WePlan2020

# Improving Community Health & Health Equity *for* Suburban Cook County





we | PLAN

Cook County DEPT. *of* Public Health

Promoting health. Preventing disease. **Protecting you.**

## Suggested citation

Cook County Department of Public Health (2016), WePlan2020 Suburban Cook County Community Health Assessment and Community Health Improvement Plan (unpublished document), Oak Forest, IL.

## For more information about WePlan2020

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## Letter from Dr. Terry Mason

Cook County Residents and Partner Organizations,

It is with great pride and gratitude that I introduce WePlan2020, the community health assessment and improvement plan for suburban Cook County (SCC). This plan is the culmination of many activities over the last year.

While it was by led by staff from the Cook County Department of Public Health (CCDPH), it could not have been completed without the input, engagement and expertise offered by the many organizations and residents who call SCC home. Thank you for your participation in this planning process.

Our collaboration has yielded a plan that will guide the activities of both CCDPH and community partners – all of us who make up the local public health system – for the next five years. The information included here will help residents, institutions, and leaders of Cook County by informing their work to prevent illness and disease, improve population health, and move towards health equity.

SCC is a complex and dynamic place, composed of 125 municipalities, 30 townships, more than 700 schools, and some of the wealthiest and poorest populations in the country. Together, we can address the inequities that unjustly affect some of our most vulnerable residents, build on the strengths where communities have successfully supported approaches to building and sustaining health-promoting environments, and grow the number of places that make healthy living easier where we live, work, learn, worship, play and receive healthcare in SCC.

I am energized by the opportunities and priorities identified in WePlan2020, and look forward to working with you, our community partners and residents, in making SCC the healthiest region in the nation.

Terry Mason, MD
Chief Operating Officer
Cook County Department of Public Health

# WePlan2020
# Partners & Participants

CCDPH would like to thank the following community partners and participants for contributing their time and effort to the development of this plan.

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# WePlan2020
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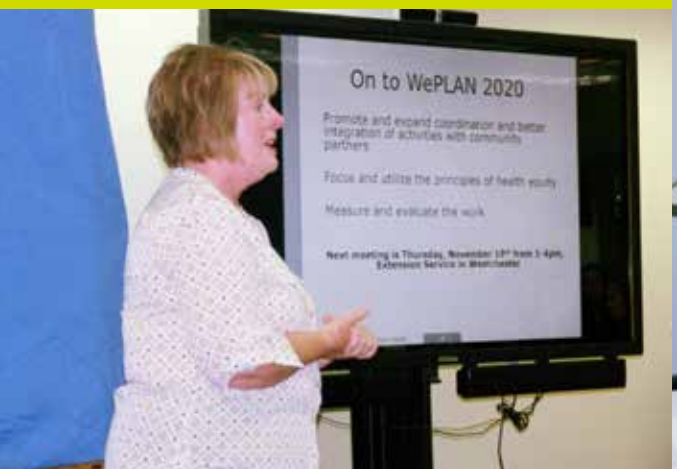


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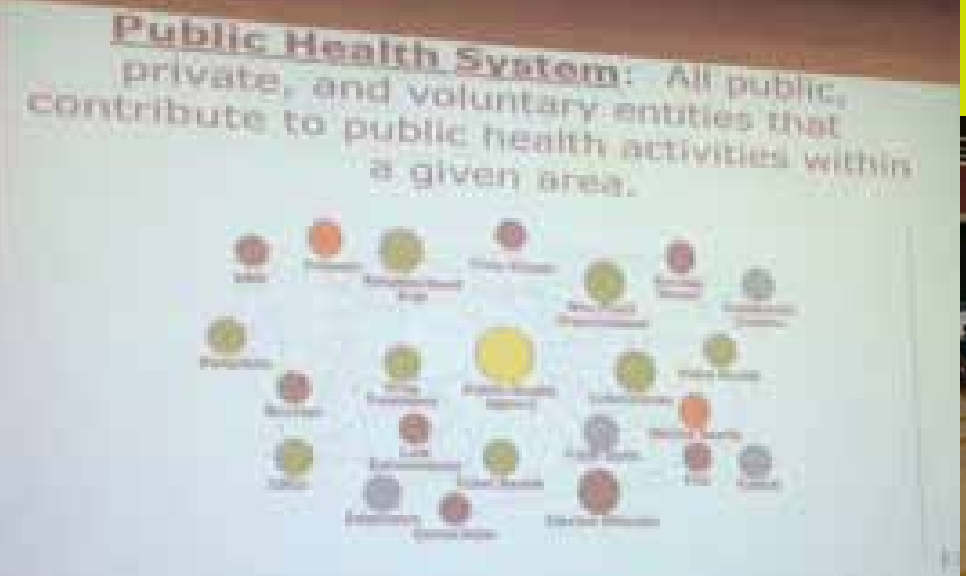


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Thank you to the following Cook County Department of Public Health staff for their contributions to WePlan2020:

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*"The greatest danger for most of us*
*is not that our aim is too high*
*and we miss it,*
*but that it is too low*
*and we reach it."*

Michelangelo

# Vision

A shared vision provides an overarching goal for the community – a statement of what the ideal future looks like. To develop a shared vision for WePlan2020, in October 2015, project staff met with members of CCDPH's Community Health Advisory Committee (CHAC) to review the vision statement used in WePlan 2015. CHAC members were asked to respond to the following 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."

From this discussion, a revised draft vision statement was created and presented to a committee of WePlan2020 community partners. They were asked to respond to the following draft statement:

**Healthy and resilient SCC communities with equitable and sustainable conditions where everyone can achieve optimum health.**


The word cloud shown above was created from their responses, highlighting the key terms of "Equity" and "Health" as consensus components of the WePlan2020 vision.

WePlan2020 represents a significant shift from the past, in both its emphasis and intent. Health department Community Health Improvement Plans (CHIPs) have traditionally been oriented towards preventing adverse health outcomes by seeking to reduce risk factors and change behaviors. This approach, while important, can overlook the root causes (determinants) of heath inequities; both **structural** (socioeconomic position, discrimination, social policies) and **social** (housing, food insecurity, healthcare access).

From the outset of WePlan2020, which began in September 2015, CCDPH sought to shift towards prioritizing health equity and social and structural determinants. This was accomplished through a participatory process engaging many organizations and residents.

CCDPH began with a visioning exercise, which yielded the following: "Healthy and resilient suburban Cook County communities with equitable and sustainable conditions where everyone can achieve optimum health." Using the Mobilizing for Action through Planning and Partnerships (MAPP) framework, from NACCHO and CDC, and approved by IDPH and the Public Health Accreditation Board (PHAB), department staff and partners conducted four assessments - the Community Themes and Strengths Assessment (CTSA), Forces of Change Assessment (FOCA), Community Health Status Assessment (CHSA) and Local Public Health System Assessment (LPHSA). Integrated into these were methods and topics that focused on health equity and related determinants. Throughout the process, time was intentionally set aside for discussion with the Community Partner Committee about health equity and the structural and social determinants. In selecting health priorities for WePlan2020, community partners were explicitly asked to identify at least one priority that was a "health equity issue" – focused on a social or structural determinant. A consensus process was then used to select priority issues.

The following priorities were selected:

**Health Equity** – Reduce structural racism, a root cause of health inequities, and advocate for pro-equity policies on economic development, the built environment, transportation, income and wage disparities.

**Chronic Disease** – Reduce inequities and the burden of chronic disease by cultivating environments, healthcare systems and a culture that promote health.

**Behavioral Health** – Support and enhance the mental health and well-being of all SCC residents.

The final WePlan2020 CHIP was developed by CCDPH staff with consideration for existing plans and new opportunities for alignment to impact health equity. Community stakeholder and partner input was sought throughout the CHIP development.


*we:*

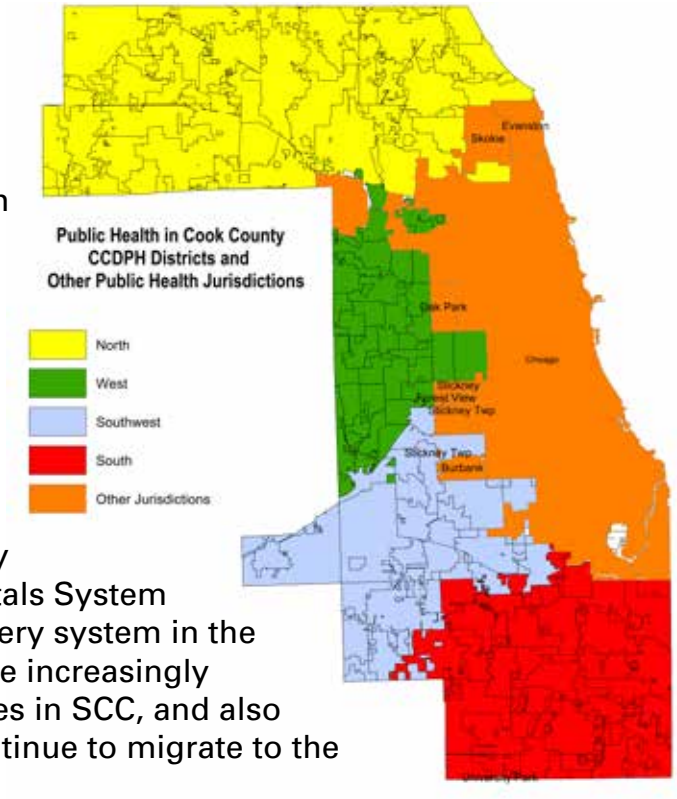
**providers organizations agencies businesses local governments community groups and residents of SCC**

## WHO IS 'WE' IN WEPLAN2020?

WePlan2020 is a community-driven health assessment and improvement plan. While this effort is led by CCDPH, it is meant to be owned by all of the providers, organizations, agencies, businesses, local governments, community groups and residents of SCC, as a guide and focus for community health planning and improvement efforts. This plan was developed with input from a wide range of partner organizations, nearly 1,200 residents, public health and healthcare professionals and others working in SCC. It seeks to improve the conditions in which our residents live, learn, work, worship, play and receive healthcare.

The assessments that were conducted as part of the CHA reflect the health status and health inequities within our communities. These inequities are driven by powerful structural and social determinants, whose impacts are not limited to any one region, community, or municipality in SCC. According to Dr. Martin Luther King, Jr. "Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly."

Given the complexity and increasingly recognized importance of the root causes of health, any plans to address health improvement priorities cannot be the domain of a single local public health department or healthcare organization alone, but require the collective efforts and resources across all sectors – from region-wide organizations and agencies to smaller, local community and grassroots efforts. Working together across community and organizational boundaries, 'we' hope to implement the plans and strategies outlined in WePlan2020 and achieve real health improvement goals. We welcome you to join with us, our community partners and residents, in making SCC the healthiest region in the nation.




## JURISDICTION

CCDPH serves a large and complex jurisdiction in SCC with nearly 2.5 million residents, 125 municipalities, 30 townships, and more than 700 schools. The agency is also 1 of 6 IDPH-certified health departments in Cook County and an affiliate of Cook County Health and Hospitals System (CCHHS), the third largest public healthcare delivery system in the country. CCDPH's population continues to become increasingly diverse, with new immigrants beginning their lives in SCC, and also increasingly poor as low-income populations continue to migrate to the suburbs from Chicago.

*"Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly."*

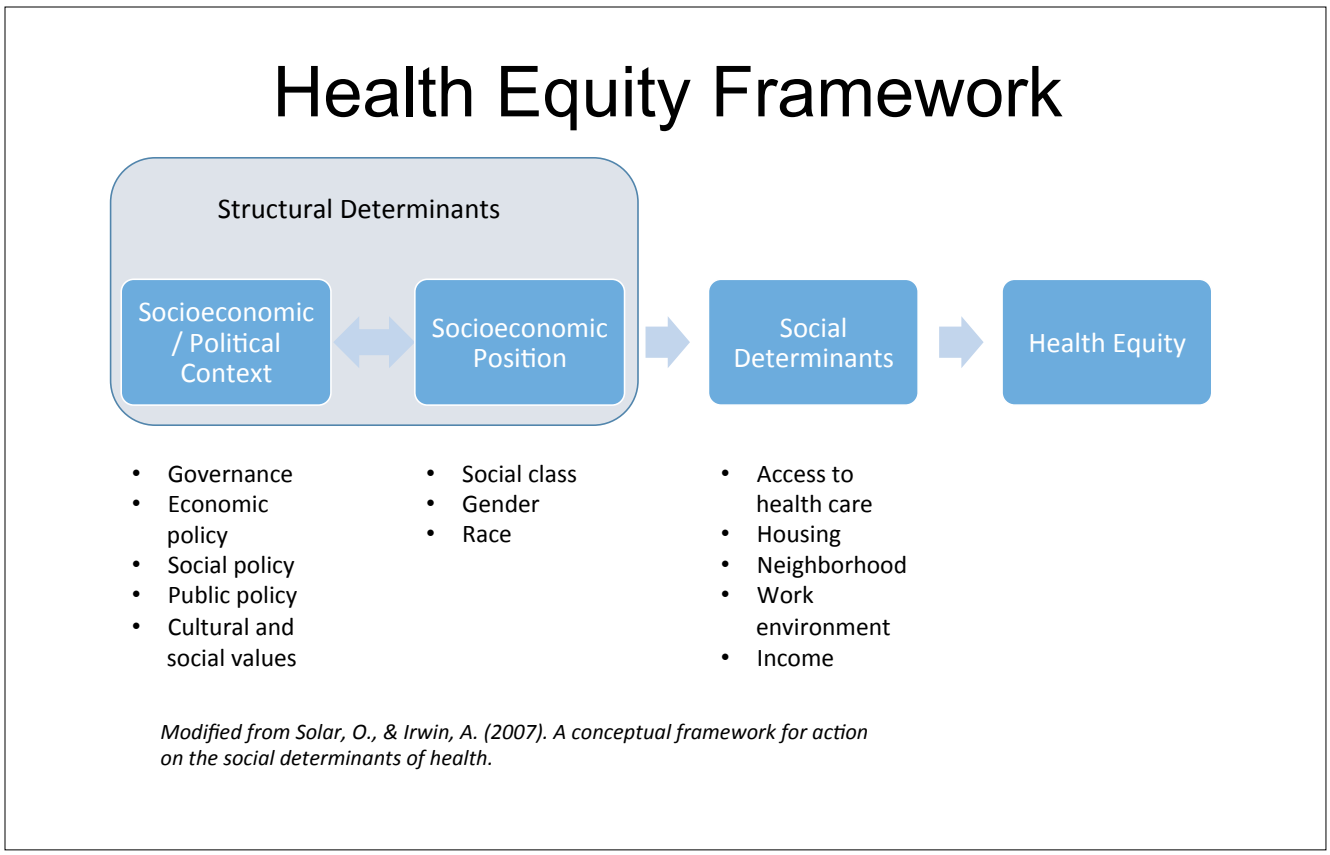
Martin Luther King, Jr.

## Health Equity Background

Health inequities are differences in health status between groups of people that result from unjust social inequalities between those groups. Health inequities violate the human right to health because they result from policy decisions, and are thus viewed as unnecessary and preventable (Graham 2009).

Health inequities have gradually gained prominence as a public health priority in the United States, since the publication of the Final Report of the Commission on the Social Determinants of Health (CSDH) by the World Health Organization (WHO) in 2008. Previous attention to what was termed "health disparities" tended to focus on the role of health care as a cause of differences in health outcomes between different racial and ethnic groups. In Healthy People 2020, the U.S. government specifically describes a goal of eliminating health inequities through a social determinants of health approach (Koh et al. 2011). Public health researchers and practitioners struggle to reconcile this with a traditional approach that prioritizes individual behavior change in diet, exercise and tobacco use, along with medical care, as the focus of public health activities (Heller 2016; NACCHO 2014). At the national level, comparative research has shown that the U.S. context is not supportive of health equity because of the structure of the U.S. safety net system (Bambra 2011). In contrast, other similarly wealthy industrialized countries do a better job than the U.S. Their residents have the resources necessary for health and well-being, and as a result have lower levels of health inequities.

"The central issue is that good conditions of daily life, the things that really count, are unequally distributed, much more so than is good…for health. The result of unequal distribution of life chances is that health is unequally distributed," according to Chair, Commission on the Social Determinants of Health, Sir Micheal Marmot writing in *The Health Gap*. The existence of high levels of social inequalities between groups with privilege and power and those without, results in inequities in health status between those groups at the population level. The consequences of these inequities are disparities in health outcomes including life expectancy, infant mortality, chronic diseases, injury (including violence) and behavioral health.




Governmental agencies in the U.S. at all levels charged with protecting the health of the public do not share a consensus on actions to be taken to eliminate health inequities. CCDPH bases its understanding of health inequities on: 1) the World Health Organization (WHO) social determinants of health framework described in detail in 2010 by Orielle Solar and Alec Irwin; 2) strategies and recommendations from the National Association of County and City Health Officials (NACCHO 2014); 3) *Healthy People 2020* (Koh et al. 2011); and 4) a growing body of research literature on the root causes of health inequities.

