A Community Health Needs Report and Action Plan
FY2022 CHNA + FY2023-2025 CHIP

RUSH University Medical Center
RUSH Oak Park Hospital
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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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.

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.

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.

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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.*

<table>
<thead>
<tr>
<th>GOAL 1</th>
<th>REDUCE INEQUITIES CAUSED BY THE SOCIAL, ECONOMIC AND STRUCTURAL DETERMINANTS OF HEALTH</th>
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<tbody>
<tr>
<td>STRATEGY</td>
<td>Improve K-16 educational outcomes through skills development, internships and industry-recognized credentials</td>
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<tr>
<td>MEASURES</td>
<td>RESULTS</td>
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<tr>
<td>Provide high school and college apprenticeship/ internship programs that serve at least 750 students</td>
<td>560 students completed paid internship programs (participant numbers were reduced due to COVID-19)</td>
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<tr>
<td>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</td>
<td>11,449 students and 2,069 parents/community members served</td>
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<tr>
<td>Ensure that 75% of all participating high school students are on track to receive an industry-recognized credential</td>
<td>4,317 students (77% of paid interns) earned an industry-recognized credential</td>
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*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

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<th>MEASURES</th>
<th>RESULTS</th>
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<tr>
<td>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</td>
<td>38,191 people screened</td>
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<tr>
<td>Integrate social determinants of health screening into community-based programming, connecting with at least 9 partners</td>
<td>Connected with 4 partners before initiative was paused due to COVID-19</td>
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STRATEGY Increase local hiring and develop career ladders for employees

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<tr>
<td>Launch 4 career pathway programs, including medical assistant, nursing assistant, nursing and health IT, serving 1,255 people through WSU partner hospitals</td>
<td>63 RUSH employees served; 152 served through WSU. Funder has provided an additional year to reach the goal because of COVID-19 delays</td>
</tr>
<tr>
<td>Work with WSU toward its goal of employing 3,500 West Side community members across six partner hospitals</td>
<td>2,716 people hired across all hospitals; 876 people hired by RUSH</td>
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STRATEGY Increase spending with local businesses

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<tr>
<td>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)</td>
<td>18 vendor partnerships</td>
</tr>
<tr>
<td>RUSH University Medical Center will aim to increase its FY20 spending with West Side vendors by at least $4.2 million</td>
<td>More than $8 million spent</td>
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STRATEGY Increase investment in West Side communities

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<tr>
<th>MEASURE</th>
<th>RESULT</th>
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<tr>
<td>Invest $75 million in West Side communities through partnership with WSU</td>
<td>$8.5 million invested by RUSH</td>
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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

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<tr>
<td>Pilot a West Side health ministry among 5 churches in those communities</td>
<td>Paused during COVID-19; launched pilot in Spring 2022</td>
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<tr>
<td>Conduct Mental Health First Aid training for 500 people</td>
<td>300 people trained (paused during COVID-19; resumed in Spring 2022)</td>
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STRATEGY Increase community screenings and referrals to mental health services

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<tr>
<td>Pilot a faith-based mental health support service across 3 West Side churches</td>
<td>Paused during COVID-19</td>
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<tr>
<td>Provide mental health screenings to 1,000 Chicago Public Schools students through School-Based Health Centers (SBHCs)</td>
<td>1,197 students screened</td>
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<tr>
<td>Conduct workshops on trauma-informed care, awareness building, and stigma reduction in 5 West Side churches</td>
<td>6 workshops held, including 2 with representatives from 20 churches</td>
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STRATEGY Provide mental health clinical services in community settings through partnerships; support community-based efforts

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<tr>
<td>Partner with 5 West Side schools that do not have SBHCs</td>
<td>Partnered with 21 schools</td>
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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** Determine interventions and set baseline measures in the first year; ongoing implementation in the second and third years

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

**RESULT** 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**
- Provide coordinated referrals for parenting support services to those with those with ACEs ≥ 3
- 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
- Implement depression screening and linkages to care during new OB visits, postpartum visits and newborn/infant visits

**RESULTS**
- 180 people referred
- 1,500 patients received care
- 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 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.

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*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 — are 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 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 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.

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.

<table>
<thead>
<tr>
<th>Category</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 positivity and mortality rates</td>
<td>Chicago Health Atlas, Illinois Department of Public Health, Cook County Department of Public Health (2020)</td>
</tr>
<tr>
<td>COVID-19 vaccination rates</td>
<td>Chicago Health Atlas, Illinois Department of Public Health, Protect Chicago 77 (2022)</td>
</tr>
<tr>
<td>Perceptions of neighborhood safety</td>
<td>Chicago Health Atlas, Healthy Chicago Survey (2020-2021)</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>Chicago Department of Public Health (2020), Cook County Department of Public Health (2017)</td>
</tr>
<tr>
<td>Early and adequate prenatal care (city)</td>
<td>Chicago Health Atlas, Healthy Chicago Survey (2021)</td>
</tr>
<tr>
<td>Late or no prenatal care (suburbs)</td>
<td>Cook County Department of Public Health (2013-2017)</td>
</tr>
<tr>
<td>Diabetes prevalence, obesity, hypertension</td>
<td>Chicago Health Atlas, Healthy Chicago Survey, CDC’s PLACES (2016-2021)</td>
</tr>
<tr>
<td>Servings of fruits and vegetables</td>
<td>Chicago Health Atlas, CDC’s Behavioral Risk Factor Surveillance System (2020-2021)</td>
</tr>
<tr>
<td>Hardship index</td>
<td>American Community Survey (2016-2020)</td>
</tr>
</tbody>
</table>
**Archer Heights**

*60632*

**Race/Ethnicity**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Archer Heights</th>
<th>Chicago</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>80%</td>
<td>75%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>15%</td>
<td>23%</td>
</tr>
<tr>
<td>White</td>
<td>5%</td>
<td>60%</td>
</tr>
<tr>
<td>AAPI</td>
<td>&lt;1%</td>
<td>34%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td>6%</td>
</tr>
</tbody>
</table>

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

**Life expectancy**

- Archer Heights: 77
- Chicago: 75

**COVID-19**

- Positivity rate: 13%
- Mortality rate: 0.16%
- Vaccination rate: 80%

**Unemployment**

- Archer Heights: 9%
- Chicago: 8%

**Moms getting good prenatal care**

- Archer Heights: 69%
- Chicago: 65%

**People who feel safe in their community**

- Archer Heights: 60%
- Chicago: 61%

**People with chronic conditions that contribute to the life expectancy gap**

- Diabetes: 19%
- Obesity: 41%
- Hypertension: 24%

**People living in poverty**

- Adults: 11%
- Children: 18%

**Unemployment**

- Archer Heights: 9%
- Chicago: 8%

**Moms getting good prenatal care**

- Archer Heights: 69%
- Chicago: 65%

**People who feel safe in their community**

- Archer Heights: 60%
- Chicago: 61%

**People with chronic conditions that contribute to the life expectancy gap**

- Diabetes: 19%
- Obesity: 34%
- Hypertension: 24%

**People living in poverty**

- Adults: 11%
- Children: 18%

*denotes new CHNA community in 2022

"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."

