



# Mount Sinai Hospital

## 2019 Community Health Needs Assessment



# Mount Sinai Hospital 2019 Community Health Needs Assessment

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## One with Our Communities

This year, Sinai Health System (SHS) celebrates 100 years of serving our community. Reflecting on this history, we are pleased to release our 2019 Community Health Needs Assessment, which outlines our priorities for improving community health in the coming years.

SHS 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 – Mount Sinai Hospital (MSH), Sinai Children's Hospital (within MSH), 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.

The SHS service area largely comprises communities of color that face historic disinvestment and marginalization, oftentimes due to racist policies and practices. This history has resulted in staggering differences in health between the communities we serve and our well-resourced neighbors. As a longstanding health care system, we also understand the incredible resilience of the people and organizations within our communities. We know that despite the immense challenges, these groups continue to address housing and economic inequities, mend the fractures, and grow their communities in an effort to make them whole, thriving places of wellness, where everyone has the opportunity to flourish.

The following report highlights the many challenges faced within our communities. Tackling these challenges and pursuing wellness for all is not an easy task, but our system has pursued this endeavor alongside our community partners for the past 100 years. Looking forward, we reiterate our commitment to this effort, and strive to strengthen our work to build thriving communities and individuals.

We see this Community Health Needs Assessment and subsequent Community Health Improvement Plan as our commitment to work with community residents and organizations as resilient partners, fighting back against injustices which threaten the overall wellbeing of those we serve. We focus this assessment and our improvement plan around treating the whole person, across the whole lifespan, within whole communities. We focus on the whole because no one can reach complete wellbeing if we only treat one part. As we work to pursue this wholeness, we also recognize that our City too must be made whole. Chicago cannot flourish and thrive when many of its communities are left out.

When we treat the whole person, we not only consider their physical wellness and absence of disease, but also their psychological, social, and spiritual wellbeing. When we provide care across the whole lifespan, we consider unique approaches to addressing health issues from



We focus on treating the **whole person, across the whole lifespan, within whole communities.** We focus on the whole because no one can reach complete wellbeing if we only treat one part.

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infancy to adolescence to middle age to seniorhood. Underlying these efforts is our commitment to working with residents and local partners to build whole communities – to find innovative and multi-faceted solutions that end community violence, to ensure that affordable and nutritious food is accessible to all, to dismantle unjust policies that disproportionately incarcerate fathers, brothers, and sons.

The CHNA is our first step to identifying the ways we seek to treat the whole person, across the whole lifespan, within whole communities. While the challenges are great, we will not stand down in this time of need. We will work alongside our communities to treat, heal, grow, and ensure that all are made whole, and that all can thrive in wellness.

#### **Sinai Health System's 2019 Community Health Improvement Priorities**



To achieve these aims, we will focus our efforts in five key areas. First and foremost, we will leverage our community and professional partnerships to collaboratively address the social determinants of health, such as financial security and economic opportunity, healthy food access and affordability, and freedom from injustice. Second and related to our first aim, we will seek out multi-sector solutions that create safe communities, free from violence, and also address the trauma caused by past violence. Third, we will ensure that quality, age- and ability-appropriate health care is accessible to all, regardless of race, ethnicity, zip code, income, involvement with the justice system, gender identity, sexual orientation, or citizenship status. Fourth, we will work to prevent the onset of infectious and chronic disease, and provide excellence in care when community members fall ill. Fifth, we will ensure we treat the whole person by focusing on mental health and substance use disorders, providing timely and culturally sensitive care to those in need.

It is with these priorities in mind that we will enter the coming years, dedicated to pursuing community wellbeing and wholeness. We would like to acknowledge and thank each and every contributor to the development of these priorities. In particular, we would like to thank Sinai leadership and caregivers as well as the Alliance for Health Equity. Most importantly, we thank the community members themselves. It is to you that we dedicate this Community Health Needs Assessment and subsequent Community Health Improvement Plan. Without you, Sinai Health System would not be here. It is our great honor to serve you and stand alongside you in the fight for a better, more just future.

**Karen Teitelbaum**

President and Chief Executive Officer of Sinai Health System

# Sinai Health System

Sinai Health System (SHS) is a safety net health care system that provides services to all, regardless of insurance or citizenship status. Founded 100 years ago on the West and Southwest Sides of Chicago, SHS originally provided care to Eastern European Jewish immigrants. Today we serve predominantly Non-Hispanic Black and Hispanic/Latinx communities. As a national model of an urban health care delivery system, SHS is devoted to making a positive difference in the lives of the people in the communities we serve.



## Mission, Vision, and Values

The mission, vision, and values of SHS guide our work to provide care and services to diverse communities and to improve overall health and wellbeing.

### *Mission*

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

### *Vision*

Sinai Health System 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.

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

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

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

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

## Sinai Health System Member Institutions

SHS comprises seven member institutions: Mount Sinai Hospital (MSH), Holy Cross Hospital (HCH), Schwab Rehabilitation (Schwab), Sinai Children's Hospital (SCH), Sinai Community Institute (SCI), Sinai Medical Group (SMG), and Sinai Urban Health Institute (SUHI).

Our member institutions provide a full range of high quality outpatient and inpatient services, and a variety of innovative, community- and data-driven health, research, and social service programs. SHS caregivers deliver a wealth of knowledge, expertise, and passion to improve the lives of the more than 1.5 million people living in our diverse service area and are dedicated to building stronger, healthier communities.

### Sinai Health System

- ❖ Mount Sinai Hospital (MSH)
- ❖ Holy Cross Hospital (HCH)
- ❖ Schwab Rehabilitation (Schwab)
- ❖ Sinai Children's Hospital (SCH)
- ❖ Sinai Community Institute (SCI)
- ❖ Sinai Medical Group (SMG)
- ❖ Sinai Urban Health Institute (SUHI)

#### ❖ *Mount Sinai Hospital*

Located on Chicago's West Side, MSH has 288 licensed beds and provides an array of medical, surgical, pharmaceutical, behavioral health, and diagnostic services. MSH is a level 1 trauma center and provides care to 44,000 emergency department and 2,400 trauma patients annually. As a teaching hospital, MSH trains more than 700 health care professionals each year. MSH is accredited by the Joint Commission and received the Joint Commission's "Gold Seal of Approval."

#### ❖ *Holy Cross Hospital*

Joining SHS in 2012, HCH is a 264-licensed bed community hospital located on Chicago's Southwest Side. HCH receives more ambulance visits than any other hospital in Illinois. In 2017, HCH saw more than 48,000 emergency department visits and 9,500 hospital admissions. HCH is accredited by the Health Facilities Accreditation Program and is Primary Stroke Certified.

#### ❖ *Schwab Rehabilitation*

Located on Chicago's West Side, Schwab provides comprehensive inpatient and outpatient rehabilitation services to adults and children and is one of only two free-standing rehabilitation hospitals in Chicago. Schwab offers a unique environment that features 102 licensed beds, 7 treatment gyms with state-of-the-art equipment, and an award-winning therapeutic rooftop garden. Schwab maintains community affiliations with the University of Chicago Pritzker School of Medicine and the University of Illinois. In 2017, Schwab was ranked 11 of 84 hospitals for its residency program in physical medicine and rehabilitation by Doximity (an online professional network for U.S. physicians). It is accredited by the Joint Commission, with its teaching program accredited by the Accreditation Council for Graduate School Medicine.

Patient services include: general rehabilitation, kids rehabilitation, orthotics and prosthetics, pain management, spinal cord injury, stroke, and a sub-acute care center. Levels of care include: inpatient acute rehabilitation, sub-acute rehabilitation, and specialized physician clinics and therapy services.

#### ❖ *Sinai Children's Hospital*

Located in MSH on Chicago's West Side, SCH provides the highest level of neonatal care (level III neonatal intensive care unit). SCH offers an array of outpatient pediatric care, including specialties such as pediatric surgery and anesthesiology, gastroenterology, hematology, endocrinology, and neurology. Other pediatric specialties include cardiology, infectious disease, and neonatology. SCH also offers a variety of support services, such as HIV/AIDS programming and pediatric weight management.

#### ❖ *Sinai Community Institute*

SCI provides comprehensive and individualized health and human services to address social and economic barriers to health. SCI's portfolio includes a variety of programs that serve over 14,000 clients of all ages each year. Programs include Workforce Development, Sinai Technology Center, Sinai Adult Protective Services, Early Childhood Development Program, and Learn Together Afterschool Program.

#### ❖ *Sinai Medical Group*

SMG comprises 18 clinical sites located on Chicago's West and Southwest Sides. SMG has more than 300 health care providers dedicated to offering high quality primary care and specialty care across 40 specialties.

#### ❖ *Sinai Urban Health Institute*

SUHI is the nationally-recognized community research center of SHS. With its epidemiologists, public health professionals, and community health workers, SUHI is devoted to improving health through community partnership, data-driven research, and health interventions. From its Community Health Survey to its community health worker model, SUHI works on an array of research projects that are emulated across the country.

### **Mount Sinai Hospital Community Benefits**

In 2018, MSH provided \$34.6 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 \$23.9 million of total community benefits. These benefits provide support to community programs and initiatives that improve overall community health.





## Alliance for Health Equity

The Alliance for Health Equity (Alliance) is a collaboration of 37 hospitals, 3 health departments, and community-based organizations working to improve health equity, wellness, and quality of life across 77 Chicago community areas and 125 Cook County suburban municipalities. The Illinois Public Health Institute (IPHI) serves as the Alliance's backbone organization. The purpose of the Alliance 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.

As part of its work to improve community health, the Alliance conducts a collaborative county and citywide Community Health Needs Assessment (CHNA). The 2019 CHNA is the second consecutive collaborative CHNA in Cook County and Chicago, and was intentionally built on the success of previous efforts, including the 2016 collaborative CHNA, Healthy Chicago 2.0 (2016), and Cook County WePLAN (2016). The Alliance worked closely with its Steering Committee and the City and County health departments to compile, design, and create the CHNA to meet regulatory requirements for nonprofit hospitals.

### Alliance for Health Equity Structure and Shared Leadership

The Alliance convenes a Steering Committee and several workgroups and committees working on implementation approaches to address community health priorities (see Figure 1 in the Alliance Collaborative CHNA Report at [allhealthequity.org/2019-chna-reports/](http://allhealthequity.org/2019-chna-reports/)). Sinai Health System (SHS) is an active member of the Alliance, with hospital representatives across workgroups and committees, most notably the Steering Committee, Policy Committee, and CHNA Committee. Through this membership, SHS contributors collaborated with Alliance partners to: 1) design, implement, and guide the CHNA approach; 2) identify, interpret, assess, and analyze primary and secondary data; and 3) identify, review, and prioritize community health issues. Participating in the Alliance's collaborative CHNA was critical to the determination of Mount Sinai Hospital's (MSH) own health priorities.

### Collaborative Assessment Model and Process

The Alliance worked with its Steering and CHNA Committees to design and facilitate a collaborative, community-engaged CHNA between March 2018 and March 2019. 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 Alliance's approach are outlined in the Alliance Collaborative CHNA Report located at [allhealthequity.org/2019-chna-reports/](http://allhealthequity.org/2019-chna-reports/). In short, the Alliance adapted the Mobilizing for Action through Planning and Partnerships framework.

# CHNA Methodology

## Primary and Secondary Data Collection – Alliance Collaborative CHNA Report

The Alliance collected primary data via four methods: 1) a 16-question community input survey administered to over 5,900 adults aged 18 and over; 2) 27 community resident focus groups and 22 learning map sessions; 3) three health care and social service provider focus groups; and, 4) two stakeholder assessments (Forces of Change and Health Equity Capacity Assessments) led by partner health departments.

Alliance partners and stakeholders identified, gathered, and analyzed secondary data from a variety of sources. The data was organized into six categories: social and structural determinants of health, physical environment, health behaviors, health care and clinical care, behavioral health (mental health and substance use disorders), and health outcomes (birth outcomes, morbidity, and mortality).

For complete information about the Alliance, the collaborative CHNA process, and data collection, see the Collaborative CHNA Report at [alltheequity.org/2019-chna-reports/](http://alltheequity.org/2019-chna-reports/).

## Mount Sinai Hospital CHNA Methodology

To understand the health of the communities served by Mount Sinai Hospital (MSH), we leveraged the primary and secondary data gathered by the Alliance and its partners as well as data from MSH's 2016 CHNA. We compiled data at the community area level to assess the unique health needs of the diverse populations living in MSH's service area.

