Strategic Implementation Plan

2020–2022

AT THE FOREFRONT

UChicago Medicine

University of Chicago Medical Center Community Health Needs Assessment
Strategic Implementation Plan: June 2019

INTRODUCTION

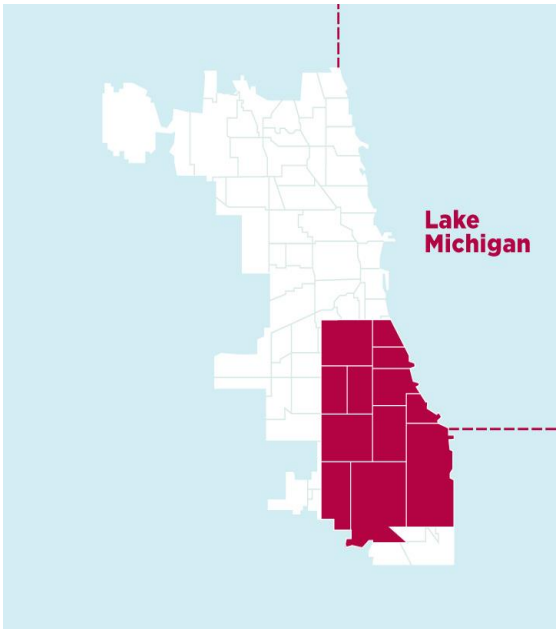
The University of Chicago Medicine and Biological Sciences, one of the nation's leading academic medical institutions, has been at the forefront of medical care since 1927. Collectively, it is comprised of the University of Chicago Pritzker School of Medicine, the University of Chicago Biological Sciences Division, and the University of Chicago Medical Center (UCM).

UCM's mission is to provide superior health care in a compassionate manner, ever mindful of each patient's dignity and individuality. To accomplish this mission, we call upon the skills and expertise of all of UCM's medical professionals who work together in collegiality to advance biomedical innovation, care for our patients, serve the health needs of the community, and further the knowledge of medical students, physicians, and others dedicated to caring. UCM strives to improve the health of Chicago's South Side by working in collaboration with community members, community and faith-based organizations, public agencies, faculty and staff, and others to implement interventions to address the priority health care needs and social determinants of health that impact members of our community. The following pages in this strategic implementation plan provide an overview of UCM's approach to assess, prioritize, and address specific health needs.

TARGET AREA AND PRIORITY POPULATION

UCM is located within the Hyde Park neighborhood on Chicago's South Side. Chicago's South Side is a storied and unique collection of vibrant, resilient, culturally rich and diverse communities. Steeped in African-American heritage and history, the South Side is marked by deep social bonds and anchored by vital community and faith-based organizations. UCM defines its service area (UCM SA) as 12 contiguous zip codes surrounding UCM (see Figure 1).[1] The UCM SA spans 35 locally defined community areas and has a population of approximately 625,707 residents. Between 2010 census and the 2012-2016 estimates from the American Community Service, the service area population decreased by 3.8 percent, this is an inverse trend to the slight increase in population experienced by

Figure 1: UCM Service Area (UCM SA)



[1] UCM SA zip codes: 60609, 60615, 60617, 60619, 60620, 60621, 60628, 60636, 60637, 60643, 60649, 60653.

the County (0.6%) and Chicago (0.7%).[2]

Currently, six out of the eleven poorest communities in Chicago are in the UCM SA.[3] Residents in these communities face many social and economic challenges that contribute to health care inequities as compared to other areas of Chicago. Moreover, health disparities across the UCM SA are vast as demonstrated by strikingly high rates of asthma, diabetes, obesity, breast cancer, and other chronic diseases.[4]

AT THE FOREFRONT OF HEALTH EQUITY

UCM believes all members of our community should have the opportunity to attain their full health potential, and that no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. This commitment to health equity drives all of our work. UCM is a vital part of a community with both tremendous strengths and significant vulnerabilities. UCM's Urban Health Initiative (UHI) ensures that UCM is doing its fair share for the community, working to create better health, investing in trusted community partners, leveraging the assets of UCM and the University to bring resources to redress the health disparities that prevail throughout the South Side of Chicago. The UHI provides a vehicle for connecting UCM's world class clinicians, researchers, staff and care to the lives and health our neighbors in the 12 zip codes on the historic South Side.

