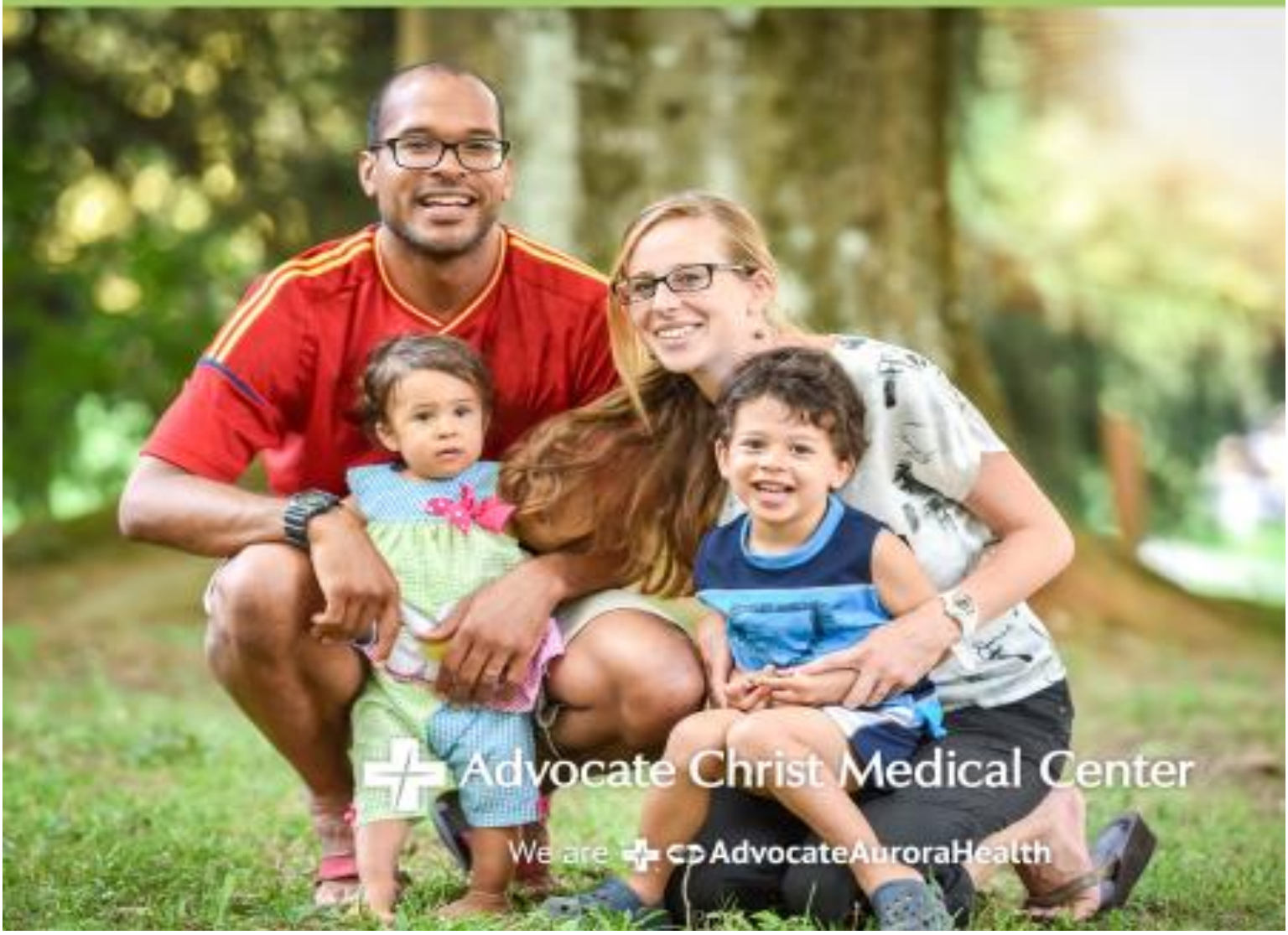
Community Health Implementation Plan

2020 - 2022



Advocate Christ Medical Center
Community Health Implementation Strategy Plan
January 1, 2020 – December 31, 2022