## SHS CHNA Oversight

A Sinai Health System (SHS) Executive Advisory Board comprising 11 members of SHS leadership oversaw the hospital-specific CHNAs, ongoing system-wide CHNA activities and priorities, and the strategic approach for developing the subsequent Community Health Improvement Plan (CHIP). The Executive Advisory Board met to confirm the health priorities resulting from this CHNA in June 2019.

The Executive Advisory Board includes: Dr. Airica Steed, Executive Vice President and Chief Operating Officer; Laurie Hernandez, SHS Board of Directors; Roberta Rakove, Senior Vice President of Government Affairs; Dr. Sharon Homan, President of Sinai Urban Health Institute; Dan Regan, Director of Communications and Public Relations; Dr. Michelle Gittler, Director of Schwab Rehabilitation; Sallie Hazelrigg, Chief Development Officer; Dr. Maria Iliescu, Chief Medical Officer; Karen Janousek, Chief Population and Growth Officer; Edward Carne, President of Sinai Medical Group; and, Debra Wesley, President of Sinai Community Institute.

In addition, we convened three Hospital CHNA Committees (one each for Holy Cross Hospital, MSH, and Schwab Rehabilitation) to provide specific guidance on the development of hospital

priorities. The Hospital CHNA Committees each convened once during the development of the CHNA and reviewed and ranked health needs by priority for each hospital using a multi-voting approach. The committees included about 10 caregivers (i.e., staff members), with at least one hospital representative who leads community engagement efforts.

MSH's CHNA Committee representatives included: Eric Lenzo, Executive Director of Behavioral Health; Raquel Prendkowski, System Director of the Emergency Department (ED); Karen Skeens, ED Registered Nurse; Raul Garcia, Director of Diversity and Community Relations; Stewart Thomas, System Manager of Cardiology and Radiology; Rosanelly Garcia, Emergency Department/ED Social Worker; Kimberly Ramirez, Infectious Disease Program Manager; Steve Foley, WIC Director; Lisa Szafranowski, Diabetes Educator; and Claude Hall, Director of Grants and Strategy.

## Health Need Identification and Prioritization

We identified a comprehensive list of health needs for MSH's service area by aligning priority health needs from the 2019 Alliance Collaborative CHNA Report with findings from MSH's 2016 CHNA report. The process for identifying priority health needs in the 2019 Alliance CHNA is outlined at [allhealthequity.org/2019-chna-reports/](https://allhealthequity.org/2019-chna-reports/).

The MSH CHNA Committee prioritized the hospital's health needs using a multi-voting approach and the following criteria: 1) the magnitude and seriousness of the health problem; 2) the reoccurrence of a health issue from MSH's 2016 CHNA; 3) the prioritization of health issues by community members (from community input data); and, 4) the changeability of the health problem. Using these criteria, MSH's CHNA Committee determined a list of health needs organized from highest to lowest priority. The outputs of this activity were reviewed with the SHS Executive Board, which finalized the health priorities highlighted in this CHNA report. A summary of each health need can be found in the **Community Health Needs** section.

## Gaps in Data Collection and Challenges

Although we gathered extensive data and input from the communities we serve, there are some limitations and challenges to consider. First, there is often a lag in population health data availability, such as individual poverty rates. Therefore, many data within this report represent timeframes prior to 2019. In addition, we used data available at various geographic levels (e.g., census tract, zip code, community area). Doing so may make it difficult to compare indicators representing different geographic levels. Lastly, while the Alliance conducted various activities focused on collecting primary data from community members, it is important to note that qualitative data only reflects the viewpoints of those community members who attended and participated in community input surveys and focus groups.

# Mount Sinai Hospital Progress Since 2016

Mount Sinai Hospital's (MSH) 2016 Community Health Needs Assessment (CHNA) prioritized five key areas over the past three years. While not comprehensive, the list below highlights the key efforts taken by MSH and Sinai Health System (SHS) since 2016 to improve community health. Activities focused on improving care for those suffering from disease as well as primary prevention.

## Chronic Disease (including heart disease, diabetes, and stroke)

### *Cardiovascular Health in Heart Failure Patients*

- In 2019, SHS began working with other Chicago-area hospitals and the American Heart Association in an effort to improve the cardiovascular health of heart failure patients. The partners will work together to create standard process guidelines for working with heart failure patients. Some of the processes include creating medication checklists, getting patients timely appointments, ensuring that patients understand their condition and care, and creating standard discharge algorithms that address physical and emotional health.

### *Chicago Quits*

- In 2017, Sinai Urban Health Institute (SUHI) partnered with the Respiratory Health Association and the Chicago Department of Public Health (CDPH) as part of Chicago Quits, a program that aims to bring smoking cessation services to the Chicago communities most affected by tobacco use. As part of this initiative, SUHI is providing two programs: (1) the Courage to Quit Adult Smoking Cessation Program, an evidence-based tobacco treatment program providing information, support, and skills to help participants quit tobacco use; and (2) the Counsel to Quit Brief Clinical Tobacco Intervention, which aims to identify tobacco users, encourage them to quit, and provide referrals to tobacco cessation resources.

### *Controlling Hyperglycemia Among Minority Patients*

- In 2016, SUHI began recruiting diabetic patients from Mount Sinai Hospital (MSH), Holy Cross Hospital (HCH), and Sinai Medical Group (SMG) outpatient clinics to test whether providing them with diabetes-related text messages or home visits from a CHW in addition to usual care improved diabetes outcomes. At the end of the study, participants in the usual care group were more likely to have a higher (worse) HbA1c level than when they started than participants in the CHW group that completed all of the home visits. Participants in the CHW group were more likely than those in the text message group to be very satisfied with the program.

### *Development and Pilot of Complex Care Model*

- In 2018, SUHI began 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 community health worker (CHW) who helps link them to appropriate health care services and connect them to programs and services that address social needs like housing, food access, and employment.

### *Diabetes Health Education and Lifestyle Program*

- Sinai Community Institute (SCI) offers Diabetes Health Education and Lifestyle Program (HELP) to diabetic patients. As part of the program, patients receive education about: meal planning and lifestyle changes; medications and how to use them; and preventing complications. Patients are also invited to schedule individual consultations with a registered dietician or nurse.

### *Diabetes Prevention Program Implementation*

- In 2018, SUHI, in partnership with CDPH and the Illinois Public Health Institute (IPHI), was funded by the Centers for Disease Control and Prevention (CDC) to develop the Chicago Collaboration to Advance Reach, Equity, and Systems (CARES) to Prevent Diabetes. As part of this project, SUHI will participate in a collaborative of health care providers, CHWs, researchers, and other experts working to reduce disparities in diabetes outcomes. In addition, SUHI's CHWs were trained as Diabetes Prevention Program (DPP) lifestyle coaches in early 2019 to provide evidence-based lifestyle change support in SHS communities.

### *Mobile Retinal Exam Program*

- Sinai's Mobile Retinal Exam Program is available at a variety of SMG clinics every month. As part of the program, patients can receive their required annual diabetic eye exam sooner and without visiting a separate location. Photos taken at the mobile exam site are reviewed by ophthalmologists and patients are contacted for follow-up exams as necessary.

### *Sinai Wearable Device Pilot*

- Early in 2018, SHS undertook a pilot quality improvement project at five SMG clinics that serve diabetic patients. Through the program, participants wore continuous glucose monitoring devices and reviewed readings with their provider. In addition, a CHW completed two home visits and provided education and referrals to patients and their families to help manage their diabetes and social needs.

## **Birth Outcomes**

### *Family Case Management and Better Birth 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.

## **Asthma**

### *Asthma CarePartners*

- Since 2011, SHS has partnered with insurance and managed care organizations to provide asthma interventions to their participants, including a new partnership in 2017. In these interventions, CHWs conduct home visits with participants to provide asthma education, perform home environmental assessments, and provide medical device training. Past program participants have seen improvement in outcomes such as health resource use, asthma control, and others.

### *Center for CHW Research, Outcomes, and Workforce Development*

- In 2017, SUHI established the Center for CHW Research, Outcomes, and Workforce Development (CROWD) in response to the growing demand for CHW training and technical consulting throughout the Midwest. CROWD provides general core skills, basics of chronic disease, and other trainings to CHWs, as well as disease-specific trainings in asthma, diabetes, and breast health. In addition to CHW training, CROWD provides hiring, consulting, and evaluation services to their clients. SUHI CHWs are also available to provide interventions directly to their clients' patients.

## **Mental and Behavioral Health**

### *Cook County Health and Hospital System Behavioral Health Consortium*

- In 2018, SHS joined the Cook County Health and Hospital System (CCHHS) 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 completing intake, patients can be scheduled to receive services at SHS or another BHC site. SHS social workers and case managers also have referral relationships through the BHC that give patients access to behavioral health and substance use services outside SHS.

### *Illinois Department of Human Services – Digital Toolkit Recovery Support*

- In 2019, SHS was awarded a grant from the Illinois Department of Human Services (IDHS) to develop and pilot a Digital Recovery Support Toolkit that will 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.

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

- In 2019, SHS received a two-year grant from IDHS for the Coordinating Comprehensive Services for Opioid Use Disorder in Westside Chicago Communities project. Through the program, MSH will collaborate with Federally Qualified Health Center partners to provide services and referrals to patients with opioid use disorders that need treatment after a hospital visit.

### *Medical Legal Partnership*

- The SHS Under the Rainbow clinic provides outpatient behavioral health services for children and adolescents, including therapy, psychiatry, and case management. In early 2016, Legal Council for Health Justice 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.

### *Transition of Care*

- SHS is home to four certified mental health outpatient clinics that serve children, adolescents, and adults, as well as 52 beds for acute adult inpatient psychiatric care at MSH and HCH. Providers from the Department of Psychiatry and Behavioral Health (SPBH) also provide consultations to patients hospitalized for other conditions. In 2018, SHS launched a transition of care program for patients admitted to inpatient psychiatric care. Since the program launched, the outpatient appointment attendance rate has improved by nearly 20%.

### *SAMHSA Mental Health Awareness Training Grant*

- In 2018, SHS was awarded a three-year training grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for the Promoting Awareness of Mental Health in Chicago's Underserved Communities (PAMH) program. PAMH is a train-the-trainer program that works to increase awareness of mental health among teachers and other school personnel, parents, and community leaders that may come into contact with people with serious mental illness or serious emotional disturbance.

## **Violence**

### *Chicago Gun Violence Research Collaborative*

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

### *ConnectED Project*

- MSH is a part of a network of hospitals, CDPH, and health and human service partners working to connect the health care system, including the emergency department (ED), with community service providers across Chicago's West Side. In April 2019, SUHI CHWs began screening MSH ED patients with non-fatal gun violence injuries for social needs. The CHWs aim to refer patients to community organizations that can assist with housing, food access, job training, public benefit program enrollment, and other needs.

### *Domestic Violence Program*

- Historically, Schwab Rehabilitation (Schwab) has offered support services to people with disabilities that experience domestic violence. However, in 2017, the program was expanded to offer services to any domestic violence victims living in Cook County. The program offers counseling, support, advocacy, and education to clients referred from MSH's emergency department, SCI, and other departments. In fiscal year 2018, the program served over 50 male and female adult clients ranging in age from 18 to over 60 years old and responded to numerous hotline calls for support, information, and referrals.

### *Exploring Non-Fatal Gun Violence at Mount Sinai Hospital and Schwab Rehabilitation*

- In 2018, SUHI completed an in-depth study of gun violence at MSH and Schwab. The study sought to describe the extent of gun violence by looking beyond gun-related homicides and exploring non-fatal gun violence injuries. The project gathered data on the experiences of health care providers and patients that deal with gun violence and also examined demographic and injury-specific data on gun violence victims. Through these various data sources, the team was able to identify ways to improve care for gun violence victims across SHS.

## **Overarching Community Health Improvement**

### *West Side United*

- SHS is a member of West Side United (WSU), a collaborative of health systems and community partners working together to improve health on Chicago's West Side. SHS is deeply involved in the WSU effort, with SHS personnel serving on the Executive Leadership Team, co-leading WSU's overarching evaluation approach, and co-chairing WSU's Maternal and Child Health committee. SHS also participates in WSU's career pathways program, which provides training to SHS employees in entry-level positions to help them advance into higher paying, in-demand clinical positions.

