# HEALTHY
## CHICAGO 2.0
### COMMUNITY HEALTH ASSESSMENT:
INFORMING EFFORTS TO ACHIEVE HEALTH EQUITY

2016-2020

**HEALTHY CHICAGO**

CHICAGO DEPARTMENT OF PUBLIC HEALTH
In coordination with the Partnership for Healthy Chicago

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# TABLE OF CONTENTS

## INTRODUCTION

The Chicago Department of Public Health (CDPH) collaborated with the Partnership for Healthy Chicago (Partnership), a public-private partnership comprised of over 35 multi-sector members, to complete Healthy Chicago 2.0, a comprehensive, four-year community health assessment and community improvement plan for the city of Chicago. This report details the purpose, process and findings of the assessment that led to the development of the improvement plan, Healthy Chicago 2.0: Partnering to Improve Health Equity 2016-2020.

Purpose: Conducting a community health assessment and developing a health improvement plan supports the mission of CDPH, "To promote and improve health by engaging residents, communities and partners in establishing and implementing policies and services that prioritize residents and communities with the greatest need." CDPH, the local public health authority for the city of Chicago, uses the findings from the assessment to guide its work with partners toward populations at most risk. This is one of the components of the Ten Essential Public Health Services framework developed by US Public Health Service agencies and other major public health organizations. The Healthy Chicago 2.0 assessment and plan work also adheres to CDPH's requirements for public health accreditation by the National Public Health Accreditation Board and for local health department certification by the State of Illinois.

Inherent in CDPH's mission is a focus on health equity, which is defined by the US Department of Health and Human Services' Healthy People 2020 (HP 2020) health promotion and disease prevention initiative as the attainment of the highest level of health for all people. Healthy Chicago 2.0 utilized a health equity lens for both the assessment and development of the plan through focused discussions, data collection and broad-based participation of community residents and public health stakeholders.

Process: CDPH and the Partnership utilized the Mobilizing for Action through Planning and Partnerships (MAPP) tool, developed by the National Association for County and City Health Officials (NACCHO) in cooperation with the Centers for Disease Control & Prevention (CDC). MAPP is a community-wide strategic planning framework that assesses multiple aspects of community health and guides development of priority action areas based on strategic issues.

This report documents CDPH and the Partnership's journey through the following MAPP process and presents each phase's purpose, process and findings (as appropriate):

**PHASE 1:** Organize for Success/Partnership Development

**PHASE 2:** Develop the Vision

**PHASE 3:** Conduct the 4 MAPP Assessments

> 3a: Community Health Status
>
> 3b: Community Themes and Strengths
>
> 3c: Forces of Change
>
> 3d: Local Public Health System

**PHASE 4:** Identify Strategic Issues and Action Areas

**PHASE 5:** Formulate Goals, Objectives and Strategies

The results of this comprehensive assessment (i.e., the action areas' goals, objectives and strategies) are detailed in the Healthy Chicago 2.0 Community Health Improvement Plan. In addition, the plan outlines our efforts toward health equity, Health in All Policies and becoming a trauma-informed city.

The last phase of MAPP, **PHASE 6:** Action Cycle, is an ongoing effort consisting of implementation, monitoring, evaluation and adjustment based on these findings. CDPH will conduct this in collaboration with our public health partners who implement and advise the strategies. We will work with a leadership team of community experts on each priority action area and the Partnership for Healthy Chicago. Updates will be shared through quarterly communications and an annual meeting will provide more detailed information on the progress of our work.

Community Health Assessment:

## PHASE 1: ORGANIZE FOR SUCCESS/ PARTNERSHIP DEVELOPMENT

Purpose: Community engagement and partnership development are the foundation of Healthy Chicago 2.0, an assessment and plan conducted by and implemented with community and public health stakeholders. Healthy Chicago 2.0 defines health broadly, encompassing social and structural determinants of health and issues of health equity, which underscore the importance of engaging a wide array of partners whose efforts focus within these areas. Therefore, the partnership development phase engaged representatives from diverse sectors of the public health system and the community to incorporate these unique perspectives.

Process: One method CDPH used to engage diverse system representatives was to work with the Partnership for Healthy Chicago (Partnership). The Partnership has a long history of working with CDPH on community health assessments and improvement plans, completing three plans since its formation in 1998. The Partnership's mission is to align stakeholders to strengthen Chicago's public health system. The Partnership is co-chaired by CDPH and a community organization, staffed by CDPH and includes representatives from the following sectors: provider associations, social service agencies, policy and advocacy organizations, business, faith-based organizations, medical-legal partnerships, academia and research, education and City and other governmental agencies (see Acknowledgments Section).

### THE PARTNERSHIP FOR
### HEALTHY CHICAGO

| ACADEMIA/ RESEARCH | PROVIDERS | BUSINESS | PLANNING, POLICY & ADVOCACY | SOCIAL SERVICES | MEDICAL-LEGAL PARTNERSHIPS | CITY GOVERNMENT | FAITH-BASED | OTHER GOVERNMENT |
|---|---|---|---|---|---|---|---|---|

Campaign for Better Health Care

Center for Faith and Community Health Transformation

Chicago Board of Health

Chicago CHW Local Network

Chicago Coalition for the Homeless

Chicago Department of Family & Support Services

Chicago Department of Public Health

Chicago Housing Authority

Chicago Lawyers' Committee for Civil Rights Under Law, LLC

Chicago Metropolitan Agency for Planning

Chicago Park District

Chicago Police Department

Chicago Public Schools

Chicagoland Chamber of Commerce

Consortium to Lower Obesity in Chicago Children

Cook County Health & Hospitals System

EverThrive IL

Health & Medicine Policy Research Group

Heartland Alliance for Human Needs & Human Rights

Illinois Department of Public Health

Illinois Health and Hospital Association (formerly operating as the Metropolitan Chicago Healthcare Council)

Illinois Nurses Association

Illinois Partners for Human Service

Illinois Primary Health Care Association

Illinois Public Health Institute

Institute of Medicine-Chicago

Local Initiatives Support Corporation Chicago

Loyola University Health Justice Project

Mayor's Office for People with Disabilities

Metropolitan Planning Council

Metropolitan Tenants Organization

Northwestern University Center for Community Health

Oral Health Forum

Playworks

Public Health Institute of Metropolitan Chicago

Respiratory Health Association

Sinai Urban Health Institute

University of Illinois at Chicago, School of Public Health

CDPH also sought more community engagement with organizations and residents in all stages of the assessment and plan development. As will be further described in this report, CDPH held eight community conversations to solicit stakeholder and resident feedback while providing a forum for meaningful discussion; five were held during the assessment phase and three were directed toward implementation. CDPH also shared information and updates on the assessment process through our listserv, Facebook account and posted information and PowerPoint presentation on the Healthy Chicago 2.0 website. Many of these partners were actively involved in the assessment and planning phases, participating on the Action Teams that met over a four-month period to develop goals, objectives and strategies for the action issues. In addition, many of these partners agreed to take primary responsibility for strategies identified in Healthy Chicago 2.0, which will then solidify these collaborative efforts throughout the four-year plan and beyond.

Community Health Assessment:

## PHASE 2: Develop the Vision

Purpose: The purpose of Healthy Chicago 2.0 is to improve the health and well-being for Chicago residents, with a special focus on health equity. As such, the vision needs to project these strong values. Used as an overall guide-post, the vision allowed CDPH to contrast the ideal state of health and well-being for Chicago residents to the current status that emerged from the assessments. The vision provided a consistent marker through which to focus our efforts and maintain a strong connection among partners.

Process:  At the September 12, 2014 Partnership for Healthy Chicago meeting, members reviewed the vision statement developed for the 2012-2016 community health assessment and improvement plan. Members decided to start fresh and then had a multi-layered discussion on key concepts to include in the new vision. Between meetings, several Partnership members word smithed the statement and emailed members a draft version. Partnership members voted to adopt this vision at the December 12, 2014 meeting:

> *A city with strong communities and collaborative stakeholders, where all residents enjoy equitable access to resources, opportunities and environments that maximize their health and well-being.*

## THE VISION:
**A city with strong  communities and collaborative stakeholders, where all residents  enjoy equitable access to resources, opportunities and environments that  maximize their health and well-being**
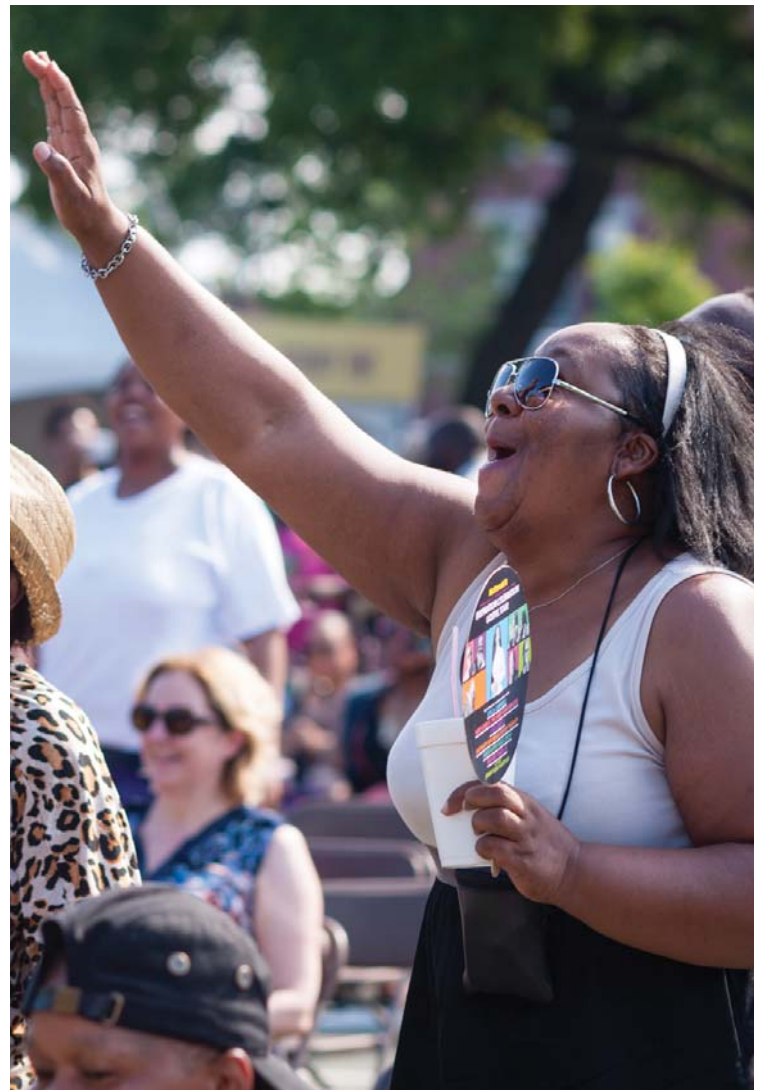
## PHASE 3:  CONDUCT THE
### 4 MAPP ASSESSMENTS

## PHASE 3A:  *Community Health*
### *Status Assessment*

Purpose: The Community Health Status Assessment (CHSA) answers the questions, "How healthy are our residents?" and "What does the health status of our community look like?" The result of this phase is a strong understanding of the community's health status, as portrayed through quantitative data. Data on demographic characteristics, socioeconomic characteristics, health resource availability, quality of life, behavioral risk factors, environmental health indicators, social and mental health, maternal and child health, death, illness and injury, infectious disease and sentinel events are collected and analyzed. The CHSA identifies specific health issues and high-risk populations. The broad range of data collected from census, surveillance, vital records and surveys serves as the foundation for analyzing and identifying community health issues and social determinants of health.

Process: The CDPH Office of Epidemiology & Public Health Informatics worked with the Partnership for Healthy Chicago's data committee to identify relevant data and data sources. CDPH compiled and analyzed all data on the demographics, social determinants of health and health of Chicagoans. One of the new data sources used for this assessment was the Healthy Chicago Survey (HCS), an annual telephone survey launched by CDPH in 2014 to obtain data on Chicagoan's health status and health behaviors. With data available for several years, CDPH was able to analyze the health of the 77 Chicago community areas in many areas of health and social determinants, including discrimination, social cohesion and neighborhood conditions.

Highlights of findings were presented to the Partnership for a Healthy Chicago at their meeting on February 27, 2015 and are detailed in this assessment. The complete results of the data analysis were assembled into a health data compendium.

Critical to the development of this assessment was to: (1) expand the collection of social determinant of health data including information on economic stability, education, social and community context, health care and neighborhood and built environment; (2) analyze data at smaller geographic levels (i.e., community area, zip code and census tract) when possible to better reflect the diversity of Chicago neighborhoods and (3) stratify traditional health outcomes, such as infant mortality, preventable hospitalizations and obesity by more than age, race/ethnicity, community area and gender but by various

social determinants of health (economic, housing, educational, etc.) as demonstrated by the Economic Hardship Index and the Child Opportunity Index.
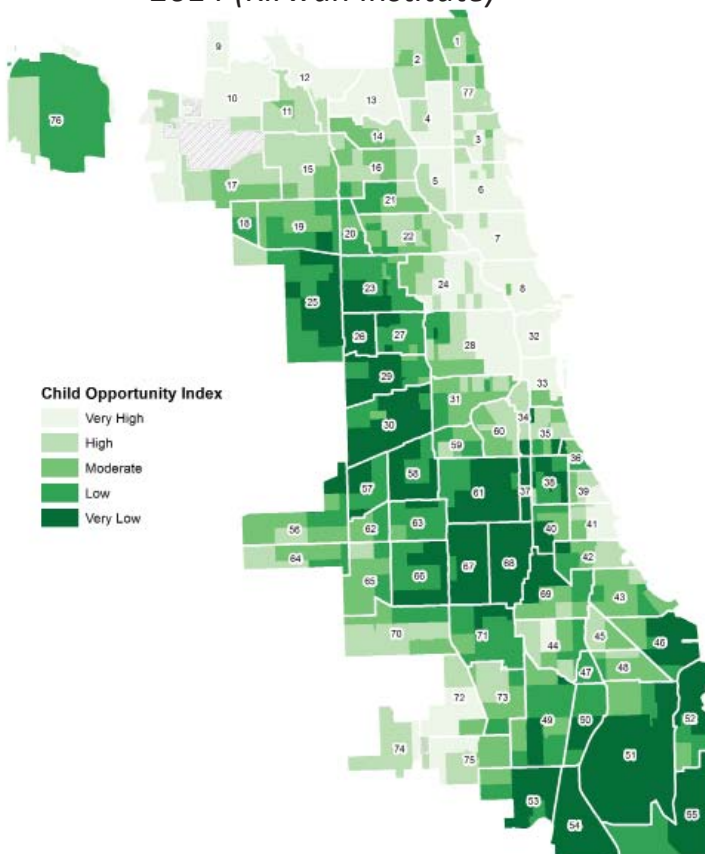
The Economic Hardship Index is an indicator of relative economic conditions that includes six factors: dependent-age population, crowded housing, household poverty, household income, unemployment and education.[1] A higher Hardship Index score signifies that economic conditions are worse in that neighborhood (Figure 1).

### *Figure 1.* *Economic hardship by census tract, 2013 (US Census)*
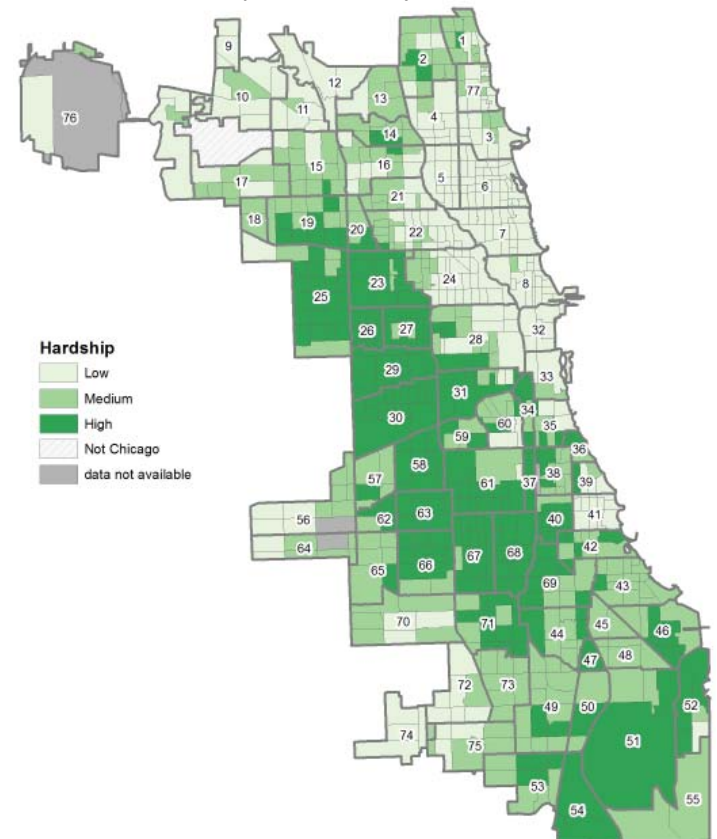
The Child Opportunity Index is an indicator of relative educational, health and environmental and economic conditions that includes 19 variables: adult educational attainment, student (school) poverty, reading proficiency, math proficiency, early childhood education, neighborhood participation patterns, high school graduation, retail healthy food index, housing vacancies, neighborhood foreclosures, poverty, unemployment, public assistance, volume of nearby toxic release and proximity to high-quality early childhood education centers, early childhood education centers of any type, toxic waste release sites, parks and open spaces, health care facilities and employment (Figure 2).[2]

**Figure 2.** *Child opportunity by census tract, 2014 (Kirwan Institute)*



- Access to Health Care
- Economic Stability
- Built Environment
- Conclusion

*Demographics:* Chicago is a diverse but segregated city, socioeconomically, racially and ethnically, which leads to a disproportionate burden of poor health among certain communities. Among the 100 most populous cities in the United States, Chicago ranks as the 7th most racially/ethnically diverse at the city level and 1st as the most racially/ethnically segregated city in the nation (Figure 3).[3]

Residential segregation has been a key factor in creating substantial inequalities in opportunity across neighborhoods and for individuals along racial/ethnic lines. Segregation can lead to dramatic variations in factors conducive to the practice of healthy or unhealthy behaviors, which exacerbate health outcomes. Racial and economic segregation has been shown to be positively associated with mortality rates and adverse health outcomes among racial minorities. Segregation ultimately affects health through concentrated poverty, the quality of neighborhood environment and reduced access to services.[4]

**Figure 3.** *Population distribution by community area and race/ethnicity, 2008-2012 (US Census)*



Findings: The data findings are presented in the following sequence:
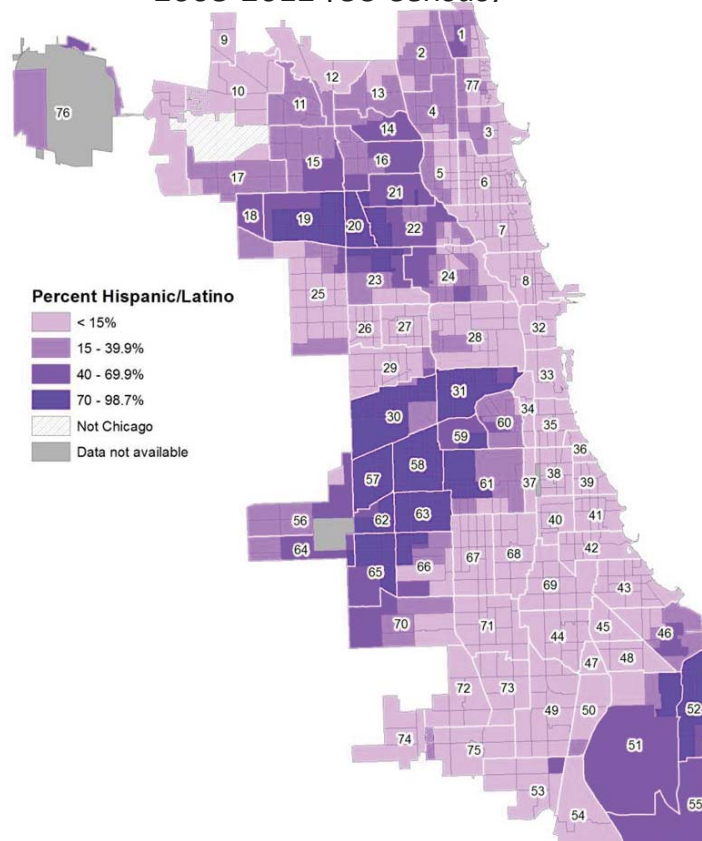
- Demographics (population, race/ethnicity)
- Length and Quality of Life
- Maternal and Infant Health
- Sexually Transmitted Infections
- Adolescent Health and Health Behaviors
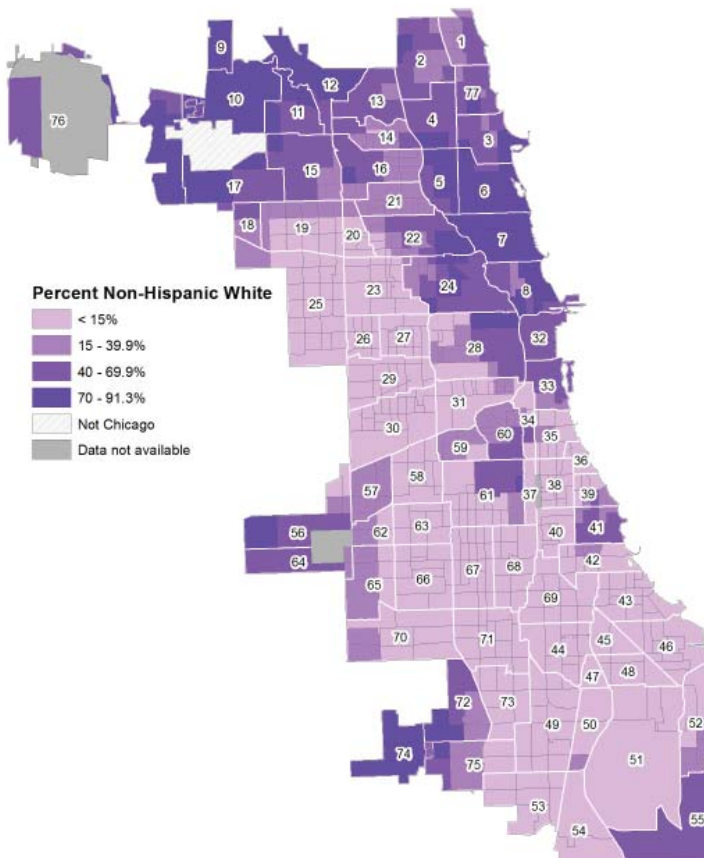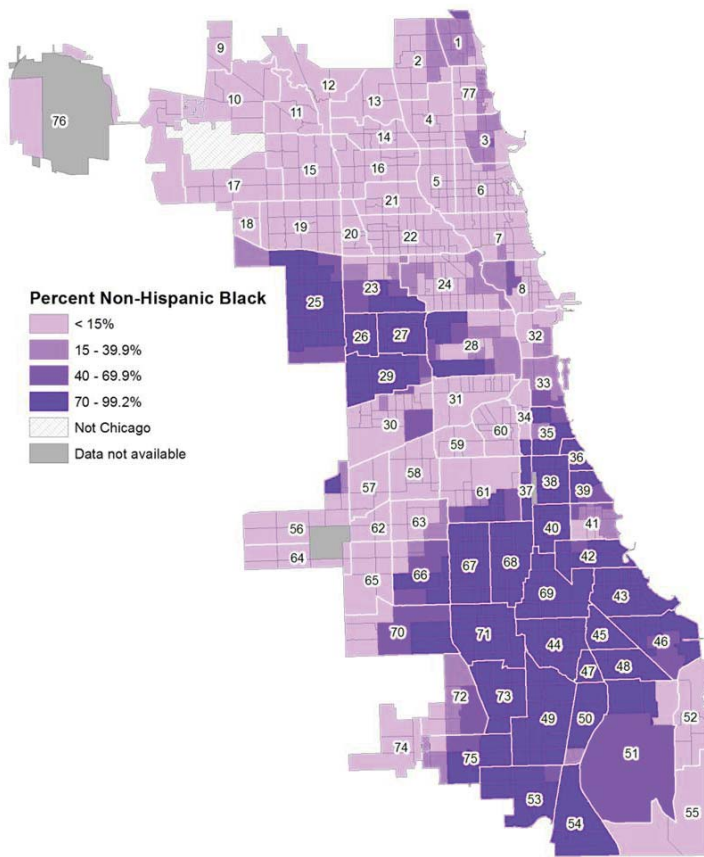- Behavioral Health-Adult
- Violence
- Education

**Percent Non-Hispanic Black**
- < 15%
- 15 - 39.9%
- 40 - 69.9%
- 70 - 99.2%
- Not Chicago
- Data not available



**Percent Non-Hispanic White**
- < 15%
- 15 - 39.9%
- 40 - 69.9%
- 70 - 91.3%
- Not Chicago
- Data not available

*Length and Quality of Life:* Self-assessed health status is a measure of whether an individual perceives his or her health as excellent, very good, good, fair or poor. Overall, 18.4% of adults in Chicago report their health as fair or poor compared to 10.3% in the U.S. In Chicago, twice as many Hispanics and three times as many non-Hispanic blacks report fair or poor health compared to non-Hispanic whites. Self-rated health is also related to age. Adults 45 years and older are more likely to report fair or poor health than those 18-44 years old. Self-rated health status does not differ between men and women. Community areas that have high hardship have twice as many residents who report fair or poor health status compared to community areas with low hardship.[5]

Between 1990 and 2010, life expectancy at birth in Chicago increased by 7.3 years to 77.8 years but still remains slightly below the average life expectancy in the United States (78.7 years). Community area variability exists, with a 16-year difference in life expectancy observed between the communities of Near North and West Garfield Park (Figure 4a). Increases in life expectancy were observed between 1990 and 2010 among all race/ethnic groups, although disparities still exit. Hispanics/Latinos have the highest life expectancy at 84.7 years (a 3% increase from 1990), followed by non-Hispanic white at 79.2 years (an 8% increase from 1990) and non-Hispanic black at 72.4 years, a 10% increase from 1990 (Figure 4b). Life expectancy at birth is correlated with economic hardship and child opportunity at the community area level. Life expectancy is higher in community areas with lower hardship and more opportunity.[6]
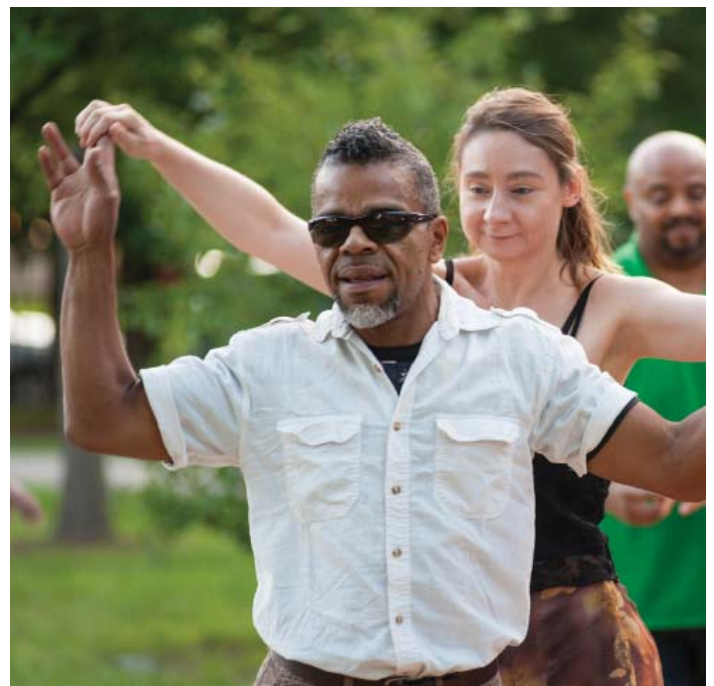
*Figure 4a.* Life expectancy at birth by community area, 1990-2010 (IDPH, US Census)



Life Expectancy at Birth (years)

- 55.0 - 59.9
- 60.0 - 64.9
- 65.0 - 69.9
- 70.0 - 74.9
- 75.0 - 79.9
- 80.0 +
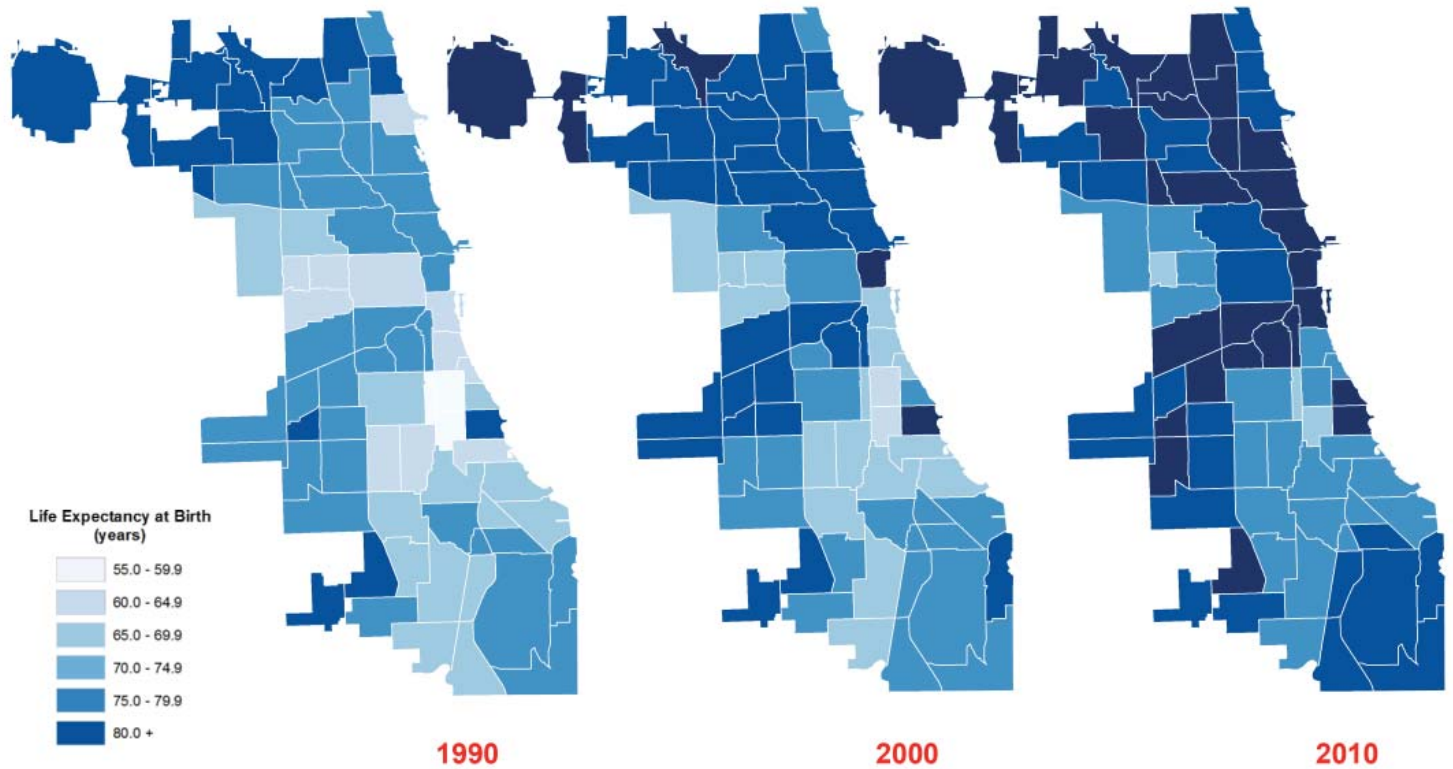
1990    2000    2010

*Figure 4b.* Life expectancy at birth by race/ethnicity, 1990-2010 (IDPH, US Census)



Legend:
- All Race-Ethnicities
- Hispanic or Latino
- Non-Hispanic African-American or Black
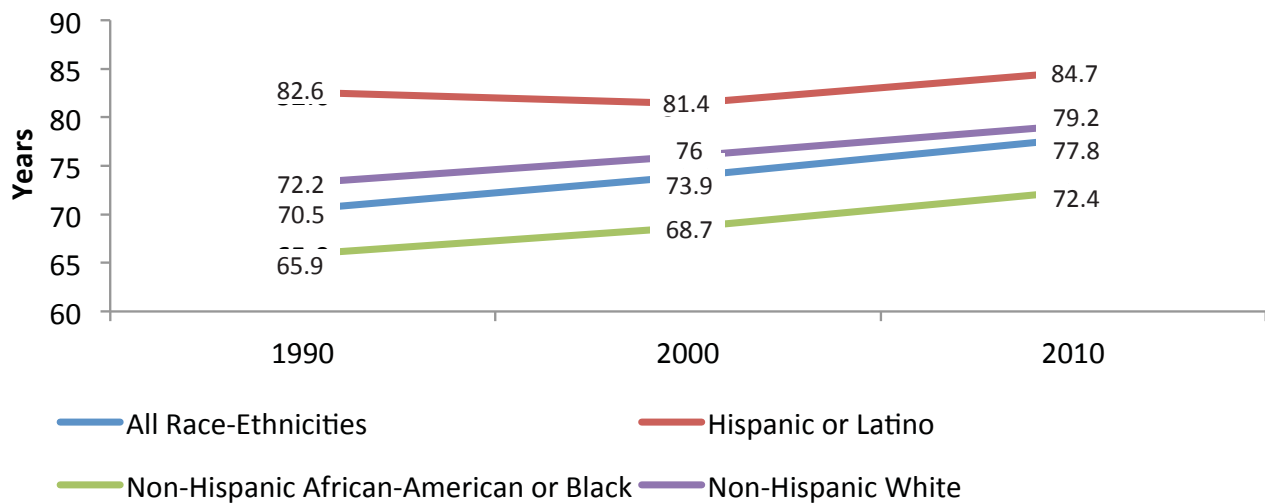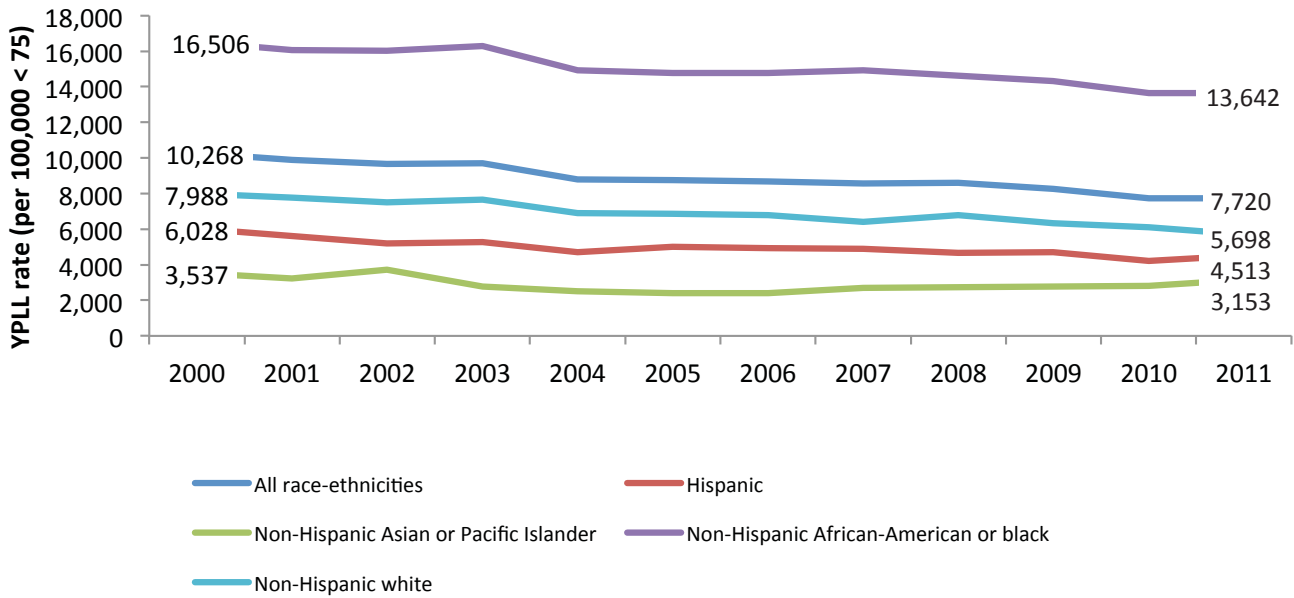- Non-Hispanic White

**Figure 5.** *Years potential life lost by race/ethnicity, 2000-2011 (IDPH, US Census)*



Premature mortality or Years of Potential Life Lost (YPLL) is defined as the average time a person would have lived had they had not died prematurely. This measure is used to help quantify social and economic loss owing to premature death. Premature mortality differs greatly by race/ethnicity and hardship in Chicago. Overall, Chicago has declined 24.8% from 2000 to 2011. However, during the same time period, non-Hispanic whites have seen a much greater decline, 28.7%, compared to non-Hispanic blacks, 17.4% (Figure 5).

Furthermore, as hardship level increases so does the rate of premature mortality. In 2011, persons living in community areas with the highest hardship are more than twice as likely to die prematurely compared to those in the lowest hardship community areas. During the years 2007-2011, community areas on the west and south sides were disproportionately affected with higher rates of premature mortality. Among the highest rates of premature mortality, West Garfield Park, West Englewood and Fuller Park have rates of premature mortality twice that of the city as a whole (Figure 6).[7]

**Figure 6.** *Years potential life lost by community area, 2007-2011 (IDPH,US Census)*
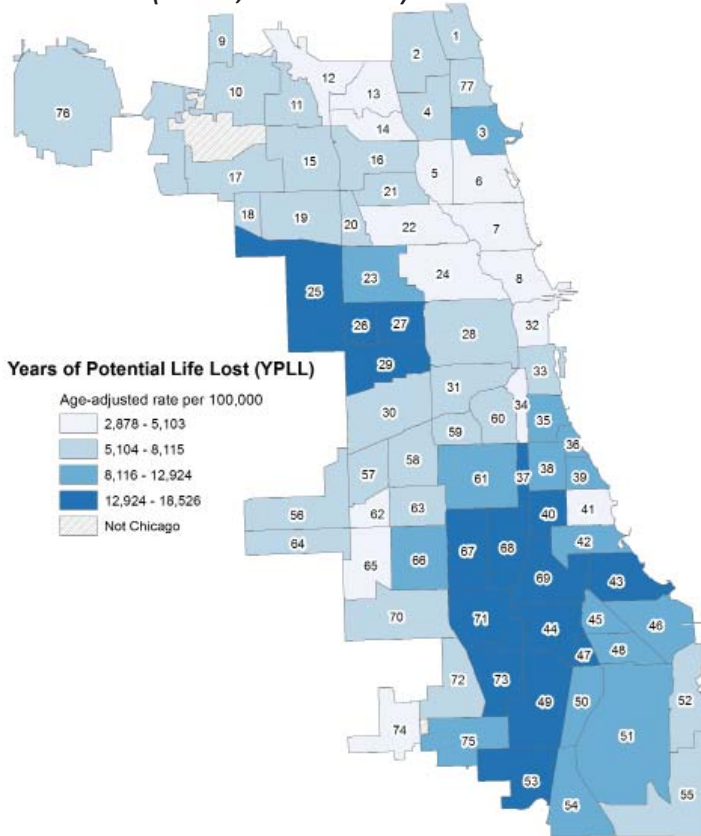


Chronic diseases are the leading causes of morbidity and mortality. In 2011, there were a total of 401,089 inpatient hospitalizations among Chicago's residents. Approximately 20% of these were for pregnancy and childbirth and were not included in the ranking of leading causes of hospitalization. Excluding pregnancy and childbirth, the five leading causes of hospitalization were heart disease, substance-related disorders (including alcohol-related), mood disorders, schizophrenic disorders and cancer. Of the ten leading causes of hospitalization, five were due to chronic disease and include heart disease, cancer, stroke, asthma and diabetes (Figure 7).[8]

In 2011, the ten leading causes of death accounted for 74% of all deaths occurring in Chicago. Six of the ten leading causes of death were attributable to chronic disease including heart disease, cancer, stroke, chronic lower respiratory disease, diabetes and kidney diseases, which account for 64% of all deaths (Figure 8).[7]

**Figure 7.** *Leading causes of hospitalizations, 2011 (IDPH, US Census)*

| Cause of hospitalization | Visits | Crude Rate (per 10,000) | US Rate 2006 (per 10,000) | Rank |
|---|---|---|---|---|
| All Hospitalizations | 401,089 | 1,487.9 | NA | -- |
| Pregnancy, childbirth and the purperium | 45,723 | 169.6 | NA | -- |
| Certain conditions originating in the perinatal period | 40,544 | 150.4 | NA | -- |
| Heart disease | 33,689 | 125.0 | 140.9 | 1 |
| Substance-related disorders | 23,267 | 86.3 | NA | 2 |
| Mood disorders | 17,778 | 66.0 | 15.4 | 3 |
| Schizophrenic disorders | 14,730 | 54.6 | NA | 4 |
| Malignant neoplasms | 11,029 | 40.9 | 40.5 | 5 |
| Septicemia | 9,011 | 33.4 | 17.8 | 6 |
| Pneumonia | 8,278 | 30.7 | 41.3 | 7 |
| Cerebrovascular disease | 8,093 | 30.0 | 29.8 | 8 |
| Asthma | 7,325 | 27.2 | 14.9 | 9 |
| Diabetes mellitus | 7,112 | 26.4 | 19.6 | 10 |
| Asthma | 7,325 | 27.2 | 14.9 | 9 |
| Diabetes mellitus | 7,112 | 26.4 | 19.6 | 10 |

*Figure 8. Leading causes of death, 2011 (IDPH)*

| Rank | Cause of Death | Number | Percent |
|---|---|---|---|
| … | All Causes | 18,769 | -- |
| 1 | Heart Disease | 4,991 | 26.7 |
| 2 | Cancer | 4,316 | 23.1 |
| 3 | Stroke | 886 | 4.7 |
| 4 | Chronic Lower Respiratory Diseases | 717 | 3.8 |
| 5 | Accidents | 636 | 3.4 |
| 6 | Diabetes | 565 | 3.0 |
| 7 | Influenza and Pneumonia | 472 | 2.5 |
| 8 | Nephritis, Nephrotic Syndrome and Nephrosis | 452 | 2.4 |
| 9 | Septicemia | 413 | 2.2 |
| 10 | Homicide | 399 | 2.1 |
| … | All Other Causes | 4,922 | 25.9 |

Hospitalization and mortality rates due to disease and injury are decreasing (Figures 9 and 10). Through improved quality of care, use of blood pressure medications, statin drugs, more rapid and effective treatment of heart attacks and an increased awareness of the benefits of healthy diet and exercise there have been marked declines in mortality and hospitalizations due to coronary heart disease, the most prevalent chronic disease. Despite these reductions, strong racial disparities between non-Hispanic black and white Chicagoans persist. Higher rates of heart disease mortality and hospitalizations are consistently seen in neighborhoods with high rates of economic hardship. Diabetes hospitalizations have risen over 30% in the past decade, representing over 7,000 hospitalizations per year. Both hospitalizations and deaths from diabetes occur more often among persons living in neighborhoods with high economic hardship and occur at twice the rate among non-Hispanic blacks compared to non-Hispanic whites in Chicago. Although rates of asthma hospitalization among young children (less than 5 years) have decreased over 50% in the past decade, Chicago's hospitalization rate is double the national rate. Both non-Hispanic black and Hispanic children are hospitalized more often than white children, as are the children living in west side communities (i.e., West and East Garfield Park have the highest rates compared to all other community areas). Asthma-related emergency department visits for persons under 5 years old in Chicago exceed the national rate (194.8 per 100,000 in Chicago compared to 138.3 per 100,000 nationally). This rate was 412.9 per 100,000 among non-Hispanic black children in Chicago, higher than all other racial/ethnic groups.[7,8]

Hospitalizations for behavioral health conditions (mental health and alcohol/substance use) have seen marked increases in the past decade and now represent over one in six hospitalizations overall. Rates of mood disorder hospitalizations in Chicago eclipse the national rate by more than four times. Non-Hispanic black Chicagoans are hospitalized for mental health-related conditions at two to ten times the rate of non-Hispanic white and Hispanic Chicagoans. Residents of East and West Garfield Park, Uptown, Englewood, Washington Park and Woodlawn have the highest rates of hospitalizations due to mental health conditions.[8]

**Figure 9.** *Summary of hospitalizations, 2011 (IDPH)*

| Cause of Hospitalization | Number | Percent† | Percent change 2001-2011 | Chicago vs. US¥ | Correlation to Hardship (R²) | Geographic Disparity* | Black:White Disparity** | Hispanic Disparity€ |
|---|---|---|---|---|---|---|---|---|
| Heart Disease | 33,689 | 10.7 | 35% ↓ | 0.9 | Moderate | 3.1 | 2.0 | 1.0 |
| Substance-related Disorders | 23,267 | 7.4 | 36% ↑ | NA | Weak | 45.0 | 2.0 | 0.2 |
| Mood Disorders | 17,778 | 5.6 | 11% ↑ | 4.3 | Weak | 6.0 | 2.0 | 0.6 |
| Schizophrenic Disorders | 14,730 | 4.7 | 6% ↓ | NA | None | 27.7 | 3.6 | 0.6 |
| Asthma | 7,325 | 2.3 | -- | -- | -- | -- | -- | -- |
| <5 years | 663 | 0.2 | 55% ↓ | 2.0 | Moderate | 14.0 | 2.3 | 1.3 |
| ≥ 65 years | 1,299 | 0.4 | 18% ↑ | 2.3 | None | 17.4 | 3.6 | 3.8 |
| Diabetes | 7,112 | 2.3 | 30% ↑ | 1.3 | Strong | 4.8 | 2.4 | 1.7 |
| Preventable Hospitalizations | 42,642 | 13.5 | 30% ↓ | NA | Moderate | 4.8 | 2.8 | 1.4 |

†Of all non-childbirth-related hospitalizations; ¥ Ratio of Chicago and US rates; *Ratio of zip code with highest age-adjusted rate and zip code with lowest rate; **Ratio of Non-Hispanic African-American or black and Non-Hispanic white rates; € Ratio of Hispanic and non-Hispanic white rates

Homicide mortality in Chicago has decreased by over one-third between 2001 and 2011, despite the most recent rate being over 2.5 times the national rate. Racial/ethnic disparity is particularly pronounced in rates of homicide mortality. Non-Hispanic black Chicagoans are almost 25 times more likely to die via homicide than non-Hispanic white Chicagoans and Hispanics are 6 times more likely, particularly those who live in areas of high economic hardship where the homicide rate is up to 80 times higher than that of the areas in the city with low economic hardship.[7]

**Figure 10.** *Summary of mortality, 2011 (IDPH, US Census)*

| Cause of Death | Percent† | Percent Change 2000-2011 | Chicago vs. US¥ | Relationship to Hardship | Geographic Disparity* | Black:White Disparity** | Hispanic Disparity€ | YPLL | YPLL: NH White | YPLL: Hispanic |
|---|---|---|---|---|---|---|---|---|---|---|
| Heart Disease | 27% | 30%↓ | 1.2 | Moderate | 3.3 | 1.2 | 0.6 | 2,537 | 1,216 | 549 |
| Cancer | 23% | 19%↓ | 1.1 | Moderate | 2.3 | 1.3 | 0.7 | 2,264 | 1,367 | 648 |
| Diabetes | 3% | 13%↓ | 1.0 | Strong | 5.5 | 1.8 | 1.4 | 310 | 100 | 86 |
| Stroke | 5% | 35%↓ | 1.0 | Moderate | 3.2 | 1.7 | 0.8 | 369 | 127 | 84 |
| Accidents | 3% | 37%↓ | 0.6 | Strong | 5.2 | 1.3 | 0.8 | 968 | 582 | 469 |
| Homicide | 2% | 34%↓ | 2.5 | Strong | 81.1 | 24.9 | 6.0 | 1,775 | 51 | 479 |
| Suicide | 1% | 21%↓ | 0.5 | Strong | NA | 0.7 | 0.4 | 227 | 282 | 148 |
| YPLL | -- | 25%↓ | 1.2 | Strong | 6.4 | 2.4 | 0.8 | 13,642 | 5,698 | 4,513 |
| Life Expectancy | -- | 10%↑ | 1.0 | Moderate | 1.2 | 0.9 | 1.1 | -- | -- | -- |

†Of all deaths; ¥Ratio of Chicago and US rates; *Ratio of community area with highest age-adjusted rate and community area with lowest rate; **Ratio of Non-Hispanic African-American or black and Non-Hispanic white rates; €Ratio of Hispanic and non-Hispanic white rates

Incidence of chronic disease is increasing. Overall, 26.6% of adults in Chicago (approximately 508,000 adults) have ever been diagnosed with hypertension or high blood pressure, slightly lower than the US rate of 29.1% (Figure 11). There is a significant difference in hypertension prevalence between racial-ethnic groups; the highest rate is observed among non-Hispanic blacks (29.3%), compared to 23.6% among non-Hispanic whites and 18.6% among Hispanics. Increased age is associated with increased rates of hypertension, with prevalence at 6.5% among those aged 18-29 years and 62.2% among those aged 65+. There is no difference in rates of hypertension between men and women, or between low, medium and high hardship.[5]

**Figure 11.** *Percentage of adults with hypertension, 2001-2011 (BRFSS), 2104 (HCS)*
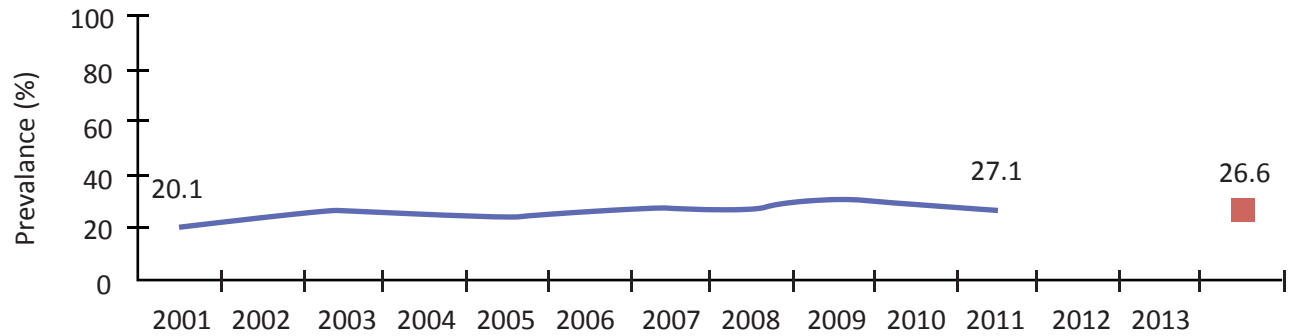


The overall prevalence of high cholesterol among adults in Chicago is 28.5% (approximately 424,000 adults), similar to previous years and what is observed nationally, 31.7% (Figure 12).[5,9] While there is no difference in high cholesterol by gender, race/ethnicity or community hardship, higher cholesterol prevalence is related to age. Those over the age of 45 are three times as likely to have high cholesterol compared to those 30-44 and four times as likely as those aged 18-29.[5,9]

**Figure 12.** *Percentage of adults with high cholesterol, 2001-2011 (BRFSS), 2014 (HCS)*
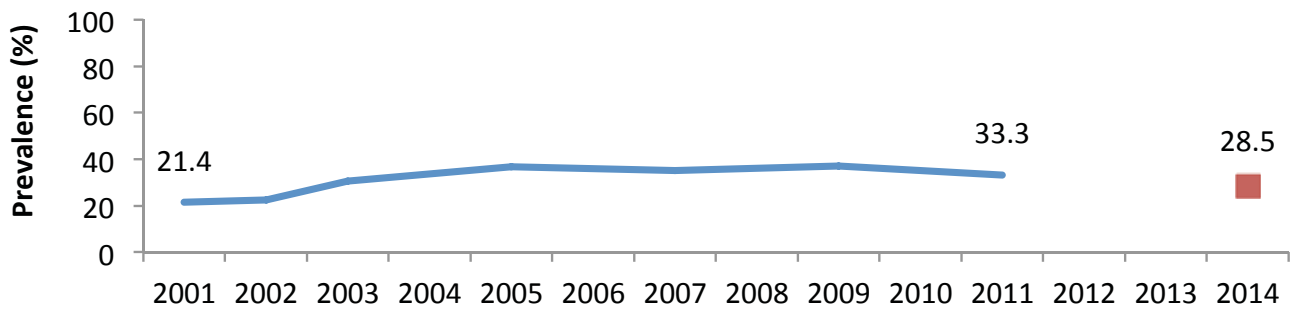


In Chicago, 28.8% of adults (approximately 552,000 adults) have a body mass index that classifies them as obese, continuing a gradually increasing trend in obesity observed since 2001 (Figure 13).[5,9] Reducing the proportion of adults who are obese is a goal of Healthy People 2020 (HP 2020), with a national target of 30.5%. In Chicago, obesity is most prevalent among women (32.3%, compared to 24.9% among men), non-Hispanic blacks (37.8%, compared to 32.1% among Hispanics and 23.7% among non-Hispanic whites) and those aged 45-64 (36.8%, compared 23.2% among those aged 18-29, 27.2% among those aged 30-44 and 24.8% among those aged 65+). Obesity is almost twice as prevalent in high hardship communities (37.3%) as in low hardship communities (21.0%).[5,9]