“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.”
Stronger Together: Advancing Equity for All

Austin

60681, 60644

**Race/Ethnicity**

<table>
<thead>
<tr>
<th>TODAY</th>
<th>2019 CHNA</th>
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</thead>
<tbody>
<tr>
<td>Total</td>
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<tr>
<td>Black</td>
<td>76%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>17%</td>
</tr>
<tr>
<td>White</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>AAPI</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
</tbody>
</table>

**Life expectancy**

<table>
<thead>
<tr>
<th>TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin</td>
<td>69</td>
</tr>
<tr>
<td>Chicago</td>
<td>75</td>
</tr>
</tbody>
</table>

**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**

- **18% 2019 CHNA**
- **16% TODAY**
  - 14% AUS
  - 8% CHI

**Moms getting good prenatal care**

- **11% 2019 CHNA**
- **8% TODAY**
  - 14% AUS
  - 6% CHI

**People who feel safe in their community**

- **55% 2019 CHNA**
- **37% TODAY**
  - 37% AUS
  - 61% CHI

**Adults eating enough fruits & vegetables**

- **39% 2019 CHNA**
- **39% TODAY**
  - 39% AUS
  - 31% CHI

**People with chronic conditions that contribute to the life expectancy gap**

- **Diabetes**: 21% TODAY
- **Obesity**: 34% TODAY
- **Hypertension**: 47% TODAY

“**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**

- **30% 2019 CHNA**
- **26% TODAY**
  - 30% AUS
  - 26% CHI

- **22% 2019 CHNA**
- **17% TODAY**
  - 22% AUS
  - 17% CHI

- **42% 2019 CHNA**
- **35% TODAY**
  - 42% AUS
  - 35% CHI

- **31% 2019 CHNA**
- **25% TODAY**
  - 31% AUS
  - 25% CHI
Belmont Cragin*

Race/Ethnicity†

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
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<tbody>
<tr>
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<td>White</td>
<td>14%</td>
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<tr>
<td>AAPI</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
</tbody>
</table>

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.

COVID-19

- Positivity rate: 13%
- Mortality rate: 0.22%
- Vaccination rate: 77%

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.

Life expectancy

- Belmont Cragin: 75
- Chicago: 75

Unemployment

- Belmont Cragin: 5%
- Chicago: 8%

Moms getting good prenatal care

- Belmont Cragin: 72%
- Chicago: 65%

People who feel safe in their community

- Belmont Cragin: 52%
- Chicago: 61%

Adults eating enough fruits & vegetables

- Belmont Cragin: 30%
- Chicago: 34%

People with chronic conditions that contribute to the life expectancy gap

1. Diabetes: 12%
2. Obesity: 34%
3. Hypertension: 30%

People living in poverty

- Adults: 17%
- Children: 25%

*denotes new CHNA community in 2022
Race/Ethnicity

- Total: 54,850
- Black: 3,628 (7%)
- Hispanic/Latino: 14,321 (26%)
- White: 16,791 (30%)
- AAPI: 509 (1%)
- Other: 7,071 (13%)

Race/Ethnicity†

- Life expectancy: 77 years in Berwyn, 75 years in Chicago

COVID-19

- Positivity rate: 20%
- Mortality rate: .16%
- Vaccination rate: 63%

Unemployment

- Berwyn: 3%
- Chicago: 8%

Moms getting late or no prenatal care

- Berwyn: 29%
- Chicago: 35%

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

- Diabetes: 10%
- Obesity: 12%

People living in poverty

- Adults: 34%
- Children: 25%

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

"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."

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

60632

Race/Ethnicity†

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Race/Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>Hispanic/Latino</td>
</tr>
<tr>
<td>7%</td>
<td>White</td>
</tr>
<tr>
<td>2%</td>
<td>Black</td>
</tr>
<tr>
<td>1%</td>
<td>Other</td>
</tr>
</tbody>
</table>

Life expectancy

- 77 Brighton Park
- 75 Chicago

COVID-19

- Positivity rate: 11%
- Mortality rate: 0.17%
- Vaccination rate: 76%

Unemployment

- 11% Brighton Park
- 8% Chicago

Moms getting good prenatal care

- 66% Brighton Park
- 65% Chicago

People who feel safe in their community

- 47% Brighton Park
- 61% Chicago

Adults eating enough fruits & vegetables

- 30% Brighton Park
- 34% Chicago

People with chronic conditions that contribute to the life expectancy gap

- Diabetes: 12%
- Obesity: 34%
- Hypertension: 30%
- Child obesity: 28%
- Adult obesity: 21%

Unemployment

- 11% Brighton Park
- 8% Chicago

Moms getting good prenatal care

- 66% Brighton Park
- 65% Chicago

People who feel safe in their community

- 47% Brighton Park
- 61% Chicago

Adults eating enough fruits & vegetables

- 30% Brighton Park
- 34% Chicago

People with chronic conditions that contribute to the life expectancy gap

- Diabetes: 12%
- Obesity: 34%
- Hypertension: 30%
- Child obesity: 28%
- Adult obesity: 21%

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

- 37% Obesity
- 34% Adult obesity
- 24% Hypertension
- 30% Child obesity
- 28% Children

“Unemployment, 11% Brighton Park, 8% Chicago.

“Moms getting good prenatal care, 66% Brighton Park, 65% Chicago.

“People who feel safe in their community, 47% Brighton Park, 61% Chicago.

“Adults eating enough fruits & vegetables, 30% Brighton Park, 34% Chicago.

“People with chronic conditions that contribute to the life expectancy gap, 12% Diabetes, 34% Obesity, 30% Hypertension, 28% Child obesity, 21% Adult obesity.

“People living in poverty, 37% Obesity, 34% Adult obesity, 24% Hypertension, 30% Child obesity, 28% Children.”

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

Brighton Park 31
### Race/Ethnicity

<table>
<thead>
<tr>
<th>TODAY</th>
<th>2019 CHNA</th>
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<tbody>
<tr>
<td>Total</td>
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<td>5%</td>
</tr>
<tr>
<td>White</td>
<td>6%</td>
</tr>
<tr>
<td>AAPI</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
</tr>
</tbody>
</table>

### Life expectancy

- **TODAY**:
  - East Garfield Park: 75
  - Chicago: 78
- **2019 CHNA**:
  - East Garfield Park: 75
  - Chicago: 78

### COVID-19

- **Positivity rate**: 7%
- **Mortality rate**: 0.15%
- **Vaccination rate**: 58%

### People who feel safe in their community

- **TODAY**:
  - East Garfield Park: 67%
  - Chicago: 78%
- **2019 CHNA**:
  - East Garfield Park: 67%
  - Chicago: 78%

### People with chronic conditions that contribute to the life expectancy gap

- **Diabetes**
  - TODAY: 10%  (8% 2019 CHNA)
  - 2019 CHNA: 12%  (9% TODAY)

### Unemployment

- TODAY: 19%
  - East Garfield Park: 18%
  - Chicago: 11%

### Moms getting good prenatal care

- TODAY: 56%
  - East Garfield Park: 52%
  - Chicago: 64%

### Adults eating enough fruits & vegetables

- TODAY: 28%
  - East Garfield Park: 17%
  - Chicago: 31%

### People living in poverty

- TODAY: 22%
  - East Garfield Park: 17%
  - Chicago: 25%

---

“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

“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.”
Elmwood Park* 60707

Race/Ethnicity†

- **Total**: 24,274
- **Black**: 34%
- **Hispanic/Latino**: 58%
- **White**: 5%
- **AAPI**: 1%
- **Other**: 2%

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

Life expectancy

- **Elmwood Park**: 78
- **Chicago**: 75

COVID-19

- **Positivity rate**: 24%
- **Mortality rate**: .16%
- **Vaccination rate**: 62%

