Nurturing Health Equity

Growing Stronger Communities, Together

A Community Health Needs Report and Action Plan

FY2025 CHNA + FY2026-2028 CHIP

Rush University Medical Center & Rush Oak Park Hospital

RUSH

Everyone should get the chance to be healthy

Given the right conditions — stable housing, quality education, good jobs, nutritious food, accessible health care — everyone can thrive. However, decades of disinvestment and systemic discrimination have created an environment where not everyone gets an equal chance to lead long and fruitful lives in the communities they call home. Like tending a shared garden, achieving equity takes strong relationships, a common vision and collaborative work.

The mission of Rush University System for Health (Rush) is to improve the health of the individuals and diverse communities we serve through the integration of outstanding patient care, education, research and community partnerships.

We believe that **everyone should get the chance to live their healthiest lives.** That's how we define health equity. And while the quality health care we provide at Rush can help bring that vision to life, it's not enough on its own.

In 2016, Rush made health equity a strategic focus that's now fully embedded systemwide in the way we work, research, teach, spend and more. Our approach is unique because it addresses barriers to good health with a focus on building community wealth.

Nurturing an environment where health equity becomes a reality relies on large institutions like Rush working with others to break down barriers and invest in the essentials needed for health. Over the years, we've developed strong relationships with nonprofit organizations like Enlace in South Lawndale and houses of worship like New Mt. Pilgrim Missionary Baptist Church in West Garfield Park. Deeply rooted and trusted in their neighborhoods, these organizations lead the way in driving local change. Every community has strengths that help create solutions.

We know that by building authentic partnerships and making smart, lasting investments, we can help improve health and well-being in every community.

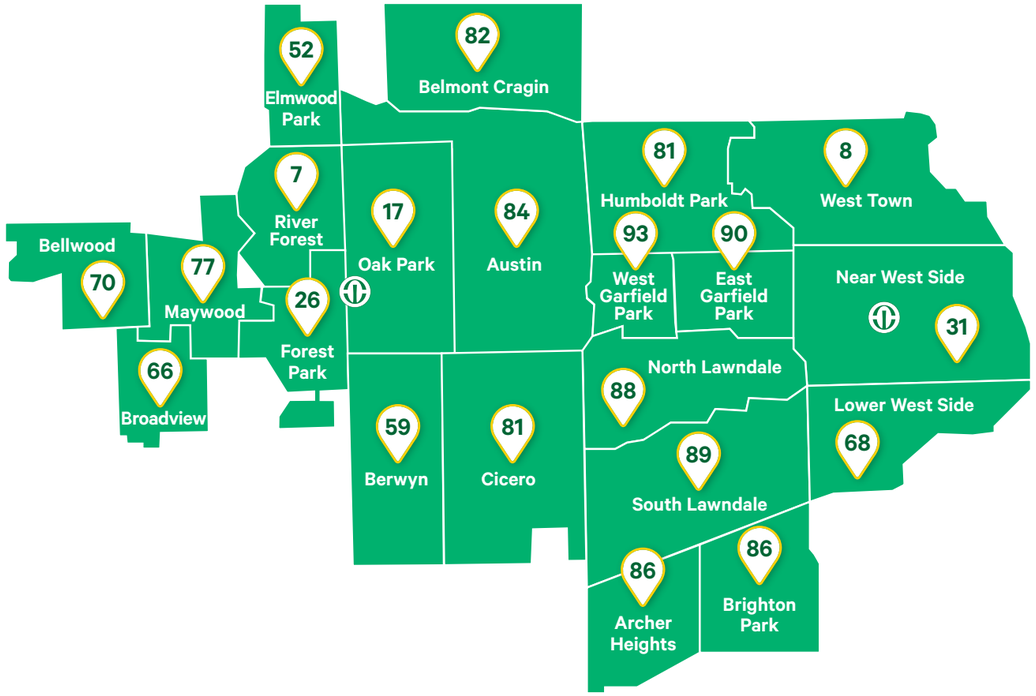
Mapping the field: Our triennial Community Health Needs Assessment and Community Health Implementation Plan

Every three years, Rush collects data and invites input from the community to identify the key issues that affect the health of people and neighborhoods in the Rush service area. We use that data to create a **Community Health Needs Assessment** (CHNA). In collaboration with community members and nonprofits, health care organizations, government agencies and others, we create a **Community Health Implementation Plan** (CHIP) that lays out how we'll address those issues.

What began with a focus on 11 neighborhoods in 2016 has grown steadily as we've deepened our understanding of where our patients live. By 2022, our CHNA and CHIP covered 17 communities, and in 2025, we've expanded again, adding four more communities — Bellwood, Broadview, Cicero and Maywood — for a total of 21. These additions are driven by data on the ZIP codes of patients who receive inpatient and emergency department care at Rush University Medical Center and Rush Oak Park Hospital, helping us target our investments and partnerships where they matter most.*

*Rush Copley Medical Center creates its own CHNA and CHIP.

Rush University Medical Center and Rush Oak Park Hospital service area, 2025: Hardship Index



This map shows each community's score on the Hardship Index. Its 1-100 scale, with 100 indicating the highest level of hardship, is based on six factors from the annual American Community Survey conducted by the U.S. Census Bureau.

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

River Forest has the lowest Hardship Index score in the Rush service area (7). West Garfield Park has the highest (93).

These 21 communities reflect the incredible diversity of the city of Chicago and its surrounding suburbs.

The nearly 906,000 people who live in this map area speak more than 40 languages, and more than one-third of them speak a language other than English. Some neighborhoods, like the Near West Side, are home to a diverse mix of racial and ethnic backgrounds. Others, like Cicero, are more homogeneous. About 90% of Cicero residents are Hispanic/Latino.

Where you live may affect how long you live: The neighborhood life expectancy gap

Neighborhood conditions and access to resources have a big impact on health and average life expectancy.

The history of how some neighborhoods came to have less access to resources goes back many decades.

From the late 1930s to the late 1960s, laws and rules promoting racial residential segregation restricted home ownership and residency based on race and ethnicity. For example, banks were warned against lending money to buy homes in so-called "undesirable" areas where Black people, Latinos, new immigrants and Jewish people lived. Restrictive covenants (clauses placed in mortgages or leases) prohibited white homeowners from selling or renting their homes to anyone of a different racial or ethnic group.

This forced segregation limited not only home ownership, but local job opportunities. As a result, residents had limited access to jobs that offered a living wage. Segregated workers either had low-paying jobs nearby, traveled long distances for work or faced unemployment. This meant that many in these communities were more likely to experience poverty.

Segregation affected not only the earning power of particular families, but the environment and opportunities for the entire community. Lower home values translated into lower property taxes, which in turn meant fewer resources devoted to schools, affecting children's access to quality education. And when businesses like supermarkets abandoned these areas, families had to travel long distances for food.

Whole communities of people were unable to access the building blocks of good health: nutritious food, safe housing, quality education, well-paying jobs and quality health care.

Almost 60 years after restrictive housing rules were made illegal, we still see the effect of the limits they placed on economic development, community safety and residents' power. Unequal access to resources has created and worsened large differences in life expectancy between neighborhoods with higher levels of racial segregation and those with lower levels.

What unequal access looks like: In North Lawndale, where more than 30,000 people live and the population is more than three-fourths Black, there's only one supermarket. Just across Western Avenue in the Near West Side neighborhood, where the population is about one-fourth Black, there are about twice as many people but 10 times the number of supermarkets offering healthy food options.

In West Garfield Park, average life expectancy is 63.4 years. Just three miles away, in the better-resourced Near West Side, it's 77.4 years. And in Chicago overall, Black residents have the lowest average life expectancy among all racial and ethnic groups: 69.8 years. That's 11.4 years less than the average of 81.2 years for all non-Black residents.

Average life expectancy is the estimated number of years a person is expected to live, based on the average age of death in a specific population. It doesn't predict anyone's exact lifespan. Some people will live much shorter or much longer lives than the average.

We know that these disparities in health and life expectancy are preventable, not inevitable. Research into neighborhood revitalization shows that investment in resources and wealth-building can make a measurable difference in community health.

A note on health and life expectancy data: We compare life expectancy data between neighborhoods and by race and ethnicity. Because it takes time for researchers and government agencies to collect, analyze and share information, the data in this report reflects a range of time periods between 2018 and 2023. This range, plus changes in methods of data collection and analysis, mean that life expectancy comparisons between one period and the next should be interpreted with care.

Nourishing an environment where everyone can flourish

We are working alongside community members, nonprofits, health care partners and public agencies to create the conditions that support health, access and fairness.

As an anchor institution and economic engine in the community, we are harnessing our resources and connections to invest in neighborhoods for the long term. Through our Anchor Mission strategy, we advance inclusive community development near Rush by making direct investments (for example, low-interest loans to community businesses), hiring locally, offering career pathways, forging community partnerships and purchasing from local businesses. And in 2018, we invested in creating West Side United, a collaborative of hospitals and community organizations that has become a national model for improving community health.

Investing in education is another strategic focus, as research consistently shows that people with more education have improved health outcomes and longer life expectancies.

While Chicago Public Schools (CPS) graduation rates have increased about 10% since 2013, only 31% of 9th-graders are projected to complete any college degree or certificate within 10 years. Despite the higher graduation rate, many CPS students face structural barriers to higher education like college affordability, access to academic advising and overall preparedness for college success. Through the Rush Education and Career Hub (REACH), students from ages 4 to 24 can access academic enrichment, careers and job pathway exploration, work readiness skills development and personalized supports if needed.

Tracking growth: Measuring our progress

We track the impact of our work toward health equity because we know that only by assessing what's working and what needs more attention can we ensure that our efforts lead to lasting change.

At Rush, when we want to improve something, we measure it and then focus on how to make it better. That sounds easy enough, but it can be challenging when the issue is large and complex. The obstacles to health equity are significant — and no one organization can tackle them alone.

Yet there are practical, feasible steps we can take to begin making progress. To identify some of those steps during our 2022 CHNA process, we listened to community members who identified five priority areas for improving health in their communities.

