Health Impact Collaborative of Cook County

Working together for healthy communities.

Health Impact Collaborative of Cook County

Community Health Needs Assessment South Region

June 2016

Participating hospitals and health departments:

- Advocate Children's Hospital
- Advocate Christ Medical Center
- Advocate South Suburban Hospital
- Advocate Trinity Hospital
- Chicago Department of Public Health
- Cook County Department of Public Health
- Illinois Public Health Institute
- Mercy Hospital and Medical Center
- Provident Hospital - Cook County Health and Hospital System
- Roseland Community Hospital
- Park Forest Health Department
- Stickney Public Health District

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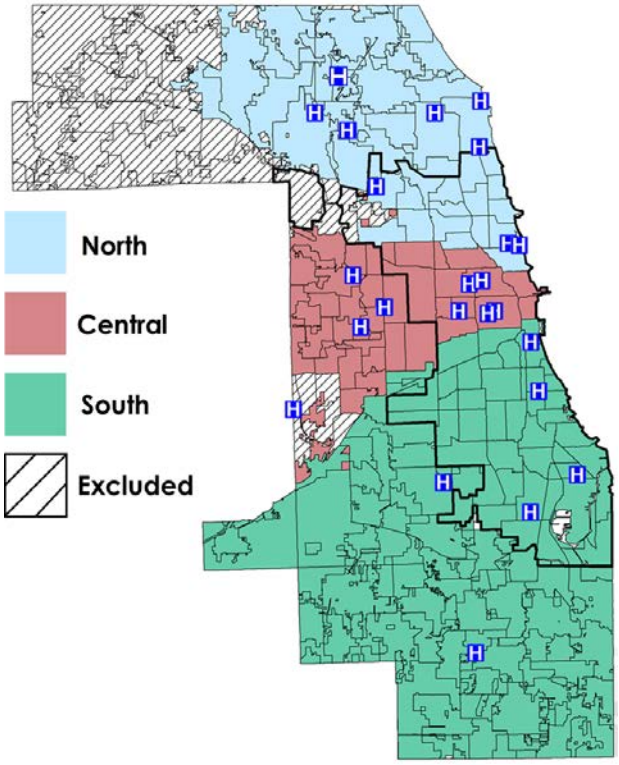
Executive Summary – South Region

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 nearly 100 community organizations across Chicago and Cook County are partners in the Health Impact Collaborative. The Illinois Public Health Institute (IPHI) is serving as the process facilitator and backbone organization for the collaborative CHNA and implementation planning processes.



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 Chicago community areas 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 improvement in the future.

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

This CHNA report is for the South region of the Health Impact Collaborative of Cook County. As of the 2010 census, the South region had 2,081,036 residents which represents a 5% decrease in total population from the year 2000. Non-Hispanic whites and non-Hispanic blacks experienced the largest population decreases. Between 2000 and 2010 the non-Hispanic white population decreased by 163,693 residents and the non-Hispanic black population decreased by 65,704 residents. Despite an overall population decrease in the South region from 2000 to 2010, the Hispanic/Latino and Asian populations increased by 86,747 and 15,846 residents, respectively, during the same time period. Children and adolescents represent more than a quarter (26%) of the population in the South region. The majority of the population is between ages 18 and 64 and approximately 12% of the population is older adults aged 65 and over. Overall, the South 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

Six nonprofit hospitals, one public hospital, four health departments, and approximately 30 stakeholders partnered on the CHNA for the South region. The participating hospitals are Advocate Christ Medical Center and Children's Hospital, Advocate South Suburban Hospital, Advocate Trinity Hospital, Mercy Hospital and Medical Center, Provident Hospital of Cook County, and Roseland Community Hospital. Health departments are key partners in leading the Health Impact Collaborative and conducting the CHNA. The participating health departments in the South region are Chicago Department of Public Health, Cook County Department of Public Health, Park Forest Health Department, and Stickney Health Department.

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 has met monthly during the assessment phase to provide input at every stage and to engage in consensus-based decision making. Additional opportunities for stakeholder engagement during assessment have 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, uninsured, 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 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 2,250 of the surveys were collected from residents in the South region. The survey was disseminated in four languages and was available in paper and online formats. Between October 2015 and March 2016, IPHI conducted eight focus groups in the South region. Focus group participants were recruited from populations that are typically underrepresented in community health assessments including diverse racial and ethno-cultural groups; immigrants; limited English speakers; families with children; older adults; lesbian, gay, bisexual, queer, intersex, and asexual (LGBQIA) individuals; transgender individuals; formerly incarcerated adults; individuals living with mental illness; and veterans and former military.

[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 South, Central, 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, with a focus 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 healthcare, lack of education, 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 most of the 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 Americans, Hispanic/Latinos, and Asians have higher rates of poverty than non-Hispanic whites and lower annual household incomes. More than half (54%) of children and adolescents in the South region live at or below the 200% 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 South region from 2009 to 2013 was 17% 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 overall high school graduation rates in the South region (83%) are only slightly lower than the state and national averages of 85% and 84%, respectively. However, the high school graduation rates for the South region (83%) are substantially lower than those in neighboring DuPage (94%) and Will (91%) counties.
Housing and transportation. Many residents indicated poor housing conditions in the South region and a lack of quality affordable housing that leads to cost-burdened households, crowded housing, and homelessness. There are inequities in access to public transportation options and transportation services for multiple communities in the city and suburbs of the South 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 South region. The South region is particularly vulnerable to natural and manmade disasters and disease outbreaks due to its areas of high economic hardship and low economic opportunity. In addition, vacant or foreclosed housing has contributed to the long-term economic decline and divestment in the South region and has caused a noticeable increase in crime.
Safety and Violence. Firearm-related and homicide mortality are highest among Hispanic/Latinos and African American/blacks in the South region. Police violence, gang activity, drug use/drug trafficking, intimate partner violence, child abuse, and robbery were some of the safety concerns identified by residents in the South region. The South and Central regions of the collaborative are 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 South 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 South 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 and this 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 South 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 South region. Focus group participants and survey respondents in the South region reported stigma, cost or lack of insurance, lack of knowledge about where to get services, and wait times for treatment as barriers to accessing needed mental health treatment. Community survey respondents from the South region indicated that 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, 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 South 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 South region.

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

Chronic disease prevention was another strategic issue that arose in all the assessments. The number of individuals in the U.S. who are living with a chronic disease is projected to

[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

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 health environments and policies supporting healthy eating and active living. Nearly half (47%) of community survey respondents in the South region indicated challenges in availability of healthy foods in their community. Nearly a third (30%) of survey respondents reported few parks and recreation facilities in their communities, and 47% 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 (84.9%) and Chicago (70.8%) self-report eating less than five daily servings of fruits and vegetables a day. In addition, more than a quarter of adults in suburban Cook County (28%) and Chicago (29%) report not engaging in physical activity during leisure times. 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 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 South region are heart disease, cancer, and stroke. There are stark disparities in chronic-disease related mortality in the South 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.[6] Disparities in access to care and community resources were identified as underlying root causes of many of the health inequities experienced by residents in the South region. 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.

[5] Anderson, G. & Horvath, J. (2004). The growing burden of chronic disease in America. *Public Health Reports,* 119, 263-270.
[6] 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 South region and Stakeholder Advisory Team members emphasized that cultural and linguistic competence and humility are key aspects of access to quality healthcare and community services. Participants in six of eight focus groups in the South region cited lack of sensitivity to cultural difference as a significant issue impacting health of diverse racial and ethnic groups in the South region.
Insurance coverage. Aggregated rates from 2009 to 2013, show that 23% of the adult population age 18-64 in the South 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%) compared to women (14%). In addition, ethnic and racial minorities are much more likely to be uninsured compared to non-Hispanic whites. In 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 compared to the rates for Illinois and the U.S. 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. Nearly 20% of adults in Chicago report that they do not have at least one person that they consider to be their personal doctor or healthcare provider. In addition, 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 South region that are classified by the Health Resources and Services Administration as areas 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 do not receive prenatal care prior to the third month of pregnancy or receive no prenatal care.

Introduction

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

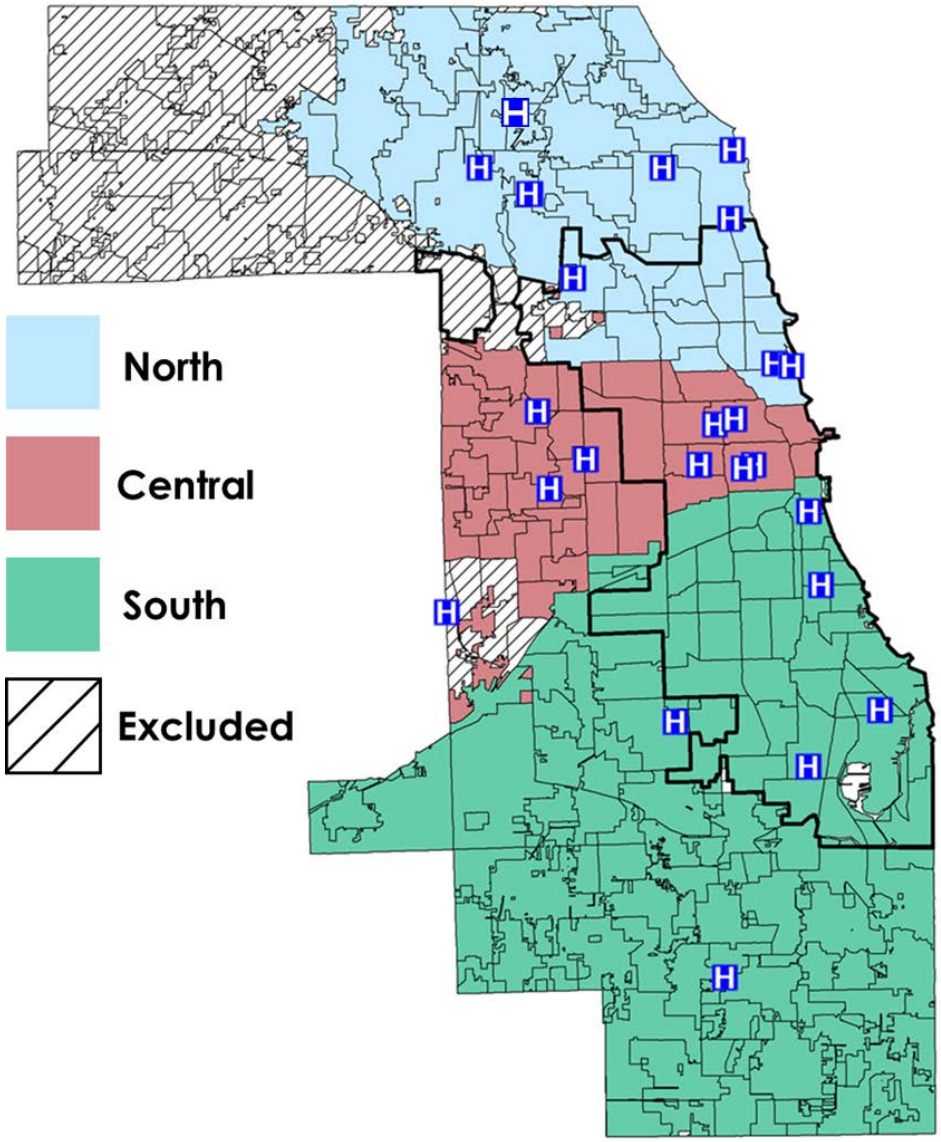
In addition to providing health coverage for millions of uninsured people in the U.S., the Affordable Care Act includes a number of components designed to strengthen the healthcare delivery system's focus on prevention and keeping people healthy rather than simply treating people who are ill. One component 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.[7] 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 **South** region. Similar reports will be available for the North and Central regions of the county at www.healthimpactcc.org/reports2016 by summer 2016.

[7] 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

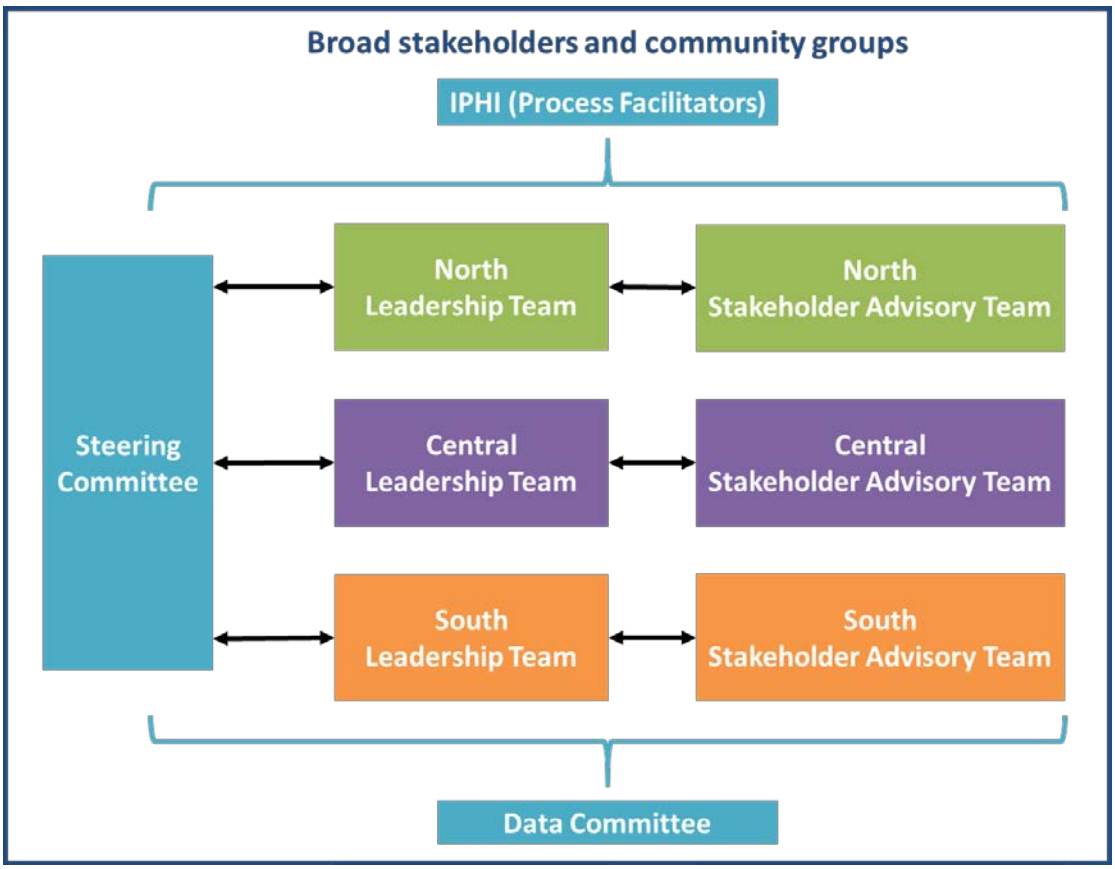


**Advocate Lutheran General Hospital and Advocate Children's Hospital – Park Ridge are located at the same address and represented by a single icon*

***Northshore University HealthSystem Highland Park Hospital is participating in the collaborative although it is located outside Cook County*

Six nonprofit hospitals, one public hospital, four health departments, and approximately 30 stakeholders are collaborating partners on the South region CHNA for Chicago and suburban Cook County. The participating hospitals are Advocate Christ Medical Center and Advocate Children's Hospital, Advocate South Suburban Medical Center, Advocate Trinity Hospital, Mercy Hospital and Medical Center, Provident Hospital of Cook County, and Roseland Community Hospital. Health departments are key partners in leading the Health Impact Collaborative and conducting the CHNA. The participating health departments in the South region are Chicago Department of Public Health, Cook County Department of Public Health, Park Forest Health Department, and Stickney Health Department.

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 South 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 South Stakeholder Advisory Team includes representatives of diverse community organizations from across the South Side of Chicago and South Cook suburbs. Members of the Stakeholder Advisory Team are 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 South Stakeholder Advisory Team are listed in Figure 2.3.

Figure 2.3. South Stakeholder Advisory Team as of March 2016

South Region Stakeholder Team Members
AERO Special Education Cooperative
Arab American Family Services
Aunt Martha's
Calumet Area Industrial Commission
Cancer Support Center
Chicago Hispanic Health Coalition
Chinese American Service League
Christian Community Health Center
Claretian Associates
Consortium to Lower Obesity in Chicago Children (CLOCC)
Crossroads Coalition
Cure Violence / CeaseFire
Family Christian Health Center
Healthcare Consortium of Illinois
Health Care Rotary / Oak Lawn
Healthy Schools Campaign
Human Resources Development Institute (HRDI)
Illinois Caucus for Adolescent Health
Metropolitan Tenants Organization
National Alliance on Mental Illness (NAMI) South Suburban
PLOWS Council for Aging
Salvation Army Kroc Center
Southland Chamber of Commerce - Healthcare Committee
Southland Hispanic Leadership Council
South Suburban College
South Suburban PADS
South Suburban Mayors and Managers Association

Formation of the South Stakeholder Advisory Team

Between March and May 2016, the Illinois Public Health Institute (IPHI) worked with the participating hospitals and health departments in the South region of Cook County (i.e., South 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 Hispanic/Latinos, African Americans, Asians, and Eastern Europeans; youth; older adults; homeless individuals; individuals with mental illness; unemployed; 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 South 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.

The South Stakeholder Advisory Team provided input at every stage of the assessment and was instrumental in shaping the assessment findings and priorities issues that are presented in this report. The South Stakeholder Advisory Team met with the participating hospitals and health departments (i.e., South 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.

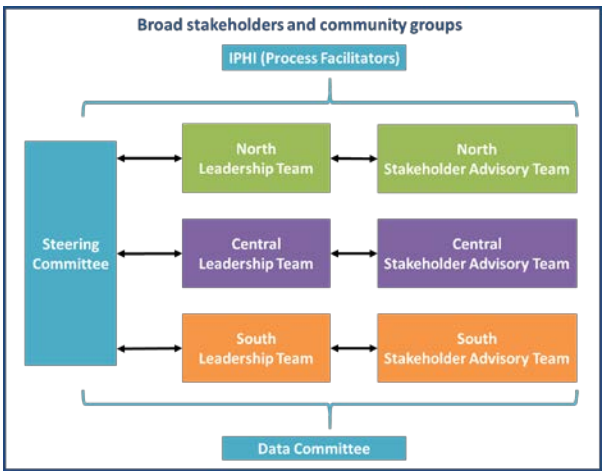
Figure 2.4. Stakeholder Wheel

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

South 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 South 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 South Leadership Team held monthly planning calls with IPHI and monthly in-person meetings with stakeholders. The South region lead is the Lead Community Health Consultant from Advocate Health Care.

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 South 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 diverse 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 South 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 conducted a collaborative CHNA between February 2015 and June 2016. IPHI designed and facilitated 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 for 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)

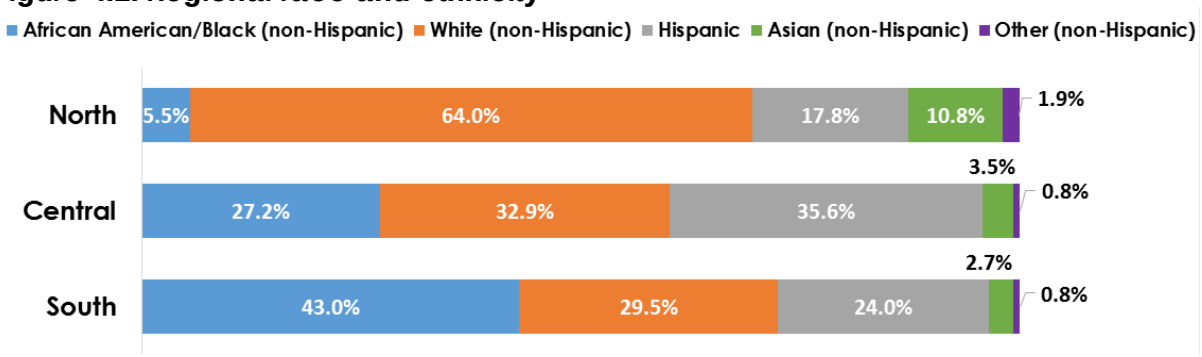
The Key Findings sections of this report highlight key assessment data and findings from the four MAPP assessments. As part of continuing efforts to align and integrate community health assessment across Chicago and Cook County, the Health Impact Collaborative leveraged recent assessment data from local 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 South Stakeholder Advisory Team, and data from the Community Health Status Assessments was also incorporated into the data presentation for this CHNA. See pages 26-32 for description of the assessment methodologies used in this CHNA.

Community Description for the South Region

The South region of the Health Impact Collaborative of Cook County includes approximately 30 community areas in Chicago and 50 municipalities in suburban Cook County. In the 2010 census, the South region had 2,081,036 compared to 2,213,031 residents in the 2000 census. The total land areas encompassed by the South region is roughly 495 square miles and the population density in the region is approximately 4,471 residents per square mile based on the 2010 census data.[8]

Non-Hispanic African American/blacks make up the largest racial or ethnic group in the South region, representing 43% of the population. Compared to the North and Central regions, the South region has the highest percentage of African American/black individuals. Approximately 29.5% of individuals in the South region identify as white and 24.0% as Hispanic/Latino. A relatively small percentage of the South region's population is Asian (2.7% as of 2010). However, the Asian population is experiencing significant growth with an increase of 15,846 Asian residents (32% increase) between 2000 and 2010 in the South region. The Hispanic/Latino population is also experiencing significant growth with a 21% increase (86,747 residents) in population size between 2000 and 2010.

Figure 4.1. Regional race and ethnicity



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

Although African American/blacks are the largest population group in the South region, they are experiencing large population decreases (See Figures 4.2) across Chicago and suburban Cook County. In the South region, the African American population decreased by 7% (65,704 individuals) from 2000 to 2010.

Figure 4.2. Population change in race/ethnicity between 2000 and 2010, South region

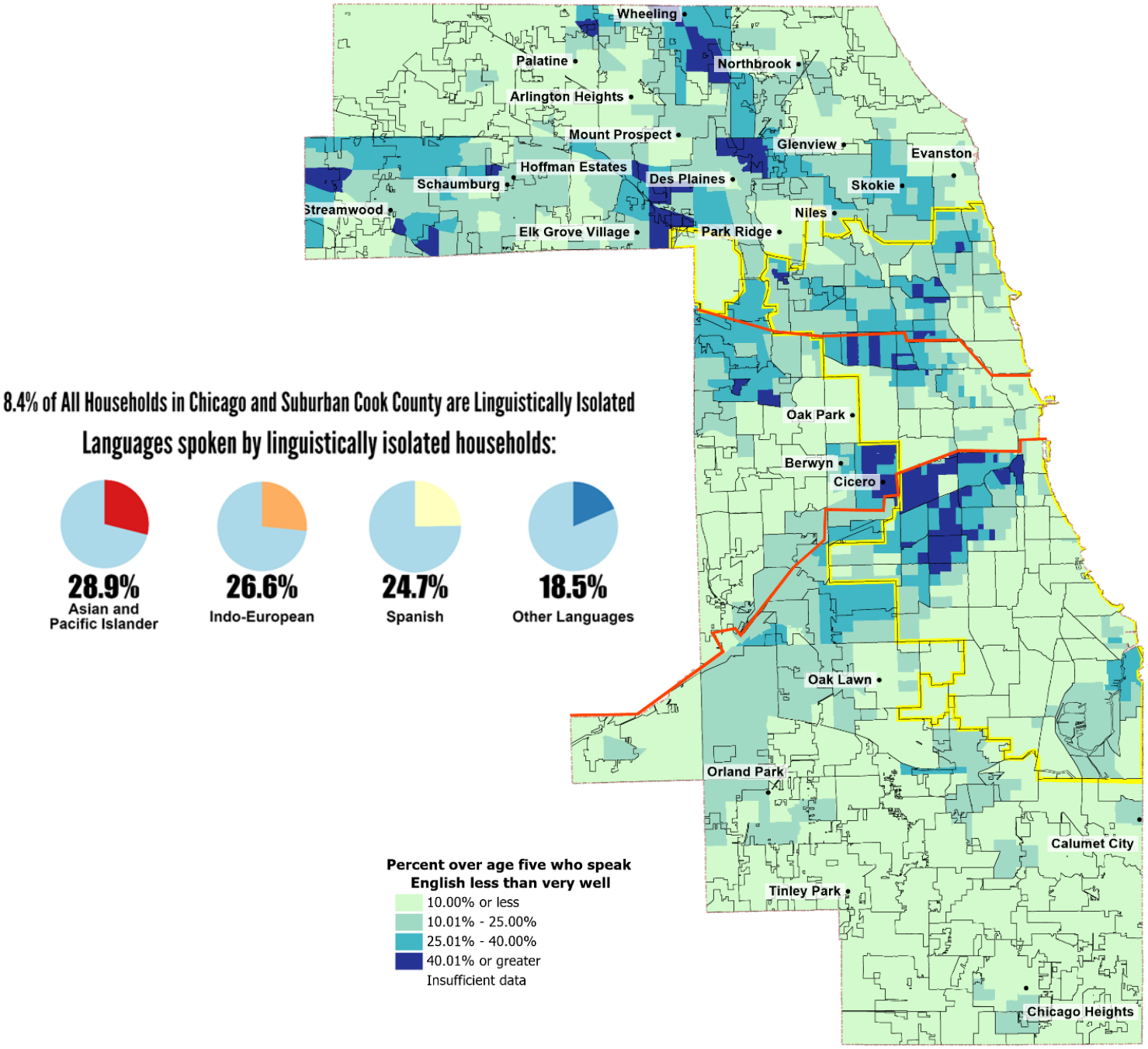
Race/Ethnicity	2010 Population	2000 Population	Change in Population	Percent Change in Population
African American/black (non-Hispanic)	872,226	937,930	-65,704	-7%
White (non-Hispanic)	619,507	783,200	-163,693	-21%
Hispanic/Latino	498,264	411,517	+ 86,747	21%
Asian (non-Hispanic)	66,146	50,300	+ 15,846	32%

Data Source: U.S. Census Bureau 2010 Census

[8] 2010 Decennial Census and American Communities Survey, 2010-2014.

Two important metrics provide a picture of recent immigrant populations that speak languages other than English: percent of the population who report limited English proficiency and linguistically isolated households. Within the South 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."

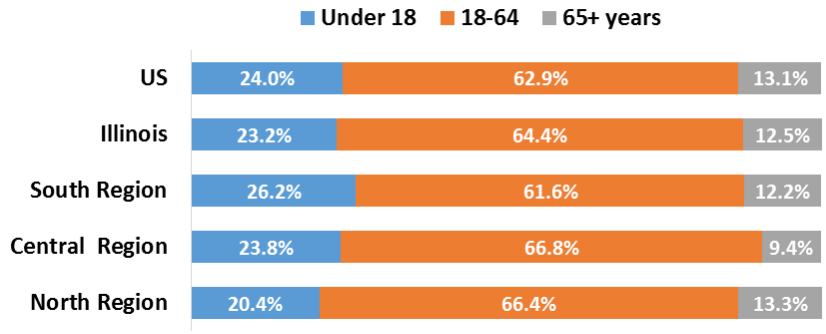
Figure 4.4. Limited English Proficiency, 2009-2013



Data Source: American Communities Survey, 2009-2013

Children and adolescents under 18 represent more than a quarter (26.2%) of the population in the South region. Approximately 62% of the population is 18 to 64 years old and about 12% are older adults age 65 and over.

Figure 4.5. Age distribution of residents, by region, Chicago and suburban Cook County, 2010



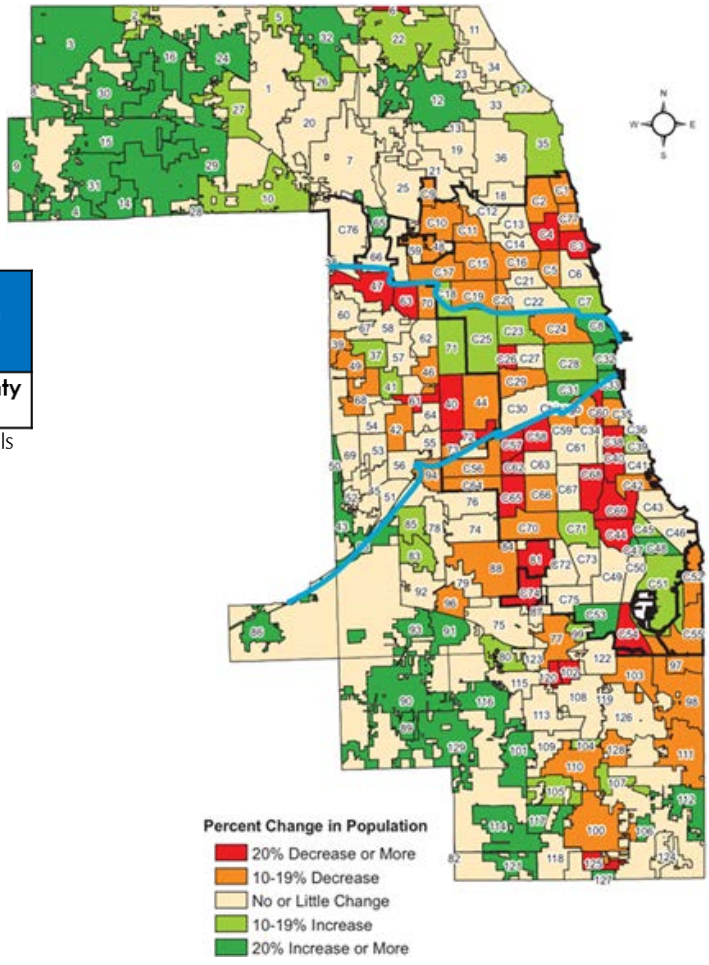
Data Source: U.S. Census Bureau 2010 Census

The overall population aged 65 and older remained approximately the same between 2000 and 2010. However, several communities in the South region experienced a growth in their older adult population (Figure 4.6.). More assessment data about the community health implications of a growing older adult population can be found on page 47 of this report.

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

Several communities in the South region experienced an increase in the older adult (65+) population between 2000 and 2010

Chicago	Suburban Cook County
• Grand Boulevard • Woodlawn • Greater Grand Crossing • Calumet Heights • Avalon Park • Kenwood • West Pullman • Auburn Gresham	• Country Club Hills • Crestwood • East Hazel Crest • Flossmor • Ford Heights • Glenwood • Lemont • Lynwood • Matteson • Oak Forest • Olympia Fields • Orland Hills • Orland Park • Palos Heights • Palos Park • Richton Park • Tinley Park



Census data show that the population of males and females in Chicago and suburban Cook County 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.[9] It is estimated that approximately 5.7% of Chicago residents identify as lesbian, gay, or bisexual.[10] 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.[11] The demographic characteristics of additional priority population groups are shown in Figure 4.7.

Figure 4.7. Demographic characteristics of key populations in the South 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 12% of the population in the South 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 South region, approximately 100,453 individuals (6% of the population) are classified as veterans.	*American Communities Survey, 2010-2014*

[9] 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

[10] 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

[11] 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[12]

The Health Impact Collaborative of Cook County employed a mixed-methods approach to assessment, utilizing the four MAPP assessments[13] to analyze and consider data from diverse sources to identify significant community health needs for the South 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, so 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.

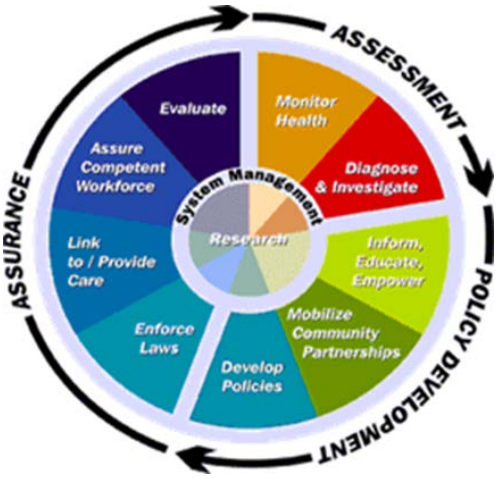
The LPHSA assessments conducted in Chicago and Cook County in 2015 were led by the respective health departments, and each engaged nearly 100 local representatives of various sectors of the public health system including clinical, social services, policy makers, law enforcement, faith-based groups, coalitions,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

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

[13] The MAPP Assessment framework is presented in more detail on page 21 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 the 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 South 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.

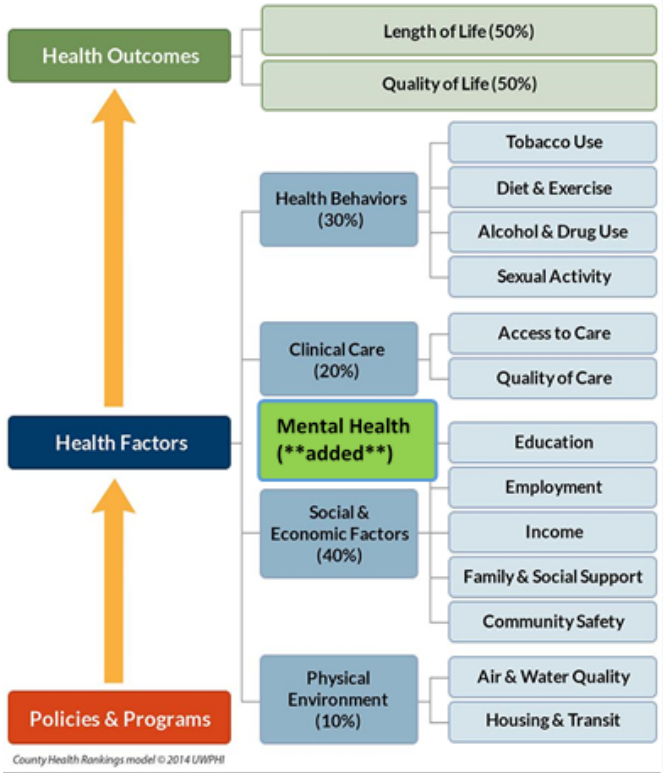
Methods – Community Health Status Assessment

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, laying 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 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 be comprehensive in data collection and analysis 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 South 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 this community input data was to identify issues of importance to 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 in South region

By leveraging its partners and networks, the Collaborative collected approximately 5,200 resident surveys between October 2015 and January 2016, including 2,288 in the South region. The survey was available on paper and online and was disseminated in five languages – English, Spanish, Polish, Korean, and Arabic.[14] 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 a convenience sample survey, distributed by hospitals and community-based organizations through targeted outreach to diverse communities in Chicago and Cook County, with a particular interest in reaching low income communities and diverse racial and ethnic groups to hear their input into this Community Health Needs Assessment. 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 approximately 12 existing surveys to identify possible questions, and worked iteratively with hospitals, health departments, and stakeholders from the 3 regions to hone in on the most important survey questions. IPHI consulted with the UIC Survey Research Laboratory to refine the survey design. The data from paper surveys was entered into the online SurveyMonkey system 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 survey data tables and charts.

The majority of survey respondents from the South region identified as heterosexual (91%, n=2146) and African American/black (57%, n=2146). Twenty-seven percent (27%) of survey respondents identified as white, 2% Asian/Pacific Islander, and 2% Native American/American Indian.[1] Approximately 25% (n=1651) of survey respondents in the South region identified as Hispanic/Latino and approximately 10% identified as Middle Eastern (n=1651).[1] Two-percent of survey respondents from the South region indicated that they were living in a shelter and 1% indicated that they were homeless (n=2257). The South region had the highest percentage of individuals with less than a high school education (12%, n=2027) compared to the North and Central regions of Cook County, and the majority of respondents from the South region (68%, n=1824) reported an annual household income of less than $40,000.

[14] 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.

Focus Groups - methods and description of participants in South region

IPHI conducted eight focus groups in the South region between October 2015 and March 2016. The collaborative ensured that the focus groups included populations who are typically underrepresented in community health assessments, including racial and ethno-cultural groups, immigrants, limited English speakers, low-income communities, families with children, LGBQIA and transgender individuals and service providers, 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:

1. Understand needs, assets, and potential resources in the different communities of Chicago and suburban Cook County
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 host 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 to accommodate the needs of the participants, and some groups included as many as 25 participants. A description of the focus group participants from the South region is presented in Figure 5.3.

Figure 5.3. Focus groups conducted in the South region.

Focus Groups	Location and Date
Arab American Family Services Participants in the focus group at Arab American Family Services were residents in the South region and staff at the organization. Their clients include Arab American immigrants and families.	Bridgeview, Illinois (12/4/2015)
Chinese American Service League Participants in the focus group at the Chinese American Service League were residents of the Chinatown neighborhood in Chicago and staff at the organization. Their clients include multiple immigrant groups, children, older adults, disabled individuals, and families.	Chinatown, Chicago, Illinois (1/19/2016)
Human Resources Development Institute (HRDI) Participants were clients in HRDI's day programs on the South Side of Chicago. Individuals in the focus group had experienced mental illness at some point in the past and some had previous interactions with the criminal justice system.	West Roseland, Chicago, Illinois (12/15/2015)
National Alliance on Mental Illness (NAMI) South Suburban Participants included the parents, families, and caregivers of adults with mental illness living in South suburban Cook County.	Hazel Crest, Illinois (1/21/2016)
Park Forest Village Hall Community residents, health department staff, service providers, and local government representatives in the South Cook suburbs.	Park Forest, Illinois (11/12/2015)
Sexual Assault Nurse Examiners (SANE) SANE providers serving the South side of Chicago and South suburbs at Advocate South Suburban Hospital.	Hazel Crest, Illinois (12/17/2015)
Stickney Senior Center Participants were older adults participating in the services provided at a senior center in the South Cook suburbs.	Burbank, Illinois (12/3/2015)
Veterans of Foreign Wars (VFW) Post 311 Participants included veterans, retired military, and former military living in the South Cook suburbs.	Richton Park, Illinois (1/28/2016)

There were residents from the South region that participated in focus groups that were conducted in other regions. A focus group in the Austin community area (in the Central region) that was conducted with formerly incarcerated individuals and hosted by the National Alliance for the Empowerment of the Formerly Incarcerated included participants who were residents in the South region. A focus group in the Lakeview community area (in the North region) that was conducted with LGBQIA and transgender individuals and hosted by Howard Brown Health Center also included several participants who were residents in the South region.

Prioritization process, significant health needs, and Collaborative focus areas

IPHI facilitated a collaborative prioritization process that took place in multiple steps. In the South region, the participating hospitals, health departments, and Stakeholder Advisory Team worked together through 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 and 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 South 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 reflection, 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 South region at the March 2016 stakeholder meetings were:

- Social and structural determinants of health
    - With an emphasis on economic inequities, educational inequities, and structural racism
- Healthy environment
    - Including built environment and transportation, environmental contamination, and related health issues
- Mental health and substance use
    - With an emphasis on the connections between mental health and issues related to trauma, 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 addressing barriers to access for low income households, improving health literacy, improving cultural and linguistic competence, and supporting linkages between healthcare and community-based organizations for prevention

Following the South 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 South and Central 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 while reducing social and economic inequities. ***
2. **Improving mental health and decreasing substance abuse.**
3. **Preventing and reducing chronic disease, with a 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 heathcare providers and community-based organizations for prevention

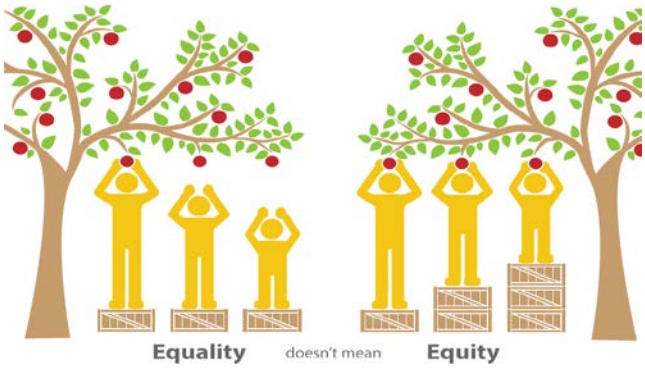
The regional discussions highlighted the relationship between healthy environment, chronic disease, and social and structural determinants of health. As a result, healthy environment is listed under both chronic disease and determinants of health. Participants emphasized the connections between community 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 will start 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.[15, 16] 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.[15]

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.[15] Additionally, social determinants of health often vary by geography, gender, sexual orientation, age, race, disability, and ethnicity.[17] 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.

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

[16] 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/

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

- Suicide rates are highest among American Indians/Alaskan Natives and non-Hispanic whites for both men and women.[17]
- Discrimination against LGBQIA and transgender community members has been linked with high rates of psychiatric disorders, substance use, and suicide.[18]
- Nearly a quarter of immigrants (23%) and 40% of undocumented immigrants are uninsured compared to 10% of U.S. born and naturalized citizens.[19]

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 Americans 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 South region, African Americans 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 teens have much higher birth rates compared to white teens in Chicago and suburban Cook County.
- African American 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 Americans and Hispanics.
- In 2012, the firearm-related mortality rate in the South region (20.4 deaths per 100,000) was more than four times higher than the rate for the North region (4.6 deaths per 100,000). In 2012, the homicide mortality rate in the South region (19.8 deaths per 100,000) was more than six 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 South region as being key drivers of health outcomes.

[18] Healthy People 2020. (2016). Lesbian, Gay, Bisexual, and Transgender Health. https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

[19] 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/

Economic inequities

Socioeconomic factors are the largest determinants of health status and health outcomes.[20] Poverty can create barriers to accessing quality health services, healthy food, and other necessities needed for good health status. [21] Poverty also largely impacts housing status, educational opportunities, the physical environment that a person works and lives in, and health behaviors.[20] 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 32% of children and adolescents live below 100% of the federal poverty level and more than half (57%) of children below 200% of the federal poverty level in the South region. Of the three regions, the South has the highest rates of childhood poverty. Unemployment can create financial instability and as result can create barriers to accessing healthcare services, insurance, healthy foods, and other basic needs.[21] The unemployment rate in the South region is higher (17.0%) compared to the Central (12.1%) and North (8.2%) regions. The unemployment rate in the South region also exceeds the rates for Illinois (10.5%) and the U.S. (9.2%). In the South region and across Chicago and Cook County, African Americans/blacks have a much higher rate of unemployment compared to whites and Asians.

Education inequities

Community residents in the South region often described their local school systems as poorly performing, underfunded, and 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 South region are concerned about abandoned buildings in their communities, potential lead exposure in homes, and the possibility of poor water and air quality. Nearly half (44%) of residents surveyed in the South region indicated one or more problems in their current homes that could have a negative impact on health. Residents also indicated that there is a lack of quality affordable housing in the South region, contributing to homelessness in their communities. Participants also highlighted inequities in access to transportation and access to health foods in the South region.

Inequities in community safety and violence

Violent crime disproportionately affects residents living in communities of color in Chicago and suburban Cook County.[22] In addition, homicide and firearm-related mortality is highest in the South and Central regions and in African American and Hispanic/Latino communities. Community residents in the South region indicated that a lack of positive community policing, gang activity, drug use/drug trafficking, the presence of guns, domestic violence,

[20] Centers for Disease Control and Prevention. (2014). Social Determinants of Health. http://www.cdc.gov/nchhstp/socialdeterminants/faq.html.
[21] American Community Survey, 2010-2014; CommunityCommons.org CHNA Data (2015).
[22] Data Sources for Violent Crime: CDPH 2014, CCDPH 2009-2013, IDPH 2012

child abuse, human trafficking, property crimes (home break-ins, theft, muggings), and poorly maintained foreclosed or vacant properties were some of the primary reasons that they 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, as well as self-harm and suicide attempts.[23]

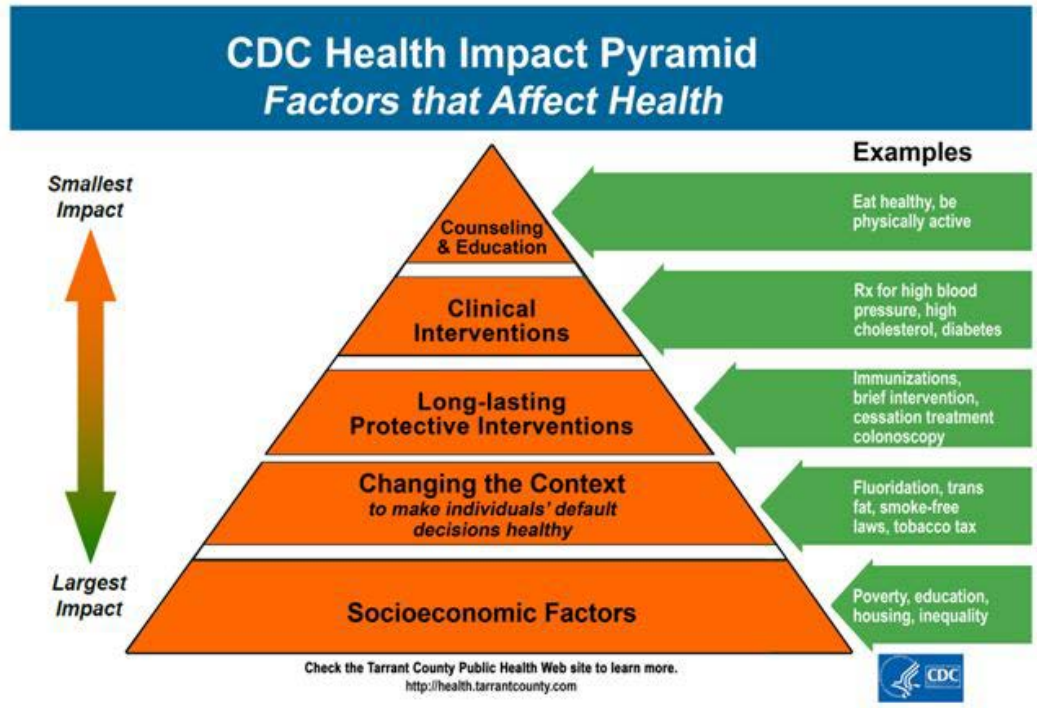
Structural racism

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.[24] Community input indicates that many residents consider the ongoing long-term divestment in the South region, particularly in communities of color, a serious problem. Community residents stated that people belonging to diverse 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).

[23] Mayor, S. (2002). WHO report shows public health impact of violence. *The BMJ,* 325(7367).
[24] 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.

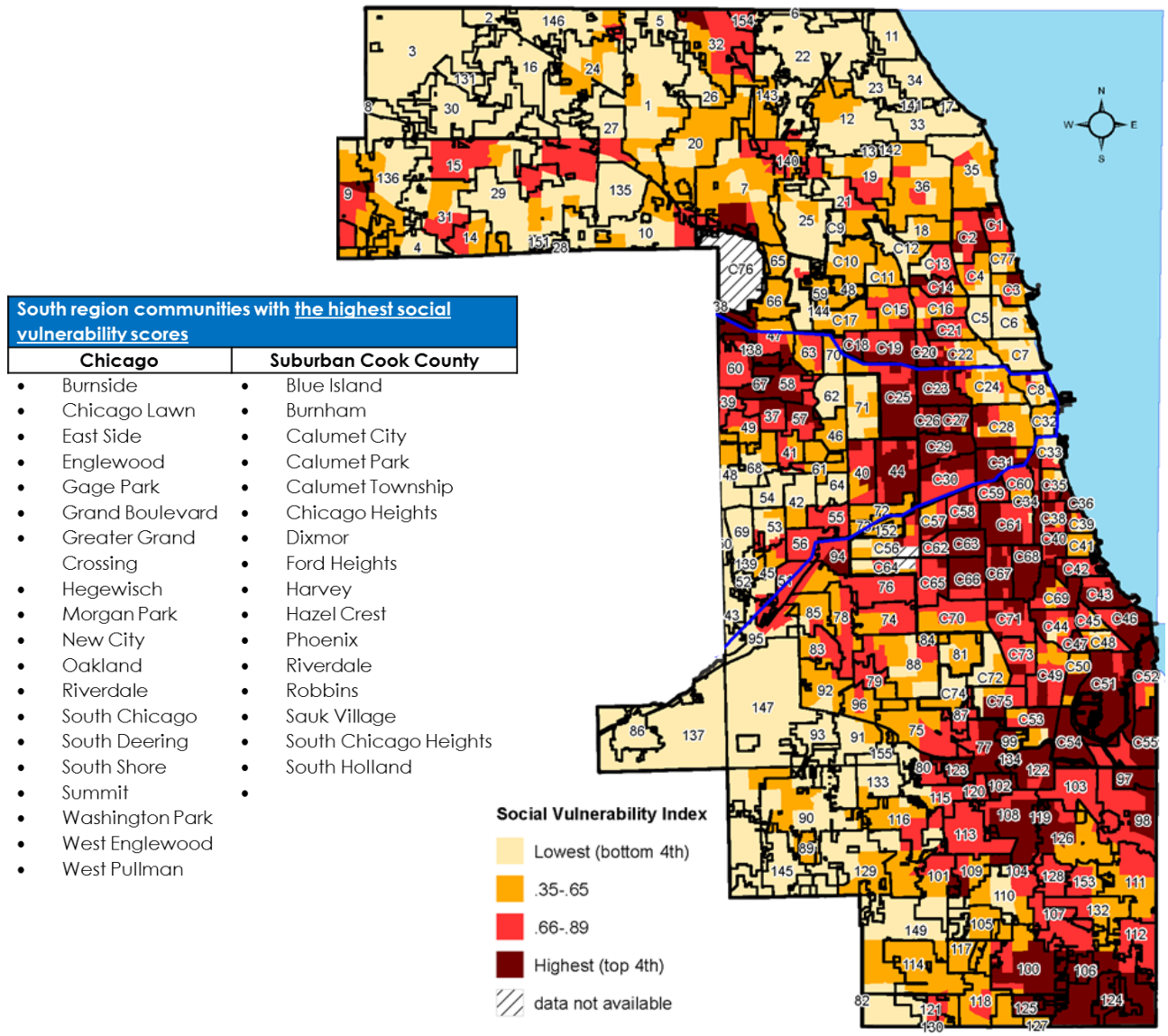
Key Findings: Social, Economic, and Structural Determinants of Health

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 on human health.

Figure 7.3. Social Vulnerability Index by Census Tract, 2010 [25]

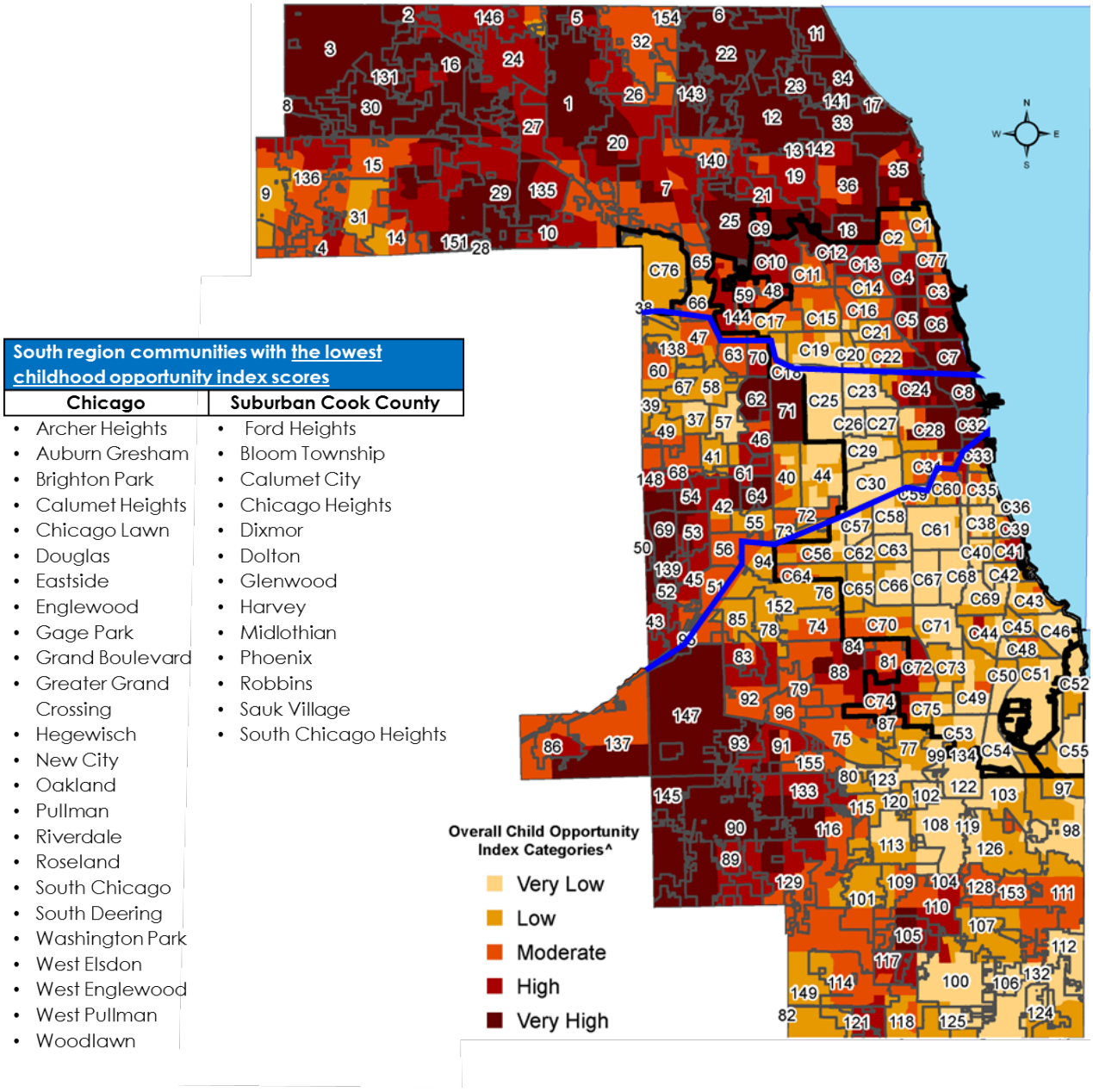


[25] Agency for Toxic Substances and Disease Registry. (2014). The Social Vulnerability Index. http://svi.cdc.gov/

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.[26]

Figure 7.4. Childhood Opportunity Index by Census Tract, 2007-2013



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

Poverty, Economic, and Education Inequity

Poverty

Poverty can create barriers to accessing health services, healthy food, and other necessities needed for good health status.[21] It can also affect housing status, educational opportunities, an individual's physical environment, and health behaviors.[21] 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.[27]

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.

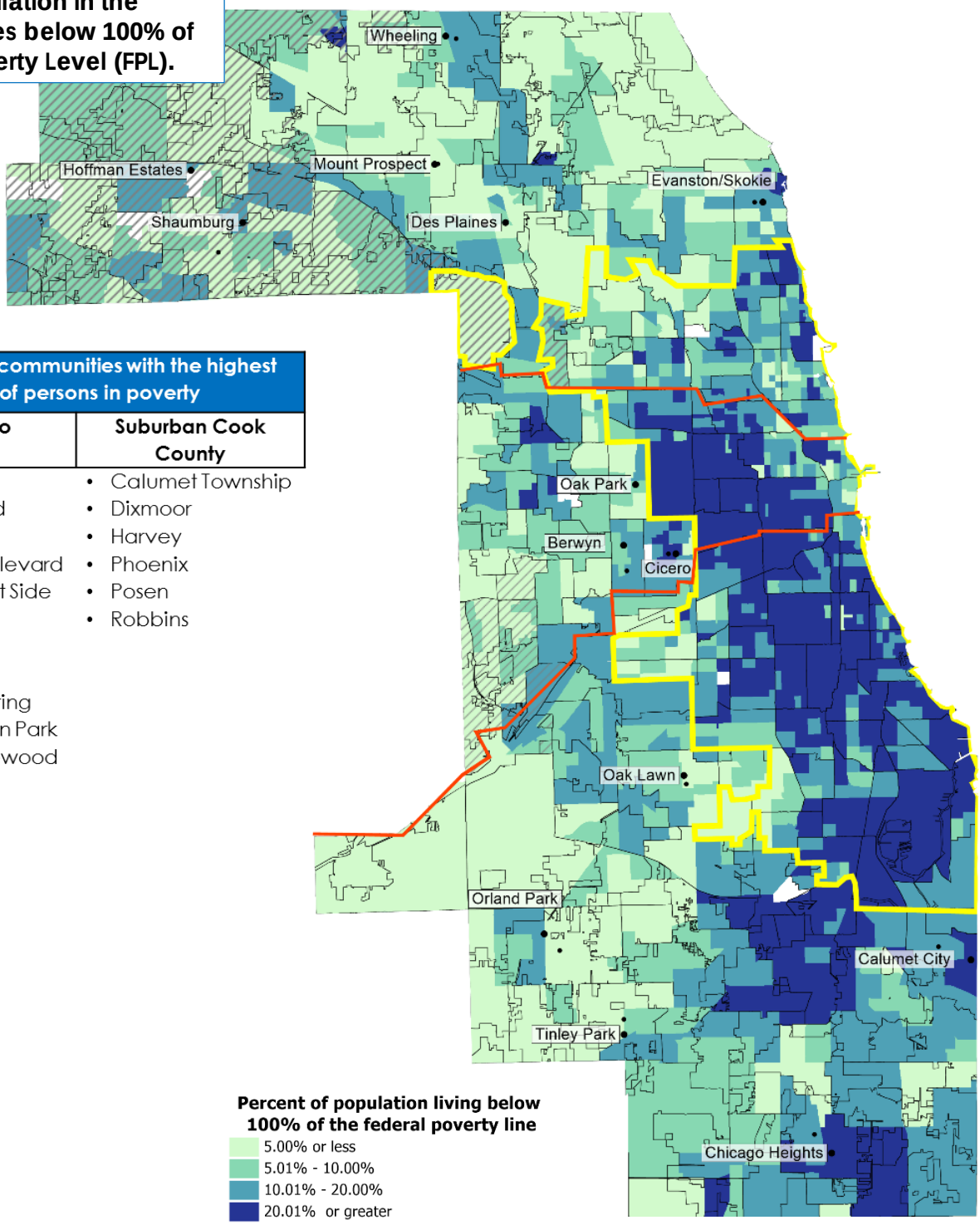
The FOCA results were echoed in the eight focus groups conducted in the South region. Focus group participants identified poor economic growth and unemployment, long-term divestment in the South region, lack of vocational education opportunities, and a lack of job and workforce development as some of 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 Americans, 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 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.

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

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

20% of the population in the South region lives below 100% of the Federal Poverty Level (FPL).

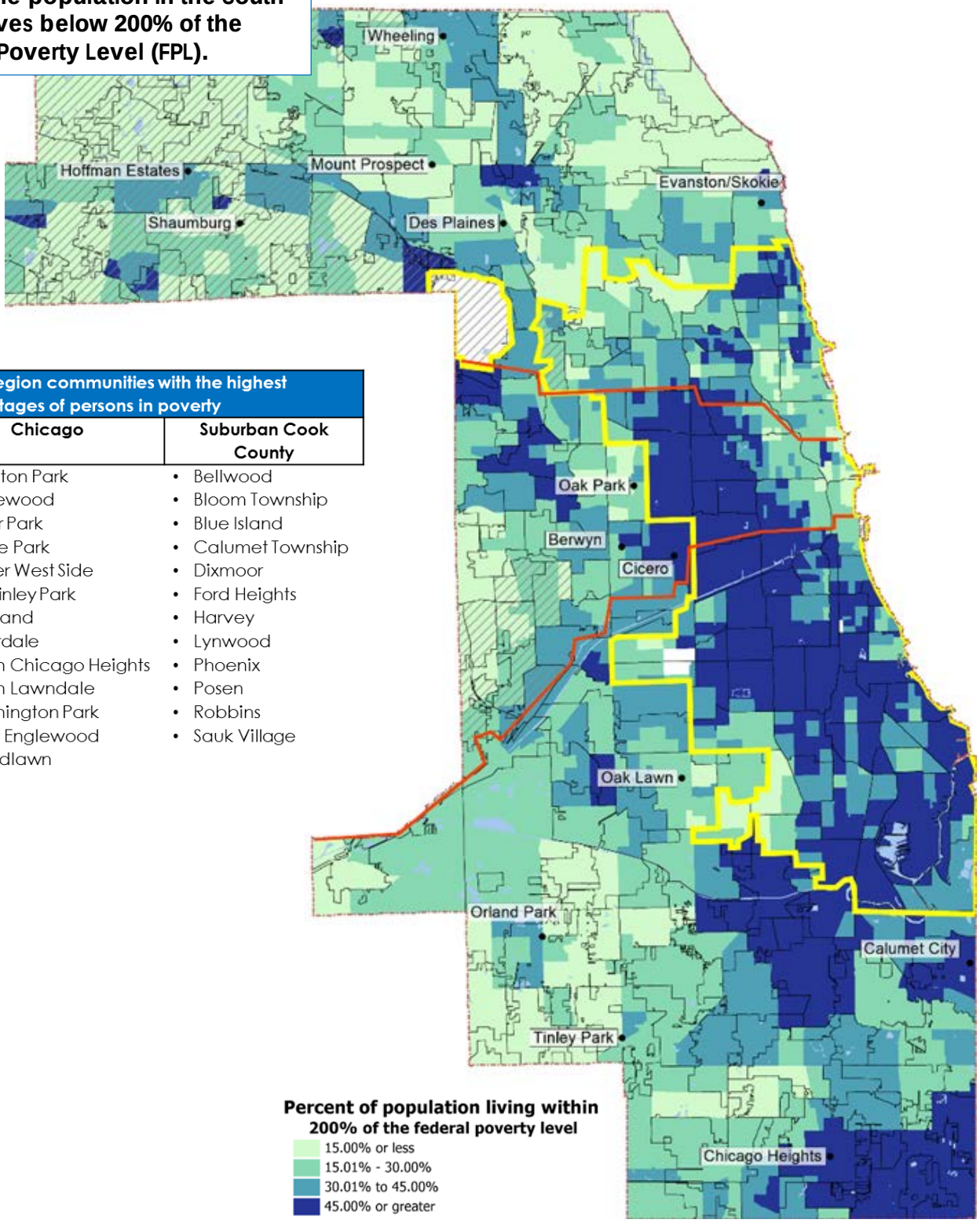


South region communities with the highest percentages of persons in poverty	
Chicago	**Suburban Cook County**
• East Side • Englewood • Fuller Park • Grand Boulevard • Lower West Side • New City • Oakland • Riverdale • South Deering • Washington Park • West Englewood	• Calumet Township • Dixmoor • Harvey • Phoenix • Posen • Robbins

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

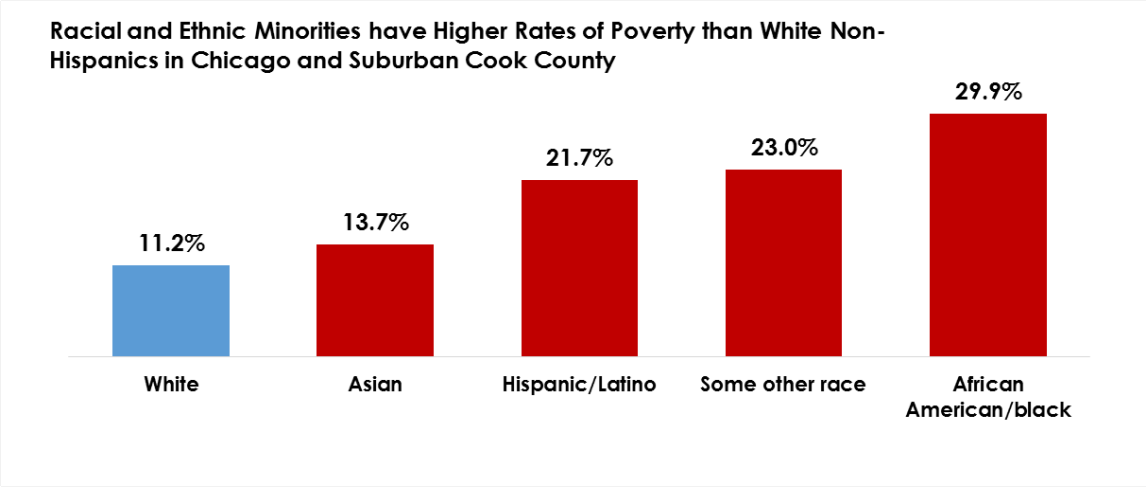
43% of the population in the South region lives below 200% of the Federal Poverty Level (FPL).



South region communities with the highest percentages of persons in poverty	
Chicago	**Suburban Cook County**
• Brighton Park	• Bellwood
• Englewood	• Bloom Township
• Fuller Park	• Blue Island
• Gage Park	• Calumet Township
• Lower West Side	• Dixmoor
• McKinley Park	• Ford Heights
• Oakland	• Harvey
• Riverdale	• Lynwood
• South Chicago Heights	• Phoenix
• South Lawndale	• Posen
• Washington Park	• Robbins
• West Englewood	• Sauk Village
• Woodlawn	

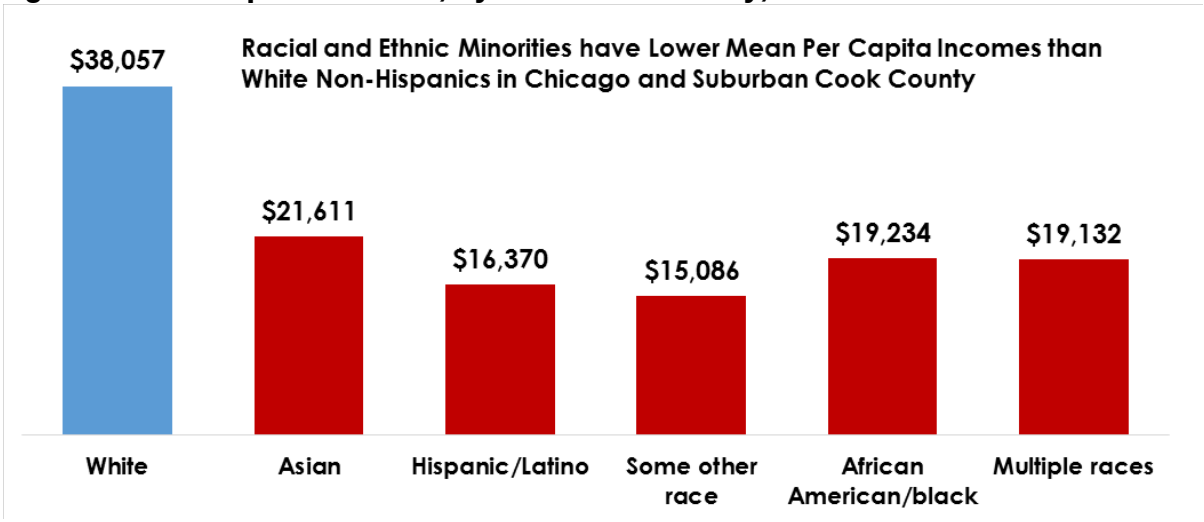
Data Source: American Communities Survey, 2009-2013

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[28], 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 in poverty is higher for Cook County than it is for Illinois and the U.S., and African American and Latino children have much 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 South region having low or very low economic opportunity.

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

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

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.[29] 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

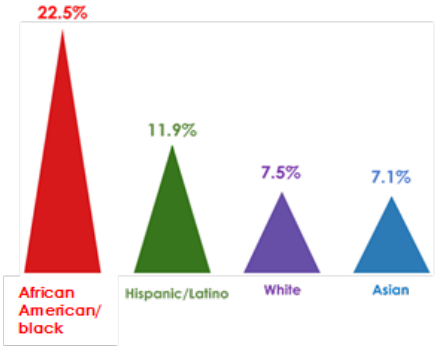
Opportunities to address these potential issues in Chicago and suburban Cook County include creating age-friendly cities and communities.

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 Americans 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 in the South region is high (17.0%) compared to the Central (12.1%) and North (8.2%) regions. The unemployment rate in the South region also exceeds the rates for Illinois (10.5%) and the U.S. (9.2%). Only 7% of respondents to the community resident survey from the South region reported that there were "a lot" or "a great deal" of good jobs in their communities. In addition, 24% respondents indicated that job training and adult education in their communities were inadequate.

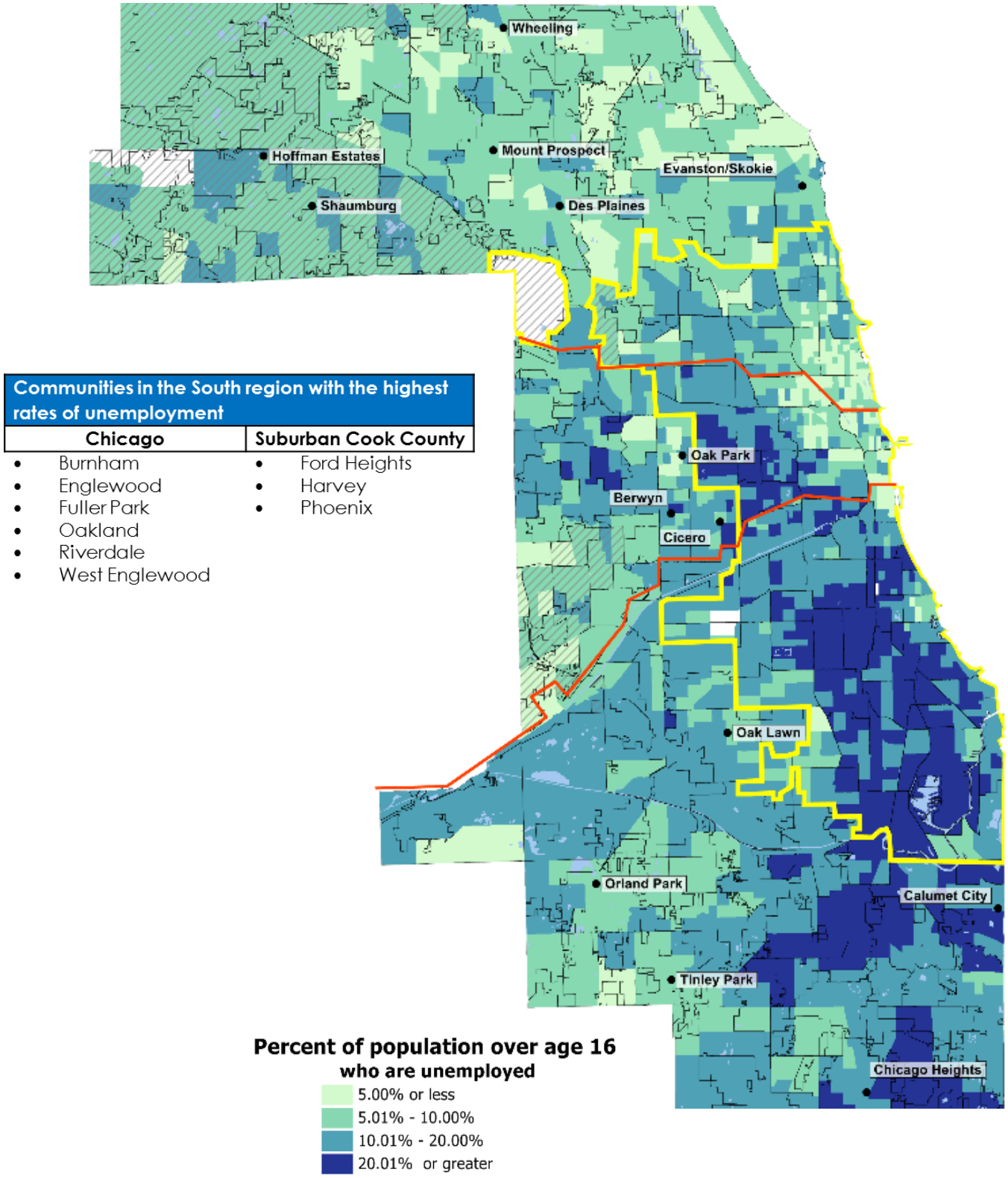
Figure 7.9. Unemployment disparities by race and ethnicity, 2009-2013African American/blacks have the highest rates of unemployment in Chicago and suburban Cook County



Data Source: American Communities Survey, 2009-2013

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

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



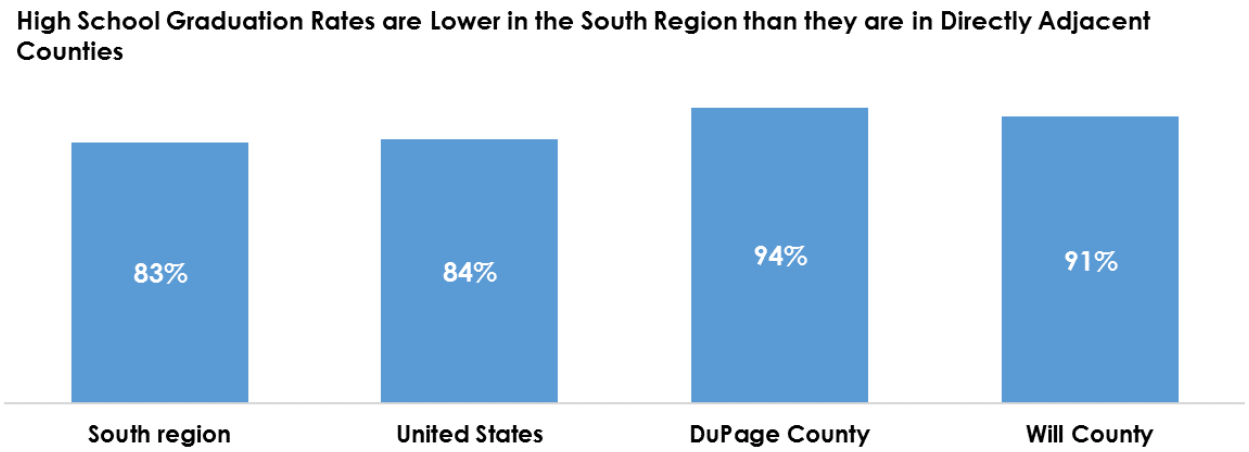
Data Source: American Communities Survey, 2009-2013

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 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.

