

# UNIVERSITY OF ILLINOIS

## Community Assessment of Needs (UI-CAN) 2016: Toward Health Equity



The University of Illinois Hospital & Health Sciences System  
is part of the University of Illinois at Chicago

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## EXECUTIVE SUMMARY

In 2013, the University of Illinois Hospital & Health Sciences System, or UI Health, published The UI Community Assessment of Needs (UI-CAN), our first community health needs assessment (CHNA). The 2013 UI-CAN used a phone-based survey to identify 4 key priorities, as well as our initial strategies to address those needs. Although UI Health has long been committed to its communities, this was the first time we had taken such a broad, systematic view of the people who access care at our sites. UI-CAN revealed not only substantial health needs, but also some weaknesses in our ability to adequately assess those needs.

In the 2013 UI-CAN, we committed to improving the data we would be able to access for our next assessment. We are happy to report that the University of Illinois Survey on Neighborhood (UNISON) Health, an ambitious, innovative in-home, in-person survey that included the collection of biometric data, was successfully completed in 2014 and has since proven to be a valuable source of information. The 2016 UI-CAN is based on findings in the 2013 UI-CAN, UNISON Health, the city of Chicago's 2016 Healthy Chicago 2.0, the state of Illinois' Healthy Illinois 2021, and other reports, as well as feedback from members of the communities we serve.

The theme that runs through the 2016 UI-CAN and through everything we do here at UI Health is dedicated to achieving *health equity*. We are a public academic medical center that is driven by a mission of serving the people of our immediate geographic area, greater Chicago, and indeed Illinois itself. With the arrival of our new Vice Chancellor for Health Affairs, Dr. Robert Barish, in January 2016, we have recommitted our clinical and academic resources to the pursuit of health equity. The reasons for this will be clear in the UNISON Health data reported below, which show sometimes dramatic differences in health burden by the race or ethnicity of the patients we serve. It is also quite clear that Black and Hispanic residents have more challenges in accessing the care they need to address those conditions, and that those challenges are exacerbated by social determinants of health.

These social determinants of health are often beyond the scope of what a single healthcare provider can address. However, we believe it is our responsibility to do whatever we can, even in lean times, to help improve the health of our patients. That is why we have launched a number of novel, aggressive approaches, including specific initiatives to reduce the need to visit the emergency department for healthcare, to reduce avoidable readmissions to the hospital, and, most recently, to actually provide housing for a small number of homeless patients who face enormous challenges in improving their health.

For this 2016 report, we have identified 3 broad priority areas that will guide our strategic planning:

1. Addressing the social determinants of health
2. Improving access to care
3. Reducing the risk of chronic disease or the impact of chronic disease on health

In the coming months, we will launch a comprehensive internal conversation about how we can begin to address these three priority areas. As in 2013, we will view the University of Illinois Hospital through a broad lens, incorporating the other elements of the UI Health family – including our 22 outpatient clinics, 12 community health centers, pharmacies, and dental clinics – into our planning. As we shift away from inpatient care toward a population health approach that emphasizes preventive care and managing disease, we need to continue to improve our ability to work together and leverage the broader resources of UI Health. The implementation plan that results from this process will guide our decisions for the next three years as we choose how to invest our scarce funds, precious time, and abundant energy.

In a final note, we recognize that the efforts of a single institution will not be enough to meet the overwhelming health-related needs of the communities we serve. For that reason, this assessment and prioritization deliberately aligns with efforts of the city of Chicago, the state of Illinois, and our local hospital and health system peers. We have attempted to use similar language and, where possible, to focus on shared areas of concern. The hope is that this can point us toward shared implementation strategies and ultimately shared successes in achieving health equity in the communities we collectively serve.



## UI HOSPITAL

### Organization

UI Health provides comprehensive care, education, and research to the people of Illinois and beyond. A part of the University of Illinois at Chicago (UIC), UI Health comprises a clinical enterprise that includes a [495-bed tertiary care hospital](#), 22 outpatient clinics, and [12 Mile Square Health Center facilities](#), which are Federally Qualified Health Centers. It also includes the seven UIC health science colleges: the [College of Applied Health Sciences](#); the [College of Dentistry](#); the [School of Public Health](#); the [Jane Addams College of Social Work](#); and the Colleges of [Medicine](#), [Pharmacy](#), and [Nursing](#), including regional campuses in Peoria, Quad Cities, Rockford, Springfield, and Urbana. UI Health is dedicated to the pursuit of health equity.

The UI Hospital is inseparable from its broader health system. The collective expertise of UI Health with its seven health science colleges brings a contemporary healthcare workforce to the task of changing healthcare delivery models. An academic environment allows performance of traditional investigation as well as community-based approaches to health identification and health management. And as we move toward community-based and preventive care, our outpatient clinics and community health centers become critical to our ability to manage populations and serve the full continuum of needs.

### Mission, Vision, and Values

#### A PATIENT CENTERED ORGANIZATION

The University of Illinois Hospital and Clinics is a patient centered organization. Providing safe, high-quality and cost-effective care for our patients is our foremost responsibility. The care of our patients and their families will always be at the heart of our mission.

#### OUR MISSION

In collaboration with our academic partners, our mission is to advance healthcare to improve the health of our patients and communities, promote health equity and develop the next generations of healthcare leaders.

#### OUR VISION

Our vision is to be the preeminent healthcare provider known for improving the health and wellness of our communities, providing exemplary care for our patients and advancing the knowledge to do so.

## OUR VALUES

### **Compassion**

We will treat our patients and their families with kindness and compassion and strive to better understand and respond to their needs.

### **Accountability**

We will hold ourselves accountable as an organization and as individuals to act ethically and responsibly in everything we do, to be excellent stewards of our resources and to be transparent in our actions.

### **Respect**

We will act with respect, openness and honesty in our dealings with patients, families and coworkers. We will work collaboratively to promote the well-being of the communities we serve and to advance patient care, education and research.

### **Excellence**

We will work as a team to leverage best practices and innovation in providing the highest-quality care for our patients and families. We will devote ourselves to continuously improve in everything we do.

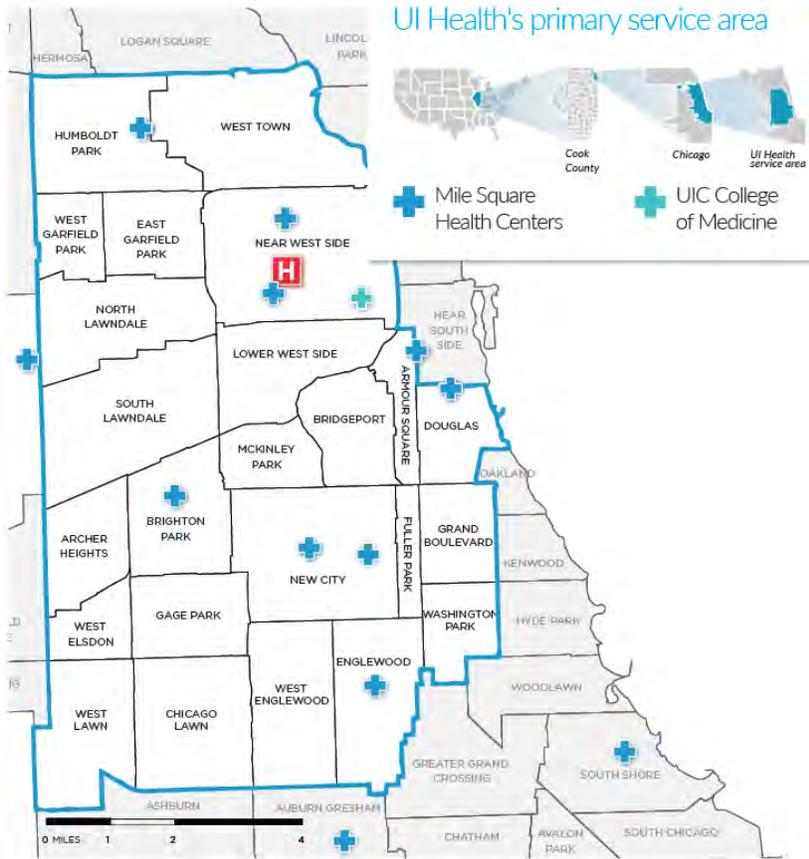


**COMMUNITY SERVED BY UNIVERSITY OF ILLINOIS HOSPITAL & HEALTH SCIENCES SYSTEM (UI HEALTH)**

For the purpose of this CHNA, UI Health focused on its Primary Service Area (PSA). UI Health’s PSA is comprised of 24 neighboring communities. In Chicago these are referred to as *community areas*. UI Health’s hospital and most of its twelve Federally Qualified Health Centers (FQHCs), Mile Square, are located within this area (Figure 1).

In the past, we have generally thought of our PSA in terms of the seven zip codes that account for the largest proportion of UI Health clinical encounters: 60608, 60609, 60612, 60623, 60624, 60629, and 60632. Because community areas tend to be more meaningful for Chicago residents, we have chosen to focus on this geographic unit here. We included every community area that has a significant portion of territory within one of these seven zip codes.

