AT THE FOREFRONT
UChicago Medicine

Community Health Needs Assessment

2024-2025

Contact for Feedback

Questions or comments regarding the Community Health Needs Assessment (CHNA), Evaluation Report, or Strategic Implementation Plan (SIP) can be sent via email to communitybenefit@uchicagomedicine.org.

For more information on the CHNA or Community Benefit at UChicago Medicine, please scan the QR code to the right or visit www.uchicagomedicine.org/about-us/community/benefit

Table of Contents

IRS Form 990
Schedule H Compliance

For nonprofit hospitals, a Community Health Needs Assessment also serves to satisfy requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Form 990, Schedule H, the following table cross-references related sections.

Section	Description	Page(s)
Part V Section B Line 3a	*A definition of the community served by the hospital facility*	15
Part V Section B Line 3b	*Demographics of the community*	16-18
Part V Section B Line 3c	*Existing healthcare facilities and resources within the community that are available to respond to the community's health needs*	11-12, 52-54
Part V Section B Line 3d	*How data was obtained*	19-23
Part V Section B Line 3e	*The significant health needs of the community addressed by the hospital facility*	49-50
Part V Section B Line 3f	*Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups*	26-48
Part V Section B Line 3g	*The process for identifying and prioritizing community health needs and services to meet community health needs*	49
Part V Section B Line 3h	*The process for consulting with persons representing the community's interests*	20-21
Part V Section B Line 3i	*The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)*	Appendix 2

Letter to Our Community

To our community members and partners:

At UChicago Medicine, we believe that everyone deserves the opportunity to live their healthiest life. For more than 20 years, through our Urban Health Initiative, we have worked alongside community members and partners, fellow healthcare providers, public health leaders, and elected officials to better understand and respond to the health needs of our communities.

We are sharing the results of our 2024–2025 Community Health Needs Assessment (CHNA), shaped by the voices, concerns, and priorities of the communities we serve, and grounded in our shared commitment to health equity. By combining public health data, community input, and thoughtful analysis, the CHNA has guided our equity-focused efforts across the South Side and the Southland since 2012.

Our work is also guided by Elevate 2035, UChicago Medicine's 10-year strategic plan that turns our Mission, Vision, and Values into action—focusing on making a difference, committing to excellence, embracing curiosity, taking ownership, and advancing equity. These values shape how we invest in and with the communities we serve.

With the 2024 opening of our multispecialty care center in Crown Point, Indiana, we're also expanding access to care and bringing new investment to support the health of Northwest Indiana communities.

Across all of the communities we serve, we remain deeply committed to finding long-term solutions to complex health challenges and inequities. To our community partners—we're grateful for your insight, energy, and collaboration which make this work possible. We look forward to continuing this journey toward improved health equity, together.

Mark Anderson, MD, PhD
Dean and Executive Vice President for Medical Affairs, University of Chicago

Krista M. Curell, Esq., RN, BSN
President, UChicago Medicine Northwest Indiana

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Michael Antoniades
President, UChicago Medicine Ingalls Memorial Hospital

Executive Summary

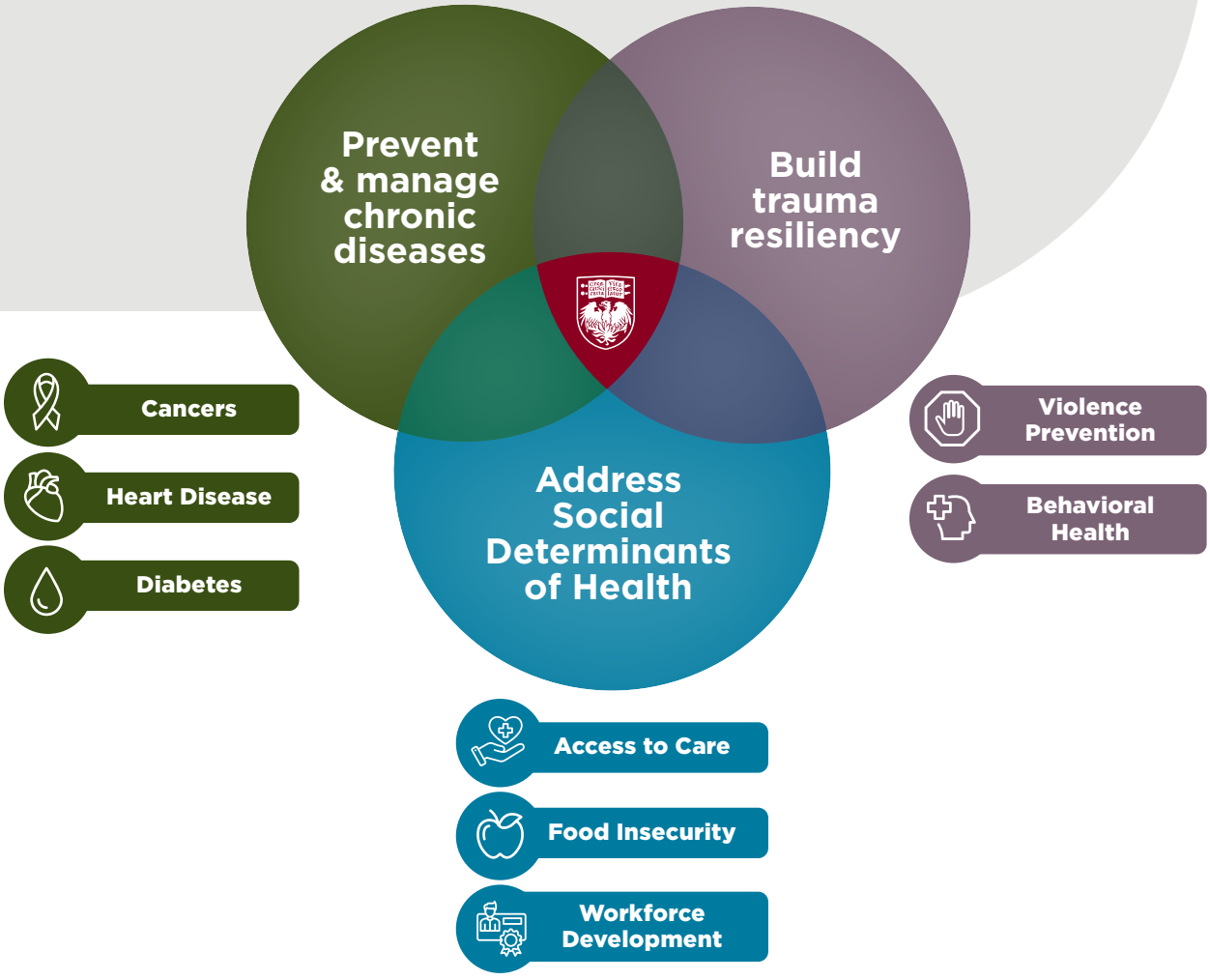
The University of Chicago Medical Center (Medical Center) conducted a Community Health Needs Assessment (CHNA) to identify areas of greatest need and allocate resources to improve community health and wellness within the hospital's primary service area (PSA). To complete the 2024–2025 CHNA, the University of Chicago Medical Center partnered with UChicago Medicine Ingalls Memorial and Metopio, a software and services company.

The CHNA process engaged multiple stakeholders to gather and interpret data and prioritize health areas. Stakeholder groups provided insight and expertise around health indicators, types of community input questions to ask, interpretation of results, and prioritization of the areas of highest need.

A variety of data sources were used for the CHNA, including community input surveys, focus groups, key informant interviews, and secondary data from federal sources, local and state health departments, and community-based organizations.

This report provides a thorough overview of the process that the Medical Center implemented to complete the CHNA, including data collection methods and an overview of the PSA. It also includes results on certain social determinants of health and health conditions for the PSA.

Based on the findings from the CHNA, the Medical Center identified the following community benefit priorities for the next three years, FY 2026-2028:



Introduction

Since the passage of the Affordable Care Act in 2010, the University of Chicago Medical Center (Medical Center) has conducted and completed a Community Health Needs Assessment (CHNA) every three years. Through this process, the Medical Center directly engaged community members and stakeholders to identify the issues of greatest need and the largest obstacles to health.

The CHNA provides a community-informed and data-driven overview of the health needs within our Primary Service Area (PSA) and is a critical tool in our mission to advance community health. With the help of community stakeholders, we identified the most pressing health priorities that will guide the Medical Center on how to best use resources. As a nonprofit safety-net hospital that provides services regardless of a patient's ability to pay, the Medical Center is committed to enhancing community health in a measurable and impactful way.

The CHNA process was designed to meet federal requirements and guidelines in Section 501(r), including:

- Clearly defining the community served by the hospital and ensuring that the defined community does not exclude low-income, medically underserved, or minority populations in proximity to the hospital
- Providing a clear description of the CHNA process and methods; community health needs; collaboration, including with public health experts; and a description of existing facilities and resources in the community
- Receiving input from persons representing the broad needs of the community
- Documenting community comments on the CHNA and health needs in the community
- Documenting the CHNA in a written report and making it widely available to the public

This report outlines the CHNA process and summarizes the collected community health needs data. The subsequent SIP will detail strategies designed to address these identified health needs.

Who We Are:
One UChicago Medicine

The **University of Chicago Medicine** is a not-for-profit academic health system based on the University of Chicago campus on the city's South Side. UChicago Medicine unites three organizations to fulfill their shared mission of patient care, research, and education.

- **University of Chicago Health System:** The Health System is anchored by the University of Chicago Medical Center and includes hospitals, outpatient clinics, and physician practices across Chicago, its suburbs, and Northwest Indiana.
- **Biological Sciences Division:** UChicago's largest academic division includes 10 basic science and 14 clinical departments. Research and academic activities sit under the Biological Sciences Division.
- **Pritzker School of Medicine:** UChicago's medical school is co-located on campus, offering students a unique learning environment for education, research collaboration, and community service.

Mission, Vision, Values

UChicago Medicine set out to create guiding principles to unify all UChicago Medicine entities with a shared framework aligned with the values of the University of Chicago. These principles will help UChicago Medicine achieve new heights together in our community.

UChicago Medicine's **Mission** is what drives the organization; it explains why we do what we do and the impact we want to have on society and the world. Our **Vision** is our long-term goal and the ambitious future we want to create. Our **Values** are the guiding principles that inform our actions, behavior, and decisions.

MISSION

As part of the University of Chicago, we pursue globally impactful solutions to seemingly unsolvable challenges. Through our rigorous research, innovative education, and comprehensive care and healing, we collaborate on life-changing advancements that create meaningful results for our community and the world, including a greater, more equitable future for all.

VISION

Together, we can elevate the human experience with knowledge and health care.

VALUES

Commit to Excellence
We contribute our exceptional talents to all we do and empower the same spirit of excellence in others.

Embrace Curiosity
We stay open to new ideas, champion diverse perspectives, and drive a culture of thoughtful risk taking to deliver transformative innovation.

Embody Equity
We identify systemic issues then foster change to drive a more equitable environment inclusive of diverse people, ideas, and fields of science.

Grow Together
We meaningfully collaborate with one another to create something bigger than we could ever achieve alone.

Make a Difference
We lead with heart and compassion in all our interactions. We create positive change in our areas of influence whether expanding scientific inquiry, developing the next generation of leaders, or healing our community.

Take Ownership
We accomplish what we say we will and hold ourselves and one another accountable for our actions.

The Health System

The University of Chicago Health System has a history dating back to 1927. It is known publicly as UChicago Medicine.

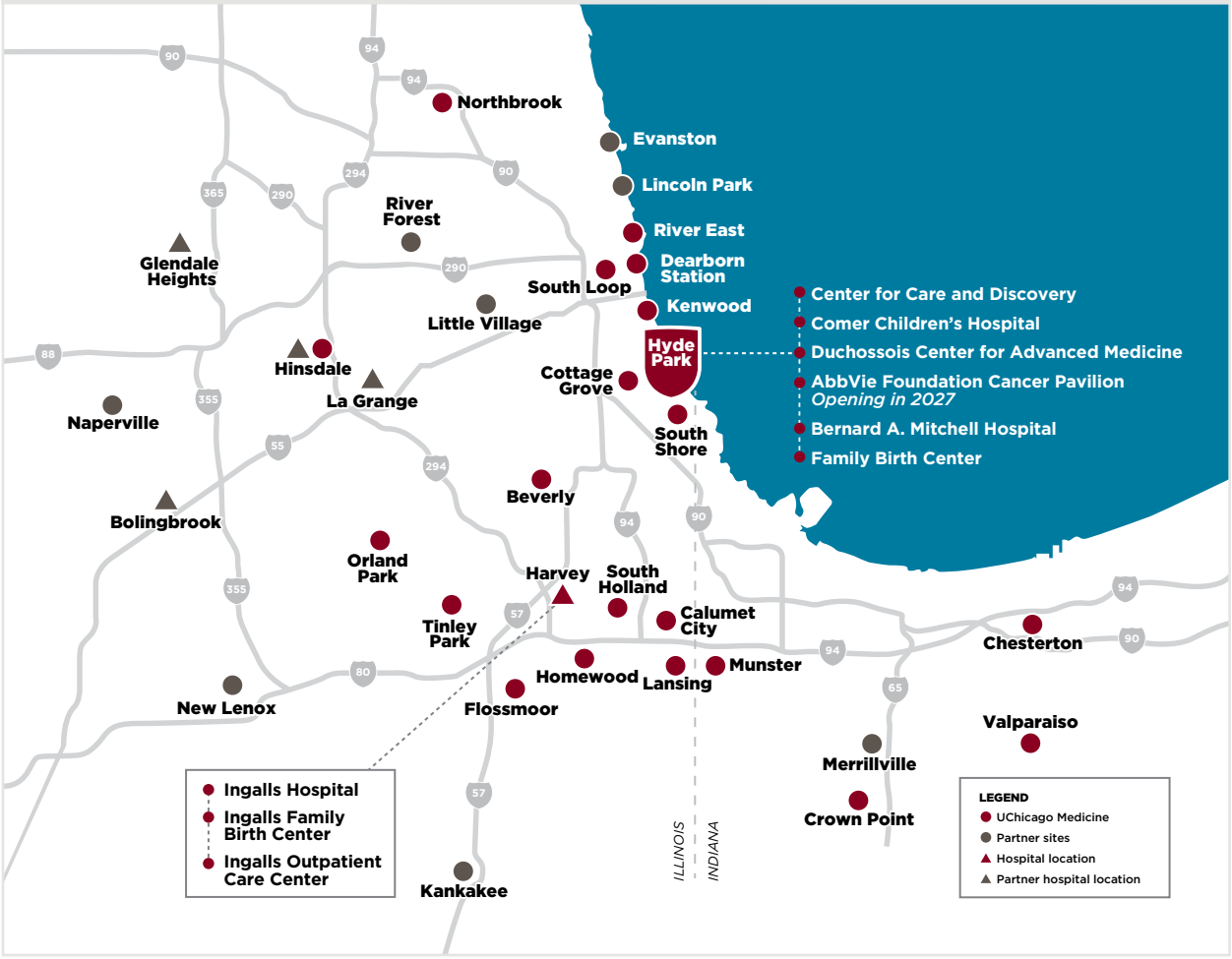
University of Chicago Medical Center
Health System flagship in Hyde Park, serving Chicago's South Side

UChicago Medicine Ingalls Memorial
Serving the Southland & south suburbs

UChicago Medicine AdventHealth
Joint venture serving the western suburbs

UChicago Medicine Crown Point
Multispecialty center & micro-hospital in Northwest Indiana

UChicago Medicine Medical Group
A clinically integrated network of providers affiliated with UChicago Medicine and independent community providers



University of Chicago Medical Center

At a Glance: Fiscal 2024

FACILITIES

3 Inpatient Facilities

- Center for Care and Discovery
- Bernard M. Mitchell Hospital
- Comer Children's Hospital

Also: Level 1 Adult and Pediatric Trauma Center

811 Licensed Beds

678 Staffed Beds
506 Med-Surg
146 ICU
46 OB-GYN
60 General Pediatrics
53 NICU

42 Operating Rooms

5 Ambulatory Care Facilities

- Duchossois Center for Advanced Medicine
- River East
- South Loop
- Printers Row
- Orland Park

Also: AdventHealth Great Lakes, Comprehensive Cancer Center at Silver Cross, and off-site clinics in Chicago and suburbs

PEOPLE

11,341 Employees

Including:

906 Faculty Physicians
168 Community-based Physicians
3,223 Nurses
1,085 Residents & Fellows
512 APPs

VOLUME

1,005,532 Ambulatory Appointments*
1,023,681 Outpatient Encounters
27,645 Surgical Cases
34,969 Hospital Admissions
235,459 Hospital Patient Days
2,608 Births
103,793 ED Visits
69,752 Adult
34,041 Pediatric
4,895 Trauma Activations
3,975 Adult
920 Pediatric

*Appointments include both onsite and telehealth

Connecting with Community

The Urban Health Initiative (UHI)

The Urban Health Initiative (UHI) is UChicago Medicine's community health division. The UHI facilitates and coordinates efforts to address the complex health and social needs of those living on the South Side of Chicago. The UHI ensures that UChicago Medicine is an active part of improving the lives of South Side residents by bringing a collaborative, community-based, and participatory problem-solving approach to the health and social needs of our patients and the broader community.

The UHI provides an essential public health perspective for UChicago Medicine. UHI programs cover all public health function areas and essential services. The UHI analyzes upstream factors, including social and institutional inequities and living conditions that affect health, and implements services and programs to address these issues.

In addition, the UHI develops high-quality educational programs and communications that reflect and address the needs of community residents. It oversees population health management and community benefit programs, working with community health centers, community hospitals, community-based organizations, local schools, churches, and other groups to develop innovative strategies to improve the quality of and access to services on the South Side. The UHI serves as a two-way bridge to the community and ensures UChicago Medicine is an active part of improving the lives of residents in the Medical Center's service area.

Community health challenges are approached with a collaborative, community-based, and participatory focus that promotes health equity.

Asset-Based Community Development

The UHI implements strategies to promote health in the community and provide equitable care in the hospital through Asset-Based Community Development. Asset-Based Community Development (ABCD) is a strategy for sustainable community-driven development that begins with a community's strengths instead of its deficits.

How the ABCD strategy works:

ASSET

Communities identify and mobilize existing, but often unrecognized, assets.

BASED

Individuals, associations, and institutions come together to build based on their assets and further leverage the skills and resources available in the community.

COMMUNITY

Using these identified individual and collective assets, communities respond to needs and create new opportunities.

DEVELOPMENT

Together with organizations and partners, the community leverages its strengths to invest in itself and address its challenges.

Community Benefit Primary Service Area (PSA)

The Medical Center's Primary Service Area (PSA) is represented by 12 ZIP codes that surround the hospital campus on the South Side of Chicago. The PSA is comprised of 28 Chicago Community Areas, with partial coverage of additional communities.

UNIVERSITY OF CHICAGO MEDICAL CENTER PRIMARY SERVICE AREA

ZIP Codes and Chicago Community Areas

60609
Armour Square
Bridgeport
Douglas
Fuller Park
Gage Park
Grand Boulevard
McKinley Park
New City
Washington Park

60615
Grand Boulevard
Hyde Park
Kenwood
Washington Park

60617
Avalon Park
Calumet Heights
East Side
Hegewisch
South Chicago
South Deering

60619
Avalon Park
Burnside
Calumet Heights
Chatham
Greater Grand Crossing
Roseland
South Shore

60620
Ashburn
Auburn Gresham
Beverly
Chatham
Englewood
Greater Grand Crossing
Roseland
Washington Heights

60621
Englewood
Greater Grand Crossing
Washington Park

60628
Pullman
Riverdale
Roseland
Washington Heights
West Pullman

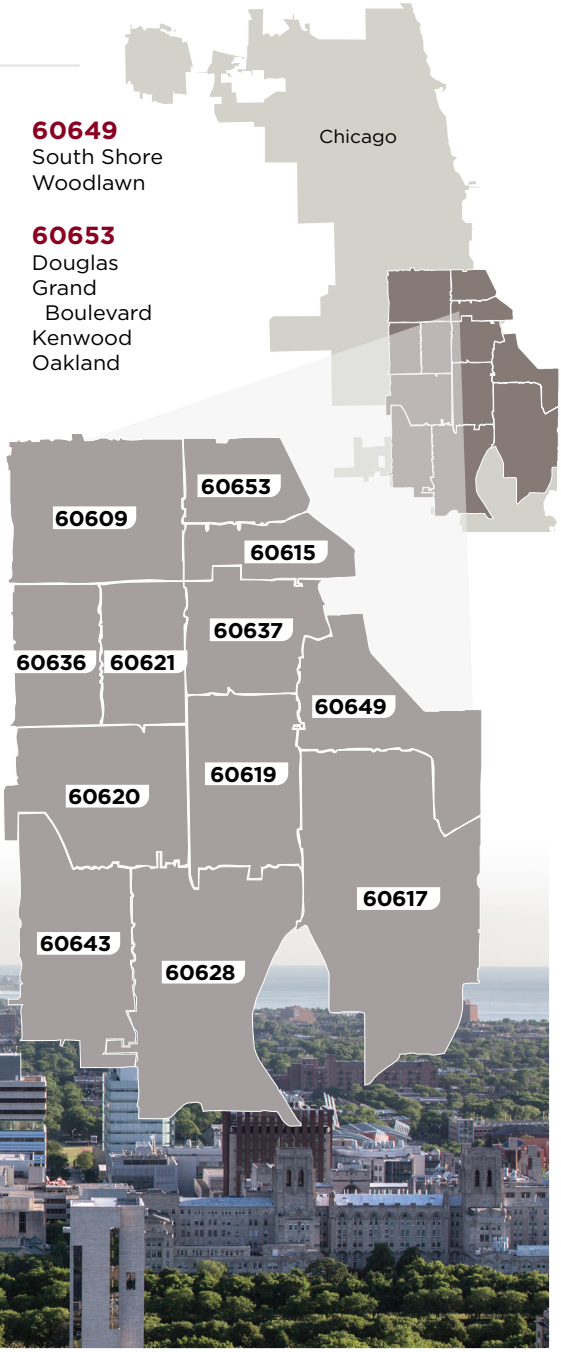
60636
Chicago Lawn
Gage Park
West Englewood

60637
Greater Grand Crossing
Hyde Park
South Shore
Washington Park
Woodlawn

60643
Beverly
Morgan Park
Washington Heights
West Pullman

60649
South Shore
Woodlawn

60653
Douglas
Grand Boulevard
Kenwood
Oakland



*Some community areas stretch across multiple ZIP codes. Our community benefit service area extends only to those parts of a community area within the 12 ZIP codes identified.

PSA Demographics

The Medical Center PSA is home to 613,792 residents, which has decreased 3.06% since 2010 (U.S. Census Bureau). The following figures show key demographics for the PSA, compared to the county, state, and national averages when applicable.

POPULATION BY RACE/ETHNICITY

University of Chicago Medical Center PSA, 2018-2022

Full Population
613,792
±9,180 residents

Non-Hispanic Black
439,315
±8,228 residents

Hispanic or Latinx
94,260
±4,203 residents

Non-Hispanic White
49,997
±2,247 residents

Asian
12,588
±1,094 residents

Native American
495
±181 residents

Pacific Islander/Native Hawaiian
141
±125 residents

Two or more races
14,724
±1,988 residents

Created on Metopio | metop.io/i/f1xinc8b | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (ACS: Table B01001; Decennial Census: Table P012)
Population: Average population over the time period.

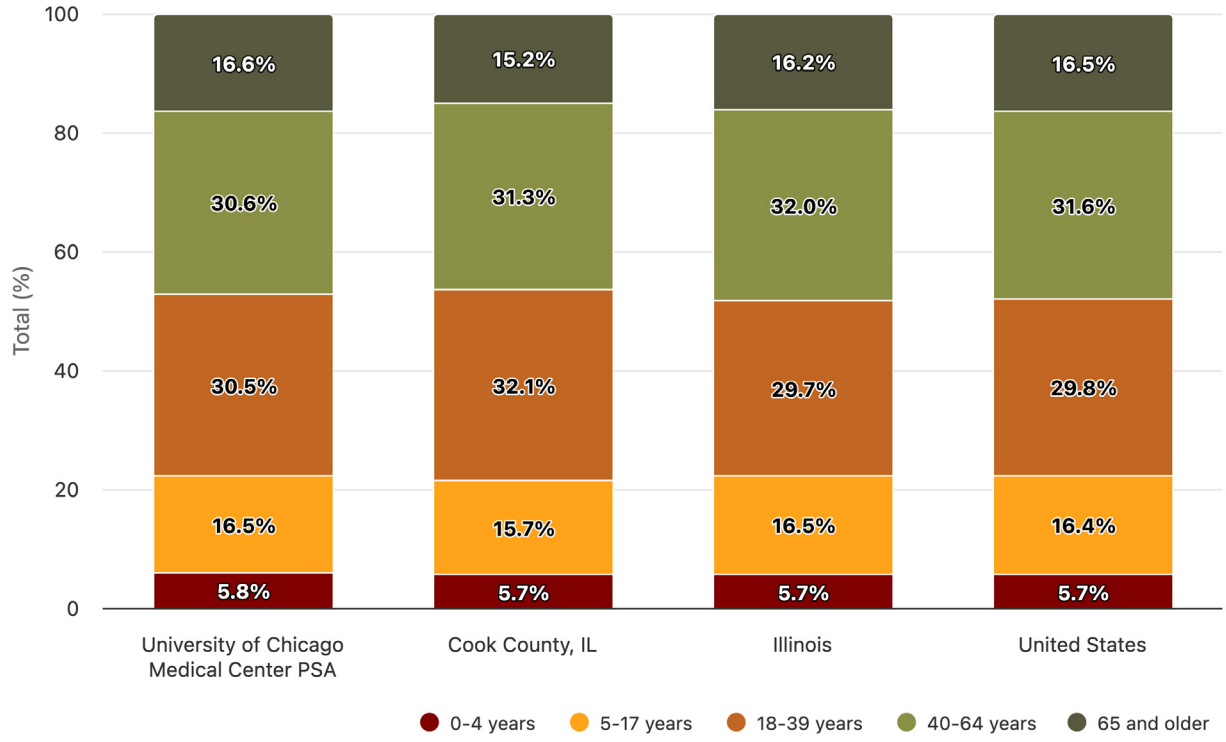
73.2% of the PSA's population is Non-Hispanic Black

14.6% is Hispanic or Latinx

8.2% is Non-Hispanic White

POPULATION BY AGE

University of Chicago Medical Center PSA and comparison, 2018-2022



Created on Metopio | metop.io/i/sj9m49fp | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (ACS: Table B01001; Decennial Census: Table P012)
Population: Average population over the time period.

