University of Chicago Medical Center Community Health Needs Assessment

2016 Strategic Implementation Plan
INTRODUCTION
The University of Chicago Medicine and Biological Sciences, one of the nation’s leading academic medical institutions, has been at the forefront of medical care since 1927. Collectively, it is comprised of the University of Chicago Pritzker School of Medicine, the University of Chicago Biological Sciences Division, and the University of Chicago Medical Center (UCMC).

UCMC’s mission is to provide superior health care in a compassionate manner, ever mindful of each patient’s dignity and individuality. To accomplish this mission, we call upon the skills and expertise of all of UCMC’s medical professionals, who work together in collegiality to advance biomedical innovation, serve the health needs of the community, and further the knowledge of medical students, physicians, and others dedicated to caring. UCMC carries out its mission by focusing on improving the health of Chicago’s South Side. The following pages in this strategic implementation plan provide an overview of UCMC’s approach to assess, prioritize, and address specific health needs.

TARGET AREA AND PRIORITY POPULATION
UCMC is located within the Hyde Park neighborhood on Chicago’s South Side. Chicago’s South Side is a storied and unique collection of vibrant, resilient, culturally rich and diverse communities. Steeped in African-American heritage and history, the South Side is marked by deep social bonds and anchored by vital community and faith-based organizations. UCMC defines its service area (UCMC SA) as 12 contiguous zip codes surrounding UCMC (see Figure 1).1 The UCMC SA spans 31 locally defined community areas and has a population of approximately 640,000 thousand people.2

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

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1 UCMC SA zip codes: 60609, 60615, 60617, 60619, 60620, 60621, 60628, 60636, 60637, 60643, 60649, 60653.
obesity, breast cancer, and other chronic diseases.\(^4\)

COMMUNITY HEALTH NEEDS ASSESSMENT

To understand the current health outcomes in the UCMC SA, UCMC contracted with Professional Research Consultants (PRC) to conduct a community health needs assessment (CHNA). The CHNA provided data regarding the health status, behaviors, and needs of adult and pediatric populations in the UCMC SA. The CHNA was used to identify health issues of concern in the UCMC SA and to help make informed, data-driven decisions regarding the allocation of resources and effort for both adult and pediatric populations.

Methods

PRC employed a mixed methods approach to the UCMC SA CHNA. Adapting well-established, Centers for Disease Control and Prevention (CDC) endorsed health and behavioral survey tools, PRC conducted primary quantitative data collection through telephone (landline and cell phone) interviews with 515 adults and a supplemental battery of telephone interviews with 462 pediatric guardians to better inform health data for the child and adolescent population. In addition, qualitative health and behavioral data was collected through informational interviewing with 38 key health informants. These key informants included residents, community leaders, public health experts, social service providers, and physicians.

Quantitative survey data was then synthesized and trended against public health vital statistics and secondary data. Secondary data sources included Illinois and nationwide risk factor data and Healthy People 2020 benchmarks.

Process for Determination of Health Priorities

Through community based forums and the formation of a multidisciplinary UCMC CHNA workgroup, UCMC prioritized its health issue areas for the next three years of community benefit programming from 2016-2019. The UCMC CHNA workgroup included representatives from the UCMC Urban Health Initiative, select UCMC faculty, and UCMC nurses were among the three major constituencies involved in health priority selection process. These constituencies were strategically selected for their respective understanding of community perspectives, community based health engagement, and community health education efforts.

Using the CHNA as a foundational tool, the workgroup conducted a two-pronged analysis to determine health issue prioritization:

1. First, the workgroup compared the 2015 UCMC SA health outcome data to state, national and historical UCMC SA health outcome data. Health issues that were statistically significantly worse than comparative state and national data were slated for consideration.

When compared to state and national benchmark data, the comprehensive set of CHNA

outcomes representing the UCMC SA fared statistically significantly worse in at least one metric across 16 unique adult health issues and 18 pediatric health issues, as defined by the PRC CHNA.

