



The Chicago Plan for Public Health System Improvement 2012-2016

A five-year plan for strengthening the health of the city –
developed by the Chicago Partnership for Public Health.



Submitted on February 28, 2012

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February 15, 2012

Arthur Kohrman, M.D.
Interim Director
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Dear Dr. Kohrman:

On behalf of the Chicago Board of Health, I am pleased to present the Chicago Plan for Public Health System Improvement 2012 – 2016, which was adopted by the Board on February 15, 2012.

The Chicago Plan presents a health improvement plan for the City of Chicago that addresses key system issues. The strategies in the Plan bring together myriad public health stakeholders to coordinate their work and implement identified activities. By focusing on the public health system, the Chicago Plan takes broad steps to impact cross cutting infrastructure concerns while addressing the needs of Chicago's most vulnerable populations. The priority areas identified in the Plan emerged from a comprehensive planning process detailed in the community health assessment section of the plan.

The Chicago Plan was completed through the Chicago Partnership for Public Health, a public-private partnership established in 1998 to strengthen Chicago's public health infrastructure. The Chicago Board of Health was pleased to participate as a member of this body. The Chicago Department of Public Health convenes these meetings and guided members through this process.

Therefore, please accept the Chicago Plan for Public Health System Improvement 2012 – 2016 as completion of the Illinois Project for Local Assessment of Needs (IPLAN) requirement.

Sincerely,

Carolyn Lopez, M.D.
President

cc: Tom Szyprka, IPLAN Administrator

The Chicago Plan

for Public Health System Improvement

2012-2016

**A Five-Year Plan for Strengthening
the Health of the City**

COMPLETED BY THE
CHICAGO DEPARTMENT OF PUBLIC HEALTH,
IN PARTNERSHIP WITH THE
CHICAGO PARTNERSHIP FOR PUBLIC HEALTH

February 2012

Acknowledgements

Thank you to the members of the Chicago Partnership for Public Health for participating in the development of the Chicago Plan for Public Health System Improvement 2012-2016. The Chicago Plan demonstrates your commitment to improving the health and quality of life for Chicago residents and a fundamental value of collaboration across the broad spectrum of public health stakeholders.

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Introduction

PURPOSE

Every five years the Chicago Department of Public Health, as the local public health authority for the City of Chicago, is required to complete an Illinois Project for Local Assessment of Needs (IPLAN), a community health assessment and health improvement plan completed in accordance with the Illinois Administrative Code Title 77 Section 600. The community health assessment and community health improvement plan also meet the prerequisites for the Public Health Accreditation Board's (PHAB) Local Public Health Accreditation.

PROCESS

Planning Body: The Chicago Department of Public Health's (CDPH) community health assessment and improvement plan, the *Chicago Plan for Public Health System Improvement 2012-2016*, was completed in collaboration with the Chicago Partnership for Public Health. The Chicago Partnership for Public Health formed in 1998 as part of the National Turning Point Demonstration Project, sponsored by the W.K. Kellogg and Robert Wood Johnson Foundations. The Chicago Partnership, convened and managed by CDPH, is a public-private partnership with a diverse membership of public health stakeholders working toward the goal of strengthening the local public health infrastructure. The Chicago Partnership served as the planning body for two previous IPLANs (2000, 2006-2011).

Timeline: The Chicago Partnership meets every other month to discuss key issues affecting Chicago's public health infrastructure. Committees working on specific initiatives meet as needed to plan and implement strategies, and status reports are shared at the full Partnership meetings. With this schedule already in place, strategic planning efforts began in early 2010 to bring in new member organizations, inform members about the planning process, and develop

the system vision. Experts presented on key forces and trends affecting Chicago's health system (e.g., housing and public health, economic issues, and state, county, and local governmental resources for public health), which clarified system components and added context to the Partnership's discussions on key forces of change and the local public health system assessment.

The Chicago Plan was originally due to the Illinois Department of Public Health (IDPH) in August 2011. However, a decision was made that the Chicago Plan, to be relevant for its five year span, should include the soon-to-be-released 2010 U.S. Census Bureau Decennial Census. Given the comprehensiveness of the planning process and the Partnership's schedule, the due date needed to be extended to accommodate this new data set. Therefore, CDPH requested and received a six-month extension from IDPH.

System Focus: Since its creation, the Chicago Partnership has focused on strengthening the system as a means to improving public health and health status. The Partnership believes broad-based system changes which impact policy making, communication, structure, and collaboration;

will facilitate improvements in many health conditions and underlying social determinants of health. Therefore, the *Chicago Plan for Public Health System Improvement* identifies key system issues that the Partnership will address during these next five years. The system focus is also believed to have contributed to the Partnership’s longevity. Diverse members maintain their involvement because the overarching system strategies the Partnership works on benefits all sectors.

Strategic Planning Process: The Chicago Partnership for Public Health utilized the Mobilizing for Action through Planning and Partnerships (MAPP) strategic planning process as an IPLAN equivalent, as approved by the Illinois Department of Public Health. MAPP was developed by the National Association of County & City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC) and is cited by PHAB as a recommended health assessment and improvement plan model.

As shown by the graphic below, MAPP has six phases, which the Chicago Partnership has identified as:

Phase 1: Partnership Development

Phase 2: Visioning

Phase 3: Four MAPP Assessments

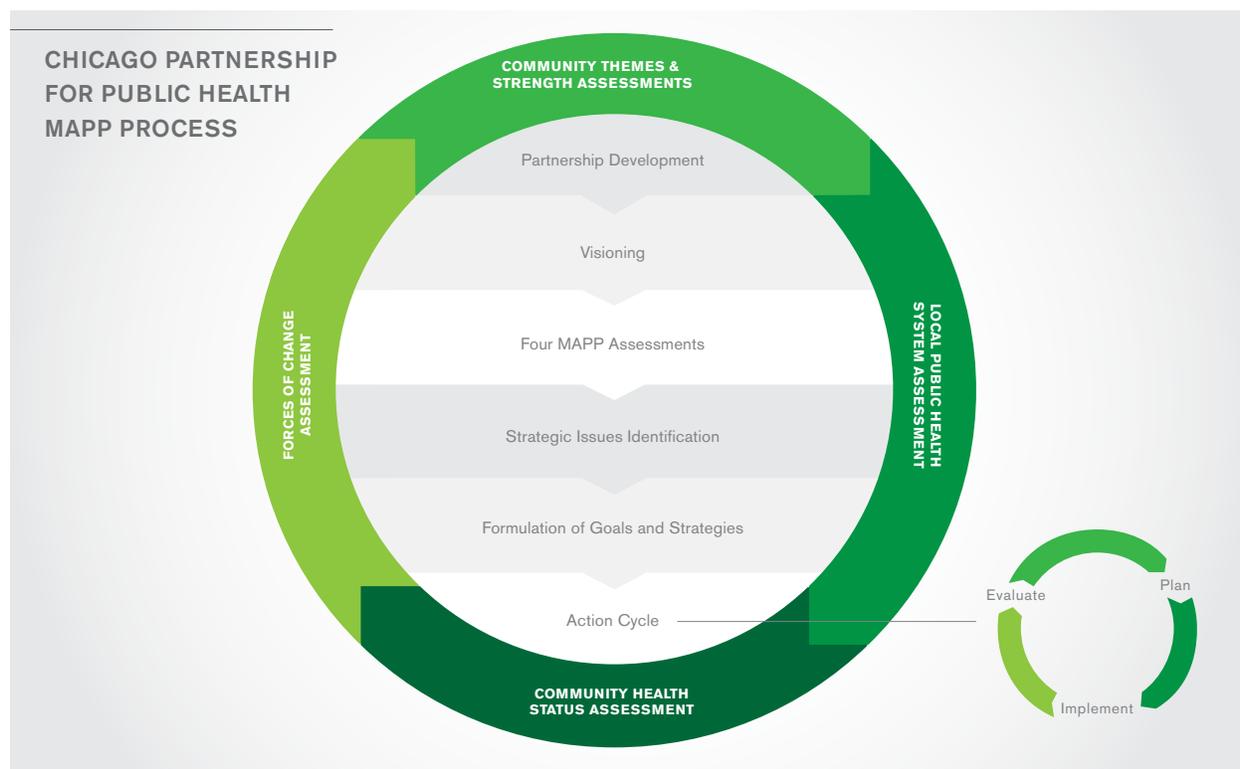
- Community Health Status
- Community Themes & Strengths
- Local Public Health System
- Forces of Change

Phase 4: Strategic Issues Identification

Phase 5: Formulation of Goals and Strategies

Phase 6: Action Cycle

The following chapters describe the process and results for each of these phases. Please note that Phase 5 and Phase 6 are combined, as the action cycle will continue to be developed and implemented through Chicago Partnership committees focused on the priority areas after the plan is submitted.



Partnership Development

PURPOSE

The Chicago public health system is composed of a broad range of multi-sector organizations that impact public health and the health of Chicago's residents. While many of these organizations are currently involved in public health collaborations, a still sizeable amount do not yet recognize their influence on the system or understand how system improvements would affect their work. However, for any sustainable improvements to be made, it is necessary that these organizations join together to comprehensively address long-standing system issues. Therefore, the purpose of this phase was for the Chicago Partnership for Public Health to engage and re-engage diverse stakeholders, who will both represent their sectors and also work on larger system issues.

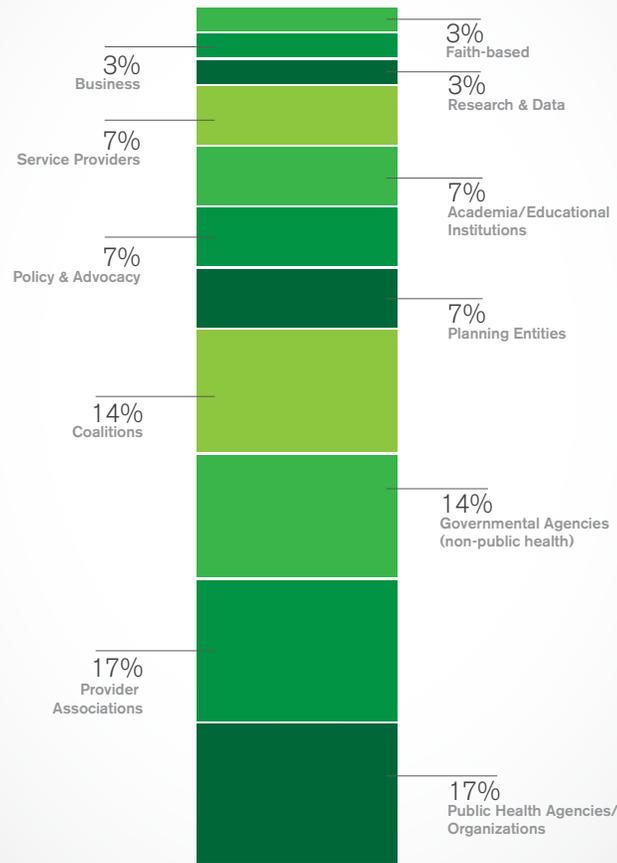
PROCESS

The Chicago Department of Public Health (CDPH) first re-established relationships with organizations, including City of Chicago departments and other agencies whose participation on the Partnership had waned in the past several years. Then, based on an analysis of sectors that did not currently sit on the Partnership, other organizations were invited to join this collaborative. To strengthen members' connection to the process and encourage active participation, Partnership staff often reiterated the importance of each member's input, insight, and involvement in the strategic planning process.

RESULTS

Twenty-nine organizations participated in the strategic planning process as members of the Chicago Partnership for Public Health. The largest category of members was public health agencies (state and local) and provider associations, both representing 17% of all Chicago Partnership member organizations. Non-public health governmental agencies, such as the City of Chicago departments, made up 14% of the members, as did community coalitions. Other organizations involved were from the following sectors: planning, policy and advocacy, academia, service providers, research and data, business, and faith-based.

MEMBERS OF THE CHICAGO PARTNERSHIP FOR PUBLIC HEALTH



Visioning for a Healthy Chicago Public Health Infrastructure

PURPOSE

Creation of the Chicago Partnership's vision for Chicago's public health infrastructure served two purposes, the first of which was the development of a specific set of activities and values of what Chicago's public health system should do and how this system should function. This structure served as a guide or "moral compass" throughout the remainder of the planning process.

The development of the vision also served a second purpose—bringing long term members and new partners together as a strategic planning entity. Through this visioning phase, the Partnership established its decision-making procedures and was oriented to the broad scope and scale of the planning process.

PROCESS

Through prior strategic planning processes, the Chicago Partnership had developed a vision for Chicago's public health infrastructure. Partnership staff presented this vision to the members, who then, over a series of two meetings, edited and expounded upon the wording, components, and inclusiveness of the vision. These changes were made to help stakeholders recognize their role within the public health infrastructure and make them more inclined to participate in the priorities that emerged from the Plan.

VISION

The Chicago Partnership for Public Health's vision for the Chicago Public Health System:

A responsive, sustainable system that actively addresses current and future public health challenges, while protecting and promoting the health, safety, and well-being of Chicago's communities, residents and visitors, particularly the most vulnerable. The system conducts this work through:

- Cooperative efforts of all stakeholders,
- Planning and policy development,
- A broad focus on access to services, information, and empowerment,
- Disease prevention, health promotion, and health protection,
- Shared leadership and accountability for the essential services of public health, and
- Surveillance and assessment.

Whom the System Will Serve:

- 2.7 million individuals who live in Chicago
- 1.4 million persons who work in Chicago
- Over 45 million visitors

What the System Will Do:

- Provide services that prevent disease and promote and protect health
- Support and facilitate community empowerment to address health concerns
- Provide comprehensive and holistic services, which work to reduce the effects of violence, poverty and racial/ethnic/other disparities
- Carry out the Ten Essential Public Health Services:
 1. Monitor health status to identify community health problems
 2. Diagnose and investigate health problems and health hazards in the community
 3. Inform, educate, and empower people about health issues
 4. Mobilize community partnerships to identify and solve community problems
 5. Develop policies and plans that support individual and community health efforts
 6. Enforce laws and regulations that protect health and ensure safety
 7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
 8. Assure a competent public and personal health care workforce
 9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
 10. Research for new insights and innovative solutions to health problems

System Values/How the System Will Function:

- Operates a highly visible public-private partnership, with shared leadership and public accountability
- Includes all stakeholders, groups, and communities, with a special focus on the most vulnerable
- Directs resource allocation that reflects commitment to populations most in-need
- Facilitates and maintains solid interconnectedness to other public health systems in Illinois, neighboring states, and nationally
- Promotes networking and communication among organizations
- Is solution-focused and committed to social justice

Community Health Status Assessment

PURPOSE

The Community Health Status Assessment, the most traditional component of the four MAPP assessments, presents data on the health status of Chicago, its communities, and its population groups. However, since the purpose of this comprehensive planning process (and the Chicago Partnership as a whole) is to address the broad public health system, this assessment moves beyond “traditional” public health data to look at indicators reflective of the focus of the system partners. Therefore, this assessment analyzes a range of indicators, from demographic and socioeconomic to the built environment to housing and to health status. By examining trends in these broad areas, the assessment presents a picture of the health and well-being of Chicago and its communities.

PROCESS

A committee of Partnership members formed to identify data sources and define the approach for this overview. Critical to the development of the assessment was to obtain and present data representative of the broad expanse of the public health system, modeling discussions throughout the community health assessment process as well as the tenure of the Chicago Partnership. Committee members made their data available for the assessment and also recommended other organizations and data sources through which other pertinent data could be obtained.

The assessment presents data and trends occurring in Chicago over time as well as the relative health of the 77 community areas. When available and appropriate, data are presented by sub-population, including race/ethnicity, education, income, age, and gender. The committee reviewed the findings and provided further recommendations prior to the data presentation at the Chicago Partnership meeting.

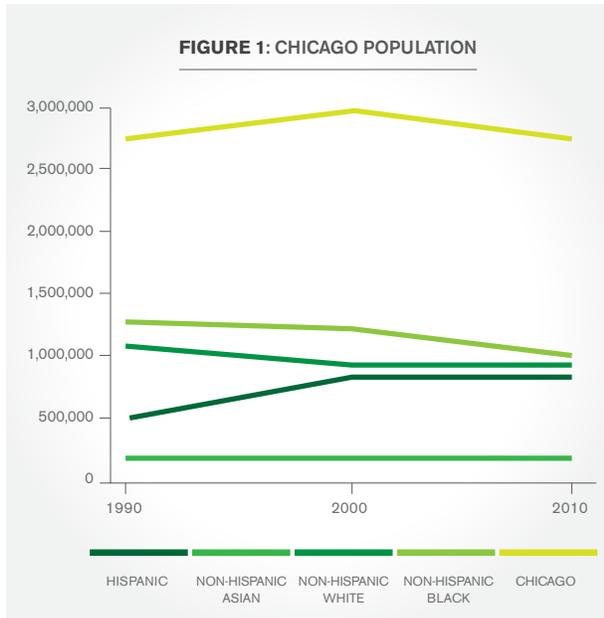
Data presented herein encompass the twelve priority areas in the Chicago Department of Public Health’s policy agenda and strategic plan, *Healthy Chicago Agenda: Transforming the Health of Our City*. A list of data sources that were used in the development of this assessment is provided in **Appendix A**.

FINDINGS: DEMOGRAPHIC AND SOCIOECONOMIC

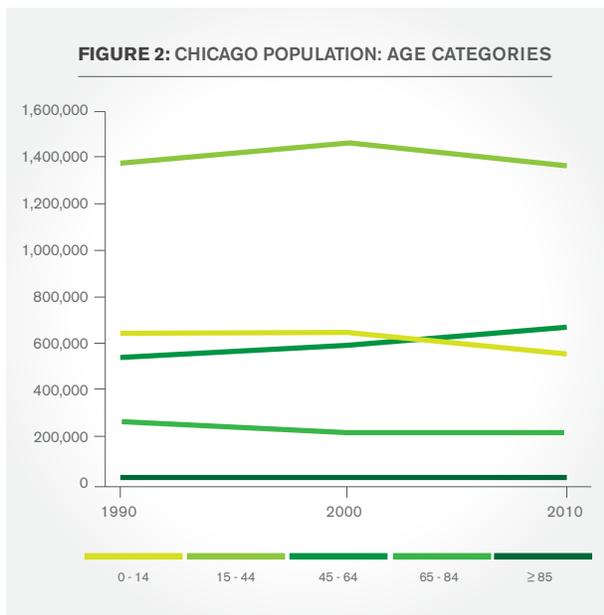
Demographic and Socioeconomic:

Population Numbers: Data from the U.S. Census Bureau’s 2010 Decennial Census indicate that 2,695,598 people live in Chicago. Comparing to 1990s population of 2,783,726, Chicago’s population is relatively stable, with only a 3% decrease. However, comparing to the 2000 Census data, which was 2,896,016, Chicago lost 200,418 people or 7% of its population. (**Figure 1**)

The Non-Hispanic White and Non-Hispanic Black populations in Chicago have decreased since 1990; the

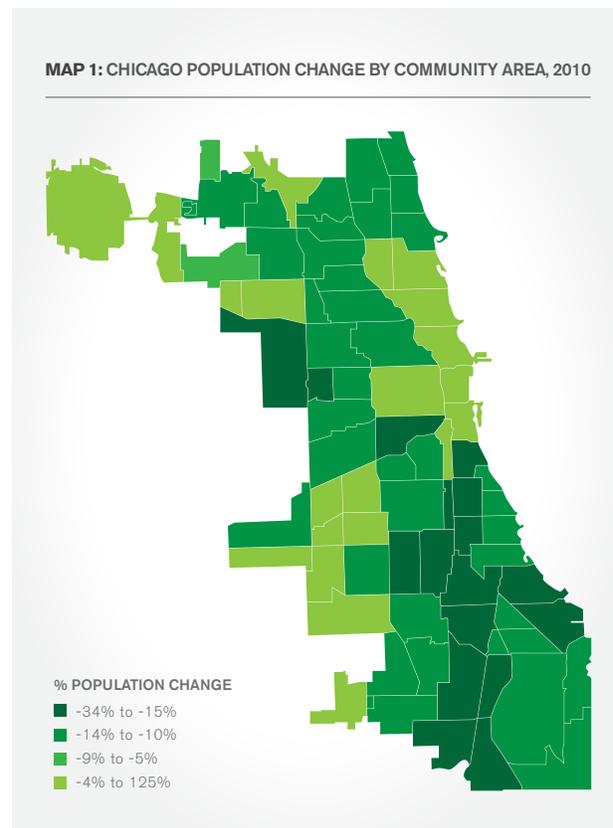


Non-Hispanic White population decreased by 148,882 between 1990 and 2000 and the Non-Hispanic Black population decreased by 181,453 between 2000 and 2010. In contrast, the Hispanic population increased by 233,010, between 1990 and 2010. In 2010, Chicago’s population was 32% for both the Non-Hispanic Black and Non-Hispanic White population, 29% Hispanic, and 5% Non-Hispanic Asian.



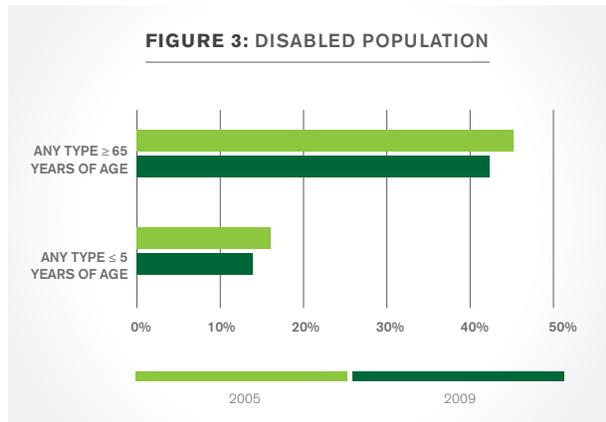
Chicago’s 2010 Hispanic population was comprised of several different nationalities, of which Mexican was the largest group, at 74%. Puerto Ricans made up 13%, Cubans 1%, and other Hispanics 12%. Chicago’s Asian population was more diverse, with 29% of Chinese nationality, 20% Asian Indian, 20% Filipino, 8% Korean, 6% Vietnamese, 3% Japanese, and 14% other Asian.

Throughout this twenty-year time period, the age of Chicago’s population remained relatively consistent. (Figure 2) Since 1990, the percent of the population between 0-14 years of age decreased slightly, as did the percentage of 65-84 year olds. A slight increase occurred in the percentage of 45-64 year olds. And in all the years, almost 50% of the population was in the 15-44 age category. Of note, the very old (85 years and older) continues to comprise 1% of Chicago’s population.



Most of Chicago’s community areas experienced a decrease in population between 2000 and 2010. **Map 1** shows the range of population changes by community area. The community areas of Riverdale and Douglas had the largest decreases, of 34% and 31%, respectively. Population increases occurred in the central/business district; the Near South Side increased its population by 125% and the Loop increased by almost 80%.¹

Disabled: In 2009, 10% of Chicago’s population was disabled, according to the U.S. Census American Community Survey. Individuals aged 65 and older had much higher disability rates: 41% in 2009 down from 46% in 2005. A decrease was also noted in the population aged 5 years and older, from 14% in 2005 to 11% in 2009. Disabilities are more common in the Non-Hispanic Black population, with 15% reporting being disabled, compared to 9% for Non-Hispanic Whites, 7% for Hispanics, and 6% for the Non-Hispanic Asian population.² (**Figure 3**)



Education levels: Eighty percent of Chicago’s population has at least a completed their high school education, an 11% increase since 2000. Chicago’s rate is similar to New York City and higher than other Los Angeles, but lower than the rate for Illinois and the U.S. Improvements in educational levels increased among all race/ethnic populations, as seen in **Figure 4**; however disparities

FIGURE 4: PERCENT OF POPULATION WITH AT LEAST A HIGH SCHOOL EDUCATION

	2000	2005	2009
U.S.	80%	84%	85%
ILLINOIS	81%	86%	86%
CHICAGO	72%	78%	80%
NEW YORK	72%	79%	79%
LOS ANGELES	67%	72%	74%

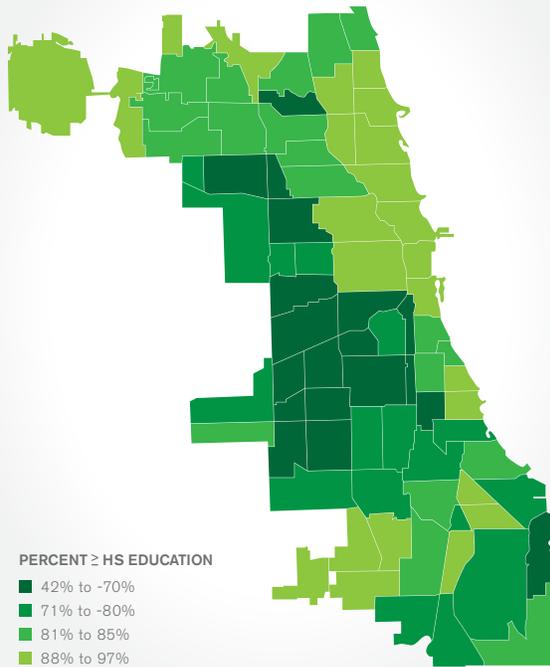
continue to exist among racial/ethnic populations. Hispanics have the lowest percentage of population who has at least a high school education for both 2000 and 2009. However their percentage of high school graduates increased by 22% during this time period, double the percentage increase for all Chicagoans.³ (**Figure 5**)

FIGURE 5: PERCENT OF POPULATION WITH AT LEAST A HIGH SCHOOL EDUCATION, CHICAGO BY RACE/ETHNICITY

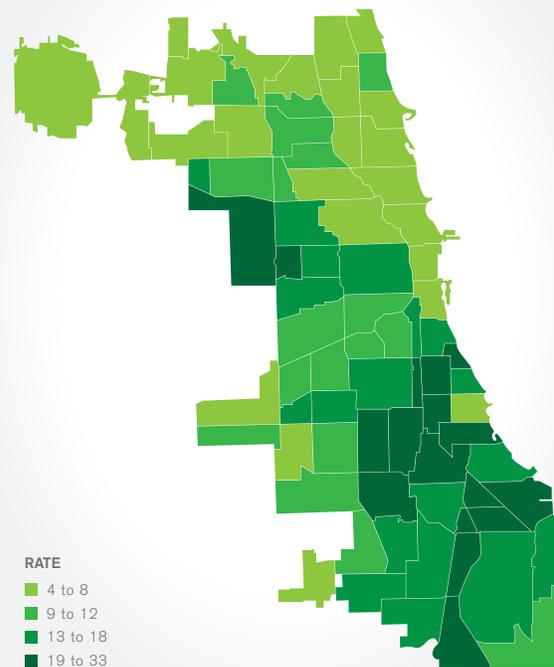
	2000	2009
NON-HISPANIC WHITE	85%	93%
NON-HISPANIC BLACK	71%	81%
HISPANIC	47%	57%
NON-HISPANIC ASIAN	80%	86%

The percentage of population with at least a high school education varies widely throughout our Chicago communities. **Map 2** illustrates the range of this level of educational attainment. Forty-two percent of South Lawndale

MAP 2: PERCENT OF POPULATION WITH AT LEAST A HIGH SCHOOL EDUCATION BY COMMUNITY AREA, 2009



MAP 3: CHICAGO UNEMPLOYMENT RATE BY COMMUNITY AREA, 2009



residents had at least a high school education, the lowest percentage in Chicago. Gage Park had the second lowest rate at 49%. The Loop and Lake View communities had the highest percentage of high school graduates, both with 97%.⁴

was 10%.⁵ This rate was higher than New York City, Los Angeles, Illinois, and the U.S. Among racial/ethnic populations, Non-Hispanic Blacks continue to have much higher rates than other population groups. (Figure 6)

Unemployment*: Chicago’s unemployment rate in 2009 was 13%, an increase from 2000 when unemployment

Map 3 shows the diversity of unemployment rates throughout the city. Englewood has the highest rate, at 32%, while the Loop has the lowest rate, at 4%.

FIGURE 6: UNEMPLOYMENT RATES

	2000	2009
CHICAGO	10%	13%
NON-HISPANIC WHITE	5%	8%
NON-HISPANIC BLACK	18%	21%
HISPANIC	10%	13%
NON-HISPANIC ASIAN	7%	10%

Poverty: In 2009 22% of Chicago’s population was living below the Federal Poverty Level. This percentage is slightly higher than 2000, when the rate was at 20%. Chicago’s rate is slightly higher than New York City, at 19%, and

¹ US Census Bureau: Decennial Census

² US Census Bureau: American Community Survey

³ US Census Bureau: Decennial Census, American Community Survey

⁴ US Census Bureau: Decennial Census, American Community Survey (2005-2009 tabulated by MCIC)

⁵ Ibid.

* Chicago’s rate includes labor force of 16+ years; Community Area rates* includes labor force of 16-<65 years.

much higher than for Illinois and the U.S., at 13% and 14%, respectively. For a family of four, the poverty level is \$22,050 a year.

FIGURE 7: 2009 POVERTY RATES

	OVERALL	< 18	> 65
CHICAGO	22%	31%	18%
NON-HISPANIC WHITE	10%	7%	10%
NON-HISPANIC BLACK	32%	45%	23%
HISPANIC	24%	32%	22%
NON-HISPANIC ASIAN	18%	20%	29%

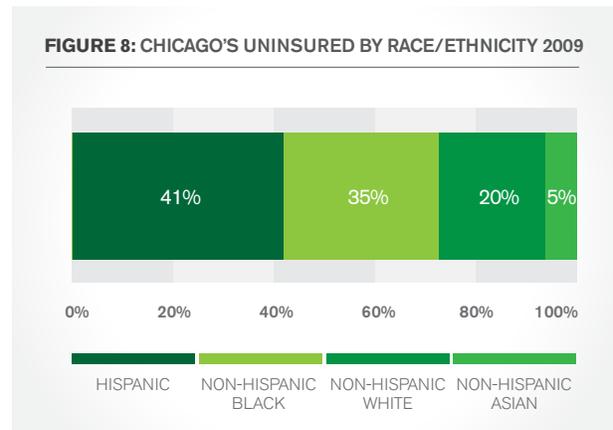
Large disparities in poverty rates exist among racial/ethnic groups. (Figure 7) As shown in graph provided, while Non-Hispanic Whites had an overall poverty rate of 10%, other populations' rates ranged from 80% to 220% higher. Even more stark contrast was seen for those under the age of 18, where the difference among racial/ethnic groups ranged from 185% to over 500% greater than the rate for Non-Hispanic Whites. In both these cases, the Non-Hispanic Black population had the highest rate. The Non-Hispanic Asian population had the highest differential for individuals over age 65 in poverty, when compared to the Non-Hispanic White population.⁶

Chicago's population living at less than 200% of poverty increased, from 40% to 43%.⁷ These statistics are an important measure to consider when assessing the effect of poverty because it includes individuals and families that are working, but at low-wage jobs.

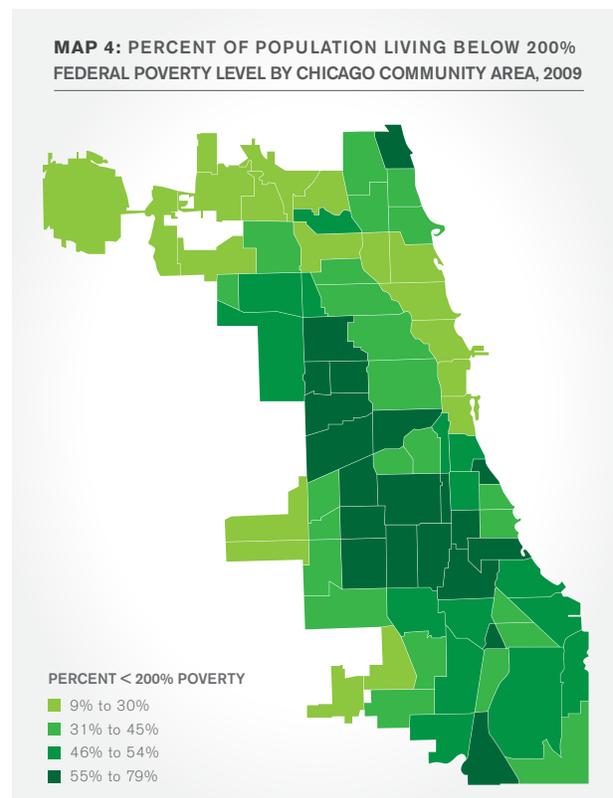
As shown in Map 4, many of Chicago's communities have high percentages of their population living below 200% of poverty. The highest rates were in Riverdale, Washington Park, and West Englewood, at 78%, 74%, and 70%, respectively.⁸

Uninsured: In 2009, over a half a million people, 556,000 (or 20%) of Chicago's population did not have health insurance. Of the uninsured, Hispanics comprise the largest proportion, at 41%, followed by Non-Hispanic Blacks (35%), Non-Hispanic Whites (20%), and Non-Hispanic Asians (5%). (Figure 8) Within racial/ethnic population groups, 29% of Hispanics are uninsured, followed by 21%

FIGURE 8: CHICAGO'S UNINSURED BY RACE/ETHNICITY 2009

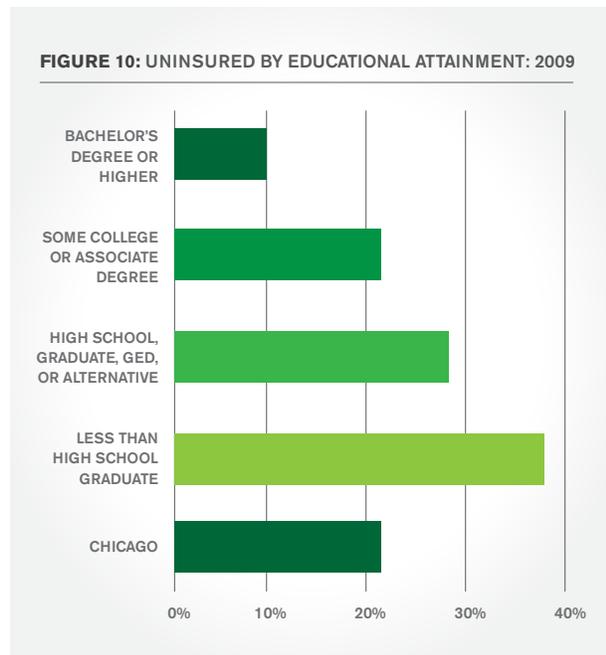
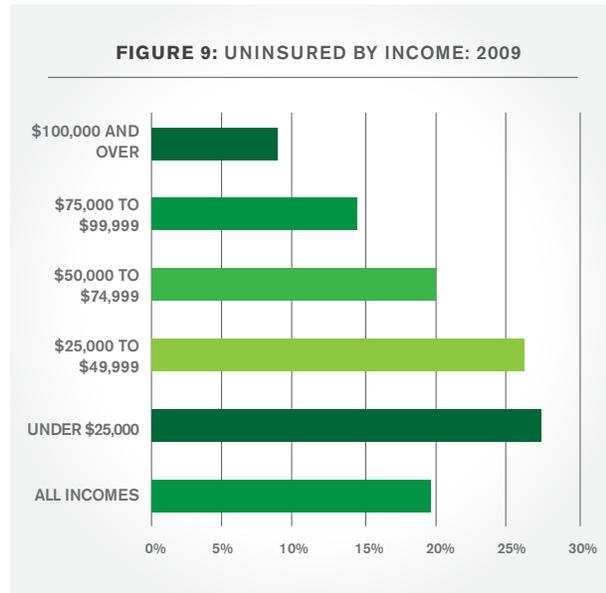


MAP 4: PERCENT OF POPULATION LIVING BELOW 200% FEDERAL POVERTY LEVEL BY CHICAGO COMMUNITY AREA, 2009



of Non-Hispanic Blacks, 19% of Non-Hispanic Asians, and 12% of Non-Hispanic Whites.⁹

Not unexpectedly, data also show that the percentage of uninsured individuals is higher within lower income and lower educational attainment groups. (Figures 9 and 10)



Housing Cost Burden: The percentage of household income spent on housing costs, either monthly owner costs (mortgage, assessment fees, taxes, utilities) or gross rent (rent plus utilities), is another measure of socioeconomic status that reveals communities in need. Affordable housing is considered housing that costs up to 30% of household income.¹⁰ (For this report, housing cost burden was defined as housing that requires 35% or higher percentage of household income.)

