Getting to the Root

HEALTHY CHICAGO SYMPOSIUM REPORT

CHICAGO DEPARTMENT OF PUBLIC HEALTH FEBRUARY 2019

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ACKNOWLEDGMENTS

The Healthy Chicago 2.0 Symposium was convened by the Chicago Department of Public Health (CDPH), sponsored by the Otho S. A. Sprague Memorial Institute and hosted by Blue Cross Blue Shield. CDPH thanks the many organizations that participated in the symposium. For a full list of registered organizations, see Appendix A.

INTRODUCTION

When the Chicago Department of Public Health (CDPH) joined more than 200 local groups to launch Healthy Chicago 2.0 in 2016, we committed to a common cause: partnering across sectors to improve health equity. We recognized that the only way to close gaps in health outcomes was to address the root causes of health, including housing, education, public safety and economic development in our communities.

Over the last three years, Healthy Chicago 2.0 has guided action not just for CDPH, but for community-based organizations, foundations, hospitals, public agencies and other members of the local public health system. Our partners work every day to realize Healthy Chicago 2.0's wide ranging goals.

Notable accomplishments include:

- Chicago recorded the lowest number of new HIV infections in nearly 30 years, setting us on our path to eliminate new HIV diagnoses within the next decade.
- Teen births hit an historic low with declines achieved by every ethnic group. The greatest declines have been seen by African American teens, which have historically faced the greatest inequities.
- New laws reflect our public health priorities, from instituting our city's first paid sick leave policy to raising the tobacco purchasing age.

And yet, we still have deep challenges. The gap in life expectancy between communities of high and low economic hardship has widened by 3.4 years since 2012.

Similar to what is found across the nation, Chicago's differences in health outcomes are often seen across racial lines. Not surprisingly, we also see racial inequities in education attainment, transportation options and housing quality. When we look closely at what causes these inequities, we can trace them to the same source: racist systems. For instance, redlining and other racist policies led to residential segregation; the resulting disinvestment and under-resourcing of predominantly black and brown communities contributed to higher concentrations of gun-related violence, higher rates of infant mortality and obesity, and larger numbers of opioid overdoses.

These communities are also full of robust economic and civic assets, rich cultural heritage, and resilient residents who deserve the same opportunities to lead a healthy life. So we must do more.

Through Healthy Chicago 2.0, we have transformed our mission to focus on closing gaps in health outcomes and deconstructing racist systems through policies, systems and environmental changes. That's why, on November 16, 2018, we convened more than 200 of our Healthy Chicago 2.0 supporters for a symposium where we asked a key question: ***What is the role of the public health system in addressing racist systems and other root causes of health?***

This report summarizes what we learned from the symposium and how we will use that information to continue to build a public health system that provides resources and opportunities for everyone to get and stay healthy. New elected officials will be taking office in a few months. The symposium was the first step in refreshing Healthy Chicago 2.0 by building on our successes and refining our goals. We will continue this work through the creation of a new community health improvement plan for 2020 – because the best gift we can give our city is a roadmap to more effectively fight racism and propel our health equity work forward.

After all, that's what Healthy Chicago means.

Julie Morita, M.D., Commissioner
Chicago Department of Public Health

Partners came together on November 16, 2018 for the Healthy Chicago 2.0 Symposium, where CDPH staff shared information about progress on the plan's strategies and indicators, and continuing challenges. Together, participants discussed the relationship between underlying racist systems, root causes of health, and health outcomes. What we shared and what we learned is summarized in this report.

MEASURING PROGRESS

In order to improve health, we must make data about a wide range of health indicators readily available to the public. As part of Healthy Chicago 2.0, CDPH committed to report on 75 key measures of health annually. We highlight important findings and trends from 2018 below, and the full, updated dashboard is included as Appendix B. The data come from a variety of sources, including the Healthy Chicago Survey, CDPH's annual survey of health and community well-being.

Many critical interventions happen on a local level, so citywide data isn't good enough; we need to show how health behaviors, neighborhood conditions and health outcomes differ across communities and demographic groups, and also how they change over time. We invite you to visit the Chicago Health Atlas, an interactive website to track and map these and many more measures of health at the neighborhood level.

CELEBRATING SUCCESSES

Across nearly every key indicator, Chicago is not only healthier than when we launched Healthy Chicago 2.0, we are healthier than at any point in our history. Behind every success there are innumerable programs, policies and partners working in tandem. Here are just a few examples that contributed to significant improvements in community health.

- The **Illinois Coalition for Health Access** is increasing access to health coverage and care by focusing enrollment efforts and resources on the communities where they are needed most.
- Through a new partnership between the **National Alliance for Mental Illness (NAMI) Chicago** and **CHI311**, residents can call 311 and reach NAMI's Helpline for support to navigate the mental health system and get connected to treatment providers and community agencies.
- **Chicago Healthy Adolescents & Teens (CHAT)** — a collaboration of CDPH, Chicago Public Schools (CPS) and Planned Parenthood of Illinois — provides Chicago's youth with education, confidential screening and connection to care for sexually transmitted infections.
- The Chicago City Council adopted the **Good Food Purchasing Program**, a policy that prioritizes nutritious, local and sustainable food purchasing across City agencies.
- Chicago's passage of the **Tobacco 21 policy** and **ban on flavored tobacco near schools** has resulted in major declines in youth smoking.
- CDPH, the Illinois Department of Public Health, AIDS Foundation of Chicago, and a number of other healthcare organizations set a goal to end the HIV epidemic in the state by 2030. The **Getting to Zero** initiative is increasing the use of prevention medications and ensuring that people living with HIV receive the necessary treatment.
- CPS supports **OUT for Safe Schools**, a national campaign that helps educators, administrators, and other school district employees 'come out' as visible allies for lesbian, gay, bisexual, transgender and questioning (LGBTQ) students and staff.

HEALTH IN ALL POLICIES

A key goal in Healthy Chicago 2.0 is to formalize a Health in All Policies (HiAP) approach in city government so that all City agencies consider the health impacts of their policy and programming decisions. At the request of City Council, CDPH convened a task force to determine how City departments and sister agencies can do more to improve health. As a result of this work, the City has increased access to permanent supportive housing through the Flexible Housing Pool, trained City employees on delivering trauma-informed services, and more. You can read all the details in the HiAP progress report that is attached as Appendix C.

