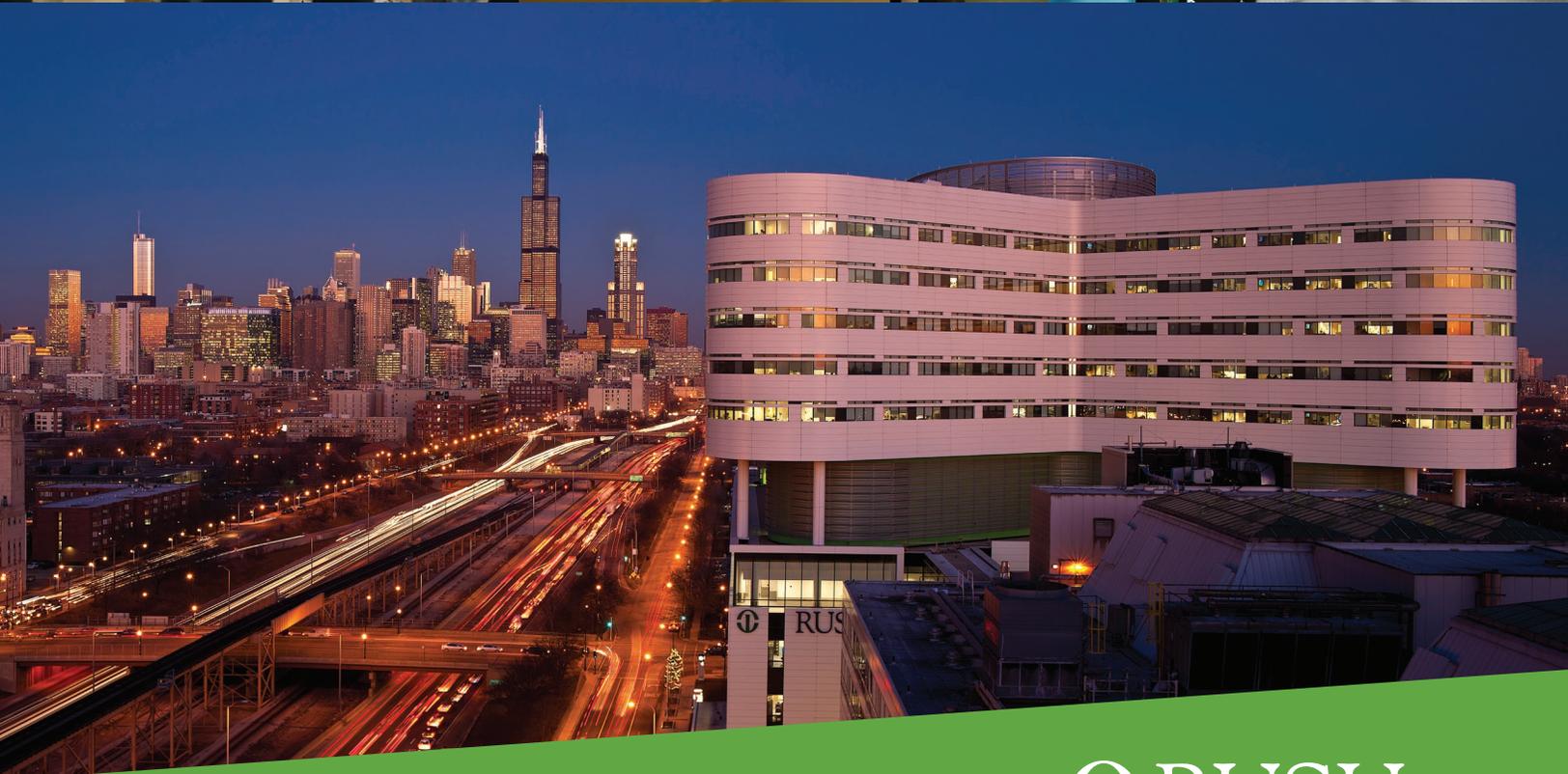
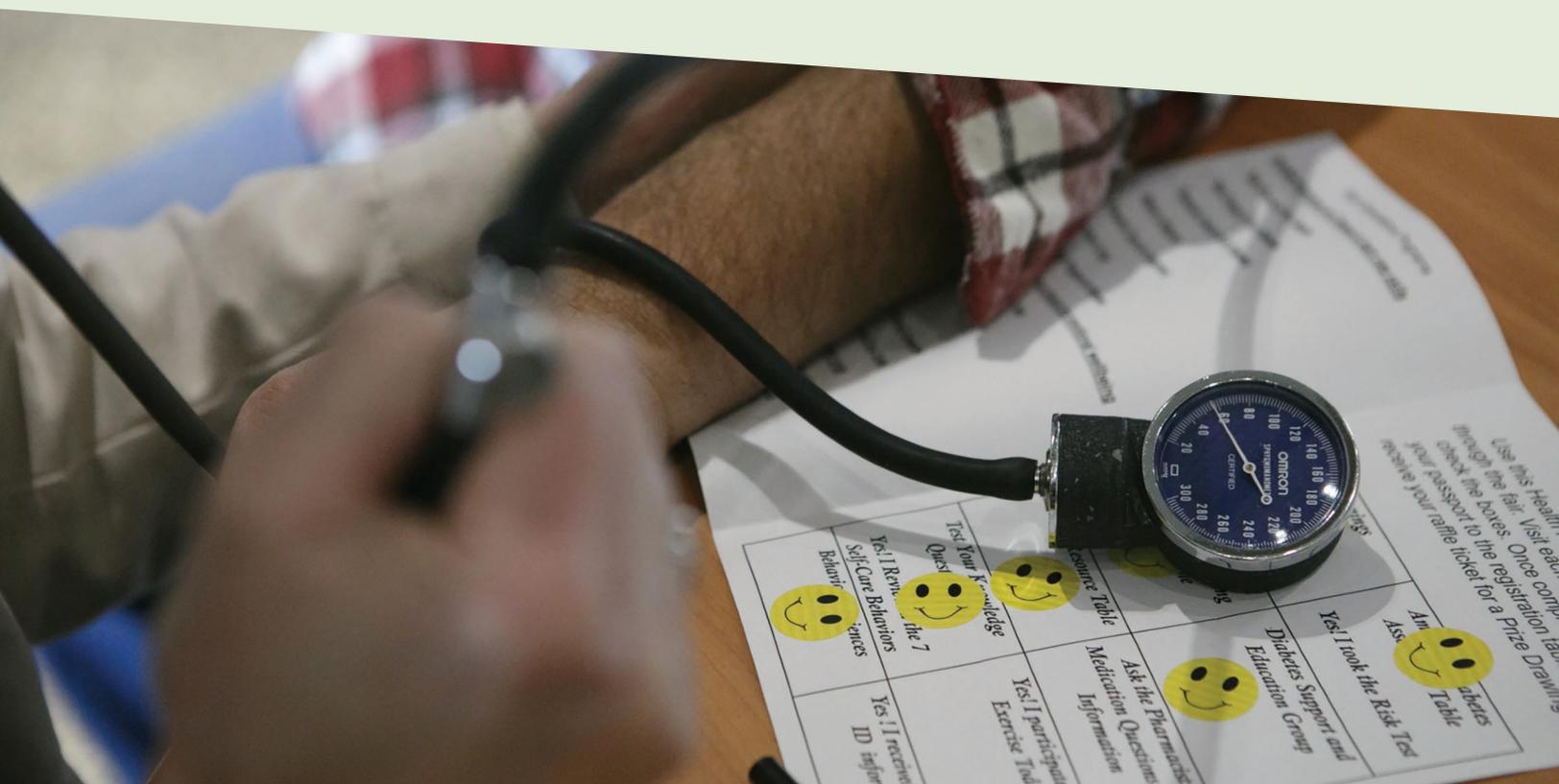