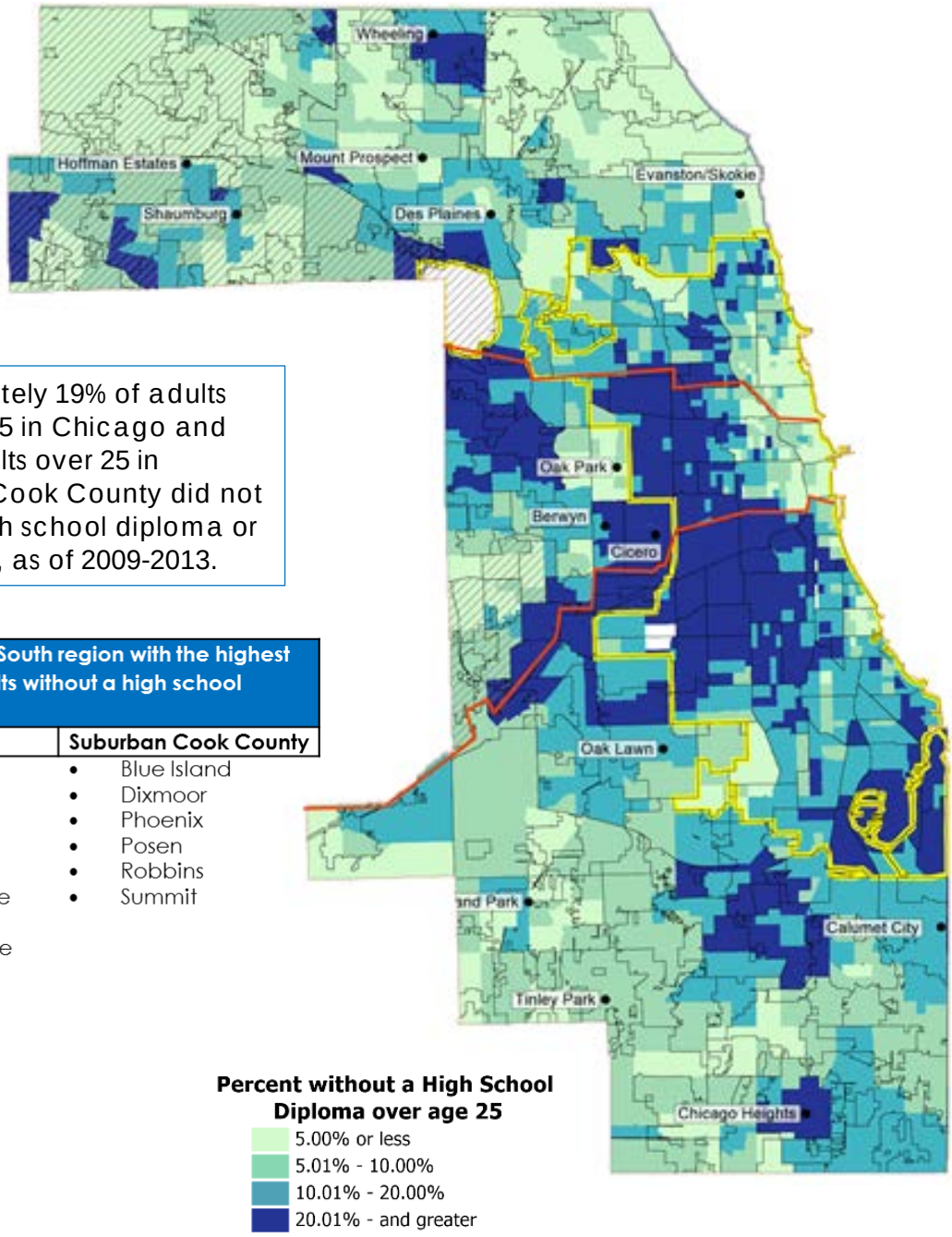
The high school graduation rates in the South region (83%) are approximately the same as the state and national averages of 85% and 84%, respectively. However, the high school graduation rates for the South region (83%) are substantially lower than those in neighboring DuPage (94%) and Will (91%)

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



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

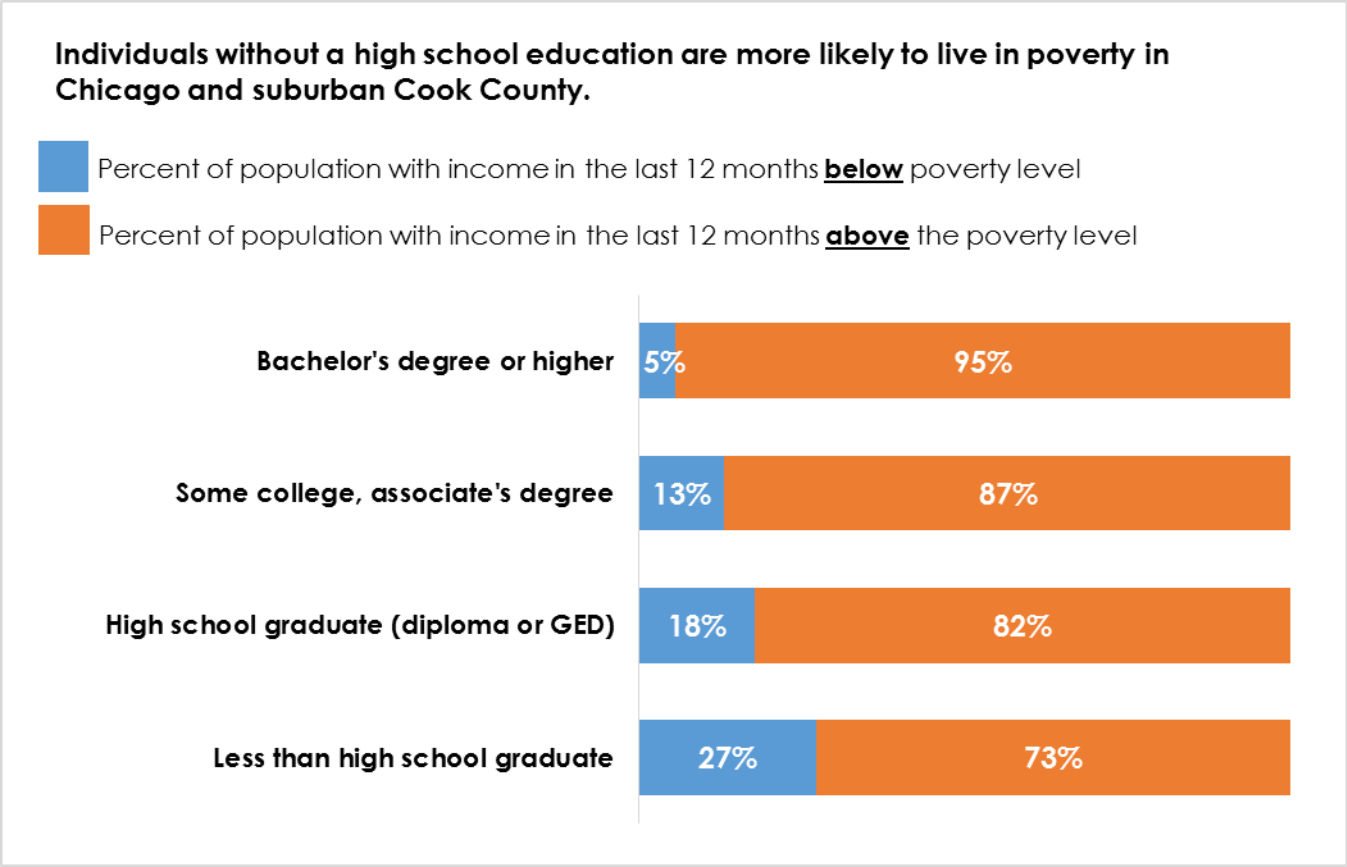


Approximately 19% of adults over age 25 in Chicago and 12% of adults over 25 in suburban Cook County did not have a high school diploma or equivalent, as of 2009-2013.

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

Chicago	Suburban Cook County
• Archer Heights	• Blue Island
• Armour Square	• Dixmoor
• Brighton Park	• Phoenix
• Burnside	• Posen
• Gage Park	• Robbins
• Lower West Side	• Summit
• McKinley Park	
• South Lawndale	
• West Elsdon	

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



Data Source: American Communities Survey, 2010-2014

Seven out of the eight focus groups in the South region mentioned schools and education as a major component of health in their communities. Participants in four of the focus groups described their public school district as substandard. Approximately 59% of Community Resident Survey respondents from the South 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 of commute to work is high in the South region and Cook County compared to Illinois and the U.S.

Geography	Percent of population using public transit to commute to work
South Region	16.1%
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 South region and Cook County compared to Illinois and the U.S., and could indicate a need for transportation alternatives.

Geography	Percentage of Households with no motor vehicle
South Region	18.1%
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 South region. Transportation services for seniors and disabled individuals have been discontinued or are extremely limited. As a result, it is difficult to use public transportation to go to clinics and medical appointments and pick-up prescriptions. Several residents in the South region mentioned the need to expand public transit routes and/or hours. Approximately 21% of survey respondents from the South region rated the convenience of timing and stops for public transit as “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. Approximately 23% of survey respondents from the South region reported that housing in their communities was not affordable. In addition, as previously stated, 44% of survey respondents in the South 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.[30] 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/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.[30]

Over 75% of enrolled school children in the South region are eligible for free or reduced price lunches

Residents in the South region highlighted inequities in access to healthy foods. Focus group participants reported that many communities in the South region do not have access to markets with fresh produce. Seniors were described as having more difficulty accessing healthy food due to high costs and lack of senior transportation services. Approximately 55% of survey respondents from the South 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. Over 75% of enrolled schoolchildren in the South region of Chicago and Suburban Cook County are eligible for free or reduced price lunch. In addition, 21% of all households in the South region are receiving SNAP benefits, the highest percentage of all the regions.

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.[31] Lead exposure is particularly dangerous to children

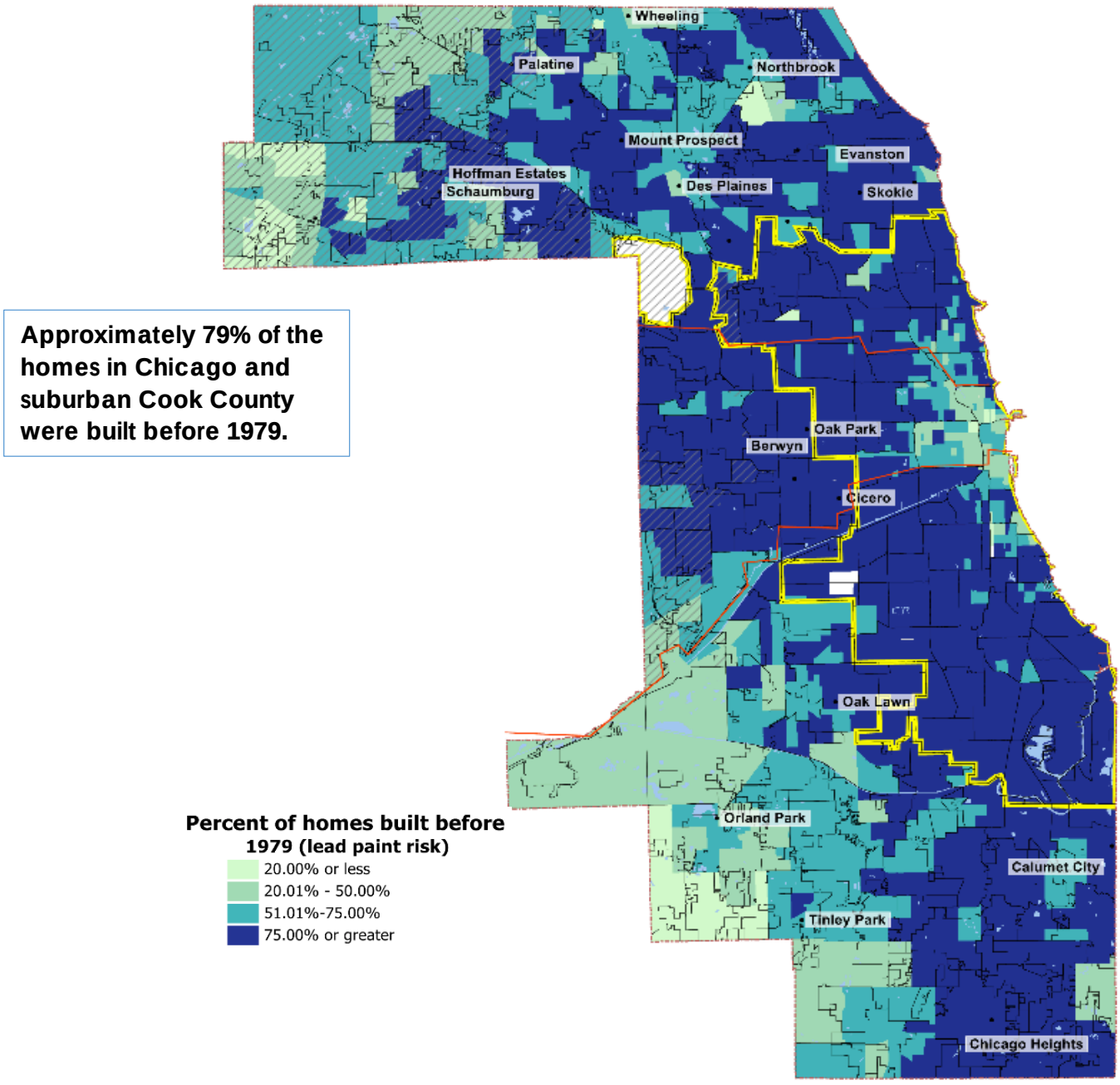
[30] USDA. (2014). http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics.aspx#insecure

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

because their bodies absorb more lead than adults and their brains and nervous systems are more sensitive to the damaging effects of lead.[32] If pregnant women are exposed to lead paint particles, there is a risk of exposure to their developing baby.[32]

Environmental concerns mentioned by focus group participants included lead exposure and water and air quality. Forty-four percent of survey respondents from the South region indicated one or more problems with their current homes that could have a negative impact on health.

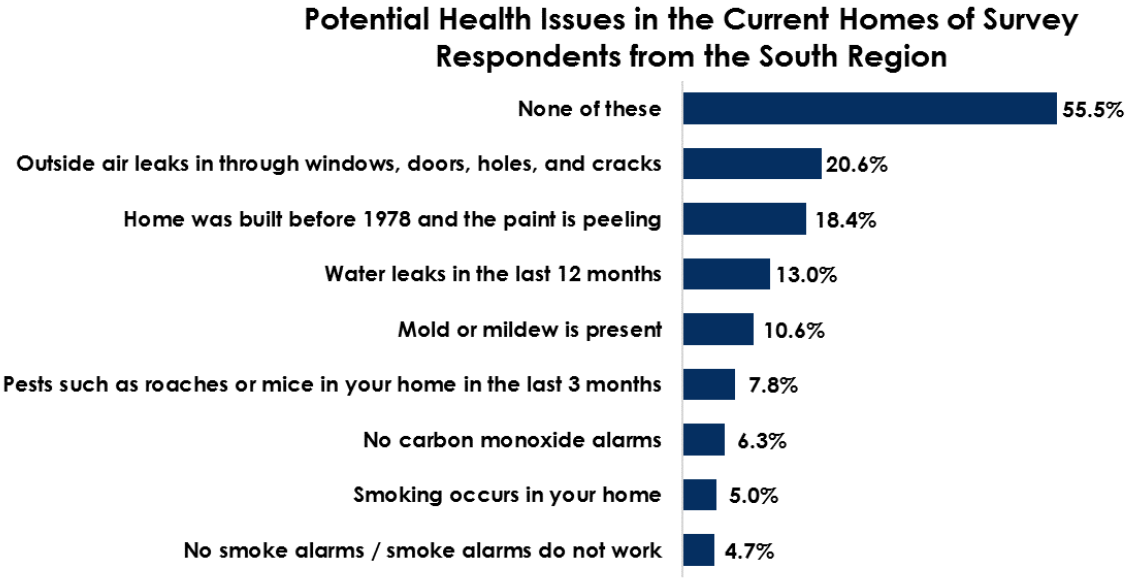
Figure 7.16. Map of homes built before 1979 (lead paint risk)



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

Figure 7.17. Housing conditions identified by community residents in the South region, Health Impact Collaborative Community Survey, 2015

Which of the following describes your current home? Check all that apply. (n=2142)



Nearly a quarter of survey respondents from the South 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 about 18% of respondents. Approximately 13% of respondents reported water leaks over the past 12 months and 10.6% of respondents reported 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.[33] 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 (35 micrograms per cubic meter per year) is higher than the rate for Illinois and the U.S.

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

Geography	Percentage of days exceeding the National Ambient Air Quality Standard (35 micrograms per cubic meter) – Population Adjusted Average
South Region	1.8%
Cook County	1.6%
Illinois	1.1%
United States	1.2%

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

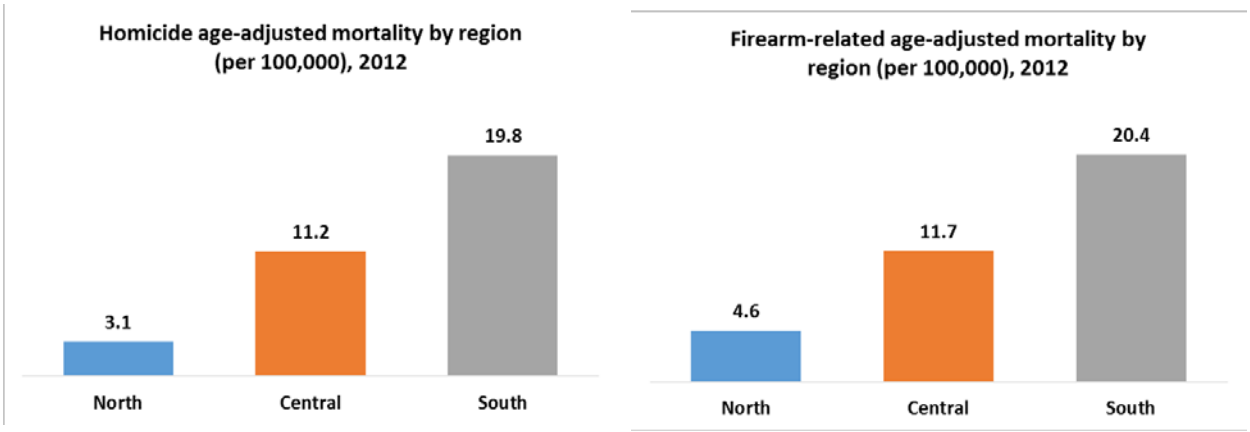
[33] World Health Organization. (2014). Ambient (outdoor) air quality and health. http://www.who.int/mediacentre/factsheets/fs313/en/

Safety and Violence—Social, economic, and structural determinants of health

Although violent crime occurs in all communities, violent crime disproportionately affects communities of color in Chicago and suburban Cook County.[34] In addition, there are multiple negative health outcomes associated with exposure to violence and trauma.[34] 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 group results. Participants in six out of the eight focus groups in the South region mentioned safety concerns in their communities. Safety issues highlighted by participants in the South region include lack of positive community policing, gang activity, and drug use/drug trafficking, domestic violence, child abuse, robbery, and personal safety. Residents who live in the South Cook suburbs described how the foreclosure crisis has led to many abandoned properties and that those properties have become hubs of drug activity and other illegal activities in their communities. The focus group results align with the results of the Community Resident Survey where respondents from the South region indicated that gang activity (33%), drug use/drug dealing (28%), presence of guns in the neighborhood (23%), and property/homes not maintained (18%) as the top four reasons that they felt unsafe in the last 12 months. Homicide and firearm mortality were highest in the South region of Chicago and suburban Cook County.

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



Data Source: Illinois Department of Public Health, 2012

[34] Chicago Department of Public Health. (2016). Health Chicago 2.0.

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

Chicago community areas and suburban cities in the South region with the highest violent crime rates	
Chicago Communities	**Suburban Cities and Towns**
West Englewood	Harvey
Washington Park	Sauk Village
Greater Grand Crossing	Robbins
Englewood	Phoenix
Riverdale	Chicago Heights
Auburn Gresham	Burnham

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

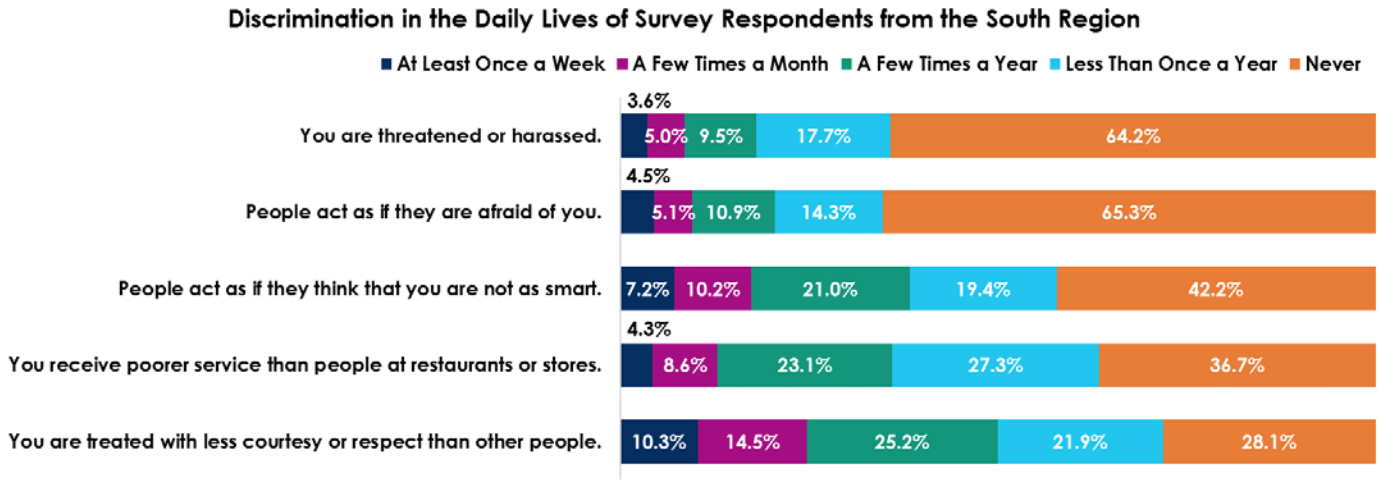
Structural racism and systems-level policy change—Social, economic, and structural determinants of health

The WHO has found that 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 increased 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 South region focus groups indicated that communities of color have a disproportionate burden of health problems. The ongoing long-term divestment in the South region was considered a serious problem by several residents. Participants stated that African Americans, Latinos and immigrants were more likely to live in low-income neighborhoods with fewer job opportunities. Residents emphasized the need to give locally owned businesses incentives to establish in low-income neighborhoods. School districts in low-income communities of color were often described as substandard. In addition, many of the survey respondents from the South region indicated that they had experienced discrimination in their daily lives (Figure 7.21).

Figure 7.21. Discrimination in the daily lives of community survey respondents, Health Impact Collaborative Community Survey, 2015

In your day to day life, how often have any of the following things happened to you? (n=2120)



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 that are needed to address inequities. Additional systems level issues identified by focus group participants include treatment for mental illness and substance use in lieu of incarceration, outreach and advocacy to veterans and former military, advocacy and support for older adults and caregivers, advocacy for the rights and fair treatment of immigrants and refugees, and sustainable funding alternatives for community based organizations.

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

As summarized on pages 37-40 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, average life expectancy is approximately 79.7 years, whereas 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.[35] 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 South 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.

[35] Healthy Chicago 2.0. (2016).

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

Lowest life expectancies:

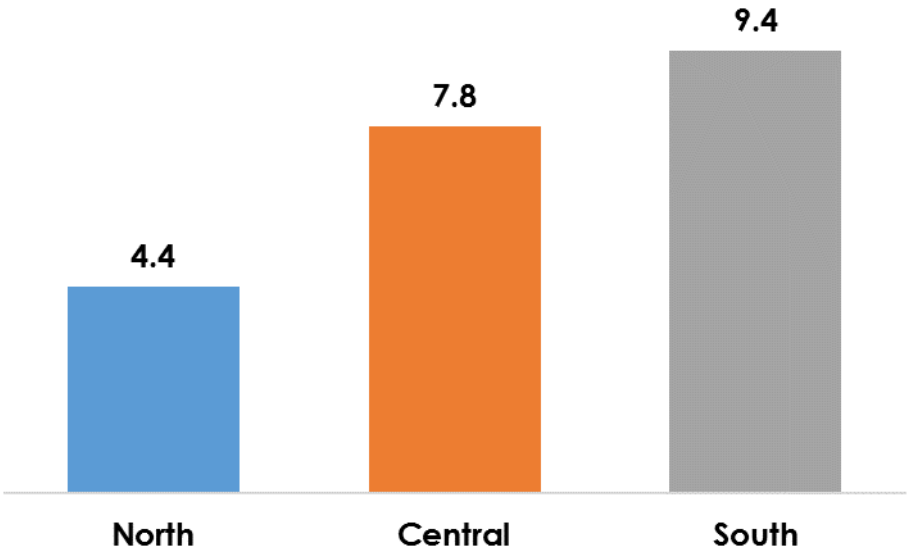
Chicago	Life expectancy (Years)	Suburban Cook County	Life expectancy (Years)
Fuller Park	67.1	Steger	71.4
Englewood	70.3	Robbins	72.0
Burnside	70.4	Riverdale	72.3

Highest life expectancies:

Chicago	Life expectancy (Years)	Suburban Cook County	Life expectancy (Years)
McKinley Park	82.3	**Orland Park**	81.2
Hyde Park	82.4	**Orland Hills**	81.3
Armour Square	83.9	**Willow Springs**	81.8

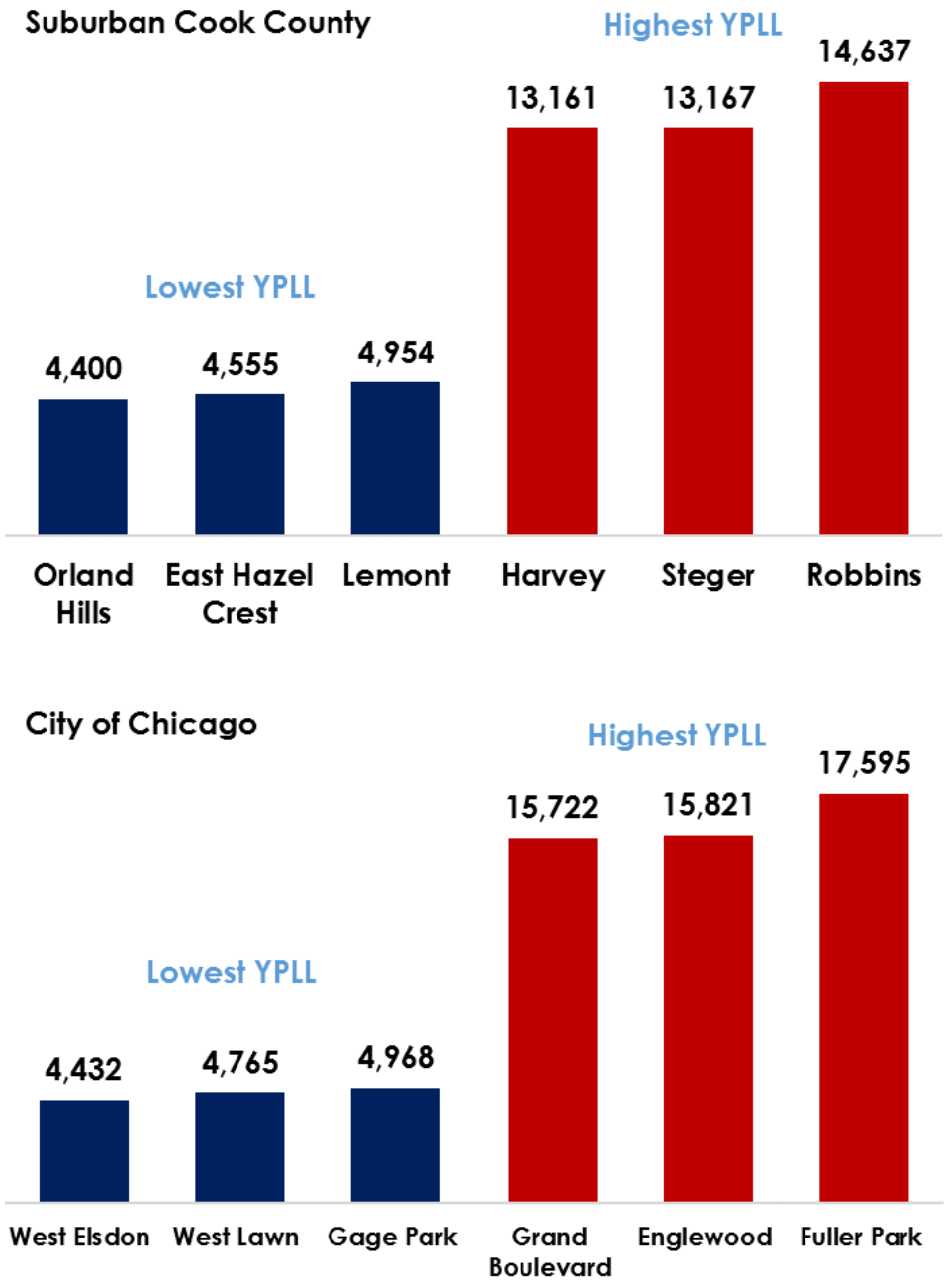
Data Source: Illinois Department of Public Health, 2008-2012

7.22b. Natality (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

Figure 7.22c. Years of Potential Life Lost (YPLL), comparison of communities in the South 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 South 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 South region. However, inequities related to the social and structural determinants of health have profound impacts on who is most impacted by the shortage of facilities and services. The following groups were identified as being at increased risk to be 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 individuals and transgender individuals
- Residents in long-term care facilities
- Uninsured and underinsured
- Veterans and former military

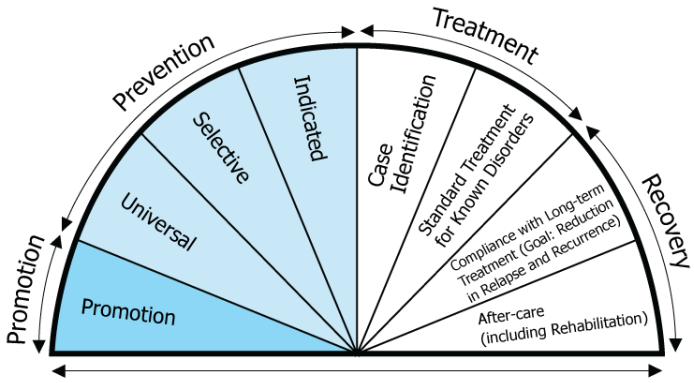
Mental health and substance use were two of the most discussed issues in the FOCA. The FOCA findings emphasized that social and structural determinants have substantial impacts on mental health. In particular, the following factors were identified as impacting mental health in communities: socioeconomic 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.[36]

[36] http://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences

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.[37] 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.[37] In addition, research indicates that better integration of behavioral health services, including substance abuse treatment into the healthcare continuum, can have a positive impact on overall health outcomes.[38] The Substance Abuse and Mental Health Services Administration (SAMHSA) emphasizes the importance of promotion to create environments and conditions that support mental and emotional well-being and the ability of individuals to withstand challenges and prevention and early intervention to reduce the burden of mental health and substance use in communities.

Figure 8.1. Behavioral Health Continuum of Care Model



Communities in the South region that have high rates of emergency department (ED) visits for behavioral health	
Chicago	**Suburban Cook County**
• Auburn Gresham • Chicago Lawn • East Side • Englewood • Gage Park • Greater Grand Crossing • Hegewisch • New City • Riverdale • Roseland • South Chicago • South Deering • South Lawndale • South Shore • Summit • Washington Park • West Elsdon • West Englewood • West Pullman • Woodlawn	• Bloom Township • Burnham • Calumet City • Calumet Park • Calumet Township • Chicago Heights • Dixmor • Dolton • East Hazel Crest • Ford Heights • Glenwood • Harvey • Hazel Crest • Midlothian • Phoenix • Riverdale • Robbins • Sauk Village • South Chicago Heights

[37] World Health Organization. (2007). http://www.who.int/mediacentre/news/notes/2007/np25/en/
[38] 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 is 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. The Community Health Status Assessment indicators included in the CHNA are:

- Self-reported mental health status
- Emergency department (ED) visits for mental health, intentional injury and suicide, substance use, and alcohol abuse
- Healthcare provider shortage areas for mental health

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

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%).

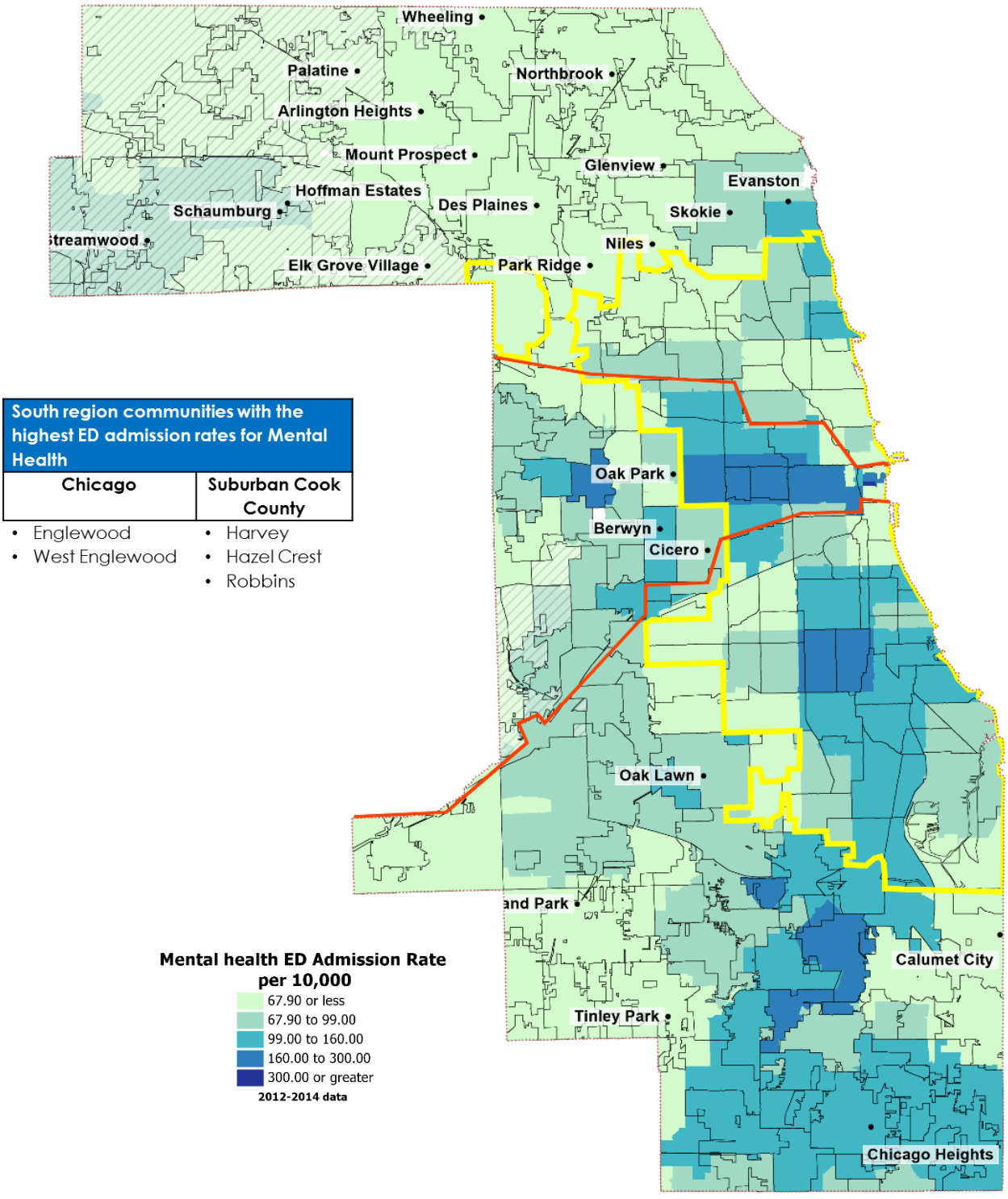
Figure 8.2. Self-reported emotional and mental health indicators

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 previous month) 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)

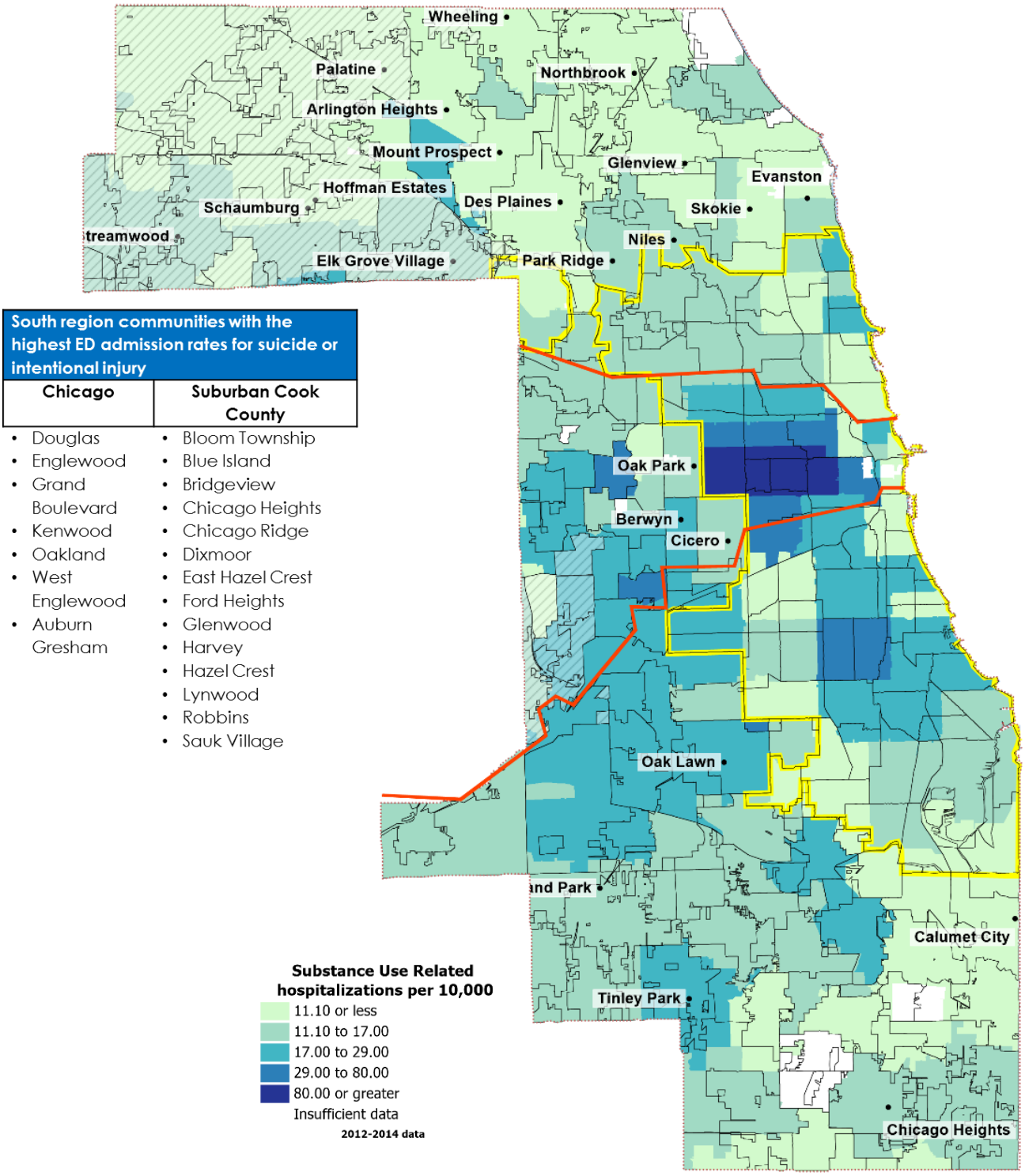
High rates of Emergency Department (ED) visits for mental health and substance use may indicate a lack of community-based treatment options, services, and facilities.

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)



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

Substance use

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), many factors influence a person's chance of developing a mental and/or substance use disorder. From a community health perspective, the "variable risk factors" and 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, and 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.[39] Figure 8.6 shows the communities in the South 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 seen to have profound impacts on community health in the South region of the Health Impact Collaborative 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

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 (all of which have led to provider shortages). 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 8.7 and 8.5. Additionally, 9% of Chicago adults report heavy drinking in the past month, which is substantially higher than the U.S. overall (6%).

[39] 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

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.[40] Drug use in adolescent or teenage years can result in multiple negative outcomes including school failure, problems with relationships, loss of interest in normal healthy activities, impaired memory, increased risk for infectious disease, mental health issues, and overdose death.[40] As a result, preventive measures to prevent or reduce drug use among adolescents and teens are important.[40]

Substance use among youth in suburban Cook County

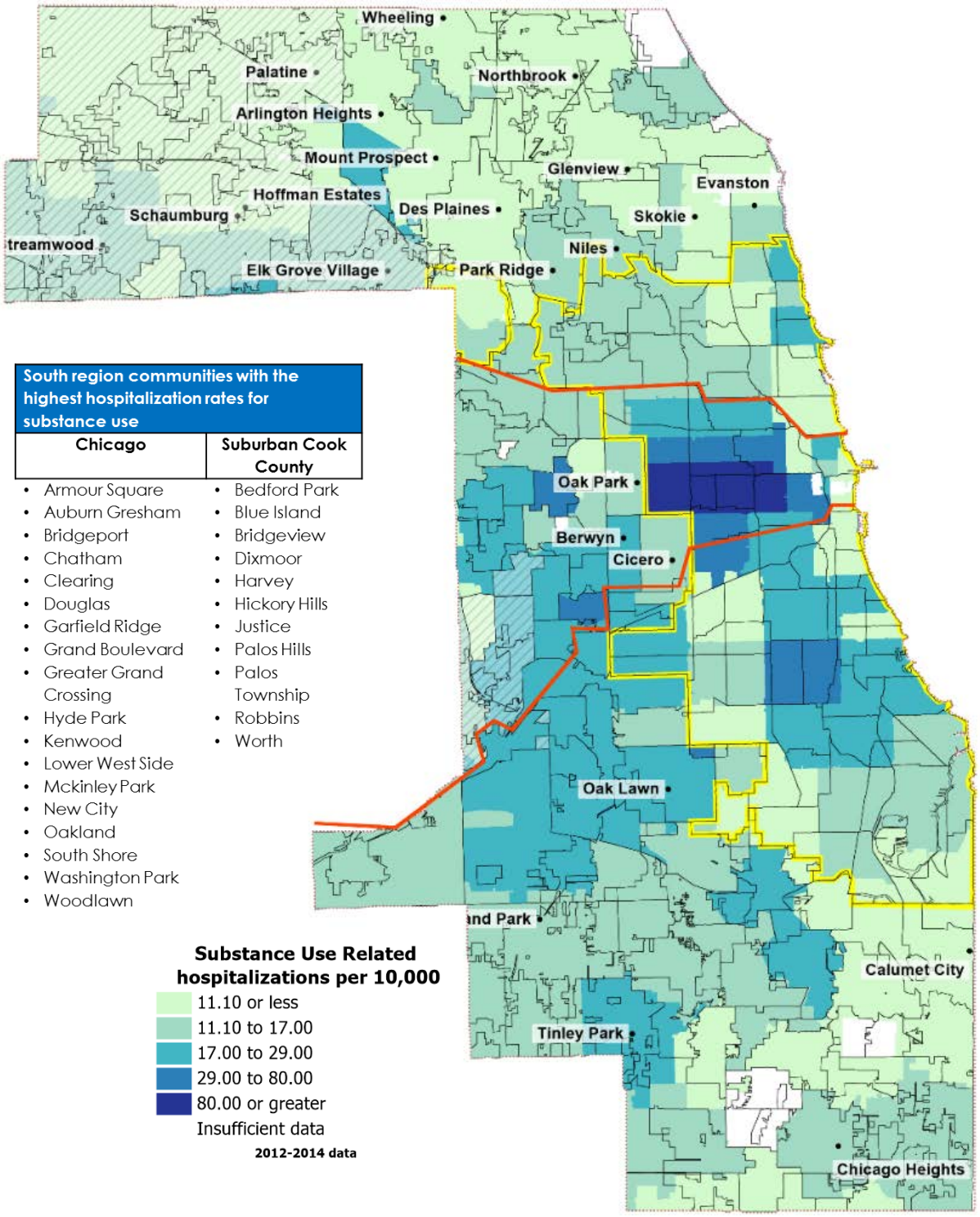
Illinois Youth Survey, comparing 2010 and 2014 survey results

- 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.

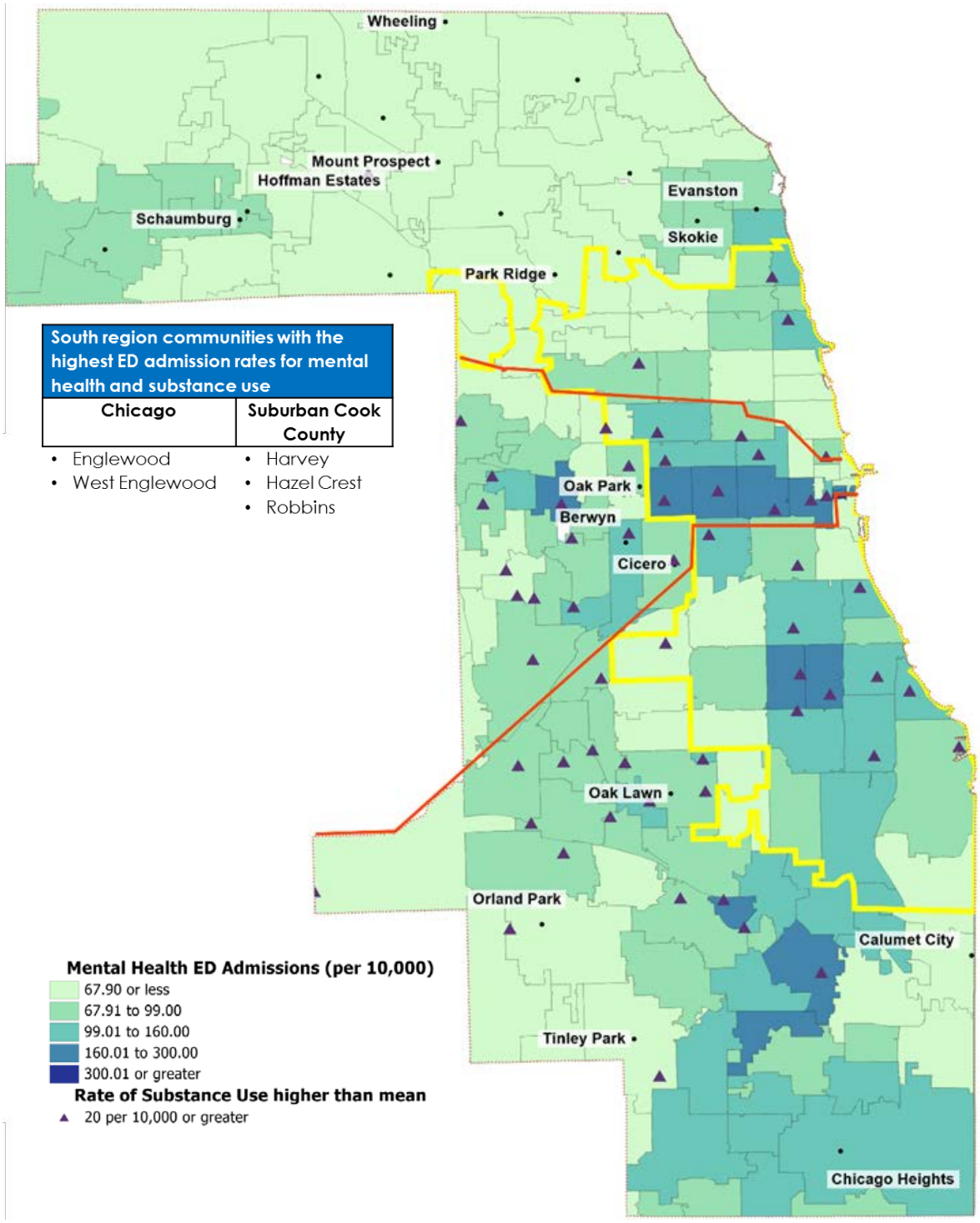
[40] National Institute on Drug Abuse. (2014). Principles of adolescent substance use disorder treatment: A research-based guide.

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



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

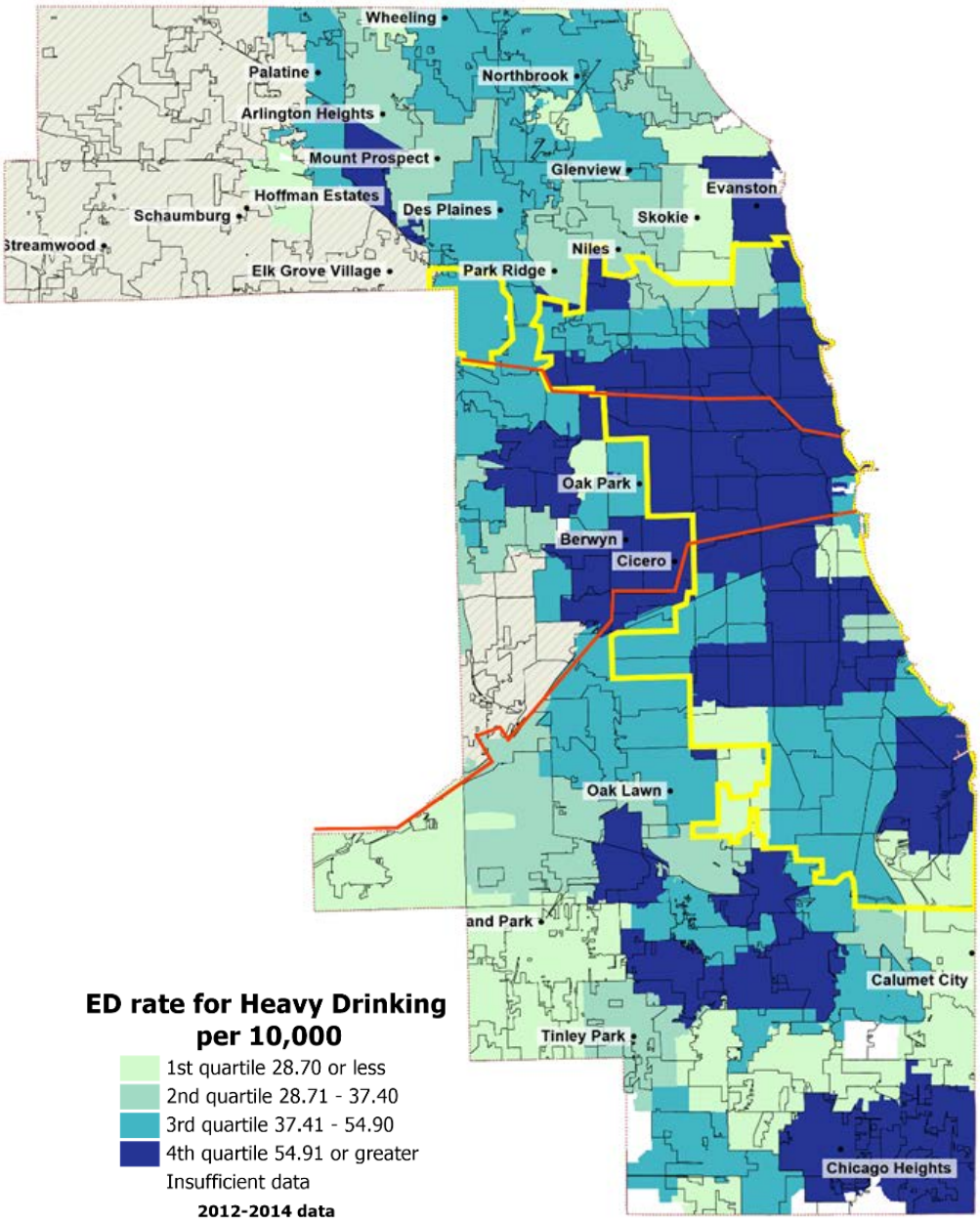
Figure 8.6. Emergency Department (ED) visits for mental health and substance abuse in Cook County, by zip code (age-adjusted rates per 10,000)



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 South 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.[41]

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

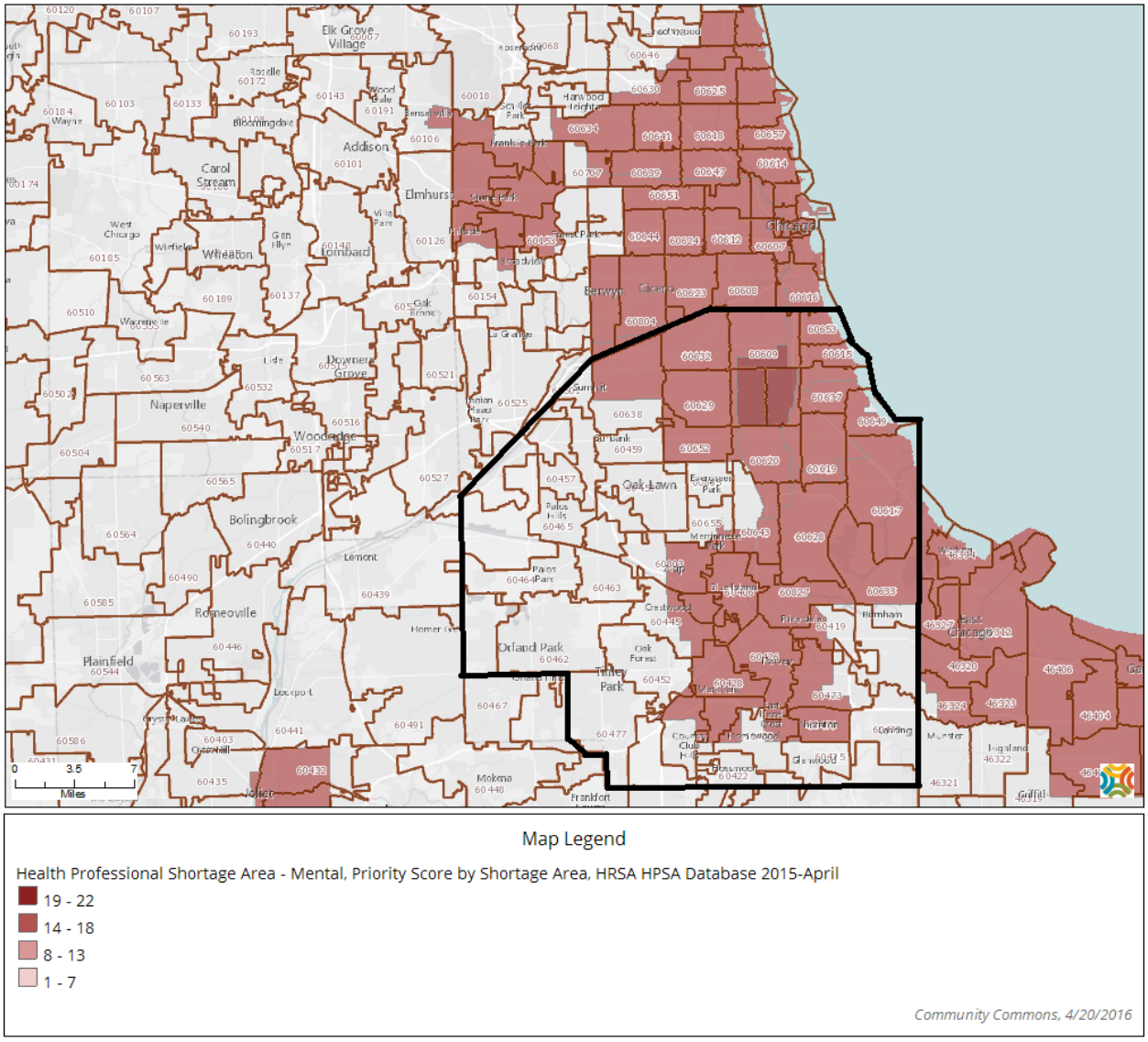


Data Source: Healthy Communities Institute, Illinois Hospital Association COMPdata, 2012-2014

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

There are several communities in the South region that are designated as 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) as areas having shortages of mental health providers. 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).[42] 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 South region are designated as mental health professional shortage areas.

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



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

[42] 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. Focus groups in the South region discussed how the lack of mental health services has led to a number of problems, including increased hospitalization, more expensive care, high incarceration, homelessness, substance use, suicide, and overburdening of existing programs or facilities.

Community members also emphasized that there is a lack of sensitivity for patients in crisis and their families in both first responders and medical professionals. Community input highlighted the need for sensitivity training for healthcare staff to improve their interaction with both patients and their families.

The stigma related to mental illness was stated to be a major barrier to accessing care for many residents in the South region. Community members indicated a need for community outreach to increase mental health awareness and decrease stigma.

Community resident survey – mental health

15% of community survey respondents in the South region indicated that they or a family member did not seek needed mental health treatment because of cost or a lack of insurance coverage.

- 15% 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.
- 9% indicated that wait times for treatment or counseling appointments were a barrier to accessing needed care.

Approximately half (51%) of survey respondents from the South region indicated that their financial situation or financial strain contributed most to feelings of stress in their day-to-day lives.

Nearly a third of respondents (30%) indicated that the health of family members contributed to feelings of stress in their daily lives and 28% indicated that time pressure or constraints 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 issues, and chronic disease is also extremely costly to individuals and to society.[43] The South 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 and race and ethnic groups in the South region. However, social and economic inequities have profound impacts on which individuals and communities 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 and active living, and related to 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

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 starting on page 53.

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

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 South region with a high burden of chronic disease across multiple indicators*

Chicago	Suburban Cook County
• Auburn Gresham	• Bloom Township
• Chicago Lawn	• Burnham
• East Side	• Calumet City
• Englewood	• Calumet Park
• Gage Park	• Calumet Township
• Greater Grand Crossing	• Chicago Heights
• Hegewisch	• Dixmor
• New City	• Dolton
• Riverdale	• East Hazel Crest
• Roseland	• Ford Heights
• South Chicago	• Glenwood
• South Deering	• Harvey
• South Lawndale	• Hazel Crest
• South Shore	• Midlothian
• Summit	• Phoenix
• Washington Park	• Riverdale
• West Elsdon	• Robbins
• West Englewood	• Sauk Village
• West Pullman	• South Chicago Heights
• Woodlawn	

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

Mortality related to chronic disease

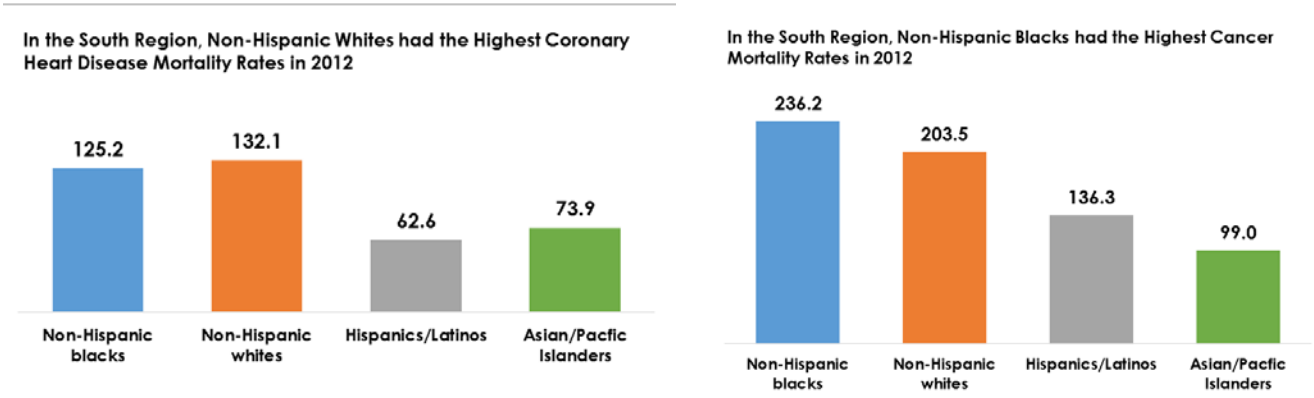
The Healthy Chicago 2.0 Assessment found that **chronic diseases accounted for approximately 64% of deaths in Chicago in 2014**.[34] The top three leading causes of death across Chicago and suburban Cook County are heart disease, cancer, and stroke (Figure 9.1).

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 Disease • Chronic Lower Respiratory Diseases • Accidents	• Heart Disease • Cancer • Chronic Lower Respiratory Disease • Stroke and Cerebrovascular Diseases • Accidents	• Heart Disease • Cancer • Chronic Lower Respiratory Disease • Accidents • Stroke and Cerebrovascular Diseases

Racial and ethnic disparities in mortality rates persist in the South region of Chicago and Cook County, as shown in Figures 9.2 and 9.5. And, 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.

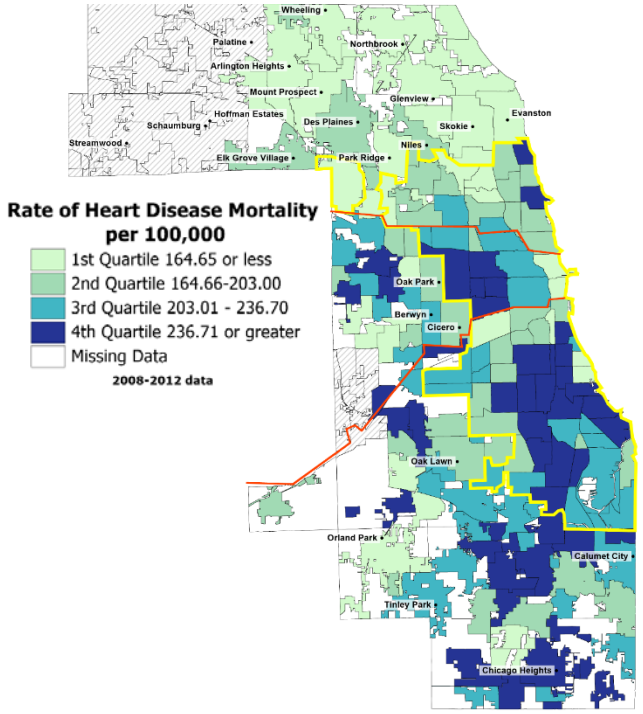
Figure 9.2. Chronic disease-related mortality (per 100,000) for the South region in 2012, by race and ethnicity



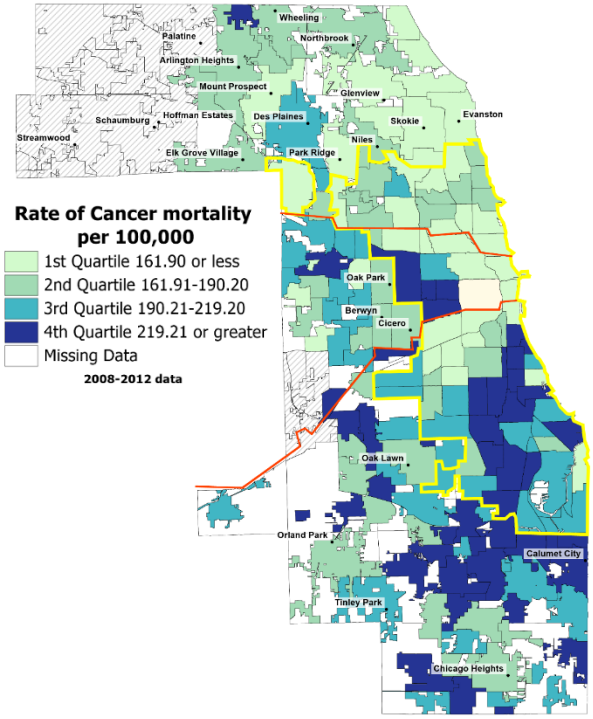
Data Source: Illinois Department of Public Health, 2012

Figure 9.3. Chronic disease-related mortality (per 100,000), age adjusted rates, 2008-2012

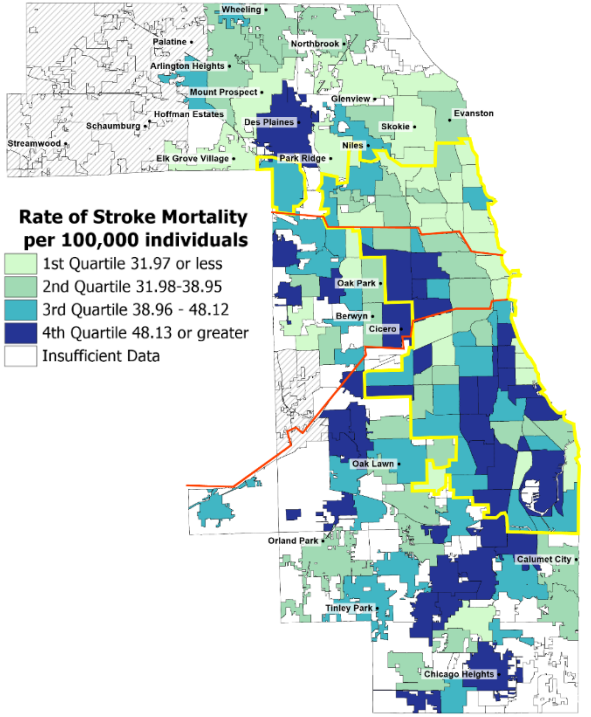
Heart Disease Mortality



Cancer Mortality



Stroke Mortality



The coronary heart disease mortality rate in the South region was **120.4 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 South region was **205.8 deaths per 100,000** population in 2012. The Healthy People 2020 target is 161.4 per 100,000 population.

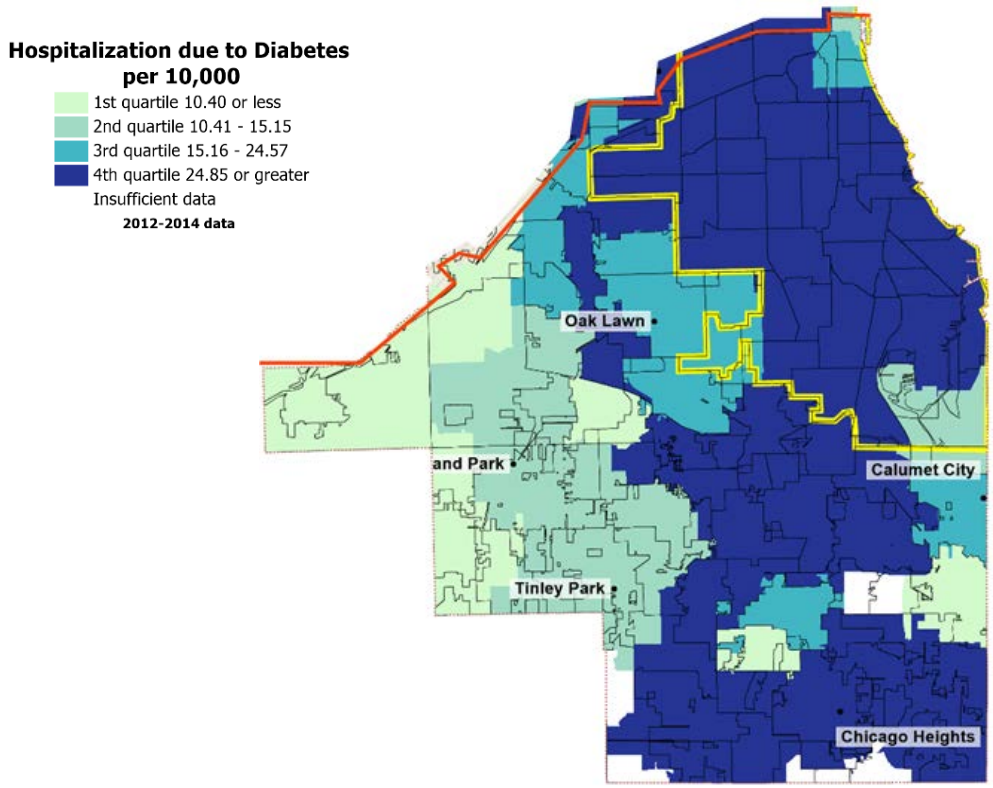
The stroke mortality rate in the South region was **40.1 deaths per 100,000 population** in 2012. The Healthy People 2020 target is 34.8 per 100,000 population.

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

Obesity and diabetes

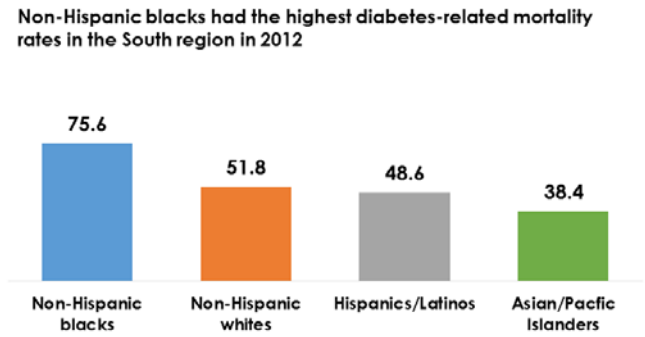
Hospitalization and emergency department (ED) visits are indicative of poorly controlled chronic diseases such as diabetes and a lack of access to routine preventive care. Poorly controlled diabetes can lead to severe or life-threatening complications such as heart and blood vessel disease, nerve damage, kidney damage, eye damage and blindness, foot damage and lower extremity amputation, hearing impairment, skin conditions, and Alzheimer's disease.[44] Non-Hispanic African American/blacks in the South region have the highest rates of diabetes-related mortality.

