Holy Cross Hospital
2019 Community Health Needs Assessment

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One with Our Communities

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

SHS is a safety net health care system on Chicago’s West and Southwest Sides that provides services to all, regardless of insurance or citizenship status. Our hospitals – Mount Sinai Hospital (MSH), Sinai Children’s Hospital (within MSH), Holy Cross Hospital, and Schwab Rehabilitation – as well as our system entities, Sinai Medical Group, Sinai Community Institute, and Sinai Urban Health Institute – are committed to improving the health of the individuals and communities that we serve.

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

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

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

When we treat the whole person, we not only consider their physical wellness and absence of disease, but also their psychological, social, and spiritual wellbeing. When we provide care across the whole lifespan, we consider unique approaches to addressing health issues from
From infancy to adolescence to middle age to seniorhood. Underlying these efforts is our commitment to working with residents and local partners to build whole communities — to find innovative and multi-faceted solutions that end community violence, to ensure that affordable and nutritious food is accessible to all, to dismantle unjust policies that disproportionately incarcerate fathers, brothers, and sons.

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

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

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

Karen Teitelbaum
President and Chief Executive Officer of Sinai Health System
Sinai Health System

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

Mission, Vision, and Values

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

Mission

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

Vision

Sinai Health System will become the national model for the delivery of urban health care.

Values

Respect – We will create an atmosphere of mutual respect and fairness, treating each person with dignity that recognizes each individual’s unique talents and contributions.

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

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

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

Safety – We will foster an environment that focuses on protecting our patients, visitors, and caregivers from harm or injury.
Sinai Health System Member Institutions

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

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

❖ Mount Sinai Hospital

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

❖ Holy Cross Hospital

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

❖ Schwab Rehabilitation

Located on Chicago’s West Side, Schwab provides comprehensive inpatient and outpatient rehabilitation services to adults and children and is one of only two free-standing rehabilitation hospitals in Chicago. Schwab offers a unique environment that features 102 licensed beds, 7 treatment gyms with state-of-the-art equipment, and an award-winning therapeutic rooftop garden. Schwab maintains community affiliations with the University of Chicago Pritzker School of Medicine and the University of Illinois. In 2017, Schwab was ranked 11 of 84 hospitals for its residency program in physical medicine and rehabilitation by Doximity (an online professional network for U.S. physicians). It is accredited by the Joint Commission, with its teaching program accredited by the Accreditation Council for Graduate School Medicine.
Patient services include: general rehabilitation, kids rehabilitation, orthotics and prosthetics, pain management, spinal cord injury, stroke, and a sub-acute care center. Levels of care include: inpatient acute rehabilitation, sub-acute rehabilitation, and specialized physician clinics and therapy services.

**Sinai Children’s Hospital**

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

**Sinai Community Institute**

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

**Sinai Medical Group**

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

**Sinai Urban Health Institute**

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

**Holy Cross Hospital Community Benefits**

In 2018, HCH provided $13.0 million in community benefits, including charity care (free care based on family size, income, and other criteria), community health services, language assistance, donations, coverage for bad debts, and volunteer services. Charity care comprised $10.0 million of total community benefits. These benefits provide support to community programs and initiatives that improve overall community health.
Alliance for Health Equity

The Alliance for Health Equity (Alliance) is a collaboration of 37 hospitals, 3 health departments, and community-based organizations working to improve health equity, wellness, and quality of life across 77 Chicago community areas and 125 Cook County suburban municipalities. The Illinois Public Health Institute (IPHI) serves as the Alliance’s backbone organization. The purpose of the Alliance is to improve population and community health by: 1) promoting health equity; 2) supporting capacity building, shared learning, and connecting local initiatives; 3) addressing social and structural determinants of health; 4) developing broad city- and county-wide initiatives and creating systems; 5) engaging community partners and working collaboratively with community leaders; 6) developing data systems to support shared impact measurement and community assessment; and 7) collaborating on population health policy and advocacy.

