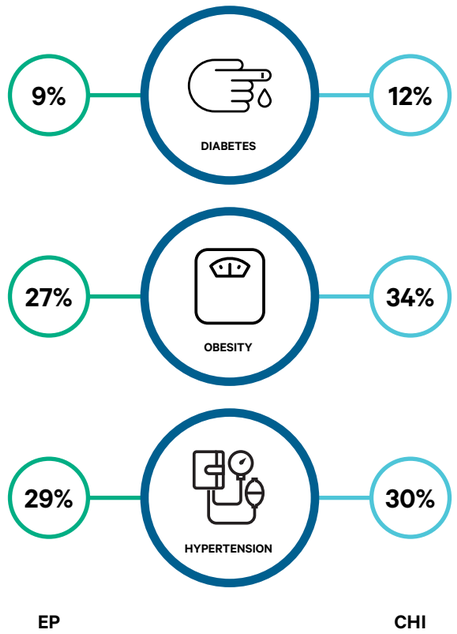
Moms getting late or no prenatal care

"I feel proud [to live here], because in my home country, I did not feel support and care for others — but it is different here."

Top health concerns of focus group participants:

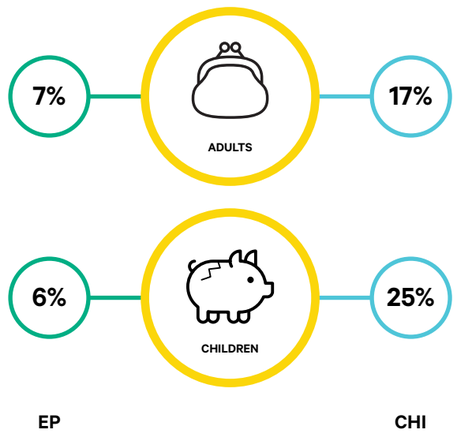
- Mental health, including suicide, domestic violence, sexual abuse
- Chronic diseases
- Isolation
- Access to nutritious food
- Crowded housing

People with chronic conditions that contribute to the life expectancy gap



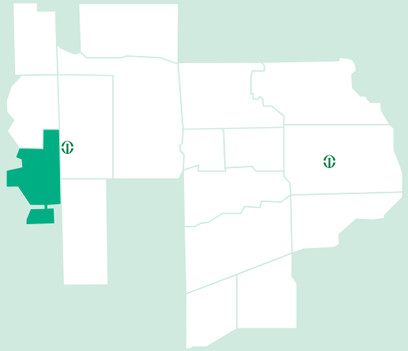
"Transportation is a challenge. There are Divvy stations but not many, and a lot of people can't afford a bike or bus fare."

People living in poverty

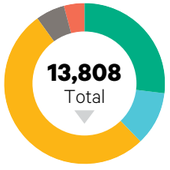


Forest Park

60130

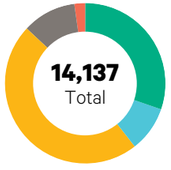


Race/Ethnicity†



TODAY

27% Black
11% Hispanic/Latino
52% White
6% AAPI
4% Other

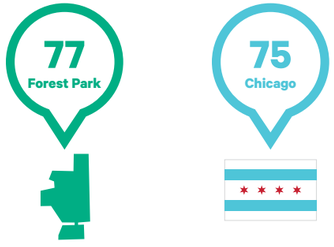


2019 CHNA

31% Black
9% Hispanic/Latino
48% White
11% AAPI
2% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy

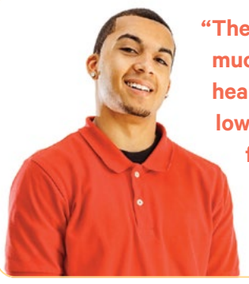


COVID-19

Positivity rate
19%

Mortality rate
.18%

Vaccination rate
66%



"There needs to be much more mental health access, free to low-cost. Screenings for adolescents to help identify problems early."

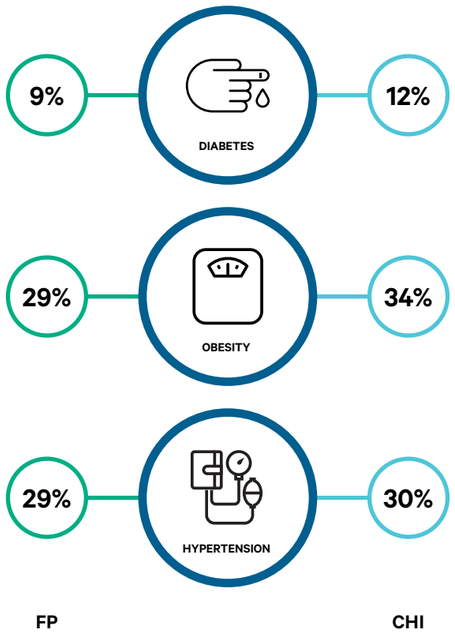
- **2** grocery stores
- **5** childcare centers
- **4** health care and **5** mental health facilities
- **2** pharmacies
- **7** public parks
- **6** public and private schools

Unemployment

Moms getting late or no prenatal care

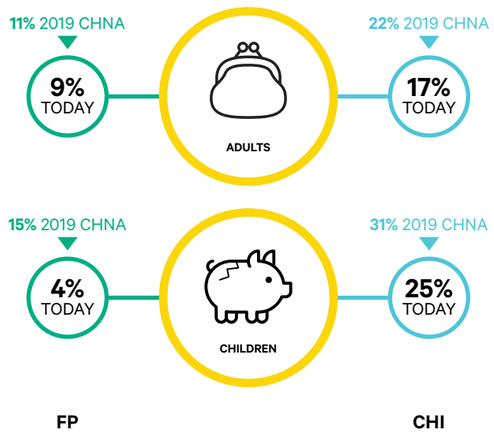
"One challenge for people with limited resources is being able to find ways to get answers to questions. For example, what can someone do if they're experiencing food insecurity?"

People with chronic conditions that contribute to the life expectancy gap



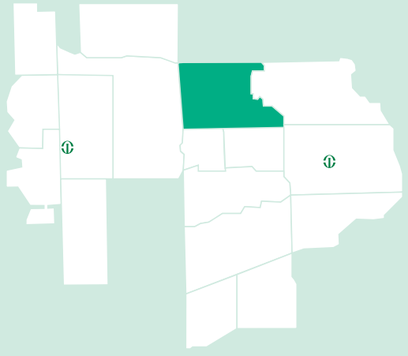
"The small-town vibe here makes it comforting. Everyone knows one another; it's very welcoming and there's a great volunteer base."

People living in poverty

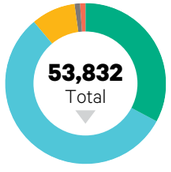


Humboldt Park

60647, 60651

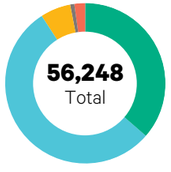


Race/Ethnicity†



TODAY

33% Black
56% Hispanic/Latino
9% White
1% AAPI
1% Other

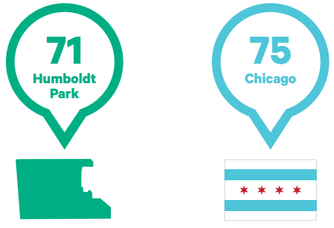


2019 CHNA

37% Black
55% Hispanic/Latino
6% White
1% AAPI
2% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy



COVID-19

Positivity rate
10%

Mortality rate
.16%

Vaccination rate
71%

"It's easy to get to the hospital, but only certain hospitals can help you with certain things — like a trauma center."

