Moving the Needle Forward

Collaborating on a County-wide Community Health Needs Assessment

Friday, September 6, 2019

ALLIANCE for HEALTH EQUITY

Hospitals and Communities
Improving Health Across
Chicago and Cook County

Agenda

ALLIANCE for HEALTH EQUITY
Hospitals and Communities Improving Health Across Chicago and Cook County

1. Introduction
2. Overview of the Alliance for Health Equity CHNA
   A. Process and Partnerships
   B. Data, Community Engagement and Input
3. Priority Community Health Issues
4. Partnering on Implementation Strategies to Advance Health Equity

Jackie Rouse, Advocate Aurora Health and Steering Committee, Alliance for Health Equity

Andi Goodall,
Illinois Public Health Institute

Presenters

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Sheri Cohen, MPH
Senior Health Planning Analyst
Chicago Department of Public Health

Kelli Day, MPH
Director of Operations, Healthy Communities
Ann & Robert H. Lurie Children's Hospital of Chicago

Catina Latham, PhD
Director, Community Benefit and Evaluation
University of Chicago Medicine

Christopher Nolan, MPA
System Manager, Community Health and Benefit
Rush University Medical Center

Jackie Rouse, MHA, DrPH
Director, Community Health, South Chicagoland
Advocate Aurora Health

Jameika Sampson, MPH, MBA
Director of Community Health and Well-Being
Mercy Hospital & Medical Center

Jess Lynch, Leah Barth, Andi Goodall
Illinois Public Health Institute

POLL QUESTION

What type of organization are you representing?

A. Healthcare Organization

B. Community-based Organization

C. Health Department

D. Other

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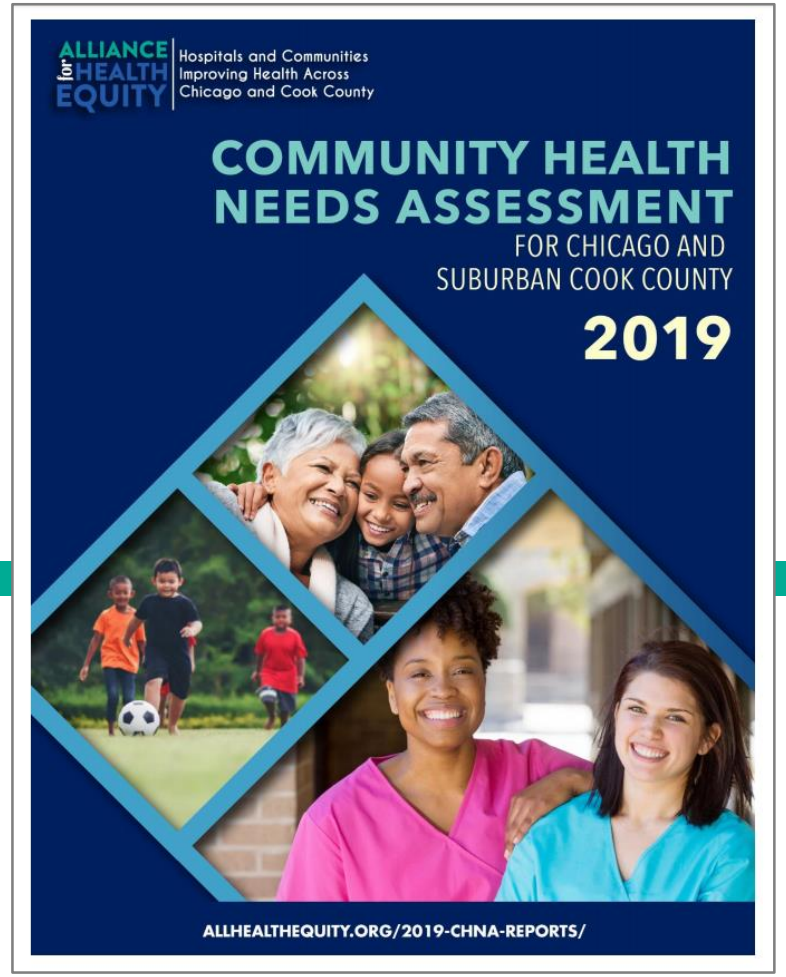
Alliance for Health Equity



Jess Lynch, Illinois Public Health Institute

Collective Purpose

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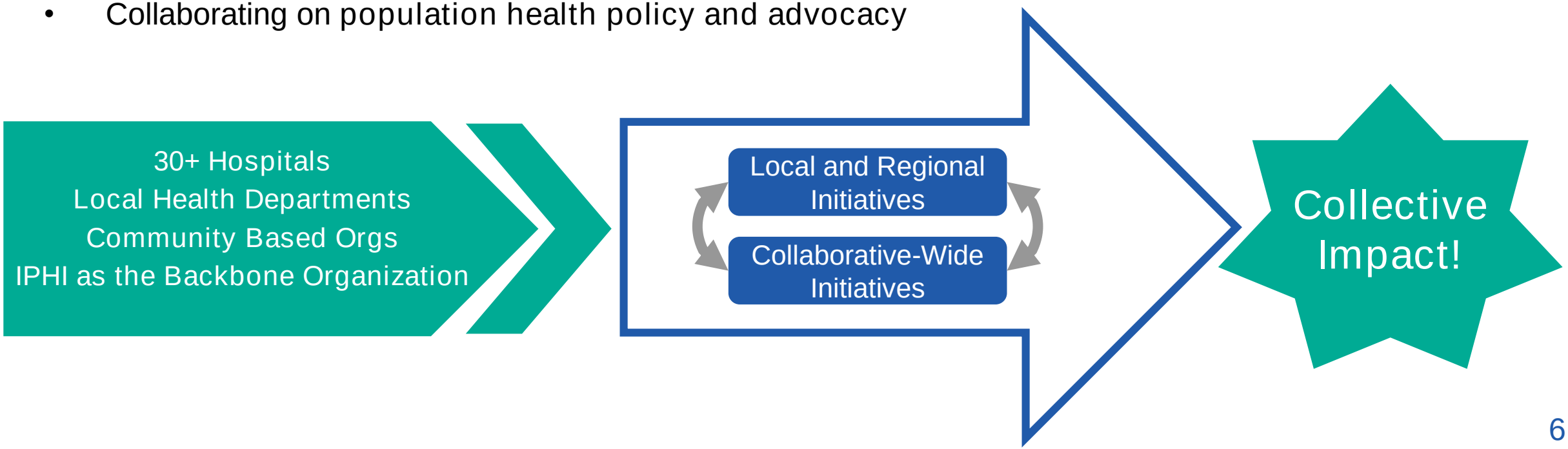
Improve population and community health by:

- Advancing health equity
- Capacity building, shared learning, and connecting local initiatives
- Addressing social and structural determinants of health
- Developing broad city/county wide initiatives and creating systems
- Engaging community partners and working collaboratively with community leaders
- Developing data systems for population health to support shared impact measurement and community assessment
- Collaborating on population health policy and advocacy



Current Hospital Members

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- Ann & Robert H. Lurie Children's Hospital of Chicago
- AT THE FOREFRONT UChicago Medicine Ingalls Memorial
- Norwegian American Hospital "...Committed to your health"
- SINAI Sinai Health System
- AdvocateAuroraHealth
- Loretto Hospital
- Northwestern Medicine
- South Shore hospital
- AMITA HEALTH
- LOYOLA MEDICINE We also treat the human spirit.
- PALOS HEALTH
- Swedish Covenant Hospital
- COOK COUNTY HEALTH
- LOYOLA MEDICINE MacNeal Hospital
- Roseland Community Hospital
- AT THE FOREFRONT UChicago Medicine
- HOLY CROSS HOSPITAL
- MERCY Mercy Hospital & Medical Center
- RUSH
- UI Health UIC

ILLINOIS PUBLIC HEALTH INSTITUTE
HEALTHY CHICAGO CHICAGO DEPARTMENT OF PUBLIC HEALTH
Cook County DEPT. of Public Health Promoting health. Preventing disease. Protecting you.

Examples of Additional Partners

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Health & Medicine POLICY RESEARCH GROUP

HH Center for Housing & Health

WEST SIDE UNITED: Building Blocks to Better Health

The CATHOLIC CHARITIES OF THE ARCHDIOCESE OF CHICAGO

GREATER CHICAGO FOOD DEPOSITORY

Moving Health Care Upstream — Collaborating. Innovating. Improving Community Health.

DBSA Depression and Bipolar Support Alliance

CSH

Access Community Health Network

Christian Community Health Center

Centros de Salud erie Family Health Centers

HEARTLAND ALLIANCE HEALTH — HEARTLAND HEALTH OUTREACH, INC

CHICAGO FOOD POLICY ACTION COUNCIL

CHICAGO BOTANIC GARDEN — Windy City Harvest

NAOMI RUTH COHEN Institute for Mental Health Education at The Chicago School of Professional Psychology

IAFP

PROVISO PARTNERS FOR HEALTH

BEYOND HUNGER

CareAdvisors

THRESHOLDS — HOME | HEALTH | HOPE

Maryville — Caring for Children. Strengthening Families.

Strengthening Chicago's Youth — Ann & Robert H. Lurie Children's Hospital of Chicago

Sertoma Centre, Inc.

LUCHA — ADVANCING HOUSING AS A HUMAN RIGHT

Consortium to Lower Obesity in Chicago Children — clocc

ENLACE CHICAGO

SWOP — THE SOUTHWEST ORGANIZING PROJECT — EL PROYECTO ORGANIZADOR DEL SUROESTE

Green & Healthy Homes Initiative

NAMI National Alliance on Mental Illness — South Suburbs of Chicago

Enterprise housing FORWARD — ending homelessness

American Academy of Pediatrics — DEDICATED TO THE HEALTH OF ALL CHILDREN — Illinois Chapter

RESPIRATORY HEALTH ASSOCIATION

SHRIVER CENTER — Sargent Shriver National Center on Poverty Law

AHS FAMILY HEALTH CENTER

NAMI CHICAGO

SINAI URBAN HEALTH INSTITUTE SUHI

ADLER UNIVERSITY

ChangeLab Solutions — Law & policy innovation for the common good.

IHC ILLINOIS HOUSING COUNCIL

GARFIELD PARK COMMUNITY COUNCIL

The Center for Faith and Community Health Transformation

ICIRR ILLINOIS COALITION FOR IMMIGRANT AND REFUGEE RIGHTS

Lewis College of Human Sciences — ILLINOIS INSTITUTE OF TECHNOLOGY

ILLINOIS PUBLIC HEALTH INSTITUTE

HEALTHY CHICAGO — CHICAGO DEPARTMENT OF PUBLIC HEALTH

Cook County Dept. of Public Health — Promoting health. Preventing disease. Protecting you.

What is a Community Health Needs Assessment?

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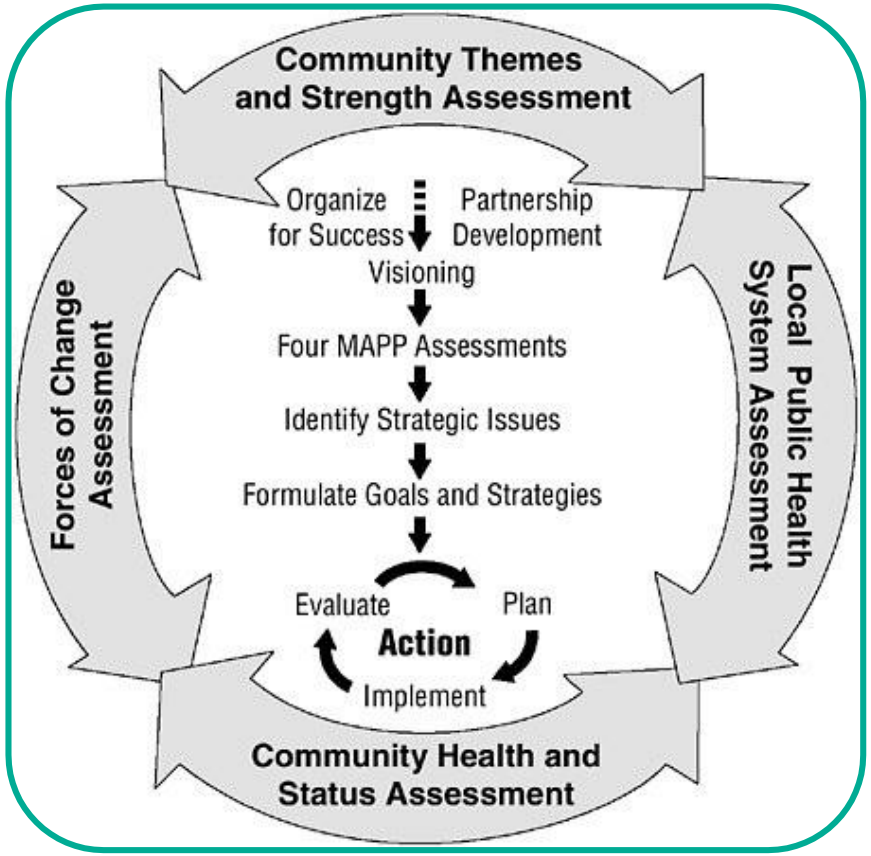
- CDPH and CCDPH have been working with partners on Community Health Assessment and Community Health Improvement Plans for 20+ years
- Starting in 2012, non-profit hospitals have been required to conduct CHNAs under the Affordable Care Act (ACA) every 3 years, in partnership with communities. And, hospitals also develop a community health implementation strategy.
- 2016-2017 was the first time multiple hospitals and health departments worked together on CHNA in Chicago/Suburban Cook County
- The 2018-2019 CHNA builds on the previous CHNAs as well as Healthy Chicago 2.0 and Cook County WePLAN

MAPP Assessment and Planning Process

Mobilizing for Action through Planning and Partnerships (MAPP)



Source: National Association of County and City Health Officials

CHNA and Implementation Process for Hospitals

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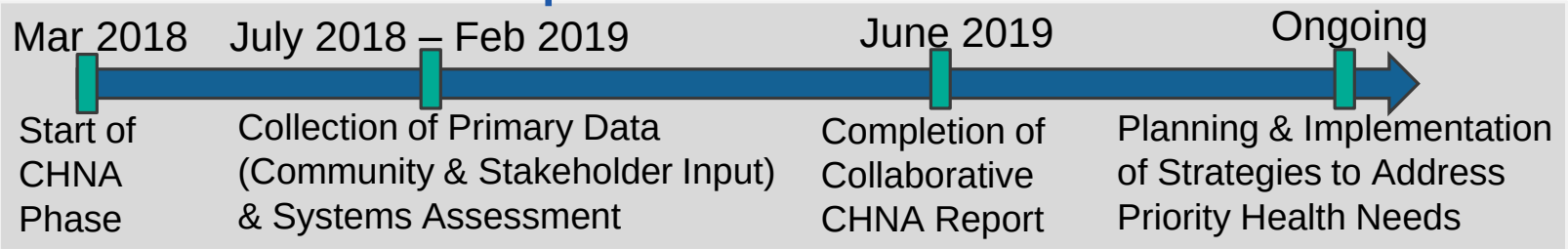