In 2009, 33% of owner households in Chicago spent 35% or more of their income on housing costs. This percentage represented a 52% increase since 2000, when 22% of Chicago owner households spent this amount. The percentage of owner households spending 50% or more of their income on housing increased even more, from 11% in 2000 to 19% in 2009, a 66% increase.¹¹

The percentage of rental households that experienced housing cost burden is higher than for owners, with 46% having costs at 35% or more of their income in 2009, an increase from 33% in 2000. Rental households experiencing a severe housing cost burden of 50% or more of their income increased from 21% to 30% during the same time period.¹²

Compared to other large cities, Chicago's percentage is similar or lower than other large cities. For owner housing cost burdened population ($\geq 35\%$), Chicago's percentage (33%) is similar to New York City (34%) but less than Los Angeles (43%) for the population percentage with housing costs at 35% or more of their income. For those owners spending 50% or more of their income on housing costs, Chicago's rate (19%) is lower than New York City (21%) and Los Angeles (26%). When comparing housing cost

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

⁹ US Census Bureau: American Community Survey

¹⁰ <http://www.hud.gov/offices/cpd/affordablehousing/>

¹¹ US Census Bureau: Decennial Census, American Community Survey

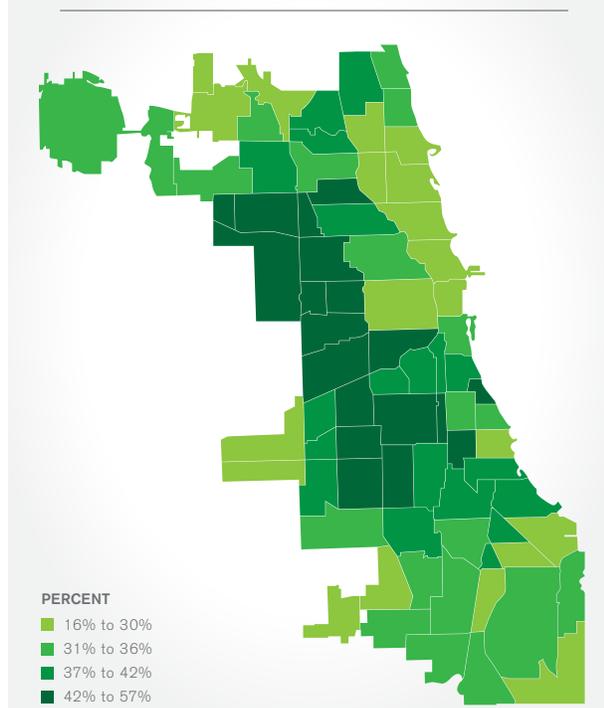
¹² Ibid.

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burden percentages for Illinois and the U.S., however, Chicago ranks higher: $\geq 35\%$ for Illinois at 24% and for the U.S at 23%; $\geq 50\%$ for Illinois at 13% and the U.S. at 12%.

Although owner housing cost burdens vary among locations, percentages of rental households experiencing these burdens are more similar across both the large cities, Illinois and the U.S.

MAP 5: PERCENT OF OWNER OCCUPIED HOUSEHOLDS SPENDING $\geq 35\%$ ON HOUSING COSTS (HOUSING COST BURDEN) BY CHICAGO COMMUNITY AREA, 2009



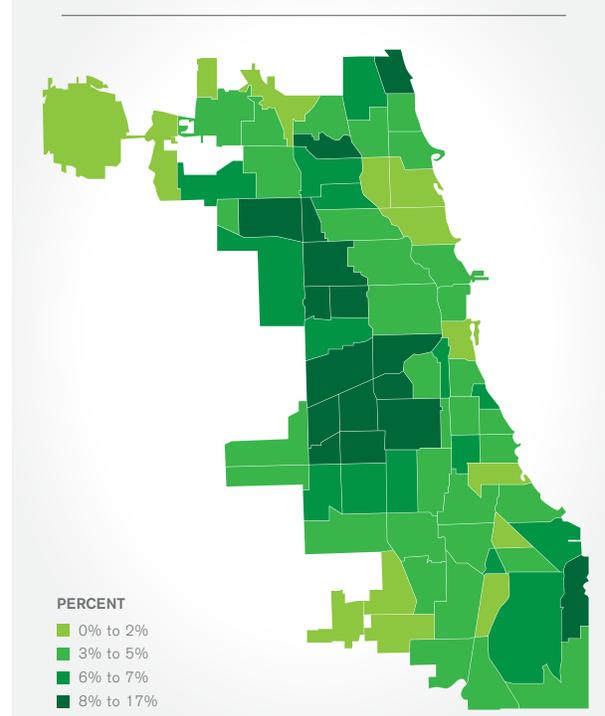
Map 5 indicates the range of housing cost burden impact on Chicago's communities. Humboldt Park had the highest percentage, with 57% of its owner households experiencing a housing cost burden. Other communities that had over 50% of their population with high housing costs compared to their income include: West Garfield Park (55%), Belmont Cragin (52%), and Washington Park (51%). The communities with the lowest percentages of housing cost burden are Mount Greenwood and Beverly, at 16% and 17%, respectively.

Housing Overcrowding: People live in overcrowded housing primarily due to poverty. New immigrants may also live in crowded dwellings, with family and/or friends, to help them become acclimated to their new environment. Dwellings that allow overcrowding are more likely to not be well maintained and contain health hazards, including lead-based paint, rodent infestations, and radon exposure.¹³

One measure of overcrowding is the percent of households that have more than one person per room (including the bedroom, living room, dining room, or kitchen). Chicago's rate of overcrowding decreased from 10% of households with more than one person per room in 2000 to 5% of households in 2009. Chicago's rate is lower than New York City (8%) and Los Angeles (15%), but higher than Illinois and the U.S., both at 3%.

Map 6 shows the range of overcrowding among Chicago's community areas. South Lawndale and Gage Park both

MAP 6: PERCENT OF HOUSING UNITS WITH > 1 PERSON PER ROOM BY CHICAGO COMMUNITY AREA, 2009



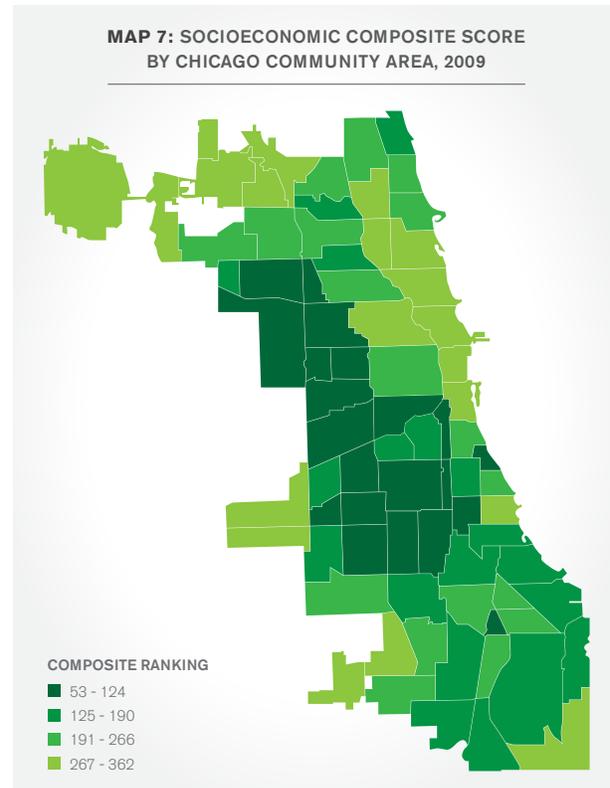
have the highest percentage of overcrowding, at 17% of their household population. On the other spectrum, the following communities have less than 1% overcrowding: Edison Park, North Center, and Beverly.

Socioeconomic Composite Score: These socioeconomic (SES) indicators provide a broad view of the relative need of Chicago's communities. To understand these data collectively, a composite score was developed. The 77 community areas were ranked by the following census data, with the lower ranking (i.e., 1, 2,...) indicating the negative measures and the higher ranking (...76,77) indicating positive measures.

- Percent of population who have at least a high school education
- Percent of population who is unemployed
- Percent of population living below Federal Poverty Level
- Percent of owner households experiencing housing cost burden (spending $\geq 35\%$ of income on housing costs)
- Percent of households living in overcrowded conditions (> one person per room)

All the rankings were added together and the total numbers were ranked. For example, when all West Garfield Park's rankings were added together, the total added up to 53. This total included the percent of West Garfield Park residents that have at least a high school education, which was 73% and ranked 24th out of 77 communities. For the indicators of unemployment, poverty, housing cost burdened households, and overcrowded households, West Garfield ranked 5th, 2nd, 8th, and 14th out of the 77 communities, respectively. This number was the lowest total of all the community areas.

Map 7 illustrates the range of SES composite scores. Along with West Garfield Park, Washington Park and West Englewood were the communities with the lowest scores/ranks. The communities with the highest SES composite scores, i.e., the highest ranks, were Edison Park, Mount Greenwood, and North Center.



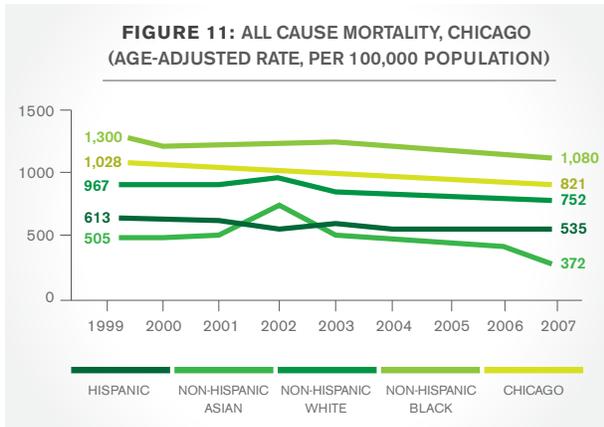
FINDINGS: HEALTH STATUS AND HEALTH BEHAVIORS/PERCEPTIONS

Health Status and Health Behaviors/Perceptions

In 2007, 19,824 deaths occurred in Chicago for an age-adjusted all-cause mortality rate of 821 per 100,000 population. (Figure 11) As compared to 1999, the number of deaths decreased by 21% and the all-cause mortality rate decreased by 21%. With a rate of 1080 per 100,000 population, Non-Hispanic Blacks had the highest rate among all racial/ethnic groups: 44% higher than the Non-Hispanic White rate, over 100% higher than Hispanics and almost 200% higher than Non-Hispanic Asians.

Heart disease, cancer, and stroke accounted for the first, second, and third most common causes of death in 2007

¹³ The Social Determinants of Health: Housing as a Determinant of Health. Public Health Agency of Canada. http://www.phac-aspc.gc.ca/ph-sp/oi-ar/09_housing-eng.php



for Chicago, Illinois, and the U.S. When analyzing data by racial/ethnic groups, however, some variation emerged. The Hispanic population's third most common cause of death was accidents; which ranked fourth for Non-Hispanic Blacks, fifth for Non-Hispanic Whites, and eight for Non-Hispanic Asians. Homicide ranking also varied among these populations: sixth for both Non-Hispanic Blacks and Hispanics but not in the ten leading causes for either Non-Hispanic Whites or Non-Hispanic Asians. (Figure 12)

FIGURE 12: LEADING CAUSES OF DEATH (BY NUMBER) 2007 BY RACE/ETHNICITY

	CHICAGO	NON-HISPANIC WHITE	NON-HISPANIC BLACK	HISPANIC	NON-HISPANIC ASIAN
1	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Cancer
2	Cancer	Cancer	Cancer	Cancer	Heart Disease
3	Stroke	Stroke	Stroke	Accidents	Stroke
4	Accidents	Chronic Lower Respiratory Disease	Accidents	Stroke	Diabetes
5	Diabetes	Accidents	Diabetes	Diabetes	Nephritis
6	Chronic Lower Respiratory Disease	Influenza & Pneumonia	Homicide	Homicide	Influenza & Pneumonia
7	Septicemia	Septicemia	Septicemia	Liver Disease & Cirrhosis	Chronic Lower Respiratory Disease
8	Influenza & Pneumonia	Diabetes	Nephritis	Septicemia	Accidents
9	Nephritis	Nephritis	Chronic Lower Respiratory Disease	Perinatal Period Conditions	Septicemia
10	Homicide	Alzheimer's Disease	Influenza & Pneumonia	Nephritis	Hypertension

Heart Disease and Stroke: As in 1999, heart disease and stroke were the number one and number three causes of death for Chicagoans, although their percentage of all deaths decreased from 37% in 1999 to 33% in 2007.

Coronary heart disease mortality rates declined steadily, from 264 to 169 per 100,000 population, or 36%.¹⁴ Decreases were seen in all racial/ethnic groups, with Non-Hispanic Asians showing the lowest rate, while Non-Hispanic Blacks had the highest rate. (Figure 13)

Stroke mortality rates decreased by 22% for all Chicagoans, from 60 per 100,000 population to 47. Decreases occurred in all racial/ethnic groups except for the Hispanic

FIGURE 13: CORONARY HEART DISEASE MORTALITY RATES (AGE-ADJUSTED) PER 100,000 POPULATION, CHICAGO RESIDENTS,

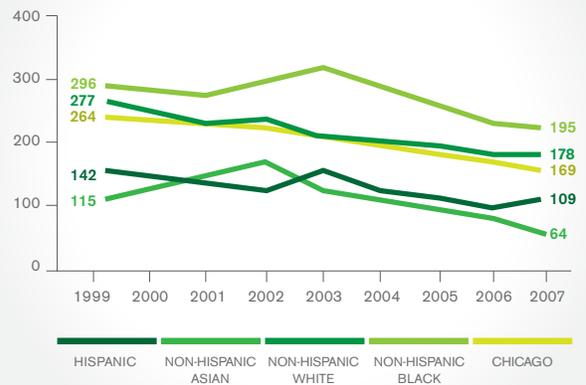
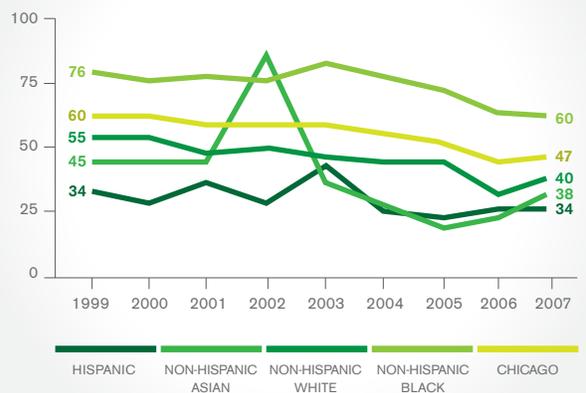


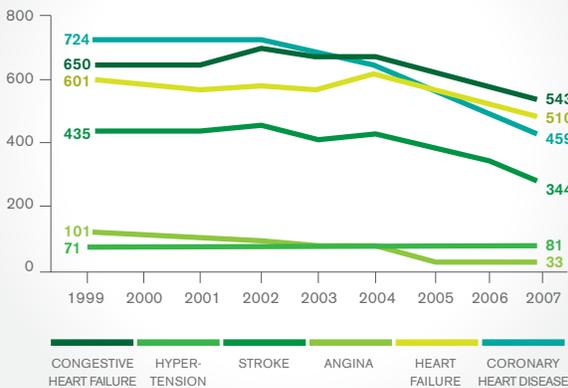
FIGURE 14: STROKE MORTALITY RATES (AGE-ADJUSTED) PER 100,000 POPULATION, CHICAGO RESIDENTS



population, where stroke mortality increased from 34 per 100,000 population to 38. (Figure 14)

Hospital discharge rates, which report the frequency of hospitalizations by diagnoses, decreased for most heart disease and related conditions between the period of 1999 and 2007, as shown in Figure 15. Coronary heart disease showed the steepest decline, of 37%. Hypertension was the only condition in this group that showed an increase in hospital discharges, at 14%.

FIGURE 15: HOSPITAL DISCHARGE RATES (AGE-ADJUSTED) FOR CARDIOVASCULAR-RELATED AMBULATORY CARE-SENSITIVE CONDITIONS PER 100,000 POPULATION, CHICAGO RESIDENTS



As illustrated in Map 8, hospitalizations for coronary heart disease were seen at a higher rates in various communities in the northwest, west, and southwest, as well as the south and far south.

Diabetes

Diabetes is the fifth leading cause of death for Chicago, as well as for Non-Hispanic Blacks and Hispanics. Diabetes ranked as the fourth leading cause of death for Non-Hispanic Asians and eighth for Non-Hispanic Whites.

As noted in Figure 16, mortality rates show some variation throughout the years, with rates decreasing by 16% for all Chicagoans. Non-Hispanic Blacks have the highest mortality

MAP 8: CORONARY HEART DISEASE HOSPITALIZATIONS BY CHICAGO ZIP CODES, 2007

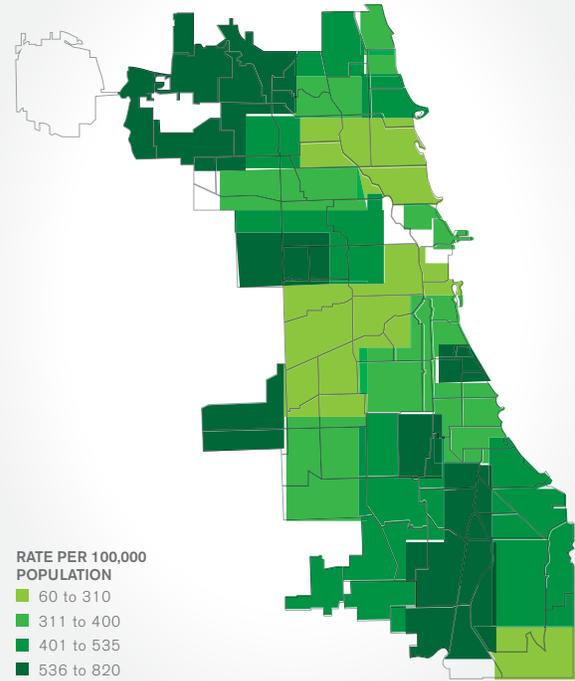
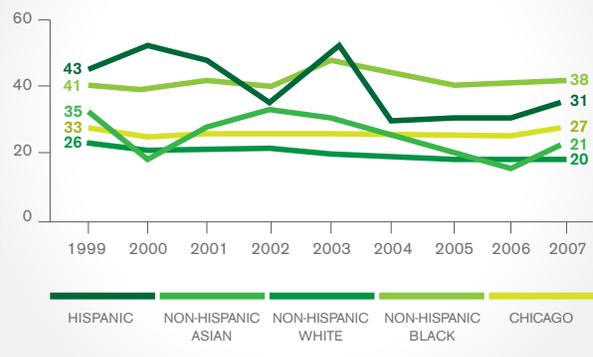


FIGURE 16: DIABETES MORTALITY RATES (AGE-ADJUSTED) PER 100,000 POPULATION, CHICAGO RESIDENTS



rate, at 38 per 100,000 population.¹⁵ While diabetes mortality has decreased, hospitalizations show a variety of patterns. (Figure 17) Uncontrolled diabetes decreased by 34%.

¹⁴ Illinois Department of Public Health Division of Vital Records; US Census Bureau: Decennial Census, American Community Survey

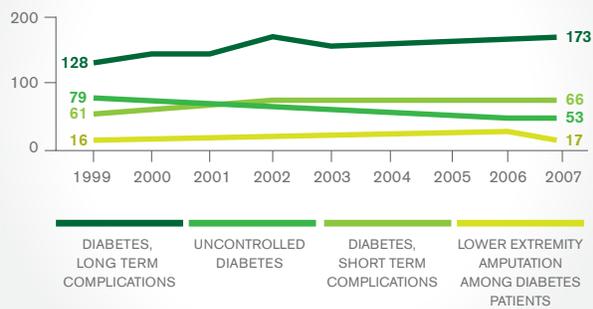
¹⁵ Ibid.

3.1

COMMUNITY HEALTH ASSESSMENT

Community Health Status

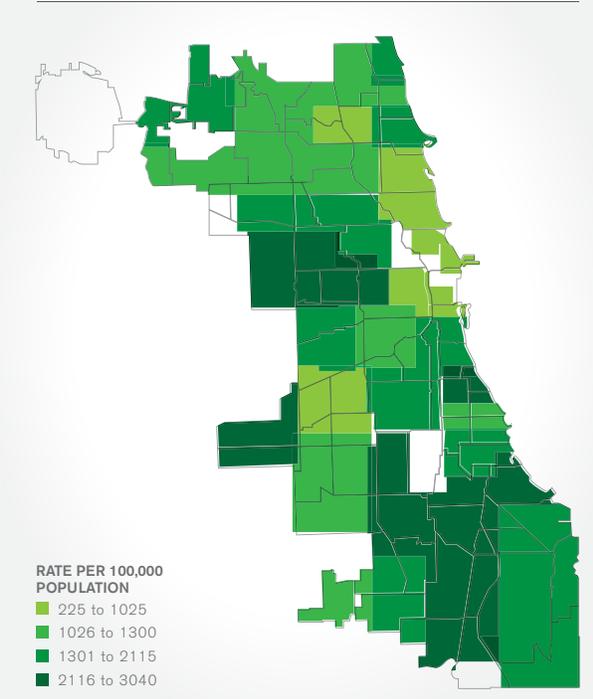
FIGURE 17: HOSPITAL DISCHARGE RATES FOR DIABETES-RELATED AMBULATORY CARE-SENSITIVE CONDITIONS PER 100,000 POPULATION, CHICAGO RESIDENTS



However hospitalization rates increased for both short-term and long-term complications, by 8% and 35%, respectively. Lower extremity amputations hospitalization rates stayed the same.

Map 9 shows geographically the range of uncontrolled diabetes hospitalization rates, with the highest rates occurring in the far south and west.

MAP 9: DIABETES HOSPITALIZATIONS BY CHICAGO ZIP CODES, 2007



In 2000, 5% of Chicago's adult population reported they had been told they have diabetes; in 2009, this percentage was 10%, a 100% increase.¹⁶ Large increases occurred in specific groups: adults aged 25-44 year old (increased 350% to 6%), adults over 65 years of age (increased 170% to 22%), and individuals with incomes less than \$15,000 (increased 40% to 19%).

Cancer: As the second most common cause of death, cancer affects all populations. However, disparities among racial/ethnic groups put some groups at higher risk. (Figure 18) Non-Hispanic Blacks have the highest cancer mortality

FIGURE 18: CANCER MORTALITY RATES (AGE-ADJUSTED) PER 100,000 POPULATION, CHICAGO RESIDENTS

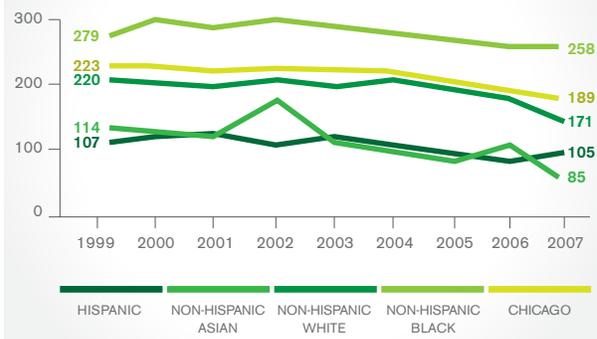
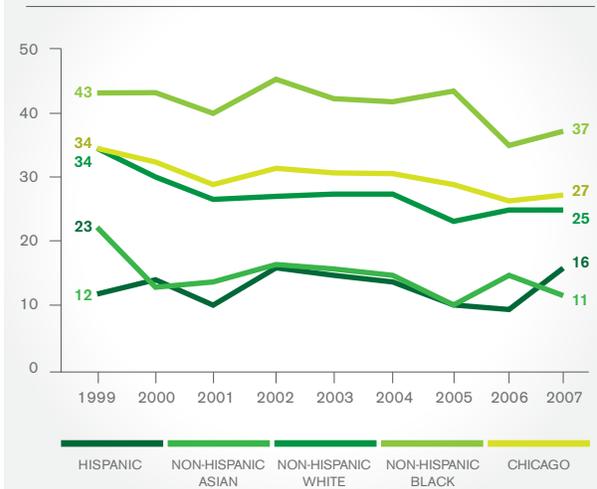
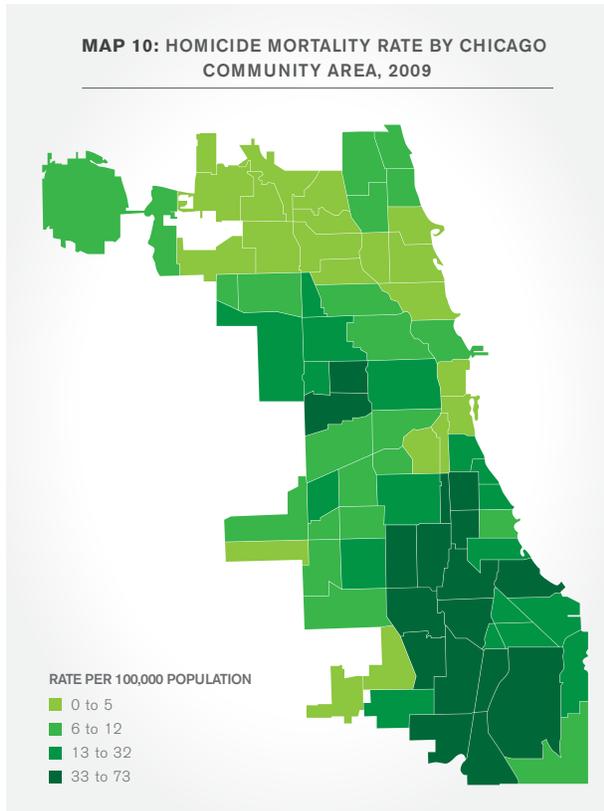


FIGURE 19: BREAST CANCER MORTALITY RATES (AGE-ADJUSTED) PER 100,000 POPULATION, CHICAGO RESIDENTS





Map 10 shows the range of homicide mortality by community areas. The highest rates are seen in Fuller Park, Riverdale, North Lawndale, Greater Grand Crossing, and Englewood.

Between 2001 and 2009, self-reported youth violent behaviors indicate both positive and negative changes.¹⁸ In 2009, 9% of high school students (grade 9-12) indicated they had been “physically forced to have sexual intercourse” when they did not want to, a 13% decrease from the percentage that reported force in 2001. In 2009, all racial/ethnic groups reported a similar percentage, which represents a 40% decrease for the Non-Hispanic Black population, but a 26% increase for Hispanics and 13% increase for Non-Hispanic Whites.

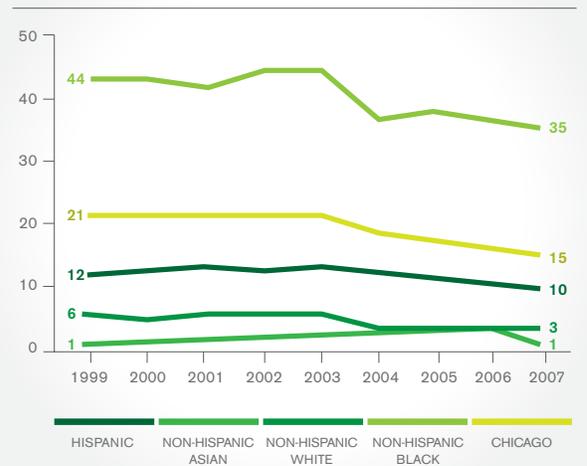
Slight improvements also occurred in the percentage of youth who carried a weapon on at least one day during the prior 30 days, from 21% in 2001 to 18% in 2009. Non-Hispanic Blacks have the highest percentage, with 20% reporting carrying a weapon, compared to 18% of Hispanics and 11% of Non-Hispanic White youth.

rate, at 258 per 100,000 population in 2007, 51% higher than the Non-Hispanic White population.

Breast cancer mortality data exhibit similar disparities. (Figure 19) Although Non-Hispanic Black breast cancer mortality decreased by 14% between 1999 and 2007, it still is 48% higher than Non-Hispanic Whites, 131% higher than Hispanics, and 236% higher than Non-Hispanic Asians.

Violence: Homicide was the tenth leading cause of death in 2007, accounting for 439 deaths and a rate of 15 per 100,000 population. These data represent a decrease since 1999 from 638 deaths and a mortality rate of 21. Decreases occurred in rates of racial/ethnic populations, however, significant disparities are evident. (Figure 20) Non-Hispanic Blacks had a rate of 35 homicides per 100,000 in 2007 compared to Hispanics (10), Non-Hispanic Whites (3), and Non-Hispanic Asians (1).¹⁷

FIGURE 20: ASSAULT MORTALITY (HOMICIDE) RATES (AGE-ADJUSTED) PER 100,000 POPULATION, CHICAGO RESIDENTS



¹⁶ Illinois Department of Public Health Behavioral Risk Factor Surveillance Survey

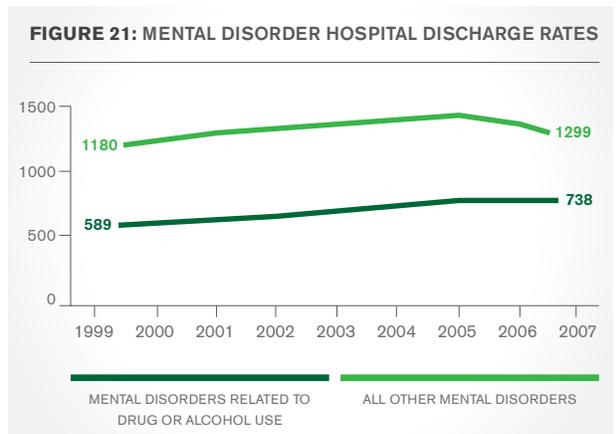
¹⁷ Illinois Department of Public Health Division of Vital Records, US Census Bureau: Decennial Census, American Community Survey

¹⁸ Centers for Disease Control and Prevention: Youth Risk Behavior Surveillance System

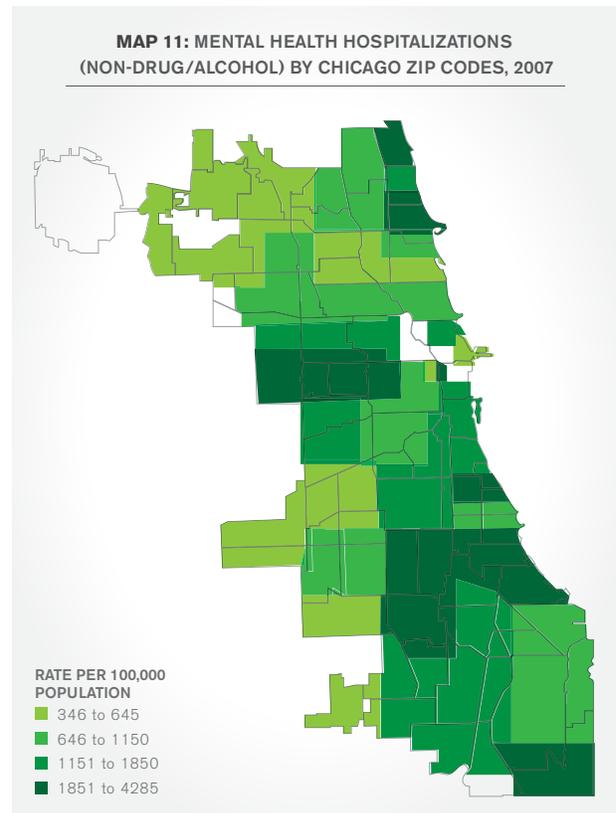
Forty-two percent of youth reported they had been in a physical fight one or more times during the past 30 days, similar to the percentage in 2001. Males had higher percentages of this behavior, at 47%, compared to 36% for females. Forty-eight percent of Non-Hispanic Blacks reported being in fights, which was higher than Hispanics and Non-Hispanic Whites, at 35% and 34%, respectively.

The percentage of youth who were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend increased between 2001 and 2009, from 11% to 19%. Non-Hispanic Blacks reported a higher percentage at 21% compared to Non-Hispanic Whites at 15% and Hispanics at 14%.

Mental Health: Acute mental illness accounted for 12% of all 2010 inpatient hospital days in Illinois.¹⁹ Between 1999 and 2007, the number of hospital discharges with the diagnosis of mental health (non-drug or alcohol related) increased by 10%. Hospitalizations for mental health (drug or alcohol related) also increased, by 25%, during this same time period.²⁰ (Figure 21)



Map 11 shows the variation in rates of mental health hospitalizations throughout Chicago. Data, by zip code, show that communities in the far north, west, south, and far south had the highest rates of mental health hospitalizations. Areas with the highest rates of mental health hospitalization may indicate locations with limited access to ambulatory care.

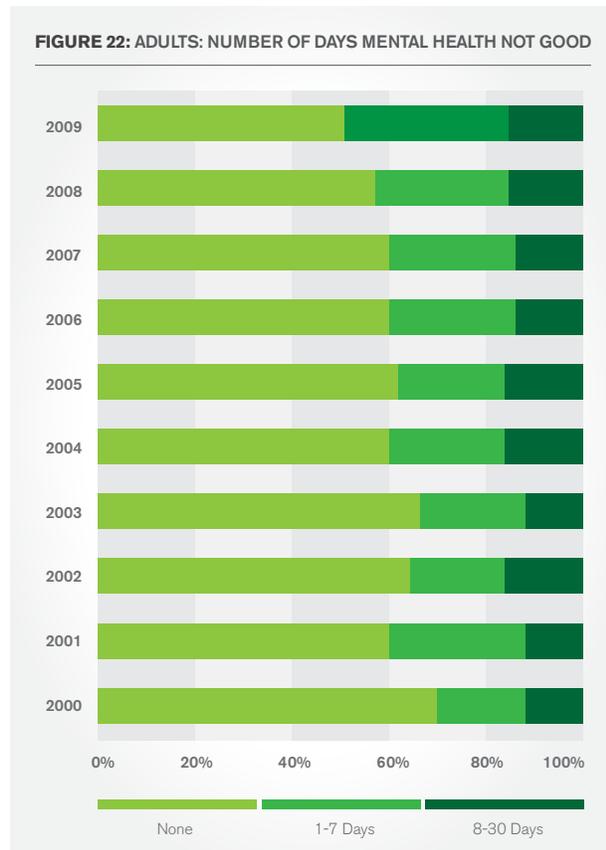


The status of individuals’ mental health affects their quality of life, their health behaviors, as well as their physical health. Data indicate that, in comparison to 2000, a higher percentage of Chicago’s adult population in 2009 had more days when “their mental health was not good.” (Figure 22) In 2000, 68% of adults reported that there were no days within the last 30 days when their mental health was not good. In 2009, this percentage decreased to 55%. Correspondingly, the percent who indicated their mental health was not good for 1-7 days increased from 21% to 29% and those who said their mental health was not good for 8-30 days increased from 11% to 16%.²¹

Population subgroups reported different frequencies of poor mental health (mental health not good for 8-30 days). For example, 30% of adults who had less than a high school education reported poor mental health, compared to 22% of high school graduates and 12% of people who had

some college or had a college degree. Females reported at a higher level also, at 21% compared to 11% for males. Among racial groups, 22% of Blacks indicated their mental health was not good for 8-30 days, while White adults reported at 13%. Among ethnic groups, Hispanics reported lower rates of indicating their mental health was not good (12%) compared to Non-Hispanics (18%).

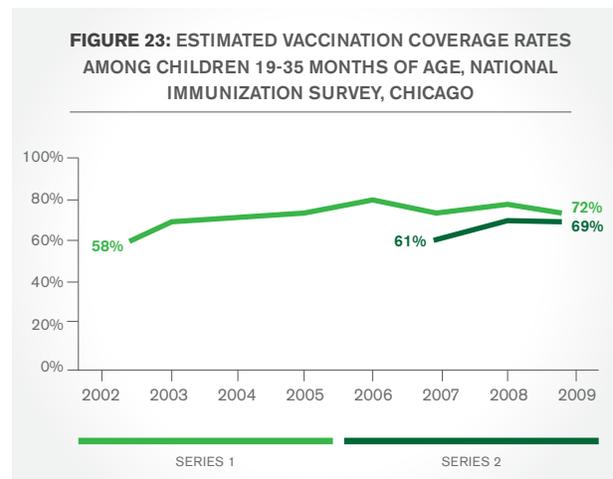
Data on youth mental status is collected by self-reported answers to survey questions. When asked if they “felt sad or hopeless,” 31% of Chicago youth reported these feelings in 2009. This percentage was slightly lower than the response in 2001 when 34% responded yes to this question. Females had higher percentages of feeling sad or hopeless, at 37% compared to 25% of males. Hispanic and Non-Hispanic Black youth reported percentages of 34% and 30%, respectively, compared to Non-Hispanic White youth at 23%.



Thirteen percent of Chicago youth indicated that they had attempted “suicide one or more times” in the 12 months prior to the survey, similar to the 2001 percentage of 12%. Rates by racial/ethnic populations were similar.