As a division of the UHI, UCM's Diversity, Inclusion and Equity Department works in concert with our community efforts to promote health equity within UCM through staff training in cultural competence and plain language patient education materials.

COMMUNITY HEALTH NEEDS ASSESSMENT

To understand the current health outcomes in the UCM SA, UCM partnered with 37 nonprofit hospitals in Cook County, Illinois, through a membership collaborative called the Alliance for Health Equity led by the Illinois Public Health Institute (IPHI). The CHNA provided data regarding the health status, behaviors, and needs of adult and pediatric populations in the UCM SA. The CHNAs were used to identify health issues of concern in the UCM SA and to help make informed, data-driven decisions regarding the allocation of resources and effort for both adult and pediatric populations.

[2] United States Census Bureau. Population Division. "Illinois: Population for selected ZIP Codes." *United States Census.* Washington: US Census Bureau, Census Bureau. 2010.
[3] 2019 Community Health Needs Assessment.
[4] 2019 Community Health Needs Assessment.

Methods

As the coordinating agency for the collaborative CHNA, The Alliance for Health Equity worked with the Illinois and Chicago and Cook County Departments of Public Health to carry out a collaborative CHNA process between March 2018 and March 2019. The CHNA process is adapted from the Mobilizing for Action through Planning and Partnerships (MAPP) framework, a community-engaged strategic planning framework that was developed by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). The MAPP framework promotes a system focus, emphasizing the importance of community engagement, partnership development, and data-driven decision-making. The Alliance for Health Equity chose this inclusive, community-driven process to leverage and align with health department assessments and to actively engage stakeholders including community members in identifying and addressing strategic community health priorities to advance health equity. More details about the CHNA process and method are included on page 26 of the Alliance for Health Equity collaborative CHNA report in Appendix 4.

Primary data for the CHNA was collected through four methods:

- Community resident surveys
- Community resident focus groups
- Health care and social service provider focus groups
- Two stakeholder assessments led by the Chicago Department of Public Health—Forces of Change Assessment and Health Equity Capacity Assessment

Process for Determination of Health Priorities

Building on UCM's past two CHNAs, our Community Benefit and Evaluation Team worked with the Community Benefit Management and Steering Committees, as well as a workgroup of the Community Advisory Council to prioritize health issues for UCM's next three years of community benefit programming from fiscal years 2020-2022. Representatives from the UCM Urban Health Initiative, select UCM faculty, and community stakeholders were among the three major constituencies involved in health priority selection process. These constituencies were strategically selected for their respective understanding of community perspectives, community based health engagement, and community health education efforts.