Top health concerns of focus group participants:
- Mental health, including suicide, domestic violence, sexual abuse
- Chronic diseases
- Isolation
- Access to nutritious food
- Crowded housing

Unemployment

- **Elmwood Park**: 3%
- **Chicago**: 8%

People getting late or no prenatal care

- **Elmwood Park**: 23%
- **Chicago**: 35%

People with chronic conditions that contribute to the life expectancy gap

- **Elmwood Park**: 9%
- **Chicago**: 12%

Necessary for a healthy community,

People living in poverty

- **Elmwood Park**: 27%
- **Chicago**: 34%

Unemployment

- **Elmwood Park**: 7%
- **Chicago**: 17%

Moms getting late or no prenatal care

- **Elmwood Park**: 6%
- **Chicago**: 25%

Unemployment

- **Elmwood Park**: 3%
- **Chicago**: 8%

People getting late or no prenatal care

- **Elmwood Park**: 23%
- **Chicago**: 35%

People with chronic conditions that contribute to the life expectancy gap

- **Elmwood Park**: 9%
- **Chicago**: 12%

Necessary for a healthy community,

People living in poverty

- **Elmwood Park**: 27%
- **Chicago**: 34%

Unemployment

- **Elmwood Park**: 7%
- **Chicago**: 17%

Moms getting late or no prenatal care

- **Elmwood Park**: 6%
- **Chicago**: 25%

Unemployment

- **Elmwood Park**: 3%
- **Chicago**: 8%

People getting late or no prenatal care

- **Elmwood Park**: 23%
- **Chicago**: 35%

People with chronic conditions that contribute to the life expectancy gap

- **Elmwood Park**: 9%
- **Chicago**: 12%

Necessary for a healthy community,

People living in poverty

- **Elmwood Park**: 27%
- **Chicago**: 34%

Unemployment

- **Elmwood Park**: 7%
- **Chicago**: 17%

Moms getting late or no prenatal care

- **Elmwood Park**: 6%
- **Chicago**: 25%

Unemployment

- **Elmwood Park**: 3%
- **Chicago**: 8%

People getting late or no prenatal care

- **Elmwood Park**: 23%
- **Chicago**: 35%

People with chronic conditions that contribute to the life expectancy gap

- **Elmwood Park**: 9%
- **Chicago**: 12%

Necessary for a healthy community,

People living in poverty

- **Elmwood Park**: 27%
- **Chicago**: 34%

Unemployment

- **Elmwood Park**: 7%
- **Chicago**: 17%
Forest Park

**Race/Ethnicity**

<table>
<thead>
<tr>
<th>TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>27%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>52%</td>
</tr>
<tr>
<td>White</td>
<td>31%</td>
</tr>
<tr>
<td>AAPI</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Life expectancy**

TODAY: 77

Forest Park: 77

Chicago: 75

**COVID-19**

- **Positivity rate**: 19%
- **Mortality rate**: 0.18%
- **Vaccination rate**: 66%

**People with chronic conditions that contribute to the life expectancy gap**

- Diabetes: 9% FP, 12% CHI
- Obesity: 29% FP, 34% CHI
- Hypertension: 29% FP, 30% CHI

**Unemployment**

- FP 2019 CHNA: 10%
- FP TODAY: 4%
- CHI 2019 CHNA: 11%
- CHI TODAY: 8%

**People living in poverty**

- FP 2019 CHNA: 15%
- FP TODAY: 9%
- CHI 2019 CHNA: 31%
- CHI TODAY: 17%

**Moms getting late or no prenatal care**

- FP TODAY: 19%
- CHI TODAY: 35%

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

"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?"

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

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

"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?"
Humboldt Park
60647, 60651

Race/Ethnicity

<table>
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<tr>
<th>TODAY</th>
<th>2019 CHNA</th>
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<tbody>
<tr>
<td>53,832</td>
<td>56,248</td>
</tr>
<tr>
<td>33% Black</td>
<td>56% Hispanic/Latino</td>
</tr>
<tr>
<td>9% White</td>
<td>65% Hispanic/Latino</td>
</tr>
<tr>
<td>1% AAPI</td>
<td>2% Other</td>
</tr>
</tbody>
</table>

Life expectancy

- 71 Humboldt Park
- 75 Chicago

COVID-19

- Positivity rate 10%
- Mortality rate 0.16%
- 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

- 11% TODAY
- 8% TODAY

Moms getting good prenatal care

- 65% TODAY
- 65% TODAY

People who feel safe in their community

- 52% 2019 CHNA
- 36% 2019 CHNA
- 78% 2019 CHNA
- 61% TODAY

People living in poverty

- 35% 2019 CHNA
- 35% TODAY
- 34% 2019 CHNA
- 34% TODAY
- 30% 2019 CHNA
- 27% TODAY

People with chronic conditions that contribute to the life expectancy gap

- 13% 2019 CHNA
- 8% TODAY
- 48% 2019 CHNA
- 9% 2019 CHNA
- 12% TODAY
- 3% TODAY

Adults eating enough fruits & vegetables

- 19% 2019 CHNA
- 18% 2019 CHNA
- 34% TODAY
- 31% 2019 CHNA

People with obesity

- 38% 2019 CHNA
- 35% TODAY
- 34% 2019 CHNA
- 31% 2019 CHNA
- 30% TODAY
- 28% 2019 CHNA
- 25% TODAY

People with diabetes

- 35% 2019 CHNA
- 35% TODAY
- 34% 2019 CHNA
- 31% 2019 CHNA
- 30% 2019 CHNA
- 30% TODAY
- 28% 2019 CHNA

People with hypertension

- 35% 2019 CHNA
- 34% TODAY
- 34% 2019 CHNA
- 31% 2019 CHNA
- 30% TODAY
- 28% 2019 CHNA

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

Unemployment

- 11% TODAY
- 8% TODAY

Moms getting good prenatal care

- 65% TODAY
- 65% TODAY

People who feel safe in their community

- 52% 2019 CHNA
- 36% 2019 CHNA
- 78% 2019 CHNA
- 61% TODAY

People living in poverty

- 35% 2019 CHNA
- 35% TODAY
- 34% 2019 CHNA
- 34% TODAY
- 30% 2019 CHNA
- 27% TODAY

People with chronic conditions that contribute to the life expectancy gap

- 13% 2019 CHNA
- 8% TODAY
- 48% 2019 CHNA
- 9% 2019 CHNA
- 12% TODAY
- 3% TODAY

Adults eating enough fruits & vegetables

- 19% 2019 CHNA
- 18% 2019 CHNA
- 34% TODAY
- 31% 2019 CHNA

People with obesity

- 38% 2019 CHNA
- 35% TODAY
- 34% 2019 CHNA
- 31% 2019 CHNA
- 30% TODAY
- 28% 2019 CHNA

People with diabetes

- 35% 2019 CHNA
- 35% TODAY
- 34% 2019 CHNA
- 31% 2019 CHNA
- 30% 2019 CHNA
- 30% TODAY
- 28% 2019 CHNA

“I like all the functions that we host in this community.”
Lower West Side

Race/Ethnicity†

- TODAY: 33,716 Total
  - 3% Black
  - 68% Hispanic/Latino
  - 6% White
  - 8% AAPI
  - 2% Other

- 2019 CHNA: 32,998 Total
  - 4% Black
  - 78% Hispanic/Latino
  - 15% White
  - 2% AAPI
  - 1% Other

Life expectancy

- TODAY: 79 Lower West Side
- 2019 CHNA: 75 Chicago

COVID-19

- Positivity rate: 10%
- Mortality rate: 0.20%
- 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.”