**Figure 1. UI Health Primary Service Area and Health Facilities**



## Community Description

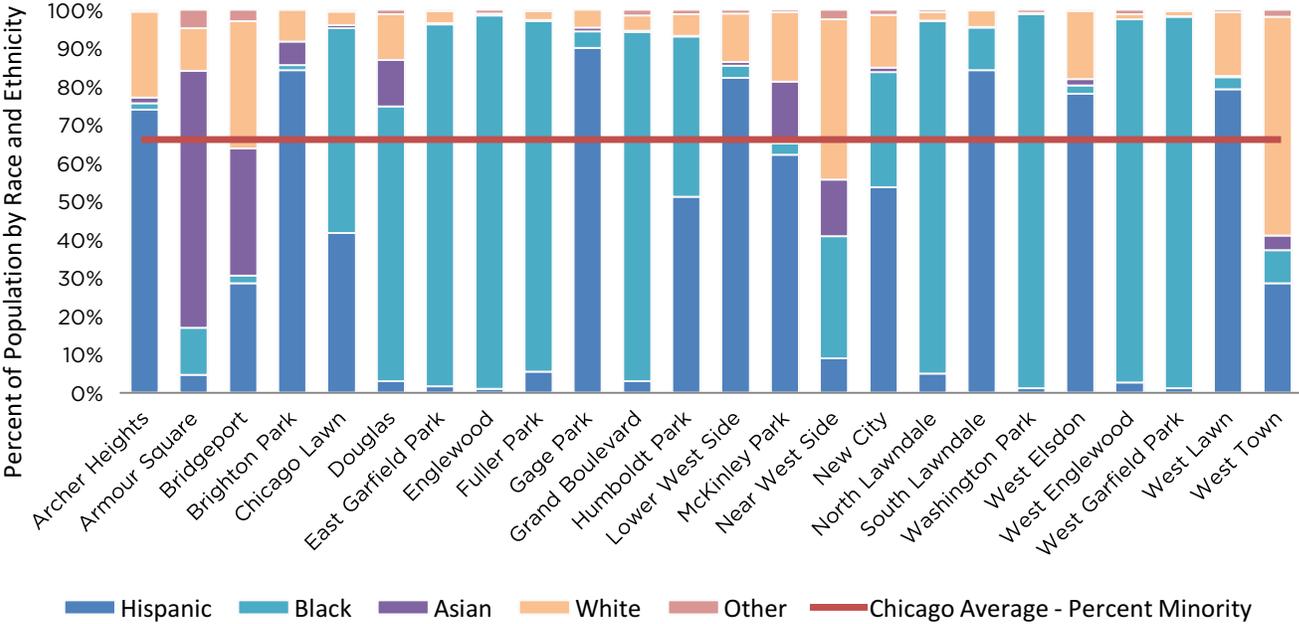
The UI Health’s PSA is comprised of 24 of the 77 community areas in the city of Chicago. Our PSA includes a diverse set of communities on Chicago’s west and southwest sides. As a way of introduction to these communities, we present demographic and economic characteristics for each community area. Later in this report we will discuss the health of the community as a whole.

- Archer Heights
- Armour Square
- Bridgeport
- Brighton Park
- Chicago Lawn
- Douglas
- East Garfield Park
- Englewood
- Fuller Park
- Gage Park
- Grand Boulevard
- Humboldt Park
- Lower West Side
- McKinley Park
- Near West Side
- New City
- North Lawndale
- South Lawndale
- Washington Park
- West Elsdon
- West Englewood
- West Garfield Park
- West Lawn
- West Town

## Demographic Characteristics

Over the past decade racial segregation in Chicago neighborhoods has declined, but for some areas of the city segregation remains high. Neighborhoods that have a majority minority population (minority includes Hispanic, Black and Asian populations) often face social and economic hardships. Twenty-one of the 24 communities in the UI Health PSA have a minority population greater than 75% (Figure 2).

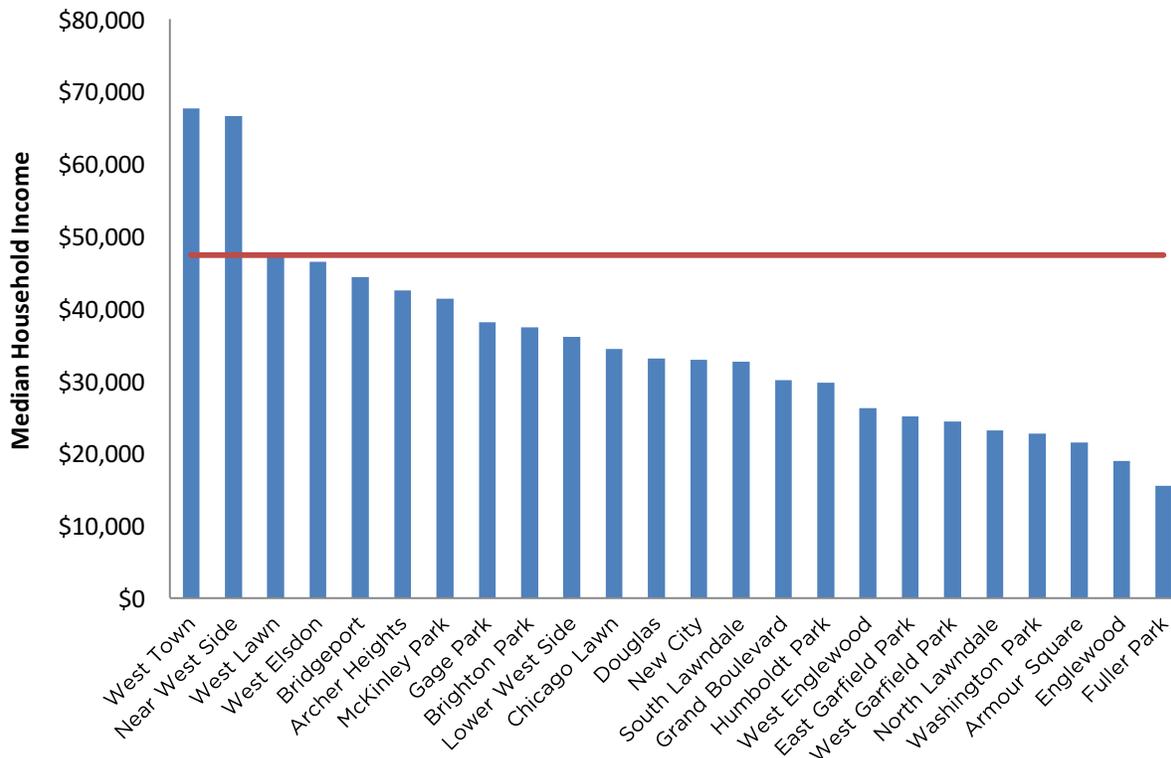
**Figure 2. Race and Ethnicity by Community Area of UI Health’s Primary Service Area**



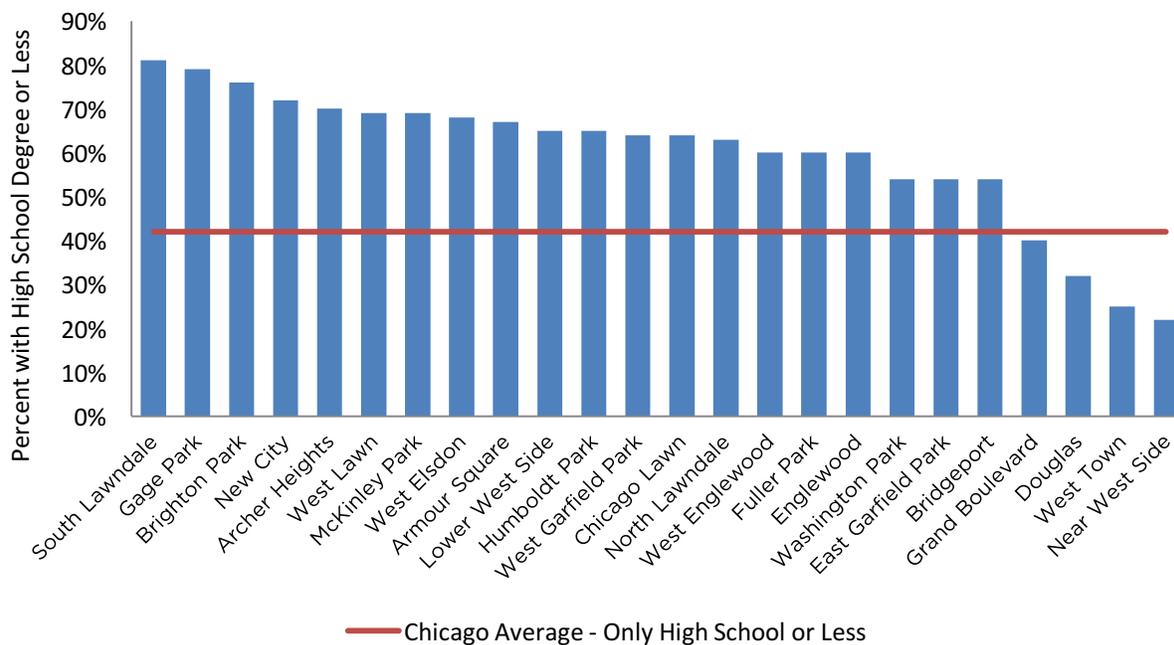
The communities in UI Health’s PSA have some of the greatest needs in Chicago. Most (83%) of the communities in UI Health’s PSA have a median household income lower \$47,408, the median household income in the city of Chicago (Figure 3). Fuller Park, a majority Black community, has a median household income of \$15,516.

Many of the communities in the UI Health PSA also have lower levels of educational attainment and higher rates of unemployment compared to the overall average for the city of Chicago. Twenty of the 24 communities in our PSA have a higher percentage of people who only have a high school degree or less compared to the overall average for the city of Chicago (Figure 4). Unemployment rates are higher in 21 of the communities in our PSA than the overall average for the city of Chicago (Figure 5).

