CHICAGO HEAL INITIATIVE

APRIL 2022

Hospital Engagement Action and Leadership

2022 Report to Stakeholders

A third-year report from Illinois health systems and U.S. Senator Richard J. Durbin on strengthening neighborhood engagement to reduce violence and improve health.

DICK DURBIN
UNITED STATES SENATOR
ILLINOIS

18 Chicago neighborhoods. One powerful goal.

AdvocateAuroraHealth

AMITA HEALTH™

Ann & Robert H. Lurie Children's Hospital of Chicago®

COOK COUNTY HEALTH

LOYOLA MEDICINE

Northwestern Medicine®

RUSH UNIVERSITY MEDICAL CENTER

Sinai Chicago

AT THE FOREFRONT UChicago Medicine

UI Health | UIC

Ten Leading Health Systems

One Powerful Goal

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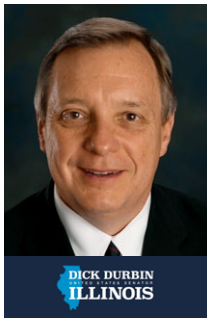
Building a National Model for Engaging Communities

Progress on Health Disparities and the Epidemic of Gun Violence



When I first convened the CEOs of 10 major hospitals serving Chicago in January 2018, I was encouraged by the interest of hospital leaders in enhancing efforts to address gun violence. Based on the intensive care provided in emergency departments to gunshot victims, everyone in the room understood the toll of shootings in our communities.

After reflecting on shared experiences, this group launched a historic commitment to collaborate on 16 public commitments to reduce gun violence and health disparities in the neighborhoods with the highest rates of poverty, violence, and economic disinvestment.

Gun violence accounts for a staggering 2.1 years of the 8.8-year life expectancy gap between Black and White residents of Chicago—but that means our work also must tackle the underlying structural causes of poor health.

An essential part of the remedy is community-based work to address trauma, stigma, and historical bias.

These hospitals are meeting the Chicago HEAL Initiative's mission of targeting neighborhood outreach to prevent retaliatory shootings and enlisting trusted messengers to promote COVID-19 testing and vaccine confidence. By using their healthcare expertise and economic footprint, they have connected with their communities to address the most challenging health issues.

The Chicago HEAL Initiative created an emphasis on accountability and fidelity to the neighborhoods served. Our initial plan was for a three-year effort to test and evaluate this approach.

By many measures, this three-year effort has worked effectively—addressing root causes of violence by:

21% Increase
IN LOCAL HIRING (SINCE 2018)

27% Increase
IN PROCUREMENT FROM LOCAL BUSINESSES (SINCE 2018)

28% Increase
LOCAL STUDENTS WERE PROVIDED WITH AN INTERNSHIP AND OTHER PIPELINE PROGRAMS INTO HEALTH CAREERS (SINCE 2018)

130% Increase
IN SERVING PATIENTS WITH POST-INJURY TRAUMA RECOVERY PROGRAMS (SINCE 2018)

242% Increase
IN NUMBER OF EMPLOYEES TRAINED TO CONDUCT SCREENINGS FOR SOCIAL DETERMINANTS OF HEALTH (SINCE 2018)

That these achievements occurred amid the upheaval of the COVID-19 pandemic is nothing short of remarkable.

I'm happy to support the hospitals in this meaningful work. As a senior member of the Senate Appropriations Committee, I worked to ensure the Fiscal Year (FY) 2022 Omnibus Appropriations Bill included significant resources for programs in Chicago that fund community mental health, housing, job training, and violence prevention. It provided a combined **$40 million** for youth violence and gun violence prevention programs at the Centers for Disease Control and Prevention (CDC) and National Institutes of Health, programs that are successfully funding efforts in Chicago. The spending bill also included **$209 million** I helped to secure for programs at the CDC and Substance Abuse and Mental Health Services Administration to address mental health, trauma, and Adverse Childhood Experiences in schools and communities. The FY22 spending bill also included more than **$6 million** in specific congressionally directed spending requests I secured for Illinois-based projects to HEAL hospitals and their community partners to prevent violence and expand mental health services in our communities.

I also supported passage of the American Rescue Plan, which provides significant pandemic relief funds that are being used at the State, County, and City levels to support violence prevention and intervention efforts in Chicago. And as the Chair of the Senate Judiciary Committee, I convened a field hearing in Chicago in December 2021 to examine the epidemic of gun violence, which featured witnesses from the CDC, University of Chicago Crime Lab, and Chicago Police Department, among others, to discuss public health interventions and trauma-informed care.

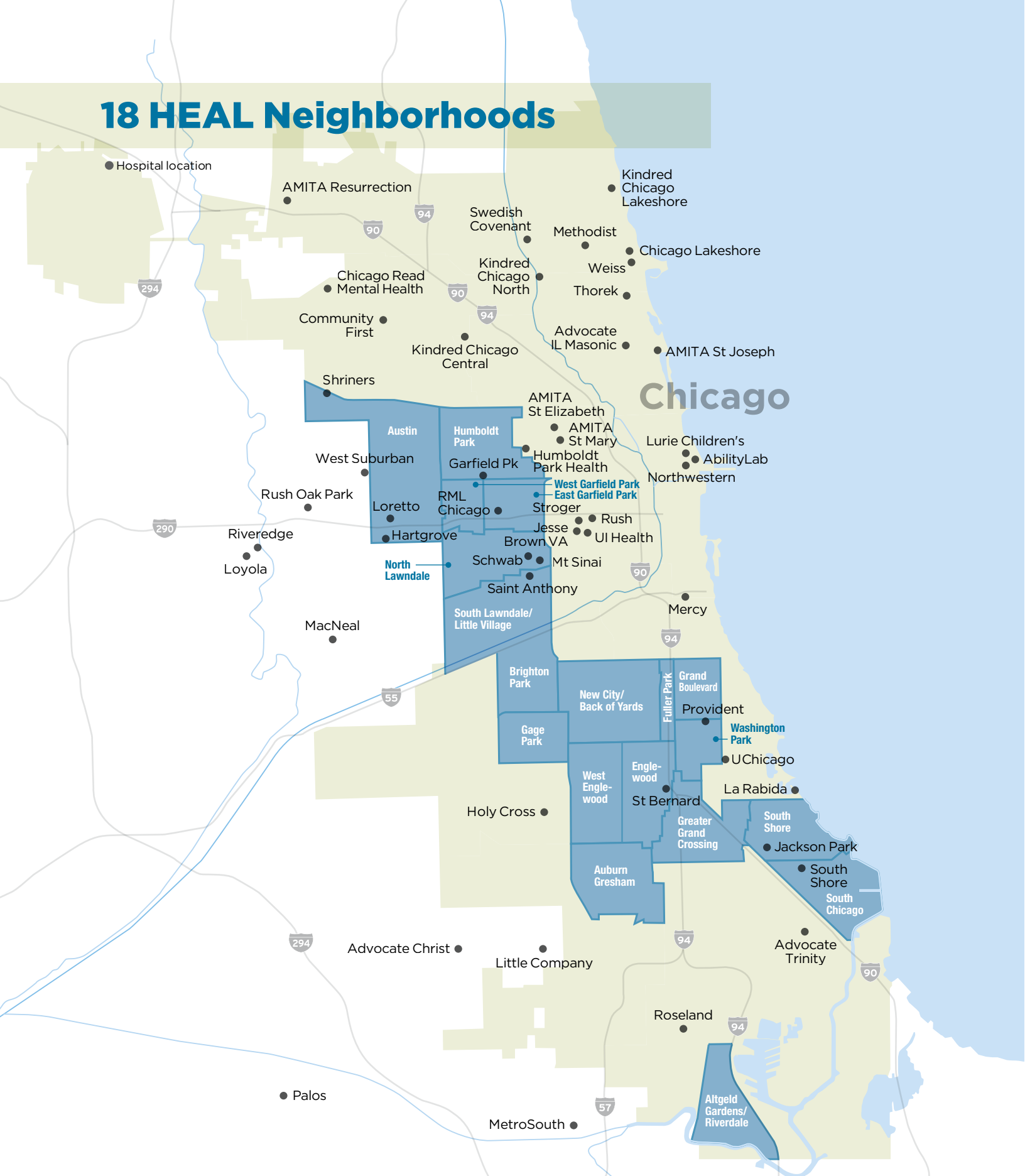
Despite all of the uncertainty and setbacks over the past three years, the hospitals in the Chicago HEAL Initiative have managed to continue their profound positive impact and commitment to their communities.

Together, not only is this collaborative effort making progress on health disparities and the epidemic of gun violence, it also is building a national model for engaging communities—whether in targeted COVID-19 responses or providing a roadmap for important structural investments to address inequality. I am grateful for these efforts, and I encourage more partners to join us as we scale up this framework and embed our lessons across health systems.

Richard J. Durbin
United States Senator

The results outlined in this report speak for themselves. They are a testament to the dedication that these 10 hospitals have to their neighborhoods and the people they serve.

18 HEAL Neighborhoods



HEAL Neighborhood Zip Codes

Auburn Gresham	60620	Gage Park	60609, 60629, 60632, 60636	Riverdale	60827
Austin	60644, 60639, 60651, 60707	Grand Boulevard	60609, 60615, 60653	South Chicago	60617
Brighton Park	60632	Greater Grand Crossing	60619, 60620, 60621, 60637	South Lawndale/Little Village	60623, 60608
East Garfield Park	60624, 60612	Humboldt Park	60622, 60624, 60647, 60651	South Shore	60649, 60637, 60619
Greater Englewood	60621, 60636	New City	60609	Washington Park	60637, 60621, 60615, 60609
Fuller Park	60609	North Lawndale	60608, 60623, 60624	West Garfield Park	60624

Overview

Efforts to strengthen historically underserved communities usually come in the form of funding. While this type of investment is critical, community partnerships are key to effecting lasting change. Joining forces to achieve community betterment can significantly multiply the impact of financial investments. Partnerships drive collaboration through a blend of human and financial resources to support common goals of individual success and community well-being.

In the zip codes that comprise the 18 HEAL neighborhoods, partnerships between 10 leading health systems and neighborhood organizations are flourishing. By working together, these organizations and the 10 leading health systems are creating opportunities for individual advancement and building a better future for the communities they serve.

In October 2018, the 10 leading health systems joined forces with U.S. Senator Richard J. Durbin (D-IL) to use their economic and community footprints over a three-year period to curb violence and improve health and health equity in HEAL neighborhoods. In 2021, the HEAL initiative made important strides in advancing HEAL goals. The cumulative results achieved over the three years of the HEAL initiative (2019 – 2021) are all the more remarkable in light of the tremendous strain COVID-19 imposed on HEAL hospitals, forcing many organizations to limit hiring, capital investments and program expansions.

With strong support from Senator Durbin and other government leaders, HEAL healthcare leaders and professionals responded heroically to an unprecedented health crisis. Their heroic efforts reveal an enduring commitment to providing care in all communities.

Healthcare is not just about appointments and medications.
It's about changing lives.

What is HEAL?

Chicago **HEAL**— **H**ospital **E**ngagement, **A**ction and **L**eadership—is a bold, three-year initiative (2019 – 2021) to reduce violence and improve health through neighborhood engagement. The HEAL initiative is focused on three pillars:

- **Increase local workforce commitment** to reduce economic hardship
- **Support community partnerships** to improve health and safety of public environments
- **Prioritize key in-hospital clinical practices** to address unmet needs

Driven by the leadership of Senator Durbin, Chicago HEAL hospitals have come together to share best practices and identify ways to collaborate to address social risk factors impacting HEAL communities and advance health equity.

This third-year HEAL report focuses on the work of HEAL hospitals to strengthen community partnerships, enhance collaboration and impact individual lives. Through storytelling, the hospitals share how they are improving individual health and health equity in their communities.

Just like the communities they serve, HEAL hospitals are driven by a common goal of a better today and a better future for Chicago's HEAL communities. Their stories—and the lives impacted—provide inspiration and hope.

All of the health systems are working on each pillar, with a focus on achieving tangible results on 16 metrics developed by Senator Durbin's staff and compiled into a dashboard with the assistance of the Illinois Health and Hospital Association (IHA). Following are key HEAL initiative highlights.

HEAL Initiative Highlights

PILLAR ONE

Increase local workforce commitment to reduce economic hardship

One facet of reducing violence and improving health equity is ensuring that residents in HEAL communities have economic opportunities, including access to good-paying jobs, opportunities for advancement and more youth summer employment.

Despite being forced to limit or delay hiring and capital spending due to the COVID-19 pandemic, HEAL hospitals continued to provide economic opportunities in HEAL neighborhoods. The results of HEAL hospital efforts include:

- From 2019 to 2021, on average **3,535 individuals** from HEAL neighborhoods were hired each year by HEAL institutions, a **21% increase compared to 2018**.
- **3,839 individuals** from HEAL neighborhoods were hired by HEAL institutions in 2021, compared to **2,933** in 2018.
- From 2019 to 2021, on average **$120 million** per year was spent on local supplies and services by HEAL institutions, a **27% increase compared to the $95 million spent in 2018**.
- Invested in workforce retention and career development. In 2021, **860 individuals** from HEAL neighborhoods were promoted or advanced in their careers, compared to **509 individuals** in 2018. While challenged by the pandemic in 2021, **4,921 high school and college students** from HEAL neighborhoods participated in workforce development programs to promote careers in healthcare fields and paraprofessional roles.