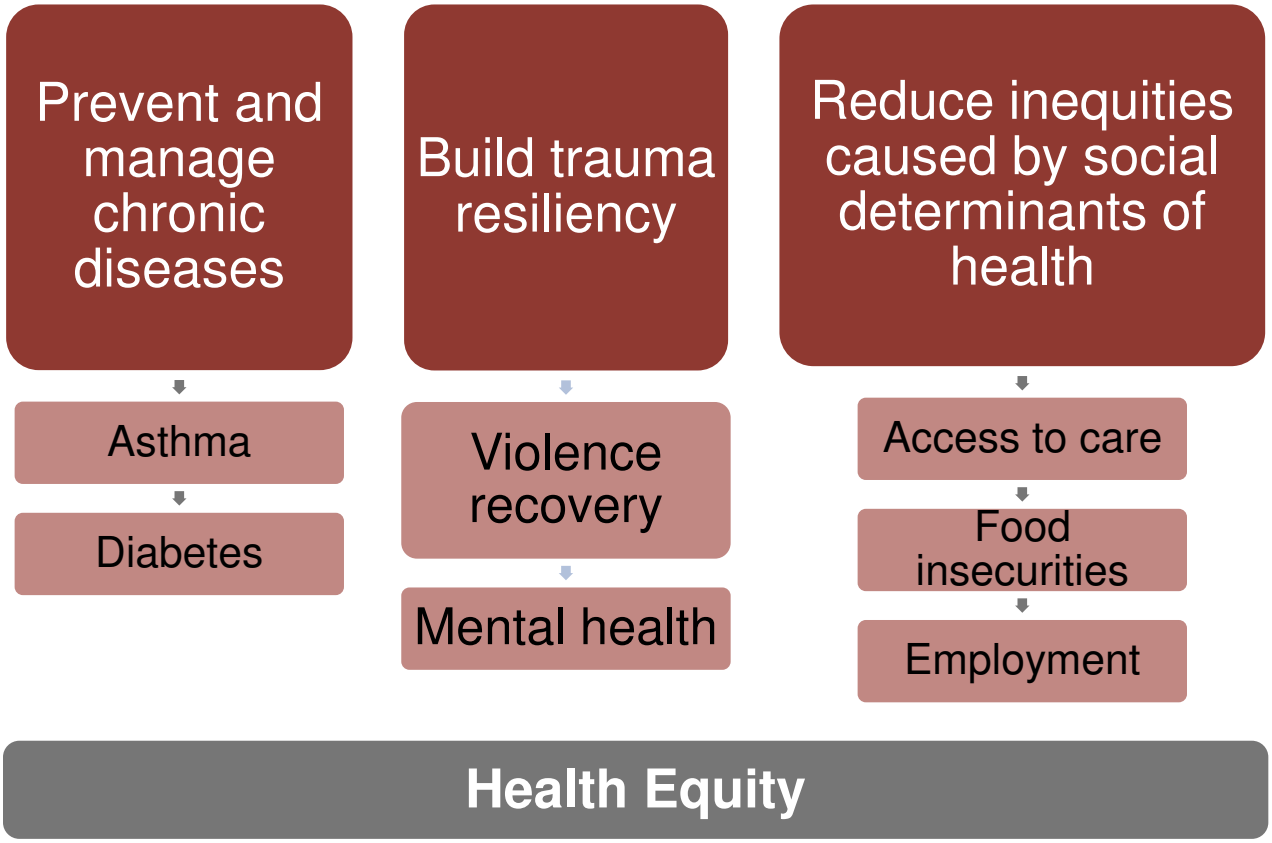
Using the CHNA as a foundational tool, the Community Benefit and Evaluation Team reviewed and compared the 2019 UCM SA health outcome data to previous CHNA health outcome data. New data and health issues that were worse than previous years were slated for consideration.

UCM SELECETED HEALTH PRIORITY AREAS

UCM retained three of the primary health priority issues from the 2016 CHNA: *diabetes*, *asthma*, and *violence prevention*. We added new issues in response to the needs assessment. These include *social determinants of health* and *mental health*.

The framework for the priority health areas are organized under three primary domains. These will serve as the designated issue areas for official reporting and are the principle health concern that UCM community benefit efforts will target. (see Figure 2).

Figure 2: Framework for Community Benefit Priorities (Fiscal Years 2020-2022)



UCMC SELECETED HEALTH PRIORITY AREAS

UCMC removed two priority health areas that were included in the 2016 strategic implementation plan: *cancer* and *sexually transmitted infections/HIV* (adult/pediatric). In acknowledging the wide range of priority health issues that emerged from the CHNA process, UCM determined that it could only effectively focus on those which were determined to fit within the current resources available. Although UCM will not directly address *cancer* and *sexually transmitted infections/HIV* as part of its strategic plan, the programs established and identified in previous reports will continue and a significant amount of resources will be devoted to addressing them. Thus, while the selected health priority issues will serve as the designated issue areas for official reporting and are the principle health concern that UCM community benefit efforts will target, UCM will continue to leverage its internal resources to address these as well as other issues noted in the CHNA. Additionally, *pediatric obesity* – another priority health area identified in 2016 – will be considered as a secondary health issues and recognized as a risk factor associated with *diabetes*.

