2022 HCH Community Health Needs Assessment

HOLY CROSS HOSPITAL

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MORE THAN MEDICINE. IT'S PERSONAL. Sinai Chicago

Holy Cross Hospital 2022 Community Health Needs Assessment

This report was compiled by:

Stephanie Jara, MPH *Epidemiologist I*

Lubia Núñez-Montelongo, MPH *Manager of Community Engagement*

Myles Castro, MPH *Program Manager*

Yvette Castañeda, Ph.D., MBA, MPH *Associate Director of Health Equity and Assessment Research*

Pamela T. Roesch, MPH *Director of Health Equity and Assessment Research*

Helen Margellos-Anast, MPH *President of Sinai Urban Health Institute*

In partnership with:

Sinai Chicago's 2022 Community Health Needs Assessment (CHNA) and Community Heath Improvement Plan (CHIP) Community Advisory Committee

Sinai Chicago's 2022 CHNA and CHIP Executive Advisory Committee

Sinai Chicago leadership and caregivers

The Alliance for Health Equity

Kara Smith *Graphic Designer*

Metop.io *community data software provider*

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Executive Summary

In Sinai Chicago's 2022 Community Health Needs Assessments (CHNA), we reflect on the past three years and the challenges faced across Chicago and in our service area. The COVID-19 pandemic has had lasting impacts on the health and wellbeing of our patients and communities, exacerbating existing health inequities and laying bare the legacy of racism and its disproportionate impact on Black/African American and Hispanic/Latinx populations. Whether examining the pandemic in terms of cases, hospitalizations, and deaths, or through its social and economic impacts, the communities served by Sinai Chicago have faced immense struggles during this time. Leveraging perseverance and determination, Sinai Chicago patients, community members, and caregivers have worked collaboratively within the hospital walls and beyond to alleviate the suffering caused by the pandemic.

Despite these challenges, the past three years have offered an opportunity to celebrate the strength of our caregivers, patients, and community partners. The communities served by Sinai Chicago – often historically disinvested – have rallied, organized, fought, and strived to make a positive impact in their neighborhoods. They have turned to strong family and community networks, resiliency and faith, and trusted organizations to take on the challenges created by the pandemic and longstanding racism.

"We don't need the outsiders to come in and use the resources for their programing, we need it from the community." - Alliance for Health Equity (AHE) Focus Group Member

"Rough neighborhood, but it's got a way of hanging-on - they stick together, there's a sense of togetherness." - AHE Focus Group Member

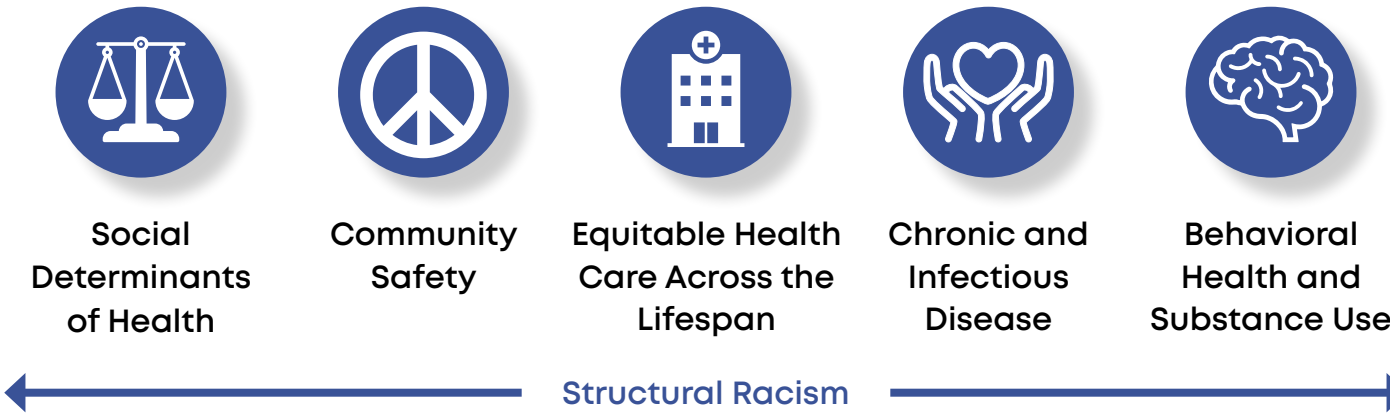
"I feel proud because in my home country, I did not feel support and care for others, but it is different here." - AHE Focus Group Member

Throughout our 2022 CHNA, we focus on gaining a deeper understanding of the role that structural racism plays in creating and perpetuating racial and ethnic health inequities across our service area.

Structural racism refers to the "totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice."[1]

The recognition and documentation of the historical and systemic causes of inequities will ground our system's subsequent Community Health Improvement Plan (CHIP) in anti-racist approaches. Further, within the report, we elevate the strength of communities served by Sinai Chicago, including insights from community conversations and highlights of a small set of the many organizations critical to improving wellbeing. We highlight a sampling of ways our system aligns our work to address health in partnership and solidarity with residents, local leaders, and community-based organizations.

Sinai Chicago is a safety net health care system on Chicago's West and Southwest Sides that provides services to all, regardless of insurance or citizenship status. Our hospitals – Holy Cross Hospital, Sinai Children's Hospital, Holy Cross Hospital, and Schwab Rehabilitation – as well as our system entities, Sinai Medical Group, Sinai Community Institute, and Sinai Urban Health Institute – are committed to improving the health of the individuals and communities that we serve.



Our 2022 Community Health Priorities are consistent with those brought forward in our 2019 CHNA and CHIP, allowing for stability in our strategic approaches to improving community wellbeing over time.

In returning to our Health Priorities for the 2022 CHNA, we considered emerging issues such as the COVID-19 pandemic and its deleterious effects; new publicly-available data sources; community discussions regarding structural racism; and recent data collected by the Alliance for Health Equity via focus groups and their 2021 Community Input Survey.

We refined our priorities to reflect this information, ensuring our 2022 Community Health Improvement Plan (CHIP) will respond to the longstanding and emerging needs of those we serve. Together, the CHNA and CHIP serve as a cornerstone to our system's internal work to address health inequities and to our collaborative partnerships to improve health across the communities we serve.

Before sharing our 2022 CHNA report, we would like to acknowledge and thank everyone who has contributed to its development and the refinement of our Community Health Priorities. In particular, we would like to thank Sinai Chicago leadership and caregivers from across the organization who informed, developed, and reviewed the CHNA. We thank the Alliance for Health Equity which provided critical data to contextualize our findings. We thank our CHNA/CHIP Community Advisory Committee who shared their time, expertise, and experiences with us to improve upon our initial approach. And, most importantly, we thank our patients and partners who work with us every day to confront injustice and pursue health equity in our communities and across Chicago.

Preface: Approaching our 2022 CHNA and CHIP

Throughout our 2022 Community Health Needs Assessment (CHNA), we focus on gaining a deeper understanding of the role that structural racism plays in creating and perpetuating racial and ethnic health inequities across our service area.

> **Structural racism refers to the "totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice."**[1]

The recognition and documentation of the historical and systemic causes of inequities will ground our system's subsequent Community Health Improvement Plan (CHIP) in anti-racist approaches. Together, the CHNA and CHIP serve as a cornerstone to our system's internal work to address health inequities and to our collaborative partnerships to improve health across the communities we serve.

Beyond the overarching impact of structural racism, we emphasize the healthcare system's role in perpetuating inequity because we are uniquely positioned for action in this space. The CHNA solidifies our commitment to addressing racial equity as a healthcare institution and sets us on the path of **acknowledgement, redress, and closure**.[2] ***Acknowledgement*** is

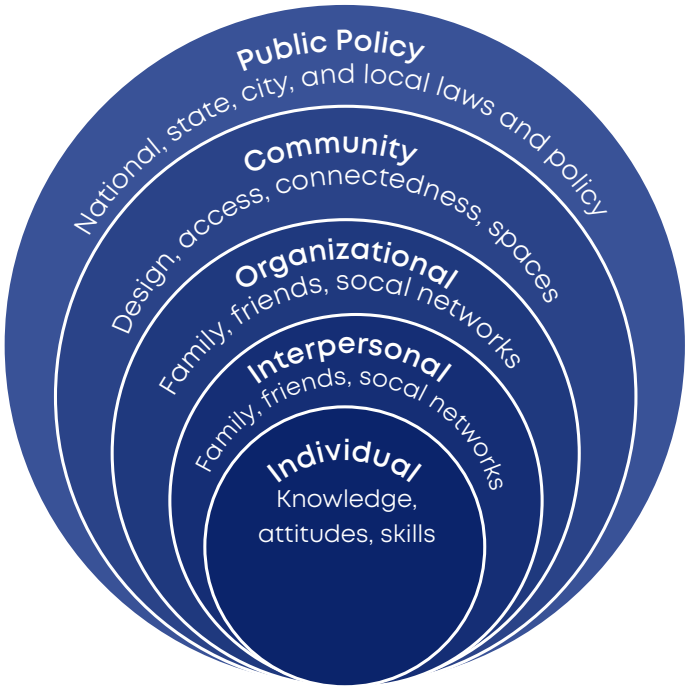
the first step of understanding and recognizing how structural racism has contributed to racial and ethnic health inequities – a key element of this CHNA. ***Redress*** creates pathways that address service barriers and enhance patient wellbeing. ***Closure*** is an ongoing phase of strengthening or rebuilding relationships with communities that have been harmed and establishing an iterative path forward. Walking this path takes intentionality and dedicated effort and is vital to Sinai Chicago's ongoing commitment to the pursuit of racial and ethnic justice and health equity. As a testament to this commitment, in early 2022, Sinai Chicago pursued a Health Equity within Healthcare Plan in collaboration with the Illinois Hospital Association that outlines our strategic commitment and short- and long-term aims to pursue racial and ethnic equity within our own policies and approaches.

Our Framework

Conceptually, our CHNA seeks to examine community wellbeing through three complementary lenses. **First, we examine health outcomes and determinants of health using the socio-ecological model (Figure 1).** The socio-ecological model allows us to frame health outcomes within a complex system of factors – including racism – that impact wellbeing at multiple levels. It conceptualizes health as something influenced by more than individual attributes (e.g., behaviors, attitudes) and accounts for the impact of public policies and laws, communities, organizations (e.g., workplaces, schools), and interpersonal relationships on wellbeing.

Second, throughout the CHNA, we focus on structural racism's role in shaping inequitable health outcomes across the socio-ecological layers, with a focus on organizational and public policies and the systems within which they function. Based on current understanding of the term and its measurement, we provide a historical perspective, geographic context (the Sinai Chicago service area and Chicago), and multifaceted assessments of structural racism.[3] We examine the housing policies that have resulted in residential segregation by race/ethnicity and income; economic and educational policies that have limited opportunity and financial security within Black/African American and Hispanic/Latinx communities; and the role of the healthcare system in addressing structural racism both internally and through community-facing health initiatives.

Figure 1. A Social-Ecological Model for Physical Activity — Adapted from Heise L., Elsberg M., & Gottemoeller, M. (1999).



Third, we take an assets-based approach in the way we frame, think about, and share data, ensuring that our future initiatives acknowledge and augment the wealth of resources and power present in the communities we serve, despite the challenges that we also underline.

Within the CHNA, we use publicly-available data and reports, conversations with our CHNA/CHIP Community Advisory Committee, and findings from the Alliance for Health Equity's (AHE) Community Focus Groups and Community Input Survey to better understand health outcomes and the role of structural racism in creating and perpetuating community health inequities. Where possible, we present measures of health factors and outcomes by race and ethnicity as a marker of the distinct experiences of racism across socio-ecological levels and the lifespan.

We reject the notion that differences in our findings by race and/or ethnicity are rooted in genetic or biological factors, but affirm that they result from historic and persistent structural racism across time and space.

Outline to Reading the CHNA

We begin by describing our health system – Sinai Chicago – and follow with details regarding our methodological approach to the CHNA. Next, we provide three sections that contextualize health and wellbeing within the communities we serve: demographics, COVID-19 Impacts, and Community Health Priorities. The Community Health Priorities are consistent with those brought forward in our 2019 CHNA and CHIP processes, allowing for stability in our strategic approaches to community health improvement over time. Each section compiles quantitative data for our service area, qualitative data from discussions with our Community Advisory Committee and focus groups on the West and Southwest Sides, an overview of Sinai Chicago's current activities in the Health Priority, and a brief summary of local organizations working to address the Health Priority. The report is to serve as the basis for our 2022 CHIP, which will outline our strategic plan to address the Community Health Priorities.

Sinai Chicago Overview

Sinai Chicago is a safety net healthcare system comprising a network of four hospitals, many community clinics, a center providing wraparound social services, and a nationally-recognized community-based research institute that serves Chicago's West and Southwest Sides. Originally founded in 1919 as a 60-bed hospital on Chicago's West Side to serve Eastern European Jewish immigrants and to train Jewish physicians and nurses denied educational opportunities elsewhere, Sinai Chicago has a rich history of supporting those who have been marginalized. Today, Sinai Chicago serves predominantly Black/African American and Hispanic/Latinx communities that have faced decades of systematic economic and social divestment. Our commitment to improving community wellbeing is evident by our wide array of community-based programming that reaches beyond our physical walls to provide critical health and social services.

Mission, Vision, and Values

Mission: To improve the health of the individuals and communities we serve.

Vision: Sinai Chicago will become the national model for the delivery of urban health care.

Values:

Respect – We will create an atmosphere of mutual respect and fairness, treating each person with dignity that recognizes each individual's unique talents and contributions.

Teamwork – We will celebrate the opportunity to come together as caregivers in an inclusive workplace where diversity and open communication are valued.

Integrity – We will hold ourselves accountable for our actions and be honest and ethical in all our dealings.

Safety – We will foster an environment that focuses on protecting our patients, visitors, and caregivers from harm or injury.

Quality – We will continuously improve our services as measured by the best practices in the industry.

Sinai Chicago's Member Institutions

Holy Cross Hospital

Holy Cross Hospital (HCH) is located in Chicago Lawn on Chicago's Southwest Side. Joining Sinai Chicago in 2012, HCH is a community hospital that provides inpatient and outpatient care for a range of services that include medical, surgical, intensive care, emergency, primary care, and behavioral health services – including Chicago's first comprehensive crisis stabilization unit – as well as hospice and palliative care services operated by Seasons Hospice.

264
licensed beds

8,000+
inpatient admissions each year

45,000
Emergency Department patients cared for annually. Our HCH emergency department delivers comprehensive care for a broad range of critical and urgent medical needs

18,000+
ambulance runs annually

Sinai Chicago's Member Institutions

Mount Sinai Hospital

Mount Sinai Hospital (MSH) is located in North Lawndale on Chicago's West Side. MSH is an acute care safety net hospital that provides a wide array of quality medical, surgical, therapeutic, diagnostic, and behavioral health services, including crisis stabilization.

319
licensed beds

12,000+
inpatient admissions each year

1,500
trauma visits annually. MSH is one of five Level I Adult Trauma Centers in Chicago

41,000
Emergency Department patients cared for annually

15,000
ambulance runs each year

1,600
newborns are welcomed annually in our Labor and Delivery Unit and Level III Neonatal Intensive Care Unit

700+
aspiring health care professionals are trained at MSH each year through undergraduate and graduate programs and four GME-accredited residency programs in family medicine, internal medicine, general surgery, and pharmacy, and offers four fellowship programs

Sinai Chicago's Member Institutions

Schwab Rehabilitation

Schwab Rehabilitation (Schwab) provides comprehensive inpatient and outpatient rehabilitation services for adults and children, including stroke, brain injury, spinal cord injury, musculoskeletal and neurological rehabilitation, amputation rehabilitation, and general rehabilitation. Levels of care include inpatient acute rehabilitation, and specialized outpatient physician clinics and therapy services. Several Schwab physicians have been named top doctors in U.S. News and World Report and Chicago Magazine.

102
licensed beds

1 of 2
free-standing rehabilitation hospitals in the Chicago

6
Schwab offers a unique therapeutic environment featuring six treatment gyms with advanced equipment, private treatment rooms, a warm-water indoor therapeutic pool, and an award-winning therapeutic rooftop garden

Sinai Chicago's Member Institutions

Sinai Children's Hospital (SCH)

Sinai Children's Hospital (SCH) is located within HCH, bringing together a multidisciplinary pediatric program that provides a continuum of care, including community health education and a Level III (the highest level of care) Neonatal Intensive Care Unit. A wide range of specialty outpatient pediatric care is available through SCH, including pediatric surgery, gastroenterology, nephrology, allergy, hematology, endocrinology, urology and neurology. The hospital offers a variety of resources for children, including diabetes management, HIV/AIDS treatment and care, WIC nutrition assistance, Juvenile Intervention Support Center (JISC), violence prevention programs, and a youth career development center.

14,000
families benefit from SCI's services annually

Sinai Community Institute (SCI)

Sinai Community Institute (SCI) has a history of developing effective community-based health and social service programs to improve the wellbeing of its clients by addressing social, economic and environmental factors. SCI's goal is to use intensive case management to identify and eliminate barriers that impact the social wellbeing and health status of individuals, families, and the community. SCI uses trained professional and credentialed case managers to provide comprehensive in-home assessments, care planning implementation and coordination, and case closures. Programs include Sinai Adult Protective Services, Sinai Better Birth Outcomes, the Early Childhood Development/Prevention Initiative, and Learn Together afterschool program, Sinai Volunteer and Community Services, and Sinai Technology Center.

Sinai Chicago's Member Institutions

15

SMG clinical sites, including 8 free-standing clinics

300+

physicians, physician assistants and nurse practitioners make up the SMG team

Sinai Medical Group (SMG)

Sinai Medical Group (SMG) is a physician-led primary care and specialty medicine provider across Chicago. SMG primary care physicians perform routine check-ups and preventative screenings and have access to essential diagnostic tests. SMG has a full panel of specialists located either at primary care offices or the Seigle Outpatient Center. All SMG doctors are affiliated with MSH, HCH, and Schwab, offering patients access to hospital resources and expertise. SMG services include behavioral health, cardiology, infectious disease, obstetrics/gynecology, orthopedics, pulmonary critical care medicine, and trauma.

Sinai Urban Health Institute (SUHI)

Sinai Urban Health Institute (SUHI) was established in 2000 as the community-based research arm of Sinai Chicago. SUHI is a unique, nationally-recognized research center that works in partnership with community members and organizations to identify and address health inequities across Chicago. SUHI's team of epidemiologists, public health professionals, and community health workers is devoted to improving health through community partnerships, data-driven research, innovative health interventions, community health worker training and consultation, and evaluation services. In particular, SUHI works in partnership with West and South Side communities to better understand social factors underlying health inequities and to collaboratively develop, implement, evaluate, and scale innovative solutions to reach health equity.

Community Benefits

The Lown Institute Hospitals Index ranks hospitals for adherence to standards around social responsibility by examining performance across health outcomes, value, and equity. In 2022, the Lown Institute Hospitals Index ranked over 3,000 hospitals nationally and 167 in Illinois.

- **Equity** *(reflects a hospital's commitment to inclusivity, pay equity, and community investment)*: **HCH received a Grade A and was eighth out of 167 Illinois hospitals**
- **Community Benefit** *(reflects how well hospitals invest in community health: charity care spending, community investment, and Medicaid revenue as a share of patient revenue)*: **HCH received a Grade A and was twentieth in Illinois**
- **Inclusivity** *(reflects how well hospitals serve people of color, people with lower incomes, and people with lower levels of education)*: **HCH received a Grade A, was ranked thirteenth in Illinois**

In fiscal year 2021, Sinai Chicago provided $119.5 million in community benefits, including charity care (free care based on family size, income, and other criteria), community health services, language assistance, education, donations, coverage for bad debts, and volunteer services. Charity care comprised $45.6 million of our total community benefits. Behavioral health services, emergency and trauma services, community health education, community outreach, patient navigators, interpreters, and enrollment assistance in public programs are critical to making healthcare accessible and relevant for individuals in our hospital service areas. Other important community benefits that make healthcare more affordable and equitable are those that subsidize the cost of care and prescription drugs and/or forgiveness of past medical debt. These benefits provide support to community programs and initiatives that improve overall community wellbeing.

CHNA Detailed Methodology

The Sinai Chicago Community Health Needs Assessment (CHNA) team collaborated with internal and external partners to gather secondary and primary data that informed our CHNA. We outline our partners, data collection procedures, and methods for identifying Community Health Priorities below.

Alliance for Health Equity

The Alliance for Health Equity (AHE) is a collaborative of 35 hospitals, 3 health departments, and regional and community-based organizations working to improve health equity, wellness, and quality of life across all 77 Chicago community areas and 130 Cook County suburban municipalities. Every three years, the AHE conducts a county and citywide CHNA with the 2022 CHNA being the third consecutive Chicago and Cook County collaborative CHNA.

The purpose of the AHE is to improve population and community health by: 1) promoting health equity; 2) supporting capacity building, shared learning, and connecting local initiatives; 3) addressing social and structural determinants of health; 4) developing broad city- and county-wide initiatives and creating systems; 5) engaging community partners and working collaboratively with community leaders; 6) developing data systems to support shared impact measurement and community assessment; and 7) collaborating on population health policy and advocacy. The Illinois Public Health Institute (IPHI) worked closely with its Steering Committee and the Chicago and Cook County health departments to compile, design, and create the 2022 CHNA to meet regulatory requirements. The 2022 CHNA was built on the success of previous efforts, including the 2016 and 2019 collaborative CHNAs, Healthy Chicago 2025, and Cook County WePLAN (2022).

Alliance for Health Equity Structure and Shared Leadership

The AHE convenes a Steering Committee and several workgroups to pursue implementation strategies that address community health needs. Sinai Chicago is an active member of the AHE, with hospital representatives on the Steering Committee and several workgroups. Through this membership, Sinai Chicago representatives collaborated with AHE partners to: 1) design, guide, and implement the 2022 CHNA approach; 2) identify, develop, and disseminate data collection tools; 3) interpret, analyze, and visualize primary and secondary data; and 4) identify and review strategic priority community health issues.

Collaborative Assessment Model and Process

The AHE worked with its Steering and CHNA Planning Committees to design and facilitate a collaborative, community-engaged CHNA between May 2021 and March 2022. The AHE collaborative process adapted the community-engaged strategic planning framework, Mobilizing for Action through Planning and Partnerships (MAPP). Engagement from community members across diverse social and economic backgrounds and multi-sector community-based organizations was prioritized as a crucial aspect of the assessment and implementation processes. Details regarding the approach are outlined in the Alliance Collaborative CHNA Report.

CHNA Process Oversight

Sinai Community Health Needs Assessment (CHNA)/Community Health Improvement Plan (CHIP) Community Advisory Committee

The role of the CHNA/CHIP Community Advisory Committee (CAC) is to provide feedback from community members and leaders on our CHNA approach. Their insights helped us refine our 2022 Community Health Priorities to reflect community experiences and emerging needs since 2019 and incorporate a deeper understanding of structural racism. Members met virtually in March 2022 to discuss the CHNA and will meet again in Summer 2022 to provide guidance as we design our 2022 CHIP. All representatives receive a small stipend for their time and the review of materials outside of meetings, and all meetings are simultaneously translated from English to Spanish to ensure shared dialog in the preferred language of all committee members.

To select CAC members, we asked Sinai Chicago staff to connect the Sinai CHNA/CHIP team with members on existing Sinai Chicago community-based and patient advisory committees who were familiar with our system and lived and/or worked in our service area. Members ranged from community residents to Sinai patients to community organization leaders. Once individuals were recommended, we connected with them individually to ensure they could commit to member roles and responsibilities. The CAC comprises 15 individuals representing residents and organizations from the following communities: Austin, North Lawndale, East Garfield Park, Marquette Park, Beverly, Bronzeville, Little Village/South Lawndale, Brighton Park, and Pilsen.

Beyond being residents in the Sinai service area, CAC members were affiliated with the following organizations: Lawndale Christian Health Center, Alivio Medical Center, Moms Demand Action for Gun Violence, Universidad Popular, Southwest Organizing Project, Latinos Progresando, North Lawndale Historical and Cultural Society, I Am Able, Brighton Park Neighborhood Council, The Resurrection Project, and the University of Illinois-Chicago Center for Healthy Work.

At our March CAC meeting, we introduced members to the CHNA/CHIP process, provided information on their roles and

responsibilities, collaboratively refined our 2019 Community Health Priorities to reflect emerging needs, and then engaged the Alliance for Health Equity (AHE) team to facilitate a discussion around the role of structural racism in shaping health and wellbeing. We integrated findings from this conversation in the CHNA's **Community Perspectives** sections.

Sinai CHNA/CHIP Executive Advisory Committee

The Executive Advisory Committee (EAC) oversees the CHNA/CHIP processes for Sinai Chicago, providing feedback on the overarching approach and priority health needs, reviewing CHNA and CHIP content, and guiding the development of the strategic response to these needs within our system-wide CHIP (to be released by late 2022). Committee members represent a broad range of departments across Sinai Chicago.

Figure 2. Sinai Chicago 2022 CHNA/CHIP Executive Advisory Committee members

EAC Member	Title
Donnica Austin-Cathey	President of Holy Cross Hospital, Vice President of Operations, Acute Care
Jean Barret-Blake	Chief Nursing Officer/Vice President, Patient Care Services, Sinai Chicago
Dr. Russell M. Fiorella	Chief Medical Officer, Sinai Chicago
Dr. Michelle Gittler	Chief Medical Officer, Schwab Rehabilitation
Dr. Olusegun Ishmael	Associate Chief Medical Officer, Sinai Chicago
Karen Janousek	Vice President and Chief Population Health and Growth Officer, Sinai Chicago
Julia Libcke	President, Schwab Rehabilitation
Helen Margellos-Anast	President, Sinai Urban Health Institute
Nathalie Nunes	Chief Diversity, Equity, and Inclusion (DEI) Officer, Sinai Chicago
Dr. Christopher Sprowl	President, Sinai Medical Group
Dr. Airica Steed	Executive Vice President and Chief Operating Officer, Sinai Chicago
Dr. Gina Walton	Vice President of GME Diversity and Inclusion, Sinai Chicago
Debra Wesley	President, Sinai Community Institute

The first EAC meeting was held in April 2022. During that session, we refined the description and emphasis of our Community Health Priorities, discussed our approach to incorporating and measuring structural racism, and affirmed updates and programs across Sinai Chicago. The EAC will meet throughout Summer 2022 to define our 2022 CHIP.