NACCHO describes seven elements of health equity practice in the 2014 publication *Expanding the Boundaries: Health Equity and Public Health Practice*. The recommendations are the result of recent discussions of leading U.S. public health practitioners with experience and expertise on tackling health inequities. Healthy People is a public health roadmap and compass for the country for national health promotion and disease prevention coordinated by the U.S. Department of Health and Human Services. The fourth version of this national plan, *Healthy People 2020*,"breaks new ground" by "emphasiz[ing] the need to consider factors such as poverty, education, and numerous aspects of the social structure that not only influence the health of populations but also limit the ability of many to achieve health equity" (Koh et al., 2011, p551).

## Terms and definitions

**Health** - Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, and a fundamental human right. (World Health Organization 1978)

**Health disparities** - Simply differences in health outcomes with no political implications. Health inequities, by definition, involve issues of social injustice. (NACCHO 2016)

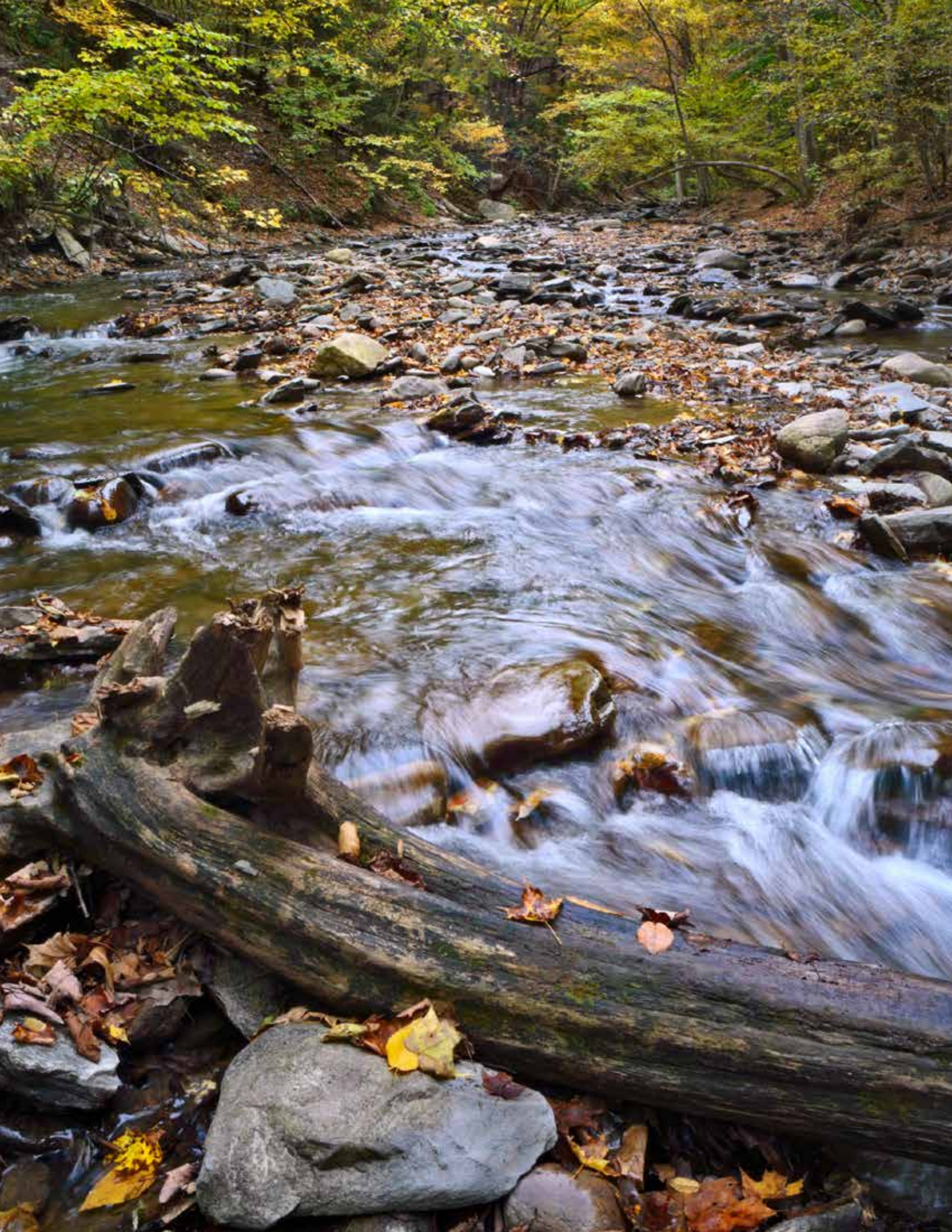
**Health equity** - There are numerous definitions of health equity. The World Health Organization defines health equity "as the absence of systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically." Dr. Camara Jones, Morehouse College, states that "Health equity is assurance of the conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need." (NACCHO 2016)

**Health inequity** - Health inequity refers to differences in population health status and mortality rates that are systemic, patterned, unjust, and actionable. Health inequities, most importantly, are not the result of unfortunate, random events or differences caused by individual behavior or genetics. (NACCHO 2016)

**Structural racism** - A fundamental cause of health inequity, associated with imbalances in political power throughout society. It functions to normalize and legitimize cultural, institutional, and personal hierarchies and inequity that routinely advantage whites while producing cumulative and chronic adverse health outcomes for people of color. Structural racism perpetuates residential segregation, concentrated poverty, disinvestment in neighborhoods, and targeting neighborhoods for toxic waste—all issues related to serious health outcomes. (NACCHO 2016)

Among a large body of scientific literature (Smith Hill and Bambra 2016; NACCHO 2016) on health inequities are findings that 'downstream' public health interventions, or interventions that focus on changing the behavior of individuals, have been shown to generate health inequities (Lorenc, et al., 2013). Public health researchers have called for the field of public health to re-engage with social movements, to study history in which public health made alliances to achieve political authority, and to "create a base of power for progressive social change" (Freudenberg et al. 2015; Krieger 2011; quotation Fairchild et al., 2010 p61).

Local public health department CHIPs have traditionally been oriented towards preventing adverse health outcomes for the populations they serve. This conventional outcomes-based approach does not take into consideration the powerful social and structural forces which drive health inequities and the resultant disparate health outcomes. Our approach will be to achieve optimum health for all by prioritizing structural and social determinants and health equity.



## WEPLAN2020 APPROACH TO PLANNING

The guiding framework for the conduct of WePlan2020 is the assessment and planning model developed by the Centers for Disease Control and Prevention (CDC) and the National Association of County and City Health Officials (NACCHO) called MAPP: Mobilizing for Action through Planning and Partnerships. MAPP is a strategic planning process for community health, which seeks to foster and collectively create a vision of a healthy community, engage community members in four comprehensive assessments, identify strategic community improvement priorities and develop actionable plans for implementation.

## HOW WEPLAN2020 IS ORGANIZED

WePlan2020 consists of two major components:

- **Community Health Assessment** (CHA)
- **Community Health Improvement Plan** (CHIP)

WePlan2020 was led by a 10-member planning committee made up of CCDPH staff. For the CHA, sub-committees were formed that included managers and staff from each of the department's units. Subcommittees were charged with planning and implementation of each of the assessments, identifying approaches and resources, and planning. Committees met at least monthly, beginning in mid-2015.

### WePlan2020 Community Planning

The WePlan2020 Community Planning Committee met three times during the fall of 2015 and winter of 2016 and examined a range of aspects of SCC's public health system. These were planned to engage more than 50 members of the committee, representing diverse sectors of the local public health system across SCC including local government, healthcare, social services, business, academia, faith, public safety, education, and residents.

The meetings involved the following activities:

- Revision and development of a bold and inspirational vision statement;
- Review of issues, assets and needs as identified by survey data from community members;
- 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;
- 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 community health priorities for which to develop plans to improve the community's health status.

Once the assessments were completed and priorities were identified selected members of the core planning team were assigned to prepare the CHIP documents for each of the three priorities. These plans were developed through a variety of methods, including a review of current opportunities outlined in existing work or published plans, and feedback and engagement of local partner agencies involved in addressing the priorities to assure that plans were meaningful, actionable and had support from those who might be involved in implementation.

## IDPH CERTIFICATION, PHAB ACCREDITATION & MAPP PROCESS

In conducting and preparing the final report for WePlan2020, the community health ssessment (CHA) and community health improvement plan (CHIP) final report fulfill the requirements of the Illinois Administrative Code, Title 77, Subsection 600.210 for certification for local public health departments by the Illinois Department of Public Health (IDPH). This document presents the WePlan2020 methods and results of a year-long process undertaken from September 2015 to October 2016, involving CCDPH managers and staff, our Community Health Advisory Committee (CHAC), over 170 community organizations and suburban residents.

The WePlan2020 assessment and plan presents a new emphasis and opportunities to address the following strategic health issues:

- Health equity
- Chronic disease
- Behavioral health

This WePlan2020 report was informed by CCDPH's Strategic Plan 2015 and the efforts and successes of WePLAN 2015. It identifies and acknowledges the need to shift focus from population and community health practice toward an emphasis on social and structural determinants of health; including the conditions, policies and disparities in resources that result in inequities. In addition to the strategies and opportunities outlined in WePlan2020, we intend to incorporate these priorities in CCDPH's Strategic Plan 2020, which will be completed in 2017.

# Community Health Assessment

The CHA consists of four assessments:

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

The purpose, methods used and main findings of each of these assessments are presented in this section.

## The Community Themes and Strengths Assessment

### Purpose

The CTSA provides community members' perceptions of leading health issues and community needs. It answers the questions:

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

### Methods

Conducted August through October of 2015, the CTSA was conducted to identify themes that engage and are of interest to the community, perceptions about the quality of life, conditions that support health and community assets. The CTSA was designed with a commitment to: realizing health equity and optimum health for all SCC residents; forging partnerships with community organizations; and including residents experiencing health inequities or representing the geographic and linguistic diversity of SCC. A survey questionnaire was developed by a CCDPH committee. Members researched, reviewed and compiled questions that were tested, validated and sourced related to the conditions of health, including:

CHA

- Economic security and financial resources
- Livelihood security and employment opportunity
- School readiness and educational attainment
- Quality environmental conditions
- Availability and utilization of quality medical care
- Adequate, affordable and safe housing
- Community safety and security
- Civic Engagement
- Transportation

An online 48 question survey instrument was available in both English and Spanish. The survey was accessible electronically and on paper. A total of 1,193 surveys were analyzed to develop the CTSA.

The process of survey collection and outreach was conducted as follows:

- The survey was piloted with the department committee and feedback gathered for modification before going live on the department website.
- A company was retained to conduct online surveys with resident panels. The majority of online responses (69%) was a result of the panels who assured a sample of 500 adults living in suburban Cook County and adequate representation of minority groups by reaching 150 African American and 150 Hispanic adults.
- An extensive community outreach effort by department staff included the following levels:
    - **Level 1**: Email to community-based organizations (CBOs) with a description of the survey, and a request to link to and promote the survey through their organizational website, publications, and mailing lists. Examples of CBOs contacted include: RAILS (Reaching Across IL Library System), AgeOptions (organization serving older adults), CCDPH Community Health Advisory Council, South Suburban Cook County HIV/AIDS Council.
    - **Level 2**: Level 1 outreach strategies plus personal contact from committee representatives to discuss the intent of the survey, specifics on how best to reach their constituencies, development of individual outreach plans to include possible paper surveys, banner, fliers, etc. for distribution and display at community site. Distribution of flier at community events or community meetings.
    - **Level 3**: Level 1 and Level 2 outreach strategies, plus conducting survey administration at community sites to encourage participation by groups experiencing poor conditions or poor outcomes.
- Administration of surveys was conducted by department staff at six CCHHS clinic sites and a coordination of paper-based surveys was conducted with the Housing Authority of Cook County at four suburban public housing sites.

- Extensive social media was generated and materials designed to outreach to public health stakeholders and residents (races, ethnicities and ages, gender, sexual orientations, etc.). Invitation art was used to design a banner on the CCDPH website inviting visitors to take the online survey. The invitation art and survey link were also used in social media posts on Facebook and Twitter as an additional way to reach audiences.


*This postcard was distributed via email as a PDF attachment to community partners.*

## Results

**Over 50% of respondents rated their community in SCC as a very good place to live, raise children, work and grow old. However, respondents who rated their community as fair or poor were more likely to be from the south and west suburbs.**

- Survey respondents consider most community services as assets; especially recreational and religious activities and services for older adults residing in the north suburbs. Affordable health, dental, and mental health services were most likely to be rated as Fair and Poor.
- A significant number of respondents (>75 percent) are food and economically secure. In both categories, most respondents who were less secure made less than $50,000/year and lived in south suburban communities.
- Most residents responded to being treated fairly (80 percent) related to age, gender/sex, race/skin color, language, and sexual orientation. However, if respondents said they were treated unfairly, this was due primarily to race (African American/Asian/Hispanic). Unfair treatment by the criminal justice system and employers was also reported more frequently by minority respondents, especially African Americans.

Survey respondents rated their overall health status as Excellent, Very Good or Good (86 percent), and 92 percent rated their mental health/emotional status similarly. Of respondents rating their overall health as Fair or Poor (13.4 percent), 83 percent were lower income ($50,000 or less/year) and 58 percent were either African American, Asian, or Hispanic. Similarly, 69 percent of respondents who rated their mental health as fair or poor were lower income and 57 percent were racial/ethnic minority residents. Survey respondents identified:

- Leading health issues as aging; cancer; heart disease, diabetes and mental health.
- Lack of exercise, unemployment, poor diet, high blood pressure and low wages as factors needing to be addressed to improve health.
- Access to quality medical services, financial security/stable income and resources and quality environmental conditions such as air, water, food as community conditions critical to improving health.

Quality of life and conditions that support health were determined most often by where a person lived, their race/ ethnicity and income.

- More respondents from the south and west communities rate the quality of their community as Fair/Poor; especially as a place to work, raise children, grow old and as a safe place to live. Community services including affordable housing, shopping, senior services, and public transportation were also more likely rated as Fair/Poor (20-40 percent) in south and west communities.
- Nearly 20 percent of respondents believe they were treated unfairly in the past 12 months; most because of their race or skin color, or because of the way they speak English.
- Of the 20 percent of respondents making less than $50,000 per year: 1 in 3 could not meet basic needs and 2 in 5 did not have secure financial means to pay off a $400 emergency expenditure. One-third of those less economically secure lived in the south suburbs. Most of the respondents who were often or sometimes 'food insecure' during the past 12 months lived in the south suburbs.

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## The Forces of Change Assessment

### Purpose

The FOCA focuses on identifying forces that affect the context and conditions in which the community and the local public health system operate. This answers the questions:

- What is occurring or might occur that affects the health of our community or the local public health system?
- What specific threats or opportunities are generated by these occurrences?

### Methods

For this assessment a qualitative focus group methodology was employed. A total of four focus groups were conducted in the Spring of 2016. Focus group participants represented leadership from a broad range of organizations and with several areas of expertise. Identification of participants was based on several criteria. Purposeful sampling (Patton 2002) was used to invite participants, based on the potential of a focus group participant to provide useful information on resources necessary for health (Figures 1 and 2). Participants fit criteria for eligibility if they had significant knowledge based on their working experience in the areas of housing, income, education, transportation, health care, community design, food, social services, work and employment, social inclusion, public safety, and daily living conditions (Figure 3). These resources are the social determinants of health. Concepts and the underlying rationale are described in depth in two documents that provided the foundation for the assessment: "Healthy People: A 2020 Vision For the Social Determinants Approach" (Koh, et al. 2011) and the World Health Organization's social determinants of health conceptual framework (Solar & Irwin 2010). Sites were selected from across SCC (Figure 4). Participants were provided guidelines encouraging them to listen and interact with each other, to express different opinions and points of view.

