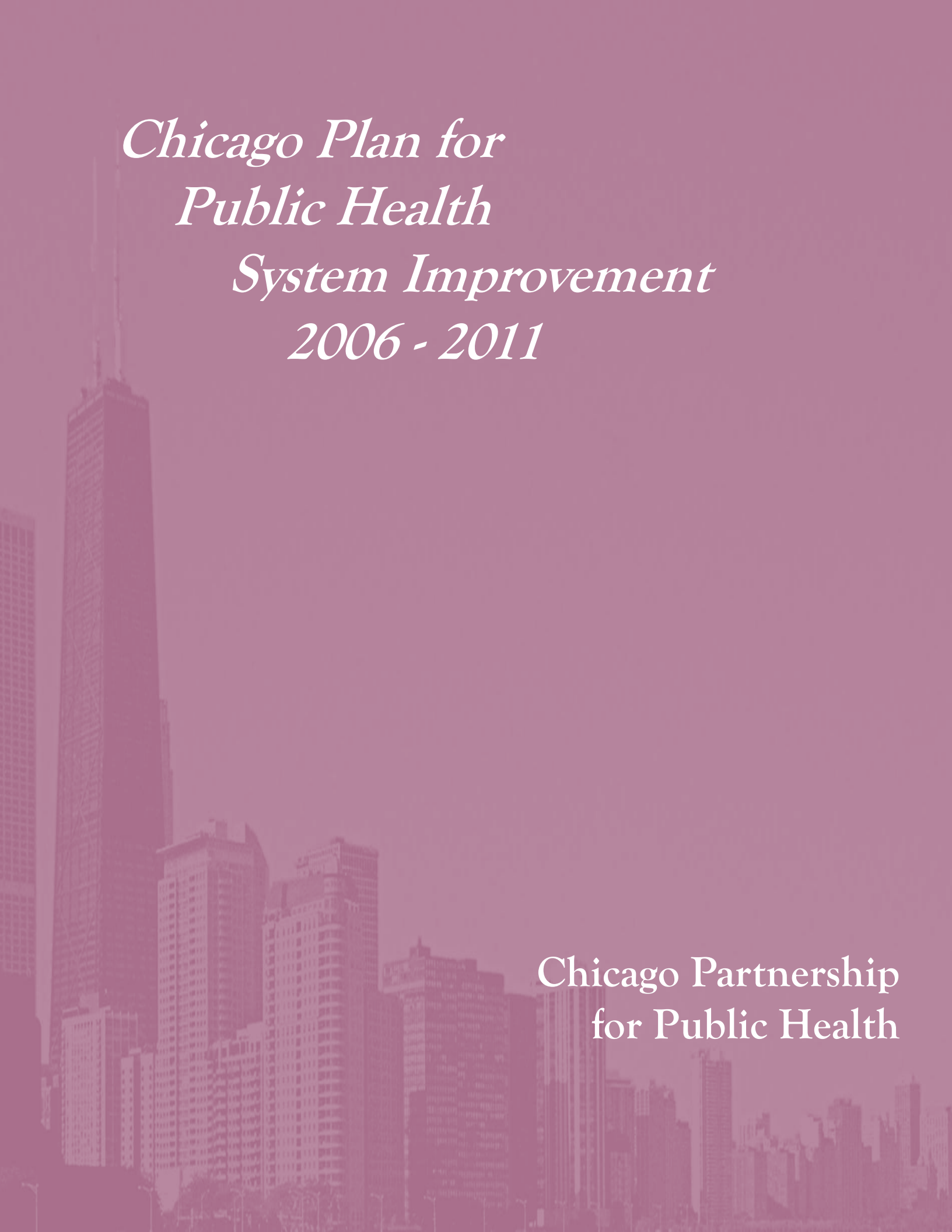
Chicago Plan for Public Health System Improvement 2006 - 2011



Chicago Partnership for Public Health

This report is available on the Chicago Department of Public Health's website at: www.cityofchicago.org/health. For more information, contact Sheri Cohen at cohen_sheri@cdph.org or 312/747-9562

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August 23, 2006

Eric E. Whitaker, MD, MPH
Director
Illinois Department of Public Health
535 West Jefferson Street
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Dear Dr. Whitaker:

On behalf of the Chicago Board of Health, I am pleased to present the *Chicago Plan for Public Health System Improvement 2006 – 2011*, which was adopted by the Board of Health on August 16, 2006.

The Chicago Plan presents a comprehensive assessment of the public health infrastructure in Chicago; complete with community input, health status assessment, system description, and analysis of external forces and trends affecting system functioning. The Plan synthesizes these data to identify strategic issues, cross-cutting action areas, and priority objectives that will focus the work of health system partners toward instigating change.

I appreciate the work of the Chicago Partnership for Public Health in undergoing this strategic planning process and leading the way to improve the public health system in Chicago.

Sincerely,

James R. Webster, Jr., MD, MACP
President

Chicago Plan for Public Health System Improvement 2006 - 2011

Chicago Partnership for Public Health
August 2006

Acknowledgements

The Chicago Partnership for Public Health was the convening body through which the *Chicago Plan for Public Health System Improvement 2006-2011* was developed. In addition to the members of the Chicago Partnership, many other people contributed to the formation of the plan, including Community Perceptions Focus Group participants, CDPH project staff, and other CDPH staff.

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Community Perceptions Focus Groups

Focus groups were held in collaboration with the following organizations/agencies:

Albany Park Community Center
Alivio Medical Center
Arab American Action Network
Brighton Park Neighborhood Council
Greater Southwest Development Corp.
Healthy Albany Park
Healthy Austin
Healthy Chicago Lawn
Healthy South Chicago
Holy Cross Church
Holy Cross Hospital
Iman Health Clinic
Korean American Senior Center
Latino Organization of the Southwest
Maria High School
Namaste School
PCC Community Wellness Center
Queen of the Universe School
Roosevelt High School
San Miguel School
Southwest Organizing Project
Von Steuben High School
Westside Health Authority
World Relief Chicago

Thank you to all CDPH staff that contributed their time and effort to this project.

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Table of Contents

Table of Figures

Figure Page

Table of Figures

Figure Page

Table of Figures

Figure Page

Table of Figures

Figure Page

Executive Summary

Purpose

The Chicago Department of Public Health (CDPH), in cooperation with the Chicago Partnership for Public Health presents the *Chicago Plan for Public Health System Improvement 2006-2011*. The *Chicago Plan 2006-2011* is a strategic plan that identifies objectives to improve Chicago's public health system, and is submitted to meet the Illinois Administrative Code requirements to develop a community health needs assessment and a community health plan.

Strategic Planning Process

The Chicago Partnership employed the *Mobilizing for Action through Planning and Partnerships* (MAPP) planning process to complete the strategic plan. MAPP was developed by the National Association of County & City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC) and focuses strategic planning on the system changes necessary to improve the health of all Chicagoans. The Chicago Partnership utilized MAPP as an equivalent to the process suggested by the Illinois Project for Local Assessment of Needs (IPLAN), by previous arrangement with the Illinois Department of Public Health.

Phase 1: Partnership Development: The Chicago Plan for Public Health System Improvement 2006 - 2011 was completed through the Chicago Partnership for Public Health, a public-private partnership comprised of a diverse membership of public health stakeholders. The Chicago Partnership, which formed in 1998 through the National Turning Point Demonstration Project sponsored by the W.K. Kellogg and Robert Wood Johnson Foundations, was the planning body for the 2000 IPLAN and has continued to meet since that time to address the priority strategies.

At the beginning of the current strategic planning process, the Chicago Partnership reviewed its membership and identified additional stakeholders and organizations to ensure the strategic plan includes input from a broad spectrum of the public health system. Six organizations and agencies joined or renewed their involvement with the Chicago Partnership, resulting in a membership of over 30 organizations.

Phase 2: Vision: The Chicago Partnership members reviewed their vision for Chicago's public health system and refined it to reflect current goals for the system. The Chicago Partnership further developed its vision by describing the populations and communities that are part of the system and the services the local public health system will provide, including the Ten Essential Services of Public Health. The Partnership also identified several system values, including shared leadership and public accountability, inclusiveness of all stakeholders, and resource allocation that reflects commitment to vulnerable populations and social justice.

The Chicago Partnership for Public Health's Vision for the Local Public Health System

A responsive, sustainable system that through:

- *cooperative efforts of all stakeholders,*
- *planning and policy development,*
- *a broad focus on access to services and information,*
- *health promotion and disease prevention, and*
- *shared leadership and accountability for the essential services of public health;*

will actively addresses current and future public health challenges, while protecting and promoting the health and well-being of Chicago's communities, residents and visitors, particularly the most vulnerable.

Phase 3: Situation Assessments:

Health Status Profile*:* Citywide, Chicago experienced improvements in most areas of health status and health behaviors. However, closer analysis of these gains revealed widening gaps in health disparities among populations, most commonly the male and Black populations. For many of the morbidity and mortality indicators, residents of the West and South regions had higher rates than other regions in Chicago.

Health Status

- Mortality: Citywide mortality age-adjusted rates decreased by 11% between 1996 and 2002. Mortality rates of heart disease, cancer, and stroke (which account for 60% of all deaths) decreased also. Males had higher age-adjusted mortality rates than females (1,166 per 100,000 compared to 782 in 2002). Blacks had higher rates than other race/ethnicities (1,235 per 100,000 in 2002 compared to 856 for Whites, 616 for Hispanics, and 570 for Asians).

- Maternal and Child Health: Indicators revealed improvement in women and children's health as the infant mortality rate decreased over 21% from 1996 and 2002. Teen births, maternal substance use, and child mortality decreased, and more women accessed prenatal care in the first trimester. Despite these advances, Black infants had significant disparities: an infant mortality rate twice the overall rate and four times the rate of the White population. However, the increase in Hispanic births contributed to decreasing Black percentages of overall cases.

- Sexually Transmitted Diseases: Disease patterns varied, influenced by outbreaks in specific communities and testing opportunities. For example, syphilis increased in the population of men who have sex with men, which also increased the percentage of cases in the White population and for residents living in the North region. Chlamydia cases

increased by 70% from 1996 to 2003, and females, who are more apt to obtain general exams, continue to represent the majority of cases. The number of gonorrhea cases in 2003 was similar to 1996, with Blacks and those living in the West region showing the highest number of cases.

- HIV/AIDS: The number of HIV cases in 2000 and 2003 remained about the same, at slightly over 1,100. There was a 35% decrease in AIDS cases from 1996 to 2003, reflecting the use of more effective treatments. Blacks and males represent the largest racial/ethnic and gender groups with HIV or AIDS, although female cases are increasing.

Health Perceptions/Behaviors

- Mental Health: Thirty percent of youth reported feeling sad or hopeless for 2 weeks or more during the past 12 months. Females were more likely to experience these feelings and be more at risk of suicide.
- Alcohol: About 20% of youth reported excessive drinking, with males and White youth having the highest percentages.
- Tobacco: Smoking in youth decreased from 27% to 17% (≥ 1 cigarette during last month), with White youth smoking at the highest percentage. The percentage of adult smokers is stable at 24%.
- Weight and Exercise: There was a slight increase of overweight youth while the percentage of youth who exercise decreased to less than half. Sixty percent of adults are overweight and less than half participate in sufficient exercise.

Community Perceptions: Although focus groups were held in 10 different community areas across Chicago, participants voiced similar concerns when asked about the health of their community. Community safety topped people's lists of problems, along with rising housing costs, and the lack of services. Groups made up of primarily Latino participants mentioned the need for more providers that speak Spanish and understand their culture. New immigrants were concerned about using services because they thought accessing health care depended on their immigration status. Youth focus groups complained about police hassling them while focus groups made up of older residents wanted more police presence in their community to deter crime.

While more difficult for them to identify, focus groups did recognize positive aspects of their communities, including the relationships they had with other community members and the diversity of their neighborhoods. People wanted more services in their area, but were appreciative of available resources. Focus group participants keep their neighborhoods healthy by joining local coalitions, taking an interest in keeping their neighborhoods clean, and looking out for local children.

Increasing information about services was a key suggestion participants had to improve their community's health. Residents thought this could be accomplished by creating more community resource centers. In addition, suggestions were for the Police Department to increase their presence to improve safety and for the Chicago Pubic Schools to improve the quality of education provided in local schools. Participants also acknowledged that trust among the neighborhood residents must improve if the community is going to get better.

Public Health System Assessment: The local public health system is comprised of numerous governmental and non-governmental agencies that together provide the Ten Essential Public Health Services to Chicago residents. The Chicago Department of Public Health, as the local public health authority, is one of the key organizations of the local public health system, along with other governmental agencies, community health providers, hospitals, social service organizations, policy & advocacy groups, coalitions, educational institutions, businesses, philanthropic foundations, and faith-based organizations.

The System Assessment revealed many areas in which the public health system is making progress. One of these is essential service #4, which calls for mobilizing community partnerships. As a result of the Chicago Plan for Public Health System Improvement in 2000, the Chicago Center for Community Partnership was formed and is currently working with coalitions in six of Chicago's communities to improve their community's health. Essential service #2 requires the public health system to diagnose and investigate health problems. Advances in this area are due to the work of emergency preparedness activities in the Office of Emergency Management and Communications and CDPH. Many governmental agencies collect data that assist in monitoring health status, essential service #1. With increased use of the Internet, more agencies and community groups have easier access to these data. And most organizations involved in the public health system link people to available resources, as described as essential service #7. However, only a limited few assure the provision of care.

Challenges and opportunities exist for Chicago's public health system in carrying out the Essential Services. Workforce shortages and the lack of minority providers provide challenges for essential service #8, to assure a competent workforce. Essential Service #6, the enforcement of public health laws, is challenged when there is only limited coordination for these activities among governmental agencies. However, Chicago's Emergency Preparedness Plan provides a model for cross-agency communication and coordination and other public health work can build on this success. Public health partners acknowledge the importance of evaluating public health services, Essential Service #9, but are challenged due to lack of funding and time constraints. Opportunities

do exist to increase and improve evaluation efforts as access to real-time data and ability to monitor health status, Essential Service #1, improves.

Forces & Trends: Through a discussion of current and potential forces and trends affecting the public health system, Partnership members identified thirteen categories of trends, covering a wide range of issues. These trends provide both challenges that the system will need to overcome to continue to provide care, as well as opportunities that may end up strengthening the overall system. Opportunities often may be realized by collaborations among agencies and development of more cost-effective strategies. For example, health professional shortages threaten the quality and provision of health care. However, solutions that bring more students into the health careers will also serve to increase workforce diversity.

Forces and Trends Affecting the Public Health System

- Demographic Changes in Chicago's Population Mix
- Gentrification changing communities and displacing low-income populations
- Economic and Business Changes
- Medicaid and Other State Health Insurance Programs
- Growing Number of Uninsured and Underinsured
- Changes in Health System
- Health Disparities (Racial, Ethnic, Other)
- Health Behaviors and Chronic Diseases
- Limited Resources and Community Support
- Public Health and Health Care Workforce
- Emergency Preparedness Systems
- War in Iraq
- Public Health Accreditation Programs

Phase 4: Strategic Issue Identification: In this next phase of the strategic planning process Partnership members identified the strategic issues affecting the public health system. To determine these issues, the Partnership compared the findings from the situation assessments to the vision statement to expose gaps and underlying causes for these disparities. Strategic issues clarify the areas where the local public health system should focus if it is to make substantial improvements in the health of Chicago residents.

Strategic Issues

Issue #1: How can the local public health system best assure access to care?

Issue #2: How can Chicago's public health system partners most effectively work to eliminate disparities in health status?

Issue #3: How can the public health system best support communities in an effort to improve neighborhood cohesion, communication, and coordination of public health care resources?

Issue #4: How can the public health system assure a competent and responsive work force to meet the population's needs?

Issue #5: How can the local public health system best facilitate a paradigm shift so that preventive practices are incorporated at both the system and individual level?

Phase 5: Strategy Development: The development of strategies moves the strategic planning process further along from assessment toward implementation. The Partnership members considered each of the five strategic issues identified in the previous phase of the planning process and formulated strategies to respond to these concerns based on criteria of economic feasibility, acceptability, resource availability, and concordance with the Ten Essential Public Health Services.

This exercise resulted in over 40 strategies, of which most will benefit more than one strategic issue. To focus on these proposed actions and reflect the Partnership's approach, the strategies were grouped into seven cross-cutting action areas. Partnership members identified their priority action areas and strategies within each of the areas through a survey and discussion at a meeting. The following action areas are listed in order of Partnership priority:

Cross-cutting Strategy Action Areas

1. Use data to influence resource allocation.
2. Improve processes to access to health and social services.
3. Build community structure to facilitate healthier behaviors and appropriate use of the health care system.
4. Advocate for legislative and institutional policy changes to increase access to care.
5. Conduct media campaigns to promote prevention and increase awareness of how social determinants affect health.
6. Establish non-traditional training methods to promote health care careers and increase workforce diversity.
7. Promote provider and community competencies.

Phase 6: Action Cycle: As noted above, Partnership members completed a survey to identify the top three action areas and the top one or two strategies within each area. The Partnership then developed implementation plans for each of these areas, including measurable outcome and impact objectives. These plans also identify what organizations will lead the work on these strategies, needed resources, and evaluation methods. In addition, these plans relate the objectives of the Chicago Partnership to the Healthy People 2010 National health objectives.

Action Area 1: Use data to influence resource allocation.

Outcome Objective 1.1: By December 31, 2011, state and local public health care funding will be allocated based on need, as documented by data-driven analysis.

State and local public health funding are large determinants of the breadth and depth of public health programs and ultimately the program's ability to impact the population. Therefore, governmental funding is of utmost importance in properly addressing public health problems. However, the level of public funding often does not correspond to documented needs.

To address this situation, the Chicago Partnership will facilitate the development of a comprehensive health care needs analysis that strengthens the case for data-driven funding allocation. The needs analysis will incorporate data from a wide variety of traditional and non-traditional sources. The Chicago Partnership will work to disseminate the findings of this analysis and advocate that decision makers utilize this information for funding allocation decisions.

Action Area 2: Improve processes to access health and social services.

Outcome Objective 2.1: By December 31, 2011, 50% of clients who enroll in state health and social programs will use the state's online one-stop application process. (Estimated baseline in 2006: 25%)

Many factors affect access to health care and social services, including the process by which people enroll in state programs. In Illinois, this process can be confusing, time consuming, and complicated. Many programs have different eligibility requirements and different verification processes. The State of Illinois did create an online application form for the All Kids program that guides enrollees through the process and downloads the information directly to the Department of Healthcare and Family Services. However, since this application covers only one program, individuals still need to complete more applications for the other programs. A joint application is available online for some

programs, but is just a copy of the hard copy form already being used and must be printed up and delivered to the office rather than being able to be submitted online.

To improve access to care, the Chicago Partnership will advocate to the State of Illinois to develop and implement an online one-stop application form for all its health and social service programs. This would make the enrollment process easier and quicker and help people obtain all the benefits for which they are eligible.

Outcome Objective 2.2: By December 31, 2011, clients at Chicago Department of Public Health clinics who were served by an interpreter (both onsite and through telephone interpreting services) will report similar satisfaction levels as clients served by providers who spoke their primary language.

Clear communication between a provider and a client improves the client's ability to access the health care and social services they need. Treatment is also influenced by communication, to ensure the provider fully understands the client's symptoms and that the client complies with the provider's recommendations. Therefore, when serving clients with limited English proficiency (LEP) or who are hearing impaired, providers must either hire bilingual staff or use interpreters.

The Chicago Department of Public Health (CDPH) clinics provide services to people who speak over 25 different languages through a variety of methods, including bilingual staff and interpreters. However, CDPH has not fully assessed how these efforts are meeting clients' needs. The CDPH Office of Multicultural Affairs will form an Advisory Group to analyze CDPH's capacity to serve LEP clients and develop and implement a plan to improve this capacity. The Chicago Partnership will participate as a member of the Advisory Group to assist with this process. The Advisory Group will measure CDPH's ability to serve LEP clients through a client satisfaction survey.

<u>Action Area 3: Build community structure to facilitate healthier behaviors and appropriate use of the health care system.</u>

Outcome Objective 3.1: By December 31, 2011, the public health system partners will work with community organizations to involve residents in at least 30% of Chicago's community areas in discussions about use of the health care system and adoption of healthy behaviors.

Health status indicators affirm the need to share more information about healthy behaviors and use of the health care system with community residents. When done

through local organizations, these health-related discussions can draw a good-sized audience who will voice their concerns and participate in developing local solutions.

To facilitate this process, local organizations will need to be recruited and provided with the latest information. This will be accomplished by CDPH's Center for Community Partnerships for community agencies and by a collaboration between Advocate Health Care's Congregational Health Partnerships and CDPH's Team for Faith-Based Collaboratives for faith-based agencies.

Outcome Objective 3.2: By December 31, 2011, the number of known community-based public health efforts will increase by 25%. (Baseline to be determined by December 31, 2007.)