HEAL Initiative Highlights

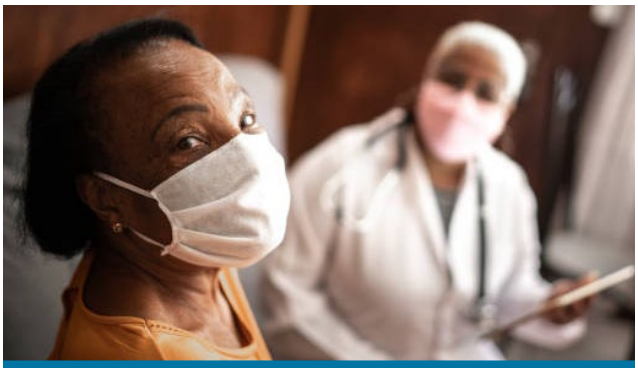
PILLAR TWO

Support community partnerships to improve health and safety of public environments

Improving health gets at the heart of what hospitals do every day. Physical health, though, no longer stands alone. Mental health, including the emotional scars of trauma, and a feeling of safety are key factors in overall well-being.

In 2021, HEAL hospitals:

- Increased trauma-informed, community-based counseling and support services by **82%** from **86 programs** in 2018 to **157 programs** in 2021.
- Improved behavioral health partnerships, including partnering with federally qualified health centers and schools to open clinics in HEAL neighborhoods, with **nine HEAL hospitals** engaged in such partnerships.
- Improved physical neighborhood vitality by supporting affordable housing pilot programs for the homeless, housing renovations, restoration of vacant lots and community garden development with **nine HEAL hospitals** offering neighborhood vitality programs in 2021.



PILLAR THREE

Prioritize key in-hospital clinical practices to address unmet needs

Underserved communities require a holistic approach to understanding what's missing in the fabric of their healthcare needs in order to reduce health disparities and improve health equity.

In 2021, HEAL hospitals:

- Provided **133,863 social risk factor screenings**. In addition, **7,479 intake staff and primary care practitioners** were trained in behavioral health and trauma screenings and communicating with patients on firearm safety—a 617% increase from 2018.
- Established **14 additional trauma-informed, post-injury counseling programs** to support the long-term healing for all victims of violence and paired **2,935 patients** with these services as compared to **1,828** in 2018—a **60% increase**.
- Utilized **23 common data-sharing platforms** across hospitals and stakeholders to better coordinate services, identify trends and improve care, compared to **18 such platforms** in 2018.
- Continued efforts to reduce health disparities and improve health equity, with **nine HEAL hospitals** providing implicit bias and cultural competency training to providers.

These numbers are truly impressive, but the most profound impact is on the individual lives uplifted by HEAL hospital initiatives.

HEAL Initiative Progress Dashboard

Target Status: 14 On target 2 In progress 1 To be addressed

1 Increase local workforce commitment to reduce economic hardship

	Description	2018 to 2021 Highlights	Status
1.1	**Hiring:** Compared to 2018 levels, target a 15% increase in hiring out of the 18 communities by 2021	Hires from the HEAL neighborhoods—CY 2018: 2,933 | 3-Year Average: 3,535 **(21% increase in hiring)** | CY 2019: 3,686 | CY 2020: 3,080 | CY 2021: 3,839	
1.2	**Procurement:** Compared to 2018 levels, target a 20% increase in purchasing relevant supplies and services from local suppliers by 2021	Dollars spent on supplies & services from HEAL neighborhoods—CY 2018: $95M | 3-Year Average $120M **(27% increase in procurement)** CY 2019: $137M | CY 2020: $131M | CY 2021: $93M	
1.3	**Workforce Retention:** Develop career advancement and growth opportunities to foster local workforce retention	Students promoted or advance—CY 2018: 509 | CY 2019: 574 | CY 2020: 661 | CY 2021: 860	
1.4	**Workforce Development:** Create additional youth summer employment, workforce development, and apprenticeship programs to promote careers in healthcare fields and paraprofessional roles to students in target neighborhoods	Number of high school and/or college student participants—CY 2018: 4,742 | CY 2019: 11,607 | CY 2020: 1,688 | CY 2021: 4,921	

2 Support community partnerships to improve health and safety of public environments

	Description	2018 to 2021 Highlights	Status
2.1	**Trauma-Informed Counseling and Support:** Deliver trauma-informed, community-based counseling and peer support services across all target neighborhoods, including through home visiting programs, case management, youth mentorship programs, and violence interruption programming	Number of programs—CY 2018: 86 | CY 2019: 96 | CY 2020: 148 | CY 2021: 157	
2.2	**Behavioral Health Partnerships:** Promote colocation of behavioral health services, including by partnering with federally qualified health centers and schools to open new clinics in target neighborhoods	% of hospitals engaged in partnerships—CY 2018: 80% | CY 2019: 80% | CY 2020: 90% | CY 2021: 90%	
2.3	**Neighborhood Vitality:** Improve physical neighborhood vitality by supporting affordable housing pilot programs for the homeless, housing renovations, restoration of vacant lots, and community garden development	% of hospitals engaged with programs—CY 2018: 90% | CY 2019: 100% | CY 2020: 90% | CY 2021: 90%	
2.4	**Safe Zones:** Establish Safe Haven, Safe Passage routes, and gun-free zones surrounding hospital-owned buildings and facilities	Number of partnerships—CY 2018: 25 | CY 2019: 27 | CY 2020: 21 | CY 2021: 20	
2.5	**Health Fairs:** Hold community health fairs and other summer and nighttime events at city parks and community centers to increase access to wraparound services and reduce violence	Number of health fairs—CY 2018: 544 | CY 2019: 481 | CY 2020: 183 | CY 2021: 271	

3 Prioritize key in-hospital clinical practices to address unmet needs

	Description	2018 to 2021 Highlights	Status
3.1	**Screenings & Firearm Safety:** Train all hospital intake staff and primary care practitioners in behavioral health and trauma screenings, and communicating with patients on firearm safety	Patients screened—CY 2018: 219,761 | CY 2019: 344,151 | CY 2020: 66,022| CY 2021: 133,863 Employees trained—CY 2018: 1,043 | CY 2019: 1,420 | CY 2020: 1,815 | CY 2021: 7,479	
3.2	**Counseling & Case Management:** Establish trauma-informed post-injury counseling and community case management programs to support long-term healing for all appropriate victims of violence	Patients paired w/services—CY 2018: 1,828 | CY 2019: 5,177 | CY 2020: 4,524 | CY 2021: 2,935 Programs—CY 2018: 12 | CY 2019: 15 | CY 2020: 16 | CY 2021: 14	
3.3	**Opioid Prescribing:** Compared to 2018 levels, reduce inappropriate opioid prescribing rates by 20%—to help prevent potential drug misuse and addiction—by 2021	Prescribing in the region has decreased much more than 20% in the 2016-2019 time period. With opioid deaths being driven by illicit fentanyl overdoses, HEAL hospitals have increased efforts in harm reduction and opioid use disorder treatment in response to the increasing number of fatal and non-fatal overdoses.	
3.4	**Lead Poisoning Screening:** Compared to 2018 levels, reduce inappropriate opioid prescribing rates by 20%—to help prevent potential drug misuse and addiction—by 2021	To be addressed—establishing potential partnership with the CDPH.	
3.5	**Data Sharing:** Develop common data sharing infrastructure and platforms across hospitals and with relevant stakeholders to coordinate services, identify trends, and improve patient care	Number of data platforms—CY 2018: 18 | CY 2019: 17 | CY 2020: 30 | CY 2021: 23	
3.6	**Chicago Gun Violence Research Collaborative:** Participate in the Chicago Gun Violence Research Collaborative to expand violence prevention research network and agenda to additional sites with at least five new projects citywide	% of hospitals participating in the collaborative—CY 2018: 70% | CY 2019: 60% | CY 2020: 60% | CY 2021: 50%	
3.7	**Illinois Perinatal Quality Collaborative:** Participate in the Illinois Perinatal Quality Collaborative	% of hospitals participating in ILPQC—CY 2018: 60% | CY 2019: 60% | CY 2020: 70% | CY 2021: 80%	
3.8	**Bias and Cultural Competency Training:** Provide implicit bias and cultural competency training to providers—to help reduce racial disparities in health outcomes	% of hospitals providing bias and competency training—CY 2018: 80% | CY 2019: 70% | CY 2020: 100% | CY 2021: 90%	

"IHA is proud to support the work of the HEAL hospitals as they work together individually and collaboratively with Senator Durbin to advance healthcare for Illinois residents and enhance community well-being."

— A.J. Wilhelmi, IHA President & CEO

Illinois Health and Hospital Association

10 Powerful Stories

Touching Individual Lives

It's the people who make a community strong. HEAL hospitals are working hand-in-hand with community partners to uplift individuals, giving them a chance to pursue their dreams and achieve success. HEAL hospitals and community groups are having an impact. Together, they're building stronger communities.

**One powerful goal—
so many lives changed.**

Advocate Aurora Health

Dedicating His Life to Making a Huge Impact

The impact of the crash with the 18-wheeler truck sent **Rashard Johnson**'s 1994 Infiniti G20 ricocheting down the Florida Turnpike in Miami.

Yet when his car finally came to a stop, Rashard walked away with no injuries.

"The EMS technician on the scene said he was amazed I was able to walk away from that accident without a scratch. He said he rarely sees people walk away from a crash like that," Rashard says.

In that moment, Rashard came to fully appreciate his life was spared for a reason.

So, at 24 years old, Johnson promised God and himself that he would dedicate his already-bright future to making a huge impact on the world.

Fourteen years later, Rashard is married to his high school friend, Donnidra, a proud father of four and president of both **Advocate South Suburban Hospital in Hazel Crest** and **Advocate Trinity Hospital** on Chicago's Southeast Side.

Since stepping into this executive role at Advocate Health Care (now Advocate Aurora Health) in 2017, Rashard has expanded access to care in these communities—which see the highest rates of stroke and diabetes in metro Chicago—through physician recruitment, the addition of advanced robotic surgery, childbirth services, and outreach and community education. He also oversaw construction of a $90 million Surgical Procedural Center that added 88,000 square feet to Advocate South Suburban.

Rashard says his childhood roots in Miami's tough Liberty City neighborhood give him special insights into what it will take to improve the overall health of underserved communities like the ones his hospitals serve—namely addressing education, income and other societal inequities.

Rashard Johnson *Photo credit: John Boehm/Crain's Chicago Business*

Today, Rashard sits on the Chicagoland March of Dimes Board of Directors and facilitates partnerships to support the South Side's new mothers. The March of Dimes recently partnered with Advocate Trinity to host the hospital's first drive-through baby shower, which offered newborn care packages to new mothers with financial difficulties caused by the pandemic.

In 2020, Rashard and wife Donnidra created the Rashard and Donnidra Johnson Scholarship for college-bound seniors. Every year the scholarship awards $1,000 to top-performing students graduating from the couple's high school alma mater in Miami. Over time, the couple intends to endow full-tuition college scholarships for students living in historically marginalized communities in Miami, Dallas, Houston and Chicago.

"I'm looking to make an impact through generational change, and that starts one person at a time, one interaction at a time, and we're just getting started."

Rashard Johnson

■ Website links

AMITA Health

One Mother in Need

Solutions for rent, utilities and food.

Recently, we screened a toddler for social determinants of health in one of our emergency departments, and his mother responded on her son's behalf. The mother was unemployed due to COVID-19 and was having difficulty keeping up with her family's cost of living, including rent, utilities and food. The family's apartment is drafty, resulting in exceptionally high gas bills, and the utility company threatened to terminate services. She had contacted the Community and Economic Development Association of Cook County, Inc. (CEDA) and was waiting for financial support at the time of her screening because she was also behind on her rent.

An AMITA Community Services Navigator gave the mother a list of local food pantries and information about Chicago Public Schools' breakfast and lunch program, which is essentially a pantry for children's nutritional needs. The navigator also provided the mother with guidance on how to present a written request to the landlord for the necessary repairs and information to contact the Lawyers Committee for Better Housing in case of any ongoing neglect of the property.

The mother's plan, which she created in partnership with the navigator, also included an inquiry for financial assistance for rent and utilities from Housing Forward and Hands to Help Ministries.

Upon follow-up, the mother indicated that she started utilizing a food pantry and her children's school for boxed food on a weekly basis. She also indicated that her landlord has made repairs to the apartment building, which have resolved its moisture, pest and mold problems. The landlord also helped the family find financial resources to help pay the rent! The mother is still waiting for a letter to prove her unemployment status for the CEDA program but has not been disconnected from services and is now on a payment plan for her gas service.

The mother didn't know where or how to start approaching her landlord with these issues and was so grateful for the support and follow-up assistance that AMITA Health could provide with connecting her to community resources.

Ann & Robert H. Lurie Children's Hospital of Chicago

Changing Life's Trajectory

How the Mentoring and Workforce Development program connected with a high school student and led to success.

Jessica Saavedra didn't always know she wanted to work in healthcare. It all began in 2011, when Jessica was a high school junior seeking an internship and her counselor connected her with the Ann & Robert H. Lurie Children's Hospital's Mentorship and Workforce Development program. In partnership with local schools, the Workforce Development program offers young people living in Chicago's under-resourced neighborhoods mentorship

and career development opportunities in the healthcare field.

Jessica grew up in Belmont-Cragin, a largely Hispanic neighborhood in northwest Chicago. Now 27, she holds a chemistry degree and is a newly minted medical assistant at Lurie Children's. She attributes much of her success to Maria Rivera, the director of the Workforce Development program, who gave Jessica her first of many roles at Lurie Children's. "Maria was more of a mentor than a boss. She supported me, encouraging me to pursue higher education and my dreams," Jessica says.

Since that summer internship, Jessica has worked in administrative and programmatic roles at the hospital, including outreach work with high school juniors and seniors. "I helped a lot of students with things like resume workshops and creating elevator pitches. I really loved the work because I felt I was giving back to the community I was from," she says.

Jessica shares that the COVID-19 pandemic was the "wake-up call" she needed to fulfill her goal of pursuing a career as a healthcare worker. Ultimately, she aspires to become a physician assistant and is applying to programs in the coming year. "I feel like I'm a product of the Workforce Development program. I dream of coming back to the program as a physician assistant and telling the students that I've been in the same seat they're sitting in now," she says.