INCREASING ACCESS

24%↓ (2014-2017) Latinx with no health insurance

7%↑ (2015-2017) Healthcare satisfaction among young adults 18-29 years

8%↑ (2015-2017) Dental cleanings among persons living in poverty (< 200%)

IMPROVING HEALTH OUTCOMES

Strengthening Child and Adolescent Health

36%↓ (2013-2016) Teen births in very low child opportunity communities

Preventing and Controlling Chronic Disease

23%↑ (2014-2017) Fruit and vegetable servings among black adults

44%↓ (2013-2017) Youth cigarette smoking

24%↑ (2014-2017) HPV vaccination among females

11%↑ (2014-2017) Colon cancer screening among persons living in poverty

Reducing Burden of Infectious Disease

10%↓ (2014-2016) HIV incidence among black men who have sex with men

29%↑ (2014-2016) HIV viral suppression

Reducing Violence

41%↓ (2013-2017) Fighting in schools

20%↓ (2013-2017) Bullying of LGB youth

Promoting Behavioral Health

10%↓ (2013-2017) Suicide attempts among LGB youth

ADDRESSING ROOT CAUSES

7%↑ (2014-2017) Permanent supportive housing

10%↓ (2014-2017) Housing cost burden

9%↓ (2014-2017) Unemployment among blacks

CONTINUING CHALLENGES: UNPACKING THE LIFE EXPECTANCY GAP

For all of this progress, we know many communities continue to struggle with persistent health inequities. This is clear from the single most distressing Healthy Chicago 2.0 indicator: since 2012, the gap in life expectancy between high and low economic hardship communities has widened by 3.4 years – to a gap of more than 8 years. Of the over 858,000 people living in high economic hardship communities in Chicago, 91% are black or Latinx.

So we have to ask ourselves, *what is driving the gap?*

Over 40% of the gap can be attributed to four main factors: infant mortality, community violence, opioid overdose and obesity.

- **Infant Mortality**: 266 infants died before age one in 2016. These deaths disproportionately affected communities of color; since 2013, infant mortality has increased by 21% in communities of high economic hardship. See Figure 1A.
- **Community Violence**: Despite significant decreases in gun-related homicide in the past two years, Chicagoans were the victims of over 29,000 violent crimes in 2017. The social, economic and psychological impacts of violence are not equally distributed across Chicago. For example, the rate of violent crime in Washington Park, a high economic hardship community, is over ten times the rate of violent crime in Forest Glen, a low economic hardship community. See Figure 1B.
- **Opioid Overdose**: Chicago's opioid crisis is caused primarily by fatal overdose of heroin combined with Fentanyl, a highly potent synthetic opioid; 92% of the overdoses in Chicago are due to this deadly mix. Opioid-related overdoses in 2017 resulted in 796 fatalities scattered throughout the city, with a significant cluster on the west side. Beyond the impact of overdoses, the scourge of opioids also impacts a community's social fabric through the over 2,000 arrests for opioid possession each year. The arrest rate in high economic hardship communities is 20 times greater than low economic hardship communities. See Figure 1C.
- **Obesity**: Over 700,000 Chicago residents are obese. That is 30% of adults, 18% of public high school students and 19% of children in kindergarten. As of 2017, over half the population in these six communities were obese: Archer Heights, Avalon Park, Roseland, West Pullman, Woodlawn, West Englewood. See Figure 1D.

While these may seem like distinct issues, they share important similarities: they are largely preventable, strongly correlated to community conditions and disproportionately affect people and communities of color.

CONNECTING RACISM AND ROOT CAUSES TO PUBLIC HEALTH CHALLENGES

Root causes of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks (Healthy People 2020). These root causes include safe and affordable housing, access to quality education, public safety, availability of healthy foods, local emergency/health services and environments free of life-threatening toxins.

When we describe inequities in the root causes of health, we see the effects of decades of policy that segregated or displaced people by race and drove different levels of community development and investment, contributing to the presence or absence of resources that have a significant influence on population health outcomes. Ultimately, racist systems are the cause of many health inequities.

FIGURE 1A. INFANT MORTALITY, CHICAGO, 2016[1]

Infant mortality is three times higher in non-Hispanic blacks and almost twice as high in Latinx than non-Hispanic whites.

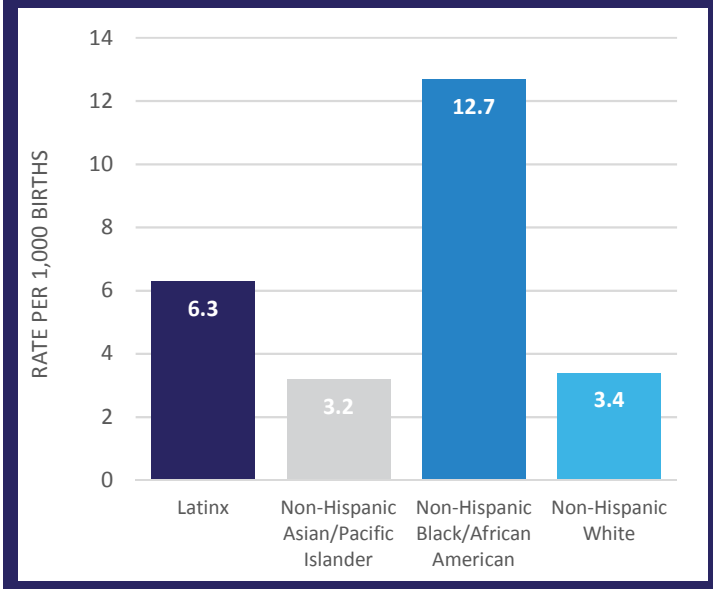


FIGURE 1B. GUN-RELATED HOMICIDE, CHICAGO, 2016[2]

Gun-related homicides are 39 times higher among non-Hispanic blacks and seven times higher among Latinx than non-Hispanic whites.

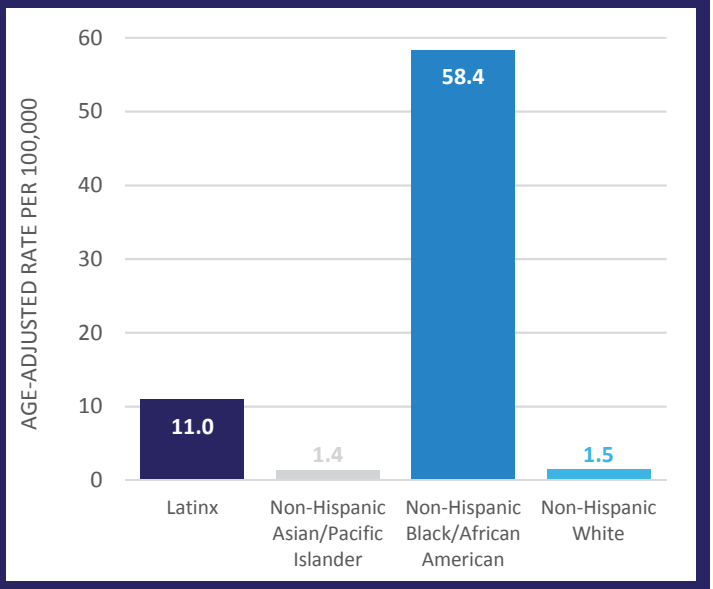


FIGURE 1C. FATAL OPIOID OVERDOSE, CHICAGO, 2017[3]

Opioid-related mortality is two-three times higher among non-Hispanic blacks than non-Hispanic whites and Latinx.