SUMMARY OF CHNA PROCESS

For the 2017-2019 Community Health Needs Assessment (CHNA), the Advocate Christ Medical Center (Advocate Christ) and Advocate Children's Hospital-Oak Lawn (Advocate Children's) community health department reviewed data from primary and secondary sources. The data highlighted the prevalent health issues within the medical center's primary service area (PSA). After review of medical center data, data from the Alliance for Health Equity and Conduent Healthy Communities Institute (HCI) data, the most significant health issues were summarized and presented to the hospital's Community Health Council (CHC) for prioritization. Data presented to the CHC targeted the following significant health conditions for Advocate Christ's PSA: heart disease, cancer, diabetes, mental health, substance abuse and asthma.

A structured prioritization process provided a framework to analyze health problems as well as explore solutions that have the greatest impact on the health of the community. In order to determine the health priorities, a prioritization matrix was presented to the CHC during the May 2019 meeting. The process enabled CHC members to prioritize health needs by narrowing options and systematically comparing choices through the selection and application of criteria. The process was selected because it provided a strong solution to effectively and successfully guide implementation of interventions.

As a result, the CHC members prioritized violence prevention, diabetes and mental health/substance abuse as Advocate Christ's focus areas for the next three years. Advocate Children's will focus their efforts on mental health, preterm births/low birth weight/infant mortality and access to care.

SIGNIFICANT HEALTH NEEDS IDENTIFIED BUT NOT SELECTED AND WHY

While cancer, heart disease/stroke and asthma are important health concerns in the PSA, the CHC felt that these health concerns were among the highest resourced health needs in the community. In addition, Advocate Christ and Advocate Children's have well established clinical institutes and respiratory health resources that are focused on cancer, heart disease/stroke and asthma.

Cancer

Advocate Christ's cancer program has been certified by the American College of Surgeons Commission on Cancer and includes both inpatient and outpatient units, a radiation oncology unit, CyberKnife treatment, intraoperative electron radiation therapy (IOERT), a home health/hospice program, a breast health program and a community education program. Nutritional services, social services, pastoral care and an oncology certified pharmacist are available on site to work with patients and their families. Clinical research trials are also available through the Children's Oncology Group (COG), the Eastern Cooperative Oncology Group (ECOG) and the Gynecologic Oncology Group (GOG).

Advocate Christ offers cancer-focused hospice care and free seminars open to the public. A specially trained oncology nutritionist sees patients in the medical center and those undergoing outpatient treatment. The palliative care team works closely with physicians and patients to provide comfort, communication assistance and assess patients' physical needs to enhance their quality of life at any stage of illness. In addition, there is an on-site American Cancer Society patient representative and a Gilda's Club satellite location.

Heart Disease/Stroke

Advocate Heart Institute at Advocate Christ is Illinois' most comprehensive center for heart care according to Becker's Healthcare for 2018. The Heart Institute offers a full range of treatments and programs including preventative, diagnostics, clinical trials, heart transplants and rehabilitation services. Rehabilitation plays a key role in recovery from a heart attack or heart surgery. The goal of the comprehensive cardiac rehabilitation program is to help patients regain strength and improve their health and quality of life after a heart attack or heart surgery. The Heart Institute has been certified by the American Association of Cardiac and Pulmonary Rehabilitation.

Advocate Christ offers a series of community health classes that increase awareness of heart disease and support individuals in their journey to better heart health. A variety of support groups that encourage healthy heart care are also provided in the community. The Live from the Heart program, a partnership between Chicago's Museum of Science and Industry and Advocate Christ, educates high school students about heart health through live interactive heart surgeries provided through video monitoring in a classroom. The interactive program also helps to foster interest in the health sciences. Advocate Children's is the first children's hospital in the country to receive congenital heart disease accreditation from ACE (Accreditation for Cardiovascular Excellence) for setting the highest standards of quality care for

children. The hospital is also a designated Pediatric Critical Care Center by the Illinois Department of Public Health.