Unemployment

- TODAY: LWS 7% / CHI 8%
- 2019 CHNA: LWS 9% / CHI 11%

Moms getting good prenatal care

- TODAY: LWS 65% / CHI 64%
- 2019 CHNA: LWS 66% / CHI 64%

People who feel safe in their community

- TODAY: LWS 78% / CHI 61%
- 2019 CHNA: LWS 69% / CHI 78%

Adults eating enough fruits & vegetables

- TODAY: LWS 34% / CHI 31%
- 2019 CHNA: LWS 34% / CHI 28%

People with chronic conditions that contribute to the life expectancy gap

- TODAY: LWS 12% / CHI 9%
- 2019 CHNA: LWS 11% / CHI 9%

People living in poverty

- TODAY: LWS 22% / CHI 17%
- 2019 CHNA: LWS 22% / CHI 14%

36 grocery stores
8 childcare centers
9 health care and 10 mental health facilities
1 pharmacy
9 public parks
9 public and private schools
Near West Side

60612, 60607

Race/Ethnicity

<table>
<thead>
<tr>
<th>Group</th>
<th>TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>24%</td>
<td>10%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>30%</td>
<td>42%</td>
</tr>
<tr>
<td>White</td>
<td>44%</td>
<td>2%</td>
</tr>
<tr>
<td>AAPI</td>
<td>19%</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Near West Side: 67,817, Total: 62,560

Life expectancy

- 75 Near West Side
- 75 Chicago

COVID-19

- Positivity rate: 6%
- Mortality rate: .06%
- Vaccination rate: 75%

“People who feel safe in their community

- 82% 2019 CHNA
- 78% TODAY

“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.”

“Unemployment

- 9% 2019 CHNA
- 7% TODAY

“Moms getting good prenatal care

- 11% 2019 CHNA
- 8% TODAY

“Adults eating enough fruits & vegetables

- 34% 2019 CHNA
- 31% TODAY

“People living in poverty

- 22% 2019 CHNA
- 17% TODAY

“Unemployment

- 19% 2019 CHNA
- 19% TODAY

Strengths

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

“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.”
North Lawndale

Race/Ethnicity:
- TODAY: Black 83%, Hispanic/Latino 8%, White 3%, Other 1%
- 2019 CHNA: Black 88%, Hispanic/Latino 8%, White 2%, Other 2%

Life expectancy:
- TODAY: North Lawndale 67 years, Chicago 75 years
- 2019 CHNA: North Lawndale 60 years, Chicago 78 years

COVID-19:
- TODAY: Positivity rate 7%, Mortality rate 0.24%, Vaccination rate 55%
- 2019 CHNA: Positivity rate 13%, Mortality rate 2.4%,
Vaccination rate 31%

Unemployment:
- TODAY: NL 17%, CHI 8%
- 2019 CHNA: NL 22%, CHI 11%

Moms getting good prenatal care:
- TODAY: NL 57%, CHI 65%
- 2019 CHNA: NL 53%, CHI 64%

People who feel safe in their community:
- TODAY: NL 47%, CHI 34%
- 2019 CHNA: NL 45%, CHI 36%

People with chronic conditions that contribute to the life expectancy gap:
- TODAY: Diabetes 12%, Heart disease 9%

People eating enough fruits & vegetables:
- TODAY: NL 34%, CHI 31%
- 2019 CHNA: NL 31%, CHI 30%

People living in poverty:
- TODAY: NL 17%, CHI 17%
- 2019 CHNA: NL 31%, CHI 39%

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

“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.”
Oak Park
60301, 60302, 60303, 60304

Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Total TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>18%</td>
<td>16%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>White</td>
<td>61%</td>
<td>62%</td>
</tr>
<tr>
<td>AAPI</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Life expectancy

- Oak Park: 82
- Chicago: 75

COVID-19

- Positivity rate: 4%
- Mortality rate: 0.09%
- Vaccination rate: 88%

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

Unemployment

- 7% 2019 CHNA
- 5% TODAY
- 8% TODAY

Moms getting late or no prenatal care

- 11% 2019 CHNA
- 18% TODAY
- 35% TODAY

People with chronic conditions that contribute to the life expectancy gap

- Diabetes: 12% TODAY
- Obesity: 34% TODAY
- Hypertension: 30% TODAY

People living in poverty

- 9% 2019 CHNA
- 7% TODAY
- 22% 2019 CHNA
- 17% TODAY
- 6% TODAY
- 31% 2019 CHNA
- 4% TODAY
- 25% TODAY

"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."

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

Race/Ethnicity:

<table>
<thead>
<tr>
<th></th>
<th>TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>11,717</td>
<td>11,217</td>
</tr>
<tr>
<td>Black</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>White</td>
<td>83%</td>
<td>78%</td>
</tr>
<tr>
<td>AAPI</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>&lt;1%</td>
<td>3%</td>
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</tbody>
</table>

Life expectancy:

<table>
<thead>
<tr>
<th></th>
<th>TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>RF</td>
<td>86</td>
<td>75</td>
</tr>
<tr>
<td>Chicago</td>
<td>75</td>
<td>75</td>
</tr>
</tbody>
</table>

COVID-19:

<table>
<thead>
<tr>
<th></th>
<th>TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positivity rate</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>Mortality rate</td>
<td>.02%</td>
<td>.02%</td>
</tr>
<tr>
<td>Vaccination rate</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>

“Moms getting late or no prenatal care”

Unemployment:

<table>
<thead>
<tr>
<th></th>
<th>RF TODAY</th>
<th>CHI TODAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>3%</td>
<td>11%</td>
<td></td>
</tr>
</tbody>
</table>

People with chronic conditions that contribute to the life expectancy gap:

- Diabetes: 7% TODAY 12% TODAY
- Obesity: 23% TODAY 34% TODAY
- Hypertension: 26% TODAY 30% TODAY

People living in poverty:

<table>
<thead>
<tr>
<th></th>
<th>RF TODAY</th>
<th>CHI TODAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>3%</td>
<td>17%</td>
<td></td>
</tr>
</tbody>
</table>

“People with chronic conditions that contribute to the life expectancy gap”

- Diabetes: 7% TODAY 12% TODAY
- Obesity: 23% TODAY 34% TODAY
- Hypertension: 26% TODAY 30% TODAY

“Moms getting late or no prenatal care”

Unemployment:

<table>
<thead>
<tr>
<th></th>
<th>RF TODAY</th>
<th>CHI TODAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>3%</td>
<td>11%</td>
<td></td>
</tr>
</tbody>
</table>

People with chronic conditions that contribute to the life expectancy gap:

- Diabetes: 7% TODAY 12% TODAY
- Obesity: 23% TODAY 34% TODAY
- Hypertension: 26% TODAY 30% TODAY

People living in poverty:

<table>
<thead>
<tr>
<th></th>
<th>RF TODAY</th>
<th>CHI TODAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>3%</td>
<td>17%</td>
<td></td>
</tr>
</tbody>
</table>

“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.”
**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

**Life expectancy**

- **TODAY**: 75 years (South Lawndale, 78; Chicago, 75)
- **2019 CHNA**: 75 years (South Lawndale, 73; Chicago, 71)

**COVID-19**

- **Positivity rate**: 11%
- **Mortality rate**: 0.27%
- **Vaccination rate**: 70%

**Unemployment**

- **10% 2019 CHNA**, **9% TODAY**

**Moms getting good prenatal care**

- **11% 2019 CHNA**, **8% TODAY**

**People who feel safe in their community**

- **54% 2019 CHNA**, **36% TODAY**

**Adults eating enough fruits & vegetables**

- **23% 2019 CHNA**, **14% TODAY**

**People with chronic conditions that contribute to the life expectancy gap**

- **16% 2019 CHNA**, **12% TODAY**

**People living in poverty**

- **35% 2019 CHNA**, **25% TODAY**

---

“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.”