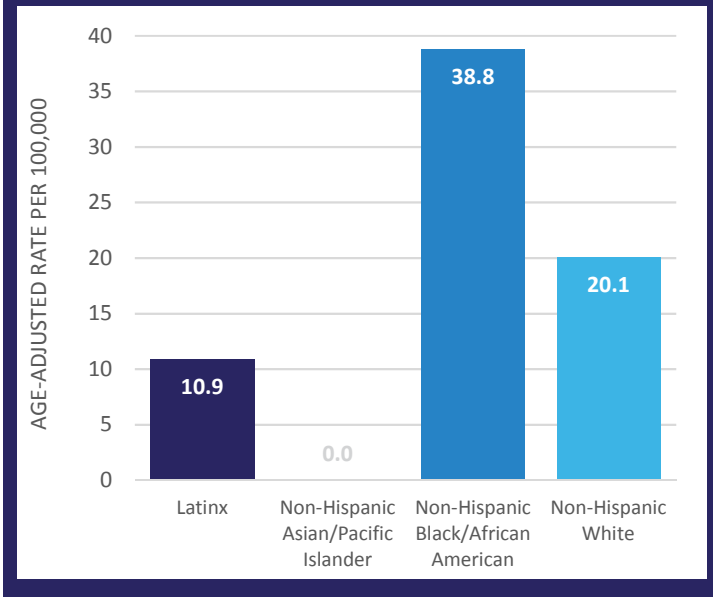
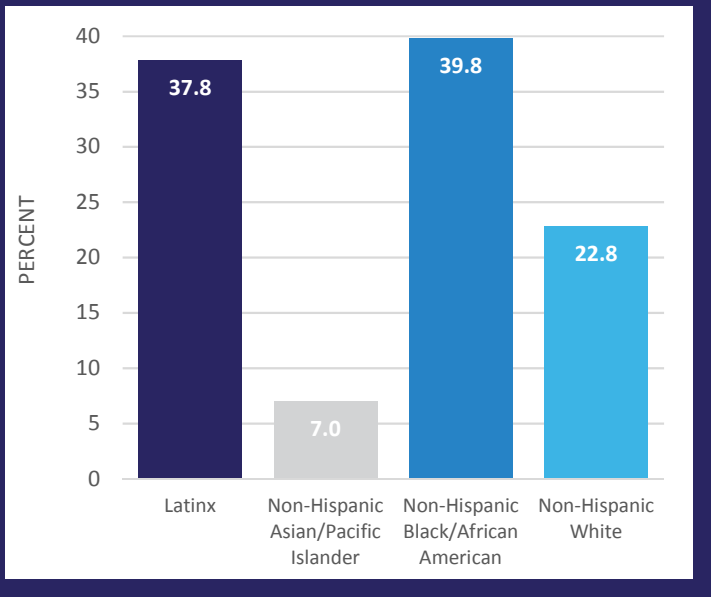


FIGURE 1D. ADULT OBESITY, CHICAGO, 2017[4]

Obesity among Latinx and non-Hispanic black adults is 70% higher than non-Hispanic white adults.



[1]Illinois Department of Public Health, Division of Vital Records, Birth and Death Certificate Data files; [2]Illinois Department of Public Health, Division of Vital Records, Death Certificate Data files; US Census Bureau; [3]Cook County Medical Examiner's Office, US Census Bureau; [4]Chicago Department of Public Health, Healthy Chicago Survey.

To help symposium attendees better understand how racism affects health outcomes, CDPH screened "How Racism Makes Us Sick," a 2016 TedTalk presented by Dr. David Williams, a professor at the Harvard T.H. Chan School of Public Health and an authority on the connection between racism and health.

DEFINING THE PUBLIC HEALTH SYSTEM'S ROLE

After presenting this information at the symposium, we asked participants to discuss a series of questions designed to capture how they are thinking about racism and the root causes of health. In a small group setting, individuals representing community groups, foundations, healthcare providers, advocacy organizations, housing organizations, and others discussed these questions:

- What is the role of the public health system in addressing racist systems and other root causes?
- What is the value that the public health system brings to efforts to address root causes?
- How do we use cross sector collaborations to do this work?
- Are our own organizations (or our system) contributing to the continuation of racist systems?

Each group summarized their conversation by finishing the statement, "Public Health can address racist systems by …" on poster boards. The poster statements are listed in Table 1 and pictured in the photograph below.

Group representatives share their posters at the symposium.

TABLE 1. PUBLIC HEALTH CAN ADDRESS RACIST SYSTEMS BY...
POSTER 1: Disseminating data directly to the communities. Strengthening connections to and within communities. Continuing the conversation! Keep at it!
POSTER 2: Being pro-active rather than reactive. Ensuring cross sector collaboration that shifts power and builds capacity into the hands of the community to push for changes in structural and institutional racist policies.
POSTER 3: Leading in an intentional way community engaged conversations and work that provides a health frame, which includes race and other forms of oppression, to policy, education, and practice across all sectors of society.
POSTER 4: Affirming that racism is the #1 cause of health disparities.
POSTER 5: Restoring human dignity by addressing the internal biases and being explicit about structural racism, and by engaging communities.
POSTER 6: Promoting shared humanity by listening to, organizing and connecting Chicago residents.
POSTER 7: Creating cross sector collaborations to implement innovative distribution networks to impact chronic disinvestment.
POSTER 8: Acknowledging our own racism/racist foundation first… and then dismantling that/those systems by ensuring meaningful engagement of share power with people and communities who are hardly reached and not just "hard to reach". We recognize the impact of intersectionality.
POSTER 9: Take it to the policy level- make politicians and corporations more accountable to community members. Update language- share the light on racism and its complexity and how it affects ALL Chicagoans. Working towards residential integration.
POSTER 10: Centering the people most affected to lead the process of building new equitable systems, while speaking truth to power.
POSTER 11: Amplifying resident voices by connecting communities through civic engagement, story sharing and community led solutions to demand a citywide commitment to desegregate Chicago!
POSTER 12: Decreasing violence through actionable, asset-based approaches informed by local community residents with lived experience. Prioritize funding for affordable housing programs and policies to eliminate housing instability. Prioritize funding of trauma-informed mental health services. Collect and share data. Convene and engage community residents and other stakeholder around solutions, promote policy solutions, advocate for funding, illustrate connections between root causes and solutions, provide examples of solutions and community level initiatives that work.
POSTER 13: Incorporating community members and equal partners to develop and implement community driven, system level change.
POSTER 14: Publicly naming and challenging – don't stay silent. Be a connector horizontally and vertically. Be a convener. Emphasize bottom-up approach. Think more holistically- identify other root causes. Make humans the center!
POSTER 15: Labeling is not enough; labeling racism as a root cause must be joined by redress of historical injustice, examining policies, reparation, sharing resources, expanding the table, and building power.
POSTER 16: Uniting organizations and listening to community and addressing their concerns.
POSTER 17: Intentionally increasing representation of impacted communities in leadership positions and investing in community-centered and led cross-sector collaborations for public health.
POSTER 18: First naming racism in all of its forms, then raising visibility of inequities through sharing lived experience together with data, to dismantle racist policies and practices and replace them with policies and practices grounded in equity.
POSTER 19: Raising awareness, ensuring equity in all policies, distributing resources and improving cross sector collaborations.
POSTER 20: Building power in communities through long term strategies, community-led change and equitable investment.
POSTER 21: Dismantling and activating data. Illustrating and validating lived experience of people most impacted by racist systems to dismantle root causes to achieve justice.
POSTER 22: Bringing together diverse stakeholders, openly addressing racism's impact across contexts, and promoting best practices to address disparity and achieve racial equity

WHAT WE LEARNED: OUR FRAMEWORK FOR ACTION

Several key themes emerged from small group conversations about the public health system's role in addressing racial inequities and the root causes of health. These will guide the next phases of implementing Healthy Chicago 2.0 and future plans.

