Suburban Cook County
Community Health Assessment and Plan

we PLAN 2015
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Abstract
I. ABSTRACT

The Cook County Department of Public Health (CCDPH) has completed its community health planning process, WePLAN 2015, and incorporated the community health assessment and improvement plan into its organization-wide strategic plan.¹ The WePLAN 2015 planning process and final report fulfills the requirements of the Illinois Joint Committee on Rules for certification for local public health departments by the Illinois Department of Public Health.² This document summarizes the WePLAN 2015 process undertaken June 2010 – December 2010 by CCDPH and the 50 member Community Planning Committee. Building upon accomplishments from WePLAN 2010, and with new findings from the community health assessment conducted Summer/Fall 2010, the community health improvement plan addresses four strategic health issues:

- Chronic Disease, focusing on cardiovascular disease prevention;
- Violence Prevention, focusing on reducing youth violence;
- Improve Sexual Health Status of Youth, focusing on reducing youth sexually transmitted infections and teen pregnancy; and
- Access to Healthcare Services, focusing on increasing access to primary care.

These four strategic health issues and the findings of WePLAN 2015 will become the basis for the implementation of a Cook County strategic health plan, which is one of the main initiatives of the CCDPH 2015 Strategic Plan.

CCDPH serves a large and complex jurisdiction in suburban Cook County with 125 municipalities, 30 townships, more than 1000 schools, and some of the wealthiest and poorest populations in the country. The agency is also one of six certified health departments in Cook County and is a part of the third largest public health care delivery systems in the country. Over the past decade, CCDPH’s population has become increasingly diverse, with an influx of new immigrants and increasingly poor as low income populations migrate to the suburbs, from Chicago.

Planning offers an opportunity to examine how to strategically address the issues facing our jurisdiction in a coordinated way that reduces duplication and optimizes prevention efforts for all, especially the most vulnerable. With the implementation in July 2010 of the Cook County Health and Hospitals System (CCHHS) Strategic Plan: Vision 2015, CCDPH began providing leadership with a population approach to optimize health across the entire health system, while also embarking on its own organization-wide strategic planning process in August 2010. It was fortuitous that the 5-year cycle of WePLAN began again at this same time, providing CCDPH with a vehicle for active community participation in assessment and planning. WePLAN 2015 will support both the strategic health plan initiative set forth in the CCDPH 2015 Strategic Plan, as well as fulfill requirements for national accreditation established by the Public Health Accreditation Board.³

The WePLAN 2015 planning process attempted to 1) gain community input into the complex health and health related issues facing suburban Cook County residents; 2) build partnerships to maximize

¹ See document, “CCDPH 2015 Strategic Plan Final Report, April 2011”.
efforts and resources in addressing the leading challenges to a healthy population; 3) identify ways to increase coordination throughout the entire county including CCHHS and other public health jurisdictions within Cook County; and 4) develop actionable strategies for improving health that the public health system can accomplish.

There are two major components to this document: The Community Health Assessment and the Community Health Plan. The Community Health Assessment presents the results of four assessments:

1) **Community Themes and Strengths Assessment** – provides community members’ perceptions of leading health issues and community needs. Major findings include concerns with certain health problems (mental health, cancers, diabetes and aging issues), economic problems (unemployment, lack of ability to pay for health insurance and medicine), and the lack of social services in local communities. Community assets include opportunities to improve local communities, and an overall sense that their communities are good places to live. A common theme of disparity was identified, primarily related to access to services and the impact of economic opportunity.

2) **Community Health Status Assessment** - assesses the health status of the population through an examination of a variety of population and health indicators. Health status improvements include a decrease in coronary artery disease mortality by 20%; cerebrovascular (stroke) mortality decrease by 18%; and an 8% decrease in teen birth rates among 15-19 year olds. Declines in health status include increased Chlamydia rates (56%) among 15-19 year olds and a twenty-six percent increase in gonorrhea for the same age group. Racial/ethnic disparities persisted or worsened with respect to coronary artery disease mortality (increase by 6%), stroke mortality (no change), diabetes-related mortality, and homicide for African-Americans. The teen birth rate for Hispanics and African-Americans continued to outpace Whites (10 times and 7 times, respectively).

3) **Local Public Health System Performance Assessment** - identifies strengths and gaps in the performance of system partners that have a role in assuring the public’s health in relation to national model standards. The Community Planning Committee found the local public health system in moderate to significant compliance providing the 10 Essential Services for public health in suburban Cook County. Services rated as significantly provided by the public health system include: monitoring health status; diagnosing and investigating health problems and health hazards in the community; developing policies and plans that support individual and community health efforts; enforcing laws and regulations that protect health and ensure safety; and assuring a competent public and personal health care workforce. Gaps were found in informing, educating and empowering individuals and communities about health issues; mobilizing community partnerships to identify and solve health problems; linking people to needed personal health services and assuring the provision of healthcare when otherwise unavailable; evaluating effectiveness, accessibility, and quality of personal and population-based health services; and researching for new insights and innovative solutions to health problems. Participants reported cultural and language barriers, lack of timely funding and resources, lack of coordination between public health system partners and lack of community engagement as weakening the ranking of the provision of the 10 Essential Services by the public health system partners.
4) **Forces of Change Assessment** - considers some of the key forces that may impact the region’s health now and in the next five years. The forces identified include health care reform; lack of insurance and lack of healthcare; economic crisis; social inequity; and increasing immigrant and undocumented populations.

After reviewing and discussing these data, the Community Planning Committee reached consensus on the four areas on which to focus health improvement efforts. The strategies selected to address these priorities include health promotion focused on prevention; capacity building through health education; making communities more livable through policy and environmental change; promoting advocacy and public support for public health issues; and improving access through coordination and network development. The overarching principles of equity, prevention and collaboration guide the strategies to implement the community health plan.

Planning is vital, especially during difficult economic times. As resources decrease and community needs increase, it is imperative to explore opportunities for efficiency and effectiveness, leverage current resources, develop shared plans when resources may become available, and craft a common pathway to achieve success. The WePlan 2015 process has resulted in a plan to guide the Cook County Department of Public Health in its population based efforts over the next five years, aligned with the overall CCDPH 2015 Strategic Plan.
Summary
II. SUMMARY

a. Introduction

The Cook County Department of Public Health (CCDPH) has completed its community health planning process, WePLAN 2015, and incorporated the community health assessment and improvement plan into its organization-wide strategic plan. This document summarizes the WePLAN 2015 process undertaken June 2010 – December 2010 by CCDPH and the 50 member Community Planning Committee.

WePLAN 2015 continues the 5 year cycle for jurisdiction-wide community health planning first established in 1994. The planning process and resulting document fulfills the requirements of the Illinois Administrative Code for certification for local public health departments by the Illinois Department of Public Health (IDPH). Specifically, “the process shall involve community participation in the identification of community health problems, priority-setting, and completion of the community health needs assessment and community health plan.”

CCDPH serves a large and complex jurisdiction in suburban Cook County with 125 municipalities, 30 townships, more than 1000 schools, and some of the wealthiest and poorest populations in the country. The agency is also one of six certified health departments in Cook County and is a part of the third largest public health care delivery systems in the country. Over the past decade, CCDPH’s population has become increasingly diverse, with an influx of new immigrants and increasingly poor as low income populations migrate to the suburbs, from Chicago.

CCDPH now considers the WePLAN process not only a mandate, but an important component of public health practice in suburban Cook County (SCC). Planning offers an opportunity to examine how to strategically address the issues facing our jurisdiction in a coordinated way that reduces duplication and optimizes prevention efforts for all, especially the most vulnerable. With the implementation in July 2010 of the Cook County Health and Hospitals System (CCHHS) Strategic Plan: Vision 2015, CCDPH began providing leadership with a population approach to optimize health across the entire health system, while also embarking on its own organization-wide strategic planning process in August 2010. It was fortuitous that the 5-year cycle of WePLAN began again at this same time, providing CCDPH with a vehicle for active community participation in assessment and planning.

b. Process

WePLAN 2015 was led by a five member planning committee representing CCDPH’s Prevention Services and Medical Units. A fifty member Community Planning Committee, comprised of a diverse cross section of sectors from throughout the CCDPH region, including local government, health, business, academia, social services, faith-based and public safety, participated

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4 See document, “CCDPH 2015 Strategic Plan Final Report, April 2011”.
and helped guide and craft the components of the assessment and plan. The planning process was
designed to 1) gain community input into the complex health and health related issues facing
suburban Cook County residents; 2) build partnerships to maximize effort and resources in
addressing the leading challenges to a healthy population; 3) identify ways to increase coordination
throughout the entire county including CCHHS and other public health jurisdictions within Cook
County; and 4) develop actionable strategies for improving health that the public health system can
accomplish.

CCDPH used a nationally recognized model, recognized as state-of-the-art in public health planning,
called MAPP – Mobilizing for Action through Planning and Partnership. The MAPP process led to
the development of the two major components of WePLAN 2015: the Community Health
Assessment and the Community Health Plan. At the start of the WePLAN 2015 process, the
Community Planning Committee reviewed the priorities and accomplishments of WePLAN 2010.
In WePLAN 2010, the Community Health Plan prioritized chronic disease, specifically diabetes and
obesity, youth violence prevention and access to care. CCDPH aligned fiscal and staff resources to
two of the priorities (youth violence and chronic disease prevention) and additional grant funding
was received to address issues related to access to primary care. Task forces were created around the
three priorities and met on a quarterly basis to increase awareness and coordination on these issues.
Among the achievements related to the WePLAN 2010 priorities was: a $16 million federal grant to
address obesity and chronic diseases, development of a resource directory for violence prevention
and referral resources and a report summarizing the experiences of patient navigators accessing
healthcare for their uninsured and underinsured clients.

For WePLAN 2015, CCDPH adapted its planning process with an emphasis on two key issues: a
focus on implementation by the agency and its partners from the outset and promotion of a public
health system approach to address key strategic issues. The resulting WePLAN 2015 planning
process used technology including webinars for selected data presentations and keypad voting to
streamline data gathering of the planning process, allow more time for discussion and build
consensus toward action. This approach led to fewer in-person meetings and increased participant
interaction. As a result, the Community Planning Committee’s work developed into a clear
conceptual model to address the selected health priorities, and an approach that potentially could be
applied to nearly any public health improvement priority.

The WePLAN 2015 Community Planning Committee met during two webinars and four in-person
meetings and examined a range of aspects of the SCC’s public health system. The meetings involved
the following activities:

- Development of a bold and inspirational vision statement;
- Review of issues, assets and needs as identified by survey data from community members;
- A review of health status, disparities and trends in SCC health indicator data including
demographic and socioeconomic data, infectious disease, chronic diseases, maternal and
child health indicators, injury and violence data and measures of selected health risk factors;

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6 Mobilizing for Action through Planning and Partnership, National Association of City and County Health Officials,
• An examination of key informant data on the local public health system’s performance in relation to national standards followed by facilitated discussion and rating;
• Presentation and discussion on emerging forces, trends, threats and opportunities in the public health system at the local, state and national levels;
• Identification and prioritization of three (3) community health priorities on which to develop plans to improve the community’s health status; and
• Consensus on a broad conceptual model, with four strategic approaches that could be tailored to each health priority.

The final meeting focused entirely on action planning – suggesting interventions and activities to address the priorities within the proposed framework. In addition, the Community Planning Committee encouraged the development of a Community Health Advisory Committee (CHAC) to foster ongoing coordination, assure community input and guidance into the implementation of WePLAN 2015.

c. Community Health Assessment Findings

The Community Health Assessment presents the results of four assessments: 1) the Community Themes and Strengths Assessment (CTSA) gauged community members’ perceptions of leading health issues and community needs; 2) the Community Health Status Assessment (CHSA) assessed the health status of the population through an examination of a variety of population and health indicators; 3) the Local Public Health System Performance Assessment (LPHSPA) identified strengths and gaps in the performance of system partners that have a role in assuring the public’s health in relation to national model standards; and 4) the Forces of Change Assessment (FOCA) considered some of the key forces that impacts the region’s health now and in the next five years.

Community Themes and Strengths Assessment

This assessment involved collecting information via in-person and online surveys. The survey asked residents about their perceptions of major community problems, strengths and issues related to the health and well-being of their community. Completed surveys were received from a total of 354 respondents. These data were compared where possible to a randomized 1200 household survey conducted by the Metropolitan Chicago Healthcare Council. We recognize that the small number of surveys collected by CCDPH is not representative of the entire region, but the purpose of this assessment is not to measure trends. Its main strength is that it presents a community voice in this process. Its goal is to draw attention to broad areas of concern and also to identify community expectations and desires, providing a context for the other assessments, and for use in defining both priorities and plans.

While overall community respondents indicated their communities were good places to live, one-third of respondents stated their community was not healthy. The respondents expressed concern with certain health problems including mental health, cancers, diabetes and issues associated with the aging process – loss of sight/hearing, arthritis, etc. One key community asset identified was the opportunity to participate in making their communities better. However, the economy and lack of economic opportunity, including availability of jobs, were major concerns repeated by residents. In addition, the lack of social services in local communities was a reported concern. Community respondents also identified low crime rates, safe neighborhoods and access to healthcare as leading
elements needed to make a community a healthy place to live – characteristics that all communities should share, recognizing that some do not.

While respondents felt that access to healthcare was an important component of a healthy community, barriers to healthcare were evident. Among the most important barriers to care indicated by the community were lack of insurance, lack of ability to pay for healthcare services and lack of ability to pay for medicines/prescriptions, factors that impact low income residents and impact the health communities with fewer resources. Not surprisingly, lower income respondents were more likely to report that their health was not good, or fair at best.

From the survey data, the Community Planning Committee recognized a common theme of disparity, primarily related to access to services and the impact of economic opportunity. These were evident in the responses related to access to primary care, concerns about mental health and chronic diseases, and in the variations in access seen by socioeconomic status. For example, while most respondents indicated that they had access to healthy food, nearly 1 in 6 did not, raising questions about whether this was an acceptable standard in a suburban area in one of our country’s largest cities. The need for more equitable distribution of social and community services was also identified by the Committee, recognizing the importance of improved systems and better coordination as a means of addressing this issue.