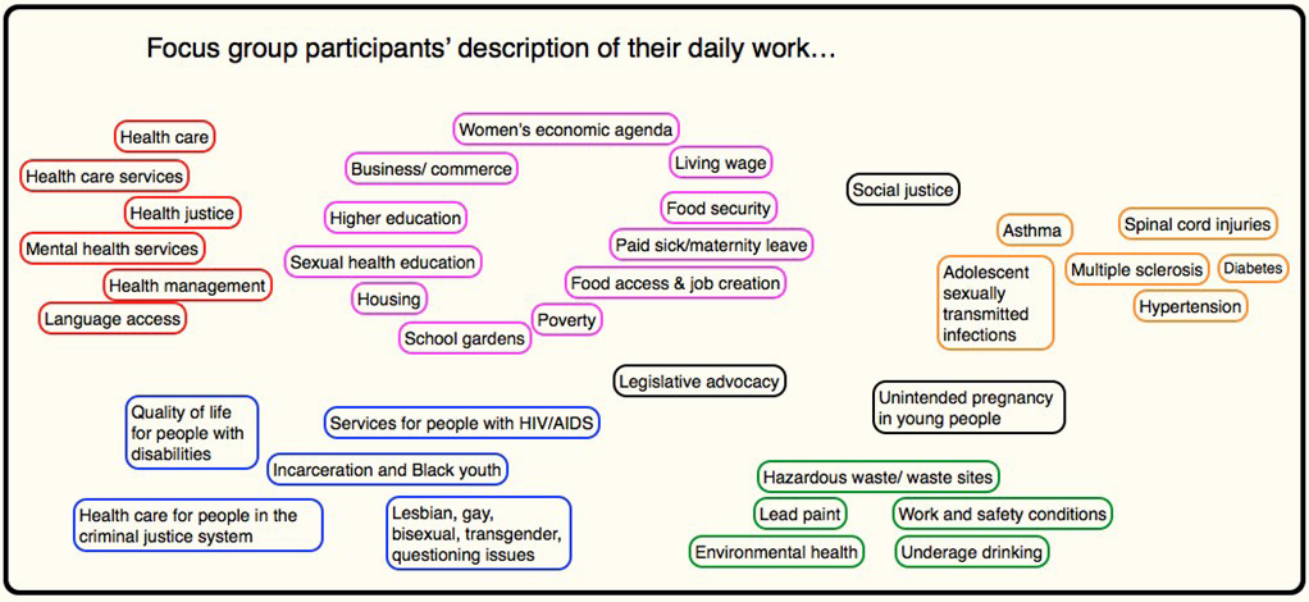
Each focus group was asked to reflect and respond to three overarching questions:

- What has occurred recently that may affect our local public health system or community?
- What patterns of decisions, policies, investments, rules, and laws affect the health of our community?
- Who or what institutions have the power to create, enforce, implement, and change these decisions, policies, investments, ruled, and laws?

## Figure 1 | FOCA Participants (listed by organization or description)

| | |
|---|---|
| Advocate Health Care | Illinois Self Advocacy Alliance |
| Agency for Toxic Substances & Disease Registry USDHHS | Kenneth Young Center |
| AIDS Foundation of Chicago; Black Youth Project 100 | Loyola Stritch School of Medicine |
| Backbones | Member of the Public |
| Chicago Southland Chamber of Commerce (2 Participants) | Metropolitan Tenants Organization |
| City of Harvey | Northwest Compass |
| Food Chain Workers Alliance | Prevention Partnership |
| Grand Prairie Services | Respond Now |
| Greater Chicago Food Depository | Restaurant Opportunities Center-United |
| Greater IL Chapter-National Multiple Sclerosis Society | Safer Foundation |
| Health & Medicine Policy Research Group | SEIU Health Care Illinois |
| Illinois African-American Family Commission | South Suburban College |
| Illinois Caucus for Adolescent Health | U.S. Environmental Protection Agency |
| Illinois Coalition for Immigrant & Refugee Rights | |

## Figure 2 | FOCA Participants Descriptions of Their Daily Work



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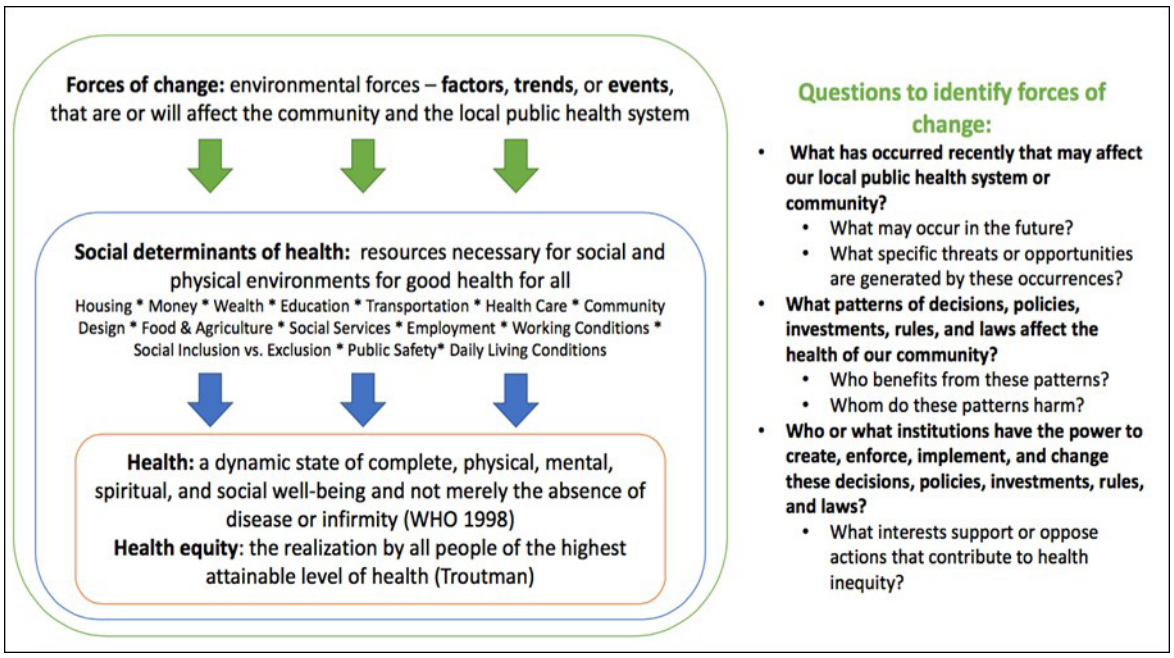


**Figure 3 | CCDPH FOCA Framework**

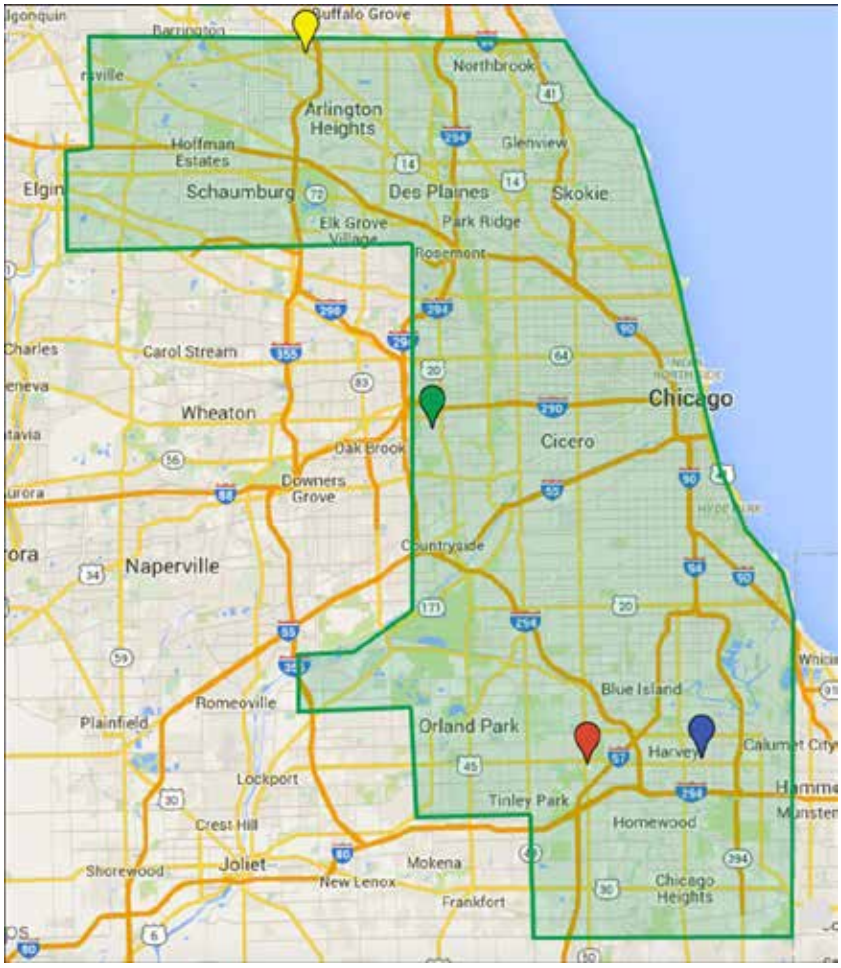


**Figure 4 | FOCA Focus Group Locations**

Four focus group transcripts were loaded to Atlas.ti Version 1.0.34. The FOCA Coordinator used the three overarching questions to develop preliminary codes; the transcripts and preliminary coded quotations were distributed to FOCA Committee members to provide their opinion of the quotation and the preliminary codes. Committee members were encouraged to suggest new interpretations of quotations, and to identify any additional text they thought was significant. This process enriched and strengthened the interpretation of the qualitative data produced by the focus groups. The draft report was sent to focus group participants for their reactions and insights.

**Results**

**Most focus group (FG) members identified the Affordable Care Act and the budget of the State of Illinois as both opportunities and threats that affect the local public health system and community.**

- The Affordable Care Act provides more people with health insurance and increases access to care while encouraging health care providers to develop new partnerships in communities. But undocumented immigrants are not covered, and a shortage of providers, lack of transportation, and uncovered costs are barriers to care.
- State of Illinois budget cuts force people to examine the system and how we collaborate. The state budget limits access to childcare, health care, mental health care, and high quality public education.
- Other themes included: Other benefits identified included marriage equality for same-sex couples, and the growing awareness of transgender people and their rights. Additional threats included the penalties experienced by disabled couples resulting from loss of resources after marriage, and impending effects of climate change.

Most FG members identified patterns of decisions, policies, investments, rules, and laws as harming people of color, middle-class and working people, and women, while benefiting wealthy people, corporations, White people, and men.

- Incarceration and police contact disproportionately affect people of color and gender minorities.
- While corporations benefit from tax breaks, and prioritize profit-making over a commitment to communities, there is a redistribution of wealth as pensions are weakened, rights of workers to organize is threatened, and wealth disparity increases.
- There is a perception of lack of control over one's community, an inability to affect policy and legislation, and disillusionment with elections and voting.

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Many FG members also identified very wealthy people and corporations as having more power than average people to create, enforce, implement, and change decisions, policies, investments, rules and laws.

- The interests of the very wealthy and large corporations were often described as contributing to health inequity.
- Elected officials are too often disconnected from the day-to-day lives of their constituents, and unaware of the scarcity of resources confronting the people they represent.
- People without great wealth have power when they unite to advocate for their interests through participation in social movements, advocacy, and community organizing.

## The Community Health Status Assessment

### Purpose

The Community Health Status Assessment (CHSA) assesses the health status of the population through an examination of a variety of population and health indicators. It seeks to determine "How healthy are our residents?" and "What does the health status of our community look like?"

### Methods

An eight step process was used to conduct the CHSA.

1. Create a sub-committee
2. Determine indicators
3. Organize, collect and analyze data
4. Determine best way to present data (i.e. charts, tables, maps, etc.)
5. Compile and disseminate results
6. Identify sources to monitor indicators over time
7. Create a list of challenges and opportunities
8. Share results with community

# 1 Create a subcommittee

The CHSA sub-committee was composed of a small team of epidemiologists, an informatics specialist, and content experts (e.g. healthy homes, communicable diseases, chronic diseases, etc.)

# 2 Determine indicators

Our approach is based on the County Health Rankings and Roadmaps (CHRR) data framework (Figure 5) by the University of Wisconsin Population Health Institute. Building on the work of America's Health Rankings, it is based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play. Our framework consisted of over 125 indicators organized into seven broad categories (Figure 6). Guidance for selection of indicators included the following sources: Resources for Social Determinants of Health Indicators (NACCHO), CHSA Core Indicator List for MAPP (NACCHO), Data Set Directory of Social Determinants of Health at the Local Level (CDC, U.S. DHSS), CHA for Population Health Improvement – Most Recommended Health Outcomes and Determinants (CDC, U.S. DHSS), Community Commons (managed by the Institute for the People, Place, and Possibility, the Center for Applied Research and Environmental Systems, and Community Initiatives), and Healthy People 2020 Leading Health Indicators (CDC, U.S. DHSS).

Figure 5 | CHRR Data Framework

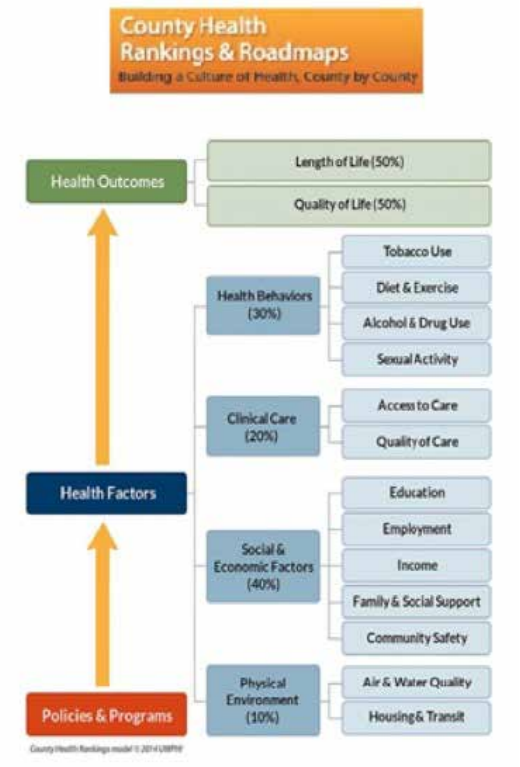


Figure 6 | Indicators Categories

## 3 Organize, collect and analyze data

Data organization followed our framework of categories and indicators. Primary and secondary data was collected from a variety of sources including: U.S. Census Bureau, American Community Survey, Illinois Department of Public Health Mortality and Natality Files, Healthy People 2020, Community Commons, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Survey, Environmental Public Health Tracking Network, Kids Count and the County Health Rankings and Roadmaps.

The main analytical objectives were:

1. Identify disparities
2. Include information on behaviors that contribute to diseases (e.g. smoking, physical activity, poor nutrition)
3. Detect differences between communities and groups (e.g. race/ethnicity, gender, geographical)
4. Describe the social and economic factors that may contribute to a community's health (e.g. poverty, educational attainment, language barriers)
5. Compare the community to benchmarks such as the Healthy People 2020 objectives (HP2020 objectives, when available, served as benchmarks. Otherwise, the state average/median was used)

## 4 Determine best way to present data (i.e. charts, tables, maps, etc.)

Data was compiled into briefs highlighting each indicator. The briefs were composed of four sections:

1. Bar charts comparing race/ethnicity and gender by geographical area, and highlighting differences between communities and groups as well as factors that cause inequalities in health in suburban communities.
2. More data about differences between communities and groups including men and women, elderly and the young, and more about the factors that cause inequalities in health in suburban cook communities.
3. Maps comparing communities and their outcomes to a benchmark (usually a Healthy People 2020 objective or the state average) allowing communities to identify at-risk populations as well as gain insight from populations that are thriving.
4. Data tables that assist in determining differences between communities and groups. These tables also provide more information on factors that cause inequalities, including data on people of color/different ethnicities, trends in disease over time, trends in disease by race/ethnicity, trends in disease by age and gender, and data on special populations.

## 5 Compile and disseminate results

Preliminary results were disseminated and discussed during two meetings with partners and community members. Dates of presentations and materials were posted on CCDPH's website at www.cookcountypublichealth.org.

## 6 Identify sources to monitor indicators over time

The majority of indicators are from the following data sources:

- U.S. Census Bureau, American Community Survey (5-year rates available each year)
- IDPH Mortality and Natality Files (annual data is received from IDPH each year)
- Environmental Public Health Tracking Network (available from website on an annual basis)
- County Health Rankings (available from website on an annual basis)
- Behavioral Risk Factor Surveillance System (IDPH provides 4-year estimates. Data will be updated as it becomes available)
- Youth Risk Behavior Survey (Data gap exists. Recommendation is to conduct survey within the next 3 years.)

## 7 Create a list of challenges and opportunities

During the prioritization process, partners examined the CHSA results keeping the following in mind:

- Does this health problem affect a large number of people?
- Does it have serious consequences?
- Does it show evidence of wide inequity between groups?
- Is it susceptible to proven interventions?
- Does the issue have broad implications over the long term?
- Is there a potential for a major breakthrough in improving health outcomes?

## 8 Share results with community

Results were to be presented to the WePLAN Community Partner and Planning Committee meeting attendees.

Partners and community members have been invited to visit CCDPH's website where CHSA results are available.

**There has been a significant net increase in the overall number of vulnerable populations, including children living in poverty, in SCC.**

**Results**

- From 2000 to 2009-2013, the number of people living in poverty in SCC increased by 71% (from 156,249 to 267,274 persons).
- Poverty rates ranged from over 16% in the south district to 6% in the North district.
- The number of children living in poverty in SCC more than doubled from 2000 to 2009-2013.
- A deplorable 1 of every 4 children in the south district lives in poverty compared to 1 out of 10 children in the North district.
- Although there was very little population growth in SCC, the racial/ethnic composition changed drastically. The total minority population increased by over 30%, while the non-Hispanic White population decreased by 14%.
- The Hispanic population in SCC grew by 46%, the highest rate of growth for racial/ethnic populations in the region. African-American populations grew by 17%. According to the 2010 Census, the Hispanic population exceeded the African American population in SCC for the first time.

Chronic diseases continue to be the leading causes of death in SCC.