CHNA Reviews

Beyond reviews with the CAC and EAC, the CHNA was reviewed by SUHI epidemiologists and public health professionals, Sinai Chicago's top executives and its Executive Board.

CHNA Data Collection

We conducted a literature review to identify recommended approaches and measures for assessing health equity and structural racism within the Sinai Chicago service area.[4] Due to the multifaceted and intersectional nature of structural racism, we cannot assess its impact on wellbeing through a single measure or from the viewpoint of one system (e.g., economic, housing, education). Guided by our review, we took an approach that considered a range of quantitative and qualitative data and focused on the historical and geographical contexts wherein structural racism operates. We also sought to unpack the multifaceted nature of structural racism in impacting health.

Quantitative Data

We incorporated quantitative data on health factors and outcomes from publicly-available sources as well as the Community Input Survey administered by the AHE. Where possible, we present data by race and ethnicity to underline health inequities and the role of structural racism in perpetuating poor health outcomes. Given that neighborhoods have been the predominant geographic level used to conceptualize structural racism[5], we examine data indicators at the community area and zip code levels, as well as across our service area (where data allows). We further assess changes over time where possible.

We used data from publicly-available national and local sources such as the U.S. Census Bureau and the Chicago Health Atlas to report on infrastructure, socioeconomic, and service accessibility measures. We complemented these with data from the IHA (provided through our engagement with AHE) to assess service use, such as emergency department visits and hospitalizations. Lastly, we incorporated findings from the AHE Community Health Input Survey, which was administered throughout the Chicagoland area to understand priority health needs, recommended improvements to address these needs, and COVID-19 experiences (additional survey methodology details can be found on the AHE website).[6]

Qualitative Data

Our qualitative data collection helped us explore aspects of structural racism and its multifaceted nature, which may not be captured quantitatively.

To understand community perspectives on structural racism and its impact on wellbeing, we hosted the aforementioned discussion with our CHNA/CHIP. In addition, we leveraged the findings of AHE Focus Groups held throughout the Chicagoland area (additional details can be found on the AHE website).[7] In addition, we gathered existing reports around specific Community Health Priorities to understand the historic context of health outcomes as well as emerging data and insights that are unavailable via our other data sources.

Data Limitations

Although we gathered extensive data and input from the communities we serve, there are limitations and challenges to consider. First, there is often a lag in population health data availability, such as individual poverty rates or demographics. Therefore, many data within this report represent timeframes prior to 2022. Second, we used data available at various geographic levels (e.g., zip code, community area), and at times were unable to compile information to provide service area estimates. In this instance, we report medians and ranges. Third, although we stratified data by race and ethnicity where possible, not all data sources provided the detail needed to show racial and ethnic comparisons across our service area. Fourth, while the AHE gathered primary data from community members (over 5,000 surveys and 43 focus groups conducted by the Alliance with community member throughout Chicago and Suburban Cook) and we held our own CAC discussion, it is important to note that qualitative data only reflects the viewpoints of those who attended and participated in community input surveys and focus groups. Lastly, our data continues to remain incomplete in terms of fully understanding the impacts of structural racism on health and wellbeing. There are perspectives and areas of impact that have yet to be unpacked beyond this report.

Identifying Community Health Priorities

Rather than defining new priorities, our 2022 CHNA leverages and refines our 2019 Community Health Priorities based on updated data and conversations with our CAC and EAC. Our 2022 CHNA Health Priorities mirror those from 2019, but reflect changes in existing and emerging community needs. Our priorities also align with those from the 2020 and 2022 AHE Collaborative CHNA Reports and the aims of other local initiatives, such as Healthy Chicago 2025, West Side United, the West Side Health Equity Collaborative, and the South Side Healthy Communities Organization. We took this approach to ensure continuity in our strategic efforts to improve community wellbeing over time.

Holy Cross Hospital Service Area Overview

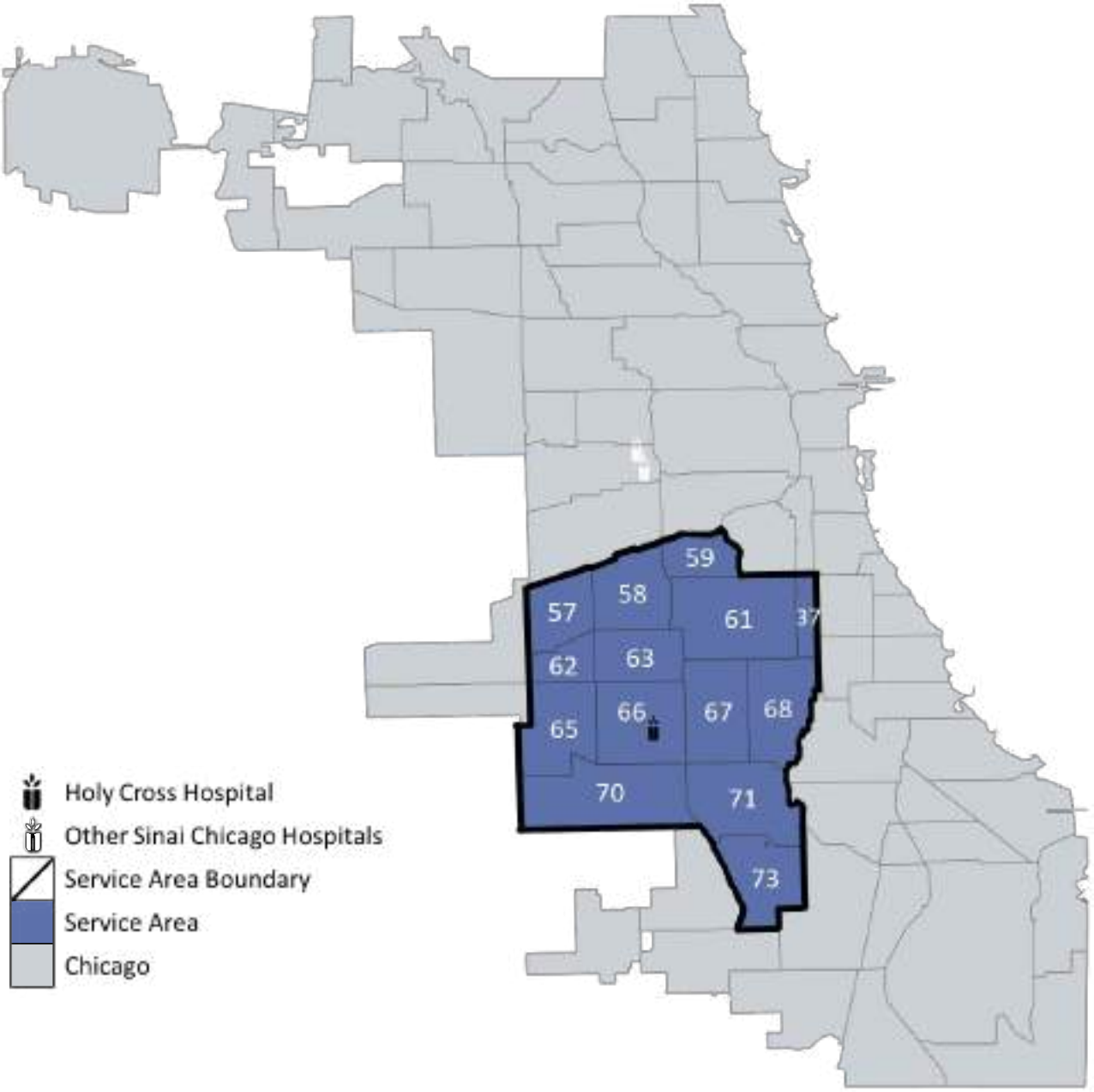
Service Area

Holy Cross Hospital's (HCH) service area is defined as the largest 75% geographic catchment for all inpatient hospital discharges. Based on this definition, HCH's service area comprises seven zip codes and 14 Chicago community areas **(Figure 3)**.

Figure 3. Holy Cross Hospital service area zip codes and associated community areas

Zip code	Community area(s)
60609	McKinley Park, New City (Back of the Yards), Fuller Park
60620	Auburn Gresham, Washington Heights
60621	Englewood
60629	Chicago Lawn, West Elsdon, West Lawn
60632	Archer Heights, Brighton Park, Gage Park
60636	West Englewood
60652	Ashburn


Figure 4. Holy Cross Hospital service area community areas



CA number	Community area (CA)	CA number	Community area (CA)
37	Fuller Park	65	West Lawn
57	Archer Heights	66	Chicago Lawn
58	Brighton Park	67	West Englewood
59	McKinley Park	68	Englewood
61	New City (Back of the Yards)	70	Ashburn
62	West Elsdon	71	Auburn Gresham
63	Gage Park	73	Washington Heights

Demographics

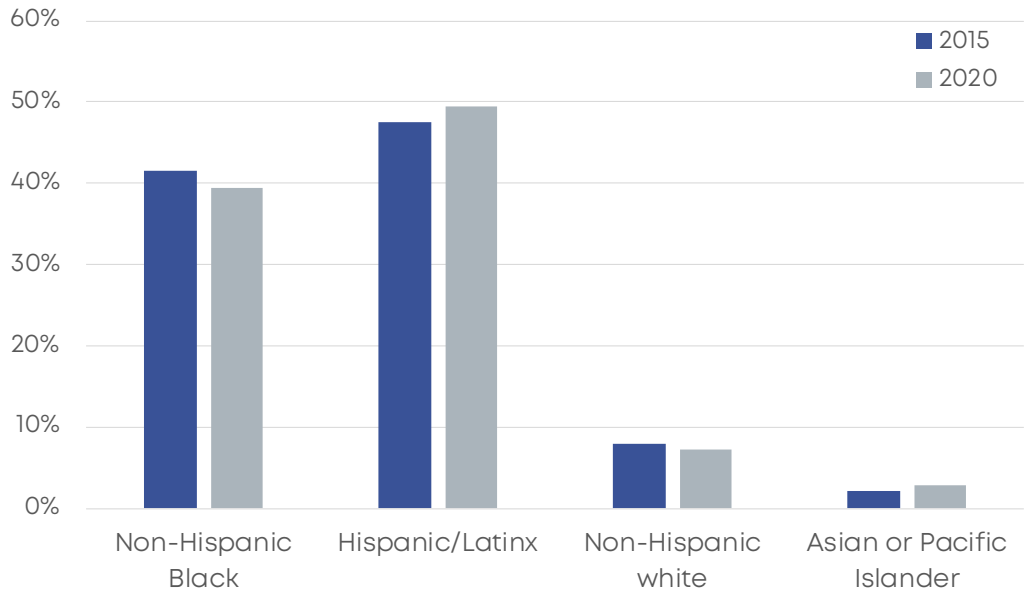
HCH serves close to half a million of Chicago's residents. **Figure 5** provides an overview of HCH service area demographics. Since the late 2000s, the HCH service area has seen a decrease in their non-Hispanic white and non-Hispanic Black populations while the Hispanic/Latinx and Asian or Pacific Islander populations have increased. In our assessment of population changes over the past five years, we did not observe statistically significant changes in these groups in the service area overall; however, there were significant increases in the Asian or Pacific Islander population for the Englewood, West Englewood, and Washington Heights neighborhoods and a significant increase in the non-Hispanic white population for the Auburn Gresham neighborhood.

Figure 5. Holy Cross Hospital service area demographics

General demographics	Chicago	HCH service area
Total population	2,699,347	423,028
Non-Hispanic Black	29%	40%
Hispanic/Latinx	29%	49%
Non-Hispanic white	33%	7%
Asian or Pacific Islander	7%	3%
Males	49%	48%
Foreign-born individuals	20%	22%
Individuals with a disability	11%	12%
Population aged <18 years old (children)	21%	26%
Population aged >65 years old (seniors)	13%	13%

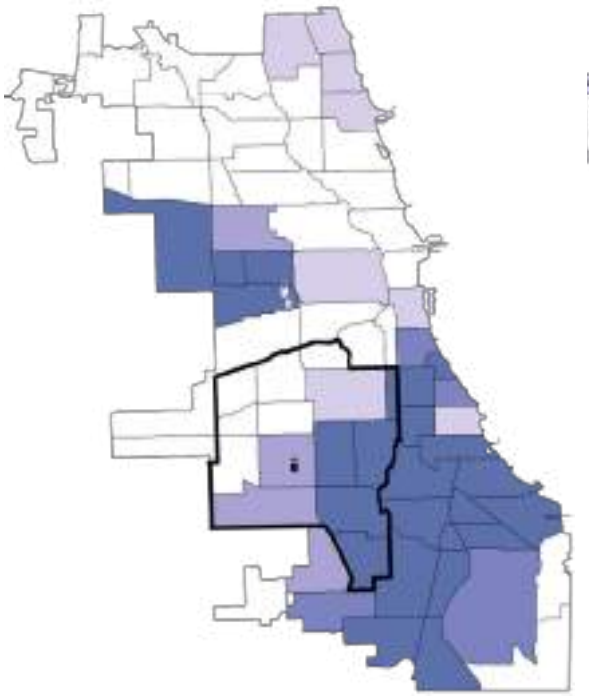
Source: American Community Survey 2020 Five-year Estimates

Figure 6. Changes in racial and ethnic groups across the HCH service area (2015 vs. 2020)

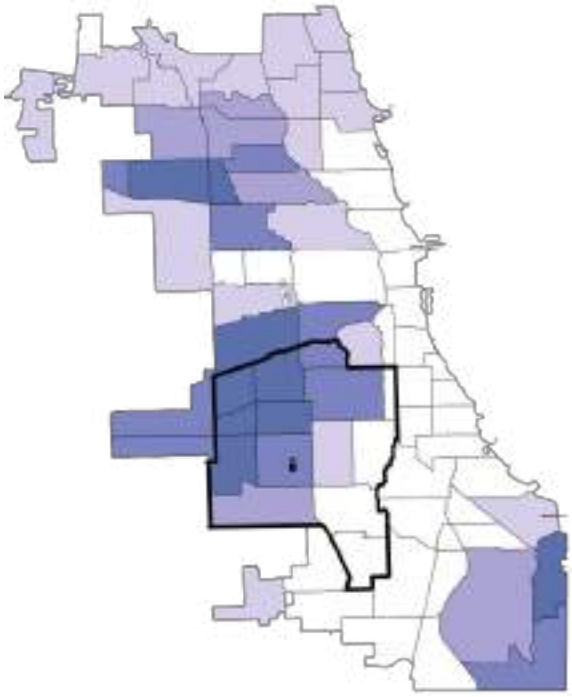


Source: American Community Survey 2015 and 2020 Five-year Estimates

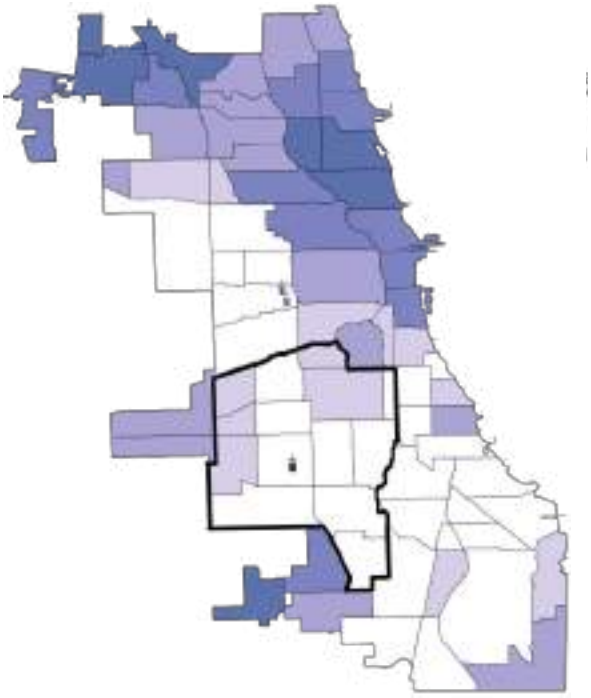
Figure 7. Non-Hispanic Black, Hispanic/Latinx, and Non-Hispanic white populations, HCH service area



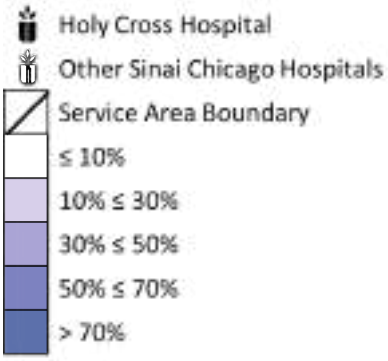
Non-Hispanic Black



Hispanic/Latinx



Non-Hispanic white



Source: American Community Survey 2020 Five-year Estimates

Chicago's History of Structural Racism

Chicago has a deeply entrenched history of geographic segregation by race and ethnicity, stemming from discriminatory policies that overtly and implicitly prioritized the wellbeing of higher-income white groups over that of low-income Black/African American, Hispanic/Latinx, and other communities of color.[8] A study of U.S. cities ranked Chicago fifth for segregation of Black/African American and white residents and sixth for Hispanic/Latinx and white.[9] A study by The Metropolitan Planning Council found that the impacts of racial and economic segregation include lost annual income as high as $2,982 per Black/African American resident, lost regional gross domestic product of $8 billion, 229 lost lives to homicide per year, and 83,000 fewer Chicagoland residents with bachelor's degrees.[10]

While each neighborhood served by HCH holds its unique history, many communities on the West and Southwest Sides have experienced similar drivers of segregation and its deleterious impacts on wellbeing over time. Following an increase of Black/African American migrants from the southern U.S. seeking manufacturing jobs as part of the Great Migration,[11] Chicago saw a plethora of discriminatory housing and economic policies enacted by white, racist institutions and government. Real estate practices such as redlining, contract buying, restrictive covenants, and blockbusting[12, 13, 14, 15] restricted where Black/African American families could live and impact access to resources to this day.

As an example, federally-sanctioned redlining on account of the post-Depression era Home Owner's Loan Corporation (HOLC) systematically deemed Black/African American communities "undesirable," charging higher interest rates and withholding loans[16]. The longstanding impacts of withheld loans from Black/African American families combined with the disinvestment from redlined neighborhoods contributed to racial inequities in home ownership and wealth accumulation, to inequitable investment across Chicago communities, and to elevated levels of community segregation. Further, a recent report highlighted that even today, Chicagoans of equal credit who are Black/African American or Hispanic/Latinx are more likely to pay higher premiums and interest rates than their white counterparts.[17]

Related to and compounding discriminatory housing policies were a series of economic disinvestments in communities of color, leading to economic flight of manufacturing

[9]As measured by the dissimilarity index, a measure of group distribution across a city or other geographic area.

jobs that had offered residents local, secure employment.[18] While white and economic flight was already underway, local rebellions in the wake of Dr. Martin Luther King, Jr.'s assassination led to the departure of several large, well-paying employers to the suburbs, where Black/African Americans and others of color were systematically denied housing loans.[19, 20, 21] The downward trend in manufacturing jobs from 1960 to 2015 particularly impacted the economic opportunities for young Black/African American and Hispanic/Latinx groups, leading to higher representation of white populations in professional jobs and of Black/African American and Latinx populations in retail and service sector positions, which paid lower wages than manufacturing jobs.[22]

After 1960, many Mexican immigrants arrived on Chicago's West Side, residing in neighborhoods such as South Lawndale or "La Villita" which were adjacent to Black/African American and white communities. Limited resources and economic opportunities across communities of color further contributed to racial and ethnic segregation in Chicago's neighborhoods, not only between white communities and communities of color, but also across racial and ethnic groups. Compounding the effects of discriminatory housing, economic, and social policies is the legacy of over-policing, police brutality, and a corrupt criminal justice system on communities of color across Chicago. The myriad racist policies and procedures pursued by the criminal justice system over time have not only contributed to a further lack of safety in Black/African American and Hispanic/Latinx communities, but have inflicted inter-generational trauma on these families that reverberates in the form of inequities in behavioral health outcomes.

The effects of these interconnected and mutually-reinforcing discriminatory policies and practices have led to lasting inequities in income levels, accumulation of wealth, access to safe and financially stable work, community safety, healthy and affordable food, high-quality education, and quality health care access across Chicago's Black/African American and Hispanic/Latinx communities.[23] A robust body of literature underlines how these inequities in access to financial wellbeing, social opportunity, and material and social resources lead to inequities in health – from elevated diabetes incidence to increased depression rates to higher overall mortality.[24] A recent book published by researchers at Sinai Urban Health Institute in collaboration with local academic partners highlighted how Chicago has the fourth greatest life expectancy gap

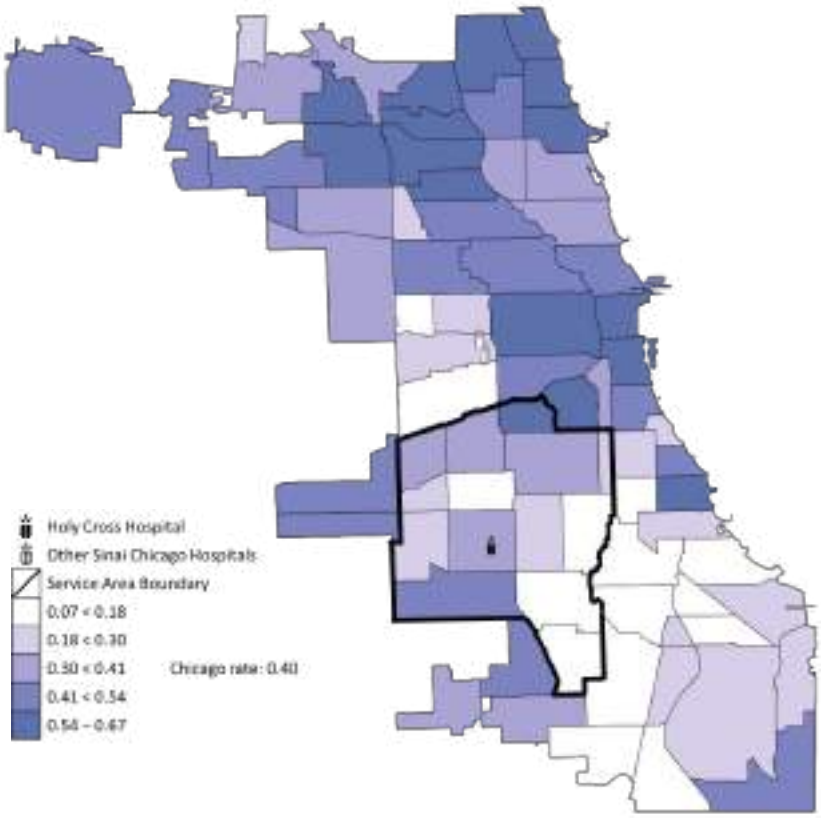
between Black/African American and white populations of the 30 largest U.S. cities.[25] The reality of this immense inequity in life expectancy lies explicitly in the longstanding structural racism faced by Chicago's Black/African American and Hispanic/Latinx communities – many of which reside on the West and Southwest Sides and many of which are served by Sinai Chicago institutions.

It is with this historical context at the forefront that we approached the remainder of our CHNA, discussing the interrelated ways that inequities in the social determinants of health, community safety, and healthcare access and quality – stemming from longstanding structural racism – lead to unjust health outcomes in the communities we serve.

Segregation in the HCH Service Area

While not a comprehensive measure of the interrelated systems that reinforce racial discrimination, we examined the race-ethnicity index to understand the legacy of structural racism in our service area (**Figure 8**). The index compiles several indicators to provide a single score of community diversity.[26] As our CHNA unfolds herein, we reflect on this map and consider the association of structural racism and segregation with a vast range of community inequities in social, economic, and health outcomes.

Figure 8. Race-ethnicity diversity index, HCH service area



Source: American Community Survey 2020 Five-year Estimates

Lighter colors indicate a less racially/ethnically diverse community whereas darker colors indicate a more racially/ethnically diverse community.

Overall Health

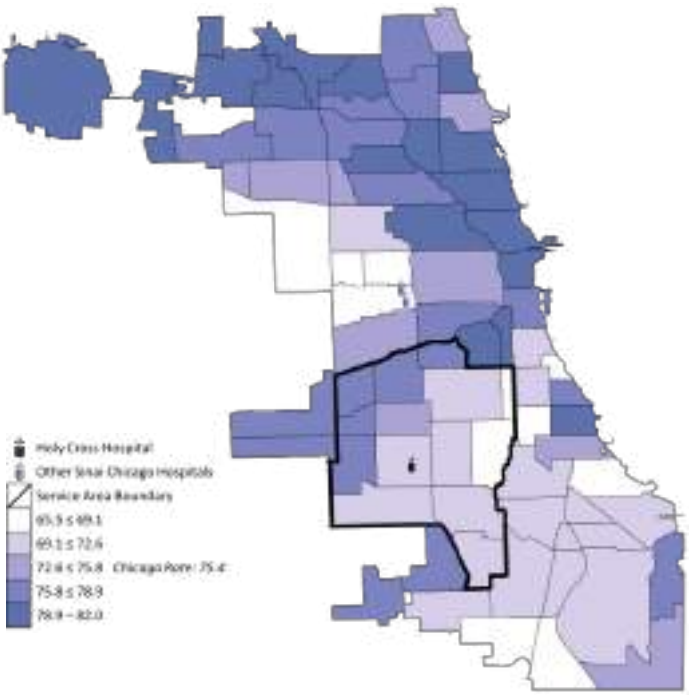
Inequities in health outcomes such as life expectancy and mortality between Black/African American, Hispanic/Latinx, and white communities tie back to the ongoing legacy of structural racism. Reflecting on the socio-ecological model, multiple factors – from behaviors to relationships to social determinants to systems and policies – impact overall health and wellbeing.

