Community Health Needs Assessment

2016

Health Impact Collaborative of Cook County

Working together for healthy communities.

Health Impact Collaborative of Cook County

Community Health Needs Assessment Central Region

June 2016

Participating hospitals and health departments:

- Chicago Department of Public Health
- Cook County Department of Public HealthGottlieb Memorial Hospital
- Illinois Public Health Institute
- Loyola University Medical Center
- Norwegian American Hospital
- Oak Park Health Department
- Presence Saints Mary and Elizabeth Medical Center
- RML Specialty Hospitals (Hinsdale & Chicago)
- Rush Oak Park
- Rush University Medical Center
- Stroger Hospital - Cook County Health and Hospital System

healthimpactcc.org/reports2016

Table of Contents

I. Introduction

Founded in 1894, Norwegian American Hospital (NAH) is a safety-net hospital located in the Humboldt Park neighborhood in Chicago. Norwegian American Hospital believes its role as a community health care provider is to treat and cure disease and to promote wellness through health education, prevention, and early intervention. Norwegian American Hospital's mission statement is central to all organizational planning and is a direct reflection of the organization's more than 120-year-old tradition of caring for its neighbors and the families who live in the surrounding communities.

Norwegian American Hospital's Mission, Vision, and Values

Mission:

Norwegian American Hospital provides high quality and compassionate health care services by partnering with patients and their families, our employees, physicians, and the communities we serve.

Vision:

Norwegian American Hospital is the hospital of choice for our communities and our caregivers. We are best in class for clinical care, customer service, employee engagement, access to care and stewardship.

Values:

- Respect: Treat all individuals with courtesy, dignity, and appreciation for their unique needs
- Compassion: Be caring, empathetic, and understanding
- Excellence: Deliver care of the utmost quality and safety with the best outcomes
- Integrity: Adhere to the highest standards of professionalism and ethics in everything we do
- Diversity: Embrace and celebrate the differences among our patients, physicians, employees, and community

Norwegian American Hospital is dedicated to offering the best care for the community in a 200-bed hospital, as well as a full-service professional building, community clinics, and two mobile health units. Norwegian American Hospital has an array of medical services that are available including: emergency, acute care, surgical, outpatient clinics, Women's Center of Excellence, GI lab and endoscopy, internal medicine, detox and substance abuse, cardiology and respiratory, imaging, behavioral medicine, Wound Healing Center, family medicine and pediatrics, physical therapy, and corporate health services.

Communities Served by Norwegian American Hospital

Norwegian American Hospital (NAH) primarily serves seven zip codes in the City of Chicago: 60618, 60622, 60624, 60639, 60642, 60647, 60651. These zip codes include the following community areas: Austin, Avondale, Belmont-Cragin, East Garfield Park, Hermosa, Humboldt Park, Irving Park, Logan Square, North Center, North Lawndale, West Garfield Park, and West Town. Over 610,000 individuals reside in Norwegian American Hospital's service area. (2010 Census) Norwegian American Hospital serves a diverse community of 39% Hispanic, 32% African American, 25% White, and 2% Asian identifying people.

II. Overview of the Community Health Needs Assessment Process

as part of the Health Impact Collaborative of Cook County

The Health Impact Collaborative of Cook County (HICCC) is a collaborative of 26 hospitals, seven health departments, and more than 100 community organizations facilitated by the Illinois Public Health Institute (IPHI). In 2015 and 2016, HICCC conducted a collaborative Community Health Needs Assessment (CHNA) for Chicago and suburban Cook County along with action planning and implementation activities across three Cook County regions: South, Central, and North. The Community Health Needs Assessment for the Central Region includes Norwegian American Hospital, Chicago Department of Public Health, Cook County Department of Public Health, Gottlieb Memorial Hospital, Loyola Medical Center, Oak Park Health Department, Presence Saints Mary and Elizabeth Medical Center, RML Specialty Hospitals (Hinsdale and Chicago), Rush Oak Park, Rush University Medical Center, and Stroger Hospital.

Under the Affordable Care Act, nonprofit hospitals are required to conduct a CHNA every three years that has specific components including:

- a description of the CHNA process, methods, collaborations, prioritized community health needs, and a description of existing facilities and resources in the community;
- input from persons representing the broad needs of the community;
- summary of implementation activities by the hospital since the previous CHNA;
- the CHNA must be posted and made available to the public; and
- the hospital must adopt and submit an implementation strategy to IRS within 4½ months of posting the CHNA.

Norwegian American Hospital has served on the Steering Committee for the Health Impact Collaborative of Cook County since its launch in 2015. The collaborative CHNA process started in April 2015, and Norwegian American Hospital participated in monthly meetings with public health departments and community stakeholders throughout 2015 and early 2016 to assess and prioritize community health needs. The collaborative CHNA process was designed based on the MAPP framework, developed by the National Association of County and City Health Officials (NACCHO), and includes four assessment components:

- Local Public Health System Assessment (LPHSA) (Completed 2015)
- Forces of Change Assessment (FOCA) (Completed 2015)
- Community Themes and Strengths Assessment (CTSA) (Completed 2016)
- Community Health Status Assessment (CHSA) (Completed 2016)

The Health Impact Collaborative of Cook County chose this community-driven assessment model to ensure that the assessment and identification of priority health issues were informed by the direct participation of stakeholders and community residents. Stakeholder and community input was collected by the collaborative through focus groups, community resident surveys, and stakeholder advisory meetings. Stakeholders that are participating in the Collaborative come from diverse areas of expertise including housing, law enforcement, education, community development, behavioral health, Federally Qualified Health Centers, human service providers, state and regional organizations, government agencies, universities, and faith-based organizations. Community residents from the communities served by Norwegian American Hospital participated in at least four focus groups and submitted over 300 surveys. Surveys were distributed onsite at Norwegian American Hospital and also through community partner organizations. More information about the CHNA process is included in the Central Region CHNA report, starting on page 19.

III. Key Community Health Needs

Through a collaborative prioritization process involving hospitals, health departments, and Stakeholder Advisory Teams, the Health Impact Collaborative of Cook County identified four focus areas as community health priorities.

1. **Improving social, economic, and structural determinants of health while reducing social and economic inequities.**
   The social and structural determinants of health, such as poverty, unequal access to community resources, unequal education funding and quality, structural racism, and environmental conditions, are underlying root causes of health inequities. Additionally, social determinants of health often vary by geography, gender, sexual orientation, age, race, disability, and ethnicity. The strong connections between social, economic, and environmental factors and health are apparent in Chicago and suburban Cook County, with health inequities being even more pronounced than many national trends.

2. **Improving mental health and decreasing substance use disorders.**
   Mental health and substance use arose as key issues in each of the four assessment processes in the Central region. Community mental health issues are exacerbated by longstanding inadequate funding, as well as recent cuts to social services, healthcare, and public health. The World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA) emphasize the need for a network of community-based mental health services. The WHO has found that the closure of mental health hospitals and facilities is often not accompanied by the development of community-based services which leads to a service vacuum. In addition, research indicates that better integration of behavioral health services, including substance use treatment, into the health care continuum, can have a positive impact on overall health outcomes.

3. **Preventing and reducing chronic disease, focused on risk factors – nutrition, physical activity, and tobacco.**
   Chronic disease prevention was another strategic issue that arose across all four assessments. The number of individuals in the U.S. who are living with a chronic disease is projected to continue increasing well into the future. In addition, chronic diseases accounted for approximately 64% of deaths in Chicago in 2014. As a result, it will be increasingly important for the health care system to focus on prevention of chronic disease and the provision of ongoing care management.

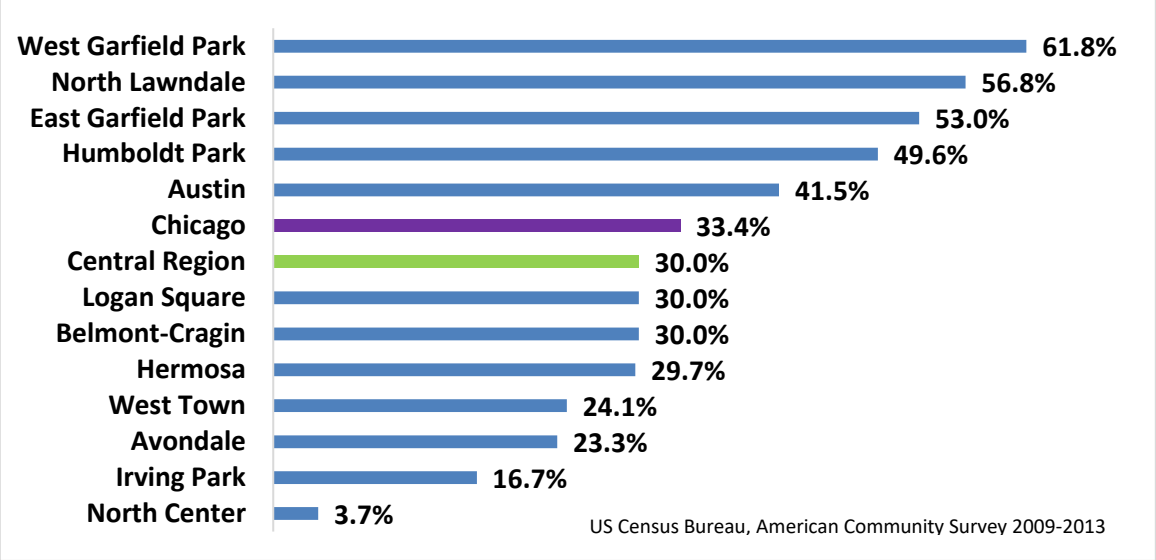
4. **Increasing access to care and community resources.**
   Healthy People 2020 states that access to comprehensive health care services is important for achieving health equity and improving quality of life for everyone. Disparities in access to care and community resources were identified as key contributors to health inequities experienced by residents in the Central region. Access is a complex and multi-faceted concept that includes dimensions of proximity, affordability, availability, convenience, accommodation, reliability, quality, acceptability, openness, cultural competency, appropriateness, and approachability.

Norwegian American Hospital and our community partners agree that these four areas for the Central Region of Chicago and Cook County encompass the needs in the communities we serve. The Norwegian American Hospital service area has specific needs within these focus areas, which are described in more detail here.

Norwegian American Hospital Community Needs

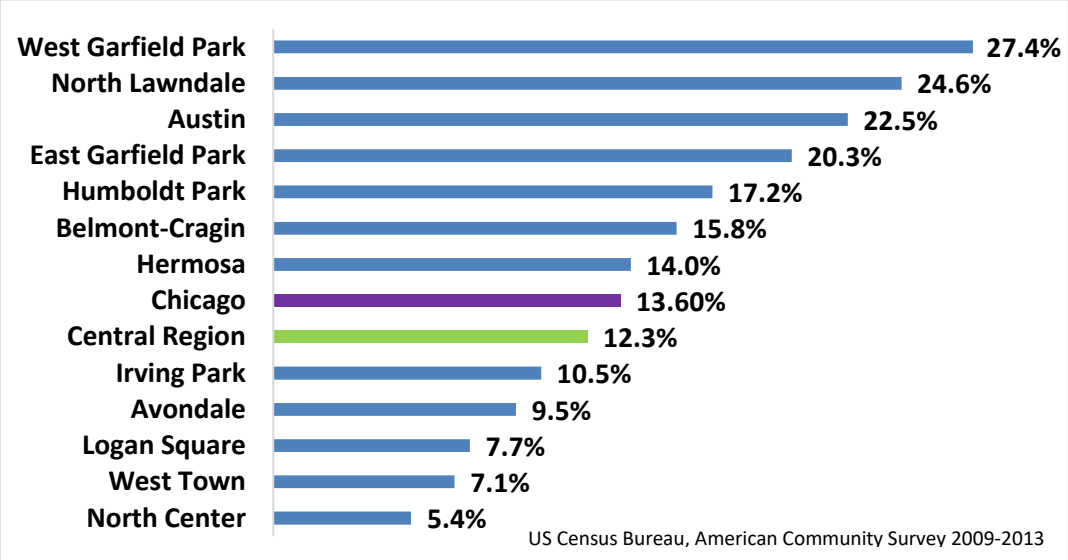
- **Poverty**: Eight communities in NAH's service area have poverty rates over 20%, and NAH's home community of Humboldt Park has one of the highest rates of poverty in the region at 34.7%. Of particular concern from a health perspective, child poverty is very high in the NAH service area. In four communities – West Garfield Park, North Lawndale, East Garfield Park, and Humboldt Park – at least half of the children in the community were living in households making less than the federal poverty level.

Percentage of Children Living in Poverty (100% FPL), 2009-2013



- **Income and Employment:** North Center, Irving Park, Avondale, and West Town have the highest median incomes in the NAH service area and lower rates of poverty. Unemployment rates in the service area vary widely across the service area, ranging from 5.4% in North Center to 27.4% in West Garfield Park. Six communities – West Garfield Park, North Lawndale, Austin, East Garfield Park, Humboldt Park, and Belmont Cragin – had over 15% unemployment over the period of 2009-2013, and this was substantially higher than the Chicago citywide rate of 13.6%.

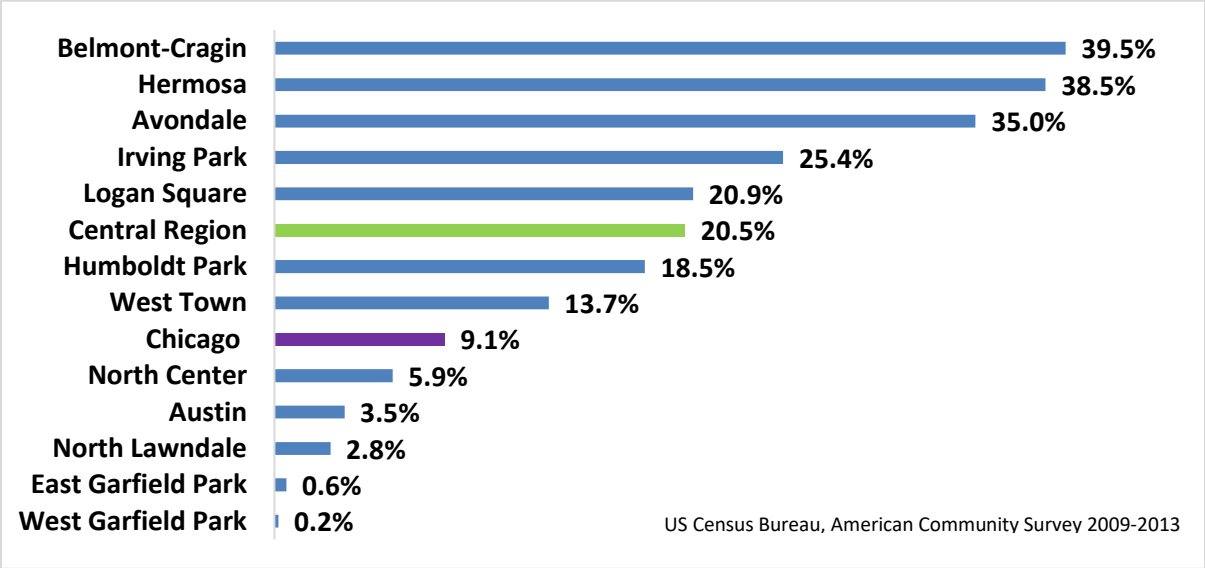
Percentage of Unemployed, 2009-2013



- **Housing**: Almost 50% of residents in the NAH service area were cost-burdened by housing between 2009-2013 (meaning they paid more than 30% of their income on housing).

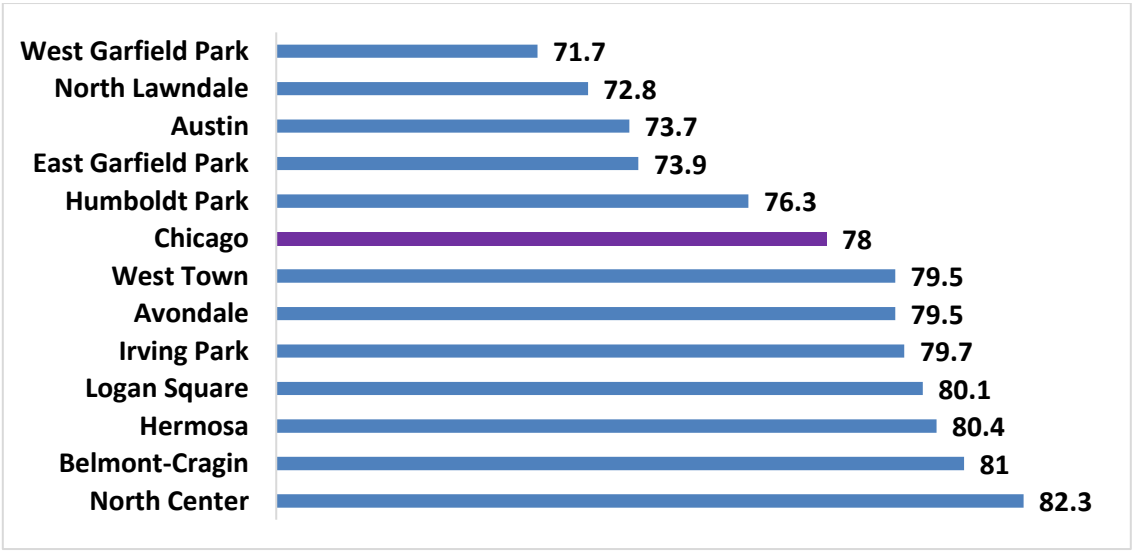
- **Limited English Speaking Households**: Several community areas in the NAH service area have high percentages of limited English speaking households. In Belmont Cragin and Hermosa, nearly 40% of households are limited English speaking. Most of these residents speak Spanish as their first language with a sizable minority speaking Polish. There are also a number of communities with large African American populations (West Garfield Park, East Garfield Park, North Lawndale, Austin) with very low numbers of limited English speaking households, pointing to the concentration of new immigrant and limited English speaking households in certain parts of the NAH service area.

Percentage of Limited English Speaking Households, 2009-2013



- **Life Expectancy**: Life expectancy in NAH's service area varies from 71.7 years in West Garfield Park to 82.3 years in North Center. While the majority of communities in the service area have a greater life expectancy than Chicago overall, residents of West Garfield Park, North Lawndale, Austin, and East Garfield Park have substantially lower life expectancy than the City.

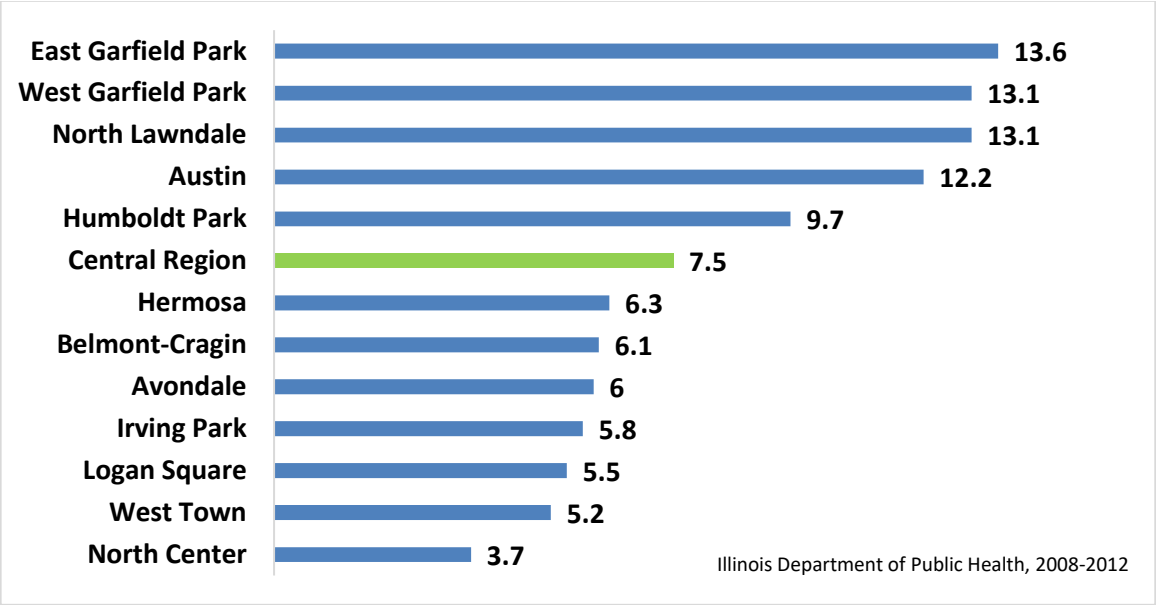
Life Expectancy at Birth (years)



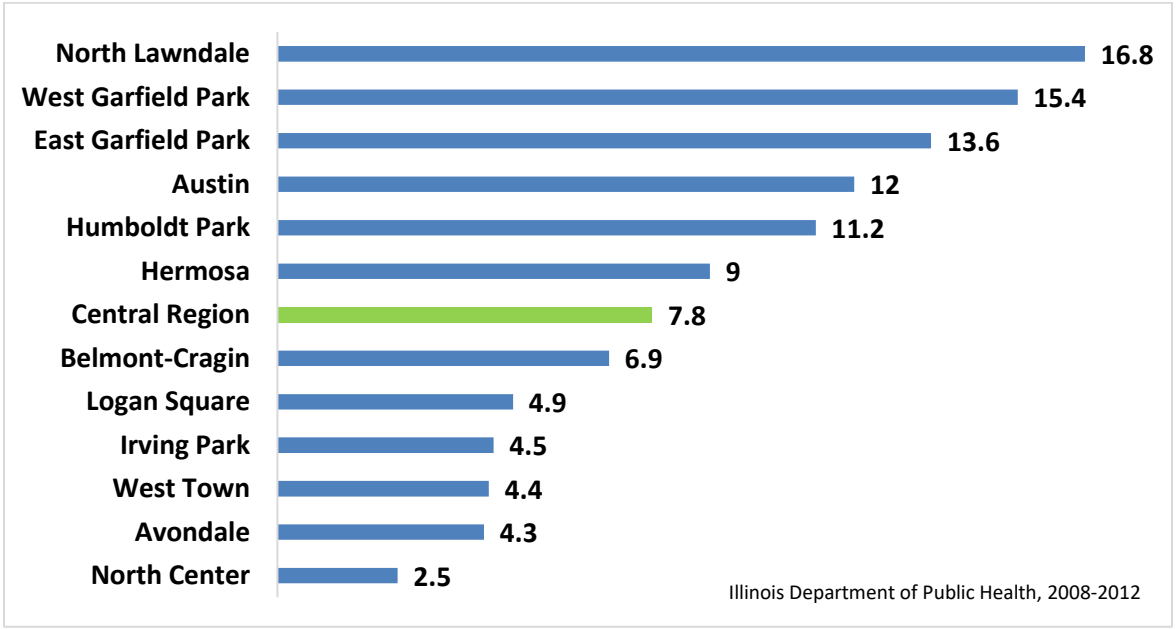
US, IL, Cook County data: CDC Wonder; IDPH Mortality Files, 2008-2012, US Census 2010 Population

- **Maternal and Child Health:** Maternal and child health outcomes vary across NAH's service area, highlighting the overall inequities in health across the communities served by NAH. Low birthweight rates range from 3.7 per 100 live births in North Center to 13.6 per 100 live births in East Garfield Park. Similarly, the rate of infant mortality varies between community areas in NAH's service area. Six communities have an infant mortality rate greater than 9 per 1,000 births. Similar disparities are also seen in teen births.

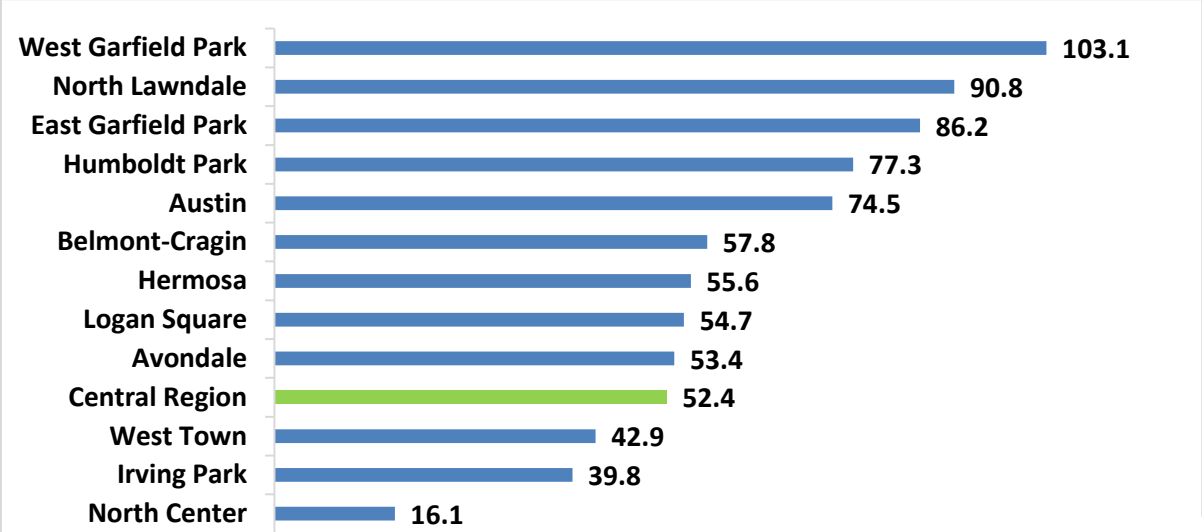
Low Birthweight (Number of single births with birth weight less than 2,500 grams per 100 single live births)



Infant mortality (Number of deaths of infants less than one year old per 1,000 live births)



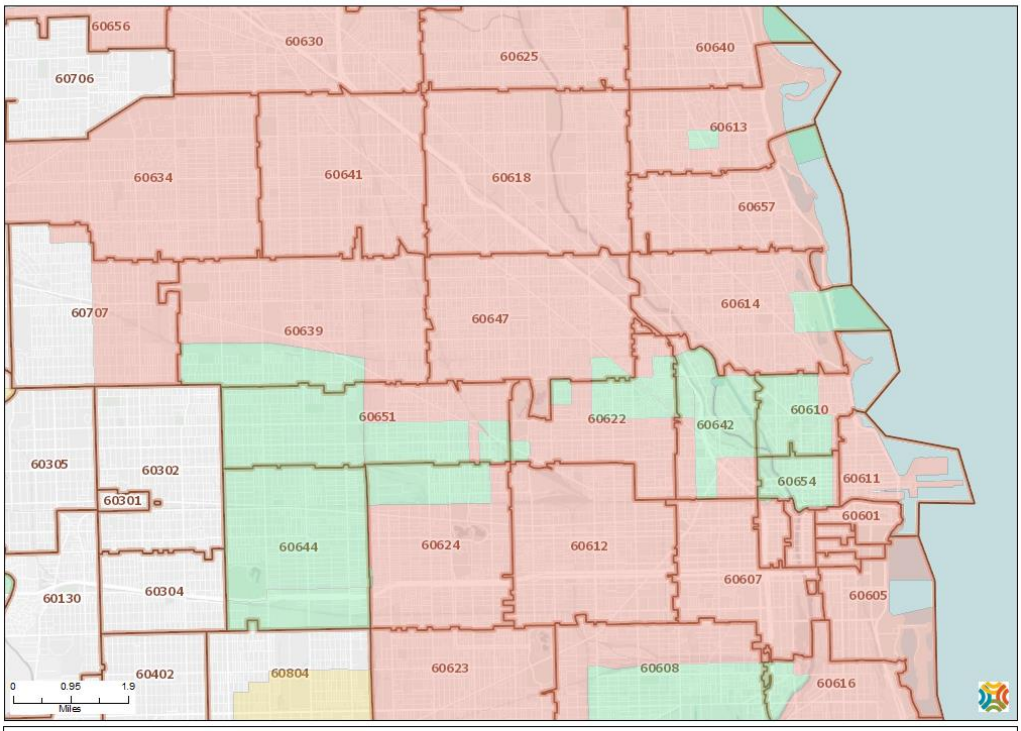
Teen births (Number of births to mothers under 20 years of age per 100 live births)



Illinois Department of Public Health, 2008-2012

- **<u>Medical Professional Shortages</u>**: Austin, Belmont Cragin, East, and West Garfield Park, Hermosa, Humboldt Park, Logan Square, and North Lawndale are medically underserved areas as shown in the following map.

Medically Underserved Areas



Map Legend

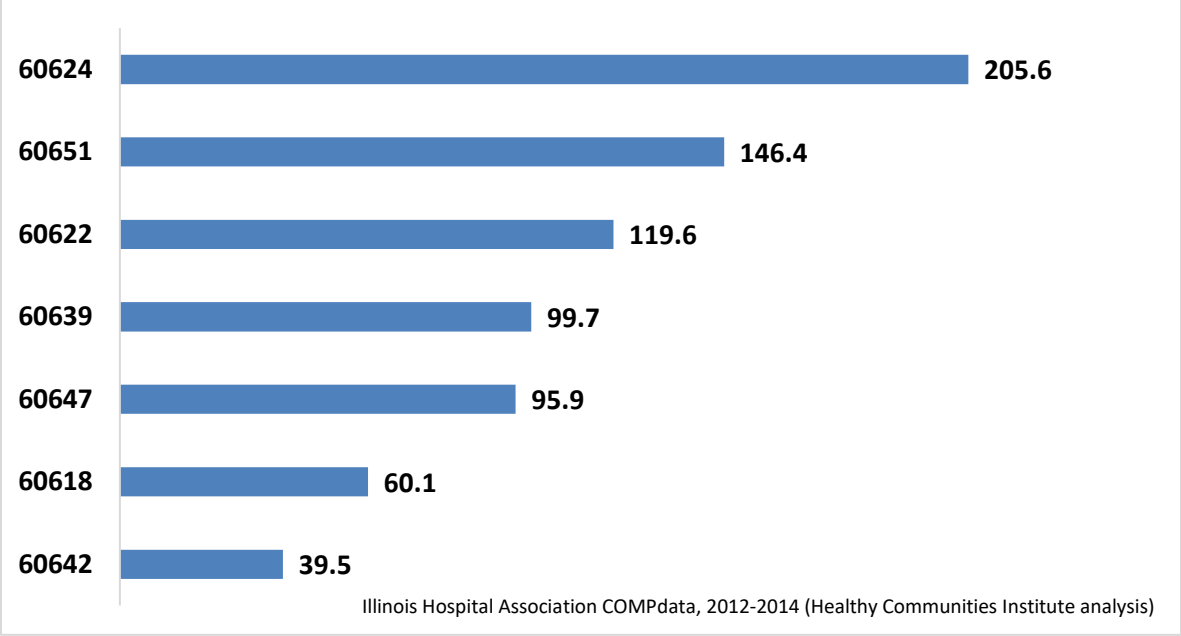
Medically Underserved Area/Population by Shortage Area, HRSA April 2016

- Medically Underserved Area
- Medically Underserved Area - Governor's Exception
- Medically Underserved Population
- Medically Underserved Population - Governor's Exception

Community Commons, 9/28/2018

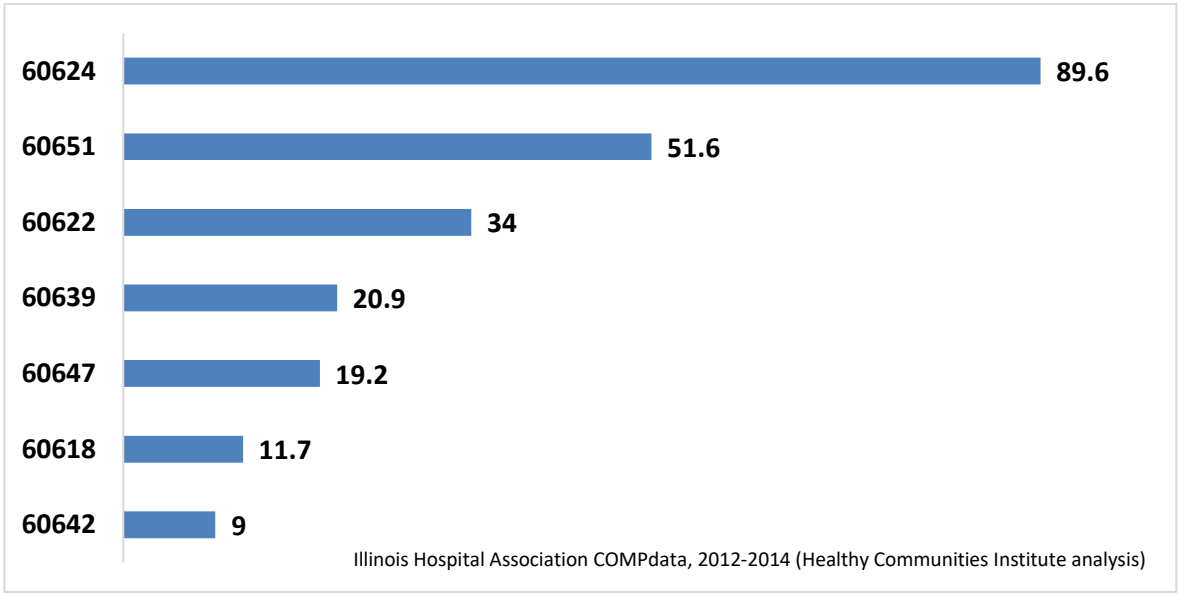
- **Mental Health and Substance Use Disorders:** Mental Health provider shortages are experienced across the NAH service area. The rate of emergency room usage due to mental health varies greatly between zip codes, with the lowest rate being 39.5 per 10,000 in zip code 60642 and the highest being 205.6 per 10,000 in zip code 60624.

Emergency Department (ED) visits due to Mental Health, (age-adjusted rate per 10,000) 2012-2014



The rate of emergency room usage due to substance abuse ranges from 9.0 per 10,000 in zip code 60624 to 89.6 per 10,000 in zip code 60642.

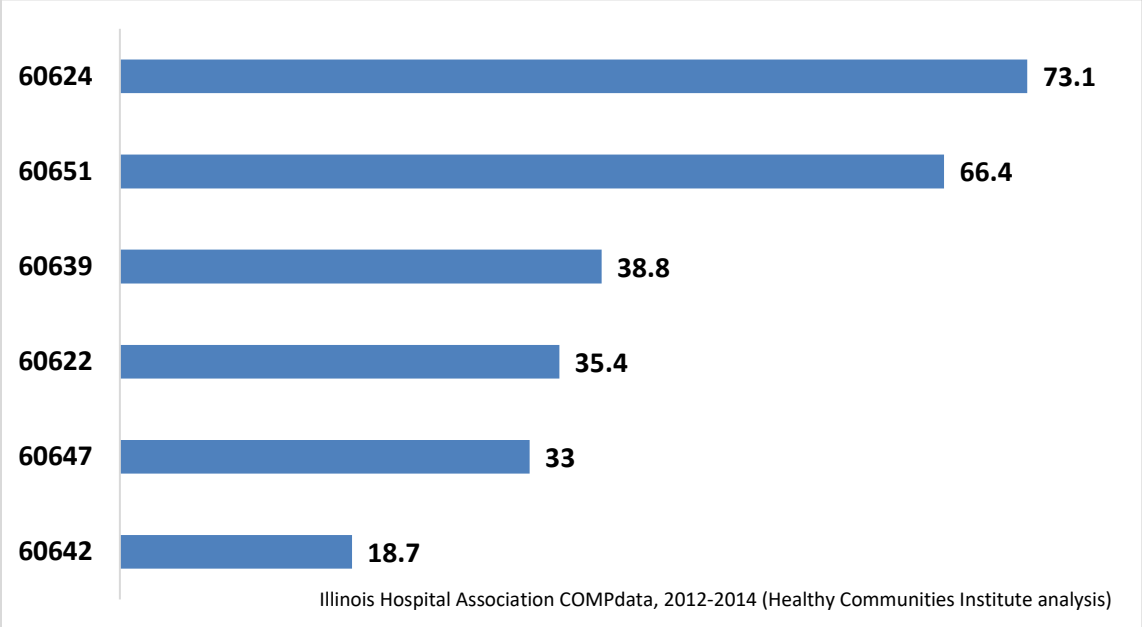
Emergency Department (ED) Rate due to Substance Abuse, (age-adjusted rate per 10,000) 2012-2014



- **Leading Causes of Death and Chronic Disease Risk Factors**: Heart disease and cancer are the leading age-adjusted causes of mortality across the NAH service area.