The largest group (30.6%) of the PSA's population is 40 to 64-years-old

30.5% is 18 to 39-years-old

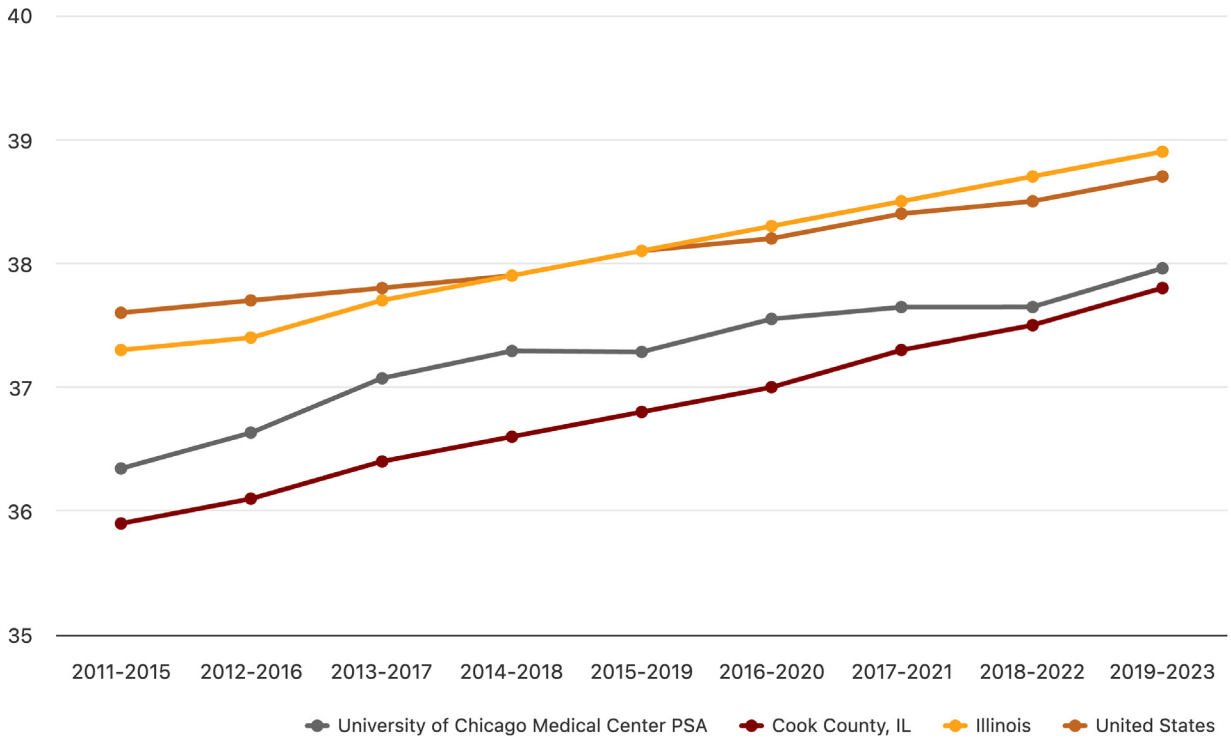
There are more females than males in the total population

POPULATION BY SEX

According to the U.S. Census Bureau (2018-2022) American Community Survey (ACS), there are more females (54.5%) than males (45.5%) in the Medical Center PSA. When the data was collected, the ACS only had two options for sex.

POPULATION BY MEDIAN AGE

University of Chicago Medical Center PSA and comparison



Created on Metopio | metop.io/i/zfrdhioo | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Table B01002)

Median age: The median age represents the age of the "middle" resident, if they were all lined up from youngest to oldest. (Half of all residents are older than this, and half are younger.)

The Medical Center PSA has had an increase in median age since 2011, from 36.3 to 38.0 years.

CHNA Process and Methods

The Medical Center conducted its CHNA process between March 2024 and March 2025 using an adapted process from the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework (NACCHO, 2025). This planning framework is one of the most widely used for CHNAs. It focuses on community engagement, partnership development, and participation from people who are historically excluded from community decision-making processes. One example of proactive community outreach included conducting a focus group in Spanish to reflect the growing Latinx or Hispanic population in the Medical Center PSA.

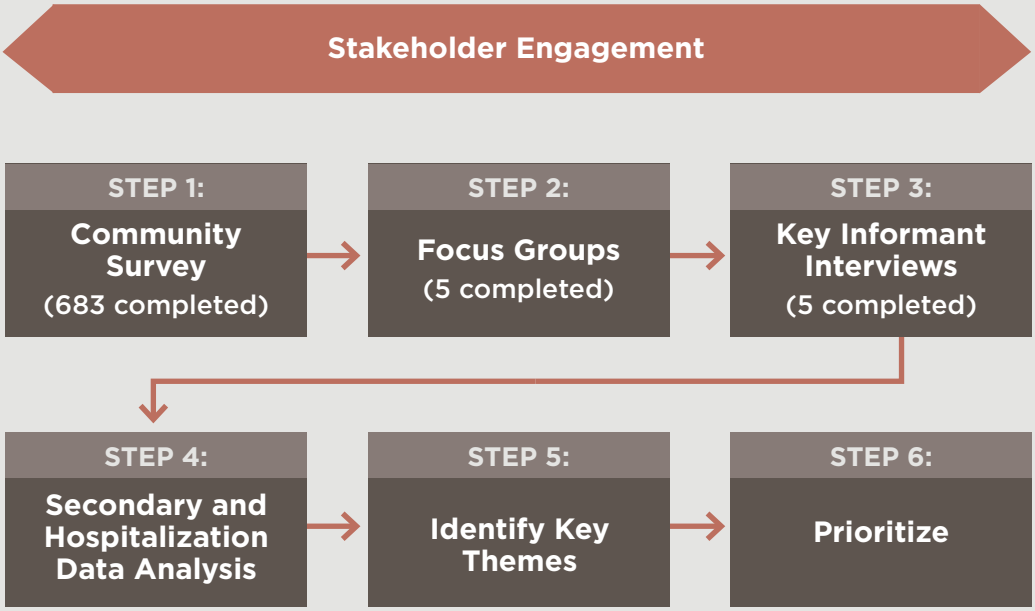
- Built on prior CHNAs from 2021-2022, as well as other local assessments, regional assessments, and plans.
- Contributed to greater understanding and insight into community health needs for ongoing community health priorities, including the Medical Center SIP.
- Leveraged the expertise of community residents, community partners, and key stakeholders, including a broad range of sectors and people disproportionately affected by health inequities.
- Provided an overview of the community health status of a designated area and highlighted data related to health inequities.
- Informed strategies related to population health, connections between community and clinical sectors, anchor institution efforts, policy change, and community partnerships.
- Highlighted health inequities and underlying root causes throughout the report.

The Medical Center collaborated with Metopio for the 2024-2025 CHNA. Metopio is a software and services company with a data visualization platform. Leaders from the Urban Health Initiative (UHI) worked with Metopio to guide the strategic direction of the CHNA and engaged various internal committees and workgroups to ensure broad engagement of diverse perspectives across the Medical Center. Together, we utilized a variety of primary and secondary data sources to ensure a robust analysis of the community's health needs. This assessment leverages the following data sources:

- Primary survey data
- Community focus group data
- Detailed key informant interviews
- Claims data
- Secondary data

Once collected and compiled, the data were analyzed to compare health needs in our PSA to benchmarks at the city, county, state, and national levels. Results were then presented to and reviewed by key stakeholders in the community and across the hospital system. This multi-faceted approach ensures that our findings and subsequent actions were informed by a wide audience.

Detailed methods are described in the figure below:



Stakeholder Engagement

The CHNA process engaged several internal and external groups to collect, curate, and interpret data. That data was then used to prioritize the health needs of the community. Stakeholder groups and their roles are defined below:

UCHICAGO MEDICINE COMMUNITY BENEFIT STEERING COMMITTEE

The Community Benefit Steering Committee is comprised of staff and faculty who provide advice and oversight of UChicago Medicine's community benefit programs, reporting, and CHNA development and execution. The committee is responsible for providing input on the planning and implementation of policies, processes, and programs that support the community benefit function of the Hospital System. The committee meets quarterly and oversees the development and implementation of the CHNA process and reports, as well as the overall Community Benefit strategy.

UNIVERSITY OF CHICAGO MEDICAL CENTER COMMUNITY ADVISORY COUNCIL (CAC)

The Medical Center's Community Advisory Council (CAC) is a representative group of 32 volunteer members who live and/or work on the South Side of Chicago. The full CAC meets every three months and is organized into two workgroups focused on Chronic Disease and Violence Prevention Trauma Care. The CAC advises the Medical Center on issues that impact the broader community, such as ensuring the new Cancer Center will have features and services that address the needs and preferences of South Side residents. In addition, it advises Medical Center leadership on strategic engagement and communication to inform the CHNA and its subsequent Strategic Implementation Plan. Specifically, members of the CAC played a key role in identifying community organizations for focus groups, recruiting participants for qualitative data, disseminating the survey, and ensuring diverse community voices were heard throughout the CHNA process.

Data Collection

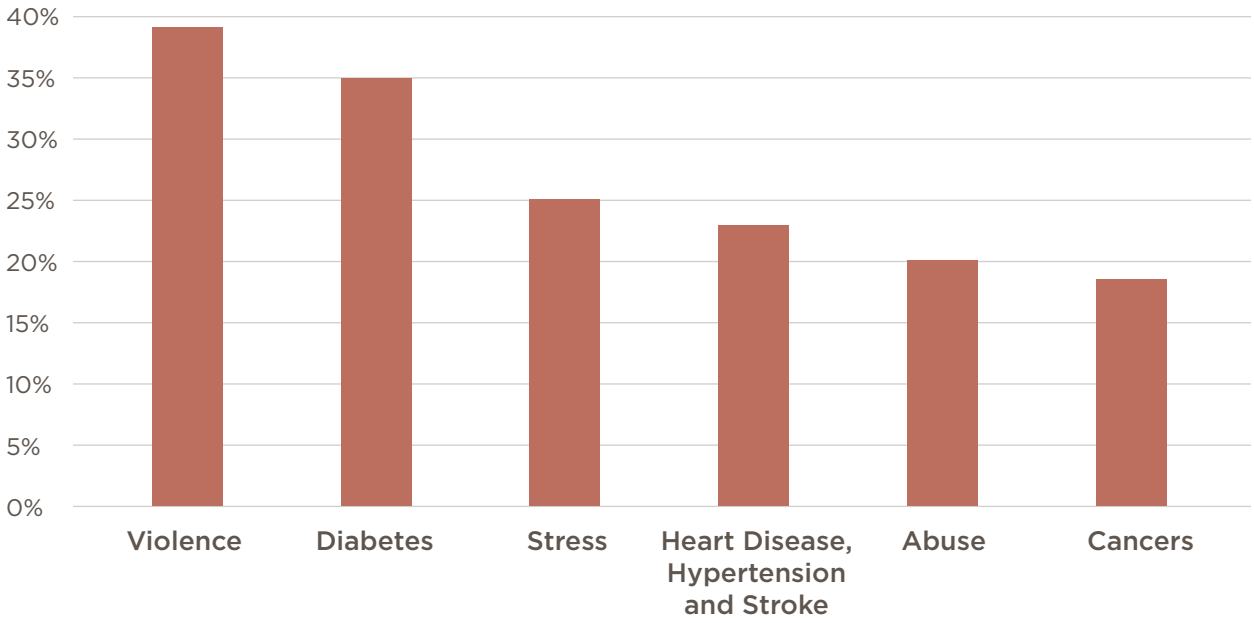
Primary and secondary data from residents who live in the Medical Center PSA were collected from July to December 2024. Below is an explanation of the methods, as well as some key findings.

PRIMARY DATA

Community Input Survey at a Glance

- Conducted between July 2024 and October 2024
- 683 Medical Center PSA resident surveys were collected
- Available online or on paper
- Disseminated in English and Spanish, with additional languages available upon request
- 22 questions on the survey (the full survey tool can be found in Appendix 3)
- Survey topics included healthcare access, top community health issues, and demographics
- Promoted via community partner events, email, and digital and in-person outreach within the hospital
- Survey data was weighted to reflect the demographic makeup of the Medical Center's PSA

Community Input Survey respondents ranked the top health issues as follows:



Additional community input survey results and demographic data can be found in Appendix 4.

Community Focus Groups at a Glance

Conducted between October 2024 and November 2024

Participants were recruited through hospital-community partnerships

Participants were age 12 or older

Conducted four Medical Center PSA resident focus groups focused on the following population or health issue area:

- Youth
- Chronic Disease (conducted in Spanish)
- Mental Health and Trauma
- Workforce Development

Focus groups were held in a semi-structured format and were conducted in person, via video conference, or as a hybrid model

One Healthcare Provider and Care Coordinator focus group was conducted with internal hospital staff

Key Informant Interviews at a Glance

Conducted in December 2024

Interviews were conducted in a semi-structured format

Participants were community leaders with expertise on our community health priorities and have either lived or worked in the Medical Center PSA

Five interviews were completed

Respondents were asked to identify the top Social Determinants of Health (SDOH) and health conditions/ behaviors in the community

The focus groups and key informant interviews provided nuanced insights into the personal health experiences and obstacles faced by residents living in the Medical Center PSA. Altogether, these interviews and focus groups provided valuable qualitative data on the specific health and wellness challenges, resources, and priorities in the community.

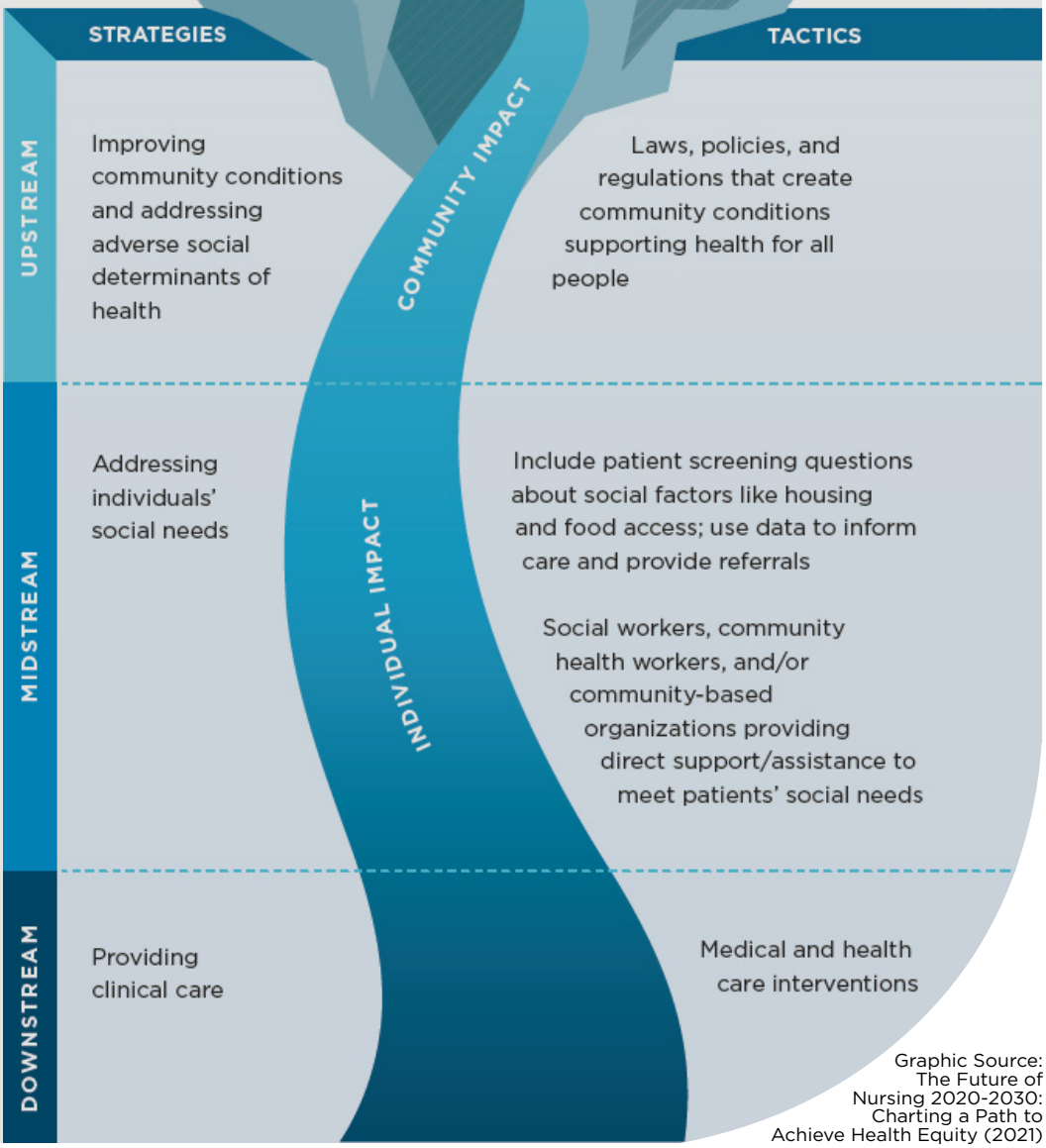
SECONDARY DATA

The Medical Center used a common set of health indicators to understand the prevalence of health conditions and mortality in the PSA, then compared these statistics to benchmark regions at the county, state, and federal levels. Where possible, the Medical Center used data with stratifications to better explore and articulate health inequities. These health equity indicators were used for key stakeholder review. For a list of secondary data sources, see Appendix 5.

Drivers of Health Inequities

University of Chicago Medicine is focused on understanding the social, structural, and systemic factors that may impact health outcomes. The framework below outlines tactics for achieving health equity that address both the root causes and potential interventions to reduce disparities.

Social Determinants and Social Needs

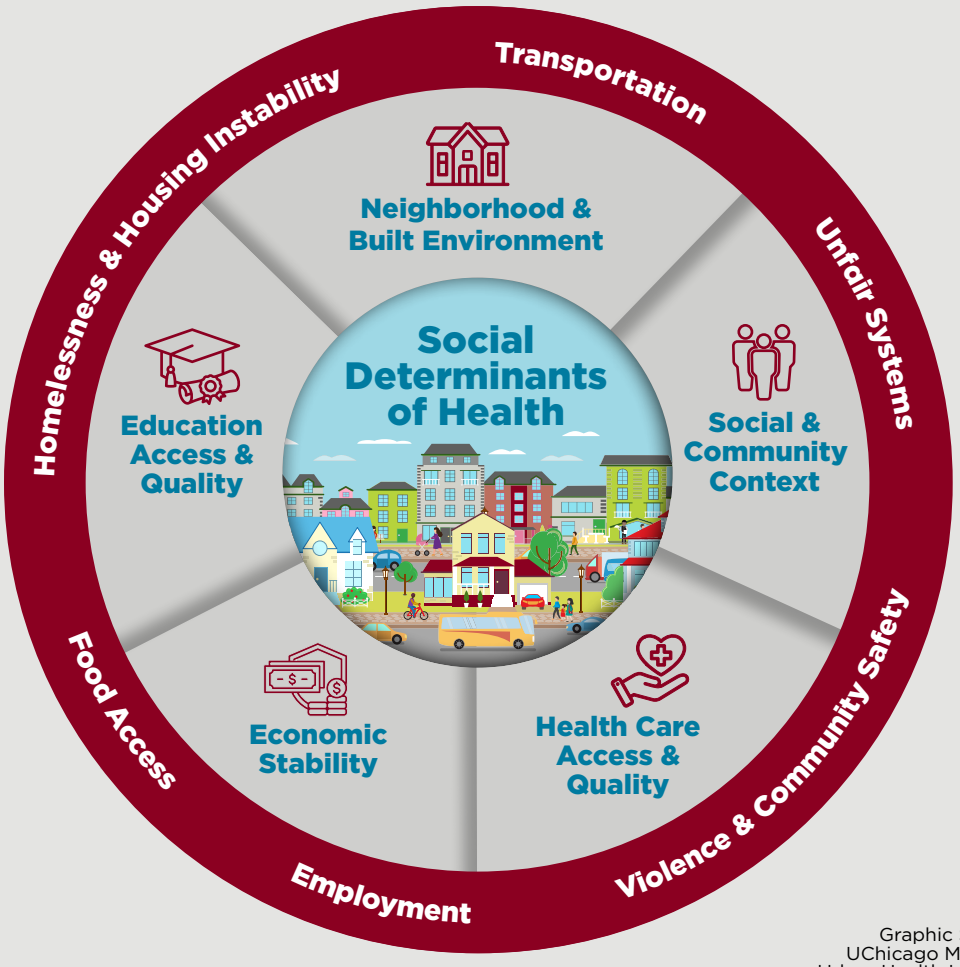


Graphic Source: The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity (2021)

Social Determinants of Health

As defined by the Centers for Disease Control and Prevention (CDC), the Social Determinants of Health (SDOH) are non-medical factors that affect health outcomes. They include the conditions in which people are born, grow, work, live, and age. They also include the broader forces and systems that shape everyday life conditions. SDOH are often linked to a lack of opportunity and resources to protect, improve, and maintain health. The CDC encourages health organizations to address the underlying factors related to key categories of SDOH, including:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context



Graphic Source:
UChicago Medicine
Urban Health Initiative
SDOH (2025)

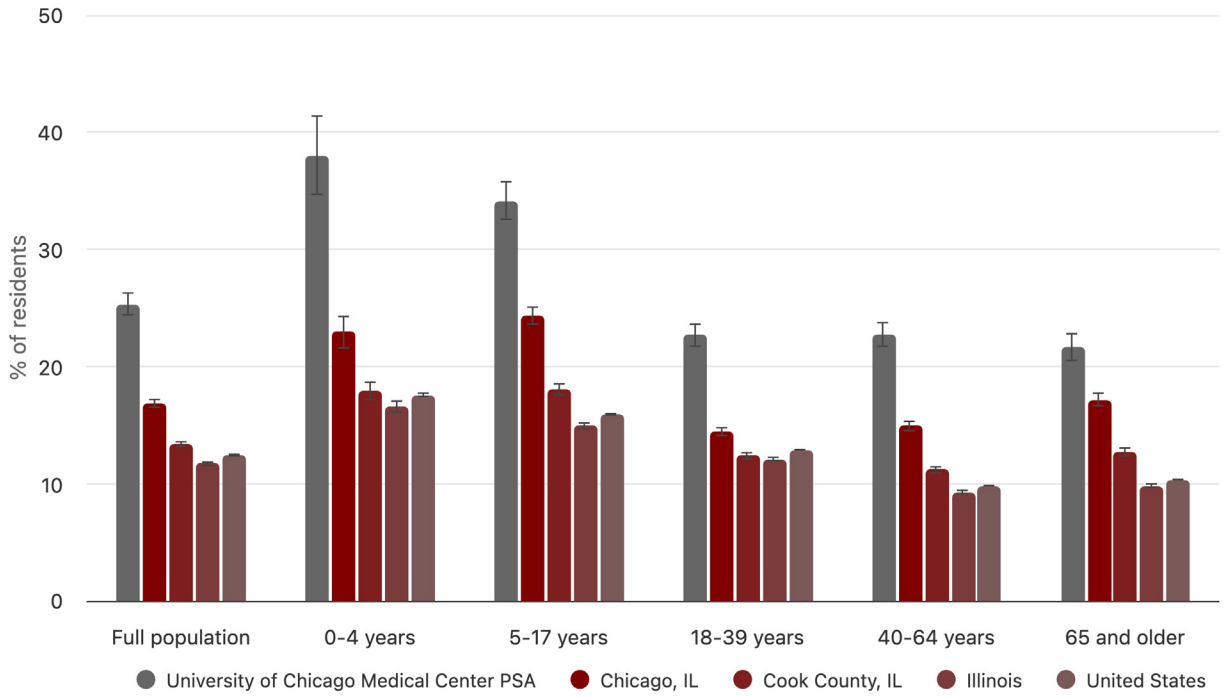
Economic Stability

Economic stability explores the link between an individual's financial resources and their health. To evaluate economic stability, we analyzed indicators such as poverty, income, and employment.

> "If you have economic depression and poverty, you already have overall bad health."
>
> - Key Informant Participant

POVERTY RATE BY AGE

Medical Center PSA and comparison, 2019-2023



Created on Metopio | metop.io/i/1qquv1fm | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Table B17001)

As seen in the chart above, the Medical Center PSA poverty rate (25.29%), or the percent of residents in families that live below the Federal Poverty Level, is higher on average than the rate in Chicago (16.83%), Cook County (13.34%), and Illinois (11.72%). The poverty rate in the Medical Center PSA is highest among people who are 17 years old or younger. As shown in the table below, the Medical Center PSA unemployment rate is higher than the Cook County and Illinois averages. Additionally, the median household income is lower than the Cook County and Illinois averages.

	Medical Center PSA	Cook County, IL	Illinois
Unemployment Rate % of residents 16 and older	**14.5%**	5.6%	4.7%
Median Household Income	**$49,519**	$80,579	$80,306

Education

As shown in the table below, the high school graduation, higher education, and college graduation rates for the Medical Center PSA are lower than the Cook County and Illinois averages.

	Medical Center PSA	Cook County, IL	Illinois
High School Graduation Rate % of residents	**86.0%**	88.6%	90.6%
Any Higher Education Rate % of residents	**59.1%**	66.7%	65.3%
College Graduation Rate % of residents	**27.4%**	43.6%	38.3%

> “For people of color, obstacles and barriers to become a doctor (to go to college, medical school, and to complete a residency) are so insurmountable.”
>
> - Key Informant Participant

Healthcare Access and Quality

Limited access to healthcare providers can result in delayed or inadequate healthcare, affecting the overall health outcomes of community members. Access can be restricted by a lack of providers, poor geographic distribution of services, difficulty affording and signing up for health insurance, and the cost of services, even with health insurance.

During focus groups and key informant interviews, community members noted issues with transportation, lack of centralized information, insurance coverage, language barriers, and the physical distance to healthcare facilities. These barriers can lead to delayed treatments, misdiagnoses, and poorer health outcomes. Community members also described the importance of culturally competent care and the need for healthcare systems to adapt to the diverse needs of the community they serve.

Community members described notable efforts to accommodate non-English speakers and those without insurance, yet significant gaps remain, particularly in emergency services and subspecialty care. Community members described challenges with the physical accessibility of healthcare facilities, especially in urgent situations, and the high costs associated with care that discourage many from seeking necessary services.