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

Alliance for Health Equity Structure and Shared Leadership

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

Collaborative Assessment Model and Process

The Alliance worked with its Steering and CHNA Committees to design and facilitate a collaborative, community-engaged CHNA between March 2018 and March 2019. Engagement from community members across diverse social and economic backgrounds and multi-sector community-based organizations was prioritized as a crucial aspect of the assessment and implementation processes. Details regarding the Alliance’s approach are outlined in the Alliance Collaborative CHNA Report located at [allhealthequity.org/2019-chna-reports/](http://allhealthequity.org/2019-chna-reports/). In short, the Alliance adapted the Mobilizing for Action through Planning and Partnerships framework.
**CHNA Methodology**

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

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

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

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

**Holy Cross Hospital CHNA Methodology**

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

**SHS CHNA Oversight**

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

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

In addition, we convened three Hospital CHNA Committees (one each for HCH, Mount Sinai Hospital, and Schwab Rehabilitation) to provide specific guidance on the development of...
hospital priorities. The Hospital CHNA Committees each convened once during the development of the CHNA and reviewed and ranked health needs by priority for each hospital using a multi-voting approach. The committees included about 10 caregivers (i.e., staff members), with at least one hospital representative who leads community engagement efforts.

HCH’s CHNA Committee representatives included: Raquel Prendkowski, System Director of the Emergency Department; Mark Brow, Registered Nurse; Mireya Vera, Director of Community and Patient Relations; Gregory Horeni, Manager of Nursing Education; Sameer Shah, Director of Pharmacy; Luis Marquez, Director of Imaging Services; Maria Carrillo, Social Work Associate/Case Management; Gabrielle Zoldan, RD, Nutrition Services/Diabetes Educator; and Claude Hall, Director of Grants and Strategy.

Health Need Identification and Prioritization

We identified a comprehensive list of health needs for HCH’s service area by aligning priority health needs from the 2019 Alliance Collaborative CHNA Report with findings from HCH’s 2016 CHNA report. The process for identifying priority health needs in the 2019 Alliance CHNA is outlined at allhealththequity.org/2019-chna-reports/.

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

Gaps in Data Collection and Challenges

Although we gathered extensive data and input from the communities we serve, there are some limitations and challenges to consider. First, there is often a lag in population health data availability, such as individual poverty rates. Therefore, many data within this report represent timeframes prior to 2019. In addition, we used data available at various geographic levels (e.g., census tract, zip code, community area). Doing so may make it difficult to compare indicators representing different geographic levels. Lastly, while the Alliance conducted various activities focused on collecting primary data from community members, it is important to note that qualitative data only reflects the viewpoints of those community members who attended and participated in community input surveys and focus groups.
Holy Cross Hospital Progress Since 2016

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

**Chronic Disease (including diabetes, hypertension, and asthma)**

**Asthma CarePartners**

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

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

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

**Chicago Quits**

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

**Controlling Hyperglycemia Among Minority Patients**

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

**Development and Pilot of Complex Care Model**
- In 2018, SUHI began an intervention for patients with complex medical and social needs, focusing on patients with multiple chronic health conditions. In the program, each patient is paired with a community health worker (CHW) who helps link them to appropriate health care services and connect them to programs and services that address social needs like housing, food access, and employment.

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

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

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

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

Helping Her Live

- Helping Her Live (HHL) is a breast health program for women living on Chicago’s West and Southwest sides that provides breast health education and assistance in obtaining screening mammograms and diagnostic follow-up services. In addition to regularly navigating women from HCH’s service area to mammography services, in 2018, HHL CHWs provided appointment reminder calls to HCH mammography patients and attended mammography clinic days to provide in-person patient education and support.

Mental and Behavioral Health

Cook County Health and Hospital System Behavioral Health Consortium

- In 2018, SHS joined the Cook County Health and Hospital System (CCHHS) Behavioral Health Consortium (BHC), a group of behavioral health and substance use treatment providers across Cook County. The BHC allows around-the-clock access to a single point of contact for behavioral health and substance use services. After completing intake, patients can be scheduled to receive services at SHS or another BHC site. SHS social workers and case managers also have referral relationships through the BHC that give patients access to behavioral health and substance use services outside SHS.

Crisis Stabilization Unit

- The HCH Crisis Stabilization Unit (CSU) is the first hospital-based crisis triage and stabilization program of its kind in Illinois. In the CSU, patients are stabilized and de-escalated before they continue to the next level of care – whether it is admission to inpatient or outpatient care or discharge home. Over 3500 patients have been treated in the CSU since it opened in 2015 and 70% of patients are discharged home or to lower levels of care within 24 hours, as opposed to being admitted for inpatient psychiatric care. A new unit expansion is due to open in summer 2019.