Community-based public health efforts are an essential component of the public health system since they involve community residents and address key concerns affecting the quality of life in their neighborhoods. This objective aims to facilitate more community-based and community-run public health activities. Currently, CDPH's Center for Community Partnerships works with coalitions in six of Chicago's community areas to support their activities. To encourage more community activities and support ongoing work, the Center will provide direct technical assistance and community-wide trainings. This will grow the number of community efforts occurring in Chicago as well as the increase the effectiveness of all community work.

Next Steps

The Chicago Partnership will further develop the implementation plans for the priority strategies through internal work groups. To ensure that the key implementers of these strategies are involved, the Chicago Partnership will reassess their membership and recruit additional stakeholders as indicated. The work groups will develop detailed work plans and focus on obtaining necessary resources to implement these plans. The majority of the work will occur for these identified priorities. However if strategic opportunities or emerging issues arise, the Partnership may become involved in initiatives for additional action areas.

Introduction

Purpose

The Chicago Department of Public Health (CDPH), the local public health authority for the City of Chicago, is required to complete a community health needs assessment and health plan every five years, in accordance with the Illinois Administrative Code. This assessment, the Illinois Project for Local Assessment of Needs (IPLAN), consists of a comprehensive community health needs assessment and development of a community health plan.

CDPH worked through the Chicago Partnership for Public Health to complete its strategic plan for Chicago's public health system. An IPLAN equivalent process was used, by arrangement with the Illinois Department of Pubic Health. The strategic planning process, *Mobilizing for Action through Planning and Partnerships* (MAPP), was developed by the National Association of County & City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC).

History of the Chicago Partnership for Public Health

The Chicago Partnership for Public Health was formed in 1998 by CDPH as part of the National Turning Point Demonstration Project sponsored by the W.K. Kellogg and Robert Wood Johnson Foundations. The Chicago Partnership is a public-private partnership with a diverse membership of public health stakeholders working toward its goal of strengthening the local public health infrastructure. The Chicago Partnership was the planning body responsible for the *Chicago Plan for Public Health System Improvement*, which was published in 2000 and satisfied the state's requirement for the CDPH IPLAN. The Chicago Partnership is serving at the planning body for the IPLAN 2006-2011.

Approach

Through the MAPP process, the Chicago Partnership for Public Health collected and analyzed data on many issues and from numerous sources, which addressed a broad view of the public health system. This comprehensive assessment not only resulted in an in-depth understanding of the public health system, but also reinforced members' involvement and commitment to implement the plan.

The Chicago Partnership for Public Health completed its strategic planning over a year and a half, meeting every one to two months. Partnership members participated in every phase of the plan: partnership development, refining the vision, guiding the work of the situation assessments, developing strategic issues, and creating strategies and priority strategy work plans.

Much of the data were obtained in cooperation with the CDPH Office of Epidemiology, other CDPH programs, and available state and national data sources. Community perceptions were obtained through focus groups conducted by and in cooperation with CDPH's Center for Community Partnership and their participating coalitions.

Overview of Planning Process

Partnership Development: Before starting the strategic planning process, it is important that all key stakeholders/organizations/system areas are represented at the table. This assures that diverse opinions are heard and that all public health system members are involved in assessing the environment and devising strategies that respond to the community's needs. During this planning process, the Chicago Partnership added new members so that a total of 30 organizations were represented.

Vision: Refining the vision for the public health system proved an important step in clarifying the scope of the strategic plan. Chicago Partnership members strengthened the previous vision by highlighting key system activities and system values. The vision provided an overarching goal for the strategic planning process and acted as a guidepost when Partnership members developed system strategic issues.

Situation Assessment: The situation assessment comprises the main data-gathering component of the MAPP process. This assessment is akin to the community health needs assessment portion of the IPLAN. It contains four parts, each providing a unique and complementary perspective of the public health system. By discussing the assessment findings as a group, Partnership members found a common understanding of the status of public health system and a foundation on which to develop system interventions.

Health Status Profile: The Health Status Profile presents data that describes Chicago's population by demographic and socioeconomic status, health status, health perceptions and health behaviors, and measures of access to care. These data provide insight into populations at risk, disease trends, and behavior patterns that influence health status. Data are provided by gender, race/ethnicity, and city region.

Community Perceptions: Residents in ten Chicago communities participated in focus groups to share their input on the health care system. They voiced concerns about health care in their community, shared what was working for their community, and made suggestions on how to improve the system so their communities could be healthier. While feedback centered on health care, community members did recognize how other factors, such as the environment, education, and poverty, influenced their health.

Local Public Health System Assessment: Using the Ten Essential Public Health Services as a guide, the Partnership reviewed the current system activities. The Ten Essential Services describe the responsibilities and activities of local public health system. This list of services was developed in 1994 by a working group of representations from the Centers for Disease Control and Prevention, U.S. Public Health Service agencies, and other national public health organizations. For each essential service, Partnership members cited service components, current activities, and organizations that play a major role accomplishing this work. This assessment highlighted gaps in services that will challenge the system, as well as possible opportunities that could arise from these situations.

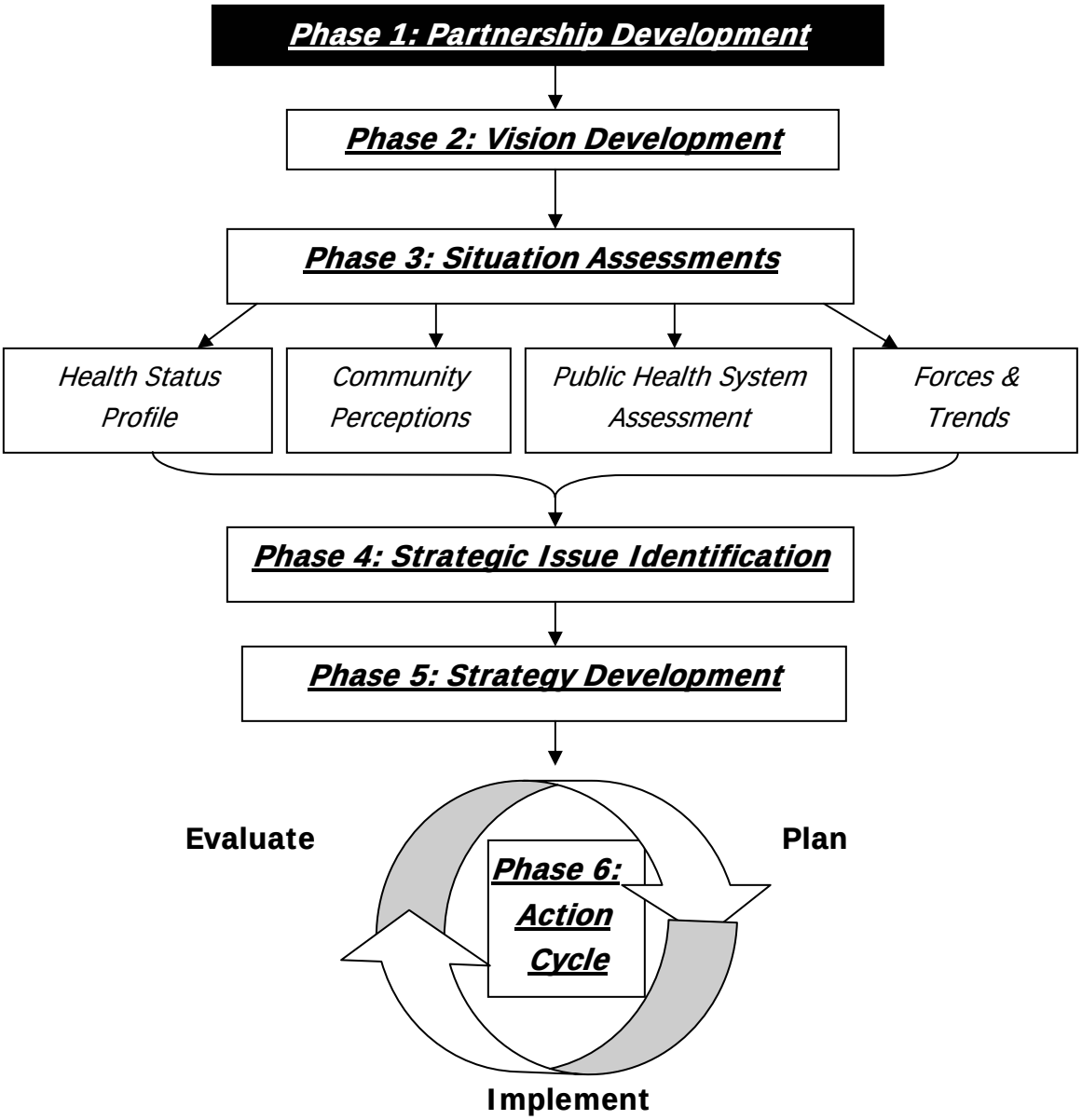
Forces and Trends: The Forces and Trends assessment allows the Partnership members to move beyond current system activities to identify external and internal forces and trends that will affect the future functioning of the health system. The Forces and Trends assessment also requires identification of possible challenges and opportunities that may come out of these changes. This information provides another distinct analysis that is imperative to consider when identifying strategic issues and developing objectives and implementation plans.

Strategic Issue Identification: Chicago Partnership members examined the vision and the findings from all four parts of the situation assessment to identify the strategic issues affecting Chicago's public health system. The five strategic issues that came out of this session focused on key concerns that must be addressed to make improvements in the health care system.

Strategy Development: Strategy development occurred in several phases. First, Partnership members identified strategies that responded to each of the five strategic issues. In many cases, the strategies were closely related and impacted more than one strategic issue. These strategies were then grouped into seven crosscutting action areas that described what the Partnership thought was needed to improve the system. To focus its efforts, Partnership members ranked the action areas and their strategies to come up with the three top priorities.

Action Cycle: Partnership members developed implementation plans for priority strategies at a Partnership meeting. Measurable objectives were created for each strategy to guide the implementation and to assess progress. Implementation plans clarified the lead and secondary implementers, as well as the resources needed to carry out that strategy. The Chicago Plan also identifies how each objective will be evaluated, another key component of the strategic plan's action cycle and the one by which the Plan's success will be measured.

Chicago Partnership for Public Health
MAPP Process



Partnership Development

Purpose

The results of the strategic planning process depend on the input and decisions of the members of the Partnership. Therefore, it was essential to this process to establish a broad-based Partnership, representative of the public health system, to ensure the strategic plan fully addressed all areas affecting the public health system.

Approach

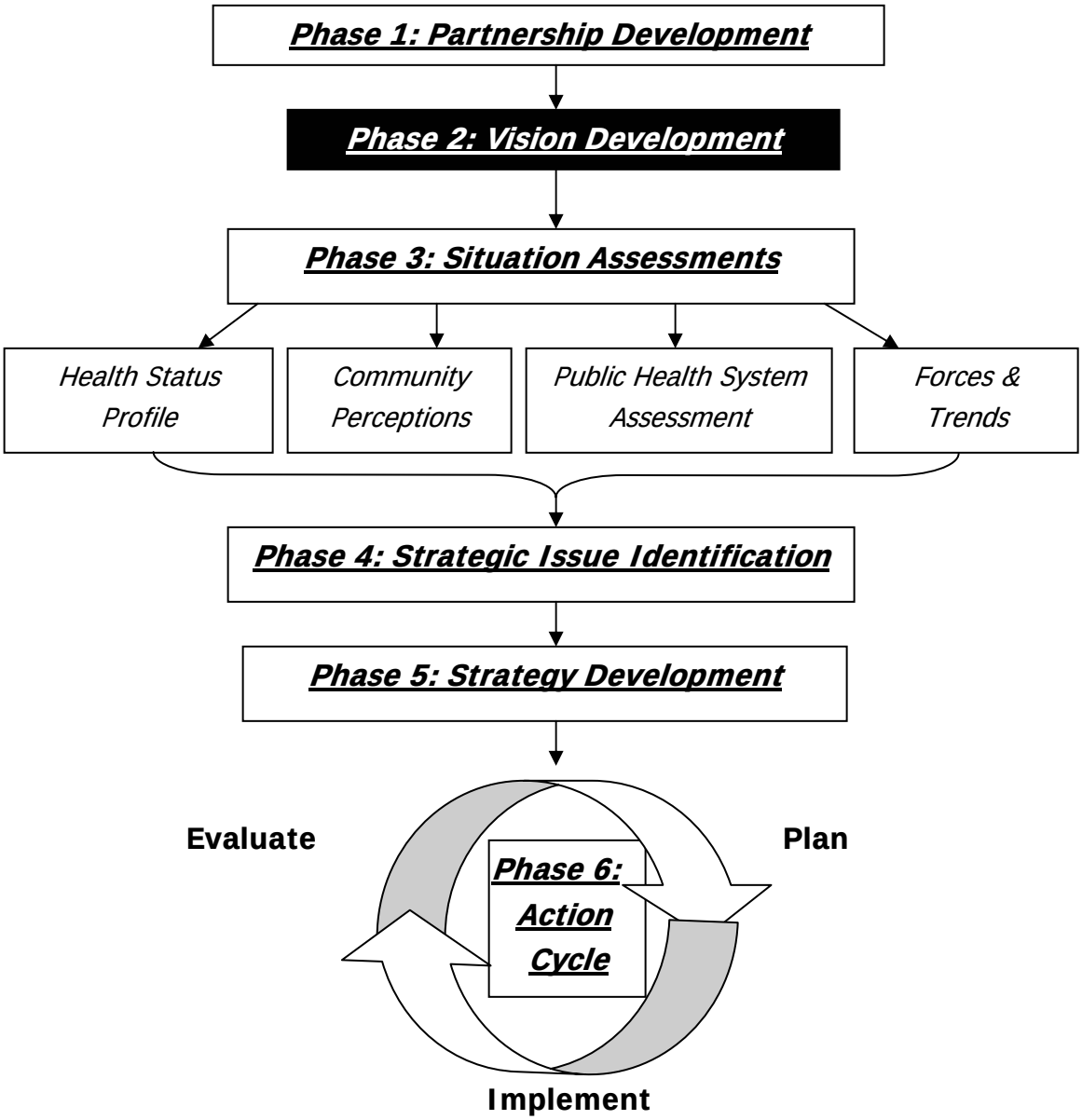
The Chicago Partnership for Pubic Health is the body through which the Illinois Project for Local Assessment of Needs (IPLAN) for Chicago was conducted. The Chicago Partnership is a public-private partnership that was established in 1998 in response to the National Turning Point initiative through the W.K. Kellogg and Robert Wood Johnson Foundations. The Chicago Department of Public Health supports and staffs the Chicago Partnership and the Commissioner is the Partnership Chair. The Chicago Partnership was instrumental in developing Chicago's IPLAN for 2000, and has continued since its inception to meet six times a year to work toward its goal of strengthening the public health system.

Partnership Development

At the beginning of the strategic planning process, members of the Partnership reviewed the representation of current member organizations and recommended additional public heath stakeholders to ensure a comprehensive planning body. As a result of these invitations, six organizations joined or renewed their membership.

Governmental agencies comprise 30% of all the Partnership participants, representing public health, human services, aging, children and youth services, police, and fire. Representatives from both policy and advocacy/social service agencies and community coalitions each account for 17% of the Chicago Partnership members. Thirteen percent of the Partnership members represent provider associations for medical providers and health care facilities, 10% of the members are from educational institutions and research facilities, and 7% come from faith-based agencies. Members from business and philanthropy each represent 3% of the total partnership. (See Chicago Partnership membership list in *Acknowledgements* section.)

Chicago Partnership for Public Health
MAPP Process



Vision Development for Chicago's Public Health System

Purpose

Developing a vision for the public health system is an essential component of the strategic planning process, as it provides the focus for the rest of the strategic planning activities. The vision describes conditions and activities of the public health system when functioning at its highest level of effectiveness and efficiency. This ideal picture of the local public health system is then used for comparison to the current level of system functioning to facilitate identifying those changes that are necessary to improve the system. A vision is used as a marker to help guide development of strategic development and will be also used to evaluate outcomes

Approach

In developing the vision, Partnership members discussed what Chicago's public health system should look like at its best, including inherent characteristics and values. Partnership members also considered:

- Who the system would serve?
- What the system would do?
- How the system would function?

Chicago Partnership members started with the current vision, developed in 1999, and adapted it to address current considerations.

The Vision Statement

The Chicago Partnership for Public Health's vision for the local public health system is:

> *A responsive, sustainable system that through:*
> - *cooperative efforts of all stakeholders,*
> - *planning and policy development,*
> - *a broad focus on access to services and information,*
> - *health promotion and disease prevention, and*
> - *shared leadership and accountability for the essential services of public health;*
>
> *will actively addresses current and future public health challenges while protecting and promoting the health and well-being of Chicago's communities, residents, and visitors, particularly the most vulnerable.*

Who the System Will Serve:

- 2.8 million individuals who live in Chicago
- Communities, Partnerships, and Populations-in-need
- 1.2 million persons who work in Chicago
- Nearly 41 million visitors

What the System Will Do:

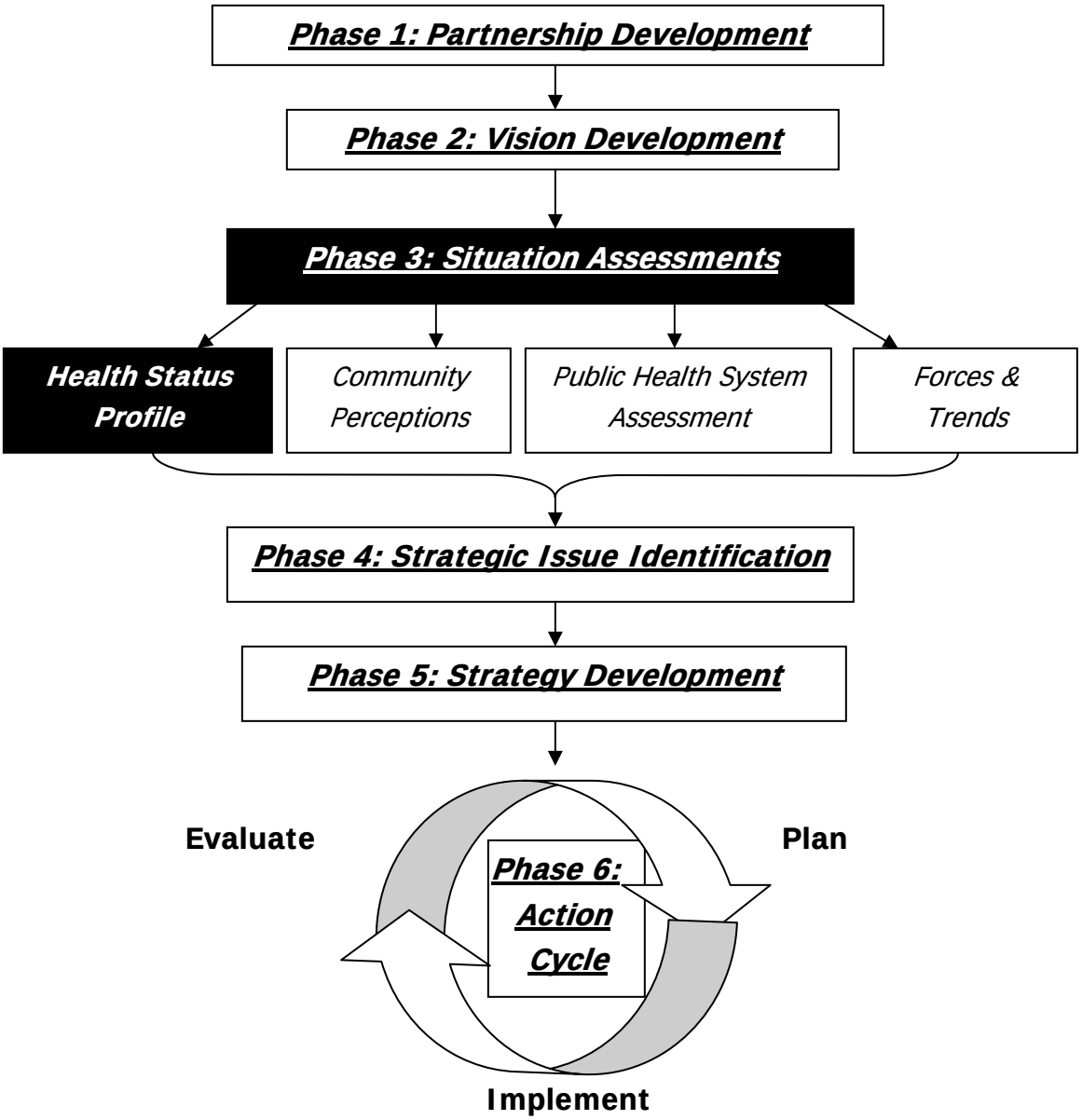
- Provide services that promote health and prevent disease
- Support and facilitate community empowerment to address health concerns
- Provide comprehensive and holistic services, which work to reduce the negative effects of poverty and racial/ethnic/other disparities.
- Carry out the Ten Essential Services of Public Health:
    - Monitor health status to identify community health problems.
    - Diagnose and investigate health problems and health hazards in the community.
    - Inform, educate, and empower people about health issues.
    - Mobilize community partnerships to identify and solve health problems.
    - Develop policies and plans that support individual and community health efforts.
    - Enforce laws and regulations that protect health and ensure safety.
    - Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
    - Assure a competent public and personal health care workforce.
    - Evaluation effectiveness, accessibility, and quality of personal and population-based health services.
    - Research for new insights and innovative solutions to health problems.