The table below shows that a higher percentage of adults in the Medical Center PSA have visited a doctor within the past 12 months for a routine checkup than the Cook County and Illinois averages. However, there are fewer primary care providers in the Medical Center PSA compared to Cook County and Illinois. Furthermore, there is a higher percentage of Medical Center PSA residents using Medicaid or Medicare than in other surrounding areas.

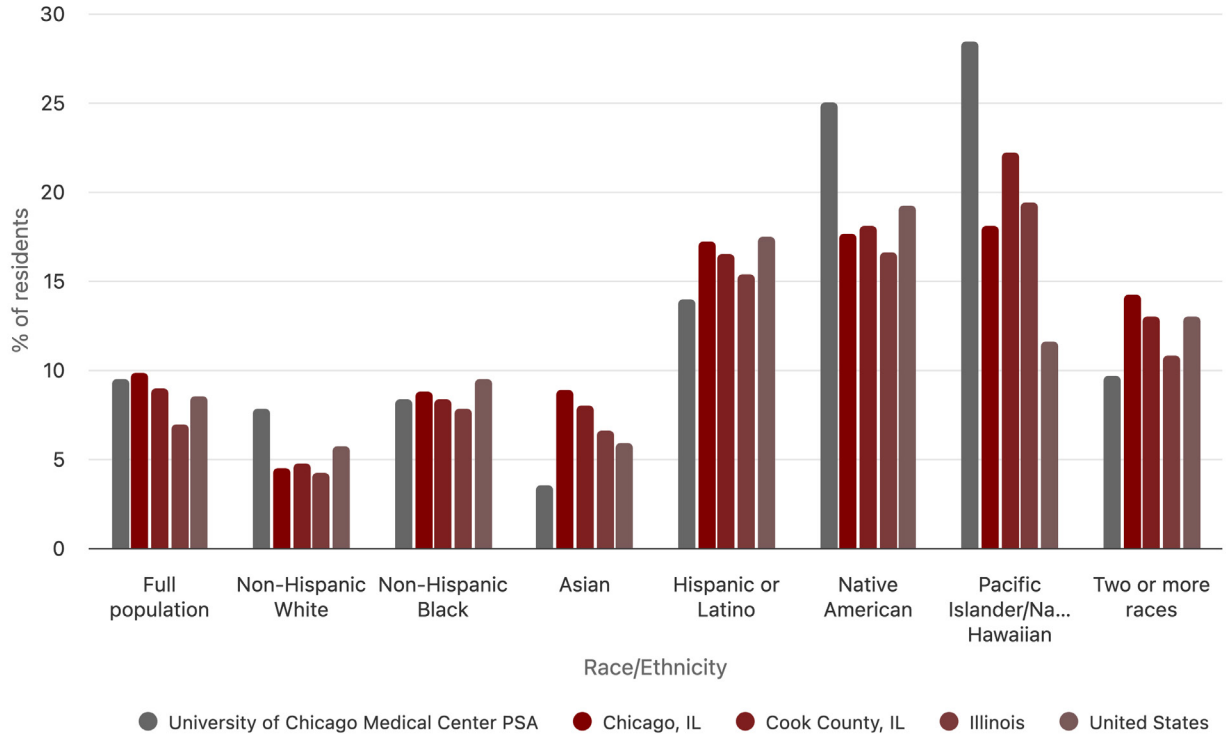
	Medical Center PSA	Cook County, IL	Illinois
Visited a Doctor for a Routine Checkup % of residents	**79.0%**	74.3%	74.5%
Primary Care Providers Per 100,000 residents	**64.4**	107.4	88.8
Medicaid Coverage % of residents	**37.1%**	22.3%	19.9%
Medicare Coverage % of residents	**18.5%**	16.7%	18.1%
No Vehicle Available % of households	**29.5%**	17.7%	10.8%

> “A lot of our patients live in pharmacy deserts.”
>
> - Provider Focus Group

As shown in the chart below, the data on uninsured rates across different racial and ethnic groups reveal disparities in access to healthcare. Non-Hispanic White individuals consistently have the lowest uninsured rates in the Medical Center PSA, Chicago, Cook County, and Illinois. These disparities suggest unequal access to healthcare and highlight the impact of race and ethnicity on insurance coverage within the community.

UNINSURED RATE BY RACE/ETHNICITY

Medical Center PSA and comparison, 2019-2023



Created on Metopio | metop.io/i/nj36dix7 | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Tables B27001/C27001)

Uninsured rate: Percent of residents without health insurance (at the time of the survey).

As shown in the table below, 86.2% of survey respondents reported having a primary care provider. The rate was lowest among individuals who identified as White or Latinx or Hispanic. Among survey respondents, 59.9% of respondents reported ever having a cancer screening. This rate was lowest among individuals who identified as Latinx or Hispanic.

	Asian	Black	Latinx or Hispanic	White	Total Population
Primary Care Provider	100.0%	87.8%	78.8%	77.9%	**86.2%**
Screenings (General)	74.7%	62.0%	41.8%	62.6%	**59.9%**

Neighborhood and Built Environment

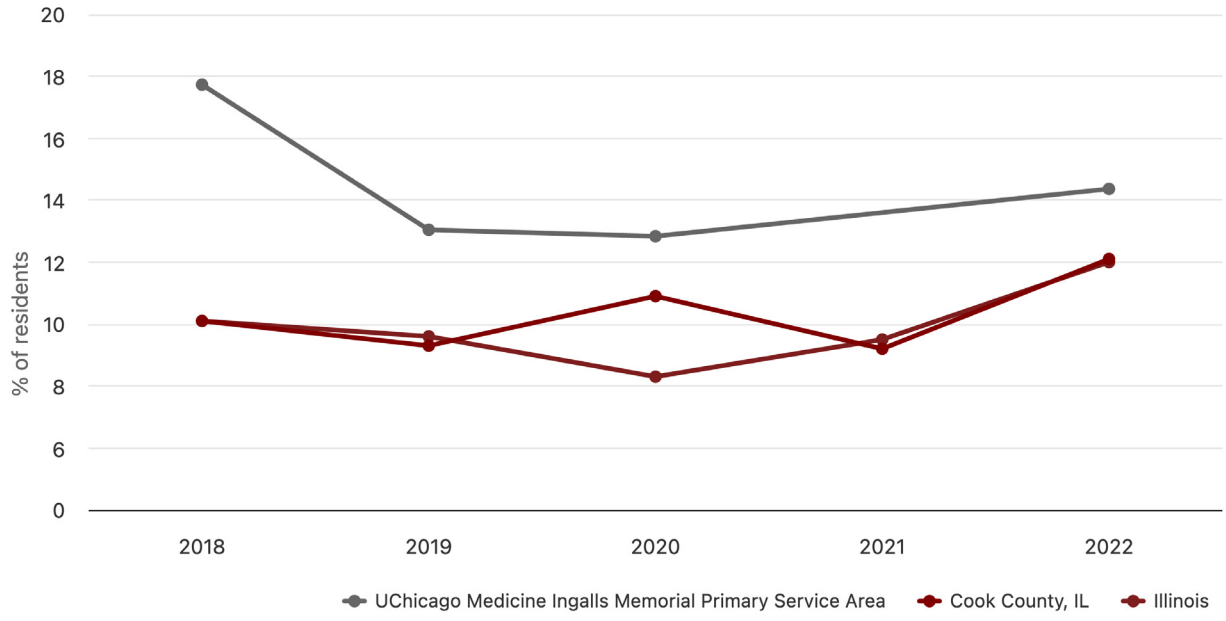
The built environment refers to the human-made surroundings in which people live, work, and play. It includes buildings, streets, parks, transportation systems, and other infrastructure, as well as levels of environmental pollution and hazards. Aspects of the built environment significantly influence public health outcomes, including physical activity levels, access to resources, and exposure to environmental hazards.

The built environment significantly impacts public health by influencing access to healthcare services, availability of resources, and overall community well-being. Community members in focus groups and key informant interviews noted a lack of nearby healthcare facilities, particularly for marginalized communities, and insufficient public transportation options that hinder timely access to medical care. Additionally, the Medical Center PSA was described as having limited access to essential medications and screening services, which exacerbates health disparities. The availability of healthy food options and safe recreational spaces also plays a critical role in shaping health outcomes. Community members noted an imbalance in the distribution of health-promoting resources such as fresh produce and green spaces, compared to less healthy options like liquor stores and CBD dispensaries.

Community members voiced their concerns about the physical barriers that prevent them from accessing healthcare. These barriers include long travel times to healthcare facilities, causing some to seek care far from their homes or forgo necessary treatments. Community members also described environmental justice issues, highlighting high rates of asthma and cancer linked to local industry pollution and the pressing need for cleaner, safer living environments.

FOOD INSECURITY

Medical Center PSA and comparison



Created on Metopio | metop.io/i/xotqxznv | **Data source:** Feeding America: Map the Meal Gap

Food insecurity: Percentage of the population experiencing food insecurity at some point. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food, as represented in USDA food-security reports. 2020 data is a projection based on 11.5% national unemployment and 16.5% national poverty rate.

> “I feel like we don’t have a lot of easy access to healthy food, and it’s really expensive.”
>
> - Youth Focus Group Participant

Access to healthy foods is imperative for wellness. Food insecurity is defined by Feeding America as uncertain or limited access to food.

According to Feeding America data from 2020, a higher percentage of adults in the PSA experience food insecurity, compared to the Cook County, Illinois, and United States averages.

Housing is also an important element of an area’s built environment. As shown in the table below, 42.7% of Medical Center PSA residents are considered housing cost burdened (spending more than 30% of their income on housing costs), which is higher than the county and state averages. Moreover, 24.3% of residents are severely housing cost burdened, meaning they are spending more than 50% of their income on housing costs. Notably, 14.3% of available housing units are vacant, and there is a lower percentage of home ownership than in Cook County and Illinois.

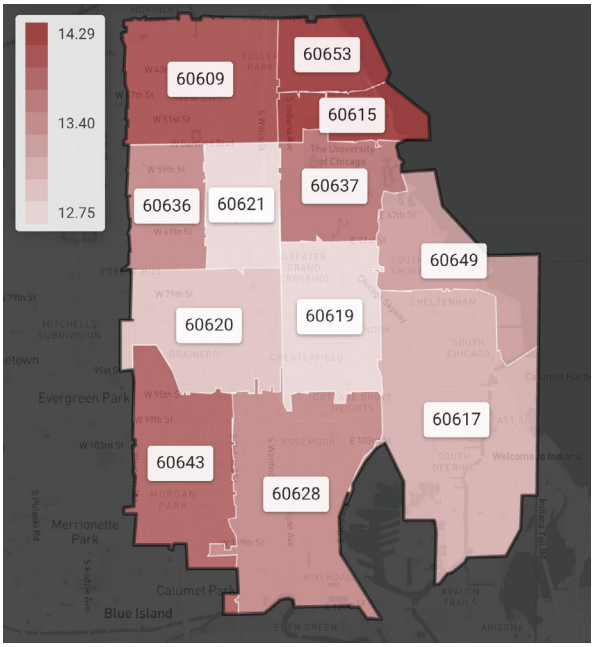
	Medical Center PSA	Cook County, IL	Illinois
Housing Cost Burden % of occupied housing units	**42.7%**	34.4%	29.4%
Severe Housing Cost Burden % of occupied housing units	**24.3%**	19.6%	13.9%
Owner Occupied % of occupied housing units	**43.1%**	57.8%	67.4%
Vacant % of housing units	**14.3%**	7.2%	7.3%

WALKABILITY INDEX

Medical Center PSA

The Walkability Index provides a ranking of the walkability of various areas based on intersection density, proximity to transit, diversity of businesses, and housing density. The data reveals that the walkability index varies across different ZIP codes in Chicago, with values ranging from 12.75 to 14.29. The map shows that areas shaded darker are more walkable than others, potentially impacting the community’s accessibility and quality of life.

The ZIP codes with the least walkability are 60653 and 60615.



Social and Community Context

Social and community factors significantly influence healthcare access and outcomes, impacting the availability and quality of medical services across different communities. Socio-economic disparities can lead to differences in the quality of care received and in the health outcomes of various demographic groups. Addressing these socio-economic barriers is crucial for improving health equity and ensuring that all community members have access to necessary healthcare services.

Community members express a range of concerns related to socio-economic factors that affect their health and access to care. These include challenges due to a lack of insurance, difficulties in accessing specialist care, and the high costs associated with certain medical services even when insured. Challenges included long wait times in emergency services, limited availability of essential medications, and significant travel distances to reach healthcare facilities.

Several community members have voiced specific frustrations: **"Even if you have medical insurance, there is a fear factor instilled in these individuals regarding high costs out of pocket when asking for ambulance services."** Statements like this underscore the critical nature of socio-economic factors in determining the accessibility and affordability of healthcare.

Individuals also noted challenges related to safety, violence, and access to care for individuals who have experienced trauma: **"There is a huge, huge gap that we see, obviously with our trauma population."**

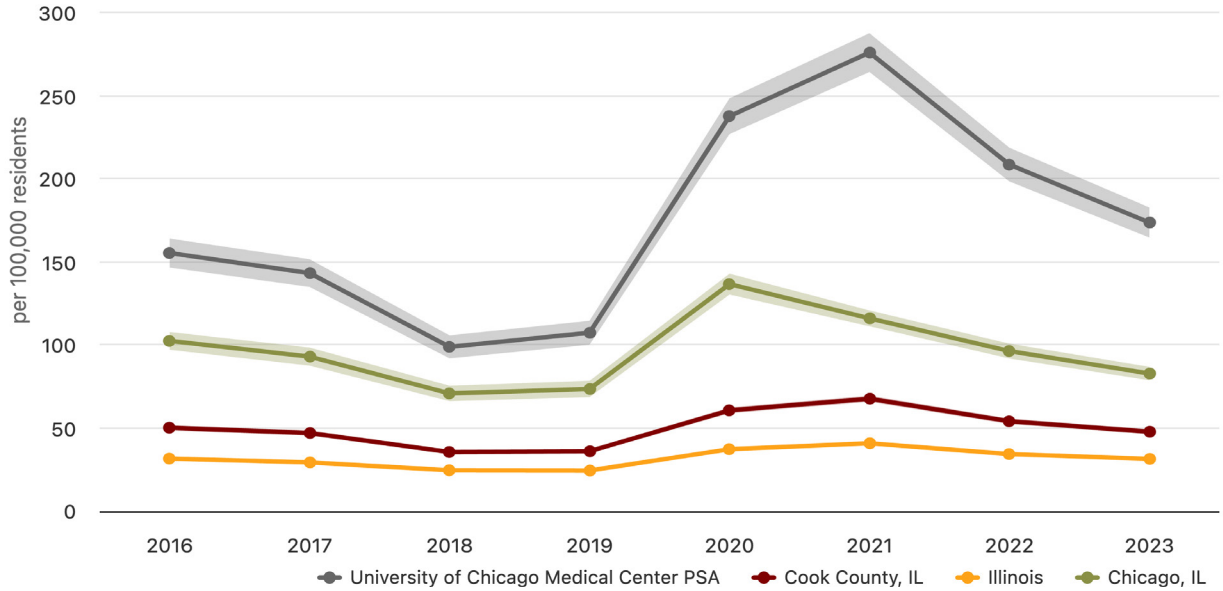
The table below shows community safety rates for the Medical Center PSA compared to Chicago averages. The Medical Center PSA experienced higher rates of burglary, homicide, larceny, arson, property crime, robbery, criminal sexual assault, and motor vehicle theft compared to the Chicago averages.

Condition (crimes per 100,000 residents)	Medical Center PSA	Chicago, Illinois
Violent Crime	1,718.4	1,812.4
Aggravated Assault/Battery	1,077.1	1,617.3
Burglary	450.5	233.1
Homicide	76.6	7.9
Larceny	2,090.0	1,205.7
Arson	52.0	9.4
Property Crime	4,028.7	1,818.6
Robbery	502.2	121.1
Criminal Sexual Assault	99.1	66.1
Motor Vehicle Theft	1,462.0	370.4

Key informants and focus group participants emphasized the need for social connectedness as a response to increasing rates of certain violent crimes. One key informant noted, **"Where you build community, there is less gun violence."** Furthermore, the top community need noted by survey respondents (57%) was activities for teens and youth, highlighting the importance of social and economic opportunities to reduce violence in the community.

ASSAULT BY FIREARMS EMERGENCY DEPARTMENT VISIT RATE

Medical Center PSA and comparison



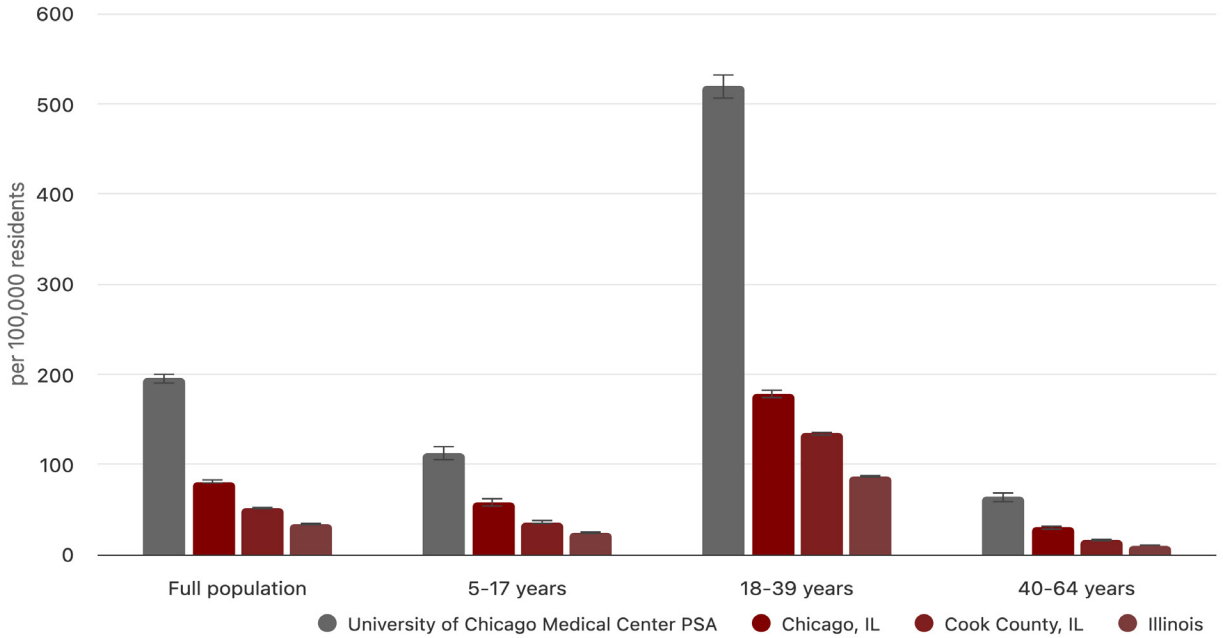
Created on Metopio | metop.io/i/ax5a7n36 | **Data source:** IHA COMPdata Informatics (Calculated by Metopio)

Assault by firearms emergency department visit rate: Annual emergency department visits for assaults with firearms per 100,000 residents. Risk-adjusted by age and sex. All hospital providers, all payers, based on patient residence.

The assault by firearms emergency department visit rate in the PSA remains higher than the Chicago, Cook County, and Illinois averages, although the rate has decreased since 2021. The rate is highest among individuals 18-39 years old.

ASSAULT BY FIREARMS EMERGENCY DEPARTMENT VISIT RATE BY AGE

Medical Center PSA and comparison, 2019-2023



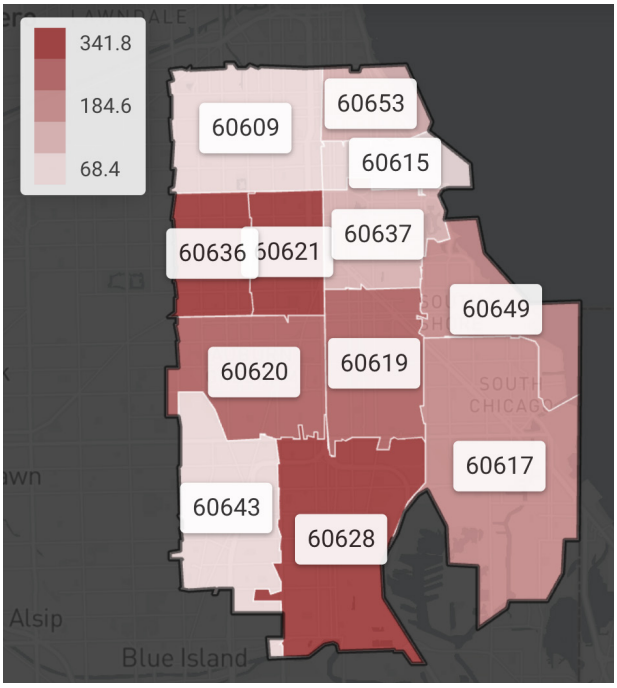
Created on Metopio | metop.io/i/pzypumw3 | **Data source:** IHA COMPdata Informatics (Calculated by Metopio)

Assault by firearms emergency department visit rate: Annual emergency department visits for assaults with firearms per 100,000 residents. Risk-adjusted by age and sex. All hospital providers, all payers, based on patient residence.

ASSAULT BY FIREARMS EMERGENCY DEPARTMENT VISIT RATE

Medical Center PSA, 2019-2023

As shown in the map below, the Medical Center PSA assault by firearms emergency department visit rate varies by ZIP code. The rate is highest in the 60636, 60621, and 60628 ZIP codes.



Economic opportunities (or a lack thereof) are often correlated with higher rates of violent crime.

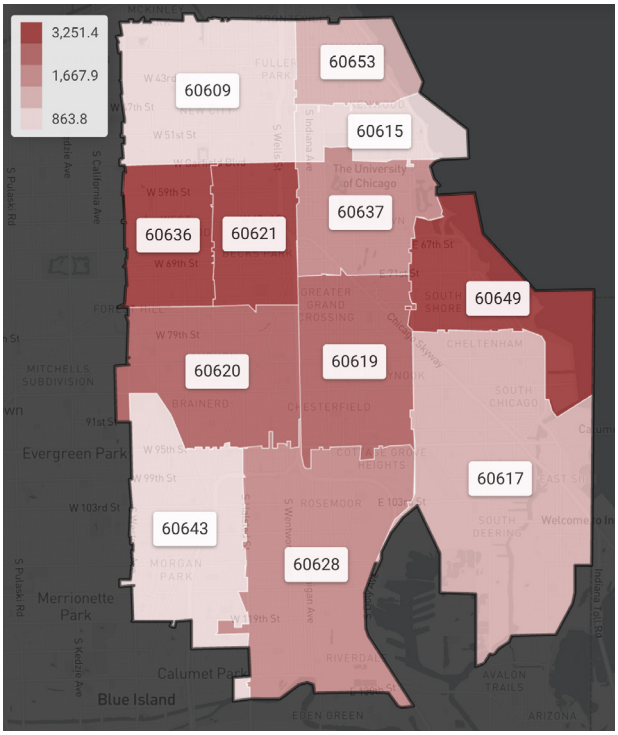
The two maps below show violent crime and the Social Vulnerability Index (SVI) at the ZIP code level.

The SVI indicates relative vulnerability by ranking places on 15 social factors, including unemployment, minority status, and disability, and combining the rankings into a single scale, lowest vulnerability (lighter shaded areas of map) to highest vulnerability (darker shaded areas of map).

The highest rates of crime and the highest SVI in the PSA are in the 60636, 60649, and 60621 ZIP codes.

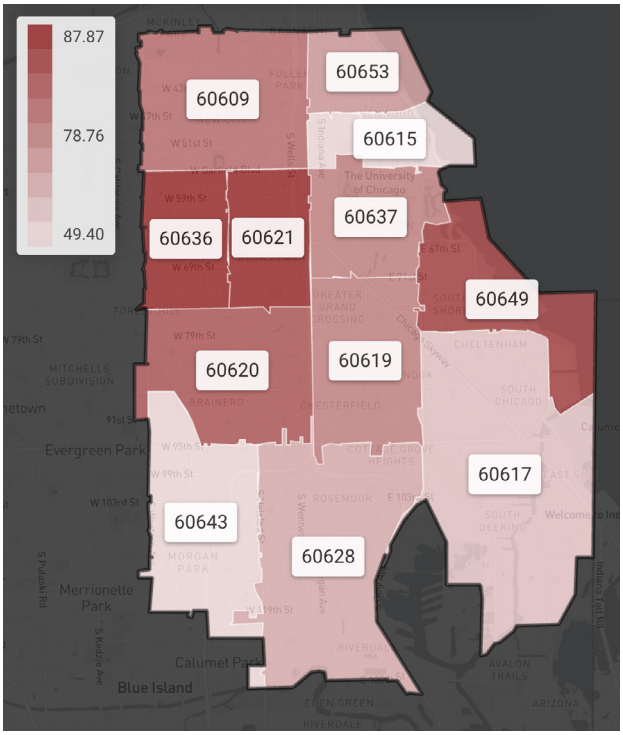
VIOLENT CRIME

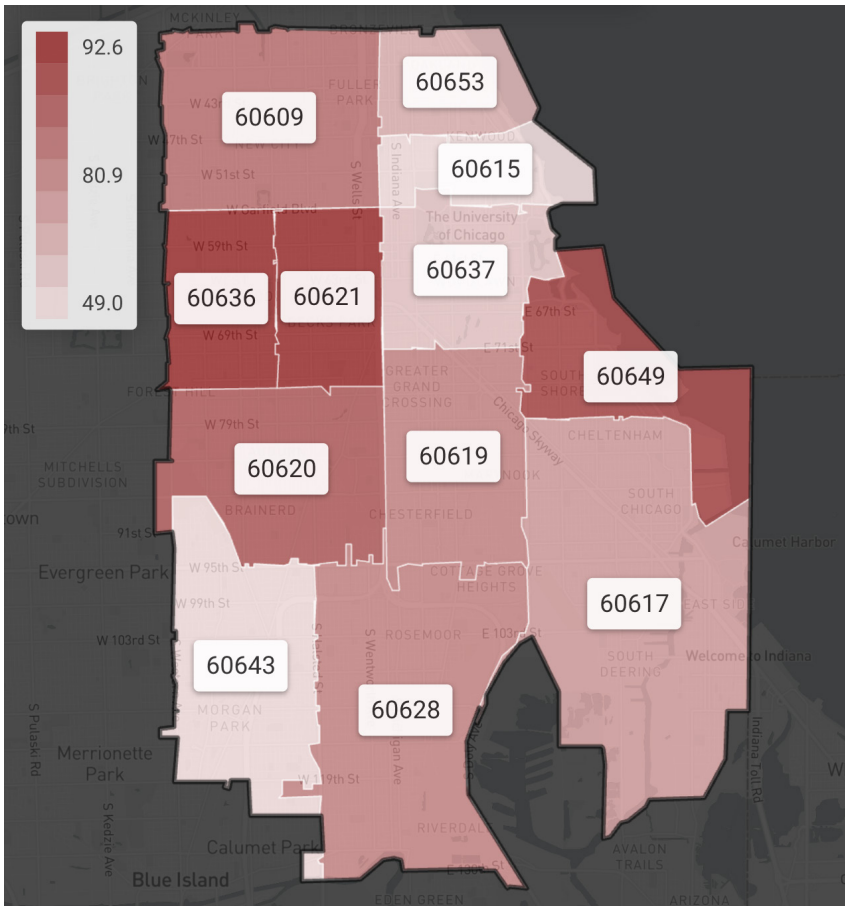
Medical Center PSA, 2018-2022



SOCIAL VULNERABILITY INDEX

Medical Center PSA, 2022





HARDSHIP INDEX

Medical Center PSA

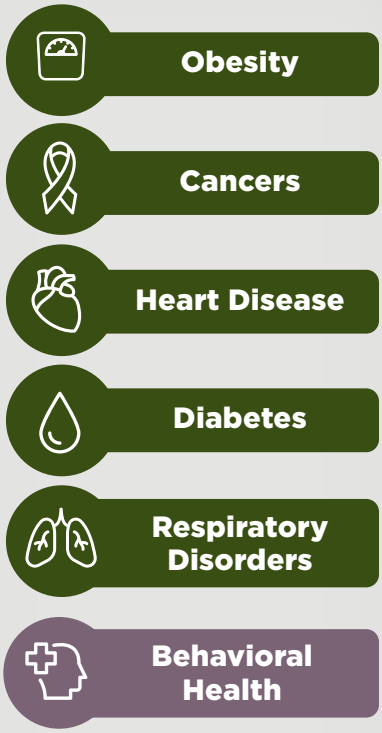
The Hardship Index map to the left is a composite score reflecting hardship in the community (higher values indicate greater hardship). It incorporates unemployment, age dependency, education, per capita income, and crowded housing. Higher scores (darker shaded areas of map) are correlated with poor health outcomes.

