Strategic Implementation Plan

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

FY 2026-2028

Introduction

Every three years, University of Chicago Medicine Ingalls Memorial Hospital (Ingalls Memorial) conducts a Community Health Needs Assessment (CHNA) to identify local health-related concerns within its community and Primary Service Area (PSA). This process includes direct engagement with community members and other stakeholders to identify the greatest health-related issues and obstacles.

This Strategic Implementation Plan (SIP) reviews the community benefit priority areas from the Ingalls Memorial 2024-2025 Community Health Needs Assessment and summarizes goals, strategies, objectives, and programs to address them.

At the Forefront of Health Equity

A foundational component of fulfilling UChicago Medicine's mission, vision, and values is health equity. We strive to ensure everyone in the community can reach their full health potential. The Urban Health Initiative (UHI) department at UChicago Medicine does this by collaborating with trusted community organizations and leveraging all of University of Chicago's resources to address the health inequities. The UHI works to build strong connections between UChicago Medicine and local neighborhoods, bringing doctors, researchers, and staff together with the community.

The UHI also supports Ingalls Memorial by addressing inequities that persist throughout Chicago's Southland (Southland) through programming and partnerships.

About Ingalls Memorial Primary Service Area

Although Ingalls Memorial provides care for patients throughout the Southland and the surrounding counties and townships, the community-based initiatives are focused on the 13 ZIP codes in Thornton Township. The PSA surrounding the hospital campus has a population of approximately 242,262 residents. Residents in these communities face social and economic challenges that contribute to health inequities, demonstrated by strikingly high rates of heart disease, diabetes, obesity, cancers, and other chronic diseases when compared to other areas of Cook County. These health problems are made worse by social and structural issues like poverty, high housing costs, too few options for food, few job opportunities, community violence, and struggles with mental health.