**Figure 13.** *Percentage of adults who are obese, 2001-2011 (BRFSS), 2014 (HCS)*
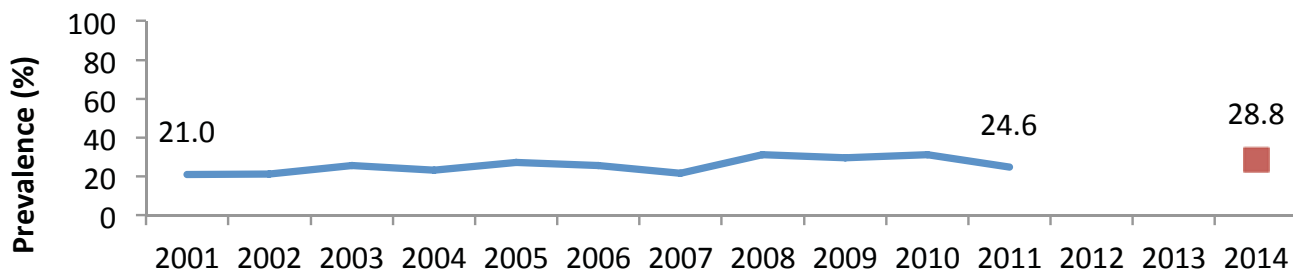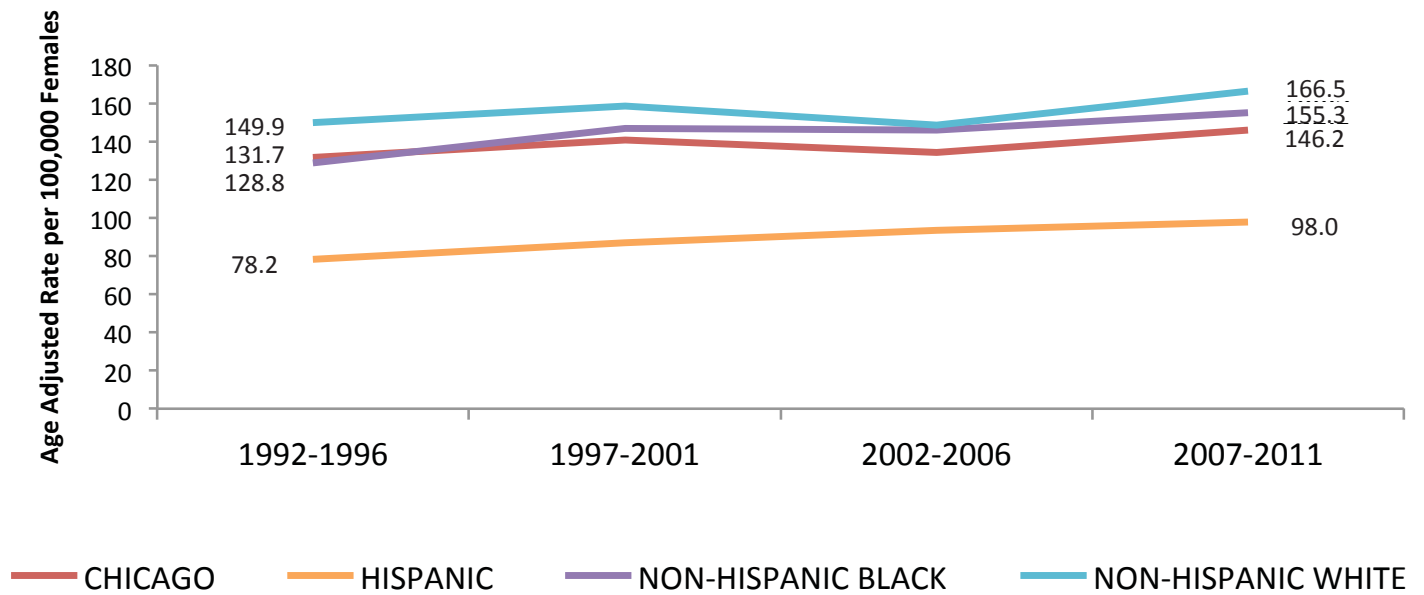
**Figure 14.** *Female breast cancer incidence rates by race/ethnicity, 1992-2011 (IDPH, US Census)*



Overall, female breast cancer incidence in Chicago has increased by ten percent between 1992-1996 and 2007-2011 and rates in Chicago are 17% higher than nationally (Figure 14). Non-Hispanic white women have the highest rates of breast cancer incidence in Chicago, though incidence increased more for Hispanic and non-Hispanic black women during the study period, 20% and 17%, respectively. Hispanic females have the lowest rates of breast cancer in Chicago. Rates are 58% higher among non-Hispanic blacks and 70% higher among non-Hispanic whites.[10]

Diabetes prevalence in Chicago is 9.0% (approximately 172,000 adults), similar to previous years and similar to what is observed nationally, 9.3% (Figure 15). Disparities in diabetes prevalence exist between racial-ethnic groups. The highest rate is among non-Hispanic blacks (12.3%), compared to Hispanics (8.6%) and non-Hispanic whites (5.8%). A significant trend is observed between diabetes prevalence and age. While only 1.0% of those aged 18-29 have diabetes, this increases to 4.7% among those aged 30-44, 14.0% among those aged 45-64 and 22.1% among those over the age of 65. Men and women have similar proportions with diabetes and diabetes is not significantly associated with neighborhood hardship.[5]

**Figure 15.** *Percentage of adults with diabetes, 2001-2011 (BRFSS), 2014 (HCS)*
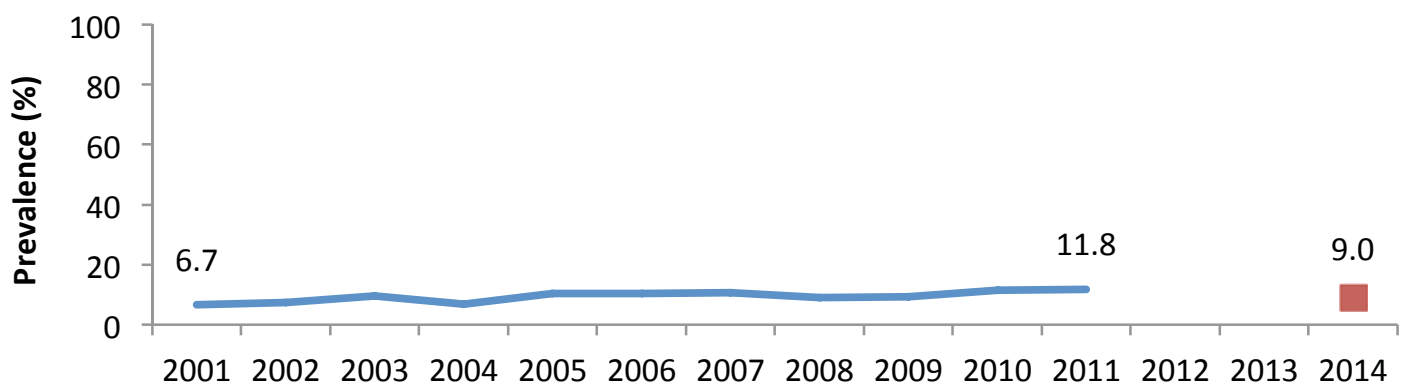
Little to no improvement has occurred in overall adult healthy behaviors. The current smoking rate among Chicago adults is 18.4% (approximately 351,000 adults)[5], similar to what is observed nationally, 17.8% (Figure 16).[11] An objective of HP 2020 is to reduce cigarette smoking by adults to 12.0%.[12] In Chicago, cigarette smoking is higher among men (21.8%) compared to women (15.4%) and is highest among non-Hispanic blacks (25.3%) compared to other racial-ethnic groups (non-Hispanic white: 13.7%; Hispanic/Latino: 18.5%). Smoking is more prevalent in high hardship neighborhoods (25.4%) than in low hardship neighborhoods (11.5%).[5]

**Figure 16.** *Percentage of adults who are current smokers, 2001-2011 (BRFSS), 2014 (HCS)*
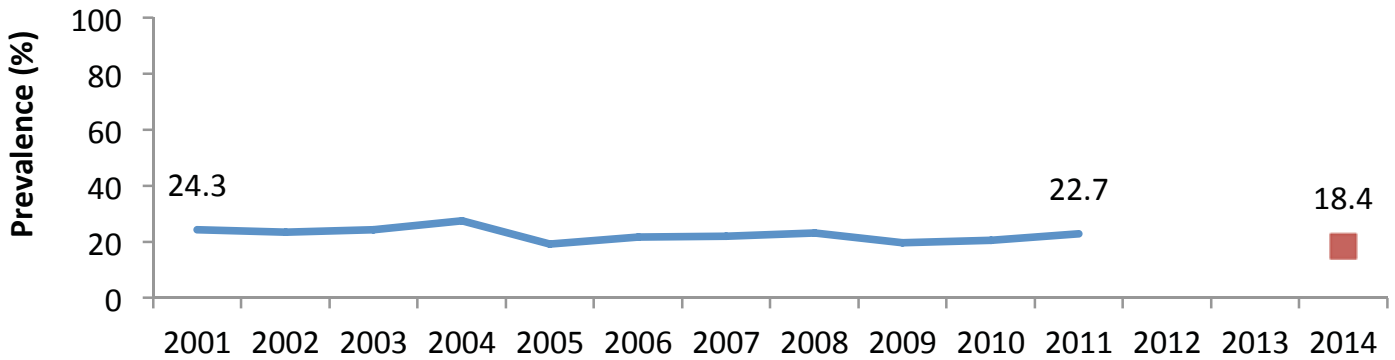


Overall, 29.2% of adults (approximately 554,000 adults) report eating five or more servings of fruits and vegetables per day (Figure 17). Fruit and vegetable consumption is higher among residents who live in low hardship neighborhoods (36.1%) compared to those in medium hardship neighborhoods (29.8%) and high hardship neighborhoods (19.5%). While there is no difference in fruit and vegetable consumption between men and women or between ages, rates are higher among non-Hispanic whites (41.3%) compared to Hispanics/Latinos (23.6%) and non-Hispanic blacks (18.9%).[5]

**Figure 17.** *Percentage of adults who eat 5 or more servings of fruit and vegetables daily, 2001-2011 (BRFSS), 2014 (HCS)*
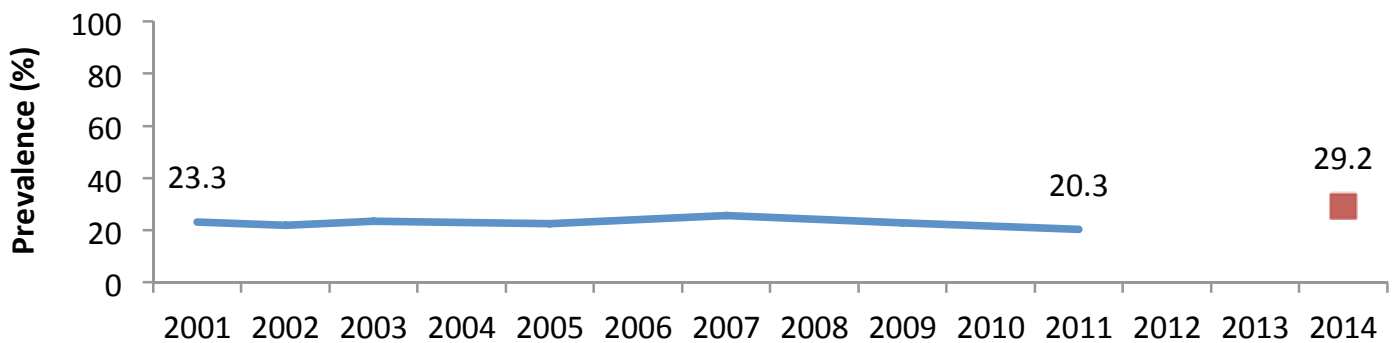


Overall, 18.3% of adults (approximately 350,000 adults) report that they did not participate in any physical activity or exercise in the past month, similar to previous years (Figure 18).[5,9] While it is encouraging that the rate in Chicago is below the national rate and the HP 2020 target, disparities remain between race/ethnic groups and between neighborhoods. While 12.3% of non-Hispanic whites report no physical activity, this is almost doubled among Hispanics/Latinos (20.3%) and non-Hispanic blacks (22.4%). In low hardship neighborhoods, 13.5% of adults report no physical activity compared to 25.4% in high hardship neighborhoods.[5]

**Figure 18.** *Percentage of adults who do not exercise, 2001-2011 (BRFSS), 2014 (HCS)*
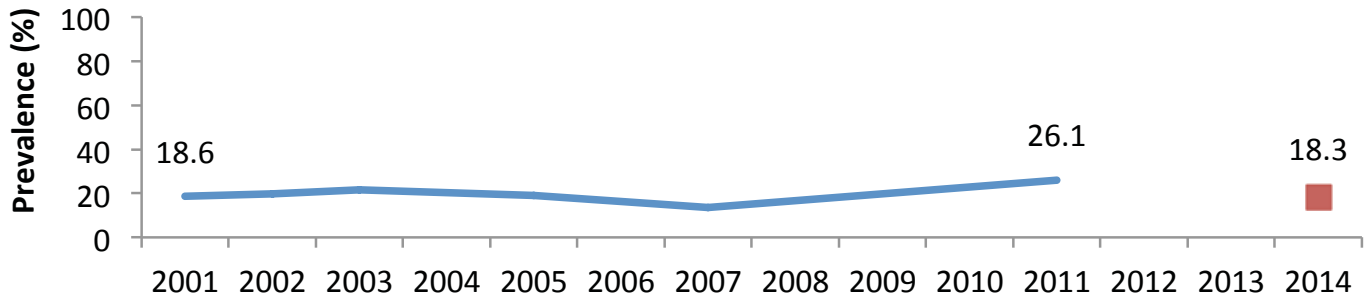


The US Preventive Services Task Force (USPSTF) recommends mammograms every two years for women between the ages of 50 and 74 years. In Chicago, 75.6% of women are meeting this recommendation (Figure 19)

and there are no differences by racial-ethnic groups or by neighborhood hardship.[5] HP 2020 has set the national target of 81.1% of women meeting this recommendation.[12]
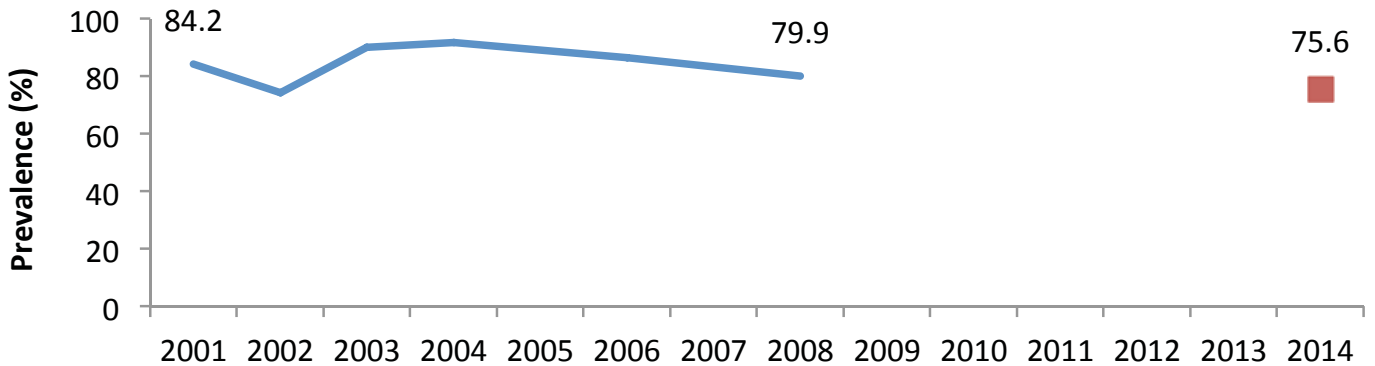
**Figure 19.** *Percentage of adult females aged 50-74 years who met the breast cancer screening guideline, 2001-2008 (BRFSS), 2014 (HCS)*



USPSTF recommends a Pap smear to screen for cervical cancer every three years for women aged 21 to 65 years. In Chicago, 82.9% of women are meeting this recommendation (Figure 20), similar to what is observed nationally (82.8%), although lower than the HP 2020 target

(93.0%)[5,12]. Younger women, aged 21 to 29 years, are less likely to have had a Pap test within the past three years (70.3%), compared to those aged 30-44 (92.6%) and aged 45-64 (82.1%).[5]

**Figure 20.** *Percentage of adult females aged 21-65 years who met the cervical cancer screening guidelines, 2001-2008 (BRFSS), 2014 (HCS)*



*Note: For 2001-2003, number reflects women aged 21 to 65 who have not had a hysterectomy and have had a Pap test in the past two years*
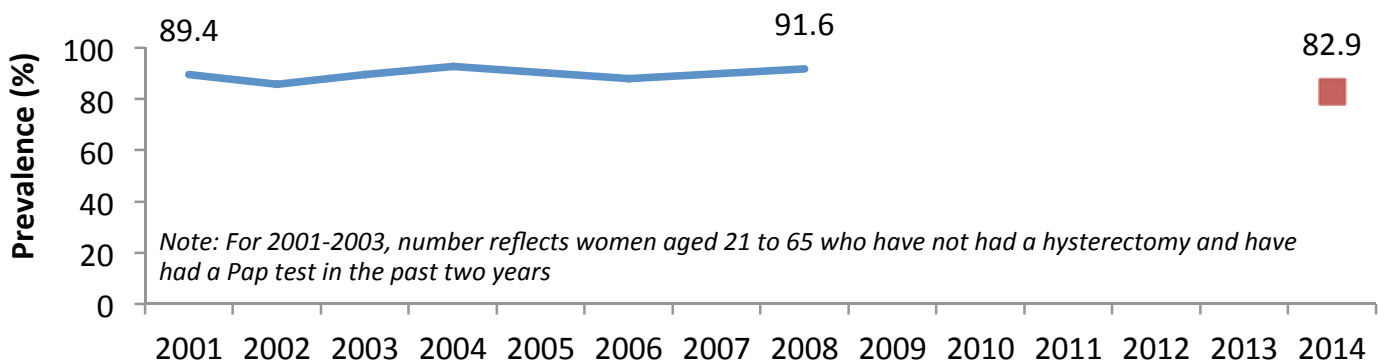
USPSTF recommends screening for colorectal cancer using high-sensitivity fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 50 and continuing until age 75. In Chicago, 60.5% of adults 50 to 75 years of age reported having a sigmoidoscopy or colonoscopy in the past 10 years, having a sigmoidoscopy or colonoscopy in the past 5 years along with a blood stool test in the past 3 years or having a blood stool test in the past year (Figure 21).[5] This is similar to the national rate, but below the objective set by HP 2020 (70.5%).[11] In Chicago, Hispanics have screening rates (48.8%) that are significantly lower than non-Hispanic blacks (60.0%) and non-Hispanic whites (64.4%). Screening rates are higher in low hardship communities (67.5%), compared to medium hardship (60.8%) and high hardship communities (50.6%).[5]

**Figure 21.** *Percentage of adults aged 50-75 years who reported having a sigmoidoscopy or colonoscopy in past 10 years, having a sigmoidoscopy or colonoscopy in the past 5 years and a blood stool test in past 3 years, or having a blood stool test in the past year, 2001-2008 (BRFSS), 2014 (HCS)*
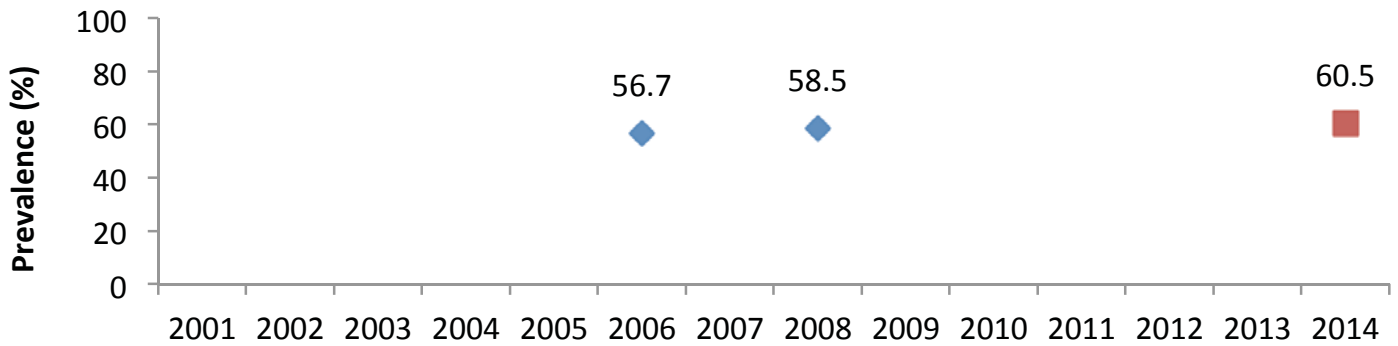


*Maternal and Infant Health:* Gains have been made in reducing teen births and infant mortality. Teen births decreased by 35% between 2000 and 2010 to 52.3 per 1,000 females aged 15-19, but the overall rate for Chicago remains above the national rate of 34.3 (Figure 22). Despite the reduction in teen births, disparities persist. Non-Hispanic black and Hispanic teens have four to six times higher rates than non-Hispanic whites and non-Hispanic Asian/Pacific Islander mothers. Teen birth rates are higher in community areas with more economic hardship and less child opportunity. Chicago's teen birth rate remains 50% higher than the national average. Infant mortality also decreased, by 36%, between 2000 and 2010 to 7.4 infant deaths per live births (Figure 23). Overall, Chicago's infant mortality rate is higher than the US, at 6.1. Infant mortality among non-Hispanic blacks is almost three times higher compared to non-Hispanic whites. In addition, community areas with high levels of economic hardship have infant mortality rates more than twice that of community areas with low hardship.[13]

**Figure 22.** *Teen birth rate by race/ethnicity, 2000-2010 (IDPH, US Census)*



Legend:
- All race-ethnicities
- Hispanic
- Non-Hispanic Asian or Pacific Islander
- Non-Hispanic African-American or black
- Non-Hispanic white
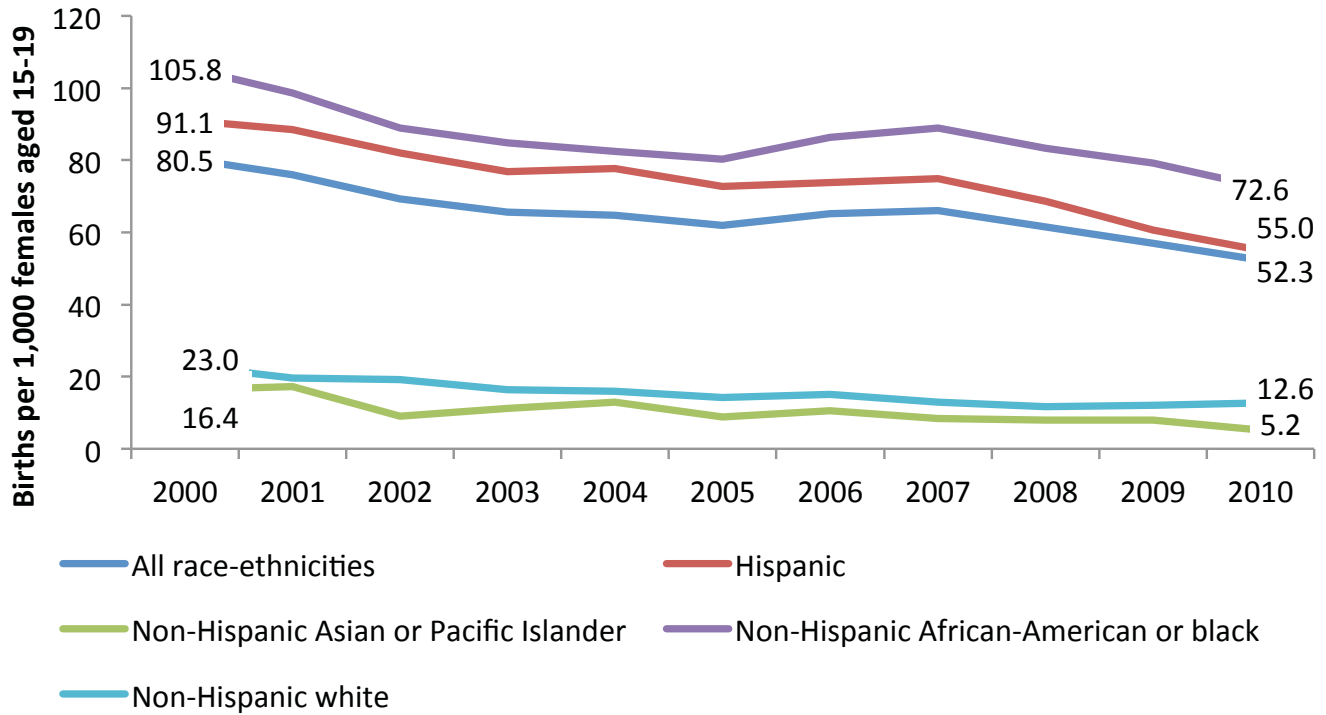
**Figure 23.** *Infant mortality by race/ethnicity, 2000-2010 (IDPH)*



Legend:
- All race-ethnicities
- Hispanic
- Non-Hispanic Asian or Pacific Islander
- Non-Hispanic African-American or black
- Non-Hispanic white
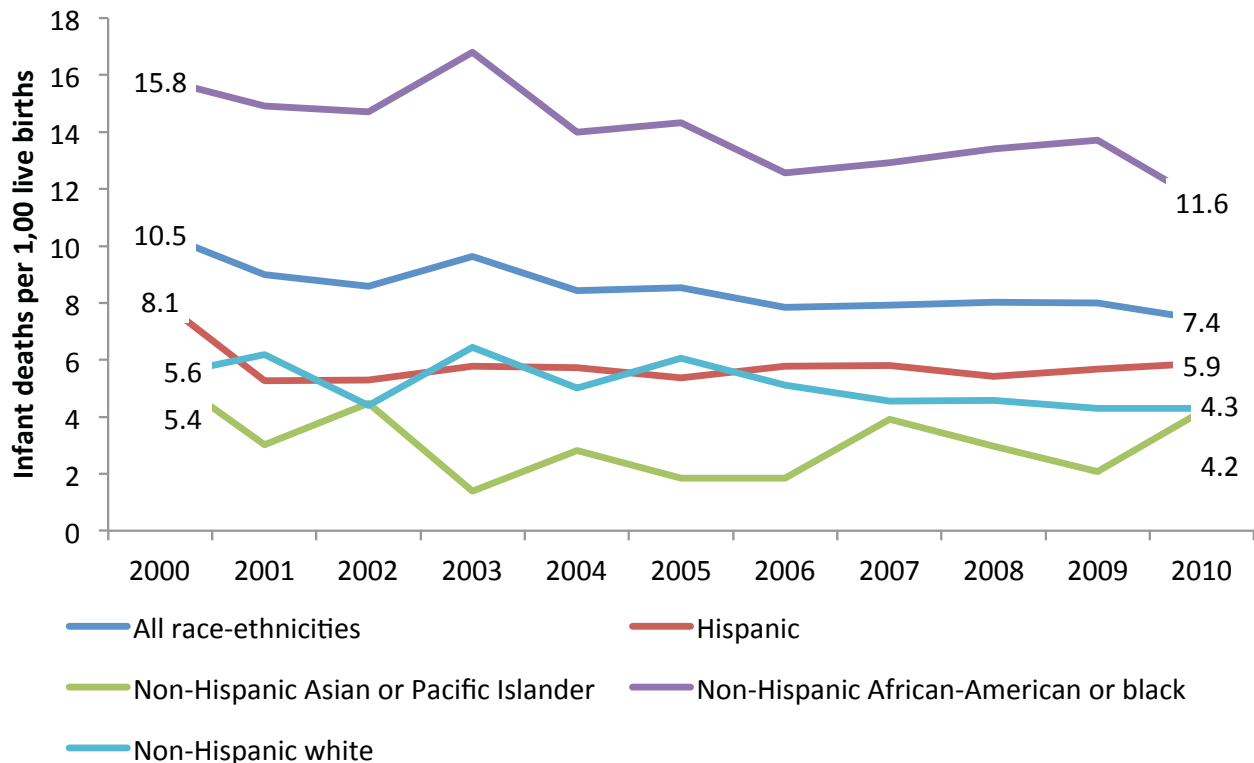
Over the past 10 years, significant gains have been made in healthy natality outcomes (Figure 24). Early initiation of prenatal care has improved across all racial/ethnic groups, although disparities persist for non-Hispanic black and Hispanic mothers. Early prenatal care utilization is significantly lower among areas with high economic hardship. Mothers in those areas consequently tend to have babies with low or very low birth weight more frequently than mothers who reside in low hardship communities.[13]

**Figure 24.** *Summary of natality, 2010 (IDPH)*

| Natality Indicator | Percent change 2000-2010 | Chicago vs. US¥ | Correlation to Hardship | Geographic Disparity* | Black:White Disparity** | Hispanic Disparity€ |
|---|---|---|---|---|---|---|
| Early and adequate prenatal care (%) | 19% ↑ | 1.1 | Moderate | 1.7 | 0.8 | 1.0 |
| First trimester prenatal care (%) | 12% ↑ | 1.2 | Strong | 1.5 | 0.8 | 0.9 |
| Teen birth rate | 35% ↓ | 1.5 | Strong | 17.9 | 5.8 | 4.4 |
| Preterm (%) | 6% ↓ | 0.9 | Weak | 3.6 | 1.4 | 1.0 |
| Low birth weight (%) | 1% ↓ | 1.2 | Moderate | 6.5 | 1.9 | 1.0 |
| Very low birth weight (%) | 10% ↓ | 1.4 | Moderate | 40.0 | 2.4 | 1.1 |
| Infant mortality rate | 30% ↓ | 1.2 | Strong | 9.6 | 2.7 | 1.4 |

¥Ratio of Chicago and US rates/percentages; *Ratio of community area with highest rate/percent and community area with lowest rate/percentage;
**Ratio of Non-Hispanic African-American or black and Non-Hispanic white rates/percentages;
€ Ratio of Hispanic and non-Hispanic white rates/percentages

*Sexually Transmitted Infections:* Chlamydia is the most commonly reported infectious disease in Chicago. In 2013, almost 25,000 chlamydia infections were diagnosed in Chicago. Over one-third were among Chicago youth less than 19 years old. Residents of neighborhoods with high levels of economic hardship were diagnosed up to 50 times more often than those in low hardship neighborhoods (Figure 25). Over 8,000 cases of gonorrhea were diagnosed in Chicago in 2013, almost one-third of which were among those less than 19 years old. Gonorrhea diagnoses rates in West Garfield Park were over 5,000 times the rate in Mt. Greenwood. This is the single largest geographic disparity of any health condition in Chicago.[14]

**Figure 25.** *Chlamydia infections in persons less than 19 years of age by community area, 2013 (CDPH)*
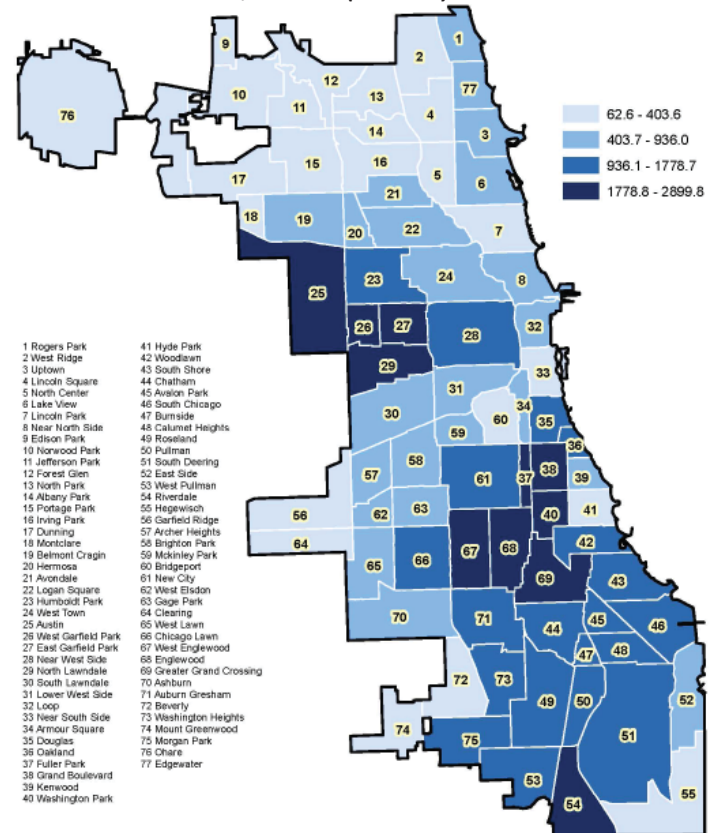
*Adolescent Health and Health Behaviors:* Over one-third of Chicago's school-aged children are overweight or obese. Overweight or obesity prevalence ranges from 27% to 52%. The percentage of Chicago Public School (CPS) kindergarteners, 6th and 9th graders who are overweight or obese tend to be lowest in north and northeastern community areas and highest in northwest and southwest community areas (Figure 26).[15]

All race/ethnicity groups experienced an 11.4-13.7% increase in the percentage of overweight or obese students between kindergarten and 6th grade, then subsequent 2.6-5.0% decrease between 6th and 9th grades (Figures 27a-c). However, Hispanic youth enter school more likely to be overweight or obese than their non-Hispanic black and white peers (41.1% vs. 32.8% vs. 26.2% respectively for the 2012-2013 school year) and remain the most affected group through all three grades. Though males are more likely to be overweight or obese than females in all grades, this is not a meaningful difference.[15]

*Figure 26.* *Overweight or obesity in CPS kindergarteners, sixth and ninth graders by community area, 2012-2013 (CPS)*



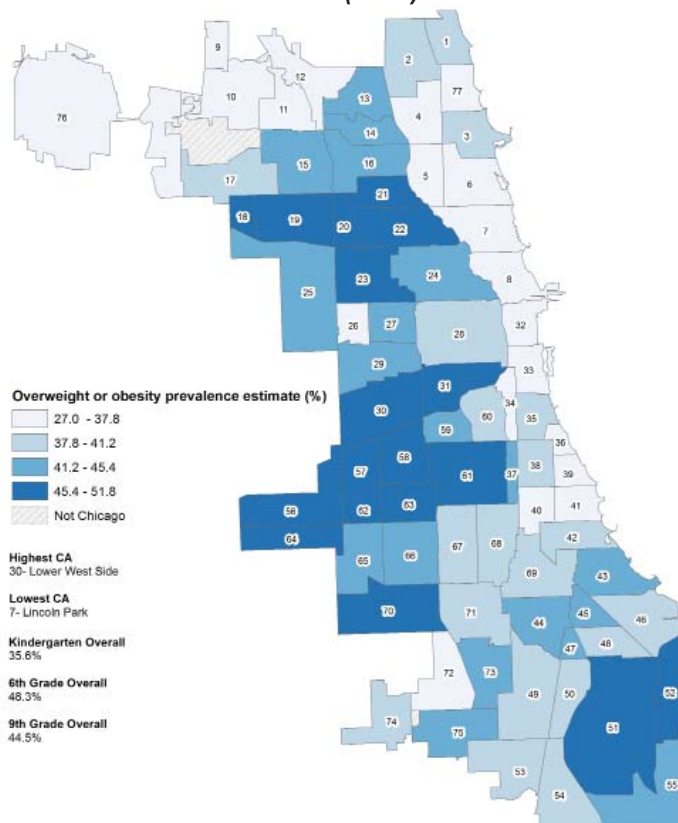Overweight or obesity prevalence estimate (%)

- 27.0 - 37.8
- 37.8 - 41.2
- 41.2 - 45.4
- 45.4 - 51.8
- Not Chicago

Highest CA
30- Lower West Side

Lowest CA
7- Lincoln Park

Kindergarten Overall
35.6%

6th Grade Overall
48.3%

9th Grade Overall
44.5%

**Figure 27a.** *Obesity or overweight in CPS ninth graders, 2010-2013 (CPS)*



Prevalence estimate (%)

49.4 — 51.5 — 49.8
44.7 — 45.5 — 44.5
43 — 42.8 — 42.2
33.7 — 36.2 — 34.8

2010-2011 · 2011-2012 · 2012-2013
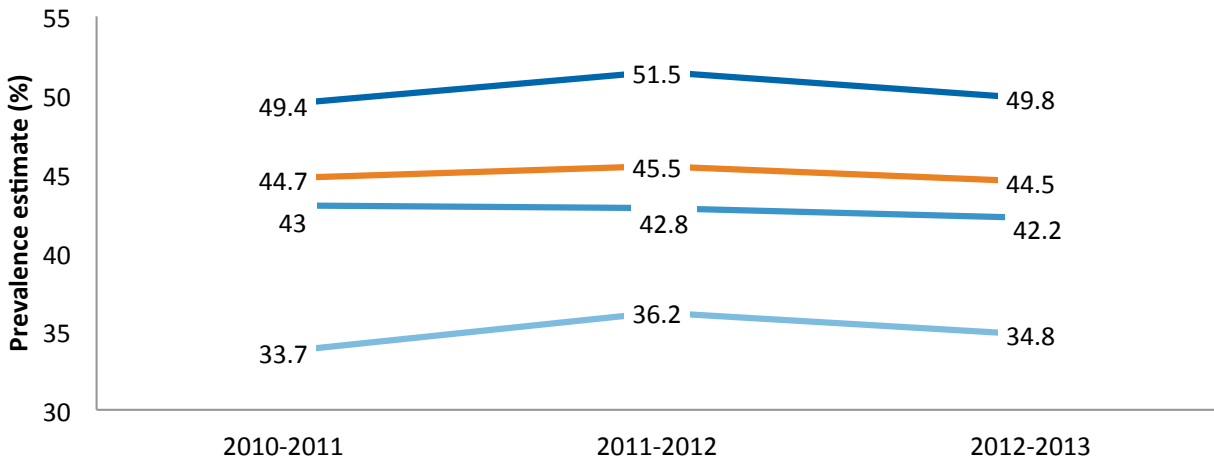
**Figure 27b.** *Obesity or overweight in CPS sixth graders, 2010-2013 (CPS)*



Prevalence estimate (%)

55 — 55.4 — 54.8
48.6 — 49.1 — 48.3
45.2 — 45.5 — 44.8
37.9 — 38.4 — 37.6

2010-2011 · 2011-2012 · 2012-2013

— All — Hispanic — NH Black — NH White
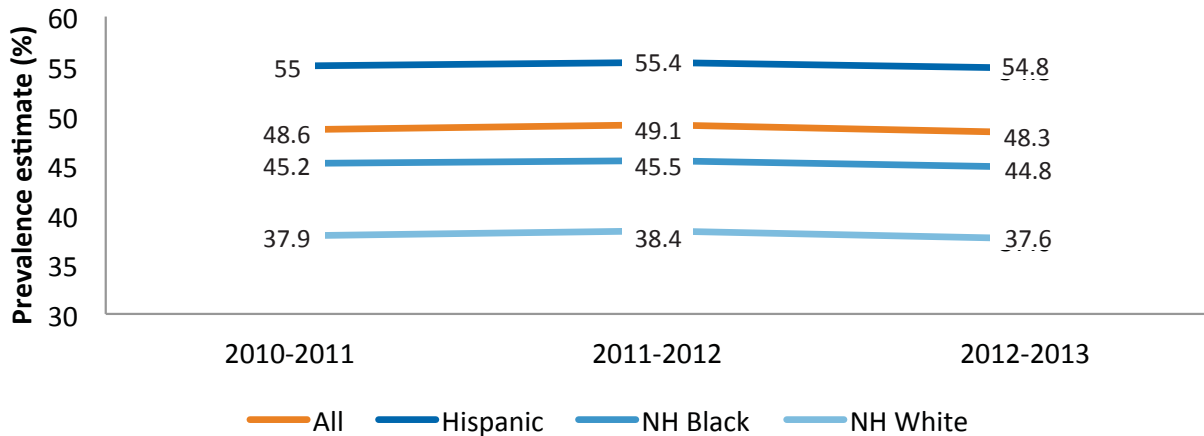
**Figure 27c.** *Obesity or overweight in CPS kindergartners, 2010-2013 (CPS)*



Prevalence estimate (%)

42.2 — 41.1 — 41.1
36.5 — 35.7 — 35.6
34.1 — 33.4 — 32.8
26 — 26.4 — 26.2

2010-2011 · 2011-2012 · 2012-2013

— All — Hispanic — NH Black — NH White
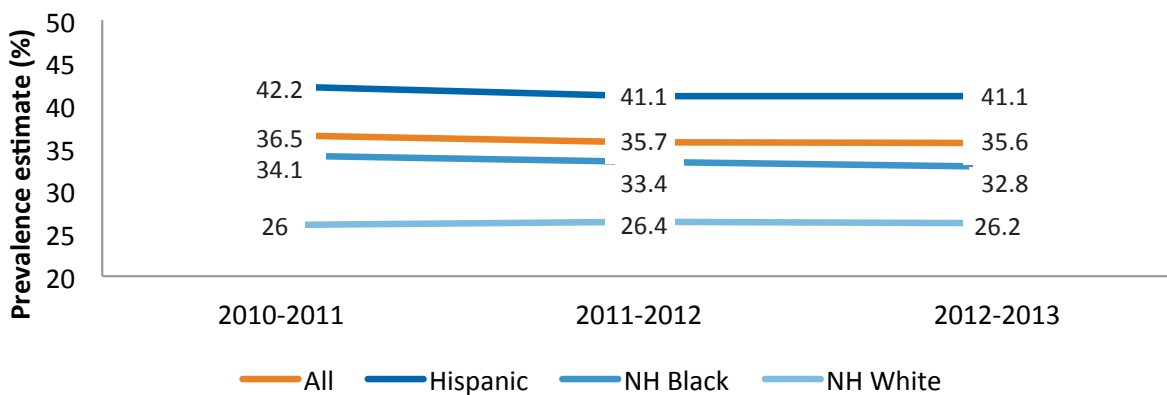
Lesbian, gay, bisexual (LGB) youth experience higher rates of health-risk behaviors than their heterosexual peers. In 2013, 13.0% of students reported being bullied on school property within the previous 12 months, no difference from previous years (Figure 28).[16] This percentage is significantly lower than the national percentage (19.6%)[11] and HP 2020 goal (17.9%).[12] Ninth graders (18.5%) report significantly more bullying than 12th graders (9.0%). Students who identify as LGB are three times more likely to report being bullied in the past 12 months compared to their heterosexual-identified peers (30.4% vs. 10.2% respectively).[16]

**Figure 28.** *Percentage of high school students reporting being bullied on school property, 2001-2013 (YRBS)*
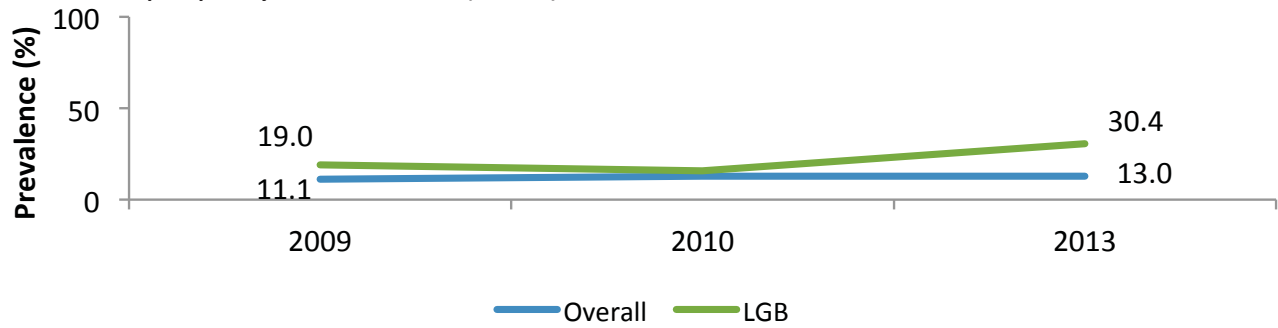


Of those students who made a suicide attempt in the last 12 months, 3.5% reported requiring medical attention as a result of the attempt in 2013 (Figure 29). This is higher than the national percentage (2.7%) and the HP 2020 goal (1.7%), but similar to previous years. Students identifying as LGB are much more likely to report a suicide attempt resulting in injury (11.3%) than those who identify as heterosexual (1.9%).[16]

**Figure 29.** *Percentage of high school students reporting a suicide attempt with injury, 2001-2013 (YRBS)*
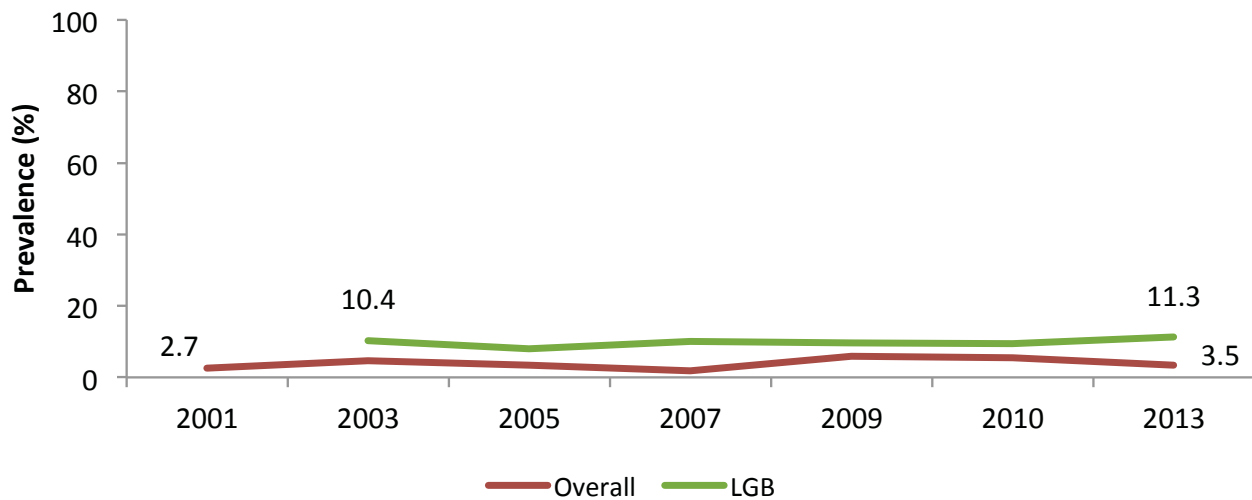


In 2013, 32.5% of high school students reported that in the past 12 months they had felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities. This is similar to the national percentage (29.9%) and previous years. Females (40.7%) are almost twice as likely as males (23.5%) and LGB-identified and unsure students (55.1%) are almost twice as likely as heterosexual-identified students (28.8%) to report prolonged feelings of sadness or hopelessness. More than three percent (3.5%) of high school students reported attempting suicide in the past 12 months; however, among LGB youth that rate was over 11%.[16]

Disordered eating behaviors include going without food for 24 hours or more (fasting), taking pills, powders or liquids without a doctor's advice and vomiting or taking laxatives to lose or keep from gaining weight. In 2013, 18.1% of students report disordered eating behavior in the past 30 days. This is significantly higher than the HP 2020 goal of

12.9%, but similar to previous years, including 2001 when the percentage was 19.1%. Females (22.5%) are more likely to report disordered eating behaviors compared to males (13.2%) and LGB-identified students (37.5%) are more than twice as likely as heterosexual-identified students (14.5%) to report disordered eating.[16]

The percentage of students reporting smoking one or more cigarettes in the past 30 days has decreased 56.7% between 2001 and 2013, from 24.7% to 10.7% (Figure 30). The current rate is lower than both the national average (15.7%)[11] and the HP 2020 goal (16.0%).[12] Students who identify as LGB (19.3%) are significantly more likely to report current smoking than their heterosexual peers (9.0%). Non-Hispanic white and Hispanic students are more likely to be current cigarette smokers than non-Hispanic black students (18.4%, 13.1% and 5.5%, respectively).[16]

**Figure 30.** *Percentage of high school students who are current smokers, 2001-2013 (YRBS)*
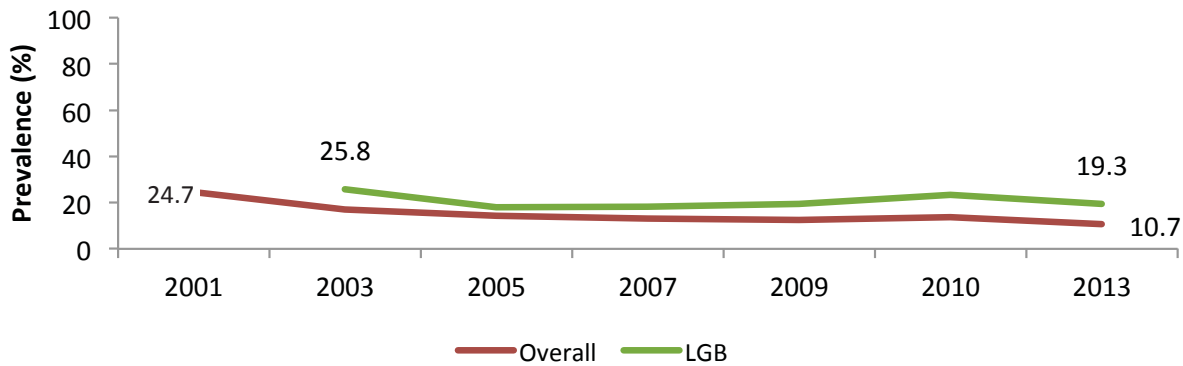


In 2013, 28.5% of students reported having used marijuana one or more times in the preceding 30 days (Figure 31). This is similar to the percentage in 2001 (28.7%), but higher than the national percentage of 23.4%.[11] Heterosexual-identified youth (25.9%) are significantly less likely than LGB-identified youth (42.0%) to currently use marijuana.[16]

**Figure 31.** *Percentage of high school students who reported currently using marijuana, 2001-2013 (YRBS)*
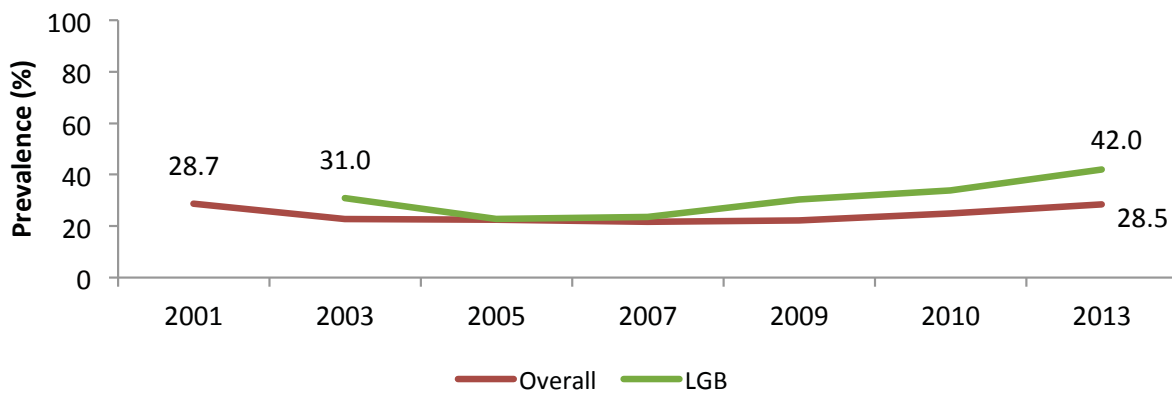


Binge drinking, defined as having five or more drinks of alcohol within a couple of hours, in the past 30 days was reported among 17.6% of high school students in 2013 (Figure 32). This is lower than the national percentage (20.8%), but statistically similar to past years. Non-Hispanic blacks (10.9%) are half as likely as Hispanics (21.0%) and non-Hispanic whites (24.3%) to report binge drinking. Students identifying as LGB (25.1%) are much more likely to report recent binge drinking than heterosexual-identified students (16.0%).[16]