The Hardship Index for the Medical Center PSA is highest in the 60636 and 60621 ZIP codes.

> "Although there's public transportation to get there, in the case of an emergency, it is still far away."
>
> - Chronic Disease Focus Group Participant

Health Conditions and Mortality

During this CHNA cycle, the Medical Center identified obesity, cancers, heart disease, diabetes, respiratory disorders, and behavioral health as significant health conditions in the community.



CHNA Findings

Chronic Diseases

Chronic diseases such as diabetes, hypertension, asthma, and various forms of cancer significantly impact community health, often requiring continuous management and intervention. Community members from focus groups and key informant interviews expressed concerns about the accessibility and quality of healthcare services for managing these conditions, especially in areas with high poverty rates and limited healthcare facilities. Issues like incorrect diagnoses, inadequate treatment, and poor access to specialist care, such as dietitians and obesity medicine, were frequently mentioned. Additionally, environmental factors like pollution and lack of green spaces contribute to the exacerbation of chronic conditions, affecting both mental and physical health.

> “It’s holistic... what you eat has an impact, how much you exercise has an impact, the fact that you’re doing preventative screenings...”
>
> - Key Informant Participant

The table below shows the rates of chronic disease prevalence for the Medical Center PSA compared to the City of Chicago averages.

	Medical Center PSA	City of Chicago
Asthma % of residents	**11.5%**	9.7%
Arthritis % of residents	**27.8%**	21.5%
Cancer % of residents	**5.2%**	5.2%
Coronary Heart Disease % of residents	**6.8%**	5.3%
High Cholesterol % of residents	**30.0%**	27.0%

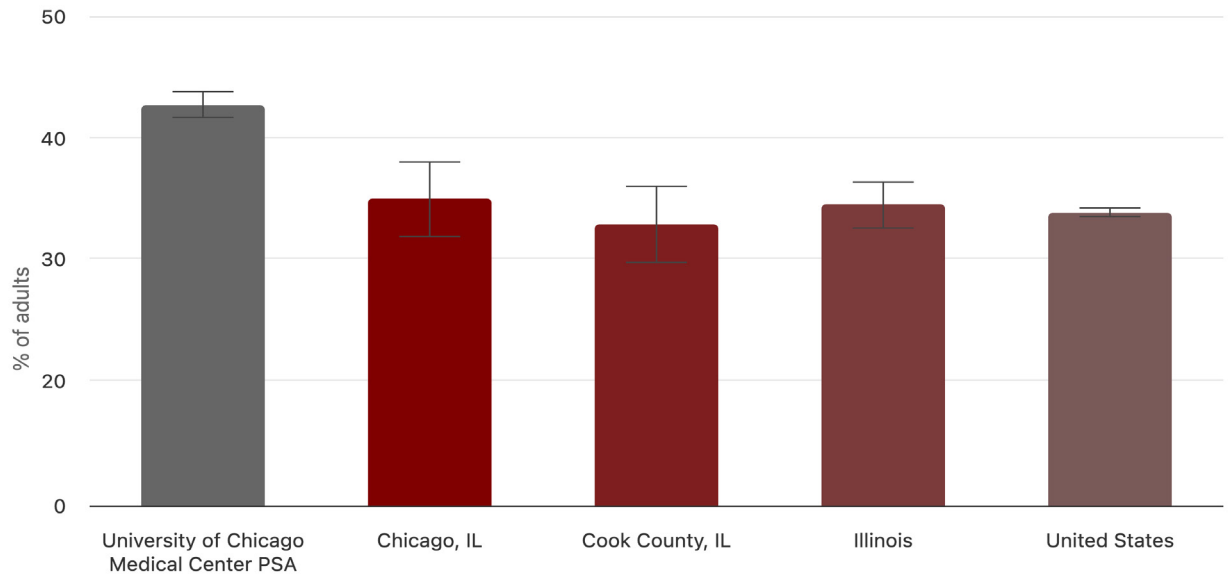
	Medical Center PSA	City of Chicago
Chronic Kidney Disease % of residents	**4.0%**	2.9%
Diabetes % of residents	**17.3%**	12.2%
High Blood Pressure % of residents	**28.6%**	29.6%
Obesity % of residents	**42.7%**	34.9%
Stroke % of residents	**5.5%**	3.5%

Source: Centers for Disease Control and Prevention (CDC) PLACES Data, 2022

The obesity rate for adults is 42.7% in the Medical Center PSA, which is several percentage points higher than the rest of the city and state.

OBESITY

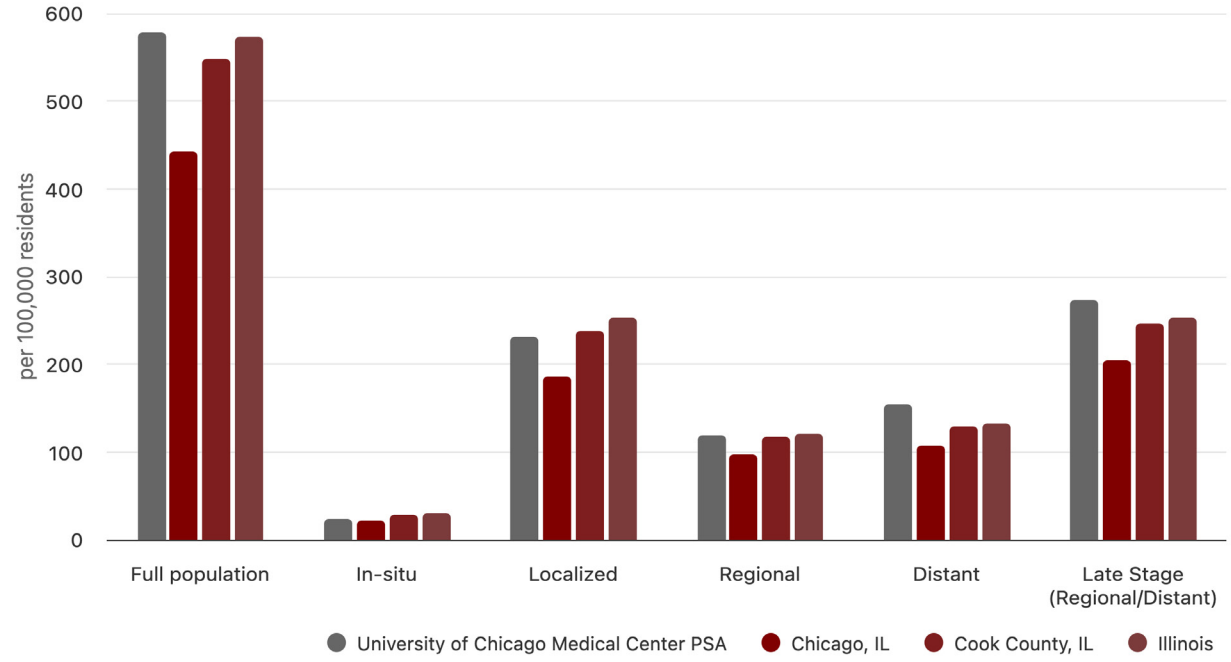
Medical Center PSA and comparison, 2022



Created on Metopio | metop.io/i/8akjoq1h | **Data sources:** Diabetes Atlas (County level data), Behavioral Risk Factor Surveillance System (BRFSS) (State and US data), Centers for Disease Control and Prevention (CDC): PLACES (Sub-county data (zip codes, tracts))
Obesity: Percent of resident adults aged 18 and older who are obese (have a body mass index (BMI) ≥30.0 kg/m² calculated from self-reported weight and height). Excludes those with abnormal height or weight and pregnant women.

CANCER DIAGNOSIS RATE BY STAGE OF CANCER AT DIAGNOSIS

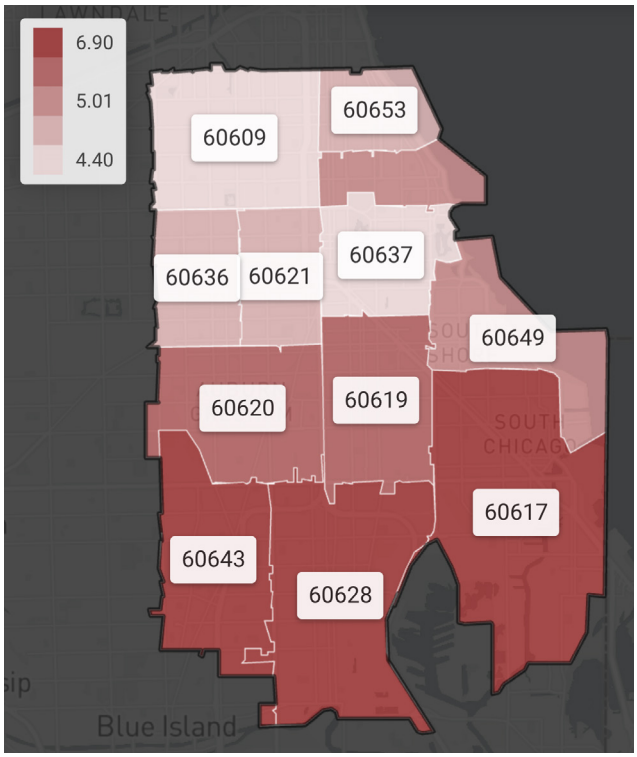
Medical Center PSA and comparison, 2017-2021



Created on Metopio | metop.io/i/67h3x53q | **Data sources:** National Cancer Institute (NCI): State Cancer Profiles (WI: racial stratifications only) (Everywhere except IL), Illinois Department of Public Health (IDPH): Illinois State Cancer Registry (Calculated by Metopio) (Only in IL)
Cancer diagnosis rate: Annual diagnosis rate for all invasive cancers. Does not include pre-cancerous diagnoses such as breast cancer in situ or urinary cancer in situ. All ages, risk-adjusted.

The chart on the previous page shows the cancer diagnosis rate by stage. More people per capita are diagnosed with cancer in the Medical Center PSA (577.97 per 10,000) than in Chicago (443.24), Cook County (547.69), and Illinois (573.24).

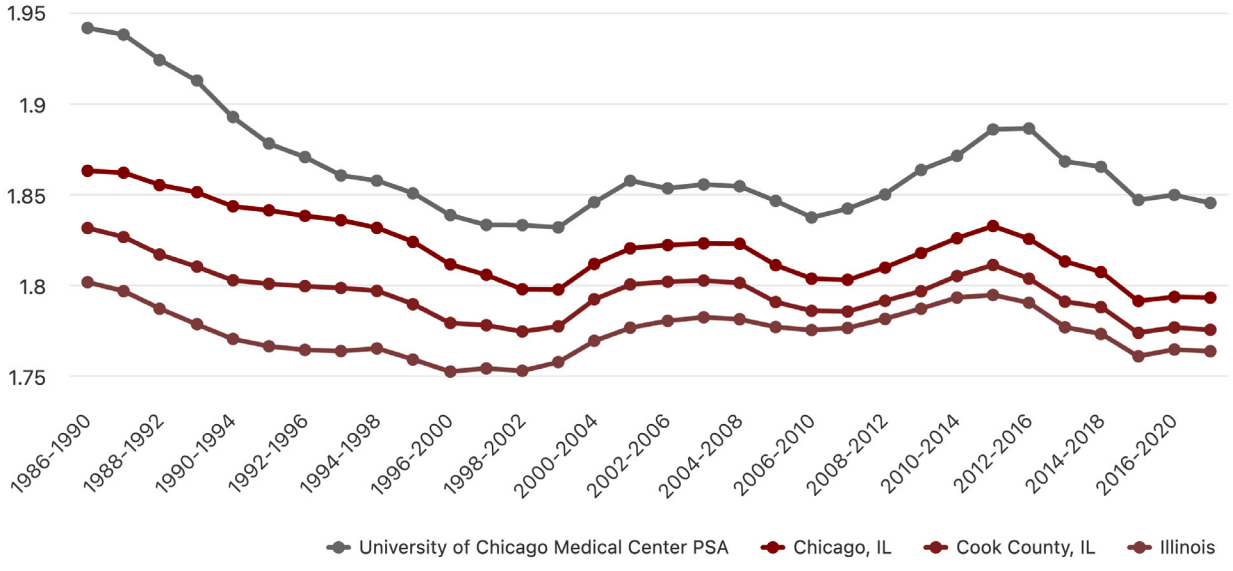
The map on the right shows the percentage of adults who have ever been diagnosed with cancer. Throughout the Medical Center PSA, the prevalence of cancer varies across different ZIP codes, with rates ranging from 4.4% to 6.9%. The ZIP codes with the highest rates are 60617, 60628, and 60643.



AVERAGE STAGE OF CANCER AT DIAGNOSIS

Medical Center PSA and comparison

The Medical Center PSA has consistently reported a higher average stage of cancer diagnosis compared to the county and state averages, as seen in the graph below. This trend suggests that while there have been minor fluctuations, the overall stage at diagnosis has not significantly improved.



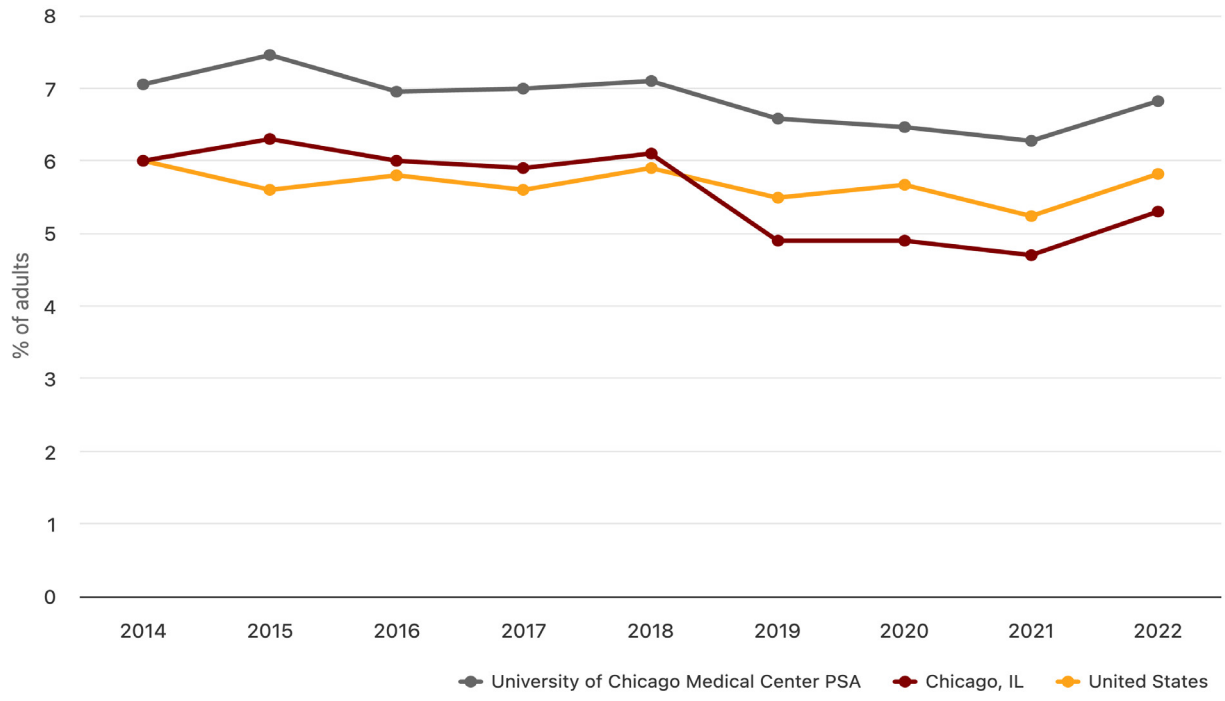
Created on Metopio | metop.io/i/uy1e9uxt | **Data source:** Illinois Department of Public Health (IDPH): Illinois State Cancer Registry (Calculated by Metopio)

Average stage of cancer at diagnosis: Average stage of cancer at time of diagnosis, for all invasive cancers; 1 - localized, 2 - regional, 3 - distant. Higher values are worse because they mean that cancers are more progressed when diagnosed. Does not include pre-cancerous diagnoses such as breast cancer in situ or urinary cancer in situ.

HEART DISEASE

Medical Center PSA and comparison

The Medical Center PSA has the highest rate of coronary heart disease at 6.8% of adults, compared to Illinois (5.4%), Cook County (5.1%), and the United States (5.8%).

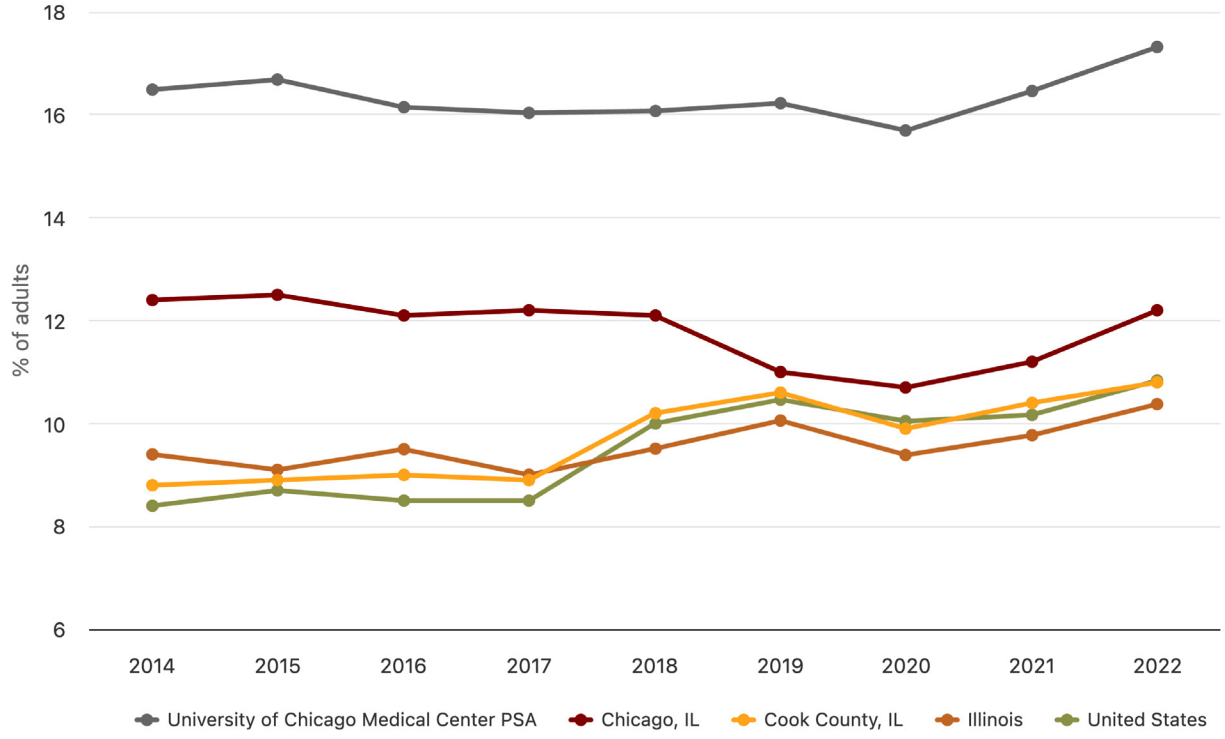


Created on Metopio | metop.io/i/evrb78gd | **Data sources:** Centers for Disease Control and Prevention (CDC): PLACES (Sub-county data (zip codes, tracts)), Behavioral Risk Factor Surveillance System (BRFSS) (County and state level data)
Coronary heart disease: Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have angina or coronary heart disease. Data for counties and states are age-adjusted. Data for zips, tracts and smaller layers are raw.

DIAGNOSED DIABETES

Medical Center PSA and comparison

The rate of diabetes is higher in the Medical Center PSA than in Chicago or Illinois, and it has increased since 2020.

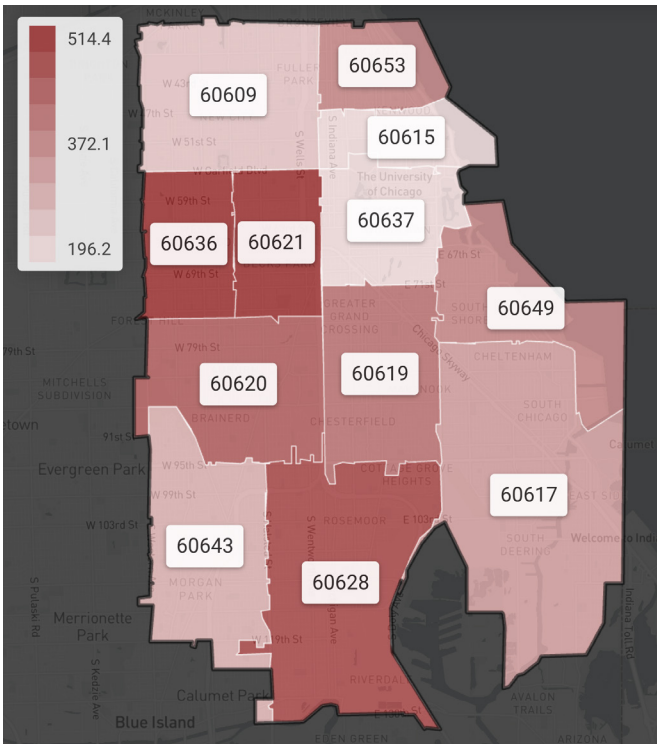


Created on Metopio | metop.io/i/xjxomoa8 | **Data sources:** Centers for Disease Control and Prevention (CDC): PLACES, Diabetes Atlas (County and state level data before 2017)
Diagnosed diabetes: Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have diabetes, other than diabetes during pregnancy. Data for counties and states are age-adjusted. Data for zips, tracts and smaller layers are raw.

DIABETES HOSPITALIZATION RATE

Medical Center PSA and comparison

The diabetes hospitalization rates are highest in the 60636 and 60621 ZIP codes.



Behavioral Health

Behavioral health includes the prevalence of mental health disorders and access to mental health services, addressing issues like depression, anxiety, and other disorders, as well as substance use and addiction to drugs and alcohol.

These issues are even more prominent following the pandemic, when many people, especially elderly individuals suffering from conditions like dementia and Alzheimer's, experienced increased isolation and loneliness. Young people also continue to struggle with the psychological effects of the pandemic.

> "It's very difficult to get people seen by a psychologist or psychiatrist, even if you do have adequate insurance, it's still a struggle to get people in."
>
> - Provider Focus Group Participant

Community members from focus groups and key informant interviews expressed concerns about the inaccessibility of specialized mental health professionals, such as psychologists and psychiatrists, particularly for individuals with Medicaid. Individuals noted a lack of resources, especially in trauma care and post-traumatic support for victims of violence.

For instance, community members have pointed out that "it's very difficult to get people seen by a psychologist or psychiatrist, even if you do have adequate insurance, it's still a struggle to get people in." There is a need for more robust mental health services and better access to care. Additionally, the impact of SDOH further complicates the community's ability to manage health effectively, particularly mental health.