- **Explicitly Acknowledge Racism.** We should be upfront about racism, injustice and the historical context of segregation and racist policies in Chicago that created and perpetuate health inequities.
- **Use and Disseminate Data about Racial Inequities.** The collection and analysis of data is a key function of the public health system. We can use our data to illustrate and educate the community and government officials about the effects of racism on health and its root causes.
- **Engage Affected Communities.** We must convene the people and communities that experience structural racism to hear their concerns and ideas for solutions. This will require expanded partnerships between community-based organizations and corporate/governmental entities. The public health system can help disseminate lessons learned across communities.
- **Advocate for Equity.** The public health system can influence policy, systems and environmental changes that will address structural racism. It is our responsibility to promote resources and investments in communities most affected by inequities, and to help build capacity so community members can advocate directly for local priorities.
- **Ensure Representation and Power.** When we are making decisions about policy and resource allocation, we should bring community partners to the table with a clearly defined role and shared power. The public health system can help ensure that affected communities are represented, especially those we commonly fail to reach.
- **Build the Movement with Partners.** It will take everyone, across all sectors and at all levels, working together to break down traditional silos that hinder progress on the root causes of health and structural racism. The public health system can serve as conveners, supporting new collaborations both within and beyond public health.
- **Start from Within.** We must identify how structural racism affects our own organizations (e.g. lack of workforce diversity). Members of the public health system can conduct racial equity and internal power assessments, then develop action plans to improve our own practices.

GETTING TO THE ROOT: OUR NEXT STEPS

As we welcome a new year, we celebrate the many successes of Healthy Chicago 2.0. We are deeply grateful to all of the people and organizations that have supported its vision. But even with these improvements to our public health system and the progress on health in our communities, we know there is still more work to do. We will incorporate what we learned from the symposium as part of our next Healthy Chicago community health assessment and improvement plan, which will guide us beyond 2020. In the coming months, CDPH will be reaching out to you, our Healthy Chicago 2.0 supporters, for your input and expertise. In the meantime, we encourage you to start tackling the issues and ideas that surfaced during the symposium.

For instance, CDPH has already begun our own process toward becoming an anti-racist organization. In 2018, more than 400 staff members and community partners participated in training with the People's Institute for Survival and Beyond to uncover our own hidden biases and organizational structures that allow racist systems to persist. We also joined the Government Alliance on Race & Equity (GARE), so that we can learn best practices from other jurisdictions to help CDPH live out our racial equity values through our hiring, budgeting, procurement and public engagement policies and practices. We look forward to sharing these learnings more broadly across our public health system.

With new elected officials taking office in a few months, we have a special opportunity to build on the successes of Healthy Chicago 2.0 and refine our goals. This is our moment to help Illinois' next governor and Chicago's next mayor embrace a vision that centers on promoting cross-sector partnerships and increasing investments to address the root causes of health and structural racism.

These are just the first steps to more effectively fight racism and propel our health equity work forward. Thank you for taking the journey with us.

APPENDIX A. ORGANIZATIONS REGISTERED TO ATTEND SYMPOSIUM

Access Community Health Network
Active Transportation Alliance
Alliance for Research in Chicagoland Communities
Alliance for the Great Lakes
AllianceChicago
American Cancer Society
American Heart Association
American Lung Association
American Osteopathic Association
AMITA Health
Ann & Robert H. Lurie Children's Hospital of Chicago
Asian Health Coalition
Aunt Martha's Health & Wellness
BBF Family Services
Blue Cross Blue Shield
Bright Star Community Outreach
BUILD
Caring Ambassadors Program, Inc.
Catholic Charities
Center for Asian Health Equity
Center for Clinical and Translational Science
Cermak Health Services
Chicago Area HIV Integrated Services Council
Chicago Black Gay Men's Caucus
Chicago Children's Advocacy Center
Chicago Department of Family and Support Services
Chicago Department of Public Health
Chicago Department of Transportation
Chicago Food Policy Action Council
Chicago Park District
Chicago Public Schools
Chicago Torture Justice Center
Chicagoland Equity Network
Coalition for a Better Chinese American Community
Cook County Department of Public Health
Cook County Government
Cook County Health
Corporation for Supportive Housing
DePaul University
Divvy Bike Share
Elevate Energy
Enlace Chicago
Enterprise Community Partners
Erie Family Health Centers
Erie Neighborhood House
EverThrive Illinois
Gads Hill Center
Gateway Foundation
Goshen College
Greater Chicago Food Depository
Hartgrove Behavioral Health System
Health & Medicine Policy Research Group
HealthConnect One
Healthy Schools Campaign
Heartland Alliance
Heartland Alliance Health
Heartland Health Centers
Housing Authority of Cook County
I AM ABLE Center for Family Development, Inc
IFF
Illinois ACEs Response Collaborative
Illinois Action for Children
Illinois Coalition for Health Access
Illinois Public Health Institute
JAS Family Support Services, Inc
Justice Advisory Council
Loretto Hospital
Loyola University Chicago
Lurie Cancer Center of Northwestern University
Mercy Hospital and Medical Center Chicago
Metropolitan Tenants Organization
Michael Reese Health Trust
Mikva Challenge
Mobile Care Chicago
NAMI Chicago
National Louis University
Neighborhood Housing Services of Chicago
New Covenant CDC
Noble Network of Charter Schools
North Lawndale Community Coordinating Council
Northwestern Memorial Hospital
Norwegian American Hospital
Olive Harvey College
Options for Youth
Oral Health Forum, Heartland Alliance Health
Otho S. A. Sprague Memorial Institute
Ounce of Prevention Fund
PCC Community Wellness Center
Playworks Illinois
Presence Saint Joseph Hospital
Presence Saints Mary and Elizabeth Medical Center
Public Health Institute of Metropolitan Chicago
Respiratory Health Association
Rush University Medical Center
Sinai Urban Health Institute
Social IMPACT Research Center at Heartland Alliance
Southwest Organizing Project
Sudden Infant Death Services of Illinois, Inc.
The Changing Children's Worlds Foundation
The Chicago Area Health Education Center
The Chicago Center for Youth Violence Prevention
The Chicago Community Trust
The Consortium to Lower Obesity in Chicago Children
The Experimental Station
The Freadom Road Foundation
The Hepatitis C Community Alliance to Test and Treat
The Kedzie Center
The Kennedy Forum
The Next Generation of Leaders, INC
The Sargent Shriver National Center on Poverty Law
The University of Chicago
The Local Initiatives Support Corporation
Thounsand Waves Martial Arts & Self-Defense Center
Thresholds
Trilogy Behavioral Healthcare
University of Chicago Medicine
University of Illinois at Chicago
USDA Food & Nutrition Service, Office on Women's Health
VNA Foundation
West Side United
World Sport Chicago