- Prevent and reduce chronic diseases like high blood pressure, diabetes and cancer
- Improve access to mental and behavioral health services
- Reduce inequities in the social, economic and structural drivers of health
- Increase access to quality health care
- Improve maternal and child health outcomes

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

In the three years since those conversations, we've made measurable progress, thanks to 52 initiatives that contribute to these priorities. Some examples:

- Preventing and reducing chronic diseases by offering better access to nutritious foods for **3,000 patients** enrolled in our Food Is Medicine/Veggie Rx program to receive healthy food at no cost
- Improving access to mental health services for **65% of Rush School-Based Health Center patients** with mental health needs who we connected to care
- Reducing inequities in the economic drivers of health for **70% of Rush Education and Career Hub (REACH) learners,** who earned industry-recognized credentials for entry-level jobs
- Increasing access to care for **47,875 patients and community members** screened and connected to resources, including primary care
- Supporting a healthy start for **2,400 new moms** who received support for social needs

Results: Rush Community Health Implementation Plan, FY2023-2025

GOAL	STRATEGY	INITIATIVES	FY23 TARGET	FY24 TARGET	FY25 TARGET	3-YEAR TOTAL
GOAL 1 Prevent and/or manage chronic conditions and risk factors	**1.1 Reduce risk factors through assessments, education; focus on chronic disease** A W	**1.1.1** Provide evidence-based chronic disease self-management and falls prevention programming to older adults (age 55+)	200 enrolled, 75% completing/ controlling condition in the program **Actual: 365; 77%**	200 enrolled, 75% completing/ controlling condition in the program **Actual: 350; 70%**	200 enrolled, 75% completing/ controlling condition in the program **Estimated: 400; 75%**	1,115 enrolled; 74% completed
		1.1.2 Expand Health Legacy diabetes education/prevention programs to Rush Oak Park, Rush Copley	Plan/secure resources for FY24 launch **Actual: Achieved**	50 people enrolled, 75% complete program **Actual: 35; 76%**	125 people enrolled, 75% complete program **Estimated: 60; 75%**	95 enrolled; 75% completed
	1.2 Reduce risk factors through assessments, education, condition management programs; focus on hypertension/diabetes A W	**1.2.1** Screen community members for uncontrolled hypertension through Alive Faith Network; refer those in need to disease management program	300 screened, 12% referred **Actual: 507; 18%**	350 screened, 12% referred **Actual: 438; 40%**	350 screened, 12% referred **Estimated: 350; 12%**	1,295 screened; 23% referred
		1.2.2 Enroll people with uncontrolled hypertension in 6-month reduction program through Alive Faith Network; connect to community health workers (CHWs) for education	36 enrolled, 80% completing program; 10% connected to CHWs **Actual: 35 enrolled; study ongoing; 98% connected**	42 enrolled, 80% completing program; 10% connected to CHWs **Actual: 66 enrolled; study ongoing; 46% connected**	42 enrolled, 80% completing program; 10% connected to CHWs **Estimated: 42 enrolled; study ongoing; 10% connect**	143 enrolled; 51% connected
		1.2.3 Screen people with physical mobility limitations and refer to 6-month program to increase mobility	300 screened, 12% referred **Actual: 56; 38%**	300 screened, 12% referred **Actual: 231; 45%**	300 screened, 12% referred **Estimated: 300; 12%**	587 screened; 32% referred
		1.2.4 Enroll 120 people with physical mobility limitations in 6-month mobility improvement program through Alive Faith Network	24 enrolled **Actual: 0** (screening began in Q4)	48 enrolled **Actual: 103**	48 enrolled **Estimated: 120**	223 enrolled
	1.3 Implement systemwide quality improvement/data action plan integrating racial equity A W	**1.3.1** Standardize systemwide training/implementation for collecting patient data (REaL, SOGI, SDOH)	Plan/secure resources for FY24 launch **Actual: Achieved**	50% of targeted staff trained **Actual: 25-50 trained @ RUMC, 50-150 trained @ ROPH**	80%+ of targeted staff trained **Estimated: 85%+**	75-200 staff trained; 85%+ of targeted staff
		1.3.2 Standardize process to derive insights from patient-reported data/clinical outcomes to recognize/address health disparities in vulnerable patient groups	Plan/secure resources; launch Spring 2023 **Actual: Achieved**	N/A	N/A	N/A
	1.4 Improve access to healthy food for patients screened as food-insecure A W	**1.4.1** Expand Food is Medicine program to ROPH; CHWs use NowPow to track meal recipients	100 patients receive food **Expansion slated for FY26**	150 patients receive food **Expansion slated for FY26**	200 patients receive food **Estimated: 450**	450 received food
		1.4.2 Integrate QR codes for healthy recipes (created by Rush University nutrition students) into meal boxes	10 recipes created for diabetes, hypertension, obesity **Actual: 10**	10 recipes created for diabetes, hypertension, obesity **Actual: 15**	10 recipes created for diabetes, hypertension, obesity **Estimated: 10**	35 recipes created
		1.4.3 Create Veggie Rx Pantry to provide meals for people screened as food-insecure and referred by PCPs	650 people referred to pantry through 6 clinics; serve 80% of those referred **Actual: 990; 96%**	4,320 people referred to pantry through 12 clinics; serve 90% of those referred **Actual: 3,690; 94%**	5,760 people referred to pantry through 12 clinics; serve 90% of those referred **Estimated: 2,200; 80%**	6,880 referred; 90% served
		1.4.4 Continue Rush Food Surplus Program; donate 18,000 lbs. of food annually	18,000 lbs. donated **Actual: 15,000**	18,000 lbs. donated **Actual: 16,100**	18,000 lbs. donated **Estimated: 25,000**	56,100 lbs. donated
		1.4.5 Partner with Community-based organizations (CBOs) and/or schools to create food and nutrition course	Partner with 1 CBO/school **Actual: 0**	Partner with 1 CBO/school **Actual: 0**	Partner with 1 CBO/school **Estimated: 3**	3 partnerships

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

GOAL	STRATEGY	INITIATIVES	FY23 TARGET	FY24 TARGET	FY25 TARGET	3-YEAR TOTAL
GOAL 2 Increase access to mental and behavioral health services	**2.1** Increase community screenings and referrals to mental health services (A) (H) (W)	**2.1.1** Provide therapy sessions to referred patients via Rush outpatient community psychotherapy clinic	3,433 sessions provided **Actual: 11,714**	3,535 sessions provided **Actual: 2,103**	3,640 sessions provided **Estimated: 10,600**	24,417 sessions provided
		2.1.2 Provide mental health screenings through Alive Faith Network	1,000 people screened; 70% linked to community resources **Actual: 0; seeking funding**	1,000 people screened; 75% linked to community resources **Actual: 0; seeking funding**	1,000 people screened; 80% linked to community resources **Estimated: 3,000; 75%**	3,000 screened; 75% linked
		2.1.3 Provide mental health screenings to Chicago Public Schools students through Rush School-Based Health Centers (SBHCs)	1,000 students screened; 65% receive additional support **Actual: 1,527; 49%**	1,000 students screened; 65% receive additional support **Actual: 1,656; 74%**	1,000 students screened; 65% receive additional support **Estimated: 1,000; 70%**	4,183 screened; 64% receive additional support
	2.2 Conduct community-based trainings — including train-the-trainer programs — in Mental Health First Aid (MHFA) (A) (W)	**2.2.1** Provide Mental Health First Aid facilitator training	10 people trained **Actual: 10**	25 people trained **Actual: 7**	25 people trained **Estimated: 85**	112 people trained
		2.2.2 Train community members in MHFA/trauma-informed care; partner with violence prevention organizations	500 people trained; 20% also trained in violence prevention **Actual: 489; other community partners provided violence prevention training**	700 people trained; 20% also trained in violence prevention **Actual: 161; other community partners provided violence prevention training**	700 people trained; 20% also trained in violence prevention **Estimated: 233; other community partners provided violence prevention training**	883 people trained
	2.3 Increase access to behavioral health services via telehealth (A) (H) (W)	**2.3.1** Pilot technology distribution program to support telehealth access for youth **Discontinued due to lack of feasibility**	Research, develop plan, secure funding support for FY24 launch	Pilot tech distribution to support telehealth for up to 50 people	Evaluate progress with pilot; update to support 50-75 people	N/A
		2.3.2 Advocate to: increase access for services; expand broadband for telehealth; increase Medicare/Medicaid reimbursement for mental health services; sustain telehealth flexibilities	Partner with WSU to research/ develop plan for policy/advocacy approach **Actual: Achieved**	Launch advocacy efforts **Actual: Achieved**	Evaluate progress and update approach as needed; secure telehealth resources **Actual: Increased telehealth access for high-need target group**	N/A
	2.4 Increase access to diverse, licensed mental health professionals (A) (W)	**2.4.1** Develop pipeline/fellowship opportunities for mental health professionals of color	Partner with Chicago State University to formalize program/ begin recruitment **Actual: 2 completed program**	Launch fellowship with 2 fellows **Actual: 4 completed program**	Fellowship active with 2 fellows **Estimated: 3 of 4 will complete program**	9 completed program
		2.4.2 Provide graduate-level internship opportunities for social work students in affirming mental health services for LGBTQ+ patients **Added FY24**	N/A	1 MSW intern integrated into Affirm team for training on affirming mental health services for LGBTQ+ patients **Actual: 1 trained**	Fellowship active with 2 fellows **Estimated: 1 intern trained**	2 trained

