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Executive Summary - North Region

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

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

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

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

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

This CHNA report is for the North region of the Health Impact Collaborative of Cook County. As of the 2010 census, the North region had 1,356,161 residents which represents a 3% decrease in total population from the year 2000. Non-Hispanic whites and non-Hispanic blacks experienced the largest population decreases. Between 2000 and 2010 the non-Hispanic white population decreased by 57,039 residents and the non-Hispanic black population decreased by 7,509 residents. Despite an overall population decrease in the North region from 2000-2010, the Hispanic/Latino and Asian populations increased by 17,762 and 7,131 residents respectively during the same time period. Children and adolescents represent 20% of the population in the North region. The majority of the population is between ages 18-64 and approximately 13% of the population is older adults aged 65 and over. Overall, the North region is diverse and several priority groups were identified during the assessment process.

Collaborative structure
Nine nonprofit hospitals, four health departments, and approximately 30 stakeholders partnered on the CHNA for the North region. The participating hospitals are Advocate Illinois Masonic Medical Center; Advocate Lutheran General Hospital; Northshore University HealthSystem, including Evanston, Glenbrook, and Skokie Hospitals; Presence Holy Family Medical Center; Presence Resurrection Medical Center; Presence Saint Francis Hospital; and Presence Saint Joseph Hospital. Health departments are key partners in leading the Health Impact Collaborative and conducting the CHNA. The participating health departments in the North region are Chicago Department of Public Health, Cook County Department of Public Health, Evanston Health Department, and Skokie Health Department.

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

Stakeholder engagement
The Health Impact Collaborative of Cook County is focused on community-engaged assessment, planning and implementation. Stakeholders and community partners have been involved in multiple ways throughout this assessment process, both in terms of community input data and as decision-making partners. To ensure meaningful ongoing involvement, each region’s Stakeholder Advisory Team has met monthly during the assessment phase to provide input at every stage and to engage in consensus-based decision making. Additional opportunities for stakeholder engagement during assessment have included participation in hospitals’ community advisory groups and community input through surveys and focus groups. There will be many additional opportunities for engagement as action planning
begins in the summer of 2016. The Stakeholder Advisory Team members bring diverse perspectives and expertise. They represent populations affected by health inequities including diverse racial and ethnic groups; immigrants and refugees; older adults; youth; homeless individuals; unemployed; lesbian, gay, bisexual, queer, intersex, and asexual (LGBQIA) and transgender individuals; uninsured; and veterans.

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

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

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

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

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

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

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

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

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

Community Themes and Strengths Assessment (CTSA). The Community Themes and Strengths Assessment included both focus groups and community resident surveys. Approximately 5,200 surveys were collected from community residents through targeted outreach to communities affected by health disparities across the city and county between October 2015 and January 2016. About 1,500 of the surveys were collected from residents in the North region. The survey was disseminated in four languages and was available in paper and online formats. Between October 2015 and March 2016, IPHI conducted eight focus groups in the North region. Focus group participants were recruited from populations that are typically underrepresented in community health assessments including diverse racial and ethno-cultural groups; immigrants; limited English speakers; families with children; older adults; lesbian, gay, bisexual, queer, intersex, and asexual (LGBQIA) individuals; transgender individuals; formerly incarcerated adults; individuals living with mental illness; and veterans and former military.

Forces of Change Assessment (FOCA) and Local Public Health System Assessment (LPHSA). The Chicago and Cook County Departments of Public Health each conducted a Forces of Change Assessment and a Local Public Health System Assessment in 2015, so the Collaborative was able to leverage and build off of that data. IPHI facilitated interactive

\(^1\) The seven data indicator categories were adapted from the County Health Rankings model - demographics, socioeconomic factors, health behaviors, physical environment, health care and clinical care, mental health, and health outcomes.
discussions at the August and October 2015 Stakeholder Advisory Team meetings to reflect on the findings, gather input on new or additional information, and prioritize key findings impacting the region.

**Significant health needs**

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

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

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

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

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

**Key assessment findings**

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

   The social and structural determinants of health such as poverty, unequal access to health care, lack of education, structural racism, and environmental conditions, are underlying root causes of health inequities. Additionally, social determinants of health often vary by geography, gender, sexual orientation, age, race, disability, and ethnicity. The strong connections between social, economic and environmental factors and health are apparent in Chicago and suburban Cook County, with health inequities being even more pronounced than most of the national trends.
Figure 1.1. Summary of key assessment findings related to the social, economic, and structural determinants of health

<table>
<thead>
<tr>
<th>Social, Economic, and Structural Determinants of Health</th>
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</thead>
<tbody>
<tr>
<td><strong>Poverty and economic equity.</strong></td>
</tr>
<tr>
<td>African Americans, Hispanic/Latinos and Asians have higher rates of poverty than non-Hispanic whites and lower annual household incomes. More than a third (34%) of children and adolescents in the North region live at or below the 200% Federal Poverty Level. In Chicago and suburban Cook County, residents in communities with high economic hardship have life spans that are five years shorter on average compared to other areas of the county.</td>
</tr>
<tr>
<td><strong>Unemployment.</strong></td>
</tr>
<tr>
<td>The unemployment rate in the North region from 2009-2013 was 8.2% compared to 9.2% overall in the U.S. However, African American/blacks in Chicago and suburban Cook County have an unemployment rate that is three times higher (22.5%) than the rate for whites (7.5%) and Asians (7.1%).</td>
</tr>
<tr>
<td><strong>Education.</strong></td>
</tr>
<tr>
<td>The rate of poverty is higher among those without a high school education and those without a high school education are more likely to develop chronic illnesses. The overall high school graduation rates in the North region (82%) are only slightly lower than the state and national averages of 85% and 84% respectively. However, the high school graduation rates for the North region (82%) are lower than those in neighboring Lake County (88%).</td>
</tr>
<tr>
<td><strong>Housing and transportation.</strong></td>
</tr>
<tr>
<td>Multiple residents in the North region indicated that although there is an abundance of quality housing in the North Side of Chicago and North Cook suburbs, it is not necessarily affordable. Approximately 31% of survey respondents from the North region indicated that housing is “not very” or “not at all” affordable in their communities. In addition, residents stated that there are severe crowding issues in some parts of the North region. Several community members stated that transportation assistance for seniors, individuals with disabilities, and low-income residents needs to be expanded.</td>
</tr>
<tr>
<td><strong>Environmental concerns.</strong></td>
</tr>
<tr>
<td>Potential environmental issues in the North region include lead exposure and air quality. Homes built prior to 1979 are at an increased risk of containing lead paint. Approximately 79% of the homes in Chicago and Suburban Cook County were built before 1979. The percentage of days with poor air quality in the North region is higher than the percentage for Illinois and more than double the percentage for nearby Lake County.</td>
</tr>
<tr>
<td><strong>Safety and Violence.</strong></td>
</tr>
<tr>
<td>Firearm-related and homicide mortality are highest among Hispanic/Latinos and African American/blacks in the North region. Drug trafficking, gangs, human trafficking, violence in residential facilities, and vandalism are some of the major safety issues mentioned by residents from the North Side of Chicago and North Cook Suburbs.</td>
</tr>
</tbody>
</table>

Disparities related to socioeconomic status, access to quality and affordable housing, safety and violence, education, policies, and structural racism were identified in the North region as being key drivers of community health and individual health outcomes.

2. Improving mental and behavioral health.

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

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

<table>
<thead>
<tr>
<th>Mental Health and Substance Use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community-based mental health care and funding.</strong></td>
</tr>
<tr>
<td>Community mental health issues are being exacerbated by long-standing inadequacies in funding as well as recent cuts to social services, healthcare, and public health. Socioeconomic inequities, disparities in healthcare access, housing issues, racism, discrimination, stigma, mass incarceration of individuals with mental illness, community safety issues, and violence are all negatively impacting the mental health of residents in the North region. Focus group participants and survey respondents in the North region reported stigma, a lack of community-based services, a lack of workforce development programs, cost/lack of insurance, lack of knowledge about where to get services, and wait times for treatment as barriers to accessing needed mental health treatment. Survey respondents from the North region indicated that their financial situation (not enough money, debt), time pressures/not enough time, and the health of family members were the biggest factors contributing to feelings of stress in their day-to-day lives.</td>
</tr>
<tr>
<td><strong>Substance use.</strong></td>
</tr>
<tr>
<td>The lack of effective substance use prevention, easy access to alcohol and other drugs, the use of substances to self-medicate in lieu of access to mental health services and the criminalization of addiction are factors and trends affecting community health and the local public health system in the North region. There are several barriers to accessing mental health and substance use treatment and services including social stigma, continued funding cuts, and mental health/substance use provider shortages. The need for policy changes that decriminalize substance use and connect individuals with treatment and services were identified as needs in the North region.</td>
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3. Preventing and reducing chronic disease (focus on risk factors - nutrition, physical activity, and tobacco).