Asthma

Advocate Christ offers comprehensive, multi-disciplinary services for lung and respiratory care, including the treatment of asthma. The lung and respiratory care center provides inpatient and outpatient respiratory care services to help patients achieve a better quality of life. With board certified pulmonologists who collaborate with related specialists, airway diseases are treated from prevention and diagnostics to advanced treatment and support services. The department offers advanced treatment of asthma through bronchial thermoplasty, a safe and effective FDA-approved treatment option that uses a proven medical device procedure for adults with severe or persistent asthma. In addition, Advocate Children's allergy and asthma specialists work with children and their families to manage asthma and provide education on how to prevent asthma attacks. Respiratory care specialists provide family consultation, treatment to eliminate chronic problems from allergy and asthma triggers and education on asthma management. Lastly, Advocate Children's offers a variety of resources through the Asthma Center, which provides educational resources for children, teens and parents and one-to-one asthma education to patients on the Ronald McDonald Care Mobile (RMCM).

SIGNIFICANT HEALTH NEEDS IDENTIFIED AND SELECTED FOR IMPLEMENTATION PLAN AND WHY

To summarize, as a result of the 2017-2019 CHNA process, Advocate Christ and Advocate Children's selected several priorities for implementation planning from 2020-2022.

- Mental & Behavioral Health/Substance Abuse
- Diabetes
- Violence Prevention (social, economic and structural determinants of health)

Advocate Children's Hospital selected the following health priorities for implementation planning from 2020-2022.

- Mental health
- Access to Care
- Preterm births/low birth weight/infant mortality

Mental/Behavioral Health/Substance Abuse

Data trends indicate that mental health and substance use are increasing in both children and adults, and the need for programming is continuing to grow. Mental

health and substance use often co-occur. The CHC has recommended developing approaches and interventions that address both health issues. Mental health and substance use issues of individuals impacted by trauma will be addressed through the Advocate Trauma Recovery Center. The high rates of Emergency Department (ED) visits and hospitalization due to mental health issues are preventable through employing coping mechanisms and resilience training. Examples include restorative justice activities, Mental Health First Aid trainings and trauma-informed workshops. Strategies will be adopted that improve the rates of mental health emergencies and decrease ED visits and hospitalization due to mental health issues in both children and adults. Advocate Children's will focus on providing behavioral health resource assistance at schools identified in high need/high risk areas to improve social and psychological functioning of children and families in order to maximize well-being and academic performance.

Diabetes

Hospitalization and ED visits are indicative of poorly controlled chronic diseases and a lack of access to routine preventive care. Poorly controlled diabetes can lead to severe or life-threatening complications, such as heart and blood vessel disease, nerve damage, kidney damage, eye damage and blindness, foot damage and lower extremity amputation, hearing impairment, skin conditions and Alzheimer's disease.

ED visits for diabetes are heavily concentrated in the West and South sides of Chicago and the southern region of Suburban Cook County. The areas with high rates of ED visits largely overlap with communities with high rates of poverty, unemployment and cost-burdened households. As a result, the medical center's CHC decided that diabetes initiatives in this service area are still needed as these issues continue to be a burden for residents (Alliance for Health Equity, 2019).

Violence Prevention

To a large extent, the conditions of the environments in which we live, work, play, grow and age determine our quality of life and health outcomes. These conditions are called social determinants of health, and they explain why some people face a more difficult challenge in achieving and maintaining good health.

Violence has profound direct and indirect impacts on health in communities and can have broader socioeconomic effects that further impact the health of communities. Violence in communities has been associated with reduced investment in community resources, such as parks, recreational facilities and programs that promote healthy activity (Prevention Institute, 2011). Food resources, such as supermarkets, are more reluctant to enter communities of color with higher rates of violence further reducing

access to healthy foods (Odoms-Young et al., 2009; Zenk et al., 2005). Gun violence can significantly decrease the growth of new retail and service businesses, decrease the number of new jobs available and slow home value appreciation (Irvin-Erickson et al., 2017). In addition, high rates of gun violence are associated with lower home values, credit scores and home ownership rates (Irvin-Erickson et al., 2017).