2. Next, the workgroup debated the merit of selecting each previously identified health issue. A listing of UCMC’s inventory of existing community-based programs and resources were examined as part of the prioritization. The following Internal Revenue Service (IRS) 501r and Catholic Health Association recommended criteria were considered in each debate:

- **Magnitude**: the number of people impacted
- **Severity**: the risk of morbidity
- **Historical trends**: data findings over time
- **Alignment**: organizational strength and priorities
- **Impact**: problem on vulnerable populations
- **Importance**: problem to the community
- **Existing resources**: addressing the problem with internal/community resources
- **Relationship**: problem to other community issues
- **Feasibility**: ability to make change
- **Value**: immediate intervention versus delay, especially for long-term or complex threats

**UCMC SELECTED HEALTH PRIORITY AREAS**

UCMC retained the primary health priority issues from the 2013 strategic implementation plan: *cancer* (adult), *diabetes* (adult), *asthma* (pediatric), *obesity* (pediatric). In addition, UCMC elevated *violence prevention* (adult/pediatric) and *sexually transmitted infections/HIV* (adult/pediatric), noted as areas for future focus in UCMC’s 2013 strategic implementation plan, to priority health issues in this current plan.

Whereas UCMC targeted singular health issues in its previous strategic implementation plan, the current strategic implementation plan highlights secondary issues, as well. The selected health priority issues will continue to serve as the designated issue areas for official reporting and are the principle health concern that UCMC community benefit efforts will target. However, in some cases secondary health issues are recognized as comorbidities and/or attributes associated with the primary health priority. These will serve as programming guides for the primary health issue area (see Figure 2).
Rationale for Unaddressed Needs

UCMC believes that in order to best impact health outcomes, it is in its strategic interest to focus and consolidate efforts on the selected health issues for which there are existing internal and/or external resources, a reasonable feasibility to affect change, and that for which there is an alignment with institutional strengths. On this backdrop, although the following areas compared unfavorable to the state and national data, they lacked UCMC alignment, expertise in the specialty and/or existing resources and were thereby not selected as primary health issue areas:

- Immunizations & Infectious Disease: Occurs at UCMC with inpatient care only and will be addressed specifically around the STI/HIV health issue area
- Mental Health: UCMC is currently working in this area for post-acute care and currently does not have extensive programming in this area
- Oral Health: UCMC currently does not have extensive programming in this area
- Cognitive & Behavioral Disorders in Children: Although there are UCMC providers engaged in providing this care, UCMC does not have extensive programming in this area

Furthermore, other health issues initially included for UCMC prioritization have been recognized as comorbidities to primary, priority health issues. Consequently, these health areas will be addressed through priority health issue programs and efforts. For example:

- **Respiratory Disease** (adults): Adult tobacco smoking will be included when addressing triggers of pediatric asthma
• **Cardiovascular Disease** (adults): Adult heart diseases and stroke will be addressed through existing adult diabetes efforts
• **Diabetes** (pediatric): Pediatric diabetes will be mitigated through efforts to address pediatric obesity
• **Access to care** (adults/pediatrics): Although this will not be a standalone priority area, given the change in the health care landscape with the Affordable Care Act, focus will be made around access to services that address each of the health issues selected

**UCMC APPROACH TO ADDRESSING HEALTH PRIORITY ISSUES**

All UCMC community benefit investments and programming are framed by the community benefit overarching goal: to enhance community health and wellness around CHNA priority health needs in the UCMC Service Area. To effectively work closer to achieve this goal, UCMC applies resources to the following approaches to executing activities, services and/or programs:

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

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

• **Summary of Issue:** A brief outline of the rationale for addressing the issue as well as the needs identified within the health issue area
• **Goal:** The community benefit health priority area’s long-term expectation of what should happen as a result of programming
• **Objectives:** The community benefit health priority area’s expected results to be achieved as an outcome of programming
• **Approach & Action Plan:** The UCMC mode of approach that will be utilized to implement programming and the types of actions that will be included in the programming
• **Intended Outcomes and Key Metrics:** The intended effect of the program in the target population of the program. As appropriate, these will align to local/state/national metrics
(e.g., CDC, Healthy People 2020, Institute of Medicine, Chicago Department of Public Health). When possible, specific targets and outcome metrics will be applied to each individual program, these are not fully outlined in this document.