Community Health Status Assessment
From a comprehensive review of births, disease morbidity, mortality and risk factors, the following key findings were reported.

Improvements in health status were seen in these indicators:
• Coronary heart disease mortality decreased by 20% from 145.6/100,000 in 2000-2002 to 166.0/100,000 in 2005-2007. In 2006, the coronary heart disease mortality rate for the U.S. was (135.0/100,000). The HP2010 for this disease was 166/100,000.

• Cerebrovascular (stroke) mortality decreased by 18% from 55.4/100,000 to 45.5/100,000 between 2000-2002 and 2005-2007. In 2006 the U.S. rate for cerebrovascular disease mortality was 43.6/100,000. With a cerebrovascular mortality rate of 52.1/100,000 in 2005-2007, the South District was the only region in SCC to not meet the HP2010 goal of 48/100,000 for this disease.

• Teen birth rates among 15-19 year olds decreased by 8% from 35.8 births per 1,000 females age 15-19 years to 32.9 birth per 1,000 females age 15-19 years between 2000-2002 and 2005-2007. In 2006, the U.S. teen birth rate was 44.3 births per 1,000 females age 15-19 years.

Declines in health status were seen for these indicators:
• Chlamydia incidence rate increased 56% among ages 15-19 years from 1,168.1/100,000 to 1,825.0/100,000 between 2000-2002 to 2006-2008.
• Gonorrhea incidence rate rose 26% for youth ages 15-19 from 447.9/100,000 in 2000-2002 to 575.4/100,001,168.1 in 2006-2008.
Racial/ethnic disparities persisted or worsened for these indicators:

- Coronary heart disease mortality rate increased for African Americans in CCDPH from 237.2/100,000 to 251.7/100,000 between 2000-2002 and 2005-2007. At the same time the mortality rates for this disease decreased among Whites from 180.7/100,000 to 140.3/100,000. The African American mortality rate for this disease was almost 1.8 times higher than the White rate. The HP2010 goal of for this disease was 166.0/100,000.

- Diabetes-related mortality rate for African Americans increased 14% from 120.8/100,000 to 136.8/100,000 between 2000-2002 and 2005-2007. In 2005-2007, the diabetes mortality rate for African Americans was nearly 2.5 times higher than the rate among Whites (55.2/100,000). The overall U.S. rate was 75.5/100,000).

- Homicide rate among African Americans increased 12.8% from 23.3/100,000 to 26.3/100,000. The homicide rate for African Americans in SCC (25.5/100,000) was higher than the U.S. rate (21.6/100,000) and 4 times higher than the HP 2010 goal of 6.0/100,000.

- Teen birth rate among Hispanics in SCC (85.6/1,000) was almost 10 times greater than the teen birth rate among Whites (8.6/1,000) in 2005-2007. The teen birth rate among African Americans (69.1/1000) was more than seven times greater than the White rate.

While the Community Planning Committee found some positive improvement for the overall population of SCC, racial/ethnic inequities are apparent. Due mainly to medical advances and the decline in smoking, the cardiovascular disease (CVD) mortality rate has declined both in SCC and nationally. Despite this decline, coronary heart disease and stroke are still the leading causes of death in SCC, responsible for 33% of all deaths in 2005-2007.

The Community Planning Committee noted the increase in poverty in SCC, and a decrease in income of white men and women with previously high income. Additionally, obesity and smoking, the leading causes of CVD, are higher among the poor, less educated, and minorities. The Community Planning Committee observed that many of the major health issues were preventable, and could be addressed through changes in all populations having access to resources before they get sick. This further emphasized the need for coordination and system-wide strategies to promote health equity in SCC.

**Local Public Health System Assessment**

The Local Public Health System Performance Assessment (LPHSPA) evaluates the strengths and gaps of the system’s ability to perform its duties, as outlined by the 10 Essential Services (ES). The Community Planning Committee found the local public health system in moderate to significant compliance providing the 10 Essential Services in suburban Cook County (rating of 50 %.) All of

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the ES were assessed as being provided at a moderate level of activity or higher (5/10 rated significant activity; 5/10 rated moderate activity).

Essential Services rated as significantly provided by the public health system include:

- #1 - Monitor health status to identify community health problems;
- #2 - Diagnose and investigate health problems and health hazards in the community;
- #5 - Develop policies and plans that support individual and community health efforts;
- #6 - Enforce laws and regulations that protect health and ensure safety; and
- #8 - Assure a competent public and personal health care workforce.

Gaps in services were identified as follows:

- #3 - Inform, educate and empower individuals and communities about health issues;
- #4 - Mobilize community partnerships to identify and solve health problems;
- #7 - Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable;
- #9 - Evaluate effectiveness, accessibility, and quality of personal and population-based health services; and
- #10 - Research for new insights and innovative solutions to health problems.

Participants reported cultural and language barriers, lack of timely funding and resources, lack of coordination between public health system partners and lack of community engagement as significant problems in the provision of the ES by the public health system partners.

The LPHSPA was also used to gauge CCDPH organizational capacity to perform the 10 Essential Services. This assessment was conducted with Senior Managers at CCDPH. There was consensus between the Community Planning Committee’s and the CCDPH Senior Program Staff’s ranking of the ES for both service provision and priority for the public health system. Diagnose and Investigate Health Problems and Health Hazards in the Community (#2) and Enforce Laws and Regulations that Protect Health and Ensure Safety (#6) were both rated the highest in current provision of the service (4/5) and in priority for the public health system (9/10).

**Forces of Change Assessment**

The FOCA assessment, conducted with the Community Planning Committee, described trends, factors and events, and the likely impact of these forces on the community’s health or the public health system. Responses were further categorized as threats or opportunities. Five major categories were identified and appear below with one participant quote summarizing the forces:

- **Health Care Reform** - As healthcare reform unfolds, we have an opportunity to contribute to the development of a newly structured healthcare system with a focus on prevention and a stronger public health system.
- **Lack of insurance and lack of healthcare** - Consequences of loss of health insurance include delayed diagnosis, decreased opportunities for effective treatment options at a later stage of diagnosis, greater likelihood of spread of communicable disease and health apathy.
- **Economic crisis** – The economic downturn has and will continue to impact the health of our community.
- **Social inequity** – Black, Hispanic and low income communities are plagued by multi-level systemic problems including lack of education, limited goods and services, limited quality jobs, poor transportation.
Increasing immigrant and undocumented populations - Increasing number of poor immigrants in need of services, leading to an increased need for interpreters and translators.

The WePLAN Planning Committee concurred with the areas of concern identified in the FOCA. Forces such as political instability, shortage of primary care providers and dentists, adequate funding and resources continue to threaten access to healthcare services. The Committee supported the opportunity offered in healthcare reform, but recognized that it will still not provide health coverage for all of the uninsured or the undocumented. Health Information Exchange was also seen as an opportunity to both improve access to population health data that can be used to support population based prevention efforts and as a means of improving continuity of care.

d. Community Health Plan

After reviewing and discussing these data, the Community Planning Committee reached consensus and four areas on which to focus health improvement efforts:
- Chronic Disease Prevention with an emphasis on cardiovascular disease prevention;
- Improve Sexual Health Status of Youth, focusing on reducing youth sexually transmitted infections and teen pregnancy;
- Violence Prevention, focusing on reducing youth violence; and
- Access to Healthcare Services, focusing on increasing access to primary care.

With these priority areas, the Community Planning Committee identified operating principles of equity, prevention and collaboration to guide the strategies to implement the community health plan. The strategies selected to address these priorities include health promotion and health education; policy and advocacy to change and support prevention efforts; and coordination to assure efficiency and effectiveness. A Community Health Plan was developed with measurable objectives, practice and evidence-based interventions, and preliminary implementation steps, noting potential resources and barriers for CCDPH and its system partners, as they work together to implement this plan over the next five years. The WePLAN 2015 priorities and findings will also be incorporated into the CCDPH 2015 Strategic Plan, and will be further reviewed and improved as CCDPH implements a strategic health plan for Cook County.

Priority Health Indicators and Potential Interventions:

1. Chronic Disease: Cardiovascular Disease Prevention

Because cardiovascular disease is responsible for 33% of all deaths in SCC, and a majority of these deaths were preventable, the Community Planning Committee continued to prioritize CVD as a major health concern. Coronary heart disease was responsible for more than half of CVD deaths in SCC and stroke was responsible for 17% of CVD deaths. Although the mortality rate for coronary heart disease in SCC has declined 30% from 2000 to 2007, CVD still remains the leading cause of death for all groups, regardless of race/ethnicity or gender. While the stroke mortality rate for SCC (45.2/100,000) is below the HP 2010 goal of 48.0/100,000, stroke is still the leading cause of adult disability.
WePLAN 2010 assisted CCDPH in aligning resources and creating a Chronic Disease Prevention Unit. This unit was able to secure two grants -- an ACHIEVE (Action Communities for Health, Innovation, and EnVironmental change) demonstration project funded by NACCHO that assisted five communities in assessing their capacity to implement systems changes to promote chronic disease prevention; and a $16 million Communities Putting Prevention to Work (CPPW) Centers for Disease Control and Prevention grant to support real policy, systems and environmental changes in communities related to address access to healthy foods, physical activity and obesity prevention. In 2010, model communities grants were awarded to suburban communities and community agencies through a Request for Proposal process. The grant also is working to develop a Cook County Chronic Disease Prevention Network and a web-based community capacity building center to provide resources for training and information for community partners on chronic disease prevention. In addition, tobacco prevention efforts continue to address the impact of tobacco dependence on chronic diseases.

To prevent or reduce cardiovascular disease mortality and morbidity, WePLAN 2015 proposes:

**Strategies**

- Develop and increase consistent use of health communications messaging related to cardiovascular disease prevention.
- Implement a social marketing campaign targeted at high risk groups for tobacco use.
- Implement opportunities for access to healthy food, especially in areas without adequate access to fresh foods.
- Implement local policies for access to safe places to play/exercise.
- Foster adoption of joint use agreements for use of existing community facilities as public locations for physical activity.
- Enact a comprehensive region-wide policy for smoke free housing, parks and public spaces.
- Advocate for state-wide support for chronic disease prevention programs.
- Develop multidisciplinary networks to address community based plans for chronic disease prevention interventions.
- Advocate for increased chronic disease morbidity and risk factor data to identify at risk populations.

2. Improve Sexual Health Status of Youth

Concerned with the increase in certain STIs, early and unprotected sexual activity and teen pregnancy, the Community Planning Committee prioritized prevention efforts to improve the sexual health status of youth. The WePLAN participants recognized that improving youth sexual health is closely associated with improving community factors such as factual science-based information, availability of community social and recreational services, as well as access to quality healthcare services.

With over 2,500 teen births in SCC in 2007 and an increase in sexually transmitted infections among youth, the WePLAN Steering Committee recognized the need to prioritize the health of our youth. For example, between 2000-2002 and 2006-2008, the rates for gonorrhea increased 26% and
Chlamydia increased 56% among youth (15-19 years) in CCDPH jurisdiction. Among high school students, 37% have had intercourse and 11% have had intercourse with 4 or more people. And among students who have had sexual intercourse during the past 3 months, 40% did not use a condom and 19% drank alcohol or used drugs before intercourse.

To reduce the rates of sexually transmitted infections and unintended pregnancies in youth, WePLAN 2015 proposes:

**Strategies**

- Increase awareness of the sexual health status of youth, the implications of early and unprotected sexual activity and the factors influencing youth sexual decisions.
- Advocate for policy change on the state and local levels to address implementation of sexual health education curriculum in schools.
- Assess the needs of youth in high risk communities to advocate for increased funding to provide opportunities for youth development.
- Increase coordination of youth health and social service providers to increase understanding of current community resources and to better meet the needs of youth.

3. **Violence Prevention**

Participants in WePLAN 2015 again acknowledged a healthy community as a safe community. Recognizing that violent acts threaten the quality of life and the mental well-being, residents were concerned that with the economic recession, the threat of violence in their communities and in their families could worsen.

Significant disparities by community, age and race/ethnicity exist. Homicide was responsible for one out of four deaths among youth ages 15-19 in SCC and resulted in an average of 46 years of potential life lost per death. The firearm-related mortality rate for SCC (7.1/100,000) was almost double the Healthy People 2010 goal of 3.6/100,000.

Among the prevention efforts to reduce the threat of violence conducted in the past few years are:

- Development of the WePLAN FOR ACTION Youth Violence Taskforce resource directory and youth leadership efforts.
- The CCDPH Violence Prevention Coordination Unit reaches out to the community’s most impacted by violence with capacity-building and networking opportunities as well as data collection.
- CCDPH, Stroger Hospital Trauma and University of Illinois at Chicago are examining the trauma needs in South Cook County. The impetus for this study was the closing of the only trauma center in the far southern suburbs of Cook County in 2009.
- All clients attending CCDPH clinics were assessed for sexual coercion and unhealthy relationships.

To prevent or reduce personal, family and community violence especially in communities suffering from disproportionate rates of violent acts, WePLAN 2015 proposes:
Strategies

- In partnership with community stakeholders, develop a community assessment profile to survey community stability and protective factors.
- Advocate for stronger purchasing requirements for handguns.
- Increase collaborative and networking opportunities to address community resources and referral processes, leverage resources and advocate for support of early childhood programs and improved access to mental health and substance abuse treatment services.
- Conduct provider training on domestic violence and bullying.
- Develop and/or provide tool kits for schools, daycares, churches, youth activities on violence prevention.
- Develop a campaign to bring attention to family violence and the protective factors needed for prevention of violence.

4. Access to Healthcare Services

Access to comprehensive healthcare services remained a priority in our region as confirmed in the community assessments. Residents identified that paying for services and prescriptions, primarily because of no health insurance, remains a significant barrier to staying healthy. Unfortunately, the number of uninsured residents has increased mainly due to rising unemployment and the economic recession.