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

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

<table>
<thead>
<tr>
<th>Chronic Disease</th>
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<tr>
<td><strong>Policy, systems and environment.</strong> Findings from community focus groups, the Forces of Change Assessment (FOCA), and the Local Public Health System Assessment (LPHSA) emphasized the important role of health environments and policy for healthy eating and active living.</td>
</tr>
</tbody>
</table>

| Health Behaviors. | The majority of adults in suburban Cook County (84.9%) and Chicago (70.8%) self-report eating less than five daily servings of fruits and vegetables a day. In addition, more than a quarter of adults in suburban Cook County (28%) and Chicago (29%) report not engaging in physical activity during leisure times. Approximately 14% of youth in suburban Cook County and 22% of youth in Chicago report not engaging in physical activity during leisure time. Poor diet and a lack of physical activity are two of the major predictors for obesity and diabetes. A significant percentage of youth and adults report engaging in other health behaviors such as smoking and heavy drinking that are also risk factors for chronic illnesses. Low consumption of healthy foods may also be an indicator of inequities in food access. |

| Mortality related to chronic disease. | The top three leading causes of death in the North region are cancer, heart disease, and diabetes-related. There are disparities in chronic-disease related mortality in the North region, both in terms of geography and in terms of race and ethnicity. |

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**4. Increasing access to care and community resources.**

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

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

<table>
<thead>
<tr>
<th>Access to care and community resources</th>
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<tbody>
<tr>
<td><strong>Cultural and linguistic competence and humility.</strong> Focus group participants in the North region and Stakeholder Advisory Team members emphasized that cultural and linguistic competence and humility are key aspects of access to quality healthcare and community services. Participants in all of the focus groups in the North region cited lack of sensitivity to cultural difference as a significant issue impacting health of diverse racial and ethnic groups in the North region.</td>
</tr>
</tbody>
</table>

| Insurance coverage. | Aggregated rates from 2009-2013, show that 23% of the adult population age 18-64 in the North region reported being uninsured, compared to 19% in Illinois and 20% in the U.S. Men in Cook County are more likely to be uninsured (18%) compared to women (14%). In addition, ethnic and racial minorities are much more likely to be uninsured compared non-Hispanic whites. In 2014, nearly a quarter of immigrants (23%) and 40% of undocumented immigrants are uninsured compared to 10% of U.S. born and naturalized citizens. |

| Use of preventive care. |

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Overall rates of self-reported cancer screenings vary greatly across Chicago and suburban Cook County compared to the rates for Illinois and the U.S. This could represent differences in access to preventative services or difference in knowledge about the need for preventative screenings. Approximately one-third of Chicago residents aged 65 or older reported that they had not received a pneumococcal vaccination in 2014. Health education about routine preventative care was mentioned by multiple residents as a need in their communities.

**Provider availability.**
A large percentage of adults in the U.S. report that they do not have at least one person that they consider to be their personal doctor or health care provider. In addition, LGBQIA and transgender youth and adults are less likely to report having a regular place to go for medical care. There are multiple communities in the North region that are designated by the Health Resources and Services Administration as areas having shortages of primary care, dental care, or mental health providers.

**Use of prenatal care.**
Nearly 20% of women in Illinois and suburban Cook County do not receive adequate prenatal care prior to the third month of pregnancy or receive no prenatal care.
Introduction

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

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

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

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

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7 Certified local health departments in Illinois have been required by state code to conduct “IPLAN” community health assessments on a five year cycle since 1992.
Figure 2.1. Map of the three CHNA regions in Cook County, Illinois

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

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

Nine nonprofit hospitals, four health departments, and approximately 30 stakeholders partnered on the CHNA for the North region. The participating hospitals are Advocate Illinois Masonic Medical Center; Advocate Lutheran General Hospital; NorthShore University HealthSystem, including Evanston, Glenbrook, and Skokie Hospitals; Presence Holy Family Medical Center; Presence Resurrection Medical Center; Presence Saint Francis Hospital; and Presence Saint Joseph Hospital. Health departments are key partners in leading the Health Impact Collaborative and conducting the CHNA. The participating health departments in the North region are Chicago Department of Public Health, Cook County Department of Public Health, Evanston Health Department, and Skokie Health Department.
Community and stakeholder engagement

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

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

The North Stakeholder Advisory Team includes representatives of diverse community organizations from across the North Side of Chicago and North Cook suburbs. The Stakeholder Advisory Team contributed to the collaborative in the following ways:

2. Contributing to developing the Collaborative’s mission, vision and values.
3. Providing input on assessment design, including data indicators, surveys, focus groups, and asset mapping.
4. Sharing data that is relevant and/or facilitate the participation of community members to provide input through surveys and focus groups.
5. Reviewing assessment data and assist with developing findings and identifying priority strategic issues.
6. Will participate in action planning to develop goals, objectives and strategies for improving community health and quality of life.
7. Will join an action team to help shape implementation strategies.
The organizations represented on the North Stakeholder Advisory Team are listed in Figure 2.3.

**Figure 2.3. North Stakeholder Advisory Team as of March 2016**

<table>
<thead>
<tr>
<th>North Region Stakeholder Team Members</th>
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<tbody>
<tr>
<td>Access to Care</td>
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<tr>
<td>Access Community Health Network, Genesis Center, Des Plaines</td>
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<tr>
<td>American Cancer Society</td>
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<tr>
<td>American Indian Health Services</td>
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<tr>
<td>Asian Human Services</td>
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<tr>
<td>Catholic Charities</td>
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<tr>
<td>Center of Concern, Des Plaines Ministerial Association</td>
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<tr>
<td>Centro Romero</td>
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<tr>
<td>Cook County Housing Authority</td>
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<tr>
<td>DePaul University</td>
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<tr>
<td>Erie Health Center</td>
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<tr>
<td>Howard Brown Health</td>
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<tr>
<td>Lutheran Social Services of Illinois</td>
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<tr>
<td>Maine Community Youth Assistance Foundation (MCYAF)</td>
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<td>Maryville Academy</td>
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<tr>
<td>Ministerial Alliance</td>
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<tr>
<td>National Alliance on Mental Illness (NAMI)</td>
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<tr>
<td>North Park University</td>
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<tr>
<td>Norwood Park Senior Center</td>
</tr>
<tr>
<td>Patient Innovation Center</td>
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<tr>
<td>Polish American Association</td>
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<tr>
<td>Salvation Army</td>
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<tr>
<td>Turning Point Behavioral Health Center</td>
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</tbody>
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**Formation of the North Stakeholder Advisory Team**

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

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

The North Stakeholder Advisory Team provided input at every stage of the assessment and was instrumental in shaping the assessment findings and priorities issues that are presented in this report. The North Stakeholder Advisory Team met with the participating hospitals and health departments (i.e. North Leadership Team) seven times between May 2015 and March 2016. IPHI designed and facilitated these meetings to solicit input, make recommendations, identify assets, and work collaboratively with hospitals and health systems to identify priority health needs.

**Figure 2.4. Stakeholder Wheel**

Adapted from Connecticut Department of Public Health and Health Resources in Action (HRiA)
North Leadership Team
Each region of the Health Impact Collaborative of Cook County has a leadership team consisting of the hospitals and health departments participating in the collaborative in the defined regional geography. The charge of the North Leadership Team is to:

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

During the assessment process, the North Leadership Team held monthly planning calls with IPHI and monthly in-person meetings with stakeholders. The North region leads are the Director of Community and Health Relations at Advocate Lutheran General Hospital and the Regional Director of Community Health Integration, NWC Region for Presence Health.

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

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

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

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

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

Figure 3.1. MAPP Framework

The key phases of the MAPP process include:
- Organizing for Success and Developing Partnerships
- Visioning
- Conducting the Four MAPP Assessments
- Identifying Strategic Issues
- Formulating Goals and Strategies
- Taking Action - Planning, Implementing, Evaluating

The four MAPP assessments are:
- Community Health Status Assessment (CHSA)
- Community Themes and Strengths Assessment (CTSA)
- Forces of Change Assessment (FOCA)
- Local Public Health System Assessment (LPHSA)

The Key Findings sections of this report highlight key assessment data and findings from the four MAPP assessments. As part of continuing efforts to align and integrate community health assessment across Chicago and Cook County, the Health Impact Collaborative leveraged recent assessment data from local health departments where possible for this CHNA. Both the Chicago and Cook County Departments of Public Health completed community health assessments using the MAPP model between 2014 and 2015. As a result, IPHI was able to compile data from the two health departments’ respective Forces of Change and Local Public Health System Assessments for discussion with the North Stakeholder Advisory Team, and data from the Community Health Status Assessments was also incorporated into the data presentation for this CHNA. See pages 26-31 for description of the assessment methodologies used in this CHNA.
Community Description for the North Region

In the 2010 Census, the North region had 1,356,161 residents compared to 1,399,914 residents in the 2000 Census. The total land area encompassed by the North region is roughly 193 square miles and the population density is approximately 9,340 residents per square mile based on the 2010 Census data.\(^8\)

Non-Hispanic whites are the largest racial or ethnic group in the North region, representing 64% of the population. Compared to the South and Central regions, the North region has the highest percentage of non-Hispanic whites. The North region also has the highest percentage of Asian residents (10.8). Approximately 17.8% of individuals in the North region identify as Hispanic/Latino and 5.6% identify as African American/black. Despite an overall decrease in the total population of the North region, the Asian and Hispanic/Latino populations grew by 6% and 7% respectively between 2000 and 2010.

Figure 4.1. Regional race and ethnicity

[Figure 4.1 showing the percentage of various races and ethnicities in the North region, Central region, and South region.]

Data Source: U.S. Census Bureau 2010 Census

African American/blacks are experiencing large population decreases across Chicago and suburban Cook County. In the North region, the African American/black population decreased by 9% between 2000 and 2010. The non-Hispanic white population is also decreasing across the county and decrease by 6% in the North region between 2000 and 2010 (See Figures 4.2 and 4.3).

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

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White (non-Hispanic)</td>
<td>858,190</td>
<td>915,229</td>
<td>-57,039</td>
<td>-6%</td>
</tr>
<tr>
<td>Black (non-Hispanic)</td>
<td>77,809</td>
<td>85,318</td>
<td>-7,509</td>
<td>-9%</td>
</tr>
<tr>
<td>Asian (non-Hispanic)</td>
<td>131,302</td>
<td>124,171</td>
<td>7,131</td>
<td>6%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>256,419</td>
<td>238,657</td>
<td>17,762</td>
<td>7%</td>
</tr>
</tbody>
</table>

Data Source: U.S. Census Bureau, 2010 Census

\(^8\) 2010 Decennial Census and American Communities Survey, 2010-2014.
Figure 4.3. Regional population change by race and ethnicity, 2000-2010

Population change in the North region by race and ethnicity, 2000-2010

- Hispanic/Latino: 17,762
- Asian: 7,131
- African American/black: -7,509
- White: -57,039

Population change in the South region by race and ethnicity, 2000-2010

- Hispanic/Latino: 86,747
- Asian: 15,846
- African American/black: -65,704
- White: -163,693

Population change in the Central region by race and ethnicity, 2000-2010

- Hispanic/Latino: 32,558
- Asian: 11,809
- African American/black: -54,024
- White: -19,453

Data Source: U.S. Census Bureau 2010 Census
Two important metrics provide a picture of recent immigrant populations that speak languages other than English: percent of the population who report limited English proficiency and linguistically isolated households. Within the North region, there are geographic variations in the percentages of the population with limited English proficiency as shown in Figure 4.4.