# Mount Sinai Hospital

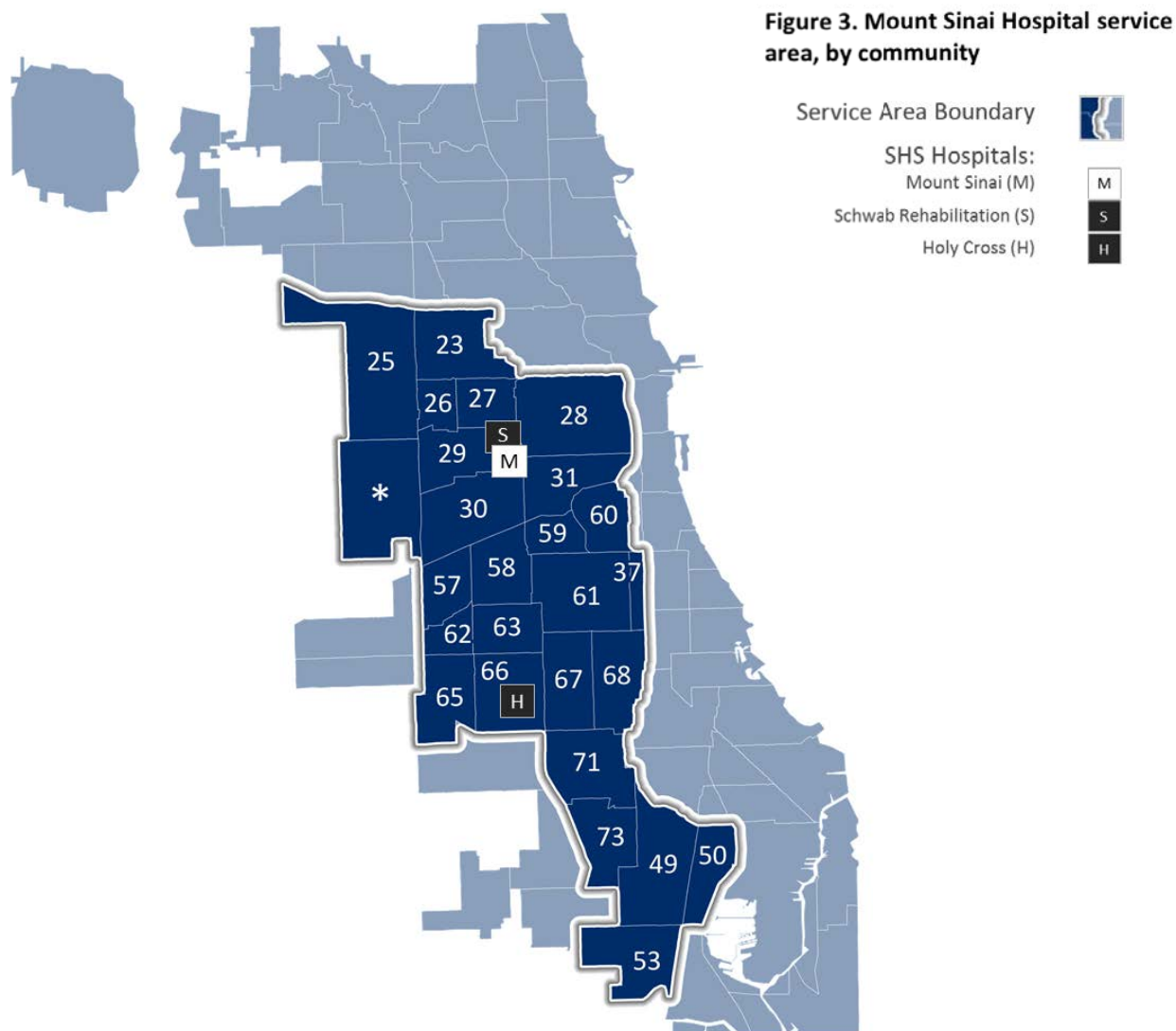
## Service Area

Mount Sinai Hospital (MSH) is dedicated to providing care to all individuals, across all stages of life, living in socially and economically diverse communities on Chicago's West and Southwest sides. MSH's service area is defined as the largest 75% catchment area for all inpatient hospital discharges. Based on this definition, MSH's service area comprises 14 zip codes and 26 communities (25 Chicago community areas and the town of Cicero) (**Figure 2**). **Figure 3** shows MSH's service area.

**Figure 2. Mount Sinai Hospital service area zip codes and associated communities**

Zip Code	Community Area(s)
60608	Lower West Side, Bridgeport
60609	McKinley Park, New City, Fuller Park
60612	Near West Side
60620	Auburn Gresham, Washington Heights
60621	Englewood
60623	North Lawndale, South Lawndale
60624	East Garfield Park, West Garfield Park
60628	Roseland, Pullman, West Pullman
60629	Chicago Lawn, West Elsdon, West Lawn
60632	Archer Heights, Brighton Park, Gage Park
60636	West Englewood
60644	Austin
60651	Humboldt Park
60804	Cicero (outside Chicago)



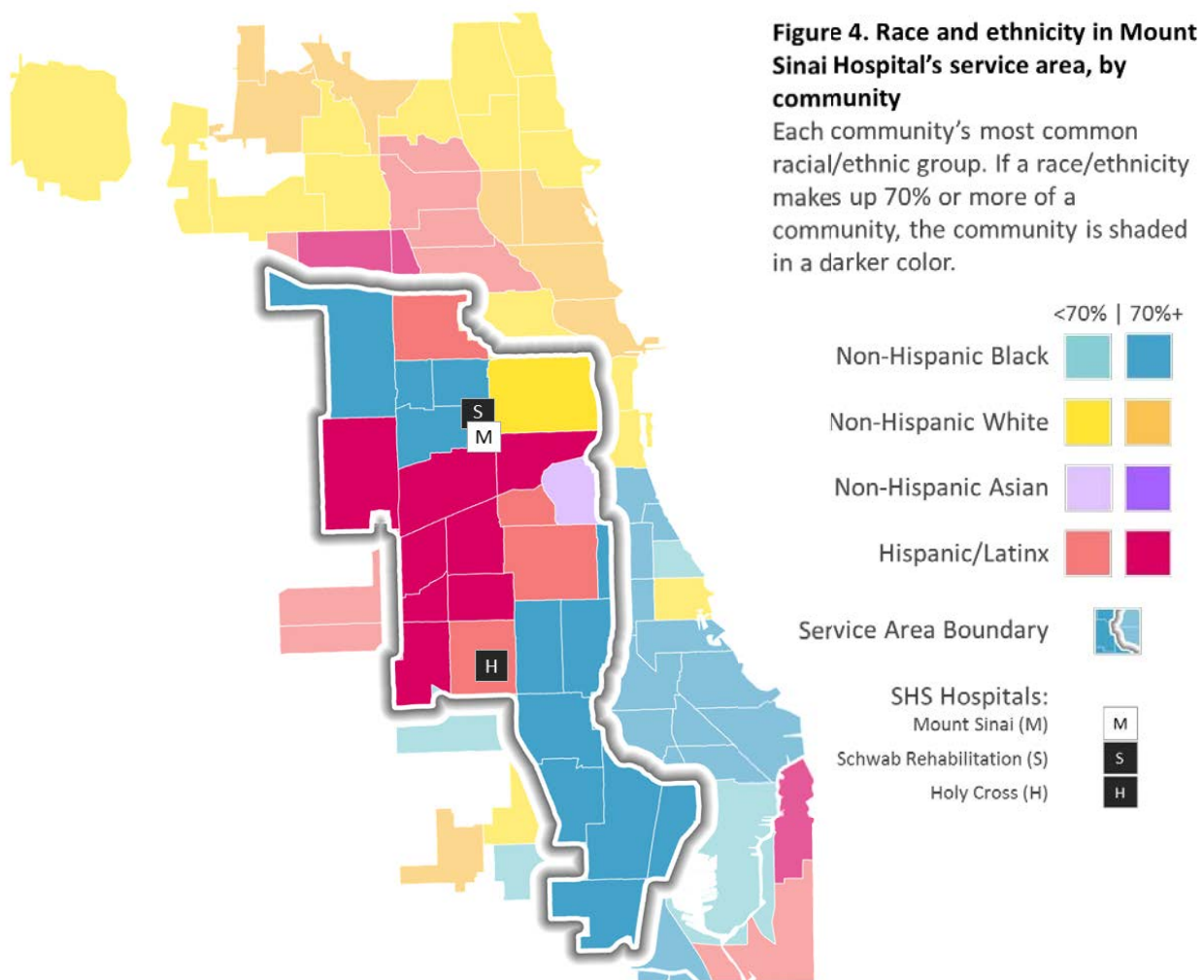


Community Area Number	Community Area	Community Area Number	Community Area
23	Humboldt Park	58	Brighton Park
25	Austin	59	McKinley Park
26	West Garfield Park	60	Bridgeport
27	East Garfield Park	61	New City
28	Near West Side	62	West Elsdon
29	North Lawndale	63	Gage Park
30	South Lawndale	65	West Lawn
31	Lower West Side	66	Chicago Lawn
37	Fuller Park	67	West Englewood
49	Roseland	68	Englewood
50	Pullman	71	Auburn Gresham
53	West Pullman	73	Washington Heights
57	Archer Heights	*	Cicero (outside Chicago)



## Demographics

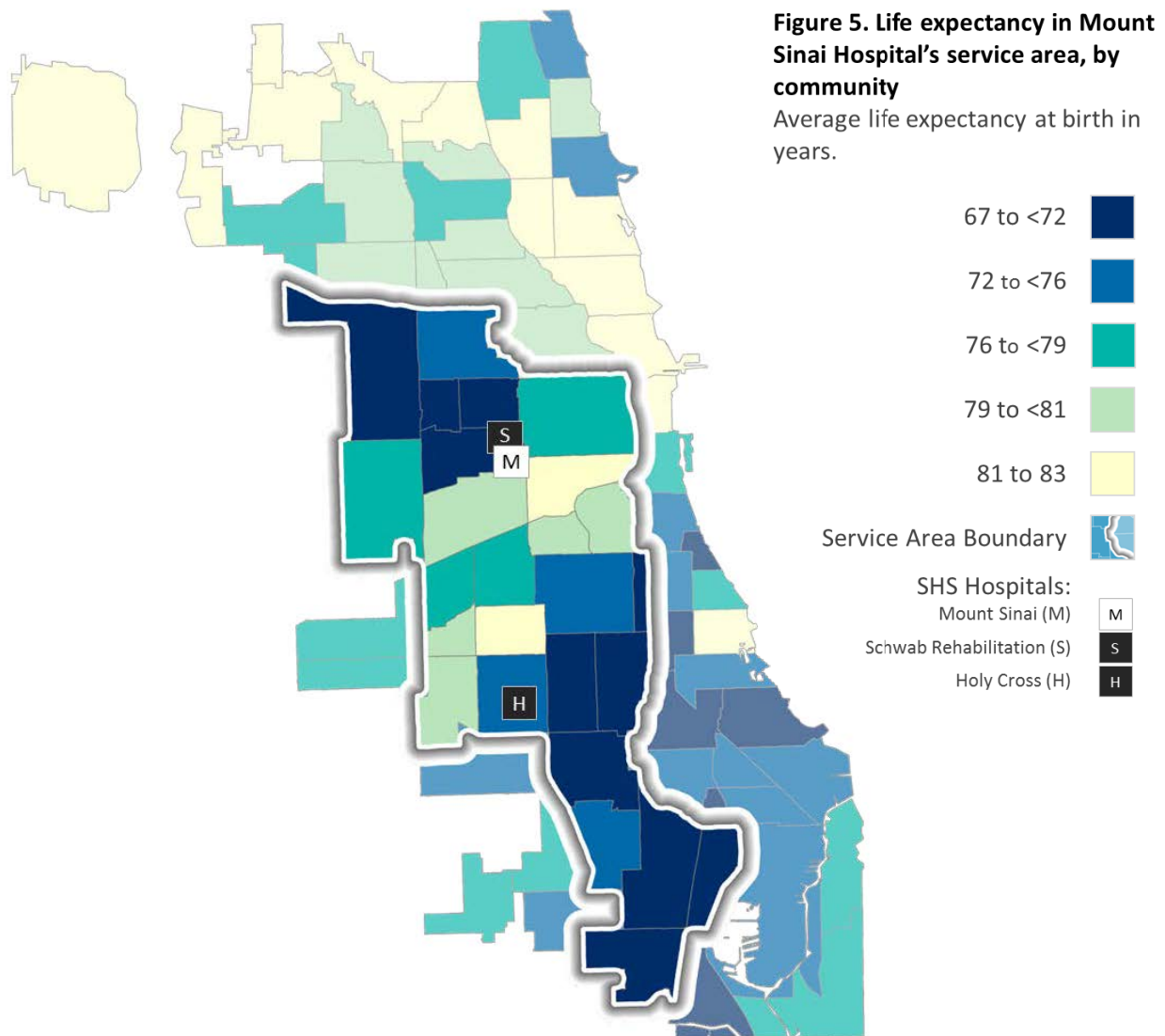
MSH serves a diverse population of over 980,000 people, 36% of Chicago's total population. Importantly, MSH provides care to an area of Chicago experiencing an overall population decrease, particularly among Non-Hispanic Black residents. Today, over 70% of the population in 24 of MSH's 26 communities identify as people of color (Non-Hispanic Black, Hispanic/Latinx, and/or Non-Hispanic Asian/Pacific Islander). Of these 24 communities, half are predominantly Non-Hispanic Black and eight are predominantly Hispanic/Latinx (**Figure 4**). The proportion of foreign-born individuals in 12 of MSH's communities is greater than that of the city (21%), which underlines the importance of MSH addressing the unique needs of this group in health improvement planning. Further, 27% of the population in MSH's service area is under the age of 18 and 10% is over the age of 65.