# Rush Community Health Implementation Plan 2017-2019



The mission of Rush University Medical Center and Rush Oak Park Hospital — together known as Rush — 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.

Our vision is that Rush will be the leading academic health system in the region and nationally recognized for transforming health care.



# Introduction

## Lessons Learned

For more than 175 years, Rush has been dedicated to delivering health care to diverse communities in the Chicago area.

Our first Community Health Implementation Plan (CHIP), created in 2013 and covering fiscal years 2014–2016, highlighted a number of programs through which we worked to improve the health of people in the communities we serve.

In those programs, many of which are ongoing, Rush physicians, nurses, students and employees work in partnership with dozens of neighborhood clinics, hospitals, schools and social services agencies to deliver care when and where people need it. We also nurture healthy communities by providing health education and programs for people interested in health care careers.

Between fiscal years 2014 and 2016, we served more than 588,402 people through 226 community partnerships and 281 programs, with a total value to the community of more than \$23 million.

We learned several important lessons as we created and carried out these initiatives.

**First**, despite all of our programs, outreach, investments and good intentions, health inequities persist in the communities surrounding Rush. Health inequities are systematic differences in the health status of different population groups. These differences have significant social and economic costs to individuals and to societies.<sup>1</sup>

**Second**, to decrease these inequities and improve the health of people and communities, we must address the complex social, economic and structural determinants of health that we highlighted in Rush's most recent Community Health Needs Assessment (CHNA). On Chicago's West Side, these determinants



include structural racism, economic deprivation, substandard housing, violence and a failing educational system, among other issues. These factors have a strong influence on how healthy a person is.<sup>2</sup> The lower a person's socioeconomic position, the higher his or her risk of poor health. To reduce hardship and health inequities, any CHIP must ultimately address these underlying structural issues.