Life Expectancy

Life expectancy provides a snapshot of a community's overall health and wellbeing. A recent national report underlined the depth of inequity across Chicago – showing the widest life expectancy gap between neighborhoods (30.1 years) as compared to other U.S. cities.[27] Further, a 2021 data brief from the Chicago Department of Public Health (CDPH) indicated that the life expectancy gap between Black/African American and non-Black/African American populations in Chicago was widening – even before the COVID-19 pandemic.[28]

Most recently, CDPH released 2020 life expectancy data (**Figure 9**) and assessed trends over time. From 2019 to 2020, the first year of the COVID-19 pandemic, Chicago saw a decrease in overall life expectancy of almost two years – the greatest ever recorded.[29] Further, while life expectancy across all racial and ethnic groups declined, the sharpest declines occurred among Black/African American and Hispanic/Latinx groups (decreases of 2 and 3.2 years, respectively).[30] In addition to COVID-19, these trends were driven by increases in deaths due to heart disease, diabetes, homicides, and accidents like overdoses, all of which were drivers of the life expectancy gaps between Black/African American, Hispanic/Latinx, and white groups prior to the pandemic.[31]

Figure 9. Life expectancy in years, HCH service area



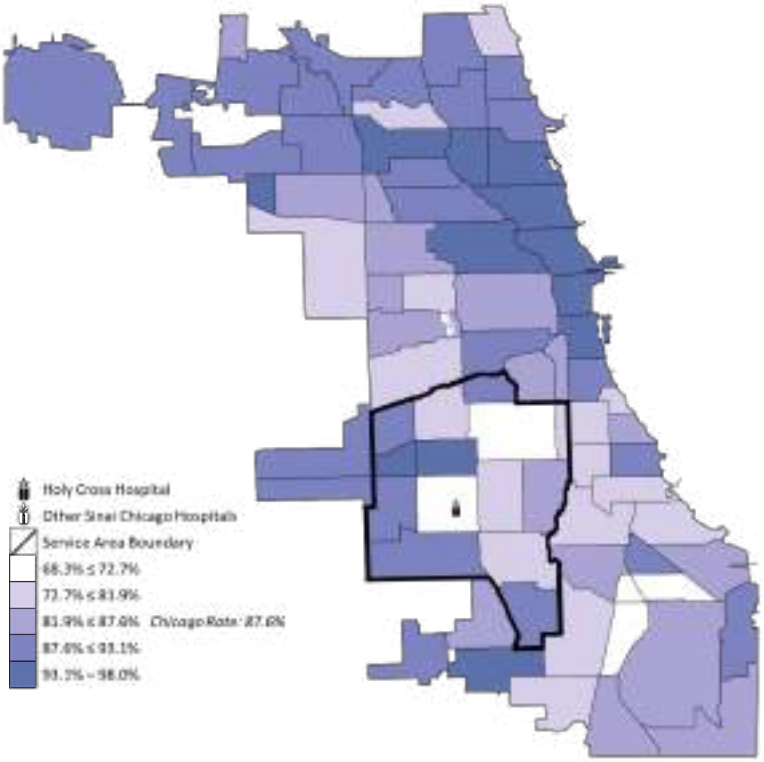
Source: Illinois Department of Public Health (2020)

Lighter colors indicate lower life expectancies at birth.

Self-Reported Health Status

In addition to life expectancy, self-reported health status is a validated measure for understanding the overarching health of populations. Across studies and populations, self-reported health is a strong independent predictor of mortality – even more so than objective measures.

Figure 10. Percent of adults reporting good, very good, or excellent overall health, HCH service area



Source: Chicago Department of Public Health, Healthy Chicago Survey (2020-21)

The COVID-19 Pandemic

The COVID-19 pandemic has had lasting impacts on the health of those living in Holy Cross Hospital's (HCH) service area and has exacerbated existing health inequities. COVID-19[32] is a respiratory disease with a range of health implications – from no symptoms to hospitalization to death. Immunocompromised individuals, adults aged 65 years and older, and people of any age with underlying medical conditions are at higher risk for severe symptoms and complications. Across measures of COVID-19, cases, hospitalizations, and deaths have disproportionately impacted Chicago's Black/African American and Hispanic/Latinx groups – many residing in our service area. Further, these same communities faced subsequently lower rates of vaccination.

COVID-19 laid bare the legacy of structural racism through its disproportionate impact on Black/African American and Hispanic/Latinx infection and mortality rates, as well as the inequitably distributed repercussions of the pandemic on social and economic factors.[33] Persistent COVID-19 inequities have drastically diminished any progress made over the past ten years to close the life expectancy gap between white and Black/African American and Hispanic/Latinx communities.[34] The disproportionate loss of life from COVID-19 cannot be understated. National estimates suggest that nearly 1 million people in the U.S. have died from COVID-19 since the pandemic began in 2020,[35] and life expectancies in Chicago have been severely impacted (see the Life Expectancy section, page 27).

Life expectancy gaps are expected to worsen as communities face the lasting health, social, and economic impacts of COVID-19. Many of those who have recovered from COVID-19 now face long-term complications related to respiratory, cardiovascular, and behavioral health. Communities decimated by the economic and social impacts of COVID-19 face heightened levels of behavioral health needs, substance use disorders, safety concerns, and economic, food, and housing insecurities, as well as declines in educational progress and opportunity.

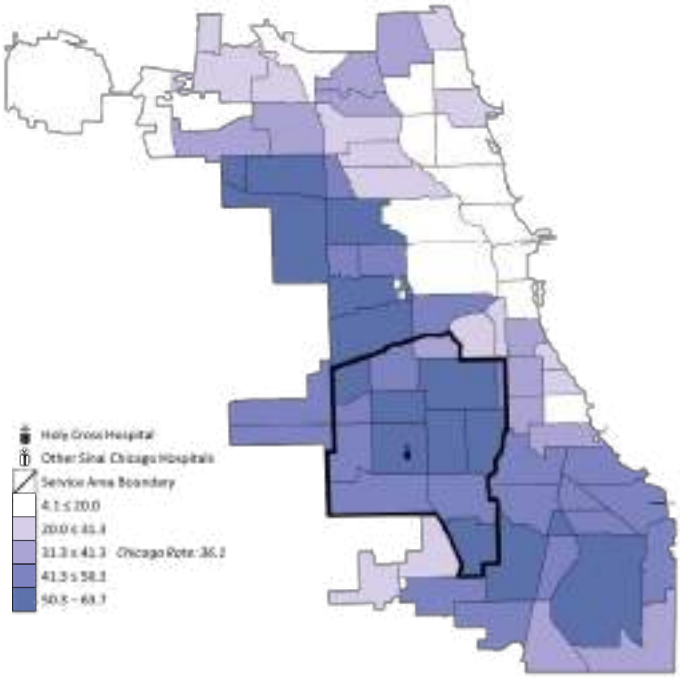
Health Indicators

COVID-19 Vulnerability Index

The COVID-19 pandemic impacted everyone regardless of socioeconomic status, race/ethnicity, age, or gender. Despite the pandemic's universality, communities already experiencing inequities saw these needs exacerbated. The COVID Vulnerability Index

combines a set of sociodemographic, epidemiological, and occupational factors as well as the cumulative burden of COVID-19 in a single score. Higher scores indicate greater COVID-19 burden, identifying communities disproportionately impacted by COVID-19 and uniquely vulnerable to vaccine uptake barriers.

Figure 11. COVID-19 Vulnerability Index, HCH service area



Source: Chicago Department of Public Health (2020)

Higher scores indicate greater COVID-19 vulnerability.

Health and Health Services Indicators

The COVID-19 pandemic has had various health and health services impacts. As outlined in **Figure 12**, the HCH service area faced a higher death rate and lower vaccination rate than Chicago overall.

Figure 12. COVID-19 indicators in the HCH service area

COVID-19 indicators	Chicago	HCH service area
Cumulative case rate [a, b, c]	21,035	21,390
Hospitalization rate [b, d]	833	1,119[e]
Death rate [b, f]	175	211
Vaccination rate [a, g]	76%	74%

[a] *As of 4/16/22*

[b] *Rate per 100,000 Total Population*

[c] *The New York Times, Chicago Department of Public Health (2020-21)*

[d] *Illinois Department of Public Health (2020-21)*

[e] *Median across HCH service area community areas*

[f] *Cook County Medical Examiner (2020)*

[g] *Chicago Department of Public Health (2022)*

COVID-19 Vaccination

In addition to the publicly-available COVID-19 data, the Alliance for Health Equity's (AHE) Community Input Survey explored experiences with accessing the COVID-19 vaccine. **Figure 13** shows the percent of survey respondents within HCH's service area who were able to access a COVID-19 vaccine if they wanted one overall and by select factors. The results suggest that the survey was biased towards individuals who were more receptive to vaccination than the general population (only 74% of individuals in our service area have been vaccinated as seen in **Figure 12**, versus 95% of survey respondents). Although these results are not a representative sample, they indicate inequities in vaccine access and lower vaccine confidence within certain groups. Older respondents (65+ years),

white respondents, and those with lower levels of education were more likely to report not wanting the vaccine. Hispanic/Latinx respondents, younger respondents (18-34 years) and those with lower levels of education were more likely to report being unable to access the vaccine.

Figure 13. Percent of respondents who were able to access COVID-19 vaccine overall and by select factors (HCH service area, 2021-22 Alliance for Health Equity Community Input Survey, N=192)

	Yes	No	Did not want	p-value [a]
Overall	95	1	4	n/a
Language of survey				
English	95	1	4	0.526
Spanish	100	0	0	
Age of respondent				
18-34 years	97	2	2	0.899
35-64 years	97	1	2	
65+ years	95	0	5	
Race/ethnicity				
Black/African American Only	94	0	6	0.677
Hispanic/ Latinx Only	95	2	3	
White Only	93	0	7	
Educational attainment				
Less than high school	88	3	9	0.453
High school diploma or equivalent	96	0	4	
Some college	98	0	2	
College graduate or higher	96	1	3	
Low-income household [b]				
No	95	1	4	0.831
Yes	96	0	4	

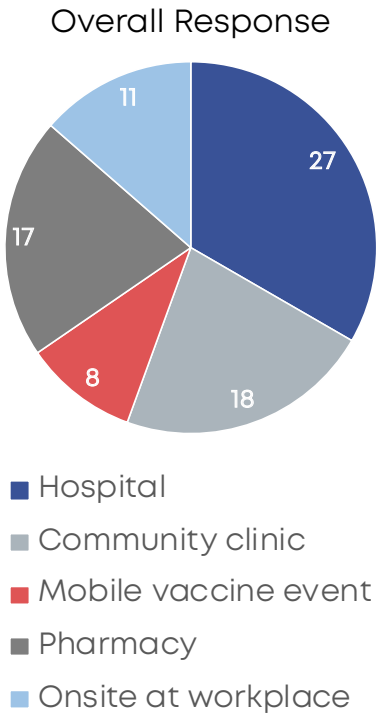
[a] Global Chi-Square Test; values <0.05 represent statistically significant differences between groups.

[b] Includes those households with annual incomes <$20,000.

In addition to vaccine access, the AHE Community Input Survey explored location of vaccine. **Figure 14** highlights the top vaccine locations overall and by group. While not a representative sample, some respondent groups were more likely to receive the vaccine at certain locations than others. For example, respondents who took the survey in Spanish were less likely to receive their vaccine at a hospital and more likely to receive it at a mobile vaccine event than English survey respondents.

Figure 14. Percent of COVID-19 vaccines received at top locations among vaccinated respondents (HCH service area, 2021-22 Alliance for Health Equity Community Input Survey, N=180)

	Hospital	Community clinic *	Mobile vaccine event	Pharmacy [b]	Onsite at workplace
Overall	27	18	8	17	11
Language of Survey					
English	29	19	6	16	11
Spanish	14	14	23	18	14
Age of Respondent					
18-34 years	28	19	7	17	10
35-64 years	27	13	11	17	16
65+ years	37	21	0	11	0
Race/Ethnicity					
Black/ African American Only	28	21	3	17	17
Hispanic/ Latinx Only	29	19	11	11	9
White Only	31	15	8	19	8
Educational Attainment					
Less than high school	7	37	7	26	0
High school diploma or equivalent	32	27	9	14	9
Some college	25	14	8	6	24
College graduate or higher	33	13	7	21	8
Low-income Household [b]					
No	28	19	7	17	13
Yes	23	27	14	14	5



Key: low to high indicated light to dark
Other locations not listed include: Health Department Site, At Home, United Center, and Other Location.

[a] *Includes health center, urgent care, etc.*

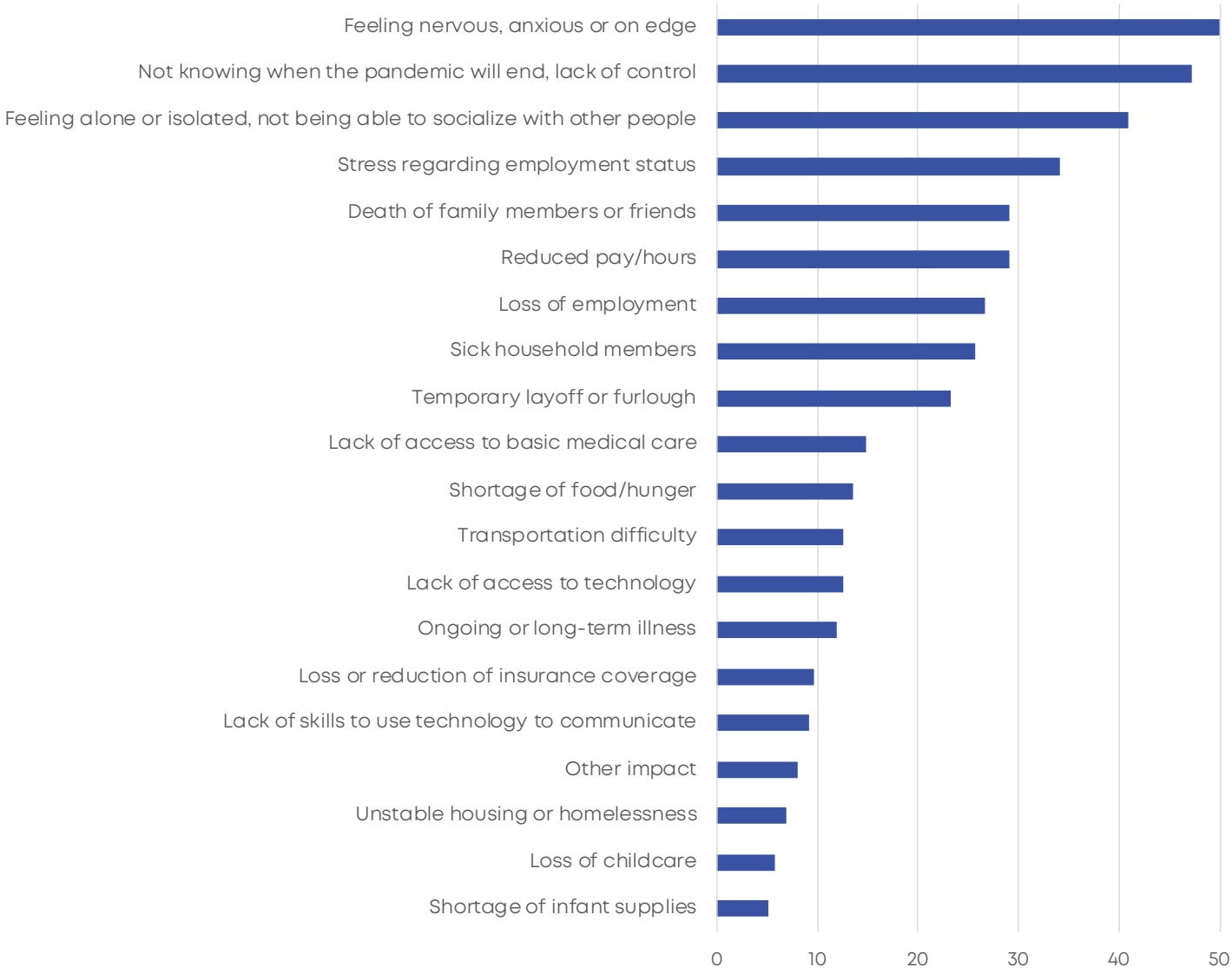
[b] *Includes Walgreens, CVS, etc.*

[c] *Includes those households with annual incomes <$20,000*

Social and Economic Impacts

The AHE Community Input Survey assessed other COVID-19 household impacts. **Figure 15** summarizes these impacts across respondents from the HCH service area. Overall, behavioral health-related experiences were most commonly reported, with employment-related issues and family health issues also frequently reported.

Figure 15. Percent reporting household experiences due to the COVID-19 pandemic (HCH service area, 2021-22 Alliance for Health Equity Community Input Survey, N=503)



Examples of other impacts include: remote learning challenges, concern for relatives who work in healthcare or have chronic health issues, inability to socialize and engage in physical activity, increasing government control (masks, restrictions), conflict between vaccinated and unvaccinated people, and separation from family member(s).

We also examined differences in these experiences across subgroups. Overall, the top 10 household impacts were similar based on language of survey taken, age of respondent, race/ethnicity of respondent, and if the respondent came from a low-income household. However, we found several meaningful differences across subgroups living in HCH's service area.

Black/African American respondents were four times as likely to report lack of access to basic medical care and unstable housing, and twice as likely to report loss of employment than white respondents.

Hispanic/Latinx respondents were three times as likely to report lack of access to basic medical care, and twice more likely to report shortage of food/hunger, and employment-related impacts (loss of employment, and temporary layoff or furlough) than white respondents.

Respondents who took the survey in Spanish were twice as likely to report reduced pay/hours than English survey respondents.

Respondents aged 18-34 years were five to seven times more likely to report employment-related impacts (temporary layoffs/furloughs, and reduced pay/hours), and seven times more likely to report losing family members or friends than older groups.

Respondents from low-income households were twice as likely to report lack of access to basic medical care, shortage of food/hunger, and shortage of infant supplies.

Community Perspectives

Overall and across racial/ethnic groups (white, Black/African American, and Hispanic/Latinx), COVID-19 was ranked as a top five community health need in the HCH service area (**Figure 16**, AHE Community Input Survey).

In focus groups conducted by AHE and during our own CHNA/CHIP CAC discussions, many talked of the health repercussions of COVID-19 and barriers to vaccine uptake. One individual highlighted the need to focus on COVID-19's impacts on the wellbeing of youth.

> "Before COVID, I think [Sinai] was looking at older people, but with COVID, [Sinai] needs to look at other groups, like young people."
>
> - Sinai CHNA/CHIP CAC Member

Misinformation combined with mistrust of official sources were common themes, both of which exacerbated already low vaccine uptake in communities of color. Participants also expressed challenges in addressing misinformation within their communities and elevated the importance of trusted messengers in addressing vaccine uptake barriers.

> "There is a significant misinformation problem, particularly for young people..."
>
> - Sinai CHNA/CHIP CAC Member

> "People want to make healthy decisions about their vax status, but with so much misinformation out there, people don't know where to turn."
>
> - AHE Focus Group Participant

Participants also discussed the lasting impact of COVID-19 on all aspects of life. Many are still coping with the repercussions of losing employment – both voluntary due to childcare challenges and involuntary because of the economic downturn. Others discussed the challenges of remote learning for students and worries about ongoing education outcomes.

> "Parents who stay at home are under a lot of pressure..."
>
> - AHE Focus Group Participant

> "The pandemic highlighted that going back to work for the little money it raises isn't worth it. Mothers are paid $15/hour but childcare is $13/hour so there's no money being made."
>
> - AHE Focus Group Participant

People experienced higher levels of mental distress as a result of COVID-19. The forced isolation experienced during the pandemic contributed to lower levels of connection across neighbors and elevated feelings of fear in interacting with others – eroding community trust.

> "Going to work was scary, COVID exposure from working in factory and unable to social distance, still must work no matter what,"
>
> - AHE Focus Group Participant

Many discussed behavioral health issues and substance use disorders across communities on account of the trauma caused by disproportionate loss of family and friends, economic devastation, inaccessible benefits for those who are undocumented, and exacerbated challenges such as food and housing insecurity.

> "Mental health awareness and personal development needed to make a larger impact in our communities and have workshops about mental health and guidance on how to deal with depression, anxiety, stop the bullying and violence."
>
> - AHE Focus Group Participant

Compounding these challenges, many discussed the lack of community resources, which was already a challenge prior to the pandemic.

> "I don't think there's adequate resources and I think as a result of the pandemic it has gotten worse."
>
> -Sinai CHNA/CHIP CAC Member

Sinai Chicago's Response

Sinai Chicago's response to the COVID-19 pandemic has been multi-faceted and multi-level. Internally, we created a system for surveillance, incidence tracking, organization, documentation, and reporting by creating a Resource Center that offered COVID-19 clinical care guidelines for management, transmissions precautions, home care clinical guidelines, home care patient instructions, and documentation designed to minimize spread inside households. Additionally, Sinai Urban Health Institute's (SUHI) Community Health Workers (CHWs) were linked with social worker referrals from Sinai's emergency departments and inpatient units to follow-up with those discharged with a COVID-19 diagnosis and provide resources, linkages, social service referrals, and they also provided much needed emotional support.

We further addressed challenges in COVID-19 treatment and prevention by establishing effective, community-engaged strategies. Schwab Rehabilitation opened the first COVID-19 rehabilitation unit in April 2020. Key examples of these partnerships include:

Pandemic Response Corps

SUHI is a lead collaborator with Chicago Department of Public Health, Chicago Cook Workforce Partnership, the University of Illinois at Chicago School of Public Health, NORC at the University of Chicago, and Malcolm X College to train and oversee the progress of Chicago's community-based contact tracing workforce. SUHI, through CROWD (the **C**enter for CHW **R**esearch, **O**utcomes, and **W**orkforce **D**evelopment) led the training, ongoing support, and skills building for the 600-person workforce, all community members hired directly by 31 CBOs in Chicago neighborhoods that were designated high economic hardship areas and disproportionately impacted by COVID-19.

Sinai - SCI Mobile Vaccination Grants for West and Near South Regions

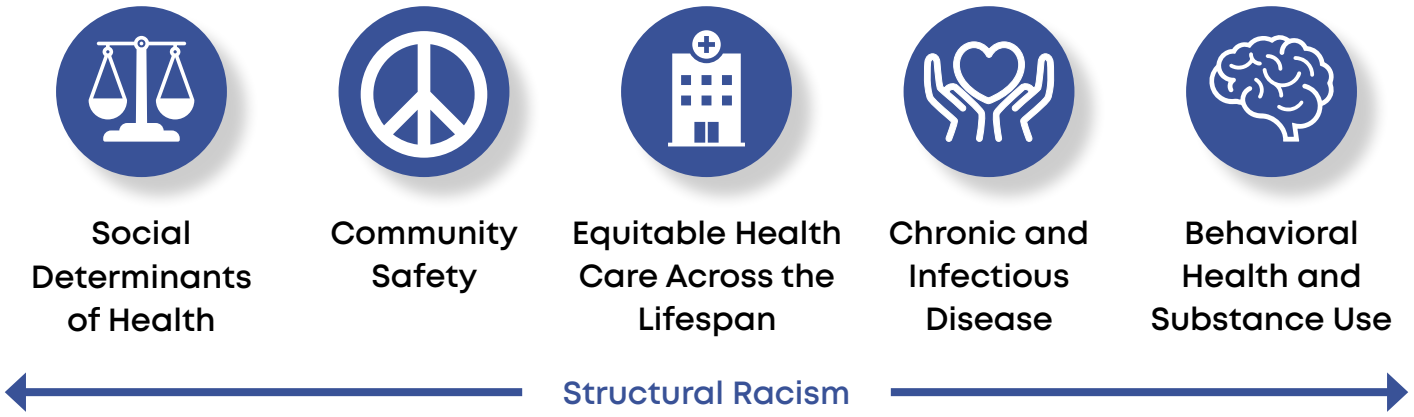
In May 2021, Sinai Chicago – particularly Sinai Community Institute – started working with the City of Chicago to bring safe mobile delivery and administration of COVID-19 vaccinations to the West Side and Near South communities of Chicago. Sinai Chicago and its collaborators provided three community-centric vaccination services that aim to maximize our vaccination capacity and our ability to navigate access barriers faced by residents.

Chicagoland CEAL Collaborative

SUHI is a proud co-leader of the Chicagoland Community Engagement Alliance (CEAL) Collaborative, a NIH-sponsored partnership of community health inequities experts working together to address COVID-19 in Chicago communities. We focus on bolstering research and outreach to help communities disproportionately affected by COVID-19 – specifically identifying, co-implementing, and evaluating the effect of community-based strategies to boost vaccine uptake among Black/African American and Hispanic/Latinx populations, along with enhancing access to testing, COVID-19 trials, and other COVID-19 supports. Within CEAL, SUHI leads the CHW Collaborative Core in which we follow an iterative process to develop a comprehensive and adaptive CHW training program, including optimal content design for cultural competency/humility.