Source: 2016, American Community Survey 5-Year Estimates

## Overall Health

The populations served by MSH reveal substantial disparities in life expectancy and overall health. Life expectancy at birth, in years, ranges from 67 (Fuller Park) to 81 (Gage Park, Lower West Side, and South Lawndale), compared to 77 in Chicago (**Figure 5**). Further, the proportion of residents reporting good, very good, or excellent overall health was lower in 16 MSH communities than in Chicago as a whole (2015-17, data unavailable for Cicero).



Source: 2016, Illinois Department of Public Health, Division of Vital Records

# Community Health Needs and Priorities

## 2019 Community Health Priorities

Mount Sinai Hospital's (MSH) 2019 health priorities were selected based on quantitative and qualitative data (see subsequent sections), as well as thoughtful consideration of Sinai Health System's (SHS) entire service area. To achieve the SHS aim of treating the whole person, across the whole lifespan, within whole communities, the following five priorities were selected as key areas of focus for SHS and MSH over the next three years:

- ❖ **Social Determinants of Health:** Social determinants include a broad range of factors that are not traditionally considered “health-related,” but are critically important to achieving optimal wellbeing. Social determinants of health include factors such as financial security and economic opportunity, healthy food access and affordability, and freedom from injustice.
- ❖ **Community Safety:** Communities and people cannot thrive while feeling unsafe in their neighborhoods. Within this priority, we will seek out multi-sector solutions that create safe communities, free from violence, and also address the trauma caused by past violence.
- ❖ **Health Care Accessibility and Use:** This priority focuses on access to quality primary and specialty care, as well as adequate insurance coverage. Within this aim, we will ensure that quality, age- and ability-appropriate health care is accessible to all, regardless of race, ethnicity, zip code, income, involvement with the justice system, gender identity, sexual orientation, or citizenship.
- ❖ **Chronic and Infectious Disease:** This priority area includes a focus on preventing and treating cardiometabolic disease (heart disease, stroke, and diabetes), cancer, and infectious disease (predominantly HIV and hepatitis).
- ❖ **Behavioral Health:** We cannot treat the whole person without addressing behavioral health. In this focus area, we will address the great burden of mental health and substance use disorders within our communities, providing timely and culturally sensitive care to those in need.

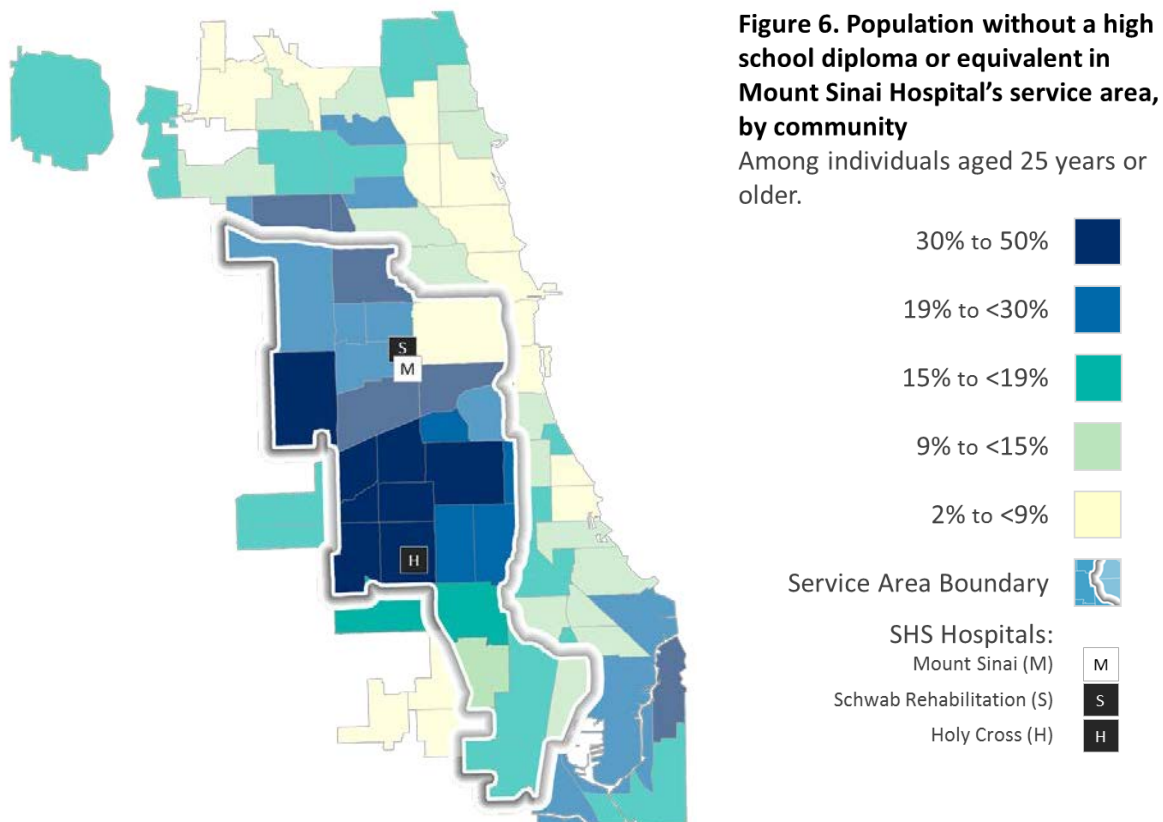
It is with these priorities in mind that SHS and MSH enter the coming years, dedicated to pursuing community wellbeing and wholeness. For additional information on how the five priority areas were selected from this complete list of health needs, see the **CHNA Methodology** section.

## Social and Structural Determinants of Health

### Educational Attainment

Twenty-one of the 26 communities in MSH's service area had lower high school graduation rates than Chicago as a whole (**Figure 6**), and 25 had lower college graduation rates than the city.

- The percent of the population aged 25 years or older **without a high school diploma** or equivalent ranged from 8% (Near West Side) to 50% (South Lawndale), compared to 16% in Chicago (**Figure 6**).
- The percent of the population aged 25 years or older **with a bachelor's degree or higher** ranged from 5% (West Garfield Park) to 66% (Near West Side), compared to 39% in Chicago (2012-16).



Source: 2016, American Community Survey 5-Year Estimates

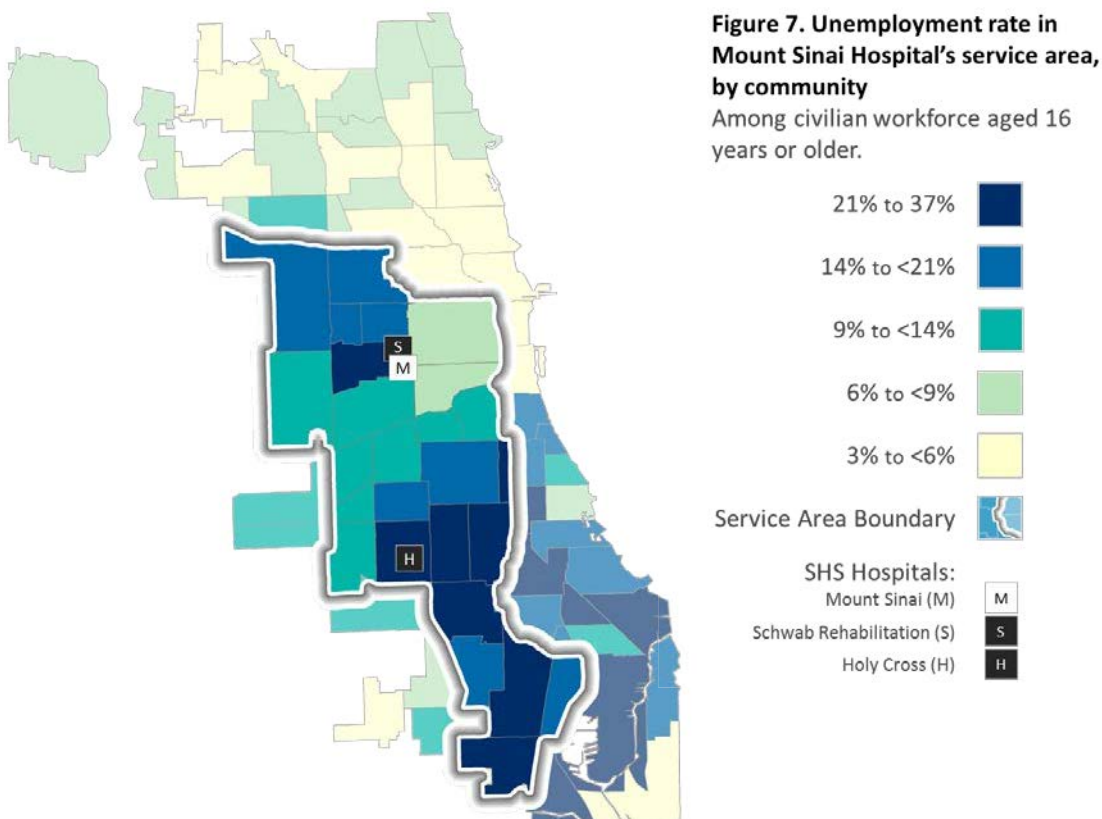
**Community Insights:** While some community survey participants said that education was a local strength, others expressed a need for improvement. Respondents identified good schools as one of the top 10 necessities for a healthy community.

“On the West Side, there isn’t much funding to create better opportunities like schools and jobs.”

### Financial Instability

All 26 communities in MSH's service area had higher unemployment rates than Chicago as a whole (**Figure 7**). In addition, 25 communities had lower median household incomes and 22 had higher poverty rates than the city overall.

- **Unemployment rates** ranged from 9% (Lower West Side, Near West Side) to 35% (Englewood), compared to 8% in Chicago (**Figure 7**).
- **Median household income** ranged from \$21,437 (Fuller Park) to \$57,302 (Near West Side), compared to \$53,006 in Chicago (2012-16).
- **Individual poverty** (the proportion of the population living in households with incomes below the federal poverty level) ranged from 14% (West Elsdon) to 47% (West Garfield Park), compared to 19% in Chicago (2012-16).



Source: 2016, American Community Survey 5-Year Estimates

**Community Insights:** Survey respondents said that they would like to see economic growth in their community and identified quality jobs as essential for a healthy community.

“I have to go out of my neighborhood to do anything. I don’t shop in my neighborhood. I don’t eat in my neighborhood.”