Figure 4.4. Limited English Proficiency, 2009-2013

North region communities with the highest percentages of households with limited English proficiency

<table>
<thead>
<tr>
<th>Chicago</th>
<th>Suburban Cook County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avondale</td>
<td>Elk Grove Village</td>
</tr>
<tr>
<td>Albany Park</td>
<td>Mount Prospect</td>
</tr>
<tr>
<td>Norridge</td>
<td>Northfield Township</td>
</tr>
<tr>
<td>West Ridge</td>
<td>Norwood Park Township</td>
</tr>
<tr>
<td></td>
<td>Palatine Township</td>
</tr>
<tr>
<td></td>
<td>Wheeling</td>
</tr>
</tbody>
</table>

Data Source: American Communities Survey, 2009-2013
Approximately 8% of all households in Chicago and suburban Cook County are linguistically isolated, defined by the Census as households where “all members 14 years old and over have at least some difficulty with English.”

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

Languages spoken by linguistically isolated households:

- **28.9%** Asian and Pacific Islander
- **26.6%** Indo-European
- **24.7%** Spanish
- **18.5%** Other Languages

Children and adolescents under 18 represent 20.4% of the population in the North region. Approximately 66.4% of the population is 18 to 64 years old and about 13% are older adults age 65 or over.

**Figure 4.5. Age distribution of residents in the North region, 2010**

<table>
<thead>
<tr>
<th></th>
<th>Under 18</th>
<th>18-64</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>24.0%</td>
<td>62.9%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Illinois</td>
<td>23.2%</td>
<td>64.4%</td>
<td>12.5%</td>
</tr>
<tr>
<td>South Region</td>
<td>26.2%</td>
<td>61.6%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Central Region</td>
<td>23.8%</td>
<td>66.8%</td>
<td>9.4%</td>
</tr>
<tr>
<td>North Region</td>
<td>20.4%</td>
<td>66.4%</td>
<td>13.3%</td>
</tr>
</tbody>
</table>

Data Source: U.S. Census Bureau 2010 Census

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

<table>
<thead>
<tr>
<th>Chicago</th>
<th>Suburban Cook County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln Park</td>
<td>Buffalo Grove</td>
</tr>
<tr>
<td></td>
<td>Elk Grove Village</td>
</tr>
<tr>
<td></td>
<td>Evanston</td>
</tr>
<tr>
<td></td>
<td>Glenview</td>
</tr>
<tr>
<td></td>
<td>Lyons</td>
</tr>
<tr>
<td></td>
<td>Northbrook</td>
</tr>
<tr>
<td></td>
<td>Prospect Heights</td>
</tr>
<tr>
<td></td>
<td>Rolling Meadows</td>
</tr>
<tr>
<td></td>
<td>Wheeling</td>
</tr>
</tbody>
</table>

Data Source: U.S. Census Bureau 2010 Census

Census data show that the population of males and females in Chicago and suburban Cook County is approximately equal. While data on transgender individuals is very limited, a 2015 study by the U.S. Census Bureau estimates that there are approximately 3.4 to 4.7 individuals per 100,000 residents in Illinois that are transgender.\(^9\) It is estimated that approximately 5.7% of Chicago residents identify as lesbian, gay, bisexual, queer, asexual, or intersex (LGBQIA).\(^10\)


There are disparities in many health indicators such as access to clinical care, health behaviors such as smoking and heavy drinking, and self-reported health status for LGBTQIA and transgender populations.\(^{11}\) The demographic characteristics of additional priority population groups are shown in Figure 4.7.

### Figure 4.7. Demographic characteristics of key populations in the North region

<table>
<thead>
<tr>
<th>Key Population</th>
<th>Demographic Characteristics</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formerly Incarcerated</td>
<td>40-50% of people released from Illinois prisons return to the City of Chicago. In 2013, that represented 12,000 individuals re-entering the community in Chicago over the course of the year.</td>
<td>City of Chicago. (2016). Ex-offender re-entry initiatives. <a href="http://www.cityofchicago.org/city/en/depts/mayor/supp_info/ex-offender_re-entryinitiatives.html">http://www.cityofchicago.org/city/en/depts/mayor/supp_info/ex-offender_re-entryinitiatives.html</a></td>
</tr>
<tr>
<td>Homeless</td>
<td>An estimated 125,848 people were homeless in Chicago in 2015, and children and teens represent 35% (43,958) of the homeless population. In 2015, 2,025 homeless individuals were accessing shelter services in suburban Cook County.</td>
<td>Chicago Coalition for the Homeless. (2016). <a href="http://www.chicagohomeless.org/faq-studies/">http://www.chicagohomeless.org/faq-studies/</a>; Alliance to End Homelessness in Suburban Cook County. (2015). <a href="http://www.suburbancook.org/counts">http://www.suburbancook.org/counts</a></td>
</tr>
<tr>
<td>People living with mental health conditions</td>
<td>11% of adults in Illinois reported living with a mental or emotional illness in 2012.</td>
<td>Behavioral Risk Factor Surveillance System</td>
</tr>
<tr>
<td>People with disabilities</td>
<td>Approximately 9% of the population in the North region lives with a disability.</td>
<td>American Communities Survey, 2010-2014</td>
</tr>
<tr>
<td>Veterans and former military</td>
<td>Overall, approximately 202,886 veterans live in Chicago and suburban Cook County. In the North region, approximately 63,915 individuals (6% of the population) are classified as veterans.</td>
<td>American Communities Survey, 2010-2014</td>
</tr>
</tbody>
</table>

Overview of Collaborative Assessment Methodology\textsuperscript{12}

The Health Impact Collaborative of Cook County employed a mixed methods approach to assessment, utilizing the four MAPP assessments\textsuperscript{13} to analyze and consider data from diverse sources to identify significant community health needs for the North region of Cook County.

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

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

What are the FOCA and the LPHSA?

The Forces of Change Assessment (FOCA) seeks to identify answers to the questions:
1. What is occurring or might occur that affects the health of our community or the local public health system?
2. What specific threats or opportunities are generated by these occurrences?
   • For the FOCA, local community leaders and public health system leaders engage in forecasting brainstorming, discussion and in some cases prioritization.
   • Participants are encouraged to think about forces in several common categories of change including: economic, environmental, ethical, health equity, legal, political, scientific, social, and technological.
   • Once all potential forces are identified, groups discuss the potential impacts in terms of threats and opportunities for the health of the community and the public health system.

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

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

\textsuperscript{12} Note: Some hospitals and health systems conducted additional assessment activities and data analyses which are presented in the hospital-specific CHNA report components.

\textsuperscript{13} The MAPP Assessment framework is presented in more detail on page 19 of this report. The four MAPP assessments are: Community Health Status Assessment (CHSA), Community Themes and Strengths Assessment (CTSA), Forces of Change Assessment (FOCA), and Local Public Health System Assessment (LPHSA).
IPHI worked with both Chicago and Cook County health departments to plan, facilitate and document the LPHSAs. Many members of the Health Impact Collaborative of Cook County participated in one or both of the LPHSAs and found the events to be a great opportunity to increase communication across the local public health system, increase knowledge of the interconnectedness of activities to improve population health, understand performance baselines and benchmarks for meeting public health performance standards and identify timely opportunities to improve collaborative community health work.

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

**Methods - Community Health Status Assessment**

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

- Demographics
- Socioeconomic Factors
- Health Behaviors
- Physical Environment
- Health Care and Clinical Care
- Mental Health
- Health Outcomes (Birth Outcomes, Morbidity, Mortality)
Figure 5.2. County Health Rankings Model

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

Data were compiled from a range of sources, including:

- Seven local health departments: Chicago Department of Public Health, Cook County Department of Public Health, Evanston Health & Human Services Department, Oak Park Health Department, Park Forest Health Department, Stickney Public Health District, and Village of Skokie Health Department
- Additional local data sources including: Cook County Housing Authority, Illinois Lead Program, Chicago Metropolitan Agency for Planning (CMAP), Illinois EPA, State/Local Police
- Hospitalization and ED data: Advocate Health Care through its contract with the Healthy Communities Institute made available averaged, age adjusted hospitalization and Emergency Department statistics for four time periods based on data provided by the Healthy Communities Institute and Illinois Hospital Association (COMPdata)
- Federal data sources: Decennial Census and American Communities Survey via two web platforms-American FactFinder and Missouri Census Data Center, Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), Dartmouth Atlas of Health Care, Feeding America, Health Resources and Services Administration (HRSA), United States Department of Agriculture (USDA), National Institutes of Health (NIH) National Cancer Institute, and the Community Commons / CHNA.org website
The mission, vision, and values of the Collaborative have a strong focus on improved health equity in Chicago and suburban Cook County. As a result, the Collaborative utilized the CHSA process to identify inequities in social, economic, healthcare, and health outcomes in addition to describing the health status and community conditions in the North region. Many of the health disparities vary by geography, gender, sexual orientation, age, race, and ethnicity.

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

**Methods – Community Themes and Strengths Assessment**

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

**Community Survey - methods and description of respondents in North region**

By leveraging its partners and networks, the Collaborative collected approximately 5,200 resident surveys between October 2015 and January 2016, including approximately 1,500 in the North region. The survey was available on paper and online and was disseminated in five
The community resident survey was a convenience sample survey, distributed by hospitals and community based organizations through targeted outreach to diverse communities in Chicago and Cook County, with a particular interest in reaching low income communities and diverse racial and ethnic groups to hear their input into this Community Health Needs Assessment. The community resident survey was intended to complement existing community health surveys that are conducted by local health departments for their IPLAN community health assessment processes. IPHI reviewed approximately 12 existing surveys to identify possible questions, and worked iteratively with hospitals, health departments, and stakeholders from the 3 regions to hone in on the most important survey questions. IPHI consulted with the UIC Survey Research Laboratory to refine the survey design. The data from paper surveys was entered into the online SurveyMonkey system so that electronic and paper survey data could be analyzed together. Survey data analysis was conducted using SAS statistical analysis software, and Microsoft Excel was used to create survey data tables and charts. The majority of survey respondents from the North region were heterosexual (89%, n=1140) and white (71% n=1148). Approximately 19% (n=1082) of survey respondents identified as Hispanic/Latino and approximately 4% identified as Middle Eastern (n=1082). Roughly 0.1% (n=1256) of survey respondents from the North region indicated that they were living in a shelter and 0.5% (n=1256) indicated that they were homeless. Most respondents from the North region had a college degree or higher (53%, n=1205). The majority of North region respondents had an annual household income of $60,000 or less (63%, n=1067).

