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Executive Summary

As part of the Affordable Care Act of 2010, each hospital facility in the U. S. must conduct a Community Health Needs Assessment (CHNA). This very important aspect of that Act mandates that hospitals must assess the health of the communities they serve, not just the patients who walk into their buildings, and that they must make a plan to improve community health.

Mount Sinai Hospital (MSH), part of the Sinai Health System, is located on the west side of the city Chicago, serving mostly Black and Latino people from some of the poorest communities in the U.S. Ten years ago, the Sinai Health System conducted what was then arguably the largest health assessment of Chicago’s communities (see our book describing this assessment and the subsequent interventions, *Urban Health: Combating Disparities with Local Data*). The opportunity to revisit and update this assessment is a welcome one that will serve our health system and our neighboring communities well.

This report is heavily evidence-based. That is, it is driven by data and shaped by the input and observations of community members, health professionals, and public health practitioners. Together, the data findings and community input helped us determine the most important health issues to address as a health system.

The Sinai Model

As described in our book, the Sinai Model was developed to define and guide our strategy for improving community health. Like much of the work of the Sinai Health System, this model emphasizes the importance of pre-primary care\(^*\), or the recognition that most determinants of health exist outside of the walls of the hospital. The Sinai Model consists of an iterative cycle that moves from the collection of data to the development, implementation, and evaluation of interventions to improve health. As new data are gathered, either through the interventions or through the next health assessment, the cycle starts all over again. This model is unique because most medical and public health research projects stop after the data findings are published. The new requirements of the ACA will help to ensure that hospitals do not follow in such an unproductive pattern but, instead, move to the steps of the process involving the development of relevant programs and policies to address the identified problems.

Here at Sinai, we are well-prepared to continue taking these steps, in addition to completing the full cycle. For example, our previous assessment gave us the opportunity to gather data from the community, bring resources for improved health to those we serve, and to be cost-effective in the process. The current CHNA is part of our continual process to not only understand the health-related needs of the communities we serve, but to work with our community partners and members to develop and implement creative strategies to address them.
The Sinai Model

Structure of This Report

In Section 2, we present social and demographic data to describe the communities we serve. This is followed by some of the most detailed analyses of causes of death (Section 3), reasons for hospitalizations (Section 4), and then for re-hospitalizations (Section 5) that we have ever seen. We then present survey data (Section 6) that help us understand the behaviors and social factors that shape the health of these communities. Next come separate sections on birth outcomes (Section 7), child and adolescent health (Section 8), and sexually transmitted infections (Section 9). We follow this data with a very substantial discussion of input into what the data mean to the communities we serve, what issues are of greatest importance, and how the hospital can begin to work with the community to improve health (Sections 11-13). The report culminates with a plan of action and a road map for the implementation of this plan.

Findings

This assessment is necessarily long and detailed. We certainly do not expect all people to read all of the sections, but we do believe there is something here for everyone. In great brevity, the Primary Service Area of Mount Sinai Hospital includes 13 communities containing 19% of Chicago’s population with a total population of 505,488 people and 152,706 households. These people are mostly poor Blacks, Mexicans, and Puerto Ricans. Although health outcomes vary among these communities, by and large, far too many people are sick and die too early.

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

Dr. Martin Luther King, Jr, 1966
For example, life expectancy, how long we can expect to live, is considered by many to be the single most important measure of health. Life expectancy for Chicago was 77 years but it varied between 69 and 82 years for the 13 communities we serve. A map of life expectancy for the city (in Section 3) shows that low life expectancies are clustered overwhelmingly on the south and west sides, areas which are populated predominantly by Black people. We find the same patterns prevail when we look at various causes of death like diabetes (Section 3), hospitalizations (Section 4), and health behaviors like smoking (Section 6), birth outcomes like infant mortality and low birth weight (Section 7), childhood diseases like asthma (Section 8), and sexually transmitted infections like syphilis (Section 9).

A recent publication by members of the Sinai Urban Health Institute\(^1\) demonstrates that racial disparities in health are growing much worse in Chicago. That is, rather than making progress in this crucial area of human rights, our city is moving backwards. This must be changed, and Mount Sinai Hospital is at the forefront of efforts to make this change.

To guide our efforts, we presented all of the data findings to various individuals and organizations within the communities we serve. At these sessions, we asked people to help us prioritize the issues and brainstorm solutions that the health system could implement, alone or in partnership with community organizations. In Sections 11 and 12, we describe this input. In general, community members identified problems such as diabetes, high blood pressure, cancer, obesity, mental health, and sexually transmitted infections as the most important health issues to be addressed. They felt that MSH (and other hospitals) could improve the health of the community by providing more health education, offering better quality service at a lower cost, and increasing the cultural competence of the staff.

Two components of MSH, the Sinai Community Institute and the Sinai Urban Health Institute, are expected to be a large part of this process. As discussed in Section 13, these institutes are leading Sinai’s foray into the community, literally going door to door and block by block to implement our vision of pre-primary care\(^2\). One can very reasonably argue that one of the central thrusts of the Affordable Care Act and these community assessments is

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Priority Health Issues for MSH Primary Service Area</th>
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<tr>
<td>MORTALITY</td>
<td>Diabetes, Heart Disease, Stroke</td>
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<tr>
<td>HOSPITALIZATIONS</td>
<td>Asthma, Diabetes, Mental Health</td>
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<tr>
<td>READMISSIONS</td>
<td>Diabetes, Asthma, Stroke</td>
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<tr>
<td>SURVEY DATA</td>
<td>Diabetes, Overweight &amp; Obesity, Smoking, Depression</td>
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<tr>
<td>BIRTH OUTCOMES</td>
<td>Low Birth Weight, Premature Births, Maternal Smoking</td>
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<td>CHILD &amp; ADOLESCENT HEALTH</td>
<td>Asthma, Diabetes, Nutrition &amp; Physical Activity</td>
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<tr>
<td>SEXUALLY TRANSMITTED INFECTIONS</td>
<td>HIV, Gonorrhea, Syphilis, Chlamydia</td>
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to determine just how to move our programs outside the walls of the hospital and into the community, helping people be well there, where they live. Pre-primary care has the potential to be both health-effective and cost-effective. This is our model, this is our vision. But of course we cannot do all of this without you, our community members, and your input, leadership, and passion. In this sense, this Community Health Needs Assessment is an invitation for you to come along with us on our journey. We welcome you aboard.

**Implementation Strategy**

The real goal of conducting a Community Health Needs Assessment is to use it to motivate and guide actual changes. Given our familiarity with translating data into action, we are excited to take the information learned through this assessment and use it to make a plan of action. First, the data described above was used to identify priority health concerns for the communities we serve. As part of this process, we also examined existing efforts and resources available to improve these conditions. With this information, we were able to map out new programs and policies that we can implement to address the needs identified by the data and community members. Details about these extensive plans are summarized in Section 14.

**Conclusion**

MSH has a long history of striving to improve the health of the poor communities on the west side of Chicago. This assessment and corresponding plan of action provide an ideal blueprint from which MSH can continue to improve community health through changes inside and outside our walls. We welcome any comments or suggestions you may have to help us on this journey.

**References**

Part I
Mount Sinai Hospital
Section 1: Introduction

By any definition, health has multiple components. Consequently, poor health is caused by many factors ranging from less than optimal habits (e.g., smoking, lack of physical activity), to inadequate access to health care (e.g., no health insurance, lack of health care providers), to structural factors in society (e.g., inadequate housing, failing schools), to what have been called the fundamental causes of poor health (e.g., poverty, lack of education, segregation, racism).\(^1\) In order to improve health outcomes within a community, each of these factors needs to be understood and addressed. Conducting a Community Health Needs Assessment (CHNA) is an ideal opportunity for hospitals to do just this. Such assessments allow hospital administrators and health care providers to better understand the health-related needs of their community members in order for them to better tailor services and implement interventions. Such an assessment may also be valuable to other organizations and community members.

Obviously, many determinants of health operate outside the walls of our hospital. Attempting to understand and address these factors is a process that we at Mount Sinai have come to label as “pre-primary care”\(^2\). For example, as we describe below, one of the highly successful programs of Mount Sinai has consisted of a series of interventions to help children with asthma. Over the past 12 years, we have learned that more is needed than just effective health care. Children with asthma have to be freed from second-hand smoke, dust mites, rodent feces, and inadequately ventilated living quarters. This, in turn, requires collaboration with physicians, community health workers, housing experts, and even attorneys. Going beyond traditional health care services is what makes Mount Sinai unique and is one of the ways we are attempting to become the national model for the delivery of urban health care.

Figure 1.1 presents a schema for this concept of pre-primary care. Traditional hospital care includes both primary care, which is represented by the cloud in the center, and acute care, which is provided by the institutions at the right. We believe that we at Mount Sinai Hospital (which is part of the Sinai Health System) do both of these things well and we are proud of the high scores we have achieved for different components of these types of care. However, what makes us truly unique are the activities and institutions shown in the left-most column. These are the components of the Sinai Health System that speak most directly to the health of the communities we serve and which will be discussed throughout this assessment.

Here we present, with pleasure, the 2013 Community Health Needs Assessment for Mount Sinai Hospital. This report is consistent with the mission and vision of our health system (see Figure 1.2) and also with the language and spirit of the new federal regulations requiring such assessments. It is hoped that this assessment, like the previous ones we have done, will provide a roadmap to improved health for communities on the west side of Chicago. We believe this report is not only critical for guiding the actions of our health system, but also that it may be valuable for members of our community and those organizations which serve them. It is in this spirit that we share this CHNA with the reader. To contact us, please use the following email address maria.natal@Sinai.Org or phone number (773) 257-5960. We would very much appreciate your feedback. We would also be pleased to arrange for a presentation of the main findings of this report to your organization, and/or to provide hard copies.

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Sinai Health System

The Sinai Health System (SHS) is a unique health care delivery system on the west side of Chicago. SHS was founded in 1919 to provide care to Eastern European Jewish immigrants in the area as well as to create a place for Jewish doctors to practice. We now serve predominantly African-American and Latino communities, but our mission has remained the same. This mission addresses our desire to make a difference in both the individuals and the communities we serve. As we develop innovative and effective ways to do this, we strive to become the national model for the delivery of urban healthcare (see Figure 1.2).

Our health care system is comprised of Mount Sinai Hospital, Schwab Rehabilitation Hospital, Sinai Children’s Hospital, Holy Cross Hospital, Sinai Medical Group, the Sinai Community Institute (SCI), and the Sinai Urban Health Institute (SUHI) (Figure 1.3).

Mount Sinai Hospital is a 319-bed teaching hospital with a Level 1 Trauma Center, 60,000 annual emergency visits, and 4,000 deliveries. We are a community-based hospital that provides exceptional medical, surgical, behavioral health, therapeutic and diagnostic services. A major teaching hospital for the Chicago area, Sinai trains more than 700 health care professionals each year.
Figure 1.2 Mission, Vision and Values of the Sinai Health System

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

**Vision Statement**
To be the national model for the delivery of urban healthcare.

**Values**
*We will do this with:*

**Respect**
*We create an atmosphere of mutual respect and fairness, treating each person with dignity, recognizing we all have unique talents.*

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

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

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

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

- **Schwab** was the first accredited rehabilitation hospital in the Midwest. Today it serves as a regional 102 bed rehabilitation center with innovative therapies including music and horticulture. It is the only rehabilitation facility in the Chicago area accredited by both the Joint Commission and CARF in the disease-specific area of stroke.

- **Sinai Children’s Hospital** (SCH) includes pediatric cardiology, gastroenterology, nephrology, allergy, endocrinology, urology, physical medicine and rehabilitation, and neurology services. In 2010, there were 2,280 admissions to SCH. SCH has a Level III Neonatal Intensive Care Unit Center, which is the highest level of care for fragile newborns. We also have a Pediatric Intensive Care Unit to provide specialized care for children with serious or life-threatening injuries or illnesses.

- **Sinai Medical Group** includes 295 physicians with 39 medical and surgical specialties who work at Mount Sinai Hospital and other Sinai Health System sites throughout the Chicago area.
SCI provides education, employment counseling, case management, and nutrition services that address the social and economic factors affecting the health of the community’s most vulnerable members—infants, children, adolescents and older adults. Of the 30,000 annual client visits, approximately 98 percent are for low-income minority women and children.

SUHI is a leading research center focused on eliminating health disparities through social epidemiology, program evaluation, interventions, teaching and consulting. SUHI is currently implementing a wide range of health interventions within the community to address issues such as pediatric asthma, breast cancer screening, and diabetes.

Holy Cross Hospital (HCH) joined the Sinai Health System on January 16, 2013. HCH is a 274-bed Catholic community hospital on the southwest side of Chicago, offering intensive care, medical and surgical services, as well as obstetrics, rehabilitation, hospice, and an array of diagnostic and therapeutic services. Its Emergency Department receives 50,000 visits per year, and more ambulance runs than any hospital in the state, a function of the hospital’s geographic isolation and local unaddressed health needs. Holy Cross is deeply engaged with its surrounding communities in collaborative efforts to address housing, education, immigration and safety concerns that impact health, particularly in Chicago Lawn and the Englewood communities.

Together, these components of the Sinai Health System serve some of the most socio-economically challenged neighborhoods in Illinois, providing medical and social services not otherwise available to these diverse communities with a combined population base of 1,500,000 people. Notably, Mount Sinai Hospital is Illinois’ largest provider of Medicaid services. Despite these challenges, Mount Sinai Hospital was recently named one of the best hospitals in the Chicago area by U.S. News & World Report.

The Community We Serve

The primary service area of MSH serves the following Chicago community areas: Archer Heights, Brighton Park, Chicago Lawn, East Garfield Park, Gage Park, Humboldt Park, Lower West Side, Near West Side, North Lawndale, South Lawndale, West Elsdon, West Garfield Park, West Lawn. A detailed description of the demographic and socioeconomic characteristics of the individuals living in this community is provided in the next section.

MSH Community Benefits

In 2012, MSH provided $51 million in community benefits, including charity care, subsidized health services, language assistance, education, research, donations, coverage for bad debts, and volunteer services. Breaking this number down, charity care comprised $27 million of that $51 million and other community benefits added up to another $24 million. These benefits provide funding for many unfunded community initiatives that promote health, healing, or treatments.
MSH’s services represent a vital safety net for community residents providing healthcare for the largest number of low-income patients in Illinois and representing a high percentage of uncompensated care, totaling to 21% of the entire Sinai Health System’s annual operating costs.

MSH offers a wide variety of specialties that provide sophisticated healthcare to patients who are under-or un-insured. Despite complex and difficult community problems, MSH is committed to creating solutions that focus on developing the neighborhood’s most vital resource—the people. Its programs are designed to address the social and economic factors that impact the health of the community's at-risk members, including infants, adolescents and older adults.

**Affordable Care Act of 2010**

The Patient Protection and Affordable Care Act (ACA) was recently passed into law and with it the provision (Section 501(r)(3)) which mandates that every hospital facility conduct a needs assessment every three years. The language of the bill emphasizes that this requirement is not just a formality, but a way to ensure that all hospitals are aware of, and are attempting to address, real health needs within the communities they serve. According to the provisions of the act, the assessment must incorporate input from individuals who represent diverse groups within the community, including those with health expertise, be made public, and contain an implementation strategy to address the identified needs. Once completed, the report must be made public.

**Previous Community Health Assessments**

In order to understand the needs of the communities we serve, the Sinai Health System conducted a health survey between 2002 and 2003. To our knowledge, it was the largest community health assessment ever conducted in Chicago and it resulted in comprehensive analyses of the health and wellbeing of 10 different community areas in the city. These diverse communities included Blacks, Mexicans, Puerto Ricans, Whites, Chinese, Cambodians, Vietnamese, and Orthodox Jews. We have published a book describing this process (Figure 1.4) and the resulting data entitled *Urban Health: Combating Disparities with Local Data*. In addition, the results have been disseminated through numerous articles in peer-reviewed journals and community reports. All of these articles and reports are available through the Sinai Urban Health Institute website. Selected findings from this work are presented in the Survey Data section.

As a result of the data gathered in this health assessment, many grants were written by the SHS and millions of dollars were brought to the various surveyed communities and others like them. Most importantly, these grants enabled us to put into place several interventions to improve the health of the communities we serve in such areas as breast health, pediatric asthma, diabetes, pediatric and adult obesity, and smoking cessation. Furthermore, our health system was not the only organization to use the data. Other health agencies across the city employed the data to obtain grants, target programs, and implement new interventions for improved health.
The Sinai Model

As first described in our book, the Sinai Model was developed to illustrate our strategy for improving community health. As is portrayed in Figure 1.5, this model consists of a cycle that moves from the collection of data to the development, implementation, and evaluation of interventions to improve health. As new data are gathered, either through the interventions or through the next health assessment, the cycle starts all over again. This model is unique because most medical and public health research projects stop after the data findings are published. The new requirements of the ACA will help to ensure that hospitals do not follow in this unproductive pattern but, instead, at least move along to the steps of the process involving the development of relevant programs and policies to address the identified problems.

Here at Sinai, we are extraordinarily prepared to continue taking these steps, in addition to completing the full cycle. For example, our previous assessment gave us the opportunity to implement this model, bring resources for improved health to the communities we serve, and to be cost-effective in the process. The current CHNA is part of our continual process to not only understand our communities’ health-related needs, but to work with our community partners and members to develop and implement creative strategies to address those needs.
Report Methodology

To best understand the health of our community, we have collected data from a variety of sources through a variety of methods. For example, we have used both quantitative and qualitative data from both primary and secondary sources. More specifically, this report includes data from surveys, birth and death certificates, program evaluations, and hospital data. We have attempted to interpret the findings in order to make them more accessible to everyone in the community. We have also included information obtained through more personal methods, such as interviews. The knowledge we gathered from community members in this way helps to provide context to the empirical findings. When combined, the overall report offers a great deal of information to help guide our health system’s priorities and the efforts of other community organizations.

More specifically, we will begin by describing the communities we serve. Next, in Part I, we examine prominent causes of death in these communities, leading reasons for hospital admissions and readmissions, and what survey data tell us about the health of these communities. Also in Part I, we present discussions of birth outcomes, child and adolescent health, sexually transmitted infections, and disability and violence. In Part II, we present information we obtained from input from the communities we serve through focus groups and town hall meetings. Finally, in Part III, we describe our strategies for dealing with the health concerns we identified, along with our initial implementation efforts.

Contributors

Many people have helped write this report. Among these has been the staff of the Sinai Urban Health Institute. These are ALL people trained in public health (most are graduates of schools of public health with MPH or PhD degrees). One of the authors (Dr. Whitman) was the founding member of the Epidemiology Program of the Chicago Department of Public Health. That program grew from 0 to 53 people during his 10-year tenure at the Department. We thus believe that the public health credentials of the authors of this report are substantial and notable.
References


Section 2: Description of the Communities

The MSH Primary Service Area is comprised of 13 communities, representing 19% of Chicago’s population with a total of 505,488 people and 152,706 households. These communities are largely made up of minority populations with 86% of the population being either Hispanic (56%) or African-American (30%). The MSH Primary Service Area is among the most economically challenged in the city, with nearly 30% of the population living below the poverty line and 37% of children living below the poverty line. Unemployment (for adults ages 20-64) ranges from 8% to 21% across the MSH communities and median household income ranges from $23,933 to $64,331. Additionally, these communities are young; the population under 18 years of age ranges from 14% to 36% and the percent over 65 years of age ranges from 5% to 10%. Although the demographic and socioeconomic characteristics of the 13 communities within the MSH Primary Service Area widely vary, even among communities that sit side-by-side, all are relatively disadvantaged. When we discuss the MSH Primary Service Area, it is necessary to examine data at the community level to truly understand the demographic and health profiles of the communities we serve.

What is a community?

It is natural that a Community Health Needs Assessment (CHNA) would start by describing the community or communities that the hospital serves, and that is what we have done in this section. At the same time, it is absolutely essential to realize that a community is more than just a geographically delineated area in which residents share common resources. A community has a history and an historical memory. Both of these contribute to the essence of the community and in this case help shape its health and well-being. For context, the city of Chicago was divided into 75 geographically defined Community Areas in the 1920’s; two additional areas have been subsequently added. These areas were loosely related to the city’s already established neighborhoods. They are aligned with census tracts and provide a unit of measurement for everything from urban planning to comparing health outcomes. This section describes the specific communities in the Mount Sinai Hospital (MSH) Primary Service Area. Also, for illustrative purposes we provide a brief history of North Lawndale, the community in which MSH is based, to give insight into how the history of these communities impacts the health and well-being of the current residents.

The Mount Sinai Hospital Primary Service Area

The MSH Primary Service Area is comprised of 13 communities (Box 2.1). This area was defined based on where 80% of our patients live. Within this area there are approximately 55 clinics addressing a range of health needs including nutrition, general, reproductive, child, and mental health. There are 10 hospitals that serve this area including ours, which is located at the intersection of North and South Lawndale.
Figure 2.1 presents a map of our Primary Service Area, its corresponding communities, and health resources located in the area.

The 13 communities in the MSH Primary Service Area represent 19% of Chicago’s population with a total of 505,488 people and 152,706 households. Chicago generally has a large Hispanic and African American population compared to the U.S. as a whole (61% vs. 29%), but this is particularly true within our service area, with 86% of the population belonging to one of these groups. Chicago is among the most hyper-segregated cities in the nation with a Black: White Index of Dissimilarity (IOD) score in 2009 of 82.48. The IOD measures how evenly the two races in question are distributed across a geographic area. A score of 100 would indicate that an area was 100% segregated and a score of 0 would indicate perfect integration. Thus for Chicago, 82.48% of either the White or Black population would need to move to another census tract within Chicago to achieve an even distribution of the two races in the city. Therefore the defined community areas within the MSH Primary Service Area do not just represent geographically defined groupings of neighborhoods, but can also be fairly homogenous in terms of race and ethnicity. The MSH Primary Service Area is also among the most economically challenged in the city, with nearly 30% of the population living below the poverty line. For comparison, approximately 20% of the population in Chicago and 14% of the U.S. population live below the poverty line.

An Historic Perspective

This has not always been the profile of the MSH Primary Service Area. While each community has a unique history, we will examine North Lawndale, the community in which MSH is located, as an example of how this area has changed and why it is pertinent to our discussion of the health and overall well-being of the current residents. Until the 1950’s North Lawndale was predominantly Caucasian. In the early 1900’s Jewish immigrants fleeing persecution moved from Eastern Europe (primarily Russia and Poland) to North Lawndale. This community became known as “Chicago Jerusalem”. Medical care was not readily available for Jewish immigrants and Jewish doctors could not generally practice in existing Chicago hospitals. MSH was established to serve the health needs of Jewish immigrants and to provide medical education and a place where Jewish doctors could treat their patients. This history of service to the community is still practiced and embodied in the mission and vision of MSH.

Around the time of World War II, African-Americans from the South were migrating to the North to find jobs and to escape the Jim Crow laws of enforced segregation. As African-Americans began moving into North Lawndale, the White Jewish population started moving out. In 1950, the North Lawndale population was almost all white. By 1960, 91% of the North Lawndale population was African-American (Figure 2.2) and the majority of the companies, and thus jobs, had left the area. The population in
Figure 2.1 The Mount Sinai Hospital Primary Service Area, Corresponding Community Areas, and Health Resources
North Lawndale during this time remained roughly 120,000, which means that there was a total migration of nearly 240,000 people during this transition. In addition to this huge population shift, one must consider the manner in which it took place. The Federal Housing Authority assumed, in a racist manner, that if African-American people were moving into a neighborhood it would be destabilized. They drew a red line around such neighborhoods and refused to support mortgages. In the 1960s, this practice was coined by John McKnight as “redlining”. Thus, the only way for African-Americans to purchase homes in communities like North Lawndale was on contract, a process that was completely unregulated and thus could be and was used to fully exploit people. This frequently resulted in their paying three or more times the value of a house. In 1966, Martin Luther King, Jr. chose North Lawndale as the base for the northern civil rights movement, and he moved his family within walking distance of MSH (Figure 2.3). As a response to Dr. King’s assassination in 1968, large parts of the community were burned, and crime, unemployment, and physical deterioration led to further flight by residents and businesses. According to 2010 Census estimates, North Lawndale has only 35,912 residents now and is one of the poorest communities in Chicago. We believe it is critical to remember this past when thinking about current problems.

Many residents of North Lawndale understand and remember this history and struggle mightily to rebuild their community. Organizations like Family Focus, the Sinai Community Institute, I AM ABLE, the Westside Association for Community Action, and many others fight on daily – and are making some progress. North Lawndale is, of course, just one example. Every community has a history and a memory of that history. Those of us trying to help improve the health of the communities we serve will be able to work more effectively by better understanding these dynamics. The book Family Properties: Race, Real Estate and the Exploitation of Black Urban America by Beryl Satter provides an excellent historic description of the racial transition of Chicago’s neighborhoods, specifically North Lawndale, and how Chicago became one of the most segregated cities in the nation. Another book, entitled Great American City: Chicago and the Enduring Neighborhood Effect, describes this phenomenon in a more general, theoretical way.

Demographic and Economic Profile of the MSH Primary Service Area

Due to Chicago’s hyper-segregation and vast economic inequality, demographic and health indicators can vary widely from one community area to the next. This is even true of community areas that are side-by-side such as North and South Lawndale. Tables 2.1 (page 7) and 2.2 (page 8) present many of the social, demographic, and economic characteristics of the communities in our Primary Service Area. We will discuss five of these in detail. These include race and ethnicity, age distribution (under 18 years and over 65 years), unemployment (ages 20-64), poverty, and household income.

Race and Ethnicity

Although it is true that a large proportion of the patients MSH serves are economically disadvantaged and/or from minority families, the population is extremely diverse. Of the 13 communities included in the MSH Primary Service Area, 12 have minority populations that exceed 75% (Table 2.1). Three of the communities are mostly African-American and seven are mostly Hispanic/Latino. The other two communities that have minority populations that exceed 75% include both Hispanic/Latinos and African-Americans (Figure 2.4).
Figure 2.4 Community Areas in Chicago with Minority Populations that Exceed 75%

Map Source: Sinai Health System, 2012.

Legend
- CAs ≥ 75% Population Hispanic/Latino
- CAs ≥ 75% Population NHB
- CAs ≥ 75% Population NHB/Hispanic/Latino
- MSH Primary Service Area
**Age Distribution**

The communities in the MSH Primary Service Area are young. The percent of the population under 18 years of age ranges from 14% to 36% and the percent over 65 years of age ranges from 5% to 10% (Table 2.1). To give some perspective, 12 of the 13 communities have a greater proportion of children than the city of Chicago (23%) and 12 of the 13 community areas have a lower proportion of people who are over the age of 65 than the city of Chicago (10%) (Figure 2.5). The data presented in Figure 2.5 are supported by data presented in later sections of this report (Sections 3 and 7) that show that these neighborhoods have more births and lower life expectancy compared to the City of Chicago.

**Figure 2.5 Age Distribution for Communities in the MSH Primary Service Area Compared to the City of Chicago**

**Economic Characteristics**

These communities are also among the poorest in Chicago. Unemployment (ages 20-64) ranges from 8% to 21% (Table 2.2). Unemployment is higher in 11 of the 13 communities compared to the city of Chicago. Median household income ranges from $23,933 to $64,331 and the percent living below the poverty line ranges from 12% to 42% (Table 2.2). Household income is lower in 10 of the 13 communities and the percent living below the poverty line is higher in 9 of the communities compared to the city of Chicago (Figure 2.6).
Figure 2.6 Percent of Children and Overall Population Living Below the Poverty Line by Community Area in the MHS Primary Service Area Compared to Percentages for the City of Chicago

Table 2.1 Demographic Data for the U.S., Chicago, and the MSH Primary Service Area

<table>
<thead>
<tr>
<th></th>
<th>Population*</th>
<th>Population &lt; 18 Years* (%)</th>
<th>Population &gt; 65 Years* (%)</th>
<th>Hispanic (%)</th>
<th>White (%)</th>
<th>Black (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chicago</strong></td>
<td>2,695,598</td>
<td>23</td>
<td>10</td>
<td>32</td>
<td>32</td>
<td>29</td>
</tr>
<tr>
<td><strong>MHS Service Area</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Archer Heights</td>
<td>506,488</td>
<td>28</td>
<td>7</td>
<td>56</td>
<td>11</td>
<td>30</td>
</tr>
<tr>
<td>Brighton Park</td>
<td>13,393</td>
<td>30</td>
<td>9</td>
<td>76</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>Chicago Lawn</td>
<td>45,368</td>
<td>34</td>
<td>6</td>
<td>85</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>East Garfield Park</td>
<td>55,628</td>
<td>32</td>
<td>6</td>
<td>45</td>
<td>4</td>
<td>49</td>
</tr>
<tr>
<td>Gage Park</td>
<td>20,567</td>
<td>30</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>91</td>
</tr>
<tr>
<td>Humboldt Park</td>
<td>39,894</td>
<td>36</td>
<td>5</td>
<td>89</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Lower West Side</td>
<td>56,323</td>
<td>31</td>
<td>7</td>
<td>53</td>
<td>4</td>
<td>41</td>
</tr>
<tr>
<td>North Lawndale</td>
<td>35,769</td>
<td>27</td>
<td>7</td>
<td>82</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>South Lawndale</td>
<td>35,912</td>
<td>33</td>
<td>9</td>
<td>6</td>
<td>1</td>
<td>91</td>
</tr>
<tr>
<td>West Elsdon</td>
<td>39,288</td>
<td>30</td>
<td>5</td>
<td>83</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>West Garfield Park</td>
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<td>31</td>
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<td>79</td>
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<tr>
<td>West Lawn</td>
<td>18,001</td>
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<td>10</td>
<td>2</td>
<td>1</td>
<td>96</td>
</tr>
<tr>
<td>West Lawn</td>
<td>33,355</td>
<td>31</td>
<td>8</td>
<td>80</td>
<td>15</td>
<td>4</td>
</tr>
</tbody>
</table>

* Source: U.S. Census (2010)
Conclusion

While it is true that a large proportion of the people MSH serves are from minority families and are economically disadvantaged, the economic and demographic profiles of these communities vary greatly even among communities that sit side-by-side. Thus, when we discuss the MSH Primary Service Area, it is necessary to examine data at the community level to truly understand the demographic and health profiles of the communities we serve. By examining local level data and understanding each community’s history MSH can develop health care strategies and programs that specifically address the needs of the overall service area and the communities within it.

References


Table 2.2 Selected Economic Characteristics for the U.S., Chicago, and the MSH Primary Service Area

<table>
<thead>
<tr>
<th></th>
<th>Unemployment Rate (Ages 20-64)* (%)</th>
<th>Median Household Income*</th>
<th>Population Living Below Poverty Line* (%)</th>
<th>Children Living Below Poverty Line* (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicago</td>
<td>10</td>
<td>$46,877</td>
<td>21</td>
<td>31</td>
</tr>
<tr>
<td>MHS Service Area</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Archer Heights</td>
<td>14</td>
<td>$44,538</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>Brighton Park</td>
<td>10</td>
<td>$39,737</td>
<td>24</td>
<td>31</td>
</tr>
<tr>
<td>Chicago Lawn</td>
<td>11</td>
<td>$39,437</td>
<td>25</td>
<td>35</td>
</tr>
<tr>
<td>East Garfield Park</td>
<td>14</td>
<td>$25,568</td>
<td>42</td>
<td>53</td>
</tr>
<tr>
<td>Gage Park</td>
<td>13</td>
<td>$38,674</td>
<td>21</td>
<td>29</td>
</tr>
<tr>
<td>Humboldt Park</td>
<td>11</td>
<td>$30,152</td>
<td>33</td>
<td>45</td>
</tr>
<tr>
<td>Lower West Side</td>
<td>13</td>
<td>$34,005</td>
<td>29</td>
<td>40</td>
</tr>
<tr>
<td>Near West Side</td>
<td>13</td>
<td>$64,331</td>
<td>28</td>
<td>39</td>
</tr>
<tr>
<td>North Lawndale</td>
<td>17</td>
<td>$26,062</td>
<td>42</td>
<td>54</td>
</tr>
<tr>
<td>South Lawndale</td>
<td>12</td>
<td>$34,267</td>
<td>30</td>
<td>40</td>
</tr>
<tr>
<td>West Elsdon</td>
<td>13</td>
<td>$50,140</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>West Garfield Park</td>
<td>21</td>
<td>$23,933</td>
<td>40</td>
<td>52</td>
</tr>
<tr>
<td>West Lawn</td>
<td>8</td>
<td>$47,595</td>
<td>19</td>
<td>22</td>
</tr>
</tbody>
</table>

* Source: American Community Survey (2010), 5-year Estimates


Part II
Community Health Data
Section 3: Mortality

In this section (and the associated Appendix A) we present, for all 13 communities in the Mount Sinai Hospital (MSH) Primary Service Area, calculations for each of life expectancy, total death rates, and the death rates for the 10 leading causes of death. In each case we show how these calculations compare to both the City of Chicago and the U.S. as a whole. Life expectancy, how long we can expect to live, is considered by many to be the single most important measure of health. Life expectancy for Chicago was 77 years, but varied from 69 to 82 years across the 13 communities. A map of life expectancy for the city shows that low life expectancies are clustered overwhelmingly on the south and west sides, areas which are populated predominantly by Black people. The leading cause of death in Chicago (and the U.S.) is heart disease. The heart disease death rate for Chicago was 242 (per 100,000 population), but ranged from 180 to 343 across the 13 communities. Once again a map showed some of the highest rates on the south and west sides. Many details, tables, and maps for the leading causes of death may be found in this section.

What we die from and how old we are when we die tell us a lot about our health and how to go about improving it. With this in mind, we continue our Community Health Needs Assessment (CHNA) in this section by examining life expectancy and mortality data for the city of Chicago and its 77 officially designated community areas (communities). Life expectancy is the number of years a person can expect to live at the time of birth. Mortality data tell us what people are dying from. When a person dies, a physician must determine the cause of death and that cause is recorded on the death certificate. Death certificates can thus be used to determine the leading causes of death for different groups of people. In this case, our population of interest is the city of Chicago and the communities it contains. The data in this section come from our analysis of the death certificate files for the city of Chicago for the years 2005-2007, the most recent information available. We use a report published by the Chicago Department of Public Health to inform us about the 10 leading causes of death in Chicago in 2006. We present an analysis of some of these causes in this section and of the remaining causes in Appendix A.

<table>
<thead>
<tr>
<th>Leading Causes of Death for Chicago Residents, 2006¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heart Disease</td>
</tr>
<tr>
<td>2. Cancer</td>
</tr>
<tr>
<td>3. Accidents</td>
</tr>
<tr>
<td>4. Stroke</td>
</tr>
<tr>
<td>5. Chronic Lower Respiratory Disease</td>
</tr>
<tr>
<td>6. Diabetes</td>
</tr>
<tr>
<td>7. Septicemia</td>
</tr>
<tr>
<td>8. Nephritis</td>
</tr>
<tr>
<td>9. Influenza &amp; Pneumonia</td>
</tr>
<tr>
<td>10. Homicide</td>
</tr>
</tbody>
</table>

Life Expectancy. Let’s start by looking at life expectancy data for Chicago. On average, a baby born in Chicago in 2005-2007 can expect to live to the age of 77 years. However, when we look at life expectancy for the communities within Chicago, we see that where you live changes how long you might expect to live. For instance, let’s say the Smith family has just welcomed a baby into the world and they
return to their home in North Lawndale. At the same time, the Jones family welcomes their first baby and returns to their home in Lake View. If both babies remain in their respective communities, Baby Jones in Lake View can expect to live to the age of 86 years, while Baby Smith in North Lawndale can expect to live only to the age of 71 years. This means that, on average, people in Lake View live over 15 years longer than people in North Lawndale. This is not to say that there are not going to be people who live longer in North Lawndale – it just means that on average, this is how long one can expect to live in each of these communities. Indeed, to offer another example, there is quite a bit of variation in life expectancy across the 77 communities of Chicago, with those in Hyde Park living 84 years on average, and those in Fuller Park living 69 years on average. Figure 3.1 shows the 77 communities of Chicago with light to dark shading for highest to lowest life expectancy. The data are presented in quartiles (see Box 3.1 for a discussion of quartiles).

**Box 3.1 Quartiles**
Throughout this section, data are presented for various health conditions by Chicago community and the data are presented in quartiles. Quartiles represent a breakdown of the data for the 77 communities into 4 groups such that the first quartile captures the first 25% of the data (the best off); the second quartile captures the next 25%; the third quartile captures the next 25% and the fourth quartile captures the last 25% (the worst off).