Rates of obesity and overweight adults in Chicago are similar to national rates; 31.1% of adults reported being overweight, and 28.8% of adults reported obesity in Chicago in 2011. The rate of self-reported diabetes in Chicago is 9% of adults, and rates are known to be higher in the areas served by NAH, particularly in West Town and Humboldt Park. The rate of emergency department visits due to diabetes varies significantly across NAH's service area, with the lowest rate of 18.7 per 10,000 in the 60642 zip code to the highest rates of over 65 per 10,000 in 60624 and 60651 (Humboldt Park, West Town, Austin.)

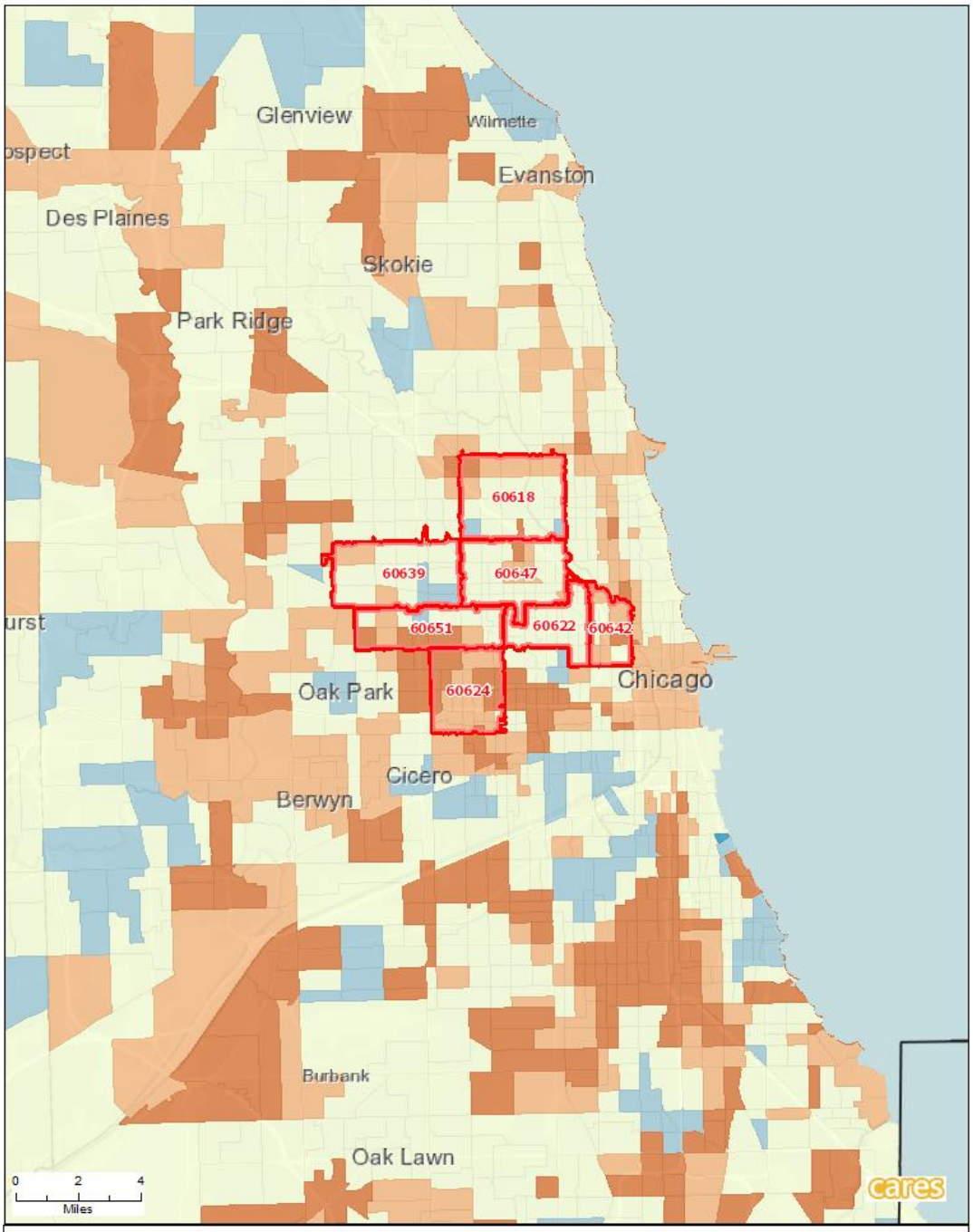
Emergency Department (ED) Rate due to Diabetes, (age-adjusted rate per 10,000)



Illinois Hospital Association COMPdata, 2012-2014 (Healthy Communities Institute analysis)

- **Food Insecurity and Food Access:** West Garfield Park, North Lawndale, Austin, East Garfield Park, Logan Square, Humboldt Park, Belmont Cragin, and Hermosa all have areas where there are few or no healthy food options compared to the number of fast food choices. Those same communities, as well as West Town, Avondale, and Irving Park all,, have food insecurity rates higher than the U.S. average. In NAH's service area, there is a rate of 89.3 fast food restaurants per 100,000 population and a rate of 28.2 grocery stores per 100,000 population. A map of NAH's service area with respect to the modified retail food environment index, or the percentage of the population living with no or low access to healthy retail food stores, shows that within zip codes there is a variety of access to healthy retail food stores.

Modified Retail Food Environment Index



Map Legend

Modified Retail Food Environmental Index Score by Tract, DNPAO 2011

- Index Score Over 30 (High Access)
- Index Score 15 - 30 (Moderate Access)
- Index Score 5 - 15 (Low Access)
- Index Score Under 5 (Poor Access)
- No Healthy Retail Food Outlet (No Access)
- No Retail Food Outlets Present (Food Desert)

Report Location, ZIP code

https://engagementnetwork.org/map-room/, 9/26/2018

IV. Progress Addressing Needs Identified in 2014 CHNA and Implementation Strategies Going Forward

In our ongoing mission to address health care disparities, Norwegian American Hospital continues to provide critical services tailored specifically to the Humboldt Park community. We are transforming how health care is delivered in powerful ways. Our services continue to make a difference in the quality of life of area residents, many considered at-risk, empowering them with valuable resources to lead healthier lives in their communities. Consistent with our mission, we proactively identify innovative programs to further meet the health and wellness needs of underserved communities, while delivering strong outcomes.

Mobile Services 2015

- The Care-A-Van had a record year of service in 2015, following unprecedented growth that resulted from an established staff, a concentrated service area, and improved procedures and efficiencies – all in the context of increasing community needs. Total services provided are up 115% from the previous year, and the number of visits provided more than doubled to 3,133. The Care-A-Van also provided over 2,500 referrals to primary care, dental care, insurance enrollment, and optometry.
- During the past year, the Care-A-Van staff continued to improve relationships with schools and daycare centers in the service area. Because the team carefully fosters these relationships, the school staff better understands the Care-A-Van's scope of services and how to prepare for the day when the Care-A-Van will be at their school. This improvement allows the Care-A-Van staff to give greater attention to the children and their families. These strong working relationships with key school personnel are the basis upon which trust has been established and continues to grow. Now, the Care-A-Van is the first place schools call when medical services are needed. Because of the Care-A-Van's established staff, school administrators regularly recommend the Care-A-Van to colleagues at other schools. The van is continuously booked several months in advance and has a waiting list of schools. The Care-A-Van also strengthened its relationship with Loyola's Care-A-Van and other mobile health providers from around Illinois. The staff from all of the mobile units communicate regularly to reinforce the implementation of best practices among all programs.
- One example of best practice implementation on the Care-A-Van is the hiring of a Care Coordinator in 2015. The Care Coordinator ensures smoother operations by improving coordination with schools, refers patients to ongoing medical and dental care and to insurance enrollment services, monitors follow up visits, and educates children and their families about health. The intended longer-term impact of the Care Coordinator is to connect children to primary care medical homes, thus improving each child's ability to sustain optimal long-term health.
- Finally, based on the steadfast and continued support from the Children's Care Foundation, Norwegian American Hospital (Norwegian) was able to place its new Dental Van into operation. Services began in April 2015, including preventive and restorative dental care to children who live in or attend school in the service area. This program was formed based on the data-driven model of Care-A-Van that Children's Care Foundation has supported for eight years. The long-term support from Children's Care Foundation put Norwegian in a strong strategic position to initiate

the Dental Van, thus expanding the Care-A-Van into a two-van program that will be named Mobile Health Services starting in Fiscal Year 2016.

Mobile Services 2016

- In 2016, the Norwegian American Hospital (NAH) Care-A-Van continued its record level of service established in 2015, following unprecedented growth that resulted from an established staff, a concentrated service area, and improved procedures and efficiencies. Total services provided were slightly above 2015 levels and 135% higher than in 2014. The number of visits provided has also been maintained at these extraordinary levels, with nearly 3,000 total visits, just under 2015's number of visits, all in the context of increasing community needs. The Care-A-Van also provided more referrals than ever before, providing nearly 4,000 referrals to primary care, dental care, insurance enrollment, and optometry.
- The Care-A-Van staff has continued to improve relationships with schools and daycare centers in the service area. The team carefully fosters these relationships, which allows the school staff to understand better the Care-A-Van's scope of services and how to prepare for the day when the Care-A-Van will be at their school. These strong working relationships with key school personnel are the basis upon which trust has been established and continues to grow and enables the Care-A-Van staff to give greater attention to the children and their families. Now, the Care-A-Van is the first place schools call when medical services are needed. Because of the Care-A-Van's established staff, school administrators regularly recommend the Care-A-Van to colleagues at other schools. The van is continuously booked several months in advance and has a waiting list of schools. The Care-A-Van also strengthened its relationship with Loyola's Care-A-Van and other mobile health providers from around Illinois. The staff from all of the mobile units communicate regularly to reinforce the implementation of best practices among all programs.
- NAH's Care-A-Van program has continued to innovate and expand throughout FY16. In response to the dramatic increase in services provided in 2015, at a level that has been maintained throughout 2016, NAH hired a second nurse practitioner in order to ensure smooth operation of the Care-A-Van at these higher patient volumes. It also ensures that the nurse practitioner is able to be directly involved in scheduling, thereby building relationships with the schools and the community, without facing any decrease in provider capacity. The program is also approaching the final launch of its EHR, AthenaNet. This will put the Care-A-Van among the mobile programs that have been able to surmount connectivity challenges and implement a technology that promises to improve care coordination, integration with the hospital, and tracking of patient data and referrals.
- Finally, NAH's new Dental Van that was launched in April 2015 experienced its first full year of services in FY16. Since its inception, the Dental Van has provided necessary preventive and restorative dental care to over 1,000 children who live in or attend school in the service area. In January 2016, NAH hired Dr. Susana Torres as the dentist and program director, transitioning to an in-house staffing approach that mirrors the successful Care-A-Van approach. Thanks to the continued steadfast support of the Children's Care Foundation, NAH was not only able to launch this critical and strategic program to supplement the already-successful Care-A-Van program, but also take steps to adjust its program and staffing model over the course of its first full year.

Women's Health

- In 2016, Norwegian American Hospital addressed the specific health needs of women in Humboldt Park and the surrounding communities. As women's health concerns change, Norwegian seeks to provide patients with personalized care in every stage of their life—from adolescence through pregnancy to menopause. With years of experience, the physicians and midwives of the Women's Health Specialists at Norwegian American Hospital demonstrate professionalism and expertise at every level.
- Norwegian is affiliated with maternal-fetal medicine specialists from Northwestern's Prentice Women's Hospital who care for women with high-risk pregnancies. Other services include mammograms, bone density testing, family planning, pap, cervical smear, and HPV testing. The Women's Health Specialists can also serve as primary care physicians for routine preventive visits.

Norwegian American Hospital's Diabetes Learning Center

- The new and expanded Diabetes Learning Center will enable Norwegian American Hospital to offer comprehensive diabetes management programs for patients and their families in the Humboldt Park community. The Diabetes Learning Center provides concentrated medical care in one convenient and centralized location. Patients also have access to Norwegian American Hospital physicians in other health specialties.
- The Diabetes Learning Center offers an education program focusing on teaching self-management skills to patients with diabetes and their families. The program utilizes a team approach in developing an individualized plan for each participant. The program is offered in both English and Spanish. The Diabetes Learning Center staff are certified diabetes educators, including a registered nurse and a dietitian. Components of care include pharmacy, surgery, nutrition, wound care, and physical therapy.

Strategic Renovations

- In 2016, Norwegian laid the groundwork for a strategic renovation of the hospital's first floor. A master plan has been made for construction to begin at the start of 2017. The work will feature a new lobby design, first-floor corridor, an enhanced emergency room with a new Fast Track program that will broaden treatment access for 5,000 patients per year, and an expanded residency clinic for the new Family Medicine program.
- The new layout will also allow for an increase in services from the Specialty Clinic, including Podiatry, General Surgery, Urology, and Ophthalmology. The renovations will enable Corporate Health to expand their services to meet a larger demand from businesses in the community with pre-employment and corporate health needs.

Stroke Program

- Certification from the Health Care Facilities Accreditation program. Norwegian is committed to a higher standard of care by ensuring that stroke patients receive treatment according to nationally accepted guidelines. Norwegian strives to provide the most up-to-date, research-based guidelines, with the goal of speeding recovery and reducing death and disability for stroke patients.
- These measures include aggressive use of medications and risk-reduction therapies aimed at reducing death and disability and improving the lives of stroke patients.
- Human Resources, nursing education, clinical managers, and preceptors to discuss their positive experiences, the challenges they faced, and ways to improve the program moving forward.

Norwegian had 2 groups undergo the program in 2015 and early 2016 with a total of 35 new hires and retained 33, resulting in a 95% retention rate. The program will be offered twice yearly with the newest group having started in September 2016.

V. Conclusion

As a founding member of the Health Impact Collaborative of Cook County, Norwegian American Hospital came together with colleagues from 25 other hospitals, Chicago Department of Public Health and other county health departments, and community partners local to the NAH service area as well as regional partners to complete a comprehensive community health needs assessment. The MAPP assessments produced robust data from various perspectives including health status and health behaviors, forces of change, public health system strengths and weaknesses, and perceptions and experiences from diverse and often underserved community populations. A focus on health equity, community input, stakeholder engagement, and collaborative leadership and decision making have been some of the hallmarks of the process thus far. The CHNA process engaged diverse groups of community residents and stakeholders. The input from those community partners has been invaluable in identifying and understanding the priority community health issues that we need to address collectively for meaningful impact. Leveraging the continued participation of community stakeholders invested in health equity and wellness, including actively identifying and engaging new partners, will be essential for developing and deploying aligned strategic plans for community health improvement in the following priority areas:

- Improving social, economic, and structural determinants of health while reducing social and economic inequities.
- Improving mental health and decreasing substance abuse.
- Preventing and reducing chronic disease (focused on risk factors – nutrition, physical activity, and tobacco).
- Increasing access to care and community resources.

Norwegian American Hospital continues to participate in the Health Impact Collaborative of Cook County and in our local partnerships for community health improvement. Driven by a shared mission and a set of collective values, Norwegian American Hospital, and the Health Impact Collaborative will work together with regional and community partners to develop implementation plans and collaborative action to achieve the shared vision of improved health equity, wellness, and quality of life across Chicago and Cook County. The CHNA process has developed a solid foundation for health equity collaboration and has opened the door for many opportunities to continue partnerships for improved health in the communities served by Norwegian.

On behalf of the Norwegian American Hospital board of Trustees, Billy Ocasio, Board Chair approved and adopted the FY 2016 Community Health Needs Assessment that was conducted in 2015-2016 in collaboration with the Health Impact Collaborative of Cook County.

This Community Health Needs Assessment (CHNA) is available online at www.Nahospital.org. The CHNA contact at Norwegian American Hospital is Jacqueline Soto, Manager, Community Affairs, who can be contacted at JSoto@nahospital.org to comment on this CHNA or to request more information or paper copies of the CHNA.

Health Impact Collaborative of Cook County

Working together for healthy communities.

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Community Health Needs Assessment Central Region

June 2016

Participating hospitals and health departments:

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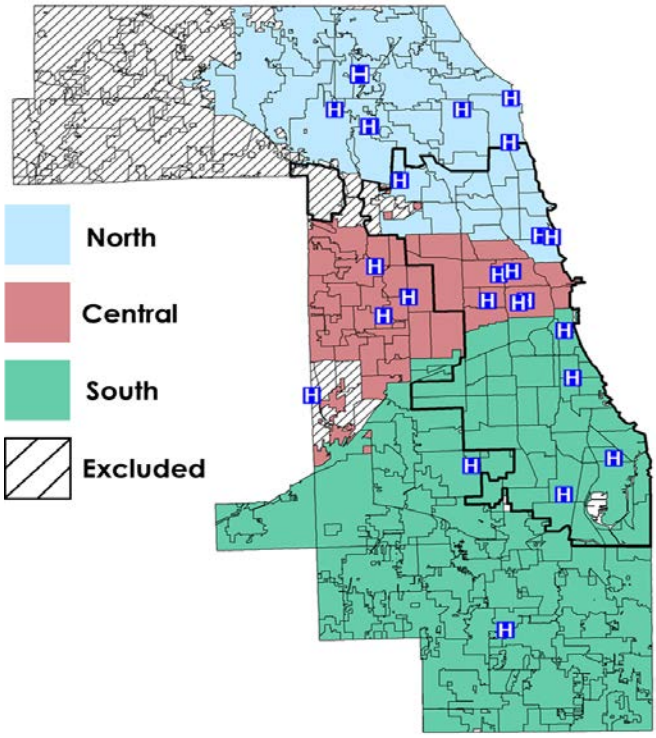
Table of Contents

Executive Summary – Central Region

The Health Impact Collaborative of Cook County is a partnership of hospitals, health departments, and community organizations working to assess community health needs and assets, and to implement a shared plan to maximize health equity and wellness in Chicago and Cook County. The Health Impact Collaborative was developed so that participating organizations can efficiently share resources and work together on Community Health Needs Assessment (CHNA) and implementation planning to address community health needs - activities that every nonprofit hospital is now required to conduct under the Affordable Care Act (ACA). Currently, 26 hospitals, seven health departments, and more than 100 community organizations are partners in the Health Impact Collaborative of Cook County. The Illinois Public Health Institute (IPHI) is serving as the process facilitator and backbone organization for the collaborative CHNA and implementation planning processes.



**Advocate Children's Hospital is co-located at the Advocate Lutheran General Hospital and Advocate Christ Medical Center sites and does not have a separate icon.*

*** Highland Park Hospital is geographically outside of Cook County and not shown on this map, but is participating in the North region of the Collaborative as part of NorthShore University HealthSystem.*

A CHNA summarizes the health needs and issues facing the communities that hospitals, health departments, and community organizations serve. Implementation plans and strategies serve as a roadmap for how the community health issues identified in the CHNA are addressed. Given the large geography and population of Cook County, the Collaborative partners decided to conduct three regional CHNAs. Each of the three regions, North, Central, and South, include both community areas within the city of Chicago and suburban municipalities.

IPHI and the Collaborative partners are working together to design a shared leadership model and collaborative infrastructure to support community-engaged planning, partnerships, and strategic alignment of implementation, which will facilitate more effective and sustainable community health improvements in the future.

Community description for the Central region of the Health Impact Collaborative of Cook County

This CHNA report is for the Central region of the Health Impact Collaborative of Cook County. As of the 2010 census, the Central region had 1,120,297 residents, which represents a 3% decrease in total population from the year 2000. The African American/black population experienced the largest population decrease in the Central region with 54,024 fewer African American/black residents in 2010 compared to 2000.

Despite an overall population decrease in the Central region from 2000 to 2010, the Hispanic/Latino and Asian populations increased by 32,558 and 11,809 residents respectively during the same time period. Children and adolescents under 18 represent nearly a quarter (24%) of the population in the Central region. The majority of the population is 18 to 64 years old and approximately 10% are older adults aged 65 and over. Overall, the Central region is extremely diverse, and several priority groups were identified during the assessment process.

Priority populations identified during the assessment process include:

- Children and youth
- Diverse racial and ethnic communities
- Homeless individuals and families
- Incarcerated and formerly incarcerated
- Immigrants and refugees, particularly undocumented immigrants
- Individuals living with mental health conditions
- LGBQIA and transgender individuals
- Older adults and caregivers
- People living with disabilities
- Unemployed
- Uninsured and underinsured
- Veterans and former military

Collaborative structure

Seven nonprofit hospitals, one public hospital, three health departments, and approximately 30 community stakeholders partnered on the CHNA for the Central region. The participating hospitals are Loyola University Health System (including Loyola University Medical Center and Gottlieb Memorial Hospital), Norwegian American Hospital, Presence Saints Mary and Elizabeth Medical Center, RML Specialty Hospitals, Rush (including Rush University Medical Center and Rush Oak Park), and Stroger Hospital of Cook County. Health departments are key partners in leading the Collaborative and conducting the CHNA. The participating health departments in the Central region are the Chicago Department of Public Health, Cook County Department of Public Health, and Oak Park Department of Public Health.

The leadership structure of the Health Impact Collaborative includes a Steering Committee, Regional Leadership Teams, and Stakeholder Advisory Teams. Collectively, the hospitals and health departments serve as the Regional Leadership Team.

Stakeholder engagement

The Health Impact Collaborative of Cook County is focused on community-engaged assessment, planning, and implementation. Stakeholders and community partners have been involved in multiple ways throughout this assessment process, both in terms of community input data and as decision-making partners. To ensure meaningful ongoing

involvement, each region's Stakeholder Advisory Team met monthly during the assessment phase to provide input and to engage in consensus-based decision making. Additional opportunities for stakeholder engagement during assessment included participation in hospitals' community advisory groups, community input through surveys and focus groups, and there will be many additional opportunities for engagement as action planning begins in the summer of 2016. The Stakeholder Advisory Team members bring diverse perspectives and expertise, and represent populations affected by health inequities, including diverse racial and ethnic groups, immigrants and refugees, older adults, youth, homeless individuals, unemployed individuals, uninsured individuals and families, and veterans.

Mission, vision, and values

IPHI facilitated a three-month process that involved the participating hospitals, health departments, and diverse community stakeholders to develop a collaborative-wide mission, vision, and values to guide the CHNA and implementation work. The mission, vision, and values have been at the forefront of all discussion and decision making for assessment and will continue to guide action planning and implementation.

Mission:

The Health Impact Collaborative of Cook County will work collaboratively with communities to assess community health needs and assets and implement a shared plan to maximize health equity and wellness.

Vision:

Improved health equity, wellness, and quality of life across Chicago and Cook County

Values:

1) We believe the highest level of health for all people can only be achieved through the pursuit of **social justice and elimination of health disparities and inequities**.
2) We value having a shared vision and goals with alignment of strategies to achieve **greater collective impact while addressing the unique needs of our individual communities**.
3) Honoring the diversity of our communities, we value and will strive to include all voices through **meaningful community engagement and participatory action**.
4) We are committed to emphasizing assets and strengths and ensuring a process that identifies and **builds on existing community capacity and resources**.
5) We are committed to **data-driven decision making** through implementation of evidence-based practices, measurement and evaluation, and using findings to inform resource allocation and quality improvement.
6) We are committed to building **trust and transparency** through fostering an atmosphere of open dialogue, compromise, and decision making.
7) We are committed to **high quality work to achieve the greatest impact possible**.

Assessment framework and methodology

The Collaborative used the Mobilizing for Action through Planning and Partnerships (MAPP) Assessment framework. The MAPP framework promotes a system focus, emphasizing the importance of community engagement, partnership development, shared resources, shared values, and the dynamic interplay of factors and forces within the public health system. The four MAPP assessments are:

- Community Health Status Assessment (CHSA)
- Community Themes and Strengths Assessment (CTSA)
- Forces of Change Assessment (FOCA)
- Local Public Health System Assessment (LPHSA)

The Health Impact Collaborative of Cook County chose this community-driven assessment model to ensure that the assessment and identification of priority health issues was informed by the direct participation of stakeholders and community residents.

The four MAPP assessments were conducted in partnership with Collaborative members and the results were analyzed and discussed in monthly Stakeholder Advisory Team meetings.

Community Health Status Assessment (CHSA). IPHI worked with the Chicago Department of Public Health and Cook County Department of Public Health to develop the Community Health Status Assessment. This Health Impact Collaborative CHNA process provided an opportunity to look at data across Chicago and suburban jurisdictions and to share data across health departments in new ways. The Collaborative partners selected approximately 60 indicators across seven major categories for the Community Health Status Assessment.[1] In keeping with the mission, vision, and values of the Collaborative, equity was a focus of the Community Health Status Assessment.

Community Themes and Strengths Assessment (CTSA). The Community Themes and Strengths Assessment included both focus groups and community resident surveys. Approximately 5,200 surveys were collected from community residents through targeted outreach to communities affected by health disparities across the city and county between October 2015 and January 2016. About 1,200 of the surveys collected were from residents in the Central region. The survey was disseminated in four languages and was available in paper and online formats. Between October 2015 and March 2016, IPHI conducted seven focus groups in the Central region. Focus group participants were recruited from populations that are typically underrepresented in community health assessments including racial and ethno-cultural groups; immigrants; limited English speakers families with children; older adults; lesbian, gay, bisexual, queer, intersex, and asexual (LGBQIA) individuals; and transgender individuals.

[1] The seven data indicator categories—demographics, socioeconomic factors, health behaviors, physical environment, healthcare and clinical care, mental health, and health outcomes—were adapted from the County Health Rankings model.

Forces of Change Assessment (FOCA) and Local Public Health System Assessment (LPHSA). The Chicago and Cook County Departments of Public Health each conducted a Forces of Change Assessment and a Local Public Health System Assessment in 2015, so the Collaborative was able to leverage and build off of that data. IPHI facilitated interactive discussions at the August and October 2015 Stakeholder Advisory Team meetings to reflect on the findings, gather input on new or additional information, and prioritize key findings impacting the region.

Significant Health Needs

Stakeholder Advisory Teams in collaboration with hospitals and health departments prioritized the strategic issues that arose during the CHNA. The guiding principles and criteria for the selection of priority issues were rooted in data-driven decision making and based on the Collaborative's mission, vision, and values. In addition, partners were encouraged to prioritize issues that will require a collaborative approach in order to make an impact. Very similar priority issues rose to the top through consensus decision making in the Central, South, and North regions of Chicago and Cook County.

Through collaborative prioritization processes involving hospitals, health departments, and Stakeholder Advisory Teams, the Health Impact Collaborative of Cook County identified four focus areas as significant health needs:

- **Improving social, economic, and structural determinants of health while reducing social and economic inequities. ***
- **Improving mental health and decreasing substance abuse**
- **Preventing and reducing chronic disease (focused on risk factors – nutrition, physical activity, and tobacco).**
- **Increasing access to care and community resources.**

* All hospitals within the Collaborative will include the first focus area—*Improving social, economic, and structural determinants of* health—as a priority in their CHNA and implementation plan. Each hospital will also select at least one of the other focus areas as a priority.

Based on community stakeholder and resident input throughout the assessment process, the Collaborative's Steering Committee made the decision to establish *Social, Economic and Structural Determinants of Health* as a collaborative-wide priority. Regional and collaborative-wide planning will start in summer 2016 based on alignment of hospital-specific priorities.

Key assessment findings

1. Improving social, economic, and structural determinants of health while reducing social and economic inequities

The social and structural determinants of health, such as poverty, unequal access to community resources, unequal education funding and quality, structural racism, and environmental conditions, are underlying root causes of health inequities.[2] Additionally, social determinants of health often vary by geography, gender, sexual orientation, age, race, disability, and ethnicity.[2] The strong connections between social, economic, and environmental factors and health are apparent in Chicago and suburban Cook County, with health inequities being even more pronounced than many national trends.

Figure 1.1. Summary of key assessment findings related to the social, economic, and structural determinants of health

Social, Economic, and Structural Determinants of Health
Poverty and economic equity. African American/blacks, Hispanics/Latinos and Asians have higher rates of poverty than non-Hispanic whites and lower annual household incomes. Nearly half of all children and adolescents in the Central region live at or below 200% of the Federal Poverty Level. In Chicago and suburban Cook County, residents in communities with high economic hardship have life spans that are five years shorter on average compared to other areas of the county.
Unemployment. The unemployment rate in the Central region from 2009 to 2013 was 12.3% compared to 9.2% overall in the U.S. African American/blacks in Chicago and suburban Cook County have an unemployment rate that is three times higher (22.5%) than the rate for whites (7.5%) and Asians (7.1%).
Education. The rate of poverty is higher among those without a high school education, and those without a high school education are more likely to develop chronic illnesses. The high school graduation rates in the Central region (72%) are lower than the average for Chicago and Suburban Cook County (78%).
Housing and transportation. Many residents in the Central region indicated poor housing conditions and a lack of quality affordable housing that is in part leading to homelessness. There are inequities in access to public transportation for multiple communities in the city and suburbs of the Central region.
Environmental concerns. Climate change, poor air quality, changes in water quality, radon, and lead exposure are environmental factors that were identified as having the potential to affect the health of residents in the Central region. The Central region is particularly vulnerable to natural and man-made disasters and disease outbreaks due to its areas of high economic hardship and low economic opportunity.
Safety and violence. Firearm-related and homicide mortality are highest among Hispanic/Latinos and African American/blacks. The Central and South regions of the collaborative appear to be disproportionately affected by trauma, safety issues, and community violence.

[2] Centers for Disease Control and Prevention. (2013). CDC Health Disparities and Inequalities Report. Morbidity and Mortality Weekly Report, 62(3).

Disparities related to socioeconomic status, built environment, safety and violence, policies, and structural racism were identified in the Central region as being key drivers of community health and individual health outcomes.

2. Improving mental health and decreasing substance abuse

Mental health and substance use arose as key issues in each of the four assessment processes in the Central region. Community mental health issues are exacerbated by long-standing inadequate funding, as well as recent cuts to social services, healthcare, and public health. The World Health Organization (WHO) emphasizes the need for a network of community-based mental health services.[3] The WHO has found that the closure of mental health hospitals and facilities is often not accompanied by the development of community-based services which leads to a service vacuum.[3] In addition, research indicates that better integration of behavioral health services, including substance use treatment, into the healthcare continuum can have a positive impact on overall health outcomes.[4]

Figure 1.2. Summary of key assessment findings related to mental health and substance use

Mental Health and Substance Use
Community-based mental health care and funding. Community mental health issues are being exacerbated by long-standing inadequacies in funding, as well as recent cuts to social services, healthcare, and public health. Socioeconomic inequities, disparities in healthcare access, housing issues, racism, discrimination, stigma, mass incarceration of individuals with mental illness, community safety issues, violence, and trauma are all negatively impacting the mental health of residents in the Central region. There are several communities that have high Emergency Department visit rates for mental health, intentional injury/suicide, substance use, and heavy drinking in the Central region. Focus group participants and survey respondents in the Central region report cost and lack of insurance coverage as major barriers to seeking needed mental health treatment. Community survey respondents from the Central region indicated that their financial strain and debt were the biggest factors contributing to feelings of stress in their daily lives.
Substance use. The lack of effective substance use prevention programs, easy access to alcohol and other drugs, the use of substances to self-medicate in lieu of access to mental health services, and the criminalization of addiction are factors and trends affecting community health and the local public health system in the Central region. There are several barriers to accessing mental health and substance use treatment and services, including social stigma, continued funding cuts, and mental health/substance use provider shortages. The need for policy changes that decriminalize substance use and connect individuals with treatment and services were identified as needs in the Central region.

[3] World Health Organization. (2007). http://www.who.int/mediacentre/news/notes/2007/np25/en/
[4] American Hospital Association. (2012). Bringing behavioral health into the care continuum: opportunities to improve quality, costs, and outcomes. http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf

3. Preventing and reducing chronic disease (focus on risk factors – nutrition, physical activity, and tobacco)

Chronic disease prevention was another strategic issue that arose across all four assessments. The number of individuals in the U.S. who are living with a chronic disease is projected to continue increasing well into the future.[5] In addition, chronic diseases accounted for approximately 64% of deaths in Chicago in 2014.[6] As a result, it will be increasingly important for the healthcare system to focus on prevention of chronic disease and the provision of ongoing care management.[5]

Figure 1.3. Summary of key assessment findings related to chronic disease

Chronic Disease
Policy, systems and environment. Findings from community focus groups, the Forces of Change Assessment (FOCA), and the Local Public Health System Assessment (LPHSA) emphasized the important role of healthy environments and policies supporting healthy eating and active living. Thirty-nine percent of community resident survey respondents in the Central region indicated challenges related to the availability of healthy foods in their community. A quarter of the survey respondents reported few parks and recreation facilities in their communities, and 54% of survey respondents rated the quality and convenience of bike lanes in their community to be "fair," "poor" or "very poor."
Health Behaviors . The majority of adults in suburban Cook County (85%) and Chicago (71%) report eating less than five daily servings of fruits and vegetables. In addition, more than a quarter of adults in suburban Cook County (28%) and Chicago (29%) report not engaging in physical activity during leisure time. Approximately 14% of youth in suburban Cook County and 22% of youth in Chicago report not engaging in physical activity during leisure time. Poor diet and a lack of physical activity are two of the major predictors for obesity and diabetes. A significant percentage of youth and adults report engaging in other health behaviors, such as smoking and heavy drinking, that are also risk factors for developing chronic illnesses. Low consumption of healthy foods may also be an indicator of inequities in food access.
Mortality related to chronic disease. The top three leading causes of death in the Central region are heart disease, cancer, and stroke. There are stark disparities in chronic-disease related mortality in the Central region, both in terms of geography and in terms of race and ethnicity.

4. Increasing access to care and community resources.

Healthy People 2020 states that access to comprehensive healthcare services is important for achieving health equity and improving quality of life for everyone.[7] Disparities in access to care and community resources were identified as key contributors to health inequities experienced by residents in the Central region. Access is a complex and multi-faceted concept that includes dimensions of proximity, affordability, availability, convenience, accommodation, reliability, quality, acceptability, openness, cultural competency, appropriateness, and approachability.

[5] Anderson, G. & Horvath, J. (2004). The growing burden of chronic disease in America. *Public Health Reports*, 119, 263-270.
[6] Chicago Department of Public Health. (2016). Healthy Chicago 2.0.
[7] Healthy People 2020. (2016). Access to Health Services. https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

Figure 1.4. Summary of key assessment findings related to access to care and community resources

Access to care and community resources
Cultural and linguistic competence and humility. Focus group participants in the Central region and Stakeholder Advisory Team members emphasized that cultural and linguistic competence/humility are key aspects of access to quality healthcare and community services. Participants in six of seven focus groups in the Central region cited lack of sensitivity to cultural difference as a significant issue impacting health of diverse racial and ethnic groups in the Central region.
Insurance coverage. Aggregated rates from 2009 to 2013, show that 26% of the adult population age 18-64 in the Central region reported being uninsured, compared to 19% in Illinois and 21% in the U.S. Men in Cook County are more likely to be uninsured (18%) than women (14%). In addition, ethnic and racial minorities are much more likely to be uninsured than non-Hispanic whites. As of 2014, nearly a quarter of immigrants (23%) and 40% of undocumented immigrants are uninsured compared to 10% of U.S. born and naturalized citizens.
Use of preventive care and health literacy. Overall rates of self-reported cancer screenings vary greatly across Chicago and suburban Cook County. This could represent differences in access to preventative services or in knowledge about the need for preventative screenings. Approximately one-third of Chicago residents aged 65 or older reported that they had not received a pneumococcal vaccination in 2014. Health education about routine preventative care was mentioned by multiple residents as a need in their communities.
Provider availability. A large percentage of adults reported that they do not have at least one person that they consider to be their personal doctor or healthcare provider. In the U.S., LGBQIA and transgender youth and adults are less likely to report having a regular place to go for medical care. There are several communities in the Central region that are classified by the Health Resources and Services Administration as having shortages of primary care, dental care, or mental health providers.
Use of prenatal care. Nearly 20% of women in Illinois and suburban Cook County receive inadequate prenatal care.