UCM APPROACH TO ADDRESSING HEALTH PRIORITY ISSUES

All UCM community benefit investments and programming are built on a framework that promotes **health equity** and is framed by the community benefit overarching goal: **to enhance community health and wellness around CHNA priority health needs in the UCM Service Area**. To achieve this goal, UCM executes its interventions, services and/or programs through the following methods:

- **Care Delivery Initiatives:** Direct health, medical, or wellness services and programs to community members that leverage UCM and community partners' resources
- **Grant making:** Grants and technical assistance provided to community based organizations that implement programs to address the UCM health priority areas
- **Medical Education:** Faculty advance medical knowledge in the field by educating providers and medical students serve the community through clinical care and community services/scholarship
- **Community Based Education & Outreach:** Educational activities intended to better inform and educate the community on their health and promote better health self-management practices
- **Partnerships:** Innovative collaborations with a community health lens that leverages technology, cross sector collaborations, and multi-disciplinary application learnings to improve health and engage the community

Each health priority will incorporate aspects of the above methods. The plans and actions tied to each of the UCM health priority areas are grounded in the following principles and criteria to ensure successful implementation and sustainability for the identified UCM health priority areas:

- **Summary of Issue**: A brief outline of the rationale for addressing the issue as well as the needs identified within the health issue area
- **Goal**: The community benefit health priority area's long-term expectation of what should happen as a result of programming
- **Objectives**: The community benefit health priority area's expected results to be achieved as an outcome of programming
- **Approach & Action Plan**: The UCM method that will be utilized to implement programming and the types of actions that will be included in the programming
- **Intended Outcomes and Key Metrics**: The intended effect of the program in the target population of the program. As appropriate, these will align to local/state/national metrics (e.g., CDC, Healthy People 2020, Institute of Medicine, Chicago Department of Public Health). Furthermore, the following pages outline a defined, high-level direction for UCM to guide programming to address specific health priority issues.

I. Prevent and Manage Chronic Diseases

ASTHMA

SUMMARY OF ISSUE

In Chicago's South Side communities, asthma continues to persist as a considerable health issue. As demonstrated in the 2019 UCM CHNA, the rate of asthma related emergency department (ED) visits among youth and adults (18 and younger) is disproportionately high in UCMSA compared to the rest of the city.[5] UCMCSA zip codes 60637 (252.4 per 10,000) and 60636 (243.6 per 10,000) have the highest rate of asthma ED visits among youth compared to the Chicago rate of 92.6 per 10,000. Asthma-related ED visits among adults is highest in zip codes 60621 (203.6 per 10,000) and 60636 (196.8 per 10,000) compared to the Chicago rate of 62.5 per 10,000.

GOAL

Strengthen the ability of persons with asthma to appropriately manage asthma.

OBJECTIVE

UCM works towards achieving the following objectives:

- Reduce hospitalizations, emergency department visits, and missed school/work days for asthma
- Increase education and treatment plans for persons with asthma
- Improve provider understanding and treatment of asthma
- Increase understanding of asthma triggers and environmental modification

APPROACH & ACTION PLANS

UCM continues to invest, partner and collaborate on programs that address environmental factors and asthma management behaviors—this includes delivering consistent and standardized asthma education and addressing triggers such as tobacco smoke and irritants.

UCM engages in **partnerships** with community hospitals, community based organizations, community health centers and UCM faculty to implement programs that engage children in a variety of settings. In 2017, UCM's Urban Health Initiative and the Department of Pediatrics joined forces with La Rabida Children's Hospital, Friend Family Health Center and St. Bernard's Hospital to develop the South Side Pediatric Asthma Center (SSPAC). The center's objective is to develop and advance a collaborative, innovative and high-quality system of care to improve asthma management among children on the South Side.

[5] 2019 Community Health Needs Assessment.