**Communicable disease control and prevention
Immunization and Vaccine Preventable Diseases**

Immunization coverage: An important measure of prevention is the vaccination coverage rate for children 19-35 months of age. In Chicago, the rate shows a steady 24% increase, from 58% in 2002 to 72% in 2009 for the 4:3:1:3:3:1 series of immunizations for: diphtheria, tetanus, pertussis, poliovirus, measles, Haemophilus influenza Type B, hepatitis B, and varicella (Series 1).²² (Figure 23)

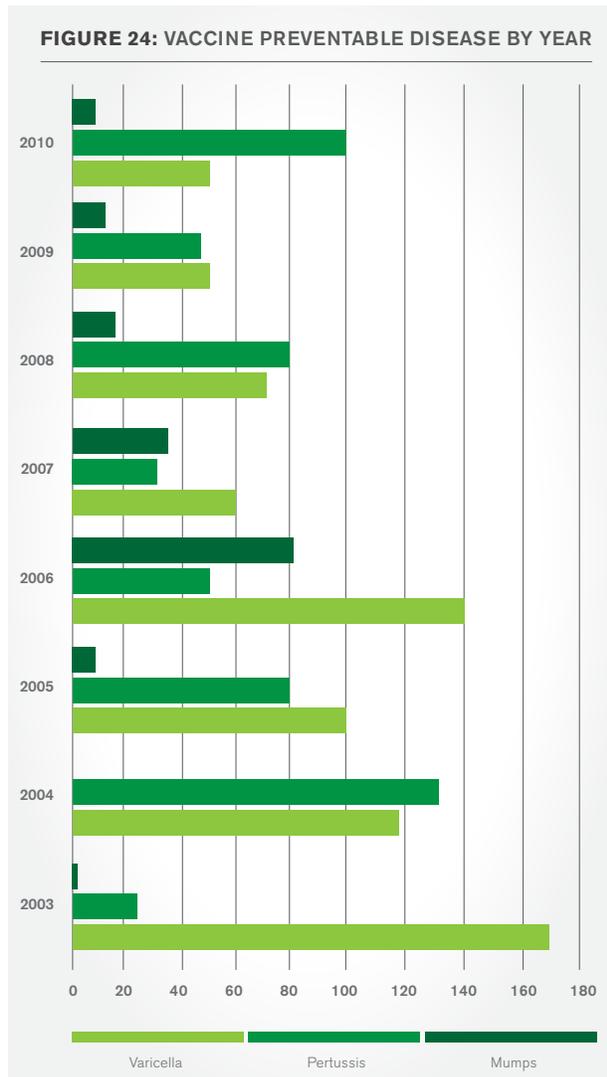


In 2007, pneumococcal conjugate vaccine was added to the recommended series. Since that time, immunization rates for this new series increased by 13% (Series 2).

Mumps, Pertussis, and Varicella: The number of cases of mumps, pertussis, and varicella vary each year, dependent upon exposures, adherence to immunization requirements,

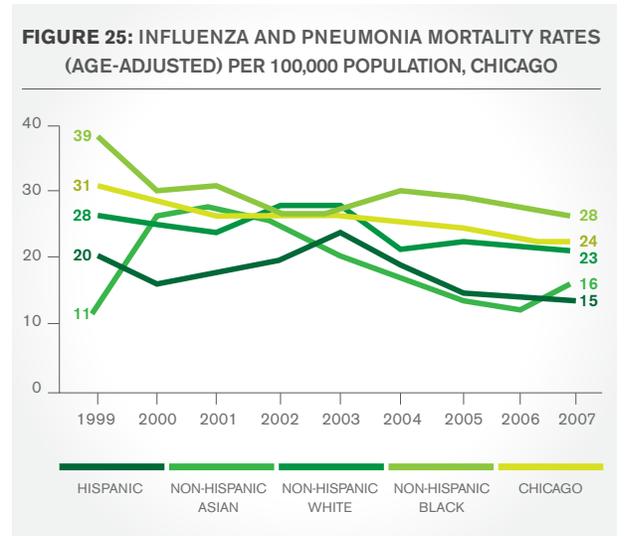
¹⁹ Illinois Health Facilities and Services Review Board, State Hospital Data Summary 2010 <http://www.hfsrb.illinois.gov/pdf/2010%20Hospital%20State%20Summary.pdf>
²⁰ Illinois Department of Public Health, Hospital Discharge Dataset
²¹ Illinois Department of Public Health: Behavioral Risk Factor Surveillance System
²² National Immunization Survey (conducted by the National Center for Immunizations and Respiratory Diseases and the National Center for Health Statistics, Center for Disease Control and Prevention)

and the cyclical nature of each disease. As noted in **Figure 24**, the number of cases of varicella has decreased, from 170 in 2003 to 59 in 2010. Pertussis cases numbered more in 2010, at 98 compared to 20 in 2003. Mumps cases peaked in 2006, due to an outbreak, but returned to a low incidence in 2010.

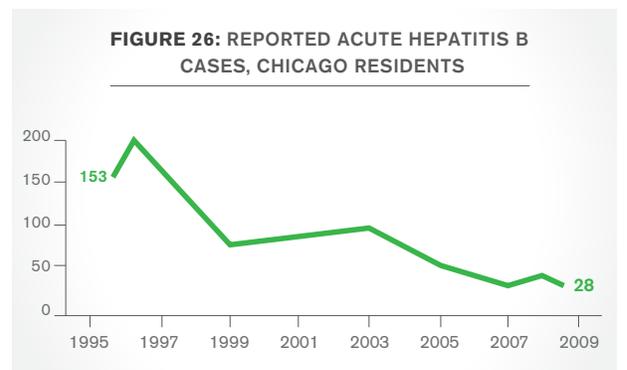


Influenza and pneumonia: Although vaccines exist to lessen their severity, influenza and pneumonia continue to be in the top ten causes of death in Chicago (eighth leading cause of death in 2007).²³ Mortality rates decreased during

this time period, by 23% for Chicago and by 28% for Non-Hispanic Blacks, who had the highest mortality rate. (**Figure 25**) In contrast to other populations, mortality rates Non-Hispanic Asians increased.

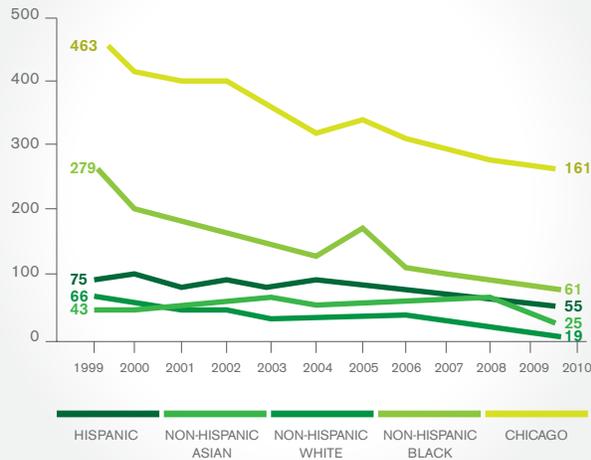


Hepatitis B: Since 1995, the number of reported cases of Hepatitis B has undergone a steep decline, from 153 to 28 in 2009, or by 82%. (**Figure 26**)



Tuberculosis: Between 1999 and 2010, the number of tuberculosis (TB) cases decreased 65% to the lowest number ever recorded in Chicago, from 463 to 161.²⁴ When analyzing these data by race and ethnicity, the majority of change occurred within the Non-Hispanic Black population, whose rates decreased by 78% between 1999 and 2010. (**Figure 27**)

FIGURE 27: REPORTED TUBERCULOSIS CASES BY RACE/ETHNICITY, CHICAGO RESIDENTS



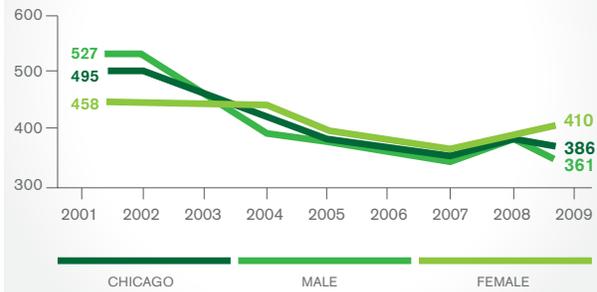
When analyzing TB data by place of birth, improvements are noted within the U.S. born population, for which the number of cases decreased by 79%. Although a slight decrease in cases occurred in the foreign born population, they now represent a higher percentage of all TB cases, from 24% in 1999 to 57% in 2010. (Figure 28)

No geographic data are presented due to the small number of cases by community area.

FIGURE 28: REPORTED TB CASES BY PLACE OF BIRTH, CHICAGO RESIDENTS



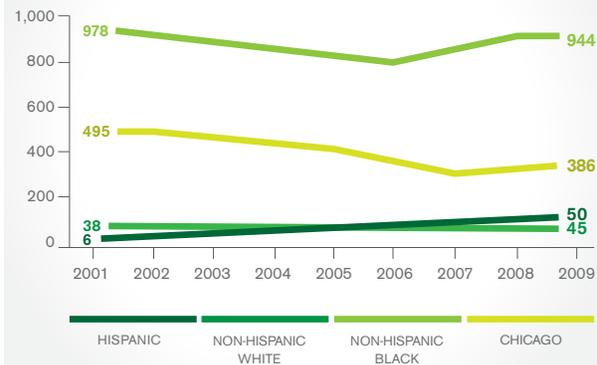
FIGURE 29: GONORRHEA INFECTION RATES PER 100,000 POPULATION, CHICAGO RESIDENTS



Sexually Transmitted Infections

Gonorrhea: Gonorrhea infection rates decreased by 22% between 2001 and 2009.²⁵ As noted in Figure 29, males initially had a higher rate, however, in 2009 females had the higher rate. When analyzing data by race/ethnicity, Non-Hispanic Blacks have much higher rates, almost 2000% higher than Non-Hispanic Whites. (Figure 30)

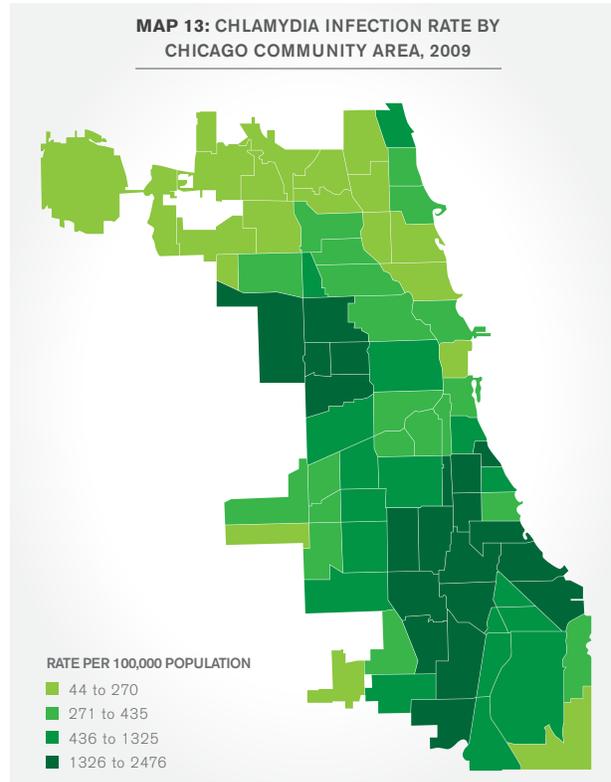
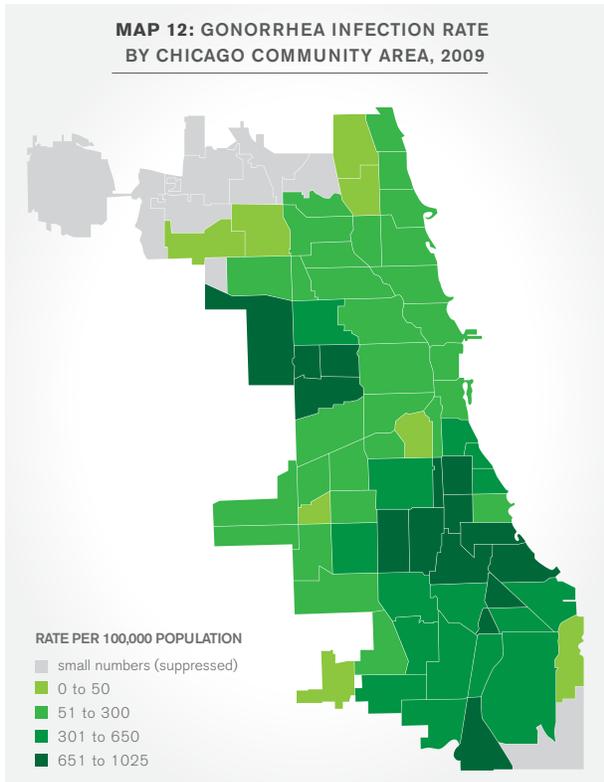
FIGURE 30: GONORRHEA INFECTION RATES PER 100,000 BY RACE/ETHNICITY, CHICAGO RESIDENTS



²³ Illinois Department of Public Health Division of Vital Records, US Census Bureau: Decennial Census, American Community Survey

²⁴ Chicago Department of Public Health Tuberculosis Control Program

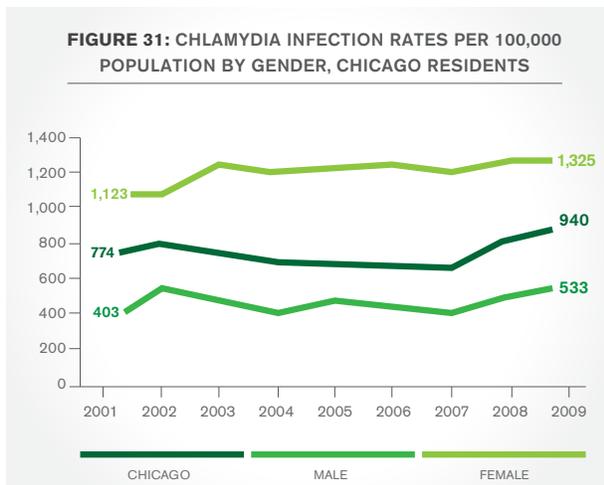
²⁵ Chicago Department of Public Health STI Surveillance Program



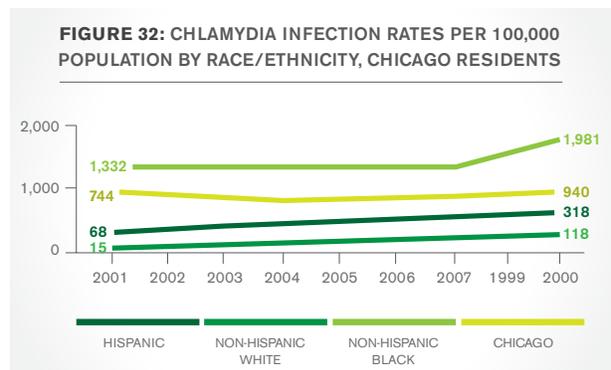
Map 12 shows the rates of gonorrhea infections throughout Chicago. Washington Park and Englewood had the highest rates of gonorrhea, at over 1000 per 100,000 population.

Chlamydia: The rate of chlamydia, the most commonly reported sexually transmitted infection, increased by 21%

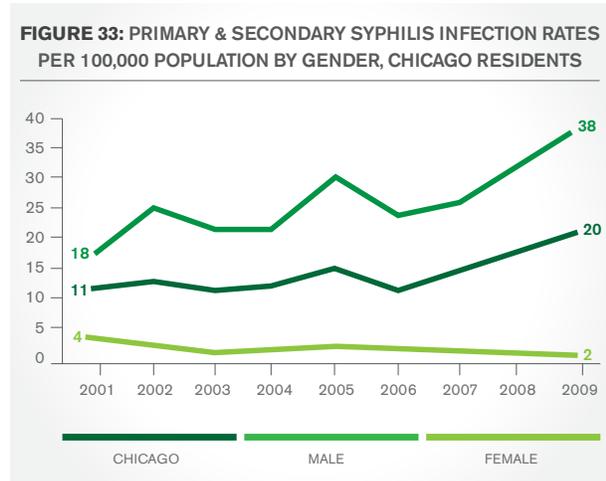
between 2001 and 2009.²⁶ Similar patterns were noted for both males and females; however females continue to have much higher infection rates, at almost 150% higher than males. (**Figure 31**) These patterns are consistent with national data.



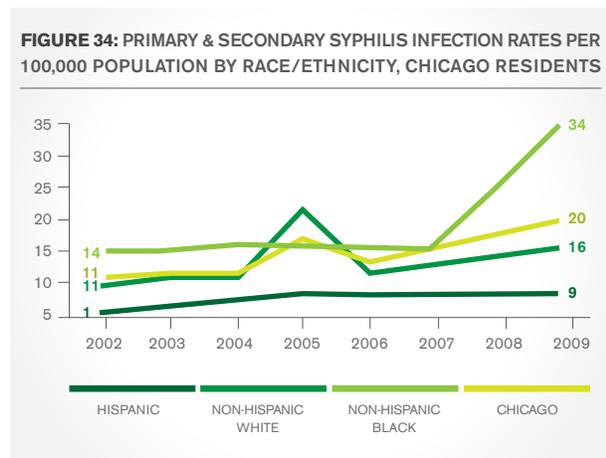
Non-Hispanic Blacks had higher rates of chlamydial infection than other racial or ethnic population: Over 500% higher than Hispanics and over 1500% than Non-Hispanic Whites. (**Figure 32**)



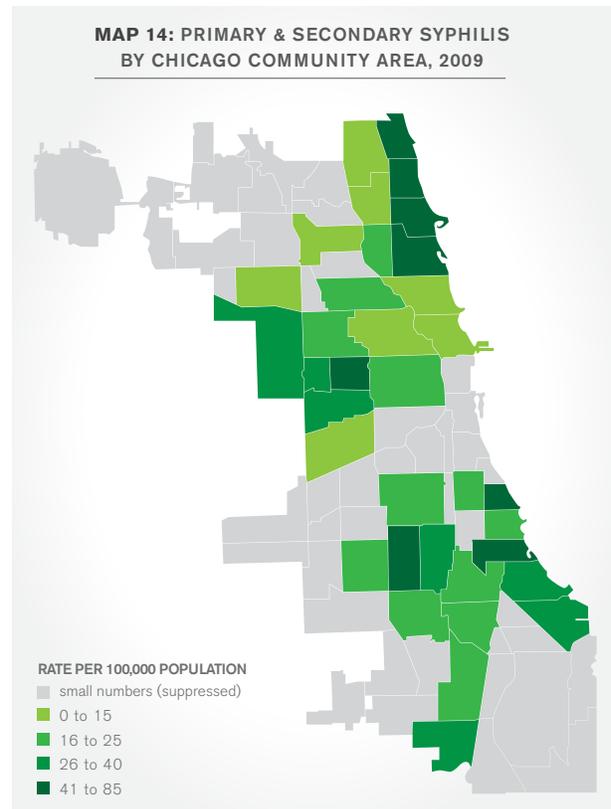
Map 13 illustrates the rate of chlamydial infections, with the highest rates in the communities of North Lawndale and West Garfield Park.



Primary and Secondary Syphilis: Primary and secondary syphilis rates increased by 81% in Chicago between 2001 and 2009.²⁷ This increase was seen in the male population, whose rate increased by over 100%. In contrast, primary and secondary syphilis rates decreased in the female population by 50%. (Figure 33)



Primary and secondary syphilis data by race and ethnicity show that Non-Hispanic Blacks and Non-Hispanic Whites had similar rates from 2001 through 2007. However, the rate



for Non-Hispanic Blacks rose from 15 per 100,000 in 2007 to 34 per 100,000 population in 2009. The Non-Hispanic Black rate is now over 100% higher than the rate for Non-Hispanic Whites and over 275% higher than the Hispanic rate. (Figure 34)

Map 14 shows the concentration of primary and secondary syphilis. Edgewater and Uptown had the highest rates in 2009, at 83 and 67 per 100,000 population, respectively.

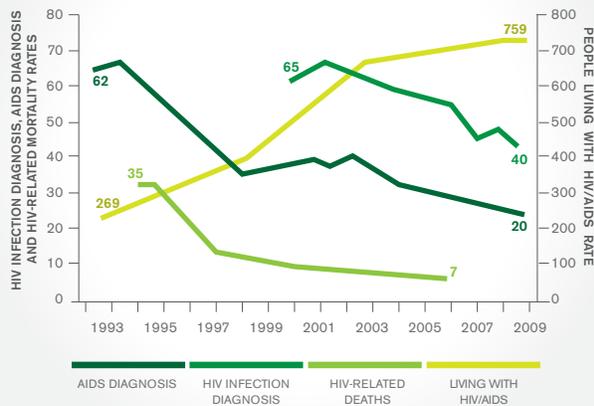
HIV/AIDS

HIV and AIDS Infections: The rate of HIV and AIDS diagnoses each year is continuing to decrease. In 2009, Chicago’s HIV infection rate was 40 per 100,000 population, a

²⁶ Ibid.

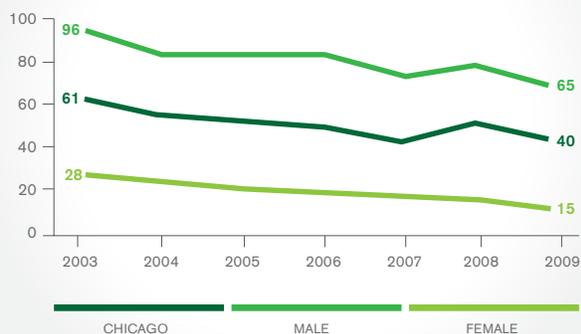
²⁷ Ibid.

FIGURE 35: HIV INFECTION DIAGNOSIS, AIDS DIAGNOSIS, HIV-RELATED MORTALITY AND PEOPLE LIVING WITH HIV/AIDS RATES PER 100,000 POPULATION, CHICAGO RESIDENTS



39% decrease since 2000 when the rate was 65 per 100,000. AIDS diagnoses decreased by 41% since 2000, from 34 to 20 per 100,000, and by 68% since 1992. Deaths related to HIV or AIDS have also decreased. In 1994, Chicago’s death rate from AIDS was at 35 per 100,000 population. In 2007, AIDS mortality rate decreased by 80% to a rate of 7 per 100,000 population. With the decrease in HIV/AIDS deaths, more people are living with the disease, as indicated by the 182% increase in the rate of people living with HIV/AIDS since 1992.²⁸ (Figure 35)

FIGURE 36: HIV INFECTION DIAGNOSIS RATES PER 100,000 POPULATION BY YEAR OF DIAGNOSIS AND GENDER, CHICAGO RESIDENTS



HIV infection: HIV infection diagnoses rates decreased for all genders and racial/ethnic groups between 2003 and 2009.²⁹ During this time period, the male HIV infection rate decreased by 32% and the female rate decreased by 45%. Males continue to have higher rates of HIV diagnoses—over 300% higher than females. (Figure 36)

Non-Hispanic Blacks consistently have higher HIV infection rates than other racial/ethnic populations, which was over 175% higher than infection rates for Non-Hispanic Whites and Hispanics in 2009. The largest decline in rates occurred for the Non-Hispanic White population, at 46%, compared to 32% for Hispanics and 30% for Non-Hispanic Blacks. (Figure 37)

Map 15 shows the geographic ranges in HIV infection rates. The two highest infection rates are in communities on opposite ends of Chicago: Edgewater and Greater Grand Crossing, at 99 and 92 per 100,000 population, respectively.

MAP 15: HIV INFECTION RATES BY CHICAGO COMMUNITY AREA, 2009

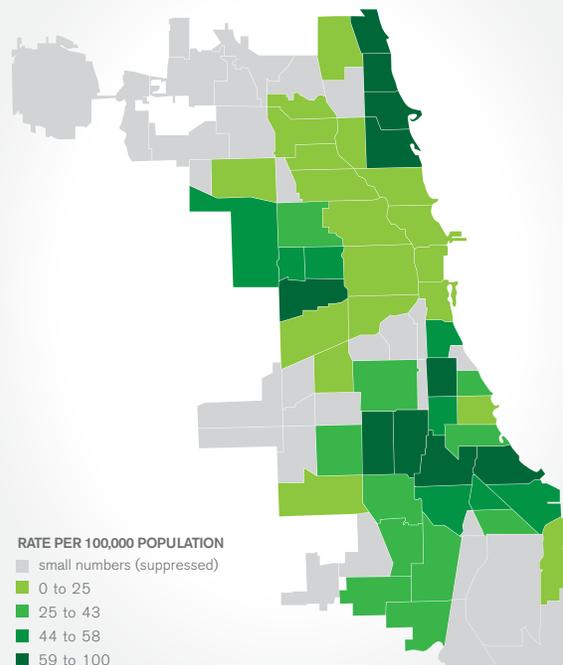
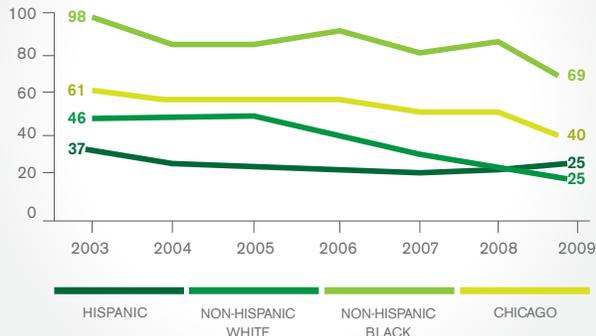
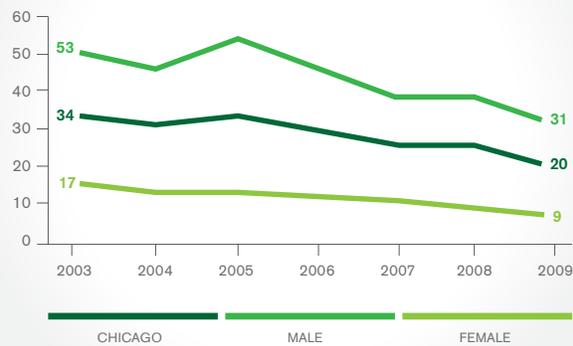


FIGURE 37: HIV INFECTION DIAGNOSIS RATES PER 100,000 POPULATION BY YEAR OF DIAGNOSIS AND RACE/ETHNICITY CHICAGO RESIDENTS



AIDS Diagnoses: Since 2003, AIDS diagnosis rates decreased for both genders by approximately 40%. However, the rate of male AIDS diagnoses is over 200% higher than females, at 31 per 100,000 population compared to 9 in 2009.³⁰ (Figure 38)

FIGURE 38: AIDS DIAGNOSIS RATES PER 100,000 POPULATION BY YEAR OF DIAGNOSIS AND GENDER, CHICAGO RESIDENTS



AIDS diagnoses rates also decreased for each racial and ethnic population. Non-Hispanic Blacks have the highest rates, at 45 per 100,000 population, compared to Hispanics and Non-Hispanic Whites, at rates of 16 and 12 per 100,000 population. (Figure 39)

Map 16 illustrates the range of AIDS diagnoses rates throughout Chicago. Calumet Heights and East Garfield

Park have the highest rates of AIDS diagnoses, at 65 and 54 per 100,000 population.

MAP 16: AIDS DIAGNOSES RATES BY CHICAGO COMMUNITY AREA, 2009

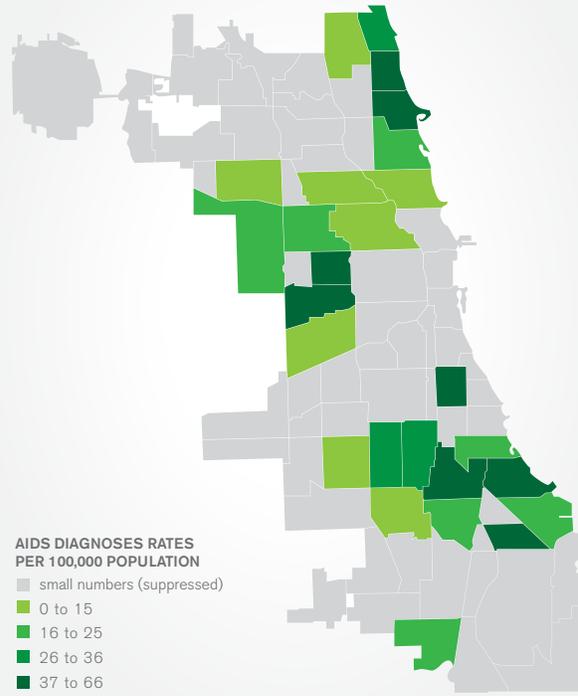
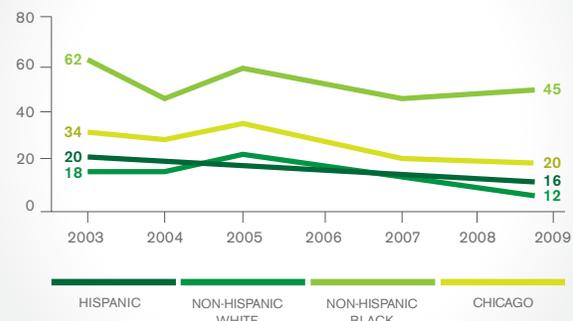


FIGURE 39: AIDS DIAGNOSIS RATES PER 100,000 POPULATION BY YEAR OF DIAGNOSIS AND RACE/ETHNICITY CHICAGO RESIDENTS



²⁸ Chicago Department of Public Health STI/HIV Surveillance Program, US Census Bureau: Decennial Census, American Community Survey

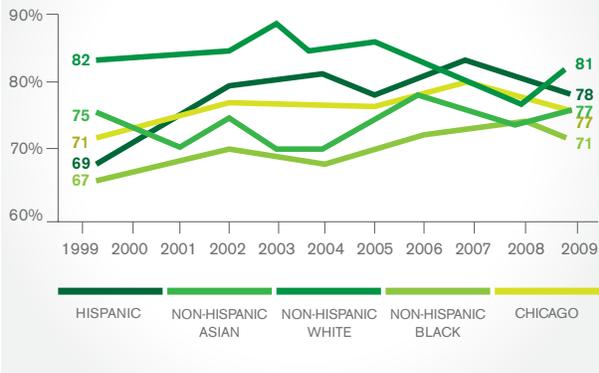
²⁹ Chicago Department of Public Health STI/HIV Surveillance Program

³⁰ Ibid.

Healthy Mothers and Babies

Prenatal Care in First Trimester: Accessing health care early in a pregnancy helps to increase the likelihood of a healthy baby. In Chicago, 77% of all births occurred to women who received prenatal care in their first trimester in 2009.³¹ This represents an 8% increase from 1999. Non-Hispanic Whites have the highest percentage of births with care in their first trimester; however this percentage stayed about the same during this time period. In contrast, the percentage of Hispanic births with first trimester care increased from 69% in 1999 to 79% in 2009. The percentage of Non-Hispanic Asian births with first trimester care showed many variations, but with little change in overall rate. Non-Hispanic Blacks have the lowest percentage of births with first trimester care, at 71%. (Figure 40)

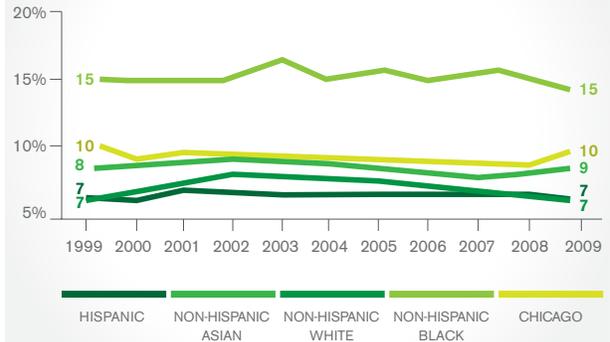
FIGURE 40: PERCENT OF BIRTHS WITH PRENATAL CARE IN THE FIRST TRIMESTER, CHICAGO RESIDENTS



Map 17 shows the range of prenatal care by community area. The communities of West Englewood and Hegewisch have the lowest percent of early prenatal care, at 64% and 67%, respectively.

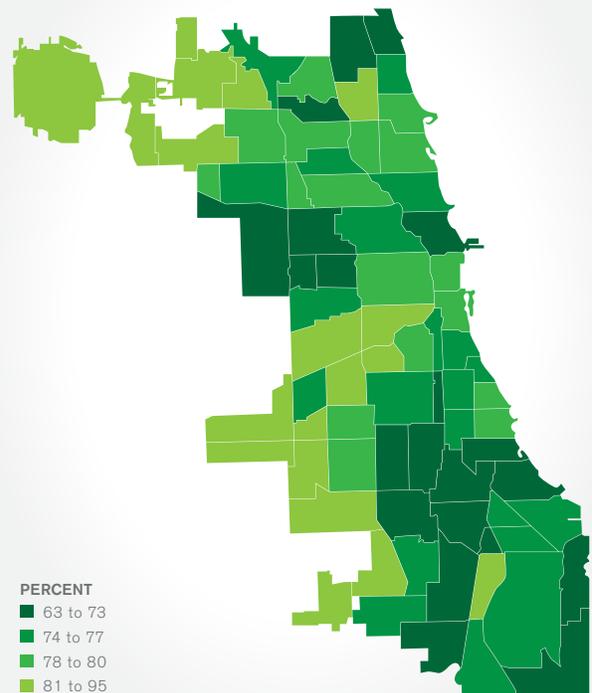
Low Birth Weight Babies: In 2009, 10% of Chicago’s babies weighed less than 2500 grams (5 pounds 8 ounces), which indicates low birth weight (LBW). LBW is a leading cause of infant death and LBW babies are at risk for physical and developmental health problems.³²

FIGURE 41: PERCENT OF BIRTHS THAT ARE <2500 GRAMS (LOW BIRTH WEIGHT), CHICAGO RESIDENTS

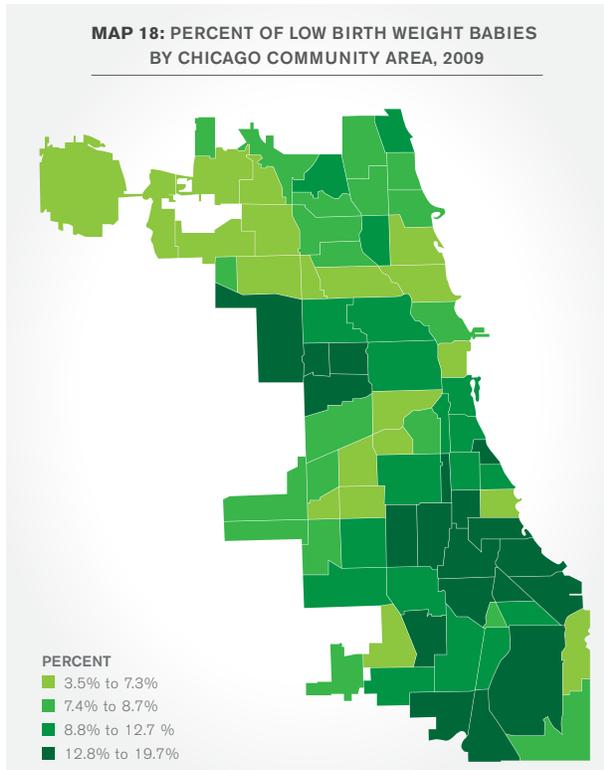


Despite the seriousness of this condition, the percent of LBW babies has not changed since 1999. Non-Hispanic Blacks continue to have the highest percentage, which is double the rate for Non-Hispanic Whites and Hispanics. (Figure 41)

MAP 17: PERCENT OF BIRTHS WITH PRENATAL CARE IN FIRST TRIMESTER BY CHICAGO COMMUNITY AREA, 2009



As noted in **Map 18**, variations of the percentages of LBW babies occur throughout Chicago. Avalon Park and Washington Heights have the highest percentages, at 20%

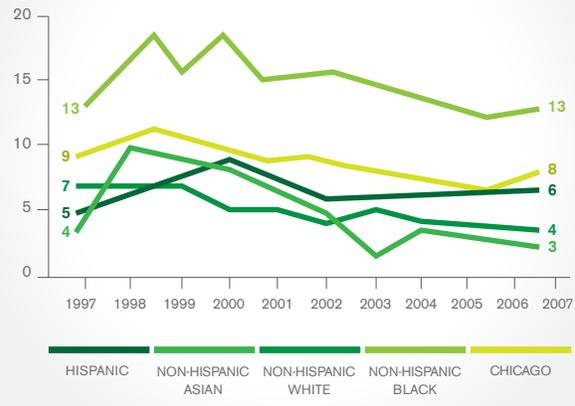


Infant Mortality: Infant mortality, i.e., the rate of infant deaths per 1,000 live births, is a key indicator of the health of a community as it reflects many factors of health system, including access to quality care and socioeconomic influences.