Introduction

Collaborative Infrastructure for Community Health Needs Assessment (CHNA) in Chicago and Cook County

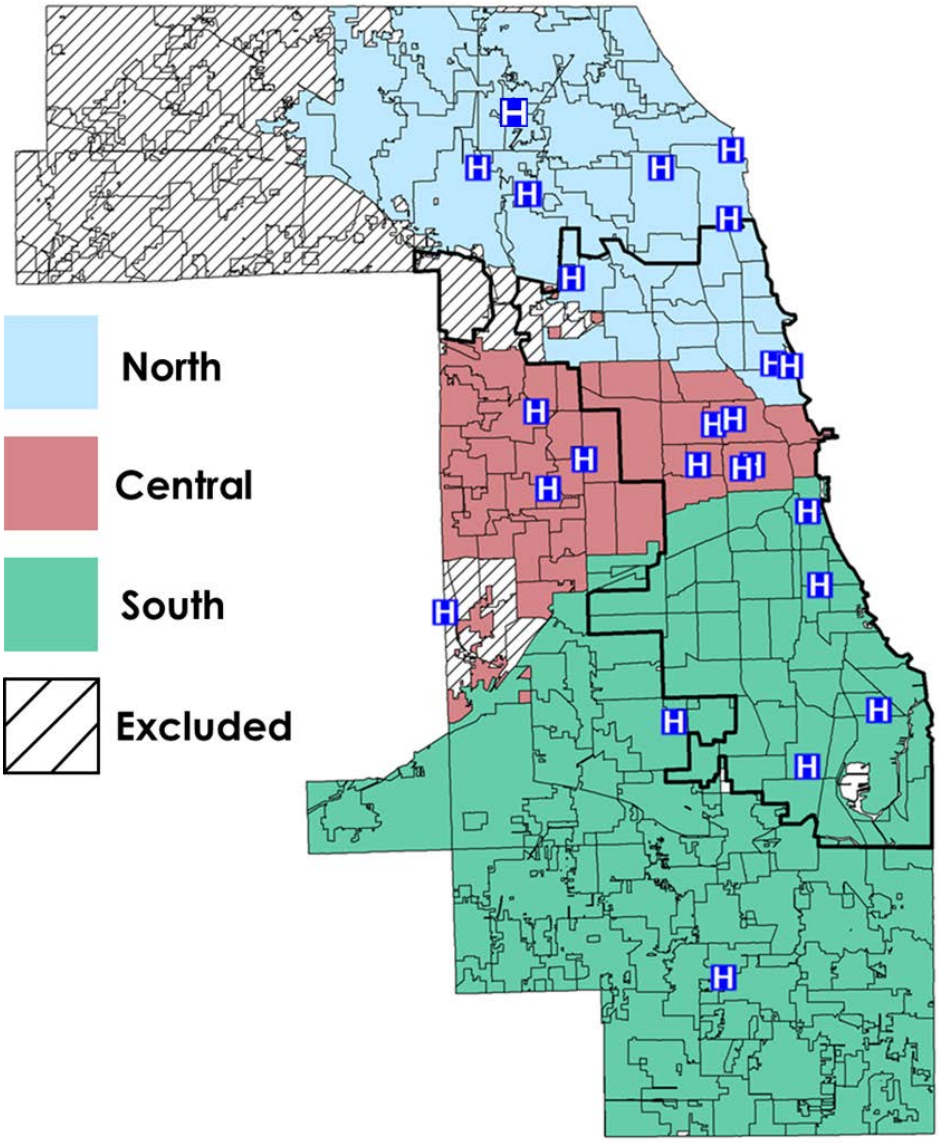
In addition to providing health coverage for millions of uninsured people in the U.S., the Affordable Care Act includes a number of components designed to strengthen the healthcare delivery system's focus on prevention and keeping people healthy rather than simply treating people who are ill. One component is the requirement that nonprofit hospitals work with public health and community partners every three years to conduct a Community Health Needs Assessment (CHNA), identify community health priorities, and develop implementation strategies for those priorities. The CHNA summarizes community health needs and issues facing the communities that hospitals serve, and the implementation strategies provide a roadmap for addressing them.

After separately developing CHNAs in 2012-2013, hospitals in Chicago and suburban Cook County joined together to create the Health Impact Collaborative of Cook County ("Collaborative") for the 2015-2016 CHNA process. This unprecedented collaborative effort enabled the members to efficiently share resources and foster collaboration that will help them achieve deep strategic alignment and more effective and sustainable community health improvement. Local health departments across Cook County have also been key partners in developing this collaborative approach to CHNA to bring public health expertise to the process and to ensure that the assessment, planning, and implementation are aligned with the health departments' community health assessments and community health improvement plans.[8] As of March 2016, the Collaborative includes 26 hospitals serving Chicago and Cook County, seven local health departments, and approximately 100 community partners participating on three regional Stakeholder Advisory Teams. (Appendices A and B list the full set of partners collaborating across the three regions.) The Illinois Public Health Institute (IPHI) serves as the "backbone organization," convening and facilitating the Collaborative. The Collaborative operates with a shared leadership model as shown in Figure 2.2.

Given the large geography and population in Cook County, the Collaborative partners decided to conduct three regional CHNAs within Cook County. The three regions each include Chicago community areas as well as suburban cities and towns. Figure 2.1 shows a map of the three CHNA regions – North, Central, and South. This report is for the **Central** region. Similar reports will also be available for the North and South regions of the county at www.healthimpactcc.org by fall 2016.

[8] Certified local health departments in Illinois have been required by state code to conduct "IPLAN" community health assessments on a five-year cycle since 1992.

Figure 2.1. Map of the three CHNA regions in Cook County, Illinois



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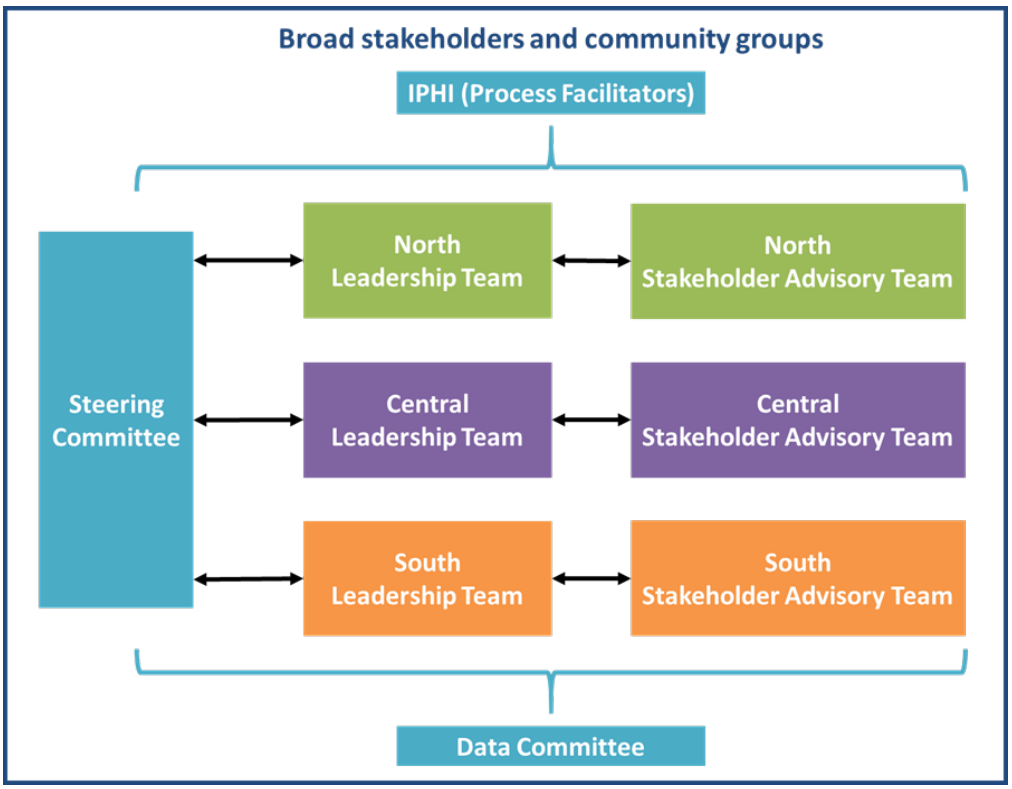
*** Highland Park Hospital is geographically outside of Cook County and not shown on this map, but is participating in the collaborative as part of NorthShore University HealthSystem.*

Seven nonprofit hospitals, one public hospital, three health departments, and approximately 30 stakeholders are collaborating partners on the Central region CHNA for Chicago and suburban Cook County. The participating hospitals are: Loyola University Health System (including Loyola University Medical Center and Gottlieb Memorial Hospital), Norwegian American Hospital, Presence Saints Mary and Elizabeth Medical Center, RML Specialty Hospitals, Rush (including Rush University Medical Center and Rush Oak Park), and Stroger Hospital of Cook County. Health departments are key partners in leading the Collaborative and conducting the CHNA; the participating health departments in the Central region are

Chicago Department of Public Health, Cook County Department of Public Health, and Oak Park Department of Public Health.

Figure 2.2. Structure of the Health Impact Collaborative of Cook County



Community and stakeholder engagement

The hospitals and health systems involved in the Health Impact Collaborative of Cook County recognize that engagement of community members and stakeholders is invaluable in the assessment and implementation phases of this CHNA. Stakeholders and community partners have been involved in multiple ways throughout the assessment process, both in terms of providing community input data and as decision-making partners. Avenues for engagement in the Central region CHNA include:

- Stakeholder Advisory Team
- Hospitals' community advisory groups
- Data collection – community input through surveys and focus groups
- Action planning for strategic priorities (to begin summer 2016)

The Central Stakeholder Advisory Team includes representatives of diverse community organizations from across the West side of Chicago and West Cook suburbs. Members of the Stakeholder Advisory Team are very important partners in the CHNA and implementation planning process, contributing in the following ways:

1. Participating in a series of 8-10 meetings between May 2015 and August 2016
2. Contributing to development of the Collaborative's mission, vision, and values

3. Providing input on assessment design, including data indicators, surveys, focus groups, and asset mapping
4. Sharing data that is relevant and/or facilitating the participation of community members to provide input through surveys and focus groups
5. Reviewing assessment data and assisting with developing findings and identifying priority strategic issues
6. Will participate in action planning to develop goals, objectives, and strategies for improving community health and quality of life
7. Will join an action team to help shape implementation strategies

The organizations represented on the Central Stakeholder Advisory Team are listed in Figure 2.3.

Figure 2.3. Central Stakeholder Advisory Team as of March 2016

Central Region Stakeholder Team Members
Age Options
Aging Care Connections
American Cancer Society
Casa Central
Catholic Charities
Chicago Police Department - 14th District
Chicago Public Schools
CommunityHealth
Diabetes Empowerment Center
Healthcare Alternatives Systems
Housing Forward
Infant Welfare-Oak Park/The Children's Clinic
Interfaith Leadership Project
Loyola University Stritch School of Medicine
Metropolitan Planning Council
Mile Square Health Center
PCC Wellness
PLCCA: Proviso Leyden Council for Community Action
Proviso Township Mental Health Commission
Respiratory Health Association
Saint Anthony's Hospital
West 40 Intermediate Service Center
West Cook YMCA
West Humboldt Park Development Council
West Side Health Authority
Wicker Park Bucktown Chamber of Commerce

Formation of the Central Stakeholder Advisory Team

Between March and May 2016, IPHI worked with the participating hospitals and health departments in the Central region of Cook County (i.e., Central Leadership Team) to identify and invite community stakeholders to participate as members of the Stakeholder Advisory Team.

All participating stakeholders work with or represent communities that are underserved or affected by health disparities. The Stakeholder Advisory Team members represent many constituent populations including populations affected by health inequities; diverse racial and ethnic groups including Latinos, African American/blacks, Asians, and Eastern Europeans; older adults; youth; homeless individuals; individuals with mental illness; unemployed individuals; and veterans and former military. To ensure a diversity of perspectives and expertise on the Stakeholder Advisory Team, IPHI provided a Stakeholder Wheel tool (shown in Figure 2.4) to identify stakeholders representing a variety of community sectors. The Central Leadership Team gave special consideration to geographic distribution of stakeholder invitees and representation of unique population groups in the region. Stakeholders showed a high level of interest, with approximately 25 of 30 community stakeholders accepting the initial invite. Given the large geography and population in the area, honing in on advisory team members was an iterative process, and the Stakeholder Advisory Team has been open to adding members throughout the process when specific expertise was needed or key partners expressed interest in joining.

Figure 2.4. Stakeholder Wheel

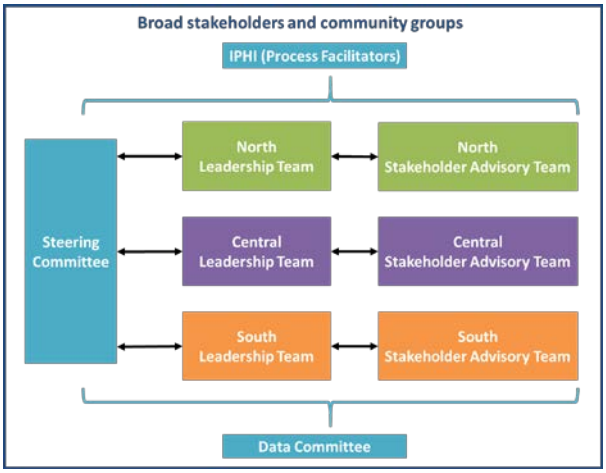
Adapted from Connecticut Department of Public Health and Health Resources in Action (HRiA)

The Central stakeholder team provided input at every stage of the assessment and was instrumental in shaping the assessment findings and priority issues that are presented in this

report. The Central Stakeholder Advisory Team met with the participating hospitals and health departments (i.e., Central Leadership Team) seven times between May 2015 and March 2016. IPHI designed and facilitated these meetings to solicit input, make recommendations, identify assets, and work collaboratively with hospitals and health systems to identify priority health needs.

Central Leadership Team

Each region of the Health Impact Collaborative of Cook County has a leadership team consisting of the hospitals and health departments participating in the collaborative in the defined regional geography. The charge of the Central Leadership Team is to:



- Work together with IPHI and community stakeholders to design and implement the CHNA process;
- Work together with IPHI on data analysis; and
- Liaise with other hospital staff and with community partners.

During the assessment process, the Central Leadership Team held monthly planning calls with IPHI and monthly in-person meetings with stakeholders. The Central region leads are the Director of Community Benefit from Loyola University Health System and the Director of Medical Affairs and Performance Improvement from Norwegian American Hospital.

Steering Committee

The Steering Committee helps to determine the overall course of action for the assessment and planning activities so that all teams and activities remain in alignment with the mission, vision, and values. The Steering Committee makes all decisions by consensus on monthly calls, designation of ad hoc subcommittees as needed, and through email communications. The Steering Committee is made up of regional leads from the three regions, representatives from three large health systems, the Illinois Hospital Association, IPHI, and the Chicago and Cook County Departments of Public Health. Members of the Central Leadership Team and the Collaborative-wide Steering Committee are named in Appendix B.

Mission, vision, and values

Over a three-month period between May and July 2015, the partners involved in the Health Impact Collaborative of Cook County worked together to develop a collaborative-wide mission, vision, and values to guide the CHNA and implementation work. The mission, vision, and values reflect input from 26 hospitals, seven health departments, and nearly 100 community partners from across Chicago and suburban Cook County. To collaboratively develop the mission, vision, and values, IPHI facilitated three in-person workshop sessions, including one with the Central Stakeholder Advisory Team. IPHI coordinated follow-up edits and vetting of final drafts over email to ensure the values represented the input of diverse partners across the collaborative. The Collaborative's mission, vision, and values are presented in Figure 2.5.

Figure 2.5. Health Impact Collaborative of Cook County Collaborative Mission, Vision, Values

Mission:

The Health Impact Collaborative of Cook County will work collaboratively with communities to assess community health needs and assets and implement a shared plan to maximize health equity and wellness.

Vision:

Improved health equity, wellness, and quality of life across Chicago and Cook County

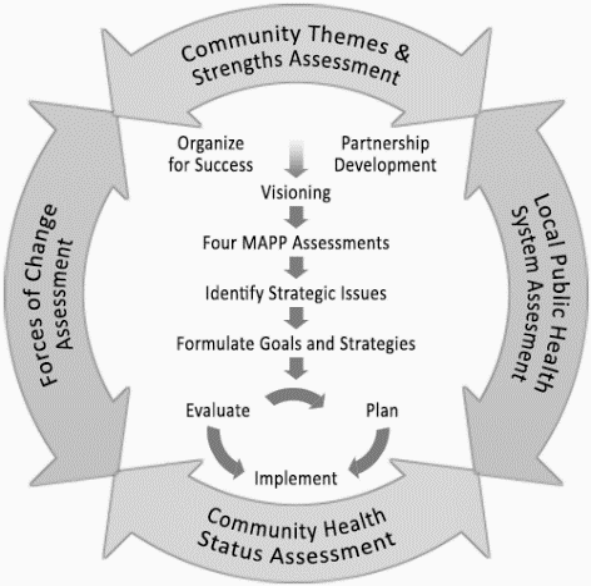
Values:

1) We believe the highest level of health for all people can only be achieved through the pursuit of **social justice and elimination of health disparities and inequities**.
2) We value having a shared vision and goals with alignment of strategies to achieve **greater collective impact while addressing the unique needs of our individual communities**.
3) Honoring the diversity of our communities, we value and will strive to include all voices through **meaningful community engagement and participatory action**.
4) We are committed to emphasizing assets and strengths and ensuring a process that identifies and **builds on existing community capacity and resources**.
5) We are committed to **data-driven decision making** through implementation of evidence-based practices, measurement and evaluation, and using findings to inform resource allocation and quality improvement.
6) We are committed to building **trust and transparency** through fostering an atmosphere of open dialogue, compromise, and decision making.
7) We are committed to **high quality work to achieve the greatest impact possible**.

Collaborative CHNA – Assessment Model and Process

The Health Impact Collaborative of Cook County carried out a collaborative CHNA between February 2015 and June 2016. IPHI worked with the Collaborative partners to design and facilitate a collaborative, community-engaged assessment based on the Mobilizing for Action through Planning and Partnerships (MAPP) framework. MAPP is a community-driven strategic planning framework that was developed by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). Both the Chicago and Cook County Departments of Public Health use the MAPP framework for community health assessment and planning. The MAPP framework promotes a system focus, emphasizing the importance of community engagement, partnership development, and the dynamic interplay of factors and forces within the public health system. The Health Impact Collaborative of Cook County chose this inclusive, community-driven process so that the assessment and identification of priority health issues would be informed by the direct participation of stakeholders and community residents. The MAPP framework emphasizes partnerships and collaboration to underscore the critical importance of shared resources and responsibility to make the vision of a healthy future a reality.

Figure 3.1. MAPP Framework



The key phases of the MAPP process include:

- Organizing for Success and Developing Partnerships
- Visioning
- Conducting the Four MAPP Assessments
- Identifying Strategic Issues
- Formulating Goals and Strategies
- Taking Action - Planning, Implementing, Evaluating

The four MAPP assessments are:

- Community Health Status Assessment (CHSA)
- Community Themes and Strengths Assessment (CTSA)
- Forces of Change Assessment (FOCA)
- Local Public Health System Assessment (LPHSA)

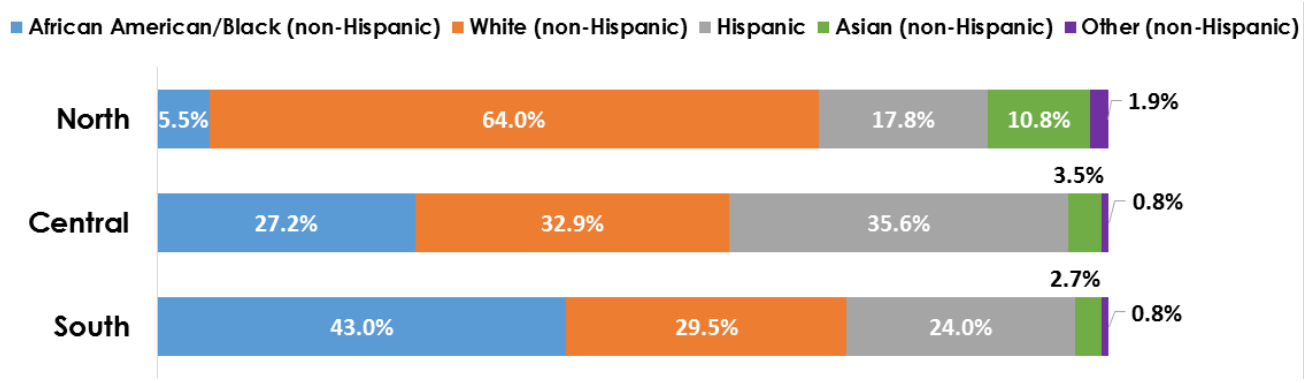
The Key Findings sections of this report highlight key assessment data and findings from the four MAPP assessments. As part of continuing efforts to align and integrate community health assessment across Chicago and Cook County, the Health Impact Collaborative leveraged recent assessment data from local health departments where possible for this CHNA. Both the Chicago and Cook County Departments of Public Health completed community health assessments using the MAPP model between 2014 and 2015. As a result, IPHI was able to compile data from the two health departments' respective Forces of Change and Local Public Health System Assessments for discussion with the Central Stakeholder Advisory Team, and data from the Community Health Status Assessments was also incorporated into the data presentation for this CHNA. See the overview of assessment methodology section starting on page 26 for a description of the methodologies used in this CHNA.

Community Description for Central Region

The Central region of the Health Impact Collaborative of Cook County covers approximately 11 Chicago community areas and 20 municipalities in suburban Cook County. As of the 2010 census, the Central region has 1,120,297 residents compared to 1,152,141 residents in the 2000 census. The total land area encompassed by the Central region is roughly 94 square miles, and the population density in the region is approximately 11,918 residents per square mile based on 2010 Census data.[9]

Hispanic/Latino individuals make up the largest ethnic group in the Central region, representing nearly 36% of the total population. Compared to the North and South regions, the Central region has the highest percentage of Hispanic/Latino individuals. Approximately 33% of the Central region is white, and African American/black (non-Hispanic) residents represent 27% of the population. A relatively small percentage of the Central region's population is Asian (3.5% as of 2010). However, the Asian population is experiencing significant growth with an increase of 11,809 Asian residents (42% increase) between 2000 and 2010 in the Central region.

Figure 4.1. Regional race and ethnicity



Data Source: Cook County Department of Public Health, U.S. Census Bureau 2010 Census

In addition to being the largest population group in the Central region, the Hispanic/Latino ethnic group is also experiencing a high rate of growth (see Figure 4.2) across Chicago and suburban Cook County. In the Central region, the Hispanic/Latino population increased by 9% (32,558 individuals) from 2000 to 2010.

Figure 4.2. Population Change in race/ethnicity between 2000 and 2010, Central Region

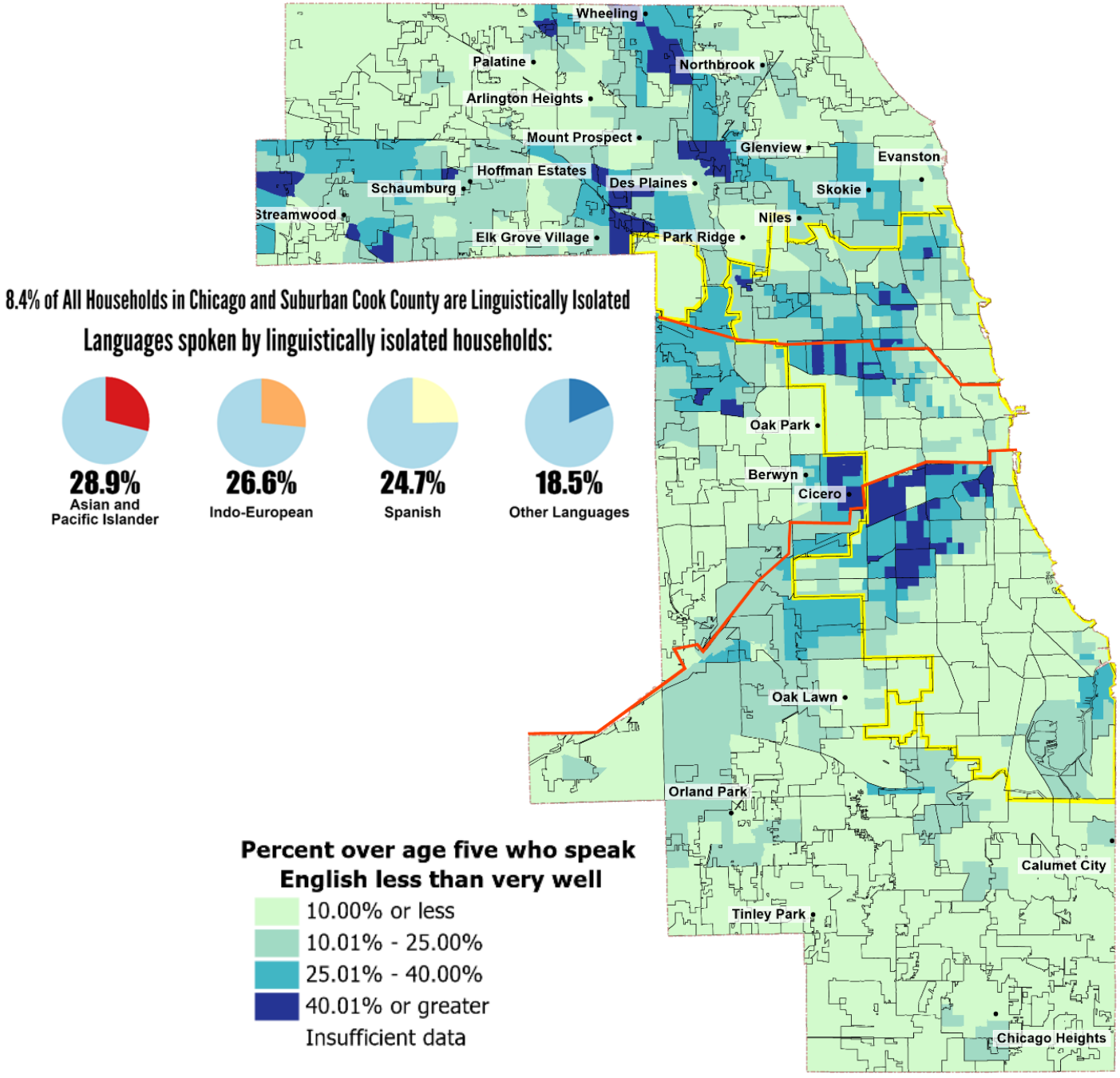
Race/Ethnicity	2010 Population	2000 Population	Change in Population	Percent Change in Population
Black (non-Hispanic)	293,389	347,413	-54,024	-16%
White (non-Hispanic)	385,235	404,688	-19,453	-5%
Asian (non-Hispanic)	39,661	27,852	11,809	42%
Hispanic/Latino	387,818	355,260	32,558	9%

Data Source: U.S. Census Bureau 2010 Census

[9] 2010 Decennial Census and American Communities Survey, 2010-2014.

The percentage of population who report limited English proficiency and the percentage of linguistically isolated households are two important metrics that a provide a picture of immigrant populations that speak languages other than English. Within the Central region, there are geographic variations in the percentages of the population with limited English proficiency as shown in Figure 4.4. Approximately 8% of all households in Chicago and suburban Cook County are linguistically isolated, defined by the Census as households where "all members 14 years old and over have at least some difficulty with English."

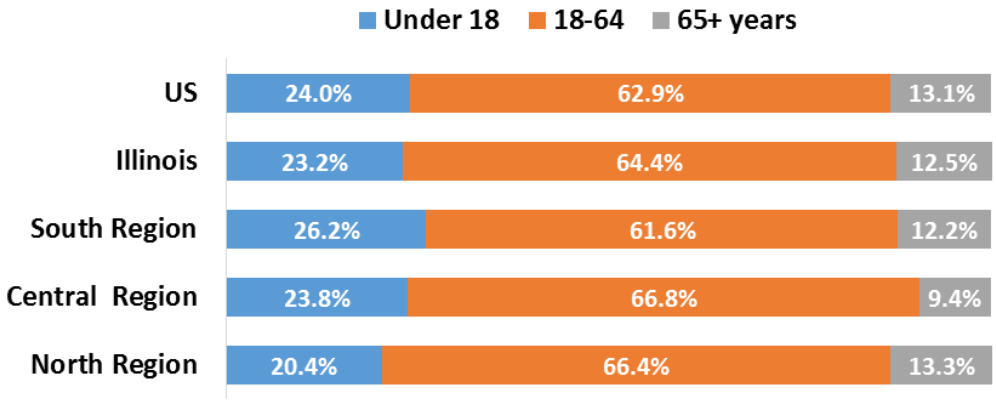
Figure 4.4. Limited English Proficiency, 2009-2013



Data Source: American Communities Survey, 2009-2013

Children and adolescents under 18 years old represent nearly a quarter (24%) of the population in the Central region. Two-thirds of the population is 18 to 64 years old, and about 10% are older adults age 65 and over (Figure 4.5).

Figure 4.5. Age distribution of residents, by region, 2010

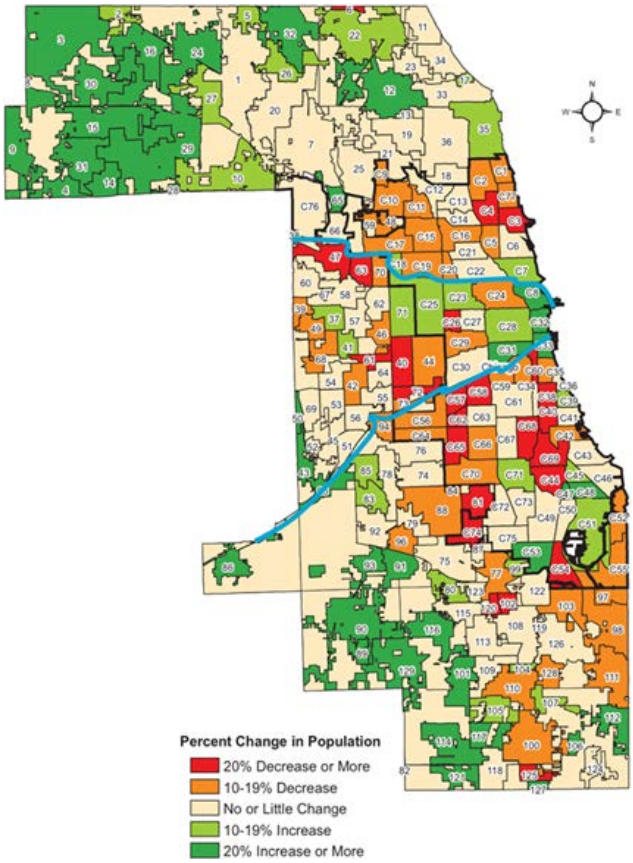


Data Source: U.S. Census Bureau 2010 Census

The overall population age 65 and older remained approximately the same between 2000 and 2010. However, several communities in the Central region experienced a growth in their older adult population (Figure 4.6.).

Figure 4.6. Change in population age 65 or older in Chicago and Cook County, 2000-2010

Several communities in the Central region experienced an increase in the older adult (65+) population between 2000 and 2010	
Chicago	**Suburban Cook County**
• Austin	• Bellwood
• Humboldt Park	• Broadview
• The Loop	• Oak Park
• Lower West Side	• Burr Ridge
• Near North Side	• Hinsdale
• Near West Side	



Data Source: U.S. Census Bureau 2010 Census

Census data shows that the population of males and females in the Central region is approximately equal. While data on transgender individuals is very limited, a 2015 study by the U.S. Census Bureau estimates that there are approximately 3.4 to 4.7 individuals per 100,000 residents in Illinois that are transgender.[10] It is estimated that approximately 5.7% of Chicago residents identify as lesbian, gay, or bisexual.[11] There are disparities in many health indicators such as access to clinical care, health behaviors such as smoking and heavy drinking, and self-reported health status for LGBQIA and transgender populations.[12] The demographic characteristics of additional priority population groups are shown in Figure 4.7.

Figure 4.7. Demographic characteristics of key populations in the Central region

Key Population	Demographic Characteristics	Data Sources
Formerly Incarcerated	40%-50% of people released from Illinois prisons return to the City of Chicago. In 2013, that represented 12,000 individuals re-entering the community in Chicago over the course of the year.	*City of Chicago. (2016). Ex-offender re-entry initiatives. http://www.cityofchicago.org/city/en/depts/mayor/supp_info/ex-offender_re-entryinitiatives.html)*
Homeless	An estimated 125,848 people were homeless in Chicago in 2015, and children and teens represent 35% (43,958) of the homeless population. In 2015, 2,025 homeless individuals were accessing shelter services in suburban Cook County.	*Chicago Coalition for the Homeless. (2016). http://www.chicagohomeless.org/faq-studies/);* *Alliance to End Homelessness in Suburban Cook County. (2015). http://www.suburbancook.org/counts*
People living with mental health conditions	11% of adults in Illinois reported living with a mental or emotional illness in 2012.	*Behavioral Risk Factor Surveillance System*
People with disabilities	Approximately 10% of the population in the Central region lives with a disability.	*American Communities Survey, 2010-2014*
Undocumented immigrants	Approximately 308,000 undocumented immigrants live in Cook County (183,000 in Chicago and 125,000 in suburban Cook County), accounting for approximately 6% of the County's population.	*Tsao, F. & Paral, R. (2014). Illinois' Undocumented Immigrant Population: A Summary of Recent Research by Rob Paral and Associates. http://icirr.org/sites/default/files/Illinois%20undocumented%20report_0.pdf*
Veterans and former military	Overall, approximately 202,886 veterans live in Chicago and suburban Cook County. In the Central region, approximately 45,086 individuals (3.8% of the population) are classified as veterans.	*American Communities Survey, 2010-2014*

[10] Harris, B.C. (2015). Likely transgender individuals in U.S. Federal Administration Records and the 2010 Census. *U.S. Census Bureau.* http://www.census.gov/srd/carra/15_03_Likely_Transgender_Individuals_in_ARs_and_2010Census.pdf

[11] Gates, G.J. (2006). Same-sex Couples and the Gay, Lesbian, Bisexual Population: New Estimates from the American Community Survey. *The Williams Institute on Sexual Orientation Law and Public Policy, UCLA School of Law*. http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-Same-Sex-Couples-GLB-Pop-ACS-Oct-2006.pdf

[12] B.W. Ward et al. (2014). Sexual Orientation and Health among U.S. Adults: National Health Interview Survey, 2013. *National Center for Health Statistics, Centers for Disease Control and Prevention*.

Overview of Collaborative Assessment Methodology[13]

The Health Impact Collaborative of Cook County employed a mixed-methods approach to assessment, utilizing the four MAPP assessments[14] to analyze and consider data from diverse sources to identify significant community health needs for the Central region of Cook County.

Methods - Forces of Change Assessment (FOCA) and Local Public Health System Assessment (LPHSA)

The Chicago and Cook County Departments of Public Health each conducted a Forces of Change Assessment and a Local Public Health System Assessment in 2015 and as a result the Collaborative was able to leverage and build on that data.

What are the FOCA and the LPHSA?

The Forces of Change Assessment (FOCA) seeks to identify answers to the questions:

1. What is occurring or might occur that affects the health of our community or the local public health system?
2. What specific threats or opportunities are generated by these occurrences?

- For the FOCA, local community leaders and public health system leaders engage in forecasting, brainstorming, and, in some cases, prioritization.
- Participants are encouraged to think about forces in several common categories of change including: economic, environmental, ethical, health equity, legal, political, scientific, social, and technological.
- Once all potential forces are identified, groups discuss the potential impacts in terms of threats and opportunities for the health of the community and the public health system.

The Local Public Health System Assessment (LPHSA) is a standardized tool that seeks to answer:

1. What are the components, activities, competencies, and capacities of our local public health system and how are the 10 Essential Public Health Services (see Figure 5.1) being provided to our community?
2. How effective is our combined work toward health equity?
    - For the LPHSA, the local public health system is defined as all entities that contribute to the delivery of public health services within a community.
    - Local community leaders and public health system leaders assess the strengths and weaknesses of the local public health system.
    - Participants review and score combined local efforts to address the 10 Essential Public Health Services and efforts to work toward health equity.
    - Along with scoring, participants identify strengths and opportunities for short- and long-term improvements.

The LPHSA assessments conducted in Chicago and Cook County in 2015 were led by the respective health departments and each engaged nearly 100 local representatives from various sectors of the public health system, including clinical, social services, policy makers, law enforcement, faith-based groups, coalitions, schools and universities, local planning groups, and many others.

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[13] Note: Some hospitals and health systems conducted additional assessment activities and data analyses that are presented in the hospital-specific CHNA report components.

[14] The MAPP Assessment framework is presented in more detail on page 20 of this report. The four MAPP assessments are: Community Health Status Assessment (CHSA), Community Themes and Strengths Assessment (CTSA), Forces of Change Assessment (FOCA), and Local Public Health System Assessment (LPHSA).

IPHI worked with both Chicago and Cook County Departments of Public Health to plan, facilitate, and document the LPHSAs. Many members of the Health Impact Collaborative of Cook County participated in one or both of the LPHSAs and found the events to be a great opportunity to increase communication across the local public health system, increase knowledge of the interconnectedness of activities to improve population health, understand performance baselines and benchmarks for meeting public health performance standards, and identify timely opportunities to improve collaborative community health work.