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



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

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



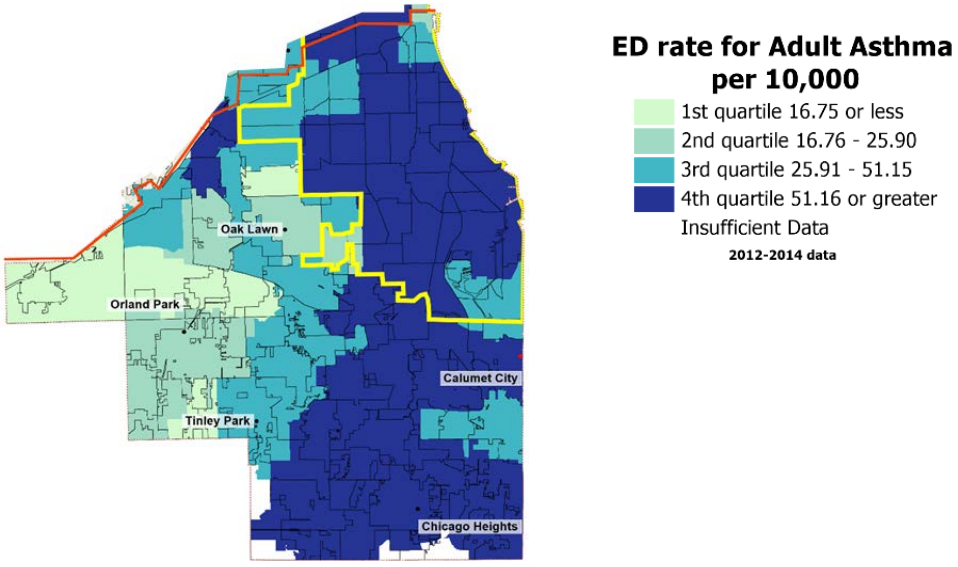
Data Source: Illinois Department of Public Health, 2012

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

Asthma

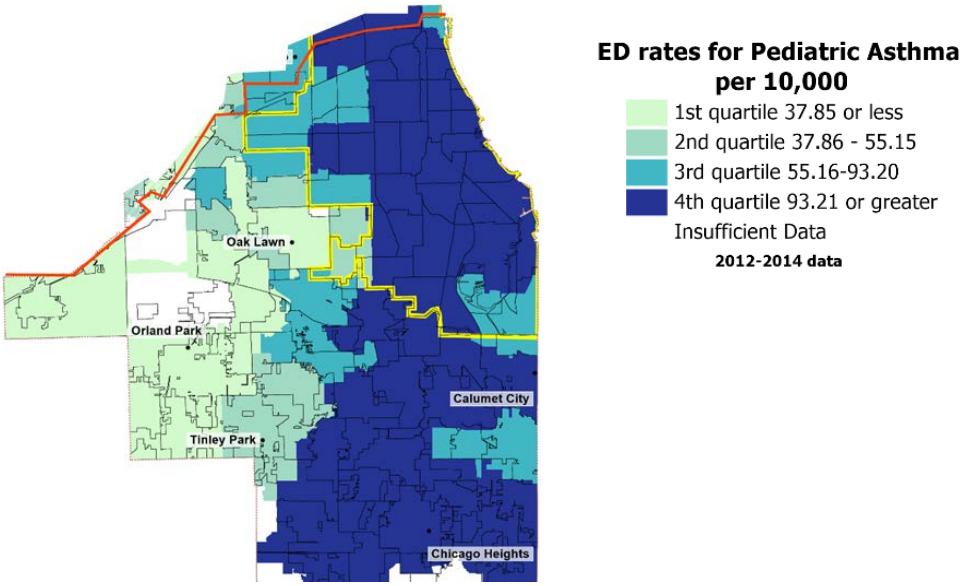
Figures 9.6 and 9.7 show the geographic distributions of emergency department (ED) visits due to adult and pediatric asthma. Communities on the South Side of Chicago and South Cook suburbs have disproportionately high rates of ED visits for asthma. ED visits are indicative of increased exposure to environmental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

Figure 9.6. Emergency Department (ED) visits in the South region due to adult asthma (age-adjusted rates per 10,000), 2012-2014



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

Figure 9.7. Emergency Department (ED) visits in the South region due to pediatric asthma (age-adjusted rates per 10,000), 2012-2014



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

Health behaviors

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 South region of Chicago and suburban Cook County are eligible for free or reduced price lunch, and 21% of all households in the South region report receiving SNAP benefits. More data and information about food access is included on page 53 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**.
- More than 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.[45] As the population of Persons Living with HIV/AIDS (PLWHA) grows, it is important to have systems in place for their continuity of care.[46]

In suburban Cook County, the number of PLWHAs increased 87% from 2,500 in 2004 to 4,683 in 2013.[47] In 2012, there were 22,346 PLWHAs in Chicago, which is a 12% increase from 2005 (19,892 PLWHAs).[48,49] The communities with the largest numbers of PLWHA are shown in Figure 9.9.

In addition to geographic disparities in PLWHAs, 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.[50] 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 South region with the highest percentages of Persons Living with HIV/AIDS (PLWHA), per 100,000 population

Communities in the South region with the highest percentages of persons living with HIV/AIDS			
Chicago			Suburban Cook County
• Auburn Gresham • Avalon Park • Burnside • Calumet Heights • Chatham • Chicago Lawn • Douglas • Englewood • Fuller Park • Grand Boulevard • Greater Grand Crossing • Hyde Park • Kenwood	• Morgan Park • Near South Side • New City • Oakland • Pullman • Riverdale • Roseland • South Chicago • South Deering • South Lawndale • South Shore • Washington Heights • Washington Park	• West Englewood • West Pullman • Woodlawn	• Burnham • Calumet Park • Calumet Township • Dolton • Harvey • Hazel Crest • Markham • Phoenix

[45] Centers for Disease Control and Prevention. (2016). Living with HIV. http://www.cdc.gov/hiv/basics/livingwithhiv/index.html

[46] Chicago Department of Public Health – HIV/STI Bureau. (2016). Chicago EMA HIV/AIDS Profile.

[47] 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

[48] 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

[49] Chicago Department of Public Health. (2014). HIV/STI Surveillance Report, 2014. http://www.cityofchicago.org/content/dam/city/depts/cdph/HIV_STI/2014HIVSTISurveillanceReport.pdf

[50] Centers for Disease Control and Prevention. (2015). HIV in the United States: At a glance. http://www.cdc.gov/hiv/statistics/overview/ataglance.html

Community input on chronic disease prevention

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

- need for non-emergency preventative care and linkage to care following hospitalization;
- inequities in access to healthcare services;
- a lack of youth-friendly providers, services, and facilities;
- the built environment and transportation systems needed 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 social determinants of health section starting on page 37.

Residents in the South region discussed inequities in access to healthy foods. Focus group participants reported that many communities in the South region, particularly communities on the South Side of Chicago have limited access to healthy fresh foods and grocery stores.

Community survey data – Healthy eating and active living

- **Food insecurity.** Approximately 55% of survey respondents from the South 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.
- **Healthy food availability.** The South region had the lowest percentage of respondents (53%) indicating that healthy foods, including fresh fruit and vegetables, are available in their communities.
- **Parks and recreation.** Nearly a third of respondents (30%) from the South region indicated that there are few or no parks and recreation facilities available in their communities.
- **Reliability of public transportation.** Approximately 34% of respondents found the reliability of public transportation to be fair and 18% of respondents rated it as poor. These were the lowest ratings of the three regions.
- **Quality and convenience of bike lanes.** About 30% of respondents rated the quality and convenience of bike lanes in their communities as fair, while 16.8% rated them as 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 and access to community-based social services and access to community resources for wellness such as accessible and affordable parks and recreation and healthy food access. These are many of the same communities that are also being most impacted by social, economic, and environmental inequities, so lack of access to education, housing, transportation, and jobs are also underlying root causes of inequities that affect access to care and community resources.[51]

Access is a complex and multifaceted 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 the 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 preventative 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 South region
- Desire for cross-generational and family-oriented programs and services

[51] 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 provide 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 preventative 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 beginning on page 37.

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

Communities in the South region have rates of negative health indicators and poor health outcomes	
Chicago	**Suburban Cook County**
• Auburn Gresham • Chicago Lawn • East Side • Englewood • Greater Grand Crossing • Gage Park • Hegewisch • New City • Riverdale • Roseland • South Chicago • South Deering • South Lawndale • South Shore • Summit • Washington Park • West Elsdon • West Englewood • West Pullman • Woodlawn	• Bloom Township • Burnham • Calumet City • Calumet Park • Calumet Township • Chicago Heights • Dixmor • Dolton • East Hazel Crest • Ford Heights • Glenwood • Harvey • Hazel Crest • Midlothian • Phoenix • Riverdale • Robbins • Sauk Village • South Chicago Heights

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 approximately 23% of the adult population age 18-64 in the South 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 Americans, Latinos, and diverse immigrants are much more likely to be uninsured compared to 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 South region.

Self-reported use of preventative 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.[52] 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.

[52] 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 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.[53] As a result, it is an important form of prevention.

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

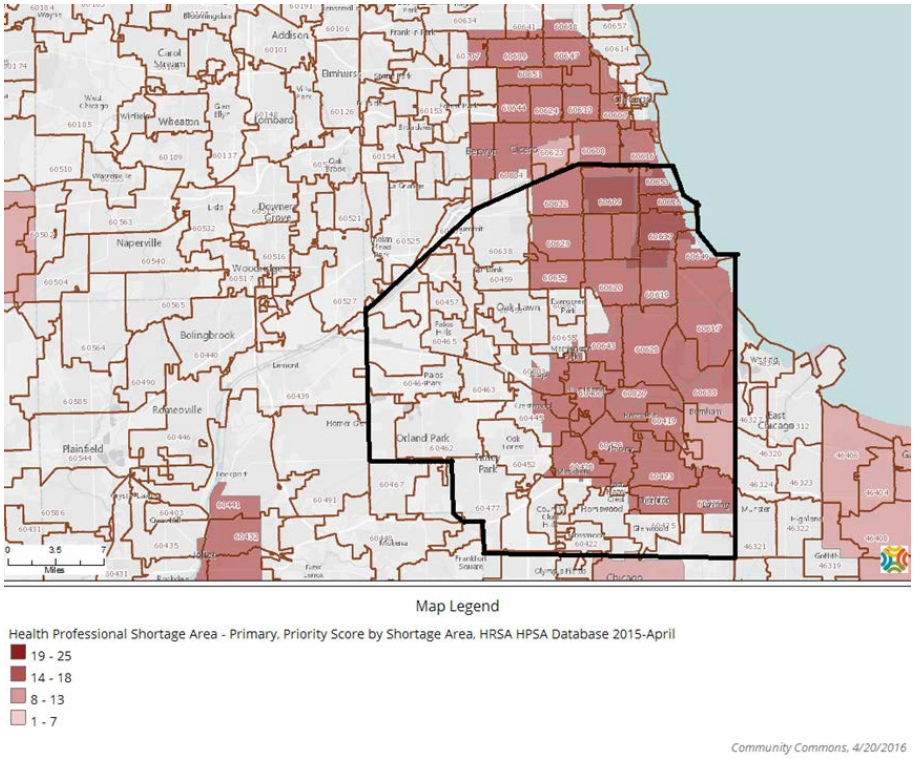
Figure 10.3. Self-reported lack of primary care

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).[54] 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 South region that are designated as primary care health professional shortage areas as shown in Figure 10.4. Shortages of mental health professionals is also a critical aspect of access to healthcare.

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



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

Multiple focus groups in the South region 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

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

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 preventative 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.[55] 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 cultural humility

As detailed in the Community Description on pages 22-25 of this report, the South 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 South 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 by several groups. Although language interpretation services are available at hospitals, a few groups cited long wait times for interpreters and incorrect interpretations of medical terminology as barriers to utilizing those services. In addition, participants indicated that more services are needed to help immigrants and refugees navigate the complex U.S. healthcare system. Multiple groups explained the need for more health-related data collection and research for certain racial and ethnic groups, so that their needs and any access issues can be adequately assessed.

Access to quality home healthcare services was identified as an important need for individuals and families that choose to age in place. Multiple focus group participants indicated that oversight of home healthcare agencies, integration of the different home healthcare services, and standardization of home healthcare training would improve the quality and safety of the services that are provided.

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

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 over 5 million, 26 hospitals, 7 health departments, and more than 100 community partners came together for a comprehensive community health needs assessment in Chicago and Cook County. Using the MAPP model for the CHNA proved to yield 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 this process thus far. The CHNA process presented an exciting opportunity to engage diverse groups of community residents and stakeholders. The input from those community partners has been invaluable in helping to identify and understand 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 continue to be essential for developing and deploying aligned strategic plans for community health improvement in any of the following priority areas:

1. Improving social, economic, and structural determinants of health while reducing social and economic inequities.
2. Improving mental health and deceasing 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 outcome objectives. Further, the shared leadership model driving the CHNA will be essential to 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 that have guided the CHNA process and decision making, the Health Impact Collaborative will work together to develop implementation plans and collaborative action targeted to achieving the shared vision of Improved health equity, wellness, and quality of life across Chicago and Cook County. Engaging in this collaborative CHNA process has developed a solid foundation and opened the door for many opportunities moving forward. Participating in 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 initiative. 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 in communities across Chicago and Cook County.

Health Impact Collaborative of Cook County

Working together for healthy communities.

COMMUNITY HEALTH NEEDS ASSESSMENT

South Region

APPENDICES

Appendix A – Steering Committee and Regional Leadership Team Members

Appendix B – Stakeholder Advisory Team Members (North, Central, and South)

Appendix C – Community Themes and Strengths Assessment Report for South Region: Focus Groups and Community Survey

Appendix D – Community Health Status Assessment Report for South Region

Appendix E – Forces of Change Assessment Report

Appendix F – Local Public Health System Assessment Report

Illinois Public Health Institute

Health Impact Collaborative of Cook County

Working together for healthy communities.

Steering Committee of the Health Impact Collaborative of Cook County

Steering Committee for the Health Impact Collaborative of Cook County	
Armand Andreoni, Co-lead for Central Region	Loyola University Medical Center/ Gottlieb
Barb Giloth, Lead for South Region	Advocate Health Care
Bonnie Condon	Advocate Health Care
Charles Williams, Co-lead for Central Region	Norwegian American Hospital
Elissa Bassler, Laurie Call	Illinois Public Health Institute
Jaime Dircksen, Sheri Cohen, Ivonne Samblin	Chicago Department of Public Health
Jay Bhatt	Illinois Hospital Association
Mariana Wrzosek, Co-lead for North Region	Presence Health
Paula Besler, Co-lead for North Region	Advocate Lutheran General Hospital
Raj Shah, Christopher Nolan	Rush University Medical Center
Steve Seweryn, Kiran Joshi	Cook County Department of Public Health
Will Snyder	Presence Health

South Region Leadership Team of the Health Impact Collaborative of Cook County

South Region Leadership Team	
Barb Giloth (lead)	Advocate Health Care
Jim Bloyd	Cook County Department of Public Health
Lenora Bridges	Advocate South Suburban Hospital
Xandria Hair, Kathy Chan, Marcelino Garcia	Cook County Health and Hospital System
Christopher Grunow	Stickney Public Health District
Jameika Sampson	Mercy Medical Center
Robyn McMath	Roseland Community Hospital
Jaime Dircksen	Chicago Department of Public Health
Jackie Rouse	Advocate Trinity Hospital
Nancy Mabbott	Advocate Children's Hospital
Jacqueline Carson	Advocate Christ Medical Center

Health Impact Collaborative of Cook County Currently Participating Hospitals and Health Departments:

Hospitals

Advocate Children's Hospital (adjunct)
Advocate Christ Medical Center
Advocate Illinois Masonic Medical Center
Advocate Lutheran General Hospital
Advocate South Suburban Medical Center
Advocate Trinity Hospital
Gottlieb Memorial Hospital
Loyola University Medical Center
Mercy Hospital & Medical Center
NorthShore Evanston Hospital
NorthShore Glenbrook Hospital
NorthShore Highland Park Hospital (adjunct)
NorthShore Skokie Hospital
Norwegian American Hospital
Presence Holy Family Medical Center
Presence Resurrection Medical Center
Presence Saint Francis Hospital
Presence Saint Joseph Hospital
Presence Saints Mary and Elizabeth Medical Center
Provident Hospital of Cook County
RML Specialty Hospitals (Chicago & Hinsdale)
Roseland Community Hospital
Rush Oak Park
Rush University Medical Center
Stroger Hospital of Cook County

Health Departments

Chicago Department of Public Health
Cook County Department of Public Health
Evanston Health and Human Services Department
Oak Park Department of Health
Park Forest Health Department
Stickney Public Health District
Village of Skokie Department of Public Health

MISSION, VISION, AND VALUES (Developed Collaboratively May-July 2015)

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.

Health Impact Collaborative of Cook County
Stakeholder/Community Partners

(as of June, 2016)

North Region Stakeholder Advisory Team Members, as of June 2016
Access to Care
Access Community Health Network, Genesis Center
American Cancer Society
American Indian Health Services
Asian Human Services
Catholic Charities
Center of Concern
Centro Romero
Cook County Housing Authority
Des Plaines Ministerial Association
DePaul University
Erie Family Health Center
Howard Brown Health
Lutheran Social Services of Illinois
Maine Community Youth Assistance Foundation (MCYAF)
Maryville Academy
National Alliance on Mental Illness (NAMI) Cook County North Suburban
North Park University
Norwood Park Senior Center
Patient Innovation Center
PEER Services
Polish American Association
Salvation Army
Turning Point Behavioral Health Center

Central Region Stakeholder Team Members, as of June 2016
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 (HAS)
Housing Forward
Infant Welfare-Oak Park/The Children's Clinic
Interfaith Leadership Project
Loyola University Stritch School of Medicine
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

South Region Stakeholder Advisory Team Members, as of June 2016
AERO Special Education Cooperative
Arab American Family Services
Aunt Martha's
Calumet Area Industrial Commission
Cancer Support Center
Chicago Hispanic Health Coalition
Chinese American Service League (CASL)
Christian Community Health Center
Claretian Associates
Consortium to Lower Obesity in Chicago Children (CLOCC)
Crossroads Coalition
Cure Violence / CeaseFire
Family Christian Health Center
Healthcare Consortium of Illinois
Health Care Rotary, Oak Lawn
Healthy Schools Campaign
Human Resources Development Institute (HRDI)
Illinois Caucus for Adolescent Health (ICAH)
Metropolitan Tenants Organization
National Alliance on Mental Illness (NAMI) South Suburban
PLOWS Council on Aging
Salvation Army Kroc Center
Southland Chamber of Commerce, Healthcare Committee
Southland Hispanic Leadership Council
South Suburban College
South Suburban PADS
South Suburban Mayors and Managers Association

Background

The Health Impact Collaborative of Cook County organized 23 focus groups throughout Chicago and Suburban Cook County between October 2015 and March 2016, including eight focus groups in the South region. The goal of the focus groups was to understand the needs, assets, and potential resources in various communities of Chicago and Suburban Cook County and to gather ideas about how hospitals can partner with communities to improve health. The focus groups findings are an integral component of data in the CHNA, and the hospitals and their partners in the Health Impact Collaborative of Cook County focused on hearing from community representatives who have direct knowledge and experience related to the health inequities in the region.

Focus Groups

The Illinois Public Health Institute (IPHI) facilitated the focus groups, most of which were implemented in 90 minute sessions with approximately 8 to 10 participants. IPHI adjusted the length of some sessions to be as short as 45 minutes and as long as two hours to accommodate the needs of the participants, and some groups included as many as 25 participants.

The questions and topics that were discussed during the focus groups included the following:

- How do you define a healthy community?
- What are the best things about your community? What is good about your community that you wish there was more of?
- What are some things about your community that are not so great or need to be improved?
- Looking over the list of things the group has identified that need to be improved, what are the biggest issues facing your community? If you had to make one thing better what would it be?
- Are there particular groups of people that are more vulnerable than others or have unique needs that are important to address to be a healthier community?
- What ideas do you have for how these issues could be addressed or improved?

Participants

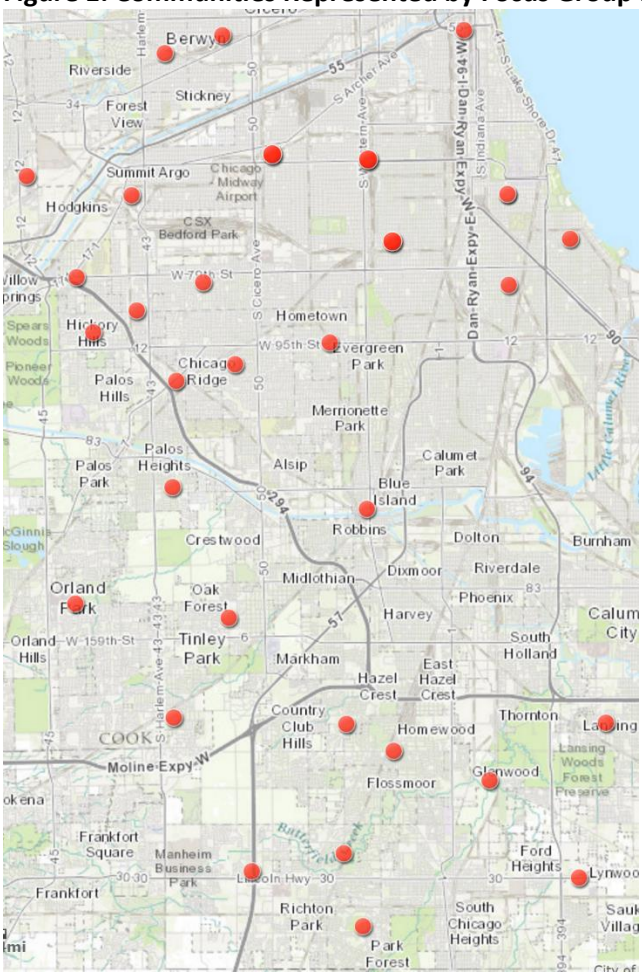
Members of the Regional Leadership Team and Stakeholder Advisory Team hosted the focus groups and recruited focus group participants, with an intentional approach to include a diverse range of communities and service providers. Recruiters specifically sought out participants who belong to or interact with populations such as racial or ethnic minorities, immigrants, limited English speakers, low-income communities, families with children, formerly incarcerated individuals, veterans, seniors, and young adults. Recruiters directed their efforts towards populations with unique needs because they often experience health inequities and their voices are often unheard in assessment processes. Cross-regional input from these populations of interest is summarized on pages 16-20.

Table 1 describes the focus group participants in the South region of the Health Impact Collaborative of Cook County. Participants represented diverse racial and ethnic backgrounds and varied socioeconomic statuses. Participants in the Arab-American Family Services (AAFS) and Chinese American Service League (CASL) focus groups worked and lived in immigrant communities and many were immigrants themselves. The Human Resources Development Institute (HRDI) group included multiple minority men and women who are living with mental illness. The HRDI group also included individuals who had experienced incarceration in the past. Participants in the National Alliance on Mental Illness (NAMI) group were parents, family, and caregivers of adults living with mental illness. The focus group conducted at the Veterans of Foreign Wars (VFW) Post 311 included current military, former military, retired military, and veterans. Figure 1 is a map of the communities represented by participants.

Table 1. Focus Groups Completed in the South Region

Host Organization	Location	Description
Arab American Family Services (AAFS)	Bridgeview, Illinois (12/4/15)	Participants were agency staff who were residents of the surrounding communities. Almost all of the staff identified as part of the Arab American community, with 2 or 3 staff of other races or ethnicities. Arab American Family Services is a social service organization providing assistance to South Suburban residents, with special sensitivity to the cultural and linguistic needs of Arab Americans.
Chinese American Service League (CASL)	Chinatown neighborhood in Chicago (1/19/16)	Participants were Chinese-American staff who were residents of the Chinatown neighborhood in Chicago. CASL provides child services, elder services, employment training services, family counseling, and housing and financial education.
Human Resources Development Institute (HRDI)	HRDI facilities in the South Shore community of Chicago (12/15/15)	Participants were HRDI addresses the lack of behavioral health services for African Americans specifically those experiencing mental illness, disability, and/or incarceration.
National Alliance on Mental Illness (NAMI)	Advocate South Suburban Hospital in Hazel Crest, Illinois (1/21/16)	Participants were the parents, families, and caregivers of adults with mental illness. NAMI is a grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.
Park Forest Health Department	Park Forest Village Hall in Park Forest, Illinois (11/12/15)	Participants included community residents, health department staff, service providers, and local government representatives.
Sexual Assault Nurse Examiners (SANE)	Advocate South Suburban Hospital in Hazel Crest, Illinois (12/17/15)	Participants were SANE providers serving the South Side of Chicago and South suburbs at Advocate South Suburban Hospital.
Stickney Senior Center	Stickney Senior Center in Stickney, Illinois (12/3/15)	Participants were seniors participating in the services provided at the center. The Stickney Senior Center provides several services for older adults including social interaction, nutritious meals, hobbies, exercise classes, computer services, driver safety classes, trips, volunteer opportunities, special parties, and educational speakers.
Veterans of Foreign Wars (VFW) Post 311	VFW Post 311 in Richton Park, Illinois (1/28/16)	Participants were veterans, retired military, and former military. The mission of the VFW is to foster camaraderie among United States veterans of overseas conflicts; to serve veterans, the military, and the community; and to advocate on the behalf of all veterans.

Figure 1. Communities Represented by Focus Group Participants in the South Region.



Focus group participants represented a large geographical area within the South region. Communities on the South Side of Chicago and South Cook Suburbs were both well represented.

Cross-cutting themes

Several cross-cutting themes emerged from the eight focus groups during the analysis phase. The major themes that focus group participants identified as having a significant impact on overall community health included:

- access to affordable healthcare;
- immigrant and refugee health;
- the health of veterans and former military;
- behavioral health (facilities, providers, treatment options);
- policy change and advocacy-funding and the state budget crisis (cuts to services, grant writing support for community organizations, advocacy and outreach to priority groups);
- senior health (day programs, aging in place, caregiver support);
- family services (activities and programs for youth, exercise and recreation facilities, entertainment, block parties and other opportunities to improve community cohesiveness);
- educational opportunities (poorly preforming schools, support for children experiencing trauma, lack of non-college tract options for high school students);

- funding and the state budget crisis –policy change and advocacy (severe service cuts, alternative forms of funding for community based organizations);
- community safety (negative police presence; vacant housing is leading to an increase in illicit activities; gang violence, drug use/drug trafficking; and human trafficking);
- infrastructure and the built environment (expansion of public transit; lead exposure in both children and adults; air and water quality; reduction in city lots/brown fields, clean and safe parks and/or trails, accessible neighborhoods, lighted streets);
- economic growth (business development, workforce development, volunteer opportunities, protection of collective bargaining);
- quality affordable housing (tailored programs to assist homeless individuals who are living with mental illness, veterans and former military, and individuals struggling with substance abuse); and
- access to healthy foods.

Priority Groups Identified by Focus Group Participants in the South Region:

- Racial and ethnic minorities
- Immigrants and refugees
- Veterans and former military
- Individuals living with mental illness and their families
- Seniors
- Families with children
- Low income communities

Access to Care

Barriers to Accessing Care

- Lack of community-based preventative services and urgent care facilities
- Lack of easily accessible information about healthcare services and social services
- Inequities in access
- Lack of in-home services and free local clinics for seniors
- Lack of specialized youth friendly services
- Cultural differences and language barriers

All eight focus groups in the South region identified access to affordable healthcare as an important component of healthy communities. Participants in the AAFS, SANE, CASL, and Stickney Senior Center groups mentioned the need for more community-based preventative services and additional urgent care clinics to prevent hospitalization. Community residents from every group expressed a need for easily accessible information about the healthcare services and social services available in their communities. Multiple groups indicated that the process for accessing community resources, social services, and government benefits needs to be significantly simplified and that many residents need assistance with the application processes for receiving aid or benefits. Caregivers in the NAMI group explained that they needed assistance with medical decisions and legal advice concerning their adult family members living with mental illness. Community residents in the Park Forest group highlighted the need for youth-friendly information that is in an easily accessible format for young people such as websites.

There were multiple groups identified in the South region as having less access to affordable care than other community members including veterans, racial and ethnic minorities, immigrants, low-income

families, individuals living with mental illness, seniors, and youth. SANE providers and CASL staff indicated that multi-purpose low-cost clinics with a variety of specialists and generalists at one location could greatly improve access to healthcare services for populations experiencing inequities in access. SANE providers mentioned that previous partnerships between faith-based organizations and healthcare providers were successful, allowing residents to receive much-needed wellness checks and preventative screenings at local churches. Seniors participating in programs at Stickney Senior Center indicated that in-home services and free local clinics are particularly important for isolated or low-income seniors who need to access health services. The Park Forest, NAMI, SANE, and AAFS groups explained that specialized intervention and treatment options for youth, such as behavioral health services, substance abuse treatment, reproductive health services, violence prevention and services for survivors of abuse or assault, are needed to improve their access to care. CASL and AAFS staff stressed the importance of linguistically and culturally competent healthcare providers. Participants stated that language barriers and cultural differences prevented immigrants from accessing healthcare services. Individuals in the CASL and AAFS groups also indicated that services are needed to help immigrants and refugees navigate the complex U.S. healthcare system.

Immigrant and Refugee Health

The CASL and AAFS groups indicated that immigrants are at an increased risk for health issues related to isolation, behavioral health, personal safety, and discrimination and have less access to quality medical care. The importance of culturally and linguistically appropriate care was highlighted in multiple groups. CASL staff stated that incentivizing international and local students that are bi-lingual and multi-lingual to work in immigrant communities for a specified period of time may be one solution to the shortage of culturally and linguistically competent providers.

Residents in the Stickney Senior Center, Park Forest, CASL, and AAFS groups indicated that limited English proficiency is a major barrier to accessing care. Long wait times for interpreters and incorrect interpretations of medical terminology were cited as barriers to utilizing translation services. AAFS staff highlighted that hospitals could create contracts with immigrant and refugee serving community based organizations to provide accurate and culturally specific interpretation services. CASL staff members stated that many of the immigrants that they serve do not know about the interpretation services available to them. CASL participants indicated that there is a need for additional multi-lingual police officers as well. Immigrant community members were described as having difficultly seeking help from and communicating with emergency responders due to language barriers.

> **"There should be a basic integration service for immigrants and a handbook of resources telling them where they can go to get help and that they can get interpreters."**
>
> *- CASL Staff Member -*

Participants in both the CASL and AAFS groups stated that immigrants often feel mistreated by healthcare staff and that sensitivity training of providers is needed to ensure that immigrants feel that they are treated with dignity and respect.

Veterans and Former Military

Participants in the VFW 311, HRDI, and Park Forest groups indicated that veterans are at an increased risk for experiencing health issues such as homelessness and mental or behavioral health problems. Individuals in the VFW 311 post also emphasized that many veterans and former military experience unique barriers to receiving health care and social services. Participants explained that veteran status is an official designation that determines eligibility for benefits and that many former and retired military

do not qualify for veteran status for a variety of reasons including but not limited to restrictions in certain branches of service and deployment history. Residents in the VFW 311 group expressed the need to expand veteran benefits to all former and retired military.

VFW 311 participants explained that quality services are provided at Veteran Affairs (VA) facilities, however, there are excessively long wait times to see a provider. Participants stated that expansion of programs, such as Choice Care, that allow veterans to utilize healthcare services outside of VA medical centers is needed. The VFW group also expressed the need to expand coverage of emergency care and similar benefits to the families of former military. Veterans stated that they were required to prove their status at every healthcare provider that they visited and indicated the need for data sharing systems between healthcare providers, VA facilities, and the federal government.

"Documentation needs to be linked between organizations and the government."

- Former Military Member at VFW Post 311 -

Participants in the VFW 311 group identified female veterans and former military as having unique needs. Individuals indicated that service members who have been victims of sexual assault are in need of both advocacy and recovery services. Health services that are designed to meet the needs of female service members such as gender specific behavioral health treatments and reproductive health services need to be improved and expanded.

The VFW group also expressed the need for increased outreach to veterans who are struggling with health issues such as homelessness and Post Traumatic Stress Disorder (PTSD), because they often do not know about the benefits and services available to them. Participants in the VFW 311 group also indicated that untreated PTSD or other behavioral health issues and traumatic brain injuries have led to interpersonal violence and domestic abuse issues among former service members and their families. As a result, participants highlighted the need to accurately assess the prevalence of interpersonal violence issues among former military so that they can receive treatment and care along with their families.

Mental and Behavioral Health

Multiple focus group participants stated that the closure of mental health facilities is placing an extreme burden on caregivers and communities as well as the remaining mental health facilities. The NAMI, Park Forest, CASL, and HRDI groups highlighted the need for more local community-based mental health services. In addition, NAMI participants indicated that step-down facilities and services are needed for individuals transitioning from inpatient care. NAMI participants also explained that quality long-term mental health facilities are extremely hard to find and that most facilities are closed to new patients. NAMI and Park Forest participants stated that both inpatient and outpatient mental health services and facilities are extremely limited for children and adolescents.

"My loved one has had to go to the emergency room three times in the last two weeks in crisis because there are no other options for him."

- Parent and caregiver participating in a NAMI support group -

The federal parity law of 2014 requires insurance companies to cover mental health and substance abuse services at rates consistent with medical and surgical benefits. Multiple NAMI participants indicated that despite the federal parity law, they often struggle to get insurance coverage for the behavioral health services their family members need.

NAMI and Park Forest participants stated that the stigma related to mental health issues prevents many individuals from seeking care or support. NAMI participants cited outreach and awareness campaigns for community residents as a potential method for reducing stigma. In addition to stigma, residents in the NAMI group explained that many individuals living with mental illness and their caregivers feel that they have been treated poorly by healthcare providers. Participants stated that many health professionals need sensitivity training to ensure that individuals with mental illness and their families are treated fairly and with respect.

"The inpatient unit just gave me a booklet when my son was admitted. I called with questions the next day and they told me that they didn't have time to answer them."

- Parent and caregiver participating in a NAMI support group -

Caregivers and parents in the NAMI group cited a need for support services to help the families of individuals living with mental illness. Support services that were mentioned included legal advice, educational information about mental illness, and support groups.

NAMI participants indicated that emergency responders in the South Cook suburbs would be better equipped to respond to individuals experiencing a mental health crisis if more personnel completed Crisis Intervention Training.

Senior Health

Seniors were identified as another priority group with unique needs. Individuals participating in the programs at the Stickney Senior Center stated that the social opportunities, exercise classes, meals, and wellness checks provided by the center improved their health. Participants at the Senior Center who lived outside Stickney explained that they were willing to travel to participate in programs, but wished that there were facilities with programs in more communities. The CASL and Park Forest groups stated that additional day programs for older adults would allow aging residents to receive basic healthcare services and remain active in their communities on the South Side of Chicago.

Individuals in the Stickney Senior and Park Forest groups expressed the need for guidance on legal issues related to caregiving and a surviving spouse's benefits and rights. They also emphasized the need for information and services to assist families with the rapidly increasing financial burden of long-term care.

"Family caregivers don't know what resources are available - dementia, Alzheimer's and caretaker support."

- Community resident in Park Forest, Illinois -

Participants in the CASL focus group highlighted that aging immigrant community residents that have lived in the U.S. and contributed to the economy for an extended period of time should be naturalized, so that they have access to health services such as the healthcare marketplace.

Child, Adolescent, and Young Adult Health

All eight focus groups in the South region indicated the need for specialized services to address the health concerns of children, adolescents, and young adults. Participants mentioned several health issues that are exacerbated by a lack of youth specific services, providers, and interventions including teen births, sexually transmitted infections (STI), behavioral health problems, sexual assault, domestic violence, threats to personal safety, and human trafficking. Individuals in the CASL group highlighted the need for resources and information for children living with disabilities and their families. Participants in

the Park Forest group indicated that information about health resources needs to be in a format that is easily accessible for young people such as a website.

Participants identified several safety issues that are disproportionately affecting children and adolescents in the South region. SANE providers indicated that sexual assault, domestic violence, and abuse is high among children and adolescents on the South Side of Chicago and in the south suburbs. CASL staff stated that child abuse is high among community residents including immigrants on the South Side of Chicago. HRDI participants stated that illegal drug activities, gang activity/gang recruitment, and the violent crime that results from those activities are having a negative impact on the young people in their communities and endangering their lives. SANE providers cited the need for increased awareness and interventions for the issues related to human trafficking. Participants in the SANE group indicated that the Hispanic/Latino and Asian immigrant communities in particular are experiencing serious problems with the trafficking of children and young adults in the south suburbs.

The Park Forest and NAMI groups indicated the need for youth-specific behavioral health services. NAMI participants stated that there needs to be increased school support for children diagnosed with mental illness. NAMI participants also highlighted that schools in the South region are not equipped to address the needs of students who are exposed to trauma in their daily lives. NAMI described a Judicial Mental Health Court that is being piloted in a few south suburban communities as a potential solution to the incarceration of young people with mental illness. Participants explained that the Judicial Mental Health Court sentences juveniles experiencing mental illness who have committed minor offenses to treatment facilities instead of jail.

Family Services

Participants in six of the eight focus groups in the South region indicated that more intergenerational services are needed in their communities. CASL participants explained that providers and community-based organizations often serve multiple members of an intergenerational family and that family-based solutions to health problems are needed. Participants in the HRDI and VFW 311 groups agreed that addressing community health needs should start at the family level and should include multiple generations when appropriate. VFW 311 participants stated that family values and a sense of community are essential to the health of residents.

> **"Without the family structure, good health can't exist."**
>
> *- Former Military Member at VFW Post 311 -*

> **"There are many single people trying to work, go to school and take care of kids."**
>
> - Community resident in Park Forest Illinois -

Residents in the Park Forest and the CASL groups indicated a need for additional affordable daycare options for working parents. Participants in the SANE, Park Forest, and Stickney Senior Center groups stated that the lack of affordable daycare options was particularly difficult on single parents. Individuals in the CASL, HRDI, Park Forest, SANE, and VFW 311 groups expressed the need for additional activities and programs for children and adolescents in their communities. SANE providers indicated that programs for children and adolescents were opportunities to engage youth and promote healthy lifestyles.

Education

Seven out of the eight focus groups mentioned quality education as an essential component to community health. Participants in the HRDI, Park Forest, SANE, and VFW 311 groups described their local schools as substandard. VFW 311 participants indicated that poorly performing schools and a lack of vocational school options has left many students with limited or no options for continuing education or workforce development following the completion of high school. Issues related to education quality and funding surfaced in all of the assessments, indicating that education inequities are affecting many of the communities in Chicago and Suburban Cook County and particularly in the South region.

Individuals in the VFW 311 group stated that the loss of trade schools in their communities has contributed to a loss of economic opportunities for the community and lost job opportunities for students in the South Cook suburbs. Participants in the HRDI group also indicated that there should be more trade schools and vocational colleges in their communities on the South Side of Chicago.

Participants in the CASL, HRDI, NAMI, and SANE groups explained that schools can be a starting point for a number of health interventions including health education, healthy meals, mental illness screening, and sexual violence prevention education.

Community Safety

Participants in six out of the eight focus groups in the South region mentioned safety concerns in their communities. Residents in the CASL group indicated that domestic violence, child abuse, robbery, and personal safety were some of the major concerns in their community and more broadly on the South Side of Chicago. HRDI participants discussed a lack of positive community policing, gang activity, and drug use/drug trafficking as the biggest safety concerns in their communities on the South Side of Chicago. VFW 311 residents who live in the South Cook suburbs described how the foreclosure crisis has led to many abandoned properties and that those properties have become hubs of drug activity and other illegal activities in their communities. Participants in the Park Forest focus group stated that economic problems in the South Cook suburbs have led to an overall increase in crime. The focus group results align with the results of the Community Resident Survey where respondents from the South region indicated that gang activity (33%), drug use/drug dealing (28%), presence of guns in the neighborhood (23%), and property/homes not maintained (18%) as the top four reason that they felt unsafe in the last 12 months.

Participants in the SANE, VFW 311, and CASL groups indicated that interpersonal violence is a major issue affecting communities in the South region. VFW 311 participants stated that domestic violence resulting from PTSD, untreated behavioral health issues, and traumatic brain injuries is not being adequately addressed among former service members. VFW 311 participants also stated the need to address the problem of sexual assault against female service members and the need for services that assist survivors of assault. Individuals in the SANE and CASL groups indicated that physical and sexual child abuse is a serious problem affecting communities in the South region and that more health services, interventions, community education, and domestic violence screenings will be needed to address the issue. SANE providers explained that there needs to be more interventions addressing the continually growing human trafficking problem in the South region. SANE participants indicated that Hispanic/Latino and Asian immigrant communities in particular are experiencing serious problems related to the trafficking of children and young adults in the south suburbs.

Policy Change and Advocacy – Funding and the State Budget Crisis

Most of the focus groups in the South region, participants emphasized that policy change is needed to stabilize and sustain funding for community based organizations and to maintain the essential health and social services that the organizations provide. Participants named multiple populations that particularly need advocacy support including individuals living with mental illness, immigrants and refugees, veterans and former military, seniors and caregivers, and racial and ethnic minorities. In addition to policy change, individuals in six of the eight groups expressed the need for alternative funding sources for community based organizations such as grants from foundations and contracts with hospitals to provide services and trainings.

Infrastructure and the Built Environment

Residents in five of the eight focus groups indicated that a healthy built environment including clean and safe green spaces, intact sidewalks and street lights, as well as convenient public transportation as essential components of a healthy community. Multiple participants in the HRDI group indicated that some of their communities lacked clean streets and that vandalism negatively affected the built environment which in turn affects overall community health and well-being.

The need for improved transportation options was a major point of discussion in the South region. The CASL, HRDI, and Stickney Senior Center groups emphasized the importance of convenient public transportation options and transportation services across the South region in the city and suburbs. Individuals in the CASL and Stickney Senior Center groups indicated that transportation services for seniors to medical appointments and stores needed to expanded and improved.

Economic Development

Focus group participants in both the city and suburban areas of the South region described that many communities are suffering from severe economic issues related to long-term divestment, economic and residential segregation, the foreclosure crisis, loss of local and national businesses, and job loss. Participants in the HRDI, Stickney Senior Center, VFW 311 and Park Forest groups indicated that their communities were struggling due to a lack of business and job opportunities. Participants in the Stickney Senior Center group described how empty storefronts and closed businesses are negatively impacting their ability to attract new businesses to their community. The HRDI, Stickney Senior Center, VFW 311, and Park Forest groups all indicated the need for strategies to incentivize local businesses to establish and remain in their communities.

If you were Mayor what is the one thing that you change?

"I would build businesses, stores, and housing in the community"

- HRDI Client -

Housing

Participants in the HRDI, Park Forest, SANE, and VFW 311 groups stated that a lack of quality affordable housing is a significant problem in the South Side of Chicago and South Cook Suburbs. This echoes the findings from the Community Resident Survey with 44% of survey respondents in the South region describing poor housing conditions in their current homes.

Residents in the HRDI and VFW 311 groups indicated that a lack of affordable housing was contributing to homelessness in their communities. HRDI, VFW 311, and NAMI participants stated that individuals living with mental illness and veterans often have more difficulty accessing safe and affordable housing compared to other community members. Both groups cited the need for specialized programs to help transition homeless individuals into permanent housing. Participants in the VFW 311 group mentioned

that empty or foreclosed properties could be utilized as affordable housing options for veterans or other priority groups that have less access to permanent housing solutions.

Individuals in the VFW 311 and Park Forest group indicated that vacant homes and issues related to squatting are leading to a devaluation of property values. VFW 311 participants stated that property devaluation has had an effect on many other important aspects of their communities including a decrease in the funds that are available to local schools and a loss of local businesses.

Healthy Foods
Participants in four of the eight focus groups indicated that healthy foods are an important component of healthy communities. Residents in the AAFS, Stickney Senior Center, and Park Forest focus groups explained that there are inequities in access to fresh healthy foods for some communities. Individuals in the Stickney Senior Center and Park Forest groups described seniors as having more difficulty accessing healthy food due to high costs and lack of senior transportation services.

Summary of Key Findings

Table 2 describes some of the key findings from each of the focus groups in the South region.

Table 2. Key Summary of Findings from Focus Groups in the South Region

Key Findings of Focus Groups Completed in the South Region	
Host Organization	**Key Findings**
Arab American Family Services Arab-American staff who were residents of Bridgeview, IL and surrounding communities.	• Arab-American immigrants feel that they are treated disrespectfully by hospital staff. There needs to be more diversity in the front-line staff at hospitals. • There is a need for more culturally competent providers and better quality translation services at hospitals. Hospitals could contract with immigrant and refugee serving community-based organizations to provide cultural sensitivity and educational workshops as well as quality translation services. • Culturally competent providers that are trauma informed are needed to serve immigrant women who are victims of domestic violence or sexual violence. • There is a need for better ethnic and racial data collection at hospitals.
Chinese American Service League (CASL) Chinese-American staff who were residents of the Chinatown community in Chicago.	• More qualified Chinese-speaking and culturally competent doctors are needed. Both generalists and specialists are needed. International students at medical schools and in healthcare programs could be incentivized to serve immigrant communities. It can be hard for immigrant patients to go to hospitals because they do not understand the healthcare system. In addition, there is a language barrier at some of the major medical centers. • There should be culturally specific integration services for immigrants that are new to the community. Information should include lists of healthcare facilities that have translation services. There is a language barrier preventing immigrants from accessing behavioral health services and many do not know about mental health resources that are available. • Aging residents and residents with disabilities can become isolated. Funding is needed to provide services for disabled community members and seniors. • There is a disconnection of social service organizations. Competition and political issues need to be put aside so that community issues can be addressed. • Safety is major concern of residents in the Chinatown neighborhood in Chicago. Community members reported robberies, physical violence, and assault as some of the biggest safety concerns.

Table 2. Key Summary of Findings from Focus Groups in the South Region

Key Findings of Focus Groups Completed in the South Region	
Host Organization	**Key Findings**
Human Resources Development Institute (HRDI) Clients in HRDI's day programs on the South Side of Chicago.	• Gang activity and illicit drugs are major issues leading to many of the other safety-related concerns on the South Side of Chicago. • Opportunities, such as block parties, are important for building community cohesiveness and trust among neighbors. • There needs to be more positive community involvement from the police. • Family-based solutions are needed to address many of the health issues in the city. • The mental health needs of many residents living on the South Side of Chicago are not being met.
National Alliance on Mental Illness (NAMI) Parents, families, and caregivers of adults with mental illness living in South Suburban Cook County.	• Hospitals need to be more sensitive to mental health patients. Behavioral health therapists, doctors, and nurses all need sensitivity training so that patients and their families feel that they are treated with dignity and respect. • Doctors and social workers need to be incentivized to go into behavioral health. • Health education of family members is important so that they know how to navigate the system. There needs to be a place that family members can go to learn about the services that are available and where they can get • Stigma surrounding behavioral health problems is an issue that needs to be addressed with family members, community residents, and healthcare providers. • There needs to be a shift in healthcare so that more attention is given to recovery from mental illness than crisis management. • Mental health services for children and adolescents are severely lacking in the South Suburbs. Some communities have judicial mental health courts that sentence young people with minor offenses to treatment instead of jail and they should be expanded to other communities. Young adult and youth peer-to-peer support groups for persons with mental illness could be beneficial. • Greater transparency is needed at residential facilities to ensure that residents are receiving proper care. More coordinated efforts are needed between providers and long-term nursing home facilities to screen and place nursing residents with mental illness in more appropriate housing and programs.

Table 2. Key Summary of Findings from Focus Groups in the South Region

Key Findings of Focus Groups Completed in the South Region	
Host Organization	**Key Findings**
Park Forest Community residents, health department staff, service providers, and local government representatives in Park Forest, IL.	• More local businesses are needed. • There is a need for a variety of locally grown and affordable healthy food options in grocery stores. • More information is needed about the healthcare resources, facilities, and services available in Park Forest. • There is a limited number of behavioral health services available in the south suburbs. • There are a number of safety-related issues in the south suburbs. • There is less community cohesiveness in low-income areas. • Funding issues have affected the availability of homeless shelters. There needs to be additional funding and support for intergenerational services such as daycares, caregiver support services, senior services, and services for children and adolescents.
Sexual Assault Nurse Examiners (SANE) SANE providers serving the South side of Chicago and South Suburbs at Advocate South Suburban Hospital.	• Education inequity is a huge problem on the South Side of Chicago and the South Suburbs. • Sexual violence prevention, awareness of human trafficking issues, as well as screenings for domestic violence and sexual abuse in women and children are needed in the south region. Health education in the community and prevention education of healthcare providers is an important need in the South Side of Chicago and the South Suburbs. More prevention focused health education curriculum, such as violence prevention education, is needed in schools. • There needs to be more low-cost or free community-based healthcare resources and clinics outside of the emergency department. Individuals need to be connected to services in the community following hospitalization so that there is a continuum of care. • Personal safety and crime are very big concerns in the South region.

Table 2. Key Summary of Findings from Focus Groups in the South Region

Key Findings of Focus Groups Completed in the South Region	
Host Organization	**Key Findings**
Stickney Senior Center Seniors participating in the services provided at the center in Stickney, IL.	• Crime, drugs, gangs, and vandalism are some of biggest safety-related issues facing resident in South Suburbs of Cook County. • Many stores, businesses, and restaurants have closed in the South Suburbs and it has caused numerous issues including job loss, decreased access to healthy foods, lost revenue for the city, and decreases in the overall aesthetics of the community. • Additional screening and preventative services are needed in the community. In-home healthcare services are needed for individuals who are isolated and/or have mobility problems. More urgent care clinics are needed in the community, because that are not many options for urgent care outside of a doctor's office or hospital. • Senior centers provide opportunities for socializing, hot meals, and activities. Many residents stated that the center improved their overall health and wellness. Participants stated that other communities in the South Suburbs could benefit from having local senior centers.
Veterans of Foreign Wars (VFW) Post 311 Veterans, retired military, and former military living in Richton Park, IL and the surrounding areas.	• The definition of veteran status varies widely and it affects the benefits to which former military personnel are entitled. Veteran's benefits should be expanded to all former or retired military. • The services provided by the Veterans Administration's (VA) hospitals and medical centers are generally of good quality, however, there are extremely long waits to see a provider. Choice Care, which extends veteran benefits to additional hospitals outside the VA, should be expanded. • In the South Suburbs, school quality is substandard. Rich Township schools have been placed on academic probation for the last four years. Schools need to provide more job preparedness coursework, expand trade schools, and provide business training. • The South Suburbs have been particularly hard hit by the foreclosure crisis and it has led to the devaluing of property, fewer resources for school districts, and businesses leaving the communities. There needs to be bank and business re-investment in the communities they serve. • Homelessness is a serious issue affecting many veterans and former military. • Many veterans do not know about the benefits and services that are available to them. As a result, there needs to be additional outreach to individuals not already engaged with a veteran's organization.

Cross-Regional Populations of Interest in Chicago and Suburban Cook County

Over the course of twenty-three focus groups held from October 2015 to March 2016 in the three Health Impact Collaborative regions in Cook County, several populations were identified as being in need of special consideration during the assessment, planning, and implementation phases of the CHNA process. Focus group participants in Chicago and Suburban Cook County indicated that several groups of community members were more likely to experience health inequities.

Priority Groups in Chicago and Suburban Cook County that are more likely to experience health inequities, as identified by focus group participants

- Racial and ethnic minorities
- Immigrants (including undocumented immigrants, and linguistically isolated individuals)
- Children and adolescents
- Single parents
- Older adults
- Caregivers
- Women
- Lesbian, Gay, Bisexual, Queer, Intersex, and Asexual (LGBTQIA) individuals
- Transgender individuals
- Veterans
- Individuals living with mental illness
- Individuals with intellectual disabilities
- Individuals with physical disabilities
- Low-income communities
- Homeless individuals or families
- Incarcerated or formerly incarcerated

Much of the focus group input about opportunities to improve community health for these groups transcended the three regions and is relevant and applicable across all of Chicago and Cook County. As a result, cross-regional information for the priority groups is included in this report. The following summaries provide information about the needs that were identified across the three regions (North, Central and South Cook County). A listing of all 23 focus groups conducted in the three regions is included below.

Racial and Ethnic Minorities

Community members indicated that racial and ethnic minorities have a disproportionate burden of health problems. Hospitals often do not collect specific ethnic or racial data on the communities in their service areas. As a result, it is difficult to assess the needs of minority communities. Residents explained that they felt minorities were not treated as well by healthcare professionals and highlighted the need for culturally and linguistically competent providers.

Multiple groups cited discrimination against minorities by local law enforcement. The need for culturally and linguistically competent community police officers was indicated. Racism in the

social justice system[1] was considered a serious problem by several residents. Government agencies were also cited as discriminatory and as lacking linguistically competent staff.

Participants stated that minorities were more likely to live in low-income neighborhoods with fewer job opportunities. Residents emphasized the need to give locally owned businesses incentives to establish in low-income minority neighborhoods. School districts in low-income minority communities were often described as substandard. Inequities in quality affordable housing were also mentioned.

Sexual Assault Nurse Examiners emphasized that there is not equitable access to services for victims of domestic violence and sexual assault, with many racial and ethnic groups having less access. Participants indicated that sexual violence prevention efforts need to be culturally competent.

Immigrants

Immigrants were identified in all three regions of Chicago and Suburban Cook County as having unique needs. Focus groups that discussed the needs of immigrant communities included:

- Arab American Family Services (Arab-American staff members serving Bridgeview, Illinois and the surrounding communities in South Suburban Cook County);
- Asian Human Services (staff members serving the Asian community on the North Side of Chicago and Northern Suburbs);
- English as a Second Language (ESL) Class at St. Mary of Celle Church (students participating in an ESL class located Berwyn, Illinois in the Southwest Suburbs);
- Casa Central (local community members accessing the social services provided by Casa Central);
- Chinese American Service League (Chinese-American staff members serving residents of the Chinatown neighborhood on the South Side of Chicago);
- Hanul Family Alliance (Korean community members living on the North Side of Chicago); and the
- Polish American Association (Polish staff and community residents living on the North Side of Chicago).

Community members in seven of the eight groups focused on immigrant health stated that cultural differences were often barriers to accessing care. They indicated a need for sensitivity training of healthcare professionals so that immigrants feel that they are treated with dignity and respect regardless of English proficiency or citizenship status. Additional culturally and linguistically competent providers are needed. Participants from Arab American Family Services indicated the need for culturally competent providers could be met if hospitals provided more opportunities for training and hiring in local immigrant communities. Participants in the CASL group suggested incentivizing international students, minority students, and bilingual students in health profession majors to serve for a specified period of time in immigrant communities. Staff and community residents cited the need for hospital partnerships with trusted community-based organizations that serve immigrant, refugee, and minority communities.

The Arab American Family Services, Polish American Association, and Asian Human Services groups mentioned that health department and hospital methods of data collection should include collecting information on additional racial and ethnic groups. For example, Polish-Americans are one of the largest ethnic groups in Chicago and Suburban Cook County, however, they are often recorded as “white” only with current data collection practices. As a result, community-based organizations serving Polish-

[1] Social Justice System was a term utilized by participants to refer to the broader societal issues related to criminal justice, incarceration, and societal-values.

Americans find it difficult to fully assess their community's needs. Collection of additional data would allow the needs of many ethnic and racial groups to be more accurately assessed.

Undocumented immigrants and linguistically isolated individuals were identified as being at increased risk for not having their health needs met. Undocumented immigrants were described as being less likely to access needed healthcare services due to fear of deportation. Undocumented seniors were identified as a group needing specific services and benefits. The ESL, Casa Central, Hanul Family Alliance, and Polish American Association groups stated that individuals with limited English proficiency have difficulty accessing healthcare services, even if interpreter services are available. Participants cited long wait times for interpreters and inaccurate translations of medical terminology as major barriers to seeking and/or obtaining medical care. Community members in the ESL and Hanul Family Alliance groups stated that they have had trouble reporting crimes and communicating with police due to language barriers. Multiple residents in the ESL and Polish American Association groups indicated the need for additional multi-lingual staff in local police districts and other government agencies. Services for translating health-related information, such as discharge papers, should also be more readily available. The Polish American Association, Asian Human Services, and Arab American Family Services groups all described the importance of having community resource information in a variety of languages.

Immigrant community members indicated a need for services that help individuals understand the complex U.S. healthcare system. Residents highlighted the need for those services to be culturally and linguistically appropriate.

Multiple immigrant groups indicated that shifting demographics and socioeconomics in their communities have led to an overall decrease in community safety.

Seniors and Caregivers

Participants identified community centers, activities, and events as positively contributing to the health of seniors in Chicago and suburban Cook County. Community members indicated a need for additional activities and services for older adults. Other services mentioned as a need for seniors in Chicago and Suburban Cook County Included:

- affordable housing services (particularly for LGBTQ individuals and undocumented immigrants);
- transportation to medical appointments;
- in-home health services (check-ups, preventive screenings);
- check-ins with seniors living alone; and
- services that support aging in place.

Support for caregivers was mentioned as a community need in multiple groups. Caregivers described the need for oversight and standardization of home health aides and their training. Caregivers also mentioned the need for help with aging in place and end-of-life decisions. LGBTQ seniors need culturally sensitive providers and caregivers that understand their unique needs

LGBQIA and Transgender Community Members

Participants explained that LGBQIA and transgender community members are more likely to experience a number of health-related issues including:

- homelessness (in particular youth homelessness);
- substance abuse;

- a lack of culturally competent mental and behavioral health services;
- a lack of resources for aging in place; and
- a lack of residential facilities available to older adults.

Community members indicated that healthcare services and providers that are culturally competent in the needs of LGBQIA and transgender residents are strongly needed.

Many community members indicated that they felt mistreatment by law enforcement, schools, and healthcare providers is negatively impacting members of the LGBQIA and transgender community. Rights[2] for transgender community members were described as particularly lacking in the communities throughout Chicago and Suburban Cook County. Residents highlighted the need for inclusive policies and practices in many community-based institutions.

Veterans and Former Military

Veterans and former military service members were another population that was mentioned as having unique community health needs. There are widely varying definitions of veteran status and participants explained that it affects the benefits for which former and retired military are eligible. Community residents that were veterans and former military indicated that there needs to be more resources and benefits available to everyone who has served in the U.S. military.

Veterans and former military stated that VA hospitals provide quality care but that there are excessively long waits to see medical providers. Residents stated that Choice Care, which extends veteran's medical benefits to institutions outside the VA, should be expanded.

Participants who are former service members identified female veterans and former military as having unique needs. Individuals indicated that service members who have been victims of sexual assault are in need of both advocacy and recovery services. Health services that are designed to meet the needs of female service members such as gender specific behavioral health treatments and reproductive health services need to be improved and expanded.

Veterans and former military expressed the need for increased outreach to veterans who are struggling with health issues such as homelessness and Post Traumatic Stress Disorder (PTSD), because they often do not know about the benefits and services available to them. Participants also indicated that untreated PTSD or other behavioral health issues and traumatic brain injuries have led to interpersonal violence and domestic abuse issues among former service members and their families. As a result, participants highlighted the need to accurately assess the prevalence of interpersonal violence issues among former military so that they can receive treatment and care along with their families.

Veterans and former military cited the need for help with grant writing so that funding can be secured for community-based organizations that serve veteran communities.

Individuals Living with Mental Illness or Substance Abuse

Due to severe budget cuts in the last several years, many mental health institutions and community based providers have closed and several services have been discontinued. Community residents

[2] Participants are referring to the broader societal movement to provide equal rights and protections for LGBQIA and transgender community members.

indicated that, as a result of budget cuts over several years, the mental and behavioral health needs of youth and adults in their communities are not being met. Community members stated that the closing of mental health institutions has caused or exacerbated a number of community health problems including:

- the mass incarceration of individuals with mental illness and substance abuse problems;
- substance abuse as a form of self-medication for individuals with unmet mental health needs;
- increased hospitalization;
- homelessness;
- suicide; and
- the overburdening of existing programs and facilities

Individuals living with mental illness and their caregivers explained that community-based crisis prevention services, such as drop-in counseling, would improve their health outcomes. Multiple individuals believed that there should be scholarships and incentives for physicians and social workers to enter behavioral health fields. Some participants stated the need for additional Crisis Intervention Trained community responders.

Community residents indicated that transitional living services such-as group homes are important following an inpatient program. Formerly incarcerated individuals cited the need for transition services following incarceration to prevent relapse.

Participants in a number of groups stated that they felt mistreated (received lower quality treatment, not receiving treatment for medical issues unrelated to mental illness, and had their concerns about behavioral health treatment options ignored by medical staff) because of their mental illness or intellectual disability. Families of individuals living with mental illness or an intellectual disability stated that their concerns are often ignored by medical staff during the decision making process surrounding treatments and that it has resulted in family members receiving previously ineffective treatments. Sensitivity training for current healthcare staff and students in health-related fields of study was cited as a potential solution.

Needed policy changes mentioned by participants included treatment instead of incarceration for individuals with mental illness or substance abuse health issues as well as advocacy and funding for mental health services.

Individuals living with intellectual or physical disabilities
Several community members explained that some communities are not accessible for disabled residents. In addition, transportation services and other independent living resources for individuals with disabilities have decreased in the last several years.

Community members highlighted that healthcare information needs to be provided in a format that can be understood by individuals with intellectual disabilities. Participants stated that individuals with intellectual disabilities are often not treated with dignity or respect by healthcare providers. Multiple participants cited problems of abuse and neglect in residential facilities. LGBQIA and transgender community members with disabilities are more likely to experience discrimination and health inequities.

Job training and fair employment of individuals with mental illness or intellectual disabilities was also a need mentioned by multiple groups.

Summary of Key Findings

Each of the focus groups provided insight into several broad community health issues. Figure 2 highlights the topics covered in each of the focus groups. The social determinants of health, access to care, infrastructure and the built environment, behavioral health; and policy change and advocacy were the major topic areas discussed across regions. Several key themes arose related to the social determinants of health including educational opportunities, workforce development, community cohesion, safety, immigration status, linguistic isolation, and economic opportunities. Participants mentioned multiple issues related to the built environment including transportation, lead exposure, quality affordable housing, and access to healthy foods. Policy change and advocacy were repeatedly mentioned as avenues for improving community health. Advocacy for individuals living with mental illness and their families; advocacy for homeless individuals and families; discontinuing incarceration for substance abuse and mental illness; advocacy for individuals living with disabilities; better medical benefits for the formerly incarcerated; expansion of veterans benefits to all former military; and the promotion of economic equity were some of the systems-level policy changes recommended by community residents. Table XX. Summarizes the key findings from each of the focus groups.

Figure 2. Key Themes Discussed in each of the 23 Focus Groups

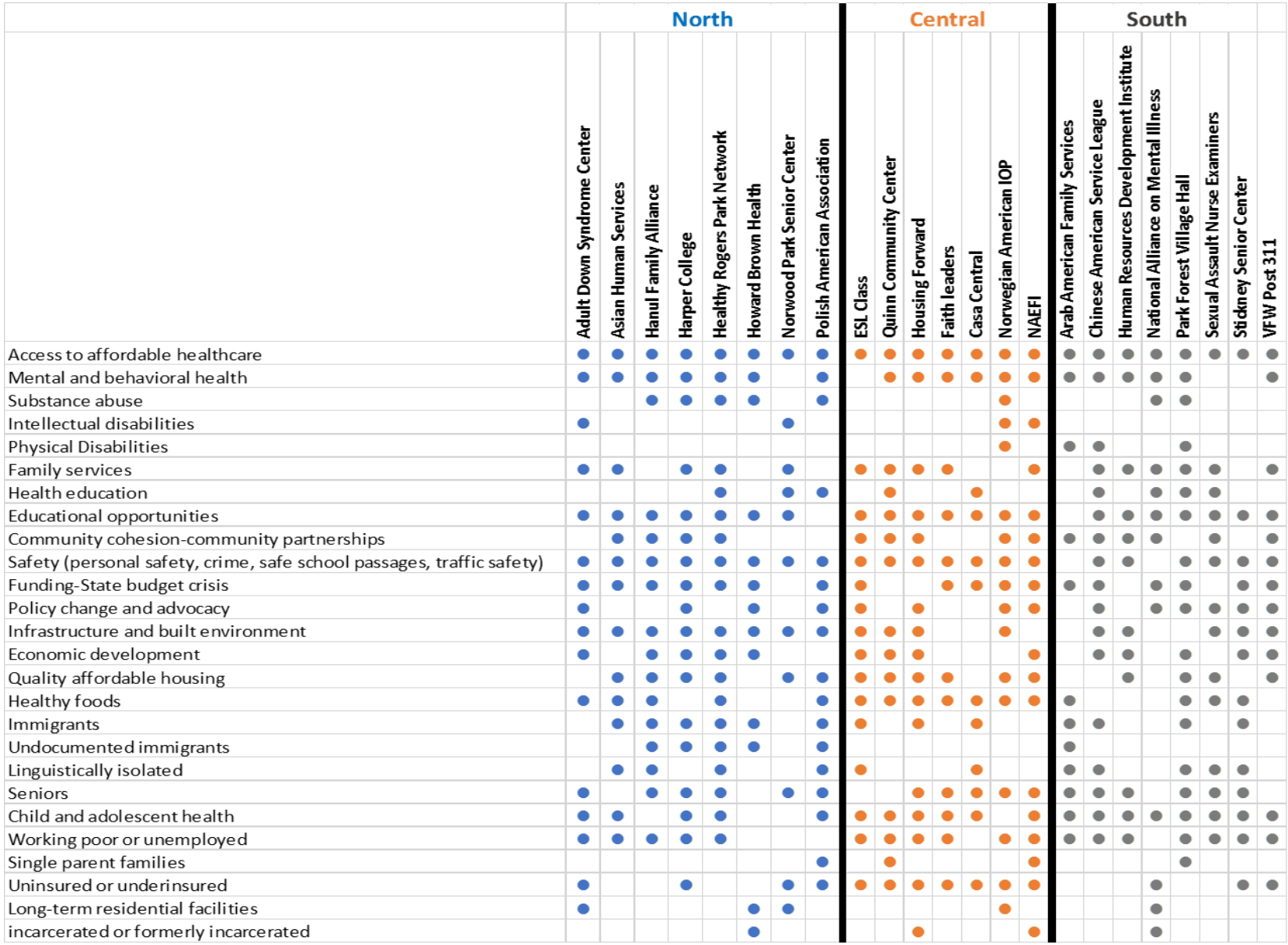


Table 3. Key Findings of Focus Groups Completed in the North Region

Host Organization	Key Findings
Adult Down Syndrome Center Parents and families of individuals with Down Syndrome, medical providers, a representative from a residential facility, and adults living with Down Syndrome in the City of Chicago and Suburban Cook County.	• Inpatient and outpatient mental health facilities, day programs, special recreation programs, residential facilities, and support systems for both youth and adults are all needed to ensure the health of individuals with intellectual disabilities. Funding issues and the state budget crisis is threating services that are needed for individuals in the community that have intellectual disabilities and their caregivers. • There is a lack of behavioral and mental health services for individuals with intellectual disabilities. Behavioral health services specifically for aging adults with intellectual disabilities are also greatly lacking. • It takes families a long time to find resources because there are no consolidated resource centers and existing databases need improvement. Schools provide ties to resources, but there is no continuity into adulthood. Families also need information on legal resources and advice. • Job training, fair employment, and volunteer opportunities can significantly improve the health and independence of individuals living with Down syndrome. However, employment and volunteer opportunities are severely lacking.
Asian Human Services (AHS) AHS staff members and community residents in the Uptown and Edgewater communities of Chicago.	• There is a need for data collection about the needs, health statuses, and healthcare utilization of different Asian communities. Hospitals and health departments should work with community based organizations to design assessments. • Underfunding of services such as schools, adult literacy programs, daycare, mental health services, and preventative health screenings needs to be addressed. • The need for case coordination, case management, health navigation, and referrals systems is one of the biggest issues facing Asian communities in Chicago and Suburban Cook County. • Language barriers and a lack of cultural competency are major issues affecting access to medical services, social services, and schools. • Access to non-emergency preventative care as well primary prevention, such as healthy eating and exercise, help communities members avoid health crises in the future. • There is a need to educate immigrant community members about the Affordable Care Act and the benefits that are available.

Table 3. Key Findings of Focus Groups Completed in the North Region

Host Organization	Key Findings
Hanul Family Alliance Korean community members in the Albany Park community of Chicago.	• The one resounding complaint across all participants was health care for undocumented community members and immigrants. Several participants commented that there is not enough useful resources and facilities for immigrants and refugees. • Language barriers have led to difficulty communicating with police or emergency services. There are excessively long waits for translation services at some of the hospitals. A couple participants believed that culturally competent police officers and health care professionals would help immigrants communicate better regarding societal and health related frustrations. Language barriers prevent immigrants from accessing free health care prevention workshops and screening services. Informational publications need to be in a variety of languages. • Emergency rooms at hospitals are too slow and some immigrant community members perceive the staff there as unfriendly. • Better public education opportunities are needed.
Harper College Students and faculty in the college's Health Services Department as well as community partners including staff at social service organizations and representatives from local government in the Northwest suburbs of Cook County.	• If health systems and hospitals better integrated community health workers into their institutions, then they could better respond to community health needs in a culturally competent way. • Better Medicaid coverage for dental, vision, and auditory services is needed, particularly for seniors. State and federal governments should incentivize students including doctors, social workers, and other healthcare providers to serve Medicaid and uninsured populations. • Premature discharge of patients with mental health needs because of lack of insurance coverage is a problem in the Northwest Suburbs. Young adults with mental health need are at an increased risk for not receiving the healthcare services they need. Many young adults are transferred back and forth between facilities every few days because of poor Medicaid coverage and as a result become lost in the healthcare system. • Mental health training for emergency responders is needed. Many arrest issues are due to mental health. • There needs to be standardized screening for everything from domestic violence to mental health. • In the entire state of Illinois there is a lack of affordable housing. • Funding for programs and services needs to be stabilized and sustained. • Services and care for homeless individuals are an asset that could be expanded.

Table 3. Key Findings of Focus Groups Completed in the North Region

Host Organization	Key Findings
Healthy Rogers Park Community Network Representatives from local social service organizations, clinics, hospitals, and community groups that are a part of the Healthy Rogers Park Community Network in the Rogers Park community on the North Side of Chicago.	• Language and cultural backgrounds affect how well immigrants on the North side of Chicago access healthcare services. • There is instability in funding for smaller organizations. There needs to be a shift from project-based funding in the non-profit sector. • There is a large population of low-income seniors in the Rogers Park and Edgewater neighborhoods of Chicago. The state funding for many of the services for seniors has been severely cut. Staff in organizations serving seniors has also been cut. There are not enough transportation services to medical appointments available for seniors. • Expansion of Community Health Worker programs and hospital partnerships with local high schools would improve community health. • Behavioral health services including inpatient programs need to be expanded or created on the North side of Chicago. • There is a large number of children who are food insecure on the North side of Chicago. Healthy food is expensive and there needs to be more education on how to eat healthy for less cost. • There is a large variation in school success on the North side of Chicago. • There needs to be violence prevention curriculum in schools starting at a very young age. • There is a large percentage of overcrowded homes in the Rogers Park neighborhood of Chicago.