- **6** grocery stores
- **5** childcare centers
- **7** health care and **3** mental health facilities
- **3** pharmacies
- **18** public parks
- **10** public and private schools

Unemployment

HP CHI

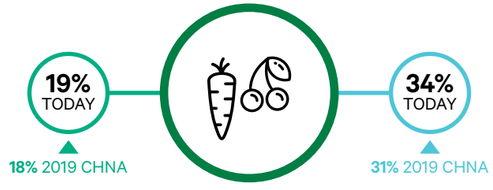
Moms getting good prenatal care

HP CHI

People who feel safe in their community

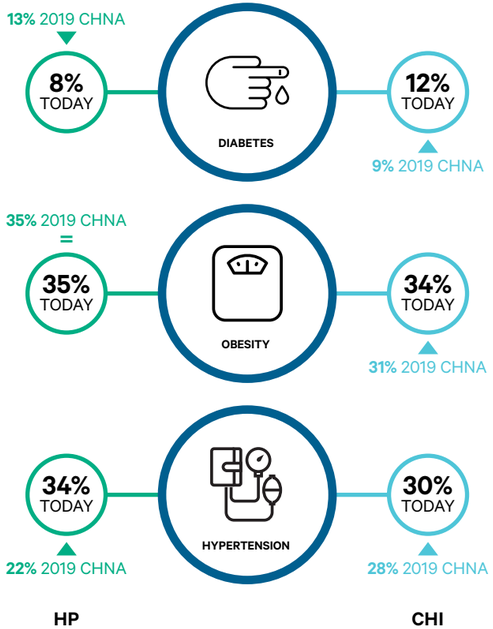
HP CHI

Adults eating enough fruits & vegetables



HP CHI

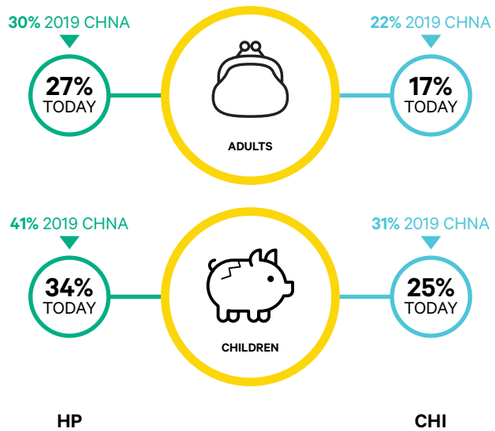
People with chronic conditions that contribute to the life expectancy gap



HP CHI

"I like all the functions that we host in this community."

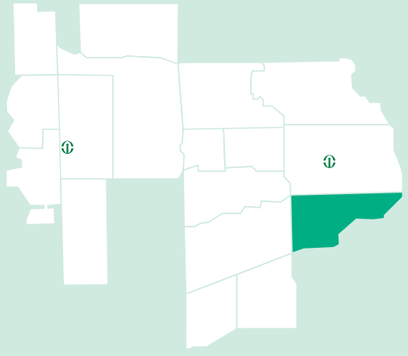
People living in poverty



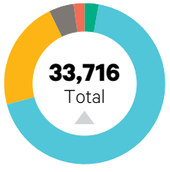
HP CHI

Lower West Side

60608

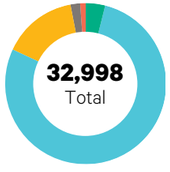


Race/Ethnicity†



TODAY

3% Black
68% Hispanic/Latino
22% White
5% AAPI
2% Other

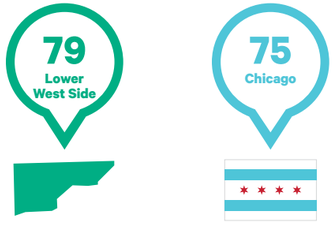


2019 CHNA

4% Black
78% Hispanic/Latino
15% White
2% AAPI
1% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy



COVID-19

Positivity rate
10%

Mortality rate
.20%

Vaccination rate
77%

"Pilsen is a mix of cultures from Mexico and of the people who come from other Latin American countries, which makes a very special community."

- **6** grocery stores
- **8** childcare centers
- **9** health care and **10** mental health facilities
- **1** pharmacy
- **9** public parks
- **9** public and private schools

Unemployment

LWS CHI

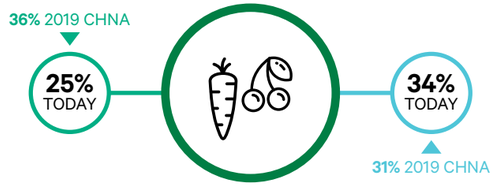
Moms getting good prenatal care

LWS CHI

People who feel safe in their community

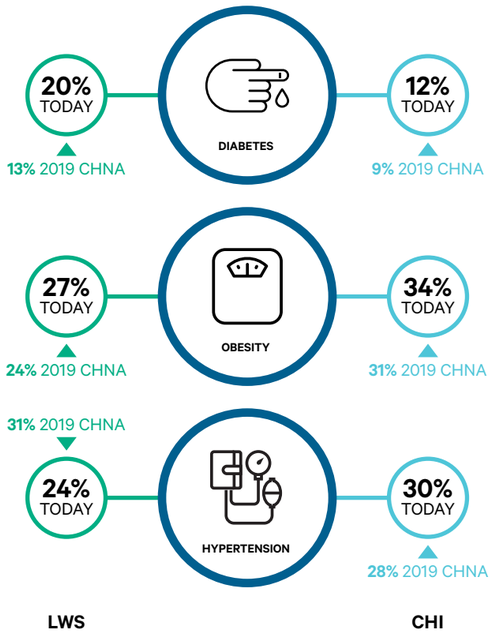
LWS CHI

Adults eating enough fruits & vegetables



LWS CHI

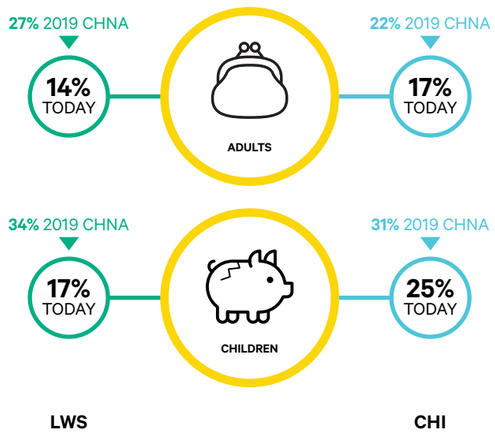
People with chronic conditions that contribute to the life expectancy gap



LWS CHI

"Our biggest challenges because of COVID-19 are jobs, depression, delinquency and violence. People are angrier these days, which leads to these challenges."

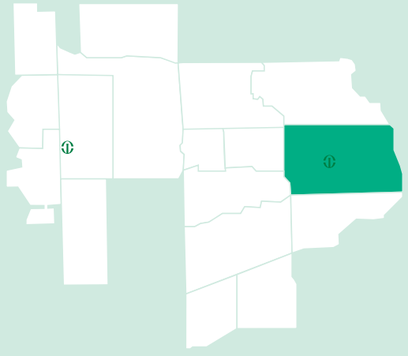
People living in poverty



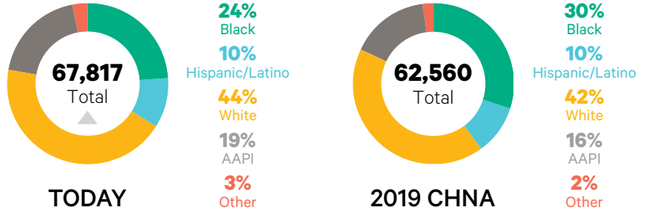
LWS CHI

Near West Side

60612, 60607

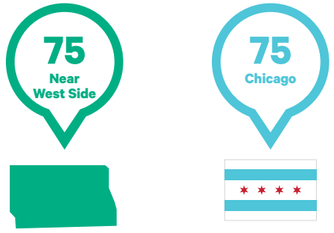


Race/Ethnicity†



*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy



COVID-19

Positivity rate
6%

Mortality rate
.06%

Vaccination rate
75%

"We used to have no playground; now we take pride in keeping it nice. We take pride in where we live, and we want new residents to enjoy it as well."