Access to Care

Access to Care was selected due to the importance of vulnerable, at-risk children having access to primary care services. Lack of access to primary care is also linked to obesity and poor nutrition, which is associated with poor health outcomes and quality of life. Infant mortality is an important indicator for the overall health status of a community. Infant mortality is the death of an infant before his or her first birthday. Low birthweight and pre-term deliveries are leading causes of infant death (Centers for Disease Control and Prevention, 2019). Access to essential medical care for vulnerable, at-risk children is necessary to ensure a healthy future, including successful performance in school, positive health outcomes and improved quality of life.

Infant Mortality/ Preterm Delivery/Low Birth Weight Babies

Preterm labor is associated with preterm birth and babies born prematurely have a greater risk of health complications. In Cook County from 2015-2017, 4.8 percent of mothers were hospitalized for preterm labor and delivery, which is higher than most other counties in Illinois and higher than the overall state rate. The African American population had the highest rate of preterm labor and delivery at 6.9 percent, which indicates a significant health disparity (Conduent Healthy Communities Institute, 2019).

AAH COMMUNITY STRATEGY AND ADDRESSING ROOT CAUSES

Advocate Aurora Health (AAH) has a strong history of community engagement and service. Following the merger of Advocate Health Care and Aurora Health Care in 2018, a targeted strategy has been developed to build on this history—one that transforms Advocate Aurora's community facing work to provide even stronger support for patient health and to build community health. The AAH vision statement is: *We will build health equity, ensure access, and improve health outcomes in our communities through evidence-informed services and innovative partnerships by addressing medical needs and social determinants.*

To execute on this vision, all community facing work has been aligned through a health equity lens. For Advocate Aurora's purposes, health inequity is defined as differences in health that are systemic, avoidable, unfair or unjust. The overarching aim of this

strategy is to decrease the inequity gap in life expectancy across the Advocate Aurora footprint. Currently, there is a 26-year gap in life expectancy across the communities served by Advocate Aurora. The community strategy goal is to increase life expectancy by 5% in targeted low-income communities over a span of ten years. To that end, the Advocate Aurora community health, community relations, diversity and inclusion, and faith and health partnerships work has been aligned to focus on six areas, including: access/primary medical homes; access/behavioral health services; workforce development; community safety; housing; and food security. These six transformational focus areas are identified in current industry literature as being "game changers," having an upstream effect on health equity, and are also strongly confirmed by organization wide CHNA data. A rigorous tracking and evaluation process is being developed to establish baseline and annual progress goals for each focus area and strategy.

HEALTH PRIORITY: DIABETES

DESCRIPTION OF HEALTH NEED DATA:

- **In the Advocate Christ PSA, the age-adjusted ER rate due to diabetes is 29.9 ER visits per 10,000 population, which is higher than the state rate of 27.7 ER visits per 10,000 population.**

- **The communities with the highest ER rates due to diabetes include Midlothian (51.8), Auburn Gresham (56.7), Oak Forest (60.7) and West Englewood (71.6).**

- **In the Advocate Christ PSA, the age-adjusted hospitalization rate due to diabetes is 23.7 hospitalizations per 10,000 population 18 years and older, which is higher than the state rate of 17.6 hospitalizations per 10,000 population 18 years and older.**

Source: Conduent Healthy Communities Institute, 2018

TARGET POPULATION: Community residents with type 2 diabetes or pre-diabetes diagnosis in the Advocate Christ PSA

GOAL: Reduce diabetes and increase access to resources for residents with type 2 diabetes and pre-diabetes diagnosis living in the PSA

ALIGNMENT WITH ADVOCATE AURORA COMMUNITY STRATEGY

- Access to Primary Medical Care
- Food Security

ALIGNMENT WITH ADDITIONAL STRATEGIES

- **Healthy People 2020**
  - Reduce the annual number of new cases of diagnosed diabetes in the population
  - Reduce the diabetes death rate

- **National Diabetes Prevention Program**
  - Promote awareness of prediabetes among people at high risk for type 2 diabetes
  - Increase use of lifestyle intervention programs in community settings for the primary prevention of type 2 diabetes