Over 16% of adults in SCC in 2009 have not had a routine check-up in the last two years and 13% did not have a regular primary care provider. In SCC, the diabetes-related hospitalization rate from 2008-2009 among African Americans was 2,243.7/100,000, which is more than 2.5 times the rate for Whites (846.6/100,000). Likewise, the uncontrolled hypertension hospitalization rate for SCC (115.1/100,000) is much lower than the rate for African Americans (392.3/100,000). The asthma hospitalization rate for children under the age of 5 was 128.8/100,000 for Whites, 258.0/100,000 for Hispanics and 608.1/100,000 for African Americans.

Among past efforts to understand and address the barriers to healthcare were:

- An Access to Care Task Force of the WePLAN for Action committee developed a report: Access to Primary Care Resources for Un/Underinsured Residents in Suburban Cook County, examining experiences of community patient navigators and identifying barriers for the un/underinsured. Regionally, Health & Medicine Policy Research Group in Chicago, assessed the status of the healthcare safety net in the Chicago Metropolitan Region and Center for Faith and Community Heath Transformation examined influences on primary care including health care reform;
- State and local partners worked to plan for Health Information Exchange (HIE). Planning grants to two regional partners – Metropolitan Chicago Healthcare Council and Health Care Consortium of Illinois were used to develop plans for an HIE structure in the Chicago region. An IDPH HIE workgroup examined the value and role of HIE in supporting population and public health.

To improve access to personal healthcare services, especially comprehensive primary care. WePLAN 2015 proposes:
Strategies

- Focus local/regional social marketing campaigns on the importance of preventive services, where to obtain them, and assure that they are culturally and linguistically appropriate.
- Foster the development of an online electronic clearinghouse of all available local specialty services that includes the ability to make referrals (in addition to CCHHS).
- Increase regional capacity to effectively implement the Patient Protection and Affordable Care Act of 2010 (Health Reform).
- Develop materials on return on investment of population-based public health.
- Advance universal health care access and coverage.
- Advocate for integration of comprehensive services within primary care.
- Foster the implementation of the CCHHS Strategic Plan, especially as it relates to expansion of ambulatory care services.
- Engage opportunities to implement evidence based models of community-oriented primary care.
- Advocate for and participate in the development of a regional Health Information Exchange focused on both personal and population health.

e. WePLAN 2015 Vision and Implementation

A strong community health improvement plan requires a bold vision of the future. During the planning process, the WePLAN Community Planning Committee members discussed what suburban Cook County’s public health system might look like when WePLAN 2015 is successfully implemented. The Community Planning Committee members described the strengths of the current public health system which included: collecting and analyzing data, planning for change, and promoting certain public health services. The weaknesses identified by the Community Planning Committee included: a need for increased coordination, more uniform and increased distribution and leveraging of resources across the system, and a stronger focus on primary prevention. The dialogue resulted in new proposition - a call for a formal, sustained effort to integrate and coordinate the public health system.

WePLAN 2015 Vision Statement

A public health system that provides equitable, coordinated, and comprehensive primary prevention strategies in an environment that supports healthy living for SCC residents and organizations in an enduring way.

To be successful in achieving the vision for the public health system, the WePLAN Community Planning Committee articulated the activities that will need to occur. The participants call for a formal effort to bring the public health system together by forming a WePLAN Community Health Advisory Committee (CHAC). The mission of this group was defined as follows: The WePLAN Community Health Advisory Committee is committed to improving the mental, physical, emotional and social health of suburban Cook County residents.

The establishment of the Community Health Advisory Committee is also included as a strategic initiative in the CCDPH 2015 Strategic Plan, to support the implementation of a county-wide strategic health plan, of which WePLAN 2015 will be included as a central component. The work of the collaborative effort by stakeholders will:
• Raise awareness and publicize priority health issues;
• Identify community needs and resources;
• Serve as a centralized source of information and data to drive collaborative decision making to improve health;
• Educate and train community leadership, building the community’s capacity to initiate change;
• Organize and coordinate resources and opportunities to get involved;
• Advocate for increased and equitable health opportunities for the underserved;
• Promote health improvement change by addressing the root causes of health issues through a focus on primary prevention and a policy, systems and environmental approach;
• Implement plans, monitor progress, and evaluate efforts; and
• Coordinate responses to major health threats that impact the system.

f. Conclusion
Planning offers an opportunity to examine how to strategically address the issues facing our jurisdiction in a coordinated way that reduces duplication and optimizes prevention efforts for all, especially the most vulnerable. During difficult economic times, planning becomes even more important, as resources decrease and community needs increase.

With the implementation in July 2010 of the Cook County Health and Hospitals System (CCHHS) Strategic Plan: Vision 2015, CCDPH began providing leadership with a population approach to optimize health across the entire health system, while also embarking on its own organization-wide strategic planning process in August 2010. It was fortuitous that the 5-year cycle of WePLAN began again at this same time, providing CCDPH with a vehicle for active community participation in assessment and planning. WePLAN 2015 will support both the strategic health plan and national voluntary accreditation initiatives set forth in the CCDPH 2015 Strategic Plan.
Community Health Assessment

we PLAN 2015
III. COMMUNITY HEALTH ASSESSMENT

a. Overview
The Community Health Assessment, completed in the Summer of 2009 and in 2010, fulfills the IDPH requirements for the local public health department’s recertification. There were four assessments conducted as components of the planning process, including:

- **Community Themes and Strengths Assessment (CTSA)** – soliciting perceptions about quality of community life and issues affecting the community, both positive and negative;
- **Local Public Health System Assessment (LPHSA)** - fulfills the IPLAN requirement for an organizational capacity assessment, and measures the capacity and performance of the local public health system;
- **Community Health Status Assessment** – in depth review of current health indicators and community demographics; identification of data trends impacting health status and a comparison of current indicator levels with national benchmarks (i.e., HP2010 and HP2020); and
- **Forces of Change Assessment** – both current and future forces that may affect the ability to improve health status.

b. Community Themes and Strengths Assessment
The goal of this assessment is to provide a deeper understanding of community issues and concerns, and a map of community assets. This assessment answered the questions:

1. What is important to our community?
2. How is quality of life perceived in our community?
3. What assets do we have that can be used to improve community health?

One method for implementing the assessment included CCDPH surveying participants who attended the Cook County Health and Hospital Systems Vision 2015: Strategic Plan community feedback meetings in 2009. Suburban Cook County town hall locations were in Maywood, South Holland and Des Plaines. In addition, CCDPH used an online survey, sent to public health partner agencies as well as posted on the CCDPH webpage for individuals to complete.

In an attempt to gauge the reliability of these surveys, CCDPH compared its results to those from a 1,200 household random sample survey in five geographic regions of metropolitan Chicago conducted by the PRC-Metropolitan Chicago Healthcare Council. The sample for this survey was considered representative of households in Cook County.

In total, 354 people responded to the surveys conducted by CCDPH; 154 in 2009 and 200 in 2010. Three quarters of respondents were women. By race/ethnicity, 25% of respondents were African American; 60% were White; 7% were Hispanic; and 7% were Asian/Pacific Islander. By age, the group with the highest representation was aged 45-60 years, with 56% participation by this age group. Over three quarters of respondents reported a college degree or higher. The majority reported an annual income of over $60,000.

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Community Themes and Strengths Findings
Major findings include concerns with certain health problems (mental health, cancers, diabetes and aging issues), economic problems (unemployment, lack of ability to pay for health insurance and medicine), and the lack of social services in local communities. Community assets include opportunities to improve local communities, and an overall sense that their communities are good places to live. A common theme of disparity was identified, primarily related to access to services and the impact of economic opportunity. Further detail on individual questions are noted below.

- **What makes for a healthy and safe community?**
  In both the 2009 and 2010 surveys, the majority of community respondents identified low crime/safe neighborhoods as a primary factor for a healthy community. Approximately 2 out of 5 respondents selected access to healthcare as the next leading factor that they believed makes communities healthy and safe. Other factors that ranked high in the surveys were good jobs and a healthy economy, healthy behaviors and lifestyles and good place to raise children (Table 1).

### Table 1. The most important things that make a community a healthy place to live.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low crime / safe neighborhoods ✓</td>
<td>53.3%</td>
<td>60.7%</td>
</tr>
<tr>
<td>Access to healthcare ✓</td>
<td>42.2%</td>
<td>36.8%</td>
</tr>
<tr>
<td>Good jobs and healthy economy ✓</td>
<td>31.8%</td>
<td>29.1%</td>
</tr>
<tr>
<td>Healthy Behaviors and lifestyles ✓</td>
<td>24.0%</td>
<td>34.6%</td>
</tr>
<tr>
<td>Good place to raise children</td>
<td>22.7%</td>
<td>29.1%</td>
</tr>
</tbody>
</table>

Note: Check marks denote the highest frequency items in each survey.

Responding to the question “Would you say that the community you live in is ‘healthy?’”, one-third responded that they thought their community was not healthy. Disparities by household income were noted. Only 50% of respondents with income less than $60,000 reported their community to be ‘healthy,’ compared to 70% of respondents with income over $60,000.

- **What are the health problems in your community?**
Community respondents identified the following as the most important health problems in their community.
  - Heart disease and stroke
  - Mental Health Problems
  - Cancers
  - Diabetes
  - Aging Problems (e.g., Arthritis, hearing/vision loss).

- **What factors affect good health in a community?**
The following risk factors were rated highest in impacting good health: overweight; poverty/low income; and poor eating habits.
• **How is your own health?**

About 15% of respondents indicated that their personal health was not “good”. These results were similar to those revealed by the PRC-MCHC household survey where 16% of Cook County respondents reported their health as “poor” or “fair.” Health inequities were reflected in the results as well. In the northern region of Cook County 7% of people reported ‘fair’ or poor’ health as compared for residents of southern Cook County nearly 1 in 4 (22%) reported ‘fair’ or ‘poor’ health.

• **What are the most serious barriers to getting healthcare?**

Inability to pay for service and lack of health insurance were identified in both the 2009 and 2010 surveys, with over 60% of respondents selecting these items (Table 2). Another barrier that the surveys identified was the inability to pay for prescription medications; nearly half of those surveyed felt this issue was a concern.

Respondents to the PRC-MCH survey also most commonly identified cost of prescriptions (20%) and cost of a doctor’s visit (18%) as barriers to healthcare. The PRC-MCH surveys found that people who lacked health insurance were less likely to have routine health care or receive recommended health screenings. For instance, 91% of people who lacked health insurance had not had a blood pressure test in the last two years (data not shown).

Table 2. Most serious barriers to healthcare.

<table>
<thead>
<tr>
<th>2009</th>
<th>2010</th>
<th>Barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>66.2%</td>
<td>64.1%</td>
<td>Unable to pay for health services✓</td>
</tr>
<tr>
<td>64.3%</td>
<td>61.3%</td>
<td>No health insurance✓</td>
</tr>
<tr>
<td>49.3%</td>
<td>43.3%</td>
<td>Unable to pay for medicines/prescriptions✓</td>
</tr>
</tbody>
</table>

Note: Check marks denote the highest frequency items in each survey.

**Community Characteristics**

As part of the surveys, respondents were asked to agree or disagree on a scale of 1 (low) to 5 (high) with 11 statements describing characteristics of their community. The range of characteristics included economic opportunity to ‘a good place to grow old,’ to ‘participate in making the community a better place to live’ (Table 3). Items rated highest in both surveys were ‘Can purchase fresh fruits and vegetables’ and ‘Able to participate in the community’ with average scores at or near 4.0 out of 5.0. The items that community respondents rated lowest were ‘Economic opportunity’ and ‘Enough social services’ with scores around 3.0.
Table 3. Average Rating on Community Characteristics:  
1=low/bad - 5 = high/good

<table>
<thead>
<tr>
<th>Description</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of life</td>
<td>3.3</td>
<td>3.5</td>
</tr>
<tr>
<td>Quality of education</td>
<td>3.1</td>
<td>3.5</td>
</tr>
<tr>
<td>Good place to grow old</td>
<td>3.4</td>
<td>3.4</td>
</tr>
<tr>
<td>Economic opportunity</td>
<td>2.9</td>
<td>3.0</td>
</tr>
<tr>
<td>Safe place to live</td>
<td>3.4</td>
<td>3.5</td>
</tr>
<tr>
<td>Support networks available</td>
<td>3.2</td>
<td>3.6</td>
</tr>
<tr>
<td>Receive quality health services</td>
<td>3.2</td>
<td>3.3</td>
</tr>
<tr>
<td>Enough social services</td>
<td>2.8</td>
<td>3.0</td>
</tr>
<tr>
<td>Opportunities for recreation</td>
<td>3.4</td>
<td>3.7</td>
</tr>
<tr>
<td>Can purchase fresh foods</td>
<td>3.8</td>
<td>4.1</td>
</tr>
<tr>
<td>Able to participate in community</td>
<td>3.9</td>
<td>4.0</td>
</tr>
</tbody>
</table>

These data were examined further based on the two income categories of respondents--those with household incomes earning less than $60,000 and those earning more than $60,000. There were differing results when respondents were grouped by income for community economic opportunity. About 33% of respondents earning over $60,000 agreed or strongly agreed with the statement ‘there is economic opportunity in the community,’ compared to just over 22% of respondents who earned under $60,000.

Regarding social services, only 40% of respondents earning over $60,000 agreed or strongly agreed that ‘there are enough social services in the community.’ Less than 30% respondents who earned under $60,000 agreed or strongly agreed with that statement.

One of ten (10%) respondents in the upper income group reported having difficulty ‘purchasing fresh foods.’ The problem purchasing fresh food doubled for the respondents reporting income under $60,000 with about nearly 20% reporting difficulty in purchasing fresh fruits and vegetable in their community.