**Figure 32.** *Percentage of high school students who report binge drinking, 2001-2013 (YRBS)*
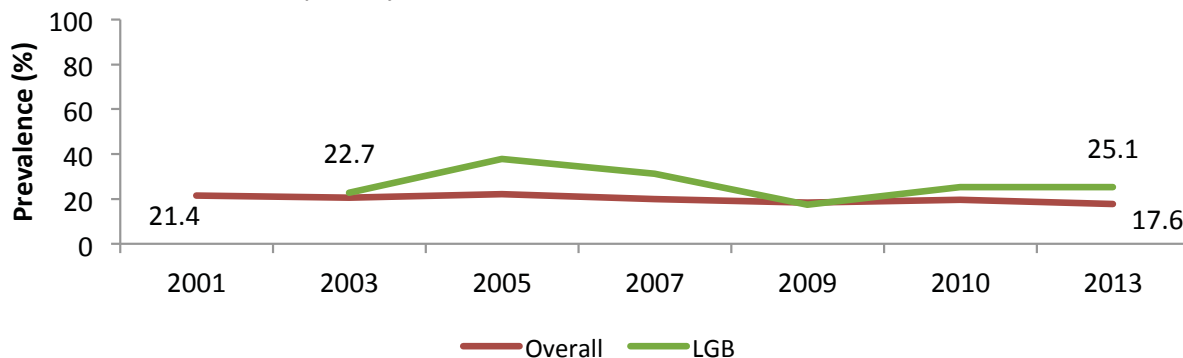
*Behavioral Health-Adult:* Mental illness is a leading cause of hospitalizations. Substance-related hospitalizations are inpatient admissions with a principal diagnosis related to alcohol or drug use. Between 2001 and 2011, the age-adjusted rate of substance-related visits per 10,000 population increased from 65.4 to 89.5, with the highest rates in 2011 seen among non-Hispanic blacks (204.3),

followed by non-Hispanic whites (102.2), Hispanics (24.5) and non-Hispanic Asian/Pacific Islanders (5.1) (Figure 33). Rates of substance-related hospitalization vary greatly between Chicago's zip codes; there is a 45-fold difference between the zip code with the highest rate and the zip code with the lowest rate (Figure 34).[8]

*Figure 33.* *Substance-related hospitalizations by race/ethnicity, 2001-2011 (IDPH, US Census)*
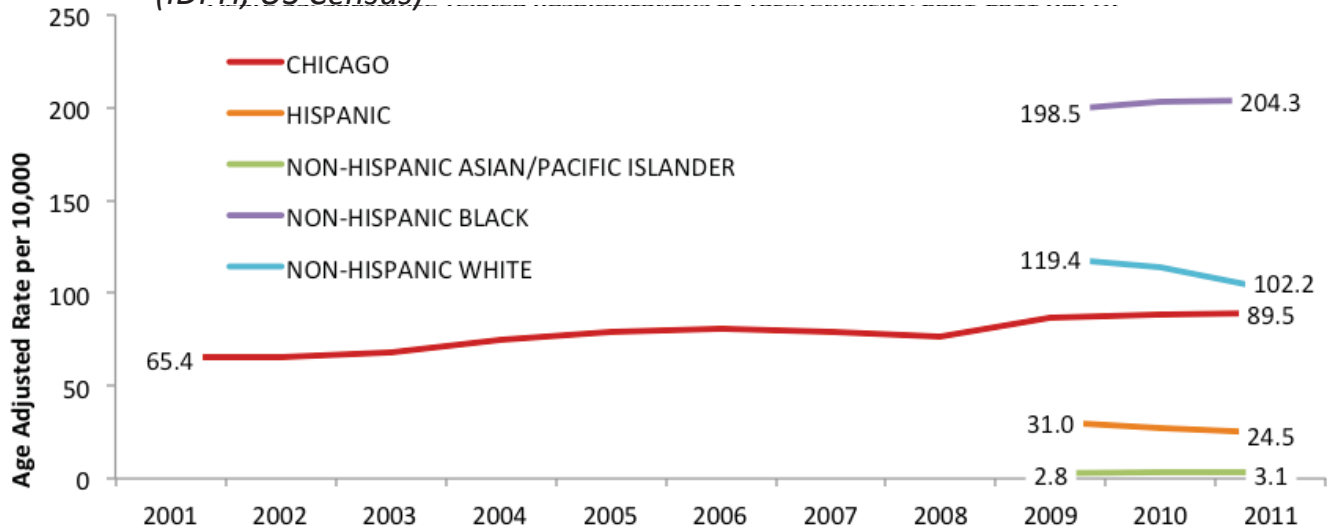


*Figure 34.* *Substance-related hospitalizations by zip code, 2011 (IDPH, US Census)*
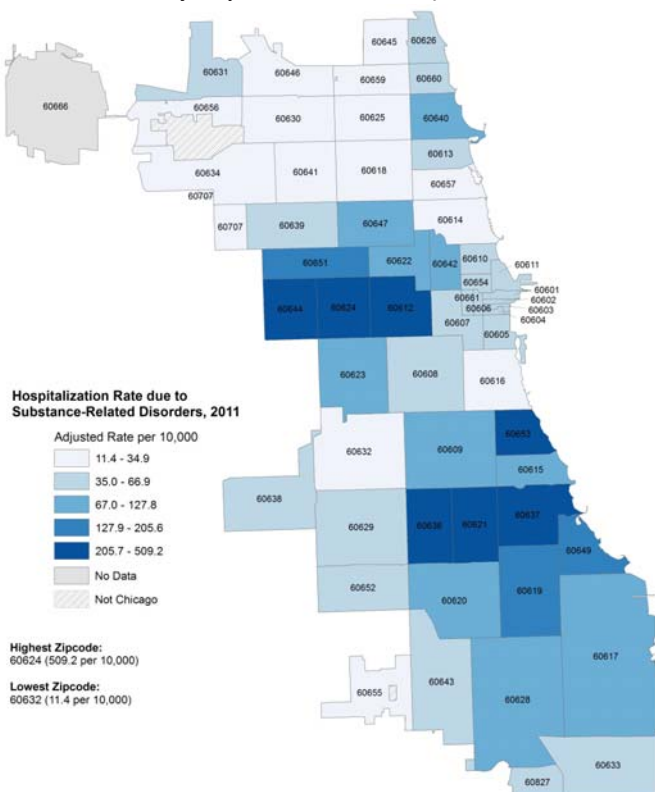


The age-adjusted rate of hospitalization due to schizophrenic disorders did not change significantly in Chicago between 2001 and 2011. Overall, Chicago had 54.3 admissions per 10,000 population in 2011, but this varied greatly by race/ethnicity (Figure 35). The rate among non-Hispanic blacks (101.4) is 3.5 times as high as non-Hispanic whites (28.2), 6 times as high as Hispanics (16.7) and 9 times as high as non-Hispanic Asians/Pacific Islanders (11.6). While there is a 30-fold difference between the zip code with the highest rate and the zip code with the lowest rate, these communities are dispersed throughout the city (Figure 36).[8]

**Figure 35.** *Hospitalizations due to schizophrenic disorders by race/ethnicity, 2001-2011 (IDPH, US Census)*
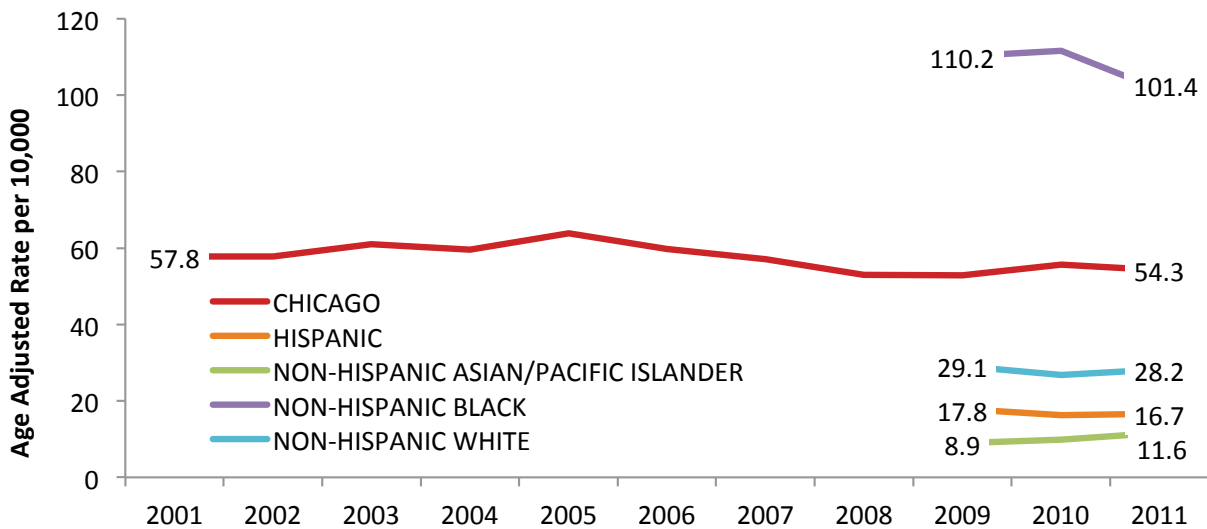


**Figure 36.** *Hospitalizations due to schizophrenic disorders by zip code, 2011 (IDPH, US Census)*



Hospitalization Rate due to Schizophrenia, 2011

Adjusted Rate per 10,000

- 6.5 - 16.4
- 16.5 - 35.8
- 35.9 - 73.3
- 73.4 - 108.6
- 108.7 - 180.0
- No Data
- Not Chicago

Highest Zipcode:
60640 (180.0 per 10,000)

Lowest Zipcode:
60655 (6.5 per 10,000)
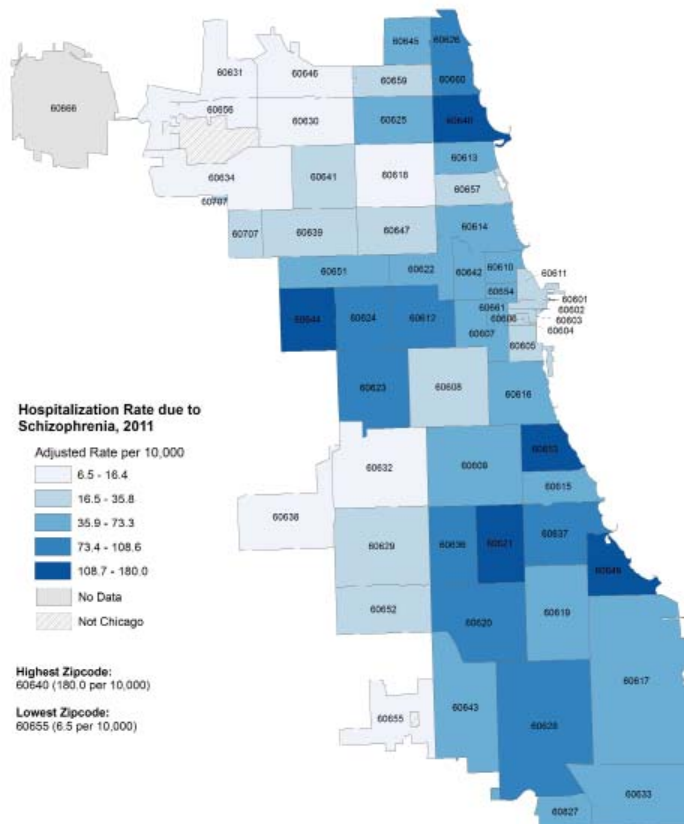
The age-adjusted rate of hospital admissions due to mood disorders, including bipolar disorder and depression did not change significantly between 2001 and 2011 (Figure 37). Overall, in 2011, there were 66.2 admissions due to mood disorders per 10,000 population. This rate was highest among non-Hispanic blacks (102.5), followed by non-Hispanic whites (52.0), Hispanics (31.5) and non-Hispanic Asian/Pacific Islanders (12.7). Zip codes with the highest rates are clustered in Chicago's west side (Figure 38).[8]

**Figure 37.** *Hospitalizations due to mood disorders by race/ethnicity, 2001-2011 (IDPH, US Census)*
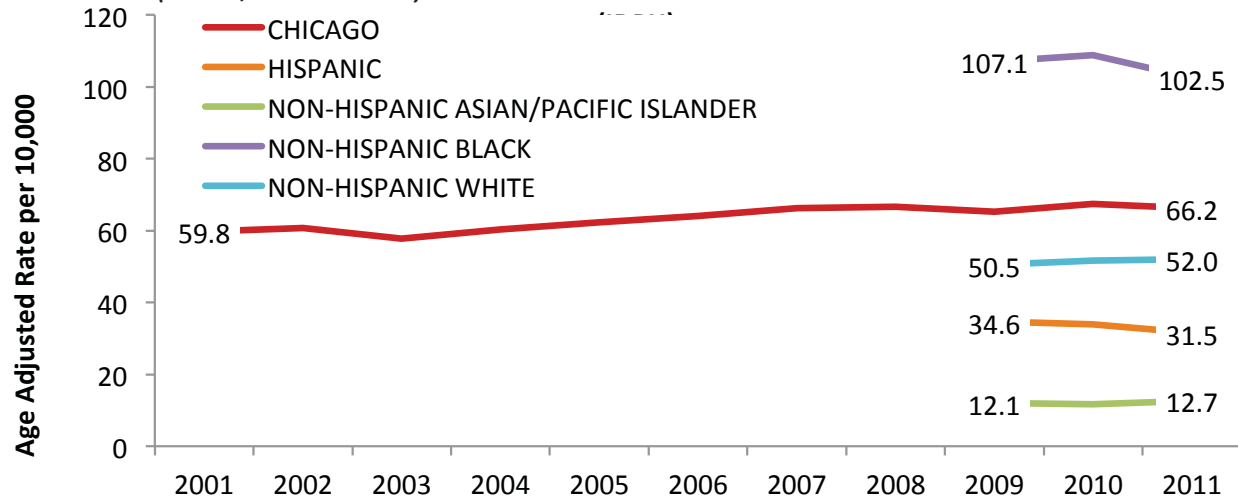


**Figure 38.** *Hospitalizations due to mood disorders by zip code, 2011 (IDPH, US Census)*
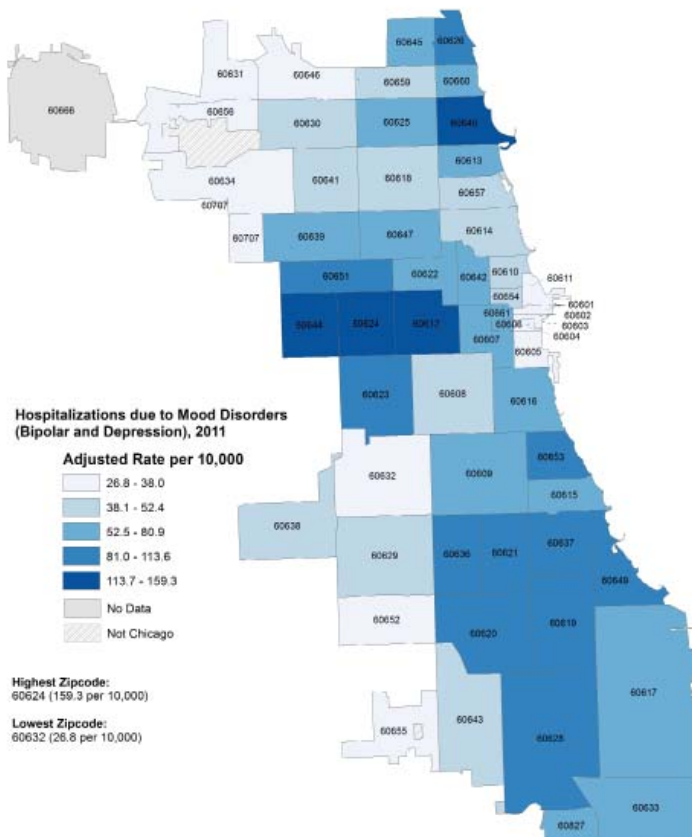


On average, Chicago adults reported 3.1 days in the past 30 days that their mental health, including stress, depression and problems with emotions was not good, similar to what is reported nationally. This represents a decrease from 2002 when the average number of mentally unhealthy days per month among Chicagoans was 9.7 (Figure 39). While there are no differences by age, gender or race/ethnicity, those living in medium hardship community areas report the highest number of mentally unhealthy days (3.9) compared to low (2.6) or high hardship community areas (3.1). More than nine percent (9.2%) of Chicagoans reported 14 or more mentally unhealthy days, defined as frequent mental distress.[5]

**Figure 39.** *Average number of mentally unhealthy days, 2001-2011 (BRFSS), 2014 (HCS)*
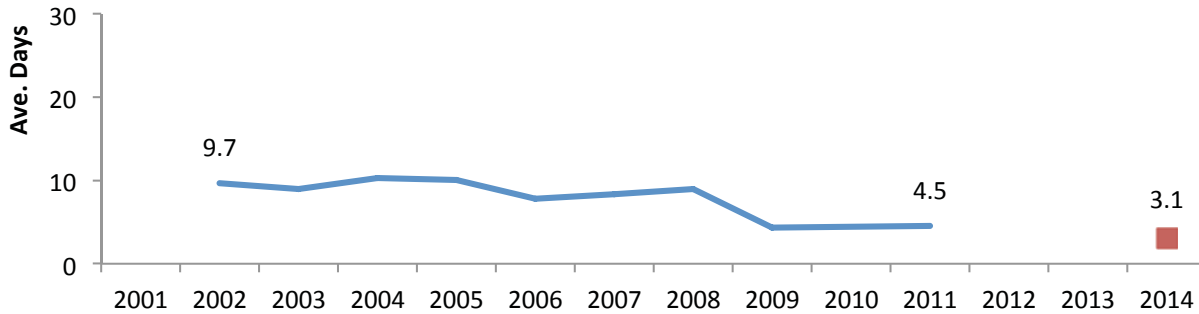


The Kessler-6 score (based on how often in the past month an individual feels nervous, hopeless, restless, depressed, worthless and that everything was an effort) indicates that 8% of Chicagoans are currently living with mild/moderate psychological distress and 5% with serious psychological distress. Overall, 16.7% of Chicago adults report that they've ever been diagnosed with depression, similar to what is reported nationally. Just over ten percent (10.4%) are currently taking medication or receiving treatment for a mental health condition. Almost six percent (5.8%) of Chicagoans report that during the past 12 months, there was a time that they needed mental health treatment but didn't get it, however among persons with frequent mental distress almost 50% were not receiving mental health treatment. Of those, the most commonly cited reason why they didn't get the treatment they needed was that they couldn't afford it (43.1%), followed by not knowing where to go for services (21.4%), health insurance doesn't cover or pay enough for mental health treatment (16.9%), worried about stigma or privacy (8.1%) and concern that they would be committed to a psychiatric hospital (7.5%).[5]

Excessive alcohol use can have negative consequences on one's physical health, work and family life and mental well-being. Overall, 29.0% of Chicago adults report binge drinking, defined as males having five or more drinks on one occasion or females having four or more drinks on one occasion, at least once in the past month. This is higher than what is reported nationally (17.1%). Binge drinking is more common among men (38.1%, compared to 20.3% among women) and non-Hispanic whites and Hispanics (38.6% and 33.2% respectively, compared to 18.6% among non-Hispanic blacks).[5]

Overall, suicides slightly decreased between 2000 and 2011 in Chicago, but only for non-Hispanic whites and non-Hispanic blacks. Non-Hispanic whites had the highest rates of suicide between 2000 and 2011 (Figure 40). In 2011, non-Hispanic whites' suicide rate was more than three times the rate of non-Hispanic Asian/Pacific Islanders, more than twice the rate of Hispanics and one-and-half times that of non-Hispanic blacks. The suicide rate varies substantially across Chicago's 77 community areas. For instance, West Elsdon on the southwest side has the highest mortality rate (12.9) compared to Archer Heights on the west side which reported no suicides (Figure 41). Rates of suicide in community areas with low economic hardship are almost twice as high as those community areas with medium to low hardship.[7]

**Figure 40.** *Suicide by race/ethnicity, 2001-2011 (IDPH, US Census)*
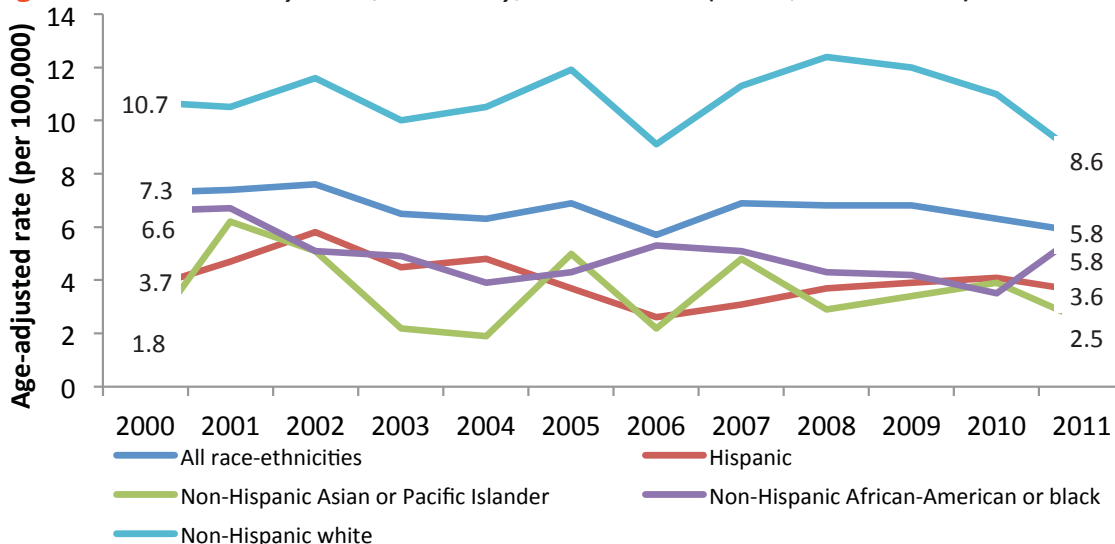
Alcohol-induced mortality in Chicago decreased by four percent between 2000 and 2011. Among race/ethnicity groups, non-Hispanic whites had the highest rates of alcohol-induced mortality and non-Hispanic Asian/Pacific Islanders had the lowest (Figure 42). Rates for each were stable between 2000 and 2011. Alcohol-induced mortality increased by 33% between 2000 and 2011 for Hispanics and decreased for non-Hispanic blacks (24%). The alcohol-induced mortality rate varies substantially across Chicago's 77 community areas. For instance, Hegewisch on the far south side has the highest mortality rate (18.3), while Oakland on the south side has the lowest rate, 0.0 (Figure 43). As economic hardship in community areas increases so does the rate of alcohol-induced mortality.[7]

*Figure 41.* Suicide by community area, 2007-2011 (IDPH, US Census)
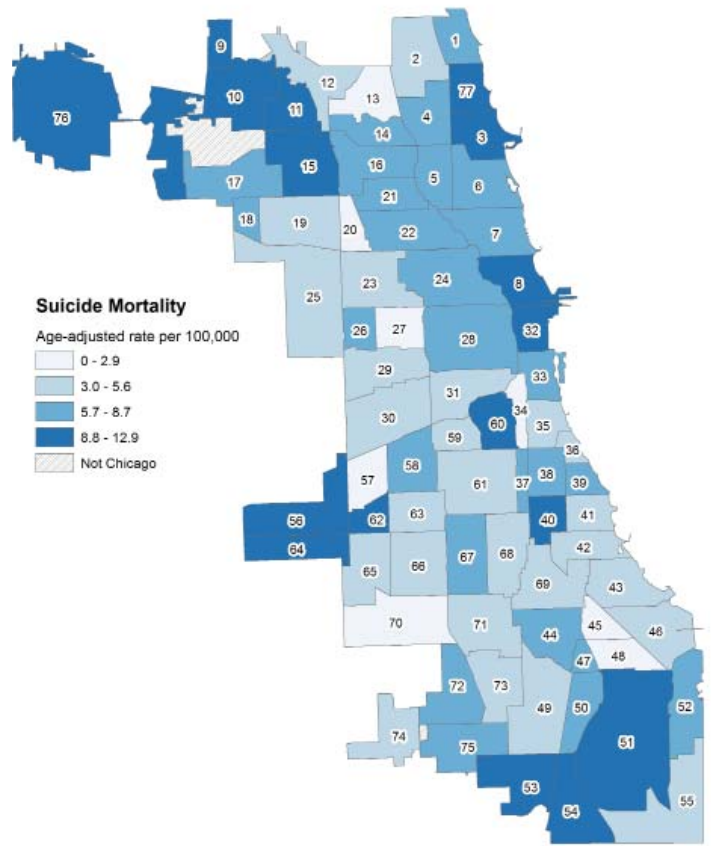


*Figure 42.* Alcohol-induced mortality by race/ethnicity, 2000-2011 (IDPH, US Census)
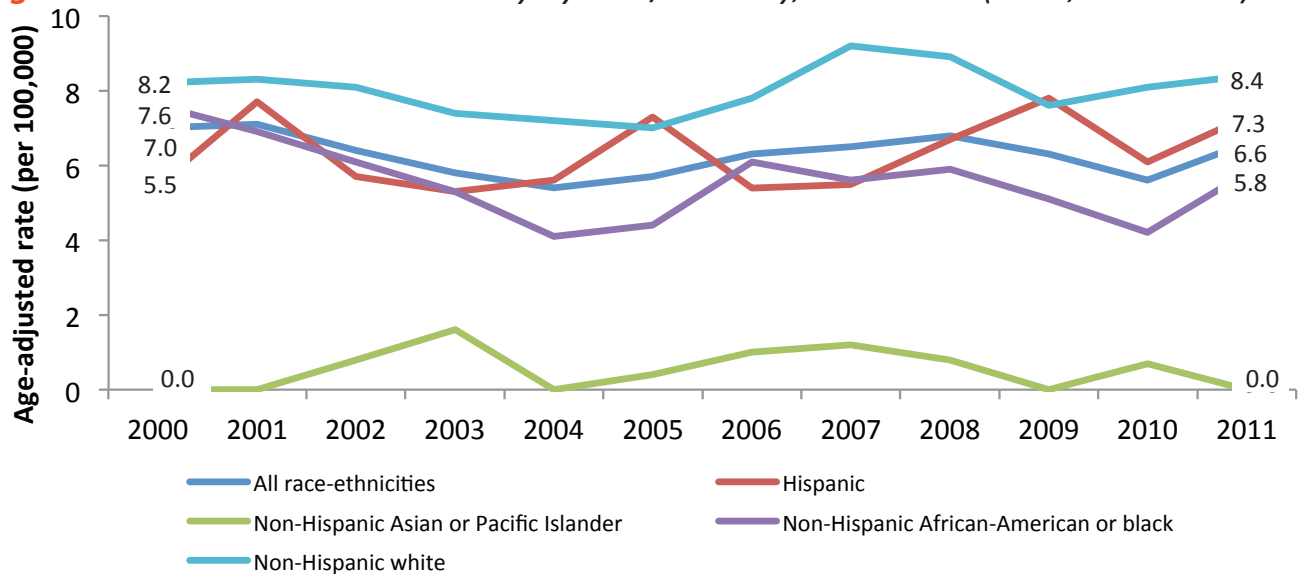
**Figure 43.** *Alcohol-induced mortality by community area, 2007-2011 (IDPH, US Census)*



Alcohol-induced Mortality
Age-adjusted rate per 100,000

- 0.0
- 0.1 - 6.3
- 6.4 - 9.6
- 9.7 - 15

**Highest Community Area**
Hegewisch (55): 15*
Clearing (64): 14.3*
Montclarre (18): 13.7*
Archer Heights (57): 13.4*
New City (61): 11.8*
Hermosa (20): 11.2*
Uptown (3): 9.7

**Lowest Community Area**
Oakland (36): 0.0*
Burnside (47): 0.0*
Riverdale (54): 0.0*
Calumet Heights (48): 0.0*
Avalon Park (45): 0.0*
North Park (13): 0.0*
Fuller Park (13):0.0*

**Chicago: 11.9**
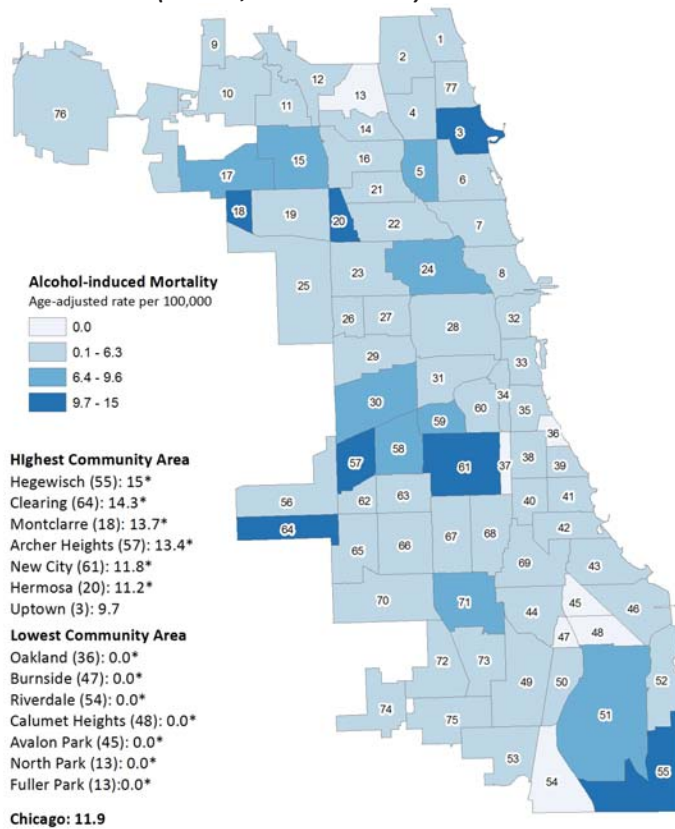
*Violence:* Violent crimes are defined as offenses involving force or threat of force and include murder and non-negligent manslaughter, forcible rape, robbery and aggravated assault. Violent crime has decreased more than 50% since 2001 in Chicago (Figure 44). Rates of violent crimes are higher in community areas in the west and south sides of Chicago. The disparity of violent crime is dramatic. The difference in community areas with the highest and lowest rates are thousands-fold (Figure 45). Violent crime rates are higher in community areas with higher levels of hardship.[17]

**Figure 44.** *Violent crime, 2001-2014 (Chicago Police Department)*
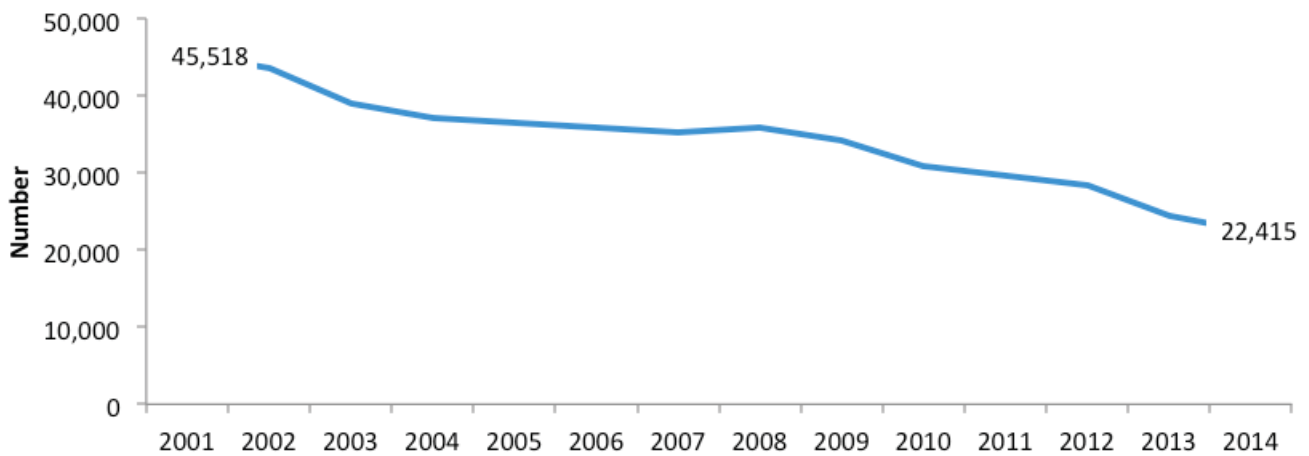
**Figure 45.** *Violent crime by community area, 2014 (Chicago Police Department)*
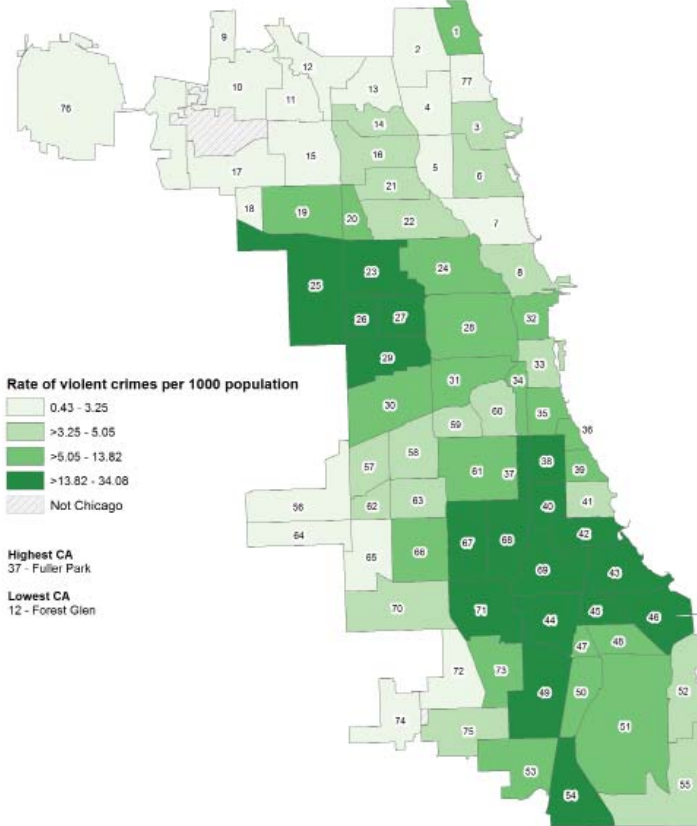


Non-fatal shootings occurred citywide but were strongly concentrated on the city's west and south sides (Figure 46). There is a strong correlation between non-fatal shootings and child opportunity. Community areas with higher levels of child opportunity also exhibited the lowest rates of non-fatal shootings.[17]

Findings from the 2014 Healthy Chicago Survey reveal that almost 20% of Chicagoans felt unsafe utilizing outdoor spaces in their neighborhood. Among residents of neighborhoods with high economic hardship, over 32% of residents felt unsafe.[5]

Thirteen percent (13%) of high school students in Chicago reported being bullied in the past year. Among LBG youth the rate was over 30%. Overall, almost one-third of students reported getting into a fight at school in the past year.[16]

**Figure 46.** *Non-fatal shootings by community area, 2014 (Chicago Police Department)*
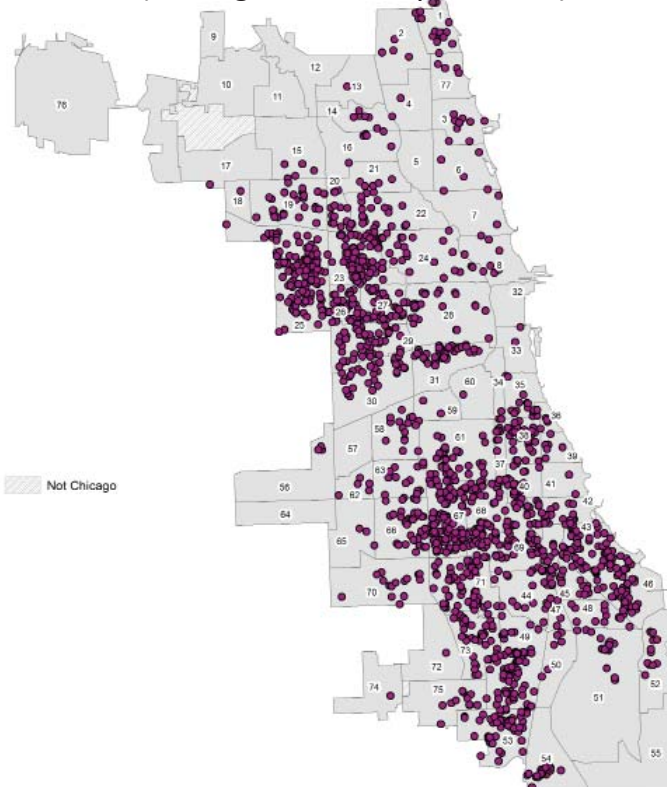
*Figure 47.* Homicide by race/ethnicity, 2000-2011 (IDPH, US Census)
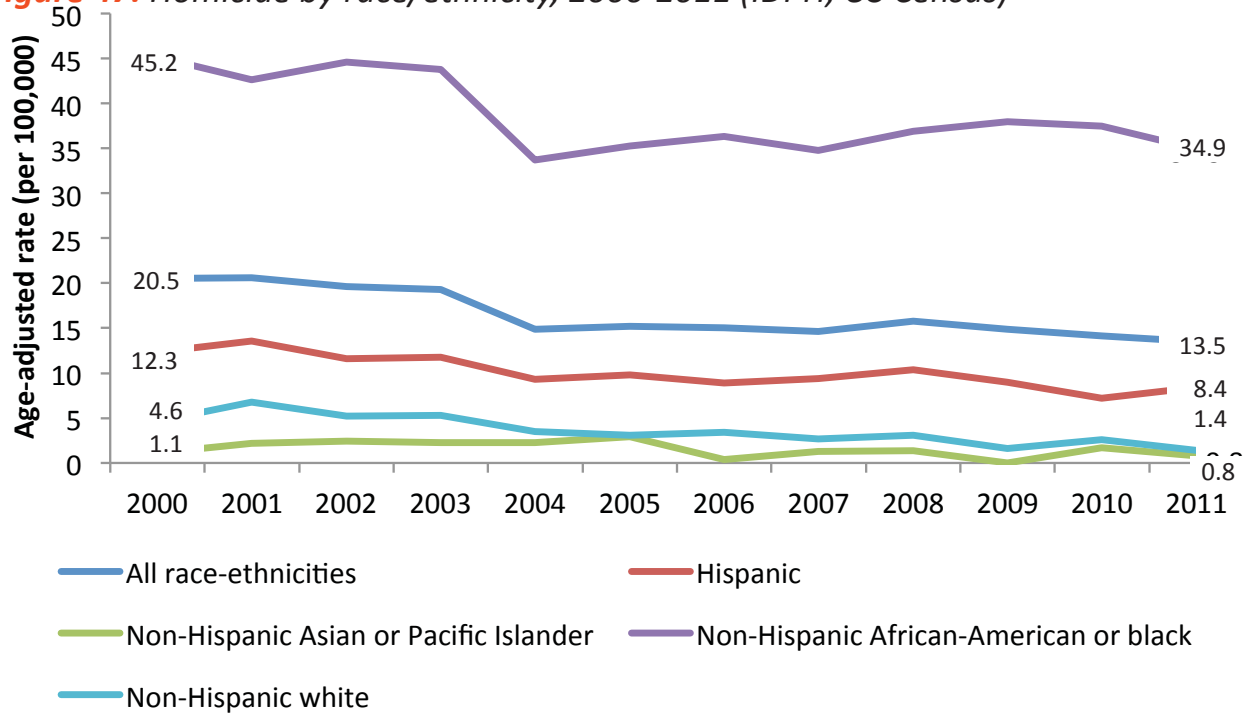


The homicide rate decreased by 37% between 2000 and 2011, from 20.5 to 13.5 per 100,000 (Figure 47). However, the Chicago homicide rate is two and a half times higher than the United States. Homicide rates are highest among non-Hispanic blacks, 25 times higher than non-Hispanic whites and four times higher than Hispanics in 2011. Moreover, although homicide mortality ranks 10th among the leading causes of death for all Chicagoans, for non-Hispanic blacks and Hispanics, homicides ranked fourth and fifth, respectively. In addition, since 2006, 47% of all homicide victims were less than 25 years old. The homicide rate varies markedly across Chicago's 77 community areas. The difference between community areas with the lowest and highest homicide rates is 800 percent (Figure 48). In community areas with high economic hardship, the homicide rate is ten times higher compared to community areas with low hardship.[7]

*Figure 48.* Homicide by community area, 2007-2011 (IDPH, US Census)



**Homicide Mortality**
Age-adjusted rate per 100,000

- < 5
- 5 - 14.4
- 14.5 - 28.8
- 28.9 - 52.4

**Highest Community Area**
Fuller Park (37): 52.4*
Burnside (47): 51.5*
West Englewood (67): 46.8
Washington Park (40): 44.3

**Lowest Community Area**
Logan Square (22): 99.6

**Chicago: 14.4**
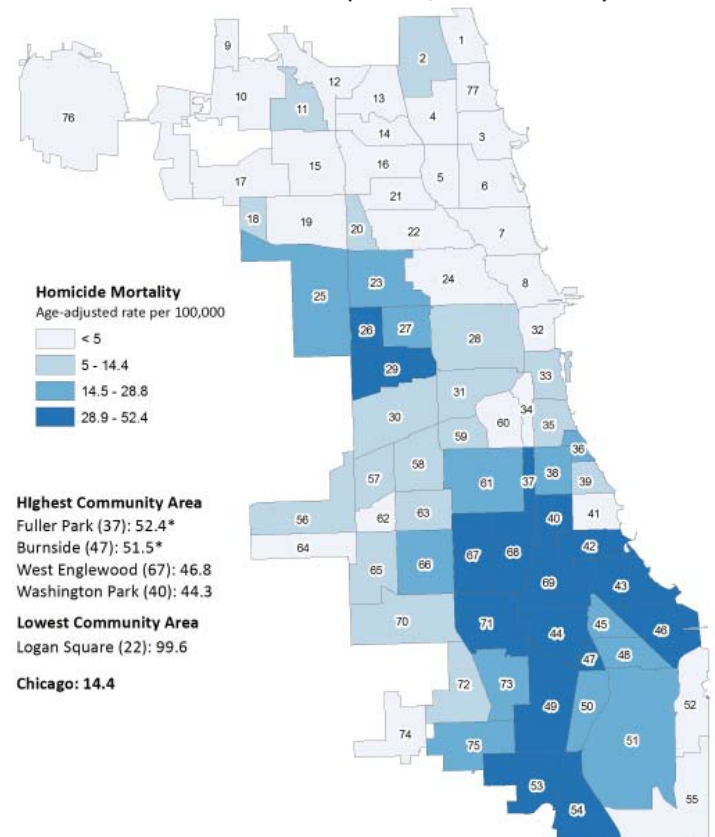
**Figure 49.** *Percentage of population with at least a college degree by census tract, 2008-2012 (US Census)*
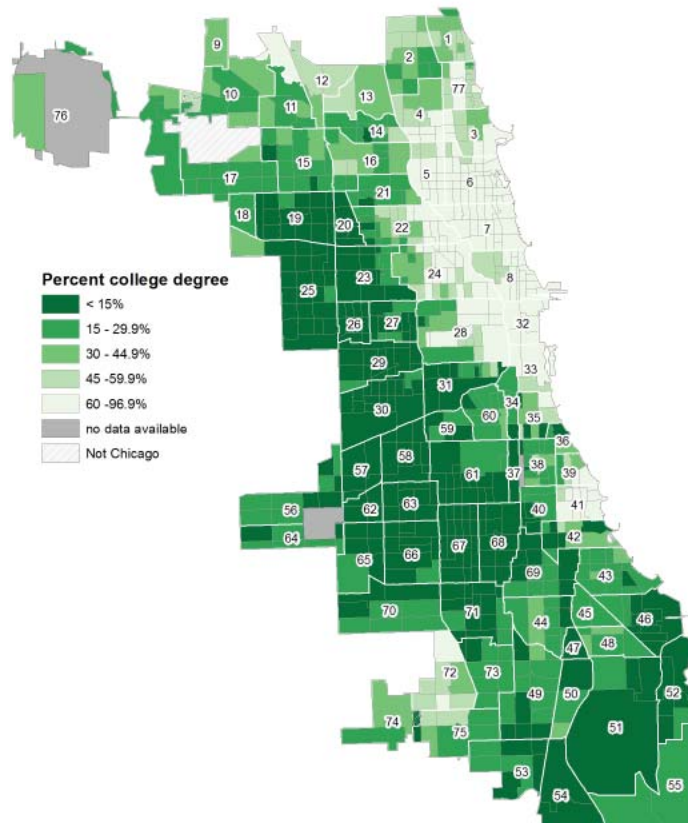


**Figure 50.** *Percentage of population less than 18 by census tract, 2010 (US Census) and CPS schools with 1+ quality rating, 2014-2015 (CPS)*
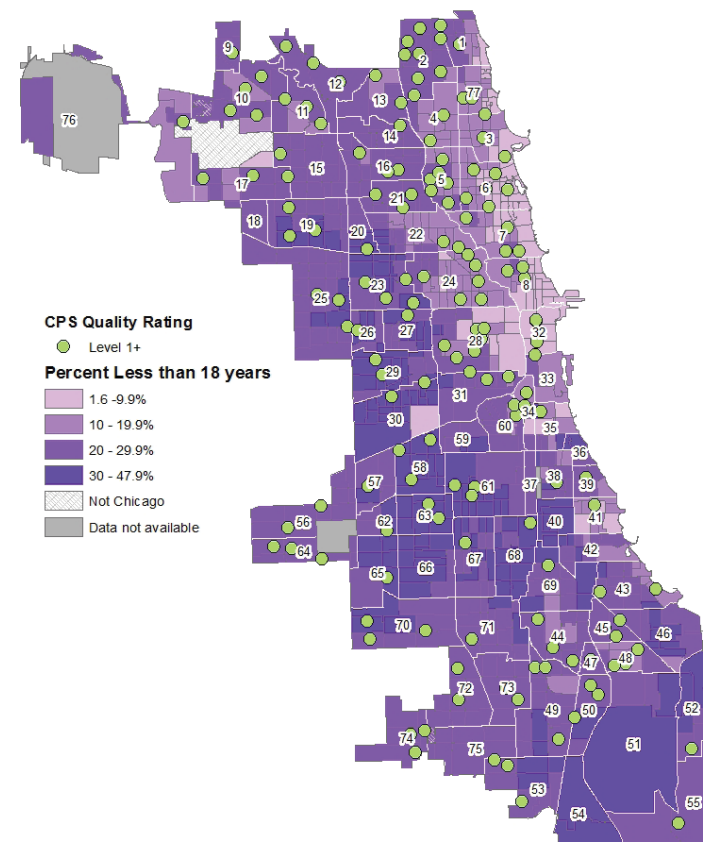


*Education:* A sentinel JAMA study indicated that persons with higher educational attainment have lower rates of chronic disease compared to those with less education.[18] The percentage of Chicagoans aged 25 years or older who have at least a Bachelor's degree increased by 74% between 1990 and 2000. Increases were seen in non-Hispanic white, non-Hispanic black and Hispanic populations with varying degrees (90%, 55% and 33%, respectively). In 2010, the percentage of non-Hispanic whites with at least a Bachelor's degree (55%) was more than 3 times that of non-Hispanic blacks (17%) and more than four times that of Hispanics (12%). Community areas on the west and south sides of Chicago have disproportionate rates of adults without a college diploma compared to the communities on the north side (Figure 49). Although Chicago as a whole has about a third of adults (33.6%) with at least a college diploma, there is a large variation by community area from 5.4% in Englewood to 82.2% in Lincoln Park.[19]

In the CPS rating system for schools, "1+" is the highest level, indicating the best schools. When mapping the location of "1+" schools and the population of children under 18, it appears that "1+" schools tend to be located in areas with fewer school aged children (Figure 50) which suggests that educational opportunity is not equitably apportioned throughout the city.[20]

There are eight variables that comprise the Educational Opportunity Index: early childhood education participation, quality and proximity, student poverty rate, reading and math proficiency rates, high school graduation rate and adult educational attainment. Archer Heights has the lowest educational opportunity, while the Loop has the highest (Figure 51). There is a small correlation between educational opportunity and obesity among CPS kindergarteners, 6th and 9th graders. Students are slightly more likely to be obese in community areas with low educational opportunity.[2,15]

**Figure 51.** *Educational opportunity by census tract, 2014 (Kirwan Institute)*



Educational Opportunity Index
- Very High
- High
- Moderate
- Low
- Very Low
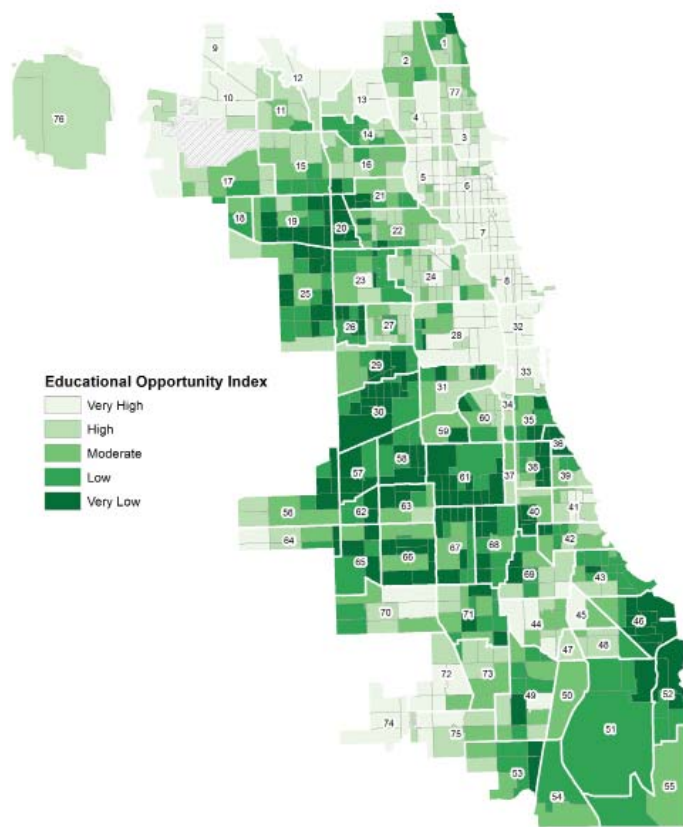
**Figure 52.** *Percentage of population aged 18 to 64 years without health insurance by census tract, 2008-2012 (US Census)*



Percent No Health Insurance
- < 10%
- 10 - 19.9%
- 20 - 29.9%
- 30 - 39.9%
- 40 - 70.4%
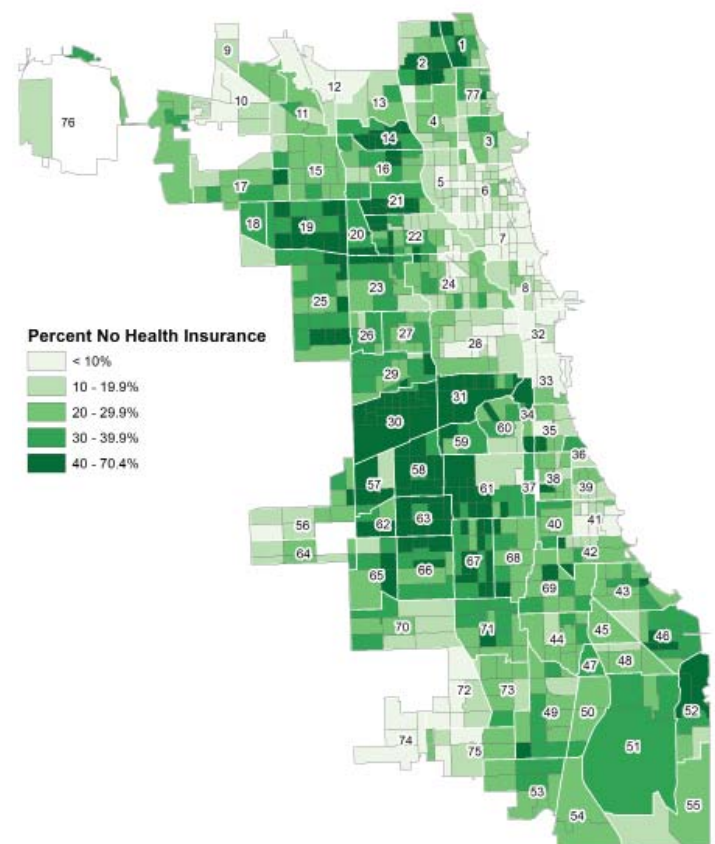
*Access to Health Care:* In a recent publication from the Henry J. Kaiser Family Foundation, uninsured individuals report that cost poses a major barrier to purchasing coverage. Not all workers have access to coverage through their jobs. Many uninsured workers are self-employed or work for small employers where health benefits are not likely to be offered. In Chicago, one out of every five adults between the ages of 18-64 is uninsured. The rate of uninsured persons is higher on the southwest and northwest sides of the city (Figure 52). More than one in three adults (36.3%) in South Lawndale is without health insurance.[19]

Beginning in 2014, as part of the Affordable Care Act (ACA), most uninsured Illinoisans became eligible for health coverage through the state's expanded Medicaid program or through the Illinois Health Insurance Market-

place. Overall, 82% of adults in Chicago report being covered by some type of health care coverage, such as private health insurance, HMOs, Medicaid, Medicare and Indian Health Services (Figure 53).[5] This is similar to the national rate (83.1%) but still below the HP 2020 target of 100%.[12] In Chicago, men are more likely to report being without coverage than women (77.1% vs. 86.3%), as are Hispanics (65.3%, compared to 83.3% of non-Hispanic blacks and 91.8% of non-Hispanic whites).[15] The percentage of the Chicago population who has health coverage increases with age; while only 75.4% of those aged 18 to 29 indicate they have health coverage, 96.6% of those aged 65 years and older do. Health coverage is related to community area level hardship, 89.5% of those living in low hardship community areas reported having health coverage, compared to only 75% of those living in high hardship community areas.[19]