Medical Legal Partnership

- The SHS Under the Rainbow clinic provides outpatient behavioral health services for children and adolescents, including therapy, psychiatry, and case management. In early 2016, Legal Council for Health Justice partnered with Under the Rainbow to provide in-clinic legal services to families and children through the Medical Legal Partnership (MLP). Many MLP clients have experienced trauma as the result of a crime. Through the MLP, a lawyer is regularly available in the clinic (2.5 days/week) to consult with clinicians and clients and to determine the best legal course of action.

Transition of Care

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

Violence

Chicago Gun Violence Research Collaborative

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

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

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

Overarching Community Health Improvement

West Side United

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

Service Area

Holy Cross Hospital (HCH) is dedicated to providing care to all individuals, across all stages of life, living in socially and economically diverse communities on Chicago’s Southwest side. HCH’s service area is defined as the largest 75% catchment area for all inpatient hospital discharges. Based on this definition, HCH’s service area comprises seven zip codes and 14 Chicago community areas (Figure 2). Figure 3 shows HCH’s service area.

Figure 2. Holy Cross Hospital service area zip codes and associated community areas

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Community Area(s)</th>
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<tbody>
<tr>
<td>60609</td>
<td>McKinley Park, New City, Fuller Park</td>
</tr>
<tr>
<td>60620</td>
<td>Auburn Gresham, Washington Heights</td>
</tr>
<tr>
<td>60621</td>
<td>Englewood</td>
</tr>
<tr>
<td>60629</td>
<td>Chicago Lawn, West Elsdon, West Lawn</td>
</tr>
<tr>
<td>60632</td>
<td>Archer Heights, Brighton Park, Gage Park</td>
</tr>
<tr>
<td>60636</td>
<td>West Englewood</td>
</tr>
<tr>
<td>60652</td>
<td>Ashburn</td>
</tr>
</tbody>
</table>
Figure 3. Holy Cross Hospital service area, by community area

Service Area Boundary

SHS Hospitals:
Holy Cross (H)
Mount Sinai (M)
Schwab Rehabilitation (S)

<table>
<thead>
<tr>
<th>Community Area Number</th>
<th>Community Area</th>
<th>Community Area Number</th>
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<td>37</td>
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<td>Ashburn</td>
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<td>West Elsdon</td>
<td>71</td>
<td>Auburn Gresham</td>
</tr>
<tr>
<td>63</td>
<td>Gage Park</td>
<td>73</td>
<td>Washington Heights</td>
</tr>
</tbody>
</table>
**Demographics**

HCH serves a diverse population of over 430,000 people, 16% of Chicago’s total population. Importantly, HCH provides care to an area of Chicago experiencing an overall population decrease, particularly among Non-Hispanic Black residents. Today, over 70% of the population in all 14 community areas in HCH’s service area identify as people of color (Non-Hispanic Black, Hispanic/Latinx, and/or Non-Hispanic Asian/Pacific Islander). Of these 14 community areas, five are predominantly Non-Hispanic Black and five are predominantly Hispanic/Latinx (Figure 4). The proportion of foreign-born individuals in eight of HCH’s community areas is greater than that of the city (21%), which underlines the importance of HCH addressing the unique needs of this group in health improvement planning. Additionally, 28% of the population in HCH’s service area is under the age of 18 and 11% is over the age of 65.

![Figure 4. Race and ethnicity in Holy Cross Hospital’s service area, by community area](image)

Each community’s most common racial/ethnic group. If a race/ethnicity makes up 70% or more of a community, the community is shaded in a darker color.

Source: 2016, American Community Survey 5-Year Estimates
Overall Health

The populations served by HCH reveal substantial disparities in life expectancy and overall health. Life expectancy at birth, in years, ranges from 67 (Fuller Park) to 81 (Gage Park), compared to 77 in Chicago (Figure 5). Further, the proportion of residents reporting good, very good, or excellent overall health was lower in eight HCH community areas than in Chicago as a whole (2015-17).