Between 1997 and 2007, infant mortality rates for Chicago decreased slightly, from 9 per 1000 live births in 1997 to 8 in 2007. The largest change was for Non-Hispanic Whites, whose infant mortality rate decreased from 7 per 1000 live births to 4. The infant mortality rate for Non-Hispanic Blacks was triple the rate for Non-Hispanic Whites and Non-Hispanic Asians. (**Figure 42**)

Teen Birth Rates: The teen birth rate is calculated from the number of births to teens aged 15-19 per 1000 population

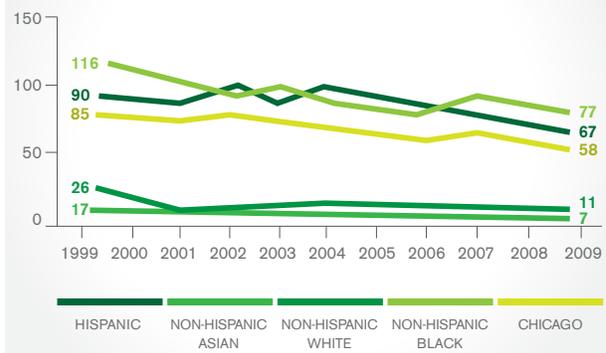
FIGURE 42: INFANT MORTALITY RATES PER 1,000 LIVE BIRTHS, CHICAGO RESIDENTS



of females 15-19 years old. This rate is important to monitor because teen mothers are more likely to receive late or no prenatal care and they are more likely than women in their 20s and 30s to have low birth weight babies.³³

In Chicago, teen birth rates decreased by 33% between 1999 and 2009.³⁴ Non-Hispanic Blacks and Hispanics continue to have the highest rates, which are over 500% higher than the rates of births in Non-Hispanic White teens. (**Figure 43**)

FIGURE 43: TEEN BIRTH RATES PER 1,000 FEMALE (15-19 YEARS) POPULATION, CHICAGO RESIDENTS

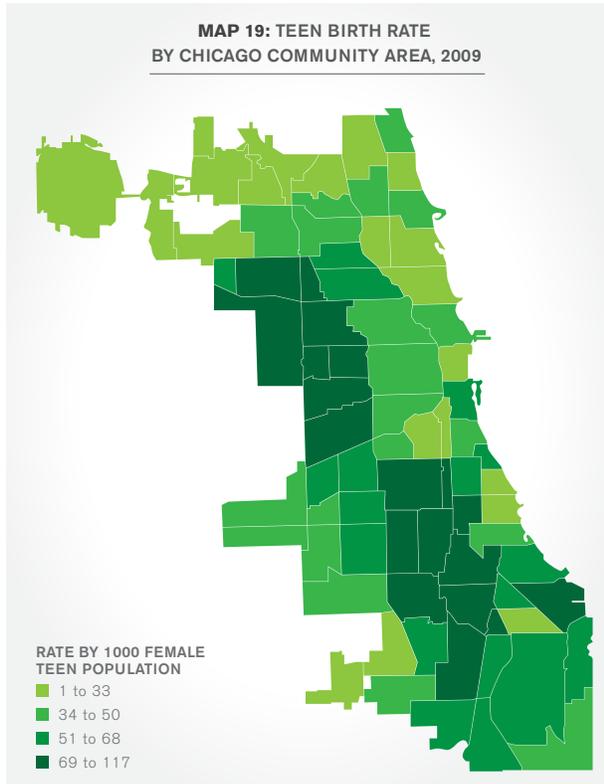


³¹ Illinois Department of Public Health Division of Vital Records

³² Stein REK, Siegel MJ, Bauman LJ. Are children of moderately low birth weight at increased risk for poor health? A new look at an old question. *Pediatrics* 2006; 118: 217-223

³³ Martin JA et al., Births: final data for 2003, National Vital Statistics Reports, 2005, Vol. 54, No 2.

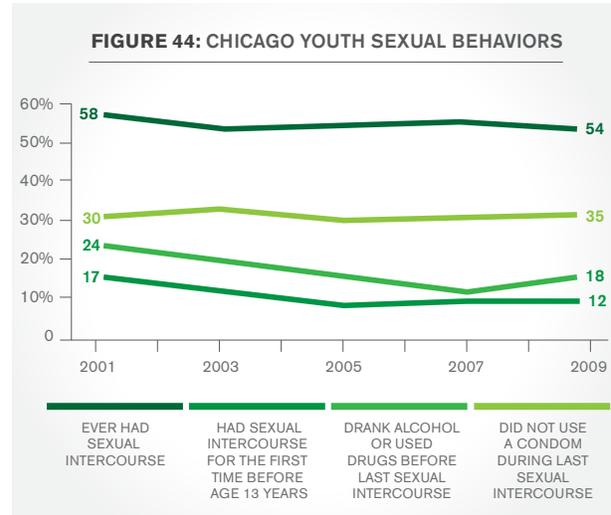
³⁴ Illinois Department of Public Health Division of Vital Records



Map 19 shows the range of teen birth rates throughout Chicago. Chicago communities with the highest rates are West Englewood at 117 per 1000 female teen population and West Garfield Park, with a rate of 115.

Adolescent Health

Youth Sexual Behaviors: Decreases in youth risky sexual behaviors occurred in several areas between 2001 and 2009.³⁵ (Figure 44) The percentage of youth who ever had sexual intercourse decreased from 58% to 54%, the percentage who had sexual intercourse before age 13 decreased from 17% to 12%, and the percentage who drank alcohol or used drugs before sexual intercourse decreased from 24% to 18%. However during this same time period, the percentage who reported they did not use a condom during their last sexual intercourse increased from 30% to 35%. Rates of risky health behaviors are higher among specific groups. Males reported more risky behaviors than females; being 37% more likely to report ever having sexual intercourse,

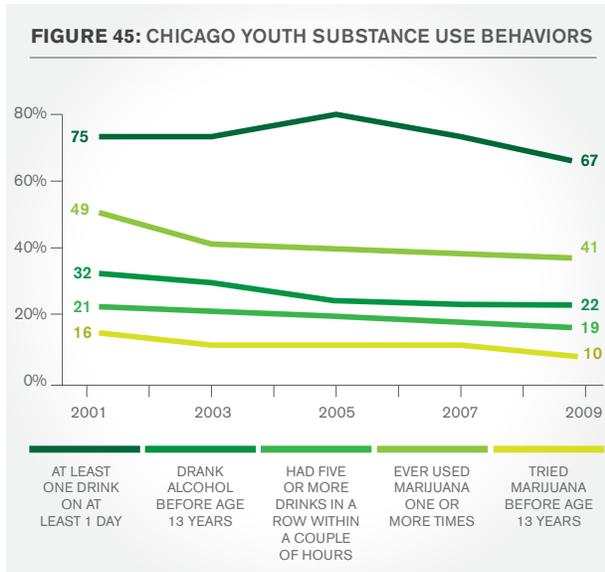


over 250% more likely to have had sexual intercourse before age 13, and 88% more likely to drink alcohol or use drugs before sexual intercourse. Females are 46% more likely to report not using a condom.

Compared to the Chicago total, Non-Hispanic Black youth were 12% more likely to have sexual intercourse and 38% more likely to have sexual intercourse before age 13. Hispanic youth were 18% more likely to have drunk alcohol or used drugs before intercourse and are 36% more likely not use to a condom.

Youth Substance Use: The percentage of youth engaging in risky substance use behaviors decreased between 2001 and 2009.³⁶ (Figure 45) The largest decreases were noted for drinking alcohol, and trying marijuana before age 13, down from 32% to 22% and 16% to 10%, respectively.

Hispanic youth reported higher percentages of many of these risky behaviors, including being 38% more likely than all youth and 88% more likely than Non-Hispanic Black youth to have five or more drinks of alcohol in a row within a couple of hours. Non-Hispanic White youth were 84% more likely than all youth to every use any form of cocaine. No significant differences in these behaviors were noted between the genders.



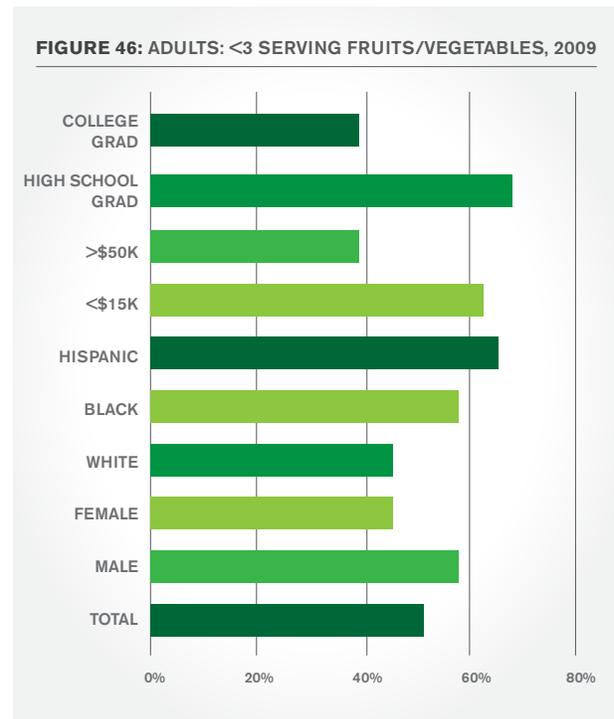
Obesity/Overweight: The prevalence of obesity in Chicago’s population has increased in the past decade. Thirty percent of Chicago adults rated themselves as obese in 2009, an increase of 22% from 2000 when the rate was 24%. The percentage of overweight Chicagoans has remained steady at 37%, for a total of 67% of the population who were either obese or overweight in 2009.³⁷

Levels of adult obesity vary by population groups. Females are more likely than males to rate themselves as obese, at 33% compared to 27% in 2009. Blacks had higher rates of obesity, at 40%. Obesity rates analyzed by educational level indicates that individuals who either did not graduate from high school or those who were solely high school graduates had higher obesity rates, at 41% and 40%, respectively, compared to college graduates whose obesity rate was 21%.

In 2009, 15% of Chicago’s youth rated themselves as obese and 21% as overweight, for a combined total of 36%.³⁸ In comparison, 32% of youth rated themselves as either overweight or obese in 2001: 13% obese and 19% overweight. Non-Hispanic Black and Hispanic youth had higher percentages of being overweight and obese than

Non-Hispanic White youth; the percentage overweight was 92% higher (22% and 23% compared to 12%) and the percentage obese was 45% higher (16% compared to 11%).

Nutrition and physical activity affect an individual’s weight/body mass index. Data, however, indicate that these behaviors are not improving. In 2009, 47% of adults reported they eat less than three servings of fruits and vegetables a day compared to 42% in 2000.³⁹ Less than one fourth (23%) of adults ate more than five servings for each of those years. As indicated in **Figure 46**, Blacks and Hispanics had higher percentages of eating limited portions of fruits and vegetables, as did individuals earning less than \$15,000 a year and people whose highest educational level was high school graduate.



³⁵ Centers for Disease Control and Prevention: Youth Risk Behavior Surveillance System

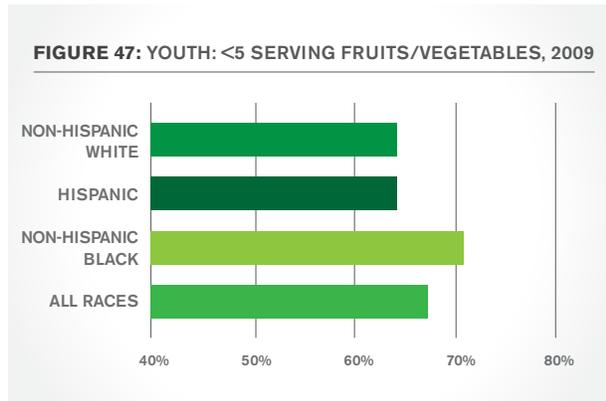
³⁶ Ibid.

³⁷ Illinois Department of Public Health: Behavioral Risk Factor Surveillance System

³⁸ Centers for Disease Control and Prevention: Youth Risk Behavior Surveillance System

³⁹ Illinois Department of Public Health: Behavioral Risk Factor Surveillance System

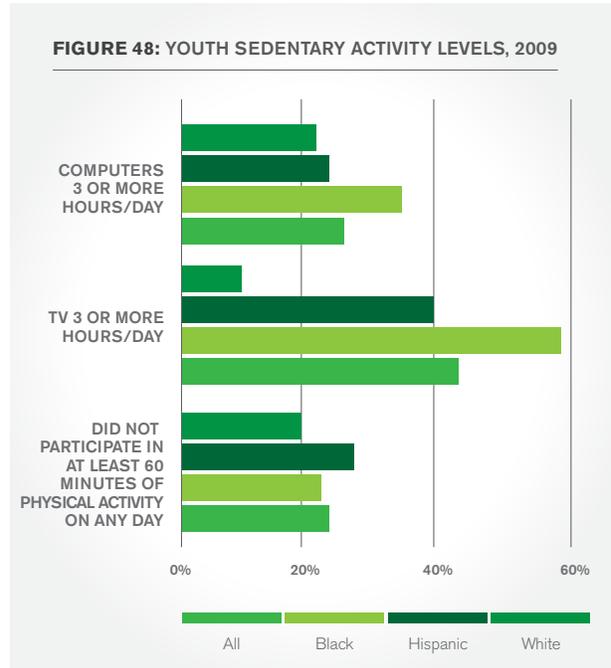
Youth also report poor nutritional habits, with 77% indicating they ate less than five servings of fruits and vegetables a day in 2009.⁴⁰ This percentage is even higher than 2001, when 71% reported these nutritional behaviors. As noted in **Figure 47**, Non-Hispanic Blacks had a slightly higher percentage of eating less than five servings, at 80% compared to 76% of Hispanics and 75% of Non-Hispanic Whites. Non-Hispanic Black youth also had higher percentages of drinking soda or pop (excluding diet soda) at least one time a day, at 32% compared to 25% of Hispanic youth and 18% of NonWhite youth.



Nearly a quarter of all youth did not participate in at least 60 minutes of physical activity a day in 2009. Hispanic youth had the highest percentage of limited physical activity, at 27%, compared to Non-Hispanic Black youth and Non-Hispanic White youth, at 22% and 19%, respectively.

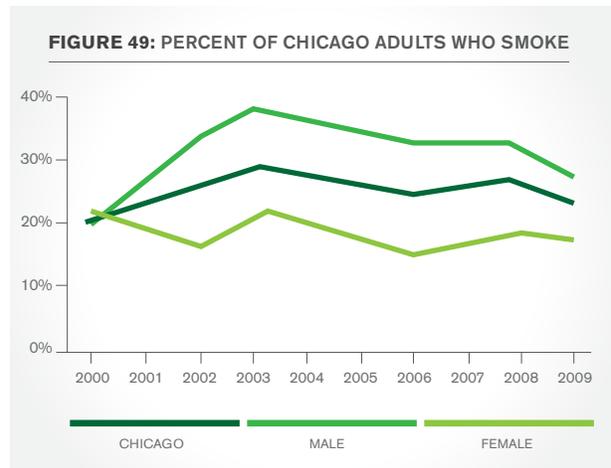
Since 2001, sedentary activity is consuming more time within a youth's day. Forty-five percent of Chicago's youth watched television three or more hours a day. That percentage actually represents a decrease from 2001, when 59% of youth reported watching this amount of TV per day. However, 28% reported spending three or more hours a day on computers. The percentage of Black youth spending time on the computer or watching TV was higher than the percentage for White youth.

(Figure 48)



Tobacco Use: Tobacco use, including smoking cigarettes, accounts for nearly one out of every five deaths in the U.S. each year and increases the risk of coronary heart disease, stroke, and cancer.⁴¹

In addition, exposure to second hand smoke can cause lung cancer in non-smokers and trigger asthma attacks in young children.



Adults: Nineteen percent of adults in Chicago reported smoking cigarettes in both 2000 and 2009.⁴² Although rates have decreased from their high in 2004 (28%), the current rate is still 62% higher than the Healthy People 2020 target of 12%.⁴³ (Figure 49)

In 2000, 19% of both genders reported smoking cigarettes. Since that time, the rates diverged. In 2009, 23% of males smoke compared to 16% of females. Among racial groups, Blacks have slightly higher percentages of smokers, at 22%, compared to Whites at 19%.

Differences in smoking behavior were noted by education level; 28% of people whose highest educational level was high school graduation indicated they smoked, compared to 15% of college graduates.

Youth: In 2009, 13% of high school youth reported they smoked cigarettes on one or more of the prior 30 days.⁴⁴ This represented a 48% decrease from the 25% who smoked in 2001. Differences between racial/ethnic groups show both Hispanics and Non-Hispanic Whites prevalence at 20% compared to 6% for Non-Hispanic Blacks. (Figure 50)

FIGURE 50: YOUTH SMOKING BEHAVIORS

SMOKED AT LEAST 1 CIGARETTE			
	2001	2005	2009
CHICAGO	25%	14%	13%
HISPANIC	32%	19%	20%
NON-HISPANIC BLACK	20%	9%	6%
NON-HISPANIC WHITE	31%	n/a	20%
SMOKES 20+ CIGARETTES/DAY			
	2001	2005	2009
CHICAGO	8%	4%	2%
HISPANIC	6%	2%	3%
NON-HISPANIC BLACK	6%	3%	1%
NON-HISPANIC WHITE	18%	n/a	9%
TRIED CIGARETTE BEFORE 13 Y/O			
	2001	2005	2009
CHICAGO	21%	15%	13%
HISPANIC	22%	21%	15%
NON-HISPANIC BLACK	19%	12%	10%
NON-HISPANIC WHITE	30%	n/a	16%

Similar decreases occurred for other youth smoking characteristics. The percentage of youth who smoked 20 or more cigarettes a day decreased by 75% and by 38% for the percentage of Chicago youth who smoked before age 13.

Smoking behaviors decreased among racial/ethnic populations since 2001, however differences among these population still exist. Non-Hispanic White youth have a higher prevalence of most smoking behaviors, followed by Hispanics. Non-Hispanic Black youth had the lowest prevalence of smoking.

Health composite score: To demonstrate the impact of many health indicators on a community's health, community areas were ranked for each of the indicators below and these rankings were added to develop a health composite score for each community area.

- Mortality data (influenza & pneumonia, coronary heart disease, homicide, all cancer, diabetes, breast cancer)
- Morbidity data (AIDS diagnosis, HIV infection diagnosis, gonorrhea, chlamydia, syphilis, elevated blood lead levels)
- Natality data (prematurity, low birth weight, prenatal care in first trimester, infant mortality rate, teen births)

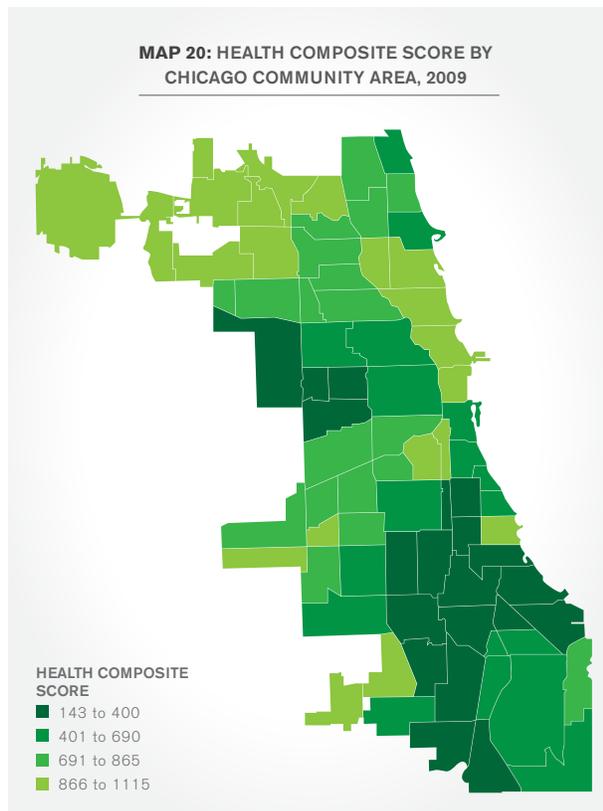
⁴⁰ Centers for Disease Control and Prevention: Youth Risk Behavior Surveillance System

⁴¹ http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/

⁴² Illinois Department of Public Health: Behavioral Risk Factor Surveillance System

⁴³ Centers for Disease Control and Prevention: Healthy People 2020

⁴⁴ Centers for Disease Control and Prevention: Youth Risk Behavior Surveillance System



Map 20 shows the geographic dispersion of these scores. Communities with the lowest scores, in order of lowest score, are: West Garfield Park, West Englewood, North Lawndale, and Englewood. Communities in the northwest had the highest scores: Forest Glen, Norwood Park, Edison Park, and Dunning.

FINDINGS: ENVIRONMENTAL HEALTH AND THE BUILT ENVIRONMENT

Environmental Health

Air and water pollution can damage the natural environment as well as impact the health status of the residents. This section presents indicators of air quality, water quality, and lead as a contaminant affecting health. The U.S. Environmental Protection Agency (U.S. EPA), the lead Federal agency monitoring environmental health, monitors standards through the following federal laws: (1) The 1963 Clean Air

Act (CAA) requiring establishment of ambient air quality criteria and standards; (2) The 1986 Environmental Protection Right-to-Know Act establishing the Toxic Release Inventory (TRI); a report informing the general public of toxic releases from industrial facilities in specific geographical areas; and (3) The Safe Drinking Water Act (SDWA) requiring the EPA to establish and enforce standards that protect the drinking water and its sources.

Air Quality

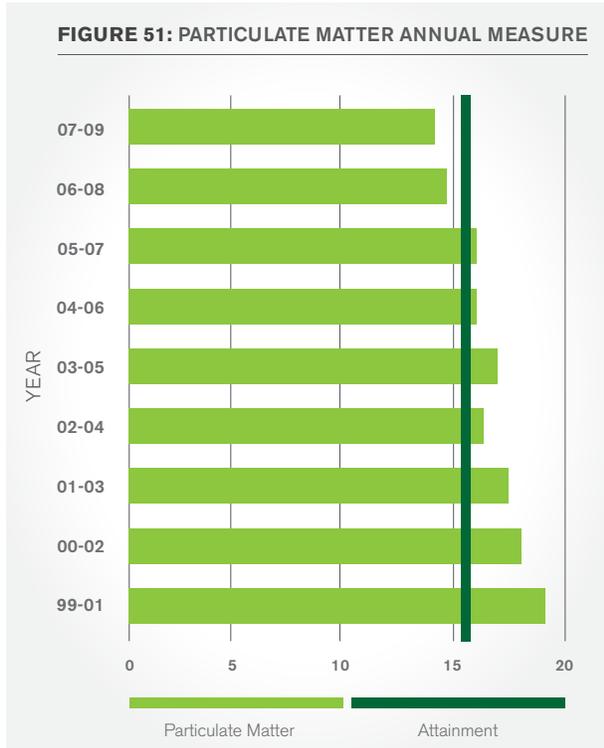
Background: To assess and monitor air quality, the U.S. Environmental Protection Agency (EPA) established the National Ambient Air Quality Standards (NAAQS). These standards measure the concentration levels of six pollutants most commonly found in the United States (i.e., “criteria pollutants”) that also are hazardous to the environment and human health. A network of air monitoring stations collects samples, which are analyzed to determine compliance status. Non-attainment designations are given when locations fail to meet the NAAQS. Cook County has 27 air monitors throughout its geography, including Chicago. (N.B. EPA does not have designations for Chicago levels as the pollutants are regional-scale, formed by broad atmospheric processes, and do not vary at local levels.)

Findings: Since 2000, Cook County has been in attainment for four of the six measured pollutants: carbon monoxide, sulfur dioxide, nitrogen dioxide, and lead.

Particulate Matter 2.4 (PM), one of the six measured pollutants, is a combination of many chemicals and small particles, primarily emitted through vehicle emissions, volcanic ash, and burning of vegetation. PM can enter the lungs and can cause respiratory irritation, breathing difficulty, and decreased lung function.

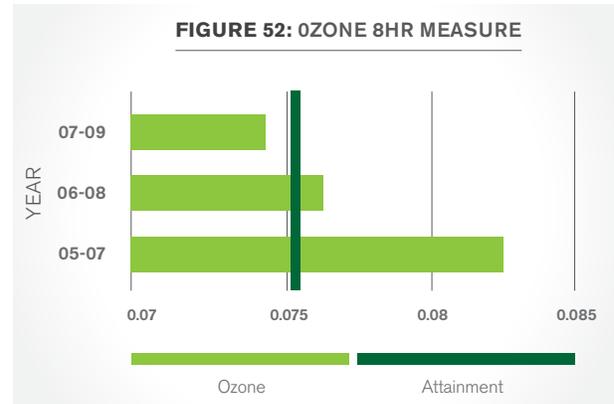
PM was in non-attainment status in 1999/2000. Although PM was in non-attainment for many years, this measure

has been steadily decreasing and reached attainment levels as of 2006-2008. (Figure 51)



Another pollutant measured by NAAQS is ground-level ozone. Ground-level ozone, the layer of ozone between the earth's surface and 10 miles into the atmosphere, results from the exposure of certain volatile chemicals to direct sunlight. Unlike stratospheric ozone (between 10-30 miles from the earth's surface), which is protective against UV radiation, ground-level ozone can cause respiratory irritations, aggravates asthma, and repeated exposure can lead to permanent lung damage.⁴⁵ As shown in Figure 52, ground-level ozone in Cook County is decreasing, and as of its 2007-2009 reading, is in attainment levels.

Lead is another pollutant that can be found in the air through factory emissions. While lead has been in attainment for Cook County, community concerns about factory emissions in the Pilsen neighborhood resulted in the local placement of an EPA air monitoring station.



(Figure 53) Based on the three month averages of air quality readings between November 2010 and January 2011, EPA concluded that the Pilsen area has failed to meet the National Ambient Air Quality Standards and is in nonattainment status.⁴⁶



Another measure of several criteria pollutants is the Air Quality Index (AQI), a daily air quality report generated by the U.S. EPA.⁴⁷ Criteria pollutants' concentration levels

⁴⁵ <http://www.ciese.org/curriculum/airproj/ozoneprimer.html>

⁴⁶ <http://www.epa.state.il.us/community-relations/fact-sheets/pilsen-neighborhood-lead/fact-sheet-1.html>

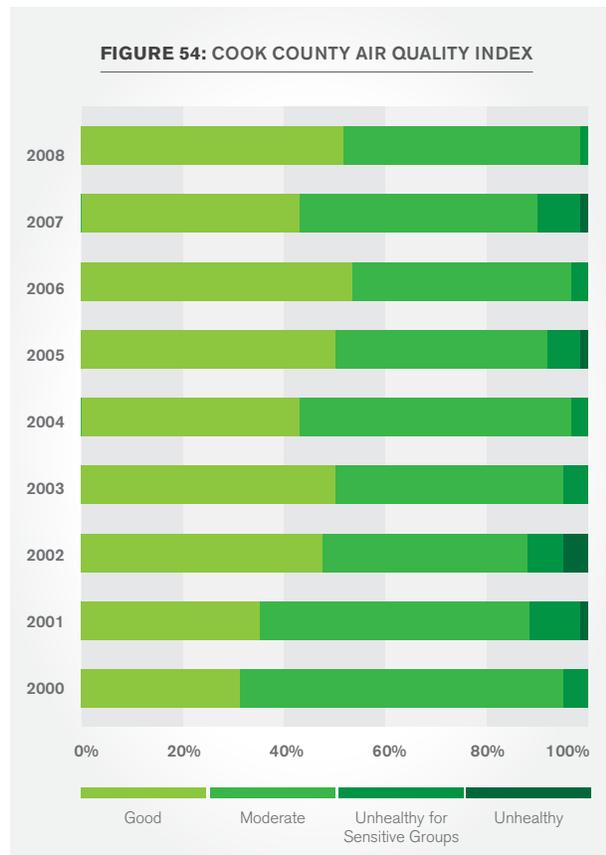
⁴⁷ <http://airnow.gov/index.cfm?action=aqibasics.aqi>

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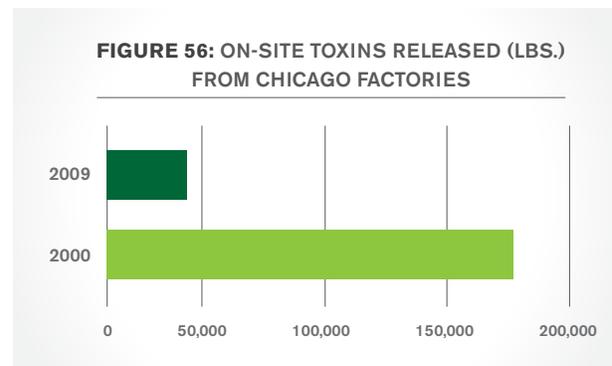
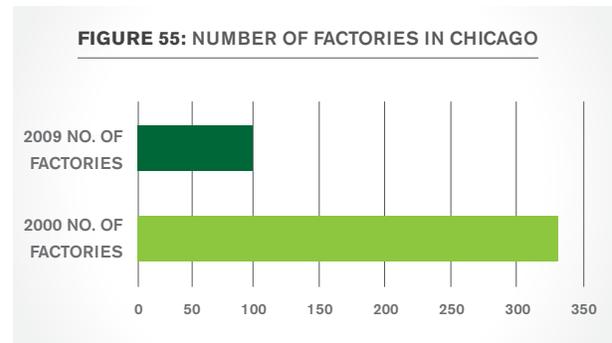
COMMUNITY HEALTH ASSESSMENT

Community Health Status

are converted to an AQI value and the highest value is categorized into one of the six levels of the AQI for that day: good, moderate, unhealthy for sensitive groups, unhealthy, very unhealthy, and hazardous. As seen in **Figure 54**, Cook County’s AQI ratings improved, with a 65% increase in the percent of days rated as “good,” from 30% in 2000 to 50% in 2008. Concurrently, the percentage of days rated as moderate and unhealthy for sensitive groups decreased by 22% and 95%, respectively.

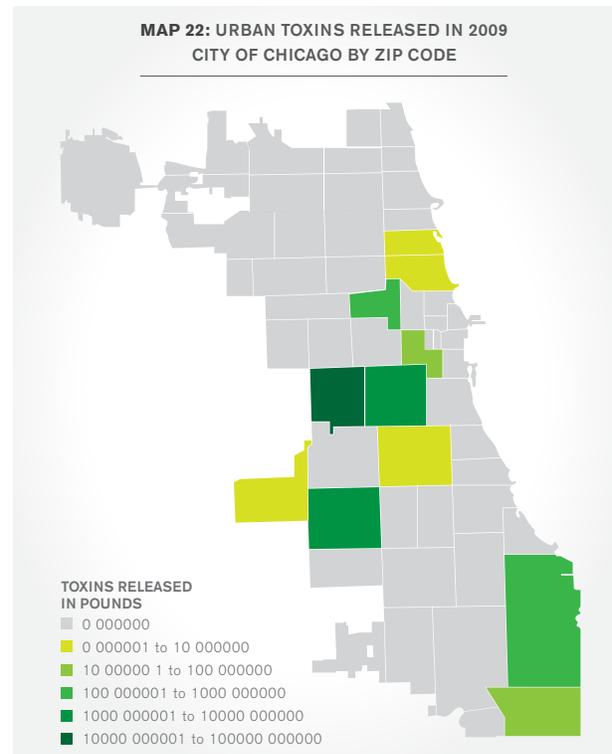
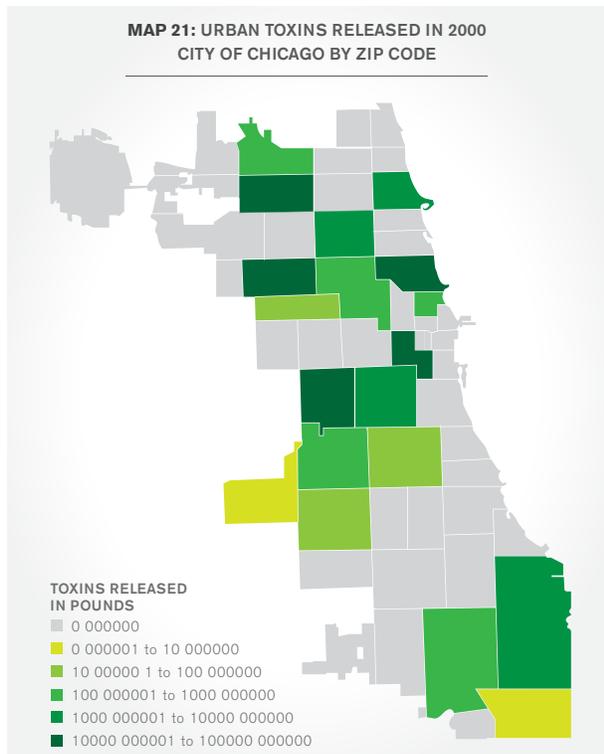


Air quality is also measured by the EPA’s Toxic Release Inventory (TRI), which collects data on facility urban toxic emissions (if they exceed 25 tons annually). Although the TRI contains important measures of urban toxic release, data limitation exist because the TRI does not reflect public exposure to released chemicals or their potential to cause harm to human health or the environment.



The TRI reports show that the number of facilities with Chicago zip codes reporting on-site emissions decreased by 71%, from 330 sites to 96.⁴⁸ (**Figure 55**) The number of pounds of toxins reported being released on-site decreased by 79%, from 172,585 lbs. to 35,418 lbs. (**Figure 56**) When analyzing these data geographically, substantial changes occurred between 2000 and 2009. (**Maps 21, 22**) Factories in 20 of Chicago zip codes reported on-site releases in 2000, located in the northwest, west, southwest, and far south areas. In 2009, the number of zip codes in which factories reported toxic emissions decreased to 11, with only one zip code area reporting the highest level of poundage release, and many areas showing decreases in the amount released. Most of the zip codes in the north and northwest part of the city no longer report toxic emissions. However, some areas in the west and far south continue to report high levels of emissions.

Drinking Water Quality: Another potential source of environmental contamination is drinking water pollution.



The 1974 Safe Drinking Water Act (SWDA) mandates the EPA to establish and enforce regulations and standards to ensure the protection of the nation's public drinking water and its sources which include rivers, lakes, reservoirs, springs and ground water wells that serve more than 25 individuals. The City of Chicago Department of Water Management (CDWM) delivers close to 1 billion gallons of drinking water from Lake Michigan to residents of 77 Chicago communities and 125 suburban communities.

Based on the findings from the 2010 Chicago Department of Water Management Water Quality Report, the City of Chicago drinking water met all Federal regulations and standards.⁴⁹ However, in August 2011, water samples in 7 out of 38 Chicago homes were found to have high lead levels.⁵⁰ The U.S. EPA is currently assessing sampling processes and will recommend change if necessary.

Lead Poisoning: Exposure to lead is a health risk because it can cause learning disabilities and behavioral

problems in children.⁵¹ Although people can be exposed to lead through air and water (as noted above), the most common means of exposure is through lead-based paint. Lead in paint was banned in 1978 by the U.S. Consumer Product Safety Commission, but is still found in older housing units. Chicago is at particular risk because 80% of the housing stock was built prior to the ban of lead-based paint.⁵²

Although lead is not safe at any quantity, an elevated blood lead level in children is currently defined as ≥ 10 microgram per deciliter.⁵³ Much improvement in lead poisoning has occurred, with the percent of Chicago children with elevated blood lead levels decreasing from 24% in

⁴⁸ <http://www.epa.state.il.us>

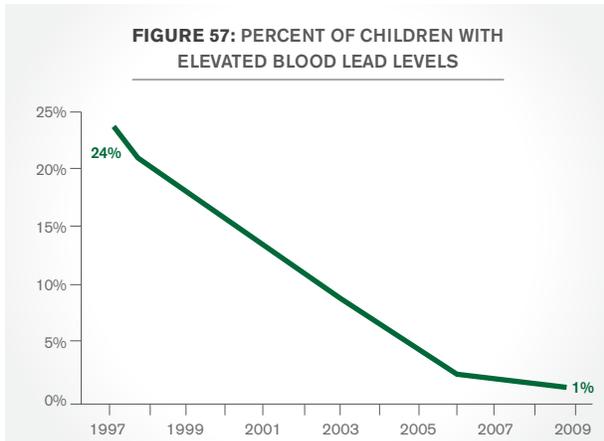
⁴⁹ <http://www.cityofchicago.org/content/dam/city/depts/water/ConsumerConfidenceReports/2010WaterQualityReport.pdf>
<http://www.cityofchicago.org/content/dam/city/depts/water/ConsumerConfidenceReports/2010WaterQualityReport.pdf>

⁵⁰ <http://www.chicagotribune.com/health/ct-met-lead-in-water-20110805,0,2821410.story>

⁵¹ <http://www.cdc.gov/lead/>

⁵² <http://archives.hud.gov/reports/plan/il/chicagil.html>

⁵³ <http://lead-info.com/meaning.html>



1997 to 1% in 2009.⁵⁴ (Figure 57) This steep decline is in part due to a collaborative effort to identify children with elevated blood lead levels, case management these children, enforce local lead ordinances, and conduct abatement on these residences.