STRATEGY #1	COLLABORATIVEPARTNERS	INTENDED RESULTS
Offer diabetes prevention educational programs and resources to Advocate Christ PSA residents with pre-diabetes **Specific Interventions** • Implement the evidence-based National Diabetes Prevention Program for residents of the Advocate Christ PSA *https://www.cdc.gov/diabetes/prevention/index.html*	• Diabetes Educators • Stroke Center • Cardiac Rehab Lab • Dietitian • Faith Institutions	• Increased collaboration with hospital and community partners • Increased access to healthy lifestyle resources • Improved A1C levels • Increased weight loss • Increased physical activity

MEASURING OUR IMPACT

- Number of cohort participants
- Percent of participants who lost 5-7% of their body weight
- Percent of participants who completed a minimum of 150 minutes of exercise per week
- Percent of participants with improved A1C levels
- Number of food referrals to Diabetes Prevention Program (DPP) participants

STRATEGY #2	COLLABORATIVE PARTNERS	INTENDED RESULTS
Implement educational programs and resources to Advocate Christ PSA residents with diabetes **Specific Interventions** • Offer the evidence-based Diabetes Empowerment Education Program (DEEP) curriculum for PSA residents with diabetes *https://mwlatino.uic.edu/deep-program/* • Implement food insecurity screening and refer to healthy food access points *https://hungerandhealth.feedingamerica.org/2018/04/hospital-food-bank-partnerships-recipe-community-health/*	• Diabetes Educators • Stroke Center • Cardiac Rehab Lab • Dietitian • Faith Institutions	• Increased access to healthy food • Increased weight loss • Establish lifestyle change behaviors • Improved A1C levels

MEASURING OUR IMPACT
• Number of cohort participants • Percent of participants with weight loss • Percent of improved glucose metrics • Percent of participants who screen positive for food insecurity • Percent of participants accessing healthy food items • Rate of ER visits for Diabetes

HEALTH PRIORITY: MENTAL/BEHAVIORAL HEALTH/SUBSTANCE USE

DESCRIPTION OF HEALTH NEED DATA:

- **The Advocate Christ PSA age-adjusted ER rate due to mental health is 86.3 ER visits per 10,000 population 18 years and older, which is lower than the state rate of 95.3 visits per 10,000 population due to mental health visits.**

- **The ER rate due to mental health is greatest for those aged 18 to 24 with a rate of 133.6 per 10,000 population and those aged 25-34 with a rate of 115.6 per 10,000 population.**

- **The age-adjusted ER rate due to pediatric mental health is 49.8 per 10,000 population, which is lower than the state of Illinois at 64.5 per 10,000 population, although the rate has risen steadily from 25.7 in 2009.**

- **The Advocate Christ PSA ER rate due to pediatric mental health is highest among the African American and American Indian/Alaskan Native populations.**

- **The age-adjusted PSA rate for adolescent suicide and intentional self-inflicted injury rose from 23.2 in 2010 to 49.9 in 2017, with the highest rate among adolescents 15-17 years.**

- **The top three zip codes exceeding the Advocate Christ PSA rates include West Englewood (205.4), Auburn Gresham (157.8) and Hometown (144.5).**

- **The PSA age-adjusted ER rate due to adolescent alcohol use is 8.8 ER visits per 10,000 population.**

Source: Conduent Healthy Communities Institute, Illinois Hospital Association, 2015-2017

TARGET POPULATION: Community members living in the PSA of Advocate Christ and Advocate Children's

GOALS:

- **Provide access to Mental Health First Aid trainings and mental health/substance abuse resources**
- **Increase education, awareness and access to services for mental health**

ALIGNMENT WITH ADVOCATE AURORA COMMUNITY STRATEGY

- Access to Behavioral Health Services

ALIGNMENT WITH ADDITIONAL STRATEGIES

- **Illinois State Health Improvement Plan (ISHIP) 2021**
  - Build upon and improve local system integration for behavioral health
  - Improve the opportunity for people to be treated in the community rather than in institutional settings