Notably, this map reveals that all of the communities with the lowest life expectancies are on the south and west sides of the city where the largest concentrations of Non-Hispanic Black (Black) people reside. In fact, of the 20 communities with the lowest life expectancy, all but one are primarily Black (70% or more of the population is Black) and 15 are almost entirely Black (90% or more of the population is Black). Given that Blacks in Chicago tend to live in higher poverty areas than Non-Hispanic Whites (Whites) and that poverty is associated with poorer health, this finding, while totally unacceptable, is not necessarily surprising. Interestingly, while Chicago’s Hispanic populations also tend to live in higher poverty areas, we actually see higher life expectancy among this group. A brief discussion of why this might be the case is found in Box 3.2.

**Box 3.2 The Hispanic Health Paradox**
In almost all parts of the world, lower levels of education and income are associated with worse health and higher death rates. The Hispanic Health Paradox refers to the fact that even though Hispanics in the U.S. tend to have lower levels of education and income than Non-Hispanic Whites, they often have health outcomes that are comparable to or, in some cases, better than those of their White counterparts. This includes lower mortality rates and higher life expectancy.

The specific causes of this phenomenon are not well understood, but several theories exist that seek to explain it. One of these is the “Acculturation Hypothesis” which proposes that newer arrivals to this country tend to have fewer bad health behaviors like smoking, over-eating, and drug use. Another of these is the “Healthy Migrant Effect” which maintains that those who migrate to this country tend to be healthier than the average resident. Finally, the “Salmon Bias Hypothesis” posits that some Hispanic people may return to their countries of origin to retire or when they become chronically ill. In such cases, no U.S. death certificate is ever filed and death rates calculated based on these certificates will be artificially low.
the U.S., Chicago, and the 13 communities in the MSH Primary Service Area. Within this area, life expectancy ranged from a low of 69 in West Garfield Park to a high of 82 in South Lawndale. Life expectancies below the Chicago average were found in 6 of the 13 Sinai communities.

**Figure 3.2 Life Expectancy (2005-2007)**

*How Does Place Influence Health?* There are several ways in which where a person lives might affect health outcomes such as life expectancy. For instance, affordable healthy foods and a safe place to exercise are not always readily available in every area of Chicago. People who can access healthy foods and exercise may be more likely to lead a healthy lifestyle and thus live longer. In addition to poverty, other societal factors such as racism, low education, and pollution also impact health. It follows then that *how many people die* and *what people die from* varies from community to community.
Figure 3.1 Life Expectancy by Chicago Community Area

**All-Cause Mortality.** The all-cause mortality rate is a summary measure which tells us how many people will die, on average, in a given year for any reason. In the same way that we see differences across the city in how long people live, we also see differences in the rate at which people die in the various communities. The death certificate contains the decedent’s address, which is used to determine the community for which the death will be counted. In other words, mortality data are based on where the decedent was living, not where s/he was when s/he died.

Figure 3.3 presents the all-cause mortality rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area. The all-cause mortality rate for Chicago was 850. This means that for every 100,000 people in Chicago, an average of 850 of them died in any given year between 2005 and 2007. The rate for the U.S. was 779, much lower than that for Chicago. Within the MSH Primary Service Area, the rates ranged from a low of 615 in South Lawndale to a high of 1263 in West Garfield Park. Rates above the Chicago average were found in 5 of the 13 Sinai communities.

**Figure 3.3 All-Cause Mortality (2005-2007)**

![Graph showing all-cause mortality rates for various Chicago communities]

Figure 3.4 indicates which community areas are most burdened with mortality. The map displays all 77 of Chicago’s communities with light to dark shading for lowest to highest all-cause mortality rates. Notably, all of the communities with the highest rates were on the south and west sides of the city. The map also illustrates that three of the communities with the highest all-cause mortality rates (those in the 4th quartile) fell within the MSH Primary Service Area.

**Cause-Specific Mortality.** Above, we focused on how long people in different communities live and how frequently they die. Now we will examine what diseases are causing people to die.

In this section, we present data for the top two causes of death – heart disease and cancer. Similar to our discussion of life expectancy and all-cause mortality, we continue to provide rates for Chicago, the U.S., and the 13 communities in the MSH Primary Service Area and we present this data in bar charts and maps. This structure is carried over in Appendix 1 where we continue our examination of the other leading causes of death for Chicago and its communities.
Figure 3.4 All-Cause Mortality by Chicago Community Area

Heart Disease: #1 Cause of Death in Chicago #1 Cause of Death in the U.S.

What is heart disease? Heart disease mainly affects older people and occurs when the heart and blood vessels are not working the way they should. There are several factors that can increase a person's chance of getting heart disease. Some of these are things we have no control over, like being older or having a family history of heart disease. But there are many things we might be able to change, like smoking, having high blood pressure, being overweight, and not exercising -- all of which can increase the chance of developing heart disease. Death from heart disease includes, among many other categories, heart failure. National data for the U.S. show that heart failure (HF), which accounts for nearly 10% of heart disease mortality, is one of the most common causes of hospitalization and readmission. In 2006, HF was the leading cause of hospitalization for people over 64 years of age in the United States. Furthermore, about 25% of people hospitalized with HF are readmitted within 30 days and 30% within 60 to 90 days. More information on hospital discharge and readmissions rates can be found in Sections 4 and 5 of this report.

- Figure 3.5 presents the heart disease mortality rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area.
- The heart disease death rate was:
  - 242 for Chicago
  - 201 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 157 for the Lower West Side to a high of 343 in East Garfield Park
  - Rates above the Chicago average were found in 6 of the 13 Sinai communities

![Figure 3.5 Heart Disease Mortality (2005-2007)](chart)

- Figure 3.6 displays all 77 of Chicago’s communities with light to dark shading for lowest to highest heart disease death rates
  - Nearly all of the communities with the highest rates were on the south and west sides of the city
  - Three of the communities with the highest rates (those in the 4th quartile) fell within the MSH Primary Service Area
- Heart disease deaths accounted for 23-35% of the 77 communities’ total deaths, more than any other cause
Figure 3.6 Heart Disease Mortality by Chicago Community Area

Cancer: #2 Cause of Death in Chicago
#2 Cause of Death in the U.S.

What is Cancer? Cancer refers to a group of diseases, all having to do with abnormal cell growth that can spread quickly throughout the body. A normal cell grows and divides, but it knows when to stop growing and eventually dies. Cancer cells, on the other hand, continue to grow and divide out of control and do not die when they are supposed to. A tumor forms when cancer cells group together. The cancer cells can destroy the normal cells around the tumor and can also damage healthy tissue. The cancer cells can also break away from the original tumor, travel to other parts of the body, and continue to grow and form new tumors. This disease process is called metastasis and it is how cancer spreads.

Just like with heart disease, there are certain things we have some control over that can help us reduce the risk for developing some cancers, including exercising, eating healthy foods, maintaining a healthy body weight, and abstaining from cigarette smoking and drinking alcohol. However, it is still possible to develop cancer even if we live a very healthy lifestyle. For this reason, cancer screening is important. Screening can help detect cancer early before it has had a chance to spread to other parts of the body. The sooner cancer is found, the sooner treatment can begin, and the better the chances for a full recovery. The type of recommended cancer screening(s) people need depends on their age and gender.

- Figure 3.7 presents the cancer mortality rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area
- The cancer death rate was:
  - 196 for Chicago
  - 181 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 120 in South Lawndale to a high of 295 in West Garfield Park
  - Rates above the Chicago average were found in 5 of the 13 Sinai communities

Figure 3.7 Cancer Mortality (2005-2007)
Figure 3.8 Cancer Mortality by Chicago Community Area

• Figure 3.8 demonstrates which community areas are most burdened with cancer mortality
  • The map displays all 77 of Chicago’s communities with light to dark shading for lowest to highest cancer death rates
  • Nearly all of the communities with the highest rates were on the south and west sides of the city
  • Two of the communities with the highest rates (those in the 4th quartile) fell within the MSH Primary Service Area

• Cancer deaths accounted for 16-28% of the 77 communities’ total deaths

Among the different types of cancer, prostate, lung, breast, and colorectal cancer together accounted for 52% of all cancer deaths in Chicago. Prostate cancer death rates above the Chicago average were found in 8 of the 13 Sinai communities. Lung cancer death rates above the Chicago average were found in 7 of the 13 Sinai communities. Breast and colorectal cancer death rates above the Chicago average were found in 5 of the 13 Sinai communities.

Conclusion

In this section, we have presented some data about causes of death. More data on this topic is presented in Appendix 1. Although death is, of course, the final step in our journey, it is not nearly the only consideration in determining how healthy our lives are or what the quality of life is like. In the following sections, we address these topics and others as we search for ways in which Mount Sinai Hospital can help the communities we serve live healthier and longer lives.

References

1. 2006 is the most recent year for which the Chicago Department of Public Health has published these data. See report at: http://www.cityofchicago.org/dam/city/depts/cdph/statistics_and_reports/SR_leading%20causes%20of%20death%202006.pdf.
### Section 4: Hospitalizations

Hospitalization data can be a useful tool for measuring poor health and the ways in which individuals utilize the health care system. In this section, we examine hospitalization rates for selected conditions within the MSH Primary Service Area zip codes and compare them to Chicago and national estimates. Hospitalization rates are presented for asthma, diabetes, heart disease, stroke, and mental health disorders, as well as pneumonia, HIV/AIDS, nephritis, cirrhosis, and injury and poisoning in the corresponding appendix (B). Disproportionately high hospitalization rates were seen in several MSH zip codes for all of the conditions listed above. Asthma and mental health hospitalizations were especially noteworthy, with rates almost three times higher than the corresponding Chicago rates in one MSH zip code. Significant racial disparities were seen as well, as the hospitalization rates for many conditions were directly correlated to the proportion of non-Hispanic Black residents in a given community. Hospitalization data and corresponding disparities in utilization may be particularly important to health care organizations interested in developing community interventions to address preventable hospitalizations or access to care issues.

Like information about what people die from (described in Section 3), hospitalization data help us to understand the burden of specific diseases and conditions for different groups of people. In this section, we examine hospitalization rates for selected conditions for the city of Chicago and Mount Sinai Hospital (MSH) Primary Service Area zip codes. The information we use comes from hospital discharge diagnoses. These are determined by a doctor or another qualified health care provider when a patient is released from the hospital. Hospitals currently use a system called the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) to categorize diagnoses. The hospital records a leading discharge diagnosis, as well as up to 24 secondary diagnoses, for each hospital visit and reports these data to the state. In Illinois, data are also reported to the Illinois Hospital Association, which maintains a discharge database called COMPdata. Discharges in COMPdata can be tabulated by hospital or by patient’s state, county, or zip code of residence. Hospitalization rates are presented by zip code below.

We were not able to organize data by community area since zip code and community area boundaries do not correspond. For example, one zip code may include portions of several community areas that vary greatly in terms of demographics and disease trends. This makes it difficult to extrapolate hospitalization rates to the community level. Table 4.1 provides the racial/ethnic make-up of each zip code in the MSH Primary Service Area in an effort to assist with data interpretability.

#### Table 4.1 Demographics of MSH Primary Service Area Zip Codes

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Hispanic (%)</th>
<th>White (%)</th>
<th>Black (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>60608</td>
<td>56</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>60612</td>
<td>13</td>
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<td>60623</td>
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<td>60629</td>
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</tr>
<tr>
<td>60632</td>
<td>84</td>
<td>11</td>
<td>2</td>
</tr>
</tbody>
</table>
The following results come from our analyses of hospitalization data by zip code from COMPdata for the years 2009-2011. Conditions were selected based on three criteria: 1) a critical assessment of nationally reported data from the National Hospital Discharge Survey\(^1\); 2) the leading causes of hospitalization for the MSH Primary Service Area reported by the Chicago Department of Public Health; and, 3) the leading causes of hospitalization at Mount Sinai Hospital. Selected conditions include asthma, diabetes, heart disease, stroke, and mental health. Appendix B also includes information on pneumonia, HIV/AIDS, kidney disease, liver disease, and injury and poisoning. The rates listed below can be interpreted as the average annual number of hospitalizations during 2009-2011 for a specific condition per 10,000 people. Rates are based on discharges with a leading diagnosis of the selected condition.

**Asthma Hospitalizations**

*What is asthma?* Asthma is a lung disease that causes breathing difficulties and is especially common in children. Symptoms include wheezing, breathlessness, chest tightness, and coughing.\(^2\) Asthma is one of the leading causes of hospitalization in the MSH Primary Service Area and is also considered an ambulatory care sensitive condition (ACSC), which means it is potentially preventable with the proper outpatient care. Thus, it is especially important to focus on ACSC conditions from a public health standpoint since they are potentially controllable and preventable. See Box 4.1 for more information on ACSC.

### Box 4.1 Ambulatory Care Sensitive Conditions (ACSC)\(^3\)

The Agency for Healthcare Research and Quality (AHRQ) defines Ambulatory Care Sensitive Conditions (ACSC) as “conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.” The AHRQ developed a set of Prevention Quality Indicators (PQIs) in order to assess quality of care issues and potential health disparities surrounding preventable hospitalizations. There are currently 16 PQIs, including one or more indicators for diabetes, perforated appendix, COPD or asthma, hypertension, heart failure, low birth weight, dehydration, bacterial pneumonia, urinary tract infection, and angina. We highlight diabetes, asthma, heart disease in general, and pneumonia in this report.

- Figure 4.1 presents asthma hospitalization rates for the U.S., Chicago, and the 6 zip codes in the MSH Primary Service Area

- The asthma hospitalization rate (per 10,000) was:
  - 28 for Chicago
  - 14 for the U.S.

- Within the MSH Primary Service Area:
  - Rates ranged from a low of 12 in 60632 to a high of 80 in 60624
  - Rates above the Chicago average were found in 3 of the 6 MSH zip codes
**Figure 4.1 Asthma Hospitalization Rates for the MSH Primary Service Area**

Data source: COMPdata (Chicago, 2009-2011); CDC Health Data Interactive (U.S., 2010)

- Figure 4.2 displays 56 zip codes in Chicago with light to dark shading for lowest to highest asthma hospitalization rates
  - Nearly all the zip codes with the highest rates were on the south and west sides of the city
  - Three of the six zip codes in the MSH Primary Service Area had asthma hospitalization rates within the highest (4th) quartile (see Box 3.1 in Section 3 for a description of quartiles)

---

**Box 4.2 Racial/Ethnic Trends in Hospitalization Rates**

The trends seen in the asthma graph above are consistent throughout this entire section. For every condition presented here, zip code 60624 has the highest hospitalization rate and 60632 has the lowest. It is informative to examine the racial/ethnic make-up of these zip codes when assessing trends. The hospitalization rate of each zip code is directly correlated with the proportion of Black residents in that zip code (Table 4.1). Zip code 60624, which has the highest hospitalization rate for every condition, is 94% Black. As the proportion of Black residents decreases across these zip codes, so do the corresponding hospitalization rates. Zip code 60632, which has the lowest rate for every condition presented here, is 84% Hispanic and only 2% Black.

This disparity in hospitalization rates among predominantly Black zip codes may represent several things, including a higher disease burden, less access to preventive care, or a greater number of readmissions for poorly controlled chronic diseases. Additionally, lower hospitalization rates among predominantly Hispanic zip codes such as 60632 may signify a lower disease burden or lower health care utilization due to a lack of insurance. It is important to keep these factors in mind when interpreting these trends, as the end result of hospitalization may have a multitude of complex and interrelated social causes.
Figure 4.2 Asthma Hospitalization Rates by Chicago Zip Code

Asthma Hospitalizations per 10,000

- Fourth Quartile (38 - 80)
- Third Quartile (19 - 37)
- Second Quartile (12 - 18)
- First Quartile (6 - 11)
- MSH Primary Service Area

Chicago Asthma Hospitalizations: 28
U.S. Asthma Hospitalizations: 14

Diabetes Hospitalizations

What is Diabetes? Diabetes (known in some communities as “sugar”) is a disease characterized by high blood sugar. Blood sugar is made naturally in our bodies and also comes from the food we eat. We need sugar for energy, but too much sugar in the blood can have negative side effects. Usually, a hormone called insulin helps sugar enter our cells in order to regulate the amount of sugar in our blood. However, in people with diabetes, the body either does not make enough insulin or the insulin does not work properly. Diabetes is the result of prolonged high blood sugar and can lead to serious health consequences such as kidney failure and blindness. People with diabetes are also at higher risk for heart disease and stroke. However, diabetes can be controlled with proper diet, exercise, and medication. Since diabetes complications are preventable, it is defined as an ambulatory care sensitive condition by AHRQ (see Box 4.1).

- Figure 4.3 presents diabetes hospitalization rates for the U.S., Chicago, and the 6 zip codes in the MSH Primary Service Area
- The diabetes hospitalization rate (per 10,000) was:
  - 28 for Chicago
  - 19 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 23 in 60632 to a high of 50 in 60612 and 60624
  - Rates above the Chicago average were found in 4 of the 6 MSH zip codes

Figure 4.3 Diabetes Hospitalization Rates for the MSH Primary Service Area

![Graph showing diabetes hospitalization rates for the MSH Primary Service Area](image)

Data source: COMPdata (Chicago, 2009-2011); CDC Health Data Interactive (U.S., 2010)

- Figure 4.4 displays 56 zip codes in Chicago with light to dark shading for lowest to highest diabetes hospitalization rates
- Nearly all the zip codes with the highest rates were on the south and west sides of the city
- Two of the six zip codes in the MSH Primary Service Area had diabetes hospitalization rates within the highest (4th) quartile

33
Figure 4.4 Diabetes Hospitalization Rates by Chicago Zip Code

Heart Disease Hospitalizations

What is heart disease? Heart disease mainly affects older people and occurs when the heart and blood vessels are not working the way they should. There are several factors that can increase a person’s chance of getting heart disease. Some of these are things we have no control over, like being older or having a family history of heart disease. But there are many things we might be able to change, like smoking, having high blood pressure, being overweight, and not exercising -- all of which can increase the chance of developing heart disease. Death from heart disease includes, among many other categories, heart failure. National data for the U.S. show that heart failure (HF), which accounts for nearly 10% of heart disease mortality, is one of the most common causes of hospitalization and readmission. In 2006, HF was the leading cause of hospitalization for people over 64 years of age in the United States. Furthermore, about 25% of people hospitalized with HF are readmitted within 30 days and 30% within 60 to 90 days.

- Figure 4.5 presents heart disease hospitalization rates for the U.S., Chicago, and the 6 zip codes in the MSH Primary Service Area
- The heart disease hospitalization rate (per 10,000) was:
  - 127 for Chicago
  - 112 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 94 in 60632 to a high of 206 in 60624
  - Rates above the Chicago average were found in 4 of the 6 MSH zip codes

Figure 4.5 Heart Disease Hospitalization Rates for the MSH Primary Service Area

- Figure 4.6 displays 56 zip codes in Chicago with light to dark shading for lowest to highest heart disease hospitalization rates
- Nearly all the zip codes with the highest rates were on the south and west sides of the city
- Three of the six zip codes in the MSH Primary Service Area had heart disease hospitalization rates within the highest (4th) quartile
Figure 4.6 Heart Disease Hospitalization Rates by Chicago Zip Code

Stroke Hospitalizations

What is a stroke? Similar to a heart attack, a stroke can result when a blood vessel is damaged or blocked, denying oxygen-rich blood to the brain. When this happens, brain cells begin to die in the region that is not receiving blood, resulting in brain damage. Depending on the location of the stroke, speech, movement, or memory may be affected. People who survive larger strokes may be left with permanent disabilities. The risk factors for stroke, including unhealthy lifestyle factors and conditions such as high blood pressure, may be modified or prevented. For more on these risk factors and the relationship between stroke and other vascular diseases, see Box 4.3 [below].

- Figure 4.7 presents stroke hospitalization rates for the U.S., Chicago, and the 6 zip codes in the MSH Primary Service Area
- The stroke hospitalization rate (per 10,000) was:
  - 34 for Chicago
  - 31 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 25 in 60632 to a high of 56 in 60624
  - Rates above the Chicago average were found in 4 of the 6 MSH zip codes

Figure 4.7 Stroke Hospitalization Rates for the MSH Primary Service Area

![Bar Chart: Stroke Hospitalization Rates for the MSH Primary Service Area](chart.png)

Data source: COMPdata (Chicago, 2009-2011); CDC Health Data Interactive (U.S., 2010)

- Figure 4.8 displays 56 zip codes in Chicago with light to dark shading for lowest to highest stroke hospitalization rates
  - Nearly all the zip codes with the highest rates were on the south and west sides of the city
  - Two of the six zip codes in the MSH Primary Service Area had stroke hospitalization rates within the highest (4th) quartile
Figure 4.8 Stroke Hospitalization Rates by Chicago Zip Code

Stroke Hospitalizations per 10,000

- Fourth Quartile (38 - 56)
- Third Quartile (31 - 37)
- Second Quartile (28 - 30)
- First Quartile (21 - 27)
- MSH Primary Service Area


Chicago Stroke Hospitalizations: 34
U.S. Stroke Hospitalizations: 31
Mental Health Hospitalizations

**What is mental health?** According to the Surgeon General, mental disorders are “health conditions that are characterized by alterations in thinking, mood, or behavior associated with distress or impaired functioning.” Mental disorders are extremely prevalent in the U.S. and throughout the world. An estimated 83% of U.S. adults are not in a state of optimal mental health, and depression is expected to become the second leading cause of disability worldwide by the year 2020.9,10

Mental health is important not only for our psychological well-being, but also because mental disorders can negatively affect our physical health as well. People with mental health problems are more likely to have certain physical health problems, including poor pregnancy outcomes, gastrointestinal disorders, and heart disease.11 Furthermore, even common mental health problems such as stress have the ability to impact our physical health. **Mental health-related conditions are the second leading cause of hospitalization at MSH, second only to childbirth.** Therefore, it is especially important to understand the level of the mental health burden in our surrounding communities.

- Figure 4.9 presents mental health-related hospitalization rates for the U.S., Chicago, and the 6 zip codes in the MSH Primary Service Area
- The mental health hospitalization rate (per 10,000) was:
  - 203 for Chicago
  - 68 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 57 in 60632 to a high of 639 in 60624
  - Rates above the Chicago average were found in 3 of the 6 MSH zip codes

**Box 4.4 Caution! Interpreting Rate Magnitude**

Although the bar charts presented in this section appear to follow the same distribution pattern, it is important to pay attention to the scale (vertical or y-axis) of each graph. For example, diabetes hospitalizations in the MSH Primary Service Area range from 23 to 50 per 10,000 population. However, mental health hospitalizations range from 57 to 639 per 10,000 population. This means that hospitalizations for mental health related-conditions were much more common during these years than hospitalizations for diabetes. Make sure to look at the scale of each graph when interpreting hospitalization rates.
Figure 4.9 Mental Health-Related Hospitalization Rates for the MSH Primary Service Area

Box 4.5 Top 3 Mental Health Discharges in Chicago
The following three categories made up over 95% of mental health-related hospital discharges in Chicago from 2009-2011:

1. Drug and alcohol-related (39%)
2. Mood disorders (31%)
3. Psychotic disorders (26%)

Mood disorders include diagnoses such as depression, psychosis, manic disorders, and bipolar disorders. Psychotic disorders include diagnoses such as schizophrenia and delusion. In 60624, the zip code in the MSH Primary Service Area with the greatest burden of mental health hospitalizations, drug and alcohol-related discharges made up over 60% of all mental health-related hospitalizations. It is important to consider the subcategories that make up mental health-related diagnoses in order to understand the risk factors and potential treatment options for different populations.

- Figure 4.10 displays 56 zip codes in Chicago with light to dark shading for lowest to highest mental health hospitalization rates
  - Nearly all the zip codes with the highest rates were on the south and west sides of the city
  - Three of the six zip codes in the MSH Primary Service Area had mental health hospitalization rates within the highest (4th) quartile
Figure 4.10 Mental Health Hospitalization Rates by Chicago Zip Code

Conclusion

In this section, we presented information about some of the main reasons that people are hospitalized in the MSH Primary Service Area. Every condition listed above has disproportionately high rates in several MSH Primary Service Area zip codes. Especially noteworthy conditions include asthma and mental health disorders, in which zip code 60624 has rates approximately three times higher than the corresponding Chicago rate. While hospitalization rates may somewhat reflect the burden of disease in a community, it is important to keep several things in mind when interpreting these rates. First, these data are based on number of hospital visits, not unique patients. Therefore, if a person is hospitalized 10 times for diabetes in a given time period, s/he would be counted as 10 visits when calculating the diabetes hospitalization rate. This may influence the comparability of zip code rates if residents from certain zip codes are more likely to be hospitalized repeatedly for a given condition. Secondly, this is only a measure of people with disease who make it to the hospital for treatment. There may be many people who have a disease and are not hospitalized due to a number of reasons, including insurance status, citizenship, or disease awareness. So while hospitalization rates are an important tool, they are not necessarily a measure of disease prevalence in a community. However, these data, used in combination with other health status indicators, provide another important piece of information to use when assessing the health status of a given community.

References

Section 5: Readmissions

Readmission data provide a hospital with valuable information on the specific diseases and conditions that are burdening its patient population and can highlight areas where additional resources are warranted. A readmission is defined as a repeat admission within a certain time frame of being discharged alive from the hospital. We use the 30-day readmission rate index (RRI) to compare MSH to other hospitals using a nationally representative database (Premier). A RRI over 1 implies that MSH is doing worse than the average rate, a RRI below 1 implies that MSH is doing better than average, and if the RRI is equal to 1 then the MSH rate is the same as the average rate. The overall 30-day readmission rate for MSH in 2010-2011 was 2.8%, 20% higher than for the national sample of hospitals. At MSH, the top three reasons for readmission are all severe mental health conditions (schizophrenia, bipolar disorder, and major depressive disorders). Of the 21 conditions with 10 or more readmissions in this time period, MSH had RRIs greater than 1 for 16 conditions and RRIs equal to or less than 1 for 5 conditions. The data presented in this section suggest that hospital-based initiatives such as comprehensive discharge planning will only partially reduce readmission rates. In addition, we need to incorporate more creative methods to address the social barriers faced by the patients in the MSH Primary Service Area.

Much like life expectancy, mortality, and hospitalization data (described in previous sections), readmissions provide a hospital with valuable information on the specific diseases and conditions that are burdening its patient population. They also highlight areas in which additional resources might be warranted. Although hospital readmission rates have been studied as an indicator of quality of care for over 30 years, the recent penalties imposed under the Patient Protection and Affordable Care Act have led to heightened attention to readmissions, particularly those that occur within 30 days of discharge. The importance of readmissions to the medical community is emphasized by the devotion of an entire issue of the prestigious medical journal, The Journal of the American Medical Association (JAMA), to the topic.

A readmission is defined as a repeat admission within a certain time interval of being discharged alive from the hospital. In an attempt to reduce readmissions, the Affordable Care Act now allows the Centers for Medicare and Medicaid Services (CMS) to penalize hospitals a portion of their total Medicare revenue for excess readmissions. CMS calculates readmission rates and compares these to the national average for all hospitals. If readmissions rates for certain conditions are in excess of the average rate, a penalty is imposed. Currently, CMS readmission penalties apply to three conditions: acute myocardial infarction, heart failure, and pneumonia. By fiscal year (FY) 2015, the penalty is expected to be extended to other conditions including chronic obstructive pulmonary disease (COPD), coronary artery bypass graft surgery, percutaneous coronary interventions, and other vascular procedures. The penalty will also be increasing in future years from the current penalty of 1% to 3%.
Policy makers are focused on readmissions because they believe that readmissions are an indicator of the quality of care received and the coordination of outpatient care once a patient leaves a hospital. Unnecessary or preventable readmissions drive up healthcare costs, have an impact on patient quality of life, and can be indicative of poor outpatient and/or transitional care. However, the reality is that many other patient factors likely contribute to excess readmissions rates, several of which are outside a hospital’s immediate control (for example, insurance status, finances, living situation, social support, or transportation issues). Innovative approaches that extend beyond traditional medical models may therefore be needed to address certain readmissions. Although many people are concerned with readmissions because of the financial impact they can have on a health care system, it is because of the negative impact readmissions have on the health of individuals and thus the community that we have chosen to pay careful attention to this topic in our needs assessment.

**Box 5.1 Data Sources and Special Considerations**

Data was obtained from the Premier Alliance database (www.premierinc.com). Premier is a collaborative healthcare alliance of more than 2,700 member hospitals and health systems designed to improve the quality and cost-effectiveness of healthcare. Premier’s database is the most comprehensive in the industry, including information on 1 of 4 discharges nationwide. Therefore, the Premier Alliance database allows for a meaningful analysis of readmissions for children and adults of all ages with the possibility of comparing MSH’s rate to a national sample. Use of the Premier Alliance database limits the analysis to readmissions for clinically-related reasons to the same facility as opposed to readmissions for any reason to any facility (as is done by CMS). In other words, if a patient is readmitted within 30 days to another hospital, that readmission is not captured by Premier and thus not by our analysis. This fact, combined with our focus on clinically-related readmissions, as opposed to readmissions for any reason, leads to the rates presented in this report appearing lower than rates derived from CMS and some other published reports. Both the Premier database and the CMS database have different strengths and weaknesses. For the reasons noted above, we use the Premier data for this report.

In this section, we examine 30-day, clinically-related readmissions for Mount Sinai Hospital (MSH) for the calendar years 2010-2011 combined (see Box 5.1 for more details). Our analysis considers the total number of readmissions over the interval, the 30-day readmission rate, and the Readmission rate index (RRI) (see Box 5.2 for definitions). Although we summarize the data through two main numbers, the total number of readmissions

**Box 5.2 Readmission Definitions**

- **30-day readmission rate** = the number of repeat admissions within 30 days of being discharged alive from a hospital stay divided by the total number of admissions over the same period
  - Can be interpreted as the proportion of patients discharged for a given condition who are readmitted within 30 days
  - Our analysis is limited to readmissions that are clinically-related to the initial admission and are readmitted to MSH

- **Readmission rate index (RRI)** = a ratio of the 30-day readmission rate for the facility divided by the risk-adjusted average readmission rate
  - Allows for a comparison of MSH’s rate to a national sample of hospitals
  - If RRI is greater than 1.0, then MSH’s readmission rate exceeds the national average for the same condition
and the RRI, we focus more heavily on the RRI. The total number of readmissions is correlated with the
total number of admissions. Therefore, leading causes of admissions to MSH would also be expected to
be among the leading causes of readmissions. A more meaningful indicator is the RRI, which allows for
an assessment of whether the 30-day readmission rate is greater than the average for the participating hospitals (see Box 5.2).

Table 5.1 presents aggregated data (i.e., for all conditions combined) on the total number of admissions, total number of readmissions within 30 days, 30-day readmission rate, and 30-day readmission rate index (RRI) for MSH for calendar years 2010 and 2011 for children and adults. Of the 41,036 admissions to MSH over the interval, about one-quarter were for children 17 years of age and younger and three-quarters were for adults 18 years of age and older. Over the same interval there were 1,166 clinically-related readmissions within 30 days of discharge, resulting in an overall 30-day readmission rate of 2.8%. In other words, nearly 3% of all discharges from MSH in 2010-2011 were readmitted for a clinically-related reason within 30-days. The RRI was 1.2, suggesting that the 30-day readmission rate for MSH is 20% higher over the interval than the average rate. Interestingly, the readmission rate index for children is 1.0, suggesting that the 30-day readmission rate for MSH is no higher than it is for the average Premier member hospital. The rest of this section will focus exclusively on the adult data.

**Table 5.1 Total Number of Admissions, Readmissions within 30 days, 30-day Readmission Rates, and Readmission Rate Index (RRI) by Age Group**

<table>
<thead>
<tr>
<th>Age</th>
<th>Total Admissions</th>
<th>Number of Readmissions Within 30 Days</th>
<th>30-Day Readmission Rate</th>
<th>RRI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17</td>
<td>10,582</td>
<td>94</td>
<td>0.9%</td>
<td>1.0</td>
</tr>
<tr>
<td>18+</td>
<td>30,454</td>
<td>1,072</td>
<td>3.5%</td>
<td>1.2</td>
</tr>
<tr>
<td>Total</td>
<td>41,036</td>
<td>1,166</td>
<td>2.8%</td>
<td>1.2</td>
</tr>
</tbody>
</table>

**Top Reasons for Readmissions**

Table 5.2 presents the top reasons for readmissions for adults 18 years of age and older within 30-days of an index admission sorted by the number of readmissions. Table 5.3 presents the same data, but now sorted by RRI. It is essential to keep both rankings in mind when thinking about readmissions at MSH or anywhere else. When examining these readmissions data, several interesting findings emerged. Here we focus on the findings that we feel are most relevant and appropriate for intervention. However, we urge the reader to consider all of the information provided by both these tables.

Of the 21 conditions for which there were at least 10 readmissions in 2010-2011 and which are therefore included in Tables 5.2 and 5.3, 16 (76%) have a RRI over 1.0, meaning the 30-day readmission rate for MSH is higher than average. Five conditions (24%) have RRIs greater than 2 (shaded in blue in both tables), indicating that the 30-day readmission rate at MSH is at least twice as high as the average rate. The five conditions with the highest RRIs from high to low are: (1) toxic effects of non-medicinal substance (RRI=4.4), (2) asthma (RRI=3.2), (3) major hematologic/immunologic diagnosis...
Table 5.2 Top Reasons for Readmissions within 30-days Ranked by Number of Readmissions (For adults 18 years and older, 2010-2011, Mount Sinai Hospital)

<table>
<thead>
<tr>
<th>APR DRG* /Condition</th>
<th>Total Admissions</th>
<th>Readmissions within 30 days (#)</th>
<th>Rank (# of 30-day Readmissions)</th>
<th>30-Day Readmission Rate</th>
<th>RRI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>943</td>
<td>142</td>
<td>1</td>
<td>15.1%</td>
<td>1.0</td>
</tr>
<tr>
<td>Bipolar Disorders</td>
<td>784</td>
<td>85</td>
<td>2</td>
<td>10.8%</td>
<td>1.1</td>
</tr>
<tr>
<td>Major Depressive Disorders &amp; Other/Unspecified Psychoses</td>
<td>934</td>
<td>82</td>
<td>3</td>
<td>8.8%</td>
<td>1.2</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>605</td>
<td>77</td>
<td>4</td>
<td>12.7%</td>
<td>1.6</td>
</tr>
<tr>
<td>Sickle Cell Anemia Crisis</td>
<td>159</td>
<td>74</td>
<td>5</td>
<td>46.5%</td>
<td>1.9</td>
</tr>
<tr>
<td>Other Antepartum Diagnosis</td>
<td>766</td>
<td>70</td>
<td>6</td>
<td>9.1%</td>
<td>1.1</td>
</tr>
<tr>
<td>Toxic Effects of Non-medicinal Substance</td>
<td>500</td>
<td>41</td>
<td>7</td>
<td>8.2%</td>
<td>4.4</td>
</tr>
<tr>
<td>Asthma</td>
<td>384</td>
<td>31</td>
<td>8</td>
<td>8.1%</td>
<td>3.2</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>58</td>
<td>28</td>
<td>9</td>
<td>48.3%</td>
<td>1.0</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>379</td>
<td>20</td>
<td>10</td>
<td>5.3%</td>
<td>0.7</td>
</tr>
<tr>
<td>Angina Pectoris &amp; Coronary Atherosclerosis</td>
<td>351</td>
<td>16</td>
<td>11</td>
<td>4.6%</td>
<td>2.6</td>
</tr>
<tr>
<td>Disorders of the Pancreas except Malignancy</td>
<td>131</td>
<td>14</td>
<td>12</td>
<td>10.7%</td>
<td>1.5</td>
</tr>
<tr>
<td>Diabetes</td>
<td>319</td>
<td>14</td>
<td>12</td>
<td>4.4%</td>
<td>0.8</td>
</tr>
<tr>
<td>Percutaneous Cardiovascular Procedure without MI</td>
<td>336</td>
<td>12</td>
<td>14</td>
<td>3.6%</td>
<td>2.1</td>
</tr>
<tr>
<td>Kidney &amp; Urinary Tract Infections</td>
<td>389</td>
<td>11</td>
<td>15</td>
<td>2.8%</td>
<td>1.4</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>335</td>
<td>11</td>
<td>15</td>
<td>3.3%</td>
<td>0.8</td>
</tr>
<tr>
<td>Major Hematologic/Immunologic Diagnosis Excluding Sickle Cell &amp; Coagul.</td>
<td>47</td>
<td>10</td>
<td>17</td>
<td>21.3%</td>
<td>3.1</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>682</td>
<td>10</td>
<td>17</td>
<td>1.5%</td>
<td>2.0</td>
</tr>
<tr>
<td>Other Anemia &amp; Disorders of the Blood</td>
<td>312</td>
<td>10</td>
<td>17</td>
<td>3.2%</td>
<td>1.2</td>
</tr>
<tr>
<td>Malfunctions, Reactions &amp; Complications of Genitourinary Device, Graft or Transplant</td>
<td>162</td>
<td>10</td>
<td>17</td>
<td>6.2%</td>
<td>1.2</td>
</tr>
<tr>
<td>Cellulitis &amp; Other Bacterial Skin Infections</td>
<td>447</td>
<td>10</td>
<td>17</td>
<td>2.2%</td>
<td>1.2</td>
</tr>
</tbody>
</table>

*APR DRG = All Patient Refined Diagnosis Related Group. APR DRGs are adjusted for illness severity, risk of death, and disease resource intensity.³

Excluding sickle cell crisis & coagulation (RRI=3.1), (4) angina pectoris & coronary atherosclerosis (RRI=2.6), and (5) percutaneous cardiovascular procedure without MI (RRI=2.1). These are conditions that are generally associated with urban environments and what distinguishes an urban center like MSH from others serving more affluent or suburban environments.