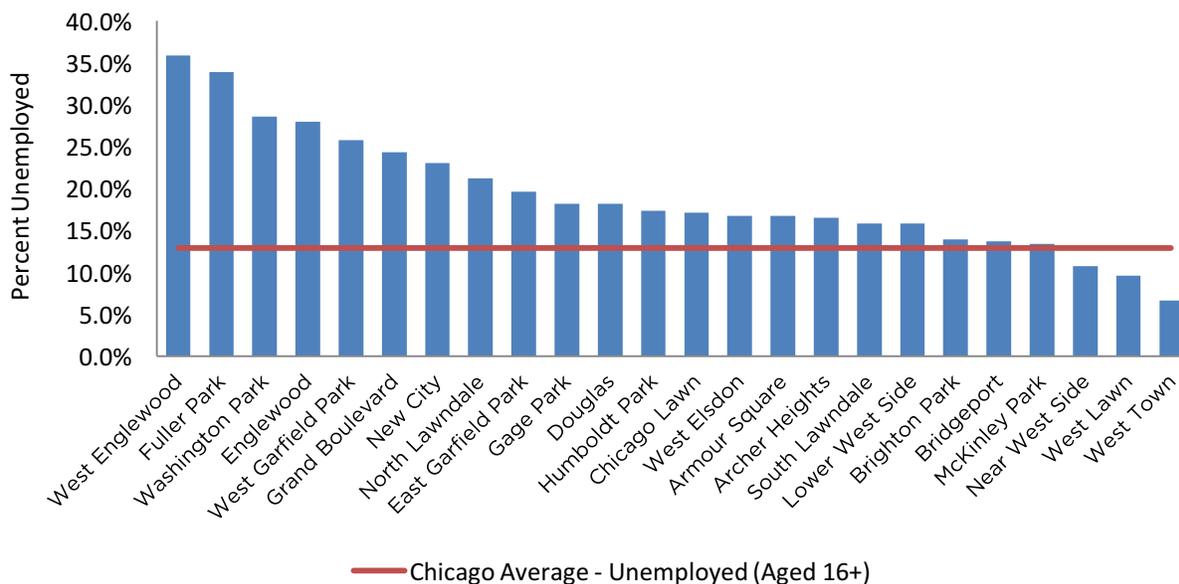
**Figure 3. Median Household Income by Community Area for UI Health’s Primary Service Area**



**Figure 4. Education by Community Area for UI Health’s Primary Service Area**



**Figure 5. Unemployment by Community Area for UI Health’s Primary Service Area**



### Community Assets

UI Health recognizes that there are many existing healthcare resources within the community that are available to respond to the needs of its residents. Figure 1 above maps the UI Health clinical resources, including all Mile Square Health Center, school-based health center, and integrated health center locations. Appendix A identifies additional health resources in UI Health’s primary service area, including hospitals, community health centers, school-based health centers, and nursing homes. These health-related assets provide an opportunity for joint efforts to address the needs of the communities we collectively serve.



## DEVELOPMENT OF CHNA

The 2016 Community Health Needs Assessment was developed by the Office of the Vice Chancellor for Health Affairs (OVCHA), with leadership from Jerry Krishnan, MD, PhD, Associate Vice Chancellor for Population Health Sciences, and Nicole Kazez, PhD, Assistant Vice Chancellor for Strategy. This effort incorporated input from the following groups:

- [Office of Community Engagement and Neighborhood Health Partnerships](#)
  - Partner's Council for Community Health
  - Healthy City Collaborative
- [Healthy Chicago Hospital Collaborative](#)
- Chicago Department of Public Health

Our process focused on incorporating feedback from groups that represent the community and the varied internal stakeholders, and the long term objective of obtaining the appropriate data that will best meet our needs. We will continue to work with these partners and others as we develop and roll out the UI Health Implementation Strategy to impact the health needs that have been identified in this CHNA.

## UNISON Survey Methodology

As described in our first report, UI Health determined in building the 2013 UI-CAN that our commitment to our core mission required that we think bigger about how we could more accurately assess our community's needs. We believed that the telephone surveys available three years ago left significant gaps in our understanding of our particular communities, and that self-reported data collected via phone had important flaws. As a result, we launched the **University of Illinois Survey On Neighborhood Health (UNISON Health)**, an ambitious, innovative community health needs assessment that involved in-person interviews and biometric testing in our PSA.

UNISON Health, conducted in 2013 and 2014 by the Survey Research Laboratory in the University of Illinois at Chicago's College of Urban Planning and Public Affairs, included a random sample of community members in the 24 community areas in UI Health's PSA. Utilizing a stratified probability sampling methodology, UNISON Health enrolled 454 adults in Group 1. The community survey included questions on health behaviors, healthcare access and utilization, prevalence of disease conditions, and quality of life indicators. The survey was offered in both English and Spanish. The survey also included collecting biometric data such as blood pressure, height, and weight, in order to measure a small number of actual health indicators. For example, such data could reveal important differences between diagnosed and undiagnosed hypertension in the community, as well as the level of blood pressure control among those with a diagnosis of hypertension.

The sample of 454 adults age 18 to 60+ is representative of the 24 community areas, with similar racial and ethnic composition. This was crucial for us, since many surveys underrepresent

minorities. Nineteen percent were Non-Hispanic Whites, 34% were Non-Hispanic Blacks, 40% were Hispanic, and 7% indicated an 'Other' race/ethnicity. The average age of respondents was 40 years, and 52% were female. Fifty-seven percent of respondents had a high school degree or less.

UNISON Health also included modules that focused on a random subset of adults who seek care at UI Health with a diagnosis of hypertension or diabetes, and children with a diagnosis of asthma who live in one of the 24 community areas that define our PSA. These portions of the survey included additional questionnaires as well as in-person clinic visits where further biometric data were collected. Findings from these modules will be shared with our communities in other venues, as part of our strategy to develop an Implementation Plan specific to the communities we serve.

## Community Stakeholder Input

To complement the UNISON survey data, the CHNA engaged community stakeholders to solicit input on health needs and priorities. The community members and organizations who provided input were identified through the [Office of Community Engagement and Neighborhood Health Partnerships](#) (OCEAN) and included members and organizations representing the interests of medically underserved, low-income, and minority populations in the community. The focus group discussions and specific comments made by participants are included throughout this report, as they relate to other information presented.

The first focus group was held on June 2, 2016 and included three community stakeholders. A larger [Healthy City Collaborative & Partners Council for Community Health](#) meeting was held on June 14, 2016, and included 20 community stakeholders, including the Chicago Department of Public Health. The community organizations that were represented in either of these events included:

- Office of Community Engagement and Neighborhood Health Partnerships
- Chicago Department of Public Health
- Chicago Hispanic Health Coalition
- University of Illinois Cancer Center
- UIC Midwest Latino Health Research, Training and Policy Center
- Treatment Alternatives for Safe Communities (TASC)
- Chicago State University
- Brighton Park Neighborhood Council
- DePaul University
- Rush Alzheimer's Disease Center
- UIC College of Dentistry
- UIC Office of Health Literacy
- UIC School of Public Health
- Unaffiliated community members



## COMMUNITY HEALTH PROFILE

Using UNISON Health data, as described above, and additional data sources when appropriate, the following is a description of the health of UI Health PSA communities. We present data in three main categories: (1) Access to Care; (2) Chronic Diseases; and (3) Social Determinants of Health & Health Behaviors.

### Access to Care

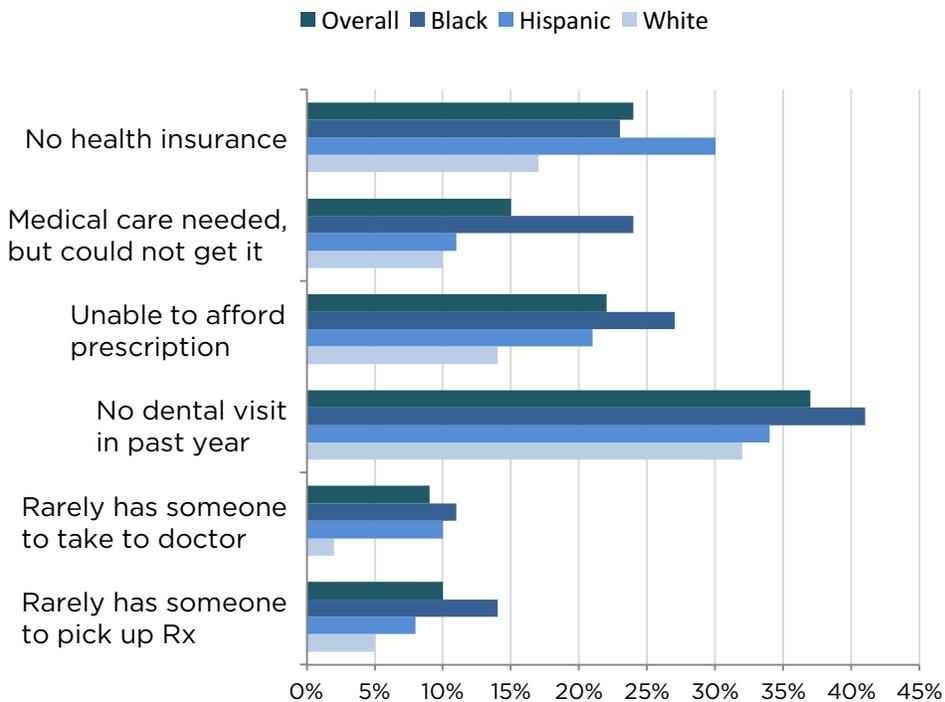
Access to healthcare can be measured in various ways, but is typically concerned with the availability, quality, and affordability of healthcare services. While many Americans have good access to quality healthcare, others face barriers that prevent them from obtaining basic health services. Minority populations and those with low socioeconomic status often face significant barriers to accessing care.