**Third**, we must concentrate and align Rush's available resources so they will have the greatest impact.

**Fourth**, the issues identified in our CHNA are so significant that they cannot possibly be solved in the three years that this CHIP covers. Instead, they require a long-term strategy that will extend over multiple CHIPs. This gives us the chance to think broadly and boldly about what it will take to achieve measurable results and build healthy communities.

<sup>1</sup> "10 Facts on Health Inequities and Their Causes," World Health Organization, October 2011. Retrieved 9.28.16 at [http://www.who.int/features/factfiles/health\\_inequities/en/](http://www.who.int/features/factfiles/health_inequities/en/).

<sup>2</sup> World Health Organization, October 2011.

**Fifth**, we need to track our progress by testing and measuring so we can learn what really works. We will be able to see which interventions have the most impact, and can use what we learn to refine our tactics and programs to make them more effective.

**Finally**, community health improvements will require extraordinary leadership; the engagement of both the public and private sectors; and strong guidance from people in the community.

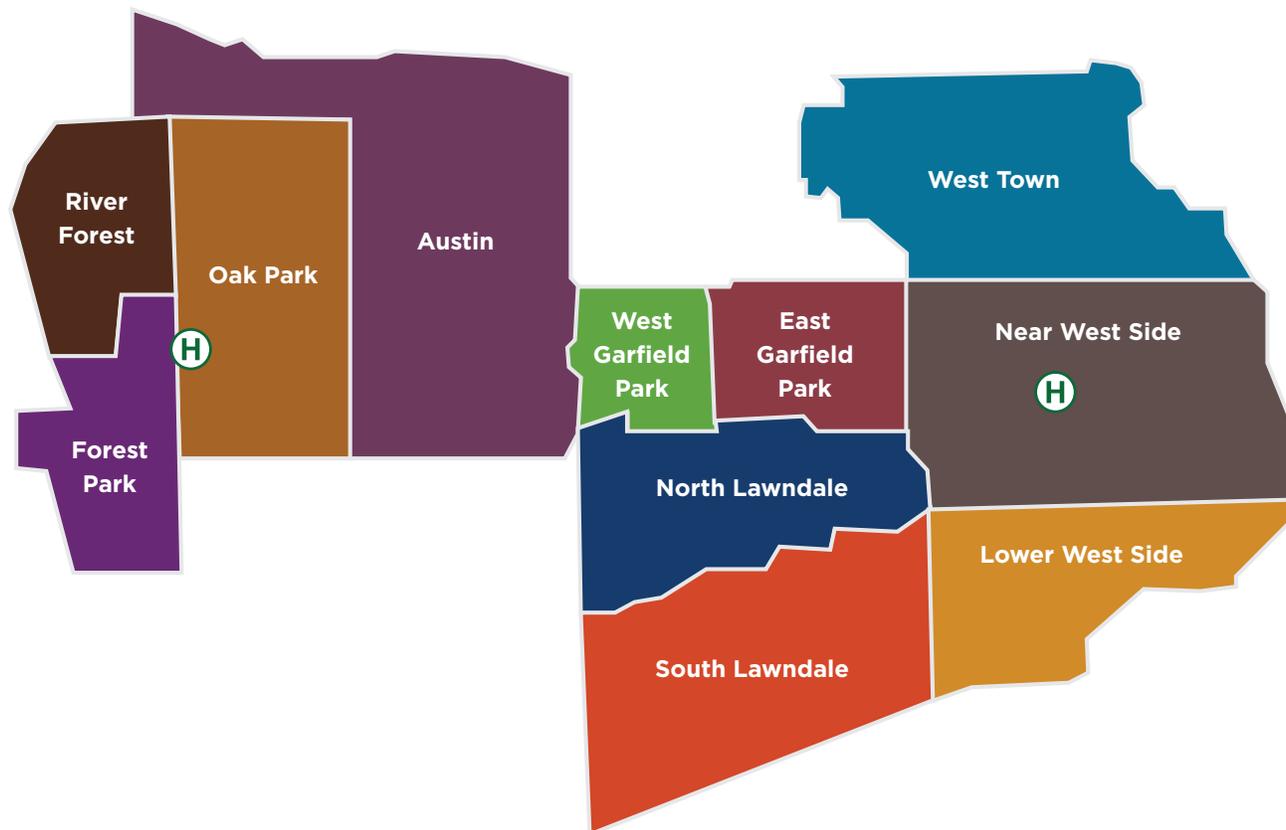
In light of these lessons, we have created this CHIP for fiscal 2017-2019 to do the following:

- Be the first in a series of linked CHIPs that will inform one another over the next decade or more.
- Identify short-term outcomes that will build toward larger, long-term goals of Rush's strategy to be an anchor for community health and vitality (see p. 13 for more details).
- Use the data collected in our CHNA to prioritize the communities of need in Rush's service area — those that have the highest levels of hardship and therefore need the most resources.
- Focus Rush's efforts on the people most in need in each community: children, young adults and people with chronic illnesses.
- Expand, retool, align and invest in existing programs that focus on community health.
- Highlight a partial list of potentially promising solutions for each need we've identified, while also recognizing that we need to create a comprehensive evaluation strategy to help us understand what works and what does not.
- Offer ways that community members can help us design, implement and evaluate these solutions.



# Rush's 2017 – 2019 Community Health Needs Assessment

In 2016, in accordance with Section 501(r)(3) of the Internal Revenue Code, we conducted our second CHNA to understand the needs of the 11 communities in the Rush service area:



We collaborated on the CHNA with key Rush stakeholders and with the Health Impact Collaborative of Cook County, a group convened by the Illinois Public Health Institute and consisting of 26 hospitals, seven health departments and more than 100 community-based organizations.

Working together, we identified the following four main needs in the Rush service area:

- Reducing inequities caused by the social, economic and structural determinants of health.
- Improving access to mental and behavioral health services.
- Preventing and reducing chronic disease by focusing on risk factors.
- Increasing access to care and community services.

These needs translate into the four goals addressed in this CHIP. To achieve them, we will continue to work closely with other health care institutions, businesses, government agencies and community-based organizations — and, where needed, we will advocate for systemic change. To implement the strategies we outline, it is also critical that we work with the people living in these communities. Their voices, needs and thoughts must be a significant driver of the work.

# Improving Community Health

## Goals and Implementation Strategies

<p><b>Goal</b></p> <p>Reduce inequities caused by the social, economic and structural determinants of health</p>		
<p><b>Strategies</b></p> <p>Improve educational attainment</p> <p>Identify, measure and mitigate the social determinants of health among those at risk — particularly children, young adults and people with chronic illnesses</p> <p>Participate in regional community health improvement collaboratives</p>		
		
<p><b>Goal</b></p> <p>Improve access to mental and behavioral health services</p>	<p><b>Goal</b></p> <p>Prevent and reduce chronic disease by focusing on risk factors</p>	<p><b>Goal</b></p> <p>Increase access to care and community services</p>
<p><b>Strategies</b></p> <p>Address psychological trauma through screening tools and referral programs in school-based health centers and faith-based organizations</p> <p>Expand access to other screenings and services</p>	<p><b>Strategies</b></p> <p>Reduce risk factors through assessments, disease management programs and improved access to healthy food</p> <p>Expand free and subsidized screenings</p> <p>Develop and deliver community services to help people stop smoking</p>	<p><b>Strategies</b></p> <p>Expand access to primary care medical homes for people without insurance and for others without medical homes</p> <p>Implement adverse childhood event screenings and referrals at school-based health centers</p> <p>Expand access to insurance</p>

**Goal**/Reduce inequities caused by the social, economic and structural determinants of health

**Strategy**/Improve educational attainment

The research is clear: Communities with higher levels of education are healthier. A high-quality education can lay the foundation for financial prosperity, which in turn can boost people's access to quality health care and improve their health outcomes.

But each year, thousands of low-income students in Chicago face barriers that prevent them from attending high-quality schools and having access to college. As a result, large achievement gaps remain between students from low-income families and their higher-income peers.

Rush currently partners with many middle schools and high schools in our service area, with varying degrees of success. We want to make these programs more effective.

Alongside partners that include Chicago Public Schools, community-based organizations, city colleges and businesses, Rush will focus on children between the ages of 11 and 18 to create a pipeline that guides interested students into postsecondary education and health care careers. To do this work, Rush will do the following:

- Choose three neighborhood middle schools that feed into three neighborhood high schools in one or more of the highest-need communities that Rush serves.
- Pilot or expand programs in these partner schools that provide evidence-based science and math curricula.
- Support the development of health sciences-related programs that create a bridge to college by allowing high school students to take college-level courses and receive college credit.
- Refine and strengthen Rush's internship programs that provide training in health sciences, health administration and health information technology.
- Participate in tutoring and mentorship programs that provide social and educational support.
- Evaluate all programs continuously to see which are working best, and invest additional resources in the programs that have the most impact.