- Coronary heart disease (CHD) is the second leading cause of death among SCC residents. However the CHD mortality rate is significantly decreasing in SCC largely due to improved medical care.
- Cancer is the leading cause of death in SCC with significant disparities. The south district experienced the highest overall age-adjusted cancer mortality rate (213 deaths per 100,000) as well as African Americans (207 deaths per 100,000). The age-adjusted mortality rate for colorectal cancer for African Americans was nearly 70% higher than that of Whites (26.0 vs 16.0 per 100,000).
- Similar disparities exist for breast cancer mortality rates among females as well. The age-adjusted female breast cancer mortality rate for the North district (19.1 per 100,000) was 40% smaller than rates for females in the south district (33.2 per 100,000).
- Stroke (cerebrovascular disease) is the third leading cause of death in SCC. Stroke mortality for the south district is significantly decreasing since 2008.
- The age-adjusted diabetes-related mortality rate for African Americans in SCC (82.0 per 100,000) is more than double that of Whites (37.9 per 100,000).

- Age-adjusted mortality rate for suicide among Whites (13.9 per 100,000) in SCC is more than double that of African Americans (5.7 per 100,000). However, for homicides, the age-adjusted mortality rate for African Americans is 20.4 per 100,000 compared to SCC whites at 1.6 per 100,000.
- Overall crude birth rates are decreasing in SCC with teen birth rates decreasing for all race/ethnic groups except Asians.
- Infant mortality rates for African Americans in SCC (14.7 per 1,000 live births) is significantly higher than that for Whites (3.6 per 1,000 live births).

## The Local Public Health System Assessment

### Purpose

The Local Public Health System Assessment (LPHSA) focuses on all of the organizations and entities that contribute to the public's health. It answers the questions:

- "What are the components, activities, competencies, and capacities of our local public health system?"
- "How are the 10 Essential Services being provided to our community?"

### Methods

To measure the strengths and challenges, the Local Public Health System Assessment (LPHSA) tool, developed by NACCHO and CDC, was used. This tool measures the performance of the local public health system – defined as the collective efforts of public, private and voluntary entities, as well as individuals and informal associations that contribute to the public's health within a jurisdiction. This may include organizations and entities such as the local health department, other governmental agencies, healthcare providers, human service organizations, schools and universities, faith institutions, youth development organizations, economic and philanthropic organizations, and many others. Any organization or entity that contributes to the health or wellbeing of a community is considered part of the public health system.

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The instrument is framed around the 10 Essential Public Health Services (EPHS) that are utilized in the field to describe the scope of public health broadly. For each essential service in the local instrument, model standards describe or correspond to the primary activities conducted at the local level. The number of model standards varies across the essential services; while some essential services include only two model standards, others include up to four. There are a total of 30 model standards in this instrument. For each standard in each essential service, there are a series of questions that break down the standard into its component parts. Performance on each model standard is scored by participants using a standard scale.

Prior to the LPHSA Assessment meeting on September 1, 2015, CCDPH distributed Key Informant instruments to selected external partner representatives as well as selected internal staff members. The purpose of this tool was to gather initial information about the provision of each of EPHS by asking " What is being done?" "Who is doing this?" and "What are the gaps?" Responses were then compiled and provided to each participant for review prior to the assessment event.

For this assessment, CCDPH partnered with the Illinois Public Health Institute (IPHI) to conduct the one day assessment event. The assessment retreat began with a 60-minute plenary presentation to welcome participants, provide an overview of the process, introduce the staff and answer questions. Participants dispersed into five breakout groups to conduct the assessment using the standardized NPHPS local tool. Each group was responsible for discussing, exploring and scoring performance measures for two different Essential Public Health Services as outlined in Figure 7. Scoring was based on a standard scale for the process (Figure 8). Each group was professionally facilitated, recorded, and staffed by a note taker. The program ended with a plenary session where highlights were reported by members of each group.

Figure 7 | Essential Public Health Services Breakout Groups

| LPHSA Breakout Groups | |
|---|---|
| **Group** | |
| **A** | EPHS 1 – Monitor health status to identify community health problems.<br>EPHS 2 – Diagnose and investigate health problems and health hazards in the community. |
| **B** | EPHS 3 – Inform, educate, and empower people about health issues.<br>EPHS 4 – Mobilize community partnerships to identify and solve health problems. |
| **C** | EPHS 5 – Develop policies and plans that support individual and community health efforts<br>EPHS 6 – Enforce laws and regulations that protect health and ensure safety. |
| **D** | EPHS 7 – Link people to needed personal health services and assure the provision of health services.<br>EPHS 9 – Evaluate effectiveness, accessibility and quality of personal/population-based health services. |
| **E** | EPHS 8 – Assure a competent public and personal health care workforce.<br>EPHS 10 – Research for new insights and innovative solutions to health problems. |

Figure 8 | LPHSA Scoring Scale


Figure 9 | LPHSA Summary Essential Public Health Service Scores

| Summary Essential Public Health Service Scores | | | |
|---|---|---|---|
| **EPHS** | **EPHS Description** | **2015 Score** | **Overall Ranking** |
| **1** | Monitor health status to identify community health problems. | 47 | 7th |
| **2** | Diagnose and investigate health problems and health hazards in the community. | 79 | 1st |
| **3** | Inform, educate, and empower people about health issues. | 50 | 6th |
| **4** | Mobilize community partnerships to identify and solve health problems. | 58 | 3rd |
| **5** | Develop policies and plans that support individual and community health efforts. | 55 | 5th |
| **6** | Enforce laws and regulations that protect health and ensure safety. | 78 | 2nd |
| **7** | Link people to needed personal health services and assure the provision of health services. | 43 | 8th |
| **8** | Assure a competent public and personal health care workforce. | 37 | 10th |
| **9** | Evaluate effectiveness, accessibility, and quality of personal/population-based health services. | 57 | 4th |
| **10** | Research for new insights and innovative solutions to health problems. | 40 | 9th |
| **Overall LPHS Performance Score** | | **54** | |

**Results**

Results of scoring on each Essential Service as well as summaries of qualitative notes from discussions were compiled by IPHI (Figure 9).

**The LPHS was seen as providing optimal services in traditional areas of public health activities for EPHS 2 Diagnose and Investigate Health Problems and Health Hazards in the Community and EPHS 6 Enforce Laws and Regulations.**

- Highest Ranked: EPHS 2, Diagnose and Investigate Health Problems and Health Hazards in the Community, received a cumulative score of optimal activity (79). Lowest Ranked: EPHS 8, Assure a Competent Public and Personal Health Care Workforce, received a cumulative score of moderate activity (37). Overall Performance: The average of all EPHS scores resulted in a cumulative score of significant activity (54).
- Systems exist for disease surveillance and notification of public health emergencies, including partnerships between public health, hospitals and laboratories to support activities. Strong health codes, legal expertise and capacity to enforce laws and ordinances exist in the region.
- Lags and gaps exist in the data available which may impact action to address problems. Further, specific systematic action has not been undertaken by the LPHSA to address health inequities.
- Additional capacity to enforce laws and technical expertise to draft new legislation is needed.
- Making data more accessible and approachable for community members could improve the ability of all within the LPHSA to identify and address health problems and inequities.
- Increased advocacy and constituency building to gain wide support for improving and creating new laws to support population health is needed.

Lower performing EPHS included EPHS 7 link people to needed personal health services and assure provision of healthcare when otherwise unavailable, EPHS 8 assuring a competent public health and personal healthcare workforce and EPHS 10 research for new insights and innovative solutions to health problems.

- The Affordable Care Act (ACA) has provided health insurance coverage for uninsured individuals and the LPHS has done a good job enrolling newly eligible, however there is opportunity for improvement.
- Geographic differences persist in access to health care and other services; transportation access is seen as a barrier to access in SCC.

- While agencies are engaged in workforce assessment there is a lack of coordination of these efforts across agencies.
- An abundance of universities provide a robust research infrastructure, but there is a lack of resources to fund innovation and implement findings in practice.
- There are limited opportunities for less experienced, non-licensed staff in partner organizations.
- Efforts should seek to improve care coordination and interpreter services.
- Better coordination and effort to assure professional development opportunities for all LPHS workforce is needed.
- Funding and incentives for continuing education for LPHS workforce should be developed.
- LPHS should continue to strengthen bi-directional exchange between practice organizations and researchers, and establish a research collaborative to foster coordination.
- Communities should be engaged in setting research priorities.

## HEALTH EQUITY SUPPLEMENTARY ASSESSMENT

To assess the LPHSA's capacity and readiness to address health equity, selected, additional questions, taken from the NACCHO LPHSA Health Equity Supplement were included in the assessment of specific EPHS. These results were included in the overall assessment of the EPHS and are also presented individually here. These data indicate there is a low level of achievement of the model standards with a health equity focus (Figure 10). This is of significance in planning and implementing efforts to achieve health equity.

Figure 10 | Health Equity Standard Scoring Results

| Model Standard | | Score |
|---|---|---|
| 3.1.4 | Provide information about community health status and community health needs in the context of health equity and social justice | 25 Minimal |
| 8.1.4 | Assessment of staff capacity to support health equity initiatives | 25 Minimal |
| 8.4.5 | Recruitment of staff members committed to achieving health equity | 50 Moderate |
| 10.1.5 | Use of health equity impact assessments | 0 No Activity |

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## Health Priority Selection Process

Participants at the January 21, 2016 WePlan Community Health Partner Committee meeting worked together to identify priority health issues for the community health improvement plan as part of WePlan2020. Participants engaged in a multi-step process, first individually determining key issues, and then working in small and large groups to identify consensus priorities. Participants were asked to consider priorities that were either a:

- **Health Outcome:** A condition which is considered undesirable, is likely to exist in the future, and is measured as death, disease, or disability.
- **Equity/System Issues:** An issue that is focused on the social and structural determinants of health, which are the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities and require intervention on a multi-sectorial, multi- discipline, multi-component level.

In determining priorities, participants considered extensive assessment findings and statistical health data, as well as their own experience, work expertise, and knowledge of their communities. Several key questions that helped participants to arrive at potential priority issues included:

- What is the extent of the impact of the issue? Who is affected?
- What disparities exist that drive these conditions or issues? What is the source of disparities?
- How much of a burden is placed on the community, in terms of disease, disparity, years of potential life lost, potential worsening of the problem, financial or other social impacts?
- What are the consequences of not addressing these conditions or issues? What are the benefits? Would other problems be reduced in magnitude if the problem were corrected?
- Can the issue be addressed with existing knowledge and resources? How resource-intensive are the interventions?
- What is currently being done to address these issues or conditions?
- What opportunities exist to address them?

After identifying priorities individually and through small group discussion, participants engaged in a large-group process to rank their chosen issues. Each potential priority was evaluated according to:

- **IMPACT** – Does the issue or condition have high impact or low impact on health? Would addressing it make a big impact on health and health inequity/structural determinants?
- **OPPORTUNITY TO ACT** – Are groups currently working on this issue? Are there many or few opportunities to advance the work? Is this aspirational, or something we could 'make happen' now?

Highest priority issues were identified as being both high impact and great opportunity (1st priority), and high impact but lower opportunity (2nd priority). The group determined the following health conditions and determinants of health as priority action issues for the public health system:

- Chronic Disease
- Institutional Racism (later broadened to structural racism and grouped under Health Equity)
- Economic Development/Living Wage/Pro-equity Policies (later grouped under Health Equity)
- Transportation/Built Environment (later grouped with Health Equity)
- Mental Health (subsequently broadened to Behavioral Health)

Additionally, participants discussed values and approaches to the work on priority issues that were critical for success in advancing equity. They determined that a focus on systems change and working in true collaboration across silos must be the approach employed in addressing our priority issues.

# Community Health Improvement Plan

The Community Health Improvement Plan (CHIP) sets systemic goals and identifies potential strategies for improving the health for improving the health and reducing health inequities among the residents of suburban Cook County by 2020. The CHIP sets a common vision and shared goals for CCDPH and other local agencies, organizations and groups working collectively to improve the health of our residents and conditions that promote health equity in our communities. To achieve the improvements proposed in this plan, the CCDPH will build on existing efforts and partnerships and foster new collaborations and approaches.

The purpose of the CHIP is to develop a health improvement agenda with a deliberate focus on eliminating health inequities by directing efforts toward improving structural and societal factors that impact poor health outcomes, in addition to factors related to behavior. The CHIP also promotes a framework for community health action with an emphasis on policy, systems and environment change approaches leading to broader collective impact. With this common agenda, partners from different sectors (e.g. healthcare, housing, transportation, education, community groups, etc.) can come together to align individual efforts, thereby improving coordination and fostering collaboration.

The CHIP is informed by the CHA and seeks to acknowledge current efforts and align with existing plans addressing the priority health conditions, either directly or indirectly. It also attempts to identify and delineate new opportunities to address these issues and the related health inequities and community conditions. The CHIP integrates significant input from stakeholders engaged during the assessment process and through other health improvement planning and implementation efforts at CCDPH and elsewhere in Cook County.

The WePlan2020 CHIP addresses three priority health conditions, along with measurable objectives and strategies to accomplish the objectives. It is important to note that the CHIP priorities are not the sole priorities or actions of CCDPH. While many of the strategies will be led and operationalized by CCDPH, and incorporated into our strategic plan, others will be supported or monitored with partner organizations taking the lead.

## WePlan2020 Health Priorities:

### **Health Equity** or more precisely, the structural and social determinants of health

- Structural Racism
- Transportation and the Built Environment
- Economic Development and Living Wage

### Chronic Diseases

### Behavioral Health

- Mental Health
- Substance Abuse

# Health Equity


## Priority 1: Health Equity

### GOAL

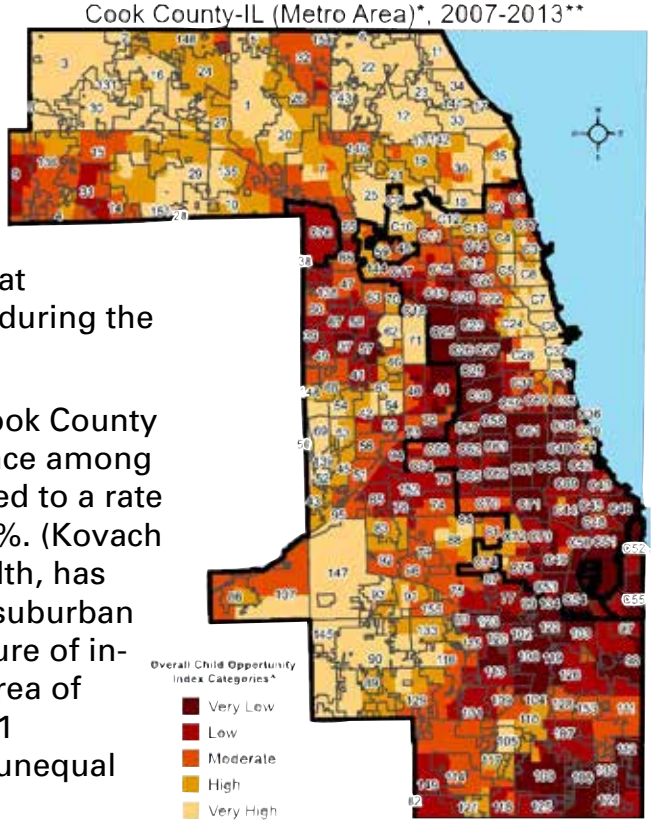
*Reduce structural racism and advocate for pro-equity policies re: economic development, built environment, transportation and income & wealth.*

### WHY THIS IS A PRIORITY ISSUE

The disparities in health in SCC reflect the social inequities of society. The resources and living conditions that make health possible are not equally available to the children, women and men who live here, resulting in health inequities, which are "systematic differences in the health of people occupying unequal positions in society" (Graham 2009).

CCDPH and the WePlan2020 community health assessment recognize that local, state, and federal policies simultaneously affect the circumstances and living conditions of residents of SCC. For instance, state-level education financing policy has led to African American and Latino children receiving a systematically lower quality of education compared to White children (Martire 2014). The context for early child development (see Childhood Opportunity Index Map at right) in Cook County follows a national pattern of racial/ethnic inequities in the exposure to environments that support or undermine optimal human development during the first five years of life (Acevedo-Garcia 2014).

Childhood Opportunity Index by Census Tract
Cook County-IL (Metro Area)*, 2007-2013**




Racial/ethnic inequities in access to health care in Cook County are reflected in the 12% rate of lack of health insurance among both African Americans and Latinos in 2015 compared to a rate of uninsurance among whites of 8% and Asians of 7%. (Kovach 2016). Income, another powerful determinant of health, has become more concentrated among residents in the suburban area. From 1970 to 2010 the Gini coefficient, a measure of income distribution and inequality, for the suburban area of Cook County increased from under 0.15 to about 0.21 (Nolan 2015). Values closer to 1 signify increasingly unequal income distribution.

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Many communities in south SCC do not have adequate infrastructure (e.g., lack of jobs, sidewalks and identified bikeways) that promotes active living, which in turn has led to a higher prevalence of chronic diseases there. For example, the strong jobs-housing-transit mismatch places many majority-minority communities in the south suburbs far from jobs, resulting in lengthy commutes and a significant dependence on motor vehicles (Cook County Department of Planning and Development within the Bureau of Economic Development, 2015).