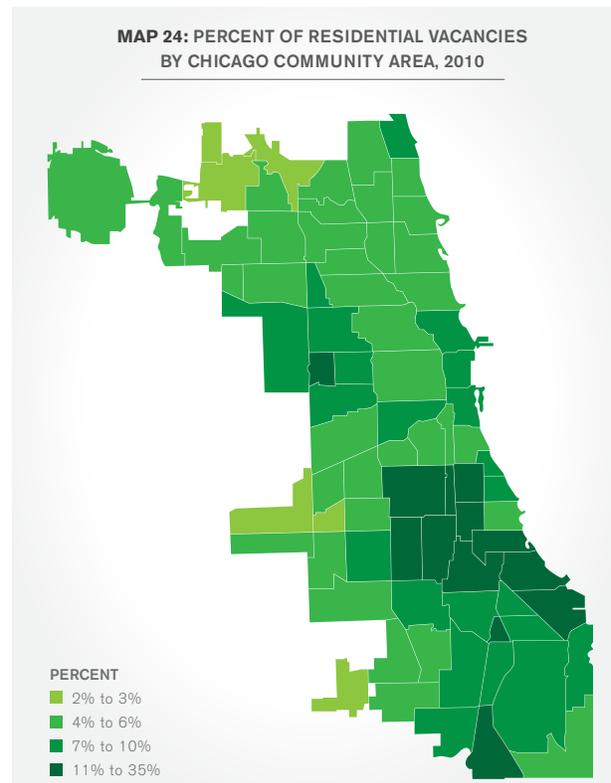
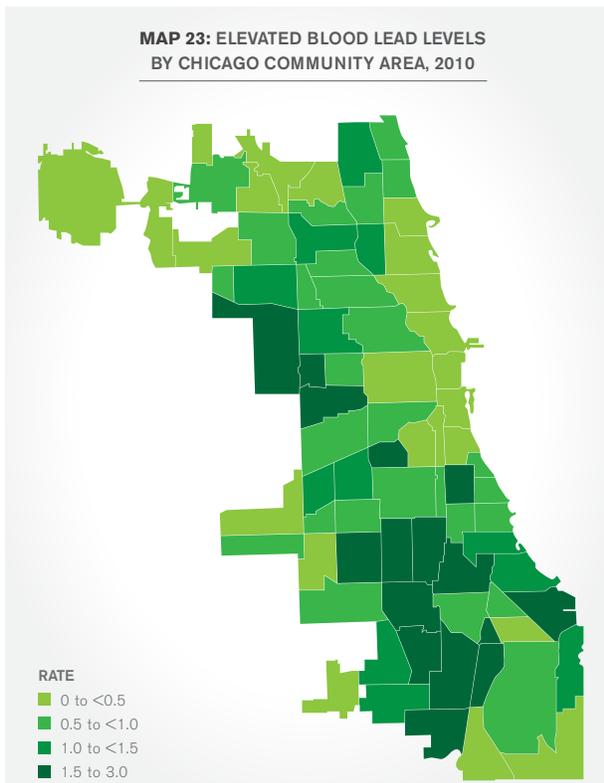
Even with low lead poisoning rates in Chicago, geographic disparities exist.

Map 23 shows ranges in children’s lead poisoning rates by community. The highest rates are in the communities of Pullman, Greater Grand Crossing, and Roseland, with 2.7%, 2.6%, and 2.5%, respectively.

Built Environment

Vacant properties can have serious negative effects on the health and safety of their community, including the collection of debris, health risks, risk of fire, and attraction to crime. In addition, vacant properties speak to the lack of stability and economic welfare of a community. Data on vacant properties, therefore, is an important measure of community health.⁵⁵

In 2010 the United States Postal Services identified that Chicago had 1.3 million residential addresses that received mail. This represented an increase of 8% of the number of residences from 2006. However, the number of residential vacancies also increased. Between 2006 and 2010, the number of vacant residences increased by



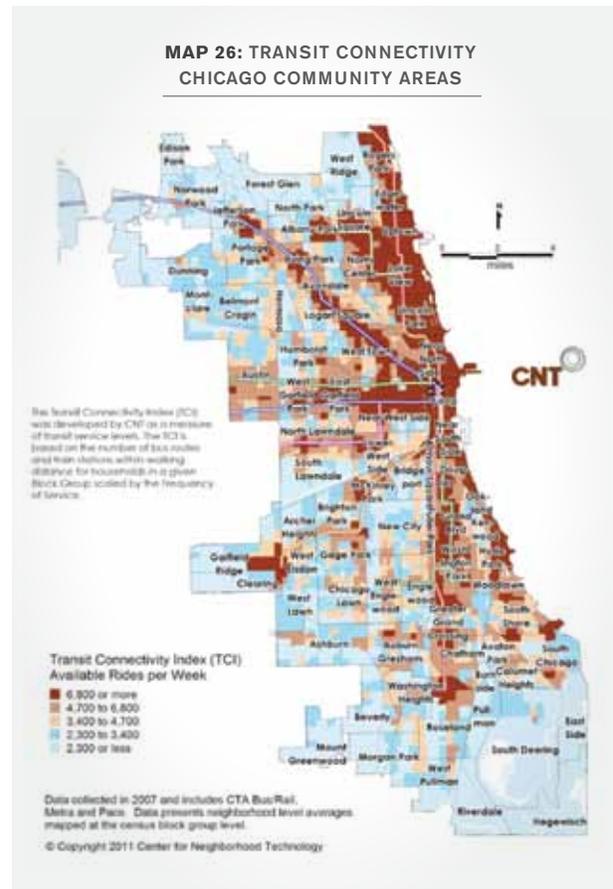
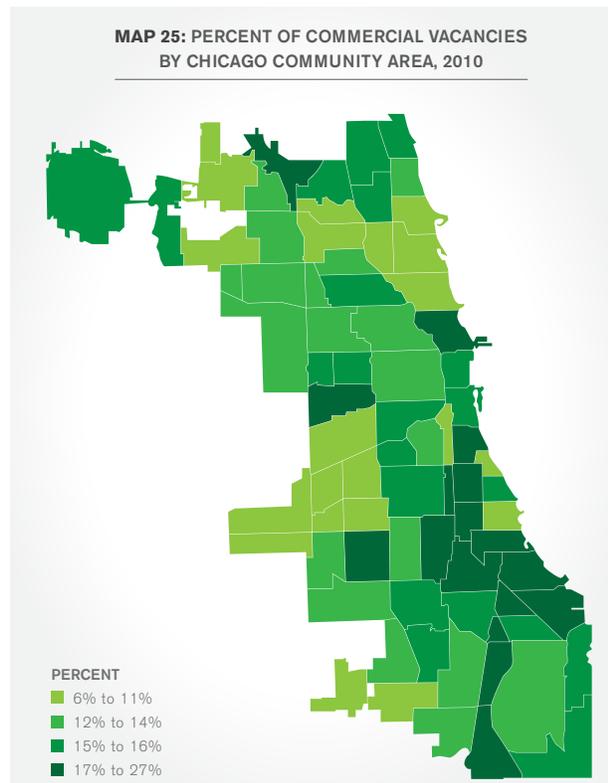
almost 21%, for a total of 83,553 vacant properties. The largest increase was noted between 2009 and 2010, when residential vacancies increased by 8,226, or 11%.⁵⁶ As **Map 24** illustrates, all communities throughout Chicago have residential vacancies; however, Riverdale had the largest percent of residential vacancies, at 32%, followed by Fuller Park at 18%, and South Chicago and Englewood at 15%. In contrast, Norwood Park had only 3% vacant residences in 2010.

Commercial vacancies experienced a similar pattern as residential vacancies. Commercial addresses increased by 3% between 2007 and 2010, however at the same time, the number of vacant addresses increased by 9%. Therefore, in 2010, 14% of Chicago business addresses were vacant (14,464 out of 103,772). **Map 25** shows the range of commercial vacancies throughout Chicago. The community area of Washington Park had the highest commercial vacancy percentage, at 26%, followed by Grand Boulevard and Riverdale,

at 25%. Lincoln Park and Armour Square both had the lowest percentage of commercial vacancies, at 7%.

Transportation is another component of the built environment that is important to the health of communities. Easy access to public transportation is important to access job opportunities, educational experiences, as well as access to health care and healthy food. In addition, the better the public transit is, the more individuals with pair transit with walking, which contributes to healthy physical activity.

To monitor and analyze access to public transportation, the Center for Neighborhood Technology (CNT)



⁵⁴ Chicago Department of Public Health Lead Poisoning Prevention Program

⁵⁵ <http://www.usmayors.org/brownfields/library/vacantproperties0805.pdf>

⁵⁶ United States Postal Service 2006- 2010, tabulated by MCIC

developed the Transit Connectivity Index (TCI).⁵⁷ **Map 26** shows a TCI analysis of the Chicago Transit Authority’s subway “El” and bus system routes and service data, i.e., the number of bus routes and train stations within walking distance. High scores (in red) indicate easy access to public transportation, while lower scored areas (in blue) have limited public transit options. The map shows that areas within walking distance to the “El” have the highest levels of transit connectivity. Those areas appear more to cover more of the north and northwest areas of Chicago. Communities that are more often served by bus routes have much lower access to transit: far south, southwest, northwest, and far northwest.

Access to grocery stores that sell healthy foods is a component of the built environment that identifies areas of low food access, which in turn affects health status. Access to a variety

of produce and healthy food options supports individual behavior change to prevent chronic disease and manage conditions such as diabetes, obesity, and high blood pressure. **Map 27** shows data collected by Chicago State University Neighborhood Assistance Center on distances needed to travel to the nearest large supermarket. These distances in 2011 remain approximately the same as in 2007. Access to food in the Roseland community even decreased when one large grocery store relocated further west, creating a larger area of low food access.⁵⁸ Since these data were collected, other food access locations are being developed, including the availability of healthy foods at local Walgreens and Target stores.

**FINDINGS:
CRIME AND TRAFFIC SAFETY**

Crime and Traffic Safety

Crime: Data reported by the Chicago Police Department from 2000 to 2010 indicate that the total number of crimes,

MAP 27: DISTANCE TO THE NEAREST LARGE SUPERMARKET AND PREDOMINATELY AFRICAN-AMERICAN COMMUNITIES CHICAGO, 2011 (PRELIMINARY MAP)

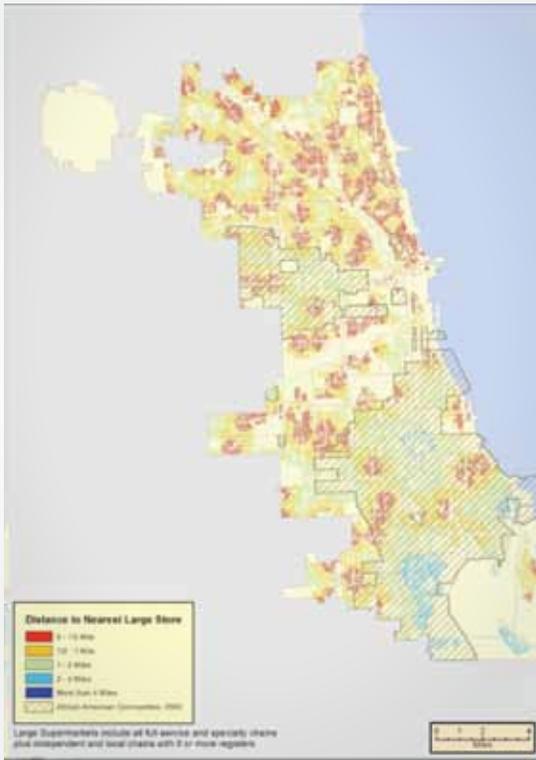
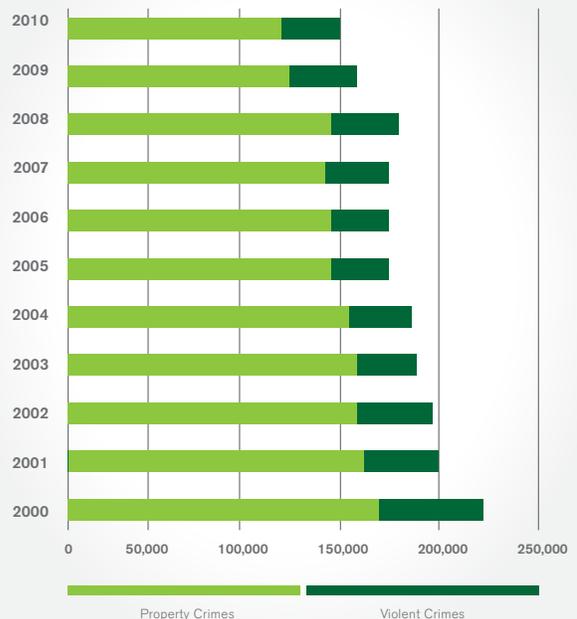
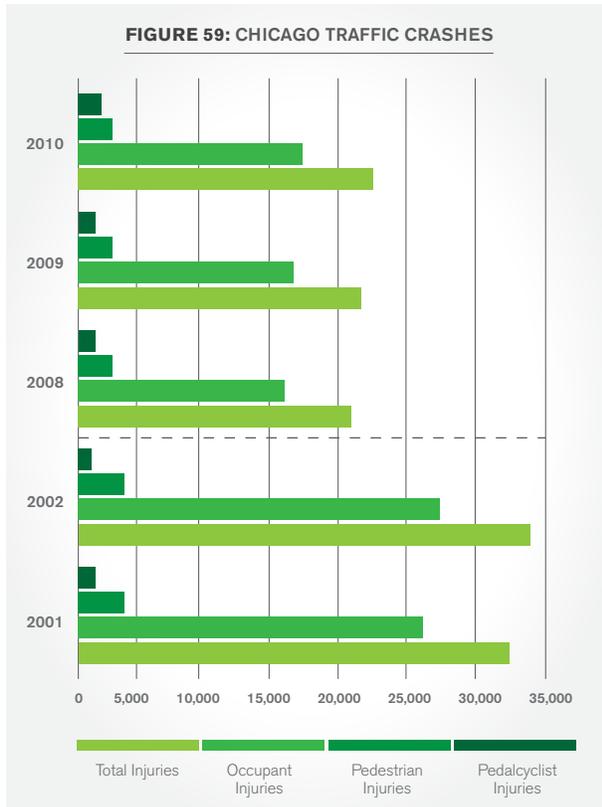


FIGURE 58: TOTAL CRIME INDEX: PROPERTY AND VIOLENT

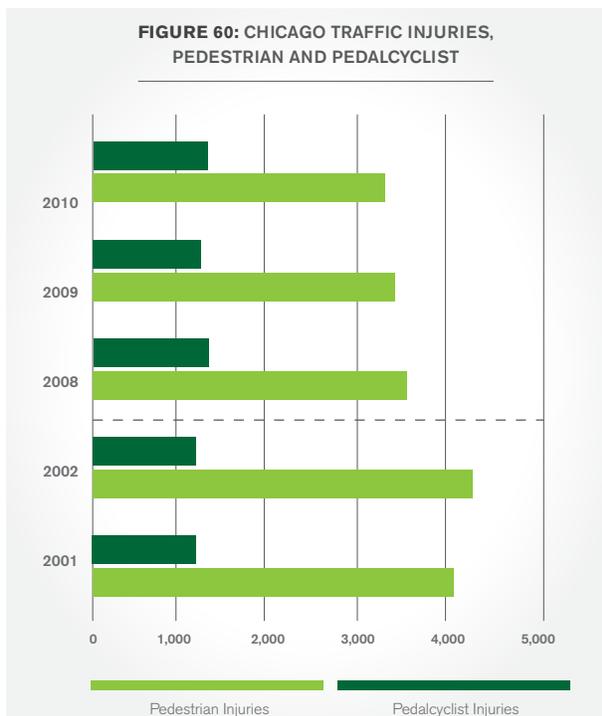




as documented by the Total Crime Index, decreased by 29%.⁵⁹ (Figure 58) As shown, property crimes decreased by 27% and violent crimes decreased by 37%. In 2010, homicides totaled 435, a decrease of 32% from 633 in 2000. Decreases were also noted for hate crimes (69%) between 2000 and 2009. Calls to the police department on domestic violence decreased by 5,000 during this same time span, from 205,000 to 200,000.

Traffic Safety: Traffic safety is an important component of public health that represents the intersection of transportation, safety, and health. As noted in Figure 59, the total number of injuries due to traffic crashes decreased 32%. Occupant injuries decreased by 36% and pedestrian injuries by 25%. In contrast, pedalcyclist injuries (i.e., bicycle) increased by 30%, from 1,212 in 2001 to 1,579 in 2009. (Figure 60)

**FINDINGS:
ACCESS TO CARE**



Access to Care: In 2009, 20% of Chicagoans “avoided the doctor due to cost,” a more than 100% increase since 2000.⁶⁰ This increase occurred in all populations and was highest for Hispanics and people whose highest educational level was high school graduation. The largest disparity among groups occurred educational levels, with 36% of high school graduates reporting they avoided the doctor due to cost compared to 14% of college graduates. Variations were seen by age groups, with 22% of 25-44 year olds and 20% of 45-64 year olds avoiding the doctor due to the cost, compared to 7% of individuals aged 65 and older. (Figure 61)

To focus efforts on areas of high need, the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Care

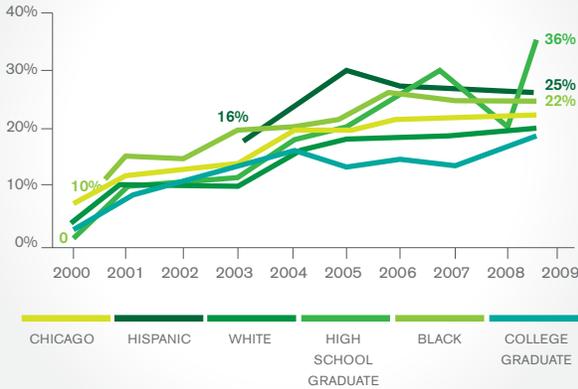
⁵⁷ <http://www.cnt.org/repository/AffordabilityIndexBrief.pdf>

⁵⁸ Chicago State University Neighborhood Assistance Center <http://www.csu.edu/nac/>

⁵⁹ Chicago Police Department Annual Reports 2000-2009. www.chicagopolice.org

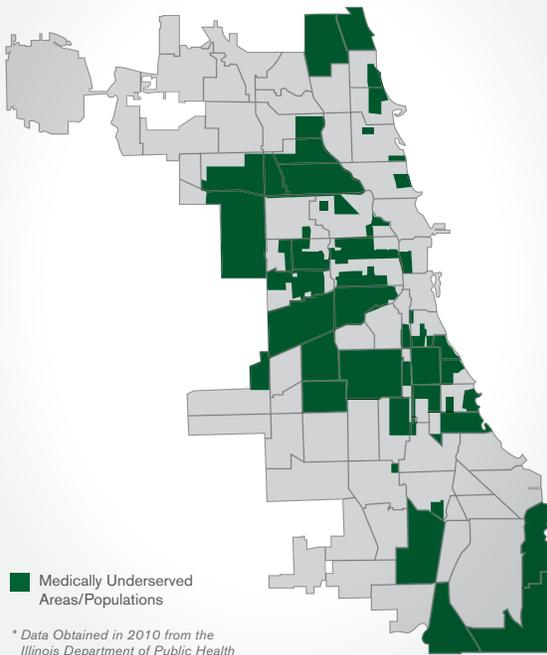
⁶⁰ Illinois Department of Public Health: Behavioral Risk Factor Surveillance System

FIGURE 61: AVOIDED DOCTOR DUE TO COST: RACE/ETHNICITY, EDUCATION

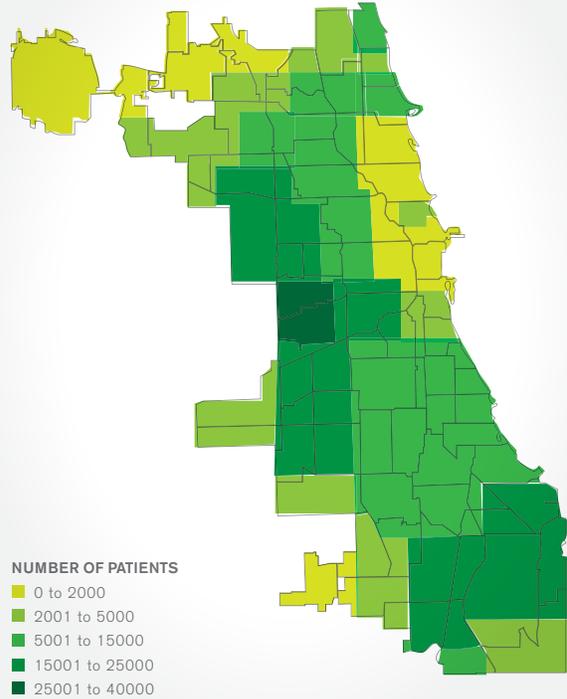


(HRSA) identifies geographic areas that do not have a sufficient amount of providers to serve the medically needy population. These areas are designated as “Medically Underserved.”⁶¹ As **Map 28** illustrates, many areas throughout Chicago meet this designation.

MAP 28: CHICAGO'S MEDICALLY UNDERSERVED AREAS/POPULATIONS*

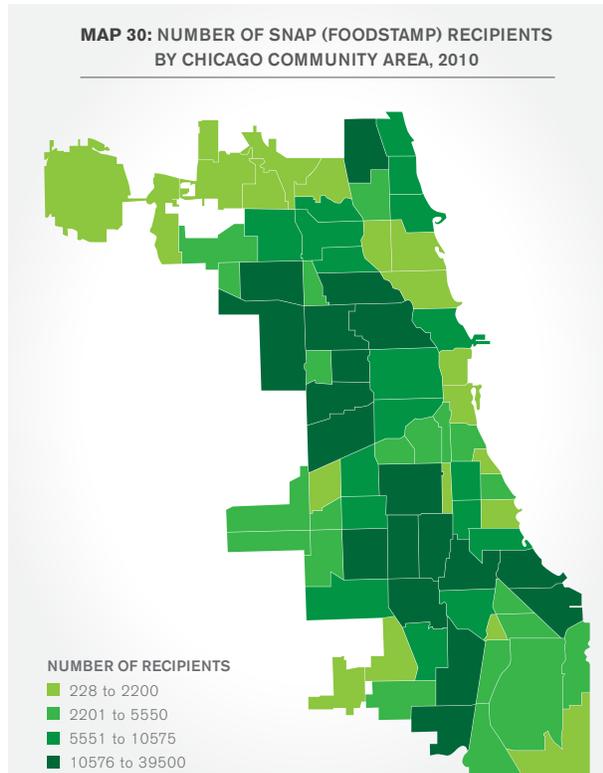


MAP 29: NUMBER OF PATIENTS SEEN AT FEDERALLY QUALIFIED HEALTH CENTERS BY CHICAGO ZIP CODE, 2009



To facilitate the provision of primary care services in these medically underserved areas, HRSA awards grant funds to Federally Qualified Health Centers (FQHCs). FQHCs provide health care services; which may include primary care, behavioral health, and oral health care; for Medicaid recipients as well as the uninsured and underinsured. In 2009, FQHCs provided care to 432,000 Chicagoans, an increase of 20% since 2005. As noted in **Map 29**, more individuals living in the west and south were served by FQHCs.

Safety net services are provided by FQHCs, as well as other entities, including hospitals, City and County-run facilities, and other clinics that have a mission to serve the underserved. (**Appendix C**) In 2011, 99 community health centers provided care in Chicago; 79 serving the general population and 20 serving special populations (e.g., teens, HIV positive patients, developmentally delayed, etc.). School-based health centers were available at 32 schools.



The Chicago Department of Public Health operated seven sites and the Cook County Health & Hospital System operated seven sites. In addition, twelve free health clinics provided some health care, with one organization (two clinics) offering access to a full range of services. Since 2005 the number of community health centers increased by 20% and the number of school-based health centers increased by 33%. In addition, 31 acute care hospitals provide care within Chicago communities.

Another measure that identifies people receiving safety net services is the number of people registered in the Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps), which provides assistance to purchase healthy food. People are eligible for SNAP based on several factors including income (net income below 100% of federal poverty level). In 2010, 571,000 Chicagoans received SNAP benefits. This number represents a 24% increase since the number of recipients in 2005.⁶²

As indicated in this **Map 30**, the number of SNAP recipients vary widely among the community areas: from almost 40,000 in Austin and 21,737 in Humboldt Park.

CONCLUSION

Findings from this comprehensive set of indicators highlight improvements in Chicago's health and quality of life, while other data point to more negative trends. Positive changes occurred in both communicable disease rates (e.g., TB, HIV) and mortality rates of chronic diseases (e.g., stroke, cardiac heart disease). Many health behaviors also showed movement toward less risky behaviors, including: sexual behaviors, tobacco use, and substance use. More air quality measures are in attainment levels and the number of days when the air quality was rated as "good" increased by 65%. In addition, more health care resources opened to provide care to uninsured and underinsured Chicagoans.

In the midst of these improvements, other measures showed either no change or a worsening effect on Chicago's health. As described in the section on socioeconomic status, trends since 2000 document that more people are affected by poverty, unemployment, and high housing costs. Hospitalization rates for common conditions (e.g., diabetes, mental health) increased and maternal and child health indicators have not improved despite ongoing public health efforts. Two-thirds of Chicago adults are either overweight or obese and many adults and youth do not engage in behaviors to change weight status (i.e., healthy eating, physical activity). In addition, many of Chicago's rates are worse than national goals and rates in other large cities. This report's overarching finding highlights disparities among racial/ethnic, income, and educational level for this comprehensive set of indicators that describe and/or impact health.

⁶¹ <http://bhpr.hrsa.gov/shortage/muaps/>

⁶² Data obtained from the City of Chicago Department of Family and Support Services

Community Themes and Strengths

PURPOSE

Learning what community members think about the health and quality of life in their neighborhoods is an essential component of a community assessment. These personal insights, which are the basis of the Community Themes and Strengths Assessment, allow the Chicago Partnership to identify both what is impacting people's lives and possible solutions to these local and system wide issues. Through focus groups and an online survey, the Chicago Partnership obtained community-level perspectives on: (1) major health and quality of life concerns, (2) community assets and barriers, (3) health information and health-seeking behavior, and (4) suggestions for healthier communities.

PROCESS

To oversee this assessment, the Chicago Partnership formed a committee of 16 representatives from 12 organizations, which included both Partnership members and external partners. The committee decided to gather both in-person feedback, through focus groups, and anonymous feedback, in the form of an online survey, to reach a broad spectrum of Chicago residents. Committee members created focus group questions, identified target populations, and took the lead in securing focus group locations, hosting groups, and facilitating some of the groups. The committee also designed and piloted the online survey questions and identified dissemination outlets. In compliance with CDPH Institutional Review Board (IRB) requirements, Chicago Department of Public Health (CDPH) staff working on the assessment completed IRB training and obtained IRB exemption from review for the focus groups and online survey. Once approved, the survey was translated into Spanish by a certified interpretation/translation agency.

Because this assessment analyzes opinions of Chicago residents, the Chicago Partnership and the committee wanted to obtain feedback from diverse populations and geographic areas. To assist in this process, the Partnership

developed seven regions: Central, North, Northwest, West, South, Southwest, and Far South. (**Appendix B**) The findings compare responses by population groups and geographic regions.

Data limitations: It should be noted that the findings from the survey and focus groups represent the opinions of those people who took the survey and attended focus groups, and are not necessarily representative of Chicago as a whole. Though the committee put effort into obtaining a broad representation of opinions from different regions and demographic groups and also worked to target specific populations that might otherwise be underrepresented, the results are not generalizable to all Chicago communities.

In-person feedback: The Chicago Partnership ran a total of 13 focus groups throughout Chicago during July and August 2010, in collaboration with specific partner organizations that had access to hard-to-reach populations who could best be reached in person, such as senior citizens, transient youth, and immigrant and refugee populations. Five of the groups were conducted in Spanish or bilingually in Spanish and English and one was interpreted into Arabic.

Focus group questions were broad and open-ended and included:

1. What would you say are the main challenges (health challenges or other types of challenges) in your community?
2. Where do you get health services? Where do you get health information?
3. What barriers do you or people you know face when trying to stay healthy? What people or opportunities help you or people you know stay healthy?
4. What are your suggestions for making it easier for your community to stay healthy?

Anonymous survey: The online survey became available online in early August 2010 and was available for five weeks. It was available in both English and Spanish, and partner organizations were able to distribute it in whichever language(s) seemed most appropriate. Many Partnership members and other agencies and organizations sent out the survey through a variety of email newsletters and alert systems. (Appendix A)

Survey questions were primarily closed-ended and included:

1. Which health issues most affect your community?
2. Which behaviors most affect the health and safety of your community?
3. How would you rate your community as a good place to raise children?
4. How would you rate your community as a good place to grow old?
5. How would you describe your own personal health status?
6. Where do you usually go for health care services (non-emergency)?
7. How do you pay for your health care?
8. How far do you usually travel to get health care?
9. In the past 12 months, was there a time when you needed health care but did not seek it?
10. What do you feel are barriers to staying healthy in your community?

Overall participation: Survey respondents and focus group participants came from all regions of Chicago. (Figure 1) At least 8% of survey respondents came from each region, with the largest proportion of respondents coming from the North (27%), Northwest (17%), and South (15%). Because the committee posited that Spanish speaking residents and low-income residents may be less likely to complete an online survey, focus groups were held in areas with higher Spanish speaking populations and in areas with higher poverty rates (i.e., West, South, and Southwest regions). Therefore, the proportion of focus group participants in those regions was greater than the proportion of survey respondents from those regions.

FIGURE 1: GEOGRAPHIC DISTRIBUTION OF SURVEY RESPONDENTS AND FOCUS GROUP PARTICIPANTS

	Focus Groups	Survey	Chicago (U.S. Census Bureau Decennial Census 2010)
CENTRAL	4%	11%	5%
NORTH	20%	27%	17%
NORTHWEST	14%	17%	21%
WEST	16%	12%	18%
SOUTH	20%	15%	11%
SOUTHWEST	20%	10%	18%
FAR SOUTH	8%	8%	10%

Focus group participant demographics: In total, 141 individuals from 27 different community areas participated in the focus groups. Demographically, focus group participants

were predominantly female and predominantly identified as African-American/Black or Hispanic/Latino. Nearly 60% had a household income below \$25,000, and over 65% had a highest level of education of high school diploma/GED or less than high school. These demographics reflect the purposeful targeting of populations less likely to be reached by the anonymous online survey. (Figure 2)

Survey respondent demographics: The anonymous online survey collected data from 1,834 respondents (defined as

those who answered some or all of the survey questions). Of these individuals, 22 provided responses to the Spanish language survey and 1,812 to the English version. Similar to the focus groups, survey respondents were predominantly female. However, in this group, nearly 49% of respondents identified as Caucasian/White, almost 55% had a household income of \$50,000, and over 60% had a college degree or higher. Survey respondents had, on average, smaller households than the focus group participants and had lived in their community, on average, for fewer years than the focus group participants. This again may be indicative of the mode of the survey (online) and the method of distributing it (through City and community agencies).

FIGURE 2: SURVEY RESPONDENT AND FOCUS GROUP PARTICIPANT DEMOGRAPHICS

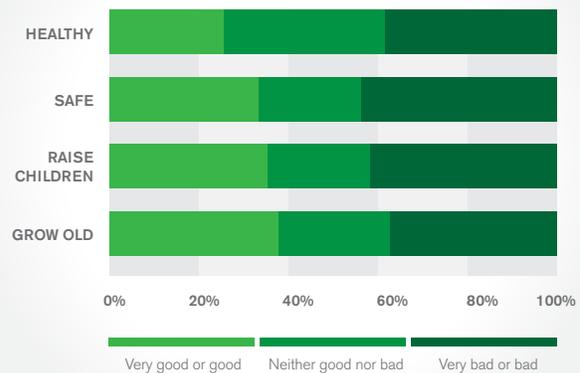
	Focus Groups	Survey	Chicago <i>(U.S. Census Bureau American Community Survey 2006-2008)</i>
MEAN AGE (RANGE)	49 (18-93)	43 (18-82)	N/A
% MALE	14%	27%	48% (of >18)
% FEMALE	86%	73%	52% (of >18)
% CAUCASIAN/WHITE	3%	49%	40%
% AFRICAN-AMERICAN/BLACK	33%	26%	35%
% HISPANIC/LATINO (ALONE OR WITH ONE OTHER GROUP)	55%	16%	28%
% ASIAN/PACIFIC ISLANDER	2%	4%	5%
% AMERICAN INDIAN	1%	3%	0%
MEAN HOUSEHOLD SIZE	3.2	2.7	2.61
MEAN YEARS IN COMMUNITY	19	14	N/A
% LESS THAN \$25,000	60%	20%	N/A
% \$25,000 - \$49,999	22%	26%	N/A
% \$50,000 - \$74,999	10%	22%	N/A
% \$75,000 AND ABOVE	9%	33%	N/A
% LESS THAN HIGH SCHOOL	25%	0%	22% (of >25)
% HIGH SCHOOL DIPLOMA/GED	41%	17%	42% (of >25)
% ASSOCIATE'S DEGREE	1%	13%	6% (of >25)
% COLLEGE DEGREE	27%	28%	18% (of >25)
% MASTER'S DEGREE OR HIGHER	27%	36.3%	12% (of >25)

FINDINGS

Major health and quality of life concerns

Rating the community's quality of life: When asked about the health of their community, 38% of survey respondents rated their community as "very good" or "good." Approximately 26% rated their community as "very bad" or "bad." When respondents rated their community in terms of safety, as a place to raise children, and as a place to grow old, a similar pattern emerged. (Figure 3)

FIGURE 3: RATING COMMUNITY'S QUALITY OF LIFE



Respondents appeared to have the strongest opinions on the safety of their communities, with only 26% of respondents rating their community as “neither good nor bad” with regard to safety (compared to 36% for health).

Survey respondents from the West, South, Southwest and Far South rated their communities more negatively than respondents from the Central, North, or Northwest regions. Respondents identifying as African-American/Black, Hispanic/Latino, or American Indian tended to rate their community as “bad” or “very bad” with greater frequency than respondents identifying as Caucasian/White and Asian/Pacific Islander. Younger respondents rated their community more negatively than older respondents, regardless of race/ethnicity.

Responses also varied by household income, with respondents from higher income groups rating their communities more positively than respondents from lower income groups. (Figure 4)

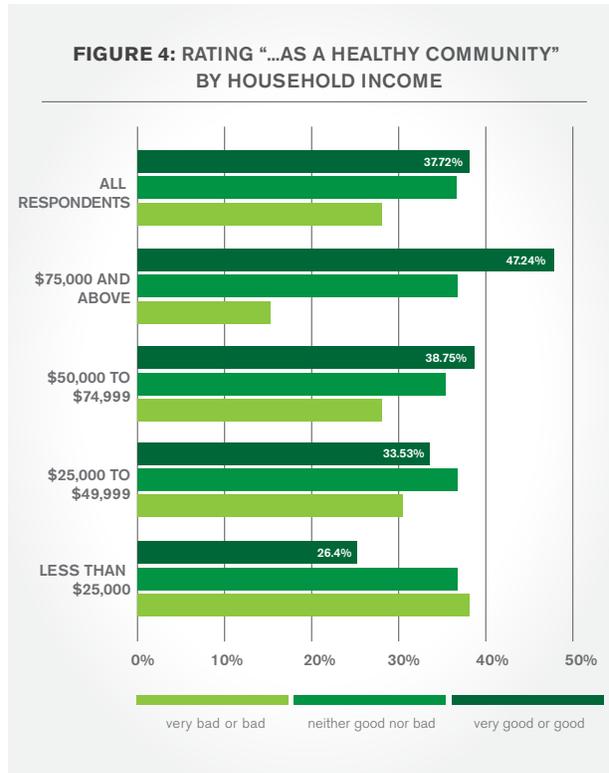


FIGURE 5: TOP EIGHT HEALTH ISSUES BY REGION

	CENTRAL	NORTH	NORTHWEST	WEST	SOUTH	SOUTHWEST	FAR SOUTH	CHICAGO
1	Obesity	Obesity	Obesity	Obesity	Obesity	Obesity	High Blood Pressure	Obesity
2	High Blood Pressure	Violence	Violence	Violence	High Blood Pressure	Violence	Obesity	Violence
3	Diabetes	Depression	Diabetes	Diabetes	Diabetes	Diabetes	Diabetes	Diabetes
4	Heart Disease	Diabetes	High Blood Pressure	High Blood Pressure	Violence	High Blood Pressure	Violence	High Blood Pressure
5	Violence	Heart Disease	Depression	Depression	Cancer	Teen Pregnancy	Cancer	Depression
6	Cancer	High Blood Pressure	Heart Disease	Teen Pregnancy	Teen Pregnancy	Depression	Depression	Heart Disease
7	Depression	Cancer	Cancer	Heart Disease	Heart Disease	Cancer	Heart Disease	Cancer
8	Asthma	Asthma	Asthma	Asthma	Asthma	Heart Disease	Teen Pregnancy	Teen Pregnancy

Health issues that most affect the community: When asked to identify five health issues that most affect their community, survey respondents selected the following issues, in order of frequency: (1) obesity, (2) violence, (3) diabetes, (4) high blood pressure, and (5) depression. Concern about these five health issues was relatively consistent across communities and demographic groups. Other health concerns were identified in the top eight issues but varied in importance across the regions. For example, teen pregnancy was selected more frequently in the West, South, and Southwest than in other regions. (Figure 5)

Among focus group participants, many of the same health issues emerged from the discussion. Obesity was mentioned by 12 of the 13 focus groups, with many specifically noting childhood obesity as a community concern. Some participants expressed concerns about food served in schools and a lack of exercise in the school day, saying that the schools “make our kids fat.” Violence was also mentioned by all but one

focus group. One focus group felt that violence may be a major problem but it is more hidden now than previously. One participant felt that “gang activity is not as blatant as before” but that safety and violence are just as concerning, even if less obvious, than in the past. Diabetes was also mentioned as a health issue of concern by a few focus groups.