Focus Groups - methods and description of participants in North region

IPHI conducted eight focus groups in the North region between October 2015 and March 2016. The collaborative ensured that the focus groups included populations who are typically underrepresented in community health assessments, including racial and ethno-cultural groups, immigrants, limited English speakers, low-income communities, families with children, LGBQIA and transgender individuals and service providers, individuals with disabilities and their family members, individuals with mental health issues, formerly incarcerated individuals, veterans, seniors, and young adults. The main goals of the focus groups were:

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

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14 Written surveys were available in English, Spanish, Polish and Korean; all surveys with Arabic speakers were conducted with the English version of the survey along with interpretation by staff from a community based organization that works with Arab-American communities.
Each of the focus groups was hosted by a hospital or community based organization, and the host organization recruited participants. IPHI facilitated the focus groups, most of which were implemented in 90-minute sessions with approximately 8 to 10 participants. IPHI adjusted the length of some sessions to be as short as 45 minutes and as long as two hours to accommodate the needs of the participants, and some groups included as many as 25 participants.

**Figure 5.3. Focus groups conducted in the North region**

<table>
<thead>
<tr>
<th>Focus Groups</th>
<th>Location and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Down Syndrome Center (Advocate Lutheran General Hospital)</strong>&lt;br&gt;Participants included parents and families of individuals with Down syndrome, medical providers, a representative from a residential facility, and adults living with Down syndrome.</td>
<td>Park Ridge, Illinois (1/28/2016)</td>
</tr>
<tr>
<td><strong>Asian Human Services</strong>&lt;br&gt;Participants were staff members with AHS. AHS is a Social Service Organization serving immigrants, refugees, and other underserved communities in Chicago and the northern suburbs of Cook County.</td>
<td>West Ridge, Chicago, Illinois (1/27/2016)</td>
</tr>
<tr>
<td><strong>Hanul Family Alliance</strong>&lt;br&gt;Participants were Korean-American community members</td>
<td>Albany Park, Chicago, Illinois (1/13/2016)</td>
</tr>
<tr>
<td><strong>Harper College</strong>&lt;br&gt;Focus group participants included students and faculty in the college’s Health Services Department as well as community partners including staff at social service organizations and representatives from local government.</td>
<td>Palatine, Illinois (2/8/2016)</td>
</tr>
<tr>
<td><strong>Healthy Rogers Park Network</strong>&lt;br&gt;Participants included representatives from local social service organizations, clinics, hospitals, and community groups.</td>
<td>Rogers Park, Chicago, Illinois (1/20/2016)</td>
</tr>
<tr>
<td><strong>Howard Brown Health</strong>&lt;br&gt;Participants were LGBQIA and transgender community members from across Chicago and Suburban Cook County and staff who were residents of surrounding communities.</td>
<td>Uptown, Chicago, Illinois (3/11/2016)</td>
</tr>
<tr>
<td><strong>Norwood Park Senior Center</strong>&lt;br&gt;Focus group participants were family members and caregivers of individuals requiring assisted living or full-time care.</td>
<td>Norwood Park, Chicago, Illinois (1/24/2016)</td>
</tr>
<tr>
<td><strong>Polish American Association</strong>&lt;br&gt;Focus group participants were Polish American staff who were also community members.</td>
<td>Portage Park, Chicago, Illinois (2/9/2016)</td>
</tr>
</tbody>
</table>
Prioritization process, significant health needs, and Collaborative focus areas

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

Figure 6.1. Prioritization Criteria

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

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

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

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

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

- Social and structural determinants of health
  - With an emphasis on economic inequities, educational inequities, and structural racism
- Healthy environment
  - Including built environment and transportation and related health issues
- Mental health and substance use
- Chronic disease prevention
  - With a focus on health equity, prevention, and the connections between chronic disease and built environment and social determinants of health
- Access to care and community resources
  - Including addressing barriers to access for low income households, improving health literacy, improving cultural and linguistic competence, and supporting linkages between health care and community based organizations for prevention
- Budget and financing at state and local levels

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

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

Healthy Environment came up as a key issue in all three regions, although it was classified differently during prioritization in the different regions. Because of the close connections between Healthy Environment and two of the other top issues - Social Determinants of Health and Chronic Disease - Healthy Environment is included as a topic within both of those broad issues, as shown in Figure 6.3.
Figure 6.2. Summary of priorities identified during March 2016 stakeholder meetings, by region

<table>
<thead>
<tr>
<th>Social and Structural Determinants</th>
<th>Healthy Environment</th>
<th>Mental Health and Substance Use (Behavioral Health)</th>
<th>Chronic Disease</th>
<th>Access to Care and Community Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>North</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Under social determinants and chronic disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Central</strong></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Under social determinants and chronic disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>Emphasized connections between healthy environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>and chronic disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>South</strong></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emphasized connections between community safety,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>trauma, and mental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Social, economic and structural determinants of health</th>
<th>Mental health and substance abuse (Behavioral health)</th>
<th>Chronic disease</th>
<th>Access to care and community resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Economic inequities and poverty</td>
<td>• Overall access to services and funding</td>
<td>• Focus on risk factors - nutrition, physical activity, tobacco</td>
<td>• Cultural &amp; linguistic competency/ humility</td>
</tr>
<tr>
<td>• Education inequities</td>
<td>• Violence and trauma, and its ties to mental health</td>
<td>• Healthy environment</td>
<td>• Health literacy</td>
</tr>
<tr>
<td>• Systemic racism</td>
<td></td>
<td></td>
<td>• Access to healthcare and social services, particularly for uninsured and underinsured</td>
</tr>
<tr>
<td>• Housing</td>
<td></td>
<td></td>
<td>• Navigating complex health care system and insurance</td>
</tr>
<tr>
<td>• Healthy environment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Safety and violence</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The regional discussions highlighted the relationship between healthy environment, chronic disease, and social and structural determinants of health. As a result, healthy environment is listed under both chronic disease and determinants of health. Participants emphasized the connections between community safety, trauma, and mental health during the regional meetings. As a result, safety and violence is listed as both a social determinant and a behavioral health determinant. All three regional discussions also identified policy, advocacy, funding, and data systems as key strategies and approaches that should be applied across all of the focus areas.

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

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

Health inequities

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

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

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Discrimination against LGBTQIA and transgender community members has been linked with high rates of psychiatric disorders, substance use, and suicide.\textsuperscript{18} Nearly a quarter of immigrants (23\%) and 40\% of undocumented immigrants are uninsured compared to 10\% of U.S. born and naturalized citizens.\textsuperscript{19}

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

### Health inequities in Chicago and suburban Cook County

- African Americans experienced an overall increase in mortality from cardiovascular disease between 2000-2002 and 2005-2007 in suburban Cook County while whites experienced an overall decrease in cardiovascular disease-related mortality during the same time period.
- In the South region, African Americans have the highest mortality rates for cardiovascular disease, diabetes-related conditions, stroke, and cancer compared to other race/ethnic groups in the region.
- Hispanic and African American teens have much higher birth rates compared to white teens in Chicago and Suburban Cook County.
- African American infants are more than four times as likely as white infants to die before their first birthday in Chicago and suburban Cook County.
- Homicide and firearm-related mortality are highest among African Americans and Hispanics.
- In 2012, the firearm-related mortality rate in the South region (20.4 deaths per 100,000) was more than four times higher than the rate for the North region (4.6 deaths per 100,000). In 2012, the homicide mortality rate in the South region (19.8 deaths per 100,000) was more than six times higher than the rate for the North region (3.1 deaths per 100,000).
- There are significant gaps in housing equity for African American/blacks and Hispanic/Latinos compared to whites and Asians.
- The life expectancy for Chicagoans living in areas of high economic hardship is five years lower than those living in better economic conditions.

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


Economic inequities
Socioeconomic factors are the largest determinants of health status and health outcomes. Poverty can create barriers to accessing quality health services, healthy food, and other necessities needed for good health status. Poverty also largely impacts housing status, educational opportunities, the physical environment that a person works and lives in, and health behaviors. Asians, Hispanic/Latinos, and African American/blacks have higher rates of poverty compared to non-Hispanic whites as well as lower annual household incomes. In addition, approximately 15% of children and adolescents live below 100% of the federal poverty level and 34% of children below 200% of the federal poverty level in the North region. Unemployment can create financial instability and as result can create barriers to accessing healthcare services, insurance, healthy foods, and other basic needs. The unemployment rate in the North region (8.2%) is slightly lower than the rates for Illinois (10.5%) and the U.S. (9.2%). However, there are disparities in unemployment in the North region and across Chicago and Cook County with African American/blacks having a much higher rate of unemployment compared to whites and Asians.

Education inequities
Community residents in the North region described inequities in access to quality education. Education is an important social determinant of health, because the rate of poverty is higher among those without a high school diploma. In addition, those without a high school education are at a higher risk of developing certain chronic illnesses.

Inequities in the built environment
Potential environmental issues identified in the North region include lead exposure and air quality. Community input indicates that although there is an abundance of quality housing in the North Side of Chicago and North Cook suburbs, it is not necessarily affordable. Approximately 31% of survey respondents from the North region indicated that housing is “not very” or “not at all” affordable in their communities. In addition, residents stated that there are severe crowding issues in some parts of the North region. Several community members stated that transportation assistance for seniors, individuals with disabilities, and low-income residents needs to be expanded.

Inequities in community safety and violence
Violent crime disproportionately affects residents living in communities of color in Chicago and suburban Cook County. In addition, homicide and firearm-related mortality is highest in African American and Hispanic/Latino communities. Community residents in the North region indicated that drug trafficking, drug use, gangs, human trafficking, violence in residential facilities, and vandalism were some of the primary reasons that they felt unsafe in their communities. Exposure to violence not only causes physical injuries and death, but it also has been linked to negative psychological effects such as depression, stress and anxiety, as well as self-harm and suicide attempts.