Community Health Needs Assessment

County-wide priority health issues

Selection of hospital priorities (Alliance priorities or a subset)

Implementation

Inputs

- Community input collected through surveys and focus groups
  - 5,934 community input surveys
  - 52 focus groups/Learning Map Sessions
- Input from existing AHE workgroups and committees
- Population data collected by health departments
- Assessments, plans, and data sources developed by external organizations
- Existing research

Considerations

- Health equity
- Data-driven
- Community priorities
- Urgency
- Feasibility
- Existing priorities
- Alignment with work of health departments, other hospitals, and community partners

Process

- Outline how hospitals will implement selected priorities
- Develop new partnerships or expand existing partnerships around selected priorities
- Create shared metrics and goals
- Implement new or support existing programs and projects
- Track progress
- Report on progress during next CHNA cycle (2022)

The BARHII Health Equity Framework

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Source: BARHII http://barhii.org/framework/

Timelines – Health Department Community Health Assessment and Planning

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Chicago Dept. of Public Health

CDPH and CCDPH are on different timelines for their respective accreditation cycles and dates for community health assessment and plans

These timelines are intended for high-level reference, they are not official City or County documentation

Fall 2018

Partnership for a Healthy Chicago begins meeting for assessment/ planning process (directly incorporating components of AHE CHNA)

Winter/Spring 2018-2019

Additional public health system assessments

Community townhall sessions

Partnership works to identify/prioritize strategic issues

Summer/ Fall 2019

Healthy Chicago 2025 action planning workgroups

Late 2019/ Early 2020

Launch of Healthy Chicago 2025 strategies

Cook County Dept. of Public Health

Fall 2019

CCDPH and public health system partners begin meeting in Suburban Cook County for assessment/ planning process (directly incorporating components of AHE CHNA)

Fall 2019 - Spring 2020

Fall/Winter: Community and stakeholder engagement

Spring: Partners work to identify/ prioritize strategic issues

Summer/ Fall 2020

Suburban Cook County action planning

Late 2020

Launch of next Suburban Cook County community health improvement plan

How to find the CHNA Report

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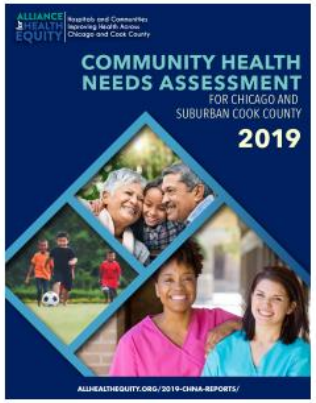
The collaborative CHNA Report can be found on the Alliance for Health Equity website here: https://allhealthequity.org/projects/2019-chna-reports/

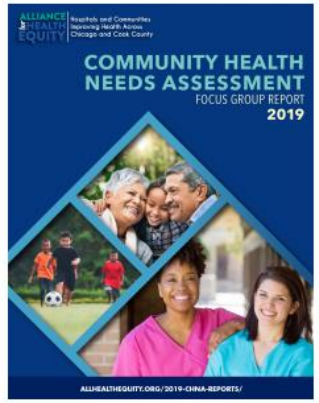
The webpage looks like this:

2019 Community Health Needs Assessment

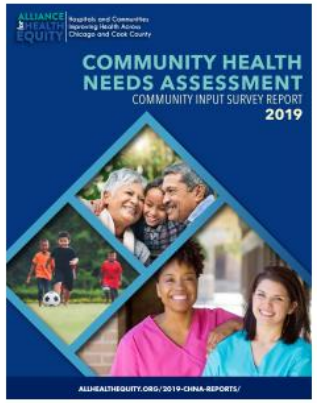
In 2019, the Alliance for Health Equity completed a collaborative Community Health Needs Assessments (CHNA) for Chicago and Suburban Cook County. The report builds on the previous assessments and allows partners to identify strategic priorities that they can collectively address to improve community health. You can access a copy of the report and the appendices by clicking below.



2019 CHNA Report



Focus Group Report



Community Input Survey Report

Find the individual hospital CHNAs **here.**

The individual hospital CHNA reports can be accessed from the collaborative CHNA page and through a direct link (https://allhealthequity.org/projects/2019-chna-reports/2019-hospital-chnas/)

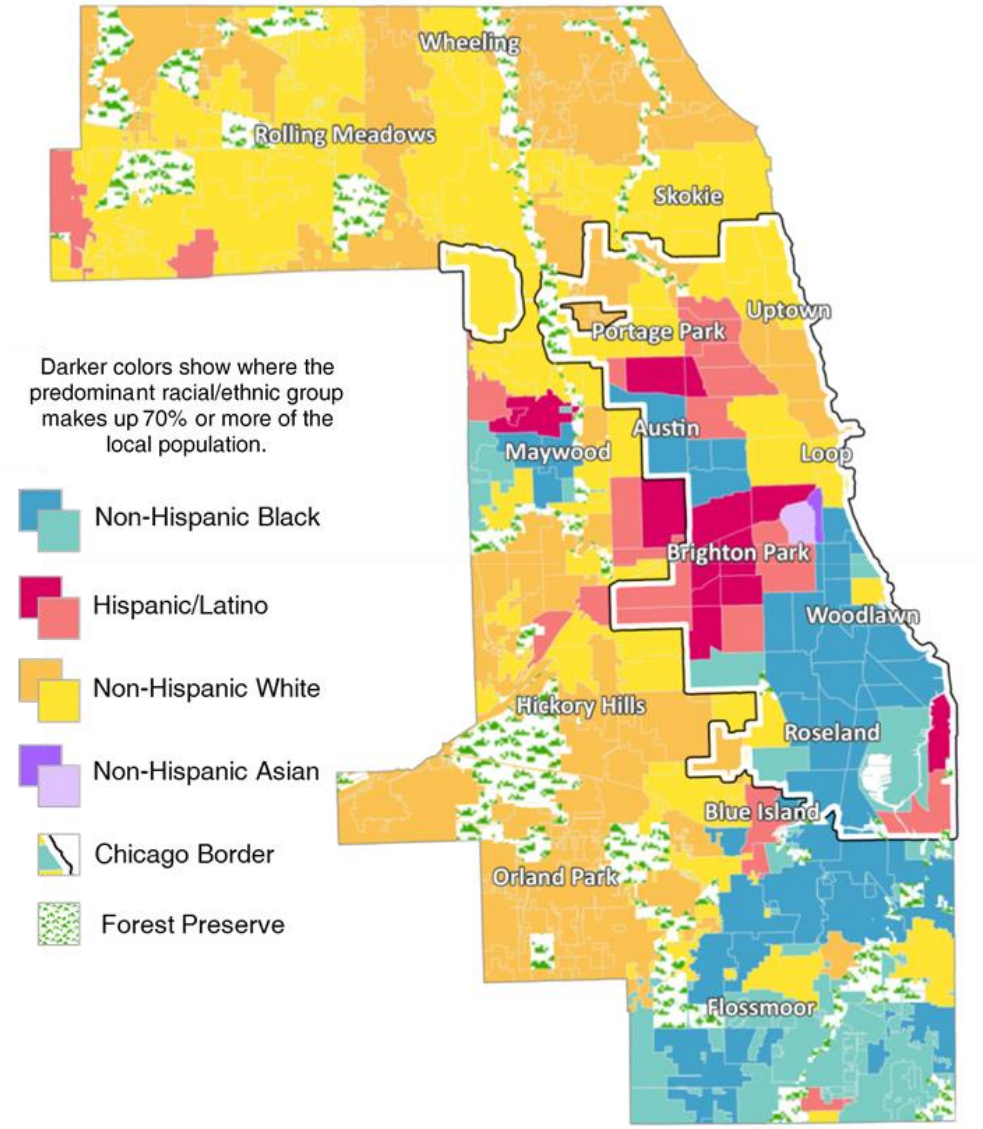
CHNA Overview

Community input is integrated into every chapter of the CHNA

CHNA Outline

- Introduction
- Collaborative assessment model, methods, and process
- Priority Community Health Issues
- Overview of Health Inequities
- Social and Structural Determinants of Health
- Access to Quality Health Care
- Mental Health and Substance Use Disorders
- Chronic Conditions
- Conclusion
- References

Predominant racial and ethnic groups in Cook County, Illinois (2016, 5-year estimates)



U.S. Census Bureau, American Community Survey, 2012-2016

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Community Input Driving the CHNA

Primary Data and Community Input

Recorded: June 13, 2019

Leah Barth & Andi Goodall, Illinois Public Health Institute

Community Input

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Community input for the CHNA was collected through four methods:

- Community input surveys
- Community resident focus groups and learning map sessions
- Health care and social service provider focus groups
- Two stakeholder assessments led by Chicago Department of Public Health and Cook County Department of Public Health
  - Forces of Change Assessment
  - Health Equity Capacity Assessment

Purpose of collecting community input

To gather community feedback on:

- The current health status of communities
  - What do communities think are the best things about where they live, work, or play?
  - What is making communities healthy or unhealthy?
  - What are the top health needs or issues in different communities?
- Barriers or facilitators to a healthy community
  - How easy or hard is it to access health care or behavioral health care?
  - What types of programs and services are available in your community?
  - How do we improve health equity—social and economic strategies?
- Strategies for addressing health needs
  - What are community priorities around what is most important to improve?
  - How can hospitals, health departments, and community-based organizations work together to address health needs?
  - What role do communities see themselves playing in solutions?

Community Participants

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Alliance for Health Equity partners focused on gathering input from communities that are usually underrepresented in assessment processes and who face a disproportionate burden of health inequities.

Examples of the communities and populations that were focused on for survey collection and focus group participation

- LGBTQ+
- People with Disabilities
- Youth & Young Adults
- Homeless Youth & Adults
- Low-Income Families with Children
- Immigrants
- People Living with Mental Illness
- Veterans
- Justice Involved Youth & Adults
- Adults & Youth with Asthma
- Older Adults
- People Living with Substance Use Disorders
- Faith Communities
- Communities of Color
- Adults with Diabetes

Community Input – Survey

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5,934 surveys collected from August 2018-February 2019

Key Data Collection Strategies

Partner with organizations in key communities

By working with organizations already ingrained in priority communities, the Alliance for Health Equity was able to collect more surveys and increase capacity.

Discuss survey collection with partners to find the best approaches

Multiple meetings were held between the Alliance for Health Equity team and community organizations to determine the best approaches to collecting survey responses.

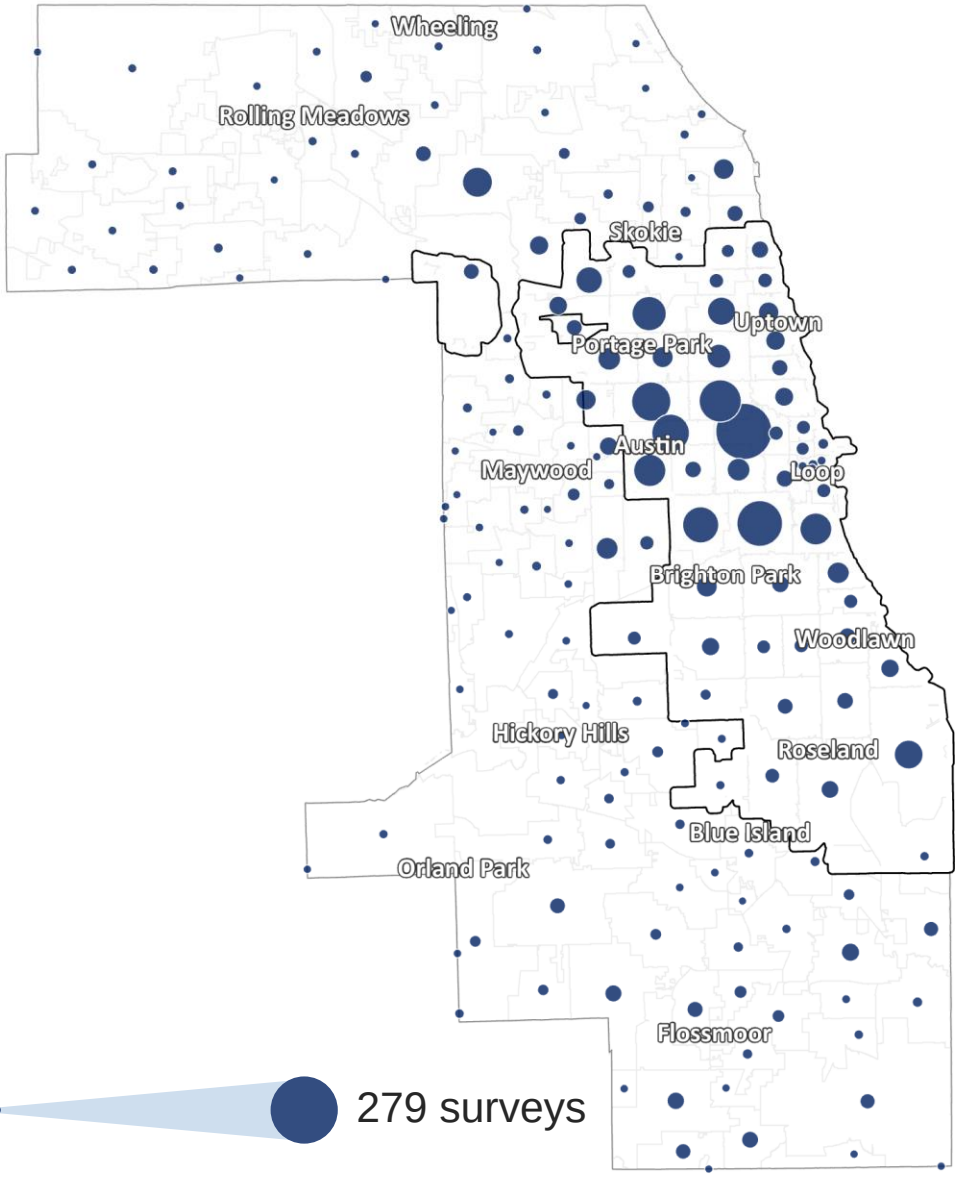
Translate the survey tool

The community input survey was translated into Spanish, Chinese, Polish, and Ukrainian

Priority Populations

- Communities of color
- Immigrant communities
- Low-income communities
- LGBTQ+ community members
- Individuals with disabilities

Geographic distribution of survey respondents



1 survey — 279 surveys

Community Input – Survey

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5,934 surveys collected Cook County-wide

County-wide Summary:

- 568 in Spanish
- 157 in Chinese
- 104 Polish+
- 1,561 responses from those with someone in the household with a disability
- 386 responses from the LGBTQ+ community
- 1,784 responses from individuals in households with <$20K income

+ Polish surveys include both surveys completed in Polish and respondents who selected Polish as an ethnicity.