Results from the CHA in WePlan2020 support the strategies described below. Place, income, and race were important characteristics in the CTSA. For example, respondents residing in South or West suburbs were more likely to rate their communities as Fair or Poor places in which to "live, raise children, work, and grow old." Respondents who were "food- and economically-insecure" were more likely to earn less than $50,000 per year and live in the south suburbs. Unfair treatment by police, courts, and at work was reported more by people of color. In short, quality of life and conditions that support health were determined most often by where a person lived, their race/ ethnicity and income.

The CHSA identified several inequities in health outcomes: the age-adjusted diabetes-related mortality rate for African Americans in SCC (82.0 per 100,000) is more than double that of whites (37.9 per 100,000). The likelihood that a baby will die before living for one year is four times higher for African Americans (14.7 deaths/1000 live births) than for whites (3.6 deaths/1000 live births) in SCC. Patterns of homicide mortality demonstrate inequities by geography, age, race and gender: the homicide rate in the southern suburbs was more than twice that of the average rate for SCC and the Hispanic and African American rates of homicide were, respectively, 2.5 and 12.7 times higher than the homicide rate for whites.

Several of the strategies outlined here also follow from the results of the FOCA, which found that people of color, women, and low- and middle-income people are being harmed by the patterns of decisions, policies, investments, rules, and laws that affect the health of the community. Groups who are benefiting from these patterns are White people, men, wealthy people, and large corporations. Additionally, the assessment found that average people have the power to support actions and policies that contribute to health equity through advocacy, unity and collaboration, social movements, and organizing.

As described above, the roots of the problem of health inequities lie in the processes and systems that allocate resources. People and groups with privilege receive a great amount of resources, and as a result live longer, healthier lives than people with fewer resources. People and groups of people in Cook County who have privilege have the power to make the policies creating these circumstances.

There are a number of challenges that confront efforts to address health inequities with a focus on structural and social determinants. First, public health practice has tended to focus on risk factors and behaviors despite the growing evidence that inequalities in income, wealth, power, and status are the root causes of health inequities. Tackling the root causes in the social structure requires changing use of resources, and most importantly transforming the accepted wisdom about where health and wellbeing comes from and what creates it. Second, most existing evidence on the effectiveness of interventions focuses on behavioral risk factors, and clinical interventions. Third, there is disagreement and a wide range of readiness among local public health practitioners about how to apply the social determinants of health approach recommended by Healthy People 2020 and outlined by the WHO. Fourth, the media tends to present health as a matter of lifestyle, individual behavior. Fifth, changing the health-damaging and unfair distributions of the social determinants of health – conditions of housing, education, health care, early childhood, income, employment and other resources – requires policy changes that are opposed by powerful interests who benefit from the status quo.

## WHAT HAS BEEN DONE TO ADDRESS THIS ISSUE?

Much of the rationale and evidence supporting this goal is described in detail in the WHO framework for action on the social determinants of health (Solar & Irwin 2010). This framework expands the focus of the determinants of health beyond individual, and behavioral factors, to include both social determinants (such as income, access to healthcare and neighborhood conditions) and structural determinants of health (which include issues of gender, race class and also public, social and economic policy).

WePlan2020 proposes to use the Association of State and Territorial Health Officers (ASTHO) Triple Aim for Health Equity to organize our work in health equity. This model, mirroring the Triple Aim for Healthcare developed by the Institute for Healthcare Improvement, focuses on action to address broader determinants of health.

The Triple Aim for Health Equity Model:

- Expands the understanding of what creates health
- Strengthens the capacity of communities
- Takes a "health in all policies" approach, with health equity as the goal

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One arm of this Triple Aim for Health Equity approach seeks to Expand Our Understanding of What Creates Health by "change[ing] the dominant narrative that health is determined mostly by medical care and personal choices." (Ehlinger 2015). In fact, unfair and preventable health inequities are mostly the result of policy decisions that systematically disadvantage some populations and systematically advantage others. Structural racism, for example, "is the normalization of an array of dynamics—historical, cultural, institutional and interpersonal—that routinely advantage White people while producing cumulative and chronic adverse outcomes for people of color and American Indians." (Minnesota Department of Health, 2014).

Another arm involves Strengthening the Capacity of Communities to Create Their Own Healthy Future. According to ASTHO, "We need to acknowledge that communities themselves need to be involved in creating policies and systems that improve conditions for their residents." (Ehlinger 2015). An example of this is the organizing efforts of immigrant rights activists in Cook County resulting in an ordinance which has helped protect residents against racial profiling, detention and deportation, and violence and trauma that damages the health of children and adults. Examples of campaigns which other local health departments participated in or supported have attempted to increase low wages, prevent mortgage foreclosures, and prevent airpollution exposure (Freudenberg, Franzosa, Chisholm, & Libman, 2015).

The third arm, Health in All Policies (HiAP), is a strategic focus to assist leaders and policymakers in integrating considerations of health, well-being, and equity during the development, implementation, and evaluation of policies and services. HiAP strategies are meant to ensure that all policies and services from all sectors have beneficial or neutral impacts on the determinants of health (ASTHO 2016).

Cook County has begun the journey towards implementing HiAP, initially by working to address the social determinants of health. For example, Cook County Department of Transportation and Highways (CCDOTH) set a national example for making active transportation safer and easier. After a Complete Streets executive order in 2009, the county decided to take a stronger approach and put in place a Complete Streets ordinance – unanimously approved by the Cook County Board of Commissioners – that would be used and enforced. CCDOTH also created a policy to ensure that the new ordinance would be implemented. Today, this policy aligns with the Cook County long-range transportation plan, *Connecting Cook County: 2040, Long Range Transportation Plan*. CCDOTH, 2016). This plan will serve as a road map for the design and implementation of a fully integrated, multi-jurisdictional, multi-modal transportation system designed to support the growth and economic vitality of communities in Cook County. WePlan2020 builds on successes like this, other planning efforts, and existing assets across Cook County to include strategies that ensure the built environment can support and promote health.

The Collaborative for Health Equity Cook County (CHE), a multi-sector health equity initiative supported for ten years by CCDPH, will serve as a source of leadership and strategic guidance in implementing strategies described in this plan. Since 2007, CHE has contributed to a national community of health equity practice called the National Collaborative for Health Equity (NCHE). The purpose of CHE is to build capacity to tackle health inequities along with local health departments and their community partners. CHE is led by an 18-member Steering Committee composed of leaders of multiple sectors with experience working as a team on policy and practice in Cook County and Chicago-area communities.

The CHE's Steering Committee includes people from a number of sectors and areas of expertise, including: community organizing, labor organizing, education administration, education, school food and community gardening, health care, public health, health policy, food access, immigrant rights, labor law, needs of people with disabilities, lesbian, gay, bisexual and transgender issues, social work, anti-racism organizing, social enterprise, early child development, and policy advocacy.

## WHAT WE WILL DO ABOUT IT

WePlan2020 will expand the boundaries of traditional public health practice and take action towards eliminating structural racism, and advocate pro-equity policy related to economic development, the built environment, transportation, and achieving a living wage for SCC residents. These actions are based on the values of human rights, social justice, and the ethics of public health. The actions are informed by the growing understanding that health inequities are caused by the inequitable distribution of money, power, and resources at the local, national and global level which produce the different and unequal circumstances in which people live their lives. (US Health Resources and Services Administration, Region V).

The strategies beginning on the next page originate in the following sources: Expanding the Boundaries: Health Equity and Public Health Practice (NACCHO 2014); Foundational practices for health equity: A learning and action tool for state health departments DRAFT May 2016 (Region V Social Determinants of Health Team 2016); Health Inequity: A Charge for Public Health (NACCHO 2016); Planning for Progress (Cook County Bureau of Economic Development, 2015); Illinois State Health Improvement Plan (Illinois Department of Public Health, 2016).

CHIP

## WHAT WE WILL DO ABOUT IT

### 1 Expand our understanding of what creates health.

**KEY PARTNERS**

- Chicago Metropolitan Agency for Planning (CMAP)
- Cicero Neighborhood Network
- Cook County Health and Hospitals System
- UIC School of Public Health, MidAmerica Center for Public Health Practice
- University of Illinois Extension

### 1.1 Raise awareness of the existence of health inequities & create a new narrative.

Develop a narrative with partner organizations that is not circumscribed by diseases, risk factors, or populations, but rather articulates the relationship between health inequities and underlying social inequalities, such as those in education and housing.

Highlight the role of societal values in creating or eliminating health inequities.

Shift focus away from individual responsibility for health and behaviors towards social and collective responsibility.

Use the WHO CSDH framework to increase the understanding of structural and social determinants of health.

### 1.2 Analyze, assess, and report on social conditions and health inequities using participatory processes.

Gather and use health equity indicators and measures such as the Index of Concentration at the Extremes (ICE) Index.

Analyze and disseminate information, beyond health outcomes, about the institutions and decision-making processes that generate health inequity.

Use data to demonstrate the connections among social and economic conditions and health outcomes.

Conduct a power analysis: Identify the power arrangements and interests that produce social and economic inequalities.

Promote integration of Health Impact Assessments for transportation, community development and other projects (IDPH, 2016).

### 1.3 Transform community and public health practice through organizational development.

Train staff on the application of health equity principles in program planning efforts and their daily work.

Develop leadership across sectors that is consistent in applying a health equity lens to focus attention in word and action on the role of power and privilege in creating health inequities.

Promote the adoption of health equity principles, including effective community engagement, into programs and organizational procedures.

Increase municipal capacity through collaboration and technical assistance.

## 2 Strengthen the capacity of communities to create their own healthy future.

**KEY PARTNERS**

- Backbones
- Black Youth Project 100
- Chicago Metropolitan Agency for Planning (CMAP)
- Cook County Bureau of Economic Development, Department of Planning and Development
- Foodchain Workers Alliance
- Interfaith Leadership Project of Cicero, Berwyn and Stickney
- Proviso Partners for Health
- Proyecto de Acción de los Suburbios del Oeste (PASO)
- Restaurant Opportunities Center Chicago
- West Suburban Action Project

### 2.1 Build capacity and power of communities to secure resources necessary for health in their neighborhood and living conditions.

Develop relationships with neighborhood community residents that are based on mutual recognition of each other's strengths and leadership capabilities, are long-term rather than situational, and are based on shared interests in confronting social inequalities.

Engage and support communities affected by social injustice taking collective policy action at various levels to increase control over resources that affect their neighborhoods and living conditions.

Support and work collaboratively with leadership from grassroots and civic organizations whose activities and campaigns advance health equity.

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**2.1 cont'd** **Build capacity and power of communities to secure resources necessary to improve living conditions and health in their neighborhood.**

Implement a place-based approach to planning and action to address health inequities, that frames health status as a societal rather than an individual responsibility.

Improve alignment of Cook County residents' skill with employer demand (Cook County Planning for Prosperity).

**3 Implement a 'Health in All Policies' approach with health equity as the goal.**

**KEY PARTNERS**

- Active Transportation Alliance
- American Lung Association of Greater Chicago
- Chicago Metropolitan Agency for Planning (CMAP)
- Cook County Bureau of Economic Development, Department of Planning and Development
- Cook County Department of Environmental Control
- Cook County Department of Transportation and Highways
- Councils of Government, including, South Suburban Mayors and Managers Association
- Forest Preserves of Cook County
- Health Impact Collaborative of Cook County (HICC)
- Housing Authority of Cook County
- Local landlord associations
- Metropolitan Tenants Organization
- Proviso Partners for Health
- Respiratory Health Association
- 7th District Health Taskforce
- South Suburban Parks and Recreation Professional Association

**3.1 Recommend and advocate for policies that advance health equity and tackle root causes.**

Explore, identify and promote structures and systems that facilitate communication, collaboration and coordination and integrate a Health in All Policies approach among Cook County agencies and other key stakeholders.

Advise and inform governmental non-health sectors, agencies, and officials on health equity in all policies.

Develop a public health policy agenda focusing on the causes of social inequalities.

Incorporate critical questions involving who benefits, power and accountability, and values, to influence how policies and practices are developed.

Build and join networks of organizations that address health equity and social justice issues.

Pursue policies and programs that create an environment for economic growth, particularly in Areas of Need (Cook County Planning for Progress).

## 3.2 Ensure safe, equitable, affordable and healthy housing.

Preserve housing stock in disinvested areas of SCC including efforts to address lead poisoning in the home (Cook County Planning for Progress).

Support an inclusionary housing ordinance that would apply in unincorporated Cook County (Cook County Planning for Progress).

Promote policies that encourage infill development, supporting housing affordability.

Increase the number of low income households receiving healthy homes assessments and, as needed and as funds are available, support physical improvements to the home environment. (Cook County Planning for Progress).

Encourage building code adoption, implementation and enforcement as part of an effective rental housing framework that promotes the health and safety of residents.

## 3.3 Improve the built environment and increase active transportation.

Promote multi-jurisdictional community planning that promotes a healthy, sustainable built environment by increasing the number of and ensuring alignment of municipal comprehensive plans that integrate an Active Transportation Plan.

Support implementation of Cook County's Complete Streets policy and practices.

Support development or implementation of transit-oriented development (walkable, mixed-used communities located around transit stations).

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**3.3 cont'd** **Improve the built environment and increase active transportation.**

Increase the development and/or implementation of land-use and active transportation plans and policies such as Complete Streets policies; Safe Routes to School plans; walk and bicycle-friendly private development standards across SCC municipalities.

Support improvements in transit access and implementation of Gateway Sites to make the Forest Preserves of Cook County accessible to everyone.

Increase access to physical activity opportunities at the Forest Preserves of Cook County through implementation of Nature Play; development and improvement of trails, and enhanced programming.

Reduce barriers to access recreation space (e.g., cost, accessibility, joint-use agreements).

Support efforts toward inclusive growth across the region (CMAP, OnTo2050).

# Chronic Disease




## GOAL

*Reduce inequities and the burden of chronic disease by cultivating environments, healthcare systems, and a culture that promote health.*

## WHY THIS IS A PRIORITY ISSUE

Chronic diseases continue to be the leading cause of morbidity, disability, and mortality in SCC. They contributed to nearly 7 in 10 deaths, and hospitalizations due to asthma, diabetes heart attacks, heart failure, and stroke totaled more than 34,500 in 2013. While the rates of chronic diseases in SCC mirror the U.S., striking disparities have remained persistent among race/ethnic groups and across geographical regions of SCC that reflect patterns of social inequities. For example, African Americans in SCC experience a mortality rate for cardiovascular disease (297.2 per 100,000) that is over 40% higher than the rate for all of SCC (211.0 per 100,000). This difference is far greater for African Americans residing in the West District of SCC with a mortality rate of 333.8 per 100,000. The pattern of disparity is repeated for African Americans for many other chronic diseases, including stroke, diabetes, and cancer (CCDPH, 2016).

Contributing to the burden of chronic disease is the prevalence of obesity, poor nutrition and physical inactivity, tobacco use, high blood pressure, high cholesterol, and hospitalizations and emergency room (ER) visits resulting from poorly controlled chronic conditions. Comparable to national rates, more than 1 in 4 adults (26.5%) are obese, with the rates for African Americans at 38.1%.(CCDPH, 2011) The obesity rates for youth in SCC are especially concerning, with obesity among SCC kindergartners and 9th grade students being significantly higher than national averages for similarly aged children (CCDPH, 2013). This is not surprising, as data indicate that both adults and youth in SCC, for the most part, have unhealthy diets (e.g., over 80% of adults and youth do not eat at least five servings of fruits and vegetables) and do not meet recommended standards for physical activity (e.g., 27% of adults are physically inactive and half of high school youth do not get recommended daily physical activity) (CCDPH, 2010, 2011). Adult smoking rates for SCC remained higher than national prevalence at 22%, which is nearly 30% higher than U.S. (17.3%) and Illinois (16.9%) rates. The SCC BRFSS survey data further identified that 36.4% reported they had high

cholesterol overall, with the Hispanic rate at 41.1%. Disparities in hypertension prevalence were evident in African Americans with more than 1 in 3 adults (36.2%) having high blood pressure, compared to 28.2% in SCC, 31% for Illinois and 30.8% for the U.S. Additionally, poorly controlled chronic conditions are resulting in hospitalizations and emergency room visits that can be prevented. In SCC, hospital admission rates for hypertension, uncontrolled diabetes, and asthma in younger adults are higher than rates for Illinois (Illinois Department of Public Health, 2016) and the U.S. (AHRQ, 2013).

Lower income levels, educational attainment and limited access to resources increase the likelihood of chronic diseases and are disproportionately associated with low-income and minority populations. SCC has some of the poorest municipalities in the nation in the South and West Districts, with some having more than 40% of their residents below 200% of federal poverty level. In addition, several of these communities have over 20% of their residents aged 25 years and older with less than a high school education as compared to the SCC and statewide average of 12%. Inevitably, unemployment rates are further considerably higher in the south and west Districts than for SCC, the State of Illinois and U.S.(CCDPH, n.d.).