- **5** grocery stores
- **10** childcare centers
- **9** health care and **9** mental health facilities
- **8** pharmacies
- **20** public parks
- **21** public and private schools

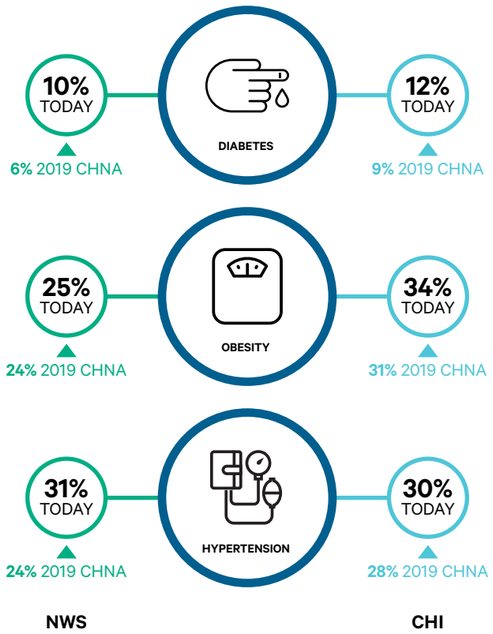
Unemployment

Moms getting good prenatal care

People who feel safe in their community

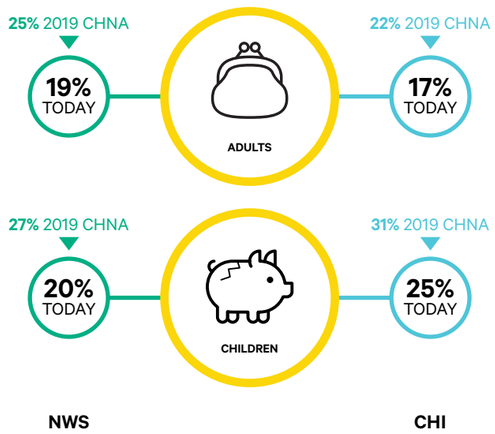
Adults eating enough fruits & vegetables

People with chronic conditions that contribute to the life expectancy gap



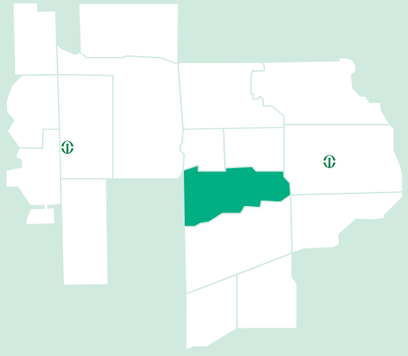
"The community is changing; low-income individuals are being pushed out, persons of color are being pushed out. The changes aren't for us, they're for the new people coming in."

People living in poverty

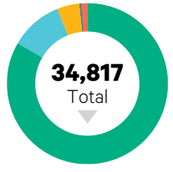


North Lawndale

60623

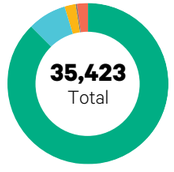


Race/Ethnicity†



TODAY

83% Black
11% Hispanic/Latino
5% White
<1% AAPI
1% Other

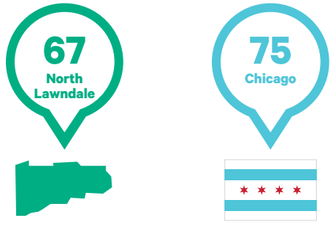


2019 CHNA

88% Black
8% Hispanic/Latino
2% White
<1% AAPI
2% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy



COVID-19

Positivity rate
7%

Mortality rate
.24%

Vaccination rate
55%

"Having the North Lawndale Employment Network here makes me feel proud."

- **2** grocery stores
- **3** childcare centers
- **9** health care and **4** mental health facilities
- **5** pharmacies
- **12** public parks
- **15** public and private schools

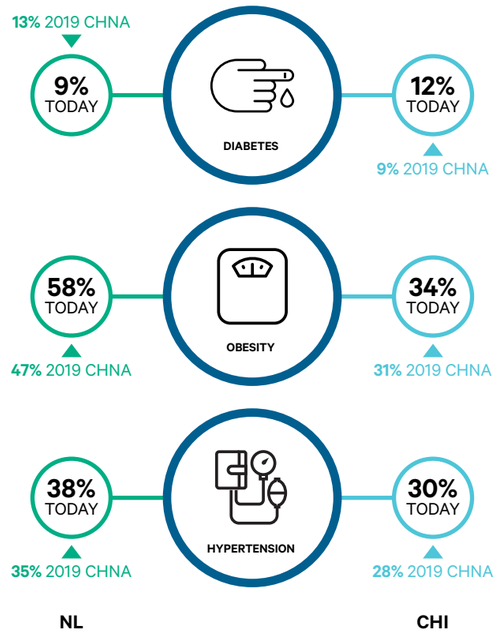
Unemployment

Moms getting good prenatal care

People who feel safe in their community

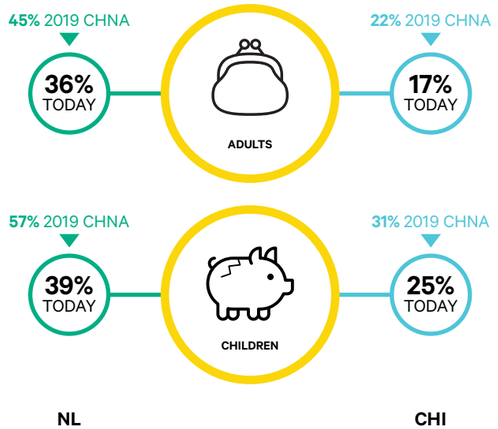
Adults eating enough fruits & vegetables

People with chronic conditions that contribute to the life expectancy gap



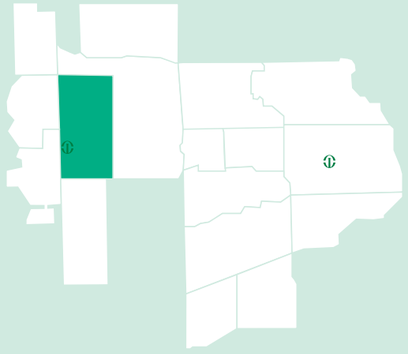
"Whole households had COVID-19 and a lot of people passed away. We have long-term mental health issues due to deaths. We have lost incomes. It was a devastating event in our communities."

People living in poverty

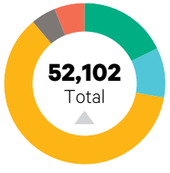


Oak Park

60301, 60302, 60303, 60304

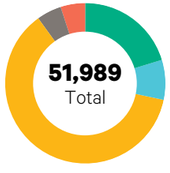


Race/Ethnicity†



TODAY

18% Black
10% Hispanic/Latino
61% White
5% AAPI
6% Other

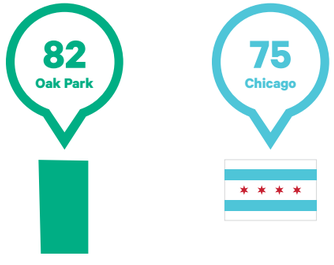


2019 CHNA

21% Black
8% Hispanic/Latino
62% White
5% AAPI
5% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy



COVID-19

Positivity rate
4%

Mortality rate
.09%

Vaccination rate
88%

"The pandemic actually helped a little bit with access to food — popup food pantries and organizations giving away food boxes."