Figure 5. Life expectancy in Holy Cross Hospital’s service area, by community area
Average life expectancy at birth in years.

Source: 2016, Illinois Department of Public Health, Division of Vital Records
Community Health Needs and Priorities

2019 Community Health Priorities

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

- **Social Determinants of Health:** Social determinants include a broad range of factors that are not traditionally considered “health-related,” but are critically important to achieving optimal wellbeing. Social determinants of health include factors such as financial security and economic opportunity, healthy food access and affordability, and freedom from injustice.

- **Community Safety:** Communities and people cannot thrive while feeling unsafe in their neighborhoods. Within this priority, we will seek out multi-sector solutions that create safe communities, free from violence, and also address the trauma caused by past violence.

- **Health Care Accessibility and Use:** This priority focuses on access to quality primary and specialty care and adequate insurance coverage. Within this aim, we will ensure that quality, age- and ability-appropriate health care is accessible to all, regardless of race, ethnicity, zip code, income, justice system involvement, gender identity, sexual orientation, or citizenship.

- **Infectious and Chronic Disease:** This priority area includes a focus on preventing and treating cardiometabolic disease (heart disease, stroke, and diabetes), cancer, and infectious disease (predominantly HIV and hepatitis).

- **Behavioral Health:** We cannot treat the whole person without addressing behavioral health. In this focus area, we will address the great burden of mental health and substance use disorders within our communities, providing timely and culturally sensitive care to those in need.

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

Social and Structural Determinants of Health

*Social Isolation and Support*

Within HCH’s hospital committee conversation, caregivers discussed the need for improved social and family support for patients outside of the hospital walls. The group discussed challenges with engaging specific groups, such as seniors and families, in preventive and specialty health care due to the lack of social and community support. Examining secondary data, 13 of the 14 community areas served by HCH had higher proportions of single-parent households than the city average and 13 had a lower proportion of adults reporting that they really feel a part of their neighborhood.
• The percent of **single-parent households** (households with a male householder/no wife present or a female householder/no husband present with their own children aged <18 years) ranged from 8.1% (Fuller Park) to 22% (Englewood), compared to 9% in Chicago (2012-16).

• The percent of adults who reported that they strongly agree or agree that **they really feel a part of their neighborhood** ranged from 41% (Fuller Park) to 69% (McKinley Park), compared to 62% in Chicago (2015-17).

**Community Insights:** Community survey respondents emphasized that strong community cohesion, social networks, and family life were necessary for a healthy community.

“We need to be able to live without isolation.”

**Educational Attainment**

Twelve of the 14 community areas in HCH’s service area had lower high school graduation rates than Chicago as a whole (**Figure 6**), and all 14 had lower college graduation rates than the city.

• The percent of the population aged 25 years or older **without a high school diploma or equivalent** ranged from 10% (Washington Heights) to 44% (Brighton Park), compared to 16% in Chicago (**Figure 6**).

• The percent of the population aged 25 years or older **with a bachelor’s degree or higher** ranged from 6% (Gage Park) to 23% (Washington Heights), compared to 39% in Chicago (2012-16).
Community Insights: While some community survey participants said that education was a local strength, others expressed a need for improvement. Further, respondents identified good schools as one of the top 10 necessities for a healthy community.

Financial Instability

All 14 community areas in HCH’s service area had higher unemployment rates than Chicago as a whole (Figure 7). In addition, 13 community areas had lower median household incomes and nine had higher poverty rates than the city overall.

- **Unemployment rates** ranged from 10% (Archer Heights) to 35% (Englewood), compared to 8% in Chicago (Figure 7).
- **Median household income** ranged from $21,437 (Fuller Park) to $67,063 (Ashburn), compared to $53,006 in Chicago (2012-16).
- **Individual poverty** (the proportion of the population living in households with incomes below the federal poverty level) ranged from 12% (Ashburn) to 45% (Englewood), compared to 19% in Chicago (2012-16).

![Figure 7. Unemployment rate in Holy Cross Hospital's service area, by community area](image)

Source: 2016, American Community Survey 5-Year Estimates
Community Insights: Community survey respondents wanted to see more economic growth in their community and identified quality jobs as essential for a healthy community.

“We need jobs that pay a living wage closer to where we live.”