APPENDIX B. HEALTHY CHICAGO 2.0 DASHBOARD

INDICATOR	CITYWIDE							PRIORITY POPULATION	PRIORITY POPULATION							2020 Target
	2011	2012	2013	2014	2015	2016	2017		2011	2012	2013	2014	2015	2016	2017	
OVERARCHING																
Overall health status *Percentage of adults who report their health as "good", "very good" or "excellent"*				81.6%	82.0%	83.1%	81.0%	Citywide	--	--	--	--	--	--	--	85.7%
Life expectancy (years) *Life expectancy at birth in years*		77.8	78.0	77.9	77.7	77.4		Citywide	--	--	--	--	--	--	--	79.4
Preventable hospitalizations (per 10,000) *Age-adjusted rate of potentially preventable hospitalizations which includes certain acute illnesses (e.g., dehydration) and worsening chronic conditions (e.g., hypertension) that might not have required hospitalization had these conditions been managed successfully by primary care providers in outpatient settings*	216.3	201.5	191.2	192.6		193.3		Citywide	--	--	--	--	--	--	--	194.7
Childhood obesity *Percentage of Chicago Public School (CPS) kindergartners who are obese*			19.1%					Citywide	--	--	--	--	--	--	--	18.2%
Youth obesity *Percentage of CPS high school students who are obese*			14.5%				18.2%	Citywide	--	--	--	--	--	--	--	13.8%
Adult obesity *Percentage of adults who are obese*				29.0%	29.3%	29.7%	30.8%	Citywide	--	--	--	--	--	--	--	27.6%
Economic Hardship (persons) *Population living in communities experiencing high economic hardship*				835,249	841,589	858,356		Citywide	--	--	--	--	--	--	--	793,487
Child Opportunity (children) *Number of children (0-17 years) living in communities with low or very low child opportunity*				297,352				Citywide	--	--	--	--	--	--	--	282,484
ACCESS																
Primary care provider *Percentage of adults who have a personal doctor or health care provider*				80.8%	75.5%	72.6%	73.2%	Latinx				68.4%	65.7%	65.4%	64.9%	75.2%
No health insurance *Percentage of population without health insurance*				14.3%	10.5%	9.6%	9.8%	Latinx				22.9%	18.5%	16.9%	17.5%	18.3%
Dental care emergencies (per 10,000) *Age-adjusted rate of dental-related emergency department visits*	43.3	47.2	47.3	50.9		40.8		High hardship communities	61.7	67.4	68.9	75.7		59.7		58.6
Health care satisfaction *Percentage of adults who were satisfied with the health care they received*					64.3%	71.4%	69.0%	Young adults aged 18-29					59.2%	65.9%	63.3%	65.1%
Routine checkup *Percentage of adults who visited a doctor or health care provider for a routine checkup in the past year*				76.8%	78.0%	77.3%	76.5%	Citywide	--	--	--	--	--	--	--	80.6%
Received needed care *Percentage of adults who report it is "usually" or "always" easy to get the care, tests, or treatment they needed through their health plan*					82.6%	86.8%	82.6%	Persons living at or below 100% poverty level					71.2%	80.0%	75.3%	78.3%
Annual dental cleanings *Percentage of adults who report having had their teeth cleaned by a dentist or dental hygienist in the past year*					62.1%	60.6%	61.4%	Persons living below 200% poverty level					47.3%	45.4%	51.1%	52.0%
BUILT ENVIRONMENT, ECONOMIC DEVELOPMENT, HOUSING																
Housing cost burden *Percentage of households whose housing costs are at least 35% of household income*				36.5%	35.1%	33.4%	32.8%	Citywide	--	--	--	--	--	--	--	32.9%
Permanent supportive housing *Number of permanent supportive housing units*				6,946	6,536	7,191	7,414	Citywide	--	--	--	--	--	--	--	7,293
Lead poisoning *Percentage of children less than 3 years of age with elevated blood lead levels (> 6 mcg/dL)*				3.0%	2.7%	2.3%	2.2%	Very low child opportunity communities				5.3%	4.8%	3.9%	4.1%	3.7%

FOOTNOTES: ***All data current as of 11/30/2018.***

1. *The indicator descriptions, baseline values, and/or 2020 targets as represented on this update may appear different than the baseline metrics and targets published by CDPH in March 2016. Values and definitions may have been modified: a) to meet revised definitions or calculation methodology; b) due to revised data sources or; c) to correct errors. All changes were made in consultation with HC2.0 implementation teams. For information about data definitions and data sources please visit: www.chicagohealthatlas.org.*

2. *For indicators that have priority populations, the 2020 Target refers to the priority population. Otherwise, the 2020 Target is for the citywide value.*

3. *Data for five original HC2.0 indicators remain unavailable for quantitative assessment as of January 2019 and do not appear on this dashboard: a) Trauma-Informed City; b) Healthy Homes; c) Hepatitis C Treatment; d) Racial Discrimination; e) Discrimination by the Criminal Justice system. Baseline measures for these indicators are not readily available and require further development. HC 2.0 remains committed to finding reliable and consistent ways of measuring and monitoring these critical issues.*