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GOAL	STRATEGY	INITIATIVES	FY23 TARGET	FY24 TARGET	FY25 TARGET	3-YEAR TOTAL
GOAL 3 Reduce inequities caused by the social, economic and structural determinants of health	**3.1 Improve K-16 educational outcomes; provide support through workforce development, industry-recognized credentials, wraparound supports** H W	**3.1.1** Provide high school/college internships/apprenticeships	250 students intern/apprentice **Actual: 409**	250 students intern/apprentice **Actual: 185**	250 students intern/apprentice **Estimated: 250**	844 interned/apprenticed
		3.1.2 Increase student/family interest/awareness of STEM/health care topics/careers	5,000 students/parents/families participate in programs/workshops/events **Actual: 12,400**	5,000 students/parents/families participate in programs/workshops/events **Actual: 2,026**	5,000 students/parents/families participate in programs/workshops/events **Estimated: 5,000**	19,426 participated
		3.1.3 Expand wraparound supports for students and families	90% of students/families eligible for high-touch programs complete REACH health equity assessment tool/receive eRx **Actual: 90%**	90% of students/families eligible for high-touch programs complete REACH health equity assessment tool/receive eRx **Actual: 90%**	90% of students/families eligible for high-touch programs complete REACH health equity assessment tool/receive eRx **Estimated: 90%**	90% completed assessment/ received eRx
		3.1.4 Provide workforce training for young people through age 24 to earn industry-recognized credentials	75% of enrollees complete training and earn credentials **Actual: 76%**	75% of enrollees complete training and earn credentials **Actual: 90%**	75% of enrollees complete training and earn credentials **Estimated: 75%**	80% completed training and earned credentials
		3.1.5 Provide college/career readiness enrichment to under-represented youth	90% of REACH participants enroll in post-secondary options; 75% persist **Actual: 93% enrolled; 90% persisted**	90% of REACH participants enroll in post-secondary options; 75% persist **Actual: 95% enrolled; 90% persisted**	90% of REACH participants enroll in post-secondary options; 75% persist **Estimated: 90% enroll; 75% persist**	93% enrolled; 85% persisted
	3.2 Collaborate to address workforce development, maximize income and benefits, increase financial literacy/ asset-building H W	**3.2.1** Expand workforce development/stackable credentials training for staff/community members to prepare for living-wage jobs	Launch up to 3 stackable credentials aligned with family-sustaining wages; enroll 50 community members and incumbent staff; 70% of those eligible earn credentials **Actual: 5; 50; 40%**	25 community members and incumbent staff enrolled in credentials program; 70% of those eligible earn credentials **Actual: 39; 40%**	50 community members and incumbent staff enrolled in credentials program; 70% of those eligible earn credentials **Estimated: 50; 70%**	5 credentials launched; 139 enrolled; 50% earned credentials
		3.2.2 Work with partners to develop/implement community-wide workforce development initiatives to increase employment access and opportunities	Collaborate with 3 community partners; target 18.5% of new hires to local communities **Actual: 20+; 18.1%**	Collaborate with 3 community partners; target 20% of new hires to local communities **Actual: 20; 19.75%**	Collaborate with 3 community partners; target 20% of new hires to local communities **Estimated: 20; 19.8%**	Collaborated with 20+ community partners; 19.2% of new hires from local communities
		3.2.3 Work with partners to create/implement community-wide workforce development initiatives to increase job stability	Collaborate with 3 community partners; refine plan for partnership (sourcing, educating, placing candidates); align target with system workforce needs; recruit high-need openings from community partners **Actual: 20 partners**	Collaborate with 3 community partners; develop system playbook for partnership; recruit high-need openings from community partners **Actual: 20 partners**	Collaborate with 3 community partners; refine and update playbook; recruit high-need openings from community partners **Estimated: 20 partners**	Collaborated with 20 community partners across 3 years
	3.3 Identify social determinants of health (SDOH) through screenings; refer those in need of social services A W	**3.3.1** Adopt systemwide approach to SDOH screening; roll out to RUMC, ROPH and RCMC; connect people with unmet needs (food, transportation, housing) to resources: social work referrals, community resource navigation	40,000 patients screened; 75% of those with needs receive interventions **Actual: 66,078; intervention data N/A**	40,000 patients screened; 75% of those with needs receive interventions **Actual: 46,216; 75%**	40,000 patients screened; 75% of those with needs receive interventions **Estimated: 40,000; 75%**	152,294 screened; 75% of those with needs received interventions
		3.3.2 Conduct screening through West Side Health Equity Collaborative (Medicaid Transformation initiative); provide resource navigation to community-based organizations	1,500 people screened; 85% screening positive for unmet needs receive interventions **Actual: 543; 92%**	1,500 people screened; 90% screening positive for unmet needs receive interventions **Actual: 969; 91%**	1,500 people screened; 95% screening positive for unmet needs receive interventions **Estimated: 1,776; 94%**	3,288 screened; 92% screening positive received interventions
		3.3.3 Integrate SDOH screening into community-based programming; create sustainable partnerships with CBOs to facilitate direct social service referrals	Partner with 1 CBO; 80% of referred patient needs addressed **Actual: 1 CBO; 80%**	Partner with 1 CBO; 80% of referred patient needs addressed **Actual: 1 CBO; 80%**	Partner with 1 CBO; 80% of referred patient needs addressed **Estimated: 1 CBO; 80%**	3 partnerships; 80% of referred patient needs addressed
		3.3.4 Provide social care assistance and care management to address social needs and barriers to care for community members and as part of select Rush quality improvement and equity initiatives **Added FY24**	N/A	1,000 individuals served with social work and/or CHW services **Actual: 963**	1,000 individuals served with social work and/or CHW services **Estimated: 1,564**	2,527 individuals served

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GOAL	STRATEGY	INITIATIVES	FY23 TARGET	FY24 TARGET	FY25 TARGET	3-YEAR TOTAL
GOAL 3, continued Reduce inequities caused by the social, economic and structural determinants of health	**3.4** Leverage coalition-building and partnerships for collective impact to advance health equity (H)	**3.4.1** Serve as active member/strategic lead in collaboratives to maximize impact; partner with WSU, Garfield Park Rite to Wellness, CHRRGE, Chicagoland Healthcare Workforce Collaborative, HEAL Initiative, Racial Equity Rapid Response Team	Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups **Actual: Achieved**	Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups **Actual: Achieved**	Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups **Estimated: Will achieve**	N/A
		3.4.2 Launch Phase II of RUSH BMO Institute for Health Equity (community programs and clinical practices; policy; education; health equity research)	Participate in meetings; provide capacity- building support; co-lead or lead committees/working groups **Actual: Achieved**	Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups **Actual: Achieved**	Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups **Estimated: Will achieve**	N/A
	3.5 Increase spending with local businesses (H) (W)	**3.5.1** Identify spend categories; work with RUMC/ROPH department leads to determine spend that can be shifted to small vendors; host events to connect with small vendors	Identify 2-3 spend categories; develop capacity-building workshop series for vendors; pilot with 5-7 vendors **Actual: Developed baseline**	Identify 2-3 spend categories; select vendors **Actual: Vendor symposium held**	Identify 2-3 spend categories **Estimated: 8 identified**	8 spend categories identified
		3.5.2 Spend $15.3 million with West Side vendors	Spend $5.1 million **Actual: $5.1 million**	Spend $5.1 million **Actual: $5.9 million**	Spend $5.1 million **Total through April 2025: $5.1 million**	$16.1 million spent
	3.6 Increase investment in local communities (H) (W)	**3.6.1** Work with community partners (Women's Business Development Center, Chicago Supplier Minority Development Council, WSU) to strengthen local vendors' capacity	Participate in meetings; communicate with partners for vendor support opportunities (events, meetings, fairs) **Actual: Achieved**	Participate in meetings; communicate with partners for vendor support opportunities (events, meetings, fairs) **Actual: Achieved**	Participate in meetings; communicate with partners for vendor support opportunities (events, meetings, fairs) **Estimated: Will achieve**	N/A
		3.6.2 Make place-based investments; work with treasury and partner community development financial institutions to support investments in healthy food and wellness	Invest $1.33 million **Actual: $1.33 million**	Invest $1.33 million **Actual: $1.33 million**	Invest $1.33 million **Actual: $3.82 million**	$6.48 million invested

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GOAL	STRATEGY	INITIATIVES	FY23 TARGET	FY24 TARGET	FY25 TARGET	3-YEAR TOTAL
GOAL 4 Increase access to quality health care	**4.1 Expand community clinical practices; partner with collaboratives to improve health status of Medicaid-insured and uninsured people** A H W	**4.1.1** Serve as clinical provider via city/regional initiatives (Connect Chicago/Congregate Testing, Health Equity Zones, CHHRGE)	Target and complete 8,000 SDOH screenings and health risk assessments (HRAs) **Actual: 1,004**	Target and complete 8,000 SDOH screenings and HRAs **Actual: 25,570**	Target and complete 8,000 SDOH screenings and HRAs **Estimated: 24,000**	50,574 screenings and HRAs completed
		4.1.2 Partner with CBOs and health care organizations (HCOs) on state health care transformation initiative (West Side Health Equity Collaborative)	Connect with 13 CBOs and 9 HCOs, with 5% of total referrals **Actual: 33; 8%**	Partner with 1 more CBO and 5 more HCOs, with 5% of total referrals **Actual: 2; 6%**	Partner with 16 CBOs and 17 HCOs, with 5% of total referrals **Estimated: 33; 5%**	33 partnerships, 5% of total referrals
		4.1.3 Partner with LGBTQ+-focused CBO to link uninsured and underinsured patients with affirming health care and social services **Added FY24**	N/A	Partner with 2 CBOs **Actual: 1**	Partner with 2 CBOs **Estimated: 2**	3 partnerships
	4.2 Expand access to primary care; schedule primary care follow-up appointments for patients before discharge A W	**4.2.1** Primary care navigation provided to people accessing Rush's Emergency Department **Updated definition FY24**	80% of appointments scheduled; refer 350 people to CommunityHealth or partner agencies **Actual: 80%; 350**	83% of appointments scheduled; refer 350 people to CommunityHealth or partner agencies **Actual: 83%; 350**	90% of appointments scheduled; refer 350 people to CommunityHealth or partner agencies **Estimated: 90%; 350**	84% of appointments scheduled; 1,050 people referred
	4.3 Maintain a highly qualified CHW team A W	**4.3.1** Train or develop cadre of CHWs to complete chronic disease self-management program (CDSMP) training; lead CDSMP sessions with 10 community partners	3 CHWs complete training; lead up to 9 sessions with community partners **Actual: 3 completed; 7 hosted/co-hosted sessions**	2 CHWs complete training; lead up to 9 sessions with community partners **Actual: 10 completed; 11 hosted/co-hosted sessions**	1 CHW completes training; leads up to 9 sessions with community partners **Estimated: 6 complete; 27 host/co-host sessions**	19 CHWs completed training; 45 hosted/co-hosted sessions
		4.3.2 CHWs complete Malcolm X College CHW certificate program (offered during the work day at no cost to CHWs)	4 CHWs complete program **Actual: 9**	4 CHWs complete program Actual: 1	4 CHWs complete program **Estimated: 1**	11 CHWs completed program
		4.3.3 Engage CHWs as frontline public health workers to connect people to nursing and social work services	Determine baseline for eligible referrals; refer 720 people **Actual: 862**	720 people referred **Actual: 939**	720 people referred **Estimated: 720**	2,521 people referred
		4.3.4 Develop meaningful, sustainable connections to CHW services with 5 new community partners	1 new partner engaged **Actual: 1**	2 new partners engaged **Actual: 3**	2 new partners engaged **Estimated: 2**	5 new partners engaged
		4.3.5 Host community events to provide health education and promotion, resource coordination, care navigation, other services (financial literacy, public benefits enrollment)	Host quarterly events to reach up to 400 people **Actual: 717**	Host quarterly events to reach up to 400 people **Actual: 570**	Host quarterly events to reach up to 400 people **Estimated: 400**	1,687 people reached
		4.3.6 Expand CHW integration into SBHCs to increase access to wraparound supports	Support 33 families and connect to services **Actual: 225**	Support 33 families and connect to services **Actual: 640**	Support 33 families and connect to services **Estimated: 362**	1,227 families served
	4.4 Expand access to affirming health care for LGBTQ+ patients A H W	**4.4.1** Engage patient navigators to connect LGBTQ+ community members to primary care and specialty services **Added FY24**	N/A	500 referrals, 25% appointments scheduled **Actual: 1,280; 52%**	500 referrals, 25% appointments scheduled **Estimated: 1400; 45%**	2,680 referrals; 49% scheduled