It is important to note that there are five conditions for which MSH is actually performing at least as well as or better than the average for all hospitals (RRI≤1.0). These five conditions are: (1) schizophrenia (RRI=1.0), (2) chemotherapy (RRI=1.0), (3) COPD (RRI=0.7), (4) diabetes (RRI=0.8), and (5) renal failure (RRI=0.8).
Mental Health Issues

The top three reasons for readmissions at MSH ranked by the number of readmissions are all mental health issues: (1) schizophrenia, (2) bipolar, (3) major depressive disorders and other/unspecified psychoses. This finding is hardly surprising given that mental health conditions are the second leading cause of hospitalization at MSH and have a major impact on the communities surrounding MSH (see Section 4, Hospitalizations). Combined, these three conditions result in 309 readmissions over the 2-year interval, which comprises nearly one-third (29%) of all of MSH’s readmissions during that period. Furthermore, these 3 conditions have a 30-day readmission rate of 11.6% meaning nearly 1 in every 9 discharges for a mental health condition results in a clinically-related readmission within 30 days. However, the RRI for the 3 mental health conditions range from 1.0 to 1.2, indicating that MSH’s readmission rate is just marginally higher than national rates. In other words, MSH is doing as well as the average hospital in the area of mental health readmissions.

Table 5.3 Top Reasons for Readmissions within 30-days Ranked by 30-Day Readmission Rate Index (RRI)
(For Adults 18 years and older, 2010-2011, Mount Sinai Hospital)

<table>
<thead>
<tr>
<th>APR DRG* /Condition</th>
<th>Total Admissions</th>
<th>Readmissions within 30 days (#)</th>
<th>30-Day Readmission Rate</th>
<th>RRI</th>
<th>Rank (RRI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toxic effects of Non-Medicinal Substance</td>
<td>500</td>
<td>41</td>
<td>8.2%</td>
<td>4.4</td>
<td>1</td>
</tr>
<tr>
<td>Asthma</td>
<td>384</td>
<td>31</td>
<td>8.1%</td>
<td>3.2</td>
<td>2</td>
</tr>
<tr>
<td>Major Hematologic/ Immunologic Diagnosis Excluding Sickle Cell &amp; Coagul. Angina Pectoris &amp; Coronary Atherosclerosis Percutaneous Cardiovascular Procedure without MI</td>
<td>47</td>
<td>10</td>
<td>21.3%</td>
<td>3.1</td>
<td>3</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>351</td>
<td>16</td>
<td>4.6%</td>
<td>2.6</td>
<td>4</td>
</tr>
<tr>
<td>Sickle Cell Anemia Crisis</td>
<td>159</td>
<td>74</td>
<td>46.5%</td>
<td>1.9</td>
<td>7</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>605</td>
<td>77</td>
<td>12.7%</td>
<td>1.6</td>
<td>8</td>
</tr>
<tr>
<td>Disorders of the Pancreas except Malignancy Kidney &amp; Urinary Tract Infections Other Anemia &amp; Disorders of the Blood Major Depressive Disorders &amp; Other/Unspecified Psychoses Malfunctions, Reactions &amp; Complications of Genitourinary Device, Graft or Transplant Cellulitis &amp; Other Bacterial Skin Infections Other Antepartum Diagnosis Bipolar Disorders Schizophrenia Chemotherapy Diabetes Renal Failure Chronic Obstructive Pulmonary Disease</td>
<td>131</td>
<td>14</td>
<td>10.7%</td>
<td>1.5</td>
<td>9</td>
</tr>
<tr>
<td>389</td>
<td>11</td>
<td>2.8%</td>
<td>1.4</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>312</td>
<td>10</td>
<td>3.2%</td>
<td>1.2</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>934</td>
<td>82</td>
<td>8.8%</td>
<td>1.2</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>162</td>
<td>10</td>
<td>6.2%</td>
<td>1.2</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>447</td>
<td>10</td>
<td>2.2%</td>
<td>1.2</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>766</td>
<td>70</td>
<td>9.1%</td>
<td>1.1</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>784</td>
<td>85</td>
<td>10.8%</td>
<td>1.1</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>943</td>
<td>142</td>
<td>15.1%</td>
<td>1.0</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>28</td>
<td>48.3%</td>
<td>1.0</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>319</td>
<td>14</td>
<td>4.4%</td>
<td>0.8</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>335</td>
<td>11</td>
<td>3.3%</td>
<td>0.8</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>379</td>
<td>20</td>
<td>5.3%</td>
<td>0.7</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

*APR DRG = All Patient Refined Diagnosis Related Group. APR DRGs are adjusted for illness severity, risk of death, and disease resource...
Heart Failure and Other CMS Focus Areas (Present and Future)

Heart failure, one of CMS’s focus areas, is the 4th leading reason for readmissions at MSH, with 77 readmissions within 30 days of discharge over the 2-year interval. More importantly, the RRI is 1.6 meaning 30-day readmissions are 60% higher than average, putting MSH at risk for financial penalties by CMS under the ACA Hospital Readmissions Reduction Program. The other two current areas of focus for CMS, acute myocardial infarction and pneumonia, do not appear on the list of conditions with 10 or more 30-day readmissions in 2010-2011. In FY 2015, the penalty is expected to be expanded to include COPD and other coronary and vascular conditions. Interestingly, the RRI for COPD is 0.7, meaning that MSH’s 30-day readmission rate for COPD is 30% lower than average. However, there are three other coronary and vascular conditions and procedures that appear on the list: angina pectoris & coronary atherosclerosis, percutaneous cardiovascular procedure without MI, and chest pain. In each case, the RRI is 2.0 or higher, indicating 30-day readmissions are at least twice as high as the average levels.

Sickle Cell Anemia Crisis

Sickle cell anemia crisis, which overwhelmingly affects African-American populations in the United States, is the 5th leading cause of readmissions, with 74 clinically-related readmissions within 30 days. Sickle cell anemia crisis also has a particularly high 30-day readmission rate, with nearly half (46.5%) of all those discharged being readmitted for a clinically-related reason within 30-days. The readmission rate index of 1.9 indicates that this readmission rate is well in excess of the average rate.

Toxic Effects of Non-Medicinal Substance

Toxic effects of non-medicinal substance is the 7th leading cause of readmission at MSH, with 41 clinically-related readmissions within 30 days of discharge within the 2-year interval. Although the readmission rate is not relatively high compared to other conditions, the RRI is 4.4, meaning that the 30-day readmission rate is 340% higher than the average rate. In fact, this condition had the highest RRI among those listed in Table 5.2.

Asthma

Section 4 presents data indicating that asthma is one of the leading causes of hospitalizations in the communities surrounding MSH. Furthermore, there is ample evidence (including findings from Sinai’s Improving Community Health Survey) that asthma disproportionally affects poor, inner-city, and minority Chicago communities. Sinai’s survey revealed that 18% of adults in both North Lawndale (the primarily African American community in which MSH is located) and Humboldt Park (a Puerto Rican community in the MSH Primary Service Area) had physician diagnosed asthma, a rate considerably higher than the 11% of U.S. adults and 13% of Chicago adults with asthma at that time. Since 2000, MSH has implemented a series of individualized, home visit interventions utilizing Community Health Workers (CHWs) aimed at improving asthma management among children with poorly controlled asthma. These programs, which are described in more detail in Section 14, have been found to be extremely effective in improving asthma control and therefore in reducing urgent health resource utilization among children. A similar approach has not yet been adequately tested for adults. Given that MSH’s 30-day readmission rate for adults is 8.1% and is 3.2 times higher than average, the time is right to implement and evaluate the effectiveness of a similar approach for adults. The 30-day RRI for asthma for children in 2010-2011 is 0.5, further supporting the effectiveness of the Sinai Pediatric Asthma Program in reducing unnecessary asthma-related admissions and readmissions.
Social Determinants of Health and Readmissions

The World Health Organization defines social determinants of health as “the conditions in which people are born, grow, live, work and age, including the health system.” Underlying these circumstances are larger societal factors such as the distribution of money, power, and resources at local, national, and global levels. Health disparities are primarily the result of differences in these social determinants of health.

There is an emerging body of literature suggesting that social determinants of health and socioeconomic conditions are associated with high readmission rates and that quality of care is only one part of the picture. As one example, researchers recently analyzed data from 72 published papers that examined the reasons people died of, or were readmitted to the hospital for, heart failure or community acquired pneumonia and found that age, race, employment status, living situation, education, and income levels are just some of the factors that may play a role. Specifically, the elderly, people of African American or Latino race/ethnicity, and patients on Medicaid emerged as being at higher risk for readmission across studies. In addition, people with unstable housing over a 12 month period and people with less social support and those living alone were more likely to be readmitted. Furthermore, one study suggests that there is a higher risk of readmission at hospitals predominately serving non-White populations, with the site of care being more strongly associated with readmission risk than the race/ethnicity of the individual patient.

It cannot be ignored that the patients and communities served by MSH often do not have the resources needed to not only initially prevent the diseases that lead to hospital admissions and readmissions, but also to ensure adequate follow-up care when discharged from a hospital. These resources can include not having a doctor to follow-up with, not having enough money to purchase needed medications or devices, unstable housing, or lack of a reliable food source. In addition, in many of the MSH communities, even those who have resources, such as health insurance, may nonetheless be unable to carry out a discharge plan due to financial constraints with co-pays, time off from work, or family responsibilities. In addition, medical resources may be limited. Safety-net hospitals such as MSH would therefore likely have higher readmission rates than the average rate emerging from a national database such as Premier, which includes large, for-profit and university based hospitals in addition to safety-net and public hospitals. That is not to say that MSH should not aim high in achieving the best possible

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**Box 5.3 Examples of Social Determinants of Health**

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to health care services
- Availability of community-based resources in support of community living
- Transportation options
- Exposure to crime, violence, and social disorder
- Residential segregation
- Access to emerging technologies (e.g., cell phones, the internet, social media)
- Access to educational, economic, and job opportunities
- Quality of education and job training
- Opportunities for recreational and leisure-time activities
- Public safety
- Social norms and attitudes (e.g., discrimination)
- Socioeconomic conditions
- Language and literacy
- Culture
- Social support
results for our patients, but rather that innovative approaches may be needed to overcome the unique challenges that face our patient population. Box 5.3 provides some examples of the social determinants of health that must be considered when thinking about interventions or policy changes.

**Addressing High Readmission Rates**

We have seen in Sections 4 (hospitalization) and 5 (readmission) that there are higher than average rates of hospitalization for certain preventable conditions. These data imply a higher burden of these diseases in certain communities within the MSH Primary Service Area. In addition, readmission rates at MSH suggest that there is a high rate of hospital use and re-use for similar conditions. Some of these conditions may not be completely preventable, but we can prevent some complications and morbidity. The prevention of readmissions may be similar to individual prevention of further illness. There are also measures hospitals can take to prevent further admissions, such as multidisciplinary discharge planning or patient safety initiatives. Additionally, there are still other factors that can influence how well an individual follows a discharge plan. Some of these factors include early follow-up care after discharge, disease management, health education, social determinants of health, such as demographic, economic, and environmental factors, among others. One study suggests that among Medicare patients discharged from the hospital less than half follow-up with either their primary care physician or an ambulatory care provider within two weeks of the discharge. These results varied by region in the US and also by condition. Note that the Chicago area was shown to have one of the lower follow-up rates studied. This can be due to poor discharge instructions or it can be related to limited access or resources.

Despite the limitations noted above, there is one overarching theme based on the data available: many of the conditions or risk factors leading to conditions where the MSH readmission rate is higher than average are preventable. Although asthma may not be a preventable disease, as the causes are unknown, hospitalizations and readmissions for asthma can be prevented. In addition, heart disease is the number one cause of death in the U.S. and in Chicago. The risk of heart disease has been tied to modifiable behaviors such as weight, diet, physical activity, and stress. Finally, evidence suggests that substance abuse may be a symptom of other mental health illnesses. Thus, if we can reduce these risk factors, the related readmissions should decrease as well.

**Limitations**

There are four key limitations worth noting for this section.

1. The data does not come from a data source comparable to those commonly utilized for published analyses on readmissions. Since the ACA penalty impacts reimbursements to patients with Medicare, most published analyses have utilized Medicare claims data. Other national databases of claims data have also been utilized (e.g., private insurers). The use of nationally representative claims databases allows a researcher to assess readmissions to any hospital, not just to one specific hospital, while the data we present includes only readmissions to MSH. This is an important distinction as the CMS reimbursement penalty applies to readmissions within 30-days to any facility.

2. Methodologically, CMS penalizes hospitals for readmissions for any reason within 30-days of an index admission rather than limiting analyses to clinically-related readmissions as we did. For example, using the CMS definition, if a person is initially admitted for pneumonia and is then readmitted within 30 days for a broken leg, he/she would still be counted as a readmission. For that reason, the readmission rates for MSH presented herein will appear lower than they do in
an analysis by CMS. Most non-CMS studies published in the literature have focused on clinically-related diagnoses as we did. Clinically related readmissions seem more solvable and more related to quality than readmission from any cause. Regardless of how one arranges the data, there is a general limitation in this field of substantial inconsistency in reporting. For example, some facilities use hospital claims data and others use medical records.\textsuperscript{14}

3. Another issue with the data source is that we are comparing MSH to the other Premier members, which could be considered a nationally representative group of hospitals. However, this means we are comparing ourselves to large for-profit hospitals and university-based hospitals rather than other safety-net hospitals. An analysis comparing MSH to other safety-net or public hospitals would be more meaningful, but the database does not allow for such an analysis. That is not to say that we should not compare our rates to facilities with more abundant resources but, given the known association between social factors and the risk for readmission, an analysis focused on public or safety-net hospitals may be more meaningful.

4. Finally, there is a general limitation of the measure. There is controversy in the use of a 30-day time limit and a general consensus that there are issues beyond the control of a hospital that influences readmission rates.\textsuperscript{11,12,15-17} The literature suggests that perhaps a 7-day readmission rate is a better indicator of quality whereas the longer time (such as 30 days, 60 days, or 180 days) are more indicative of social barriers to follow-up care.

\textbf{Conclusion}

The data shown in this section suggest that the overall readmission rate at MSH is 20% higher than average for all hospitals in the database. Of the 21 conditions examined here, 16 are above average readmission rates and 5 are at or below average. Of the conditions with higher than average readmission rates, 5 are more than twice as high as the average rate. In addition, while mental health conditions comprise the top 3 reasons for readmission at MSH by total numbers, RRI\textsuperscript{s} range from 1.0 to 1.2, indicating that MSH’s readmission rate is just marginally higher than average. In other words, MSH is doing as well as the average hospital in the area of mental health readmissions. The conditions with the highest RRI\textsuperscript{s} are toxic effects of non-medicinal substance, asthma, major hematologic/immunologic diagnosis excluding sickle cell crisis and coagulation, angina pectoris and coronary atherosclerosis, and percutaneous cardiovascular procedure without MI. Finally, MSH has lower than average readmission rates for chronic obstructive pulmonary disease, renal failure, and diabetes. The data here suggest that hospital-based initiatives, such as comprehensive discharge planning, will only partially reduce readmission rates. In addition, we need to incorporate more creative methods to address the social barriers faced by the patients in the MSH Primary Service Area.
References

Section 6: Survey Data

Although data about health behaviors and certain health outcomes are available at the city level, it is very difficult to find out information specifically for individual communities. To address this lack of data, SHS conducted its own survey in 2002-03. Sinai’s Improving Community Health Survey is perhaps the largest door-to-door health survey ever conducted in Chicago. Although this information is now about 10 years old, it is the most recent survey data available regarding health issues specifically in the communities served by MSH. Overall, these data identify diabetes, obesity, smoking, and depression as some of the most pressing issues affecting individuals living in our communities. For example, in both North and South Lawndale, over two-thirds of adults were overweight or obese. In addition, nearly one-third of respondents in our communities had suffered from depression in their lifetime. And smoking levels in North Lawndale and Humboldt Park were almost double the national rates. Across outcomes, both the Sinai data and Chicago-wide data repeatedly revealed that members of racial and ethnic minority groups experience worse levels of health than Whites. For example, in Humboldt Park, the percent of Puerto Ricans with diabetes was seven times higher than the percent of Whites (21% vs. 3%). Clearly, local level survey data is valuable for identifying leading health issues and guiding subsequent interventions.

Introduction

Prior to the new requirements that hospitals must conduct a Community Health Needs Assessment (CHNA), leaders of Mount Sinai Hospital (MSH) and the Sinai Urban Health Institute (SUHI) recognized the value of such an assessment. Specifically, we recognized that we needed to know more about the communities we serve in order to improve the health of the individuals in those communities. Health surveys are a valuable source of this type of information. Surveys are needed to determine how many people are sick, what type of illnesses they have, and what causes their poor health. Without fully understanding these issues, developing long term and sustainable health interventions becomes a serious challenge.

Limitations of Existing Health Data

Unfortunately, existing data sources have several limitations that reduce their usefulness for hospitals (and other organizations).

Few Sources of Local Data. Surveys are critical for understanding the overall health of the nation, a state, and sometimes even a city. Rarely, however, are they available for communities. Although local information about births and deaths is available from vital records files and information about hospital admissions and discharges exists (as seen in previous sections), little other health information can be found at the community level. Thus, it is not possible to figure out how many people in a community are affected by a certain chronic disease or how many people smoke in a particular area, for example. This is especially important in a big city of distinct neighborhoods like Chicago. It is also important to know because many health services in Chicago are arranged according to the officially designated community areas.
**Lack of Data for Specific Race/Ethnic Groups.** Another problem with existing data sources is that they often cannot provide specific information about smaller racial and ethnic groups within diverse cities like Chicago. For example, most survey data are limited to non-Hispanic (NH) Blacks, NH Whites, and sometimes Hispanics, but seldom are they available for Hispanic subgroups, Asians, or any of their many subgroups. Note NH Blacks and NH Whites will be referred to as Blacks and Whites here.

**Local Health Data**

There are two ways to get survey data about a particular community or group of people in whom you have interest:

1. **Use Existing Surveys.** A few existing surveys provide valuable health information for the U.S., each state, and certain big cities.

2. **Collect Your Own Data.** This methodology allows you to gather exactly the data you need from the population you are interested in. However, collecting statistically valid data is very expensive and time-consuming. It also requires expertise in survey sampling and data collection methodologies. As discussed previously, SHS undertook such an effort in 2003 and the results will be shared below, along with data from a government survey (at the city level).

**BRFSS.** The Behavioral Risk Factor Surveillance System (BRFSS) collects information from individuals related to their health behaviors, preventive health practices, and use of health care services. BRFSS is the largest telephone health survey in the world, interviewing more than 350,000 adults each year. This data is valuable for health-related agencies, researchers, and other groups, which use the data to identify new health problems, make and track health goals, and develop and evaluate relevant policies, programs, and legislation. Although it is a state-based system, data are also available for many large metropolitan areas (including Chicago), but not for smaller communities.

**Sinai Survey.** In 2003, the Sinai Urban Health Institute conducted what is likely the largest door-to-door health survey ever done in Chicago. The specific goals of Sinai’s Improving Community Health Survey were: 1) To document the health status of selected community areas; and 2) To use this information to improve the delivery of health services, attract additional resources, and stimulate collaborative community-based interventions. The survey collected extensive health information from 1,700 scientifically selected households in six Chicago community areas. Many of the findings were startling in their comparison to national and citywide statistics, and they highlighted the large health disparities present in Chicago. Although these data are nearly 10 years old now, we include them here because they are the most recent estimates from the communities we serve.

**Methodology**

**BRFSS.** BRFSS data are collected through monthly telephone interviews with community-dwelling adults aged 18 years or older. BRFSS interviewers call both landlines and cell phones. The data were obtained through the Chicago Department of Public Health. The data for “Other” races and ethnicities are not shown here due to small sample sizes, as well as the questionable value of trying to interpret such a category. Observations were analyzed using SAS, version 9.2 (SAS Institute Inc., 2002-2003). A sampling weight was applied to survey observations to account for the probability of selection.

**Sinai Survey.** Six community areas were selected for the original Sinai Survey. These communities were chosen because they represent the rich racial, ethnic, and socioeconomic diversity of Chicago. The value
of these surveys soon became widely recognized and an additional four communities then partnered with SUHI to implement the survey in their communities. These included the Jewish, Cambodian, Vietnamese, and Chinese communities in Chicago. Of all of these ten communities, only four are discussed in this section. We include the three areas that are part of the Mount Sinai Hospital Primary Service Area (North Lawndale, South Lawndale, and Humboldt Park), as well as West Town, which is contiguous to Humboldt Park and where we work with a lot of the community members and organizations.

A survey design committee was organized to select the topics that would appear on the survey. This committee consisted of community members who were affiliated with social service agencies, government and educational programs, and other local community-based organizations. The committee members agreed on a final list of topics for the survey, with 469 questions for adults and 144 for children (through the primary caregiver). The questions were selected (whenever possible) to be comparable to questions asked on national and state surveys. Respondents were randomly chosen by first selecting census blocks from each community area, then households from each block, then adults and children from each household. Interviews were conducted in the homes of the respondents in either English or Spanish. The survey required about an hour. Each household was given $40 for completing the adult portion of the survey and $20 for the child portion. A substantial packet of health literature was also left with each household. The survey was conducted between September 2002 and April 2003. A total of 1,699 adult interviews and 811 child interviews were completed. Statistical software was used to adjust for effects of the complex sampling design. All estimates were weighted for the probability of selection. The Sinai Survey also included a post-stratification weight to ensure that the sample resembled the distribution of age, sex, and race from each CA’s population according to the 2000 U.S. Census.

Survey Results - BRFSS Chicago

Findings related to the following topics are discussed here: physical health, mental health, health behaviors, and health care utilization. The Chicago data are available for three race/ethnic groups (NH White, NH Black, and Hispanic). Also, whenever possible, the Chicago results are compared with national data.

Physical Health

Chronic Conditions. Almost one-half of all adults in the U.S. have one or more chronic conditions.¹ And, as people continue to live longer, the number suffering from these illnesses will grow. Not only are chronic conditions responsible for the majority of deaths in the U.S., they also are responsible for over 75% of all health care costs in our country.¹ Thus, it is critical to have a good understanding of their prevalence in Chicago. To determine this, BRFSS asked respondents whether they had ever been diagnosed with a particular health outcome, such as: “Has your doctor or a health professional ever told you that you have diabetes?” Table 6.1 presents some of the most common health conditions in Chicago, by race/ethnic group.
Table 6.1 Selected Findings on Physical Health Outcomes in Chicago

<table>
<thead>
<tr>
<th>Chronic Conditions</th>
<th>All</th>
<th>Black</th>
<th>White</th>
<th>Hispanic</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>15</td>
<td>17</td>
<td>9</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Cancer</td>
<td>5</td>
<td>7</td>
<td>9</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>9</td>
<td>9</td>
<td>10</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Diabetes</td>
<td>10</td>
<td>15</td>
<td>6</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>30</td>
<td>45</td>
<td>27</td>
<td>16</td>
<td>29</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>37</td>
<td>42</td>
<td>30</td>
<td>46</td>
<td>38</td>
</tr>
<tr>
<td>Stroke</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weight Status</th>
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<th></th>
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<tr>
<td>Normal or underweight</td>
<td>36</td>
<td>23</td>
<td>42</td>
<td>29</td>
<td>36</td>
</tr>
<tr>
<td>Overweight</td>
<td>34</td>
<td>39</td>
<td>33</td>
<td>39</td>
<td>36</td>
</tr>
<tr>
<td>Obese</td>
<td>30</td>
<td>38</td>
<td>25</td>
<td>32</td>
<td>27</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Measures of Health</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any activity limitations</td>
<td>18</td>
<td>25</td>
<td>19</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Days poor physical health (in past month) (mean)</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>--³</td>
</tr>
</tbody>
</table>

| Sample Size | 782 | 250 | 398 | 99 |

Notes: Data are weighted
³Exact comparison data not found

The findings show that levels of chronic conditions were generally slightly higher in Chicago compared to the rest of the U.S. The prevalence of these selected conditions also varied greatly by race and ethnicity. For example, the percent of Black residents with asthma was almost twice as high as the percent of Whites with this condition (17% versus 9%, respectively). Hispanics had higher levels of some diseases compared to Whites (such as asthma, diabetes, and high cholesterol), but lower levels of other conditions compared to both Blacks and Whites (such as cardiovascular disease and high blood pressure).

**Weight Status.** Over one-quarter of all adults in the U.S. were currently obese and an additional 36% were overweight (as seen in Figure 6.1). Obesity can lead to many of the chronic conditions discussed above. Weight status is usually categorized according to a person’s body mass index (BMI), which is calculated with his or her weight and height. A BMI between 25 and 29.9 indicates that a person is “overweight.” A BMI greater than or equal to 30 classifies the person as “obese.” Within Chicago, 30% of adults were obese and another 34% were overweight. Thus, the majority of Chicagoans weighed more than doctors recommend for their height. Although being overweight or obese is a problem for all race/ethnic groups, it is more common among Blacks and Hispanics compared to Whites.

**Other Measures of Health.** Having a chronic condition or being obese can limit a person’s activities. In Chicago, 18% of adults report that they were limited in at least one type of activity by their health problems. This percentage was highest among Blacks, followed by Whites, and then Hispanics. Another way to describe the extent of physical health problems in a person’s life is to ask how many days in the
past month were they in poor physical health. On average, Chicagoans reported 4 days of poor physical health per month. Hispanics reported half as many poor health days as Blacks (3 versus 6, respectively).

**Health Behaviors**

Many health problems, such as the ones discussed above, can be prevented (or at least delayed) by a healthy lifestyle. In fact, 38% of all deaths can be attributed to just four health behaviors: smoking, poor diet, physical inactivity, and alcohol consumption. To illustrate levels of these health risk factors in Chicago, information on smoking, drinking, and physical activity behaviors are shown in Table 6.2.

**Table 6.2 Health Behaviors in Chicago by Race/Ethnicity**

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Black</th>
<th>White</th>
<th>Hispanic</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Use</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently smokes</td>
<td>19</td>
<td>23</td>
<td>17</td>
<td>19</td>
<td>18</td>
</tr>
<tr>
<td>Ever smoked</td>
<td>39</td>
<td>43</td>
<td>44</td>
<td>28</td>
<td>45</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently drinks</td>
<td>56</td>
<td>46</td>
<td>70</td>
<td>52</td>
<td>54</td>
</tr>
<tr>
<td>Binge drank past month</td>
<td>19</td>
<td>14</td>
<td>23</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td>Physical Activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever exercises</td>
<td>76</td>
<td>68</td>
<td>80</td>
<td>78</td>
<td>76</td>
</tr>
<tr>
<td>Moderate activity</td>
<td>86</td>
<td>84</td>
<td>92</td>
<td>83</td>
<td>--</td>
</tr>
<tr>
<td>Vigorous activity</td>
<td>51</td>
<td>45</td>
<td>54</td>
<td>55</td>
<td>--</td>
</tr>
<tr>
<td><strong>Sample Size</strong></td>
<td>782</td>
<td>250</td>
<td>398</td>
<td>99</td>
<td></td>
</tr>
</tbody>
</table>

Source: Chicago and US data from BRFSS, 2009

* Exact comparison data not found

Although over one-third of Chicago residents have smoked at some point in their lives, only 19% currently do. This percentage was higher for Blacks compared to other groups. According to Healthy People 2020, which documents our nation’s health-related targets and progress, the goal for our country is to reduce this number to 12%. In contrast, Whites were more likely to drink alcohol. Nearly one-quarter of both Whites and Hispanics reported binge drinking in the past month. Both current and binge drinking percentages were slightly above national averages. Finally, the majority of all residents reported at least minimal levels of exercising. Nearly half of Chicago residents reported regular vigorous physical activity, which includes activities like jogging and swimming.

**Health Care Access and Utilization**

An individual’s ability to access health care is closely tied to his/her health and well-being. The lack of health insurance coverage is at the forefront on our nation’s health agenda today, yet little is known about how local communities utilize services. Findings related to insurance coverage, access to primary care, and use of preventive services are presented in Table 6.3.

Overall, 82% of non-elderly adults in Chicago had insurance coverage, which is very similar to the national rate of 83% according to BRFSS data. As expected, the percentage of Hispanics with health insurance was substantially lower. In terms of accessing health services, more than half of all individuals had been to the doctor for a check-up in the past year and most reported having a health care facility or
provider where they generally go for care. Unfortunately, 20% of Chicago residents did not receive the care that they needed in the past year because it cost too much. This percentage was approximately twice as high for minorities compared to Whites.

Particularly before the passage of the new health care act (the Affordable Care Act of 2010), a significant consequence of not having health insurance was limited utilization of routine preventive health services. These data show that only about one-third of Chicago adults received a flu shot in the past year. The Healthy People 2020 goal for the U.S. is to have 80% of adults aged 18-64 receive a flu shot each year. Even smaller percentages received a pneumococcal vaccine, and only half of adults had ever been tested for HIV.

Table 6.3. Selected Findings on Health Care Access and Utilization in Chicago

<table>
<thead>
<tr>
<th></th>
<th>All %</th>
<th>Black %</th>
<th>White %</th>
<th>Hispanic %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has health insurance (18-64 yrs)</td>
<td>82</td>
<td>79</td>
<td>91</td>
<td>61</td>
</tr>
<tr>
<td>Had a check-up in past year</td>
<td>62</td>
<td>72</td>
<td>59</td>
<td>54</td>
</tr>
<tr>
<td>Has a usual source of care</td>
<td>78</td>
<td>77</td>
<td>82</td>
<td>74</td>
</tr>
<tr>
<td>Did not obtain needed medical care in past year because of cost</td>
<td>20</td>
<td>23</td>
<td>12</td>
<td>25</td>
</tr>
<tr>
<td>Received flu shot in past year</td>
<td>32</td>
<td>33</td>
<td>39</td>
<td>21</td>
</tr>
<tr>
<td>Received pneumococcal vaccine in past year</td>
<td>21</td>
<td>21</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Ever Tested for HIV</td>
<td>50</td>
<td>62</td>
<td>47</td>
<td>42</td>
</tr>
</tbody>
</table>

Source: Chicago BRFSS, 2009

Mental Health and Quality of Life

Unfortunately, despite their importance to overall well-being, very few measures of mental health or quality of life are available from the BRFSS.

Mental Health. One question asked on the BRFSS was related to the number of days in the past month when an individual’s mental health was poor. On average, individuals in Chicago reported just over 4 days per month during which they would rate their mental health as poor. This number

![Figure 6.1 Overall Life Satisfaction by Race/Ethnicity in Chicago](source: BRFSS, 2009)
satisfied. Less than 10% were dissatisfied. Life satisfaction was fairly similar across race/ethnic groups.

**Social Support.** The BRFSS also asks about social support because it has been repeatedly shown to influence health and well-being. Specifically, individuals were asked how often they get the social and emotional support that they need (from any source). The majority of respondents reported that they usually or always get enough support (see Figure 6.2). Hispanics were noticeably more likely to report that they never or rarely get enough support, followed by Blacks, and then Whites.

**Self-Rated Health.** Existing research has demonstrated that an individual’s subjective assessment of his/her own health is a useful measure of their state of complete physical, mental, and social well-being. To assess this, respondents were asked, “Would you say that in general your health is excellent, very good, good, fair, or poor?” As seen in Figure 6.3, the majority of Chicago residents said their health was good or better. However, this varies widely by race/ethnicity. Specifically, Whites were more likely than Blacks or Hispanics to say their health is excellent or very good. Similarly, Whites in Chicago were more likely to report excellent or very good health compared to Americans as a whole (data not shown), and less likely to report fair or poor health. The opposite was true for Blacks and Hispanics.
Survey Results – Sinai Survey

As noted above, data was collected by the Sinai Health System to better understand health at the local level. The full results from this extensive survey can be found on our website (www.suhichicago.org/reports-publications/community-health-surveys) or in our book (Urban Health: Combating Disparities with Local Data). Selected results are shown here. As noted above, results are only available for four communities within the MSH Primary Service Area.

Physical Health

Weight Status. Our survey found that the proportion of people who are obese in the communities around MSH is very high – for example, 41% in North Lawndale compared to 23% in the United States (Figure 6.4). In general, the majority of adults in these communities weighed more than is recommended. This is a big concern, given the long list of health problems associated with obesity.

Chronic Conditions. Levels of selected chronic conditions in the four MSH communities are presented in Table 6.4. Compared to Chicago and U.S. rates, these communities often have much higher rates of these conditions. For example, although only 9% of adults in the U.S. and 11% of those in Chicago have asthma, a much higher percent of adults in Humboldt Park, North Lawndale, and West Town had this condition (17%, 18%, and 21%, respectively). High rates of cardiovascular disease were also found, with over one-quarter of adults in some communities reporting this disease. The rates of the different conditions varied greatly by community.

Table 6.4 Chronic Conditions in Four MSH Communities

<table>
<thead>
<tr>
<th>Condition</th>
<th>Humboldt Park</th>
<th>North Lawndale</th>
<th>South Lawndale</th>
<th>West Town</th>
<th>Chicago</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>23 %</td>
<td>25 %</td>
<td>10 %</td>
<td>27 %</td>
<td>21 %</td>
</tr>
<tr>
<td>Asthma</td>
<td>17 %</td>
<td>18 %</td>
<td>10 %</td>
<td>21 %</td>
<td>11 %</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>26 %</td>
<td>15 %</td>
<td>12 %</td>
<td>26 %</td>
<td>N/A</td>
</tr>
<tr>
<td>Diabetes</td>
<td>16 %</td>
<td>10 %</td>
<td>6 %</td>
<td>14 %</td>
<td>10 %</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>35 %</td>
<td>41 %</td>
<td>17 %</td>
<td>28 %</td>
<td>28 %</td>
</tr>
</tbody>
</table>

Sources: Sinai Survey, 2003; BRFSS, 2003
Note: Age-adjusted estimates
area (which indicates race/ethnic differences). To better understand these data, we discuss diabetes in more detail here.