INDICATOR	CITYWIDE							PRIORITY POPULATION	PRIORITY POPULATION							2020 Target
	2011	2012	2013	2014	2015	2016	2017		2011	2012	2013	2014	2015	2016	2017	
Unemployment *Percentage of civilian labor force who are unemployed*				10.9%	9.5%	8.1%	8.3%	African-Americans				20.6%	18.7%	16.8%	18.7%	9.8%
Savings and assets *Percentage of adults who report that no one in their household currently has a checking or savings account*						19.5%		African-Americans						33.3%		30.0%
Active transportation *Percentage of workers who walk, bike, or take public transportation as their primary mode of getting to work*				38.3%	38.5%	38.3%	38.5%	Citywide	--	--	--	--	--	--	--	42.1%
Neighborhood safety *Percentage of adults who feel safe in their neighborhood "all" or "most" of the time*					76.3%	72.5%	78.1%	African-Americans					66.2%	55.9%	67.8%	69.5%
Traffic crash injuries *Number of serious injuries resulting from traffic crashes (excluding highways)*				2,332	2,848	2,289		Citywide	--	--	--	--	--	--	--	1,530
EDUCATION																
Early childhood education *Percentage of eligible 3 and 4 year olds in early childhood education*				73.0%				Citywide	--	--	--	--	--	--	--	80.0%
School attendance *Percentage of school days attended by CPS students*				93.1%	93.2%	93.4%	92.8%	Homeless students				"87.0%	87.1%	86.9%	86.8%	93.1%
Post-secondary education *Percentage of CPS students who persist in 4-year college one year after enrollment*				72.0%	72.1%	72.2%		Citywide	--	--	--	--	--	--	--	79.2%
BEHAVIORAL HEALTH																
Serious psychological distress *Percentage of adults who reported serious psychological distress based on how often they felt nervous, hopeless, restless or fidgety, depressed, worthless, or that everything was an effort in the past 30 days*				5.2%	3.2%	5.4%	4.8%	Individuals living in poverty				10.8%	6.7%	11.0%	9.3%	10.3%
Behavioral health treatment *Percentage of adults who experience serious psychological distress and who are currently taking medicine or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem*				50.3%	43.0%	47.9%	50.3%	Adults with serious psychological distress				50.3%	43.0%	47.9%	50.3%	55.3%
Suicide attempts *Percentage of high school students who attempted suicide that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse in the past 12 months*			3.5%				5.1%	LGBTQ youth			11.9%				10.7%	10.7%
Depression *Percentage of high school students who reported feeling sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the past 12 months*			32.5%				34.7%	Female adolescents			40.7%				43.6%	38.7%
Prescription opiate misuse *Percentage of adults who report in the past 12 months either ever taking prescription pain relievers, such as oxycodone or hydrocodone, at a higher dosage or taking it more often than directed in the prescription, or ever taking a prescription pain reliever that was not prescribed to them*					3.0%	2.1%	2.8%	Citywide	--	--	--	--	--	--	--	2.7%
Opioid overdose *Number of ambulance runs in response to suspected opiate overdose*				2,277	2,978	6,590	7,526	Citywide	--	--	--	--	--	--	--	1,822
Adult binge drinking *Percentage of adults who report binge drinking in the past month*	29.0%				25.4%	24.2%	24.8%	Non-Hispanic white males	45.8%				37.9%	35.5%	32.8%	43.5%
Behavioral health hospitalizations (per 10,000) *Age-adjusted rate of hospitalizations due to behavioral health disorders*	226.4	197.9	161.7	176.3		174.6		Citywide	--	--	--	--	--	--	--	203.8
Primary care utilization *Percentage of adults who visited a doctor or health care provider for a routine checkup in the past year*				76.8%	78.0%	77.3%	76.5%	Adults with serious psychological distress				78.9%	86.3%	89.7%	64.7%	86.8%

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INDICATOR	CITYWIDE 2011	2012	2013	2014	2015	2016	2017	PRIORITY POPULATION	PRIORITY POPULATION 2011	2012	2013	2014	2015	2016	2017	2020 Target
CHILD & ADOLESCENT HEALTH																
Infant mortality (per 1,000) *Rate of deaths before age 1 per live births*			6.5	7.1	7.9	7.1		High hardship communities			8.1	7.9	10.5	9.8		7.3
Early intervention services *Number of children with developmental delays less than 4 years of age who have a plan for special services*						3.0%	3.1%	Citywide	--	--	--	--	--	--	--	4.0%
School-based health services - vision *Number of CPS students who receive a school-based vision exam*					45,663	48,450	55,016	Citywide	--	--	--	--	--	--	--	48,753
School-based health services - dental *Number of CPS students who receive a school-based dental exam*					115,238	109,603	89,786	Citywide	--	--	--	--	--	--	--	144,048
School-based health services - STI screening *Number of CPS students who receive a school-based screening for sexually transmitted infections (STI)*					6,433	8,162	6,372	Citywide	--	--	--	--	--	--	--	7,076
Teen birth rate (per 1,000) *Rate of births to mothers aged 15-19 years*			35.5	32.0	27.5	24.6		Very low child opportunity communities			57.3	49.6	45.1	36.5		51.6
CHRONIC DISEASE																
Youth fruit and vegetable servings *Percentage of high school students who reported consuming five or more fruit and vegetable servings daily in the past week*			18.3%				18.1%	Citywide	--	--	--	--	--	--	--	20.3%
Adult fruit and vegetable servings *Percentage of adults who reported consuming five or more fruit and vegetable servings yesterday*				29.2%	28.4%	24.3%	30.5%	African-Americans				19.0%	20.0%	15.6%	23.4%	20.9%
Youth soda consumption *Percentage of high school students who reported consuming one or more can/bottle/glass of soda daily in the past week*			23.1%				17.9%	Citywide	--	--	--	--	--	--	--	21.9%
Adult soda consumption *Percentage of adults who drank soda or pop at least once per day in the past month*					28.7%	24.9%	25.5%	Citywide	--	--	--	--	--	--	--	25.8%
Youth physical activity *Percentage of high school students who were physically active at least 60 minutes per day during the last week*			19.6%				17.2%	Citywide	--	--	--	--	--	--	--	20.6%
Adult physical inactivity *Percentage of adults with no leisure time physical activity in the past month*				18.3%	25.8%	26.5%	22.9%	Individuals living in poverty				23.2%	35.9%	36.4%	28.3%	22.0%
Youth smoking *Percentage of high school students who currently smoke cigarettes*			10.7%				6.0%	Citywide	--	--	--	--	--	--	--	9.6%
Adult smoking *Percentage of adults who currently smoke cigarettes*				18.4%	20.2%	18.4%	18.6%	Citywide	--	--	--	--	--	--	--	16.6%
Adult e-cigarette use *Percentage of adults who currently use electronic cigarettes*				3.9%	4.2%	3.0%	2.6%	Adults aged 18-29 years				6.3%	6.2%	3.7%*	6.0%	5.7%
Breast cancer screening *Percentage of women aged 50-74 years reporting having a mammogram in the past 2 years*				75.6%	82.8%	76.2%	80.0%	Citywide	--	--	--	--	--	--	--	79.4%
Cervical cancer screening *Percentage of women aged 21-65 years reporting having a Pap test within the past 3 years*				82.9%	78.7%	81.4%	80.3%	Citywide	--	--	--	--	--	--	--	87.0%
Colorectal cancer screening *Percentage of adults aged 50-75 years reporting having a sigmoidoscopy/colonoscopy in the past 10 years, having a sigmoidoscopy/colonoscopy in the past 5 years and a blood stool test in the past 3 years, or having a blood stool test in past year*				60.4%	65.2%	62.4%	65.6%	Individuals living in poverty				47.8%	55.7%	49.1%	53.2%	52.6%
HPV vaccination *Percentage of female adolescents aged 13-17 years who received three or more doses of HPV vaccine*				52.6%	47.7%	54.3%	65.2%	Citywide	--	--	--	--	--	--	--	80.0%
Breast cancer mortality (per 100,000) *Age-adjusted rate of female breast cancer deaths*			25.1	23.1	24.0	26.4		African-American women			34.0	30.8	35.1	36.6		30.6