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

GOAL	STRATEGY	INITIATIVES	FY23 TARGET	FY24 TARGET	FY25 TARGET	3-YEAR TOTAL
GOAL 5 Improve maternal and child health outcomes	**5.1** Invest, develop and participate in two-generation initiatives to support whole-family health (A) (H) (W)	**5.1.1** Partner with WSU, Sinai Urban Health Institute, CDPH to support East Garfield Park Best Babies Zone to improve birth outcomes in East Garfield Park	Hold 8 advisory team meetings; disseminate storytelling project; develop strategic plan; add 2 residents at large and 1 representative from another sector to advisory team **Actual: 11 meetings**	Hold 8 advisory team meetings; identify project to pursue; secure grant funding for project **Actual: 8 meetings; folded Best Babies Zone into BRIDGES program in FY24**	Hold 8 advisory team meetings **Estimated: 8 meetings**	27 meetings held
		5.1.2 Continue participation in Family Connects Chicago for nurse home visits to families with newborns, health checks, SDOH screening and referrals	800 families served; 75% connected to additional resources **Actual: 136; 75%**	880 families served; 80% connected to additional resources **Actual: 195; 86%**	960 families served; 85% connected to additional resources **Estimated: 250; 85%**	581 families served; 82% connected
	5.2 Partner with community-based organizations to expand behavioral health initiatives that promote relational health (A) (H) (W)	**5.2.1** Use Adverse Child Experiences screening to identify pregnant/parenting people affected by childhood trauma; offer evidence-based home visiting plus connections to programs and other parenting supports	Serve 100 families; refer 50% successfully to supports **Actual: 72; 42%**	Serve 110 families; refer 55% successfully to supports **Actual: 93; 68%**	Serve 110 families; refer 60% successfully to supports **Estimated: 110; 55%**	275 families served; 55% referred
		5.2.2 Continue developing Building Early Connections: behavioral health support/parenting groups for families; behavioral health training/consultation support for childcare providers	Serve 800 families and 15 childcare providers **Actual: 11,202; 27**	Serve 900 families and 15 childcare providers **Actual: 5,315; 10**	Serve 1,000 families and 15 childcare providers **Estimated: 2,700; 45**	19,217 families and 82 childcare providers served
		5.2.3 Provide CHW support for 300 pregnant/postpartum people seeking emergency department care: identify/support linkages to primary/obstetric/specialty care; connect people to parenting support programs; determine resources to support unmet social needs	Support 100 people; connect 75% of their families to additional resources **Actual: 768; 13%**	Support 100 people; connect 80% of their families to additional resources **Actual: 1,400; 80%**	Support 100 people; connect 85% of their families to additional resources **Estimated: 300; 80%**	2,468 people supported; 58% of families connected

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

The Rush 2025 Community Health Needs Assessment: Grounded in community voices

If you're looking for answers to challenges in a community, it makes sense to begin by listening to those who are deeply rooted there. We co-create solutions with residents and other stakeholders, rather than assuming we know what's best or acting alone. As our service area grows, so does the complexity of our work to reduce health disparities. The result: sensible strategies that make the most of communities' strengths, focus on the needs local people care about most and incorporate their ideas for building a healthier neighborhood.

Angela Taylor, a lifelong West Sider, former social worker and current wellness director of the Garfield Park Community Council, is a driving force behind better health, better food and more opportunities in her community. Under her leadership, the Garfield Park Garden Network transformed three acres of vacant lots into vibrant community gardens that provide fresh produce to residents and host a paid summer internship program where teens learn horticulture, nutrition and job skills. "If we eat healthy, we'll think healthy and then we can build healthy," she says.

An integral voice in ensuring that the new Sankofa Wellness Center (see p. 26) is "for us, by us," Taylor says that institutional partners like Rush "came to hear what the community had to say about needs and wants, and listened to what they heard the community say they wanted. There was no sitting in a room deciding, 'they need this, they need that.' Didn't work that way." She calls the Sankofa project "the first seed we have planted in the growth of West Garfield Park," and envisions "a well-cultivated community" with a thriving Madison Street corridor at its heart. "Working together and finding value in each other, that's a great model. That's where the work happens."

With our partners at the Association for Health Equity (AHE), we spent time listening to people who live in these communities. Residents completed 1,800 surveys about their communities' health needs. We met in person with more than 400 community residents in 54 focus groups across our service area. And we also invited community members, local nonprofits, Rush staff and others to a series of town hall meetings in early 2025. Together, attendees generated ideas for addressing the issues raised by community members. The goals, strategies and measures in our new CHIP have been shaped to match what community members say they need most.

What we learned: Community member concerns and public health data

The health issues that residents talked about most often in **focus groups:**

Mental health and substance use

"There's a stigma within the Black community with regard to mental health, and it's been building over the years."

Economic security

"I want to see people with more opportunity to have jobs, more mental stability, more financial stability."

Violence prevention

"There is more violence now and people cannot go outside as much. Kids have to be more worried about danger. Here, violence is a big problem. It means that youth is not as free or healthy."

Access to healthy food

"I would love to get rid of every liquor store that says they're a full grocery store in this community. I'm like, a full grocery store because you have a banana or an apple? That's how they classify you as a grocery store."

Access to quality health care

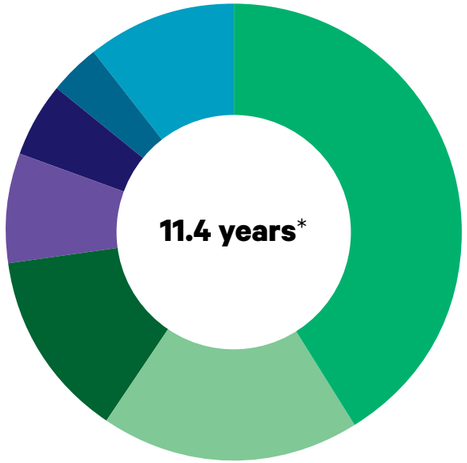
"The younger population want to access services, but need help to navigate the system. They access the ED when there is a crisis, but not preventative small interventions to avoid crisis."

The health needs that residents identified most often in **surveys:**

- Improving mental health treatment, especially for stress and trauma
- Substance use treatment
- Addressing violent crime and property crime to make neighborhoods safer
- Better management of diabetes and better access to grocery stores that carry fresh fruits and vegetables
- Solutions to decrease homelessness and increase affordable housing
- A holistic approach for people with obesity

We also looked at data from the Illinois Department of Public Health, including information about what drives the life expectancy gap and what causes of death are most common.

Conditions driving Chicago's average life expectancy gap: In our online community profiles, you'll see data related to the conditions that contribute to the 11.4-year gap in average life expectancy between Black and non-Black Chicagoans.



Chronic disease (4.7 years)
Heart disease, cancer, stroke, diabetes, COPD, kidney disease, other circulatory diseases

Homicide (2.1 years)
Firearm and all-cause homicide

Opioid overdose (1.5 years)
Fatal overdoses from substances including heroin, fentanyl, pain relievers, methadone

Infectious diseases (0.9 years)
Syndemic infectious diseases including HIV and respiratory diseases including influenza, pneumonia, COVID-19

Accidents (0.6 years)
Motor vehicle accidents, non-opioid drug overdoses, unintentional injuries, etc.

Infant mortality (0.4 years)
Deaths before 1 year of age

Other (1.2 years)
All other causes of death

*Source: West Side United 2022 Life Expectancy Debrief, January 2025

Leading causes of death on the West Side: As is the case across Chicago, chronic diseases like heart disease and cancer are among the leading causes of death on the West Side. Yet external causes like opioid overdoses and homicide occur at higher rates than in the city overall.

Disparities are even larger when we compare Chicago neighborhoods to some suburban communities. For example, in Oak Park, the homicide rate is 5 per 100,000 people.

But when you cross Austin Boulevard into the Austin neighborhood, you're in much different territory. There, the homicide rate is 66 per 100,000 people — more than 13 times higher than in Oak Park.

There are many reasons for this difference. We know that violence is often driven by a lack of opportunities for meaningful employment — and that the effects of systemic racism dampen job prospects in communities of color. In Austin, unemployment rates are much higher than in Oak Park, and students in Austin are less likely to complete high school and go on to college or well-paying jobs. And people's lack of trust in the police may lead to more self-protective behaviors like carrying weapons.

By addressing the root causes of these problems, we can help improve the safety of Austin and other neighborhoods that are harmed by violence.

Top 10 leading causes of death on the West Side*

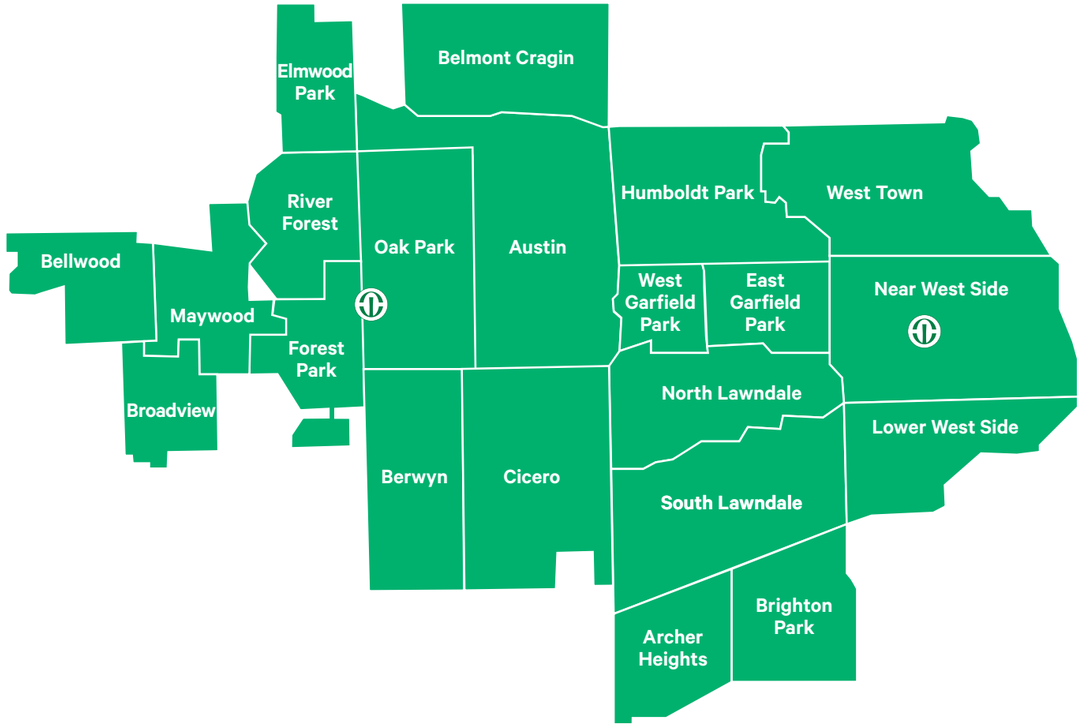
1	Heart disease
2	Accidents (injuries)
3	Cancer
4	Drug overdose
5	Coronary heart disease
6	Stroke
7	Homicide
8	Firearm-related
9	Chronic liver disease
10	Lung, trachea and bronchus cancer

A look at the landscape: Community profiles

Different neighborhoods possess different strengths and challenges. While some areas have long benefited from abundant resources, others have faced systemic barriers to access. Seeing the full picture means understanding community assets, quantifying the challenges and hearing residents' thoughts about what works and what could improve.