“We need employment and jobs within our community for young adults to get off the ground.”

HCH Caregiver Insights: Caregivers discussed that a particular challenge in addressing the social determinants of health, like financial insecurity, is that they all interweave to create major barriers to community wellness.

Community Safety
Community violence, as measured by the violent crime rate, was higher in seven of HCH’s 14 community areas than Chicago as a whole (Figure 8). In addition, the proportion of adults who felt safe in their neighborhood was lower in 10 community areas than Chicago.

- The violent crime rate (crime incidents reported to the Chicago Police Department relating to violence, including homicide, assault, robbery, and battery) per 100,000 total population ranged from 2,237 (West Elsdon) to 16,238 (Fuller Park), compared to 4,491 in Chicago (Figure 8).
- From 2015 to 2017, the percent of adults who reported that they felt safe in their neighborhood “all” or “most of the time” ranged from 51% (Englewood) to 84% (Fuller Park), compared to 78% in Chicago.

Figure 8. Violent crime rate in Holy Cross Hospital’s service area, by community area
Reported violent crime incidents, including assault, battery, homicide, criminal sexual assault, offenses involving children, and robbery per 100,000 population.

Source: 2016, Chicago Police Department
**Community Insights:** Overall, community residents saw community safety as a core component to overall health and wellbeing. While some community survey participants felt safe in their community, violence was identified as the number one community health problem (selected by 41% of respondents). Violence was also a health priority in HCH’s 2016 CHNA.

“We need to be able to move without fear and with a sense of confidence that we can fix broken things.”

**HCH Caregiver Insights:** Caregivers discussed the strong relationship between violence and behavioral health, and the need to focus on intimate partner and domestic violence. They also reported that violence is a frequent discussion topic at community meetings.

**Housing and Food Security**

The proportion of households facing severe housing cost burden was higher in 10 of the 14 HCH community areas than in Chicago as a whole (Figure 9). Additionally, the proportion of residents with easy access to fruits and vegetables was lower in 10 of HCH’s community areas compared to Chicago and nine of HCH’s community areas had higher rates of limited food access than the city.

- Across HCH’s community areas, the proportion of households with severe housing cost burden (households spending 35% or more of income on housing) ranged from 30% (Ashburn) to 56% (Englewood), compared to 36% in Chicago (Figure 9).
- From 2015 to 2017, the percent of adults who reported that they had very easy access to fruits and vegetables ranged from 57% (New City) to 79% (McKinley Park), compared to 69% in Chicago.
- In 2015, limited food access (individuals with an annual family income ≤200% of the federal poverty level for family size and who lived more than ½ mile from the nearest supermarket, supercenter, or large grocery store) ranged from 0% (Gage Park) to 57% (Fuller Park), compared to 9% in Chicago (2015).
Community Insights: Community survey participants noted that affordable housing and access to everyday needs (e.g., work, grocery stores) were not community strengths. At the same time, respondents identified these as two of the top 10 necessities for a healthy community.

“You need to be able to drive to get healthy food.”

“Comparatively [to Chicago], housing here is affordable, but not if you have a low income or are unemployed.”
Health Care Access and Use

Primary and Specialty Care Access and Use

Nine of HCH’s 14 community areas had a lower proportion of adults receiving needed clinical care than Chicago adults overall. Avoidable emergency department (ED) visits are those that are non-urgent or treatable in primary care settings (e.g., asthma flare-ups, diabetes, and congestive heart failure). These visits often suggest barriers to primary care. Five of HCH’s seven zip codes had higher rates of avoidable ED visits than Chicago as a whole.

- From 2015 to 2017, the percent of adults who reported that they received a routine annual checkup with a doctor or health care provider ranged from 53% (West Elsdon) to 96% (Archer Heights), compared to 77% in Chicago.
- From 2015 to 2017, the percent of adults who reported that it was "usually" or "always" easy to get needed care, tests, or treatment through their health plan in the past year ranged from 59% (Fuller Park) to 87% (Auburn Gresham), compared to 83% in Chicago.
- In 2017, the avoidable ED visit rate per 10,000 population ranged from 443 (60632) to 1,008 (60621), compared to 544 in Chicago.

Community Insights: Community survey respondents identified access to health care and mental health services as the second most important factor for ensuring a healthy community (these factors were selected by 39% of respondents).