How the System Will Function/System Values:

- Operates as a highly visible public-private partnership, with shared leadership and public accountability.
- Includes all stakeholders, groups, and communities, with a special focus on the most vulnerable.
- Allocates resources to reflect commitment to populations most in-need.
- Facilitates and maintains solid interconnectedness to other public health systems in Illinois and neighboring states.
- Promotes networking and communication among organizations.
- Focused on solutions.
- Committed to social justice.

Chicago Partnership for Public Health

MAPP Process



Health Status Profile

Purpose

The health status profile is one of the four situation assessments of the strategic planning process and the one most common to public health due to its foundation in epidemiology. Through this assessment, data were collected and analyzed to identify population-based changes through a variety of measures, including demographics, socioeconomic status, health status, health perceptions, health behaviors, and health system utilization. These data provide information that points toward trends in the health of the community and establishes a baseline to help direct the focus of the strategic planning, as well as demonstrate improvements and challenges that occurred during the specific time periods.

Approach

Use of multiple sources provided data on key areas that highlight the health of Chicago, including:

- Demographic and Socioeconomic Status
- Health Status Indicators
- Health Perceptions and Health-Related Behaviors
- Health Care Delivery and Access to Care

Data Sources

This Health Status Profile presents data collected from a variety of sources. One of the largest sources was the Chicago Department of Public Health's (CDPH) Office of Epidemiology, which operates surveillance systems and maintains data on many health conditions, including:

- HIV/AIDS
- Sexually Transmitted Diseases
- Lead Poisoning
- Tuberculosis
- Vaccine-Preventable Diseases

The Chicago Department of Public Health was also able to access the following databases:

- Illinois Department of Public Health's hospitalization database for data on morbidity and mortality
- Vital Records for maternal and child health indicators
- U.S. Census for demographic and socioeconomic data

Data on the uninsured were obtained through the publications of The Gilead Outreach & Referral Center. The Chicago Police Department's annual reports were used to report information on crime by type and location.

The Behavioral Risk Factor Surveillance Survey (BRFSS) collects information annually on behaviors and conditions of adults 18 years of age or older that are related to leading causes of death. The survey is conducted by telephone as a collaboration between the Centers for Disease Control and Prevention (CDC) and state health departments, and its findings on adult behaviors, such as preventive health screenings, weight control, exercise, tobacco, and alcohol use are released annually on its website.

The Youth Risk Behavior Surveillance Survey (YRBSS) is a biennial survey conducted with representative samples of 9th through 12th grade students to monitor priority health risk behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults in the United States. YRBSS provides national, state, and local data on tobacco use, dietary behaviors, exercise, alcohol and other drug use, sexual behaviors, unintentional injuries, and violence.

Levels of Analysis

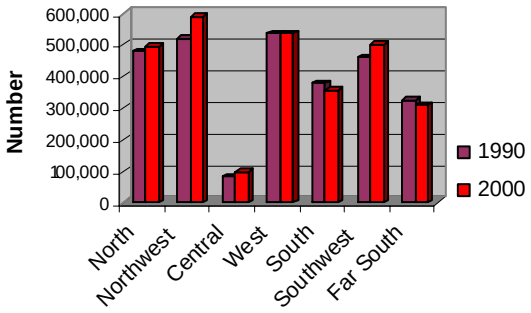
Data were analyzed by gender, race/ethnicity and, when available, the seven Chicago Planning Regions. These regions are based on the 77 formally designated community areas in Chicago and primarily follow the Chicago Department of Planning and Development's (DPD) regional approach to planning (Appendix A). Analyzing data by these regions helps to better identify trends and issues occurring in different regions.

Findings

Demographic and Socioeconomic Status

Chicago's population of nearly 2.9 million in year 2000 was 4% greater than the city's 1990 population. Within the seven regions, 2000 population size ranged from 98,708 (Central region) to 590,720 (Northwest region). Across the city, four regions experienced population increases, while the populations in two regions declined (Figure 1). The Central and Northwest regions experienced the greatest population growth during this period, 21% and 14% respectively. The populations in the South and Far South regions decreased 6% and 5% respectively. There was no change in overall population size in the West region.

Figure 1: Population by Region 1990 and 2000



The distribution of Chicago's population by race and ethnicity in 1990 and 2000 is reflected in Figure 2. During this ten-year period there were notable shifts in the composition of the city's population. Much of this change was driven by large increases in Chicago's Hispanic population, which increased by 38%. While the much smaller Asian population increased by 27% during this period, there were decreases in the number of Black (2%) and White (14%) residents.

Figure 2: Population by Race/Ethnicity 1990 and 2000

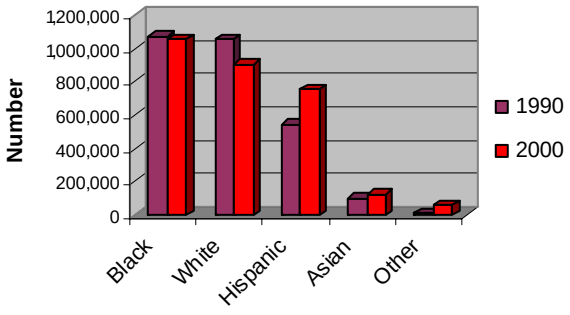
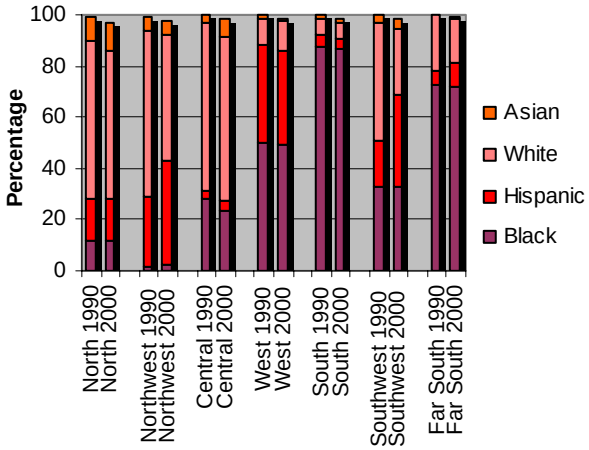


Figure 3 presents the 1990 and 2000 population distributions of each region by race and ethnicity. Among Hispanics, population increases were most notable in the Southwest (117%) and Northwest (71%) regions; decreases occurred in the South (13%) and West (2%) regions. The Black population increased in four regions, with the greatest increase, 50%, in the Northwest region. Decreases, all of less than 10%, were seen in three regions. The White population decreased in all but the West and Central regions, while the number of Asians increased in six of the seven regions.

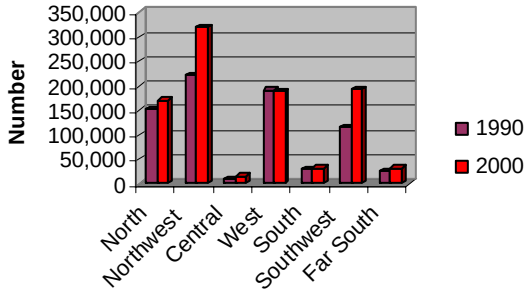
Figure 3: Population Distribution by Race/Ethnicity, 1990 and 2000



With the changes in the city's racial and ethnic composition, it is not surprising that there were fairly dramatic changes in the primary language spoken by Chicagoans. Between 1990 and 2000, there was an increase of 27%, or nearly 205,000 Chicagoans, who reported speaking a primary language at home that is not English. This population segment represented 29% of the city's entire population five years of age and older in 1990 and 36% of the 2000 population. By region, increases ranged from 5% (South) to 85% (Central). The West region was the only region that saw a decrease among this segment of the population (Figure 4).

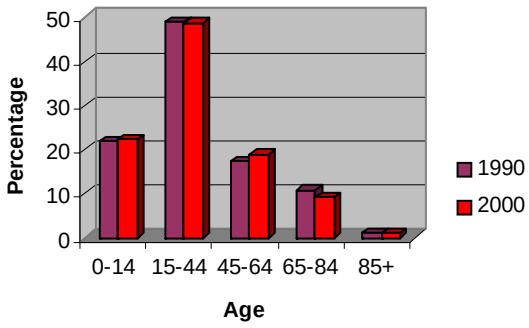
Nationally, there has been much discussion about the aging of the U.S. population. The number of people 65 years and older in the U.S. increased 12% from 1990 to 2000. However, the overall percentage of older people decreased from 12.7% of the 1990 population to 12.4% of the 2000 population. In Chicago, the population of people aged 64 to 84 decreased by 12%. Although Chicago's data do not indicate a growth in the population of older adults, it will be important to monitor population changes to ensure the health care system has the capacity to serve its residents.

Figure 4: Chicagoans Whose Primary Spoken Language at Home is Not English 1990 and 2000



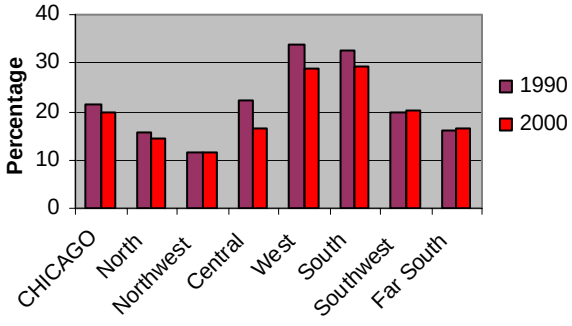
Besides the older population, almost all the other age groups increased; although there was very little change in the overall composition of the city by age. In both 1990 and 2000, persons ages 14 years and younger comprised about 22% of Chicago's population, while just under 50% of the population was between 15 and 44 years old (Figure 5).

Figure 5: Population Distribution by Age, 1990 and 2000



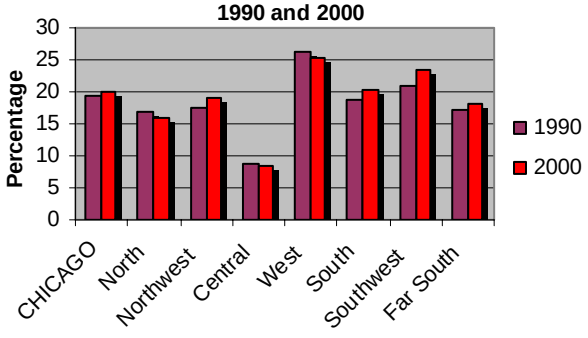
The proportion of Chicagoans living below the poverty level decreased by 9% between 1990 and 2000 (Figure 6). In 1990, 592,325 persons (22%) reported living below the federal poverty level; in 2000 that figure had declined to 556,791 or 20%. Regionally, decreases in the proportion of the population living in poverty ranged from 9% (North) to 26% (Central) and were seen in four of seven regions. The increases observed in the remaining three regions were each less than 3%.

Figure 6: Percent Population Living Below Poverty Level, 1990 and 2000



Despite the declining population living below poverty level, during this same period there was an increase of 3% in the proportion of Chicagoans who are near poor, that is living between 100 and 199% poverty (Figure 7). These persons are the least likely to be covered by either public or private health insurance. Increases in the proportion of the population at this income level ranged from 5% to 12% and occurred in four regions. Decreases from 3% to 6% were seen in the remaining three regions.

Figure 7: Percent Population Living Between 100-199% of Poverty Level 1990 and 2000



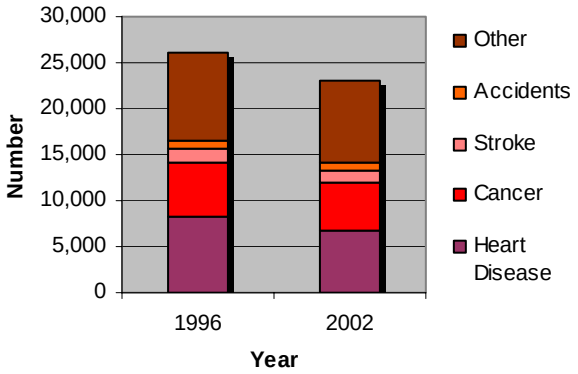
Health Status Indicators

Mortality

Leading Causes of Death

In 2002, 22,998 deaths occurred in Chicago, almost 3,000, or 12%, fewer deaths than occurred in 1996 (25,980). The age-adjusted death rate decreased from 1,059 per 100,000 population to 945. Heart disease remains the leading cause of death, accounting for 32% and 30% of all deaths in 1996 and 2002, respectively (Figure 8). Cancer, stroke, and accidents were the second, third, and fourth leading causes of death in both 1996 and 2002 and together with heart disease comprised 64% and 62% of all deaths in 1996 and 2002, respectively. Deaths due to accidents include cases of narcotics overdoes, which increased from 348 in 1996 to 515 in 2002, or from 35% to 50% of all accident deaths.

Figure 8: Leading Causes of Death by Year



Gender: Males have higher age-adjusted mortality rates than females on all the top ten leading causes of death. The largest variation was for homicides, where the 2002 age-adjusted rates indicated that males were almost seven times as likely to die than females.

Rate of death due to accidents showed males dying at a rate that was three times that for females.

Race/Ethnicity: Deaths due to accidents accounted for the third leading cause of death for Hispanics in 2002, the fourth leading cause for Blacks, the fifth leading cause for Whites, and the seventh leading cause for Asians. (Table 1) Narcotic overdoes, which comprised 50% of accident deaths in 2002, showed higher numbers and age-adjusted mortality rates for the Black and White populations (32 and 16 in 2002), although the Hispanic rate increased by 125% from 1996 to 2002 (4 per 100,000 to 9).

Table 1: Leading Causes of Death (by number) in 2002 By Race/Ethnicity

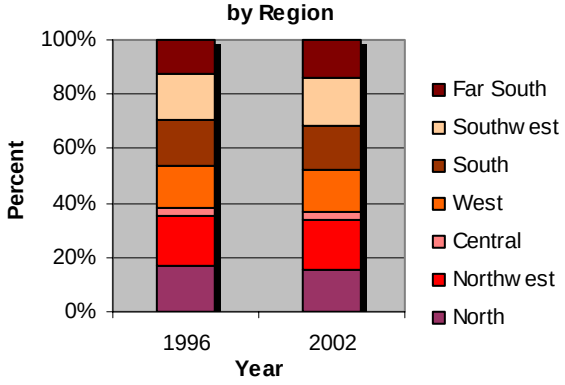
Rank\ Group	White	Black	Hispanic	Asian
1	Heart Disease	Heart Disease	Heart Disease	Heart Disease
2	Cancer	Cancer	Cancer	Cancer
3	Stroke	Stroke	Accidents	Stroke
4	Chronic Lower Respiratory Disease	Accidents	Homicide	Diabetes
5	Accidents	Homicide	Diabetes	Influenza/Pneumonia
6	Influenza/Pneumonia	Septicemia	Stroke	Chronic Lower Respiratory Disease
7	Diabetes	Chronic Lower Respiratory Disease	Liver Disease	Accidents
8	Septicemia	Nephritis	Septicemia	Nephritis
9	Nephritis	Diabetes	Influenza/Pneumonia	Suicide
10	Alzheimer's Disease	HIV/AIDS	Chronic Lower Respiratory Disease	Septicemia

Homicides were the fourth leading cause of death for Hispanics, the fifth for Blacks, and the eighth leading cause citywide. The number of deaths due to homicide decreased from 801 in 1996 to 612 in 2002, in part due to the decrease in the number of homicide deaths in the Black population, down from 624 in 1996 to 454 in 2002.

HIV/AIDS was the sixth leading cause of death in 1996 for Chicago, the fifth leading cause for both males and Hispanics (third for Puerto Ricans), the sixth cause for Blacks, and ninth for Whites. Since that time, treatment for AIDS has improved, helping to decrease the number of deaths by 63% (from 847 to 317). Except for the Puerto Rican and Black populations, for which HIV/AIDS was the eighth and tenth leading causes of death, respectively, HIV/AIDS was not among the top ten causes of death in 2002.

Regionally: The percentages of regional deaths by total deaths were similar for both 1996 and 2002, with the Northwest region accounting for the highest percentage of all deaths (18% and 19% in 1996 and 2002, respectively) and the Central region having the lowest percentage (3% in 1996 and 2002) (Figure 9). Age-adjusted mortality rates by region for 2002 showed similar rankings (Appendix B).

Figure 9: Total Number of Deaths by Region



By specific cause of death, regions showed some variations in the ranking of leading causes of death (Table 2). Accidents were the third leading cause of death for the West and Central regions; the fourth leading cause for Northwest, South, Southwest and Far South; and the sixth leading cause for North. By age-adjusted mortality rate for accidents, the West, South, and Southwest regions had the highest rates of all the regions, respectively (Appendix C). South region had the highest percentage of accident deaths due to narcotic overdoses in 2002, 63%, which had increased from 45% in 1996. Southwest region also had a large increase, with narcotic overdoses representing 47% of all accident deaths in 2002 up from 23% in 1996 .

Diabetes ranked as either the sixth, seventh, or eighth leading cause of death for most of the regions, except for the Central region, where it ranked tenth. The West and Far South regions had the highest death rates for diabetes (37 and 36 per 100,000) and the Central region had the lowest rate (11 per 100,000 population).

Table 2: Leading Causes of Death (by number) in 2002 By Region							
Rank\ Region	**North**	**Northwest**	**Central**	**West**	**South**	**Southwest**	**Far South**
1	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease
2	Cancer	Cancer	Cancer	Cancer	Cancer	Cancer	Cancer
3	Stroke	Stroke	Accidents	Accidents	Stroke	Stroke	Stroke
4	Influenza/ Pneumonia	Accidents	Stroke	Stroke	Accidents	Accidents	Accidents
5	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease	Homicide	Septicemia	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease
6	Accidents	Diabetes	Septicemia	Diabetes	Homicide	Diabetes	Septicemia
7	Diabetes	Influenza/ Pneumonia	Influenza/ Pneumonia	Chronic Lower Respiratory Disease	Nephritis	Homicide	Diabetes
8	Septicemia	Septicemia	Alzheimer's Disease	Septicemia	Diabetes	Septicemia	Nephritis
9	Alzheimer's Disease	Nephritis	Suicide	Nephritis	Chronic Lower Respiratory Disease	Influenza/ Pneumonias	Homicide
10	Nephritis	Liver Disease	Diabetes	Influenza/ Pneumonia	Influenza/ Pneumonia	Nephritis	Influenza/ Pneumonia

Influenza and pneumonia ranked as North's fourth leading cause of death and had a mortality rate of 32 deaths per 100,000 population in 2002. In contrast, influenza and pneumonia ranked as the tenth leading cause of death in the Far South, West, and South regions and Far South has the lowest mortality rate of 19 per 100,000 population.

Years of Potential Life Lost

Years of Potential Life Lost (YPLL) is a mortality index that assesses premature mortality and is defined as the number of years of life lost among persons who die before age 65. YPLL presents the relative impact of various diseases and behavioral forces. In 2002, the 22,998 deaths that occurred in Chicago resulted in 161,320 years lost. This was a decrease from 1996 where the 25,980 deaths resulted in 202,329 years lost. YPLL decreased by 20% while the number of deaths decreased by 12%. (Figure 10).

Gender and Race/Ethnicity: Males accounted for the majority of the YPLL, at 66% in 1996 and 65% in 2002. This represented a decrease of almost 30,000 years (from 134,400 in 1996 to 104,700 in 2002) or 22%. Females also had a decrease in years of potential life

lost of 17% (from almost 68,000 to 56,000). Blacks comprised 60% of the years of life lost in 2002, a slight decrease from 63% in 1996. In comparison, Hispanics had an increase in the percentage of years of life lost, from 14% in 1996 to 17% in 2002, in part due to the rise for Mexicans, from 9% to 11%.

Differences between the percent of YPLL and the percent of numbers of deaths show the effect of deaths on a younger population. For both 1996 and 2002, the percentage of deaths was generally split fifty-fifty between males and females, but males comprised about two-thirds of all YPLL indicating that males died at a younger age (Figure 11). The Black population also showed this trend, as seen in 2002, when they comprised 46% of all deaths, but 60% of total YPLL (Figure 12). The White population made up a similar percent of deaths as Blacks, 44% in 2002, but only 21% of YPLL. The Hispanic population had a higher proportion of YPLL compared to percent of deaths. Asians represented 2% of all deaths as well as 2% of YPLL.