- **5** grocery stores
- **7** childcare centers
- **19** health care and **10** mental health facilities
- **9** pharmacies
- **20** public parks
- **5** public and private schools

Unemployment

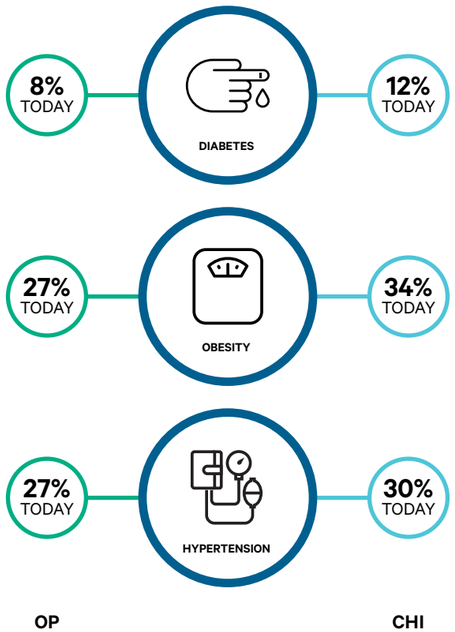
OP CHI

Moms getting late or no prenatal care

OP CHI

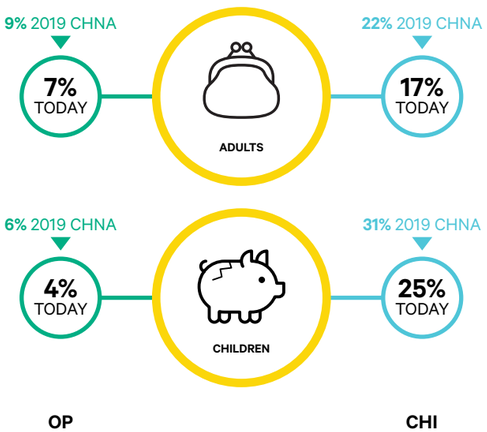
"We still have a lot of people out of a job. Even if you do have a job, there's still not a living wage. Rent is up, gas is up, light bills are up, and you're always two steps behind."

People with chronic conditions that contribute to the life expectancy gap



OP CHI

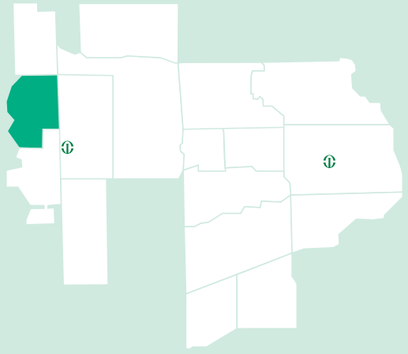
People living in poverty



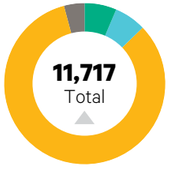
OP CHI

River Forest

60153, 60160

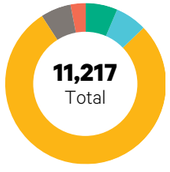


Race/Ethnicity†



TODAY

- 7% Black
- 7% Hispanic/Latino
- 83% White
- 4% AAPI
- <1% Other

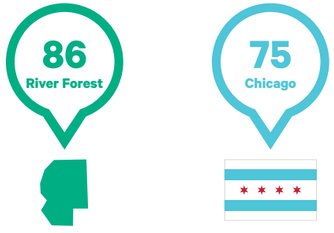


2019 CHNA

- 6% Black
- 6% Hispanic/Latino
- 78% White
- 6% AAPI
- 3% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy



COVID-19

Positivity rate
17%

Mortality rate
.02%

Vaccination rate
75%

"The pandemic had a big impact on children's mental health. They've been kept in for 18 months, and now they're experimenting with vaping, drugs, alcohol just to get out of the house."

- **3** grocery stores
- **8** childcare centers
- **4** health care and **3** mental health facilities
- **3** pharmacies
- **8** public parks
- **9** public and private schools

Unemployment

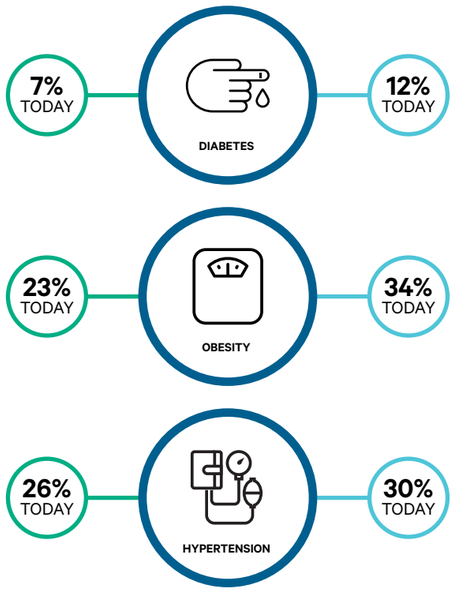
RF CHI

Moms getting late or no prenatal care

RF CHI

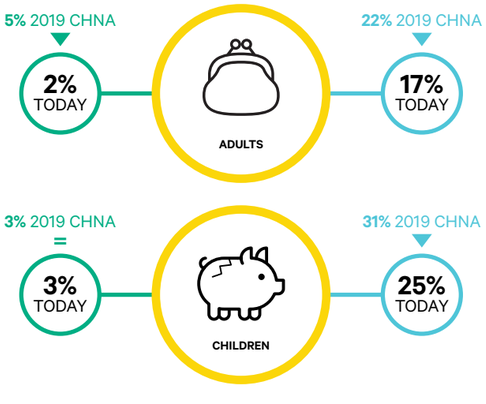
"It feels aging-friendly here, with a lot of community events for different age groups. There are tons of things for little ones at the library and the park district."

People with chronic conditions that contribute to the life expectancy gap



RF CHI

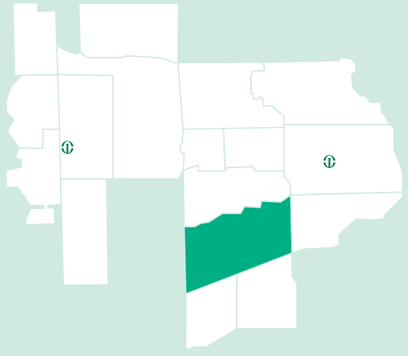
People living in poverty



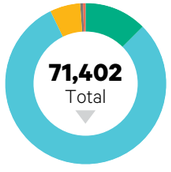
RF CHI

South Lawndale

60623

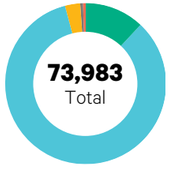


Race/Ethnicity†



TODAY

13% Black
81% Hispanic/Latino
6% White
<1% AAPI
<1% Other

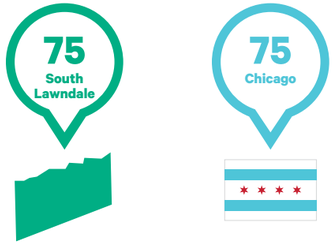


2019 CHNA

12% Black
84% Hispanic/Latino
3% White
<1% AAPI
<1% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy



COVID-19

Positivity rate
11%

Mortality rate
.27%

Vaccination rate
70%

"I love the spirit and unity of our community. It's like a family of families — a neighborhood where people look out and care for one another."

- **8** grocery stores
- **9** childcare centers
- **12** health care and **3** mental health facilities
- **5** pharmacies
- **8** public parks
- **18** public and private schools

Unemployment

SL CHI

Moms getting good prenatal care

SL CHI

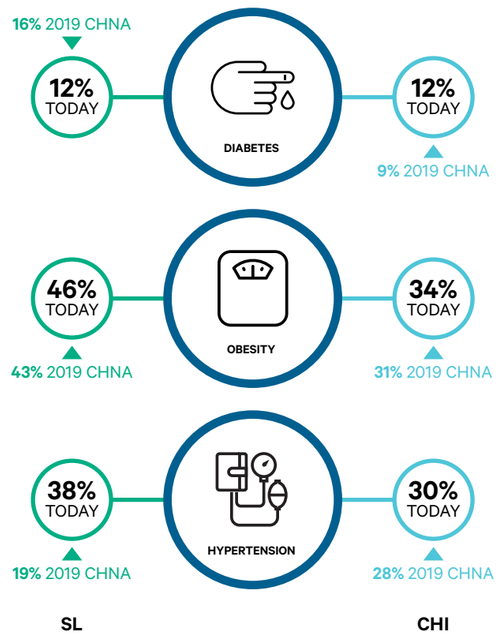
People who feel safe in their community

SL CHI

Adults eating enough fruits & vegetables

SL CHI

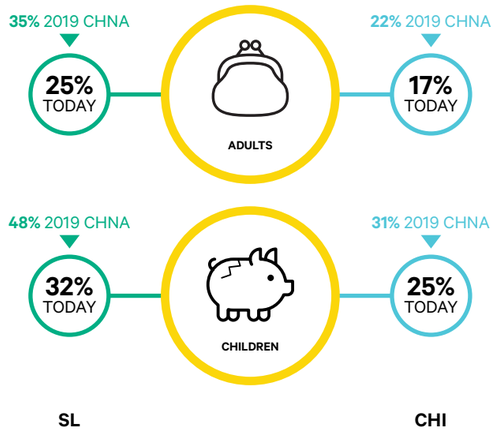
People with chronic conditions that contribute to the life expectancy gap



SL CHI

"Jobs block bullets. If we could get these kids good jobs and an education, do you think they'd be slinging crack on the corners?"