Diabetes is one of the major causes of premature death in the U.S. and disproportionately affects some racial and ethnic minority populations. Our survey not only revealed that the prevalence of diagnosed diabetes in one community was extremely high compared with national and Chicago levels, but that, in South Lawndale, an alarming contrast existed between the prevalence of diagnosed diabetes and the diabetes mortality rate. Consistent with many national surveys, we asked, “Have you ever been diagnosed with diabetes?” As seen in Table 6.4, the proportions saying “yes” to this question in Humboldt Park, West Town, and North Lawndale were much higher than for Chicago. In addition, only 6% of the people in South Lawndale, almost all of whom are Mexican, reported such a diagnosis. When this finding is compared with rates of mortality from diabetes, the contrast is striking since South Lawndale has a high rate of mortality from diabetes (data not shown). Low insurance coverage among this immigrant population likely explains the low diabetes prevalence found by the Sinai Survey in contrast to the high diabetes mortality. In other words, immigrants are less likely to have insurance, people without insurance are less likely to visit a doctor, and thus they are less likely to be diagnosed with diabetes. Because of the racial and ethnic diversity of these two communities, data were also examined by specific racial and ethnic groups. Results indicated that 21% of Puerto Ricans had diabetes compared to 15% of Blacks, 4% of Mexicans, and 3% of Whites. The prevalence of diabetes among Puerto Ricans from the Sinai Survey was the highest rate ever reported for any non-Native American population and was twice as high as estimates for Puerto Ricans from national surveys.7,8

Health Behaviors

Smoking. As alluded to above, smoking is the leading preventable cause of disease, disability, and death in the United States.7 To investigate levels of smoking within our communities, the Sinai Survey asked adults several questions related to smoking. The results showed very high proportions of people who were current smokers. In some communities, rates were twice as high as national and Chicago rates. In the U.S., about 18% of adults currently smoked (which is down from 23% in 2003). In contrast, 39% of the people in North Lawndale reported that they smoked, almost double the percentage of smokers in South Lawndale, just down the street. (Figure 6.5). It is also important to note that more than half of the smokers said that they were trying to quit. Another important way to looks at the elevated rate in North Lawndale (for example) is that the last time the U.S. as a whole smoked at a rate of 39% was in 1970. Thus, North Lawndale (and other communities served by MSH) were more than 30 years behind the smoking cessation curve of the entire country. More on this topic can be found in one of the many articles and chapters that we have published using data from our surveys.8,9
Health Care Access and Utilization

Health Insurance. Individuals without health insurance are less likely to have a usual source of care, to use preventive or specialty services, to obtain needed prescription medications, or to receive high quality health care services. As a result, they are at increased risk of poor health outcomes and death. There were several questions included in the Sinai Survey about access to health care services. The proportion of residents in these communities with any form of health insurance (either private or public) was substantially lower than the national average, even when adjusted for race and ethnicity (Figure 6.6). Communities with the largest immigrant populations had the lowest insurance coverage. Only 44% of people in South Lawndale and 60% of people in Humboldt Park and North Lawndale reported currently having any type of health insurance. This is well below national proportions of approximately 86% having any kind of health insurance. As a result of this lack of insurance, many respondents report not being able to afford needed medical care. For example, 24% of respondents in North Lawndale reported not getting medications that they needed due to cost and 34% of respondents in West Town reported not being able to afford needed dental care.

Preventive Service Utilization. Residents in these communities reported receiving fewer

Figure 6.6 Percent of Adults (18-64 years) Covered by Private and Public Health Insurance in Selected MSH Communities

Figure 6.7 Percent of Women Ages 40-75 Who Had a Mammogram in the Past 2 Years

preventive services such as blood pressure screening and mammography than in the U.S., on average. For example, a mammogram is the best tool for early detection of breast cancer and it is recommended by several organizations that women age 40 years and older obtain a mammogram every 2 years. The percentage who reported having had a mammogram in the past 2 years ranged from 70% in West Town to 90% in South Lawndale (see Figure 6.7). Given the low coverage of insurance in the Mexican community, this finding was surprising. Some studies have found that all women tend to over-report mammography history, and that the degree of accuracy varies by racial and ethnic group. Thus, the true prevalence is likely not as high. We have published numerous articles related to mammography utilization and breast cancer mortality.\textsuperscript{10-12}

Mental Health and Quality of Life

Depression. A very high percentage (32\%) of our sample had suffered from depression in their lives. We measured depression in two ways. First, we used the common survey question: “Have you ever been diagnosed as being depressed?” We also used the Depression Scale of the Center for Epidemiological Studies (CES-D), which consists of ten questions about depressive symptoms in the past week. Roughly similar percentages had been diagnosed with depression as had screened positively. There were slight variations in these proportions according to community area (Figure 6.8).

Respondents were also asked to estimate how many days in the past month their mental health (including stress, depression, and problems with emotions) was not good. The number of days varied from 3.1 days in South Lawndale to 4.7 days in Humboldt Park.

Self-Rated Health. As noted above, one common way to assess overall health is to ask individuals to rate their own health as excellent, very good, good, fair, or poor. There were huge variations in the proportions of people who rated their health as only fair or poor (Figure 6.9). Most significantly, over half of people living in South Lawndale reported fair or poor health. In comparison, only 14\% of all Americans report such low levels of subjective health (BRFSS, 2001).
Health Disparities

The findings from our survey and other existing city and national surveys continue to document disparities in health, most often related to race and ethnicity. In other words, we repeatedly find that members of racial and ethnic minority groups experience worse levels of health than Whites. These disparities are caused by numerous factors, from individual determinants (e.g., genetics, health behaviors) to socioeconomic factors (e.g., income, education, insurance) to societal factors (e.g., segregation, discrimination, culture, health care system insufficiencies or inadequacies?). Reducing these inexcusable differences in levels of health is one of the overarching goals of the work at the Sinai Urban Health Institute. It is also one of the two main objectives of the Healthy People Initiative (a set of about 500 goals developed by the leading national health agencies that guides much of the public health work in the United States). Yet, despite the effort that we, and our nation at large, are committing to this task, there has been little success. In fact, researchers at SUHI have found that disparities are actually worsening in Chicago, rather than improving.\textsuperscript{13} Thus, it is critical that researchers continue to highlight differences in health between groups in a population in order to guide future interventions and hopefully eliminate these disparities.

Conclusion

Beyond documenting health disparities, data from national, city, and community surveys are needed to guide future health interventions and policies. The data presented here will enable MSH and other community organizations to better direct their scarce resources to the most prevalent health problems. In particular, this section identifies chronic conditions (like diabetes in particular), obesity, smoking, and depression as some of the most pressing issues affecting individuals living near MSH.

References


Section 7: Birth Outcomes and Infant Mortality

Infant mortality (death in the first year of life) remains an international indicator of a country’s health. This section presents infant mortality rates for all 13 communities in the MSH Primary Service Area and compares them to the rates in Chicago and the U.S. Infant mortality rates ranged from a low of 4.2 in South Lawndale to a high of 20.3 in West Garfield Park. Nine of the 13 communities had higher infant mortality rates than the U.S., and the U.S. rate remains the worst among its peer countries. Seven of the top 10 causes of infant mortality were related to the neonatal period (the first 28 days of life) and nearly 65% of all infant deaths in the MSH Primary Service Area occurred during this period. Because over 25% of all infant deaths in the communities served by MSH were linked to prematurity and low birth weight, we describe how many infants are being born too soon and too small. We also present several key behavioral factors that might influence these birth outcomes, including first trimester prenatal care, smoking during pregnancy, and teen births.

The months leading up to birth and a child’s first year of life, especially the first 28 days, represent a critical time of rapid growth and change and a period of high risk for poor health outcomes and death. The factors that influence newborn and infant health are a complicated mix of biology and the environment into which an infant is born. Health issues and behaviors during pregnancy and after birth impact child survival and long-term mental and physical well-being. In 2008, there were 44,913 live births in the city of Chicago, of which 10,535 (21%) occurred in one of the 13 communities included in the Mount Sinai Hospital (MSH) Primary Service Area. Of these births, 3,930 (37%) occurred at MSH.

This section will focus on the burden of newborn and infant mortality in the U.S., Chicago, and the 13 communities in the MSH Primary Service Area. It will also highlight several key health outcomes and behaviors that have been found to impact newborn and infant survival, including low birth weight, prematurity, first trimester prenatal care, teen births, and tobacco use during pregnancy. Finally, this section will describe programs currently in place through Sinai Health System to address infant mortality and related risk factors.

The most recent data on infant deaths available for the city of Chicago are from 2008. To provide the best estimates of infant and neonatal mortality, we have calculated three-year averages using City of Chicago birth and death data from 2006, 2007 and 2008. Although more recent data are available for the U.S., we present 2006-2008 data for the U.S. as well as a base for comparison.

Infant Mortality

Nearly 88% of all deaths among children under 5 years old in the U.S. occur during the first year of life (infant mortality) and approximately 56% occur in the first 28 days (neonatal mortality). The U.S. infant mortality rate of 6.7/1,000 live births means that for every 1,000 babies born alive, approximately 7 died before their first birthdays. This equates to over 28,000 deaths in the first year of life.
Figure 7.1 presents the infant mortality rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area

- The infant mortality rate was:
  - 8.0 for Chicago\textsuperscript{1-6}
  - 6.7 for the U.S.\textsuperscript{7-9}

- Within the MSH Primary Service Area, rates ranged from a low of 4.2 in South Lawndale to a high of 20.3 in West Garfield Park

- Rates above the Chicago average were found in 8 of the 13 Sinai communities

\textbf{Figure 7.1 Infant Mortality Rates (2006-2008)}\textsuperscript{1-9}

- Figure 7.2 displays all 77 of Chicago’s communities with light to dark shading for lowest to highest infant mortality rates
- Nearly all of the communities with the highest rates were on the south and west sides of the city
- Three of the communities with the highest rates (those in the 4th and 5th quintiles) fell within the MSH Primary Service Area and immediately surround the hospital.

\textbf{Racial/Ethnic Disparities in Infant Mortality}

When we examined differences in infant mortality by race, we found that within the city of Chicago and the MSH Primary Service Area, infant mortality among Non-Hispanic Black (Black) families was more than 2 times greater than among Hispanic families and 2.5 times greater than infant mortality among Non-Hispanic White (White) families (Figure 7.3).
Figure 7.2 Infant Mortality Rates by Community Area in Chicago

Infant Mortality Rate per 1,000 Live Births

- Greater than 11.4
- 8.1 - 11.4
- 4.6 - 8.0
- Less than 4.6
- MSH Primary Service Area

Map Source: Sinai Health System, 2012.
Causes of Infant Mortality

To better understand why our babies are dying, we looked at the most common causes of infant mortality in the U.S., Chicago, and the MSH Primary Service Area (Table 7.1). In the U.S., congenital malformations were the number one cause of infant mortality with prematurity and low birth weight closely following. The inverse was true in Chicago and the MSH Primary Service Area, where prematurity and low birth weight were the top causes, followed by congenital malformations. It is of note that the percentage of deaths due to Sudden Infant Death Syndrome (SIDS) in the MSH Primary Service Area was lower than that observed for the City of Chicago and the U.S. Nearly 65% of infant deaths in our communities happened during the first month of life, and of the top ten most common causes of infant mortality presented in Table 7.1, seven were related to the neonatal period. This emphasizes the need to increase our focus on the prenatal and neonatal periods as a strategy to reduce infant mortality.
Box 7.1 Definitions

Premature = an infant who is born at less than 37 weeks gestation

Low Birth Weight (LBW) = an infant who weighs less than 2,500g (5.5 lbs) at birth

The Impact of Being Born Too Soon and/or Too Small

In the U.S., nearly 17% of all infant deaths are related to a child being born too soon (premature) and/or too small (low birth weight)\textsuperscript{11}, and in Chicago and the MSH Primary Service area, roughly 25% of all deaths are attributable to these causes.\textsuperscript{4-6} It is therefore essential that we examine these issues at the local level to better understand where and when intervention is needed in our specific communities.

Infants Who Are Born Too Soon

Infants who are born too soon are inherently more likely to be LBW. Just being premature, however, increases an infant’s risk of morbidity and mortality during the neonatal period and beyond. Premature infants often have immature lungs and frequently experience problems with breathing, feeding and dehydration.\textsuperscript{12} They also can have a difficult time regulating their body temperature and blood sugar levels.\textsuperscript{12} These newborns frequently have immature immune systems and lack maternal antibodies since the bulk of antibodies are transferred from mother to baby in the third trimester of pregnancy.\textsuperscript{12} All of these factors make premature newborns more susceptible to infection.\textsuperscript{12}
• Figure 7.4 presents the premature birth rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area

• The premature birth rate was:
  • 11% for Chicago\textsuperscript{1,3}
  • 13% for the U.S.\textsuperscript{7,9}

• Within the MSH Primary Service Area, rates ranged from a low of 8% in Archer Heights and Gage Park to highs of 16% in North Lawndale, and East Garfield Park and 17% in West Garfield Park

• Rates above the Chicago average were found in 6 of the 13 Sinai communities

**Figure 7.4 Premature Birth Rates (2006-2008)\textsuperscript{1,3,7-9}**

Infants Who Are Born Too Small

Infants who are born too small are typically described as being LBW, under 2,500g (5.5 pounds) at birth.\textsuperscript{12,13} A baby could be too small because s/he is born too soon, because s/he did not grow enough in-utero, or both. In 2004, UNICEF reported that worldwide LBW newborns are at 20 times greater risk of dying than normal weight newborns.\textsuperscript{14} Infants who are born too small, like those who are born too soon, have a difficult time regulating body temperature and blood sugar levels. They also can have difficulty breathing, are more susceptible to infection, experience gastrointestinal perforation, and long-term metabolic reprogramming.\textsuperscript{15,16}

• Figure 7.5 presents the low birth weight rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area
• The low birth weight rate was:
  • 10% for Chicago\(^1-3\)
  • 8% for the U.S.\(^7,9\)

• Within the MSH Primary Service Area, rates ranged from a low of 6% in Gage Park to highs of 15, 16 and 17% in East Garfield Park, North Lawndale and West Garfield Park respectively

• Rates above the Chicago average were found in 5 of the 13 Sinai communities

**Figure 7.5 Low Birth Weight Rates (2006-2008)**\(^1,7,9\)

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**Racial Disparities in Prematurity and LBW**

Studies have shown over and over again that a disproportionate number of Black newborns are born too soon and too small.\(^9,17\) In the U.S. (2008) Black infants were 1.5 times more likely to be born too soon and nearly twice as likely to be born too small than White infants.\(^9\) Even more alarming is the fact that Black newborns were 2.5 times more likely than White infants to be born very low birth weight (less than 1,500g, or 3.3 pounds).\(^9\) In Chicago and the MSH Primary Service Area there were similar trends. Black infants were 1.6 times more likely to be born too soon and twice as likely to be born too small. These trends unfortunately further propagate racial differences in newborn and infant mortality.

**Behavioral Factors that Impact Neonatal and Infant Mortality**

We examined a few key health behaviors that are thought to affect birth outcomes, including prenatal care, maternal age, and maternal smoking.
**First Trimester Prenatal Care**

Prenatal care is often thought of as the key to reducing the prevalence of LBW and premature births. However, studies indicate that improving access to prenatal care is not sufficient and that to make a real impact we must improve the quality and content of it. For example, adapting prenatal care to fit the needs of the mother and risk level of the pregnancy has had some success. Some alternatives to universal prenatal care have included group prenatal care (as is currently being implemented in North Lawndale by Lawndale Christian Health Center) and adaptive, risk-appropriate care. Unfortunately, neither of these methods of providing prenatal care have been implemented on a large enough scale to date to really make an impact on our communities.

We discuss prenatal care here because it not only remains a primary indicator in many current infant mortality reducing programs, but also provides important opportunities, beyond prevention of premature births and LBW, for screening tests, monitoring of the mother and fetus for complications or problems, and education and social support/counseling, all of which may contribute to birth weight specific reductions in infant mortality.

- Figure 7.6 presents the rates of no prenatal care in the first trimester for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area

- The rate of no prenatal care in the first trimester was:
  - 22% for Chicago
  - 30% for the U.S.

- Within the MSH Primary Service Area, rates ranged from a low of 15% in South Lawndale to a high of 26% in West Garfield Park

- Rates above the Chicago average were found in 4 of the 13 Sinai communities
Figure 7.6 Rates of No Prenatal Care in the First Trimester (2006-2008)\(^1\)\(^3\)\(^,\)\(^18\)

![Bar chart showing rates of no prenatal care in the first trimester for different communities.](image)

**Teen Births**

Another factor that has been associated with poor birth outcomes is young maternal age. In general, infants born to teenage mothers (under 20 years of age) are at higher risk of being born prematurely or LBW and have increased risk of neonatal and infant mortality compared to infants born to mothers who are 20 years or older.\(^{19-22}\)

- Figure 7.7 presents the teen birth rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area.

- The teen birth rate was:
  - 13% for Chicago\(^1\)\(^3\)
  - 10% for the U.S.\(^7\)\(^9\)

- Within the MSH Primary Service Area, rates ranged from a low of 9% in Near West Side to a high of 26% in West Garfield Park.

- Rates above the Chicago average were found in 9 of the 13 Sinai communities.
Smoking during pregnancy is linked to a host of adverse birth outcomes such as premature birth, intrauterine growth restriction resulting in higher proportions of infants born LBW, and increased rates of mortality during the last months of pregnancy and first weeks after birth.\textsuperscript{18,23,24}

- Figure 7.8 presents the rates of smoking during pregnancy for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area.
- The rate of smoking during pregnancy was:
  - 4\% for Chicago\textsuperscript{1-3}
  - 11\% for the U.S.\textsuperscript{18}

- Within the MSH Primary Service Area, rates ranged from a low of 1\% in Brighton Park, South Lawndale, West Elsdon, and West Lawn to a high of 11\% in North Lawndale and West Garfield Park.

- Rates above the Chicago average were found in 4 of the 13 Sinai communities.
Conclusion

Infant mortality rates in Chicago and the MSH Primary Service Area are significantly higher than the rate in the U.S. The communities with the highest rates are part of the MSH Primary Service Area, and more specifically are the communities that directly surround MSH. Our babies are disproportionately affected by prematurity and LBW and our moms are not receiving adequate or appropriate prenatal care. Additionally, in many of our communities we are seeing babies born to mothers who are too young and to mothers who smoking during pregnancy. While birth defects are the number one killer of babies throughout the U.S., our babies are most likely to die from disorders related to being born too soon or too small, and nearly 65% of the babies who die in our communities die during the first month of life. To reduce the percent of infants born too soon and too small and the infant mortality rates in our communities, efforts must be focused on the prenatal and neonatal periods. Additionally, prenatal care must be completely revised in content and delivery method to meet our communities’ needs, as what is currently being implemented is not proving to be effective. Finally, although there have been many failed interventions to reduce LBW and prematurity, we must continue to actively address this problem in our communities as over 25% of the deaths among our babies are related to these issues.

References


Section 8: Child and Adolescent Health

Section 8 presents data related to child and adolescent health in the MSH Primary Service Area and the city of Chicago. Data from the Youth Risk Behavior Surveillance System (YRBSS), which are only available for Black and Hispanic youth in Chicago, show several trends. For example, the use of tobacco and alcohol was higher among Hispanic students compared to Black students. In addition, minority high school students in Chicago were more than twice as likely to not consume vegetables as U.S. students. They are also twice as likely to attempt suicide compared to students nationwide. The Sinai Survey examined the prevalence of risk factors and diseases in four communities served by MSH. These data suggest an extremely high prevalence of pediatric asthma, as well as a high rate of asthmatic children living with a smoker. In addition, children in these communities have overweight/obesity rates which are more than two times the national average and many of their parents do not perceive a weight problem. In addition to survey data, hospital discharge data on asthma, bronchitis, pneumonia, and diabetes are used to examine the burden of disease for children and adolescents. Within our zip codes, hospitalization rates were often higher than rates for the U.S. and Chicago, showing that these children and adolescents are sicker than children in the city or nation as a whole. Finally, mortality data show that children in Chicago are slightly more likely to die than children in the U.S., based on all-cause mortality rates. In sum, the burden of disease in Chicago, and particularly in the communities served by MSH, is higher than the burden of disease in the U.S. for both children and adolescents. This is important to study because behaviors and health problems in childhood strongly influence health outcomes in adulthood.

Introduction

To establish a context for looking at the health of children and adolescents in Chicago and in the Mount Sinai Hospital (MSH) Primary Service Area, it is instructive to see how this population fares in the U.S. compared to other countries of the world. A new report, “U.S. Health in International Perspective: Shorter Lives, Poorer Health,”\(^1\) compares the U.S. to 16 other similarly developed countries. These countries are: Australia, Austria, Canada, Denmark, Finland, France, Germany, Italy, Japan, Norway, Portugal, Spain, Sweden, Switzerland, The Netherlands, and the United Kingdom. Especially in regard to child and adolescent health, the U.S. data paint a dismal picture.

Among these 17 countries, some of the more disquieting statistics for children and adolescents are:

- The U.S. has the highest child poverty rate
- Overall child and adolescent mortality is the 2\(^{nd}\) highest
- The probability of a child dying before his or her 5\(^{th}\) birthday is highest in the U.S.
- For ages 5-19, the U.S. has the highest rate of obesity for girls and the 2\(^{nd}\) highest for boys
- The U.S. has the highest rate of child deaths from negligence, maltreatment or physical assault
- U.S. adolescent males ages 15-19 are 5 times more likely to die of violence than the average of all the other 16 countries
- U.S. adolescents have the highest rate of pregnancy
What makes these data so important to understand is that the health, habits, and practices established in youth and adolescence shape the health of the person into adulthood. Disease risk factors for poor adult health begin in the womb and continue through childhood and adolescence. Therefore, the health care community must protect and enhance the life of its young if we are to be a nation of healthy adults. This point is highlighted in Box 8.1.

**Box 8.1 The Life Course Perspective on Health**

“The seeds of illnesses that strike older adults are often planted before age 25, a period when adverse social and environmental exposures and the establishment of unhealthy behaviors and risk factors can lead to life-long consequences. The striking health and social disadvantages documented among U.S. infants, children, and adolescents emphasize the importance of child and family services, support for education, especially in early childhood, and social services that safeguard young people...”

Section 8 of this Community Health Needs Assessment (CHNA) is focused on the health issues that affect children and adolescents. Particularly, we will describe and examine the following data sources to illuminate the health of the children and adolescents in the MSH Primary Service Area (where available) and/or in the Chicago area:

- **Youth Risk Behavior Surveillance System (YRBSS):** We use a nationally representative data source of behavioral risk factors among high school students to discuss risk behaviors among Chicago adolescents;
- **The Sinai Survey:** We use findings from Sinai’s Improving Community Health Survey (child portion) to discuss community level variations of asthma and obesity among children;
- **Hospitalization data:** Similar to Section 4, we discuss hospitalization rates for certain conditions of interest among children and adolescents;
- **Mortality data:** Similar to Section 3, we describe the leading causes of death for children;

In each section below, the data sources, methods, and findings are described in detail. These data illustrate the disproportionately high burden of disease among youth in the MSH Primary Service Area. In the course of making these data available and assessing the health needs of our patients, it is our intention to try to improve their lives and health.

**Adolescent Health: Youth Risk Behavior Surveillance System Survey**

Surveys are one of the best ways to obtain information about health behaviors. Unfortunately, health survey data at the local level is difficult to obtain for children. Fortunately, the Youth Risk Behavior Surveillance System (YRBSS) provides one way to gain insight into the health of adolescent populations at the local level, like in Chicago. YRBSS data are used to: measure progress toward achieving national health objectives for Healthy People 2020; assess trends in health behaviors among high school students; and evaluate the impact of school and community interventions at the national, state, and local levels.
Data

The YRBSS monitors six types of health behaviors and related topics that contribute to major causes of death and disability among youth and adults, described in Box 8.2. YRBSS includes a national school-based survey conducted by the Centers for Disease Control and Prevention (CDC), as well as local surveys conducted by state, territorial, and local education and health agencies and tribal governments. The survey is conducted in 43 states and 21 large urban school districts (including Chicago) among students in grades 9–12. YRBSS data have been collected every two years from 1991-2011.

<table>
<thead>
<tr>
<th>Box 8.2 Health Topics Highlighted in this Section</th>
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The data presented here are based on questions asked of students in 2011. We present data on the six different health topics for Black and Hispanic/Latino high school students in Chicago, compared to the city of Chicago overall and the U.S. Chicago data from non-Hispanic Whites and other race/ethnic groups were not available due to the small number of respondents in these categories.

Tobacco Use

Tobacco use can lead to a lifetime of poor health. In the previous decade, the U.S. saw a decrease in the percentage of teens who smoke. However, this decline has leveled off in recent years, with the percent of teens who smoke remaining relatively constant. Figure 8.1 displays data on two tobacco-related YRBSS topics:

1. High school students who had ever smoked (ever tried cigarette smoking — even 1 or 2 puffs)
2. High school students who currently smoke cigarettes (had smoked cigarettes on at least 1 day during the 30 days before the survey)
In Chicago, 51% of students had ever smoked and 14% currently smoked. Each of these percentages was lower among Black students and higher among Hispanic/Latino students.

**Drinking and Drug Use**

Alcohol and drug use can increase the risk for health problems such as injuries, violence, HIV infection, and other diseases and may even result in death. Figure 8.2 displays data on four drug and alcohol-related YRBSS topics:

1. High school students who ever drank (had had at least 1 drink of alcohol on at least 1 day during their life)
2. High school students who currently drink (had had at least 1 drink of alcohol on at least 1 day during the 30 days before the survey)
3. High school students who ever used marijuana (had used marijuana 1 or more times during their life)
4. High school students who currently use marijuana (had used marijuana 1 or more times during the 30 days before the survey)
In Chicago, over two-thirds of students had ever drunk and over one-third currently drink. Marijuana use was less common, but 43% had used marijuana in the past and 25% currently smoke it. The percentage of students who had ever drunk alcohol and who currently drink alcohol was lower among Blacks (65% and 33%, respectively) and higher among Hispanic/Latinos (76% and 44%, respectively). Conversely, the percentage of students who had ever used marijuana was slightly higher among Blacks (45%), while the percent who currently use marijuana was the same for Blacks and Hispanics (25%). In each case, for both Black and Hispanic students, the rates are generally the same or lower than for the U.S.

**Behaviors that Contribute to Violence**

Violence among adolescents in the U.S. has become a serious problem in the past few decades. Fighting and carrying weapons endangers both those directly and indirectly involved. These behaviors often carry into adulthood and may escalate in nature. Figure 8.3 displays data on three violence-related YRBSS topics:

1. High school students who had been in a physical fight (had been in a physical fight 1 or more times during the 12 months before the survey)
2. High school students who had carried a weapon (e.g., a gun, knife, or club on at least 1 day during the 30 days before the survey)
3. High school students who had carried a gun (on at least 1 day during the 30 days before the survey)
In Chicago, 39% of students had been in a physical fight; 17% had carried a weapon; and 6% had carried a gun. The percentage of students who had been in a fight was higher among Blacks (45%) and lower among Hispanics (35%). The percentage of students who had carried a weapon or gun was about the same for Blacks and Hispanics. These rates are about the same as national rates.

**Depression and Suicide**

Depression among adolescents, particularly when untreated, can affect school absenteeism and grades, relationships with parents and peers, and may lead to an increase in the frequency and severity of thoughts of suicide. Figure 8.4 displays data on three depression and suicide-related YRBSS topics:

1. High school students who had felt sad or hopeless (had felt so sad or hopeless almost every day for 2 or more weeks in a row that they stopped doing some usual activities)
2. High school students who had contemplated suicide (had seriously considered attempting suicide during the 12 months before the survey)
3. High school students who had attempted suicide (had attempted suicide at least once during the 12 months before the survey)
In Chicago, 34% of Hispanic students had felt sad or hopeless; 16% had contemplated suicide; and 15% had actually attempted suicide, a rate that is twice as high as the U.S. rate of 8%. The rates for Black students were lower for those who felt sad or hopeless and about the same for the other two measures.

Sexual Behaviors

Many young people engage in risky sexual behaviors that may have unintended health outcomes like HIV infection, other sexually transmitted infections (STIs), and unintended pregnancy. Figure 8.5 displays data on three sexual behavior YRBSS topics:

1. High school students who had ever had sex (sexual intercourse)
2. High school students who were currently sexually active (had sexual intercourse with at least one person during the 3 months before the survey)
3. High school students who did not use a pregnancy prevention method (had not used any method to prevent pregnancy during the last sexual intercourse (among those currently sexually active))

Figure 8.4 Percent Felt Sad or Hopeless, Contemplated Suicide, and Attempted Suicide (YRBSS 2011)
In Chicago, more than half (52%) of students had sex; 38% were currently sexually active; and 17% did not use a pregnancy prevention method. The percentage of students who had ever had sex and who were currently sexually active was higher among Blacks (60% and 45%, respectively) and lower among Hispanics (47% and 33%, respectively). The percentage of students who did not use a pregnancy prevention method was slightly higher among Hispanics.

**Nutrition and Physical Activity**

A healthy diet and physical activity are important for proper growth and development and can help reduce one’s risk of developing health problems later in life. Figure 8.6 displays data on four nutrition and physical activity-related YRBS topics:

1. **High school students who drank soda 3 or more (3+) times per day** (had drunk a can, bottle, or glass of soda or pop (not counting diet soda or diet pop) 3+ times per day during the 7 days before the survey)
2. **High school students who did not eat vegetables** (had not eaten vegetables (green salad, potatoes (excluding French fries, fried potatoes, or potato chips), carrots, or other vegetables) during the 7 days before the survey)
3. **High school students who watched 3+ hours of TV per day** (watched television 3+ hours per day on an average school day)
4. **High school students who had no physical activity** (had not participated in at least 60 minutes of any kind of physical activity that increased their heart rate and made them breathe hard some of the time on at least 1 day during the 7 days before the survey (i.e., did not participate in at least 60 minutes of physical activity on any day)
In Chicago, 14% of students drank soda 3+ times per day and 12% did not eat vegetables in the past week. The percentage of students who drank soda 3+ times per day was slightly lower among Hispanic/Latinos (11%), while the percentage who did not eat vegetables was slightly higher among Blacks (14%). In Chicago, 41% of students watched 3+ hours of TV per day and 21% had no physical activity. The percentage of students who watched 3+ hours of TV per day was higher among Blacks (48%) and lower among Hispanics (35%). The percentage who had no physical activity was slightly lower among Hispanics (19%).

These data provide us with a general idea of the health behaviors of Chicago teens. The next section helps us better understand the health problems these children and adolescents may be experiencing.

The Sinai Survey

Often, we have to rely on large area surveys, such as YRBSS, to understand the distribution of disease risk factors and disease prevalence among children because local level data is often not available at the community level. Thus rather than assuming that the prevalence of these risk factors are equally distributed across all community areas in Chicago, we decided to gather data from the community members regarding their health, we call this the Sinai Survey.\(^3,4\)

Data

MSH conducted one of the largest door-to-door surveys ever conducted in Chicago in 2003. There were two parts to the survey: an adult survey and a child survey (see Section 6 for adult data and survey methodology). Once the adult survey was completed, the surveyor took a household census of children under the age of 12. Then one child was randomly selected. Finally, the adult who knew the most about the selected child was interviewed. For participation in the child portion of the survey, each participant received an additional $20.
We report data provided by 612 caretakers of children in 4 of the 6 community areas surveyed. We selected these four community areas because some or all of the community area falls within the MSH Primary Service Area (Humboldt Park, North Lawndale, and South Lawndale) or we work with many community members and organizations (West Town). The child portion included a variety of health topics with 144 questions. Here, we focus on selected questions relating to asthma and obesity.

**Asthma**

There were 22 questions related to asthma included in the child survey. The prevalence of pediatric asthma was generated in two ways. First, caretakers were asked whether the child had received a diagnosis of asthma. Second, we asked a series of four commonly used questions to screen for undiagnosed asthma.\(^5\) Figure 8.7 displays data on physician diagnosed asthma and screened asthma by four community areas. The combined total of each community area can be thought of as the prevalence of asthma for the community area. The range of asthma prevalence is 12% in South Lawndale and 28% in both Humboldt Park and West Town. The comparison data for the U.S. is only available for asthma that has been diagnosed by a physician, suggesting that 12% of U.S. children have been diagnosed with asthma. Of the four community areas presented in Figure 8.7, three have higher rates of physician diagnosed asthma than this.

**Figure 8.7 Percent of Children with Physician Diagnosed and Screened Asthma**

![Bar chart showing percentage of children with physician diagnosed and screened asthma](image)

Sources: Sinai Survey, 2003; National Health Interview Survey, 1998 (Prevalence of physician diagnosed asthma)

Secondhand smoke is a well known trigger to an asthma attack. It is thus interesting to see how many children with asthma are at risk for asthma attacks because they live with a smoker. Figure 8.8 displays the percent of children with physician diagnosed asthma who live with a smoker.
Figure 8.8 Percent of Children with Physician Diagnosed Asthma Who Live with a Smoker

From Figure 8.8 we can see that approximately half of children with diagnosed asthma live with a smoker in Humboldt Park and North Lawndale. Note that Humboldt Park had one of the highest prevalence rates for pediatric asthma in the MSH Primary Service Area. There are no data available to compare with nationally.

**Overweight and Obesity**

Obesity may be one of the most pressing public health issues facing the U.S. It is almost completely preventable and has long been associated with nearly every chronic and debilitating condition, namely cancer, heart disease, diabetes, asthma, and depression among others. Importantly, obesity in childhood is associated with the early onset of many chronic diseases as well as obesity in adulthood. The child portion of the Sinai Survey included seven questions on weight status and several additional questions on diet, screen time, and physical activity. Only data relating to weight status are included in this section. Each caretaker was asked to report the child’s age, gender, height, and weight. A Body Mass Index (BMI) was calculated for those children aged 2-12 years. The BMI was then used to classify children as underweight, normal weight, overweight, or obese, according to the 2000 CDC age- and gender-specific growth charts. Children who fell in the 85th but less than the 95th percentile for age and gender were considered overweight (at risk for obesity). Children who fell in the 95th percentile and above were considered obese.

Figure 8.9 displays the percent of children who were overweight and obese by community area in the MSP Primary Service Area. Children in North Lawndale had the highest rate of overweight or obese children (68%) and South Lawndale had the lowest overweight/obesity rate (58%). Note that all four of the communities in the MSH Primary Service Area had overweight/obese rates over 50% and the rates of obesity were 2 to 3.5 times higher than the rates of overweight. The comparable rate of overweight for the U.S. is 13% which is similar to the overweight rates in the MSH Primary Service Area. However, the rate of childhood obesity in the communities in our service area are more than twice the U.S. rate of 26%. This suggests that obesity is a major health crisis facing these communities.
In order to combat childhood obesity, caregivers must first recognize that their child’s weight is too high. In order to understand the issue of childhood obesity, we asked caretakers of children if they perceived their child’s weight as overweight, underweight, or about the right weight. Figure 8.10 shows the proportion of caretakers of overweight or obese children aged 2-12 who viewed their child’s weight as the right weight or underweight by community area. Between 56% and 86% of caretakers of overweight or obese children perceived no weight problem. One nationally representative study showed that 58% of mothers of overweight or obese children misclassified the weight status for their children as “about the right weight” or “underweight.” Thus, educating parents about healthy weight levels should be a priority in our communities and across the country.

Hospitalizations

One way to examine the burden of disease and health care utilization for the children and adolescents in the communities served by Mount Sinai Hospital (MSH) is to analyze hospital discharges to determine how often and for which conditions people are discharged from a hospital (see also Section 4 of this report). In addition, hospitalizations can illuminate social barriers to care in a community such as access to primary care or socioeconomic barriers to receiving follow-up care.8,9

Data

All hospitalizations are counted whether or not a child is admitted one time or many times. The data come from COMPdata which is described in Section 4. In brief, ICD-9-CM codes were used to determine the leading cause of hospitalization. The hospitalizations for the MSH Primary Service Area (see Section 4, Table 4.1 for a list of community areas by zip code) based on zip code of the patient’s residence at discharge were tabulated. A rate was calculated based on the Census population. Each rate can be interpreted as the average number of annual hospitalizations for a certain condition per 10,000 people living in Chicago between the years 2009 and 2011. The rates are based on discharges with a leading diagnosis of asthma, bronchitis, pneumonia, and diabetes. These diagnoses were selected because they are conditions impacting children and adolescents in the U.S. and in the MSH Primary Service Area.

Asthma

Asthma is the leading chronic childhood disease in the U.S., affecting 14% of children nationally in 2011.10 Unfortunately, in some Chicago communities, the prevalence of asthma reaches one in four children.11 While we do not know how to prevent asthma, it can be controlled and children with asthma
can live long and healthy lives. Through proper management by reducing exposure to asthma triggers, taking appropriate medications with proper technique, and maintaining a relationship with a child’s primary care physician, most trips to the Emergency Department and hospitalizations due to asthma can be prevented.

**Figure 8.11 Asthma Hospitalizations among Children or Adolescents (0-17 Years)**

![Graph showing asthma hospitalizations among children or adolescents (0-17 years)]

Sources: COMPdata (Chicago, 2009-2011); CDC Health Data Interactive (U.S., 2008-2010)

- Figure 8.11 presents asthma hospitalizations among children aged 0-17 years old for the U.S., Chicago, and the 6 zip codes in the MSH Primary Service Area.

- The asthma hospitalization rate was:
  - 27 for Chicago
  - 19 for the U.S.

- Within the MSH Primary Service Area:
  - Rates ranged from 16 in 60632 to 53 in 60612
  - Rates above the Chicago average were found in 3 of the 6 MSH zip codes
  - Rates above the U.S. average were found in 5 of the 6 MSH zip codes
  - In zip code 60612, the rate is nearly twice that of Chicago and 2.8 times that of the U.S.