**Figure 53.** *Percentage of adults who reported having health coverage, 2001-2011 (BRFSS), 2014 (HCS)*
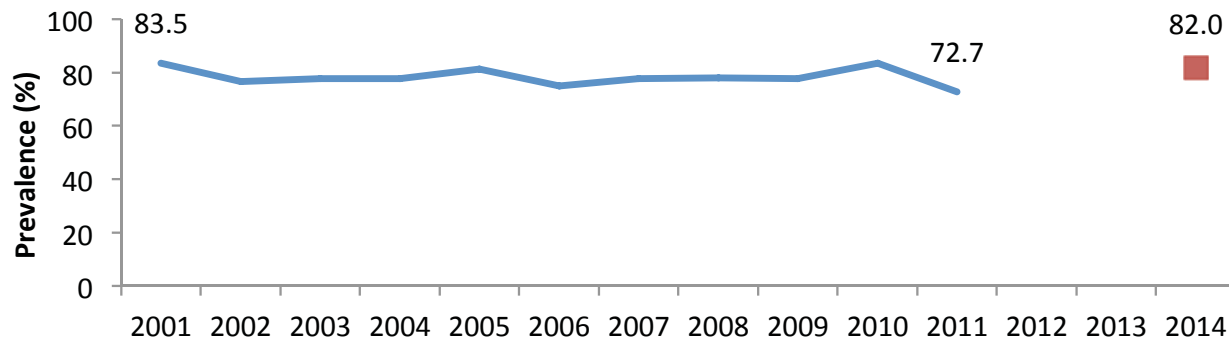


Overall, 80.8% of Chicago adults report they have one or more person who they think of as their personal doctor or health care provider, similar to previous years (Figure 54).[5] This is also similar to what is reported nationally (77.3%) and the HP 2020 objective (83.9%).[11,12] Women are more likely than men to have a personal doctor (88.2% compared to 72.6%, respectively), as are non-Hispanic whites compared to other race/ethnicities (89.7%, compared to 79.4% of non-Hispanic blacks and 68.4% of Hispanics). Older adults are also more likely to have a

personal doctor; 94% of those aged 65 years and older, compared to 86.8% of those aged 45- 64, 76.6% of those aged 30-44 and 71.3% of those aged 18-29. In high hardship community areas, 74.1% report having a personal doctor, compared to 80.9% in medium hardship community areas and 85.8% in low hardship community areas. Overall, 77% of Chicagoans reported visiting a doctor for a routine checkup in the past year. This rate was significantly lower in males (69%).[5]

**Figure 54.** *Percentage of adults with a personal doctor or health care provider, 2001-2011 (BRFSS), 2014 (HCS)*
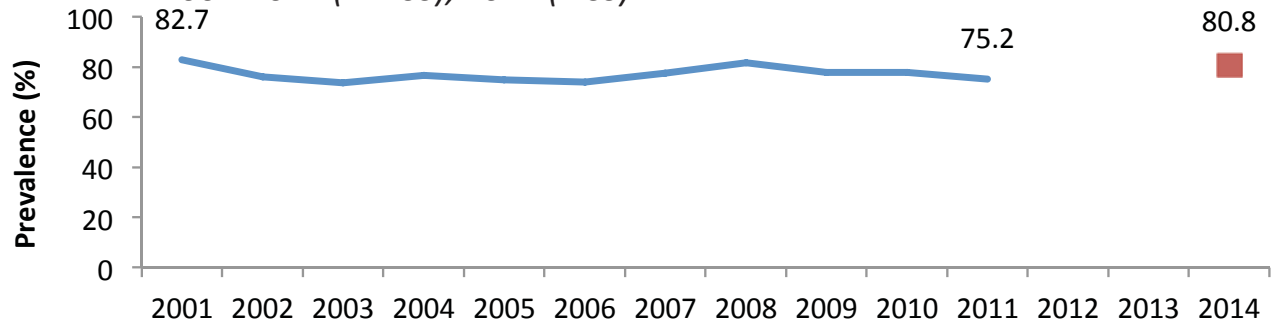
**Figure 55.** *Preventable hospitalizations by race/ethnicity, 2000-2011 (IDPH, US Census)*
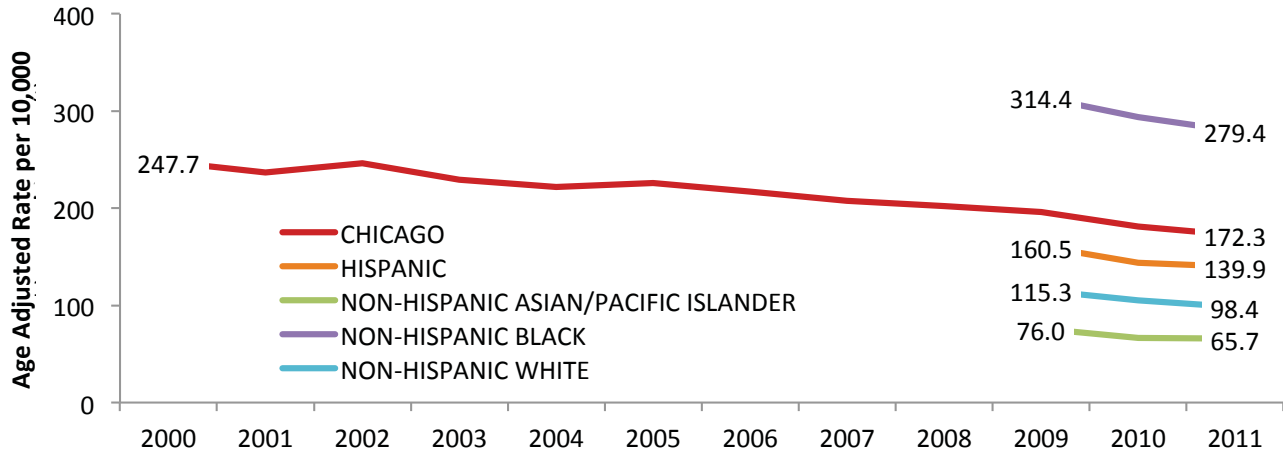


**Figure 56.** *Preventable hospitalizations by zip code, 2011 (IDPH, US Census)*
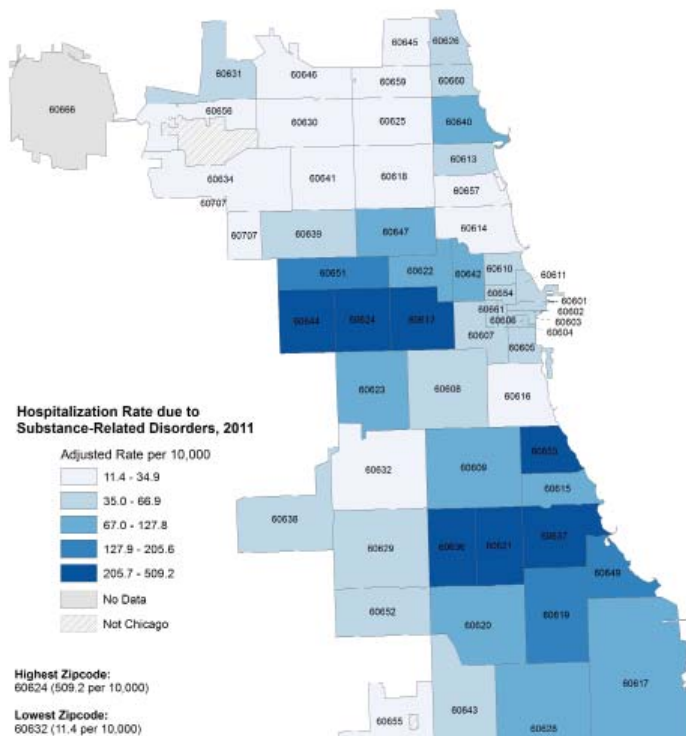


Preventable hospitalizations, inpatient stays that could potentially have been avoided with the delivery of high quality outpatient treatment and disease management, are an indicator of potentially unmet community health needs. In Chicago, the age-adjusted rate of preventable hospitalizations in 2011 was 172.3 per 10,000 population, a decrease from 247.7 in 2000 (Figure 55). This rate is decreasing across all race/ethnicities, but disparities have not changed. The rate of preventable hospitalizations among non-Hispanic blacks is 279.4 per 10,000 compared to 159.9 per 10,000 among Hispanics, 98.4 per 10,000 among non-Hispanic whites and 65.7 per 10,000 among non-Hispanic Asian/Pacific Islanders. The rate of preventable hospitalizations varies by zip code (Figure 56). The difference in preventable hospitalizations between the zip codes with the highest and lowest rates is more than 350%. The preventable hospitalization rate is strongly correlated to economic hardship; persons living in zip codes with higher economic hardship have higher rates of preventable hospitalizations.[8]

Avoidable emergency department (ED) visits are those that could have been more appropriately managed by and/or referred to a primary care provider in an office or clinic setting and include such diagnoses as tonsillitis, urinary tract infections and headaches. In Chicago, the age-adjusted rate of avoidable ED visits is 535.5 per 10,000 population, similar to previous years (Figure 57). The rate is highest among non-Hispanic blacks (908.5 per 10,000), followed by Hispanics (468.6 per 10,000), non-Hispanic whites (209.2 per 10,000) and non-Hispanic Asian/Pacific Islanders (174.8 per 10,000). The rate of avoidable ED visits varies by zip code (Figure 58). The difference in avoidable ED visits between the zip codes with the highest and lowest rates is more than 750%. The rate of avoidable ED visits is strongly correlated to economic hardship; persons living in zip codes with higher economic hardship have higher rates of avoidable ED visits.[8]

**Figure 57.** *Avoidable emergency department visits by race/ethnicity, 2009-2011 (IDPH, US Census)*



Legend:
- CHICAGO
- HISPANIC
- NON-HISPANIC ASIAN/PACIFIC ISLANDER
- NON-HISPANIC BLACK
- NON-HISPANIC WHITE
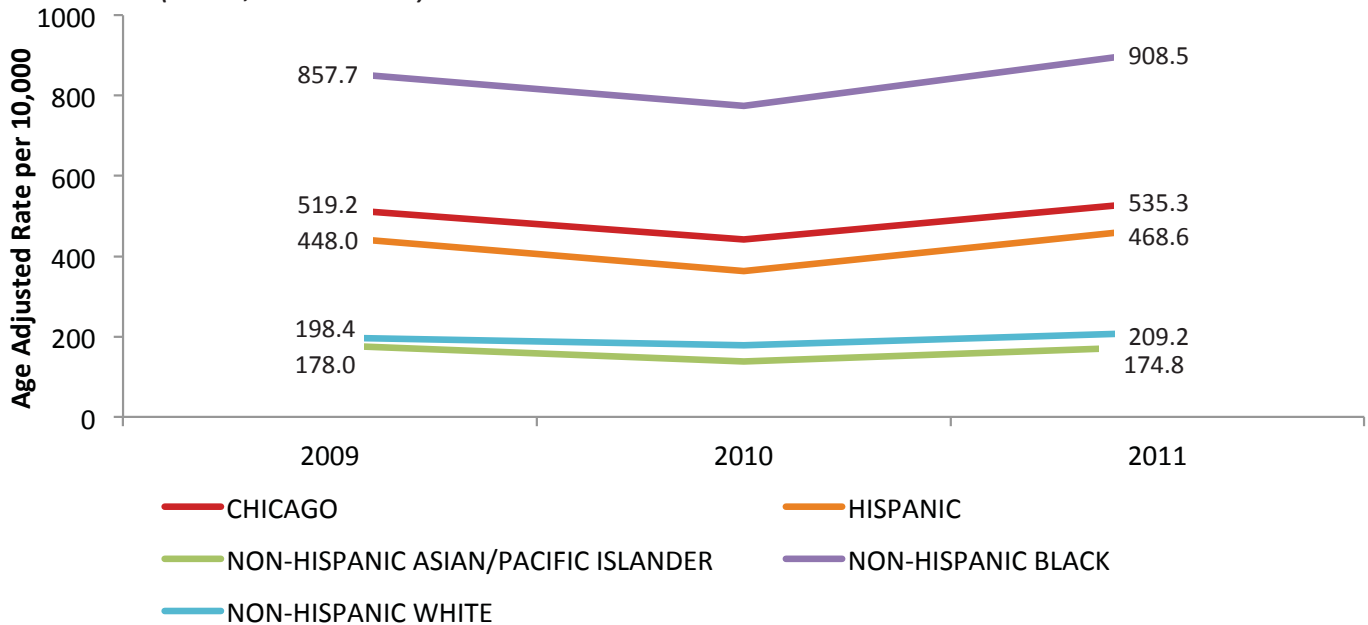
**Figure 58.** *Avoidable emergency department visits by zip code, 2011 (IDPH, US Census)*



Hospitalization Rate due to Schizophrenia, 2011

Adjusted Rate per 10,000
- 6.5 - 16.4
- 16.5 - 35.8
- 35.9 - 73.3
- 73.4 - 108.6
- 108.7 - 180.0
- No Data
- Not Chicago

Highest Zipcode:
60640 (180.0 per 10,000)

Lowest Zipcode:
60655 (6.5 per 10,000)
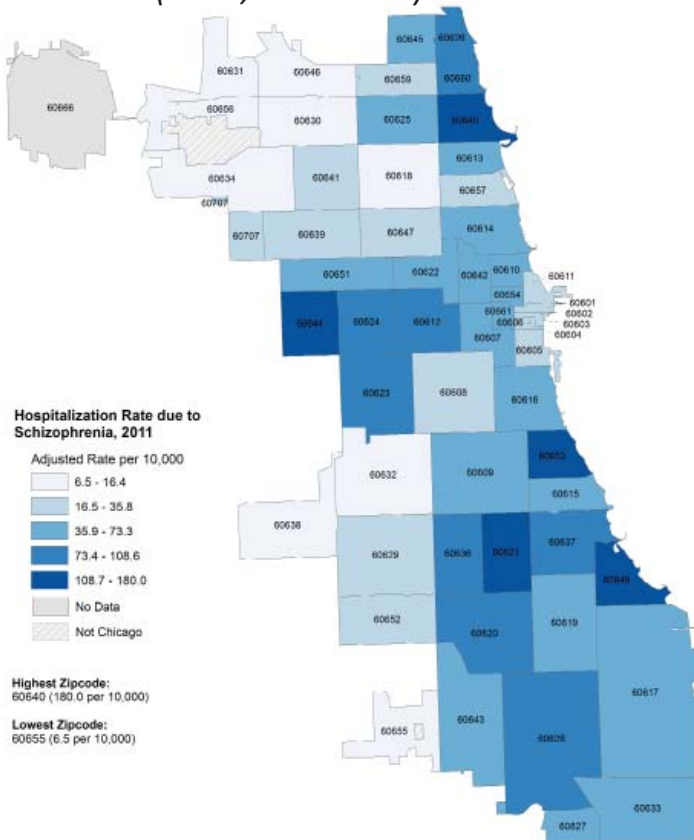
**Figure 59.** *HIV continuum of care, 2011 (CDPH, CDC)*
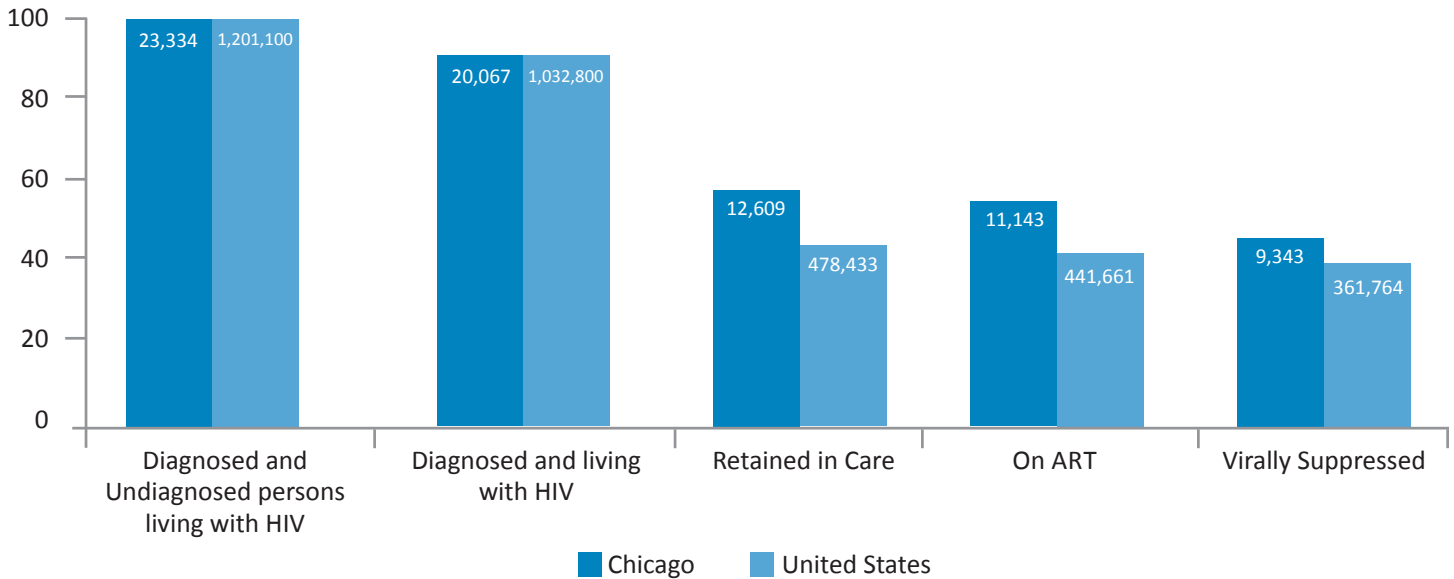


Data Sources: CDC National Estimate of Persons Living with HIV (Diagnosed and Undiagnosed); Number of persons ≥18 years of age on 12/31/2010 diagnosed with HIV infection through 12/31/2010, and living with HIV on 12/31/2011. Total weighted population estimate of HIV-infected adults who had at least 1 documented HIV medical care visit in 2011. Total HIV-infected adults (# of Retained, % of Living) who had at least 1 documented HIV medical care visit in 2011 with a documented prescription for antiretroviral therapy (ART) in 2011. Total HIV-infected adults (# of on ART, % of Living) who had at least 1 documented HIV medical care visit in 2011 and had a documented HIV viral load of undetectable or ≤ 200 copies/mL at most recent viral load test.

Data from the CDPH Office of HIV Surveillance demonstrate that of the estimated 23,334 living with HIV infection in Chicago, only 86% (20,067) have been diagnosed (Figure 59). Of those diagnosed, only 63% (12,609) are currently receiving HIV medical care. Of those currently in care, 88% (11,143) are on antiretroviral therapy. Of those currently on therapy, approximately 84% (9,343) have no detectable HIV virus in their blood (viral suppression). Thus, only 47% of those diagnosed and living with HIV in Chicago have achieved viral suppression. The 2015 updated National HIV Strategy aims to have 80% of those diagnosed and living with HIV achieve viral suppression by 2020.[14]

Community Health Assessment:

*Economic Stability: E*conomic hardship varies by race/ethnicity, age and household type (Figure 60). Non-Hispanic blacks and Hispanics are overrepresented in the highest hardship community areas, with 48.2% and 46.2% respectively. Children and youth are more often in the higher hardship community areas, with 43.2% of 5-14 year-olds living in areas with high hardship. Almost half (47.6%) of all female-headed households with children under 18 years of age live in community areas with higher levels of hardship.[19]

*Figure 60. Hardship by selected population characteristics, 2010 (US Census)*

| | Low | | Medium | | High | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| **Total Population** | 907,911 | 33.4 | 949,202 | 34.9 | 864,172 | 31.8 |
| **Race/ethnicity** | | | | | | |
| Hispanic or Latinos | 136,867 | 17.5 | 284,258 | 36.3 | 362,353 | 46.2 |
| Non-Hispanic African American or black | 96,011 | 10.9 | 356,149 | 40.6 | 424,661 | 48.4 |
| Non-Hispanic Asian or Pacific Islander | 68,288 | 46.4 | 56,546 | 38.4 | 22,346 | 15.2 |
| Non-Hispanic white | 586,752 | 67.5 | 236,014 | 27.2 | 46,508 | 5.4 |
| **Age (years)** | | | | | | |
| Less than 5 | 49,400 | 26.4 | 64,271 | 34.3 | 73,707 | 39.3 |
| 5-14 | 66,993 | 20.1 | 122,775 | 36.8 | 144,067 | 43.2 |
| 15-24 | 123,492 | 30.2 | 139,063 | 34.0 | 146,886 | 35.9 |
| 25-34 | 238,561 | 46.0 | 148,740 | 28.7 | 131,390 | 25.3 |
| 35-44 | 137,611 | 36.1 | 131,113 | 34.4 | 112,911 | 29.6 |
| 45-54 | 109,376 | 31.9 | 127,489 | 37.2 | 105,720 | 30.9 |
| 55-64 | 89,121 | 33.5 | 101,510 | 38.2 | 75,360 | 28.3 |
| 65-74 | 50,133 | 32.8 | 61,003 | 39.9 | 41,821 | 27.3 |
| 74-85 | 29,772 | 32.7 | 37,151 | 40.8 | 24,182 | 26.5 |
| 85 and older | 13,452 | 35.7 | 16,087 | 42.7 | 8,128 | 21.6 |
| **Gender** | | | | | | |
| Male | 444,605 | 33.7 | 455,580 | 34.5 | 420,353 | 31.8 |
| Female | 463,306 | 33.1 | 493,622 | 35.2 | 443,819 | 31.7 |
| **Households** | 181,496 | 31.1 | 214,648 | 36.8 | 187,127 | 32.1 |
| **Households with children less than 18 years** | 72,031 | 27.1 | 96,150 | 36.2 | 97,686 | 36.7 |
| **Households with female head of household and children less than 18 years** | 13,668 | 15.0 | 34,180 | 37.4 | 43,437 | 47.6 |
| **Seniors living alone (65 and older)** | 35,819 | 39.3 | 34,721 | 38.1 | 20,498 | 22.5 |

**Figure 61.** *Household income diversity by census tract, 2009-2013 (US Census)*
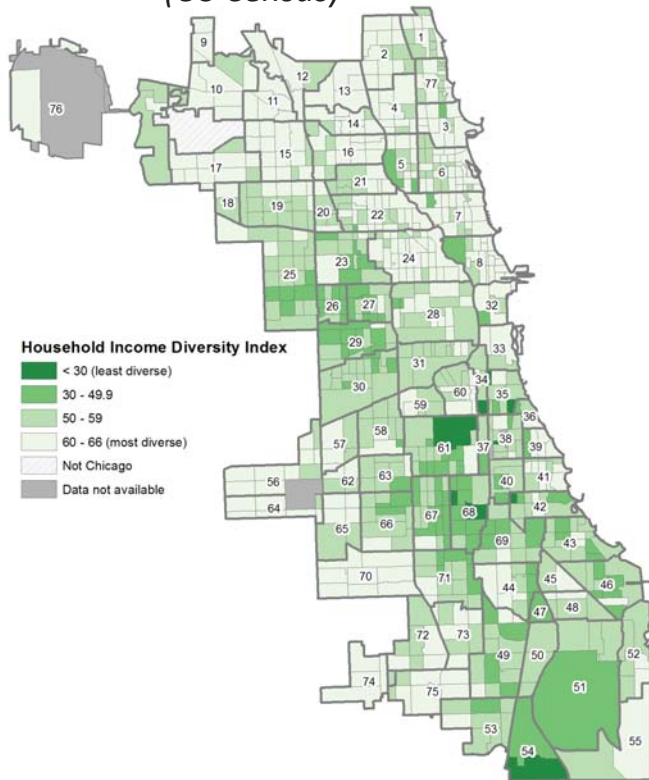
Economic hardship is associated with many health outcomes in Chicago. High hardship strongly correlates with inadequate prenatal care, teen births, self-reported fair or poor health status, smoking, low fruit and vegetable consumption, no physical activity, adult obesity, poor mental health, chlamydia incidence, hospitalizations related to heart disease, diabetes and chronic obstructive pulmonary disease, cervical cancer incidence and mortality, premature mortality, homicides, drug-induced mortality and infant mortality. Low hardship is correlated with breast cancer incidence and suicide (Figures 62a and 62b).

**Household Income Diversity Index**

- < 30 (least diverse)
- 30 - 49.9
- 50 - 59
- 60 - 66 (most diverse)
- Not Chicago
- Data not available

**Figure 62a.** *Selected health indicators by economic hardship, 2010 (US Census)*

**FAIR OR POOR HEALTH STATUS (% of adults):** 13.8, 18.3, 24.6

**MENTALLY UNHEALTHY DAYS (avg. in past month):** 2.6, 3.9, 3.1

**SMOKING (% of adults):** 11.5, 20.3, 25.4

**<5 SERVINGS FRUITS & VEGETABLES (% of adults):** 63.9, 70.2, 80.5

**NO PHYSICAL ACTIVITY (%):** 13.5, 17.3, 25.4

**ADULT OBESITY (%):** 21.0, 30.5, 37.3

**TEEN BIRTH RATE (per 1,000 females aged 15-19):** 12.0, 37.7, 59.8

**CERVICAL CANCER MORTALITY (per 100,000 females):** 2.5, 3.9, 6.2

**BREAST CANCER MORTALITY (per 100,000 females):** 23.2, 25.9, 25.9

**INFANT MORTALITY (per 1,000 live births):** 5.1, 8.6, 11.6

**SUICIDE (per 100,000):** 7.6, 4.8, 4.5

**HOMICIDE (per 100,000):** 2.4, 13.1, 24.5

Low hardship = light blue; Medium hardship = medium blue; High hardship = dark blue.

**Figure 62b.** *Selected health indicators by neighborhood economic hardship, 2010 (IDPH, US Census)*
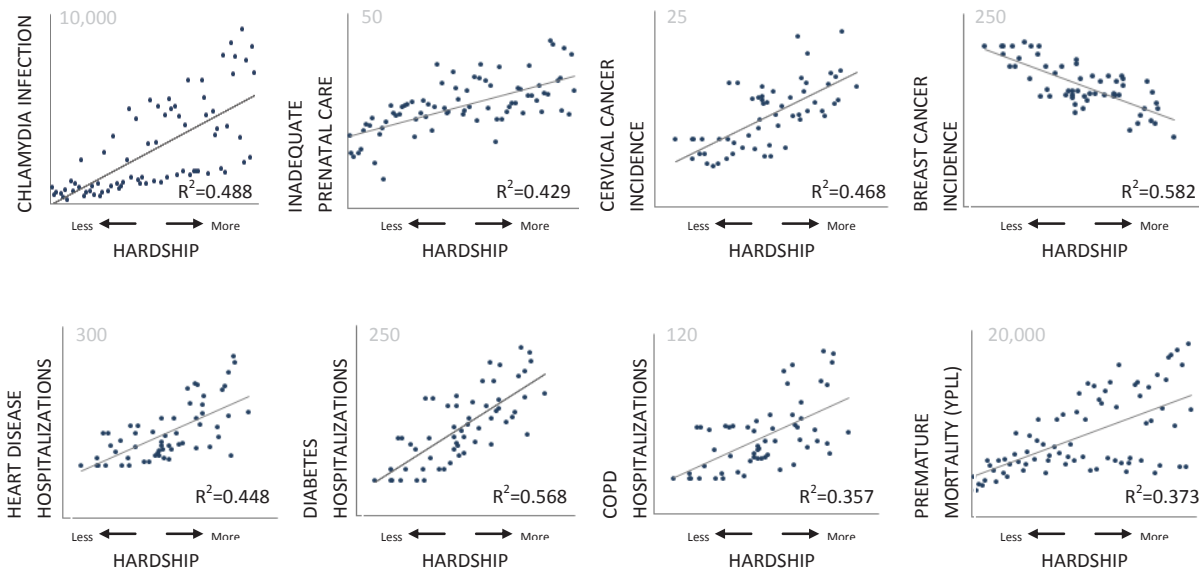


**Figure 63.** *Severe housing cost burden by census tract, 2008-2012 (US Census)*
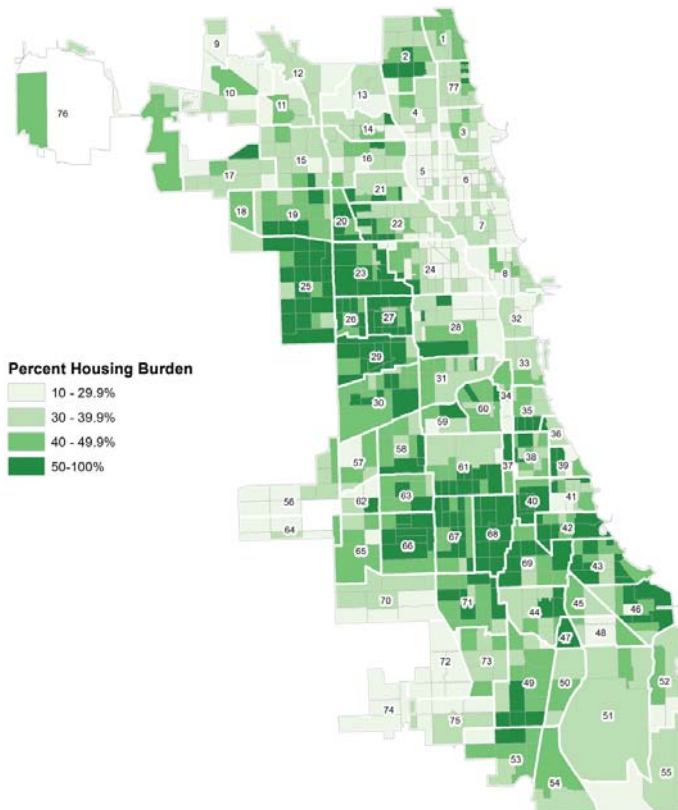


Although about one-third (31.7%) of Chicago households spend at least 30% of household income on housing costs, this rate varies greatly by community area from 10% to 83.8%. Higher rates of severe housing cost burden disproportionately affect the west and south sides of Chicago (Figure 63). On the west side in Hermosa, more than half (52%) of the households have severe housing cost burden.[19] Severe housing cost burden has had a negative impact on chronic disease mortality. In Chicago, persons living in census tracts with the highest housing burden levels also have the highest rates of heart disease, cancer and diabetes mortality.

*Built Environment:* In Chicago, less child opportunity in a community area is strongly correlated with shootings, elevated blood lead levels, child obesity, lower life expectancies, diabetes-related and diet-related mortality and teen births (Figure 64).

*Figure 64. Selected health indicators by neighborhood child opportunity, 2014 (CDPH, CPD, CPS, IDPH, Kirwan Institute, US Census)*
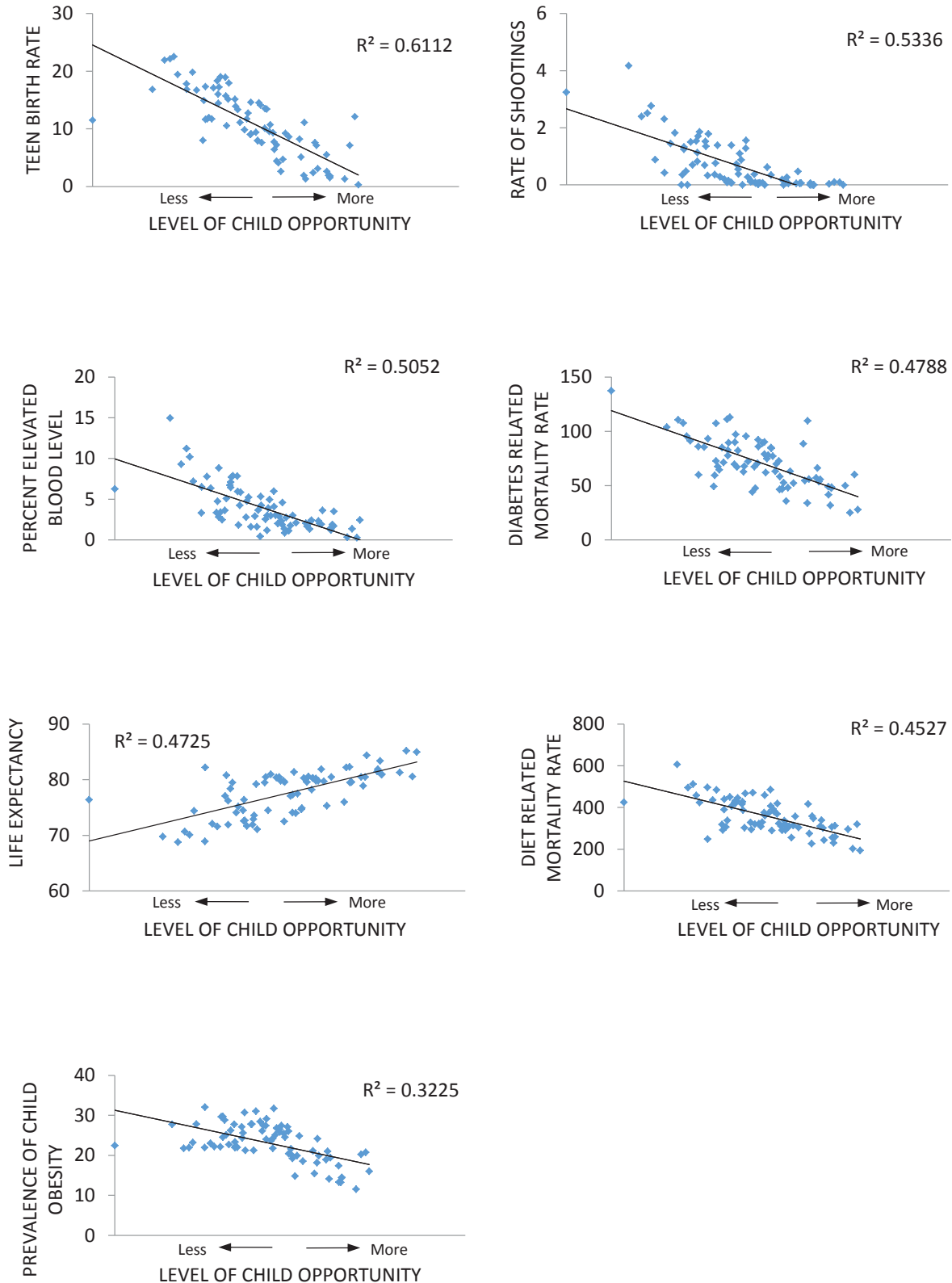
Overall in Chicago, 4.5% of children tested for lead are found to have elevated blood lead levels, with the highest percentages located in the western and southern parts of the city. Fuller Park has the highest concentration of tested children with elevated blood lead levels (15.0%), while the Near South side has the lowest percentage (0.3%), a 15% difference (Figure 65). Community areas with lower child opportunity have a higher percentage of children with elevated blood lead levels.[21]

Approximately 500,000 Chicagoans (18.3%) experienced food insecurity in 2012, with the highest concentrations on the west and south sides (Figure 66).[22] Fuller Park has the highest percentage of residents experiencing food insecurity (56.4%) and the Loop has the lowest (6.5%), a difference of 50%. Diet-related mortality rates are higher in community areas with higher concentrations of residents experiencing food insecurity.[7] Nearly 400,000 residents of Chicago live in areas with reduced food access; there are 14 food deserts (two or more contiguous census tracts with reduced food access) in the city, with most occurring on the south side (Figure 67).[22]

**Figure 65.** *Percentage of children under 5 years with elevated blood lead levels by community area, 2014 (CDPH)*



**Figure 66.** *Percentage of population experiencing food insecurity by community area, 2012 (Greater Chicago Food Depository)*
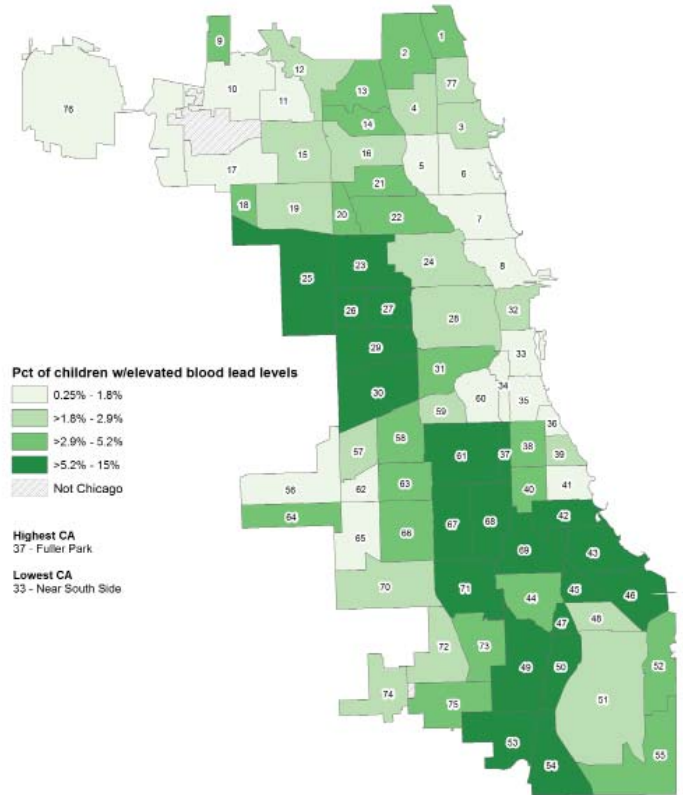
**Figure 67.** *Locations of food deserts by census tract, 2014 (US Department of Agriculture)*



Food Access
- Food Desert
- Food oasis
- Not Chicago
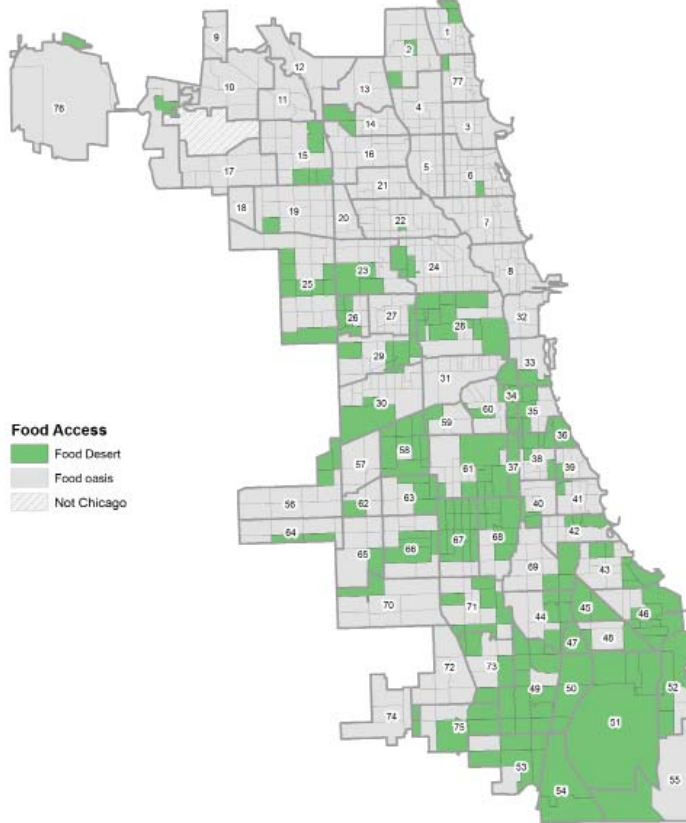
Conclusion: Chronic diseases, including heart disease, cancer, stroke, diabetes and respiratory diseases are the leading causes of morbidity and mortality in Chicago. Chicago has made progress on many health measures, including teen births, infant mortality and early prenatal care. However inequities persist among racial-ethnic groups, neighborhoods and levels of economic hardship. In addition, incidence of some chronic diseases and chronic disease risk factors (i.e., obesity, diabetes, breast cancer, hypertension and high cholesterol) are increasing. For adults overall there is little to no improvement in the health behaviors related to smoking, nutrition, physical activity and preventive cancer screenings, although, as referenced before with many health indicators, inequities exist based on the population.
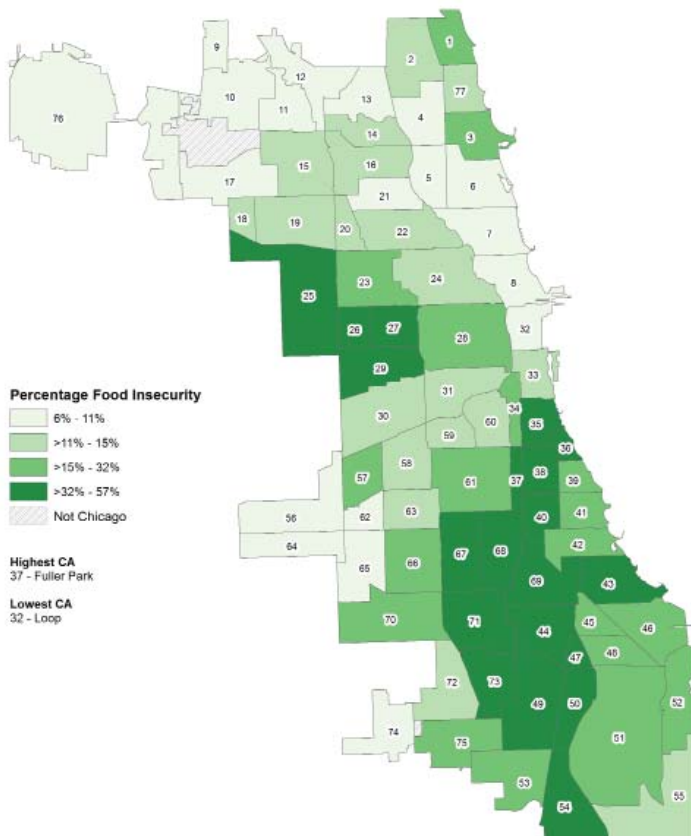
Children, adolescents and young adults face unique health challenges compared to adults. Sexually transmitted infections and violence embody the most extreme inequities seen in Chicago. LGB youth exhibit higher rates of risky behaviors, bullying, depression, suicide attempts and eating disorders. Over one-third of Chicago's school-aged children are overweight or obese. Young females were more likely to report feeling sad or hopeless and disordered eating.

Aside from childbirth and heart disease, mental illness is the leading cause of hospitalizations, which includes substance-related, mood and schizophrenic disorders—the

second, third and fourth leading causes of hospitalizations in Chicago. Suicide was higher in community areas with lower hardship. Cost and access to mental health services were the most common reasons for not seeking treatment.

Overall violent crime decreased between 2001 and 2014 but extreme inequities exist by community area. Among all leading causes of death, the greatest inequities are seen in homicide rates between low and high economic hardship, non-Hispanic black and whites and Hispanic/Latino and non-Hispanic whites.

The Educational Opportunity Index illustrates the presence and quality of early education and elementary schools at the neighborhood level. Lack of educational opportunity was shown to be strongly correlated with childhood obesity, teen births and lower rates of early prenatal care.

In 2011, 42,642 preventable hospitalizations occurred in Chicago, down 30% since 2000, but still high as they accounted for 14% of all hospitalizations. Both preventable hospitalizations and avoidable emergency department visits were strongly correlated with hardship. Asthma and diabetes-related hospitalizations in Chicago are much higher than national rates. Youth, Hispanics and residents living in high hardship areas are less likely to have a doctor. Of the 22,346 people living with HIV in Chicago, slightly more than half (54%) are in care.

The Hardship Index groups the economic characteristics at the neighborhood level, while the Child Opportunity Index analyzes infrastructure elements that facilitate healthy child development at the neighborhood level. Both indices were strongly correlated with many health outcomes, indicating the powerful relationship between social determinants and health in Chicago. Across all analyses, equity was consistently related to place, socioeconomic status and race/ethnicity.

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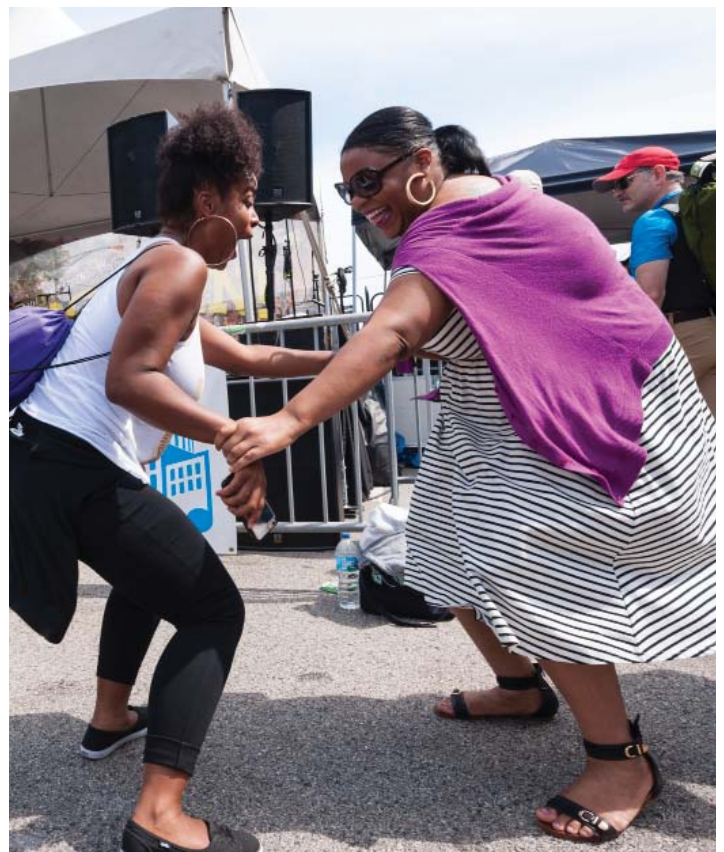
## PHASE 3B: *COMMUNITY THEMES AND STRENGTHS ASSESSMENT*

Purpose: The goal of the Community Themes and Strengths Assessment was to gather community resident feedback about their health and the health of their communities and Chicago, i.e., what are community strengths/assets that improve residents' health and what are barriers that impede their health. The assessment also obtained community-level strategies to how to improve community health and well-being. The findings from this assessment will contribute to overall findings from the other three assessments and be used to develop strategic issues during the Healthy Chicago 2.0 planning phase.

Process: CDPH collaborated with the University of Illinois at Chicago School of Public Health to conduct this assessment. To reach a broad section of residents, CDPH employed a mixed-methods approach, using four different methods of data collection: (1) an online neighborhood survey, (2) community conversations, (3) focus groups and (4) oral histories. By design, the online survey and community conversations reached larger numbers and broader segments of Chicago's population. To reach marginalized communities and populations who often are not represented in broader data collection efforts, CDPH conducted focus groups and oral histories.

Data Collection Methods:

*Online Neighborhood Survey:* An online neighborhood survey is a cost-efficient method of collecting a large number of community residents' opinions on how they rate the health of their community and the health of Chicago. A subcommittee designed the survey to obtain data on the following components that represent a broad view of health and well-being: education, safety, social cohesion, affordability, civic engagement, neighborhood upkeep, availability of services, transportation, quality of life and equity. The survey collected individual demographics and contained twenty-four agree/disagree statements and two qualitative questions (Appendix 2a). Direction for the survey emerged through a review of community surveys made available by the National Association of County and City Health Officials (NACCHO) website on Community Health Assessment and Improvement Planning. CDPH piloted the survey, made adjustments and then released both the English and Spanish versions on November 11, 2014. The survey closed on December 8, 2014.

CDPH promoted the survey through many communication channels to obtain responses from a broad spectrum of Chicago residents. Public health partners and stakeholders, such as Partnership for Healthy Chicago members, forwarded the survey link to their colleagues and networks. CDPH also worked through the Aldermen's offices and other City departments to share the survey link. For example, the

Chicago Public Library's website featured a link to the survey on their home page. CDPH used social media (i.e. Facebook and Twitter) and our Healthy Chicago Monthly Update e-newsletter to promote the survey.

In total, 1,033 individuals completed the survey. Survey data were analyzed based on the Economic Hardship Index of the respondent's community area. The Economic Hardship Index was developed by Rockefeller Institute and compares geographic areas based on several data indicators from the U. S. Census Bureau's American Community Survey: crowded housing, households below poverty, unemployment, high school graduation, dependent population and income. A higher Hardship Index score represents worse economic conditions. The survey grouped community areas into hardship quartiles and analyzed responses based on the quartile (Figure 68). Demographics of survey respondents as compared to Chicago's population are described in Figure 69.

### *Figure 68. Economic hardship by community area, 2012 (US Census)*
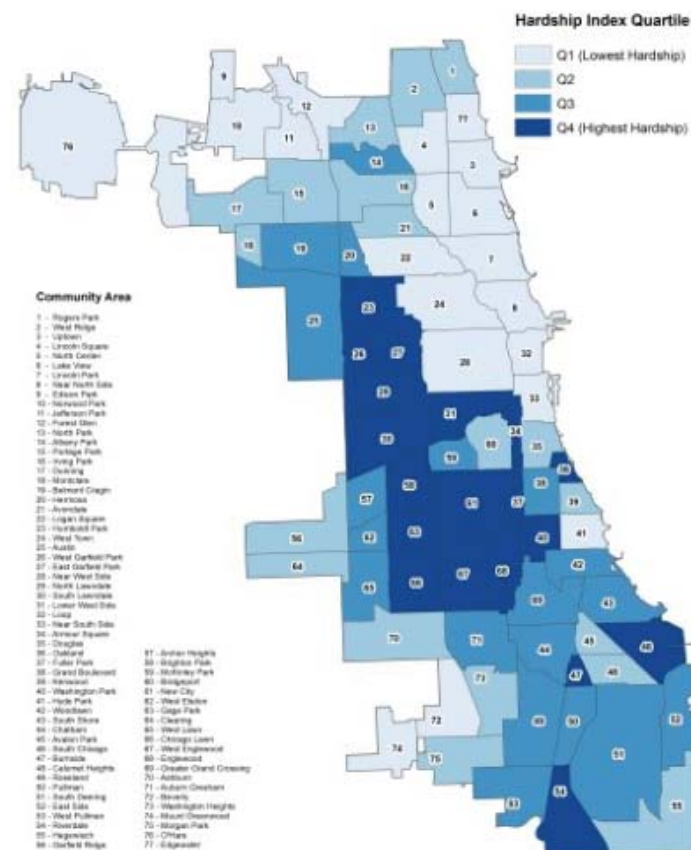
***Figure 69.*** *Demographics of online neighborhood survey respondents, 2015, and City of Chicago residents, 2010 (US Census)*

|  | Survey Respondents | City of Chicago |
|---|---|---|
| **Gender** |  |  |
| Female | 71.0% | 51.5% |
| Male | 28.4% | 48.5% |
| Transgender | 0.6% | N/A |
| **Race/Ethnicity** |  |  |
| Hispanic | 20.3% | 28.7% |
| Non-Hispanic white | 56.3% | 32.2% |
| Non-Hispanic black | 17.6% | 31.9% |
| Non-Hispanic Asian | 3.6% | 5.7% |
| Non-Hispanic other or multi-racial | 4.2% | 1.6% |
| **Income** |  |  |
| Less than $20,000 | 8.9% | N/A |
| $20,000-$39,999 | 11.0% | N/A |
| $40,000-$59,999 | 19.3% | N/A |
| $60,000-$79,999 | 17.2% | N/A |
| $80,000 or more | 43.6% | N/A |
| **Education** |  |  |
| Less than high school diploma | 7.9% | 18.9% |
| High school graduate | 2.1% | 23.2% |
| Some college, Associates degree | 13.9% | 23.8% |
| Bachelors degree | 27.4% | 20.4% |
| Graduate degree or higher | 48.7% | 13.8% |
| **Age** |  |  |
| Mean age (years) | 41.0 | 33.3 |
| 10 to 19 years | 8.4% | 12.7% |
| 20 to 29 years | 16.8% | 18.3% |
| 30 to 39 years | 24.2% | 16.2% |
| 40 to 49 years | 16.8% | 13.1% |
| 50 to 59 years | 17.7% | 11.7% |
| 60 to 69 years | 13.2% | 7.8% |
| 70 to 79 years | 2.5% | 4.4% |
| 80+ years | 0.4% | 2.8% |

*Community Conversations:* To reach community residents and public health stakeholders throughout the city, CDPH held community conversations in five diverse Chicago neighborhoods. These two-hour conversations brought people together to discuss assets and barriers to health and quality of life in their community and in Chicago as a whole. The locations and site hosts represent communities likely to have health inequities because of racial/ethnic, income, sexual orientation and/or gender identification status. CDPH, together with the Partnership, worked with local partners to host conversations in the communities of Austin, Grand Boulevard, Lake View, Lower West side and Near North side.

CDPH advertised the community conversations through social media, CDPH listservs and the Partnership members' contact lists. Host sites posted flyers promoting the events. Similar conversations occurred with other partners and public health experts, including the Chicago Board of Health, EverThrive Illinois Chapter Members, substance abuse providers and advocates, violence prevention providers, City of Chicago Interdepartmental Task Force on Childhood Obesity, Mikva Challenge Teen Health Youth Council, the Partnership for Healthy Chicago and CDPH management and staff.

> **A complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity**
>
> **World Health Organization definition of health**

A total of 299 individuals participated in the conversations. Although CDPH did not formally collect participants' demographics, most either represented a community-based organization in that area or lived in or nearby the community where the meetings were held. During the conversations, facilitators asked the following questions (Appendix 2b):

1. What are the attributes of your neighborhood/Chicago that improve health and well-being?
2. What are the barriers to achieving health and well-being?
3. What can we (the public health system/communities) do over the next 3-5 years to improve health and well-being?