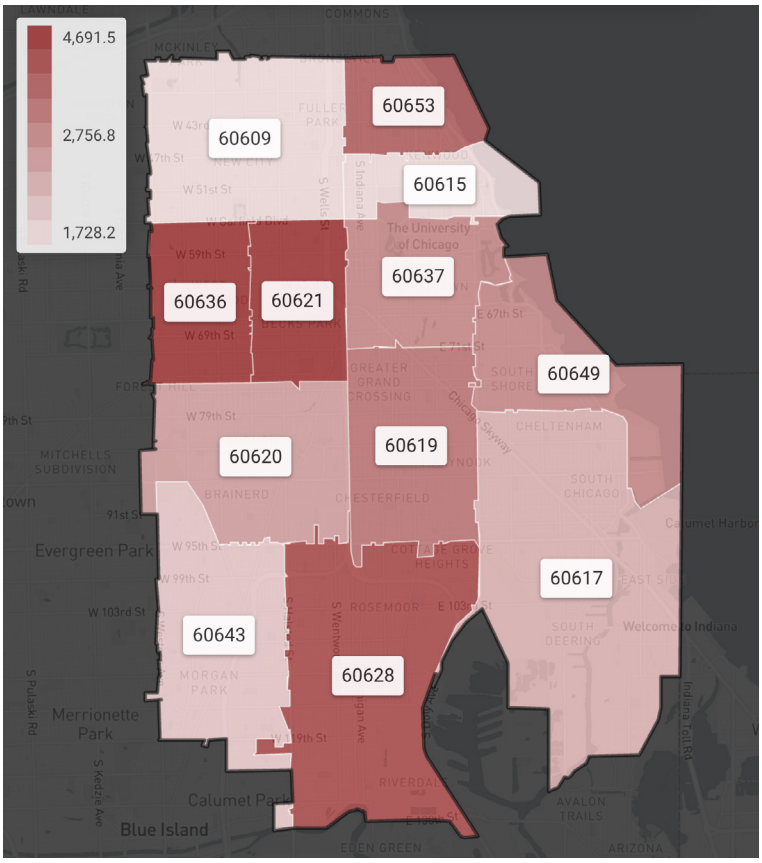
Condition	Medical Center PSA	Cook County, IL	Illinois
Poor self-reported mental health % of adults	**18.4%**	15.3%	16.1%
Suicide and self-injury emergency department visit rate Per 100,000 residents	**52.9**	45.9	72.0
Behavioral health emergency department visit rate Per 100,000 residents	**2,695.4**	1,761.8	1,625.2
Alcohol use emergency department visit rate Per 100,000 residents	**689.9**	474.9	390.6
Mental health emergency department visit rate Per 100,000 residents	**1,169.8**	805.4	906.3
Substance use emergency department visit rate Per 100,000 residents	**1,525.6**	956.4	718.9

BEHAVIORAL HEALTH EMERGENCY DEPARTMENT VISIT RATE

Medical Center PSA, 2019-2023

The Medical Center PSA's behavioral health emergency department visit rate is higher than the Cook County and Illinois averages and varies across ZIP codes.

The rate is highest in the 60628, 60636, and 60621 ZIP codes.

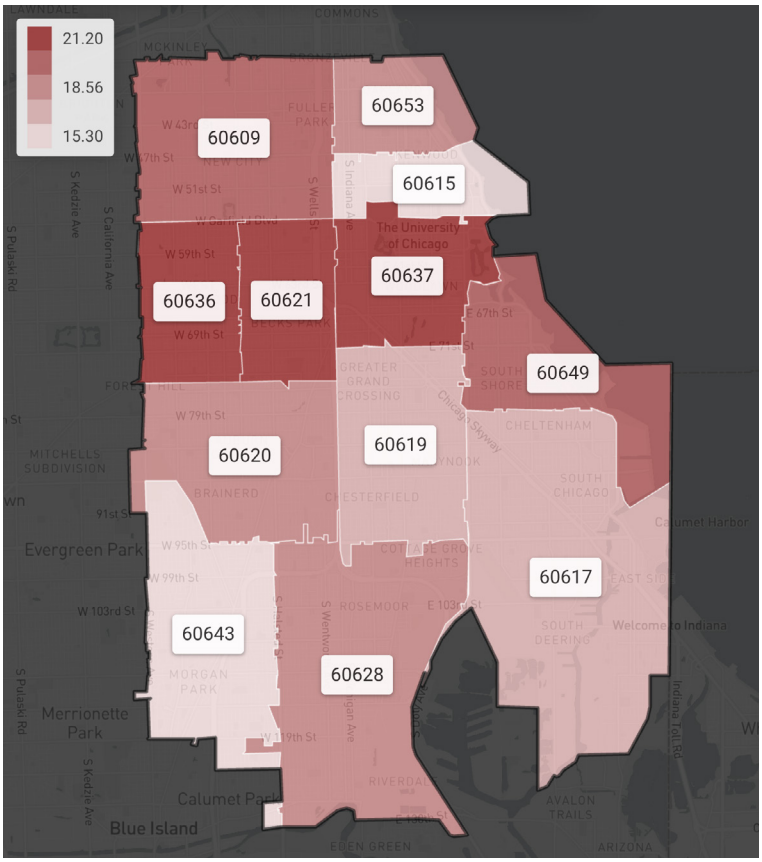


SELF-REPORTED POOR MENTAL HEALTH

Medical Center PSA, 2022

The map on the right shows the percent of adults who report 14 or more days during the past 30 days during which their mental health was not good.

The rate is highest in the 60636, 60621, and 60637 ZIP codes.

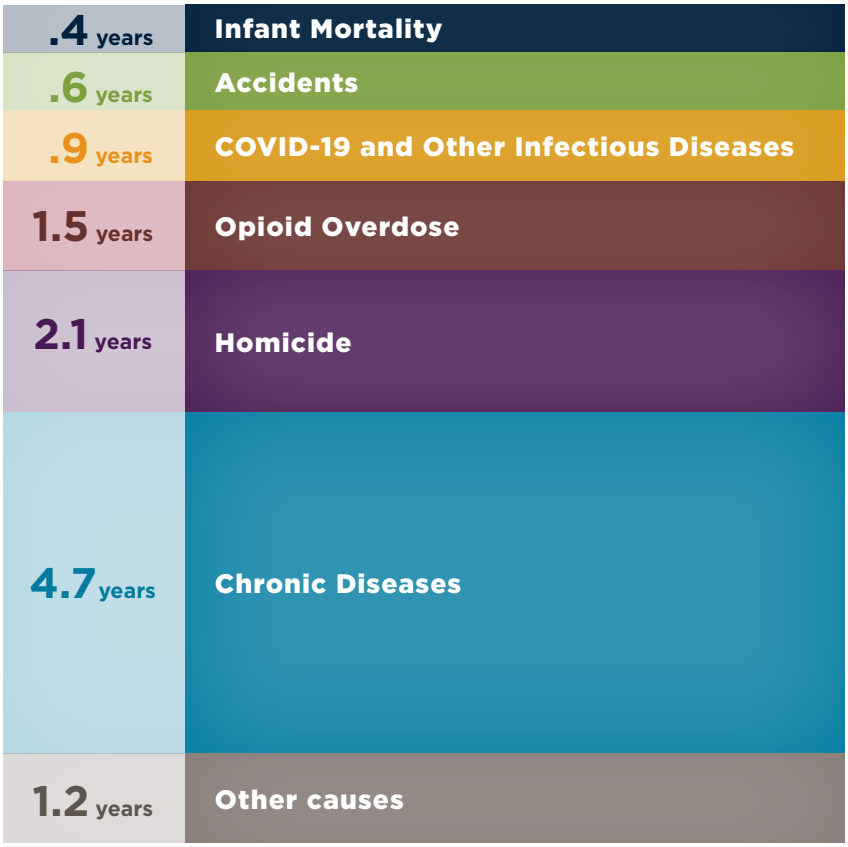


Life Expectancy and Mortality

When a Chicagoan is born, their life expectancy is 77.2, on average, but this number varies by race and ethnicity. The estimated life expectancy is lower among individuals who identify as Non-Hispanic Black (69.8 years), and higher among those who identify as Non-Hispanic Asian or Pacific Islander (85.5 years), Non-Hispanic White (80.3 years), or Latinx or Hispanic (81.4 years). Life expectancy data is not available for the specific ZIP codes or neighborhoods in the Medical Center PSA after 2015.

The table below shows the drivers of the life expectancy gap, with the largest differences contributed to chronic disease.

Number of Years Contributed to the Life Expectancy Gap between Black and Non-Black Chicagoans from each Cause of Death Category in 2022.



Infant Mortality (0.4 years): death before 1 year of age

Accidents (0.6 years): motor vehicle accidents, non-opioid drug overdoses, unintentional injuries, etc.

Infectious Diseases (0.9 years): syndemic infectious diseases including HIV and respiratory diseases including influenza, pneumonia, COVID-19

Opioid Overdose (1.5 years): fatal overdoses from substances including heroin, fentanyl, pain relievers, and methadone

Homicide (2.1 years): firearm and all-cause homicide

Chronic Diseases (4.7 years): heart disease, cancer, stroke, diabetes, COPD, kidney disease, other circulatory diseases

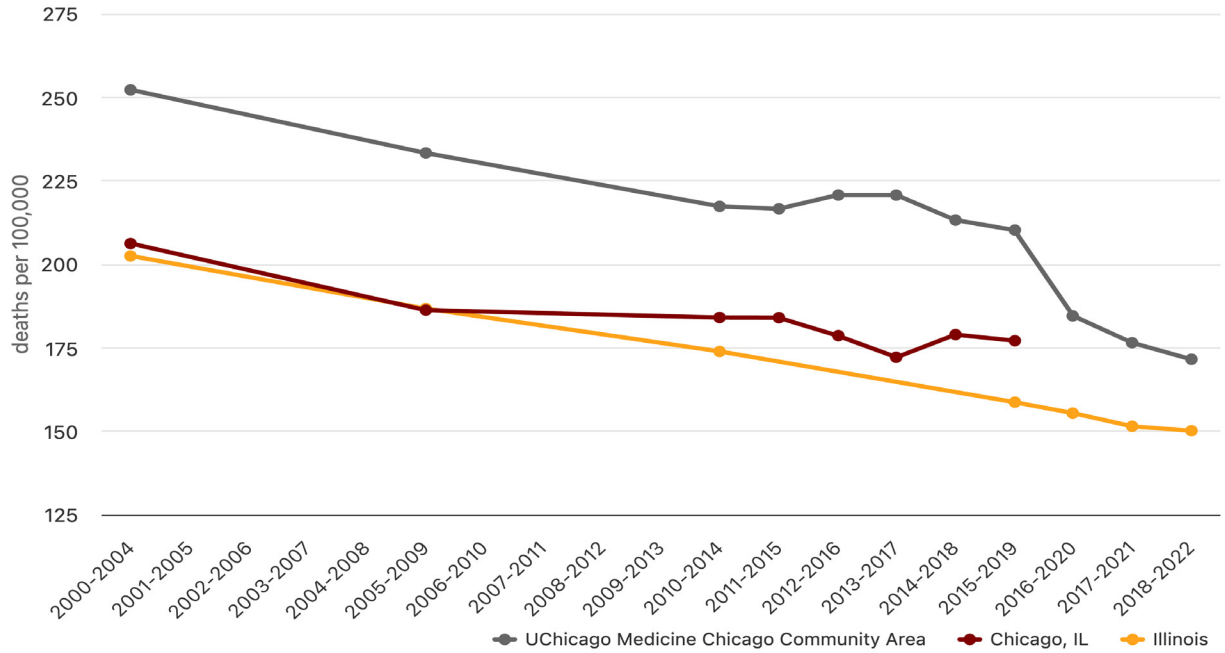
Other Causes (1.2 years): all other causes of death

Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files, 2022; U.S. Census Bureau, 2020 Decennial Census.

The charts on the following pages show some of the mortality rates for the Medical Center Chicago Community Area (CCA, also known as neighborhoods that exist in the PSA). These mortality rates are compared to Chicago and Illinois rates over time for the main contributors to the life expectancy gap. The data show that individuals living in the Medical Center CCA are more likely to die from chronic disease, homicide, or drug overdose compared to the Illinois averages.

CANCER MORTALITY

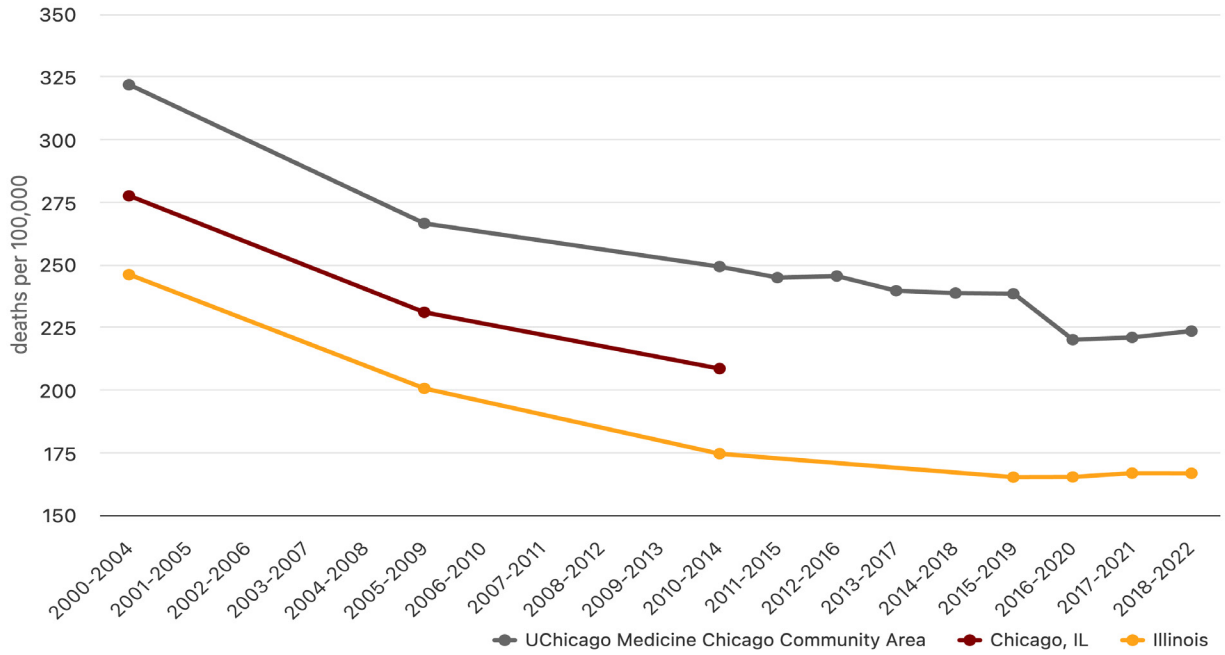
UChicago Medicine Community Area and comparison



Created on Metopio | metop.io/i/ncqa8qzq | **Data sources:** Chicago Department of Public Health (Epidemiology Department: Chicago community area level data only) (Only in IL), Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (county, state, and US
Cancer mortality: Deaths per 100,000 residents due to cancer (ICD-10 codes C00-C97). This indicator is not a good measure of the burden of cancer in a community, because it is complicated by other causes of death (especially in the elderly); instead, use CCR (cancer diagnoses).

HEART DISEASE MORTALITY

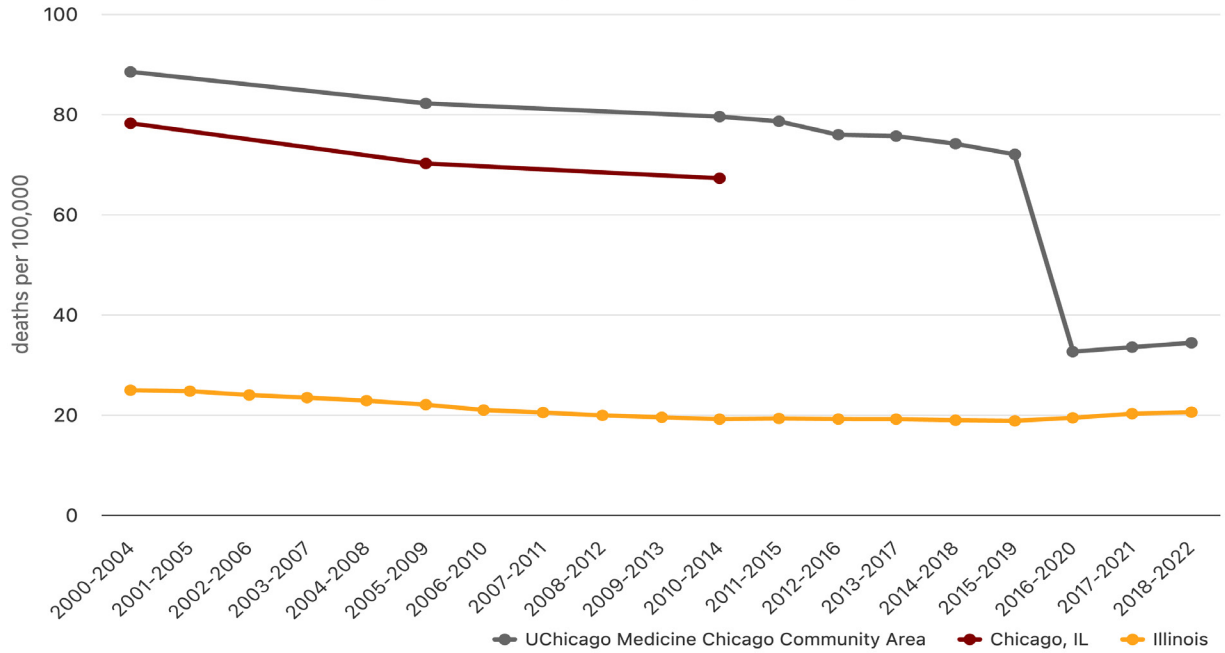
UChicago Medicine Community Area and comparison



Created on Metopio | metop.io/i/sdfeqgzu | **Data sources:** Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) (Only
Heart disease mortality: Deaths per 100,000 residents with an underlying cause of heart disease (ICD-10 codes I00-I09, I11, I13, I20-I51).

DIABETES MORTALITY

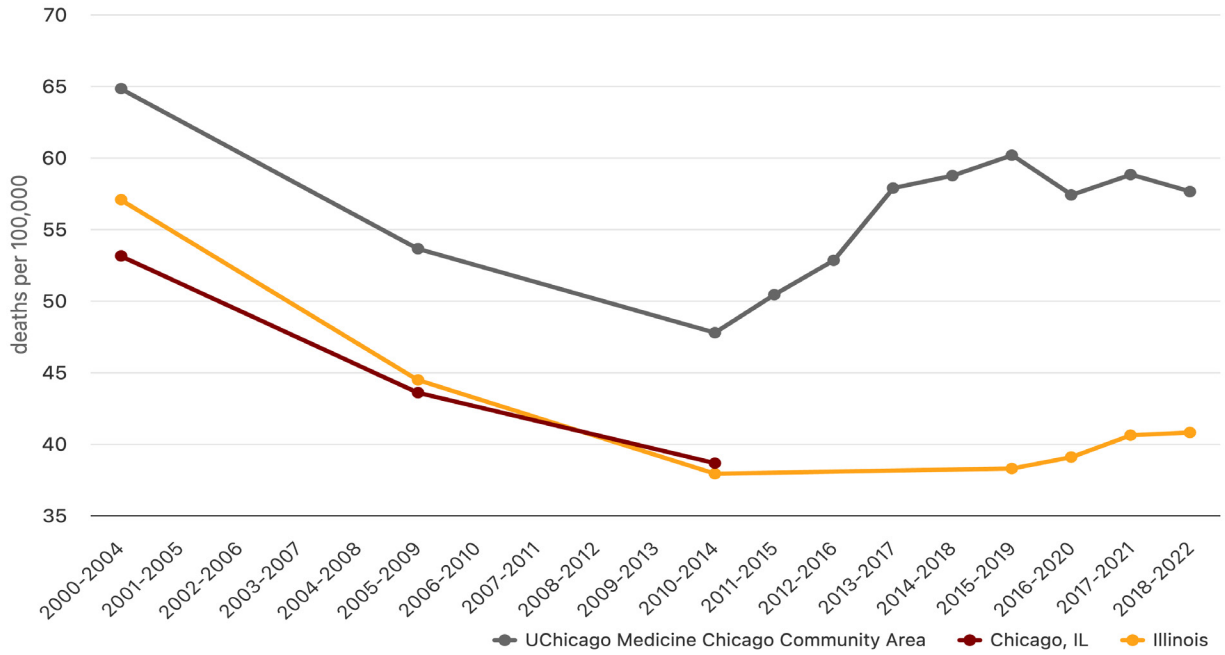
UChicago Medicine Community Area and comparison



Created on Metopio | metop.io/i/ajm7erbc | **Data sources:** Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC Wonder), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) (Only in IL)
Diabetes mortality: Deaths per 100,000 residents with an underlying cause of diabetes (ICD-10 codes E10-E14).

STROKE MORTALITY

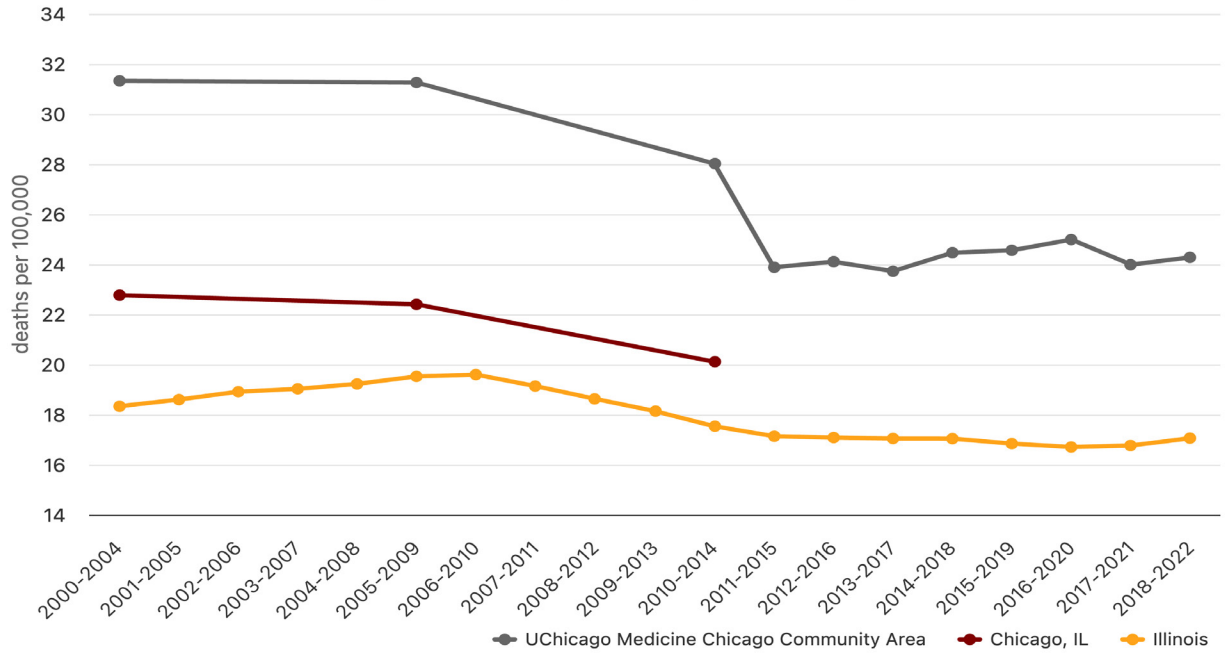
UChicago Medicine Community Area and comparison



Created on Metopio | metop.io/i/947aw7hb | **Data sources:** Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) (Only
Stroke mortality: Deaths per 100,000 residents due to stroke (ICD-10 codes I60-I69).

KIDNEY DISEASE MORTALITY

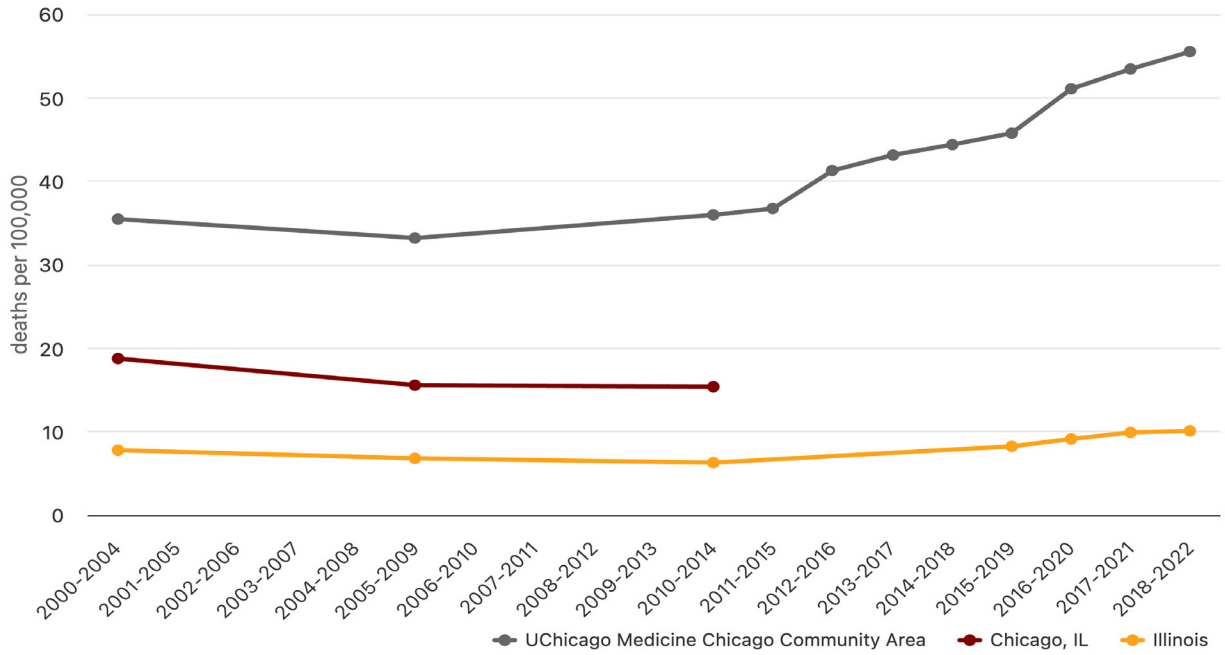
UChicago Medicine Community Area and comparison



Created on Metopio | metop.io/i/ng5esz2c | **Data sources:** Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC Wonder), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) (Only in IL)
Kidney disease mortality: Deaths per 100,000 residents with an underlying cause of death of kidney diseases (ICD-10 codes N00-N07, N17-N19, N25-N27). Includes nephritis, nephrotic syndrome, and nephrosis.