In addition to socioeconomic factors, the disparities in health status across SCC are further largely connected to the conditions under which people live, work, learn and play. Many community environments do not support equitable access to and availability of high quality, nutritious and affordable food, tobacco-free environments and quality health care, as well as opportunities or safe places for physical activity. Several low-income, predominantly African-American, communities in SCC are low food access areas, where high-calorie, high-fat foods are more readily available. More specifically, the south suburbs have the least access to full service chain supermarkets per person (Block et al., 2012), and a high density of corner stores with few that carry more than 10 produce items or healthy food options (Block et al., 2014). Food insecurity is particularly a concern in this area of SCC, where communities such as Ford Heights, Robbins, Phoenix, Harvey, and Riverdale have food insecurity rates (33%-50%) that are more than double the statewide rate (13.6%) (Greater Chicago Food Depository and Cook County Government, 2015).

Unfortunately, there is an array of obstacles that include, but are not limited to, transportation, municipal comprehensive plans that, for the most part, do not integrate the health of their residents with decisions related to housing, transportation, or land use (CMAP, n.d.) and current regulatory environments that do not support, for example, farmers' markets, development of urban farms; limited production of locally grown food (e.g., few farmers in the area); lack of economic incentive and concerns about safety for large retail stores; and cost of fruits and vegetables, which are expensive or at least perceived to be (The Illinois Local and Organic Food and Farm Task Force, 2009).

Additionally, while research indicates that there is no risk-free level of exposure to secondhand smoke and only 100% smoke-free environments adequately protect from the dangers of secondhand smoke, there are still parks, multi-unit housing and college campuses in SCC that allow smoking. For example, a poll commissioned by CCDPH in 2013 found that 66% of respondents lived in buildings where smoking inside individual housing units was allowed. Retail environments further can encourage youth to start smoking, often prominently displaying tobacco products, in-store advertising and other in-store promotions (U.S. Department of Health and Human Services, 2012). Healthcare system barriers such as lack of culturally-competent health services; limited linkages between clinical care and community-based resources; and the broader social determinants of health lend themselves to the burden of chronic disease and increasing health inequities.

CHIP

## WHAT HAS BEEN DONE TO ADDRESS THIS ISSUE?

Efforts to improve policies that support health have been initiated or supported at the state, county, and local levels. The State of Illinois has enacted several pieces of legislation promoting healthy eating and active living (e.g., breastfeeding promotion and protection; development of nutrition and physical activity standards in early childhood programs and services; production, distribution, access and consumption of healthy food); school wellness and physical fitness assessment and reporting; and funding to implement the Safe Routes to School Program); tobacco-free environments (e.g., Smoke-Free Illinois Act and 2014 Smoke-Free Campus Act); and transformation of the healthcare system (e.g., Illinois 1115 Waiver). State departments have further embarked on collaborative planning processes to create comprehensive plans (e.g., Illinois Blueprint for Breastfeeding) and have developed toolkits to support legislative requirements.

Cook County Government has also taken positive steps. Examples include: adoption of a stronger Complete Streets policy in 2011 and the development of Connecting Cook County: 2040 Long-Range Transportation Plan (June 2016) that gives new focus to developing a comprehensive, integrated transportation network; incorporation of nutritional standards in a recently finalized snack contract; implementation of smoke-free protections in Housing Authority of Cook County developments; and efforts to increase access, visibility and promotion of the Forest Preserves of Cook County that connect residents to nature and outdoor recreation; and expansion of a customizable food insecurity screening and referral system across Cook County Health and Hospitals System community health centers to connect patients at risk for food insecurity with community food resources.

At the local level, regional associations, coalitions, and community organizations are engaging in planning efforts, as well as implementing policy, systems and environmental improvements that change the context in which people live, work, learn and play, making healthy living easier and promoting health equity. Examples include:

- **Regional councils of governments** supporting walking and biking (e.g., Northwest Municipal Conference Bike Plan promoting a regional bicycle network and the South Suburban Mayors and Managers Association Complete Streets and Trails Plan);
- **Municipalities and park districts** starting to integrate health directly in their comprehensive or master plans (e.g., Lan-Oak Park District Master Plan) or develop health-related chapters focused on food access or active transportation (e.g., City of Blue Island), as well as implementing farmer's markets, healthy corner stores and urban agriculture initiatives (e.g., Giving Garden in Maywood, IL);
- **School districts** changing school policies and practices to support student and staff wellness (e.g., implementation of the Safe Routes to School program or work with the Alliance for a Healthier Generation, Healthy Schools Program).
- **Universities and colleges** implementing smoke-free campuses, and market-rate multi-unit housing implementing smoke-free protections;
- **Healthcare systems** like JenCare strengthening their referral systems to link patients with community-based resources that support them with prevention, risk reduction or management of chronic conditions.

While numerous initiatives exist, the ability to link them together and move towards collective action continues to be a challenge. Current infrastructure and resources in the region do not adequately support the complexity and needs of the communities to prevent and control chronic diseases. Without an overall collaborative system that can plan strategies systematically; advance broad-based policies; and mobilize and leverage scarce resources, we anticipate growing disparities in our jurisdiction.

Addressing this complex public health issue will require continued coordinated action among partners of the public health system to improve community conditions (physical and social environment), health care systems, and clinical linkages to community resources that support healthy behaviors and promote effective management of chronic conditions. Over the last five years, the Alliance for Healthy and Active Communities (AHAC) has sustained and built an active membership that currently comprises of nearly 20 multi-sector organizations. Each serves a region or all of SCC; brings a wealth of technical expertise; and/or participates in policy, systems or environmental change efforts.

CHIP

## Overview of the AHAC by Sector

| Sector | Organization |
|---|---|
| Academic Institutions | UIC School of Public Health MidAmerica Center for Public Health Practice |
| Community Development & Planning | Active Transportation Alliance<br>Chicago Metropolitan Agency for Planning<br>South Suburban Mayors and Managers Association |
| Community Organizations | AgeOptions<br>American Lung Association of Greater Chicago<br>Respiratory Health Association |
| Coalitions | Consortium to Lower Obesity in Chicago Children<br>Proviso Partners for Health |
| Faith-Based Organization | The Center for Faith and Community Health Transformation |
| Government | CCDPH (convener)<br>Forest Preserves of Cook County |
| Healthcare | Advocate Health Care |
| Media | CBS/WBBM 2 |
| Public Health | Illinois Public Health Institute |
| Education | Alliance for a Healthier Generation<br>West 40 Intermediate Service Center |
| Voluntary Organizations | American Heart Association, Midwest Affiliate |

## WHAT WE WILL DO ABOUT IT

### 1 Reduce prevalence and inequities of obesity and obesity-related diseases.

**KEY PARTNERS**

- Advocate Health Care
- AgeOptions
- Alliance for a Healthier Generation
- American Heart Association, Midwest Affiliate
- The Center for Faith and Community Health Transformation
- Consortium to Lower Obesity in Chicago Children
- Cook County Bureau of Economic Development, Department of Planning and Development
- Cook County Health and Hospitals System
- Greater Chicago Food Depository
- Illinois Action for Children
- Illinois Public Health Institute
- Loyola Medicine
- North, West and South Intermediate Service Centers
- Proviso Partners for Health
- South Suburban Parks & Recreation Professional Association
- SCC Townships

### 1.1 Increase access to and availability of healthy food and beverages, and decrease access to and availability of unhealthy food and beverages.

Promote trainings and use of Nutrition and Physical Activity Self-Assessment for Child Care program (NAP SACC) to develop and implement improvements that embed nutrition and physical activity best practices in early childhood care and education programs.

Increase the number of municipal comprehensive plans with health sections and/or health-based recommendations – especially in areas of the region with significant health disparities – that identify zoning, land use, and transportation system improvement opportunities to increase availability, affordability, quality of healthy foods and municipal connectedness to healthy retail.

Expand urban farm initiatives, and healthy food and beverage options in existing retail venues (e.g., corner stores) or food service establishments (e.g., vending machines).

CHIP

**1.1 cont'd** **Increase access to and availability of healthy food and beverages, and decrease access to and availability of unhealthy food and beverages.**

Encourage new grocery stores or other healthy retail developments (e.g., local farmer's markets, roadside stands) invested in long-term economic development of the community, with an emphasis on establishment and growth of minority-owned businesses.

Explore and expand partnerships that would result in increased availability of affordable, healthy foods to low-income communities (e.g., Top Box Foods).

Promote school wellness through adoption and implementation of policies and practices that support students and staff in eating better and moving more throughout the day through implementation of CDC's Whole School, Whole Community, Whole Child Model, national frameworks like the U.S.D.A. Healthier Schools Challenge or Alliance for a Healthier Generation's Healthy Schools Program, or Community Schools approach.

Increase adoption and implementation of comprehensive workplace wellness policies and practices in organizational or institutional settings that includes improving the availability of healthy foods and beverages (including reduced sodium content).

Promote strategies to limit availability and access to sugar-sweetened beverages (SSB's) in community settings, including an SSB tax (IAPO Roadmap)

**1.2** **Reduce household food insecurity.**

Increase student access to and participation in School Breakfast and Summer Meals programs (Cook County Food Access Plan).

Work with food pantries and emergency meal programs to stock and deliver healthy foods and beverages.

Implement dollar-matching programs (e.g., "double value coupons") for consumers that participate in federal nutrition assistance programs including SNAP and WIC to increase affordability of healthy foods.

Expand customizable food insecurity screening and referral system to connect patients at risk for food insecurity with community food resources.

## 1.3 Increase physical activity opportunities.

Promote best practices and training opportunities to improve physical activity and screen time practices in early childhood care and education settings.

Support statewide efforts to strengthen Illinois's Safe Routes to School program by boosting funding for the program, making it easier for low-income communities to participate, and improving the administrative practices of the program to align with national best practices.

Promote, develop and implement Safe Routes to School programs to ensure that students can safely walk or bike to and from school.

Improve the quality and amount of physical education and physical activity before, during and after school through implementation of Whole School, Whole Community, Whole Child Model, national frameworks like the U.S.D.A. Healthier Schools Challenge or Alliance for a Healthier Generation's Healthy Schools Program, or Community Schools approach.

Support elimination of physical education (P.E.) waivers, and the protection and implementation of Illinois' elementary and secondary school P.E. daily requirement (IDPH, 2016).

CHIP

**1.3 cont'd** **Increase physical activity opportunities.**

Promote and implement joint use agreements (e.g., school grounds open to the public after hours).

**1.4** **Promote breastfeeding.**

Increase proportion of women participating in Women, Infant and Children (WIC) services who exclusively breastfeed for the first six months.

Increase adoption and implementation of comprehensive work-place wellness policies and practices in organizational or institutional settings that include promotion of breastfeeding.

Promote paid maternity or family leave, which is a key support to early breastfeeding success and duration.

**2** **Reduce prevalence and inequities in tobacco-related diseases.**

Key Partners:

- American Lung Association of Greater Chicago
- The Center for Faith & Community Health Transformation
- Housing Authority of Cook County
- North, West and South Intermediate Service Centers
- Respiratory Health Association
- Proviso Partners for Health
- South Suburban Mayors and Managers Association

**2.1** **Increase smoke-free or tobacco-free environments.**

Increase number of settings with 100% smoke- or tobacco-free policies

Increase age to purchase tobacco from 18 to 21 years

Support efforts to raise cigarette taxes statewide by $1 (IDPH, 2016)

Increase and create equal taxation on all types of tobacco (e.g., e-cigarettes and tobacco-derived products) (IDPH, 2016).

Restrict youth access to tobacco products through community mobilization, retailer education, and enforcement of retailer sales laws.


THIS BUILDING
SMOKE-FREE
Thank you for not smoking in any residential units or comm
HealthyHotSpot.org
Made possible with funding from the Centers for Disease Control and Preventio

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**2.1 cont'd** **Increase smoke-free or tobacco-free environments.**

Strengthen enforcement of the Cook County Indoor Air Act and Smoke-Free Illinois Act.

Implement mass reach health communications interventions (counter marketing, cessation, secondhand smoke exposure, e.g., in cars).

**2.2 Increase access to and demand for cessation services, including the Illinois Tobacco Quitline and evidence-based community programs (e.g., Courage to Quit and Freedom from Smoking).**

Support funding for the Illinois Tobacco Quitline.

Ensure tobacco dependence treatment, both counseling and prescriptions, is available to all residents regardless of ability to pay.

Implement tobacco user identification and referral system in healthcare and behavioral healthcare settings.

**3 Improve prevention, risk reduction, and management of chronic conditions**

**KEY PARTNERS**

- Advocate Health Care
- AgeOptions
- American Lung Association of Greater Chicago
- CCHHS Ambulatory and Community Health Network
- Consortium to Lower Obesity in Chicago Children
- Forest Preserves of Cook County
- HealthConnect One
- Health Impact Collaborative of Cook County (HICC)
- Illinois Chapter, American Academy of Pediatrics
- Illinois Public Health Institute
- Loyola Medicine
- Medical Legal Partnership
- Presence Health
- Respiratory Health Association

**3.1 Increase implementation of quality improvement processes in health systems that support clinical diagnosis and chronic care management.**

Explore opportunities for health information exchange systems to improve health care quality or support community health.

Explore need and opportunities to engage pharmacists and improve medication management.

Promote team-based approach (patient care team) and practice systems organized to provide effective treatment (clinical, behavioral, supportive); information and support for self-management; systematic follow-up and assessment tailored to severity of condition; coordination of care across settings and professionals; and linkages with effective community resources.

### 3.2 Increase access to, coverage for, and utilization of community-based services for chronic disease prevention, risk reduction and disease management.

Promote Medicaid and other insurance reimbursement for evidence-based community preventive services such as cessation services or programs; National Diabetes Prevention Program; and Chronic Disease Self-Management/Diabetes Self-Management Programs.

Implement formalized identification and referral systems in healthcare settings (including behavioral health, as applicable) that link patients to evidence-based community resources (e.g., Illinois Tobacco Quitline; Take Charge of Your Health; National Diabetes Prevention Program; WIC/SNAP and other food resources; asthma management programs).

Support expansion and opportunities for community health workers or community paramedicine in prevention, risk reduction and management of chronic diseases (e.g. peer-to-peer capacity).

Explore innovative opportunities to implement green prescriptions (e.g., healthcare partnering with the Forest Preserves of Cook County, parks or recreational organizations to connect patients to physical activity opportunities, nature and/or outdoor recreation) to support prevention, risk reduction or disease management.

Encourage integration of preventive health services as part of regional dialogue around need for comprehensive referral system to social services (Planning for Progress, 2015).

Support adoption of Early Intervention policies allowing lead-poisoned children to qualify for developmental support services.

Build upon partnerships with hospitals and health care providers through the Health Impact Collaborative of Cook County (HICC) to improve community health through use of community benefit investments and advocacy.

### 3.3 Improve asthma management, especially in children.

Continue to promote implementation of legislation around self-carry of asthma medication, and updates to asthma action plans for children with asthma.

Promote policies to increase access to evidence-based asthma interventions with an environmental focus (e.g., reimbursement for home-based, multi-trigger, multi-component asthma interventions).

### 3.4 Increase rates of exclusive breastfeeding at hospital discharge.

Promote and support designation of maternity care hospitals as Baby-Friendly.

### 4 Change awareness, knowledge, attitudes, behaviors and skills to promote a culture of health.

**KEY PARTNERS**

- Alliance for Healthy & Active Communities and Healthy HotSpot initiative (members of)
- Statewide entities like the Illinois Alliance to Prevent Obesity; Illinois Prevention Research Center; and Illinois Public Health Association
- The Center for Faith & Community Health Transformation
- UIC School of Public Health, MidAmerica Center for Public Health Practice
- WBBM/CBS

*Photo from 2016 Change Institute: A Food Summit, sponsored by CCDPH, in collaboration with Loyola University and UIC Mid-America Center for Public Health Practice.*

**4.1 Increase knowledge, skills and self-efficacy of organizations that serve SCC in adopting, implementing and evaluating, policy, systems and environmental improvements that make healthy living easier.**

Organize and implement an annual Change Institute for SCC.

Align with, promote and/or leverage opportunities offered by other national, state, and local organizations (e.g., Illinois Alliance to Prevent Obesity; Illinois Prevention Research Center; and Illinois Public Health Association).

**4.2 Continue to implement the Healthy HotSpot campaign to build multi-sector stakeholder and public support for policy, systems and environmental improvements or community solutions.**

Use a multi-faceted media approach to promote the benefit and value of community solutions and environmental changes, as well as share planned efforts and achievements.

Engage and leverage partnerships and existing events to effectively communicate about the importance of community solutions and environmental changes

Identify criteria and develop a recognition process for Healthy HotSpots.

Determine and execute strategies to engage champions and organizations (e.g., competition program).