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21 American Community Survey, 2010-2014; CommunityCommons.org CHNA Data (2015).
Structural racism and discrimination

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

Discrimination also creates significant disadvantages for other sub-populations in communities. Community input indicates that systemic discrimination against LGBQIA and transgender individuals has contributed to health inequities across Chicago and suburban Cook County.

The importance of upstream approaches

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

Discrimination against LGBQIA and transgender community members can negatively impact:
- **Income** and whether or not an individual can get or keep a job
- **Access to high quality healthcare** that is responsive to their needs
- **Mental health** and contribute to poor coping skills such as substance abuse, risky sexual behaviors, and suicide attempts


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

Social Vulnerability Index and Child Opportunity Index

Social Vulnerability Index

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

Figure 7.3. Social Vulnerability Index by Census Tract, 2010

North region communities with the highest social vulnerability scores

<table>
<thead>
<tr>
<th>Chicago</th>
<th>Suburban Cook County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany Park</td>
<td>Des Plaines</td>
</tr>
<tr>
<td>Avondale</td>
<td>Wheeling</td>
</tr>
<tr>
<td>Logan Square</td>
<td></td>
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<tr>
<td>Portage Park</td>
<td></td>
</tr>
<tr>
<td>Rogers Park</td>
<td></td>
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<tr>
<td>Uptown</td>
<td></td>
</tr>
<tr>
<td>West Ridge</td>
<td></td>
</tr>
</tbody>
</table>

Childhood Opportunity Index

The Childhood Opportunity Index is based on several indicators in each of the following categories: demographics and diversity; early childhood education; residential and school segregation; maternal and child health; neighborhood characteristics of children; and child poverty. Children that live in areas of low opportunity have an increased risk for a variety of negative health indicators such as premature mortality, are more likely to be exposed to serious psychological distress, and are more likely to have poor school performance.26

Figure 7.4. Childhood Opportunity Index by Census Tract, 2007-201327

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Poverty and Economic Equity

Poverty

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

Forces of Change Assessment (FOCA) findings related to Poverty and Economic Inequity

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

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

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

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

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

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

The FOCA results were echoed in the eight focus groups and survey findings in the North region. Community input in the North region emphasized the detrimental health impacts of economic inequities and the need to address poverty and improve economic opportunity in communities with high poverty rates. Community members indicated that economic leakage in the North region has led to some of the economic inequities in their communities. Several community residents described the need for additional workforce development and job opportunities in some communities, including job opportunities for individuals living with disabilities.

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

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29 Economic leakage refers to money leaving a local economy and being spent in other nearby communities.
population living at or below 100% and 200% FPL are higher in Chicago and suburban Cook County than the rates for Illinois and the U.S.

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

12% of the population in the North region lives at or below the 100% Federal Poverty Level.

| North region communities with the highest percentages of persons in poverty |
|-----------------------------|-----------------------------|
| Chicago                     | Suburban Cook County        |
| • Albany Park               | • Evanston/Skokie           |
| • Edgewater                 | • Horwood Heights           |
| • Irving Park               | • Maine Township            |
| • Portage Park              |                             |
| • Rogers Park               |                             |
| • Uptown                    |                             |
| • West Ridge                |                             |

Percent of population living below 100% of the federal poverty line

- 5.00% or less
- 5.01% - 10.00%
- 10.01% - 20.00%
- 20.01% or greater

Data Source: American Communities Survey, 2009-2013
28% of the population in the North region lives at or below the 200% Federal Poverty Level.

North region communities with the highest percentages of persons in poverty:
- Albany Park
- Avondale
- Irving Park
- Rogers Park
- Uptown
- West Ridge

Percent of population living within 200% of the federal poverty level:
- 15.00% or less
- 15.01% - 30.00%
- 30.01% to 45.00%
- 45.00% or greater

Data Source: American Communities Survey, 2009-2013
Nearly half of all children living in Chicago and Cook County live at or below 200% of the federal poverty level. The percentage of children in poverty is higher for Cook County than it is for Illinois and the U.S., and African American and Latino children have much higher poverty rates than non-Hispanic white children. Although the number of children living in poverty decreased overall in Chicago between 2009 and 2013, the number of children living in poverty doubled in suburban Cook County. As shown in the map of the Childhood Opportunity Index in Figure 7.2, there are large inequities in childhood opportunity across Chicago and suburban Cook County.

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

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

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

Unemployment

The unemployment rate in Chicago increased by 69% between 2000 and 2009-2013 and increased in suburban Cook County by 133% during the same time period. In addition, unemployment disparities persist in Chicago and suburban Cook County with African Americans and Hispanic/Latinos having higher unemployment rates than non-Hispanic whites. Unemployment can create financial instability and as a result can create barriers to accessing healthcare services, insurance, healthy foods, and other basic needs. Trends and factors related to employment identified in the FOCA included the outsourcing of jobs from the U.S. A lack of jobs threatens community health through increasing social and community breakdown. The unemployment rate in the North region (8.2%) is low compared to the Central (12.1%) and South (17.0%) regions. However, there are large disparities in unemployment rates across Chicago and Suburban Cook County. The African American/black community has an unemployment rate that is approximately three times higher than the rates for whites and Asians (Figure 7.9).

Nearly a third (29%) of respondents to the community resident survey from the North region reported that there were little or no good jobs in their communities. In addition, 12% of respondents indicated that job training and adult education in their communities were inadequate.

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Figure 7.9. Unemployment Disparities by Race, 2009-2013

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

Data Source: American Communities Survey, 2009-2013

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

Data Source: American Communities Survey, 2009-2013
Education

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

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

High School Graduation Rates in 2012 were higher in Lake County compared to the North region of Chicago and suburban Cook County

<table>
<thead>
<tr>
<th></th>
<th>North</th>
<th>Cook County</th>
<th>Lake County</th>
<th>Illinois</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>82%</td>
<td>78%</td>
<td>88%</td>
<td>82%</td>
<td>82%</td>
</tr>
</tbody>
</table>

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

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

Data Source: American Communities Survey, 2009 -2013
Figure 7.13. The relationship between education and poverty in Chicago and suburban Cook County

Individuals without a high school education are more likely to live in poverty in Chicago and suburban Cook County.

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Below Poverty Level</th>
<th>Above Poverty Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor’s degree or higher</td>
<td>5%</td>
<td>95%</td>
</tr>
<tr>
<td>Some college, associate’s degree</td>
<td>13%</td>
<td>87%</td>
</tr>
<tr>
<td>High school graduate (diploma or GED)</td>
<td>18%</td>
<td>82%</td>
</tr>
<tr>
<td>Less than high school graduate</td>
<td>27%</td>
<td>73%</td>
</tr>
</tbody>
</table>

Data Source: American Communities Survey, 2010-2014

Seven out of the eight focus groups in the North region mentioned schools and education as a major component of health in their communities. Multiple focus group participants indicated that quality education should be available to all students regardless of where they live. In addition, several residents and community workers indicated that in many parts of Chicago and Suburban Cook County, including the North region, the education system has failed tremendously. Approximately 30% of Community Resident Survey respondents from the North region indicated that the schools in their community were less than good.
North Region CHNA 52

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

Housing and Transportation

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

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

<table>
<thead>
<tr>
<th>Geography</th>
<th>Percent of population using public transit for commute to work</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Region</td>
<td>21.2%</td>
</tr>
<tr>
<td>Cook County</td>
<td>18.1%</td>
</tr>
<tr>
<td>Illinois</td>
<td>8.9%</td>
</tr>
<tr>
<td>United States</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

Data Source: American Communities Survey, 2010-2014

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

<table>
<thead>
<tr>
<th>Geography</th>
<th>Percentage of Households with no motor vehicle</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Region</td>
<td>17.4%</td>
</tr>
<tr>
<td>Cook County</td>
<td>17.8%</td>
</tr>
<tr>
<td>Illinois</td>
<td>10.8%</td>
</tr>
<tr>
<td>United States</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

Data Source: American Communities Survey, 2010-2014

Transportation services and assistance for seniors, disabled individuals, and low-income community members have been discontinued or are extremely limited. As a result, it is difficult to use public transportation to go to clinics and medical appointments, to pick-up prescriptions, or to access grocery stores or farmer’s markets with healthier food options. Approximately 15% of survey respondents from the North region rated the convenience of timing and stops for public transit as “poor” or “very poor.” In addition, 20% of North region survey respondents rated the cost of fares as “poor” or “very poor.”

Quality affordable housing was another major issue identified by focus group participants. In addition, several focus group participants mentioned the need to address homelessness in their communities. Approximately 31% of survey respondents from the North region reported that housing in their communities was not affordable. In addition, as previously stated, 41% of survey respondents in the North region described poor housing conditions in their current homes.
Food access and food security

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

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

Focus group participants reported that there is high food insecurity among children in some of the communities on the North side of Chicago and that it has profound effects on child health and development. Approximately 29% of survey respondents from the North region indicated that they or their families have had to worry about whether or not their food would run out before they had the money to buy more. Half of enrolled school children in the North region of Chicago and Suburban Cook County are eligible for free or reduced price lunch. In addition, 9% of all households in the North region are receiving SNAP benefits.

Environmental concerns

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

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

more sensitive to the damaging effects of lead.\textsuperscript{34} If pregnant women are exposed to lead paint particles, there is a risk of exposure to their developing baby.\textsuperscript{34}

Forty-one percent of survey respondents from the North region indicated one or more problems with their current homes that could have a negative impact on health (Figure 7.17).