**Box 8.3 Readmission for Asthma in Children and Adolescents**

The readmission rate for Asthma among children aged 0-17 years old is 1.1% and has a Readmission Rate Index (RRI) of 0.5. This indicates that the readmission rate for Asthma at MSH is less than half of the average of other hospitals in the U.S. (data not shown). See Section 5 for details on readmissions. We attribute this low readmission rate, in part, to the long running and highly successful Pediatric Asthma Initiative described in Section 14.
**Bronchitis and Bronchiolitis**

Bronchitis is an inflammation in the larger tubes of the lungs, while bronchiolitis is an inflammation in the smaller tubes in the lungs. Bronchitis can be acute or chronic. Some cases can also be caused by environmental pollutants, such as smoking and second hand smoke. Because the symptoms of asthma and bronchitis are similar, bronchitis and asthma may often be misclassified. Children with asthma may be more likely to have bronchitis. In addition, children living in urban areas, like Chicago, are more likely to have bronchitis.

**Figure 8.12 Bronchitis & Bronchiolitis Hospitalizations among Children or Adolescents (0-17 Years)**

![Graph showing hospitalizations among children or adolescents (0-17 years) in different zip codes in the Mount Sinai Hospital Primary Service Area.]

**Sources:** COMPdata (Chicago, 2009-2011); CDC Health Data Interactive (U.S., 2008-2010)

- Figure 8.12 presents the bronchitis and bronchiolitis hospitalizations among children aged 0-17 years old for the U.S., Chicago, and the 6 zip codes in the MSH Primary Service Area.

- The bronchitis/bronchiolitis hospitalization rate was:
  - 18 for Chicago
  - 16 for the U.S.

- Within the MSH Primary Service Area:
  - Rates ranged from 17 in 60629 to 31 in 60623
  - Rates above the Chicago average were found in 5 of the 6 MSH zip codes
  - Rates above the U.S. average were found in all 6 MSH zip codes
  - In zip code 60623, the rate is 1.7 times the Chicago rate and nearly twice the U.S. rate
Pneumonia

In 2009, 1.1 million people in the U.S. were hospitalized with pneumonia and more than 50,000 people died from the disease. Pneumonia is an infection in the lungs. It is more common among children under 5 years old and adults over 65 years old. Pneumonia, like other lung infections, can be prevented.¹⁵

Figure 8.13 Pneumonia Hospitalizations among Children or Adolescents (0-17 Years)

- Figure 8.13 presents pneumonia hospitalizations among children aged 0-17 years old for the U.S., Chicago, and the 6 zip codes in the MSH Primary Service Area
- The pneumonia hospitalization rate was:
  - 21 for Chicago
  - 22 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from 20 in 60629 to 30 in 60624
  - Rates at or above the Chicago average were found in 5 of the 6 MSH zip codes
  - Rates at or above the U.S. average were found in 4 of the 6 MSH zip codes

Sources: COMPdata (Chicago, 2009-2011); CDC Health Data Interactive (U.S., 2008-2010)
Diabetes

Diabetes is a chronic disease where there is a high level of sugar in the blood. There are 2 types of diabetes. Type 1 diabetes is typically diagnosed in younger people and is a congenital chronic disorder in which the body does not produce insulin. Type 2 diabetes occurs when there is chronic excess sugar in the blood, typically from lack of exercise and poor diet over an extended period of time. Type 2 diabetes was known in the past as “Adult Onset Diabetes.” However, as the obesity epidemic continues to grow and impact children and adolescents at alarming rates, we have begun to see cases of diabetes typically seen in adults occurring in younger people. Although there is no cure for diabetes (either Type 1 or 2), the disease can be managed with medications, diet and/or weight management.¹⁶

Figure 8.14 Diabetes Hospitalizations among Children or Adolescents (0-17 Years)

Mount Sinai Hospital Primary Service Area

- Figure 8.14 presents diabetes hospitalizations among children aged 0-17 years old for the U.S., Chicago, and the 6 zip codes in the MSH Primary Service Area

- The diabetes hospitalization rate was:
  - 5.3 for Chicago
  - 3.9 for the U.S.

- Within the MSH Primary Service Area:
  - Rates ranged from 2.5 in 60632 to 7.7 in 60624
  - Rates above the Chicago and U.S. averages were found in 5 of the 6 MSH zip codes
  - In zip code 60632, the rate is about half that of Chicago, whereas zip code 60624 is notably higher than for Chicago

The data presented here focused on child and adolescent hospitalizations that can be prevented. Unfortunately, some health conditions and complications, whether preventable or not, result in severe illness or disability and sometimes death. The next section shows how frequently children and adolescents are dying.

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Child and Childhood Mortality

Children's health is influenced by their biology, social and physical environment, behavior, and the availability of social and health care services. Section 3 of this Community Health Needs Assessment discussed life expectancy and mortality in general. Here, we briefly discuss mortality among children in Chicago and the U.S. Mortality data tell us how many people are dying and from what causes.

The world and the U.S. have made tremendous progress in reducing the number of deaths among children. Across the globe in 2011, 7 million children under age 5 died, down from 8 million in 2010, and 12 million in 1990. Over the past 60 years, advancements in child safety, vaccinations and infection control, and medical technologies have decreased mortality among this age group in the U.S. by 80%. Specifically, in 1950, when mortality among children under age 5 was first tracked in the U.S., there were 37 deaths per 1,000 children. By 1980, that number had decreased by more than half (to 15 deaths per 1,000). In 2010, the rate had dropped to 7 deaths per 1,000.

For our purposes, child mortality refers to the death of a child between the ages of 1-4 and childhood mortality refers to the death of a child between the ages of 5-14. The all-cause child and childhood mortality rates are summary measures which tell us how many deaths occurred in age groups 1-4 (child) and 5-14 (childhood), on average, in a given year for any reason.

In other sections, we have been able to examine data for the MSH Primary Service Area, which helps us understand how various health conditions are affecting the communities we serve. Because (fortunately!) deaths to children are relatively rare, we are unable to examine child/childhood mortality at the community level. There simply are not enough deaths among children to be able to look at the deaths by community area.

The all-cause child mortality rate (2005-2007) was 29 for the U.S. and 31 for Chicago. This means that for every 100,000 children ages 1-4 in Chicago, an average of 31 of them died in any given year between 2005 and 2007. In Chicago, the leading causes of death for children ages 1-4 were accidents and congenital anomalies (birth defects).

The all-cause childhood mortality rate (2005-2007) was 15 for the U.S. and 19 for Chicago. This means that for every 100,000 children ages 5-14 in Chicago, an average of 19 of them died in any given year between 2005 and 2007. In Chicago, the leading causes of death for children ages 5-14 were accidents, cancer, and homicide.

Conclusion

Although it is difficult to obtain current health data for children and adolescents in specific Chicago communities, we combine information from several sources to highlight key risk factors and subsequent conditions of concern for youth in the MSH Primary Service Area. It is important to focus on many points along the spectrum of health, because the risk factors discussed above, such as smoking, diet and physical activity behaviors, and mental health status, are directly linked to prevalent health outcomes among youth. These outcomes may manifest as preventable hospitalizations for conditions such as asthma or diabetes, or even an increased risk of early death. It is critical to attempt to address these issues during childhood in active partnership with the community in order to have a lasting impact on the health of youth.
References


Section 9: Sexually Transmitted Infections

Sexually transmitted infections (STIs) are a major threat to the health and well-being of our communities. In this section, we examine four STIs: HIV, Gonorrhea, Chlamydia, and Syphilis. Since most STIs are transmitted through unprotected sex, they are also an indicator of potential unplanned pregnancies. The HIV incidence rate (the rate of new infections in a year) is much higher than the rate for the U.S. in almost all of the communities in the MSH Primary Service Area, sometimes by a factor of 3 or 4. Because new therapies are helping keep people with HIV alive much longer, the number of people living with HIV (the prevalence) is increasing quickly. Gonorrhea infection rates are also quite high in the MSH Primary Service Area with rates in some communities as much as 7 times higher than the national rate. The same patterns were seen for syphilis and Chlamydia. Overall, the problem of STIs is most severe in African American communities. It is here that a wide-spread community campaign could and must be effective if we are to help improve the health of the communities we serve.

Sexually transmitted infections (STIs) are a major problem throughout the world, including in Chicago. These infections are overwhelmingly acquired by having unprotected sex with someone who has the infection. The causes of STIs are bacteria, parasites, and viruses. There are more than 20 types of STIs. In this section we present data for four of the most common STIs in Chicago, focusing on the communities we serve. Data for this section were drawn from a Chicago Department of Public Health Report.¹

STIs can lead to both immediate and long-term health problems, including an increased risk for HIV. Although most of these conditions affect both men and women, women face additional problems related to their reproductive health. In addition, if a pregnant woman has an STI, it can cause serious health problems for the baby. Most STIs are caused by bacteria or parasites and can be treated with antibiotics or other medicines. If an individual has an STI caused by a virus (like HIV), there is no cure, although medicines can frequently keep the disease under control. Correct usage of latex condoms greatly reduces, but does not completely eliminate, the risk of catching or spreading STIs. Some STIs can be spread in ways other than through sexual activity, for example, through blood transfusions or shared needles. If the reader would like to know more about these infections we refer her/him to either of the following excellent websites: http://www.cdc.gov/std/stats11/trends-2011.pdf or http://www.cdc.gov/std/healthcomm/fact_sheets.htm.
The Problem of Under-Estimation
The Centers for Disease Control and Prevention (CDC) suggests that only about half of all STIs are ever reported. Thus, disease rates that are discussed below are all under-estimates of the true problem. In addition, data about STIs generally come from local public health departments, who collect the information and publish reports about it. Unlike other types of “surveillance” data, for example, birth and death certificate files or hospital discharge data, some STI reports may not be submitted by all clinical facilities. It is widely understood that public facilities are more likely to submit such reports compared to private health providers, which of course biases the data somewhat in still another way. Nonetheless, these are the best population data that exist and they are adequate to inform us about the vulnerable communities served by Mount Sinai Hospital.

HIV/AIDS

Figure 9.1 presents a bar chart illustrating the average annual new HIV infection rate (the incidence rate) for 2009-2010 for the 13 community areas in the SHS Primary Service Area. Note that these rates range from a low of 8 new cases (per 100,000 population) in Gage Park to a high of 61 new cases in North Lawndale. Note also that two community areas, Archer Heights and West Elsdon, have unreported rates due to a small number of cases. It is informative to compare all of these incidence rates with the rate for the U.S. (17) and Chicago (37).

Figure 9.1 Average Annual HIV Infection Rate (2009-2010)

Figure 9.2 presents the rate of people living with HIV (the prevalence rate) in these same communities in 2009. Some of these people have progressed to AIDS and some have not. As our effectiveness in treating HIV infections continues to improve, fewer people are dying from the disease, thus increasing the prevalence. We can see from Figure 9.2 that East Garfield Park has the highest prevalence (1070 per
100,000 population) while Archer Heights has the lowest prevalence (82). Note that although South Lawndale has a comparatively low incidence rate (Figure 9.1), it has a comparatively high prevalence rate. This suggests that the epidemic of new infections is slowing down but that a large number of previously infected people continue to live in this community. The 13 prevalence rates may be compared with those for the U.S. (277) and Chicago (757).

**Figure 9.2 Prevalence Rate of People Living with HIV Infection (2009)**

Gonorrhea

Figure 9.3 presents the Gonorrhea infection rate per 100,000 population in 2010. Once again, North Lawndale had the highest infection rate (741) followed by West Garfield Park (683) and East Garfield Park (574). Chicago Lawn also has a comparatively elevated rate (422). It is interesting to note that the Gonorrhea rate for Chicago is three times higher than the rate for the U.S. but the rates for North Lawndale, East Garfield Park and West Garfield Park are more than two times higher than that for Chicago and six times higher than that for the U.S.
Figure 9.3 Gonorrhea Infection Rate (2010)

Syphilis

The 2010 incidence rates for Primary and Secondary Syphilis are shown in Figure 9.4. Since the number of such infections is thankfully small, the rates for several of the community areas have not been calculated and are missing in the figure. Those that have been calculated are much higher than that for the U.S. (5) and about the same as for Chicago (25). The one exception to this is West Garfield Park, with a rate (83) that is 3.3 times higher than Chicago’s rate and about 18 times higher than the U.S. rate.

Figure 9.4 Primary and Secondary Syphilis Infection Rate (2010)
Chlamydia

Finally, Figure 9.5 shows the incidence rates for Chlamydia for 2010. Virtually all of these rates are higher than that for the U.S. (426) and several are higher than Chicago’s rate (938). As has been common throughout this section, the rate for North Lawndale (2345) is much higher than the rates for both the U.S. and Chicago.

Figure 9.5 Chlamydia Infection Rate (2010)

Conclusion

It is apparent that the rates for all of these STIs are greatly elevated in several of the communities served by Mount Sinai Hospital. It is clear that a concerted effort by the medical centers that serve this area (including Mount Sinai), the city, the state, and the federal government is needed. It is interesting and important to note that we know how to mitigate these epidemics. Condoms, safe sex, needle exchanges, and sex education are all known to effectively prevent many of these infections. When we implemented our community survey, there was overwhelming support for such measures in a random sample of people living in these communities. The answers are obvious and the needed strategies are there. They are ours to implement if we can find the resources to do so. If we do not, then many lives will be laid to waste needlessly.

References

Section 10: Disability in the Community

An important part of the community served by the Sinai Health System includes persons with disabilities. As noted in the Introduction section of this document, Schwab Rehabilitation Hospital (Schwab) is a part of the Sinai Health System and is the entity within the system that most directly addresses the needs of the disability community. We therefore refer the reader to the Schwab Community Health Needs Assessment, which can be accessed on their website: http://www.schwabrehab.org/. Below is information from their Executive Summary.

Schwab Rehabilitation Hospital Community Health Needs Assessment:
Executive Summary

Schwab Rehabilitation Hospital (Schwab) is a 102-bed rehabilitation hospital that serves persons with disabilities. The mission of Schwab is to improve the health, functioning, and well-being of persons with disabilities by offering effective and efficient rehabilitation services. Schwab is a nationally recognized facility for physical medicine and rehabilitation that also serves as an advocate for the prevention of disabling injuries. Located on Chicago’s west side, Schwab provides a comprehensive array of rehabilitation services, community-based disability education, prevention, advocacy programs, and support groups to a predominantly low-income African American and Hispanic population. Across the spectrum of adult and pediatric rehabilitation, services include physiatry, speech-language pathology, occupational, physical, and recreational therapies, mental health services, and vocational rehabilitation. Schwab treats more than 1,800 inpatients each year plus thousands more for outpatient visits.

As a member of the Sinai Health System, Schwab is an organizational partner with Mount Sinai Hospital, Sinai Community Institute, Sinai Medical Group, Sinai Urban Health Institute, and its newest member, Holy Cross Hospital. One of just two comprehensive rehabilitation hospitals in Chicago, Schwab serves those who have the least. Schwab is located in North Lawndale, a community whose residents experience a host of poverty-related problems: high unemployment, low educational attainment, poor housing, and a lack of adequate support systems necessary to ensure physical and mental health.

As a rehabilitation hospital, Schwab defines its community as both the residents of the Schwab Primary Service Area (PSA) and the disability community (that is, the community of people who have disabilities, and in particular, those with physical and cognitive disabilities – the people who are most likely to use the services of a rehabilitation hospital).

Findings

The Schwab PSA is made up of nine communities, each with a distinct personality. However, there are many similarities between eight of the communities: Avalon Park, Calumet Heights, Chatham, Greater Grand Crossing, North Lawndale, Roseland, South Shore, and Washington Heights. The population of each is at least 90% African American and has more females than males. The unemployment rate is 16-18%, much higher than the city average of 10%. Of the children ages 0-17
years living in these 8 communities, 42% live below the poverty line. Conversely, South Lawndale is over 80% Hispanic and has a much higher percentage of men than women. The unemployment rate is 12%, slightly higher than the city average, but well below the remainder of the Schwab PSA. Despite this, 40% of the children in South Lawndale live below the poverty line.

Throughout Chicago (and the U.S. overall), disability is more common in the Black and Hispanic population, and so it is not surprising that it is more commonly seen in the Schwab PSA than in the city overall. As compared to people without disabilities, people with disabilities living in the Schwab PSA are less likely to work, have lower earnings if they are employed, and are more likely to live in poverty.

Data show that African Americans and Hispanics, as compared to Whites, disproportionately experience the health priorities we identified – obesity, diabetes, stroke, and violence in the community. The reasons for this are complicated, and data are not always available at the community level. However, rates for diabetes, stroke, and violence are higher within Schwab’s community areas than for Chicago or the nation. Compared to the nation and region, Schwab patients tend to have strokes at younger ages, as well as having more comorbidities. The majority of stroke patients have hypertension, but rates of diabetes and smoking are also higher than regional and national levels. As for violence, all but one of Schwab’s communities has a homicide rate higher than the city average, and some communities (North Lawndale, Chatham, and Greater Grand Crossing) have rates that are approximately three times higher than the Chicago average. At the same time, it is estimated that for every fatal gunshot wound, there are between four and seven non-fatal injuries. These statistics provide a context to explain the high percentage of violently acquired injuries seen at Schwab. Gunshot wounds were the cause of 43% of the traumatic brain injuries – and 51% of the traumatic spinal cord injuries – seen at Schwab in 2012.

**Conclusion**

Schwab has a long history of working with and for the disability community, providing education and advocacy for patients, families and caregivers, and the broader community. This assessment and corresponding plan of action provide an ideal blueprint from which Schwab can continue to improve community health through changes inside and outside our walls. Any comments or suggestions you may have to help us on this journey are welcome.
Part III

Community Input and Involvement
Section 11: Focus Groups

MSH partnered with community-based organizations to facilitate seven focus groups with 66 community members. The purpose of these focus groups was to gain insight into the most pressing health conditions affecting each community, the barriers to overcoming those issues, and how a community hospital such as MSH can help improve the community’s health. Across all focus groups, the most important health issues selected by participants generally included diabetes, high blood pressure, cancer, obesity, mental health, and sexually transmitted infections (including HIV/AIDS). According to community members, these health conditions were caused by many things, including lack of knowledge, lack of exercise, stress, genetics, trauma, and poor diet. However, the participants felt that hospitals could improve the health of the community by providing more health information, offering better quality service at a lower cost, and hiring and training bilingual and culturally sensitive staff and physicians.

Community engagement refers to the process of building relationships with community members and community organizations, with the purpose of developing a collective vision to benefit the community. In order to fully understand the complex issues faced by the communities served by Mount Sinai Hospital (MSH), community engagement is essential. One way of enabling community engagement is via focus groups, which are guided discussions with a small group of individuals to gain input on a particular topic. Focus groups have been shown to be an effective way of gaining direct insight from a community about specific health problems as well as ideas for planning and implementing interventions to address these problems. This is the method we used for this needs assessment.

This section of the report will present data on adult, child and adolescent health obtained from seven focus groups conducted by MSH in its Primary Service Area. Two focus groups were conducted in Humboldt Park, North Lawndale, and South Lawndale each, and a single group was conducted in Chicago Lawn. The purpose of the focus groups was to gain insight on the most pressing health conditions affecting each community, the barriers to overcoming those conditions, and how a community hospital such as MSH might help improve the community’s health. In addition, focus group participants were asked specific questions on child and adolescent health topics, including the most important health issues facing children and adolescents, challenges to raising healthy children, and how a hospital can improve child and adolescent health.

<table>
<thead>
<tr>
<th>Box 11.1 Purpose of Focus Groups</th>
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<tbody>
<tr>
<td>1. To gain insight into the most pressing health conditions affecting each community</td>
</tr>
<tr>
<td>2. To determine the barriers to overcoming those conditions</td>
</tr>
<tr>
<td>3. To gather ideas about how a community hospital such as MSH can help improve the community’s health</td>
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</tbody>
</table>
Methodology

Members of community-based organizations in each community were contacted to assist in organizing the focus groups. A minimum of 10 and a maximum of 15 participants were requested for each group. Participants had to be 18 years of age or older, live or serve residents of the target community, and speak the language of the host group (English or Spanish). It should be noted that some participants in each focus group resided in neighborhoods outside of the target community’s zip code, but were affiliated with the organization where the focus group was held and were thus recruited to participate in the group.

A guide was used to facilitate the discussion, which lasted between 60-90 minutes for each focus group. Before each session began participants were asked for permission to audio record the focus groups. Each participant who completed the focus group was given a $15 gift card. Basic demographic information was collected by a written survey before the focus group began. The demographic questions were altered after the Humboldt Park focus group had taken place to include the question: “Are you the caregiver of a child under the age of 18?”

Information obtained during the focus groups is presented by community as described below. Within each community, we have provided demographic characteristics of the focus group participants, followed by responses to the three main topics discussed during the focus groups (see Box 11.1). Each focus group conversation was reviewed and analyzed carefully in order to extract main themes within and across groups, as well as to organize comments and present meaningful quotes and summaries of the topics the participants were most passionate about. Finally, a summary of the three main topics across all four communities is provided, as well as a brief discussion of the similarities and differences among focus groups.

<table>
<thead>
<tr>
<th>Table 11.1 Demographic Characteristics of Focus Group Participants</th>
</tr>
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<tbody>
<tr>
<td><strong>Total # of participants</strong></td>
</tr>
<tr>
<td>66</td>
</tr>
<tr>
<td><strong>Age group (years)</strong></td>
</tr>
<tr>
<td>18-20 – 8%</td>
</tr>
<tr>
<td>21-30 – 21%</td>
</tr>
<tr>
<td>31-40 – 15%</td>
</tr>
<tr>
<td>41-50 – 27%</td>
</tr>
<tr>
<td>51-60 – 15%</td>
</tr>
<tr>
<td>61-70+ – 12%</td>
</tr>
<tr>
<td><strong>Resident of community area?</strong></td>
</tr>
<tr>
<td>Yes – 73%</td>
</tr>
<tr>
<td>No – 23%</td>
</tr>
<tr>
<td><strong>Language</strong></td>
</tr>
<tr>
<td>English– 53%</td>
</tr>
<tr>
<td>Spanish–47%</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>Female – 67%</td>
</tr>
<tr>
<td>Male – 30%</td>
</tr>
<tr>
<td>Transgender –3 %</td>
</tr>
<tr>
<td><strong>Race/ethnicity</strong></td>
</tr>
<tr>
<td>Mexican – 47%</td>
</tr>
<tr>
<td>Non-Hispanic Black– 21%</td>
</tr>
<tr>
<td>Puerto Rican – 12%</td>
</tr>
<tr>
<td>Other Hispanic/Latino– 3%</td>
</tr>
<tr>
<td>Non-Hispanic White – 2%</td>
</tr>
<tr>
<td>Asian/Pacific Islander – 2%</td>
</tr>
<tr>
<td>Mixed Race Ethnicity–15%</td>
</tr>
<tr>
<td><strong>Caregiver of child under 18? (n=46, Question not asked in HP)</strong></td>
</tr>
<tr>
<td>Yes – 50%</td>
</tr>
<tr>
<td>No Answer: 7%</td>
</tr>
<tr>
<td>No – 43%</td>
</tr>
<tr>
<td><strong>Insurance Status</strong></td>
</tr>
<tr>
<td>Public – 26%</td>
</tr>
<tr>
<td>Private – 17%</td>
</tr>
<tr>
<td>No Insurance – 53 %</td>
</tr>
<tr>
<td><strong>Have a primary care doctor?</strong></td>
</tr>
<tr>
<td>Yes – 64%</td>
</tr>
<tr>
<td>No – 32%</td>
</tr>
<tr>
<td><strong>If yes, have visited their primary care doctor within the last year?</strong></td>
</tr>
<tr>
<td>Yes – 88%</td>
</tr>
<tr>
<td>No – 12%</td>
</tr>
</tbody>
</table>

Note: Categories may not add to 100% due to rounding and missing data
Findings

Focus Group Participant Characteristics. Sixty-six community residents from four neighborhood areas participated in seven focus groups. Their ages included an equally diverse range and there were about the same number of English and Spanish speakers. The female to male ratio was about 2:1 and 3% identified as transgender. A majority of the participants were Mexican, followed by non-Hispanic Black and mixed race. Half of the participants self-reported as being a caregiver for someone under the age of 18. The sample was almost evenly divided between insured and uninsured (43% and 53% respectively). Although the sample had a high percentage of uninsured, 64% of all reported that they have a primary care doctor and 88% had visited their doctor in the last year.

Most Important Health Issues. The focus groups began by asking participants to identify the most important health issues affecting them and their community. Each participant was given three votes. Across all focus groups, the most important health issues selected by participants included diabetes, high blood pressure, cancer, obesity, mental health, and sexually transmitted infections (STIs) and HIV/AIDS (see Box 11.2). There were other health issues that prompted spirited discussions such as domestic violence, dental care, thyroid conditions, asthma, and rodent infestations. One female participant commented that North Lawndale is one of the only communities where you will see the garbage cans empty and trash on the ground. In a few focus groups, participants were especially concerned about the safety and economic deterioration of their neighborhoods.

Causes of Community Health Conditions. When asked about the causes of the most pressing health concerns, participant responses ranged from individual to societal factors. Oftentimes, participants suggested that the community was plagued with many of these health issues due to lack of knowledge, lack of exercise, stress, genetics, trauma, and poor diet. One Chicago Lawn participant exclaimed, “If you buy a whole pack of tortillas and eat the whole pack, whose fault is it? Yours!” In almost all of the focus groups, participants discussed the expensive cost and lack of availability of fresh fruits and vegetables in their neighborhoods. There were complaints that the resources had been drained from their communities with relatively no reinvestment. One man that has lived on the west side and in North Lawndale all his life said, “I hate this community – it is like walking through a twilight zone and it is done to us on purpose....” See Box 11.3 for a list of the other common causes of poor health given by participants.

Barriers to Overcoming Health Conditions. When the focus group participants were asked about barriers to improving the most prevalent community health issues, many of the suggestions echoed the causes of the problem. (See Box 11.4 below.) For example, lack of knowledge was cited as a reason why community residents have worse health outcomes and it was a barrier to getting better as well. In
Humboldt Park, participants continually emphasized how the Latino culture does not allow someone to admit that they might be “crazy”. One participant stated that no one wants to approach people with mental health issues. Humboldt Park participants were especially outraged at the lack of resources for those with mental health issues - especially with the recent closing of several community mental health clinics. In North Lawndale, African American participants discussed the stigma surrounding an HIV positive diagnosis. When talking about resources, the groups all knew about the CORE center, a county-run infectious disease clinic. However, one participant maintained that, “People don't want to walk into the CORE center because everyone knows what you are there for and what you are doing.”

Other major barriers were a lack of medical insurance or being unable to pay for prescriptions, treatment, and medical supplies. Participants complained about the lack of convenient, quality medical facilities near them. There was also fear, often unfounded, that people without citizenship papers would be denied medical services. Lastly, some folks fear being over-medicated. Participants commented that physicians are too eager to give a prescription instead of exploring other methods of treatment such as counseling.

**Community Recommendations: How MSH Can Improve Community Health.** The focus group participants gave several suggestions for what a hospital can do to improve the numerous health conditions in the community. The four most commonly mentioned recommendations are listed in Box 11.5.

In all of the groups, participants felt that the hospital should be offering more health education, such as culturally appropriate cooking, nutrition, and exercise classes. A Chicago Lawn participant said, “The whole family needs to be educated because if only I am educated and I cook a healthy meal, maybe the rest of my family will not eat it.”

Many participants recommended that the hospital should offer free or low cost medical services. In Chicago Lawn, participants suggested that hospitals could create medical coupon programs that provide discounts for certain services. One woman stated, “If I were to get a flyer from Sinai promoting great discounts for a medical test, I would definitely consider making an appointment.”

In many of the focus groups, participants complained that services - especially for those with diabetes - were not convenient. In Chicago Lawn and Humboldt Park, participants mentioned that they do not come to

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**Box 11.4 Barriers to Improving Health**

- Stigma (cultural and religious)
- Lack of medical services in Spanish
- Fear of diagnosis
- Fear among undocumented residents in seeking care
- Lack of health knowledge
- Perceived overmedication by physicians
- Fast food and junk food
- Lack of culturally sensitive providers

**Box 11.5 Recommendations for MSH to Improve Community Health**

- Provide more health education and health workshops and sponsor community events
- Offer free or low cost medical services and greater access to medical supplies and treatment
- Hire and train more bilingual and culturally sensitive staff and physicians
- Improve the quality of services and shorten time to follow-up
MSH for services because it is too far away. It is important to note that although Chicago Lawn and Humboldt Park are within the MSH Primary Service Area, these participants did not feel that their communities are Sinai’s responsibility. One Humboldt Park participant remarked that Sinai is not a part of this community. Others chimed in that other hospitals such as St. Mary’s and Norwegian American Hospitals should be more engaged because they are located within the boundaries of the Humboldt Park community.

All of the groups recommended that the hospital staff and physicians receive more training on how to respect cultural differences and help people seeking care to feel more comfortable at the hospital. Repeatedly, participants stated that all Latinos are not culturally the same. Staff should understand the difference between Puerto Rican and Mexican culture (i.e., cuisine, language, culture, etc.) and have competent translators available. In the predominately African-American focus groups, those participants also discussed the need to feel respected and be given fair and equal treatment.

Many of the participants felt that MSH should provide better quality wellness checks. A North Lawndale resident stated that, “They used to do this [comprehensive wellness checks] every time you would go to the doctor or hospital and now they don’t, so people don’t know what else is going on with them until it gets bad.” Many of the participants were uninsured and admitted to using the emergency room as their primary care clinic. They recommended that the hospital establish more primary care clinics and also improve the timely follow-up after a diagnosis of diabetes, mental illness, or other serious health condition. This could be accomplished by scheduling appointments within a few weeks versus months away and having a comprehensive and effective patient referral system.

Special Focus: Child and Adolescent Health

<table>
<thead>
<tr>
<th>Box 11.6 Most Important Health Issues Affecting Children and Adolescents</th>
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<tbody>
<tr>
<td>• STIs</td>
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<tr>
<td>• Mental health</td>
</tr>
<tr>
<td>• Diabetes</td>
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<tr>
<td>• Obesity</td>
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When comparing each of the four communities’ focus group results, important overall themes emerged in regard to health issues affecting children and adolescents, barriers to raising a healthy child, and suggestions for a community hospital to improve child/adolescent health.

In a discussion about STIs, HIV/AIDS was mostly commonly mentioned. Many focus group participants felt that HIV/AIDS in particular is not discussed enough in their communities, especially with children and adolescents, and that more efforts to raise awareness about the disease need to be made. Depression and Attention Deficit Disorder (ADD) were frequently mentioned in terms of mental health. In general, participants felt that these illnesses are all too common among children, and parents either do not have the ability to recognize the symptoms or they try to hide them due to the stigma of mental illness. Lack of parent education and knowledge of what comprises a healthy diet were topics that came up when participants mentioned the high rates of diabetes and obesity among children in their communities.

Focus group participants in each community area were very passionate that many parents lack the necessary parenting skills and education to raise a healthy child. Specific to health, participants expressed that they feel

<table>
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<tr>
<th>Box 11.7 Challenges to Raising Healthy Children and Adolescents</th>
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<tbody>
<tr>
<td>• Lack of parenting skills and education</td>
</tr>
<tr>
<td>• Lack of availability of parents</td>
</tr>
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</table>
they do not have the necessary skills to teach children to form healthy habits at a young age. One male participant from North Lawndale said, “Children simply do not have parents these days.” Participants from the Hispanic communities of Humboldt Park and South Lawndale expressed that many parents do not speak or read English. Participants felt that this, coupled with a lack of general education, leaves parents with limited tools to educate and provide an optimal childhood for their children.

Many participants also expressed sadness that parents do not give their children enough of their time. Participants in the Chicago Lawn focus groups specifically mentioned that this is due to single parenthood and/or both parents working long hours. At least two Chicago Lawn participants stated “Kids raise themselves”. In South Lawndale, one woman expressed her guilt about her teenage son and stated that after she gets off work, she often brings him along to her English as a Second Language class so he can sit next to her while she learns English and thus “spend time together.”

It is interesting to point out that all focus groups suggested that hospitals should partner more with schools so that children and adolescents could receive accurate information and be able to discuss issues related to health. In South Lawndale, this spurred conversation about the balance of responsibility between the school and the parent when it comes to raising children. It was agreed that it is not solely the school’s responsibility, but the school should be used as a major avenue for health information. One woman from South Lawndale passionately said, “The schools cannot (fully) educate our children, it is our responsibility too!” Michelle Obama’s school initiative “Let’s Move!” was mentioned as an example of a health initiative that could be offered in the schools.

Participants stated that parenting classes offered by community hospitals would help remove the stigma of certain health conditions and in turn encourage parents to seek help when needed. Each of the focus groups expressed a lack of knowledge of what programs are available to them. Many people said they would like to see accurate health information more readily available. One man from North Lawndale said, “If we do not know better, how can we do better?”

<table>
<thead>
<tr>
<th>Box 11.8 Recommendations for MSH to Improve Community Health</th>
</tr>
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<tbody>
<tr>
<td>• Partner with community schools to get more accurate information to children</td>
</tr>
<tr>
<td>• Provide parenting classes for caregivers</td>
</tr>
<tr>
<td>• Disseminate more information on health conditions and community programs</td>
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</tbody>
</table>

It is important to note that some of the suggestions made by focus group participants were programs/services that are already in existence. However, this is important information for MSH to receive, as it may indicate that our outreach efforts should be more effectively marketed in order to increase awareness of MSH’s programs among its surrounding communities.

**Conclusion**

The focus groups held in MSH’s surrounding communities of North Lawndale, South Lawndale, Chicago Lawn and Humboldt Park provided useful insights on the current state of health among adults, children and adolescents living in their respective communities. For example, Sinai Community Institute offers parenting classes, however, North Lawndale was the only community group that was aware of this program. Information on health conditions affecting adults and children, barriers to improving health, barriers to raising healthy children, and suggestions for how a hospital can be more involved in improving community health will greatly assist in informing hospital staff about the development of
future community-based programs. MSH is committed to continuing to gather direct community input in its efforts to best serve the needs of adult, child, and adolescent community members and their caregivers. The efforts of MSH to address the needs of the community presented in these focus groups will be addressed in Section 14.
Section 12: Community Feedback

Local community members are a key resource in the assessment of community health needs. Efforts to improve community health depend in large part on active community engagement. Dialogue between community members and the hospital pertaining to perceptions of health and understanding of health care needs is a solid first step. Engaging community stakeholders as partners in expanding health care access and improving quality of care is an important way to create shared accountability and to leverage shared resources.

We presented findings from our Community Health Needs Assessment at community forums in three communities in the Mount Sinai Hospital (MSH) service area. The communities were Humboldt Park, North Lawndale, and South Lawndale. We learned that

a) MSH communities are welcoming of data regarding community health;
b) MSH communities are willing to act on such data to address health related issues unique to their area;
c) MSH can leverage resources to collaborate with key stakeholders for public advocacy and sustained engagement.

More specifically, through these forums, community members helped us to prioritize health issues and consider potential ways in which MSH can work with the communities to improve health.

Community Forums

In March and April of 2013, community stakeholders including residents, organizational leaders, social service providers, clergy, business leaders, and community health care providers were invited to presentations of community-specific health data. The forums had three purposes: 1) To present community health data; 2) to solicit feedback on the data findings; and 3) to collect ideas about how MSH can best address the most important health issues.

We held the forums in three of the largest community areas from the thirteen in the MSH Primary Service Area. They were Humboldt Park, South Lawndale, and North Lawndale. South Lawndale is a predominantly Hispanic community (83%) and North Lawndale is a predominantly African-American community (95%). Humboldt Park, however, is more diverse with 53% Hispanic and 41% African-American populations. Prior to the scheduled meeting dates, invitations and flyers were sent to community stakeholders. (A sample flyer can be seen in Figure 12.1.) Each meeting lasted approximately two hours. A free meal was provided at each forum, catered from a restaurant in the corresponding community. In all, 114 individuals attended the meetings. The data gathered from these meeting will be instrumental in the development of MSH action planning.
A wide variety of data were presented in each forum (see Figure 12.2 for details). Each section contained data unique to the area as well as Chicago-wide data. To begin, we provided demographic and contextual data related to the community, described the interconnected services of Sinai Health System, which includes MSH, and highlighted the importance of the community meetings in the Affordable Care Act. Mortality and hospitalization data were then presented, along with a map illustrating community areas of health inequality in the city of Chicago. Data from our own Improving Community Health Survey were also highlighted, particularly since much of these data were gathered from the three communities where the meetings were held. Lastly, data were provided related to birth outcomes, child and adolescent health, and sexually transmitted infections.
Community Feedback

Moderation and discussion following the presentations was guided by three questions. The audience feedback is presented below by these questions, though many comments dealt with more than one of the questions.