The 21 communities in the Rush CHNA service area reflect a wide range of demographics, assets and challenges. Our online profiles provide a close-up, interactive look at each community.

View them here: rush.edu/communities2025



Public health data sources

The public health data in the 2025 community profiles comes from a variety of sources, including the Chicago Department of Public Health (CDPH), Cook County Department of Public Health (CCDPH) and Illinois Department of Public Health (IDPH). You can explore much of the data online in the Chicago Health Atlas and the Cook County Health Atlas.

To make sure we're looking at similar factors in city and suburban communities, we adjusted two of the things we measure: "Moms getting prenatal care in first trimester" and "Easy access to fruits and vegetables" are slightly different than the measures in our last CHNA.

Because it takes time for researchers and government agencies to collect, analyze and share data, the data in our neighborhood profiles reflects a range of time periods as shown below.

Percentages are rounded.

Average life expectancy	CDPH and CCPDH analysis of IDPH data, 2022
Race/ethnicity and total population	American Community Survey, 2019-2023
Top five causes of death	CDPH and CCDPH, 2019-2023
Low birth weight percentage	CDPH and CCDPH, 2019-2023
Asthma ED visits per 10K	IDPH via CDPH, 2019-2023 *(data is for one representative ZIP code per community)*
Child poverty percentage	American Community Survey, 2019-2023
Overall health status	Healthy Chicago Survey and Healthy Cook Survey, 2022-2023
Indicators for heart disease	Healthy Chicago Survey (CDPH) & Healthy Cook Survey (CCDPH), 2022-2023
Cancer mortality rates	IDPH Vital Records, 2018-2022
High blood pressure	Healthy Chicago Survey and Healthy Cook Survey, 2022-2023
Diabetes	Healthy Chicago Survey and Healthy Cook Survey, 2022-2023
Obesity	Healthy Chicago Survey and Healthy Cook Survey, 2022-2023
Moms getting prenatal care in first trimester	IDPH Vital Records, 2018-2022
Easy access to fruits and vegetables	Healthy Chicago Survey and Healthy Cook Survey, 2022-2023
People living in poverty	American Community Survey, 2019-2023
Unemployment	American Community Survey, 2019-2023
Sense of safety	Healthy Chicago Survey and Healthy Cook Survey, 2022-2023

The Rush 2026-2028 Community Health Implementation Plan: Cultivating meaningful change

Just as a flourishing garden doesn't spring up overnight, the journey toward health equity takes sustained effort. We're committed to working with our community partners to identify the most fruitful places to direct our energy and investment — and the most meaningful ways to measure what works.

Using input from our communities, facts about the patients we serve and information about the incidence of specific health conditions, we take a data-informed, equity-focused approach to improving health outcomes for everyone in the Chicago area.

We emphasize community-driven interventions. That means we take them on in partnership with community members, local nonprofits and other stakeholders who join us in planning and implementing the solutions we create together, and in measuring their impact so we can make them more effective.

Public, private and community collaboration is like the "three sisters" method of growing crops. When you plant corn, beans and squash together, the corn provides stalks for the beans to climb. Beans replenish nutrients in the soil. And squash covers the ground, retaining moisture and keeping weeds down. Each plant fulfills a specific role and supports the others. Together, they create a self-sustaining system where all three thrive instead of struggling alone. Rush applies the same idea: public agencies, private partners and community groups each have a role, and working together replenishes our ideas and energy.

In West Garfield Park, a transformative project to improve health outcomes and close the life expectancy gap won the 2022 Pritzker-Traubert Foundation Chicago Prize for community economic development and broke ground in September 2024. The Sankofa Wellness Village development, led by the Garfield Park Rite to Wellness Collaborative, The Community Builders and MAAFA Redemption Project, brings $50 million in public and private investments to a series of interconnected health, recreation and wealth-building projects, including the Rush Center for Community Well-Being. As an anchor partner of the Sankofa Wellness Center, Rush will provide services that include connections to needed resources, health education, mental health care and career development programs.

We are making systemic change by implementing systemic solutions. This means working in partnership with other institutions that are pursuing the same goal. Our CHIP aligns with the city's Healthy Chicago 2025 Strategic Plan and with Healthy People 2030, the nationwide initiative headquartered in the Office of Disease Prevention and Health Promotion in the U.S. Department of Health and Human Services.

Our CHIP for 2026-2028 is built around five goals and 66 corresponding initiatives.

GOAL 1

Preventing and reducing chronic conditions and risk factors

"The YMCA has programs for weight loss, hypertension, pre-diabetes. I think there should be more programs like these elsewhere. I can see these programs being offered at the libraries and park districts for free. Doctors give medication for diabetes and hypertension, but I think with some help and some conversations [about nutrition], we can make it better."

GOAL 2

Expanding access to mental and behavioral health services

"The state closed the mental health centers, but we have to have those services available. We still have the needs, but they are not being provided for in the community."

GOAL 3

Addressing social, economic and structural drivers of health to reduce inequities

"For adults, stress comes from lack of a job or worries about children. Some adults work at night, so they do not sleep well; they also stress over chronic conditions."

GOAL 4

Enhancing access to quality care and community services

"We don't have access to health care, right? It's not a lot of health care close to where I live, like, I always have to travel, and I feel like it's just not a lot of resources."

GOAL 5

Advancing maternal and child health outcomes

"Having education and resources or options before and during labor makes a big difference. There are resources, but not everyone knows, or people think it takes too much time. One person I know has a doula coming in every two weeks postpartum, which has helped a lot."

Our initiatives reflect the three strategies that inform our health equity work:

- **Implement evidence-based approaches to reduce the life expectancy gap:** We use research-backed strategies and proven interventions to address health disparities and ensure all communities have access to the resources needed for longer, healthier lives.
- **Emphasize measurable outcomes and population-specific strategies:** We set clear goals, track progress, and tailor initiatives to the unique needs of different communities to ensure effective, equitable impact.
- **Drive impact through innovation, strategic partnerships, policy and advocacy:** We collaborate with other organizations to create new solutions and influence policies to create lasting, systemic changes that promote health equity.

Rush Community Health Implementation Plan, FY2026-2028

GOAL	STRATEGY	INITIATIVES	FY26 TARGET	FY27 TARGET	FY28 TARGET	3-YEAR TOTAL	MEASURES
GOAL 1 Preventing and reducing chronic conditions and risk factors	**1.1 Reduce risk factors through assessments/education; focus on chronic disease** A W	**1.1.1** Provide evidence-based chronic disease prevention and self-management programming to adults in Rush's service area, including targeted outreach to women through the Health Legacy Program (HLP)	160 people enrolled in Rush Generations self-management workshops (72% complete); 3 HLP workshops supporting lifestyle change delivered to at least 30 women (75% complete)	160 people enrolled in Rush Generations self-management workshops (72% complete); 120 enrolled in falls prevention programming (55% complete); 3 HLP workshops delivered to at least 30 women (75% complete)	160 people enrolled in Rush Generations self-management workshops (72% complete); 3 HLP workshops delivered to at least 30 women (75% complete)	480 people enrolled in Rush Generations self-management workshops (72% complete); 90 women participated in HLP workshops (75% complete)	# enrolled; % completing/ controlling condition in the program; % program completion
		1.1.2 Provide evidence-based chronic disease prevention and self-management programming to adults in Rush's service area, including targeted outreach to women through the Health Legacy Program (HLP)	175 adults screened and connected to services/ programs as needed	185 adults screened and connected to services/ programs as needed	195 adults screened and connected to services/ programs as needed	555 adults screened at 60 community events and connected to services/ programs as needed	# adults screened; % connected to services/programs post-screening; # screening events; avg. # screened per event; % with identified needs; % receiving follow-up support
		1.1.3 Provide evidence-based falls prevention programming to older adults and people with mobility issues	120 people enrolled in Rush Generations falls prevention programming; 55% complete	120 people enrolled in Rush Generations falls prevention programming; 55% complete	120 people enrolled in Rush Generations falls prevention programming; 55% complete	360 people enrolled in Rush Generations falls prevention programming; 55% completed	# enrolled in falls prevention programming; % completing program; # enrolled annually, % completing program
		1.1.4 Integrate peer-led Rush Generations workshops (healthy living programs, falls prevention, chronic disease self-management) into West Side community organizations by building trained cadre of community members (including youth) to deliver chronic disease education/outreach/self-management support	Partner with 8 community-based organizations (CBOs) to host workshops and/or train staff and volunteers; engage at least 5 community members in chronic disease self-management program (CDSMP) workshops using train-the-trainer model	Partner with 8 CBOs to host workshops and/or train staff or volunteers; engage at least 15 community members in CDSMP workshops using train-the-trainer model	Partner with 8 CBOs to deliver CDSMP workshops; train at least 15 community members or staff using train-the-trainer model	Delivered 24 evidence-based workshops at faith-based organizations and CBOs, supported by at least 12 newly trained co- facilitators and 35 community members trained to provide chronic disease self-management peer education	# CBO partners; # workshops; # annually; # trained community members; # new co-facilitators; % at community/faith sites
		1.1.5 Provide cancer and colorectal screenings to adults living in Rush service area	100 adults screened in partnership with 2 CBOs, using outreach/navigation/ staff or volunteer training	150 adults screened in partnership with 4 CBOs; focus on high-need West Side ZIP codes	200 adults screened in partnership with 6 CBOs; prioritize high-need areas; build sustainable referral pathways through culturally responsive outreach	450 screened; 12% referred	# screened; % increase each year; # partnering CBOs
	1.2 Reduce risk factors through assessments, education, condition management programs; focus on hypertension/diabetes A W	**1.2.1** Screen community members for uncontrolled hypertension through Alive Faith Network; refer those in need to disease management program	300 screened; 12% referred	350 screened; 12% referred	350 screened; 12% referred	1,000 screened; 12% referred	# screened; % referred to management program
		1.2.2 Increase diabetes prevention and treatment uptake by expanding access to formal diabetes education and support services for people who have or are at risk for diabetes	20 people enrolled in diabetes education program (80% complete); 5-point BP reduction; 10% connected to CHWs; establish baseline participation among pre-diabetic and diabetic people in 3 priority community areas	40 enrolled (80% complete); 5-point BP reduction; 10% connected to CHWs; 5% more pre-diabetic and diabetic people participate across 3 priority community areas	40 enrolled (80% complete); 5-point BP reduction; 10% connected to CHWs; 5% more pre-diabetic and diabetic people participate across 3 priority community areas	100 enrolled (80% completed); 5-point BP reduction; 10% connected to CHWs; 10.25% more pre-diabetic and diabetic people participated across 3 priority community areas	# enrolled/participating; % completing program; BP reduction; % connected to CHWs; % increase in participation
		1.2.3 Screen people with physical mobility limitations; enroll 120 participants in 6-month mobility improvement program through Alive Faith Network	300 screened; 12% referred to services; 24 enrolled in mobility improvement program	300 screened; 12% referred; 48 enrolled	300 screened; 12% referred; 48 enrolled	900 screened; 12% referred; 120 enrolled	# screened; % referred to mobility program; # enrolled
		1.2.4 Provide health risk and disease management assessments and interventions for primary care patients with hypertension and/ or diabetes (Wellness West, E3, Live Healthy Chicago)	160 served per month (average)	240 served per month (average)	**Wellness West project will close in FY27; no targets**	240 served per month (average)	# qualifying contacts
	1.3 Implement systemwide quality improvement/data action plan, including stratification for racial/gender equity A W	**1.3.1** Standardize systemwide training and implementation for collecting patient demographic and social needs data (REaL, SOGI, SDoH) to improve accuracy and consistency	Plan and secure resources for FY26 launch, targeting 5% accuracy/consistency improvement over baseline	75% of targeted staff trained; 20% improvement in SOGI data collection; 5% improvement over last year's target	80%+ of targeted staff trained; 25% improvement in SOGI data collection; 5% improvement over last year's target	85%+ of targeted staff trained; 40% improvement in SOGI data collection; 15% improvement in accuracy of REaL/SOGI data capture	% of targeted staff trained; % of patients with complete SOGI data; % of overall improvement in data captured