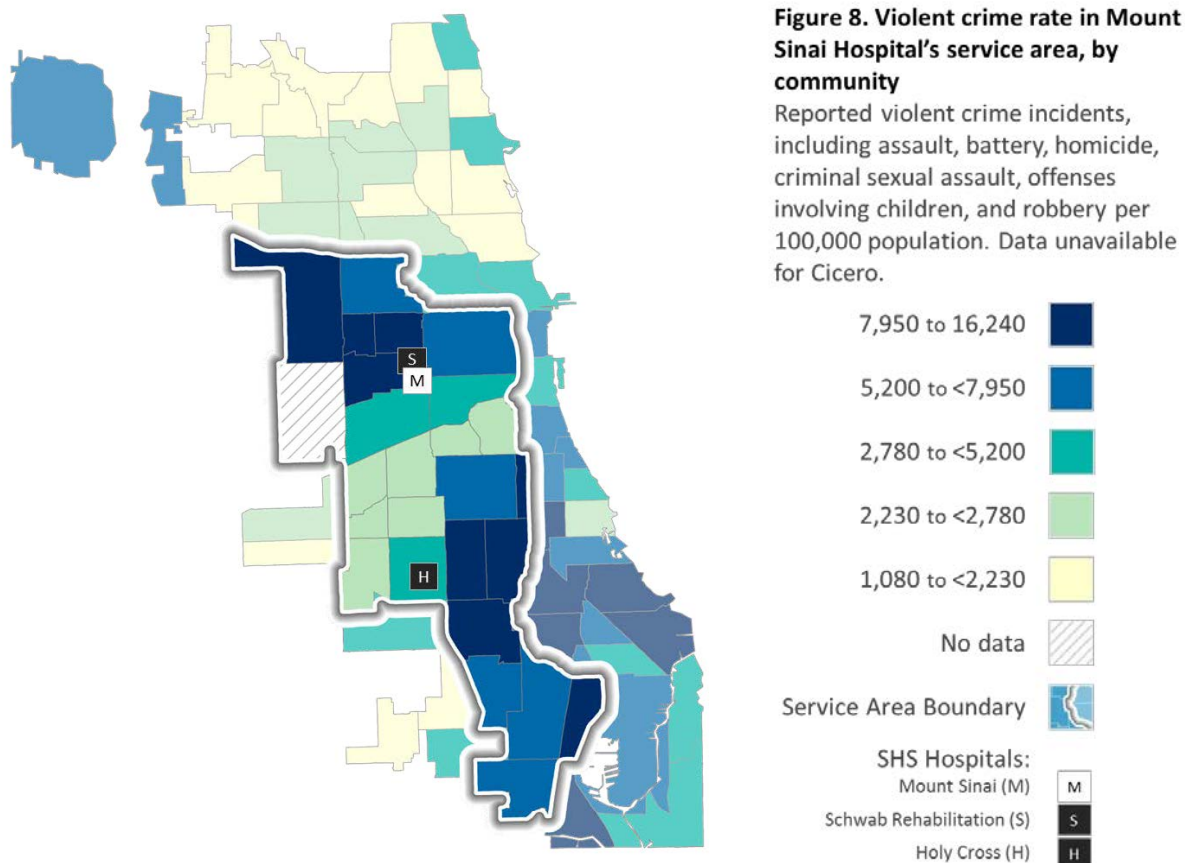
**MSH Caregiver Insights:** Caregivers discussed current community efforts to improve upstream factors, such as workforce development, and the importance for MSH to continue strategies that support this community-level work. Caregivers also noted the relationship between managing financial responsibilities and behavioral health.



## Community Safety

Community violence, measured by the violent crime rate, was higher in 16 of MSH's 25 Chicago community areas than across Chicago (**Figure 8**). In addition, the proportion of adults who felt safe in their neighborhood was lower in 19 MSH Chicago community areas than Chicago.

- The **violent crime rate** (crime incidents reported to the Chicago Police Department relating to violence, including homicide, assault, robbery, and battery) per 100,000 total population ranged from 2,237 (West Elsdon) to 16,238 (Fuller Park), compared to 4,491 in Chicago (**Figure 8**).
- From 2015 to 2017, the percent of adults who reported that they **felt safe in their neighborhood** "all" or "most of the time" ranged from 48% (North Lawndale) to 89% (Pullman), compared to 78% in Chicago.



Source: 2016, Chicago Police Department

**Community Insights:** While some community survey participants felt safe in their community, violence was identified as the second most important community health problem (selected by 40% of respondents). Violence was also a health priority in MSH's 2016 CHNA.

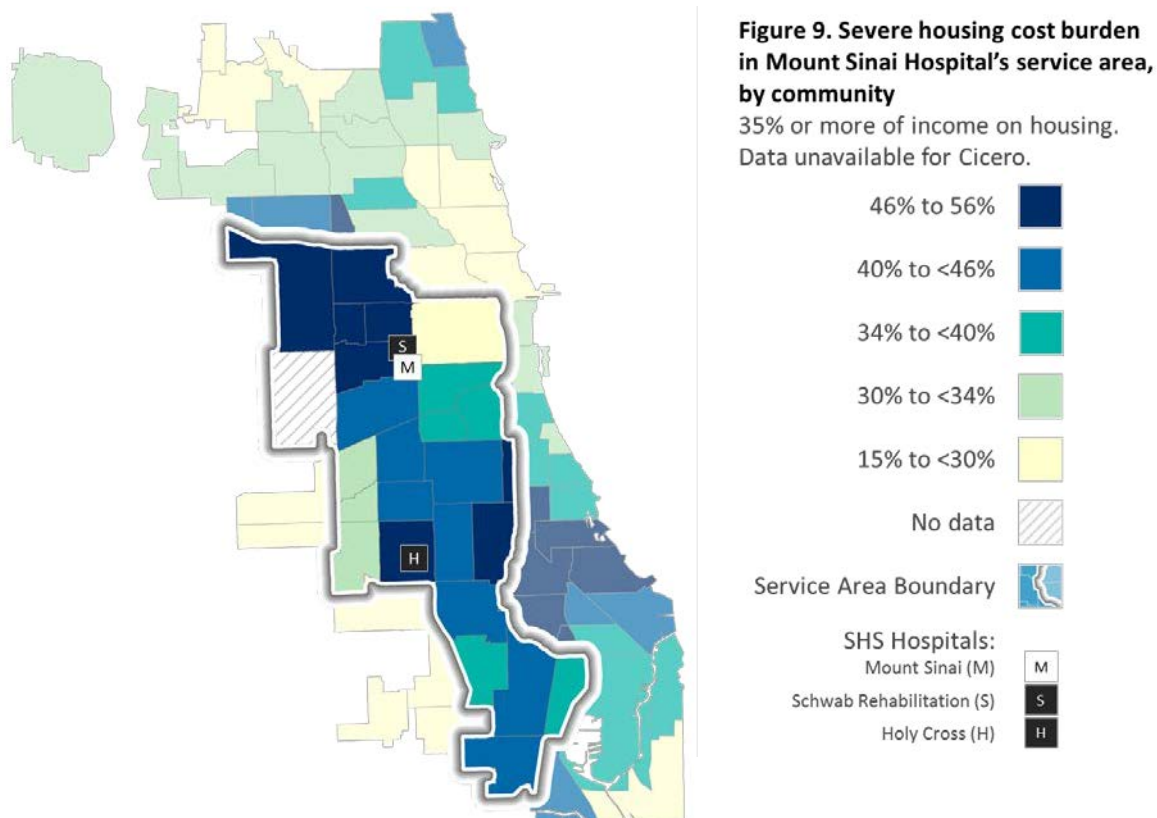
"It's not just violence it's the lack of money in the area. If people had money, there would be less violence."

**MSH Caregiver Insights:** Caregivers noted that community partnerships are leading the way in violence prevention.

## Housing and Food Security

The percent of households facing severe housing cost burden was higher in 20 of the 25 MSH Chicago community areas than in Chicago as a whole (**Figure 9**). Additionally, the proportion of residents with easy access to fruits and vegetables was lower in 18 of MSH's Chicago communities compared to Chicago and 15 of MSH's Chicago communities had higher rates of limited food access than the city.

- Across MSH's Chicago communities, the proportion of **households with severe housing cost burden** (households spending 35% or more of income on housing) ranged from 28% (Near West Side) to 56% (Englewood), compared to 36% in Chicago (**Figure 9**). In Cicero, 47% of households spent 30% or more of their income on housing (2012-16).
- From 2015 to 2017, the percent of adults reporting **very easy access to fruits and vegetables** ranged from 54% (North Lawndale) to 79% (McKinley Park), compared to 69% in Chicago.
- In 2015, **limited food access** (individuals with an annual family income  $\leq 200\%$  of the federal poverty level for family size and who lived more than  $\frac{1}{2}$  mile from the nearest supermarket, supercenter, or large grocery store) ranged from 0% (Gage Park, Lower West Side) to 57% (Fuller Park), compared to 9% in Chicago (2015).



Source: 2016, American Community Survey 5-Year Estimates

**Community Insights:** Community survey participants noted that affordable housing and access to everyday needs (e.g., grocery stores) were not community strengths. At the same time, respondents identified these as two of the top 10 necessities for a healthy community.

“I think we need more supermarkets because not everyone has a car. Then maybe kids will learn about fruits and vegetables and learn how to eat.”

**MSH Caregiver Insights:** Caregivers highlighted that limited food access is a driver of many health issues, such as obesity. They felt it was important for MSH to continue to build community partnerships that address food access and affordability.

## Health Care Access and Use

### *Primary and Specialty Care Access*

Fourteen of MSH’s 25 Chicago community areas had a lower proportion of adults receiving needed clinical care than Chicago adults overall. Avoidable emergency department (ED) visits are those that are non-urgent or treatable in primary care settings (e.g., asthma flare-ups, diabetes, and congestive heart failure). These visits often suggest barriers to primary care. Eleven of MSH’s 13 Chicago zip codes had higher rates of avoidable ED visits than Chicago as a whole.

- From 2015 to 2017, the percent of adults who reported that they received a **routine annual checkup** with a doctor or health care provider ranged from 53% (West Elsdon) to 96% (Archer Heights), compared to 77% in Chicago.
- From 2015 to 2017, the percent of adults who reported that it was **"usually" or "always" easy to get needed care, tests, or treatment** through their health plan in the past year ranged from 59% (Fuller Park) to 96% (Pullman), compared to 83% in Chicago.
- In 2017, the **avoidable ED visit rate** per 10,000 population ranged from 393 (60608) to 1,300 (60644), compared to 544 in Chicago.

**Community Insights:** Community survey respondents identified access to health care and mental health services as the most important factor for ensuring a healthy community (these factors were selected by 43% of respondents).

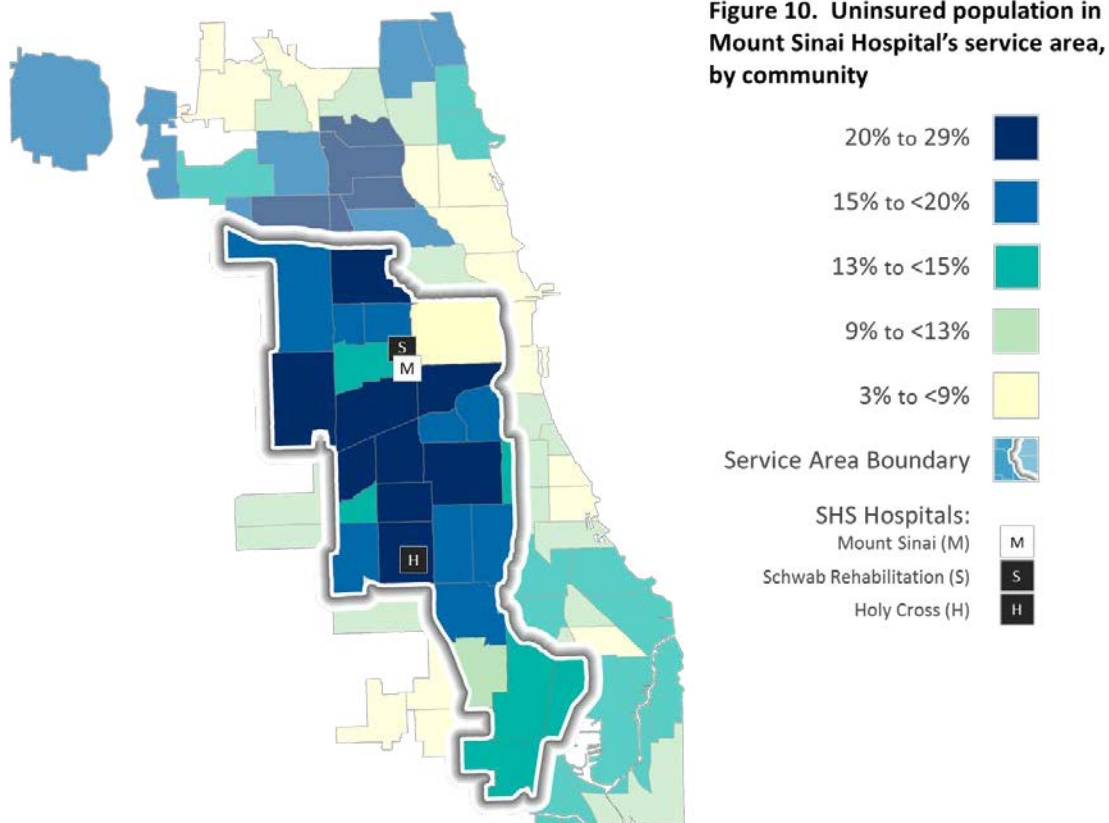
“I want to see the same services at County [another local safety-net hospital near MSH] as Rush and Northwestern, the same medical benefit.”