STRATEGY #1	COLLABORATIVE PARTNERS	INTENDED RESULTS
Offer educational programs to reduce behavioral health stigma and increase mental health awareness **Specific Interventions** • Implement Mental Health First Aid (MHFA) courses in the Advocate Christ PSA *https://www.mentalhealthfirstaid.org/*	• Sertoma Center • Council on Substance Use and Mental Health • Advocate Trauma Center • Alliance for Health Equity • Federally Qualified Health Center (FQHC) • Chicago public school partners	• Established access to mental health resources • Improved skills to identify a mental health crisis • Increased knowledge of mental health resources

MEASURING OUR IMPACT

- Number of MHFA workshop participants in the Advocate Christ PSA by community area, ZIP code, gender, race/ethnicity and age
- Number of workshops implemented in the Advocate Christ PSA by community area and ZIP code
- Number of staff trained at partner schools

STRATEGY #2	COLLABORATIVE PARTNERS	INTENDED RESULTS
Measure the impact of the MHFA training in the Advocate Christ PSA **Specific Interventions**	• Alliance for Health Equity • Colleges and Universities	• Established evaluation design • Incorporated skills learned in the MHFA

• Implement an evaluation of MHFA training, three months post workshop		training to real life situations • Sustained MHFA skills

MEASURING OUR IMPACT

- Percent of participants who utilized skills learned from the MHFA training
- Percent of participants adequately prepared to address mental health issues

STRATEGY #3	COLLABORATIVE PARTNERS	INTENDED RESULTS
Provide behavioral health services and education at select schools in the Advocate Christ PSA **Specific Interventions** • Implement mental health education for faculty, students and parents *https://www.nasponline.org/resources-and-publications/resources-and-podcasts/mental-health/school-psychology-and-mental-health/school-based-mental-health-services* • Implement mental health, social services and resource assistance at select schools in the Advocate Christ PSA *https://youth.gov/youth-topics/youth-mental-health/school-based*	• Advocate Children's Hospital • Chicago Public Schools in the PSA to be determined	• Increased access to behavioral health care • Increased awareness and knowledge of mental health conditions • Increased awareness of mental health resources

MEASURING OUR IMPACT

- Number of students seen by a licensed clinical professional counselor
- Number of faculty/students/parents receiving education/intervention
- Number of referrals made for additional services and/or to community resources

STRATEGY #4	COLLABORATIVE PARTNERS	INTENDED RESULTS
Complete mental research studies that support the development of new prevention programming for the adolescent population **Specific Interventions** • Enroll eligible adolescents at risk for depression in the Path2Purpose mental health research study *https://chicago.medicine.uic.edu/departments/academic-departments/pediatrics/research/path-2-purpose/*	• Advocate Children's Hospital • Community based programs serving adolescents • Primary care providers	• Identified adolescent patients for the study • Established adolescent study advisory committee

MEASURING OUR IMPACT

- Number of patients eligible based on standard of care PHQ-9 screening
- Number of adolescents enrolled in program
- Number of adolescent members of advisory committee

HEALTH PRIORITY: VIOLENCE PREVENTION

DESCRIPTION OF HEALTH NEED DATA:

- **In Cook County, the violent crime rate is 619.8 crimes per 100,000 population between 2014-2016. This value is significantly greater than the 2014-2016 state of Illinois value and the U.S. value of 403.1 and 386.5 crimes per 100,000 population, respectively.**

- **Neighborhoods with the highest number of homicides include South Shore, South Chicago, Roseland, Riverdale, Englewood, Clearing, Ashburn, Chicago Lawn, New City and Hegewisch.**

Sources: Conduent Healthy Communities Institute, 2019; County Health Rankings, 2019; Chicago Police Department Annual Report, 2019

TARGET POPULATION: Community members living in the Advocate Christ PSA

GOAL: Increase access, awareness and availability of violence prevention resources in Advocate Christ's PSA