INTENDED OUTCOMES AND KEY METRICS

Long term outcome: Persons with asthma are informed on asthma management and environmental triggers

When possible, UCM will integrate metrics that align with its established evaluation framework to assess program impacts. These metrics include the following:

- The proportion of persons with asthma that had an ED visit for asthma in past year
- The number of persons with asthma that report receiving formal asthma education
- The proportion of persons with asthma who received written asthma management plans from their health care provider
- The proportion of persons with asthma who have received an assessment of environmental triggers in the home
- Percent reduction in hospitalization, ED visits and missed school days

Key Programs and Components

Existing programs are consistently identified and evaluated to assess efficacy and impacts on asthma. Programs are assessed regularly to determine changes, modifications or discontinuation. Below are the key components of the SSPAC which is the primary program area of focus to address asthma. Future plans include expanding this program to the adult population.

COMMUNITY HEALTH WORKER (CHW) PROGRAM

- CHWs offer individualized services and a home visit program to assist patients and families with managing asthma, including asthma triggers.

EDUCATION

- SSPAC provides easy-to-understand asthma education materials to providers, patients, community members and schools.
- Health care providers, managed care representatives, community members, school personnel, faith leaders and other community participants are invited to attend an annual Asthma Education Summit. The summit presents best practices for diagnosing, treating and managing asthma.

ASTHMA RESOURCE LINE

- Community members can call (toll-free) 1-833-3ASTHMA to ask questions, learn about resources and get help connecting to their primary care physician.

ADULT DIABETES

SUMMARY OF ISSUE

According to the CDC estimates, 30.3 million people have diabetes in the U.S and 23.8 percent of these individuals have not been diagnosed.[6] Overall prevalence of diabetes is higher among non-Hispanic blacks (12.7%) compared to non-Hispanic whites (7.4%). There is a wide racial disparity in diabetes related death in Chicago – in 2017, diabetes related death among non-Hispanic blacks was 80.2 per 100,000 and non-Hispanic whites was 41.0 per 100,000.[7] ED visits due to diabetes among adults in most of the UMCSA zip codes is higher than the Chicago rate of 37.7 per 10,000. Three zip codes with the highest rate of ED visits due to diabetes are 60621 (83.1 per 10,000), 60636 (71.6 per 10,000), and 60628 (68.8 per 10,000). UCM's 2019 CHNA notes that among the community members surveyed, 44 percent of respondents indicated that diabetes was as a major problem in the community.

GOAL

Improve the health and quality of life for those living with diabetes

OBJECTIVES

UCM works towards achieving the following objectives:

- Improve glycemic control and diabetes related care among persons with diabetes
- Increase the proportion of persons with diagnosed diabetes who receive formal education
- Increase consumption of nutritious food and physical activity among persons with diagnosed diabetes
- Increase prevention behaviors in persons at high risk for diabetes with prediabetes

APPROACH & ACTION PLANS

UCM continues to invest and participate in programs that are community based and which target diabetics and pre-diabetics. UCM staff and faculty will continue to engage in **community based education & outreach** in the community setting (e.g., churches, farmer markets, schools) to promote education and/or programming around nutrition and physical activity in order to promote diabetes prevention and managing diabetes. Additionally, through the **community benefit grant program**, UCM partners with community based organizations in community settings including community health centers and cultural centers, to reach residents that are diagnosed or borderline diagnosed diabetics to participate in formal diabetes management workshops. UCM will engage in the following actions to address diabetes in the UCM SA:

- Engaging diabetics and/or pre-diabetics in formal education
- Promoting places for healthy lifestyle habits for people at risk of diabetes and diabetics

[6] Centers for Disease Control (CDC). https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

[7] Chicago Department of Public Health. Health Atlas. https://www.chicagohealthatlas.org/indicators/diabetes-related-deaths. Accessed on April 30, 2019.