Figure 10: YPLL and Number of Deaths in 1996 and 2002

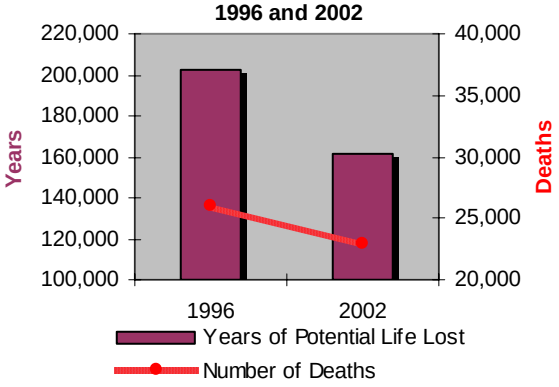


Figure 11: Number of Deaths compared to YPLL by Gender: 2002

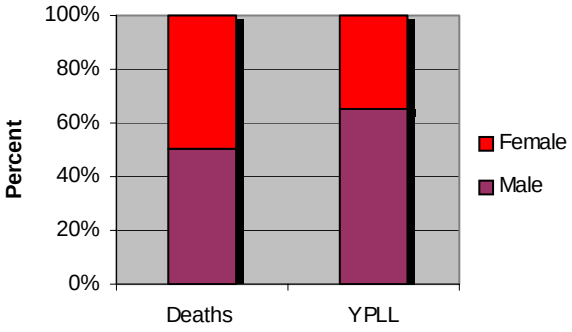
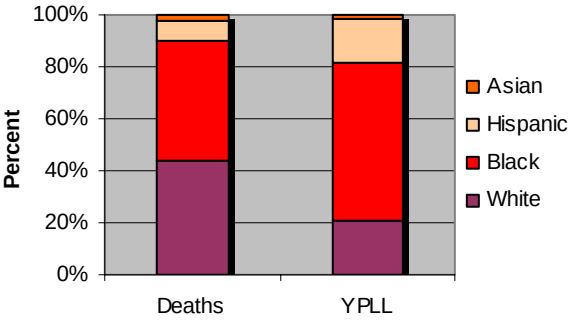


Figure 12: Number of Deaths compared to YPLL by Race/Ethnicity: 2002



Regionally: All regions had decreases in number of years of life lost in 2002 compared to 1996. The largest decreases occurred in the North region (32%), South (29%), Far South (27%), and Central (27%). Of all the regions, the West had the largest percentage of years of potential life lost (YPLL): 24% in 1996 and 23% in 2002 (Figure 13). The Southwest and South regions made up the regions with the next highest proportions of YPLL. When

comparing YPLL rates, the South region has the highest rate, at 875 per 10,000 population under age 65 (Appendix D).

By Specific Causes: The number of years of potential life lost (YPLL) decreased for several causes of death (Figure 14). Homicides accounted over 29,700 years lost to homicide in 1996, or 13% of all causes. This number decreased in 2002, with homicides the cause of 21,800, or 14% of all years lost. Blacks still comprised a majority of life lost to homicide in 2002, at 74%, although a decrease of 7,000 years lost, or 30%, occurred when comparing to 1996 (from 23,000 years lost to 16,000 years lost).

Figure 13: YPLL by Region and Year

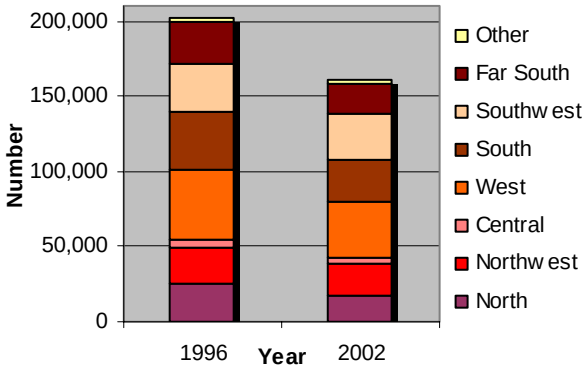
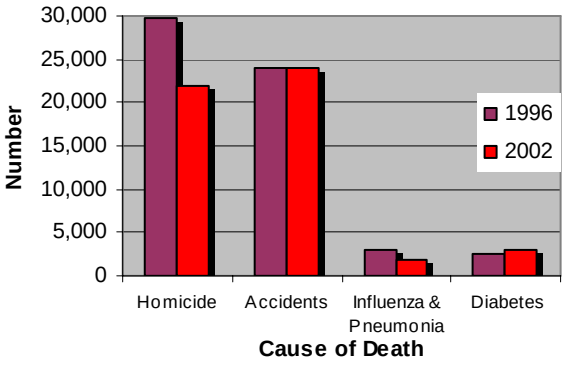


Figure 14: YPLL by Cause of Death



Accidents replaced homicide as the leading contributor of years of life lost in 2002, up from 12% in 1996 at 24,057 years lost to 15% in 2002 at 23,904 years lost. Increases were noted for the White population (up 8%) and Hispanics (up 21%, including an increase of 34% for Puerto Ricans and 18% for Mexicans). The number of years lost due to accidents decreased slightly for Blacks (by 7%) and significantly for Asians (by 71%). Narcotics overdoses represented a substantial portion of YPLL for accidents, at 31% in 1996 and 28% in 2002.

Influenza/pneumonia showed the largest percent decrease of all leading causes of death when comparing 1996 and 2002. In 1996, 3,000 years were lost to influenza/pneumonia compared to 1,800 in 2002, a 40% decrease. All populations experienced decreases: White population (73%), Asian (55%), Hispanic (39%), and Black (30%).

Diabetes was responsible for approximately 700 deaths a year, but for almost 3,000 years of potential life lost in 2002. In contrast to decreases in overall YPLL, diabetes YPLL rose by 448, or 28%. Increases were noted in the Black (39%) and Asian (26%) populations. YPLL for diabetes rose in the Hispanic population by 19%, which represented a 25%

increase for the Mexican population, although the YPLL for diabetes actually decreased in the Puerto Rican population by 13%. A decrease in the YPLL due to diabetes also occurred in the White population, down by 6% when comparing 1996 to 2002.

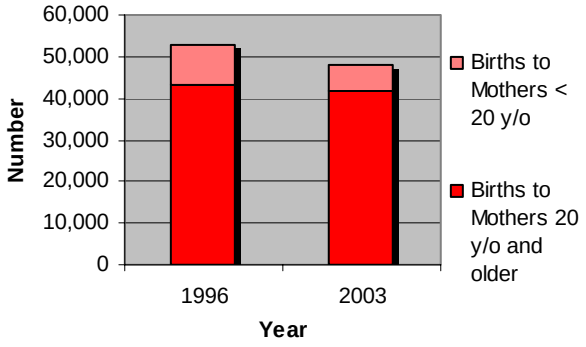
Maternal and Child Health Status

Measures of a community's health often focus on maternal and child health status indicators because a community's ability to care for its vulnerable populations, including children and pregnant women, is a marker of that community's ability to care for its other residents. Indicators of maternal and child health include teen births, infant mortality, low birth weight babies, babies born to mothers who had no prenatal care, and women who used substances during pregnancy. Data from 1996 are compared to 2003, the most recent data available for births, except for infant mortality, for which 2002 is the most recent year for which data are available.

Births to Teens

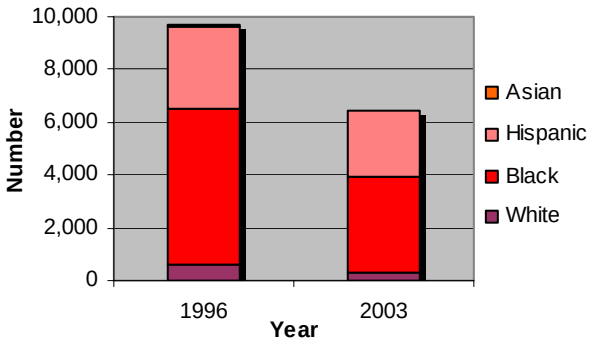
The number of live births in Chicago in 2003 decreased by 9%, or 4,787, when compared to births in 1996 (from 52,831 in 1996 to 48,044 in 2003). The number of births to teens also decreased, but at a higher proportion. In 1996, 9,696 births occurred to teens under 20 years old, while in 2003, 6,469 births occurred to teens—a decrease of 33%. A decrease was also noted in the proportion of teen births to the total of live births: 18% in 1996 to 14% in 2003 (Figure 15).

Figure 15: Births by Year and Age of Mother



Race/Ethnicity: The largest number decrease in teen births occurred within the Black population, where teen births decreased by over 2,300, or 40%, when comparing 1996 and 2003 (Figure 16). The percentage of Black teen births to all teen births also decreased, from 61% in 1996 to 56% in 2003. As a percentage of all Black births, teens made up a decreasing

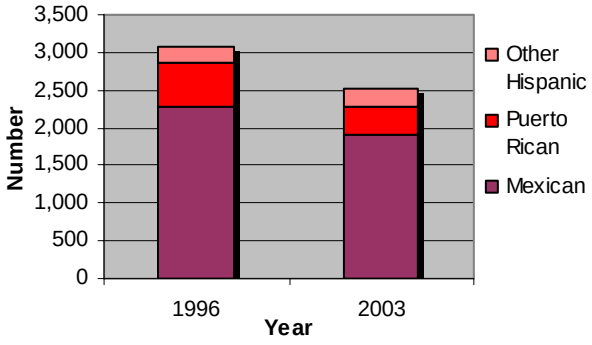
Figure 16: Teen Births by Race/Ethnicity



proportion, from 27% of all Black births in 1996 to 21% in 2003. White teens also had a decrease in the number of births by 330, which was the largest percent decrease at 54%. As the proportion of teen births, White youth decreased from 6% of all teen births in 1996 to 5% in 2003, and from 6% of all White births in 1996 to 3% in 2003.

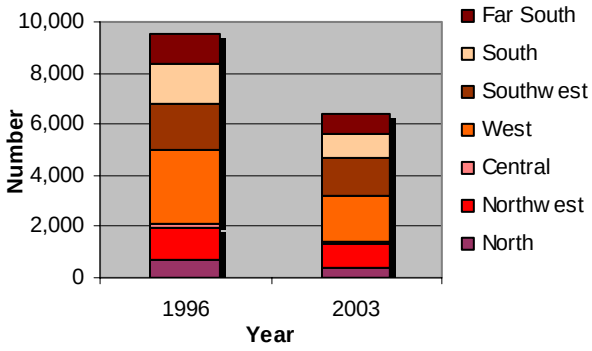
Eighteen percent of births in the Hispanic population in 1996 were to teens under 20 years old. While the total number of Hispanic births of all ages increased in 2003, Hispanic teen births decreased by 567, or 14%. This was seen in both the Mexican population (from 17% to 13%) and the Puerto Rican population (from 25% to 20%). However, as a proportion of the total teen birth population, Hispanic births increased from 32% of all teen births in 1996 to 39% in 2003. Of the Hispanic teen births, Mexicans comprised the majority, 74% in 1996 and 76% in 2003 (Figure 17). Puerto Rican teen births decreased from 19% to 15% of Hispanic teen births and Other Hispanics increased from 7% to 9%.

Figure 17: Hispanic Teen Births by Nationality



Regionally: All regions had decreases in the number of teen births when comparing 1996 and 2003, with the largest decrease in the North (48%) (Figure 18). The largest percentage of teen births occurred in the West region in both 1996 and 2003, which correlates to West also having the largest percentage of live births in both these years. However, the West region's percentage of teen births to all teen births is higher than its percentage of live births to all live births: 30% of all teen births and 23% of all live births in 1996; 27% of all teen births and 20% of all live births in 2003.

Figure 18: Teen Births by Regions

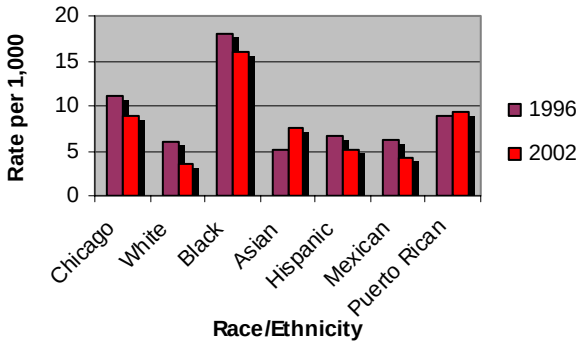


Infant Mortality

The infant mortality rate decreased over 21% when comparing 1996 and 2002, from 11.2 deaths per 1,000 live births to 8.8. The number of infant deaths decreased by 171 (from 592 deaths in 1996 to 421 in 2002).

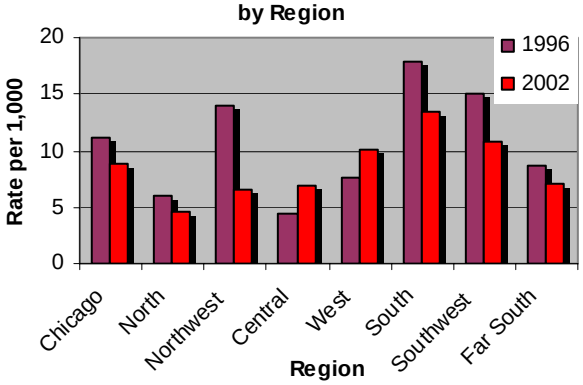
Race/Ethnicity: While these data show improvements in overall health status, the rates of infant mortality among racial/ethnic minorities indicate substantial disparities (Figure 19). The White population had the lowest infant mortality rate in 2002 (3.5), the largest percent decrease in numbers (a decrease of 43%, from 65 in 1996 to 37 in 2002), and the largest percent rate decrease (40%, from 5.9 in 1996 to 3.5 in 2002). Other racial and ethnic groups did show improvements, although their infant mortality rates were higher than the White population. In 2002, the infant mortality rate for Blacks was 15.9 and for Asians was 7.5. The infant mortality rate for all Hispanics was 5.2, although Puerto Ricans had a much higher rate of 9.4, while the rate for the Mexican population was 4.3. Except for the Asian and Puerto Rican populations, these rates were lower than in 1996, but still were higher, in some cases much higher, than the White population. Black infants are most at risk of death, with their rate at four times as high as the White population and almost double the overall rate. Black infant deaths accounted for 67% and 65% of all infant mortality cases in 1996 and 2002, respectively.

Figure 19: Infant Mortality Rates by Race/Ethnicity



Regionally: Infant mortality rates in 1996 and 2002 varied in both severity and trending across the seven regions in Chicago (Figure 20). Consistent with Chicago's trend, five of the seven regions (North, Northwest, South, Southwest, and Far South) had rate decreases. The Northwest region decreased 53% during this time period, from 14.0 deaths per 1,000 live births in 1996 to 6.6 in 2002. The South region had the highest infant mortality rate in 1996 (17.9), which decreased by 25% (to 13.4) in 2002. The North region also decreased by 1.3 points to a low of 4.6 in 2002, the lowest infant mortality rate in the city.

Figure 20: Infant Mortality Rates by Region



Two regions had increases in infant mortality rate. Although Central region represented very small numbers, the infant mortality rate increased 60%, from 4.3 in 1996 to 7.0 in

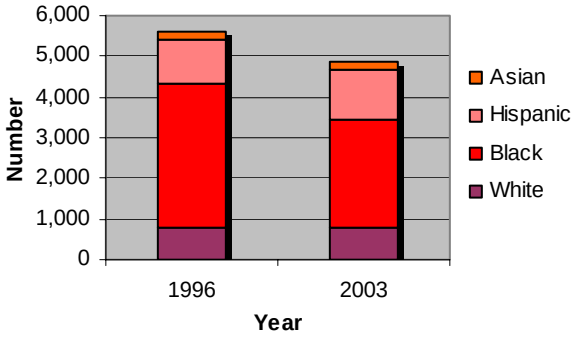
2002. West region also had a 32% increase, from 7.7 in 1996 to 10.2 in 2003.

Low Birth Weight

In 2003, 10.1% of the live births in Chicago were classified as low birth weight (LBW), or less than 5 lbs 8 oz (2500 grams). While lower than the low birth weight percentage in 1996 (10.6%), this percentage has remained similar for many years. The number of LBW babies decreased from 5,559 in 1996 to 4,858 in 2003, or 13%.

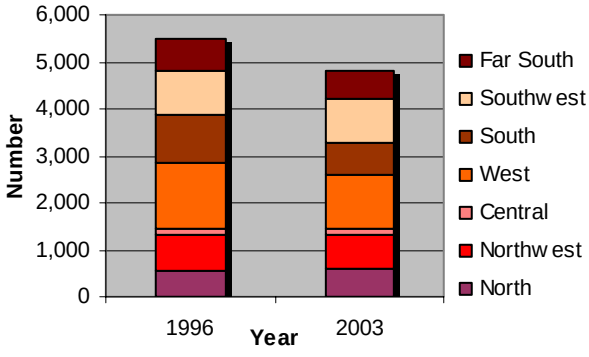
Race/Ethnicity: As with other maternal and child health indicators, racial and ethnic disparities are evident in percentages of LBW babies (Figure 21). Blacks comprised the majority of LBW babies (63% in 1996 and 55% in 2003) and the highest percentage of LBW babies of live births within each racial/ethnic group (16% of Black live births in 1996 and 2003). The percentage of White LBW babies made up 15% and 16% of all LBW babies in 1996 and 2003, respectively and 7% of all White live births in each year. The percentage of LBW babies in the Hispanic population rose from 20% of all LBW babies in 1996 to 25% in 2003, mostly due to an increase of Mexican LBW babies (from 14% of all LBW babies to 18% in 2003). Of all racial/ethnic groups, Hispanics had the lowest percent of LBW babies within the number of live births. The Asian population of LBW babies made up 3% and 4% of all LBW babies in 1996 and 2003, respectively, and 8% and 9% of all Asian births, respectively.

Figure 21: Low Birth Weight Babies by Race/Ethnicity



Regionally: West region accounted for the highest proportion of all LBW babies in both 1996 and 2003 at 25% and 24%, respectively (Figure 22). South region, which had the second highest percentage of LBW babies in 1996 at 18%, experienced a decrease of over 300 cases in 2003, and now houses 15% of all LBW babies. The second highest region in 2003 was Southwest, at 19% of all LBW babies. Although South had the largest

Figure 22: Low Birth Weight Babies by Region

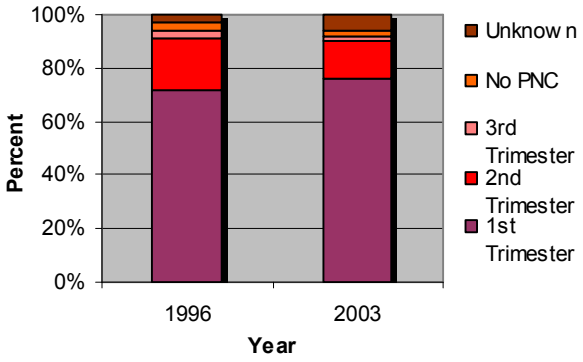


decrease among the regions, it still has the highest percentage of its babies born at a LBW of all the regions (15% in 1996 and 14% in 2003).

Initiation of Prenatal Care

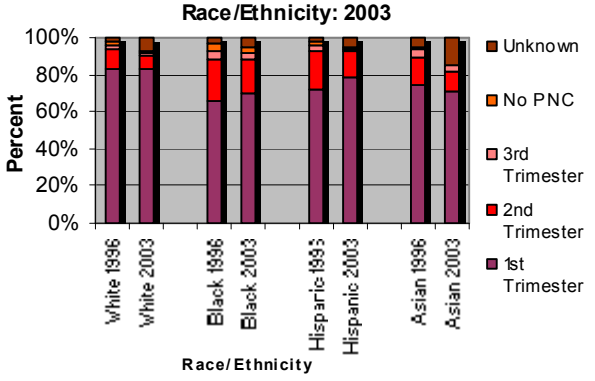
Entry into prenatal care within the first trimester is recommended to monitor the pregnancy and prevent and/or treat problems early. The majority of babies are born to women who enter prenatal care in the first trimester; 72% in 1996 and 76% in 2003 (Figure 23). This percentage increase was accompanied by a decrease in the percentage of babies whose mothers initiated care in the second trimester, from 19% to 14% in 1996 and 2003, respectively. The percentages of babies born to women who entered care in the third trimester or those who received no care at all comprised 3% of all births in 1996 and 2% in 2003.