About three quarters of respondents reporting income under $60,000 agreed/strongly agreed that “I can participate in making the community a better place to live.” Over 80% of the higher earning respondents agreed/strongly agreed with that statement. The results of the CCDPH survey and the
PRC survey were very similar. This bolstered the results of the CCDPH survey because the PRC used a probability sample, making statistical inference to the population possible.

c. Local Public Health System Performance Assessment

Introduction

The Local Public Health System Performance Assessment (LPHSPA) provided an opportunity for planning committee participants to review and gauge the extent to which the local public health system was providing the ten Essential Public Health Services (ES). It is important to note that the focus of this assessment was not on the activity of the local health department (CCDPH) alone, but on the local public health system (which includes public, private and volunteer agencies that contribute to performing the Essential Public Health Services in a jurisdiction).  

The 10 Essential Public Health Services (Figure 5) formed the framework for the 30 Model Standards (MS) used in the assessment, representing the spectrum of activities to assure public health within a jurisdiction. Since the MS are based on the ES, they were divided into 10 sections, one for each ES. The number of MS varied across the ES. Each contained between two and four MS.

This assessment can assist the local public health system in identifying areas of strength and weakness in addressing public health needs. From this, health improvement plans can build on areas where the local public health system (LPHS) is performing well, and enhance areas where services are weaker.

Local Public Health System Assessment Methods

The LPHSPA tool, developed by CDC and 6 other national partners, was used as a guide for this assessment. CCDPH had employed an earlier version of this tool in 2005 for WePLAN 2010 that required asking participants approximately 20 or more questions on each MS. This amounted to nearly 600 questions total. The process was very labor and time intensive. Three meetings were required and participation and engagement of planning committee partners suffered. Unfortunately, a lot of time was spent on the actual voting, limiting the time allowed for discussion of relevant issues that could identify system strengths and weaknesses.

For WePLAN 2015, CCDPH revised the process used to conduct the LPHSPA to streamline and focus the process. First, a decision was made to focus solely on the first level questions in the assessment tool for each MS. For example, for ES# 1, MS 1.1. Population Community Health Profile:

1.1.1. Has the LPHS conducted a community health assessment?
1.1.2. Does the LPHS compile data from the community health assessment into a community health profile?
1.1.3. Is community-wide use of community health assessment or CHP data promoted?

A Local Public Health Performance Assessment Key Informant Survey tool was created to collect information from selected internal and external stakeholders about the provision of each ES and the extent to which each MS was achieved. The survey tool consisted of a description of each ES and MS taken from the CDC LPHSPA tool. In addition, a table was created to use as a survey tool. For each MS, three questions were asked: “What are examples that this activity is being accomplished?” “Which agencies or groups perform or engage in this activity?” “What are the gaps in provision or accomplishment of this activity?”

This instrument was sent out via email to selected key informants both internal to CCDPH and working in agencies within the jurisdiction. To assure that key informants were knowledgeable about the areas surveyed, the list of participants were subdivided by ES. Surveys were sent to persons whose area of expertise or practice aligned with the ES. This was also done so as not to over-burden any one person or agency with completing the survey tool on all 30 MS. Multiple key informants were selected for each ES. A central contact was identified at CCDPH for each ES, to answer questions from other survey participants, if needed. Survey responses were compiled for each ES and prepared for use by the Community Planning Committee.

At a WePLAN Community Planning Committee meeting, the group was oriented to the LPHSPA tool. They were then divided into small groups of 5 to 7 participants. Each group was to focus on one ES. The compiled responses to the LPHSPA Key Informant Survey for each group’s assigned ES were distributed among the group members. The data included responses on all MS related to a specific ES. The group’s task was to review the material distributed and to create statements about the survey data answering the following questions: What is the LPHS currently doing? What are the gaps in performance of this service?

Following the small group discussion, a spokesperson presented the findings to the larger Community Planning Committee. Time was allotted for the larger group to raise questions and to add to the description of the system’s performance of the ES. Once discussion was completed, the entire WePLAN Community Planning Committee was asked to vote. Voting was performed using wireless keypad voting provided by the Chicago Metropolitan Agency for Planning (CMAP), which used audience-response software. Each participant was asked to vote, responding to the following:

A) Overall, to what degree is the LPHS providing this service:

1 Not at all [No activity: 0%]
2 Minimally [Minimal activity: 1-25%]
3 Low partially [Moderate activity: 26-50%]
4 High partially [Significant activity: 51-75%]
5 Optimally [Optimal activity: 76%+]
B) On a scale of 1 to 10 what is the priority of this Essential Service to our LPHS?
LOW 1 2 3 4 5 6 7 8 9 10 HIGH

Results of the voting were displayed instantaneously on the screen once voting was completed. The system also presented the data graphically. Once results were displayed, a short discussion followed to assure consensus on the overall results. This process was repeated for each ES.

Summary of the LPHSPA Results: WePLAN Community Planning Committee
The LPHSPA voting provided a rating for each ES. The first score was the “Extent of ES Provision” rating. All of the ES were rated as 3 (Low Partially) or higher. ES #2 (Diagnose and Investigate Health Problems) was rated highest with an overall rating of 4 (High Partially) and an average score of 4.5 out of 5.0 (Figure 6). Other ES scoring as 4 (High Partially) were: ES #1 (Monitor Health Status), ES #8 (Workforce Development), and ES #9 (Enforce Laws).

Figure 6.

The second rating for each ES was the Priority Score. This rating provided information on the Community Planning Committee’s assessment of how much of a priority a given ES was in the Local Public Health System in CDPH’s jurisdiction. The Community Planning Committee assigned the highest rating to ES #6 (Enforce Laws and Regulations) and ES #2 (Diagnose and Investigate Health Problems) both with median scores of 9.0 (Figure 7). ES #10 (Research for New Insights) ranked lowest among priorities with a median score of 5.5. Other ES ranged from scores of 7.0 [ES #8 (Assure a Competent Workforce) and ES #9 (Evaluate)] to 8.5 [ES #7 (Linking People to Personal Health Services)].
Summary of the LPHSPA Results: CCDPH Senior Program Staff
CCDPH Senior Staff results for the LPHSPA voting on the local health department’s responsibility for the provision of ESs showed that ES #2 (Diagnose and Investigate Health Problems) rated highest with a median score of 5 (Primary Responsibility) (Figure 3). ES #8 (Assure a Competent Workforce), ES #9 (Monitor Health Status) and ES #10 (Research for New Insights) were all rated lower with a score of 3 (Moderate Responsibility). The remaining ES had scores that indicated senior managers considered them a Significant Responsibility of the health department (Figure 8).
CCDPH Senior Managers also rated the priority of each ES in the local public health system. ES #2 (Diagnose and Investigate Health Hazards) was rated highest with a score of 9 out of 10. ES #10 (Research of New Insights) was rated lowest with a priority score of 5 (Figure 9).

A comparison of the priority rates from the WePLAN Community Planning Committee and the CCDPH Senior Staff was conducted to identify areas of agreement on system-level priority areas. The general pattern of the rating was similar for both groups (Figure 10). ES #2 (Diagnose and Investigate Health Hazards) was rated as high priority by both community members and CCDPH managers with a score of 9.0. The Community Planning Committee members rated ES #6 (Enforce Laws and Regulations) slightly higher, with a score of 9.0, than CCDPH managers with a score or 8.0. The lowest scores in both groups were for ES #10 (Research for New Insights) with the Community Planning Committee rating the item as 6.0 and the CCDPH managers rating it as a 5.0.

Comparison of Essential Service Priority Rating

Figure 10.
The full report of results (in supplemental materials) provides a summary of rating scores for each ES, the LPHSPA Key Informant Survey Tool, results of the LPHSPA Assessment small group discussion themes, and voting results for individual ES for both groups.

d. Community Health Status Assessment

Introduction
An assessment of selected population health indicators was conducted for CCDPH’s jurisdiction, comprised of four administrative/geographic districts within suburban Cook County: North, West, Southwest and South. Analyses comparing local indicators to state and national rates were included when possible.\textsuperscript{11} Healthy People 2010 targets were presented when corresponding goals were available.\textsuperscript{12, 13}

The categories examined in this assessment include:

- Demographic and Socioeconomic Indicators
- Leading Causes of Death
- Risk Factors
- Chronic Diseases
- Maternal and Child Health
- Injury & Violence
- Communicable Diseases
- Healthcare Access and Utilization

Major findings of the Community Health Status Assessment were presented to the Community Planning Committee in a webinar. For a more comprehensive presentation and analysis of the health status indicators refer to supplemental materials.

Demographic Highlights

Population Size by Race and Ethnicity
The size of the population changed very little overall. There was only a 0.7% increase in the population in the Cook County Department of Public Health’s jurisdiction between 2000 and 2010 Censuses. However, there was a large shift in the racial/ethnic makeup in the CCDPH region between the 2000 and 2010 Censuses. The Hispanic population increased 44% from 302,000 to


\textsuperscript{13} Data from the IPLAN Data System were reviewed prior to this assessment. As in the past, the system does not contain data for CCDPH jurisdiction alone (suburban Cook County, exclusive of the villages of Evanston, Oak Park, Skokie and Stickney Township). CCDPH generated its own data from the following sources: U.S. Bureau of the Census, Centers for Disease Control and Prevention, IDPH birth and death registries, IDPH Hospital Discharge data set, IDPH Behavioral Risk Factor Surveillance System (BRFSS), CCDPH Communicable Disease Registries, and the CCDPH Youth Risk Behavior Survey.
437,000 people. The African American population increased 20% from 310,000 to 371,000 people. The Asian population increased 30% from 115,000 to 150,000. The White population was the only group to decrease, from 1,494,000 to 1,280,000.

Population Age
The median age of the population increased between the 2000 Census and the 2005-2009 American Community Survey, reflecting an aging population.

- The median age of the CCDPH jurisdiction increased from 37.2 to 38.7 years.
- From the 2005-2009 American Community Survey, there were fewer people in the 24-44 age group (-9.9% males and -11.6% females) compared to the 2000 Census.
- The 45-64 age groups increased approximately 12% for both males and females.

Socio-economic status
The median income increased by approximately 12% in the CCDPH jurisdiction ($52,746 to $58,974) between the 2000 Census and the 2005-2009 American Community survey. (Note that these figures are not adjusted for inflation; hence the real increase in median income may be less than presented here.) The population in poverty increased by 34% in CCDPH’s jurisdiction (excluding unincorporated areas). The percentage of people living at or below the 100% federal poverty level increased from 6.4% in 2000 to 8.5% for 2005-2009 estimates. The South District had the highest percentage of people living in poverty (13.6%) in 2005-2009.

Leading Causes of Death
The 10 Leading Causes of Death accounted for 77% of the 62,521 total deaths from 2005 to 2007 in SCC. Six of the top 10 leading causes of death were attributed to chronic diseases and accounted for 67% of all deaths. Chronic diseases (heart disease, cancer, and stroke) were the top 3 leading causes of death in SCC, accounting for 57.4% of all deaths from 2005 to 2007.

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14 Methodological Notes:

Vital statistics – Birth and death record data are the most consistently available source of health data. For this reason, this analysis largely presents data from these sources. It is important to be aware the mortality data represent only a portion of all disease morbidity and the most serious consequence of a disease process.

Morbidity data – Actual illness, not necessarily resulting in death, is available for some diseases. Selected communicable diseases, such as the sexually transmitted infections presented here, are reportable to the Communicable Disease Registry. For other conditions, morbidity statistics are less readily available, especially for chronic conditions such as heart disease, diabetes and stroke. Similarly, risk factor data such as obesity, smoking, and exercise are only available as prevalence estimates and are not routinely reported for the population.
Figure 2: Leading Causes of Death

![Leading Causes of Death, SCC, 2005-2007](chart)


**Years of Potential Life Lost (75 Years)**

In SCC, cancer and heart disease contributed the most years of potential life lost (YPLL) between 2005 and 2007. The total YPLL for cancer was 103,083 years with an average of 13.0 YPLL per death. Heart disease accounted for a total of 76,968 YPLL with an average of 13.9 YPLL per death.

Figure 3: Years of Potential Life Lost

![Overall: Years of Potential Life Lost, Suburban Cook County, 2005-2007](chart)


1. In SCC, unintentional injuries ranked third in the total YPLL (33,407) with an average of 33.4 YPLL per death from 2005 to 2007.
2. Homicide ranked third in both total (12,275 YPLL) and average YPLL (47.2 YPLL per death) in SCC from 2005-2007.
Risk Factors
A majority of deaths among the top ten leading causes of death can be attributed to risk behaviors such as tobacco use (smoking), physical inactivity and poor nutrition. Physical inactivity and poor nutrition can lead to obesity as well.

Figure 4: Chronic Disease Risk Factors

Risk factors associated with the top three leading causes of death (heart disease, cancer, and stroke) in SCC include:

- **Tobacco Use**: Sixteen percent of adults in 2009 and 12% of high school students in 2010 smoked cigarettes.
- **Physical Inactivity**: Approximately 7 in 10 adults in 2009 did not meet the minimum standards for physical activity. Over 75% of high school students in 2010 were not physically active for 60 minutes every day.
- **Poor Nutrition**: Seventy five percent (75%) of adults in 2009 and 80% of high school students in 2010 did not eat the recommended five servings of fruits and vegetables.
- **Obesity**: One in four adults (25%) in 2009 and 11% of high school students in 2010 self-reported as being obese

Chronic Diseases
Heart Diseases (including coronary heart disease) was the leading cause of death in SCC, responsible for approximately 5,600 deaths per year from 2005 to 2007. This is equivalent to 15 deaths per day in SCC. Heart disease was also the leading cause of death for African Americans and Whites in SCC.

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Disparities exist:
- The coronary heart disease mortality rate increased for African Americans in CCDPH from 237.2 to 251.7/100,000 while the rate decreased for Whites (from 180.7 to 140.3/100,000) between 2000-2002 and 2005-2007. The coronary heart disease mortality rate among African Americans in CCDPH (251.7/100,000) was higher than the HP 2010 goal of 166.0/100,000). The rate for Whites (140.3/100,000) was below the goal.
- In SCC, the cerebrovascular mortality rate for African Americans (87.1/100,000) was twice the rate for Whites (41.0/100,000) in 2005-2007 and 81% higher than the HP 2010 goal of 48.0/100,000.