---

“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?”

---

- 8 grocery stores
- 9 childcare centers
- 12 health care and 3 mental health facilities
- 5 pharmacies
- 8 public parks
- 18 public and private schools
2019 CHNA

52

Stronger Together: Advancing Equity for All

West Garfield Park

60624

Race/Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>17,490</td>
<td>17,423</td>
</tr>
<tr>
<td>Black</td>
<td>93%</td>
<td>92%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>White</td>
<td>1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>AAPI</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

Life expectancy

West Garfield Park 68

Chicago 75

COVID-19

Positivity rate 6%

Mortality rate 0.13%

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.”

6 grocery stores

4 childcare centers

3 health care and 4 mental health facilities

3 pharmacies

5 public parks

5 public and private schools

Unemployment

<table>
<thead>
<tr>
<th></th>
<th>TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>WGP</td>
<td>24%</td>
<td>19%</td>
</tr>
<tr>
<td>CHI</td>
<td>8%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Moms getting good prenatal care

<table>
<thead>
<tr>
<th></th>
<th>TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>WGP</td>
<td>53%</td>
<td>51%</td>
</tr>
<tr>
<td>CHI</td>
<td>65%</td>
<td>64%</td>
</tr>
</tbody>
</table>

People who feel safe in their community

<table>
<thead>
<tr>
<th></th>
<th>TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>WGP</td>
<td>40%</td>
<td>49%</td>
</tr>
<tr>
<td>CHI</td>
<td>34%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Adults eating enough fruits & vegetables

<table>
<thead>
<tr>
<th></th>
<th>TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>WGP</td>
<td>21%</td>
<td>78%</td>
</tr>
<tr>
<td>CHI</td>
<td>31%</td>
<td>61%</td>
</tr>
</tbody>
</table>

People with chronic conditions that contribute to the life expectancy gap

<table>
<thead>
<tr>
<th></th>
<th>TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>Obesity</td>
<td>34%</td>
<td>31%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>30%</td>
<td>28%</td>
</tr>
</tbody>
</table>

People living in poverty

<table>
<thead>
<tr>
<th></th>
<th>TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>WGP</td>
<td>47%</td>
<td>40%</td>
</tr>
<tr>
<td>CHI</td>
<td>22%</td>
<td>17%</td>
</tr>
</tbody>
</table>

“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.”
West Town

60622

Race/Ethnicity

- TODAY: 87,942 total
- 2019 CHNA: 84,458 total

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>TODAY</th>
<th>2019 CHNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>21%</td>
<td>22%</td>
</tr>
<tr>
<td>White</td>
<td>64%</td>
<td>61%</td>
</tr>
<tr>
<td>AAPI</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Life expectancy

- TODAY: 79 West Town, 75 Chicago
- 2019 CHNA: 78 West Town, 73 Chicago

COVID-19

- Positivity rate: 7%
- Mortality rate: 0.12%
- Vaccination rate: 80%

People who feel safe in their community

- TODAY: 85% West Town, 78% Chicago
- 2019 CHNA: 61% West Town, 55% Chicago

People with chronic conditions that contribute to the life expectancy gap

- TODAY: 5% diabetes, 12% hypertension, 12% obesity, 21% children
- 2019 CHNA: 4% diabetes, 9% hypertension, 34% obesity, 25% children

People living in poverty

- TODAY: 15% West Town, 17% Chicago
- 2019 CHNA: 19% West Town, 22% Chicago

Unemployment

- TODAY: 4% West Town, 8% Chicago
- 2019 CHNA: 3% West Town, 8% Chicago

Moms getting good prenatal care

- TODAY: 11% West Town, 8% Chicago
- 2019 CHNA: 4% West Town, 9% Chicago

Adults eating enough fruits & vegetables

- TODAY: 34% West Town, 31% Chicago
- 2019 CHNA: 31% West Town, 31% Chicago

“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.”

“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
Stronger Together: Advancing Equity for All

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, HEAL, and WSU.
## GOAL 1: Prevent and/or manage chronic conditions and risk factors