Furthermore, the following pages outline a defined, high-level direction for UCMC to guide programming around addressing specific health priority issues.
ADULT CANCER

Invasive breast cancer is among the leading causes of death for African-American women.\(^5\) In 2015, it is estimated that approximately 232,000 African-American women will be diagnosed with invasive breast cancer. Moreover, colorectal cancer is the second leading cause of cancer deaths in the United States among men and women, collectively.\(^6\)

SUMMARY OF ISSUE

In Cook County, female breast cancer rates fare worse than both state and national rates. Furthermore, while the colorectal cancer mortality rate is similar to that of Illinois, it is decidedly higher than the national rate.\(^7\) Cancer mortality rates are highest among non-Hispanic Blacks.\(^8\) Given Chicago’s South Side predominately African-American population, both breast cancer in females and colorectal cancer continue to present considerable health issues affecting adults. The following data highlights key findings\(^9\) in UCMC’s SA from the 2015 UCMC CHNA.

- 38% of CHNA key informants most commonly perceive cancer as a major problem in the community
- 88% of women 50+ had a mammogram in the past 2 years
- 83% of women 40+ having had a mammogram in the past 2 years
- 78% of adults age 50-75 have had an appropriate colorectal cancer screening

GOAL

Support and build community based breast and colorectal cancer education and screening programs

OBJECTIVES

UCMC works towards achieving the following objectives:

- Increase cancer education in the community
- Increase cancer screening in the community
- Increase knowledge on cancer screening guidelines

APPROACH & ACTION PLANS

UCMC continues to invest and partner on programs that reach the most vulnerable populations to promote breast and colorectal screenings. UCMC engages in partnerships with community

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\(^8\) Ibid.

health clinics, community based organizations, the public health department, and UCMC faculty and staff to expand its reach and further education on Chicago’s South Side. Additionally, through care delivery services and community based education & outreach, UCMC is able to use its resources and expertise to provide education and screening services to South Side residents. UCMC will focus its efforts on the following areas:

- Conducting breast and colorectal cancer screenings
- Promoting education sessions on screenings in community settings

### INTENDED OUTCOMES AND KEY METRICS

**Long term outcome:** Adults are practicing regular cancer screenings

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

- The number of adults who receive a colorectal cancer screening
- The number of female adults who receive a breast cancer screening

### Key Programs and Collaborations

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

#### Beyond October

- UCMC partners with the Metropolitan Chicago Breast Cancer Task Force to provide free screening mammograms and diagnostics to uninsured and underinsured women living in Illinois each year. The program aims to emphasize the importance of breast cancer screening beyond breast cancer awareness month.

#### Illinois Breast & Cervical Cancer Program (IBCCP)

- A state funded program where UCMC participates in the mammography and breast cancer screening portion of the program through a referral process to eligible women in partnership with the Illinois Department of Public Health and Chicago Family Health Center—a SSHC partner which serves as a Lead Agency for IBCCP.

#### Office of Community Engagement & Cancer Disparities

- As part of UCMC, UCMC faculty work with local communities through research, education, advocacy, and outreach. The OCECD works in strategic partnerships with various organizations including community based and faith-based organizations.

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10 UCMC recognizes that national standards for screening guidelines vary across the field.
ADULT DIABETES

Between 1980 and 2012, the number of adults diagnosed with diabetes in the United States nearly quadrupled (from 5.5 million to 21.3 million).\textsuperscript{11} African-Americans are disproportionately affected by diabetes and are 1.7 times more likely to have diabetes as non-Hispanic whites.\textsuperscript{12}

SUMMARY OF ISSUE

Cook County diabetes age adjusted mortality rate (20.6) fares similar to the Healthy People 2020 target (20.5); however, the mortality rate is notably higher among African-Americans (32.5).\textsuperscript{13} The 2015 UCMC CHNA data\textsuperscript{14} highlighted below depicts the outcomes in UCMC’s SA.