“Now, I just go north to access [health care] services.”
“Doctors don’t pay attention to what we say. It is not about the person, it’s about the time.”

HCH Caregiver Insights: Primary and specialty care access was a major topic of discussion among caregivers. Key points included:

- **Appointment Access**: There is a need for improved linkages to ongoing care from the Emergency Department (ED). Many patients use the ED as a primary source of care due to financial and system barriers to outpatient care. Caregivers highlighted the need for appointments to be scheduled before discharge, and discussed innovative ideas for helping patients navigate the health care and insurance systems.

- **Medication Access**: Beyond appointments, caregivers discussed various challenges to medication access and treatment adherence. Caregivers were unsure of all barriers; however, they felt that financial challenges, exacerbated by inadequate insurance plans, were a major factor in medication access.

- **Culturally Sensitive Care**: As many HCH patients do not speak English as their primary language and are unfamiliar with navigating the U.S. health system, caregivers discussed the need to provide culturally sensitive care.
Insurance Coverage

All of HCH’s community areas had higher percentages of uninsured individuals than Chicago as a whole (Figure 10).

- The percent of the population without health insurance coverage ranged from 11% (Washington Heights) to 27% (Brighton Park), compared to 10% in Chicago (Figure 10).

![Figure 10. Uninsured population in Holy Cross Hospital’s service area, by community area](image)

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

“We have to balance [preventive] care costs with other costs – rent versus diabetes medications?”

“There is nowhere to go without health insurance.”

HCH Caregiver Insights: Caregivers discussed insurance coverage at length. Overall, they agreed that being uninsured is a major barrier to accessing health care. However, they also highlighted that even if patients are insured, being under-insured or having unaffordable copayments creates barriers to care. Caregivers further discussed the need to identify interventions that are unique to certain populations, such as immigrants, who may face particular barriers to accessing insurance and health care. Lastly, caregivers discussed the need to educate patients on the ways that HCH can assist with financial concerns.
Improved Health and Health Equity

Asthma

Adult asthma prevalence was higher in six of HCH’s 14 community areas than in Chicago as a whole (data unavailable for Archer Heights, Fuller Park, and Gage Park). In addition, three of the seven zip codes in HCH’s service area had higher annual rates of child asthma ED visits than Chicago (Figure 11).

- From 2015 to 2017, the percent of adults who reported that a doctor, nurse, or other health professional had diagnosed them with asthma ranged from 6% (New City) to 17% (Auburn Gresham), compared to 9% in Chicago.
- The age-adjusted child (<18 years) asthma ED rate per 10,000 population ranged from 42 (60632) to 244 (60636), compared to 127 in Chicago (Figure 11).
- The age-adjusted adult asthma ED rate per 10,000 population ranged from 21 (60632) to 204 (60621) (2015-17, data unavailable for Chicago).

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

All of the community areas in HCH’s service area had higher rates of heart disease mortality than Chicago as a whole (Figure 12). Further, the stroke mortality rate was higher than the city average in nine HCH community areas. Eight community areas had a higher proportion of residents diagnosed with high blood pressure (also known as hypertension) than Chicago.

- The age-adjusted heart disease mortality rate per 100,000 total population ranged from 155 (McKinley Park) to 369 (Fuller Park), compared to 93 in Chicago (Figure 12).
- The age-adjusted stroke mortality rate per 100,000 total population ranged from 26 (West Elsdon) to 77 (West Englewood), compared to 40 in Chicago (2012-16).
- From 2015 to 2017, the percent of adults who reported that a doctor, nurse, or other health professional had diagnosed them with high blood pressure (excluding borderline high, pre-hypertensive, or pregnancy-related hypertension) ranged from 16% (Archer Heights, West Elsdon) to 48% (West Englewood), compared to 28% in Chicago.

Community Insights: Community survey participants identified heart disease and stroke as two of the top 10 most important community health problems. Additionally, hypertension was a health priority in HCH’s 2016 CHNA.