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INDICATOR	CITYWIDE 2011	2012	2013	2014	2015	2016	2017	PRIORITY POPULATION	PRIORITY POPULATION 2011	2012	2013	2014	2015	2016	2017	2020 Target
Asthma ED visits (per 10,000) *Age-adjusted emergency department (ED) visit rate due to asthma for the population less than 18 years of age*	147.7	144.2	140.5	140.1		123.5		African-Americans	280.0	247.4	251.4	249.9		211.3		252.0
Diabetes-related hospitalizations (per 10,000) *Age-adjusted hospitalization rate due to diabetes-related lower extremity amputations*	2.0	1.9	1.8	1.8		2.3		African-Americans	3.2	2.5	1.9	2.1		3.1		2.9
INFECTIOUS DISEASE																
HIV incidence *Number of new diagnosed HIV infections*				914	922	839		African-American men who have sex with men				299	281	270		269
Linkage to HIV care *Percentage of persons with newly diagnosed HIV infections that are linked to HIV medical care within 90 days of diagnosis*				81.5%	85.6%	88.0%		African-Americans				77.2%	79.8%	87.2%		88.4%
Engagement in HIV care *Percentage of persons living with HIV that are engaged in HIV medical care*		54.6%	56.5%	59.2%	58.0%	60.0%		Citywide	--	--	--	--	--	--	--	74.3%
HIV viral suppression *Percentage of persons living with HIV who have an undetectable viral load*		37.1%	42.0%	45.3%	48.0%	48.0%		Citywide	--	--	--	--	--	--	--	74.2%
Chlamydia (per 100,000) *Rate of diagnosed chlamydia cases*			925.8	1013.5	1076.5	1104.6		African-American females under 25 years			4567.0	4567.4	4536.5	3828.7		3425
VIOLENCE																
Gun-related homicides (per 100,000) *Age-adjusted homicide rate as the result of firearm use*			11.3	12.5	13.7	20.9		African-American males			66.7	66.9	81.3	120.5		53.4
Non-fatal shootings *Number of non-fatal shootings reported*				2,435	2,776	3,980		Citywide	--	--	--	--	--	--	--	1,948
Sexual assault *Number of sexual assault crimes reported*				1,425	1,460	1,543	1,804	Citywide	--	--	--	--	--	--	--	1,442
Violent crime in public spaces *Number of gun-related violent crimes reported that occurred in public spaces (e.g. street, sidewalk, park, etc.)*				9,580	10,332	14,411		Citywide	--	--	--	--	--	--	--	7,662
Suspensions *Percentage of CPS students who received out-of-school suspensions*					4.8%	4.9%	3.8%	Citywide	--	--	--	--	--	--	--	2.4%
School fights *Percentage of high school students who were in a physical fight on school property one or more times during the past 12 months*			16.9%				10.0%	Citywide	--	--	--	--	--	--	--	12.7%
Bullying *Percentage of high school students who report being bullied on school property*			13.0%				15.2%	LGBTQ youth			27.9%				22.4%	25.1%
School safety *Percentage of high school students who reported missing school due to safety concerns*			12.9%				10.0%	Citywide	--	--	--	--	--	--	--	10.3%
Social cohesion *Percentage of adults who agree or strongly agree that they feel like a part of their neighborhood*					66.7%	58.5%	61.9%	Citywide	--	--	--	--	--	--	--	73.4%

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APPENDIX C. HEALTH IN ALL POLICIES - YEAR ONE PROGRESS REPORT

HEALTH IN ALL POLICIES

YEAR ONE REPORT

HEALTHY CHICAGO

CHICAGO DEPARTMENT OF PUBLIC HEALTH

I. INTRODUCTION

Healthy Chicago 2.0, the city's plan to improve health equity, recognizes that collaboration across local government departments and agencies is essential to address the root causes of health – like transportation, housing, and neighborhood development. In 2016, the Chicago City Council passed a resolution to establish that the City of Chicago will consider residents' health needs and the potential health impacts as part of our decision making. The resolution also called for the creation of a Health in All Policies (HIAP) Task Force. Convened by the Chicago Department of Public Health (CDPH) and comprised of leaders from various City departments and sister agencies, the Task Force ultimately adopted several recommendations for improving health through better City collaboration. These can be found in the Health in All Policies Report.

After a year of implementing HIAP recommendations, the City has made significant progress. We are pleased to offer this report as an overview of our work in 2018, along with plans to enhance these efforts in the years ahead – so that we can work toward the Healthy Chicago 2.0 vision of a city where all residents enjoy equitable access to resources, opportunities and environments that maximize their health and well-being.

II. PROGRESS REPORT ON RECOMMENDATIONS

Integrating Research and Data Systems

Data Collection/Data Sharing In addition to collecting data on health, social and environmental factors through the annual Healthy Chicago Survey, CDPH partners with other city departments to analyze and disseminate up-to-date data through the Chicago Health Atlas. We work with the **Chicago Department of Transportation (CDOT)** and the **Chicago Police Department (CPD)** to analyze and interpret traffic crash data to advance the priorities of the City's Vision Zero initiative, with **Chicago Public Schools** to share data related to the health and wellbeing of students, and with the **Chicago Fire Department** and the **CPD** to share opioid overdose data and coordinate our response. We will continue to explore ways to improve data sharing across departments.

Incorporating Health into Decision-Making

Health Impact Reviews In partnership with external stakeholders, CDPH developed a condensed health impact review process to assess health and equity impacts of a proposed project or policy in time to modify the proposal to maximize benefits and minimize harms. In June, CDPH trained members of its staff on this process. CDPH also partnered with community organizations, the **Department of Planning and Development (DPD)**, Cook County Land Bank Authority, and the Metropolitan Planning Council to incorporate this process into two community-driven participatory planning processes: one focused on the redevelopment of the Washington Park National Bank Building in Woodlawn, and one focused on the development of an Eco-Orchard in Garfield Park. We are building capacity to bring this expertise to new projects in the coming year.

Evaluating Projects and Funding Decisions Along with the **DPD, CDOT**, **Chicago Transit Authority (CTA)**, **Office of the City Treasurer** and the **Mayor's Office**, CDPH serves on the Elevated Chicago leadership council to promote racial equity, health and resiliency through equitable transit-oriented development around seven CTA stations. In 2018, Elevated developed a framework for evaluating capital projects based on their potential to impact racial equity, health and climate resilience. With the **Office of Budget and Management (OBM)**, CDPH is providing health data and supporting community engagement to inform the City's 2020 Consolidated Plan to allocate more than $100 million in federal funds to revitalize low and moderate-income communities.