Top 5 Most Important Factors for a Healthy Community

- Access to health care & mental health services
- Safety and low crime
- Access to community services
- Access to healthy food
- Affordable housing

Top 5 Most Important Health Problems

- Diabetes
- Mental Health
- Age-related Illness
- Substance Use
- Heart Disease and Stroke

What is one thing that you would like to see improved in your community? (open-ended)

- Safety and Low Crime
- Economic Development
- Infrastructure
- Community Cohesion
- Health Care

What are the greatest strengths in the community where you live? (open-ended)

- Community Cohesion
- Community Services
- Safety and Low Crime
- Transportation
- Education

Community Input – Survey

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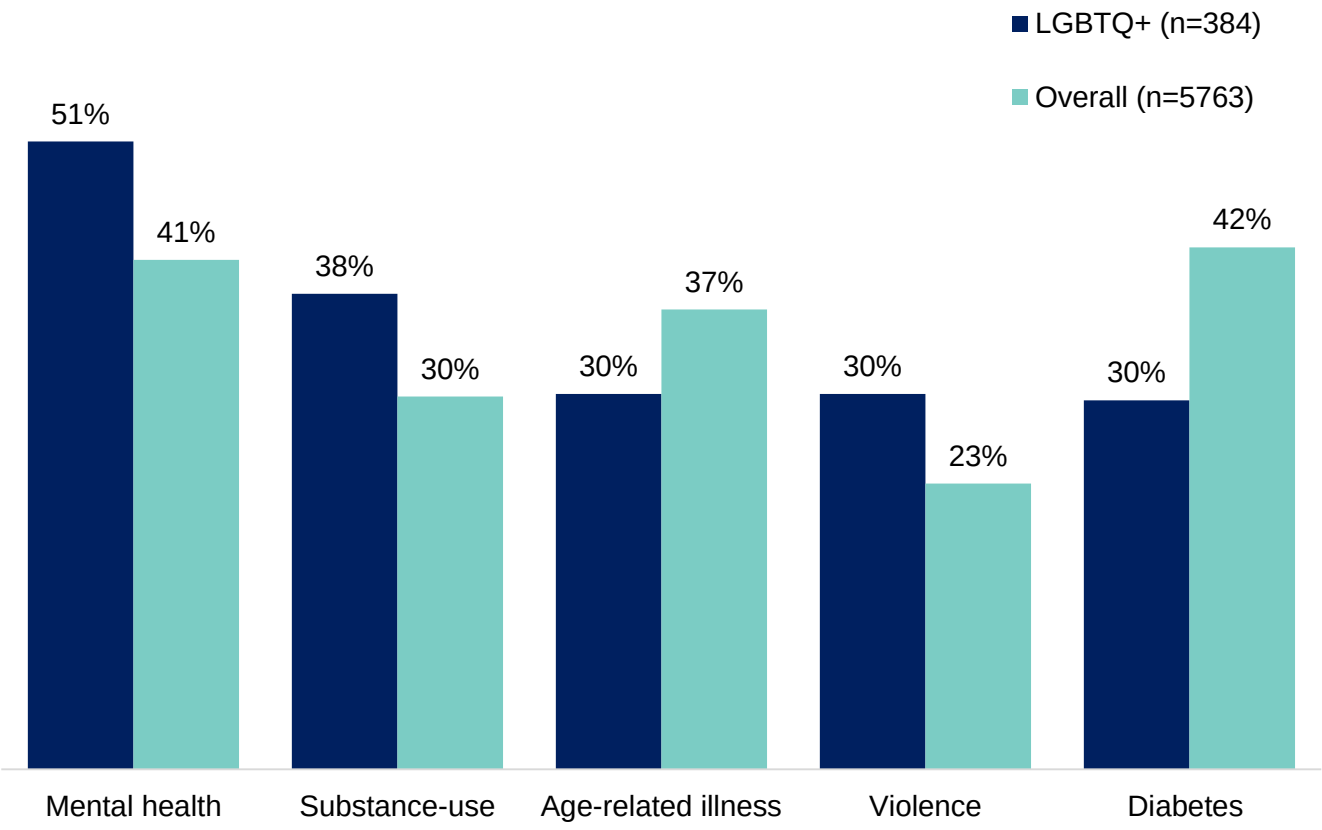
Comparison data example
LGBTQ+ respondents compared to total respondents

What do you think are the three most important health problems in your community?



Most Important Health Problems	Overall (n=5763)	LGBTQ+ (n=384)
Age-related illness	37%	30%
Cancers	27%	20%
Child abuse	5%	4%
Dental problems	12%	11%
Diabetes	42%	30%
Heart disease and stroke	27%	20%
Infectious diseases	5%	6%
Lung disease	8%	7%
Mental health	41%	51%
Mother and Infant health	6%	7%
Motor vehicle crash injuries	6%	5%
Obesity	23%	23%
Other	4%	2%
STIs/STDs, including HIV	8%	23%
Substance-use	30%	38%
Violence	23%	30%

Community Input – Survey

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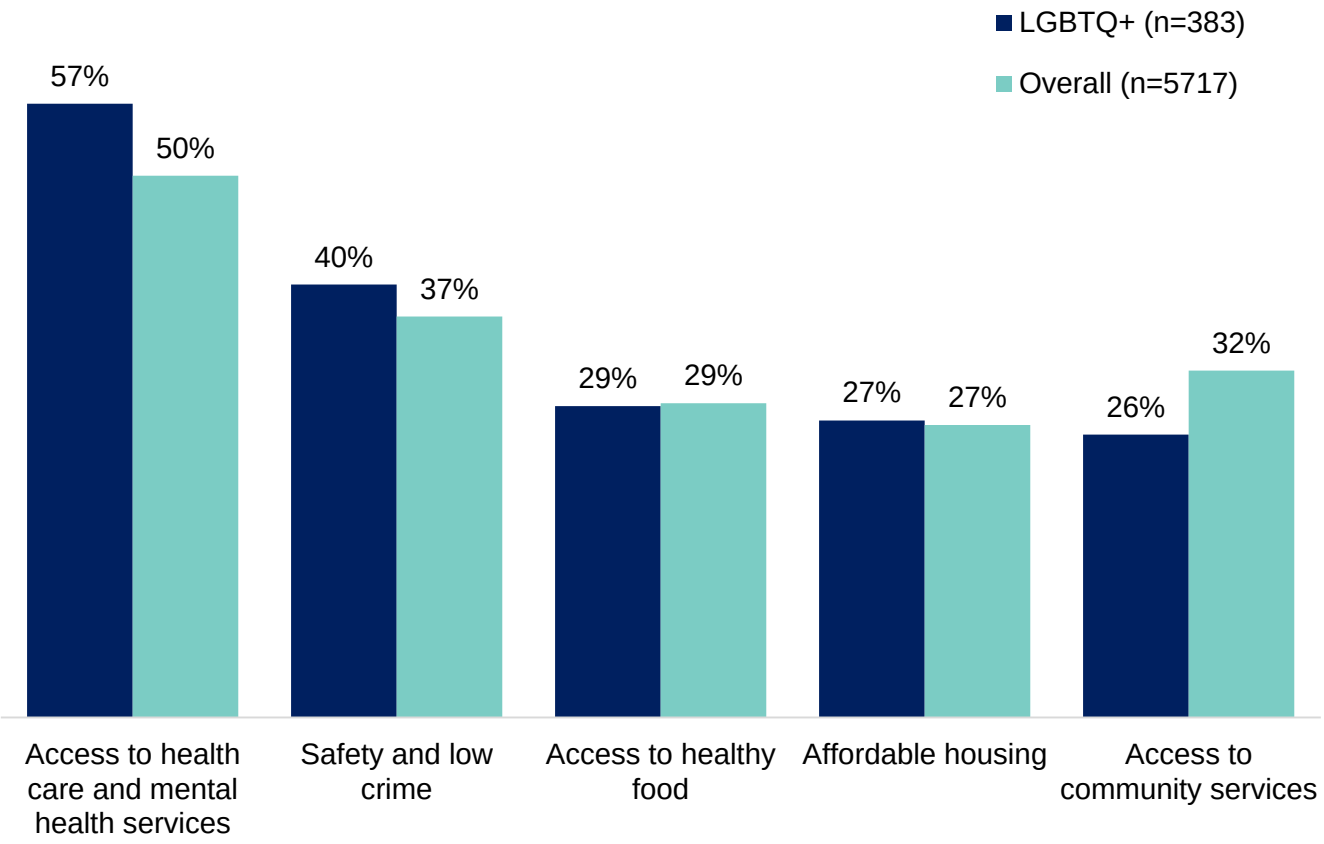
Comparison data example
LGBTQ+ respondents compared to total respondents

What do you think are the three most important things necessary for a healthy community?



Most important factors for a healthy community	Overall (n=5717)	LGBTQ+ (n=383)
Access to community services	32%	26%
Access to health care and mental health services	50%	57%
Access to healthy food	29%	29%
Access to transportation	17%	12%
Affordable childcare	8%	7%
Affordable housing	27%	27%
Arts and cultural events	6%	8%
Clean environment	18%	19%
Diversity and inclusion	8%	15%
Good schools	21%	16%
Other	1%	1%
Parks and recreation	12%	8%
Quality job opportunities	18%	17%
Religion or spirituality	11%	6%
Safety and low crime	37%	40%
Strong community cohesion and social networks	12%	16%
Strong family life	13%	10%

Community Input – Survey

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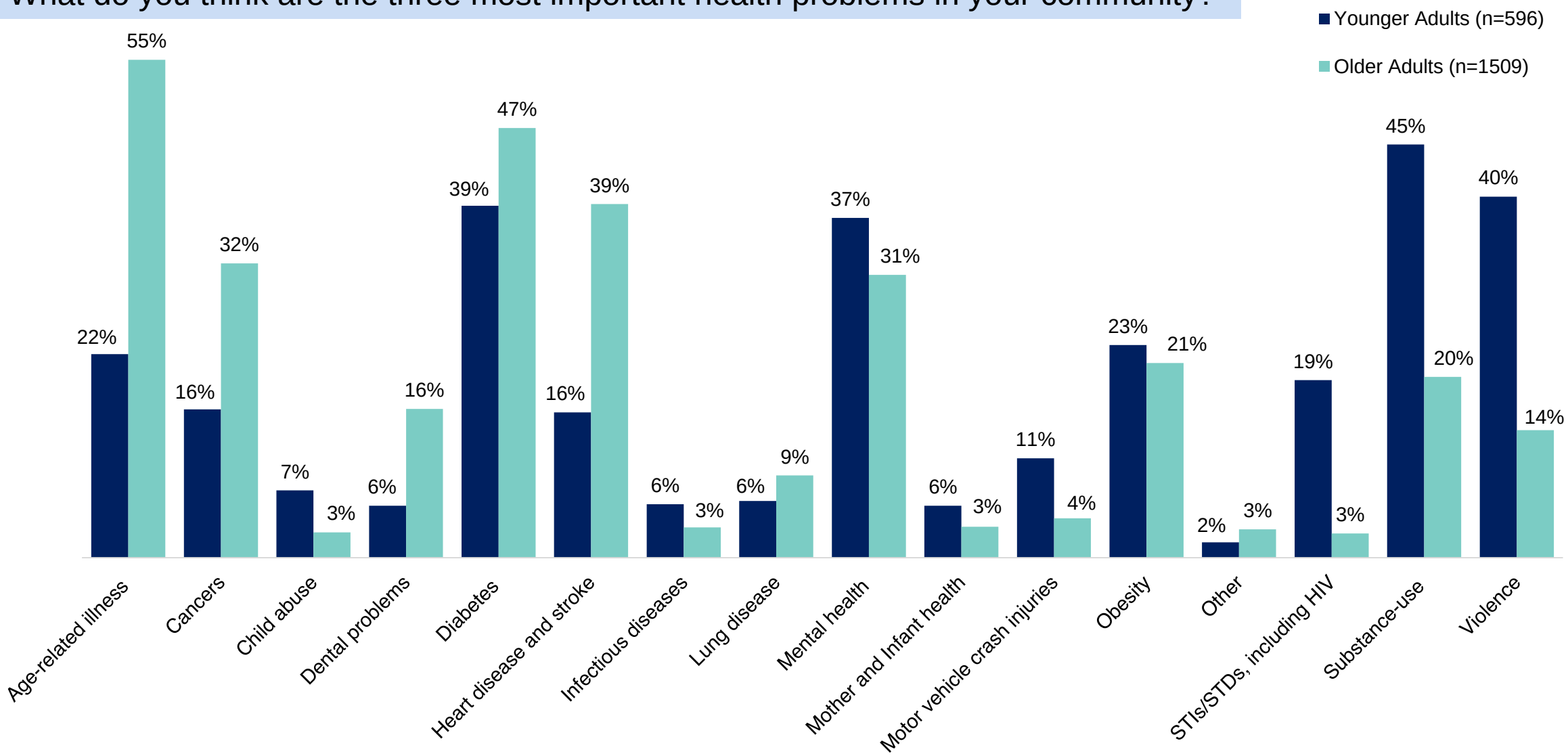
Comparison data example

Younger Adult respondents (18-24) compared to Older Adult respondents (65+)

What do you think are the three most important health problems in your community?