Figure 23: Initiation of Prenatal Care



Race/Ethnicity: Variations exist by race/ethnicity for the trimester in which the woman initiated prenatal care (Figure 24). The White population had the highest percentage of babies born to women who accessed care in the first trimester: 83% for both 1996 and 2003. Care beginning in the second trimester decreased from 11% in 1996 to 7% in 2003. Cases where care started in the third trimester and where no prenatal care was reported made up 2% and 1% of the White babies born in 1996 and 2003, respectively. The Black population had the lowest percentage initiating care in the first trimester, 66% in 1996, which increased to 70% in 2003. Prenatal care that started in the second trimester comprised 22% of the Black births in 1996 and 18% in 2003, 4% and 3% for third trimester, and 5% and 4% for no prenatal care at all. The percentage of Hispanics accessing early prenatal care increased: 72% to 78% in the first trimester, 20% down to 14% in the second trimester, 4% to 2% in the third trimester, and 2% down to 1% for no

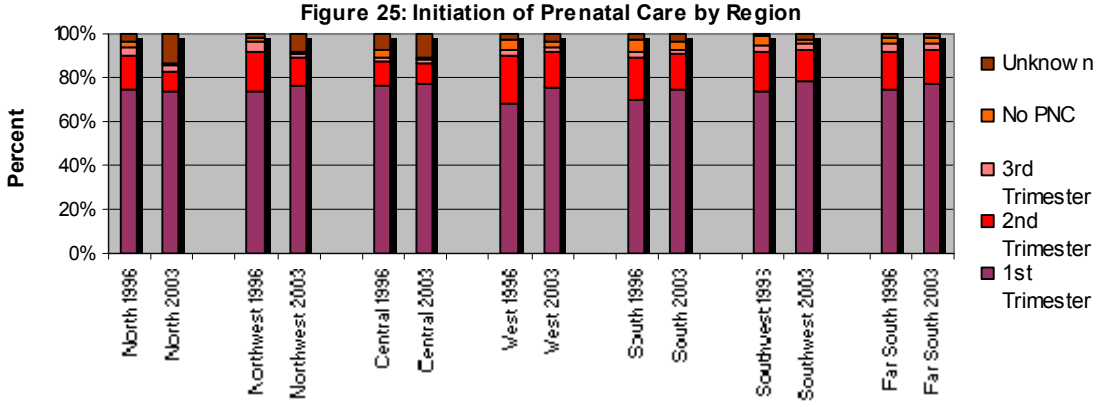
Figure 24: Initiation of Prenatal Care by Race/Ethnicity: 2003



prenatal care. The Asian population was the only group that experienced a decrease in the percentage of babies born with care starting in the first trimester, down from 74% of all Asian births to 71%. Care initiated in the second trimester decreased from 15% to 11%. The percentage of Asian births born to women who started prenatal care in the third trimester was higher than other races/ethnicities in 1996, at 5%. This percentage decreased to 3% in 2003, similar to the percentage in the Black population. However, within the Asian population, babies born without prenatal care comprised only 1% of all Asian births in 1996 and 0.2% in 2003.

Regionally: In 1996, 79% of all the babies born in the Central Region were to women who accessed prenatal care in their first trimester (Figure 25). This was the highest percentage of all the regions. West region had the lowest percentage, with only 68% of all it babies born to women who initiated care by the recommended time. In 2003, five of the seven of the regions had increased percentages of women accessing early care, including the West region, whose percentage rose to 75% of all babies born. Most of the increases in first trimester care were due to decreases in women who first accessed care in their second trimester. The largest percentage of women accessing care initially in their second trimester was seen in the West region, with 22% of all babies born in 1996 and 16% in 2003. Central region had the lowest rate in 1996 (12%) and 2003 (9%), as did the North region in 2003 (9%). Initiation of prenatal in the third trimester ranged from 4% of babies born (North, Northwest) to 2% (Central) in 1996 and decreased to 2% for all regions in 2003. Babies born to women who did not access prenatal care varied more, from 5% in the South region to 2% in Northwest in 1996. Percentages decreased in 2003 to 3% in South to 1% in Central.

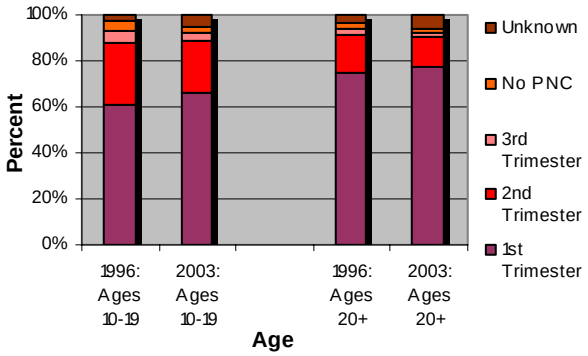
Figure 25: Initiation of Prenatal Care by Region



Mother's Age: Prenatal care was less likely to be initiated in the baby's first trimester when the mother was 10 to 19 years of age, compared to mothers aged 20 and up (Figure 26). However first trimester care did increase, from 61% of babies born to teens in 1996 to 66% in 2003. Seventy four percent of babies born to mothers aged 20 and older had their

care initiated in the first trimester in 1996, 78% in 2003. The percentage of babies born to women first receiving prenatal care in the 2nd and 3rd trimesters decreased in both age groups, as did the percentage of babies born to women who did not receive any prenatal care.

Figure 26: Initiation of Prenatal Care by Mother's Age



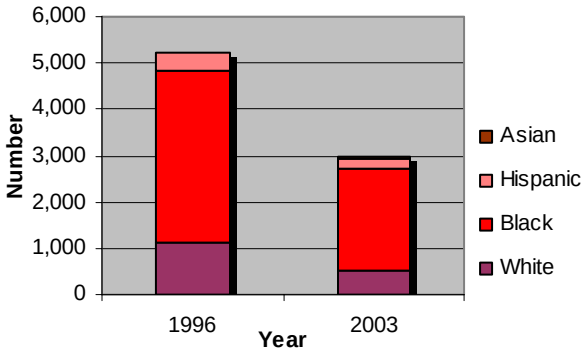
Maternal Substance Use

Cigarette smoking or use of other substances during pregnancy can affect the health of the newborn and can cause pregnancy complications. Data on these variables are collected from birth certificates; however, since these data are self-reported, the numbers may not fully represent the frequency of these occurrences.

Maternal Smoking: In 1996, 10% (or 5,249) of live births were to women who reported smoking during their pregnancy. This percentage decreased to 6% of live births in 2003 (or 2,981).

Race/Ethnicity: Of all racial/ethnic groups, Blacks had the largest number of births to women who smoked, but also had the largest decrease in number of cases, from 3,704 births to 2,174 in 2003 (Figure 27). Blacks also had the largest percent of births born to women who smoked within racial/ethnic groups (17% in 1996 and 13% in 2003). The number of cases of maternal smoking decreased in other racial/ethnic groups, except for Asians, whose numbers increased slightly (from 17 in 1996 to 22 in 2003).

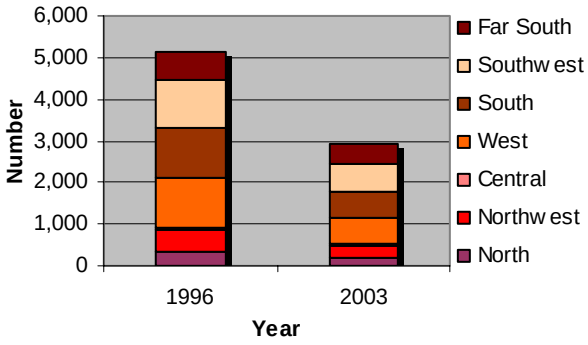
Figure 27: Maternal Smoking by Race/Ethnicity



Regionally: The West, Southwest, and South regions made up almost 70% of the cases of women who reported they smoked during pregnancy in both 1996 and 2003 (Figure 28). The number of cases was generally split among these three regions, with the South reporting slightly more cases in 1996 and West reporting more in 2003.

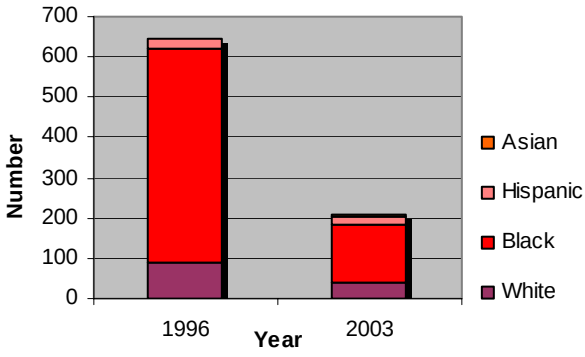
Maternal Drinking: The Behavioral Risk Factor Surveillance System's data states that 28% of pregnant women in 2002 reported having taken a drink during the past 30 days. This represents a higher proportion of women than were identified through the self-reports on birth certificates, which found 647 cases of maternal drinking in 1996 and 208 in 2003, or 1.2% and 0.4% of live births, respectively.

Figure 28: Maternal Smoking by Region



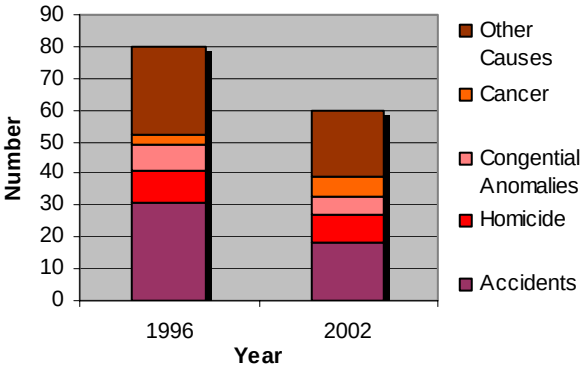
Race/Ethnicity: Blacks had the most cases of reported maternal drinking (532 in 1996 and 144 in 2003) or 82% and 69% of all cases, respectively (Figure 29). This number decreased by 73%, which was slightly higher than the decrease for all populations. The White population had a 55% decrease in cases of maternal drinking (from 87 in 1996 to 39 in 2003). While the Hispanic numbers in 2003 were fewer than in 1996, the decrease was only 8% (from 24 to 22), much less than other groups and due in part of the slight rise of maternal drinking cases attributed to the Mexican population (from 15 to 17), while the cases to the Puerto Rican population decreased (from 7 to 3).

Figure 29: Maternal Drinking by Race/Ethnicity



Leading Causes of Mortality for Children: In 2002, 60 children between the ages of one and four died. This number was 25% less than the 80 child mortalities that occurred in 1996. Accidents were the primary cause of death, followed in order by homicide and congenital anomalies (abnormalities present at birth, whether genetic, problems in utero, or at the time of birth) (Figure 30).

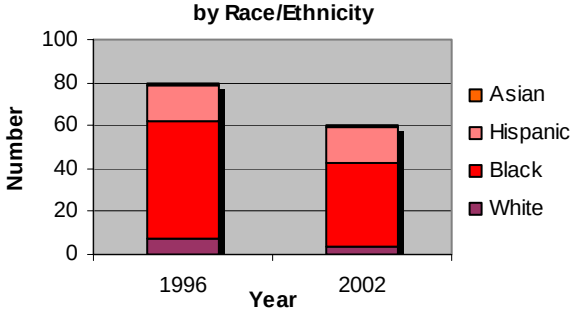
Figure 30: Causes of Child Mortality



The number of deaths due to accidents decreased both in number and percentage of deaths when comparing 1996 to 2002: from 30 deaths to 18, and from 38% of all child deaths to 30%. Deaths due to homicides decreased by one when comparing these years, but increased from 13% to 15% of all child deaths in 2002. Congenital anomalies were the cause of 10% of all deaths in both 1996 and 2002: 8 deaths in 1996 and 6 deaths in 2002. An increase in deaths due to cancer occurred, up from 3 deaths in 1996 (4% of total) to 6 deaths (10% of total).

Race/Ethnicity: In both years, deaths of Black children accounted for the majority of child deaths (Figure 31). However, the number of Black deaths decreased by 29%, from 55 to 39 deaths, slightly more than the overall percentage decrease. Accidents were the number one cause of death for Blacks for both years, but decreased by 10 percentage points from 38% of all Black child mortalities in 1996 to 28% in 2002. Homicides comprised 16% and 20% of total deaths to Black children, respectively. Hispanics made up 21% and 27% of all children who died in 1996 and 2002, respectively. The majority of these deaths occurred in the Mexican population, accounting for just over 80% of all Hispanic child deaths for each year. The White population made up 9% and 7% of all child deaths in Chicago.

Figure 31: Child Mortality by Race/Ethnicity



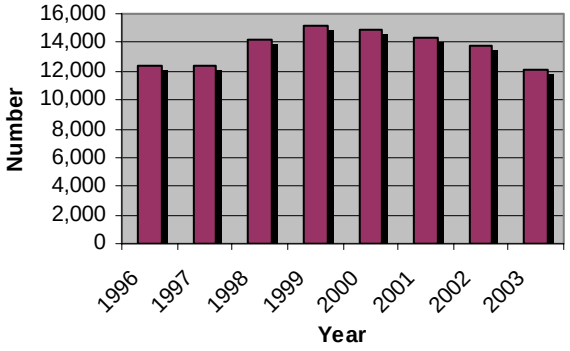
Infectious Disease Indicators

Sexually Transmitted Diseases (STDs)

Gonorrhea

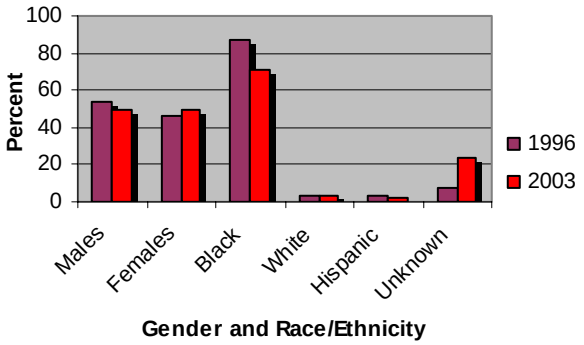
When comparing the number of gonorrhea cases in 1996 (12,314) to the number of cases in 2003 (12,121), the numbers are very similar, with only a slight decrease of 193 cases, or 2%. In actuality, the number of cases during this time span has not been steady (Figure 32). From 1996 to 1999, the number of cases rose to a high of 15,169, 23% higher than 1996. Since then, cases decreased to the number recorded in 2003.

Figure 32: Gonorrhea Cases 1996-2003



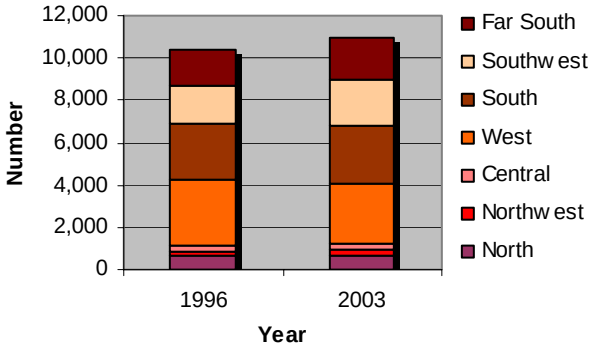
Race/Ethnicity and Gender: In 1996 Blacks made up the largest racial/ethnic group of those identified with gonorrhea, at 87% of all cases. Blacks also comprised the largest racial/ethnic group in 2003, but their numbers decreased by over 2,000 and their percentage decreased to 71% of all gonorrhea cases (Figure 33). The change in the percentage of Black cases may also be due to the increase of cases whose race/ethnicity was unknown. The number of Hispanics diagnosed with gonorrhea decreased by 22% and the proportion of Hispanic gonorrhea cases decreased slightly. The proportion of male cases decreased slightly in 2003, making the gender breakout equal in 2003.

Figure 33: Gonorrhea - Gender and Race/Ethnicity



Regionally: Five of the seven regions experienced increases in numbers, with the largest in Southwest, with an increase of 399 cases (from 1,822 to 2,221). The largest percent increase occurred in Northwest, at 38% (from 213 to 293 cases). Decreases in the number and percentage of cases occurred in two regions, with West showing the largest decrease: down 10%, or 313 cases, from 3,127 to 2,814 (Figure 34).

Figure 34: Gonorrhea Cases by Region

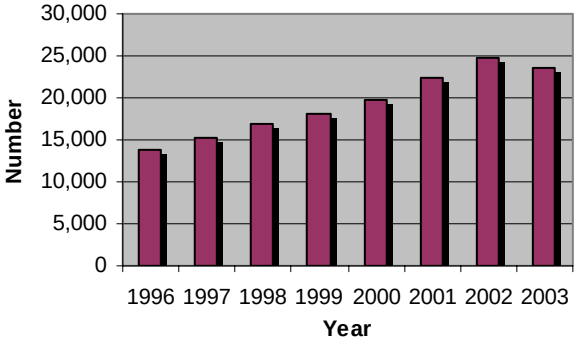


Changes in gonorrhea testing procedures and policies contributed to the trends noted in these data. In 1998, a new test was initiated that was more sensitive, resulting in more positive identifications. The decrease in cases after 1999 might have been affected by the decreases seen nationally as well as a CDPH policy change to track only high priority cases, i.e., adolescents and pregnant women. Regionally, the decrease in cases identified in the West Region for 2003 were partially due to the change in Cook County Jail's policy, which stopped universal gonorrhea testing of inmates. Testing was available only for symptomatic individuals.

Chlamydia

Chicago experienced an almost 70% increase of chlamydia from 1996 to 2003 (13,893 to 23,466 cases). This number is slightly lower from its peak of 24,674 in 2002 (Figure 35).

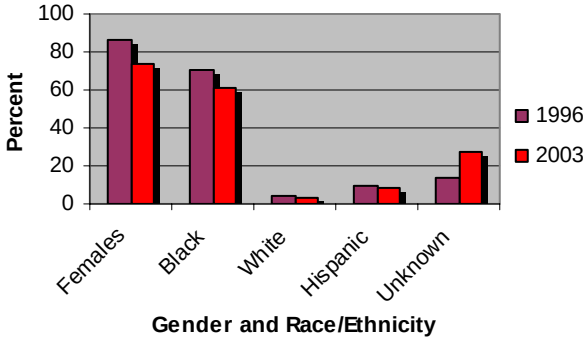
Figure 35: Chlamydia Cases 1996-2003



Gender: Due to the mostly asymptomatic nature of chlamydia, cases are primarily detected through screening or general exams, which are more often targeted to females. Therefore, it is not surprising that in 2003, almost 75% of all chlamydia cases were female. This percentage decreased compared to 1996, when females comprised 86% of all cases in Chicago.

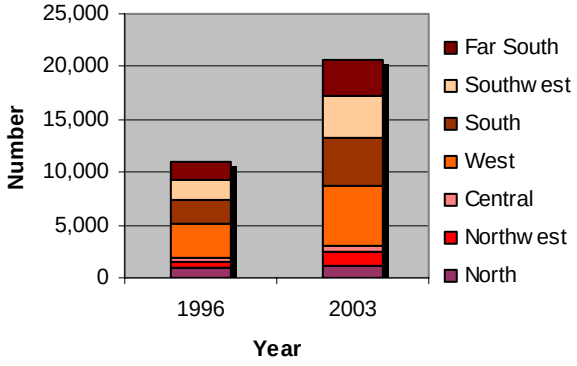
Race/Ethnicity: In both 1996 and 2003, Blacks were the largest racial/ethnic group diagnosed with chlamydia. As the overall number of cases increased citywide, so did the cases among Blacks (from 9,905 to 14,409, a 46% increase). However, the percentage that Blacks represented of all Chicago's cases decreased by 10%, due in part to the rise of cases for which race/ethnicity was unknown (27% in 2003) (Figure 36).

Figure 36: Chlamydia: Gender and Race/Ethnicity



Regionally: All seven regions showed increases, with the largest number increase in the West Region (increased 2,592 cases, from 3,160 to 5,752) and the largest percent increase in Southwest (120%) (Figure 37). Central region had the smallest number increase of cases (increased from 308 to 454) and the North region had the smallest percentage increase, at 38%.

Figure 37: Chlamydia Cases by Region

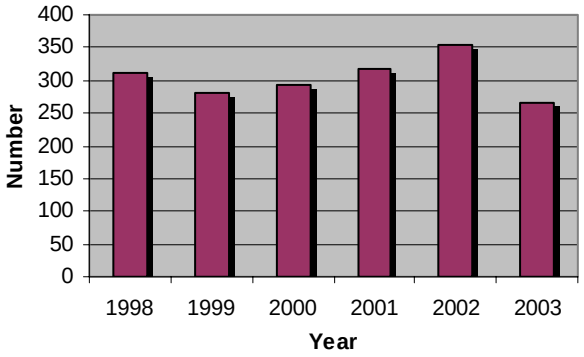


These trends demonstrate the ongoing growth of chlamydia cases in the general population, influenced by both new infections and the increase in re-infections. Trends also reflect greater access to STD testing and treatment sites.

Primary and Secondary Syphilis

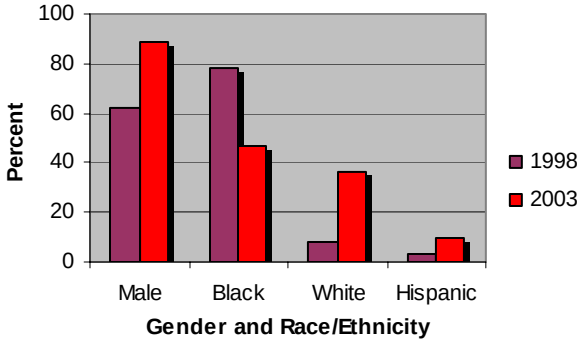
When comparing 1998 to 2003, syphilis cases in Chicago decreased by 14% (310 to 267). However, during the course of these six years, the number of cases actually increased to a high of 353 cases in 2002, or 14% higher than 1998. From 2002 to 2003, the number of syphilis cases in Chicago dropped 24%, or 86 cases (Figure 38).