Cancer was the second leading cause of death in SCC, responsible for approximately 5,050 deaths per year from 2005 to 2007. Among Asian and Hispanic populations, cancer was the leading cause of death.
- Lung cancer, strongly associated with smoking, was the most common cause of cancer death from 2005-2007 in SCC. While rates for other racial/ethnic groups in SCC were below the Healthy People (HP) 2010 goal of 44.9/100,000, the lung cancer mortality rate for African Americans (83.7/100,000) was 86% higher than the HP 2010 goal.
- Colorectal, breast (female only), and prostate cancer mortality rates among African Americans in 2005-2007 were more than double the rates for Whites in SCC.

Stroke was the third leading cause of death in SCC, associated with 1,207 deaths per year from 2005 to 2007. The CCDPH cerebrovascular mortality rate decreased 18% from 55.4 to 45.5/100,000 between 2000-2002 to 2005-2007. In 2006, the cerebrovascular mortality rate for CCDPH (45.4/100,000) was similar to the U.S. rate (43.6/100,000).

Diabetes-related mortality accounted for 4,951 (7.8%) of all deaths in SCC from 2005 to 2007. The diabetes (any cause) mortality rate for African Americans in CCDPH increased 14% from 120.8 to 136.8/100,000 between 2000-2002 and 2005-2007. In 2005-2007, the diabetes mortality rate for African Americans in CCDPH (136.8/100,000) was higher than the rate for Whites (55.2/100,000). The overall U.S. rate was 75.5/100,000).
- Diabetes-related mortality among African Americans in the South district (431 deaths) accounted for 58% of all deaths related to diabetes in SCC from 2005-2007.
- From 2008 to 2009, there were 52,924 diabetes-related hospitalizations. The diabetes-related hospitalization rate among African Americans in SCC was 2,243.7/100,000; more than double the rate for Whites (846.6/100,000).

Maternal and Child Health
Teen Birth rates (30.8/1,000) for SCC were below both the U.S. (42.9/1,000) and Illinois (42.9/1,000) rates from 2005 to 2007. There was an 8% decrease in the CCDPH teen birth rate (from 35.8 to 32.9/1,000) between 2000-2002 and 2005-2007.
• The Hispanic teen birth rate in 2005-2007 in SCC (85.6/1,000) was higher than other racial/ethnic groups in SCC. However, the Hispanic teen birth in SCC was similar to Hispanic rates in the U.S. (93.2/1,000) and Illinois (86.0/1,000).

• While the highest teen birth rate in 2005-2007 in SCC was among Hispanics in the South District (97.9/1,000), teen birth among Hispanics in the West district accounted for 21% of all teen births in SCC from 2005-2007. This may be due to the high population of Hispanics in the West district.


• The infant mortality rate in SCC has decreased from 8.3/1,000 in 2000 to 6.0/1,000 in 2007.

• The African American infant mortality rate (15.1 deaths/1,000 live births) in SCC was more than triple that of Whites (4.8/1,000) and similar to those for the U.S. (14.1/1,000) and Illinois (14.5/1,000). The infant mortality rate among African Americans in CCDPH has remained stable (approximately 14.2/100,000) between 2000-2002 and 2005-2007.

• The South district was disproportionately affected by infant mortality. While the South district accounted for only 20% of all births in Suburban Cook County, approximately 30% of all infant deaths occurred in the district.

Low Birth Weight (LBW) is the main risk factor for neonatal mortality and greater morbidity later in an infant’s life. The LBW rate in CCDPH has remained stable (5.9/1,000) between 2000-2002 and 2005-2007.

• The overall LBW rate for SCC in 2005-2007 was 5.9% higher than the HP2010 goal of 5.0%.

• From 2005-2007 in SCC, the LBW rate for African Americans (10.7%) was double that for Whites (4.4%). The LBW rate for African Americans in CCDPH did, however, decrease from 11.3 to 10.8/1,000 between 2000-2002 and 2005-2007.

Injury and Violence
Homicide was the leading cause of death for youth (ages 15-24yrs) in SCC, accounting for one out of every 4 deaths among this age group from 2005 to 2007.

• From 2005-2007, the homicide rate for African Americans (25.5/100,000) was 15 times that of Whites (1.7/100,000) in SCC.

• Homicide was responsible for an average 46.1 years of potential life lost per death in SCC from 2005-2007.

Firearm-related deaths in SCC accounted for 148 deaths in 2007.

• Approximately half of all firearm deaths in SCC were among African Americans in 2005-2007. The SCC firearm-related mortality rate (7.1/100,000) was higher than the Healthy People 2010 goal of 3.6/100,000.
Communicable/Infectious Diseases
The Gonorrhea incidence rate in the jurisdiction area of CCDPH for 2008 (113.6/100,000) was six times higher than the Healthy People (HP) 2010 goal (19.1/100,000).

- The gonorrhea rate for youth ages 15-19 increased 26% from 447.9 to 575.4/100,000 between 2000-2002 and 2006-2008.

Chlamydia incidence rate in CCDPH increased 56% for youth ages 15-19 from 1,168.1 to 1,825.0/100,000 between 2000-2002 to 2006-2008.

- Chlamydia incidence rate for African Americans in CCDPH increased 82% from 733.2/100,000 in 2000-2002 to 1,333.5/100,000 from 2006 to 2008.

New HIV Diagnoses increased substantially in persons aged 20-29 years, from a rate of 9.7/100,000 in 2000-2002 to 21.8/100,000 from 2006 to 2008.

Healthcare Utilization (Preventable Hospitalizations)
Uncontrolled Hypertension accounted for 5,712 hospitalizations in SCC from 2008 to 2009.

- During 2008 to 2009, the overall uncontrolled hypertension hospitalization rate for SCC was 115.1/100,000.
- The rate of uncontrolled hypertension hospitalizations from 2008 to 2009 among African Americans in SCC was 392.3/100,000 about six times that of Whites (67.3/100,000).

Diabetes-related hospitalizations accounted for 52,924 hospitalizations in SCC from 2008 to 2009; approximately 8% of all hospitalizations.

- The overall diabetes related hospitalization rate from 2008 to 2009 for SCC was 1,066.4/100,000.
- The rate of diabetes related hospitalizations among African Americans in SCC in 2008 to 2009 was 2,243.7/100,000 which was more than double that of Whites (84,606/100,000).

Asthma accounted for 7,258 hospitalizations in SCC from 2008 to 2009.

- The asthma hospitalization rate in SCC for males under the age of 5 was 323.1/100,000 or 68% higher than the rate for females (192.2/100,000) in the same age group from 2008 to 2009.

Uninsured: In 2009, 11% of adults in SCC reported having no healthcare coverage.

No Primary Care Provider: In 2009, 13.2% of adults in SCC did not have a regular primary care provider.

Routine Check-up: In 2009, over 16% of adults in SCC had not had a routine check-up in the last two years.
e. **Forces of Change Assessment**

The Forces of Change Assessment (FOCA) focused on the identification and impact of forces that are presently affecting or might affect the context in which the community and public health system operate. FOCA responses describe trends, factors and events, and the likely impact of these forces on the community’s health or the public health system.

FOCA was gathered using several collection methods. First, an online survey (www.surveymonkey.com) was sent to all WePLAN Community Planning Committee invitees. The survey consisted of two open ended questions:

- Identify one or two issues that are occurring or might occur that affect the health of our community or the local public health system?
- What specific threats or opportunities are produced by the issues you identified in the previous question?

Respondents were asked to consider both positive and negative issues as well as local, regional, national or global issues.

A total of 24 responses were collected or a response rate of 50%. Each response included a minimum of two issues or trends with corresponding threats or opportunities. Responses were compiled and categorized for vetting and additional input was collected at the subsequent Community Planning Committee meeting. Meeting participants were asked to react to the survey responses by identifying what was most striking and of concern. Participants identified opportunities and threats and elaborated on how identified forces/trends would impact health and health improvement efforts. The full report of FOCA responses can be seen in the supplemental materials.

This exercise identified five major categories to consider for the public health system to function optimally. The following identifies the categories and participant responses (in *italics*).

**Health Care Reform**

- **Threats include:** Increased demand on finite primary care by newly Medicaid eligible; many more people will be buying health insurance and will need a medical home; greater strain on the present healthcare workforce to meet the demand for care; exclusion of undocumented people with no reimbursement for safety net providers; there is no provision for addressing the need for oral health services for adults. The health reform bill makes the healthcare system even more complicated.

- **Opportunities include:** As healthcare reform unfolds, we have an opportunity to contribute to the development of a newly structured healthcare system with a focus on prevention and a stronger public health system. Note: The healthcare system or provision of clinical services is a component of the public health system. There are many provisions of health care reform that will help improve access to healthcare and the quality of care.

**Lack of insurance and lack of healthcare**

- **Threats include:** Poor and inequitable health outcomes resulting from lack of healthcare; dealing with health issues is a result of the disparities in availability of health services including options for specialty care; people are unable to afford healthcare, particularly preventive healthcare, putting a greater strain on counseling and psychiatric services, consequences of loss of health insurance include later diagnosis, decreased opportunities for effective treatment options at a later stage of diagnosis, greater likelihood of spread of communicable disease and health apathy.

- **No opportunities cited.**
Economic Crisis

- **Threats include:** The state budget crisis will impact local health department budgets and necessitate workforce reductions, furloughs, and decreased work hours. The state cannot pay its bills resulting in cuts in community services. The current economic conditions are having an effect on funding of health related programs in both the public and private sector. People do not have adequate incomes to allow them to spend extra money on healthier foods and they may not have money to spend on healthcare. Increasing unemployment means increasing need for health services. The economic impact at the state and national level disproportionately impact Black, Hispanic and low-income communities.

- **Opportunities include:** This crisis calls for an overall of how we structure communities and could be a catalyst for change. We could stop creating the same old problems and try something radically different for community health where the community stands up for itself. This may be a chance to positively reform the way in which we deliver care that is more patient-centered, quality-focused, and cost-effective.

Social Inequity

- **Threats include:** Worsening problems for poor communities, including lack of quality education, limited goods and services, lack of employment/underemployment, poor transportation, and increased violence. Black, Hispanic and low income communities are plagued by multi-level systemic problems including lack of education, limited goods and services, limited quality jobs, poor transportation.

- **Opportunities include:** Crisis and inequality bring opportunities. For example, limited access to grocery stores encourages community gardens or protests against overcrowding recently led to the development of a new high school.

Increasing immigrant and undocumented populations

- **Threats include:** No benefits for the undocumented under health care reform; lack of immigration policies; increasing number of poor immigrants in need of services; increased need for interpreters and translators; lack of trust in the public health system.

- **Opportunities include:** There is an opportunity for development of community organizations to address and advocate for immigrant issues.

The Community Planning Committee meeting focused on processing the FOCA survey. Invited speakers represented key topics likely to affect the public health system in the next five years, including:

- Mary Driscoll, RN, MPH on Health Information Exchange (HIE). Ms. Driscoll is a member of the Illinois HIE Public Health Workgroup.
- Ralph Martire, JD on the State of Illinois’ budget. Mr. Martire is an economist and executive director of the Center for Tax and Budget Accountability.
- Linda Murray, MD, MPH on Health Reform: How do we best align our resources to make sure the residents of Cook County get the things they need? Dr. Murray is Chief Medical Officer of CCDPH and President of the American Public Health Association.
Community Health Plan

we PLAN 2015
IV. COMMUNITY HEALTH PLAN

a. Purpose
The second component of the WePLAN 2015 process is the planning process and the development of the Community Health Plan. The plan serves as a population-based, prevention-focused health improvement plan for the next five years. Firmly grounded in the IPLAN Certification Rules, the Community Health Plan compiles the voices of the community represented in the community assessments, the LPHPSA results, the community data and trends, the lessons learned from previous IPLAN efforts, and the Community Planning Committee’s experience and wisdom to forge a community health improvement strategy.\(^{16}\)

b. Process of Health Priority Identification
After completing a brief review of the four MAPP assessments, the WePLAN 2015 Community Planning Committee completed an exercise to identify potential health issues and problems in the CCDPH region. The committee was divided into five groups and asked to identify problems associated with each of five issues: access, coordination, education, health inequity and the built environment. The MAPP Strategic Issues Identification Worksheet was used as a tool to guide the identification of strategic health issues. It asked each participant to: 1) Identify a strategic issue; 2) Describe Why is this an issue? (based on the MAPP assessments) and 3) Identify the consequences of not addressing the issue. From this session an initial list of 37 problems and issues were generated.

A Nominal Group Technique was used to prioritize the 37 health issues. Participants were asked to consider them in terms of the local public health system at large, based on the following criteria: greatest community impact (number of people impacted, inequities, increasing or decreasing trend); the seriousness of the issue (does it result in death or serious disability or quality of life?); the timeframe to intervene (short or long; does the issue impact the most vulnerable residents); issues that already are being addressed or that have some momentum from other approaches; the potential for available solutions or intervention; the cost of impacting this issue and the proportion of the population, stakeholders or sectors that are or would need to be engaged to achieve success.

Each participant was instructed to select five issues or health problems that aligned with the criteria above. They were asked to write these on single sheet of paper. Next, the Community Planning Committee was asked to form small groups to identify a consensus list of five strategic health issues or health problems. Through a facilitated process, the results of the small group exercise were shared and reviewed by the Committee. When each group had submitted their initial two responses, similar items were grouped into categories. The remaining items from the small groups were then processed in a similar manner. The entire committee worked to define consensus categories for the items. As a result of this process a consensus list of health problems and issues were identified by the Community Planning Committee:

Initial Health Priorities
• Chronic Disease
• Violence Prevention
• STIs/Teen Pregnancy (Sexual Health)
• Access to Healthcare Services
• Health Inequities
• Lack of Coordination
• Lack of Health Promotion/Education
• Lack of Funding
• Lack of Livable Communities

Following the identification of the initial list of health priorities for the health plan development, the Community Planning Committee reviewed definitions of a health problem, a strategic health issue, values and strategies. Based on this information and further discussion, the Committee agreed that Chronic Disease, Violence Prevention, and Sexual Health (including STI, HIV and teen pregnancy prevention) were considered priority health problems. Access to Care was determined to be a strategic health issue. The Community Planning Committee identified three operating principles of the LPHS that they believed needed to be addressed in all issues at all times. These values included health equity (or the problem of health inequity/disparity), collaboration and prevention. Coordination, health promotion, health education, funding and livable communities represented potential approaches to improve health in communities and would be used as priority strategies in addressing the health problems. The identified issues were organized into a conceptual model (Figure 11) to guide the health improvement plan.