### GOAL STRATEGY INITIATIVES

<table>
<thead>
<tr>
<th>GOAL</th>
<th>STRATEGY</th>
<th>INITIATIVES</th>
<th>FY23 TARGET</th>
<th>FY24 TARGET</th>
<th>FY25 TARGET</th>
<th>TOTAL</th>
<th>MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Reduce risk factors through assessments, education; focus on chronic disease</td>
<td>1.1.1 Provide evidence-based chronic disease self-management and falls prevention programming to older adults (age 55+)</td>
<td>200 enrolled, 75% completing/controling condition in the program</td>
<td>200 enrolled, 75% completing/controling condition in the program</td>
<td>200 enrolled, 75% completing/controling condition in the program</td>
<td>600 enrolled, 75% completing/controling condition in the program</td>
<td># enrolled; % completing/controling condition in the program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1.2 Expand Health Legacy diabetes education/prevention programs to RUSH Oak Park, RUSH Copley</td>
<td>Plan/secure resources for FY24 launch</td>
<td>50 people enrolled, 75% complete program</td>
<td>125 people enrolled, 75% complete program</td>
<td>175 people enrolled, 75% complete program</td>
<td># enrolled; % program completion</td>
</tr>
<tr>
<td>1.2</td>
<td>Reduce risk factors through assessments, education, condition management programs; focus on hypertension/diabetes</td>
<td>1.2.1 Screen community members for uncontrolled hypertension through Alive Faith Network; refer those in need to disease management program</td>
<td>300 screened, 12% referred</td>
<td>350 screened, 12% referred</td>
<td>350 screened, 12% referred</td>
<td>1000 screened, 12% referred</td>
<td># screened; % referred to management program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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</td>
<td>36 enrolled, 80% completing program; 5-point BP reduction; 10% connected to CHWs</td>
<td>42 enrolled, 80% completing program; 5-point BP reduction; 10% connected to CHWs</td>
<td>42 enrolled, 80% completing program; 5-point BP reduction; 10% connected to CHWs</td>
<td>120 enrolled, 80% completing program; 5-point BP reduction; 10% connected to CHWs</td>
<td># enrolled; % completion program; BP reduction; % connected to CHWs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2.3 Screen people with physical mobility limitations and refer to 6-month program to increase mobility</td>
<td>300 screened, 12% referred</td>
<td>300 screened, 12% referred</td>
<td>300 screened, 12% referred</td>
<td>900 screened, 12% referred</td>
<td># screened; % referred</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2.4 Enroll 120 people with physical mobility limitations in 6-month mobility improvement program through Alive Faith Network</td>
<td>24 enrolled</td>
<td>48 enrolled</td>
<td>48 enrolled</td>
<td>120 enrolled</td>
<td># enrolled</td>
</tr>
<tr>
<td>1.3</td>
<td>Implement systemwide quality improvement/data action plan integrating racial equity</td>
<td>1.3.1 Standardize systemwide training/implementation for collecting patient data (REAL, SOGI, SDOH)</td>
<td>Plan/secure resources for FY24 launch</td>
<td>50% of targeted staff trained</td>
<td>80%+ of targeted staff trained</td>
<td>85%+ of targeted staff trained</td>
<td>% of targeted staff trained; % of patients with complete REAL, data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.3.2 Standardize process to derive insights from patient-reported data/clinical outcomes to recognize/address health disparities in vulnerable patient groups</td>
<td>Plan/secure resources; launch Spring 2023</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Process launched, sustained, still operating in 2025</td>
</tr>
<tr>
<td>1.4</td>
<td>Improve access to healthy food for patients screened as food-insecure</td>
<td>1.4.1 Expand Food is Medicine program to ROPH; CHWs use NowPow to track meal recipients</td>
<td>100 patients receive food</td>
<td>150 patients receive food</td>
<td>200 patients receive food</td>
<td>450 patients served</td>
<td># served</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.4.2 Integrate QR codes for healthy recipes (created by RUSH University nutrition students) into meal boxes</td>
<td>10 recipes created for diabetes, hypertension, obesity</td>
<td>10 recipes created for diabetes, hypertension, obesity</td>
<td>10 recipes created for diabetes, hypertension, obesity</td>
<td>30 recipes created for diabetes, hypertension, obesity</td>
<td># of recipes created/distributed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.4.3 Create Veggie Rx Pantry to provide meals for people screened as food-insecure and referred by PCPs</td>
<td>2,880 people referred to pantry through 6 clinics, serve 80% of those referred</td>
<td>4,320 people referred to pantry through 12 clinics, serve 90% of those referred</td>
<td>5,760 people referred to pantry through 12 clinics, serve 90% of those referred</td>
<td>12,960 people referred to pantry, serve 80% of those referred</td>
<td># referred; % served</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.4.4 Continue RUSH Food Surplus Program; donate 18,000 lbs. of food annually</td>
<td>18,000 lbs. donated</td>
<td>18,000 lbs. donated</td>
<td>18,000 lbs. donated</td>
<td>54,000 lbs. donated</td>
<td># of lbs. donated in each delivery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.4.5 Partner with Community-based organizations (CBOs) and/or schools to create food and nutrition course</td>
<td>Partner with 1 CBO/school</td>
<td>Partner with 1 CBO/school</td>
<td>Partner with 1 CBO/school</td>
<td>3 partnerships developed</td>
<td># of CBO/school partners</td>
</tr>
<tr>
<td>GOAL</td>
<td>STRATEGY</td>
<td>INITIATIVES</td>
<td>FY23 TARGET</td>
<td>FY24 TARGET</td>
<td>FY25 TARGET</td>
<td>TOTAL</td>
<td>MEASURES</td>
</tr>
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</tr>
<tr>
<td>GOAL 2</td>
<td>Increase access to mental and behavioral health services</td>
<td>2.1 Increase community screenings and referrals to mental health services (\text{A} \quad \text{H} \quad \text{W})</td>
<td>2.1.1 Provide therapy sessions to referred patients via RUSH outpatient community psychotherapy clinic</td>
<td>3,433 sessions provided</td>
<td>3,535 sessions provided</td>
<td>3,640 sessions provided</td>
<td>10,600 sessions provided</td>
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<td>2.1.2 Provide mental health screenings through Alive Faith Network</td>
<td>1,000 people screened; 70% linked to community resources</td>
<td>1,000 people screened; 75% linked to community resources</td>
<td>1,000 people screened; 80% linked to community resources</td>
<td>3,000 people screened</td>
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<td>2.1.3 Provide mental health screenings to Chicago Public Schools students through RUSH School-Based Health Centers (SBHCLs)</td>
<td>1,000 students screened; 65% receive additional support</td>
<td>1,000 students screened; 65% receive additional support</td>
<td>1,000 students screened; 65% receive additional support</td>
<td>3,000 students screened; 65% receive additional support</td>
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<td>Conduct community-based trainings — including train-the-trainer programs — in Mental Health First Aid (MHFA) (\text{A} \quad \text{W})</td>
<td>2.2.1 Provide Mental Health First Aid facilitator training</td>
<td>10 people trained</td>
<td>25 people trained</td>
<td>25 people trained</td>
<td>60 people trained</td>
<td># trained</td>
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<td>2.2.2 Train community members in MHFA/trauma-informed care; partner with violence prevention organizations</td>
<td>500 people trained; 20% also trained in violence prevention</td>
<td>700 people trained; 20% also trained in violence prevention</td>
<td>700 people trained; 20% also trained in violence prevention</td>
<td>1,900 people trained; 20% (380) also trained in violence prevention</td>
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<td>2.3.1 Pilot technology distribution program to support telehealth access for youth</td>
<td>Research, develop plan, secure funding support for FY24 launch</td>
<td>Pilot tech distribution to support telehealth for up to 50 people</td>
<td>Evaluate progress with pilot, update to support 50-75 people</td>
<td>100 people in program</td>
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<td>2.3.2 Advocate to: increase access for services; expand broadband for telehealth; increase Medicare/Medicaid reimbursement for mental health services; sustain telehealth flexibilities</td>
<td>Partner with WSU to research/develop plan for policy/advocacy approach</td>
<td>Launch advocacy efforts</td>
<td>Evaluate progress and update approach as needed; secure telehealth resources</td>
<td>Increased access for telehealth for high-need target group (screened and need tech to enable mental health services)</td>
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<td>Increase access to diverse, licensed mental health professionals (\text{A} \quad \text{W})</td>
<td>2.4.1 Develop pipeline/fellowship opportunities for mental health professionals of color</td>
<td>Partner with Chicago State University to formalize program/ begin recruitment</td>
<td>Launch fellowship with 2 fellows</td>
<td>Fellowship active with 2 fellows</td>
<td>3 of 4 fellows completed program for licensure</td>
<td># completing program for licensure</td>
</tr>
<tr>
<td>GOAL</td>
<td>STRATEGY</td>
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<td>GOAL 3</td>
<td>Reduce inequities caused by the social, economic and structural determinants of health</td>
<td>3.1.1 Provide high school/college internships/apprenticeships</td>
<td>250 students intern/apprentice</td>
<td>250 students intern/apprentice</td>
<td>250 students intern/apprentice</td>
<td>750 students intern/apprentice</td>
<td># interning/apprenticing</td>
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<td>3.1.2 Increase student/family interest/knowledge of STEM/health care topics/careers</td>
<td>5,000 students/parents/families participate in programs/workshops/events</td>
<td>5,000 students/parents/families participate in programs/workshops/events</td>
<td>5,000 students/parents/families participate in programs/workshops/events</td>
<td>15,000 students/parents/families participated in programs/workshops/events</td>
<td># participating</td>
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<td>3.1.3 Expand wraparound supports for students and families</td>
<td>90% of students/families eligible for high-touch programs complete REACH health equity assessment tool/receive eRx</td>
<td>90% of students/families eligible for high-touch programs complete REACH health equity assessment tool/receive eRx</td>
<td>90% of students/families eligible for high-touch programs complete REACH health equity assessment tool/receive eRx</td>
<td>90% of students/families eligible for high-touch programs completed REACH health equity assessment tool/receive eRx</td>
<td>% completing assessment tool/receiving eRx</td>
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<td>3.1.4 Provide workforce training for young people through age 24 to earn industry-recognized credentials</td>
<td>75% of enrollees complete training and earn credentials</td>
<td>75% of enrollees complete training and earn credentials</td>
<td>75% of enrollees complete training and earn credentials</td>
<td>75% of enrollees completing training and earning credentials</td>
<td>% completing training and earning credentials</td>
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<td>3.1.5 Provide college/career readiness enrichment to under-represented youth</td>
<td>90% of REACH participants enroll in post-secondary options; 75% persist</td>
<td>90% of REACH participants enroll in post-secondary options; 75% persist</td>
<td>90% of REACH participants enroll in post-secondary options; 75% persist</td>
<td>90% of REACH participants enrolled in post-secondary options; 75% persisted</td>
<td>% persisting in post-secondary completion</td>
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<td>3.2 Collaborate to address workforce development, maximize income and benefits, increase financial literacy/asset-building</td>
<td>Launch up to 3 stackable credentials aligned with family-sustaining wages; enroll 50 community members and incumbent staff; 70% of those eligible earn credentials</td>
<td>25 community members and incumbent staff enrolled in credentials program; 70% of those eligible earn credentials</td>
<td>50 community members and incumbent staff enrolled in credentials program; 70% of those eligible earn credentials</td>
<td>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)</td>
<td>% of enrolled students; % earning credentials; % increase in wages</td>
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<td>3.2.2 Work with partners to develop/implent community-wide workforce development initiatives to increase employment access and opportunities</td>
<td>Collaborate with 3 community partners; target 18.6% of new hires to local communities</td>
<td>Collaborate with 3 community partners; target 20% of new hires to local communities</td>
<td>Collaborate with 3 community partners; target 20% of new hires to local communities</td>
<td>Collaborate with up to 9 community partners to implement initiatives</td>
<td># of collaborating organizations; % of participants hired</td>
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<td>3.2.3 Work with partners to create/implement community-wide workforce development initiatives to increase job stability</td>
<td>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</td>
<td>Collaborate with 3 community partners; develop system playbook for partnership; recruit high-need openings from community partners</td>
<td>Collaborate with 3 community partners; refine and update playbook; recruit high-need openings from community partners</td>
<td>Collaborate 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</td>
<td># of collaborating organizations; # of community members sourced; % placed and hired</td>
</tr>
</tbody>
</table>