Figure 38: Syphilis Cases 1998-2003



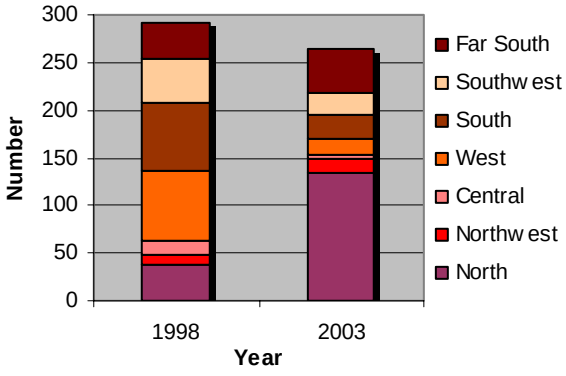
Gender and Race/ethnicity: The outbreak of syphilis in the population of men who have sex with men in 2001 influenced the gender and racial/ethnic distribution of syphilis. In 1998, 62% of all cases were male, compared to a high of 89% in 2003. The percentage of Whites increased from 8% to 36%, while the percentage of Blacks decreased from 78% to 47%. Hispanics also experienced an increase in their percentage of total cases, from 3% to 10% (Figure 39).

Figure 39: Syphilis: Gender and Race/Ethnicity



Regionally: When assessed by region, large variations are evident (Figure 40). Three regions had more syphilis cases in 2003 than 1998, with the largest increase in the North region, at over 250%. Four of the seven regions had fewer numbers of syphilis cases, with at least a 50% decrease. The West region had the largest decrease of over 78%. These data, specifically

Figure 40: Syphilis Cases by Region



the large increase of cases in the North region, document the 2001 syphilis outbreak in the population of men who have sex with men.

HIV/AIDS

The number of people living with AIDS in Chicago increased almost 80% from 1996 (5,259 people) to 2003 (9,452) (Figure 41). This increase represents both the number of newly diagnosed cases, as well as people with AIDS who are living longer due to improved treatment. In 1999, the Chicago Department of Public Health started HIV case surveillance. Tracking people living with HIV serves as a better marker of the spread of the disease because, with access to anti-retroviral therapy, HIV is becoming a chronic, manageable illness, where progression from HIV to AIDS is controlled or delayed. In 1999, 3,029 people in Chicago were HIV-positive. This number increased in 2003 by 150%, or 4,600 people, resulting in a total of 7,668 people living with HIV in Chicago (Figure 42).

Figure 41: People Living with AIDS

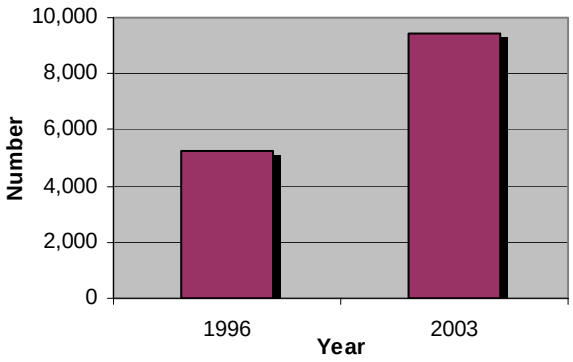
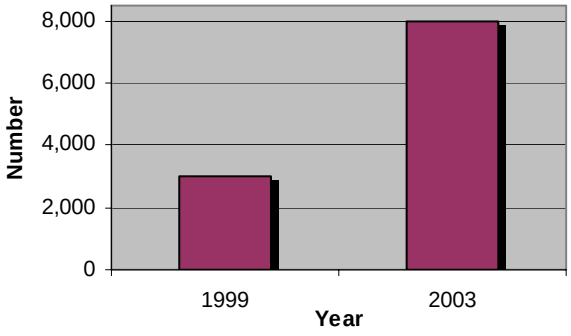


Figure 42: People Living with HIV

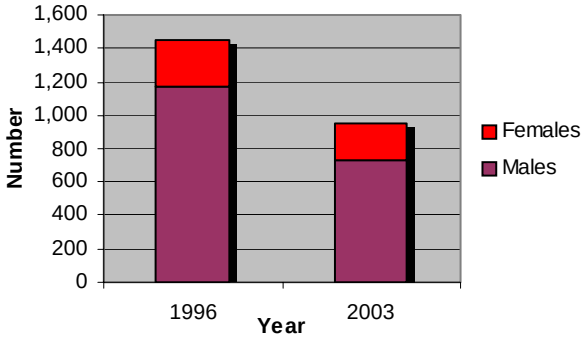


AIDS

In 2003, 951 people were diagnosed with AIDS. This represents a 35% decrease compared to 1996, when 1,456 cases were diagnosed.

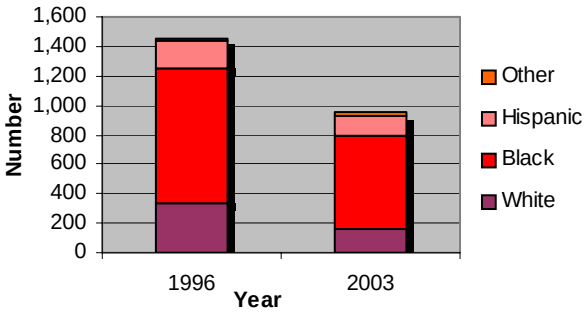
Gender: At 76%, males continue to comprise the majority of AIDS cases in 2003, although the percentage of males decreased from 81% in 1996 as the number of female cases represents a growing proportion of all AIDS cases (Figure 43).

Figure 43: AIDS Cases by Year and Gender



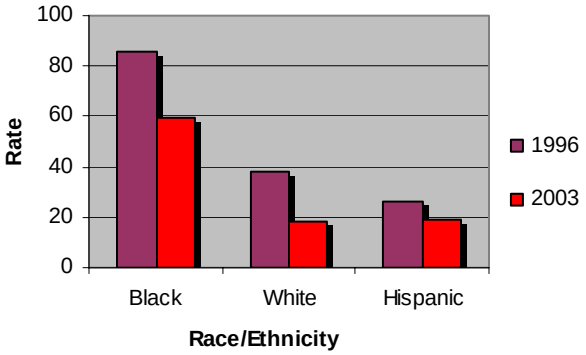
Race/Ethnicity: All races/ethnicities (except the "Other" group) experienced a decrease in the number of AIDS cases when comparing 2003 to 1996 (Figure 44). Representing the majority of new AIDS cases in Chicago for both years, Blacks also represented the group with the largest decrease in number of cases, down by 208 (from 904 in 1996 to 624 in 2003). The number of cases decreased in the White population, with 179 fewer cases in 2003 than 1996 (163 in 2003 compared to 342 in 1996). This decrease also occurred in the percentage of all cases, where Whites represented 23% of all AIDS cases in 1996 and 17% in 2003. While the number of Hispanic cases decreased, their percentage increased slightly, from 14% of the caseload in 1996 to 15% in 2003.

Figure 44: AIDS Cases by Race/Ethnicity



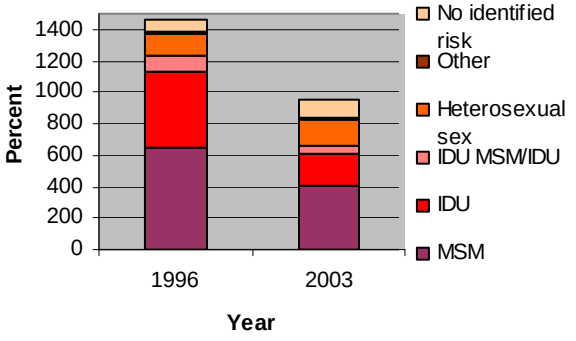
AIDS incidence rates also illustrate the decrease in AIDS cases by race/ethnicity (Figure 45). Blacks had the highest AIDS incidence rate of all races/ethnicities in 2003, at 59.2 per 100,000. While higher than other racial/ethnic groups, this rate showed a decrease of 31% compared the Black incidence rate in 1996 (85.8 per 100,000). The incidence of AIDS also fell in the White population (from 37.7 per 100,000 to 18.0) and the Hispanic population (26.4 to 19.4).

Figure 45: AIDS Incidence Rates by Race/Ethnicity



Modes of Transmission: Modes of AIDS transmission include men who have sex with men, intravenous drug use (IDU), as well as heterosexual sex. As the number of total cases decreased from 1996 to 2003, so has the number associated with each transmission group, except for heterosexual sex, which grew from 132 cases to 166 and from 9% to 18% of all new AIDS cases (Figure 46). The 26% increase in cases due to heterosexual sex coincides with the

Figure 46: AIDS Modes of Transmission

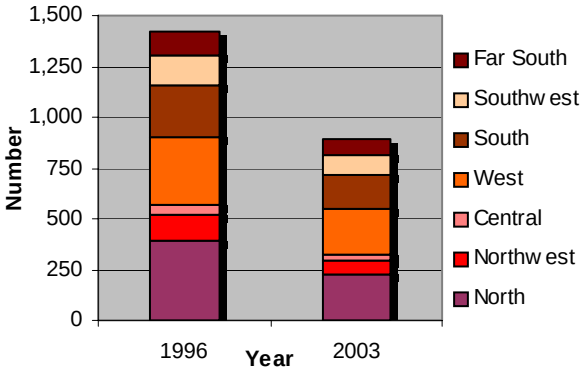


increase in females diagnosed with AIDS.

The primary cause of infection continues to be men who have sex with men, accounting for 45% for AIDS cases diagnosed in 1996 and 43% in 2003. AIDS cases due to IDU decreased from 33% to 20% of all cases. The number of cases with "no identified risk" increased, although the actual risk is often identified eventually, so this number may decrease.

Regionally: All regions in Chicago had decreases in the number of new AIDS cases diagnosed in 2003 although the regional proportion of AIDS cases remained fairly constant (Figure 47). The North and West regions each house 24% of the newly diagnosed cases. Central region had the least amount of new AIDS cases in both 1996 and 2003.

Figure 47: AIDS Cases by Region

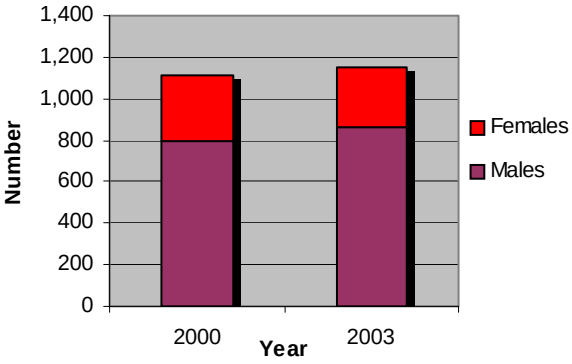


HIV

The number of HIV cases diagnosed in 2003 was slightly higher than the number of cases diagnosed in 2000 (1,117 in 200 and 1,150 in 2003). 2000 was the first full year for which data were available.

Gender: The male/female breakout shifted a bit (Figure 48), with the number of male cases growing by 9%, while female cases decreased by 11%. Overall, males represented 75% of all cases in 2003, slightly higher than 2000, when males comprised 71% .

Figure 48: HIV Cases by Year and Gender



Race/Ethnicity: Race/ethnicity proportions remained similar when comparing 2000 to 2003: Blacks accounted for 59% and 57% of all HIV cases, Whites at 24% and 25%, and Hispanics at 15% and 16% (Figure 49). However, while the number of cases of Blacks and Whites decreased, Hispanics experienced a 15% increase. The category described as "Other" also showed an increase. Incidence rates also illustrate the growth in the Hispanic and "Other" categories (Figure 50).

Figure 49: HIV Cases by Race/Ethnicity

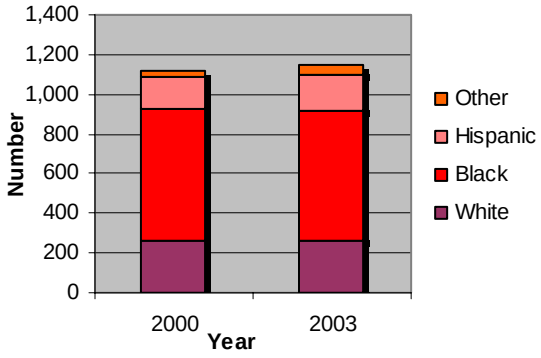
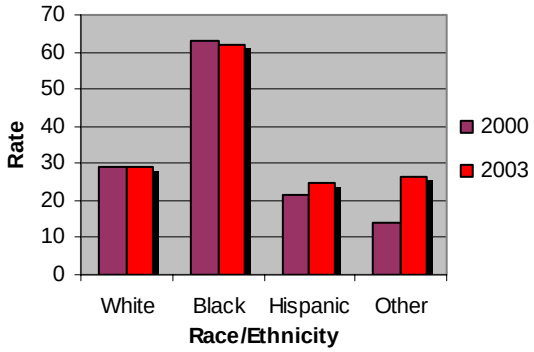


Figure 50: HIV Incidence Rates by Race/Ethnicity



Modes of Transmission: Patterns in transmission of HIV from 2000 to 2003 showed a greater influence of men who have sex with men and a decrease of intravenous drug use (IDU) and heterosexual sex (Figure 51). The number of HIV diagnoses attributed to men who have sex with men increased by 124 (from 408 to 532) and grew from 37% to 46% of all cases. Transmission through IDU decreased from 20% to 14% of all cases and heterosexual contact decreased from 17% to 14%. The group with no identified risk had similar percentages in 2000 as in 2003: 22% and 23%, respectively.

Regionally: The proportions of HIV cases were consistent for 2000 and 2003 within the seven regions, with the highest numbers and percentages in the North and West regions (Figure 52). These data were also consistent with AIDS case patterns.

Figure 51: HIV Modes of Transmission

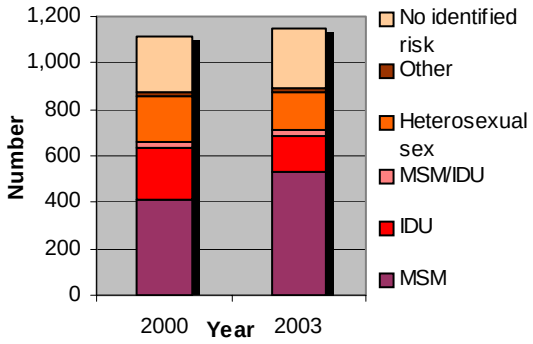
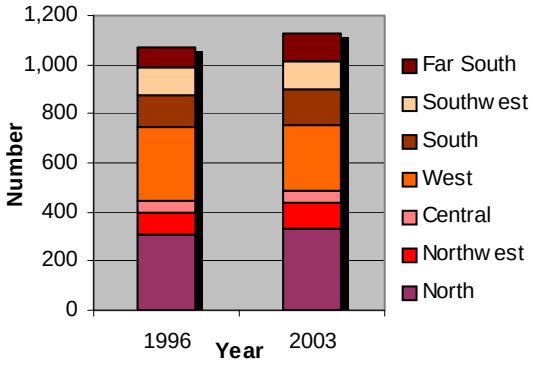


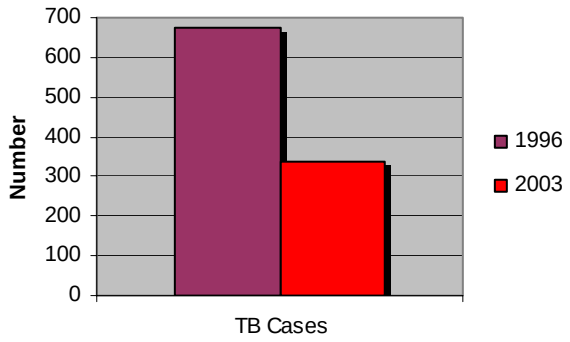
Figure 52: HIV Cases by Region



Tuberculosis

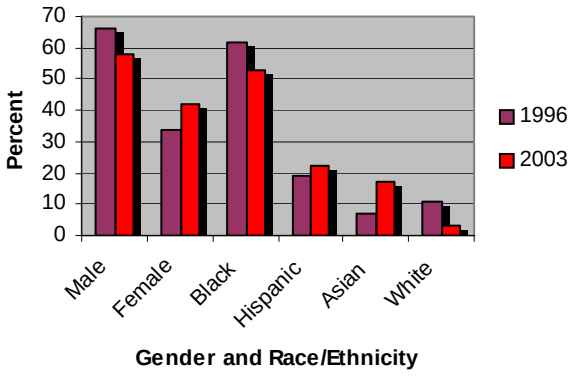
The number of cases of tuberculosis (TB) in Chicago was 50% less in 2003 (339 cases) than in 1996 (673 cases) (Figure 53).

Figure 53: Tuberculosis Cases



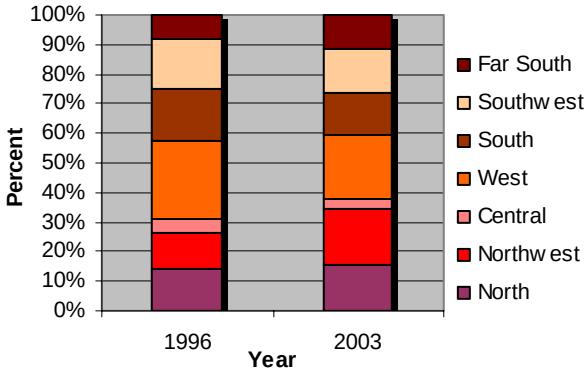
Gender and Race/Ethnicity: While males still represented the majority of TB cases, their percentage of all cases decreased from 66% in 1996 to 58% in 2003 as more females were diagnosed. Blacks comprised 53% of the TB cases, or 181 cases, in 2003, down from 62% or 415 cases in 1996 (Figure 54). Hispanics also had fewer TB cases, but their percentage of all cases increased from 19% in 1996 to 22% in 2003. Cases of TB in the Asian population increased from 45 in 1996 to 58 in 2003, as did their percentage of all cases, from 7% to 17%, respectively. The number of TB cases in the White population decreased from 73 to 21 and from 11% of all cases in 1996 to 6% in 2003.

Figure 54: TB Cases by Gender and Race/Ethnicity



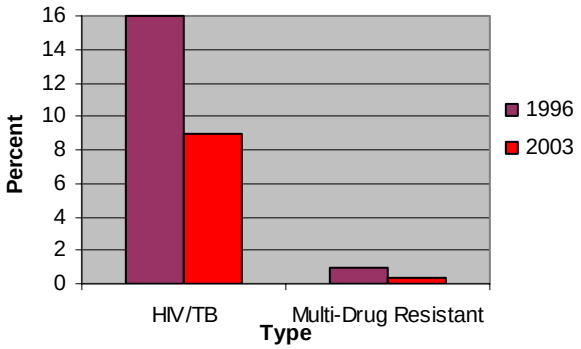
Regionally: As Chicago TB cases decreased, so did the number of cases in all of the seven regions. The West had the largest number of cases in both 1996 and 2003, although this number decreased by over 100 cases, from 177 to 73. The West region also had the largest percentage of all cases in both 1996 and 2003, although this percentage decreased from 26% to 22%, respectively (Figure 55). The percentages of cases in the South and Southwest regions decreased, while the proportion of cases grew in the Far South, North, and especially, in the Northwest regions.

Figure 55: TB Cases by Region



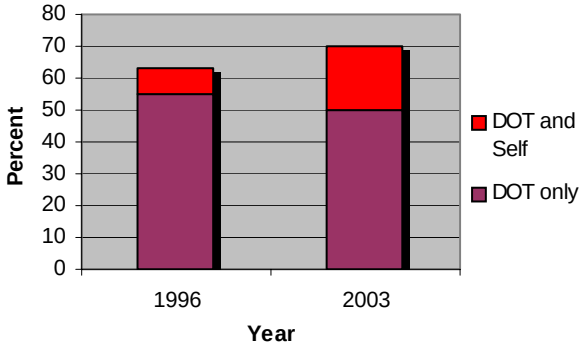
HIV/TB Co-incident & Multi-resistant Cases: The number of HIV/TB co-incident cases decreased from 105 cases to 29, or 72%, when comparing data from 1996 and 2003. This subset of TB cases now makes up 9% of all TB cases, down from 16% in 1996 (Figure 56). The number of multi-drug resistant cases decreased also, from 8 cases, or 1.2% of all cases, to 1 case, or 0.3% of all cases.

Figure 56: Percentage of HIV/TB & Multi-Drug Resistant TB Cases



Directly Observed Therapy: Since 1992, Directly Observed Therapy (DOT) has been the standard of care for patients with TB. While most TB patients participate in this type of therapy, some agree to do both DOT and self-administration of their medications, while others solely self-administer their medications. The number of people undergoing DOT only decreased from 368 in 1996 (58% of all cases) to 168 in 2003 (50%), although the number of people participating in both DOT and self-administered treatment increased from 54 individuals to 67 (Figure 57). This made the total percentage of those participating in either DOT only and DOT and self-administered treatment at 63% and 69% of all cases in 1996 and 2003, respectively .