Community Input – Survey

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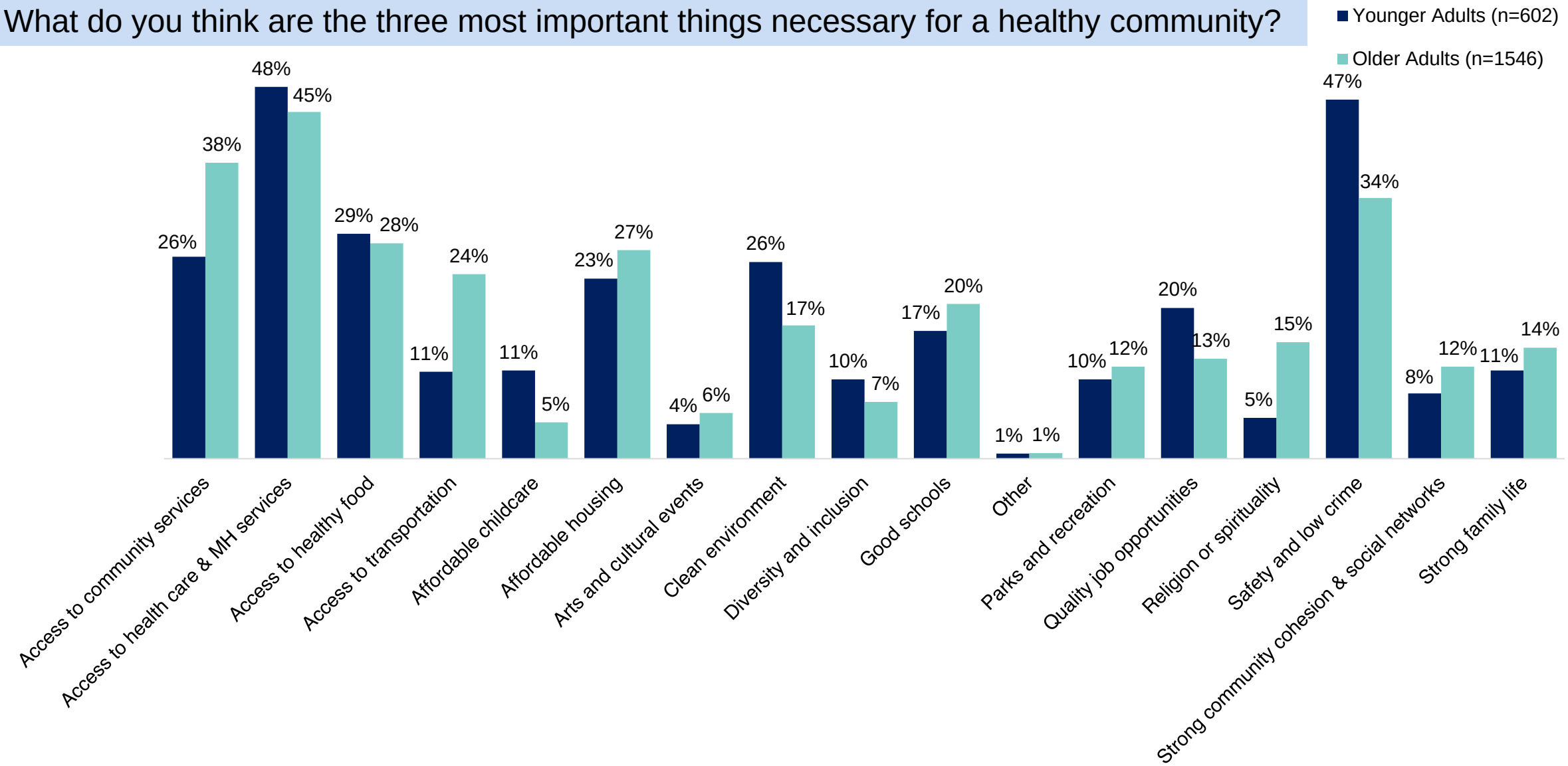

Focus Group Input

57 Focus Groups and Learning Map Sessions Completed

- 31 Focus groups conducted by AHE; 21 Learning Map Sessions conducted by West Side United, with AHE notetaker; 5 Focus groups completed with service providers and community leaders

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Focus Group Host Organizations

ABJ Services	Greater Galilee Baptist Church
Affinity Community Services	Habilitative Systems
After School Matters (2 groups)	Hanul Family Alliance
Alivio Medical Center	Housing Forward - Tenant's Club Meeting
AMITA Saints Mary and Elizabeth Medical Center	Kedvale New Mount Zion M.B. Church
Asian Human Services Family Health Center	Maine Community Youth Assistance Foundation
Breakthrough	NAMI Chicago family members
BUILD, Inc.	NAMI Chicago individuals with lived experience
By the Hand	New Moms (2 groups)
Chicago Public Library - Austin-Irving Park	New Morning Star MB Church (2 groups)
Chicago Public Library - Edgebrook Branch	Northwest Side Housing Center
Chicago Public Library - Jefferson Park Branch	Oak Park River Forest Food Pantry
Chicago Public Library - Oriole Park Branch	Oakley Square Apartments (3 groups)
Chicago Youth Programs	PLOWS Council on Aging
CJE SeniorLife	Restoration Ministries
Coalition of Hope	Rich Township VFW Post 311
CristoRey High School	Saint Stephen AME
Deborah's Place	Solutions for Care
El Valor	Southwest Organizing Project (2 groups)
Enlace Chicago	Teen Living Program
Evanston General Assistance (2 groups)	Temple of Faith MB Church
Friedman Place	Theace Goldsberry Community House (2 groups, parents and youth)
Frisbie Senior Center	TCA Health, Inc.
Garfield Park Community Council	Timothy Community Corporation
Gary Comer Youth Center	UCAN (2 groups, community residents and youth)

Community Leader and Provider Focus Groups

Faith Leaders (Countywide)
Immigrant service providers
South Shore Hospital community service providers
Swedish Covenant Hospital community service providers
MacNeal Hospital health care providers

What Communities Told Us

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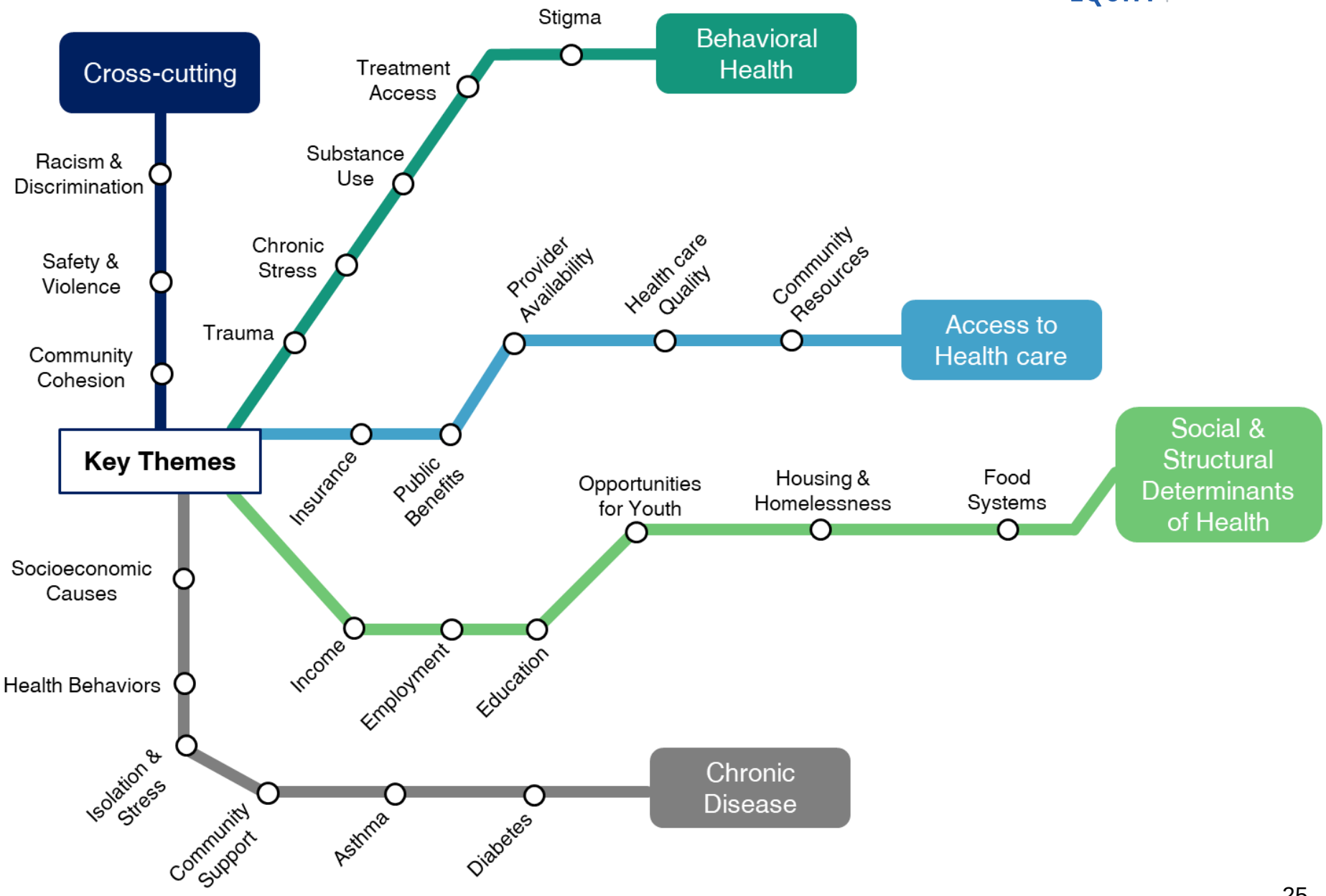
Key Themes

- Cross-Cutting
  - Racism & Discrimination
  - Safety & Violence
  - Community Cohesion
- Behavioral Health
- Access to Health Care
- Social & Structural Determinants of Health
- Chronic Disease



Focus Group Results – Mental Health & Substance Use

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Key Topics Discussed Related to Mental Health and Substance Use Disorders

- Chronic stress and trauma are underlying root cause of poor health outcomes and social determinants such as violence
- Homelessness, mental illness, stress, and trauma were identified as both root causes and direct outcomes of substance use disorders
- A lack of mental health awareness and education leads to stigma, worsening of mental illness and substance use disorders, poor overall health, and lost lives
- Providers and communities agree that access to mental health and substance use disorder services are essential to a healthy community and that access is lacking for most communities

"For folks that are trying to make it through multiple stressful events, they can collapse if they don't have stress management and coping services available to them." (Evanston General Assistance – North Suburbs)

"There is a lot of stigma about mental health. People will say 'I'm not crazy' " (Enlace – West Side of Chicago)

"There's people I know who do things they are not supposed to, like drugs, to deal with stress because there is nothing else to do." (Restoration Ministries – South Suburbs)

"Patients need to have access to healthcare financially, geographically, and logistically" (NAMI Chicago - Citywide)

Focus Group Results – Access to care and community resources

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Top Access to Care Issues Discussed

- Discussions were largely focused on how systems-level issues such as policy changes and access to private and public benefits are affecting access to care
- Differences in quality of care
- Inadequate healthcare coverage and provider availability (for those on public benefits or veterans benefits in particular)
- Lack of affordable community activities and community-based services
- Lack of insurance and access can cause stress and trauma

"Most of us don't have health insurance. You can't get a mammogram or go to the doctor for checkups. If we had health insurance we would go more often, not just when we are sick."
(Oakley Square Apartments – West Side of Chicago)

"For my dad, he is very diabetic. He has a catheter. We have to go to ER 3-4 times a month. Before he knew about Medicare, he was paying out of pocket. So, he delayed seeing a doctor and it damaged his kidneys" (NAMI Chicago - Citywide)

[Referring to public aid office] It ridiculous and they are there to help. I waited 1 hour 15 mins on hold and someone hung up on me. Even when you go to the public aid office it is ridiculous.
(Solutions for Care – West Suburbs)

"Administration has put so much fear into communities. Immigrants are afraid of getting things they need like medical cards because they are afraid of getting deported."
(AHS Family Health Center – North Side of Chicago)

Focus Group Results – Social Determinants

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Most Frequently Discussed Topics

- Economic inequities
- Employment opportunities
- Education
- Opportunities for Youth
- Housing and homelessness
- Food access

"Lots of young people are not able to get jobs because schools are under-resourced and they are not prepared for jobs"
(AMITA Saints Mary & Elizabeth Medical Center – West Side of Chicago)

"I feel like in Chicago where it's affordable; it's not safe. Where it is safe; it's overpriced."
(New Moms – West Side of Chicago)

"I was homeless in 2014 and it was so cold my health got really bad - pneumonia, frost bite on toes - everything gets complicated when you are homeless."
(Housing Forward – West Suburbs)

"Cost – McDonalds is much cheaper than Pete's in Oak Park for vegetables, why is it that greasy foods are so much cheaper? Then they want to talk about obesity, yeah look what's in our community."
(After School Matters – West Side of Chicago)

Focus Group Results – Chronic Disease

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Top Chronic Disease Issues Discussed

- Social determinants of health such as poverty, limited access to healthy foods, exposure to violence, and housing conditions are both underlying root causes of chronic disease and are barriers to the management of chronic disease
- Education about preventing chronic disease, risk factors, and when to seek medical help is lacking in communities
- Chronic illnesses such as asthma and diabetes can be isolating for youth, parents, and adults
- Additional community groups that share information about resources and support each other with adjusting to healthier lifestyles would be extremely helpful to communities

"You have to go to another community to exercise." (Restoration Ministries – South Suburbs)

"Build more stores like Whole Foods, Cermack, and Mariano's on the low ends instead of places like Popeyes." (Gary Comer Youth Center – South Side of Chicago)

"We need to change the generational curse. Families keep quiet about what occurs in our families. You can have a mother pass away and the family doesn't know that they died of - diabetes or cancer. We need to change that tradition of being quiet so that we can save some people. We as a community don't talk about what is hurting our families health wise. (Timothy Community Corporation – South Side of Chicago)