INTENDED OUTCOMES AND KEY METRICS

Long term outcome: Adults self-manage their diabetes and related care

When possible, UCM will integrate metrics that align with its established framework to assess program impacts. These may include the following:

- The number of adults with diagnosed diabetes or prediabetes who completed formal diabetes education series
- The proportion of adults with diagnosed diabetes or prediabetes whose HbA1c measures >9%
- The proportion of adults with diagnosed diabetes or prediabetes who report improved knowledge of diabetes self-management

Key Programs and Collaborations

Existing programs are currently being evaluated to assess efficacy and impact on diabetes. Programs are assessed regularly to determine changes, modifications or discontinuation. Below are several key programs and collaborations that focus on diabetes management and prevention.

South Side Fit (SSF)

- In partnership with the Timothy Community Corporation, UCM supports a community wellness program on the south side -- South Side Fit. Participants receive a complete assessment of their health, exercise, diet habits, weight Body Mass Index (BMI) and blood pressure. To meet health goals, participants commit to regular exercise, health consultations, nutrutional and lifestyle seminars, and on-site exercise classes. In addtion, for individuals diagnosed with diabetes or pre-diabetes a formal diabetes management workshop is offered.

Diabetes Empowerment Education Program (DEEP)

- DEEP provides training for community members to become certified diabetes educators. Four members at UCM's community relations team are certified to provide training to community members in English and Spanish.

Managing My Diabetes (MMD) Program

- UCM supports TCA Health to implement their MMD program to support diabetic and pre-diabetic individuals to manage diabetes through improved self-management behaviors. MMD program is tailored to the patient's needs and includes several components: fitness programs, healthy eating programs, and self-managment classes led by a certified diabetes educator and one-on-one consultations with the diabetes educator.

II. Build Trauma Resiliency

SUMMARY OF ISSUE

Violence and community safety is a very important public health issue that has been emphasized by community residents through their input into this CHNA and also shows up starkly in health data. One third of Chicago's homicides and violent crimes occur within 5 miles of UCM. The homicide rate in this catchment area is nearly three times that of the rest of Chicago (61/100K vs 23/100k). Between November 2016 and October 2017, there were 944 shootings, 351 homicides, and 11,365 incidents of violent crime reported in this area.[8,9] The majority of trauma patients receiving care in UCM trauma centers either live and/or have suffered violent trauma in UCM's most immediate 12 zip code service area, which comprises 35 of the 77 community neighborhoods in Chicago. Respondents to the community input survey in the UCMSA identified violence as a top health problem as well as identifying safety and low crime as the number one priority necessary for a healthy community. As shown in the Community Health Needs Assessment, homicide mortality is one of the leading causes of death in UCMCSA.[10]

Furthermore, African American community members living in low income, high crime areas reported greater difficulties managing their chronic illnesses, poor mental health, and poor overall physical health as a direct result of continuing trauma. As reported in the CHNA, UCMCSA is considered a health professional shortage area for primary care and mental health.[11]

GOAL

Trauma Prevention and Recovery on the South Side

OBJECTIVES

UCM works towards achieving the following objectives:

- Reduce violent re-injury
- Provide wraparound resources to support the holistic needs of our patients and their families experiencing trauma and linking them to specialized, trauma-informed counseling services and other community-based social supports.
- Investing in community-based organizations that provide critical resources aimed at helping children and adults as well as their families and the community to build long-term trauma resiliency.

APPROACH & ACTION PLANS

[8] UChicago Urban Labs - Crime Lab.

[9] Violent crime as defined by FBI: homicide, criminal sexual assault, robbery, aggravated assault, and aggravated battery.

[10] 2018- 2019 Community Health Needs Assessment.

[11] 2018- 2019 Community Health Needs Assessment.