**How we'll measure our progress** / In fiscal year 2017, we plan to evaluate and retool our existing education-based programs and identify the neighborhoods and schools with the highest need. Then, in fiscal year 2018, we will begin to implement our updated education strategy. While it will take time to achieve measurable results, our ultimate aim is to see improvements in the following measures of educational success in Rush's partner schools:

- Students' expectations of attending college compared to those who don't participate in our programs.
- Students' self-confidence compared to those who don't participate in our programs.
- Standardized test scores in science and math.
- Overall grade point averages.
- High school graduation rates.
- College access, enrollment and persistence.
- A reduction in the achievement gap between Rush's partner schools and the higher-performing schools in our surrounding communities.



**Strategy** / Identify, measure and mitigate the social determinants of health among those at risk — particularly children, young adults and people with chronic illnesses

In collaboration with other health care systems and community partners, Rush will develop a screening tool that we'll use to help identify the social and structural determinants of health that could be affecting our patients (such as drug and alcohol use; mental health; access to quality food, housing, transportation and health care; and feelings of safety in the community).

If the screening shows that a patient needs assistance in any of these areas, Rush will refer him or her to care providers, agencies and organizations that can help.

**How we'll measure our progress** / We plan to develop the screening tool by the end of fiscal year 2017 and implement it by the first quarter of fiscal year 2018, with the goal of screening and referring 25 percent of eligible patients by fiscal year 2019.

**Strategy** / Participate in citywide and countywide community health improvement collaboratives

We know that improving the social, economic and structural determinants of health is a much bigger task than Rush can achieve on its own. We will work with city and county agencies, other health systems

and community organizations through collaboratives that include the Health Impact Collaborative of Cook County, the Healthy Chicago Hospital Collaborative, Healthy Chicago 2.0 and Cook County WePlan.

**How we'll measure our progress** / We will work with these partners to create ways to collect and share health data at the community level and among health systems.

In fiscal years 2017-2019, we will also work together to create, each year, a regional approach to improving one or more of these social, economic and structural determinants of health: housing, transportation, food insecurity, access to utilities and safety.

**Goal** / Improve access to mental and behavioral health services

People who live in communities where poverty is concentrated are more likely than those who live in wealthier communities to suffer the psychological effects of trauma caused by abuse, neglect, family dysfunction, violence, discrimination, racism, poverty and use of drugs and alcohol. As outlined in our CHNA, violence is prevalent in all the communities in Rush's service area that show high levels of hardship — and it takes a toll on the physical and mental well-being of people living in those neighborhoods.

**Strategy** / Address psychological trauma through screening tools and referral programs in school-based health centers and faith-based organizations

To address the consequences of trauma and improve the health outcomes of people who have lived through it, we will take a “trauma-informed” approach to facilitating healing. This approach acknowledges the widespread impact of trauma; teaches people to recognize the signs of trauma in patients and families; and integrates what we know about the effects of trauma into Rush’s programs and practices.

**We plan to do the following:**

- Develop a school-based mental health screening, wellness and referral network in one or more of the neighborhoods in need that Rush serves.

**How we’ll measure our progress** / Each year, we will screen 500 students at Rush’s school-based health centers and refer those in need of additional care.

- Develop a church-based mental health screening, wellness and referral network for the churches that are part of Rush’s Clergy and Faith-Based Network.

**How we’ll measure our progress** / We will develop and pilot the program in fiscal year 2017, and we will roll it out to at least five partner churches each year.

**Strategy** / Expand access to screenings and services

**We plan to do the following:**

- Create a “Mental Health First Aid” program for one or more of the neighborhoods in need that Rush serves.

**How we’ll measure our progress** / Beginning in fiscal year 2017, each year we will train 200 community leaders, parents and teachers to recognize the signs of psychological disorders, and ensure that people who need help can get it.

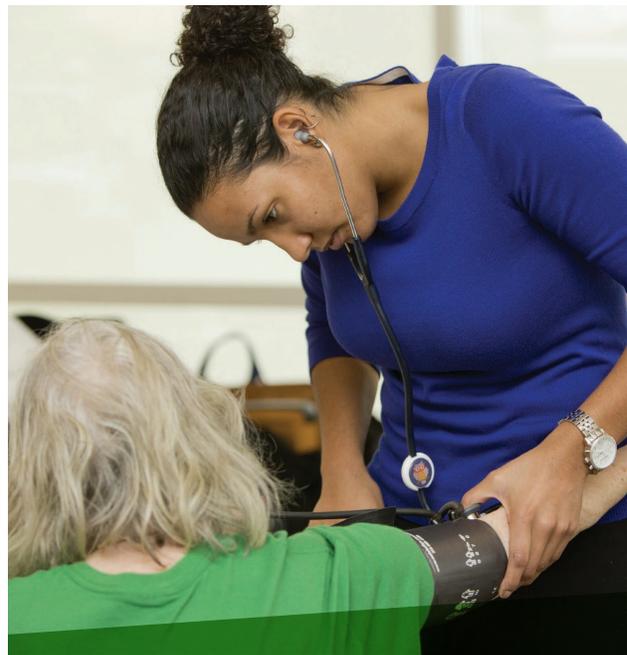
- Expand screenings and referrals for mental and substance use disorders for at-risk patients.