Figure 57: TB Therapy Completion



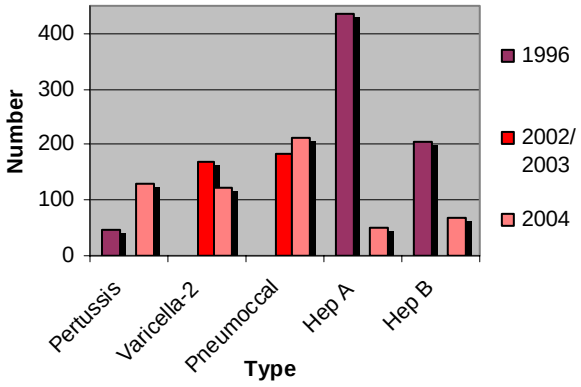
Although the majority of TB therapies are completed within a 12-month period, some cases are more complex and take longer to finish. Both of these measures improved from 1996 to 2003: within 12-months from 66% of all cases to 77%; overall completion from 81% to 88%.

Vaccine-Preventable Diseases

Estimated vaccination coverage rates for Chicago children aged 19-35 months increased between 1996 and 2004, from 68% to 80%. This progress is due in part to the increase of federal funding in 2000, which allowed for the development of programs and partnerships to increase provider use of effective immunization practices and the general public's awareness of vaccine-preventable diseases and the safety and effectiveness of immunizations.

Despite these improvements, some vaccine-preventable diseases experienced a rise in cases during this time period (Figure 58). Most notably was the incidence of pertussis, which increased from 47 cases in 1996 to 128 in 2004. This trend, also seen nationally, occurred in older children and adults who are more susceptible to this disease since immunity wanes over time. New reporting requirements were also instituted, which often increases provider awareness and identification of cases.

Figure 58: Vaccine-Preventable Diseases



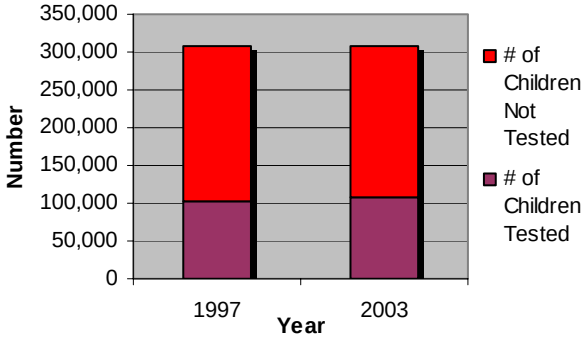
An increase was noted for pneumococcal disease, with 182 cases identified in 2002 (first full year of reporting) to 214 in 2004. As with pertussis, new reporting requirements may augment the number of cases identified due to increased awareness and focus on the disease, although nationally, pneumococcal disease experienced a dramatic decrease.

Several preventable diseases did decrease substantially between 1996 and 2004. The number of cases of hepatitis A and hepatitis B was reduced by 88% and 68%, respectively. Although only a small number of cases were identified for both years, fewer cases of haemophilus influenza type B (Hib) and rubella occurred in 2004 compared to 1996. No cases of measles, mumps, tetanus, or polio occurred during either 1996 or 2004.

Lead Poisoning

According to the 2000 US Census, Chicago is home to 308,414 children who are six years of age or younger. This population is at risk of lead poisoning due to housing stock, environmental conditions, or exposure from a family member's occupation. High levels of lead in children can contribute to learning disabilities, language processing disorders, shortened attention span, and behavioral problems (Figure 59).

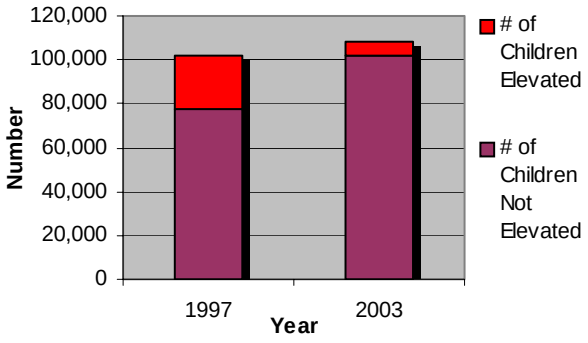
Figure 59: Number of Children Tested for Lead Poisoning



In 2003, 108,644 children received a blood test for lead. This represents 35% of the population of children and an increase of 6% from 1997 when 102,351 children were tested. During this time period in Illinois, the Medicaid program had been admonished for not assuring adequate health screening for young children. As a result, the Medicaid program increased its promotion of child health screening, which included lead screenings. This change may have contributed to the increase that occurred in the number of children tested.

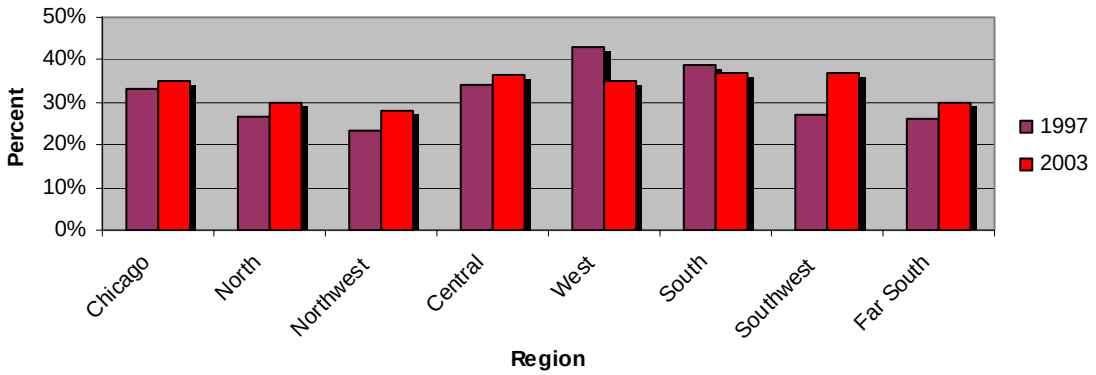
Of the children who were tested in 2003, 6,844, or 6%, had blood lead levels at or greater than 10 mcg/dL (considered above normal by Centers for Disease Control and Prevention) (Figure 60). These data, compared to the almost 25,000 children, or 24%, who were diagnosed in 1997, show substantial improvement in reducing the number of children diagnosed with lead poisoning.

Figure 60: Number of Children with Elevated Blood Lead Levels



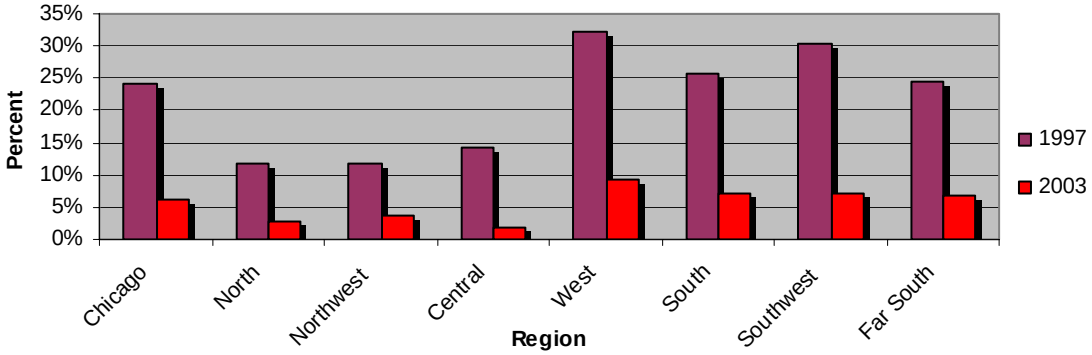
Regionally: When analyzed regionally, the West Region had the highest percentage of its children tested in 1997, at 43% (Figure 61). In 2003, five of the seven regions showed gains in both the percentage and number of children tested. Southwest region experienced the largest increase of children tested, from 27% (17,248 children) in 1997 to 37% (23,547) in 2003. West region still tested the largest number of children, although its percentage decreased to 35%. South region also experienced a decrease in children tested, from 15,406 in 1997 to 14,683 in 2003.

Figure 61: Percent of Children tested for Lead Poisoning by Region



All regions experienced decreases of at least 60% in the number of children with elevated blood lead levels (Figure 62). The largest number decrease occurred in West, with 9,310 children with elevated levels in 1997 down to 2,162 in 2003. The largest percentage decrease was in Central, with 86% fewer children having elevated levels. Improvements similar to those in Chicago occurred in many large cities in the United States during this time period, with the advent of public health programs and gentrification and renovation activities that removed lead paint and dust.

Figure 62: Percent of Children with Elevated Blood Lead Levels by Region



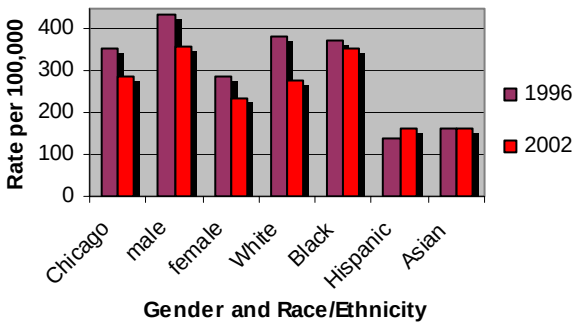
Selected Chronic Disease Indicators

Heart Disease

Although deaths caused by heart disease decreased in 2002 compared to 1996, heart disease continued to be the leading cause of death in Chicago. The number of deaths decreased by almost 20% (from 8,367 in 1996 to 6,792 in 2002). The age-adjusted rate decreased by 19%, from 353 per 100,000 to 287.

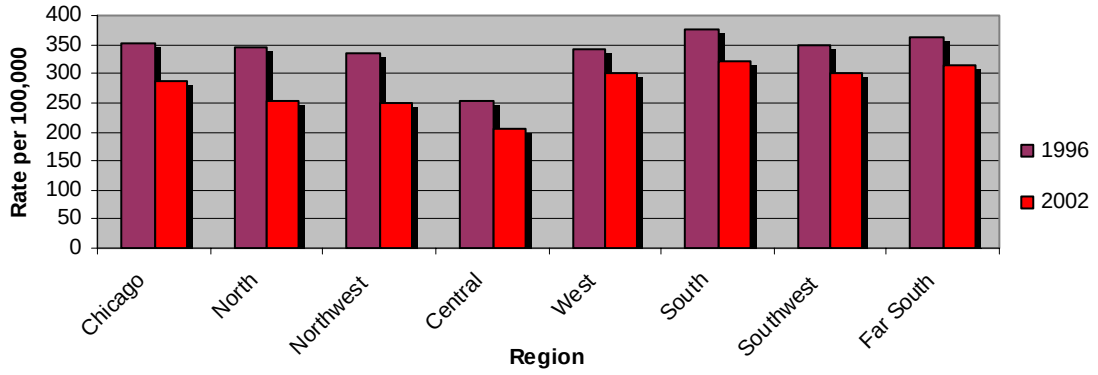
Gender and Race/Ethnicity: Males had a higher age-adjusted rate of mortality from heart diseases than females in both 1996 and 2002 (Figure 63). The White population had the highest rate in 1996, although this decreased by 28% (from 384 to 276 per 100,000 population) raising the ranking of the Black population to the highest in 2002. The rate of deaths due to heart disease stayed about the same in the Asian population, but increased in the Hispanic population.

Figure 63: Heart Disease Mortality Rate by Gender and Race/Ethnicity



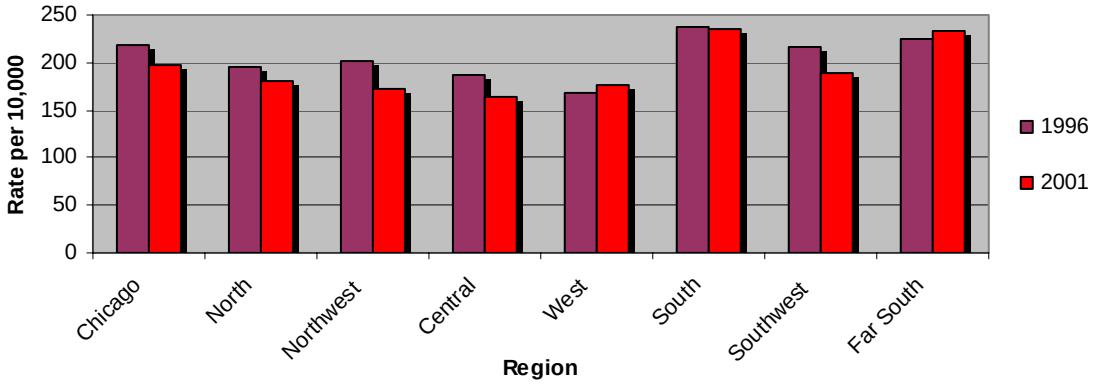
Regionally: The age-adjusted death rates for heart disease decreased in all regions when comparing 1996 and 2002 (Figure 64). The largest decrease was noted in the North region, a decrease of 27%, from 346 per 100,000 population to 253. The Northwest region also had a large rate decrease, from 335 to 249, or 26%. The South region had a 14% decrease in its death rate, but continued to be the highest of all regions at 376 per 100,000 in 1996 and 322 in 2002.

Figure 64: Heart Disease Mortality Rates by Region



Hospitalization Rate: Consistent with the death rate for heart disease, the South region had the highest hospitalization rate for heart disease: 237 per 10,000 population in 1996 and 236 in 2001, with the Far South Region close behind in 2001 at 234 per 10,000 (Figure 65). While the other regions had rate decreases, Far South and West both had a 5% increase in hospitalizations for heart disease . Overall, Chicago had a 10% decrease in hospitalizations related to heart disease.

Figure 65: Heart Disease Hospitalization Rates

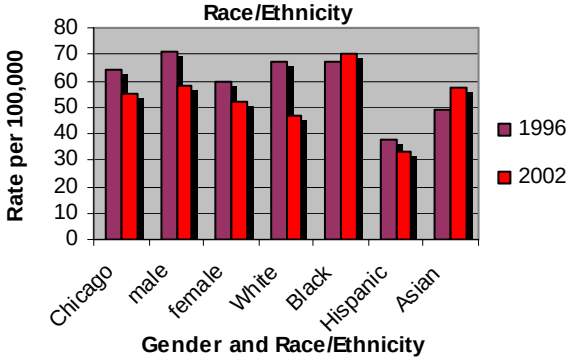


Cerebrovascular Disease/Stroke

Both the number of deaths due to cerebrovascular disease and its age-adjusted mortality rate decreased when comparing 1996 to 2002: from 1,518 deaths to 1,288 and from a rate of 64 deaths per 100,000 population to 55.

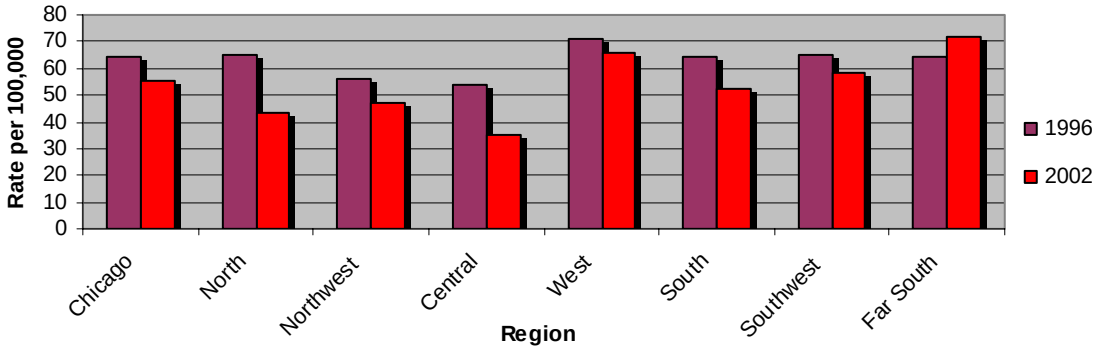
Gender and Race/Ethnicity: Males had a higher mortality rate for cerebrovascular disease than females, 71 in 1996 and 58 in 2002 compared to the rate for females at 60 in 1996 and 52 in 2002 (Figure 66). The White and Black populations had the same mortality rate in 1996 (67 per 100,000 population), although in 2002 the rate for the White population decreased by 30% (to 47) while the Black population had a 5% increase (to 70). The rate of stroke mortality in the Asian population increased from 49 to 57 in 1996 and 2002, respectively. The Hispanic rate was the lowest of all racial/ethnic groups, at 38 per 100,000 population in 1996 and 33 in 2002.

Figure 66: Cerebrovascular Disease Mortality Rate by Gender and Race/Ethnicity



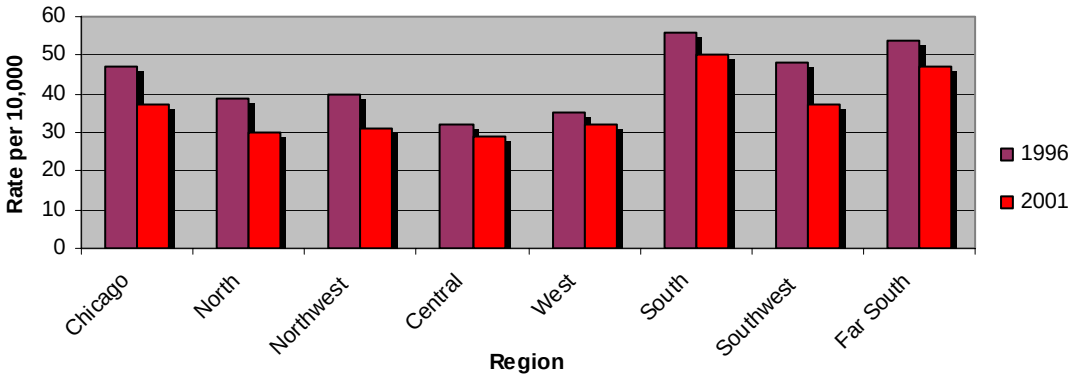
Regionally: The West region had the highest age-adjusted mortality rate for cerebrovascular disease than all other regions in 1996, at 71 per 100,000 population (Figure 67). While rates in all other regions decreased, the Far South region experienced a 13% rate increase, from 64 to 72, making it the region with the highest rate in 2002. The rates in the Central and North regions decreased by 35% and 34% in 2002, respectively, making them the lowest of all regions.

Figure 67: Cerebrovascular Disease Mortality Rate by Region



Hospitalization Rate: The hospitalization rate for cerebrovascular disease in Chicago decreased by 21% when comparing 1996 and 2001, from 47 per 10,000 population to 37 (Figure 68). As with the rates for heart disease, the South and the Far South regions had the highest rates of all the regions for hospitalizations: South was 56 per 10,000 in 1996 and 50 in 2001; Far South was 54 and 47, respectively.

Figure 68: Cerebrovascular Disease Hospitalization Rates

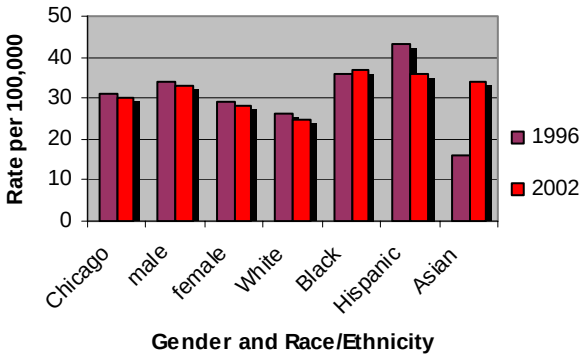


Diabetes

738 people died of diabetes in 1996, at an age-adjusted rate of 31 per 100,000 population. In 2002, there was a slight decrease in the number of deaths (721 deaths) and age-adjusted mortality rate (30).

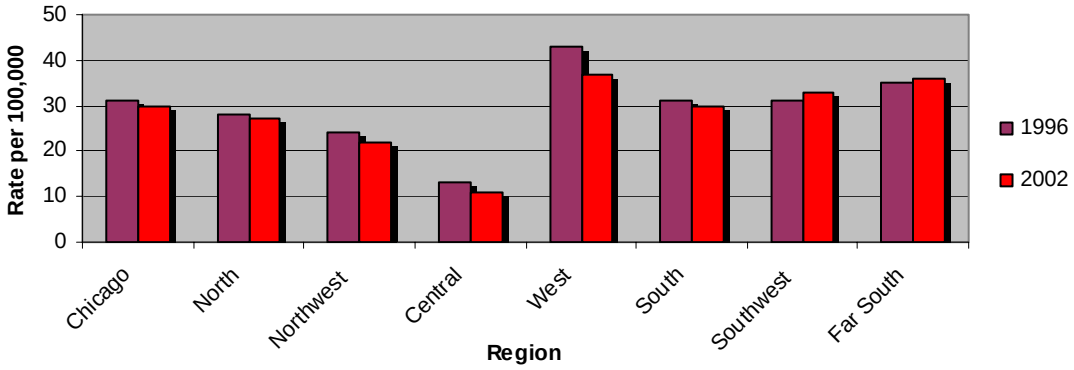
Gender and Race/Ethnicity: Females made up the majority of cases for both 1996 and 2002, at 55% and 56%, respectively. However, males had higher age-adjusted mortality rates (34 and 33 in 1996 and 2002) compared to females (29 and 28) (Figure 69). While the rates for the Black and White populations were similar in both 1996 and 2002, changes occurred within the Hispanic and Asian populations. Hispanics had the highest age-adjusted mortality rate for diabetes in 1996, at 43 per 100,000 population. However, this rate decreased by 16% (to 36 per 100,000), so that the Black population had the highest mortality rate in 2002 (37 per 100,000). The Asian population's age-adjusted mortality rate due to diabetes more than doubled, from 16 per 100,000 in 1996 to 34 in 2002.