Figure 5.1. The 10 Essential Public Health Services

IPHI created combined summaries of the city and suburban data for both the FOCA and the LPHSA (see Appendices E and F), which were shared with the Central Leadership Team and Stakeholder Advisory Team. IPHI facilitated interactive discussion at in-person meetings in August and October 2015 to reflect on the FOCA and LPHSA findings, gather input on new or additional information, and prioritize key findings impacting the region.

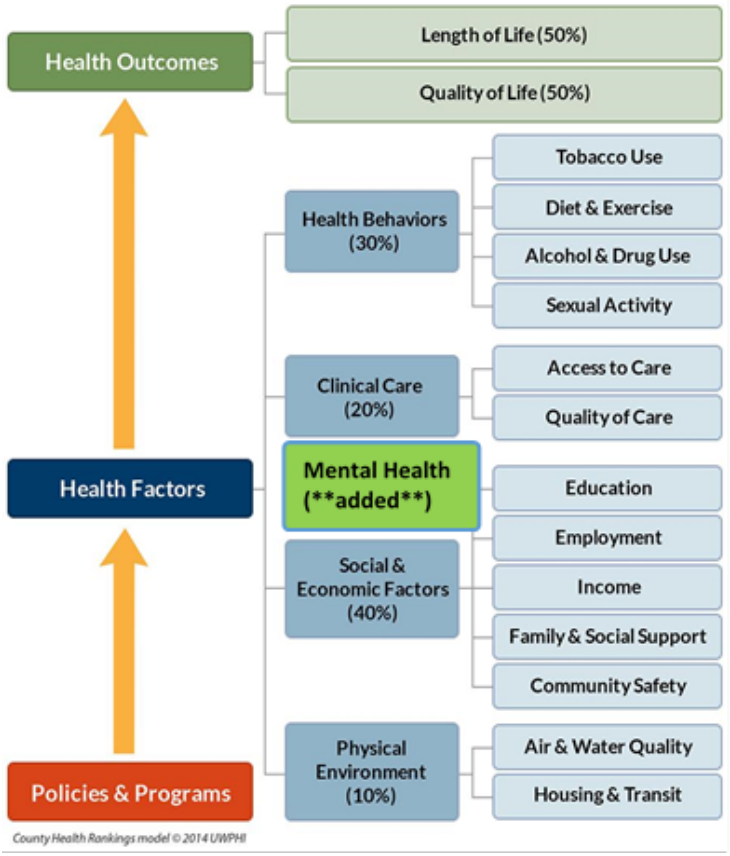
Methods - Community Health Status Assessment (CHSA)

Epidemiologists from the Cook County Department of Public Health and Chicago Department of Public Health have been invaluable partners on the Community Health Status Assessment (CHSA). This CHNA presented an opportunity for health departments to share data across Chicago and suburban jurisdictions and laid the groundwork for future data collaboration. The health departments and IPHI worked with hospitals and stakeholders to identify a common set of indicators, based on the County Health Rankings model (see Figure 5.2). In addition to the major categories of indicators in the County Health Rankings model, this CHNA also includes an indicator category for Mental Health. Therefore, the CHSA indicators fall into seven major categories:

- ✓ Demographics
- ✓ Socioeconomic Factors
- ✓ Health Behaviors
- ✓ Physical Environment
- ✓ Health Care and Clinical Care
- ✓ Mental Health
- ✓ Health Outcomes (Birth Outcomes, Morbidity, Mortality)

Figure 5.2. County Health Rankings model

The Health Impact Collaborative of Cook County used the County Health Rankings model to guide selection of assessment indicators. IPHI worked with the health departments, hospitals, and community stakeholders to identify available data related to Health Outcomes, Health Behaviors, Clinical Care, Physical Environment, and Social and Economic Factors. The Collaborative decided to add Mental Health as an additional category of data indicators, and IPHI and Collaborative members also worked hard to incorporate and analyze diverse data related to social and economic factors.



Data were compiled from a range of sources, including:

- Seven local health departments: Chicago Department of Public Health, Cook County Department of Public Health, Evanston Health & Human Services Department, Oak Park Health Department, Park Forest Health Department, Stickney Public Health District, and Village of Skokie Health Department
- Additional local data sources, including: Cook County Housing Authority, Illinois Lead Program, Chicago Metropolitan Agency for Planning (CMAP), Illinois EPA, State/Local Police
- Hospitalization and ED data: Advocate Health Care through its contract with the Healthy Communities Institute made available averaged, age adjusted hospitalization and Emergency Department statistics for four time periods based on data provided by the Healthy Communities Institute and the Illinois Hospital Association (COMPdata)
- State agency data sources: Illinois Department of Public Health (IDPH), Illinois Department of Healthcare and Family Services (HFS) Illinois Department of Human Services (DHS), Illinois State Board of Education (ISBE)
- Federal data sources: Decennial Census and American Communities Survey via two web platforms-American FactFinder and Missouri Census Data Center, Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), Dartmouth Atlas of Health Care, Feeding America, Health Resources and Services Administration (HRSA), United States Department of Agriculture (USDA), National Institutes of Health (NIH) National Cancer Institute, and the Community Commons / CHNA.org website

Cook County Department of Public Health, Chicago Department of Public Health, and IPHI used the following software tools for data analysis and presentation:

- Census Bureau American FactFinder website, CDC Wonder website, Community Commons / CHNA.org website, Microsoft Excel, SAS, Maptitude, and ArcGIS.

Data Limitations

The Health Impact Collaborative of Cook County made substantial efforts to comprehensively collect and analyze data for this CHNA, however, there are a few data limitations to keep in mind when reviewing the findings:

- Population health and demographic data often lag by several years, so data is presented for the most recent years available for any given data source.
- Data is reported and presented at the most localized geographic level available – ranging from census tract for American Communities Survey data to county-level for Behavioral Risk Factor Surveillance System (BRFSS) data. Some data indicators are only available at the county or City of Chicago level, particularly self-reported data from the Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance System (YRBS).
- Some community health issues have less robust data available, especially at the local community level. In particular, there is limited local data that is available consistently across the county about mental health and substance use, environmental factors, and education outcomes.
- The data analysis for these regional CHNAs represents a new set of data-sharing activities between the Chicago and Cook County Departments of Public Health. Each health department compiles and analyzes data for the communities within their respective jurisdictions, so the availability of data for countywide analysis and the systems for performing that analysis are in developmental phases.

The mission, vision, and values of the Collaborative have a strong focus on improved health equity in Chicago and suburban Cook County. As a result, the Collaborative utilized the CHSA process to identify inequities in social, economic, healthcare, and health outcomes in addition to describing the health status and community conditions in the Central region. Many of the health disparities vary by geography, gender, sexual orientation, age, race, and ethnicity.

For several health indicators, geospatial data was used to create maps showing the geographic distribution of health issues. The maps were used to determine the communities of highest need in each of the three regions. For this CHNA, communities with rates for negative health issues that were above the statistical mean were considered to be high need.

Methods - Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment included both focus groups and community resident surveys. The purpose of collecting community input data was to identify issues of importance for community residents, gather feedback on quality of life in the community, and identify community assets that can be used to improve communities.

Community Survey - Methods and description of respondents from the Central region

By leveraging its partners and networks, the Collaborative collected approximately 5,200 resident surveys between October 2015 and January 2016, including 1,200 in the Central region. The survey was available on paper and online and was disseminated in five languages – English, Spanish, Polish, Korean, and Arabic.[15] The majority of the responses were paper-based (about 75%) and about a quarter were submitted online.

Community Resident Survey Topics

- ✓ Adult Education and Job Training
- ✓ Barriers to Mental Health Treatment
- ✓ Childcare, Schools, and Programs for Youth
- ✓ Community Resources and Assets
- ✓ Discrimination/Unfair Treatment
- ✓ Food Security and Food Access
- ✓ Health Insurance Coverage
- ✓ Health Status
- ✓ Housing, Transportation, Parks & Recreation
- ✓ Personal Safety
- ✓ Stress

The community resident survey was collected though convenience sampling by hospitals and community-based organizations. There was targeted outreach to diverse communities in Chicago and Cook County, with a particular interest in reaching low income communities and marginalized racial and ethnic groups. The community resident survey was intended to complement existing community health surveys that are conducted by local health departments for their IPLAN community health assessment processes. IPHI reviewed 12 existing surveys to identify possible questions and worked iteratively with hospitals, health departments, and stakeholders from the three regions to hone in on the most important survey questions. IPHI consulted with the University of Illinois at Chicago Survey Research Laboratory to refine the survey design. The data from paper surveys was entered into the online SurveyMonkey software so that electronic and paper survey data could be analyzed together. Survey data analysis was conducted using SAS statistical analysis software and Microsoft Excel was used to create data tables and charts.

The majority of survey respondents from the Central region were female (68%, n=879) and white (44%, n=812) or African American/black (42%, n=812). Five percent (5%) of respondents identified as Asian/Pacific Islander and 4% identified as Native American/American Indian. Approximately 29% of survey respondents from the Central region identified as Hispanic/Latino (n=775) and 3% identified as Middle Eastern/Arab American (n=775).[16] The Central region had the highest percentage of survey respondents indicating that they were homeless or living in a shelter (6%, n=937). Nine percent of survey respondents from the Central region had less than a high school education and the majority of respondents had an annual household income of less than $40,000 (67%, n=769).

[15] Written surveys were available in English, Spanish, Polish, and Korean; all surveys with Arabic speakers were conducted with the English version of the survey along with interpretation by staff from a community-based organization that works with Arab-American communities.

[16] Race and ethnicity categories do not add to 100% because a few paper-based surveys included write-in responses and because 163 surveys that were conducted with Arab American Family Services included an additional race option of "Arab".

Focus Groups - methods and description of participants in Central region

IPHI conducted seven focus groups in the Central region between October 2015 and March 2016. The Collaborative ensured that the focus groups included populations that are typically underrepresented in community health assessments, including marginalized racial and ethnic groups, immigrants, limited English speakers, low-income communities, families with children, LGBQIA and transgender individuals, individuals with disabilities and their family members, individuals with mental health issues, formerly incarcerated individuals, veterans, seniors, and young adults.

The main goals of the focus groups were to:

1. understand needs, assets, and potential resources in the different communities of Chicago and suburban Cook County; and
2. start to gather ideas about how hospitals can partner with communities to improve health.

Each of the focus groups was hosted by a hospital or community-based organization and the hosting organization recruited participants. IPHI facilitated the focus groups, most of which were implemented in 90-minute sessions with approximately 8 to10 participants. IPHI adjusted the length of some sessions to be as short as 45 minutes and as long as two hours, and some groups included as many as 25 participants to accommodate the needs of the participants and hosting organizations. A description of the focus group participants from the Central region is presented in Figure 5.3.

Figure 5.3. Focus Groups conducted in the Central region

Focus Groups	Location and Date
Casa Central & Diabetes Empowerment Center Focus group participants were staff members for Casa Central programs and community residents participating in programs at the Diabetes Empowerment Center who live in the Humboldt Park community and surrounding areas on the West Side of Chicago	Humboldt Park, Chicago, Illinois (2/18/2016)
Catholic Charities & St. Mary of Celle Church Participants were English as a Second Language (ESL) students at St. Mary de Celle Church in the West Cook suburbs.	Berwyn, Illinois (12/10/2015)
Faith Leader Network & Presence Saints Mary and Elizabeth Medical Center Participants included faith leaders, hospital staff, and community members in the Humboldt Park and West Town communities on the West side of Chicago.	West Town, Chicago, Illinois (12/15/2015)
Housing Forward Participants were clients who had utilized Housing Forward's services to obtain permanent housing in the West Cook suburbs.	Maywood, Illinois (11/30/2015)
National Alliance for the Empowerment of the Formerly Incarcerated (NAEFI) Participants included clients participating in the re-entry circle for formerly incarcerated individuals and staff members for several NAEFI programs.	Austin, Chicago, Illinois (1/30/2016)
Norwegian American Hospital Intensive Outpatient Program (2 focus groups) Focus group participants were patients in the Norwegian American Hospital's Intensive Outpatient Program (IOP) who are living with mental illness.	Humboldt Park, Chicago, Illinois (12/1/2015)
Quinn Community Center Participants were community residents from the West Cook suburbs who were participating in programs at the Quinn Community Center.	Maywood, Illinois (10/28/2015)

There were also residents from the Central region that participated in focus groups that were conducted in other regions. A focus group in the North region that was conducted with LGBQIA and transgender community members and hosted by Howard Brown Health Center included several individuals who were residents in the Central region.

Prioritization process, significant health needs, and Collaborative focus areas

IPHI facilitated a collaborative prioritization process that took place in multiple steps. In the Central region, the participating hospitals, health departments, and the Stakeholder Advisory Team worked together in February and March 2016 to prioritize the health issues and needs that arose from the CHNA. Figure 6.1 shows the criteria used to prioritize significant health needs and focus areas for the three regions of Chicago and Cook County.

Figure 6.1. Prioritization criteria

The guiding principles for prioritization were: The Health Impact Collaborative's mission, vision, and values; alignment with local health department priorities; and data-driven decision making.

The Collaborative used the following criteria when selecting strategic issues as focus areas and priorities:

- **Health equity**. Addressing the issue can improve health equity and address disparities
- **Root cause/Social determinant**. Solutions to addressing the issue could impact multiple problems
- **Community input**. Identified as an important issue or priority in community input data
- **Availability of resources/feasibility.** Resources (funding and human capital, existing programs and assets), Feasibility (likelihood of being able to do something collaborative and make an impact)

Collaborative participants identified and discussed key assessment findings throughout the collaborative assessment process from May 2015 to February 2016. IPHI worked with the Collaborative partners to summarize key findings from all four MAPP assessments between December 2015 and February 2016. Once the key findings were summarized, IPHI vetted the list of significant health needs and strategic issues with the Steering Committee in February 2016, and they agreed that those issues represented a summary of key assessment findings. Following the meeting with the Steering Committee, the Stakeholder Advisory Teams hospitals, and health departments participated in an online poll to provide their initial input on priority issues to inform discussion at the March 2016 regional meetings.

During the Central region Stakeholder Advisory Team meeting conducted in March 2016, team members reviewed summaries of assessment findings, the prioritization criteria, the mission, vision, and values, and poll results. The meeting began with individual reflections, with each participant writing a list of the top five issues for the Collaborative to address. Following individual reflection, representatives from hospitals, health departments, and community stakeholders worked together in small groups to discuss their individual lists of five priorities. IPHI instructed the small groups to work toward consensus on the top two to three issues that the collaborative should address collectively for meaningful impact. The small groups then reported back, and IPHI facilitated a full group discussion and consensus building process to hone in on the top five priorities for the region.

Priority issues identified in the Central region at the March 2016 stakeholder meetings were:

- Social and structural determinants of health
    - With an emphasis on economic inequities, educational inequities, structural racism, and community safety and violence
- Mental health and substance use

    - With an emphasis on the connections between mental health and the built environment and connections to issues related to community safety, and violence prevention
- Chronic disease prevention
    - With a focus on health equity, prevention, and the connections between chronic disease and built environment and social determinants of health
- Access to care and community resources
    - Including improving cultural and linguistic competence of healthcare and community services, addressing barriers to access for low income households, improving health literacy, and supporting linkages between healthcare and community-based organizations for prevention
- Funding and the state budget

Following the Central region prioritization meeting, the Health Impact Collaborative Steering Committee met and reviewed the top issues that emerged in all three regions (summarized in Figure 6.2).

The priorities identified across the three regions were very similar, so the Health Impact Collaborative of Cook County was able to identify Collaborative-wide focus areas, which are shown in Figure 6.3.

Healthy Environment came up as a key issue in all three regions, although it was classified differently during prioritization in the different regions. Because of the close connections between Healthy Environment and two of the other top issues – Social Determinants of Health and Chronic Disease - Healthy Environment is included as a topic within both of those broad issues, as shown in Figure 6.3.

Based on input from the Central and South Stakeholder Advisory Teams, Community Safety and Violence Prevention is included as a topic under both Social Determinants of Health and Mental Health and Substance Use.

Figure 6.2. Summary of priorities identified during March 2016 stakeholder meetings, by region

	Social and Structural Determinants	Healthy Environment	Mental Health and Substance Use (Behavioral Health)	Chronic Disease	Access to Care and Community Resources
North	✓	Under social determinants and chronic disease	✓	✓	✓
				Emphasized connections between healthy environment and chronic disease	
Central	✓	Under social determinants and chronic disease	✓	✓	✓
	Emphasized connections between healthy environment, safety, and socioeconomic factors			Emphasized connections between healthy environment and chronic disease	
South	✓	✓	✓	✓	✓
			Emphasized connections between community safety, trauma, and mental health	Emphasized connections between healthy environment and chronic disease	

Note: Policy, advocacy, funding and data systems Issues were also priority topics of discussion in all 3 regional discussions, and they were all identified as areas for improvement in the Local Public Health System Assessment (LPHSA). These are strategies that should be applied across all priorities.

Figure 6.3. The Four Focus Areas for the Health Impact Collaborative of Cook County

Through the Collaborative prioritization process involving hospitals, health departments, and Stakeholder Advisory Teams, the Health Impact Collaborative of Cook County identified four "focus areas" as significant health needs:

1. **Improving social, economic, and structural determinants of health / reducing social and economic inequities. ***
2. **Improving mental health and decreasing substance abuse.**
3. **Preventing and reducing chronic disease (focus on risk factors – nutrition, physical activity, and tobacco).**
4. **Increasing access to care and community resources.**

**** All hospitals within the Collaborative will include the first focus area—Improving social, economic, and structural determinants of health—as a priority in their CHNA and implementation plan. Each hospital will also select at least one of the other focus areas as a priority.***

Policy, advocacy, funding, and data systems are strategies that should be applied across all priorities.

Key Community Health Needs for Each of the Collaborative Focus Areas:

Social, economic and structural determinants of health	Mental health and substance abuse (Behavioral health)	Chronic disease prevention	Access to care and community resources
• Economic inequities and poverty • Education inequities • Structural racism • Housing and transportation • Healthy environment • Safety and violence	• Overall access to services and funding • Violence and trauma, and its ties to mental health	• Focus on risk factors - nutrition, physical activity, tobacco • Healthy environment	• Cultural & linguistic competency/ humility • Health literacy • Access to healthcare and social services, particularly for uninsured and underinsured • Navigating complex healthcare system and insurance • Linkages between healthcare providers and community-based organizations for prevention

The regional discussions highlighted the relationship between healthy environment, chronic disease, and social and structural determinants of health. As a result, healthy environment is listed under both chronic disease and determinants of health. Participants emphasized the connections between community safety, trauma, and mental health during the regional meetings, particularly in the South region. As a result, safety and violence is listed as both a social determinant and a behavioral health determinant. All three regional discussions also identified policy, advocacy, funding, and data systems as key strategies and approaches that should be applied across all of the focus areas.

All hospitals within the Collaborative will include the first focus area—***Improving social, economic, and structural determinants of health***—as a priority in their CHNA report. Each hospital will then select at least one additional focus area as a priority. Based on alignment of the hospital-specific priorities, regional and Collaborative-wide planning started in summer 2016.

Health Equity and Social, Economic, and Structural Determinants of Health

A key part of the mission of the Health Impact Collaborative is to work collaboratively with communities to implement a shared plan to maximize health equity and wellness. In addition, one of the core values of the Collaborative is the belief that the highest level of health for all people can only be achieved through the pursuit of social justice and the elimination of health disparities and inequities. The values of the Collaborative are echoed by both the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO), which state that addressing the social determinants of health is the core approach to achieving health equity.[17, 18] In addition, the CDC encourages health organizations, institutions, and education programs to look beyond behavioral factors and address the underlying factors related to social determinants of health.[17]

Figure 7.1. Health equity

Source: Saskatoon Health Region, https://www.communityview.ca/infographic_SHR_health_equity.html

Health inequities

The social determinants of health such as poverty, unequal access to healthcare, lack of education, stigma, and racism are underlying contributing factors to health inequities.[17] Additionally, social determinants of health often vary by geography, gender, sexual orientation, age, race, disability, and ethnicity.[19] Nationwide some of the most prominent health disparities include the following:

- Cardiovascular disease is the leading cause of death in the U.S. and non-Hispanic blacks are at least 50% more likely to die of heart disease or stroke prematurely than their non-Hispanic white counterparts.
- The prevalence of adult diabetes is higher among Hispanics, non-Hispanic blacks, and those of other mixed races than among Asians and non-Hispanic whites.
- Diabetes prevalence is higher among adults without college degrees and those with lower household incomes.
- The infant mortality rate for non-Hispanic blacks is more than double the rate for non-Hispanic whites. There are higher rates of infant mortality in the Midwest and South than in other parts of the country.
- Suicide rates are highest among American Indians/Alaskan Natives and non-Hispanic whites for both men and women.[19]

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[17] Centers for Disease Control and Prevention. (2014). NCHHSTP Social Determinants of Health. http://www.cdc.gov/nchhstp/socialdeterminants/faq.html

[18] World Health Organization. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. *Final Report of the Commission on Social Determinants of Health*. http://www.who.int/social_determinants/thecommission/finalreport/en/

[19] Centers for Disease Control and Prevention. (2013). CDC Health Disparities and Inequalities Report. Morbidity and Mortality Weekly Report, 62(3)

- Discrimination against LGBQIA and transgender community members has been linked with high rates of psychiatric disorders, substance use, and suicide.[20]
- Nearly a quarter of immigrants (23%) and 40% of undocumented immigrants are uninsured compared to 10% of U.S. born and naturalized citizens.[21]

The strong connections between social and economic factors and health are also apparent in Chicago and suburban Cook County, with health inequities being even more extreme than many of the national trends. Some of the major health inequities present in Chicago and suburban Cook County are listed below.

Health inequities in Chicago and suburban Cook County

- African American/blacks experienced an overall increase in mortality from cardiovascular disease between 2000-2002 and 2005-2007 in suburban Cook County while whites experienced an overall decrease in cardiovascular disease-related mortality during the same time period.
- In the Central region, African American/blacks have the highest mortality rates for cardiovascular disease, diabetes-related conditions, stroke, and cancer compared to other race/ethnic groups in the region.
- Hispanic and African American/black teens have much higher birth rates compared to white teens in Chicago and suburban Cook County.
- African American/black infants are more than four times as likely as white infants to die before their first birthday in Chicago and suburban Cook County.
- Homicide and firearm-related mortality are highest among African American/blacks and Hispanics.
- In 2012, the firearm-related mortality rate in the Central region (11.7 deaths per 100,000) was 2.5 times higher than the rate for the North region (4.6 deaths per 100,000). In 2012, the homicide mortality rate in the Central region (11.2 deaths per 100,000) was more than 3.5 times higher than the rate for the North region (3.1 deaths per 100,000).
- There are significant gaps in housing equity for African American/blacks and Hispanic/Latinos compared to whites and Asians.
- The life expectancy for Chicagoans living in areas of high economic hardship is five years lower than those living in better economic conditions.

In all of the assessments, the social and structural determinants of health were identified as underlying root causes of the health inequities experienced by communities in Chicago and suburban Cook County. Disparities related to socioeconomic status, built environment, safety and violence, policies, and structural racism were highlighted in the Central region as being key drivers of health outcomes.[22]

[20] Healthy People 2020. (2016). Lesbian, Gay, Bisexual, and Transgender Health. https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health
[21] The Henry J. Kaiser Family Foundation. (2016). Health coverage and care for immigrants. http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-immigrants/
[22] Kaufman, R., Krivo, L. (2004). *Housing and wealth inequality: Racial-ethnic differences in home equity in the United States*. Demography, 41(3). 585-605.

Economic inequities

Socioeconomic factors are the largest determinants of health status and health outcomes.[23] Poverty can create barriers to accessing quality health services, healthy food, and other necessities needed for good health status.[24] Poverty also largely impacts housing status, educational opportunities, the physical environment that a person works and lives in, and health behaviors.[23] Asians, Hispanic/Latinos, and African American/blacks have higher rates of poverty compared to non-Hispanic whites as well as lower annual household incomes. In addition, approximately 30% of children and adolescents live below 100% of the federal poverty level and nearly half of all children and adolescents live below 200% of the federal poverty level in the Central region. Unemployment can create financial instability and as result can create barriers to accessing healthcare services, insurance, healthy foods, and other basic needs.[24] The unemployment rate in the Central region from 2009-2013 was 12.3% compared to 9.2% overall in the U.S. In the Central region and across Chicago and Cook County, African American/blacks have a much higher rate of unemployment compared to whites and Asians.

Education inequities

Community residents in the Central region often described their local school systems as substandard. Education is an important social determinant of health, because the rate of poverty is higher among those without a high school diploma. In addition, those without a high school education are at a higher risk of developing certain chronic illnesses.[5]

Inequities in the built environment

Community input data indicates that residents in the Central region are concerned about abandoned buildings in their communities, potential lead exposure in homes, and the possibility of poor water and air quality. Half of the residents surveyed in the Central region indicated one or more problems with their current homes that could have a negative impact on health. Residents also described a lack of quality affordable housing as an underlying root cause of homelessness in the communities of the Central region. Participants also highlighted inequities in access to transportation and access to healthy foods in the Central region.

Inequities in community safety and violence

Violent crime disproportionately affects residents living in communities of color in Chicago and suburban Cook County.[6] In addition, homicide and firearm-related mortality is highest in the Central and South regions and in predominantly African American/black or Hispanic/Latino communities. Community residents in the Central region indicated that illicit drugs/drug trafficking, gang violence, the presence of guns, negative police presence (ethnic and racial profiling, police corruption), property crimes (home and vehicle break-ins, theft), youth violence and bullying, and traffic were some of the primary reasons that they

[23] Centers for Disease Control and Prevention. (2014). Social Determinants of Health. http://www.cdc.gov/nchhstp/socialdeterminants/faq.html.
[24] American Community Survey, 2010-2014; CommunityCommons.org CHNA Data (2015).

felt unsafe in their communities. Exposure to violence not only causes physical injuries and death, but it also has been linked to negative psychological effects such as depression, stress, and anxiety, which in turn have been linked to self-harm and suicide attempts.[25]

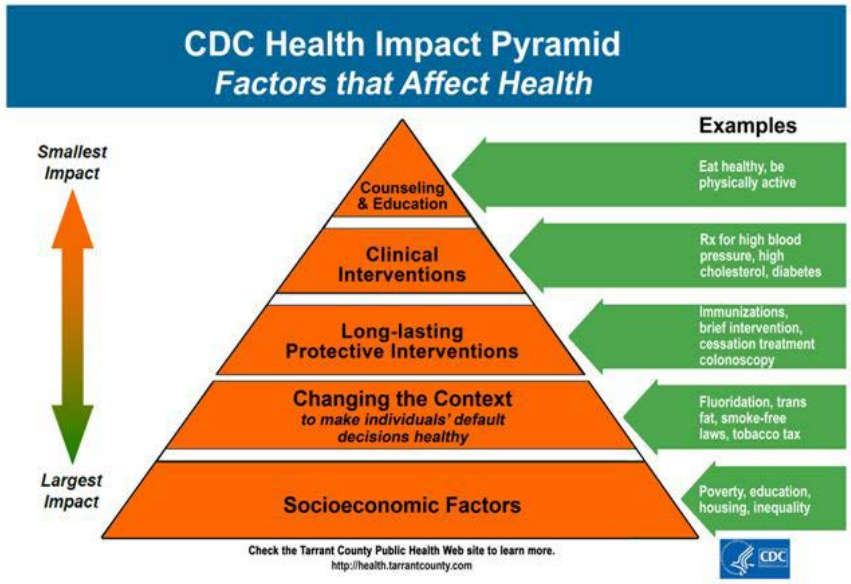
Structural racism and discrimination

Policies that reinforce or promote structural racism have detrimental effects on community health. Not only do communities of color experience higher rates of morbidity and mortality, but individuals who report experiencing racism exhibit worse health than individuals that do not experience it.[26] Community input indicated that several residents consider racism related to criminal justice, incarceration, and societal values as serious problems in their communities. Community residents stated that people belonging to marginalized racial and ethnic groups were more likely to live in low-income neighborhoods with fewer job opportunities and many indicated that they had experienced discrimination in their day-to-day lives.

The importance of upstream approaches

As shown in Figure 7.2, health is determined in large part by the social determinants of health including economic resources, built environment, community safety, and policy. As a result, an upstream approach that addresses the social determinants of health has the greatest impact on health outcomes.

Figure 7.2. Centers for Disease Control and Prevention, Health Impact Pyramid



Source: Freiden, T. Centers for Disease Control and Prevention. 2010. A framework for public health action: The health impact pyramid. *American Journal of Public Health*. *100*(4): 590-595. (6p).

[25] Mayor, S. (2002). WHO report shows public health impact of violence. BMJ, 325(7367).
[26] Williams, D., Costa, M., Odunlami, A., Mohammed, S. (2012). Moving Upstream: How Interventions that Address the Social Determinants of Health Can Improve Health and Reduce Disparities. *Journal of Public Health Management and Practice*, 14(Suppl) S8-17.

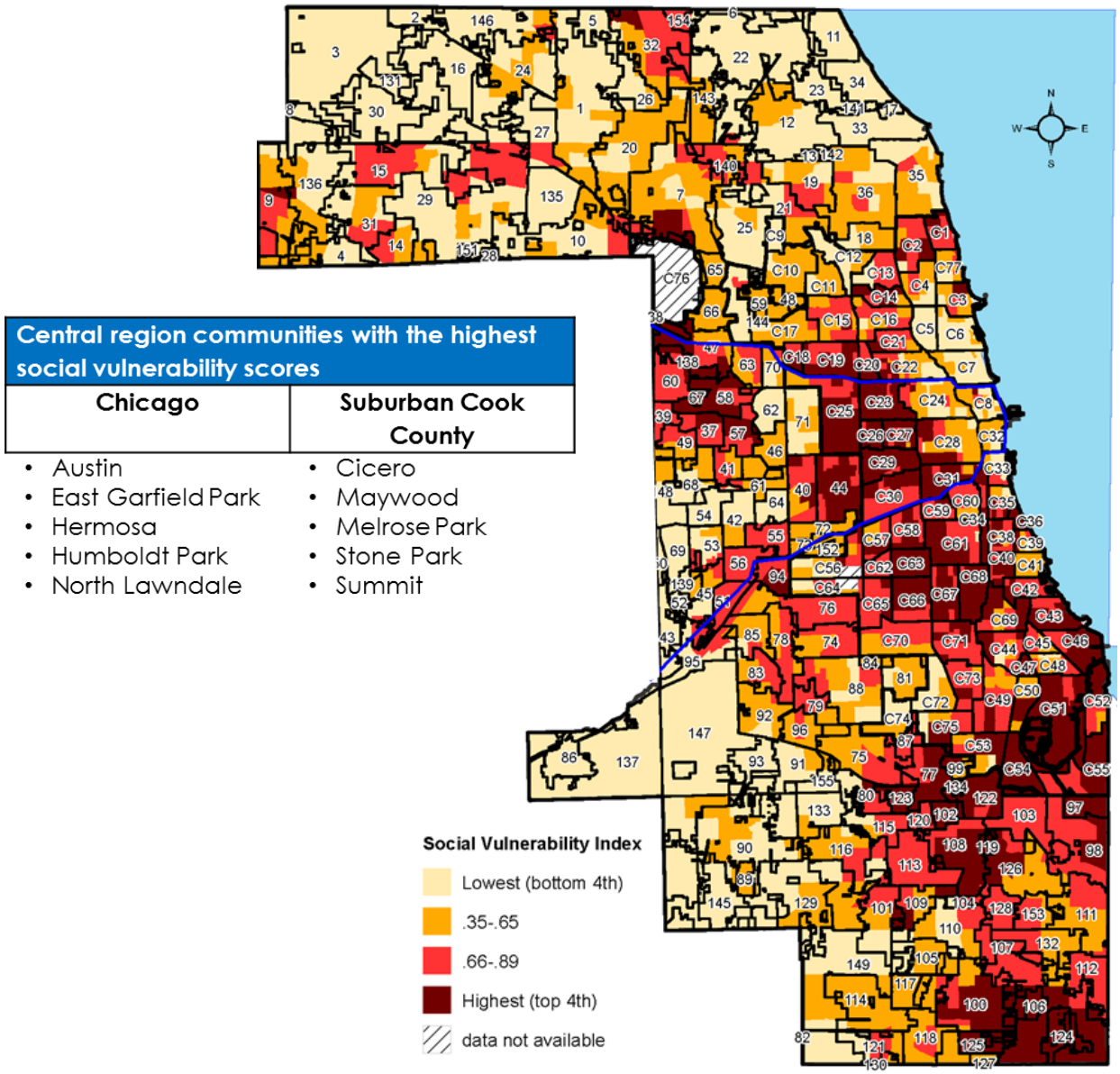
Key Findings: Social, Economic, and Structural Determinants of Health

Social Vulnerability Index and Child Opportunity Index

Social Vulnerability Index

The Social Vulnerability Index is an aggregate measure of the capacity of communities to prepare for and respond to external stressors on human health such as natural or human-caused disasters, or disease outbreaks. The Social Vulnerability Index ranks each census tract on 14 social factors, including poverty, lack of vehicle access, and crowded housing. Communities with high Social Vulnerability Index scores have less capacity to deal with or prepare for external stressors and as a result are more vulnerable to threats to human health.

Figure 7.3. Social Vulnerability Index by Census Tract, 2010 [27]

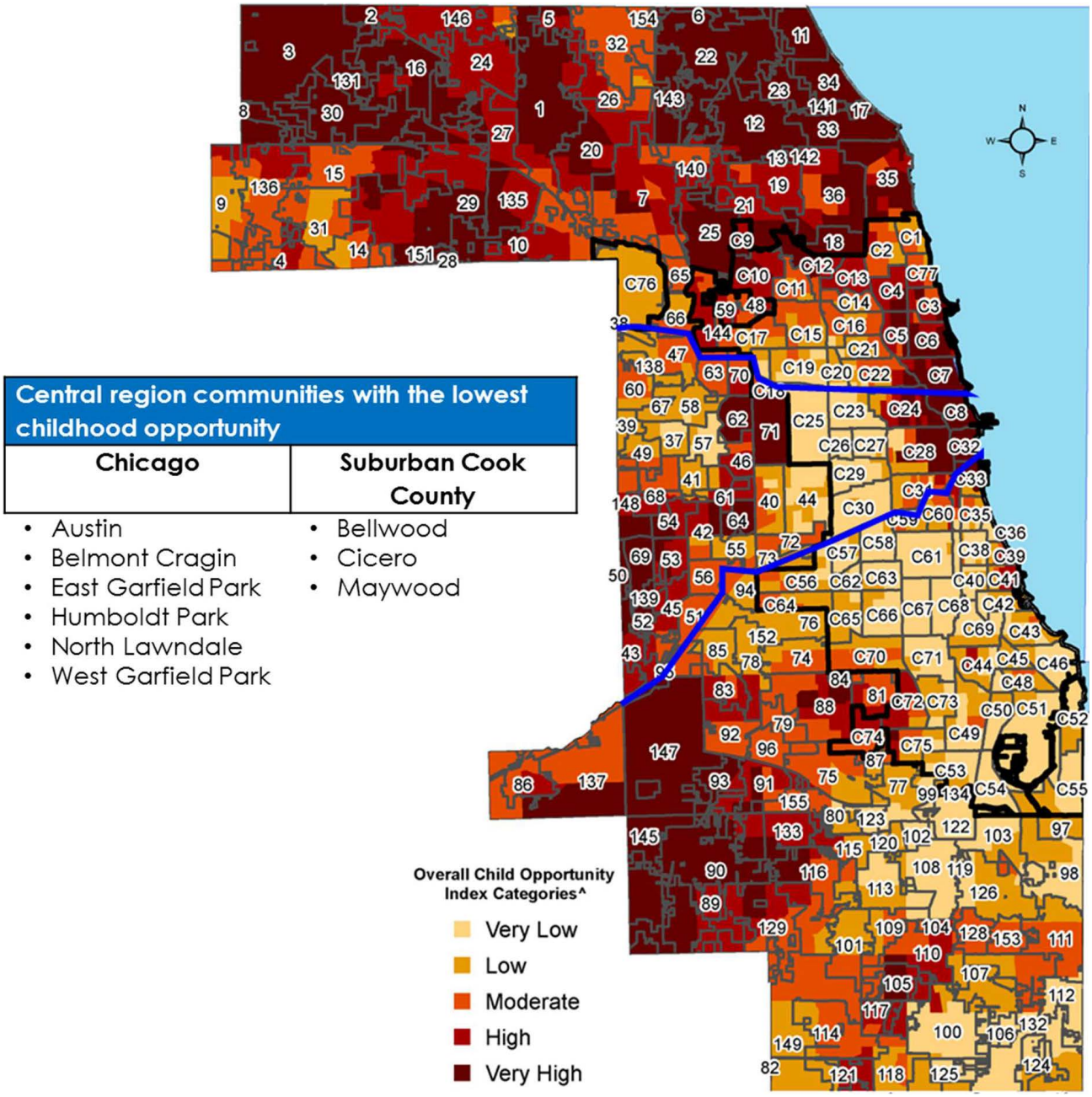


[27] Agency for Toxic Substances and Disease Registry. (2014). The Social Vulnerability Index. http://svi.cdc.gov/

Childhood Opportunity Index

The Childhood Opportunity Index is based on several indicators in each of the following categories: demographics and diversity; early childhood education; residential and school segregation; maternal and child health; neighborhood characteristics of children; and child poverty. Children that live in areas of low opportunity have an increased risk for a variety of negative health indicators such as premature mortality, are more likely to be exposed to serious psychological distress, and are more likely to have poor school performance.[28]

Figure 7.4. Childhood Opportunity Index by Census Tract, 2009-2013



[28] Ferguson, H., Bovaird, S., Mueller, M. (2007). *Pediatrics and Child Health*, 12(8), 701-706.