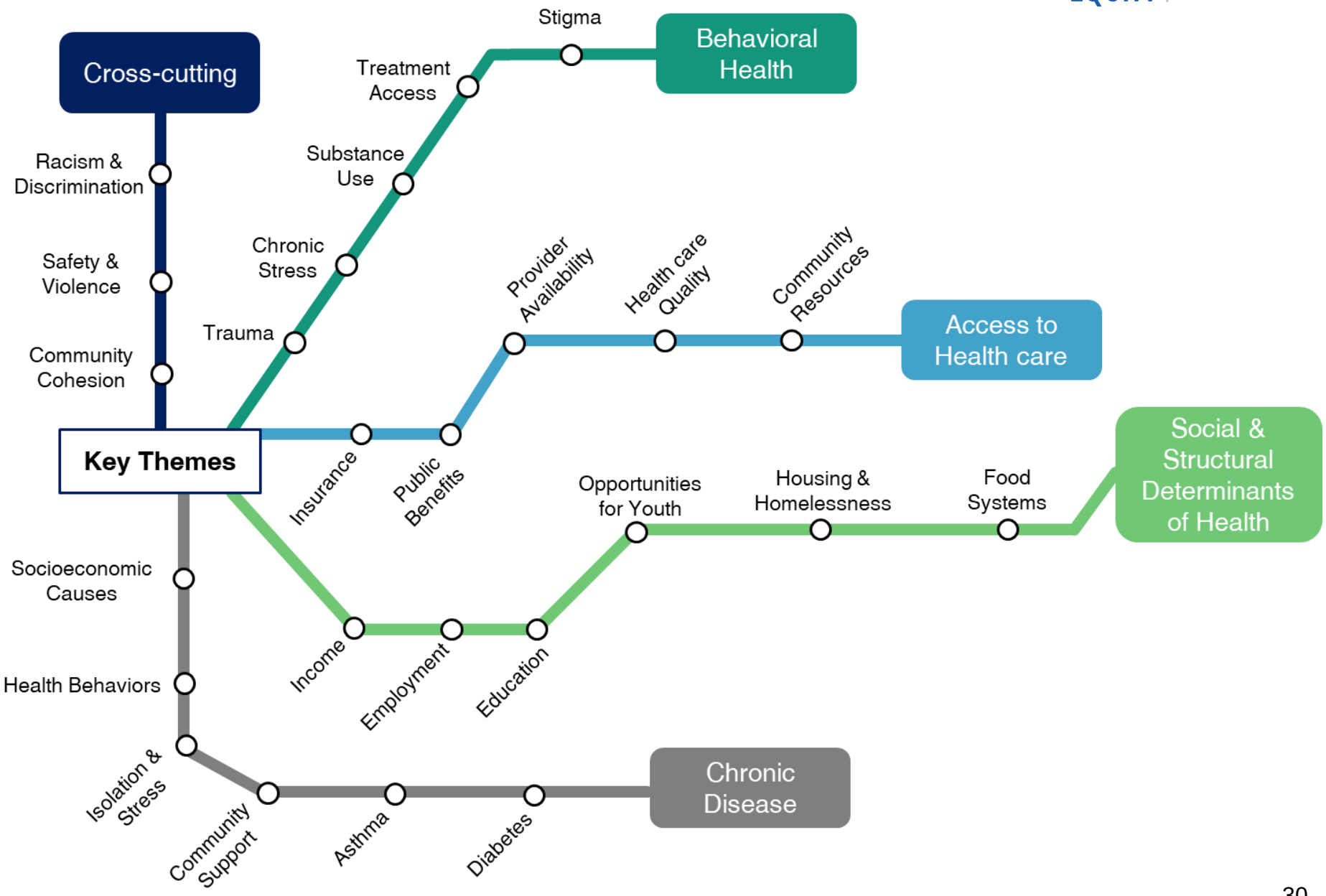
"I have discussions with people who struggle with diabetes and we discuss recipes. I also use Pinterest and they have a lot of good ideas - recipes, meal plans." (Timothy Community Corporation – South Side of Chicago)

What Communities Told Us

ALLIANCE for HEALTH EQUITY
Hospitals and Communities Improving Health Across Chicago and Cook County

Key Themes

- Cross-Cutting
  - Racism & Discrimination
  - Safety & Violence
  - Community Cohesion
- Behavioral Health
- Access to Health Care
- Social & Structural Determinants of Health
- Chronic Disease



ALLIANCE for HEALTH EQUITY

Hospitals and Communities Improving Health Across Chicago and Cook County

Secondary Data

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

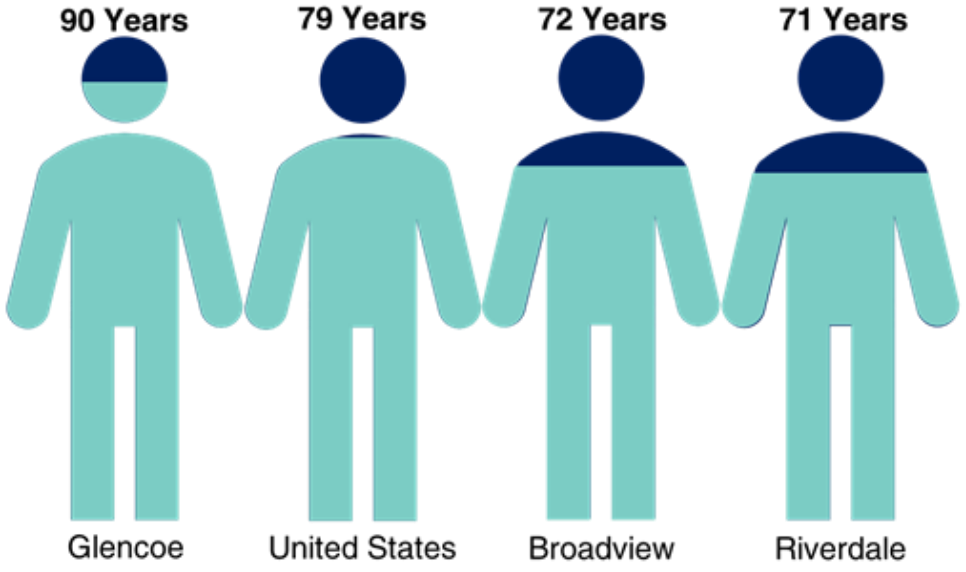
Cook County DEPT. of Public Health
Promoting health. Preventing disease. *Protecting you.*

ILLINOIS PUBLIC HEALTH INSTITUTE

Catina Latham, University of Chicago Medicine

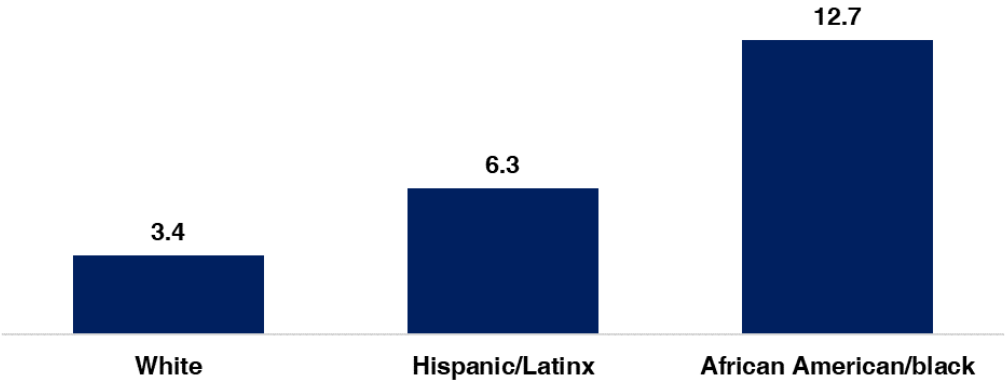
Examples of Health Inequities

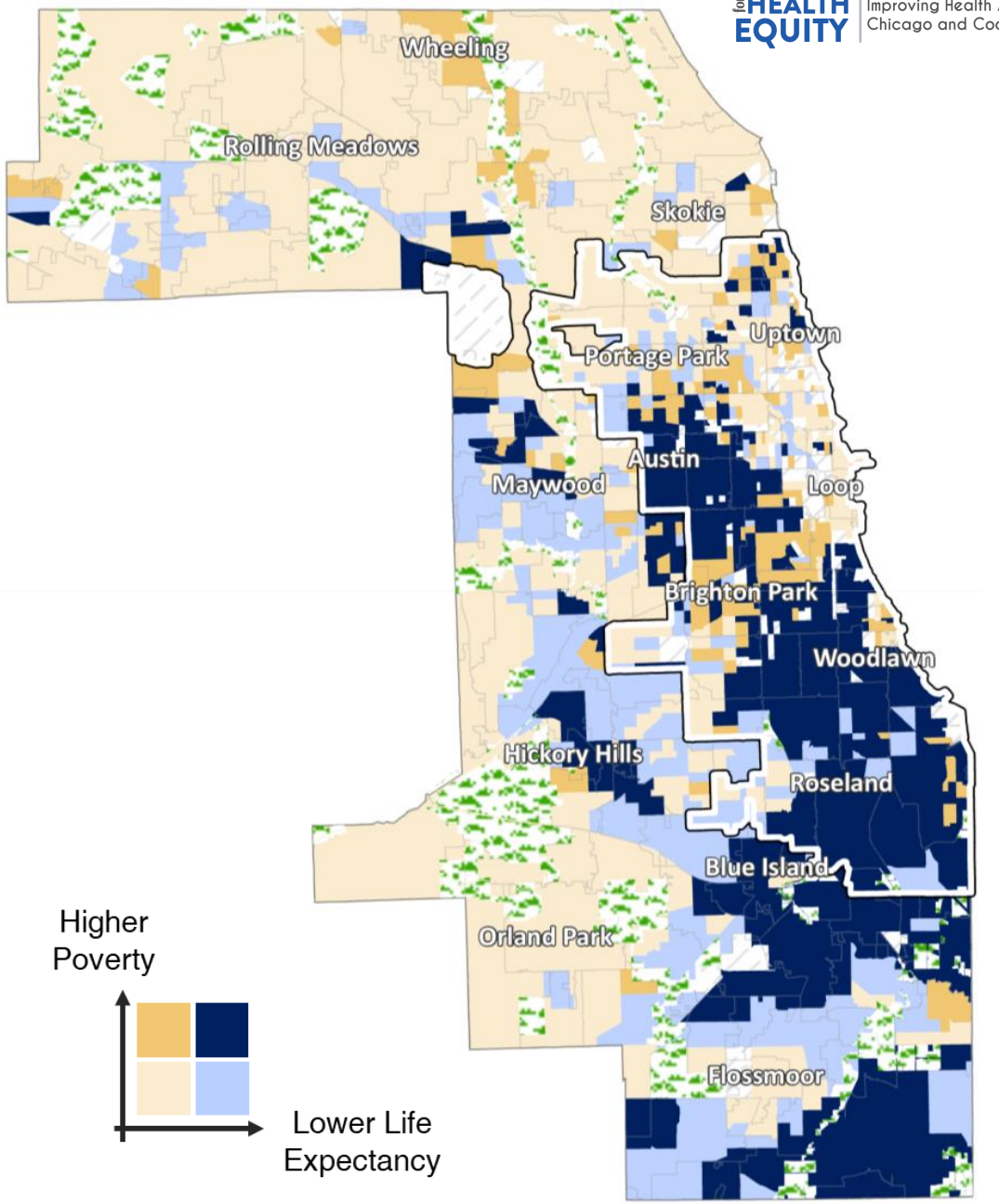
Comparisons of life expectancy, Suburban Cook County



Infant mortality rates per 1,000 live births in Chicago by race and ethnicity

In Chicago, infant mortality rates are highest among African American/blacks





IDPH, Division of Vital Records, 2012-2016; American Community Survey, 2012-2016

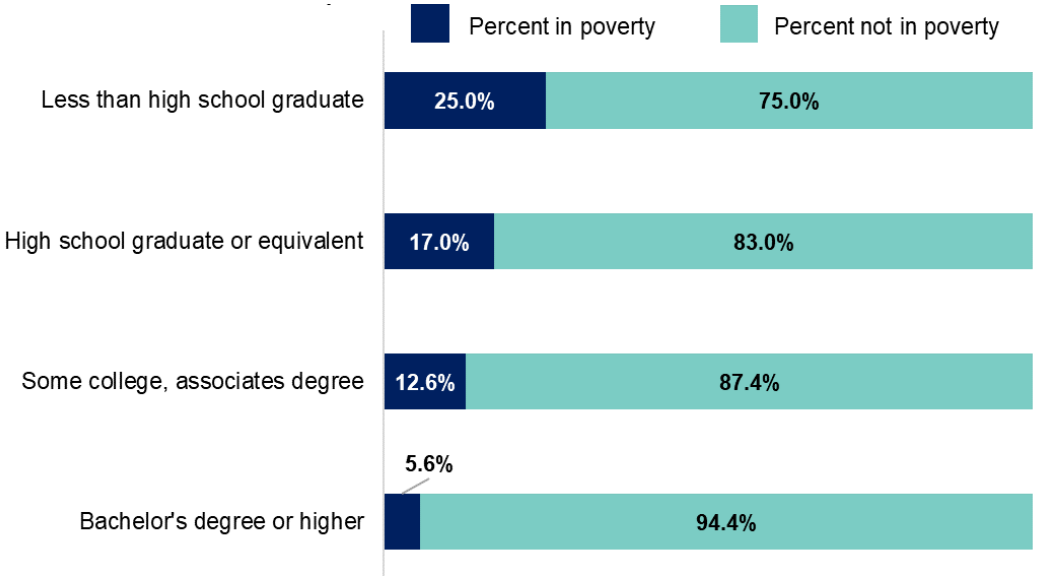
CHNA: Social and Structural Determinants of Health Chapter

ALLIANCE for HEALTH EQUITY | Hospitals and Communities Improving Health Across Chicago and Cook County

Social and structural determinants chapter sections

- Poverty and opportunity
- Unemployment and underemployment
- Education
- Food access and food security
- Housing
- Environmental health
- Community safety and violence

Poverty status and educational attainment for adults 25 and older in Cook County



U.S. Census Bureau, American Community Survey, 2012-2016

Four pathways connecting housing and health

(Taylor, 2018)

Community areas with the highest and lowest violent crime rates in Chicago, 2016

Highest	Crude Rate (per 100,000 population)	Lowest	Crude Rate (per 100,000 population)
Fuller Park	16237.8	Forest Glen	1086.0
West Garfield Park	13904.8	North Center	1292.9
East Garfield Park	13103.5	Edison Park	1340.8
North Lawndale	12714.4	Mount Greenwood	1456.0
Riverdale	12511.6	Lincoln Park	1531.6
Washington Park	12127.7	Norwood Park	1680.0
Englewood	11173.1	Clearing	1776.2
Greater Grand Crossing	10680.3	Beverly	1796.9
West Englewood	10133.8	Dunning	1845.8
Chatham	9417.3	Jefferson Park	1945.1

Chicago Police Department Research and Development Division; U.S. Census Bureau 2010 Census

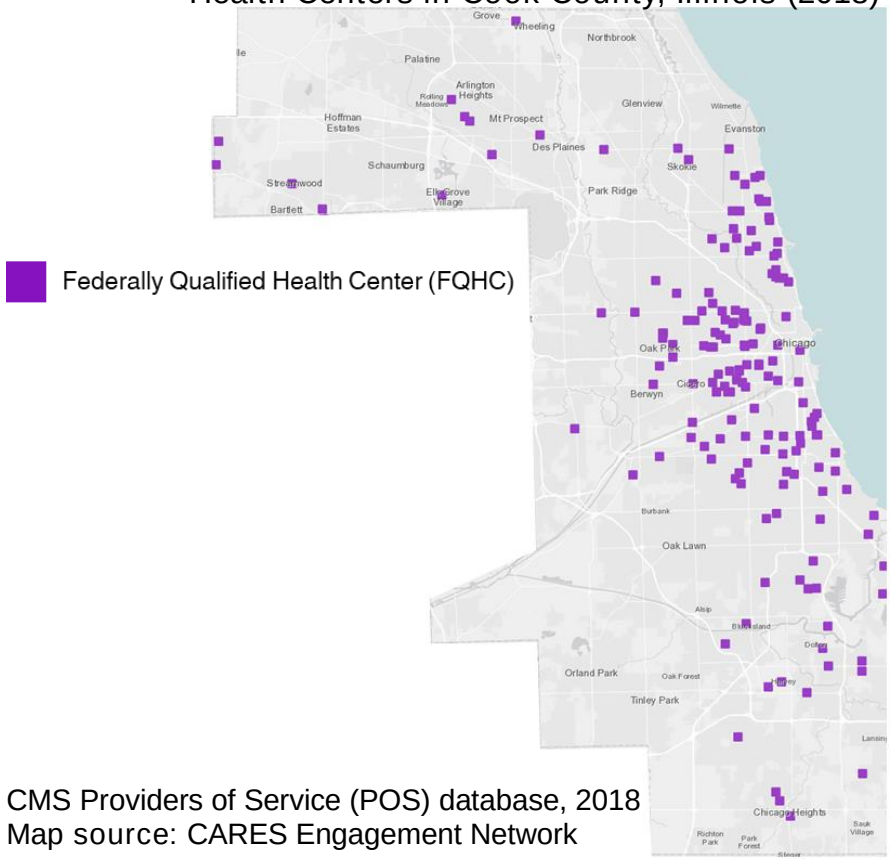
CHNA: Access to quality health care chapter