- 69% of CHNA key informants perceive diabetes as a major problem
- 13% of adults report that they have been diagnosed with diabetes
- 7% of adults report that they have been diagnosed with pre-diabetes

GOAL

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

OBJECTIVES

UCMC works towards achieving the following objectives:

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

APPROACH & ACTION PLANS

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

\textsuperscript{11} National Center for Chronic Disease Prevention and Health Promotion. \textit{Number and Rate per 100 of U.S. Population with Diagnosed Diabetes}. Atlanta: Centers for Disease Control and Prevention, 2015.


\textsuperscript{14} Ibid.
• Engaging diabetics and/or pre-diabetics in formal education
• Promoting healthy lifestyle habits among diabetics and pre-diabetics

INTENDED OUTCOMES AND KEY METRICS

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

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

• The proportion of adults with diagnosed diabetes or prediabetes who completed formal diabetes education series
• The proportion of adults with diagnosed diabetes who report receiving annual diabetes related exams

Key Programs and Collaborations

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

Asian Health Coalition: Diabetes Prevention Project for Asians in Chinatown (DPPAC)

• Collaborating with the Asian Health Coalition and the Chinese American Service League, DPPAC engages vulnerable Asian-American and Pacific Islanders living in the Southside Chinatown community to raise diabetes awareness, promote preventative behaviors, and connect at-risk individuals to diabetes self-management programming.

CommunityHealth: Take Action! Diabetes Management Program

• Through CommunityHealth, a free community health center, the Take Action! Diabetes Management Program addresses the needs of patients living in the Englewood community who are living with diabetes by combining clinical care and case management with education and medication therapy management to improve A1C level.
PEDIATRIC ASTHMA

The CDC estimates that 6.3 million or 8.6% of children in the United States currently have asthma.\textsuperscript{15} With the prevalence of asthma increasing over the years, asthma research is not only focused around genetic factors but environmental influencers (e.g., sensitization to irritants and allergens) as well. Significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations.\textsuperscript{16}

SUMMARY OF ISSUE

In Chicago’s South Side communities, pediatric asthma continues to persist as a considerable health issue. As demonstrated in the 2015 UCMC CHNA, outcomes around key pediatric asthma metrics show that African-American children in the UCMC SA are more likely to have asthma.\textsuperscript{17} Key metrics from the 2015 UCMC CHNA regarding childhood asthma in UCMC’s SA are noted below.\textsuperscript{18}

- 20% of children currently have asthma
- 55% of children with asthma went to the ER/urgent care for asthma in the past year

GOAL

Strengthen child and caregiver’s ability to appropriately manage asthma.

OBJECTIVE

UCMC works towards achieving the following objectives:

- Increase asthma screening and outreach
- Reduce asthma hospitalization and absenteeism among children
- Increase education and treatment plans for children with asthma
- Improve provider understanding and treatment of asthma
- Increase children/caregivers understanding of asthma triggers/environmental modification

APPROACH & ACTION PLANS

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

UCMC engages in partnerships with community hospitals, community based organizations, community health centers and UCMC faculty to implement programs that engage children in a variety of settings. Through the community benefit grant program, UCMC collaborates with

\textsuperscript{15} National Center for Disease Control and Prevention. \textit{Number and Rate per 100 of U.S. Population with Diagnosed Diabetes}. Atlanta: Centers for Disease Control and Prevention, 2015.


\textsuperscript{17} Professional Research Consultants. \textit{2015 Community Health Needs Assessment: University of Chicago Medical Center Service Area, Cook County, Illinois}. Omaha: Professional Research Consultants, 2015.