Community Health Priorities

Sinai Chicago's 2022 Community Health Priorities are consistent with those brought forward in our 2019 Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP), allowing for stability in our strategic approaches to improving community wellbeing over time. Our Community Health Priorities include:



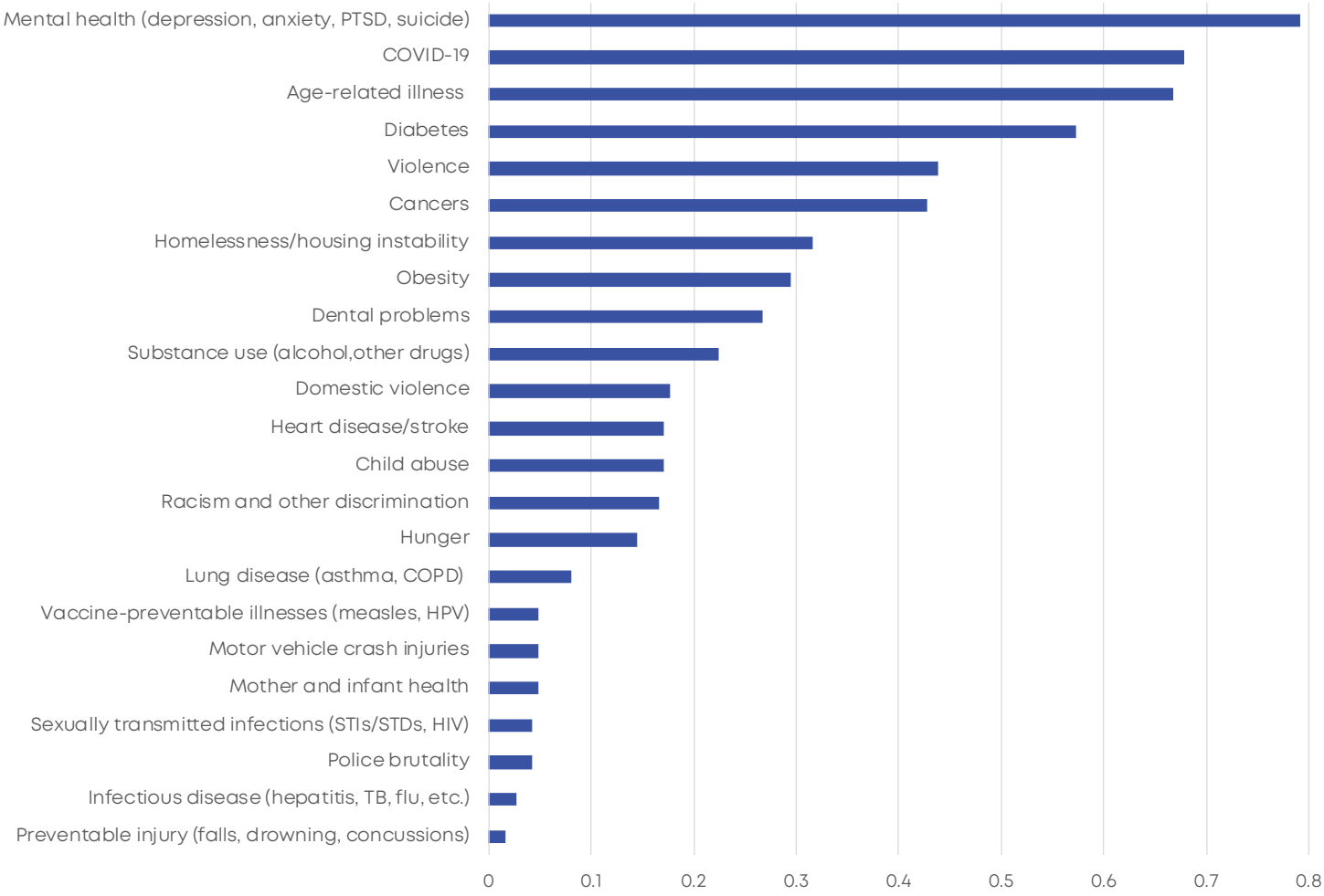
In returning to our Health Priorities for the 2022 CHNA, we considered emerging issues such as the COVID-19 pandemic and its deleterious effects, new publicly-available data, community discussions regarding structural racism, and recent data collected by the Alliance for Health Equity (AHE) in focus groups and their 2021 Community Input Survey. We refined our priorities to reflect this information, ensuring our 2022 CHIP will respond to the longstanding and emerging needs of those we serve.

In the following sections, we describe each Health Priority in detail, offering reflections on the historic and ongoing role of structural racism in inequitable outcomes, highlighting the latest data, sharing a sampling of Sinai Chicago's efforts to respond to inequities, and elevating key community assets.

Overall Community Insights

As part of the AHE Community Input Survey, respondents were asked to rank their top three community health needs from 23 options. **Figure 16** shows the overall ranking of these needs by respondents living in MSH's service area as measured by an average ranked score (accounts for the number of times a need was ranked first, second, third, or not at all, with higher numbers indicating higher rankings). Behavioral health was the top-rated health need, which reflects some of the top COVID-19 experiences found in **Figure 16**. In addition to chronic diseases such as diabetes and cancer, social determinants such as violence, housing, and racism were also listed within the top ten health needs.

Figure 16. Ranked community health needs overall (HCH service area, 2021-22 Alliance for Health Equity Community Input Survey, N=197)



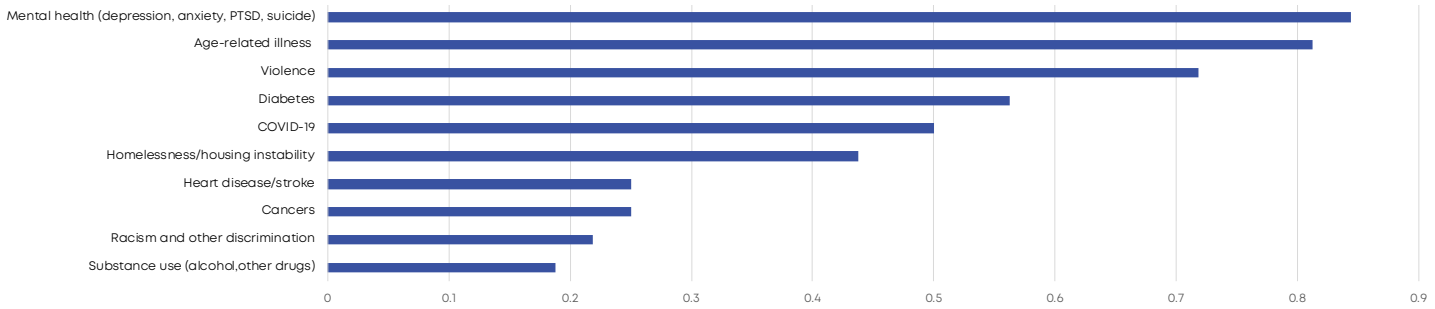
Measured using average ranked score (bars) wherein a larger score reflects a higher ranking.
Age-related illness includes arthritis, hearing/vision loss, Alzheimer's/dementia.

We examined the top ten needs across the three dominant racial/ethnic groups in HCH's service area (**Figure 17**). While these were similar across racial/ethnic groups, Black/African American and Hispanic/Latinx respondents ranked behavioral health first while white respondents ranked it fourth. Social determinants such as violence and housing were ranked higher for both Black/African American and Hispanic/Latinx respondents. Racism and other discrimination was ranked ninth for Black/African American respondents but it was not in the top ten for either Hispanic/Latinx and white respondents.

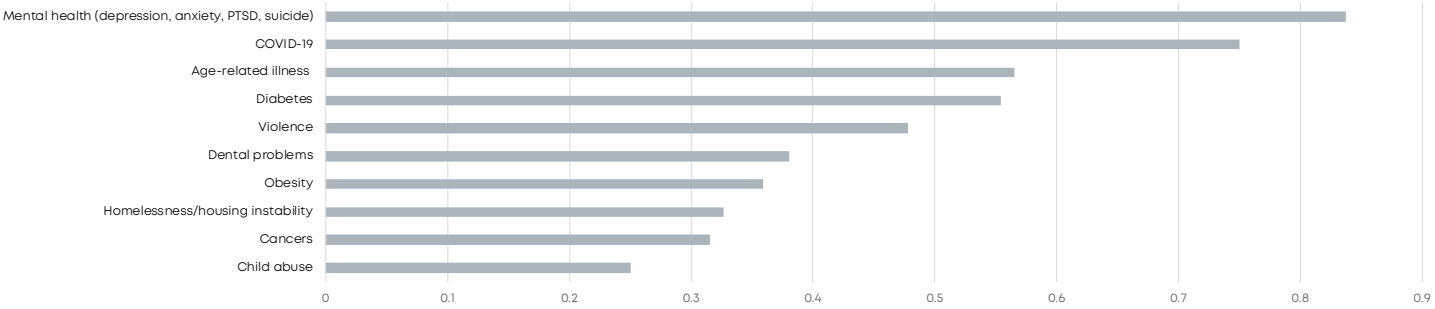
While not shown, we also examined rankings by respondent's chosen survey language (English/Spanish), age (18-34, 35-64, and 65+ years), and household income (low [<$20,000/ year] vs. high). In brief, while these groups shared similar top ten needs as the overall group, Spanish survey respondents ranked cancers as second overall, respondents aged 18-64 years ranked behavioral health and COVID-19 higher than respondents aged 65 years and older, and respondents from low-income households ranked age-related illness first, and COVID-19 and behavioral health second overall.

Figure 17. Top 10 community health needs by race/ethnicity (HCH service area, 2021-22 Alliance for Health Equity Community Input Survey, N=15)

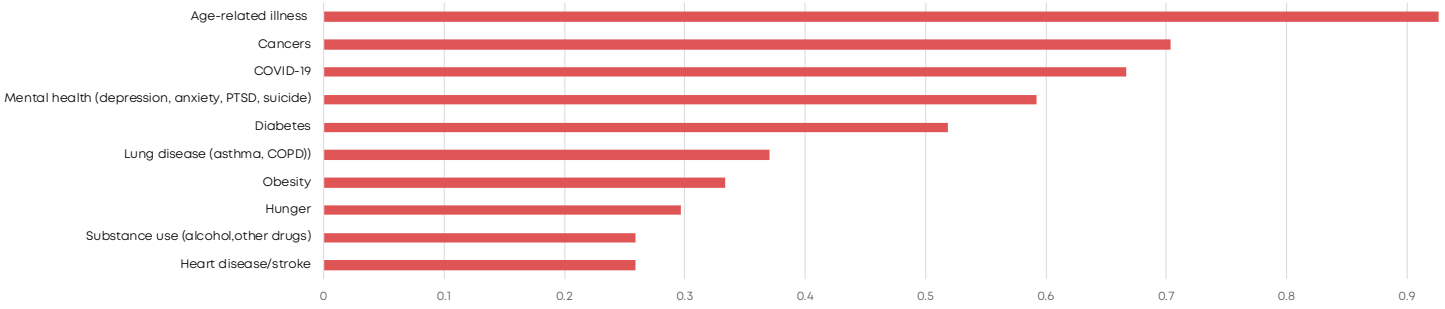
Black/African American Respondents (N=32)



Hispanic/Latinx Respondents (N=92)



White Respondents (N=27)



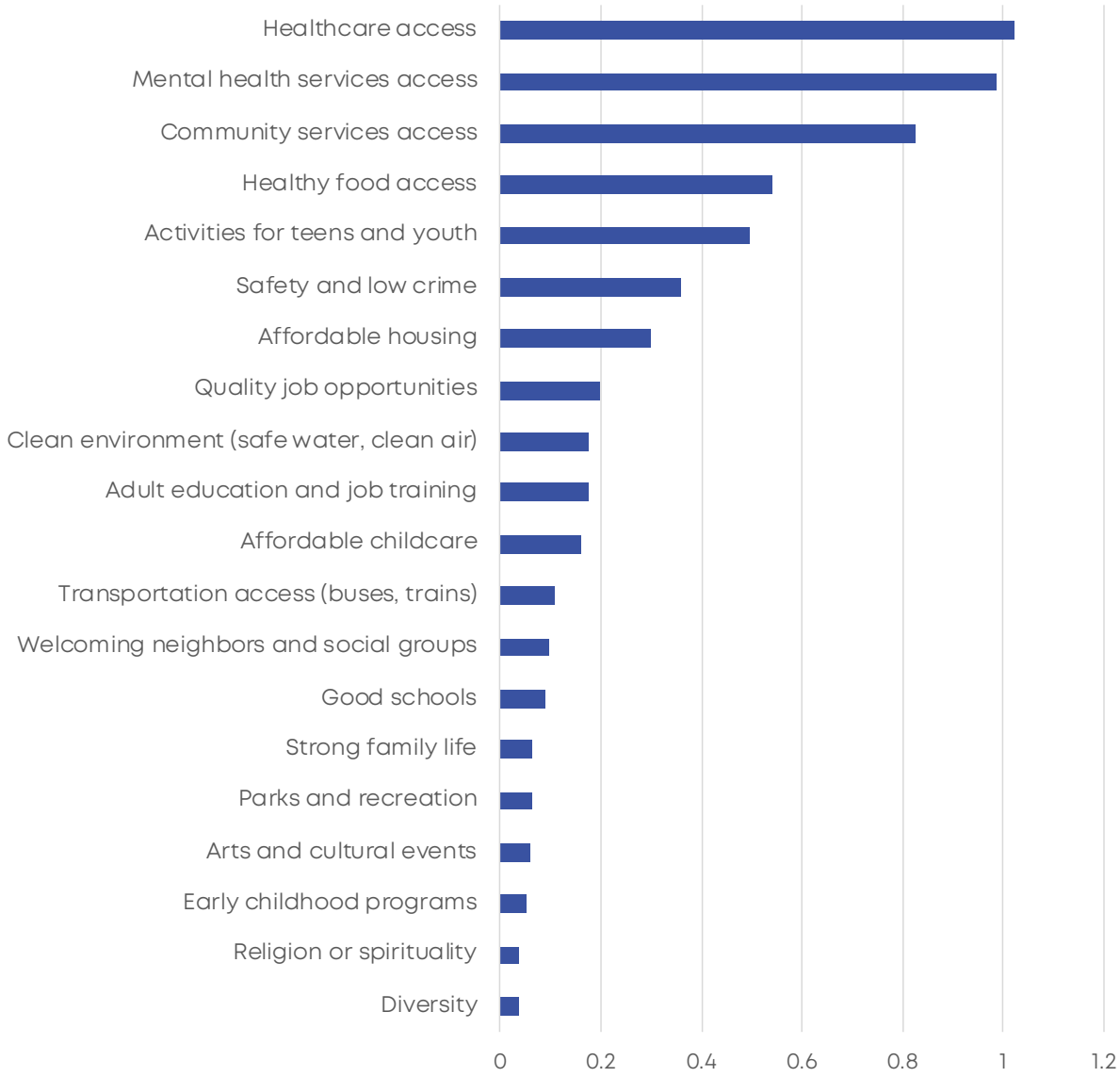
Measured using average ranked score (bars) wherein a larger score reflects a higher ranking.
Age-related illness includes arthritis, hearing/vision loss, Alzheimer's/dementia.

Actions to Address Community Health Needs

In addition to reporting community needs, the AHE Community Input Survey asked respondents to rank the top three items needed to support improvements in their selected health issues. **Figure 18** shows the overall ranking of these actions by respondents living in HCH's service area as measured by an average ranked score.

Access to healthcare, behavioral health, and community services, as well as access to healthy food rose to the top of the list. Other key social determinants such as safety, housing, employment, environment, and education are found in the top ten actions to address health needs.

Figure 18. Ranked Actions to Address Community Health Needs Overall (HCH Service Area, 2021-22 Alliance for Health Equity Commuinity Input Survey, N=187)



Measured using average ranked score (bars) wherein a larger score reflects a higher ranking.

Social Determinants of Health

Social determinants of health are "the conditions in which people are born, grow, live, work, and age"[36] and are inextricably linked to health and wellbeing. Social determinants include financial security and economic opportunity, healthy food access and affordability, safe and affordable housing, and freedom from injustice. Due to longstanding, mutually reinforcing systems of oppression and discrimination that privilege certain groups over others, not all Chicagoans benefit from access to social determinants that support their wellbeing.

The World Health Organization (WHO) defines social determinants of health as "the conditions in which people are born, grow, live, work, and age."[37] Essentially, social determinants consist of the social, economic, political, and otherwise non-clinical factors that influence individual health, wellbeing, and access to medical care. As outlined previously, COVID-19 exacerbated preexisting inequities in the social determinants of health that operated along racial and geographic lines, disproportionately impacting many of those served by HCH.

The following section discusses six social determinants of health – educational attainment, economic stability, food security, housing, transportation, and public safety – for which Sinai Chicago has focused its community health programming in recent years. This list is not exhaustive, and as outlined by our CHNA/CHIP Community Advisory Committee (CAC), there are many interrelated systems that perpetuate structural racism and health inequities.

"...Economics, the environment, pollution, you name it, and there is a historical context for it."

- Sinai CHNA/CHIP CAC Member

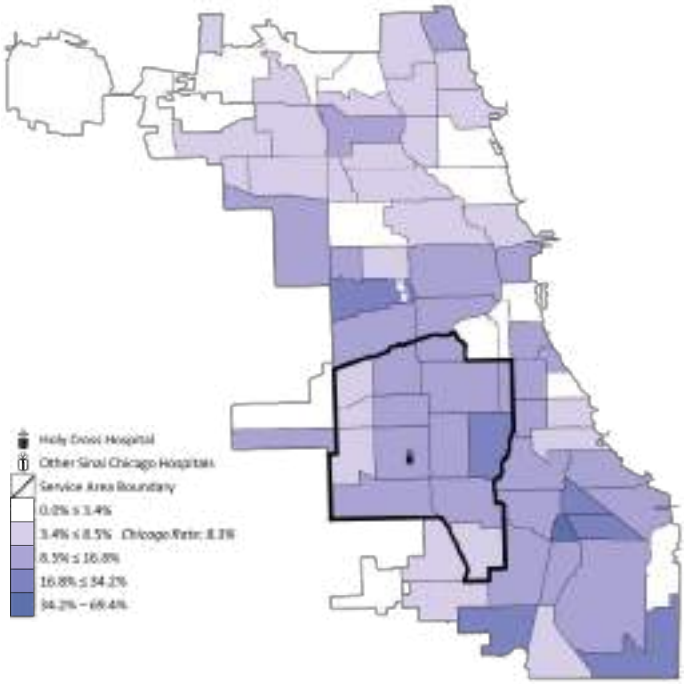
Educational Attainment and Economic Stability

Longstanding discriminatory housing policies alongside racially-driven economic disinvestment from Chicago's South West side have left a legacy of lower quality educational opportunities, financial instability, and inequitable access to jobs and career opportunities in the communities served by HCH. Overall, communities in the HCH service area have lower levels of educational attainment, greater unemployment, and higher poverty rates than Chicago overall.

Health Indicators

The HCH service area has a higher percent of disconnected youth (**Figure 19**), residents aged 16-19 who are neither in school nor working, compared to the city (12% vs. 8%). Within our service area, Englewood, Ashburn, and Auburn Gresham have the highest rates of disconnected youth – 29%, 16%, and 14% respectively.

Figure 19. Disconnected youth - percent of residents aged 16 to 19 years who are not in school nor working, HCH service area



Source: American Community Survey 2020 Five-year Estimates

Table 20. Educational attainment indicators in the HCH service area

	Chicago	HCH Service Area
High school graduation rate [a]	86%	76%
Percent receiving any higher education [b]	64%	39%
Disconnected youth [c]	8%	12%

Source: American Community Survey 2020 Five-year Estimates

[a] Residents 25 or older with at least a high school degree: including GED and any higher education

[b] Residents 25 or older with any post-secondary education, including less than 1 year

[c] Residents aged 16-19 who are neither in school nor working

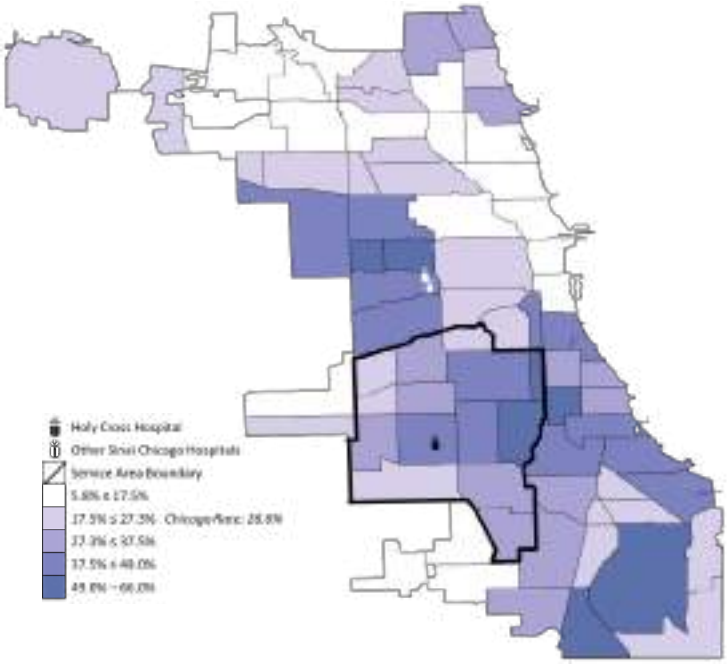
The median annual household income for the overall HCH service area was $45,298 with neighborhood medians ranging from $20,529 (Fuller Park) to $76,315 (Ashburn). The unemployment rate for the overall HCH service area was 15%, with Englewood, Fuller Park, and West Englewood having the highest rates at 25% each. Overall, within the HCH service area, the Black/African American population had over double and the Hispanic/Latinx population had almost 1.5 times the unemployment rate that whites had (**Figure 21**).

Figure 21. Economic stability indicators in the HCH service area

	Chicago	HCH service area
Median annual household income	$65,445	$45,298
Individual poverty (below 150% of poverty level)	27%	36%
Poverty rate for workers [a]	7%	10%
Overall unemployment rate [b]	8%	15%
Non-Hispanic Black	16%	23%
Hispanic/Latinx	8%	13%
Non-Hispanic white	4%	10%

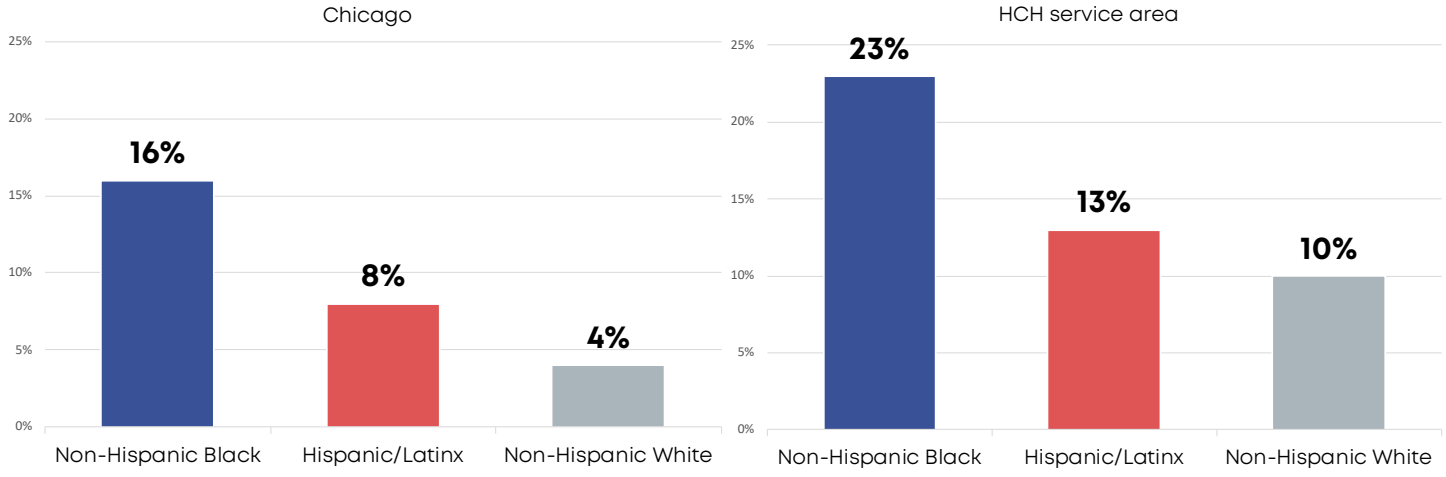
Source: American Community Survey 2020 Five-year Estimates
[a] Percent of currently employed residents 16 and over who are in poverty
[b] Percent of residents 16 and older who are actively seeking employment

Figure 22. Individual poverty (below 150% of the federal poverty level), HCH service area



Source: American Community Survey 2020 Five-year Estimates

Figure 23. Unemployment rate by race/ethnicity in Chicago and the HCH service area



Source: American Community Survey 2020 Five-year Estimates

Community Perspectives

AHE Focus Group participants discussed inequities in school quality, outlining the ways in which schools often fail to provide a supportive environment to those who need it most. Longer term, this can exacerbate and perpetuate inequities in community educational and economic outcomes.

"High quality education. We have one charter school only, and that school is leading in expulsions and suspension. Charter schools do whatever they want to keep their scores high."
- AHE Focus Group Participant

"The 2013 school closures in the South and West sides under the previous mayor's administration negatively impacted the educational attainment for students and continues to do so."
- Sinai CHNA/CHIP CAC Member

Participants also discussed economic challenges, how they have been exacerbated by COVID-19, and approaches for improving economic stability in communities. Suggestions included increasing access to affordable childcare, pursuing workforce development initiatives, strengthening the local economy to create living-wage jobs, coordination/ transparency, and increasing access to financial institutions.

"We need a solid infrastructure."
- AHE Focus Group Participant

"Make available grants, funds, or donations for the community to create employment assistance for parents and their youth."
- AHE Focus Group Participant

The groups also highlighted barriers to employment for youth and immigrant communities, specifically the challenges immigrants face finding employment commensurate with their level of education and skillset due to documentation status.