Poverty, Economic, and Education Inequities

Poverty

Poverty can create barriers to accessing health services, healthy food, and other necessities needed for good health status.[17] It can also affect housing status, educational opportunities, an individual's physical environment, and health behaviors.[17,18] The Federal Poverty Guidelines define poverty based on household size, ranging from $11,880 for a one-person household to $24,300 for a four-person household and $40,890 for an eight-person household.[29]

Forces of Change Assessment (FOCA) Findings Related to Poverty and Economic Inequity

Several trends and factors were identified related to poverty and economic equity including:

- increasing poverty and wealth disparities;
- lack of livable wage jobs;
- high student loan debt; and
- interconnections among economics, housing, transportation, and workforce issues.

The potential threats to community health that these factors pose include:

- poverty and its relationship to poor health;
- the increasing need for social services as economic security declines;
- the risk of homelessness; and
- reduced power of labor unions, which can affect job security and wages.

Opportunities to address the economic stability issues and economic inequities threatening health include:

- living wage legislation;
- school-based job training;
- promoting lower-cost/debt-free higher education; and
- leveraging the case management aspects of healthcare transformation to assist individuals with housing, food, and other social determinants of health.

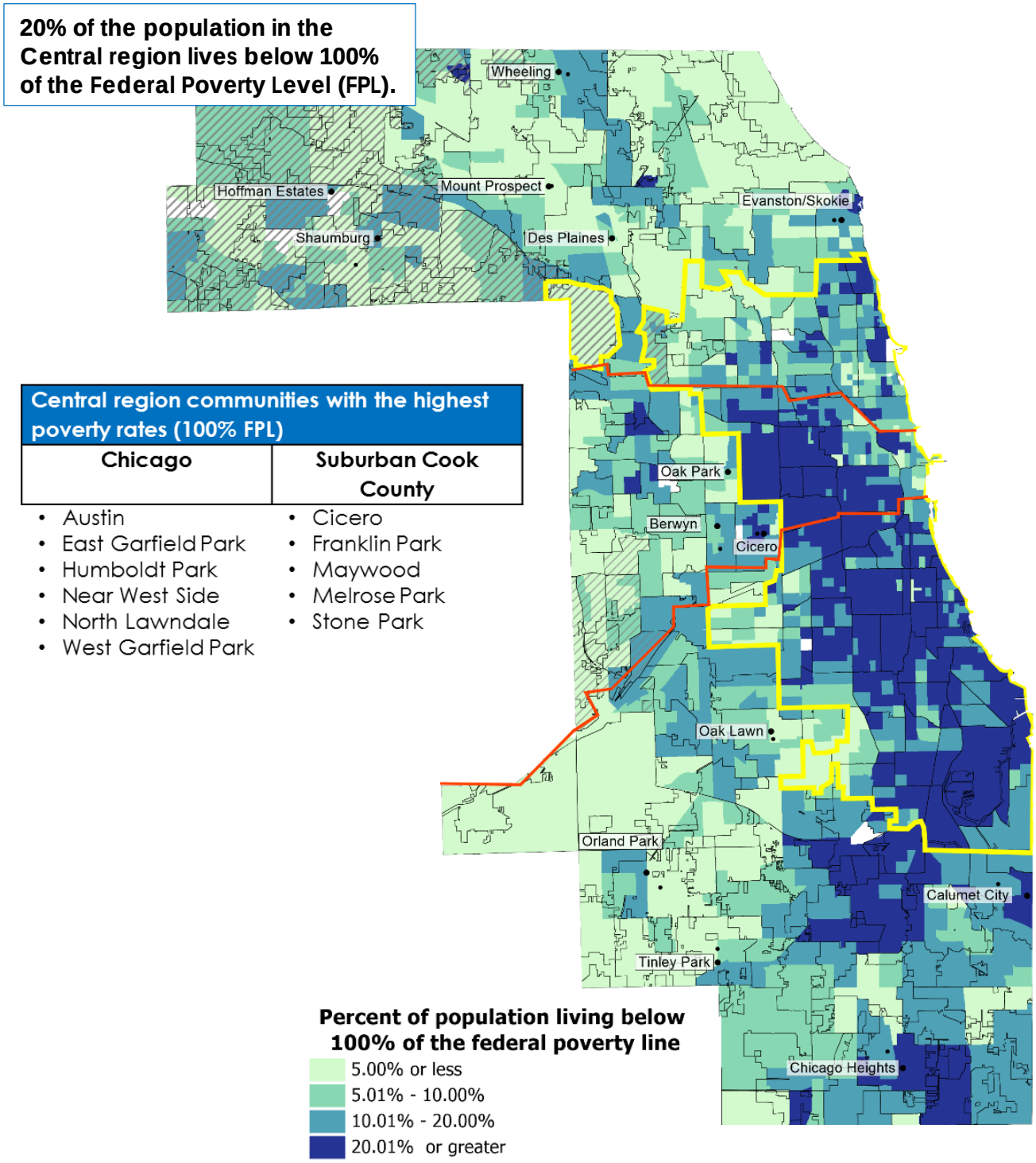
These FOCA findings were echoed in the seven focus groups conducted in the Central region. Focus group participants identified poor economic growth and unemployment; long-term divestment in the Central region; lack of vocational education opportunities; and a lack of job and workforce development as some of the major economic issues facing their communities.

The Community Health Status Assessment (CHSA) highlighted many of the economic disparities in Chicago and suburban Cook County. As shown in Figure 7.8, the mean per capita income for Asians, African American/blacks, and Hispanic/Latinos is lower than it is for non-Hispanic whites. In addition, those same racial and ethnic groups are more likely to live at or below 100% and 200% of the federal poverty level (FPL). Overall, the percentages of the

[29] U.S. Department of Health and Human Services. (2016). Poverty Guidelines. https://aspe.hhs.gov/poverty-guidelines.

population living at or below 100% and 200% FPL are higher in Chicago and suburban Cook County than the rates for Illinois and the U.S.

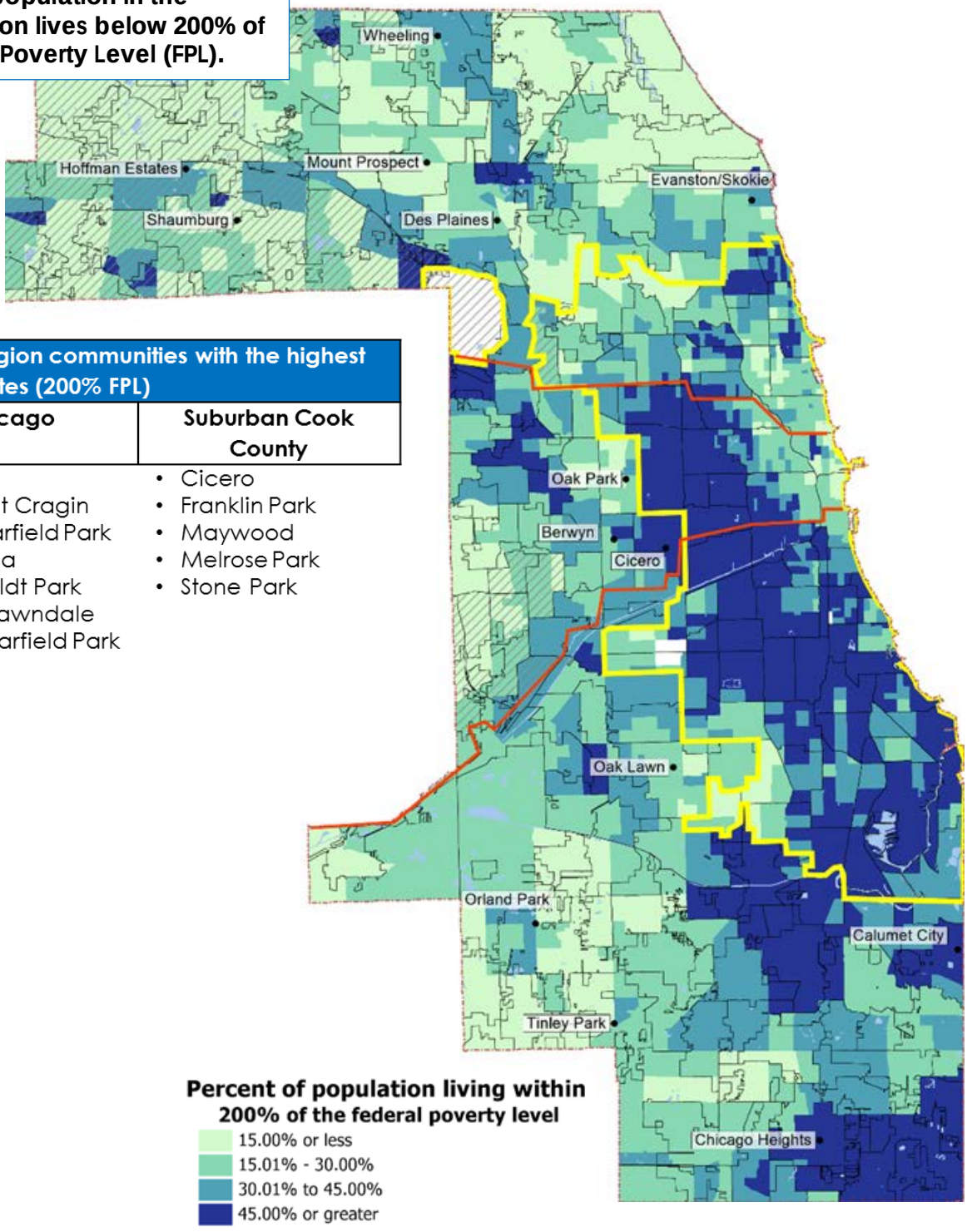
Figure 7.5. Map of poverty rates in Cook County – population living below 100% of the Federal Poverty Level (FLP), 2009-2013



Data Source: American Communities Survey, 2009-2013

Figure 7.6. Map of poverty rates in Cook County – population living below 200% of the Federal Poverty Level (FLP), 2009-2013

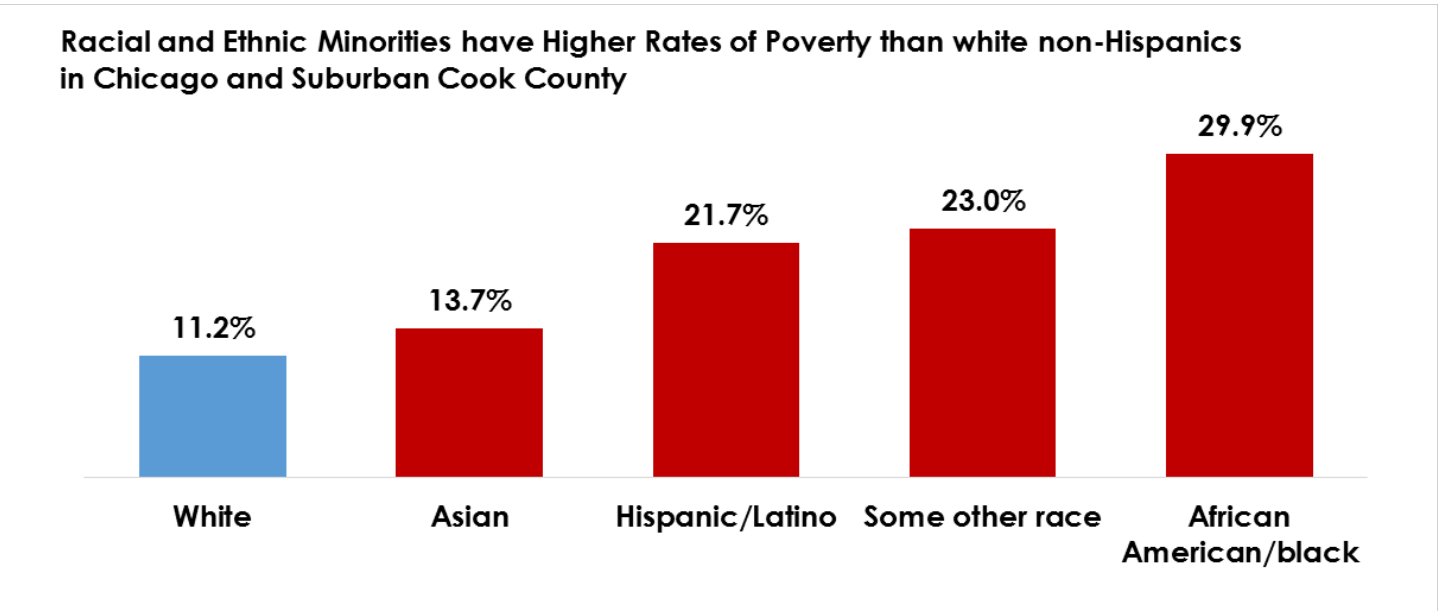
41% of the population in the Central region lives below 200% of the Federal Poverty Level (FPL).



Central region communities with the highest poverty rates (200% FPL)	
Chicago	**Suburban Cook County**
• Austin • Belmont Cragin • East Garfield Park • Hermosa • Humboldt Park • North Lawndale • West Garfield Park	• Cicero • Franklin Park • Maywood • Melrose Park • Stone Park

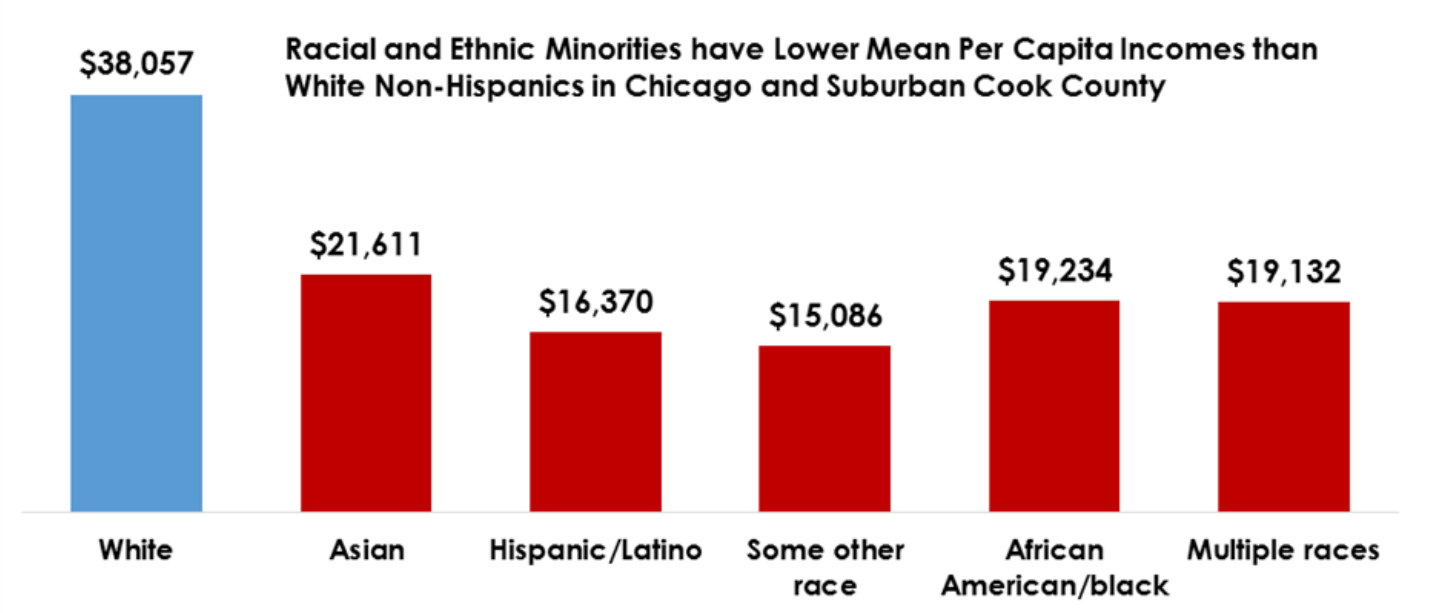
Data Source: American Communities Survey, 2009-2013

Figure 7.7. Percentage of the population living at or below 100% of the poverty level by race and ethnicity, 2009-2013



Data Source: American Communities Survey, 2009-2013

Figure 7.8. Per capita income,[30] by race and ethnicity, 2009-2013



Data Source: American Communities Survey, 2009-2013

Nearly half of all children living in Chicago and Cook County live at or below 200% of the federal poverty level. The percentage of children living in poverty is higher for Cook County than it is for Illinois and the U.S., and African American/black and Hispanic/Latino children have much

Nearly half of all children living in Chicago and Cook County live at or below 200% of the federal poverty level.

[30] Per capita income is defined as the mean income per person for a specific subgroup of the population.

higher poverty rates than non-Hispanic white children. Although the number of children living in poverty decreased overall in Chicago between 2009 and 2013, the number of children living in poverty doubled in suburban Cook County. As shown in the map of the Childhood Opportunity Index in Figure 7.4, there are large inequities in childhood opportunity across Chicago and suburban Cook County with the majority of communities in the Central region having low or very low economic opportunity.

Individuals aged 65 or older account for 12% of those living in poverty in Chicago and suburban Cook County as of 2013. The population of older adults is projected to at least double in the U.S. between 2012 and 2050.[31] The growing population of older adults was identified as a significant trend that impacts community health in a variety of ways. The FOCA identified a number of potential community health impacts of a rapidly growing older adult population including:

The population of older adults is projected to at least double in the U.S. between 2012 and 2050.

- Decreased tax base and increased number of retirees and pensioners
- Increased costs associated with long-term care and a growing burden of age-related chronic disease
- Increased need for caregivers

Opportunities to address these potential issues in Chicago and suburban Cook County include creating age-friendly cities and communities.

Unemployment

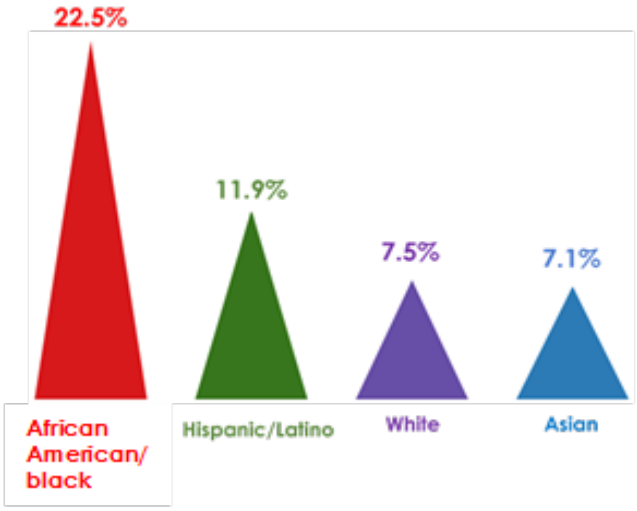
The unemployment rate in Chicago increased by 69% between 2000 and 2009-2013 and increased in suburban Cook County by 133% during the same time period. In addition, unemployment disparities persist in Chicago and suburban Cook County with African American/blacks and Hispanic/Latinos having higher unemployment rates than non-Hispanic whites.

Unemployment can create financial instability, and as a result can create barriers to accessing healthcare services, insurance, healthy foods, and other basic needs. Trends and factors related to employment identified in the FOCA included the outsourcing of jobs from the U.S. A lack of jobs threatens community health through increasing social and community breakdown. The unemployment rate for the Central region (12.1%) is higher than the rates for Illinois (10.5%) and the U.S. (9.2%). Only 11% of respondents to the community resident survey from the Central region indicated that there were "a lot" or "a great deal" of good jobs in their communities. In addition, 16% of respondents indicated that job training and adult education in their communities were inadequate.

Figure 7.9. Unemployment disparities by race and ethnicity, 2009-2013

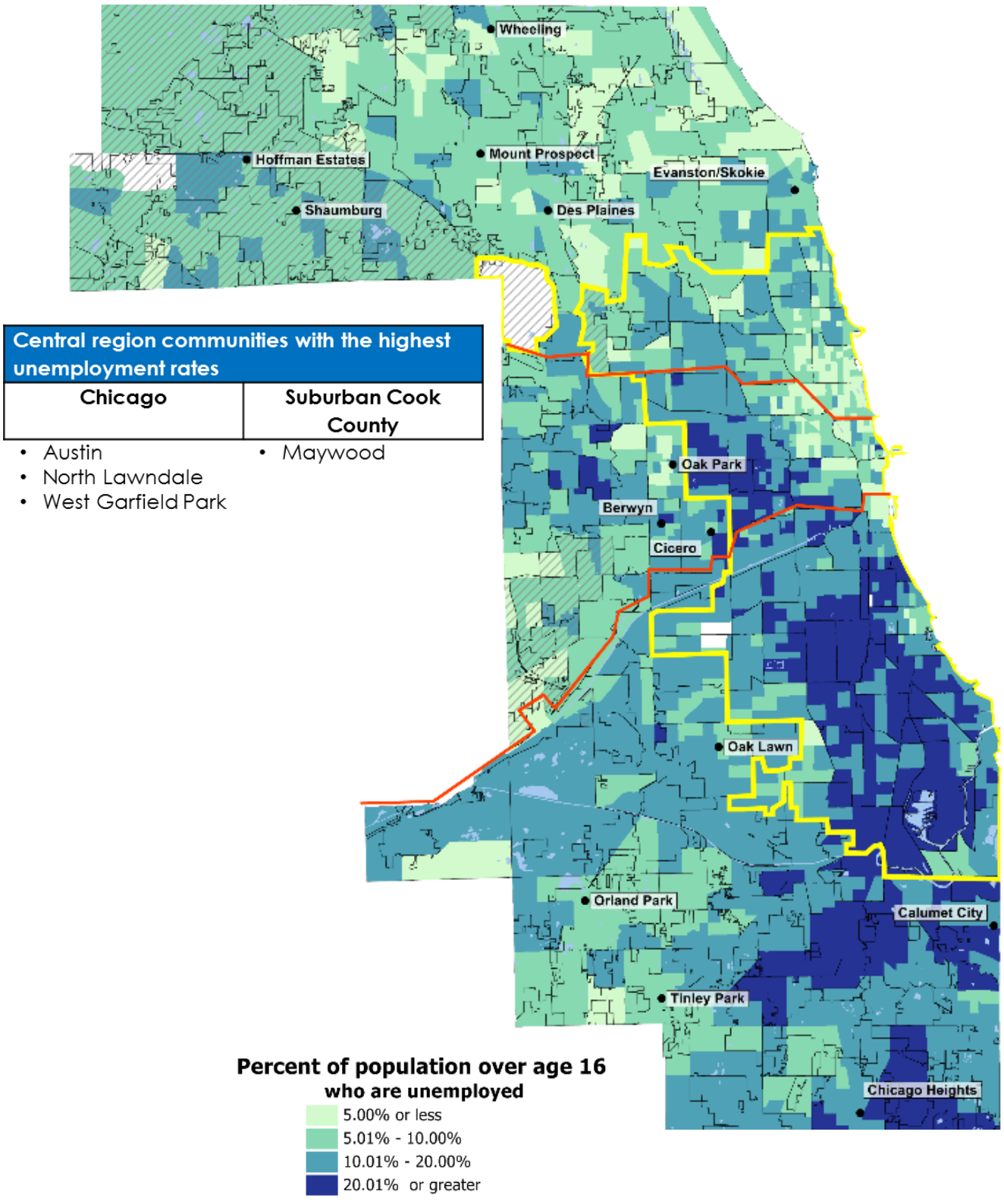
[31] U.S. Census Bureau. (2014). An aging nation: The older population in the United States. https://www.census.gov/prod/2014pubs/p25-1140.pdf

African American/blacks have the highest rates of unemployment in Chicago and suburban Cook County



Data Source: American Communities Survey, 2009-2013

Figure 7.10. Map of unemployment rates, population over age 16, 2009-2013



Central region communities with the highest unemployment rates	
Chicago	**Suburban Cook County**
• Austin • North Lawndale • West Garfield Park	• Maywood

Data Source: American Communities Survey, 2009-2013

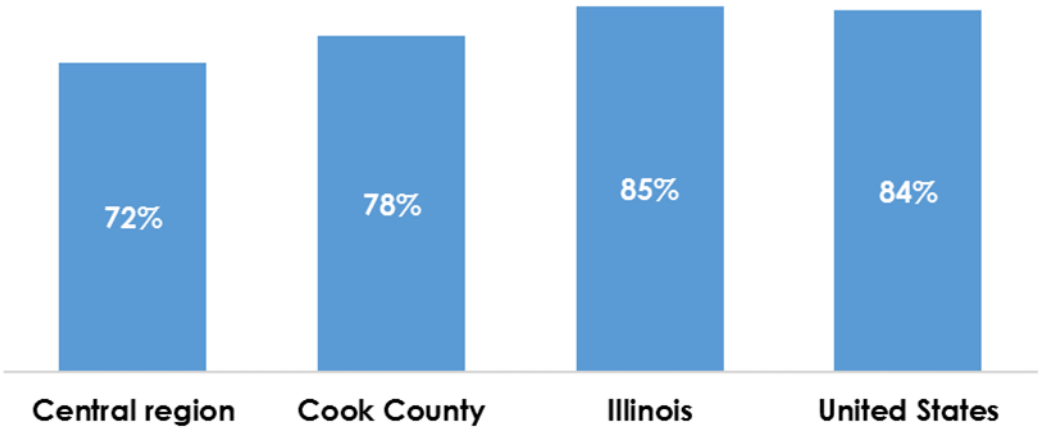
Education

Education is an important social determinant of health, because the rate of poverty is higher among those without a high school diploma or GED. In addition, as previously mentioned, those without a high school education are at a higher risk of developing certain chronic illnesses, such as diabetes.[5] The FOCA identified multiple trends and factors influencing educational attainment in Chicago and suburban Cook County including inequities in school quality and early childhood education, school closings in Chicago, and unequal application of discipline policies for black and Hispanic/Latino youth. These factors and trends produce threats to health such as a lack of job and college readiness as well as an increased risk of becoming chronically involved with the criminal justice system as an adult. Opportunities to address education issues include efforts to apply evidence-based school improvement programs, vocational learning opportunities, advocacy, and using maternal/child health funding to improve early childhood outcomes.

High school graduation rates were lower for Cook County (78%) than the rates for Illinois (85%) and the United States (84%) in 2011-2012. The high school graduation rates in the Central region (72%) are lower than the average for Chicago and suburban Cook County.

Figure 7.11. High school graduation rates in Chicago and suburban Cook County, 2011-2012

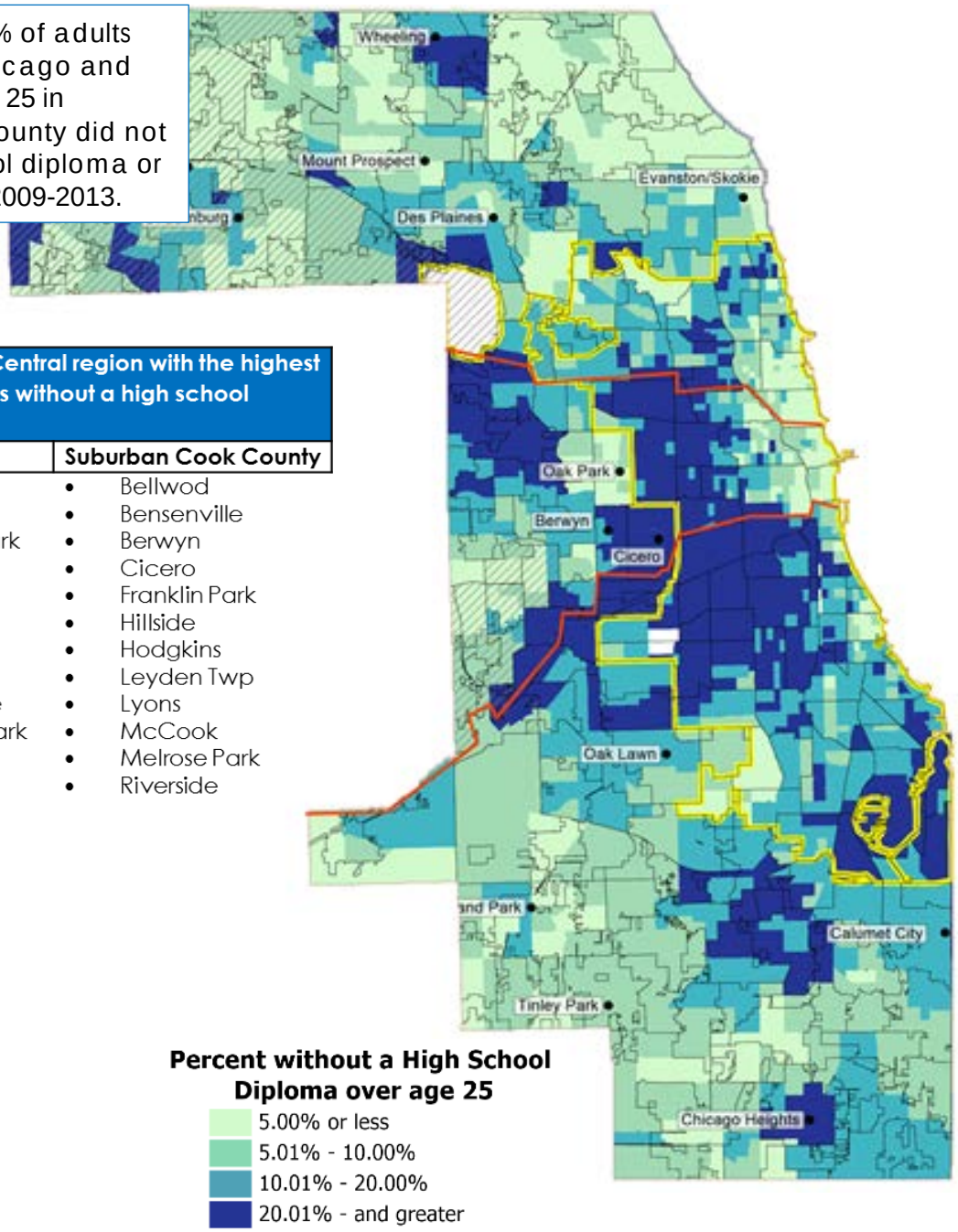
High school graduation rates are lower in the Central region than they are for the County, Illinois, and the U.S.



Data Source: U.S. Department of Education, EDFacts (2011-2012)

Figure 7.12. Map of population over age 25 without a high school education, 2009-2013

Approximately 19% of adults over age 25 in Chicago and 12% of adults over 25 in suburban Cook County did not have a high school diploma or equivalent, as of 2009-2013.

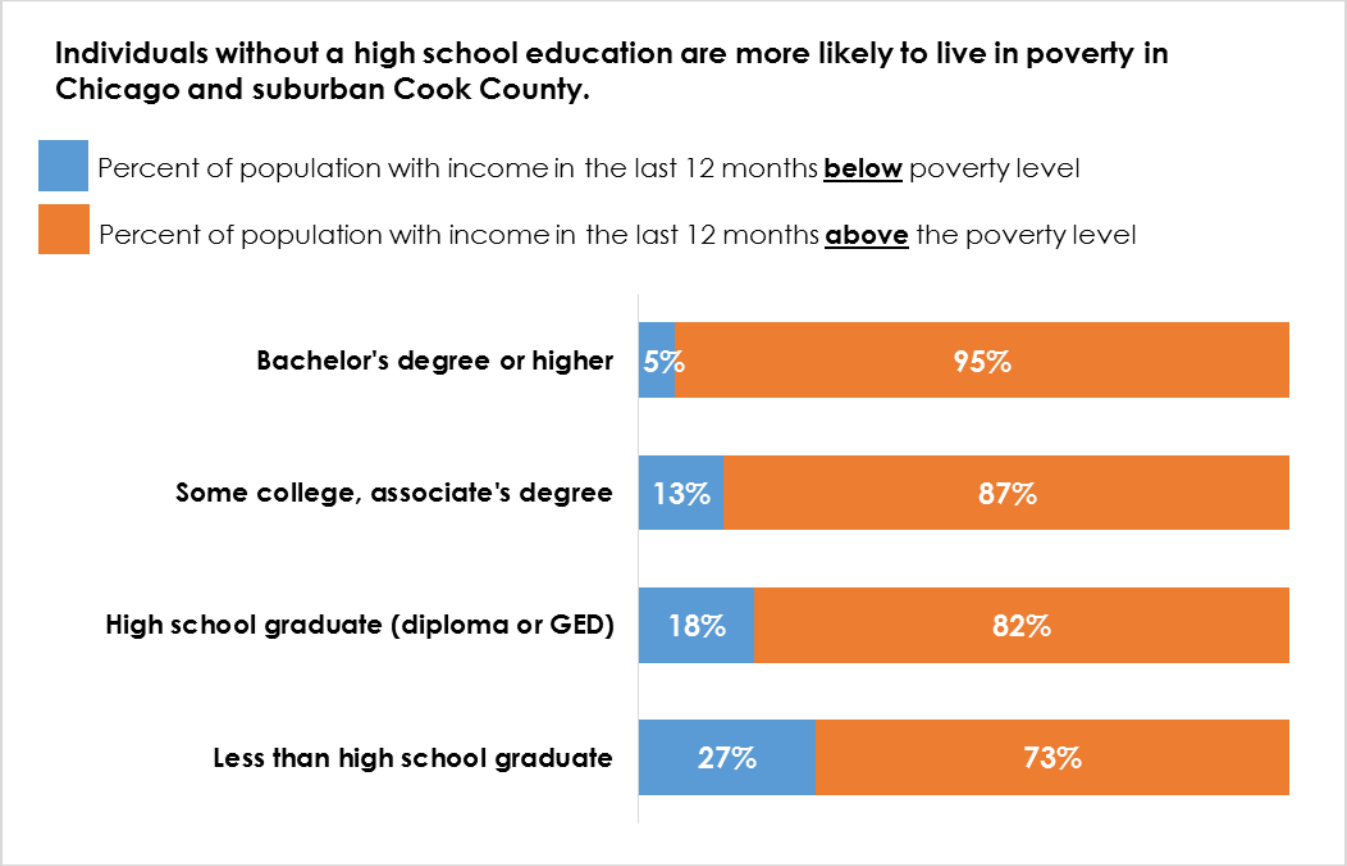


Communities in the Central region with the highest percentages of adults without a high school education

Chicago	Suburban Cook County
• Austin	• Bellwod
• Belmont Cragin	• Bensenville
• East Garfield Park	• Berwyn
• Hermosa	• Cicero
• Humboldt Park	• Franklin Park
• Logan Square	• Hillside
• Montclare	• Hodgkins
• Near West Side	• Leyden Twp
• North Lawndale	• Lyons
• West Garfield Park	• McCook
• West Town	• Melrose Park
	• Riverside

Data Source: American Communities Survey, 2009-2013

Figure 7.13. The relationship between education and poverty in Chicago and suburban Cook County



Data Source: American Communities Survey, 2010-2014

All of the focus groups in the Central region mentioned schools and education as a major component of health in their communities. Every group had participants who stated that their public school district was substandard. Approximately 57% of Community Resident Survey respondents from the Central region indicated that the schools in their community were less than good.