Behaviors that most affect the health and safety of the community: When asked to select behaviors that most affect their community’s health and safety, survey respondents most frequently selected: (1) gang-related activity, (2) alcohol abuse, (3) drug abuse, (4) guns, (5) unhealthy eating, and (6) lack of exercise. Concern about these behaviors was relatively consistent across communities and demographic groups, although those respondents in the higher income groups selected unhealthy eating and lack of exercise more frequently than their lower income counterparts. In addition, some behaviors were selected more often within certain communities. For example,

FIGURE 6: TOP EIGHT BEHAVIORS AFFECTING HEALTH AND SAFETY BY REGION

	CENTRAL	NORTH	NORTHWEST	WEST	SOUTH	SOUTHWEST	FAR SOUTH	CHICAGO
1	Lack of Exercise	Gang-related Activities						
2	Alcohol Abuse							
3	Gang-related Activities	Unhealthy Eating	Drug Abuse					
4	Unhealthy Eating	Drug Abuse	Lack of Exercise	Unhealthy Eating	Unhealthy Eating	Guns	Guns	Guns
5	Drug Abuse	Lack of Exercise	Guns	Alcohol Abuse	Alcohol Abuse	Unhealthy Eating	Unhealthy Eating	Unhealthy Eating
6	Guns	Guns	Unhealthy Eating	Domestic Violence	School/ Youth Violence	School/ Youth Violence	Lack of Exercise	Lack of Exercise
7	Unsafe Driving	Unsafe Driving	Unsafe Driving	Lack of Exercise	Lack of Exercise	Domestic Violence	School/ Youth Violence	School/ Youth Violence
8	Racism	School/ Youth Violence	School/ Youth Violence	School/ Youth Violence	Domestic Violence	Lack of Exercise	Unsafe Driving	Unsafe Driving

domestic violence was the sixth most frequently selected behavior affecting health and safety among respondents from the West region, but was eleventh among respondents from the Central region. Among respondents from the Southwest and South, domestic violence ranked as the seventh and eighth most commonly selected behavior, respectively. (Figure 6)

In focus group conversations, 12 of the 13 groups brought up violence as a behavior of concern in the community, with seven of them explicitly mentioning gang-related activity. A young man living on the West side felt that gang activity restricted his movement in the community, saying “right now just because we live on the other side of the park, you can get shot or beat up.” Access to firearms was brought up in other groups as well; two other participants told stories about shootings near their homes and in nearby communities. Nearly all (12 of 13) focus groups also mentioned unhealthy eating and lack of exercise as a problem. Participants mentioned not only school food, but also limited food choices at local grocery stores and restaurants to blame for much of the unhealthy eating in the community. One participant said “I have to travel a long distance to get to a grocery store with organic foods.” She added that others she knows take two buses to get to the South Loop from communities such as Woodlawn and Hyde Park. Domestic violence was mentioned by two of the 13 focus groups, both held in regions where survey respondents ranked domestic violence as six or eight respectively (West and South).

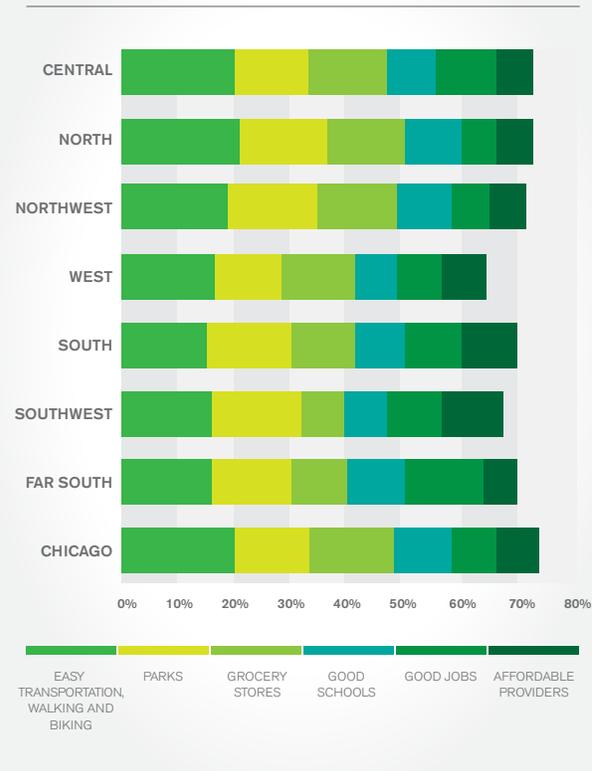
Community assets and barriers

Community assets: Both survey respondents and focus group participants identified several types of assets that make it easy to stay healthy in their communities. Survey respondents, who were allowed to select as many assets as applied, made an average of 3.5 selections. The most frequently selected survey responses overall cited features that offer access to recreation and activity, such as parks

(15% of total responses) and access to easy transportation, walking, and biking (17%). These components support healthy lifestyles and are more possible when communities are safer. Access to grocery stores, good schools, and good jobs were also among the most frequently named strengths within communities, at 14%, 8%, and 8% of responses, respectively.

Though all regions of the city selected these same assets in the same order, not all assets were selected with the same frequency in every community. For instance, although all regions selected easy transportation, walking, and biking most often, this answer made up 20% of the responses from the North and 19% from the Central, while it only made up 14% of responses from the South, Southwest, and Far South. (Figure 7)

FIGURE 7: ASSETS THAT MAKE IT EASY TO STAY HEALTHY BY REGION

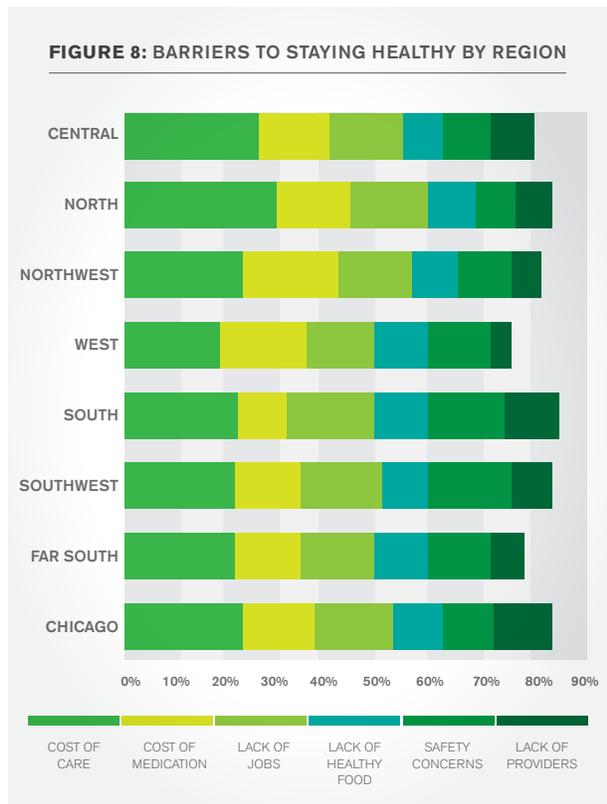


Some assets were also more often selected by specific populations. For instance, bilingual/bicultural health and social service providers were more frequently chosen as an asset among Hispanic/Latino respondents (9% of responses) than among respondents of other ethnicities (1% and 4% among African-American/Black and Caucasian/White respondents, respectively). In addition, community health workers (CHWs) were named as assets by those with a household income under \$25,000 (8%), with only a high school diploma/GED (7%) or Associate’s degree (7%), or who are looking for work (7%) more frequently than by those from other socioeconomic groups (5% among all survey responses).

Among focus group participants, similar assets, such as walking and public transportation, were mentioned. In particular, parks were mentioned by 10 of the 13 focus groups (including but not limited to those focus groups held in or affiliated

with a park site). Those groups held at park districts were very enthusiastic about the programs they attended and felt the classes and instructors were major assets to the community. Other focus groups that were not affiliated with a park site noted other ways parks and recreation spaces promote health, such as by being places for jogging, walking groups, mini golf, day camps for children, and picnics. The lakefront path and beach were also mentioned as community assets by participants from the North.

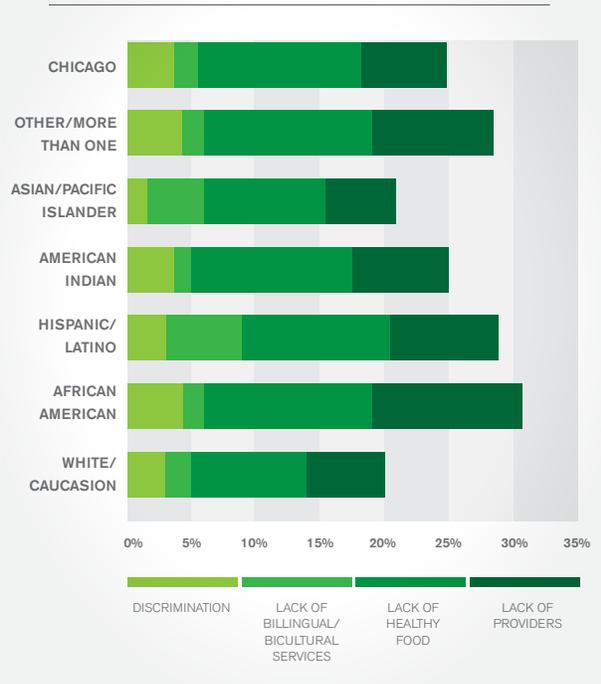
Several focus groups noted new resources or facilities that have improved their communities. For example, one group from the South mentioned the opening of new chain stores that sell healthy foods and that a library has opened that enables residents to use the internet, and that a health club has been built in an area “where you can count on one hand the number of gyms.” Other assets noted included: block clubs, community gardens, school-based health centers, church groups, WIC, and CAPS or other work with the police department.



Community barriers: The main barriers to staying healthy that emerged from both the survey and the focus groups related to economic difficulties: lack of jobs, lack of insurance, and affordability issues. Most frequently selected barriers were the cost of care and cost of medication, with 21% and 18% of responses, respectively, followed by lack of good paying jobs at 14%. Lack of healthy food options (11%), safety concerns, (9%) and lack of health or social service providers (8%) were also commonly selected.

All regions again selected the top few barriers in the same order, but some were selected with greater frequency in certain communities. For instance, although lack of healthy food options was the fourth most often selected barrier in every region, it made up nearly 14% of the responses from the South while making up less than 9% of the responses from either the North or Northwest. (Figure 8)

FIGURE 9: SELECTED BARRIERS TO STAYING HEALTHY BY RACE/ETHNICITY



Some barriers were also more often selected by specific populations. For instance, only 1% of responses from those identifying as African-American/Black selected a lack of bilingual/bicultural services as a barrier while 6% of those identifying as Hispanic/Latino selected this choice. (Figure 9) Among those identifying as African-American/Black, 5% of the total responses indicated that discrimination is a barrier to staying healthy, while only 2% of responses from those identifying as Asian/Pacific Islander indicated this as a problem.

Access to healthcare was mentioned as a barrier to staying healthy in all of the 13 focus groups. Of those, 10 groups specifically mentioned health insurance, cost of care, and/or cost of medication as barriers. Though the other three groups did not explicitly mention cost of care, they did all mention other aspects of access to care, such as language barriers, transportation, or difficulties getting an appointment. In addition, all focus groups mentioned lack of good paying

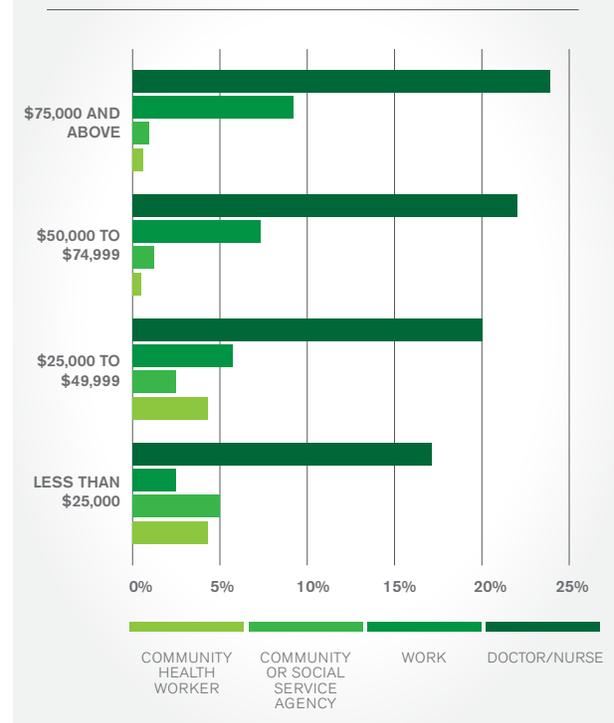
jobs or affordability of food, rent, fitness programs, or other services as a barrier to staying healthy. Focus groups with particularly vulnerable participants, such as refugees and transient youth, frequently noted major economic barriers to staying healthy, such as lack of jobs or affordability.

Eight of the 13 focus groups also mentioned access to healthy food, both in terms of cost and physical location, as a major barrier. Such barriers were mentioned across community regions, though concerns about access to healthy food were particularly common among respondents and participants from the West, South, Southwest, and Far South.

Health information and health-seeking behavior

Sources of health information: Survey respondents were asked where they get their health information and were

FIGURE 10: SELECTED SOURCES OF HEALTH INFORMATION BY HOUSEHOLD INCOME



allowed to select as many choices as applied. The most frequently selected response was doctor/nurse, followed by Internet websites, family, friends, newspapers, TV, radio, and work.

While doctor/nurse and Internet websites were the top two most commonly selected sources of health information among all demographic groups, some differences were seen in the relative frequency of their selection. For instance, doctor/nurse made up 23% of all the responses selected by those reporting a household income of \$75,000 or higher, while it represented only 17% of the responses from those with a household income of \$25,000 or less. (Figure 10)

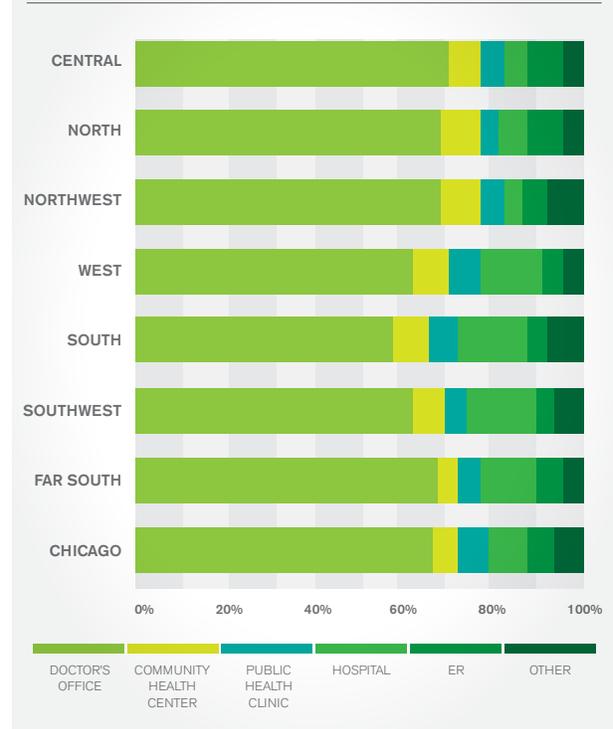
Community health workers (CHWs), though not one of the most frequently selected sources of health information, were selected more frequently among lower income respondents. In addition, although CHWs made up less than 1% of the total responses from those identifying as Caucasian/White, they made up 3-6% of the responses from each of the other racial/ethnic groups.

Internet websites were not only the second most frequently selected choice among survey respondents, but were also frequently mentioned by focus group participants. Examples of websites visited for health information noted by survey and focus group participants included: medical information websites (e.g. WebMD), websites from federal agencies (e.g. Centers for Disease Control and Prevention, Food and Drug Administration, National Institutes of Health), websites from insurance companies, websites from hospitals (e.g., University of Chicago and Rush University Medical Center), websites from disease-specific organizations (e.g. American Heart Association, American Diabetes Association, American Cancer Society), and websites from pharmacies or about prescription drugs. Many also noted they use Google or other search engines and visit “whatever comes up when I search,” though as one focus group participant warned, you “can’t trust all information from the web.”

In addition to Internet websites, focus group participants stated that they receive their health information from many of the same places selected by survey respondents, including from doctors and other healthcare providers, and from TV, radio, and other media. Many focus group participants also said that they get health information from the organization or agency that hosted their focus groups, such as from CDPH, the park district program, or a social service agency.

Sources of health care: When survey respondents were asked where they usually go for primary care services, doctor’s office was by far the most frequently selected choice, with 68% of total responses. Other responses included community health center (8%), hospital (7%), public health clinic (6%), and emergency room (5%). Nearly 16% of survey respondents chose to select more than one option, often both doctor’s office and hospital or

FIGURE 11: USUAL SOURCE OF PRIMARY CARE BY REGION

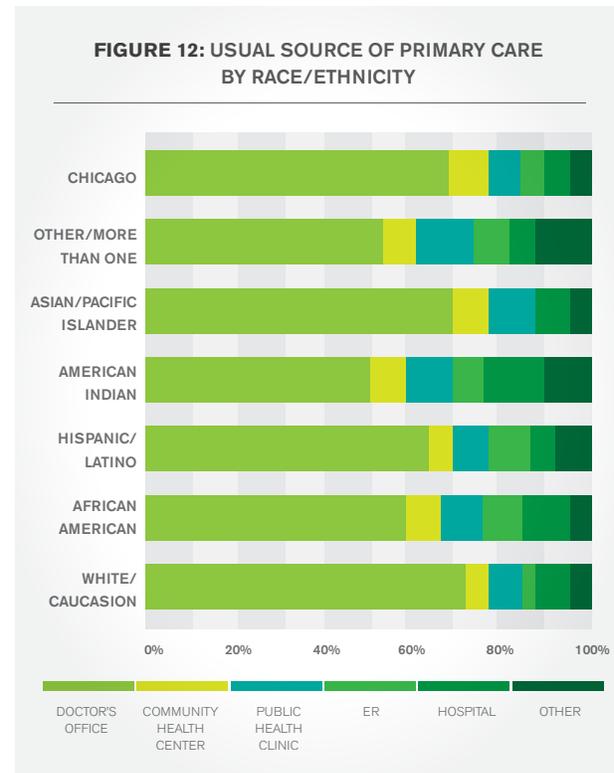


doctor's office and community health center. About 2% of survey respondents selected a combination of community health center, public health clinic, and emergency room. Of the 6% of survey respondents that selected "other," common sources of primary care included: school or university health centers, the VA hospital, or clinics at pharmacies (e.g. Walgreens Take Care Clinic). Some respondents who selected "other" said they have not received any care recently and do not usually go anywhere for primary care due to lack of insurance.

Though doctor's office was the more frequent response in every region, it was not selected quite as often among respondents from the West, South, and Southwest (58-63% of all responses) as among respondents in the Central, North, Northwest, and Far South (58-73%). (Figure 11) Selecting emergency room as a source of primary care was twice as common in the South (10%) as in Chicago as a whole (5%). Selecting community health center was more common in the West (11%) than in other regions (7-8%).

Survey responses indicated that source of primary care varied by socioeconomic status. Among respondents in the highest household income group (\$75,000 and above), doctor's office made up nearly 86% of all responses while emergency room made up only 2%. Among respondents in the lowest income group (less than \$25,000), only 40% of the responses were doctor's office while 10% were emergency room.

A relationship was also seen between source of care and race/ethnicity. (Figure 12) Though all groups selected doctor's office more frequently than any other source of care, among those identifying as White/Caucasian, 75% of the selected responses were the doctor's office. Among those identifying as American Indian, African-American/Black, Hispanic/Latino, or as multiracial/other, the proportion of responses indicating doctor's office was much lower (49%, 59%, 62%, and 55%, respectively). Other sources



of care were thus selected more frequently among these groups. Community health centers, public health clinics, and emergency rooms were all selected about twice as often among respondents identifying as American Indian, African-American/Black, and Hispanic/Latino as among those identifying as White/Caucasian.

Focus group participants noted similar sources of health care as those noted by survey respondents. Most often mentioned were physicians, community health centers, and hospitals. Non-profit organizations and other social service programs were also mentioned, both in terms of providing some healthcare services and in terms of helping participants access hospitals or navigate the health system. Several participants noted that family members play a large role in influencing where they usually receive care.

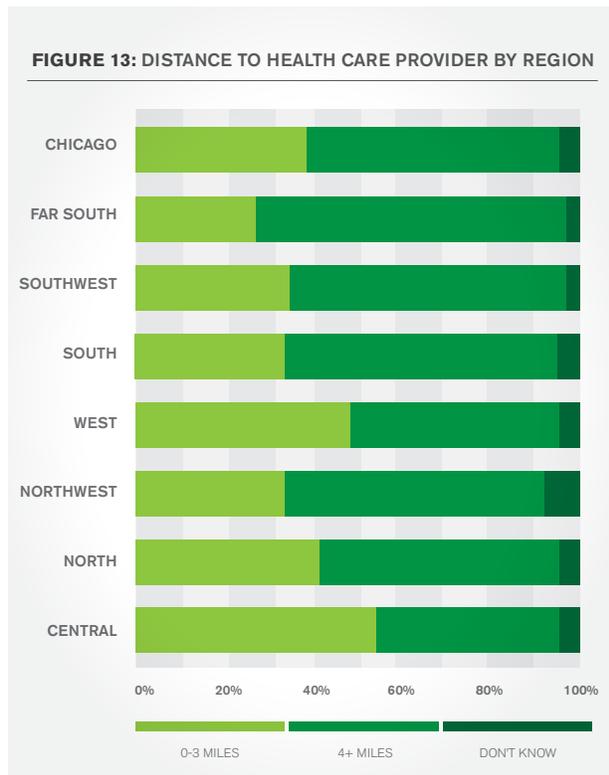
Responses were similar to the question of where respondents usually receive dental care. Just as the most frequent

source of primary care in every region was doctor’s offices, the most frequent source of dental care in every region was private dentist (76%). However, those in the West selected this response quite a bit less frequently (66%) than those in the North or Central regions (81%). Not having a place to receive dental care made up a substantial minority of responses in every region, with 13% of all responses. Not having a place to receive care ranged in frequency from the West, where it made up nearly 19% of responses, to the Far South, where only 7% of responses indicated not having a place to receive dental care.

In regards to mental health care services, only 11% of respondents indicated that they receive any mental health services at all. Of those who do, a pattern similar to that of primary care and dental care emerged. Private provider (e.g. psychiatrist, psychologist, social worker, or counselor) was the most frequent selection, with 63% of all responses, followed by community mental health center (8%), hos-

pital (8%), faith professional (7%), primary care provider (6%), and community health center (6%).

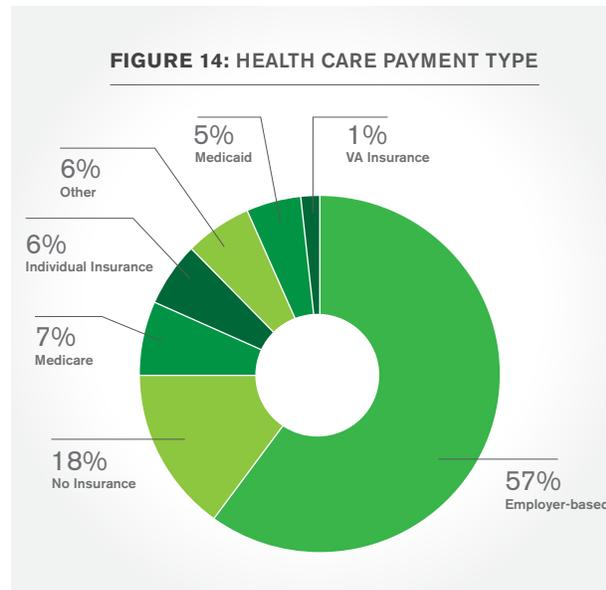
Distance to care/location of care: Overall, more than 50% of survey respondents received some health service(s) outside their community within the past 12 months. This rate was higher among respondents from the South, Southwest, and Far South (55-63%) and among those identifying as homosexual (58%) or African-American/Black (58%). Reasons stated for going outside the community included access to: specialty care not offered in the community, care covered by a particular insurance, free clinics or sliding scale providers not located in the community, and services catered to a very specific population, such as a particular ethnic or cultural group. Other reasons given for traveling for care are a preference for going to providers based on recommendations rather than on location and a perceived lack of quality providers in the local community.



Focus group participants echoed many of these reasons for traveling outside the community for care. One participant said she felt more comfortable at a women’s health facility in the North that caters to all sexual orientations than with providers in her region. Several participants in the Arabic-speaking group receive services at a clinic that, although located outside of their community, caters to their population. Other participants expressed that they go outside the community for care due to recommendations or referrals, or due to lack of knowledge about providers in their local area.

Among survey respondents, 58% said they usually travel four or more miles to receive health care, while 38% travel three or fewer miles. Those from the South, Southwest, and Far South more frequently responded that they travel four or more miles for care (62-75%) while those from the Central or West regions least frequently gave this response (40-50%). (Figure 13)

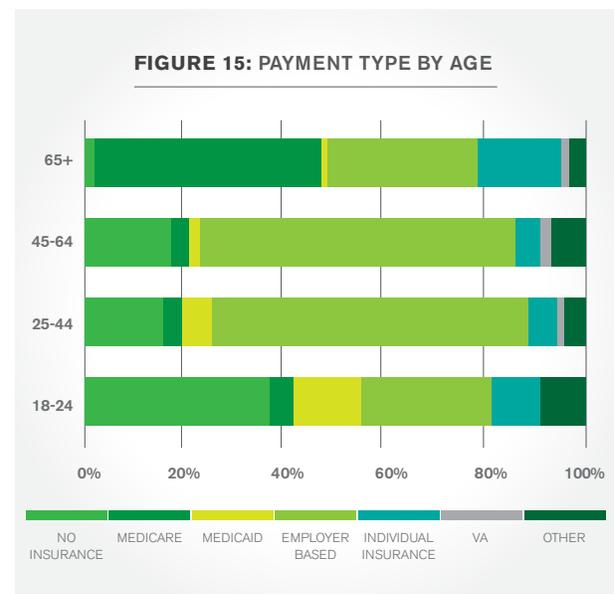
Health care payment: When asked how they usually pay for their health care, the most frequently selected response among survey respondents was employer-based insurance coverage at 57% of the total responses. (Figure 14)



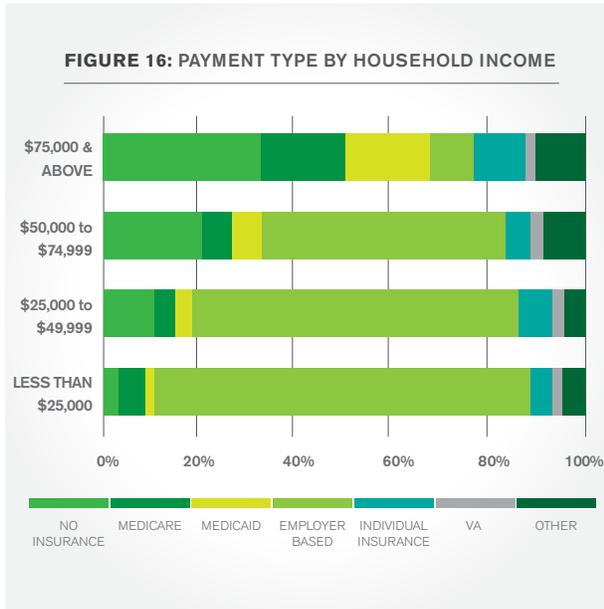
Other responses were: Medicare (7%), individual insurance (6%), Other (6%), Medicaid (5%), and Veteran’s Administration coverage (1%). Just under 18% of responses selected were “I pay out-of-pocket (no insurance).” Among only those respondents ages 18-64, just over 18% of responses indicated no insurance, which is less than the 27% of Chicago residents ages 18-64 who are uninsured, as noted in the 2009 U.S. Census Bureau American Community Survey. About 10% of survey respondents selected more than one response, often both Medicare and a form of private insurance (4%), Medicare and Medicaid (1%), or both uninsured and a form of insurance (5%), perhaps indicating either insufficient coverage, high out-of-pocket costs, a household with both uninsured and insured members, or respondent error.

Payment type seemed to be related to some demographic characteristics. For instance, respondents age 18-24 were

the age group most likely to select uninsured, with 26% of responses (Figure 15). Only 3% of the responses from the 65 and older group and only 16% of responses from the middle two groups indicated being uninsured, showing that the burden of uninsured may be among younger adults. Among the oldest age group, 42% of responses indicated Medicare. Among the middle two age groups, 25-44 and 45-64, 65% and 62% of the responses, respectively, were employer-based coverage, while employer-based coverage made up only about 30% of the responses from the oldest and youngest age groups.



Income was also related to payment type. (Figure 16) Though individuals from every income category selected every response, the proportion of uninsured responses went down dramatically as income went up. Among those with a household income of \$25,000 or under, 36% of responses were uninsured; among those with a household income of \$75,000 and above, the percent of uninsured responses went down to 5%. Similarly, the proportion of employer-based coverage responses went up steadily as income went up. Only 12% of responses



from the less than \$25,000 group were employer-based coverage, while 51% of responses from the next category, 72% of responses from the third category, and 82% of responses from the \$75,000 and above category indicated employer-based coverage.

When looking only at those respondents from households of a given size, the distribution of payment type looked more and more similar to the lowest income group as the number of household members went up. For example, when considering only households of four or more, all income ranges below \$75,000 had a very similar distribution of payment types.

Payment type and employment status also appeared to be related. (Figure 17) The proportion of uninsured responses was highest among those who were looking for work (41%) and those working part-time at multiple jobs (36%). Uninsured responses were lowest among those working full-time (8%) and those who were not employed but not seeking work due to being retired, a student, a caregiver, etc. (16%). Employer-based insurance made up over 82% of the responses from those working full-time,

while it made up 32% and 28% of the responses from those working one or more jobs part-time, respectively.

Seeking needed care: Survey respondents were asked if, in the past 12 months, there had been a time when they needed health care but did not seek it. Overall, 34% of respondents answered that yes, there had been such an occasion in the past year. No gender difference was seen in responses to this question. Those identifying as Hispanic/Latino and those in the youngest age group (18-24), however, selected yes more frequently than respondents as a whole (40% and 50% respectively).

In addition, those from specific socioeconomic groups more frequently responded that there had been an occasion in the past 12 months when they did not seek needed care. For instance, 49% of those with household incomes of less than \$25,000 and 45% of those with incomes of \$25,000-\$49,999 responded that they had had such a situation in the past year. Of those whose highest degree was a high school diploma/GED, 46% responded in the affirmative. Similarly, 53% of those who were looking for work and 47% of those working two or more part-time jobs had had a situation this year where they did not seek needed care.

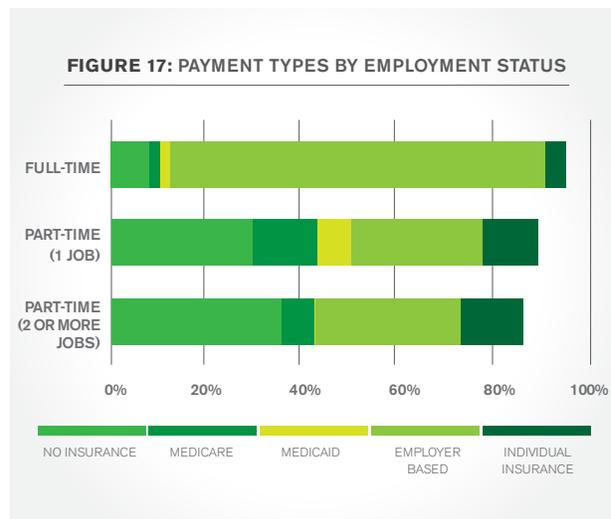
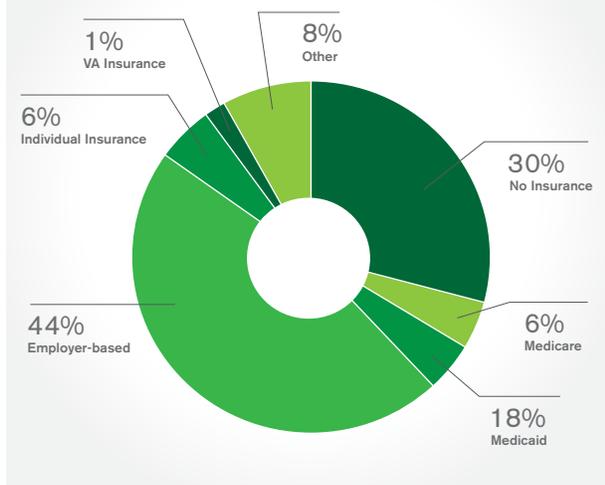


FIGURE 18: NEEDED CARE BUT DID NOT SEEK IT

A relationship was also seen between health care payment type and seeking needed care. Of those who, in the past year, did not seek needed care, 30% of the responses indicated having no insurance. (Figure 18) However, as Figure 14 showed, 18% of all survey responses indicated they did not have insurance. However, it should be noted that while the proportion of uninsured responses was higher among those who did have an occasion in the past year where they did not seek needed care, the most frequent payment type among those who did not seek needed care was still employer-based insurance, at 44%. Thus even though not having insurance may be related to not seeking care, most survey respondents who did not seek needed care in the past year did indicate a form of public or private insurance as their payment type.

Personal health status: When asked to rate their personal health status, most survey respondents indicated that their health was good (61%) or even excellent (18%). Nearly 20% described their health as fair, and the remaining less than 2% stated their health as poor. Self-reported health status varied by community region. In the North and Central, for instance, over 22% of respondents

described their health as excellent, compared the 13% in the Southwest region and 6% in the Far South.

Education and income were related to self-reported health status, with those in the higher education and higher income categories tending to rate their health more favorably.

Responses to other health seeking behavior questions showed a connection to their health status. For example, payment type was linked to health status, with those who ranked their health as excellent or good having a higher proportion of employer-based responses and those who ranked their health as fair or poor having a higher proportion of uninsured responses. Similarly, those who ranked their health as excellent or good more frequently listed doctor's office as a source of primary care, whereas those who ranked their health as fair or poor more frequently listed community health centers, public health clinics, and emergency rooms as sources of primary care.

Suggestions for healthier communities

Participants' suggestions on how to improve the health of their communities ranged from broad-based system changes to repairing current resources to more community collaboration. Most respondents appeared invested in their communities and interested in changes to improve both community and individual health.

Broad policy and systems changes: Both survey respondents and focus group participants suggested large-scale policy changes as ways to improve the health of their communities. In particular, universal health insurance was identified as a way to address current barriers to staying healthy. One focus group participant commented that "health is a luxury – it shouldn't be, but it is," and expressed the ways she felt a nationalized health system would contribute to better health and reduced disparities in her community. Other policy and systems changes recommended were:

improvements to job and economic prospects, changes to the tax system, and “revamping” the public schools.

New community facilities and resources: Many suggestions focused on building new community facilities and resources in areas that lacked, including: pools, clinics, community centers, community gardens, and farmers’ markets. Respondents and participants from the West, South, and Southwest also frequently suggested that grocery stores and restaurants with healthy food be established in their communities. Though suggestions for new facilities and resources came from every part of the city, residents of the West, South, and Southwest regions seemed especially interested in such facilities coming to their area.

Improvements to existing resources: Other suggestions focused on improving existing community resources as a way to improve the health of the community. Safer bike routes were suggested frequently, especially among survey respondents from the North and Northwest regions. Many respondents wanted more bike lanes, better routes that connect to bike trails, better protective laws for bicyclists, and more opportunities that facilitate biking, such as community bike nights and the ability to rent bicycles from park sites.

Another common recommendation was to make improvements to park facilities. This suggestion came from those participating in the focus groups held in park districts and from other focus groups and survey respondents. Community members who were pleased with their park district facilities had suggestions to further improve services, such as: more exercise classes throughout the day, more family-friendly programming, bike rentals, health fairs, more workout facilities, and indoor pools. In addition, respondents wanted a higher level of security at park district sites. Community members who were less satisfied with the parks were concerned with basic safety and function. For instance, one survey respondent wanted lights on the basketball court and

repair of broken swings and equipment. Another person highlighted the need for better park maintenance and more programming. Overall, all community members felt that greater improvements, particularly around safety and maintenance, would make these facilities better community health assets.