INGALLS MEMORIAL PRIMARY SERVICE AREA

ZIP Codes and Cities/Municipalities

60406
Blue Island
Dixmoor
Riverdale
Posen

60409
Calumet City
Lansing
Burnham

60419
Dolton

60425
Glenwood

60426
Harvey
Dixmoor
Markham
Phoenix

60429
Hazel Crest
Harvey
East Hazel Crest
Markham

60430
Homewood
Hazel Crest
Thornton

60438
Lansing

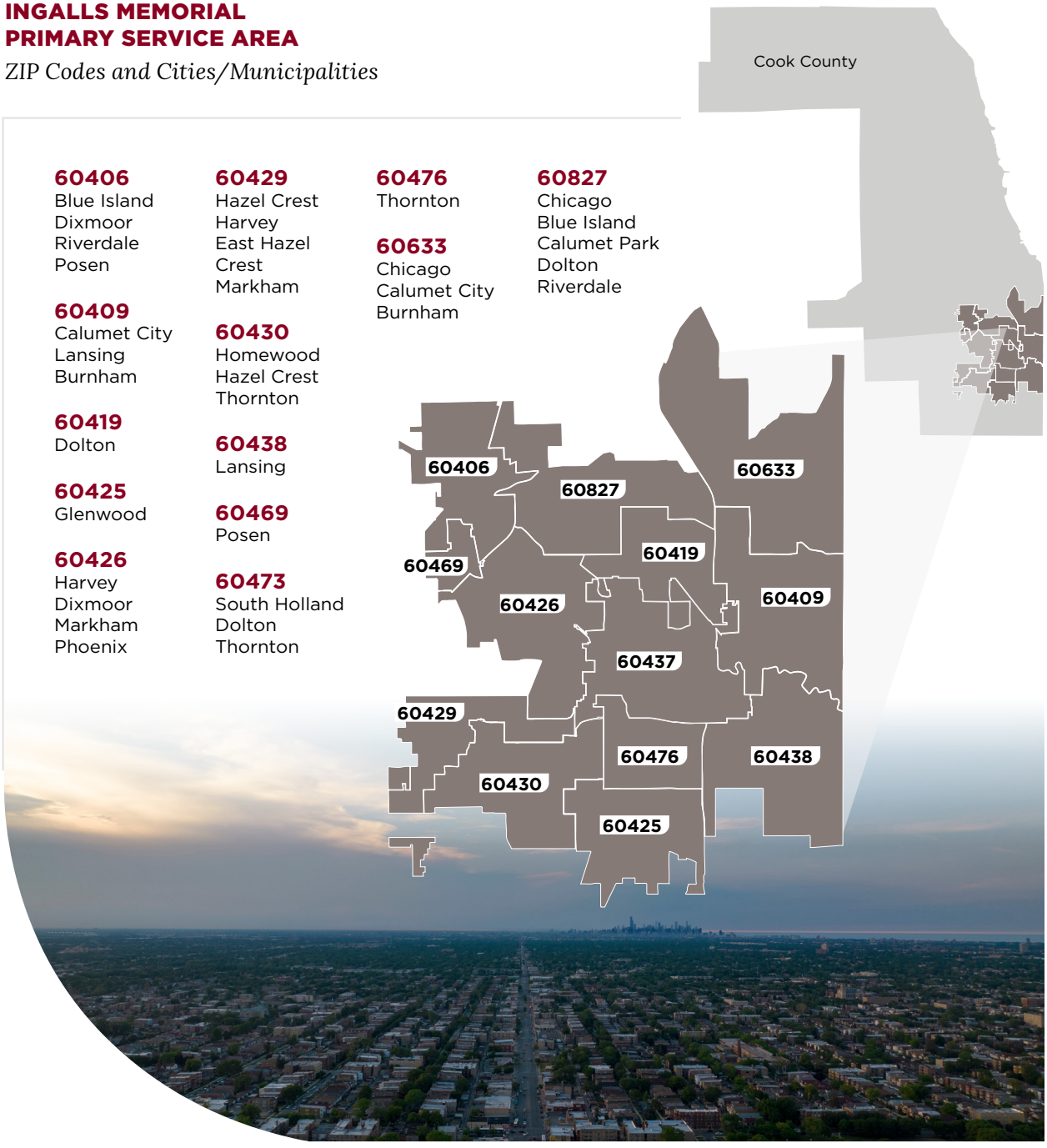
60469
Posen

60473
South Holland
Dolton
Thornton

60476
Thornton

60633
Chicago
Calumet City
Burnham

60827
Chicago
Blue Island
Calumet Park
Dolton
Riverdale



Creating Ingalls Memorial's Strategic Implementation Plan

Ingalls Memorial used a variety of methods to develop strategies and impactful solutions to address these community benefit priority areas:

» **Subject Matter Expert Focus Groups:** Experts from Ingalls Memorial and community-based organizations participated in focus groups centered on each priority area to better understand barriers and identify approaches to making an impact.

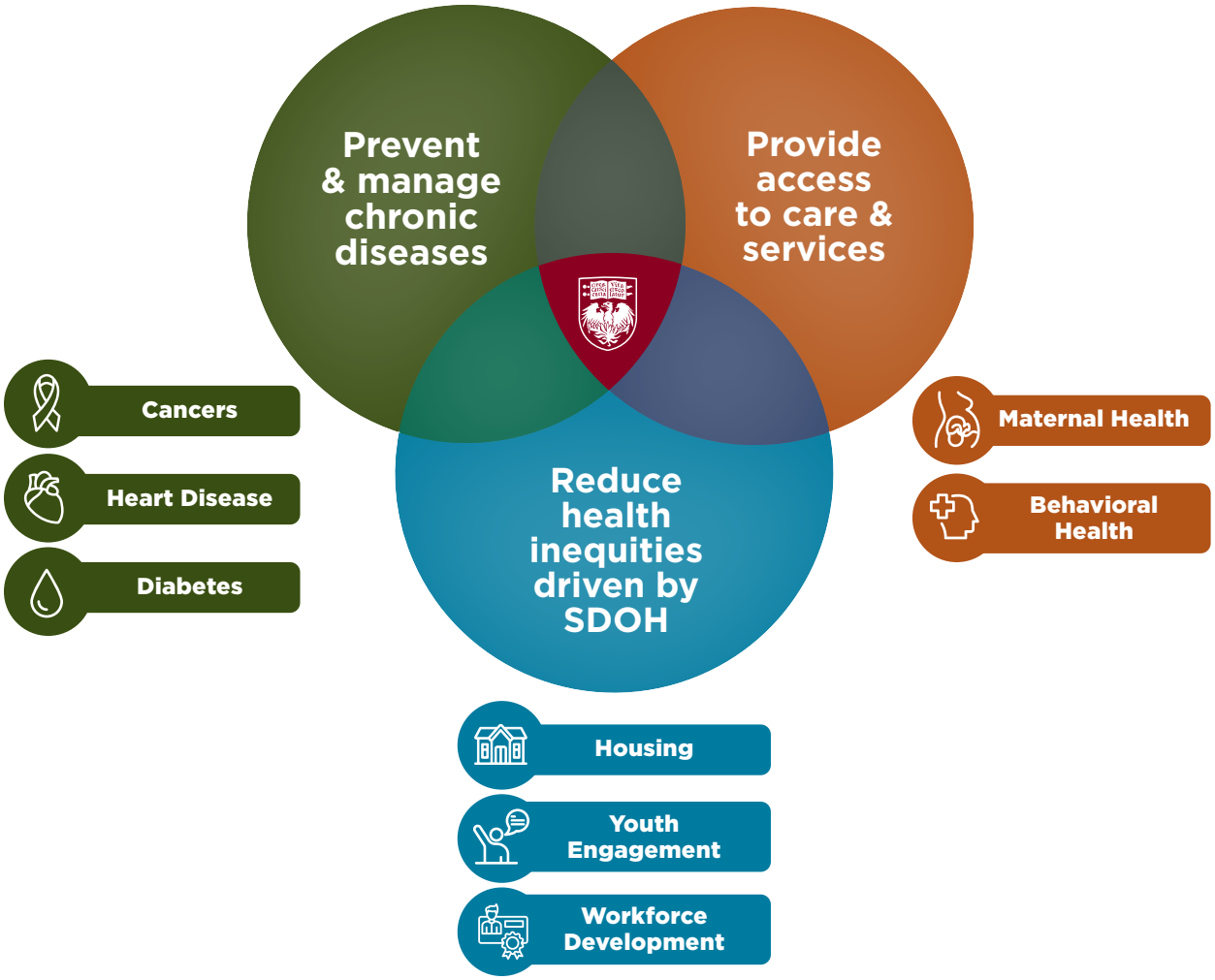
» **UChicago Medicine Elevate 2035 Plan:** Ingalls Memorial aligned its 3-year plan with UChicago Medicine's 10-year plan to transform healthcare and community health, which aligns with community and public health initiatives.