Built environment: Housing, infrastructure, transportation, safety, and food access—Social, economic, and structural determinants of health

Housing and Transportation

The FOCA identified lack of affordable housing and transportation especially for vulnerable populations as significant forces affecting health in Chicago and suburban Cook County. Homelessness, gentrification, and transit inequalities were seen as threats to health. Building on current efforts to improve physical infrastructure like sidewalks, bike lanes, and outdoor recreation space, initiatives to rehab vacant housing, policies to support affordable housing, and creating jobs through housing initiatives were identified as opportunities.

The percentage of the population that utilizes public transportation as their primary means to commute to work is higher in the Central region at 21% than in Cook County (18% overall), Illinois and the U.S.

Figure 7.14. Percentage of population using public transit for commute to work, 2010-2014

Geography	Percent of population using public transit to commute to work
Central Region	21.7%
Cook County	18.1%
Illinois	8.9%
United States	5.1%

Data Source: American Communities Survey, 2010-2014

The percentage of households with no motor vehicle is higher in the Central region compared to Cook County, Illinois, and the U.S. and could indicate a need for transportation alternatives.

Figure 7.15. Percentage of households with no motor vehicle, 2010-2014

Geography	Percentage of Households with no motor vehicle
Central Region	23.1%
Cook County	17.8%
Illinois	10.8%
United States	9.1%

Data Source: American Communities Survey, 2010-2014

Transportation was a major issue discussed by focus group participants in the Central region. Specifically, participants reported that transportation services for seniors and disabled individuals have been discontinued or are extremely limited. As a result, participants reported that it is difficult to use public transportation to go to clinics, attend medical appointments, and pick-up prescriptions. Several residents in the Central region mentioned the need to expand public transit routes and/or hours. Participants from the West Cook suburbs appear to be disproportionately affected by infrequent bus service and a lack of public transportation options particularly in the evenings and on weekends. Approximately 51% of survey respondents from the Central region rated the convenience of timing and stops for public transit as “fair”, “poor”, or “very poor”.

Quality affordable housing was another major issue identified by focus group participants. In addition, several focus group participants mentioned the need to address homelessness in their communities. Only 23% of survey residents from the Central region indicated that housing was affordable in their communities. In addition, as previously stated, 50% of survey respondents from the Central region described poor housing conditions in their current homes.

Food Access and Food Security

Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food.[26] Factors and trends related to food and systems that were identified in the FOCA include lack of healthy food access, unhealthy food environments driven by federal food policies and food marketing, and increasing community gardens and urban agriculture. Threats to health related to the forces of change include increasing obesity and chronic disease and lowered school performance. Numerous opportunities were identified to address food systems in Chicago and suburban Cook County, including SNAP double bucks programs, incentivizing grocery store and community gardens, using hospital campuses/land as places for gardens, increasing the number of farmers markets and grocery stores, and the workforce development prospects for urban agriculture.

Approximately 15% of the population in Chicago and suburban Cook County have experienced food insecurity in the report year (2013). According to the USDA in 2014, all households with children, single-parent households, non-Hispanic black households, Hispanic/Latino households, and low-income households below 185% of the poverty threshold had higher food insecurity rates compared to other populations in the U.S.[32]

Over 75% of enrolled school children in the Central region of Chicago and suburban Cook County are eligible for free or reduce price lunch.

Residents in the Central region highlighted inequities in access to healthy foods. Focus group participants reported that many communities in the Central region, particularly communities on the West side of Chicago as well as the areas surrounding Maywood and Bellwood in the West Cook suburbs, do not have access to markets with fresh produce. Those who had the ability to travel outside their community in order to buy healthier foods indicated that they are not always affordable. Approximately 45% of survey respondents from the Central region indicated that they or their families have had to worry about whether or not their food would run out before they had the money to buy more. In addition, 17% of all households in the Central region report receiving SNAP benefits, compared to 12% in Illinois overall.

[32] USDA. (2014). http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics.aspx#insecure

Environmental Concerns

Climate change, air quality, radon, lead, and water quality were identified as forces of change that present direct threats to health. Federal action on climate change and multi-sector healthy housing initiatives are potential opportunities to improve health.

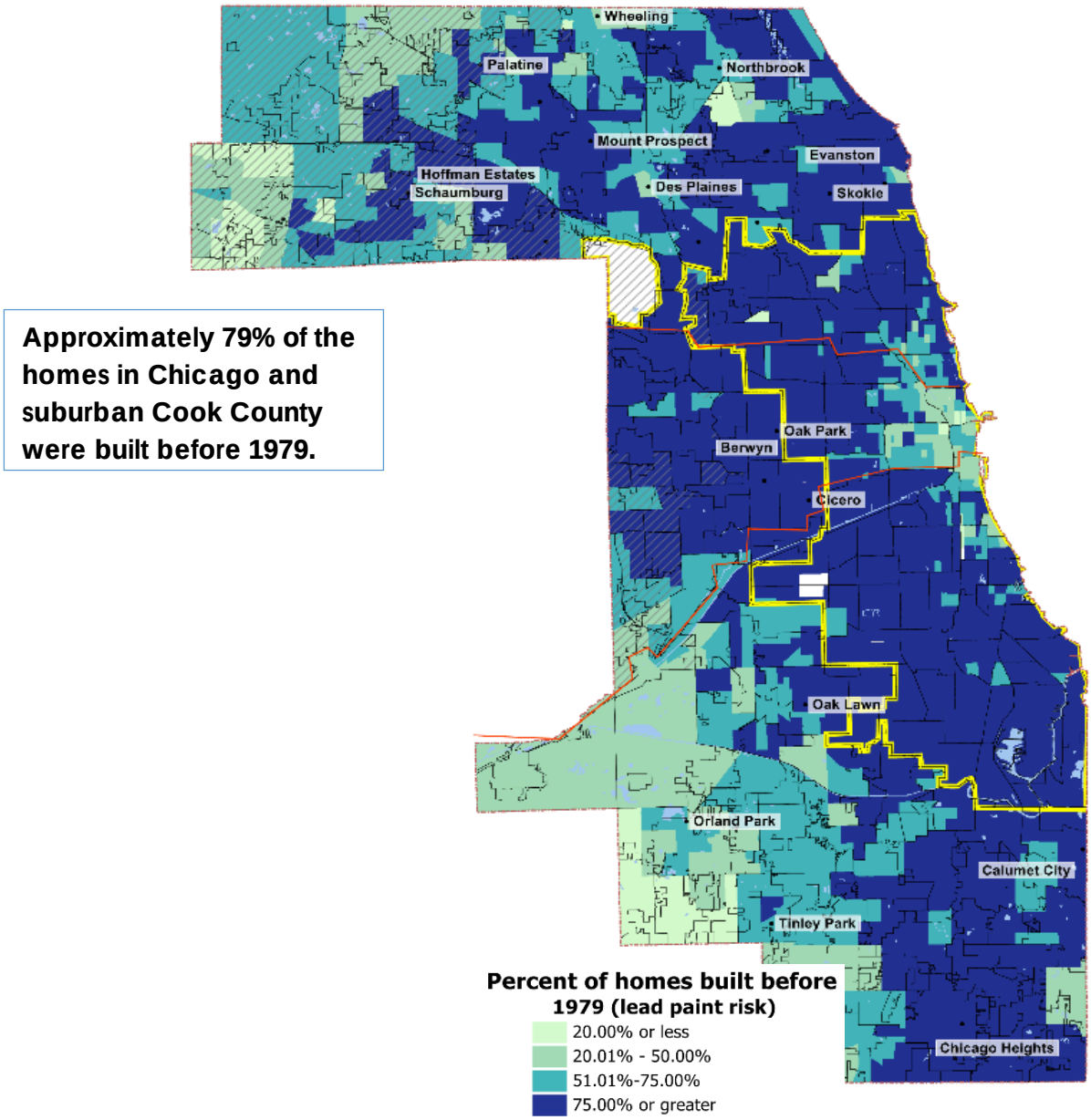
The use of lead paint in homes was stopped in 1979. Most homes (79%) in Chicago and suburban Cook County were built before 1979, indicating an increased risk of lead paint being present in the home. Exposure to lead paint particles through ingestion, absorption, and inhalation can cause numerous adverse health issues including gastrointestinal problems, fatigue, neurological problems, muscle weakness and pain, as well as developmental delays in children.[33] Lead exposure is particularly dangerous to children because their bodies absorb more lead than adults and their brains and nervous systems are more sensitive to the damaging effects of lead.[34] If pregnant women are exposed to lead paint particles, there is a risk of exposure to their developing baby.[28]

Environmental concerns mentioned by focus group participants included lead exposure, water quality, and air quality. Residents, particularly from the West Cook suburbs, reported the presence of abandoned buildings that need to be demolished in their neighborhoods. Half of the survey respondents from the Central region indicated one or more problems with their current homes that could have a negative impact on health (Figure 7.17).

[33] Centers for Disease Control and Prevention. (2013). Health problems caused by lead. http://www.cdc.gov/niosh/topics/lead/health.html

[34] U.S. Environmental Protection Agency (2015). https://www.epa.gov/lead/learn-about-lead

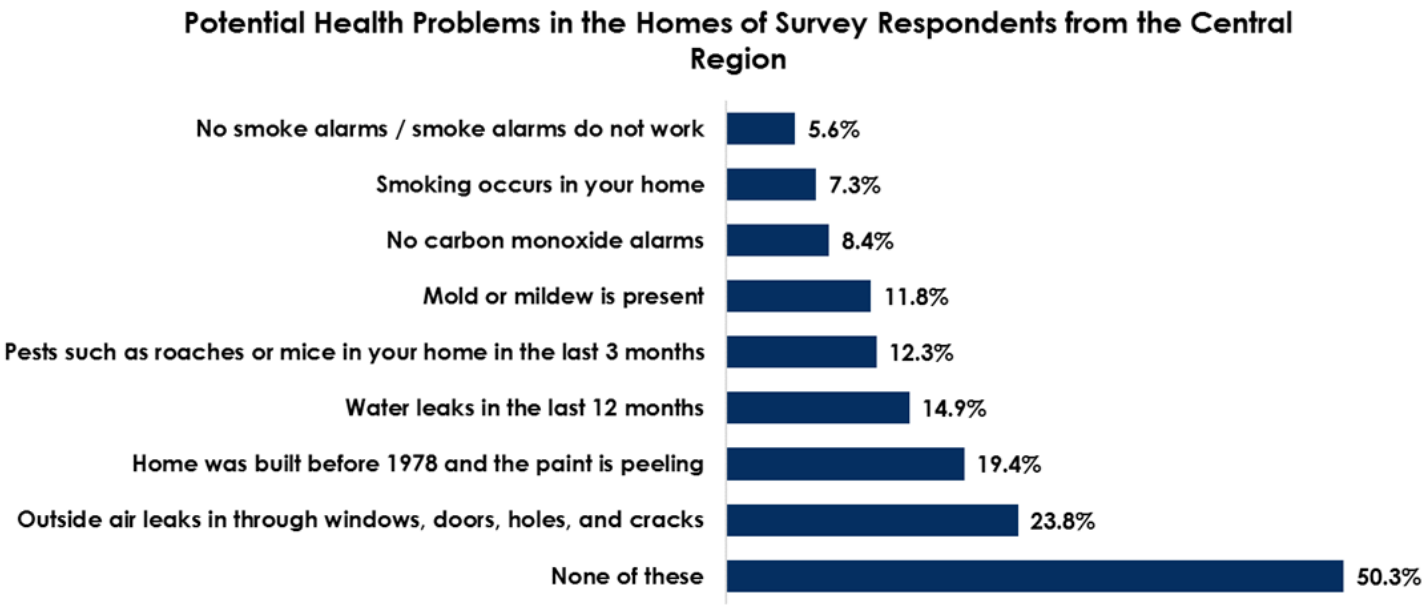
Figure 7.16. Map of homes built before 1979 (lead paint risk)



Approximately 79% of the homes in Chicago and suburban Cook County were built before 1979.

Data Source: American Communities Survey, 2009-2013

Figure 7.17. Housing conditions identified by Central region community survey respondents
Which of the following describes your current home? Check all that apply. (n=867)



Nearly a quarter of survey respondents from the Central region reported outside air leaking through windows, doors, and crevices. The next most frequent home maintenance concern reported was peeling paint, which was cited by 19% of respondents. Fifteen percent of respondents reported water leaks over the past 12 months and 12% of respondents reported pests such as roaches or mice in the last 3 months, as well as mold/mildew being present in their homes.

The World Health Organization (WHO) has identified air particles with a diameter of 10 microns or less, which can penetrate and lodge deeply inside the lungs, as the most damaging to human health.[35] This form of particle pollution is known as particulate matter or PM. Chronic exposure to these particles contributes to the risk of developing cardiovascular problems, respiratory diseases, and lung cancer. The percentage of days with PM 2.5 levels exceeding the National Ambient Air Quality Standard per year is higher in the Central region than it is for Cook County, Illinois, and the U.S.[36,35]

[35] World Health Organization. (2014). Ambient (outdoor) air quality and health. http://www.who.int/mediacentre/factsheets/fs313/en/

[36] PM 2.5 stands for fine particulate matter less than 2.5 micrometers in diameter. The National Ambient Air Quality Standard is 35 micrograms of PM 2.5 per cubic meter per day.

Figure 7.18. Percentage of days exceeding the National Ambient Air Quality Standard for PM 2.5, 2008 [36]

Geography	Percentage of days exceeding the National Ambient Air Quality Standard (35 micrograms per cubic meter) – Population Adjusted Average
Central Region	1.9%
Cook County	1.6%
Illinois	1.1%
United States	1.2%

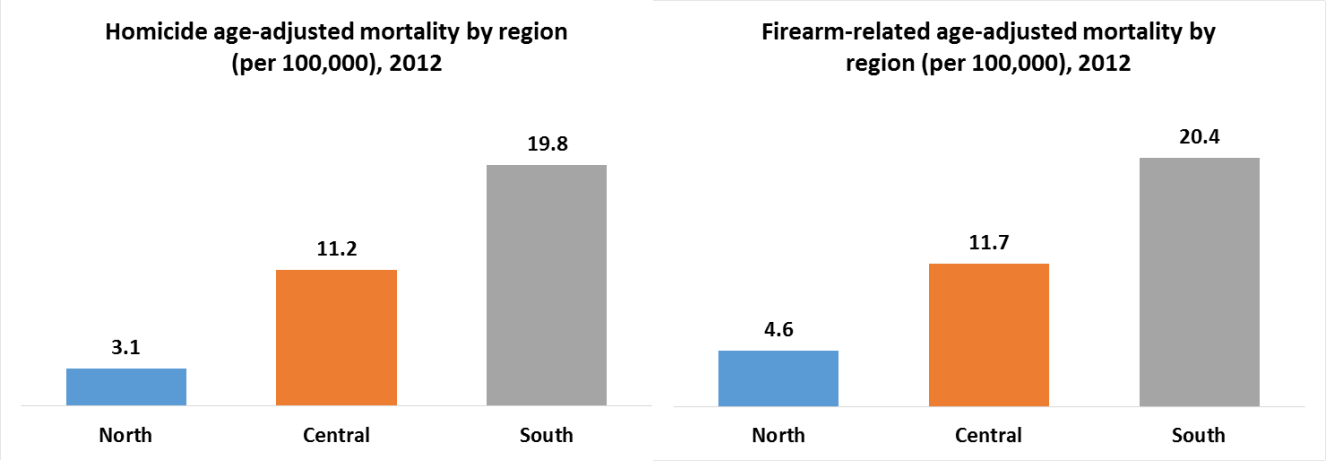
Data Source: CDC, National Environmental Public Health Tracking Network, 2008.

Safety and violence—social, economic, and structural determinants of health

As previously mentioned, although violent crime occurs in all communities, violent crime disproportionately affects communities of color in Chicago and suburban Cook County.[11] In addition, there are multiple negative health outcomes associated with exposure to violence and trauma.[12] Factors and trends in safety and violence identified in the FOCA include gun violence, intimate partner violence, police violence, and bullying. The threats to health from these forces include the links between community violence, chronic disease, and mental health problems, plus the impact of fear and stress on health and well-being. Opportunities to address safety and violence issues in Chicago and suburban Cook County include supporting the role of schools in violence prevention and services for families, and increasing communication between communities and police.

Concerns about safety and violence were echoed in the focus groups in the Central region. The majority of focus group participants felt that their community was unsafe. Some of the safety issues mentioned as having the greatest impact on community health in both Chicago and the West Cook suburbs included illicit drugs/drug trafficking, gang violence, negative police presence (ethnic and racial profiling, police corruption), property crimes (home and vehicle break-ins, theft), youth violence/ bullying, and traffic. General concerns about safety and violence were voiced more often by residents in the Central and South regions than in the North, indicating that there are inequities in the root causes of violence that are disproportionately affecting those regions. Results from the Community Health Survey were similar, with many respondents from the Central region indicating that they had felt unsafe in the last 12 months due to gang activity (31%), drug use/drug dealing (29%), and the presence of guns in the community (20%). African American/blacks and Hispanic/Latinos have the highest firearm-related mortality rates and homicide mortality rates in Chicago and suburban Cook County.

Figure 7.19. Homicide and firearm-related mortality by region, 2012



Data Source: Illinois Department of Public Health, 2012

Figure 7.20. Communities in the Central region with the highest violent crime rates, 2014

Chicago community areas and suburban cities in the Central region with the highest violent crime rates.	
Austin	McCook
West Garfield Park	Maywood
East Garfield Park	Stone Park
North Lawndale	Hillside
Humboldt Park	Cicero
West Town	Broadview

Data Source: UCR Crime Data, U.S Federal Bureau of Investigation, 2014

Structural racism and systems-level policy change—Social, economic, and structural determinants of health

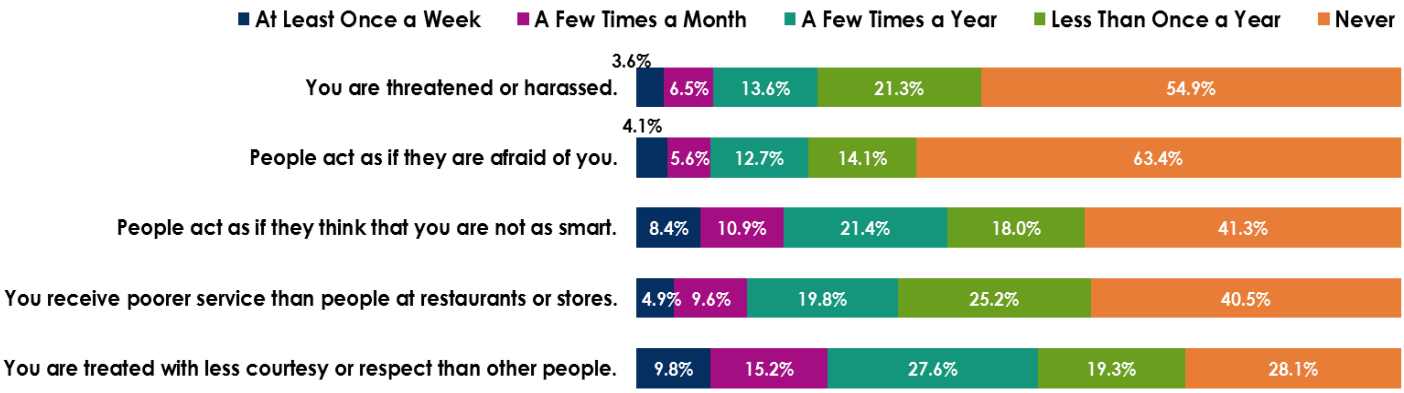
As previously referenced, structural racism is a direct cause of health inequities.[2] The FOCA identified many factors and trends related to racism, discrimination, and stigma including the ongoing existence of implicit bias; mass incarceration affecting communities of color; and unequal quality of education across racial, ethnic, and class categories. These forces present threats to overall health outcomes and increase health disparities. The FOCA identified some opportunities to address issues related to racism and discrimination in Chicago and suburban Cook County including public education campaigns, embedding equity into organizational values, implementing collective impact and community organizing, and promoting social movements.

Community members in the Central region focus groups indicated that communities of color have a disproportionate burden of health problems. Racism related to criminal justice, incarceration, and societal values was considered a serious problem by several residents.

Focus group participants observed that immigrants, African American/blacks, and Latinos were more likely to live in low-income neighborhoods with fewer job opportunities. Many of the survey respondents indicated that they had experienced discrimination in their day-to-day lives (see Figure 7.21).

Figure 7.21. Discrimination in the daily lives of Central region community survey respondents

In your day to day life, how often have any of the following things happened to you? (n=1999)



The Forces of Change Assessment (FOCA) and Local Public Health System Assessment (LPHSA) identified that policy and advocacy to address inequities are essential to an upstream approach to addressing the social determinants of health. The FOCA and LPHSA discussions also emphasized that communities being affected by inequities should be involved in leading policy change efforts and that there needs to be changes to state and local politics in order to achieve the systems changes required to address inequities.

Additional systems-level issues identified by focus group participants include outreach and advocacy for the homeless community, treatment for mental illness or substance use in lieu of incarceration, advocacy for mentally ill individuals and/or individuals with intellectual disabilities, changes to employment policies for formerly incarcerated individuals, and increased and sustainable funding for community-based services.

Health Impacts—Social, economic, and structural determinants of health

In the Central region, life expectancy is 10 years higher in some communities compared to neighboring areas. This is true in both the city and suburban jurisdictions.

As summarized in the Health Equity section starting on page 35 of this report, there are many health disparities that relate to racial inequities and income inequities. These societal inequities have profound effects on life expectancy. In both Chicago and suburban Cook County, life expectancy varies widely between communities with high economic opportunities and communities with low economic opportunities. In suburban Cook County, life expectancy is approximately 79.7 years. The 2012 citywide life expectancy for residents in Chicago is 77.8 years. Overall in Chicago, life expectancy for people in areas of high economic hardship is five years lower

than those living in communities with better economic conditions.[37] In addition, infant mortality is higher in the Central and South regions than it is in the North (Figure 7.22.b.). Years of potential life lost is the average number of years a person might have lived if they had not died prematurely. It can also be used as an indicator of health disparities. The Chicago community areas and suburban municipalities in the Central region with the highest and lowest life expectancies, natality, and years of potential life lost by region are presented in Figures 7.22a. - 7.22.c.

Figure 7.22a. Communities in the Central region with the lowest and highest life expectancies

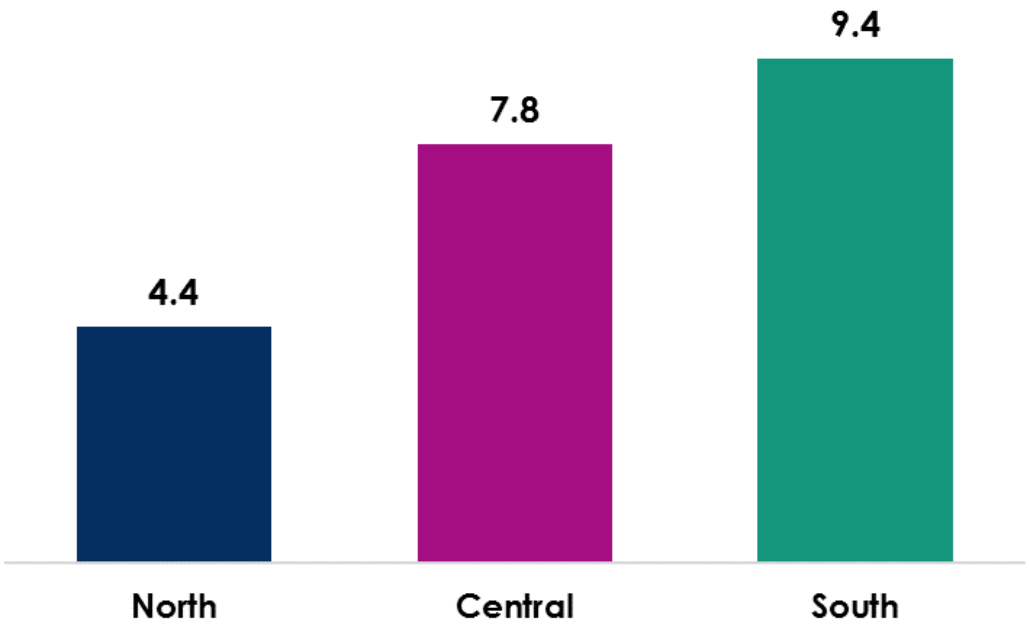
Lowest life expectancies:

Chicago	Life expectancy (Years)	Suburban Cook County	Life expectancy (Years)
West Garfield Park	71.7	Maywood	74.4
North Lawndale	72.8	Melrose Park	75.2
Austin	73.7	Bellwood	76.7

Highest life expectancies:

Chicago	Life expectancy (Years)	Suburban Cook County	Life expectancy (Years)
Lower West Side	80.9	River Forest	83.5
South Lawndale	81.3	Western Springs	83.6
Loop	83.7	La Grange Park	84.1

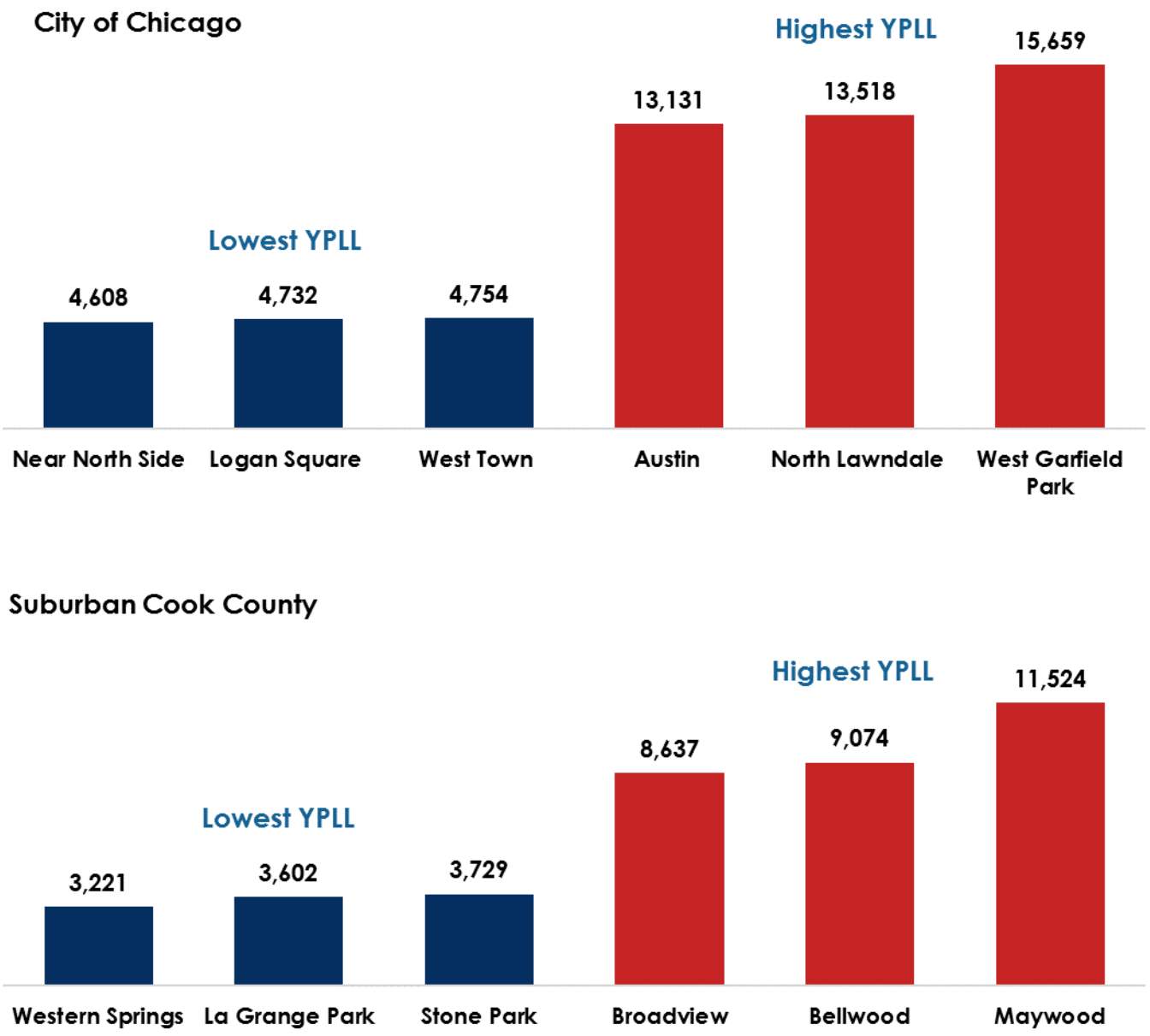
Figure 7.22b. Infant mortality: number of deaths of infants less than one-year-old per 1,000 live births, by region, 2012



Data Source: Illinois Department of Public Health, 2008-2012

[37] Healthy Chicago 2.0. (2016).

Figure 7.22c. Years of Potential Life Lost (YPLL), comparison of communities in the Central region



Data Source: Illinois Department of Public Health, 2008-2012

Key Findings: Mental Health and Substance Use

Overview

This section summarizes needs and issues related to mental health and substance use, referred to jointly as behavioral health. The Central region CHNA found that mental health and substance use are issues that are in need of collaborative action to improve systems and support better health status and health outcomes in communities. In particular, the CHNA found that funding and systems are inadequate across the board to support behavioral health needs in Chicago and Cook County. Stigma and lack of open conversation about behavioral health are also factors that contribute to community mental health and substance use issues in youth and adults.

The Forces of Change Assessment (FOCA) and Local Public Health System Assessment (LPHSA) findings emphasized that current community mental health and substance use issues are the result of long-standing inadequate funding that has been exacerbated by recent cuts to social services, healthcare, and public health.

The findings from the FOCA and community focus groups emphasized that behavioral health is an issue that affects population groups across income levels and race and ethnic groups in the Central region. However, inequities related to the social and structural determinants of health have profound impacts on who is most affected by the shortage of facilities and services. The following groups were identified as being most affected by cuts to community-based mental health and substance use services and facilities, shortages of mental and behavioral health professionals, and lack of trauma-informed care:

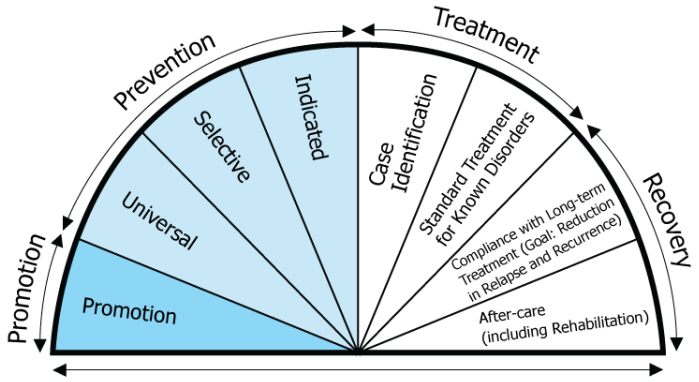
- Children and adolescents
- Family caregivers
- Homeless individuals
- Incarcerated and formerly incarcerated individuals
- Individuals with a history of mental illness and/or substance use
- LGBQIA and transgender individuals
- Residents in long-term care facilities
- Uninsured and underinsured
- Veterans and former military

Mental health and substance use were two of the most discussed issues in the FOCA. The FOCA findings emphasized that social and structural determinants have substantial impacts on mental health. In particular, the following factors were identified as impacting mental health in communities: socioeconomic inequities; inadequate healthcare access; lack of affordable and safe housing; racism, discrimination, and stigma; and lack of safety or perceived safety, violence, and trauma.

In terms of the connections between trauma and mental health, substantial evidence has emerged over the past decade that adverse childhood experiences (ACEs) strongly relate to a wide range of physical and mental health issues throughout a person's lifespan. ACEs

include physical and emotional abuse and neglect, observing violence against relatives or friends, substance misuse within the household, mental illness in the household, and forced separation from a parent or close family member through incarceration or other means.[38]

Figure 8.1. Behavioral Health Continuum of Care Model



The FOCA discussions identified some opportunities to address behavioral health access issues such as training first responders and implementing new prevention and community-based care models. The Behavioral Health Continuum of Care Model (Figure 8.1) includes Promotion, Prevention, Treatment, and Recovery. The World Health Organization (WHO) emphasizes the need for a network of community-based mental health services.[39] The WHO has found that the closure of mental health hospitals and facilities is often not accompanied by the development of community-based services and this leads to a service vacuum.[21] In addition, research indicates that better integration of behavioral health services, including substance use treatment into the healthcare continuum, can have a positive impact on overall health outcomes.[40] The Substance Abuse and Mental Health Services Administration (SAMHSA) emphasizes the importance of health promotion in creating environments and conditions that support mental and emotional well-being. This improves the ability of individuals to withstand challenges. In addition, prevention and early intervention reduce the burden of mental health and substance use in communities.

Communities in the Central region that have high rates of emergency department (ED) visits for behavioral health	
Chicago	**Suburban Cook County**
• Austin • East Garfield Park • Humboldt Park • Near West Side • West Garfield Park	• Bellwood • Berwyn • Cicero • Maywood • Melrose Park • Stone Park

[38] http://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences
[39] World Health Organization. (2007). http://www.who.int/mediacentre/news/notes/2007/np25/en/
[40] American Hospital Association. (2012). Bringing behavioral health into the care continuum: opportunities to improve quality, costs, and outcomes. http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf

Scope of the issue – mental health and substance use

Data availability was a challenge for assessing mental health and substance use within the Community Health Status Assessment. The Health Impact Collaborative of Cook County made efforts to include as much mental health-related data as possible in this CHNA including the following indicators:

- self-reported mental health status;
- emergency department (ED) visits for mental health, intentional injury and suicide, substance use, and alcohol abuse; and
- healthcare provider shortage areas for mental health.

Mental Health

The Behavioral Risk Factor Surveillance System (BRFSS) and Healthy Chicago Survey found that approximately 34-44% of adults in Chicago and suburban Cook County report not having enough social or emotional support (Figure 8.2). These rates are higher than the rates for Illinois (20%) and the United States (23%).