**How we’ll measure our progress** / We will screen and refer 100 at-risk patients in each year in the neighborhoods Rush serves.

**Goal** / Prevent and reduce chronic disease by focusing on risk factors and health education

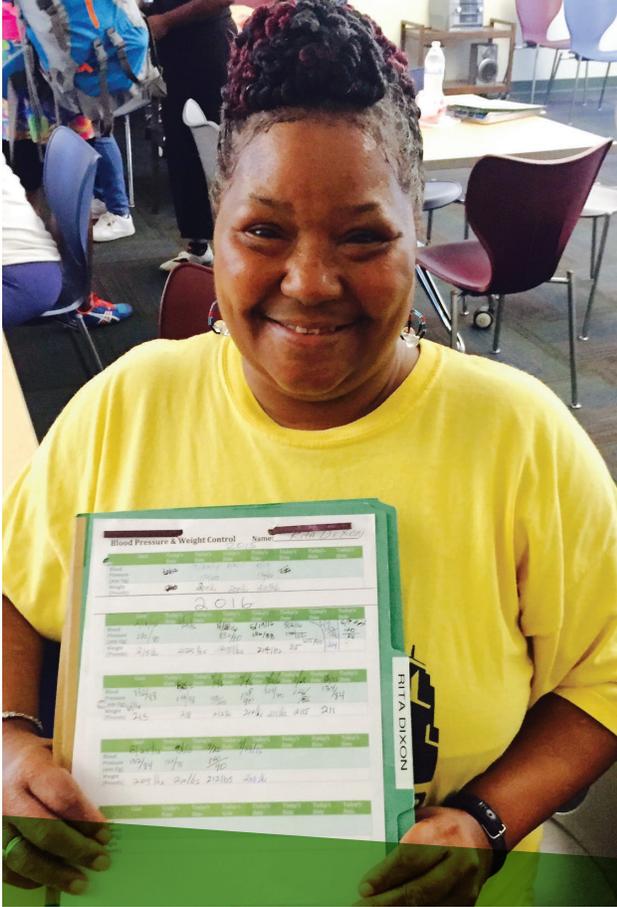
Chronic diseases and conditions such as heart disease, stroke, cancer, diabetes, respiratory disease and obesity are some of the health conditions that commonly affect people in Rush’s service area. These diseases are costly to treat — but they are also among the most preventable health problems.

**Strategy** / Reduce risk factors through assessments, chronic disease management programs for adults and improved access to healthy food



**We plan to do the following:**

- Work with faith communities to create more programs to help people reduce their cardiovascular and diabetes risk factors. We plan to build on the success of initiatives like Rush’s ALIVE Research Partnership and the Health Legacy Program — two faith-based programs that have helped members build healthier behaviors and reduce health disparities related to cardiovascular disease and Type II diabetes.



**How we'll measure our progress** / By fiscal year 2018, we will expand programs into at least one community of need in Rush's service area.

- Expand Rush Oak Park Hospital's Surplus Project — a food recovery and depository program — to Rush University Medical Center. Lack of access to reliable sources of healthy food is both a cause of food insecurity and a determinant of health that leads to a greater risk of adults developing high blood pressure, high cholesterol and diabetes. The Surplus Project currently repackages surplus food from the hospital for donation to the Oak Park River Forest Food Pantry.

**How we'll measure our progress** / We will donate food daily to our community partners for distribution to individuals and families in need.

- Expand health education programming for older adults through Rush Generations health promotion wellness programs and workshops that focus on chronic disease management.

**How we'll measure our progress** / By fiscal year 2018, we will expand programs into at least one community of need in Rush's service area and will hold community-based health fairs, health education events and workshops with free health screenings for at least 300 people.