"Youth wages are needed to be same as adults because they do the same hours and same work, wages need to be the same." - AHE Focus Group Participant

In particular, our CAC discussed workforce development and healthcare's role in promoting economic development and opportunity within the communities it serves. The CAC discussed the role of healthcare systems in the local economy, how hospitals like HCH employ large numbers of residents from the surrounding communities, and how these healthcare systems can benefit communities through purchasing and training practices.

> "Healthcare is a big employer and a big part of the local economy, [with] training, pipelines, [and] retention for Black and Brown community members in Sinai's service area."
> - Sinai CHNA/CHIP CAC Member

The group also discussed the need to encourage people of color from the surrounding areas to explore careers in healthcare to address health inequities.

> "Encouraging people to explore [healthcare] careers will give access to better healthcare and the quality of healthcare." - Sinai CHNA/CHIP CAC Member

Sinai Initiatives

Career Pathways for Sinai Caregivers and Community Members

In 2021, our Human Resource Department began several initiatives to support caregivers at Sinai Chicago and local community members in pursuing healthcare careers. The Bridge Initiative Chicago launched in October 2021 and is a workforce development initiative funded by the JPMorgan Chase Foundation. The program pursues innovative solutions to create a more equitable and inclusive Sinai Chicago workforce, expand career pathways in healthcare for Chicagoland's unemployed and underemployed populations focusing on the West and South Sides, and develops rapid responses to the evolving needs of the healthcare industry. Sinai Chicago, along with Advocate Aurora Health and UChicago Medicine, lead this initiative.

Population Health Career Pathway

The Population Health Career Pathway program aims to build a more equitable, inclusive healthcare workforce in Chicago by expanding career development opportunities for Hispanic/Latinx job seekers with a high school diploma. Sinai Chicago aims to open new career pathways for local Hispanic/Latinx residents and increase access to bilingual, biculturally competent health care in Chicago via a well-trained bilingual population health workforce. This innovative model works in close collaboration with the Chicago Cook Workforce Partnership, the largest workforce development organization in the country, as well as with West Side United (WSU) and Esperanza Health Centers.

Diversity, Equity, and Inclusion (DEI) at Sinai Chicago

In September 2020, Sinai Chicago launched its own Diversity, Equity, and Inclusion (DEI) department that was tasked with aligning our values with the tenants of DEI, including integrity, quality, respect, safety, and teamwork. The DEI Team has established monthly Diversity Awareness Events for caregivers, and it also launched Caregiver Resource Groups that create an opportunity for caregivers to come together to act as a resource for both the members of the groups and for Sinai Chicago. In these resource groups, members can give caregivers a voice and connect them to Sinai Chicago services, policies and processes while increasing overall awareness around cultural competency and inclusion.

Community Transformation Initiative

The Community Transformation Initiative is a collaboration between Sinai Urban Health Institute (SUHI), North Lawndale Community Coordinating Council (NLCCC), and Enlace Chicago (Enlace) to assess, innovate and amplify the efforts of CHWs working in North and South Lawndale and to create a collective of community based organizations (CBOs) and federally qualified health centers (FQHCs) to elevate the coordinating efforts among the ample and diverse CHW agencies in these communities. The group works to bring critical health services and capacity into community settings by building a community-wide, integrated health services and training network for the CHWs working in the neighborhood.

Metropolitan Family Services: Metropolitan Family Services' Young Fathers program helps fathers become employed and financially self-sufficient so they can raise healthy children. The program includes job readiness training and placement, money management training, parent education and co-parenting counseling.

Centers for New Horizons: Centers for New Horizons helps children, youth, and families in becoming self-sufficient, improving quality of life, and participating in rebuilding their communities. Their economic development program partners with over 200 businesses to place individuals in high demand industries such as maintenance, medical assistance, and hospitality. Additionally, they assist youth aged 16-24 years with paid summer employment in various entry-level jobs.

Food Insecurity

Nutrition plays a crucial role in chronic disease prevention and health promotion. Having adequate nutrition is associated with improved health, lower risk for chronic diseases, and longevity. Having access to affordable fresh fruits and vegetables and healthy food options is fundamental to promoting wellbeing. For additional details regarding food insecurity more broadly across Chicago and beyond, refer to the AHE CHNA report found here.[37]

Health Indicators

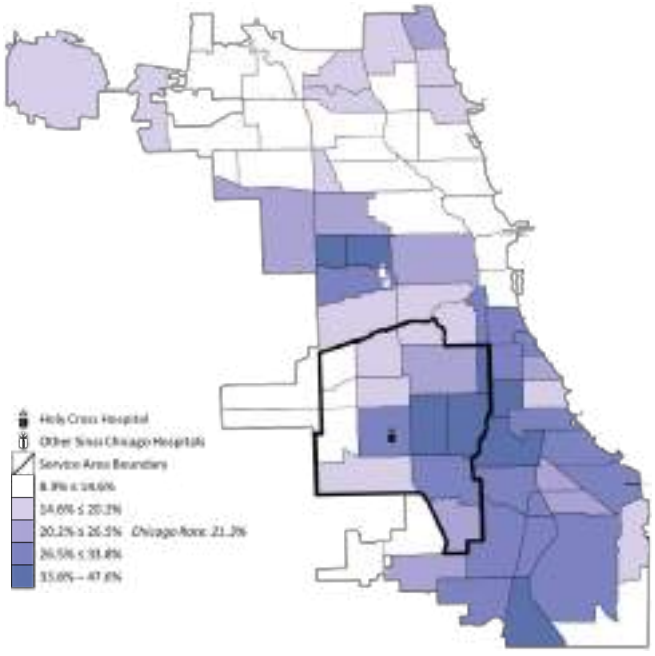
The percent of residents in the HCH service area who have experienced food insecurity is lower than the Chicago rate (15% vs. 21%) (**Figure 24**); however, 32% of HCH service area residents lived more than 0.5 miles from a supermarket and 0.5% of low-income residents lived more than a mile away (**Figure 25**).

Figure 24. Food insecurity indicators in the HCH service area

Food Insecurity	Chicago	HCH Service Area
Residents who have ever experienced food insecurity [a]	21%	15%
Residents who live in a food desert [b, c]	0.6%	0.5%
Residents who have low access to food [b, d]	22%	32%

[a] Feeding America (2020); residents with limited or uncertain access to adequate food
[b] USDA (2019)
[c] Low-income individuals (poverty rate >20% or income ≤80% of metropolitan-area median family income) who live more than a mile away from the nearest supermarket
[d] Defined solely on distance. Percent of individuals who live more than 0.5 miles away from the nearest supermarket

Figure 25. Percent of residents who have ever experienced food insecurity, HCH service area



Source: Feeding America (2020)

Community Perspectives

Within our Sinai CHNA/CHIP CAC discussion and throughout AHE-led focus groups in our service area, food access was a common topic. Both groups discussed how living in communities that are under-resourced impedes access to healthy foods. They explained that the lack of grocery stores with quality food and produce has been a persistent problem that harms community health. Many indicated that they must travel outside of their community for healthier food options and wished that their communities had the same amount of grocery stores as the North Side.

> "The one grocery store, is costly. They have a variety of food, but we need more grocery chains... [It's the] only store in the community...need more affordable food, and of quality."
> - AHE Focus Group Participant

> "That affects everything, quality of goods we can buy - especially food - but also other resources that go with that." - Sinai CHNA/CHIP CAC Member

Within AHE focus groups, participants discussed the lack of resources for families and highlighted how COVID-19 exacerbated barriers to accessing healthy foods, particularly as schools went remote, as food costs rose, and as economic challenges worsened. They also discussed the need for additional food infrastructure, including accessible farmers markets, community gardens, and grocery stores, and the importance of emergency food resources throughout the pandemic.

> "Stamps, Link, but if you don't have a grocery store what good is that?"
> - AHE Focus Group Participant

> ''Not too many resources in the community at all."
> - AHE Focus Group Participant

Many tied food access to high rates of chronic disease – particularly diabetes and cardiovascular disease.

> "Chronic health issues communities are facing come from diet and access to healthy and affordable foods." - AHE Focus Group Participant (neighborhood)

Sinai Initiatives

Supplemental Nutrition Program for Women, Infants and Children (WIC Program)

Sinai Community Institute's (SCI) WIC Program provides West Side residents needed nutrition support to pregnant individuals and children in the early stages of life. Beyond core services, SCI has pursued innovative approaches to address food insecurity through WIC. The Sinai WIC team recently partnered with the North Lawndale Community Coordinating Council (NLCCC) to provide food vouchers to approximately 400 families with school-aged children. Starting in April 2022, the WIC team has been working with the West Side United Food Strategy Workgroup to distribute food vouchers to approximately 30 food insecure families.

Food Pantry Initiatives

SCI also addresses food insecurity by partnering with established emergency food providers in the area. As part of this work, SCI partnered with Harmony Food Pantry in North Lawndale, a local pantry, to increase the availability of food and produce for community residents. SCI's health educators established and maintained a relationship with Harmony Food Pantry to provide COVID-19 support that included information on testing and treatment. Next steps include working with Harmony to begin resident food bag deliveries and to establish a partnership with Schwab Rehabilitation to refer patients to the food pantry.

Select Community Assets

Greater Chicago Food Depository: The Greater Chicago Food Depository is a food bank that includes a network of more than 700 food pantries, soup kitchens, shelters and programs that provide food to households across Chicago.

Women, Infants, and Children (WIC) Food and Nutrition Centers: The WIC Food and Nutrition Centers are a network of 16 facilities located in underserved communities across Chicago. The food and nutrition centers provide a variety of nutritious, WIC-approved foods that eligible participants obtain with WIC coupons. Participants can also access other wraparound services and programs, including a nutrition education program and a farmers market nutrition program.

Growing Home: Growing Home is a USDA-Certified Organic and non-profit urban farm that provides local, healthy, and affordable food as well as in-person and online cooking demonstrations, adult and youth workshops, and experimental community gardening.

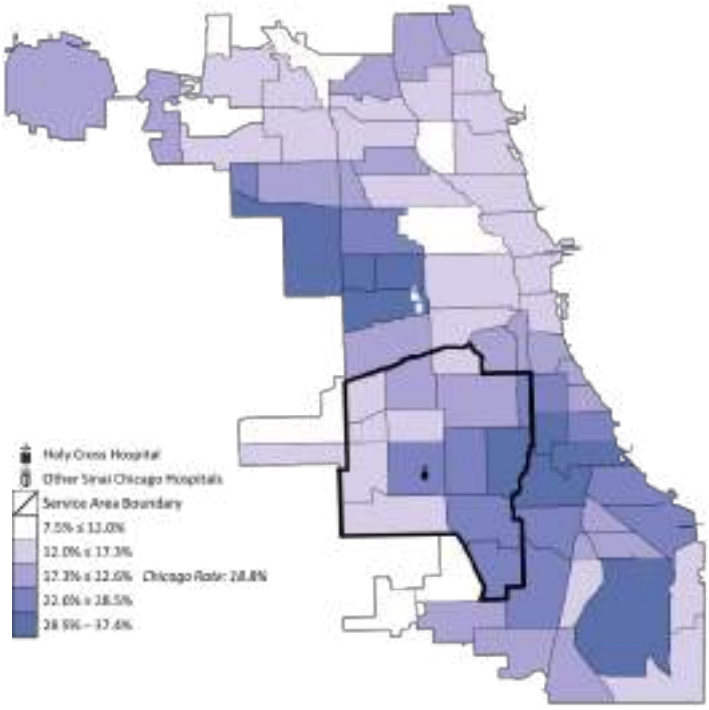
Housing

The legacy of discriminatory housing policies and practices continues to harm Chicago communities. The city remains one of the most segregated big cities in the U.S. and many Black/African American and Hispanic/Latinx people still face inequitable housing access and outcomes.

Health Indicators

In the HCH service area, 22% of households spend more than 50% of their incomes on housing-related costs such as rent, mortgage, utilities, and fees (**Figure 26**).

Figure 25. Severe housing cost burden (percent of households spending more than 50% of their incomes on housing-related costs), HCH service area



Source: American Community Survey 2020 Five-year Estimates

Figure 27 provides information on additional housing-related indicators. Many local organizations are working to increase owner-occupied housing rates to improve community safety, create opportunities for wealth accumulation, and to foster greater community cohesion and collectiveness.

Figure 27. Housing indicators in the HCH service area

Housing	Chicago	HCH service qrea
Severe housing cost burden [a, c]	19%	22%
Percent of owner-occupied housing units [a]	45%	50%
Percent of renter-occupied housing units [a]	55%	50%
Crowded housing [a, d]	3%	5%
Prevalence of housing vouchers [b, e]	9%	14%

[a] American Community Survey 2020 Five-year Estimates
[b] Department of Housing and Urban Development (2022)
[c] Households spending more than 50% of their incomes on housing-related costs such as rent, mortgage, utilities, and fees
[d] Percent of housing units where there is more than one occupant per room
[e] Percent of renter-occupied housing units that use Housing Choice Vouchers, which help elderly, disabled, and very low-income families afford housing

Community Perspectives

The Sinai CHNA/CHIP CAC elevated the impact of housing insecurity on health. Stakeholders talked about lacking resources like rental assistance for low-income populations, older adults, and people with disabilities. As with other themes, the lack of housing resources was tied back to structural inequities.

> "We need to look at things like housing and transportation, thinking about access within healthcare." - Sinai CHNA/CHIP CAC Member

Among HCH residents who completed the AHE Community Input Survey, homelessness and housing insecurity were listed as the sixth highest health-associated need in MSH's service area. Both white and Black/African American service area respondents listed it in their top five health needs. Stakeholders who participated in the AHE Focus Groups discussed the grave inequities in access to safe and affordable housing. Displacement was another related issue discussed, which stems from gentrification.

> "The community is changing. Low-income individuals are being pushed out. Persons of color are being pushed out. The changes going on are not for us, they are for the new people coming into the neighborhood. Ten years from today you won't see a person of color in this community." - AHE Focus Group Participant

Ogden Commons

Located in Chicago's North Lawndale neighborhood, Ogden Commons is a new commercial and residential development that intends to bring new jobs, housing, and investment to vacant property that was home to the now-demolished Ogden Courts public housing development. Ogden Commons is part of the City of Chicago's Invest South/West initiative and in June 2021, the first phase of this $200 million dollar development opened. The space includes Sinai Chicago's One Lawndale Community Care and Surgery Center which houses our Renal Dialysis Center, ambulatory surgery services, and GI lab. Patients will have access to the full range of Sinai offerings, including nurse navigators, CHWs, and intensive case management through Sinai Community Institute (SCI). The space is also home to affordable housing, retail space, and film production space for Cinespace Chicago.

Select Community Assets

Metropolitan Tenants Organization: The Metropolitan Tenants Organization provides various programs to organize and empower tenants to have a voice in the decisions that affect the affordability and availability of safe, decent, and accessible housing. They work directly with individual tenants to resolve landlord and apartment problems, provide free tools and resources via a tenant's rights hotline, support the development of building tenant associations, and advocate to strengthen rental laws and create better tenant protections.

Outreach Chicago: Outreach Chicago is a veteran-led, faith-based organization that addresses the needs of homeless families and individuals in Chicago. Outreach Chicago assists low-income, homeless, or near homeless individuals and families on the street with outreach programs and resources, including providing nutritional bag lunches, personal hygiene products, school supplies, and clothing for homeless and low-income individuals and families.

All Chicago Making Homelessness History (All Chicago): All Chicago provides financial assistance to people experiencing an emergency that could lead to homelessness, convenes stakeholders to drive collaboration, manages a citywide database to collect and analyze data on people experiencing or at risk of homelessness, and provides partners with trainings, tools, information, and research to more effectively address homelessness.

Transportation

Access to reliable transportation can promote positive health behaviors and improve wellbeing. Expanded public transportation options are associated with better access to medical care, increased physical activity, and reduced air pollution.[38] Inadequate transportation can increase social isolation as well as the risk for early mortality, depression, and dementia.[39]

Health Indicators

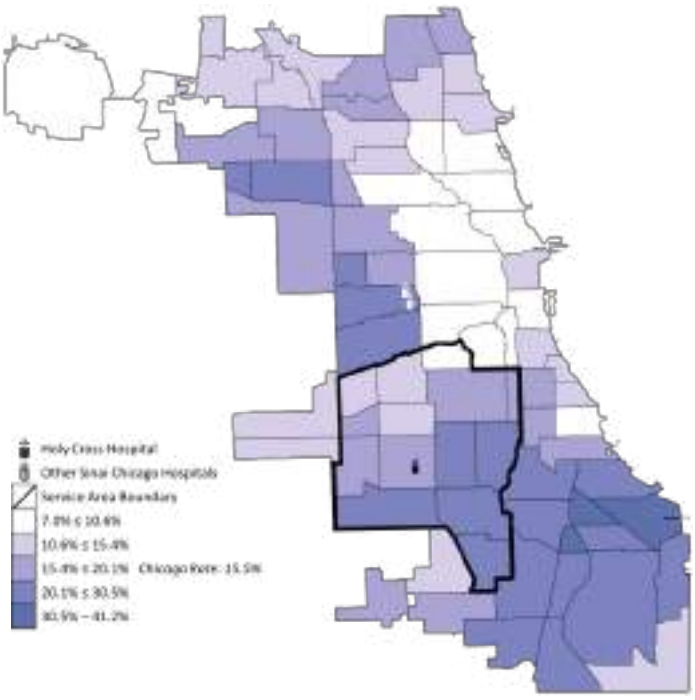
Across the HCH service area, a higher percent of residents have commutes to work of over an hour (**Figure 28**) and a lower percent take active transportation to work (walk, bike, public transit) compared to the city overall. Longer commutes and less active transportation may reflect the absence of local job opportunities as well as the lack of adequate public transportation options.

Figure 28. Severe housing cost burden (percent of households spending more than 50% of their incomes on housing-related costs), HCH service area

Transportation	Chicago	HCH service area
Residents whose commute to work is over 1 hour	16%	19%
Mean travel time to work	35 minutes	37 minutes
Active transporation (residents who either walk, bike, or take public transporation to work)	34%	24%

Source: American Community Survey 2020 Five-year Estimates

Figure 29. Percent of residents whose commute to work is over an hour in HCH service area



Source: American Community Survey 2020 Five-year Estimates

Community Perspectives

The Sinai CHNA/CHIP Community Advisory Committee (AC) discussed the need for more transportation resources in underserved communities. They elevated the transportation needs of older adults and people with disabilities and the important role that healthcare systems play in expanding transportation services for patients.

Sinai Initiatives

Superior Ambulance Service Partnership

In September 2021, Sinai Chicago partnered with Superior Ambulance Service to launch a non-emergency medical transportation program that is freely available to patients from surrounding communities who have an appointment at one of our locations. The service includes door-to-door appointment pick-ups and drop-offs, and is designed to be easy, reliable, and stress-free for those with limited public transit options.

Select Community Assets

Chicago Metropolitan Agency for Planning (CMAP): CMAP is a comprehensive planning organization implementing its ON TO 2050 plan to implement strategies addressing transportation, housing, economic development, open space, the environment, and other quality of life issues across Chicago.

Active Transportation Alliance: Active Transportation Alliance is a non-profit advocacy organization that works to improve conditions for bicycling, walking, and transit and engage people in healthy and active ways to get around. Additionally, Active Transportation Alliance works with lawmakers, advocates, and partner organizations to pursue laws that support safe and easy biking, walking, and transit.

Chicago Transit Authority (CTA): The CTA's All Stations Accessibility Program (ASAP) is a dedicated planning effort for making the 42 remaining non-accessible rail stations vertically accessible (ADA compliant) over the next 20 years.

Community Safety

Communities and people cannot thrive while feeling unsafe in their neighborhoods. Within this priority, we will seek to address structural racism's impact on community safety and its contributions to all forms of violence. We will partner with communities to pursue multi-sector solutions that promote public safety, enhance community collaboration and power, and address the trauma caused by past violence.

Violence was rated as the fifth greatest community health need by HCH service area residents who took the AHE Community Input Survey – with Black/African American residents listing it as the third community health priority after behavioral health and age-related illnesses. Ongoing threats to community safety stem from the myriad mechanisms of structural racism, including a corrupt criminal justice system, over-policing, economic disadvantage, poverty, and discriminatory housing policies. Intricately connected to experiences of community violence is the longstanding, inter-generational trauma faced by a disproportionate number of HCH service area residents. Ongoing exposure to violence leads to heightened levels of behavioral health issues, substance use disorders, and chronic diseases – all of which are more common in communities served by HCH.

Despite the challenges, the communities served by HCH have made significant progress in pursuing solutions that address community violence. As active members of our communities, Sinai Chicago celebrates the power and collective strength of communities in pursuing initiatives that push against the oppressive structures that have eroded community safety. At Sinai Chicago, we not only focus on trauma-informed practices and offering services critical for physical and mental wellbeing, but we actively partner with community residents, leaders, and organizations to collectively pursue local solutions that address violence at multiple levels.

Health Indicators

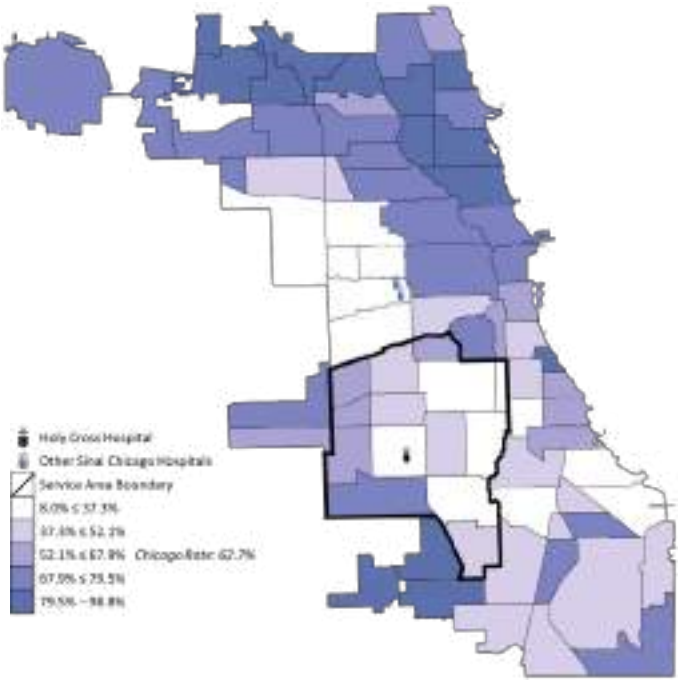
Overall, the rate of violent crime is similar to the Chicago average; however, the firearm-related mortality rate in HCH's service area is higher than the Chicago average, with some communities facing violent crime rates over three times and firearm-related mortality rates over five times the Chicago rates (**Figure 30**).

Figure 30. Community safety indicators in HCH service area

Transportation	Chicago	HCH service area (median & range)
Adults who feel safe in their neighborhood most or all of the time [a]	63%	41% (26% - 70%)
Adults who feel part of their community they live in [a]	45%	47% (18% - 60%)
Violent crime per 100,000 total residents [b]	929	929 (392 - 3,439)
Firearm-related mortality rate per 100,000 total population [c]	16	23 (5 - 89)

[a] *Chicago Department of Public Health, Healthy Chicago Survey (2020-21)*
[b] *Chicago Police Department (2021)*
[c] *Illinois Department of Public Health (2019)*

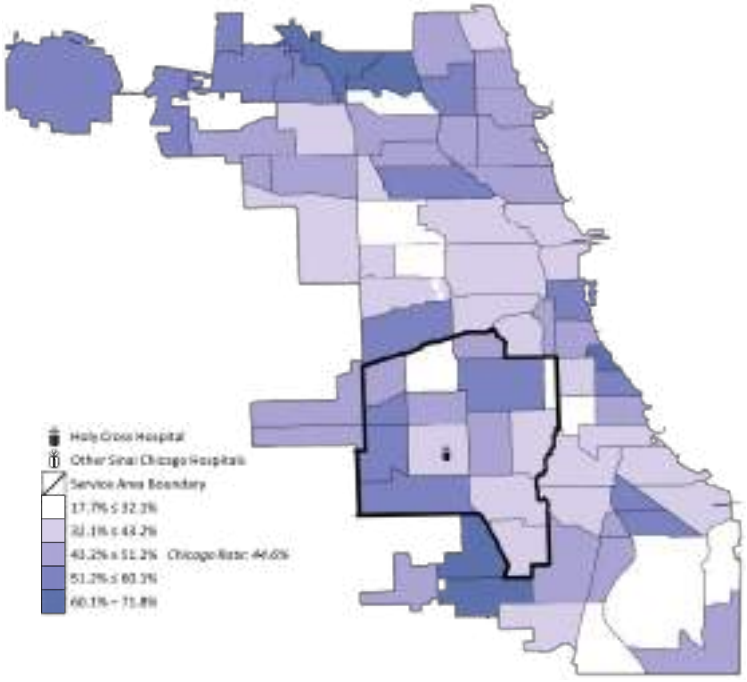
Figure 31. Percent of residents who feel safe in their neighborhood "all of the time" or "most of the time," HCH service area



Source: Chicago Department of Public Health, Healthy Chicago Survey (2020-21)

In addition to community violence, we collected measures related to community cohesion and connectedness. Social cohesion – the sense of solidarity and the strength of relationships among community members – plays an important role in physical and psychosocial wellbeing.[40] Studies suggest that in communities with high social cohesion, individuals are more open to working together toward a common goal. Similarly, it is believed that higher social cohesion can prevent community crime.[41] In the HCH service area, only 41% of adults expressed feeling safe in their neighborhood most or all of the time compared to the citywide rate of 63% (**Figures 31 and 32**).