**MSH Caregiver Insights:** Caregivers discussed the necessity of community engagement and input to design culturally competent and linguistically appropriate interventions and care. They also underlined the importance having a diverse health care workforce.

### Insurance Coverage

Almost all of MSH's communities (24 of 26) had higher percentages of uninsured individuals than Chicago as a whole (**Figure 10**).

- The percent of the population **without health insurance** coverage ranged from 7% (Near West Side) to 29% (South Lawndale), compared to 10% in Chicago (**Figure 10**).



Source: 2016, American Community Survey 5-Year Estimates

**Community Insights:** Many community survey respondents emphasized that improvements were needed in health care and health insurance access and quality.

“Most of us don’t have health insurance. You can’t get a mammogram or go to the doctor for checkups. If we had health insurance we would go more often, not just when we are sick.”

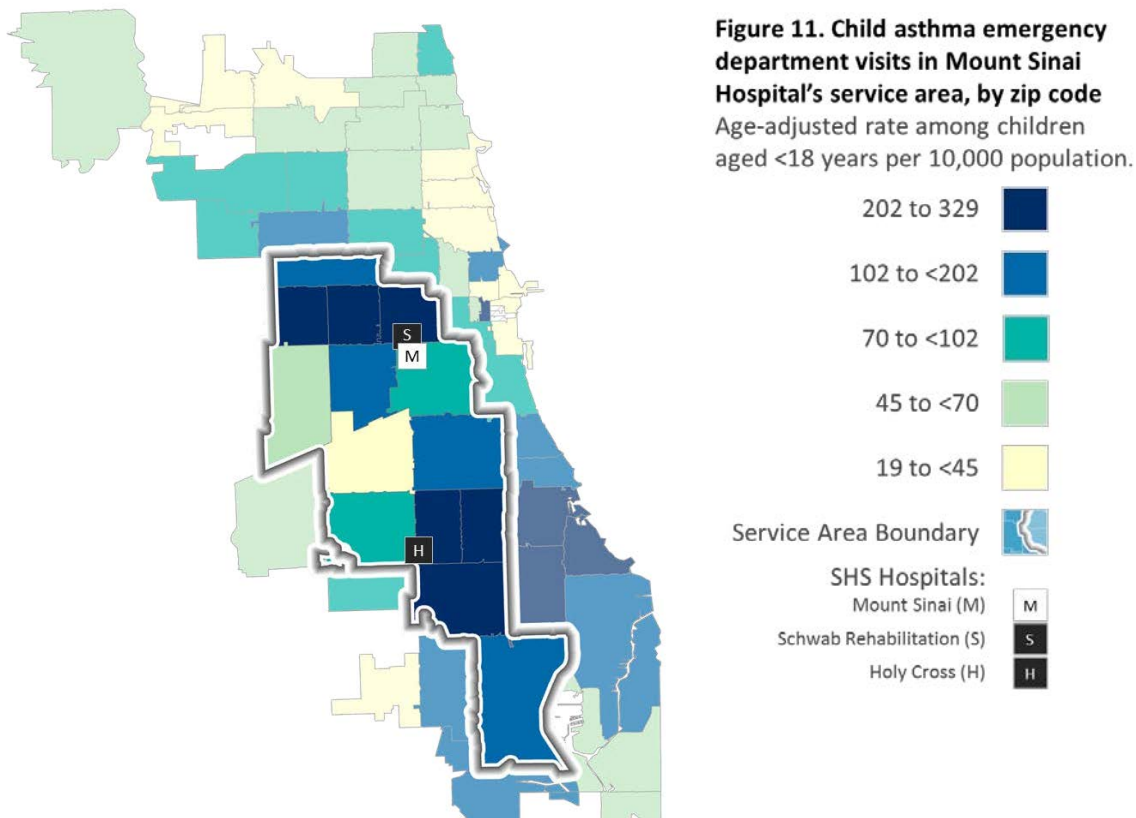
**MSH Caregiver Insights:** Caregivers discussed the need to address unaffordable copayments as a barrier to care. In addition, they underlined the importance of insurance coverage for undocumented populations.

## Improved Health and Health Equity

### Asthma

Adult asthma prevalence was higher in 14 of MSH's 25 Chicago community areas than in Chicago as a whole (data unavailable for Archer Heights, Fuller Park, Gage Park, Lower West Side, and Pullman). In addition, eight of the 14 zip codes in MSH's service area had higher annual rates of child asthma ED visits than Chicago (**Figure 11**).

- From 2015 to 2017, the percent of adults who reported that a doctor, nurse, or other health professional had diagnosed them with **asthma** ranged from 6% (New City, South Lawndale) to 18% (East Garfield Park), compared to 9% in Chicago.
- The age-adjusted **child (<18 years) asthma ED rate** per 10,000 population ranged from 42 (60632) to 244 (60636), compared to 127 in Chicago (**Figure 11**).
- The age-adjusted **adult asthma ED rate** per 10,000 population ranged from 21 (60632) to 233 (60624) (2015-17, data unavailable for Chicago).



Source: 2015-2017, Illinois Health and Hospital Association COMP Data

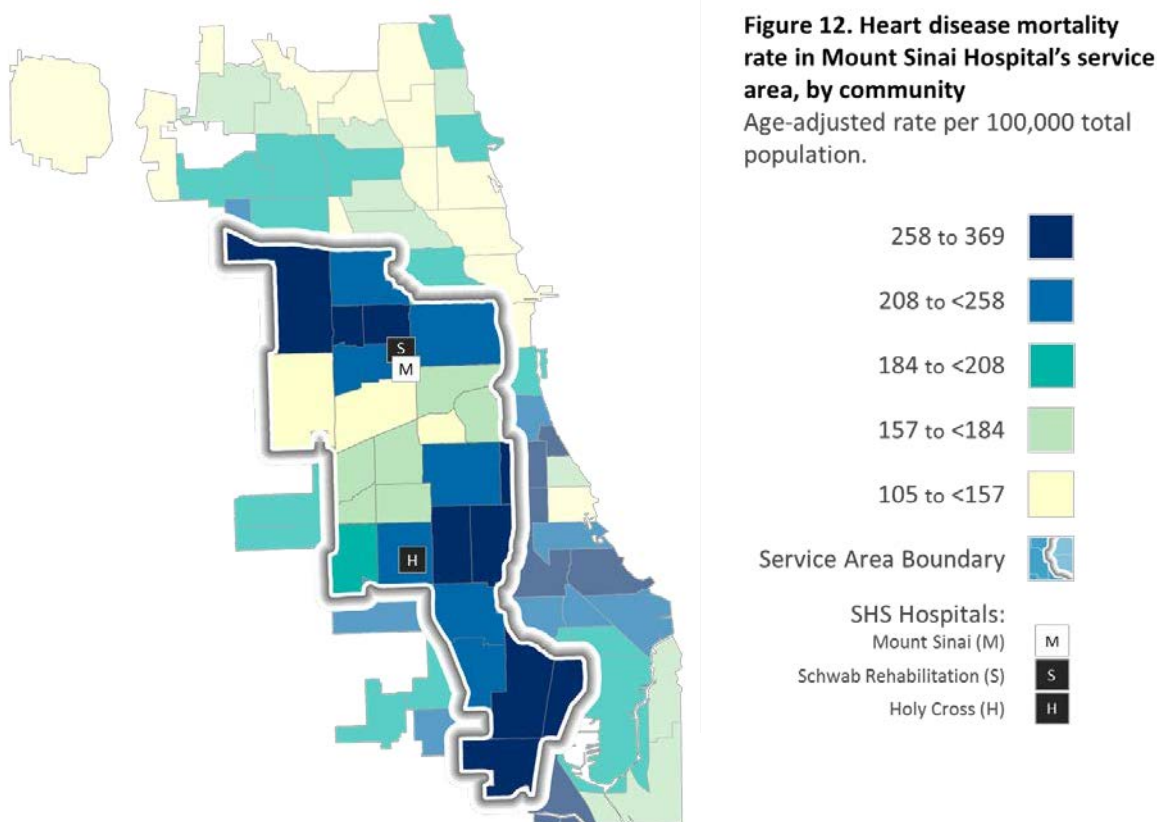
**Community Insights:** Lung disease, such as asthma and chronic obstructive pulmonary disease (COPD), was identified by community survey participants as a key community health problem, although it was not in the top five selected health problems. Asthma was also identified as a health priority in MSH's 2016 CHNA.



### Cardiovascular Health

All of the communities in MSH's service area had higher rates of heart disease mortality than Chicago as a whole (**Figure 12**). Further, the stroke mortality rate was higher than the city average in 17 MSH communities. Fifteen of MSH's 25 Chicago communities had a higher proportion of residents diagnosed with high blood pressure (also known as hypertension) than Chicago.

- The age-adjusted **heart disease mortality rate** per 100,000 total population ranged from 148 (South Lawndale) to 369 (Fuller Park), compared to 93 in Chicago (**Figure 12**).
- The age-adjusted **stroke mortality rate** per 100,000 total population ranged from 26 (West Elsdon) to 77 (West Englewood), compared to 40 in Chicago (2012-16).
- From 2015 to 2017, the percent of adults who reported that a doctor, nurse, or other health professional had diagnosed them with **high blood pressure** (excluding borderline high, pre-hypertensive, or pregnancy-related hypertension) ranged from 16% (Archer Heights, West Elsdon) to 48% (West Englewood), compared to 28% in Chicago.



Source: 2012-2016, Illinois Department of Public Health, Division of Vital Records

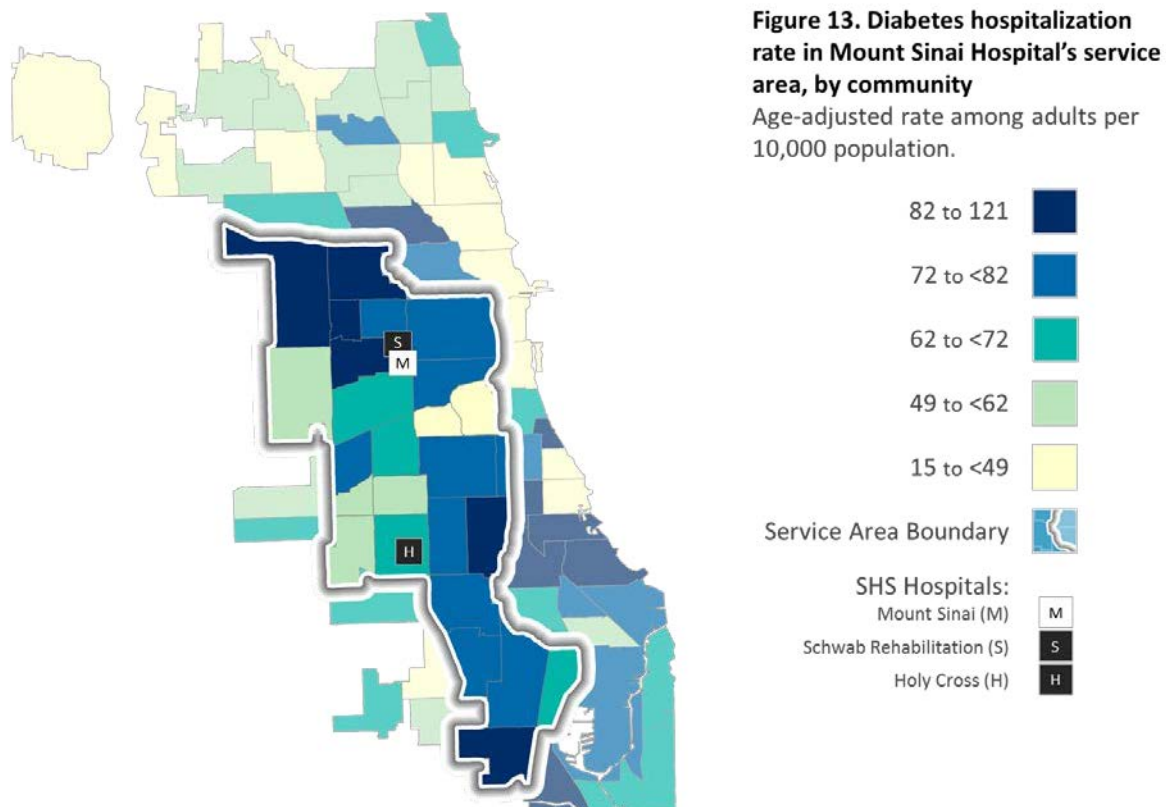
**Community Insights:** Community survey participants identified heart disease and stroke as two of the top 10 most important community health problems. Additionally, heart disease and stroke were health priorities in MSH's 2016 CHNA.