# Alliance for Health Equity (AHE)  
* Chicago Heal Initiative (HEAL)  
* 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

<table>
<thead>
<tr>
<th>GOAL 3, continued</th>
<th>STRATEGY</th>
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<th>FY23 TARGET</th>
<th>FY24 TARGET</th>
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<tbody>
<tr>
<td>3.3 Identify social determinants of health (SDOH) through screenings; refer those in need of social services</td>
<td>3.3.1 Adopt systemwide approach to SDOH screening; roll out to RUMC, ROPH and RCIMC; connect people with unmet needs (food, transportation, housing) to resources; social work referrals, community resource navigation</td>
<td>40,000 patients screened; 75% of those with needs receive interventions</td>
<td>40,000 patients screened; 75% of those with needs receive interventions</td>
<td>40,000 patients screened; 75% of those with needs receive interventions</td>
<td>120,000 patients screened; 75% of those with needs receive interventions</td>
<td># screened; % receiving corresponding intervention within 1 month</td>
<td></td>
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<tr>
<td>3.3.2 Conduct screening through West Side Health Equity Collaborative (Medicaid Transformation initiative); provide resource navigation to community-based organizations</td>
<td>1,500 people screened; 85% screening positive for unmet needs receive interventions</td>
<td>1,500 people screened; 90% screening positive for unmet needs receive interventions</td>
<td>1,500 people screened; 95% screening positive for unmet needs receive interventions</td>
<td>4,500 people screened; 90% screening positive for unmet needs receive interventions</td>
<td>% screened; % reduction in needs; % receiving interventions within 1 month of screening positive</td>
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<tr>
<td>3.3.3 Integrate SDOH screening into community-based programming; create sustainable partnerships with CBOs to facilitate direct social service referrals</td>
<td>Partner with 1 CBO; 80% of referred patient needs addressed</td>
<td>Partner with 1 CBO; 80% of referred patient needs addressed</td>
<td>Partner with 1 CBO; 80% of referred patient needs addressed</td>
<td>3 partnerships created; % of successful referrals; % of patients with referred needs addressed/ mitigated</td>
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<td>3.4 Leverage coalition-building and partnerships for collective impact to advance health equity</td>
<td>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</td>
<td>Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups</td>
<td>Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups</td>
<td>Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups</td>
<td>Participated in meetings; provided capacity-building support; co-led or led committees/working groups</td>
<td># of meetings; amount of support provided; # of committees/working groups co-led or led</td>
<td></td>
</tr>
<tr>
<td>3.4.2 Launch Phase II of RUSH BMO Institute for Health Equity (Community programs and clinical practices; policy; education; health equity research)</td>
<td>Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups</td>
<td>Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups</td>
<td>Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups</td>
<td>Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups</td>
<td>Participated in meetings; provided capacity-building support; co-led or led committees/working groups</td>
<td># of meetings; amount of support provided; # of committees/working groups co-led or led</td>
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<tr>
<td>3.5 Increase spending with local businesses</td>
<td>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</td>
<td>Identify 2-3 spend categories; develop capacity-building workshop series for vendors; pilot with 5-7 vendors</td>
<td>Identify 2-3 spend categories; select vendors</td>
<td>Identify 2-3 spend categories</td>
<td>8 spend categories identified</td>
<td># spend categories identified; # of small business vendors in support program; # and % with new spend or increased spend (baseline TBD in FY23)</td>
<td></td>
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<tr>
<td>3.5.2 Spend $15.3 million with West Side vendors</td>
<td>Spend $5.1 million</td>
<td>Spend $5.1 million</td>
<td>Spend $5.1 million</td>
<td>$5.3 million spent</td>
<td>$ spent with West Side vendors (identify 2 underrepresented communities per year for targeted spend)</td>
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<td>3.6 Increase investment in local communities</td>
<td>3.6.1 Work with community partners (Women’s Business Development Center, Chicago Supplier Minority Development Council; WSU) to strengthen local vendors’ capacity</td>
<td>Participate in meetings; communicate with partners for vendor support opportunities (events, meetings, fairs)</td>
<td>Participate in meetings; communicate with partners for vendor support opportunities (events, meetings, fairs)</td>
<td>Participate in meetings; communicate with partners for vendor support opportunities (events, meetings, fairs)</td>
<td>Participated in meetings; communicated with partners for vendor support opportunities (events, meetings, fairs)</td>
<td># of meetings; # of events</td>
<td></td>
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<tr>
<td>3.6.2 Make place-based investments; work with treasury and partner community development financial institutions to support investments in healthy food and wellness</td>
<td>Invest $1.33 million</td>
<td>Invest $1.33 million</td>
<td>Invest $1.33 million</td>
<td>$4 million invested</td>
<td>$ in place-based investments</td>
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<td>GOAL</td>
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<td>4.1</td>
<td>Expand community clinical practices; partner with collaboratives to improve health status of Medicaid-insured and uninsured people</td>
<td>4.1.3 Serve as clinical provider via city/regional initiatives (Connect Chicago/Congregate Testing, Health Equity Zones, CHHRGE)</td>
<td>Target and complete 8,000 SDOH screenings and health risk assessments (HRAs)</td>
<td>Target and complete 8,000 SDOH screenings and HRAs</td>
<td>Target and complete 24,000 SDOH screenings and HRAs</td>
<td>36,000</td>
<td># of people served (tested, vaccinated, etc.); # of Medicaid insured and uninsured residents in targeted ZIP codes with improved health status; % reduction of unnecessary utilization</td>
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<td>4.1.2 Partner with CBOs and health care organizations (HCOs) on state health care transformation initiative (West Side Health Equity Collaborative)</td>
<td>Connect with 13 CBOs and 9 HCOs, with 5% of total referrals</td>
<td>Partner with 1 more CBO and 5 more HCOs, with 5% of total referrals</td>
<td>Partner with 2 more CBOs and 3 more HCOs, with 5% of total referrals</td>
<td>Connect with 16 CBOs and 17 HCOs, with 5% of total referrals</td>
<td># of connections to CBOs/health care organizations; % of referrals</td>
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<tr>
<td>4.2</td>
<td>Expand access to primary care; schedule primary care follow-up appointments for patients before discharge</td>
<td>4.2.1 Inpatient navigator schedules 85% of appointments before patient is discharged, referring to CommunityHealth or partner agencies</td>
<td>80% of appointments scheduled; refer 350 people to CommunityHealth or partner agencies</td>
<td>83% of appointments scheduled; refer 350 people to CommunityHealth or partner agencies</td>
<td>90% of appointments scheduled; refer 350 people to CommunityHealth or partner agencies</td>