Figure 32. Percent of residents who feel part of their neighborhood, HCH service area



Source: Chicago Department of Public Health, Healthy Chicago Survey (2020-21)

Community Perspectives

Community safety and cohesion were major discussion topics within our SUHI CHNA/CHIP CAC sessions as well as across AHE Focus Groups. In terms of root causes, participants discussed the lack of economic opportunity, particularly for young people and formerly incarcerated individuals, as playing a critical role in ongoing violence.

> "Violence, people feel they got to do whatever it takes to survive."
> - AHE Focus Group Participant

> "Provide a way to not reenter the jail system." - AHE Focus Group Participant

Groups talked about the profound impact of police brutality, a corrupt criminal justice system, and inequitable incarceration on the physical and behavioral health of communities of color.

> "The system is built to make things difficult [for people of color]."
> - Sinai CHNA/CHIP CAC Member

These discussions also underlined the lack of community trust in the police to respond to community needs, highlighting examples of inadequate responses to emergency and behavioral health situations.

> "[Calling the police] doesn't make things better. [People of color] tend not to have great interactions with the government."
> - Sinai CHNA/CHIP CAC Member

> "They run people over, they hit my husband's car, they hit a young man and ran him into a tree. I call 911, they ask questions [and] when I say I don't know, they say 'what do you want me to do?'" - AHE Focus Group Participant

> "When police get a call of shooting around here, they hear that street 'stuff like that always happens there' so they take their time. Then the person dies waiting."
> - AHE Focus Group Participant

Most of the group agreed that Sinai Chicago and other healthcare systems need to do more to address community safety issues. The CAC called on Sinai Chicago and other Chicago healthcare systems to "...put a big emphasis..." on community safety. However, participants also warned that there is a need to partner with communities in pursuing solutions and to address a lack of coordination across existing efforts.

"There is a lot of money going around with no coordination on where the money is going and how it is supporting the needs of all communities."
- AHE Focus Group Participant

Participants also discussed potential solutions and opportunities to increase neighborhood safety and tied these recommendations specifically to youth.

"Due to community violence, it is hard being healthy. It's not just about having a park, but for people to feel safe and to feel comfortable letting our kids out late."- AHE Focus Group Participant

"Resources are also important for community safety as well as having adequate safe space local to the community members especially for youth." - AHE Focus Group Participant

"Getting kids to come to the park if they can get something out of it, clean it up, put some lights up, invest some money in the parks so they feel safe." - AHE Focus Group Participant

Despite the challenges, participants also highlighted the strength and importance of community networks.

"Rough neighborhood, but it's got a way of hanging-on - they stick together, there's a sense of togetherness." - AHE Focus Group Participant

"Resilience... perseverance rooted in helping each other."
- AHE Focus Group Participant

"Moved in three years ago. I feel safe, close to my job. Safe to leave my door unlocked. I feel safe and secure, we look out for one another. Neighbors make me feel welcome." - AHE Focus Group Participant

CHW Support Program (CSP)

MSH is a part of a network of hospitals, Chicago Department of Public Health, and Health and Human Service (HHS) partners working to connect the healthcare system, including the emergency department, with community service providers across Chicago's West Side. In April 2019, SUHI CHWs began screening MSH emergency department patients with non-fatal gun violence injuries for social needs. Currently, CHWs screen ED patients, COVID-19 patients and others for social determinants of health, referring them to community organizations that assist with with housing, food access, job training, public benefit program enrollment, and other needs.

Chicago Gun Violence Research Collaborative (CGVRC)

The Chicago Gun Violence Research Collaborative (CGVRC) is a group of academic researchers, community groups, and other stakeholders originally convened in 2016 by Sinai Chicago and the Illinois Public Health Institute in response to high levels of gun violence in Chicago. Sinai Chicago, specifically Sinai Urban Health Institute (SUHI), led the first year of the CGVRC fellowship. During the fellowship program, graduate-level fellows work on projects to identify the root causes and perceptions of gun violence and explore effective prevention strategies.

Chicago Hospital Engagement, Action and Leadership (HEAL) Initiative

Launched in 2018 in partnership with Senator Durbin, the Chicago HEAL Initiative entails the commitment of ten leading Chicago hospitals to collaborate around public pledges to address community violence in the 18 Chicago neighborhoods with the highest rates of poverty and violence. In its first three years, the effort focused on increasing health system local hiring, providing more internship opportunities and pipeline programs, screening for social needs, and offering additional trauma recovery programs. The hospitals recently agreed to renew the initiative for another three years, revising its plan to better-align with existing community and hospital efforts.

Domestic Violence Program (DVP)

Historically, Schwab Rehabilitation has provided support services to people with disabilities that experience domestic violence; however, the Domestic Violence Program (DVP) supports Sinai Chicago patients referred from MSH's emergency department, Sinai Community Institute, and other departments. The DVP offers resources, counseling, emotional support, advocacy, and education to clients. It also includes a support hotline and focuses on increasing awareness of the unique forms of abuse faced by those with disabilities. In fiscal year 2021, the DVP served over 100 clients, including 75 new individuals, aged 18 to over 60 years.

Research Activism for Youth (RAY)

RAY is a six-week, paid summer program for high school students aged 16 to 19 years living on the Southwest and West Sides of Chicago. Students engage with public health professionals to learn how research and advocacy can be used to improve community health and wellbeing. RAY students learn about community health, research, and civic engagement; explore public health and advocacy as career possibilities; and network with community leaders and health professionals. The summer 2022 program will focus on COVID-19's impact among youth and identify potential solutions to address key issues.

Select Community Assets

Enlace Chicago (Enlace): Enlace Chicago is a community-based organization that takes a comprehensive, multi-systemic, and trauma-informed approach to building safety and promoting peace. Enlace does this through street interventions, street-and school-based counselors, school-based safe passages, and organizing and advocacy.

Brighton Park Neighborhood Council (BPNC): BPNC is a community-based, grassroots organization that seeks to eliminate street and domestic violence through a comprehensive approach that includes violence prevention programs, intervention services, and increasing employment and educational opportunities for young people.

Chicago CRED: To create lasting change, Chicago CRED works directly with the individuals who are most likely to carry a concealed weapon or have a greater likelihood of being impacted by gun violence — with the communities where gun violence is most concentrated. This is accomplished through their various programs, including Street Outreach, Coaching and Counseling, Workforce Development, and Advocacy and Prevention.

READI Chicago: Administered by Heartland Alliance, READI (Rapid Employment and Development Initiative) Chicago is a one-year program that connects people most highly impacted by gun violence to cognitive behavioral interventions, paid transitional jobs, and wraparound support services.

UCAN: UCAN is a community-based organization that provides a variety of youth and family-oriented services, including violence prevention and trauma-related programs. Additionally, UCAN is the lead agency in The Peace Hub, a collaborative of more than 30 youth-serving Chicago nonprofit organizations whose goals are to increase engagement of Chicago's youth aged 12-24 years in programs and services to address violence in Chicago.

Equitable Health Care Across the Lifespan

A critical priority of our multi-faceted approach to dismantling structural racism in the health care system, this priority focuses on providing access to high-quality preventive and specialty care that respectfully responds to the unique needs of every individual across their lifespan, regardless of race, ethnicity, zip code, income, ability, insurance, literacy levels, language, involvement with the justice system, gender identify, sexual orientation, or citizenship. We will offer culturally appropriate and linguistically aligned care by pursuing anti-racist approaches within our own system. We will track health outcomes across our patients to ensure our efforts result in improved wellbeing for all.

Historic and ongoing structural racism is also pervasive within the healthcare system which is intended to improve wellbeing for all. Equitable access to quality health care has been limited for people of color throughout U.S. history due to discriminatory policies such as the Hospital Survey and Construction Act of 1946 that established federal support for "separate-but-equal" hospitals between Black/African American and white populations.[42] Further, trust in the healthcare system across communities of color has been eroded due to the extensive list of unethical and inhumane atrocities conducted throughout its history,[43] including the U.S. Public Health Service Syphilis Study at Tuskegee (1932-1972), the forced sterilization of Native American women (1960s and 1970s), the racial biases that led to under-diagnosis and treatment of pain for Black/African American patients, and the lack of attention given to conditions most likely to impact people of color.[44, 45, 46, 47] In addition, immigrant communities face additional barriers to quality healthcare, including systems that do not support those with limited English proficiency, policies around publicly-funded health care, and xenophobic policies targeting those without documentation.[48]

The impact of structural racism on undocumented immigrants is of particular importance to the HCH service area. Federal efforts to expand medical insurance coverage, such as the Affordable Care Act (ACA) of 2010, left an important portion of the immigrant community without access to insurance. Immigrants who are ineligible for health insurance face a heightened risk for delayed diagnosis of serious illness. COVID-19 has underlined the vulnerable position that undocumented immigrants are forced into through systemic barriers to routine, preventive, and quality health care. Thousands of COVID-19 hospitalizations and deaths on the Southwest Side were related to underlying and uncontrolled conditions such as Type 2 Diabetes, heart disease, pulmonary conditions, and obesity. Sinai Chicago is a member of the Healthy IL Campaign, supporting legislation to provide health coverage to all immigrants in Illinois.

Healthcare systems have a significant role in addressing structural racism and other systemic inequities (e.g., gender, linguistic, age). Sinai Chicago is in a unique position to identify and address social needs, remove barriers to access such as transportation and low health

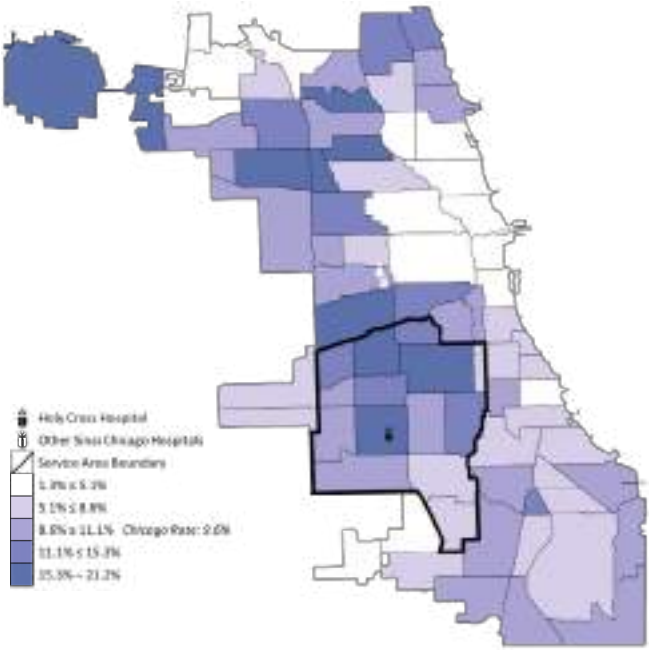
literacy, go beyond our hospital walls to provide care within community, and collaborate with community members to address the root causes of health inequities.[49] As a community anchor institution, it is also our role to address inequities in the healthcare workforce, pursuing initiatives that support and encourage residents and people of color to enter healthcare careers and grow into healthcare leaders. This work will not only improve diversity within our system, but also contribute to improved community economic wellbeing. In 2020, Sinai Chicago, along with 36 other Chicago-wide healthcare organizations, came together to acknowledge racism as a public health crisis.[50] We take this commitment seriously, focusing on addressing the inequities in healthcare access, quality, and experiences outlined herein.

Health Indicators

Health Insurance Coverage

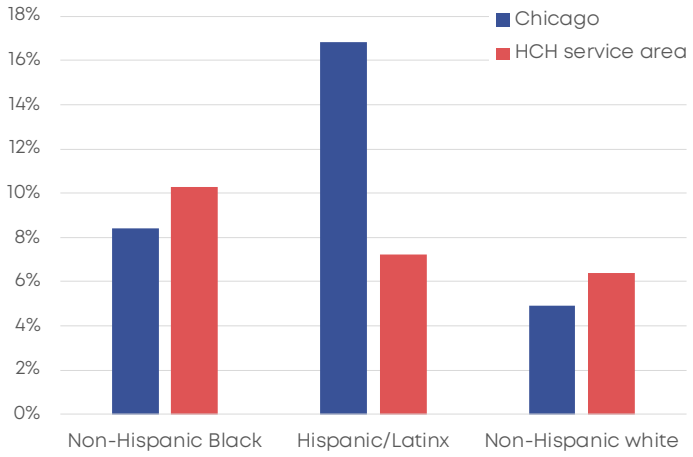
Having adequate health insurance is associated with improved health outcomes, lower all-cause mortality, and a greater personal sense of wellbeing because insured individuals are more likely to use preventive services and have better chronic disease management.[51] In 2020, around 28 million individuals in the U.S. (8.6% of total population) were uninsured.[52] Chicago and the HCH service area have higher uninsured rates (10% and 13% respectively). Examining uninsured rates in the HCH service area by Race/ethnicity, Hispanic/Latinx populations are the most likely to be uninsured (17%) (**Figure 34**). We also observe differences in insurance coverage by community area (**Figure 33**).

Figure 33. Percent of uninsured residents, HCH service area



Source: American Community Survey 2020 Five-year Estimates

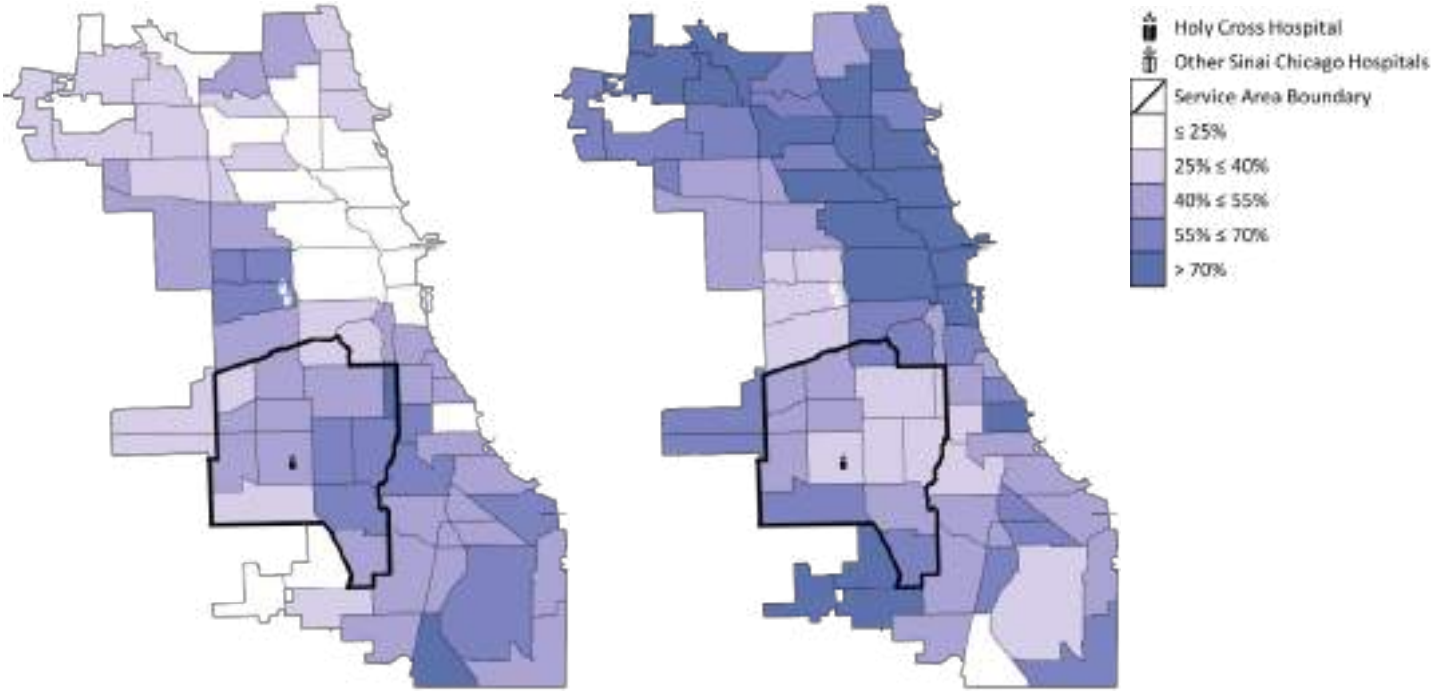
Figure 34. Uninsured rates in Chicago and HCH service area by race/ethnicity



Source: American Community Survey 2020 Five-year Estimates

Even individuals with health insurance may face barriers because their coverage could be insufficient for their needs, charge high copayments and deductibles, limit provider selection and location, and require intensive referral processes. Many report differences in access to timely, affordable, and adequate care between private and public insurers.[53] Half of HCH service area residents (50%) have public health insurance whereas 45% have private (**Figure 35**).

Figure 35. Percent of residents with public (left) and private (right) insurance coverage, HCH service area



Source: American Community Survey 2020 Five-year Estimates

Young invincibles is a term used to describe adults aged 19 to 25 years who have chosen against purchasing health insurance because they expect to be healthy or find the premiums unaffordable. The HCH service area has a 30% higher rate of young invincibles than Chicago overall (19% vs. 14%) (**Figure 36**).

Figure 36. Health Insurance Coverage Indicators in the HCH service area

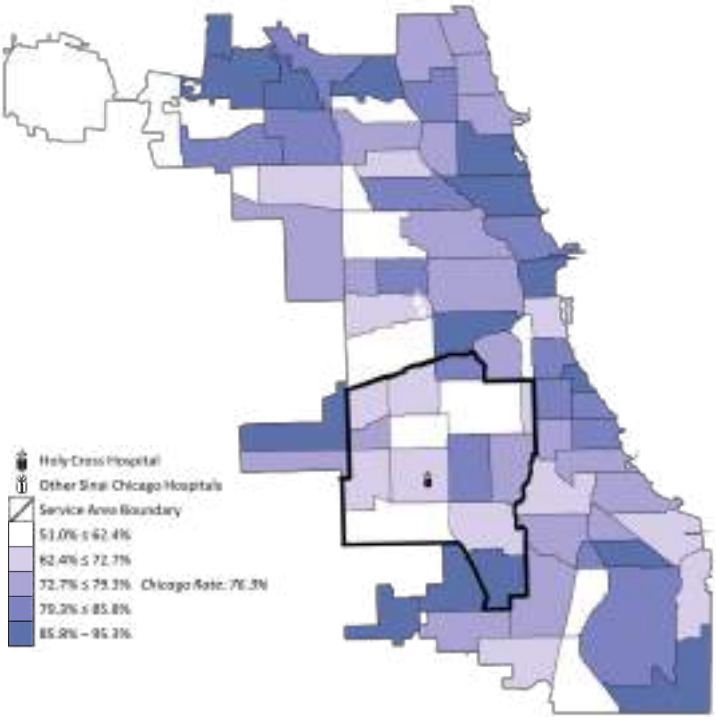
	Chicago	HCH Service Area
Uninsured rate	10%	13%
Non-Hispanic Black	8%	10%
Hispanic/Latinx	17%	17%
Non-Hispanic white	5%	6%
Residents with private health insurance coverage	62%	45%
Residents with public health insurance coverage	36%	50%
Residents aged 19 to 25 years without health insurance (young invincibles)	14%	19%

Source: American Community Survey 2020 Five-year Estimates

Primary Care Access

Primary care is a critical component of wellbeing as it is tied to better health outcomes such as lower all-cause mortality and increased self-reported health.[54] For 76% of Chicago residents, it is 'usually' or 'always' easy to get services through their health plan; however, in the HCH service area, this rate ranges from 54% (Ashburn) to 87% (Washington Heights) (**Figure 37**). Additional information on access to primary care can be found in **Figure 38**.

Figure 37. Percent of residents who reported that it is 'usually' or 'always' easy to get the care, tests, or treatment they need through their health plan, HCH service area



Source: Chicago Department of Public Health, Healthy Chicago Survey (2020-21)

Figure 38. Access to primary care and quality of care indicators in the HCH service area

	Chicago	HCH Service Area (Median & Range)
Percent who have a primary care provider [a]	81%	85% (55% - 88%)
Healthcare satisfaction rate [b]	59%	56% (38% - 73%)
Usually or always easy to get care, tests, and needed treatment [c]	76%	69% (54% - 87%)
Routine check-up in the past year [d]	71%	76% (59% - 93%)

Source: Chicago Department of Public Health, Healthy Chicago Survey (2020-21)

[a] Percent of adults who report that they have at least one person they think of as their personal doctor or health care provider

[b] Percent of adults who report that they were very satisfied with the health care they received in the past year

[c] Percent of adults who report that it is "usually" or "always" easy to get the care, tests or treatment they needed through their health plan

[d] Percent of adults who visited a doctor or health care provider for a routine checkup in the past year

Preventive Screenings

Preventive health screenings are considered one of the most important health care strategies because early diagnosis and treatment can lead to improved quality of life and reduced premature mortality and disability.[55] Aside from skin cancers, breast cancer is the most common cancer among U.S. women (1 in 8 receive this diagnosis within their lifetimes[56]). In Chicago, 73% of women aged 45 and older have had a mammogram in the past two years. In the HCH service area, this rate ranges from 55% (New City – Back of The Yards) to 88% (Washington Heights). **Table 39** shows the screening rates for common types of cancer prioritized under Healthy Chicago 2025 (Chicago Department of Public Health).

Table 39. Cancer screening in the HCH service area

Preventitive Screenings	Chicago	HCH Service Area (Median & Range)
Breast cancer screening rate [a]	73%	78% (55% - 88%)
Colorectal cancer screening rate [b]	58%	54% (31% - 72%)
Cervical cancer screening rate [c]	64%	60% (39% - 85%)

Source: Chicago Department of Public Health, Healthy Chicago Survey (2020-21)

[a] Percent of women ages 45 and older who reported having a mammogram in the past two years

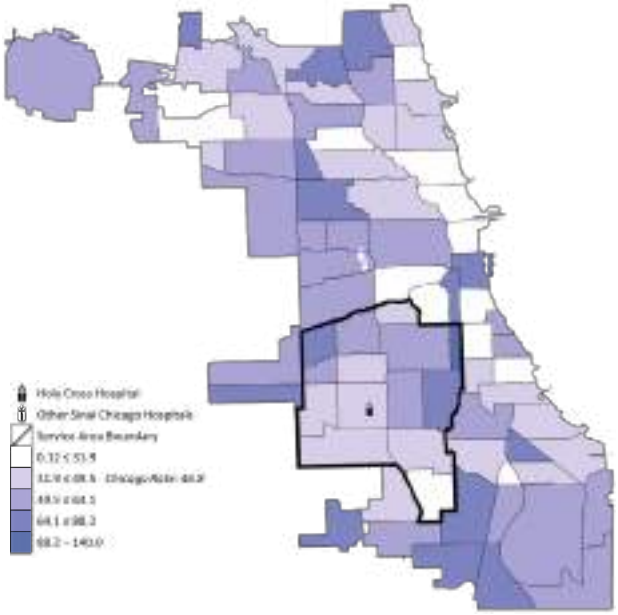
[b] Percent of adults aged 45 and older who report a colonoscopy or sigmoidoscopy in the past 5 years or a blood stool test in the past year

[c] Percent of women who have not had a hysterectomy and who report having a Pap test within the past 3 years

Maternal, Infant, and Family Health

Maternal and infant health indicators – namely maternal mortality – are critical measures of overall community health and the ability of societies to ensure the wellbeing of all individuals throughout the lifespan. Birth rate is considered an important indicator of population wellbeing as it reflects changes in underlying social and economic factors that support or challenge families.[57] Although the birth rate in the HCH service area exceeds that of Chicago, birth rates have consistently declined over the past five years. As of 2020, the birth rate in Chicago was 47 births per 1,000 women, whereas in the HCH service area this rate was 52 (**Figure 40**).

Figure 40. Births per 1,000 women aged 15 to 50 years in HCH service area



Source: American Community Survey 2020 Five-year Estimates

While unavailable for our service area as a whole, a report from the Chicago Department of Public Health on 2016-17 births underlined grave inequities in maternal health between Black/African American and Hispanic/Latinx and white groups in Chicago. The pregnancy-associated mortality ratio among Non-Hispanic Black and Hispanic/Latinx Chicagoans is nearly six and two times that of Non-Hispanic white Chicagoans, respectively (98.8 and 34.3 deaths per 100,000 births vs. 17.0[58]). Further, severe maternal morbidity (SMM) was 2.5 times higher for Black/African American Chicagoans and 1.3 times higher for Hispanic/Latinx Chicagoans than white (120.8, 60.0, and 46.9 per 10,000 deliveries, respectively). In the HCH service area, one of the communities most impacted by SMM (rate of over 100 per 10,000 deliveries) is Englewood (60621).[59] Chicagoans with births reimbursed by Medicaid and those living in communities with high economic hardship have the highest rates of poor outcomes.[60] In Chicago, 77.6% of maternal deaths occur in the first year postpartum,[61] with 27.6% occurring within 42 days postpartum. Cardiovascular factors are often the top underlying causes for pregnancy-associated deaths and morbidities.

Additional maternal and infant health indicators are included in **Figure 41**. Low birthweight and preterm birth are important determinants of infant morbidity and mortality. The rates of low birthweight and preterm births in some HCH service area communities are as high as 1 in 5 infants – both almost or double the Chicago rates. Similarly, infant mortality in some HCH service area communities is over twice as high as the Chicago-wide rate. Having early access to adequate prenatal care can reduce the risk of complications; however, we also see inequities in access to early and adequate prenatal care across our HCH communities.[62, 63, 64]

Table 41. Maternal and child health indicators for HCH service area

Maternal and Child Health	Chicago	HCH Service Area (Median & Range)
Birth rate per 1,000 women ages 15-50 [a]	47	52 (32 - 140)
Teen birth rate per 1,000 women ages 15-19 [a]	12	3 (0 - 260)
Early and adequate prenatal care [b, c]	65%	65% (50% - 71%)
Low birthweight (<2500 grams) [b]	9%	9% (6% - 19%)
Preterm births (<37 weeks gestation) [b]	11%	11% (8% - 21%)
Infant mortality per 1,000 live births [b]	7	8 (2 - 17)

[a] *American Community Survey 2020 Five-year Estimates*
[b] *Illinois Department of Public Health (2017)*
[c] *The timing and number of prenatal visits are combined in a summary score to determine whether the birthing person received adequate prenatal care*

Community Perspectives

Our Sinai CHNA/CHIP CAC engaged in a robust discussion on the topic of equitable access to healthcare. Members detailed many barriers to accessing healthcare services, both from personal experiences and from stories shared by family and friends. One of the major themes was discrimination within the healthcare system based on account of a patient's skin color, immigration status, or language proficiency.