Table 3. Key Findings of Focus Groups Completed in the North Region

Host Organization	Key Findings
Howard Brown Health LGBTQ community members from across Chicago and Suburban Cook County and staff who were residents of communities on the North Side of Chicago.	• Multiple individuals highlighted the inequities between the different regions of Chicago and Suburban Cook County. Participants stated that compared to the west and south sides of the city, the north side of Chicago has the best access to public transportation, more access to healthy foods, more community involvement from residents, and more homeless shelters. • More culturally competent mental health providers are needed in LGBTQ and minority communities. Culturally competent substance abuse services are also needed. The stigma associated with seeking behavioral health services needs to be addressed, particularly in ethnic or racial minority communities. • LGBTQ community members stated that they have experienced transphobia, ableism, and racism from other residents and that sensitivity training is needed in many sectors of the community. • Major changes are needed in police culture and police interactions with community members. Psychological evaluations and mental health services should be mandatory for police officers, especially those who work in high crime areas or experience trauma. Several changes are needed in the criminal justice system as a whole including a decrease in the imprisonment rate for the mentally ill, rights for transgendered incarcerated individuals, better medical care in correctional facilities, educational opportunities in prisons, and transitional services for the formerly incarcerated. • Quality education should be available to all students regardless of where they live. In many parts of Chicago and Suburban Cook County the education system has failed tremendously. Schools should empower students and provide workforce development opportunities.
Norwood Park Senior Center Family members and caregivers of individuals requiring assisted living or full-time care in the Norwood Park community of Chicago.	• There needs to be a single source of information about community resources, social services, and healthcare services. • Standardization of training for home health aides and oversight of home healthcare agencies is needed. • Caregivers need help accessing legal resources and navigating issues surrounding survivor's benefits. • In-home wellness checks are important for home-bound and isolated seniors. Managed care services that include routine check-in calls from doctor's offices are helpful and should be expanded.

Table 3. Key Findings of Focus Groups Completed in the North Region

Host Organization	Key Findings
Polish American Association Polish-American staff who were also community members of the Portage Park and surrounding neighborhoods on the North Side of Chicago.	• Closing of mental health clinics has resulted in extremely limited mental health services being available in the portage park neighborhood of Chicago, a lack of substance abuse services, and a lack of services for youth. • There is an affordable housing shortage on the North side of Chicago. There is a large homeless community in Portage Park and the surrounding areas. Many undocumented immigrants cannot access housing services because of their immigration status. Navigating applications for services and housing is often too difficult for immigrants with limited English proficiency. It is difficult to find even temporary housing for individuals, families, and seniors if they are experiencing a housing crisis. • Communities on the North side of Chicago are lacking positive leadership in local government that understands the needs of the Polish community. • There is a lack of Polish speaking medical providers in low-cost or free clinics throughout Chicago and Suburban Cook County. Immigration status also affects whether or not individuals can access insurance through the Healthcare Marketplace. • There needs to be better data collection at the hospital, health department, state, and federal levels on the different Ethnic and Racial communities living in the U.S.

Table 4. Key Findings of Focus Groups Completed in the Central Region

Host Organization	Key Findings
Casa Central Participants in Casa Central programs and staff from the Diabetes Empowerment Center in the Humboldt Park community and surrounding areas on the west side of Chicago.	• Community-based services are positively impacting the health of individuals living in communities on the west side of Chicago. • There needs to be more community engagement from local hospitals located on the west side of Chicago. • Residents trust and have relationships with community-based organizations such as Casa Central and the Diabetes Empowerment Center and those connections could be leveraged by hospitals to engage the communities they serve. • There are long-waits to see bi-lingual providers and some interpretation services do not accurately interpret medical terminology. • Healthcare providers are not sensitive to the needs of immigrants. • Programs for youth living on the west side of Chicago are needed. • The mental and behavioral health needs of residents in the city are not being addressed. • Community Health Workers could be trained to identify individuals that need to be connected with mental and behavioral health services. • Schools on the west side of the city that do not have as many resources are struggling. • There is a need for programs that empower community residents to engage in prevention and self-care to improve their health.
English as a Second Language (ESL) Students at St. Mary de Celle Church in Berwyn, IL.	• Many communities in the West suburbs are low income so medical services need to be more affordable. • Hospitals could do more work to provide community-based services where West Suburban residents live. • The long waits for translation services at hospitals is a major barrier to immigrants accessing medical services. • Sensitivity training for medical staff at hospitals is needed. • A lack of culturally and linguistically competent staff was cited as a problem in government agencies including local police and emergency responders. • Drug, gangs, break-ins, and theft are some of the biggest issues affecting the health of communities in the West suburbs. • Community leaders could be convened and leveraged to address the safety and security needs of everyone in the community (Churches, businesses, schools, and police are some of the entities that should be involved). • Many residents indicated a need for more information about programs and services available in their communities. • Information about political policies and political candidates should be provided in multiple languages so that residents can make informed choices when they vote. • There is a need for Bilingual politicians in local government that can speak to the needs of the immigrant community.

Table 4. Key Findings of Focus Groups Completed in the Central Region	
Host Organization	**Key Findings**
Faith Leaders Faith leaders, hospital staff, and community members in the Humboldt Park and West Town communities on the west side of Chicago.	• There are pockets in the west side of Chicago that are unsafe, particularly in the evening and early morning. • Prescription drug abuse and illegal drug use are becoming increasingly bigger problems in the west region of the city. • Schools, particularly those on the west side of Chicago, are substandard due to severely limited resources. • Low-income families are being pushed out of the neighborhoods on the west side of Chicago because of the changing socioeconomic demographics. • There is a large number of homeless individuals in the communities on the west side of the city, it is in part due the closings of mental health institutions in the last several years.
Housing Forward Clients of Housing Forward in Maywood, IL.	• There are several inequities among townships and villages in the west suburbs. • Community health in the west suburbs would improve if there were better community-police relationships. • The expansion of public transit hours and routes is needed, particularly in the west suburbs • Youth violence has become socially acceptable, so more positive youth programs are needed. • Individuals with substance abuse issues and/or mental illness should be sent to treatment not prison. • Family-based solutions to community health problems are needed. • Additional outreach and advocacy are needed to get homeless individuals into community based programs and health care services.

Table 4. Key Findings of Focus Groups Completed in the Central Region	
Host Organization	**Key Findings**
NAEFI National Alliance for the Empowerment of the Formerly Incarcerated (NAEFI) re-entry circle participants and staff.	• Individuals in correctional facilities often have low literacy rates which affects their ability to understand healthcare information, decreases their ability to find much needed transition services, further decreases their employment opportunities, and negatively impacts other aspects of their health. • Participants stated that the education system in the west and south sides of Chicago is deplorable. • Older adults transitioning back into the community following incarceration often have health problems but are frequently ineligible for benefits such as Medicare and Medicaid. • A lack of mental health services is contributing to poor health and crime in the community. • Post-traumatic stress disorder (PTSD) treatment needs to be available for youth and adults who live in areas with high violent crime rates and for those transitioning back to the community following incarceration.
Norwegian IOP Patients in the Norwegian IOP program on the West Side of Chicago.	• Preventive mental and behavioral health services, such as drop-in counseling appointments, are needed in most communities. • Information about healthcare resources needs to be in a format that individuals with intellectual disabilities can understand. • Healthcare professionals do not visit long-term care facilities often enough. • Individuals in residential facilities receive low quality medical care, less effective treatments, and low quality assistive devices. • It can be difficult for individuals with mental illness or intellectual disabilities to advocate for their needs alone, so they need people to advocate for and with them to policymakers.

Table 4. Key Findings of Focus Groups Completed in the Central Region	
Host Organization	**Key Findings**
Quinn Community Center Community residents participating in programs at the Quinn Community Center in Maywood, IL.	• Illegal drug activity is one of the biggest negative health behaviors in the west suburbs. • Tobacco and alcohol use is high in some of the suburban communities. • Access to healthy foods is extremely limited in some of the townships and villages, and it is leading to other health problems in the community including obesity and diabetes. • The mental and behavioral health needs of youth in the west suburbs are not being met and it has led to other serious issues such as depression and suicide. • Many adults in west suburban communities are unemployed due to a lack of economic opportunity. • A shortage of youth programs has led to other community problems such as youth violence and bullying. • Intergenerational family-based interventions are needed to improve health in suburban communities. • In some of the suburban communities there is a need for improved access to free or low-cost clinics as well as more affordable medication and treatment options.

Table 5. Key Findings of Focus Groups Completed in the South Region

Host Organization	Key Findings
Arab American Family Services Arab-American staff who were residents of Bridgeview, IL and surrounding communities.	• Arab-American immigrants feel that they are treated disrespectfully by hospital staff. There needs to be more diversity in the front-line staff at hospitals. • There is a need for more culturally competent providers and better quality translation services at hospitals. Hospitals could contract with immigrant and refugee serving community-based organizations to provide cultural sensitivity and educational workshops as well as quality translation services. • Culturally competent providers that are trauma informed are needed to serve immigrant women who are victims of domestic violence or sexual violence. • There is a need for better ethnic and racial data collection at hospitals.
Chinese American Service League (CASL) Chinese-American staff who were residents of the Chinatown community in Chicago.	• More qualified Chinese-speaking and culturally competent doctors are needed. Both generalists and specialists are needed. International students at medical schools and in healthcare programs could be incentivized to serve immigrant communities. It can be hard for immigrant patients to go to hospitals because they do not understand the healthcare system. In addition, there is a language barrier at some of the major medical centers. • There should be culturally specific integration services for immigrants that are new to the community. Information should include lists of healthcare facilities that have translation services. There is a language barrier preventing immigrants from accessing behavioral health services and many do not know about mental health resources that are available. • Aging residents and residents with disabilities can become isolated. Funding is needed to provide services for disabled community members and seniors. • There is a disconnection of social service organizations. Competition and political issues need to be put aside so that community issues can be addressed. • Safety is major concern of residents in the Chinatown neighborhood in Chicago. Community members reported robberies, physical violence, and assault as some of the biggest safety concerns.

Table 5. Key Findings of Focus Groups Completed in the South Region	
Host Organization	**Key Findings**
Human Resources Development Institute (HRDI) Clients in HRDI's day programs on the South Side of Chicago.	• Gang activity and illicit drugs are major issues leading to many of the other safety-related concerns on the South Side of Chicago. • Opportunities, such as block parties, are important for building community cohesiveness and trust among neighbors. • There needs to be more positive community involvement from the police. • Family-based solutions are needed to address many of the health issues in the city. • The mental health needs of many residents living on the South Side of Chicago are not being met.
National Alliance on Mental Illness (NAMI) Parents, families, and caregivers of adults with mental illness living in South Suburban Cook County.	• Hospitals need to be more sensitive to mental health patients. Behavioral health therapists, doctors, and nurses all need sensitivity training so that patients and their families feel that they are treated with dignity and respect. • Doctors and social workers need to be incentivized to go into behavioral health. • Health education of family members is important so that they know how to navigate the system. There needs to be a place that family members can go to learn about the services that are available and where they can get • Stigma surrounding behavioral health problems is an issue that needs to be addressed with family members, community residents, and healthcare providers. • There needs to be a shift in healthcare so that more attention is given to recovery from mental illness than crisis management. • Mental health services for children and adolescents are severely lacking in the South Suburbs. Some communities have judicial mental health courts that sentence young people with minor offenses to treatment instead of jail and they should be expanded to other communities. Young adult and youth peer-to-peer support groups for persons with mental illness could be beneficial. • Greater transparency is needed at residential facilities to ensure that residents are receiving proper care. More coordinated efforts are needed between providers and long-term nursing home facilities to screen and place nursing residents with mental illness in more appropriate housing and programs.

Table 5. Key Findings of Focus Groups Completed in the South Region	
Host Organization	**Key Findings**
Park Forest Community residents, health department staff, service providers, and local government representatives in Park Forest, IL.	• More local businesses are needed. • There is a need for a variety of locally grown and affordable healthy food options in grocery stores. • More information is needed about the healthcare resources, facilities, and services available in Park Forest. • There is a limited number of behavioral health services available in the south suburbs. • There are a number of safety-related issues in the south suburbs. • There is less community cohesiveness in low-income areas. • Funding issues have affected the availability of homeless shelters. There needs to be additional funding and support for intergenerational services such as daycares, caregiver support services, senior services, and services for children and adolescents.
Sexual Assault Nurse Examiners (SANE) SANE providers serving the South side of Chicago and South Suburbs at Advocate South Suburban Hospital.	• Education inequity is a huge problem on the South Side of Chicago and the South Suburbs. • Sexual violence prevention, awareness of human trafficking issues, as well as screenings for domestic violence and sexual abuse in women and children are needed in the south region. Health education in the community and prevention education of healthcare providers is an important need in the South Side of Chicago and the South Suburbs. More prevention focused health education curriculum, such as violence prevention education, is needed in schools. • There needs to be more low-cost or free community-based healthcare resources and clinics outside of the emergency department. Individuals need to be connected to services in the community following hospitalization so that there is a continuum of care. • Personal safety and crime are very big concerns in the South region.

Table 5. Key Findings of Focus Groups Completed in the South Region	
Host Organization	**Key Findings**
Stickney Senior Center Seniors participating in the services provided at the center in Stickney, IL.	• Crime, drugs, gangs, and vandalism are some of biggest safety-related issues facing resident in South Suburbs of Cook County. • Many stores, businesses, and restaurants have closed in the South Suburbs and it has caused numerous issues including job loss, decreased access to healthy foods, lost revenue for the city, and decreases in the overall aesthetics of the community. • Additional screening and preventative services are needed in the community. In-home healthcare services are needed for individuals who are isolated and/or have mobility problems. More urgent care clinics are needed in the community, because that are not many options for urgent care outside of a doctor's office or hospital. • Senior centers provide opportunities for socializing, hot meals, and activities. Many residents stated that the center improved their overall health and wellness. Participants stated that other communities in the South Suburbs could benefit from having local senior centers.
Veterans of Foreign Wars (VFW) Post 311 Veterans, retired military, and former military living in Richton Park, IL and the surrounding areas.	• The definition of veteran status varies widely and it affects the benefits to which former military personnel are entitled. Veteran's benefits should be expanded to all former or retired military. • The services provided by the Veterans Administration's (VA) hospitals and medical centers are generally of good quality, however, there are extremely long waits to see a provider. Choice Care, which extends veteran benefits to additional hospitals outside the VA, should be expanded. • In the South Suburbs, school quality is substandard. Rich Township schools have been placed on academic probation for the last four years. Schools need to provide more job preparedness coursework, expand trade schools, and provide business training. • The South Suburbs have been particularly hard hit by the foreclosure crisis and it has led to the devaluing of property, fewer resources for school districts, and businesses leaving the communities. There needs to be bank and business re-investment in the communities they serve. • Homelessness is a serious issue affecting many veterans and former military. • Many veterans do not know about the benefits and services that are available to them. As a result, there needs to be additional outreach to individuals not already engaged with a veteran's organization.

Health Impact Collaborative of Cook County, South Region

Community Themes and Strengths Assessment: Community Resident Survey Results

Purpose and Methodology

Purpose

The purpose of the Community Themes and Strengths Assessment (CTSA) was to identify themes that interest and engage the community, demonstrate perceptions about quality of life, and identify community assets. Community resident surveys were utilized in combination with focus group data to identify community themes and strengths for Chicago and Cook County.

Community Survey Methodology

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

By leveraging its partners and networks, the Collaborative collected approximately 5,200 resident surveys between October 2015 and January 2016, including about 2,200 in the South region. The survey was available on paper and online and was disseminated in five languages; English, Spanish, Polish, Korean, and Arabic. Approximately 75% of the surveys were submitted in printed form and about a quarter were submitted online. Survey responses were collected through convenience sampling. Hospitals and community-based organizations distributed the surveys through targeted outreach to many of the diverse communities in Chicago and Cook County. There was particular interest in reaching low income communities, racial and ethnic groups, and other minority populations. 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.

Community Resident Survey Topics

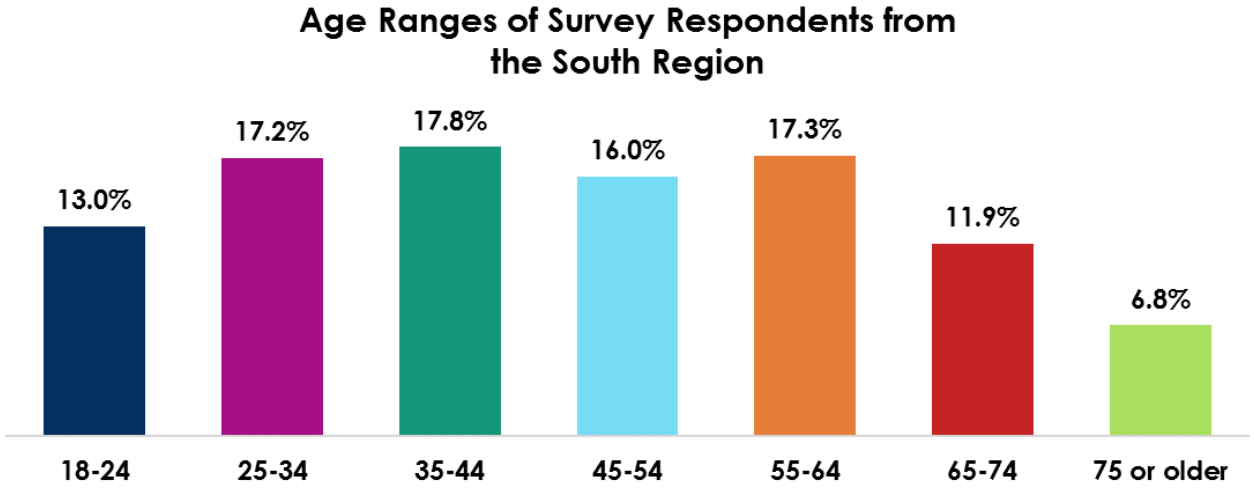
- Adult Education and Job Training
- Barriers to Mental Health Treatment
- Childcare, Schools, and Programs for Youth
- Community Resources and Assets
- Discrimination/Unfair Treatment
- Food Security and Food Access
- Health Insurance Coverage
- Health Status
- Housing, Transportation, Parks & Recreation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

IPHI reviewed approximately 12 existing surveys to identify possible questions. IPHI, hospitals, health departments, and stakeholders from the three regions worked collaboratively to identify 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 platform so that all data could be analyzed together. Survey data analyses were conducted using SAS statistical analysis software and Microsoft Excel was used to create survey data tables and charts.

Demographic characteristics of survey respondents

Age

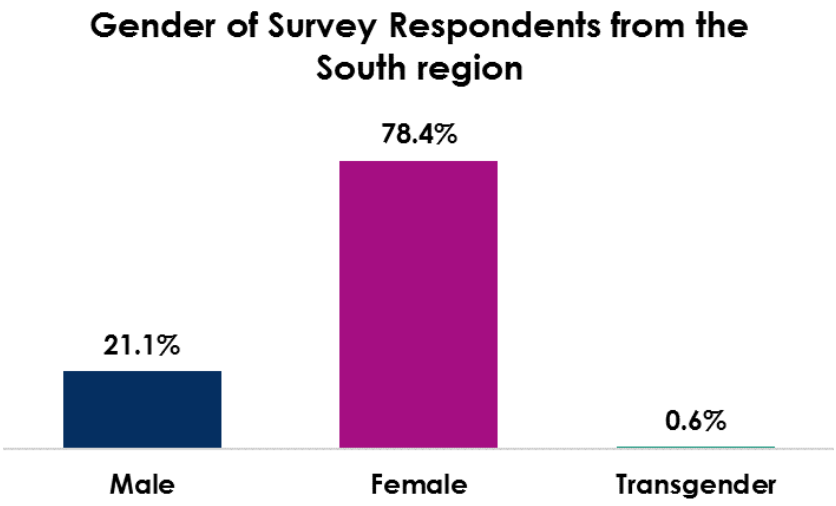
Age	Percent (n=2191)
18-24	13.0%
25-34	17.2%
35-44	17.8%
45-54	16.0%
55-64	17.3%
65-74	11.9%
75 or older	6.8%



Survey respondents represented a wide range of ages, with the largest group of respondents between ages 25-34 (17.2%), 35-44 (17.8%), and 55-64 (17.3%). The least represented age group was 75 or older (6.8%).

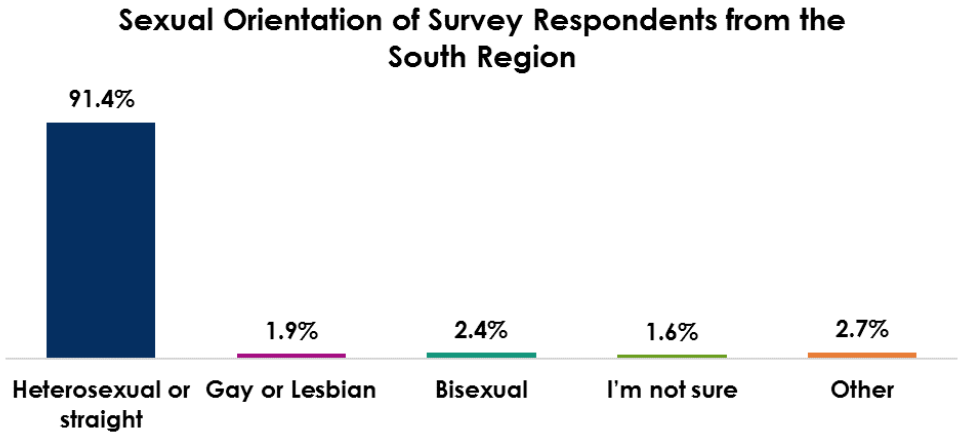
Gender

Gender	Percent, (n=2146)
Male	21.1%
Female	78.4%
Transgender	0.6%



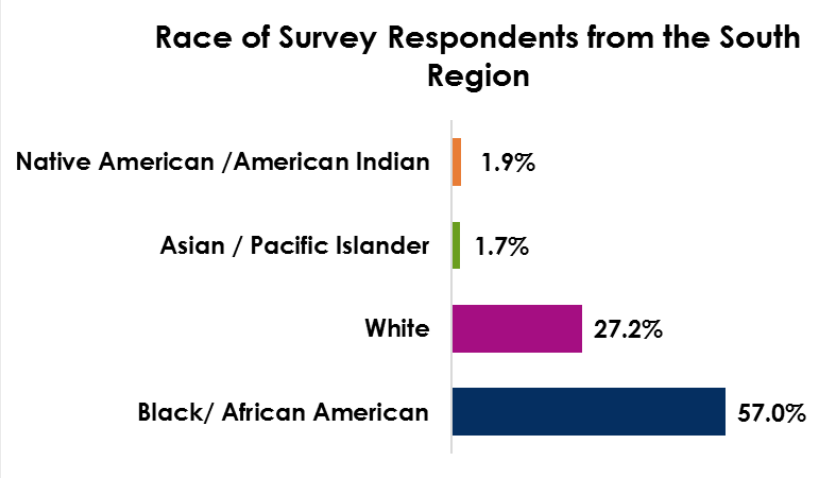
Sexual Orientation

Sexual Orientation	Percent, (n=2146)
Heterosexual or straight	91.4%
Gay or Lesbian	1.9%
Bisexual	2.4%
I'm not sure	1.6%
Other	2.7%



Race

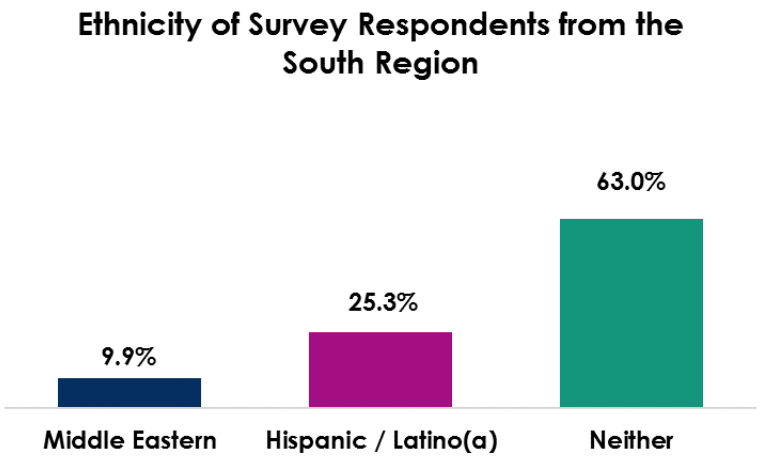
Race (n=2146)	Percent (Yes)	Percent (No)
Black/ African American	57.0%	43.0%
White	27.2%	72.8%
Asian / Pacific Islander	1.7%	98.3%
Native American /American Indian	1.9%	98.1%



The majority of respondents from the South region identified as Black/African American (57.0%). Individuals identifying as white (27.2%), Native American/American Indian (1.9%), and Asian/Pacific Islander (1.7%) comprised the remaining 37.4% of respondents.

Ethnicity

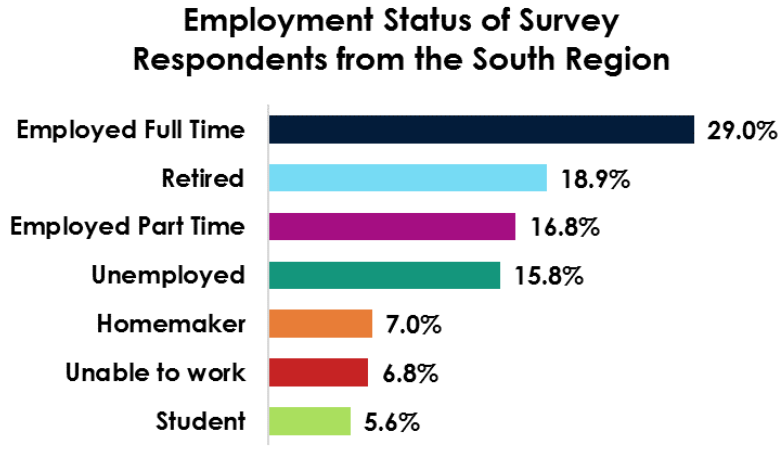
Ethnicity (n=1804)	Yes	No
Middle Eastern	9.9%	90.1%
Hispanic / Latino(a)	25.3%	74.7%
Neither	63.0%	37.0%



Individuals identifying as Hispanic/Latino(a) comprised 25.3% of survey respondents. Those identifying as Middle Eastern comprised 9.9% of respondents, while the remaining 63.0% identified as neither. The South region has the highest percentage of survey respondents identifying as Middle Eastern.

Employment Status

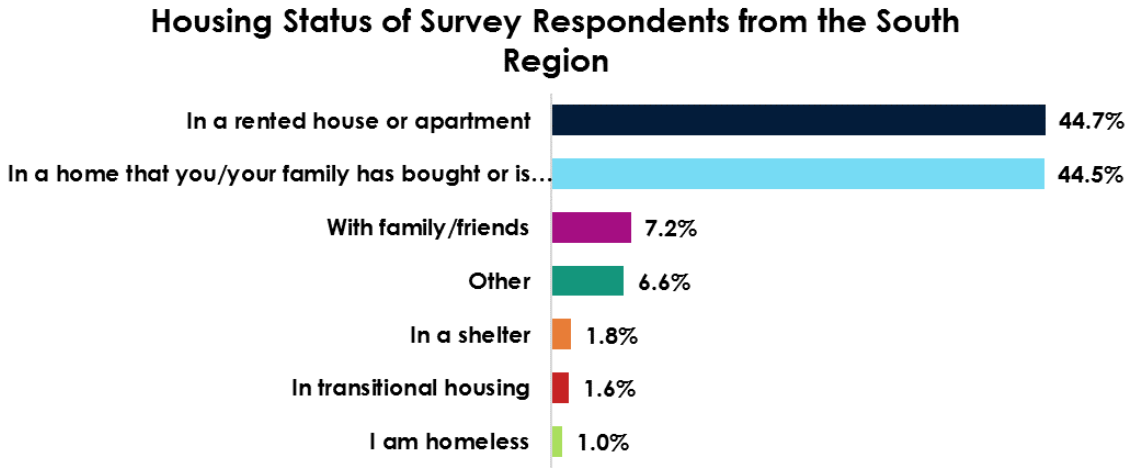
Employment Status	Percent (n=2102)
Student	5.6%
Unable to work	6.8%
Homemaker	7.0%
Unemployed	15.8%
Employed Part Time	16.8%
Retired	18.9%
Employed Full Time	29.0%



The largest groups of respondents were either employed full-time (29.0%) or retired (18.9%). Those who were unemployed (15.8%) or unable to work (6.8%) represented a large proportion of the respondents from the South region.

Housing Status

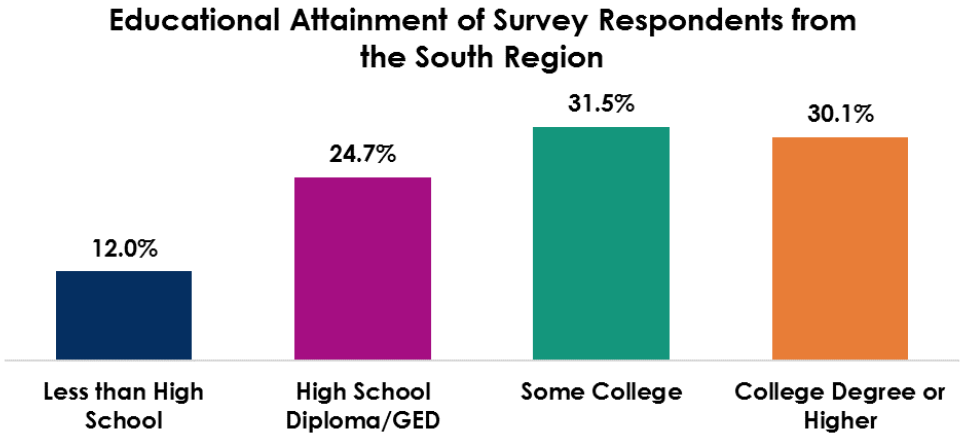
Housing Status	Percent (n=2257)
I am homeless	1.0%
In transitional housing	1.6%
In a shelter	1.8%
Other	6.6%
With family/friends	7.2%
In a home that you/your family has bought or is buying	44.5%
In a rented house or apartment	44.7%

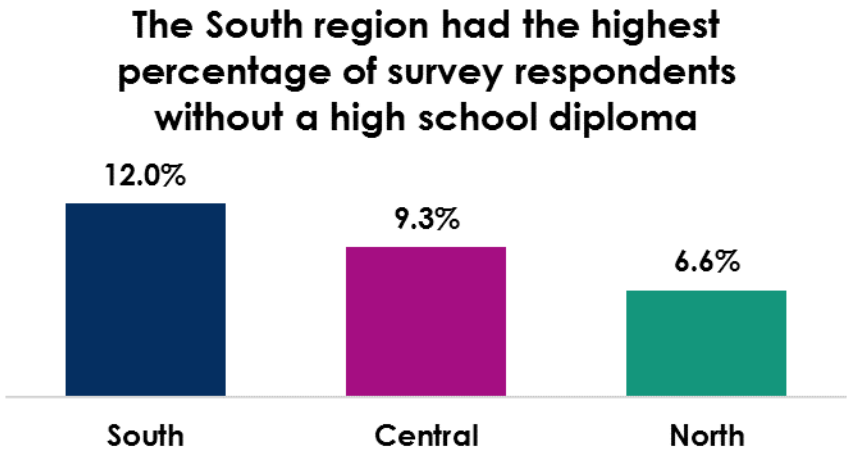


Most respondents from the South region (44.7%) live in a rented house or apartment. An additional 44.5% of respondent live in a home that they or their family has bought or is buying.

Educational Attainment

Educational Attainment	Percent (n=2027)
Less than High School	11.7%
High School Diploma/GED	24.9%
Some College	32.5%
College Degree or Higher	30.9%
Less than High School	11.7%

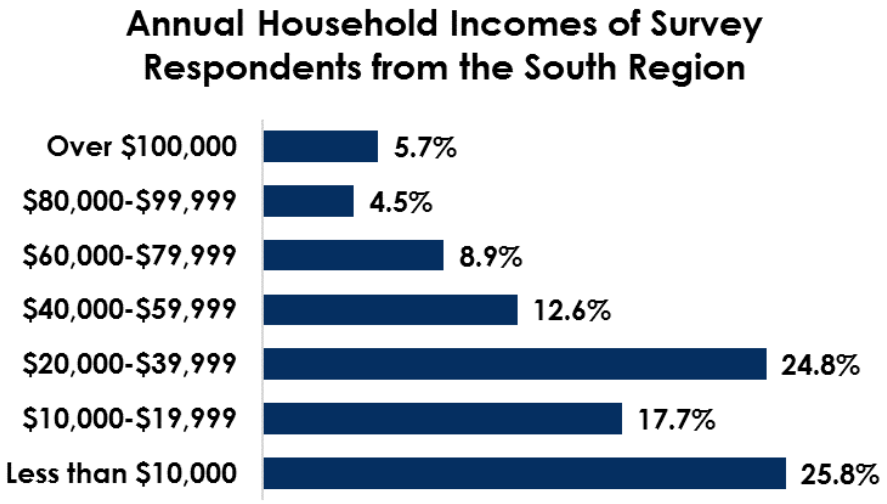




The majority of respondents from the South region have had some college education (31.5%), however, the South region has the highest percentage of respondents without a high school education (12.0%) compared to the Central (9.3%) and North (6.6%) regions.

Annual Household Income

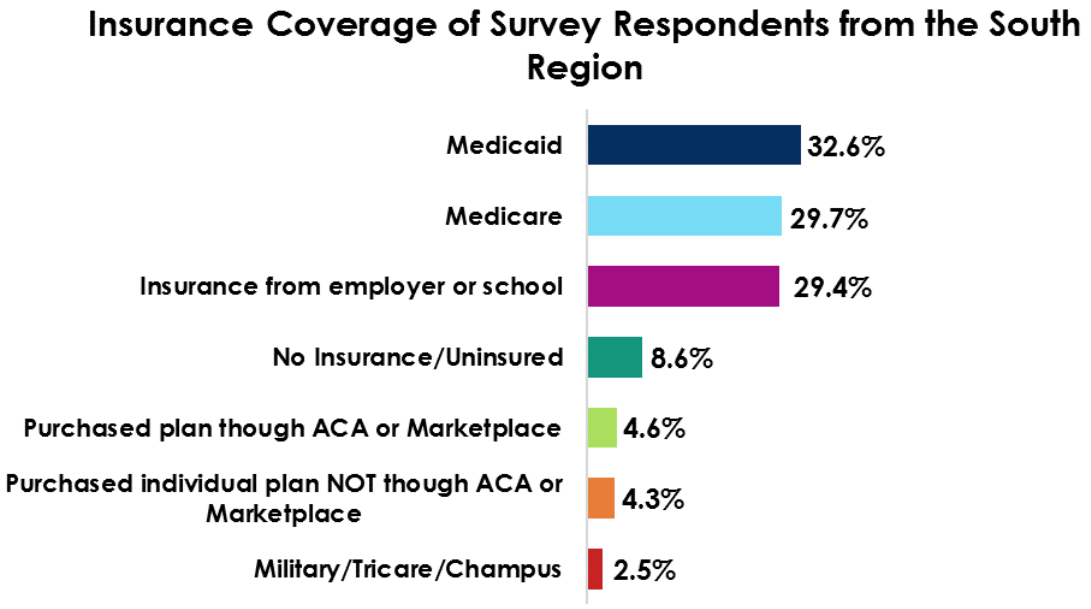
Annual Household Income	Percent (n=1824)
Less than $10,000	25.8%
$10,000-$19,999	16.3%
$20,000-$39,999	24.8%
$40,000-$59,999	13.1%
$60,000-$79,999	9.4%
$80,000-$99,999	4.6%
Over $100,000	6.1%



Most survey respondents from the South region have an annual household income of $39,999 or less (68.3%). The South and Central regions had higher percentages of respondents reporting an annual household income of $10,000 or less (25.8%) and (25.6%) respectively, compared to the North region (10.4%).

Insurance coverage

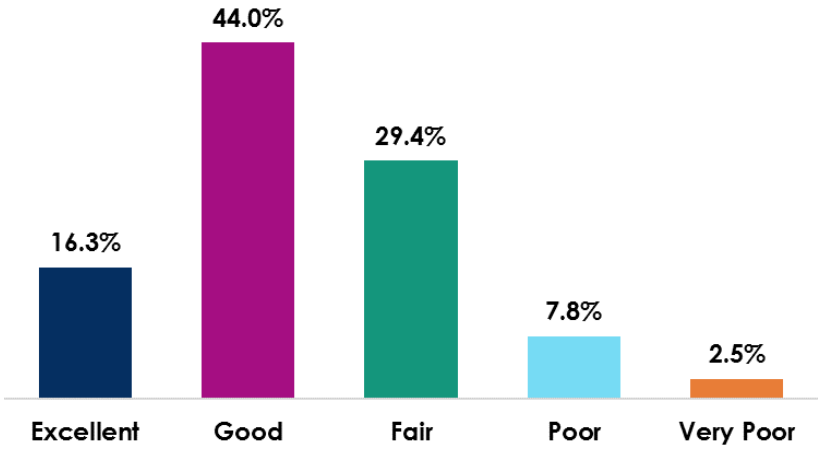
Insurance Coverage (n=2065)	Yes	No
Military/Tricare/Champus	2.5%	97.5%
Purchased individual plan NOT though ACA or Marketplace	4.3%	95.7%
Purchased plan though ACA or Marketplace	4.6%	95.4%
No Insurance/Uninsured	8.6%	91.4%
Insurance from employer or school	29.4%	70.6%
Medicare	29.7%	70.3%
Medicaid	32.6%	67.4%



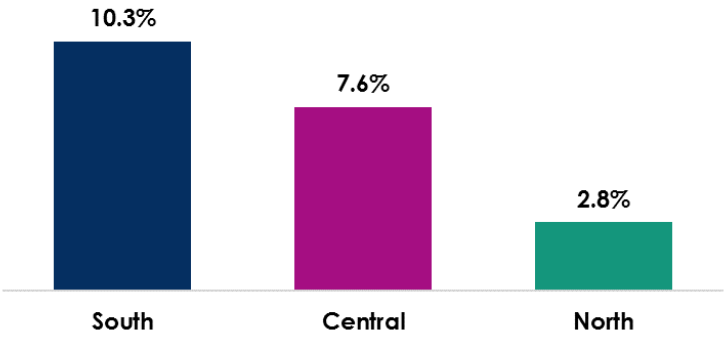
The majority of survey respondents from the South region have either Medicaid (32.6%), employer or school-based (29.4%), or Medicare (29.7%) insurance coverage. The South region has the highest percentage of respondents receiving Medicaid benefits (32.6%) compared to the Central (28.9%), and North (17.9%) regions.

Quality of life

How would you rate your community as a healthy place to live? (n=2376)

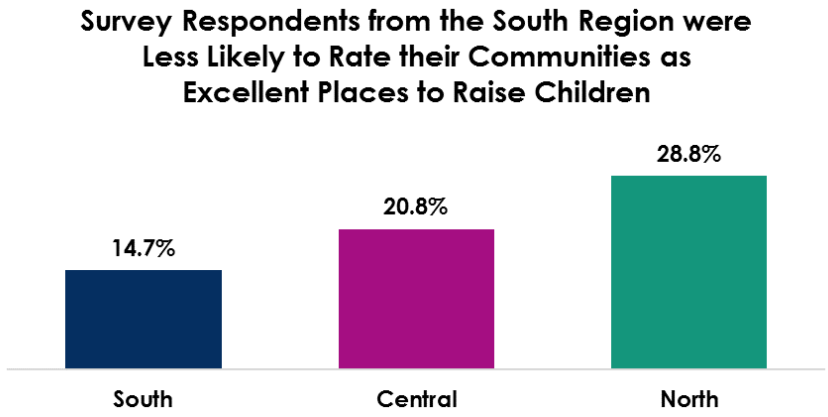


The South region had the highest percentage of respondents rating their communities as poor or very poor healthy places to live



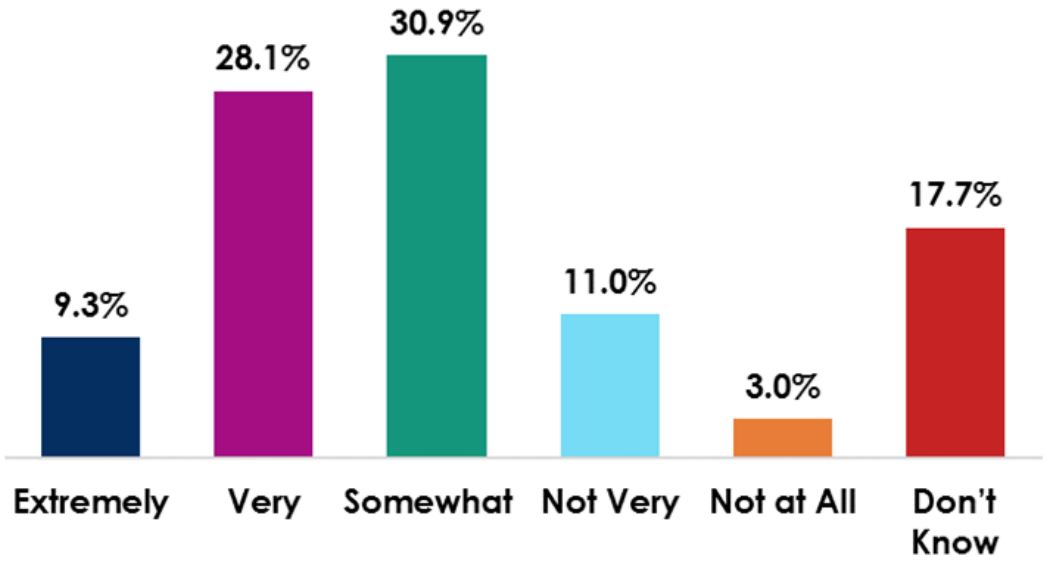
The majority of respondents from the South region rate their communities as healthy places to live (60.3% excellent or good ratings). However, the South region had the highest percentage of survey respondents that rated their communities as poor or very poor places to live compared to the Central (7.6%) and North (2.8%) regions.

How would rate your community as a place to raise children? (n=2334)



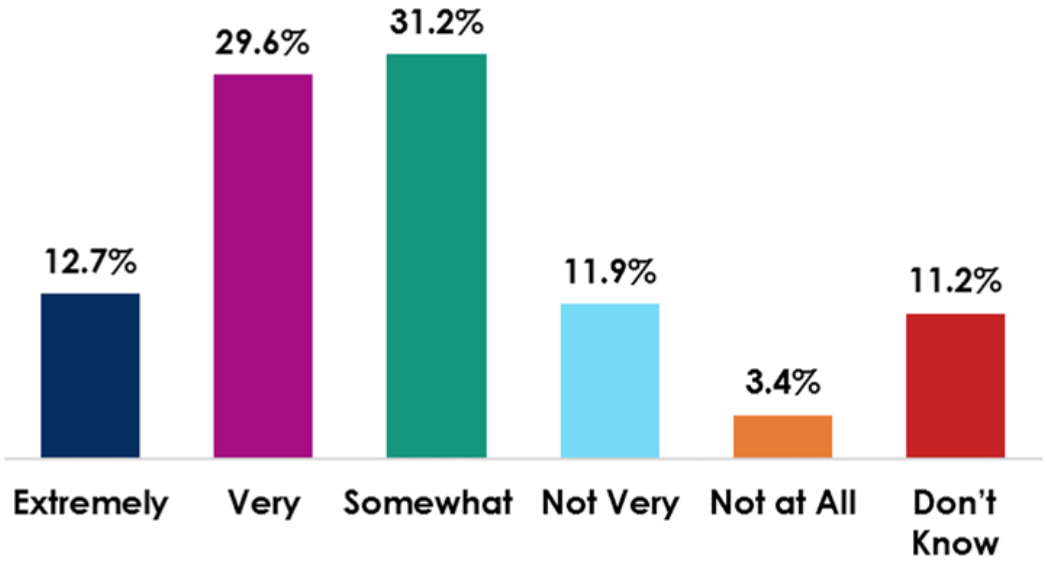
The South region has the lowest percentage of survey respondents that rate their communities as excellent places to raise children (14.7%) compared to the Central (20.8%) and North (28.8%) regions. The South region also has the highest percentage of respondents rating their communities as poor or very poor places to raise children (16.5%) compared to 13.1% of Central and 6.09% of North respondents.

How available is good childcare in your community? (n=2356)



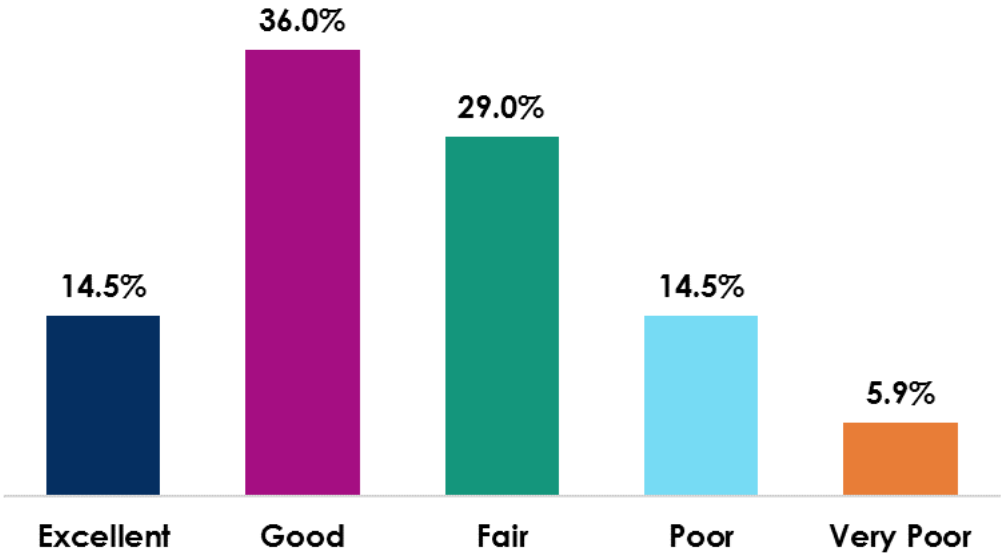
Slightly more than one-third of respondents (37.4%) reported that good childcare is extremely or very available in their communities. Another 30.9% indicated that good childcare is somewhat available, while 14.0% found childcare to be not very or not at all available.

How good are the schools (kindergarten through 12th grade) in your community? (n=2354)



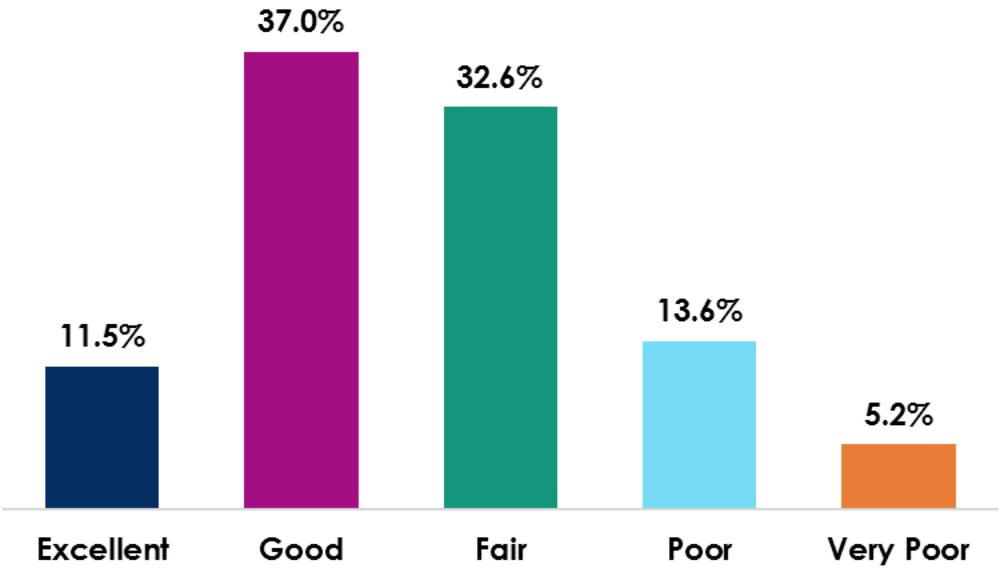
Fifteen percent of respondents rated the quality of the schools in their communities as not very or not at all good. An additional 31.2% of respondents rate the schools in their community as somewhat good, while 42.3% rate the schools in their communities as very or extremely good.

How would you rate your community as a place to grow old? (n=2345)

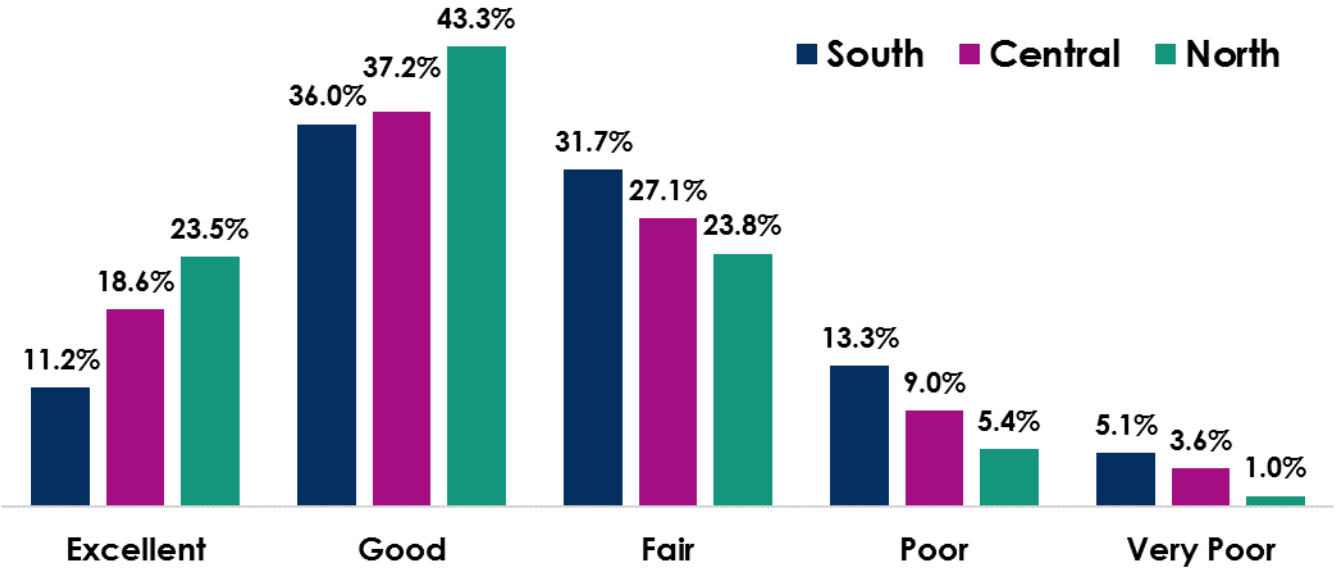


Half of the respondents from the South region rate their communities as excellent or good places to grow old (50.5%). However, 20.4% of respondents in the South region rate their communities as poor or very poor places to grow old compared to 16.8% of Central and 11.2% of North respondents.

How would you rate your community as a place to work? (n=2312)

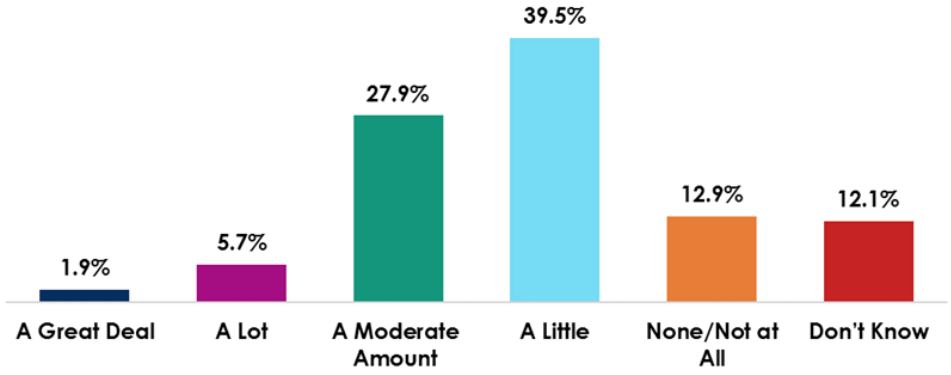


The South Region had the Highest Percentage of Respondents that Rated their Communities as Poor or Very Poor Places to Work



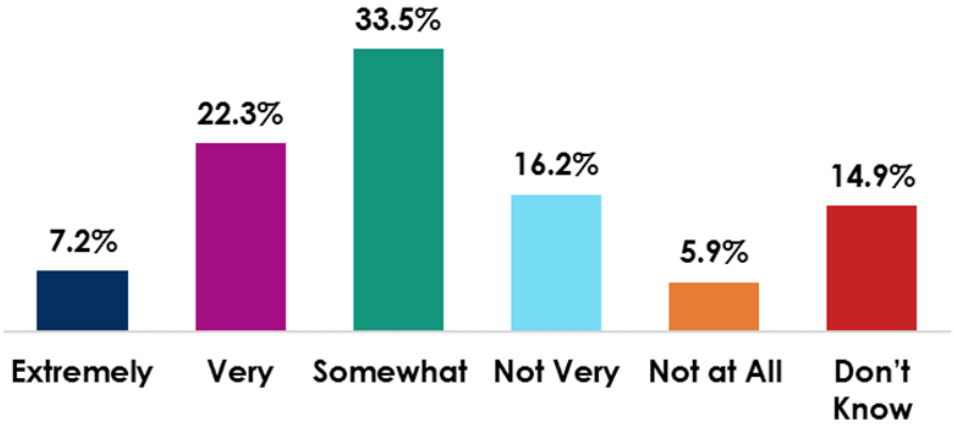
Nearly half of respondents rate their community as an excellent or good place to work (48.5%). An additional 32.6% rate their communities as fair places to work, while 18.8% rate their communities as poor or very poor places to work. The percentage of respondents that rate their communities poorly is highest in the South region.

How many good jobs can be found in your community? (n=2307)



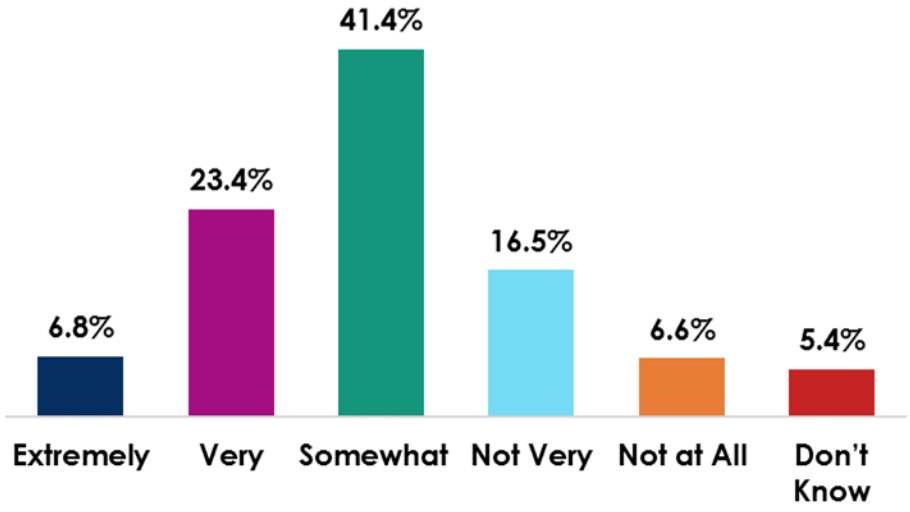
More than half of the respondents from the South region indicated that few good jobs could be found in their communities (52.4%). An additional 27.9% indicated that good jobs are somewhat available and only 7.6% indicated that many jobs are available.

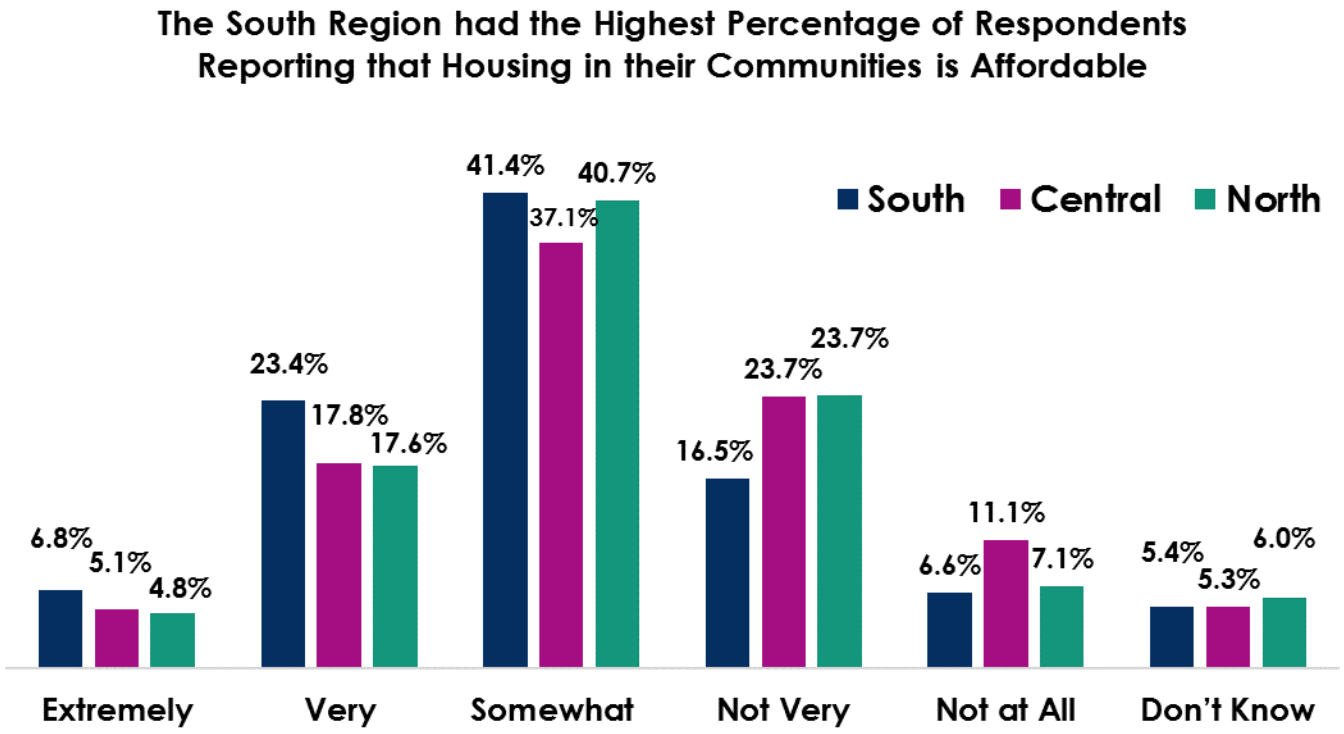
How adequate is adult education and job training in your community? (n=2353)



Approximately one-third of respondents indicated that job training was somewhat adequate in their communities (33.5%). Nearly another third indicated that adult education and job training was extremely adequate in their communities (29.5%). The remaining respondents indicated that it was not very or not at all adequate (22.1%) and 14.9% indicated that they did not know.

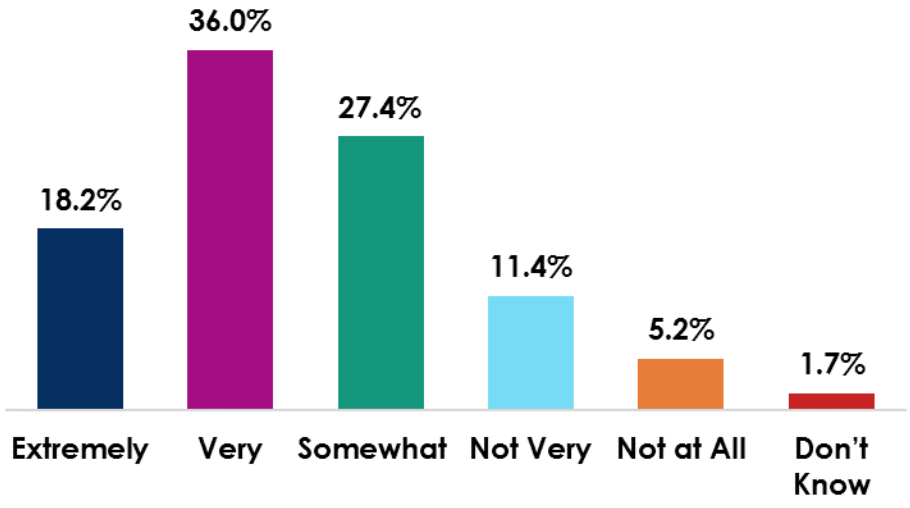
How affordable is the housing in your community? (n=2354)



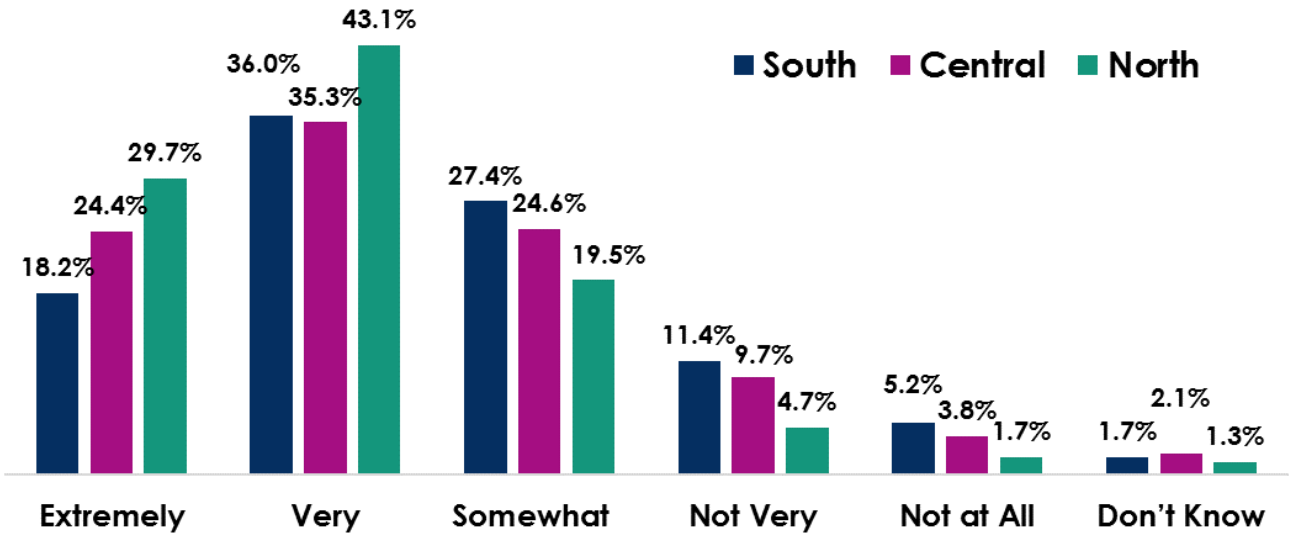


Nearly a third of respondents from the South region indicated that housing is extremely or very affordable in their communities (30.2%). An additional 41.4% of respondents indicated that housing is somewhat affordable, while 23.1% indicated that housing is not very or not at all affordable. The South region has the highest percentage of survey respondents reporting that housing in their communities is affordable.

How available are healthy foods, including fresh fruits and vegetables, in your community? (n=2367)

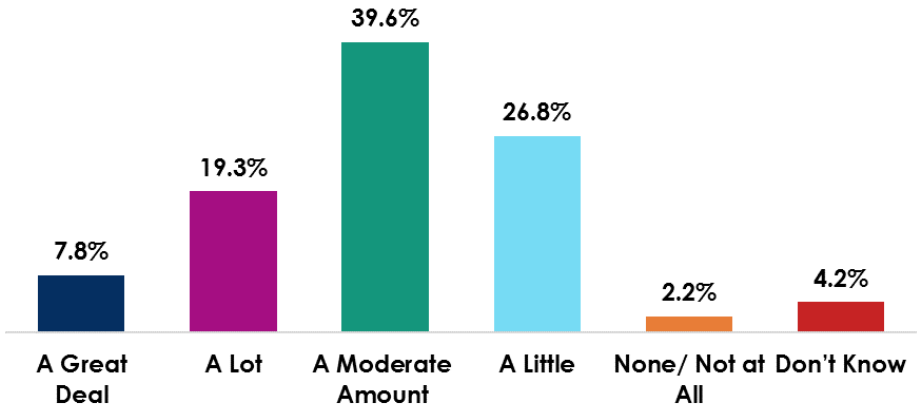


The South Region had the Lowest Percentage of Respondents Indicating that Healthy Foods are Available in their Communities



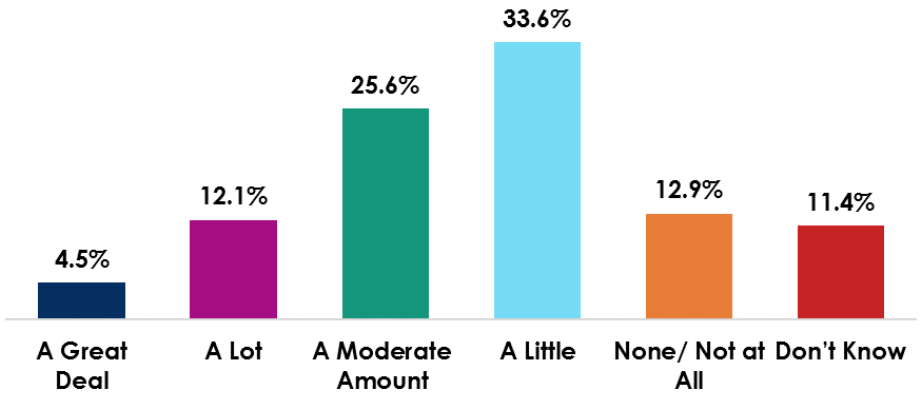
The South region has the lowest percentage of survey respondents indicating that healthy foods, including fresh fruit and vegetables, are available in their communities (54.2%). The South region also has the highest percentage of survey respondents reporting that healthy foods are not very or not at all available (16.6%) compared to 13.5% of Central respondents and 6.4% of North respondents.

How many parks and recreational facilities does your community have? (n=2311)

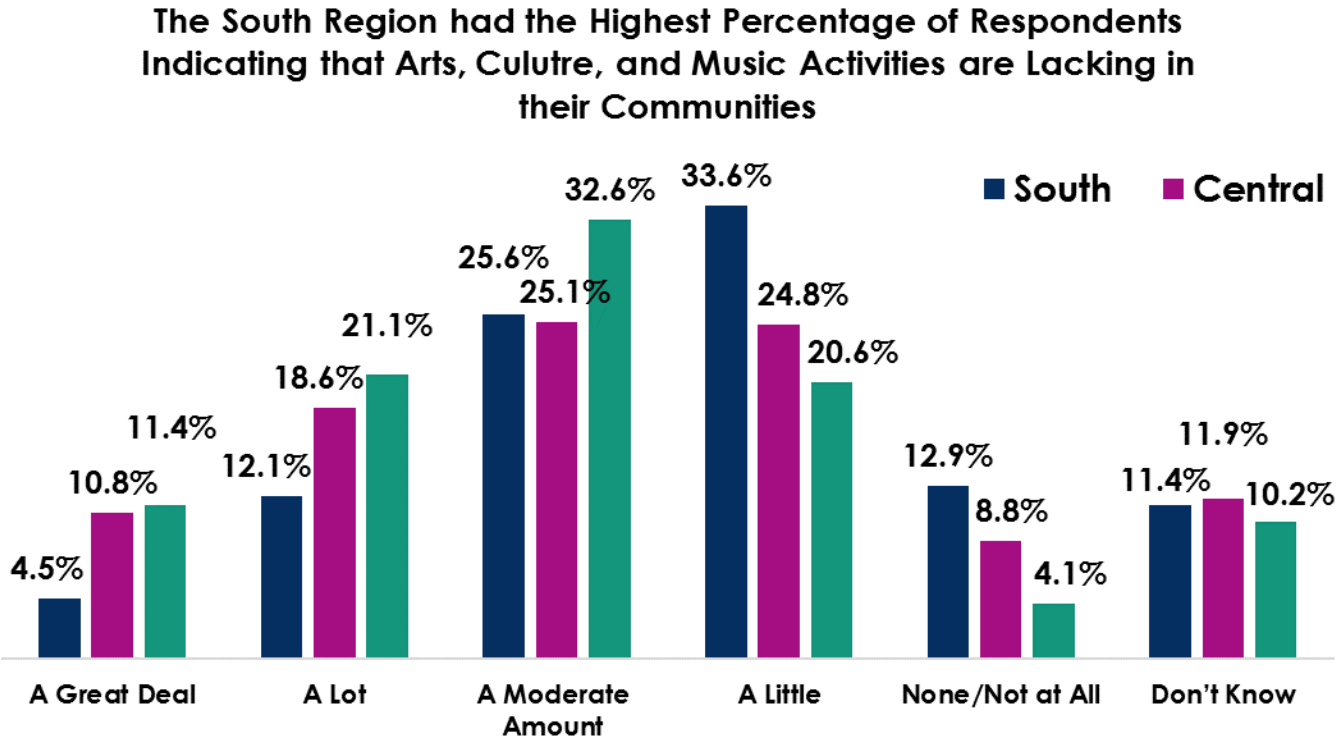


Most survey respondents from the South region indicated that there was a great deal (7.8%), a lot (19.3%), or a moderate amount (39.6%) of parks and recreational facilities in their community. Nearly a third of respondents (29.0%) indicated that there were few parks available in their communities.

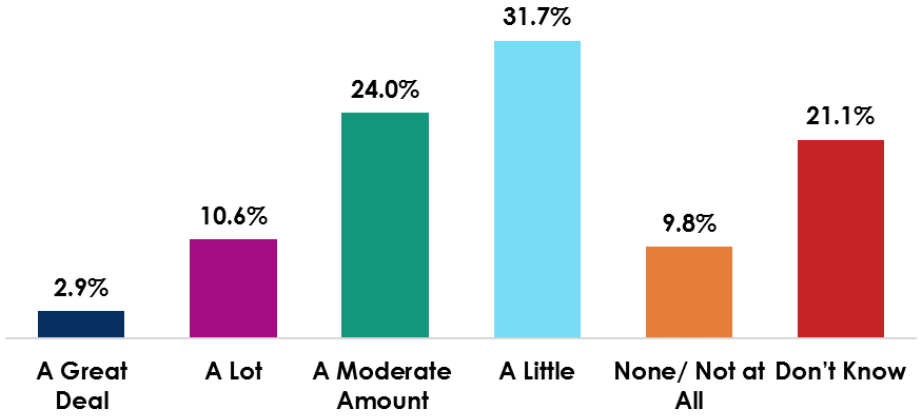
How many art, culture, and music activities does your community have? (n=2310)



Nearly half of the survey respondents from the South region indicated that their communities lack art, culture, and music activities (46.5%). The South region has a much higher percentage of survey respondents reporting a lack of cultural activities (46.5%) compared to 33.6% of Central respondents and 24.7% of North respondents.