*Focus Groups:* To obtain insights from marginalized individuals who are less likely to answer a survey or attend a public meeting, CDPH collaborated with the Community Assessment graduate level class (CHSC-431) at the University of Illinois at Chicago (UIC) School of Public Health to conduct five focus groups. CDPH sought and received Internal Review Board (IRB) approval from both the University of Illinois at Chicago and the Chicago Department of Public Health for the protection of human subjects, specifically vulnerable populations and use of the focus group process and procedures. CDPH held an additional focus group with ten

members of the Mikva Challenge Teen Health Youth Council, a group of diverse high school students who research health issues and develop policy recommendations to improve the health of CPS students. Held between October and November, 2014, the focus groups engaged the following populations: teen mothers, ex-offenders, families in shelters, housing advocates and members of a faith congregation in the community areas of: Austin, North Lawndale, Douglas and Lower West and Englewood, respectively. A total of 48 individuals participated in the focus groups. The focus groups were confidential, so demographic information was not collected. However, the majority of participants shared that they lived in or nearby the location of the focus group.

UIC graduate students led the 90-minute focus groups, which were conducted in English (Appendix 2c). To prompt focus group participants to think broadly about health and social determinants of health, UIC students presented the World Health Organization definition of health, i.e., "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity."

The graduate students asked the following questions to facilitate discussion and input:

- What do you like about your community and what are some things that support healthy living in Chicago? What are the biggest challenges to being healthy in your community?
- What are some barriers to being healthy in Chicago?
- When you think about the health of your community, what are barriers to good health?

*Oral Histories:* UIC worked with local partners and StoryCorps (the national story archival project of the American Folk Life Center at the U.S. Library of Congress) to collect oral histories from individuals who live in the Little Village neighborhood of South Lawndale. The local partners/host identified six individuals to be interviewed (two men and four women) and conducted the interviews in Spanish (four of the interviews) or English (two of the interviews), based on the interviewee's request. The interview consisted of six questions that encouraged interviewees to share experiences related to their health and the health of their families (Appendix 2d). The interviewees spoke about their experiences living in Little Village, a predominantly Latino and Mexican immigrant neighborhood in Chicago and the aspects of their community that contribute to their opportunities to be healthy, i.e., their perceptions of the social and structural roots of health, safety and wellness.

Data Limitations: This report acknowledges data limitations in the data collection methods, primarily due to the limited sample size and the limited diversity of participants. The online survey, although distributed widely and available in English and Spanish, did not obtain as broad of a participation as sought. In addition, the demographics of the respondents

from the online survey do not represent the population of the city of Chicago. CDPH attempted to address this problem by promoting the survey through the Chicago Public Library and designing the survey to be completed on a smart phone. Even with these accommodations in place, survey response was skewed to higher income and lower minority populations.

Community conversations were held at sites familiar to key population groups from whom CDPH wanted feedback and involvement. CDPH conducted outreach through our communication channels and other partners to engage community residents. The majority of attendees, while Chicago residents, were staff at local community-based organizations. Although the discussions were rich, as the attendees represented the concerns of their clients, feedback did not include as much of the direct resident input sought.

CDPH conducted the focus groups and oral histories specifically to obtain data from marginalized populations; therefore, they by design were not representative of the entire population. The focus groups allowed us to obtain information on perceptions of health and quality of life from 48 participants. Due to these small numbers, however, these findings cannot be generalized to those communities or to other populations. The focus groups were conducted in English and four of the six oral histories were conducted in Spanish.

Findings: As CDPH analyzed findings from the various data collection methods, nine themes emerged. These themes highlight both the problems impacting people's health as well as opportunities to improve peoples' lives. Most themes are inter-related and supportive of each other.

   Theme #1: Stress

   Theme #2: Safety

   Theme #3: Education

   Theme #4: Social Cohesion

   Theme #5: Community and Civic Engagement

   Theme #6: Affordability

   Theme #7: Availability of Services/Resources

   Theme #8: Neighborhood Upkeep

   Theme #9: Transportation

*Stress:* The central theme mentioned consistently in all the data collection methods was stress. People shared how the stress they experience impacts all levels of their health and quality of life. Research shows that the presence of stress, especially when it is continuous or frequent, can affect both mental and physical health, including the following conditions: heart disease, stroke, cancer and functioning of the immune system.[1] Participants in this assessment recognized how stress impacts not only their health and the health of their family, but also the structure of their

community. Focus group members connected their high levels of stress to conditions in their neighborhood and limited access to resources—feeling unsafe, education inequities, transportation inequities, lack of health care resources, lack of social cohesion and connectedness, cost of living and poverty. Many community conversation participants discussed issues of violence and educational inequities as stressors. Oral history interviewees spoke at length about the many stressors that impact their health, including neighborhood violence, which impedes their ability to accomplish their daily activities. The built environment was also mentioned as a cause of stress for a participant who had difficulty navigating the neighborhood where the sidewalks were inaccessible for someone using a wheelchair.

*Safety:* Findings from all the data collection methods showed that individuals perceive community safety as a major impact on their health and the health of their community. Online survey respondents from all four hardship quartiles identified safety as a concern and ranked efforts to increase safety as the number one way to make Chicago a healthier place to live (Figure 70).

**Figure 70.** *Health concern ranking by quartile, 2015 (Online Neighborhood Survey)*

| How would you make Chicago a healthier place to live? | Q1 Rank | Q2 Rank | Q3 Rank | Q4 Rank |
|---|---|---|---|---|
| Safety | 1 | 1 | 1 | 1 |
| Healthy Food | 2 | 2 | 2 | 2 |
| Equity | 4 | 5 | 3 | 3 |
| Education | 5 | 4 | 6 | 4 |
| Built Environment | 3 | 3 | 4 | 6 |

However, the survey revealed large disparities between the perceptions of respondents in the highest and lowest hardship quartiles in response to questions about safety in their neighborhoods (Figure 71). Compared to quartile 4, twice the percentage of respondents in quartile 1 identified that they felt safe in their neighborhood and felt that law enforcement was responsive. Conversely, higher percentages of quartile 4 residents identified problems of property and violent crime, at more than one-third and two-thirds times of those living in quartile 1, respectively.

*Figure 71. Percentage of respondents agreeing to safety questions by quartile, 2015 (Online Neighborhood Survey)*

| Survey Questions | Quartile 1 | Quartile 2 | Quartile 3 | Quartile 4 |
|---|---|---|---|---|
| I feel safe in my neighborhood | 86.2 | 71.1 | 44.4 | 40.0 |
| I feel law enforcement is responsive in my neighborhood when needed | 86.8 | 71.6 | 49.3 | 43.4 |
| Property crime is a problem in my neighborhood | 41.9 | 56.6 | 65.1 | 75.3 |
| Violent crime is a problem in my neighborhood | 21.1 | 27.3 | 50.3 | 67.4 |

Participants in the focus groups, community conversations and oral histories connected issues of safety and violence to the lack of available services and inequitable distribution of resources. Perception of police corruption was also identified as a barrier to health. Focus group members spoke at length about their mistrust of the police and that community members have been harassed. One focus group participant shared that "…you got to deal with all the negative vibrations in the community like the police officers." Another person stated that many neighborhood residents experience stress because they do not believe the police are interested in helping them.

Three of the five focus groups addressed lack of safety as a barrier to health—a focus that also emerged repeatedly in the oral histories. Focus group participants conveyed they feel stress induced by the fear of being shot and being a victim of violence. Participants also shared their feelings that violence in their communities is at the foundation of inequitable health outcomes and opportunities. One focus group member described how violence specifically affects her ability to take her child to the park: "they [the gang members] can shoot you or [you will] be caught in crossfire…" Being surrounded by violence limits these individuals' health and quality of life. The Mikva youth group echoed concerns with community violence, saying, "If you want to meet up with someone, you have to be careful what route you take." They also shared that the presence of gangs makes it difficult to go to the park, so "it's easier to stay inside and play video games." Oral history interviewees also discussed the long-term effects that gang violence has had on them and their neighbors.

Many programs and community organizations are working to reduce and prevent violence. Focus group members spoke in support of afterschool programs for middle school students as effective deterrents. These programs provide at-risk children with positive adult support and offer an alternative to joining a gang. The success of these programs was shared by a focus group member, who said, "…[if] they can do what they love to do, they will put down the guns." Another person stated that resources are needed to prevent children from getting involved in crime "…Every child has a gift. And kids they love… basketball, kids love football. And with nothing out there to keep them [busy]…" Another comment was… "We need Boys & Girls Clubs out here. We need something for these kids to be doing so when they get out [of] school, they can

have something to do, instead of just standing outside on the blocks… They don't have nothing to do." Mikva teens also identified the need for a safe community center where they could go after school to participate in structured activities.

To address mistrust of police, community members proposed several strategies, including trainings. Both police and community members need to be involved with trainings to build trust and understanding and to help identify common goals for a safe neighborhood. Community members also want more neighborhood watch programs that engage residents.

Group participants reinforced the importance of the Chicago Park District's neighborhood parks for both physical activity and community engagement. However, park usability is dependent on their safety and community members' perception of safety. This varies widely throughout Chicago's neighborhoods and efforts must focus on making parks safe for all residents, especially the most marginalized.

*Education:* All of the adult focus groups and the participants in the community conversations discussed education and identified ways in which the quality of the education and the education system itself were both an asset and a barrier to good health. Community members inherently knew that high quality education leads to jobs that more likely provide better health-related benefits and higher salaries, which allow individuals to make healthier choices in housing, food consumption and other factors of daily living. Research also connects higher educational status with more proliferative social networks and supports.[2]

When identifying educational system assets, participants highlighted Chicago Public Schools' (CPS) recess policy. Beginning in school year 2012-2013, all CPS elementary students are required to have daily recess. This policy is aligned with governmental agencies' recommendations and recognizes recess as a vital component of a child's physical, social and academic development.[3]

Focus group and community conversation members also applauded CPS' work with health care providers to improve access to care for their students through the presence of 30 School-based Health Centers (SBHCs). Students are able to obtain onsite health care (e.g., physicals, immunizations and ongoing care for chronic conditions such as asthma). SBHCs

Community Health Assessment:

also offer behavioral health care and services for the prevention and treatment of sexually transmitted infections. With services provided in the school building, children do not need to be taken out of school and their parents/guardians do not need to miss work to help them obtain care. Research shows that SBHCs increase students' health knowledge and access to health-related services.[4] Other CPS system improvements discussed include the establishment of the Office of Student Health and Wellness, which provides leadership to the district on health policy, program evaluation and delivery of school health services through community partners. These programs include CDPH-coordinated dental care and vision services.[5]

Although participants did identify the previous CPS system assets, more often they listed problems with CPS and the lack of quality education for all Chicago children. The most often cited concern was CPS' closing of 49 schools in 2013.[6] Community members were still angry about these school closings for many reasons—that closings occurred primarily in minority and low-income neighborhoods, the stress the students had because of changing schools, crowded classrooms at welcoming schools and the blight the closed schools will have on their neighborhood. Participants shared their perceptions that the Chicago Board of Education did not respect or consider parents' and community members' voices during the process.

Focus group and community conversation members complained that educational quality and innovative learning opportunities are not equitable throughout the city. Participants spoke at length about their concerns over the lack of quality education in neighborhoods on the south and

**Figure 72.** *Online neighborhood survey, 2015*



Children in my neighborhood have access to high quality education.
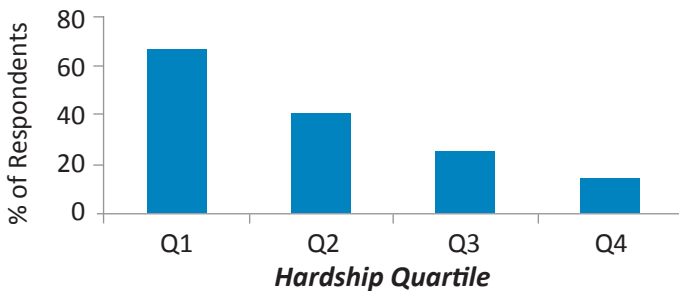
west sides. The data from the online neighborhood survey supported these findings, with stark differences between hardship quartile 1 and quartile 4 responses on access to high quality education (Figure 72).

Participants made several suggestions to improve education and the educational system. CPS should focus on improving neighborhood schools through increased investment and

integration of innovative programming. More vocational training programs in the high schools would improve student opportunities to obtain better paying jobs. To improve the health of marginalized populations, respondents wanted more school-based or school-linked health and social services.

*Social Cohesion:* Participants in the focus groups and community conversations brought up issues of social cohesion and community interaction and involvement when discussing health and quality of life. Research shows that these factors provide stress-buffering properties and are important predictors of subjective well-being and greater life satisfaction.[7,8,9] McMillan and Chavis defined sense of community as "a feeling that members have of belonging, a feeling that members matter to one another and to the group and a shared faith that members' needs will be met through their commitment to be together."[10] Participants in our groups advocated for the public health system to incorporate social networks and community involvement as necessary components of public health improvement efforts.

The online neighborhood survey asked questions about social cohesion and community connection. Similar percentages of respondents from all quartiles agreed with the following

**Figure 73.** *Online neighborhood survey, 2015*



I feel like I belong in my neighborhood.
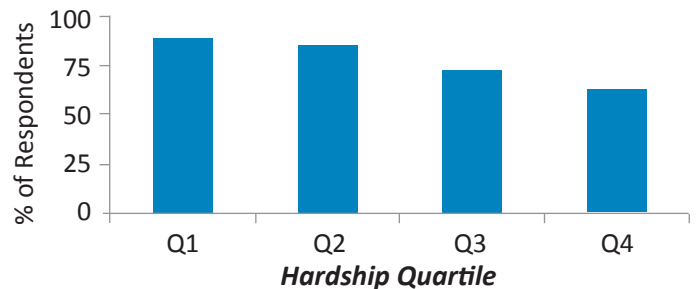
statements: "I know and talk with my neighbors" (ranged from 69%-74%) and "There are places for people to gather in my neighborhood" (ranged from 92% to 83%). However, differences were evident by hardship quartile for percentages of people who agreed with the statements "I feel like I belong in my neighborhood" (90% to 64%) and "I have felt discriminated against in my neighborhood" (10% to 30%) (Figures 73 and 74).

Focus group members shared stories of social cohesion in their communities. One of these aspects discussed in a focus group on the west side was the positive influence of "nosey neighbors." "...There are a lot of people around here that watch out for others people's kids...there are still a lot of good people around here."

**Figure 74.** *Online neighborhood survey, 2015*
*I have felt discriminated against in my neighborhood.*
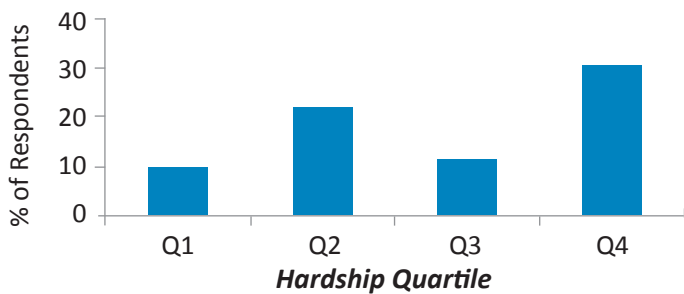


Faith and spirituality and its relationship to social cohesion emerged as an asset to health for many of the oral histories interviewees and attendees at the community conversations and focus groups. Not only did people identify their faith as a major driving force that encourages them to be healthy and thrive in difficult times, but they also credited their faith communities as being a strong social network for them.

Although participants who contributed to this assessment recognized a positive relationship between their level of involvement in their community and their health, they lamented that more of their neighbors are not involved. To address this, participants suggested that City agencies and local community organizations include community socialization and involvement in public health interventions and focus efforts on bringing neighbors together in an organized manner.

**Figure 75.** *Online neighborhood survey, 2015*
*I know what is going on in my neighborhood.*
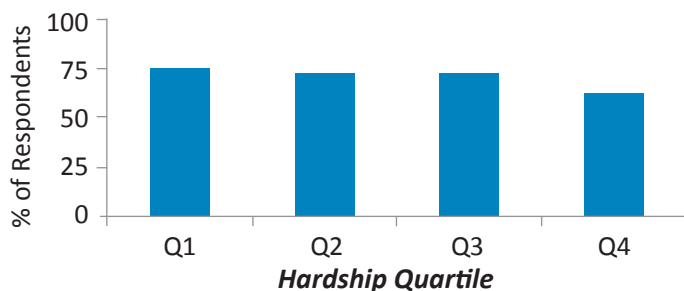


*Community and Civic Engagement:* Community engagement is defined as "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people."[11] Civic engagement refers to the ways in which citizens participate in the life of a community in order to improve conditions for others or to help shape the community's future.[12] Community and civic engagement can be a powerful vehicle to bring about environmental and behavioral changes that can improve the health of the community and the people that live there. To be most successful, these efforts develop and engage partnerships and coalitions working together to mobilize

resources that serve as catalysts for changing policies, programs and practices.[13]

The online neighborhood survey obtained data on community and civic engagement across the four hardship quartiles. As shown in Figure 75, a similar percentage of respondents from all four quartiles agreed with the statement "I know what is going on in my neighborhood." However, the responses to the statement "People in my neighborhood have input on important community and city decisions" show that three times as many respondents in quartile 1 agree with this statement compared to respondents in quartile 4 (Figure 76).

**Figure 76.** *Online neighborhood survey, 2015*
*People in my neighborhood have input on important community and city decisions.*
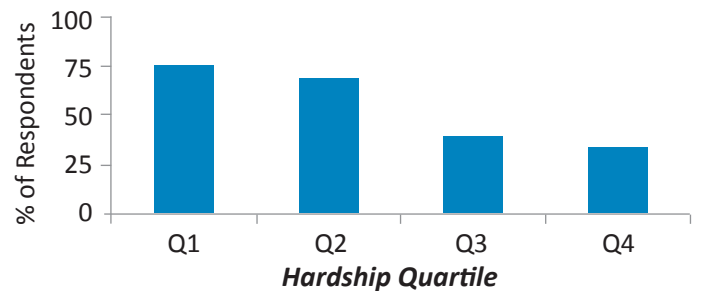


Focus group members shared that many of their neighbors are not involved in decision making in their communities. They thought this was due in part to their lack of efficacy in this role—that people do not feel they have the autonomy to make decisions. At the same time, people also wanted government officials to offer guidance and demonstrate their commitment to engaging residents in this work and improving their communities' health.

To build community engagement, community conversation participants suggested that universities and research centers could reach out to marginalized communities through community-based participatory research (CBPR). CBPR is a research approach that requires and prioritizes partnerships and balances scientific and community interests with a goal of promoting social change to improve health and quality of life of communities.[14] By fostering more CBPR in marginalized communities, resident engagement with decision making could grow as residents see their opinions valued and priorities addressed.

*Affordability:* Participants in the focus groups, oral histories and community conversations linked issues of poverty and stress to their health and the health of their families and communities. They talked about the high cost of living and their struggle to meet their daily expenses. At one of the focus groups, a participant responded to the question about what health meant, "...Health to me is having money. As long as you have money, you will never be stressful." He also shared that stress from not having enough money leads to unhealthy behaviors. Participants also spoke vehemently

Community Health Assessment:

about the need to increase the minimum wage to a livable wage. Linking affordability and health has been substantiated through research, which shows that (1) people with lower socioeconomic status (SES) tend to experience more stress and (2) high levels of stress combined with low SES contribute to poor health outcomes.[15]

Several focus groups discussed affordability of housing, relating it to safety and quality of life. They complained about the poor quality of affordable housing in their communities, which is often not well maintained and contains many health hazards, such as mold.

### Figure 77. *Online neighborhood survey, 2015*

*Houses and apartments in my neighborhood are affordable.*
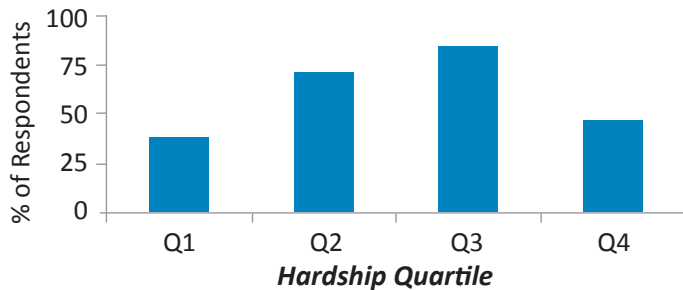


Survey respondents in both quartile 1 and quartile 4 had lower percentages of agreement with the statement "Houses and apartments in my neighborhood are affordable" than respondents living in quartile 2 or 3 (Figure 77). This indicates that people living quartile 1 and 4 both recognize that their housing is not affordable. However, most people living in quartile 1 have chosen expensive housing compared to those in quartile 4, who may have no other choices.

The participants at several of the community conversations brought up concerns about wage inequities. Wages impact residents' ability to purchase basic needs for their families. Even holding a full-time position, most minimum wage earners do not have sufficient income to cover all of his or her family expenses. One community member pointed out that at $8.25 an hour for a 40-hour work week, an employee wouldn't even take home $300 dollars. A focus group member talked about the experience of working but not earning enough to pay bills. "Some people don't want to live off the government. You know 'cause I don't. I try to live off of food stamps. I get paid every 2 weeks and get $413 for one month. What is that going to do? I have rent to pay. Rent is $670. I have 2 kids. One in diapers. So I'm being serious though, how are you going to survive with $413 with 2 kids..." Focus group members discussed that not being able to support one's family is a driving factor to illegal activity. Participants also discussed their concerns over the high cost of child care. One focus group participant explained that after finding and paying for childcare he/she could not make enough income to support rent and other bills.

Focus group, oral history and community conversation participants suggested increasing the minimum wage as a strategy to improve health. (N.B. After the assessment was completed, the Chicago City Council passed an ordinance that incrementally raises the minimum wage to $13 per hour by 2019.)[16] Strategizing further, participants suggested developing more affordable childcare programs and increasing available affordable housing options, including single room occupancy and single-family homes.

*Neighborhood Upkeep:* Participants in the focus groups and community conversations identified the built environment and neighborhood upkeep as an important factor of health and quality of life. Not only does adequate infrastructure allow people to go outside and be physically active, it also reinforces safety. Research aligns with participant feedback, showing that housing and neighborhood quality have an impact on perceptions of safety and on satisfaction with the local physical environment.[17]

### Figure 78. *Online neighborhood survey, 2015*

*The streets and sidewalks in my neighborhood are in good shape.*
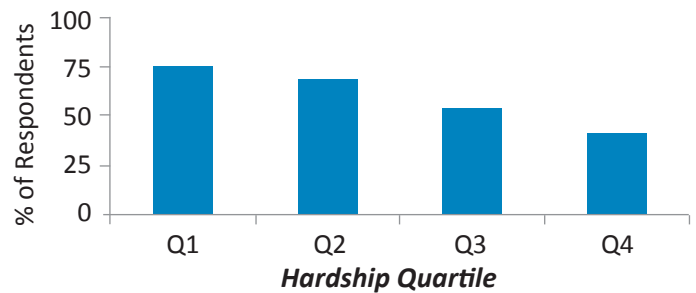
The online neighborhood survey revealed large variances across the four quartiles in respondents' perceptions of upkeep and shape of their neighborhood, including the status of their streets and sidewalks (Figure 78). Focus group members were emotional about the disparities in neighborhoods. One person contrasted the condition of homes in his/her neighborhood to richer neighborhoods, "They might be missing the doors off of their porches. Porches falling down. And I mean these are buildings people are living in and…it was something to see. And I mean, it was blocks and blocks and blocks and blocks and then you get to further east. And you got nicer homes." People also expressed concern that poor housing conditions (mold, lead and lack of heat) compound existing health issues.

Several of the oral histories interviewees brought out how lack of neighborhood upkeep creates a direct barrier to health for the disabled and aging population. Crumbling and impassable streets and sidewalks create significant obstacles for people with disabilities, limiting their ability to access resources and move more freely around the city. Focus group participants also complained about the poor road conditions in their neighborhood.

Many ideas on how to improve neighborhood upkeep arose at the community conversations. Participants suggested neighborhood beautification several times, envisioning the recruitment of local residents and other volunteers for these projects. Establishing more community gardens was also cited as an opportunity to improve neighborhood upkeep.

**Figure 79.** *Online neighborhood survey, 2015*

*Basic amenities, such as a grocery store, pharmacy or library are easily accessible to me.*
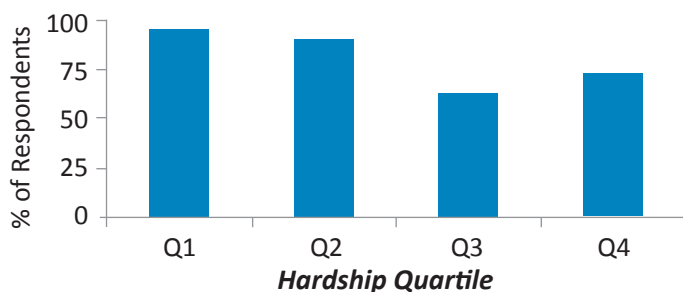


*Availability of Services/Resources:* Availability of basic amenities such as a grocery store, pharmacy, or library is an important measure of community health and quality of life and perceptions of availability differed by hardship quartile (Figure 79). Respondents reported inequities in access to healthy food, with almost twice as many respondents in quartile 1 than quartile 4 reporting access (Figure 80).

Members at several focus groups spoke at length that they do not feel they have quality grocery stores in their south and west side neighborhoods. One woman cited seeing "bad" meat and wilted vegetables for sale at her local grocery store. She voiced that these offenses would not be tolerated at a grocery store on the north side.

**Figure 80.** *Online neighborhood survey, 2015*

*I have access to healthy food in my neighborhood.*
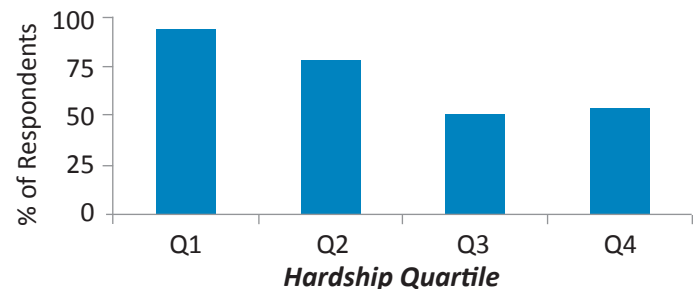


Participants in the focus groups (including the Mikva Teen group) and community conversations talked about their personal experiences trying to obtain healthy food. Mikva Teens shared that their families buy food in the neighborhood because it is cheaper. However, one teen remarked that "… the corner stores sell cheaper inferior goods that are un-healthy." In addition to lack of access to healthy food, focus group participants brought up that people need to know more about how to cook healthy food and proper food storage methods.

Focus group and community conversation participants discussed accessing health care resources for physical health and mental health. Participants spoke about the need for culturally-effective services throughout the whole system to reach marginalized populations. Community members expressed frustration due to the reduction of mental health services sites when the City of Chicago consolidated its 12 mental health clinics into six centers in 2012. Community members expressed that the closing of these facilities further denigrated the level of inadequate mental health services for Chicago residents—they stated that it is more difficult to find resources, there is a longer wait for appointments and they believe that many people are not getting their needed services.

Group participants discussed how the Patient Protection and Affordable Care Act (ACA) is working to increase access to health care insurance and health care. However, people also stated that many community members do not understand how to enroll or use their health plan when they get it. Participants knew that ACA patient navigators are working to reach uninsured populations and applauded all the work being done on this effort. At the same time, people shared there are still many groups that have not yet been reached with this information. Therefore, they recommended continued efforts in the communities to reach the uninsured and also help people understand the health care system.

**Figure 81.** *Online neighborhood survey, 2015*
*Health services I use are easy to get to from my neighborhood.*
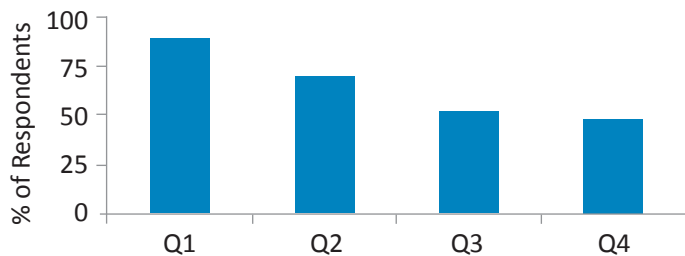


Results from the online s***Hardship Quartile***ing
perceptions of neighborhood access to health services and
social and recreational opportunities across hardship
quartiles. Figures 81 and 82 show larger percentages of
respondents in quartile 1 indicated easier access to both
health services and social and recreational opportunities
compared to respondents in quartile 4. Similarly, focus group
participants, who primarily lived in low-income
neighborhoods, discussed the limited availability of
recreational activities, which were due to lack of
programming and cost.

**Figure 82.** *Online neighborhood survey, 2015*
*My neighborhood provides social and recreational
opportunities for me and my family.*
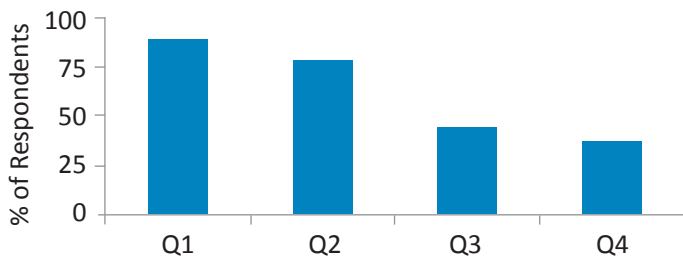


To improve access to hea***Hardship Quartile*** the
community conversations suggested increasing farmers
markets in marginalized neighborhoods and allowing
purchase with the Supplemental Nutrition Assistance
Program (SNAP—formerly known as food stamps) LINK card
and incentives, such as double value benefits.

*Transportation:* The ability to travel around one's neighbor-
hood and throughout the city to commute to work, access
services, utilize resources and visit family and friends is an
important aspect of health and quality of life. Participants
from all the data collection methods recognized the impact
of accessible transportation on their health. Survey respon-
dents across the city generally felt their neighborhood was
well served by public transport (Figure 83). However, when
asked about walking and bicycling, differences were evident
between quartile 1 and quartile 4 (See Figure 84).

**Figure 83.** *Online neighborhood survey, 2015*
*My neighborhood is well served by public transit.*
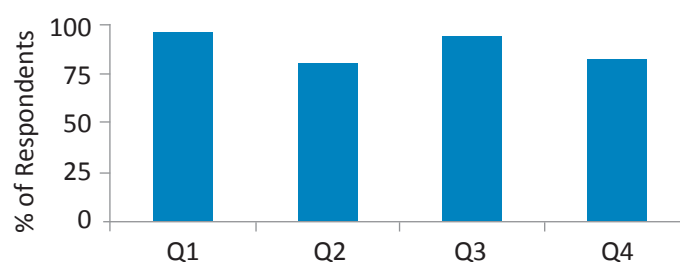


The Divvy bike sharing p***Hardship Quartile***ain
transportation and public health efforts mentioned
throughout this assessment. Chicago's Divvy program supplies
over 4,760 bikes at 476 stations across the city and provides
a healthy option for transportation, encouraging people to be
active.[18]

On the flip side, group participants raised concerns that Divvy
stations are not distributed equitably, with no stations located
south of 55th Street.

**Figure 84.** *Online neighborhood survey, 2015*
*I see a lot of people walking or biking in my neighborhood.*
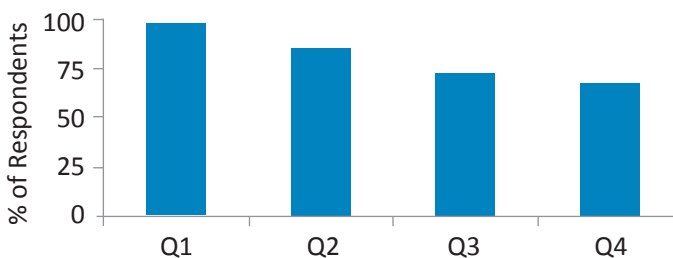


Focus group members a***Hardship Quartile*** to walking
and biking. Many associated poor lighting, safety and
dismantled infrastructure with a limited number of
individuals choosing active transportation modes on the
south and west sides of Chicago. Both community
conversations and focus group participants expressed
frustration about the pot holes and poor roads. Community
conversation participants also presented the opportunity to
improve the walkability of streets by prioritizing pedestrians
and converting more neighborhood streets to "Complete
Streets," i.e., designing streets that ensure safe access for all
modes of transportation, including pedestrians, bicyclists,
motorists and transit riders. Adopting a Complete Streets
policy creates a better network of streets that is safer for
everyone, regardless of age or ability.[19] Although Chicago
adopted this policy in 2013, most participants did not know
about it and most neighborhoods have not benefited yet.

Public transportation emerged as a barrier impacting health
and quality of life in one of the focus groups. Participants
expressed frustration with the slow and limited bus service,
causing them to be late or set aside long stretches of time to
transfer buses to get to work or other appointments outside

of their neighborhood on the south and west sides. One participant said, "Out here, the buses around here run so slow but on the north side them buses literally come back to back to back to back." People saw these inequities as increasing their stress and therefore impacting their health.

Suggestions for improvements included improved access to transportation on the south and west sides of Chicago. At the community conversations, participants suggested the City invest more funding into the road and sidewalk infrastructure, specifically on the south and west sides. Focus group participants also indicated improved safety has a direct effect on improving transportation in and around the city.

*Importance of policies and political support for public health:* Through all the data collection methods for the Community Themes and Strengths Assessment (i.e., focus groups, oral histories, community conversations and online neighborhood survey), participants acknowledged the importance of policy on improving health. As identified in the themes above, participants discussed several current policies that they believe are improving health status (e.g., CPS recess policy, LINK card usage at farmers markets, minimum wage ordinance, etc.). Participants also highlighted the tobacco ordinances passed in 2014 that reduce access. Chicago City Council banned the sale of flavored cigarettes (including menthol) within 500 feet of a school and passed an ordinance that aligns restrictions on e-cigarettes with tobacco cigarettes.

Focus group and community conversation participants discussed how politics and the political system influence health. Several of the meetings were held prior to the 2014 gubernatorial election and people speculated possible changes that could occur with a new administration. For the post-election meetings, participants asked questions about the impact the new administration would have on funding for both the public health sector and efforts to address health equity. People also discussed possible changes based on the upcoming Chicago mayoral election that was scheduled for early 2015.

Participants made several suggestions regarding future policy strategies for improving health and equitable distribution of resources. One strategy both stakeholders and community members brought up at community conversations was the need for long-term collaboration across the public health system to improve access and coordination of services. Community members felt collaboration with the public health system would help streamline services and improve access for residents. They also noted that policy makers need to focus on social determinants of health, i.e., social and economic factors, social support networks, physical and social environments, access to health services and social and health policies.[20]

Creating a system of Health in All Policies (HiAP) was another suggestion of an opportunity to improve inequities within Chicago. HiAP is a collaborative approach to incorporate health considerations into decision-making across sectors and policy areas and informs decision-makers about health consequences of various policy options during the policy development process.[21]

Conclusion: Community residents and public health stakeholders described many health assets and barriers in their neighborhoods and Chicago as a whole. In most cases, assets for some residents and communities are barriers for others. This was illustrated with the discussions on community safety. Participants recognized that many organizations are working to decrease violence. Youth programming was highlighted as an important factor in impacting both individual and community safety. People also identified relationships in the community as helping to improve issues of safety. However, these programs are too limited and reliant on unstable funding sources. In addition, most organizations do not focus on community cohesion. This dichotomy was also around issues of education and access to healthy food. Underlying all these discussions was individual and community-level stress. And throughout, participants emphasized the importance of health and resource equity and a steadfast focus on social and structural determinants of health.

Along with specifying the assets and barriers, CDPH asked participants for strategies to improve health. Participants identified the need to develop new policies and strengthen current efforts. People also suggested expanding successful programs, developing new efforts and increasing resources in communities. Essential within these suggestions was their call for community involvement and social cohesion when conducting this work. Participants reiterated that impacts will only fully be made with resident engagement and buy-in with health improvement efforts.

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## PHASE 3C: *FORCES OF CHANGE ASSESSMENT*

Purpose: The purpose of the Forces of Change assessment (FOCA) is to identify forces (trends, factors or events) that presently or in the future will influence the health and quality of life of the community and the local public health system. Threats and opportunities that could result from the forces are also identified.

Process: CDPH conducted the FOCA between October 2014 and January 2015 through several methods. The five Community Conversations (see the description in Community Themes and Strengths Assessment section) engaged stakeholders and residents and asked the following questions: "What are the forces and trends that are happening now or are likely to happen in the near future that will impact the health of Chicagoans?" "What are the threats or bad consequences of these forces?" "What are the opportunities of these forces?" CDPH advertised these conversations through emails, social media, the CDPH listserv, flyers and the assistance of the host sites. CDPH engaged other groups in this assessment, including violence prevention providers, substance abuse providers, food insecurity advocates, the Chicago Board of Health and CDPH staff. CDPH combined participants' responses into 12 different categories. At the January 30, 2015 Partnership for Healthy Chicago meeting, members met in small groups to add to and refine the forces identified through the conversations. Finally, all feedback was further synthesized and analyzed for themes. Over 200 people contributed to the Forces of Change Assessment.

Findings: Stakeholder discussion centered on the 12 categories of forces listed below. This section presents the forces identified and provides information and data that illustrate the context around these themes and related threats. Potential opportunities associated with the forces are also identified.

> Force #1: Health and Mental Health
>
> Force #2: Cost-of-Living and Inequality
>
> Force #3: Housing and Homelessness
>
> Force #4: Safety and Violence
>
> Force #5: Education
>
> Force #6: Policy and Politics
>
> Force #7: Food and Food Systems
>
> Force #8: Discrimination and Stigma
>
> Force #9: Climate and Environment
>
> Force #10: Data and Technology
>
> Force #11: Older Adults
>
> Force #12: Cultural Competence

*Health and Mental Health*: Starting in 2013, the Patient Protection and Affordable Care Act (ACA) and Illinois Public Act 98-104 extended health insurance coverage for many previously uninsured Chicagoans. Coverage provisions included the expansion of Medicaid eligibility to almost all nonelderly adults with incomes at or below 138% poverty, the extension of health care coverage to young adults to age 26 through their parents' insurance and the availability of insurance through the Health Insurance Marketplace for persons without employer-based insurance or Medicaid. Persons with incomes between 100% and 400% of the federal poverty level are potentially eligible for tax credits with Marketplace insurance.[1] However, stakeholders expressed concern that the ACA does not provide universal health care coverage, leaving some people, including undocumented immigrants, without coverage.

> **People have a choice of health plans, but care varies and there is a lot of confusion about the plans.**
>
> **-Community Conversation Participant**

In addition, Illinois Public Act 96-1501, passed in 2011, mandated that 50% of Medicaid clients enroll in managed care by 2015, including the vast majority of Chicago clients.[2] The Illinois Department of Healthcare and Family Services is focusing on these system changes to improve quality of care, reduce growth in health care costs and improve overall population health.[3] Managed care entities organize a network of providers, with care coordinators assisting with system navigation, care transitions and follow-up care. Providers will be rewarded for quality and health outcomes.

The mental health safety net is another concern for many. Community mental health treatment services and support services are critical for persons with serious mental illness. From FY2009-FY2012, Illinois cut $113.7 million in general revenue funding for mental health services. While increased insurance coverage through the ACA increases mental health coverage for some, Medicaid does not cover some services needed by persons with serious mental illness, such as early intervention. Medicaid pays low rates for some services, leaving many organizations with a need for additional funding sources.[4]

Threat: The system forces that improve health care access for many Chicagoans may also cause access difficulties for others. People who have trouble navigating new insurance systems may be unable to obtain needed care. Many newly-covered people have little to no experience with health insurance. Still others may have difficulty understanding the system due to English language, cultural and/or literacy barriers. Indeed, consumer assistance services for the recently insured have been in demand nationwide. Those who are uninsured will continue to need safety net services. Without provisions to maintain services for the uninsured, persons without

insurance, such as undocumented individuals, risk a lack of preventive care and untreated medical problems. Restricted medication formularies pose serious risks to individuals who require specific medications to control and manage their health. Overall, system changes, without focus on populations in need, could lead to inadequate care, which then negatively impacts health outcomes for persons with mental illness, including increased hospital emergency department use, hospitalization and contact with the criminal justice system.

Cuts to Medicaid funding and reimbursement are a potential threat looming for health providers, including mental health agencies. In addition, the overall capacity of the mental health system may be too small to address the needs of all Chicagoans.

Opportunity: Health care system changes bring opportunities to expand the workforce of important lay providers—patient navigators and community health workers. This workforce is recognized as an effective and cost-efficient method to assist individuals and families in understanding their insurance and obtaining the care they need. The opportunity to grow this workforce can also address issues of trust in the health care system, further promoting access to care in marginalized communities. The public health system can work with managed care providers to assure network adequacy.

Ongoing, high quality and accessible mental health treatment and support allows persons with serious mental illness to live independent, healthy and fulfilling lives in the community. Advocacy for increased mental health funding, access to medications and provider reimbursement are needed. System coordination and service integration strategies can improve care access, quality and efficiency.

*Cost-of-Living and Inequality:* Financial problems, e.g., poverty, high cost of living and the lack of jobs paying a livable wage, are a reality for many Chicagoans. In 2013, 10.8% of Chicagoans experienced poverty, with incomes at 0-99% of the poverty level, while 20.9% were classified as low income (100-199%).[5] Although the nation is no longer in a recession, many of the mid-wage jobs that were lost have not been recovered. For many, wages remain flat despite higher costs of living. Income inequality is another issue that impedes equity in Chicago. Currently eighth in income inequality among 50 cities in the United States, Chicago has experienced a sharp increase in income inequality since 1990.[6,7] Poverty is concentrated in some communities, creating large inequities between neighborhoods.

> **The cost of living increases (housing, food, health care and transportation) but wages remain the same.**
>
> **-Community Conversation Participant**

Threat: Financial problems and poverty are a threat to housing stability, putting community members at risk for foreclosures and homelessness. Others are forced to move from Chicago to find jobs or a more affordable place to live. Those experiencing financial problems may newly qualify for public assistance and social services. Poverty, a key social determinant of health, is associated with poorer health outcomes overall.

Opportunity: In December 2014, Chicago City Council passed an ordinance to increase the minimum wage to $13.00 an hour by 2019.[8] The passage of living wage legislation, indexed to inflation, is a step to further improve the well-being of Chicagoans and will have sustainable effects year-to-year. Chicago Public School (CPS) job training and apprenticeships that are well-matched to growing Chicago job sectors could improve job outlooks for graduating seniors and vocational training could be utilized by all age groups. Incentives provided to companies that train employees or have hiring programs for the prisoner reentry population are opportunities that could benefit employers and employees alike.

*Housing and Homelessness:* Stakeholders discussed the need for affordable, safe housing, which is essential to good health. However, about one-half of Chicagoans spent more than 30% of their income on rent in 2012, more than the accepted measure of affordability, with many paying more than one-half of their total income on rent.[9] A 2014 analysis by Chicago Coalition for the Homeless estimates that 138,575 Chicagoans were homeless during the course of the 2013-2014 school year.[10] Youth, veterans, domestic violence survivors and persons returning to the community following incarceration are populations in need of interventions to address the root causes of homelessness.

Threat: Unsafe and unaffordable housing threatens health, mental health and well-being. When housing is unaffordable, individuals have less money to spend on other essential needs, including healthy food and health care, which may lead to increased stress. Decent housing in safe neighborhoods helps to reduce stressors and provides mental health benefits. Homelessness is a potential consequence for those unable to obtain housing and closely linked to poor health outcomes. The rates of chronic and acute health problems are high among persons who are homeless.

Opportunity: An amendment to the Affordable Requirements Ordinance passed in March 2015 is designed to make 10 to 20 percent of the units in market rate developments more affordable.[11] Opportunities exist for further amendments to this ordinance and for new policies and incentives to increase affordable housing in Chicago. Initiatives to rehab vacant housing to create affordable housing and to create long-term housing for vulnerable groups have potential to provide more options for housing stability for Chicago residents. Advocacy for federal funding to support affordable housing is needed.

> **There is an opportunity to develop vacant properties for housing, specifically for low-income, formerly incarcerated individuals.**
>
> **-Community Conversation Participant**

*Safety and Violence:* Violence is a concern for many Chicagoans. Gun violence makes everyday life in some communities stressful and even life threatening. While homicides in Chicago decreased in 2014, the number of shootings increased compared to 2013.[12] Many Chicagoans face other types of violence, including intimate partner violence or bullying. Police brutality is both a local and national concern and is currently widely discussed in the media.

> **The continued violence that plagues the city has become business as usual. There's more reaction to Ebola than our kids dying.**
>
> **-Community Conversation Participant**

Threat: In addition to the risk of injury and death, community violence is linked to chronic disease and mental health problems. Residents who feel unsafe in their own homes experience harmful stress and may stay inside, limiting their ability to exercise.

Opportunity: Schools can play an important role in providing a safe, nurturing environment for children and youth. Schools with more advocates, including school social workers, can deliver support to children experiencing stress, fear and grief and can provide social skill development, conflict resolution and bullying prevention interventions. They can connect families with needed services. Furthering restorative justice practices in schools is another way to reduce conflict by focusing on repairing harm and potentially reducing school suspensions and juvenile justice involvement.

Increased communication between communities and police could increase trust between residents and police. Collaborations between police and communities have had positive outcomes in some areas of the country and could be used as a model. Police training may assist in creating greater understanding of community needs that ultimately improve relationships between police and communities.

*Education:* As in many American cities, quality and equal education is on the minds of Chicagoans. Chicago Public School closures in 2013 were controversial and directly affected about 12,000 students.[13] Limited school resources, student testing, poor student outcomes and the use of charter schools were frequently discussed issues in these conversations. Overall, poor school quality is a concern among families.

> **Our children don't have access to equal education.**
>
> **-Community Conversation Participant**

Threat: The ramifications of poor school quality include a lack of job and college readiness, a risk to a large proportion of students that threatens both individual and community well-being. A 2011 study of academic achievement and graduation rates found that the vast majority of CPS students were not prepared for college. Racial gaps in achievement had increased over the past 20 years.[14]

Opportunity: Improving school quality through model school improvements around the country and evidence-based programming has the potential to increase student achievement. Community-based learning and vocational opportunities could help to augment school-based learning and improve student outcomes. Further, advocacy efforts aimed at public education funding reform are a potential long-term solution to educational inequality. School closures left dozens of vacant school buildings and opportunities exist to convert vacant school buildings into community assets.

*Policy and Politics:* At the time of the assessment, the Mayoral election and changes in State leadership created uncertainty about how policy and politics would impact Chicago's public health system. A shrinking public health budget, the introduction of new public health policies and distrust in government affect the public health landscape.

> **Shrinking budgets threaten public health.**
>
> **-Community Conversation Participant**

Threat: With economic troubles in City and State government, budget cuts are a potential threat to public health. Cuts in government funding threaten many different sectors and services. This could influence health directly through decreased funding for public health, health care and mental health services. Budget cuts could also affect health indirectly through decreased funding for the social determinants of health, including cuts to education, human services, housing, transportation and other sectors. Decreased or inequitable service funding has the potential to increase health disparities by widening gaps between those with limited means and those who have more resources.

Opportunity: The promotion of participation in the democratic process is a potential strategy to address policymaking. Community health issue forums are well situated to provide education to community members about health, the social determinants of health and the importance of being involved in the political process. Community organizations have an opportunity to promote advocacy and policy work to community members. A Health in All Policies (HiAP) approach to government decision-mak-

ing has taken hold in many cities throughout the country and has the potential to improve health in Chicago in spite of funding challenges.

*Food and Food Systems:* A lack of healthy food access remains an issue for some Chicagoans, particularly in lower income communities, and was a focus of stakeholders. Neighborhoods without adequate access to grocery stores often have numerous fast food chains and corner stores where residents purchase food with little nutritional value. Federal food policies and food marketing contribute to unhealthy food environments. In contrast, an increase in community gardens and urban agriculture in Chicago are positive trends.

> **Family meal advertising doesn't focus on nutrition; it focuses on value.**
>
> **-Community Conversation Participant**

Threat: Obesity and chronic disease are associated with food deserts and a lack of access to healthy foods. School performance may be an issue for children with limited access to healthy foods.

Opportunity: Opportunities exist to extend the SNAP Double Up Bucks program at Chicago farmers markets, in which recipients double their purchasing power at farmers markets. City policies that incentivize small, locally owned grocery stores and the establishment of community gardens in food deserts could increase access to healthy foods.

*Discrimination and Stigma:* Stakeholders discussed how discrimination and stigma shapes their lives. While overt types of prejudice and discrimination have become less frequent, implicit or covert forms of bias are common. Many Chicagoans experience racism; discrimination because of gender, mental illness, disability, age, sexual orientation; and stigma on a regular basis. These social determinants of health are associated with poor outcomes for health and well-being.

Threat: Poorer health outcomes threaten those who experience racism, discrimination and stigma and contribute to health inequity. Stigma and discrimination have been shown to negatively impact health in several ways. First, perceived discrimination produces stress, which is harmful to health. Anticipation of discrimination can lead to long-term activation of stress response. Discrimination can affect resources in such areas as education, employment and housing. Discrimination in the health care setting can result in differential treatment leading to poor health outcomes. Internalized stigma, or self-stigma, is associated with low self-esteem, lack of social support and depressive symptoms.[15]

Opportunity: There is an opportunity to reduce stigma through public education campaigns. As more organizations recognize the importance of equity, they are making this a core component of their organizations' values. This creates an opportunity for a collective impact in addressing these issues for Chicagoans.[16]

> **We need to educate people about mental illness in order to reduce stigma.**
>
> **-Community Conversation Participant**

*Climate and Environment:* Stakeholders brought up concerns about environmental hazards and climate change on the public's health. Air quality is a significant issue. The American Lung Association's State of the Air report gave Metropolitan Chicago a grade of "F" in air cleanliness in its 2015 report. In 2014, the report ranked Chicago as the 14th most polluted city in the U.S. for short-term particle pollution and 20th for most ozone-polluted and year-round particle pollution.[17] Radon, a naturally occurring, odorless, colorless gas can be present at elevated levels in homes and too frequently goes undetected. Lead poisoning occurs disproportionately in the poorest areas of the city and funding for prevention, testing and mitigation has sharply declined in the past five years.[18]

> **The environment is not well-protected or regulated. We must think about the impact on our health.**
>
> **-Community Conversation Participant**

Threat: All of these environmental factors are direct threats to health. A 2013 report assessing climate change in the United States predicts that in coming decades, the Midwest will experience more frequent and severe heat waves and intense rainstorms and floods, while worsening air and water quality will threaten public health.[19] Poor air quality is a particular risk to children and teens, people age 65 and older, persons with asthma, chronic bronchitis or emphysema, people with cardiovascular disease or diabetes and people with low incomes.[17] Over time exposure to elevated levels of radon gas can cause lung cancer. Elevated levels of lead in children can harm mental and physical development.

Opportunity: Chicago's Climate Action Plan has five priority areas: energy efficient buildings, clean and renewable energy, improved transportation options, reduced waste and industrial pollution and adaptation. The plan provides numerous opportunities for residents and businesses to help to reduce greenhouse gas emissions and will also improve air quality.[20] Multi-sector strategies to create healthy housing (i.e., healthy homes programming or policies that incentivize building owners to address unhealthy homes) can protect the health of Chicago's residents.

*Data and Technology:* Data and technology are a substantial force in public health today, influencing all areas of the field. Trends in open data make health-related information more widely available to the general public. Health apps now track personal fitness and well-being, as clinical tools and for health research. The use of big data—large, complex and diverse data sets—to address public health needs is a new trend that is rapidly evolving. Social media has become a widely used

tool for connecting to the public. While little research has analyzed its efficacy in health messaging, social media has considerable reach and the potential to engage large audiences.

> **There's a lack of a unified or consistent medical documentation system to share information across healthcare providers, facilities and payers.**
>
> **-Community Conversation Participant**

Threat: Ethical challenges in technology must be addressed. The right to privacy, transparency and trust and the need to provide for the common good are central themes in the age of big data. Differential access to technology brings the threat of increasing health inequalities, with some communities left behind.

Opportunity: There is an opportunity to foster networks and systems to increase the use of reliable and secure platforms and mobile apps and to implement a universal electronic health record system. Open data provides a way to empower residents with data to improve their health and the health of the community. Big data provides public health with numerous opportunities for research and innovation. The use of real-time data in public health has the potential to improve public health despite limited resources. Research on the reach, efficacy and cost effectiveness of social media campaigns, including research on targeting vulnerable populations and needed levels of engagement, has the potential to improve public health outcomes.

*Older Adults:* While national trends show an increase in the population of older adults, the population of Chicago seniors has been stable. For Chicago to maintain our population of older adults, however, Chicago must ensure access to needed services and supports. These include health care services, accessible housing, age-appropriate and intergenerational recreational opportunities, transportation and other supports.

Threat: Without services and supports that enhance quality of life, the health and quality of life of Chicago's seniors may be at serious risk. This is especially concerning for seniors living in poverty, alone and in marginalized communities with little resources. Other seniors may relocate to more age-friendly areas, limiting diversity in our communities.