ALIGNMENT WITH ADVOCATE AURORA COMMUNITY STRATEGY

- Community Safety

ALIGNMENT WITH ADDITIONAL STRATEGIES

- **Healthy People 2020**
  - Reduce homicides
  - Reduce firearm-related deaths

- **Healthy Chicago 2025**
  - Further the health and vibrancy of neighborhoods most affected by inequities in the area of community safety

STRATEGY #1	COLLABORATIVE PARTNERS	INTENDED RESULTS
Support community partnerships to improve the health and safety of PSA residents **Specific Interventions** • Maintain and build on Chicago HEAL (Hospital, Engagement, Action and Leadership) and Southland RISE (Resilience Initiative to Strengthen Empowerment) Initiatives *https://www.durbin.senate.gov/imo/media/doc/Chicago%20HEAL%20Initiative%20FINAL.pdf*	• Alliance for Health Equity • Chicago HEAL Partners • Faith Institutions • Southland RISE Partners • CHC Members • Local, County and State Health Departments • Federally Qualified Health Centers • Advocate Behavioral Health Department	• Reduced levels of physical and mental trauma of PSA residents • Reduced number of street violence incidents in PSA • Increased number of workforce development programs in the PSA • Increased number of jobs that pay a living wage • Identified gaps in community services

MEASURING OUR IMPACT
• Number of organizations involved in partnerships • Number of strategies developed in partnership with organizations • Number of workforce development programs • Number of street violence incidents

STRATEGY #2	COLLABORATIVE PARTNERS	INTENDED RESULTS
Increase access to violence prevention and mitigation services for victims of violent crime **Specific Interventions** • Link victims of violence to community resources through use of NowPow tool • Provide emotional and, psychological behavioral health services to survivors of violent crimes through the Trauma Recovery Center *https://www.traumarecoverycentermodel.org/about-trauma-recovery-centers/*	• Advocate Trauma Recovery Center • Sertoma Center • Alliance for Health Equity • Chicago HEAL Partners • Southland RISE Partners	• Increased access to trauma support resources • Reduced re-victimization or re-injury incidents • Increased sense of safety

MEASURING OUR IMPACT
• Number of community partners developed • Number of individuals receiving counseling related to injuries caused by violent crime • Number of individuals referred to community resources through the NowPow tool • Number of individuals served through the Trauma Recovery Center

HEALTH PRIORITY: Access to Care

DESCRIPTION OF HEALTH NEED DATA:

- **21.7 children under 18 are living below the poverty level.**
- **18.5% of children living in Cook County are food insecure; 31% of those children are likely ineligible for assistance.**

Source: Healthy Communities Institute, 2018

- **14.8% of children in Illinois are obese.**
- **17.2% are physically active.**

Source: High School Youth Risk Behavior Survey, 2017

- **76.4% of students in the Chicago Public Schools are economically disadvantaged.**
- **79% of all 642 CPS schools achieve 90% medical compliance.**

Source: https://cps.edu/About_CPS/At-a-glance/Pages/Stats_and_facts.aspx

TARGET POPULATION: Children in the PSA who are uninsured, underinsured or are insured through the state Medicaid program

GOAL: Increase access to primary care for low income, high risk children in the Advocate Children's–Oak Lawn PSA

ALIGNMENT WITH ADVOCATE AURORA COMMUNITY STRATEGY

- Access to Primary Medical Home

ALIGNMENT WITH ADDITIONAL STRATEGIES

- **Healthy Chicago 2025**
  - Increase capacity and availability of health and human services and maximize impact of existing resources

STRATEGY #1	COLLABORATIVE PARTNERS	INTENDED RESULTS
Provide access to primary care for at-risk children in the Advocate Children's Hospital–Oak Lawn PSA **Specific Interventions** • Implement school physicals and immunizations through the Ronald McDonald Care Mobile (Care Mobile) at targeted schools in the PSA *http://pediatrics.aappublications.org/content/97/1/26.short*	• Ronald McDonald House Charities • Chicago Public Schools • Suburban School Districts	• Increased utilization of the Care Mobile • Improved compliance rates for immunizations and physicals in targeted schools