HOMICIDE MORTALITY

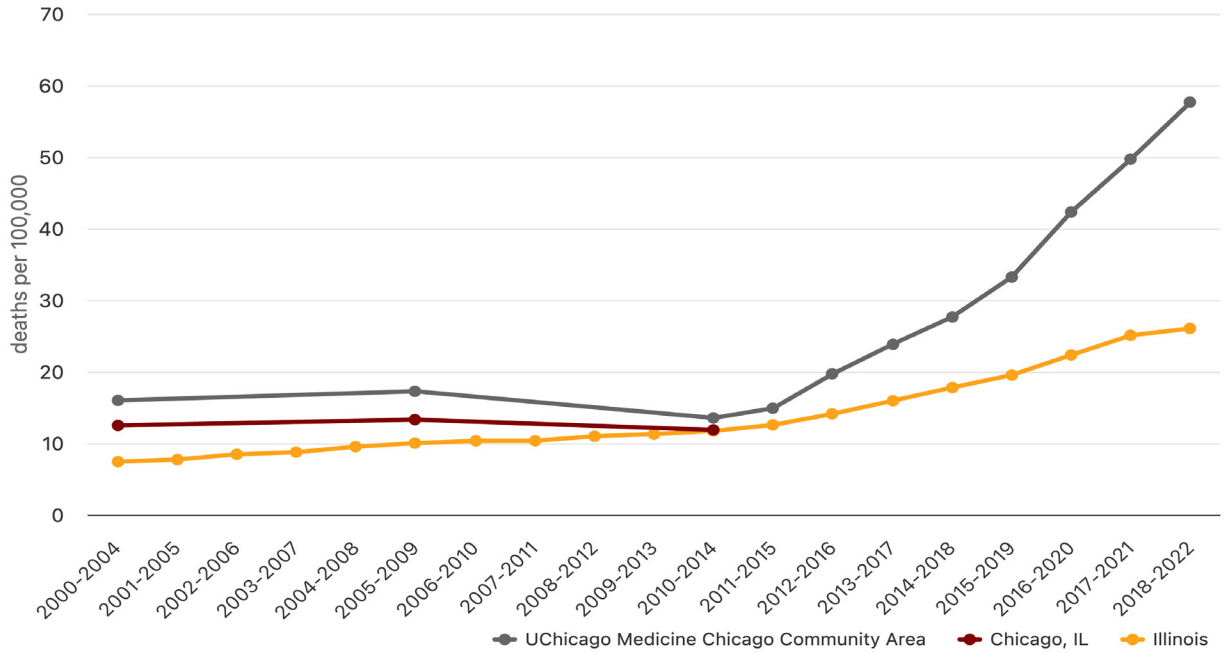
UChicago Medicine Community Area and comparison



Created on Metopio | metop.io/i/947aw7hb | **Data sources:** Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) (Only
Stroke mortality: Deaths per 100,000 residents due to stroke (ICD-10 codes I60-I69).

DRUG OVERDOSE MORTALITY

UChicago Medicine Community Area and comparison



Created on Metopio | metop.io/i/4evrqv6y | **Data sources:** Chicago Department of Public Health (Epidemiology Department: Chicago community area level) (Only in IL), Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC Wonder)
Drug overdose mortality: Deaths per 100,000 residents due to drug poisoning (such as overdose), whether accidental or intentional. The increase during the 2010s is largely due to the opioid overdose epidemic, but other drugs are also included here. Age-adjusted.

Conclusion

Prioritization of Health Needs

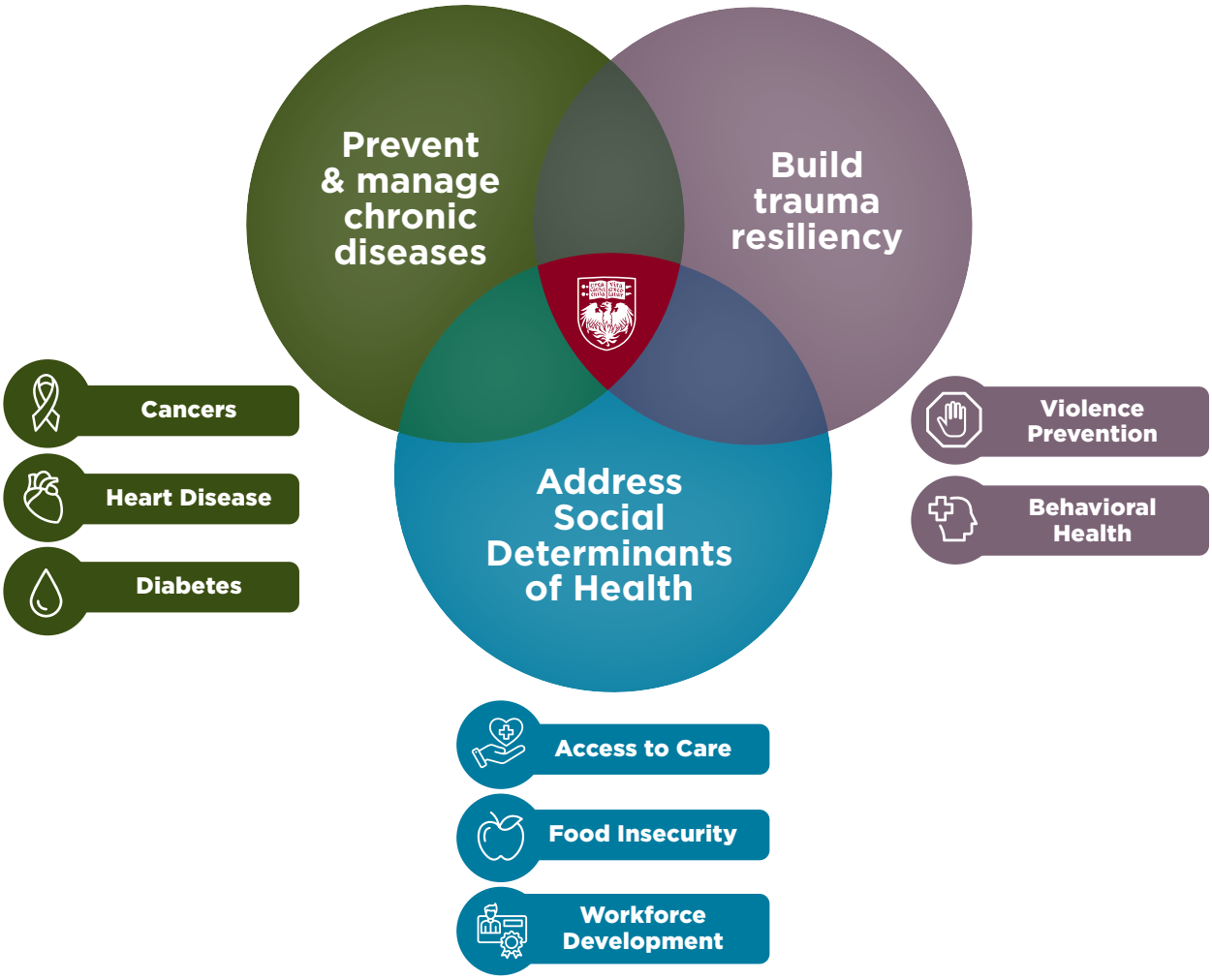
Building on the past four CHNAs, the Community Health Needs Assessment Workgroup collaborated with internal and external stakeholders to prioritize health issues for the Medical Center's community benefit programming for fiscal years 2026 through 2028. These stakeholders were strategically selected for their understanding of community perspectives, community-based health engagement, and community health education efforts.

Using the CHNA as a foundational tool, the process used a multifaceted approach to prioritize health issues.

- **Prioritization:** First, internal and external stakeholders reviewed new data, comparing the Medical Center PSA health outcome data to previous CHNA health outcome data. The health issues that had worse outcomes than in previous years were slated for consideration. The group narrowed the priorities down using a multi-voting approach.
- **Refinement:** Next, internal stakeholders reviewed the prioritized health issues, comparing them to the health priorities identified in the previous cycle.
- **Selection**: Lastly, the group defined the proposed priority framework for the Medical Center's next three years of community benefit programming (FY 2026-2028).

The framework for community benefit priorities expanded from the 2021-2022 CHNA. The current priorities are organized into three domains, outlined on the following page.

- Prevent and manage chronic diseases
- Build trauma resiliency
- Address Social Determinants of Health



The Medical Center acknowledges that there are myriad health needs identified by community members, and not all needs made it through the final prioritization process. Although not identified as priority health needs, significant health conditions such as obesity and asthma are being addressed through chronic disease management programs, as well as other community benefit programming at the Urban Health Initiative.

These three domains and eight corresponding priorities will serve as the designated issue areas for official reporting and are the principal concerns that University of Chicago Medical Center's community benefit efforts will target. They are the result of rigorous data collection and analysis in partnership with the community. These domains represent a coordinated strategy to create long-term health and prosperity in the community.

Next Steps

The results of this CHNA will be used to develop and refine health policy, programs, and partnerships responsive to identified needs, ensuring that the University of Chicago Medical Center continues to be a pivotal force in promoting health equity and quality of life in the community.

Following the publication of the CHNA report, the Medical Center will advance efforts to align and integrate the many community voices and ideas received through the data collection and analysis process. The Medical Center will engage and collaborate with community partners on the development of the Strategic Implementation Plan (SIP). By maintaining a commitment to an evidence-based approach and community engagement, the University of Chicago Medical Center strives to exceed the health expectations of those it serves.

Adoption by the Board

The UChicago Medicine's Board of Directors Government and Community Relations Committee received the 2024-2025 CHNA, FY 2023-2025 Evaluation Report, and FY 2026-2028 SIP for review. All documents were approved by the board in May 2025 according to 501(r) requirements.

Appendix 1

Community Resources in the Hospital's Primary Service Area

Organization	Resource Type	Website	Address	ZIP	Hours	Phone
Advocate Health - Trinity Hospital	Healthcare	advocatehealth.com	2320 E. 93rd St.	60617	24/7	(773) 967-2000
Believe Shelter	Shelter Services (Families with Fathers)	margaretsvillage.org/programs	9519 S. Commercial Ave.	60617	24/7	(773) 374-7705
Beloved Christian Family Wellness Center	Healthcare	bcfwc.org	6821 S. Halsted St.	60621	24/7	(773) 651-3629
Branch Family Institute	Mental Health Services	thebranchfamilyinstitute.org	11111 S. Western Ave.	60643	M-F 9am – 9pm Sat 9am – 6pm Sun 3pm – 7pm	(773) 238-1100
Catch A Ride	Transportation Resources	facebook.com/people/Catch-A-Ride-Transportation-Inc/100063762001590/#	8114 S. Lafayette Ave.	60620	M-F 3am – 7pm Sat 5am – 6pm	(773) 621-3551
Catholic Charities - WIC Food and Nutrition Center	Food Pantry	wicgrocery.org/8959-s-commerical	8959 S. Commercial Ave.	60617	M-F 8am – 8pm Sat & Sun 9am – 5pm	(773) 978-6235
Centers for New Horizons	Housing	cnh.org	4309 S. King Dr.	60653	M-F 9am – 5pm	(773) 538-2388
Chicago Coordinated Entry System	Shelter Services	allchicago.org/coordinated-entry-system	N/A	N/A	M-F 8:30am – 4pm	(312) 361-1707
Chicago Family Health Center	Healthcare	chicagofamilyhealth.org	Multiple locations	60617 - 60628		
Chicago Housing Authority - South Office	Housing	thecha.org/residents/housing-choice-voucher-hcv-program	3617 S State St.	60609	M-F 8am – 5pm	(312) 742-8500
Chicago Housing Authority (CHA) - Wentworth Gardens	Housing	thecha.org/property/wentworth-gardens	3770 S Wentworth Ave.	60609	M-F 8a – 5p	(773) 268-2859
Chicago Urban League	Workforce Development	chiul.org	4510 S. Michigan Ave.	60653	M-F 9am – 5pm	(773) 285-5800
City of Chicago Family & Support Services	Homlessness Resources, Housing, Shelter Services	chicago.gov/city/en/depts/fss	1140 W. 79th Street	60620	M-F 9am – 5pm	(312) 747-0200
Claret Center	Mental Health Services	claretcenter.org	5498 South Kimbark	60615	M-F 9am – 4pm	(773) 643-6259

Organization	Resource Type	Website	Address	ZIP	Hours	Phone
Claretian Associates - South Chicago Senior Housing	Housing (Seniors)	claretianassociates.org	3039 E 91st St.	60617	M-F 8:30a - 4:30p	(773) 734-9181
Featherfist	Housing	featherfist.org	2255 E 75th St.	60649	M-F 9:am – 5pm	(773) 721-7088
Feed1st Program	Food Pantry	obgyn.uchicago.edu/lindau-lab/feed1st	Pantry locations: University of Chicago Medical Center Campus CCD Sky Cafe, DCAM 3F & 6H, Adult ED, Comer ED, Comer lobby Floor #1	60637	24/7	(773) 834-5890
Friend Health	Healthcare	friendfhc.org	Multiple locations	60609 60629 60636 60637	Varies	Cottage Grove Health Center: (312) 682-6110
Greater Chicago Food Dispository - Hyde Park Kenwood	Food Pantry	chicagosfoodbank.org/find-food/#goog-trans(en|en)	5600 S Woodlawn Ave.	60637	Sat 10am – 1pm	(773) 363-6063
Heartland Alliance - Karibuni Place	Housing	thecha.org/property/karibuni-place	8200 S Ellis	60619	M, W, F 9am – 5pm	(312) 935-2600
HRDI	Mental Health Services	hrdi.org/ctc.html	200 E 115th St.	60628	M-F 9am – 3pm	(773) 291-2500
Ignite	Workforce Development, Housing, and Shelter Services (Youth)	ignitepromise.org	3745 S. Indiana Ave.	60653	M, W, Th 11am – 2pm; Tues 1 – 4pm	(773) 548-4443
Illinois Department of Human Services	Mental Health Services, Shelter Services, Housing	dhs.state.il.us/page.aspx?item=27893	5323 S Western Blvd.	60609	M-F 8:30am - 5pm	(773) 918-6801
Illinois Housing Search	Housing	myhousingsearch.com/tenant/education/MovingCostExample.html?ch=IL	N/A	N/A	N/A	N/A
Jackson Park Hospital	Healthcare	jacksonparkhospital.org	7531 Stony Island Ave.	60649	24/7	(773) 947-7500
Legal Aid Chicago	Legal Assistance	legalaidchicago.org	815 W. 63rd Street, #2	60621	M-TH 10am – 3pm	(773) 488-6600
Maria Transitional Shelter	Shelter Services (Women and Children)	margaretsvillage.org	7320 S Yale Ave.	60621	24/7	(773) 994-5350 and (773) 651-8372
Matthew House	Shelter Services	matthewhousechicago.org	3722-28 S Indiana Ave.	60653	M-F 7am - 1:30pm	(773) 536-6628

Organization	Resource Type	Website	Address	ZIP	Hours	Phone
Medicaid - First Transit	Transportation Resources	countycare.com/members/covered-services/#transportation-services#	121 N LaSalle St.	60602	M-F 8am – 5pm	(877) 725-0569
Metro 2-1-1 Housing Search Link	Housing	211metrochicago.org/database/?external_category=HOU	Search for resources in Cook County by keyword	N/A	N/A	N/A
Metropolitan Family Services	Housing	metrofamily.org/wp-content/uploads/2018/03/MFS_LAS_14_GENERAL_FLYER_100515.pdf	235 E. 103rd St.	60628	M, T, F 8:30am – 5pm W, Th 8:30am – 8pm	(773) 371-3600
Near North Health	Healthcare	nearnorthhealth.org	Multiple locations	60615 60653	Varies	Cottage Grove Health Center: (312) 682-6110
Olive Branch Mission	Housing	obmission.org/programs-cni1	6310 S Claremont Ave.	60636	Sat 10am – 1pm	(773) 363-6063
One On One Chicago	Workforce Development	oneononechicago.com	4655 S King Drive, Suite 202	60653	M, W, F 9am – 5pm	(312) 935-2600
Phalanx Family Services	Homlessness Resources, Housing	chicookworks.org/locations/phalanx-family-services	837 W 119th St.	60643	M-F 9am – 3pm	(773) 291-2500
REACT Clinic	Mental Health Services	voices.uchicago.edu/react	950 E 61st St., Suite 207	60637	M, W, Th 11am – 2pm; Tues 1 – 4pm	(773) 548-4443
Roseland Community Hospital	Healthcare	roselandhospital.org	45 W. 111th St.	60628	M-F 8:30am – 5pm	(773) 918-6801
South Shore Hospital	Healthcare	southshorehospital.com	8012 S. Crandon Ave.	60617	N/A	N/A
St. Bernard Hospital	Healthcare	stbh.org	326 W. 64th	60621	24/7	(773) 947-7500
St. Sabina (Cook County Workforce Partnership)	Workforce Development	chicookworks.org/locations/st-sabina-employment-resource-center	7840 S. Racine	60620	M-Th 10am – 3pm	(773) 488-6600
Sunshine Gospel Ministries	Housing	sunshinegospel.org/hei	500 E 61st St.	60637	24/7	(773) 994-5350 and (773) 651-8372
TCA Health	Healthcare	tcahealth.org		60619 60620 60628 60649		Main Clinic: (773) 995-6300
Teamwork Englewood	Workforce Development	teamworkenglewood.org	815 W 63rd St.	60621	M-F 9am - 5pm	(773) 488-6600
The Psychology Center, Inc	Mental Health Services	thepsychologycenter.biz	10343 S Western Ave.	60643	8am – 9pm (appt only)	(773) 238-2828
The Resurrection Project	Housing	resurrectionproject.org	4600 S Wood St.	60609	M-F 9am – 5pm	(312) 880-1154
The Woodlawn Resource Center	Workforce Development	poahchicago.org/sites/default/files/WRC_brochure_2018.pdf	6144 S. Cottage Grove Ave.	60637	M-F 9am – 5pm	(773) 451-8077

Appendix 2

AT THE FOREFRONT
UChicago Medicine

Community Benefit Evaluation Report

FY 2023-2025

Table of Contents

Introduction

The University of Chicago Medical Center (Medical Center) has a long history of community-based programming dedicated to improving the health of Chicago's South Side residents.

The Medical Center has diligently focused its efforts on specific priority health areas informed by the **Community Health Needs Assessment (CHNA)** and its **Strategic Implementation Plan (SIP)**.

Evaluation Report Purpose

This report looks back on the Medical Center's collective efforts to address each priority health area from our previous CHNA cycle. It provides a comprehensive summary of the work the Medical Center and its community partners undertook to address the 2021-2022 CHNA priority health areas, as outlined in the FY 2023-2025 Medical Center SIP.

The Medical Center recognizes recognize that achieving community-level impact only occurs through collaboration centered on patient and community voices. Therefore, its works to pilot and scale programs within an ecosystem of community-based partnerships, uplift work already being accomplished, and help fill in gaps where possible.

The Medical Center aims to demonstrate its reach and impact across its Primary Service Area (PSA), learning from the experience and strategies implemented over the past three years. Although there are limitations in quantifying impact (e.g., program turnover, inconsistent program reporting, adaptations of programs), the Medical Center has identified key process and outcome metrics to establish a snapshot of the broad-scale impact of our work.

The Medical Center's Primary Service Area

The Medical Center's PSA is represented by 12 ZIP codes surrounding the Medical Center campus on the South Side of Chicago. The service area is comprised of 28 Chicago Community Areas, with partial coverage in additional communities.

UNIVERSITY OF CHICAGO MEDICAL CENTER PRIMARY SERVICE AREA

ZIP Codes and Chicago Community Areas

60609
Armour Square
Bridgeport
Douglas
Fuller Park
Gage Park
Grand Boulevard
McKinley Park
New City
Washington Park

60615
Grand Boulevard
Hyde Park
Kenwood
Washington Park

60617
Avalon Park
Calumet Heights
East Side
Hegewisch
South Chicago
South Deering

60619
Avalon Park
Burnside
Calumet Heights
Chatham
Greater Grand Crossing
Roseland
South Shore

60620
Ashburn
Auburn Gresham
Beverly
Chatham
Englewood
Greater Grand Crossing
Roseland
Washington Heights

60621
Englewood
Greater Grand Crossing
Washington Park

60628
Pullman
Riverdale
Roseland
Washington Heights
West Pullman

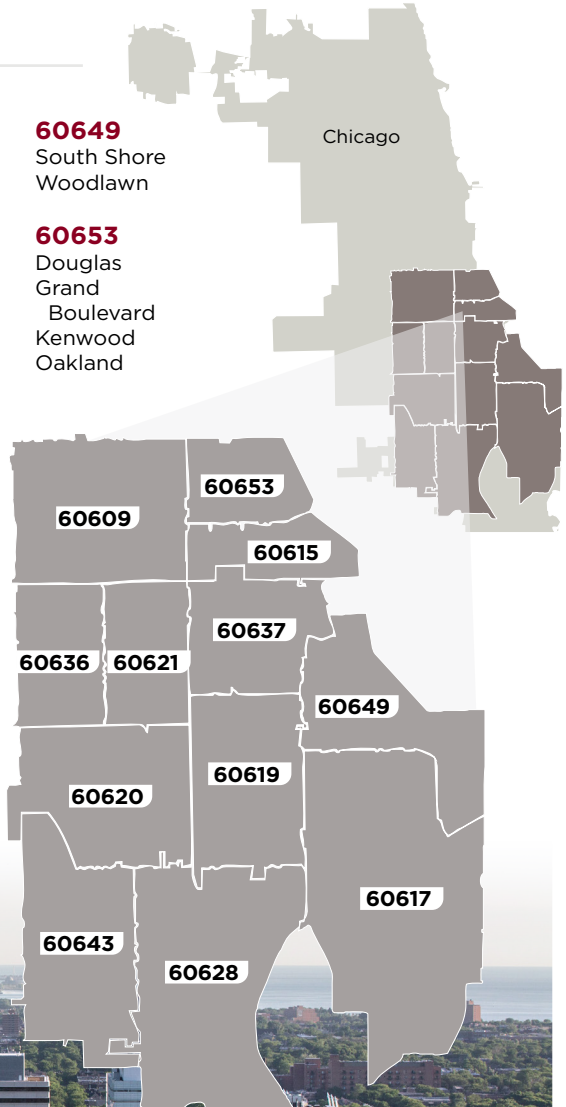
60636
Chicago Lawn
Gage Park
West Englewood

60637
Greater Grand Crossing
Hyde Park
South Shore
Washington Park
Woodlawn

60643
Beverly
Morgan Park
Washington Heights
West Pullman

60649
South Shore
Woodlawn

60653
Douglas
Grand Boulevard
Kenwood
Oakland



*Some community areas stretch across multiple ZIP codes. Our community benefit service area extends only to those parts of a community area within the 12 ZIP codes identified.

Looking Back: Community Benefit Priority Areas for FY 2023-2025

The following **eight community benefit priority areas** were the Medical Center's focus during FY 2023-2025: Heart Disease, Diabetes, Cancers, Violence Prevention and Recovery, Mental Health, Access to Care, Food Insecurity, and Workforce Development.

To maximize impact and recognize intersecting strategies, these were further organized under three domains:

- Prevent and manage chronic diseases
- Build trauma resiliency
- Reduce inequities caused by Social Determinants of Health (SDOH)*

Prevent and manage chronic diseases	Build trauma resiliency	Reduce inequities caused by Social Determinants of Health
Heart Disease	Violence Prevention and Recovery	Access to Care
Diabetes	Mental Health	Food Insecurity
Cancer		Workforce Development

**Social Determinants of Health (SDOH) are non-medical factors that influence a person's health and well-being. To learn more about SDOH, see Drivers of Health Inequities on page 24 of the Medical Center's 2024-2025 CHNA.*

Evaluation Report Methods

This evaluation report shares the Medical Center's efforts to meet the community benefit priority area goals outlined in the FY 2023-2025 Medical Center SIP. This report compiles qualitative and quantitative data collected from a wide array of stakeholders, including data from community benefit grantees, program operations and evaluation data, and community event logs—with results organized under each priority health domain.

To gain a full understanding of the programs at the Medical Center, the **Urban Health Initiative's (UHI) CHNA workgroup** conducted a comprehensive inventory via two approaches:

1. **CBISA review:** The Community Benefits Team checked its list of existing programs cataloged in the Community Benefit Inventory for Social Accountability (CBISA) platform.
2. **Departmental interviews and meetings:** Ongoing updates and reviews with Medical Center staff and faculty occurred throughout the CHNA process. The CHNA workgroup discovered additional programs and/or program details to include in this report.

Data were requested as part of the 2024-2025 CHNA cycle, in preparation for the development of this report. These requests were sent to individual contacts. All requests asked for process and outcome data aligned with the FY 2023–2025 Medical Center SIP (p.12) to streamline reporting efforts.

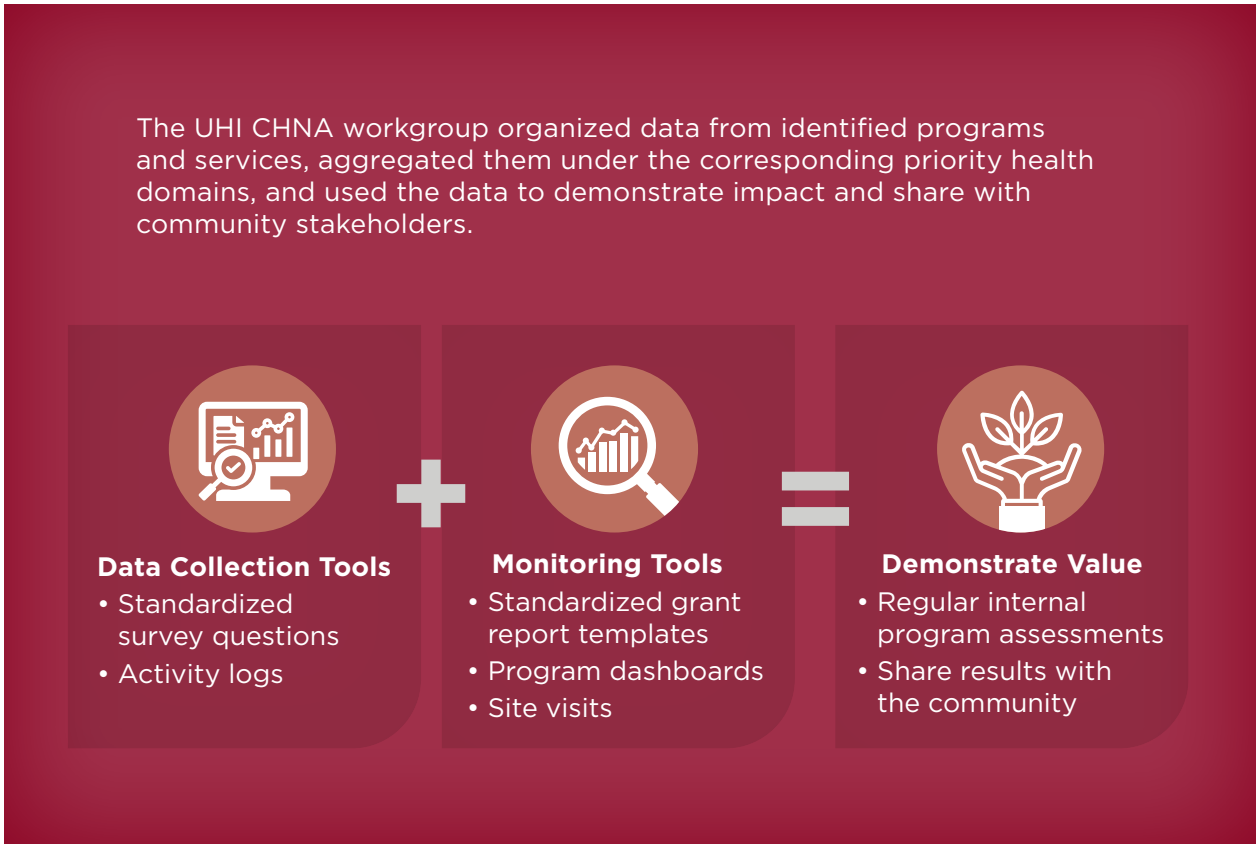
Report Data Sources

The Medical Center programs and services to share specific processes and outcome metrics listed in the FY 2023-2025 Medical Center SIP that demonstrated their impact under the priority health domains. Using these data, the Medical Center was able to compile results across programs.