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

![Map of homes built before 1979 (lead paint risk)](image)

Data Source: American Communities Survey, 2009-2013

---

\textsuperscript{34} U.S. Environmental Protection Agency (2015). [https://www.epa.gov/lead/learn-about-lead](https://www.epa.gov/lead/learn-about-lead)
Figure 7.17. Housing conditions identified by community resident survey respondents from the North region

Which of the following describes your current home? Check all that apply. (n=1193)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No smoke alarms / smoke alarms do not work</td>
<td>4%</td>
</tr>
<tr>
<td>Smoking occurs in your home</td>
<td>4%</td>
</tr>
<tr>
<td>No carbon monoxide alarms</td>
<td>7%</td>
</tr>
<tr>
<td>Pests such as roaches or mice in the last 3 months</td>
<td>7%</td>
</tr>
<tr>
<td>Mold or mildew is present</td>
<td>9%</td>
</tr>
<tr>
<td>Water leaks in the last 12 months</td>
<td>12%</td>
</tr>
<tr>
<td>Outside air leaking through windows, doors, crevices</td>
<td>16%</td>
</tr>
<tr>
<td>Home was built before 1978 and the paint is peeling</td>
<td>18%</td>
</tr>
<tr>
<td>None of these</td>
<td>59%</td>
</tr>
</tbody>
</table>

Eighteen percent of survey respondents from the North region reported that their home was built prior to 1978 and the paint was peeling. The next most frequent home maintenance concern reported was outside air leaking through windows, doors, and crevices, which was cited by 16% of respondents. Twelve percent of respondents reported water leaks over the last 12 months and 9% of respondents reported mold/mildew being present in their homes.

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

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

<table>
<thead>
<tr>
<th>Geography</th>
<th>Percentage of days exceeding the National Ambient Air Quality Standard (35 micrograms per cubic meter) - Population Adjusted Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Region</td>
<td>1.3%</td>
</tr>
<tr>
<td>Cook County</td>
<td>1.6%</td>
</tr>
<tr>
<td>Illinois</td>
<td>1.1%</td>
</tr>
<tr>
<td>United States</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

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

Safety and violence - Social, economic, and structural determinants of health

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

There are large disparities in homicide and firearm-related mortality between regions. Homicide mortality in the South region is six times higher than the rate in the North region and firearm-related mortality is four times higher in the South compared to the North (Figure 7.19). However, there are multiple communities in the North region that share a disproportionate burden of violent crime (Figure 7.20).

The major safety issues identified by focus group participants on the North Side of Chicago and in the North Cook suburbs included drug trafficking, gangs, human trafficking, violence in residential facilities, and vandalism. The focus group results were mirrored in the Community Resident Survey where respondents from the North region indicated that gang activity (16%), drug use/drug dealing (13%), and graffiti/vandalism (12%) are the most common reasons respondents felt unsafe in the last 12 months.

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

<table>
<thead>
<tr>
<th></th>
<th>Homicide age-adjusted mortality by region (per 100,000), 2012</th>
<th>Firearm-related age-adjusted mortality by region (per 100,000), 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>3.1</td>
<td>4.6</td>
</tr>
<tr>
<td>Central</td>
<td>11.2</td>
<td>11.7</td>
</tr>
<tr>
<td>South</td>
<td>19.8</td>
<td>20.4</td>
</tr>
</tbody>
</table>

Data Source: Illinois Department of Public Health, 2012
Structural racism and systems-level policy change—Social, economic, and structural determinants of health

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

Community members in the North region focus groups indicated that communities of color have a disproportionate burden of health problems. Participants stated that immigrants, Latinos and African Americans were more likely to live in low-income neighborhoods with fewer job opportunities. Residents emphasized the need to give locally owned businesses incentives to establish in low-income neighborhoods. School districts in low-income communities of color were often described as substandard.

In addition, many of the survey respondents indicated that they had experienced discrimination in their day-to-day lives (Figure 7.21).

Figure 7.21. Discrimination in the daily lives of community survey respondents, North region
In your day to day life, how often have any of the following things happened to you? (n=1213)

The Forces of Change Assessment (FOCA) and Local Public Health System Assessment (LPHSA) identified that policy and advocacy to address inequities are essential to an upstream approach to addressing the social determinants of health. The FOCA and LPHSA discussions also emphasized that communities being affected by inequities should be involved in leading policy change efforts and that there need to be changes to state and local politics in order to achieve the systems changes that are needed to address inequities.
Additional systems level issues identified by focus group participants include included treatment instead of incarceration for individuals with mental illness or substance abuse health issues as well as advocacy and funding for mental health services.

**Health Impacts - Social, economic, and structural determinants of health**

As summarized on pages 37-40 of this report, there are many health disparities that relate to racial inequities and income inequities. These societal inequities have profound effects on life expectancy. In both Chicago and suburban Cook County, life expectancy varies widely between communities with high economic opportunities and communities with low economic opportunities.

In suburban Cook County, average life expectancy is approximately 79.7 years, whereas life expectancy for residents in Chicago is 77.8 years. Overall in Chicago, life expectancy for people in areas of high economic hardship is five years lower than those living in communities with better economic conditions.

Years of potential life lost is the average number of years a person might have lived if they had not died prematurely. It can also be used as an indicator of health disparities. The Chicago community areas and suburban municipalities in the North region with the highest and lowest life expectancies, natality, and years of potential life lost by region are presented in Figures 7.22a. - 7.22.c.

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

### Lowest Life Expectancies

<table>
<thead>
<tr>
<th>Chicago</th>
<th>Life Expectancy (Years)</th>
<th>Suburban Cook County</th>
<th>Life Expectancy (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uptown</td>
<td>75.9</td>
<td>Harwood Heights</td>
<td>74.5</td>
</tr>
<tr>
<td>Rogers Park</td>
<td>76.2</td>
<td>Park Ridge</td>
<td>75.1</td>
</tr>
<tr>
<td>Norwood Park</td>
<td>77.1</td>
<td>Lincolnwood</td>
<td>75.2</td>
</tr>
</tbody>
</table>

### Highest Life Expectancies

<table>
<thead>
<tr>
<th>Chicago</th>
<th>Life Expectancy (Years)</th>
<th>Suburban Cook County</th>
<th>Life Expectancy (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln Park</td>
<td>81.1</td>
<td>Skokie</td>
<td>83.3</td>
</tr>
<tr>
<td>North Center</td>
<td>82.3</td>
<td>Schiller Park</td>
<td>83.6</td>
</tr>
<tr>
<td>Lakeview</td>
<td>82.8</td>
<td>Wilmette</td>
<td>85.2</td>
</tr>
</tbody>
</table>

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

36 Healthy Chicago 2.0. (2016).
Figure 7.22b. Natality (Number of deaths of infants less than one-year-old) per 1,000 live births, by region, 2012

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

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

Suburban Cook County

Greatest Number of YPLL

Niles 6,182 Norridge 5,900 Des Plaines 7,992

Lowest Number of YPLL

Glencoe 2,464 Winnetka 2,616 Lincolnwood 2,905

Chicago Community Areas

Greatest Number of YPLL

Uptown 8,801 Norwood Park 7,637 Jefferson Park 7,553

Lowest Number of YPLL

North Center 3,551 Lakeview 3,450 Lincoln Park 3,284

Data Sources: CCDPH 2008-2012, CDPH 2009-2013
Key Findings: Mental Health and Substance Use

Overview

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

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

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

- Children and adolescents
- Family caregivers
- Homeless individuals
- Incarcerated and formerly incarcerated individuals
- Individuals with a history of mental illness and/or substance use
- LGBQIA individuals and transgender individuals
- Residents in long-term care facilities
- Uninsured and underinsured
- Veterans and former military
Mental health and substance use were two of the most discussed issues in the FOCA. The FOCA findings emphasized that social and structural determinants have substantial impacts on mental health. In particular, the following factors were identified as impacting mental health in communities: socioeconomic inequities; inadequate health care access; lack of affordable and safe housing; racism, discrimination, and stigma; and lack of safety or perceived safety, violence, and trauma.

In terms of the connections between trauma and mental health, substantial evidence has emerged over the past decade that adverse childhood experiences (ACEs) strongly relate to a wide range of physical and mental health issues throughout a person’s lifespan. ACEs include: physical and emotional abuse and neglect; observing violence against relatives or friends; substance misuse within the household; mental illness in the household; forced separation from a parent or close family member through incarceration or other means.

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

Scope of the issue – Mental health and substance use
Data availability is a challenge for assessing mental health and substance use within the Community Health Status Assessment. The Health Impact Collaborative of Cook County made efforts to include as much mental health-related data as possible in this CHNA. The Community Health Status Assessment indicators included in the CHNA are:

- Self-reported mental health status

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• Emergency department (ED) visits for mental health, intentional injury and suicide, substance abuse, and alcohol abuse
• Health care provider shortage areas for mental health

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

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

http://www.cookcountysheriff.com/MentalHealth/MentalHealth_main.html

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

Figure 8.2. Self-reported emotional and mental health indicators

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of adults that lack social or emotional support</td>
<td>34%</td>
<td>44%</td>
<td>20%</td>
<td>23%</td>
</tr>
<tr>
<td>Average number of days that adults report their mental health as not good</td>
<td>3.2</td>
<td>3.1</td>
<td>3.3</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Data Source: Behavioral Risk Factor Surveillance System (BRFSS) (2013) and Healthy Chicago Survey (2014)
High rates of Emergency Department (ED) visits for mental health and substance abuse may indicate a lack of community-based treatment options, services, and facilities.

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

Data Source: Healthy Communities Institute, Illinois Hospital Association COMPdata, 2012-2014
Figure 8.4. Emergency Department (ED) visits for intentional injury and suicide in Cook County, by zip code (age-adjusted rate per 10,000)

North region communities with the highest ED admission rates for suicide or intentional injury

Chicago
- Edgewater
- Uptown
- Rogers Park

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

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

There is a high prevalence of co-morbidity between mental illness and drug use. The U.S. Department of Justice estimates: 61% of individuals in state prisons and 44% of individuals in local jails with current or past violent offenses and three or more past incarcerations have a mental health issue. 63% of incarcerated individuals who had used drugs in the month before their arrest had mental health problems.

Barriers to accessing mental health and substance use treatment and services include social stigma, lack of accessible and affordable mental health services due to continued funding cuts, low reimbursement rates for mental health services, and low salaries for mental health professionals (all of which have led to provider shortages). Opportunities to address behavioral health access issues include training first responders and implementing new community health models. The community health status assessment revealed some geographic disparities in the ED visit rates for heavy drinking and substance use, as shown in Figures 8.7 and 8.5. Additionally, 9% of Chicago adults report heavy drinking in the past month, which is substantially higher than the U.S. overall (6%).