**MSH Caregiver Insights:** Caregivers discussed the relationship between cardiovascular disease and diabetes, particularly that the diseases have similar root causes (e.g., food access).

## Diabetes

Compared to Chicago as a whole, the proportion of adults diagnosed with diabetes was higher in 17 of MSH's 25 Chicago community areas (data unavailable for Fuller Park, McKinley Park, and West Elsdon). In addition, 22 of MSH's 26 communities had higher diabetes-related mortality rates than Chicago and 12 of MSH's 14 zip codes had higher rates of adult diabetes-related hospitalizations (**Figure 13**).

- From 2015 to 2017, the percent of adults who reported that a doctor, nurse, or other health professional had diagnosed them with **diabetes** (excluding pre-diabetes or gestational diabetes) ranged from 6% (Brighton Park, Near West Side) to 28% (Pullman), compared to 9% in Chicago.
- The age-adjusted **diabetes-related mortality rate** per 100,000 total population ranged from 45 (Bridgeport) to 107 (West Garfield Park), compared to 56 in Chicago (2012-16).
- The age-adjusted **adult hospitalization rate due to diabetes** per 10,000 population ranged from 23 (60804) to 60 (60621), compared to 26 in Chicago (**Figure 13**).



Source: 2015-2017, Illinois Health and Hospital Association COMP Data

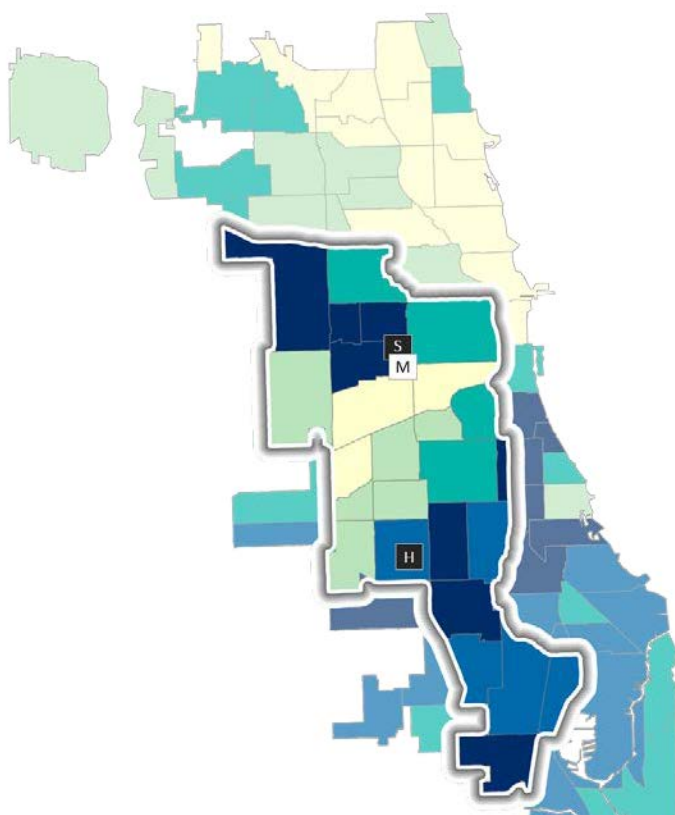
**Community Insights:** Almost half of community survey participants (47%) named diabetes as the top community health problem, making it the number one health issue as selected by community survey respondents. It was also a priority in MSH's 2016 CHNA.

"One of my concerns is that I have diabetes and so does my daughter. Sometimes when I get home, I make food and sometimes I just grab chicken. I hear some people meal prep. I leave home at 6 am and get home at 6 or 7 pm, it is hard for me."

## Cancer

The overall cancer mortality rate was higher in 19 of MSH's 26 communities than Chicago as a whole (**Figure 14**). In addition, the breast cancer mortality rate was higher in 11 communities, the prostate cancer mortality rate was higher in 15 communities (data unavailable for Cicero), the lung cancer mortality rate was higher in 16 communities, and the colorectal cancer mortality rate was higher in 20 communities than the city average.

- The age-adjusted **cancer mortality rate** per 100,000 total population ranged from 141 (Archer Heights) to 351 (Fuller Park), compared to 164 in Chicago (**Figure 14**).
- The age-adjusted **breast cancer mortality rate** per 100,000 total population ranged from 7 (Lower West Side) to 76 (Fuller Park), compared to 26 in Chicago (2011-15).
- The age-adjusted **prostate cancer mortality rate** per 100,000 total population ranged from 2 (McKinley Park) to 25 (Fuller Park), compared to 11 in Chicago (2011-15).
- The age-adjusted **lung cancer mortality rate** per 100,000 total population ranged from 19 (Archer Heights) to 100 (Fuller Park), compared to 38 in Chicago (2011-15).
- The age-adjusted **colorectal cancer mortality rate** per 100,000 total population ranged from 12 (Lower West Side) to 34 (Auburn Gresham, East Garfield Park), compared to 16 in Chicago (2011-15).



**Figure 14. Overall cancer mortality rate in Mount Sinai Hospital's service area, by community**

Age-adjusted rate per 100,000 total population.

234 to 351

194 to <234

168 to <194

146 to <168

116 to <146

Service Area Boundary

SHS Hospitals:

Mount Sinai (M)

Schwab Rehabilitation (S)

Holy Cross (H)

Source: 2012-2016, Illinois Department of Public Health, Division of Vital Records

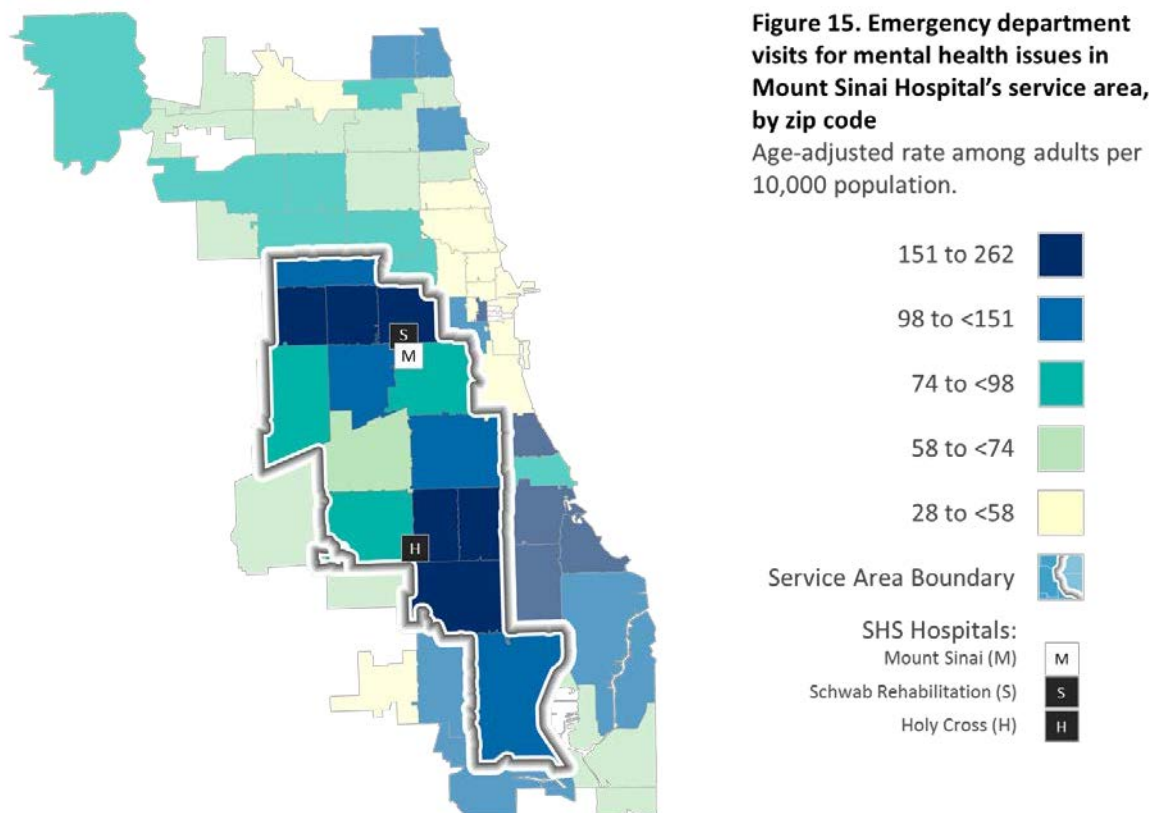
**Community Insights:** Community survey participants identified cancer as one of the top 10 most important community health problems.

**MSH Caregiver Insights:** Caregivers discussed the need to increase focus on cancer prevention by maximizing resource utilization and access to primary and specialty care, such as annual visits and regular cancer screenings. They also discussed the importance of determining and acting upon the root causes of cancer, such as environmental exposures.

### *Behavioral Health (Including Mental Health and Substance Use)*

Substantial variation was seen in the number of ED visits for mental health-related issues, such as anxiety or cognitive disorders, across MSH's service area (**Figure 15**). Additionally, ED visits for substance abuse-related issues, such as the use, abuse, and dependence of opioids, varied by a factor of 14 across MSH's service area zip codes. Nine of MSH's 25 Chicago community areas had higher drug-induced mortality rates than the city as a whole.

- Among adults, the age-adjusted **ED visit rate for mental health issues** per 10,000 population ranged from 60 (60632) to 262 (60621) (data unavailable for Chicago) (**Figure 15**).
- Among adults, the age-adjusted **ED visit rate for substance use-related issues** per 10,000 population ranged from 14 (60632) to 197 (60644) (2015-17, data unavailable for Chicago).
- The age-adjusted **drug-induced mortality rate** per 100,000 total population ranged from 7 (West Elsdon) to 55 (West Garfield Park), compared to 26 in Chicago (2012-16).



Source: 2015-2017, Illinois Health and Hospital Association COMP Data

**Community Insights:** Community survey participants identified mental health (34%) and substance use (40%) as two of the top five community health problems. Behavioral health was also a priority in MSH's 2016 CHNA.

"A lot of the facilities that cater to people with mental illness have been closed. You have to go to Oak Park or to the North Side to get care."

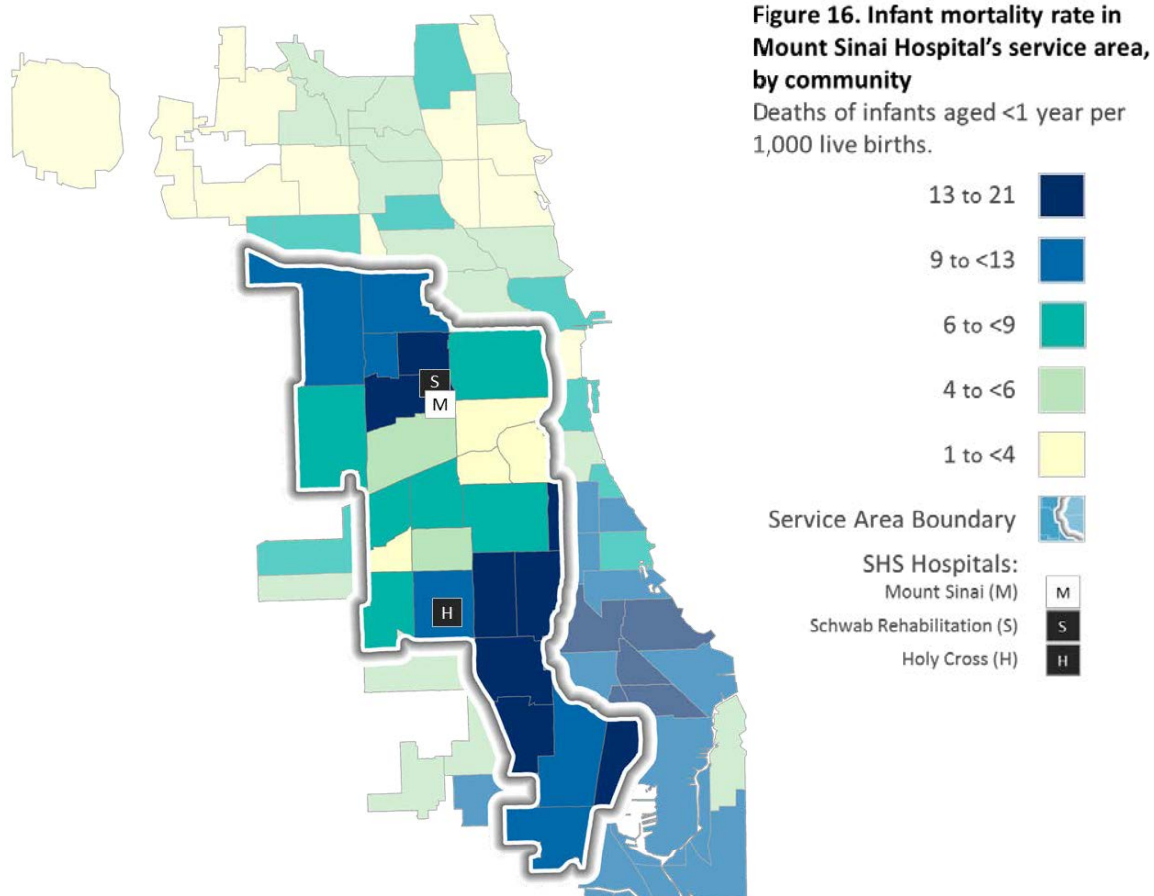
**MSH Caregiver Insights:** Caregivers discussed the importance of behavioral health in daily life, such as its influence on one's ability to secure adequate housing and employment. They also noted that behavioral health is an underlying factor in a range of health issues.