"[Racism] is not limited to color or migratory status; there are many places where [people of color] have faced discrimination like not getting correct diagnoses, not providing care in the language needed." - Sinai CHNA/CHIP CAC Member

"I had no idea where to go or how to find help, and I worked in healthcare." - AHE Focus Group Participant

"There are health centers, etc. but hard to get help. Most people just don't have insurance." - AHE Focus Group Participant

Members discussed the causes of discrimination within the healthcare system. A recurring theme was the lack of Black/African American and Hispanic/Latinx healthcare providers as well as providers from local communities. They further elaborated on stories underlining the healthcare system's lack of cultural sensitivity towards and linguistic alignment with patients and discussed the bureaucratic challenges in accessing quality health care.

"[A lack of] basic things like cultural sensitivity, empathy so that you can feel more welcomed." - Sinai CHNA/CHIP CAC Member

"The system is built to make things difficult." - Sinai CHNA/CHIP CAC Member

"Race, ethnicity, and immigration intersectionality exacerbate the disparities." - AHE Focus Group Participant

They also called for providers to genuinely address patient physical and behavioral health issues with humility and compassion, and for healthcare systems to better measure health experiences, quality, satisfaction, and ultimately outcomes by group (e.g., Black/African American patients, Spanish-speaking patients) to ensure equity in providing quality care. Members also talked about how healthcare systems and racism intersected.

"It can get to be too exhausting to always be in the position of having to prove yourself worthy of equality healthcare because you are a person of color. It is demoralizing to always be made to feel you are less than." - Sinai CHNA/CHIP CAC Member

"Doctors do not look at the whole physical human body and behavioral health is looked over. How can you treat someone for a health issue and not know that behavioral health is what's causing and triggering other issue?" - AHE Focus Group Participant

Members shared community perceptions of local healthcare institutions and how negative experiences influence their decisions to seek care. They talked about how re-establishing relationships in community is paramount to ensuring Sinai Chicago is viewed as a trusted community partner. One member described an emergency department visit in which he was treated poorly despite having a standing reputation and relationship with Sinai Chicago.

"It doesn't matter who you are, how you are dressed, your affiliation, [we] all deserve the same treatment." - Sinai CHNA/CHIP CAC Member

In addition to re-establishing relationships, members discussed the need for Sinai Chicago to respond to social needs in providing care, outlining how people often forgo paying rent and utilities to afford medications and medical care. Others discussed the importance of leveraging community health workers (CHWs) to increase community outreach, improve access to resources, and promote health education.

"Community members struggle [with] behavioral health and not hav[ing] access to healthcare and dental services and are afraid of immigration status, so we don't go to get proper care. Fear of how we are going to pay for the services when we get them." - AHE Focus Group Participant

"Immigrants are taking expired medication they brought from home because they cannot access medical care." - AHE Focus Group Participant

"We have to jump through hoops. We can't get the services. You end up giving up before we can get it." - AHE Focus Group Participant

"Health starts with economic health." - AHE Focus Group Participant

Graduate Medical Education (GME) Training Program

Sinai Chicago recognized an opportunity for improved health equity by developing a physician workforce that more closely reflects the community that we serve with regards to ethnicity, race, and cultural identity. For this reason, our Graduate Medical Education (GME) training programs underwent significant changes in the way that we select applicants for residency. Sinai Chicago is piloting a paid, six-week summer program for rising second-year underrepresented in medicine minorities (URiM) medical students at University of Illinois Chicago in the summer of 2022. The program provides the opportunity for each student to design a community engagement or research project around health equity and offers early clinical exposure, bi-directional mentoring, and health equity focused didactics.

ProgressHealth PHO

ProgressHealth PHO is a unified health care medical group affiliated with Sinai Chicago, led by highly skilled managed care and health care professionals with decades of experience committed to delivering innovative and high-quality care. Together with Sinai Medical Group, Schwab Faculty Associates, Holy Cross Physicians, Sinai Medical Center, Holy Cross Hospital, and other highly-skilled, locally based medical professionals, ProgressHealth delivers high quality healthcare to the communities we serve. Being a part of ProgressHealth PHO allows the member to have a variety of choices for health plan options, as well as full access to our broad-based specialty network and Care Coordination Program.

CMS Bundle Payments for Care Improvement-Advanced (BPCI-A) Initiative

Sinai Chicago has participated in the CMS BPCI-A, a voluntary Medicare payment model that provides a bundled payment for physicians and facilities, since late 2018. The program applies to select clinical diagnoses in each of our participating hospitals. Sinai physicians are responsible for the care of discharged patients for 90 days, with the emphasis on reducing readmission and keeping patients at the best next site of care. Physicians also work with families when appropriate on Advanced Care Planning and Goals of Care Discussions.

West Side Health Equity Collaborative (WSHEC) & South Side Healthy Community Organization (SSHCO)

Sinai Chicago is an active leader in two Illinois Department of Healthcare and Family Services (HFS) Healthcare Transformation Collaboratives which aim to systematically transform the way health care is delivered to Medicaid-eligible populations on Chicago's West, Southwest, and South Sides. The collaboratives engage hospitals, healthcare providers, service organizations, community organizations, and residents to pursue culturally-responsive healthcare that addresses the socioeconomic and health needs of

residents. The WSHEC aims to prevent and treat diabetes, hypertension, and depression by building and leveraging a community-based workforce and integrated data platform. The SSHCO addresses inequities in chronic disease, maternal and child health, behavioral health, and the social determinants of health by increasing access to primary and specialty care, building a robust CHW and care coordinator workforce, and deploying an integrated technology platform.

¡Vive Saludable!

Many residents face challenges to achieving optimal health and longevity because of racist policies and systems that create inequitable barriers to wellness. As a part of Sinai Chicago's strategic response to these challenges, we partnered with community organizations and groups to develop and launch ¡Vive Saludable!, or Live Healthy!, in 2021, a three-year system-wide and community-driven effort to enhance the health and wellness of Latino communities on Chicago's West and Southwest Sides. The ¡Vive Saludable! Implementation Plan places Sinai Chicago's community members at the forefront of our work by providing a safe and welcoming place of care for all, and ensuring the highest quality care possible.

Center for CHW Research, Outcomes, and Workforce Development (CROWD)

Sinai Urban Health Institute (SUHI) is nationally recognized for its expertise in the Community Health Worker (CHW) Model. As frontline public health workers and trusted community members, CHWs provide services that improve health care access and promote understanding of the healthcare system. SUHI's **C**enter for CHW **R**esearch, **O**utcomes, and **W**orkforce **D**evelopment (CROWD) provides support for local and national organizations and community-based initiatives in identifying, hiring, and training CHWs. The center also provides consulting services, quality assurance, and evaluation support. CROWD is at the forefront of training and supporting organizations in effectively leveraging CHWs to address health inequities in the Chicagoland area and beyond.

Family Case Management and Better Outcomes Programs

Through its Family Case Management (FCM) and Better Birth Outcomes (BBO) programs, SCI provides family and prenatal case management services to pregnant women and infants in need of support as well as pregnant women at high risk for poor birth outcomes. Services provided include health education, linkage to care, and coordination of medical and social services. Key program goals include lowering the infant mortality rate and decreasing the number of preterm and low birth weight infants among participants.

East Garfield Park Best Babies Zone (BBZ)

The BBZ was nationally recognized in 2019 by CityMatCH, the national leader in urban maternal and child health. The BBZ takes a place-based, structural approach to address racial and geographic health inequities in maternal, infant, and youth outcomes within East Garfield Park. The BBZ is led by an Advisory Team of 20 representatives from East Garfield Park-serving social service organizations, community organizations, and healthcare systems, academic professionals, and most importantly, residents. Sinai Urban Health Institute (SUHI) co-leads the BBZ as a backbone institution alongside West Side United, Rush University Medical Center, and the Chicago Department of Public Health (CDPH).

Family Connects Chicago (FCC)

Holy Cross Hospital was one of the first pilot hospitals in Chicago to offer delivery patients access to Chicago's new FCC program. FCC is a universal program for any Chicago resident who gives birth wherein nurses visit parents with newborns in their home about three weeks after giving birth. Nurses assess and respond to infant and parent physical, emotional, and behavioral health needs, and address family social needs through a rigorous referral process to local health and social resources. In addition to offering the programming, Sinai Urban Health Institute and SCI lead the West and Southwest FCC Regional Community Alignment Boards (CABs), which are responsible for assessing program appropriateness, providing systems and policy recommendations, and helping coordinate the social services infrastructure.

Access Community Health Network (ACCESS): Chicago area's largest provider of community health care, ACCESS is a federally qualified health center (FQHC) that provides a full range of comprehensive, quality health care services including maternal and child health, behavioral health, risk and prevention services, and primary services, including family practice, obstetric/ gynecological and midwifery services, such as ongoing management of chronic diseases.

The Port Ministries: Port Ministries offers a free health clinic that delivers primary and urgent care to under and uninsured Chicago residents. Services include chronic disease management, behavioral health, urgent care, minor laboratory testing, pharmaceutical administration, physicals, and referrals.

Inner-City Muslim Action Network (IMAN): The IMAN health center provides comprehensive, accessible, and culturally informed health care to its patient population regardless of their insurance status or ability to pay. IMAN provides a combination of medical and behavioral health care for children and adults, including cancer screening, diabetes care, women's health, and substance abuse counseling.

Esperanza Health Center (Esperanza): Esperanza provides high quality bilingual primary care, behavioral health care, and wellness services, regardless of immigration status, insurance status, or ability to pay. Esperanza also provides additional programs, such as pre-exposure prophylaxis, physical health and nutrition, child wellness, women centered programs, benefits counseling, and immigration physicals. In June 2022, Esperanza opened their newest location on 63rd and Karlov Ave., offering pediatric, OB-GYN, and adult medicine services.

Lawndale Christian Health Center (LCHC): Modeled as a Patient Centered Medical Home, LCHC provides patients with a care team that coordinates patient care within and outside of the clinic, including hospital services, social supports, and specialty care. LCHC provides a one-stop-shop for patients by delivering a wide range of health services, including medical, dental, vision, behavioral, HIV, and women's health care.

Chronic and Infectious Disease

We aim to treat community members with high-quality, respectful specialty care that meets their needs. Within this priority, we focus on responding to the longstanding impacts of COVID-19 as well as preventing and treating cardio-metabolic disease (heart disease, stroke, and diabetes), cancer, respiratory disease, and infectious disease (HIV, hepatitis, and other sexually-transmitted infections).

As outlined previously, the legacy of structural racism in Chicago's Black/African American and Hispanic/Latinx communities has contributed to higher levels of poverty and poorer access to resources related to the social determinants of health (e.g., housing, education, employment, air and water quality, etc.), which in turn increases risk for chronic and infectious disease.[65, 66] Consequently, communities of color served by HCH experience disproportionately higher rates of preventable health conditions and diseases, such as diabetes, respiratory disease, and cardiovascular disease, compared to white communities.[67] Further, the disproportionate impact of COVID-19 within Black/African American and Hispanic/Latinx communities not only exacerbated inequities in chronic disease, but also underscored how longstanding inequities in health can make it more difficult for communities of color to face emerging health threats.[68]

Health Indicators

Cardiovascular Health (Hypertension, Coronary Heart Disease, and Stroke)

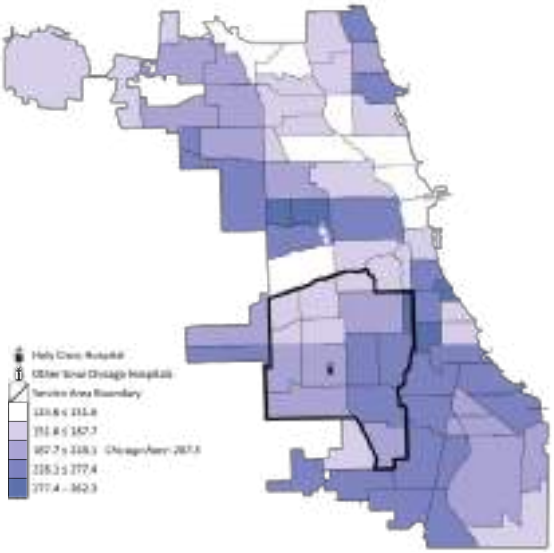
Most community areas comprising the HCH service area had higher heart disease mortality rates than the city overall (**Figure 43**). Similarly, 8 out of the 14 HCH service area communities had a higher percent of adults with hypertension than Chicago overall (**Table 42**). In Chicago-based reports, circulatory disease is the leading contributor to life expectancy gaps seen between Black/African American and white populations.[69]

Table 42. Cardiovascular health indicators in the HCH service area

Cardiovascular health	Chicago	HCH service area (median & range)
Adults with hypertension [a]	32%	36% (20% - 67%)
Coronary heart disease mortality rate per 100,000 total population [b, c]	100	99 (70 - 119)
Stroke mortality rate per 100,000 total population [b, c]	50	57 (41 - 82)
Heart disease mortality per 100,000 total population [b, c]	207	207 (160 - 334)

[a] *Chicago Department of Public Health, Healthy Chicago Survey (2020-21)*
[b] *Illinois Department of Public Health (2019)*
[c] *Age-adjusted rate*

Figure 43. Heart disease mortality rate per 100,000 total residents, HCH service area

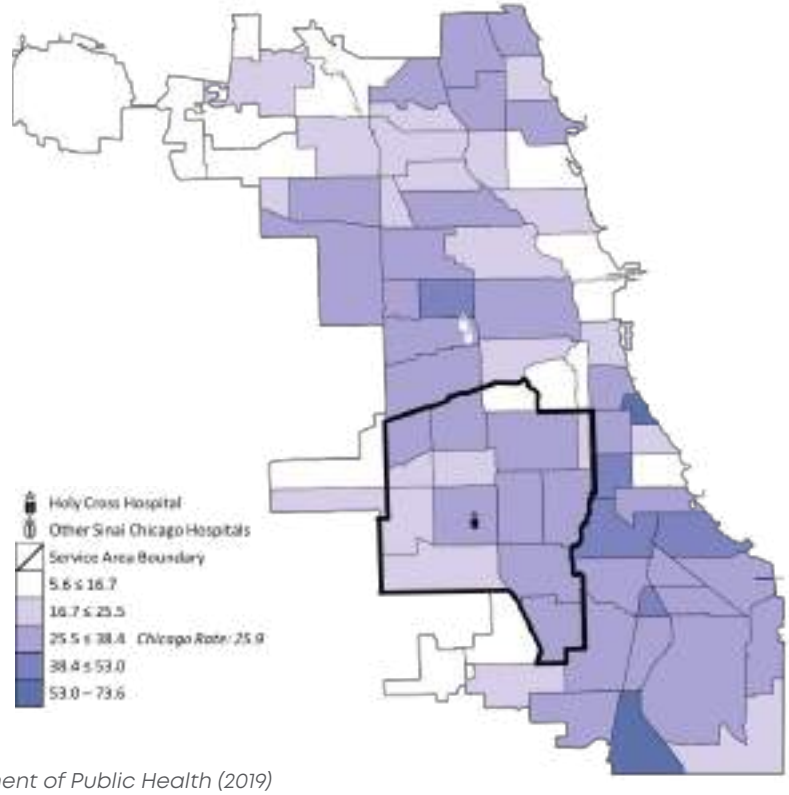


Source: Illinois Department of Public Health (2019)

Diabetes

Complications derived from unmanaged diabetes include cardiovascular disease, neuropathy, kidney disease, blindness, and lower-extremity amputations.[70] The diabetes mortality rate per 100,000 total population for the HCH service area ranged from 14.7 (McKinley Park) to 38.0 (New City — Back of the Yards) with 8 of our 14 community areas having higher mortality rates than the city overall (**Figure 44**). In a recent report, deaths due to diabetes increased by 36% between 2019 and 2020 – one of the leading non-COVID-19 related increases in death across the city.[71]

Figure 44. Diabetes mortality rate per 100,000 total residents in the HCH service area



Source: Illinois Department of Public Health (2019)

In addition, communities in the HCH service area have higher levels of diabetes-related emergency department visits per 100,000 total population, with some communities having rates two to three times higher than Chicago overall (**Figure 45**). This suggests that many in our service area face barriers to needed diagnoses and care that would help them manage their diabetes and prevent untimely emergency department visits.

Figure 45. Diabetes-related indicators in the HCH service area

Diabetes	Chicago	HCH service area (median & range)
Diabetes mortality rate per 100,000 total population [a]	26	29 (15 - 38)
Diabetes-related emergency department visits per 100,000 total residents [b]	190	307 (196 - 613)

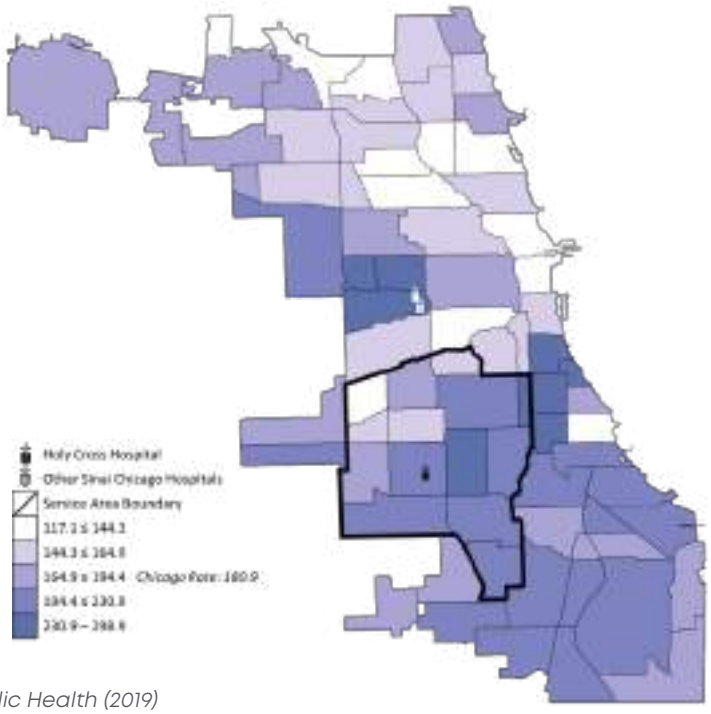
[a] *Illinois Department of Public Health, 2019*

[b] *Illinois Hospital Association, COMPdata, 2020*

Cancer

Although cancer affects individuals regardless of age, gender, race/ethnicity, and socioeconomic background, communities in the HCH service area face a disproportionate burden of diagnoses and mortality. In the HCH service area, the cancer mortality rate ranges from 131 (Archer Heights) to 289 (Fuller Park) deaths per 100,000 total population. Eight of the 14 community areas comprising the HCH service area have higher cancer mortality rates than the city overall (181 deaths per 100,000) (**Figure 46**). The HCH service area breast cancer mortality rate is slightly lower (23.3 vs 24.0 deaths per 100,000) than the citywide rate (**Table 47**).

Figure 46. Age-adjusted cancer mortality rate per 100,000 population in HCH service area



Source: Illinois Department of Public Health (2019)

Table 47. Cancer mortality rates per 100,000 total population in the HCH service area

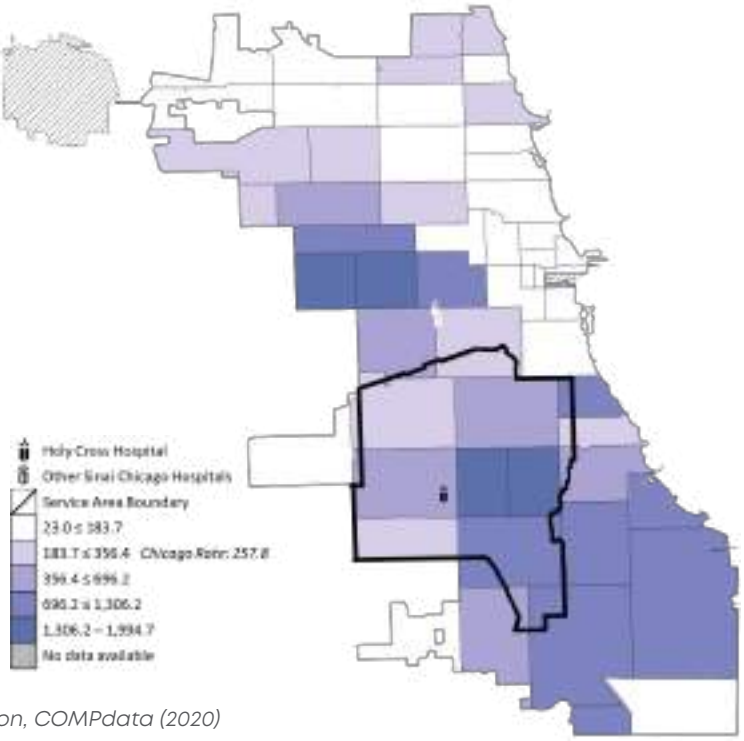
Cancer	Chicago	HCH service area (median & range)
Cancer mortality rate [a, b, d]	181	202 (131 - 289)
Breast cancer mortality rate (includes males) [c, f]	25	26 (8 - 46)
Lung, trachea, and bronchus cancer mortality rate [c, f]	806	907 (641 - 1,283)
Colorectal cancer mortality rate [a, b, d]	19	20 (12 - 30)
Cervical cancer mortality rate [a, b, d]	3	3 (0.0 - 9)
Prostate cancer mortality rate [a, b, d]	28	29 (6 - 61)

[a]*Age-Adjusted*
[b]*Rate per 100,000 total population*
[c]*Rate per 100,000 total residents*
[d]*Illinois Department of Public Health (2019)*
[e]*Chicago Department of Public Health (2018)*
[f]*Chicago Department of Public Health (2019)*

Respiratory Health

Six of the 14 community areas in HCH's service area have higher rates of asthma than Chicago overall (Chicago: 14%). The rate of asthma emergency department visits among ages 18 to 39 years per 100,000 residents ranged from 207 (60632 – Archer Heights, Brighton Park, Gage Park) to 1,995 (60636 – West Englewood) (**Figure 48**).

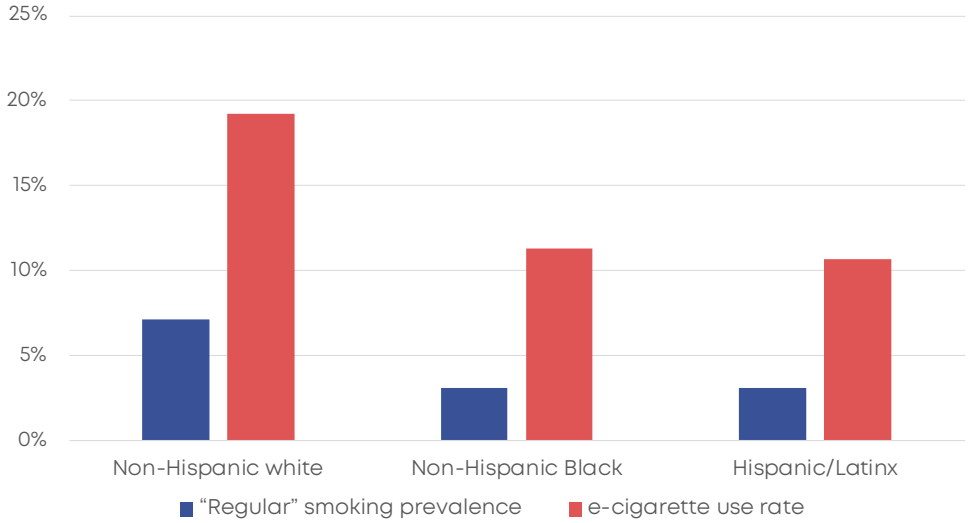
Figure 48. Asthma emergency department visits among 18- to 39-year olds per 100,000 residents in HCH service area



Source: Illinois Hospital Association, COMPdata (2020)

Adult smoking is more prevalent in 6 of the 14 community areas served by HCH than Chicago overall (Chicago: 12%). While youth smoking is lower than adult smoking, rates of e-cigarette use among youth are similar to the adult smoking rates (**Figure 49**).