Youth substance use
Drug use in adolescent and teen years may be part of a pattern of risky behavior which could include unsafe sex, driving while intoxicated, and other unsafe activities.\textsuperscript{41} Drug use in adolescent or teenager years can result in multiple negative outcomes including school failure, problems with relationships, loss of interest in normal healthy activities, impaired memory, increased risk for infectious disease, mental health issues, and overdose death.\textsuperscript{41} As a result, preventive measures to prevent or reduce drug use among adolescents and teens are important.\textsuperscript{41}

\section*{Substance use among youth in suburban Cook County}
Illinois Youth Survey, comparing 2010 and 2014 survey results

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

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

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

*There were no communities in the North region with a hospitalization rates above the mean (29.00 hospitalizations per 10,000 or greater)

Data Source: Healthy Communities Institute, Illinois Hospital Association COMPdata, 2012-2014
There is a high prevalence of co-morbidity between mental illness and drug use. Figure 8.6 shows the communities in which high ED visit rates for mental illness overlap with high ED visit rates for substance use.

**Figure 8.6. Emergency Department (ED) Visits for Mental Health and Substance Use, by zip code (age-adjusted rates per 10,000)**

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

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Figure 8.7 shows ED visit rates for alcohol abuse. Several communities in the North region of Chicago and suburban Cook County have ED visit rates of 54.91 per 10,000 or greater for alcohol abuse. Nationwide, ED visits for alcohol abuse have been on an upward trajectory. Between 2001 and 2010, the rate of ED visits for alcohol-related diagnoses for males increased 38% among both males and females. The nationwide rate for males as of 2010 is 94 per 10,000 and the rate for females is 36 per 10,000.43

Figure 8.7. Emergency Department (ED) visits for alcohol abuse, by zip code (Age-Adjusted Rate per 10,000)

![Figure 8.7: Map showing ED visits for alcohol abuse in Chicago and suburban Cook County.](image)

North region communities with the highest ED admission rates for alcohol abuse

<table>
<thead>
<tr>
<th>Chicago</th>
<th>Suburban Cook County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany Park</td>
<td>Arlington Heights</td>
</tr>
<tr>
<td>Avondale</td>
<td>Evanston/Skokie</td>
</tr>
<tr>
<td>Dunning</td>
<td></td>
</tr>
<tr>
<td>Irving Park</td>
<td></td>
</tr>
<tr>
<td>Lakeview</td>
<td></td>
</tr>
<tr>
<td>Lincoln Park</td>
<td></td>
</tr>
<tr>
<td>Lincoln Square</td>
<td></td>
</tr>
<tr>
<td>North Center</td>
<td></td>
</tr>
<tr>
<td>North Park</td>
<td></td>
</tr>
<tr>
<td>Norwood Park</td>
<td></td>
</tr>
<tr>
<td>Portage Park</td>
<td></td>
</tr>
<tr>
<td>Rogers Park</td>
<td></td>
</tr>
<tr>
<td>Uptown</td>
<td></td>
</tr>
</tbody>
</table>

ED rate for Heavy Drinking per 10,000

- 1st quartile 28.70 or less
- 2nd quartile 28.71 - 37.40
- 3rd quartile 37.41 - 54.90
- 4th quartile 54.91 or greater
- Insufficient data

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

43 [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6235a9.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6235a9.htm)
There are several communities in the North region that have multiple mental health professional shortage areas, as shown in Figure 8.8. Mental Health Professional Shortage Areas are designated by the Health Resources and Services Administration (HRSA) as areas having shortages of mental health providers. Each shortage area is assigned a score (1-22) based on a variety of different factors including geographic area (a county or service area), population (e.g., low income or Medicaid eligible), or the presence of different types of facilities (e.g., federally qualified health centers, or state or federal prisons). The higher a score is for an area, the greater the need for mental health professionals, services, or facilities. The zip codes in the North region that are designated as mental health professional shortage areas include 60625 (Albany Park), 60613 (Buena Park), 60634 (Dunning), 60660 (Edgewater), 60618 (Irving Park), 60657 (Lakeview), 60659 (Peterson Park), 60641 (Portage Park), 60626 (Rogers Park), 60640 (Uptown), and 60645 (West Ridge).

**Figure 8.8. Map of mental health provider shortage areas in the North region**

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

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Community Input on mental health and substance use

The ongoing reduction of mental health facilities and cuts to mental health services are leading to the permanent closure of many essential behavioral health resources. Six of the eight focus groups in the North region highlighted the need for more community-based mental health and substance abuse services and facilities. Seniors, individuals living with intellectual disabilities, immigrants, LGBQIA individuals, transgender individuals, children, and adolescents were identified as needing specialized behavioral health resources.

Multiple focus groups explained that the stigma associated with mental and behavioral health issues needs to be addressed. These groups highlighted that issues related to stigma are particularly problematic in minority populations. Several participants also indicated the need to decriminalize substance use and the need to address the mental health needs of incarcerated individuals.

Community resident survey - mental health

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

14% of respondents indicated that they or their family members did not seek mental health treatment due to a lack of knowledge about where to get services.

10% of respondents indicated that they or their family members did not seek mental health treatment due to the perception that other people might have a negative opinion of them.

45% of respondents in the North region indicated that their financial situation and/or employment status contributes to stress in their daily lives.

34% of respondents in the North region indicated that health of family members contributed the most to feelings of stress.
Key Findings: Chronic Disease

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

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

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

Many of the assessment findings in the social determinants of health section of this report are connected to chronic disease prevention. Assessment findings related to food access, food security and built environment are included in the social determinants section starting on page 41.

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

**Communities in the North region with a high burden of chronic disease across multiple indicators***

<table>
<thead>
<tr>
<th>Chicago</th>
<th>Suburban Cook County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edgewater</td>
<td>Des Plaines</td>
</tr>
<tr>
<td>Jefferson Park</td>
<td></td>
</tr>
<tr>
<td>Norwood Park</td>
<td></td>
</tr>
<tr>
<td>Portage Park</td>
<td></td>
</tr>
<tr>
<td>Rogers Park</td>
<td></td>
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<td>Uptown</td>
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*Indicators included here are mortality (heart disease, cancer, stroke, diabetes) and hospitalization data (asthma and diabetes).

**CDC’s Four Domains for Chronic Disease Prevention**

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

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

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

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<tbody>
<tr>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>Cancer</td>
<td>Cancer</td>
<td>Cancer</td>
<td>Cancer</td>
</tr>
<tr>
<td>Stroke and Cerebrovascular Diseases</td>
<td>Stroke and Cerebrovascular Diseases</td>
<td>Chronic Lower Respiratory Diseases</td>
<td>Chronic Lower Respiratory Diseases</td>
</tr>
<tr>
<td>Chronic Lower Respiratory Diseases</td>
<td>Chronic Lower Respiratory Diseases</td>
<td>Accidents</td>
<td>Accidents</td>
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<td>Accidents</td>
<td>Accidents</td>
<td>Accidents</td>
<td>Accidents</td>
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</table>

Racial and ethnic disparities in mortality rates persist in the North region of Chicago and Cook County, as shown in Figures 9.2 and 9.4. And, there are major variations in chronic disease-related mortality rates across both the Chicago community areas and Cook County suburbs, as shown in Figure 9.3.

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

Data Source: Illinois Department of Public Health, 2012
The coronary heart disease mortality rate in the North region was 97.3 deaths per 100,000 population in 2012. The Healthy People 2020 target is 103.4 per 100,000 population.

The cancer mortality rate in the North region was 165.3 deaths per 100,000 population in 2012. The Healthy People 2020 target is 161.4 per 100,000 population.

The stroke mortality rate in the North region was 34.1 deaths per 100,000 population in 2012. The Healthy People 2020 target is 34.8 per 100,000 population.

Data Source: Illinois Department of Public Health, 2008-2012
Obesity and Diabetes
Hospitalization and emergency department (ED) visits are indicative of poorly controlled chronic diseases such as diabetes and a lack of access to routine preventive care. Poorly controlled diabetes can lead to severe or life-threatening complications such as heart and blood vessel disease, nerve damage, kidney damage, eye damage and blindness, foot damage and lower extremity amputation, hearing impairment, skin conditions, and Alzheimer's disease.\textsuperscript{46} Non-Hispanic African American/blacks and Hispanic/Latinos in the North region have higher diabetes-related mortality rates than non-Hispanic whites and Asians.

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

![Diabetes-related hospitalization rate map](image)

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

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

![Diabetes-related mortality bar chart](image)

Data Source: Illinois Department of Public Health, 2012

Asthma

Figures 9.6 and 9.7 show the geographic distributions of emergency department (ED) visits due to adult and pediatric asthma. ED visits are indicative of increased exposure to environmental contaminants that can trigger asthma as well as poorly managed asthma.

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

![Map of North Region showing ED visits for adult asthma]

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

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

![Map of North Region showing ED visits for pediatric asthma]

Data Source: Healthy Communities Institute, Illinois Hospital Association COMPdata, 2012-2014
Health behaviors
Health behaviors can influence risk factors for chronic disease and influence management of diseases following diagnosis. Poor diet and a lack of physical activity are two of the major predictors for obesity and diabetes. Low consumption of healthy foods may also be an indicator of inequities in food access. Thirty percent of enrolled schoolchildren in the North region of Chicago and suburban Cook County are eligible for free or reduced price lunch, and 9% of all households in the North region report receiving SNAP benefits. More data and information about food access is included on page 53 of this report.

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

Figure 9.8. Self-reported behaviors in adults and youth

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<tr>
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<tbody>
<tr>
<td>Adults Eating LESS than Five Daily Servings of Fruits and Vegetables</td>
<td>85%</td>
<td>71%</td>
<td>78%</td>
<td>77%</td>
</tr>
<tr>
<td>Heavy Drinking in the Previous month</td>
<td>N/A</td>
<td>9%</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Current Smokers</td>
<td>14%</td>
<td>18%</td>
<td>18%</td>
<td>19%</td>
</tr>
<tr>
<td>No Leisure-Time Physical Activity</td>
<td>26%</td>
<td>29%</td>
<td>25%</td>
<td>25%</td>
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</table>

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

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<tbody>
<tr>
<td>Current Smokers (high school students)</td>
<td>12%</td>
<td>11%</td>
<td>18%</td>
<td>16%</td>
</tr>
<tr>
<td>No Leisure-Time Physical Activity</td>
<td>16%</td>
<td>22%</td>
<td>13%</td>
<td>15%</td>
</tr>
</tbody>
</table>

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

In suburban Cook County, the number of PLWHAs increased 87% from 2,500 in 2004 to 4,683 in 2013.49 In 2012, there were 22,346 PLWHAs in Chicago, which is a 12% increase from 2005 (19,892 PLWHAs).50, 51 The communities in the North region with the largest numbers of PLWA are shown in Figure 9.9.