1. What are your thoughts on the information you have just received?

Community members were very receptive to the data presented and commented on its usefulness. Several individuals noted being unaware of the availability of such information and they were interested in learning about their community health status in relation to surrounding areas. One of the biggest questions from participants in every forum was, “What do we do with all of this information? How do we transition from data to action?” One community resident pointed out that presentations of the data help community members know which areas and topics to target first and how to move forward in a “structured way.” One man said that he feels it would be good to have access to this information more readily and frequently, and that hospitals should make more of an effort to interact with the community in this way. The data were also said to confirm what community members “see on the ground.” Community stakeholders who were service providers felt the data confirmed outcomes seen in their service populations and could help initiate discussions on targeted health areas drawn from the data.

Community members also reacted to information about specific health issues. For example, many community stakeholders were surprised at the high rates of hypertension. In discussions related to the hypertension data, stakeholders made the correlation between diet, exercise, and economics. Specifically, many commented on stress caused by unemployment and neighborhood violence and how that affects health. For example, one person described the process as a “wear-down of chronic stress.”

Concerns regarding mental health, specifically depression, were perhaps the most surprising finding to emerge from these forums. One participant pointed out that, “People only seek services (mental health) as a last resort, when things are so bad that they don’t know what else to do.” We saw in Section 4 of this CHNA that hospitalization rates for mental health conditions were very high. They were also very high compared to rates for the U.S. or Chicago. For example, we also saw in Section 6 that the Sinai Improving Community Health Survey revealed that close to one half of the adults in these communities suffered from depression at some point. A self-identified North Lawndale resident agreed that mental health is a huge problem. He commented that screening should start in grade school so that mental health problems can be regarded as equally important as physical problems. He went on to say, “Poor mental health leads to smoking, incarceration, unemployment, and then back to poor mental health. We need to stop the passing down of these problems among generations.” As one of the attendees wrote to us afterwards, “I have to say, so far I have personally participated in three such events…what is striking to me is the correlation in the data presented regardless of the institution and perhaps the most compelling is the mental health data.”

Finally, it was noted that these communities have resources that can be used to improve health and groups/organizations that can collaborate with MSH to address the issues found. In particular, one community stakeholder suggested that there also be a collection of data pertaining to community assets and resources to include in our CHNA. MSH could also present such data in relation to its own programs and services. It was suggested that this would help create a more complete picture of community health.
2. What can MSH do in regard to the information you have just received?

When asked how MSH can address health issues raised in the data, attendees had many ideas. There was support for using the process of data collection to secure funding to continue working in communities for better health and not just to document problems. Community stakeholders were supportive of using the data and leveraging hospital resources to work towards addressing area health concerns.

Most of the feedback centered on improving communications and educational efforts with residents in the MSH service area. Community members thought the hospital could use the data to communicate with care providers to improve care. For example, one woman stated that she goes to her doctor and he just gives her medications, but that she does not feel she is given any valuable health information. She went on to say, “He (her doctor) does not explain what they (medication) do or how they work nor does he educate me on how the medications are going to interact with one another.” Another woman shared, “Patients don’t understand direction at doctor’s appointments. Community health workers are more successful as educators.” Trust of the health information providers give was a significant concern among attendees. Increasing the number of community members pursuing health care careers might be a good way to impact community health and increase cultural awareness.

A more visible presence of providers in the community could help break down some of these barriers. Providers in poor communities can do a better job building trust in the community with more doctors being available to discuss health issues at neighborhood forums and events. One resident of North Lawndale offered, “We need to go back to more traditional models of health care. Help bring more resources into the communities. For example, Sinai (Mount Sinai) can have a health care center in the communities where people could go without appointments to ask questions.” To further reach the community, one attendee at the Humboldt Park event recommended that MSH “…should support a mobile van to do health education (like on asthma) and do screenings for CVD.” As another option, it was requested that MSH consider improving transportation support to the hospital, which may include advocating with city and local government for more frequent public transportation to the hospital. During the Humboldt Park presentation, a community member suggested that the innovative door-to-door approach of reaching the community employed by the Sinai Urban Health Institute would help raise awareness about asthma health and screen for obese children. One specific comment was, “You can’t change obesity if you just deal with kids, but [you] also have to engage the family.”

Audience members commented on the racial and ethnic disparities seen and suggested they were due to barriers to health care. One woman stated that there needs to be more information for people who do not have insurance. She said, “There should be one central administrative office where they (uninsured) can go and get their questions answered and fill out paperwork.” Other comments encouraged MSH to provide more information and education on the health care system and insurance specifically as it relates to implementation of the Affordable Care Act. Audience members also informed hospital leadership attending the forums that MSH should do a better job of providing the community with information on current Sinai outreach services and health care programs.

Specific to the high levels of mental illness reported, community stakeholders recommended that MSH examine its current mental health service offerings and better inform the community on mental health care and intervention available at the hospital.

Community stakeholders were firm in their belief that the response to community needs should not be all secondary prevention. There should be a focus on education. Finally, community stakeholders
suggested that MSH use the data presented to advocate in the state legislature for issues germane to their communities.

3. What can MSH do to help the community address the health issues revealed by this data?

Meeting attendees were asked how MSH could work with the community to address any community health issues. It was suggested that hospitals not be the center of attention because then interventions would be organized around a medical model. Requests for opportunities for more dialogue between the community and the hospital resounded at all three meetings. It was suggested that having continued discussions on issues raised during the presentation was an important step to improving community health. We also heard that there should be a comprehensive approach to obesity prevention that included collaboration between hospitals and schools.

A staff member at the Puerto Rican Cultural Center said, “...the important thing was not just what Sinai could do, but what the community could do for itself.” He also agreed that they (the community) need to mobilize parents to get into the schools. While some noted problems getting access to schools, others pointed out examples where schools do collaborate around health issues. One example was that Erie Family Health (a Federally Qualified Health Center) collaborates with an elementary school (Ryerson) to provide health education. Another person informed the audience that PlayWorks, an area non-profit that encourages play in fifteen Chicago Public Schools, provides schools with grants of up to one thousand dollars and other technical support.

A representative from a local foundation stated that the data and community discussions related to the data could help shape future funding considerations. This statement highlighted the importance of local level and neighborhood-level data on community investment and decision-making.

Summary of Feedback

• Community members welcomed the presentations and thought the topic areas to be relevant and the data informative

• Community members stated that the information from our CHNA and those of other nearby hospitals should be made widely available and linked together

• Community members felt the data confirmed outcomes seen in their communities

• Community members were supportive of using the data and leveraging hospital resources to work towards addressing area health concerns

• Community members recommended using community health to improve care and expand access

• Community members emphasized that MSH could play a significant role in helping raise (and address) important health issues in various neighborhood institutions like schools

• Community members suggested that it was important for MSH to engage the community in activities and services that promote healthy lifestyles and prevention (instead of just treating disease)
Conclusion

Soliciting feedback from community members was done not just to fulfill the requirements of the CHNA regulations, but as a step of the Sinai Model of health care improvement (see Introduction for more details). MSH has numerous channels in which a genuine effort is made to communicate health information to community members and discuss solutions for addressing health issues. These community forums allowed MSH to do this on a broader scale. The responses from community members showed that individuals in the communities we serve are welcoming of data regarding community health. They are also motivated to act on such data to address health problems identified in their area and have many ideas for ways MSH can better serve them. Through these forums, community members helped us to prioritize health issues and consider potential ways in which MSH can work with the communities to improve health.
Section 13: The Sinai Community Institute and the Sinai Urban Health Institute

In this section, we give the reader a glimpse of the activities of two components of the Sinai Health System -- the Sinai Community Institute (SCI) and the Sinai Urban Health Institute (SUHI) -- both creative and innovative institutes that are working to improve the health and well-being of the residents in the communities served by MSH. SCI is primarily a social and direct service organization, while SUHI focuses on research and the subsequent application of its research findings to community outreach and evidence-based interventions. As we noted in the Introduction to this assessment, one of the main thrusts of the Affordable Care Act is to turn the attention of hospitals across the country to the communities they serve, and not just to the patients they serve. This is a dramatic change in how hospitals and medical centers view their work, goals, and purposes. MSH is particularly well-suited to this new vision. In fact, much of what we have been doing for the past several years has already been moving in this direction. MSH, SCI, and SUHI work synergistically to improve the health of the communities they serve, guided by the vision of “pre-primary care,” which has also been described in the Introduction. Here, we describe the work of both SCI and SUHI and note how their work facilitates our pursuit of pre-primary care.

**Primary Care** seeks to prevent ill health through regular contact with health care providers for check-ups, immunizations, health screenings, and education, and to halt disease processes before a person gets sick enough for hospitalization.

**Pre-Primary Care** strives to meet people where they live, work, play, and go to school for interventions now rather than poor health later. SCI and SUHI, as part of their work, try to impact those aspects that can result in healthy people living in healthy communities.

**The Sinai Community Institute (SCI)**

The **Sinai Community Institute** was founded in 1993 with the intent to create an organization that could serve as a bridge between MSH and the community at large. The institute grew out of MSH’s long history of and commitment to providing services beyond medical care to the community it serves, and its Vision and Mission are grounded in the context of pre-primary care.

**Box 13.1 SCI Vision and Mission**

**VISION:** Sinai Community Institute works to improve the lives of families by providing direct services and establishing partnerships and collaborations that will address the public, health, social, and economic needs of the community.

**MISSION:** Sinai Community Institute offers a comprehensive array of public health, referral, and social services programs designed to meet its community’s most pressing needs.

SCI currently employs 100 caregivers including program directors and managers, social workers, case workers, nutritionists, and development and administrative staff in its effort to help families and individuals improve their own health and general well-being.
For nearly 20 years, SCI has provided services that address the social and economic factors which impact the health of the most vulnerable members of the MSH Primary Service Area. By providing social services right in the community, SCI bridges gaps that, if untended, bring on poor health. SCI’s programs cover the life course from pregnancy to elder care. The institute sponsors and coordinates programs for pregnant teens and women, infants and children, parents, juveniles involved in the juvenile justice system, youth, the unemployed and the underemployed, and seniors. These programs, carried out in the SCI building, in client’s homes, and in sites all over the community, are designed to empower and educate community members. SCI aims to enable the community to solve its own problems using the resources residing in the community along with the expertise and assistance of SCI. Of the 28,000 families served by SCI each year, approximately 90% are comprised of low-income minority (Hispanic and African American) women and children.

Following are some examples of the work of SCI in the MSH Primary Service Area:

**Family Interventions**
- SCI, in collaboration with the State of Illinois, administers the Illinois Delay/Subsequent Pregnancy Program which uses an integrated model of adolescent service delivery designed to delay second pregnancies among adolescent mothers.
- The Women, Infants and Children (WIC) program is the largest private WIC program in Illinois, providing nutrition education and appropriate food items to infants and children up to age 5 and to eligible pregnant women.
- The Family Development Initiative provides an early childhood development program that works in the home with parents and their children from birth to 3 years to enhance cognitive and developmental abilities.
- The Chicago Family Case Management Program provides links to social and health services available for pregnant women and infants to ensure infants have healthy starts.

**Child-focused Interventions**
- The Learn Together Afterschool Program is an academic enrichment program that provides children of working parents a safe place to go after school. Program activities are held at SCI and include homework assistance, life skills and recreational activities. SCI was able to help children attain a 99% attendance in this afterschool program.
- SCI provided 5,347 hours of academic tutoring for children in 2011.
- SCI assists eligible families in applying for All Kids Health insurance, a state-sponsored program that offers health care coverage to children, pregnant women, and their babies.

**Health Interventions**
- The Whole Foods Market Smart Shopper Initiative allows breast feeding and pregnant women to experience the world of natural and organic foods. Participants are exposed to new foods and learn to make simple, healthy meals.
- SCI-sponsored “How Healthy is Your ZipCode” TM is a health summit series focused on informing community residents about the health disparity challenges that are prevalent in their community. It shares the latest research findings on the health of the community and educates residents on available resources to address such health issues as diabetes, asthma, obesity, breast cancer and menopause.
Community Focused Interventions

- **The Sinai Technology Center** at SCI allows community residents access to computers to conduct job searches, type resumes, and review job listings. Over 4,000 people used the Sinai Technology Center in 2011.
- **Work Force Development** provides job readiness services through assessment, career counseling, case management, occupational internships, education, and occupational skills training and post-training placement. SCI provided 1,200 hours of job readiness instruction in FY2011 and provided over 600 people with access to the SCI Jobs Fair.

Senior/Elder Interventions

- **Sinai Senior Services** offers social services and health resources to help seniors maintain independent and healthy lifestyles. There were nearly 30,000 senior visits at the Westtown Senior Center in 2011.
- **The Elder Abuse and Neglect Hotline** is a way for concerned community members to seek help for elderly friends and family whom they suspect may be victims of neglect or abuse. Staff investigate reports of alleged abuse and conduct interviews to prevent further mistreatment. The Senior Services Program responded to 358 cases of elder abuse in 2011.

Youth Interventions

- SCI’s **Juvenile Intervention Support Center (JISC)**, in conjunction with Department of Family Support Services, provides enhanced case management services to youth who have entered the juvenile justice system. In 2011, 1,026 youth avoided prosecution.

The Sinai Urban Health Institute (SUHI)

SUHI was founded in March of 2000. Its vision and mission are also grounded in the context of pre-primary care.

**Box 13.2 SUHI Vision and Mission**

**VISION**: to serve as a leading urban health research institute for eliminating health disparities and working toward health equity.

**MISSION**: to develop and implement effective approaches to improve the health of urban communities through data-driven research, interventions, evaluation, and community engagement.

SUHI currently employs 44 staff people, including epidemiologists, research assistants and community health educators in its effort to practice social epidemiology, implement and evaluate interventions, teach and mentor students, and consult with other researchers both locally and nationally. A major component of SUHI’s work involves examining the impact of social issues, such as poverty and racism, on health.

In the 13 years since its founding, SUHI has made over 600 presentations to community-based organizations, professional societies, political organizations, medical centers and health departments. SUHI has contributed chapters to 15 books and published a book on its own work, entitled *Urban Health: Combating Disparities with Local Data*. In the Introduction to this assessment, Figure 1.4 describes this book in more detail.
SUHI believes that if we do not disseminate our work it is not worth doing. With that in mind, SUHI has published 48 articles in peer-reviewed journals such as Ethnicity and Health, The Journal of Asthma, The American Journal of Public Health, Public Health Reports, Cancer Causes and Control, the Journal of Urban Health, Health Affairs, the Journal of Community Health, Annals of Emergency Medicine, and other notable publications. In this way, the results of our research and work are made available for the larger health community to read, replicate, and improve.

The dissemination of our work does not take place only in scholarly journals, however. Over the years, the mass media has also followed our work closely. Over 300 articles have covered our work in newspapers and magazines and online. In addition, almost 100 stories about SUHI’s work have been featured on television and almost 50 stories have been broadcast on both local and national radio stations.

In its 13 years, SUHI has brought in almost $27 million (more than an average of $2 million each year) in funding to the communities we serve and to the Sinai Health System. Those grants have come from a variety of funders, as seen in Box 13.3

**Box 13.3 SUHI Funding Sources**

- Federal: CDC, DHHS, NIH, HUD, HRSA
- National: American Cancer Society, Premier Healthcare Alliance
- State: IDPH, IDHS
- Local/City: The American Lung Association, the Jewish Federation of Metro Chicago, the Asian Health Coalition
- Pharmaceutical Companies: Bristol Myers Squibb, Gilead
- Health Care Entities: Northwestern Memorial Hospital, Bethany Advocate Health Care
- Insurance companies: Blue Cross Blue Shield of Illinois, CIGNA

One of the first initiatives generated by SUHI was a survey of six Chicago community areas, funded by the Robert Wood Johnson Foundation and completed in April 2003. The survey, described in more details in Section 6, was designed by a group of persons representing MSH, social epidemiologists, community members, and local area health researchers. Questions were generated and approved by all members of the design committee to address the real needs of the communities in the MSH Primary Service Area. Survey staff went door to door visiting randomly selected households and collected health data on adults and children on topics as diverse as asthma, smoking, depression, alternative medicine use, food choices, exercise, and more. This survey, with its immense data set, has become the groundwork for much of SUHI’s cancer screening and chronic disease work that has come since. For example, SUHI’s work in the areas of diabetes, obesity, asthma, and smoking cessation grew directly from our analysis of the data gathered in the survey -- data that revealed high rates of these conditions.
Current Initiatives

Current projects which reflect SUHI’s Mission and Vision and the pursuit of pre-primary care include:

- The Helping Her Live Project, funded by the Avon Breast Cancer Foundation, addresses the Black/White disparity in breast cancer mortality in North Lawndale and Humboldt Park by navigating women to breast health services. By finding unscreened women, the project aims to catch breast cancers early before they become large or untreatable.

- The Sinai Navigator Project, also funded by Avon, assists women presenting at MSH to obtain breast health services, mammograms, and breast cancer treatment if needed. Trained patient navigators accompany women to their appointments and also act as health resource intermediaries between women and their medical providers. Again, early detection, follow up of abnormal mammograms, and encouraging women to obtain needed treatment are ways to help them be healthy.

- A collaboration with Northwestern Memorial Hospital enhances diabetes intervention and prevention among residents in Humboldt Park where the diabetes prevalence is very high. Addressing this high prevalence is a perfect example of how pre-primary care works. By canvassing these communities, the program finds and directs undiagnosed people to diabetes care and management through programs that promote healthy eating and vigorous exercise, strategies that help keep their diabetes under control and keep them well and out of the hospital.

- The Lawndale Diabetes Project, a cooperative effort with Blue Cross Blue Shield of Illinois, locates residents of North and South Lawndale with diagnosed and undiagnosed diabetes, engages them in pursuing healthy lifestyles, and refers them for treatment and preventive care to improve diabetes outcomes. This project reflects the same strategy as the one in Humboldt Park above.

- The Michael Reese Health Trust engages the expertise of SUHI epidemiologists to evaluate Sinai Community Institute programs, to analyze the epidemiology of pulmonary disease, and, with the support of its Frederick and Florence Roe Health Policy Fund, to disseminate research findings to seek policy changes.

- The Chicago Community Trust (CC) provides funding for technical support for CCT community grantees. This effort changes the paradigm thus enabling smaller community-based organizations (CBO) to evaluate and thus improve their work on health issues, something that small CBOs usually cannot afford to do. SUHI shares expertise, methods, and information about health interventions to these groups working directly in the community. This then multiplies the reach of Sinai’s concept of pre-primary care.

- A project funded by the Fry Foundation studies Community Health Worker (CHW) effectiveness and best practices and will answer research and evaluation questions posed nationally throughout the CHW field. The CHW movement is a crucial piece of the pre-primary care work because working within a community setting requires that representatives from the health care circle be accepted and welcomed into homes, places of business, and faith communities. SUHI
has developed a CHW Training Module that has been shared widely because of its effectiveness. More information about this model can be found on the SUHI website.1

- The Asthma Care Partners Program collaborates with Blue Cross Blue Shield of Illinois and the Family Health Network to provide asthma management for children and adults with poorly controlled asthma. SUHI’s asthma work is among the most successful of our pre-primary care interventions. Helping children and families manage and control pediatric asthma is cost effective, and keeps children in school and parents at work.

- In March 2011, SUHI partnered with the Chicago Housing Authority to implement Helping Children Breathe and Thrive in Chicago Public Housing, one of SUHI’s current community-based healthy homes and asthma interventions. The program is funded by the Department of Housing and Urban Development and is the first to translate the Community Health Worker (CHW) intervention model to exclusively serve Chicago’s Westside public housing developments. CHWs were hired from the developments served by the program to provide comprehensive asthma education to child and adult residents with asthma. The main goals of the program are to improve asthma control, decrease asthma-related morbidity, and increase quality of life among residents living in Chicago’s public housing.

**SUHI Awards**

**SUHI has received over 25 prestigious awards in the last 13 years.**

- Awards in the area of breast health have come from the Avon Foundation, Susan G. Komen for the Cure, and the Illinois Hospital Association;
- Awards in the area of pediatric asthma have come from Premier Cares, the American Hospital Association, the U.S. Environmental Protection Agency, The Metropolitan Tenants Organization, and the National Association of Public Hospitals and Health Systems;
- Awards for the general work of SUHI have come from The Chicago Medical School, the Health and Medicine Policy Research Group, The Chicago Chapter of the National Black Nurses Association, the Chicago Department of Public Health, the Northwestern University Law School, the Institute of Medicine, the American Public Health Association, Rosalind Franklin University of Medicine and Science, the Greater Humboldt Park Community Health Initiative, the Illinois Maternal and Child Health Coalition, and Modern Healthcare.

**Community Health Workers**

*They are effective, dedicated and become excellent resources for their communities.*

Community Health Workers or Educators (CHWs) are the driving force for all of SUHI’s interventions, such as the ones described above. They are recruited from the communities they serve, are educated in extensive training programs, and are then hired to work with their communities. They are ALWAYS hired full-time and thus paid a living wage and full benefits, providing them and their families with health insurance, among other things. Their dedication and spirit often carry these interventions to success. One little discussed aspect of such a work force is that they soon become resources for their communities, which frequently are resource-poor. Thus, it is common for these CHWs to be approached in the streets or community stores by someone asking “Aren’t you that mammogram lady?” or “Can you tell me where I can get my prescription filled? or “Do you know of any exercise classes for my
daughter?” These CHWs make an enormous contribution to the work of MSH, the communities we serve, and the overall pursuit of healthy communities.

Conclusion

SCI and SUHI are important components of the pre-primary care focus of MSH. Both contribute in their own way to the goal of improved health for the people living in the community. SCI, with its many community programs, works with community residents to improve their work, school, and home lives with educational, nutritional, recreational, safety, and occupational services. These services are aimed at improving the lives and thus health of people, in this way, promoting health and well-being. SUHI, by applying its research methodology to determining what health issues need to be addressed, seeks to put effective interventions in place in the community to help improve health where people live. It also locates people with diagnosed and undiagnosed health conditions and steers them to health services all the while identifying and remedying the social determinants that challenge health in these communities. These two institutes make a huge difference in the lives of the people we serve and help MSH to improve community health by working outside of the walls of the hospital.

References

1. Http://www.suhichicago.org
Part IV

Strategies to Improve Health
Section 14: Mount Sinai Hospital’s Community Health Improvement Plan

Introduction

In this section, we present the Community Health Improvement Plan for Mount Sinai Hospital (MSH). To create this strategy, we first used our Community Health Needs Assessment to identify priority health concerns for the communities we serve. We then examined existing efforts and resources available to improve these conditions. Finally, we map out new programs and policies that can be implemented to address the needs identified by the data and community members.

MSH has a long history of striving to improve the health of the poor communities on the west side of Chicago. This is our mission. As we strive to do this, our efforts go beyond traditional health care services because we recognize that most determinants of health operate outside the walls of the hospital. Despite our status as a safety-net hospital and being Illinois’ largest provider of Medicaid services, MSH provided over $50 million in community benefits in 2012. Beyond our highly ranked healthcare services, we have many community-based programs that are designed to address the social and economic factors that impact the health of the most vulnerable community members. Many of these programs will be mentioned below, along with new endeavors spurred by the findings and opinions discussed in the previous sections. We believe this assessment, and the changes it has motivated, will help us attain our vision of being the national model for the delivery of urban healthcare.

Community Health Needs Assessment

The data that we presented throughout this report have come from many sources, including Census data (Section 2), death certificates (Section 3), hospital discharge and readmissions data (Sections 4 and 5), a city-wide health survey of adults (Section 6), the Sinai Improving Community Health Survey (Section 6), birth certificates (Section 7), a city-wide health survey of high school students (Section 8), the city of Chicago’s sexually transmitted infections surveillance data (Section 9), 7 focus groups attended by 66 people (Section 11), and 3 community forums attended by more than 100 people (Section 12). When looking at the data and thinking about what might be done to improve the health of the communities we serve, there is one overarching observation which must be considered. For virtually every one of the health measures considered in this assessment, the community areas and zip codes that are predominantly African American have by far the most challenged health status and several of these are adjacent to Mount Sinai Hospital. That does not mean that the communities that are majority Hispanic are doing fine. Some communities are and some are not, depending upon the health status measure. But the data and associated maps point to the Black communities having the greatest needs, frequently having levels of poor health comparable to those seen in underdeveloped countries throughout the world. Within this context, the data also reveal several specific challenges to the health of people who live in the Mount Sinai Hospital (MSH) Primary Service Area. When looked at collectively, the various independent data bases often brought us to the same conclusions in different ways. In order to move forward with our efforts, we had to narrow our focus by selecting and prioritizing health concerns for the communities we serve.
Priority Health Concerns

The selection of these conditions, and the priority assigned by the list below, was determined by numerous factors (see Box 14.1). Foremost among these are the data presented in the previous chapters and the feedback we received from community members. In addition, we took into account the resources of our hospital and health system, as well as the efforts of other groups in Chicago. Based on these factors, MSH chose to focus our efforts on the following health concerns:

Box 14.1 Criteria Used to Select Priority Health Concerns for MSH

- The data produced and arrayed throughout our assessment
- Substantial input from community focus groups and community forums
- The number of lives that could be impacted
- The strengths and resources of MSH and its affiliates and coalition members
- The extent to which other agencies in Chicago are addressing the problems

1. Diabetes
2. Heart disease
3. Obesity
4. Sexually transmitted infections
5. Poor birth outcomes
6. Mental health

Note that certain health outcomes that were found to be very prevalent in the communities we serve are included under these general categories. For example, the high rates of smoking identified by the data will be addressed in the strategies laid out for improving heart disease outcomes.

MSH Community Health Improvement Plan

After selecting the priority health concerns, MSH developed expanded strategies to address them. MSH has substantial experience with community health improvement efforts being implemented by the Sinai Community Institute and the Sinai Urban Health Institute (Section 13), as well as through various hospital efforts. These existing and planned efforts are summarized in the following tables. We first present our general tactics for community outreach, education, and disease management, which mostly focus on chronic conditions. We then present separate tables for each of the six priority health concerns listed above. We are excited to see the changes that these extensive programs will make in improving the health of the communities we serve.
## Mount Sinai Hospital’s Community Health Improvement Plan
### Overall Strategy for Community Health Outreach, Education, and Disease Management

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strategy</th>
<th>Steps</th>
<th>Budget</th>
<th>Responsible Party</th>
<th>Fiscal Year</th>
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</table>
| Gaps in community education and knowledge of chronic disease prevention | Education and prevention of modifiable risk factors                                                                                       | • Sinai entities to integrate resources of existing disparate educational programs/activities and develop robust educational programming for community in the areas of Diabetes, Cardiovascular Disease, COPD/Asthma, Obesity, and Stroke  
    • Create project plan and schedule  
    • Develop standardized content and language  
    • Develop centralized scheduling  
    • Identify faculty (clinical and lay)  
    • Identify teaching/outreach venues  
    • Create marketing and other educational materials  
    • Develop participant tracking systems  
    • Integrate with Patient Portal  
    • Develop measures of success  
    • Develop implementation plan  
    • Go Live                                                                                                                                  | TBD    | Directors of Service Lines of Cardiology, Diabetes, Stroke, Obesity, Multiculture Community Affairs Manager, SUHI Leaders, Medical Staff Content Experts, Director, Business Systems | 2013-2014 |
| Community outreach                                                     | Increase awareness of community of Sinai’s delivery system and resources for persons with chronic diseases | • Participate in and work with taskforces, coalitions and boards, church groups, grocery stores, and schools                                                                                         | TBD    | Directors of Service Lines of Cardiology, Diabetes, Stroke, Obesity, Multiculture Community                                                                 | 2013-2014 |
| Increase chronic disease awareness | Improve screening efforts, increase awareness on prevention and treatment | Maintain partnerships with organizations (American Heart Association, American Diabetes Association, National Kidney Foundation, American Cancer Society, Marshall Square Resource Network and others)  
- Create a Community Advisory Council to inform community members of results from health assessments and utilize input to develop effective interventions | Affairs Manager, SUHI Leaders, Medical Staff Content Experts, Marketing Specialist, VP Marketing Communications, Director Business Systems. AVP SMG Clinics | TBD | Directors of Service Lines of Cardiology, Diabetes, Stroke, Obesity, Multiculture Community Affairs Manager, SUHI Leaders, Medical Staff Content Experts. Director, Business Systems, Vice President Marketing Communications, AVP SMG Clinics | 2013-2014 |
| Patients with chronic conditions have challenges with personal activation resulting in progression of disease, avoidable visits to the Emergency room, and hospitalization | Expand the Disease Management Program for patients with chronic diseases of Diabetes, Heart Failure, and Chronic Obstructive Pulmonary Disease (COPD) | Team comprised of a nurse disease manager, patient navigator, pharmacist, dietician, social worker, physical therapist provides targeted education and coaching to the patient on managing their disease, diet, exercise, nutrition, and medication adherence.  
Reinforce follow-up to primary care physician; provide assistance with transportation and obtaining prescribed medications and other necessary medical equipment.  
Coach patients on establishing personal goals and to identify the warning signs that signal the need to contact their physicians rather than delay care and/or seek care at the emergency room.  
Assist patients with obtaining appointments with their PCP and other specialist physicians within five to seven days following discharge from the hospital to minimize the risk of readmission to the inpatient hospital or return visit to the Emergency Room.  
Extend the Diabetes Disease Management Program to | $2,000,000 (approximate) which includes $1,400,000 in grants for current program; Expansion approximates are an additional $1,500,000 | Vice President of Clinical Integration; Chief Medical Officer, SMG; Vice President, SMG; System Director, Pharmacy; Director of Social Work; Physician Team Disease Management; SCI Program Leaders, SUHI Program Directors; Directors of Diabetes and Cardiac Service Lines, Director, Business Systems | 2013-2015 |
pregnant women who have a diagnosis of gestational diabetes.

- Continue expansion of Disease Management Program to the ambulatory physician practice sites.
- Expand access of the interdisciplinary team composed of a Disease Management Nurse, Dietician, Social Worker and Pharmacist to SMG patients; hold individualized sessions with these patients during their appointment with their PCP to assess their need for medication, equipment, and social support; coach on a variety of topics including reinforcement of plan of care and healthy lifestyle concepts.
- Expand Disease Management Team to include Community Health Workers to visit patients in their homes, validate information provided to clinical team; provide additional support to patients to eliminate social determinants interfering with patient’s ability to remain activated.
- Refer patients as appropriate to SCI programs for individualized case management services or home assessments.
<table>
<thead>
<tr>
<th>Patients at risk for developing chronic disease are not always identified.</th>
<th>Administer Health Risk Assessments to Ambulatory Care Patients</th>
</tr>
</thead>
</table>
| • Health Risk Assessments (HRAs) are short questionnaires administered to individuals for the purpose of identifying those who may be at risk for the development of a chronic disease. HRAs are under development. Build basic HRAs into Next GEN.  
• Develop system of stratification of results to identify patients with greatest need to deploy available resources. | Operating Budget  
Disease Management, Physician Team and IS for development; SMG Clinics staff for implementation |
| Smoking is at high rates in the community. | Smoking Cessation Program |
| • Develop a basic smoking cessation program for patients with chronic disease and pregnant women | $100,000  
Disease Management specifically Social Worker |
| Standardizing care will assure that patients receive the right treatment, at the right time, in the right setting. | Deliver evidence-based care to patients across the continuum. |
| • Continue development of clinical care guidelines and order sets across the continuum. | Staff time; no specific dollars assigned  
Disease Management and Disease Management Physician Team |
| Provision of care and services across Sinai entities should be seamless to the patients/participants with overall plan of care and services received available for review by caregiver teams. | Electronic tracking system must be created that integrates all care/services received by the patient/participant. |
| • Create plan to integrate disparate information systems and data bases. | TBD  
CIO, VP Disease Management, Directors of SCI and SUHI, VP Physician Group, CMO of SMG |
### Mount Sinai Hospital’s Community Health Improvement Plan

#### DIABETES

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strategy</th>
<th>Steps</th>
<th>Budget</th>
<th>Responsible Party</th>
<th>Fiscal Year</th>
</tr>
</thead>
</table>
| Expand access for patients requiring immediate diabetes care during points of transition | Expand Diabetes “Bridge” Clinic concept to other locations to provide safety net care for patients transitioning between ER/hospital and their medical home. Establish community-based diabetes education “hubs” | • Expand appointment availability in current Bridge Clinic location.  
• Identify new locations.  
• Develop staffing model.  
• Obtain approval.  
• Open new site(s). | $100,000 | Diabetes Service Line | 2013-2014 |
| Diabetes patients benefit from self-management support.               | Continue Diabetes Learning Circle, a program that provides group support, personal goal setting, and lifestyle education: knowledge about diabetes, meal planning, physical activity, and problem solving. Participants are incentivized to join a local gym and also participate in cooking demonstrations. | • Establish community-based diabetes education hubs  
• Recruit and train lay staff to lead classes  
• Establish Spanish language groups | $3000 (supplies)  
$100,000 (personnel) | Diabetes Service Line | 2013-2014 |
| Uninsured patients lack access to necessary diabetes medications.      | Develop an insulin and diabetes medication assistance program.            | Collaborate with inpatient and outpatient pharmacies and pharma programs to develop the process. | $20,000 | Diabetes Service Line | 2013-2014 |
## Mount Sinai Hospital’s Community Health Improvement Plan

### OBESITY

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strategy</th>
<th>Steps</th>
<th>Budget</th>
<th>Responsible Party</th>
<th>Fiscal Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Obesity</td>
<td>Assessment of overweight or obese children at Pediatric Weight Management Clinic</td>
<td>Assess overweight and obese children’s physical health, dietary behaviors and mental health.</td>
<td>Part of regular operating expense and grant</td>
<td>Pediatric Weight Management Clinical team: Pediatrician, Dietitian, and Therapist Clinic Staff: Receptionist, Manager, Medical Assistants</td>
<td>2013</td>
</tr>
<tr>
<td>Childhood Obesity</td>
<td>Family and Child Education and Counseling at Pediatric Weight Management Clinic</td>
<td>Provide education and counseling on eating habits, lifestyle choices, physical health, and mental health to overweight and obese children and their families.</td>
<td>Part of regular operating expense and grant</td>
<td>Pediatric Weight Management Clinical team: Pediatrician, Dietitian, and Therapist</td>
<td>2013</td>
</tr>
<tr>
<td>Childhood Obesity</td>
<td>Provide healthy lifestyle programs for children and families in need that encourages healthy changes.</td>
<td>Continue Sinai Fit Program: Implement weekly nutrition and physical activity sessions for overweight and obese children and their families. Cooking Classes: Implement 2 cooking courses that are 6 weeks long for families or parents of overweight or obese children.</td>
<td>Part of grant</td>
<td>Pediatric weight management Dietician and Therapist, Schwab rehabilitation physical Therapist, Cooking Matters Program Coordinator</td>
<td>2013</td>
</tr>
<tr>
<td>Adult Obesity</td>
<td>Assessment of overweight or obese adults at Adult Weight Management Clinic</td>
<td>Assess overweight and obese adult’s physical health, dietary behaviors and mental health.</td>
<td>Part of regular operating budget</td>
<td>Adult Weight Management Program Team</td>
<td>2014</td>
</tr>
<tr>
<td>Adult Obesity</td>
<td>Education and counseling at Adult Weight Management Clinic</td>
<td>Provide education and counseling on eating habits, lifestyle choices, physical health, and mental health to overweight and obese adults.</td>
<td>Part of regular operating budget</td>
<td>Adult Weight Management Program Team</td>
<td>2014</td>
</tr>
</tbody>
</table>
# Mount Sinai Hospital’s Community Health Improvement Plan

## HEART DISEASE

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strategy</th>
<th>Steps</th>
<th>Budget</th>
<th>Responsible Party</th>
<th>Fiscal Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease screening and outreach</td>
<td>Provide comprehensive diagnostic services with an accredited Chest Pain Center - PCI at MSH.</td>
<td>Continue to provide outreach activities and screening. Collaborating our efforts and partnering with AHA.</td>
<td>Chest pain center- $20,000</td>
<td>Clinical Director of Operations/Director of Cardiology</td>
<td>2014-2015</td>
</tr>
<tr>
<td>Improve heart disease services.</td>
<td>Participate with NCDR-Action Registry Data base and compare our data with other hospitals.</td>
<td>Review best practices, review data, and provide continuous performance improvement strategies.</td>
<td>Action Registry participation- $25,000</td>
<td>Medical Director of Cardiology/Director of Cardiology</td>
<td>2014-2015</td>
</tr>
<tr>
<td>Improve access to cardiologists in the community.</td>
<td>Co-locate Sinai Medical Group cardiologists in community-based primary care offices to enhance access to care and clinical programs.</td>
<td>Identify PCP offices within the service area for expansion of specialty care.</td>
<td>$100,000</td>
<td>Vice President, Physician Services</td>
<td>2014-2015</td>
</tr>
</tbody>
</table>
# Mount Sinai Hospital’s Community Health Improvement Plan