ALLIANCE for HEALTH EQUITY | Hospitals and Communities Improving Health Across Chicago and Cook County

Access to quality health care chapter sections

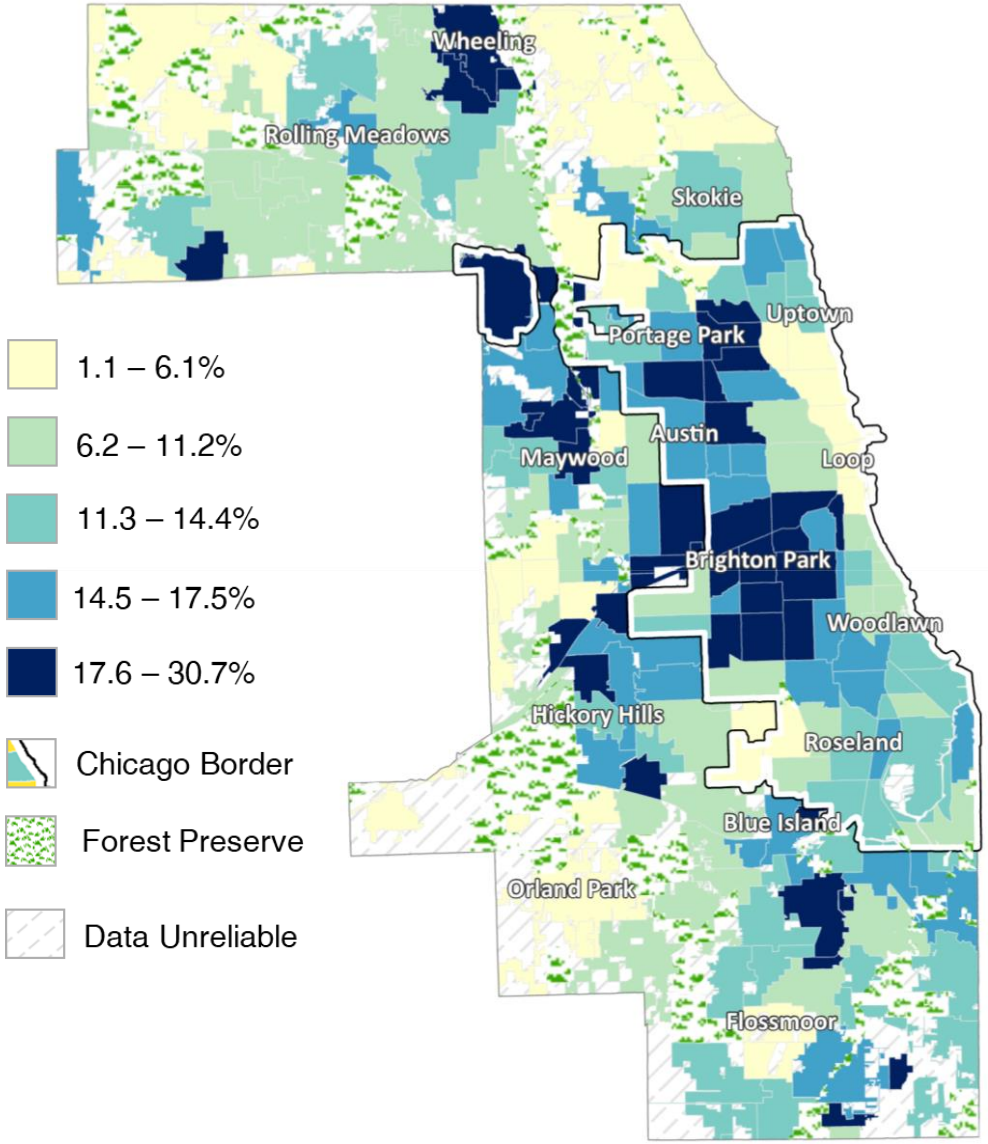
- Health care coverage
- Proximity to health care services
- Health care quality
- School-based health services

Geographic distribution of Federally Qualified Health Centers in Cook County, Illinois (2018)



CMS Providers of Service (POS) database, 2018
Map source: CARES Engagement Network

Geographic distribution of uninsured individuals in Cook County, Illinois (2016, ACS 5-Year Estimates)



U.S. Census Bureau, American Community Survey, 2012-2016

CHNA: Mental Health and Substance Use Disorders chapter

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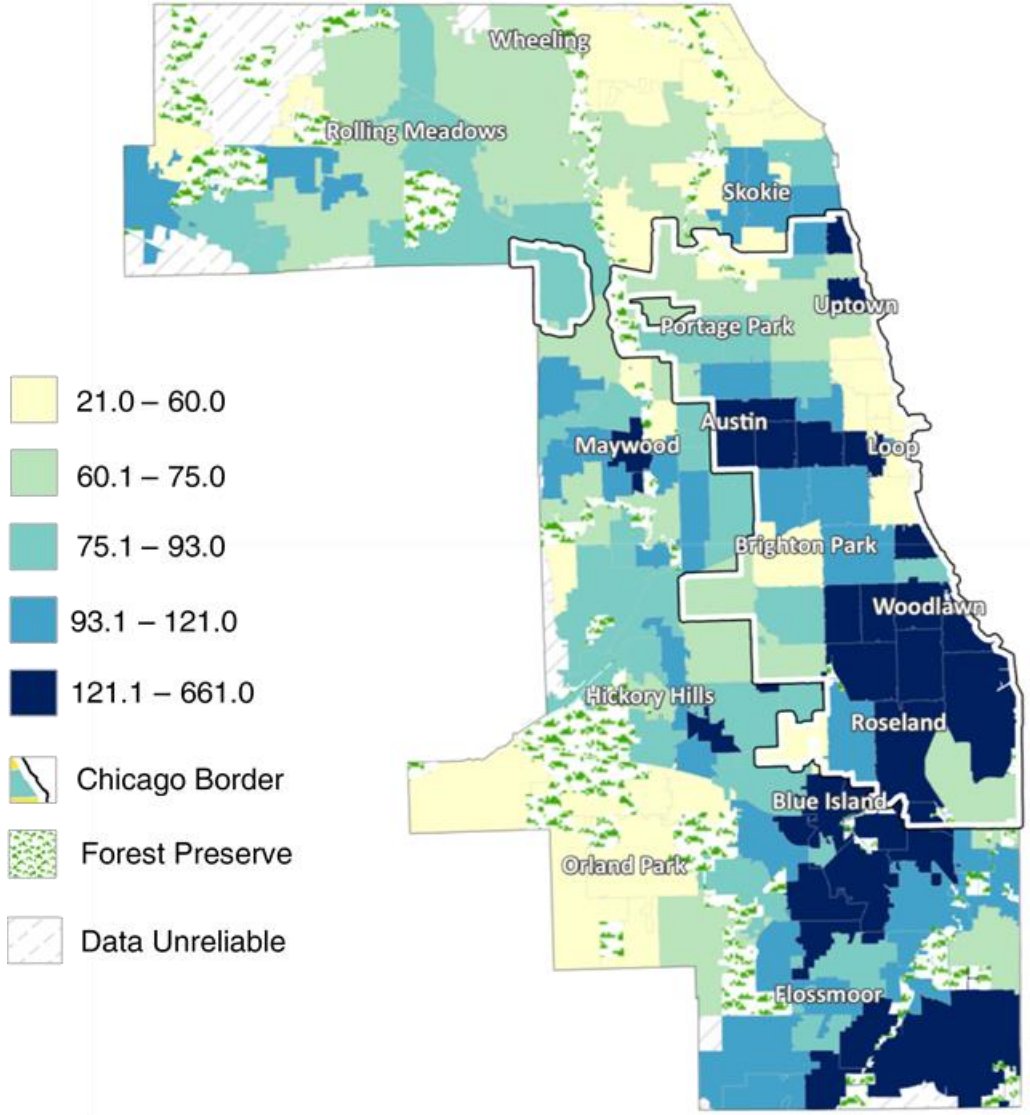
MH-SUD chapter sections

- Key takeaways
  - Overarching need: Quality
  - Fragmentation of services and integration of care
  - Social and structural determinants of health
  - Trauma and childhood adversity
  - Stigma and discrimination
  - Workforce shortages and gaps in training
- Priority Populations
- Utilization of emergency care
- Other recent assessments (Appendices)

Age-adjusted mental health emergency department visit rates per 10,000 in Cook County, Illinois (Adults)



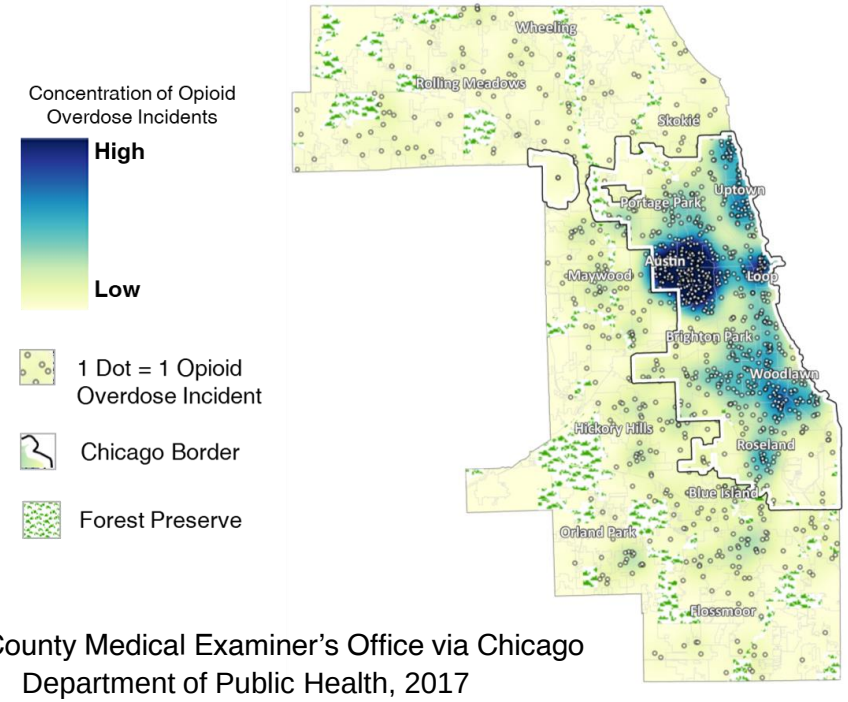
Illinois COMPdata, 2015-2017, Analysis conducted by Conduent Healthy Communities Institute

CHNA: Chronic Disease chapter

Chronic Disease chapter sections

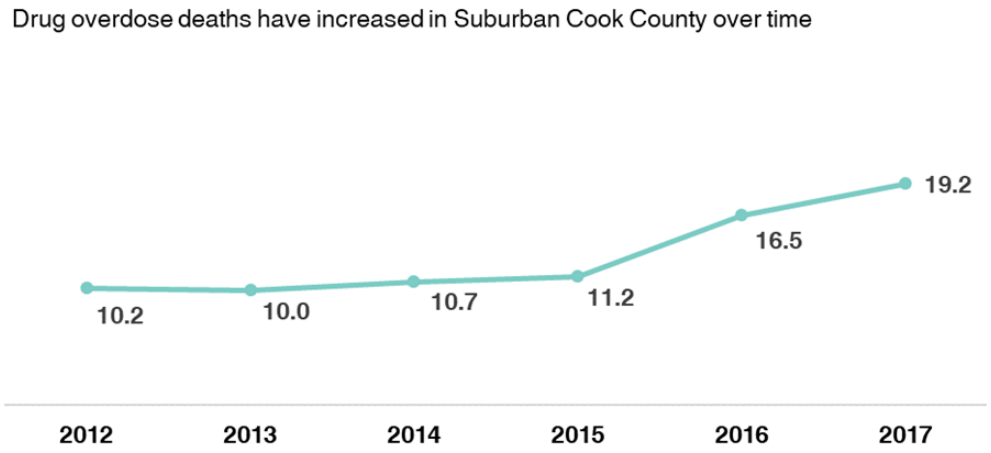
- Prevention
- Mortality
  - Mortality trends
    - Chronic disease-related mortality
    - Drug overdose mortality
- Asthma and diabetes
- Sexually transmitted infections

Incidence of opioid overdoses in Cook County, Illinois (2017)



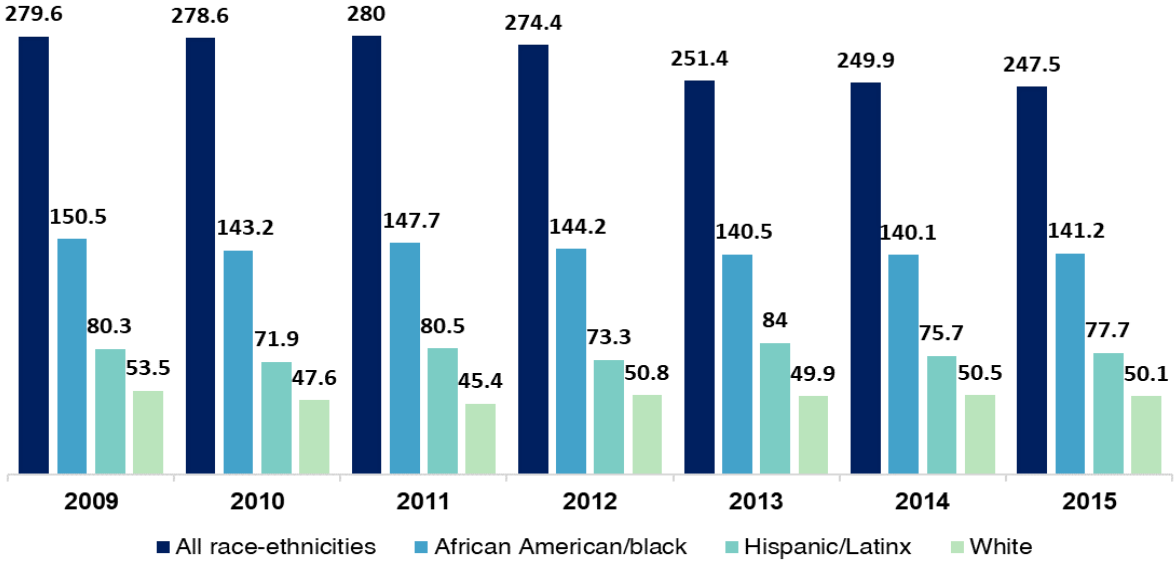
Cook County Medical Examiner's Office via Chicago Department of Public Health, 2017