For communities like hers, Jessica believes that the lack of representation and diversity in healthcare professions are significant barriers for youth wanting to enter the workforce. "There's almost a disconnect between where they are and where and who they want to be. They don't see themselves being in the role of a doctor or a surgeon because of the color of their skin," says Jessica. The numbers say it all: Today, Black and Hispanic/Latinx populations comprise less than 6% of the physician workforce in the U.S.

Jessica is pictured above (top left), with staff (top right) and with Senator Durbin (bottom, Jessica is on the far left)

Reflecting on the pandemic and how it has affected today's youth, Jessica gave this advice: "Don't lose focus, despite everything that's changing and out of your control. It's important to keep taking small steps toward your goal, and never give in to doubt. Always stay focused."

Cook County Health

One of the Largest Programs in the Country

The COVID-19 pandemic disproportionately impacted the patients and communities that CCH has traditionally served.

The approval of the first COVID-19 vaccine in December 2020 provided a ray of hope following a very difficult and dark period of time for many, including those who worked tirelessly throughout the early and ongoing days and nights of the pandemic. CCH worked closely with county and state officials to provide COVID-19 vaccines at our hospitals and health centers, mass vaccination

CCH mass vaccination site at South Suburban College in South Holland.

sites, targeted sites for specific populations, mobile and pop-up sites, and distribution through other healthcare partners including hospitals and health centers in suburban Cook County.

"I was overly impressed by the organization, and the logistics of how it works."

Terry Valentino, Arlington Heights

Initially, demand greatly exceeded supply with many more individuals who sought out vaccinations than there was vaccine available to provide. Eventually, vaccine supply became more plentiful and most of CCH's vaccination sites transitioned from appointment-only to walk-ins accepted. While the mass vaccination sites were consolidated and eventually phased out by late spring/early summer 2021 as demand waned, CCH continued to provide COVID-19 vaccines at our hospitals and health centers, while also pivoting to a hyperlocal strategy to connect with those who remained unvaccinated and make it as easy as possible for these individuals to be vaccinated in areas where they live and work. In the fall, CCH sites also began administering boosters and vaccines to children 5 years and older as soon as they were authorized by the federal government.

CCH also developed several award-winning ad campaigns to encourage residents to be vaccinated, including the "My Shot" multimedia, multilingual public education campaign, "Life is Better Vaxxed" and the "Trust Us" ad campaigns, which highlighted CCH physicians and centered around the trust patients and communities have in their doctors.

As a result, CCH developed and implemented one of the largest community vaccination programs in the country that administered more than 968,000 doses of COVID-19 vaccines through January 2022, with a particular focus on communities with low vaccination rates in our suburban public health jurisdiction.

Loyola Medicine

A Place to Heal After Heart Surgery

Housing Forward's client, John, knew he had a heart problem. He had already had two heart attacks and several strokes.

His doctor wanted him to have surgery to install a defibrillator, which John did not want. Much of the reason he didn't want it was because he had nowhere to go to heal post-procedure, since he was living at night in only congregate shelters at Housing Forward.

After telling John about Housing Forward's Medical Respite program at Sojourner House, he talked to his doctor again as he was ready to take this difficult step. After his surgery he was visited by the Sojourner House case manager. He talked with her about how he was feeling and questioned

where he would go. The case manager talked with Loyola Medicine nurses at MacNeal Hospital to let them know that he was accepted at Sojourner House, a temporary medical respite for patients experiencing homelessness, and that they should just call when he was ready to be discharged.

The three became best friends—almost like brothers.

When John first came to Sojourner House he had no energy and felt extremely fatigued. He was introduced to the client who had just left his apartment at Sojourner House, and who had the same medical issue. They talked about how it felt to be shocked by the defibrillator and other concerns. Included in this discussion often was Joe, who was in the unit across from John. The three became best friends—almost like brothers. Each left Sojourner House when they eventually became strong enough. They always helped each other out with little things like shopping, hanging shelves, unpacking, etc.

John approached the director of medical respite and asked to begin volunteering. He wanted to give back. She was delighted and invited him to help co-lead a discussion group and to have conversations with clients if needed. A weekly program was started. John brought his past challenges as well as how he had changed his life to the weekly discussions, bringing the complement of real-life experience to balance the counseling skills of the director. This has been working for almost a year now and John has been a great addition to the Medical Respite Team at Housing Forward, Loyola Medicine, MacNeal Hospital and more.

John receives furniture for his new apartment.

John began volunteering in discussion groups—bringing his past challenges as well as how he had changed his life.

Northwestern Medicine

A Better Career Starts at Northwestern Medicine

Northwestern Medicine is working to improve communities in inspiring and innovative ways.

For example, the Human Resources Department and a network of community organizations are collaborating to pool resources and create career programs for candidates who might not possess all of the minimum skills needed for a particular job.

Angelica Cervantes, a patient escort at Northwestern Memorial Hospital, found her job through a pilot program that recently launched at Northwestern Medicine. “I had been looking for a job, and someone sent me information about a Northwestern Medicine flyer they saw online,” she says. “I inquired about the opportunity, received a response, and the next thing I knew I was meeting with a Northwestern Medicine representative to discuss the requirements of the job and what additional skills I needed and could obtain through the program. It all happened so fast!”

Equus Workforce Solutions, a community organization that offers on-the-job training as well as recruits, prescreens and refers candidates

to Northwestern Medicine to fill patient escort vacancies, referred Cervantes. Equus also provided child care, transportation and additional support to Cervantes while she was training.

"I love my job! When I first meet a patient, I introduce myself and try to make them feel comfortable."

Angelica Cervantes

The patient escort role is the first position being offered for this pilot program, which currently has six participants. The number of participants will change based on the needs of the department for the position being offered at that time. Northwestern Medicine plans to offer similar on-the-job training programs for other positions in the future.

I love my job!" says Cervantes. "When I first meet a patient, I introduce myself and try to make them feel comfortable. If they have any questions, I try to answer them to the best of my ability."

Northwestern Medicine Recruitment and Community Services Manager Brian Stewart organized the pilot program. "I knew the patient escort role was the perfect position for a collaboration with community partners to offer the on-the-job training program," he says.

Angelica Cervantes

"Cervantes says she enjoys being able to work in healthcare: "Being here gives me the opportunity to interact with diverse patients, meet people from different departments and network."

Christopher Garcia, manager of the Patient Escort Department at Northwestern Memorial Hospital, says he's excited to have Cervantes on his team. "Her performance is fantastic," Garcia says. "We keep track of productivity, and she's consistently at the top level. She's helped her peers by coming in early and staying late. Overall, she was really the trailblazer for the program, and I appreciate having her. I look forward to seeing her growth."

Teamwork is a vital part of the Northwestern Medicine culture, and there is always encouragement for professional development and career growth.

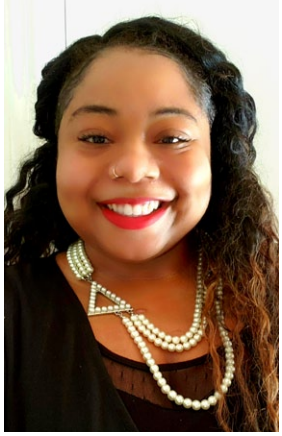
Rush University Medical Center

After Hesitancy, Choosing COVID-19 Vaccination

At Rush, patient-facing staff often speak about continuum care—that is, the cycle of caring for a patient's many (and often unseen) needs in addition to the issues for which they choose to seek care at Rush.

As part of Rush's school-based clinical work, our social workers and community health workers often come across individuals who work adjacent to our various initiatives. One of our most compelling stories is that of MaToya Marsh, a guidance counselor at the Simpson Academy for Young Women, a Chicago Public School academy for pregnant and parenting junior high and high school students and one of Rush's school-based community clinics.

After weighing her options and seeking advice from Marcy, MaToya made the decision.



MaToya Marsh

MaToya took careful precautions from the very beginning of the pandemic, and she prided herself in being a lot more guarded than many of her family and friends. Despite those precautions, MaToya still did not feel secure in getting the vaccine when it became available. MaToya does not consider herself an anti-vaccine advocate. A big challenge for MaToya during the COVID pandemic, however, has been the amount of information that she believes is readily available at one's fingertips, and which she believes often results in an inability to make a decision about vaccination due to continuously overthinking her choice. MaToya's brother, Reggie, is 51 years old and was diagnosed with autism early in his life. He cannot currently care for himself or live independently, and she along with their mother are his caretakers. Therefore, MaToya understood that her decision would impact him immensely, as he is not able to voice his concerns or communicate his own needs.

Before deciding that the vaccine was the right choice for her and her family, MaToya had a few conversations with Marcy Gonzalez, a nurse in the Community Health Equity and Engagement department at Rush. She could overlook a lack of distrust in the economic motivations of big pharmaceutical companies but the inconsistency in messaging from the U.S. government during the early months of the vaccine rollout did little to help assuage her fears of potential long-term side effects. A turning point came when MaToya's aunt, who had recently moved to Texas to begin a new chapter in her life, contracted COVID during her move. Shortly after arriving in Texas, she was admitted to the hospital where she battled the virus for about a month before she passed away from complications of the disease.

A big challenge for MaToya has been the amount of information readily available, which often results in an inability to make a decision about vaccination.

The death of her aunt was devastating, and MaToya once again sought counsel from Marcy to discuss vaccination for her, her brother and additional family members. After weighing her options and seeking advice from Marcy, MaToya made the decision to get vaccinated with her brother at the Rush School Based Health Center at Simpson Academy. She said that the process was smooth and credits Marcy with providing her with all the necessary information she needed to make a decision that was right for her and her family.

Sinai Chicago

Mentoring Others with Spinal Cord Injuries

Patrick Garcia serves as the supervisor for Schwab Rehabilitation's Peer Mentor Program. Similar to the patients he serves, he also lives with a spinal cord injury acquired through violence.

The program connects patients who have experienced a spinal cord or brain injury, stroke, or amputation to a peer mentor with a similar background and life experiences for both short- and long-term services.

Peer mentors are people with and without disabilities who provide counseling and advice to others who have similar life experience. Peers can be of the same age group, backgrounds, cultural or ethnic group, or disability type.

Peer mentors share their personal experiences with the rehabilitation process in hopes of showing others with the same disability how they can live independently. Patrick notes that it's all about accepting the situation, taking full advantage of the therapies offered and making better decisions moving forward.

It's about accepting the situation, taking advantage of therapies and making better decisions moving forward.

Patrick Garcia and peer mentors

Peer mentors have assisted patients in:

- Finding accessible living situations;
- Leaving institutional care settings like the hospital to return to a home in their community;
- Applying for Social Security, Medicaid, food stamps and other social services; and
- Entering the workforce including searching for employment, updating their documentation, learning or better understanding interviewing, and other skills need to gain and keep employment.

In addition to sharing their experiences, peer mentors also connect patients to resources such as transportation services, in-home meals and organizations that assist with home modifications.

One key resource that the peers provide is hope. Peer mentors often employ skill-building and other more subtle ways to inspire hope. Peer mentors can help patients develop communication and advocacy skills to better represent themselves. They help patients acknowledge their limitations, but also recognize their strengths and unique capabilities.

Sometimes, simply enjoying a sense of "normalcy" can liberate a patient. Patrick recounts a day when program staff organized a trip to a soccer game and tailgate for a patient with a spinal cord injury. After enjoying a much-needed night outside of the rehab hospital, the patient felt "free and good," just like any other fan in the stadium.

Collectively, these efforts benefit patients in living their lives, but also contribute to mitigating reliance on the medical care system. Effective peer mentoring increases self-efficacy and can reduce symptoms of anxiety and depression, visits to emergency rooms, and unplanned hospitalizations or readmissions. All these improvements contribute to measurably increased satisfaction with life.

After meeting their goals and being discharged from the program, a few patients have become mentors themselves. Patrick sees these stories as a success because they have found a better focus, became independent and landed a stable job.

UChicago Medicine

The Kind of Work You Wish You Didn't Have to Do

Geri Pettis, a pediatric violence recovery specialist at University of Chicago Medicine engaged 95 child and teenage victims of violence in summer 2021, a staggering number.

Among them: several teens who were rushed to Comer Children's Hospital multiple times for gunshot injuries and a 1-month-old girl shot in the head during a mass shooting while strapped in her car seat.

Pettis works with pediatric patients in the hospital's Violence Recovery Program (VRP), which identifies patients at risk of repeat injuries from violence and connects them to hospital and community-based services.

Since May 2020, she has seen 272 patients.

"This is the kind of work you wish you didn't have to do, but it's so rewarding," says Pettis. "Our patients receive case management and crisis intervention services. We connect families to mental health counseling. We take a holistic approach to make sure they're safe and not re-injured."

The program was launched in 2018 to serve adult and pediatric trauma patients and their families, the same year UChicago Medicine opened a Level 1 adult trauma center.

In its first year, VRP engaged 792 patients and 334 families dealing with the aftermath of gunshot wounds, stabbing injuries and assaults.

"Our program is actively working to not just patch up our patients, but helping them make a change in how they look at the world."

Geri Pettis

The VRP received funding from UChicago Medicine's BHC (Block Hassenfeld Casdin) Collaborative for Family Resilience. The BHC Collaborative provides personalized holistic care for children and families whether the child is the direct victim or a witness to a close family member's trauma.

BHC Collaborative's approach represents a dramatic shift in trauma care: In addition to medical treatment, it provides essential wraparound services—food, housing, and vocational and other services—to help children and their families during and after their hospital stay.

Pettis, who grew up on Chicago's South Side, says her love of children and her family background help explain why she was drawn to her job. Her mother's death from cancer when she was 17 gave her a deep understanding of grief and loss. Her son, Gabriel, 16, is the same age as some of her patients.

Gerri Pettis

"I'm empathetic and an active listener," she says. "I understand that emotions affect people differently and you have to talk to individuals going through a traumatic moment with love and patience."