HCH Caregiver Insights: Caregivers underlined the relationship between pulmonary issues and cardiovascular health.
**Diabetes and Kidney Disease**

Compared to Chicago, the proportion of adults diagnosed with diabetes was higher in seven of HCH’s 14 community areas (data unavailable for Fuller Park, McKinley Park, and West Elsdon). Eleven HCH community areas had higher diabetes-related mortality rates than Chicago and six of HCH’s seven zip codes had higher rates of adult diabetes-related hospitalizations (**Figure 13**).

- From 2015 to 2017, the percent of adults who reported that a doctor, nurse, or other health professional had diagnosed them with diabetes (excluding pre-diabetes or gestational diabetes) ranged from 6% (Brighton Park) to 25% (Archer Heights), compared to 9% in Chicago.
- The age-adjusted diabetes-related mortality rate per 100,000 total population ranged from 46 (McKinley Park) to 96 (Englewood), compared to 56 in Chicago (2012-16).
- The age-adjusted adult hospitalization rate due to diabetes per 10,000 population ranged from 25 (60632) to 60 (60621), compared to 26 in Chicago (**Figure 13**).
- The estimated percent of adults reporting that they have been diagnosed with kidney disease ranged across HCH’s census tracts from 2.7% to 5.8%, with the vast majority of tracts having rates higher than Chicago as a whole (3.1%) (500 Cities Project, 2016).

**Figure 13.** Diabetes hospitalization rate in Holy Cross Hospital’s service area, by community area. Age-adjusted rate among adults per 10,000 population.

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

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

**HCH Caregiver Insights:** Caregivers indicated that they see a large proportion of patients in renal failure and requested that data be added to highlight the burden of kidney disease.
Cancer

The overall cancer mortality rate was higher in 10 of HCH’s 14 community areas than Chicago as a whole (Figure 14). In addition, the breast cancer mortality rate was higher in six communities, the prostate cancer mortality rate was higher in eight communities, the lung cancer mortality rate was higher in eight communities, and the colorectal cancer mortality rate was higher in 11 communities than the city average.

- The age-adjusted cancer mortality rate per 100,000 total population ranged from 141 (Archer Heights) to 351 (Fuller Park), compared to 164 in Chicago (Figure 14).
- The age-adjusted breast cancer mortality rate per 100,000 total population ranged from 14 (McKinley Park, West Elsdon) to 76 (Fuller Park), compared to 26 in Chicago (2011-15).
- The age-adjusted prostate cancer mortality rate per 100,000 total population ranged from 2 (McKinley Park) to 25 (Fuller Park), compared to 11 in Chicago (2011-15).
- The age-adjusted lung cancer mortality rate per 100,000 total population ranged from 19 (Archer Heights) to 100 (Fuller Park), compared to 38 in Chicago (2011-15).
- The age-adjusted colorectal cancer mortality rate per 100,000 total population ranged from 13 (Brighton Park) to 34 (Auburn Gresham), compared to 16 in Chicago (2011-15).

![Figure 14. Overall cancer mortality rate in Holy Cross Hospital's service area, by community area. Age-adjusted rate per 100,000 total population.](image)

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

Community Insights: Community survey participants identified cancer as one of the top 10 most important community health problems. Additionally, cancer was a health priority in HCH’s 2016 CHNA.
Behavioral Health (Including Mental Health and Substance Use)

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

- Among adults, the age-adjusted ED visit rate for mental health issues per 10,000 population ranged from 60 (60632) to 262 (60621) (data unavailable for Chicago) (Figure 15).
- Among adults, the age-adjusted ED visit rate for substance use-related issues per 10,000 population ranged from 14 (60632) to 88 (60621) (2015-17, data unavailable for Chicago).
- The age-adjusted drug-induced mortality rate per 100,000 total population ranged from 6 (Ashburn) to 42 (Fuller Park), compared to 26 in Chicago (2012-16).

**Community Insights:** Community survey participants identified mental health (30%) and substance use (36%) as two of the top five community health problems. Behavioral health was also a priority in HCH’s 2016 CHNA.

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

**HCH Caregiver Insights:** Caregivers highlighted how behavioral health affects all areas of wellbeing. They underlined the need for increased community and health care resources, and stressed the number of barriers patients face in accessing the support they need.
Maternal and Child Health

The infant mortality rate was higher in seven of the 14 community areas in HCH’s service area than in Chicago (Figure 16). In addition, six community areas had a higher percent of low birth weight infants and six had a higher percent of preterm births than Chicago.