\textsuperscript{18} Ibid.
local health centers and community based organizations to greater reach community members in the school setting and community health centers. UCMC is engaging in multiple care delivery services mechanisms to achieve greater reach through the development of an Asthma Center in collaboration with South Side partners and the deployment of community based staff in home and community settings. UCMC will engage in the following actions to address asthma in the UCMC SA:

- Deploying UCMC community health worker staff to community based settings to address asthma triggers and management
- Promoting asthma education in community settings

### INTENDED OUTCOMES AND KEY METRICS

**Long term outcome:** Families are informed on asthma triggers and manage their children’s asthma

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

- The proportion of children/caregivers of children with asthma that report receiving formal asthma education
- The proportion of children/caregivers of children with asthma who received written asthma management plans from their health care provider
- The proportion of children/caregivers of children with asthma who have received an assessment of asthma triggers in the home

### Key Programs and Collaborations

Existing programs are currently being evaluated to assess efficacy and impacts on pediatric asthma. Programs are assessed regularly to determine changes, modifications or discontinuation. Below are several key programs and collaborations around pediatric asthma.

#### COMMUNITY HEALTH WORKER (CHW) PROGRAM

- UCMC employs trained CHWs to help improve asthma management among children with severe asthma. CHWs will conduct home asthma environmental assessments and education visits, as well as serve as liaisons between families and their primary care medical homes.

#### CHICAGO ASTHMA CONSORTIUM (CAC)

- The Chicago Asthma Consortium project aims to create a model that can be applied in schools to improve identification of children with asthma, education about asthma management, and implementation of policy to support children living with the condition.

#### RESPIRATORY HEALTH ASSOCIATION

- RHA is a community-based public health leader that is focusing on educating children and their caregivers through asthma management programs. Interventions include education on early recognition of asthma symptoms, common triggers, emergency care, proper inhaler use, and medications.
PEDiatric Obesity

The CDC emphasizes healthy diet, healthy body weight and daily physical activity—these all play an important role in the growth and development of healthy children. The prevalence of childhood obesity has more than doubled in children and quadrupled in adolescents in the past 30 years.19 Furthermore, in 2012, more than one-third of children and adolescents were overweight or obese.20

SUMmary of Health Issue

Pediatric obesity continues to be a considerable health issue effecting children and adolescents in Chicago’s South Side Communities. Key respondents of the CHNA believe community resources are insufficient (or non-existent) to address these problems.21 Obesity outcomes from the 2015 CHNA largely mirror those outcomes reported in the 2013 CHNA, demonstrating the persistent challenge facing the UCMC SA. Key findings from the 2015 CHNA regarding pediatric obesity and associated modifiable health risks and chronic diseases include22:

- 44% of children are overweight or obese and 29% of children are obese
- 44% of children are physically active for one hour or longer on every day of the past week
- 46% of children have five or more servings of fruits/vegetables per day

Goal

Support school based or community site programs focused on risk, prevention, physical activity and culturally relevant nutrition management.

OBJECTIVES

UCMC works towards achieving the following objectives:

- Increase programming that addresses childhood obesity in schools
- Increase physical activity among children and adolescents
- Increase healthy eating habits among children and adolescents
- Improve the weight status among children and adolescent

APPROach & Action Plans

UCMC engages in partnerships with community based organizations, UCMC faculty and Chicago Public and Charter Schools to deliver robust programs that address pediatric obesity, the social determinants that lead to pediatric obesity, and ultimately diabetes. Through community benefit grant program funding, UCMC targets the pediatric population in schools and community settings to achieve greater participation in programs spanning multiple venues

20 Ibid.
22 Ibid.
and promoting physical activity and healthy nutrition, UCMC will engage in the following activities to address child/adolescent in the UCMC SA:

- Promoting regular and consistent physical activity in community settings, with a primary focus on schools
- Promoting healthy eating and nutrition education in community settings, with a primary focus on schools

### INTENDED OUTCOMES AND KEY METRICS

**Long term outcome:** Families are eating healthy and engaging in healthy physical activity habits.

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

- The proportion of children and adolescents that do 60 minutes or more of physical activity daily
- The proportion of children and adolescents that report consuming more fruits
- The proportion of children and adolescents that report consuming more vegetables

### Key Programs and Collaborations

Existing programs are currently being evaluated to assess efficacy and impacts on pediatric obesity. Programs are assessed regularly to determine changes, modifications or discontinuation. Below are several key programs and collaborations that focus on improving physical activity and nutrition behavior.