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

GOAL	STRATEGY	INITIATIVES	FY26 TARGET	FY27 TARGET	FY28 TARGET	3-YEAR TOTAL	MEASURES
GOAL 1, continued Preventing and reducing chronic conditions and risk factors	**1.4 Improve access to healthy food for patients screened as food-insecure** (A) (W)	**1.4.1** Broaden Food Is Medicine VeggieRx Pantry to provide pantry meals/produce for people screened as food-insecure and referred by primary care providers	3,000 people referred systemwide; 80% served	3,500 people referred; 85% served	4,000 people referred systemwide; 90% served	10,500 people referred; 85% served	# referred; % served
		1.4.2 Maintain/enhance ED Pantry at RUMC to provide pantry food/fresh produce to food-insecure patients; ongoing evaluation to support clinical integration and impact	25 patients receive food; 70% receive food resources/referrals	50 patients receive food; 80% receive food resources/referrals	75 patients receive food; 85% receive food resources/referrals	150 patients served; 90% received food resources/referrals	# served; % referred
		1.4.3 Expand Food is Medicine program to ROPH ED; CHWs track meal recipients for program evaluation	50 patients receive food; 70% receive food resources/referrals	100 patients receive food; 80% receive food resources/referrals	150 patients receive food; 85% receive food resources/referrals	300 patients served, 90% received food resources/referrals	# served; % referred
		1.4.4 Implement and evaluate Food is Medicine/VeggieRx program through formal research study approved by Institutional Review Board (IRB) to assess impact on food insecurity and related health outcomes and measure effectiveness/scalability/ sustainability	100 patients with documented health needs enrolled in launch of IRB-approved study; 85% complete pre-survey and 70% complete post-survey; track outcomes in Epic/SmartSheet to assess impact on food access and health	200 patients enrolled in study annually; 90% complete pre-survey and 75% complete post-survey; improve health needs documentation and integrate outcome tracking to evaluate long-term impacts on food insecurity/ chronic disease/care use	300 patients enrolled in study annually; use outcome data to inform clinical care/policy/ long-term strategies to address food insecurity and chronic disease	600 patients enrolled; 87% completed pre-surveys and 73% completed post-surveys; outcomes tracked in Epic	# enrolled; % completing pre/post surveys
		1.4.5 Advance VeggieRx Pantry to provide medically supportive meals for food-insecure patients referred by providers; incorporate healthy cookbook and cooking classes in partnership with Preventive Medicine to promote lasting nutritional habits; explore medically tailored meals and nutritional lifestyle strategies to deepen clinical integration	100 participants enrolled in launch of medically tailored meal pilot; 80% report improved nutritional knowledge; 75% report enhanced cooking skills and greater confidence in meal preparation	80% of participants report improved nutritional knowledge/cooking skills/ confidence in healthy meal preparation to support sustained dietary change aligned with clinical care	85% of participants report improved nutritional knowledge/cooking skills/ confidence in healthy meal preparation to support sustained dietary change aligned with clinical care	80% of participants report improved nutritional knowledge/cooking skills/ confidence in healthy meal preparation; 82% demonstrate sustained improvements in dietary habits and condition-specific nutrition knowledge contributing to measurable clinical outcomes	Pre/post-program survey/ participant interviews; longitudinal follow-up; EHR integration; % of participants
		1.4.6 Continue Rush Food Surplus Program; donate 20,000 lbs. of food annually	18,000 lbs. donated	18,000 lbs. donated	18,000 lbs. donated	54,000 lbs. donated	# of lbs. donated in each delivery
		1.4.7 Continue Rush Oak Park Food Surplus Program; donate 15,000 lbs. of food annually	15,000 lbs. donated	15,000 lbs. donated	15,000 lbs. donated	45,000 lbs. donated	# of lbs. donated in each delivery

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

GOAL	STRATEGY	INITIATIVES	FY26 TARGET	FY27 TARGET	FY28 TARGET	3-YEAR TOTAL	MEASURES
GOAL 2 Expanding access to mental and behavioral health services	**2.1** Increase community screenings and referrals to mental health services (A) (H) (W)	**2.1.1** Assess referred patients and community members for mental health needs; provide brief intervention; connect to long-term mental health care	1,000 people screened/brief interventions provided; 75% connected to long-term care; continued engagement confirmed for 60% at follow-up	1,500 people screened/brief interventions provided; 80% connected to long-term care; continued engagement confirmed for 65% at follow-up	2,000 people screened/ brief interventions provided; 85% connected to long-term care; continued engagement confirmed for 70% at follow-up	4,500 people screened; 85% connected to long-term care; 70% maintain engagement at follow-up	# assessed and managed by social work; % connected to care; % engaged at follow-up
	2.2 Provide therapy to improve mental health outcomes (A) (W)	**2.2.1** Provide therapy sessions to adults through Rush Social Work and Community Health (SWaCH) outpatient community psychotherapy clinic in partnership with Sankofa Wellness Village to expand reach and support holistic mental wellness	10,000 sessions provided	10,000 sessions provided	10,000 sessions provided	30,000 sessions provided	# of sessions provided
	2.3 Provide therapy sessions to children and adolescents (A) (W)	**2.3.1** Provide therapy sessions to children, adolescents and young adults	2,100 sessions provided	2,100 sessions provided	2,100 sessions provided	6,300 sessions provided	# of sessions provided
		2.3.2 Provide mental health screenings to Chicago Public Schools students through Rush School-Based Health Centers (SBHCs)	1,000 students screened; 75% with identified needs receive additional support	1,000 students screened; 75% with identified needs receive additional support	1,000 students screened; 75% with identified needs receive additional support	3,000 students screened; maintain 75% linkage to care	# screened; % receiving support
	2.4 Conduct community-based trainings (including train-the-trainer programs) in Mental Health First Aid (MHFA) (A) (W)	**2.4.1** Provide MHFA facilitator training	10 people trained	15 people trained	25 people trained	50 people trained	# trained
		2.4.2 Train community members in MHFA/trauma-informed care; partner with violence prevention organizations	500 people trained; 20% also trained in violence prevention	600 people trained; 25% also trained in violence prevention	700 people trained; 30% also trained in violence prevention	1,900 people trained; 20% also trained in violence prevention	# trained; % trained in violence prevention
	2.5 Increase access to behavioral health services for LGBTQ+ patients (A) (H) (W)	**2.5.1** Provide graduate-level internship opportunities for social work students in affirming mental health services for LGBTQ+ patients	Develop plan and secure resources to support internship program	1 intern trained	2 interns trained	3 interns trained	# of students completing internship
	2.6 Identify trauma survivors and provide no-cost, evidence-based trauma therapy and care management (A) (W)	**2.6.1** Provide no-cost trauma screenings to patients and community members	700 screenings provided; referrals offered to all screening positive for PTSD	700 screenings provided; referrals offered to all screening positive for PTSD (pending continued funding)	700 screenings provided; referrals offered to all screening positive for PTSD (pending continued funding)	2,100 screenings provided; referrals offered to all screening positive for PTSD (pending continued funding)	# of screenings provided
		2.6.2 Provide no-cost, evidence-based PTSD therapy and/or care management to survivors of trauma via Center for Trauma Recovery at Rush	140 trauma survivors served	140 trauma survivors served (pending continued funding)	140 trauma survivors served (pending continued funding)	420 trauma survivors served (pending continued funding)	# of trauma survivors served
	2.7 Expand engagement in opioid and substance use prevention and treatment services (A) (W)	**2.7.1** Partner with health care professionals to deliver education on opioid misuse/distribute naloxone kits; use train-the-trainer model to build capacity among providers, with participants demonstrating increased knowledge of overdose prevention through pre- and post-session evaluations	500 health care professionals reached; 100 naloxone kits distributed in high-need areas; 10% of professionals train 10% of their patient panel on overdose prevention	550 health care professionals reached; 100 naloxone kits distributed; 10% of professionals train 15% of their patient panel on overdose prevention	600 health care professionals reached; 100 naloxone kits distributed; 10% of professionals educate 20% of their patient panel on overdose prevention	1650 educational sessions conducted; at least 300 naloxone kits distributed; 15% of professionals' patient panels educated	# of sessions; # of kits; % patient panel trained