**4.3 Employ public education campaigns related to risk factors associated with chronic disease (e.g., nutrition/healthy eating; physical activity/active living; tobacco cessation and exposure).**

# Behavioral Health

## Priority 3: Behavioral Health

### GOAL

*To support and enhance the mental health and well-being of all suburban Cook County residents.*

### WHY THIS IS A PRIORITY ISSUE

The behavioral health status of SCC residents is a primary health concern. Recognized as an essential component of overall health and well-being, behavioral health status reflects the degree to which people's thoughts, emotions, and actions enable them to fully participate in and enjoy the important functional roles in life. The World Health Organization in its Mental Health Action Plan 2013–2020 expanded on this definition to include "… also social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions and community social supports" (WHO, 2013). When the behavioral health status of a population is poor, many community dimensions are adversely affected including the health care system, academic and job achievement, economic productivity, social welfare expenditures, public safety and the criminal justice systems (APHA, 2015).

Behavioral health expands mental health to include problems with substance abuse or misuse, serious psychological distress, suicide, and mental and substance use disorders (SAMHSA, 2016). Behavioral disorders in the U.S. are common, recurrent and often serious and untreated (SAMHSA, 2016). Behavioral health disorders account for nearly one third of the overall disease burden in the U.S. representing the most disabling, and costliest, of all health conditions. Inequities in rates of behavioral health disorders are evident for certain populations including racial and ethnic minorities, LGBTQ, and the homeless. These groups often have higher rates and less access to prevention and treatment services than the general population. In addition, behavioral health disorders often occur with other chronic physical illnesses such as asthma, diabetes or heart disease, increasing treatment costs and increasing patient risks for poor outcomes.

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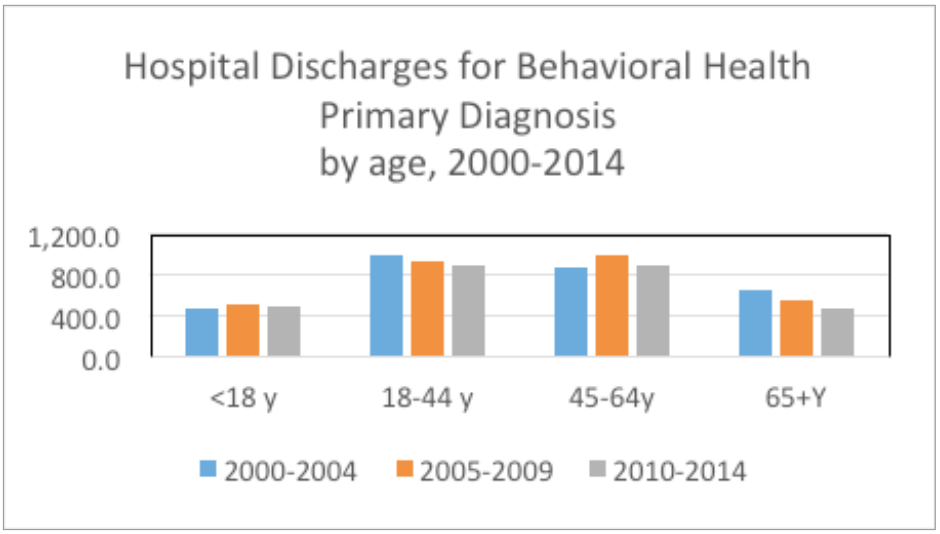
The concern from residents and service providers alike for behavioral health issues is justified when reviewing the available data. When asked about their mental health in the past month, 13.6% of SCC adults (compared with 15-17% for Illinois), responded that 8-30 days were not good and 25% (compared with 20% for Illinois) responded 1-7days were not good (IDPH, 2015). In a survey of SCC high school youth, 27% responded that they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months (CCDPH, 2010). And, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), 8.5% of all adolescents in Illinois aged 12 to 17 had at least one major depressive episode within the year prior to being surveyed (surveyed 2009-2013) (SAMHSA, 2015).

A review of the hospital discharge data for suburban Cook County residents demonstrated no appreciable change in rates of hospital discharges (from 2000 -2014) by age, with only a slight decline in the 65 years and over age group (Figure 11).

Rates by gender also stayed unchanged over the time period with males 18-64y, having the highest rates. According to the Illinois Department of Public Health, discharges by race and ethnicity were not collected prior to 2009 and rates after 2009 appear unreliable as nearly two-thirds were missing race.

An analysis of behavioral health hospitalizations by ZIP code for suburban Cook County for the years 2010-14 shows areas in the south and west suburbs with significant rates of hospitalizations greater than the overall SCC rate of 827.0 per 100,000 persons (Figure 11). These hospitalization data represent admissions for the most severe disease but are not definitive in identifying the state of behavioral health in the suburbs. Admissions are affected by residents' access to care and availability and practices within each hospital facility. According to the Illinois Hospital Association, there

Figure 11 | Hospital Discharges for Behavioral Health Primary Diagnosis

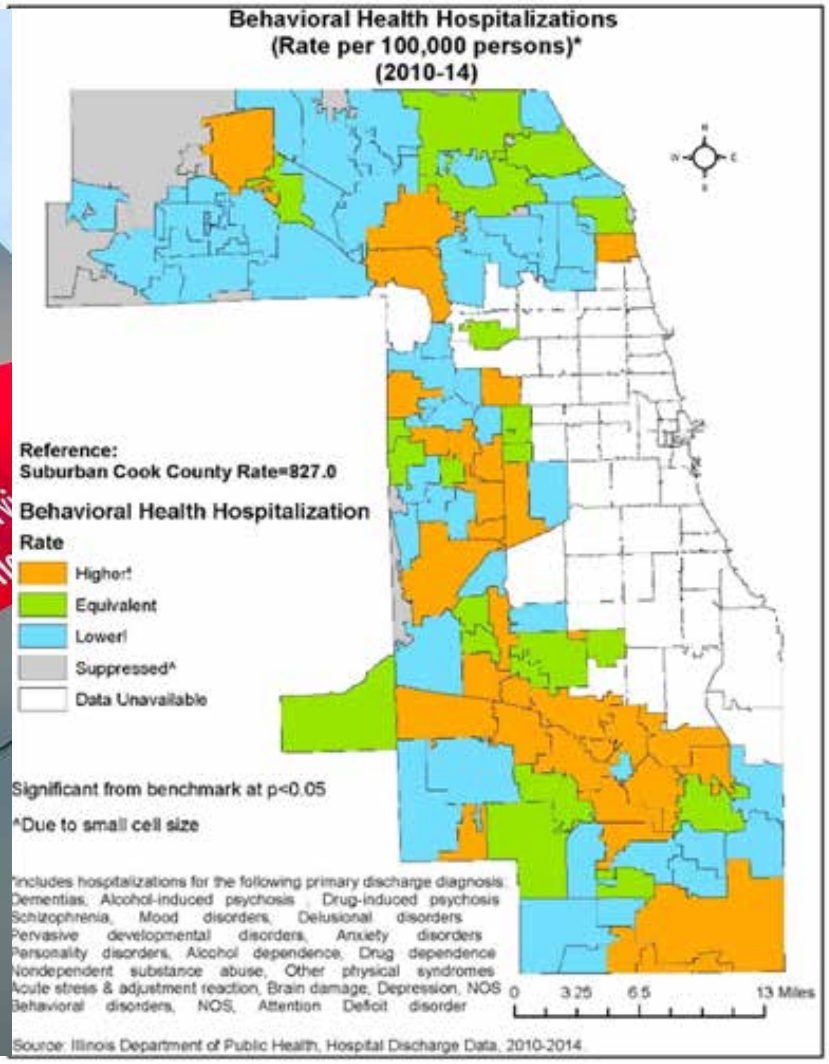


are several obstacles in accessing behavioral health services including inpatient capacity that is not evenly distributed and an inpatient and community mental health service capacity that has shrunk over the past decades.

The burden of untreated behavioral health issues and inadequate access to care is seen in the increase in the number of hospital Emergency Department visits over the past ten years. In a recent IDPH study, behavioral health visits increased an annual average of 7% from 2009 to 2013 with the highest rate of visits for the African American population (IDPH, 2015).

An analysis of emergency room admissions for behavioral health issues identified communities in the near west and south suburbs with rates 2-3 times higher than neighboring communities. Admissions for substance abuse that are higher than the mean rate appear to cluster in west suburban communities (Figure 12).

Figure 12 | Behavioral Health Hospitalization Rate

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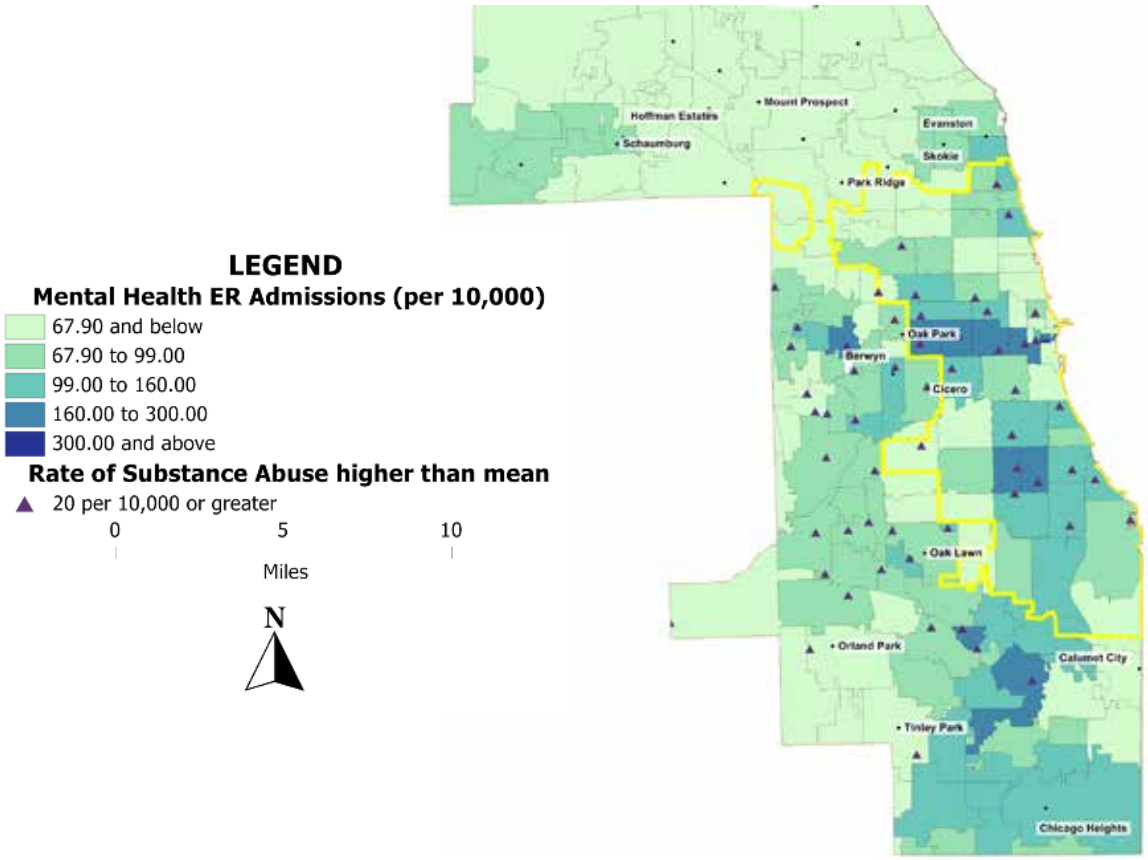
The suicide mortality rate in suburban Cook County, ranging from 6.5-9.8 deaths/100K population over the years 2008 -2012, is lower than the Healthy People 2020 goal of 10.2 deaths/100K population. Data from the CHSA shows about 200 deaths per year in suburban Cook County, affecting four times the number of males than females and mainly in Whites and persons 35-54 years.

Opiate and heroin overdose and related mortalities has become a major national behavioral health concern causing CDC to identify it as an "epidemic". In suburban Cook County, the number of deaths from opiates has been approximately 40 deaths/year since 2008. Preliminary 2013 data identified an increased number of heroin deaths (N=41) with the majority male and in the 18-25 age group. This is particularly concerning since the Illinois

Figure 13 | Mental Health ER Admissions and Rates of Substance Abuse




Youth Risk Behavior Survey and the Illinois Youth Survey have documented a small but consistent pattern of illicit and prescription drug use among school-aged youth as well as a high prevalence of alcohol use, both of which may impact later patterns of illicit drug use including heroin (Seweryn, 2014).

Availability of data on the status of behavioral health is limited in suburban Cook County as well as in the state. The Healthy Illinois 2021: State Health Improvement Plan's goal to "Improve the collection, utilization and sharing of behavioral health related data in Illinois" promises to make useful data available to local health departments and assist in WePLAN's data measures.

There are significant barriers to accessing behavioral health services and these were echoed throughout the CHA. Mentioned most often as a major barrier was the loss of services due mainly to a state budget impasse and the probability of reduced funding (and decreased services) in the years ahead. This has caused many prominent behavioral services, providers and supports to reduce or end service provision. An environmental scan of behavioral health support and services provided by townships to suburban residents identified disparities depending on residency. South suburban residents have access to far fewer support services and have greater difficulty accessing behavioral clinical services due to provider shortages. In addition, language, culturally appropriate services, insurance status and stigma are barriers identified by residents to receiving services.

Social and economic inequities contributing to behavioral health problems also resonated in the community health assessments. Findings from the self-reported WePlan2020 CTSA point to racial, ethnic and economic disparities in respondents who rated their overall health as Fair or Poor (13.4%). Of these respondents, 83% were lower income ($50,000 or less/year) and 58% were either African American, Asian, or Hispanic. Similarly, 69% of those identifying a Fair or Poor mental health status (8.3%) had incomes less than $50,000/year and 57% were either African American, Asian or Hispanic. Quality of life and conditions that support health were determined most often by where a person lived, their race and ethnicity, and their income.

Regrettably, although familiar with the higher rates of behavioral health issues as evident in the data and from community voices, WePlan2020 is unable to prioritize all of the populations at greater risk with tailored and comprehensive programs and services. Populations including older adults, incarcerated youth and adults, LGBTQ, and veterans are at greater risk often due to inequities in the structural determinants of health including poverty, lower education, unemployment, poor housing or homelessness, unsafe neighborhoods, discrimination, etc. The strategies introduced above in the health equity priority plan hold promise, and fortunately there are agencies with successful programs and services and agencies advocating for these populations including the office of Cook County Sheriff Thomas Dart, Suburban Coalition for the Homeless, AgeOptions, Community Behavioral Healthcare Association, Alliance to End Homelessness in Suburban Cook County, and Illinois Coalition for Adolescent Health.

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## WHAT HAS BEEN DONE TO ADDRESS THIS ISSUE

The available literature and research on improving behavioral health recognizes the urgency to implement a comprehensive approach to a very complex issue. Critical to improvement is: (1) advancing the integration of behavioral health with primary care services, community services and support linkages to increase access (2) promotion of family and community protective factors to support life-long health and (3) addressing the drivers/stressors that place populations at risk or the structural and social determinants of health.

Given the scarcity of mental health resources and since almost 80% of patients with behavioral health conditions present only or primarily in the clinical setting, the Community Guide and the Community Preventive Services Task Force recommend a healthcare system-intervention that integrates screening, treatment initiation, and referral to behavioral health specialists initiated by the primary care provider and supported and monitored by case managers. Evidence shows that patients in collaborative care had fewer depressive symptoms, better medication and response to treatment, better remission or recovery and better satisfaction with treatment (CDC, 2010). Within the CCDPH jurisdiction and within the region, progress has been made through community clinics and federally qualified health centers initiating expanded behavioral health services with some or all of the recommended components into primary care medical homes. A focus of the suggested strategies will concentrate in the geographical areas and with populations identified at greatest risk.

With regard to decreasing drug use, overdose and mortality, CDC has identified several best practices including reducing access to and abuse of prescription opioid painkillers by increasing harm reduction methods including Medication-Assisted Treatment (MAT) and access to and training for administering Naloxone. The Illinois General Assembly recently passed the Heroin Crisis Act or 'Lali's Law,' which made provisions to expand access to treatment and overdose prevention methods for primary care patients and providers. Implementation and monitoring of progress will be an activity of this improvement plan.

Healthy People 2020 and the Institute of Medicine are in agreement that the greatest opportunity for prevention of behavioral health issues is among young people and the strongest preventive efforts focus on early childhood interventions. Researchers have identified key factors that put young children's well-being and learning at risk including poverty, disparities because of race, ethnicity or language; parent's education level, having under-or unemployed parents, and exposure to domestic violence, stressful life events and violence in communities (Washington State Department of Health, 2010). These findings are also confirmed by the Adverse Childhood Experiences (ACE) study which documents that exposure to toxic stress can result in long-term behavioral and general health problems. There are striking

associations between increasing numbers of adverse childhood experiences and increased risks for a wide range of behavioral health and general health problems including smoking, alcohol and drug use, and risky sexual behavior as well as obesity, diabetes, heart disease, sexually transmitted diseases, and attempted suicide. Critical decisions concerning investments in our youngest children must prioritize building a strong foundation in the early years for a lifetime of good-better health.