When we think about access to care in the communities served by UI Health, we are not referring to access to more health technologies, but instead access to basic healthcare services. UNISON Health revealed that in the communities served by UI Health, a significant number of community members do not have health insurance (24% overall, 30% of Hispanics, 23% of Blacks, and 16% of Whites). With further implementation of the Affordable Care Act, we suspect that a lower proportion of community residents are uninsured. However, many residents in our communities may not be eligible for Medicaid or the Marketplace due to immigration status or have additional barriers to accessing the resources to obtain health insurance.

UNISON Health indicates that our community faces additional barriers to accessing care (Figure 6):

- When they needed medical care, 15% of all respondents (24% of Blacks, 11% of Hispanics, and 10% of Whites) reported that they could not get it. The most common barrier was the cost of care.
- The ability to afford prescriptions was a barrier for 22% of all respondents (27% of Blacks, 21% of Hispanics, and 14% of Whites).
- 37% of all respondents (41% of Blacks, 34% of Hispanics, and 32% of Whites) reported that they did not visit the dentist in the past year.
- When asked if someone was available to take them to the doctor, 9% of all respondents (11% of Blacks, 10% of Hispanics, and 2% of Whites) said they rarely had someone to help them.
- Similarly, when asked if someone was available to pick up their prescription, 10% of all respondents (14% of Blacks, 8% of Hispanics, and 5% of Whites) said they rarely had someone to help them.

**Figure 6. UI Health Primary Service Area selected Access to Care Questions by Race and Ethnicity**



Focus group participants cited additional barriers to accessing care, including the limited number of mental health facilities, lack of a regular source of transportation, and limited education and awareness around the type of care needed. These barriers place significant hardship on our community’s ability to control their health conditions and to consistently access healthcare when they need it.

### Chronic Diseases

Chronic diseases and conditions, such as heart disease, cancer, chronic obstructive pulmonary disease (COPD), stroke, type-2 diabetes, and obesity are the most common, costly, and preventable of all health problems in the U.S. In the U.S., about half of all adults have at least one chronic health condition. The following sections report on the top most common conditions, as reported in UNISON Health.

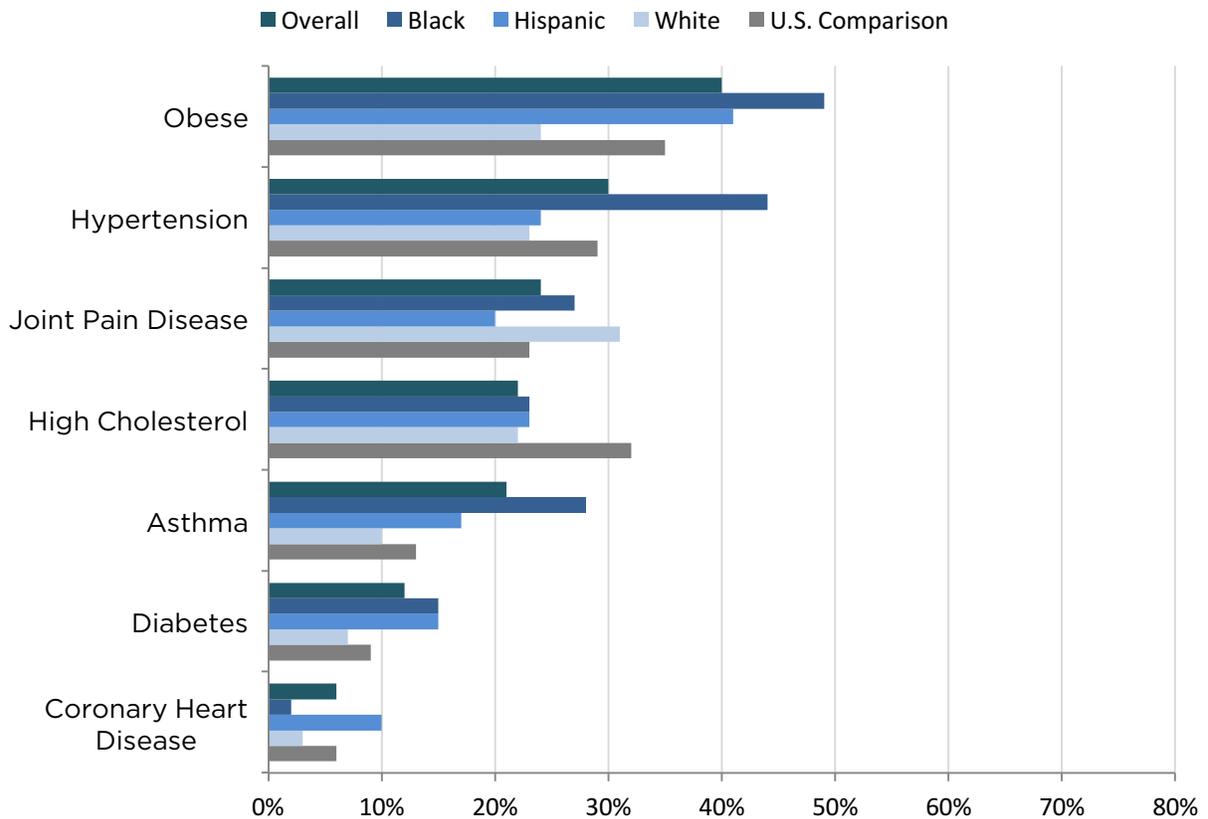
### Physical Health

The most prevalent physical health conditions in the UI Health PSA are obesity, hypertension, joint pain, high cholesterol, asthma, diabetes, and coronary heart disease.

In most cases, the prevalence of these physical health conditions is higher in the UI Health PSA than in the U.S. (Figure 7). Consistent with national trends, Blacks and Hispanics in the UI Health PSA had higher rates of chronic disease than Whites on almost all health conditions (Figure 7). Hypertension, asthma, and diabetes all show significant disparities between Blacks and Whites.

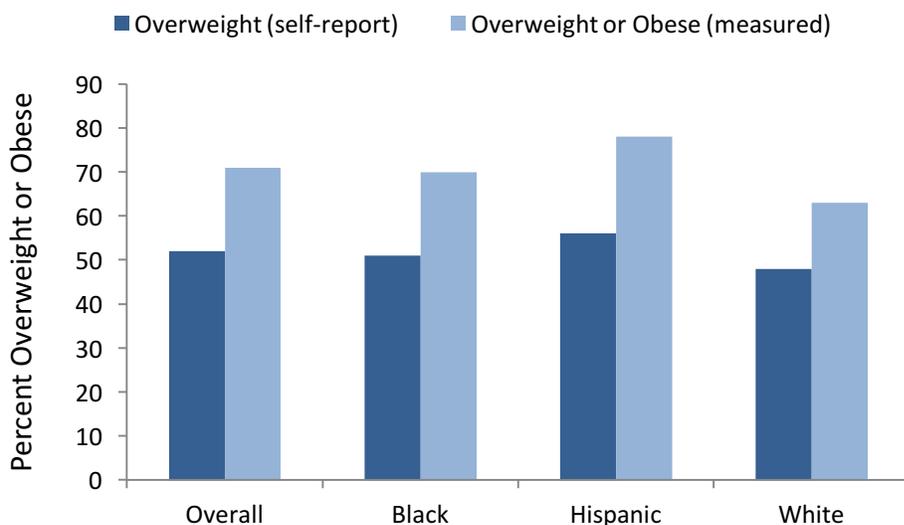


**Figure 7. UI Health Primary Service Area Top Seven Physical Health Conditions**



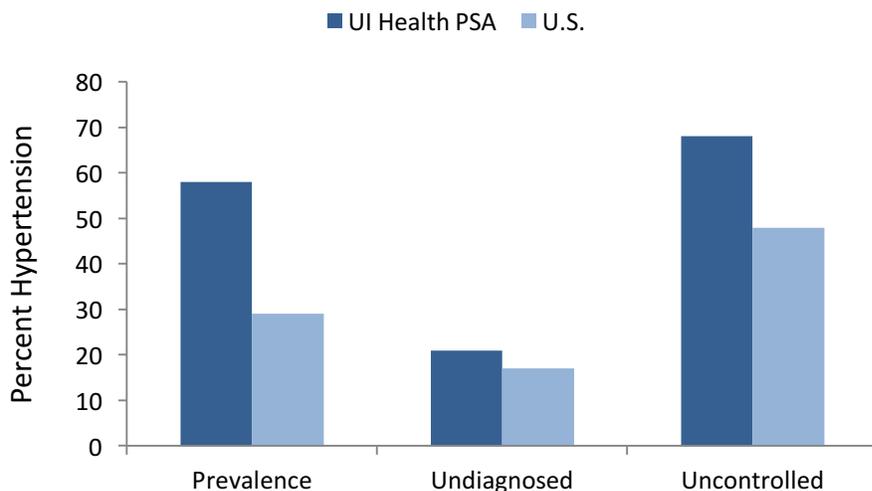
UNISON Health asked survey participants to provide self-report weight status and also took in-person measurements of height and weight. Using in-person measurements, 70% of Blacks, 78% of Hispanics, and 63% of Whites were found to be overweight or obese (body mass index 25 kg/m<sup>2</sup> or higher). Interestingly, there was a striking difference between self-report and physical measurement of weight status: on average, self-report underestimated overweight or obese body weight when compared to measurements by 19% (Figure 8). Obesity affects many other health conditions, both physical and mental, and therefore has a long-term impact on the health of our communities.