Classes, workshops, and programs: Community members felt that access to more classes, workshops, and programs would help improve the health of their communities. Most common were suggestions to increase exercise and nutrition classes. Other types of classes recommended included: tai-chi, yoga, bike safety, STI prevention, first aid, parenting, breastfeeding, childbirth, employment workshops, and arts programs. Community members also suggested that programs be geared towards certain underserved groups. Several survey respondents and focus group participants shared the need for more senior programming, e.g., transportation services, exercise opportunities, and wellness checks.

Older youth was another underserved group often mentioned in both surveys and focus groups. One survey respondent voiced that “there should be way more activities available for the young and older teens alike” and that her community would like to turn a local building into “[an] art center and a job preparedness center for the teens with mentoring for young women and men.”

Finally, classes for men were suggested several times. One focus group participant from the South region expressed that more health support and programming was needed for men, as they don’t typically go to workshops and screenings and thus do not get the information they need.

Individual parental responsibility: Parental responsibility was a commonly raised theme within the focus groups; many focus group participants suggested that we “really need to look at parenting” and that “we [as parents] need to change” so as to be better role models or to instill better habits in children. As one focus group participant stated,

“parents need to participate in sports with their kids, not drop them off and go home to watch TV or nap. It sets an example.” Though this set of suggestions focused more on individuals taking responsibility for their own families’ health, parenting programs and classes that allow parents and children to exercise together were suggested as ways the community can help encourage such responsibility.

Community collaboration and communication: Finally, one of the most important suggestions from survey respondents and focus group participants was to increase community collaboration and communication, both within individual communities and between these communities and the City or external agencies and partners. One open-ended survey response read “I feel that we need to all work together”: likewise a woman from one of the focus groups articulated the potential power of working together by saying “where there’s unity, there’s strength.” Other suggestions included: more frequent community meetings to discuss shared neighborhood issues, more interaction between residents of different ethnic backgrounds or who speak different languages, and better communication of the availability of services already being offered within the community.

Better external collaboration between the community and other entities was also suggested. Numerous focus group participants and survey respondents expressed a desire to improve communication with City agencies and other external partners. As one focus group participant put it, “we’re here – talk to us.” Common suggestions included: more participation by residents in City government, more partnerships between City agencies and pharmacies or other retailers to provide health services in communities, more communication of health services available throughout the city to residents in other communities, and more transparency between local government and community residents.

Local Public Health System Assessment

PURPOSE

This assessment collects data on current system activities and capabilities, along with its collective strengths and areas for growth. This information is an essential component of the community health assessment and planning process because it identifies the underlying system capacity to accomplish the goals and objectives identified in the plan. In addition, this assessment is of particular importance for the *Chicago Plan for Public Health System Improvement* because the goals and objectives within the Implementation Plan focus on improving system functioning as a sustainable approach to improve health status.

PROCESS

Over 50 people (Partnership members, Chicago Department of Public Health (CDPH) staff, and other representatives of Chicago's public health system) participated in a day-long meeting on July 14, 2011 to rate the public health system. (Appendix A) This assessment was completed through the use of the National Public Health Performance Standards Program (NPHPSP) Local Assessment Instrument, which was developed by a collaboration including the Centers for Disease Control and Prevention (CDC) and the National Association of County and City Health Officials (NACCHO). The assessment instrument presents model standards, stem questions, and sub-questions for each of the Ten Essential Public Health Services. (Figure 1)

Participants were assigned into one of five groups, where they scored the activity of the public health system for two of the Ten Essential Services based on specific centers criteria. (Figure 2) Participants discussed all of the questions (stem and sub-questions), but due to time limitations, only voted on the stem questions. The note takers and facilitators later scored the sub-questions based on the group discussion. Participants also shared more qualitative feedback on the system by answering the following questions:

FIGURE 1: THE TEN ESSENTIAL PUBLIC HEALTH SERVICES

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve community problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure a competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative

- What are the System's strengths?
- What are the System's areas for growth?
- What opportunities are available for immediate implementation?
- What are the priority areas for improvement?

After the meeting, the scores were entered into the NPHPSP website, which tabulated the results.

FIGURE 2: RATING OF THE ACTIVITY OF THE PUBLIC HEALTH SYSTEM

NO ACTIVITY	0% or absolutely no activity.
MINIMAL ACTIVITY	Greater than zero, but no more than 25% of the activity described within the question is met.
MODERATE ACTIVITY	Greater than 25%, but no more than 50% of the activity described within the question is met.
SIGNIFICANT ACTIVITY	Greater than 50%, but no more than 75% of the activity described within the question is met.
OPTIMAL ACTIVITY	Greater than 75% of the activity described within the question is met.

Data Limitations

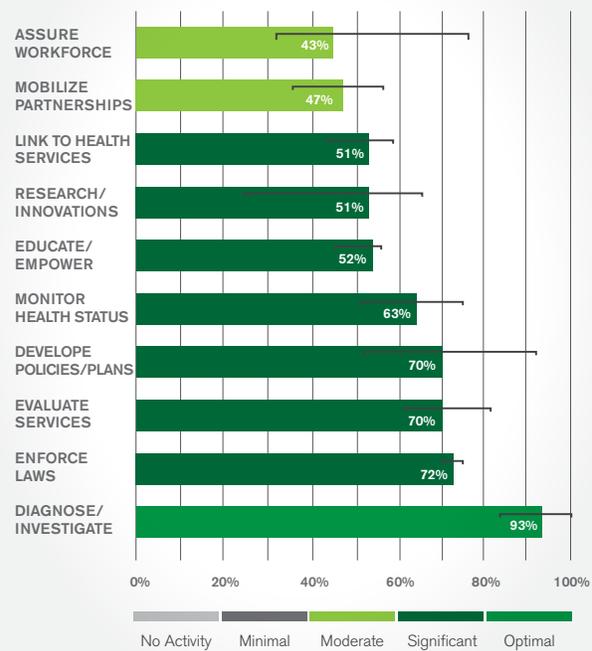
NPHPS recommends the findings be used for quality improvement, but “should not be interpreted to reflect the capacity or performance of any single agency or organization” because accuracy of the findings could be affected by several factors, including absence of key system stakeholders in the process and confusion about the meaning of specific model standards. The strength of the findings may be effected because the participants did not score the sub-questions themselves. In addition, although most of the note takers and facilitators received the same training, the groups may have been conducted with some variation, which may lead to interpretation differences.

Scoring Findings

Overall, the Chicago Public Health System (PHS) scored within the “significant” range, at 61%. Seven out of the Ten Essential Services were rated as “significant” activity occurring, with one at “optimal” level and two at “moderate”

level. (Figure 3) The Essential Service that received the highest score was #2: Diagnose and Investigate Health Problems and Health Hazards and the lowest scoring service was #8: Assure a Competent Public and Personal Health Care Workforce.

FIGURE 3: TEN ESSENTIAL SERVICES RANKED BY LEVEL OF ACTIVITY



Several Essential Services showed wide variations among model standards scores.

#5 Develop Polices/Plans: The Emergency Planning model standard was rated at 92%, much higher than the score for Government Presence, at 51%. (Figure 4)

#8 Assure Workforce: While most of the model standards scored in the “minimal” range, Workforce Standards was rated at the very top of the “significant” level. (Figure 5)

#10 Research/Innovation: Research capacity ranked much lower than the other two model standards. (Figure 6)

FIGURE 4: EPHS 5 DEVELOP POLICIES/PLANS

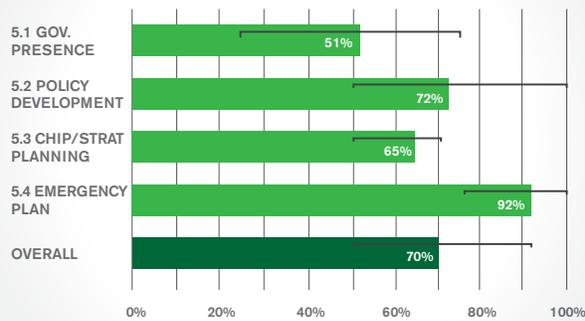


FIGURE 5: EPHS 8 ASSURE WORKFORCE

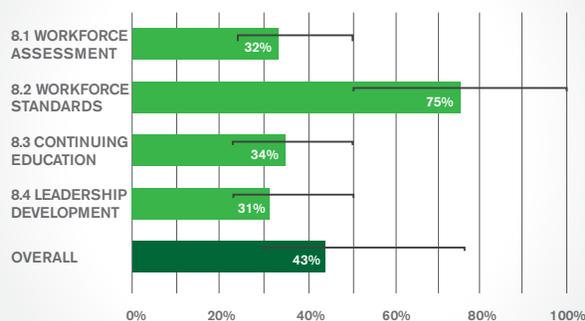
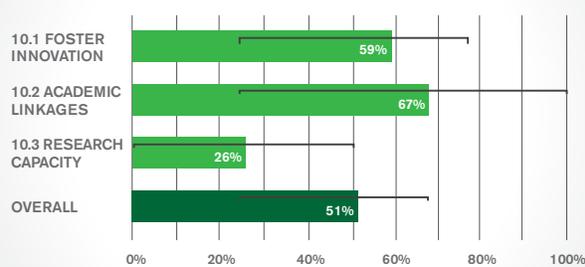


FIGURE 6: EPHS 10 RESEARCH/INNOVATIONS



Discussion Findings

During the group discussions, participants identified system strengths, areas for growth, opportunities for immediate improvement, and priority areas. In many cases, areas identified as “strengths” were also mentioned as “areas for growth” because of need for more services/programs and disparity among topics/populations.

Strengths

- *Resources to protect the public*, including surveillance capabilities, investigation expertise, public health laboratories, partnering with universities, established policies for emergency preparedness, and laws to protect the public.
- *Data and identification of issues*, including community health profiles, work on Electronic Health Records (EHR) and the Health Information Exchange (HIE). The PHS is effective at identifying problems and vulnerable populations in need of interventions.
- *Coordination among system partners*, such as institutions that are a part of communicable disease efforts, the Illinois Department of Public Health, CDPH, and institutions of higher learning. The presence of the broad range of system partners was identified as a strength of the system.
- *Workforce*, with licensure/certification requirements of clinical staff to ensure quality care. Some organizations within Chicago’s PHS employ communication specialists and/or develop processes to communicate with the public.
- *Measuring effectiveness/ performance monitoring*, used by private providers to organize their services and by CDPH to optimize interventions.
- *Innovative local efforts*, including the work of several community-based health committees, local food access, and strong community plans.

Areas for Growth

- *Improve access to data/information*, due to public/community groups’ need for guidance in how to access data (e.g., what websites to use, what organizations, etc.), lack of timely/real-time data, lack of standard dissemination processes, inconsistent availability of information and education, lack of sustained efforts to improve data access, and importance of ensuring that EHR and HIE address public health data needs.
- *System coordination*, including lack of continuity of services with people falling out of care, lack of systems working together to monitor health status and inform the public about resources, and unlinked service

evaluation efforts. Some system/community partnerships exist, but are not available citywide.

- *Funding patterns*, which limit educational and outreach efforts and perpetuate gaps in services to non-priority populations.
- *Strengthening workforce*, due to lack of comprehensive workforce assessment, lack of job standards within many PHS agencies, and lack of support for leadership development or access to training. More epidemiologists are needed to strengthen the capacity of the PHS and health economists are needed at the local level.
- *Communication and media strategies* are needed to reach diverse populations with appropriate and effective campaigns. Opportunities exist to reach these audiences through the broad base of public health system sectors (e.g., faith based).
- *System capacity* to provide timely and necessary services (e.g., State laboratory, dental care).

Opportunities for Immediate Implementation

- *Grow partnerships/non-traditional stakeholders*, within the Chicago Partnership for Public Health and through creation of ad hoc workgroups to strengthen Chicago's PHS.
- *Improve communication to the public* about available resources, social determinants, and reputable websites for health information. Develop plan to utilize social media and other non-traditional vehicles to communicate health information.
- *Connect with system partners* to educate/inform communities, including City Departments working together to reach residents.
- *Focus public health system research* by identifying a short list of relevant research priorities and working with key research groups/centers.
- *Improve effectiveness of services* and programming by connecting with model programs that provide comprehensive continuity of services.

- *Improve workforce effectiveness* by advocating for PHS support of professional development.

Priority Areas

- *Coordination among system partners* to develop strong system interdependence, create common messaging, establish formal linkage structure for both personal and population-based services, and articulate role of system partners.
- *Strengthen communication strategy* to provide more effective messaging and outreach, partner with media, and assist public in understanding public health information.
- *Data dissemination and utilization*, to the public and within the HIE system.
- *Creation and support of standards for highest quality PHS workforce*, through professional development, incentives, formal assessments, and culture shift.
- *System resource analysis* to document needs compared to available services, including specialty care; develop and sustain online directory of services.
- *Expansion of community health committees* to involve all Chicago communities in addressing local health issues.

Forces of Change Assessment

PURPOSE

The purpose of the Forces of Change assessment is to identify forces or trends that are either currently affecting Chicago's public health system or will affect the public health system in the next five years. The assessment also highlights the effects these forces could have on the system; both those that threaten the system's functioning and those that open doors to new opportunities. Inclusion of the Forces of Change as a key assessment adds an element of foresight to the strategic planning process as the Partnership documents possible intended and unintended consequences of these forces on the system.

PROCESS

Chicago Partnership members identified forces and trends affecting Chicago's public health infrastructure through an online survey. These responses were grouped into categories and Partnership members further elaborated on these issues, threats, and opportunities at a subsequent Partnership meeting.

FINDINGS

The Partnership identified eight categories of Forces of Change:

- **Health Reform and Health System Changes**
- **Public Health and Health Care Workforce**
- **The Economy and Unemployment**
- **Changes in Chicago's Population**
- **Political Environment**
- **Built Environment**
- **Violence and Health**
- **Technological Progress**

Health Reform and Health System Changes:

Force: The Patient Protection and Affordable Care Act (ACA) was signed into law in March of 2010 with goals of increasing the number of people with health care coverage, improving the quality of health services, and increasing prevention interventions. Since its passage, many consumer protection provisions have been implemented, including: the extension of health care coverage on parents' insurance policies for young adults until the age of 26, prevention of insurance companies' coverage denials of children with pre-existing conditions, and prohibition of health insurance benefit denials due to application form errors.¹ The ACA has also illegitimized lifetime health insurance coverage limits, established tax benefits for small businesses that provide health insurance benefits to employees, and required new health plans to cover preventive services, such as mammograms and colonoscopies.²

Threats: The ACA will increase the number of people with health insurance and the number of people who access care on a more regular basis. However, even with

provisions in the ACA to build the health care workforce, the system will not be adequately staffed for this influx of 500,000 more Chicagoans expected to seek care.³

Even though many more people will have coverage, a still sizeable amount of people who are not eligible for coverage—an estimated 172,000 undocumented persons—will not have access to these health coverage options.⁴ Although the uninsured will still be able to access care at Federally Qualified Health Centers (FQHCs), many are expected to continue to access services at the most expensive health care option—the hospital emergency department. Prior to the ACA, hospitals that served a high proportion of Medicaid or uninsured patients, known as Disproportionate Share Hospitals (DSH), received extra funding to help defer these costs. This funding is being reduced, which will make it harder for these hospitals to continue to care for the undocumented/uninsured. Other clinics that are not federally funded, e.g., free clinics, will not receive funding through the ACA but will most likely see an increased patient caseload.

Another threat to the public health system is the current political climate. Many candidates running for the 2012 presidential election want to repeal the ACA. In addition, several of its provisions are at risk in March 2012 when the Supreme Court will hear arguments on the ACA, including the individual mandate provision.

Opportunities: Health reform introduces many components that will improve the public health system, including access to care and a focus on prevention. The ACA will increase funding to expand the number of safety net providers (i.e., FQHCs). Opportunities exist to locate these sites in neighborhoods with the greatest need (i.e., large numbers of medically needy

and few safety net providers). With an increased focus on FQHCs, more people will learn about and utilize these community-based resources. Although free clinics and other non-FQHCA safety net sites will not be eligible to receive ACA funding, these sites could seek out private sector and foundation support that is currently going to FQHCs.

Increased job/employer flexibility is another benefit that will emerge from the ACA's provisions to improve access to affordable care. Workers will not need to remain in the same jobs to retain health benefits for pre-existing conditions.

The focus on prevention is a significant benefit and opportunity borne of the ACA. The ACA created the first-ever Prevention and Public Health Fund, which will provide \$15 billion for public health programs over ten years. Through Community Transformation Grants, state and local governments will develop interventions to reduce chronic disease rates and address health disparities. Prevention is also supported as the ACA promotes the work of Community Health Workers (CHWs) to reach vulnerable populations with education and information, thereby improving health status for many at-risk communities. In addition, the ACA improves opportunities for prevention as more employers purchase new health plans that include preventive measures.

¹ U.S. Department of Health and Human Services. Provisions of the Affordable Care Act, By Year. Available at: <http://www.healthcare.gov/law/timeline/full.html>.

² *ibid*

³ The Gilead Center for Outreach and Referral. "Taking a Closer Look at Illinois' Uninsured. A report by the Gilead Outreach & Referral Center", April 2009

⁴ Social IMPACT Research Center's analysis of the U.S. Census Bureau's 2006-2010 American Community Survey and Pew Hispanic Center's Unauthorized Immigrant Population: National and State Trends, 2010 by Jeffrey S. Passel and D'Vera Cohn.

The Public Health and Health Care Workforce

Force: The American Public Health Association predicts that by 2020 the public health workforce will fall short by 250,000 workers.⁵ Overall, the healthcare industry will continue to experience shortages in providers, particularly nurses, primary care physicians, and direct-care workers.

Threats: The aging of the baby boomer generation highlights threats to the public health infrastructure. Retirements within the public health and health care workforce of long term employees leave not only vacancies that can be difficult to fill, but also a drain of knowledge and history within the system. Also, the demand on the health care system grows as the number of elderly people increases, requiring more services and more staff to provide those services.

Other threats to the workforce include medical student disinterest in primary care and lack of provider cultural competence. Many medical students express negative perceptions of internal medicine, especially general practice, due to long hours and low compensation in comparison to specialists.⁶ Without an ongoing cohort of new primary care providers, access to care will be limited not by affordability, but by lack of system infrastructure. In addition, the lack of diverse health care providers who reflect community demographics or who provide culturally effective care threatens the ability of the system to care for diverse populations.⁷

Opportunities: Many of the threats identified are being addressed through current activities and future plans. To promote interest in primary care, the ACA increased primary care residency slots and expanded the National Health Services Corps Loan Repayment Program. The ACA further provides incentives to health care workers through tax incentives for working in underserved areas and incentives for both physicians and nurses working in primary care. In addition, initiatives to increase primary

care services through the use of nurse practitioners and physician assistants will improve access to care.⁸

Another opportunity to enhance the workforce is by promoting health care careers to all levels of students. The University of Illinois at Chicago School of Public Health runs the Health Careers and Opportunity Program (HCOP), which introduces young students to health careers. These programs reach minority youth, who will bring diversity to the future workforce. The UIC College Prep High School is a charter school, focusing on mathematics and science, with a special emphasis on the health sciences. Faculty from UIC health sciences campus (Medicine, Nursing, Dentistry, Pharmacy, Public Health, Applied Health Sciences, and Social Work) helped develop the curriculum.

Several initiatives will build the workforce and increase access to undergraduate health careers. Malcolm X College, one of the City Colleges of Chicago recently focused its curriculum to emphasize health care sciences and is partnering with local hospitals and pharmacies for student opportunities. UIC School of Public Health is initiating a public health degree for undergraduate students in the fall of 2012. The need for these innovative strategies, which focus on training a diverse healthcare workforce, continue, especially in careers such as nursing, where the problem is not the number of applicants but rather the inadequate number of available openings in the training programs.⁹

The Economy and Unemployment

Force: The state of the economy is a key force affecting Chicago's public health infrastructure due to the recession, which has both reduced individual and family income and limited available resources for public health and health care. Within Illinois, statewide budget cuts disproportionately threaten human service programs.¹⁰ The long term

sustainability of these programs that serve vulnerable populations is at risk. Shuttering human service programs would result in decreased access to care and more job loss.

With a high unemployment rate (almost 10% in September 2011), more Chicagoans are living in poverty and spending a higher percentage of their income on housing costs. As of 2009, 31% of nonprofits reported cutting services.¹¹ In the past year approximately 20% of jobs lost have been restored. However these new positions do not offset the losses because of the additional entrants to the job market during this time.¹²

Threats: A serious threat to the health care system is the downturn of the economy, increasing the number of people without health care insurance. Throughout the U.S., a one percent increase in unemployment results in an additional one million uninsured.^{13,14} Experiencing these stressful situations puts this population at risk for physical and mental illness. Individuals who lost their jobs through no fault of their own are more likely to develop high blood pressure, diabetes, and heart disease in less than two years of becoming unemployed than their employed counterparts.^{15,16} In addition, housing foreclosures have been correlated to an increase in emergency department visits for hypertension.¹⁷

Many of the newly uninsured are not familiar with Chicago's safety net system. As a result, many people may postpone care, turning up at a hospital emergency department with more acute health conditions. When people do locate low-cost health centers, such as FQHCs, the increasing number of uninsured patients may lengthen the wait times to get an appointment.

Opportunities: As demand for affordable health care grows within all populations, opportunities exist to educate the public about the need for continued funding to

expand and strengthen this important component of the public health infrastructure. Newly uninsured individuals may now be more interested in learning about and advocating for the provisions of the Affordable Care Act that ensure a basic level of health care coverage.

To serve the larger numbers of patients seeking low-cost care, health centers will need to ensure their operations are as efficient and effective as possible. This necessity provides an opportunity for centers to implement proven best practices and become more cost efficient. More focus on population-based care and preventive services will reduce system costs and demand for acute care. Much of this preventive work can be done in collaboration with other organizations. For example, collaborating agencies can offer health education classes at FQHCs on smoking cessation and nutrition to reach both the FQHC patients and other community residents. Working with the health department on identified priority areas will support

⁵ American Public Health Association. Shortage of U.S. public health workers projected to worsen: about 250,000 new workers needed. *Nation's Health*. 2008. *Nations Health*. 2008;38(4)

⁶ *Arch Intern Med*. 2011;171(8):744-749. doi:10.1001/archinternmed.2011.139 Accessed at: <http://archinte.ama-assn.org/cgi/content/abstract/171/8/744>

⁷ Institute of Medicine: Shaping the Future: Unequal Treatment: What Health Care System Administrators Need to Know about Racial and Ethnic Disparities in Healthcare. March 2002 <http://www.iom.edu/~media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/DisparitiesAdmin8pg.pdf>

⁸ Fact Sheet: Creating Jobs and Increasing the Number of Primary Care Providers. Available at <http://www.healthreform.gov/newsroom/primarycareworkforce.html>

⁹ Sochalski, Julie. The Future of Nursing Leading Change, Advancing Health. Health Care System Reform and the Nursing Workforce: Matching Nursing Practice and Skills to Future Needs, Not Past Demands. Appendix F|IOM, 2011. Available at http://www.nap.edu/catalog.php?record_id=12956#toc

¹⁰ Center for Tax and Budget Accountability. Special Report: Illinois state Funding for Human Services in Context. February 2010. Available at <http://www.ctbaonline.org/>

¹¹ Eldeib, D. Study Ranks Illinois Highest in Late Payments to Nonprofits. *Chicago Tribune*. October 2010.

¹² Strauss, William A. Economy on Cruise Control 2010 and 2011. *Chicago FED Letter*, Number 277, August 2010. Retrieved from www.chicagofed.org/digital_assets

¹³ National Association of Community Health Centers. Recession Brings More Patients to Community Health Centers, Fact Sheet No. 0209, Washington, D.C. (September 2009). Available at <http://www.nachc.com/search.cfm?searchterm=rising+patient+demand>

¹⁴ George Washington University: School of Public Health and Health Services. Examining the Health Consequences of the 2008–09 recession. Available at www.gwumc.edu/sphhs/about/rapidresponse.

¹⁵ Jin, R. J., Shah, et al. The Impact of Employment on Health: A Review of the Evidence. *Journal of the Canadian Medical Association*, Volume 153, Issue 5, 1995.

¹⁶ Rabin, R. C. Unemployment May Be Hazardous to Your Health. *The New York Times*. May 9, 2009.

¹⁷ Currie, J., & Tekin, E. (2011). *Is the Foreclosure Crisis Making Us Sick?*. Cambridge, Mass: National Bureau of Economic Research.

common goals and build alliances, ultimately improving Chicagoans' health.

Changes in Chicago's Population

Force: Based on the 2010 U.S. Decennial Census, Chicago's overall population declined 7% since 2000. The losses were seen primarily in the Non-Hispanic Black population, who now comprise 32% of Chicago's population, compared to 36% in 2000. Non-Hispanic Whites make up 32% while Non-Hispanic Asians constitute 5% of all Chicagoans. The largest population growth occurred in the Hispanic population, increasing from 26% in 2000 to 29% in 2010.¹⁸

Threats: Although many organizations do have resources and capabilities to serve the growing Spanish-speaking population, many others do not. Agencies with this capacity may be overwhelmed by need, especially at a time of significant budget cuts, and thus may have long waits to obtain appointments. Other agencies that do not have an adequate amount of bilingual/bicultural staff may not be able to provide as effective treatments to this diverse clientele. In either situation, many clients may not be receiving the best care possible. In addition, some undocumented individuals may be fearful of seeking services at governmental agencies or federally funded sites due to their legal status. By avoiding or delaying seeking care, these individuals put their health at risk.

Opportunities: The diversity of Chicago's population highlights the importance of diversity and cultural effectiveness within the public health and health care workforce. As the Hispanic population grows within Chicago, more possibilities exist to tap this population for public health and health care professions. The growing Hispanic population also highlights the importance of community-based strategies for education and outreach, such as Community Health Workers. Organizations that have successful programs can serve as models to other organizations for building cultural effectiveness into strategies that serve Chicago's racially and ethnically diverse populations.

Political Environment

Force: The current political climate was identified as a critical force affecting the future of public health. These forces include the upcoming presidential race of 2012 and new local leadership within the City of Chicago and Cook County.

Threats: The contentious political climate in Washington D.C. between the executive and legislative branches impacts the public health system. Specifically, implementation of ACA at risk, due to opposing views within Congress and among the candidates in the upcoming 2012 presidential election. If a new administration is elected, the ACA, or many of its provisions, may be repealed.^{19,20} Such actions could reduce access to care for many populations, including both uninsured and underinsured individuals, through the dismantling of public health funding. Other threats to public health include possible cuts to initiatives that work to impact social determinants of poor health.

With new local leadership at the City and County levels, changes to address budget deficits could impact public health and other social services.

Opportunities: Public health has emerged as an essential component of the new Chicago Mayor's platform, as seen with the release of the Healthy Chicago Agenda, which identifies 12 major public health challenges and proposes over 120 strategies to address them. Other initiatives proposed by this administration that strengthen the public health system include: eliminating food deserts, improving street safety, the reduction of gun violence, and the improved implementation of the Chicago Bike Plan to increase bike lanes and bicyclists' safety.²¹ Both organizations and individuals have the opportunity to become involved in this work through policy advocacy, new programming, and education and awareness activities.

Building the public health constituency and promoting advocacy on core public health values are always opportunities

that evolve out of adverse situations, especially those politically motivated. As the number of public health stakeholders grows, so does the impact of this voice in future electoral cycles.

Built Environment

Force: The built environment can be broadly defined as human modified surroundings that influence and affect activity. Parks and sidewalks are examples of the built environment and their presence or absence can alter physical activity levels within the community. Housing and transportation systems are also important elements of the built environment that affect quality of life.

For the past several years, affordable housing initiatives have slowed, in part due to the status of the housing and banking economies, as well as federal and local budget cuts. One of these programs, the Community Development Block Grants (CDBG), a program of the U.S. Department of Housing and Urban Development (HUD) to support affordable housing initiatives, anti-poverty programming, and community development, continues to absorb large cuts and reduce local funding for these issues.²²

Another possible change in the built environment that will have a significant effect on the population is the proposal to extend the Chicago Transit Authority Red Line subway station five miles south beyond its current southern-most station at 95th Street.

Threats: Research documents how affordable housing strengthens communities and facilitates improved health and educational outcomes.²³ Without access to safe and healthy housing, communities may experience an increase in overcrowding, evictions, and homelessness. Home repair may be delayed, leading to an increase in exposure to lead and other home-based hazards.

Funding issues slowed the completion of the Chicago Housing Authority's (CHA) ten-year *Plan for Transformation*,

which was originally authorized in 2000 and focuses on increasing housing choices for low-income families. CHA needed to obtain an extension from HUD to fully meet the goals.²⁴ At the same time, the need for affordable housing continues to grow. Since 2000, the percent of owners and renters that spend more than 35% of their household income on housing costs increased by 52% and 40%, respectively.²⁵

While the CTA's proposed Red Line extension will increase transportation options for the south side of Chicago, a project this size can have negative effects on the environment as well as on those communities, home owners, and businesses within its path. When the decision is made to move forward with planning, the CTA will prepare an Environmental Impact Statement to evaluate environmental impacts from the proposed project, including: land use, zoning and economic development, land acquisition, parklands and recreational facilities, neighborhood compatibility and environmental justice, visual and aesthetic impacts, natural resources (e.g., air quality, noise and vibration, water resources, wetlands, hazardous materials), safety and security, wildlife, and local ecosystems.²⁶ Decision makers need to carefully consider the impacts on the community as well as alternate proposals prior to agreeing to this significant change in transit infrastructure.

¹⁸ US Census Bureau, Decennial Census 1990-2010

¹⁹ Daily Report: Campaign 2012. <http://www.kaiserhealthnews.org/daily-report.aspx#Campaign%202012-0>

²⁰ Kaiser Family Foundation. Daily Report: Health Reform. Available at <http://www.kaiserhealthnews.org/Daily-Report.aspx?reportdate=9-16-2011#Health%20Reform-0>

²¹ Chicago Department of Public Health. Healthy Chicago. Available at cityofchicago.org/health

²² U.S. Department of Housing and Urban Development. Community Development Block Grant Program. Available at http://portal.hud.gov/hudportal/HUD?src=/program_of-fices/comm_planning/communitydevelopment/programs

²³ Lubell, Jeffrey, Rosalyn Crain, and Rebecca Cohen. 2007. *The Positive Impacts of Affordable Housing on Health*. Washington, D.C.: Center for Housing Policy and Enterprise Community Partners. The full review, as well as annotated bibliographies of key research studies, are available for download at www.nhc.org/housing/intersections or www.enterprise.org.

²⁴ http://www.thecha.org/filebin/CHA_FINAL_APPROVED_FY2012_Annual_Plan_to_HUD.pdf

²⁵ US. Census Decennial Census (2000) and American Community Survey 2009

²⁶ <http://www.transitchicago.com/redeis/faq.aspx>

Opportunities: Despite the cuts in funding for affordable housing initiatives, the City of Chicago is committed to an ongoing focus on healthy housings. The CHA's *Plan for Transformation* is moving forward and, as of 2011, had revitalized 22,000 units, or 88% of its goal. The Chicago Department of Public Health is expanding its work beyond childhood lead poisoning prevention to a more comprehensive focus on Healthy Homes, integrating interventions for lead, radon, tobacco smoke, and other home-based hazards with case management services.

The proposed CTA Red Line Extension Project will provide a significant solution to the current transportation limitations of residents living on the south side of Chicago. With this resource, south side residents will be able to access available jobs outside of their immediate neighborhood more easily and will have more choices of where to obtain services and seek care. Transit projects such as this are found to positively impact job creation; for every \$1 billion spent, 47,500 jobs are projected to be created or sustained.²⁷ In addition, public transportation also reduces road congestion and traffic pollution.²⁸

Violence and Health

Force: Although Chicago data show an overall decrease in crime, violence continues to plague many communities. As a result, families living in these communities tend to stay indoors and may not utilize available resources or access programming that could help them stay healthy, such as exercise programs at the park or after school clubs.

Threats: By staying inside, children are less at-risk for street violence, but more in danger of becoming overweight or obese due to lack of exercise and unhealthy eating habits. In addition, access to healthy food is limited in many of the high crime areas of the city. Due to this growing epidemic, more children are being diagnosed with type II diabetes and heart disease.²⁹ Obesity in adults has also increased as have poor nutritional habits, especially in low income populations.³⁰

Opportunities: Initiatives to combat the consequences of trying to keep one's family safe can be addressed by both home-based activities as well as by community partnerships. To encourage activity, public health agencies can develop and promote family-based exercise programs that can be done indoors. These programs could also be used to promote healthy family interaction and educate families on key public health issues. Opportunities also exist for community partners to safeguard their residents by extending evening hours and offering more youth-based programming, and promoting safe travel to and from school. The Chicago Alternative Policing Strategy (CAPS), which works within the community to address issues of violence, could be strengthened with heightened focus on bullying, building community gardens, and other initiatives that support community safety and infrastructure.

Technological Progress

Force: Advances in and access to technology are major force affecting the public health system. The cost of technology has gone down, making its use more widespread within the health care system (e.g., electronic health records and health care diagnostics) and for personal use (e.g., smart phones and tablet computers). With personal technology devices, more people have the capacity to communicate and access information quickly through the Internet.

Threats: While most health care providers recognize the long term value of electronic health records (EHRs), adopting this technology can be difficult, especially for a small office. The learning curve is often steep and, even with governmental incentives, EHRs are a major investment. Many patients do not understand the advantages of EHRs and fear loss of privacy and misuse of their health information.³¹

Technology, just as any innovation, is slow to reach vulnerable communities that would most benefit from its use. Community organizations working with low-income populations are often dependent on state and local grants,

and, therefore, may not have the capital to purchase this infrastructure and/or update their legacy computer systems. Individuals living in low-income communities may only have access to computers at the local library or community agency, and due to lack of usage, training, or language competencies, may not be proficient enough to use them. This disparity has serious ramifications when key pieces of information are primarily available on the Internet, including job and benefit applications.

The National Health Survey and other health research projects often use random digit dialing of landline telephone numbers to collect information. This survey methodology is at risk since, as of 2009, one out of every four American households uses a mobile phone as their primary line – a trend expected to continue. Use of landlines for emergency communication is also at risk.

Technology also impacts health status when it reduces the degree to which physical activity is a part of regular daily activities. Children spend more time in sedentary activities (television, computers, and other devices such as gaming systems), which can play a role in increasing obesity. More adults work in sedentary jobs due to the growth of technology and a focus on the service industry. The percent of Americans in jobs that require light energy expenditure increased from 38% in 1960 to 55% in 2010; the percentage in sedentary jobs increased from 15% to 23% in the same time period.³²

Opportunities: Access to real time public health data through EHRs and the health information exchange will allow public health responses to be more focused and timely, including disease outbreaks and disease control efforts. With more accurate information about their patients through EHRs, providers will be better able to assess patient conditions and prescribe medications with reduced chances of accidental drug interactions.³³ The overall cost of care will lower also.³⁴ In addition, electronic health

information will enable public health to better understand health care system resource usage patterns and to monitor chronic disease needs. To ease the transition to EHRs, the Chicago Health Information Technology Regional Extension Center (CHITREC) trains primary care providers in implementation and shares information about available incentive payments.

Technology presents creative opportunities for outreach to populations to promote healthy behaviors, share resource information, and communicate in emergencies. Many City agencies and community organizations use social media (e.g., Facebook, Twitter, etc.) distribute their messages to a broad population. Programs are being developed, and can be expanded to share health tips through text messages, such as the Text4Baby program that texts expectant and new parents.³⁵

In addition, communities have the opportunities of counteracting the impact of technology by developing physical activity programs in schools and neighborhoods that would reduce screen time and promote a healthier lifestyle for Chicago's youth.

²⁷ Ibid

²⁸ <http://www.transitchicago.com/redeis/documents.aspx> http://articles.chicagotribune.com/2010-09-26/news/ct-met-getting-around-0927-20100926_1_cta-red-line-cta-officials-new-stations/2

²⁹ <http://www.cdc.gov/diabetes/projects/cda2.htm>

³⁰ Illinois Department of Public Health. Behavioral Risk Factor Surveillance Survey 2001-2009

³¹ <http://www.practicefusion.com/ehrbloggers/2011/07/new-study-reveals-patients-fear-ehr-impact.html>

³² http://articles.businessinsider.com/2011-05-26/strategy/30037983_1_energy-expenditure-baseline-weight-nhanes

³³ Health IT. http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_home/1204Health_Information_Technology. <http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/healthit/>

³⁴ Ibid.

³⁵ <http://www.text4baby.org/>

Strategic Issues Identification

PURPOSE

As the Partnership moved from the Community Health Assessment phase towards the completion of the Community Health Improvement Plan, the focus of the work switched from gathering and analyzing data to identifying the strategic issues underlying the findings of the four assessments. This phase, formulating strategic issues, helped the Partnership coalesce the data and information into overall system issues, on which the Health Plan will be focused.