Health Criteria in RFPs and RFQs Implementing the City's Good Food Purchasing Program has the potential to direct $200 million in existing procurement spending to healthier options and local businesses. In partnership with the Chicago Food Policy Action Council, CDPH provided technical assistance to **various departments and sister agencies** in initiating baseline assessments of existing procurement practices and setting preliminary targets. CDPH has also integrated Health Equity language and requirements into our RFPs and RFQs. CDPH's HIV/AIDS program, with their consumer-led planning council, added expectations for sub-contractors to 1) work to reframe and dismantle racist policies and systems, 2) ensure services are trauma-informed, 3) provide linguistically and culturally appropriate services, and 4) allocate resources and services to people and areas with the greatest need. In 2019, we will explore opportunities to expand these requirements across CDPH and to other departments.

Making Homes and Neighborhoods Healthier Places

Healthy Homes With a $1.8 million initial investment from the **Department of Family and Support Services (DFSS)**, **DPD**, and the **Chicago Housing Authority (CHA)**, the City launched the Flexible Housing Pool, a funding mechanism to rapidly house homeless individuals and provide them with the healthcare and tenancy support services they need. CDPH worked closely with **DFSS** and external stakeholders to establish program guidelines, identify a nonprofit program administrator, and secure new financial commitments from foundations and healthcare organizations. CDPH also provided input on **DPD**'s Five-Year Housing Plan. Our recommendations included prioritization of permanent supportive housing for vulnerable populations and improved health standards for new and existing housing. In the coming year, we will continue to work with partners to explore incorporating healthy standards in the City's building code and the feasibility of proactive housing inspection models.

Active Design Including active design elements in the planning, construction, and modification of buildings and infrastructure creates environments that increase physical activity and combat obesity. To better understand and promote active design principles in commercial projects, residential housing, and public building projects, CDPH hosted a roundtable discussion with Enterprise Community Partners. **DPD** presented the City's Sustainable Development Policy, and developers and designers provided feedback and recommendations for how the City could build awareness of and strengthen incentives for active design. In 2019, we will work with the development community to operationalize these recommendations.

Zoning and Licensing CDPH works closely with the **Department of Business Affairs and Consumer Protection (BACP)** to ensure that license fees and requirements reflect the health impacts of certain business types such as food and tobacco retail. In 2018, CDPH engaged **OBM** to increase the fees for these licenses, with a portion of the revenues dedicated to hiring additional inspectors that will ensure food safety and strengthen enforcement against illegal tobacco sales. CDPH, **BACP** and the **Law Department** also developed new tobacco license requirements that restrict sampling and product displays and require posting of warning signs to reduce youth tobacco use. **DPD** invited CDPH, **CDOT** and local stakeholders to participate in the development of the Little Village Industrial Corridor Modernization plan. CDPH contributed data on local health indicators and recommendations to promote health through policy, design, and management best practices. **DPD** is updating all 26 of the City's industrial corridors, and this will serve as a model for subsequent plans.

Building Community Awareness and Participation

Incorporating Health Messaging in Communications In collaboration with the **Mayor's Press Office and other city departments**, CDPH's Public Information Office ensures that relevant external communications, such as press releases and social media posts, include public health messaging and connections to root causes of health and health outcomes when appropriate. Recent examples include joint releases with the **Office of Emergency Management and Communications (OEMC)** and **CPD** about expansion of mental health crisis response and Smart911, and with the **Office of the City Clerk** about the new Chicago Rx prescription drug discount card.

Community Engagement As part of the City's work on a resilience plan, the **Mayor's Office** led a public engagement audit. Representatives from CDPH and **nearly all other City agencies** completed a questionnaire, participated in interviews, and joined a workshop to establish a baseline for how the City conducts pubic engagement and to brainstorm ideas of where we should go from here. The final report will include a variety of recommendations to create a culture of public engagement and formalize inter-agency collaboration going forward.

Expanding Access by Coordinating Services

Health & Human Services Resource A significant barrier to getting individuals appropriate mental health and substance use care is awareness of and linkage to available resources. In October, CDPH connected **OEMC/311** to the NAMI Helpline, so residents know where to go for help in their communities. 311 operators have already begun referring individuals to NAMI for assistance, and this new service will be publicized through a citywide marketing campaign in early 2019.

Trauma-Informed City CDPH continues to make progress toward our long-term goal of transforming Chicago into a trauma-informed city. This year, in collaboration with local experts and representatives from the **CHA, Chicago Park District ("Parks")** and **Chicago Public Library (CPL)**, we developed the *Building a Trauma-informed City: Trauma and Resilience 101* workshop curriculum. CDPH delivered over 50 workshops for staff from CDPH, **CHA, Parks, CPL** and **DFSS**.

Connecting Residents Across Departments In collaboration with **DFSS**, we developed the CDPH Services Guide with information on how to access mental health care, sexually transmitted infection testing and treatment, immunization clinics, WIC (Women, Infants and Children) nutritional services and more. We plan to disseminate the guide to **other city departments** so they may more easily refer Chicagoans to needed health services.

Employee Health CDPH conducted an employee wellness survey to inform the development of a Worksite Wellness Committee, which will launch in early 2019. The Committee will explore innovative ways to support more comprehensive wellness initiatives that complement the Chicago Lives Healthy program. If successful, this pilot could be adapted as a model for other departments. CDPH also assisted the **Department of Finance** to develop the RFP for a new City employee wellness program vendor.

Cultivating New Projects and Partnerships

Cross-Sector Grant Applications **OBM** initiated an inter-departmental task force to standardize fiscal and grants processes and increase collaboration, with a goal to improve the impact and scope of grants awarded to the City. CDPH also sought opportunities to engage other departments on grants – resulting, for instance, in a collaboration with **CPD** to distribute naloxone to individuals experiencing opioid overdose, and supporting **DPD** on a grant application to revitalize Chicago's Boulevards system. CDPH and **DFSS** held their own inter-department meetings to identify areas for combined applications, and have been closely aligned on initiatives. This work will continue into 2019.

III. LESSONS LEARNED/NEXT STEPS

Chicago's HiAP Resolution provides a framework for all City departments and agencies to consider the health and equity implications of their work and provides opportunities for collaboration to improve the health of Chicagoans. To build off the successes of 2018, CDPH will re-engage City partners to advance the following priorities for the coming year:

- **Deepen our commitment to community representation and racial equity:** We cannot fully address health inequities in our city without including those most impacted in decision-making and implementation. While HiAP activities to date have successfully engaged residents through community meetings and participatory planning, it is a 2019 priority to ensure that HiAP strategic planning and decision-making tables are representative of Chicago's diverse residents.
- **Maximize effectiveness through dedicated staffing for HiAP work:** The HiAP Task Force recommended the creation of one permanent staff position to provide HiAP education and support, conduct health impact reviews and assessments, and promote health-related initiatives across departments. CDPH expects to fill this position and provide dedicated administrative and technical support towards implementing HiAP recommendations in 2019.
- **Align the HiAP agenda with City initiatives:** Departments and agencies can ensure that HiAP work continues under a new mayoral administration in 2019 by incorporating recommendations and implementation efforts into other City initiatives – for instance, CDPH's next community health improvement plan, the City's Resilience Strategy, and foundational planning for the City's new Department of Housing.

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