**Figure 8. Self-report vs. Measured Overweight and Obese by Race/Ethnicity for UI Health Primary Service Area**



Hypertension was another common health condition in the UI Health PSA. The prevalence of hypertension (greater than 140 mm Hg systolic or 90 mm Hg diastolic) in the UI Health PSA is about two-fold that in the U.S. (including the roughly 20% of individuals with undiagnosed hypertension). In addition, among those who reported a diagnosis of hypertension, about two-thirds (68%) did not have blood pressure control when measured at their home (Figure 9). Taken together, these data from UNISON Health indicate a clear need to increase efforts to identify individuals with undiagnosed hypertension, as well as to improve blood pressure control among those who have been diagnosed with hypertension.

**Figure 9. Hypertension for UI Health Primary Service Area**



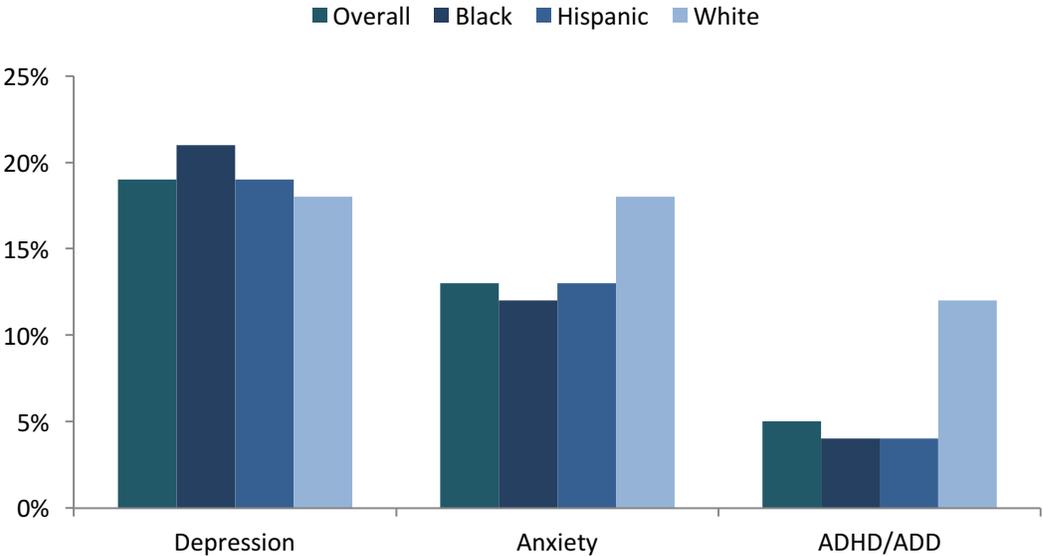
Sickle Cell Disease (SCD) is a rare genetic health condition, affecting about 2% of Blacks in our PSA. Individuals with SCD have painful crises due to sickling of their red blood cells, leading to emergency department visits and hospitalizations. The Sickle Cell Center at UI Health provides comprehensive care across the lifespan for individuals with SCD, which helps to explain why a higher proportion of individuals are seeking care at UI Health for SCD than on average elsewhere in the city of Chicago. Our own utilization data are striking given the low prevalence of SCD. In FY 2015, SCD patients accounted for 1,338 hospitalizations and 761 emergency room visits.

**Mental Health**

Three of the ten top health conditions found in UNISON Health were mental health conditions. Diagnoses of depression, anxiety, and attention deficit hyperactivity disorder (ADHD, also known as attention deficit disorder) were found in each racial/ethnic category (Figure 10).

Focus group participants cited the importance of addressing both mental and physical health. As described by a participant: *“Mental health is a big need. There is such a strong interaction between mental and physical health, which encompasses anxiety, depression, self-medication, overeating, and smoking. Many of these are comfort behaviors that happen as a result of other factors. There is a need to better integrate physical and mental health into one primary care network.”*

**Figure 10. UI Health PSA Top Three Diagnosed Mental Health Conditions**

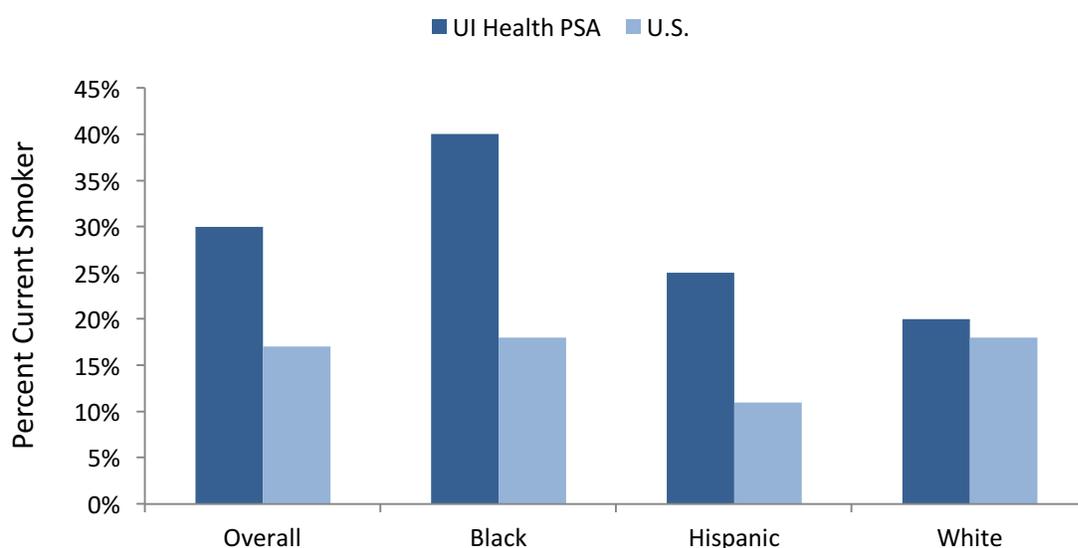


The prevalence of violence in the communities we serve, and the trauma that often results from experience with violence, can also have a detrimental effect on mental health. (For example, violent events can trigger posttraumatic stress disorder (PTSD).) The data on homicide rates presented below suggest that the need for mental health services is likely to be disproportionately high in our PSA.

## Health Behaviors

Smoking is the leading cause of preventable death in the U.S. Cigarette smoking harms nearly every organ in the body and accounts for 480,000, or one in five, deaths in the U.S. Quitting smoking greatly reduces these risks; however, we know quitting is extremely difficult and the environment and support play a crucial role in one's ability to quit. In the U.S., 17% of adults are current smokers. Prevalence varies slightly across racial and ethnic groups, but surprisingly Whites and Blacks have similar rates in the U.S. population. UNISON Health indicates that smoking is twice as common in our PSA than in the U.S. overall. This discrepancy is mostly due to higher rates of smoking among Blacks (40%) and Hispanics (25%) living in our PSA (Figure 11). To put this in perspective, the last time the U.S. had a smoking rate of 40% was 1968. These striking findings point to a clear need for improved smoking prevention and cessation programs that are culturally tailored to meet the unique needs of UI Health's communities.

**Figure 11. Percent Current Smoker by Race/Ethnicity for UI Health PSA compared to U.S.**



## Social Determinants of Health

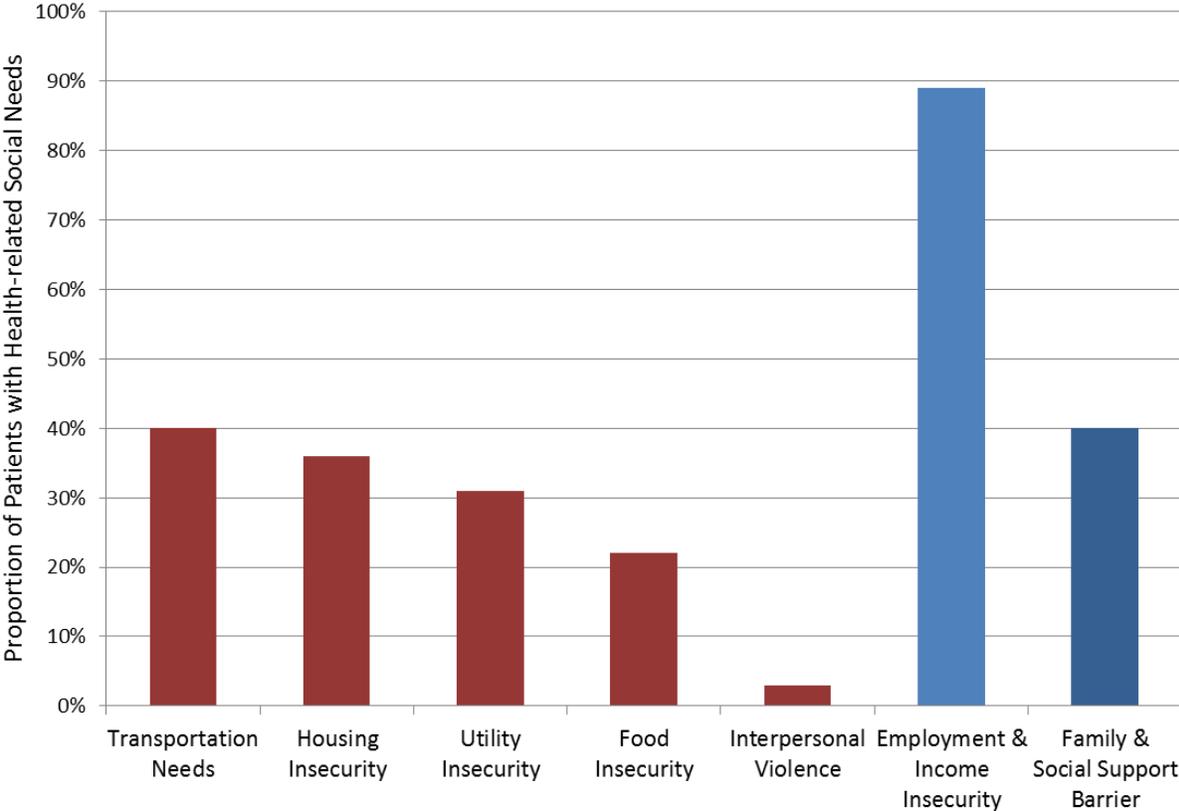
The chronic health conditions presented above show the prominent health disparities that exist in the communities served by UI Health. Healthy behaviors that are the underlying cause of these chronic conditions are often modifiable, but the conditions under which people are born, grow, live, go to school, and work often affect these behaviors. In fact, it is widely believed that approximately 70% of what impacts health happens outside of the healthcare system. We often refer to these social factors as the social determinants of health.