## Strategy / Expand free and subsidized screenings

### We plan to do the following:

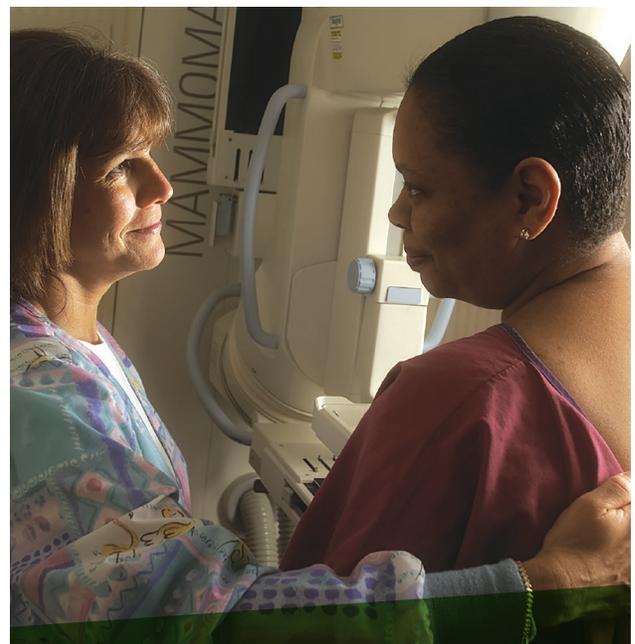
- Expand free and subsidized breast cancer screening, diagnosis and treatment programs for women without health insurance. Women in communities of need in Rush's service area receive fewer screening mammograms and have higher breast cancer mortality rates than those in wealthier neighborhoods.

**How we'll measure our progress** / Beginning in fiscal year 2017, Rush will provide screening, diagnosis and treatment services to at least 300 uninsured women annually.

## Strategy / Develop and deliver community services to help people stop smoking

### We plan to do the following:

- Integrate counseling and advice on stopping smoking into Rush's existing community service projects, using evidence-based programs like the Courage To Quit program currently offered through the Respiratory Health Association. One such program at a permanent housing facility for formerly homeless women, which includes health coaching for residents, has resulted in 57 percent of participants quitting smoking or reducing the amount they smoke.



**How we'll measure our progress** / We aim to measure a 10 percent decrease in tobacco use among adults who participate in our programs.

**Goal** / Increase access to care and community services

Many factors affect people's access to quality health care — for example, whether they have health insurance, the affordability of care and the availability of services.

Another factor can be the lack of a “medical home,” usually a primary care doctor who coordinates care. Often, people in underserved neighborhoods don't have a primary care doctor, so they seek care from multiple health care providers who are unable to share patient information with one another. The resulting fragmented care can be a barrier to getting and staying healthy because while it treats symptoms, it doesn't address the underlying and ongoing causes of poor health.

**Strategy** / Expand access to primary care medical homes for people without insurance and for others without medical homes

**We plan to do the following:**

- Ensure that all patients served at Rush — including the uninsured and those without medical homes — are referred to a primary care medical home at Rush, a community health clinic or another community-based health partner. Teams of Rush

social workers, nurses and patient navigators can help patients and their families connect with primary care medical homes for health maintenance visits after hospitalization or emergency room visits.

**How we'll measure our progress** / Each fiscal year, we will refer 150 people to a primary care medical home.

**Strategy** / Implement adverse childhood event screenings and referrals at school-based health centers

- Develop screenings for adverse childhood events such as abuse, neglect, domestic violence and parental substance use or incarceration. These screenings will be used at Rush's three school-based health centers, where advanced practice nurses, registered nurses, physicians and students from Rush University provide a full range of clinic services.

**How we'll measure our progress** / In fiscal year 2017, we will begin to use the tool and will screen 500 students.

**Strategy** / Expand access to insurance

- We will refer and/or enroll uninsured patients into insurance programs through Rush's school-based health centers, Adolescent Family Center and other community-based programs.

**How we'll measure our progress** / In fiscal year 2017, we will develop a process for referring and enrolling the uninsured, and will set baseline numbers for fiscal years 2018 and 2019.