Urban violence is a complex and systematic issue requiring multiple stakeholders investing a multitude of approaches and strategies. UCM views violence as a public health issue and as such believes that:

1. Person focused outcomes include physical, emotional and social recovery.
2. By personalizing violence recovery, we can promote healing and prevent re-injury.
3. Violence recovery requires working very closely with community partners, including those working to mitigate violence through street outreach, those who provide trauma-specific behavioral health services, as well as the collection of organizations where individuals interact for life fulfillment. These include faith organizations, schools, jobs, etc. For example, community organizations, health care providers and leaders on the south side seek opportunities for trainings on trauma informed care and UCM plans to work closely with them to address that need.
4. Community-based and faith-based organizations have a vital role in identifying and addressing the problems facing our community and UCM aims to help extend their capacity as well by providing community benefit grants to address prevention and recovery of the trauma inflicted by community violence in the UCMSA.

INTENDED OUTCOMES AND KEY METRICS

Long term outcome: South Side residents have access to trauma prevention and recovery programs

When possible, UCM will integrate metrics that align with its established framework to assess program impacts. These may include the following:

- Number of residents outreached for post-trauma intervention at the trauma center
- Number and type of connections to community-based social and behavioral health services
- Number of community leaders and healthcare providers who receive trauma informed care training
- Number of UCM employees who receive culturally competent trauma informed training
- Percent of trauma affected individuals with reduced re-injury, violent/non-violent crimes, and incidents of retaliation.

Key Programs and Collaborations

The following programs will be evaluated regularly to determine impacts to assess necessary changes, modifications or discontinuation. Below are several key programs and collaborations that focus on addressing trauma attributed to violence in the UCMSA:

Comprehensive Trauma Center

- UCM launched Level 1 adult trauma services in May 2018, adding to UCM's pediatric trauma and burn services and providing the community a comprehensive system of high-quality care to treat the full range of trauma injuries in patients of all ages.

Violence Recovery Program (VRP)

- As part of the new Level 1 adult trauma care center, the Violence Recovery Program (VRP) is working to build a violence recovery ecosystem for victims of intentional violence and their families. VRP services begin when the patient arrives in the Emergency Department for trauma services and may include crisis intervention, psychological first aid, community-based service provider referrals and assertive case management.

Healing Hurt People-Chicago

- Healing Hurt People - Chicago (HHP-C) is a collaboration among UChicago Medicine Comer Children's Hospital, John H. Stroger, Jr. Hopsital of Cook County and Drexel University in Philadelphia. HHP-C addresses trauma care and makes therapy services available to young people injured by violent acts. The goal is to promote trauma recovery in order to reduce re-injury, retaliation, involvement with the justice system and death.

Turn Center (Formerly Bronzeville Dream Center)

- UCM collaborates with Bright Star Community Outreach, Northwestern Medicine, and the United Way of Metropolitan Chicago, to implment an innovative approach to combat violence and avert behaviors that may lead to violent conflict. It is a two-pronged program that focuses on strengthening the community and preventing problem behaviors for those experiencing post-traumatic stress as a result of conflict.

Community Advisory Council (CAC)

- In the Summer of 2016, UChicago Medicine (UCM) launched its first Community Advisory Council (CAC), which is comprised of a representative group of 20 volunteer members who live and/or work in the UChicago Medicine service area. The CAC members serve as advisors to UCM on issues of interest to the broader community. The CAC is an essential partner in achieving UCM's goals related to the broader community interests, community benefit, access to care, and effective community engagement. The CAC has 3 work groups; 1) Adult Health; 2) Child and Maternal Health and 3) Trauma Care and Violence Prevention. All work groups align with and support our identified CHNA priority health needs. The CAC has advised UCM leadership on pivotal projects including, but not limited to, the design of our trauma services, launching the VRP and SSPAC, designing community communication/engagement plans, facilitating grantmaking, leading collective impact process to reduce violence, informing our CHNA and programming connected to the Strategic Implementation Plan.

Violence Recovery and Prevention Grant Program

- As part of the broader effort to address the public health crisis of intentional violence, UCM awarded grants to local community groups for summer violence prvention and recovery programs.