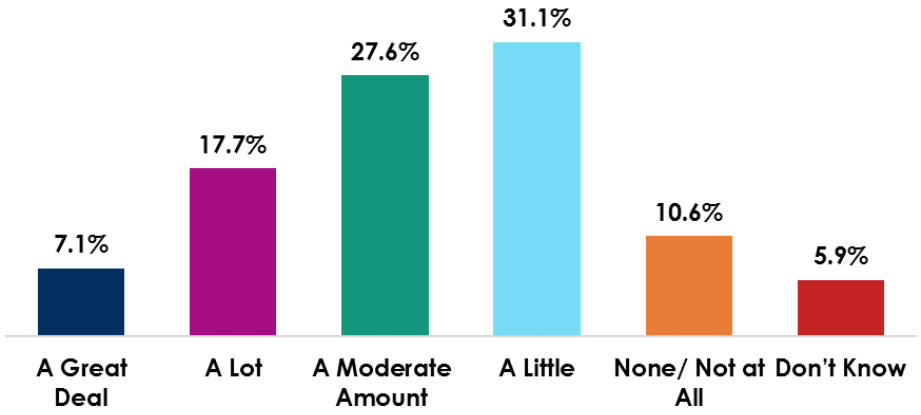


How many programs or activities for teens and youth during non-school hours does your community have? (n=2300)



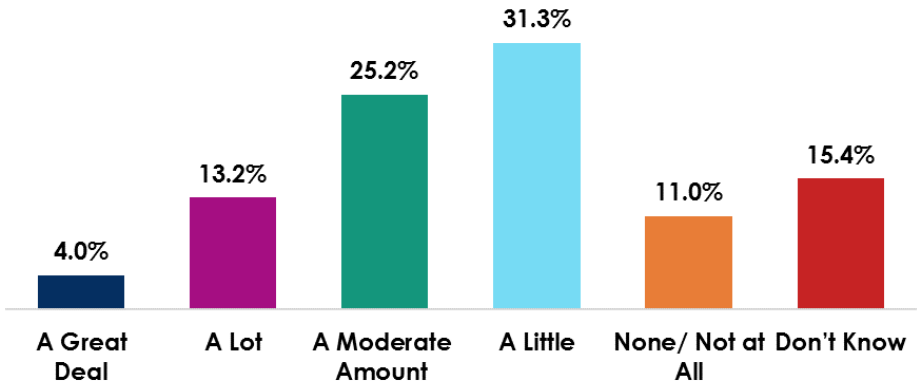
When asked about the programs and activities for teens and youth during non-school hours, well over a third of respondents (41.5%) indicated that few were available. An additional 24.0% indicated that a moderate amount was available and another 13.5% indicated that a lot or a great deal were available.

How much do neighbors trust and look out for each other in your community? (n=2311)



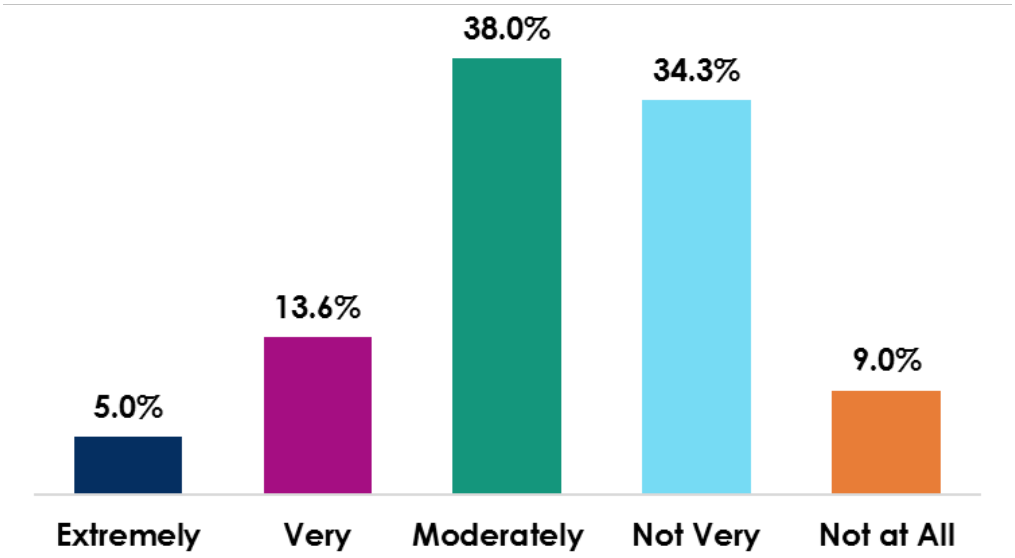
Nearly a quarter of respondents from the South region indicated that neighbors trust and look out for each other in their communities (24.8%). Another 27.6% indicated a moderate amount of trust and interaction between neighbors, with 41.7% indicating little or no trust and interaction between neighbors.

How many opportunities are available for you to participate in improving your community? (n=2303)



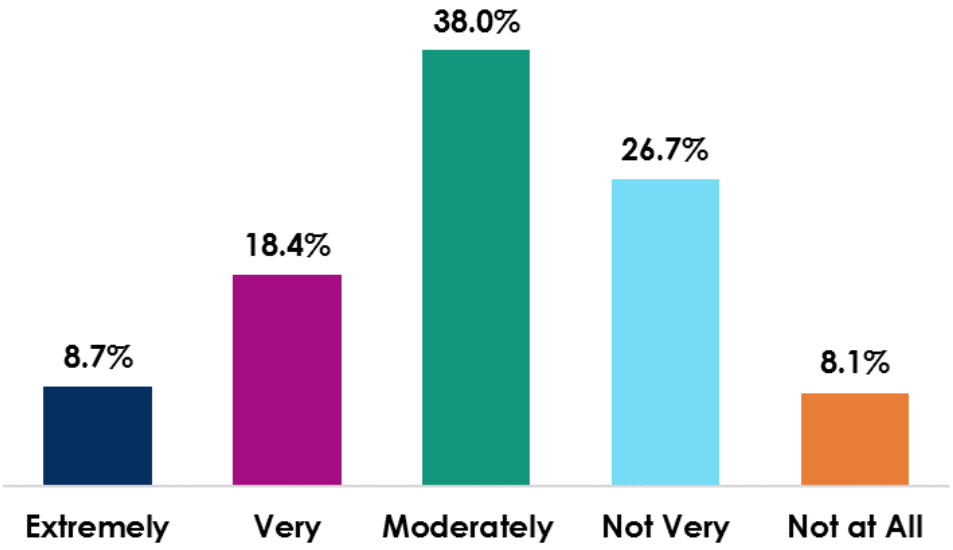
Seventeen percent of respondents from the South region indicated that there is a great deal or a lot of opportunities available to participate in improving their communities. The percentage of respondents indicating that there are little or no opportunities is highest in the South region (42.3%) compared to the Central (32.3%) and North (29.0%) regions.

How common is hunger in your community? (n=2221)



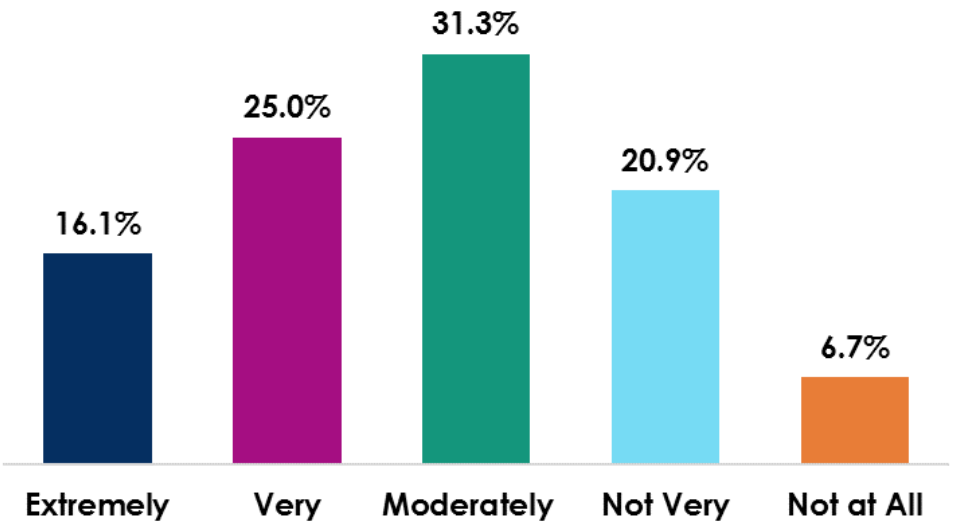
Most survey respondents from the South region indicated that hunger is either moderately, very, or extremely common in their communities (56.6%). The remaining respondents indicated that hunger is not very (34.3%) or not at all (9.0%) common in their communities.

How common is it to drop out of school in your community? (n=2163)



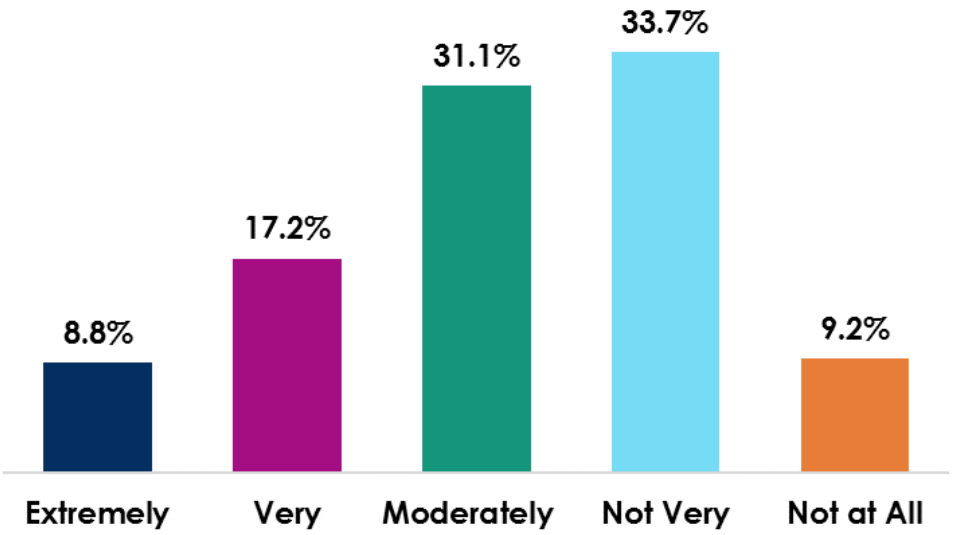
Most respondents from the South region indicated that it is moderately common to drop out of school in their communities (38.0%). An additional 27.1% indicated that it is extremely or very common to drop out of school, while 34.8% indicated that it is not very or not at all common to drop out of school.

How common is drug abuse in your community? (n=2176)



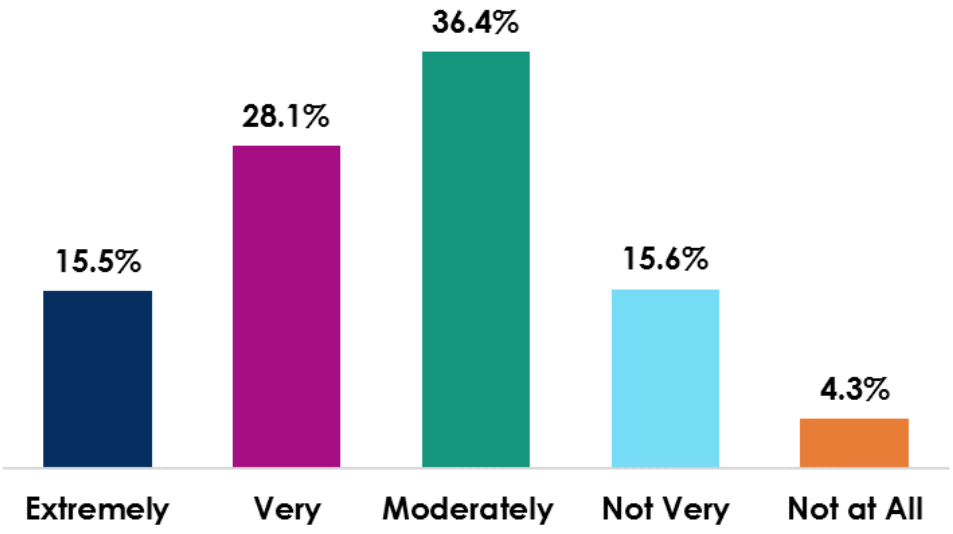
Approximately a quarter of respondents felt that drug abuse is not a problem in their communities (27.6%). The remaining 72.4% of respondents indicated that drug abuse is a moderately, very, or extremely common problem in their communities.

How common is homelessness in your community? (n=2182)



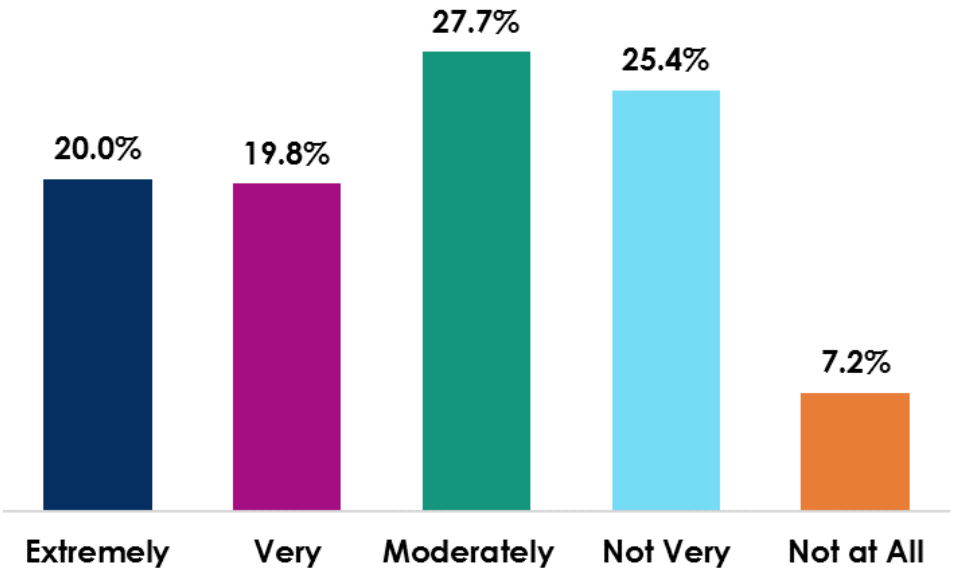
More than half of respondents indicated that homelessness is an extremely, very, or moderately common problem in their communities (57.1%). Approximately a third of respondents indicated that homelessness is not very common in their communities (33.7%) and an additional 9.2% of respondents indicated that homelessness is not at all a problem.

How common are low wages or unemployment in your community? (n=2192)



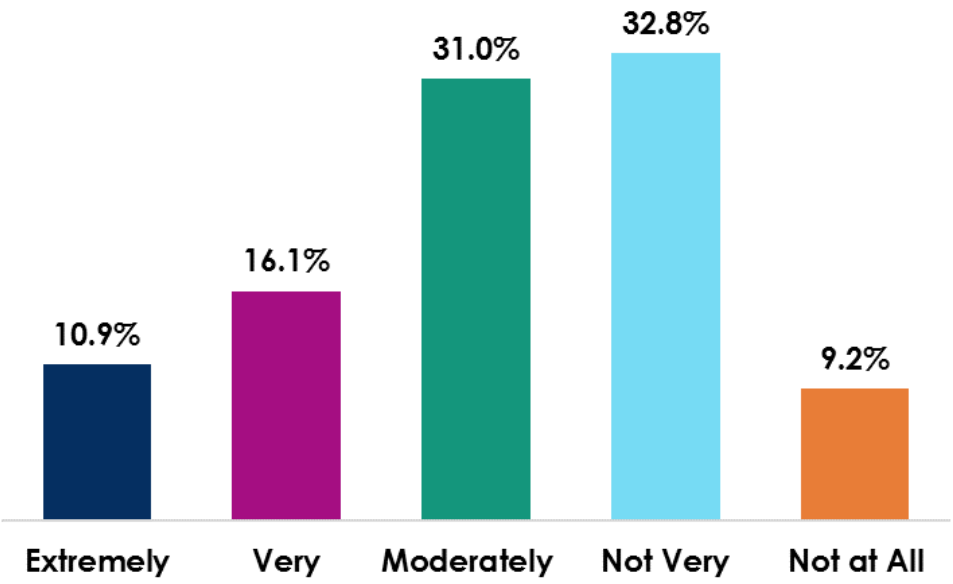
Nearly half of respondents indicated that low wages and unemployment are common in their communities (43.6%). The South region has the highest percentage of respondents indicating that low wages and unemployment are common compared to the Central (36.4%) and North (18.1%) regions.

How common is Community Violence (gang-related crime, gun violence, drug-related crime, etc.) in your community? (n=2247)



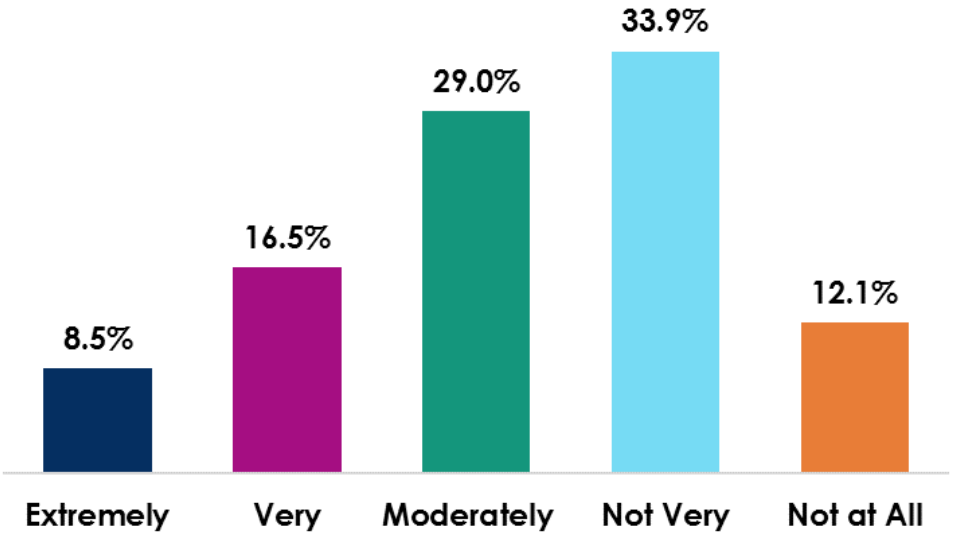
Approximately a third of respondents felt that community violence is not very or not at all common in their communities (32.6%). However, the South region has the highest percentage of respondents that felt that community violence is moderately, very, or extremely common (67.5%).

How common is Interpersonal Violence (domestic violence, child abuse, sexual assault, dating violence, elder abuse, bullying, etc.) in your community? (n=2195)



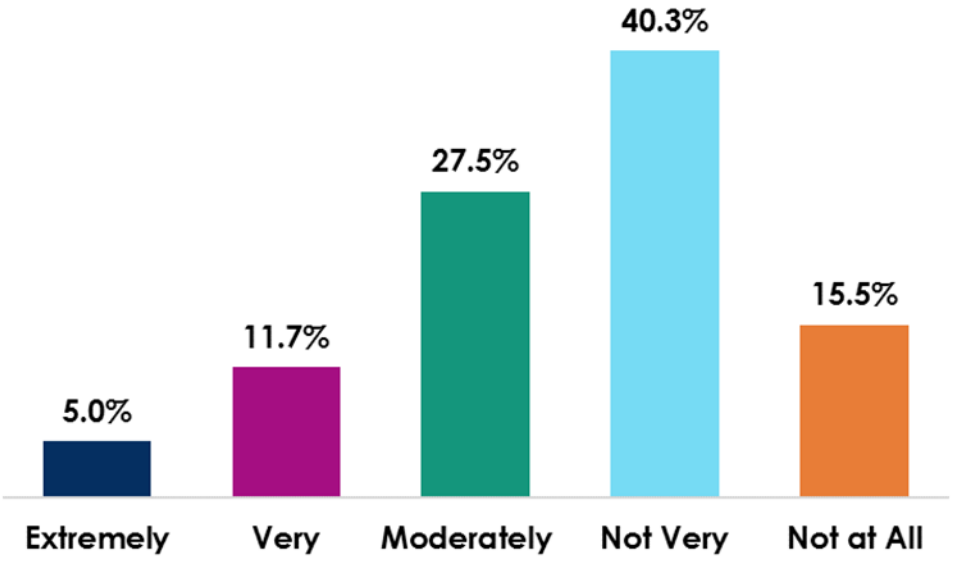
More than a quarter of respondents indicated that interpersonal violence is common in their communities (27%) and an additional 31.0% of respondents indicated that interpersonal violence is moderately common. Forty-two percent of respondents indicated that interpersonal violence is not common in their communities.

How common is it for community members to be treated unfairly because of race, ethnicity, or skin color? (n=2224)



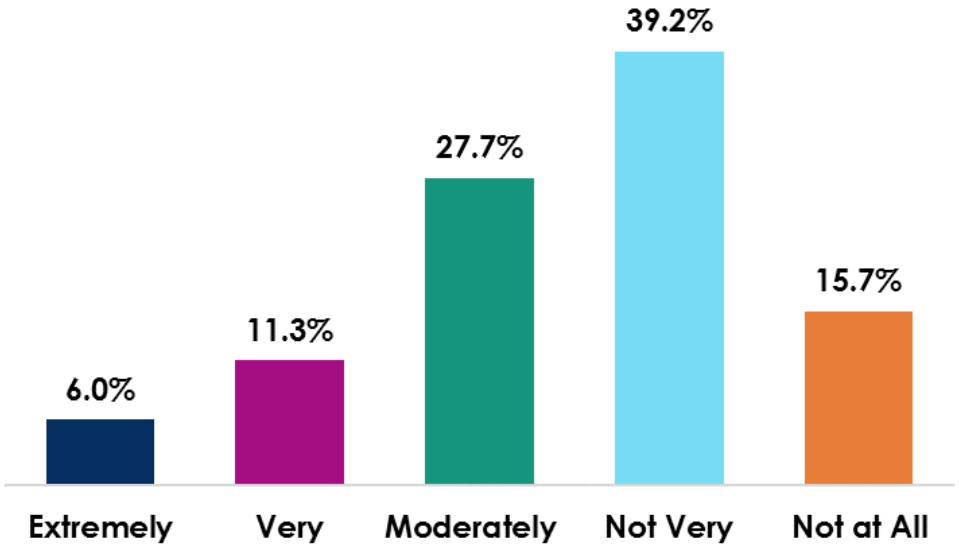
More than half of respondents felt that it is at least moderately common for community members to be treated unfairly because of race (54.0%). The remaining 46.0% of respondents felt that it is not common for community members to be treated unfairly because of race.

How common is it for community members to be treated unfairly because of gender? (n=2201)



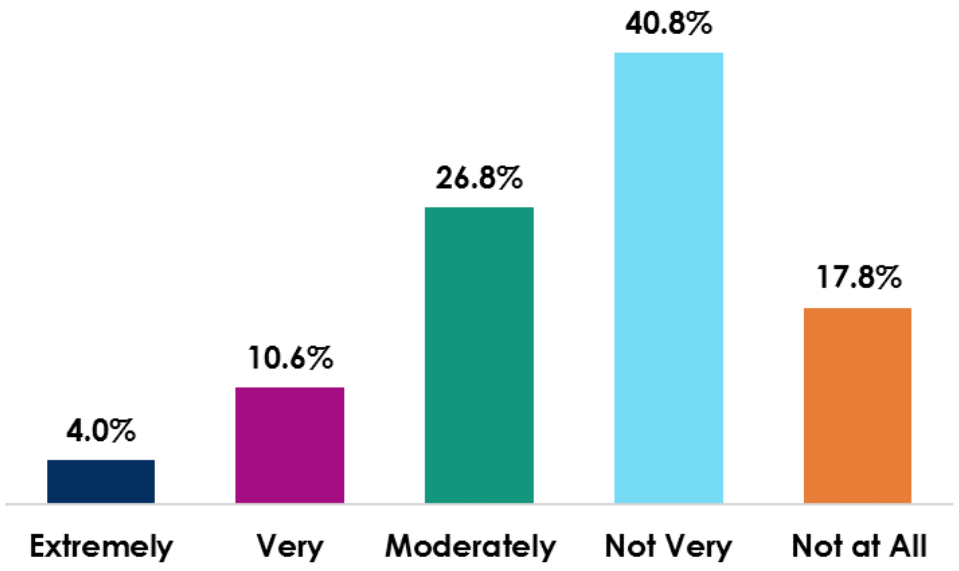
Most respondents felt that it is uncommon for community members to be treated unfairly because of gender (55.8%). Conversely 16.7% of respondents felt that it is common for community members to be treated unfairly because of gender, while an additional 27.5% felt that it is moderately common.

How common is it for community members to be treated unfairly because of sexual orientation? (n=2173)



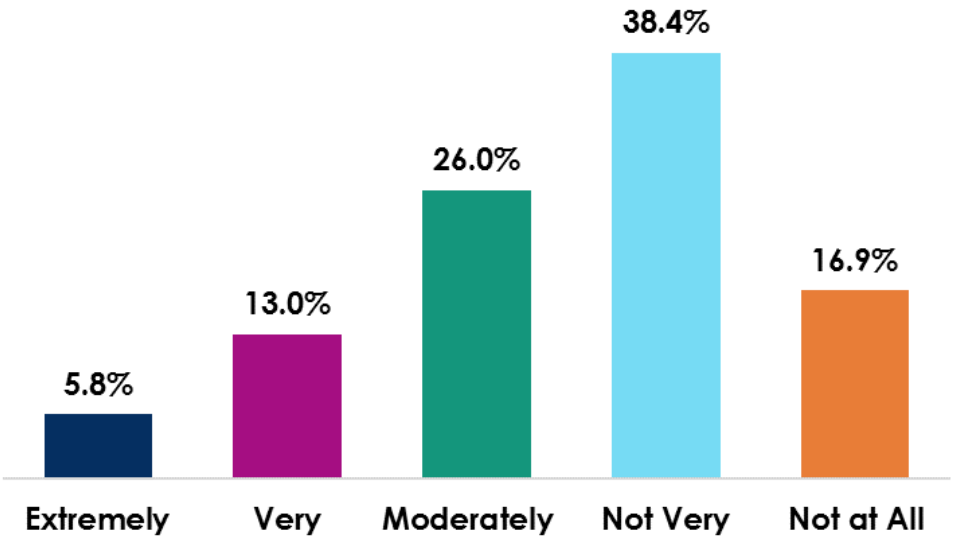
The majority of respondents indicated that it is not common for community members to be treated unfairly because of sexual orientation (54.9%). Approximately a quarter of respondents indicated that it is moderately common for community members to be treated unfairly (27.7%) and an additional 17.3% felt that it is very or extremely common.

How common is it for community members to be treated unfairly because of age? (n=2192)



Most respondents indicated that it is not common to be treated unfairly because of age in their communities (58.6%). More than a quarter indicated that it is moderately common (26.8%) and an additional 14.6% felt that it is extremely or very common.

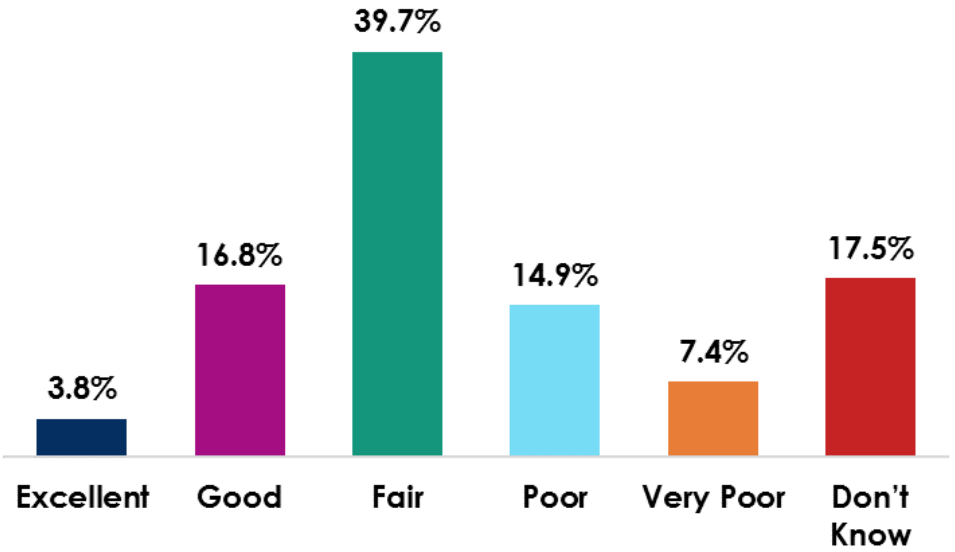
How common is it for community members to be treated unfairly because of the way that they speak English? (n=2203)



Approximately half of participants indicated that it is not common for community members to be treated unfairly because of the way that they speak English (55.3%). Twenty-six percent indicated that it is moderately common and an additional 18.8% indicated that it is very or extremely common.

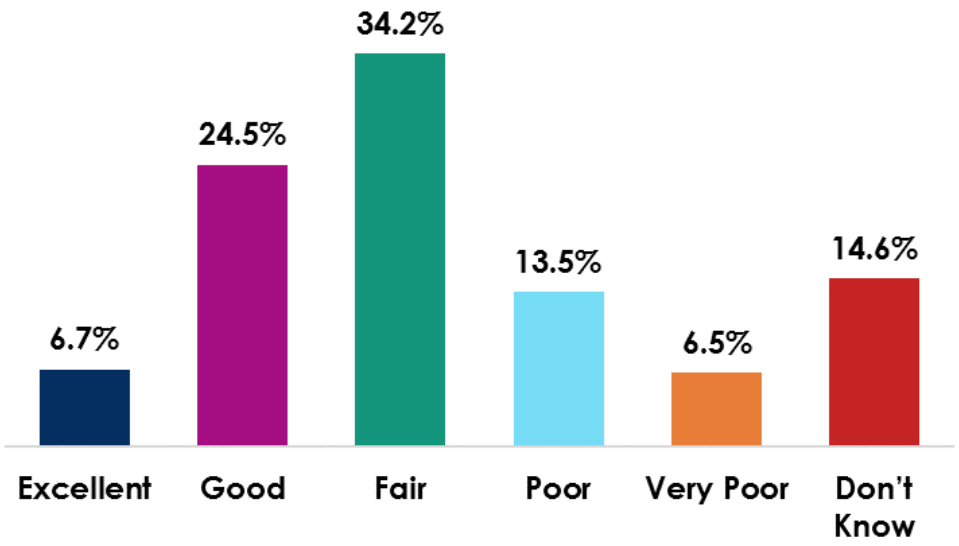
Public Transportation

Cost of Fares (n=2186)



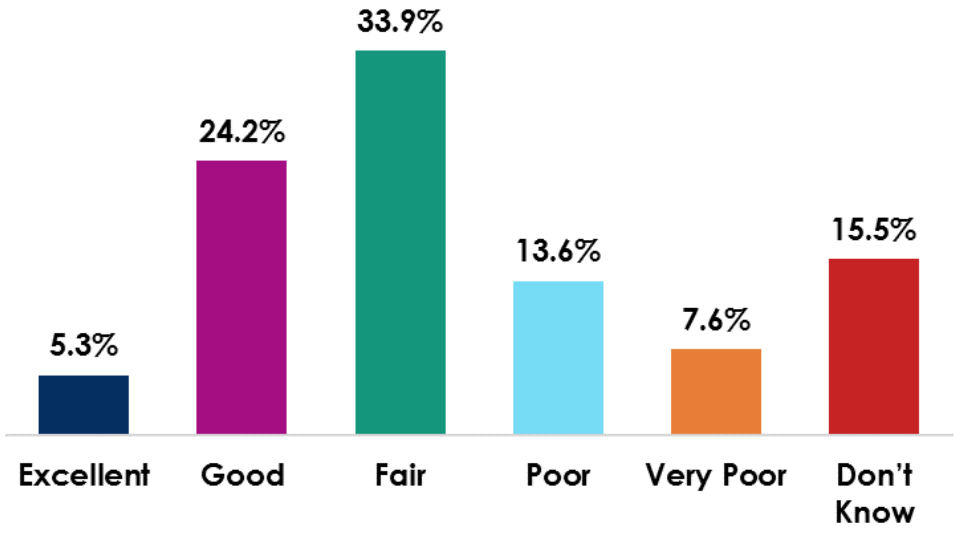
The majority of respondents from the South region rated the cost of fairs on public transportation as fair (39.7%), good (16.8%), or excellent (3.8%). However, nearly a quarter rated the cost of fares as poor or very poor (22.3%). In addition, the respondents from the South region were the least likely to rate the cost of fares as excellent or good (20.6%) compared to respondents from the Central (30.0%) and North (27.4%) regions.

Convenience of stops/timing of public transportation (n=2241)



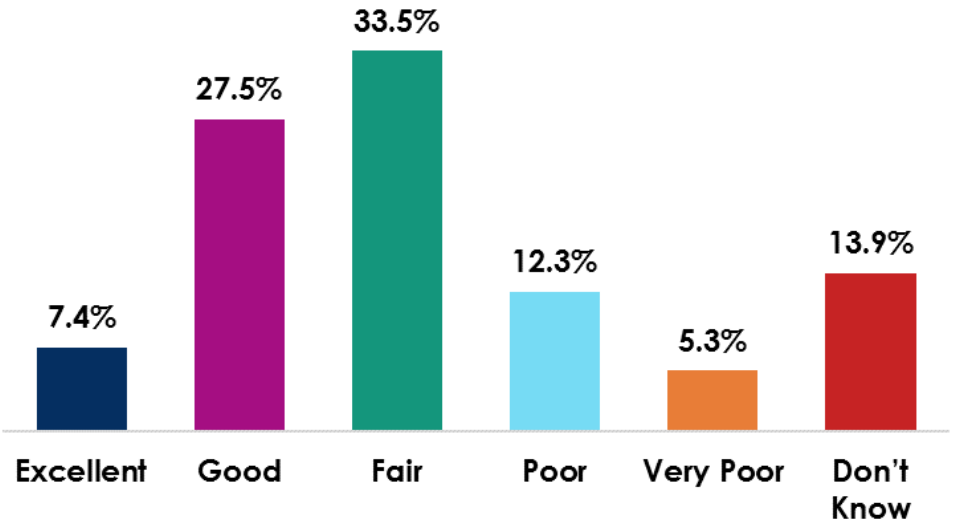
Respondents from the South region were more likely to rate the convenience of stops/timing for public transportation poorly (19.9%) compared to respondents from the Central (15.8%) and North (15.4%) regions. Approximately a third of respondents rate the stops/timing for public transportation as good or excellent (31.2%), while an additional 34.2% rate it as fair.

Personal safety on public transportation (n=2256)



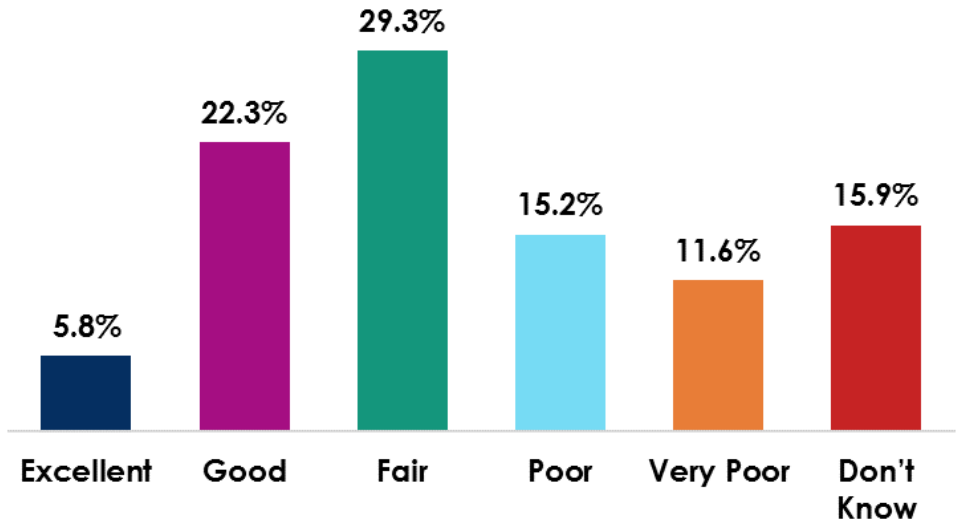
Respondents from the South region has the lowest ratings for personal safety on public transportation with 21.2% indicating that it is poor or very poor compared to 17.2% in the Central region and 11.5% in the North region. Approximately a quarter of respondents indicated that personal safety on public transportation is excellent or good (29.5%) with an additional 33.9% rating personal safety as fair.

Reliability of public transportation (n=2245)



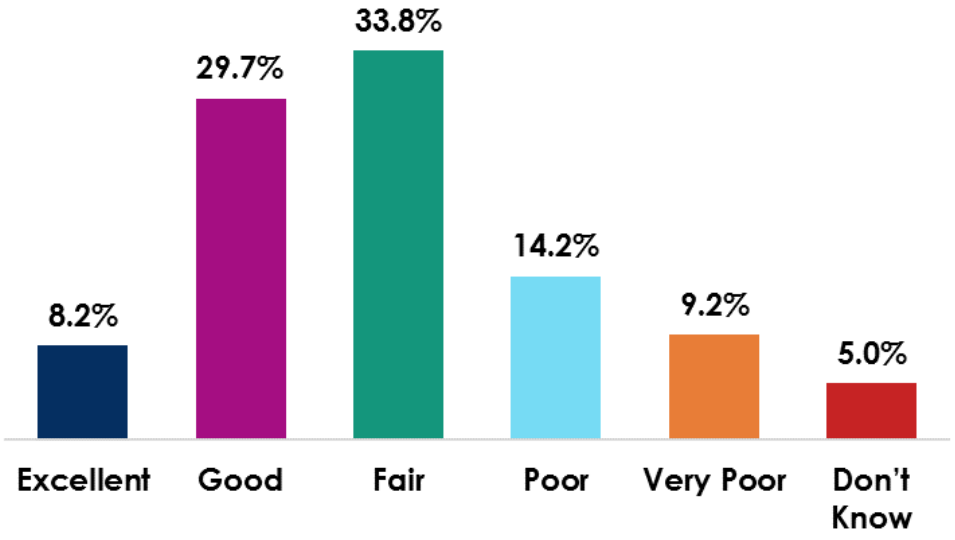
Respondents from the South region has the lowest rating for the reliability of public transportation with 17.6% of respondents rating it as poor compared to 13.7% of Central respondents and 11.3% of North respondents. The remaining respondents rate reliability as fair (33.5%), good (27.5%), or excellent (7.4%).

Quality and convenience of bike lanes (n=2256)



Most respondents rate the quality and convenience of bike lanes as fair (29.3%) with 28.1% of respondents rating it as good or excellent. More than a quarter of respondents rate the quality and convenience of bike lanes as poor (26.8%). Participants from the South region were more likely to rate bike lanes in their community as poor compared to 23.4% of Central and 22.8% of North respondents.

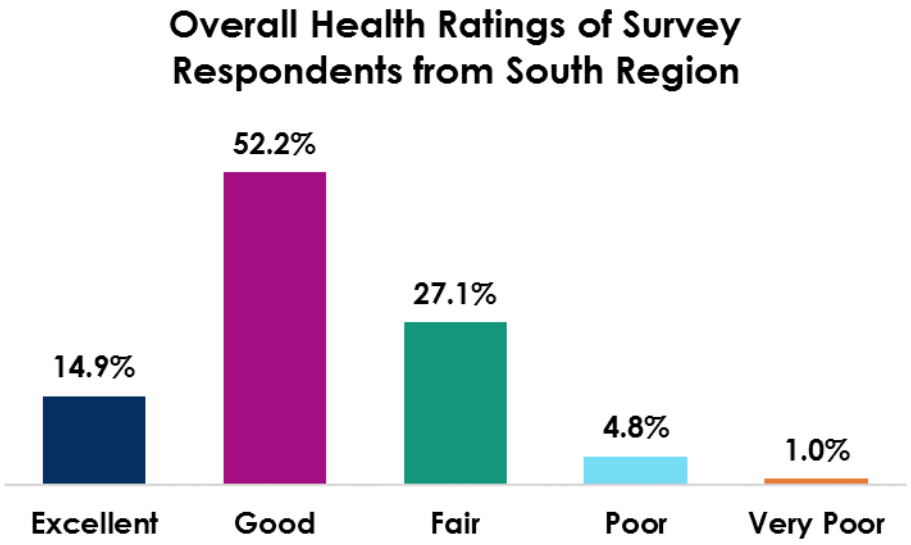
Quality of sidewalks (n=2262)



The South region has the largest percentage of respondents that rate the quality of their sidewalks poorly (23.4%) compared to respondents in the Central (16.4%) and North (18.4%) regions. Approximately a third of respondents rate the quality of the sidewalks in their communities as fair (33.8%) with an additional 37.9% rating their sidewalks as excellent or good.

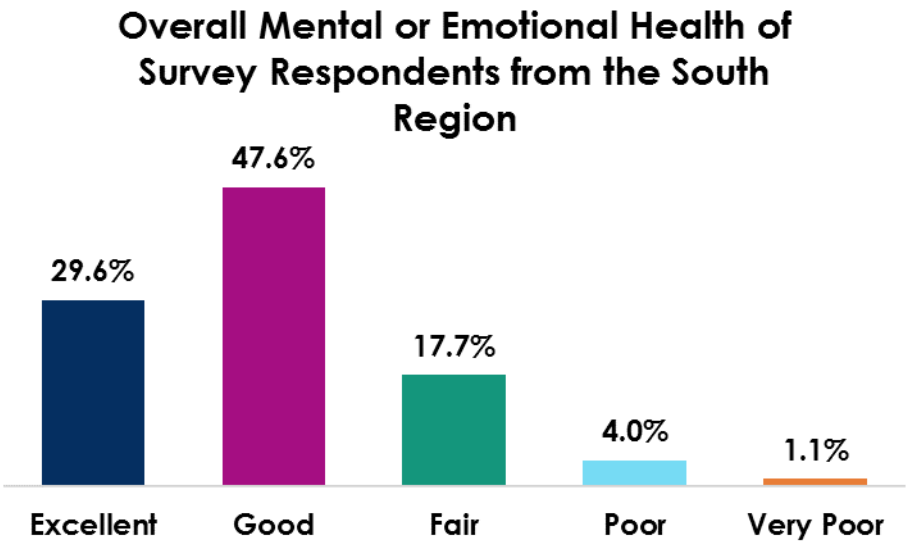
Personal Health Perceptions

In general, how would you rate your overall health? (n=2276)



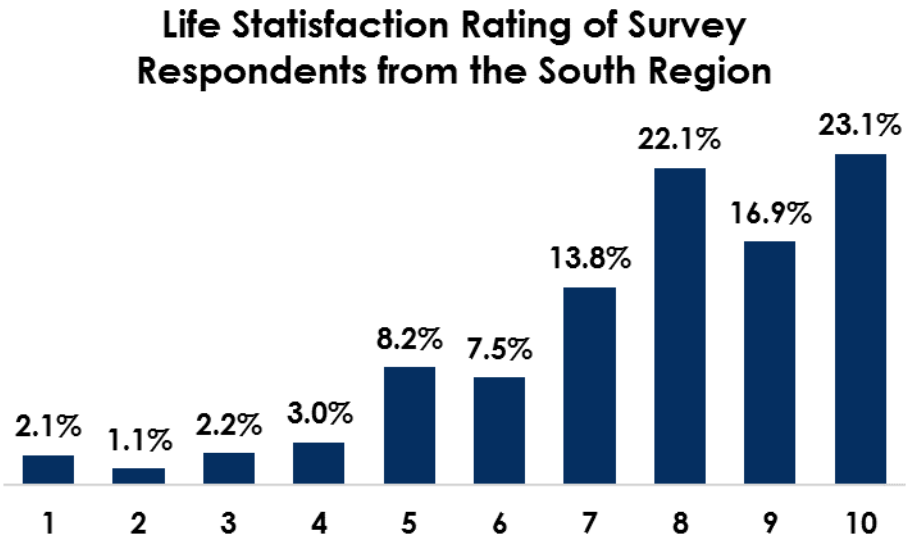
The majority of survey respondents from the South region rated their overall health as good (52.2%) or excellent (14.9%). However, more than a third of respondents rated their health as fair (27.1%), poor (4.8%), or very poor (1.0%), the highest of any region.

In general, how would you rate your overall mental or emotional health? (n=2264)



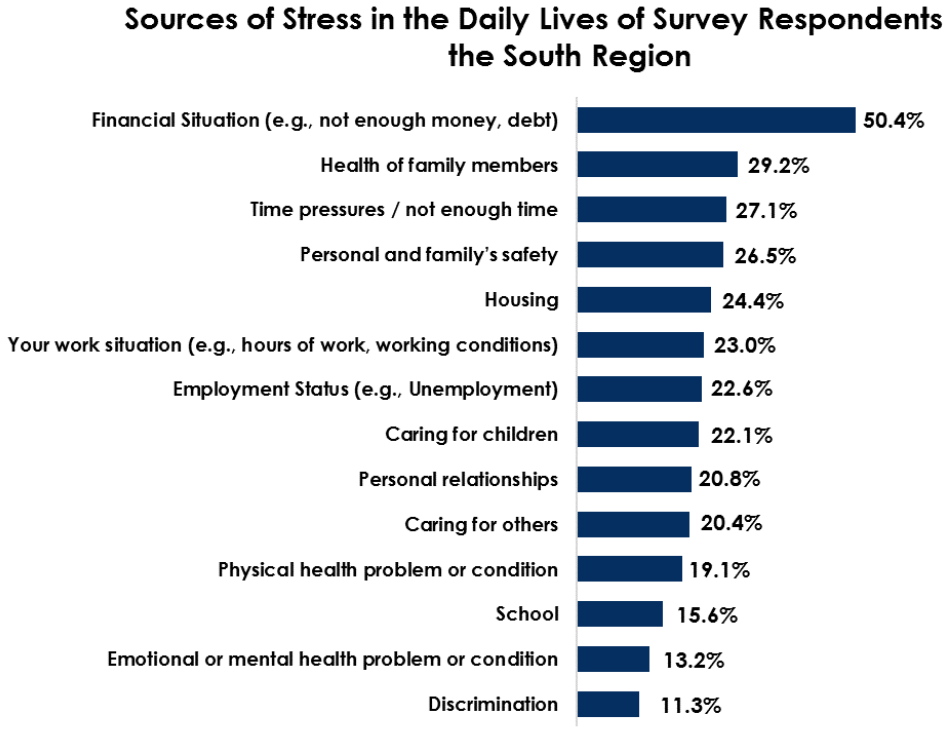
Most survey respondents from the South region rated their mental or emotional health as excellent (29.6%) or good (47.6%).

Using a scale for 1 to 10, where 1 means "very dissatisfied" and 10 means "very satisfied", how do you feel about your life as a whole right now? (n=2202)



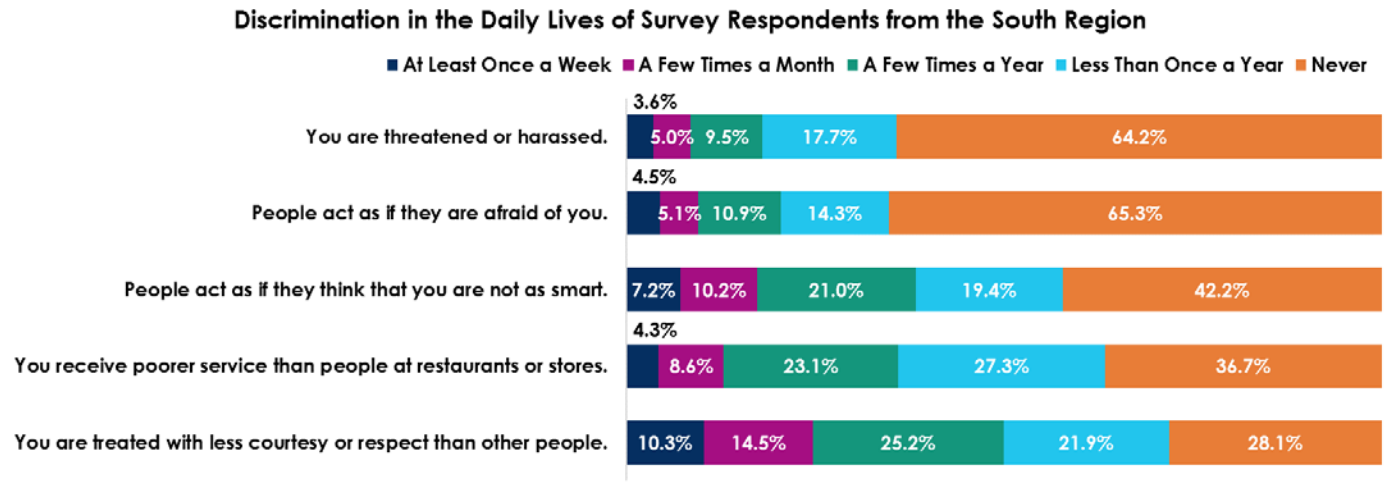
The majority of survey respondents from the South region rated their overall life satisfaction positively.

Thinking about stress in your day-to-day life, which of these contribute the most to feelings of stress you may have? (Check all that apply) (n=1187)



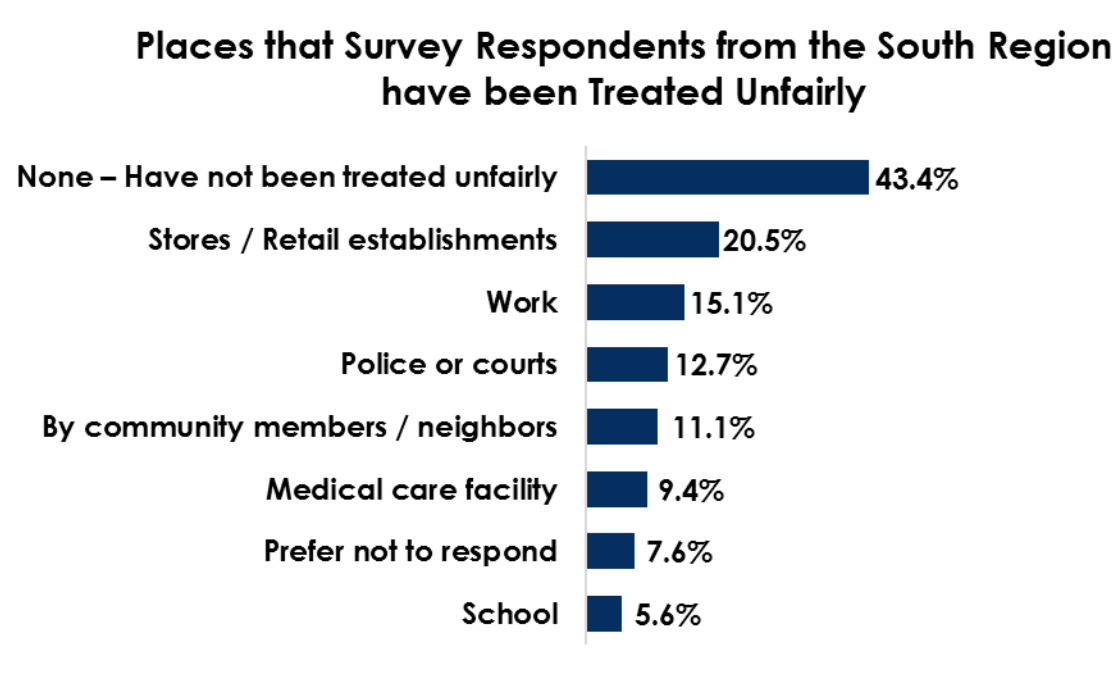
When asked about their daily lives, respondents from the South region indicated that their financial situation (50.4%), health of family members (29.2%), and time pressures/not enough time (27.1%) contributed most to their feelings of stress.

In your day to day life, how often have any of the following things happened to you: (n=2120)



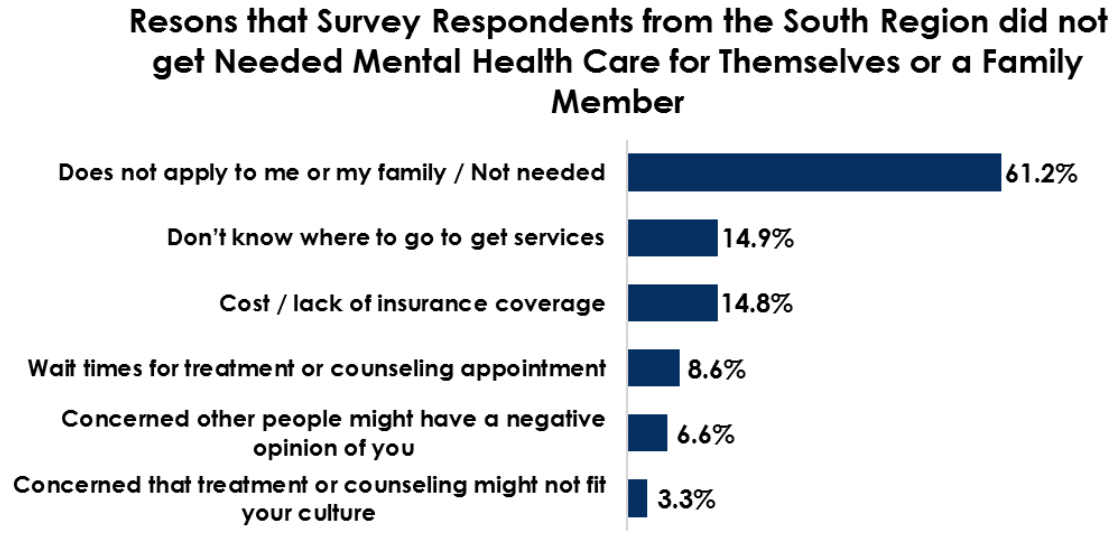
A large proportion of survey respondents from the South region experience discrimination in their day to day lives (ranging from 34.7% - 71.9% depending on the indicator).

In which of the following places have you been treated unfairly in past 12 months? (Check all that apply) (n=2140)



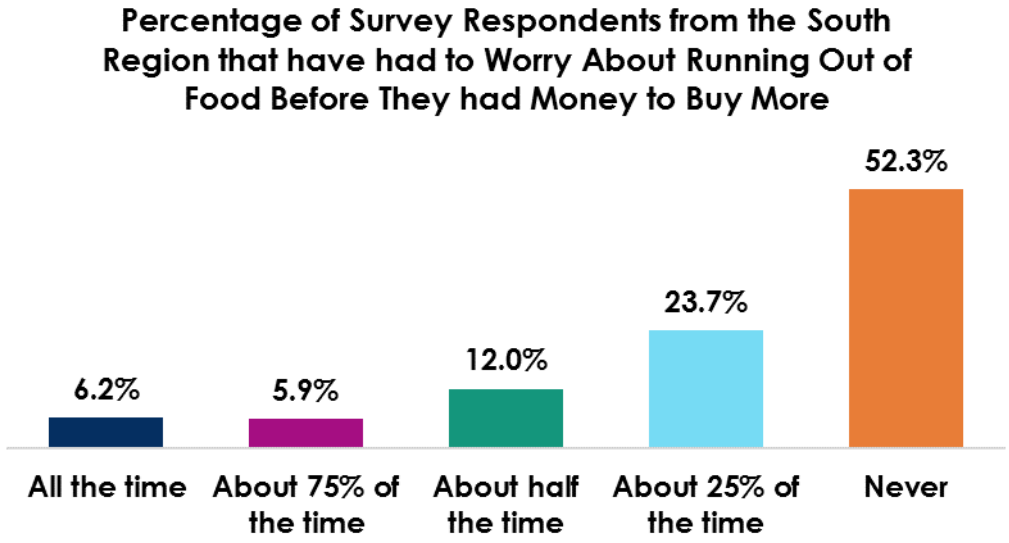
The majority of respondents from the South region indicated that they have been treated unfairly in the past 12 months (56.6%). The South region had the highest percentage of respondents reporting unfair treatment.

Please think about any time when you or a member of your family may have needed mental health treatment or counseling. If you did not get needed mental health care, which of these statements explain why you did not get it? (Check all that apply) (n=2001)



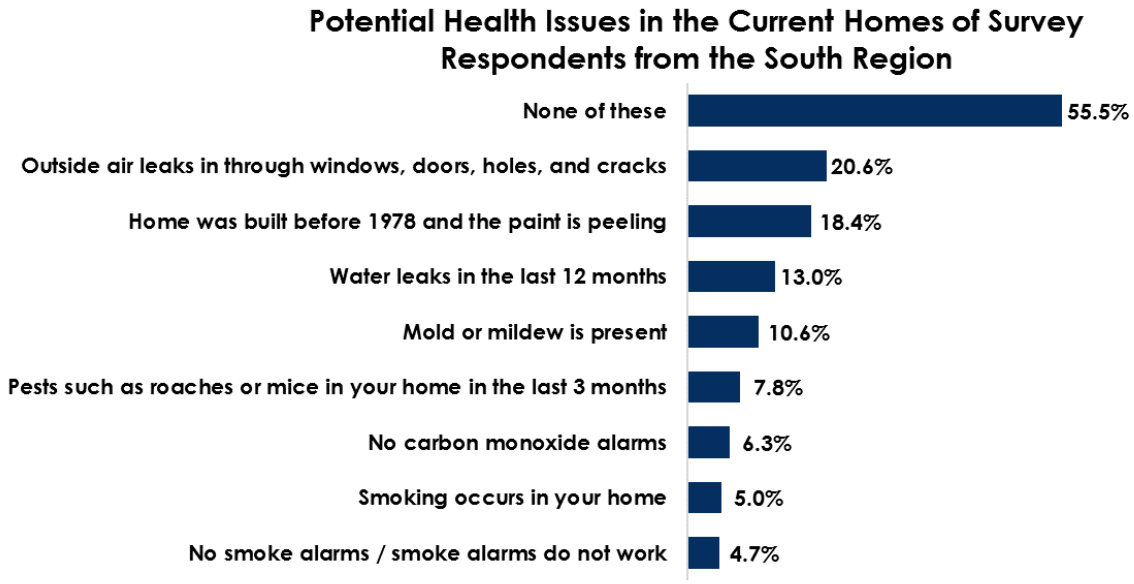
Nearly 40% of respondents from the South region did not get needed mental health care. The most common reasons for not getting needed care were not knowing where to get services (14.9%), cost/lack of insurance coverage (14.8%), and wait times for treatment or counseling appointment (8.6%).

In the past 12 months, how often did you or your family worry about whether your food would run out before you had the money to buy more? (n=2095)



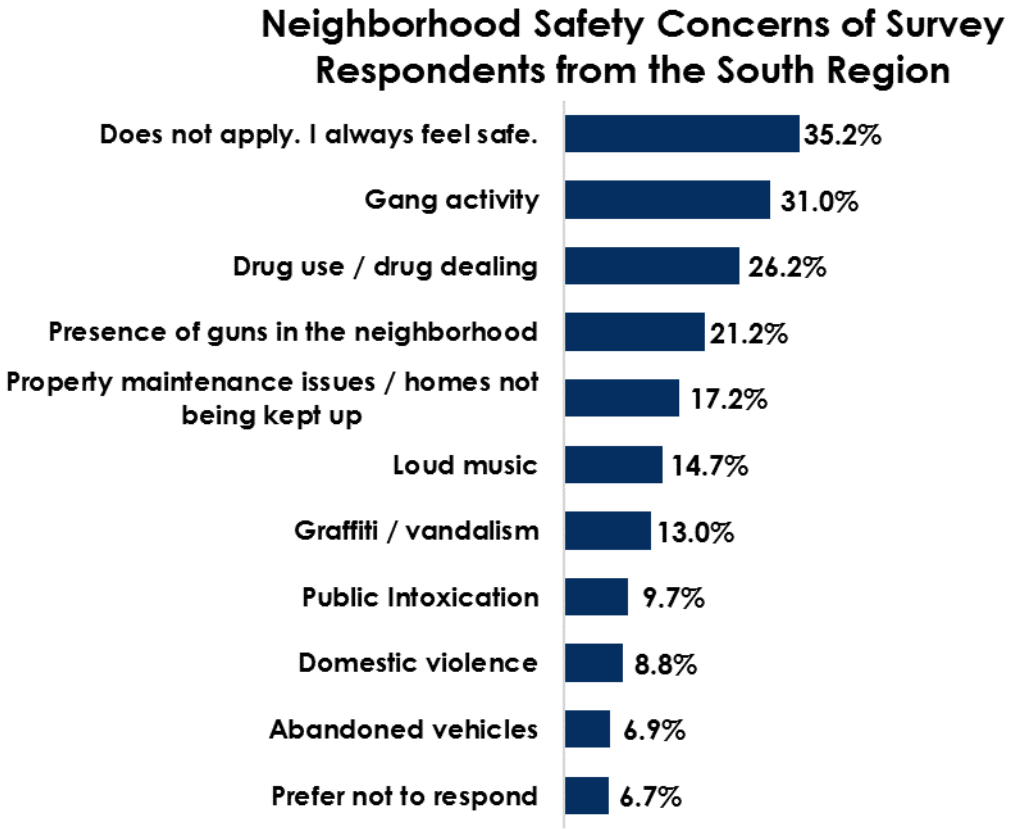
The South region had the largest percentage of respondents indicating that they have had to worry about whether or not food would run out before they had money to buy more (47.7%).

Which of the following describes your current home? (Check all that apply) (n=2142)



Nearly half of the survey respondents from the South region indicated that their current homes have one or more issues that could affect health (44.5%). The most common issues mentioned were outside air leaking in (20.6%), home built prior to 1978 and paint is peeling (18.4%), and water leaks in the last 12 months (13.0%).

Please indicate any reasons you felt unsafe in your neighborhood in the past 12 months. (n=2116)



A large majority (64.8%) of survey respondents from the South region report that they have felt unsafe in their neighborhoods in the past 12 months. The South had the highest percentage of respondents reporting that they felt unsafe of the three regions. The most commonly cited reasons for feeling unsafe included gang activity (31%), drug use/drug dealing (26.2%), and presence of guns in the neighborhood (21.2%).

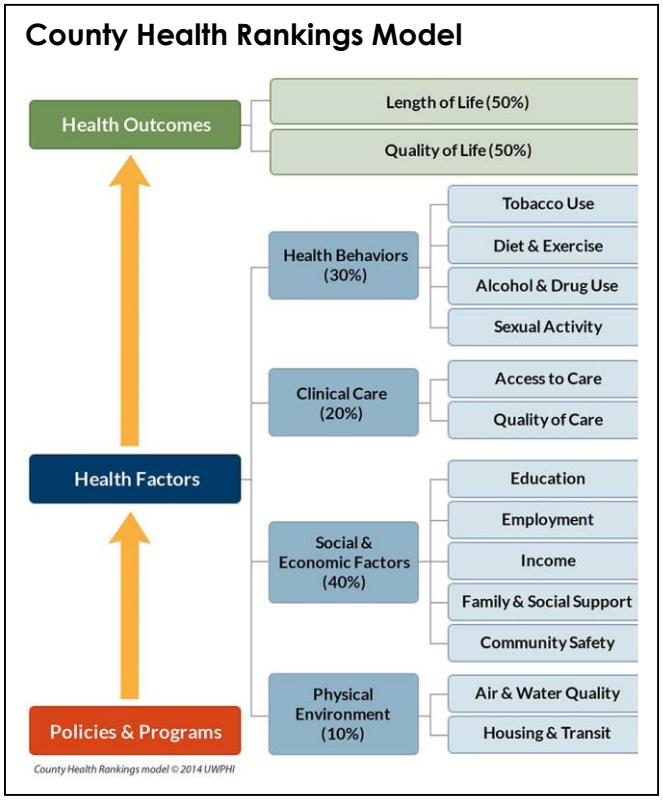
COMMUNITY HEALTH STATUS ASSESSMENT – SOUTH REGION

Overview of indicators and methods

The Community Health Status Assessment (CHSA) is one of four assessments that comprise the Health Impact Collaborative of Cook County's CHNA. This CHSA report describes health status and community conditions in the Central region. The indicators in this report fall into the following categories:

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

The CHSA was conducted by the Illinois Public Health Institute in partnership with the Cook County Department of Public Health and the Chicago Department of Public Health. The indicators for this CHNA were selected through an iterative process, with input from hospitals, health departments and community stakeholders. 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 was 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 be comprehensive in data collection and analysis 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.

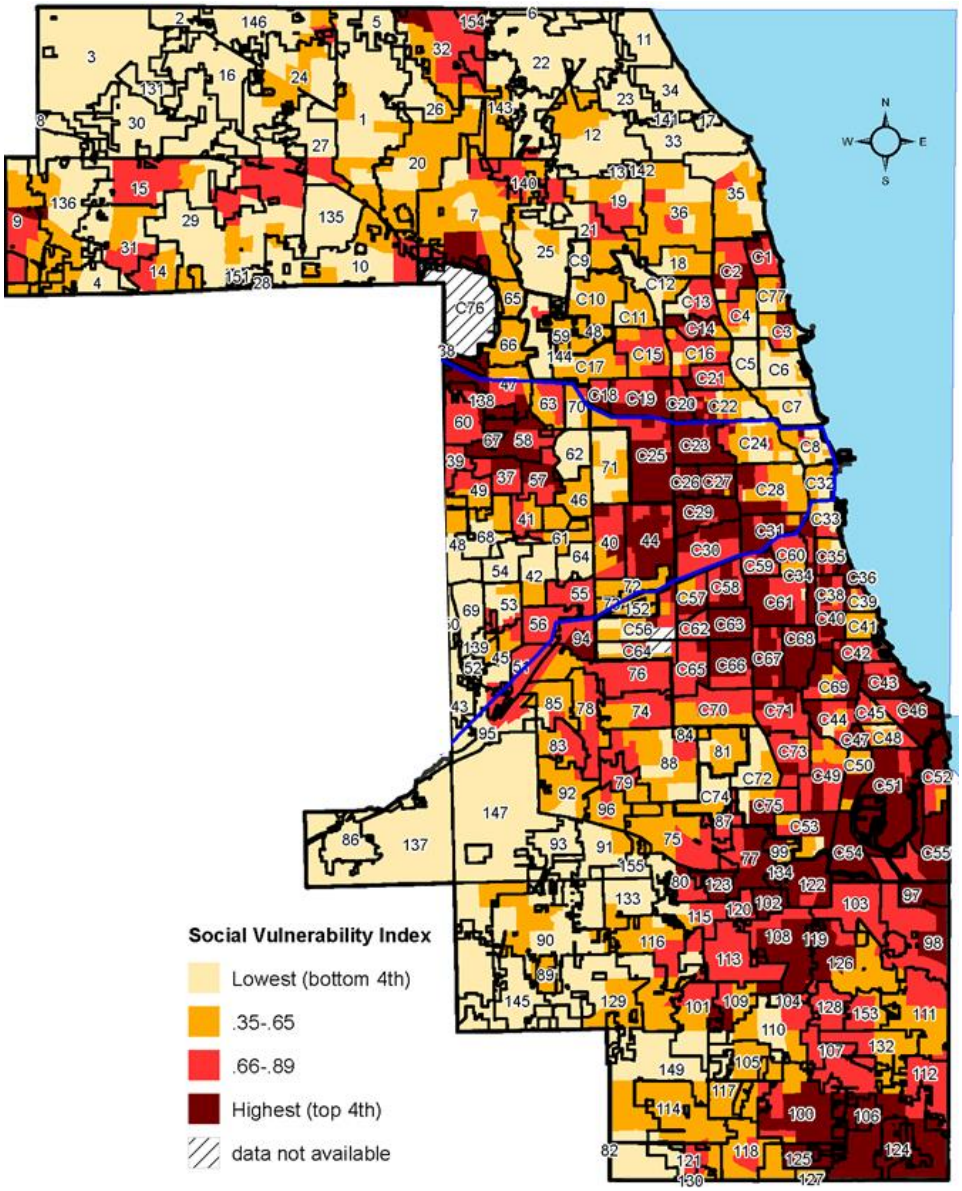
The mission, vision, and values of the Collaborative have a strong focus on improved health equity in Chicago and suburban Cook County. As a result, the Collaborative utilized the CHSA process to identify inequities in social, economic, healthcare, and health outcomes in addition to describing the health 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.

Social Vulnerability Index (SVI)

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.

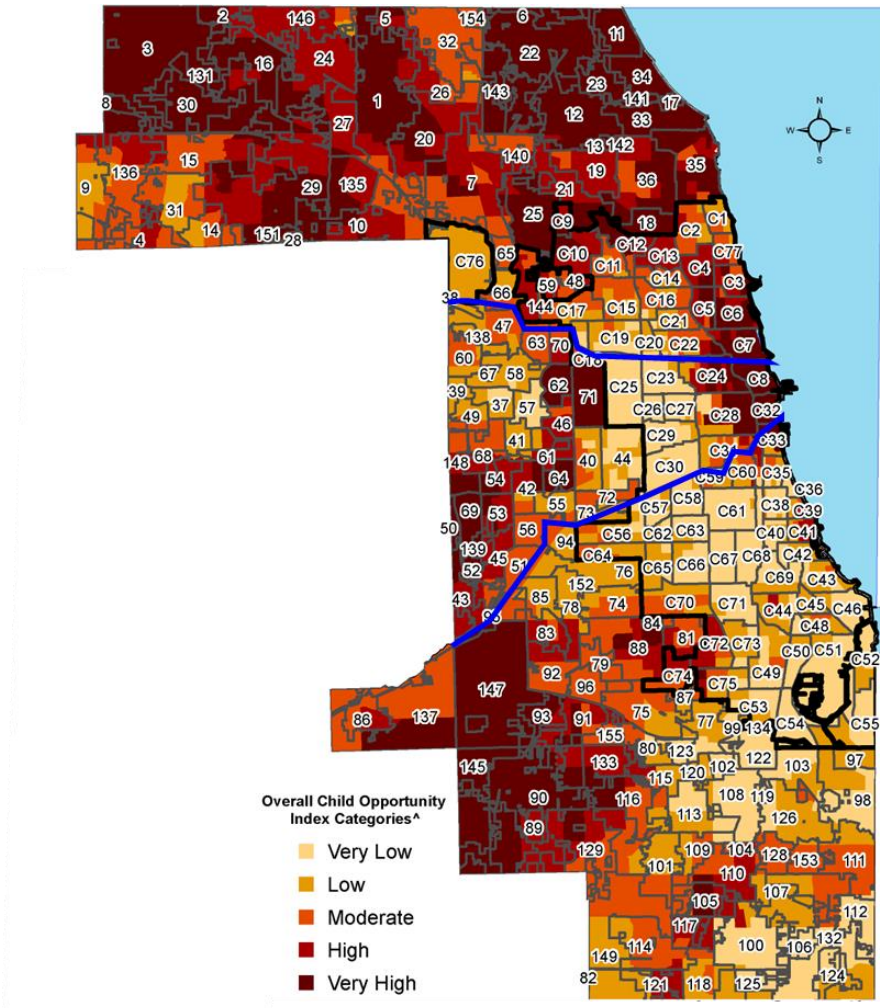
Social Vulnerability by Census Tract, 2010


Social Vulnerability Index
Lowest (bottom 4th)
.35-.65
.66-.89
Highest (top 4th)
data not available
N
W
E
S

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.[1]

The Chicago community areas in the South region with the lowest childhood opportunity include Hegewisch, Riverdale, West Pullman, Roseland, Pullman, South Deering, Eastside, South Chicago, Calumet Heights, Auburn Gresham, Chicago Lawn, West Englewood, Englewood, Greater Grand Crossing, Woodlawn, Washington Park, Grand Boulevard, Oakland, New City, Gage Park, West Elsdon, Archer Heights, Brighton Park and Douglas. The Suburban Cook County municipalities in the South region with the lowest childhood opportunity include Chicago Heights, South Chicago Heights, Ford Height, Bloom Township, Sauk Village, Glenwood, Calumet City, Dolton, Phoenix, Harvey, Midlothian, Robbins, and Dixmor.