### *Family Health*

The infant mortality rate was higher in 17 of MSH's 26 communities than in Chicago (**Figure 16**). In addition, 14 communities had a higher percent of low birth weight infants and 13 had a higher percent of preterm births than Chicago. Lastly, the percent of child obesity was higher than 20% in all of MSH's communities.

- The **infant mortality rate** (deaths of infants aged <1 year per 1,000 live births) ranged from 2 (West Elsdon) to 19 (Pullman), compared to 7 in Chicago (**Figure 16**).
- The percent of **low birth weight infants** (<2,500 grams) ranged from 6% (Archer Heights, McKinley Park) to 19% (Fuller Park), compared to 10% in Chicago (2012-16).
- The percent of **preterm births** (<37 weeks gestation) ranged from 8% (Archer Heights, McKinley Park) to 21% (Fuller Park), compared to 11% in Chicago (2012-16).
- The percent of **child obesity** (BMI equal to or greater than the 95<sup>th</sup> percentile by age and gender) ranged from 21% (Near West Side) to 32% (Lower West Side, South Lawndale) (2012-2013, data unavailable for Chicago).





Source: 2012-2016, Illinois Department of Public Health, Division of Vital Records

**Community Insights:** Survey participants identified maternal and infant health as key community health problems, although these were not in the top five selected health problems. Improving birth outcomes was a priority in MSH's 2016 CHNA.

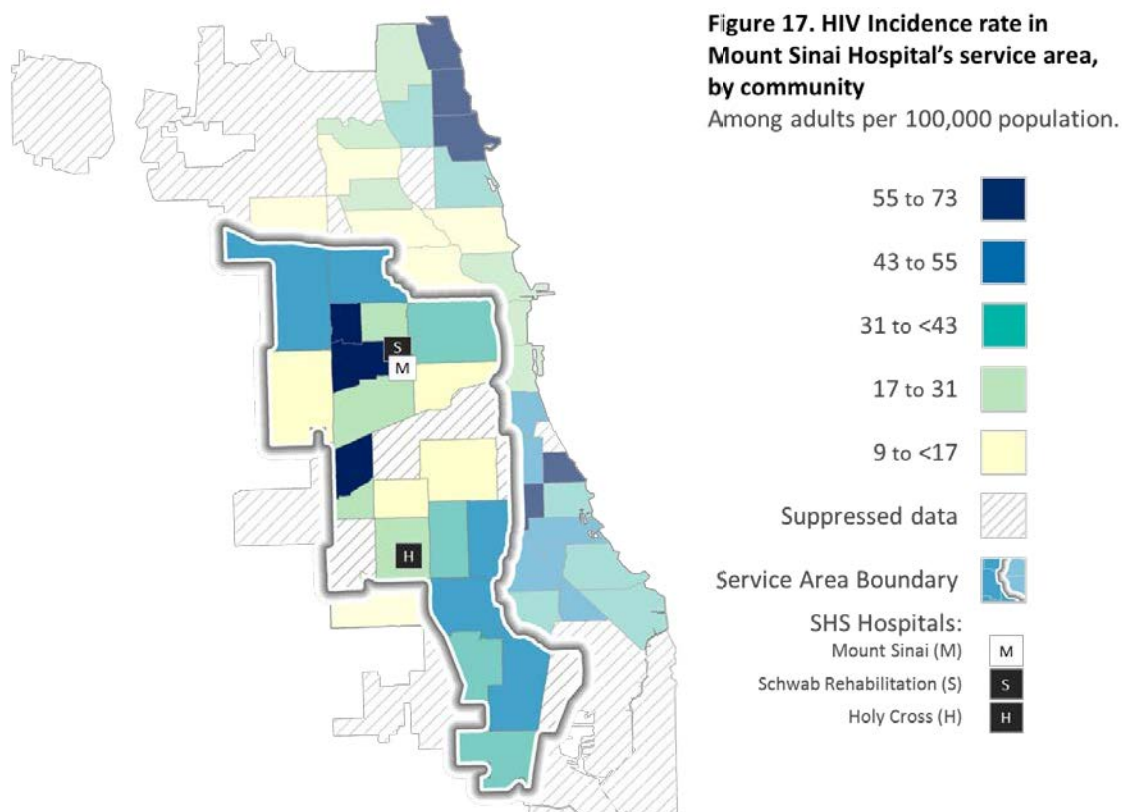
**MSH Caregiver Insights:** Caregivers noted that family health should include the health of the entire family unit, including older children and fathers. Caregivers specifically underlined the need to include men in conversations of family health.



## Infectious Disease

The HIV incidence rate was higher in 11 of MSH's 26 communities than Chicago as a whole (data unavailable for Bridgeport, Brighton Park, Fuller Park, McKinley Park, Pullman, and West Lawn) (**Figure 17**). Additionally, 16 communities had a higher chlamydia incidence rate and 14 communities had a higher gonorrhea incidence rate than Chicago.

- The **HIV incidence rate** per 100,000 population ranged from 13 (Gage Park) to 67 (Fuller Park, Pullman), compared to 31 in Chicago (**Figure 17**).
- The **chlamydia incidence rate** per 100,000 population ranged from 372 (Bridgeport) to 3,211 (North Lawndale), compared to 1,077 in Chicago (2015).
- The **gonorrhea incidence rate** per 100,000 population ranged from 33 (West Elsdon) to 1,086 (North Lawndale), compared to 326 in Chicago (2015).



Source: 2016, Chicago Department of Public Health; 2012-16 Cook County Department of Public Health

**Community Insights:** Community survey participants listed infectious disease (including sexually transmitted diseases and hepatitis) as an important community health problem, although it was not in the top five selected health problems.

**MSH Caregiver Insights:** Caregivers noted that infectious disease, such as HIV and hepatitis C, is a serious problem in MSH's service area. They also emphasized that MSH has the resources, infrastructure, and investments to continue developing targeted interventions that reduce the burden of disease.

# Community Assets

While facing many health challenges, the communities served by Mount Sinai Hospital (MSH) are filled with resources that aim to improve wellbeing. The list below highlights various assets that can help strengthen MSH's efforts to address community health. Some organizations provide direct services or lead community development efforts, and some serve as institutional partners with Sinai Health System.

## Health Services

### *Hospitals*

Advocate Health System  
Ann & Robert H. Lurie Children's Hospital of Chicago  
Garfield Park Hospital  
Hartgrove Behavioral Health System  
Jesse Brown VA Medical Center  
John H. Stroger, Jr. Hospital of Cook County  
The Loretto Hospital  
RML Specialty Hospital  
Roseland Community Hospital  
Rush University Medical Center  
Saint Anthony Hospital  
St. Bernard Hospital and Health Care Center  
The University of Illinois Hospital & Health Sciences System

### *Federally Qualified Health Centers*

Access Community Health Network  
Alivio Medical Center  
Aunt Martha's Health and Wellness  
Beloved Community Family Wellness Center  
Chicago Family Health Center  
Christian Community Health Center  
Erie Family Health Center  
Esperanza Health Center  
Friend Family Health Center  
Heartland Health Outreach  
Howard Brown Health  
Inner City Muslim Action Network  
Lawndale Christian Health Center  
Mile Square Health Center  
Near North Health Service Corporation  
PCC Community Wellness Center  
Roseland Christian Health Ministries  
TCA Health

## Social Services and Community Organizations

Action Coalition of Englewood  
The Ark of St. Sabina  
Association House  
Breakthrough  
The Catholic Charities  
Chicago Children's Advocacy Center  
Children's Home & Aid  
Connections for Abused Women and their Children  
El Valor  
Enlace Chicago  
Erie Neighborhood House  
Family Focus  
Firman Community Services  
Hope Organization  
I AM ABLE  
I Grow Chicago  
Illinois Action for Children  
Imagine Englewood if...  
Marillac St. Vincent Family Services  
Metropolitan Family Services  
Metropolitan Tenants Organization  
Mujeres Latinas en Acción  
The Night Ministry  
Outreach Chicago  
Outreach Coalition Connectivity Network  
The Port Ministries  
The Resurrection Project  
The Salvation Army  
SGA Youth and Family Services  
Taller de Jose  
Taproots  
Treatment Alternatives for Safe Communities (TASC)  
Thresholds  
Trauma Response and Intervention Movement (TR<sup>4</sup>IM)  
UCAN

Union League Boys and Girls Clubs  
Upworld  
WIC Food Centers  
Youth Outreach Services

## **Education**

Chicago Public Libraries  
Chicago Public Schools  
City Colleges of Chicago  
DePaul University  
Illinois Institute of Technology  
Loyola University Chicago  
Northwestern University  
Rosalind Franklin University  
University of Chicago  
University of Illinois at Chicago

## **Community Development**

Accion Chicago  
AFC Community Development Corporation (CDC)  
Austin Coming Together  
Austin Community Development Council  
Brighton Park Neighborhood Network  
Central Austin Neighborhood Association  
Chicago Eco House  
Greater Englewood Chamber of Commerce  
Greater Englewood CDC  
Greater Southwest Development Corporation  
Growing Home  
Hebron CDC  
Little Village Chamber of Commerce  
Local Initiatives Support Corporation Chicago  
Near West Side CDC  
New Covenant CDC  
North Lawndale Community Coordinating Council  
North Lawndale Employment Network  
People of Vision CDC  
Resident Association of Greater Englewood  
Southwest Organizing Project  
Spanish Coalition for Housing  
Sustainable Englewood  
Teamwork Englewood  
West Humboldt Park Development Council  
West Side Forward

## **Government and Other Partners**

Alliance for Health Equity  
American Heart Association  
Archdiocese of Chicago Vicariate V-A  
CareMessage

Center for Companies that Care  
Chicago Asthma Consortium  
Chicago Department of Public Health  
Chicago Hispanic Health Coalition  
Chicago Metropolitan Agency for Planning  
Cicero Youth Task Force  
Consulate of Mexico  
Cook County Department of Public Health  
Cook County Latino Advisory Council  
EverThrive Illinois  
Health and Medicine Policy Research Group  
Healthy Chicago Hospital Collaborative  
Healthy Communities Cook County  
Healthy Illinois Campaign  
Illinois Alliance for Welcoming Health Care  
Illinois Catholic Health Care Association  
Illinois Children's Healthcare Foundation  
Illinois Community Health Worker Network  
Illinois Hospital Association  
Instituto del Progreso Latino  
International Human Relations Committee  
Jewish Council on Urban Affairs  
Jewish Federation of Metropolitan Chicago  
The Kennedy Forum  
Latino Alzheimer's and Memory Disorders Alliance  
Latino Policy Forum  
Marshall Square Resource Network  
National Council on Interpreting in Health Care  
National Latino Education Institute  
Oral Health Forum  
Patient Centered Outcomes Research Institute  
Police Accountability Task Force  
Premiere Hospital Alliance  
Respiratory Health Association  
West Side United  
WINGS Advisory Council

## **Funders**

Avon Foundation for Women  
Blue Cross Blue Shield of Illinois  
Chicago Community Trust  
Healthy Communities Foundation  
The Lynn Sage Foundation  
Michael Reese Health Trust  
National Institutes of Health  
Patient-Centered Outcomes Research Institute  
Susan G. Komen Foundation  
U.S. Department of Housing and Urban Development

# Mount Sinai Hospital

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