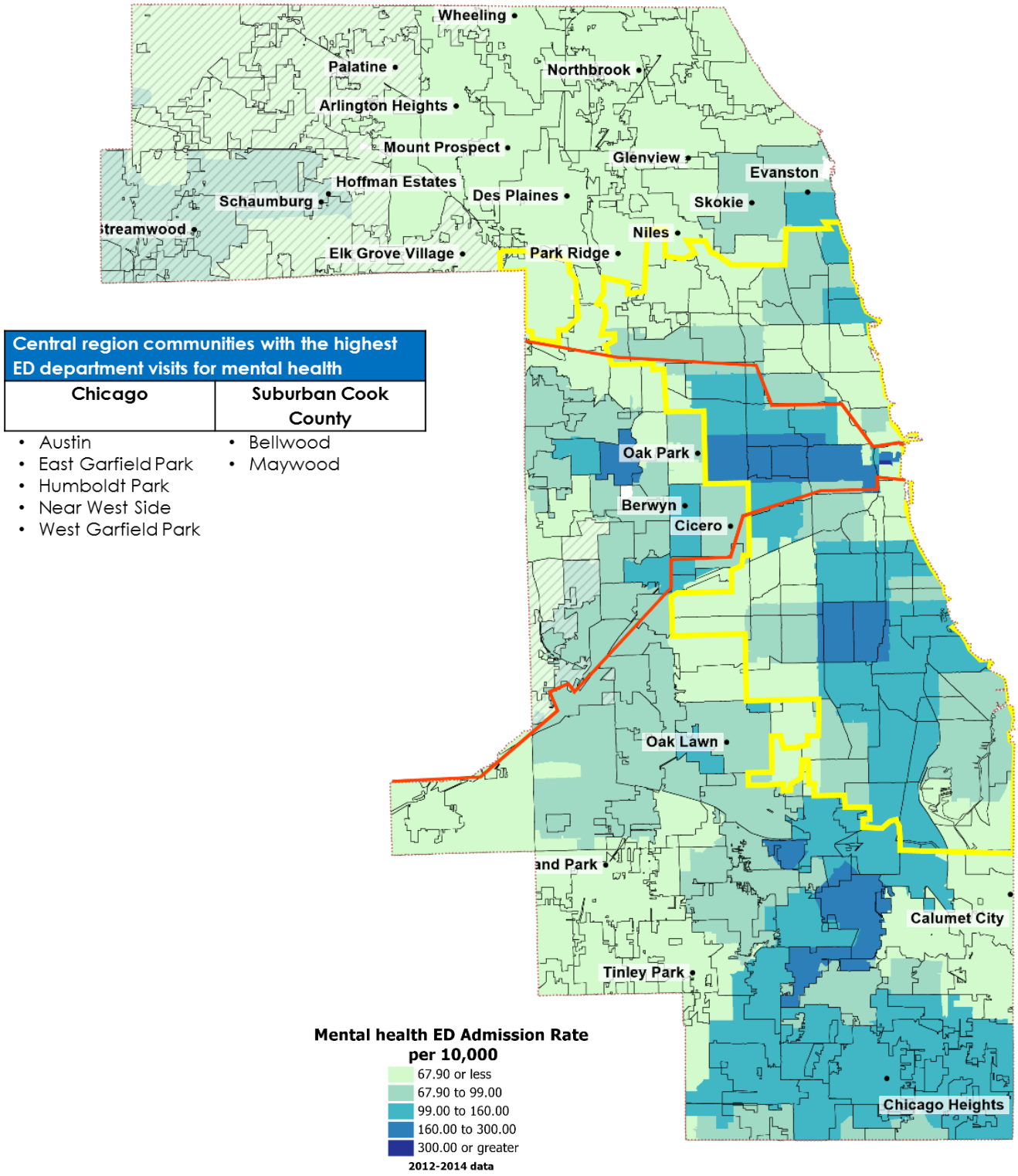
Figure 8.2. Self-reported emotional and mental health indicators

Self-reported emotional and mental health indicators				
	Suburban Cook County (2012)	**Chicago (2014)**	**Illinois (2013)**	**United States (2013)**
Percentage of adults that lack social or emotional support	34%	44%	20%	23%
Average number of days (in the past 30 days) that adults report their mental health as not good	3.2	3.1	3.3	3.4

Data Source: Behavioral Risk Factor Surveillance System (BRFSS) (2013) and Healthy Chicago Survey (2014)

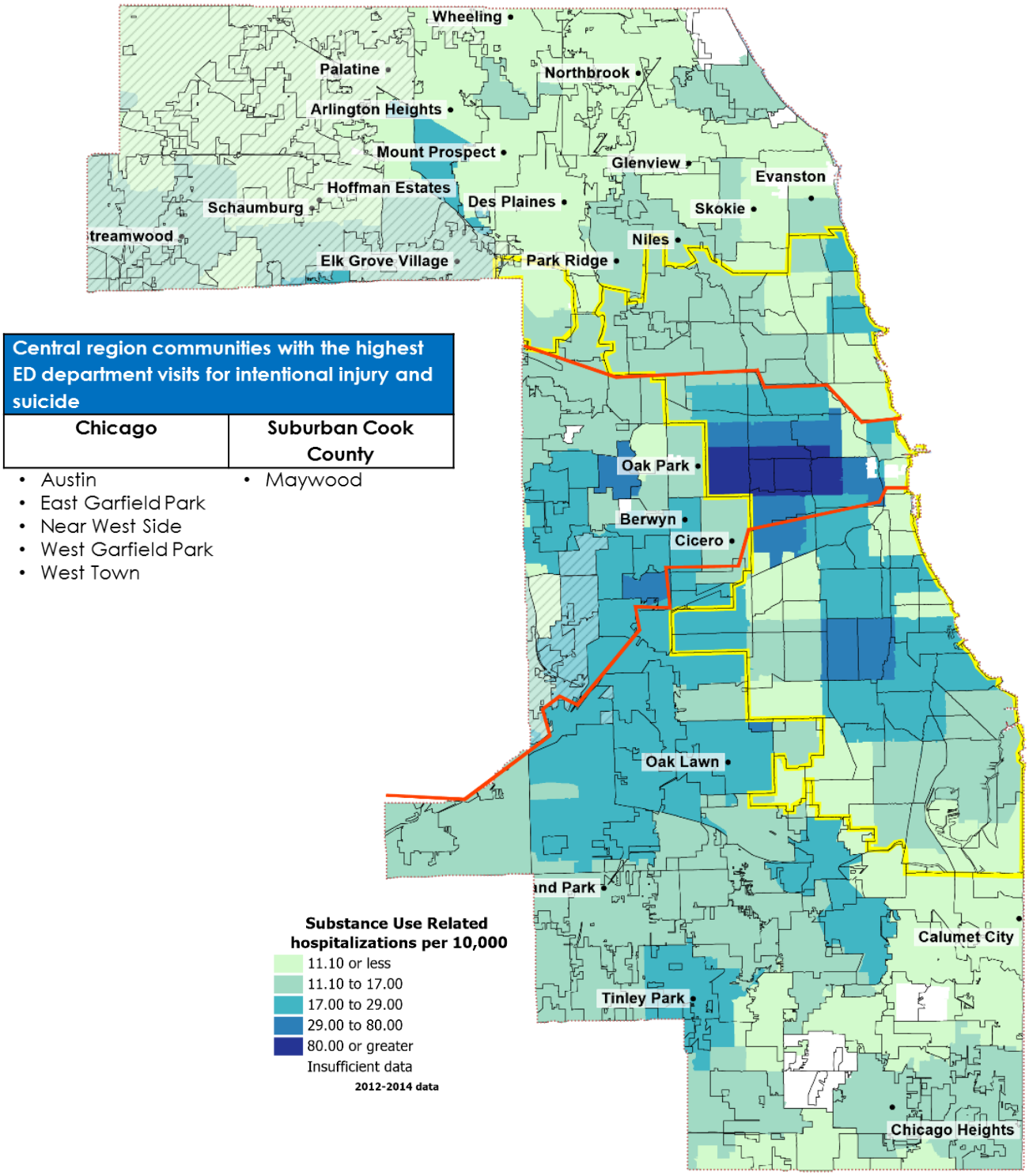
High rates of Emergency Department (ED) visits for mental health and substance use may indicate a lack of community-based treatment options, services, and facilities.

Figure 8.3. Emergency Department (ED) visits for mental health in Cook County, by zip code (age-adjusted rate per 10,000)



Data Source: Healthy Communities Institute, Illinois Hospital Association COMPdata, 2012-2014

Figure 8.4. Emergency Department (ED) visits for intentional injury and suicide in Cook County, by zip code (age-adjusted rate per 10,000)



Central region communities with the highest ED department visits for intentional injury and suicide	
Chicago	**Suburban Cook County**
• Austin • East Garfield Park • Near West Side • West Garfield Park • West Town	• Maywood

Data Source: Healthy Communities Institute, Illinois Hospital Association COMPdata, 2012-2014

Substance use

According to the SAMHSA, many factors influence a person's chance of developing a mental health and/or substance use disorder. From a community health perspective, the variable risk factors related to substance use issues are particularly important as potential intervention points for prevention. The variable risk factors for substance use align with work on the social determinants of health; SAMHSA identifies income level, employment status, peer groups, and adverse childhood experiences (ACEs) as key variable risk factors. Protective factors include positive relationships, availability of community-based resources and activities, civil rights and anti-hate crime laws, and policies limiting access to substances.

There is a high prevalence of co-morbidity between mental illness and drug use.[41] Figure 8.6 shows the communities in the Central region where high ED visit rates for mental illness overlap with high ED visit rates for substance use. Overall, the CHNA findings point to a number of societal trends related to mental health and substance use that are negatively affecting community health and the local public health system. The lack of effective substance use prevention, easy access to alcohol and other drugs, the use of these substances to self-medicate, and the criminalization of addiction in lieu of access to mental health services are thought to have profound impacts on community health in the Central region and across Chicago and Cook County.

The U.S. Department of Justice estimates: **61%** of individuals in state prisons and **44%** of individuals in local jails with current or past violent offenses and three or more past incarcerations have a mental health issue.

63% of incarcerated individuals who had used drugs in the month before their arrest had mental health problems.

U.S. Department of Justice – Office of Justice Programs. (2006). Bureau of Justice Statistics Special Report: Mental Health Problems of Prison and Jail Inmates. http://www.bjs.gov/content/pub/pdf/mhppji.pdf

Cook County Jail is currently one of the largest facilities for people with mental illness and substance use issues in the U.S.

On any given day, at least one-quarter of the inmates at Cook County Jail are people with mental illness.

http://www.npr.org/2011/09/04/140167676/nations-jails-struggle-with-mentally-ill-prisoners
http://www.cookcountysheriff.com/MentalHealth/MentalHealth_main.html

Barriers to accessing mental health and substance use treatment and services include social stigma, lack of accessible and affordable mental health services due to continued funding cuts, low reimbursement rates for mental health services, and low salaries for mental health professionals. Poor funding for mental health services has led to provider shortages.

[41] National Institutes of Health – National Institute on Drug Use. (2010). https://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses

Opportunities to address behavioral health access issues include training first responders and implementing new community health models. The Community Health Status Assessment revealed some geographic disparities in the ED visit rates for heavy drinking and substance use, as shown in Figures 8.6 and 8.7 Additionally, 9% of Chicago adults report heavy drinking in the past month, which is higher than the U.S. overall (6%).

Youth Substance Use

Drug use in adolescent and teen years may be part of a pattern of risky behavior which could include unsafe sex, driving while intoxicated, and other unsafe activities.[42] Drug use in adolescent or teenage years can result in multiple negative outcomes including poor school performance, problems with relationships, loss of interest in normal healthy activities, impaired memory, increased risk for infectious disease, mental health issues, and overdose death.[39] As a result, measures to prevent or reduce drug use among adolescents and teens are important.[39]

Substance use among youth in suburban Cook County

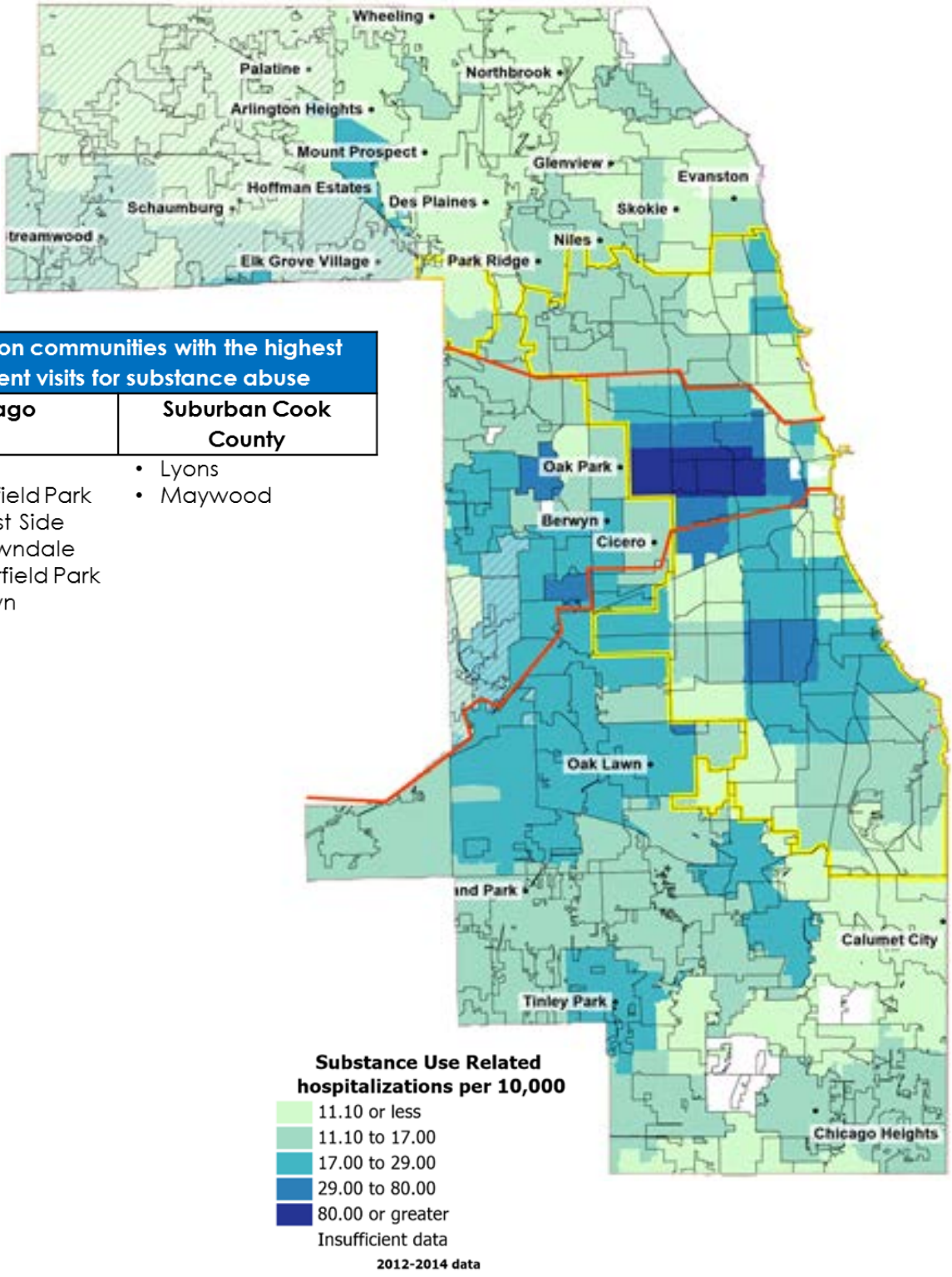
Illinois Youth Survey, comparing 2010 and 2014 survey results

- In 2014, 52% of 12th graders reported drinking alcohol in the past month, 41% reported marijuana use, 9% reported using prescription drugs to get high, and 7% reported MDMA/ecstasy use.
- The number of 12th graders in Cook County that reported drinking alcohol in the past year (52%) is lower than the state average (63%). All other self-reported rates for drug use among students in Cook County are approximately the same as those for the state of Illinois.
- Alcohol use reported among middle school and high school students decreased slightly from 2010 to 2014. This follows a national trend of decreases in adolescent and teenage alcohol use that has been occurring over the last 15 years.
- 12th graders reporting heavy drinking decreased from 33% in 2010 to 28% in 2014.
- Rates of self-reported cocaine/crack use among 12th graders decreased by 3%, and self-reported marijuana and MDMA/ecstasy use both increased by 2%.
- Self-reported use of inhalants, hallucinogens/LSD, methamphetamine, and heroin did not change between 2010 and 2014.

24% (67) of eligible elementary/middle schools and 48% (35) of eligible high schools in suburban Cook County participated in the 2014 Illinois Youth Survey.

[42] National Institute on Drug Abuse. (2014). Principles of adolescent substance use disorder treatment: A research-based guide.

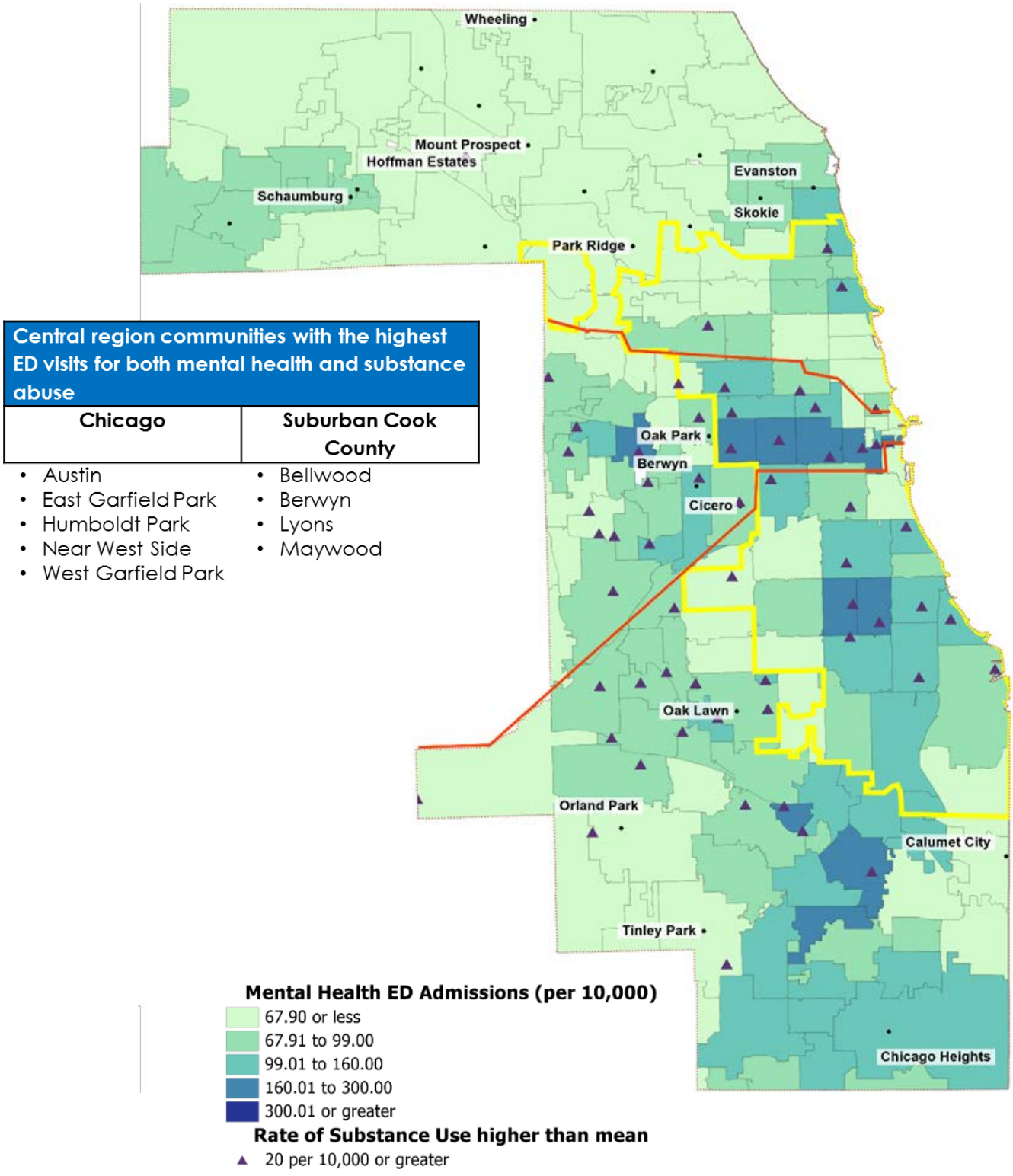
Figure 8.5. Emergency Department (ED) visits for substance abuse in Cook County, by zip code (age-adjusted rate per 10,000)



Central region communities with the highest ED department visits for substance abuse	
Chicago	**Suburban Cook County**
• Austin • East Garfield Park • Near West Side • North Lawndale • West Garfield Park • West Town	• Lyons • Maywood

Data Source: Healthy Communities Institute, Illinois Hospital Association COMPdata, 2012-2014

Figure 8.6. Emergency Department (ED) visits for mental health and substance abuse in Cook County, by zip code (age-adjusted rates per 10,000)

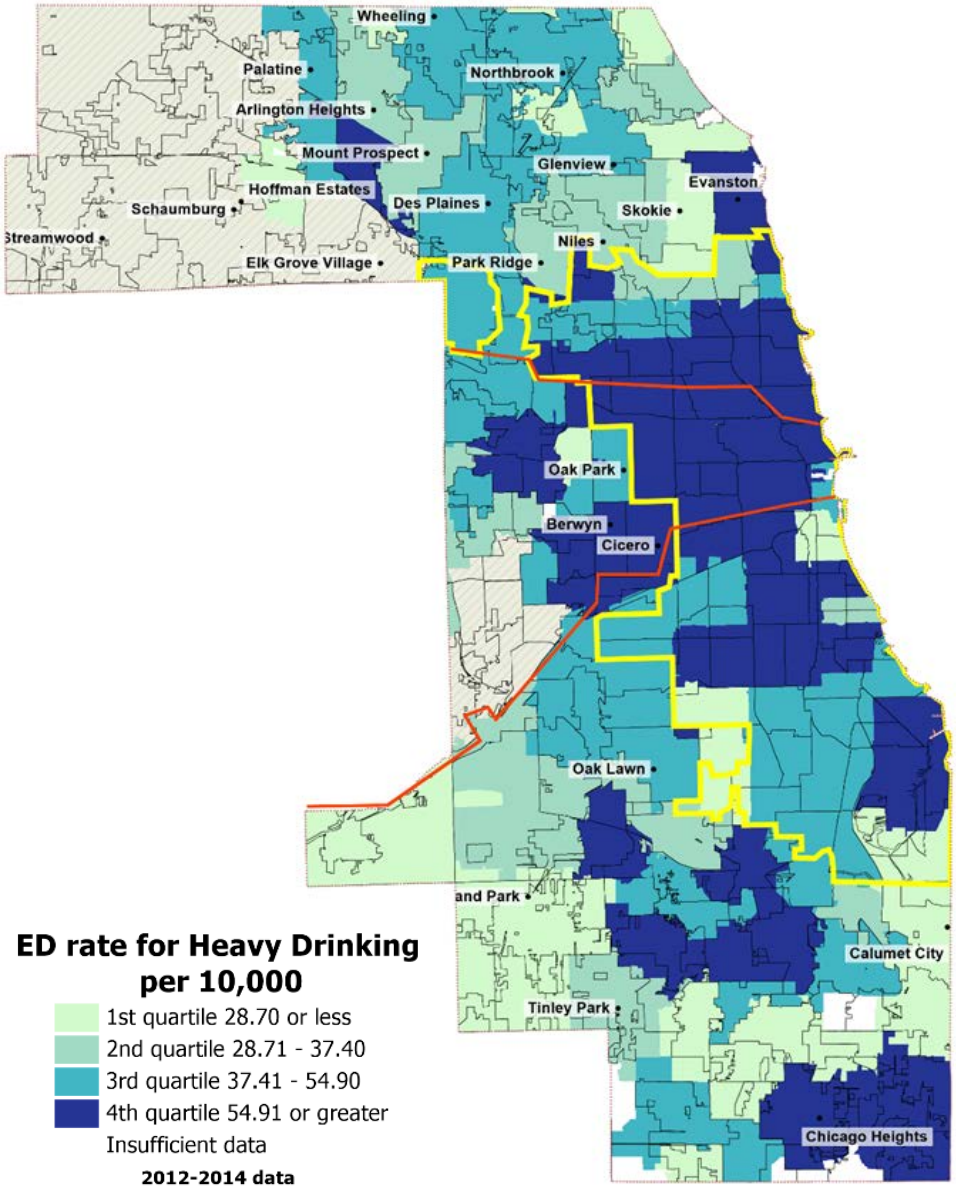


Central region communities with the highest ED visits for both mental health and substance abuse	
Chicago	**Suburban Cook County**
• Austin • East Garfield Park • Humboldt Park • Near West Side • West Garfield Park	• Bellwood • Berwyn • Lyons • Maywood

Data Source: Healthy Communities Institute, Illinois Hospital Association COMPdata, 2012-2014

Figure 8.7 shows ED visit rates for alcohol abuse. Several communities in the Central region of Chicago and suburban Cook County have ED visit rates of 54.91 per 10,000 or greater for alcohol abuse. Nationwide, ED visits for alcohol abuse have been on an upward trajectory. Between 2001 and 2010, the rate of ED visits for alcohol-related diagnoses for males and females increased 38%. The nationwide rate for males as of 2010 is 94 per 10,000 and the rate for females is 36 per 10,000.[43]

Figure 8.7. Emergency Department (ED) visits for alcohol abuse in Cook County, by zip code (age-adjusted rate per 10,000)

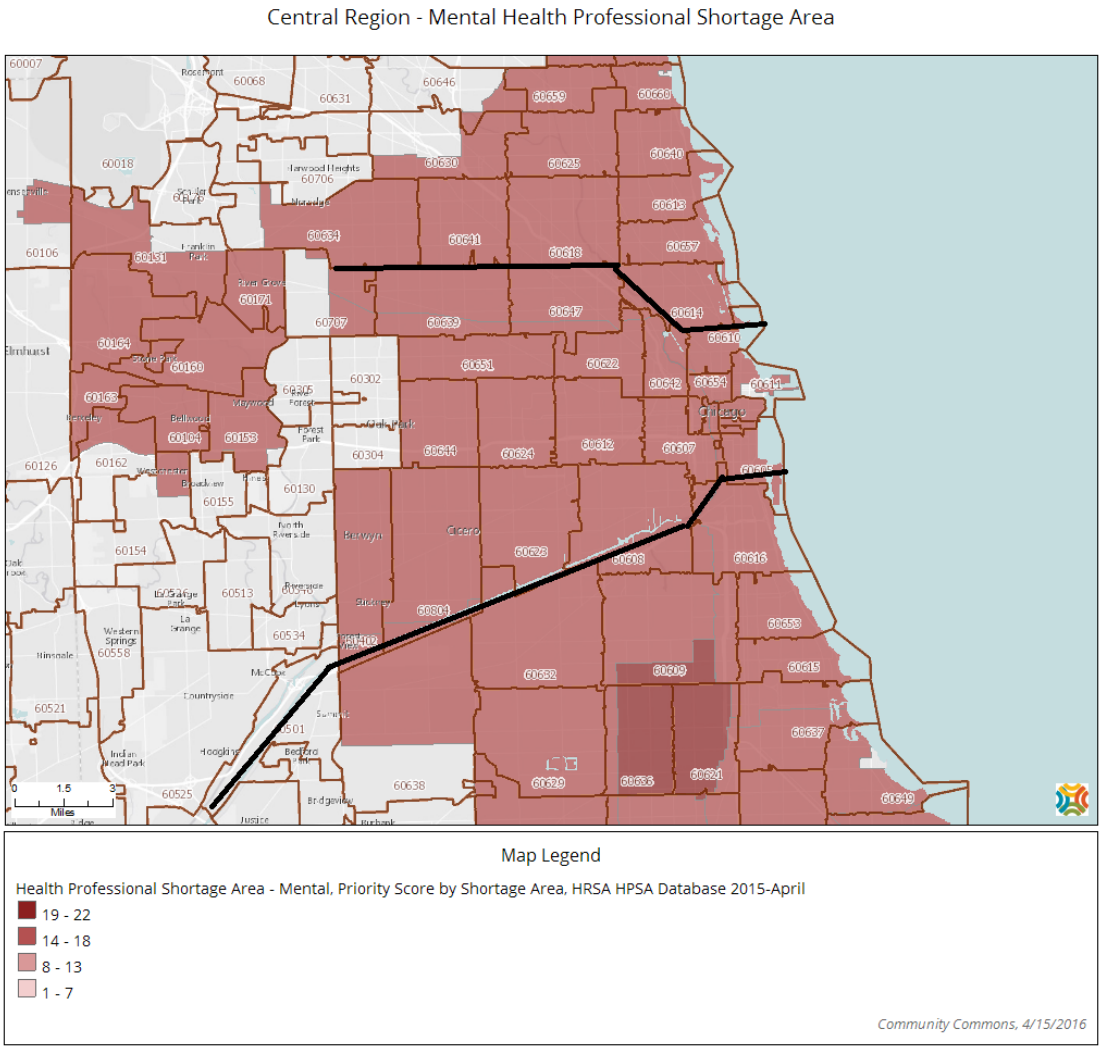


Data Source: Healthy Communities Institute, Illinois Hospital Association COMPdata, 2012-2014

[43] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6235a9.htm

There are several communities in the Central region that have multiple primary mental health professional shortage areas, as shown in Figure 8.8. Mental Health Professional Shortage Areas are designated by the Health Resources and Services Administration (HRSA). Each shortage area is assigned a score (1-22) based on a variety of different factors including geographic area (a county or service area), population (e.g., low income or Medicaid eligible), or the presence of different types of facilities (e.g., federally qualified health centers, or state or federal prisons.)[44] The higher a score is for an area, the greater the need for mental health professionals, services, or facilities. The majority of communities in the Central region are designated as mental health professional shortage areas.

Figure 8.8. Map of mental health professional shortage areas in the Central region, 2015



Data Source: U.S. Department of Health and Human Services Administration – Health Resources and Services Administration, 2016

[44] U.S. Department of Health and Human Services Administration – Health Resources and Services Administration. (2016). http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx

Community input on mental health and substance use

Closing of mental health facilities and discontinuation of services has led to an increased burden on communities and community-based organizations. All seven focus groups in the Central region discussed how the lack of mental health services has led to a number of problems including increased hospitalization, more expensive care, high incarceration rates, homelessness, substance use, suicide, and overburdening of existing programs or facilities. In addition, there are fewer resources available for community health workers and social workers to assist community members in need. Participants indicated that more long-term behavioral health programs and additional staff would be required to address the issue.

Several focus group participants explained that many people living with drug addiction are self-medicating for behavioral health issues. Focus group participants also emphasized that people with substance use issues should be sent to treatment instead of being sent to jail or prison.

Multiple focus group participants indicated the need for transitional living options and linkage to community-based organizations that provide crisis prevention services to prevent relapse, such as drop-in counseling appointments for individuals following inpatient mental health programs. Formerly incarcerated individuals reported that transitional living options are also important for those living with mental illness following incarceration.

Half of the focus groups in the Central region highlighted that children, adolescents, and young adults are more at risk for mental illness and behavioral health problems because of a lack of youth-friendly services. In addition, some participants cited the need for trauma-informed and youth-competent behavioral health providers to serve juveniles both in the community and in correctional facilities.

Community resident survey – mental health

18% of community survey respondents in the Central region indicated that they or a family member did not seek needed mental health treatment because of cost or a lack of insurance coverage.

- 14% of respondents indicated that they or their family members did not seek mental health treatment due to a lack of knowledge about where to get services.
- 11% indicated that wait times for treatment or counseling appointments were a barrier to accessing needed care.

A large percentage of respondents indicated that their financial situation (not enough money, debt) contributed the most to feelings of stress in their day to day lives.

29% of respondents indicated that health of family members contributed to stress in their daily lives.

29% of respondents indicated that time pressures or not enough time contributed the most to feelings of stress.

Key Findings: Chronic Disease

Overview

This section summarizes needs and issues related to chronic disease. Chronic disease conditions, including type 2 diabetes, obesity, heart disease, stroke, cancer, arthritis and HIV/AIDS are among the most common and preventable of all health conditions. In addition, chronic disease is extremely costly to individuals and to society.[45] The Central region CHNA findings emphasize that preventing chronic disease requires a focus on risk factors such as nutrition and healthy eating, physical activity and active living, and tobacco use. The findings across all four assessments emphasized that chronic disease is an issue that affects population groups across income levels, race, and ethnicity in the Central region. However, social and economic inequities have profound impacts on individuals and communities that are most affected by chronic disease. Priority populations to consider in terms of chronic disease prevention include: children and adolescents, low-income families, immigrants, diverse racial and ethnic groups, older adults and caregivers, uninsured individuals and those insured through Medicaid, individuals living with mental illness, individuals living in residential facilities, and incarcerated or formerly incarcerated individuals.

The CHNA findings highlighted that chronic disease prevention requires multifaceted approaches including:

- Addressing social determinants of health and underlying socioeconomic and racial inequities
- Improving the built environment to facilitate active living and access to healthy affordable food
- Addressing both food access and food insecurity in communities
- Improving access to primary and specialty care, with an emphasis on preventive care
- Improving access to affordable insurance and medications
- Facilitating multi-sector partnerships for chronic disease prevention (including community-based organizations, social service providers, healthcare providers and health plans, transportation, economic development, food entrepreneurs, etc.)
- Collaborating on policies related to healthy eating, active living, and overall funding for healthcare, public health, and community-based services
- Improving data systems to understand how chronic disease is affecting diverse communities and to measure the impact of collaborative interventions

[45] Ward B.W., Schiller J.S., Goodman R.A. (2014). Multiple chronic conditions among U.S. adults: a 2012 update. *Preventing Chronic Disease.*

Many of the assessment findings in the social determinants of health section of this report are connected to chronic disease prevention. Assessment findings related to food access, food security, and built environment are included in the social determinants section of this report.

In order to reduce chronic disease-related mortality and address inequities in mortality and disease burden, a focus on chronic disease prevention is critical. The CDC has identified four domains for chronic disease prevention. Data presented in this section and throughout the CHNA report provides information about current chronic disease burden and health behaviors, built environment and community conditions, and community input about opportunities to create healthier communities and address chronic disease risk factors.

CDC's Four Domains for Chronic Disease Prevention

1. Epidemiology and surveillance: to monitor trends and track progress.
2. Environmental approaches: to promote health and support healthy behaviors.
3. Healthcare system interventions: to improve the effective delivery and use of clinical and other high-value preventive services.
4. Community programs linked to clinical services.

Communities in the Central region with high burdens of chronic disease*	
Chicago	**Suburban Cook County**
• Austin • East Garfield Park • Humboldt Park • Near West Side • North Lawndale • West Garfield Park	• Bellwood • Cicero • Maywood • Melrose Park

*Indicators included here are mortality (heart disease, cancer, stroke, diabetes) and hospitalization data (asthma and diabetes).

Mortality related to chronic disease

The Healthy Chicago 2.0 Assessment found that **chronic diseases accounted for approximately 64% of deaths in Chicago in 2014**.[20] The top three leading causes of death across Chicago and suburban Cook County are heart disease, cancer, and stroke (Figure 9.1).

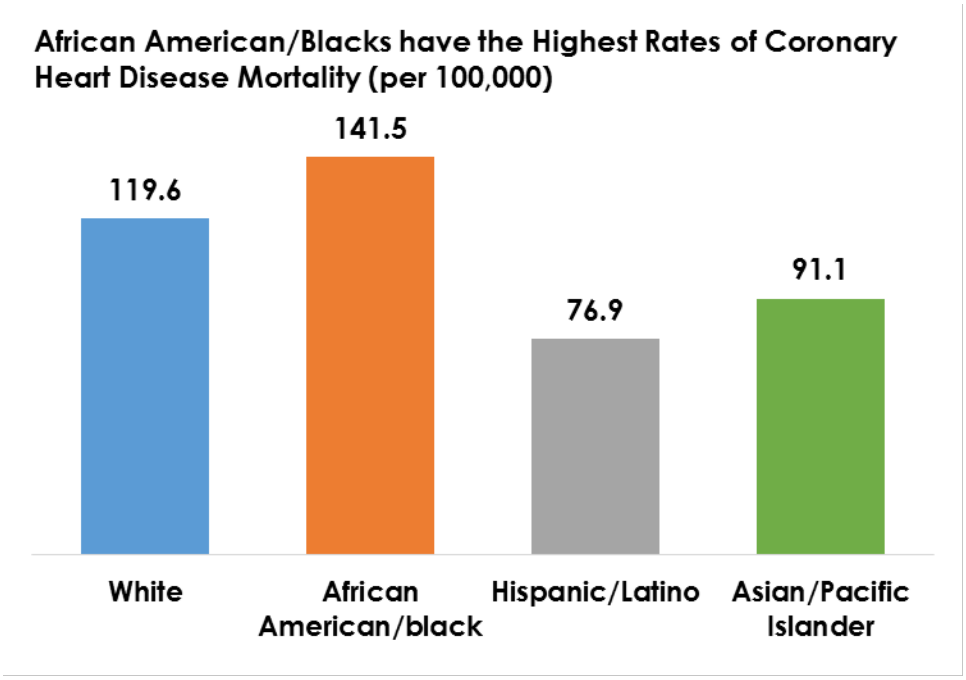
Figure 9.1. Leading causes of death, Chicago and Cook County

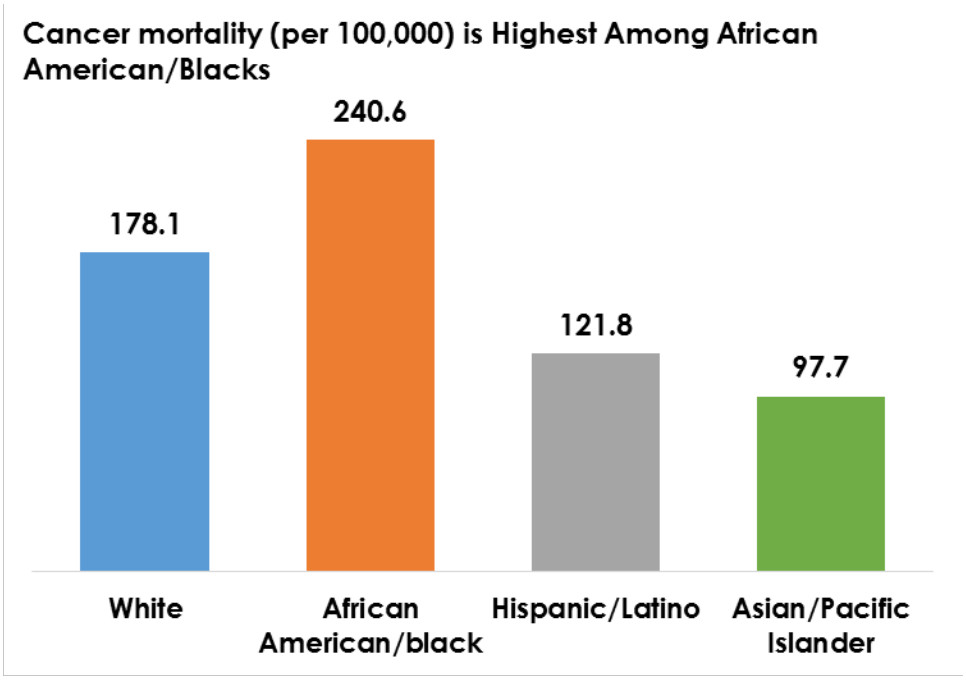
Chicago (2012)	Cook County (2012)	Illinois (2014)	United States (2014)
• Heart Disease • Cancer • Stroke and Cerebrovascular Diseases • Chronic Lower Respiratory Diseases • Accidents	• Heart Disease • Cancer • Stroke and Cerebrovascular Diseases • Chronic Lower Respiratory Diseases • Accidents	• Heart Disease • Cancer • Chronic Lower Respiratory Diseases • Stroke and Cerebrovascular Diseases • Accidents	• Heart Disease • Cancer • Chronic Lower Respiratory Diseases • Accidents • Stroke and Cerebrovascular Diseases

Data Source: Illinois Department of Public Health

Racial and ethnic disparities in mortality rates persist in the Central region of Chicago and Cook County, as shown in Figures 9.2 and 9.5. In addition, there are major variations in chronic disease-related mortality rates across both the Chicago community areas and Cook County suburbs, as shown in Figure 9.3.