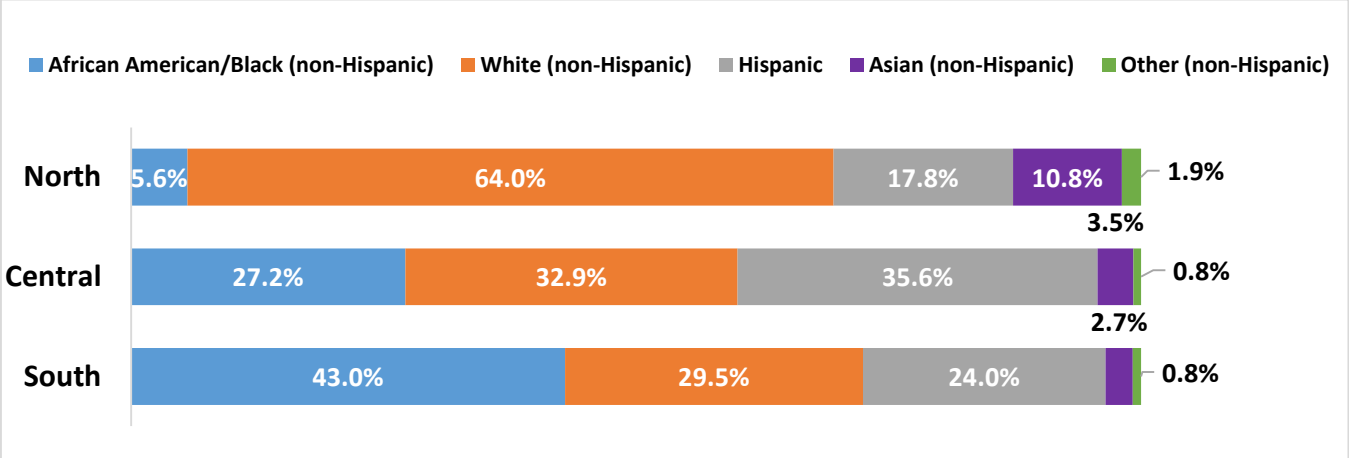
[1] Ferguson, H., Bovaird, S., Mueller, M. (2007). *Pediatrics and Child Health*, 12(8), 701-706.

Demographics

As of the 2010 census, the South region had a total population of 2,081,036 residents, making it the largest of the three regions in the Health Impact Collaborative. African American/black individuals make up the largest proportion of the population, representing 43.0% of the total population of the South region as of 2010. The South region has the highest percentage of African American/black residents compared to the North and Central regions. However, the African American/black population decreased in the South region by 65,704 from 200-2010.

The Hispanic/Latino ethnic group is experiencing the largest population increase across Chicago and Suburban Cook County. The Hispanic/Latino population in the South region increased by 86,747 from 2000-2010. The Asian population increased by 15,846 in the South region during the same time period and represent 3.5% of the total population. The white non-Hispanic population in the South region decreased by 163,693 from 2000-2010 and represent 29.5% of the total population.

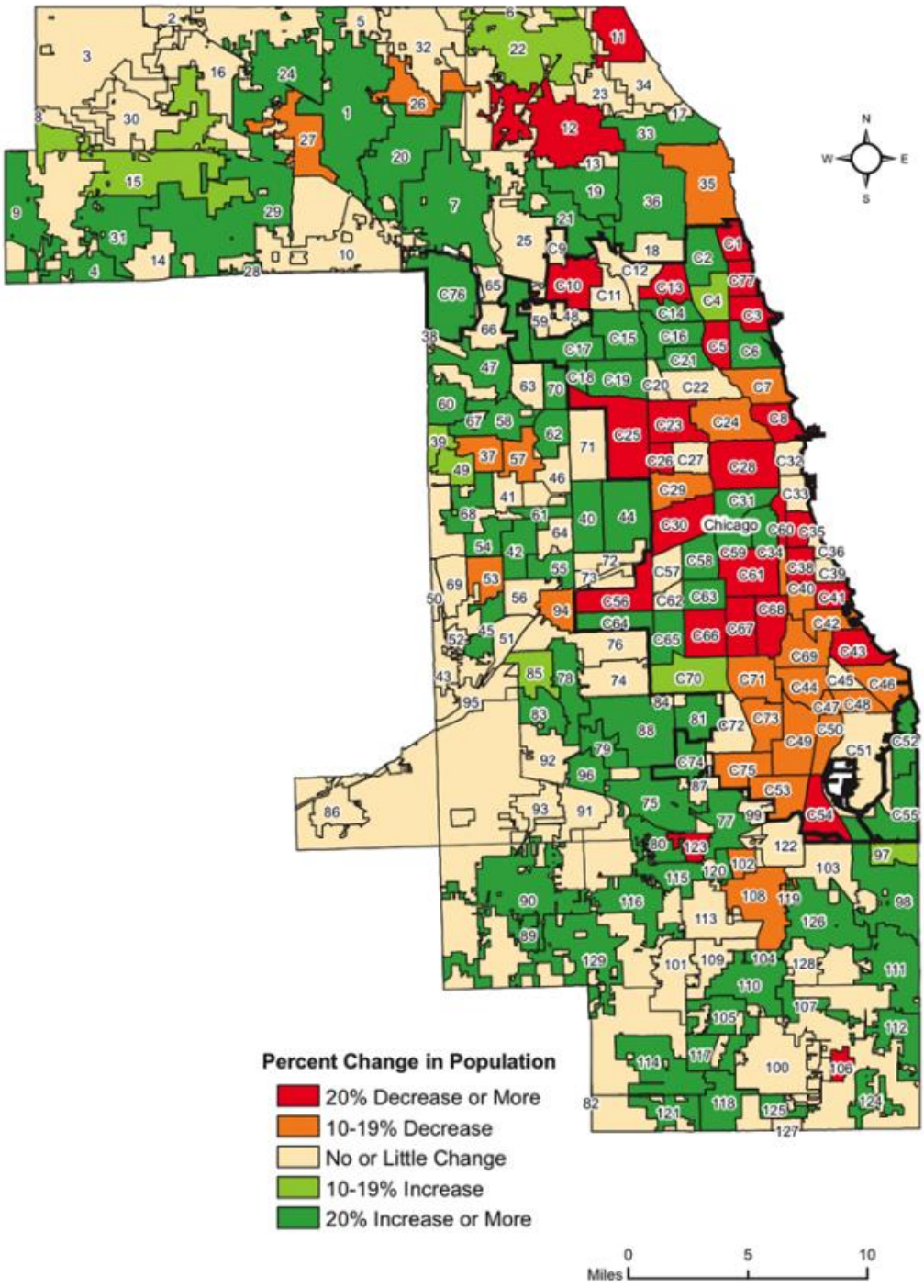
Race and ethnicity compared across three Cook County regions, 2009-2013



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

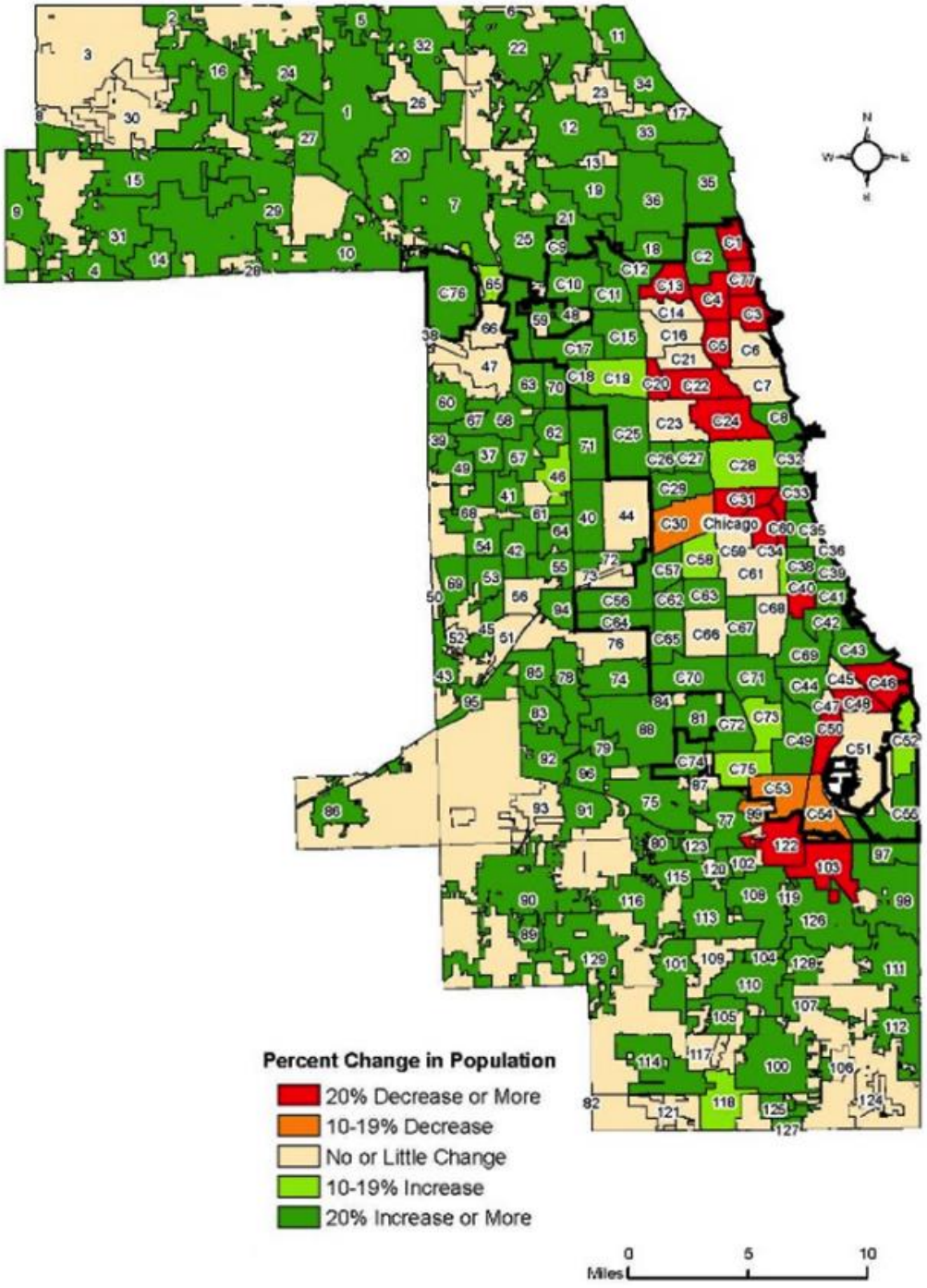
Map of the change in African American/black population, Cook County, 2000-2010

Between 2000 and 2010, the African American/black population decreased by 65,704 in the South region.



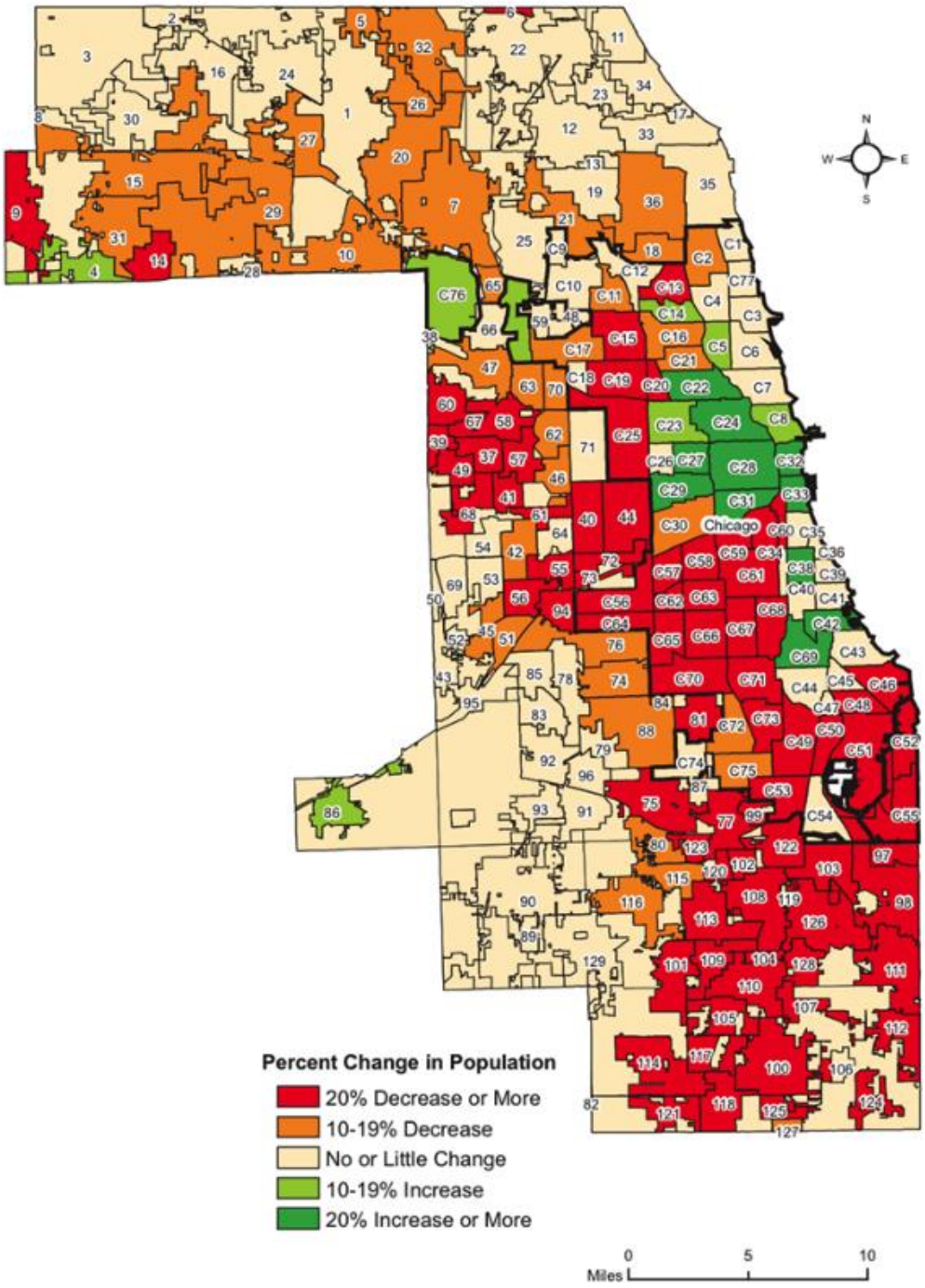
Map of the change in Hispanic/Latino population, Cook County, 2000-2010

Between 2000 and 2010, the Hispanic/Latino population increased by 86,747 in the South region.



Map of the change in White (non-Hispanic) population, Cook County, 2000-2010

Between 2000 and 2010, the non-Hispanic white population decreased by 163,693 in the South region.



Gender

The percentage of individuals that identify as male or female is approximately equal in Chicago and Suburban Cook County. A 2015 study by the U.S. Census Bureau[2] estimates that there are approximately 3.4 - 4.7 individuals per 100,000 residents in Illinois that are transgender.

Gender	United States	Illinois	Suburban Cook County	Chicago
Female Population (2010)	50.84%	50.96%	51.73%	51.47%
Male Population (2010)	49.16%	49.04%	48.27%	48.53%

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

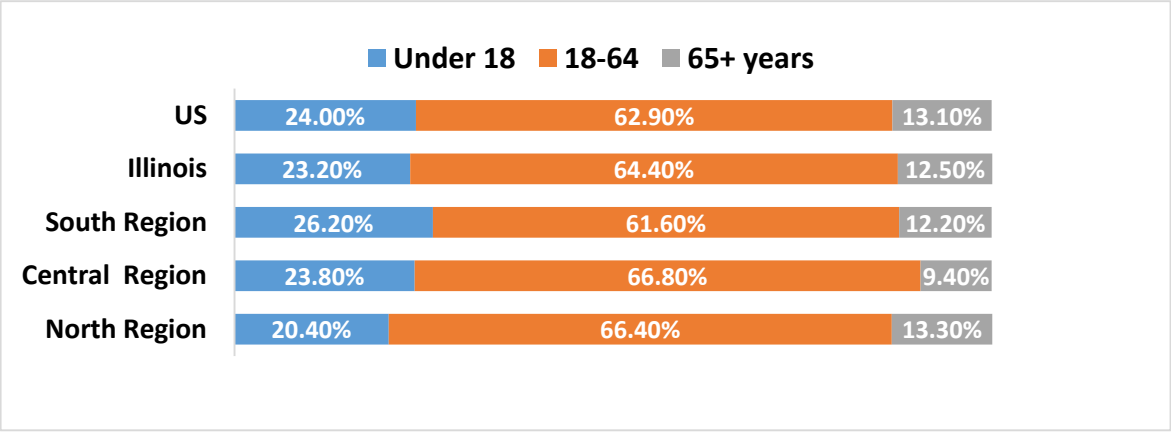
Sexual Orientation

It is estimated that approximately 3.8% of Chicago residents identify as lesbian, gay, bisexual, queer, asexual, or intersex (LGBQIA). There are disparities in many health indicators such as access to clinical care, health behaviors, and self-reported health status for the LGBQIA population.

Age

The South region has the highest percentage of children aged 18 or under (26.2%) and the lowest percentage of individuals aged 18-64 (61.6%) compared to the North and Central region. Approximately 12.2% of the population in the South region are age 65 or older.

Age distribution of individuals in Chicago and Suburban Cook County, 2010



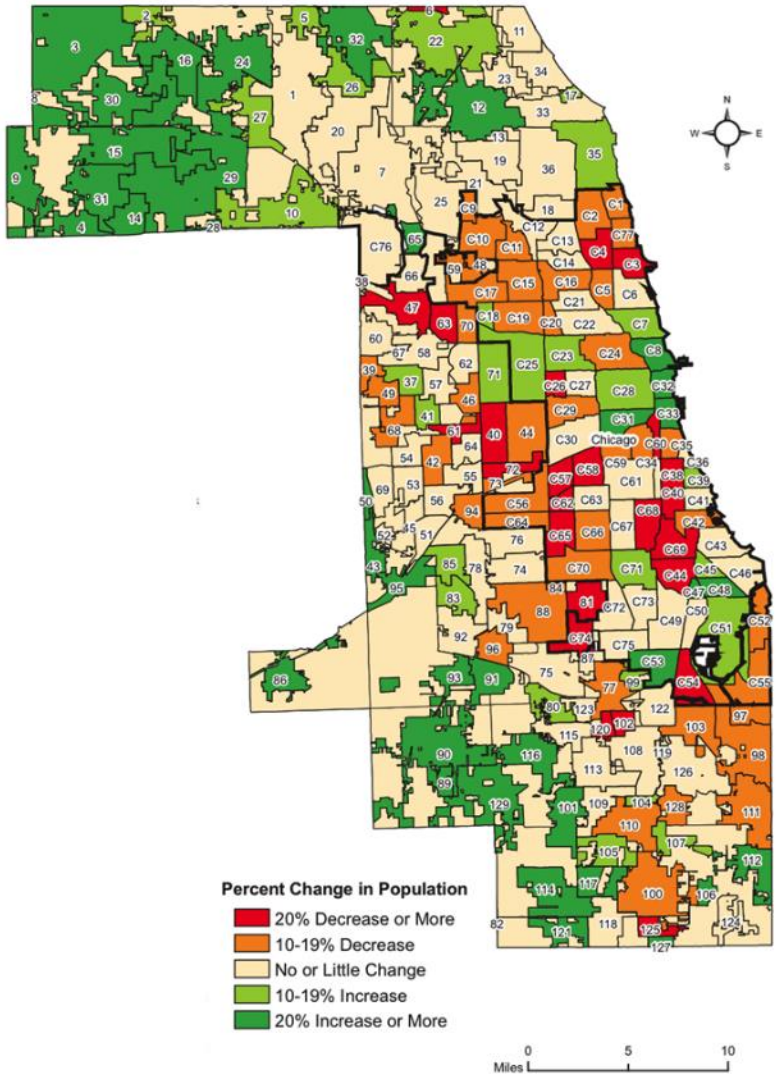
The population of Chicago and Suburban Cook County decreased across all age categories from 2000-2010 except for the population aged 55-64 which experienced a 30% increase. However, the population aged 55-64 increased less in Chicago and Suburban Cook County (30%) than it did in Illinois (42% increase) and the U.S. (51% increase). Census Bureau population estimates for 2014 indicate a continuing trend of high population loss for Chicago and Suburban Cook County.[3]

[2] 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

[3] U.S. Census Bureau. (2015). http://www.census.gov/quickfacts/table/PST120214/17031

Change in older adult population (65 or older), Cook County, 2000-2010

Between 2000 and 2010, the population of adults aged 65 or older did not significantly change in the South region.



People living with disabilities

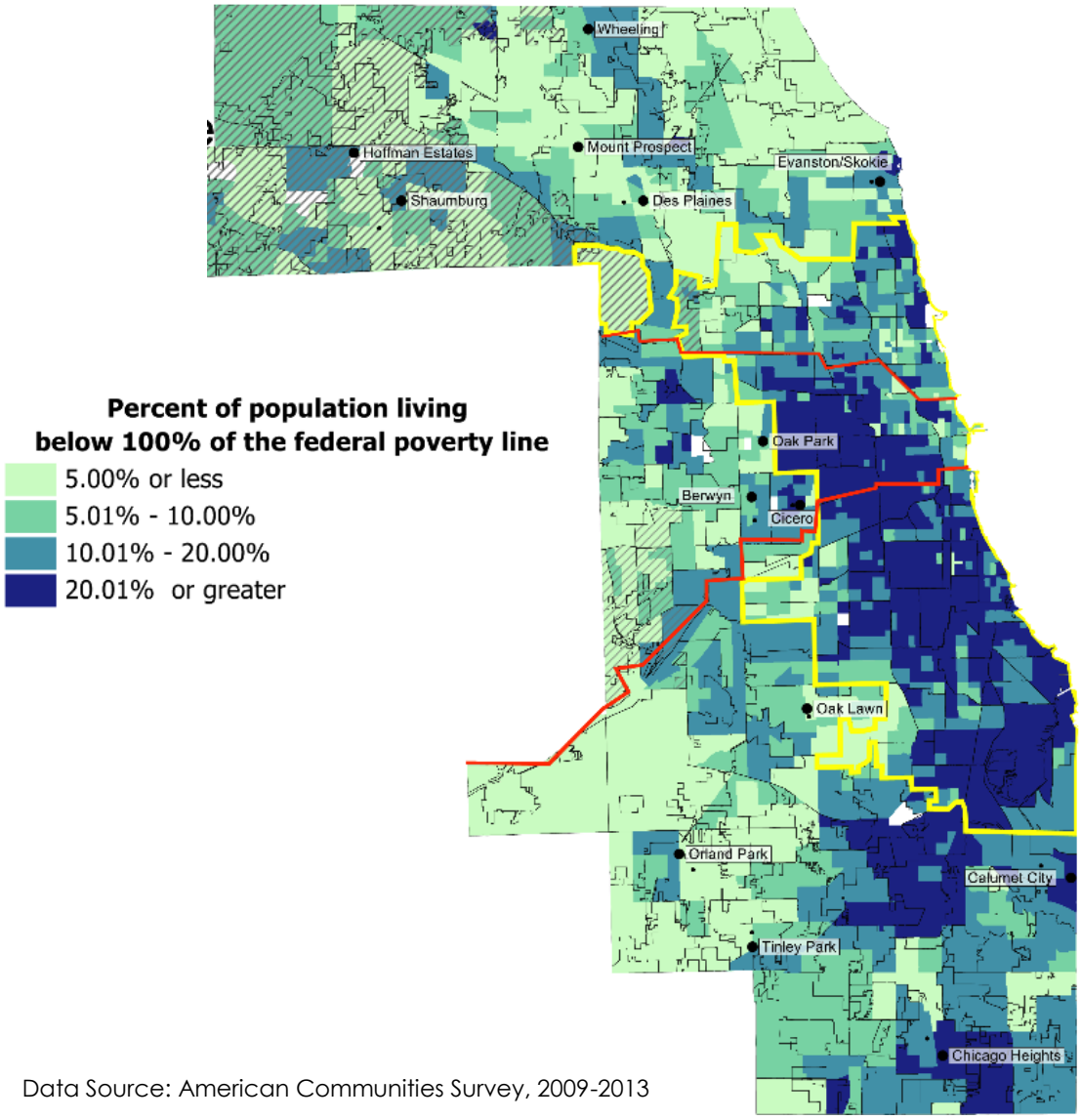
Approximately 12% of the population in the South region lives with a disability, which is slightly higher compared to Cook County (10.3%) and Illinois (10.6%). More than a third (37%) of those living with a disability in Chicago and Suburban Cook County are over the age of 65.

SOCIOECONOMIC FACTORS

Poverty

Poverty can create barriers to accessing health services, healthy food, and other necessities needed for good health status. 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. In the South region 21.6% of individuals are living in households with income below the 100% Federal Poverty Level (FPL). An additional 43.1% of individuals in the South region live at or below the 200% FPL. The percentage of residents living in poverty is high in the South region (43.1%) compared to Cook County (36.3%), Illinois (31.9%) and the U.S. (34.5%). As shown in the map, the communities in the South region with the **highest percentage of residents living at or below 100% FPL include Calumet Township, Dixmoor, East Side, Englewood, Fuller Park, Grand Boulevard, Harvey, Lower West Side, New City, Oakland, Phoenix, Posen, Riverdale, Robbins, South Deering, Washington Park, and West Englewood.**

Map of poverty rates in Cook County – population living below 100% of the Federal Poverty

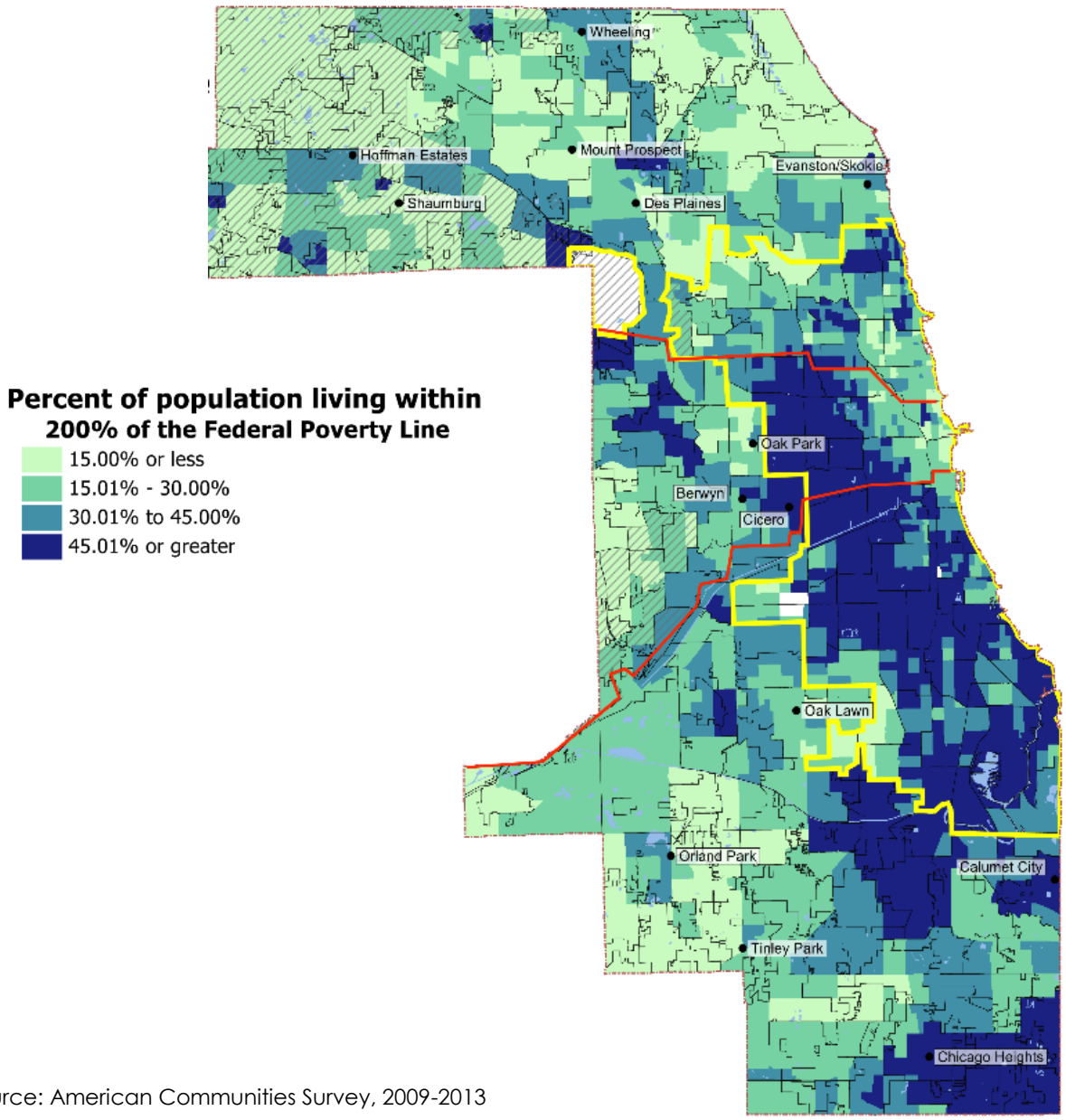


Data Source: American Communities Survey, 2009-2013

The communities in the South region with the highest percentage of residents living at or 200% FPL include Bellwood, Bloom Township, Blue Island, Brighton Park, Calumet Township, Dixmoor, Englewood, Ford Heights, Fuller Park, Gage Park, Harvey, Lower West Side, Lynwood, McKinley Park, Oakland, Phoenix, Posen, Riverdale, Robbins
South Chicago Heights, Sauk Village, South Lawndale, Washington Park, West Englewood, and Woodlawn.

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

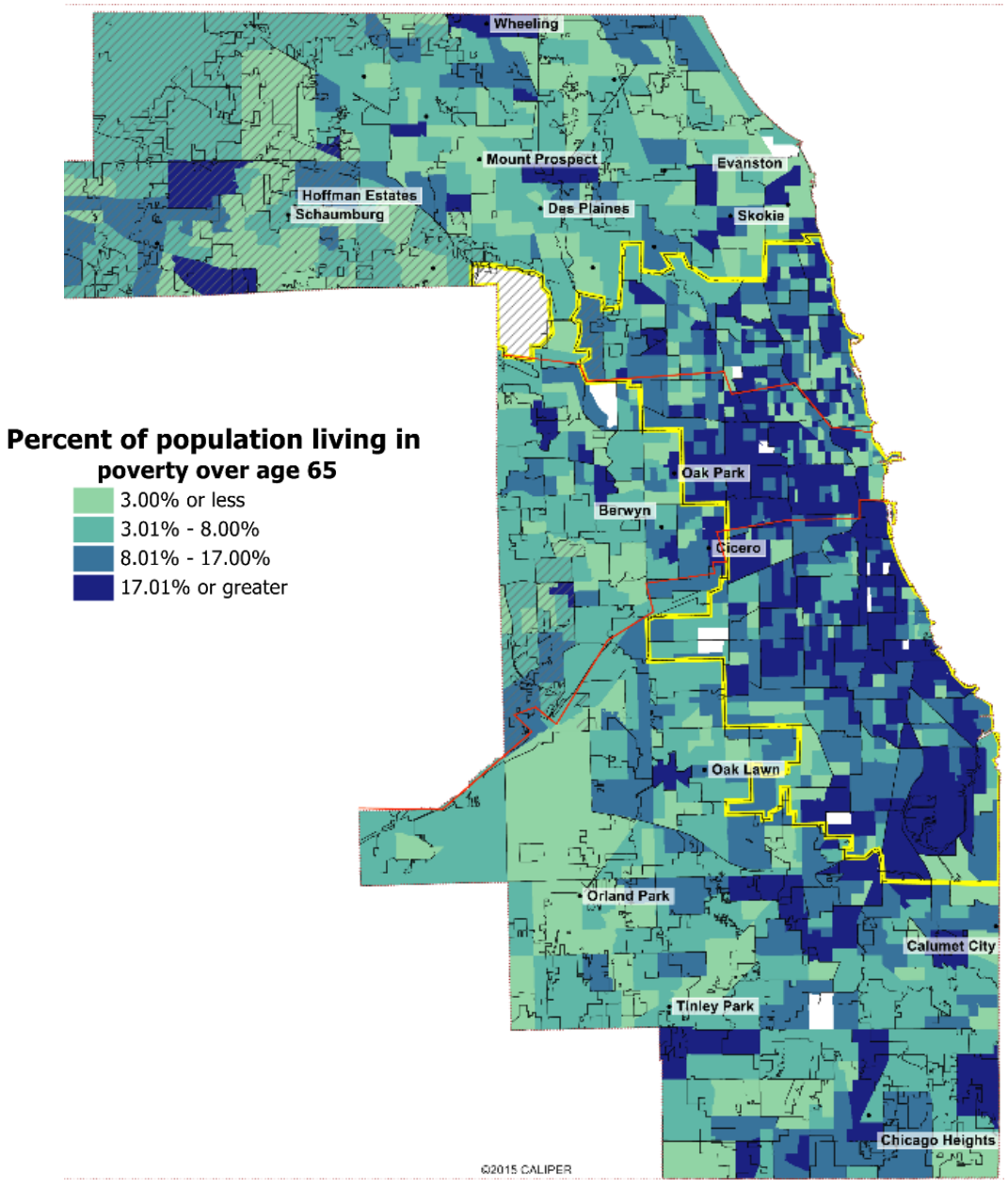
In the South region, 43.1% of individuals in the South region live at or below 200 % of the FPL.



Data Source: American Communities Survey, 2009-2013

Individuals aged 65 or older account for 12% of those living in poverty in Chicago and Suburban Cook County as of 2009-2013. In the South region, the **communities with the highest percentages of older adults in poverty include Armour Square, Fuller Park, Lynwood, Near South Side, Oakland, Posen, Riverdale, Robbins, South Deering, Washington Park, and Woodlawn.**

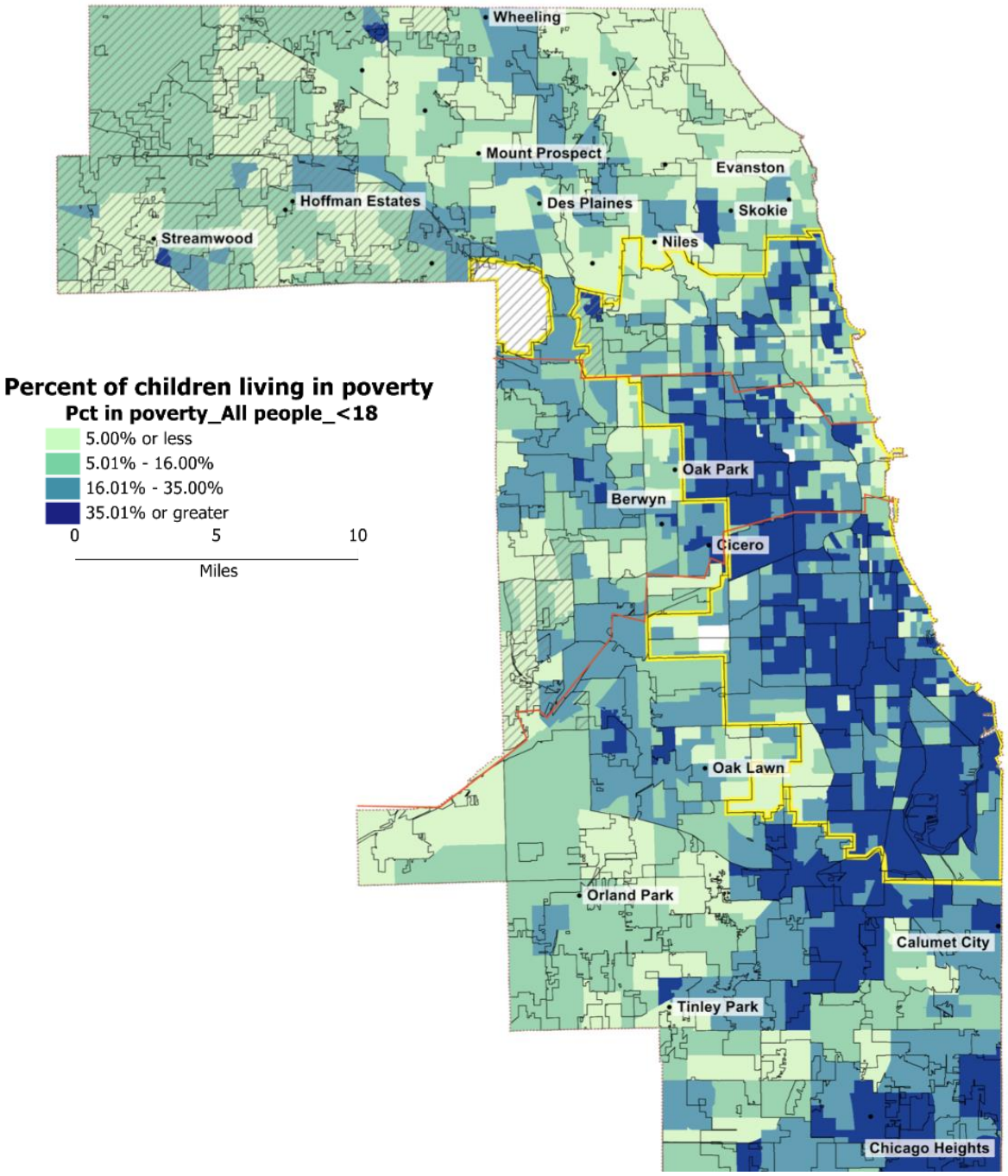
Map of older adults (65+) in poverty, 2009-2013



Data Source: American Communities Survey, 2009-2013

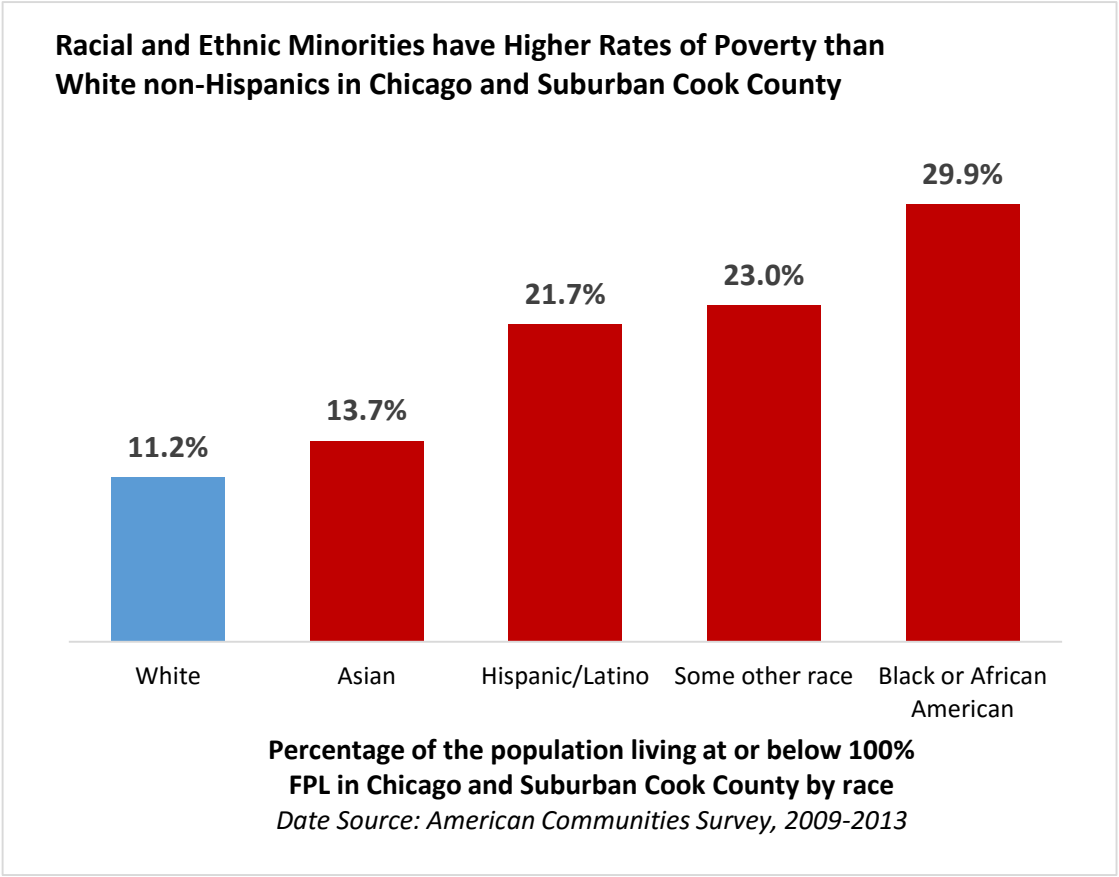
The percentage of children in poverty in Chicago and Suburban Cook County increased by 15% from 2000-2010. Nearly a third (31.8%) of children under age 18 in the South region live at or below the 100% FPL and more than half (56.9%) of children and adolescents live at or below the 200% FPL. The percentage of children living at or below 200% FPL is higher in the South region than it is in Cook County (48.3%), Illinois (41.3%) and the U.S. (44.2%). The **communities in the South region with the highest percentages of children in poverty include Calumet Township, Dixmoor, Englewood, Ford Heights, Lynwood, Phoenix, Riverdale, Riverdale (Chicago community area), Robbins, and Washington Park.**

Map of children living in poverty, 2009-2013



Communities of color are much more likely to live at or below the federal poverty levels in Chicago and Cook County.

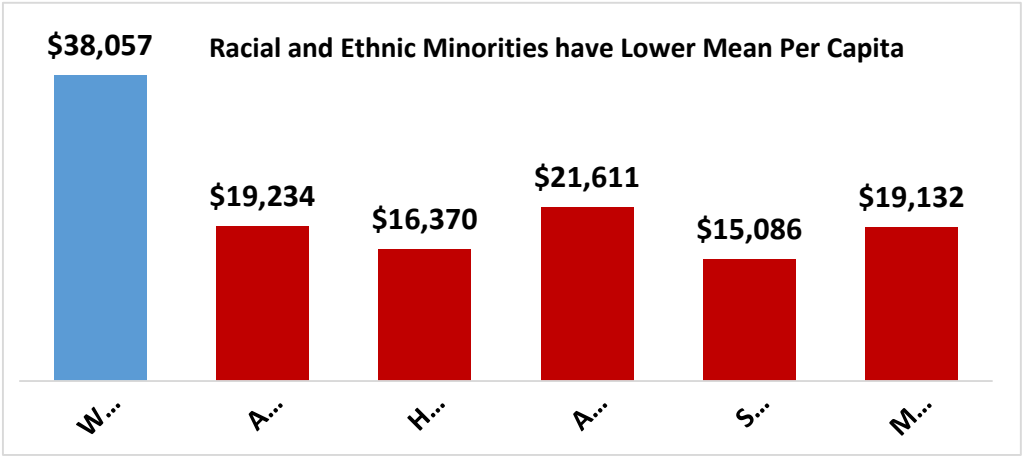
Comparison of poverty rates by race and ethnicity, 2009-2013



Income

The per capita income for individuals in the South region ($22,773) is lower than the per capita income of residents in Cook County ($30,468), Illinois ($30,019) and the U.S. ($28,554). The per capita income for racial and ethnic minorities is lower than it is for non-Hispanic whites.

Comparison of mean per capita income by race and ethnicity



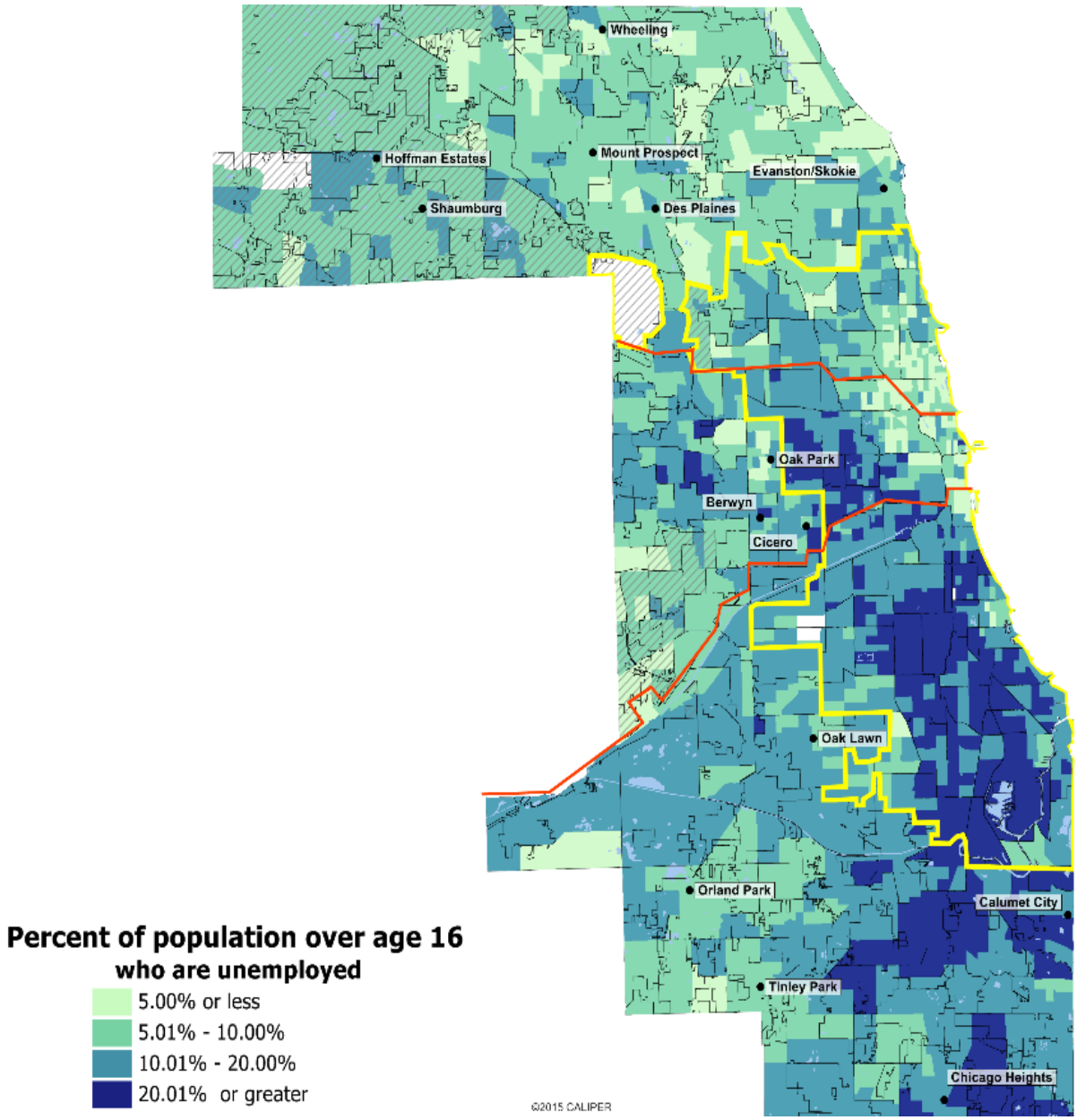
The disparity index is a measure of income inequality. A hypothetical disparity index score of "0' indicates that income is equally distributed across all members of a population and a hypothetical score of "1" indicates perfect inequality in the distribution of income (one person has all of the wealth and all other members of the population have nothing). The per capita Income Disparity Index score for Chicago and Cook County (39.48) is higher than the score for Illinois and the United States indicating that inequities in income are greater in the city and county.

A cost-burdened household is a household in which housing costs exceed 30% of total household income. Housing cost burden is indicative of housing affordability and excessive housing costs. The percentage of households that are cost-burdened is higher in the South region (44.2%) than in Cook County (42.1%), Illinois (35.3%), and the U.S. (34.9%).

Unemployment

Unemployment can create financial instability and as result can create barriers to accessing healthcare services, insurance, healthy foods, and other basic needs. 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. The unemployment rate in the South region is higher (17.0%) compared to the Central (12.1%) and North (8.2%) regions. The unemployment rate in the South region also exceeds the rates for Illinois (10.5%) and the U.S. (9.2%). Unemployment disparities persist in Chicago and Suburban Cook County with African Americans and Hispanic/Latinos having higher unemployment rates than non-Hispanic whites.

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



Educational Attainment

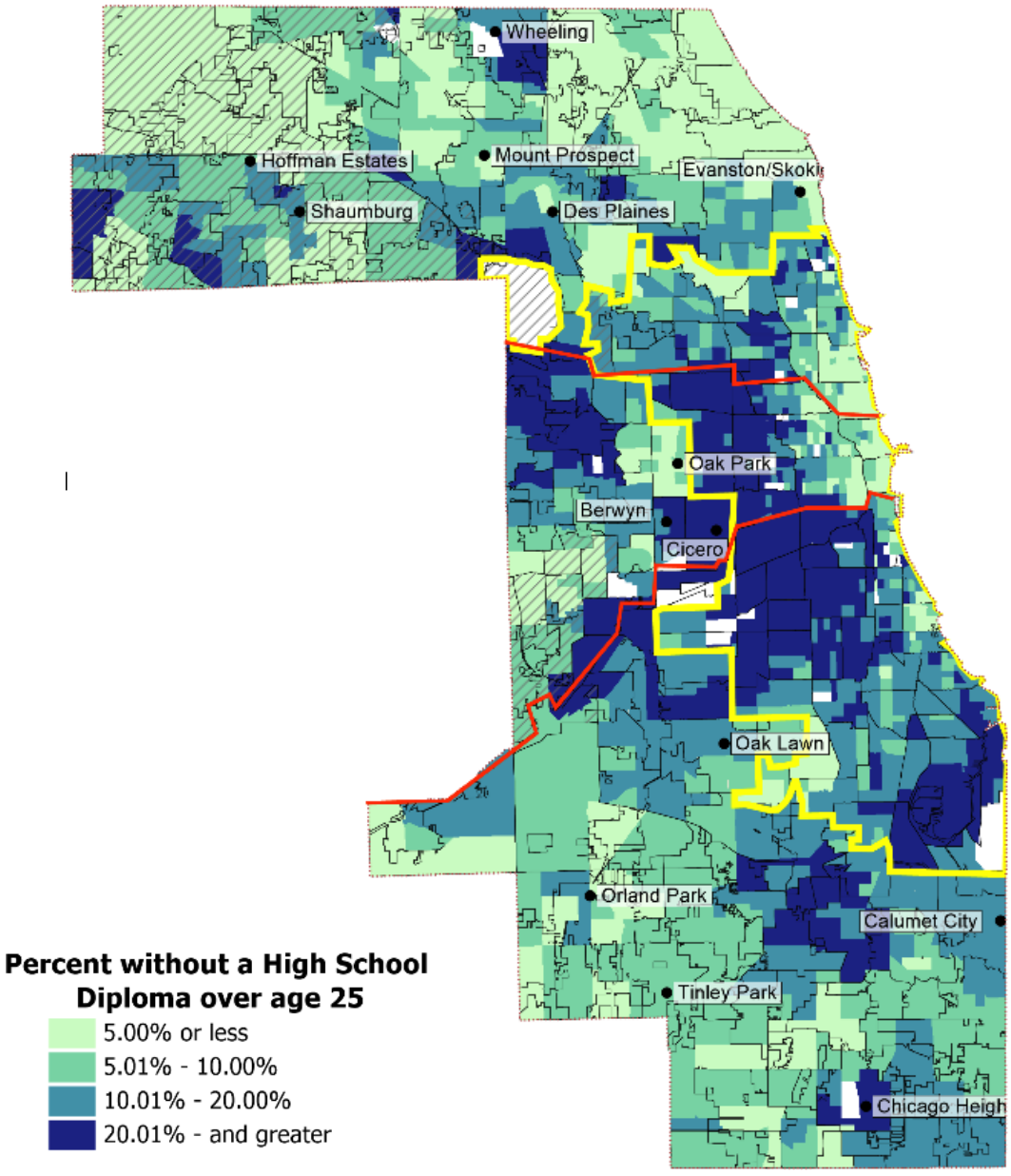
Educational attainment has long been established as a strong indicator of health. Individuals with higher levels of educational attainment have longer life expectancies, lower risks for chronic disease, and are less likely to engage in negative health behaviors.[4] Early childhood education programs increase school performance and high school graduation rates.[5]

In 2014, the high school graduation rate for the South region (82.6%) was slightly lower than the rates for Illinois (84.5%), and the U.S. (84.3%). In addition, approximately 18.9% of adults over age 25 in Chicago and 12.0% of adults in Suburban Cook County did not have a high school diploma or equivalent from 2009-2013. There are racial and ethnic disparities in educational attainment with the percentage of Hispanic/Latino adults in Chicago without a high school diploma reaching 40.5% in 2014.[6] The communities in the South region with the highest percentages of adults aged 25 or older without a high school education are Archer Heights, Armour Square, Blue Island, Brighton Park, Burnside, Dixmoor, Gage Park, Lower West Side, McKinley Park, Phoenix, Posen, Riverdale, Robbins, South Lawndale, Summit, and West Elsdon.

[4] Robert Wood Johnson Foundation. (2013). Health policy snapshot series. http://www.rwjf.org/en/library/research/2012/12/why-does-education-matter-so-much-to-health-.html
[5] CDPH. Healthy Chicago 2.0. (2016) CDPH
[6] U.S. Census Bureau. (2014). American Communities Survey.

Map of the population over Age 25 without a high school education, 2009-2013

Overall, 18.8% of the population over age 25 in the Central region does not have a high school education, compared to 12.7% in Illinois and 14.0% in the U.S.

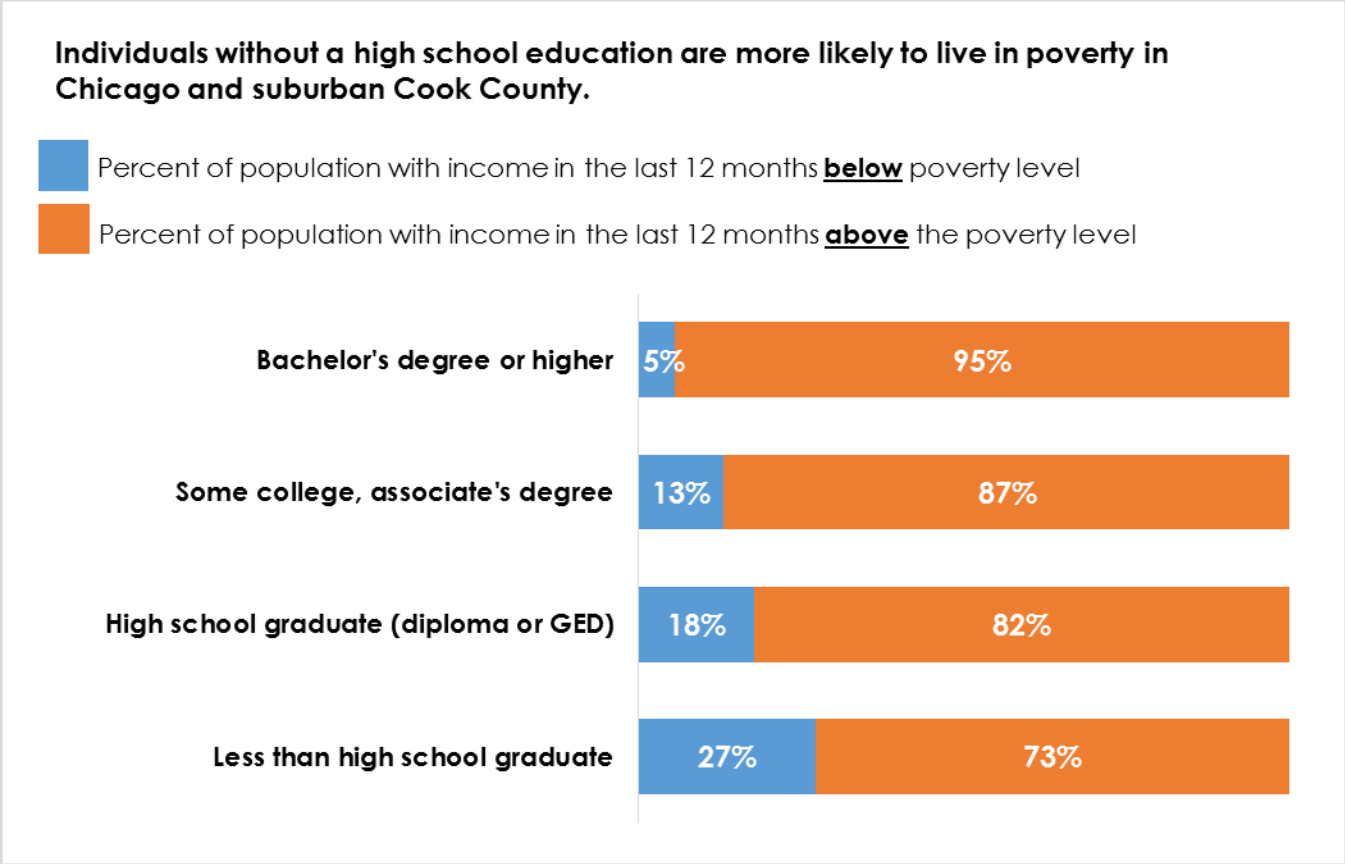


Limited English Proficiency

Limited English proficiency is defined by the U.S. Census Bureau as individuals who respond to the American Communities Survey as speaking English less than "very well." The inability to speak English well creates barriers to accessing healthcare, provider communications, and health literacy/education.[5] Approximately 45.0% of individuals in Chicago and 42.8% of individuals in Suburban Cook County were reported to be limited English speakers. The rates for the city and county are approximately the same as those for Illinois (42.1%) and the U.S. (41.7%). The communities in the South region with the highest percentages of individuals that have limited English proficiency include Archer Heights, Armour Square, Bridgeport, Brighton Park, Gage Park, Lower West Side, McKinley Park, New City, South Lawndale, and West Elsdon.

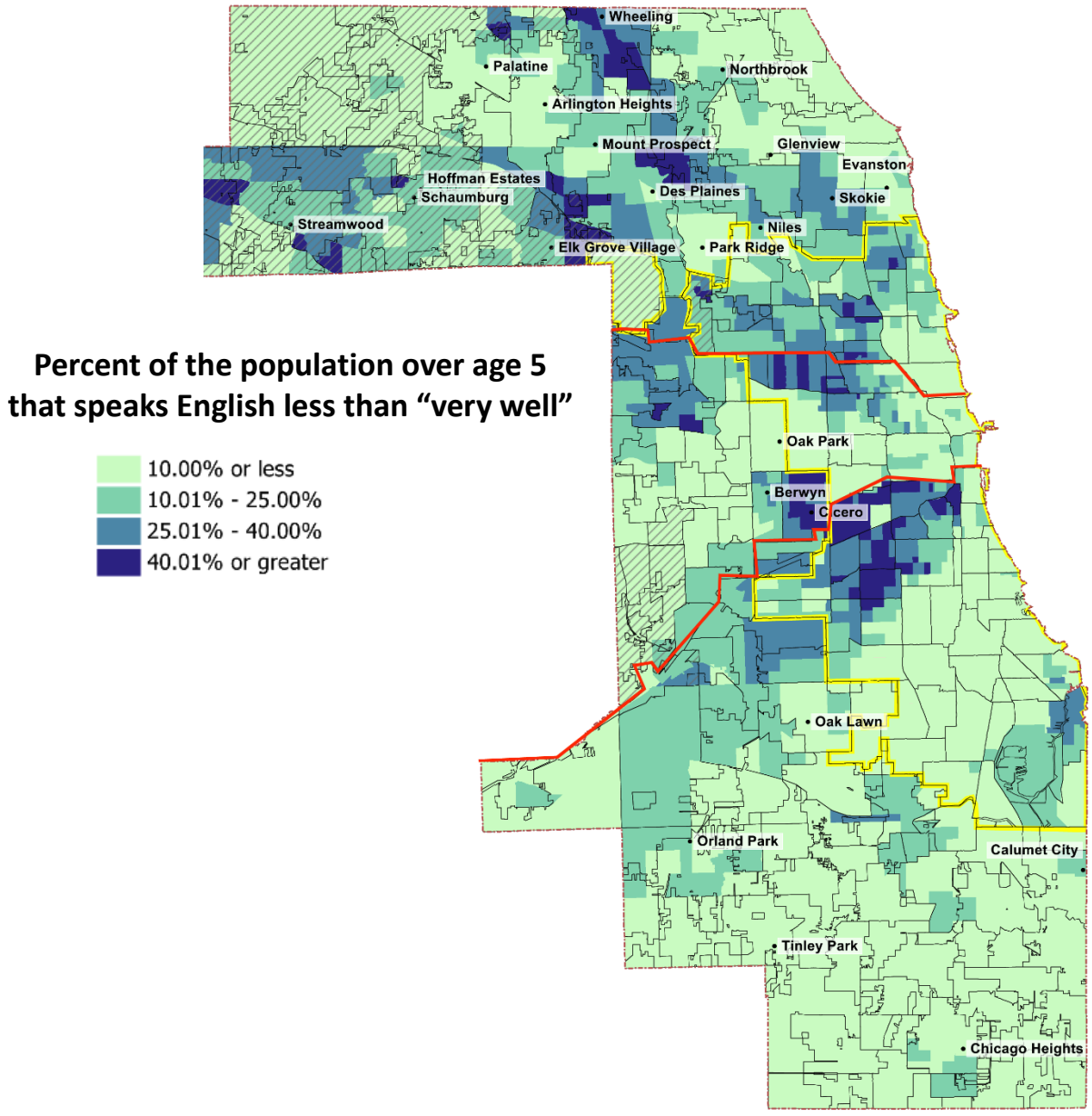
Twenty-seven percent of those without a high school education in Cook County live below the federal poverty level.

The relationship between education and poverty in Chicago and suburban Cook County



Data Source: American Communities Survey, 2010-2014

Map of Individuals with limited English proficiency, 2009-2013

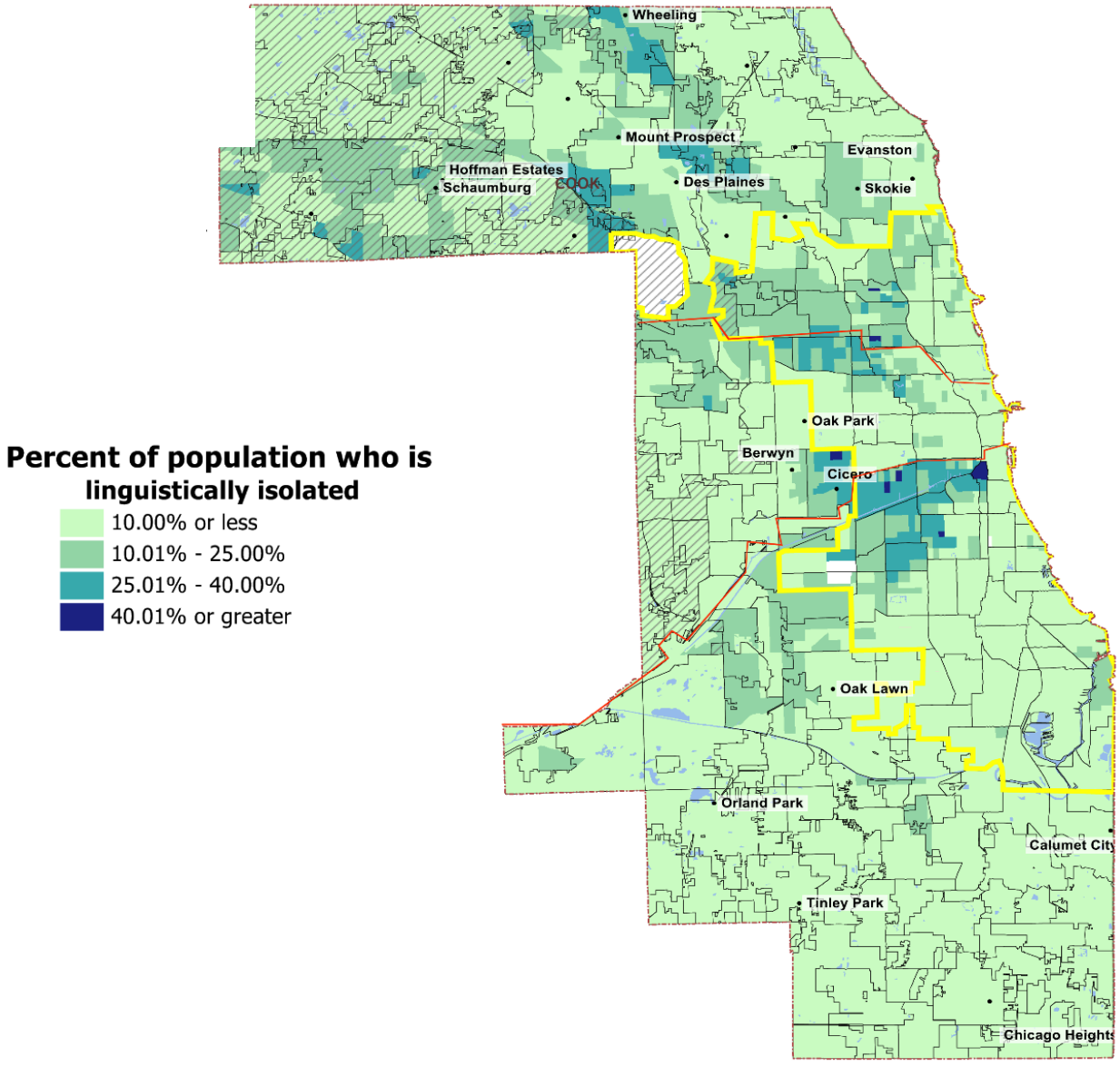


Linguistically Isolated Households

A linguistically isolated household is defined by the U.S. Census Bureau as a household where all adults have limitations communicating in English. A household is classified as linguistically isolated if no household member age 14 years and over spoke only English and no household member age 14 years and over who spoke another language spoke English "very well". Approximately 8.4% of households in Chicago and Suburban Cook County are Linguistically Isolated. **The communities in the South region with the highest percentages of linguistically isolated households include Armour Square, Bridgeport, Brighton Park, Gage Park, Garfield Ridge, Lower West Side, McKinley Park, New City, and South Lawndale.**

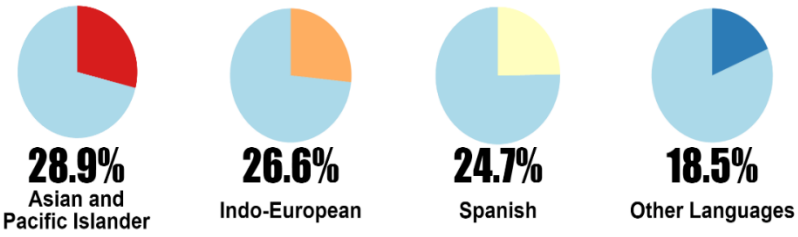
Map of linguistically isolated households, 2009-2013

Approximately 8.4% of households in Chicago and Suburban Cook County are Linguistically Isolated.



Languages spoken by linguistically isolated households, 2009-2013

8.4% of All Households in Chicago and Suburban Cook County are Linguistically Isolated



Languages Spoken by Linguistically Isolated Households in the city and county.

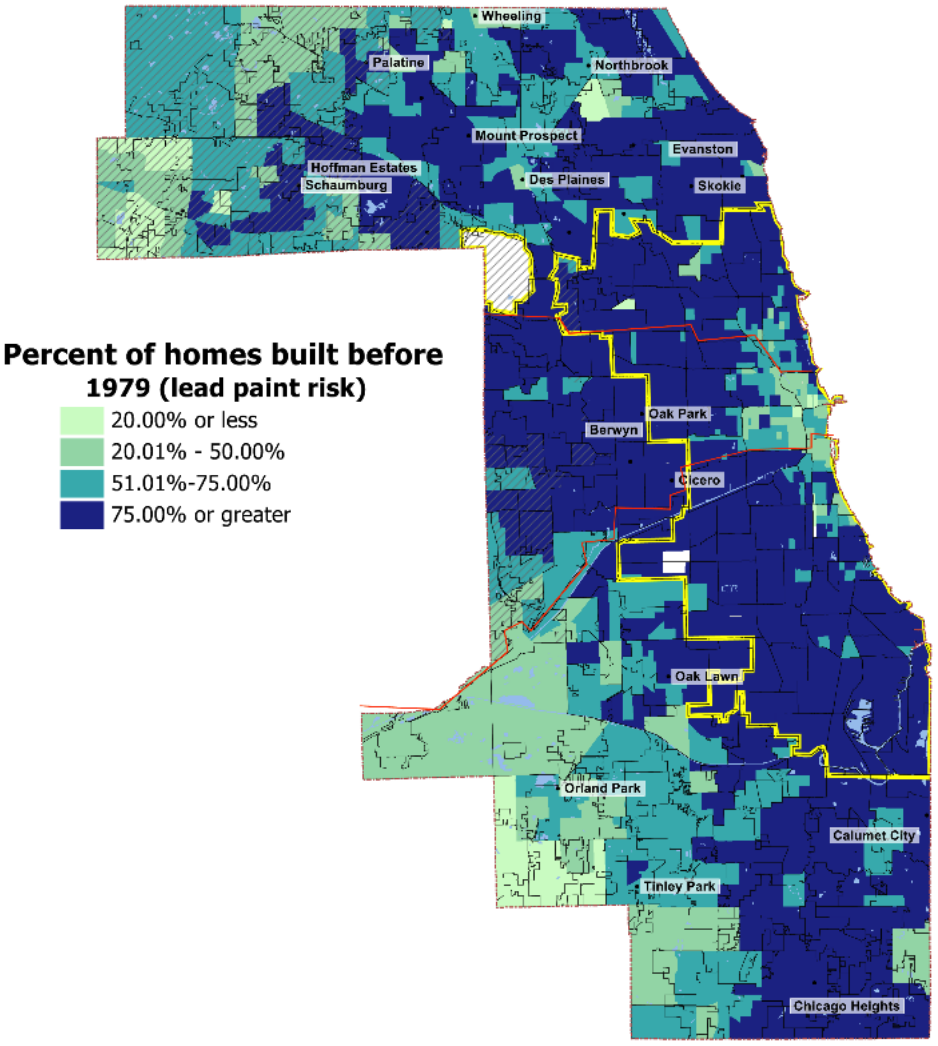
ENVIRONMENT

Physical Environment

Seventy-nine percent of homes in Chicago and Suburban Cook County were built before 1979. Homes built prior to 1979 are more likely to contain lead paint. 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.[7] 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.[8] If pregnant women are exposed to lead paint particles, there is a risk of exposure to their developing baby.[7]

Map of home built before 1979 (lead paint risk)

Approximately 79% of homes in Chicago and Suburban Cook County were built before 1979. Homes built prior to 1979 are more likely to contain lead paint.



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

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

Air Quality

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. [9] Chronic exposure to these particles contributes to the risk of developing cardiovascular, respiratory diseases, and lung cancer. The percentage of days with particulate matter 2.5 microns or less (PM 2.5) levels above the National Ambient Air Quality Standard (35 micrograms per cubic meter) per year is higher in the South region than it is for Cook County, Illinois, and the U.S. In 2008, there were no days in the South region that exceeded the National Ambient Air Quality Standard of 75 parts per billions.