## SEXUALLY TRANSMITTED INFECTIONS

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strategy</th>
<th>Steps</th>
<th>Budget</th>
<th>Responsible Party</th>
<th>Fiscal Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV testing</td>
<td>Increase HIV testing in the hospital and the community.</td>
<td>Offer HIV testing routinely in all parts of the medical system- inpatient, outpatient, and emergency department. Offer HIV testing at community events.</td>
<td>Part of routine medical care and grant funding</td>
<td>Nursing and physician staff with follow up by HIV staff to help navigate positives into HIV care</td>
<td>2013</td>
</tr>
<tr>
<td>HIV awareness</td>
<td>Increase the awareness of the rates of HIV in our community.</td>
<td>HIV awareness campaign starting in North Lawndale to make certain people are aware of rates, services available, and HIV testing sites</td>
<td>Part of grant funding</td>
<td>HIV prevention team</td>
<td>2013</td>
</tr>
<tr>
<td>Access to HIV care</td>
<td>Link people who are HIV infected to care.</td>
<td>Working with patient navigators and case managers, overcome barriers to enrolling people into HIV care.</td>
<td>Grant funding</td>
<td>HIV navigators and case managers</td>
<td>2013</td>
</tr>
<tr>
<td>HIV treatment</td>
<td>Treat people who are HIV infected with HIV therapy</td>
<td>Treat people who are HIV positive with medication that will prolong life and decrease risk of transmission to others.</td>
<td>Routine medical care</td>
<td>HIV clinicians</td>
<td>2013</td>
</tr>
<tr>
<td>Gonorrhea, Chlamydia, and syphilis</td>
<td>Increase testing for STIs at all points of contact within the health care system focusing on 15-25 year olds</td>
<td>Offer screening for STIs in symptomatic and asymptomatic clients in the ED, outpatient clinics.</td>
<td>Part of regular operating expenses, seek out additional grant support</td>
<td>Infectious disease/ HIV/STI team</td>
<td>2013</td>
</tr>
<tr>
<td>STI testing</td>
<td>Testing all high risk patients for STIs on a routine basis including HIV positive patients</td>
<td>Offer at least yearly screening for HIV positive clients and other high risk clients for STIs.</td>
<td>Part of regular operating expenses</td>
<td>Infectious diseases/primary care</td>
<td>2013</td>
</tr>
<tr>
<td>STI outreach</td>
<td>Outreach campaign around high rates of STIs in our communities</td>
<td>Have community members understand the high rates of infections and how they can get tested.</td>
<td>Part of operating expenses, options for additional grant funding</td>
<td>Prevention services</td>
<td>2013</td>
</tr>
</tbody>
</table>
## Mount Sinai Hospital’s Community Health Improvement Plan
### BIRTH OUTCOMES

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strategy</th>
<th>Steps</th>
<th>Budget</th>
<th>Responsible Party</th>
<th>Fiscal Year</th>
</tr>
</thead>
</table>
| Infant mortality               | Reduce incidence of SIDS                      | • Halo Innovations to provide “sleep sacks” for all normal newborns as well as NICU infants  
• Expand prevention education on causes of SIDS | $500 (covers cost of shipping for one year)                                                  | Director, Perinatal Services and Sinai Children’s Hospital                              | 2013-2014   |
| Poor birth outcomes            | Reduction of preterm labor, prevention of low birth weight, prematurity and infant mortality | • Provide community and targeted education, nutritional counseling to reduce prenatal risks that lead to preterm labor/birth.  
• Promote breastfeeding, immunizations, and increase access to prenatal care.  
• Provide targeted efforts on Preterm Labor/LBW in the OB Triage area.  
• Provide specific information to high risk antepartum patients while they are hospitalized on the strategies to increase duration of pregnancy.  
• Develop bilingual childbirth classes.  
• Develop and implement education for inpatient nurses that enables them to teach Gestational Diabetes patients self-management during pregnancy and immediately post-partum. | $1,940,690-WIC, $1,078,656-Family Case Management, $1,000-Gestational Brochures, $1,000-Bilingual Class Development | Sinai Community Institute’s Family Case Management Services Staff, WIC (Women, Infants and Children) Program Staff, Director, Perinatal Services and Sinai Children’s Hospital, Director of Diabetes/Endocrine Service Line | 2014        |
| Improve Access to Prenatal Care. | Improve ability to access antepartum testing (of fetus) during pregnancy. | • Work with Nutrition inpatient services to develop carbohydrate counting and provision of food trays that reflect this strategy. | None | Director, Perinatal Services and Sinai Children’s Hospital | 2013 |
| Improve Prenatal Care for High Risk Women | Develop Centering Model for high-risk OB patients. | • Partner with SCI to develop and implement a plan to identify patients not seeking timely prenatal care (those not part of existing programs).  
• Expand antepartum appointment schedule to 6 days per week (half day Saturday).  
• Coordinate OB Ultrasound appointments with antepartum testing for convenience of patients.  
• Recruit additional new providers and open outpatient facilities. | $25,000 annual salary for doula | Chairman, Department of Obstetrics and Gynecology | 2013-2014 |
| Improve Provider and Caregiver Education of High-Risk Obstetric Patients. | Education for treatment of high risk pregnancies | • Develop and implement prenatal sessions at SHS.  
• Hire doula to provide education and support to patients in Centering Prenatal Program. | None | Director, Perinatal Services and Sinai Children’s Hospital and Dr. E. Charles Lampley, Chairman, OB/Gyn Dept. | 2013-2014 |
<table>
<thead>
<tr>
<th>Project Description</th>
<th>Action Plan</th>
<th>Cost (in USD)</th>
<th>Responsible Party</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote Breastfeeding</td>
<td>Improve Breastfeeding rates for all mothers especially those with LBW/pre-term infants.</td>
<td></td>
<td>$8,000-Baby Family Hospital Initiative Director, Perinatal Services and Sinai Children’s Hospital</td>
<td>2013-2015</td>
</tr>
<tr>
<td></td>
<td>• Continue Baby Friendly Hospital Initiative.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Education and support for breastfeeding in NICU.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Skin-to-skin bonding at birth for all infants.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Use of lactation consultants and breastfeeding experts from community clinics.</td>
<td></td>
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</tr>
<tr>
<td>Inadequate Access to Prenatal Care</td>
<td>Deploy Sinai Medical Group providers and community based primary care facilities.</td>
<td></td>
<td>$600,000-Sinai Medical Group Director, Perinatal Services and Sinai Children’s Hospital</td>
<td>2014</td>
</tr>
<tr>
<td></td>
<td>• Recruit additional new providers and open outpatient facilities of identified patient need.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
## MENTAL HEALTH

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strategy</th>
<th>Steps</th>
<th>Budget</th>
<th>Responsible Party</th>
<th>Fiscal Year</th>
</tr>
</thead>
</table>
| Psychiatric readmissions                                            | Reduce psychiatric readmission rates                                    | • Create Readmission Reduction Team  
• Analyze data, identify issues leading to readmission including a review of patient compliance with discharge plans and other factors leading to readmission  
• Create method to identify and track readmitted patients  
• Perform gap analysis on resource availability to prevent readmissions  
• Create plan to develop or obtain resources | TBD  | Chairman of Psychiatry, Nursing Unit Director, Assistant Vice President, Psychiatry  
Readmission Team | 2013-2014                                                                 |
| Increase access to ambulatory psychiatric programs for community    | Expand availability of outpatient psychiatry services                     | • Analyze no show rates.  
• Identify alternatives to scheduled appointment system and implement revisions for obtaining psychiatric assessments and medication management resources.  
• Explore, create and develop independent resources and community partnerships. | TBD  | Chairman of Psychiatry and Quality Team  | 2013-2014                                                                 |
| To expand psychiatric assessments and medical management to clinics and hospitals in Illinois without access to psychiatry | Implement Telepsych                                                     | • Explore options for providing telepsych  
• Select option for SHS, execute partner and fee schedules  
• Create Implementation Plan  
• Recruit and retain staff | TBD  | Chairman of Psychiatry, Assistant Vice President, Psychiatry  | 2013-2014                                                                 |
| Expand Community-Based Mental Health Services                        | Expand Mini-Clinics to social service agencies and churches.             | • Develop needs assessment tool.  
• Administer survey to schools, churches, social agencies, and other community based entities.  
• Analyze results and develop predictive model with regards to volume, visits, revenue and expenses.  
• Identify ideal community locations.  
• Obtain approval for developing and implementation of new sites. | TBD  | Assistant Vice President, Psychiatry and Director of Child and Adolescent Psychiatry  | 2014                                                                 |
Appendices

A. Additional Mortality Information
B. Additional Hospitalization Data
C. Focus Group Details
Appendix A: Additional Mortality Data

In Section 3, we summarized the leading causes of death for Chicago residents. We talked about mortality from heart disease and cancer in more detail and presented bar charts and maps to show which communities are most burdened with these particular health problems. In this appendix, we present information on the remaining leading causes of death in a similar format.

Recall from Section 3 that the leading causes of death for Chicago residents in 2006 were:

<table>
<thead>
<tr>
<th>Leading Causes of Death for Chicago Residents, 2006¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heart Disease</td>
</tr>
<tr>
<td>2. Cancer</td>
</tr>
<tr>
<td>3. Accidents</td>
</tr>
<tr>
<td>4. Stroke</td>
</tr>
<tr>
<td>5. Chronic Lower Respiratory Disease</td>
</tr>
<tr>
<td>6. Diabetes</td>
</tr>
<tr>
<td>7. Septicemia</td>
</tr>
<tr>
<td>8. Nephritis</td>
</tr>
<tr>
<td>9. Influenza &amp; Pneumonia</td>
</tr>
<tr>
<td>10. Homicide</td>
</tr>
</tbody>
</table>

Now let’s continue looking at cause-specific mortality data for the city of Chicago. In order to understand what people are dying from within Chicago, and also how this varies across the city’s 77 communities, we calculated the 3-year average (2005-2007) age-adjusted mortality rates (rates) for several causes of death for each of Chicago’s 77 communities. Mortality rates are age-adjusted in order to allow comparisons across geographic areas (in this case, community areas) which may have very different age distributions. For example, we would expect more deaths from heart disease to occur in communities with a larger elderly population than in communities with more young people. By age-adjusting the rates, we can make comparisons between communities with very old and very young populations and everything in between.

We will resume our discussion here with the third leading cause of death – accidents.
Accidents: #3 Cause of Death in Chicago
#5 Cause of Death in the U.S.

What are accidents? Accidents encompass all unintentional injury deaths, including deaths from car accidents, falls, and drug overdoses. Accidents do not include deaths from homicide or suicide. Many fatal injuries are preventable and knowing the characteristics of those at high risk is key to prevention. For instance, falls are the leading mechanism of accidental death for elderly people over 72, while poisoning (drug overdose) is the leading mechanism of accidental death for midlife adults 35-53 years of age. For all other age groups (except children under 2 years of age), car accidents are the leading mechanism of injury death.

• Figure A.1 presents the accident mortality rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area
• The accident death rate was:
  • 40 for Chicago
  • 35 for the U.S.
• Within the MSH Primary Service Area:
  • Rates ranged from a low of 22 for South Lawndale to a high of 80 in West Garfield Park
  • Rates above the Chicago average were found in 8 of the 13 Sinai communities

Figure A.1 Accident Mortality (2005-2007)

• Figure A.2 helps demonstrate which community areas are most burdened with accident mortality
  • The map displays all 77 of Chicago’s communities with light to dark shading for lowest to highest accident death rates
  • Notably, all of the communities with the highest rates were on the south and west sides of the city
  • Four of the communities with the highest rates (those in the 4th quartile) fell within the MSH Primary Service Area
• Accident deaths accounted for 2-8% of the 77 communities’ total deaths

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Figure A.2 Accident Mortality by Chicago Community Area

Stroke:  #4 Cause of Death in Chicago  
#3 Cause of Death in the U.S.

What is a stroke? Similar to a heart attack, a stroke can result when a blood vessel is damaged or blocked, denying oxygen-rich blood to the brain. When this happens, brain cells begin to die in the region that is not receiving blood, resulting in brain damage. Depending on the location of the stroke, speech, movement, or memory may be affected. People who survive larger strokes may be left with permanent disabilities. The risk factors for stroke, including unhealthy lifestyle factors and conditions such as high blood pressure, may be modified or prevented.

- Figure A.3 presents the stroke mortality rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area
- The stroke death rate was:
  - 46 for Chicago
  - 44 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 33 for South Lawndale to a high of 78 in West Garfield Park
  - Rates above the Chicago average were found in all 9 of the 13 Sinai communities

**Figure A.3 Stroke Mortality (2005-2007)**

- Figure A.4 helps demonstrate which community areas are most burdened with stroke mortality
  - The map displays all 77 of Chicago’s communities with light to dark shading for lowest to highest stroke death rates
  - Notably, all of the communities with the highest rates were on the south and west sides of the city
  - Four of the communities with the highest rates (those in the 4th quartile) fell within the MSH Primary Service Area

  Stroke deaths accounted for 3-9% of the 77 communities’ total deaths
Chronic Lower Respiratory Disease: #5 Cause of Death in Chicago
#4 Cause of Death in the U.S.

What is Chronic Lower Respiratory Disease (CLRD)? CLRD includes chronic bronchitis, emphysema, asthma, and other illnesses in the lungs. Many of the risk factors for CLRD have been identified and can be prevented, including tobacco smoke, second-hand tobacco smoke, and indoor and outdoor air pollutants. Most importantly, cigarette smokers are 10 times more likely to die from CLRD than nonsmokers.

- Figure A.5 presents the CLRD mortality rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area
- The CLRD death rate was:
  - 29 for Chicago
  - 42 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 18 for Gage Park to a high of 34 in Chicago Lawn and Archer Heights
  - Rates above the Chicago average were found in 4 of the 13 Sinai communities

Figure A.5 Chronic Lower Respiratory Disease Mortality (2005-2007)

- Figure A.6 helps demonstrate which community areas are most burdened with CLRD mortality
  - The map displays all 77 of Chicago’s communities with light to dark shading for lowest to highest CLRD death rates
  - Notably, nearly all of the communities with the highest rates were on the south and west sides of the city
  - None of the communities with the highest rates (those in the 4th quartile) fell within the MSH Primary Service Area

- CLRD deaths accounted for 2-6% of the 77 communities’ total deaths
Figure A.6 Chronic Lower Respiratory Disease Mortality by Chicago Community Area

What is Diabetes? Diabetes (known in some communities as “sugar”) is a disease characterized by high blood sugar. Blood sugar is made naturally in our bodies and also comes from the food we eat. We need sugar for energy, but too much sugar in the blood can have negative side effects. Usually, a hormone called insulin helps sugar enter our cells in order to regulate the amount of sugar in our blood. However, in people with diabetes, the body either does not make enough insulin or the insulin does not work properly. Diabetes is the result of prolonged high blood sugar, and can lead to serious health consequences such as kidney failure and blindness. People with diabetes are also at higher risk for heart disease and stroke. However, diabetes can be controlled with proper diet, exercise, and medication.

• Figure A.7 presents the diabetes mortality rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area
• The diabetes death rate was:
  • 28 for Chicago
  • 24 for the U.S.
• Within the MSH Primary Service Area:
  • Rates ranged from a low of 18 for West Lawn to a high of 41 in East and West Garfield Park
  • Rates above the Chicago average were found in 8 of the 13 Sinai communities

Figure A.7 Diabetes Mortality (2005-2007)

• Figure A.8 helps demonstrate which community areas are most burdened with diabetes mortality
  • The map displays all 77 of Chicago’s communities with light to dark shading for lowest to highest diabetes death rates
  • Notably, many of the communities with the highest rates were on the south and west sides of the city
  • Three of the communities with the highest rates (those in the 4th quartile) fell within the MSH Primary Service Area
• Diabetes deaths accounted for 1-6% of the 77 communities’ total deaths
Figure A.8 Diabetes Mortality by Chicago Community Area

Diabetes Morality per 100,000

- Fourth Quartile (37 - 68)
- Third Quartile (31 - 36)
- Second Quartile (21 - 30)
- First Quartile (7 - 20)
- MSH Primary Service Area

Chicago Diabetes Mortality: 28
U.S. Diabetes Mortality: 24

**Septicemia: #7 Cause of Death in Chicago #10 Cause of Death in the U.S.**

**What is Septicemia?** Septicemia, sometimes referred to as “blood poisoning”, is caused by bacteria entering the bloodstream and triggering an immune response which results in inflammation and a slow shutting down of the body’s systems for handling infection. A person may be vulnerable to septicemia because of age or condition or due to surgery or a latent infection which may spread to the blood. Septicemia is difficult to prevent and can strike unexpectedly. Some measures a person can take to prevent septicemia include: maintain good hygiene and general health; closely monitor the site of any surgical procedures and speak up if you experience any soreness, swelling or discomfort around the site; seek medical attention for deep cuts and puncture wounds so that the site can be adequately flushed and antibiotics can be given if needed.

- Figure A.9 presents the septicemia mortality rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area
- The septicemia death rate was:
  - 25 for Chicago
  - 11 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 11 for Archer Heights to a high of 38 in East Garfield Park
  - Rates above the Chicago average were found in 4 of the 13 Sinai communities

**Figure A.9 Septicemia Mortality (2005-2007)**

- Figure A.10 helps demonstrate which community areas are most burdened with septicemia mortality
  - The map displays all 77 of Chicago’s communities with light to dark shading for lowest to highest septicemia death rates
  - Notably, nearly all of the communities with the highest rates were on the south and west sides of the city
  - One of the communities with the highest rates (those in the 4th quartile) fell within the MSH Primary Service Area
  - Septicemia deaths accounted for 1-5% of the 77 communities’ total deaths
Figure A.10 Septicemia Morality by Chicago Community Area

**Nephritis:**

**#8 Cause of Death in Chicago**

**#9 Cause of Death in the U.S.**

*What is Nephritis?* Nephritis, or kidney disease, is a general term which refers to any damage or inflammation of the kidneys. The kidneys are responsible for filtering the blood, removing extra fluid and unwanted chemicals, and helping the body regulate blood pressure. Therefore, kidney damage can result in a general imbalance in the body, leading to swelling, nausea, and weakness, among other things. Chronic kidney disease is often caused by diabetes and high blood pressure and may be fatal if left untreated.

- Figure A.11 presents the nephritis mortality rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area
- The nephritis death rate was:
  - 23 for Chicago
  - 14 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 6 for Archer Heights to a high of 38 in West Garfield Park
  - Rates above the Chicago average were found in 5 of the 13 Sinai communities

**Figure A.11 Nephritis Mortality (2005-2007)**

- Figure A.12 helps demonstrate which community areas are most burdened with nephritis mortality
- The map displays all 77 of Chicago’s communities with light to dark shading for lowest to highest nephritis death rates
- Notably, almost all of the communities with the highest rates were on the south and west sides of the city
- Two of the communities with the highest rates (those in the 4th quartile) fell within the MSH Primary Service Area

- Nephritis deaths accounted for 1-4% of the 77 communities’ total deaths
Figure A.12 Nephritis Mortality by Chicago Community Area

Influenza and Pneumonia: #8 Cause of Death in the U.S. #9 Cause of Death in Chicago

What are influenza and pneumonia? Influenza (flu) is a viral infection that is highly contagious and can affect people of all ages. Seasonal flu can be prevented by receiving a flu shot, which is covered by Medicare and most other health plans, and is widely available – through clinics and pharmacies alike. Pneumonia is an infection of the lungs which causes the air sacs in the lungs to become inflamed and filled with pus and other liquid. It then becomes difficult for the blood to draw oxygen from the air sacs for distribution throughout the body, which prevents the body’s cells from working properly. Lack of oxygen and the spread of infection can lead to death. Vaccination is recommended for certain age groups and those already in poor health. The flu shot can also help prevent pneumonia because of the close relationship between influenza and pneumonia.9

- Figure A.13 presents the influenza & pneumonia mortality rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area
- The influenza and pneumonia death rate was:
  - 23 for Chicago
  - 18 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 12 for Gage Park to a high of 48 in East Garfield Park
  - Rates above the Chicago average were found in 5 of the 13 Sinai communities

Figure A.13 Influenza and Pneumonia Mortality (2005-2007)

- Figure A.14 displays all 77 of Chicago’s communities with light to dark shading for lowest to highest influenza & pneumonia death rates
  - Notably, several of the communities with the highest rates were on the south and west sides of the city
  - Five of the communities with the highest rates (those in the 4th quartile) fell within the MSH Primary Service Area
  - Influenza & pneumonia deaths accounted for 1-6% of the 77 communities’ total deaths
Figure A.14 Influenza and Pneumonia Mortality by Chicago Community Area

Influenza & Pneumonia (I&P) Mortality per 100,000

- Fourth Quartile (27 - 68)
- Third Quartile (22 - 26)
- Second Quartile (18 - 21)
- First Quartile (3 - 17)
- MSH Primary Service Area

Chicago I & P Mortality: 23
U.S. I & P Mortality: 18

**Homicide: #10 Cause of Death in Chicago #15 Cause of Death in the U.S.**

*What is homicide?* Homicide is defined as a human killing another human. Nearly 70% of homicides in the US involve firearms and the highest victimization and offending rates are found among young adults. Youth homicide is particularly problematic in large urban areas, especially among Black and Hispanic teens. Major factors contributing to the elevated homicide rates among these groups include poverty, easy access to handguns, drug and gang activity, and the failure of the educational system. Violence prevention and reduction strategies are most effective when they can identify high-risk children early on and intervene at multiple levels through collaborative community partnerships.

- Figure A.15 presents the homicide mortality rates for the U.S., Chicago, and the 13 communities in the MSH Primary Service Area
- The homicide death rate was:
  - 15 for Chicago
  - 6 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 8 for West Elsdon to a high of 44 in North Lawndale
  - Rates above the Chicago average were found in 5 of the 13 Sinai communities

**Figure A.15 Homicide Mortality (2005-2007)**

- Figure A.16 displays all 77 of Chicago’s communities with light to dark shading for lowest to highest homicide death rates
  - Notably, all of the communities with the highest rates were on the south and west sides of the city
  - Two of the communities with the highest rates (those in the 4th quartile) fell within the MSH Primary Service Area

- Homicide deaths accounted for 0-7% of the 77 communities’ total deaths
Figure A.16 Homicide Mortality by Chicago Community Area


Homicide Mortality per 100,000
- Fourth Quartile (32 - 81)
- Third Quartile (12 - 31)
- Second Quartile (6 - 11)
- First Quartile (0 - 5)
- MSH Primary Service Area

Chicago Homicide Mortality: 15
U.S. Homicide Mortality: 6
References

1. 2006 is the most recent year for which the Chicago Department of Public Health has published these data. See report at: http://www.cityofchicago.org/dam/city/depts/cdph/statistics_and_reports/SR_leading%20causes%20of%20death%202006.pdf.


Appendix B: Additional Hospitalization Data

In Section 4, we discussed the hospitalization rates for selected conditions, including asthma, diabetes, heart disease, stroke, and mental health disorders. In Appendix B, we will continue to present hospitalization data on other conditions, including pneumonia, HIV/AIDS, kidney disease, liver disease and injury and poisoning. See Section 4 for a description of methods including condition selection, data sources, and rate calculation details.

Pneumonia Hospitalizations

What is pneumonia? Pneumonia is an infection of the lungs which causes the air sacs in the lungs to become inflamed and filled with pus and other liquid. It then becomes difficult for the blood to draw oxygen from the air sacs for distribution throughout the body, which prevents the body’s cells from working properly. Lack of oxygen and the spread of infection can lead to death. Vaccination is recommended for certain age groups and those already in poor health. The flu shot can also help prevent pneumonia because of the close relationship between influenza and pneumonia.

- Figure B.1 presents the pneumonia hospitalization rates for the U.S., Chicago, and the 6 zip codes in the MSH Primary Service Area
- The pneumonia hospitalization rate (per 10,000) was:
  - 34 for Chicago
  - 35 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 31 in 60629 to a high of 54 in 60624
  - Rates above the Chicago average were found in 3 of the 6 MSH zip codes

Figure B.1 Pneumonia Hospitalization Rates for the MSH Primary Service Area

![Figure B.1 Pneumonia Hospitalization Rates for the MSH Primary Service Area](image)

Data source: COMPdata (Chicago, 2009-2011); CDC Health Data Interactive (U.S., 2010)

- Figure B.2 displays 56 zip codes in Chicago with light to dark shading for lowest to highest rates
  - Many of the zip codes with the highest rates were on the south and west sides of the city
  - Three of the six zip codes in the MSH Primary Service Area had pneumonia hospitalization rates within the highest (4th) quartile
Figure B.2 Pneumonia Hospitalization Rates by Chicago Zip Code

HIV/AIDS Hospitalizations

What is HIV/AIDS? The Human Immunodeficiency Virus (HIV) is spread in several ways, including unprotected sexual activity, needle sharing during injection drug use, and mother to child transmission during pregnancy. HIV attacks the immune system, making it difficult for the body to fight off infections. It may take several years for people with HIV to show signs and symptoms of infection. Untreated HIV can lead to a severely damaged immune system, resulting in Acquired Immune Deficiency Syndrome (AIDS). People with AIDS are more likely to develop certain diseases and types of cancer. However, with the proper treatment, people can live with HIV without progressing to AIDS.

- Figure B.3 presents the HIV/AIDS hospitalization rates for the U.S., Chicago, and the 6 zip codes in the MSH Primary Service Area
- The HIV/AIDS hospitalization rate (per 10,000) was:
  - 4 for Chicago
  - 1 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 0.55 in 60632 to a high of 11 in 60612
  - Rates above the Chicago average were found in 3 of the 6 MSH zip codes

Figure B.3 HIV/AIDS Hospitalization Rates for the MSH Primary Service Area

- Figure B.4 displays 56 zip codes in Chicago with light to dark shading for lowest to highest HIV/AIDS hospitalization rates
- Many of the zip codes with the highest rates were on the south and west sides of the city
- Three of the six zip codes in the MSH Primary Service Area had HIV/AIDS hospitalization rates within the highest (4th) quartile

Data source: COMPdata (Chicago, 2009-2011); CDC Health Data Interactive (U.S., 2010)
Figure B.4 HIV/AIDS Hospitalization Rates by Chicago Zip Code

Nephritis Hospitalizations

What is nephritis? Nephritis, or kidney disease, is a general term which refers to any damage or inflammation of the kidneys. The kidneys are responsible for filtering the blood, removing extra fluid and unwanted chemicals, and helping the body regulate blood pressure. Therefore, kidney damage can result in a general imbalance in the body, leading to swelling, nausea, and weakness, among other things. Chronic kidney disease is often caused by diabetes and high blood pressure and may be fatal if left untreated.

- Figure B.5 presents the nephritis hospitalization rates for the U.S., Chicago, and the 6 zip codes in the MSH Primary Service Area.
- The nephritis hospitalization rate (per 10,000) was:
  - 16 for Chicago
  - 18 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 12 in 60632 to a high of 24 in 60612
  - Rates above the Chicago average were found in 4 of the 6 MSH zip codes

Figure B.5 Nephritis Hospitalization Rates for the MSH Primary Service Area

*Data source: COMPdata (Chicago, 2009-2011); CDC Health Data Interactive (U.S., 2010)

- Figure B.6 displays 56 zip codes in Chicago with light to dark shading for lowest to highest nephritis hospitalization rates.
  - Many of the zip codes with the highest rates were on the south and west sides of the city.
  - Three of the six zip codes in the MSH Primary Service Area had nephritis hospitalization rates within the highest (4th) quartile.
Figure B.6 Nephritis Hospitalization Rates by Chicago Zip Code

Nephritis Hospitalizations per 10,000
- Fourth Quartile (19 - 29)
- Third Quartile (16 - 18)
- Second Quartile (12 - 15)
- First Quartile (6 - 11)

Chicago Nephritis Hospitalizations: 16
U.S. Nephritis Hospitalizations: 18

Cirrhosis Hospitalizations

What is cirrhosis? Cirrhosis, or liver disease, is a condition in which scar tissue replaces the soft healthy tissue of the liver. Several risk factors, including alcoholism, chronic hepatitis, and genetic diseases can cause the liver to swell, which may lead to cirrhosis. Treatment is limited and aimed at preventing further damage and reducing complications. Therefore, it is especially important to try to prevent cirrhosis through proper diet, physical activity, limited alcohol intake, vaccination, and safe sex and needle use practices.

- Figure B.7 presents the cirrhosis hospitalization rates for the U.S., Chicago, and the 6 zip codes in the MSH Primary Service Area
- The cirrhosis hospitalization rate (per 10,000) was:
  - 4.3 for Chicago
  - 3.0 for the U.S.
- Within the MSH Primary Service Area
  - Rates ranged from a low of 5.2 in 60629 to a high of 8.2 in 60612
  - Rates above the Chicago average were found in all 6 of the MSH zip codes

Figure B.7 Cirrhosis Hospitalization Rates for the MSH Primary Service Area

![Graph showing cirrhosis hospitalization rates](image)

Data source: COMPdata (Chicago, 2009-2011); CDC Health Data Interactive (U.S., 2010)

- Figure B.8 displays 56 zip codes in Chicago with light to dark shading for lowest to highest cirrhosis hospitalization rates
  - All of the zip codes with the highest rates were on the west sides of the city
  - All six zip codes in the MSH Primary Service Area had cirrhosis hospitalization rates within the highest (4th) quartile
Figure B.8 Cirrhosis Hospitalization Rates by Chicago Zip Code


Chicago Cirrhosis Hospitalizations: 4
U.S. Cirrhosis Hospitalizations: 3
Injury and Poisoning Hospitalizations

What is included in injury and poisoning? Hospitalizations for injury and poisoning include fractures, dislocations, sprains, internal injury, wounds, burns, poisoning by drugs, medicinal, and biological substances, and toxic effects of non-medicinal substances.

- Figure B.9 presents the injury and poisoning hospitalization rates for the U.S., Chicago, and the 6 zip codes in the MSH Primary Service Area
- The injury and poisoning hospitalization rate (per 10,000) was:
  - 57 for Chicago
  - 60 for the U.S.
- Within the MSH Primary Service Area:
  - Rates ranged from a low of 52 in 60629 and 60632 to a high of 120 in 60624
  - Rates above the Chicago average were found in 4 of the 6 MSH zip codes

Figure B.9 Injury and Poisoning Hospitalization Rates for the MSH Primary Service Area

- Figure B.10 displays 56 zip codes in Chicago with light to dark shading for lowest to highest injury and poisoning hospitalization rates
  - Many of the zip codes with the highest rates were on the west and south sides of the city
  - Four of the six zip codes in the MSH Primary Service Area had injury and poisoning hospitalization rates within the highest (4th) quartile
Figure B.10 Injury and Poisoning Hospitalization Rates by Chicago Zip Code

References


Appendix C: Focus Group Details

In Section 11, we summarized overall findings for the seven focus groups conducted in the Mount Sinai Hospital Primary Service Area. In this appendix, for each of the four communities represented - Chicago Lawn, Humboldt Park, North Lawndale, and South Lawndale - we present detailed information obtained during the focus groups. In each community, we provide demographic characteristics of the focus group participants, followed by responses to the three main topics discussed during the focus groups:

- What are the most important health issues affecting community members?
- What are the barriers to improving these issues?
- Suggestions for what MSH can do to improve community health.

Each focus group conversation was reviewed and analyzed carefully in order to extract main themes within and across groups, as well as to organize and present meaningful quotes and summaries of the topics the participants were most passionate about.

Chicago Lawn

Focus Group Characteristics

One focus group of 13 Spanish-speaking participants was conducted in the southwest community of Chicago Lawn (see Table C.1). This group was recruited to represent the Hispanic population of the community. At the time of the 2010 census, Hispanic/Latinos comprised 45% of the population of Chicago Lawn. All participants were recruited by a local community organizing group affiliated with the Greater Southwest Development Corporation. The group was conducted entirely in Spanish, with all the participants identifying as Mexican. The participants were mostly uninsured women over the age of 40. Only one participant was male.

Findings

Participants were asked to brainstorm a list of the most important health issues affecting them and their community. They mentioned diabetes, poor heart health (high cholesterol/high triglycerides), cancer, obesity, high blood pressure, and depression among other issues (See Box C.1). The participants then voted for the top three health issues they see facing adults; each participant had three votes. Diabetes, poor heart health (high cholesterol/high triglycerides) and cancer were selected as the most important. Issues faced by parents of children and adolescents...
were also discussed. The discussion about cancer was limited due to time constraints. Therefore, only the discussion on diabetes, poor heart health and child adolescent health will be described for Chicago Lawn.

**Box C.1 Most Important Health Issues Identified by Chicago Lawn Focus Group**  
* (number of votes in parentheses)  
- Diabetes (10)  
- Poor heart health (9)  
- Cancer (6)  
- Obesity (5)  
- High blood pressure (5)  
- Depression (4)  
- Dental problems (2)  
- Heart attacks (1)  
- Multiple sclerosis (1)  
- Sexually transmitted infections (1)

**Discussion about Diabetes.** Box C.2 lists the causes of diabetes and the barriers to improving diabetes health. The Chicago Lawn Focus Group participants suggested that hospitals provide more information on nutrition and portion sizes. Additionally, they recommended that interventions must target the entire family and not just the member with diabetes. One female participant stated, “The whole family needs to be educated because if I am the only one educated and I cook a healthy meal, maybe the rest of the family will not eat it.”

**Box C.2 Causes of Diabetes and Barriers to Improving Diabetes as Identified by the Chicago Lawn Focus Group**

<table>
<thead>
<tr>
<th>Causes</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Being overweight</td>
<td>• Lack of education</td>
</tr>
<tr>
<td>• Lack of exercise</td>
<td>• Lack of money to buy healthy food</td>
</tr>
<tr>
<td>• Poor nutrition</td>
<td>• Language barriers (no bilingual staff)</td>
</tr>
<tr>
<td>• High cholesterol</td>
<td>• Apathy</td>
</tr>
<tr>
<td>• High blood pressure</td>
<td>• Failure to decide to live a healthy life</td>
</tr>
<tr>
<td>• Thyroid problems</td>
<td></td>
</tr>
<tr>
<td>• Genetics</td>
<td></td>
</tr>
<tr>
<td>• Lack of health information</td>
<td></td>
</tr>
</tbody>
</table>

**Discussion about Poor Heart Health.** The second most important health issue facing the Chicago Lawn community, as identified by the focus group participants, is poor heart health. Box C.3 lists the causes of poor heart health and the barriers to improving heart health as discussed by the focus group. In particular, the participants wanted to discuss high cholesterol/high triglycerides. Also raised were causes such as excessive alcohol consumption, not drinking enough water and drinking too much juice and soda. One female participant made her argument for taking personal responsibility to improve heart health by stating that, “If you buy a whole pack of tortillas and eat the whole pack, whose fault is it? Yours!” Others suggested letting people know they can make better food choices, with one participant using the example of switching to soy chorizo and her family “didn’t even know the difference.”

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1 All quotes translated to English from Spanish.
The participants gave several suggestions of what hospitals and health care providers can do to improve heart health that were also mentioned in the diabetes discussion. They asked for health care providers and hospitals to educate people about heart health and proper nutrition. Additionally, the participants wanted exercise classes, more medical services and an increase in the number of bilingual staff. They also suggested that hospitals should not overmedicate patients. The participants wanted the hospital and health care providers to provide incentives for improving heart health. One participant said that community members “don’t know what services the hospital has to offer” because area hospitals do a bad job informing the public about available health services.

**Discussion about Child and Adolescent Health**

This section summarizes the three questions posed to focus group participants specifically related to child and adolescent health in their community. Sixty-nine percent of the participants were caregivers of children under 18. Box C.4 outlines important health issues affecting children under 18 as identified by the participants.

In Chicago Lawn’s Hispanic community, many parents do not speak or read English. Participants felt that this, coupled with a lack of general education, leaves them with limited tools necessary to educate and provide an optimal childhood for their children. In this community, residents may fear being deported if they seek health care and/or health insurance. Many participants stated that they did not know where to apply for a medical card for “illegal kids,” and this is a big issue across the community.