It is fundamental to the way UI Health delivers care to acknowledge that these social determinants of health play a critical role in the long term health of our communities and in keeping patients out of the hospital and in their community. The Centers for Medicare and Medicaid Services (CMS) recognizes that social determinants of health play a key role in health improvements and outcomes. CMS-defined health-related social needs include housing instability, utility needs, food insecurity, transportation needs, and interpersonal violence. Supplemental health-related social needs include employment, income insecurity and family and social support. CMS defined these as priority areas in its funding announcement for an Accountable Health Communities model (CMS-1P1-17-001).

Here we present community-level data on these seven health-related social determinants of health. We also present data on safety and violence.

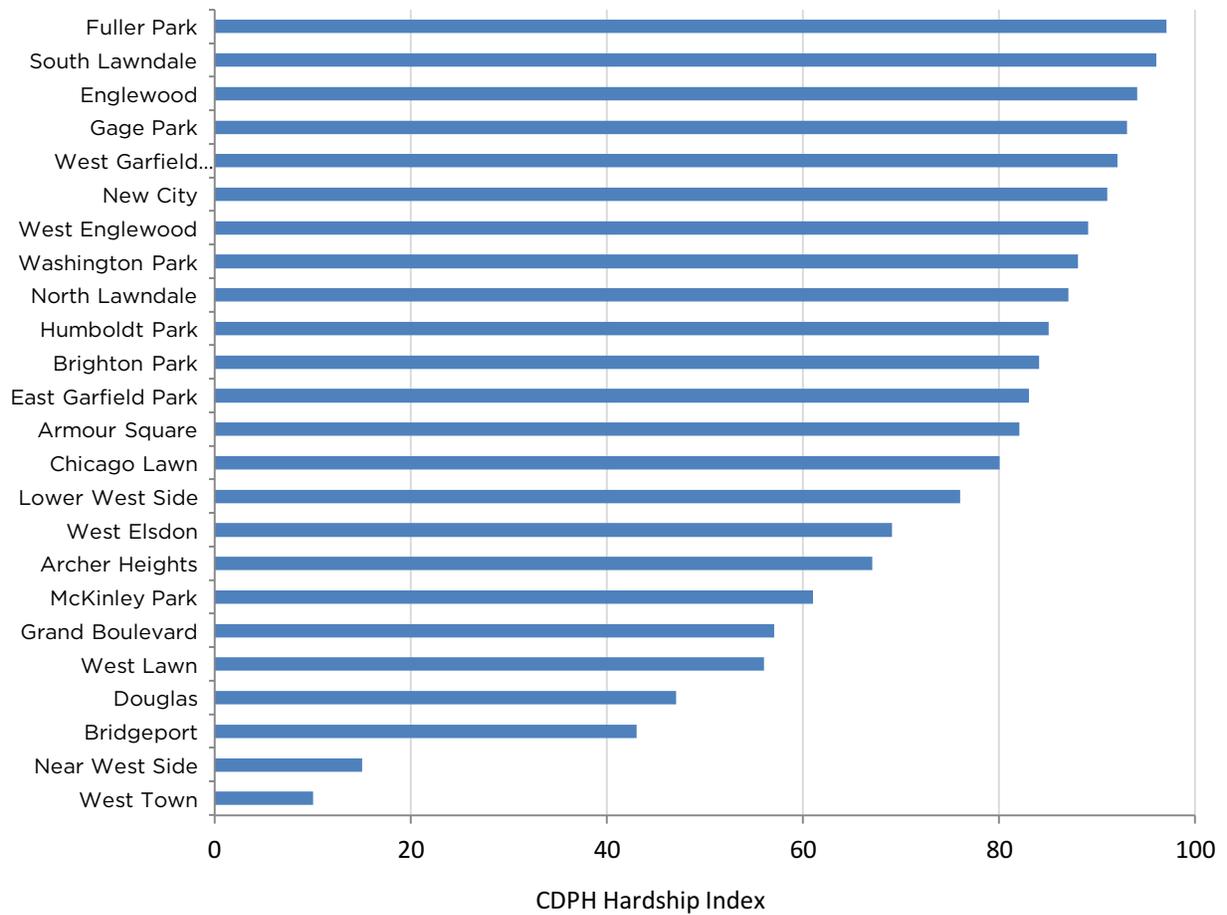
To complement the community-level data provided by UNISON Health, we collected data on the social determinants of health in patients hospitalized at UI Hospital for conditions associated with high risk of readmissions (i.e., heart failure, myocardial infarction, chronic obstructive pulmonary disease, and sickle cell). This is part of the PARtNER (PATient Navigator to rEduce Readmissions) study, which is evaluating the effectiveness of a patient navigator to support patients during hospital to home transitions. These data (from nearly 500 consecutive patients) indicate that there is a substantial need for a range of social services, including assistance with transportation, housing, employment and income support, among patients served by UI Health (Figure 12).

**Figure 12. CMS Health-Related Social Needs for UI Health Patients**



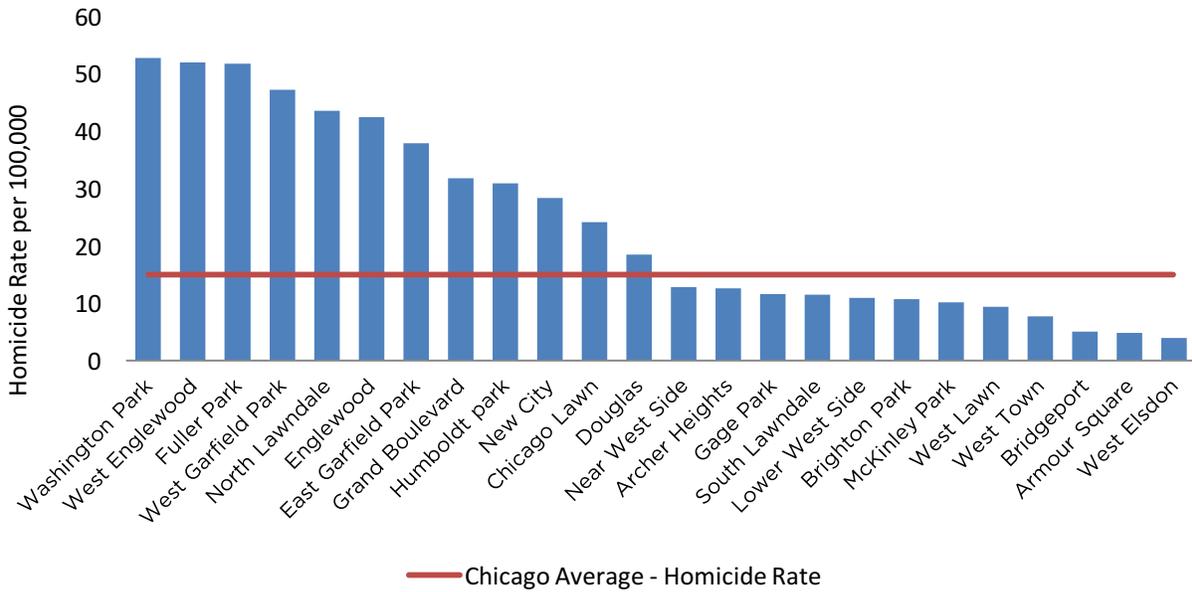
Neighborhood characteristics also play a critical role in health outcomes and behaviors. The Chicago Department of Public Health has developed a community-area level measure of socioeconomic stress (Hardship Index) based on the following indicators: percent of occupied housing units with more than one person per room (i.e., crowded housing); the percent of households living below the federal poverty level; the percent of persons in the labor force over the age of 16 years that are unemployed; the percent of persons over the age of 25 years without a high school diploma; the percent of the population under 18 or over 64 years of age (i.e., dependency); and per capita income. Possible scores on the Hardship Index are 0 to 100, with higher scores indicating worse socio-economic stress in the community area. Fourteen of the fifteen communities in Chicago with the worst Hardship Index scores are in UI Health’s PSA (Figure 13).

**Figure 13. Hardship Index by Community Area for UI Health PSA**



We know that violence plagues our communities, and the issues of violence and safety were brought to our attention by our community members and stakeholders. Half of our communities have homicide rates higher than the city rate (Figure 14). Some of the community areas that are part of the UI Health PSA have homicide rates that are more than three times the average for the city of Chicago.