<b>GOAL</b>	<b>Reduce inequities caused by the social, economic and structural determinants of health</b>
<b>STRATEGY</b>	Improve educational attainment
<b>MEASURES</b>	Fiscal year 2017 / Evaluate and retool existing programs; identify neighborhoods and schools with the highest need Fiscal year 2018 / Implement updated strategy and begin tracking improvements in the seven areas enumerated on Page 7
<b>STRATEGY</b>	Identify, measure and mitigate the social determinants of health among those at risk – particularly children, young adults and people with chronic illnesses
<b>MEASURES</b>	Fiscal year 2017 / Develop screening tool Fiscal year 2018 / Implement screening tool Fiscal year 2019 / Screen and refer 25 percent of eligible patients
<b>STRATEGY</b>	Participate in regional community health improvement collaboratives
<b>MEASURES</b>	Fiscal year 2017+ / Collect and share health data Fiscal years 2017-2019 / Annually create a regional approach to improving one or more social, economic and structural determinants of health
<b>GOAL</b>	<b>Improve access to mental and behavioral health services</b>
<b>STRATEGY</b>	Address psychological trauma through screening tools and referral programs in school-based health centers and faith-based organizations
<b>MEASURES</b>	Fiscal year 2017 / Begin screening 500 students annually at Rush’s school-based health centers; develop and pilot church-based mental health screening, wellness and referral network Fiscal year 2017+ / Roll out church-based screening to at least five partner churches annually
<b>STRATEGY</b>	Expand access to other screenings and services
<b>MEASURES</b>	Fiscal year 2017+ / Train 200 community members in “Mental Health First Aid”; screen and refer 100 at-risk patients for mental health and substance abuse annually
<b>GOAL</b>	<b>Prevent and reduce chronic disease by focusing on risk factors</b>
<b>STRATEGY</b>	Reduce risk factors through assessments, disease management programs and improved access to healthy food
<b>MEASURES</b>	Fiscal year 2017+ / Donate food daily for distribution to people in need Fiscal year 2018+ / Create faith-based programs in at least one community of need to help people reduce cardiovascular and diabetes risk factors; expand education and screening programs into at least one community of need and hold events for at least 300 people
<b>STRATEGY</b>	Expand free and subsidized screening
<b>MEASURES</b>	Fiscal year 2017+ / Provide breast cancer screening, diagnosis and treatment services to at least 300 uninsured women annually
<b>STRATEGY</b>	Develop and deliver community services to help people stop smoking
<b>MEASURES</b>	Fiscal year 2017+ / Integrate counseling into existing community service projects with goal of achieving 10 percent decrease in tobacco use among participants
<b>GOAL</b>	<b>Increase access to care and community services</b>
<b>STRATEGY</b>	Expand access to primary care medical homes for people without insurance and for others without medical homes
<b>MEASURES</b>	Fiscal year 2017+ / Refer at least 150 people to primary care medical homes
<b>STRATEGY</b>	Implement adverse childhood event screenings and referrals at school-based health centers
<b>MEASURES</b>	Fiscal year 2017+ / Develop screenings for adverse childhood events and screen 500 students annually at school-based health centers
<b>STRATEGY</b>	Expand access to insurance
<b>MEASURES</b>	Fiscal year 2017 / Develop process for referring and enrolling the uninsured; set baseline numbers for fiscal years 2018 and 2019

# Conclusion

## Looking Ahead



Rush's 2017–2019 CHNA highlights many of the economic, educational and other challenges that exist in the communities we serve, and the ways in which those challenges affect the health of the people who live in our communities.

Using the data collected in the assessment, we created this accompanying CHIP to outline a strategy to begin to address these challenges right away while also laying out a long-term vision for improving the complex social, economic and structural determinants of health. In partnership with businesses, community-based organizations and community residents, this vision will help to define the focus of multiple Rush CHIP documents for years to come.

We recognize how important it is to work closely with the community as we design, implement and evaluate these strategies, because we know that community residents have some of the best insights and ideas about what can help make themselves and their communities healthier. To ensure that their voices, concerns and ideas for solutions inform our efforts, community-based organizations and individuals will be our partners in developing work plans. This collaborative approach gives us a unique opportunity to use the CHNA and CHIP process to gather diverse ideas and perspectives that will build healthy communities today and in the future.

# An anchor for community health on Chicago's West Side

As a cornerstone of its institutional mission and strategy, Rush has committed to improving the health of Chicago's West Side communities. The ultimate aim: to increase life expectancy, improve well-being and reduce hardship. This will require an unprecedented refocusing of our resources as the largest private employer on Chicago's West Side.

We will address the longstanding structural and social determinants of health in partnership with the city, other health care providers, business partners and the community, creating a total health collaboration focused on a strategy built around the following four broad dimensions of health:

- A robust and equitable health care system.
- A high-quality educational system.
- Economic vitality, including jobs and employment.
- The physical environment, including housing, safety, food and parks.



Equitable Health Care



Quality Education



Economic Vitality



Physical Environment

To address these dimensions, the strategy requires us to analyze and align the following:

- Our internal and external partnerships and programs.
- The way we conduct the business side of health care (human resources, vendor relationships, construction projects, impact investments, etc.).
- Our health care delivery system.



## Adoption of Implementation Plan

This plan supports and responds to the 2017-2019 Community Health Needs Assessment conducted by Rush University Medical Center and Rush Oak Park Hospital, and has been reviewed and adopted by the Rush Board of Trustees with the support of the board's Government and Community Affairs Committee.

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November 2016