Children often can't articulate their feelings. Their stress might manifest in sleeplessness, disorientation and agitation. When they're medically stable, Pettis talks, draws or plays video games with them.

Kids growing up in violent circumstances can be constantly on guard and hypervigilant. They need to achieve a calm, peaceful state to fully recover, Pettis says. So, she often teaches them breathing techniques.

VRP engaged 792 patients and 334 families dealing with the aftermath of violence.

Teenagers who have been violently injured are referred to violence interrupters, who are trained to help them change their thinking and behaviors.

"Our program is actively working to not just patch up our patients, but helping them make a change in how they look at the world," Pettis says. "If we can color their worldview in a more positive way, then we've done our work."

University of Illinois Hospital & Health Sciences System

Seizing Opportunities to Pursue a Career

The UIC Urban Health Program (UHP) provides educational opportunities to students interested in health careers.

UHP's purpose is to address growing health disparities and unmet care needs in Illinois for communities of color. Today's healthcare workforce does not reflect the diversity of patient populations or keep pace with population trends, and the COVID-19 pandemic has further highlighted the disparate burden of disease among minority groups. To care for a diverse population, it is essential to increase a diverse healthcare workforce.

Despite some improvement in the educational pipeline, the persistent underrepresentation of minorities in the healthcare workforce impedes efforts to improve population health. The development of pipeline programs in health professions are a primary strategy for increasing representation of underrepresented minorities in healthcare. Creating more equitable healthcare requires early exposure to healthcare issues, research and clinical interventions.

To care for a diverse population, it is essential to increase a diverse healthcare workforce.

UHP believes the best way to address healthcare disparities within underserved, minority-populated communities is to recruit and encourage students from those communities to pursue health careers and serve the communities in which they reside. Studies have confirmed that underrepresented students are more likely to work in underserved communities if afforded the opportunity.

UHP also includes an Early Outreach Program for middle and high school students, an Urban Health Club for high school students, standardized test prep courses for pre-health students, and robust recruitment efforts.

Temiloluwa Sodipe, class of 2023, is pursuing a degree in Public Health with a minor in French and Francophone Studies. Following is Temi's perspective on UHP.

Temiloluwa Sodipe

"Currently a junior at UIC and an HES [Health Exploration Scholar], my involvement with the Urban Health Program began my freshman year when I applied and was accepted to be a PASS [Promoting Academic Scholarly Success] scholar. I am beyond grateful for the experiences that I have been awarded with and the connections and friends that I have made and developed. This program has not only solidified my intent to pursue medicine and a career in lifelong service, but it has also given me diverse perspectives into other healthcare careers, as well as numerous professional development opportunities to help support and expand my learning capabilities, as well as my extracurricular and scholarly endeavors. Francisco [Pina, UHP Assistant Director for Recruitment, Retention and Advising] and Selena [Evette Smith, Senior Associate Director] have been phenomenal mentors and support systems, and I could not be grateful enough for them, as well as each and every leadership member in the UHP PASS and HESS program!"

The PASS initiative is open to freshmen and UHP transfer students who are interested in the health sciences and is designed to assist students in developing their interests and skills, making certain they are on the right pathway to apply for any of the UIC health science professions or graduate health science programs. The HES program is a professional development program for UIC students with the intent of pursuing a career in health professions and is structured to expose participants to fellow students and members of the health science faculty.

Collective Commitment

Overview of HEAL Initiatives

Being a hospital in a community means a lot. Being a hospital and a community partner means even more. HEAL hospitals are investing in the communities they serve: hiring from HEAL communities, strengthening connections with community groups to improve health and addressing unmet needs.

Working together to effect change.

Advocate Aurora Health (AAH) is one of the 10 largest non-profit, integrated health systems in the U.S. and a leading employer in the Midwest with 75,000 employees, including more than 22,000 nurses and the region's largest employed medical staff and home health organization. A national leader in clinical innovation, health outcomes, consumer experience and value-based care, the system serves nearly 3 million patients annually in Illinois and Wisconsin across more than 500 sites of care.

Advocate Trauma Recovery Center (TRC)

TRC is a healthcare-based violence intervention program that provides social and behavioral health services, individual and group therapeutic services, and psychiatric consultation to survivors of intentional crime and/or trauma. The purpose is to aid individuals who have experienced trauma in rebuilding, restoring and strengthening their sense of safety by ending the cycle of violence. TRC provides access to trauma-informed care by acknowledging how past and present traumatic experiences and stress may impact the individuals and families served—responding to the unique needs of each survivor and their family. In late 2021, the program, originally located at Advocate Christ Medical Center, expanded its services to Advocate Condell Medical Center through support from the Illinois Criminal Justice Information Authority.

1,259 **PATIENTS SERVED IN THE COMMUNITY IN 2021**

The South Side Healthy Community Organization

The South Side of Chicago has experienced longstanding health disparities ranging from higher incidence of disease and comorbidities to substantially lower life expectancy. These health disparities reflect a history of racial inequities and significant underinvestment.

50+% **OF SOUTH SIDE RESIDENTS MUST LEAVE THE SOUTH SIDE TO RECEIVE CARE**

In an unprecedented initiative, AAH joined forces with the care providers of Chicago's South Side to form a comprehensive coalition of federally qualified health centers (FQHCs), safety net hospitals and health systems dedicated to advancing health equity for Chicago's South Side residents. The coalition, comprised of Advocate Trinity Hospital and 12 other health entities, established a new, 501(c)(3) nonprofit organization—the South Side Healthy Community Organization (SSHCO)—as the vehicle to facilitate healthcare transformation on Chicago's South Side.

NFL Externship Program

The NFL Externship Program aims to increase employment and training opportunities for entry-level healthcare positions in communities with high rates of unemployment. The initiative targets six high-risk zip codes across Advocate Illinois Masonic's Primary Service Area (PSA) and partners with several community partners, including Malcolm X College, Midwestern Career Institute, Coyne College and Triton College, to recruit students training in phlebotomy, surgical technologist and medical assistant. Along with the clinical rotations, orientation and workforce development workshops are provided to all participants in the initiative. Upon successful completion of the externship, students receive a stipend and are eligible for reimbursement for certification exams. Students are also matched with an HR recruiter to interview for any open positions that align with their training and externship.

The program achieved the following outcomes from its implementation in April 2021 through December 2021:

11 **STUDENTS HAVE COMPLETED THE PROGRAM**

10 **STUDENTS RECEIVED STIPENDS**

12 **STUDENTS COMPLETED THE WORKFORCE DEVELOPMENT WORKSHOPS AND ORIENTATION**

2 **STUDENTS WERE HIRED INTO PERMANENT POSITIONS WITHIN AAH**

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■ Website links

AMITA HEALTH™

AMITA Health is a faith-based organization with a mission to extend the healing ministry of Jesus and ensure that everyone in our communities—especially those who need it most—has a place to turn for exceptional, compassionate, faith-based healthcare. Our vision is to deliver healthcare that is **accessible** for all, **accountable** to our patients and one another, and **holistic**, treating each patient as a whole person.

Addressing Socioeconomic Determinants of Health

In line with our commitment to health equity, and firm understanding that efforts to prevent violence must be grounded in addressing socioeconomic determinants of health, AMITA Health is a participating Bridge Organization in the national Accountable Health Communities (AHC) program. The AHC program is a cooperative agreement with the Centers for Medicare & Medicaid Services Innovation Center, in which patients insured by Medicare and/or Medicaid are voluntarily screened for health-related social needs when they seek care at participating sites. If the patient is experiencing challenges in areas such as housing, paying for utilities, accessing healthy food or reliable transportation, or interpersonal violence, we connect them to community resources that can help them resolve those issues. This national program aims to study the process of assessment and the impact that assistance with meeting social needs has on patients' health outcomes and utilization.

Providing Personal Community Service Navigation

One participating screening site for the AHC program is AMITA Health Saints Mary and Elizabeth Medical Center (SMEMC), one of Illinois' largest safety net hospitals.

2,137 **PATIENTS ASSESSED WHO ARE INSURED THROUGH MEDICARE AND/OR MEDICAID AND VISITED THE EMERGENCY DEPARTMENT IN 2021**

377 **PATIENTS PROVIDED WITH COMMUNITY RESOURCE LISTS TO SELF-NAVIGATE**

181 **PATIENTS PROVIDED WITH PERSONAL COMMUNITY SERVICE NAVIGATION ASSISTANCE**

Of those 181 patients, 22% have already indicated that their needs have been resolved, and 57% are still being assisted.

The experience and key learnings from participating in the AHC model has enabled us to set up a similar program within AMITA Health Medical Group with practices located in other underserved communities.

Addressing Food Insecurity

Additionally, AMITA Health is addressing food insecurity by expanding the West Town Health Market located at SMEMC. This expansion, supported by an additional USDA grant, added partnerships with key community organizations to provide community members with improved access to healthy foods and education on food preparation.

AMITA Health stands committed to the HEAL Initiative's call to action to address systemic health inequities through community partnerships that contribute to the overall health and well-being of those we are privileged to serve.

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Ann & Robert H. Lurie Children's Hospital of Chicago®

Ann & Robert H. Lurie Children's Hospital of Chicago is the only full-service, independent, freestanding pediatric hospital in Illinois. A nonprofit, tertiary care hospital, Lurie Children's has 364 licensed beds and provides a full range of inpatient and outpatient care and related ancillary services. Lurie Children's provides more pediatric Medicaid services than any other hospital in Illinois, and more than half of the inpatient care provided is to youth insured by Medicaid.

Mentorship and Workforce Development Program

In 2021, Lurie Children's Mentorship and Workforce Development program celebrated its 20th year of providing opportunities for Black, Hispanic/Latinx and youth of color in Chicago to explore healthcare careers. The program has grown to include 13 internship and training opportunities serving youth and young adults, from middle school to college. Nearly 340 youth participated

in Workforce Development programs in 2021 and three new programs were developed to provide young adults the opportunities to earn medical or nursing certifications with the intent of being hired at Lurie Children's Hospital.

340 **YOUTH PARTICIPATED IN WORKFORCE DEVELOPMENT PROGRAMS IN 2021**

Strengthening Chicago's Youth

In partnership with Strengthening Chicago's Youth (SCY) and Lurie Children's Pritzker Department of Psychiatry and Behavioral Health, Communities United—a community-based organization—was the only Midwest finalist of the W. K. Kellogg Foundation's global Racial Equity 2030 Challenge. The award supports actionable ideas for transformative change in the systems and institutions that uphold racial inequities. As finalists, Communities United and SCY have received a $1 million grant to bring together the grassroots expertise, experience and leadership of Black, Hispanic/Latinx and youth of color from across Chicago alongside national mental health leaders to transform the mental health system into one that supports community healing.

$1M **PLANNING GRANT RECEIVED TO TRANSFORM THE MENTAL HEALTH SYSTEM INTO ONE THAT SUPPORTS COMMUNITY HEALING**

Juvenile Justice Collaborative

The Juvenile Justice Collaborative (JJC) is implementing a regional strategy in police districts in Englewood and Chicago Lawn to receive referrals for youth granted deferred prosecution during the pandemic. In 2021, the JJC connected 162 youths to services, a 4% increase. Program completion increased by 24%. Overall, JJC graduates were re-referred to court at about half the rate of other Chicago youth in the justice system following their first arrest.

162 **YOUTHS CONNECTED TO SERVICES IN 2021**

Unintentional Injury Prevention

Lurie Children's injury prevention program is the only initiative that distributed car seats and cribs to Chicagoans consistently throughout the pandemic. In 2021, the program distributed 395 car seats (with education and installation guidance) to help ensure car safety. The team also distributed 157 cribs and fitted sheets to new parents, primarily on the South and West sides of Chicago, and trained 17 community-based Safe Sleep Ambassadors.

395 **CAR SEATS DISTRIBUTED IN 2021**

Mobile Health Program

In 2021, Lurie Children's Mobile Health Program, which began in late 2019, extended its reach to 28 Chicago neighborhoods and completed 94 visits. The team conducted COVID-19 testing for more than 600 students and teachers across 13 schools and vaccinated 1,500 youth and school/childcare staff in communities most severely affected by the pandemic. The Potocsnak Division of Adolescent

and Young Adult Medicine also used the mobile health unit to conduct HIV/STI screening, sexual health education, and trainings and distribution of naloxone to prevent opioid overdoses.

1,500 **YOUTH AND SCHOOL STAFF VACCINATED IN COMMUNITIES MOST AFFECTED BY THE PANDEMIC**

Community Volunteering

In 2021, 360 Lurie Children's employees and physicians dedicated more than 1,400 hours of service at 47 community events throughout Chicago neighborhoods including Belmont-Cragin, Austin, Gage Park, Little Village, Englewood, Garfield Park, Greater Grand Crossing, Humboldt Park and Washington Park. Volunteer activities included distributing food at pantries for families experiencing food insecurity; distributing essential resources like masks, hand sanitizer and infant supplies; conducting toy and winter clothing drives; and providing logistical and medical support at over a dozen COVID-19 vaccine clinics.

COOK COUNTY HEALTH

For nearly two centuries, Cook County Health (CCH) has served Cook County residents, regardless of income, insurance or immigration status. CCH provides healthcare through our two hospitals and network of community-based health centers; the CORE Center, the largest provider of comprehensive HIV care in the Midwest; and the Cook County Jail and Juvenile Temporary Detention Center. CCH includes the Cook County Department of Public Health and CountyCare, the largest Medicaid managed care plan serving Cook County.

Increase Local Workforce Commitment to Reduce Economic Hardship

In CY2021, Cook County Health (CCH) had more than 5,600 employees. As a public hospital system that is part of Cook County government, CCH must adhere to specific policies and guidance as part of a court mandate for our recruitment and hiring process. At the same time, CCH understands the value of ensuring that our workforce is representative of the communities that we serve.