**Figure 14. Homicide by Community Area for UI Health PSA**



Focus group participants cited neighborhood characteristics and a lack of infrastructure in communities as a significant barrier to good health. As described by a participant: *“We can’t expect physical activity when people don’t feel safe to go outside or there are no parks or areas of recreation.”*

A lack of opportunity and high unemployment were also cited by participants as significant issues in their communities. As described by a participant: *“Nearly half of young black men in Chicago are unemployed. This is the root cause of many underlying health issues.”*



## PRIORITIZATION OF COMMUNITY HEALTH NEEDS

### Prioritization Process

At the conclusion of each community stakeholder meeting, participants were asked to write down (anonymously) what they individually perceived as the top five health priorities for the community, based on the discussion as well as their own experiences. Their responses were as follows:

- Chronic Disease (obesity, hypertension, asthma, diabetes)
- Mental health (depression, anxiety, PTSD)
- Trauma/violence and community safety
- Health education and health literacy
- Oral health

After reviewing the 2013 UI-CAN data from our community description and health profile, as well as feedback from our community members and the Chicago Department of Public Health, the following additional criteria were used to prioritize the health needs for action in fiscal years 2016 to 2019:

- **Magnitude.** Overall prevalence of chronic diseases and health needs, while paying particular attention to those areas where the needs are greater compared to national, state, and city-level benchmarks.
- **Disparity.** The degree to which the identified need disproportionately impacts certain populations in our PSA.
- **Impact.** The degree to which the condition or issue affects or exacerbates other quality of life and health-related issues, as well as UI Health's ability to reasonably impact the issue given resources available.
- **Alignment with UI Health System Mission.** How well the health need aligns with the health system's mission to provide high quality care to the people of Illinois and to eliminate health disparities.
- **Alignment with [Healthy Chicago 2.0](#) and [Healthy Illinois 2021](#).** In an effort to collectively make an impact and partner on strategies to improve the health of communities, how well the health need aligns with Healthy Chicago 2.0 and Healthy Illinois 2021 priority areas.

## Identified High Priority Areas of Focus

It is important to reiterate UI Health's commitment to the pursuit of health equity. Health equity is a vital part of UI Health's mission, and it will be a key theme in each of the identified high priority areas of focus during the development of strategies for the UI Health Implementation Plan.

Based on the prioritization process above, UI Health leadership identified the following health-related needs areas as the focus of effort for fiscal years 2016 to 2019:

1. **Addressing the social determinants of health:** education, employment and income, health behaviors (e.g., smoking), housing, family and social support, food, interpersonal violence, transportation, and utility insecurity.
2. **Improving access to care:** availability of high quality physical and mental healthcare on demand.
3. **Reducing the risk of chronic disease or the impact of chronic disease on health:** asthma, cardiovascular disease (including hypertension), diabetes, mental and behavioral health, obesity, and sickle cell disease.

UI Health recognizes that many of the needs above are interconnected, challenging to address, and may require innovative, multi-level (patient, provider, and system-level) strategies. We also recognize that many of the needs may be beyond the scope of what a single healthcare provider can address. However, we believe it is our responsibility to do whatever we can to promote wellness and health in the communities we serve. That is why we have launched a number of novel, aggressive approaches, including specific initiatives to reduce the need to visit the emergency department for healthcare, to reduce avoidable readmissions to the hospital, and, most recently, to provide housing for a small number of homeless patients who face enormous challenges in improving their health.

We have also taken some initial steps to work with our community partners and collaborating health systems to evaluate different models of care to improve transitions from the emergency department to home among children with uncontrolled asthma. We also recently submitted an application to CMS to develop an Accountable Health Community in collaboration with several community based organizations, the Illinois Health and Hospital Association, peer health systems, and other partners.

UI Health is committed to working with partners, where possible, in developing shared implementation strategies and ultimately shared successes in achieving health equity in the communities we collectively serve.



## EVALUATION OF IMPACT FROM 2013 CHNA

UI Health identified four areas of high priority in the 2013 UI-CAN and developed strategies as part of the implementation plan. Community input on the implementation plan was solicited by including a public email address on the back cover the 2013 CHNA. No written comments were received. How best to obtain public input on this kind of report is something that will require creative thinking as UI Health develops its 2016 implementation plan.

Considerable efforts have been made to impact each of these priority areas. Understanding that there is still much work to do around each of these areas, some of the successfully implemented strategies are highlighted below.

### Access to healthcare services, including medical, mental, vision and oral health

1. Increase infrastructure and expand capacity
  - [Mile Square Health Center](#), UI Health's Federally Qualified Health Center
    - [Urgent Care Center](#) opened in 2014, allowing patients to walk in and see a provider without an appointment. Urgent Care is currently open six days a week (Monday-Saturday), including weekday evening hours. The center is working to hire sufficient staff to expand hours to meet the considerable demand.
    - Saturday hours were added to both the [Mile Square Main](#) and [Back of the Yards](#) clinic locations.
  - [Family Medicine Clinic at University Village](#)
    - [Same-day appointments](#) are now available for all Family Medicine physicians and nurse practitioners, with over half of all appointments reserved every day for same-day access. These appointments become available when the clinic opens every morning.
    - Service was expanded to include [evening hours](#) on Tuesdays and Thursdays, as well as Saturday hours.
2. Link patients with comprehensive services through better integrated care
  - The [PATient Navigator to rEduce Readmissions \(PARtNER\)](#) program identifies high-risk patients hospitalized at UI Hospital, and utilizes combines community health workers together with a peer-led telephone information line to increase social support and improve self-efficacy to connect patients with other healthcare resources at UI Health and at community-based organizations.
  - [The Coordinated Healthcare Interventions for Childhood Asthma Gaps in Outcomes \(CHICAGO\) Plan](#) combines provider and patient education and community health worker-led home visits to facilitate care transitions in children presenting with uncontrolled asthma to the emergency department.

- [Coordination of HHealthcare for Complex Kids \(CHECK\)](#)
    - Deployed a team of highly trained community health workers and Care Coordinators to provide children and families access to extra support services, education about illness, and tools for disease management.
    - Expanded oral health services through the Mobile Care Chicago dental van, which provides comprehensive services to low income communities. Since January 2016, the dental van has had a goal of hosting at least one monthly event in UI Health communities, providing direct oral health services and linking patients to additional services at the UIC School of Dentistry.
  - [Sickle Cell Center at the University of Illinois Hospital & Health Sciences System](#)
    - As the only Sickle Cell Center in the state providing comprehensive sickle cell care for adults, the center increased its capacity by expanding service to five days a week. To better integrate care and link patients to these comprehensive services, UI Health pediatric hematologists and a dedicated social worker work with other area hospitals around potential patients being transitioned to UI Health.
3. Increase awareness of UI Health services
- [UI Health became a Certified Application Counselor](#) organization in 2013. This means that patients and community members can receive in-person enrollment assistance and education for either Medicaid or the Health Insurance Marketplace at six different locations across UI Health. Since the first open enrollment period in 2014, UI Health has assisted community members with over 3700 Medicaid applications and over 320 Marketplace applications.
  - UI Health marketing developed targeted awareness and education campaigns to improve community knowledge about services and locations of UI Health. Education campaigns provided information and resources around brain aneurysms, stroke, mammography, and sickle cell disease.

## Follow-up care

1. Provide patient navigators to guide patients through the healthcare system
  - [Emergency Patient Interdisciplinary Care \(EPIC\) Coordination for Frequent ER Visitors](#) initiative used an interdisciplinary care model to create and activate individualized health management programs to transition frequent ER visitors to a medical home.
    - The goals of the program were to enhance quality of care, improve outcomes, and lower Illinois Medicaid costs by reducing ER visit and hospitalizations. The program ran for two years, screened over 400 patients and provided care coordination for 230 patients.
  - The PARtNER program, the CHICAGO Plan, and CHECK all utilize community health workers to guide patients through the healthcare system.
2. Increase care coordination to ensure patients receive appropriate care
  - Created an Accountable Care Entity (ACE) called [UI Health Plus](#) to provide comprehensive care and care coordination for Medicaid clients across the state. UI Health Plus teamed up with Blue Cross Community Family Health Plan in January 2016. The UI Health Care Coordination team now has 13 care coordinators, coordinating the care of approximately 375 high-risk patients.

- [Better Health Through Housing](#), a partnership with the [Center for Housing and Health](#), aims to reduce healthcare costs and provide stability for the chronically homeless by moving individuals directly from hospital emergency rooms into supportive housing, with intensive case management.
  - In 2016, UI Health committed \$250,000 to help launch the initiative, and it is the only Chicago-area hospital working on this type of healthcare-and-housing initiative. Along with housing, individuals are assigned a case manager who helps them with things such as scheduling medical appointments, managing money, and refers them to other needed services.
  - Early results indicate a 34% reduction in ED and inpatient utilization for these newly housed patients, and a 75% decrease in healthcare costs.

## Chronic conditions and factors

1. Expand specialty care at FQHCs
  - Since 2014, psychiatry services have been expanded and breast surgery was added to increase on-site capacity. Mile Square providers are also working with the CHECK program for additional education and patient navigation to specialty care.
  - In 2016, the [Office of Community Engagement and Neighborhood Health Partnership](#) (OCEAN) began implementing the phased introduction of telehealth services at two school-based health centers. The telehealth program supports remote provider consultations and health evaluations for chronic and high-risk patients.
2. Increase focus on patient centered care to provide personalized treatments for chronic conditions
  - The PARTNER program, the CHICAGO Plan, and the CHECK program all include initiatives to help enrollees manage chronic conditions.
3. Increase education and awareness about chronic conditions through community outreach and screening services
  - Mile Square takes part in between 12-20 large community events each year, including Corazon Community Health Services, Hope Fest, Fiesta del Sol, Bud Biliken Parade & Picnic, Congressman Davis Back to School Picnic, and the African American Festival for the Arts.
  - Community health workers from Mile Square clinics and SBHCs regularly attended community health fairs to provide health education and screening.