Also, there are substantial scientific findings on effective promotion and prevention interventions that help children and parents build resiliency skills and prevent unhealthy outcomes. Among them are early childhood support, early diagnosis, linkages to care when needed and building parenting skills that foster strong parent-child relationships. Collaboration efforts with numerous regional service providers and community organizations offer opportunities to enhance these activities.

Lastly, observing the social circumstances and the environment in which a child/family lives often means the difference between a productive healthy life and one that is threatened. Community differences including public safety, quality and affordable housing, economic opportunity, access to care, and opportunities and services are obvious in suburban Cook County and must be addressed with a multi-layered public health approach. The interventions introduced through the health inequity priorities, e.g., advocating for a living wage and speaking to structural racism, hold promise in addressing some of the drivers (equal opportunity and economic circumstances) contributing to the development of behavioral health issues. In addition, contributing efforts of Cook County sister agencies are helping to improve housing and the environment. Engaging community voices and working with current community services promises to strengthen resolve and initiate policies to improve structural factors.

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## WHAT WE WILL DO ABOUT IT

1 **Increase the number of residents with access to behavioral health services and support, especially those most in need including persons with untreated mental illness living in south and west suburban communities; persons living in communities impacted by violence and/or discrimination; immigrants and non-English speaking residents; uninsured, and persons with chronic diseases.**

**KEY PARTNERS**

- Advocate Children's Hospital
- Alliance for Healthy and Active Communities (AHAC)
- Center for Faith and Community Health Transformation
- Community Behavioral Health Providers
- Community Behavioral Healthcare Association
- Community Memorial Foundation
- CCHHS/Behavioral Health Strategic Plan
- Cook County Township Mental Health Commissions/708 Boards
- Federally Qualified Health Centers/Community clinics
- Health and Medicine Policy Research Group's Behavioral Health-Primary Care Integration
- Health Impact Collaborative of Cook County (HICC)
- Illinois Department of Human Services/Mental Health Division
- Learning Collaborative
- Mental Health America of Ilinois
- Mental Health Authorities of Ilinois
- National Alliance on Mental Illness (NAMI)/ NAMI FaithNet
- North, West, and South Intermediate Service Centers
- South Suburban Council on Alcoholism and Substance Abuse
- Stickney Township Public Health District
- Thresholds

## 1.1 Promote and expand behavioral health resources and services integration into primary care in order to: improve routine screening and diagnosis of depressive disorders, increase provider use of evidence based protocols for active management of depressive disorders, and improve clinical and community support for active patient engagement in treatment goal setting and self-management.

Increase patient screening (adults 19 years and older and youth 12 to 18 years) for behavioral health indicators by primary care providers by promoting available screening tools and follow up processes.

Improve clinic/community integration through referral networks that simplify successful referrals to community-based programs and resources supporting and promoting positive behavioral health.

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Promote successful models of integrated care, i.e., hold/participate in a conference to share local and national "lessons learned."

Support efforts to address ways to increase the number and quality of adult and child behavioral health providers including counselors, psychiatrists and other trained behavioral health providers.

### 1.2 Increase coordination efforts to provide community prevention strategies and supportive services tailored to vulnerable populations.

Identify the need, in collaboration with organizations serving vulnerable populations, for behavioral health prevention strategies and treatment services.

Work with behavioral health providers to assure referral of clients with chronic medical conditions to primary care providers.

Incorporate behavioral health promotion into chronic disease prevention strategies.

Convene/support a collaborative of providers, users of services and community stakeholders to advise and guide strategic efforts, influence system and policy change and establish/improve coordination of behavioral health services.

### 1.3 Increase community awareness and understanding of behavioral health.

Expand the availability of Mental Health First Aid training to county employees, faith based leaders, first responders and other community partners.

Work with school personnel to expand the availability of Teen Mental Health First Aid training.

Determine current efforts to promote prevention and promotion of behavioral health by those already engaged in efforts and expand partnership efforts.

Assure dissemination of quality information that helps residents manage stress, identify early signs and symptoms of behavioral health and addiction disorders, and locate information on needed assistance.

Collaborate with community sectors to help reduce the stigma related to behavioral health disorders.

## 1.4 Reduce prescription drug and other opiate overdoses.

Expand prescription drug and other opiate overdose community education.

Expand access to Naloxone distribution

- Assess the status of Lali's Law and the training of pharmacists, first responder requirements and training, and cost and coverage of Naloxone.

Expand availability of Buprenorphine to treat opioid use disorder in primary care settings.

Encourage pharmacies to disseminate information about risks associated with the non-medical use, safe storage and disposal of prescription drugs.

## 2.0 Increase support, services and programs for behavioral health promotion and prevention efforts focusing on young children and families.

**KEY PARTNERS**

Collaborative for Health Equity Cook County
Cook County Health and Hospitals System
Councils of Government, including, but not limited to: South Suburban Mayors and Managers Association
Family case management agencies
Governor's Office of Early Childhood Development
Illinois ACE Response Collaborative (HMPRG)
Illinois Network of Child Care Resource and Referral Agencies
Illinois Department of Public Health
Illinois Department of Human Services
Illinois Early Learning Council
Law enforcement - Municipal and County
Local health departments in Cook County
Metropolitan Family Services/ Parenting Fundamentals
North, West, and South Intermediate Service Centers
Northern Illinois Public Health Consortium

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## 2.1 Maximize the number of young children enrolled in quality early childhood programs and evidence-informed family support programs in identified low opportunity suburban Cook County communities.

With early childhood/family advocates, support or develop a promotional plan to increase awareness of the benefits of high-quality early childhood education and parenting education as a primary prevention strategy to improve resiliency in children and families, especially those experiencing health inequities.

Assess the quality, affordability and availability of early childhood care and education programs and evidence-informed family support programs in low-opportunity communities.

Support community education and partnership building efforts that promote the value of high-quality early care and education and parenting support programs.

Advocate for minimum wage requirements for the early childhood workforce.

## 2.2 Increase the proportion of young children with health insurance, access to a medical home and annual well-child check-ups.

Promote expansion of successful public health programs that focus on improving maternal and child health and relationships by addressing social and structural determinants of health. (e.g. Special Supplemental Nutritional Program for Women, Infants and Children (WIC), Family Case Management, Adverse Pregnancy Outcome Reporting System (APORS),
Nurse-Family Partnership, etc.)

## 2.3 Reduce childhood exposure to toxic substances.

Promote and support Healthy Homes guidelines/principles to reduce childhood lead poisoning, exposure to tobacco smoke and improve indoor air quality.

Advocate for policy change and primary prevention to prevent childhood lead exposure.

## 2.4 Reduce exposure and help mitigate the effects of childhood violence and trauma on physical and behavioral health.

Collaborate with community partners to provide professional trainings to share the ACEs research on the impact of trauma, adversity and toxic stress on children and families.

Work with programs, organizations, and systems to integrate SAMHSA's concept of a trauma-informed approach in health care and service settings.

Increase parent learning opportunities and peer supports in diverse and family-friendly venues to provide healthy, nurturing experiences for their children.

Develop/support policies that further collection of data, i.e., adding ACE questions to the IDPH BRFSS, analysis and dissemination of findings.

# Priority Health Indicators & Objectives

| INDICATORS | DESCRIPTION | SCC BASELINE (YEAR) | PRIORITY POPULATION (PP) | PP BASELINE & YEAR | 2020 TARGET (% change from baseline) |
|---|---|---|---|---|---|
| **HEALTH EQUITY** | | | | | |
| OVERALL HEALTH STATUS | *Percentage of adults who report their health as "good", "very good" or "excellent"* | **83.1** (2012) | SCC | **83.1** (2012) | **87.3** (5% increase) |
| LIFE EXPECTANCY | *Life expectancy at birth in years* | **77.8** (2008-2012) | SCC | **77.8** (2008-2012) | **79.4** (2% increase) |
| OBESITY | *Percentage of high school students who are obese (YRBS)* | **11.0** (2010) | African American / Hispanic | **11.0 (17.4 /12.4)** (2010) | **9.9 (15.7/11.2)** (10% decrease) |
| | *Percentage of adults who are obese (BRFSS)* | **28.1** (2012) | African American | **28.1 (38.1)** (2012) | **25.3 (34.3)** (10% decrease) |
| MEDIAN HOUSEHOLD INCOME | *Median household income* | **$58,693** (2009-2013) | SCC | **$58,693** (2009-2013) | **$64,562** (10% increase) |
| PERSONS IN POVERTY | *Percentage of population living in households with income below the Federal Poverty Level (FPL)* | **10.8** (2009-2013) | SCC | **10.8** (2009-2013) | **9.7** (10% decrease) |
| CHILDREN IN POVERTY | *Percentage of children age 0-17 living in households with income below the Federal Poverty Level (FPL)* | **15.8** (2009-2013) | SCC | **15.8** (2009-2013) | **14.2** (10% decrease) |
| EDUCATION - LESS THAN HIGH SCHOOL DIPLOMA OR EQUIVALENT | *Percentage of persons aged 25 and older with less than a high school education* | **12.0** (2009-2013) | SCC | **12.0** (2009-2013) | **10.8** (10% decrease) |
| **BUILT ENVIRONMENT, ECONOMIC DEVELOPMENT, HO USING** | | | | | |
| HOUSING COST BURDEN | *Percentage of households whose housing costs are at least 35% of household income* | **34.4** (2009-2013) | SCC | **34.4** (2009-2013) | **32.7** (5% decrease) |
| UNEMPLOYMENT | *Percentage of civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)* | **10.6** (2009-2013) | SCC | **10.6** (2009-2013) | **9.5** (10% decrease) |
| **BEHAVIORAL HEATLH** | | | | | |
| BEHAVIORAL HEALTH HOSPITALIZATIONS | *Crude hospitalization rate due to behavioral health disorders for all discharges with a SCC zip code from any Illinois hospital ( IDPH)* | **827.1** per 100,000 (2010-14) | SCC | **827.1** per 100,000 (2010-14) | **744.4** per 100,000 (10 % decrease ) |
| DAYS OF MENTAL HEALTH NOT GOOD - ADULTS | *Average number of days during the past 30 days adults aged ≥18 years reported their mental health as not good. (BRFSS)* | **3.2 days** (2012) | SCC | **3.2 days** (2012) | **2.9 days** (10% decrease ) |
| DAYS OF MENTAL HEALTH NOT GOOD - YOUTH | *Percentage of high school students who reported feeling sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the past 12 months. (YRBS)* | **26.9** (2010) | African American / Hispanic females | **42.4/41.5** (2010) | **40.3/39.4** (5% decrease) |
| LACK OF SOCIAL OR EMOTIONAL SUPPORT | *Percentage of adults aged 18 or older who report never, rarely or sometimes receive the social, emotional support they need. (BRFSS)* | **33.5** (2012) | SCC | **33.5** (2012) | **36.9** (10% increase) |
| PRIMARY CARE UTILIZATION | *Percentage of adults who visited a doctor or health care provider for a routine checkup in the past year (BRFSS)* | **TBD** | SCC | **TBD** | **TBD** (10% increase ) |
| CHILDREN READY FOR SCHOOL | *Proportion of children who are ready for school.(HP2020: NSCH: National Survey of Children's Health)* | **TBD** | SCC | **TBD** | **TBD** |
| ACCESS TO CARE | *Rate of children with access to a medical home. (National Survey of Children's Health).* | **TBD** | SCC | **TBD** | **HP2020: 61.5%; TBD in SCC** (10% increase ) |
| **CHRONIC DISEASE** | | | | | |
| FRUIT & VEGETABLE SERVINGS | *Percentage of high school students who ate fruits and vegetables five or more times per day during the past seven days (YRBS)* | **19.5** (2010) | SCC | **19.5** (2010) | **21.5** (10% increase ) |
| | *Percentage of adults who reported consuming less than five fruit and vegetable servings* | **84.9** (2012) | SCC | **84.9** (2012) | **76.4** (10% decrease ) |
| PHYSICAL ACTIVITY | *Percentage of students who were physically active for a total of at least 60 minutes per day on 7 of the past seven days (YRBS)* | **22.7** (2010) | SCC | **22.7** (2010) | **25.0** (10 % increase ) |
| | *Percent of adults aged ≥18 years who report participating in no physical activity or exercise, other than what is done during one's regular job, such as running, calisthenics, golf, gardening, or walking during the preceding month* | **25.7** (2012) | SCC | **25.7** (2012) | **24.4** (5% decrease ) |
| SMOKING | *Percentage of high school students who currently smoke cigarettes (YRBS)* | **12.0** (2010) | SCC | **12.0** (2010) | **10.8** (10% decrease) |
| | *Percentage of adults who currently smoke cigarettes* | **14.4** (2012) | SCC | **14.4** (2012) | **13.7** (5 % decrease ) |
| SODA CONSUMPTION | *Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day during the past seven days (YRBS)* | **23.7** (2010) | African American / Hispanic | **26.0 / 29.3** (2010) | **22.5 (24.7/27.8)** (5 % decrease ) |
| BREASTFEEDING | *Percent of babies exclusively breastfed at hospital discharge* | **61.6** (2014) | SCC | **61.6** (2014) | **67.8** (10 % increase ) |

## Health Equity

**Outcome objective 1:** By 2020, reduce disparity in life expectancy by 10%. (SCC Place disparity: Municipality life expectancy quartile difference (Q1/high-Q4/low) – Baseline 7.4 years. Target SCC Place Disparity: 6.7 years)

**Impact Objective 1:** By 2018, reduce by 5% the percentage of households whose housing costs are 35% or more of household income. (SCC Baseline: 34.4%; Target: 32.7%)

**Impact Objective 2:** By 2018, reduce the unemployment rate by at least 10%. (SCC Baseline: 10.6%; Target: 9.5%)

**Impact Objective 3:** By 2018, reduce the percentage of persons age 25 or older with less than a high school education by 10%. (SCC Baseline: 12.0%; Target: 10.8%)

## Chronic Disease

**Outcome Objective 1:** By 2020, reduce the obesity prevalence by 10%. (SCC: African American Baseline: 38.1%; Target: 34.3%. Hispanic Baseline: 20.1%; Target 18.1%. White Baseline: 23.0; Target 20.7%)

**Impact Objective 1:** By 2018, decrease the percentage of adults who report consuming less than five fruit and vegetable servings by 5%. (SCC Baseline: 84.9%; Target: 76.4%)

**Impact Objective 2:** By 2018, increase the percentage of students who were physically active for at least 60 minutes per day by 10%. (SCC Baseline: 22.7%; Target: 25.0%)

## Behavioral Health

**Outcome Objective 1:** By 2020, reduce hospitalizations due to behavioral health disorders by 10%. (SCC Baseline: 827.1 per 100,000: Target: 744.4 per 100,000).

**Impact Objective 1:** By 2018, reduce the number of days in the past 30 days that adults reported their mental health as not good by 10%. (SCC Baseline: 3.2days: Target: 2.9days).

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# Abbreviations & Acronyms

| | |
|---|---|
| ACA | Affordable Care Act |
| ACE | Adverse Childhood Experiences |
| AHAC | Alliance for Healthy and Active Communities |
| APHA | American Public Health Association |
| APORS | Adverse Pregnancy Outcome Reporting System |
| ASTHO | Association of State and Territorial Health Officers |
| BRFSS | Behavioral Risk Factor Surveillance Survey |
| CMAP | Chicago Metropolitan Agency for Planning |
| CC | Cook County |
| CCDOTH | Cook County Department of Transportation and Highways |
| CCDPH | Cook County Department of Public Health |
| CCHHS | Cook County Health and Hospitals System |
| CDC | Centers for Disease Control and Prevention |
| CHD | Coronary Heart Disease |
| CHE | Collaborative for Health Equity Cook County |
| CHA | Community Health Assessment |
| CHIP | Community Health Improvement Plan |
| CHSA | Community Health Status Assessment |
| CSDH | Commission on the Structural Determinants of Health (WHO) |
| CTSA | Community Themes and Strengths Assessment |
| DHS | Department of Human Services |
| EPHS | Essential Public Health Services |
| ES | Essential Service |
| FOCA | Forces of Change Assessment |
| HACC | Housing Authority of Cook County |
| HICCC | Health Impact Collaborative of Cook County |
| HiAP | Health in All Policies |
| HIE | Health Information Exchange |
| HP2010 | Healthy People 2010 |
| HP2020 | Healthy People 2020 |
| ICE | Index of Concentration at the Extremes |
| IDPH | Illinois Department of Public Health |
| IPLAN | Illinois Project for Local Assessment of Needs |
| LGBTQ | Lesbian, gay, bisexual, transgender and queer individuals/identities |
| LPHS | Local Public Health System |
| MAPP | Mobilizing for Action through Planning and Partnerships |
| NACCHO | National Association of City and County Health Organizations |
| NAP SACC | Nutrition and Physical Activity Self-Assessment for Child Care program |
| P.E. | Physical Education |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SCC | Suburban Cook County |
| SHIP | State Health Improvement Plan |
| SNAP | Supplemental Nutrition Assistance Program |
| YRBS | Youth Risk Behavior Survey |
| USDA | United States Department of Agriculture |
| WHO | World Health Organization |
| WIC | Women, Infants and Children supplemental nutrition program |

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