PROCESS

Findings from each of the four assessments were reviewed at a Chicago Partnership meeting, along with the Partnership's vision for the public health system. As these findings were being presented, members were asked to take note of issues or conditions that were identified in more than one of the assessments.

In addition, members considered the definition and components of a strategic issue, as described by the National Association for County and City Health Officials (NACCHO).

Strategic Issues:

- Pose direct threats, present opportunities, or require significant change
- Require action on the part of public health system partners
- Represent a convergence of narrow, single focus issues
- Involve conflict between:
 - Current and future capacities
 - Actual and desired conditions
 - Past performance/expectations
 - Old and new roles
- Are complex and have more than one solution
- Operate at a systems or policy level and involve more than one organization

FINDINGS

The Chicago Partnership members identified six strategic issues, suggested by the community health assessment findings, that would need to be addressed before the Partnership's vision of the public health system could be realized. Each of these strategic issues poses a broad view of the functioning of the public health system.

Issue #1: How can Chicago's public health system partners work most effectively to reduce violence?

Vision: The prevention and reduction of violence is fundamental to the Chicago Partnership's vision for public health system, as described in its role of "protecting and promoting the health, safety, and well-being of Chicago's communities..." The system is also envisioned to work to counteract violence by ensuring protective factors that "...work to reduce the effects of violence, poverty and racial/ethnic/other disparities..."

Forces of Change: The decline of the economy has added stressors to individuals and to families, which may exacerbate the incidence of domestic violence. Increased substance use due to these stressors may also contribute to violent behaviors. Quality of life and health status is

affected by crime--both violent crime and gang activity. Fear of crime keeps adults and children indoors and away from the benefits of outside activities, such as exercising, walking, playing, etc.

Community Themes and Strengths: Among both focus group participants and survey respondents, violence was the second most frequently cited health issue (after obesity) that most affects the health and safety of the community. Violence-related behaviors (gang activity and gun use) were two of the six identified behaviors identified as most affecting their community's health and safety. These issues were identified across all Chicago communities and demographics.

Community Health Status: The Chicago Police Department data document decreased crime rates since 2000. The total crime index, which includes violent and property crimes, decreased by 29% between 2000 and 2009. Violent crimes decreased by 37% (2000-2009) and murders decreased by 31% (2000-2010). However, with more than 30,000 violent crimes recorded in 2009 and 435 homicides in 2010, Chicago's crime rate is much too high.

Chicago data from the 2009 Youth Risk Behavior Surveillance System (YRBSS) show a decrease in some areas of youth violence. The percent of Chicago youth who reported carrying a weapon for at least one day per month was 18% in 2009, a decrease from 21% in 2001. No change was noted for youth involved in a physical fight one or more times (49%); however, the number of youth who reported they were physically hurt on purpose by their boyfriend or girlfriend increased from 11% in 2001 to 19% in 2009.

Issue #2: How can Chicago's public health system partners best collaborate with traditional and non-traditional partners to improve health and quality of life?

Vision: Collaboration among public health partners, both traditional and non-traditional, is a cornerstone of the Chicago Partnership's vision for the public health system, with cooperative efforts and shared leadership and accountability as key pillars. The system works to carry out the Ten Essential Public Health Services, which includes mobilizing partnerships of diverse stakeholders. Values of inclusion, networking, and communication speak to collaborations among partners.

Forces of Change: Since obesity was recognized as a major health issue, public health entities have worked with non-traditional partners to address issues of the natural and built environment. Many of the opportunities for this issue, as well as other trends affecting the community's health, call for collaboration and shared goals among a broad spectrum of stakeholders.

Local Public Health System Assessment: Participants completing the system assessment highlighted several strengths, including coordination among broad system partners and innovative local efforts involving community-based health committees. However, participants also recognized the need to further grow these connections, and, therefore, identified coordination as a system priority and as an opportunity for system improvement.

Community Themes and Strengths: Focus group participants and survey respondents touted a wide variety of community assets that help their community be healthy: easy transportation, safe areas to walk and bike, parks, grocery stores, good schools, affordable providers, libraries, and church groups. Both traditional and non-traditional partners are responsible for these assets, emphasizing the importance of working with all these stakeholders to address public health. Community collaborations and communication among stakeholders, including residents, were suggested to improve the health of communities.

Community Health Status: Data on many of the social determinants of health (education, poverty, housing status, employment status) overlaid with health status indicators highlighted Chicago's at-risk populations and communities. This process in and of itself connected more non-traditional partners to the work of the Chicago Partnership and allowed all stakeholders to see more clearly both how these forces interact and the necessity to collaborate.

Issue #3: How can Chicago's public health system partners most effectively develop and strengthen the workforce that impact health status?

Vision: The vision includes a focus on the Ten Essential Public Health Services, including assurance of a competent public and personal health care workforce.

Forces of Change: With funding cuts, layoffs, and retirements of experienced workers, many programs are being scaled back or eliminated. An unstable public health workforce is all the more worrisome because of the increased need for safety net services created by the declining economy. Primary care providers who work at community-based health centers are in short supply and will be in even greater demand when the Affordable Care Act opens the doors to more patients, previously uninsured, who will be seeking care. Without an adequate workforce to promote prevention and primary care, the health of Chicago's communities may decline. Opportunities to develop the future workforce and strengthen the current staff were identified, but initiatives need to be prioritized and financially supported.

Local Public Health System Assessment: Participants of the local public health system assessment rated workforce activities occurring at a minimal level (43%), which was the lowest rating for all Ten Essential Services. Participants identified deficiencies in training opportunities, including leadership development and continuing education, and also highlighted the need for more public health staff.

Community Themes and Strengths: Health care providers were identified as both community assets and barriers. Affordable providers and community health workers assist individuals and family with accessing care and staying healthy. However, many participants shared that their community lacked providers, especially those who are bilingual/bicultural.

Community Health Status: Fifty-eight percent of Chicago's community areas (45 of 77) contain areas designated as a medically underserved area/population by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Primary Care. HRSA data also show that with increased funding for federally qualified health centers, the number of patients in Chicago being seen at these centers has grown by 20% since 2005. These data reinforce the need to grow the available workforce and to ensure they are trained to be effective with public health interventions.

Issue #4: How can Chicago's public health system partners most effectively reduce disparities?

Vision: The description of what the public health system will do includes "...work to reduce the effects of violence, poverty, and racial/ethnic/other disparities," while system values promote "...resource allocation that reflects commitment to populations-in need."

Forces of Change: Issues of disparities are closely related to many of the forces and trends affecting the health care system. Demographic changes, i.e., the growing Hispanic population, speak to the need to have more bilingual/bicultural providers and to ensure outreach campaigns are culturally effective. Health disparities are affected by environments that do not have access to green areas and open space and where housing is older and ill-maintained. Disparities in access to health care for low-income minority populations are also noted.

Local Public Health System Assessment: Through the Ten Essential Public Health Services, the Chicago public health system serves the whole jurisdiction. However, through its focus on monitoring health status to identify and solve community problems, the system prioritizes disparities among populations and geographic areas, and works to alleviate these gaps. Through this assessment, this Essential Service (#1) was rated as being performed at a “significant” level (63%), slightly higher than the overall system score (61%).

Community Themes and Strengths: Disparities were noted in many of the focus group and survey responses, including individuals’ rating of their health status. Overall, 18% described their health as excellent, 61% as good, 20% as fair, and 2% as poor. Self-reports of health status varied by geography, with 22% of respondents living in the north and central areas of Chicago rating their health as excellent, compared to 13% in the southwest, and 6% of people living on the far south side.

Geographic disparities were also noted when survey respondents identified in the presence of community assets and barriers. Although many of the same issues were mentioned, the frequency of this item being identified varied. For example, easy access to transportation was selected more often by respondents who lived in the north areas (20%) and central areas (19%), compared to respondents from the south, southwest, and far south (14%). Lack of access to healthy foods comprised nearly 14% of the responses from the south while making up less than 9% of the responses from either the north or northwest.

Community Health Status: Health status and other data showed disparities among racial/ethnic populations and geographic communities. For example, diabetes mortality rates for Non-Hispanic Blacks and Hispanics are 88% and 54% higher, respectively, than rates for Non-Hispanic Whites. Age-adjusted homicide rates are much higher in

the south and west sides of the Chicago, compared to the north/northwest and southwest sides. Similar disparities were also documented in areas of socioeconomic status, including poverty, education, employment, and housing cost burden.

Issue #5: How can Chicago’s public health system partners most effectively increase access to health education and information?

Vision: Increasing access to information and education is a fundamental component of the vision for a system that utilizes “...a broad focus on access to services, information, and empowerment” to protect the health and safety of Chicago communities. Informing, educating, and empowering people about health issues is one of the Ten Essential Public Health Services, and, therefore, part of the system’s vision.

Forces of Change: Access to health education and information has always been an important part of the public health system, and current forces and trends maintain this function as a priority. Many people have limited access to preventive health services and may miss opportunities to access health education. Chicago is home to many residents for whom English is not their primary language. These Chicagoans are in need of linguistically appropriate and culturally effective information to help them stay healthy. Technology is a trend that can positively affect access to information. Although access to information through some channels may be limited to the higher income, higher educated groups, the use of texting is growing as a means to reach all populations. For example, Text4Baby is a national initiative that sends free texts (available in both English and Spanish) to expectant and new parents with information about caring for their baby.

Local Public Health System Assessment: As part of their regular work, many public health system agencies

educate and inform their clients on how to stay healthier and where to access care. Participants at the system assessment rated this essential service as significant. Working with other system partners, including other City of Chicago departments, was identified as a priority area and an opportunity for immediate action. Other priorities identified by the system assessment that impact education, information, and empowerment include: (1) expansion of community health committees to address health issues and (2) strengthening the communication strategy among agencies.

Community Themes and Strengths: Focus group participants and survey respondents identified many community assets and barriers affecting their health. Local libraries, for example, were listed as assets because many people use the library Internet to access health information. Community Health Workers were mentioned as assets, as were bilingual/bicultural providers, who most likely provided culturally effective health education and information. Classes, workshops, and programs (i.e., interventions that educate and provide information), were suggested as ways to improve the health of communities.

Issue #6: How can Chicago's public health system partners most effectively reduce the consequences of chronic disease?

Vision: The vision promotes a system that addresses current and future health challenges, such as the consequences of chronic disease on the health and on the quality of life of Chicago residents. All Ten Essential Services help reduce this problem through: increased surveillance and data gathering; mobilizing partners to develop coordinated efforts; developing policies, plans, laws and regulations; and ongoing research for innovative behavior change strategies.

Forces of Change: The economic decline has impacted health in many ways, including decreased access to care

because of the loss of health insurance. Many people report increased stress during difficult economic times. The increased stress coupled with the loss of insurance may make it difficult for someone with a chronic disease to manage their condition and for others to stay healthy. Many communities do not support a healthy lifestyle because they lack the natural or built environment that encourages walking, bicycling, or use of public transportation. Violence and related safety concerns also impede regular exercise.

Local Public Health System Assessment: Reducing the consequences of chronic disease requires the activities of many of the Ten Essential Services. For example, the system needs to monitor chronic disease among populations, develop and implement healthy food policies and plans, enforce the Clean Air Ordinance, and conduct research for innovative approaches to promote healthier lifestyles. Chicago's system performance overall was scored as "significant". Strengths were noted with innovated local efforts, including work on local food access; however, accessing chronic disease data was an area for growth.

Community Themes and Strengths: Chronic diseases and behaviors that contribute to their severity made up many of the health and behavioral issues discussed by focus group participants and survey respondents. Health issues included obesity, diabetes, high blood pressure, and depressions; behavioral issues included unhealthy eating and lack of exercise. Similarly, community assets noted included the availability of resources to address chronic disease, such as easy transportation, walking and biking, parks, grocery stores, and community gardens. Barriers identified the lack of these resources and lack of access to health care and medications that could help manage chronic diseases. Suggestions included programmatic changes (classes), improvement in existing resources (park facilities), and policy changes to facilitate healthier behaviors.

Community Health Status: Chronic disease mortality rates have decreased between 1999 and 2007: by 36% for coronary heart disease, 22% for stroke, and 18% for diabetes. However, disparities among racial/ethnic groups exist, with the mortality rate for Non-Hispanic Blacks being higher than Non-Hispanic whites (e.g., 47% higher for diabetes mortality and 33% higher for stroke mortality). While mortality rates are going down, prevalence rates are increasing. Through the Behavioral Risk Factor Surveillance System (BRFSS), more adults report a diabetes diagnosis, with a 104% increase overall between 2000 and 2009, a 350% increase for 25-44 year olds, a 170% increase for adults older than 65 years of age, and a 40% increase for individual with an income less than \$15,000.

Obesity rates for adults, as reported through the BRFSS, increased 22% between 2001 and 2009, resulting in the total percentage of adults in Chicago that are either obese or overweight at 67%. The Youth Risk Behavior Surveillance System (YRBSS) shows that 36% of high school youth report either being overweight (21%) or obese (15%). Supporting statistics are seen through Chicagoans' dietary patterns, with 47% of adults eating less than three servings of fruits or vegetables a day and 77% of high school youth eating fewer than five fruit and vegetable servings.

Formulation of Goals and Strategies and Initiation of Action Cycle

PURPOSE

These phases, which are the final components of the Community Health Improvement Plan, guided the Partnership through a process to develop priority areas and objectives. Because the priorities are developed by consensus, these phases further strengthened the Partnership's structure through which the identified objectives will be implemented. In addition, since the cross cutting areas focus on improving the public health infrastructure, going through this process helped members recognize the relationship among broad-based public health, each organization's particular focus, and interventions to improve the quality of life for Chicago's vulnerable populations.

PROCESS

Upon the determination of the strategic issues (Phase 4), Partnership members were asked to submit strategies through an online survey. These strategies were grouped into ten cross cutting action areas, which members were asked to prioritize. At the next Partnership meeting, members voted for their top three choices, with consideration directed towards those areas that (1) were consistent with the overall capacities and reach of the Partnership, (2) were not already being addressed comprehensively by other organizations/ collaborations, and (3) were doable by the Partnership members and other public health stakeholders.

Once the priority action areas were identified, Partnership members divided into three groups and developed several objectives for each area based on the initial strategies and further discussion. These objectives were further refined with timelines.

FINDINGS

Cross Cutting Action Areas

In response to the strategic issues, the Partnership identified over 60 strategies. These strategies were grouped into ten cross cutting areas. Listed below are the action areas and an overview of strategies that Partnership members suggested

Action Area #1: Form new Partnerships and strengthen current collaborations to improve coordination of public health efforts.

Partnership members felt strongly that system improvement needs to occur with a broad base of stakeholders and within a collaborative process. Through collaborations, the Partnership can address underlying issues that can impact areas, such as violence prevention and access to healthier foods. Members also recommended holding a citywide conference through public/private collaboration, the agenda of which would be to share information and provide opportunities to address local needs.

Action Area #2: Lead efforts to train and collaborate with community-based organizations and non-traditional partners to increase the focus on public health and social determinants of health.

The Partnership suggested many strategies that emphasized the importance of the non-traditional public health workforce in reaching vulnerable populations with health messages. At the same time, Partnership members recognized that interventions provided by both traditional and non-traditional partners would benefit by focusing on social determinants of health. The Chicago Partnership, with its diverse membership, is recognized as an entity that can bring these organizations together to improve the efficiency and effectiveness of all these interventions through interagency support and focus on the underlying social determinants.

Action Area #3: Strengthen Access to Data

Technological innovation is opening doors to improve access to data, especially through Health Information Exchanges (HIE). Web-based data query systems provide opportunities to quickly obtain health data. However, these advances are slowed by bureaucracy, limited access to data, and processes that are not fully comprehensive or collaborative. Strategies suggest interventions to build on these opportunities and developing systems by including more stakeholders within the HIE process and working to include data that track social determinants of health. A focus on coordinating the use of data for community-based policy and planning underscores the importance of these data in local activities to guide work and measure progress.

Action Area #4: Utilize technology to inform Chicago residents about keeping healthy and accessing care.

Outreach to Chicago residents is an ongoing goal of the Chicago Department of Public Health as well as of many Chicago Partnership member organizations. As technology has become more widespread, less expensive, and more accessible, some agencies have integrated electronic communications into their outreach plans. However, more can be done with this medium. Strategies to assess the current landscape in Chicago will help the system better understand agencies' capabilities and users' interest and access. Partnering among organizations can increase the message's scope and reach. Web portals can be developed for both health care providers and clients to provide information about available resources. In addition, strategies suggest reaching the many populations that have limited technological access through a connection between community health workers and the Chicago Public Library.

Action Area #5: Provide leadership and training to improve the effectiveness of the public health/health care workforce and grow the future workforce.

The workforce is the most important asset in the public health system; however, it is not as effective as needed to promote health behavior change. This may be because much of this workforce primarily focuses on clinical services, is unable to allot time to prevention, or may not have access to evidence-based interventions. Strategies suggest remedying this situation through training, integration of prevention into clinical care, use of interdisciplinary teams, and partnering with teaching hospitals and community health centers. Mental health staff and community health workers can also be hired and trained as cost-effective members of the workforce.

Engaging youth in public health issues is an important way of growing the future workforce. Community-based

organizations and local government can reach diverse populations (including those involved in the juvenile justice system) through job training, internships, and apprenticeships. The education system and community organizations can encourage students to consider health professions and a career path that may begin as outreach workers. Opportunities exist to ensure the next generation of public health workers is well suited to serve Chicago's populations.

Action Area #6: Create/support initiatives and collaborations to conduct analyses of health care systems, including workforce and access to health care in Chicago and Cook County.

The public health care system includes a broad spectrum of organizations and services, many that are not connected even though they are an important part in improving the health status of Chicagoans. Partnership members suggested conducting an analysis of the system and developing regional strategies to address many issues (such as access to oral health, immigrant coverage, data, etc.). The shortage of health care workers is one of these issues that would benefit from coordinated efforts to analyze needed positions and develop strategies to alleviate long-term shortages.

Action Area #7: Advocate for and ensure a benefit to Chicago's communities within diverse health-related polices and plans developed for the nation/state/region/county/city (e.g., SHIP, ACA, etc.).

Government develops many polices and plans that affect the health and safety of Chicago residents, including the Patient Protection and Affordable Care Act (ACA) and the State Health Improvement Plan (SHIP). The Partnership proposed they monitor these policies and plans, and advocate to ensure Chicago residents benefit from these policies.

Action Area #8: Develop, implement, and monitor policies and procedures to assist Chicago residents to be healthier.

While not the only way to promote healthier behaviors, policies and procedures are effective methods that make healthier choices easier for people to make. These can be achieved through promotion of breast feeding at World Health Organization-designated "Baby-Friendly Hospitals" and implementation of new nutrition standards for foods available at Chicago Public Schools. Linking LINK/SNAP clients with healthy food providers, building safe and accessible routes for walking and bicycling in every community, and advocating for gun control legislation are many of the strategies the Partnership proposed that would improve the community's health.

Action Area #9: Set up an organization to coordinate care and other programming for vulnerable populations.

Disparities in social determinants of health, as well as racial/ethnic disparities, affect health status. These populations at risk need intensive and innovative interventions that are both culturally effective and coordinated. Partnership members promoted the importance of coordinating care to these populations within health care settings and the community through family centered care and the use of community health workers

Action Area #10: Work more closely with media and develop campaigns to educate, inform, and motivate Chicago residents to be healthy.

Chicagoans receive health information through many media outlets, including television, radio, news print, websites, and blogs and twitter. Although information through many of these sources cannot be vetted, opportunities do exist to work more closely with traditional media in providing accurate and timely information about current risks and

available services. Campaigns through the media and on billboards can also reinforce these messages and promote better health. Working in partnership with well-known individuals, e.g., sports celebrities or political figures, is another way to motivate Chicagoans to be healthy.

THREE PRIORITY ACTION AREAS, WITH OBJECTIVES

The Partnership prioritized the following three action areas, and developed objectives to address them. Timelines were developed to guide this work.

Action Area #1: Form new partnerships and strengthen current collaborations to improve coordination of public health efforts.

Objective #1.1: Starting March 2012, the Chicago Partnership for Public Health will serve as a Healthy Chicago Agenda Advisory Body, providing input to CDPH leadership and promoting dissemination of information and Healthy Chicago implementation.

- **Sub-objective #1.1.1:** The Chicago Partnership will broaden its membership to include representatives from all priority areas in the Healthy Chicago Agenda to best advise CDPH leadership on dissemination and implementation.
- **Sub-objective #1.1.2:** The Chicago Partnership will meet every other month and convene specific committees to ensure progress on Healthy Chicago priorities.

Objective #1.2: By December 2013 and annually thereafter, the Chicago Department of Public Health and the Chicago Partnership for Public Health will convene a citywide “State of Public Health and Healthy Chicago Summit” to educate, inform, and engage the public and public health stakeholders.

Objective #1.3: Starting in March 2012, the Chicago Partnership for Public Health will develop new and strengthen existing relationships with community

stakeholders and City agencies for the expressed purpose of supporting implementation of the 12 Healthy Chicago priorities: *tobacco use, obesity prevention, HIV prevention, adolescent health, cancer disparities, heart disease and stroke, access to health care, healthy mothers and babies, communicable disease control and prevention, healthy homes, violence prevention, and public health infrastructure.*

Action Area #2: Lead efforts to train and collaborate with community-based organizations and non-traditional partners to expand focus on public health and social determinants of health.

Objective #2.1: By December 2013, the Chicago Partnership will determine the most relevant social determinants of health on which to focus training and collaborative efforts.

- **Sub-objective #2.1.1:** By July 2013, the Chicago Partnership will collect data, information, and resources on social determinants of health, analyze existing relationships among these determinants, and identify areas where more data and information are needed.
- **Sub-objective #2.1.2:** By December 2013, the Chicago Partnership will work with entities to collect more data, where needed, on specific social determinants of health.

Objective #2.2: By December 2015, the Chicago Partnership will create an organizational structure through which the Partnership will coordinate training and collaboration.

- **Sub-objective #2.2.1:** By December 2012, the Chicago Partnership will investigate possible training and collaboration structures.
- **Sub-objective #2.2.2:** By July 2013, the Chicago Partnership and its partners will identify the organizational structure through which to operate this initiative.
- **Sub-objective #2.2.3:** By December 2014, the Chicago Partnership will obtain funding and/or in-kind donations to operate initiative.

Objective #2.3: By December 2016, the Chicago Partnership will collaborate to conduct training and foster program development with identified community-based organizations and non-traditional partners on cross cutting issues of public health and social determinants of health.

- **Sub-objective #2.3.1:** By December 2012, the Chicago Partnership will identify community-based organizations and non-traditional partners that may benefit from training and collaborative interventions.
- **Sub-objective #2.3.2:** By December 2014, the Chicago Partnership and its partners will investigate and develop strategies to enable community-based organizations and non-traditional partners to address key issues affecting their populations, including: training and education, program development, technical assistance, technology, and outreach.
- **Sub-objective #2.3.3:** By December 2016, the Chicago Partnership and its partners will implement strategies to impact vulnerable populations through community-based organizations and non-traditional partners' focus on social determinants of health.

Action Area #3: Strengthen access to data.

Objective #3.1: By December 2016, the Chicago Partnership will collaborate with the State of Illinois Health Information Exchange (HIE) and framework initiatives to secure access to aggregated and de-identified data for community health assessment, planning, and advocacy.

- **Sub-objective #3.1.1:** By December 2014, the Chicago Partnership will advocate for community stakeholders' active involvement in the State HIE governance and operations.
- **Sub-objective #3.1.2:** By December 2016, the Chicago Partnership will advocate for HIE initiatives to include non-traditional public health data, e.g., homeless shelter occupancy data, TANF recipients, food pantry utilization, etc.

- **Sub-objective #3.1.3:** By December 2016, the Chicago Partnership will work with the State HIE to assure privacy and security of data and to strengthen IT infrastructure and universal access to HIE.

Objective #3.2: By December 2016, the Chicago Partnership will increase coordination among providers and researchers to: (1) collect, analyze, present, and/or provide public health data, (2) release data in a more timely fashion, and (3) reduce duplications in efforts.

- **Sub-objective #3.2.1:** By December 2014, the Chicago Partnership will coordinate with partners to strengthen infrastructure to improve access to data.
- **Sub-objective #3.2.2:** By December 2016, the Chicago Partnership will work with partners to coordinate health research and health planning and to increase and connect community-based policy and planning work.

NEXT STEPS

The next step in the strategic planning process is to further develop implementation plans for each action area. This will be completed through committees of the Chicago Partnership, which may include CDPH staff and outside experts to provide additional context to the issues and to assist with implementation.

Monitoring health status and system changes will be connected to the work of the Chicago Department of Public Health's Healthy Chicago Agenda, through which monthly updates and highlights are shared with the public. Health status measures will be tracked on a yearly basis, providing the Chicago Partnership with opportunities to intervene when appropriate.

In addition, although only three areas were prioritized in this plan, Partnership members have already begun

to discuss how the other areas can be incorporated in their work (e.g., using technology as an outreach strategy). Through its diverse membership, the Partnership will continue to be involved with the cross cutting areas and the forces and trends affecting Chicago's public health system.

Appendix A: Other Contributors to the Chicago Plan for Public Health System Assessment 2012 - 2016

COMMUNITY HEALTH STATUS ASSESSMENT

Thank you to the **Community Health Status Assessment Committee** for your work in guiding the identification of data elements, helping to obtain data, and providing feedback on data analysis.

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Emily Weseman

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COMMUNITY THEMES & STRENGTHS ASSESSMENT

Thank you to the **Community Themes & Strengths Assessment Committee** for your work in leading the development of the focus groups and online survey as well as helping to secure locations for focus groups sites and disseminating the online survey link.

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Health Transformation

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Jose M. Gonzalez

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Radhika Sharma Gordon

Yolanda Vazquez

ACTS of FAITH

Chicago Department of Public Health exercise classes:

- Chicago Park District: Gage Park
- Chicago Park District : Pottawattomie Park (Rogers Park)
- Villa Guadalupe Senior Services, Inc.

Chicago Park District Humboldt Park Advisory Council

Christian Fellowship Flock

Educator Unido

Family Focus

Heartland Alliance Refugee & Immigrant Community Services

La Casa Norte

Pilgrim Baptist Church

North Lawndale Terrace

Thank you to the following organizations that distributed the link to the **Community Themes & Strengths** online survey. Because of your efforts, the survey included feedback from over 1,800 community residents on their community's health and quality of life.

ACTS of FAITH

Albany Park Community Center

American Indian Center of Chicago

Apna Ghar

Asian Health Coalition

Bronzecom.com

Chicago Board of Health

Chicago Community Health Workers Local Network

Chicago Dental Society

**Chicago Department of Housing and
Economic Development**

Chicago Department of Public Health

Chicago Hispanic Health Coalition

Chicago Park District

Chicago Partnership for Public Health

Chicago Police Department

Nixle Notification System

Chicago Alternative Policing Strategy (CAPS)

**Chicago Public Schools Office of
Coordinated School Health**

City Colleges of Chicago

City of Chicago Alderman

**Community Counseling Centers of
Chicago's Quetzal Center**

APPENDIX A

Other Contributors to the Chicago Plan
for Public Health System Assessment
2012 - 2016

Eighteenth Street Development Corporation
Health & Medicine Policy Group
Healthy Albany Park
Heartland Alliance
Illinois Coalition for School Health Centers
Latino Coalition for Prevention
Mayor's Fitness Council
Metropolitan Planning Council
Rush University
South Asian Public Health Association - Chicago Chapter
The South Side Health & Vitality Studies
**University of Illinois at Chicago (UIC) Center
for Clinical and Translational Science**
UIC College of Dentistry
UIC School of Public Health
Uptown Chamber of Commerce

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

Thank you to the following individuals who participated
in the assessment of Chicago's Public Health System.

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3.1 COMMUNITY HEALTH STATUS ASSESSMENT**DATA SOURCES****Federal**

- Centers for Disease Control and Prevention: Youth Risk Behavior Surveillance System (YRBSS) (9th-12th Grade Students)
- U.S. Census Bureau: Decennial Census and American Community Survey Data, (Metro Chicago Information Center tabulated results of the 2005-2009 American Community Survey)
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care: Medically Underserved Areas/Populations, Federally Qualified Health Centers—Number of Patients seen in Chicago
- U.S. Environmental Protection Agency: Toxic Release Inventory
- United States Postal Service: Residential and Commercial Vacancies

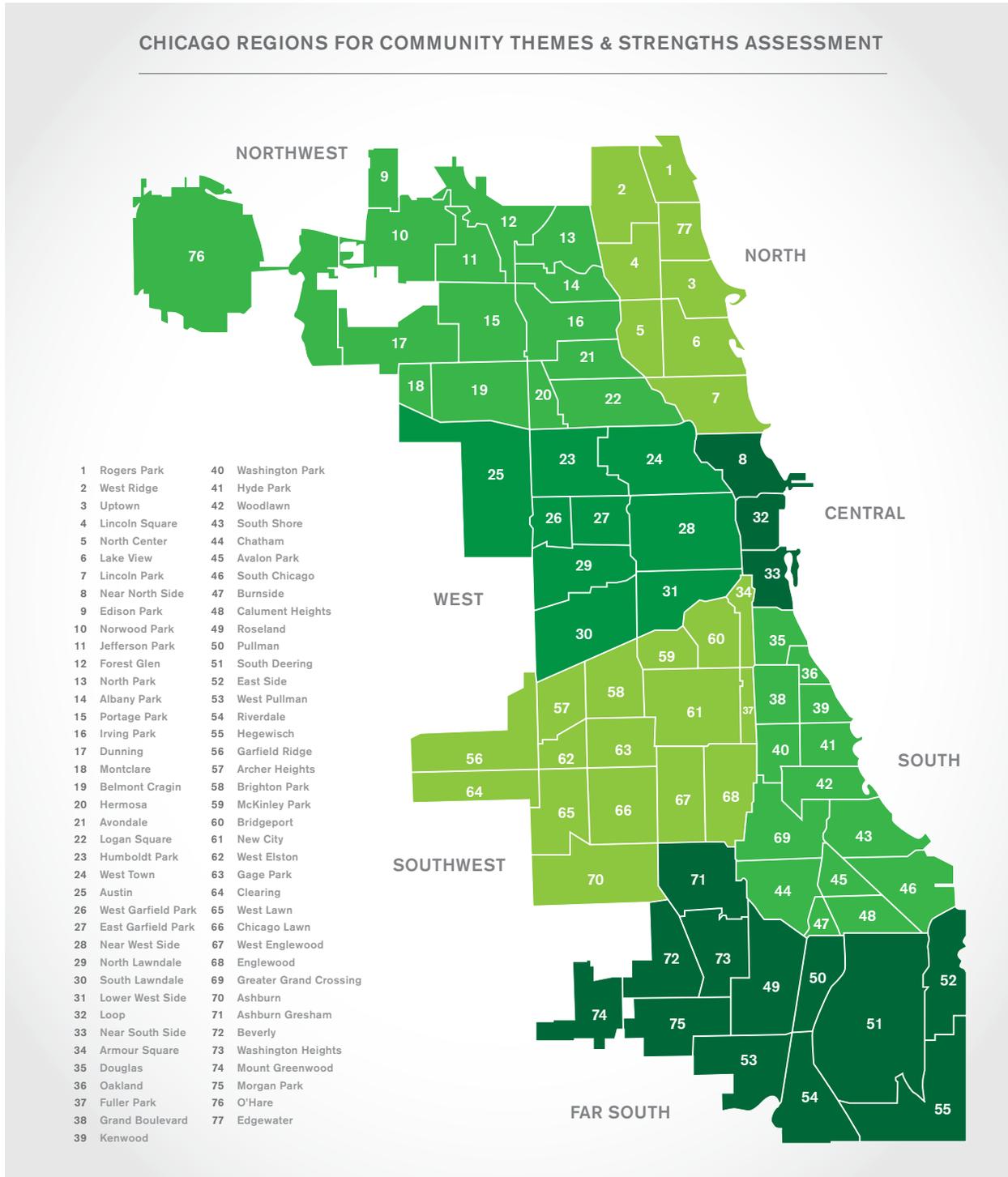
State

- Illinois Department of Public Health: Vital Statistics, Hospital Discharge Dataset, Behavioral Risk Factor Surveillance System (BRFSS)
- Illinois Department of Transportation: Traffic Safety Data
- Illinois Environmental Protection Agency: Air Quality, Toxic Release Inventory

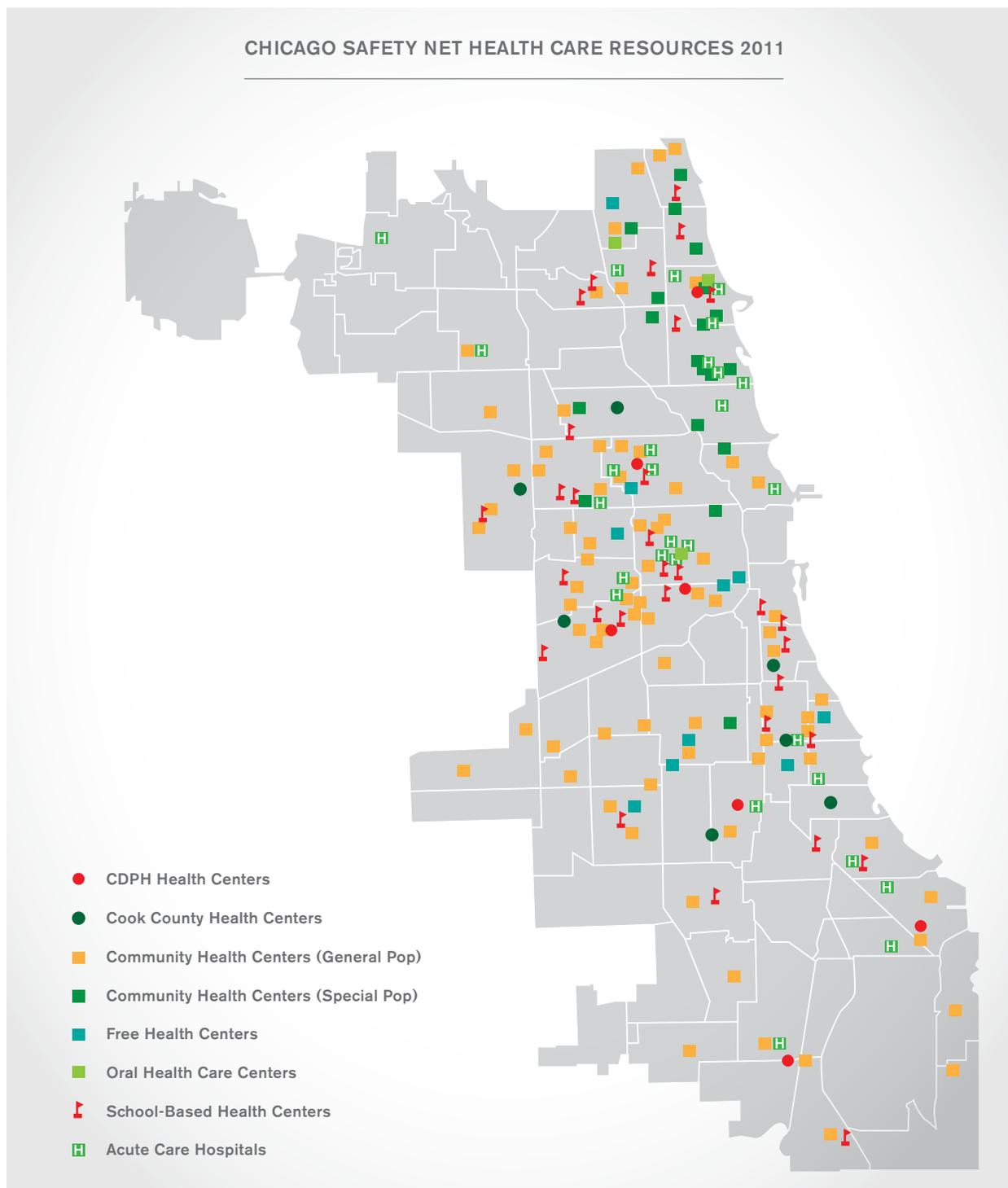
Local

- Center for Neighborhood Technology: Transit Connectivity Index
- Chicago Department of Family & Support Services: SNAP data
- Chicago Department of Public Health
 - Bureau of Policy & Planning, Chicago Health & Health Systems Project, STI/HIV/AIDS Surveillance data, blood lead level data
- Chicago Department of Water Management: Water Quality Report
- Chicago Police Department Annual Reports: Total Crime Index
- Chicago State University Neighborhood Assistance Center: Food Access Maps

Appendix B: Map of Chicago Regions



Appendix C: Map of Chicago Safety Net Health Care Resources



Data Source: Chicago Department of Public Health, Bureau of Policy and Planning



City of Chicago
Mayor Rahm Emanuel

Chicago Department of Public Health
Bechara Choucair, M.D.



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