The participants suggested that in order to combat these health issues and barriers, Mount Sinai should educate its staff in child and adolescent health issues and improve customer service so that community
members feel more welcome. They also requested breast feeding support groups and school-based healthy eating initiatives. One participant had used the “Under the Rainbow Program”, an outpatient mental health therapy program for adolescents that is housed on the SHS campus.

**Community Recommended Solutions: How MSH Can Improve Community Health**

From both discussions on diabetes and poor heart health, the community members agreed that nutritional education on the individual and family level is needed in order to improve the health of Chicago Lawn residents. Personal responsibility for one’s own lifestyle choices was stressed during both discussions. However, both groups wanted improvements at the hospital level in health education, providing nutrition classes, and in hiring more bilingual staff. Unlike the discussions of the Humboldt Park focus groups (see below), health care reform was not mentioned as a solution to health care issues facing the Chicago Lawn community.

Chicago Lawn is in Mount Sinai’s southernmost service area, with the vast majority of patients being of Mexican descent. Of the 13 participants, 31% stated that they had received services at MSH in the past. Other participants mentioned they do not go to MSH because of the long distance required to commute for services. One participant felt that most health services were out of their reach with “all services... [being] on the far south or north side [of the city.” They suggested having Mount Sinai clinics and services closer to their community. Others noted the long wait time for referrals, often several months. One participant noted the high quality of services from Under the Rainbow, but noted the run down look of MSH’s facilities. Additionally, diabetes programs such as the Sinai Urban Health Institute’s Block by Block program were understandably not mentioned because the residents live outside of the program’s current target areas.

One barrier missing from this focus group discussion is the lack of insurance for adults, as was discussed in the South Lawndale Spanish-speaking focus groups. Only three of the thirteen participants actually had insurance, but ten reported having a primary care doctor. Only when health issues involving children were discussed was lack of insurance mentioned (See Section 8). Immigration status and fear of deportation may prevent many of the Mexican residents of Chicago Lawn from seeking out health insurance. Health reform also does not address the health needs of undocumented people, so many will remain dependent on safety net services and charity care provided by hospitals such as MSH. Even when one becomes a legal U.S. resident, he or she must wait five years to become eligible for Medicaid and Medicare.

**Humboldt Park**

**Focus Group Characteristics**

Within Humboldt Park, two focus groups were conducted with a total sample size of 20 people (see Table C.2). The group was very diverse and represented the large Hispanic population in Humboldt Park. At the time of the 2010 Census, Hispanics/Latinos comprised about 53% of the population, 41% were Non-Hispanic Black and 4% were Non-Hispanic White. Overall, the participants were very health conscious. This could be a corollary of being affiliated with the HIV/AIDS organization that we partnered with to host both of the focus groups. The participants seemed to exhibit a higher level of health literacy than the general public and were very in tune with the needs and health problems of community residents. Additionally, it is important to note that neither of the focus groups included any of the African American community members of Humboldt Park and half of the participants identified as Lesbian, Gay, Bisexual, Transgender or Queer.
Findings

The participants voted for the top three health issues they see facing adults. Each participant had three votes (see Box C.5). Diabetes, cancer, hypertension, mental health issues, and alcohol and substance abuse were mentioned in both groups. It is important to note that some health issues such as Hepatitis C, thyroid conditions, dental issues and physical disabilities were passionately discussed but were not chosen for further discussion when asked which were the most important.

The first group selected cancer, diabetes and mental health in that order. The group unanimously agreed that obesity was a significant issue but considered it as a co-morbidity with the other top three selected. The second group selected mental health, diabetes, and HIV as their top three. It is interesting that both groups selected two of the same three top health issues: mental health and diabetes.

<table>
<thead>
<tr>
<th>Total # of participants</th>
<th>20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Group (years)</td>
<td></td>
</tr>
<tr>
<td>18-20 – 5%</td>
<td></td>
</tr>
<tr>
<td>21-30 – 60%</td>
<td></td>
</tr>
<tr>
<td>31-40 – 5%</td>
<td></td>
</tr>
<tr>
<td>41-50 – 5%</td>
<td></td>
</tr>
<tr>
<td>51-60 – 15%</td>
<td></td>
</tr>
<tr>
<td>61-70+ -10%</td>
<td></td>
</tr>
<tr>
<td>Resident of community area?</td>
<td></td>
</tr>
<tr>
<td>Yes – 75%</td>
<td></td>
</tr>
<tr>
<td>No – 25%</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female – 50%</td>
<td></td>
</tr>
<tr>
<td>Male – 40%</td>
<td></td>
</tr>
<tr>
<td>Transgender – 10%</td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Puerto Rican – 40%</td>
<td></td>
</tr>
<tr>
<td>Mexican – 20%</td>
<td></td>
</tr>
<tr>
<td>Other Hispanic/Latino– 5%</td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White – 5%</td>
<td></td>
</tr>
<tr>
<td>Asian/Pacific Islander – 5%</td>
<td></td>
</tr>
<tr>
<td>Mixed Race Ethnicity–25%</td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
</tr>
<tr>
<td>Public – 20%</td>
<td></td>
</tr>
<tr>
<td>Private – 35%</td>
<td></td>
</tr>
<tr>
<td>No Insurance – 45%</td>
<td></td>
</tr>
<tr>
<td>Have a primary care doctor?</td>
<td></td>
</tr>
<tr>
<td>Yes – 55%</td>
<td></td>
</tr>
<tr>
<td>No – 45%</td>
<td></td>
</tr>
<tr>
<td>If yes, have visited their primary care doctor within the last year?</td>
<td></td>
</tr>
<tr>
<td>Yes – 82%</td>
<td></td>
</tr>
<tr>
<td>No – 18%</td>
<td></td>
</tr>
</tbody>
</table>

Box C.5 Most Important Health Issues Identified by Humboldt Park Focus Groups

**Focus Group No. 1 (votes)**
- Cancer (7)
- Diabetes (6)
- Mental health (6)
- Obesity (8)
- Alcohol and substance abuse (3)
- Hypertension (3)
- Stress (2)

**Focus Group No. 2 (votes)**
- Mental health (7)
- Diabetes (6)
- HIV (5)
- Asthma (4)
- Cancer (1)
- Hypertension (1)
- Sexually Transmitted Infections (1)
- Alcohol and substance abuse (1)
- Heart disease (1)

Discussion about Diabetes. Box C.6 lists the causes of diabetes as discussed by focus groups 1 and 2. There were other proposed culprits such as marijuana, prescription drugs and even insulin.
Box C.6 Causes of Diabetes as Identified by Humboldt Park Focus Groups

<table>
<thead>
<tr>
<th>Focus Group No. 1 Causes</th>
<th>Focus Group No. 2 Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetics</td>
<td>Poverty and homelessness</td>
</tr>
<tr>
<td>Obesity</td>
<td>Discrimination</td>
</tr>
<tr>
<td>Lack of education</td>
<td>Bad childhood</td>
</tr>
<tr>
<td>Lack of exercise</td>
<td>Genetics</td>
</tr>
<tr>
<td>Food access (e.g., living in a food desert)</td>
<td>Judgment from peers/stigma</td>
</tr>
<tr>
<td></td>
<td>Media</td>
</tr>
<tr>
<td></td>
<td>Diets with oil and fried food</td>
</tr>
<tr>
<td></td>
<td>Substance abuse</td>
</tr>
<tr>
<td></td>
<td>Lack of resources</td>
</tr>
<tr>
<td></td>
<td>Lack of support (financial, love, and family)</td>
</tr>
<tr>
<td></td>
<td>Other health problems</td>
</tr>
<tr>
<td></td>
<td>Stress</td>
</tr>
</tbody>
</table>

Box C.7 lists barriers to improving the prevalence of diabetes in their communities. Interestingly, both groups extensively discussed the predatory role of pharmaceutical companies. A number of people felt like pharmaceutical companies control what medical supplies are available and “prey” on their community (e.g., a participant stated that nutrition is being removed from the food and people are being encouraged to take vitamin pills, which increase the profits of pharmaceutical companies). Both groups commented that healthy foods are not easily accessible, are expensive and that Humboldt Park is a food desert. One person specifically pointed out that, “It’s garbage like this [pointing to the “Sunny D” supplied as a refreshment choice] given to people in our communities”.

Box C.7 Barriers to Improving Diabetes as Identified by Humboldt Park Focus Groups

<table>
<thead>
<tr>
<th>Focus Group No. 1 Barriers</th>
<th>Focus Group No. 2 Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of access to diabetes supplies</td>
<td>Food access (food desert and cost)</td>
</tr>
<tr>
<td>No centralized diabetes treatment center</td>
<td>Lack of money</td>
</tr>
<tr>
<td>Pharmaceutical companies dictating supplies</td>
<td>Cultural diets</td>
</tr>
<tr>
<td></td>
<td>Pharmaceutical companies “preying on people”</td>
</tr>
</tbody>
</table>

“Hospitals need to become a part of the community.” Another person chimed in, “They [hospitals] need to provide more preventive care.” Others agreed and recommended that hospitals provide community exercise and culturally sensitive nutrition classes (e.g., Puerto Rican cuisine versus Mexican Cuisine), offer “pro bono work”, and increase access to diabetes supplies.

Discussion about Mental Health. Mental health issues, specifically depression and bi-polar disorder, were identified as one of the most pressing health issues facing the Humboldt Park community. Both
groups attributed the perceived high prevalence of mental health issues to traumatic experiences (e.g., abuse, discrimination, stress, troubled childhoods, neglect, etc), alcohol and drug abuse, cultural stigma, genetics and peer pressure. Diet, poverty, the media, and the lack of family support, love, and physical health were also named (See Box C.8).

The effect of the cultural stigma surrounding mental health was prominently mentioned in these 2 focus groups. Participants continually emphasized how the Latino culture does not allow someone to admit that they might be “crazy”. One participant stated that no one wants to approach people with mental health issues. Furthermore, religion was perceived to also perpetuate the stigma and may lead people to deny certain treatments. This denial could encourage people to self-medicate with alcohol and other drugs, delay getting diagnosed or treated or trying to self-diagnose. There were other barriers to improving this issue such as lack of education and insurance, apathy and a fear of being over-medicated (See Box C.9). Participants commented that physicians are too eager to give a prescription instead of exploring other methods of treatment such as counseling.

### Box C.8 Causes of Mental Health Issues as Identified by Humboldt Park Focus Groups

<table>
<thead>
<tr>
<th>Focus Group No. 1 Causes</th>
<th>Focus Group No. 2 Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetics</td>
<td>Genetics</td>
</tr>
<tr>
<td>Alcohol and drug abuse</td>
<td>Poverty</td>
</tr>
<tr>
<td>Trauma</td>
<td>Alcohol and drug abuse</td>
</tr>
<tr>
<td>Neglect</td>
<td>Lack of resources/support</td>
</tr>
<tr>
<td>Stress</td>
<td>Stigma of being diagnosed</td>
</tr>
<tr>
<td>Child abuse</td>
<td>Peer pressure</td>
</tr>
<tr>
<td></td>
<td>Discrimination</td>
</tr>
<tr>
<td></td>
<td>Diet</td>
</tr>
<tr>
<td></td>
<td>Child abuse</td>
</tr>
</tbody>
</table>

### Box C.9 Barriers to Improving Mental Health Issues as Identified by Humboldt Park Focus Groups

<table>
<thead>
<tr>
<th>Focus Group No. 1 Barriers</th>
<th>Focus Group No. 2 Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of knowledge about mental health</td>
<td>Lack of resources (money and insurance)</td>
</tr>
<tr>
<td>Lack of education</td>
<td>Stigma (cultural and religious beliefs)</td>
</tr>
<tr>
<td>Cultural stigma</td>
<td>Denial of diagnosis</td>
</tr>
<tr>
<td>Fear of people with mental health issues</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>Apathy</td>
<td>Low literacy level</td>
</tr>
<tr>
<td>Fear of children being over-medicated</td>
<td>Lack of culturally sensitive providers</td>
</tr>
<tr>
<td></td>
<td>Lack of education</td>
</tr>
</tbody>
</table>

### Discussion about Child and Adolescent Health

This section summarizes the three questions that were asked to focus group participants specifically related to child and adolescent health in their community. It should be noted that the child/adolescent questions in the focus group guide were not specifically asked to the Humboldt Park focus groups. However the issue of child/adolescent health was discussed. Thus, we were able to obtain some of the answers to these same questions, although limited in comparison to the other communities.
The most important health issues raised affecting children and adolescents were sexually transmitted infections (particularly HIV), diabetes and mental health. The groups identified distrust of physicians, lack of parenting skills and parent education as challenges faced by caregivers of children under 18 in Humboldt Park. Participants felt that when one has a medical card for a child, he or she is often assigned a doctor that he/she does not know and like, making it hard to build trust.

To improve child and adolescent health, the participants wanted parenting classes for caregivers that would help remove the stigma of certain health conditions and in turn encourage parents to seek help when needed. Hospitals such as Mount Sinai should partner with community schools to get more accurate information to children. Michelle Obama’s school initiative “Let’s Move!” was mentioned as an example.

Community Recommended Solutions: How MSH Can Improve Community Health

These suggestions were sometimes quite philosophically based and from a macro-systemic viewpoint. For example, one participant stated, “Health care needs to be free! Socialized medicine!” Another participant exclaimed, “Why do I need to pay for something bad that happened to me, like a gun shot? It wasn’t my fault.” Overall, participants wanted health services that were free or more affordable or to have public insurance cover more behavioral health services. In addition, participants suggested that Medicaid should be provided based on “need and not how many children you have.” One participant noted that she makes “too much money for public insurance and can’t afford private insurance through work.” Pharmaceutical companies were blamed for incentivizing doctors to overmedicate patients. One participant suggested that the only way to overcome stigma was to begin to teach children at a young age about health issues so that it is less taboo and they will become less apathetic as adults.

In respect to the broad definition of health, participants presented other ways that the hospital could improve the health of the community. MSH should not ask questions regarding immigration status. They should also not reject care for someone because he or she is undocumented. The participants urged that MSH doctors be more transparent and willing to interact with the community. They wanted cultural sensitivity training for the staff and clinicians of MSH because all Latinos are not culturally the same. Staff should understand the difference between Puerto Rican and Mexican culture (i.e. cuisine, language, etc.) and have competent translators available. Participants wanted more primary care clinics because many uninsured persons use the emergency room as their primary care clinic. The residents mentioned that timely follow-up after a diagnosis of diabetes, mental illness or other serious health condition should be standard. This would include appointments being scheduled within a few weeks versus months away, plus education and social support resources.

Insurance obstacles were repeatedly mentioned in both groups. The participants were split down the middle, with about half being insured. Most of the insured had public insurance and the remainder had private insurance. From the start, the limited coverage provided by Medicaid and Medicare were stated as obstacles in obtaining timely appointments, securing diabetes supplies and mental health services. Many of the uninsured felt that the enrollment guidelines of Medicaid were too restricted, and those with Medicaid thought that they had little to no option to choose the doctor that they wanted. It is interesting to note that many of the uninsured participants saw any type of insurance as a cure all to their health needs. Insured participants, both publicly and privately, refuted this claim and described similar restrictions and obstacles with HMOs. One participant with insurance removed her own stitches because she could not get a timely appointment. Another participant described how her brother had a heart attack and had to wait a month to see an in-network cardiologist, and that he had to visit the
emergency room a second time while waiting to be seen by a doctor. It should be noted that some of the community services that the participants wanted from MSH were already available. This demonstrates the need for a better marketing strategy for MSH services. For example, one person recommended rapid HIV testing in the Emergency Room; MSH already provides quick tests. SHS and ACCESS do not deny care for undocumented patients and instead provide them with sliding scale fees for primary care services and charity care for specialists and hospital services. Also, participants wanted culturally sensitive cooking classes which are already available at the Diabetes Empowerment Center, located on the same block where we held the focus groups. Additionally, they mentioned affordable exercise classes and safe spaces to work out, which are also provided at the Diabetes Empowerment Center. Both groups mentioned asthma but no one mentioned any of Sinai’s long standing asthma programs. It is important to note that although participants were asked throughout the focus group specifically what could Sinai do to improve services, respondents did not feel that Humboldt Park was Sinai’s responsibility. One participant remarked that Sinai is not a part of this community. Others chimed in that other hospitals such as St. Mary’s and Norwegian American Hospital should be more engaged because they are inside of the community.

North Lawndale
Focus Group Characteristics

Within North Lawndale, two focus groups were conducted with a total sample size of 15 people (see Table C.3). The participants were predominately African American, which is representative of the North Lawndale community. In addition, most of the participants were female, had some form of health insurance and had visited a primary care doctor in the last year. This is probably largely due to the fact that many of the participants were involved in one of the Sinai Community Institute programs such as Women, Infants and Children (WIC) and the teenage parenting program. Both of the focus groups were challenging for the facilitator for different reasons. In the first focus group, there were three men who were living at a drug treatment center. Two of the three gentlemen were extremely gregarious and spoke very passionately about their opinions. They seemed eager to debate and not listen to others and had a

<table>
<thead>
<tr>
<th>Total number of participants</th>
<th>15</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>18-20 – 13%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21-30 – 13%</td>
</tr>
<tr>
<td></td>
<td>31-40 – 7%</td>
</tr>
<tr>
<td></td>
<td>41-50 – 27%</td>
</tr>
<tr>
<td></td>
<td>51-60 – 33%</td>
</tr>
<tr>
<td></td>
<td>No Answer: 7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resident of community area?</th>
<th>Yes – 80%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No – 13%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Female – 80%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male – 20%</td>
</tr>
<tr>
<td></td>
<td>No Answer: 7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Black – 93%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Black &amp; White – 7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Caregiver of a child under 18 years?</th>
<th>Yes – 33%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No – 60%</td>
</tr>
<tr>
<td></td>
<td>No Answer: 7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insurance</th>
<th>Public – 40%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Private – 27%</td>
</tr>
<tr>
<td></td>
<td>None – 27%</td>
</tr>
<tr>
<td></td>
<td>No Answer: 7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have a primary care doctor?</th>
<th>Yes – 80%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No – 13%</td>
</tr>
<tr>
<td></td>
<td>No Answer: 7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes, have visited their primary care doctor in the last year?</th>
<th>Yes – 100%</th>
</tr>
</thead>
</table>
Findings

Participants were asked to identify the most important health issues affecting them and their community; each had three votes. (See Box C.10) The first focus group chose high blood pressure/hypertension, HIV/AIDS, and heart disease as main concerns. One participant was outraged that the church does not talk about HIV/AIDS enough and another participant retorted, “It’s because it is a sin to talk about HIV/AIDS in the church”. There were other health issues that stimulated lively discussion such as obesity, cancer, respiratory diseases, and rodent infestations. One lady commented that North Lawndale is one of the only communities where you will see the garbage cans empty and trash on the ground.

Obesity and cancer were selected as the top two health issues of the second North Lawndale focus group. There was a four way tie among asthma, diabetes, epilepsy, and HIV/STDs for the third most pressing issue, and after the group voted, asthma was chosen. Below you will find further discussion of the community’s assessment of the causes of these health issues, barriers to improving health, and how a hospital can meaningfully impact North Lawndale’s health.

Discussion about High Blood Pressure and Heart Disease.

When asked about the causes of high blood pressure/hypertension and heart disease, participants from the first focus group agreed on factors such as diet, genetics, obesity, lack of exercise and stress. However, when one person

<table>
<thead>
<tr>
<th>Focus Group No.1 (votes)</th>
<th>Focus Group No. 2 (votes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High blood pressure (7)</td>
<td>Obesity (4)</td>
</tr>
<tr>
<td>HIV/AIDS (6)</td>
<td>Cancer (4)</td>
</tr>
<tr>
<td>Heart disease (6)</td>
<td>Asthma (3)</td>
</tr>
<tr>
<td>Obesity (5)</td>
<td>Diabetes (3)</td>
</tr>
<tr>
<td>Cancer (4)</td>
<td>Epilepsy (3)</td>
</tr>
<tr>
<td>Respiratory diseases</td>
<td>STDs/HIV/AIDS (3)</td>
</tr>
<tr>
<td>(Asthma) (3)</td>
<td>High blood pressure (2)</td>
</tr>
<tr>
<td>Depression (1)</td>
<td>Dental (1)</td>
</tr>
<tr>
<td>Drug use (1)</td>
<td></td>
</tr>
<tr>
<td>Rodent infestation (1)</td>
<td></td>
</tr>
<tr>
<td>Infant mortality (1)</td>
<td></td>
</tr>
<tr>
<td>Sickle cell (1)</td>
<td></td>
</tr>
<tr>
<td>Hygiene (1)</td>
<td></td>
</tr>
</tbody>
</table>

Box C.11 Causes of High Blood Pressure and Heart Disease as Identified by North Lawndale Focus Group No. 1

- Diet (e.g., fried food)
- Obesity
- Genetics
- Lack of exercise
- Smoking
- Stress
- Clogged arteries
- High cholesterol
- Drug use
- Drinking
suggested drug use, another participant strongly disagreed and admitted that he had used all kinds of illicit drugs since the fifth grade and he was fine. See Box C.11 for the other causes mentioned.

Overall, the participants agreed that lack of knowledge and application of knowledge, food deserts and limited resources hindered the community’s health. One participant stated that, “So many resources have been taken from the west side and are not put back in – the city government steals money and resources from us; it is a cycle”. Another participant added that it is cheaper and more convenient to eat unhealthy food. Others mentioned the lack of quality produce stores within walking distance. Several participants said that crime makes seniors afraid to go outside. One man that has lived on the west side and in North Lawndale all his life said, “I hate this community – it is like walking through a twilight zone and it is done to us on purpose....” See Box C.12 for the other barriers mentioned.

<table>
<thead>
<tr>
<th>Box C.12 Barriers to Improving High Blood Pressure and Heart Disease as Identified by North Lawndale Focus Group No. 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Food deserts</td>
</tr>
<tr>
<td>- Do not get blood pressure checked frequently enough</td>
</tr>
<tr>
<td>- Lack of discipline and will power</td>
</tr>
<tr>
<td>- Lack of knowledge</td>
</tr>
<tr>
<td>- People do not apply knowledge</td>
</tr>
<tr>
<td>- Crime keeps seniors from going out to get services</td>
</tr>
<tr>
<td>- Lack of education and low literacy</td>
</tr>
<tr>
<td>- No money to purchase medicine</td>
</tr>
<tr>
<td>- Lack of resources</td>
</tr>
<tr>
<td>- Cheaper to eat unhealthy food</td>
</tr>
<tr>
<td>- Quality of living is different now</td>
</tr>
</tbody>
</table>

Discussion about HIV/AIDS. In the first focus group, the second most pressing problem was HIV/AIDS. Box C.13 presents the causes of HIV/AIDS discussed by the participants. The group stated that blood transfusions, rape, promiscuity, lack of knowledge and drug use contributed to people acquiring HIV/AIDS. One man declared that, “I have done illegal drugs my whole life since I was in the fifth grade, and it is a choice. It does not cause HIV/AIDS unless you are lazy and careless – I am sick of people giving drugs so much credit.”

<table>
<thead>
<tr>
<th>Box C.13 Causes of HIV/AIDS and Barriers to Improving HIV/AIDS as Identified by NL Focus Group No. 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Causes</strong></td>
</tr>
<tr>
<td>- Lack of knowledge and education</td>
</tr>
<tr>
<td>- Drugs</td>
</tr>
<tr>
<td>- Promiscuity</td>
</tr>
<tr>
<td>- Rape</td>
</tr>
<tr>
<td>- Transmission from parents</td>
</tr>
<tr>
<td>- Blood transfusions</td>
</tr>
<tr>
<td><strong>Barriers</strong></td>
</tr>
<tr>
<td>- Shame and stigma</td>
</tr>
<tr>
<td>- Fear</td>
</tr>
<tr>
<td>- Lack of knowledge</td>
</tr>
<tr>
<td>- Lack of resources (e.g. medications and preventative medicine)</td>
</tr>
</tbody>
</table>

When the first focus group was asked about barriers to improving HIV/AIDS in their community, they gave responses that are listed in Box C.13. The group spent an extensive time discussing the lack of knowledge, resources and stigma surrounding being HIV positive. When talking about resources, the group all knew about the CORE center, a county run infectious disease center.
However, one participant added, “People don’t want to walk into the CORE center because everyone knows what you are there for and what you are doing.”

**Discussion about Obesity.** When Focus Group No.2 was asked about the causes of obesity, their chosen most primary health issue, they all agreed on only one thing: fast food and junk food, such as Cheetos® Flamin’ Hot. Participants noted that it is expensive to eat healthy food, and that there are few healthy foods offered in area restaurants. Lack of exercise was noted as contributing factor to obesity; participants mentioned there are not enough activities for kids and many stay indoors.

**Community Recommended Solutions: How MSH Can Improve Community Health**

Both groups recommended that Mount Sinai should be more active in the community and host events like the walk/run. They should also provide more health information in different ways (e.g., classes, brochures, health alert flyers that could be handed out at doctors’ visits or door to door, etc). Participants felt that Mount Sinai should educate the community, as well as provide better quality wellness checks. One participant stated that, “They used to do this [comprehensive wellness checks] every time you would go to the doctor or hospital and now they don’t, so people don’t know what else is going on with them until it gets bad.” Some participants in the first focus group believed that Mount Sinai should offer free health care and also free exercise classes. Others were okay with paying for services but they wanted the medications to be more affordable and for the hospital to offer healthier foods.

The second focus group participants wanted Mount Sinai to play a greater advocacy role in removing unhealthy restaurants that sell only greasy food in the community. There was also dissension regarding whether Mount Sinai should advocate that junk food be excluded from Link card purchases. One participant admitted that she gets too many food stamps. She said that there is no way that she can spend the $700 that she is allotted every month for just her and her three small children. She said that she wastes a lot of money. Lastly, both groups recommended that the hospital staff and physicians be trained to respect cultural differences and help people feel more comfortable at the hospital.

<table>
<thead>
<tr>
<th>Table C.4 Demographic Characteristics for South Lawndale Focus Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total # of participants</strong></td>
</tr>
<tr>
<td><strong>Age Group (years)</strong></td>
</tr>
<tr>
<td>21-30</td>
</tr>
<tr>
<td>31-40</td>
</tr>
<tr>
<td>41-50</td>
</tr>
<tr>
<td>51-60</td>
</tr>
<tr>
<td><strong>Resident of community area?</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
</tr>
<tr>
<td>Mexican</td>
</tr>
<tr>
<td>Mexican &amp; Other Latino</td>
</tr>
<tr>
<td>Other Latino</td>
</tr>
<tr>
<td><strong>Caregiver of child under 18 years?</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>No Response</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
</tr>
<tr>
<td>Public</td>
</tr>
<tr>
<td>No Insurance</td>
</tr>
<tr>
<td>No Response</td>
</tr>
<tr>
<td><strong>Have a primary care doctor?</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td><strong>If yes, have visited their primary care doctor within the last year?</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>
South Lawndale
Focus Group Characteristics

Within South Lawndale (SL), two focus groups were conducted with a total sample size of 18 people. Both focus groups took place at Our Lady of Guadalupe Anglican Church, on 26th St. in the heart of the SL neighborhood. The majority self-identified as Mexican, which reflects the 2010 census data indicating that 83% of SL residents are Hispanic. Everyone that participated was either a member of the church or received ESL classes at the church. It is important to note that many of the participants had either recently immigrated to the U.S. or had not been here long; thus, they had some difficulty offering solutions to many of the issues related to the health care system. However, they were very passionate about the health-related issues currently affecting their community.

Fifty percent of participants were caregivers for a child 18 years old or younger and sixty-seven percent reported having no health insurance.

Participants were asked to select the top three health issues in their community. (See Box C.14 for the full list.) The first group selected domestic violence, cancer and diabetes, in that order. Diabetes and sexually transmitted infections were tied for making it into the top three and the group unanimously decided that diabetes was a more pressing issue for discussion. The second group chose cancer, diabetes, and high cholesterol as the most pressing issues even though several other health issues were tied for second place. It is interesting that cancer and diabetes were both in the two groups’ top three health conditions. Domestic violence was selected as the most pressing condition by all but one person in the first group, but was not even mentioned as an overall important health issue by the second group.

Discussion about Domestic Violence. As stated above, all but one participant in focus group number one voted domestic violence as the most pressing health condition in the South Lawndale community.
In terms of what causes domestic violence (see Box C.15), the group spoke very passionately about the disorder in families. To further describe this, they mentioned lack of communication between family members resulting in arguments and stated that “this is routine.” A few participants expressed that families live in the same household but do not make an effort to share their experiences, thoughts and feelings with one another. Instead, everyone just “does their own thing now-a-days.” The topic of “Machismo” in the Latino community was also mentioned as a cause of domestic violence, particularly related to the issue of cheating. One woman also expressed that drugs and alcohol are related to the issue of domestic violence. Lastly, stress and aggravation, especially for working families, was expressed as a cause.

Barriers to improving the issue of domestic violence mentioned by this group are also listed in Box C.15. The group expressed that people have a lot of trouble identifying that there is a problem, figuring out where the problem stems from, and then asking for help. The women stated that it is particularly difficult for men who are “Machismo” due to the wide-spread stigma in their community about seeking help.

**Discussion about Diabetes.**

When discussing what causes diabetes both focus groups mentioned heredity and genes as one of the major causes. See Box C.16 for other causes. One man pointed out that, “Someone may know that they or one of their family members has diabetes, but excuses such as no time and no desire keep them from getting help or attending a cooking class or seminar.” In regard to healthy foods and diet/lifestyle, one woman said, “We come from our countries, in my case Mexico, where the food is fresh with no preservatives, but once we come here we are bombarded with quick, inexpensive and at times cheaper food.”

<table>
<thead>
<tr>
<th>Box C.15 Causes of Domestic Violence and Barriers to Decreasing or Preventing Domestic Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Causes</strong></td>
</tr>
<tr>
<td>Disorder in families</td>
</tr>
<tr>
<td>“Machismo”</td>
</tr>
<tr>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>Stress/aggravation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Box C.16 Causes of Diabetes as Identified by South Lawndale Focus Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus Group No. 1 Causes</strong></td>
</tr>
<tr>
<td>Heredity/genes</td>
</tr>
<tr>
<td>Bad diet (i.e. large portions, junk food)</td>
</tr>
<tr>
<td>Eating out</td>
</tr>
<tr>
<td>Lack of education on healthy diets and cooking</td>
</tr>
<tr>
<td>Lack of prevention efforts</td>
</tr>
</tbody>
</table>
When asked what the barriers are to improving diabetes in their community a few overlapped with identified causes (see Box C.17). One participant stated, “People eat fast because they have to go to work.”

**Box C.17 Barriers to Improving Diabetes as Identified by South Lawndale Focus Groups**

<table>
<thead>
<tr>
<th>Focus Group No. 1 Causes</th>
<th>Focus Group No. 2 Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of education (lack of information in Spanish)</td>
<td>Busy lifestyle</td>
</tr>
<tr>
<td>Lack of medical services in Spanish</td>
<td>Availability of junk food</td>
</tr>
<tr>
<td></td>
<td>Lack of sports for youth</td>
</tr>
<tr>
<td></td>
<td>People not cooking at home</td>
</tr>
</tbody>
</table>

**Discussion about Cancer.** See Box C. 18 for causes identified by both focus groups in South Lawndale.

When asked about the barriers to improving the prevalence of cancer in their communities (see Box C.19), both groups stressed the inability to pay for medical services. One man spoke very passionately about minorities specifically being unable to pay, saying, “As minorities our incomes may or may not increase by a few cents but everything else around us increases in dollar amount; how can we pay to treat or seek medical attention when our incomes are simply not there….it is simply ridiculous.” A woman in the group followed up on this comment, saying that many women in SL, including herself, do not get mammograms or pap smears due to the high costs. One group member spoke of having to choose between priorities when it comes to money, stating that people choose to pay their bills and household expenses over seeking medical attention when they need it. Group one strongly expressed their feeling that working odd shifts (late night, early morning, etc.) make it difficult to seek proper medical treatment.

**Box C.18 Causes of Cancer as Identified by South Lawndale Focus Groups**

<table>
<thead>
<tr>
<th>Focus Group No. 1 Causes</th>
<th>Focus Group No. 2 Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>Exposure to the sun</td>
</tr>
<tr>
<td>Heredity/genetics</td>
<td>Lack of prevention (i.e., regular check-ups)</td>
</tr>
<tr>
<td>Bad diet (e.g., large portions, fast food)</td>
<td>Heredity/genetics</td>
</tr>
<tr>
<td>Lack of prevention (i.e., regular check-ups)</td>
<td>Smoking</td>
</tr>
<tr>
<td></td>
<td>Smog from factories and the airport</td>
</tr>
</tbody>
</table>

**Community Recommended Solutions: How MSH Can Improve Community Health**

The participants gave some suggestions of what community hospitals can do to improve both the treatment and prevention of cancer in the community, however as stated above, found it difficult to elaborate on these proposed solutions. Overall, the main suggestions involved increasing the community’s access to medical care and insurance, as well as reducing medical costs. Group one felt very strongly that hospitals should work more closely with individuals seeking medical attention in order to improve benefits and lower prices, maybe providing sliding scale fees, for the services they receive. A few participants suggested that hospitals create medical coupon programs that would provide discounts for certain services. One woman stated, “If I were to get a flyer from Sinai promoting great discounts for a medical test, I would definitely consider making an appointment.”
Box C.19 Barriers to Preventing and Treating Cancer as Identified by South Lawndale Focus Groups

Focus Group No. 1 Barriers
- Lack of facilities for treatment
- Income (not enough money to seek services)
- Working odd shifts (late night, early morning) makes it hard to get to the doctor

Focus Group No. 2 Barriers
- Lack of medical insurance
- Lack of education and information on cancer
- Lack of medical services in Spanish
- Fear of diagnosis
- Fear among undocumented to seek services
- Lack of time to attend appointments or get screenings

Participants offered several suggestions for what a hospital can do to improve the health of children and adolescents in the South Lawndale community. One major suggestion by both groups was increasing the hospital’s involvement in the schools, as a great way to disseminate accurate health information to children. In addition, the group stressed that they would like to see the hospitals involve their “neighbors” (community members) in hospital decision making processes and programs in order to make people feel more welcome at the hospital. Other suggestions included asking doctors to do a better job of explaining to parents what is going on with their health and making greater efforts in the area of prevention via increased information on support groups, community programs, and health conditions. One man also voiced the importance of family planning, saying, “If you cannot afford to have many children then plan accordingly as they need time and cost money. Hospitals should help more with this process.”
Box C.21 Challenges to Raising a Healthy Child/Adolescent as Identified by South Lawndale Focus Groups

- Parents have difficult work schedules
- Internet as a questionable source of education for children
- Parents buy their children things to make up for quality time

Community Recommended Solutions: How can MSH improve Community Health

For South Lawndale, the underlying themes of both groups’ responses to questions about the health of their community were:

- Lack of money
- Lack of education and accurate health information
- Lack of knowledge of and access to services in Spanish

The main suggestion from both Focus Groups was for the hospital to conduct a more widespread distribution of health information in Spanish. One group specifically stated that more information should be provided on site in factories, because many people (especially men) in their communities work in factories and spend most of their time there. Another main suggestion that was continually mentioned was for Sinai to offer more accessible education classes both on-site at the hospital and in the South Lawndale community. Specific examples of classes included nutrition, asthma, diabetes, parenting, and exercise classes. Domestic violence and mental health support/awareness groups were also suggested, in addition to making services for these conditions more available.

Eight of the eighteen participants stated that they had received services at MSH. Of these both positive and negative experiences were shared. Three women who gave birth to children at Sinai expressed having a good experience and receiving quality care. However, those who have been to Sinai’s ER report long wait times and high costs in comparison to other hospitals. One man shared that he once waited for a very long time in the ER, and when he finally saw a doctor he was prescribed Tylenol, sent home and shortly after received a bill for $400. The groups suggested that Sinai improve customer service to make patients feel more welcome and offer discounts for medical services. When asked if they were familiar with Sinai Health System programs, including SUHI’s community-based programs, they were not aware of any. This was surprising as they are so closely located to MSH and South Lawndale is a main service area of MSH.

It should be noted that some of the community services that the participants suggested that SHS offer are already available. Focus group facilitators took the opportunity to inform the group of some of SUHI’s community-based programs, “Helping Her Live” in particular as many women expressed not having had mammograms due to the high cost. The women in the group reiterated that they had not heard of this program, but were very grateful to now know about it. One example of the lack of knowledge of services, as stated above, is the participants who wanted MSH to work with patients individually to arrange sliding scale fees for those that are in need of financial assistance. SHS and ACCESS do not deny care for undocumented patients and do provide them with sliding scale fees for primary care services and charity care for specialists and hospital services. The most important thing to note about this is, as has been repeated, the lack of knowledge about available services.