Community-based partners and programs share data related to priority health domain goals and objectives. These data include process and outcome level measures, often captured through activity logs, standard or customized designed report templates, surveys, and qualitative reports.

Medical Center departments and programs that work collaboratively with community partners and/or internal stakeholders track and log program activities and services to capture process-level data.

Because of the varied program structures and approaches, the UHI CHNA workgroup defined two areas under which to organize data sources and reporting mechanisms, outlined in the graphic below. This helped demonstrate the comprehensive impact in the Medical Center PSA.



Report Development

Using the process outlined on the previous page, the CHNA workgroup evaluated the breadth of initiatives and their impact on the priority health areas for FY 2023-2025.

For established or completed programs, this report includes both process and outcome measures. For ongoing or early-stage programs, it includes process measures. Unless a statistical test is noted, outcome measures (change in knowledge or behavior) presented are pre-post percent changes for which statistical significance cannot be assessed.

Social Determinants of Health Intersections

Throughout this report, the Medical Center incorporated the symbols below where programmatic results addressed Social Determinants of Health (SDOH) *in addition to* chronic conditions or trauma resiliency.

Access to Care

Food Insecurity

Workforce Development

The Medical Center recognizes that addressing SDOH does not occur in a silo. Rather, there is a clear intersection between addressing SDOH factors and health outcomes.

For example, access to food and employment are deeply connected to health outcomes. Someone facing food insecurity may struggle with controlling their diabetes without consistent access to nutritious meals. This could potentially affect their ability to maintain steady employment, limiting income and access to employer-sponsored health insurance. At the same time, gaps in healthcare access could disrupt resources to manage a condition, leading to more severe health outcomes that further disrupt work and financial stability. This cycle underscores the importance of addressing SDOH factors alongside chronic conditions and access to care to create lasting improvements in community health.

Report Findings

Prevent and Manage Chronic Diseases

Addressing widespread chronic disease among adults is important to residents of all ages in the PSA, as living with multiple chronic conditions (i.e. comorbidities) is associated with a poorer quality of life and a lower life expectancy. It also contributes to financial instability and poor mental health. One way to prevent and/or manage chronic disease is to establish healthy behaviors. However, there are many impediments to living a healthy lifestyle in the Medical Center's service area.

Residents in the PSA face difficulties accessing healthy food, safe places to exercise, healthy environments, affordable and accessible healthcare screenings, and other preventive services. Building on the FY 2023-2025 Medical Center SIP and prior SIPs, the Medical Center continued to collaborate with community hospitals, community-based organizations, and community health centers to implement programs that addressed chronic diseases. The Medical Center focused its efforts on the following chronic diseases: heart disease, diabetes, and cancers.

Goal: **Prevent and Manage Chronic Diseases, Specifically Heart Disease, Diabetes, and Cancers**

Objective 1

Provide screening and education opportunities for heart disease, diabetes, and cancers

- Expand free/subsidized screenings that include education
- Continue community education initiatives focused on chronic disease prevention

Objective 2

Empower community members to manage their heart disease, diabetes, and cancers

- Increase access to healthy food
- Manage comorbidities, including hypertension and obesity

Objective 3

Increase access to care

- Assist patients with healthcare navigation
- Encourage patients to establish care with a primary care physician
- Increase the capacity of the health system for primary and specialty care, internal and external to the Medical Center
- Expand and streamline care coordination across the UChicago hospital system
- Train healthcare staff in cultural competency, shared decision-making, and plain language

Objective 4

Reduce inequities caused by SDOH

- Expand screening for SDOH across the health system
- Connect patients and community members with resources such as housing, employment, food, transportation, etc.

Chronic Disease Programs

LIAISONS IN CARE COMMUNITY HEALTH WORKER PROGRAM (LINC)

UChicago Medicine's Liaisons in Care (LinC) program addresses health inequities by hiring and utilizing Community Health Workers (CHWs) in healthcare and community settings. **CHWs are frontline public health workers who are trusted members of the community**. This trusting relationship enables CHWs to serve as a link between healthcare, social services, and community members, facilitating access to services and improving quality of life. CHWs play an essential role in UChicago Medicine's community health programs, serving patients with issues related to asthma, diabetes, hypertension, cancers, heart disease, stroke, maternal health, and sickle cell disease.

Objective 1

Provide screening and education opportunities about heart disease, diabetes, and cancers

Results

2,279 Heart Disease Education Encounters Provided	**2,056** Diabetes Education Encounters Provided	**2,396** Cancer Education Encounters Provided
24 Heart Disease Education Events	**20** Diabetes Education Events	**19** Cancer Education Events
1,152 Heart Disease Event Participants	**1,152** Diabetes Event Participants	**1,246** Cancer Event Participants

*Data Timeframe: July 1, 2022 – December 31, 2024

Objective 2

Empower community members to manage their heart disease, diabetes, and/or cancers

Objective 3

Increase access to care

Results

1,228
Patients with Diabetes Referred to LinC

1,051
Patients with Heart Disease Referred to LinC

659
Patients with Cancer Referred to LinC

159
Patients with Diabetes Enrolled in LinC

265
Patients with Heart Disease Enrolled in LinC

195
Patients with Cancer Enrolled in LinC

In addition to helping patients understand and manage their chronic diseases, LinC CHWs also help reduce care inequities caused by SDOH.

8,445
Patients Screened by Providers and Referred to LinC with SDOH Need

3,815
Additional SDOH Screenings Completed by CHWs

1,394
Referrals to Other Programs or Services for Patient's SDOH Needs

99
Health Promotion Community Events

987
Virtual Engagements with Health Promotion Communication Materials

SOUTH SIDE FIT (SSF)

In 2017, the Medical Center partnered with the Timothy Community Corporation (TCC) to launch the South Side Fit (SSF) program to empower community members to manage their heart disease, diabetes, and/or cancers. With input from the community and faith-based organizations, a four-pronged model was developed, including education, disease management, physical activity, and faith messaging. To meet health goals, participants commit to regular exercise, health consultations, nutritional and lifestyle seminars, and exercise classes, including Zumba, yoga, cycling, low-impact workouts, and walking groups.

Objective 1

Provide screening and education opportunities about heart disease, diabetes, and cancers

Objective 2

Empower community members to manage their heart disease, diabetes, and/or cancers

Objective 4

Reduce inequities caused by SDOH

Results

596	2,788	22	642
SSF Classes	Class Attendees	SSF Workshops	Workshop Attendees

*Data Timeframe: July 1, 2022 – December 31, 2024

COMMUNITY FITNESS PROGRAM (CFP)

The Community Fitness Program (CFP) is a free fitness program sponsored by UChicago Medicine's Urban Health Initiative (UHI) in partnership with the Museum of Science and Industry. For more than 30 years, CFP has aimed to encourage physical fitness and help people of all ages integrate a regular exercise program into their health routines. The program takes place at the Museum of Science and Industry on Monday, Wednesday, and Friday mornings. CFP boasts 60 to 80 members who regularly walk and do aerobic exercise inside the museum's educational quarter-mile path.

Objective 2

Empower community members to manage their heart disease, diabetes, and/or cancers

Objective 4

Reduce inequities caused by SDOH

Results

726	10,212	10	329
CFP Classes	Class Attendees	CFP Workshops	Workshop Attendees

*Data Timeframe: July 1, 2022 – December 31, 2024

MEDICAL HOME AND SPECIALTY CARE CONNECTION PROGRAM (MHSCC)

Since 2011, the Medical Home and Specialty Care Connection (MHSCC) program has connected South Side residents to community health centers and primary care and specialist doctors who provide preventive, primary, and specialty care, regular treatment for non-emergency health needs, and long-term management of chronic diseases.

Patient advocates help patients in the emergency department, educate patients on medical homes and insurance, directly connect patients to primary care providers and/or specialist follow-up appointments, and provide resource referrals to meet SDOH needs.

Objective 2

Empower community members to manage their heart disease, diabetes, and/or cancers

Objective 3

Increase access to care

Results

12,495
Total Patient Advocate Encounters

11,474
Total Appointments Made for Patients

9,212
Primary Care Provider Appointments Made for Patients

1,094
Heart Disease Patient Referrals

229
Diabetes Patient Referrals

43
Cancer Patient Referrals

336
Heart Disease Patient Encounters

56
Diabetes Patient Encounters

17
Cancer Patient Encounters

*Data Timeframe: July 1, 2022 - December 31, 2024

MHSCCP Patient Advocates also connect patients to external medical homes and other resources through UChicago Medicine's partnership with the South Side Healthy Community Organization (SSHCO) and internally through their collaboration with LinC.

907
Patients Screened for SSHCO Enrollment

1,006
Patients Screened for SDOH

70
Diabetes Patients Referred to the SSHCO

285
Heart Disease Patients Referred to the SSHCO

*Data Timeframe: January 1, 2023 – December 31, 2024

LinC Grant Programs

Part of the Medical Center's work to address community benefit priorities includes grant-making to community-based organizations. The Medical Center increased access to CHWs through community and faith-based organizations using capacity-building grants as part of the **Liaisons in Care (LinC) grant program**. These capacity-building grants aimed to improve access to care and employment by investing approximately $1.25 million into community- and faith-based organizations over a five-year period. Furthermore, these community-based CHW programs focus on chronic condition education for prevention and management.

Six community-based organizations received funding during last cycle's CHNA. These organizations were renewed to receive ongoing funds for their community-based CHW programs that complement the Medical Center-based program.

EQUAL HOPE

Equal Hope's mission is to save women's lives by eliminating health disparities in Illinois. Initially focused on breast cancer, they have expanded to address cervical cancer and other women's cancers. With three years of LinC funding, Equal Hope has developed and maintained a South Side cervical cancer CHW program to address disparities and higher mortality rates in five South Side neighborhoods.

The funds enabled Equal Hope to hire two full-time CHWs to educate uninsured women, help them access free cervical cancer screenings, and connect them to care through their public insurance plan's network of providers. The project also offers care coordination to help women establish regular care after completing cervical screenings.

Results

42,106
Community Members Reached via Community Events, Canvassing, and Resource Fairs

1,531
Community Members Screened Needed Primary Care and/or Specialty Care Appointments

711
Appointments Scheduled

1,330
SDOH Assessments Conducted for Clients

*Data Timeframe: January 1, 2023 – December 31, 2024

YWCA METROPOLITAN CHICAGO

The YWCA's CHW Program addresses high blood pressure and diabetes. The goal of the program is to improve patient experiences and patient health outcomes, reduce health disparities, and provide strong linkages between health resources and social services. With three years of LinC funding, the YWCA hired two CHWs who increase awareness of high blood pressure and diabetes and support people with access to care and resources for self-management. The project also aims to increase the use of primary and specialty care services and increase access to social services that address basic needs and SDOH.

Results

1,372
Community Members Reached at Community Events

998
Community Members Screened for High Blood Pressure

453
Community Members Screened Who Needed Follow-up Care

356
Follow-up Appointments Scheduled for Clients

*Data Timeframe: January 1, 2023 – December 31, 2024

ADVOCATES FOR COMMUNITY WELLNESS (A4CW)

Advocates for Community Wellness (A4CW) has received two years of LinC funding for their Well Women Wellness Promotion Program. These funds were used to hire one Lead CHW and one Community Engagement Coordinator. Through this program, the CHW and Coordinator increase health promotion, education, and access to healthcare services, and provide resource navigation and social services for women in underserved communities. The Well Women Wellness Promotion Program hosts health education workshops, resource fairs, and community events. At these events, community members interested in CHW support are connected to the program, which provides them with SDOH screenings and support connecting to primary and specialty care.

Results

2,458
Community Members Reached at Community Events

997
Community Members Screened for SDOH and Healthcare Needs

142
Community Members Screened Who Needed Follow-up Care

1,132
Referrals Made for Community Members

*Data Timeframe: January 1, 2023 – December 31, 2024

CHICAGO HOUSE AND SOCIAL SERVICE AGENCY

Chicago House and Social Service Agency has received two years of LinC funding for their Health Outreach and Prevention Education (HOPE) program. This funding has been used to hire one to two CHWs to work in the HOPE program. HOPE focuses on HIV-related education and outreach in community settings, emergency departments, and through mobile HIV testing at community partner events. This program provides no-cost HIV testing and increases linkages to health care services for prioritized individuals. HOPE also connects individuals to comprehensive resources and SDOH services aligned with their needs.

Results

750
Community Members Reached at Community Events

506
Community Members Screened for Care Needs

182
Community Members Referred to SDOH and Insurance Resources

326
Referrals Made to Care and SDOH Resources for Community Members Served

*Data Timeframe: January 1, 2023 – December 31, 2024

CHICAGO WOMEN'S AIDS PROJECT (CWAP)

CWAP has received two years of LinC funding for their Health Equity through Harm Reduction and Linkage to Care Program. This program funds one CHW to implement a harm reduction program focused on overdose prevention. The program engages clients through street outreach, community events, and health fairs. The CHW also provides at-home HIV test kits and overdose prevention kits and connects with individuals for case management. The CHW follows up with SDOH resources and healthcare navigation support for interested individuals.

Results

1,945
Community Members Reached at Community Events, Health Fairs, and Street Outreach

1,088
Community Members Screened for Healthcare Needs and Barriers to Care

571
Community Members Received Individualized Referrals

1,730
Referrals Made to Care and SDOH Resources for Community Members Served

*Data Timeframe: January 1, 2023 – December 31, 2024

INNER-CITY MUSLIM ACTION NETWORK (IMAN)

IMAN has received two years of LinC funding for their CHW program to fund one CHW. This program allows their CHW to conduct outreach, education, referrals, and mobilization to increase the entry of residents into the local healthcare ecosystem. IMAN's CHW provides health education ranging from asthma awareness to insurance enrollment at community events, and they also help individuals connect to resources such as food pantries and primary care providers.

Results

3,912
Community Members Reached via Community Events, Summits, and Resource Fairs

4,281
Community Members Screened for Health Care Needs and Barriers to Care

621
Primary and Specialty Care Appointments Scheduled

1,125
Community Members Referred to Resources

*Data Timeframe: January 1, 2023 – December 31, 2024

Community Benefit Chronic Conditions Grantee Programs

CHICAGO FAMILY HEALTH CENTER

Chicago Family Health Center maintains a Self-Monitoring Blood Pressure (SMBP) program for patients with hypertension, related risk factors, and chronic conditions to improve health outcomes associated with hypertension and support patients with self-management. This program includes significant internal and external outreach to increase enrollment of at-risk patients and connects community members with critical care. This program also supports patients with connections to wrap-around services.

Results

165
Outreach Opportunities and Education Events

1,096
New Participants Added to the SMBP Program

*Data Timeframe: January 1, 2023 – December 31, 2024

FRIEND HEALTH

The “Hopeful Hearts: A Holistic Approach to Managing Hypertension” program aims to address and mitigate the burden of hypertension through a comprehensive, holistic strategy with active use of digital technology. The program includes educational components around understanding disease, medication, and lifestyle changes. It also includes virtual data-driven feedback designed to improve access to care and blood pressure control, and turn patients into change agents that lead their families and neighbors in transforming their lifestyles and health outcomes.

Results

20
Educational Events Held

638
Community Members Educated at Events

*Data Timeframe: January 1, 2023 – December 31, 2024

MY DENSITY MATTERS

The Breast Density Education program educates women on the South Side of Chicago to ensure they are aware of breast density and how it can impact their risk of developing breast cancer. The program’s goal is to educate women on their breast cancer risk (e.g., breast density, race, etc.) and their next steps in the breast cancer screening process. My Density Matters (MDM) refers women to agencies that provide patient navigation through the breast cancer screening process. MDM reduces inequities by educating women of color on their breast cancer risk.

Results

3,252
Women Reached at Health Fairs, Outreach Events, and Other Community Events

607
Self-Administered Screening Guides Completed

124
Referrals Made to Agencies for Patient Navigation

*Data Timeframe: January 1, 2023 – December 31, 2024

Build Trauma Resiliency

Trauma has a profound and lasting impact on individual and community health. Building trauma resiliency is essential to fostering long-term well-being and reducing the burden of physical, mental, and behavioral health challenges associated with trauma exposure.

Urban violence is a complex and systematic issue requiring multiple stakeholders to invest in a multitude of approaches and strategies. Care delivery services such as **violence prevention** and recovery programs and **mental health** services for patients coming to the trauma center served as a primary pillar in the Medical Center's work to address community violence. The Medical Center seeks to strengthen the capacity of individuals, families, and communities to recognize, respond to, and recover from trauma through collaborative, trauma-informed strategies. Additionally, the Medical Center continued to expand its reach by growing partnerships with community-based organizations that address violence prevention at the community level.

Goal: Build Trauma Resiliency with a Focus on Violence Prevention, Trauma Recovery, and Mental Health

Objective 1

Cultivate and maintain partnerships to improve community health and safety

- Continue building a violence prevention ecosystem that addresses mental health and SDOH
- Build and strengthen partnerships with street outreach organizations across the South Side

Objective 2

Embed trauma-informed care across the hospital system

- Promote hospital and community-based programs that serve unmet needs related to SDOH
- Train healthcare staff in trauma-informed care, cultural competency, shared decision-making, and plain language
- Expand the scope and capacity of the Violence Recovery Program to more holistically address patient and family needs

Objective 3

Increase access to mental healthcare and services

- Collaborate with internal and external efforts focused on providing mental health services
- Increase the capacity of mental health services within the Medical Center and the community
- Execute interventions to address employee wellness
- Implement behavioral health services within the primary care setting

Objective 4

Reduce inequities caused by SDOH

- Expand screening for SDOH across the health system
- Connect patients and community members with resources such as housing, employment, food, transportation, etc.

Trauma Resiliency Programs

THE BLOCK HASSENFELD CASDIN (BHC) COLLABORATIVE FOR FAMILY RESILIENCE

The BHC Collaborative for Family Resilience supports children and families affected by violence and trauma. Programs in the BHC Collaborative include the VRP, Child Life, Spiritual Care, the REACT Clinic (Recovery & Empowerment After Community Trauma), and Healing Hurt People-Chicago. These programs work together to build trauma resiliency through violence prevention and recovery and mental health interventions and support. The sections below outline the impact of BHC Collaborative programs.

The Violence Recovery Program (VRP)

The Violence Recovery Program (VRP) is UChicago Medicine's hospital-based violence intervention program launched in 2018. It is a comprehensive initiative designed to reduce the risk of violent re-injury and support long-term recovery for adult and pediatric trauma patients and their families. The VRP provides immediate support and wraparound referrals, connecting individuals to community-based services. The program's services begin when a patient arrives at the Emergency Department (ED) due to a violent injury, where a Violence Recovery Specialist (VRS) immediately engages withthe patient and/or their family. The services provided include crisis intervention, navigation of the healthcare system (both immediately and post-discharge), psychosocial assessments, referrals, and intensive case management.

Objective 2

Embed trauma-informed care across the hospital system

Objective 3

Increase access to mental healthcare and services

Objective 4

Reduce inequities caused by SDOH

Results

4,730
Trauma patients (adult and pediatric) engaged and supported by the VRP

2,053
Families engaged and supported by the VRP

821
Non-patient children (i.e. child family members) engaged and supported by the VRP

3,612
Engaged patients received crisis intervention services

3,527
Patients enrolled in the VRP

1,631
Patients expressed at least one SDOH need

1,243 Patients received at least one SDOH referral and/or intervention

*Data Timeframe: January 1, 2023 – December 31, 2024

A key aspect of the program's impact is its **mental health support**. The VRP partners with internal hospital programs and community-based organizations to improve access to mental health and support for those recovering from violent trauma.

905	798	777
Patients expressed a mental health need	Patients received at least one mental health referral and/or intervention	Patients were connected with community based behavioral services

Additionally, through the **Medical Legal Partnership (Recovery Legal Care)** established in 2022 with Legal Aid Chicago, VRP patients with health-harming legal needs were enrolled in Recovery Legal Care (RLC), receiving assistance with securing public benefits such as Supplemental Nutrition Assistance Program (SNAP), disability assistance, crime victim compensation, and essential legal support.

Recovery Legal Care helped **471** VRP patients address health-harming legal needs.

Healing Hurt People - Chicago (HHP-C)

Healing Hurt People - Chicago (HHP-C) is a nationally recognized hospital-based violence intervention program (HVIP) dedicated to supporting young individuals and communities affected by trauma and violence. HHP-C provides immediate and long-term support to survivors of intentional injury, helping them navigate recovery and reduce the risk of re-injury.

Through trauma-informed care, assessments, case management, group therapy, mentoring, and community partnerships, the program empowers clients to heal physically and emotionally while addressing the root causes of violence. The program is operated by John H. Stroger, Jr. Hospital of Cook County and UChicago Medicine's Comer Children's Hospital.

HHP-C also partnered with Project FIRE, a collaborative program with Firebird Community Arts. Project FIRE combined glassblowing, trauma-informed art therapy, and mentorship, offering participants a creative outlet for processing trauma, developing skills, and building supportive peer networks.

Objective 1	*Objective 2*	*Objective 3*	*Objective 4*
Cultivate and maintain partnerships to improve community health and safety	*Embed trauma-informed care across the hospital system*	*Increase access to mental healthcare and services*	*Reduce inequities caused by SDOH*

Results

383	50	14
patients aged 19 or younger received HHP-C outreach, psychoeducation, and support	patients aged 19 or younger received HHP-C community-based intensive case management	HHP-C clients participated in the Project FIRE art therapy program

*Data Timeframe: January 1, 2023 – December 31, 2024

Recovery and Empowerment After Community Trauma (REACT)

Recovery and Empowerment After Community Trauma (REACT) delivers comprehensive **mental health support** and **trauma-informed services** to individuals impacted by community violence, with a strong focus on youth and families. The program serves children who have been exposed to violence but may not be direct survivors of violent injury.

Children and families are provided with psychiatric needs assessments, prescriptions for psychiatric medications, and referrals for ongoing counseling. REACT comprehensively addresses the psychological, psychiatric, social, and behavioral effects of exposure to violence.

Objective 1
Cultivate and maintain partnerships to improve community health and safety

Objective 2
Embed trauma-informed care across the hospital system

Objective 3
Increase access to mental healthcare and services

Objective 4
Reduce inequities caused by SDOH

Results

178
Children received individual therapy referrals

102
(58%) of these children were newly enrolled in therapy

212
Total children (new and existing clients) received therapy through REACT

95
Individuals received psychiatric assessments and/or medication management

41
Adults received caregiver support referrals

29
(71%) of those adults engaged in caregiver support services

*Data Timeframe: January 1, 2023 – December 31, 2024

REACT also prioritizes capacity building for trauma-informed care. The program hosted multiple free trainings for trauma clinicians in the community and continues to lead monthly Complex Trauma Community of Practice case consultation calls. Through this work, they strengthen the broader community response to trauma.

REACT trained **200** clinicians in the community.

Additional Trauma Resiliency Programs

In addition to BHC programs, the Medical Center supports many initiatives focused on trauma prevention, violence recovery, and mental health. These programs and services are outlined below.

AMBULATORY/OUTPATIENT SOCIAL WORKERS

The Social Work team at the Medical Center is integral to delivering comprehensive, patient-centered care that addresses medical needs and the social, emotional, and economic factors that influence health outcomes. Social workers ensure patients receive the full spectrum of support needed to improve both mental and physical well-being by focusing on factors including family dynamics, community support, and socioeconomic challenges.

In collaboration with the healthcare team, social workers connected patients to essential mental health and social services. Trained in diverse therapeutic modalities, UChicago Medicine social workers offer individual, family, and group counseling to support patients dealing with anxiety, depression, trauma, addiction, and other mental health challenges.

Objective 2

Embed trauma-informed care across the hospital systems

Objective 3

Increase access to mental healthcare and services

Objective 4

Reduce inequities caused by SDOH

Results

771 Referrals to the Collaborative Care Program (connections to mental health and social services)

*Data Timeframe: January 1, 2023 – December 31, 2024

A core part of their work involves healthcare navigation—assisting with insurance, eligibility, and service access. This support is vital for vulnerable populations, including those with limited health literacy, language barriers, or unfamiliarity with healthcare processes.

The Outpatient Social Work team also addresses SDOH, particularly food insecurity, which many patients identified as a barrier to achieving their health goals. Support includes connections to local food pantries, food drop-offs, assistance with LINK (SNAP) applications, and education on affordable, nutritious eating.

WELLNESS RESILIENCY ARTS PROGRAM (WRAP)

The Wellness Resiliency Arts Program (WRAP) is a trauma-informed initiative for teens that uses the arts to help them explore and express personal experiences with social issues such as racism and violence. The program offers a high-impact, four-week artistic education experience, culminating in a performance or exhibition. Art forms include spoken word, visual arts, African dance/percussion, and filmmaking, all led by highly skilled, trauma-informed teaching artists. In addition to the creative workshops, teens receive support from social work and counseling interns who facilitate daily reflections on thoughts, beliefs, and emotions, providing a safe, nurturing environment for personal growth.

Objective 1

Cultivate and maintain partnerships to improve community health and safety

Results

3
WRAP Sessions Hosted

57
Young People Attended WRAP Sessions

*Data Timeframe: January 1, 2023 – December 31, 2024

BEHAVIORAL HEALTH INTEGRATION PROGRAM (BHIP)

The Behavioral Health Integration Program (BHIP) provides primary care providers with clinical decision support tools to assist in diagnosing and managing conditions such as depression, anxiety, ADHD, eating disorders, and PTSD, aiming to increase access to mental health services across Chicagoland.