Figure 49. Smoking and e-cigarette use among Chicago Public Schools (CPS) students by race/ethnicity



Source: Centers for Disease Control and Prevention, Youth Risk Behavior Survey (2019)

Table 50. Respiratory health indicators in the HCH service area

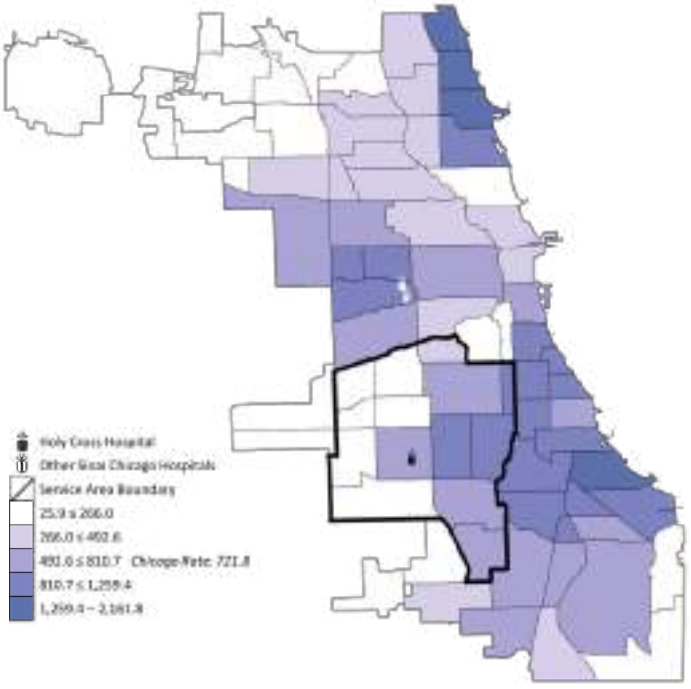
Respiratory Health	Chicago	HCH service area (median & range)
Adults with current asthma [d]	14%	17% (6% - 28%) [b]
Adults who are current smokers [d]	12%	17% (4% - 34%) [b]
Asthma emergency department visit rate (18-39 years) per 100,000 residents [h]	258 [b, c]	489 (207 - 1,995)
Adults with chronic obstructive pulmonary disease [f]	6%	6% (5% - 11%)
Tobacco-related mortality rate per 100,000 total population [a, e]	259	283 (215 - 483)
Youth e-cigarette use rate [g]	12%	***
Youth smoking rate [g]	4%	***

[a]Age-Adjusted
[b]Some community areas don't have information available
[c]Citywide rate not available, median provided instead
[d]Chicago Department of Public Health, Healthy Chicago Survey (2020-21)
[e]Illinois Department of Public Health (2019)
[f]PLACES, Behavioral Risk Factor Surveillance System (2019)
[g]Centers for Disease Control and Prevention, Youth Risk Behavior Survey (2019)
[h]Illinois Hospital Association, COMPdata (2020)
****Information is only available at the citywide level*

Infectious Disease

In 2019, the rate of newly diagnosed HIV cases in the HCH service area ranged from 11.4 (Ashburn) to 59 (Englewood) infections per 100,000 total population. HIV prevalence ranged from 140 (West Elsdon) to 1,177 (Englewood) per 100,000 total population (**Figure 51**).

Figure 51. HIV prevalence rate per 100,000 total population, HCH service area



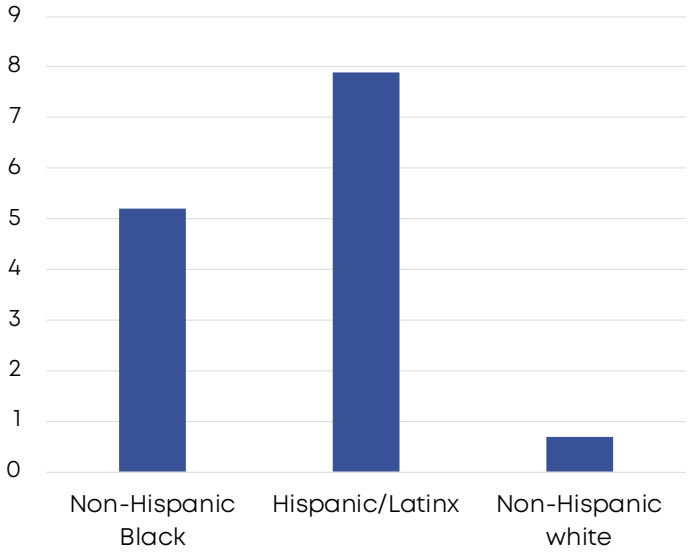
Source: Illinois Department of Public Health (2019)

Table 52. Infectious disease indicators in the HCH service area

Infectious Disease	Chicago	HCH service area (median & range)
Individuals diagnosed with chlamydia [b]	1,193	1,048 (597 – 2,396)
Individuals diagnosed with gonorrhea [b]	531	376 (129 – 1,425)
Individuals diagnosed with primary or secondary syphilis infection [c]	30	27 (0.0 – 50) [a]
Individuals newly diagnosed with HIV infection (incidence) [b]	24	27 (11 – 59) [a]
Individuals living with HIV infection (prevalence) [b]	722	408 (140 – 1,177)
HIV-related mortality rate [b]	2	***

All indicators are reported as the rate per 100,000 total population
[a]Information not available for all community areas
[b]Illinois Department of Public Health (2019)
[c]Chicago Department of Public Health (2019)
****Only citywide information available*

Figure 53. Chicago HIV-related mortality rate per 100,000 total population by race/ethnicity



Source: Illinois Department of Public Health (2019)

Community Perspectives

Among HCH service area residents who completed the AHE Community Input Survey, diabetes was ranked the fifth most important community health need and cancers were rated the 7th; however, among Hispanic/Latinx respondents, diabetes was ranked as the 3rd most important community health need. AHE Focus Group participants highlighted obesity, diabetes, hypertension, and asthma as leading community health needs.

> "Diabetes is running rampant." - AHE Focus Group Participant

Our Sinai CHNA/CHIP CAC as well as AHE Focus Group participants discussed the systemic reasons for the disproportionate burden of chronic and infectious diseases on communities of color – reflecting most often on the impact of the COVID-19 pandemic. Many noted that underlying chronic diseases which disproportionately impact Black/African American and Hispanic/Latinx populations contributed to the inequitable impact of COVID-19 within the same communities. Others highlighted how COVID-19 also exacerbated the burden of illness in Black/African American and Hispanic/Latinx communities.

> "By ignoring the history of people, and not responding to their health and medical needs, healthcare is contributing to structural racism and inequities."
> - Sinai CHNA/CHIP CAC Member

> "Unfortunately, ever since I got sick from COVID...I've had health problems, but now it's worse."
> - AHE Focus Group Participant

Across these conversations, participants pointed to interrelated behavioral factors and social determinants that contribute to chronic disease. For example, participants discussed that youth and adult inactivity stems from fewer resources such as after-school programs and gyms, as well as a lack of safe recreation spaces in divested communities – challenges that were exacerbated by the pandemic. Similarly, others discussed the lack of access to affordable and healthy food across divested communities – a situation only made worse by the economic impact of the COVID-19 pandemic.

> "Chronic health issues communities are facing come from diet and [lack of] access to healthy and affordable foods."
> - AHE Focus Group Participant

> "There ain't nothing to do around here for kids or grown-ups."
> - AHE Focus Group Participant

Asthma Home Visiting Collaborative

Sinai Chicago is one of four Illinois organizations participating in the Home Visiting Collaborative, a five-year initiative launched in 2019 by the Illinois Department of Public Health (IDPH) that provides home-based asthma management education and support. As part of this work, our community health workers (CHWs) provide home or virtual visits for children, their caregivers, and adults with uncontrolled asthma to help reduce asthma symptoms and promote overall health. The funded program serves children and adults with asthma living in high-burden areas of Illinois, collecting participant data during five standardized home visits, and ensuring participants have proper technique when taking medications.

Sinai Infectious Disease Center (SIDC)

The Sinai Infectious Disease Center (SIDC) has provided infectious disease services on Chicago's West Side for over 20 years. Our mission is to provide the highest quality care in the community for the community. Our wraparound approach means that we provide both medical and social support services, demonstrating our dedication to treating the whole person. Services are provided in the Holy Cross Hospital Infectious Disease Clinic.

Center for Diabetes and Endocrinology

The Center for Diabetes and Endocrinology provides comprehensive services to help patients with diabetes, endocrinology complaints, and weight management needs. Located at both HCH and Holy Cross Hospital, the Center's multidisciplinary teams work with patients to achieve and maintain good health and prevent short- and long-term complications by providing the knowledge, skills, and support needed for successful management of their condition. Services at the Center include but are not limited to diabetes education, weight and nutrition management, blood sugar monitoring techniques, eye examinations, medication management, and wraparound services (i.e., transportation, food access, and behavioral health referrals).

CHW Complex Care Model

Since 2019, SUHI has run an intervention for patients with complex medical and social needs, focusing on patients with multiple chronic health conditions. In the program, each patient is paired with a CHW who helps link them to appropriate health care services and connects them to programs that address social needs like housing, food access, and employment.

Health and Healing for Life (HHL)

The newly renamed program (previously called Helping Her Live) focuses on awareness and outreach around breast, cervical, and colorectal health in Chicago's West and South Side communities. HHL aims to gain control of cancer by providing Illinois residents with information and navigating them to routine screenings. With over 28,000 women educated and 5,800 mammograms performed, HHL has established itself as a model for community health care navigation. Due

to this success, HHL expanded to incorporate cervical and colorectal health services – to help all Illinois residents gain control of cancer, with the goal of eliminating the inequities that harm communities of color on Chicago's West and South Sides.

Diabetes Prevention Program (DPP)

Since 2019, Sinai Urban Health Institute's (SUHI) CHWs have trained as Diabetes Prevention Program (DPP) lifestyle coaches to provide evidence-based lifestyle change support in Sinai Chicago communities. Over the past four years, SUHI CHWs have led free, year-long educational courses for Chicago residents who have prediabetes, helping them make lifestyle changes to reduce the risk of diabetes. Participants in these courses attend a series of educational sessions in which CHWs educate, guide, and encourage participants – helping them increase physical activity levels, develop healthy eating practices, lose weight, and manage stress.

Schwab: Stroke Survivors Groups

Inpatient and outpatient stroke survivor groups are available to Schwab patients that have experienced a stroke. The groups address many challenges that come with having a stroke, including emotional and relationship issues, coping skills, risk factors, and healthy lifestyles. A key program element is the peer mentor, a former Schwab stroke patient who shares their recovery story. In addition, patients are able to access individual counseling.

Farm on Ogden: The Farm on Ogden provides the Windy City Harvest VeggieRx program. This program helps patients who are food insecure and have (or are at risk of) diet-related diseases such as cardiovascular disease. VeggieRx packages are prescribed by providers to patients, along with weekly nutrition education and cooking lessons.

Community Intervention to Reduce Cardiovascular Disease in Chicago (CIRCL-Chicago): Led by Northwestern University, CIRCL-Chicago aims to implement a community-driven intervention to address hypertension among African American adults on Chicago's South Side. The intervention will be facilitated in partnership with faith-based organizations and community health centers.

Chicago CARES to Prevent Diabetes: Led by the Centers for Disease Control and Prevention, Chicago CARES Diabetes Prevention Program is a free year-long program that provides patients with pre-diabetes education, support from peers, and weekly meetings with a trained lifestyle coach.

University of Illinois Cancer Center: The University of Illinois Cancer Center is a science-first research institution that gives every patient with cancer equal access to treatment and promising cancer therapies. Patients are also connected to the resources to understand their cancer risk, for early detection, and to obtain comprehensive treatment.

Howard Brown Health: As a leading provider in HIV/AIDS care, Howard Brown Health offers a variety of related services including, PEP, PrEP, case management, community testing sites and outreach services, linkage to care, and services for HIV positive women and youth.

Behavioral Health and Substance Use

We cannot treat the whole person without pursuing holistic mental wellbeing that considers the impact of longstanding trauma. In this priority, we will address the great burden of behavioral health and substance use disorders within our communities, providing timely and culturally sensitive care to those in need.

The legacy of historic and ongoing structural racism has led to heightened levels of trauma, behavioral health issues, and substance use throughout Chicago's Black/African American and Hispanic/Latinx communities[72] while also depriving them of needed behavioral health resources, such as crisis stabilization units, substance use services, and specialty care providers. An individual's behavioral health and wellbeing are influenced by several social and environmental factors, including financial wellbeing, the physical environment, housing access, racism and discrimination, experiences of violence, and stress. Many suffering from poorly-addressed behavioral health disorders also turn to substance use as self-medication, perpetuating a cycle of co-occurring behavioral health diseases.[73] Poor behavioral health and substance use concurrently have negative impacts on physical health. Behavioral health disorders, such as depression, are associated with higher rates of chronic disease, including heart disease, diabetes, and cancer. Further, chronic disease may intensify behavioral health disorder symptoms, causing a reinforcing cycle of poor health.

Health Indicators

Behavioral health

In the HCH service area, the rate of behavioral health emergency department visits among those aged 18 to 39 years ranged from 1,480 (60632 – Archer Heights, Brighton Park, Gage Park) to 6,517 (60621 – Englewood) per 100,000 population, compared to 2,117 in Chicago (**Figure 54**). Behavioral health hospitalization rates and suicide mortality rates were also elevated in many HCH service area communities.

Figure 54. Behavioral health indicators in the HCH service area

Behavioral health	Chicago	HCH service area (median & range)
Depression prevalence in adults [b]	18%	18% (16% - 19%) [f]
Poor self-reported behavioral health [b]	15%	17% (14% - 21%) [f]
Suicide and self-injury emergency department visit rate [a, c]	19 [e]	17 (11 – 48)
Behavioral health emergency department visit rate among young adults (ages 18-39) [a, c]	2,117 [e]	2,294 (1,481 – 6,517)
Behavioral health hospitalization rate among young adults (ages 18-39) [a, c]	694 [e]	808 (394 – 2,886)
Suicide mortality rate [a, d]	8	7 (0 – 15) [f]

[a] *Per 100,000 Population*
[b] *PLACES (2019)*
[c] *Illinois Hospital Association, COMPdata (2020)*
[d] *Chicago Department of Public Health (2019)*
[e] *Median reported as citywide rate is unavailable*
[f] *Data for Cicero (60804) not available*

Many adults with current behavioral health disorders had symptoms during childhood and adolescence that were often overlooked or left untreated. For others, experiences such as bullying lead to behavioral health disorders. While unavailable at the community level, the figures below summarize citywide behavioral health information for youth overall and by race/ethnicity. As HCH predominantly services Black/African American and Hispanic/Latinx patients, it is important to note these inequities in youth outcomes.

Figure 55. Behavioral health indicators among Chicago Public Schools (CPS) students by race/ethnicity

Behavioral health in Youth	Chicago Overall	Non-Hispanic Black	Hispanic/ Latinx	Non-Hispanic White
Bullying[a]	12%	9%	13%	12%
Youth depression rate[b]	38%	37%	43%	27%
Suicide attempt rate[c]	3%	3%	4%	**

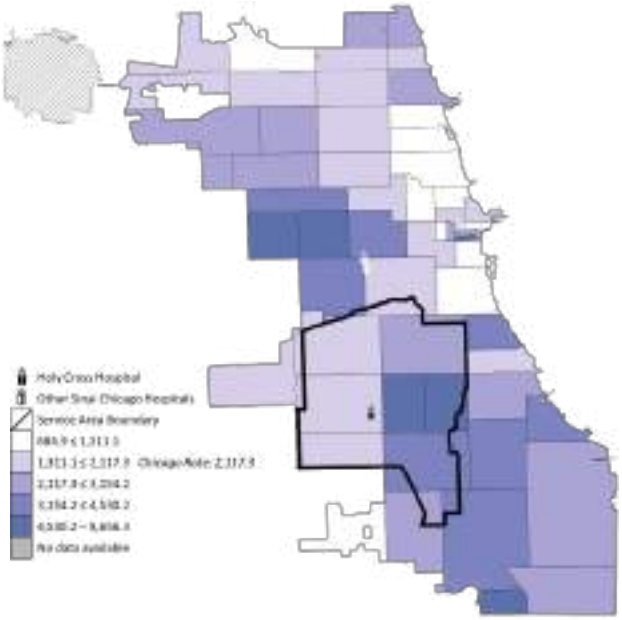
***Data for this group is not available*
Source: Centers of Disease Control and Prevention, Youth Risk Behavior Survey (2019)
Bullying: Percent of CPS high school students who report being bullied on school property in the past 12 months.
Depression rate: Percent of CPS high school students who report feeling sad or hopeless almost every day for two weeks or more in a row and this has impacted usual activities.
Suicide attempts: Percent of CPS high school students who attempted suicide and resulted in an injury, poisoning, or overdose that needed to be treated by a doctor or nurse

Figure 56. Behavioral health hospitalization and emergency department visit rates among youth (aged 5 to 17 years), HCH service area

Behavioral health in Youth	Chicago[a]	HCH service area (median & range)
Behavioral health emergency department visit rate among juveniles (ages 5-17) per 100,000 visits	901[b]	889 (640 – 1,453)
Behavioral health hospitalization rate among juveniles (ages 5-17) per 100,000 visits	487[b]	694 (367 – 1,144)

Source: Illinois Hospital Association, COMPdata (2020)
[a] Median reported as citywide rate is unavailable
[b] Data for all zip codes not available

Figure 57. Behavioral health emergency department visit rate (among 18- to 39-year-olds) per 100,000, HCH service area



Source: Illinois Hospital Association, COMPdata (2020)

Substance Use

Across metrics documenting the severity of substance use disorders, many HCH communities fared worse than Chicago overall. For example, the substance use emergency department visit rate among young adults was over two times higher in some HCH communities than Chicago overall, and the drug overdose mortality rate was over three times higher than the Chicago rate in HCH's most impacted community.

Figure 58. Substance use related indicators for HCH service area

Substance Uce	Chicago	HCH Service Area (Median & Range)
Substance use emergency department visit rate among young adults (ages 18-39) [a]	1,118 [b]	1,097 (729 – 2,912)
Substance use hospitalization rate among young adults (ages 18-39) [a]	684 [b]	344 (247 – 633)
Drug overdose mortality rate [c, d]	26	25 (8 – 77)[f]
Alcohol-use hospitalization rate among young adults (ages 18-39) [a]	184 [b]	184 (134 – 240)
Alcohol-induced mortality rate [d, f]	9	9 (2 – 17)[e]
Youth binge drinking rate [g]	8%	***

All indicators are reported as the rate per 100,000 population

[a] *Illinois Department of Public Health (2019)*

[b] *Chicago Department of Public Health (2019)*

[c] *Centers of Disease Control and Prevention, Youth Risk Behavior Survey (2019)*

[d] *Illinois Hospital Association, COMPdata (2020)*

[e] *Median reported as citywide rate is unavailable*

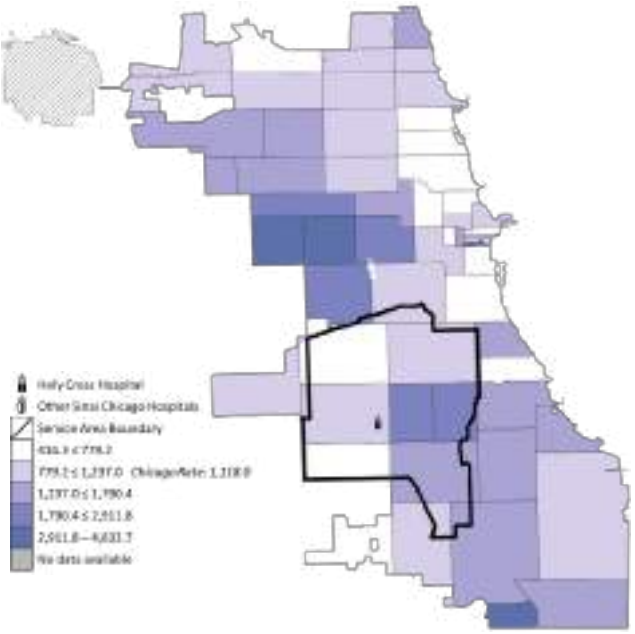
[f] *Data for Cicero (60804) not available*

[g] *Age-adjusted*

****Only citywide level data available*

In the HCH service area, the rate of emergency department visits due to substance use among those aged 18 to 39 years ranged from 729 (60632 – Archer Heights, Brighton Park, Gage Park) to 2,912 (60621 – Englewood) per 100,000 total population (**Figure 59**).

Figure 59. Substance use emergency department visit rate among 18 to 39 year olds per 100,000 population, HCH service area



Source: Illinois Hospital Association, COMPdata (2020)

Community Perspectives

Among HCH service area residents completing the AHE Community Input Survey, behavioral health was ranked the most important community health need and substance use disorders were ranked 10th. Behavioral health was ranked first by Black/African American and Hispanic/Latinx respondents, and forth by white respondents. As a top community health need, our Sinai CHNA/CHIP CAC members and AHE Focus Group participants had extensive discussion around the causes and impacts of heightened behavioral health needs in divested communities as well as potential solutions. Many discussed intergenerational trauma within Black/African American and Hispanic/Latinx communities on account of social and economic challenges stemming from structural racism.

> "For example, the interaction between ways that walking through vacant streets impacts mental wellbeing." - Sinai CHNA/CHIP CAC Member

Focusing on solutions, participants discussed the need for additional community resources to address behavioral health and substance use disorders and services that help individuals integrate back into community. Many explained how resources were scarce before the pandemic, but several became unavailable and/or went completely online during the pandemic. Our CAC stressed the importance of healthcare systems investing more resources into behavioral health interventions. They called for healthcare systems to increase awareness and to create culturally relevant interventions for behavioral health services.

> "The more money you have, the easier it is to get help."
> - AHE Focus Group Participant

> "Some clinics here only prescribe drugs but not treat the whole person."
> - AHE Focus Group Participant

Many also expressed the need for community education and information on how to respond to behavioral health crises and overdoses, how to recognize signs of behavioral health issues and substance use, and specific information on supporting groups such as children, adolescents, and older adults.

> "Awareness and education surrounding mental illness, so people can better help when it comes to deescalating a crisis."
> - AHE Focus Group Participant

Addressing stigma among individuals, communities, and healthcare providers was also discussed as a consideration for any solutions. Many discussed negative experiences with providers and suggested improved training around behavioral health and substance use stigma as possible solutions.

"Because Behavioral health is an invisible disability, others may question the legitimacy of mental illness as something that affects individuals' lives."
- AHE Focus Group Participant

"Get more people out to community outreach, resources, education, local community health workers." - AHE Focus Group Participant

Cook County Health and Hospital System Behavioral Health Consortium

Since 2018, Sinai Chicago has participated in the Cook County Health and Hospital System Behavioral Health Consortium (BHC), a group of behavioral health and substance use treatment providers across Cook County. The BHC allows around-the-clock access to a single point of contact for behavioral health and substance use services. After intake, patients can be scheduled to receive services at Sinai Chicago or another BHC site. Sinai Chicago social workers and case managers also have referral relationships through the BHC that give patients access to behavioral health and substance use services outside Sinai Chicago.

Illinois Department of Human Services – Opioid Hospital Screening and Warm Handoff Grant

In 2019, Sinai Chicago was awarded a grant from the Illinois Department of Human Services to develop and pilot a Digital Recovery Support Toolkit to support people in long-term recovery from opioid use disorders. As part of the program, providers will meet regularly with a digital champion to review and improve online digital support recovery tools and create a campaign focused on creating and sharing appropriate digital content with clients recovering from opioid use disorder.

Medical Legal Partnership

Sinai Chicago's Under the Rainbow clinic provides outpatient behavioral health services for children and adolescents, including therapy, psychiatry, and case management. Since 2016, Legal Counsel for Health Justice has partnered with Under the Rainbow to provide in-clinic legal services to families and children through the Medical Legal Partnership (MLP). Many MLP clients have experienced trauma as the result of a crime. Through the MLP, a lawyer is regularly available in the clinic (2.5 days/week) to consult with clinicians and clients and to determine the best legal course of action.

Trauma-informed Centers of Care (TICC)

In 2020, Sinai Chicago received funds for the Trauma-Informed Centers of Care program with the Chicago Department of Public Health (CDPH) to expand access to high-quality, trauma-informed behavioral health services in communities of high need.

Thresholds: Thresholds provides services and resources for individuals with serious mental illnesses and substance use disorders. They provide a variety of programs, including substance use treatment, intensive outreach for behavioral health, integrated primary and behavioral health care, justice program, deaf program, and housing and homelessness.

St. Bernard Hospital and Health Care Center (St. Bernard): St. Bernard addresses the impact of behavioral health by offering a suite of services, including a partial hospitalization program, inpatient adult crisis stabilization unit, and outpatient services that leverages a trauma-informed approach. St. Bernard also provides psychotherapy services, psychological evaluations, and a detox program.

Pilsen Wellness Center, Inc.: The Pilsen Wellness Center, Inc. has expanded its original behavioral health programming to include treatment for substance use disorder and HIV prevention services, as well as alternative secondary education. With 15 programming sites located in communities with predominately Hispanic/Latinx residents in the Chicagoland area, it remains one of the few community-based, human services organization with a 70 percent bilingual and bicultural staff.

Looking Forward

Our 2022 Holy Cross Hospital Community Health Needs Assessment (CHNA) provides an overview of the most pressing health needs within the communities we serve. Looking forward, we will use the information from this and our other hospital CHNAs (Mount Sinai Hospital and Schwab Rehabilitation), conversations with Sinai Chicago team members, and guidance from our Sinai CHNA/CHIP Community Advisory and Executive Leadership Committees to develop our 2022 Community Health Improvement Plan (CHIP). Our 2022 CHIP will be a three-year, system-wide plan to address the Community Health Priorities identified in this CHNA. The CHIP will be integrated into our overarching strategic directions, hospital programs, and collaborative efforts with communities and partners and aims to build synergy and coordination between Sinai Chicago and the communities we serve in a collective effort to improve community health.

To ensure continuity and momentum, the 2022 Sinai Chicago CHIP will update and expand upon existing strategies outlined in our 2019 CHIP across our Community Health Priorities (Social Determinants of Health, Community Safety, Equitable Health Care Across the Lifespan, Chronic and Infectious Disease, and Behavioral health and Substance use). The CHIP will include performance indicators that allow us to track our progress and facilitate accountability.

Most importantly, Sinai Chicago's 2022 CHIP will continue our efforts to address the injustices and structural racism faced by the communities we serve in partnership with residents, leaders, local organizations, and many others. We focused our CHNA on gaining a deeper understanding of the role that structural racism plays in creating and perpetuating racial and ethnic health inequities across our service area. We are confident that taking this approach will help ground our 2022 CHIP in anti-racist action. Our 2022 CHIP will share the ways in which we as a healthcare system aim to address structural racism through our own policies and activities. It is our commitment over the next three years to continue to address structural inequities and racism and improve health equity on the West and Southwest Sides of Chicago.

Sinai Chicago 2022 CHNA – References List

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