Trends in age-adjusted drug overdose mortality rates per 100,000 in Suburban Cook County



Illinois Department of Public Health, Division of Vital Records, 2012-2017

Racial and ethnic disparities in asthma ED visits, age-adjusted rates for Chicago children aged 0-17, 2009-2015



(Respiratory Health Association, 2018)

University of Chicago Medicine
CHNA Example
Community Profiles

Community Profile

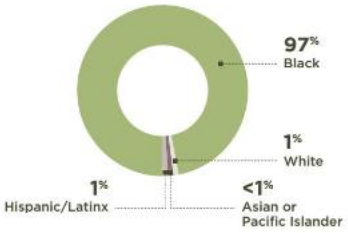
Auburn Gresham

Dan Ryan Woods

Auburn Gresham is known for its bungalow-style housing and brick two flat apartments. The Chicago Public Library's Thurgood Marshall Branch is located in this community and features a large auditorium, and houses community artwork.[1]

Who lives here?[2]

Race and Ethnicity

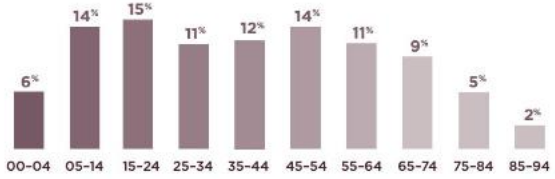


Sex

56% Female

44% Male

Age



Population: 45,770

Population change:[3] ↓6%

Chicago: ↑6%

UChicago Medicine

Auburn Gresham

Social Determinants of Health[2]

Social determinants of health are social, economic, and physical conditions in which people are born, live, and work that affect health and well-being. For example, where you live limits access to healthy foods, these can in turn increase ones risk for obesity and other chronic conditions related to diet.

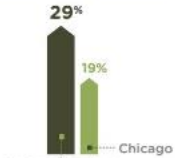
Economic Factors

Median household income

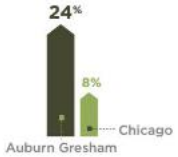
$29,285

Chicago: $53,006

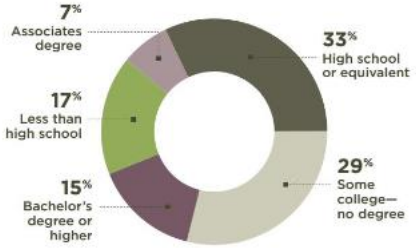
Population living in poverty[4]



Unemployment



Education[5]



45% of households spend 30% or more of their annual income on housing costs

2 in 5 children are living in poverty[4]

33% of households are receiving food stamps

52% of households are at risk for food insecurity[6]

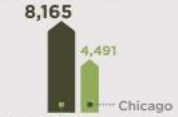
Physical Factors

16% of housing units are vacant

54% of adults report that they feel safe in their neighborhood "most or all of the time"[7]

Violent crime incidents[7]

Per 100,000 Population



2

HYDE PARK HERALD

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JULY 16, 2019

U. of C. releases assessment Of community health needs

HERALD STAFF REPORT

South Siders say chronic diseases, a need for violence prevention and trauma resiliency and health inequities are their key health concerns, according to the University of Chicago Medical Center's (UCMC) 2019 Community Health Needs Assessment, which is issued triennially. It also profiled specific neighborhoods' medical and socio-economic demographics, including Hyde Park and Kenwood.

The 2019 report included an analysis of social determinants of health inequities, like higher levels of chronic disease and violence in communities with education, poverty and employment levels and access to care. Over half of the population within the UCMC's service area lives in poverty, and half of all residents are at risk for food insecurity.

UCMC will use the report, which was researched through community resident surveys and focus groups as well as public health and crime data, when allocating resources. Through 2021, the priorities are preventing and managing chronic diseases, building trauma resiliency with a focus on violence recovery and mental health and reducing health inequities by addressing social determinants of health.

"The Community Health Needs Assessment establishes which community health concerns require UChicago Medicine's attention and resources, and we respond accordingly with strategic programs and collaborative partnerships, including those related to asthma, diabetes, violence prevention and more," said U. of C. medicine professor Doriane Miller in a statement. "Based on the latest findings and analyses of social determinants of health, our work will focus on increasing access to food for patients with food insecurities, expanding access to health care and providing more employment opportunities for community residents."

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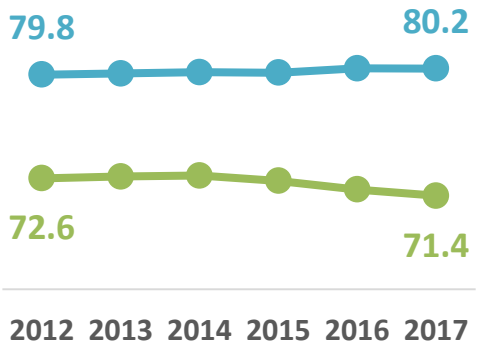
Healthy Chicago 2025-Health Equity Goals

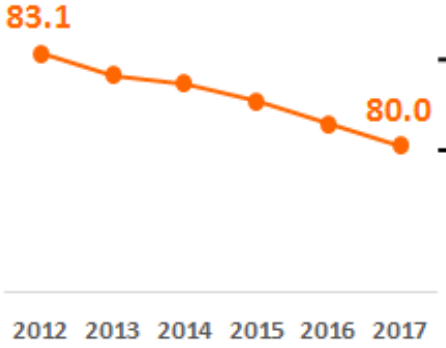
(1) Reduce life expectancy gap between black and white Chicagoans



8.8 YEAR GAP → **DRIVEN BY**

- **Chronic Disease/Obesity** (3.8 years)
- **Homicide** (2.1 years)
- **Infant and Maternal Mortality** (0.7 years)
- **HIV/Infectious Disease** (0.5 years)
- **Opioids** (0.4 years)

(2) Reverse Latinx life expectancy decline



3.1 YEAR DECLINE → **DRIVEN BY**

- **Cancer** (0.7 years)
- **Stroke** (0.5 years)
- **Heart Disease** (0.4 years)
- **Opioids** (0.3 years)
- **Homicide** (0.2 years)

(3) Increase community "well-being"

Sheri Cohen,
Chicago Department of Public Health

Healthy Chicago 2025 Goals

Goal 1: Transform policies and processes to foster anti-racist, multicultural systems

Goal 2: Strengthen community capacity and youth leadership

Goal 3: Improve Systems of Care for populations most affected by inequities

- *Behavioral Health*
- *Maternal and Child Health*
- *Access to Resources*

Goal 4: Further the health and vibrancy of neighborhoods most affected by inequities

- *Housing*
- *Food access*
- *Healthy Environments*
- *Community Safety*
- *Neighborhood Development*

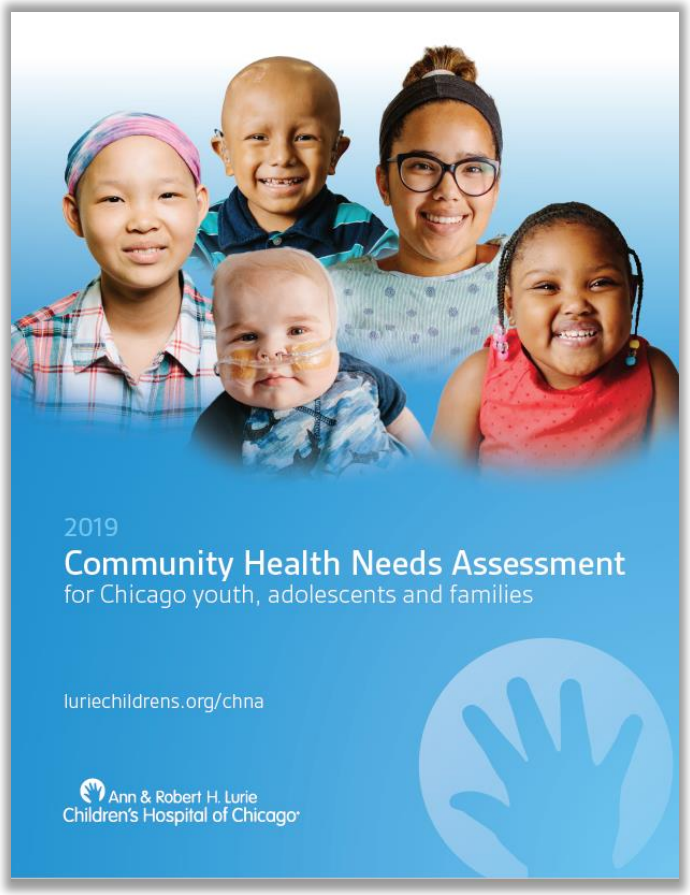
Healthy Chicago 2025 Guiding Principles

- Challenge and redress racist systems
- Apply diversity, equity and inclusion framework.
- Fortify and institutionalize community power/ influence/ decision making role
- Promote equitable wealth and income building
- Ensure equitable funding and resourcing
- Employ a trauma-informed approach
- Foster collective impact across sectors, departments and communities
- Inform and evaluate efforts through data and research
- Promote affordability and belonging

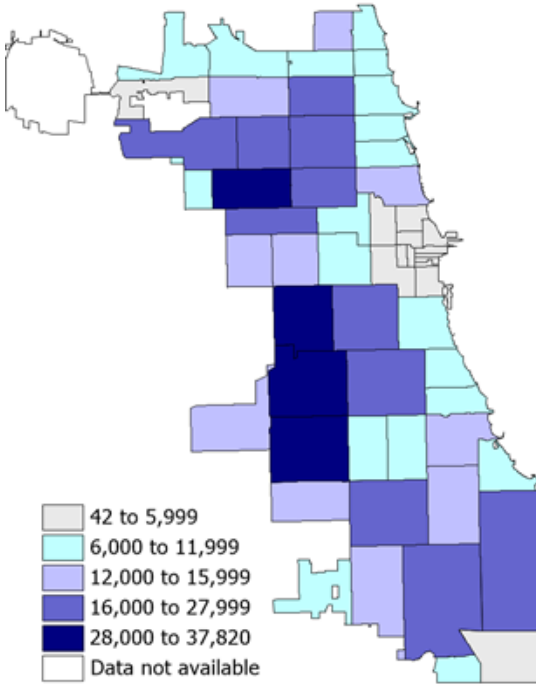
Ann & Robert H. Lurie Children's Hospital of Chicago

CHNA Example

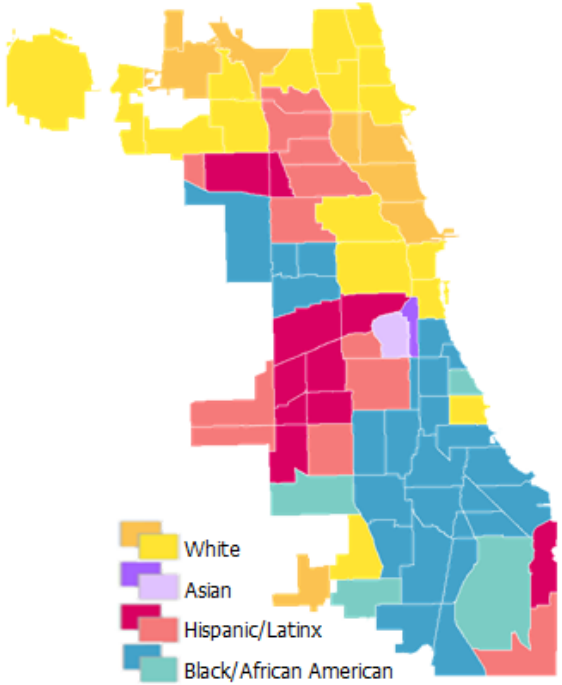
Highlighting children and adolescent data



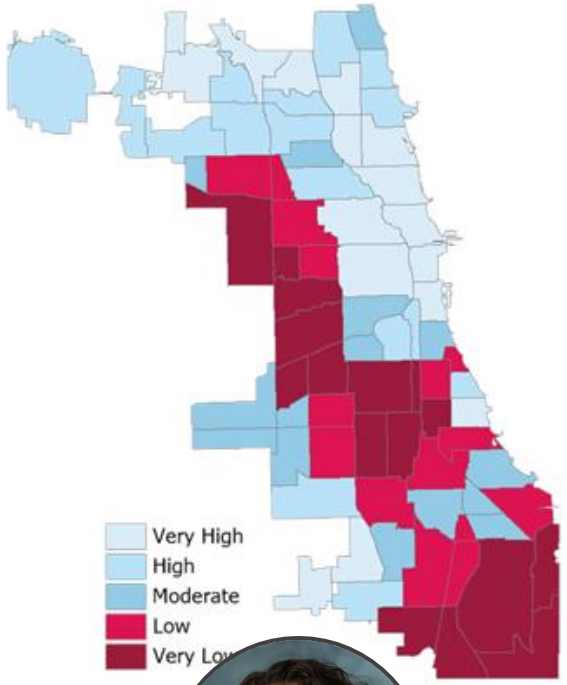
Pediatric population density, Chicago, 0-19 years old



Predominant racial and ethnic groups in Chicago by community area



Child Opportunity Index (COI) by Chicago community area



Kelli Day, Lurie Children's Healthy Communities

Priority Community Health Issues

CHNA Priority Community Health Issues

ALLIANCE for HEALTH EQUITY
Hospitals and Communities Improving Health Across Chicago and Cook County

Social and Structural Determinants of Health

Addressing Structural Racism and Advancing Racial Equity • Policies that Advance Equity and Promote Physical and Mental Well-Being • Conditions that Support Healthy Eating and Active Living • Community Engagement in Decision-Making

- Economic Vitality and Workforce Development
- Education and Youth Development
- Food Security and Food Access
- Housing, Transportation, and Neighborhood Environment
- Structural Racism and Structural Inequities
- Violence, Trauma, and Community Safety

Access to Care, Community Resources, and Systems Improvements

- Increased Timely Linkage to Appropriate Care, including Behavioral Health and Social Services
- Resources, Referrals, Coordination, and Connection to Community-Based Services
- Trauma-Informed Care
- Diversity and Inclusion in Workforce
- Care based in Cultural Humility and Cultural Competence
- Data Systems