» **Population Health Initiatives Review:** Ingalls Memorial reviewed local, state, and federal health plans to understand their alignment with the community benefit priorities (CCDPH, IDPH, and CDC Healthy People 2030).

Identifying Community Benefit Priority Areas

The SIP focuses on achieving the greatest impact on the following community benefit priority areas: Cancers, Heart Disease, Diabetes, Maternal Health, Behavioral Health, Housing, Youth Engagement, and Workforce Development.

The SIP groups strategies and goals into three domains: prevent and manage chronic diseases, provide access to care and services, and reduce health inequities driven by Social Determinants of Health (SDOH), shown below:



Other Significant Health Areas of Work

A wide range of health issues emerged from the CHNA and SIP processes, yet not all health issues could be listed as a priority. Notable exclusions in this SIP include obesity, food insecurity, and violence prevention. Obesity and food insecurity remain cross-cutting areas of concern, with many system-level factors contributing to the inequities communities experience. For this reason, efforts to address these issues will be integrated across the outlined chronic disease prevention efforts. Similarly, while violence prevention was not selected as a health priority area for FY 2026-2028, it affects the health status of the whole community. Consequently, violence will be addressed in relation to each of the priority health areas by focusing on the social inequities caused by the Social Determinants of Health (SDOH) and by providing access to mental health services.

Addressing Community Benefit Priorities

Throughout the development of the SIP, several important themes and strategies emerged across all the community benefit priority areas:

1. Using a public health approach by focusing efforts on prevention and SDOH

2. Increasing the awareness and reputation of Ingalls Memorial's services and collaboration with community partners

3. Support the Ingalls Memorial's growth as an **Anchor Institution** to build a cohesive healthcare ecosystem in the Southland

Community Benefit Priority

Goal: Prevent and Manage Chronic Diseases

Cancers, Heart Disease, Diabetes

Living with chronic disease is associated with poorer quality of life, lower life expectancy, financial instability, and poor mental health. There are many social and structural barriers to living a healthy lifestyle in the Ingalls Memorial community and PSA. Residents struggle to access healthy foods, safe places to exercise, healthy environments, disease screenings, and other preventative services.

In addition to the strategies outlined below, Ingalls Memorial continues to invest, improve, and expand its care delivery system and initiatives through partnerships and innovation that address primary, secondary, and tertiary prevention for heart disease, diabetes, cancers, and obesity.