MEASURING OUR IMPACT
• Number of patients seen on the Care Mobile • Number of physicals provided on the Care Mobile • Number of immunizations given on the Care Mobile

STRATEGY #2	COLLABORATIVE PARTNERS	INTENDED RESULTS
Implement programs to increase access to healthy food in Advocate Children's–Oak Lawn PSA **Specific Interventions** • Implement food insecurity screening for students seen on the Care Mobile and refer to healthy food access points *https://pediatrics.aappublications.org/content/136/5/e1431*	• Ronald McDonald House Charities • Chicago Public Schools • Suburban School Districts	• Provide emergency food and referral resources to food insecure children

MEASURING OUR IMPACT
• Number of students screened • Number of students that screen positive for food insecurity/percentage of total population • Number of students given emergency food and resources

HEALTH PRIORITY: Infant Mortality/Preterm Deliveries/Low Birth Weight Babies

DESCRIPTION OF HEALTH NEED DATA:

(For preterm births, the rate is described as the percentage of births with less than 37 weeks gestation among all births with valid gestation age.)

- **Since 2014, preterm birth rates have increased in Cook County.**
- **The rate for preterm births in the City of Chicago for ages 10-14 was 11.1 percent in 2017, higher than the national rate of 9.94 percent.**

- **The rate for preterm births for ages 15-19 was 13.3 percent.**
- **The highest preterm birth rates in the PSA range from 7.4-14.6 percent.**

Sources: https://www.centeringhealthcare.org/why-centering/research-and-resources 2019; Chicago Health Atlas, 2017

(Infant mortality rates are defined as the rate of infant deaths per 1,000 live births.)

- **The rate of infant mortality in Chicago is 6.9 per 1,000 live births.**
- **The highest rates in the Children's Hospital PSA are between 8.0-13.3 per 1,000 live births.**

Sources: Chicago Health Atlas, 2017; Illinois Department of Public Health, Vital Statistics, 2018

(For low birth weight, the rate is defined as the percentage of births with a birthweight less than 2500 grams among all births.)

- **The low birth weight rate in Chicago is 9.4 percent.**
- **The highest rates in the PSA are between 6.1-14.0 percent.**

Source: Chicago Health Atlas, 2017

TARGET POPULATION: Pregnant women in the Advocate Christ PSA

GOAL: Decrease infant mortality, preterm deliveries and low birth weight babies in the PSA

ALIGNMENT WITH ADVOCATE AURORA COMMUNITY STRATEGY

- Access to Primary Medical Home

ALIGNMENT WITH ADDITIONAL STRATEGIES

- **Healthy Chicago 2.0**
  - Ensure access to care and support for mothers and infants
  - Ensure access and entry into sufficient early and adequate preconception, prenatal and inter-conception care

- **Illinois State Health Improvement Plan (ISHIP) 2021**
  - Improve the well-being of mothers, infants and children
  - Assure accessibility, availability and quality of preventive and primary care for all women, adolescents and children, including children with special health care needs, with a focus on integration of services through patient-centered medical homes
  - Support healthy pregnancies and improve birth and infant outcomes

STRATEGY #1	COLLABORATIVE PARTNERS	INTENDED RESULTS
Provide education programs for at-risk pregnant women in the Advocate Christ PSA **Specific Interventions** • Implement the Centering Pregnancy Program to provide group prenatal care to at-risk pregnant women *https://www.centeringhealthcare.org/why-centering/research-and-resources* *https://cssp.org/wp-*	• Oak Lawn Family Practice Clinic • Additional partners to be determined	• Improved perinatal outcomes; reduced preterm births • Increased breastfeeding rates • Improved prenatal appointment completion rates • Increase in parents' competence and confidence to nurture their babies • Decreased self-reported isolation
MEASURING OUR IMPACT		
• Number of mothers participating in the Centering Pregnancy program • Number of monthly appointments attended • Number of babies born at average or above average birth weight • Number of babies born full term		

Note: Plans to address selected CHNA priorities are dependent upon resources and may be adjusted on an annual basis to best address the health needs of our community.