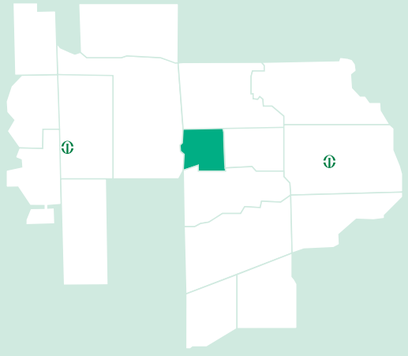
People living in poverty



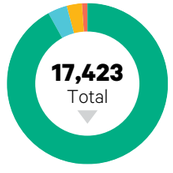
SL CHI

West Garfield Park

60624

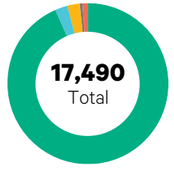


Race/Ethnicity†



TODAY

92% Black
4% Hispanic/Latino
3% White
<1% AAPI
1% Other

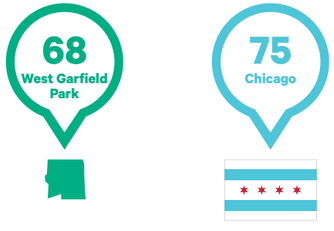


2019 CHNA

93% Black
2% Hispanic/Latino
2% White
<1% AAPI
1% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy



COVID-19

Positivity rate
6%

Mortality rate
.13%

Vaccination rate
54%

"The Boys and Girls Club really steps up. They have a mentoring program, and they come to the schools to see what's going on."

- **3** grocery stores
- **4** childcare centers
- **3** health care and **4** mental health facilities
- **3** pharmacies
- **5** public parks
- **5** public and private schools

Unemployment

WGP CHI

Moms getting good prenatal care

WGP CHI

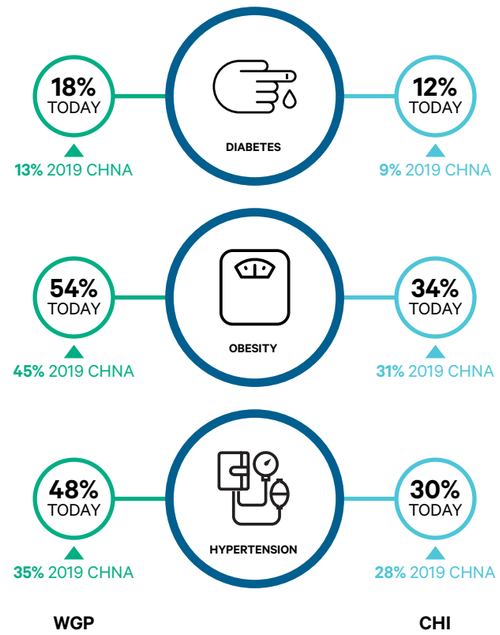
People who feel safe in their community

WGP CHI

Adults eating enough fruits & vegetables

WGP CHI

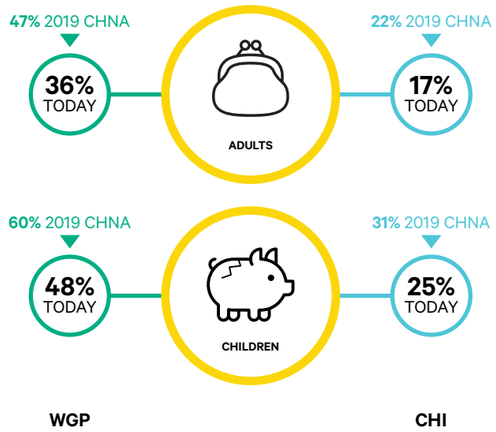
People with chronic conditions that contribute to the life expectancy gap



WGP CHI

"When someone invests in anything, they take care of it. When you don't feel taken care of, don't feel love and concern, that's why we have violence."

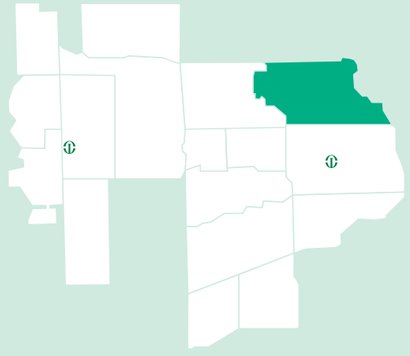
People living in poverty



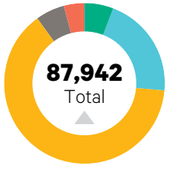
WGP CHI

West Town

60622

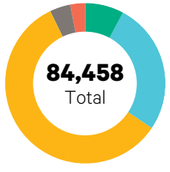


Race/Ethnicity†



TODAY

6% Black
21% Hispanic/Latino
64% White
6% AAPI
4% Other

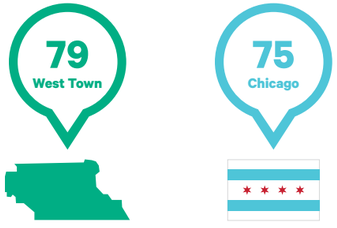


2019 CHNA

8% Black
27% Hispanic/Latino
59% White
4% AAPI
3% Other

*Percentages rounded; "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy



COVID-19

Positivity rate
7%

Mortality rate
.12%

Vaccination rate
80%

"We have good access to food, parks and outdoor spaces, which are valuable to everyone."

- **6** grocery stores
- **9** childcare centers
- **19** health care and **6** mental health facilities
- **7** pharmacies
- **16** public parks
- **26** public and private schools

Unemployment

WT CHI

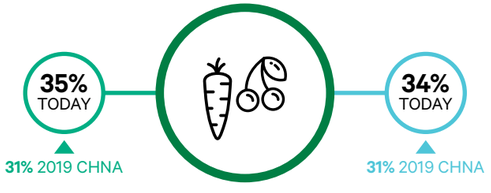
Moms getting good prenatal care

WT CHI

People who feel safe in their community

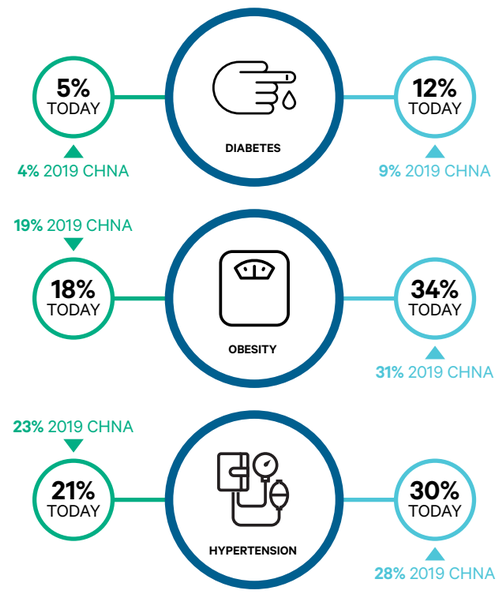
WT CHI

Adults eating enough fruits & vegetables



WT CHI

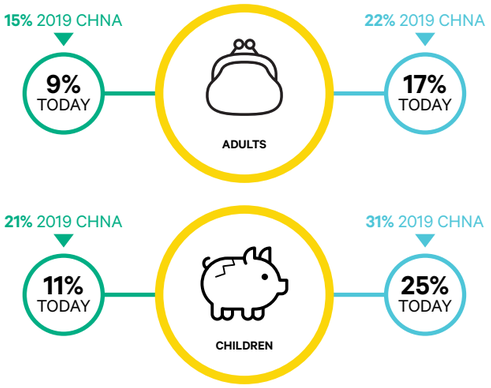
People with chronic conditions that contribute to the life expectancy gap



WT CHI

"Housing costs are a big issue — there are very few rentals and it's very expensive to rent or buy. People need to be able to stay here without getting priced out."