## Cancer screening

1. Create a lung cancer screening program
  - UI Cancer Center and MSHC created the Mi-Quit smoking cessation program to address the high rates of lung cancer in UI Health's PSA. To date, over 180 patients have been screened and the partnership has resulted in increased early detection of lung cancer in high-risk populations.
2. Leverage existing resources to promote screening for colorectal and prostate cancer
  - The Mi-Care program goal is to increase colorectal cancer screening in community-based settings through the incorporation of a community-based colorectal cancer screening and navigation program into MSHC. To date, the UI Cancer Center has been able to increase colorectal cancer screening from a baseline rate of 12.7% to over 45% due to evidence-based navigation.

## APPENDIX A: ADDITIONAL HEALTH RESOURCES

### Hospitals

University of Illinois Hospital	1740 W. Taylor St., Chicago, IL 60612
Holy Cross Hospital	2701 W. 68 <sup>th</sup> St., 60629
Jesse Brown VA Medical Center	820 S. Damen Ave., Chicago, IL 60612
John H. Stroger Jr. Hospital of Cook County	900 W. Polk St., Chicago, IL 60612
Mount Sinai Hospital	1500 S. Fairfield Ave., Chicago, IL 60608
RML Chicago	3435 W. Van Buren St., Chicago, IL 60624
Rush University Medical Center	1653 W. Congress Pkwy., Chicago, IL 60612
Sacred Heart Hospital	3240 W. Franklin Blvd., Chicago, IL 60624
Saint Anthony Hospital	2875 W. 19 <sup>th</sup> St., Chicago, IL 60623
Schwab Rehabilitation Hospital	1401 S. California Blvd., Chicago, IL 60608

Source: <http://www.ihatoday.org/hospital-directory.aspx>

### Community Health Centers

Mile Square Health Center – Main	1220 S. Wood St., Chicago, IL 60608
Mile Square Health Center – Back of the Yards	4630 S. Bishop St., Chicago, IL 60609
Mile Square Health Center – Cicero	4745-51 W. Cermak Rd., Cicero, IL 60804
Mile Square Health Center – Englewood	641 W. 63 <sup>rd</sup> St., Chicago, IL 60621
Mile Square Health Center – South Shore	7131 S. Jeffery Blvd., Chicago, IL 60649
Mile Square Health Center – Humboldt Park	3240 W. Division St., Chicago, Illinois 60651
Mile Square Health Center – South Clinic/New City	734 W. 47 <sup>th</sup> St., Chicago, IL 60609
ACCESS Servicios Medicos La Villita	3303 W. 26 <sup>th</sup> St., Chicago, IL 60623
ACCESS Madison Family Health Center	3800 W. Madison St., Chicago, IL 60624
ACCESS Centro Medico	3700 W. 26 <sup>th</sup> St., Chicago, IL 60623
ACCESS Westside Family Health Center	3752 W. 16 <sup>th</sup> St., Chicago, IL 60623
ACCESS Centro Medico San Rafael	3204 W. 26 <sup>th</sup> St. , Chicago, IL 60623
ACCESS at Sinai	2653 W. Ogden Ave., 3 <sup>rd</sup> Floor, Chicago, IL 60608
ACCESS Plaza Family Health Center	2533 W. Cermak Rd., Chicago, IL 60608
ACCESS Madison Family Health Center	3800 W. Madison St., Chicago, IL 60624
ACCESS Cabrini Family Health Center	3450 S. Archer Ave., Chicago, IL60608
ACCESS Warren Family Health Center	2409 W. Warren Blvd., Chicago, IL 60612
ACCESS Pilsen Family Health Center	1817 S. Loomis St., Chicago, IL 60608
ACCESS Located at Holy Cross	2701 W. 68 <sup>th</sup> St., 3 South, Chicago, IL 60629
Alivio Medical Center – Morgan Street	966 W. 21 <sup>st</sup> St., Chicago, IL 60608
Alivio Medical Center – Western Avenue	2355 S. Western Ave., Chicago, IL 60608
Esperanza California	2001 S. California Ave., Chicago, IL 60608
Esperanza Little Village	3059 W. 26 <sup>th</sup> St., Chicago, IL 60623
Esperanza Marquette	6550 S. Richmond St., Chicago, IL 60629
Erie Westside Health Center	646 N. Lawndale Ave., Chicago, IL 60624
Friend Family Beethoven Health Center	25 W. 47 <sup>th</sup> St., Chicago, IL 60609
Friend Family Pulaski Health Center	5635 S. Pulaski Rd., 2 <sup>nd</sup> Fl., Chicago, IL 60629
Friend Family Ashland Health Center	4802 S. Ashland Ave., Chicago, IL 60609
Lawndale Christian Health Center – Ogden	3860 W. Ogden St., Chicago, IL 60623
Lawndale Christian Health Center – Homan Square	3517 W. Arthington St., Chicago, IL 60623
Lawndale Christian Health Center – Archer	5122 S. Archer Ave., Chicago, IL 60632
PCC Clinic at The Boulevard	3456 W. Franklin Blvd., Chicago, IL 60624

Source: [http://www.iphca.org/Portals/0/Maps/Chicago\\_All\\_Sites\\_And\\_Legend.pdf](http://www.iphca.org/Portals/0/Maps/Chicago_All_Sites_And_Legend.pdf)

## School-Based Health Centers

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Mile Square - National Teachers Academy Health Center	55 W. Cermak Rd., Chicago, IL 60616
Mile Square - Bronzeville Health and Wellness Center	2641 S. Calumet Ave., Chicago, IL 60616
Mile Square - Hope Institute Learning Academy Health and Wellness Center	1628 W. Washington Blvd., Chicago, IL 60612
Mile Square - Davis Health and Wellness Center	3050 W. 39th Pl., Chicago, IL 60632
Mile Square - Auburn Gresham Health and Wellness Center	8131 S. May St., Chicago, IL 60620
Alivio Medical Center at Benito Juarez Community Academy	1450 W. Cermak Rd., Chicago, 60623
Alivio Medical Center at Jose Clemente Orozco Academy	1940 W. 18th St., Chicago, IL 60608
Alivio Medical Center at Little Village Lawndale High School	3120 S. Kostner Ave., Chicago, IL 60623
Erie Clemente Wildcats Student Health Center	1137 N. Western Ave., Chicago, IL 60622
Erie Henson School Based Health Center	1326 S. Avers Ave., Chicago, IL 60623
Erie Westside Health Center at Ryerson Elementary	646 N. Lawndale Ave., Chicago, IL 60624
Jose de Diego School Based Health	1313 N. Claremont Ave., Chicago, IL 60622
Lawndale Christian Health Center - Farragut Academy	2345 S. Christiana Ave., Chicago, IL 60623
Rush at Crane Technical Preparatory Common School	2245 W. Jackson Blvd., Chicago, IL 60612
Rush at Rezin Orr Community Academy High School	730 N. Pulaski Rd., Chicago, IL 60624
Rush at Simpson Academy for Young Women	1321 S. Paulina St., Chicago, IL 60608
Spry Community School	2400 S. Marshall Blvd., Chicago, IL 60623

Source: <http://cps.edu/OSHW/Documents/SchoolBasedHealthCenterMap.pdf>

## Nursing Homes

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Aperion Care International	4815 S. Western Ave., Chicago, IL 60609
California Gardens and Rehab	2829 S. California Blvd., Chicago, IL 60608
El Valor Residence	1931 W. 19th St., Chicago, IL 60608
Schwab Rehabilitation Center SNU	1401 S. California Blvd., Chicago, IL 60608
Park House Nursing and Rehab Center	2320 S. Lawndale Ave., Chicago, IL 60623
Sacred Heart Home	1550 S. Albany, Chicago, IL 60623
Symphony of Midway	4437 S. Cicero, Chicago, IL 60632

Source: <https://ltc.dph.illinois.gov/webapp/LTCAApp/Ltc.jsp>

## APPENDIX B: ABBREVIATIONS

ADHD: Attention Deficit Hyperactivity Disorder

CHECK: Coordination of Healthcare for Complex Kids

CHICAGO Plan: Coordinated Healthcare Interventions for Childhood Asthma Gaps in Outcomes Plan

CHNA: Community Health Needs Assessment

CMS: Centers for Medicare and Medicaid Services

COPD: Chronic Obstructive Pulmonary Disease

EPIC: Emergency Patient Interdisciplinary Care (EPIC) Coordination for Frequent ER Visitors

FQHC: Federally Qualified Health Center

MSHC: Mile Square Health Center

OCEAN: Office of Community Engagement and Neighborhood Health Partnerships

OVCHA: Office of the Vice Chancellor for Health Affairs

PARtNER: PATient Navigator to rEduce Readmissions

PSA: Primary Service Area

PTSD: Posttraumatic Stress Disorder

SBHC: School Based Health Center

SCD: Sickle Cell Disease

UI Health: University of Illinois Hospital & Health Sciences System

UIC: University of Illinois at Chicago

UNISON Health: University of Illinois Survey of Neighborhood Health