At the end of 2021, 27% of CCH's employees, or 1,524 individuals, were identified as having a zip code from one of the priority communities in the HEAL initiative. Twenty-four percent of new employees hired in CY2021 (142 employees) were residents of HEAL zip codes.

1,524 **(27%) OF CCH'S EMPLOYEES IN 2021 WERE FROM A HEAL NEIGHBORHOOD**

Support Community Partnerships to Improve Health and Safety of Public Environments

CCH continues to work with the Greater Chicago Food Depository (GCFD) to address food insecurity and connect patients with healthy food options at our community health centers. In 2021, GCFD's Fresh Truck distributed fresh fruits and vegetables to individuals in over 5,000 households, most of whom were CCH patients who were identified as food-insecure through a screening administered by a CCH provider.

CCH works with Legal Aid Chicago on a medical-legal partnership, which provides no-cost, civil legal aid to patients referred by the CCH care coordination team. Legal Aid Chicago's work with CCH patients ranges from general counseling to full legal representation on a variety of issues including housing, employment and access to public benefits. In 2021, 313 CCH patients were referred, with more than half of these patients requiring assistance with accessing Medicaid, the Supplemental Nutrition Assistance Program and/or disability income.

CCH began a new partnership with Open Books, a Chicago nonprofit dedicated to transforming lives through the power of books. The partnership with Open Books focuses on enrolling CCH patients and CountyCare members into the Dolly Parton Imagination Library Chicago, which provides children ages 0-5 who reside in specific Chicago zip codes with a new, free book every month.

5,000 **HOUSEHOLDS RECEIVED FRESH FRUITS AND VEGETABLES FROM FRESH TRUCK**

Prioritize Key In-Hospital Clinical Practices to Address Unmet Needs

CCH continued our work to address housing insecurity through our continued leadership with and investment in the Chicago-Cook County Flexible Housing Pool (FHP), which seeks to connect persistent high utilizers of crisis systems, including CCH's emergency department, Cook County Jail and the homeless system, with affordable housing and individualized, supportive services. In 2021, FHP added additional investors, including other healthcare stakeholders, which contributed to the collective impact of housing 294 individuals in permanent supportive housing; many individuals housed through FHP are CCH patients or CountyCare health plan members.

Since February 2021, Cook County Health administered more than 13,600 doses of COVID-19 vaccines including boosters to CCH patients detained at the Cook County Jail and Juvenile Temporary Detention Center. Given that many of these individuals return to the South and West sides of Chicago, this effort not only helps protect them, but also the communities they return to.

13,600 **COVID-19 VACCINE DOSES ADMINISTERED TO CCH PATIENTS DETAINED AT COOK COUNTY JAIL AND JUVENILE TEMPORARY DETENTION CENTER**

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LOYOLA MEDICINE

Loyola Medicine is a regional academic health system based in Chicago's western suburbs and a member of Trinity Health, one of nation's largest Catholic health systems. Our system includes Loyola University Medical Center in Maywood; Gottlieb Memorial Hospital in Melrose Park; MacNeal Hospital in Berwyn; and a large ambulatory network of clinics throughout Cook, Will and DuPage counties offering primary and specialty care.

VeggieRx: A First-Person Account of Living Well with Cancer

I went to see a doctor because I really needed some help—not especially with a mechanical problem—because I have been under the care of some incredible physicians within the Loyola University Medical Center, but with the rest of my life that had been spiraling since I was first diagnosed with colon cancer in 2015.

That diagnosis was followed by three more cancers (skin, thyroid and blood) and several surgeries and I'm not sure that the average person could understand what havoc that can have on your regular life, already in progress.

The doctor, to my astonishment, said she was signing me up for a vegetable program. I remember thinking: I don't need a zucchini, lady. I need some help.

I joined the VeggieRx program and the idea of taking free food was incredibly off-putting to me. In my head, I was a donator to food pantries, not a taker. So, I made a firm decision that if these people were going to write me a prescription for this food, I was going to take it seriously and, since I had collected two social media certificates along the way, I decided was going to post my creations for everyone to see. When I made the food beautiful for others, I was also making it beautiful for me.

I took full advantage of the advice given freely by registered dietitian Mary Mora and so many dietetic interns and I asked anything and everything. It's not that I didn't eat vegetables before Veggie Rx. I just never really thought I'd actually crave them.

I remember one week, I had to ask if I could leave before the outdoor food demonstration because my car was leaking gas. Things were really rough at that time.

So, the zucchini changed my life.

I learned that kale wasn't a decorative item and I broke up with beets at the same time I was admitted to the hospital for internal bleeding. But the best thing has been watching (with my doctors) how "my numbers" continue to stay in the appropriate zones. I've made permanent friends with other program participants. I stood at my door when the pandemic was still crazy frightening while interns and volunteers dropped bags of vegetables and left before we'd exchange anything more than a wave.

When there was an opportunity to volunteer, I hopped right on top of it. Pulling out huge cherry tomato plants by the roots inspired me to return to the Loyola Center for Fitness to build my strength. Being locked in with a bag of assorted vegetables gave me something to focus on during the pandemic and I really learned to cook.

One day, Mary Mora asked me to join the team. It's been both my honor and my pleasure to find myself on the other side of the farm stand.

Northwestern Medicine®

Northwestern Medicine (NM) is a nonprofit, integrated academic health system committed to serving a broad community through our mission of providing quality medical care regardless of the patient's ability to pay; transforming medical care through clinical innovation, breakthrough research and academic excellence; and improving the health of the communities we serve. NM provides world-class care through 11 hospitals, two medical groups, and hundreds of diagnostic and ambulatory locations throughout northern Illinois.

Hiring and Spending in HEAL Communities

NM remains committed to helping reduce economic hardship by increasing hiring from the targeted local HEAL communities. In 2021, NM's hiring of individuals living in the targeted HEAL zip codes increased 16% over the previous year and 89% over 2018. Today, more than 25% of NM's Chicago workforce lives in the targeted HEAL communities. Also in 2021, NM spent more than $4.7 million on supplies and services purchased from companies based in one of the targeted Chicago HEAL zip codes, a 70% increase over 2019.

25%+ **OF NM'S CHICAGO WORKFORCE LIVES IN A HEAL COMMUNITY**

$4.7M **SPENT ON SUPPLIES AND SERVICES FROM HEAL AREA COMPANIES**

Promoting Careers in Healthcare

NM also continued to engage in youth summer employment, workforce development and apprenticeship programs to promote careers in the healthcare field, including paraprofessional, to students in the targeted Chicago HEAL zip codes. Through these efforts, NM offers ongoing, comprehensive on-the-job training, youth programs for high school students, and internships and fellowships for college students and post-graduates in both clinical and administrative settings. Highlights include NM's partnership with Chicago Public Schools and George Westinghouse College Prep as part of the NM Scholars Program and NM Discovery Program.

Supporting Behavioral Health, Trauma-Informed Counseling and Violence Prevention

NM continued leveraging community partnerships to improve the health and safety of individuals and public environments. As part of these efforts, NM continued to co-locate behavioral health services in partnership with federally-qualified health centers (FQHCs) and other community partners. NM also continued to engage in and support trauma-informed post-injury counseling and community-based management programs to help bring healing to victims of violence. Highlights include NM's partnerships with Acclivus and The Resilience Partnership to support the provision of

violence interruption services, and with The Urban Reliance Network (TURN) to support the provision of case management and youth mentorship. NM also continued its participation in the Chicago Gun Violence Research Collaborative, with the goal to expand violence prevention research in Chicago.

Addressing Social Determinants of Health

Also in 2021, NM continued to prioritize key in-hospital clinical practices to help address unmet needs. NM developed a social determinants of health (SDOH) screener within the medical record with the intent to screen all patients for SDOH. If a patient screens positive for a need, NM connects them with resources to help address the need.

Reducing Opioid Prescribing and Providing Drug Disposal

NM continued to implement its opioid reduction initiative, with the goal to reduce opioid prescribing to NM surgical patients. In 2021 alone, NM achieved a 13% decrease in the prescribing of morphine milligram equivalents. NM also continued to participate in the annual National Prescription Drug Take Back Day and dedicate operational and labor resources to ensure the reduction of unused controlled prescription drugs in the communities that we serve. In 2021, NM collected more than 600 pounds of unused prescription drugs from community members. Recognizing the importance of having access to prescription drug disposal year-round, several NM hospitals, including Northwestern Memorial Hospital, have permanent kiosks on their campus locations available to the public.

13% **DECREASE IN PRESCRIBING OF MORPHINE MILLIGRAM EQUIVALENTS IN 2021**

Promoting Maternal Health Equity

To help reduce racial disparities in health outcomes, NM through its participation in the State of Illinois' Perinatal Quality Collaborative continued to provide bias and competency training to its clinical staff.

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RUSH UNIVERSITY MEDICAL CENTER

Rush University System for Health is a national leader in outstanding patient care, education, research, community partnerships and empowering a new generation of healthcare providers. The Medical Center maintains a strong commitment to the community through offerings such as the Rush Community Services Initiatives Program, an umbrella for several student-led outreach programs designed to address the social and healthcare needs of residents in neighboring communities.

Increase Local Workforce Commitment to Reduce Economic Hardship

Rush hired 28.9% of its new hires, or 701 individuals, from Chicago HEAL communities and partnered with New Moms, Pyramid Partnership, YMCA, Mercy Housing and South Suburban College to provide application hub services. Rush's Community Health Worker (CHW) Hub, aimed at improving health outcomes, hired 25 CHWs in CY21, with 64% of hires from Chicago HEAL communities. Rush spent approximately $10 million in purchased services from businesses in the Chicago HEAL communities and launched a mentoring webinar series and its first virtual Shop the West Side program to support small vendors.

Rush launched cohort 6 of the Certified Nursing Assistant Pathway Program with 10 participants and a 60% completion rate and launched cohort 4 of the Medical Assistant Pathway Program with five Malcolm X College students. Rush had several summer programs targeted to high school students, including the 5+1 that brings health education to West Side school children and revenue cycle internships with 83% of participants from Chicago HEAL communities. In CY21, the MedSTEM and College Workforce Development internship programs, which provide technical training and employability skills, had 174 participants with 50% of students from Chicago HEAL communities.

701 **(28.9%) OF NEW RUSH HIRES ARE FROM HEAL COMMUNITIES**

$10M **SPENT BY RUSH FOR SERVICES FROM BUSINESSES IN HEAL COMMUNITIES**

Support Community Partnerships to Improve Health and Safety of Public Environments

Rush co-leads the Building Relationships – Generationally Effective Systems program that bridges pregnant and parenting women with childhood adversity to home visiting and doula programs. Rush participates in Family Connects Chicago and has delivered 1,200 virtual and in-home visits to families with newborns.

Rush's Center to Transform Health and Housing and its community-based teams, in partnership with the City of Chicago and others, provided over 50,000 COVID-19 tests in the community, delivered over 8,000 COVID-19 vaccines, and cared for more than 1,000 individuals experiencing homelessness and COVID-19 in a Safe Haven homeless COVID-19 respite center. Rush referred clients to the Housing

Opportunities and Maintenance for the Elderly program and supports home repairs through the Older Adult Home Repair Program.

Rush now operates two additional school-based health centers (for a total of five) at Wendell Phillips Academy School and Dunbar Vocational High School and provides wellness and trauma-informed care.

1,200 VIRTUAL AND IN-HOME VISITS DELIVERED TO FAMILIES WITH NEWBORNS

8,000 COVID-19 VACCINES DELIVERED

1,000 HOMELESS INDIVIDUALS CARED FOR

Prioritize Key In-Hospital Clinical Practices to Address Unmet Needs

Rush's Collaborative Care Program assists patients identified with depressive symptoms with gaining access to mental health services with over 1,000 referrals/year. The Community Mental Health Practice program has highly skilled psychotherapists to provide mental health support and has implemented a trauma-informed practice that meets each individual where they are.

Rush's long-standing opioid stewardship program has demonstrated sustained reductions in opiate prescribing in outpatient primary care since 2017. Children's healthcare providers at Rush routinely screen children at well-child health visits at the nine- or 12-month visit, and at the 18- or 24-month visit. Rush is part of the Illinois Perinatal Quality Collaborative and is actively working on the Promoting Vaginal Birth and Birth Equity initiatives. Rush's Cultural Competence and Implicit Bias for Leaders training promotes an important skill of increasing sensitivity to others' experiences, with 174 leaders and staff trained in CY21.

1,000+ PATIENTS WITH DEPRESSIVE SYMPTOMS REFERRED TO MENTAL HEALTH SERVICES

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Sinai Chicago

Since 1919, Sinai Chicago has worked to create a system where community and individual beliefs, values, and needs are respected, and all languages and cultures are welcomed. People and equity are at the center of everything we do to improve the health of individuals and communities. Sinai Chicago is composed of Mount Sinai, Holy Cross, Sinai Children's and Schwab Rehabilitation hospitals; Sinai Medical Group; Sinai Community Institute; and Sinai Urban Health Institute.

Hiring and Spending in HEAL Communities

Sinai Chicago institutions increased their significant contributions toward engagement of residents in HEAL communities and their employment. During Sinai's 2021 fiscal year (FY21), 498 employees—almost 42% of Sinai's 1,189 new hires—were hired from HEAL communities, doubling successes in FY20. Of Sinai's 3,434 employees, 1,269 or 36.7% reside in these communities, an increase of over 50% from FY20.

Procurement from these communities also increased over 400% from $2.97 million to $12.7 million in FY21.

36.7% **OF SINAI'S 3,434 EMPLOYEES LIVE IN HEAL COMMUNITIES**

$12.7M **IN PROCUREMENT FROM HEAL COMMUNITIES**

Supporting Community Partnerships to Improve Health and Safety

Sinai Chicago made notable commitments to support community partnerships to improve the health and safety of public environments programmatically and in partnerships with the city and community-based organizations to address COVID, maternal and child health, and behavioral health.