Figure 9.2. Chronic disease-related mortality (per 100,000) for Central region, by race and ethnicity

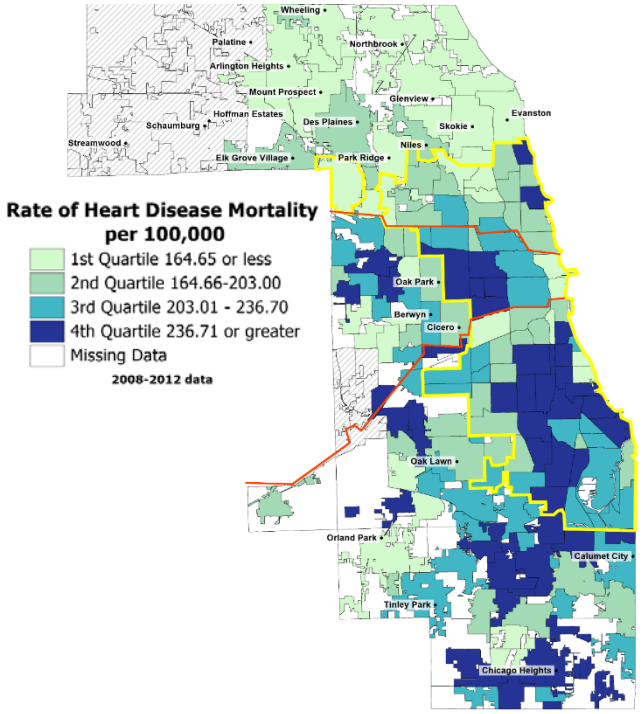




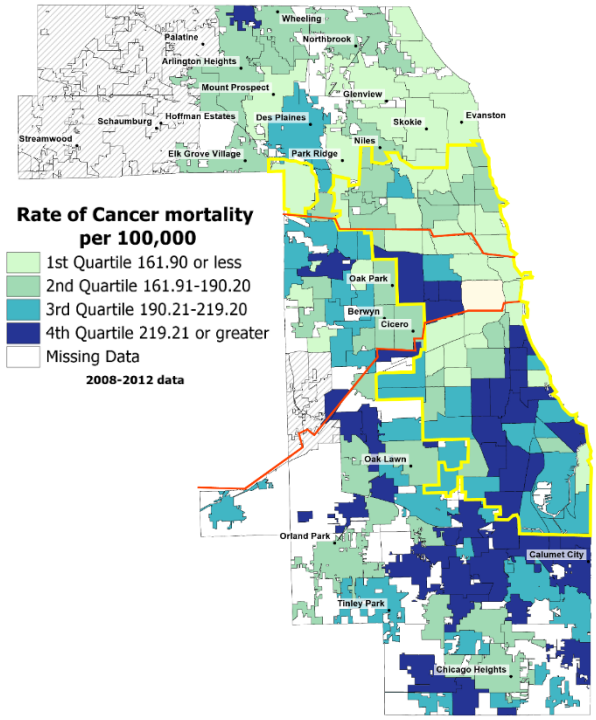
Data Source: Illinois Department of Public Health, 2012

Figure 9.3. Chronic disease-related mortality for Cook County, by community, 2008-2012 (age-adjusted rates per 100,000)

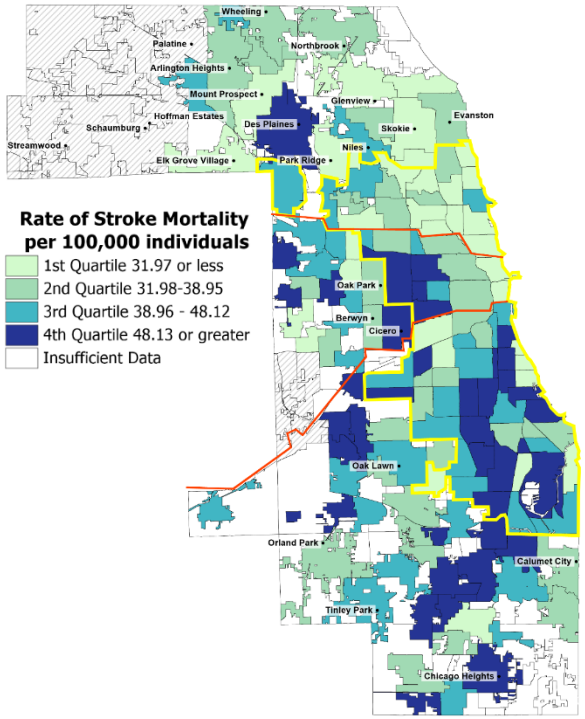
Heart Disease Mortality



Cancer Mortality



Stroke Mortality



The coronary heart disease mortality rate in the Central region was **116.7 deaths per 100,000** population in 2012. The Healthy People 2020 target is 103.4 per 100,000 population.

The cancer mortality rate in the Central region was **182.3 deaths per 100,000** population in 2012. The Healthy People 2020 target is 161.4 per 100,000 population.

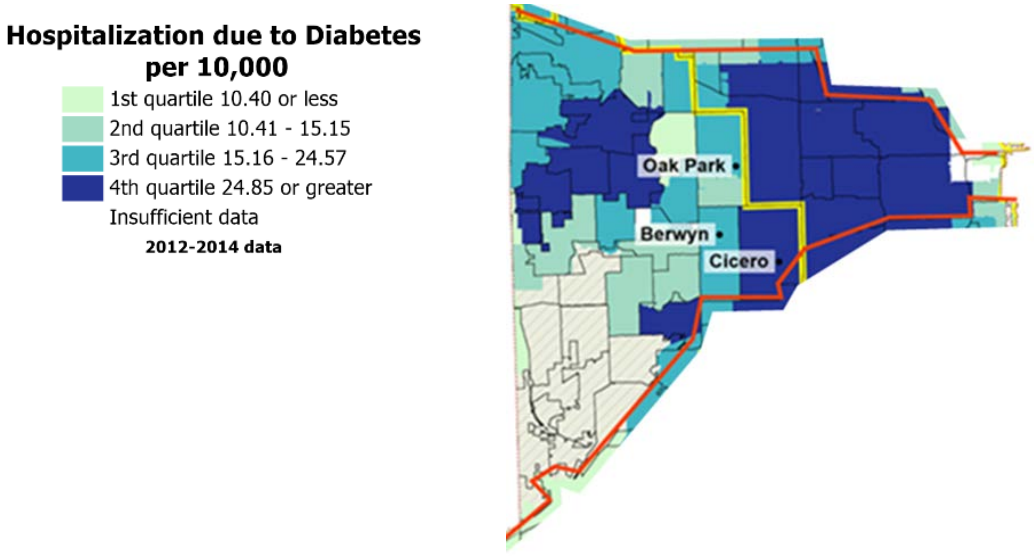
The stroke mortality rate in the Central region was **40.0 deaths per 100,000 population** in 2012. The Healthy People 2020 target is 34.8 per 100,000 population.

Data Source: Illinois Department of Public Health, 2008-2012

Obesity and diabetes

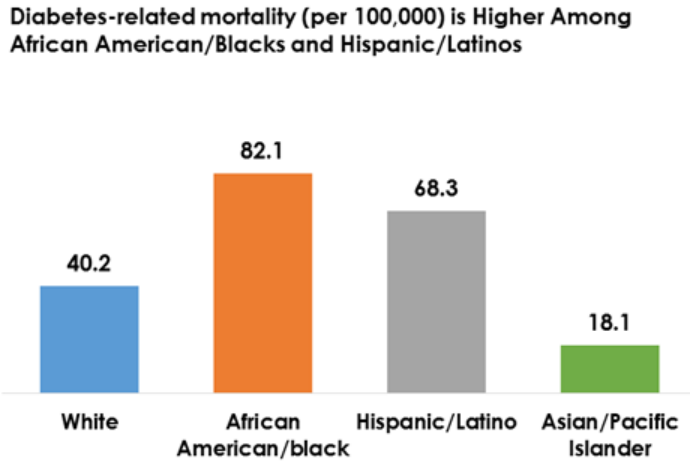
Hospitalization and emergency department (ED) visits are indicative of poorly controlled chronic diseases such as diabetes and a lack of access to routine preventive care. Poorly controlled diabetes can lead to severe or life-threatening complications such as heart and blood vessel disease, nerve damage, kidney damage, eye damage and blindness, foot damage and lower extremity amputation, hearing impairment, skin conditions, and Alzheimer's disease.[46] Non-Hispanic African American/blacks and Hispanic/Latinos in the Central region have higher diabetes-related mortality rates than non-Hispanic whites and Asians.

Figure 9.4. Diabetes-related hospitalization rate (per 10,000) in the Central region, 2012-2014



Data Source: Healthy Communities Institute, Illinois Hospital Association COMPdata, 2012-2014

Figure 9.5. Diabetes-related mortality for the Central region, by race and ethnicity, 2012 (age-adjusted rates per 100,000)



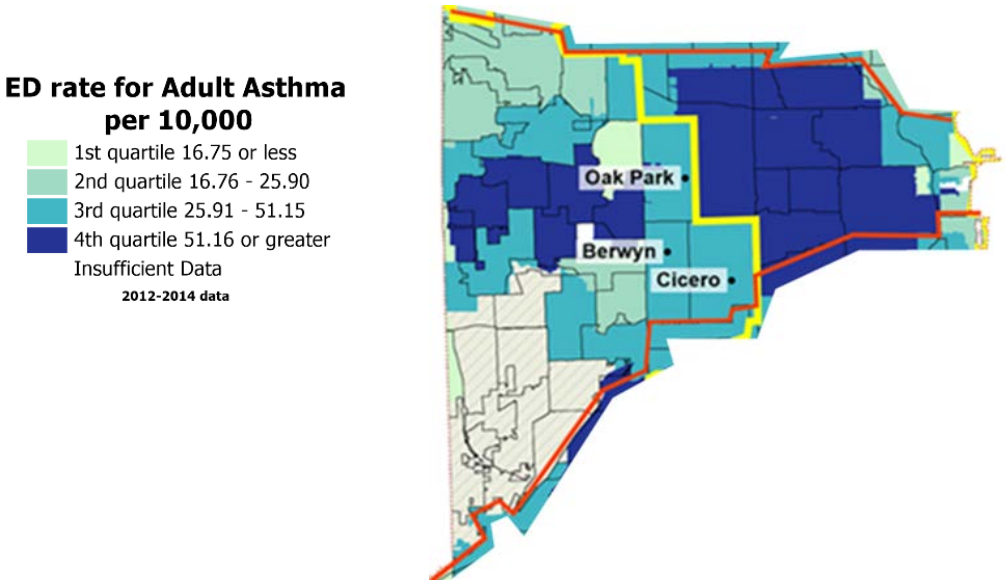
Data Source: Illinois Department of Public Health, 2012

[46] Mayo Clinic. http://www.mayoclinic.org/diseases-conditions/type-2-diabetes/symptoms-causes/dxc-20169861

Asthma

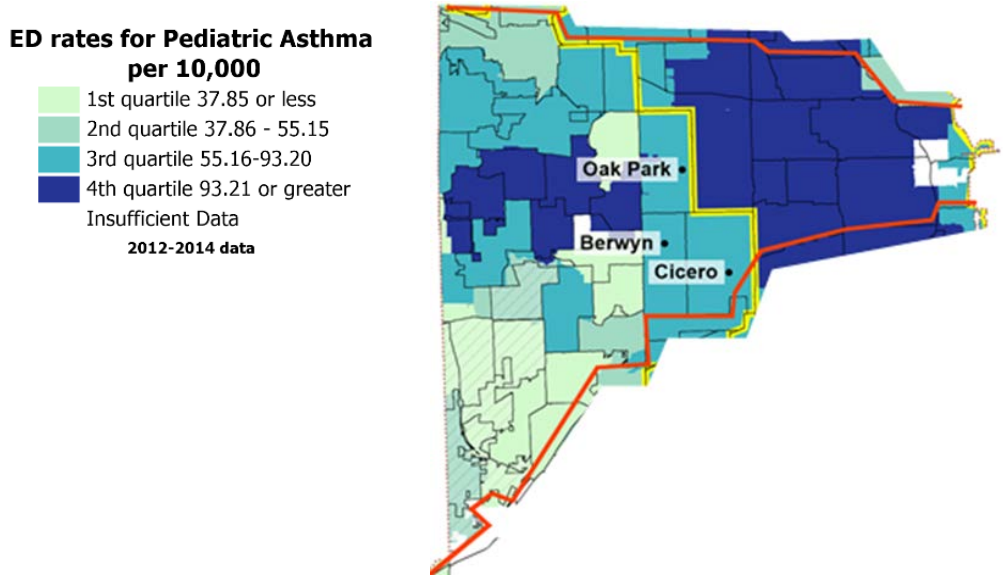
Figures 9.6 and 9.7 show the geographic distributions of emergency department (ED) visits due to adult and pediatric asthma. Communities on the West side of Chicago and West Cook suburbs have disproportionately high rates of ED visits for asthma. ED visits are indicative of increased exposure to environmental contaminants that can trigger asthma as well as poorly managed asthma.

Figure 9.6. Emergency Department (ED) visits due to adult asthma for Central region by zip code, 2012-2014 (age-adjusted rates per 10,000)



Data Source: Healthy Communities Institute, Illinois Hospital Association COMPdata, 2012-2014

Figure 9.7. Emergency Department (ED) visits due to pediatric asthma (per 10,000) for Central region by zip code, 2012-2014



Data Source: Healthy Communities Institute, Illinois Hospital Association COMPdata, 2012-2014

Health behaviors

Health behaviors can influence risk factors for chronic disease and influence management of diseases following diagnosis. Poor diet and a lack of physical activity are two of the major predictors for obesity and diabetes. Low consumption of healthy foods may also be an indicator of inequities in food access. More than 75% of enrolled schoolchildren in the Central region of Chicago and suburban Cook County are eligible for free or reduced price lunch, and 17% of all households in the Central region report receiving SNAP benefits. More data and information about food access is included in the social and structural determinants of health section of this report.

- The majority of adults in suburban Cook County (85%) and Chicago (71%) report **eating less than five daily servings of fruits and vegetables a day**.
- Approximately a quarter of adults in suburban Cook County (26%) and Chicago (29%) report **not engaging in physical activity during leisure time**.
- Approximately 16% of youth in suburban Cook County and 22% of youth in Chicago report **not engaging in physical activity during leisure time**.

Figure 9.8. Self-reported behaviors in adults and youth

Self-reported health behaviors, Adults				
	Suburban Cook County (2012)	**Chicago (2014)**	**Illinois (2013)**	**United States (2013)**
Adults Eating LESS than Five Daily Servings of Fruits and Vegetables	85%	71%	78%	77%
Heavy Drinking in the Previous month	N/A	9%	7%	6%
Current Smokers	14%	18%	18%	19%
No Leisure-Time Physical Activity	26%	29%	25%	25%

Data Source: Behavioral Risk Factor Surveillance System and Healthy Chicago Survey

Self-reported health behaviors, Youth				
	Suburban Cook County (2012)	**Chicago (2014)**	**Illinois (2013)**	**United States (2013)**
Current Smokers (high school students)	12%	11%	18%	16%
No Leisure-Time Physical Activity	16%	22%	13%	15%

Data Source: Youth Risk Behavior Surveillance System

Persons Living with HIV/AIDS

Because of antiretroviral therapy, individuals with HIV are now living longer lives with better quality of life. Consistent use of antiretroviral therapy along with regular clinical care slows the progression of HIV, keeps individuals with HIV healthier, and greatly reduces their risk of transmitting HIV.[47] As the population of Persons Living with HIV/AIDS (PLWHAs) grows, it is important to have systems in place for their continuity of care.[48]

In suburban Cook County, the number of PLWHAs increased 87% from 2,500 in 2004 to 4,683 in 2013.[49] In 2012, there were 22,346 PLWHAs in Chicago, which is a 12% increase from 2005 (19,892 PLWHAs).[50, 51] The communities in the Central region with the largest numbers of PLWHA are shown in Figure 9.9.

In addition to geographic disparities in PLWHA, there are also disparities related to gender, age, race/ethnicity, and sexual orientation. African American/black men who are young and have sex with men are most seriously affected by HIV.[52] Overall, African American/blacks have the most severe burden of HIV compared to all other racial and ethnic groups.[50] Additional data on sexually transmitted infections (STIs) is included in Appendix D.

Figure 9.9. Communities in the Central region with the highest percentages of People Living with HIV/AIDS (PLWHA), per 100,000 population

Communities in the Central region with the highest percentages of people living with HIV/AIDS (PLWHA)	
Chicago	**Suburban Cook County**
• East Garfield Park • North Lawndale • Humboldt Park	• Broadview • Bellwood • Oak Park

Community input on chronic disease prevention

Focus group participants in the Central region identified several factors that influence chronic disease in their communities including:

- the need for non-emergency preventive care and linkage to care following hospitalization;
- inequities in access to healthcare services;

[47] Centers for Disease Control and Prevention. (2016). Living with HIV. http://www.cdc.gov/hiv/basics/livingwithhiv/index.html
[48] Chicago Department of Public Health – HIV/STI Bureau. (2016). Chicago EMA HIV/AIDS Profile.
[49] Cook County Department of Public Health. (2013). Sexually Transmitted Infections Surveillance Report, 2013. http://cookcountypublichealth.org/files/pdf/publications/hiv-surv-report-2013-final-copy.pdf
[50] Chicago Department of Public Health. (Winter 2005-2006). STD/HIV/AIDS Chicago, Winter 2005-2006. http://www.aidschicago.org/resources/legacy/pdf/2006/fact_cdph_winter.pdf
[51] Chicago Department of Public Health. (2014). HIV/STI Surveillance Report, 2014. http://www.cityofchicago.org/content/dam/city/depts/cdph/HIV_STI/2014HIVSTISurveillanceReport.pdf
[52] Centers for Disease Control and Prevention. (2015). HIV in the United States: At a glance. http://www.cdc.gov/hiv/statistics/overview/ataglance.html

- need for intergenerational programs and activities;
- the built environment and transportation systems need to support healthy eating and active living; and
- healthy food access.

Community input on the connections between chronic disease and built environment is included in the built environment section of this report.

Residents in the Central region highlighted inequities in access to healthy foods. Focus group participants reported that many communities in the Central region, particularly communities on the West side of Chicago as well as the areas surrounding Maywood and Bellwood in the West Cook suburbs, do not have access to markets with fresh produce. Those who had the ability to travel outside their community in order to buy healthier foods indicated that affordability of healthy foods is an issue.

Community survey data – Healthy eating and active living

Food insecurity. 45% of survey respondents from the Central region indicated that their households have had to worry in the past year about whether or not their food would run out before they had the money to buy more.

Healthy food availability. 39% of respondents indicated challenges in availability of healthy foods in their community.

Parks and recreation. 24% of survey respondents indicated that there was "little" or no availability of parks and recreation facilities in their community.

Reliability of public transportation. 35% of survey respondents rated reliability of public transportation to be "fair" and an additional 14% found it to be "poor" or "very poor."

Quality and convenience of bike lanes. 31% of survey respondents rated the quality and convenience and bike lanes in their community to be "fair" and an additional 23% found them to be "poor" or "very poor."

Key Findings: Access to Care and Community Resources

Overview

Findings from the CHNA data clearly point to interrelated access issues, with similar communities facing challenges in terms of access to healthcare, access to community-based social services, and access to community resources for wellness such as parks and recreation facilities and healthy, affordable food. These are many of the same communities that are also heavily impacted by social, economic, and environmental inequities. Consequently, poor access to education, housing, transportation, and jobs are additional underlying root causes of inequities that affect access to care and community resources.[53]

Access is a complex and multi-faceted concept that includes dimensions of proximity, affordability, availability, convenience, accommodation, and reliability, quality and acceptability, openness, cultural competency, appropriateness and approachability.

Some specific priority needs related to access that were emphasized in the CHNA findings are:

- Inadequate access to healthcare, mental health services, and social services, particularly for uninsured and underinsured
- Opportunities to coordinate and link access to healthcare and social services
- Need to improve cultural and linguistic competency and humility
- Need to improve health literacy
- Navigating complex healthcare systems and insurance continues to be a challenge in the post Affordable Care Act environment

Several priority populations were identified through the community focus groups and Forces of Change Assessment (FOCA) as being more likely to experience inequities in access to care and community resources, including low income households, diverse racial and ethnic groups, immigrants and refugees, older adults, children and adolescents, LGBQIA individuals, transgender individuals, people living with physical or intellectual disabilities, individuals living with mental illness, individuals living in residential facilities, those currently or formerly incarcerated, single parents, homeless individuals, veterans and former military, and people who are uninsured.

Forces of Change Assessment - Healthcare System Trends

The following forces were identified as trends that are or may have an impact on health and the public health system in Cook County:

- Ongoing implementation of the Affordable Care Act (ACA) and healthcare transformation
- Transition of healthcare systems from acute care to preventive care
- Inadequate funding, services, and systems for mental health and substance use
- Increasing availability of health-related data
- Changing role of health departments from providers to coordinators
- Racism, discrimination, and stigma based on demographic characteristics and/or health conditions
- Demographic shifts - Aging population as well as increases in Latino and Asian populations in the Central region
- Desire for cross-generational and family-oriented programs and services

[53] Levesque, J. F., Harris, M. F. & Russell, G. (2013). Patient-centered access to health care: conceptualising access at the interface of health systems and populations. *International Journal of Equity in Health*, 12(1), 18.

The FOCA and LPHSA identified a number of challenges that could threaten the success of population health approaches including:

- competition among healthcare providers,
- decreasing viability of small and trusted community groups as a result of consolidation and integration of healthcare systems,
- continuing barriers to providing mental health services,
- complex insurance and reimbursement poses challenges for providers and consumers,
- inequities in the distribution of medical services,
- lack of providers accepting Medicaid,
- funding cuts to social services, and
- barriers to developing systems and capacity in hospitals and health departments to address the social determinants of health because social determinants may be seen as political or outside the realm of health.

Opportunities – Access to Care and Community Resources
Forces of Change Assessment and Community Focus Groups

- Community health workers fostering trusted relationships with community members and increasing community health literacy
- Increasing collaborative policy development and advocacy – hospitals, providers, health departments, and community organizations
- Healthcare workforce pipelines
- Collaborating to improve mental health and substance use treatment and prevention
- Technology and social media providing opportunities to promote access and knowledge of services
- Strengthening the roles of health departments and community-based organizations to promote healthy communities, wellness, and chronic disease prevention through system and environmental changes

The Community Health Status Assessment data includes multiple factors that influence access to care including poverty, insurance coverage, self-reported use of preventive care, hospitalization statistics, provider availability, and use of prenatal care. The connection between poverty and health is explored in detail in the social determinants of health section of this report starting on page 41.

Several communities in the Central region have high rates of negative health indicators and poor health outcomes, which indicates a lack of access to healthcare and community resources. Those communities include:

Communities in the Central region have high rates of negative health indicators and poor health outcomes	
Chicago	**Suburban Cook County**
• Austin • Belmont Cragin • East Garfield Park • Hermosa • Humboldt Park • Near West Side • North Lawndale • West Garfield Park	• Bellwood • Broadview • Cicero • Maywood • Melrose Park • Stone Park • Summit • Unincorporated Leyden Township

Insurance coverage

Lack of insurance is a major barrier to accessing primary care, specialty care, and other health services. In the post-Affordable Care Act landscape, the size and makeup of the uninsured population is shifting rapidly. Aggregated rates from 2009-2013 show that 25.5% of the adult population age 18-64 in the Central region reported being uninsured, compared to 18.8% in Illinois and 20.6% in the U.S. Men in Cook County are more likely to be uninsured (18.2%) compared to women (13.8%). In addition, African American/blacks, Latinos, and immigrants are much more likely to be uninsured compared non-Hispanic whites. It is estimated that 40% of undocumented immigrants are uninsured compared to 10% of U.S.-born and naturalized citizens.

High insurance costs and lack of insurance were identified as barriers to accessing healthcare in multiple focus groups in the Central region.

Self-reported use of preventive care

Lack of insurance may impact access to lifesaving cancer screenings, immunizations, and other preventive care. Routine cancer screenings may help prevent premature death from cancer and it may reduce cancer morbidity since treatment for earlier-stage cancers is often less aggressive than treatment for more advanced-stage cancers.[54] Overall rates of self-reported cancer screenings vary greatly across Chicago and suburban Cook County compared to the rates for Illinois and the U.S. This could represent differences in access to preventative services or difference in knowledge about the need for preventative screenings.

[54] National Institutes of Health – National Cancer Institute. (2016). Cancer Screening Overview. http://www.cancer.gov/about-cancer/screening/hp-screening-overview-pdq

Figure 10.1. Self-reported use of preventive care

Self-reported lack of preventive care				
	Suburban Cook County (2012)	**Chicago (2014)**	**Illinois (2013)**	**United States (2013)**
Cervical Cancer Screening	16%	20%	23%	22%
Colorectal Cancer Screening	46%	53%	24%	N/A
Breast Cancer Screening	42%	29%	27%	27%

Data Source: Behavioral Risk Factor Surveillance System and Healthy Chicago Survey

Vaccination is another important preventive measure. The CDC recommends that all adults aged 65 or older receive the pneumococcal vaccine. Approximately one-third (30%) of Chicago residents aged 65 or older reported that they had not received a pneumococcal vaccination in 2014.

Figure 10.2. Self-reported pneumococcal vaccination among adults 65+

Self-reported lack of preventive care				
	Suburban Cook County (2012)	**Chicago (2014)**	**Illinois (2013)**	**United States (2013)**
Lack of Pneumococcal Vaccination (65+)	N/A	30%	31%	53%

Data Source: Behavioral Risk Factor Surveillance System and Healthy Chicago Survey

Health education about routine preventive care was specifically mentioned in three of the focus groups as a need in their communities. Parents, youth, and immigrants were identified as populations that are more likely to not have information about how and where to seek out preventive services.

Provider availability

A large percentage of adults reported that they do not have at least one person that they consider to be their personal doctor or healthcare provider. In the U.S., LGBQIA and transgender youth and adults are less likely to report having a regular place to go for medical care. Regular visits with a primary care provider improves chronic disease management and reduces illness and death.[55] As a result, it is an important form of prevention.

[55] National Institutes of Health. (2005). Contribution of Primary Care to Health Systems and Health. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/

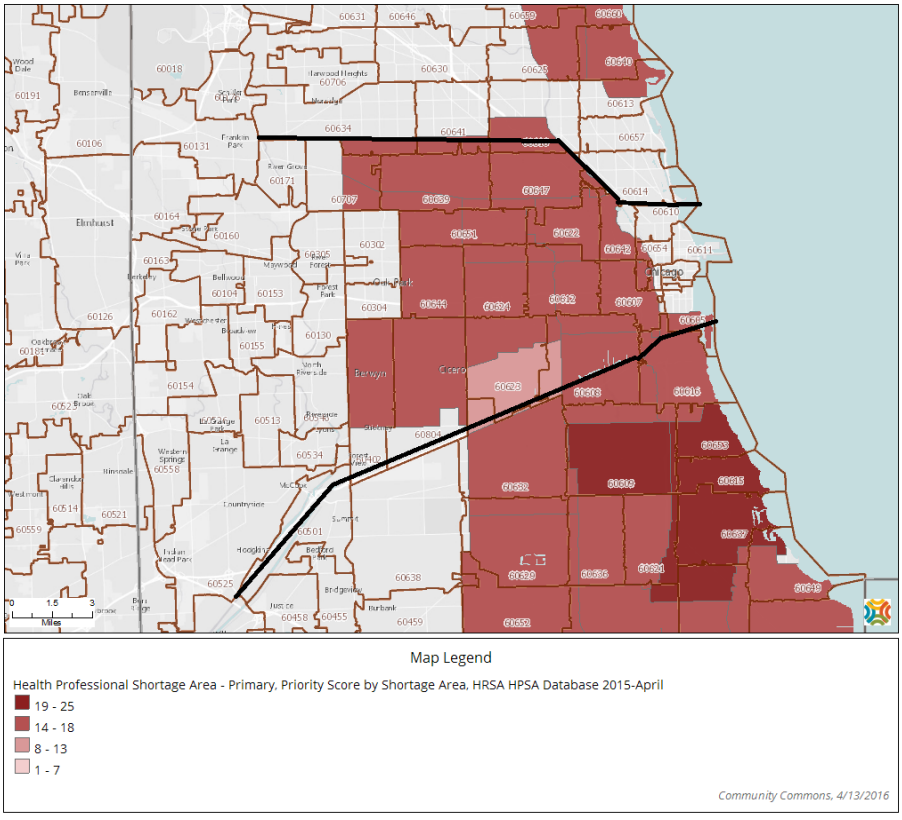
Figure 10.3. Self-reported lack of primary care

Self-reported lack of a consistent source of primary care, 2013				
	Suburban Cook County (2012)	Chicago (2014)	Illinois (2013)	United States (2013)
Lack of consistent source of primary care	13%	19%	12%	23%

Data Source: Behavioral Risk Factor Surveillance System and Healthy Chicago Survey

Health Professional Shortage Areas are designated by the Health Resources and Services Administration (HRSA) as areas having shortages of primary care, dental care, or mental health providers. Each shortage area is assigned a score based on factors such as geography (a county or service area), population characteristics (e.g., low-income or Medicaid eligible), or the presence of different types of facilities (e.g., federally qualified health centers, or state or federal prisons).[56] The shortage areas with the highest scores are the ones with the greatest need for health professionals, services, or facilities. There are several communities in the Central region that are designated as primary care health professional shortage areas as shown in Figure 10.4. Mental health professional shortage is also a critical aspect of access to healthcare.

Figure 10.4. Map of primary care provider shortage areas in the Central region, 2015



Data Source: Health Resources and Services Administration, Health Professional Shortage Area Database, 2015

[56] U.S. Department of Health and Human Services Administration – Health Resources and Services Administration. (2016). http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx

Multiple focus groups mentioned that continued funding cuts and the current State budget crisis are further reducing much needed community-based health resources. Participants stated that individuals with mental illness, individuals living with intellectual disabilities, formerly incarcerated individuals, diverse racial and ethnic groups, and immigrants have the least amount of access to healthcare resources.

Prenatal care

Access to prenatal care is an important preventive measure to reduce the risk of pregnancy complications, reduce the infant's risk for complications, reduce the risk for neural tube defects, and help ensure that the medications women take during pregnancy are safe.[57] Nearly 20% of women in Illinois and suburban Cook County do not receive prenatal care prior to the third month of pregnancy or receive no prenatal care. (Recent comparable data for the City of Chicago was not available at the time this report was produced.)

Figure 10.5. Prenatal care

Number of births to mothers with inadequate prenatal care (per 100 live births), 2008-2012			
	Suburban Cook County	**Illinois**	**United States**
Number of births to mothers that lacked prenatal care (per 100 live births)	18.6	19.0	19.3

Data Source: Illinois Department of Public Health, 2008-2012

Cultural competency and humility

As detailed in the community description presented earlier in this report, the Central region of the Health Impact Collaborative of Cook County is home to diverse racial and ethnic populations including many immigrants and limited English speaking populations. Focus group participants in the Central region observed that immigrants are at increased risk for health issues related to isolation, behavioral health, and discrimination and have less access to quality medical care. The importance of culturally and linguistically competent providers across the spectrum of care and prevention programs was mentioned in six of the seven groups. Although language interpretation services are available at hospitals, multiple groups cited long wait times for interpreters and incorrect interpretations of medical terminology as barriers to utilizing those services.

Participants cited lack of sensitivity to cultural differences as a significant issue impacting the health of racial and ethnic groups in the Central region. Several participants stated that a lack of cultural sensitivity can result in unfair treatment and perceptions that hospitals are not welcoming to diverse populations. Undocumented immigrants and linguistically isolated individuals were mentioned as being more vulnerable to poor treatment. Participants recommended sensitivity training for providers and staff to ensure that immigrants feel that

[57] National Institute of Child Health and Human Development. (2013). https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/pages/prenatal-care.aspx

they are treated with dignity and respect; and several representatives of community based organizations emphasized the knowledge and expertise that community-based organizations can contribute related to this work.

A lack of culturally and linguistically competent staff was also cited as a problem in government agencies including local police and emergency responders. ESL participants stated that they had trouble reporting crimes and communicating with police due to language barriers.

Focus group participants pointed to support and expansion of existing language programs like ESL courses as a potential opportunity to improve immigrant community health. Representation in local government and assistance in understanding various government offices were also mentioned as avenues for improving immigrant health.

Conclusion – Reflections on Collaborative CHNA

The members of the Health Impact Collaborative of Cook County have worked together to accomplish many things over the past 18 months. In the second largest county in the country - with a population of more than 5 million - 26 hospitals, 7 health departments, and over 100 community partners came together to complete a comprehensive community health needs assessment. The MAPP assessments produced robust data from various perspectives including health status and health behaviors, forces of change, public health system strengths and weaknesses, and perceptions and experiences from diverse and often underserved community populations. A focus on health equity, community input, stakeholder engagement, and collaborative leadership and decision making have been some of the hallmarks of the process thus far. The CHNA process engaged diverse groups of community residents and stakeholders. The input from those community partners has been invaluable in identifying and understanding the priority community health issues that we need to address collectively for meaningful impact. All of the issues prioritized by the Health Impact Collaborative of Cook County are issues that cannot be addressed by any one organization alone.

Leveraging the continued participation of community stakeholders invested in health equity and wellness, including actively identifying and engaging new partners, will be essential for developing and deploying aligned strategic plans for community health improvement in the following priority areas:

1. Improving social, economic, and structural determinants of health while reducing social and economic inequities.
2. Improving mental health and decreasing substance abuse.
3. Preventing and reducing chronic disease (focused on risk factors – nutrition, physical activity, and tobacco).
4. Increasing access to care and community resources.

To be successful, the Health Impact Collaborative will continue to partner with health departments across Chicago and Cook County to adopt shared and complimentary strategies and leverage resources to improve efficiencies and increase effectiveness for overall improvement. Data sharing across the health departments was instrumental in developing this CHNA and will continue to be an important tool for establishing, measuring, and monitoring outcomes. Further, the shared leadership model driving the CHNA will continue to balance the voice of all partners in the process including the hospitals, health department, stakeholders, and community members.

Driven by a shared mission and a set of collective values, the Health Impact Collaborative will work together to develop implementation plans and collaborative action to achieve the shared vision of improved health equity, wellness, and quality of life across Chicago and Cook County. The CHNA process has developed a solid foundation for health equity collaboration and has opened the door for many opportunities moving forward. The

developmental evaluation funded by the Robert Wood Johnson Foundation is helping to document process strengths and improvement opportunities as well as understand and measure specific foundational elements necessary to develop a strong collective impact model. The Regional Leadership Teams and Stakeholder Advisory Teams look forward to building on the momentum, working in partnership with diverse community stakeholders at regional and local levels to address health inequities and improve community health across Chicago and Cook County.