Figure 11: Health Improvement Plan Model
c. **Health Problem Analysis**

Once priority health issues were identified, the Community Planning Committee members were divided into small groups of 3 to 5 persons. Each group selected a specific health priority and was asked to: a) identify related risk factors and contributing factors, and then keeping these in mind, b) use a worksheet to suggest which of the potential strategies and activities identified during consensus would be appropriate to address that particular issue, and c) identify potential partners, resources and barriers to addressing the health issue were also identified.

d. **Health Improvement Priorities**

1. **Chronic Disease: Cardiovascular Disease Prevention**

**Goal 1:** Through prevention efforts, reduce the disease and economic burden of cardiovascular disease mortality in suburban Cook County.

**Issues and Trends**

Cardiovascular disease includes both coronary heart disease and cerebrovascular disease, or stroke. Diabetes is a chronic disease that is an important risk factor for the development of cardiovascular disease. The burden of cardiovascular disease in SCC is evident in the following data:

- While the coronary heart disease (CHD) mortality rate in suburban Cook County declined by 30% between 2000 and 2007 (from 192.6 deaths/100,000 population to 133.2/100,000), of concern is that the Southwest and South Districts of SCC have consistently been above the U.S. rate.
- The South District has had the highest CHD mortality rate with an average mortality rate of 164.8/100,000.
- CHD mortality rates were highest in the South District for African Americans, Hispanics, and Whites.
- Although CHD mortality rates decreased for both males and females, males continued to have a higher rate of CHD mortality (e.g. 202.1/100,000) in 2005-2007. CHD was still the leading cause of death among women.
- Overall, the CHD mortality rate decreased from 183.1/100,000 (2000-2002) to 147.3/100,000 (2005-2007). The decrease in CHD mortality among Whites was a major contributor to the overall CHD mortality rate.
- In SCC, the stroke mortality rate declined by 22% between 2000 and 2007 (from 55.8 deaths/100,000 to 43.7/100,000).
- African American stroke mortality rates were above the HP2010 goal of 48.0/100,000 at the national, state, SCC and all Districts, except for North District.

Heart disease was the leading cause of death in SCC, responsible for approximately 5,600 deaths per year from 2005 to 2007. Disparities in cardiovascular disease mortality rates reflect larger, social inequities in access to resources including medical care, income, education, neighborhood conditions, employment, and community-based factors. These social determinants of health have a
strong impact on risk factors and disease outcomes and may be considered “root causes” of disease.¹⁷

**Outcome Objective**

**O1.1** By 2015, reduce coronary heart disease (CHD) mortality to no more than 123.2 deaths/100,000 in SCC. (SCC baseline: 145.2 deaths/100,000. HP2020: 100.8/100,000)

**O1.2** By 2015 reduce cerebrovascular (stroke) disease mortality to no more than 39.5 deaths per 100,000 in SCC (HP2020: 33.8 per 100K; SCC Baseline 45.2 per 100K)

**Risk Factors**

Health risk factors for CHD include obesity, diabetes, poor nutrition, physical inactivity, high cholesterol, high blood pressure, tobacco use, and stress. Social determinants that contribute or lead to these behavioral risk factors include living in neighborhoods with high rates of poverty, neighborhood violence and related community stressors, lack of access to primary care, lack of access to healthy food, and lack of access to safe places for physical activity.¹⁸ Important ways to prevent CHD include: addressing modifiable risk factors such as increasing physical activity, healthy diet and smoking cessation; addressing contributing factors such as working with communities and policy makers to help ensure that residents and families have access to economic opportunities, healthy food and safe places for physical activity.

**Impact Objectives**

**I1.1** By 2013 reduce the prevalence of diabetes to 8% among adults in suburban Cook County. (BRFSS 2007: 9.5%) Preventing cardiovascular disease requires a dual focus. Prevention efforts must help individuals to address their own personal needs and actions, as well as help mobilize coalitions and build capacity in order to address the social, policy and environmental conditions that are upstream factors in the development of cardiovascular disease. For instance, people need to know how to avoid risk factors for diabetes, as well as needing access to healthy food where they live in order to be able to eat a nutritious diet.

**I1.2** Reduce the prevalence of obesity in suburban Cook County.

11.2a: By 2013 reduce the prevalence of obesity (BMI >=30) to less than 24% among adults. (HP2020: 30.6%; SCC Baseline 25.4%).

11.2b: By 2013 reduce the prevalence of obesity in children (>= 95% percentile) to 15% (Cook County Baseline: 17%)

WePLAN 2015 will promote communities in which there is access to parks and a safe environment, so that people can more easily act on recommendations to be physically active, and avoid obesity.


Children can benefit from increased access to after school and weekend facilities for safe play. Some existing facilities that are closed can be opened if community leaders and stakeholders work together to implement joint use agreements. Schools are also an important place where food service and opportunities to educate about diet come together. The school community can play an important role in helping reduce the prevalence of obesity in children.

I1.3 By 2013, reduce the prevalence of tobacco use to 12.0% (HP2020). [SCC Baseline (BRFSS 2009) 15.9%].
Media and social marketing are a powerful means to continue to change the norms about smoking. In addition, policy efforts should be undertaken in order to increase the number of smoke-free public places including parks.

I1.4 By 2013, increase the proportion of the population in SCC that meet the moderate physical activity standard to 25%. [SCC Baseline (BRFSS 2009) 20.8%]
In addition to other ways to promote physical activity, programs at the State of Illinois level have an important role to play. These chronic disease prevention programs will be strong only through development of a constituency that can advocate effectively on behalf of sustainable funding for chronic disease prevention. Better use of existing resources is critical to building sustainable efforts as well. Community advocates must work together with experts from multiple disciplines in order to make interventions work at the local level.

Intervention Strategies
- Increase awareness of both individual and community related risk factors for cardiovascular disease.
- Increase the number of suburban Cook County communities with policy, systems and environmental best practices to support cardiovascular disease prevention.
- Develop comprehensive region-wide policies to reduce exposure to tobacco.
- Assure the sustainability of public health prevention activities.

Recommended Activities
- Develop and increase consistent use of health communications messaging related to cardiovascular disease prevention.
- Implement a social marketing campaign targeted at high risk groups for tobacco use.
- Implement opportunities for access to healthy food, especially in areas without adequate access to fresh foods.
- Implement local policies for access to safe places to play and exercise.
- Foster adoption of joint use agreements for use of existing community facilities (e.g. schools, Park District property, auditoriums) as public locations for physical activity.
- Enact a comprehensive, regional policy for smoke-free housing, parks and public spaces.
- Advocate for state-wide support of cardiovascular disease prevention programs.
- Develop multidisciplinary networks to address community-based plans for chronic disease prevention interventions.
- Advocate for increased chronic disease morbidity and risk factor data to identify at-risk populations.
### Community Action Plan to Improve Cardiovascular Disease in suburban Cook County

#### Health Problem:
- Provide data from CHSA
- Heart disease is the leading cause of death in SCC.
- Coronary heart disease mortality among African Americans and males in SCC remain above the HP2010 goals.
- Cerebrovascular mortality among African Americans and Asians remain above HP2010 goals.

#### Outcome Objective:
- O1.1: By 2015 reduce coronary heart disease mortality to CHD no more than 123.2 deaths per 100,000 in SCC. (HP2020: 100.8 per 100K; SCC baseline 145.2 per 100K)
- O1.2: By 2015 reduce cerebrovascular (stroke) disease mortality to no more than 39.5 deaths per 100,000 in SCC. (HP2020: 33.8 per 100K; SCC baseline 45.2 per 100K)

#### Modifiable Risk Factors:
- High blood pressure
- Tobacco use
- High cholesterol
- Diabetes mellitus, especially Type II diabetes.
- Physical inactivity
- Obesity
- Stress

#### Impact Objective:
- I1.1: By 2013 reduce the prevalence of diabetes to 8% among adults in suburban Cook County. (BRFSS 2007: 9.5%)
- I1.2: Reduce the prevalence of obesity in suburban Cook County.
  - I1.2a: By 2013 reduce the prevalence of obesity (BMI >=30) to less than 24% among adults. (HP2020: 30.6%; SCC Baseline 25.4%)
  - I1.2b: By 2013 reduce the prevalence of obesity in children (>= 95th percentile) to 15% (SCC Baseline: 17%)
- I1.3: By 2013 reduce the prevalence of tobacco use to 12.0% (HP2020) [SCC Baseline (BRFSS 2009) 15.9%]
- I1.4: By 2013, increase the proportion of the population in SCC that meet the moderate physical activity standard to 25%. [SCC Baseline (BRFSS 2009) 20.8%]

#### Contributing Factors:
- Poverty/lack of resources
- Low health literacy
- Less educated
- Minority populations
- Reduced access to healthy food/poor nutrition
- --High cost of nutrient dense food/ low cost of calorie dense food
- Neighborhood violence
- Lack of access to safe places for physical activity
- Community resources/built environment
- Lack of access to tobacco cessation
- Lack of access to primary care
- Ease of access to tobacco
- Social acceptability of tobacco
- Social/cultural norms- acceptability of fast food
- Family structure

#### Process Objectives:
- P1.1: Increase awareness of both individual and community related risk factors for cardiovascular disease.
- P1.2: Increase the number of SCC communities with policy/systems/environmental best practices/policies to support cardiovascular disease prevention.
- P1.3: Develop comprehensive region-wide policies to reduce exposure to tobacco.
- P1.4: Assures the sustainability of public health prevention activities

#### Barriers:
- Lack of perceived risk
- Disparities in access to healthcare
- Disparities in access to health food
- Disparities in access to safe places for physical activity
- Lack of community cohesion
- Lack of coordination among providers and local agencies to implement preventative activities
- Lack of funding
- Lack of regional approach
- Lack of regional standards and policy

#### Recommended Activities
**Health Education (Capacity/Awareness)**
- Develop and increase consistent use of health communications messaging related to cardiovascular disease prevention.

**Health Promotion (SNC)**
- Implement a social marketing campaign targeted at high risk groups for tobacco use.

**Livable Communities**
- Implement opportunities for access to healthy food, especially in areas without adequate access to fresh foods.
- Implement local policies for access to safe places to play/exercise.
- Foster adoption of joint use agreements for use of existing community facilities (e.g. schools, park District property, auditoria) as public locations for physical activity.

**Coordination of policy development and advocacy**
- Enact a comprehensive region-wide policy for smoke free housing, parks and public spaces.

**Advocacy/Constituency**
- Advocate for state-wide support for cardiovascular disease prevention programs.
- Develop multidisciplinary networks to address community based plans for chronic disease prevention interventions.
- Advocate for increased chronic disease morbidity and risk factor data to identify at risk populations.
2. Improve Sexual Health Status of Youth

Goal 2: Reduce the rates of sexually transmitted infections (STIs) and unintended pregnancies in youth.

Issues and Trends
Almost half of new STIs each year are among people ages 15-24 years. The burden of STIs is significant both for individuals and for society. Untreated STIs can lead to serious long-term health consequences. For example at least 24,000 women in the US each year become infertile as a result of undiagnosed or untreated STIs. The cost to the health care system is estimated at $15.9 billion annually.

STIs and teen pregnancy are preventable. The Task Force on Community Preventive Services found evidence that comprehensive risk reduction interventions for adolescents are effective at reducing risk behaviors such as engaging in sexual activity or unprotected sexual activity. The evaluation of interventions conducted in group settings in schools or communities found that “for every dollar invested in comprehensive risk reduction there was a $2.70 to $3.70 return based on savings in healthcare costs related to pregnancies, HIV, and STIs and improvement in income associated with higher educational attainment.”

- In 2008, birth rates for teens (15-19 yrs) in Illinois were 38.1 per 1000 compared to 41.5 per 1000 for the United States. When reviewing Illinois data by race and Hispanic origin, health disparities exist: in 2007, teen mothers were 20.6 per 1000 for Non-Hispanic whites; 77.9 per 1000 for Non-Hispanic blacks, and 75.3 per 1000 for Hispanics. In SCC, Hispanic and non-Hispanic African-American teen birth rates (90/1,000 population and 70/1,000 population, respectively) are nine and seven times greater than the White teen birth rate (10/1,000 population).
- Inequities in STI rates by race and ethnicity are large in SCC. The rate of Chlamydia for non-Hispanic Blacks in 2008 was 24 times higher than the rate for non-Hispanic whites.

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The rate for primary and secondary syphilis in SCC in the year 2008 (2.6/100,000 population) was 13 times higher than the HP 2010 goal of 0.2 cases/100,000 population.

Illinois applied for funding in FY 2010 from the federal Personal Responsibility Education Program (PREP). Funded programs are required to provide information on both abstinence and contraception for the prevention of unintended pregnancy and sexually transmitted infections, including HIV/AIDS. Assuring that youth receive medically accurate, age-appropriate education as part of a sexual education curriculum has been shown to impact youth risky sexual behavior and empower them to make better decision to protect their own health. In 2011, the Illinois state legislature is considering a bill (SB 1619) that will require schools that provide sexual health education to include instruction on both abstinence and contraception for the prevention of pregnancy and STIs.

Access to coordinated care including primary healthcare, social and human services is a key factor in providing prevention and education services to SCC residents related to reproductive health care. These services are provided by a range of public and private organizations. Lack of (or apparent lack of) access to these important services also plays a role in the existence of large inequities in rates of STIs and teen births.