STRATEGIES		
Improve access and capabilities of programming	**Focus on Social Determinants of Health**	**Increase collaboration and partnerships for care and services**
• Improve community access to health programming • Expand current community health worker programming, department staffing, and certification access • Improve understanding of community health for community residents	• Build database of community resources and organizations for patient referrals • Develop system-wide SDOH screening and referrals process • Expand food access and nutritional education programs • Build a network of allied health professionals, including licensed and registered dieticians and nutritionists	• Assist patients with healthcare navigation and connection to primary and specialty care • Increase free and subsidized health screenings in community settings • Collaborate with youth-focused community organizations on education and preventive services

Key teams, programming, and collaborations in the PSA to support this:

Liaisons in Care (LinC) – fitness classes, hospital food drive – Complementary Nutrition Stations – community-based cancer health screenings – Integrative Wellness Center – genetic screening – Dietetic Internship Community Talks – Choose Healthier Balance Your Life Wellness – Aunt Martha's programming – Family Christian programming

Community Benefit Priority

Goal: Provide Access to Care and Services

Maternal Health and Behavioral Health

There is a significant shortage of obstetrical and gynecological care in the Ingalls Memorial PSA. In addition, the area has a labor and delivery shortage, limited prenatal care, and disparities in maternal mortality rates.

There are also high rates of self-reported mental health needs and healthcare utilization for behavioral health needs. When compared to Cook County, people in the Ingalls Memorial PSA are more likely to use the emergency department for a mental health crisis, substance use, and alcohol use. Community members consistently noted a lack of access to behavioral health support.

STRATEGIES		
Improve Ingalls Memorial's standing as a leader in healthcare and community support	**Increase access to obstetric and maternal health**	**Increase access to behavioral health and services**
• Increase awareness of OBGYN and mental health services, improvements, and outcomes • Build database of maternal and behavioral health resources and community programs • Develop and expand CHW support and training for maternal health	• Expand provider-sharing programs with FQHCs • Increase doula support for patients and community residents • Increase collaboration and capacity of high-risk OB providers • Improve maternal health data monitoring	• Support mental and behavioral health arm of the emergency department • Increase integration with primary care for screenings and referrals • Improve community awareness of and access to routine care

Key teams, programming, and collaborations in the PSA to support this:

Drive thru baby shower – ECHO – Healthy Baby Network – food and toy drive – mental health workshops – Senior Life – Integrative Wellness Center – Mamma Jamma Dance and Maternal Wellness

Community Benefit Priority

Goal: Address Social Determinants of Health (SDOH)

Access to Care, Youth Engagement, Workforce Development

Throughout the Southland, there has been a history of inequities related to Social Determinants of Health (SDOH). SDOH like education, employment, housing, and others have a major impact on people's health and must be addressed with focused strategies. They also shape how successful efforts to address other community benefit priority areas will be, so tackling them is essential for real progress.

The CHNA process identified key SDOH impacting Ingalls Memorial's PSA, including housing, youth engagement, and workforce development. Ingalls Memorial's PSA has significantly higher rates of opportunity youth, housing cost burden, poverty, and unemployment compared to county, state, and national measures.

STRATEGIES		
Increase investment in workforce development	**Expand role in screening and SDOH referrals OR Youth Engagement**	**Promote housing access and neighborhood improvements**
• Increase awareness of and participation in workforce development programs for in-demand healthcare skills and jobs • Develop a pipeline for sustainable employment and skill-building at Ingalls Memorial • Increase health and job fair participation with SDOH resource promotion	• Expand and improve youth connections to community programs and services • Develop safe community places for youth engagement and interaction • Focus on youth employment opportunities	• Champion policy change advocacy for CBOs and local needs • Continue building housing platform for Ingalls Memorial's workforce • Collaborate to establish housing services and coalitions, especially for abuse victims and employment programs
Key teams, programming, and collaborations in the PSA to support this:		
Finance intern program – Dietetic Internship Community Talks – Choose Healthier Balance Your Life Wellness program – Community Scholarships – workforce development internship program – community impact grants – You Matter 2 – Aunt Martha's programming – Anew – Family Christian programming – Southland Juvenile Justice Council		

Sharing the SIP

This plan is available online on UChicago Medicine's **website**. In addition, it will be shared with the Ingalls Memorial's Community Advisory Council, community members, local political representatives, faith leaders, healthcare providers, community-based organizations, and other stakeholders. Physical copies are available at the Urban Health Initiative office and upon request by email (**uch-communitybenefit@uchicagomedicine.org**).