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

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

<table>
<thead>
<tr>
<th>Communities in the North region with the highest percentages of people living with HIV/AIDS (PLWHA)</th>
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<tbody>
<tr>
<td><strong>Chicago</strong></td>
</tr>
<tr>
<td>Edgewater</td>
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<tr>
<td>Rogers Park</td>
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<td>Uptown</td>
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</table>

Community input on chronic disease prevention

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

- need for non-emergency preventative care and linkage to care following hospitalization;
- the need for better integration of community health workers within hospitals and health systems;
- inequities in access to healthcare services;
- need for intergenerational programs and activities;
- the built environment and transportation systems need to support healthy eating and active living;
- healthy food access.

Community input on the connections between chronic disease and built environment is included in the Health Equity and Social, Economic, and Structural Determinants of Health section beginning on page 38.

Residents in the North region highlighted inequities in access to healthy foods. Focus group participants reported that there are several communities on the North side of Chicago that have high rates of food insecurity among children and that it has a profound effect on child health and development.

### Community survey data – Healthy eating and active living

**Food insecurity.** 29% of survey respondents from the North region indicated that their households have had to worry in the past year about whether or not their food would run out before they had the money to buy more.

**Healthy food availability.** 26% of respondents indicated challenges in availability of healthy foods in their community.

**Parks and recreation.** 13% of survey respondents indicated that there was “little” or no availability of parks and recreation facilities in their community.

**Reliability of public transportation.** 28% of survey respondents rated reliability of public transportation to be “fair” and an additional 11% found it to be “poor” or “very poor.”

**Quality and convenience of bike lanes.** 28% of survey respondents rated the quality and convenience and bike lanes in their community to be “fair” and an additional 23% found them to be “poor” or “very poor.”
Key Findings: Access to Care and Community Resources

Overview

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

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

Some specific priority needs related to access that were emphasized in the CHNA findings are:
- Need to improve cultural and linguistic competency and humility
- Inadequate access to healthcare, mental health services, and social services, particularly for uninsured and underinsured
- Opportunities to coordinate and link access to healthcare and social services
- Need to improve health literacy
- Navigating complex healthcare systems and insurance continues to be a challenge in the post Affordable Care Act environment

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

Forces of Change Assessment - Healthcare System Trends

The following forces were identified as trends that are or may have an impact on health and the public health system in Cook County:
- Ongoing implementation of the Affordable Care Act (ACA) and healthcare transformation
- Transition of healthcare systems from acute care to preventative care
- Inadequate funding, services, and systems for mental health and substance use
- Increasing availability of health-related data
- Changing role of health departments from providers to coordinators
- Racism, discrimination, and stigma based on demographic characteristics and/or health conditions
- Demographic shifts - Aging population as well as increases in Latino and Asian populations in the North region
- Desire for cross-generational and family-oriented programs and services

or formerly incarcerated, single parents, homeless individuals, veterans and former military, and people who are uninsured.

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

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

The Community Health Status Assessment data includes multiple factors that influence access to care including poverty, insurance coverage, self-reported use of preventative care, hospitalization statistics, provider availability, and use of prenatal care. The connection between poverty and health is explored in detail in the Health Equity and Social, Economic, and Structural Determinants of Health section beginning on page 37.

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

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

The Community Health Status Assessment data includes multiple factors that influence access to care including poverty, insurance coverage, self-reported use of preventative care, hospitalization statistics, provider availability, and use of prenatal care. The connection between poverty and health is explored in detail in the Health Equity and Social, Economic, and Structural Determinants of Health section beginning on page 37.
Several communities in the North region have high rates of negative health indicators and poor health outcomes, which indicates a lack of access to healthcare and community resources (Figure 10.1).

**Figure 10.1. Communities in the North region that have high rates of negative health indicators and poor health outcomes**

<table>
<thead>
<tr>
<th>Communities in the North region have high rates of negative health indicators and poor health outcomes</th>
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<tbody>
<tr>
<td><strong>Chicago</strong></td>
</tr>
<tr>
<td>Albany Park</td>
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<td>Avondale</td>
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<tr>
<td>Dunning</td>
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<tr>
<td>Irving Park</td>
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<tr>
<td>Portage Park</td>
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<tr>
<td>Rogers Park</td>
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<tr>
<td>West Ridge</td>
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<tr>
<td>Des Plaines</td>
</tr>
<tr>
<td>Maine Township</td>
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<tr>
<td>Northfield Township</td>
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<td>Skokie</td>
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**Insurance coverage**

Lack of insurance is a major barrier to accessing primary care, specialty care, and other health services. In the post-Affordable Care Act landscape, the size and makeup of the uninsured population is shifting rapidly. Aggregated rates from 2009-2013 show that 23.3% of the adult population age 18-64 in the North region reported being uninsured, compared to 18.8% in Illinois and 20.6% in the U.S. Men in Cook County are more likely to be uninsured (18.2%) compared to women (13.8%). In addition, African Americans, Latinos, and diverse immigrants are much more likely to be uninsured compared non-Hispanic whites. It is estimated that 40% of undocumented immigrants are uninsured compared to 10% of U.S.-born and naturalized citizens.

High insurance costs, lack of insurance, and extremely limited Medicaid coverage were identified as barriers to accessing healthcare in multiple focus groups in the North region.

**Self-reported use of preventive care**

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

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**Figure 10.2. Percentage of adults that reported not having preventative screenings**

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<tbody>
<tr>
<td><strong>Cervical Cancer Screening</strong></td>
<td>16%</td>
<td>20%</td>
<td>23%</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Colorectal Cancer Screening</strong></td>
<td>46%</td>
<td>53%</td>
<td>24%</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Breast Cancer Screening</strong></td>
<td>42%</td>
<td>29%</td>
<td>27%</td>
<td>27%</td>
</tr>
</tbody>
</table>

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

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

**Figure 10.3. Percentage of adults aged 65 or older that did not have a pneumococcal vaccination**

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<tbody>
<tr>
<td><strong>Lack of Pneumococcal Vaccination (65+)</strong></td>
<td>N/A</td>
<td>30%</td>
<td>31%</td>
<td>53%</td>
</tr>
</tbody>
</table>

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

Caregivers for older adults and individuals with disabilities, intellectually disabled adults, and immigrants were identified in focus groups as populations that are more likely to not have information about how and where to seek out preventive services.

**Provider availability**

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

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Health Professional Shortage Areas are designated by the Health Resources and Services Administration (HRSA) as areas having shortages of primary care, dental care, or mental health providers. Each shortage area is assigned a score based on factors such as geography (a county or service area), population characteristics (e.g., low-income or Medicaid eligible), or the presence of different types of facilities (e.g., federally qualified health centers, or state or federal prisons). The shortage areas with the highest scores are the ones with the greatest need for health professionals, services, or facilities. Communities in the North region that are designated as primary care provider shortage areas include 60625 (Albany Park), 60613 (Buena Park), 60660 (Edgewater), 60659 (Peterson Park), 60626 (Rogers Park), 60640 (Uptown), and West Ridge (60645). A shortage of mental health professionals is also a critical aspect of access to healthcare. Page 71 includes information about mental health professional shortage areas in the North region.

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

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

**Prenatal care**

Access to prenatal care is an important preventative measure to reduce the risk of pregnancy complications, reduce the infant’s risk for complications, reduce the risk for neural tube defects, and help ensure that the medications women take during pregnancy are safe. Nearly 20% of women in Illinois and suburban Cook County do not receive adequate prenatal care. (Recent comparable data for the City of Chicago was not available at the time this report was produced.)

<table>
<thead>
<tr>
<th>Figure 10.6. Prenatal care</th>
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<tbody>
<tr>
<td>Number of births to mothers with inadequate prenatal care (per 100 live births), 2008-2012</td>
</tr>
<tr>
<td>Suburban Cook County</td>
</tr>
<tr>
<td>Number of births to mothers that lacked adequate prenatal care (per 100 live births)</td>
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</table>

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

**Cultural competency and humility**

As detailed in the Community Description on pages 20-25 of this report, the North region of the Health Impact Collaborative of Cook County is home to diverse racial and ethnic populations including many immigrants and limited English speaking populations. Focus group participants in the North region observed that immigrants are at increased risk for health issues related to isolation, behavioral health, aging in place, and discrimination and have less access to quality medical care. The importance of culturally and linguistically competent providers across the spectrum of care and prevention programs was mentioned in six of the eight groups. Although language interpretation services are available at hospitals, a few groups cited long wait times for interpreters and incorrect interpretations of medical terminology as barriers to utilizing those services.

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

---

Participants recommended sensitivity training for providers and staff to ensure that immigrants feel that they are treated with dignity and respect, and several representatives of community-based organizations emphasized the knowledge and expertise that community-based organizations can contribute related to this work.

A lack of culturally and linguistically competent staff was also cited as a problem in government agencies including local police and emergency responders. Korean immigrant community members at Hanul Family Alliance stated that they had trouble reporting crimes and communicating with police due to language barriers.

**Conclusion - Reflections on Collaborative CHNA**

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

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

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

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

Driven by a shared mission and a set of collective values that have guided the CHNA process and decision making, the Health Impact Collaborative will work together to develop implementation plans and collaborative action targeted to achieving the shared vision of Improved health equity, wellness, and quality of life across Chicago and Cook County. Engaging in this collaborative CHNA process has developed a solid foundation and opened the door for many opportunities moving forward. Participating in developmental evaluation, funded by the Robert Wood Johnson Foundation, is helping to document process strengths and improvement opportunities as well as understand and measure specific foundational elements necessary to develop a strong collective impact initiative. The Regional Leadership Teams and Stakeholder Advisory Teams look forward to building on the momentum, working in partnership with diverse community stakeholders at regional and local levels to address health inequities and improve community health in communities across Chicago and Cook County.