People living in poverty



WT CHI

What's next: RUSH Community Health Implementation Plan, FY2023-2025

Our examination of recent data and our community conversations both showed that our work toward our existing five CHIP goals needs to continue — not a surprise, since progress will take a sustained, coordinated effort by many partners. Please note that the goals now appear in order of their impact on the factors that contribute most to life expectancy gaps.

Over the next three fiscal years, we'll work with our partners to double down and strategically implement initiatives for achieving these goals.

- Prevent and/or manage chronic conditions and risk factors
- Increase access to mental and behavioral health services
- Reduce inequities caused by the social, economic and structural determinants of health
- Increase access to quality health care
- Improve maternal and child health outcomes

Our goals align with those adopted by the AHE, WSU, and the Chicago Hospital Engagement, Action and Leadership (HEAL) initiative. In the following pages, icons indicate where our work dovetails with that of the AHE (A), HEAL (H) and WSU (W).

The RUSH Community Health Implementation Plan, FY2023-2025

GOAL	STRATEGY	INITIATIVES	FY23 TARGET	FY24 TARGET	FY25 TARGET	TOTAL	MEASURES
GOAL 1 Prevent and/or manage chronic conditions and risk factors	**1.1 Reduce risk factors through assessments, education; focus on chronic disease** A W	**1.1.1** Provide evidence-based chronic disease self-management and falls prevention programming to older adults (age 55+)	200 enrolled, 75% completing/controlling condition in the program	200 enrolled, 75% completing/controlling condition in the program	200 enrolled, 75% completing/controlling condition in the program	600 enrolled, 75% completing/controlling condition in the program	# enrolled; % completing/controlling condition in the program
		1.1.2 Expand Health Legacy diabetes education/prevention programs to RUSH Oak Park, RUSH Copley	Plan/secure resources for FY24 launch	50 people enrolled, 75% complete program	125 people enrolled, 75% complete program	175 people enrolled, 75% complete program	# enrolled; % program completion
	1.2 Reduce risk factors through assessments, education, condition management programs; focus on hypertension/diabetes A W	**1.2.1** Screen community members for uncontrolled hypertension through Alive Faith Network; refer those in need to disease management program	300 screened, 12% referred	350 screened, 12% referred	350 screened, 12% referred	1,000 screened, 12% referred	# screened; % referred to management program
		1.2.2 Enroll people with uncontrolled hypertension in 6-month reduction program through Alive Faith Network; connect to community health workers (CHWs) for education	36 enrolled, 80% completing program; 5-point BP reduction; 10% connected to CHWs	42 enrolled, 80% completing program; 5-point BP reduction; 10% connected to CHWs	42 enrolled, 80% completing program; 5-point BP reduction; 10% connected to CHWs	120 enrolled, 80% completing program; 5-point BP reduction; 10% connected to CHWs	# enrolled; % completing program; BP reduction; % connected to CHWs
		1.2.3 Screen people with physical mobility limitations and refer to 6-month program to increase mobility	300 screened, 12% referred	300 screened, 12% referred	300 screened, 12% referred	900 screened, 12% referred	# screened; % referred
		1.2.4 Enroll 120 people with physical mobility limitations in 6-month mobility improvement program through Alive Faith Network	24 enrolled	48 enrolled	48 enrolled	120 enrolled	# enrolled
	1.3 Implement systemwide quality improvement/data action plan integrating racial equity A W	**1.3.1** Standardize systemwide training/implementation for collecting patient data (REaL, SOGI, SDOH)	Plan/secure resources for FY24 launch	50% of targeted staff trained	80%+ of targeted staff trained	85%+ of targeted staff trained	% of targeted staff trained; % of patients with complete REaL data
		1.3.2 Standardize process to derive insights from patient-reported data/clinical outcomes to recognize/address health disparities in vulnerable patient groups	Plan/secure resources; launch Spring 2023	N/A	N/A	N/A	Process launched, sustained, still operating in 2025
	1.4 Improve access to healthy food for patients screened as food-insecure A W	**1.4.1** Expand Food is Medicine program to ROPH; CHWs use NowPow to track meal recipients	100 patients receive food	150 patients receive food	200 patients receive food	450 patients served	# served
		1.4.2 Integrate QR codes for healthy recipes (created by RUSH University nutrition students) into meal boxes	10 recipes created for diabetes, hypertension, obesity	10 recipes created for diabetes, hypertension, obesity	10 recipes created for diabetes, hypertension, obesity	30 recipes created for diabetes, hypertension, obesity	# of recipes created/distributed
		1.4.3 Create Veggie Rx Pantry to provide meals for people screened as food-insecure and referred by PCPs	2,880 people referred to pantry through 6 clinics; serve 80% of those referred	4,320 people referred to pantry through 12 clinics; serve 90% of those referred	5,760 people referred to pantry through 12 clinics; serve 90% of those referred	12,960 people referred to pantry; serve 80% of those referred	# referred, % served
		1.4.4 Continue RUSH Food Surplus Program; donate 18,000 lbs. of food annually	18,000 lbs. donated	18,000 lbs. donated	18,000 lbs. donated	54,000 lbs. donated	# of lbs. donated in each delivery
		1.4.5 Partner with Community-based organizations (CBOs) and/or schools to create food and nutrition course	Partner with 1 CBO/school	Partner with 1 CBO/school	Partner with 1 CBO/school	3 partnerships developed	# of CBO/school partners

A = Alliance for Health Equity (AHE)
H = Chicago Heal Initiative (HEAL)
W = West Side United (WSU)

GOAL	STRATEGY	INITIATIVES	FY23 TARGET	FY24 TARGET	FY25 TARGET	TOTAL	MEASURES
GOAL 2 Increase access to mental and behavioral health services	**2.1 Increase community screenings and referrals to mental health services** A H W	**2.1.1** Provide therapy sessions to referred patients via RUSH outpatient community psychotherapy clinic	3,433 sessions provided	3,535 sessions provided	3,640 sessions provided	10,600 sessions provided	# of sessions provided
		2.1.2 Provide mental health screenings through Alive Faith Network	1,000 people screened; 70% linked to community resources	1,000 people screened; 75% linked to community resources	1,000 people screened; 80% linked to community resources	3,000 people screened; 75% linked to community resources	# screened; % linked to resources
		2.1.3 Provide mental health screenings to Chicago Public Schools students through RUSH School-Based Health Centers (SBHCs)	1,000 students screened; 65% receive additional support	1,000 students screened; 65% receive additional support	1,000 students screened; 65% receive additional support	3,000 students screened; 65% receive additional support	# screened; % receiving support
	2.2 Conduct community-based trainings — including train-the-trainer programs — in Mental Health First Aid (MHFA) A W	**2.2.1** Provide Mental Health First Aid facilitator training	10 people trained	25 people trained	25 people trained	60 people trained	# trained
		2.2.2 Train community members in MHFA/trauma-informed care; partner with violence prevention organizations	500 people trained; 20% also trained in violence prevention	700 people trained; 20% also trained in violence prevention	700 people trained; 20% also trained in violence prevention	1,900 people trained; 20% (380) also trained in violence prevention	# trained; % of people trained in violence prevention
	2.3 Increase access to behavioral health services via telehealth A H W	**2.3.1** Pilot technology distribution program to support telehealth access for youth	Research, develop plan, secure funding support for FY24 launch	Pilot tech distribution to support telehealth for up to 50 people	Evaluate progress with pilot; update to support 50-75 people	100 people in program	# of participants
		2.3.2 Advocate to: increase access for services; expand broadband for telehealth; increase Medicare/Medicaid reimbursement for mental health services; sustain telehealth flexibilities	Partner with WSU to research/develop plan for policy/advocacy approach	Launch advocacy efforts	Evaluate progress and update approach as needed; secure telehealth resources	Increased access for telehealth for high-need target group (screened and need tech to enable mental health services)	% of high-need group with access to telehealth
	2.4 Increase access to diverse, licensed mental health professionals A W	**2.4.1** Develop pipeline/fellowship opportunities for mental health professionals of color	Partner with Chicago State University to formalize program/ begin recruitment	Launch fellowship with 2 fellows	Fellowship active with 2 fellows	3 of 4 fellows completed program for licensure	# completing program for licensure