Tools include a library of one-page clinical decision support resources that offer screening, diagnosis, and management guidance, helping providers better address common mental health issues. **In its tenth year, BHIP received the 2024 Integrated Behavioral Health Award from AAMC in recognition of its innovative approach to mental health care.**

In September 2024, UChicago Medicine launched a system-wide depression screening program in ambulatory clinics throughout Chicago and its suburbs. Since its implementation, over 130,000 patients have been screened, with 4% identified as needing mental health support. Additionally, BHIP maintains a wide network of partner providers and programs, expanding access to mental health services.

Objective 1

Cultivate and maintain partnerships to improve community health and safety

Objective 2

Embed trauma-informed care across the hospital system

Objective 3

Increase access to mental healthcare and services

Results

130,000+
People screened for depression in ambulatory clinic settings

26
Psychotherapy partners to increase access to mental health services in the PSA

8
Psychiatry provider partners

2
Intensive outpatient/partial hospitalization programs

*Data Timeframe: January 1, 2023 – December 31, 2024

COMMUNITY GRAND ROUNDS (CGR)

The Community Grand Rounds (CGR) Program was launched in 2010 by the Medical Center's Center for Community Health & Vitality with support from the Institute for Translational Medicine. This dynamic initiative serves as a vital platform for engaging South Side residents with timely, relevant health information. Events typically feature networking, presentations, and interactive discussions.

Healthcare providers, community members, and local organizations come together to address critical health issues through open dialogue, education, and collaboration. Focused on health equity and community engagement, the program creates a platform for sharing knowledge, fostering partnerships, and developing culturally responsive solutions to health challenges impacting Chicago's South Side and beyond.

Objective 1
Cultivate and maintain partnerships to improve community health and safety

Objective 3
Increase access to mental healthcare and services

Results

3
Mental Health Events with **125** Attendees

3
Chronic Disease Events with **110** Attendees

3
Violence Prevention Events with **166** Attendees

1
Food Access Event with **42** Attendees

3
Access to Care Events with **120** Attendees

15
Total CGR Events

685
Total Attendees

*Data Timeframe: January 1, 2023 – December 31, 2024

WORKFORCE RESILIENCE ENHANCEMENT PROJECT (WREP)

Initiated in January 2020, the Workforce Resilience Enhancement Project (WREP) was made possible through grant funding by AT&T. The project is dedicated to supporting healthcare workers by providing resources to mitigate burnout, enhance well-being, and strengthen workforce resilience.

Through a combination of training, peer support, and mental health resources, WREP equips healthcare workers with tools to manage stress, build emotional resilience, and sustain long-term engagement in their roles. In this way, WREP contributes to improved patient care and the mental health of workers in our PSA.

WREP leveraged the Extension for Community Health (ECHO) – Chicago as part of its work. ECHO-Chicago is a workforce training and capacity-building program designed to promote evidence-based best practices in clinical and non-clinical settings for healthcare providers and community members. The program aims to reduce health disparities and enhance community expertise by expanding participants' knowledge and skills through telehealth learning.

One of the key series was on suicide prevention, training providers to identify, assess, and intervene in cases of suicide risk.

Objective 1
Cultivate and maintain partnerships to improve community health and safety

Objective 3
Increase access to mental healthcare and services

Results

45
ECHO Series Delivered

670
Organizations Attended Various Series

1,412
Total Attendees Across All 45 Series

*Data Timeframe: January 1, 2023 – December 31, 2024

Trauma Resiliency Grant Programs

Part of the Medical Center's work to address community benefit priorities includes grant-making to community-based organizations.

SOUTHLAND RISE (RESILIENCE INITIATIVE TO STRENGTHEN AND EMPOWER)

Southland RISE (Resilience Initiative to Strengthen and Empower) is a collaboration between the Trauma Recovery Center at Advocate Christ Medical Center in Oak Lawn and the Violence Recovery Program at the Medical Center. Inspired by U.S. Senator Dick Durbin's HEAL Initiative, the partnership funds community organizations over summer months to prevent and reduce violence-related injuries on Chicago's South Side and in south suburban neighborhoods. Southland RISE hospital partners have committed to continuing the grant program in 2025, further strengthening collaboration with grantee organizations.

Objective 1

Cultivate and maintain partnerships to improve community health and safety

Grant Dollars Distributed	Organizations Funded	Neighborhoods Served	
$150,000	18	24	Summer 2022
$150,000	19	29	Summer 2023
$150,000	19	37	Summer 2024

10,000+ **Individuals Reached in Summer 2024**

*Data Timeframe: January 1, 2023 – December 31, 2024

In addition, Southland RISE secured federal and state funds to (1) conduct joint trainings for street outreach organizations and hospital staff on improved coordination, and (2) provide direct financial assistance to survivors of intentional violence with emergency housing, utilities, and food assistance.

Results

2 Summits Held

Over **$800,000** Awarded

70+ Grassroots Organizations Received Grants

All Grantees Served Youth and Families via Violence Prevention Initiatives

BLOCK HASSENFELD CASDIN COLLABORATIVE FOR FAMILY RESILIENCE GRANTEES

In addition to the hospital programs directly supported by the BHC, this generous collaborative also supports community-level violence prevention and recovery through grants. These funds go to organizations running programs for children, families, and the community, focusing on long-term healing from trauma.

Three organizations were awarded grants for two years to provide mental health and trauma recovery services to children and families. Year 2 is now in progress, with details on Year 1's activities and impact below.

Objective 1

Cultivate and maintain partnerships to improve community health and safety

Objective 3

Increase access to mental healthcare and services

Fathers, Families, & Healthy Communities (FFHC)

Fathers, Families, & Healthy Communities (FFHC) supports Black fathers and families by offering resources, programs, and community-based support to strengthen relationships, improve well-being, and promote leadership. Their work focuses on father-child bonds, family stability, and personal growth, helping families overcome challenges, build resilience, and create lasting change.

Results

24
Fathers were enrolled in the program with complete intake and assessment forms

100%
of participants received clinical services, SDOH assistance, and legal assistance

100%
of participants completed individual success plans and needs assessments

*Data Timeframe: January 1, 2023 – December 31, 2024

YWCA Metropolitan Chicago

Founded in 1876, YWCA Metropolitan Chicago is dedicated to eliminating racism, empowering women, and promoting justice and dignity for all. A key part of its mission is supporting sexual assault survivors and their caregivers with trauma-informed therapeutic services.

Serving individuals ages 3 to 26, the YWCA provides comprehensive care to reduce the impact of trauma, improve well-being, and help survivors regain self-determination. Using evidence-based, survivor-centered approaches, the program fosters healing and resilience. The organization also offers services to address trauma, support youth and families, and promote economic equity.

- **Increased psychoeducation services delivered to survivors**
- **Increased short- and long-term group therapy offerings to survivors of sexual trauma and their caregivers**
- **Increased individual therapy availability**

Medical Careers Exposure and Emergency Preparedness (MedCEEP)

Medical Careers Exposure and Emergency Preparedness (MedCEEP), a Chicago-based nonprofit founded in 2018, addresses healthcare disparities, low health literacy, and violence in underserved communities by empowering minority youth. Through its TRAP Violence program, MedCEEP provides emergency response training and educates young people on Chicago's South and West Sides about the root causes of violence.

MedCEEP helps young people examine contributing factors and the root causes of violence, build resilience with trauma-informed coping strategies, and develop conflict resolution skills using evidence-based techniques. The program also teaches them to recognize and respond to potential violence, fostering non-violent conflict resolution and stress management skills.

Results

11	615	11	55
Single-day TRAP violence workshops were conducted	Youths participated in the single-day TRAP violence workshops	Longitudinal training sessions were conducted	Youths participated in the longitudinal training sessions

*Data Timeframe: January 1, 2023 – December 31, 2024

Reduce Inequities Caused by Social Determinants of Health (SDOH)

The Medical Center's community benefit approach focuses on partnerships and direct efforts to address SDOH needs across chronic conditions and trauma resiliency. Recognizing the multifaceted challenges that residents face, as demonstrated in primary and secondary CHNA data, the Medical Center prioritized focus on three SDOH domains: **access to care, food security, and workforce development.** As denoted by the SDOH icons throughout this report, many programs and initiatives address SDOH alongside other priority health areas.

Goal: **Reduce health inequities driven by the Social Determinants of Health (SDOH) focused on access to care, food insecurity, and workforce development**

Reduce inequities caused by SDOH

- Expand screening for SDOH across the health system
- Connect patients and community members with resources such as housing, employment, food, transportation, etc.
- Increase the local workforce's commitment to address economic hardship

Access to Care Programs

MATERNAL FETAL MEDICINE AT FRIEND HEALTH – SSHCO PARTNERSHIP

Through a partnership with South Side Healthy Communities Organization (SSHCO), the Medical Center increased access to care for various specialty and primary care providers, including Maternal Fetal Medicine.

The Medical Center's departments of Obstetrics and Gynecology and Maternal Fetal Medicine provide specialty consultations at Friend Health Cottage Grove one day per week. Through this collaboration, high-risk pregnant patients can receive pregnancy consultations or ongoing prenatal care from a community-based Federally Qualified Health Center. This increases patients' access to a highly specialized area of medicine.

Results

7
Days Average Wait Time for New and Existing Patients

95%
of Patients were Patients of Color

281
Total Number of In-Person Completed Appointments

*Data Timeframe: January 1, 2023 – December 31, 2024

Food Insecurity Programs

FEED1ST

The Feed1st program at the Medical Center, launched in 2010, is a food pantry initiative aimed at reducing hunger and food insecurity among patients, their families, and hospital staff.

Operating 24/7 across 11 pantry sites on the medical campus, Feed1st uses a no-questions-asked, self-serve model to reduce stigma and ensure dignity for those in need. The program sources food from the Greater Chicago Food Depository and is supported by volunteers, including medical students and nurses. By offering barrier-free access to nutritious food, Feed1st addresses a key SDOH, improving the overall well-being of the Medical Center's community members.

Results

119,912
Pounds of Food Distributed

61,036
Individuals Served

21,876
Families Served

*Data Timeframe: January 1, 2023 – December 31, 2024

THE MEDICAL CENTER'S COMMUNITY GARDENS

The Medical Center's Rooftop Community Garden, located on Parking Garage B, is an urban agriculture initiative that promotes healthy eating and improves food access for the Medical Center and surrounding community. Launched in 2018 as part of a sodium reduction grant, the garden grows fresh vegetables and herbs for patients, staff, and community members, especially those managing chronic conditions like cancer. The harvest is also sold at hospital farmers markets, with proceeds going to charitable causes. The garden is maintained by the nutrition services team, grounds crew, and hospital volunteers.

Results

11,263 Pounds of Fresh Produce Distributed

*Data Timeframe: January 1, 2023 – December 31, 2024

Workforce Development Programs

THE MEDICAL CENTER'S HR INITIATIVES

The Medical Center remains committed to expanding economic opportunities for its employees and the South Side community, particularly for people of color. Through a comprehensive workforce development approach, UChicago Medicine has launched several initiatives aimed at reducing skills gaps, increasing economic mobility, and supporting career growth.

The Medical Center has programs designed for both professional development and workforce pipeline opportunities. Programs such as Rise Higher and Evolve offer participants training in leadership, technical skills, and patient care, helping people secure sustainable, well-paying jobs.

Results

18
Unique Workforce Development Programs at the Medical Center

226
New Hires from Programming and Partnerships

4
Partner Organizations: Anixter, Cara, Skills for Chicagoland's Future (SFCF), Chicago Healthcare Workforce Collaborative (CHWC)

41%
of New Hires Came from the Medical Center's PSA

72
Partnership Workforce Development Events

$16,836
Allocated to Good Jobs Grant - Community Partnership Providing Resources to Workforce Program Participants

*Data Timeframe: January 1, 2023 – December 31, 2024

EVOLVE

Evolve focuses on upskilling employees to address workforce inequities and provide pathways to career advancement.

Results

48
Employees Enrolled in the Program

18
Employees Promoted After Program Completion

*Data Timeframe: January 1, 2023 – December 31, 2024

CERTIFIED NURSING ASSISTANT (CNA) PATHWAY PROGRAM

The Certified Nursing Assistant (CNA) Pathway Program offers community members and current employees a clear path to healthcare careers. Launched in 2021 in partnership with SFCF, the program provides participants with paid, non-clinical work at UChicago Medicine while they complete an eight-week accredited Basic Nursing Assistant training at Malcolm X Community College. After finishing the training, participants earn their CNA certification and move into Nursing Support Assistant roles at UChicago Medicine.

Results

11
Individuals Enrolled in the Program

9
Became State-Certified Nursing Assistants

7
Transitioned Into Permanent Roles at the Medical Center

*Data Timeframe: January 1, 2023 – December 31, 2024

RISE HIGHER

Rise Higher is a specialized leadership initiative aimed at increasing racial equity in career advancement. The program provides participants with training in project management, diversity and inclusion leadership, and business acumen.

Results

87
Employees Completed the Program

100%
Graduation Rate

26%
of Participants Moved into Higher-Wage Leadership Positions

*Data Timeframe: January 1, 2023 – December 31, 2024

Through these targeted programs and strategic partnerships, UChicago Medicine continues to drive meaningful change, creating economic opportunities, closing workforce gaps, and strengthening career pathways for employees and community members.

Data Limitations

This report does not measure all of the possible aspects of health in the community, nor does it adequately represent all possible populations. The majority of data represented here are self-reported and not based on clinical measurements.

Programs are implemented across a variety of settings and populations, which presents challenges in the validity and reliability of aggregate data.

Small, community-based programs are often under-resourced, which can limit reporting capabilities.

Conclusion

The Medical Center is committed to continuously improving its processes, structures, and programs to provide the highest quality of services to South Side residents. It is the Medical Center's priority to improve the health of South Side residents affected by the health areas outlined in this report. The Medical Center will continue to regularly evaluate each program and make adjustments as needed.

Plans to address the next three years of the Medical Center's community benefit focus are outlined in the Medical Center's FY 2026–2028 SIP. More information on the Medical Center's community efforts and current programs, events, and initiatives supported by UChicago Medicine can be found at www.uchicagomedicine.org/about-us/community.

Appendix 3

Community Input Survey

Community Health Needs Survey

Welcome to the Community Health Needs Survey for the University of Chicago Medical Center

This survey will only take about 5 minutes. We will ask you questions about the health needs of your community.

The information from the survey will help us:

- Find health problems that affect the people in our community
- Better understand the needs for our community
- Work together to find a solution

The survey is voluntary and you do not have to take part. You can also skip any questions you do not want to answer or stop the survey at any time.

The answers you give are very important to us. **Your answers will be private** (we will not know who gave the answers) and we will protect the information you are giving.

Your Information	
Your home zip code:	How many years you lived here:
What town or neighborhood do you live in?	

What do you like best about where you live? (List up to 3 things)
1.
2.
3.

Community Health Needs Survey

Community Health Problems

What do you see as the **most important health problems** in your area? Choose up to 5. **Make an X next to your 5 choices.**

	Abuse such as child abuse, emotional abuse, physical abuse, neglect, sexual assault, domestic violence, intimate partner violence
	Access to healthy food items
	Age-related illness such as arthritis, hearing or vision loss, Alzheimer's or dementia
	Cancers
	Chronic pain
	Dental disease
	Diabetes (high blood sugar)
	Family planning (birth control)
	Heart disease, hypertension (high blood pressure), and stroke
	Homelessness and housing
	Lung disease such as asthma or chronic obstructive pulmonary disease (COPD)
	Mental health such as depression, anxiety, suicide, post-traumatic stress disorder (PTSD)
	Mother and infant health
	Obesity
	Racism and other discrimination
	Sexually Transmitted Infections (STIs and STDs), including Human Immuno-deficiency virus (HIV) and acquired immuno-deficiency syndrome (AIDS)
	Substance-use such as alcohol, tobacco, prescription misuse, and other drugs
	Stress
	Violence such as community violence, homicide, aggravated assault, shootings and car jackings
	Other: Please give example

Community Health Needs Survey

Questions About Community

What do you think are the **most important things for a healthy community?**
Check up to 5 choices.

- ☐ Activities for teens and youth
- ☐ Affordable childcare
- ☐ Affordable healthy foods such as fresh fruits and vegetables
- ☐ Affordable housing
- ☐ Arts and cultural events
- ☐ Cancer screening (testing) and ways to lessen risk for cancer such as mammogram, colonoscopies, Pap smears, or HPV vaccine
- ☐ Clean streets and neighborhood
- ☐ Community services such as resources for housing
- ☐ Fitness (gym or place to work out)
- ☐ Getting good services no matter my race, gender, or where I live
- ☐ Good schools (caring, supportive, good resources)
- ☐ Health support services for conditions such as diabetes, cancer, or heart disease. This could include support for diet, weight management, quitting smoking, and end of life care.
- ☐ Health care such as being able to make appointments
- ☐ Healthy family life and relationships
- ☐ Inclusive and equal care for all people no matter their race, gender identity or sexual orientation (LGBTQ)
- ☐ Job training and good paying jobs
- ☐ Life skill trainings such as cooking and how to budget
- ☐ Mental health services
- ☐ Parks and recreation
- ☐ Preventive ways to improve health
- ☐ Racial equity
- ☐ Religion or spirituality
- ☐ Safety and low crime
- ☐ Strong sense of community and social networks (caring neighbors, sense of belonging)
- ☐ Technology (internet, computers)
- ☐ Transportation
- ☐ Other:_____

What changes do you want to see in the area where you live?

Community Health Needs Survey

Questions About You

What is your age?

_____

How do you identify yourself?

- ☐ Male
- ☐ Female
- ☐ Transgender man female-to-male (FTM)
- ☐ Transgender woman male-to-female (MTF)
- ☐ Genderqueer
- ☐ Gender non-conforming (Not only male or female)
- ☐ Other gender group Please describe: _____
- ☐ Do not want to answer

Check one of the following that best represents how you think of yourself:

- ☐ Straight or heterosexual
- ☐ Lesbian or gay
- ☐ Bisexual
- ☐ Queer
- ☐ Pansexual
- ☐ Questioning
- ☐ Do not know
- ☐ Other, please describe: _____
- ☐ Do not want to answer

What racial and ethnic groups do you identify with? (check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian or Mideast Asian
- ☐ Black or African-American
- ☐ Hispanic or Latino/Latina
- ☐ More than one race
- ☐ Do not know
- ☐ White-Caucasian
- ☐ Do not want to answer

Is a language other than English spoken in your home? ☐ Yes ☐ No

If Yes: What languages other than English are spoken in your home?

_____

What is the highest level of education you have completed?

- ☐ Less than high school
- ☐ Some high school
- ☐ High school graduate or graduate equivalency degree (GED)
- ☐ Vocational or technical school
- ☐ Some college
- ☐ College graduate
- ☐ Advanced degree (such as MS, MEd, MSW, MD, PhD, JD, etc.)

Community Health Needs Survey

Questions About Your Household

What kind of place do you live in?

- ☐ Own my home
- ☐ Rent my home
- ☐ Living in emergency or transitional shelter
- ☐ Living outside (Not a shelter, car, tent or abandoned building)
- ☐ Living with a friend or family
- ☐ Other: _____

How many people, including yourself, live in your household? Please count people who spend most of their time living in your household. Please give the number of people in each age group. If none, please enter 0.

Adults, 18 years of age or older: _____

Children, 11-17 years old: _____

Children, 6-10 years old: _____

Children, 1-5 years old: _____

Children, less than 1 year old: _____

Are you or anyone in your household a veteran? ☐ Yes ☐ No

Do you or anyone in your household have a disability? (have a condition of the body or mind that greatly limits their activities and caring for themselves)

☐ Yes ☐ No

What is the yearly household income? This is the total income of all the people in the home who financially help. Total before taxes are taken out.

- ☐ Less than $10,000
- ☐ $10,001 to $20,000
- ☐ $20,001 to $30,000
- ☐ $30,001 to $40,000
- ☐ 40,001 to $50,000
- ☐ $50,000 to $75,000
- ☐ $75,001 to $100,000
- ☐ $100,001 to $150,000
- ☐ $150,001 to $200,000
- ☐ $200,001 or more
- ☐ I don't know
- ☐ Prefer not to answer

Community Health Needs Survey

Questions about Your Health

Do you see a medical or healthcare professional on a regular basis?
(Sometimes called a primary care provider)

☐ Yes ☐ No

Have you ever had any cancer screenings? (tests for cancer) ☐ Yes ☐ No

If yes, check all that apply:

- ☐ Mammogram: breast (within past 1 to 2 years)
- ☐ Cervical: Pap smear or HPV test (within past 3 to 5 years)
- ☐ HPV vaccine for yourself, child, or grandchild
- ☐ Colonoscopy: Colon or intestinal screening for cancer (within 10 years)
- ☐ Home stool: Poop test (within past 1 year)
- ☐ Prostate cancer screening
- ☐ Lung cancer screening (if you have used tobacco products)
- ☐ Other (please describe): _____

If no, please explain why not:

- ☐ I am too young for any cancer screenings
- ☐ Did not know when or at what age to have the screenings
- ☐ No time to do this
- ☐ No transportation
- ☐ Conflicts with my work or cannot get time off
- ☐ No insurance
- ☐ Not covered by insurance
- ☐ Fear of pain
- ☐ Fear of bad results
- ☐ Fear of side effects
- ☐ I do not have a reason. I want to learn more about cancer testing.

Appendix 4

Additional Community Input Survey Results

Race/Ethnicity

74.7% Black
12.2% Latinx or Hispanic
7.2% White
2.1% Two or more
1.9% Did not disclose
1.4% Asian
0.3% Unknown
0.1% American Indian or Alaska Native

Age

37.0% 18-39
38.8% 40-64
20.2% 65+
3.0% Did not disclose

Gender

56.6% Female
40.9% Male
1.1% Gender non-conforming (Not only male or female)
0.7% Did not disclose
0.4% Transgender man female-to-male (FTM)
0.1% Other gender group
0.1% Transgender woman male-to-female (MTF)

Sexual Orientation

83.7% Straight or heterosexual
5.4% Bisexual
4.4% Did not disclose
2.7% Lesbian or gay
0.6% Do not know
0.5% Queer
0.3% Questioning

Note: Percentages may not total 100 due to rounding.

Household Status

50.0% Own my home
37.2% Rent my home
6.3% Living with a friend or family
3.9% Other
1.3% Did not disclose
1.1% Living outside (Not a shelter, car, tent, or abandoned building)
0.3% Living in emergency or transitional shelter

Education

29.7% Some college
23.1% College graduate
22.8% High school graduate or graduate equivalency degree (GED)
15.1% Advanced degree (such as MS, MEd, MSW, MD, PhD, JD, etc.)
4.0% Some high school
2.9% Vocational or technical school
1.2% Less than high school
1.4% Did not disclose

Household Income

9.7% Less than $10,000
5.7% $10,001 to $20,000
5.8% $20,001 to $30,000
4.6% $30,001 to $40,000
7.1% $40,001 to $50,000
13.9% $40,001 to $50,000
13.8% $50,001 to $75,000
12.4% $75,001 to $100,000
8.3% $100,001 to $150,000
6.1% $150,001 to $200,000
6.1% $200,001 or more
11.4% Did not disclose
1.1% I don't know

ZIP Code Counts

Number of survey respondents	Respondent ZIP code	Number of survey respondents	Respondent ZIP code	Number of survey respondents	Respondent ZIP code
41	60609	**56**	60620	**78**	60637
81	60615	**18**	60621	**49**	60643
103	60617	**66**	60628	**62**	60649
64	60619	**16**	60636	**49**	60653

"What do you think are the most important things for a healthy community?"

60% **Affordable housing**

55% **Activities for teens and youth**

51% **Affordable healthy foods such as fruits and vegetables**

35% **Clean streets and neighborhood**

31% **Affordable childcare**

Appendix 5

Secondary Data Sources and Limitations

Secondary Data Sources

In addition to the Community Input Survey shown in Appendix 3, secondary and hospitalization data for the Medical Center primary service area (PSA) was examined. Metopio helped identify, compile and analyze secondary data by curating hundreds of health equity indicators for key stakeholder review.

The following data sources were accessed:

- Hospital data:
  - Illinois Health and Hospital Association/COMPdata: Hospitalization and emergency department rates for UChicago Medicine

- Local data compiled by government agencies:
  - Chicago Department of Public Health
  - Chicago Police Department
  - Cook County Sheriff's Office of Research

- State agencies:
  - Illinois Department of Healthcare and Family Services
  - Illinois Department of Human Services
  - Illinois State Board of Education
  - Illinois Department of Public Health

- Federal sources:
  - Annie E. Casey Foundation: Kids Count
  - Behavioral Risk Factor Surveillance System (BRFSS)
  - Centers for Disease Control and Prevention: PLACES project, Diabetes Atlas, National Vital Statistics System-Natality, and Environmental Justice Index
  - Centers for Medicare and Medicaid Services
  - Environmental Protection Agency (EPA): Environmental Justice Screening
  - Federal Bureau of Investigation: FBI Crime Data Explorer
  - Feeding America
  - Health Resources and Services Administration
  - March of Dimes
  - National Cancer Institute
  - National Vital Statistics System-Mortality
  - The Eviction Lab at Princeton University
  - United States Department of Agriculture
  - United States Department of Housing and Urban Development
  - United Way ALICE Data
  - U.S. Census Bureau American Community Survey

Data Needs and Limitations

UChicago Medicine and Metopio made substantial efforts to comprehensively collect, review, and analyze primary and secondary data. However, there are limitations to consider when reviewing CHNA findings:

- Population health and demographic data are often delayed in their release, and data are presented for the most recent years available for any given data source.
- Variability in the geographic level at which data sets are available (ranging from census tract to statewide or national geographies) presents an issue, particularly when comparing similar indicators collected at disparate geographic levels. Whenever possible, we have reported the most relevant localized data.
- Due to variations in geographic boundaries, population sizes, and data collection techniques for suburban and city communities, some datasets are not available for the same periods or at the same level of localization throughout the county.
- Gaps and limitations persist in data systems for certain community health issues, such as mental health and substance use disorders for both youth and adults, crime reporting, environmental health statistics, and education outcomes. Additionally, these data are often collected and reported from a deficit-based framework that contributes to systemic bias.
- Survey data was collected using convenience sampling, which could lead to selection bias. As a response, survey data was weighted to reflect the PSA population.
- Focus group locations were selected based on partner availability.
- Any data that includes the time period of the COVID-19 pandemic and its resulting data collection disruptions can produce challenges in accuracy and relevance. Community members may have reported or experienced significantly different economic or health situations based on when the data was collected during that time period.

With this in mind, UChicago Medicine, Metopio, and all stakeholders were deliberate in discussing these limitations throughout the development of the CHNA and the selection of the FY 2026-2028 community benefit priority areas.