Opportunity: Chicago is part of the World Health Organization's (WHO) Global Network of Age-Friendly Cities, a network of cities striving to better meet the needs of residents of all ages by creating inclusive and accessible urban environments. Findings from the Age-Friendly Chicago community-wide assessment provide recommendations for improvement in numerous areas, including safe, accessible streets and conditions for walking, cycling proficiency, affordable housing and access to information about health resources and community assets to support aging in place. There is an opportunity to use the Village model to provide services and supports to seniors aging in place.[21]

*Cultural and Linguistic Competence:* While the root causes of health disparities are multi-faceted and complex, one of the evidence-based approaches to addressing them is culturally effective care. Stakeholders voiced that cultural competence and the ability to provide effective services to all populations is important not only for health care and public health workers, but for all engaged in social and human services, legal and criminal justices systems and the educational system. Culturally and linguistically effective health care requires an understanding of how sociocultural differences may affect many elements of patient wellness and illness and are important in guiding clinical interactions and decisions. Ability to navigate the health care system, health literacy, symptom presentation and values and preferences will be different for different patients. Providers must be attuned to diverse patient needs and their own biases in order to communicate effectively with patients, provide patient-centered care and make appropriate clinical decisions. In a diverse city like Chicago, culturally effective care and services are essential.

> **If information is not available in non-English languages, people will not get health care.**
>
> **-Community Conversation Participant**

Threat: When health care is not culturally and linguistically effective, unsatisfactory care and poor health outcomes may result. Similarly, consumers of other types of services, when not culturally appropriate, may not receive the highest quality services, satisfying services or the best outcomes.

Opportunity: Community health workers and patient navigators can play a central role in assuring a culturally and linguistically effective health care system. All service providers should continually develop skills that follow the principles of patient-centered care. Quality improvement interventions that are designed to improve services for everyone but with attention to diverse patient groups may be beneficial to organizations.

Community Health Assessment:

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## PHASE 3D: *LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT*

<u>Purpose</u>: The Local Public Health System Assessment's purpose is to analyze the capacities of the local public health system (LPHS) to conduct the Ten Essential Public Health Services (EPHS). Through the LPHSA, CDPH obtained information on the system's components, activities, competencies and capacities. This assessment also obtained data on how Chicago's local public health system scored on health equity measures and gathered data on the quality and comprehensiveness of the system's performance of these essential services. These findings on the functioning of the local public health system, along with the findings from the other three assessments, informed the development of strategic issues and ultimately the efforts of the Healthy Chicago 2.0 Health Improvement Plan.
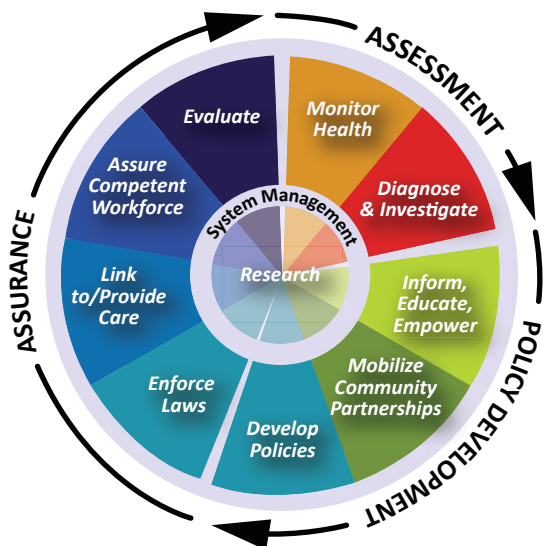


<u>Process</u>: To conduct the LPHSA, almost 90 people (Partnership members, Chicago Department of Public Health staff and other representatives of Chicago's public health system) participated in a day-long meeting on February 24, 2015. This process used the National Public Health Performance Standards Program (NPHPSP) Local Public Health System Performance Assessment Instrument (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) and is a standard for national Public Health Accreditation. The Instrument divides each essential service into three to five model standards, each of which contain several performance measures to be scored. Scoring was done by consensus and included the following categories: no activity (0%), minimal activity (1-25%), moderate activity (26-50%), significant activity (51-75%) and optimal activity (76-100%). The groups also scored the performance of the system on health equity through one health equity question per essential service, as developed in the MAPP Health Equity Supplement (Appendix 3).

Participants attended one of five groups, based on their expertise. Each group discussed two of the Ten Essential Public Health Services:

- Group 1: Essential Service # 1 and 2
- Group 2: Essential Service # 3 and 4
- Group 3: Essential Service # 5 and 6
- Group 4: Essential Service # 7 and 9
- Group 5: Essential Service # 8 and 10

In addition to the scores for each measure, the groups identified strengths, weaknesses and short-term and long-term opportunities for each of the essential services. The compiled findings are at the end of this section.

CDPH had assistance to conduct this assessment from the Illinois Public Health Institute (IPHI), who trained the group facilitators and note takers prior to the assessment. At the assessment, IPHI presented the process to the participants, supported the group facilitators and note takers and led the report back session at the end of the day. CDPH also had help from University of Illinois School of Public Health students, who took notes in each of the groups.

<u>Findings</u>:

**Essential Service 1:** *Monitor Health Status to Identify Community Health Problems*

In Essential Service 1, participants explored the extent to which the LPHS monitors health status to identify community health problems through community health assessment, technology to manage and communicate health data and the maintenance of population health registries. Overall, they scored this service as MODERATE. Participants identified several resources and an abundance of available data but emphasized a need to collaborate more and to develop systems to improve data dissemination to LPHS partners and community members. Data are collected for community health assessments on the status of Chicago residents. The health department conducts these assessments every five years for accreditation and local health department State certification. With the passage of the Affordable Care Act, non-profit hospitals are now required to complete an assessment every three years. Participants encouraged health departments and hospitals to work more collaboratively and make data more accessible for other stakeholders.

### *EPHS 1:* Monitor health status

Community Health Assessment:
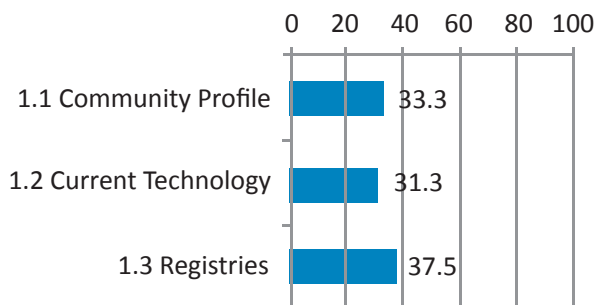
Participants shared that technology improved access to data and named specific websites where population health data are available (e.g., iquery.illinois.gov and Chicago Health Atlas). However, they highlighted a need for more continuously updated resources and application of advanced technology.

Another source of data is registries; however, most participants noted difficulty in both identifying specific registries and how to access them.

**Essential Service 2:** *Diagnose and Investigate Health Problems and Health Hazards*

Participants discussed existing surveillance systems within the local public health system to share information and understand emerging health problems and threats and were able to describe t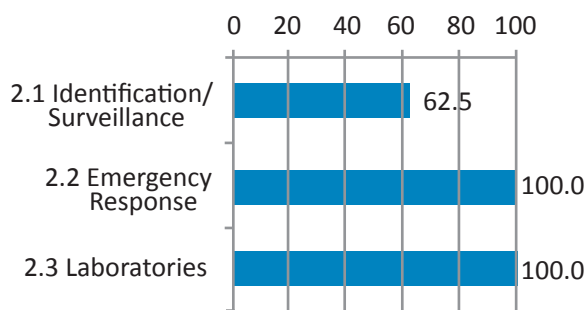he existing systems and their strengths and limitations. With the especially strong level of emergency preparedness planning and laboratory collaboration and support, participants scored this service as OPTIMAL.

## EPHS 2: *Diagnose and investigate*



Participants discussed Illinois' National Electronic Disease Surveillance System (I-NEDSS), a secure web-based system that collects and transmits surveillance data on reportable health conditions between the local, state and federal levels. Other surveillance systems exist for specialized purposes/diseases; however, they are fragmented and not as well coordinated. Surveillance systems outside of the health department, such as at Chicago Public Schools, are not fully integrated into the rest of the LPHS. This measure still scored relatively high, in the significant range, but lower than the other measures.

Group participants lauded the local public health system's efforts on both investigating and responding to public health threats and emergencies and laboratory support for investigation of health threats. Participants identified the extensive coordination and planning efforts that have taken place over the past decade. CDPH maintains its own plans with the other partners. Emergency preparedness drills and exercises are coordinated with hospitals and other partners through the Chicago Healthcare System Coalition for Preparedness and Response.

CDPH does not have its own public health laboratory, so laboratory support for investigation of health threats provides a good example where coordination within the public health system is essential. CDPH works closely with the IDPH laboratory and other health system labs to ensure 24/7 laboratory support.

Group participants identified opportunities to improve system capacity, including ensuring consistent and adequate funding for laboratory activities. Other suggestions included improving the technology used for reporting, staffing capacity and resources to expand what laboratory tests can be performed.

**Essential Service 3:** *Inform, Educate and Empower People about Health Issues*

Participants explored the performance of the local public health system in informing, educating and empowering people and communities about health issues and gave an overall rating of MODERATE. Participants acknowledged that a wide variety of education and engagement activities are taking place and reaching a broad array of community members on a variety of topics, including emergency preparedness planning processes. Participants also noted that health equity is a focus of this work. However, most agencies involved in these efforts work in silos. Better coordination would gain more sustained media attention to health issues and would move more residents beyond being informed to being engaged in efforts to address health concerns. Health education campaigns need to be conducted using a stronger evidence base for all media/outreach platforms, while evaluations of these campaigns should be done to inform future efforts.

## EPHS 3: *Educate/Empower*
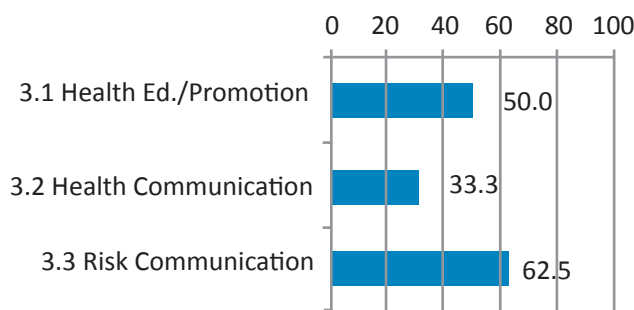


Participants discussed Health Communication through the various media and voiced frustration at having to compete for the attention of earned media as the media outlets continue to cut staff and primarily focus on the stories that earn the highest ratings, e.g., violence in Chicago communities. Without strong, specific and coordinated communication plans, attention to health issues is diluted. Coverage is especially important because agencies believe the media spotlight helps them have greater visibility with potential funders. Discussions about opportunities for improvement included increasing information sharing among partners,

holding formal training and working regularly with the media for sustained attention on health issues to counteract poor health messages in popular culture.

Many participants who were from agencies connected to and aware of the public health department's and local hospitals' emergency communication plans saw risk communication as strong. However, participants acknowledged that the system does not reach the community equally with risk messages, leaving some sectors at a disadvantage.

**Essential Service 4:** *Mobilize Community Partnerships to Identify and Solve Health Problems*

Participants explored the LPHS's performance in engaging the community in local health issues through partnerships and scored it at a MODERATE level. Discussion highlighted the existence of many committed community coalitions and their impact on community health. Many coalitions now work on upstream issues of health to make longer-term impacts and much of this work is lauded. At the same time, participants want to make sure coalitions do not abandon their focus on prevention and managing specific health conditions. Despite innovative efforts occurring with Chicago's coalitions, participants identified several areas that should be improved, including strengthening coordination among coalitions (both within same, contiguous, or similar communities) and mobilizing and securing consistent resources.

Many coalitions aim to involve multi-sector partners and community members to improve community health. Group participants shared successes with engaging some system partners; however, community residents have not been very involved and have only minimal awareness of these efforts, especially with larger, citywide coalitions. Participants thought this might improve because of the ACA requirement for non-profit hospitals to conduct community health needs assessments. These hospitals will most likely engage broader audiences in this work, which will generate more awareness and create cross-sectional initiatives to address the social determinants of health.

## EPHS 4: *Mobilize partnerships*
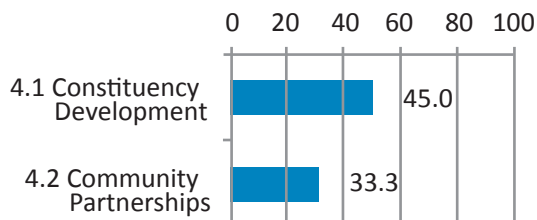


The participants explored how effectively and broadly constituents are encouraged to participate in improving community health. In sum, the participants found that additional work can be done in order to recruit more dynamic, diverse groups and community members at large to actively participate in the LPHS.

To evaluate community partnerships in Chicago, participants reviewed existing efforts that maximize public health improvement activities. They determined that there are many, but that they often operate on more localized or issue-specific levels (i.e., there is not a prominent broad-based committee) and are not very coordinated, while those that do exist are not very accessible to community members at large.

**Essential Service 5:** *Develop Policies and Plans that Support Individual and Community Health Efforts*

Participants in the Essential Service 5 group discussed public health system policy development and planning efforts that support individual and community health efforts and scored this service as SIGNIFICANT. They commented that collaborative policy development in the past several years has grown, especially around issues of tobacco cessation/prevention and obesity prevention work. As a result, significant gains have been made with regulation of e-cigarettes and restrictions on the sale of flavored (including menthol) cigarettes. However, participants did mention that often it is the "squeaky wheel" that gets attention, while other less visible public health policy issues haven't received the policy focus they deserve. Participants also acknowledged that progress and collaboration of policy development is often related to funding.

When discussing community health improvement planning, participants spoke highly of the Healthy Chicago 2.0 process, especially for its inclusivity, community engagement and focus on health equity. Although previous planning efforts did involve many diverse partners, communication did not reach the community and other stakeholders, so many of the participants were not knowledgeable about those efforts. To address these issues, participants proposed a concerted effort should be made to formalize communication of community health improvement planning efforts.

## EPHS 5: *Develop policies/plans*
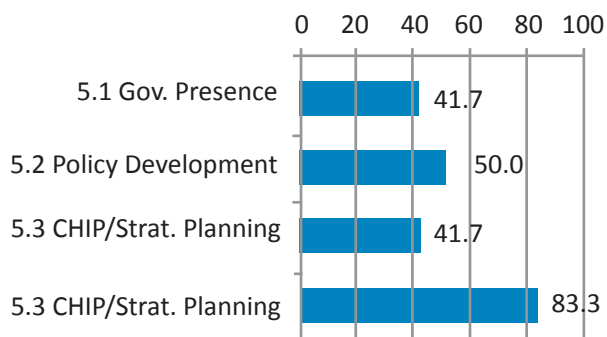


Emergency preparedness planning work scored the highest of all the measures in Essential Service 5, at OPTIMAL, with its level of comprehensive planning among strong system partnerships in place, especially the local hospitals. This high level of functioning has been recognized by the Centers for Disease Control and Prevention, with Chicago's work often being used as an example for national audiences.

Community Health Assessment:

Participants noted that the performance in this essential service increased since CDPH received National Public Health Accreditation in 2013 and was awarded the 2014 NACCHO Local Health Department of the Year Award.

**Essential Service 6:** *Enforce Laws and Regulations that Protect Health and Ensure Safety*

Governmental agencies are primarily responsible for Essential Service 6, as it addresses the enforcement of public health-related laws and regulations. In Chicago, CDPH is the main agency responsible for this work, along with other City Departments, including the Chicago Police Department, the Department of Buildings and the Department of Streets and Sanitation. Sister agencies are also involved with setting and enforcing laws, notably: Chicago Public Schools, Chicago Park District and the Chicago Housing Authority. Other partners in the public health system are intricately involved in this work by collaborating with these agencies in the development of laws and also helping to educate the community. Group participants scored this essential service as SIGNIFICANT.

## EPHS 6: *Enforce laws*

| | |
|---|---|
| 6.1 Review Laws | 43.8 |
| 6.2 Improve Laws | 66.7 |
| 6.3 Enforce Laws | 55.5 |
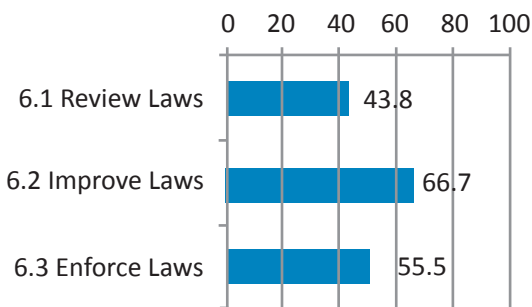
All aspects of this essential service, including the review, improvement and enforcement of laws and regulations, complement and build on one another. However, the measure focused on review of laws scored lower. CDPH staff acknowledged that with limited resources, efforts are allocated to improving and enforcing current laws and that staff mostly focus on reviewing a law only when a problem arises.

Local and national organizations have formally recognized the work Chicago is doing to improve and strengthen its tobacco control law. CDPH has consulted with many local health departments to share our approach as a national standard, which includes collaboration among many system partners and creating venues for community feedback. Many public health system partners work to educate communities about the impact of proposed laws.

Enforcement of public health laws occurs over many departments. Inspectors receive extensive training to enforce laws in their specialty area. In the course of investigating possible violations, inspectors often come upon other violations outside of their program area and are empowered to refer the program to the appropriate Department for follow up.

For example, after their inspection in response to a complaint, CDPH environmental inspectors refer concerns of excessively loud noises to the Chicago Police Department (based on the Chicago Environmental Noise Control Ordinance of the Municipal Code). Enforcement of public health laws also is the responsibility of the community and group participants discussed increasing resident involvement by encouraging 311 reporting of infractions or other illegal activity harmful to the public's health.

Participants, both from City Departments and other system partners, acknowledged that performance in this essential service is impacted because of insufficient funding for trained staff. This limits not only enforcement of current laws, but regular reviews of laws and fully comprehensive work to improve laws.

**Essential Service 7:** *Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable*

Participants in Essential Service 7 discussed the LPHS performance in connecting community members to the health services and gave this essential service an overall score of MODERATE. The participants were in general agreement that Chicago is moderately aware of populations who are falling though the gaps and need further assistance. While participants reported that basic services to primary care are fairly good, they noted that some populations still lack access to primary care services. Although the Affordable Care Act (ACA) has been a positive step in linking people to care, many people have not enrolled and find the system difficult to navigate.

Group participants stated that the LPHS does well in identifying marginalized populations (e.g., homeless, disabled and people with mental health problems). Participants reported that the community health assessment helps to inform service providers about the needs of community members, but they also highlighted the need for a system that will allow providers to share information through a systematic data exchange portal to help providers refer their clients to available community services.

## EPHS 7: *Link to health services*

| | |
|---|---|
| 7.1 Pers Hlth Svc Needs | 43.8 |
| 7.2 Assure Linkage | 31.3 |
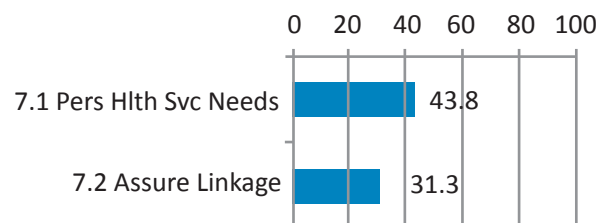
Participants scored the system's performance in assuring linkages to care as moderate and identified several areas where linkages to care fell short, including specialty care, dental care and mental health services. Participants described that strong

efforts are being made on the part of many service providers to link marginalized individuals to available resources; however, large gaps in services still remain for these populations. Most agencies neglect to follow up after referral, with no assurance that linkages resulted in service provision. While some agencies work well together to provide health services, many agencies are still working in silos. Coordination and collaboration to best meet the needs of community is an area for additional improvement. One specific area of improvement is the coordination and dissemination of information about services among providers so they can track availability of services across the city to appropri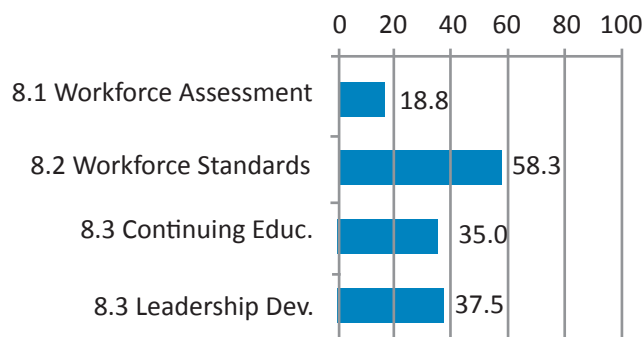ately refer and partner with other agencies. Improving the provision of culturally competent services to subpopulations within the community was another area of improvement.

**Essential Service 8:** *Assure a Competent Public Health and Personal Healthcare Workforce*

Essential Service 8 identifies activities that are undertaken within individual agencies and performed collaboratively as part of workforce development. Overall, the group scored this service as MODERATE**.**

## EPHS 8: *Assure a competent workforce*

| | |
|---|---|
| 8.1 Workforce Assessment | 18.8 |
| 8.2 Workforce Standards | 58.3 |
| 8.3 Continuing Educ. | 35.0 |
| 8.3 Leadership Dev. | 37.5 |

(scale: 0 20 40 60 80 100)

Participants scored the system's current activity on workforce assessment the lowest of all measures in this essential service. The group mentioned organizations that may be doing assessments, but they focus on individual professional titles/licenses and do not assess the whole system. Work is completed in silos and lacks a universal standard of culturally competent workforce.

Participants identified that several types of organizations within the public health system have set standards for their workforce (e.g., Federally Qualified Health Centers), which led to this measure being scored the highest within this essential service. New hires have detailed job descriptions, but these descriptions are not based on specific standards and often are not fully connected to the agency's mission. The group discussed certification for several professional titles and shared that the rigorous process can be a significant obstacle to pursuing further qualifications. Illinois is in the process of assessing certification for Community Health Workers (CHWs); however, not all parties are convinced this is the best move for CHWs.

The group identified several agencies and organizations that provide continuing education, training and professional development opportunities. Providers are required to obtain continuing education credit units (CEUs) and therefore courses are abundant, but due to the work responsibilities and the number of CEUs needed, timely completion for CHWs can be a struggle. On the other hand, public health department staff, who do not have this requirement, struggle to find relevant training courses. Nonetheless, participants emphasized that all public health system staff need better comprehensive training in health equity and disparities.

Participants acknowledged the organizations that offer leadership development programs that include both academia and practice-based focus. However, it is not clear that all staff members are familiar with these opportunities, or whether their agencies even allow participation. The group felt leadership opportunities needed to be both more diverse and to engage all sectors and levels of the public health workforce. Just as significant was the opinion that leadership development should also focus on community members and skill building.

**Essential Service 9:** *Evaluate Effectiveness, Accessibility and Quality of Personal and Population-Based Health Services*

Overall performance for Essential Service 9 was scored as MODERATE. Participants discussed how the LPHS evaluates the effectiveness of personal and population-based services. Participants reported that individually, agencies do well in evaluating their services, particularly for personal health services. However, participants stated that the lack of data sharing is a major challenge to improving system quality.

## EPHS 9: *Evaluate services*

| | |
|---|---|
| 9.1 Eval of Pop Health | 31.3 |
| 9.2 Eval of Pers Health | 40.0 |
| 9.3 Eval of LPHS | 43.8 |

(scale: 0 20 40 60 80 100)
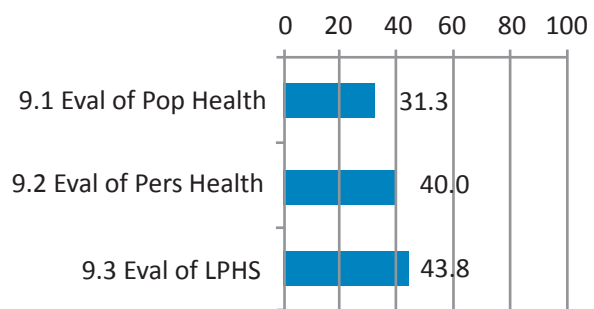
Participants discussed evaluation of population-based services, including the use of community feedback and gaps in service provision. Due to its less rigorous data and the lack of coordinated effort of evaluation of population-based services, participants scored the performance of population-based service lowest of the essential service measures. However, participants noted that HP 2020 established benchmarks, goals and objectives and assists the local public health system agencies to evaluate public health efforts. They also acknowledged academic institutions as good partners and resources for service evaluation.

Participants generally agreed that partner agencies engage in individual service evaluation to assess community satisfaction with health services. Some community partners are successful at using evaluation findings to improve population-based services. However, this practice needs to be expanded throughout the system.

Participants discussed the level to which health care providers evaluate personal health care services. Participants reported that providers frequently engage in evaluation of the accessibility, quality and effectiveness of health care and also of patient satisfaction. Participants indicated that client data from these evaluations is used to inform service, resources and program improvements. Furthermore participants acknowledge that the electronic health record system (EHR) has been an effective tool for capturing and disseminating information in an organized and efficient manner. However, one specific challenge to the EHR is the cost of the system and the lack of uniform utilization across all providers.

Participants discussed the LPHS performance in evaluating its own effectiveness as a system, reporting that overall the LPHS is moving in the right direction. The Healthy Chicago 2.0 process is key to further evaluation of the system. While there are still organizations missing, the system is engaging more and more diverse sectors and developing a formal and systematic evaluation of local public health system capacity.

**Essential Service 10:** *Research for New Insights and Innovative Solutions to Health Problems*

Participants discussed how Chicago's public health system is advancing public health practice through research and innovation. The conversation focused on collaboration among institutions of higher learning and research centers and on internal data analysis and research. Stakeholders rated Chicago an overall score of MODERATE. While the innovation and current research is somewhat limited, participants were enthusiastic about opportunities for improvement.

Though some innovation is currently ongoing, organizations have no capacity to fully integrate innovative practices into their work. Time, skill development and funding are required to facilitate greater participation and foster more public health innovation.

## EPHS 10: *Research/Innovations*

| | |
|---|---|
| 10.1 Foster Innovation | 40.0 |
| 10.2 Academic Linkages | 41.7 |
| 10.3 Research Capacity | 31.3 |
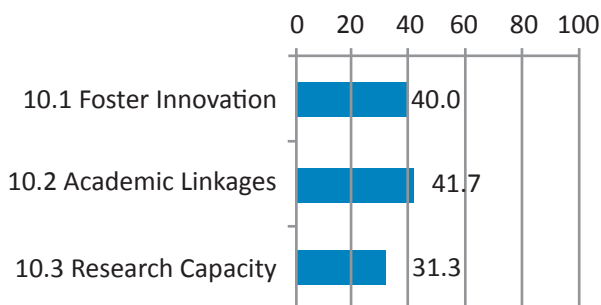
Many academic linkages exist to conduct research in Chicago, including efforts around clinical translational research that helps move research into practice. Several universities work together through the Chicago Consortium for Community Engagement (C3). C3 fosters community-based participatory research and assists with dissemination of findings into the broader community. Academia is also connected to the local public health system and to organizations and universities through student internships. However, participants said that interaction between faculty and the local public health system is infrequent. The creation of an academic health department is one opportunity to bridge these partners.

While some data are available to organizations through the community health assessment and the City data portal, overall, the research capacity of the local public health system is limited. As a result, this measure received the lowest score of all the measures in this essential service. Most organizations don't have access to libraries, journal databases, or data analysis software. Participants reported a lack of systemic data sharing and said that legal agreements are a barrier. In addition, evaluation of research was almost non-existent.

Participants shared ideas on how to improve research capacity. Reciprocal learning opportunities or co-sponsoring events would foster improved linkages between academia and other organizations. Conducting social network analysis of connections between the local public health system and their areas of work could facilitate collaboration. Universities could provide access to research findings and databases. Stakeholders desired practical and action-oriented research and said that this should be encouraged. The development of a shared research agenda with a health equity focus would not only encourage such research but could increase health equity, foster collaboration and improve system efficiency.

**Figure 85:** *Chicago local public health system functioning to assure health equity*



Legend:
- Health Equity Average
- Monitor SES conditions, practices and policies that generate SES conditions
- Resources to collect inequity data and investigate SDoH inequities
- Inform decision makers, stakeholders, public about inequities and impact of decision-making on marginalized communities
- Provide means for CBOs and community participate in decision making
- Ensure CBOs and community have role in deciding policies that govern community health efforts
- Identify issues that have disproportionate impact on marginalized communities
- Work to influence laws, policies and practices that maintain inequitable distribution of resources
- Recruit/train multidisciplinary staff who are committed to health equity
- Monitor delievery of public health services to ensure equitable distribution

Bar values: 32.5, 25, 50, 25, 25, 50, 50, 25, 25, 25, 25

*Chicago Local Public Health System Functioning to Assure Health Equity*

Based on the MAPP Health Equity Supplement guidance, each group scored the public health system on how well it incorporated health equity into its essential service functions. The combined score showed Chicago functioning at a MODERATE level. (Figure 85)

One of the health equity measures addressed whether the public health system monitors social and economic conditions, which participants scored as minimal. However, the group scored the available resources to collect data and investigate social determinant inequities as moderate. This difference suggests opportunities within the system to do a more comprehensive job of monitoring inequities. Another measure asked group participants to score the system on how well it engages the community and community-based organizations in public health policy work. Participants cited the recent work on tobacco prevention and cessation and scored this health equity measure as moderate. Group participants scored the system's performance on identifying issues with disproportionate impact on marginalized communities as moderate but discussed how implementation was usually performed at a lower level of activity.

The remaining health equity questions received a minimal activity score. This indicates that the system needs to work collaboratively to direct specific efforts to understanding these measures and institutionalizing them throughout the whole public health system.

*Strengths, Weaknesses and Opportunities*

Participants in each group discussed the strengths and weaknesses of Chicago's public health system, which were compiled into seven categories. Participants built off of these qualities to identify both short-term and long-term opportunities to improve effectiveness and efficiency of the system.

- Community Partnerships/Collaboration/Engagement
- Data and Technology
- Communication
- Health Equity
- Workforce and Training
- Evaluation, Evidence-based Interventions and Research
- Funding and Resources

## Community Partnerships/Collaboration/Engagement

• *Strengths:* Progress is being made in engaging diverse organizations in more public health collaborations, which helps to ensure planning efforts consider a broad range of perspectives and solutions. More universities and community development organizations are joining this work. Hospitals and public health departments are forming collaboratives to conduct community health needs assessments and implement priorities. Community residents expressed interest in being more involved in this work.

• *Weaknesses:* Although the public health system seeks to engage community residents, these attempts have not always been successful. This is especially true in relation to decision making and planning efforts. Most partners and organizations that participate in coalitions are usually the same few people, which reduces the diversity in the approach. Most public health work is done in silos and is not coordinated, even within an agency.

• *Opportunities:* All organizations involved in collaborative work need to engage with broad partners as an integral component of their work. This can be done in the short-term by building off current efforts and soliciting involvement from even more sectors. Organizations can also support the work of current diverse partnerships to strengthen their reach and impact on the community. Longer-term opportunities include incentivizing government agencies to improve their collective impact, with more collaboration among City departments and with more City-County-State efforts. The system also needs to consistently outreach to communities on public health issues. One way to achieve this goal is to establish and use standards for community involvement across the public health system.

## Data and Technology

• *Strengths:* System partners are developing new and innovative methods to collect and share data. Health technology is advancing through mobile apps and ideas that reach out to the consumer, which make this an exciting area for growth. More data are being collected measuring community health status, individual health and social determinants of health. Electronic Health Records (EHR) will have many uses to help providers and the public health system access and understand health status.

• *Weaknesses:* Although data are being collected, timely dissemination continues to be a major obstruction for the system. Many people do not know how to access the wide range of data and lack of data infrastructure perpetuates this problem. Regarding technology, EHRs are expensive and prohibitive for smaller practices at present. Older providers are less comfortable with technology, limiting their ability to access these tools to help improve patient care.

• *Opportunities:* With so much interest in data and data websites, this is an ideal time to work collaboratively with system partners to build a system to address the needs of

a broad spectrum of data consumers. At the same time, organizations need to develop and/or update data sharing agreements. Longer-term opportunities exist to obtain more and better data by developing a chronic disease surveillance system. Lastly, the Healthy Chicago Telephone Survey could also assist with data needs by expanding its questionnaire to include questions on adverse childhood experiences (ACE) to allow the public health system to monitor these exposures and develop effective interventions.

## Communication

• *Strengths:* Most partners communicate public health messages to their clients and constituents. Advocacy groups actively communicate with policy and decision makers to propose policy suggestions to improve public health and to document consequences of pieces of legislation.

• *Weaknesses:* No comprehensive service and resource guide exists for Chicago, reducing the effectiveness of our communication with consumers in need of services. Communication about the regulatory and enforcement roles and responsibilities of the different City Departments is also not clear to many people, including public health stakeholders.

• *Opportunities:* Opportunities to improve communication involve use of technology and a focus on end users. Social media can be used in the short term to educate and inform specific populations and recruit them to get more involved in public health efforts. Longer term, CDPH's Health Alert Network (HAN), an electronic messaging system to inform providers and other users about public health alerts, could be designed to also reach community and stakeholders with public health information. Participants spoke about the need for a comprehensive resource guide for health and human services in Chicago. In the short term, agencies could work with current resources such as Purple Binder and Now Pow websites that provide information on services, including health care, child care, job training and affordable housing. A long-term opportunity to build and sustain a resource and referral service is to expand 311 for City services to support referrals to health and human services offered by non-City agencies. Opportunities exist to collaborate with United Way and the Illinois Alliance of Information and Referral Systems on this work.

## Health Equity

• *Strengths:* The public health system is now broadly accepting the importance of health equity as an essential value of public health. Participants in the assessment process applauded the visible role health equity is taking in the Healthy Chicago 2.0 work. Policies are now prioritizing health equity, with a focus on legal strategies that address issues of marginalized populations.

• *Weaknesses:* Many people and organizations do not fully understand the implications of a focus on health equity may

have on their operations. Efforts need to educate the public health system to show how everyone will benefit when health equity is achieved.

• *Opportunities:* Short term, partners are engaging with Healthy Chicago 2.0 planning efforts and keeping the focus on health equity. Long term, partners recognize opportunities to call upon funders to support health equity by funding grants that address root causes and social determinants of health, rather than categories of health programming.

Workforce and Training

• *Strengths:* Group participants across the essential service areas highlighted the need for ongoing workforce training and mentioned several organizations that provide some training. Public health leadership training is available for the public health workforce through the MidAmerica Center for Public Health Practice at University of Illinois at Chicago (UIC). The Center also houses the Institute for Faith and Public Health Leadership, which brings faith and public health leaders together to learn how to collaborate and integrate community health and engagement approaches addressing health equity. UIC also trains public health staff through its Great Lakes Centers for Occupational and Environmental Safety and Health.

• *Weaknesses:* Public health system workforce shortages limit the effectiveness of the system. Most notable are healthcare provider shortages, including primary care, oral health and mental health. Funding for health department workforce is decreasing, limiting the programs and services offered. In addition to the workforce capacity, participants mentioned lack of consistent trainings as a problem. The workforce needs training to improve patient/client interaction (e.g., cultural competence) and efficient use of computers and technology.

• *Opportunities:* Participants saw an opportunity to work with the training centers and to expand their training series. Short term, training centers may be able to add more classes/sessions to their schedules. Long term, the system needs to work together to assess training needs across the public health workforce and identify funding to develop new classes to meet these needs. Participants also suggested educating providers and students in the health profession about challenges their patient populations have in accessing care so they can provide more effective care.

Evaluation, Evidence-based Interventions and Research

• *Strengths:* Public health departments and other system partners are adopting performance management and quality improvement standards to improve the effectiveness of their work. C3 encourages research among local universities and the community through community-based participatory research (CBPR).

• *Weaknesses:* Public health program effectiveness is deterred when it is not based on data and with limited to no robust evaluation. Other public health efforts, such as coalitions, are not being measured or assessed.

• *Opportunities:* Through the City of Chicago Data Portal and the Chicago Health Atlas, more data are now accessible for public health stakeholders. Short-term opportunities exist to publicize these data sites and encourage their use in programming and evaluation. As these data sites continue to expand with more social determinants of health and asset data, the system will be able to engage broader sectors of the public health system. More long-term opportunities to improve the effectiveness of interventions and evaluation will emerge as more system partners fully implement performance and quality improvement efforts. Chicago's research community can develop an agenda to prioritize public health issues that would benefit from research efforts. A more comprehensive approach needs to be developed to disseminate research findings across the whole public health system.

Funding and Resources

• *Strengths:* Although public health workforce capacity is not ideal, many agencies have local and national partners or other pro bono resources that help fill the gaps. This resourcefulness is a major strength of the system, as is the camaraderie among organizations serving similar populations. Some of the areas where assistance is available include technical assistance on specific public health issues, policy and technical writing. New partners to the public health system are the civic technologists and data scientists who volunteer their skills to develop user-friendly public health technology, including smartphone/tablet apps such as FoodborneCHI that finds and replies to tweets on food poisoning with information about filing a report with CDPH.

• *Weaknesses:* Funding and resource gaps impact operational efforts of the public health system. Without stable and adequate funding, the workforce is not sufficient to fully address the ten essential public health services. Programs may be discontinued or limited in scope. Without resources, innovation, especially with surveillance systems, may be stymied. Limited resources may encourage competition among system partners, not collaboration.

• *Opportunities:* Short term, opportunities exist to strengthen partnerships among public health partners to share in-kind resources and to develop grant proposals that engage multiple partners. The system can also reach out to national organizations with specific focus for assistance with special data or innovative practices. Longer term opportunities include coming together to advocate for a larger budget for public health efforts and funding to support coalition building.

## PHASE 4: IDENTIFY STRATEGIC ISSUES AND ACTION AREAS

Purpose: With quantitative and qualitative data collected from the four assessments, the Healthy Chicago 2.0 planning effort moved into the next phase of the MAPP process—identifying strategic issues and action areas. The purpose of this work is to identify overarching strategic issues the public health system needs to address to move toward the Healthy Chicago 2.0 vision and prioritize those issues into action areas. The next phase develops goals, objectives and strategies for these action areas.

Process: As in all phases of the plan, it is extremely important to engage broad public health stakeholders when developing strategic issues. To do this, CDPH held many meetings to share the assessment findings and obtained individuals' thoughts about overarching themes. The first session was held on April 13, 2015 at the Partnership for Healthy Chicago meeting. CDPH staff reviewed the findings from each of the assessments and Partnership members brainstormed strategic issues that emerged from at least two of the assessments and needed to be addressed to accomplish the Healthy Chicago 2.0 vision. CDPH then held Community Conversations with community members, public health stakeholders and CDPH staff in the following communities: at Lower West (Blue 1647), Austin (Austin Town Hall) and Englewood (Hamilton Park) on April 14, 15 and 17, respectively. Participants at these meetings proposed additional strategic issues and then voted for their top priorities through the use of five stickers, which they could divide up in any manner, e.g., five votes for one strategic issue, one vote for five strategic issues, etc.

Sixteen categories of strategic issues emerged from these meetings:

- Improve community safety (gun violence, traffic crashes, falls)

- Improve access to and seamless continuum of health care and social supports for all

- Move people and communities to action to improve community health through advocacy, leadership and community involvement

- Further engage and align the broad spectrum of public health system partners to inform funding, programming and collaboration that reduces inequities

- Drive economic development to ensure good paying jobs for marginalized populations and communities

- Reduce chronic disease disparities

- Improve the mental health system

- Strengthen data accessibility, collection efforts and dissemination for the public health system

- Employ innovative communication strategies that are informed and developed by and for marginalized populations to reduce inequities and improve health

- Improve community health by building on strengths and assets of communities and building community capacity

- Ensure the decision makers/government, funders and leadership understand and act to reduce inequities

- Increase access to affordable and safe housing

- Advocate for equitable educational policies and funding to ensure quality education (Pre-K through Post-secondary)

- Develop a collaborative city-wide public health research agenda

- Improve maternal, infant, child and adolescent health

- Work to prepare, protect the public's health and prevent spread of infectious diseases

To prioritize these issues for the plan, CDPH surveyed Partnership members and all 550 CDPH staff to rank the issues based on their importance. Through this process, ten priority action areas emerged (listed alphabetically)*:

1. Access to Health Care and Human Services
2. Behavioral Health
3. Chronic Disease Prevention and Control
4. Community Development
5. Data and Research
6. Education
7. Maternal, Infant, Child and Adolescent Health
8. Partnerships and Community Engagement
9. Prepare, Protect and Prevent Disease
10. Violence and Injury Prevention

*The names of the action areas in the Healthy Chicago 2.0 Community Health Improvement Plan are slightly different, as a result of the discussions in the action teams that developed the goals, objectives and strategies.

Findings:

*Vision:* The ten priority action areas forward achievement of the Healthy Chicago 2.0 vision, "a city with strong communities and collaborative stakeholders, where all residents enjoy equitable access to resources, opportunities and environments that maximize their health and well-being." This includes action areas that promote equitable access to care resources (Access to Health Care and Human Services; Behavioral Health; Chronic Disease Prevention and Control and Maternal, Infant, Child and Adolescent Health) and other resources/opportunities that promote advancement and improved quality of life (Education, Community Development).

The vision calls for collaborative stakeholders, which is the focus of the Partnership and Community Engagement action area. The other nine action areas also acknowledge that collaboration/engagement is a key component of health equity efforts.

The vision states that "all residents" will have equitable access and opportunities to be healthy. To ensure that everyone has access, priority action areas focus on high priority populations (e.g., Maternal, Infant, Child and Adolescent Health) and marginalized communities.

The priority area of Data and Research is crucial to the Healthy Chicago 2.0 vision, as maximizing health and ensuring access and opportunities could not be achieved without collection and analysis of health and social determinant data. Research, especially community-based participatory research, helps identify more evidence-based and evidence-informed practices to move toward health equity. Therefore, data and research are intrinsic to the vision.

*MAPP Assessments:* All action areas were supported by at least three of the four MAPP assessments. Data sources are cited in the assessment chapters. The following section outlines the relevance of each of the ten priority areas with supporting evidence from the MAPP assessments.

**Action Area #1: Access to Health Care and Human Services**

*Community Themes and Strengths Assessment:* Participants in the community conversations lauded the Affordable Care Act (ACA) and Medicaid expansion as important system components that focus on increasing access to care and improving the health of the community. People mentioned health care resources, such as Federally Qualified Health Centers and School-Based Health Centers, as essential community institutions that focus on community-based care and increase access to care. Participants and survey respondents indicated a need for more safety net services to better reach populations and communities with limited access and worse health outcomes. Survey respondents in high hardship communities indicated difficulty accessing health services in their community; only 50% agreed with the state-

ment: "Health services I use are easy to get to from my neighborhood" compared to 86% in low hardship communities. People also were concerned about accessing social service programs and other social supports and programs to help keep them healthy. Discussions also suggested more workforce training to better serve marginalized populations.

*Forces of Change Assessment:* Community conversation participants consistently mentioned that ACA regulations are key forces impacting the health of Chicagoans. These changes were primarily noted as opportunities to get more people access to health insurance and comprehensive coverage. However, people had concerns that the system is solely focused on the newly insured while segments of the population (e.g., immigrants) are not eligible for any of these insurance programs. Medicaid expansion and Medicaid Managed Care requirements also offer some opportunities for more people to have access to care; however, group participants noted that the complexity of these programs, coupled with changing rules and regulations, may deter seeking care.

*Local Public Health System Assessment:* Functioning related to access to care is addressed in two of the Ten Public Health Essential Services. Group participants scored the public health system functioning of Essential Service: #7—Link people to needed personal health services and assure the provision of health care when otherwise unavailable—at a moderate level. Linking people to services is one of the most common activities of community-based organizations and many do a great job. However, the public health system does not have one comprehensive and definitive home for resources. Therefore, organizations often create their own, which requires time and effort and is duplicative. Organizations do not have the capacity to always follow up to assure the client accessed the service and received the care they needed, especially when people need oral health care and behavioral health services.

A competent workforce improves access to care by providing evidence-based, culturally-effective care. On this Essential Service measure, #8—Assure a Competent Public Health and Personal Healthcare Workforce, Chicago's public health system scored as functioning at a moderate level. Improvements in workforce training, assessment and leadership development will improve the competency of providers, staff and public health workers.

*Community Health Status Assessment:* Data strongly support the importance of a focus on access to care. The 2013 uninsured rates show stark differences among community areas and Chicago's 2013 uninsured rate is much higher than the National baseline (19.7% compared to 13.4%). Although the ACA increased the percentage of people with health insurance coverage, rates of the uninsured in Chicago are still expected to be high because of the large foreign-born population, many of which are not eligible for

ACA or Medicaid coverage. Preventable hospitalizations (i.e., inpatient stays that could potentially have been avoided with the delivery of high quality outpatient treatment and disease management) have decreased steadily since 2000. However, rates are higher for non-Hispanic blacks and strongly correlate to high hardship community areas. Avoidable emergency department visits increased between 2009 and 2011, with the highest rate of increase for non-Hispanic blacks.

*Healthy People 2020:* Access to care is one of the main topic areas of Healthy People 2020 (HP 2020) and is recognized as important to achieving health equity and improving quality of life. HP 2020 focuses the access areas on: coverage levels, available services, timeliness of services and workforce. By improving these components, marginalized populations will obtain health care that is designed more for their needs and structured to be more user-friendly.

**Action Area #2: Behavioral Health**

*Community Themes and Strengths:* Focus group and community conversation participants expressed their concerns about limited access to mental health services in Chicago, which they felt were exacerbated by the 2012 consolidation of 12 City-operated mental health clinics. Mental health problems, especially coping with persistent stress many experience in their daily lives, resonated as participants discussed other issues (e.g., violence and police mistrust, economic uncertainty, lack of affordable housing and difficulty accessing health care and social supports).

*Forces of Change Assessment:* The ACA not only increased the number of people who can obtain health insurance, but it also institutionalized mental health and behavioral health benefits. Illinois' Medicaid health reform efforts require that Medicaid Managed Care Organizations, which cover the majority of Chicago's Medicaid clients, have an adequate behavioral health network capacity. These provisions to improve access, however, do not sufficiently cover the behavioral health needs of Chicago residents; some important services for these populations are not covered by Medicaid and advocates are not convinced plans have sufficient capacity to serve all residents in need. State funding for safety net behavioral health services has been cut, severely impacting community agencies' ability to serve under-insured populations and those ineligible for Marketplace or Medicaid plans. Increased morbidity and mortality is an ongoing threat of a system that cannot provide adequate coverage to populations in need. Opportunities to improve the behavioral health system exist by building on the efforts of the ACA patient navigators and community organizations to help people access care and understand their coverage.

*Local Public Health System Assessment:* An important public health component of the behavioral health system is addressed in ES#7: Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable. Networks of behavioral health providers, including CDPH, provide care for both uninsured and insured clients. Medical providers, FQHCs and community-based organizations refer patients to community behavioral health centers. However, this network lacks sufficient capacity to serve all clients and the referral system is not robust enough to assure coverage of all clients' needs. As a result, this essential service scored performing at only a moderate level.

*Community Health Status Assessment:* Substance-related disorders, mood disorders and schizophrenic disorders were the second, third and fourth most common diagnoses of hospital discharges in 2011 (not including birth and delivery). Rates for non-Hispanic blacks were significantly higher than other race/ethnic populations for all these diagnoses. The average number of days adults reported that their mental health; including stress, depression and problems with emotions; was not good in the past 30 days decreased from 9.7 in 2002 to 3.1 days in 2013. More than 9% of Chicagoans reported 14 or more mentally unhealthy days, defined as frequent mental distress. The percentage of students in 2013 who reported they felt so sad or hopeless almost every day for two weeks remained about the same as 2001, at 33% and 34%, respectively. Females and LGB/unsure youth had higher rates, at 41% and 55%, respectively.

*Healthy People 2020:* National data estimate 13 million American adults have a severe mental illness, substantiating its position as one of the most common causes of disability. Substance abuse disorders impact 22 million people, with most being unaware of their problem and its impacts on their health and quality of life. HP 2020 set up objectives to improve access to services for these conditions, with a focus on access to prevention efforts and services to reduce risks for both adolescents and adults.

**Action Area #3: Chronic Disease Prevention and Control**

*Community Themes and Strengths:* Both the in-person discussions and survey questions obtained feedback on access to resources that impact chronic disease, including healthy foods and opportunities to get physical activity. Across all hardship quartiles, survey respondents identified access to healthy foods as a priority to make Chicago healthier, second only to issues of safety. All communities ranked healthy food access as either the first or second priority in making their own neighborhood healthier. Suggestions include sponsoring more farmers markets in low food access areas and providing double value coupons for SNAP recipients through LINK card benefits. People identified that access to opportunities for physical activity, such as walking and biking, varied among communities. The Divvy bike sharing program was lauded for encouraging bi-

cycling; however, people criticized the lack of stations on the south side of Chicago. People also shared that the infrastructure (e.g., poor lighting, pot holes and crumbling roads) interfered with safe bicycling and walking on the south and west sides of Chicago. Participants widely supported bringing the Complete Streets model to all neighborhoods as an intervention that would help increase activity levels. Focus group participants thought that more people would use local parks and be physically active if these locations could be made safer.

*Forces of Change Assessment:* Many stakeholders had concerns about the ongoing lack of healthy food in many low-income Chicago neighborhoods. Access to farmers markets and community gardens is growing; however, federal food policies do not fully support efforts to improve healthy eating. Without improvement in access to healthy foods, obesity rates and incidence of chronic diseases will likely increase and management of chronic diseases will be more difficult and require more medical attention. Efforts to increase access include the double value LINK benefits at farmers markets and encouraging local stores to carry healthy foods.

*Local Public Health System Assessment:* The public health system work on chronic disease connects to the majority of essential public health services. Through datasets, registries and state and local surveys, the system monitors chronic disease incidence and prevalence and behaviors that impact chronic disease (ES#1). Many organizations within the system focus on chronic disease prevention and management and collaborate in an effort to mobilize the community (ES#4) and inform and empower residents on how to decrease their risk of chronic disease (ES#3). These collaborations include the City of Chicago Interdepartmental Task Force on Childhood Obesity and ongoing work with the Consortium to Lower Obesity in Chicago Children (CLOCC) and the Respiratory Health Association (RHA). In addition to mobilizing the community, the public health system has been successful in its work on tobacco control by developing policies (ES#5) and enforcing laws and regulations (ES#6). New City ordinances are now in place to reduce the sale of flavored cigarettes (Chicago Mun. Code § 4-64-180b) and impose restrictions on the sale of e-cigarettes (Regulation passed by Chicago Board of Health pursuant to authority in § 2-112-100). In part because of the innovative policy and enforcement efforts for tobacco use prevention and control, system members scored these two essential services as being performed at the significant level.

*Community Health Status Assessment:* Chronic diseases make up six of the ten leading causes of mortality, accounting for 64% of all deaths in Chicago in 2011. Chronic disease mortality rates for non-Hispanic blacks are higher than rates for non-Hispanic whites: 20% higher for heart disease, 30% higher for cancer, 70% higher for stroke and 80% higher for diabetes. Chronic disease conditions also comprised five of the top ten causes for hospitalization (excluding pregnancy and childbirth). Obesity in Chicago adults is steadily increasing, from 21% in 2001 to almost 29%

in 2014. Women have higher percentages of obesity than men (32% compared to 25%) and non-Hispanic blacks have higher rates than Hispanics and non-Hispanic whites, at 38%, 32% and 24%, respectively. Obesity is almost twice as prevalent in high hardship communities (37.3%) as in low hardship communities (21.0%).

Consistent with high rates of chronic diseases, data also show limited improvement in the behaviors that impact chronic disease. The current smoking rate for adults is 18.4%, which is less than the rate in 2001 (24.3%). However, disparities exist, with higher rates seen in men (21.8%), non-Hispanic blacks (25.3%) and high hardship communities (25.4%). Percentages of adults who reported they did not exercise in the past month stayed the same as in the previous year, at 18.3% in 2014, with higher rates for Hispanic/Latinos (20.3%), non-Hispanic blacks (22.4%) and adults living in high hardship communities (25.4%). The percentage of Chicago adults eating five or more servings of fruits and vegetables a day increased between 2001 (23.3%) and 2014 (29.2%), with disparities for Hispanic/Latinos (23.6%), non-Hispanic blacks (18.9%) and high hardship communities (19.5%).

*Healthy People 2020:* HP 2020 objectives focus on many health behaviors and conditions that impact chronic disease, including tobacco use, heart disease and stroke and nutrition and weight status. The objectives and interventions include focus on policies, systems and environmental changes to decrease risk of these conditions.

**Action Area #4: Community Development (Economic Development and Housing)**

*Community Themes and Strengths:* Focus group and community conversation participants voiced strong concerns about the lack of affordable and healthy housing, childcare and other necessities and how the lack of these necessities impact health and quality of life. People complained that low-wage jobs did not allow families to afford decent housing and healthy food and several participants shared the stress they feel when they are not able to take care of their families. Survey responses documented the differences of affordability by hardship community—88% of the respondents who live in the low hardship quartile communities agreed with the statement "I have enough money to pay for my and my family's basic needs" compared to 66% of respondents in the high hardship quartile communities.