A = Alliance for Health Equity (AHE)
H = Chicago Heal Initiative (HEAL)
W = West Side United (WSU)

GOAL	STRATEGY	INITIATIVES	FY23 TARGET	FY24 TARGET	FY25 TARGET	TOTAL	MEASURES
GOAL 3 Reduce inequities caused by the social, economic and structural determinants of health	**3.1 Improve K-16 educational outcomes; provide support through workforce development, industry-recognized credentials, wraparound supports** H W	**3.1.1** Provide high school/college internships/apprenticeships	250 students intern/ apprentice	250 students intern/ apprentice	250 students intern/ apprentice	750 students interned/ apprenticed	# interning/apprenticing
		3.1.2 Increase student/family interest/awareness of STEM/health care topics/careers	5,000 students/ parents/ families participate in programs/workshops/ events	5,000 students/ parents/ families participate in programs/workshops/ events	5,000 students/ parents/ families participate in programs/workshops/ events	15,000 students/ parents/families participated in programs/ workshops/events	# participating
		3.1.3 Expand wraparound supports for students and families	90% of students/ families eligible for high-touch programs complete REACH health equity assessment tool/ receive eRx	90% of students/ families eligible for high-touch programs complete REACH health equity assessment tool/ receive eRx	90% of students/ families eligible for high-touch programs complete REACH health equity assessment tool/ receive eRx	90% of students/ families eligible for high-touch programs completed REACH health equity assessment tool/ received eRx	% completing assessment tool/receiving eRx
		3.1.4 Provide workforce training for young people through age 24 to earn industry-recognized credentials	75% of enrollees complete training and earn credentials	75% of enrollees complete training and earn credentials	75% of enrollees complete training and earn credentials	75% of enrollees completed training and earned credentials	% completing training and earning credentials
		3.1.5 Provide college/career readiness enrichment to under-represented youth	90% of REACH participants enroll in post-secondary options; 75% persist	90% of REACH participants enroll in post-secondary options; 75% persist	90% of REACH participants enroll in post-secondary options; 75% persist	90% of REACH participants enrolled in post-secondary options; 75% persisted	% persisting in post-secondary completion
	3.2 Collaborate to address workforce development, maximize income and benefits, increase financial literacy/ asset-building H W	**3.2.1** Expand workforce development/ stackable credentials training for staff/community members to prepare for living-wage jobs	Launch up to 3 stackable credentials aligned with family-sustaining wages; enroll 50 community members and incumbent staff; 70% of those eligible earn credentials	25 community members and incumbent staff enrolled in credentials program; 70% of those eligible earn credentials	50 community members and incumbent staff enrolled in credentials program; 70% of those eligible earn credentials	125 community members and incumbent staff enrolled in credentials program; 70% of those eligible earn credentials; 60%+ increase in wages/ shift to living wages (per MIT living wage calculator)	# of enrolled students; % earning credentials; % increase in wages
		3.2.2 Work with partners to develop/ implement community-wide workforce development initiatives to increase employment access and opportunities	Collaborate with 3 community partners; target 18.5% of new hires to local communities	Collaborate with 3 community partners; target 20% of new hires to local communities	Collaborate with 3 community partners; target 20% of new hires to local communities	Collaborated with up to 9 community partners to implement initiatives	# of collaborating organizations; % of participants hired
		3.2.3 Work with partners to create/ implement community-wide workforce development initiatives to increase job stability	Collaborate with 3 community partners; refine plan for partnership (sourcing, educating, placing candidates); align target with system workforce needs; recruit high-need openings from community partners	Collaborate with 3 community partners; develop system playbook for partnership; recruit high-need openings from community partners	Collaborate with 3 community partners; refine and update playbook; recruit high-need openings from community partners	Collaborated with 9 community partners in target communities with moderate/higher than average unemployment; created systemwide community partner/ workforce development playbook; placed 75% of sourced candidates	# of collaborating organizations; # of community members sourced; % placed and hired

A = Alliance for Health Equity (AHE)
H = Chicago Heal Initiative (HEAL)
W = West Side United (WSU)

GOAL	STRATEGY	INITIATIVES	FY23 TARGET	FY24 TARGET	FY25 TARGET	TOTAL	MEASURES
GOAL 3, continued Reduce inequities caused by the social, economic and structural determinants of health	**3.3 Identify social determinants of health (SDOH) through screenings; refer those in need of social services** A W	**3.3.1** Adopt systemwide approach to SDOH screening; roll out to RUMC, ROPH and RCMC; connect people with unmet needs (food, transportation, housing) to resources: social work referrals, community resource navigation	40,000 patients screened; 75% of those with needs receive interventions	40,000 patients screened; 75% of those with needs receive interventions	40,000 patients screened; 75% of those with needs receive interventions	120,000 patients screened; 75% of those with needs received interventions	# screened; % receiving corresponding intervention within 1 month
		3.3.2 Conduct screening through West Side Health Equity Collaborative (Medicaid Transformation initiative); provide resource navigation to community-based organizations	1,500 people screened; 85% screening positive for unmet needs receive interventions	1,500 people screened; 90% screening positive for unmet needs receive interventions	1,500 people screened; 95% screening positive for unmet needs receive interventions	4,500 people screened; 90% screening positive for unmet needs receive interventions	# screened; % reduction in needs; % receiving interventions within 1 month of screening positive
		3.3.3 Integrate SDOH screening into community-based programming; create sustainable partnerships with CBOs to facilitate direct social service referrals	Partner with 1 CBO; 80% of referred patient needs addressed	Partner with 1 CBO; 80% of referred patient needs addressed	Partner with 1 CBO; 80% of referred patient needs addressed	3 partnerships created; 80% of referred patient needs addressed	% of successful referrals; % of patients with referred needs addressed/ mitigated
	3.4 Leverage coalition-building and partnerships for collective impact to advance health equity H	**3.4.1** Serve as active member/strategic lead in collaboratives to maximize impact; partner with WSU, Garfield Park Rite to Wellness, CHRRGE, Chicagoland Healthcare Workforce Collaborative, HEAL Initiative, Racial Equity Rapid Response Team	Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups	Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups	Participate in meetings; provide capacity-building support; co-lead or lead	Participated in meetings; provided capacity-building support; co-led or led committees/working groups	# of meetings; amount of support provided; # of committees/working groups co-led or led
		3.4.2 Launch Phase II of RUSH BMO Institute for Health Equity (community programs and clinical practices; policy; education; health equity research)	Participate in meetings; provide capacity-building support; co-lead or lead committees/ working groups	Participate in meetings; provide capacity-building support; co-lead or lead committees/ working groups	Participate in meetings; provide capacity-building support; co-lead or lead committees/ working groups	Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups	# of meetings; amount of support provided; # of committees/working groups co-led or led
	3.5 Increase spending with local businesses H W	**3.5.1** Identify spend categories; work with RUMC/ROPH department leads to determine spend that can be shifted to small vendors; host events to connect with small vendors	Identify 2-3 spend categories; develop capacity-building workshop series for vendors; pilot with 5-7 vendors	Identify 2-3 spend categories; select vendors	Identify 2-3 spend categories	8 spend categories identified	# spend categories identified; # of small business vendors in support program; # and % with new spend or increased spend (baseline TBD in FY23)
		3.5.2 Spend $15.3 million with West Side vendors	Spend $5.1 million	Spend $5.1 million	Spend $5.1 million	$15.3 million spent	$ spent with West Side vendors (identify 2 underrepresented communities per year for targeted spend)
	3.6 Increase investment in local communities H W	**3.6.1** Work with community partners (Women's Business Development Center, Chicago Supplier Minority Development Council, WSU) to strengthen local vendors' capacity	Participate in meetings; communicate with partners for vendor support opportunities (events, meetings, fairs)	Participate in meetings; communicate with partners for vendor support opportunities (events, meetings, fairs)	Participate in meetings; communicate with partners for vendor support opportunities (events, meetings, fairs)	Participated in meetings; communicated with partners for vendor support opportunities, (events, meetings, fairs)	# of meetings; # of events
		3.6.2 Make place-based investments; work with treasury and partner community development financial institutions to support investments in healthy food and wellness	Invest $1.33 million	Invest $1.33 million	Invest $1.33 million	$4 million invested	$ in place-based investments