- The **infant mortality rate** (deaths of infants aged <1 year per 1,000 live births) ranged from 2 (West Elsdon) to 18 (Englewood), compared to 7 in Chicago (Figure 16).
- The percent of **low birth weight infants** (<2,500 grams) ranged from 6% (Archer Heights, McKinley Park) to 19% (Fuller Park), compared to 10% in Chicago (2012-16).
- The percent of **preterm births** (<37 weeks gestation) ranged from 8% (Archer Heights, McKinley Park) to 21% (Fuller Park), compared to 11% in Chicago (2012-16).

**Community Insights:** Community survey participants identified maternal and infant health as key community health problems, although these were not in the top five selected health problems.

“Parents work a lot and kids are on their own. Kids need a place to be a kid.”

“We need more child services; there are no free youth centers.”

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**Figure 16. Infant mortality rate in Holy Cross Hospital’s service area, by community area**

Deaths of infants aged <1 year per 1,000 live births.

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

The HIV incidence rate was higher in five of HCH’s 14 communities than Chicago as a whole (data unavailable for Brighton Park, Fuller Park, McKinley Park, and West Lawn) (Figure 17). Additionally, seven communities had a higher chlamydia incidence rate and six communities had a higher gonorrhea incidence rate than Chicago.

- The HIV incidence rate per 100,000 population ranged from 13 (Gage Park) to 67 (Archer Heights), compared to 31 in Chicago (Figure 17).
- The chlamydia incidence rate per 100,000 population ranged from 547 (West Elsdon) to 2,179 (Englewood), compared to 1,077 in Chicago (2015).
- The gonorrhea incidence rate per 100,000 population ranged from 33 (West Elsdon) to 930 (Englewood), compared to 326 in Chicago (2015).

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

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

**Health Services**

**Hospitals**
- Advocate Health System
- Ann & Robert H. Lurie Children’s Hospital of Chicago
- Jesse Brown VA Medical Center
- John H. Stroger, Jr. Hospital of Cook County
- Rush University Medical Center
- St. Bernard Hospital and Health Care Center
- The University of Illinois Hospital & Health Sciences System

**Federally Qualified Health Centers**
- Access Community Health Network
- Beloved Community Family Wellness Center
- Chicago Family Health Center
- Esperanza Health Center
- Friend Family Health Center
- Heartland Health Outreach
- Howard Brown Health
- Inner City Muslim Action Network
- Lawndale Christian Health Center
- Mile Square Health Center
- TCA Health

**Social Services and Community Organizations**

**Action Coalition of Englewood**
- The Ark of St. Sabina
- Brave Space Alliance
- The Catholic Charities
- Children’s Home & Aid
- Family Focus
- Firman Community Services
- Greater Chicago Food Depository
- Hope Organization
- I Grow Chicago
- Imagine Englewood if...
- Metropolitan Family Services
- Metropolitan Tenants Organization
- Outreach Chicago
- Outreach Coalition Connectivity Network
- The Port Ministries
- The Salvation Army
- SGA Youth and Family Services
- Taproots
- Thresholds
- Trauma Response and Intervention Movement (TR4IM)
- University of Illinois at Chicago Community Outreach Intervention Projects
- Union League Boys and Girls Clubs
- Upworld
- WIC Food Centers
- Youth of Englewood

**Education**

- Chicago Public Libraries
- Chicago Public Schools
- City Colleges of Chicago
- DePaul University
- Gary Comer Youth Center
- Illinois Institute of Technology
- Loyola University Chicago
- Northwestern University
- Rosalind Franklin University
- University of Chicago
- University of Illinois at Chicago

**Community Development**

- AFC Community Development Corporation (CDC)
- Brighton Park Neighborhood Network
- Chicago Eco House
- Greater Englewood Chamber of Commerce
- Greater Englewood CDC
- Greater Southwest Development Corporation
- Growing Home
- Hebron CDC
- Local Initiatives Support Corporation Chicago
Plant Chicago
Resident Association of Greater Englewood
Southwest Organizing Project
Sustainable Englewood
Teamwork Englewood

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

Funders
Avon Foundation for Women
Blue Cross Blue Shield of Illinois

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