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GOAL	STRATEGY	INITIATIVES	FY26 TARGET	FY27 TARGET	FY28 TARGET	3-YEAR TOTAL	MEASURES
GOAL 3 Addressing social, economic and structural drivers of health to reduce inequities	**3.1 Increase access to high-quality science/technology/engineering/math (STEM) and social-emotional learning experiences** H W	**3.1.1** Increase academic and career-exploration enrichment/ social-emotional learning (in school and out of school) for youth in grades pre-K through college	1,100 participating students	1,225 participating students	1,350 participating students	3,675 participating students	# of participating students
		3.1.2 Empower and enhance teacher confidence and competency in STEM-focused practices through professional development, curriculum support and resources	50 participating educators	60 participating educators	75 participating educators	185 participating educators	# participating in professional development; % increase in confidence and competency
	3.2 Improve K-16 educational outcomes for youth and young adults; provide work-based learning and industry-recognized credentials to increase educational attainment and workforce readiness H W	**3.2.1** Engage parents/families/community members to address social needs and increase educational attainment/workforce readiness	3,500 participants in programs/workshops/events	3,500 participants in programs/workshops/events	3,500 participants in programs/workshops/events	10,500 participants	# of participants
		3.2.2 Support post-secondary enrollment and matriculation; activities aligned to IL PACE Framework	90% of REACH participants enroll in post-secondary options; 75% persist	90% of REACH participants enroll in post-secondary options; 75% persist	90% of REACH participants enroll in post-secondary options; 75% persist	90% of REACH participants enrolled in post-secondary options; 75% persist	% enrolling in postsecondary options; % persisting
		3.2.3 Provide high school/college internships/externships/ apprenticeships, including training for industry-recognized credentials	250 students intern/ apprentice; 70% of those eligible earn industry-recognized credentials	265 students intern/ apprentice; 70% of those eligible earn industry-recognized credentials	275 students intern/ apprentice; 70% of those eligible earn industry-recognized credentials	750 students interned/ apprenticed; 70% of those eligible earn industry-recognized credentials	# interning/apprenticing; % earning industry credentials
		3.2.4 Provide targeted nursing apprenticeships to strengthen pipeline and career readiness for entry-level nurses	10 college students enrolled as nurse apprentices; goal is to retain them as full-time staff post-licensure	10-20 college students enrolled as nurse apprentices; goal is to retain them as full-time staff post-licensure	10-20 college students enrolled as nurse apprentices; goal is to retain them as full-time staff post-licensure	36 student externs/ apprentices enrolled; 25% join Rush as full-time staff post-licensure	# completing program; % retained after 1 year
		3.2.5 Sustain pipeline and career readiness opportunities for emerging, underrepresented clinicians in the mental health profession (Legacy Mental Health Fellowship)	Cohort 4 begins (2 fellows); 4 graduated fellows	Cohort 5 begins (2 fellows); 6 graduated fellows	Cohort 6 begins (2 fellows); 8 graduated fellows	8 graduated fellows joined the workforce	# completing program
	3.3 Collaborate to address workforce development, promote career advancement for incumbent workers and foster a culture of mentorship and support among hiring managers H W	**3.3.1** Expand career advancement for incumbent workers (especially frontline workers) through initiatives that include participation in community-wide and citywide workforce development initiatives and cohorts	Up to 30 frontline workers enroll in pilot pathway programming for career advancement; participate in up to 3 collaborative partnerships focused on workforce development	30 employees enroll in apprenticeships and pathway programming for career advancement (70% complete); sustain 2-3 collaborative partnerships	30 employees enroll in apprenticeships and pathway programming for career advancement (70% complete); sustain 2-3 collaborative partnerships	80 employees enrolled in apprenticeships and pathway programming for career advancement (70% complete); sustain 2-3 collaborative partnerships	# of enrolled employees; % of hiring managers trained on career advancement interventions; # of partnerships
		3.3.2 Work with partners to develop/implement community-wide workforce development initiatives to increase employment access and opportunities to hire local applicants	Collaborate with 20 community sourcing partners; target 18% of new hires to local communities	Collaborate with 20 community sourcing partners; target 18.5% of new hires to local communities	Collaborate with 3 community sourcing partners; target 19% of new hires to local communities	Collaborated with up to 20 community partners to implement initiatives	# of collaborating organizations; % of participants hired
		3.3.3 Reduce barriers to hiring and onboarding	Partner with community organizations to refine collaborative workforce development plan focused on sourcing/advancing employees/eliminating barriers in hiring and onboarding. Align efforts with systemwide workforce priorities; actively recruit for high-need roles through community-based pipelines	Collaborate with community partner(s) to determine interventions for dismantling barriers to onboarding employees	Work to develop systemwide onboarding standards and integration that are inclusive for applicants and job candidates	Partnered with 3 community organizations in areas with moderate to high unemployment; targeted 1-2 interventions to dismantle barriers in employee sourcing/onboarding; integrated workforce development efforts systemwide	# of collaborating organizations; # of employees enrolled in pathway/advancement programs; % of hiring managers trained in career advancement

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GOAL	STRATEGY	INITIATIVES	FY26 TARGET	FY27 TARGET	FY28 TARGET	3-YEAR TOTAL	MEASURES
GOAL 3, continued Addressing social, economic and structural drivers of health to reduce inequities	**3.4 Identify social drivers of health (SDOH) through screenings; refer those in need of social services** A W	**3.4.1** Continue systemwide approach to SDOH screening (RUMC, ROPH, RCMC, RMG); connect people who have unmet needs (food/transportation/housing) to resources (social work referrals, community resource navigation)	80% of patients screened; 100,000 total screenings; 75% of those with needs receive interventions	85% of patients screened; 120,000 total screenings; 80% of those with needs receive interventions	87% of patients screened; 150,000 total screenings; 85% of those with needs receive interventions	370,000 patients screened; 75% of those with needs received interventions	% completed screenings; # screened; % receiving corresponding intervention within 1 month
		3.4.2 Conduct ED-based screenings and interventions through health care transformation initiatives; serve Medicaid, underinsured and uninsured populations with services such as appointment navigation, primary care referrals and support for maternal health and community wellness efforts	1,500 people screened; 85% screening positive for unmet needs receive interventions	1,500 people screened; 90% screening positive for unmet needs receive interventions	1,500 people screened; 90% screening positive for unmet needs receive interventions	4,500 people screened; 90% screening positive for unmet needs received interventions	# screened; % reduction in needs; % receiving interventions within 1 month of screening positive
		3.4.3 Partner with community-based organizations; as part of select Rush quality improvement and equity initiatives, provide social care assistance/care management to address social needs and barriers to care for community members	Up to 1,000 individuals served with social work and/or CHW services	1,000 individuals served with social work and/or CHW services	1,000 individuals served with social work and/or CHW services	Up to 3,000 individuals served with social work and/or CHW services	# of outreach encounters;% of targeted patients engaged; % of successful referrals; % of encounters documented in Epic; % of patients referred to additional health/social services
	3.5 Leverage coalition-building and partnerships for collective impact to advance health equity H	**3.5.1** Maintain/expand centralized partnership inventory and database; strengthen existing collaborations and build new strategic partnerships by serving as lead or active member in key initiatives (West Side United, Garfield Park Rite to Wellness, CHRRGE, Chicagoland Healthcare Workforce Collaborative, HEAL Initiative, Racial Equity Rapid Response Team, FQHCs, Sankofa Wellness Village) to maximize collective impact	Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups within strategic initiatives/partner networks	Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups	Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups	Participated in meetings; provided capacity-building support; co-led or led key committees and working groups	amount of support provided; # of committees/working groups co-led or led; % increase in membership; # of action plans created/revised
		3.5.2 Support execution of RUSH BMO Institute for Health Equity strategic plan through initiatives (speaker series, state of health equity report, data analytics studio, health equity accelerators) that advance community programs/clinical practices/policy/ education/research aligned with health equity goals	Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups	Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups	Participate in meetings; provide capacity-building support; co-lead or lead committees/working groups	Participated in meetings; provided capacity-building support; co-led or led committees/working groups	amount of support provided; # of committees/working groups co-led or led; % increase in membership; # of action plans created/revised
	3.6 Increase spending with local businesses H W	**3.6.1** Identify high-impact spend categories; collaborate with RUMC/ROPH department leads to shift defined portion of spend to small/diverse vendors; host targeted engagement events to strengthen connections and increase contract opportunities with vendors	Work with 2-3 category managers; develop category manager engagement framework/process for vendor onboarding; pilot onboarding program with 5–7 small or diverse vendors	Finalize local purchasing framework for category managers and vendor onboarding process; select vendors for targeted engagement and connection with category managers	Connect with vendors at annual supplier summit; conduct active outreach and seek partnerships with business service organizations to reach vendors to be onboarded at Rush	Local purchasing framework for category managers created and implemented; vendor onboarding process established; outreach begun to increase onboarding of local vendors to Rush system and vendor lists	# of spend categories identified; # of small business vendors onboarded; # and % with new spend or increased spend; # of community partners engaged; % of category managers trained in local purchasing
		3.6.2 Spend $15.3 million with West Side vendors	$5.1 million spent	$5.1 million spent	$5.1 million spent	$15.3 million spent	$ spent with West Side vendors (identify 2 under–represented communities per year for targeted spend)
	3.7 Increase investment in local communities H W	**3.7.1** Strengthen local vendor capacity; leverage Supplier Summit and community markets as key platforms for business support and capacity-building	Participate in meetings; coordinate with partners to host vendor events and track engagement/business capacity/contract readiness	Participate in meetings; coordinate with partners to host vendor events and track engagement/business capacity/contract readiness	Participate in meetings; coordinate with partners to host vendor events and track engagement/business capacity/contract readiness	Participated in meetings; coordinated with partners to host vendor events and track engagement/business capacity/contract readiness	# of vendors engaged; # of businesses supported; % reporting increased readiness to compete for contracts
		3.7.2 Advance place-based investments in healthy food and wellness by partnering with Treasury and community development financial institutions	$1.33 million invested	$1.33 million invested	$1.33 million invested	$4 million invested	$ in place-based investments; # of community-based projects supported and impact on local food and wellness access