- **Mental Health and Substance Use Disorders**
- **Chronic Conditions: Risk Factors, Prevention, and Management**
  - Asthma
  - Cancer
  - Complex Chronic Conditions
  - Diabetes
  - Heart Disease
  - Hypertension
  - Obesity
- **Maternal and Child Health**
  including maternal and infant mortality
- **Injury**
  including violence-related injury

Increased Health Equity, Improved Health, Improved Quality of Life, Increased Life Expectancy

Mercy Hospital & Medical Center CHNA Example

Prioritizing community health issues

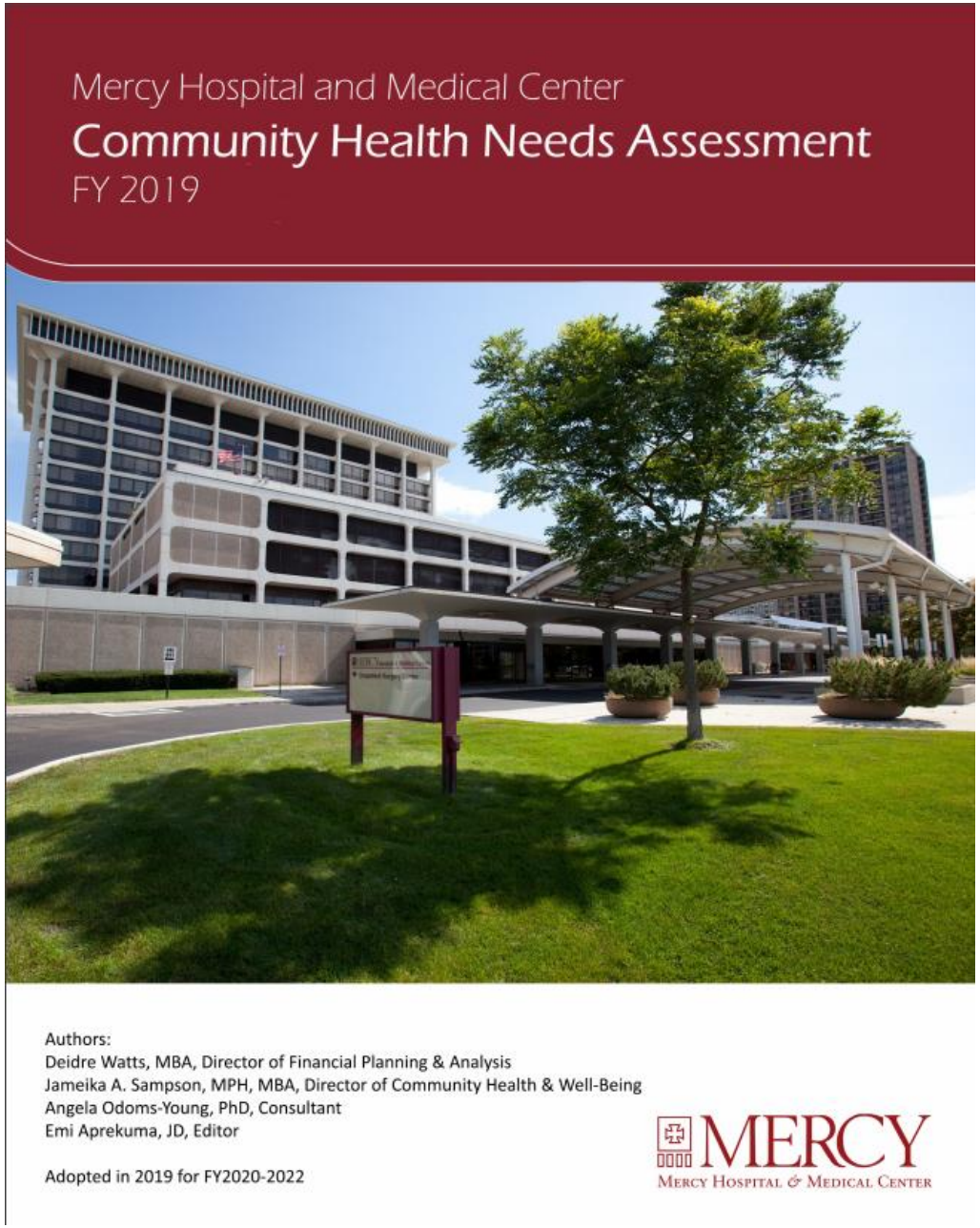
Community Health Priorities

Community stakeholders categorized priorities under three main tracks: A. Improved Health and Health Equity (focused on individuals), B. Access to Care, Community Resources and Systems Improvements and (focused on systems) and C. Social and Structural Influencers of Health (focused on the target communities). Items were ranked based upon the results of the community input surveys, current initiatives, and available resources to address the issues.

A. Targeted Care for the Following Prevalent Health Issues
1. Diabetes
2. Substance Use
3. Violence
4. Mental Health

B. Access to Care, Community Resources, and Systems Improvements
1. Resources, Referrals, Coordination, and Connection to Community-Based Services
2. Trauma Informed Care

C. Structural and Social Determinants of Health
1. Economic Vitality and Workforce Development
2. Violence and Community Safety



Jameika Sampson, Mercy Hospital and Medical Center

POLL QUESTION

What priorities are you interest in?

A. Social and Structural Determinants of Health

B. Housing and Health

C. Food Access and Food Security

D. Mental Health and Substance Use Disorders

E. Community Safety, Trauma, and Resilience

Partnering on Implementation Strategies to Advance Health Equity

Christopher Nolan,
Rush University Medical Center & Rush Oak Park

Crosswalk of Priorities and Alignment, working document

ALLIANCE for HEALTH EQUITY | Hospitals and Communities Improving Health Across Chicago and Cook County

Social and Structural Determinants of Health	WSU/ ConnectED	HEAL	Southland RISE	PP4H	CHWC	CASE	AWHC	CAPri CORN	CCH Strat Plan	We PLAN	HC 2025
Economic Vitality and Workforce Development	X	X	X	X	X	X			X	X	X
Education and Youth Development	X	X	X	X	X					X	X
Food Security and Food Access	X		X	X					X	X	X
Housing, Transportation, and Neighborhood Environment	X	X	X	X				X	X	X	X
Structural Racism and Structural Inequities	X		X	X			X			X	X
Violence and Community Safety		X	X	X				X	X		X
Access to Care, Community Resources, and Systems Improvements	**WSU/ ConnectED**	**HEAL**	**Southland RISE**	**PP4H**	**CHWC**	**CASE**	**AWHC**	**CAPri CORN**	**CCH Strat Plan**	**We PLAN**	**HC 2025**
Increased Timely Linkage to Appropriate Care including Behavioral Health and Social Services	X	X	X				X	X	X	X	X
Resources, Referrals, Coordination, and Connection to Community-Based Services	X	X	X						X		X
Trauma-Informed Care		X	X				X		X		X
Care based in Cultural Humility and Cultural Competence		X	X				X		X		X
Data Systems	X	X	X	X	X			X	X	X	X
Improved Health and Health Equity	**WSU/ ConnectED**	**HEAL**	**Southland RISE**	**PP4H**	**CHWC**	**CASE**	**AWHC**	**CAPri CORN**	**CCH Strat Plan**	**We PLAN**	**HC 2025**
Chronic Conditions: Risk Factors, Prevention, and Management	X/P		X	X				X	X	X	X
Mental Health	X	X	X						X	X	X
Substance Use Disorders		X	X						X	X	X
Maternal and Child Health	X	X	X					X	X		X
Violence and Community Safety		X	X	X				X	X		X

Any suggested additions or edits can be emailed to Andi.Goodall@iphionline.org

Acronyms and Links

- WSU/ConnectED = West Side United, West Side ConnectED --- https://westsideunited.org/
- HEAL = Chicago HEAL Initiative --- https://www.durbin.senate.gov/imo/media/doc/Chicago%20HEAL%20Initiative%20FINAL.pdf
- Southland RISE --- https://www.uchicagomedicine.org/forefront/trauma-articles/2019/july/southland-rise-awards-100000-to-14-grassroots-violence-prevention-programs-on-the-south-side
- PP4H = Proviso Partners for Health --- https://www.provisopartners.com/
- CHWC = Chicagoland Healthcare Workforce Collaborative --- https://chicagoworkforcefunders.org/chicagoland-healthcare-workforce-collaborative/
- CASE = Chicago Anchors for a Strong Economy --- https://chicagoanchors.com/about/
- AWHC = Alliance for Welcoming Health Care --- https://www.ilalliancehealth.org/
- CAPriCORN --- https://www.healthinformationforall.org/project/capricorn/
- CCH Strat Plan = Cook County Health Impact 2023 Strategic Plan DRAFT --- https://cookcountyhealth.org/wp-content/uploads/CCH_2019_Strategic_Plan_071219.pdf
- WePLAN = Cook County Department of Public Health CCDPH Community Health Improvement Plan (in process)
- HC 2025 = Healthy Chicago 2025 (in process) --- https://www.chicago.gov/city/en/depts/cdph/provdrs/healthy_communities/svcs/healthy-chicago-2025.html

Rush Community Health Implementation Plan (CHIP) Example

Goals, Strategies, and Initiatives

GOAL 1 Reduce inequities caused by the social, economic and structural determinants of health

STRATEGY Improve K–16 educational outcomes through skills development, internships and industry-recognized credentials (H) (W)

INITIATIVE Provide high school and college apprenticeship/internship programs that serve at least 250 students annually

INITIATIVE Increase student and family interest and awareness of STEM/health care topics and careers through work-based learning experiences, serving 1,250 students and 150 parents/community members annually

INITIATIVE Ensure that 75% of all participating high school students are on track to receive an industry-recognized credential

STRATEGY Identify the social determinants of health through screenings, and refer those in need of social services (A) (W)

INITIATIVE With West Side ConnectED, roll out screening tool to Rush Oak Park Hospital and Rush Copley Medical Center; screen 10,000 patients/community members annually and connect them to resources

INITIATIVE Integrate social determinants of health screening into community-based programming, connecting with at least 3 partners per year

STRATEGY Increase local hiring and develop career ladders for employees (H) (W)

INITIATIVE Launch 4 career pathway programs, including medical assistant, nursing assistant, nursing and health IT, serving 375 people over the next 3 years

INITIATIVE Work in partnership with WSU toward its goal of employing 3,500 West Side community members over the next 3 years

STRATEGY Increase spending with local businesses (H) (W)

INITIATIVE Increase local vendor presence at all 3 hospitals; goal is 3 vendors per year (beginning in FY20 for Rush Oak Park Hospital and in FY21 for Rush Copley Medical Center)

INITIATIVE Rush University Medical Center will aim to increase its FY20 spending with West Side vendors by at least $1.4 million

STRATEGY Increase investment in local communities (A) (W)

INITIATIVE Invest $7.5 million in West Side communities over 3 years through partnership with WSU

AHE (A), HEAL (H) and WSU (W).

Community involvement in interpreting CHNA findings and defining partnership strategies

ALLIANCE for HEALTH EQUITY
Hospitals and Communities Improving Health Across Chicago and Cook County

- Community Summaries
- Presentations at hospital community board meetings
- Community Events,
  i.e. On The Table (Rush/Austin Coming Together), Alliance for Research in Chicagoland Communities (Northwestern)
- Youth involvement in interpreting data, i.e. CHAMPIONS (UI Health), VOYCE (Lurie)
- Partnership with health departments
- Implementation planning
- Priority setting

Alliance for Health Equity Implementation Committees

ALLIANCE for HEALTH EQUITY
Hospitals and Communities Improving Health Across Chicago and Cook County

Steering Committee

Plan to develop a Community Advisory structure, to include members from other committees and workgroups

Data/CHNA Committee

Policy Committee

Trauma-informed Hospitals Collaborative
led and staffed by Illinois ACEs Response Collaborative

Social and Structural Determinants of Health Committee

- Community Safety Workgroup
- Food Access/ Food Security Workgroup
- Housing and Health Workgroup

Mental Health and Substance Use Disorders Committee

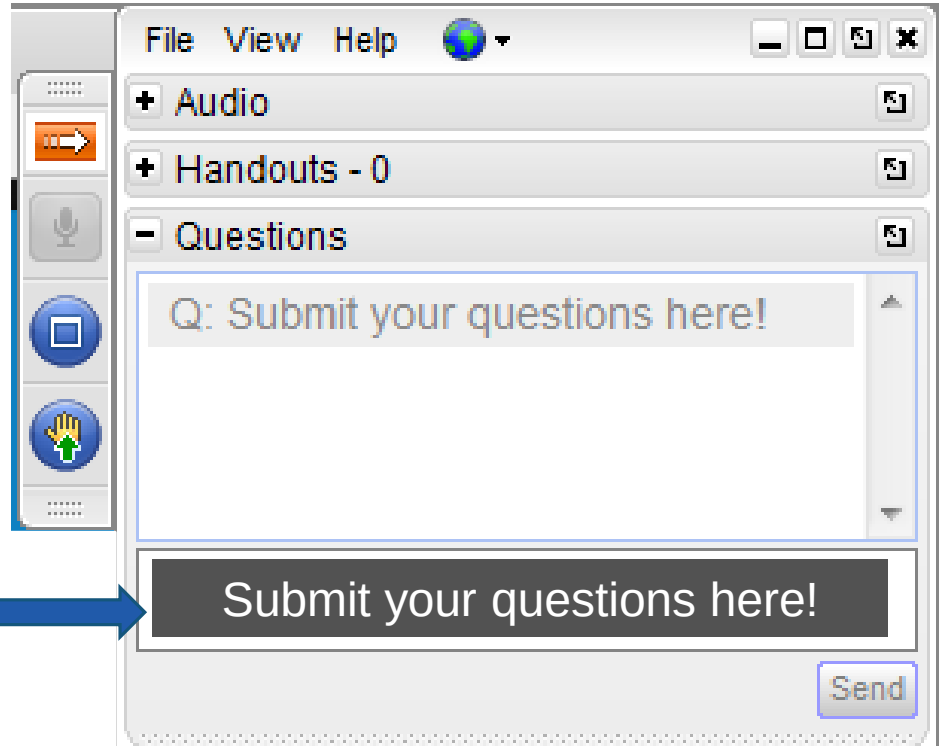
- Mental Health First Aid Workgroup
- Faith Communities Workgroup

Hospital Opioid Treatment and Response Learning Collaborative

If you would like to get involved with an Alliance for Health Equity workgroup or committee, email Andi at Andi.Goodall@iphionline.org

QUESTIONS?

Please type your questions into the chat box here



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The full CHNA report can be found at:
https://allhealthequity.org/projects/2019-chna-reports/