Geography	Percentage of days exceeding the National Ambient Air Quality Standard (35 micrograms per cubic meter) – Population Adjusted Average
South Region	1.76%
Cook County	1.56%
Illinois	1.08%
United States	1.19%

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

Food Access

Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food. 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 have higher food insecurity rates in the U.S.[10] The rate of food insecurity in Chicago and Cook County is higher than the rate for Illinois. The communities in the South region with the highest rates of food insecurity include Auburn Gresham, Burnside, Chatham, Douglas, Englewood, Fuller Park, Grand Boulevard, Greater Grand Crossing, Harvey, Oakland, Pullman, Riverdale, Robbins, Roseland, South Chicago, South Shore, Washington Park, West Englewood, West Pullman, and Woodlawn.

Geography	Percentage of the population that experienced food insecurity at some point in 2013
Cook County	14.6%
Illinois	13.6%
United States	15.2%

Date Source: Feeding America. 2013.

Public Transportation and Motor Vehicle Ownership

The percentage of the population that utilizes public transportation as their primary means of commute to work in high in the South region and Cook County compared to Illinois and the U.S.

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

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

Geography	Percent of population using public transit for commute to work
South Region	16.1%
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 South region compared to Cook County, Illinois, and the U.S. and could indicate a need for transportation alternatives.

Geography	Percentage of Households with no motor vehicle
South Region	18.1%
Cook County	17.8%
Illinois	10.8%
United States	9.1%
Data Source: American Communities Survey, 2010-2014	

Safety and Violence

Violent crime rates in Cook County (386.8 per 100,000) are higher than the rates for Illinois (306.2 per 100,000). Violent crime in each of the three regions of Cook County ranged from approximately 80.3 (per 100,000) in the North region to approximately 152.4 (per 100,000) in the South region and 187.1 (per 100,000) in the Central region. The six highest violent crime rates in Suburban Cook cities ranged from 569.4 (per 100,000) to 209.5 (per 100,000). The six highest violent crime rates in Chicago community areas.

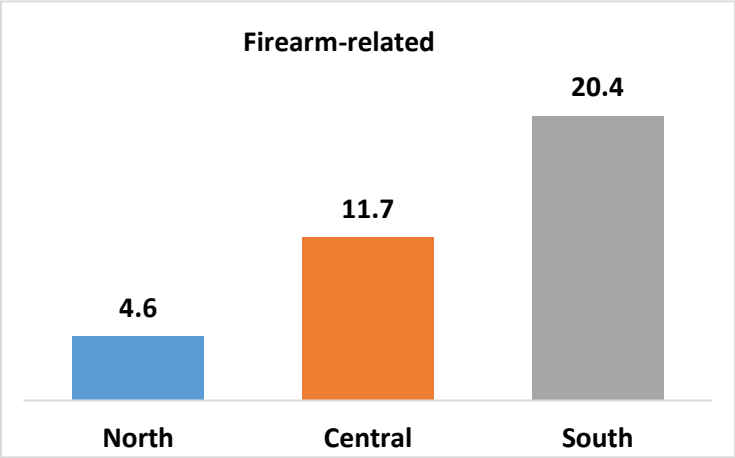
Chicago community areas and suburban cities in the South region with the highest violent crime rates.	
Chicago Communities	**Suburban Cities**
West Englewood	Harvey
Washington Park	Sauk Village
Greater Grand Crossing	Robbins
Englewood	Phoenix
Riverdale	Chicago Heights
Auburn-Gresham	Burnham

Data Sources: CDPH 2014, CCDPH 2009-2013, IDPH 2012

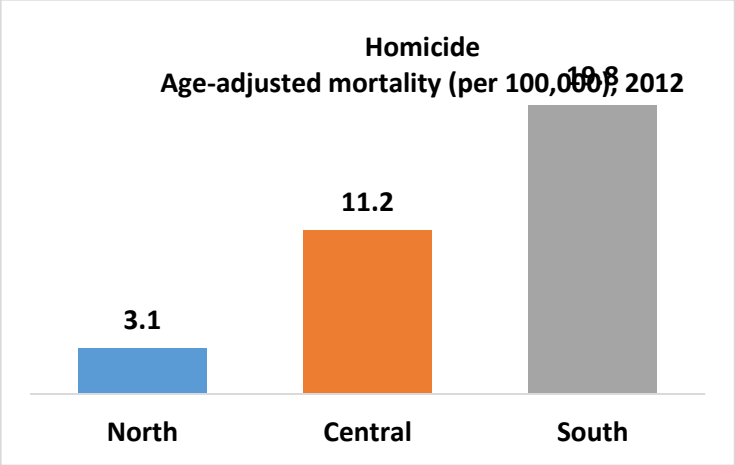
Although violent crime occurs in all communities, violent crime disproportionately affects residents living in communities of color in Chicago and Suburban Cook County.[11] In addition, homicide and firearm-related mortality are highest in the South region and among ethnic or racial minorities.

Firearm-Related mortality rate, 2012

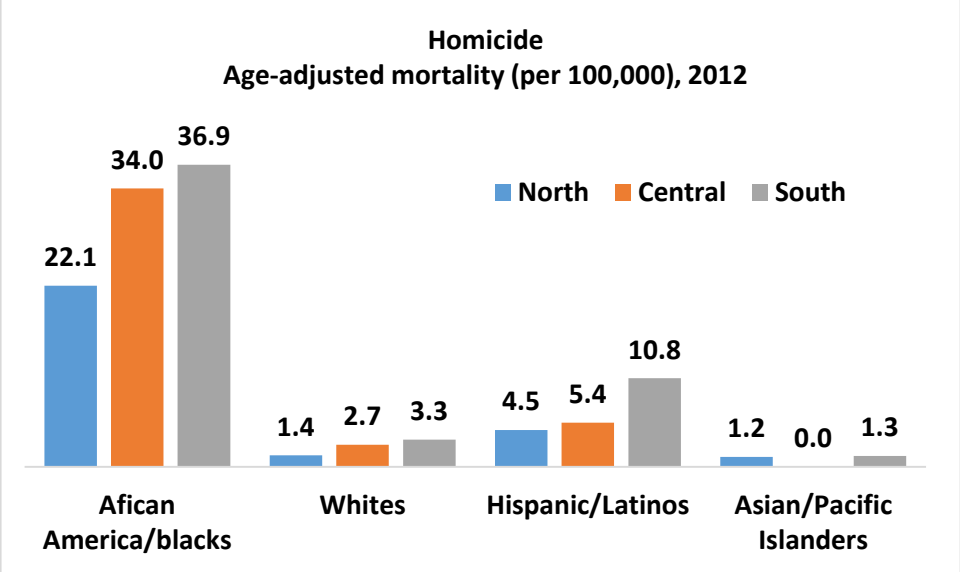
[11] Data Sources for Violent Crime: CDPH 2014, CCDPH 2009-2013, IDPH 2012



Homicide mortality rate, 2012



Homicide disparities by race and ethnicity, 2012



Health Behaviors

Most adults in Suburban Cook County (84.9%) reported that they did not eat the daily recommended amount of fruits and vegetables. In the city of Chicago, a higher percentage of adults eat the recommended amount of fruits and vegetables (29.2%) than in Illinois (28.5%) and the U.S. (23.4%). More than a quarter of adults in Chicago and Suburban Cook County reported that they did not engage in physical activity during leisure times. Youth that reported engaging in less than the daily recommended amount of physical activity (60 minutes) ranged from 13.5% in Suburban Cook County to 21.5% in Chicago. Poor diet and physical inactivity are two of the major predictors of obesity and other chronic diseases.

The percentage of adults that reported smoking a cigarette in the last 30 days ranged from 14% to more than 18% in Chicago and Suburban Cook County. The percentage of youth that reported smoking in the last 30 days ranged from 12% in Suburban Cook County to 11% in Chicago. In the city of Chicago, the percentage of adults that smoke has decreased by approximately 17% and the percentage of youth smokers has decreased by approximately 10%.[12]

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	84.9%	70.8%	77.5%	76.6%
Heavy Drinking in the previous month	N/A	9.2%	6.5%	6.2%
Current Smokers	14.4%	18.4%	18.0%	19.0%
No Leisure-Time Physical Activity	25.7%	29.2%	25.2%	25.3%
Adults Eating LESS than Five Daily Servings of Fruits and Vegetables	84.9%	70.8%	77.5%	76.6%

Data Source: Behavioral Risk Surveillance System and Healthy Chicago Survey

Self-reported health behaviors, Youth

[12] CDPH. Healthy Chicago 2.0. (2016).

	Suburban Cook County (2012)	Chicago (2014)	Illinois (2013)	United States (2013)
Current Smokers	14.4%	18.4%	18.0%	19.0%
No Leisure-Time Physical Activity	25.7%	29.2%	25.2%	25.3%

Data Source: Youth Risk Behavior Surveillance System

A nation-wide study in 2013 found that smoking was more prevalent in gay and lesbian (25.7%) and bisexual (28.6%) adults compared to adults who identified as straight (17.6%).[13] In the same study, researchers found that gay, lesbian, and bisexual adults were more likely to have had more than five alcoholic drinks in one day in the past year.[12] Researchers also found that lesbian, gay, and bisexual adults were more likely to meet the federal guidelines for aerobic physical activity. [12]

Self-reported health behaviors by sexual orientation			
	Lesbian or gay	Straight	Bisexual
Current Smokers	25.8%	17.6%	28.6%
Five or more alcoholic drinks in one day at least once in the past year	33.0%	22.3%	39.5%
Met federal guidelines for physical activity	57.9%	52.3%	55.5%

Data Source: CDC National Health Interview Survey, 2013

Healthcare and Clinical Care

Uninsured Population

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.

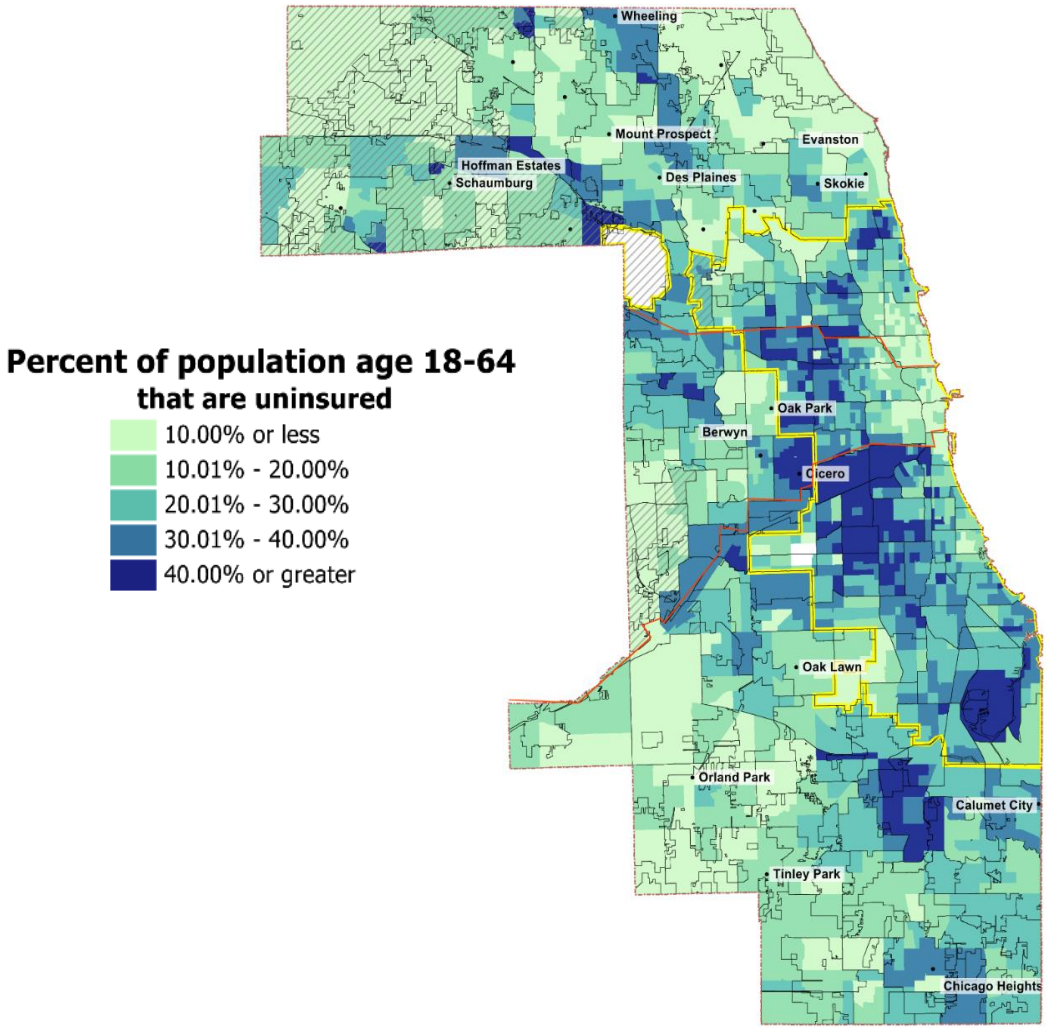
Recent 2015 estimates indicate that between 21-41% of residents in the South region of Chicago who are eligible for healthcare marketplace plans are uninsured and 33-44% of eligible Suburban Cook County residents are uninsured[14]. In addition, men in Cook County are more likely to be uninsured (18.2%) compared to women (13.79%). Ethnic and racial minorities are much more likely to be uninsured compared to non-Hispanic whites. The map below shows self-reported insurance status from the American Communities Survey, representing aggregated rates for 2009-2013. The uninsured rates for the South region (23.0%) were slightly higher than the rates for Illinois (18.5%) and the U.S. (20.4%). The communities in the South region with the highest percentages of uninsured individuals include Brighton Park, Dixmoor, Gage Park, Harvey, Lower West Side, Phoenix, South Deering, and South Lawndale.

[13] Centers for Disease Control and Prevention. (2014). Sexual orientation and health among U.S. adults: National Health Interview Survey, 2013.

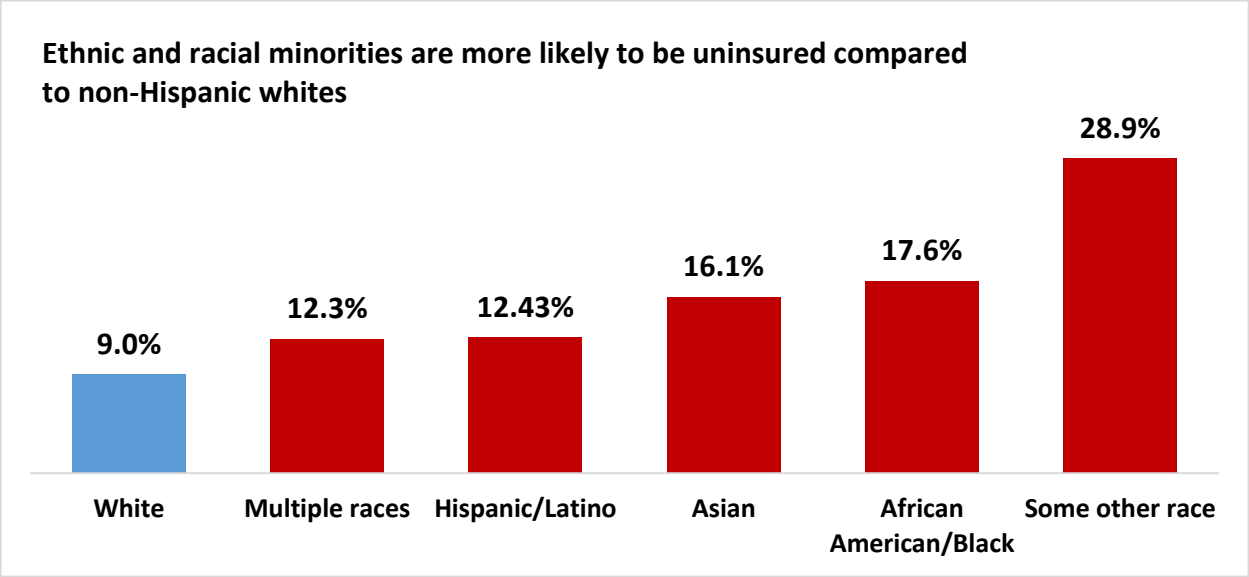
[14] Illinois Marketplace Signups 2015. (2015). Health and Disabilities Advocates. http://data.illinoishealthmatters.org/enrollment/il-marketplace-enr-2015-data.html

Map of uninsured population, age 18-64, 2009-2013

The uninsured rate for individuals age 18-64 in the South region from 2009-2013 was approximately 23.0%.



Insurance coverage by race and ethnicity, 2010-2014



Self-reported Use of Preventative Care

Routine cancer screening 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.[15] One of the objectives for Healthy People 2020 is to reduce the overall cancer death rate to a target of 161.4 cancer deaths (per 100,000 population). In 2012, the estimated cancer mortality rate was higher for the South region (205.8 per 100,000) compared to Illinois (179.1 per 100,000) and the U.S. (171.5 per 100,000) with all rates being well above the Healthy People 2020 target. In addition, cancer mortality was highest in the South region (205.8 per 100,000) compared to the Central (182.3 per 100,000) and North (165.3 per 100,000) regions. 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.

The CDC recommends that all adults aged 65 or older receive the pneumococcal vaccine. The vaccines have been shown to be 50-85% effective at preventing invasive pneumococcal disease in healthy adults.[16] Approximately one-third of Chicago residents aged 65 or older reported that they had not received a pneumococcal vaccination in 2014.

Self-reported use of preventative care				
	Suburban Cook County (2012)	**Chicago (2014)**	**Illinois (2013)**	**United States (2013)**
Cervical Cancer Screening	16.2%	22.7%	22.0%	19.5%

[15] National Institutes of Health – National Cancer Institute. (2016). Cancer Screening Overview. http://www.cancer.gov/about-cancer/screening/hp-screening-overview-pdq
[16] Centers for Disease Control and Prevention. (2015). Vaccines and Immunizations. http://www.cdc.gov/vaccines/vpd-vac/pneumo/vacc-in-short.htm

Colorectal Cancer Screening	46.3%	23.8%	N/A	52.9%
Breast Cancer Screening	41.9%	26.5%	26.0%	29.0%
Lack of Pneumococcal Vaccination (65+)	N/A	29.5%	30.5%	52.5%

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

Hospitalization Data

Diabetes-related

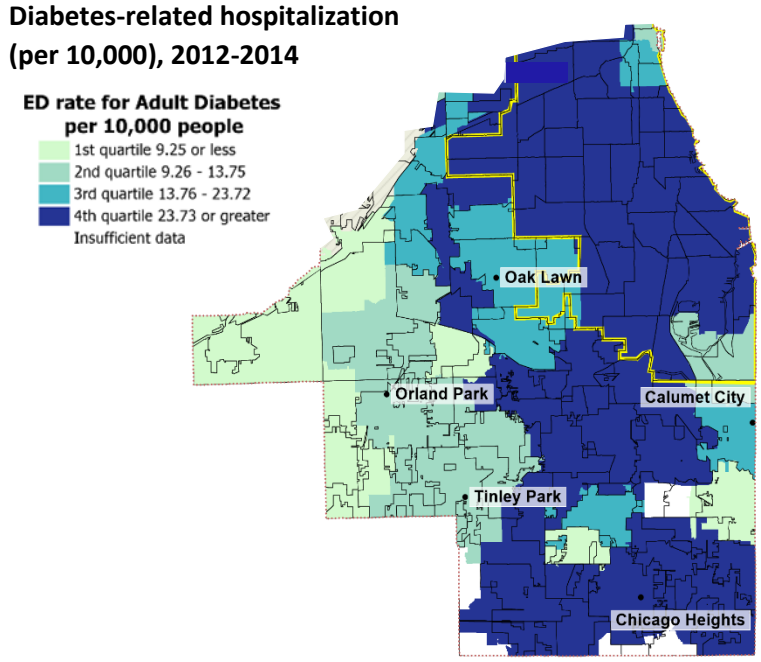
The Chicago community areas in the South region with diabetes-related hospitalization rates of 23.73 per 10,000 or greater include The Suburban Cook County municipalities in the South region with diabetes-related hospitalization rates of 23.73 per 10,000 or greater include

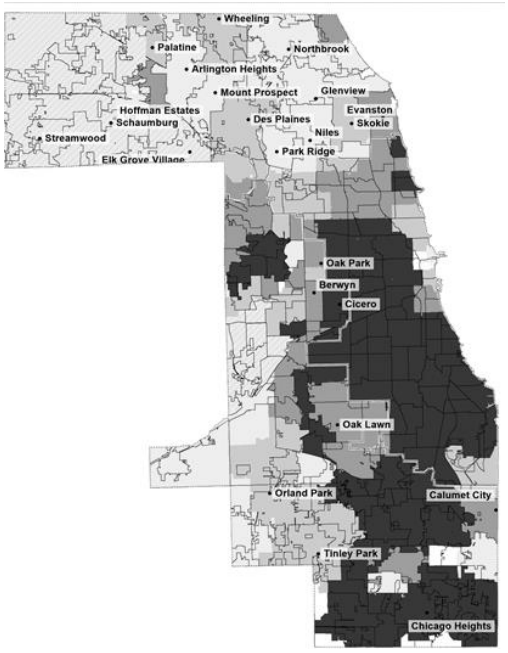
Hospitalizations and emergency room visits are indicative of poorly controlled diabetes. Poorly controlled diabetes can lead to severe or life-threatening complications such as heart and blood vessel disease; nerve damage; kidney damage; eye damage and blindness; foot damage and lower extremity amputation; hearing impairment; skin conditions; and Alzheimer's disease.[17] The mortality rate from diabetes-related conditions is almost the same for the South region (62.0 per 100,000) as it is for Illinois (63.2 per 100,000) and slightly lower than the rate for the U.S. (70.8 per 100,000). Non-Hispanic African American/Blacks in the South region have higher mortality rates (75.6 per 100,000) compared to non-Hispanic whites (51.8 per 100,000), Hispanic/Latinos (48.6 per 100,000), and Asian/Pacific Islanders (38.4 per 100,000).

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

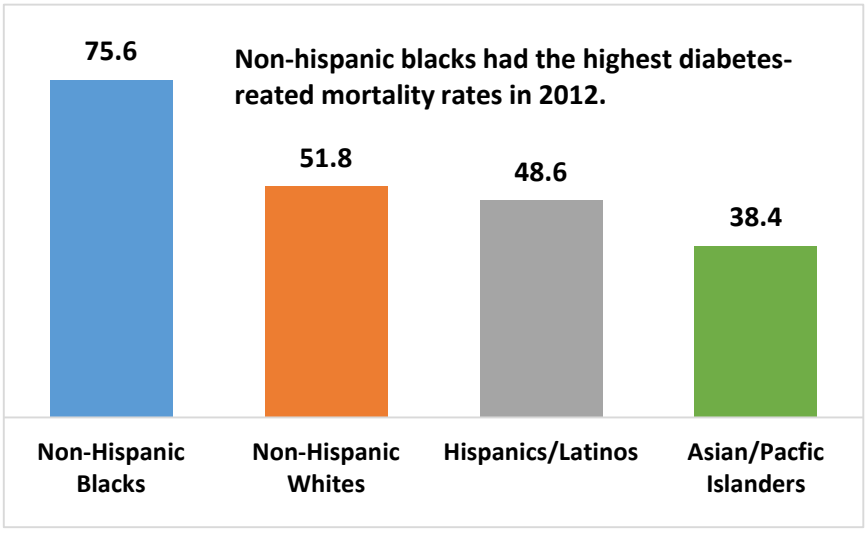
Map of diabetes-related hospitalization rates (per 10,000), 2012-2014

Several communities in the South region have diabetes-related hospitalization rates of 23.73 (per 10,000) or greater.





Diabetes-related mortality rates (per 100,000) in the South region by race and ethnicity, 2012

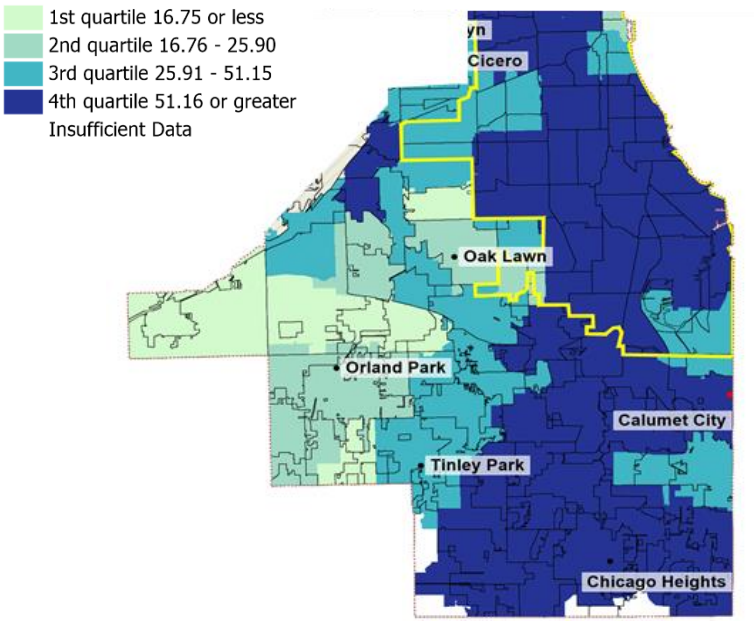


Adult and Pediatric Asthma

Map of ED visits due to adult asthma (per 10,000), 2012-2014

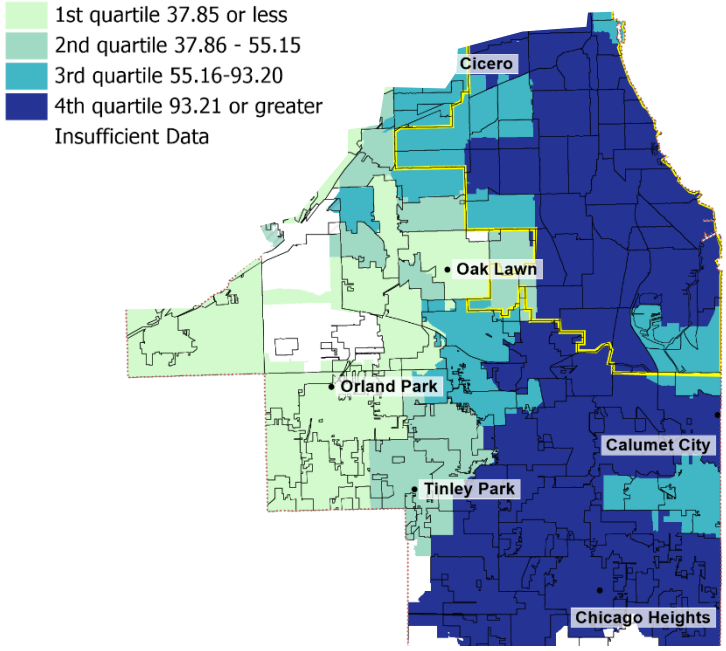
Multiple communities in the South region have rates of ED visits due to adult asthma of 51.16 (per 10,000) or greater.

ED Visits Due to Adult Asthma (per 10,000), 2012-2014



Map of ED visits due to pediatric asthma (per 10,000), 2012-2014

ED Visits Due to Pediatric Asthma (per 10,000), 2012-2014



Provider Availability

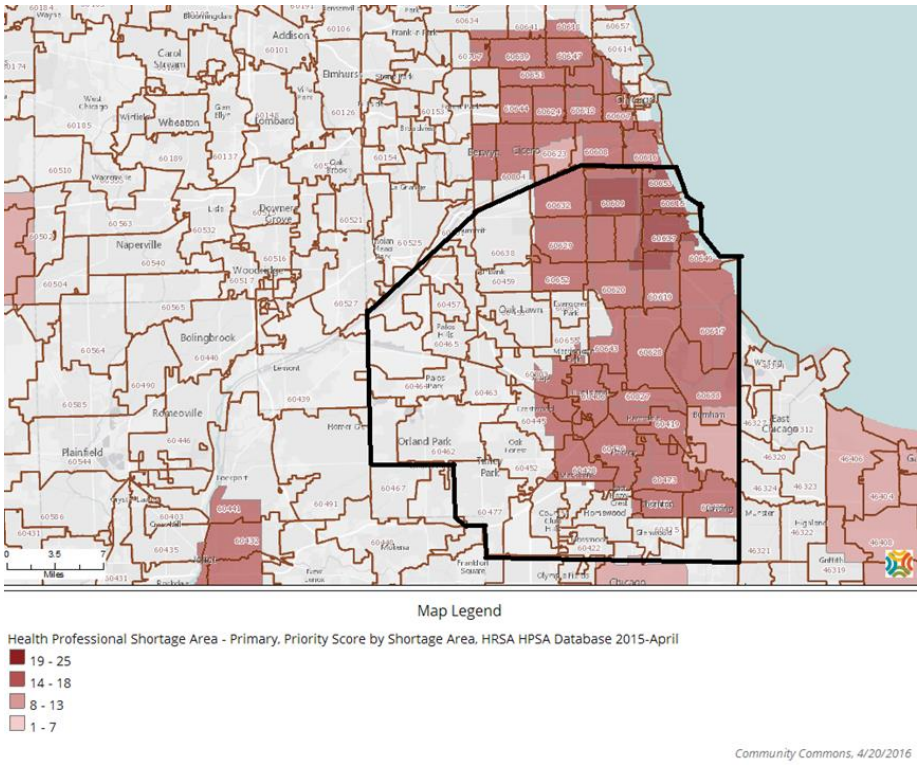
A large percentage of adults reported that they do not have at least one person that they consider to be their personal doctor or health care provider. In the U.S., LGBQIA adults are less likely to report having a regular place to go for medical care. Regular visits with a primary care provider can improve chronic disease management and reduce illness and death.[18] As a result it is an important form of prevention.

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	13.0%	20.1%	22.9%	19.2%

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

Health Professional Shortage Areas are designated by the Health Resources and Services Administration as areas having shortages of primary care, dental care, or mental health providers and may be geographic (a county or service area), population (e.g., low income or Medicaid eligible), or types of facilities (e.g., federally qualified health centers, or state or federal prisons). [19] There are several communities in the South region that have multiple primary care and mental health professional shortage areas.

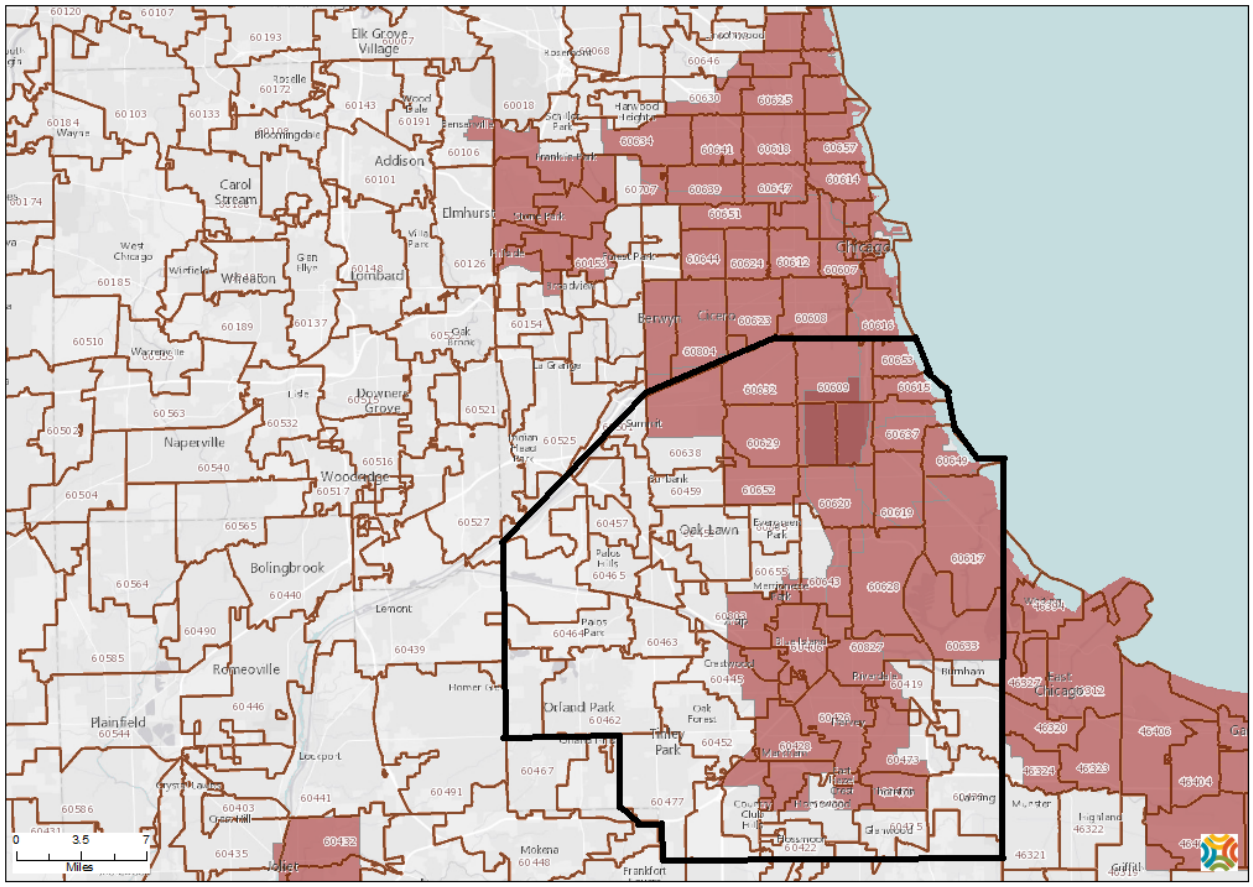
Map of primary care provider shortage areas in the South region



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

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

Map of mental health professional shortage areas in the South region



Map Legend

Health Professional Shortage Area - Mental, Priority Score by Shortage Area, HRSA HPSA Database 2015-April

- 19 - 22
- 14 - 18
- 8 - 13
- 1 - 7

Community Commons, 4/20/2016

Prenatal Care

Prenatal care can 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.[20] 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.

Number of births to mothers with prenatal care starting after the third month of pregnancy or no prenatal care received (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	19.3	19.0

Data Source: IDPH Natality, 2008-2012

Mental Health and Substance Use

Self-reported Mental Health Status

The CDC has identified indicators of mental health representing three domains: emotional well-being (such as perceived life satisfaction, happiness, cheerfulness, and peacefulness), psychological well-being (such as self-acceptance, personal growth including openness to new experiences, spirituality, self-direction, and positive relationships), and social well-being (such as social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, and sense of community).[21]

Approximately a third of residents in Suburban Cook County reported that they lack social or emotional support and the average number of days that adults aged 18 or older reported that their mental health was not good is 3.2. Approximately 20% of residents from Chicago reported that they lack social or emotional support and the average number of days that mental health was rated as not good is 3.3. In the U.S., lesbian, gay, and bisexual individuals are more likely to report having experienced serious psychological distress in the past 30 days (lesbian or gay: 5%, bisexual: 11%) compared to straight individuals (3.9%).

Self-reported average number of poor mental health days and social-emotional Support				
	Suburban Cook County (2012)	**Chicago (2014)**	**Illinois (2013)**	**United States (2013)**
Average number of days that adults report their mental health as not good	3.2	3.3	3.4	3.1
Percentage of adults that lack	33.5%	20.4%	22.5%	43.8%

[20] National Institute of Child Health and Human Development. (2013). https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/pages/prenatal-care.aspx
[21] Centers for Disease Control and Prevention. (2013). Mental Health Basics. http://www.cdc.gov/mentalhealth/basics.htm

social or emotional support				

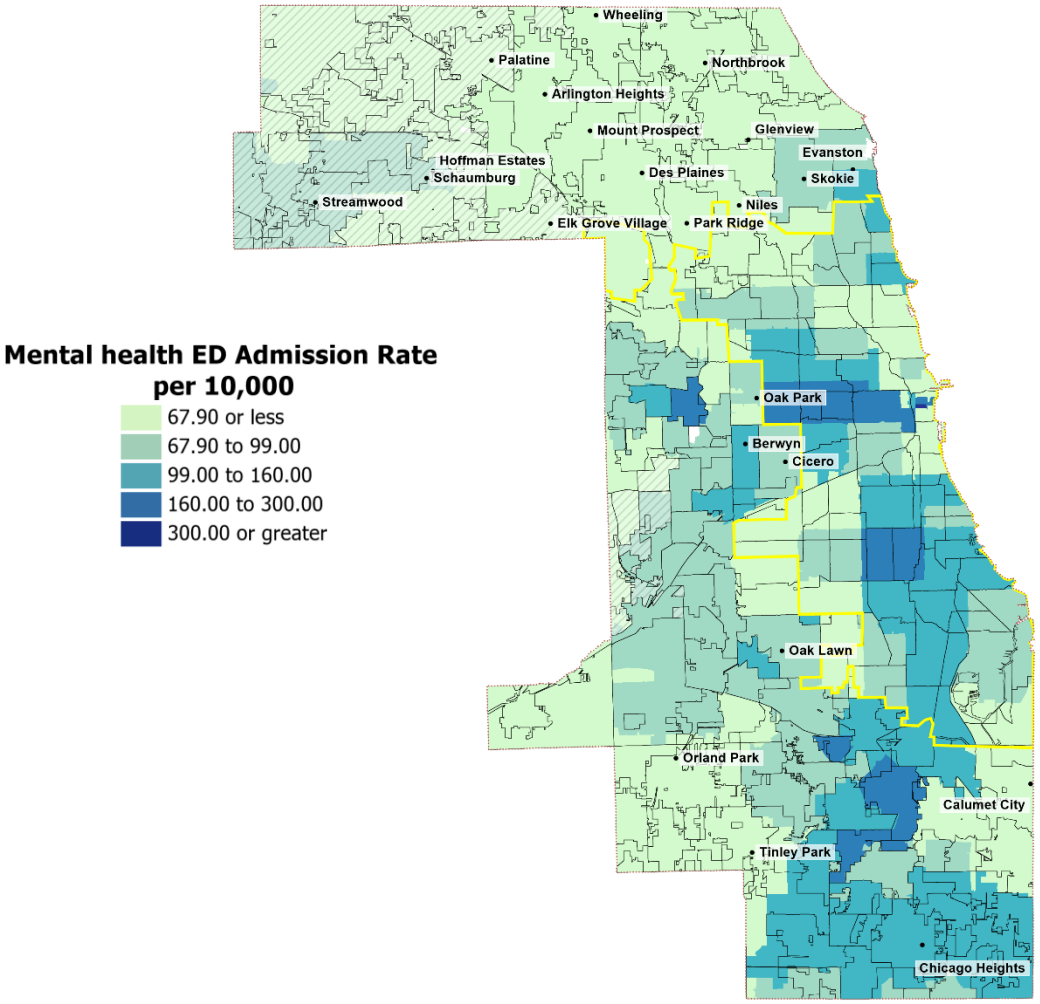
Data Source: Behavioral Risk Factor Surveillance System (2013) and Healthy Chicago Survey (2014)

The percentage of the Medicare fee-for-service population with diagnosed depression is approximately the same for the South region (14.0%), Cook County (14.1%), Illinois (14.7%), and the U.S. (15.4%).

The WHO emphasizes the need for a network of community based mental health services. [22] The WHO has also indicated that the closing of mental hospitals and facilities is often not accompanied by the development of community based services, leading to a service vacuum.[21] In addition, research indicates that better integration of behavioral health services including substance abuse treatment into the healthcare continuum can have a positive impact on health outcomes.[23] High ED admission rates for mental health and substance abuse may indicate a lack of community-based treatment options, services, and facilities.

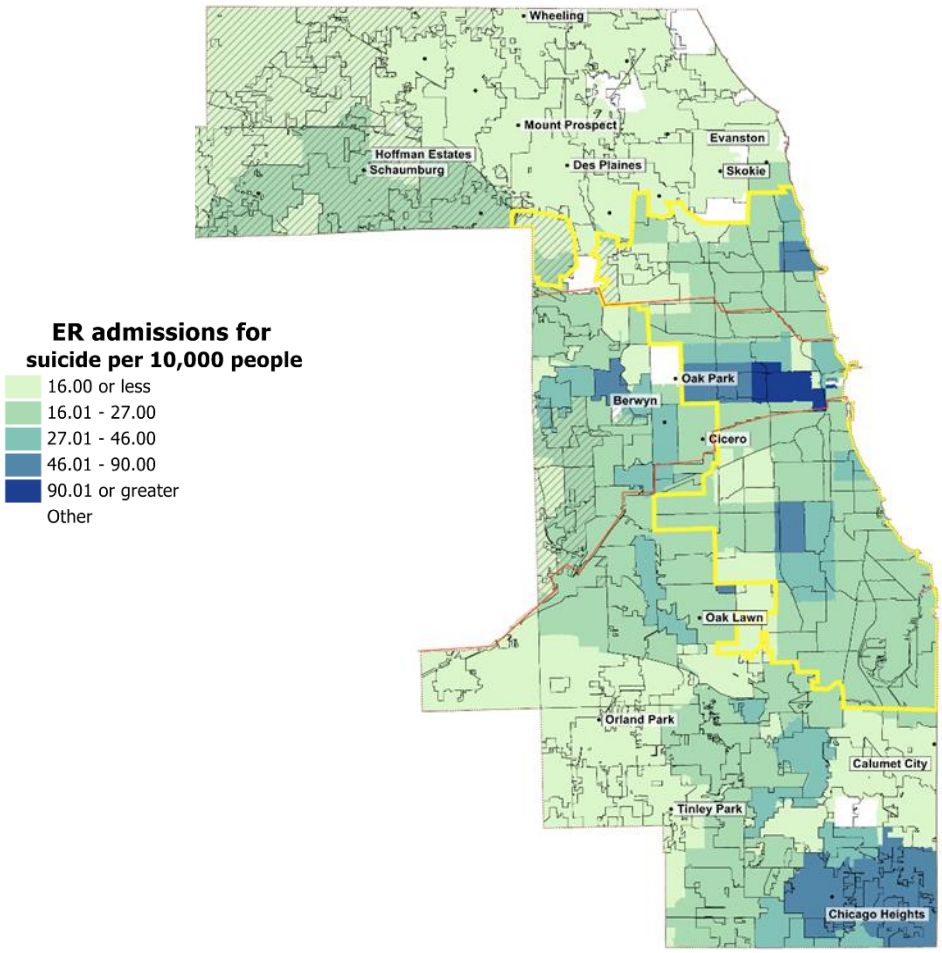
[22] World Health Organization. (2007). http://www.who.int/mediacentre/news/notes/2007/np25/en/
[23] American Hospital Association. (2012). Bringing behavioral health into the can continuum: opportunities to improve quality, costs, and outcomes. http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf

Map of ED admission rates (per 10,000) for Mental Health, 2012-2014

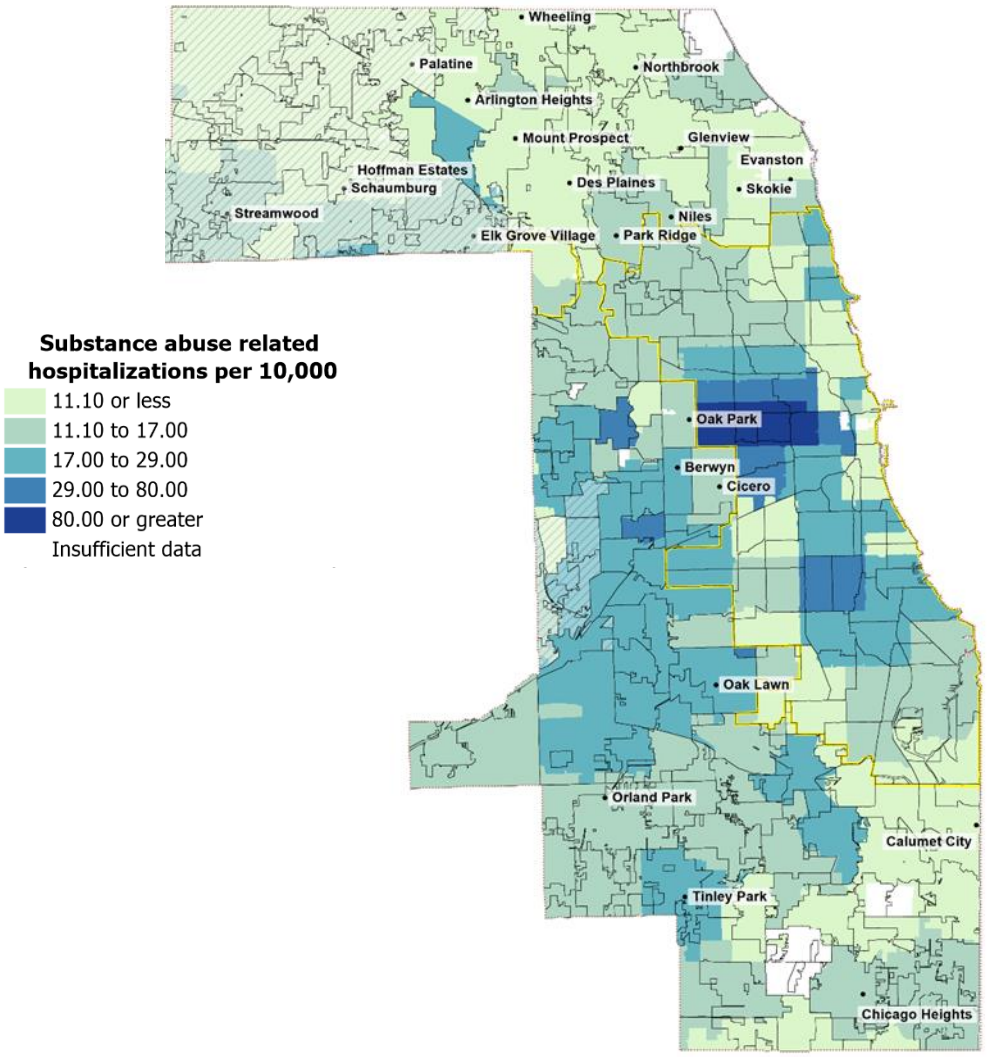


The communities in the South region with the highest ED admission rates for intentional injury and suicide include Bloom Township, Chicago Heights, Ford Heights, Hometown, Lynwood, South Chicago Heights, Sauk Village, and West Englewood.

Map of ED admission rates (per 10,000) for intentional injury and suicide, 2012-2014



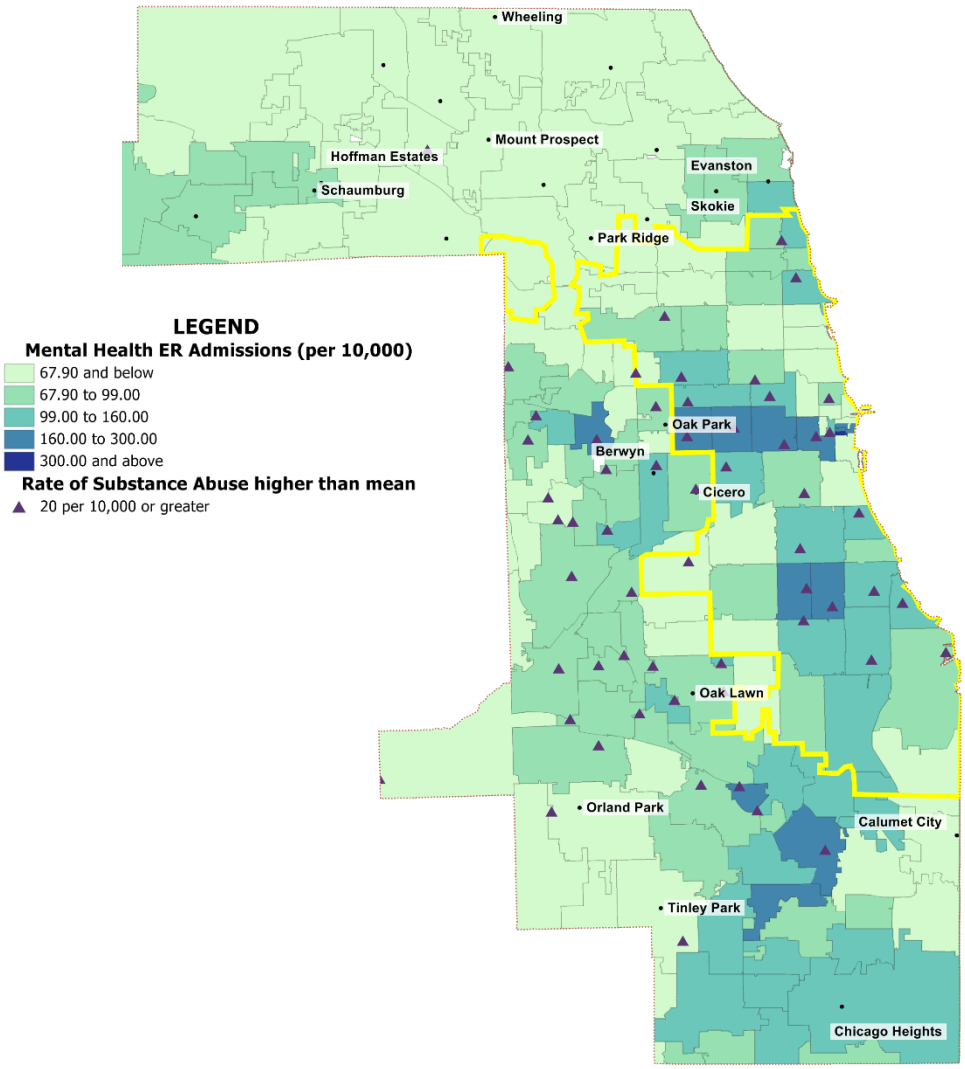
Map of ED admission rates (per 10,000) for substance use, 2012-2014



There is a high prevalence of comorbidity between mental illness and drug use.[24] The communities in which high ED admission rates for mental illness overlap with high ED admission rates for substance use. The communities in the South region that have high ED admission rates for both mental health and substance abuse include Dixmoor, East Hazel Crest, Englewood, Harvey, Hazel Crest, Phoenix, Robbins, and West Englewood.

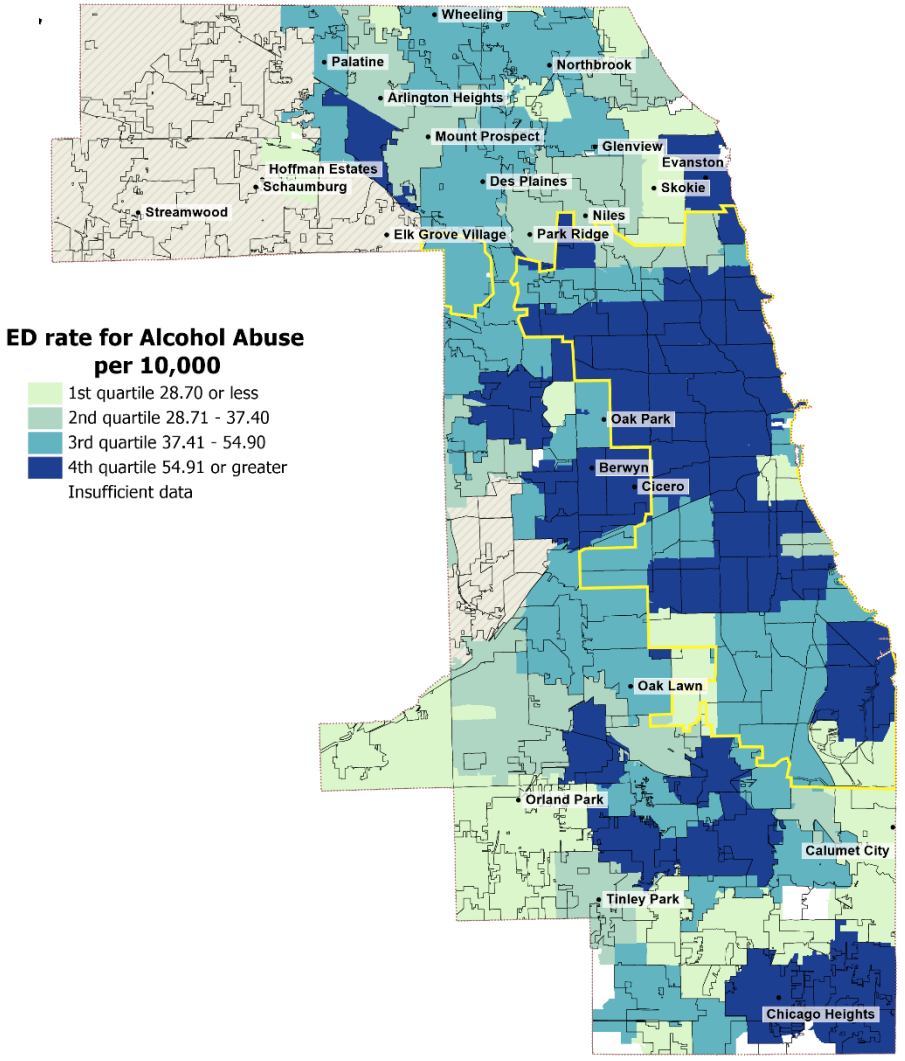
[24] National Institutes of Health – National Institute on Drug Use. (2010). https://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses

Map of ED admission rates (per 10,000) for mental illness and substance use, 2012-2014



Several communities in the South region of Chicago and Suburban Cook County have ED admission rates of 54.91 per 10,000 or greater for alcohol abuse including McKinley Park, Bridgeport, New City, Grand Boulevard, Oakland, Kenwood, Woodlawn, West Lawn, Chicago Lawn, West Englewood, Englewood, Greater Grand Crossing, Worth, Palos Heights, Worth Township, Markham, Harvey, Oak Forest, Chicago Heights, Ford Heights, Sauk Village, Bloom Township, and Lynwood.

Map of ED admission rates for alcohol abuse, 2012-2014



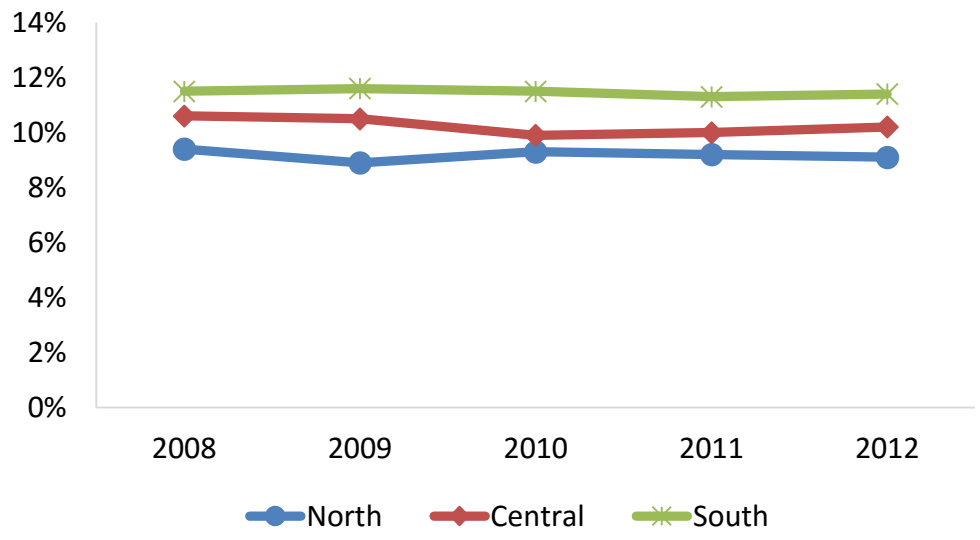
Health Outcomes

Birth Outcomes

Preterm birth and low birth weight infants are at greater risk for premature mortality and/or morbidity over the lifetime.[25] Rates of preterm births, low birthweight infants, and infant mortality have shown little variation from 2008-2012. There are large disparities for racial and ethnic minorities in birth outcomes. In Chicago and Suburban Cook County, African American infants are more than four times as likely as white infants to die before their first birthday.[26] African American infants are also more likely to be born preterm compared to white and Hispanic infants.[9] Approximately 3% of infants are born with diagnosed birth defects and 1.5% are born with very low birth weight in Chicago and Suburban Cook County.[9]

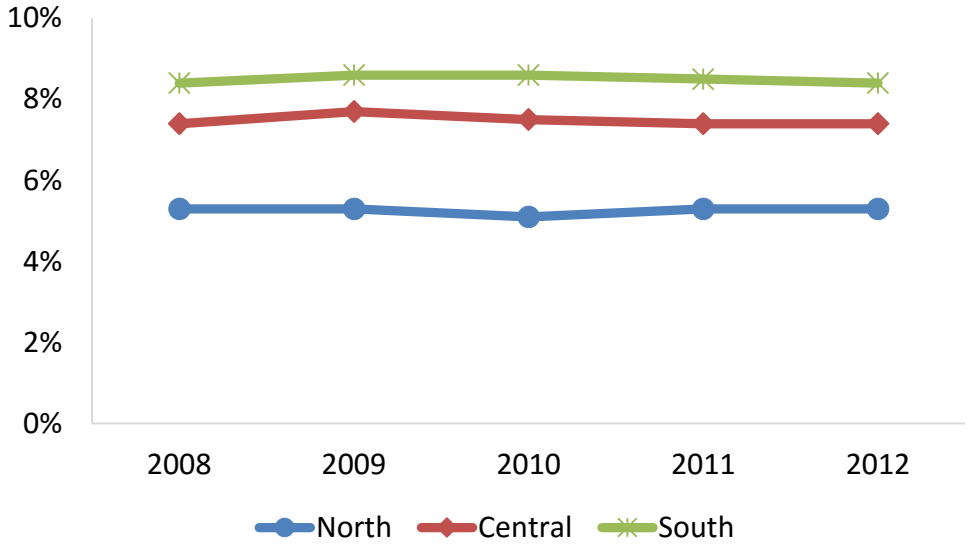
Adolescents are more likely to have a low birth weight infant or preterm birth and the risks are particularly high for second births to adolescent mothers.[27] Hispanic and African American teens are over four times more likely to give birth than white teens and the rates in communities with low child opportunity are up to 20 times that rates of communities with plentiful opportunities for children.[14] In the City of Chicago, the teen birth rate is 1.5 times higher than the national rate.[14] However, teen births have decreased overall for all ethnic groups from 2008-2013.

Regional rates of preterm births (per 100 live births), 2008-2012

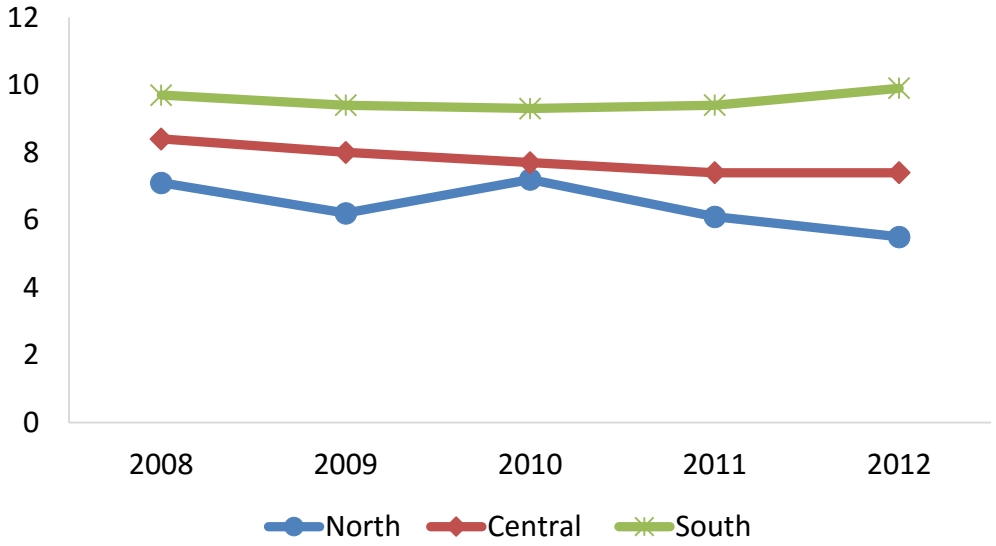


Regional rates of low birth weight infants (per 100 live births), 2008-2012

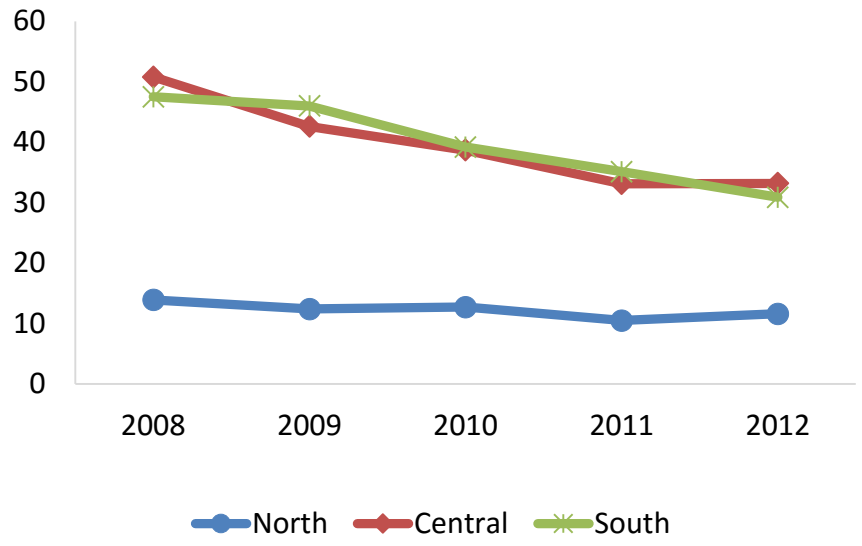
[25] County Health Rankings and Roadmaps (2016).
[26] Healthy Chicago 2.0. (2016).
[27] Guttmacher Institute. (2009) Perspectives on Sexual and Reproductive Health. https://www.guttmacher.org/about/journals/psrh/2009/06/second-births-teenage-mothers-risk-factors-low-birth-weight-and-preterm



Regional rates of infant mortality (per 100 live births), 2008-2012



Regional rates of teen births (per 100 live births), 2008-2012



Disparities in birth outcomes by race and ethnicity, city of Chicago, 2012				
Race-ethnicity of mother	**Infant Mortality Rates (per 1,000 live births)**	**Teen Birth Rate (per 1,000 females aged 15-19)**	**Percentage of Low Birth Weight Infants**	**Percentage of Preterm Births**
Hispanic	5.9	43.7	7.5%	9.0%
Non-Hispanic Asian/Pacific Islander	4.2	6.3	9.0%	8.3%
Non-Hispanic Black	11.6	57.5	14.2%	13.7%
Non-Hispanic White	4.3	10.3	7.2%	9.1%

Data Source: CDPH, 2012

Morbidity – Asthma, Overweight, Obesity, Diabetes

Overweight and obese are the comorbidities most often reported by adults in Chicago and Suburban Cook County. In addition, Suburban Cook County has a slightly higher rate of self-reported overweight diagnosis (38.6%) compared to Chicago (35.3%), Illinois (35.4%) and the U.S. (31.1%). The rates of self-reported obesity diagnosis are approximately the same for Chicago, Suburban Cook County, Illinois, and the U.S. Nationwide lesbian or gay individuals were just as likely to report an obese diagnosis (28.9%) compared to straight individuals (29.7%). However, bisexual individuals were slightly more likely to report an obese diagnosis (34.8%). Comorbidities may indicate an increased risk for mortality due to a variety of conditions. Chronic diseases accounted for approximately 64% of deaths in Chicago in 2014.[28]

Self-reported diagnoses, Adults

[28] Healthy Chicago 2.0. (2016).

	Suburban Cook County (2012)	Chicago (2014)*	Illinois (2013)	United States (2013)
Asthma	7.8%	7.6%	9.0%	9.1%
Overweight	38.6%	35.3%	35.4%	31.1%
Obesity	28.1%	29.4%	29.4%	28.8%
Diabetes	9.9%	6.6%	9.7%	9.0%

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

The percentage of youth reporting an overweight or obesity diagnosis is approximately the same across Chicago, Suburban Cook County, Illinois, and the U.S.

Self-reported diagnoses, Youth				
	Suburban Cook County (2012)	**Chicago (2014)***	**Illinois (2013)**	**United States (2013)**
Overweight	15.0%	15.6%	15.8%	16.6%
Obesity	11.0%	14.5%	11.4%	13.7%

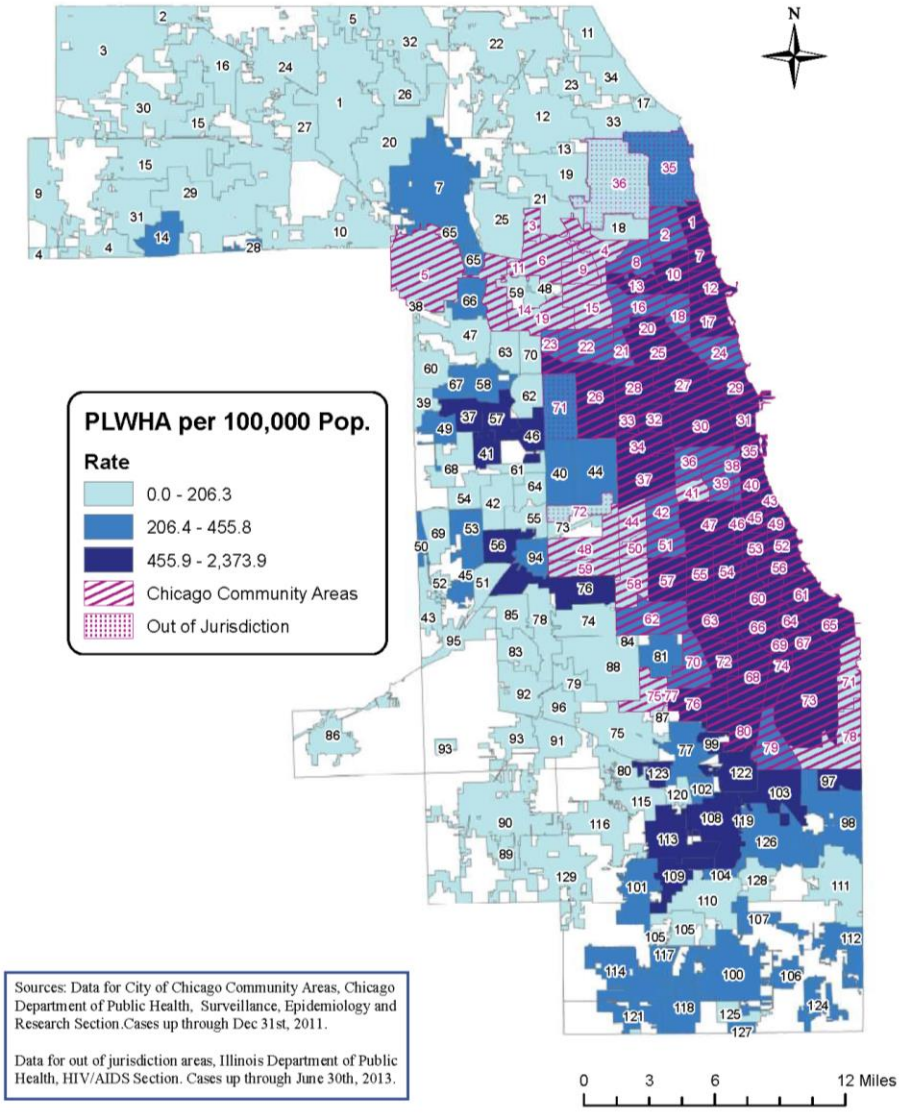
Data Source: Youth Risk Behavior Surveillance System

Morbidity - HIV and Sexually Transmitted Infections

Incidence of new HIV cases is declining. In Chicago from 2010 to 2014, the number of HIV infection diagnoses fell from 1,033 to 973, and the decline was seen across all racial and ethnic groups. There has also been a decline in Chicago in HIV diagnoses for injection drug users (28% decrease from 2009-2013) and heterosexuals (7.2% decrease from 2009-2013). However, HIV diagnoses continue to increase in Chicago for men who have sex with men (MSM) populations (4.7% increase from 2009-2013), MSM who are injection drug users (1.5% increase from 2009-2013), and other transmission groups (32.3% increase from 2009-2013). Nationwide heterosexuals are the least likely to have ever been tested for HIV (41.7%) compared to gay or lesbians (68.7%) and bisexuals (53.5%).

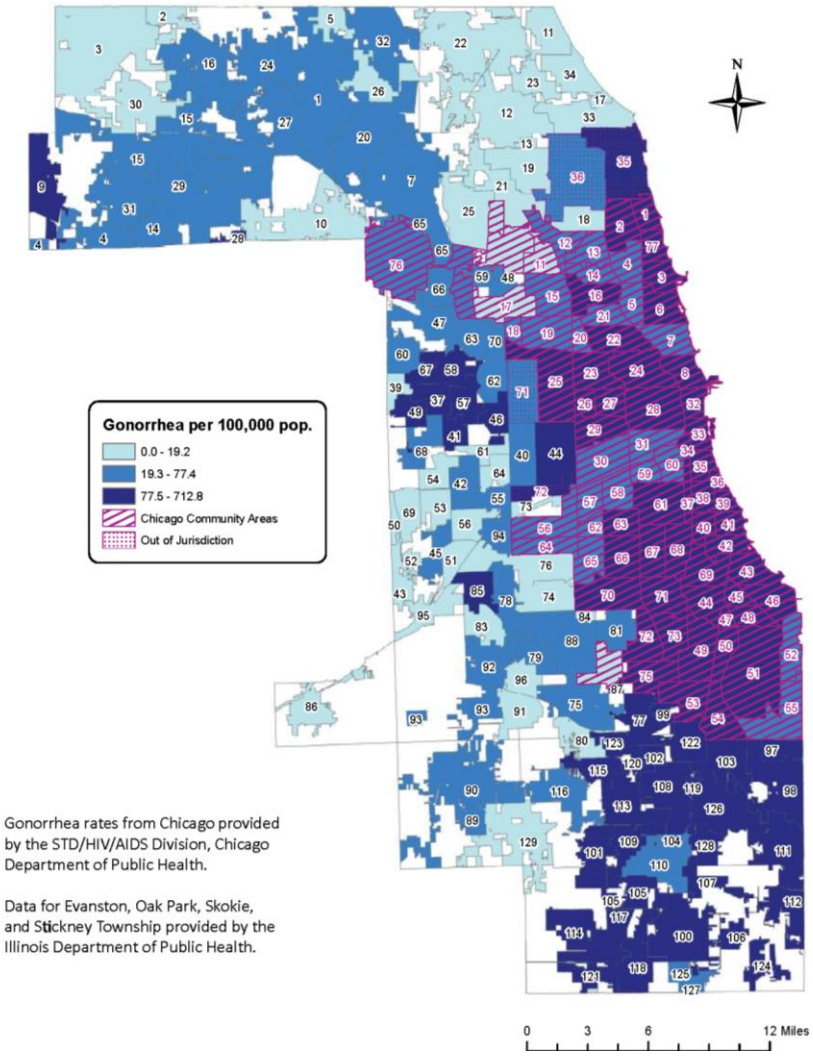
The communities in the South region with the highest rates of people living with HIV infection in 2013 include Auburn Gresham, Avalon Park, Burnham, Burnside, Calumet Heights, Calumet Park, Calumet Township, Chatham, Chicago Lawn, Dolton, Douglas, Englewood, Fuller Park, Grand Boulevard, Greater Grand Crossing, Harvey, Hazel Crest, Hyde Park, Kenwood, Markham, Morgan Park, Near South Side, New City, Oakland, Phoenix, Pullman, Riverdale, Roseland, South Chicago, South Deering, South Lawndale, South Shore, Washington Heights, Washington Park, West Englewood, West Pullman, and Woodlawn.