Sinai Chicago has partnered with Habitat Company, Cinespace Chicago Film Studios and the Chicago Housing Authority on Ogden Commons, a mixed-use development project that is the biggest investment in North Lawndale in over a decade. To address the health inequities in the community, a new One Lawndale Community Care and Surgery Center offers and expands outpatient health facilities and services where local residents will be able to access expanded services for medical, surgical and other crucial wellness needs.

Hand in hand with this effort has been Sinai Chicago's continuing effort to train staff and primary care practitioners and to emphasize the importance of social risk factors. Staff receiving formal training increased from 470 in FY20 to 880 in FY21, an 87% increase.

Providing Trauma-Informed Services

Sinai Chicago supported and initiated various trauma-informed services as well as collaborative initiatives for special populations and community residents in the targeted communities and within Sinai's service area.

Mount Sinai's Under the Rainbow Child and Adolescent Behavioral Health program offers trauma-informed counseling with a team of psychologists, psychotherapists and social workers. Sinai's Adult Behavioral Health program located in both Mount Sinai and Holy Cross offers trauma-informed services through its crisis stabilization, outpatient and acute inpatient services. Sinai Chicago became part of the Chicago Department of Public Health's network of Trauma Informed Centers of Care. Its goals include:

- Strengthening the mental health safety net in Sinai's service area (including most HEAL communities) and the coordination of mental health systems;
- Providing trauma-informed violence prevention and victim services; and
- Expanding services for persons with serious mental health illnesses and co-occurring disorders.

Collaborating to Improve Health and Health Outcomes

Notable commitments by Sinai in collaboration with other medical centers include the Chicagoland COVID Collaborative in conjunction with Rush University Medical Center, Northwestern University Feinberg School of Medicine, The University of Chicago and other centers. Sinai Chicago, through its Sinai Urban Health Institute, has participated in this community-based participatory research initiative as well as the city's Racial Equity Rapid Response Team (RERRT), Protect Chicago Plus program, Chicagoland Vaccine Partnership and the introduction of six Health Equity Zones.

In a groundbreaking collaboration with the city, Sinai Urban Health Institute and the Sinai Community Institute began Family Connects Chicago Pilot initiatives in west and southwest Chicago communities partnering with community-based organizations to improve services and systems serving Chicago families and improve maternal and child outcomes.

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AT THE FOREFRONT
UChicago Medicine

University of Chicago Medicine, with a history dating to 1927, is a non-profit academic medical health system based on the campus of The University of Chicago in Hyde Park, with hospitals, outpatient clinics and physician practices throughout Chicago and its suburbs. UChicago Medicine unites five organizations to fulfill its tripartite mission of medical education, research and patient care: Pritzker School of Medicine, Biological Sciences Division, Medical Center, Community Health and Hospital Division, and UChicago Medicine Physicians.

A Holistic Approach to Treating Those Impacted by Trauma

The BHC Collaborative started with a simple premise: Children and their families affected by trauma should be treated holistically, as their wounds are both physical and psychological.

Founded in April 2019, the BHC Collaborative provides personalized holistic care of the child and family at the UChicago Medical Center. Care continues after discharge, extending into the home, school and neighborhood through a network of community resources. This care is available to children who are victims of trauma or who witness a parent or close family member who experienced trauma.

The BHC Collaborative provides trauma patients with wraparound services during and after their hospital stay, including mental health and social service support, healthcare navigation, and help finding childcare.

The hospital has significantly expanded the scope and reach of its existing violence recovery program, which helps patients and families recover from domestic, sexual or child abuse, along with other kinds of trauma. The BHC Collaborative also partners with community-based organizations to connect people to housing, food and work, or to help them stay safe. The program has helped nearly 2,000 people since it began.

As a violence recovery specialist with the BHC Collaborative, Christine Goggins assesses the safety needs of patients and helps them recover from trauma. Goggins provides case management and helps patients with issues such as court advocacy and housing.

In times of crisis, like the pandemic, BHC Collaborative partners are essential in helping communities cope and recover. Partner organizations include The Branch Family Institute and Centers for New Horizons.

"The systems that support this work are very fragmented," said Brenda Battle, vice president of the Urban Health Initiative at UChicago Medicine. "Most have not worked alongside hospitals at the level that the BHC Collaborative brings to reduce violent recidivism."

2,000 **PEOPLE HELPED BY THE PROGRAM SINCE 2019**

UI Health | UIC

The University of Illinois Hospital and Health Sciences System (UI Health) provides comprehensive care, education and research to the people of Illinois and beyond. A part of the University of Illinois at Chicago, UI Health comprises a clinical enterprise that includes a 462-bed tertiary care hospital, 21 outpatient clinics, 14 Mile Square Health Center facilities, which are federally qualified health centers, and seven health science colleges. UI Health is dedicated to the pursuit of health equity.

Commitment to Workforce

The UIC College of Nursing and City Colleges of Chicago (CCC) will offer a dual-admissions pathway from CCC's Associate Degree in Nursing (ADN) to UIC's online RN to BSN degree completion program. With nursing shortages projected to continue, the career outlook for registered nurses is excellent. In order to help meet workforce demands for highly skilled nurses, CCC and UIC have created a dual-admissions pathway for nursing students. Under the agreement, nursing students can earn an associate's degree in nursing at CCC's Malcolm X College while at the same time enrolling in courses that are part of the fully online UIC RN to BSN degree completion program. "This is better access to education for more diverse populations, and we are excited to offer this degree pathway to our ADN students interested in getting their BSN," said David Sanders, President of Malcolm X College. "For many of our student nurses, it will now be possible to earn their BSN more quickly and relatively inexpensively." ADN students in this program will also receive additional support to stay on track. This includes regular meetings with UIC academic advisors and support from CCC.

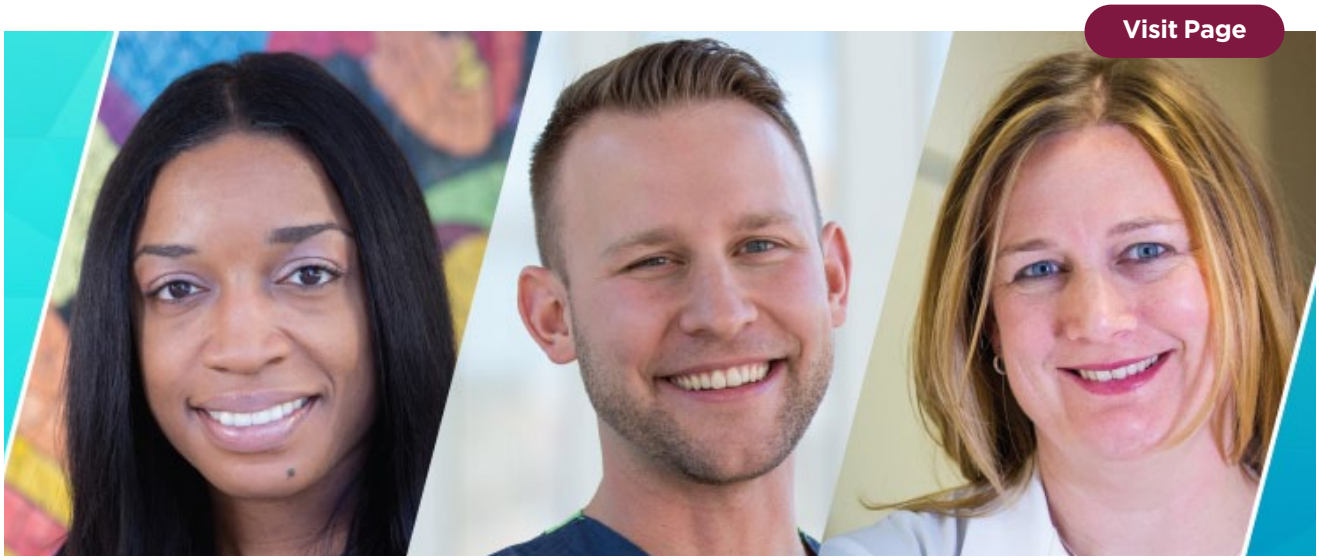
Supporting Community Partnerships

UI Health is leading a collaboration of local providers and community organizations to improve healthcare delivery and address social determinants of health in Chicago's Gage Park and West Elsdon neighborhoods. Transforming the Gage Park/West Elsdon Community Through Partnership, or T.A.R.G.ET. Health Collaborative Partnership, brings together partners to provide specialty care, advanced diagnostics, and mental and women's wellness services. UI Health, together with Alivio Medical Center, Friend Family Health Center and UI Health Mile Square, will provide healthcare services including obstetrics and gynecology, behavioral and mental health care, and dental care. UI Health is also partnering with the UIC Office of Community Engagement and Neighborhood Health Partnerships, Gage Park Latinx Council, Envision Community Services, Opportunities for All, and Latino Organization of the Southwest to address community needs and social determinants of health. This partnership is supported by the Illinois Department of Healthcare and Family Services' Healthcare Transformation Collaboratives Program.

Addressing Unmet Needs

Cook County Health and UI Health—the leading public health care providers in Cook County and Illinois—began a collaboration on specialty pediatric services under the Partnership for Pediatric Care, a new clinical affiliation for shared services. Together, Cook County Health and UI Health serve more than 100,000 Illinois children. These pediatric patients include a substantial proportion of children covered by Illinois Medicaid who receive care at nearly 40 CCH and UI Health locations across the state, primarily in Cook County and Chicago. At a celebration of the partnership, leaders from both institutions discussed the potential of the new partnership to reduce healthcare costs, advance innovations in population health, and, most importantly, improve health and developmental outcomes for children in Cook County and Chicago. For patients, integration of pediatric services under the Partnership for Pediatric Care will mean greater access to specialty and subspecialty care providers and appointments at whichever institution they receive or seek care.

100,000 **CHILDREN SERVED BY COOK COUNTY HEALTH AND UI HEALTH TOGETHER**



Opioid Epidemic Response

As a surge in synthetic opioids continues to fuel the opioid epidemic, HEAL hospitals continue to push efforts to reduce harm, increase treatment and provide lifesaving naloxone.

Working together to save lives.

Advocate Aurora Health

We at Advocate Aurora Health have continued our opioid safety journey. We believe that overcoming this epidemic requires providing both targeted treatment options for opioid use disorders (OUDs) as well as active prevention including early detection of patients with OUDs.

Best Practice Alerts

We have initiated several new best practice alerts in our electronic medical record, EPIC. We believe in optimizing the electronic medical record to assist providers in following the best opioid prescribing practices. Prescribers must now indicate whether an opioid prescription is meant to treat acute or chronic pain. If they indicate acute pain, an alert helps prevent durations more than seven days. Providers also receive an alert for high-dose opioid therapy (≥ 50 morphine milligram equivalents). We have developed a guideline to better address inconsistent drug screens for patients receiving chronic opioid therapy. This guideline includes strategies for withdrawal avoidance such as suggestions for safe weaning or adjuvant therapy.

We created a critical best practice alert that notifies a clinician prescribing any schedule 2 medication for a patient who has high suicide risk and/or has had an emergency department (ED) visit for overdose, suicide attempt or alcohol intoxication within the last year. This best practice alert not only pulls data from our organization but from any organization that is part of EPIC.

Chronic Opioid Registry and Dashboard Metrics

We have created a chronic opioid registry and dashboard metrics for both outpatient and ED clinicians. The dashboard displays a given provider's chronic opioid panel and how many of those patients are due for drug screens, have co-prescriptions for benzodiazepines or sleep aids, are due for an updated opioid agreement, and how many require a naloxone prescription. ED clinicians can also see how their own prescribing statistics compare to their peers.

Opioid Risk Assessment Tool

In 2022 we will begin using the opioid risk assessment tool for all patients 16 years and older who are undergoing an operation. Clinicians will receive a best practice alert when discharging these patients with opioids if they screen moderate or high on the opioid risk assessment tool. The goal is for the provider to have knowledge of the patient's risk of developing an OUD. This will allow a clinician to adjust the potency and/or quantity of opioids given.

PCP Continuing Medical Education (CME)

To support our primary care physicians (PCPs), we offer a bimonthly PCP CME Opioid Case Conference. During this time, we review difficult cases and discuss possible strategies. We have addiction specialists and psychiatrists who participate and provide expertise in our case conferences.

X-Waivers

We are proud to announce that all of our employed ED physicians are X-waivered. We have developed orders sets for buprenorphine and methadone induction to decrease the burden on ED providers. Additionally, we have developed patient-friendly education that automatically populates in the patient's discharge paperwork. This education reviews Medication-Assisted Treatment options if the patient has OUD or overdose on their diagnosis or problem list. We continue to dispense free naloxone from four of our hospitals and will soon be dispensing from all nine hospital sites.

AMITA Health

Acute Pain Management

The use of opioids in acute pain management has decreased significantly in the region and AMITA Health has continued to build on previous work. System-wide opioid prescriptions have a maximum length of seven days upon discharge from the hospital. We have also worked to identify the clinicians with high opioid prescribing practices. Once identified, education and action plans are provided to reduce prescribing to align with current practices. The management of pain, however, remains a critical quality objective of acute care institutions. AMITA Health is working with our parent organization, Ascension Health, to develop non-pharmacological order sets to treat pain without the use of opioids.

Harm Reduction

Harm reduction efforts at AMITA Health focus on outpatient and ambulatory services where the majority of opioids prescriptions originate. We have a pilot program on implementing specialized chronic pain care and clinics in the affiliated medical group. Such specialized care can treat patients with chronic pain with non-opioid medications and non-pharmacological regimens, which reduces the overall use of opioids in this patient population. There are also strong efforts to provide naloxone for every patient who is prescribed 50 morphine milligram equivalents or higher per day from the hospitals, clinics and emergency departments (EDs).