*Forces of Change Assessment:* Housing affordability is a concern for Chicago residents, with about 50% of renters experiencing housing cost burden (i.e., spending more than 30% of their income on rent). Populations in need (e.g., youth, veterans, domestic violence survivors and persons returning to the community following incarceration) would benefit from comprehensive interventions to address the root causes of homelessness. When people are in an unstable housing situation, their health is at risk due to unsafe housing and stress that affects one's mental health and ability to function. Without enough money to cover basic needs,

families do not have funds to cover healthier foods and to live in safer neighborhoods. Policies to increase affordable housing in Chicago passed in March 2015 through an amendment to the Affordable Requirements Ordinance (Chicago Mun. Code § 2-45-110). More amendments can be proposed to strengthen affordable housing policies. Another opportunity is to support and strengthen Chicago's Minimum Wage Ordinance (Chicago Mun. Code §§ 2-25-050, 2-92-320, 2-92-610, 4-4-320, 1-24) (Am. Legal 2015), which begins July 2015 and requires minimum wage jobs to pay $13/hour by 2019.

*Local Public Health System Assessment:* Economic equity and housing issues are addressed through ES#6, especially in regard to enforcing laws on exposure to lead and other housing-based hazards and the ordinances promoting minimum wage and affordable housing. ES#6 was scored at a significant level. In addition, ES#4 focuses on the public health system mobilizing partnerships. Since the public health system has recognized the impact of social determinants of health, more system members are joining efforts with community development partners and recruiting these organizations to participate in joint community health work. This work was scored as being performed at a moderate level.

*Community Health Status Assessment:* The findings from the Economic Hardship Index show that the communities on the west and south sides of Chicago experience poverty, low wages and housing cost burden at higher rates than other areas. The Child Opportunity Index highlights similar areas that have higher rates of housing vacancies, neighborhood foreclosures, poverty, unemployment and families covered by public assistance.

*Healthy People 2020:* HP 2020 introduced the topic of social determinants in this most recent version of the national health objectives, establishing an area of focus for what public health has known for a while—that the conditions in which we live, work, play and worship contribute to health status and health equity. HP 2020 emphasizes the importance of creating social and physical environments that promote good health for all through sectors such as: community development, education, housing, community planning and transportation.

### Action Area #5: Data and Research

*Community Themes and Strengths Assessment:* Participants suggested research, specifically Community-Based Participatory Research (CBPR), as one way to increase community involvement in their health. CBPR is a research approach that emphasizes partnerships between researchers and community members and helps balance scientific and community interests. CBPR could help increase civic engagement if community members feel they have an equal role in making decisions about their community.

*Forces of Change Assessment:* The public health system interest in data is growing rapidly as more data become available through technology (e.g., Electronic Health Records, mobile health apps for smartphones, etc.) and as the understanding of how social determinants and their data influence health equity. Several data initiatives are occurring in Chicago to increase provider/system access to patient-level data and will also allow public health entities to better monitor health conditions. Ongoing concerns with data include privacy infringement, transparency and access to timely data on key health indicators. A new community of coders, who develop programs that code open data and develop apps for public use, see opportunities to improve access to data. With access to more data, researchers will be able to conduct more studies on public health concerns, including interventions in marginalized communities.

*Local Public Health System Assessment:* The public health system collects data to monitor health status and identify community health problems (ES#1). This function is a fundamental component of public health departments. Along with surveillance data, CDPH is now conducting a telephone survey to better understand health behaviors at the community area level. Data are available on several different websites, making it confusing for less experienced users to access and understand the significance of the findings. Data are also an important part of collaboration and mobilizing community partnerships to address health system or health conditions (ES#4). CDPH will often bring data to the partnership to help identify priority populations for whom interventions should be focused. Data also help to evaluate impact of community interventions.

With an increased focus on evidence-based and evidence-informed interventions, public health system members are bringing research to the community (ES#10: Research for New Insights and Innovative Solutions to Health Problems). Several universities in Chicago conduct CBPR, engaging communities throughout the whole process. Clinical translational research helps to disseminate findings to improve the health of the community. These collaborations are growing; however, efforts need to further connect researchers with public health system members, coordinate studies and ensure providers and communities have access to learnings. Development of a shared research agenda would help to improve coordination, reduce duplication and impact health equity.

*Healthy People 2020:* Data and research are integral parts of the mission of HP 2020 as it works to identify measurable objectives and goals for its leading health indicators. An important role that will move this effort forward is through the identification of critical research, evaluation and data collection needs.

### Action Area #6: Education

*Community Themes and Strengths:* Both praise for and concerns with Chicago's schools came out in the focus groups and community conversations. Positive comments revolved around new policies (physical activity, recess), organizational efforts (formation of the Office for Student Health and Wellness) and access to health resources (School-based Health

Centers). Concerns mainly focused on CPS closing 49 schools in 2013 and the negative impact participants felt the closures have had on students and communities, including increased travel time to schools, inequitable closures in minority communities, impact on learning with high class size, etc. Perceptions of educational quality show extreme differences between hardship communities, with 66% of residents in the lowest hardship community agreeing with the statement "Children in my neighborhood have access to high quality education," compared to only 14% in the highest hardship communities.

Strategies to improve the education system focused on increasing funding and resources, including health and social services available through school-based health centers (SBHCs). To meet community needs, participants also wanted more vocational training, more neighborhood schools and revitalization of school buildings.

*Forces of Change Assessment:* The Chicago Public Schools system's bleak financial situation is a constant force that limits resources and programming and, as a result, the equity and quality of education for the students. To balance their budget, CPS closed 49 schools in 2013. This strategy was met by parental and community concerns for their children's education, which is at risk due to low graduation and college preparation rates. Further threats to the ongoing financial problems and CPS' response to them are inequities in achievement for minority and low-income students. Community conversations participants identified opportunities to improve educational status through the implementation of model school improvements and evidence-based programming throughout the District. Suggestions also pointed to changing educational funding strategies to provide a consistent and adequate budget to fully meet student needs.

*Local Public Health System Assessment:* Public education is a key social determinant of health and is associated with most of the essential public health services. Through Essential Service #3—Inform, Educate and Empower People about Health Issues, the public health system helps people understand how to take care of themselves. CPS reaches students of all grade levels with its comprehensive and age-appropriate sexual health education curricula. CPS, through its staff and collaborating organizations, helps students and parents sign up for Medicaid and the Health Insurance Marketplace and also provides direct care (ES#7: Link people to needed personal health services and assure provision of health care when otherwise unavailable). Many public health system partners work with CPS to promulgate policies to improve student health, e.g., banning the sale of flavored tobacco—including menthol—within 500 feet of a school, (ES#5: Develop policies and plans that support individual and community health efforts). Many organizations are interested in collaborating with CPS to access student data and conduct research to better understand this important segment of Chicago's population (ES#10: Research for New Insights and Innovative Solutions to Health Problems).

*Community Health Status Assessment:* Disparities in educational status occur by race/ethnicity, income and geography; with communities on the west and south sides having higher percentages of people without a high school degree. Data were also analyzed through the Educational Opportunity Index, which uses the following variables to demonstrate educational disparities: early childhood education participation, quality and proximity, student poverty rate, reading proficiency rate, math proficiency rate, high school graduation rate and adult educational attainment. As with poverty and many health conditions, communities on the west and south sides, with their lack of high quality educational resources and student achievement, are the areas of concern.

*Healthy People 2020:* HP 2020 acknowledges the many components of education that are needed to improve health. Of primary concern is an education system that focuses on quality, availability and effectiveness. Schools also provide opportunities to improve student health, through school-based and school-linked programs. Through curricula and special programs, schools teach students information and skills to decrease risk-taking behavior; while through policy, schools provide students with healthy environments that support positive health outcomes. HP 2020 also sets objectives to promote pipeline programs to encourage more minority students to choose public health as a career.

### Action Area #7: Maternal, Infant, Child and Adolescent Health

*Community Themes and Strengths:* Focus group participants shared their concerns about the opportunities for adolescents, especially those who may be involved in or impacted by violence. Participants recognized afterschool programs and sports programs as important resources for helping to guide students in more positive directions.

*Forces of Change Assessment:* Community conversations participants discussed several health concerns impacting children and adolescents, including violence and the impact from environmental conditions. To address youth and violence, participants discussed augmenting the work of schools, as they can be safe spaces and also provide locations where children can seek health care and social services. Many schools offer programs in conflict resolution and social skill development. Children also experience health problems from environmental conditions, including air quality and home-based hazards (e.g., tobacco smoke, dust mites, lead-based paint). These conditions exacerbate asthma in children and exposure to lead can harm their physical and behavioral development, including learning abilities.

*Local Public Health System Assessment:* The public health system prioritizes maternal, infant, child and adolescent health throughout all the essential services, as efforts with this population help prevent/reduce chronic health problems. Society and government have responsibilities to protect the health and safety of vulnerable populations. Therefore, most

of the essential public health services include efforts with pregnant women, children and adolescents. For example, monitoring infant mortality, first trimester care and teen births (ES#1: Monitor Healthy Status to Identify Community Health Problems) are universal health care indicators for all health departments and the U.S. Department of Health and Human Services. Other health indicators (i.e., tobacco usage rates in adolescents) prompt legislative, policy and programmatic efforts geared to these populations for the prevention of chronic health problems due to tobacco use (ES #5: Develop Policies and Plans that Support Individual and Community Health Efforts, ES#6: Enforce Laws and Regulations that Protect Health and Ensure Safety). Chicago's public health system provides services to pregnant women, parenting adults and young children (ES#7) through nurse case management, WIC nutrition programs, immunizations, family planning and other well-child services. A good referral system is available across many organizations that work with these populations.

*Community Health Status Assessment:* Chicago's infant mortality rate decreased by 36% between 2000 and 2010; however, the rate is still higher than the national rate. Disparities exist for non-Hispanic blacks, whose infant mortality rate is almost three times higher than non-Hispanic whites. Teen birth rates show similar findings, with a 35% decrease between 2000 and 2010 and higher rates for non-Hispanic black and Hispanic teens and for teens living in high hardship communities. Childhood immunization rates increased slightly from 2000 (61%) to 2013 (64%) but are lower than the US rate (70%) and the HP 2020 goal (80%). The prevalence of obesity in Chicago affects over one-third of school-aged children, shown by the decrease in the percent of children who eat five or more servings of vegetables per day (30% in 2000 to 24% in 2013) and the decrease of physical education activity five days per week (57% to 39%). Adolescents in Chicago also have high rates of sexually transmitted infections and comprise 35% of all chlamydia cases in 2013. Compared to heterosexual adolescents, those who are lesbian, gay, bisexual or unsure (LGBU) are at higher risk for unhealthy behaviors: suicide attempts (11% for LGBU compared to 2% for heterosexual), smoking (19% to 9%), marijuana use (42% to 26%) and binge drinking (25% to 16%).

*Healthy People 2020:* The health and well-being of children and adolescents is a foundational measure of public health; it is an indicator of how a nation and community cares for its most vulnerable populations and these data help to predict resources needed for future generations. HP 2020 sets goals to improve nutrition and growth and development. HP 2020 also addresses social determinants of health by setting goals to reduce inequities of health outcomes and social determinants of health by addressing racial/ethnic, income, educational attainment and other variables.

**Action Area #8:** **Partnerships and Community Engagement**

*Community Themes and Strengths:* Throughout the community conversations, participants discussed the importance of

community engagement. Although participants shared they were glad they decided to attend the meetings and discuss how to improve their community, they expressed their frustration that more residents were not there and do not get involved with neighborhood events. The online survey found that three-fourths of the respondents in each of the four quartiles agreed with the statement "I know and talk to my neighbors." However differences between quartiles came out with the percentage that agreed with "I belong in my neighborhood." Ninety percent of respondents who lived in the low hardship quartile agreed with that statement compared to 63% in the highest hardship quartile. Focus group members knew individuals who looked out for their neighborhood (i.e., "nosey neighbors") and cited them as assets because they know what is going on and were good resources. Focus group members also mentioned faith communities as a way for people to be involved and connected to their neighbors. Suggestions to increase community involvement focused on creating opportunities for residents to get involved with partnerships and to work with local community-based organizations and City agencies to improve quality of life in their community. They also thought campaigns to promote volunteerism could help with social cohesion and connection.

*Local Public Health System Assessment:* Collaboration and engaging partners is one of the ten essential public health services (ES#4: Mobilize Community Partnerships to Identify and Solve Health Problems). The public health system in Chicago has many dedicated partners and many coalitions working on a variety of health conditions and in many different communities. However, these efforts do not often communicate with each other and residents may not know about the work happening in their communities. Efforts need to be intensified to include more diverse groups and community residents. This essential service was scored as performing at a moderate level due to the limitations mentioned above.

*Healthy People 2020:* HP 2020 established these national objectives with a goal of encouraging collaborations to work together to improve the health and quality of life of people both locally and nationally. Although HP 2020 does not have a separate priority area addressing partnerships and community engagement, it is embedded throughout this effort becaused HP 2020 was developed by a "diverse group of individuals and organizations," including subject matter experts and community feedback. In addition, many of the evidence-based strategies HP 2020 promotes are conducted by coalitions.

**Action Area #9:** **Prepare, Protect and Prevent Disease**

*Forces of Change Assessment:* The public's health is impacted by environmental factors both inside and outside one's home. Second-hand smoke and dust can increase asthma attacks in children. Exposure to lead can impair learning and behavior and cause developmental problems, yet funding for public health efforts to address lead poisoning has declined. Air pollution is a problem in Chicago as well. The American Lung

Association in its 2014 report "State of the Air 2014" graded metropolitan Chicago's air quality as "F." This report ranked Chicago as the 14th most polluted city for short-term particle pollution and 20th for the most ozone-polluted and year-round particle polluted city. Opportunities to address these problems are contained in the 2010 Chicago's Climate Action Plan, which works to identify strategies to reduce greenhouse gas emissions. Collaborative efforts among the City, County, universities and other sectors focus on identifying strategies to promote healthy homes policies and programs.

*Local Public Health System Assessment:* Participants in this assessment scored the essential service of diagnosing and investigating health problems and hazards (ES#2) as being performed at an optimal level—the highest ranking given and the highest scoring of the essential services in this assessment. Participants cited the work and collaboration conducted through CDPH's communicable disease, HIV/STI surveillance and treatment and the emergency preparedness offices when scoring. CDPH depends on the state laboratory to get information on possible threats and these efforts are well coordinated. Securing consistent and sufficient funding for these laboratory services and improving technology and staffing would help improve this essential service.

This action area also focuses on educating and empowering people about threats to their health (ES#3), linking people to care and assuring care when otherwise unavailable (ES#7). Much work occurs in these essential services on HIV/STI prevention and treatment. CDPH and a network of partners work to inform and educate high risk populations about HIV/STI and help facilitate healthy sexual behaviors. The public health system also offers testing and treatment for HIV/STI and works to reach partners with expedited testing and treatment.

*Community Health Status Assessment:* Annual HIV diagnoses varied widely from 1990 to 2013, with a high in 2001 (1,857 cases) and a low in 2011 (1,015 cases). In 2013, 1,090 people were diagnosed with HIV. AIDS diagnoses peaked in 1993 (1,914 cases) and declined to a low in 2013 (536). New infections are occurring in non-Hispanic black men who have sex with men (MSM) (35% of new cases), non-Hispanic white MSM (20%), Hispanic MSM (16%) and non-Hispanic black women (12%). Those under 30 years of age represent 41% of new infections.

Rates of chlamydia and primary and secondary syphilis increased between 1998 and 2013. Chlamydia increased from 17,000 cases to almost 25,000 cases and syphilis increased from 338 to 623. Gonorrhea cases decreased from 14,000 to 8,400. However, as with chlamydia, adolescents and young adults (13 to 24 years old) represent the majority of cases: 65% of gonorrhea and 70% of chlamydia cases.

Immunization coverage in Chicago varies, with some 2013 rates meeting the HP 2020 goals: (1) measles, mumps and Rubella; (2) diphtheria, tetanus and pertussis; and (3) pneu-

monia. In contrast, rates for children aged 19 to 35 months receiving the full range of immunization coverage is at 64%, lower than both the national rate (70%) and the HP 2020 goal (80%). Human Papillomavirus (HPV) vaccine coverage rates for 13 to 17-year old females receiving three doses have increased since 2010, from 62% to 71% in 2013.

*Healthy People 2020:* As with previous national health goals, HP 2020 promotes the use of immunization to reduce spread of vaccine-preventable disease through both evidence-based approaches and community engagement. With the expansion of technology, global travel and security concerns, HP 2020's interventions now include innovative advances to aid in surveillance, early detection and rapid response to emerging diseases.

**Action Area #10:** **Violence and Injury Prevention**

*Community Themes and Strengths:* Participants in the community conversations, focus groups and oral histories mentioned safety most frequently as a concern for their health and quality of life. Survey respondents across Hardship Index quartiles also rated safety as the number one concern for Chicago. Perceptions of safety through the online survey illustrated large disparities by Hardship Index quartiles; more than twice the percentage of respondents living in the lowest hardship communities felt safe compared to respondents in the highest hardship areas. Respondents' perceptions of law enforcement show similar disparities for these quartiles. Focus group participants attributed much of their daily stress to the high rate of violence in their communities along with their mistrust of law enforcement. Suggestions for improvements pointed to increasing resources for organizations that work with youth.

*Forces of Change Assessment:* Participants discussed the high rates of violence in many Chicago communities and identified how the stress accompanying the violence threatens an individual's mental and physical health. With fear of violence, people often decrease their outside physical activity and limit travel, which often limits access to healthier foods. Opportunities to address the high rates of violence center on schools and their role in providing a safe, nurturing environment for children and youth. Schools can help students access both health and social services and can teach conflict resolution. People also identified the need for improved communication with law enforcement to build trust, improve cultural competence and collaborate on programs to address community safety.

*Local Public Health System Assessment:* The public health system has a role in reducing and preventing violence and this work is embedded in many of the Essential Public Health Services. The Chicago Police Department enforces laws that protect public health and safety (ES#6). CDPH works with many other stakeholders to mobilize community partnerships to address issues of violence (ES#4) and to inform, educate and empower communities on violence prevention (ES#3).

New programs are being developed to (1) train the health care and criminal justice workforce how to engage individuals with mental health problems in an effort to reduce criminal justice system involvement and (2) assist children and others exposed to violence or other adverse experiences to improve health and reduce recidivism (ES #8). More efforts are needed with this population, including improving the linkages of the formerly incarcerated.

*Community Health Status Assessment:* Violent crime has decreased citywide since 2001; however, inequities exist with rates of violent crime being strongly correlated with Hardship Index. Maps of non-fatal shootings show clusters in high hardship community areas.

*Healthy People 2020:* With injuries being a leading cause of death and disability, HP 2020 prioritizes work to comprehensively reduce these occurrences. Objectives look at many components, including individual behaviors, the physical environment, access to services and the social environment.

## PHASE 5: FORMULATE GOALS, OBJECTIVES AND STRATEGIES

Purpose: This phase moves the plan further toward implementation, as it converts the ten priority areas into actionable efforts, with concrete goals and objectives. Diverse work teams developed multiple strategies, to be implemented by community partners, through which the objectives will be met. Because it was inclusive of public health stakeholders, this phase strengthened community engagement and buy-in for Healthy Chicago 2.0. It also helped to ensure efficacy of the plan through a focus on evidence-based/evidence-informed, community-driven strategies.

Process: To conduct this phase of the plan, CDPH undertook a comprehensive process that engaged, trained and supported the work of stakeholders and community members. Many people were already involved in Healthy Chicago 2.0 through the community conversations, held as part of the Community Themes and Strengths Assessment, the Forces of Change Assessment and the meetings held to identify overarching strategic issues. For this phase of the plan, however, CDPH wanted even more community breadth and depth to ensure our goals and strategies reflect the most effective interventions to address health equity. To solicit broader participation in this phase, CDPH developed and release an online form for people to volunteer their time.

The form opened up on April 15, 2015 through a City of Chicago online survey tool and CDPH publicized it through many communication channels, including CDPH's Healthy Chicago Monthly Update listserv, CDPH's Facebook page, CDPH's Twitter feed and other programmatic contact lists. CDPH also sent this notice to its partners, including the Partnership for Healthy Chicago, to disseminate through their networks. By the time the application closed on April 27, 2015, over 200 people had submitted their forms to volunteer on a work group.

CDPH staff reviewed the applications and, based on criteria, such as diversity, expertise and community engagement, identified 150 applicants to join one of the ten Healthy Chicago 2.0 work groups. The work groups were co-chaired by a CDPH staff member and a community liaison, identified through their application forms or personal discussions with experts in the field. Once the work groups began, members invited additional people to join this effort to augment the knowledge base of the group.

CDPH trained its work group co-chairs and members to allow all groups to approach their work in a similar manner and with a similar understanding of their roles and responsibilities. On April 29, 2015, the Illinois Public Health Institute (IPHI) trained the CDPH and community co-chairs on group facilitation skills. IPHI also trained 75 work group members on how to write effective goals, objectives and strategies at a four-hour training on May 6, 2015 at the Chicago Public Library—Legler at 115 S. Pulaski Road, Chicago.

Facilitated by the co-chairs, each work group met an additional five to seven times between May and August 2015. At these meetings, members first developed broad goals and then more specific objectives through which to measure progress. These objectives reference data from many sources, including the Healthy Chicago Survey. Members then created strategies, with a focus on health equity and marginalized communities/populations. Work groups suggested both community organizations and governmental agencies to lead these strategies.

From August through November 2015, CDPH and the work group co-chairs prioritized the most essential elements of the ten action areas, resulting in a focused approach to improve health equity through specific goals, objectives and strategies.

Findings: The Healthy Chicago 2.0 Plan presents the goals, objectives and strategies developed by the work groups.

Next Steps: CDPH will reconvene action area work groups to develop detailed work plans for the strategies. These groups will assess their membership and invite new partners who may lead or be involved with specific strategies. CDPH and the re-formed work groups will oversee these efforts and report annually on their progress with the strategies and objectives.

Community Health Assessment:

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## HOSTS FOR COMMUNITY CONVERSATIONS AND FOCUS GROUPS

Access Living

Alumni Association of the Cook County Sheriff's Day Reporting Center

Bethel New Life

Blue 1647

Apostolic Faith Church

Catholic Charities Family Shelter

Center on Halsted

Chicago Park District-Austin Town Hall

Chicago Park District-Hamilton Park Cultural Center

Dr. Martin Luther King, Jr. City of Chicago Service Center

Metropolitan Tenants Organization

New Moms, Inc.

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# APPENDICES

## APPENDIX 1: COMMUNITY HEALTH ASSETS

Purpose: Chicago's public health infrastructure consists of a wide variety of assets that positively impact the community's health. This section provides information on several of the key assets to better understand available resources that can be mobilized to improve health.

Process: Chicago's public health system assets were categorized into 10 areas.

| Community Support | Culture | Education | Employment | Health Care System |
|---|---|---|---|---|
| Charitable Organizations | Theaters | Head Start Programs | Business Associations | Hospitals |
| Faith-Based Organizations | Museums | Daycare facilities | Small Businesses | FQHCs |
| Immigrant Communities | Film/TV Industry | Chicago Public Schools | Chambers of Commerce | Safety Net System |
| Formal & Informal Support Groups | Festivals | Religious Schools | Technology Incubators | Mental Health Clinics |
| Shelters & Drop In Centers | Media Outlets | After School Programs | Banks | Urgent Care Centers |
| Neighborhood Associations | Musicians & Artists | Local School Councils | Tourism Industry | School-based Health Centers |
| Foundations | Outdoor exhibits | Vocational Schools | Financial Services Industry | Private Medical & Dental Practices |
| | | Community College System | One Summer Chicago | Pharmacies |
| | | Colleges & Universities | Business Districts | Home Health |
| | | Public Library | Anchor institutions | Public Health Department |

| Healthy Food | Housing | Physical Activity | Public Safety | Transportation |
|---|---|---|---|---|
| Community Gardens | Affordable Housing | Neighborhood Events/Races | Community Advocacy Groups | Divvy Bike Share |
| Farmers Markets | Assisted Living Facilities | The 606-Bloomingdale Trail | Safe Passage Routes | Bike lanes & trails |
| Community Grocers | Charitable Organizations | Fitness Centers | CAPS Community Policing Program | Complete Streets |
| Food Banks/Pantries | Green building services | Recreation Centers | Juvenile Courts | CTA-El and buses |
| Restaurants | Historic Preservation Organizations | Public Pools | Cook County Jail | Metra |
| Food Trucks | Homeownership Program | Parks & Playgrounds | Chicago Police Department | Highways and surface roads |
| WIC Program & | Outdoor exhibits | Vocational Schools | Financial Services Industry | Private Medical & Dental Practices |
| SNAP Benefits | Housing Choice Voucher | Bike Trails | Chicago Fire Department | Waterways—lake and river |
| School Lunch Programs | | Running Paths | Summer Camps | Airports |

Information was collected for several of these assets. Maps illustrate geographic coverage, with further demographic overlays to assist with understanding implications of assets.

Findings:

*Education*

Chicago Public Schools (CPS) is Chicago's public education provider, with a total of 660 schools serving 396,683 students in grade pre-kindergarten through 12th grade. In addition to education in all subject areas, CPS partners with other City and community resources to provide a range of extracurricular options to support student development. These programs include resources for early childhood education (such as Head Start) and career development through the After School Matters program.

Although all Chicago children are eligible for enrollment into CPS schools, access to high performing schools (i.e., Level 1 Plus) are limited. As the map shows, Level 1 Plus schools are not spread evenly throughout the community areas: 27.9% in high hardship areas compared to 31.7% in medium and 40.4% in low hardship areas. Improving the quality of schools in high hardship communities would improve equity and strengthen academic performance of children living in these areas.

Chicago is home to many types of institutions of higher education, including two-year colleges, four-year colleges, universities and professional training programs. The majority of these resources are privately-owned and operated, except for the seven campuses of the City Colleges of Chicago system, the University of Illinois at Chicago and Chicago State University. World-renowned universities are located in Chicago, including Northwestern University and University of Chicago with national and international student bodies. Many others focus on specific training programs, including health care (Rush University, Alder School of Professional Psychology) and law (Kent Law School, Loyola University School of Law). Chicago also is home to a leading arts school—the School of the Art Institute. These institutions, especially the public ones, provide opportunities for Chicago residents to obtain education and training in many fields. The public health system benefits by having students with varied interests and backgrounds as interns and as a connection to forward research and innovation. The students also benefit by learning about public health, with a focus on health equity.



*Data Sources: U.S. Census Bureau, American Community Survey, 2009-2013*
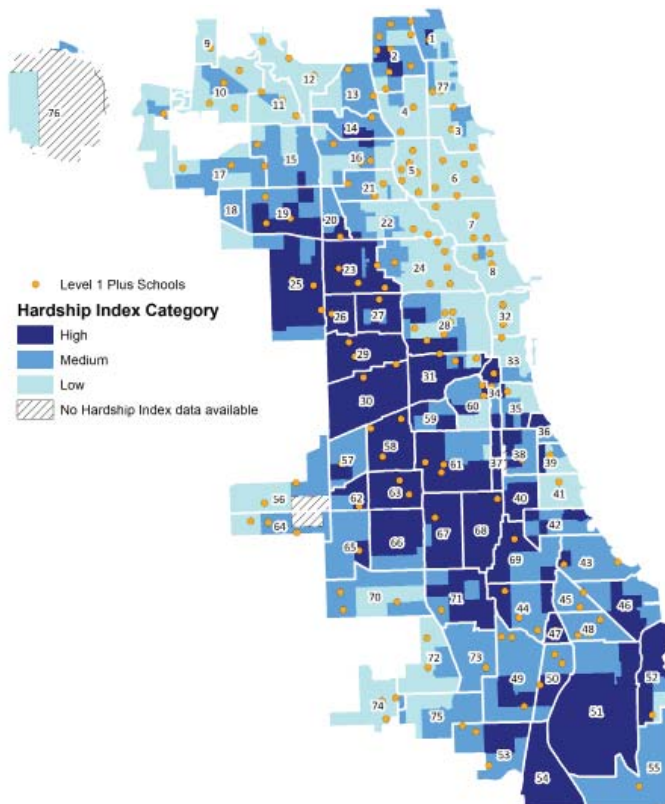


*Data Sources: U.S. Census Bureau, American Community Survey, 2009-2013; Chicago Public Schools*
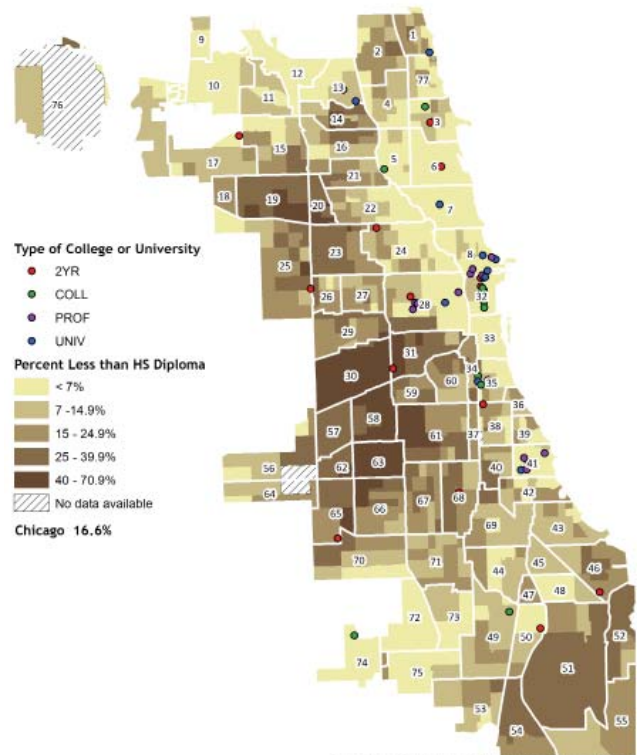
### Public Safety: Safe Passage Routes

For children to grow up with access to opportunities for a healthy and productive life, they need to feel safe at home and in their community. Many organizations, including public, not-for-profit and faith-based, run programs, provide resources and work to reduce violence and promote community safety. One of these programs is the Safe Passage Program that provides adult supervision to improve child safety when walking to and from school. Forty new routes were added for the school year 2014-2015 to accommodate children transferring to new schools after the closure of 49 neighborhood schools. Currently, almost 100 Safe Passage Routes are operating in Chicago, with most of the helping children attend their new schools and in areas of high public violence, i.e., gun-related crimes committed in the public way.
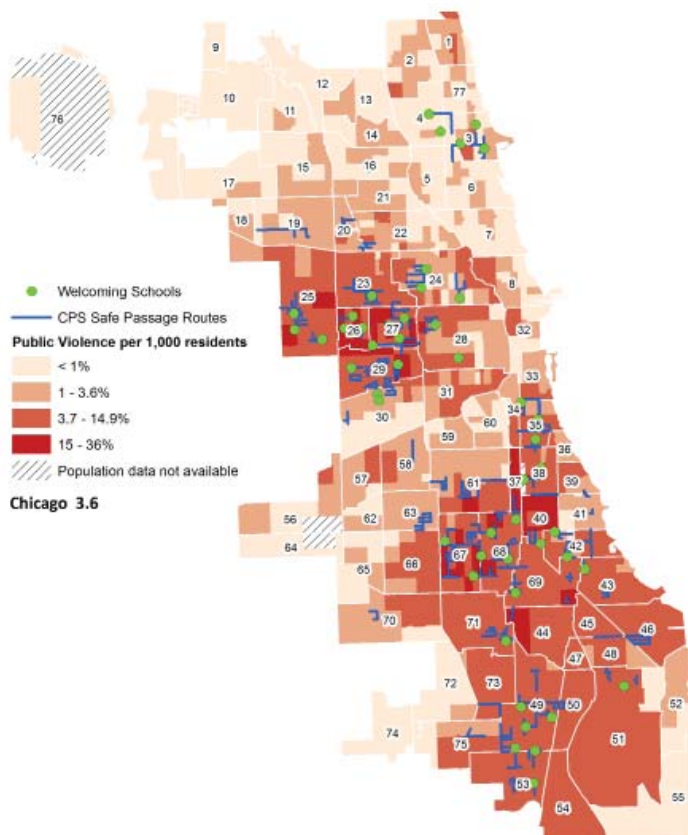


*Data Sources: Chicago Police Department, 2014 Chicago Public Schools*

### Employment: Job Training Programs

When individuals are employed in steady jobs that provide a living wage, they are more able to afford amenities (i.e., healthy food and housing, etc.) that improve their health status and the health of their families. Chicago has resources to help people obtain jobs, including job training programs, transitional job provision and assistance with job placement. The map shows the location of these programs and unemployment rates by census tract. Many of these programs are clustered in the near south side, which is easy to access through public transportation. Other programs are scattered throughout the city, primarily in areas of higher unemploy-

ment. This map, however, shows an unmet need, as many communities with high unemployment do not have easy access to job training programs.
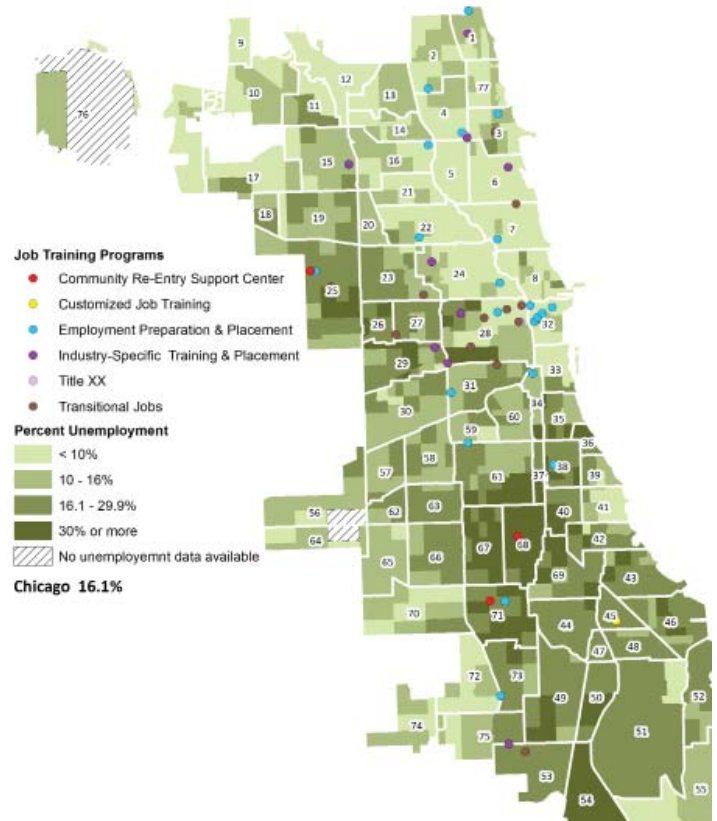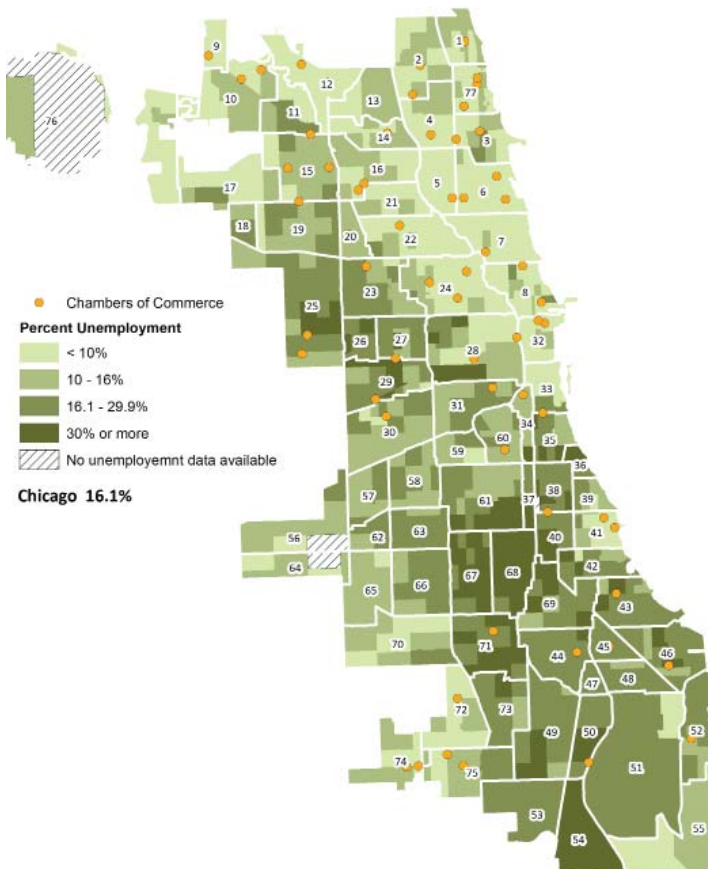


*Data Sources: U.S. Census Bureau, American Community Survey, 2009-2013*

*Employment: Business Resources*

Chicago is home to a strong and dynamic business environment, with growing opportunities for technology innovation and incubators. To promote business development, especially in the communities, the City sponsors local chambers of commerce. These 65 chambers of commerce galvanize business development support and neighborhood-level economic development in nearly all community areas, as evidenced by the map at left. The chambers often play host to the City's Neighborhood Business Development Centers (NBDCs), which are funded by the City and provide dedicated and location-specific small business support. The map notes, however, that certain areas remain underserved, particularly those most affected by rates of unemployment above 30%, on the City's southwest and far south sides.



Chambers of Commerce
Percent Unemployment
< 10%
10 - 16%
16.1 - 29.9%
30% or more
No unemployemnt data available

Chicago 16.1%

*Data Sources: U.S. Census Bureau, American Community Survey, 2009-2013*

*Transportation*

Chicago has an extensive public network of trains and buses that assist individuals and families to travel to work, school and to access resources throughout the City. Chicago is home to two international airports, commuter rail systems and a lakefront that serves boats of all sizes. The transportation network also includes several major highways and miles of surface streets available for cars and freight. A new emphasis is on Complete Streets, to improve safety and usability of street for pedestrians and bicyclists. Currently Chicago has over 225

miles of barrier protected bike lanes, buffer protected bike lanes and conventional bike lanes, marked shared lanes and neighborhood bike routes and is continuing to grow.

In 2013, Chicago inaugurated the DIVVY bike share program, which currently offers 4,760 bikes for rent at 476 stations. DIVVY stations are spread throughout the city, however are most heavily focused in the areas with low levels of hardship. As the Divvy stations expand into lower hardship communities, Divvy recently started a program allowing for those who qualify financially to obtain an annual low-cost membership. This benefit, along with the expansion of Divvy stations will offer more choices for transportation and exercise for communities in need.
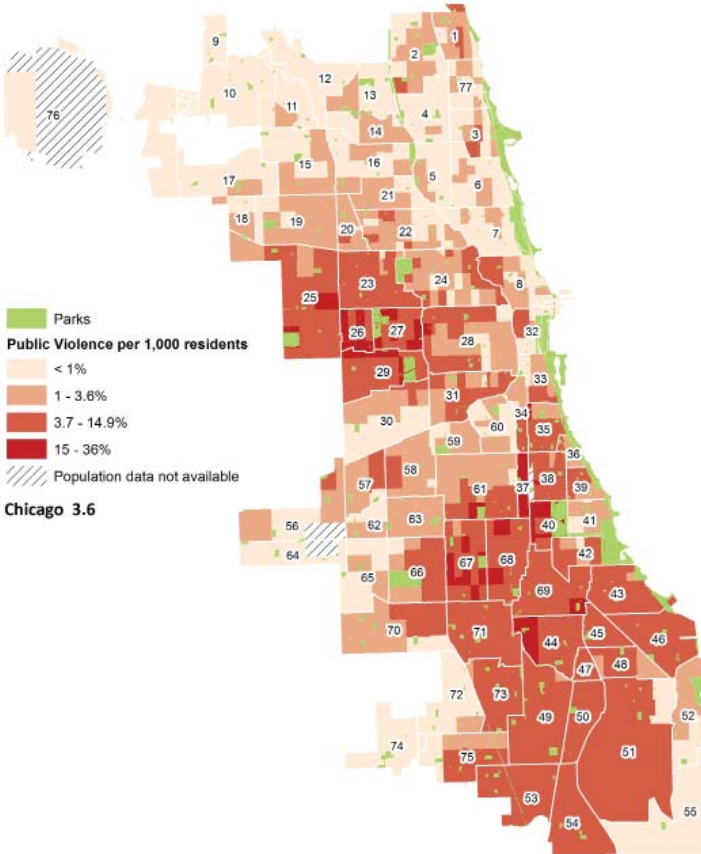


DIVVY stations
Bike Routes
Hardship Index Category
High
Medium
Low
No Hardship Index data available
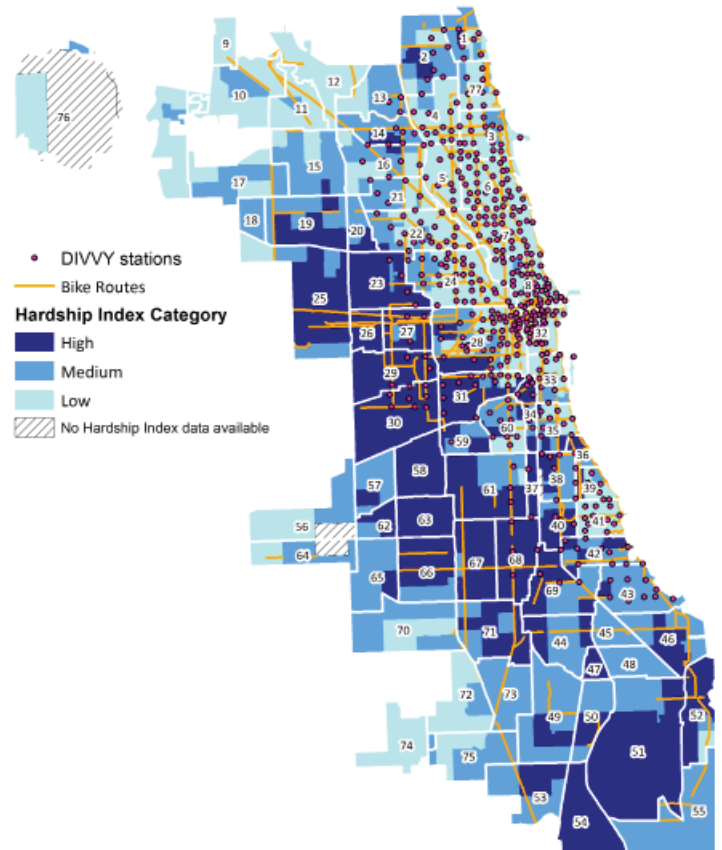
*Data Sources: U.S. Census Bureau, American Community Survey, 2009-2013*

*Physical Activity*

Chicago offers many options for physical activity, chief among them the infrastructure operated by the Chicago Park District (CPD). These resources include over 8,000 acres of open space, including over 570 parks, 31 beaches, 50 nature areas and two world-class conservatories. CPD also hosts thousands of special events, cultural, nature, sports and recreational programs that promote physical activity, play, learning and social connectedness.

As noted in the map, larger parks are primarily located on the lakefront, although several large parks are in some neighborhoods, including Humboldt Park, Douglas Park and Washing-

ton Park. Other communities are home to smaller parks and play lots, with play equipment for children. Other programs promote physical activity in communities with limited access to resources, such as PlayStreets run by the Chicago Department of Public Health. PlayStreets closes several street blocks and transforms them into play and recreation spaces for a few hours at a time.
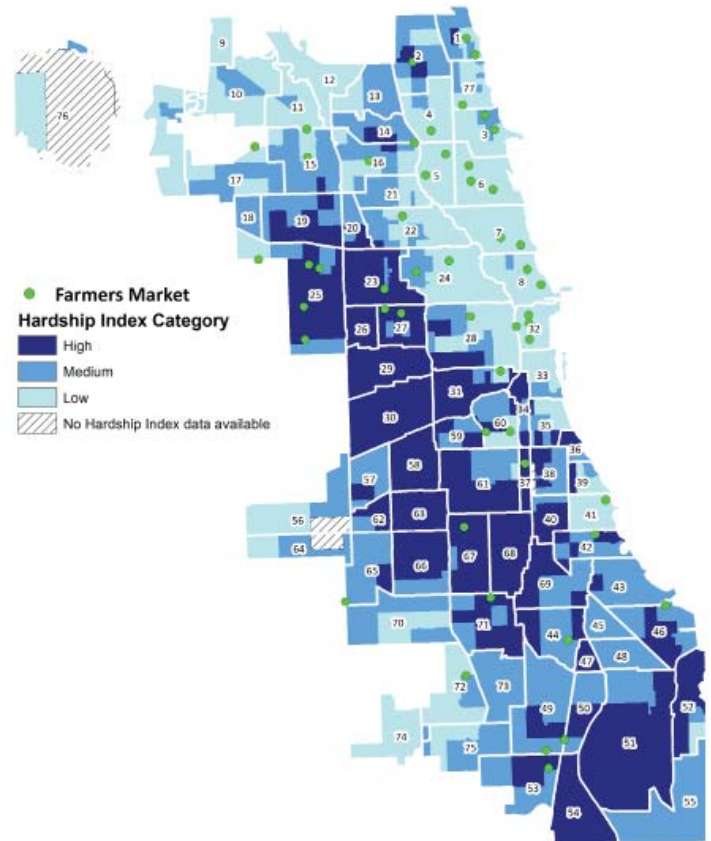
cessibility, the farmers markets now allow for purchase using Supplemental Nutrition Assistance Program (SNAP) LINK card. Although this program does provide access to healthy food, the farmers markets are not distributed equitably across the city. The map shows the geographic divide in the placement of these markets. Efforts to bring more nutritional assets to high hardship communities will help to improve health status.



*Data Sources: Chicago Police Department, 2014 Chicago Park District*



*Data Sources: U.S. Census Bureau, American Community Survey, 2009-2013*

Even with these resources available, access to physical activities is limited due to safety issues. Because of violence that occurs in or around the public spaces, many people do not benefit from these resources. To address these issues, Chicago Park District is working with the Chicago Police Department and other City and local organizations to improve community safety and ensure parks remain a safe center for physical fitness and recreation for all members of the community.

### Healthy Food

Access to healthy foods, i.e., fruits and vegetables, is a measure of a community's health and is key for individuals wanting to follow healthy nutrition guidelines. In recent years, more healthy food outlets have become available, with the advent of urban agriculture, community gardens and mobile produce carts. In addition, the City hosts farmers markets with local vendors selling fruits, vegetables, flowers and prepared foods. While some farmers markets are privately facilitated, the majority are City-run. To enhance economic ac-

*Cultural Assets*

Chicago is home to many cultural assets that foster community awareness, learning and social connectedness; and therefore influence quality of life and health. These assets include theaters, film and television industries, street festivals, media outlets, musicians and artists. Chicago is also home to several world-class museums, including the Art Institute of Chicago and the Field Museum. Most large institutions are located in the central business district to provide easier access for tourists and all Chicago residents. Some museums, such as the National Museum of Mexican Art and DuSable Museum of African American History, are located in neighborhoods and provide programming and educational opportunities for students and community residents. Development of cultural assets in communities with lower levels of education would increase exposure to new information and learning experiences
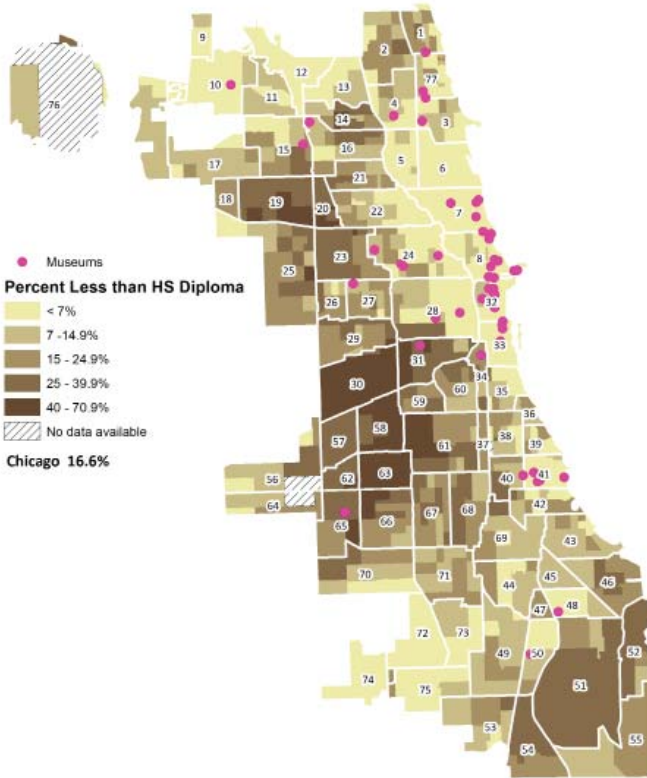
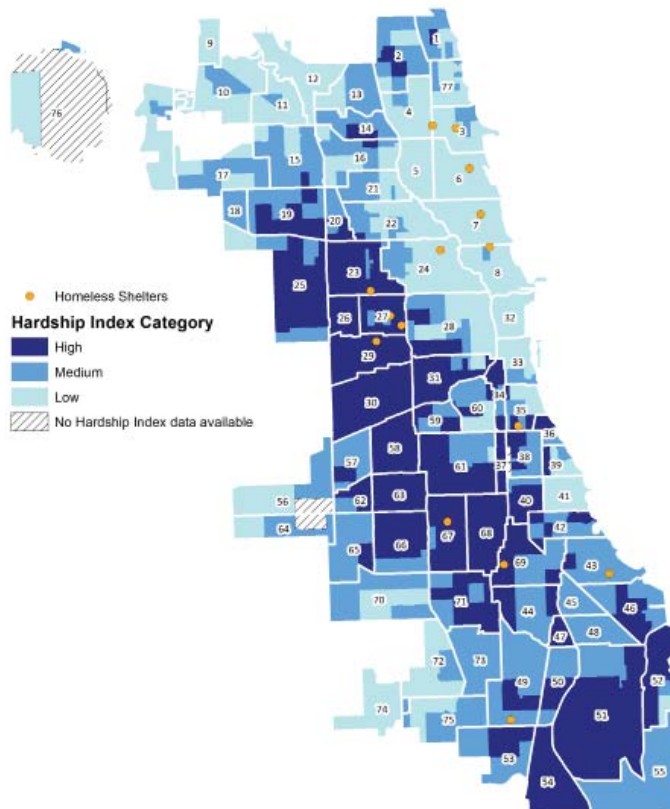*Housing: Chicago Housing Authority Residences*

With access to affordable and safe housing, individuals and families can focus on other components of their lives that improve their health, including getting physical activity, eating healthy foods and strengthening family relationships. Stable housing also helps children to stay in the same school throughout the school year, which increases their academic performance. Properties are available for families, seniors and mobility and sensory impaired individuals. The map shows that many of these sites are located in low hardship communities on the north side. CHA residents living in these properties benefit through improved access to resources available in these neighborhoods. Other sites are located in high/medium hardship communities on the near south side, west side and far south side to allow people to stay in familiar neighborhoods, when possible.