Outcome Objective
O2.1 By 2015, the incidence of unintended pregnancies and STIs will be reduced by 10% among youth in SCC where rates are higher than HP2020.

Risk Factors
Risk factors identified by the WePLAN Community Planning Committee and CCDPH staff included: early initiation of sexual activity; unprotected sexual activity; multiple sexual partners; coercive sexual relationships; mental health illness; low self esteem.

Impact Objective
I2.1 By 2013, reduce by 10% the proportion of youth who report sexual intercourse by 17 years of age. (Baseline: 37.3% 2010).

I2.2 By 2013, increase by 10% the proportion of sexually active youth who report condom use at last sexual intercourse. (Baseline: 62.1%).

Despite more than $1.5 billion spent on abstinence-only-until-marriage programs, evidence shows that they are not effective in stopping or even delaying adolescent sex. However, there is strong evidence that comprehensive approaches help young people both to withstand the pressures to have sex too soon and to have healthy, responsible, and mutually protective relationships when they do become sexually active. Many curricula exist that have been evaluated and shown to be effective in

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delaying onset of sexual intercourse. By working together with parents, educators and policy makers, WePLAN 2015 will help sexuality health education curriculum be implemented in schools.

Raising awareness of the present sexual health status of youth, and the implications of early and unprotected sexual intercourse is an important step for building the case for resources devoted to a comprehensive approach to sexual health education. Many community members, youth and educators may be served by providing a resource guide of SHE curricula that have been found to be effective. Examples of such guides already exist. For instance, Advocates for Youth publishes “Science And Success: Sex Education and Other Programs That Work to Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections.” In addition, information about youth and family-support services could be included to increase awareness of existing services and to increase coordination.

Youth can benefit from increased access to places to go for recreation during free time and at other times on weekdays and weekends. Joint Use Agreements are helpful in increasing access by facilitating a partnership between two or more entities, often school districts or parks and local government agencies, to open up spaces such as playgrounds, athletic fields, pools, and gymnasiums to the community outside of school hours, or to open up community facilities to resident at a reduced cost or for free.

In addition to school-based curricula and initiatives, an important role is played by social service and health providers serving youth. Scarce resources will be used more effectively if these providers coordinate. To better address the needs of youth in high risk communities, an assessment of existing resources and needs should be carried out.

CCDPH has a successful track record of building coalitions in school communities to improve health. Health promotion staff are able to develop a network among students, parents, educators and community leaders to ensure that communication about the significance of STI’s is effective and ongoing. Timelines and workplans should be developed in collaboration with educators and school communities. Multiple communication channels need to be used including social media, community meetings and print materials.

**Intervention strategies**

- Increase awareness of the sexual health status of youth, the implications of early and unprotected sexual activity and the factors influencing youth sexual decisions.
- Advocate for policy change on the state and local levels to address implementation of sexuality health education curricula in schools.
- Assess the needs of youth in communities with higher rates of teen pregnancy and STIs to advocate for increased funding to provide opportunities for building youth resiliency.
- Increase coordination of youth health and social service providers to increase understanding of current community resources and to better meet the needs of youth.

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Recommended Activities

- Initiate a community-wide campaign to promote healthy youth and provide training for parents, teachers and youth providers.
- Develop a community constituency to advocate for policies supporting SHE in the schools and support for expanding activities to other youth venues.
- Expand adult supervised youth after-school activities, e.g. Joint Use Agreements in high risk communities.
- Compile and distribute a resource guide of SHE curriculums and community activities to support coordination of services.

| Community Action Plan to Improve Sexual Health among youth in suburban Cook County |
|---|---|
| **Health Problem:** | **Outcome Objective:** |
| High rates of Sexually Transmitted Infections (STIs) and pregnancies in youth. Note disparities in racial/ethnic/MSM youth | O2.1: By 2015, the incidence of unintended pregnancies will be reduced by 10% and STIs will be reduced by 10% among youth in suburban Cook County. |
| **Risk Factors:** | **Impact Objective:** |
| Unprotected sexual activity | I2.1: By 2013, reduce by 10% the proportion of youth who report sexual intercourse by 17 years of age (baseline 37.3% 2010) |
| Early initiation of sexual activity | I2.2 By 2013, increase by 10% the proportion of sexually active youth who report condom use at last sexual intercourse (baseline 62.1%). |
| Multiple sexual partners | | |
| Coercive sexual relationships | | |
| Mental health disorders (depression) | | |
| Low self-esteem | | |
| **Contributing Factors:** | **Process Objectives:** |
| Nonuse/misuse of condoms and other protection | P2.1: Increase awareness of the sexual health status of youth, the implications of early and unprotected sexual activity and the factors influencing youth sexual decisions. |
| Cultural and media influences | P2.2: Advocate for policy change on the state and local levels to address implementation of SHE curriculum in schools. |
| Lack of Sexual Health Curriculum in schools | P2.3: Assess the needs of youth in high risk communities to advocate for increased funding to provide opportunities for building youth resiliency. |
| Unsupervised time for youth especially after school | P2.4: Increase coordination of youth health and social service providers to increase understanding of current community resources and to better meet the needs of youth. |
3. Violence Prevention

Goal 3: Reduce the incidence of personal, family and community violence especially in communities suffering from unequal rates of violent acts.

Issues and Trends
Between 2000 – 2007, the overall age-adjusted rate of deaths from homicide in the CCDPH jurisdiction showed little change; mirroring both state and national levels. The CCDPH homicide rate of 6.3/100,000 population for 2005-2007 is slightly higher than the HP2020 goal of 5.5/100,000 population. However, even where regions of the CCDPH jurisdiction showed some improvement, there were significant disparities in homicide rates between the regions. The South suburban region experienced a 34% increase in deaths between 2000 and 2007 (10.6/100,000: 15.2/100,000). When comparing homicide rates by race and ethnicity, African Americans were nearly 15 times more likely and Hispanics were more than 5 times more likely to die of homicide than Whites.

The homicide rate in the CCDPH jurisdiction for 15-24 year olds was three times as high (or 19.3/100,000 population) as the general homicide rate in 2005-2007. Homicide was the leading cause of death for this age group, accounting for 1 of every 4 deaths. Similar to the period 2000-2002, 162 youth lost their lives to homicide during the period 2005-2007, for an average of 56 deaths per year. The South and West Districts had the highest youth homicide rates with 45.9/100,000 and...
25/100,000, respectively. Comparatively, the youth homicide rate in the Southwest District was 8.2/100,000 and the lowest rate the North District was 4.1/ 100,000.

The firearm-related mortality rate includes homicides, suicides and accidental deaths for all ages. At 7.4/100,000, it was lower than the HP2020 objective of 9.2/100,000. However, among African American males in the South District, the rate was much higher (25.3/100,000) and accounted for 30% of the firearm related deaths overall. The firearm related mortality rate in the 15-24 year old age group was 19/100,000. This was two and half times that of the all-age firearm mortality rate for the whole jurisdiction and accounted for more than half of the total firearm fatalities.

According to the 2010 Youth Risk Behavior Survey, a scientific high school-based youth survey conducted in the CCDPH jurisdiction:
- 1 in 16 (6.6%) high school students reported being threatened or injured with a weapon on school property during the preceding 12 months.
- Nearly 1 in 6 (15.8%) high school students reported being bullied on school property in the preceding 12 months.
- 1 in 9 (11.1%) high school students reported being hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend in the preceding 12 months.

**Outcome Objective**

**O3.1 By 2015, there will be a 10% improvement in the incidence of violent acts including homicide, firearm-related deaths and acts of sexual violence in populations experiencing rates greater than Healthy People 2020. (Baseline: 6.3/100,000. deaths from homicide; HP2020 goal: 5.5/100,000: African American: 25.5/100,000 and 6.1/100,00 for Hispanics).**

Violence causes injury, death, and emotional trauma. Experiencing and witnessing violence, as well as fearing violence, is damaging and can contribute to unhealthy behavior and a diminished community environment. Violence also influences where people live, work, play and shop. Preventing violence in a neighborhood improves overall health and well being

**Risk Factors**
The safety and health risk factors for deaths from violence were identified by the Community Planning Committee as: access to firearms, untreated mental illness, substance abuse, past history of violence, neighborhood gangs and bullying. To meet the goal of reducing violent acts in populations and geographic areas most at risk, the WePLAN 2015 proposes to assess and work collaboratively with communities to address improving community protective factors.

**Impact Objective**

**I3.1 By 2013, 80% of the SCC communities impacted by violent incidents will show a minimum of five or greater community protective factors representing community cohesion. (Baseline: TBD)**

Increasing neighborhood cohesive factors to improve safety in selected communities with high rates of violence offers a comprehensive approach to reducing violence. Community cohesive factors or community assets include but are not limited to jobs and economic opportunity, strong social networks, meaningful opportunities for community participation, a positive school climate, quality education, access to educational opportunities and positive relationships.
Intervention Strategies

- Encourage efforts that address neighborhood safety and foster a sense of community in partnership with residents, faith communities, social service agencies and youth agencies through environmental and policy recommendations.

Recommended Activities

- Develop a community assessment profile in partnership with community stakeholders to survey community stability and protective factors.
- Advocate for stronger purchasing requirements for handguns.
- Increase collaborative and networking opportunities to: address community resources and referral processes; leverage resources and advocate for support of early childhood programs and improved access to mental health and substance abuse treatment services.

I3.2 By 2013, 100% of the communities impacted most by youth violence will be informed on the issues contributing to youth violence and active in advocating for policies to promote healthy youth.

Intervention Strategies

- Conduct social media campaigns and trainings to increase awareness of the issues contributing to violence and prevention approaches.
- Improve information available to schools, churches, health providers and public safety personnel on family and dating violence and bullying.

Recommended Activities

- Conduct provider training on domestic violence and bullying.
- Develop and/or provide tool kits for schools, daycares, churches, youth activities on violence prevention.
- Develop a campaign to bring attention to family violence and the protective factors needed for prevention of violence. Messages can be communicated on social network sites such as Facebook, Twitter, YouTube and in text messages to build social support and change social norms through posts and conversations.
### Community Action Plan to Decrease Incidence of Violence in Suburban Cook County

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Outcome Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disparities in homicide/firearm related death rates in SCC</td>
<td>O3.1: By 2015, there will be a 10% improvement in the incidence of violent acts including homicide, firearm-related deaths and acts of sexual violence in populations experiencing rates greater than Healthy People 2020.</td>
</tr>
<tr>
<td>Leading cause of death in African American/Hispanic males</td>
<td>(Baseline in CCDPH for deaths from homicide: 6.3/100,000, HP2020 goal: 5.5/100,000, in African American: 25.5/100,000, in Hispanics: 6.1/100,000)</td>
</tr>
<tr>
<td>Violent incidents by current or former intimate partners</td>
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<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Impact Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to firearms</td>
<td>I3.1: By 2013, 80% of the SCC communities impacted by violent incidents will show a minimum of 5 or greater community protection factors representing community cohesion.</td>
</tr>
<tr>
<td>Untreated mental illness</td>
<td>I3.2: By 2013, 100% of the communities impacted most by youth violence will be informed on the issues contributing to youth violence and active in advocating for policies to promote healthy youth.</td>
</tr>
<tr>
<td>Substance abuse</td>
<td></td>
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<tr>
<td>Past history of violence</td>
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<tr>
<td>Neighborhood gangs</td>
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<tr>
<td>Bullying</td>
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<thead>
<tr>
<th>Contributing Factors</th>
<th>Process Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current gun legislation</td>
<td>P3.1: Increase neighborhood cohesive factors to improve safety.</td>
</tr>
<tr>
<td>Poverty/unemployment</td>
<td>P3.2: Increase collaborative and networking opportunities to address community resources and referral processes and provide synergistic opportunities to address multiple health issues, i.e., preventing violence and promoting healthy eating and physical activity.</td>
</tr>
<tr>
<td>Family structure/single parent</td>
<td>P3.3: Conduct social media and education campaigns to increase awareness of the issues contributing to violence.</td>
</tr>
<tr>
<td>Lack of education</td>
<td>P3.4: Improve information available to schools, churches, health providers and public safety personnel on DV and bullying.</td>
</tr>
<tr>
<td>Access to mental health and substance abuse treatment</td>
<td></td>
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<tr>
<td>Lack of social support</td>
<td></td>
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<tr>
<td>Neighborhood environment</td>
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<tr>
<td>Denial/image protection</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Resources Available</th>
<th>Recommended Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth programs</td>
<td>Safeable Communities/ ESP: Develop a community assessment profile to survey community stability and protective factors. Advocate for stronger purchasing requirements for handguns.</td>
</tr>
<tr>
<td>D.V Shelters/food pantries</td>
<td>Health promotion/ capacity building: Provider training on domestic violence and community resources and referral systems; use social marketing to increase awareness of domestic violence; develop/purchase and distribute toolkits for school/daycares on recognizing and reducing bullying.</td>
</tr>
<tr>
<td>Mental health services</td>
<td>Advocacy/ constituency building: Bring key stakeholders together to leverage resources; advocate for and support of early childhood programs and improved access to mental health and substance abuse treatment services.</td>
</tr>
<tr>
<td>Substance abuse treatment programs</td>
<td></td>
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<tr>
<td>Public safety personnel</td>
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<tr>
<td>Schools</td>
<td></td>
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<tr>
<td>Churches/faith based agencies</td>
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<tr>
<td>IL Safe Schools Alliance</td>
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</table>
4. Access to Healthcare Services

Goal 4: Improve access to affordable, culturally competent, high-quality primary and specialty healthcare including behavioral, oral and prescription drug services.

Issues and Trends

- Many residents do not have health insurance coverage.

Amidst rising unemployment rates and an economic recession, the number of uninsured residents increased in part because of a steady decline in employer-sponsored health coverage and a weak job market. Health insurance makes a difference in: whether and when people get necessary medical care; where they get it; and ultimately, their level of health.

- According to the 2009 BRFSS, the uninsured rate among SCC residents was 11% or approximately 200,000 individuals. Comparatively, the uninsured rate was 16.7% in the U.S. and 14.8% in Illinois.