Identification and Treatment of Patients with OUD

Patients with opioid use disorder (OUD) who are appropriate for inpatient stabilization and treatment with Medication-Assisted Treatment are referred to one of several inpatient units within AMITA Health by a central logistics center that is open 24 hours a day. ED physicians are in the process of obtaining the Data 2000 waiver to prescribe buprenorphine, which allows for coverage as a bridge to definitive outpatient treatment. Patients seeking outpatient referral are currently linked to providers through the online provider locator for substance use disorder treatment through the Substance Abuse and Mental Health Services Administration. For 2022, AMITA Health is exploring a partnership with Bright Heart Health, which provides grant-supported treatment of uninsured and under-insured individuals via a Tele-addiction platform to provide consultation services for EDs.

Ann & Robert H. Lurie Children's Hospital of Chicago

Opioid Reduction—Up to 90%

Lurie Children's is recognized as a Childkind certified hospital, an international leader in care sensitive to children's pain and use of multimodal pain treatment that inherently reduces use of opioids. Lurie Children's provides state-of-the-art central and peripheral anesthetic blocks and cryoablation. As a result, Lurie Children's has reduced postoperative opioid prescriptions by up to 90% following major surgeries while maintaining proper pain control for the patient.

Harm Reduction—261 Individuals Trained

136 DISPOSERX PACKETS DISPENSED

158 NALOXONE KITS DISTRIBUTED

5+ ADOLESCENT LIVES SAVED

Lurie Children's harm reduction strategies focus on patient and family education, safe opioid disposal, and naloxone distribution. Accidental poisoning from left-over medications is the primary reason for opioid overdose in children under 10 years of age. To reduce this risk, Lurie Children's provides on-demand, interactive opioid education about prescription management, storage and disposal in all patient rooms via the hospital television network.

Lurie Children's distributed 136 DisposeRx packets, which contain a powder that, when mixed with medications and water, deactivates the medication into a non-toxic substance that can be thrown in a trash. One parent shared that she had a five-gallon paint can at home full of bottles of leftover medications because her local pharmacy could not take them. We educated her on opioid safety and disposal as well as DisposeRx and provided her with extra packets so she could quickly and safely dispose of her medications at home. She expressed how grateful she was for a home medication disposal option. Stories like this illustrate why this work is so important.

In 2021, Lurie Children's taught 261 individuals how to recognize an opioid overdose and administer naloxone. Lurie Children's distributed 158 naloxone kits containing two doses of naloxone to community members, clinicians, patients and other key stakeholders to provide increased access to this lifesaving medication. These efforts have resulted in the known reversal of several overdoses and likely many more that were not reported.

- A parent grew concerned about her adolescent child's breathing after the child had used drugs. The parent recognized the signs of an opioid overdose, used the naloxone kit and saved her child's life.
- A parent who initially declined to be trained returned to be trained because her sister struggles with opioid use disorder (OUD) and she wanted to learn how to save her life if necessary.
- Lurie Children's Adolescent Medicine Health Educators facilitated a parent-facing youth alcohol prevention training at a local Chicago Public High School. Attendees shared that a teenager from their community had passed away due to an opioid overdose. Lurie Children's staff provided naloxone training in Spanish (their native language) and sent them home with naloxone kits to use to support community members at risk of an opioid overdose.

Access to Medication-Assisted Therapy and Treatment of Individuals with Substance Use Disorder

Since its inception in 2019, Lurie Children's Division of Adolescent and Young Adult Medicine's Substance Use Prevention Program (SUPP) has assessed 86 individuals. SUPP provides treatment, including medications for OUD, along with other co-occurring substance use and mental health disorders to 50 adolescents and young adults each year.

Cook County Health

The opioid crisis continues to impact residents of Cook County. In 2021, Cook County Health (CCH) continued to innovate and partner on programs and interventions to provide comprehensive substance use disorder treatment including in the following ways:

Provided naloxone at the Cook County Jail, which has resulted in 9,500 detainees receiving education and 7,200 kits distributed at discharge since this work started in 2016.

9,500 **DETAINEES RECEIVING EDUCATION**

7,200 **KITS DISTRIBUTED AT DISCHARGE**

Partnered with the Cook County Sheriff's Office to increase referrals to Medication-Assisted Treatment (MAT) and recovery support services for individuals in the Sherriff's electronic monitoring program who are also housing insecure. Since launching in October 2021, the CCH Substance Use Disorder (SUD) team has received 289 referrals and successfully linked nearly 40% with SUD/MAT services; those who were not linked could not be reached or were not interested in services. This work was supported by a U.S. Department of Justice Bureau of Justice Assistance grant.

289 **REFERRALS RECEIVED AND NEARLY 40% WERE SUCCESSFULLY LINKED WITH SUD/MAT SERVICES**

Worked with Cook County Adult Probation to better understand the 15-fold increase in risk of opioid-related mortality among probation-involved individuals compared to the general population of Cook County and identified opportunities for partnership between public health, healthcare and the justice system to address this increased mortality risk. The findings were published in **December 2021 in the *Journal of Substance Abuse Treatment***.

Worked with the Illinois Department of Human Services Division of Substance Use Prevention and Recovery (DHS-SUPR) to implement SUPPORT, a grant from the Centers for Medicare & Medicaid Services that seeks to increase community access to medical treatment for opioid use disorders (OUDs). CCH partnered with community healthcare providers across Illinois in 2021 and provided 2,700 Illinois physicians and other health professionals with education, clinical experience and technical assistance to support their goals of providing medications for OUDs in the context of routine healthcare. Through this effort, 45 primary care and emergency department clinicians started prescribing buprenorphine to treat OUD in 2021. **Twenty-five of these new buprenorphine providers are primary care clinicians practicing in CCH community health centers within priority communities of the HEAL initiative.**

■ Website links

- Working with our SUPPORT partners, CCH also helped create web-based support for Illinois clinicians who seek assistance to begin treating their patients with buprenorphine for OUD. These free clinical toolkits, resource library and personalized support from expert clinicians are now available through the **Illinois Helpline for Opioids and Other Substances**.

2,700 ILLINOIS PHYSICIANS AND OTHER HEALTH PROFESSIONALS WERE PROVIDED WITH EDUCATION, CLINICAL EXPERIENCE AND TECHNICAL ASSISTANCE

Expanded the CCH SUD/MAT bridge clinic, which provides rapid access, low-barrier and high-capacity services on Chicago's Near West Side, to include emergency medicine and toxicology medicine providers. The bridge clinic is now a training location where toxicology fellows, preventive medicine fellows, family medicine residents and internal medicine residents work alongside recovery coaches/alcohol and drug counselors in a collaborative approach to SUD care. The bridge clinic expansion was supported through funding from the Substance Abuse and Mental Health Services Administration.

Planned for a new web-based regional recovery housing information system and navigator intervention in partnership with the DHS-SUPR and recovery home partners to enable real-time identification of vacancies in recovery homes for individuals with SUD who seek housing. The program launched in early 2022 and is supported by a U.S. Department of Justice Bureau of Justice Assistance Comprehensive Opioid, Stimulant, and Substance Abuse Program grant.

Now provides seven-day-a-week coverage of the emergency department (ED) at John H. Stroger, Jr. Hospital of Cook County and inpatient services for specialized substance use screenings, assessments and treatment referrals with our recovery coaches, as a result of a partnership with Haymarket Center. We assess about 150 patients per month for SUD.

Through training initiatives with ED physicians and Stroger hospitalists, we now have 24/7 availability for medication-assisted initiation and OUD treatment.

150 PATIENTS ASSESSED PER MONTH FOR SUD

Loyola Medicine

Loyola University Medical Center (LUMC) and its affiliated hospitals have developed programs to meet the acute and chronic pain care needs of the patients they serve, as well as the care of those with opioid use disorder (OUD).

Acute Pain Management

LUMC has incorporated Illinois Health and Hospital Association collaborative data requirements for pain stewardship in its acute pain programs. The pain stewardship programs optimize the safe and effective treatment of patients with acute and chronic pain—and reduce the misuse of prescription opioids. Metrics include surgical discharges with 12 or fewer opioid doses (typically three days' supply) and keeping within recommended limits from the Centers for Disease Control and Prevention for Morphine Equivalent Daily Doses (MEDDs) for patients discharged from the emergency department (ED).

■ Website links

Harm Reduction

LUMC has reviewed multiple electronic medical record (EMR) enhancements aligning with best practice recommendations that are in the works for 2022. These include best practice alerts for prescription monitoring program review when prescribing opioids; alerts when there is concomitant opioids/benzodiazepines prescribed at discharge; alerts on the number of opioid prescriptions; use of an MEDD calculator best practice alert to limit the amount of opioids prescribed; and the co-prescription for naloxone for high-risk opioid prescriptions.

For 2022, LUMC has requested intranasal naloxone kits from the Cook County Department of Public Health for an ED-based program where patients at risk of overdose are provided naloxone kits free of charge.

Identification and Treatment of individuals with OUD

LUMC has developed a hospital-wide program to identify and treat individuals with known or not previously known OUD in the inpatient setting. A medication for opioid use disorder (MOUD) guideline and order set was developed and successfully implemented in the EMR. In conjunction with the guideline, hospital policies for methadone and buprenorphine/naloxone administration were updated and a clinical opioid withdrawal scale was implemented to identify severity of opioid withdrawal and response to treatment.

For the outpatient environment, LUMC developed a psychiatric resident-led buprenorphine/naloxone clinic. This clinic is available system-wide (LUMC, MacNeal Hospital and Gottlieb Memorial Hospital) for continued treatment of patients with OUD. There has been education to raise awareness of the clinic and LUMC has reached out to community providers to increase options for follow-up and OUD based on patient need.

To ensure that current opioid stewardship momentum is maintained and improved, LUMC leveraged the institutional website to house resources pertaining to the Opioid Task Force and its work. LUMC also created a data dashboard for reporting metrics pertaining to opioid use, non-opioid analgesics, MOUD use and naloxone. The opioid task force is able to break down data based on department or provider so that ongoing data analysis and education can continue. Furthermore, LUMC is working towards a more formal opioid stewardship program, creating a proposal for a medical director and part-time pharmacist dedicated to the charge.

Northwestern Medicine

In January 2021, Northwestern Medicine (NM) implemented a system-wide Pain Management Quality Committee to address both inpatient and outpatient patient care needs across our 11 hospitals. Collectively, we have been able to leverage the unique strengths of each hospital to address opioids, as well as share best practices.

Some of our accomplishments include:

1. Implementation of numerous safe opioid prescribing features in NM's integrated electronic medical record (EMR).
2. A new, one-stop-shop of resources on NM's intranet to help clinicians (physicians and advanced practice providers) manage pain and prescribe opioids.

3. Creation of a centralized chronic opioid use patient registry.
4. Creation of an EMR pain medication prescribing tool to help standardize and lower opioid pill numbers and morphine milligram equivalents (MME) prescribed for postoperative pain in orthopedic, hand, spine and plastic surgery.

In addition to these updates, NM also had the below accomplishments:

Opioid Reduction

Since 2020, there has been a 13% decrease in the mean MME prescribed per patient receiving an opioid prescription. Also, NM's ambulatory care providers have adopted guidance measures to temper high-dose opioid prescriptions. As a result, NM's large multispecialty group, Northwestern Medical Group, has seen a decrease in patients on chronic opioid therapy with concerningly high prescription MME.

13% **DECREASE IN PER PATIENT MEAN MME OPIOID PRESCRIPTION**

Harm Reduction

NM continued to support programs involving harm reduction strategies, such as a take-home naloxone program in the Northwestern Memorial Hospital (NMH) emergency department (ED). Since 2018, patients with opioid overdose receive a naloxone kit at discharge, with 700 naloxone kits dispensed since the program's inception. For hospitalists and inpatient providers, NM has also developed a program to automate naloxone orders in the EMR for the discharge of patients with high MME prescriptions, in addition to augmented education on harm reduction. With education and the EMR alert, naloxone co-prescribing has increased over 800% for at-risk patients.

700 **NALOXONE KITS DISPENSED SINCE THE PROGRAM'S INCEPTION**

Access to Medication-Assisted Treatment

NMH continue to support its ED-initiated buprenorphine program, which was first launched in 2019. For patients who present with active opioid withdrawal, buprenorphine induction is performed in the ED, a prescription for a short-course of outpatient buprenorphine is provided and referral via a warm hand-off to nearby outpatient opioid use disorder clinics is accomplished. Over 60% of ED faculty were trained and received their X-waiver to prescribe buprenorphine and the EMR was customized to facilitate administration and prescribing of buprenorphine.

60+% **OF ED FACULTY WERE TRAINED IN AND RECEIVED X-WAIVERS TO PRESCRIBE BUPRENORPHINE**

Rush University Medical Center

Rush University Medical Center remains a leader in opioid stewardship though prescribing initiatives, continues to lead in the science of multimodal analgesia for postoperative patients, and has developed advanced programs to treat opioid use disorder (OUD) in both the inpatient and outpatient setting.

Acute Pain Management

In the acute postoperative period, multimodal analgesia pain management including opioid, non-opioid and regional analgesia has been pioneered at Rush University Medical Center and implemented across our postoperative patient population. Rush remains a leader in advancing the science of understanding risk factors for both prolonged pain and prolonged opioid use. We published a large prospective study in 2021 outlining patterns and trajectory of opioid use across various surgical procedures.

Harm Reduction

Several safeguards remain in place across the Rush system with respect to opiate prescribing through the electronic medical record (EMR), including connecting the EMR with Illinois Prescription Monitoring Program (ILPMP) database. EMR alerts call out morphine milligram equivalents (MMEs) and pill quantities for opioid naïve patients identified through the ILPMP. Prescribers also receive alerts that remind them to co-prescribe naloxone for patients on chronic opioids at higher MMEs if no recent prescription is noted in the EMR.

Expanded Interdisciplinary Addiction Service and MOUD Training

Rush's Substance Use Intervention Team (SUIT) is comprised of a team of addiction medicine physicians, psychiatric advanced practice providers, pharmacists and social workers who run both an inpatient consult service and a rapid-access outpatient clinic to enable treatment for individuals identified to have substance use disorder (SUD) through universal screening implemented at the hospital. The team is also focused on medications for opioid use disorder (MOUD) training for students and providers across the medical center.