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H = Chicago Heal Initiative (HEAL)
W = West Side United (WSU)

GOAL	STRATEGY	INITIATIVES	FY23 TARGET	FY24 TARGET	FY25 TARGET	TOTAL	MEASURES
GOAL 4 Increase access to quality health care	**4.1 Expand community clinical practices; partner with collaboratives to improve health status of Medicaid-insured and uninsured people** A H W	**4.1.1** Serve as clinical provider via city/regional initiatives (Connect Chicago/Congregate Testing, Health Equity Zones, CHHRGE)	Target and complete 8,000 SDOH screenings and health risk assessments (HRAs)	Target and complete 8,000 SDOH screenings and HRAs	Target and complete 8,000 SDOH screenings and HRAs	Target and complete 24,000 SDOH screenings and HRAs	# of people served (tested, vaccinated, other); # of Medicaid insured and uninsured residents in targeted ZIP codes with improved health status; % reduction of unnecessary utilization
		4.1.2 Partner with CBOs and health care organizations (HCOs) on state health care transformation initiative (West Side Health Equity Collaborative)	Connect with 13 CBOs and 9 HCOs, with 5% of total referrals	Partner with 1 more CBO and 5 more HCOs, with 5% of total referrals	Partner with 2 more CBOs and 3 more HCOs, with 5% of total referrals	Connect with 16 CBOs and 17 HCOs, with 5% of total referrals	# of connections to CBOs/ health care organizations; % of referrals
	4.2 Expand access to primary care; schedule primary care follow-up appointments for patients before discharge A W	**4.2.1** Inpatient navigator schedules 85% of appointments before patient is discharged, referring to CommunityHealth or partner agencies	80% of appointments scheduled; refer 350 people to CommunityHealth or partner agencies	83% of appointments scheduled; refer 350 people to CommunityHealth or partner agencies	90% of appointments scheduled; refer 350 people to CommunityHealth or partner agencies	85% of appointments scheduled; referred 1,050 people to CommunityHealth or partner agencies	% of appointments scheduled; # of referrals
	4.3 Maintain a highly qualified CHW team A W	**4.3.1** Select CHWs to complete chronic disease self-management program (CDSMP) training; lead CDSMP sessions with 10 community partners	3 CHWs complete training; lead up to 9 sessions with community partners	2 CHWs complete training; lead up to 9 sessions with community partners	1 CHW completes training; leads up to 9 sessions with community partners	6 CHWs completed training; led up to 27 sessions with community partners	# of CHWs completing training; # of CHW-hosted or co-hosted CDSMP sessions
		4.3.2 CHWs complete Malcolm X College CHW certificate program (offered during the work day at no cost to CHWs)	4 CHWs complete program	4 CHWs complete program	4 CHWs complete program	12 CHWs completed program	# of CHWs completing program
		4.3.3 Engage CHWs as frontline public health workers to connect people to nursing and social work services	Determine baseline for eligible referrals; refer 720 people	720 people referred	720 people referred	2,160 people referred	# of referrals; % of eligible referrals made successfully (determining data availability)
		4.3.4 Develop meaningful, sustainable connections to CHW services with 5 new community partners	1 new partner engaged	2 new partners engaged	2 new partners engaged	5 new partners engaged	# of new partnerships
		4.3.5 Host community events to provide health education and promotion, resource coordination, care navigation, other services (financial literacy, public benefits enrollment)	Host quarterly events to reach up to 400 people	Host quarterly events to reach up to 400 people	Host quarterly events to reach up to 400 people	At least 12 events hosted, reaching up to 1,200 people annually	# of events hosted; # of attendees per session; # of partner/ co-host departments or organizations
		4.3.6 Expand CHW integration into SBHCs to increase access to wraparound supports	Support 33 families and connect to services	Support 33 families and connect to services	Support 34 families and connect to services	100 families supported and connected to services	# of families supported and connected to services

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GOAL	STRATEGY	INITIATIVES	FY23 TARGET	FY24 TARGET	FY25 TARGET	TOTAL	MEASURES
GOAL 5 Improve maternal and child health outcomes	**5.1 Invest, develop and participate in two-generation initiatives to support whole-family health** A H W	**5.1.1** Partner with WSU, Sinai Urban Health Institute, CDPH to support East Garfield Park Best Babies Zone to improve birth outcomes in East Garfield Park	Hold 8 advisory team meetings; disseminate storytelling project; develop strategic plan; add 2 residents at large and 1 representative from another sector to advisory team	Hold 8 advisory team meetings; identify project to pursue; secure grant funding for project	Hold 8 advisory team meetings	24 advisory team meetings held	% of advisory team members attending each meeting (goal: 70%); complete/execute strategic plan; complete team project; $ in grant/ organization funding secured
		5.1.2 Continue participation in Family Connects Chicago for nurse home visits to families with newborns, health checks, SDOH screening and referrals	800 families served; 75% connected to additional resources	880 families served; 80% connected to additional resources	960 families served; 85% connected to additional resources	2,640 families served; 80% connected to additional resources	# of home visits delivered; % of families connected to resources
	5.2 Partner with community-based organizations to expand behavioral health initiatives that promote relational health A H W	**5.2.1** Use Adverse Child Experiences screening to identify pregnant/parenting people affected by childhood trauma; offer evidence-based home visiting plus connections to programs and other parenting supports	Serve 100 families; refer 50% successfully to supports	Serve 110 families; refer 55% successfully to supports	Serve 120 families; refer 60% successfully to supports	330 families served; 55% referred successfully to supports	# and % of families successfully referred to supports
		5.2.2 Continue developing Building Early Connections: behavioral health support/parenting groups for families; behavioral health training/consultation support for childcare providers	Serve 800 families and 15 childcare providers	Serve 900 families and 15 childcare providers	Serve 1,000 families and 15 childcare providers	2,700 families and 45 childcare providers served	# of families receiving support; # of childcare providers receiving training and support
		5.2.3 Provide CHW support for 300 pregnant/postpartum people seeking emergency department care: identify/ support linkages to primary/obstetric/specialty care; connect people to parenting support programs; determine resources to support unmet social needs	Support 100 people; connect 75% of their families to additional resources	Support 100 people; connect 80% of their families to additional resources	Support 100 people; connect 85% of their families to additional resources	300 people supported; 80% of families connected to additional resources	# of people supported, % of families connected to additional resources

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The CHNA and CHIP are part of RUSH's mission to support the vitality and well-being of our communities. For more information about RUSH's community engagement mission and activities, and to see future supplements to this document as they are posted, visit RUSH.edu/chna.

We welcome input from everyone in the community. If you have questions or comments, please contact us:

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