#### UC Charter School: Fresh Fit Fun

UCMC is partnering with the UC Charter School to target student and family-centered interventions to reduce the risk of pediatric obesity. The program serves as a model of how schools can impact the health and wellness of students and the school community.

#### Urban Initiative (UI): Work To Play

UCMC partners with UI, a community-based organization, in a cost-free and intensive program that promotes health through consistent physical activity, nutrition education and social-emotional learning.

#### Pilot Light

UCMC collaborates with Pilot Light, a community-based organization, to implement nutrition education that integrates with conventional classroom learning. Lessons have been developed using the Chicago Public Schools content frameworks, which established a curriculum map for schools.
SEXUALLY TRANSMITTED INFECTIONS AND HIV

Youth and LGBTQ populations are disproportionately affected by sexually transmitted infections (STIs). Youth 15-24 years of age make up over one-quarter of the sexually active population but account for roughly half of the 20 million new STIs that occur in the United States each year.\(^\text{23}\) In addition, populations such as gay, bisexual, and other men who have sex with men (MSM) are disproportionately impacted by syphilis, HIV, and other STIs.\(^\text{24}\)

**SUMMARY OF HEALTH ISSUE**

In Chicago’s South Side communities, STIs and HIV continue to be a considerable health issue. Between 2011 and 2013, there was an annual average age-adjusted HIV/AIDS mortality rate of 2.7 deaths per 100,000 in Cook County—a significantly higher rate than the national rate of 2.2 deaths per 100,000 population.\(^\text{25}\) The burden of STIs is particularly high in the UCMC SA, for example the chlamydia incidence rate within the UCMC SA was 1,735 per 100,000 in 2012, while the Cook County chlamydia incidence rate was 727 per 100,000 in the same year.\(^\text{26}\) In addition, STI and HIV incidence and mortality rates are disproportionate across race in Cook County with a considerably higher HIV mortality rate and STI incidence among Blacks than that reported in the White and Hispanic populations.\(^\text{27}\)

**GOAL**

Increase prevention, screening, and treatment of STI and HIV

**OBJECTIVES**

UCMC works towards achieving the following objectives:

- Increase education and awareness around STI and HIV prevention and treatment
- Increase STI and HIV identification and screening
- Increase access to STI and HIV prevention and care services

**APPROACH & ACTION PLANS**

UCMC supports programs that target populations that exhibit high rates of STIs and HIV. These community based programs work to mitigate STIs and HIV effects through research, education, advocacy, screening, and outreach. UCMC faculty has established strategic partnerships in the community with various organizations including community hospitals, nonprofits and community health centers to expand reach among the population. In addition, through a variety of care

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\(^{24}\) National Center for Disease Control and Prevention. Number and Rate per 100 of U.S. Population with Diagnosed Diabetes. Atlanta: Centers for Disease Control and Prevention, 2015.


\(^{26}\) These data were derived by the Chicago Department of Public Health from a record set supplied by the Illinois Department of Public Health (IDPH). IDPH specifically disclaims responsibility for any analysis, interpretations, or conclusions.

delivery initiatives, UCMC faulty and partners focus on improving accessibility to services targeting adolescents and adults that include, but are not limited to:

- Direct health care services: Testing, treatment and screening services
- Indirect care services: Case management, resource advocacy, non-acute mental health services and linkages to care

UCMC will further promote these services noted above and employ the following approaches to address STI/HIV in the UCMC SA:

- Promoting STI/HIV screenings among high-risk populations
- Linking HIV positive patients to care and support services

**INTENDED OUTCOMES AND KEY METRICS**

**Long term outcome:** Adults and adolescents are aware of their STI/HIV status and linked to appropriate services.

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

- Number of sexually active persons screened for chlamydia, gonorrhea, syphilis and HIV
- Number of persons at risk for HIV linked to support/care services

**Key Programs and Collaborations**

The following programs will be evaluated regularly to determine impacts to assess necessary changes, modifications or discontinuation. Below are several key programs and collaborations that focus on increasing STI/HIV screening and linkages.