*Data Sources: U.S. Census Bureau, American Community Survey, 2009-2013*
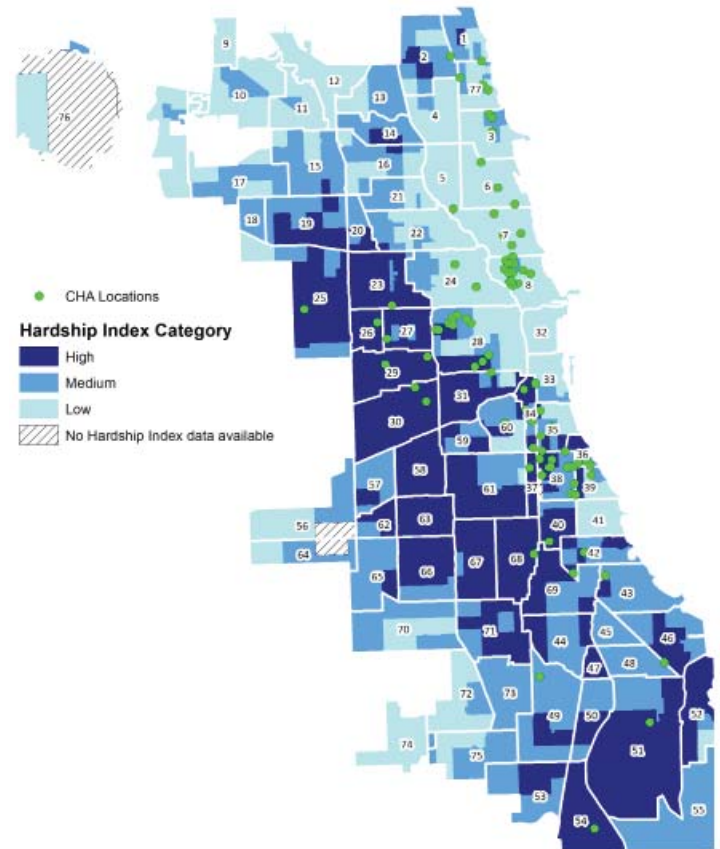


*Data Sources: U.S. Census Bureau, American Community Survey, 2009-2013; Chicago Housing Authority*
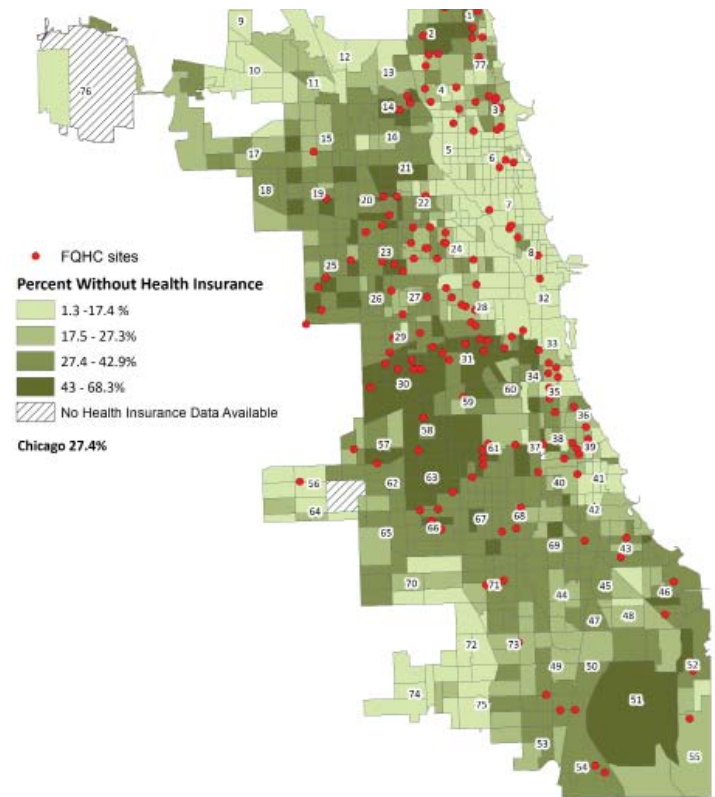
*Human Services: Homeless Shelters*

Many organizations; public, not-for-profit, faith-based; provide services for people and families in need. One of these needs is for housing, especially for the 6,800 homeless individuals in Chicago (based on the 2015 Chicago Department of Family & Support Services Point-in-Time Count & Survey Report). However, based on the information through the City of Chicago Data Portal, shelter capacity does not provide for all homeless individuals. In September 2015, capacity at both overnight shelters and interim shelters totaled 3,400 beds. The map shows the locations of shelters offering overnight facilities.

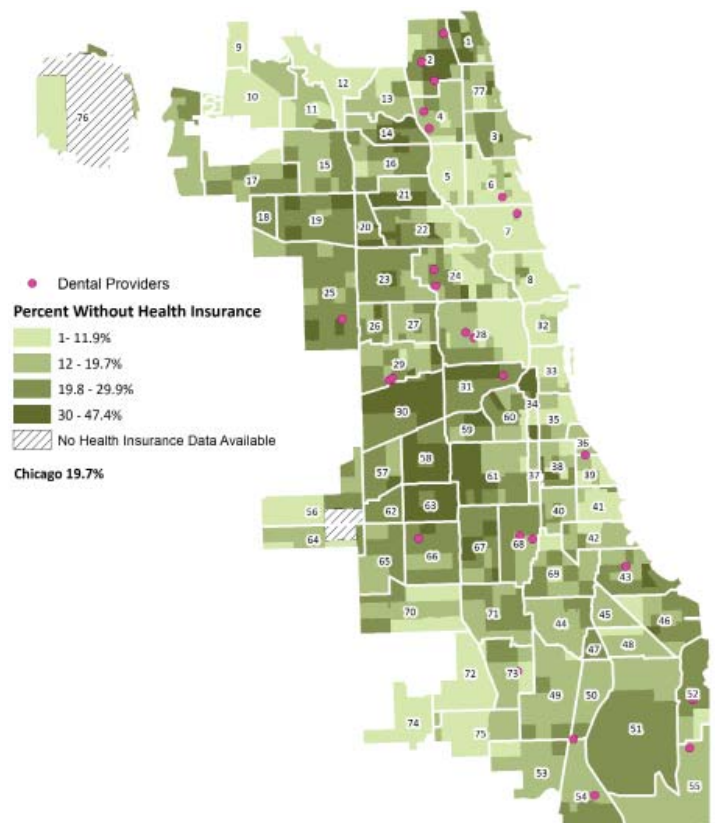*Health Care Resources: Community Health Centers*

With the passage of the Affordable Care Act (ACA), many previously uninsured individuals are now eligible for affordable health care insurance through either the Marketplace or Medicaid expansion. These individuals, along with many other patients, seek care at the 92 federally qualified health centers (FQHCs) and Look-Alike clinics, 31 school-based health centers, eight clinics operated by the Cook County Health & Hospitals System and four other safety net clinics. These clinics also provide comprehensive care to the uninsured. To meet this need, these centers are primarily located in areas with higher rates of uninsured, as shown on the map.



*Data Sources: U.S. Census Bureau, American Community Survey, 2009-2013; City of Chicago Data Portal*



*Data Sources: U.S. Census Bureau, American Community Survey, 2009-2013*

*Health Care Resources: Safety Net Oral Health Providers*

Oral health impacts physical health and influences a person's ability to conduct their daily activities, including school or work. However, oral health care can be very expensive and often is not included in health insurance plans. As such, affordable oral health providers are needed for both preventive care and acute care. The map below shows 25 safety net oral health providers, compiled by the Chicago Dental Society. Most providers are located in areas that have higher uninsurance rates. Given the need for these services for both insured and uninsured individuals, more resources need to be developed.



● Dental Providers
**Percent Without Health Insurance**
1- 11.9%
12 - 19.7%
19.8 - 29.9%
30 - 47.4%
No Health Insurance Data Available

**Chicago 19.7%**

*Data Sources: U.S. Census Bureau, American Community Survey, 2009-2013; Chicago Dental Association*

## APPENDIX 2A: HEALTHY CHICAGO 2.0 ONLINE NEIGHBORHOOD SURVEY

The Chicago Department of Public Health (CDPH) is collecting feedback from Chicagoans about the neighborhood they live in, since where you live is an important part of your health. Your responses will help CDPH and its partners develop health priorities for the city. This survey will take about 10 minutes to complete. You may choose not to answer any question on the survey and all responses will be kept confidential and anonymous. Only combined results from the survey will be shared.

Thank you for your participation!

**What neighborhood do you live in?**

**How many years have you lived in that neighborhood?**
Less than 1 year
Between 1 and 3 years
Between 3 and 5 years
Between 5 and 10 years
Between 10 and 20 years
More than 20 years

**Think about the neighborhood where you live and choose whether you agree or disagree with the following statements. We understand that you might not completely agree or disagree with some statements. In those cases, please choose the answer that best reflects your opinion.**

| Agree | Disagree | I don't know | |
|---|---|---|---|
| ☐ | ☐ | ☐ | I know and talk to my neighbors |
| ☐ | ☐ | ☐ | I know what is going on in my neighborhood |
| ☐ | ☐ | ☐ | I am satisfied with the quality of life in my neighborhood |
| ☐ | ☐ | ☐ | There are places for people to gather in my neighborhood (e.g. faith institution, community center, library, school, parks) |
| ☐ | ☐ | ☐ | I feel safe in my neighborhood |
| ☐ | ☐ | ☐ | Property crime is a problem in my neighborhood (e.g. graffiti, vandalism, burglary) |
| ☐ | ☐ | ☐ | Violent crime is a problem in my neighborhood |
| ☐ | ☐ | ☐ | Schools in my neighborhood have what they need to provide a high quality education |
| ☐ | ☐ | ☐ | Children in my neighborhood have access to high quality education |
| ☐ | ☐ | ☐ | Houses and apartments in my neighborhood are in good shape |
| ☐ | ☐ | ☐ | Houses and apartments in my neighborhood are affordable |
| ☐ | ☐ | ☐ | I have enough money to pay for my and my family's basic needs |
| ☐ | ☐ | ☐ | I have access to a personal checking account to store money |

| Agree | Disagree | I don't know | |
|:---:|:---:|:---:|---|
| ☐ | ☐ | ☐ | My neighborhood is well-served by public transit |
| ☐ | ☐ | ☐ | I see a lot of people walking or biking in my neighborhood |
| ☐ | ☐ | ☐ | I have access to healthy food in my neighborhood |
| ☐ | ☐ | ☐ | Basic amenities, such as a grocery store, pharmacy or library, are easily accessible to me |
| ☐ | ☐ | ☐ | Health services I use are easy to get to from my neighborhood |
| ☐ | ☐ | ☐ | My neighborhood provides social and recreational opportunities for me and my family |
| ☐ | ☐ | ☐ | I feel law enforcement is responsive in my neighborhood when needed |
| ☐ | ☐ | ☐ | The streets and sidewalks in my neighborhood are in good shape |
| ☐ | ☐ | ☐ | I have felt discriminated against in my neighborhood |
| ☐ | ☐ | ☐ | I feel like I belong in my neighborhood |
| ☐ | ☐ | ☐ | People in my neighborhood have input on important community and city decisions |

In your opinion, how would you make your neighborhood a healthier place to live?

# HEALTHY CHICAGO 2.0

Now thinking about the entire city, how would you make Chicago a healthier place to live?

The next few questions will ask a little bit more about you.

**What is your age?**

**What is your gender?**

☐ Male ☐ Female ☐ Transgender

**Which of the following would you say is your race (select all that apply)?**

☐ White

☐ Black or African American

☐ American Indian or Alaska Native

☐ Asian (including Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)

☐ Pacific Islander (including Native Hawaiian, Guamanian or Chamorro, Samoan, or other Pacific Islander)

**Are you of Hispanic, Latino/a, or Spanish origin?**

☐ No, not of Hispanic, Latino/a, or Spanish origin

☐ Yes, Mexican, Mexican American, Chicano

☐ Yes, Puerto Rican

☐ Yes, Cuban

☐ Yes, another Hispanic, Latino/a, or Spanish origin

**What is the highest grade or year of school you completed?**

☐ Less than 9th grade

☐ 9th to 12th grade, no diploma

☐ High school graduate (includes GED)

☐ Some college credit, no degree

☐ Associate's degree

☐ Bachelor's degree

☐ Graduate or professional degree

**Are you currently…**

☐ Employed, full-time (including self-employed)

☐ Employed, part-time (including self-employed)

☐ Out of work for 1 year or more

☐ Out of work for less than 1 year

☐ A Homemaker

☐ A Student

☐ Retired

☐ Unable to work

Community Health Assessment:

**What language do you speak most often at home?**

| | | | |
|---|---|---|---|
| ☐ English | ☐ Spanish | ☐ Polish | ☐ Arabic |
| ☐ Armenian | ☐ Cambodian (Mon-Khmer) | ☐ Chinese | ☐ Creole |
| ☐ French | ☐ German | ☐ Greek | ☐ Gujarati |
| ☐ Hebrew | ☐ Hindi | ☐ Hmong | ☐ Hungarian |
| ☐ Italian | ☐ Japanese | ☐ Korean | ☐ Laotian |
| ☐ Navajo | ☐ Persian | ☐ Polish | ☐ Portuguese |
| ☐ Russian | ☐ Scandinavian | ☐ Serbo-Croatian | ☐ Tagalog |
| ☐ Thai | ☐ Urdu | ☐ Vietnamese | |

☐ Other, please specify_____

**Which of the following best describes how you think of yourself?**

☐ Heterosexual or straight    ☐ Homosexual, gay or lesbian    ☐ Bisexual    ☐ Other

**How many adults 18 years of age or older live in your household (including yourself, if applicable)?**

☐ 1    ☐ 2    ☐ 3    ☐ 4    ☐ 5
☐ 6    ☐ 7    ☐ 8    ☐ More Than 8

**How many children less than 18 years of age live in your household (including yourself, if applicable)?**

☐ 1    ☐ 2    ☐ 3    ☐ 4    ☐ 5
☐ 6    ☐ 7    ☐ 8    ☐ More Than 8

**What is your annual household income from all sources?** ]

☐ Less than $20,000             ☐ Between $20,000 and $39,999
☐ Between $40,000 and $59,999   ☐ Between $60,000 and $79,999
☐ Between $80,000 and $99,999   ☐ $100,000 and over

**Are you limited in conducting activities of daily living because of any physical, mental, or emotional condition?**

☐ Yes        ☐ No

**Would you say that in general your health is:**

☐ Excellent    ☐ Very good    ☐ Good    ☐ Fair    ☐ Poor

Thank you for your participation! Results will be posted on the Chicago Department of Public Health website (www.cityofchicago.org/health) and will be used to inform public health priorities. If you have questions about this survey or need technical assistance, please contact us at HealthyChicago@cityofchicago.org. If you are interested in receiving regular updates on Healthy Chicago, please sign up for our mailing list here. [hyperlink to: http://visitor.r20.constantcontact.com/manage/optin/ea?v=001jsw_pnV76tUmSNJOdEkYeA%253D%253D.] Your email will never be linked to your responses.

Thank you!
Chicago Department of Public Health

**Logistics/Materials needed:**

- All Planning Team members assigned must arrive to the location 45 minutes prior to the session starting
- Room must be organized in round tables/chairs
- Each table needs a stack of post it notes and pens
- Large post it paper and sharpies are needed for larger space
- Sign in sheet
- 3 microphones

To help guide our Healthy Chicago 2.0 health plan, CDPH wants to get community and stakeholder feedback on the health of Chicago and its communities, especially vulnerable populations. We also want hear from you about future changes that could impact the Chicago's health and the public health and healthcare system.

**For Professionals**

(1) From your experience, what are the issues (such as social-political-economic and other trends) that may/will impact the health of Chicagoan s and the public health and health care systems?

  a. What are the threats from these issues?

  b. What are the opportunities from these issues?

**For Community Residents**
*(Only to be used if more than 30% of the audience are community members rather than professional stakeholders)*

(2) What are the attributes of your neighborhood and Chicago that improve health and well-being?
  Prompt: What programs or policies help support these improvements?
  Prompt: What about those vulnerable populations that experience health disparities?

(3) What are the barriers to achieving health and well-being in your neighborhood and in Chicago?
  Prompt: Why? What are some of the underlying causes of these?
  Prompt: What about special and vulnerable populations?

(4) What can we (public health system, communities, businesses, etc.) do over the next 3-5 years to improve the health and well-being of you, your family, and your community?
  Prompt: What can we do to specifically impact special and vulnerable populations?

| | | |
|---|---|---|
| Date of Focus Group: | | |
| FG location: | | |
| Focus Group Moderators Name: | | |
| Assistant Moderators Name: | | |
| Number of participants: | | |
| Time of Focus Group: | Start |__|__:__|__| | End |__|__:__|__| |

### FACILITATOR INTRODUCTION:

Thank you for participating in this discussion today. We are talking to groups of people across Chicago to better understand what Chicago residents think and feel about their health and the health of their communities. This research is part of a city-wide community health needs assessment conducted by the Chicago Department of Public Health to identify the health needs and assets of the Chicago residents. We are interested in knowing about what you think about what helps your family and community stay healthy and what things are barriers to being healthy. Please feel free to state your thoughts. We will not share your personal information that can identify you. Again, we are very interested in your thoughts and there are no right or wrong answers.

A Focus Group is a group discussion led by a moderator around a set of questions. I have the set of questions here in front of me to help guide the conversation. We ask your permission to record the conversation so that we can review the recording later and identify themes that emerged within this focus group and across the other focus groups. In addition to the use of digital recorders my colleague here [name of Assistant Moderator] may be taking some notes so that we can remember the conversation better later. As I stated before, we will not use your name or any other identifiers that you share today.

### GUIDELINES FOR FG:

For a focus group to go well we ask that:

- Only one person speaks at the time (best for audio recording quality)
- We respect all opinions (it's unlikely we will all agree on everything)
- There is no right or wrong answers or opinions
- Please respect one's privacy

It is very important that you respect everyone's privacy and confidentiality by not identifying anyone participating in the session and by not repeating the information shared with the group outside of this discussion.

Any questions or comments before we begin?

Let's begin by introducing ourselves.

Would you please share with the group your first name and how long you've lived in Chicago.

Great. So lets get started. I'm going to turn on the recorder now. I'll let you know when I turn it off at the end of our discussion as well.
 *Turn digital recorders on.*

**Today, when we are talking about health we're using broad definition of health that includes not just the absence of disease but about health as encompassing wellness, safety, mental and social health and factors in the community that influence health. These include factors in community itself, its surroundings and the people who live in the community and social or cultural influences of the residents of the community.**

## HEALTH ASSETS
So now thinking of this broad definition of health what is healthy about your community?

> ### PROBE:
> What do you like about your community?
> What are some things that support healthy living in Chicago?

The Chicago Department of Public Health is concerned with health equity, or fair opportunities for all to be healthy.

## HEALTH NEEDS
Thinking of health equity what are the biggest challenges to being healthy in your community?

> ### PROBES:
> What are some barriers to being healthy in Chicago?
> When you think about the health of your community:
> What would you say is going well?
> What are the barriers to good health?

Describe ways in which your surroundings in your neighborhood impact the health of you and your neighbors? How?

## FUTURE NEEDS AND ASSETS

What can be done in the next 3-5 years to improve the health of your community and the city?

> **PROBE:** What are your suggestions for making it easier to stay healthy?

What else do you think would be important for us to know related to the health of your community
and the residents of Chicago?

Thank you very much for your time. We appreciate your input and support of this community health needs assessment.

Community Health Assessment:

## APPENDIX 2D: ORAL HISTORY FACILITATOR GUIDE

<u>Step 1:</u> **"Pre-Interview" and Data sheet**
- Interviewer(s) <u>describe the storytelling process and review the key questions topics they will be asking the storyteller</u>. Ask the storyteller if there is anything they want to make sure they are asked about. <u>If there's anything they do NOT want to discuss</u>, be respectful and avoid that question/topic.
- <u>All interviewers and storyteller(s) should complete a data sheet</u>. This is for <u>EACH story</u> and <u>EACH person</u> involved. <u>Use black pen</u>.
- Explain the introduction cue cards
- <u>Explain that you will have about 40 minutes to record the story</u>. This will help you set the tone and schedule for the recording.

<u>Step 2:</u> **Sound Check**
- The assistant interviewer should check the sound.
- Put on headphones and hit "record-pause"
- Interviewer asks the storyteller a question, e.g., what did you have for breakfast/lunch today?
- Assistant adjust so that volume is "green" and between 12 and 6.
- Monitor sound throughout the story and adjust as necessary.
- Interviewer and storyteller should keep about a fist's length between mouth and microphone
- Most important that the audio is best for the storyteller's voice.

<u>Step 3:</u> **Record story**
- Hit "record"; you'll know it's recording when you see the numbers counting the seconds
- Assistant takes notes throughout the story and checks on audio
- Interviewer(s) introduce self using prompts on cue card
- Your location is "Chicago, Illinois"
- Storyteller introduces self using prompts on cue card
- Interviewer asks the first question

<u>Step 4:</u> **Stop recording; complete Release Form(s) and Interview Keywords From**
- Hit "stop"
- **Required:** complete a release form (generic), only need <u>one per story</u>, <u>use black pen</u>

<u>Step 5:</u> **Wrap up the cords nicely, the way you found them – no kinks. Place in box. Return to Jenn/Jeni.**

**Other details:**
- **If you need to take a break,** hit "Stop". Once you're ready to start again, hit "record". This will create a second audio track, but that is OK!
- <u>If storyteller would like to use an alias or not share their name at all, they are allowed to do that. But still have them fill out a release form.</u>
  - If they don't use their real name, it may be hard for others to find their story, though!
  - If they use a nickname, but the nickname in quotes and also put their real name (if they allow it).

- Storyteller can decide not to have the story archived.
  - o   If that happens, they do not sign the release form
- Interviewer holds the mic; assistant has on headphones and takes observational notes.
- You won't "mess up" on the audio – just be yourself! <u>If you say a question wrong, don't try and stop or rewind, just go with it.</u>
- DON'T insert your opinion or feelings into the story. Use silent probes and body language as much as possible so that you don't talk over the story.
- Plug in the recorder, but you can use double A batteries if needed.
- Place a <u>post-it with the day's date on the cue card</u> so that you don't get tongue-tied on the audio!

**Probes**

1.   What does living in Little Village community mean to you?
2.   How has your health needs and impacted your life?
3.   Describe your experience when seeking support or receiving services for health or social needs?
4.   Can you tell me a story that happened in your life that changed you?
5.   How has your work impacted your health?
6.   Tell me about a person who has made a positive difference in your life.

**APPENDIX 3: MAPP HEALTH EQUITY SUPPLEMENT***

*Available at naccho.org

Health Equity

# Mobilizing and Organizing Partners to Achieve Health Equity

"Health equity is the realization by all people of the highest attainable level of health. Achieving health equity requires valuing all individuals and populations equally, and entails focused and ongoing societal efforts to address avoidable inequalities by ensuring the conditions for optimal health for all groups."

—Adewale Troutman in *Health Equity, Human Rights and Social Justice: Social Determinants as the Direction for Global Health*

Achieving health equity requires collaboration, coordination, and collective action. The Mobilizing for Action through Planning and Partnerships (MAPP) process can help communities develop a culture of continuous collaborative health improvement that can guide them through this process. This supplement provides tools and resources for communities that seek to frame their MAPP process around health equity.

Addressing health inequities can be an ever-evolving, unpredictable process. Often, no right or wrong answer exists for how to achieve health equity. Communities may find themselves at different stages of readiness to tackle the complex questions and issues that underlie the root causes of health inequities.

Each MAPP community should consider its own expectations, goals, and vision as it undertakes health equity work and use the provided tools as appropriate. NACCHO staff and the MAPP Network (**http://mappnetwork.naccho.org**) are available as resources for MAPP and invite your thoughts and suggestions as you work in your communities on this process.

MAPP

Health Equity

# How to Use this Supplement

All stages of the MAPP process can be conducted with a health equity frame. Accordingly, the pages in this supplement are meant to be integrated into your MAPP Handbook. The page numbers below show where each health equity page can be inserted into your book. For example, "Getting Started, page 6a," can be inserted behind page 6 of your existing book.

| | |
|---|---|
| **Introduction** | • Getting Started (page 6a)<br>• Selecting a Facilitator (page 6b) |
| **Phase 1** | • Revisit Your Circle of Involvement (page 18a) |
| **Phase 2** | • Creating a Vision for Health Equity (page 38a) |
| **Phase 3** | • Community Health Status Assessment: Measuring Health Inequity (pages 56a-56b)<br>• Reflecting on Health Disparities and Health Inequity Data (page 68a)<br>• Local Public Health System Assessment: System Contributions to Assuring Health Equity (pages 72a-72d)<br>• Forces of Change Assessment: Identify Forces that Affect Health Equity (page 76a) |
| **Phase 4** | • Identifying Strategic Health Equity Issues (page 88a)<br>• Identifying Root Causes of Health Inequity (page 92a) |
| **Phase 5** | • Developing Health Equity Strategic Issues, Goals, and Strategies (page 104a) |
| **Phase 6** | • An Action Cycle for Achieving Health Equity (page 118a) |
| **Health Equity References** | • Page 136a |

## Health Equity

### Health Equity in MAPP

Achieving health equity involves identifying, preventing, and reversing the effects of patterned decisions, policies, investments, rules, and laws that have caused social and economic inequities that affect people's abilities to live healthy lives.

### Using a Health Equity Frame

The way people interpret and organize information influences the way they define a problem and how they devise strategies to solve it. As people work on protecting and preserving the public's health, they may not realize that they are influenced by certain values, assumptions, and perspectives. Frames define the following:

- Legitimate and trustworthy sources of knowledge;

- Which research questions people pursue or ignore (e.g., do we study the poor, or do we study which policies produce poverty?);

- The attribution of responsibility for health or illness (To individuals? Or systems?);

- Appropriate targets for policy; and

- How and where to use resources.

Questions are never neutral. Rather, people apply frames that influence the questions they ask. Questions are posed within specific social, political, historical, and cultural contexts. Questions are often driven by institutional agendas, values, and priorities that may or may not address community members' needs and wants.

"Health equity is the realization by all people of the highest attainable level of health. Achieving health equity requires valuing all individuals and populations equally and entails focused and ongoing societal efforts to address avoidable inequalities by ensuring the conditions for optimal health for all groups, particularly those who have experienced historical or contemporary injustices or socioeconomic disadvantage."

—Adewale Troutman in
*Health Equity, Human Rights
and Social Justice: Social Determinants
as the Direction for Global Health*

Health inequities are "differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill."

—Margaret Whitehead in
*The Concepts and Principles of
Equity and Health*

## Selecting a Facilitator

Communities can use facilitators throughout the Mobilizing for Action through Planning and Partnerships (MAPP) process to help guide group discussions. Discussions that identify sources of health inequity can be difficult to facilitate. People may feel uncomfortable discussing racism, classism, and gender inequity. Some people might feel personally attacked or responsible, while others might deny inequities exist. People might feel the problem is outside their control or too much to tackle. They may find it easier to maintain and not challenge the status quo.

A skilled facilitator brings attention to emotions, contradictions, and discomfort that often arise when discussing the root causes of health inequity and uses the tensions to identify systemic, structural, and institutional changes that can result in health equity. When selecting a facilitator, consider someone who can skillfully do the following:

- Communicate a health equity approach to community health improvement;

- Establish rules that ensure a safe place for discussion;

- Reflectively listen and create space for participants to contemplate emotional or controversial ideas and use participant reflection to bring a group to a new level of awareness of the root causes of health inequity;

- Identify tensions in the room and use the discomfort to uncover new information;

- Assess power dynamics in a room and structure conversation to prevent power dynamics from stifling participation from those with less power;

- Design a process that encourages those who are not comfortable discussing difficult topics in public a way to contribute to the discussion;

- Reinforces a health equity frame and critical thinking and analysis;

- Uncover contradictory or competing perceptions of health equity and develop a common understanding of health equity among participants; and

- Focus conversations on equality as opposed to remediating health problems with more programs and activities.

## Resources for Understanding Health Equity

The following resources may help communities as they seek to achieve health equity. These tools can help individuals and groups develop a common framework for understanding health equity and facilitate meaningful dialogue about the root causes of health inequity.

### Assessing Readiness for Addressing Health Inequities

Community partners can use the Organizational Self-Assessment for Addressing Health Inequities Toolkit developed by the Bay Area Regional Health Inequities Initiative (http://barhii.org/resources/toolkit.html) to determine if they are ready to address health inequities. The toolkit helps organizations identify the skills, practices, and infrastructure needed to achieve health equity.

### Roots of Health Inequity Web-Based Course

Communities can use the Roots of Health Inequity Web-Based Course (http://www.rootsofhealthinequity.org/) to educate public health leaders. The course includes interactive content, case studies, questions for reflection and group discussion. MAPP participants can use the course to develop a common framework for understanding health equity.

### Unnatural Causes Dialogue

Many communities have screened the Unnatural Causes documentary series (http://www.unnaturalcauses.org/) and facilitated community dialogues to increase awareness and better understand the root causes of health inequity in their communities. California Newsreel, the organization that produced the documentary series, provides a discussion guide on its website to help people digest, reflect, and apply the knowledge that is gained from viewing the documentary series.

### The Raising of America

The makers of Unnatural Causes will release The Raising of America in fall 2014. This documentary series will encourage viewers to facilitate dialogue about improving early child health and development to create a healthier, more prosperous, and more equitable nation. The series' website (http://www.raisingofamerica.org/) provides tools to promote community engagement and discussion.

**PHASE ONE: Organize for Success/Partnership Development**

**Health Equity**

10a

Mobilizing for Action through Planning and Partnerships (MAPP): User's Handbook

**WORKSHEET: Circles of Involvement**

Developing Key Relationships for Implementation

**Health Equity**

## Revisit Your Circle of Involvement

To identify, communicate, and develop strategies to achieve health equity, you need to mobilize and organize the right people. Reference the individuals, groups, and organizations you have included in your Circle of Involvement worksheet.

Ask members of the MAPP Core Group whether your Circle of Involvement includes the following:

- Population groups that are affected by decisions, policies, investments, rules, and laws that have compromised their abilities to live healthy lives. These groups include people who are the subject of racism, gender inequity, and class exploitation;
- People who have knowledge about the structure of power and patterns of decisions, policies, investments, rules, and laws that have caused health inequity;
- Groups that can influence processes that can combat, reverse, and prevent decisions, policies, investments, rules, and laws that have caused health inequity;
- People who know how to measure social, economic, and health inequities;
- Groups that can communicate the causes of health inequities in a way that inspires people to work on achieving health equity; and
- People who can facilitate productive discussions about health inequities that result in strategies and collaborative action.

Engage individuals and groups that are committed to achieving social justice and health equity, have power and influence in the community, and can be allies in an equitable partnership. Examples of groups that could have representation in your Circle of Involvement include the following:

- Civil rights organizations;
- Labor organizations;
- Organizations representing minority groups, including religious minorities, immigrant populations, and English as a foreign language groups;
- Housing authorities and service providers for the homeless;
- Community development organizations;
- Community organizing groups;
- Women's rights organizations;
- Gay, lesbian, bisexual, transgender organizations;
- Child advocacy groups;
- Developmental and physical disability rights organizations;
- Mental health advocacy organizations; and
- Organizations dedicated to transparency, accountability, representation, participation, and inclusiveness in democracy.

**PHASE ONE: Organize for Success/Partnership Development**

18a

Mobilizing for Action through Planning and Partnerships (MAPP): User's Handbook

Community Health Assessment:

## Health Equity

### Creating a Vision for Health Equity

MAPP Communities can create vision statements that aim to achieve health equity. When planning a visioning event, consider asking participants the following visioning questions:

- What does an equitable community look like to you?
- What would be different in our community if all people had circumstances in which they could live healthy and flourishing lives?
- What would institutions (e.g., local health departments, schools, prisons, hospitals, corporations) do differently if they contributed to a more equitable community?
- What would our community look like if all people and groups were equally represented in positions of power and decision-making?
- In five years, if our community successfully worked towards achieving health equity, what would we have accomplished?
- If our community were nationally recognized as an equitable place to live, what would people say?

Also consider asking the following questions to generate **value** statements that will guide your collaborative process:

- What must be in place to ensure our MAPP process is equitable, transparent, accessible, and inclusive, particularly of those affected by inequity?
- What values must we uphold to ensure equitable participation?
- How do we ensure we do not inadvertently create, contribute, or support decisions, policies, investments, rules, and laws that contribute to health inequities?
- How do we ensure the community drives and owns the process?
- How do we ensure we can share power to those affected by inequity?

**Brainwriting** is a technique that can help foster participation among all members in a group. After providing a prompt, ask each person to reflect and write his or her ideas on a sheet of paper without talking. After a limited amount of time, have people pass their papers to another person. Each person will then review the previous person's ideas and add to their thoughts. Repeat the process several times.

In Ingham County, Michigan, the health department convened staff dialogues to ask questions like, "If Ingham County were to address racism in a meaningful way, internally or externally, what would it look like?"

**PHASE TWO:** Visioning



Mobilizing for Action through Planning and Partnerships (MAPP): User's Handbook

38a

## Community Health Status Assessment: Measuring Health Inequity

**Health Equity**

Several approaches exist for exploring and documenting areas of health inequity as part of the Community Health Status Assessment. All three of the following strategies should be used to identify patterns of health inequity in a community.

### 1. Cross-Tabulations that Measure Health Disparities

Health disparities are differences in health status. The term "health disparities" is not the same as "health equity." "Health disparities" describes simply differences in health outcomes among groups and does not describe the reasons why differences in health status exist. Still, information about health disparities can provide insight on health inequities depending on how the data are analyzed and discussed.

Cross-tabulations can be used to identify differences in health status among different groups. For instance, you can collect data on cardiovascular disease prevalence. You can also collect data on race and gender. You can then use cross-tabulations to see if there are differences in the prevalence of cardiovascular disease based on race and gender.

| | White | | Black | | Hispanic/Latino | | Asian-Pacific Islander | | Native Indian/ Alaska Native | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| Prevalence of diabetes in the county | | | | | | | | | | |
| Infant mortality rate | | | | | | | | | | |
| Prevalence of youth violence | | | | | | | | | | |

| | Unemployed | | Employed, part-time | | Employed, full-time | |
|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Male | Female |
| Prevalence of heart disease | | | | | | |

Examples of data that should be collected and used in cross-tabulations to identify health disparities include the following:
- Income;
- Race;
- Ethnicity;
- Immigration status;
- Gender;
- Sexual identity;
- Education;
- Age;
- Employment status; and
- Homeownership and housing status.

These categories represent segments of your population that may experience different health outcomes. Comparing the health status of subgroups to those with the worst, the best, or the average or median health status can give you insight into groups affected by inequity. You can also compare subgroup health status with targets such as Healthy People 2020 objectives.

**PHASE THREE: Four MAPP Assessments**

Mobilizing for Action through Planning and Partnerships (MAPP): User's Handbook

56a

# Health Equity

### 2. Indicators of Inequity

In addition to measuring health disparities, you should include measures of social and economic inequity. As with health outcomes, many indicators of socioeconomic status can be stratified by demographic category to show how different groups are affected by inequity.

| | White | | Black | | Hispanic/Latino | | Asian-Pacific Islander | | Native Indian/ Alaska Native | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| High school graduation rate | | | | | | | | | | |
| Percent living in poverty | | | | | | | | | | |

Example indicators of inequity that can be included in a Community Health Status Assessment include the following:

- Median household income;
- Percent of people living in poverty;
- Median value of owner-occupied homes;
- Percent of households below poverty;
- Percent of children under 18 in poverty;
- Unemployment;
- Percent of people without car ownership;
- Percent of renters;
- Civic engagement[1];
- High school graduation rate;
- Income inequality[2];
- Wealth inequality;
- Segregation[3];
- Bank loans by race, income, gender, and neighborhood;
- Political participation by race, income, and gender;
- Allocation of city or county budget by neighborhood;
- Level of housing inspections by neighborhood;
- Home foreclosure rates by neighborhood; and
- Disinvestments in community (e.g., outsourcing jobs to other countries).

### 3. Geographic Mapping to Uncover Patterns on Health Inequity

Communities can use geographic mapping of data on health disparities and inequity to uncover patterns of health inequity. Geographic mapping provides pictures of where people are most affected by poor health status and areas where people experience relative good health. To map health status, you will need to have geographic data indicators such as zip code, census tract, or county residence. You can map health status by where people live. You can also overlay different measures of health status, race, ethnicity, age, income, immigration status, gender, and education to see patterns of inequity. Creating maps that show changes over time provides information on how inequities accumulate and concentrate over time.

Visit the Connecticut Association of Directors of Health's Health Equity Index (**https://www.sdoh.org/**) for examples of maps and health equity data. Hear the association discuss how it developed and used the Health Equity Index through NACCHO University's eLearning module, "Health Equity, Data Collection, and Analysis," available at **http://www.naccho.org/ university.cfm**.

Alameda County analyzed data by neighborhood and found that in 2003, nearly 41% of African Americans and 26% of Latinos resided in higher-poverty neighborhoods, compared to 4% of Whites.

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[1] Examples of measures of civic engagement can be found at http://www.civicyouth.org/tools-for-practice/survey-measures-of-civic-engagement/

[2] Examples of measures of income inequality can be found in De Maio, F. (2007). Income inequality measures. *Journal of Epidemiology and Community Health*, 61(10):849–852.

[3] Examples of measures of segregation can be found at https://www.census.gov/hhes/www/housing/housing_patterns/pdf/app_b.pdf

**56b** Mobilizing for Action through Planning and Partnerships (MAPP): User's Handbook

## Reflecting on Health Disparities and Health Inequity Data

The Community Themes and Strengths Assessment can be used to collect information about how community members experience the effects of health inequities. You can design this assessment to investigate what in your community currently and historically has contributed to health inequities identified in the Community Health Status Assessment. You can use the following questions to engage your community members in a conversation about the root causes of health inequities. Be sure to include individuals affected by inequity in your conversations.

1. What patterns do you see in the health inequity data?

2. Think about the groups that experience relatively good health and those that experience poor health. Why do you think there is a difference?

3. If you have identified individual behavioral reasons for differences in health status among different groups, what are some reasons why it is easier for some to make healthy choices than others?

4. What assets exist in our community? Where are these assets located, and who has access to them? How do these assets support health?

5. Who is in charge at local agencies, retail stores, healthcare providers, schools, and other institutions in our community? How do these institutions support or inhibit health?

6. What conditions (excluding individual behavior) in a community support some groups' abilities to experience better health than others? What conditions in a community inhibit some groups' abilities to experience good health? Who makes decisions that influence these conditions? What motivates the decisions they make that results in differences in health status? Where does power to make these decisions come from?

7. What public and corporate policies support healthy living? What policies inhibit healthy living? Which groups are affected by these policies? Who has the power to make and implement those policies? What motivates them to develop policies that favor some over others?

### Measure the Effects of Discrimination on Health

Consider using **Experiences of Discrimination** survey questions in your Community Health Themes and Strengths Assessment. This survey is a reliable and valid instrument for measuring the experiences of discrimination. The results can be used to understand the extent to which your community experiences discrimination. When analyzed together with Community Health Status Assessment data, your community can get a picture of how discrimination is associated with poor health outcomes.

### Conditions that Support Health Equity

The Connecticut Association of Directors of Health has identified nine social determinant domains. The following domains can be used to structure a Community Themes and Strengths Assessment that focuses on health inequity.

1. Economic security and financial resources;
2. Livelihood security and employment opportunity;
3. School readiness and educational attainment;
4. Environmental quality;
5. Availability and utilization of quality medical care;
6. Adequate, affordable, and safe housing;
7. Community safety and security;
8. Civic involvement; and
9. Transportation.

**PHASE THREE: Four MAPP Assessments**

Mobilizing for Action through Planning and Partnerships (MAPP): User's Handbook

66a

## Local Public Health System Assessment continued

### System Contributions to Assuring Health Equity

When completing the Local Public Health System (LPHS) Assessment using the National Public Health Performance Standards (NPHPS) Instrument, your group can reframe questions about essential service delivery to identify how well the LPHS acknowledges and addresses health inequities. The following questions provide examples of how the instrument can be revised to focus on health equity.

#### Essential Public Health Service 1: Monitoring Health Status

At what level does the LPHS…

- Conduct a community health assessment that includes indicators intended to monitor differences in health and wellness across populations, according to race, ethnicity, age, income, immigration status, sexual identify, education, gender, and neighborhood?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

- Monitor social and economic conditions that affect health in the community, as well as institutional practices and policies that generate those conditions?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

#### Essential Public Health Service 2: Diagnosing and Investigating Health Problems

At what level does the LPHS…

- Operate or participate in surveillance systems designed to monitor health inequities and identify the social determinants of health inequities specific to the jurisdiction and across several of its communities?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

- Collect reportable disease information from community health professionals about health inequities?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

- Have the necessary resources to collect information about specific health inequities and investigate the social determinants of health inequities?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

#### Essential Public Health Service 3: Inform, Educate, and Empower People about Health Issues

At what level does the LPHS…

- Provide the general public, policymakers, and public and private stakeholders with information about health inequities and the impact of government and private sector decision-making on historically marginalized communities?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

- Provide information about community health status (e.g., heart disease rates, cancer rates, and environmental risks) and community health needs in the context of health equity and social justice?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Mobilizing for Action through Planning and Partnerships (MAPP): User's Handbook

**PHASE THREE: Four MAPP Assessments**

72a

## Health Equity

## Local Public Health System Assessment continued

**System Contributions to Assuring Health Equity**

- Plan and conduct health promotion and education campaigns that are appropriate to culture, age, language, gender, socioeconomic status, race/ethnicity, and sexual orientation?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

- Plan campaigns that identify the structural determinants of health inequities and the social determinants of health inequities (rather than focusing solely on individuals' health behaviors and decision-making)?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

### Essential Public Health Service 4: Mobilizing Community Partnerships to Identify and Solve Health Problems

At what level does the LPHS…

- Have a process for identifying and engaging key constituents and participants that recognizes and supports differences among groups?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

- Provide institutional means for community-based organizations and individual community members to participate fully in decision-making?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

- Provide community members with access to community health data?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

### Essential Public Health Service 5: Developing Policies and Plans that Support Individual Community Health Efforts

At what level does the LPHS…

- Ensure that community-based organizations and individual community members have a substantive role in deciding what policies, procedures, rules, and practices govern community heath efforts?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

### Essential Public Health Service 6: Enforce Laws and Regulations that Protect Health and Ensure Safety

At what level does the LPHS…

- Identify local public health issues that have a disproportionate impact on historically marginalized communities (that are not adequately addressed through existing laws, regulations, and ordinances)?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**72b**

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## Local Public Health System Assessment continued

**Health Equity**

### System Contributions to Assuring Health Equity

**Essential Public Health Service 7: Link People to Needed Personal Health Services**

At what level does the LPHS…

• Identify any populations that may experience barriers to personal health services based on factors such as on age, education level, income, language barriers, race or ethnicity, disability, mental illness, access to insurance, sexual orientation and gender identity, and additional identities outlined in Model Standard 7.1?

| No Activity | Minimal | Moderate | Significant | Optimal |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

• Identify the means through which historical social injustices specific to the jurisdiction (e.g., the inequitable distribution health services and transportation resources) may influence access to personal health services?

| No Activity | Minimal | Moderate | Significant | Optimal |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

• Work to influence laws, policies, and practices that maintain inequitable distributions of resources that may influence access to personal health services?

| No Activity | Minimal | Moderate | Significant | Optimal |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Essential Public Health Service 8: Assure a Competent and Personal Health Care Workforce**

At what level does the LPHS…

• Conduct assessments related to developing staff capacity and improving organizational functioning to support health equity initiatives?

| No Activity | Minimal | Moderate | Significant | Optimal |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

• Identify staff perspectives on the facilitators and barriers to addressing health equity initiatives?

| No Activity | Minimal | Moderate | Significant | Optimal |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

• Include staff members that are often excluded from planning and organizational decision-making processes in workforce assessments?

| No Activity | Minimal | Moderate | Significant | Optimal |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

• Recruit and train staff members from multidisciplinary backgrounds that are committed to achieving health equity?

| No Activity | Minimal | Moderate | Significant | Optimal |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

• Recruit and train staff members that reflect the communities they serve?

| No Activity | Minimal | Moderate | Significant | Optimal |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**PHASE THREE: Four MAPP Assessments**

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72c

## Health Equity

## Local Public Health System Assessment continued

**System Contributions to Assuring Health Equity**

**Essential Public Health Service 9: Evaluate the Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services**

At what level does the LPHS…

• Identify community organizations or entities that contribute to the delivery of the Essential Public Health Services to historically marginalized communities?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

• Monitor the delivery of the Essential Public Health Services to ensure that they are equitably distributed?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Essential Public Health Service 10: Research for New Insights and Innovative Solutions to Health Problems**

At what level does the LPHS…

• Encourage staff, research organizations, and community members to explore the root causes of health inequity, including solutions based on research identifying the health impact of structural racism, gender and class inequity, social exclusion, and power differentials?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

• Share information and strategize with other organizations invested in eliminating health inequity?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

• Use Health Equity Impact Assessments to analyze the potential impact of local policies, practices, and policy changes on historically marginalized communities?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

• Facilitate substantive community participation in the development and implementation of research about the relationships between structural social injustices and health status?

| No Activity | Minimal | Moderate | Significant | Optimal |
|:---:|:---:|:---:|:---:|:---:|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**72d** Mobilizing for Action through Planning and Partnerships (MAPP): User's Handbook

# WORKSHEET: Forces of Change Brainstorming

## Health Equity

**Forces of Change Assessment: Identify Forces that Affect Health Equity**

**Questions to Identify Forces**

Powerful organized interests develop structures and support policies and practices that can either contribute to health equity or cause health inequities. The following questions can be answered during the Forces of Change Assessment to identify these forces, opportunities, and threats.

- What patterns of decisions, policies, investments, rules, and laws affect the health of our community?

- Who benefits from these decisions, policies, investments, rules, and laws?

- Whom do these decisions, policies, investments, rules, and laws harm?

- Who or what institutions have the power to create, enforce, implement, and change these decisions, policies, investments, rules, and laws?

- What interests support or oppose actions that contribute to health inequity?

- What opportunities exist to influence decisions, policies, investments, rules, and laws to benefit all groups?

- What forces now and in the future can reinforce health inequity in our community? How can we mitigate or prevent these forces?

- What forces now and in the future can reinforce health equity in our community? How can we take advantage of these forces?

*When posing these questions, be sure to include people that are affected by health inequity.*

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**76a**

**PHASE THREE: Four MAPP Assessments**

## Identifying Strategic Issues to Address Health Equity

As you develop strategic issues, remember that questions are never neutral. Rather, people apply frames that influence the questions they ask. They are posed within specific social, political, historical, and cultural contexts. Questions are often driven by institutional agendas, values, and priorities that may or may not address community members' needs and wants.

The following table contrasts conventional and health equity questions that can be used to understand public health problems and identify potential solutions. When analyzing data from the MAPP Assessments to identify strategic issues, use a health equity frame to ask your community these questions.

**Health Equity**

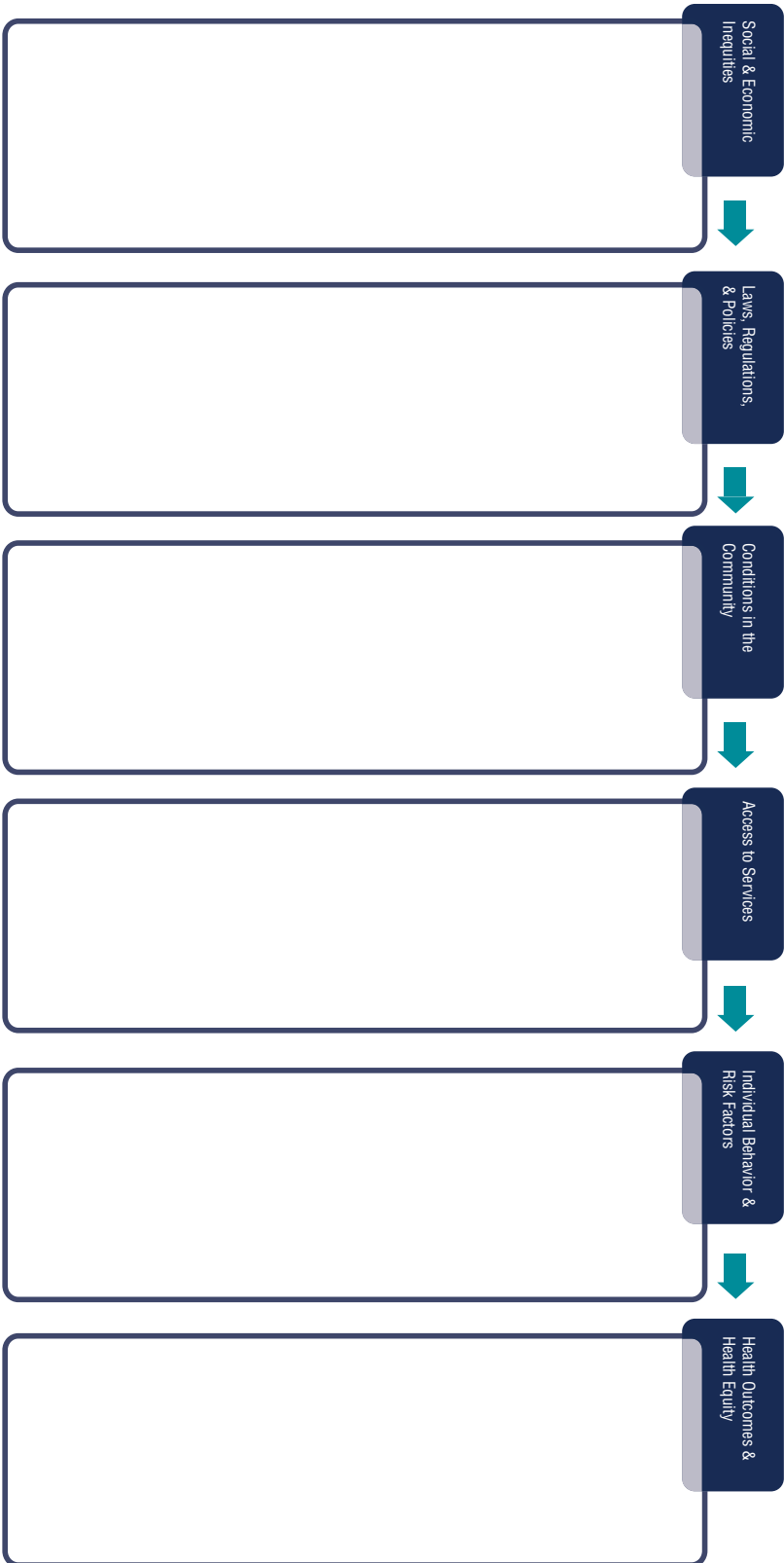| CONVENTIONAL APPROACH | HEALTH EQUITY APPROACH |
|---|---|
| Why are people unhealthy in our community? | What social conditions and economic policies make some people more likely to be unhealthy? |
| Why can't vulnerable populations access services? | What institutional policies and practices prevent people from accessing services? |
| What types of services and resources do we need to improve health? | What fundamental policy changes do we need? |
| How do we reduce disparities in health outcomes? | How do we eliminate the social injustices that produce inequities in health outcomes? |
| What programs and services do we need to address health disparities? | What kind of collective action and structural social changes do we need to tackle health inequities? |
| What unhealthy behaviors should we discourage among vulnerable populations? | What interests and power structures affect people's health and wellness? |
| Which government officials, expert researchers, or media personalities best understand the issue? | Which community members and grassroots organizations can best define the issue? |
| Which public officials and research institutions will decide on appropriate courses of action? | How can we work within our communities to define and prioritize public health concerns? |
| How can we make people more responsible for their own health? | How can we create social responsibility and public accountability to protect the public good? |

**PHASE FOUR: Identify Strategic Issues**

88a

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Community Health Assessment:

**Health Equity**

### Identifying Root Causes of Health Inequity

Ask community members to review data from the four MAPP Assessments. Ask them to map the data to show what they learned about relationships among the following:

- Health outcomes and health equity (from Community Health Status Assessment);
- Individual behavior and risk factors (from Community Health Status Assessment);
- Access to services (from Local Public Health System Assessment);
- Conditions in the community (from Community Themes and Strengths Assessment);
- Law, regulations, and policies (from Local Public Health System Assessment and Community Themes and Strengths Assessment); and
- Social and economic inequities (from Community Health Status Assessment and Community Themes Assessment).

Ask your community members to share how social and economic inequities affect how laws, regulations, and policies decisions are made and how those decisions shape the conditions in the community that affect how people can access services, engage in healthy living, and maximize their health outcomes.

Social & Economic Inequities

Laws, Regulations, & Policies

Conditions in the Community

Access to Services

Individual Behavior & Risk Factors

Health Outcomes & Health Equity

**92a**

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## Health Equity

### Developing Health Equity Strategic Issues, Goals, and Strategies

Given what group members share, ask them what fundamentally has to change in the community to achieve health equity. Fundamental change may be in the form of the following:

- Policies, laws, and decision-making processes;
- Redistribution of power in decision-making;
- Reallocation of resources;
- Transparency in decision-making processes that support social and economic equity;
- Mobilizing, engaging, and sharing power and resources with those affected by inequity; and
- Accountability in decision-making.

Use information from the discussion to develop strategic issues, goals, and strategies.

#### Example of a Health Equity Strategic Issue, Goal, and Strategy

**Strategic Issue:**
How can the public health community address shortened life spans and inferior quality of life for communities of color and poor communities?

**Goal:**
Prevent land use policies that expose neighborhoods and community members to environmental hazards, displacement, and sprawl.

**Strategy:**
Forge relationships with social movements rooted in developed coalitions and provide technical assistance that fuels advocacy.

In the rural community of Mound Bayou, Mississippi, the Delta Health Center helped establish a bank branch where local black community members were hired as tellers and supervisors. As a result, racial discrimination in mortgage lending decreased.



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104a

**PHASE FIVE: Formulate Goals and Strategies**

**Health Equity**

## An Action Cycle for Achieving Health Equity

When identifying actions for achieving health equity, remember to use a health equity frame and the data about health inequities collected in the MAPP Assessment phase. The table below contrasts remedial actions that do not address root causes of inequity with actions that investigate, reverse, or prevent the causes of health inequity.

| Remedial Actions | Health Equity Actions |
|---|---|
| Track health outcomes by county | Track the accumulation of health-harming conditions and decision processes that produce those conditions |
| Treat or repair people's health and life conditions | Tackle negative life conditions with the goal of permanent social change to prevent reproduction of conditions |
| Support subsidies for low-income housing | Oppose discriminatory housing practices and gentrification that causes displacement |
| Regulate permissible levels of toxic chemicals | Limit the production of toxic chemicals and disproportionate burden on communities of color |
| Provide inhalers and clinical services to those communities with high asthma rates | Prevent the predominant location of polluting sites in communities of color and communities with low income levels |

**PHASE SIX:** Action Cycle

118a

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