III. Reduce Inequities Caused by Social Determinants Of Health

Research has long established that socioeconomic inequities are key drivers of health outcomes. For example, low-income individuals are more likely to have a chronic disease, including higher rates of diabetes and coronary heart disease.[12] Social determinants of health (SDOH) are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect health outcomes and risks, functioning, and quality-of-life.[13] These social, economic and environmental conditions, in addition to health behaviors, relate to an estimated 80 percent of health outcomes in the United States.[14]

[12] Robert Wood Johnson Foundation, 2008.
[13] Office of Health Promotion and Disease Prevention. Healthy People 2020. Available at: https://www.healthypeople.gov/2020/topicsobjectives/topic/social-determinants-of-health
[14] County Health Rankings & Roadmap. Available at: http://www.countyhealthrankings.org/our-approach.

SUMMARY OF ISSUE

The following highlights key findings[15] in UCM's SA from the 2019 UCM CHNA.

- In UCMSA, 18.5 percent of the population is receiving Supplemental Nutrition Assistance Program benefits. Many community residents in the UCMSA are experiencing food insecurity. The Greater Chicago Food Depository estimates that half (49.5%) of the population in the UCMCSA is at risk for food insecurity.
- Unemployment and underemployment can create financial instability which can influence access to healthcare services, insurance, healthy foods, stable quality housing, and other basic needs. Unemployment rates for adults over age 16 in UCMCSA (20.9%) is double the unemployment rate in the city of Chicago (10.9%).

GOAL

Reduce inequities caused by social determinants of health

OBJECTIVES

UCM works towards achieving the following objectives:

- Increase access to food for patients with food insecurities
- Increase access to care for patients without a usual source of care
- Increase employment opportunities for community members in our service area

APPROACH & ACTION PLANS

UCM has made investments and developed partnerships on programs that reach the most vulnerable populations to address social determinants of health. For the next three years, UCM will put a concerted effort towards organizing those activities to make an impact on

- Food insecurities
- Access to care
- Employment

INTENDED OUTCOMES AND KEY METRICS

Long term outcome: Our community experience fewer barriers to access food, health care, and employment.

When possible, UCM will integrate metrics that align with its established framework to assess program impacts. These may include the following:

- The number of programs within UCM that screen for food insecurity
- Proportion of food insecure patients who are connected to food resources
- The number of patients/individuals connected to a primary care or specialty care providers
- The number of individuals from our service area employed by UCM, employed by a program supported by UCM, or connected to an employment opportunity.

[15] 2018- 2019 Community Health Needs Assessment.

Key Programs and Collaborations

Below are several key programs and collaborations that will focus on social determinants of health.

Access to Care

- The Medical Home and Specialty Care Connection links south side residents to community health centers and doctors for preventive care, treatment of non-emergency medical conditions, long-term management of chrnoic diseases and referral to specialists. Patient advocates help individuals access care by finding a medical home in a South Side Healthcare Collaborative (SSHC) clinic. The SSHC is a network of more than 30 federally qualified health care clinics, free and charitable clinics, and community hospitals provideing medical care, support and service services for optimal health and well-being.

Food Insecurities

- The following Urban Health Initiative Programs will screen participants for food insecurities and refer them to community resources, as needed: Community Health Worker, South Side Fit, Medical Home and Specialty Connection, and Violence Recovery Programs.
- Feed1st is a program of service and research that aims to alleviate hunger and food insecurity among families and caregivers of patients and staff at UCM. Food is free, self-serve and there are no lmits on how much food families may take-making the food pantry welcoming and accessible to anyone in need.

Employment

- UCM partners with Cara - a nonprofit organization focused on job placement and skills training. The Cara Connects Temporary Staffing Service provides both contract and pernament employees for UCM.
- The VRP will also assist participants with workforce development and/or employment opportunities.

COMMUNITY BENEFIT REPORT COMMUNICATION

UCM's CHNA and strategic implementation plan have both been approved and adopted by the UCM Board of Directors in May 2019 and is publicly available online. In addition, Ingalls will share the CHNA and this strategic implementation plan with its Community Advisory Council and Workgroups (e.g., community members, local political representatives, healthcare providers, and community based organizations) as well as the community and also make copies available upon request.