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GOAL	STRATEGY	INITIATIVES	FY26 TARGET	FY27 TARGET	FY28 TARGET	3-YEAR TOTAL	MEASURES
GOAL 4 Enhancing access to quality care and community services	**4.1** Expand community clinical practices; partner with collaboratives to improve health status of Medicaid-insured and uninsured people (A) (H) (W)	**4.1.1** Launch Rush Center for Community Well-Being at Sankofa Wellness Center in West Garfield Park	Up to 300 people receive clinical therapy/health education programs/ care navigation/resource connection after spring 2026 opening	Up to 1,000 people receive clinical therapy/health education programs/ care navigation/resource connection	Up to 1,350 people receive clinical therapy/health education programs/ care navigation/resource connection	Up to 2,650 people received clinical therapy/health education programs/ care navigation/resource connection	# of unique people served; % screened and connected w/resources; % improvement in behavioral health
		4.1.2 Participate in city and regional learning collaboratives, including: CHHRGE, Healthcare Partners to Address Homelessness (with Northwestern Medicine), CIE (with Illinois Public Health Institute), Cook County Medical Respite Network and COCHI, with a strong focus on supporting unhoused individuals through coordinated care, housing support and system-level collaboration	Represent Rush at weekly/ monthly meetings	Represent Rush at weekly/ monthly meetings	Represent Rush at weekly/ monthly meetings	Attended 90% of meetings	% of meetings attended
		4.1.3 Provide services at local community sites (libraries, street medicine, shelters, etc.)	30 people per month receive resources and linkages to community services (10 per library per month)	36 people per month receive resources and linkages to community services (12 per library per month)	45 people per month receive resources and linkages to community services (15 per library per month)	Up to 120 people per library per month connected with resources and community services	# of individuals provided with resources; # of individuals linked to services
		4.1.4 Partner with LGBTQ-focused CBO to link uninsured and underinsured patients with affirming health care and social services	700 patients referred; 80% of appointments scheduled	850 patients referred; 80% of appointments scheduled	1,000 patients referred; 80% of appointments scheduled	2,550 people referred; 80% of appointments scheduled with CommunityHealth or partner agencies	# of partner CBOs; # of referrals navigated to affirming care
	4.2 Expand access to primary care (A) (W)	**4.2.1** Navigate people accessing Rush's Emergency Department to follow-up primary care appointments	50 patients per month (average) receive navigation services in person or post-discharge; 10% (average) scheduled for follow-up at partner clinics and/or Rush	55 patients per month (average) receive navigation services in person or post-discharge; 15% (average) scheduled for follow-up at partner clinics and/or Rush	60 patients per month (average) receive navigation services in person or post-discharge; 25% (average) scheduled for follow-up at partner clinics and/or Rush	1,980 patients received navigation services; 17% scheduled for follow-up appointments	# of referrals; % of appointments scheduled
		4.2.2 Partner with federally qualified health centers (at the system level) to provide primary care access for unassigned and uninsured patients	1 partnership formalized; 20% successful referrals	1 partnership formalized; 20% successful referrals	2 partnerships formalized; 45% successful referrals	3 partnerships formalized; 28% successful referrals	% affiliation agreements; operational governance/ performance meetings; % successful referrals
	4.3 Maintain a highly qualified CHW team (A) (W)	**4.3.1** Identify and train CHWs in Chronic Disease Self-Management Programs (CDSMP); facilitate CDSMP sessions in partnership with 10 community organizations and develop a dedicated cadre of trained CHWs	2 CHWs complete training; lead up to 8 sessions with community partners	2 CHWs complete training; lead up to 9 sessions with community partners	1 CHW completes training; lead up to 10 sessions with community partners	5 CHWs completed training; led up to 27 sessions with community partners	# of CHWs completing training; # of CHW-hosted or co-hosted CDSMP sessions
		4.3.2 Engage CHWs as frontline public health workers to connect people to nursing and social work services	720 people referred after determining baseline for eligible referrals	720 people referred	720 people referred	2,160 people referred	# of referrals to RN and/or social worker; % of eligible referrals made successfully
		4.3.3 Train CHWs, interns and apprentices to serve as health literacy ambassadors	Develop implementation plan for health literacy training program; goal is for at least 75% of trainees to demonstrate improved health literacy knowledge and skills through pre- and post-assessments	6-10 people trained as health literacy ambassadors; at least 80% demonstrate improved health literacy knowledge and skills	6-10 people trained as health literacy ambassadors; at least 85% demonstrate improved health literacy knowledge and skills	Up to 20 people trained to serve as health literacy ambassadors; at least 85% demonstrate improved health literacy knowledge and skills	# of individuals trained; % improving knowledge
		4.3.4 Expand CHW integration into SBHCs to increase access to wraparound supports	40 families supported and connected to services	40 families supported and connected to services	45 families supported and connected to services	125 families supported and connected to services	# of families supported and connected to services
	4.4 Improve the health literacy of patients and community members; increase accessibility of health information and education (A) (H) (W)	**4.4.1** Host community events to provide health education and promotion, resource coordination, care navigation, other services (digital and financial literacy)	3 events hosted each quarter to reach up to 400 people	3 events hosted each quarter to reach up to 500 people	3 events hosted each quarter to reach up to 500 people	At least 9 events hosted, reaching up to 1,400 people annually	# of events hosted; # of attendees per session; # of partner/co-host departments or organizations
	4.5 Expanding access to affirming health care to LGBTQ+ patients (A) (W)	**4.5.1** Engage patient navigators to connect LGBTQ+ community members to primary care and specialty services	250 people referred; 25% of appointments scheduled	400 people referred; 30% of appointments scheduled	550 people referred; 35% of appointments scheduled	1,200 people referred; 30% of appointments scheduled	# of referrals; % of appointments scheduled
	4.6 Expanding access to housing supports for people experiencing homelessness (A) (W)	**4.6.1** Identify people in the Emergency Department experiencing homelessness and connect them to housing/shelter services	Determine baseline	10 people referred	20 people referred	30 people referred	# of referrals to shelters; # of patients identified as housing insecure/homeless

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GOAL	STRATEGY	INITIATIVES	FY26 TARGET	FY27 TARGET	FY28 TARGET	3-YEAR TOTAL	MEASURES
GOAL 5 Advancing maternal and child health outcomes	**5.1** Implement two-generation approaches to improve whole-family health by addressing social and economic determinants of health (A) (H) (W)	**5.1.1** Develop systemwide maternal health screening strategy by collecting data from AFC and GCG departments; implement increased screening frequency (1x per trimester, including 4th trimester/postpartum); consolidate CBP patients within Family Connects program to ensure all patients are captured under a unified approach	1,300 families screened; 73% connected to additional resources	1,480 families screened; 78% connected to additional resources	1,660 families screened; 83% connected to additional resources	4,440 families screened; average of 80% connected to additional resources/ services	# of SDOH screenings completed for pregnant and postpartum patients; # of home visits; % of identified needs connected to resources
		5.1.2 Use Adverse Childhood Experiences screening to identify pregnant/parenting people affected by childhood trauma; connect them to programs and other parenting supports	130 families served; 50% referred successfully to supports	140 families served; 55% referred successfully to supports	140 families served; 60% referred successfully to supports	410 families served; 55% referred successfully to supports	# and % of families successfully served/referred
	5.2 Partner with community-based organizations to expand behavioral health services, strengthen protective factors and promote relational health (A) (H) (W)	**5.2.1** Continue developing Building Early Connections: behavioral health support/parenting groups for families; behavioral health training/consultation support for childcare providers	900 families and 20 childcare providers served	1,000 families and 25 childcare providers served	1,100 families and 25 childcare providers served	3,000 families and 70 childcare providers served	# of families receiving support; # of childcare providers receiving training and support
		5.2.2 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	100 people supported; 75% of families connected to additional resources	100 people supported; 80% of families connected to additional resources	100 people supported; 85% of families connected to additional resources	300 people supported; 80% of families connected to additional resources	# of people supported, % of families connected to additional resources
		5.2.3 Educate patients and community members in community settings through health literacy lessons/accessible educational outreach materials focused on maternal and child health (prenatal care, chronic disease, breastfeeding, mental health)	Identify and/or develop accessible educational outreach materials focused on maternal and child health	500 patients and community members educated	1,000 patients and community members educated	1,500 patients and community members educated	# of participating patients and community members
	5.3 Partner with Westside WIC Alliance (Lurie, GCFD, ACCESS, CDPH) to increase awareness/participation/ retention in WIC program on Chicago's West Side (A) (H) (W)	**5.3.1** Educate Rush staff (providers, CHWs, care managers, navigators) on WIC program and services	50 Rush staff trained on WIC programs and services	50 Rush staff trained on WIC programs and services	50 Rush staff trained on WIC programs and services	150 Rush staff trained on WIC program and services	# of staff trained
		5.3.2 Refer WIC-eligible people via closed-loop referral to WIC Clinics (CDPH and delegate) through Unite Us	25 people referred to WIC clinics or delegate agencies	25 people referred to WIC clinics or delegate agencies	25 people referred to WIC clinics or delegate agencies	75 people referred for WIC services	# of WIC referrals made

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Tyler Fisher, program manager, Northwestern Medicine

Melissa Gutierrez Kapheim, director, health equity and assessment research, Sinai Urban Health Institute, Sinai Health System

LaWanda Holmes Williams, director, community health–Southland, Advocate Health

Rukiyat Lawal, community health program manager, Advocate Health

Helen Margellos-Anast, president, Sinai Urban Health Institute, Sinai Health System

Rebecca McCauley, assistant vice president, Jackson Park Hospital

Kenneth McGhee, chief financial officer, Loretto Hospital

Cotis Mitchell, director of health equity, University of Illinois Hospital and Health Sciences System

Elvis Muñoz, director, community health–Central Illinois, Advocate Health

Michelle Peters, regional vice president, community health and well-being, Loyola Medicine, Trinity Health

Leslie Rogers, chief executive officer, South Shore Hospital

Jackie Rouse, area vice president, community health–Midwest, Advocate Health

Traci Simmons, director, community health and engagement, Rush University System for Health

Erica Sun, senior coordinator, community health and well-being, Loyola Medicine, Trinity Health

Holly Trandel-Manprisio, program director, community services, Northwestern Medicine

Deloris Walker, regional health officer, Cook County Department of Public Health

This CHNA and CHIP are part of Rush's mission to support the vitality and well-being of our communities. Our CHIP is a living document: As we work with our partners toward our five goals and measure the impact of our initiatives, we update the CHIP to reflect innovative ideas and effective approaches. The scope and scale of our efforts will be affected by federal and state laws, funding and resources.

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-chip-2025.

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

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