Prevalence (per 100,000) of persons living with HIV, 2013

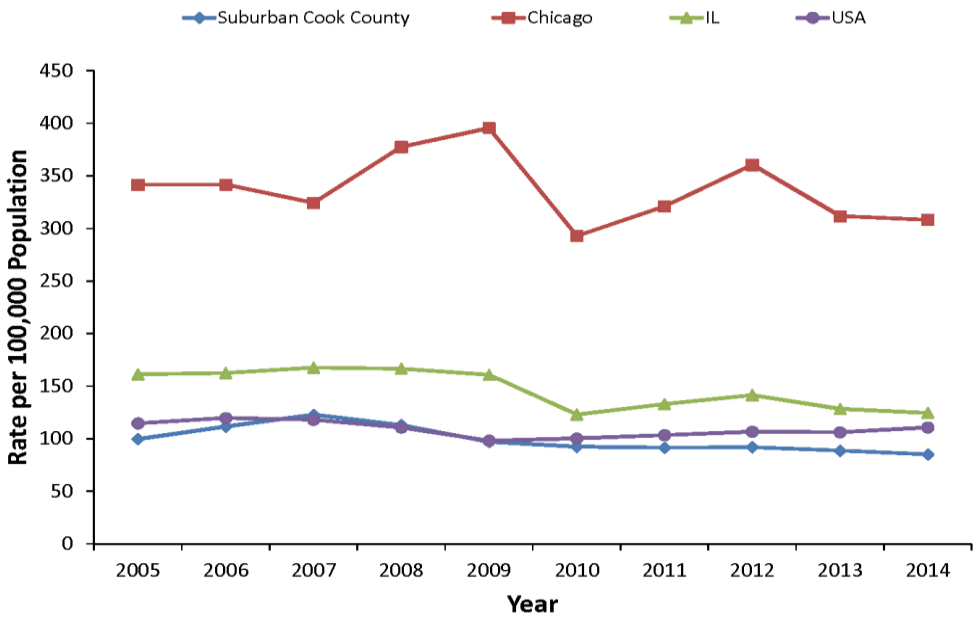


Since 2007, gonorrhea rates in Suburban Cook County have been steadily declining and were slightly lower compared to rates in Illinois and the United States. Gonorrhea rates in Chicago (308.1 per 100,000 population) are much higher than those for Suburban Cook County (85.0 per 100,000 population), Illinois (124.5 per 100,000 population), and the United States (110.7 per 100,000 population).

Incidence of gonorrhea (per 100,000 population), 2005-2014

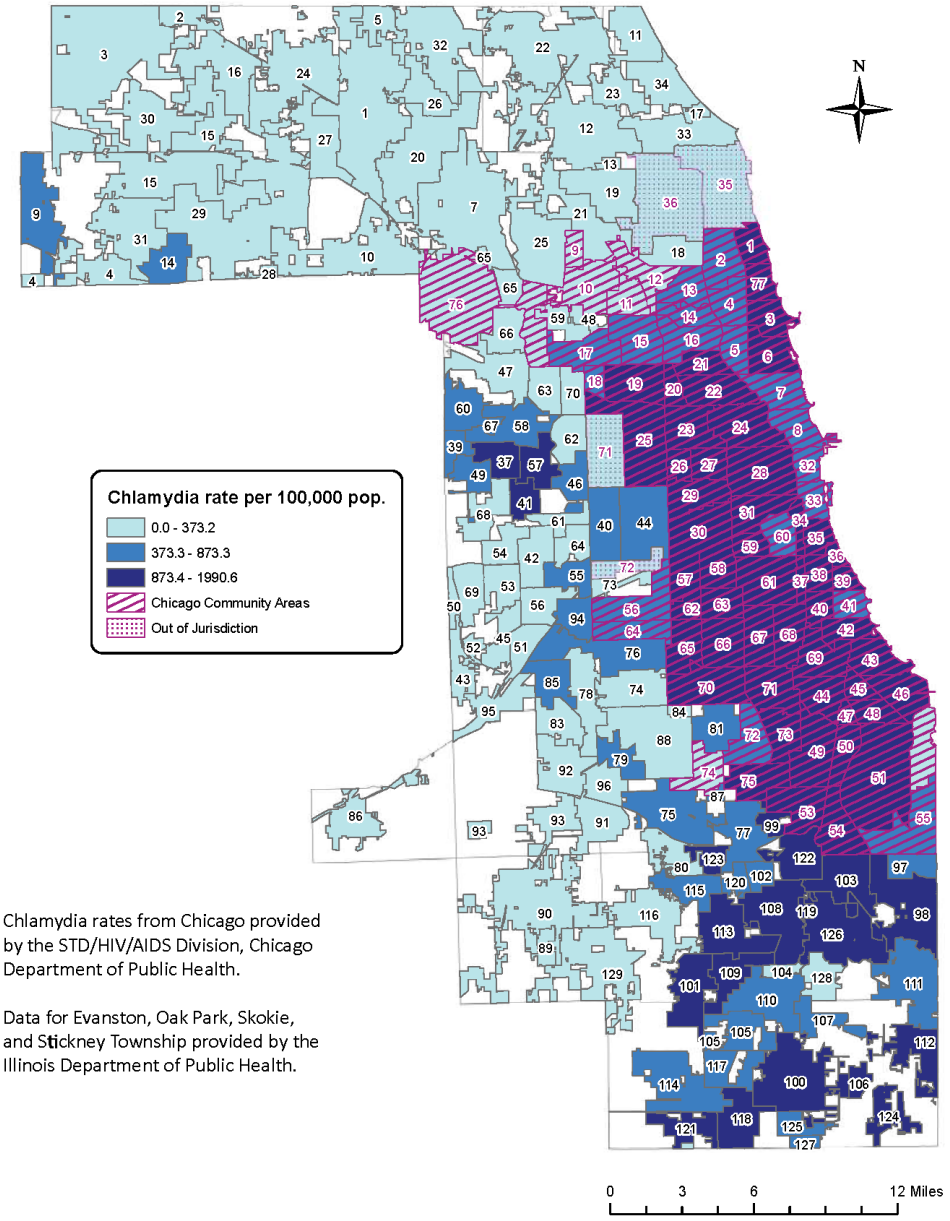


Trends in gonorrhea rates (per 100,000 population), 2005-2014



In Suburban Cook County in 2014, 44% of reported chlamydia cases were in non-Hispanic blacks. The rate of chlamydia infections for non-Hispanic blacks in Suburban Cook County (1,114.9 per 100,000 population) was much higher than the rates for Hispanics (364.1 per 100,000 population), non-Hispanic whites (113.0 per 100,000 population), and Asian/Pacific Islanders (58.1 per 100,000 population). The same trends were true for the City of Chicago with 46.7% of chlamydia cases occurring in non-Hispanic blacks, 27.1% in non-Hispanic whites, 16.7% in Hispanics, and 3.4% in Asian/Pacific Islanders. However, among non-Hispanic blacks there have been overall declines in incidence for all STIs and HIV infections.

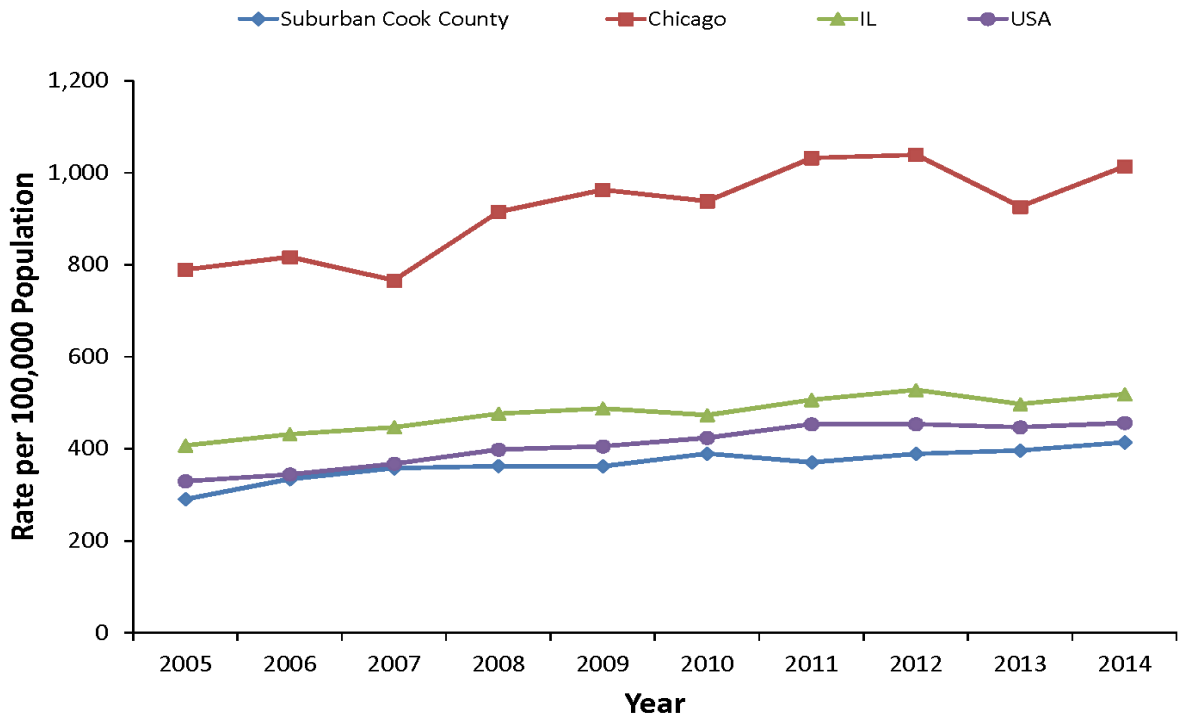
Incidence of chlamydia (per 100,000 population), 2005-2014



Chlamydia rates from Chicago provided by the STD/HIV/AIDS Division, Chicago Department of Public Health.

Data for Evanston, Oak Park, Skokie, and Stickney Township provided by the Illinois Department of Public Health.

Trends in chlamydia rates (per 100,000 population), 2005-2014



Mortality

There are disparities in life expectancy and mortality in Chicago and Suburban Cook County. In Suburban Cook County, life expectancy is approximately 79.7 years. The 2012 citywide life expectancy for residents in Chicago is 77.8 years. However, the life expectancy of Chicagoans in areas of high economic hardship is five years lower than those living in better economic conditions.[29]

The top two leading causes of death in the South region are cancer (205.8 deaths per 100,000 population) and coronary heart disease (120.4 deaths per 100,000 population). Other leading causes of death in the South region include diabetes-related (62.0 deaths per 100,000 population) and stroke (40.1 deaths per 100,000 population).

Leading causes of death in the South region (2012)	Age-adjusted Mortality Rate (per 100,000)
Cancer	205.8
Coronary Heart Disease	120.4
Diabetes-related	62.0
Stroke	40.1

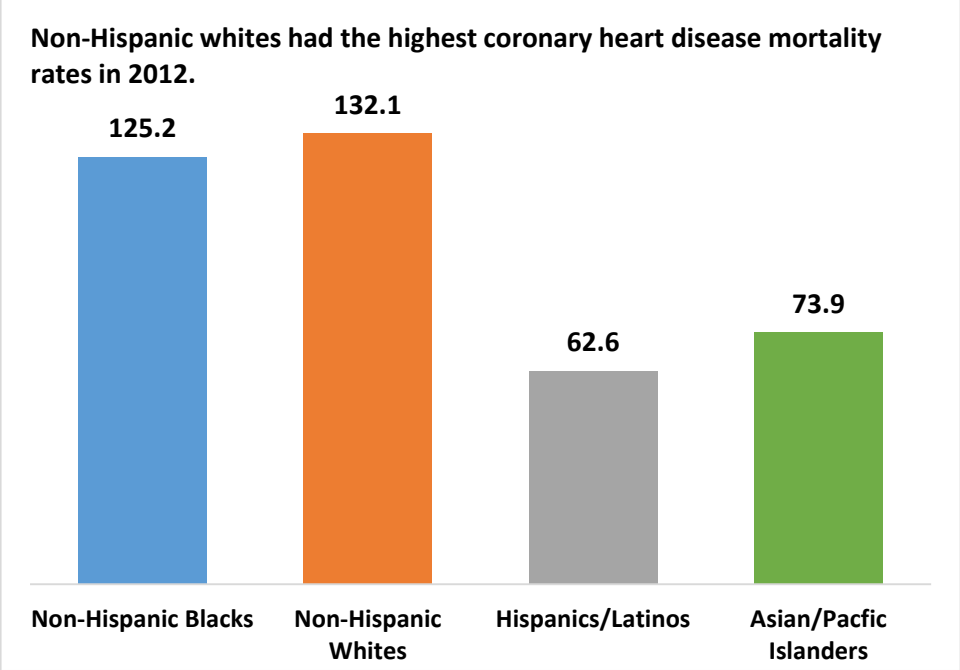
Data Sources: IDPH (2012)

Heart Disease

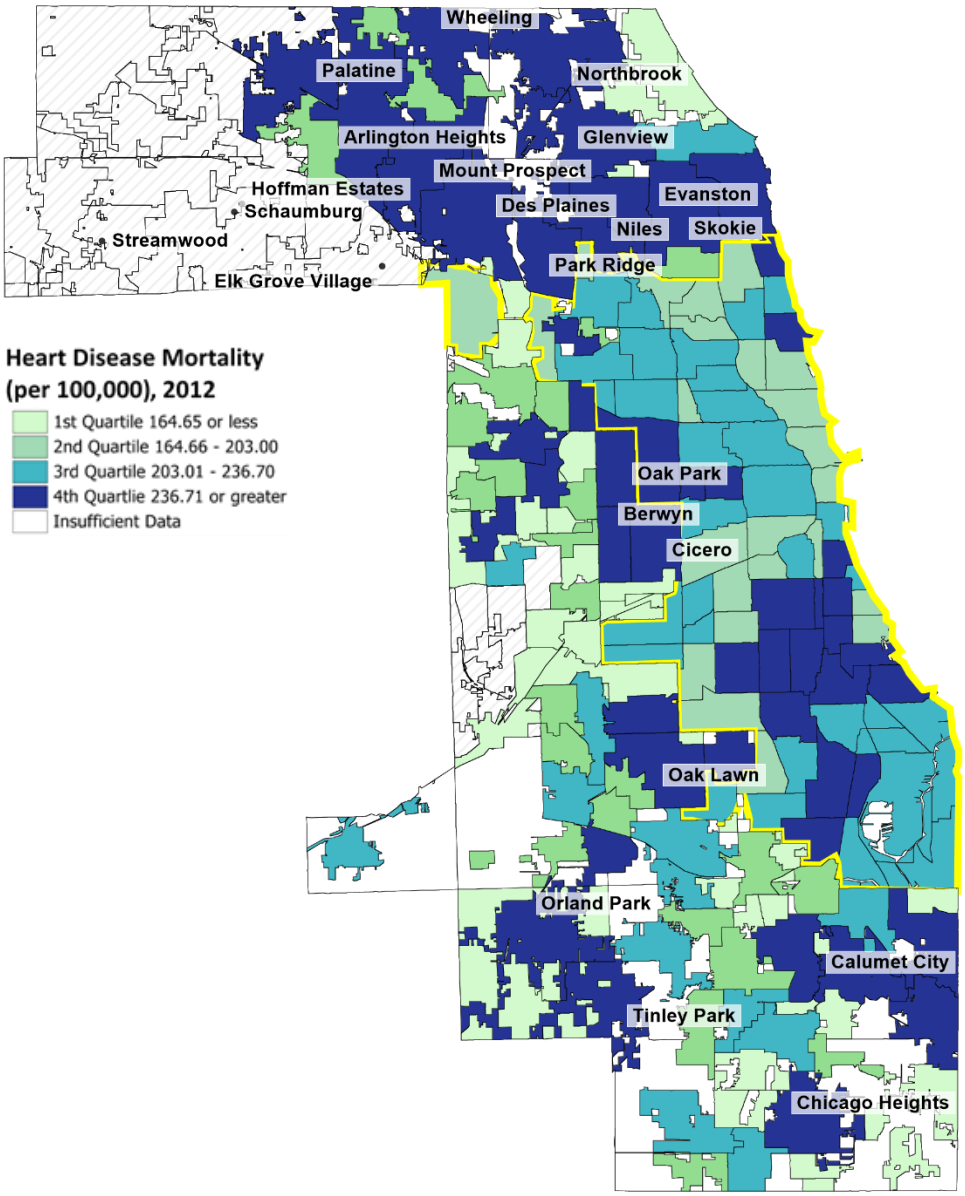
Coronary heart disease is the most common type of heart disease and the second leading cause of death in the South region. Coronary heart disease mortality was slightly higher in the South region in 2012 (120.4 deaths per 100,000 population) than it was for Illinois (112.1 deaths per 100,000 population) and the U.S. (114.2 deaths per 100,000 population). Non-Hispanic whites had the highest coronary heart disease mortality in 2012 (132.1 deaths per 100,000 population) followed by non-Hispanic blacks (125.2), Asian/Pacific Islanders (73.9 deaths per 100,000 population), and Hispanics/Latinos (62.6 deaths per 100,000 population). One of the objectives of Healthy People 2020 is to reduce coronary heart disease deaths with a target rate of 103.4 deaths per 100,000 population.

[29] Healthy Chicago 2.0. (2016).

Coronary heart disease mortality by race and ethnicity, Age-adjusted rate (deaths per 100,000 population), 2012



Map of heart disease mortality (all types).

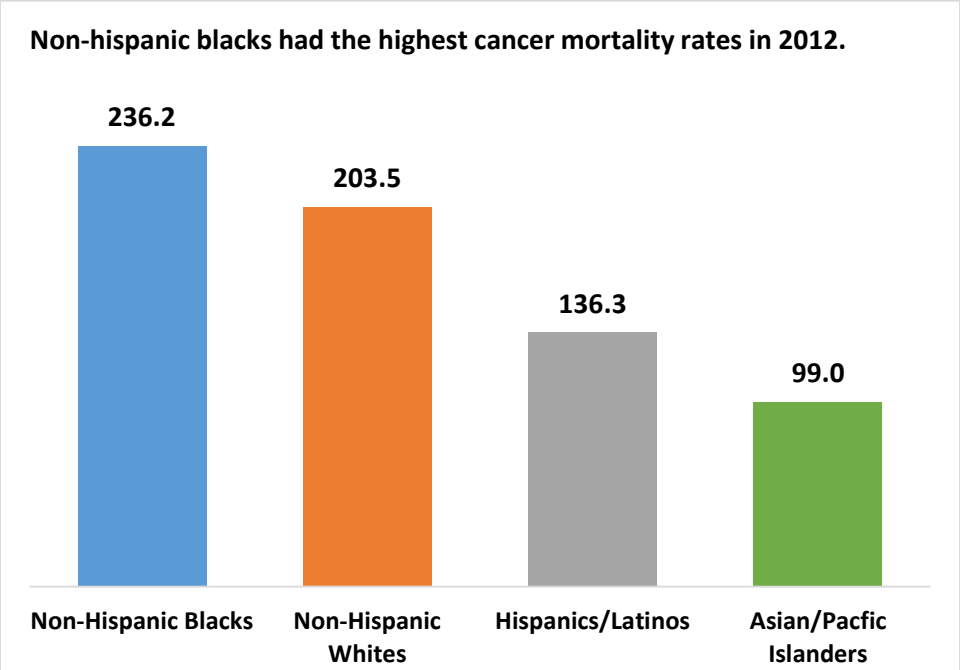


Cancer

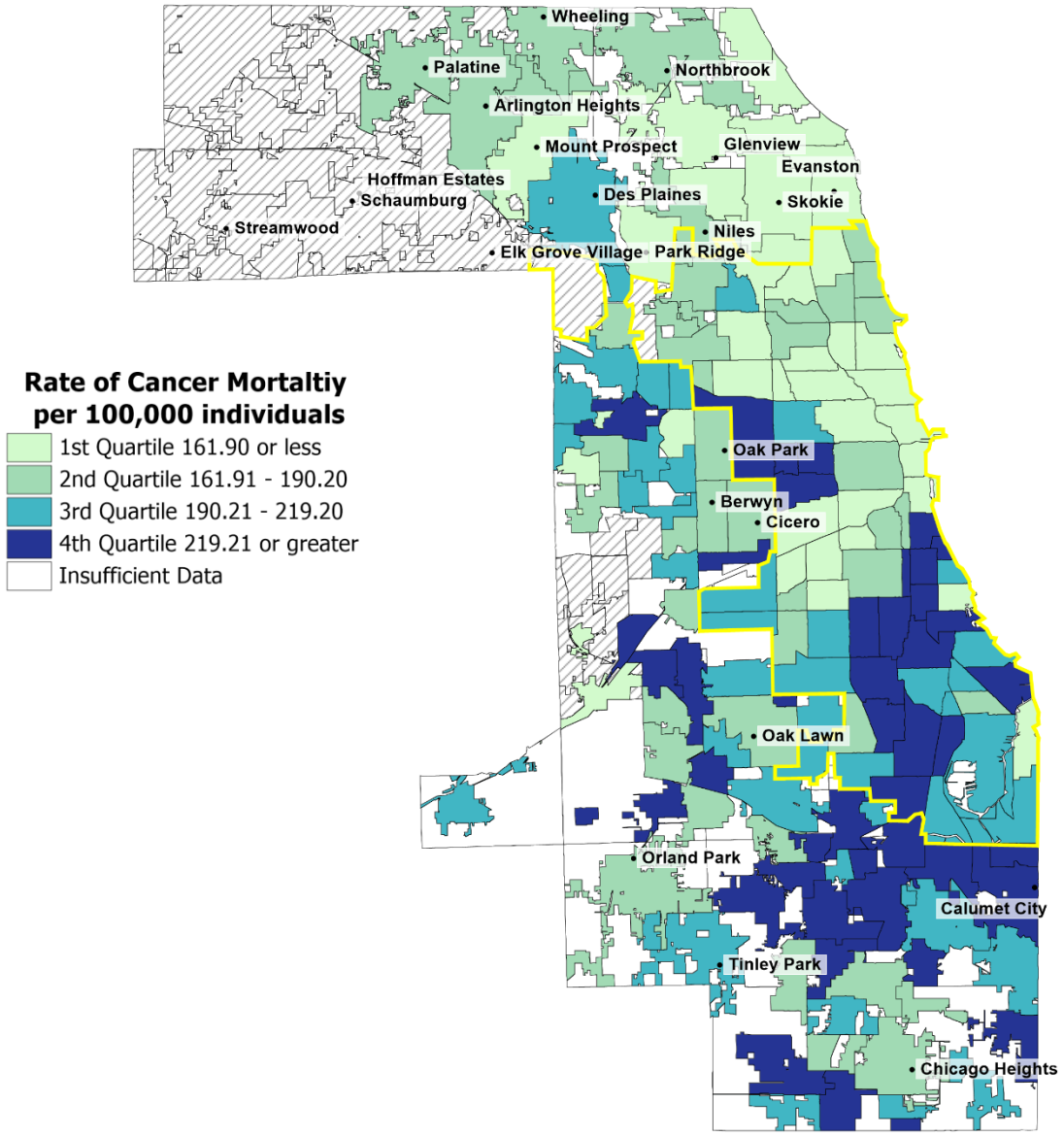
Cancer is the leading cause of death in the South region. In 2012, cancer mortality for the South region (205.8 deaths per 100,000 population) was higher than the rate for Illinois (179.1 deaths per 100,000 population) and the U.S. (171.5 deaths per 100,000 population). One of the Healthy People 2020 objectives is to reduce the overall cancer death rate. The target rate set by Healthy People 2020 is 161.4 deaths per 100,000 population. In 2012, the mortality rate for the South region was above the Healthy People 2020 target.

Non-Hispanic blacks had the highest cancer mortality rates (236.2 deaths per 100,000 population) followed by non-Hispanic whites (203.5 deaths per 100,000 population), Hispanic/Latinos (136.3 deaths per 100,000 population), and Asian/Pacific Islanders (99.0 deaths per 100,000 population).

Cancer mortality by race and ethnicity, age-adjusted rate (per 100,000) population, 2012



Map of cancer mortality rates in the South region, age-adjusted rates (per 100,000) population, 2012

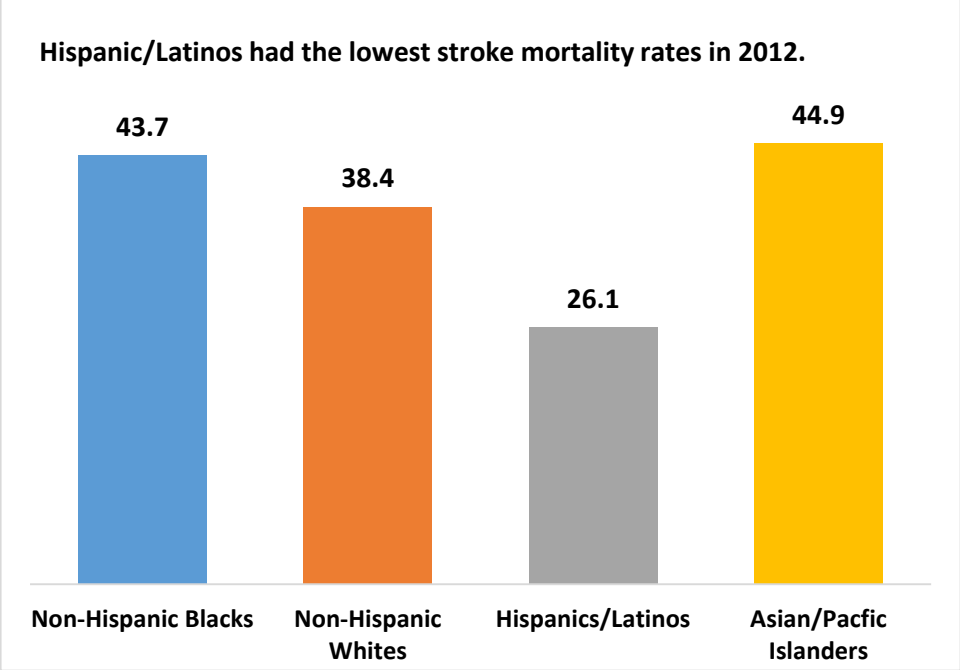


Stroke

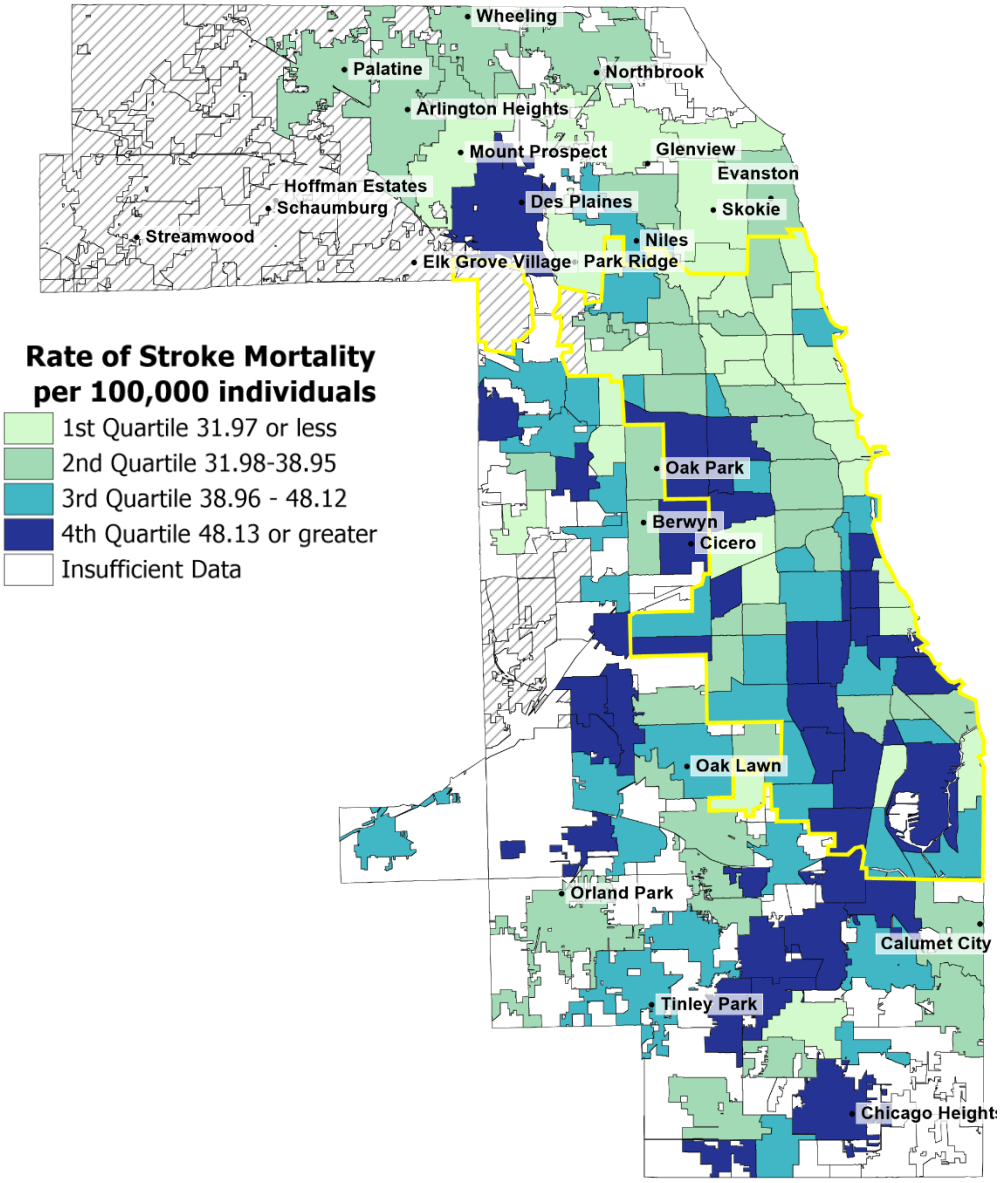
In 2012, the stroke mortality rate for the South region was approximately the same in South region (40.1 deaths per 100,000 population), Illinois (39.5 deaths per 100,000 population), and the U.S. (39.5 deaths per 100,000 population).

In 2012, there were some differences in stroke mortality between racial and ethnic groups with Asian/Pacific Islanders having a stroke mortality rate of (44.9 deaths per 100,000 population) followed by non-Hispanic blacks (43.7 deaths per 100,000 population), non-Hispanic whites (38.4 deaths per 100,000 population), and Hispanic/Latinos (26.1 deaths per 100,000 population).

Stroke mortality by race and ethnicity, age-adjusted rate (per 100,000) population, 2012



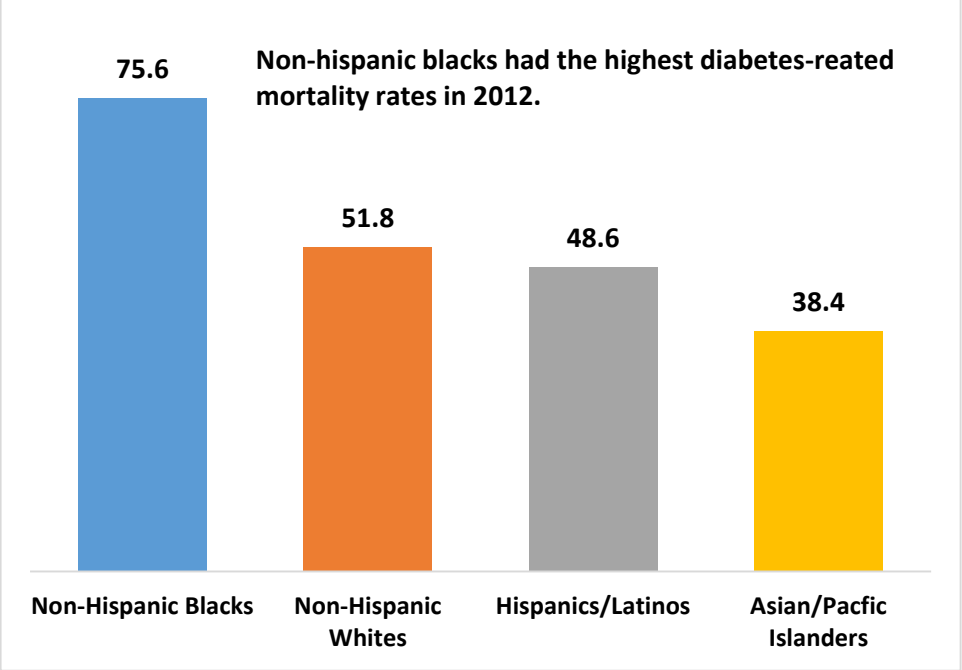
Map of stroke mortality rates in the South region, age-adjusted rates (per 100,000) population, 2012



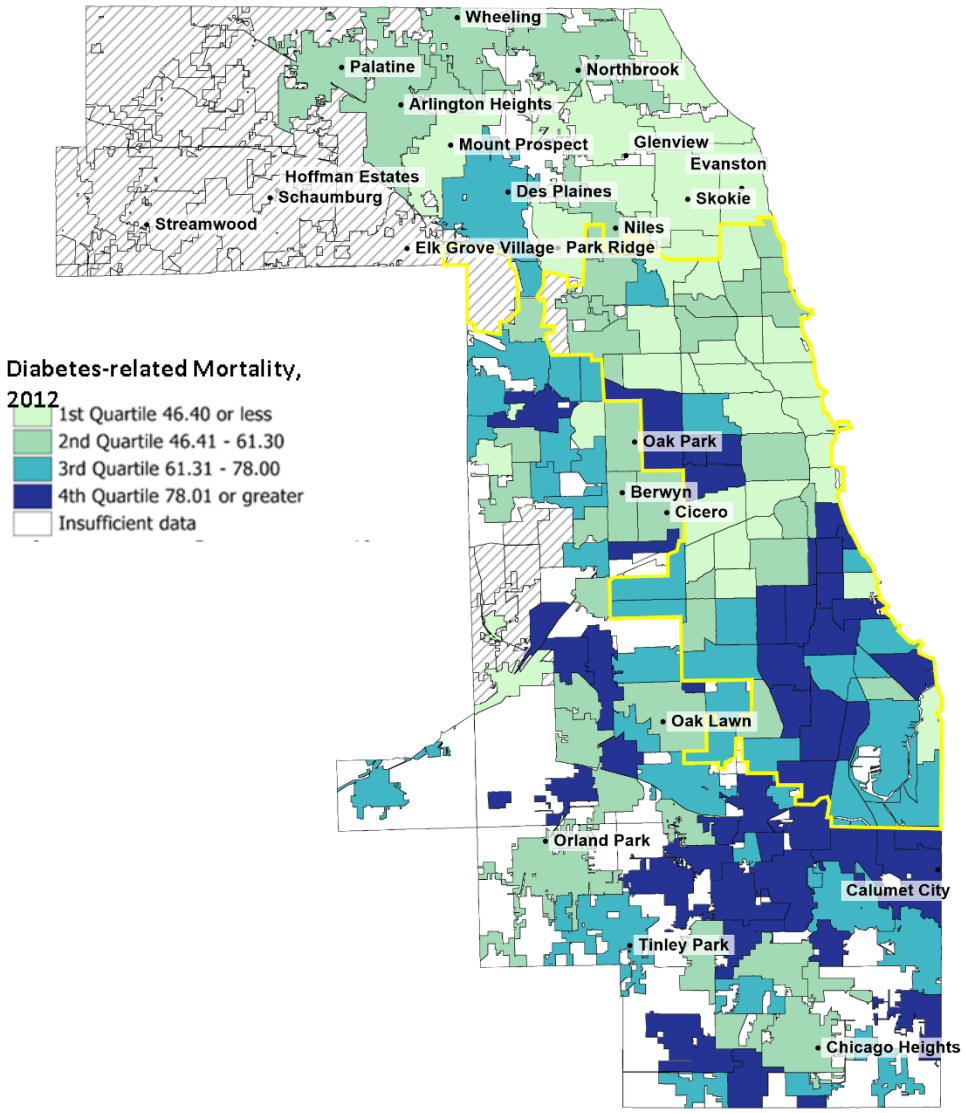
Diabetes-related

In 2012, the diabetes mortality rate was approximately the same for the South region (60.2 deaths per 100,000 population) and Illinois (63.2 deaths per 100,000 population), and slightly lower than the rate for the U.S. (70.8 deaths per 100,000 population). However, disparities persist with non-Hispanic blacks having the highest diabetes related mortality rate in 2012 (75.6 deaths per 100,000 population), followed by non-Hispanic whites (51.8 deaths per 100,000 population) and Hispanic/Latinos (48.6 deaths per 100,000 population) and Asian/Pacific Islanders (38.4 deaths per 100,000 population).

Diabetes-related mortality by race and ethnicity, age-adjusted rate (per 100,000) population, 2012



Map of diabetes-related mortality rates, age-adjusted rates (per 100,000) population, 2012



Forces of Change Assessment (FOCA) Report

Background

The Forces of Change Assessment (FOCA) is designed to consider external forces that may have an impact on community health and the public health and healthcare system's ability to promote and improve community health. The broader environment is constantly affecting communities and local public health systems. State and federal legislation, rapid technological advances, changes in the organization of healthcare services, shifts in economic forces, and changing family structures and gender roles are all examples of forces of change. These forces are important because they affect, either directly or indirectly, the health and quality of life in the community and the effectiveness of the local public health system.[1]

Forces of change are broad and all-encompassing, and include:

- **Trends:** patterns over time, such as migration in and out of a community or a growing disillusionment with government.
- **Factors:** discrete elements, such as a community's large ethnic population, an urban setting, or the jurisdiction's proximity to a major waterway.
- **Events:** one-time occurrences, such as a hospital closure, a natural disaster, or the passage of new legislation.

FOCA Process

For this collaborative CHNA, the Forces of Change Assessment was conducted as a collaborative-wide activity to understand the key forces impacting community health across Chicago and suburban Cook County. Each regional stakeholder advisory team, including the Central stakeholder team, provided input into the collaborative-wide FOCA between August and October of 2015.

Consistent with the Health Impact Collaborative's goal of efficiently leveraging existing data and processes, the stakeholder advisory teams did not start from scratch. Instead, they reviewed and reacted to the results of the Forces of Change Assessments that had been recently conducted by the Chicago Department of Public Health (CDPH) for Healthy Chicago 2.0 and the Cook County Department of Public Health (CCDPH) for their WePLAN. CDPH conducted their FOCA between October 2014 and January 2015 through a series of five community conversations along with additional input from CDPH management, the Chicago Board of Health, and the Partnership for a Healthy Chicago. CCDPH conducted their FOCA between June and July 2015 through discussion at four community focus groups.

At the three regional Stakeholder Advisory Team meetings in August 2015, Illinois Public Health Institute (IPHI) staff provided the teams with a summary of the results of these two FOCA, including a listing of identified categories, forces, potential threats presented by the forces to community health, and potential opportunities created by the forces for better community health. As a large group, each of the teams answered the following question:

- Are there any major forces missing from the summary that are likely to have an impact on health and health equity in Cook County? In particular, think about potential forces that may not be affecting health now, but will influence health and quality of life in the future. (Types of Forces include: Social, Economic, Political, Technological, Environmental, Scientific, Legal, Ethical)

[1] The FOCA is one of the four integral components of the MAPP assessment framework developed by the National Association of County and City Health Officials (NACCHO).

Then, in small groups, participants in each region reflected on the following questions, in relation to the Health Impact Collaborative's vision of improved health equity, wellness and quality of life across Cook County:

- What forces reinforce health inequity in our community?
- How can we mitigate or prevent these forces?
- Who or what institutions have the power to mitigate and prevent?
- What are some of the assets, strengths, bright spots in the communities that can be catalyzed to reinforce health equity in our community?
- What is the role of hospitals and local health departments in this work? Where do we have opportunities to partner and influence?

When the teams met again in October, 2015, they reflected briefly on the FOCA results compiled from across all three regions, and had a short discussion of which forces would have the most impact on community health if not addressed. They also discussed the role of the Health Impact Collaborative of Cook County in fostering solutions.

Findings

Sixteen categories of forces were identified as a result of all stages of this process (from the Cook County and Chicago Health Department processes and the Health Impact Collaborative dialogue). In alphabetical order, these are:

- Access to health care, behavioral health and social services
- Aging population
- Built environment: housing, infrastructure and transportation
- Chronic disease
- Climate and environment
- Data and technology
- Economic stability/security and inequality
- Education
- Food and food systems
- Globalization/global forces
- Health care systems issues/health care transformation
- Immigration and cultural competence
- Mental/behavioral health
- Policy and politics
- Racism, discrimination and stigma
- Safety and violence

Key finding – Health care systems issues/health care transformation and global forces/globalization were additional forces identified by Health Impact Collaborative stakeholders. While most of the stakeholder advisory team discussions enhanced and expanded on the results of the health department processes, the Health Impact Collaborative stakeholder advisory teams raised and added health care systems/health care transformation as a significant, previously unidentified force of change. The HICCC process also identified global forces/globalization as a separate force as well. See full descriptions below.

Key finding – Several themes emerged from the forces of change assessment.

- The identified forces of change have a significant impact on health inequities, and they are especially affecting health through their impact on social determinants of health like housing, education, racial/ethnic bias, and income.
- Housing issues were identified several times (in aging, built environment, economic stability/security/inequality; globalization; racism/discrimination/stigma)

- Negative impacts on mental health are emerging from a number of the forces of change (access to care, built environment, health care systems, mental health, racism/discrimination/stigma, and safety and violence).
- Workforce, jobs and economic issues arose not only in the economic stability category, but also in aging, built environment, education, globalization, health care systems, mental/behavioral health.
- Reduced and inadequate funding and cuts to social services, health care and public health present a threat in several of the forces of change categories (access to care, economic stability, education, health care systems, mental/behavioral health, and policy).
- Changes to systems resulting from the Affordable Care Act (access to care, health care systems) is a force of change
- Several concepts and ideas were identified more than once as presenting opportunities: collaboration among sectors, community health workers, the role of schools, advocacy and policy, social media and new technologies, and leveraging new models and evidence-based approaches.

Key finding – Economic stability/security and inequality is a crucial force of change and is likely to have the most impact on community health if unaddressed. During the October follow-up discussion, all three regional stakeholder advisory teams identified this force as one that could have the greatest impact on community health.

Key finding – Access to care, chronic illness, mental health care, the aging population, and education (including health literacy) were also identified as likely to have the most impact if unaddressed. One or more regional stakeholder advisory teams identified these forces that, if unaddressed, will have a large impact on community health or the public health system.

Key finding – Advocacy and policy development is a role for the Health Impact Collaborative of Cook County to address forces of change. Stakeholders discussed legislative advocacy and policy development as a potential role for the Collaborative in developing solutions to access to care issues, as well as a role for the Collaborative in policy and advocacy related to addressing economic instability and inequality.

Key finding – Community collaborations to promote workforce development was identified by all three teams as an appropriate role for the HICCC in solving the economic stability/security and inequality force of change.

Key trends, events, factors, threats and opportunities, categories listed in alphabetical order.

- **Access to health care, behavioral health and social services**: The key forces in this category included the effects of the Affordable Care Act and the transition to Medicaid managed care, the inadequacy of the mental health care system, and federal threats to access to reproductive health care. Threats included challenges facing residents in navigating insurance systems, lack of providers accepting Medicaid, cuts to social services, and medical service distribution issues; opportunities included the trusted relationships fostered by community health workers and increasing collaborative advocacy for access to care.
- **Aging population:** the growing population of older adults was identified as a significant trend that impacts the workforce and tax base, highlights gaps in supports and services for seniors, presents increasing cost and quality of life issues associated with an increasing burden of chronic disease, and the aging of the caregiving population. Opportunities included emerging methods for creating age-friendly cities and communities.
- **Built environment:** housing, infrastructure and transportation: Lack of affordable housing and transportation especially for vulnerable populations were identified as significant factors affecting health. Homelessness, gentrification, and transit inequalities were seen as threats,

while building on current efforts to improve physical infrastructure like sidewalks and 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 an opportunity.

- **Chronic Disease:** the growing burden of chronic disease was identified as a force of change threatening community well-being with the poorly understood interaction between genetics and environment identified as a threat, and increasing community and technological resources for disease prevention and management identified as potential opportunities.
- **Climate and environment:** Global warming, 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 opportunities.
- **Data and technology:** Increasing availability of health related data, social media and health applications for personal health improvement were identified as trends. Issues of privacy and trust and contribution differential access to data can have on health inequality are threats, while electronic health records, increasing real-time data for public health purposes, and the ability to empower residents with access to data are opportunities.
- **Economic stability/security and inequality:** The processes identified increasing poverty and wealth disparities, lack of livable wage jobs, high student loan debt, and interconnections among economics, housing, transportation, and workforce issues as forces of change. Threats include the association between poverty and poor health, the increasing need for social services as economic security declines, the risk of homelessness and the effect of reduced power of labor unions. Opportunities include living wage legislation, school-based job training, promoting lower-cost/debt-free higher education and leveraging the case management aspects of health care transformation to assist individuals with housing, food, and other social determinants.
- **Education:** Unequal school quality and school closings in Chicago, unequal application of discipline policies on minorities, and disparities in access to quality early childhood education were identified as forces of change. These produce threats like lack of job and college readiness the effect long-term on the criminal justice system of poor early childhood education. Opportunities include efforts to apply evidence-based school improvement programs, vocational learning opportunities, advocacy, and using maternal/child health funding to improve early childhood outcomes.
- **Food and food systems:** Lack of access to fresh fruits and vegetables, unhealthy food environments driven by federal food policies and food marketing and increasing community gardens/urban agriculture were the identified forces; resulting threats included increasing obesity and chronic disease and lowered school performance. Numerous opportunities were identified, including SNAP double bucks programs, incentivizing grocery store and community gardens, using hospital campuses/land as places for gardens, farmers markets and grocery stores, and the workforce development prospects for urban agriculture.
- **Globalization/global forces:** Trends and factors related to this topic centered on the outsourcing of jobs from the U.S. and the impact of terrorism and overseas US military involvement. Lack of jobs threatens community health through increasing social and community breakdown, and the culture of fear and discrimination bred by the media. Availability of new health technologies from other countries was identified as an opportunity to reduce health care costs.
- **Health care systems issues/health care transformation:** The transition of the health care system from sick care to preventive care and population health, as well as the changing role of health departments from providers to coordinators were identified as the key trends. Threats to health from these trends include competition among providers as a barrier to population health approaches, consolidation of health care and integration with services threatens the viability of small, trusted community groups, continuing barriers to providing mental health services in the transforming delivery system, and barriers to hospitals playing a role in

addressing social determinants of health because this may be seen as "political." However, this transformation process provides many opportunities to improve community health, including the emergence of telehealth, building hospitals' understanding of population health, promoting hospital collaboration on system development and advocacy, building a health care workforce pipeline, collaborating to address mental health, opportunities through social media to promote access and knowledge of services, strengthening the role of health departments to promote chronic disease prevention through system and environmental changes, and the collaboration by safety net hospitals to link early childhood and health outcomes.

- **Immigration and cultural competence:** Key factors and trends in this category were the availability of new evidence-based approaches to health disparities and growing populations of refugees. Lack of culturally effective services contribute to poor health outcomes and poor outcomes from other types of human services, and challenges that exist in ensuring access to linguistically and culturally proficient care to the many diverse populations in the region. Community health workers, the transition to patient-centered care, quality improvement interventions, working with faith organizations were identified as opportunities arising from these forces.
- **Mental/behavioral health:** Trends and factors within this category included the criminalization of addiction, easy access to drugs, and the use of drugs to self-medicate in lieu of access to mental health services. Threats related to these forces included funding cuts, low/lack of reimbursement/low salaries leading to provider shortages, and stigma as a barrier to access to treatment. Opportunities included training first responders and implementing new community health models.
- **Policy and politics:** Shrinking public health budgets, new policies, the overall Illinois budget, and growing distrust in government were identified as forces of change. Threats include budget cuts in many services, especially for social determinants of health related programs, and the potential these trends have to increase health disparities. Opportunities include promoting more civic engagement in policy, advocacy, taking a health in all policies approach, and collaboration and alignment/reducing silos.
- **Racism, discrimination and stigma:** Forces include 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 increases in health disparities. Opportunities include conducting public education campaigns, embedding equity into organizational values, and implementing collective impact and community organizing, and promoting social movements.
- **Safety and violence:** The identified factors and trends include gun violence, intimate partner violence, policy violence, and bullying. The threats from these forces include the link between community violence and chronic disease and mental health problems, and the impact of fear and stress on health and wellbeing. Opportunities promoting the role of schools to provide safety and nurture for children and services for families, and increasing communication between communities and police

Forces of Change Matrix

**Note: Items in blue font were added during regional community stakeholder advisory discussions. Bullets in which Cook or Chicago are underlined denote that an issue was specific to that local public health system.*

Categories	Forces of Change (Trends, Events, Factors)	Potential Threats Posed to Community Health	Potential Opportunities Created for Community Health
Access to Care: Health Care, Behavioral Health, Social Services	• Emergence of the Affordable Care Act and Medicaid Managed Care • Inadequate state mental health system • Chicago: City mental health clinic closures • Risk to Planned Parenthood funding- impact on reproductive health • Declining acceptance of Medicaid patients due to low reimbursement	• Difficulty navigating health/insurance systems • Not everyone covered & threat of inadequate care, many providers not accepting new Medicaid patients • Access to social services • Unequal distribution of medical services • Cuts to programs and services, including suspension of enrollment/outreach programs, childcare subsidies, etc.	• Navigators and community health workers can bring about trust in system • Public health and managed care work to assure network advocacy • Advocacy for mental health services
Aging Population	• Growing population of older adults with services and supports they need	• Impacts on workforce, economic development and tax base. • Gaps in supports and services threatens health and quality of life for seniors • Increased burden of diseases that affect older adults • From Chicago FOCA: Possibility of older adults relocating to more age-friendly, affordable areas • Aging caregivers (70 yr olds with 90 yr old parents)	• WHO Global Network of Age-Friendly Cities; community-wide assessment with recommendations for improvements • Age-friendly communities and hospital initiatives
Built Environment Housing, Infrastructure, and Transportation	• Lack of rental housing and affordable housing in safe neighborhoods • The high cost of living and property taxes have contributed to a lack of affordable and safe housing. • Aging housing stock • Economic challenges and rising housing costs have contributed to more intergenerational living	• High cost of living leaves less month for other essential needs, Threatens health, mental health and well-being • Homelessness potential consequence which linked to poor health outcomes. • Gentrification displaces communities of color • Transportation very challenging for low income, seniors, & people w/ disabilities	• Initiatives to rehab vacant housing for vulnerable populations • Chicago: Ordinance amendments require 10-20% units more affordable in market rate developments • Opportunity to create new jobs building/rehabbing housing • Efforts to redesign outdoor spaces to foster recreation by Healthy Schools Campaign

Developed with data from Chicago and Cook County Forces of Change Assessments (FOCA), and Regional Team Dialogue

Categories	Forces of Change (Trends, Events, Factors)	Potential Threats Posed to Community Health	Potential Opportunities Created for Community Health
(continued) Built Environment Housing, Infrastructure, and Transportation		• First responders act as cabdrivers to hospitals due to lack of access to transit (mentioned specific to NW suburbs) • Transit inequality- mismatch between where public transit exists and where people need it (particularly low in Southern Cook County) • Transportation service has to be scheduled 2 days in advance for public aid- this affects discharge availability- criteria to access it (case management)	• Opportunity to scale up projects that have been successful (sidewalks, play spaces, bike lanes etc.)
Chronic Disease	• Growing burden of chronic disease	• Need to understand the complex interaction between environment and genetics	• 12 step model could be adopted as model of support for people with diabetes for example • Activity trackers- could this help to shift health?
Climate and Environment	• Global warming trends • Air quality • Radon levels • Lead poisoning • Water quality	• Direct threats to health	• Federal climate change legislation • Multi-sector strategies to create healthy housing • Chicago: Climate Action Plan
Data and Technology	• Open data trends make health-related data more widely available • Health applications for personal fitness and well-being • Big data for public health needs • Social media usage to connect	Ethical challenges in technology- privacy, transparency, trust and provide for common good-must be addressed Differential access can increase health inequalities	Foster networks & systems to increase use of reliable & secure platforms/mobile apps Implement a universal EHR system Empower residents with open data Improve public health through research and real-time data
Economic stability/security and Inequality	Poverty and wealth disparity Keeping up with high cost of living Lack of decent paying jobs Social determinants of health interconnect & contribute to inequities.	Housing instability; risk for foreclosures and homelessness More people qualify for social services and assistance Poverty associated with poorer health	Living wage legislation School based job training and apprenticeships Support higher education reimbursement and lower interest rate for student loans (Example: Free tuition at City Colleges)

Developed with data from Chicago and Cook County Forces of Change Assessments (FOCA), and Regional Team Dialogue

Categories	Forces of Change (Trend, Events, Factors)	Potential Threats Posed to Community Health	Potential Opportunities Created for Community Health
(continued) Economic stability/security and Inequality	• High student loan debt: young people can't afford rent, loans and healthcare so they go uninsured • Interconnectedness of economics, housing, and transportation • Interconnectedness of workforce readiness- debt, rising rent, and lack of skilled workforce	• Cook County FOCA: Diminishing power of labor unions & "right- to-work" efforts especially affecting populations of color	• When a patient is discharged, look at whether they have housing, access to food
Education	• Unequal school quality • Chicago: School closings • Unequal discipline (suspension and expulsion) among black youth • Disparities of Access/quality of early childhood education	• Lack of job and college readiness that can threaten individual and community well-being • Inadequate early childhood education leads to greater involvement in the justice system in the future	• Improve school quality through model school improvements and evidence-based programming • Community & vocational learning opportunities • Advocacy efforts • Opportunities to leverage MCH funding to improve outcomes for birth- 5
Food and Food Systems	• Lack of healthy food access • Federal food policies and food marketing contributing to unhealthy food environments • Increase in community gardens and urban agriculture	• Obesity and chronic disease • School performance threatened	• Extension of SNAP Double Bucks incentives at farmer's markets • Incentives for locally owned grocery stores • & community gardens in food deserts • Encourage development of urban agriculture- foster through community benefit and use hospital land to build gardens, farmer's markets, grocery stores • Incentivize urban ag as a job creation mechanism- collaborate with YMCAs and other community based orgs to work with youth to educate on urban ag and foster workforce development
Globalization/ Global Forces	• Outsourcing of jobs, stock market impact, transfer of jobs • Impact of terrorism, US military involvement overseas	• Many jobs being taken overseas- telemarketing jobs- a lot of people got started off that way, now they are outsourced, banks- economy has gone down b/c jobs aren't available- leads to crime & homelessness & violence • Media coverage breeds culture of fear, perpetuates discrimination	• New technology coming in from other countries-- hospitals taking a look at what that means in terms of technology being much cheaper than what we have in the states

Developed with data from Chicago and Cook County Forces of Change Assessments (FOCA), and Regional Team Dialogue

Categories	Forces of Change (Trend, Events, Factors)	Potential Threats Posed to Community Health	Potential Opportunities Created for Community Health
Health care systems issues/Health care transformation	• Affordable Care Act (ACA) move from sick care to preventative care • Transition to population health approach • Health Department used to be direct service provider- now play more of a role as convener to create coordination	• Competition threatens population health approach • ACA consolidation make it hard for small groups that have community trust to continue to thrive • Continuing challenge of addressing mental health through the health care system • Can be challenging for hospitals to find ways to address social determinants of health without being too political	• Leverage social media to educate the public about resources and services • Emergence of telehealth and potential expansion in access • Health Departments can serve as a catalyst for system and environmental change to prevent chronic disease so people stay healthier longer • Build Hospital leaders' understanding of population health and importance of collaboration as good business • Inspire collaboration among CEOS with better perspectives- how do we tell the story of hospital budget cuts- Advocate, Presence CEOs getting together to collaborate for advocacy • Hospitals and HDs could mentor youth from underrepresented groups to nurture them as future health care professionals • Leverage collaboration to determine how to address mental health • Hospitals looking at incentivizing psychiatrists to do this work as part of their community benefit • Safety net hospitals collaborating as a group- helping to articulate how early childhood impacts health care outcomes through collective story telling

Developed with data from Chicago and Cook County Forces of Change Assessments (FOCA), and Regional Team Dialogue

Categories	Forces of Change (Trend, Events, Factors)	Potential Threats Posed to Community Health	Potential Opportunities Created for Community Health
Immigration & Cultural Competence	• Evidence-based approach to address health disparities • Culturally effective care and services are essential • Growing refugee populations	• When not culturally effective, results may be poor health outcomes or poor outcomes from other services • Challenging to ensure access to linguistically and culturally competent providers to the diversity of populations	• Community health workers and patient navigators can help build a culturally effective health care system • Continual development of skills that follow the principles of patient-centered care • Quality improvement interventions with attention to diverse patient groups • Opportunity: skype translation, community health workers, work with faith orgs where diverse people gather, leverage ACS translation service as an existing asset
Mental/ behavioral health	• Criminalization of addiction • Availability of drugs-low price of heroin • Self-medicating behavior due to lack of mental health access	• Mental health funding cuts • Lack of reimbursements for psychiatrists and medication management • Low salaries for mental health professionals leads to provider shortages • Role of stigma influences access to treatment	• Training with police and first responders on mental health first aid and first response; (specific example from Park Ridge mentioned) working on national models of community health approach to mental health • Opportunity: Evanston policy work to reduce access to tobacco
Policy and Politics	• New state leadership; shrinking public health budget • New public health policies • Distrust in government • Overall State budget	• Budget cuts impact multiple sectors and services • Decreased funding for social determinants of health • Potential to increase health disparities • From Cook County FOCA: Power is concentrated - corporations, institutions and government	• Civic engagement to address policy making • Community health issue forums & advocacy promotion • Health in all policies approach in government decision-making • Collaborate, unify, eliminate silos • From Cook County FOCA: Social movements can shift the balance of power
Racism, Discrimination and Stigma	• Implicit or covert forms of bias common • Mass incarceration-disproportionate impact on communities of color • Unequal quality of education / unequal distribution of educational resources	• Poorer health outcomes; increased health disparities; decreased access to resources	• Public education campaigns to reduce stigma • Organizational values • Collective impact, community organizing and social movements

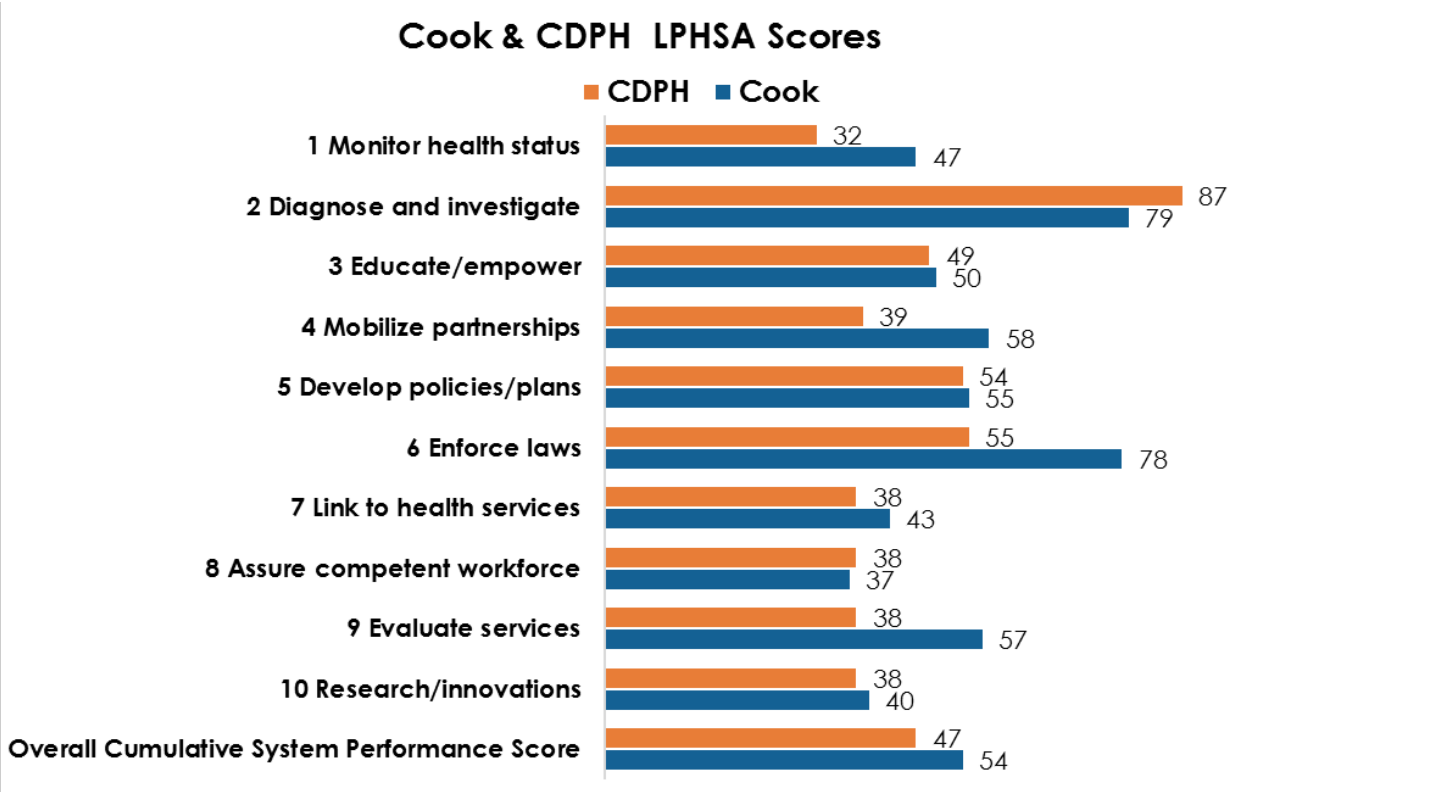
Developed with data from Chicago and Cook County Forces of Change Assessments (FOCA), and Regional Team Dialogue

Categories	Forces of Change (Trend, Events, Factors)	Potential Threats Posed to Community Health	Potential Opportunities Created for Community Health
Safety and Violence	• Gun violence • Intimate partner violence • Police violence • Bullying	• Community violence linked to chronic disease and mental health problems • Impact of fear on health and wellbeing	• Role of schools to provide safe, nurturing environment for children and youth and connect families to services • Increased communication between communities and police

Developed with data from Chicago and Cook County Forces of Change Assessments (FOCA), and Regional Team Dialogue

Local Public Health System Assessment (LPHSA)Report

Essential Public Health Service Scores			
EPHS	EPHS Description	Cook Ranking	Chicago Ranking
1	Monitor health status to identify community health problems.	7th	10th
2	Diagnose and investigate health problems and health hazards in the community.	1st	1st
3	Inform, educate, and empower people about health issues.	6th	4th
4	Mobilize community partnerships to identify and solve health problems.	3rd	5th
5	Develop policies and plans that support individual and community health efforts.	5th	3rd
6	Enforce laws and regulations that protect health and ensure safety.	2nd	2nd
7	Link people to needed personal health services & assure provision of health services.	8th	6th-9th
8	Assure a competent public and personal health care workforce.	10th	6th-9th
9	Evaluate effectiveness, accessibility, and quality of personal and population-based health services.	4th	6th-9th
10	Research for new insights and innovative solutions to health problems.	9th	6th-9th



Essential Service 1: Monitor health status to identify and solve community health problems. Both scored moderate

- Common areas for improvement:
  - Need to improve data dissemination to LPHS partners and community members
  - Need to make data more accessible, understandable, and actionable

Essential Service 2: Diagnose and investigate health problems and health hazards in the community. Both scored optimal

- Common strengths:
  - Strong surveillance
  - Strong emergency preparedness
  - Excellent laboratory capacity

Essential Service 3: Inform, educate, and empower people about health issues. Both scored moderate

- Common strength: Strong risk communication
- Common area for improvement:
  - Need to strengthen relationships with media to better disseminate messaging to the public
  - Opportunities to strengthen partnerships with communities for coordinated messaging and outreach about health issues.

Essential Service 4: Mobilize community partnerships and action to identify and solve health problems. Chicago scored moderate; Cook scored significant

- Common areas for improvement:
  - Many coalitions exist, but efforts are siloed and narrow. Increase coordination and breadth of focus to maximize impact.

Essential Service 5: Develop policies and plans that support individual and community health efforts. Both scored significant

- Common strength: Strong emergency planning

Essential Service 6: Enforce laws and regulations that protect health and ensure safety. Chicago scored significant; Cook scored optimal

- Common strength: Good enforcement of laws and regulations
- Common area for improvement:
  - Opportunities to strengthen policy review to impact social determinants of health and health equity.

Essential Service 7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
Both scored moderate

- Common strengths: Good identification/understanding of vulnerable and marginalized populations
- Common areas for improvement:
  - Need to improve care coordination through a referral follow up system
  - Need to improve access to culturally/linguistically competent care

Essential Service 8: Assure competent public and personal health

care workforce. Both scored moderate

- Common areas for improvement:
  - Workforce assessments are conducted, but they are done in silos and assess individual organizations rather than the public health system as a whole
  - Leadership development and training opportunities exist, but are not necessarily made available at all organizational levels

Essential Service 9: Evaluate effectiveness, accessibility, and quality of personal and population-based health services. Chicago scored moderate; Cook scored significant

- Common strengths: Strong evaluation of personal health services
- Common areas for improvement:
  - Need for increased data sharing across system for collective Quality Improvement
  - Evaluation of population health services is much less robust than evaluation of personal services

Essential Service 10: Research for new insights and innovative solutions to health problems. Both scored moderate

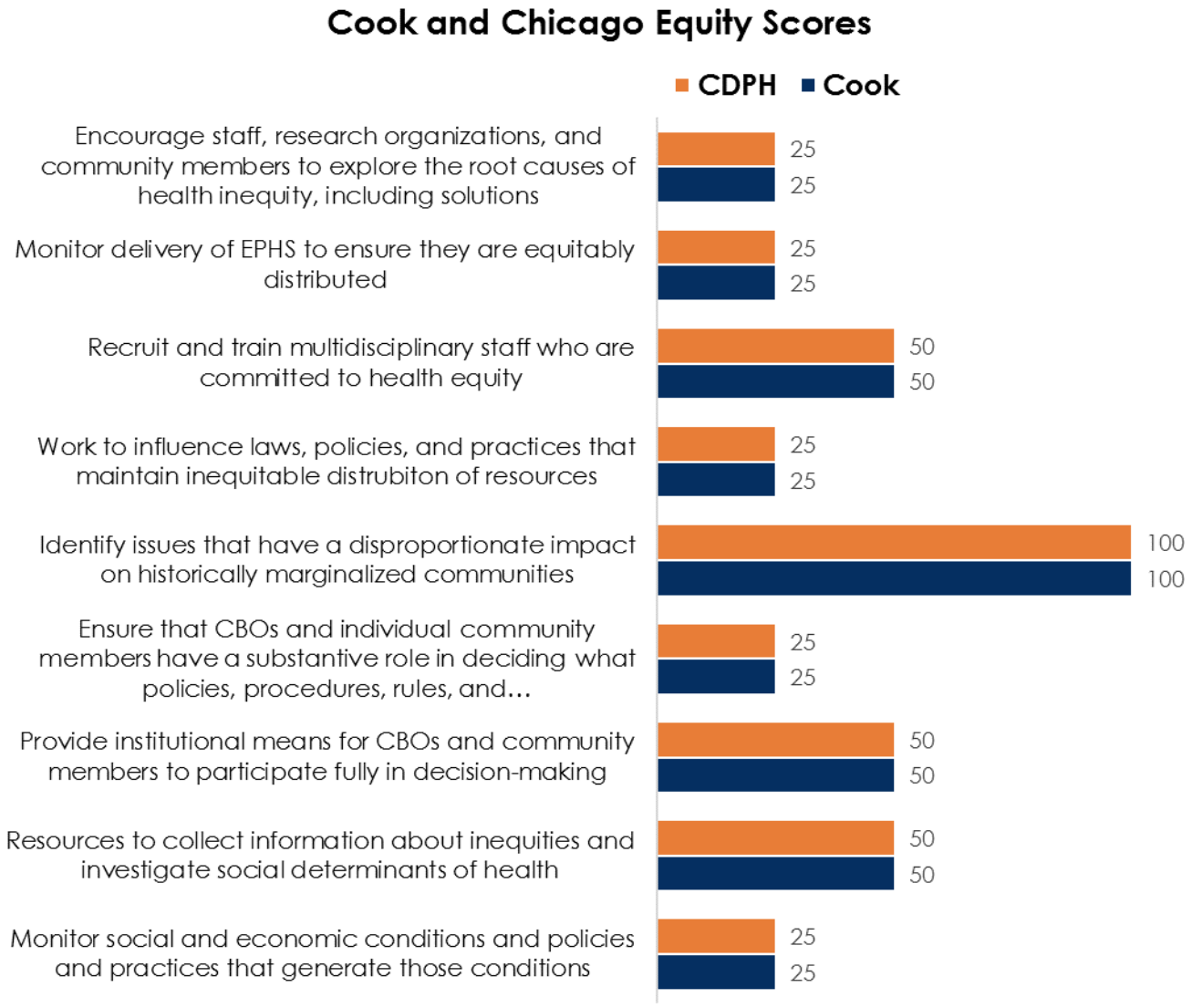
- Common strengths:
  - Many existing linkages with academic institutions
  - Growing momentum of community based participatory research
- Common areas for improvement:
  - Limited capacity to participate in research due to lack of funding and resources
  - Need for more practice-based & action-oriented research that can directly inform public health practice
  - Need to develop a shared research agenda with health equity and practice focus

Health Equity Findings from the Chicago and Cook County Local Public Health System Assessments

Both Cook and Chicago reported growing attention and emphasis on health equity across the public health system. WePlan and Healthy Chicago 2.0 have health equity integrated within their assessment frameworks. However, stakeholders from both assessments perceived a need for greater monitoring of social and economic conditions that drive inequity, and perceived that their respective systems have the resources that would allow for collection of information on health inequity.

Both Cook and Chicago stakeholders reported a growing recognition for the importance of community voices in influencing policy and decision making. While there is a good understanding of issues that have a disproportionate impact on marginalized communities and serve to perpetuate inequity, system performance in addressing and influencing these issues has been low. Stakeholders pointed to funding and political barriers as limiting factors in this work. The public health system must seek out funding opportunities that address the social determinants of health and mobilize grassroots efforts among the public to advocate for policy and systems changes that promote greater equity.

Stakeholders from both groups also underscored the importance of building greater competency and understanding of the principles of health equity across the public health workforce. Health equity should also be further built in to evaluation and research activities across the public health system.


Cook and Chicago Equity Scores
CDPH
Cook
Encourage staff, research organizations, and community members to explore the root causes of health inequity, including solutions
25
25
Monitor delivery of EPHS to ensure they are equitably distributed
25
25
Recruit and train multidisciplinary staff who are committed to health equity
50
50
Work to influence laws, policies, and practices that maintain inequitable distrubiton of resources
25
25
Identify issues that have a disproportionate impact on historically marginalized communities
100
100
Ensure that CBOs and individual community members have a substantive role in deciding what policies, procedures, rules, and…
25
25
Provide institutional means for CBOs and community members to participate fully in decision-making
50
50
Resources to collect information about inequities and investigate social determinants of health
50
50
Monitor social and economic conditions and policies and practices that generate those conditions
25
25