- The percentage of people with health insurance in Illinois decreased from 87.1% in 2008 to 85.2% in 2009. The percentage of people covered by private health insurance decreased from 71.7% in 2008 to 66.5% in 2009. (U.S. Census Bureau, 2010)

- People living near the poverty level lack health insurance coverage at rates higher than the overall population.

- The percentage of Illinois residents covered by public health insurance programs increased from 26.1% in 2008 to 29.1% in 2009. The percentage of residents covered by Medicaid increased from 13.3% in 2008 to 15.8% in 2009. The percentage of residents covered by Medicare increased from 12.6% in 2008 to 13.2% in 2009.

- The percentage of the SCC population living in poverty (<100% poverty, according to the US Census, 2010) was 9.3% in 2009. The Federal Poverty Level (FPL) for a family of four was $22,050 in 2009. The percent of Cook County (city and suburban) population with income at or below the poverty level (<100% FPL) increased by 2009. There was a larger increase in the proportion of people living at or below the poverty level in SCC (45.3%) as
compared with Chicago (10.2%) between 2000 and 2009. The near poor population (<200% FPL) increased 23% in SCC and decreased in the city of Chicago (Figure 12).

Figure 12

![Change in Poor/Near Poor Population](image)

- Minorities are much more likely to be uninsured than Whites.

Over time, the population in SCC has continued to diversify by race and ethnicity. Since 1990, African American population increased more than 50% to 15% of the total population. The Hispanic population tripled to 18% of the total population. The White population declined 20% to 58.8% of the total population. Nationally, about one third of Hispanics and about 23% of African Americans are uninsured compared to 14% of Whites.

Because racial and ethnic minority groups are more likely to come from low-income families, Medicaid is an important source of health insurance. However, its limited reach leaves large numbers of minorities uninsured, e.g., due to gender (most males not covered) or immigration status.

People with low incomes, Non-English speaking and uninsured, tend not to have a primary care physician for preventive health care and chronic disease management and often seek treatment in hospital emergency rooms for primary care when conditions become acute and incur higher costs.

- Access to comprehensive healthcare is not equal in all areas of SCC.

Access to comprehensive health services (medical, specialty, dental, mental, vision, medications, etc.) is not equal for all residents in CCDPH’s jurisdiction. A lack of high level healthcare services may affect health; especially in poorer communities of color. For example, in the last five years the South District, with over 450,000 predominantly African American residents, lost access to a Level 1 trauma center because one hospital closed. The Cook County Health and Hospital System and CCDPH are currently working to assess the issue and make recommendations for trauma center care in the South and Southwest regions of SCC.
Both South and Southwest suburban residents have lower access to trauma centers than other suburban areas or the City of Chicago. The map below shows an increase over the past decade of Health Professional Shortage Areas designated as Medically Underserved Areas (MUA) and Medically Underserved Populations (MUP) in South, West and North suburban areas of Cook County further demonstrating the areas of greatest healthcare need. (Figure 13)

Figure 13

MUA/MUP Designated Areas in Chicago and Suburban Cook County Illinois Since January 1, 2000

Source: Map: CCHPH, CEHP, 2009; Data: HRSA, 2010
Mortality rates for Black females from Breast Cancer are twice as high as white females in SCC and higher than either Chicago or the US. Death rates for diseases exhibit disparities by race as shown in the following graph of female breast cancer mortality (Figure 14).

Figure 14

Suburban Disparities in Health

Female Breast Cancer Mortality
(Age Adjusted Rate per 100,000 Population)

<table>
<thead>
<tr>
<th>Year</th>
<th>US*</th>
<th>Chicago*</th>
<th>Suburban Cook!</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>35.5</td>
<td>25.8</td>
<td>21.8</td>
</tr>
<tr>
<td>2005-2007</td>
<td>43.2</td>
<td>21.8</td>
<td>24.6</td>
</tr>
</tbody>
</table>

*Ori et al, Sinai Urban Health Institute, 2009
• CCDDH, CEHP, 2010

Outcome Objective
O4.1: By 2015, increase the percentage of adults with a usual primary source of care by 10% in populations above the HP2020 goal. (Baseline: SCC BRFSS 2009: 13.2%)

- The percentage of the population with a usual primary care provider (86.8%) according to the SCC BRFSS 2009 is higher than the HP2020 goal of 83.9%. But there are significant disparities within populations (by race and ethnicity) and improvement efforts will concentrate on improving:
  - The percentage of people without a provider who identified their race as Non-White (American Indian or Alaska Native; Asian; Black or African American; and Native Hawaiian or Other Pacific Islander): 22.9% (as compared with White, which was 8.6%).
  - The percentage of people without a provider who identified their ethnicity as Hispanic: 22.6% (as compared with Non-Hispanic, which was 12%).

Health problems such as hypertension and diabetes are often silent illnesses that, without routine check-ups, can go undetected. Individuals who have a regular doctor and healthcare coverage have
greater access to preventive check-ups and a greater likelihood of diagnosing diseases earlier, when they are more treatable.

**Risk Factors**
Identified risk factors include: lack of health insurance; high cost of out-of-pocket medical costs; inconsistent health insurance coverage; poverty, unemployment, immigration status; language and cultural barriers; and limited availability of primary care providers, specialists and dentists.

**Impact Objective**

**I4.1:** By 2013, reduce the rate of hospitalizations for uncontrolled hypertension and diabetes (Baseline: SCC Uncontrolled Hypertension Hospitalization: 115/100,000; African Americans: 392/100,000; SCC Diabetes Related Hospitalization: 1,066/100,000; African Americans: 2,243/100,000); and visits to the emergency department for primary-care-sensitive conditions (Baseline TBD using ESSENCE) especially in the populations impacted most.

The consequences attributed to lack of access to healthcare or reduced access to healthcare are serious and include: Unnecessary illness; more complicated and advanced illness; decreased quality of life; decreased productivity; premature disability and death; increased use of emergency department for primary care services, and consequent inappropriate use of resources.

**I4.2** By 2013, increase the percentage of adults who have been to a doctor for a routine checkup in the past 1-2 years by 10%. (Baseline: SCC BRFSS 2009: 83.7%)

- The percentage of people who “have never seen a doctor for a check-up” or for whom “it has been more than two years” since they’ve seen a doctor for a check-up is slightly higher for males (19.5%) than for females (13.5%).
- The percentage of people who “have never seen a doctor for a check-up” or for whom “it has been more than two years” since they’ve seen a doctor for a check-up and were making <$35,000 (35.7%) was higher than for people making more than $35,000 (26.5%).

**Intervention Strategies**

- Monitor the proportion of the population who are uninsured/insured.
- Assess the capacity in the suburbs to provide comprehensive healthcare services especially for the uninsured.
- Promote the importance of preventive services and monitor utilization of preventive services such as smoking cessation assistance, EPSDT, vision and hearing screening for children, influenza immunizations, mammograms, pap smears, cholesterol, diabetes and colorectal cancer screening.
- Increase coordination between health providers of the uninsured/underinsured and community services and private providers of oral, mental health, prescription drugs and specialty services.
- Identify strategies to improve access to healthcare and work in partnership with clinical providers to improve access.
Recommended Activities

- Assure local/regional social marketing campaigns that are culturally and linguistically appropriate and emphasize the importance of preventive services and where to get them.
- Foster the development of an online electronic clearinghouse of all available local specialty services that includes the ability to make referrals, i.e., by linking to IL Health Connect for Medicaid and IL DHS for behavioral health.
- Increase regional capacity to effectively implement the Patient Protection and Affordable Care Act of 2010 (Health Reform).
- Make available to policymakers population-based public health materials on return on investment.
- Implement evidence based models of community-oriented primary care.
- Complete an assessment of Cook County’s Primary Care needs and capacity with awarded Chicago Community Trust funding.
- Advocate for and participate in the development of a regional Health Information Exchange focused on both personal and population health.
- Advance universal healthcare access and coverage.
- Advocate for integration of comprehensive services within primary care.
- Foster the implementation of the Cook County Health and Hospital System’s Strategic Plan, especially as it relates to expansion of ambulatory care services in the suburbs.

### Community Action Plan to Improve Access to Healthcare Services in suburban Cook County

<table>
<thead>
<tr>
<th>Strategic Health Issue</th>
<th>Outcome Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do we improve access to affordable, culturally competent, high quality primary and specialty healthcare including behavioral, oral and prescription drug services?</td>
<td>O4.1: By 2015, increase the percentage of adults with a usual primary source of care by 10% in populations above the HP2020 goal. (Baseline: SCC BRFSS 2009: 13.2% without a primary source of care)</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Impact Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of access to healthcare contributes to: unnecessary illness, more complicated and advance illness, decreased quality of life, decreased productivity, premature disability and death, increased use of ED for primary care services and resources will be used inappropriately.</td>
<td>14.1: By 2013, reduce the rate of hospitalizations for uncontrolled hypertension and diabetes (Baseline: SCC Uncontrolled Hypertension Hospitalization: 115/100,000; AA: 392/100,000; SCC Diabetes Related Hospitalization: 1,066/100,000; AA: 2,243/100,000) and visits to the ED for primary care sensitive conditions (Baseline TBD using ESSENCE) especially in populations most impacted. 14.2: By 2013, increase the rate of adults who have been to a doctor for a routine checkup in the past 1-2 years by 10%. (Baseline: SCC BRFSS 2009: 83.7% )</td>
</tr>
<tr>
<td>Contributing Factors</td>
<td>Process Objectives</td>
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<tr>
<td>---------------------</td>
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<tr>
<td>Affordability, Increased uninsured due to immigration status, increased unemployment, Inconsistent insurance coverage, State budget cuts, delays in payments to providers, fewer providers accepting public insurance, Poverty/economics, Level of education, family structure, Malpractice/legal issues, Language and transportation barriers to receiving care, Changing demographics in N and S suburbs, Limited availability and access to specialty providers, No coordination of current providers and services</td>
<td>P4.1: Monitor the proportion of the population who are uninsured/insured</td>
</tr>
<tr>
<td></td>
<td>P4.2: Assess the capacity in the suburbs to provide comprehensive health care services especially for the uninsured and underinsured</td>
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<tr>
<td></td>
<td>P4.3: Promote the importance of preventive services and monitor utilization of preventive services such as smoking cessation assistance and quit smoking advice for adults, vision screening for children under 6 years of age, influenza immunizations and colorectal cancer screening for adults 50 years and over.</td>
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<tr>
<td></td>
<td>P4.4: Increase coordination between health providers of the uninsured/underinsured and community services and private providers of oral and mental health, prescription drugs and specialty services.</td>
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<td></td>
<td>P4.5: Identify and implement strategies to improve access to healthcare services.</td>
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<table>
<thead>
<tr>
<th>Resources Available</th>
<th>Recommended Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health clinics (FQHCs, health dept, SBHC, Free clinics, CHC)</td>
<td>• Assure local/regional social marketing campaigns on the importance of preventive services, where to get them, and that they are culturally and linguistically appropriate</td>
</tr>
<tr>
<td>Schools/educational institutions</td>
<td>• Foster the development of an online electronic clearinghouse of available local specialty services that includes the ability to make referrals (in addition to CCHHS)</td>
</tr>
<tr>
<td>Hospitals (healthcare providers)</td>
<td>• Increase regional capacity to effectively implement the Patient Protection and Affordable Care Act of 2010 (Health Reform)</td>
</tr>
<tr>
<td>Advocacy and service organizations</td>
<td>• Develop materials on return on investment of population-based public health</td>
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<tr>
<td>HMPRG</td>
<td>• Advance universal health care access and coverage</td>
</tr>
<tr>
<td>Media organizations</td>
<td>• Advocate for integration of comprehensive services within primary care</td>
</tr>
<tr>
<td>Institutional partners – CCT, H&amp;F, Associations</td>
<td>• Foster the implementation of the CCHHS Strategic Plan, especially as it relates to expansion of ambulatory care services</td>
</tr>
<tr>
<td>Local governments</td>
<td>• Engage opportunities to implement evidence based models of community-oriented primary care, e.g., Chronic Care Model, SBHC, etc.</td>
</tr>
<tr>
<td>HIT/technology</td>
<td>• Complete an assessment of the CC Ambulatory Care capacity (CCT funding)</td>
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<td>• Advocate for and participate in the development of a regional Health Information Exchange focused on both personal and population health</td>
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<thead>
<tr>
<th>Barriers</th>
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<tbody>
<tr>
<td>Lack of:</td>
<td></td>
</tr>
<tr>
<td>money/funding, adequate suburban public transportation, awareness, internet access/computer skill, Low health literacy, Legal challenges to Health Reform, State budget deficits and declining federal funding, Perceived competition between health providers, Local delivery system remains fragmented</td>
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</tr>
</tbody>
</table>
e. **Plan for Action**

From the outset, CCDPH’s planning process kept a focus on the Action Plan by adapting the MAPP planning process. By making slight changes in the LPHSPA and FOCA, using keypad technology for voting and conducting webinars, participants had more time to focus on consensus building and action planning. A clear conceptual implementation model developed in the process which appears below (Figure 15):

Figure 15

**Implementation Model**

Key to the implementation of WePLAN 2015 is the development of the Community Health Advisory Committee consisting of approximately 25 county-wide cross-sector representatives whose primary tasks, as identified by the Community Planning Committee, will be to develop and sustain an ongoing coordination effort to guide action, provide oversight and monitoring and advocate for health improvement. WePLAN 2015 will also be integrated into the implementation of the Cook County strategic health plan, one of the initiatives in the CCDPH 2015 strategic plan. CCDPH has committed planning staff and resources to facilitate WePLAN implementation and will continue to research and apply for funding and resources to sustain efforts. Countywide networks and sector-based and topic-based working groups will continue their work (Youth Violence Taskforce, Access to Care Taskforce, School Health, etc) or new groups will be developed that focus on the priority health indicators. And finally, a community access to an on-line platform will be formalized that includes access to trainings, evidence-based info, etc. to build community capacity.