<td>85% of appointments scheduled; referred 1,050 people to CommunityHealth or partner agencies</td>
<td>% of appointments scheduled; # of referrals</td>
</tr>
<tr>
<td>4.3</td>
<td>Maintain a highly qualified CHW team</td>
<td>4.3.1 Select CHWs to complete chronic disease self-management program (CDSMP) training; lead CDSMP sessions with 10 community partners</td>
<td>3 CHWs complete training; lead up to 9 sessions with community partners</td>
<td>2 CHWs complete training; lead up to 9 sessions with community partners</td>
<td>1 CHW complete training; leads up to 9 sessions with community partners</td>
<td>6 CHWs completed training; led up to 27 sessions with community partners</td>
<td># of CHWs completing training; # of CHW-hosted or co-hosted CDSMP sessions</td>
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<td>4.3.2 CHWs complete Malcolm X College CHW certificate program (offered during the work day at no cost to CHWs)</td>
<td>4 CHWs complete program</td>
<td>4 CHWs complete program</td>
<td>4 CHWs complete program</td>
<td>12 CHWs completed program</td>
<td># of CHWs completing program</td>
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<td>4.3.3 Engage CHWs as frontline public health workers to connect people to nursing and social work services</td>
<td>Determine baseline for eligible referrals; refer 720 people</td>
<td>720 people referred</td>
<td>720 people referred</td>
<td>2,160 people referred</td>
<td># of referrals; % of eligible referrals made successfully (determining data availability)</td>
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<td>4.4</td>
<td>Develop meaningful, sustainable connections to CHW services with 5 new community partners</td>
<td>1 new partner engaged</td>
<td>2 new partners engaged</td>
<td>2 new partners engaged</td>
<td>5 new partners engaged</td>
<td># of new partnerships</td>
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<tr>
<td>4.5</td>
<td>Host community events to provide health education and promotion, resource coordination, care navigation, other services (financial literacy, public benefits enrollment)</td>
<td>Host quarterly events to reach up to 400 people</td>
<td>Host quarterly events to reach up to 400 people</td>
<td>Host quarterly events to reach up to 400 people</td>
<td>At least 12 events hosted, reaching up to 1,200 people annually</td>
<td># of events hosted; # of attendees per session; # of partner/co-host departments or organizations</td>
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<tr>
<td>4.6</td>
<td>Expand CHW integration into SBHCs to increase access to wraparound supports</td>
<td>Support 33 families and connect to services</td>
<td>Support 33 families and connect to services</td>
<td>Support 33 families and connect to services</td>
<td>100 families supported and connected to services</td>
<td># of families supported and connected to services</td>
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&A = Alliance for Health Equity (AHE)  
&H = Chicago Heal Initiative (HEAL)  
&W = West Side United (WSU)
<table>
<thead>
<tr>
<th>GOAL</th>
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<tr>
<td>GOAL 5</td>
<td>Improve maternal and child health outcomes</td>
<td>5.1 Invest, develop and participate in two-generation initiatives to support whole-family health</td>
<td><strong>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</strong></td>
<td>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</td>
<td>Hold 8 advisory team meetings; identify project to pursue; secure grant funding for project</td>
<td>Hold 8 advisory team meetings</td>
<td>24 advisory team meetings held</td>
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<td>Hold 800 families served; 75% connected to additional resources</td>
<td>880 families served; 80% connected to additional resources</td>
<td>960 families served; 85% connected to additional resources</td>
<td>2,640 families served; 80% connected to additional resources</td>
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<td>5.1.2 Continue participation in Family Connects Chicago for nurse home visits to families with newborns, health checks, SDOH screening and referrals</td>
<td>800 families served; 75% connected to additional resources</td>
<td>880 families served; 80% connected to additional resources</td>
<td>960 families served; 85% connected to additional resources</td>
<td>2,640 families served; 80% connected to additional resources</td>
<td># of home visits delivered; % of families connected to resources</td>
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<td>5.2 Partner with community-based organizations to expand behavioral health initiatives that promote relational health</td>
<td><strong>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</strong></td>
<td>Serve 100 families; refer 50% successfully to supports</td>
<td>Serve 110 families; refer 55% successfully to supports</td>
<td>Serve 120 families; refer 60% successfully to supports</td>
<td>330 families served; 55% referred successfully to supports</td>
<td># and % of families successfully referred to supports</td>
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<td>5.2.2 Continue developing Building Early Connections: behavioral health support/parenting groups for families; behavioral health training/consultation support for childcare providers</td>
<td>Serve 800 families and 16 childcare providers</td>
<td>Serve 900 families and 16 childcare providers</td>
<td>Serve 1000 families and 46 childcare providers</td>
<td>2,700 families and 46 childcare providers served</td>
<td># of families receiving support; # of childcare providers receiving training and support</td>
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<td>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</td>
<td>Support 100 people; connect 75% of their families to additional resources</td>
<td>Support 100 people; connect 80% of their families to additional resources</td>
<td>Support 100 people; connect 85% of their families to additional resources</td>
<td>300 people supported; 80% of families connected to additional resources</td>
<td># of people supported, % of families connected to additional resources</td>
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</tbody>
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\(\text{A} = \text{Alliance for Health Equity (AHE)}\)

\(\text{H} = \text{Chicago Heal Initiative (HEAL)}\)

\(\text{W} = \text{West Side United (WSU)}\)
CHNA and CHIP collaborators

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RUSH Creative Media

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Alexis Artman, RUSH University Medical Center
Monnette Bariel, Beyond Hunger
Alexis Burks, The Community Builders/Dakley Square
James Coleman, West Side Health Authority
Emily Compton, The Sheridan at River Forest
Steve Epking, Hope Community Church
Marshall Hatch, MAAPFA Redemption Project
Jacqueline Hawkins, North Lawndale Employment Network
Emily Hendel, Community Health
Ilda Hernandez, Enlace Chicago
Osen Imoukhuede, By the Hand
Jackie Ivoveli, Park District of Forest Park
Gina Jamson, Garfield Park Council
Andrea Lee, UCAN
Emma Lozano, Lincoln United Methodist Church
Rose Mabwa, The Community Builders
Becky Martin, A House in Austin
Cheron Massenburg, Breakthrough
Suzette Porter, Hope Community Church
Esteban Rodriguez, Northwest Side Housing Center
Jackie Soto, Humboldt Park Health

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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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Please note that photos of unmasked people appearing in this document were taken before the COVID-19 pandemic.