**Expanded HIV Testing and Linkage to Care (xTLC)**

- The xTLC is a partnership of 10 South Side healthcare facilities that provide HIV screening and linkage to care for HIV positive clients.

**Better 2Gether Network (B2GN)**

- B2GN is a collaboration between UCMC, Howard Brown Health Center and Project Vida to strengthen and mobilize community networks for HIV prevention and care. Services include: social media awareness campaigns, HIV testing and STI screenings, linkage to care for HIV positive persons, prevention and support services such as nPEP/PrEP and education for high risk MSM/transwomen, and condom distribution/promotion.

**Care 2 Prevent (C2P)**

- C2P is a holistic approach to provide comprehensive care and prevention education for young people living with HIV/STI and individuals who are at-risk for new infections. Services include: holistic medical care and HIV/HCV testing, case management with resource advocacy, non-acute mental health services.
VIOLENCE PREVENTION

According to the CDC, nearly 16,000 people were victims of homicide and 43,000 took their own lives in 2014.\(^{28}\) However, for every homicide, there are 94 non-fatal violent injuries.\(^{29}\) These individuals can often be readmitted into the cycle of violence. Violent behaviors have been documented through youth surveys and have found on a national level that among youth in grades 9-12, 33% reported being a physical fight and 17% reported carrying a weapon.\(^{30}\)

SUMMARY OF HEALTH ISSUE

In Chicago communities, violence continues to be a considerable health issue. In 2015, there were nearly 3,000 shooting victims reported in Chicago.\(^{31}\) In Cook County, the age-adjusted homicide rate is well above the national rate at 10.5 per 100,000 and is disproportionately high among non-Hispanic African-Americans at 32.5 per 100,000. Selected 2015 UCMC CHNA data (below) highlights the prevalence of community violence in the UCMC SA\(^{32}\):

- 57% of CHNA key informants perceive community violence as a major problem
- 10% of adults aged 18 years and older have been a victim of a violent crime in the past 5 years
- 57% of families consider their neighborhood as "Slightly" or "Not At All" Safe
- 9% of children age 5 to 17 missed school in the past year because he/she felt unsafe at school or going to/from school

GOAL

Trauma informed Care on the South Side

OBJECTIVES

UCMC works towards achieving the following objectives:

- Increase access to trauma care
- Increase at risk youth and family engagement in violence prevention programs

APPROACH & ACTION PLANS

Urban violence is a complex and systematic issue requiring multiple stakeholders investing across a multitude of approaches and strategies. UCMC views violence as a public health issue and identifies its role as a hospital around the trauma informed care necessary for individuals affected by violence.

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\(^{29}\) Centers for Disease Control and Prevention. *MMWR, Surveillance Summaries* 2002;51 (21);460-3.


Through the **community benefit grant program**, UCMC collaborates with universities, faith-based organizations and community-based organizations to identify problems facing youth, identify risk and protective factors among youth, and invest in violence and trauma informed programs in the community. UCMC plans to provide **care delivery services** through the construction of a comprehensive level I adult trauma center. The trauma center will provide increased access to clinical care as well as comprehensive wraparound post-trauma services to the South Side community. The development of the trauma center will require cross-sector partnerships with public and community health centers, private sponsors, and local community based organizations. UCMC will implement the following approaches to address trauma inflicted by community violence in the UCMC SA.

- The development of a comprehensive trauma center
- Linking trauma affected individuals to post-trauma case management and behavioral health services
- Training community leaders on trauma informed care

**INTENDED OUTCOMES AND KEY METRICS**

**Long term outcome: South Side residents have access to trauma care**

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

- Number of residents outreached for post-trauma intervention at the trauma center
- Number of community leaders and healthcare providers who receive trauma training

**Key Programs and Collaborations**

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

UCMC will make its CHNA and strategic implementation plan publically available online via the UCMC website once it is approved and adopted by the UCMC Board of Directors in 2016. In addition, UCMC will share the strategic implementation plan information at its annual Urban Health Summit, with key UCMC SA stakeholders in attendance (e.g., community members, local political representatives, healthcare providers, and community based organizations will be in attendance) and also make copies of the strategic implementation plan available upon request.