Inpatient Harm Reduction and Medications for SUD

The inpatient SUIT sees more than 1,000 patients annually in the emergency department (ED), inpatient setting and physical rehabilitation hospital to incorporate addiction treatment into patients' medical disposition. SUIT physicians' expertise in critical care, toxicology and emergency medicine ensures that the most medically complex patients are maintained on MOUD through their hospitalization.

1,000+ **PATIENTS SEEN BY THE INPATIENT SUIT**

SUIT offers initiation and titration of buprenorphine and methadone. At discharge, patients are referred to SUIT's outpatient clinic or to a buprenorphine clinic in the community. SUIT also initiates insurance approval for Sublocade (long-acting buprenorphine injection) and offers free initiation of Vivitrol during admission.

In accordance with the philosophy of harm reduction, for patients who are not yet ready to accept MOUD, SUIT provides motivational interviewing, education on safe practices of drug use and community resources for clean needles/ supplies. SUIT educates all patients with OUD on the use of naloxone and provides all OUD patients with naloxone either by prescription or via our longstanding naloxone distribution program.

The dedicated inpatient SUIT social worker provides referral and direct linkage to all levels of behavioral health treatment, including residential substance use treatment. The SUIT social worker has also led education and advocacy efforts for patients at Rush's partnering nursing homes and long-term acute care hospitals to ensure patients can continue evidence-based substance use treatment while in these facilities.

SUIT Education Initiatives

SUIT is steadfast in its commitment to increase access to evidence-based substance use treatment by using a harm reduction model to teach and train medical and mental healthcare providers from many disciplines. Approximately 105 learners rotate on SUIT annually to receive training on medications for substance use disorder as well as motivational interviewing techniques to prioritize patient-centered care. SUIT also offers interdisciplinary training to other Rush departments to improve detection, treatment and care coordination for patients with substance use disorders. SUIT has led X-waiver trainings to expand buprenorphine prescribing within Rush: More than 70% of Rush's ED physicians and more than 90% of inpatient psychiatrists are now X-waivered.

70%+ **OF ED PHYSICIANS AND**

90%+ **OF INPATIENT PSYCHIATRISTS ARE X-WAIVERED**

Sinai Chicago

Hospital Warm HandOff Program

The Illinois State Opioid Response Hospital Warm HandOff Program focuses on people who self-report opioid use or screen positive for an opioid use disorder (OUD) during a hospital visit at Mount Sinai Hospital or Holy Cross Hospital. Geographically, Mount Sinai Hospital's service areas comprise 14 zip codes and 26 communities (25 Chicago community areas and the town of Cicero). Holy Cross Hospital's service areas comprise seven zip codes and 14 Chicago community areas. Combined, the service areas cover 27 Chicago communities.

Sinai Chicago has had participants in the Illinois State Opioid Response Hospital Warm HandOff Program since 2019. The Hospital Warm Hand Off Program aims to connect patients who test positive for opiates within the hospital system to an outside provider who can prescribe either Suboxone (buprenorphine/naloxone) or methadone on an ongoing basis. Patients meet with a Recovery Support Specialist (someone with lived experience of substance use) as well as a Substance Use therapist to engage in treatment.

This program reaches patients who are admitted to the emergency department (ED) or other medical unit at Mount Sinai Hospital or Holy Cross Hospital who self-report opioid use or test positive during an opioid usse disorder (OUD) screening. These patients are referred to the Hospital Screening and Warm Handoff program (Warm Handoff program)

through an order that the patients' physician puts into the electronic medical record. This order generates an automatic email to the Warm Handoff team, which alerts them of a new referral to their program. The Warm Handoff program works in tandem with federally qualified health centers (FQHCs) to provide referrals and services to patients with OUDs who need treatment after a hospital visit.

For patients willing to engage in treatment, the Warm Handoff Team, which includes a substance use disorder therapist, certified recovery support specialist (CRSS) and a case manager, will conduct motivational interviews, complete the Government Performance and Results Act (GPRA) tool, and assist patients with linking to a Suboxone or methadone treatment program. This includes locating an appropriate agency, obtaining a release of information from the patient and beginning the appointment scheduling process. If additional case management needs are identified, services will be provided in a setting that best meets the need of the patient. These services may include researching appropriate referral agencies based on location, availability, insurance and service need.

Warm Handoff Program Partners

As part of the Warm Handoff program, Sinai partners with three of our strongest FQHC partners: Access Community Health Network (ACCESS), Lawndale Christian Health Center (LCHC) and Family Guidance Centers, Inc. (FGC). All three are dedicated to safe and efficient treatment of opioid addiction. ACCESS's Medication-Assisted Treatment (MAT) program offers behavioral health services and counseling, group support sessions, primary health care and weekly visits with an ACCESS physician. LCHC offers an integrated primary care psychology service that provides support to LCHC clinicians and patients. LCHC provides behavioral health group therapy for OUDs. FGC supports a recovery oriented system of care which allows them to implement strategies that work best in their communities and offers an array of substance use services.

Naloxone Training

Through the Warm Handoff program, Sinai staff identify the need to complete naloxone training based on a patient's self-reported opioid use and/or a positive toxicology result during the patient's hospital visit. Staff provide a visual training on the purpose of the training, safety benefits and identify each item in the kit. They also demonstrate how to administer naloxone in case of an emergency including the areas on the body and how to use the items. Patients are informed that the naloxone kit will be provided upon discharge from the hospital. The naloxone kit is handed to the patient at the time of discharge from the nursing unit free of charge. Sinai Chicago received Opioid Education and Naloxone Distribution Program status that allows naloxone distribution under the Illinois Naloxone Standing Order.

In 2021, Sinai Chicago received 1,701 referrals from medical providers for patients who self-reported opioid use or tested positive for opioid use throughout Mount Sinai Hospital and Holy Cross Hospital. Of those referrals, 206 patients attended and enrolled in a MAT clinic for outpatient treatment services. In 2021, Sinai Chicago expanded the services we provide to this population by expanding the Warm Handoff program to Holy Cross Hospital. Sinai Chicago also began to distribute naloxone kits to Mount Sinai Hospital and Holy Cross Hospital patients. In the first year of distribution, a total of 2,562 kits were distributed to patients in the ED and/or medical units.

206 **PATIENTS IN OUTPATIENT TREATMENT SERVICES**

1,701 **REFERRALS FOR PATIENTS WHO TESTED POSITIVE FOR OPIOID USE**

2,562 **NALOXONE KITS DISTRIBUTED TO PATIENTS IN THE ED AND/OR MEDICAL UNITS**

UChicago Medicine

UChicago Medicine has developed in interdisciplinary, multi-organizational model to address health disparities affecting South Side communities, including gaps in healthcare access, quality and outcomes, which includes the health system's response to the opioid crisis. The approach relies in part on coupling patient care data, quality improvement programs in pain management, staff education and collaboration with community partners in the development of a robust opioid stewardship plan.

Acute Pain Management

The management of acute pain and the appropriate use of opioids is weaved throughout inpatient and outpatient encounters for acute pain. Multimodal pain management pathways are integrated into the electronic medical record (EMR), allowing providers to initiate a multimodal and multidisciplinary pain management treatment plan for acute pain due to perioperative, trauma and medical illness. These plans reduce the use of opioids as an inpatient and upon discharge. Through programs such as multimodal pain management and staff education, there has been a successful reduction in opioid prescribed days (average of the max days' supply of opioids prescribed) to five days over time with 30 morphine milligram equivalents (MME) per day limit. UChicago Medicine is focused on monitoring and sustaining this prescribing improvement going forward.

Harm Reduction

Improvements in the treatment of chronic pain and the prescribing or distribution of naloxone are hallmarks of harm reduction programs in hospitals. UChicago Medicine is improving older adult opioid and pain management through patient-centered clinical decision support (I-COPE) tools and provider education through Project ECHO-Chicago. A guide for over-the-counter non-oral medications to be added to I-COPE EMR guidelines include non-pharmacological treatments from self-management (heat and cold, yoga) to referrals for older adults. When opioid treatment is necessary for the treatment of chronic pain, MME daily doses greater than or equal to 50 MME are avoided when possible, as anything greater can contribute to opioid tolerance and dependence. For all patients with chronic pain who are receiving opioids, a patient-provider pain agreement is on record with a shared decision-making agreement for opioid prescription for chronic pain.

With naloxone, the health system has developed a Naloxone Best Practice Alert (BPA) in the EMR, which launched in December 2020. The BPA has led to a 2.5 times increase in the number of monthly naloxone prescriptions per month since it was launched. In addition, UChicago Medicine has created a novel protocol that allows patients to receive a naloxone kit at the bedside in the emergency department (ED) and leave the ED with this life-saving medication in hand after an adverse reaction or overdose of prescription or illicit opioids.

2.5x **INCREASE IN THE NUMBER OF MONTHLY NALOXONE PRESCRIPTIONS PER MONTH**

Identification and Treatment of Patients with OUD

UChicago Medicine has instituted an Inpatient OUD & Opioid Withdrawal pathway integrated in the EMR, which allows providers to identify and recommend appropriate evaluations and treatment of patients with and without known history of opioid use disorder (OUD). An OUD consult service is in operation and evaluates 10-15 patients per week—760 patients have been evaluated by the OUD consult service since the service launched in January 2020. The consult service has started 82% of patients on either methadone or buprenorphine with linkage to community-based treatment at discharge from the inpatient floors.

The ED has also moved to identify, treat and rapidly refer patients who have OUD. Over 75% of ED physicians have an X-waiver to prescribe buprenorphine; the ED has implemented a protocol to start patients with OUD on buprenorphine in the ED in the appropriate clinical setting. Following UChicago Medicine ED protocols, patients are started on treatment and then referred to one of several community partners such Friend Health, HRDI and Miles Square Health Center in a facilitated "warm hand-off" and patients can continue treatment for OUD.

760 **PATIENTS HAVE BEEN EVALUATED BY THE OUD CONSULT SERVICE SINCE JANUARY 2020**

75%+ **OF ED PHYSICIANS HAVE AN X-WAIVER TO PRESCRIBE BUPRENORPHINE**

University of Illinois Hospital & Health Sciences System

The University of Illinois Hospital and Health Sciences System (UI Health) has been improving opioid stewardship within the hospital and acute care setting for many years. UI Health, however, has also greatly expanded into the community to provide medication for opioid use disorder (MOUD) treatment alongside other harm reduction strategies in some of the zip codes hit hardest by the opioid overdose crisis.

Acute Pain Management

In 2019, UI Health implemented multimodal pain programs to minimize opioid use in acute care situations, including a surgical opioid-avoidance protocol for general, organ transplant, colorectal or vascular surgeries. Included in the launch were comprehensive staff and patient education on pain management and patient expectations, standardized order sets in the electronic medical record, and reinforcement of opioid-sparing multimodal analgesic techniques for treatment of acute postoperative pain in the hospital and at home. The program led to reduced opioid use in the hospital, fewer prescriptions at discharge and improved pain control in a diverse patient population with multiple healthcare disparities and across multiple surgical divisions and modalities. With this program, total use of opioids decreased by 43% in morphine milligram equivalents (MME) and the total MME prescribed at discharge decreased 43%.

43% **DECREASE IN MME AND TOTAL MME PRESCRIBED AT DISCHARGE**

Mobile MOUD Program

UI Health has been involved in the Community Outreach Intervention Project (COIP) for over 30 years. While COIP initially started in response to preventing HIV through substance use harm reduction, services have migrated into behavioral healthcare due to the overlap of opioid use disorder (OUD) with HIV and other infectious diseases. In 2021, COIP expanded program services to include Mobile MOUD, a program that provides medically assisted recovery, low-threshold buprenorphine initiation and primary medical care in tandem with naloxone distribution, syringe exchange and other harm reduction services via mobile van-based outreach on the West and South sides of Chicago. Many patients who use the mobile services comprise a significant proportion of those at risk for opioid overdose in Chicago: those who use opioids intravenously or intranasally, are currently homeless, live on the street, or otherwise lack a stable place to sleep. The mobile MOUD team includes a program coordinator, two outreach workers, a physician, a social worker and a clinical pharmacist. Through the first nine months of the program a total of 398 individuals completed 565 patient visits for care, with approximately one-third of visits made by patients seeking MOUD or MOUD refills. All patients receiving care from the mobile unit benefit from direct connection to medical, behavioral and social services.

398 **INDIVIDUALS COMPLETED 565 PATIENT VISITS FOR CARE**

Integrated Methadone Program

UI Health has a robust and comprehensive approach to care of patients with OUD utilizing community affiliations and partnerships. UI Health leveraged its affiliation with Miles Square Health Center and its 14 sites to provide care in the Chicago communities experiencing the greatest harm from the opioid crisis. Due to the scarcity of OUD and behavioral health specialists, a unique collaborative model of providing co-management of behavioral health, MOUD and primary care was developed to efficiently care for this patient population. In this flexible care model, their primary care team manages stable behavioral health patients while new patients and/or unstable patients have more frequent interaction with personnel providing specialty behavioral health services. With the addition of methadone services in 2021, Miles Square Health Center is one of the few centers that uses all three main medications for opioid use disorder—naltrexone, buprenorphine and methadone—and allows for the best treatment available, based on patient need and preference.

Making Progress Toward the Future

In 2018, HEAL hospitals answered Senator Durbin's call to improve health and well-being in 18 Chicago communities. Three years of hard work has produced significant results. Together, HEAL hospitals are improving individual lives and strengthening communities.

Committed to the call.
Committed to communities.

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AMITA HEALTH

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LOYOLA MEDICINE

Northwestern Medicine

RUSH UNIVERSITY MEDICAL CENTER

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Ten Leading Health Systems

18 Chicago Neighborhoods

One Powerful Goal