Figure 69: Diabetes Mortality Rate by Gender and Race/Ethnicity



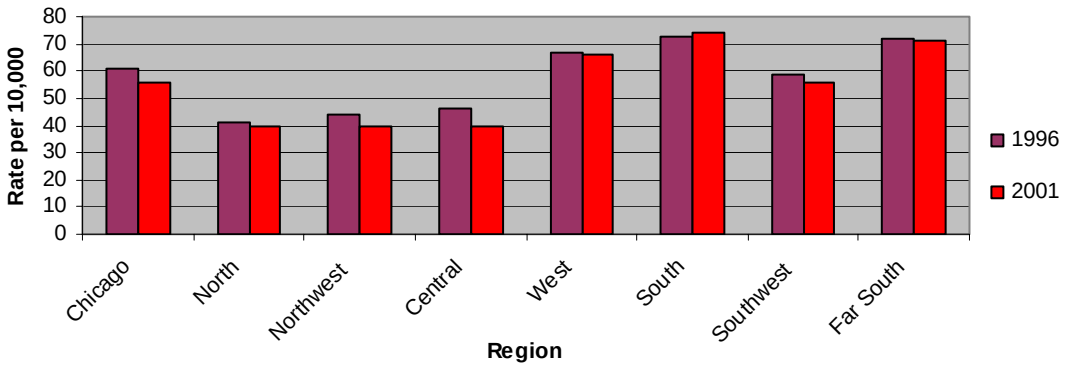
Regionally: In 1996, the West region's age-adjusted mortality rate due to diabetes (43 per 100,000 population) was 23% higher than the second highest region (Far South at 35 per 100,000) (Figure 70). West's rate decreased by 14% for 2002 to 37, but was still the highest rate of all the regions. Slight decreases were noted in the regional rates in 2002, except for Southwest (increased from 31 to 33) and Far South (increased from 35 to 36).

Figure 70: Diabetes Mortality Rates by Region



Hospitalization Rates: Diabetes hospitalization rates decreased by 8% for Chicago when comparing 1996 to 2001, from 61 hospitalizations per 10,000 population to 56 (Figure 71). In both years, the South and Far South regions had the highest hospitalization rates of all the regions: South at 73 per 10,000 population in 1991 and 74 in 2001; Far South at 72 in 1996 and 71 in 2001.

Figure 71: Diabetes Hospitalization Rates by Region



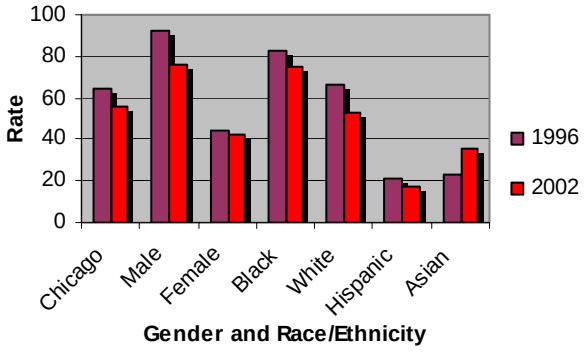
<u>Selected Cancers</u>

Cancer is the second leading cause of death in Chicago. As all mortality decreased between 1996 and 2002, so did cancer-related deaths, down 10% in both number (from

5,677 to 5,099) and age-adjusted rates (235 per 100,000 population to 212). The number of hospitalizations for all cancers decreased by 15%: from 24,036 in 1996 to 20,303 in 2001. Hospitalization rates per 10,000 population decreased by 22%, from 86.2 in 1996 to 67.6 in 2001. More information for specific types of cancer is provided below.

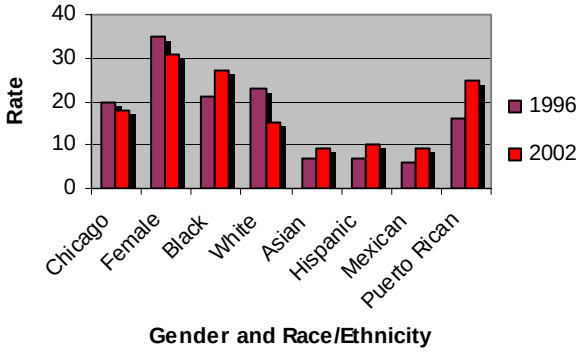
Lung Cancer: Lung cancer is the leading cause of cancer deaths, representing over one-quarter of all cancer deaths in 1996 and 2002. During these years, the number and age-adjusted rate of lung cancer deaths decreased from 1,546 to 1,334 and from 64 per 100,000 to 56 (Figure 72). Males had higher rates than females, although their lung cancer mortality rate decreased by 17% in 2002 (92 and 76 compared to 44 and 42). The Black population had the highest rate of lung cancer mortality of the racial/ethnic groups, which in 2002 was 42% higher than the next highest group, the White population. Contrary to the trends for the other race/ethnic groups, the lung cancer mortality rate for the Asian population increased from 23 to 36, or 57%. The number of hospitalizations for lung cancer decreased from 1,940 in 1996 to 1,615 in 2001, a decrease of 17%. Hospitalization rates also decreased, from 6.7 per 10,000 population in 1996 to 5.6 in 2001.

Figure 72: Lung Cancer Mortality Rates by Gender and Race/Ethnicity



Breast Cancer: Both the number and age-adjusted rate of deaths due to breast cancer in the total population decreased from 1996 to 2002: from 488 to 438, and from 20 per 100,000 to 18. Females comprised 99% of all breast cancer deaths and had age-adjusted rates of 35 per 100,000 population in 1996 and 31 in 2002 (Figure 73). The White population experienced the highest rate of all racial/ethnic groups in 1996, at 23 per 100,000 population. However, the rate in the White population decreased 35% to 15 per 100,000. In contrast, the age-

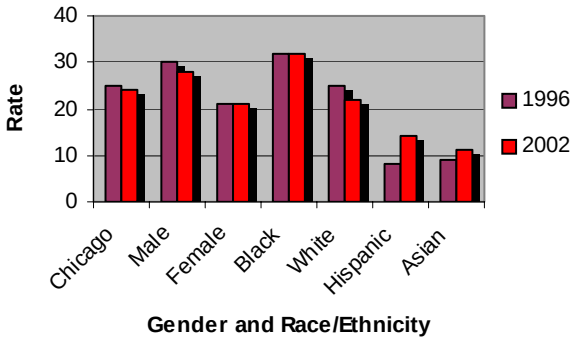
Figure 73: Breast Cancer Mortality Rates by Gender and Race/Ethnicity



adjusted rate for the Black population increased by 29%, from 21 to 27. The rates for both the Asian and Hispanic populations increased, with the Hispanic rate influenced by the rise in the rates for Puerto Ricans (from 16 to 25). Breast cancer hospitalizations decreased from 1,267 in 1996 to 1,071 in 2001, or from a rate of 4.6 per 10,000 population to 3.6.

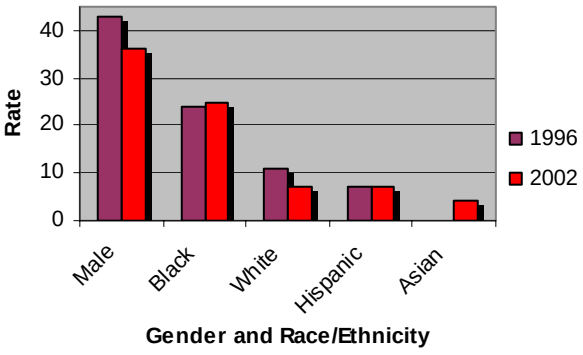
Colorectal Cancer: Deaths due to colorectal cancer comprised about 11% of the total cancer deaths and comprised 590 and 574 deaths in 1996 and 2002, respectively. Total age-adjusted death rates declined slightly, from 25 in 1996 to 24 in 2002. As with total cancers, males had higher age-adjusted rates (30 per 100,000 population in 1996 and 28 in 2002) compared to females (21 in both years) (Figure 74). The highest rates occurred in the Black population, 32 per 100,000 population in both 1996 and 2002. The rate in the White population decreased from 25 to 22 per 100,000 while the rates in both the Hispanic and Asian populations increased from 8 to 14 and 9 to 11, respectively. Hospitalizations for colorectal cancer totaled 2,310 in 1996 and 2,164 in 2001, or 10% and 11% of all cancer hospitalizations. Hospitalizations rates decreased from 8.3 to 7.2 per 10,000 population.

Figure 74: Colorectal Cancer Mortality Rates by Gender and Race/Ethnicity



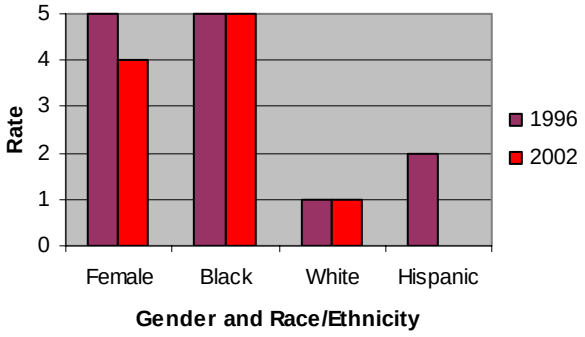
Prostate Cancer: Prostate cancer deaths decreased by 14%, from 361 deaths in 1996 to 309 in 2002. The age-adjusted mortality rate for the male population decreased from 43 per 100,000 population to 36 (Figure 75). Blacks had the highest age-adjusted mortality rates (24 and 25), which was over three times as high as the rates of other races/ethnicities for 2002. Prostate cancer hospitalizations decreased from 1,105 in 1996 to 903 in 2001, with a rate decrease from 4 per 10,000 population to 3.

Figure 75: Prostate Cancer Mortality Rates by Gender and Race/Ethnicity



Cervical Cancer: Deaths due to cervical cancer represented 1% of all cancer deaths, or 66 deaths in 1996 and 60 deaths in 2002. The age-adjusted mortality rate for females decreased from 5 to 4 (Figure 76). Blacks have highest number of deaths (42 and 43), the highest age-adjusted rate (5 in both years), and account for 64% of all cervical cancer deaths in 1996 and 72% in 2002. Cervical cancer hospitalizations decreased, from 446 hospitalizations in 1996 to 355 in 2001. Hospitalization rates decreased from 1.6 per 10,000 population in 1996 to 1.2 in 2001.

Figure 76: Cervical Cancer by Gender and Race/Ethnicity

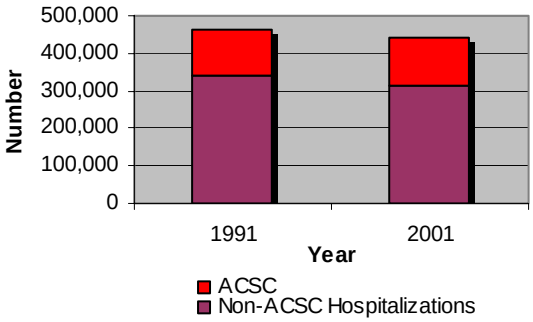


Sentinel Events

Sentinel events are unexpected occurrences, which suggest the need for further analysis. Within the public health care system, hospitalizations for ambulatory care sensitive conditions, such as asthma and hypertension, are viewed as sentinel events because they could have been avoided by proper ambulatory care treatment. Sentinel events trigger analysis of the system to clarify problems and develop solutions.

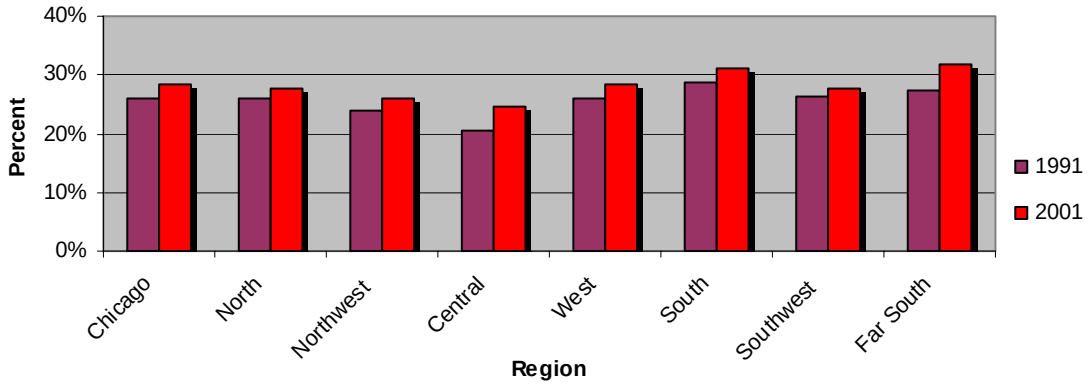
The number of hospitalizations for ambulatory care sensitive conditions (ACSC) grew by 3% from 121,028 hospitalizations in 1991 to 125,033 hospitalizations in 2001. In contrast, the number of total hospitalizations decreased by 5% during this same period, from 463,985 to 440,031. Therefore, the percentage of ACSC to total hospitalizations rose, from 26% in 1991 and 28% in 2001 (Figure 77).

Figure 77: Hospitalizations for Ambulatory Care Sensitive Conditions (ACSC) and Total Hospitalizations



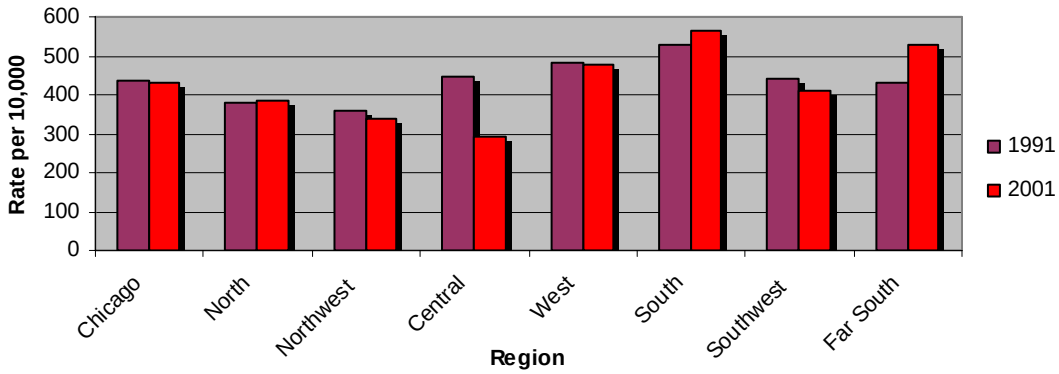
Regionally: The percentage of ACSC hospitalizations to total hospitalizations increased in each of the seven regions in Chicago, comprising 21% to 29% of all hospitalizations in 1991 and 25% to 32% in 2001 (Figure 78). The Far South and South regions had the highest percentages of ACSC to total hospitalizations.

Figure 78: ACSC Percentage of Total Hospitalizations by Region



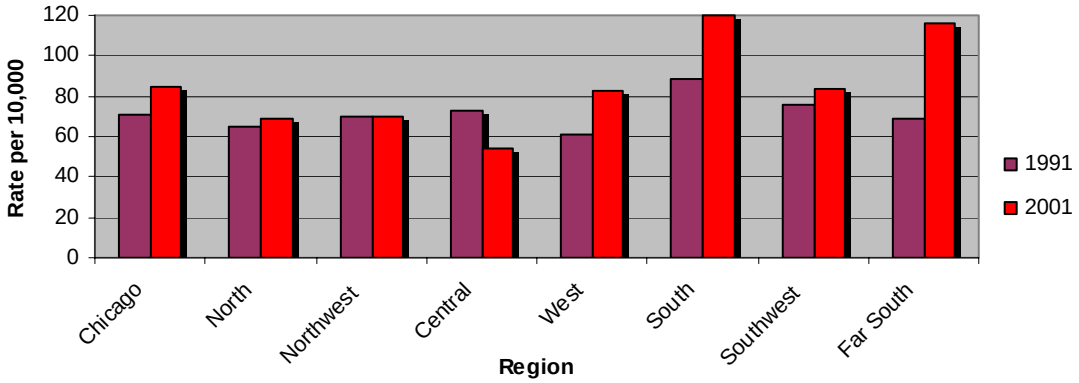
When analyzing ACSC by rate, larger variations exist among the regions (Figure 79). In Chicago, the rate decreased from 435 to 432 per 10,000 population. The highest rate of ACSC occurred in the South region, at 530 per 10,000 in 1991 and 563 in 2001. The Far South region had the largest rate increase, from 431 per 10,000 population to 529 in 2001. Central region had the largest rate decrease, from 446 in 1991 to 291 in 2001.

Figure 79: ACSC Rates by Region



Heart Diseases: Congestive heart failure was the condition with the highest number of ACSC hospital admissions in Chicago, with 19,762 in 1991 and 24,693 in 2001. The rate increased by 20% between these two years, up from 71 per 10,000 population to 85. Again, regional differences occurred, ranging from a rate decrease of 25% (Central Region) to a 67% rate increase (Far South) (Figure 80). The South region had the highest rate of hospitalizations for congestive heart failure, 25% higher than Chicago in 1991, which grew to 42% higher than Chicago's rate in 2001.

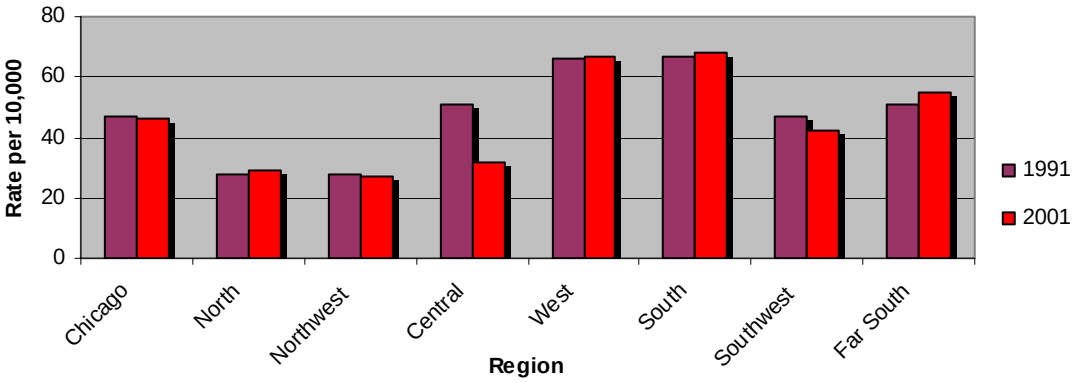
Figure 80: Hospitalizaton Rates for Congestive Heart Failure by Region



Hypertension and angina are additional ambulatory care sensitive conditions that are related to cardiovascular disease. The rate of hospitalizations due to hypertension increased by 31% (from 39 per 10,000 to 51) when comparing 1991 and 2001. In contrast to congestive heart failure and hypertension, hospitalizations for angina decreased, from a rate of 4.3 in 1991 (1,208) to 1.4 in 2001 (391).

Asthma: The rate of asthma hospitalizations for all Chicago decreased slightly, from 47 per 10,000 to 46, although many variations were seen in the seven regions. Three regions had decreases in hospitalization rates (Northwest, Central, Southwest) and four regions had increases (North, West, South, Far South) (Figure 81). Central region showed the largest change, decreasing from a rate of 51 per 10,000 population in 1991 to 32 in 2001.

Figure 81: Hospitalizaton Rates for Asthma by Region



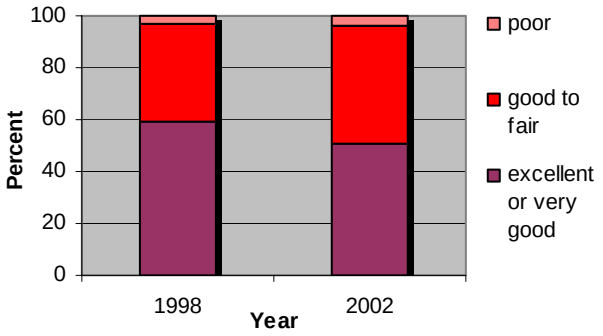
Health Perceptions and Health-related Behaviors

Perceptions of Health

Physical Health

While the majority of adults in Chicago reported their health to be either excellent or very good on the Behavioral Risk Factor Surveillance System (BRFSS) in both 1998 and 2002, this percentage decreased from 59% of the population to 51%. Those who rated themselves as having good to fair health increased from 38% to 45% and those in poor health increased from 3% to 4% (Figure 82). When asked how many days in the past month their health wasn't good, the majority responded "none" (67% in 1998 and 68% in 2002). Of the adults who said their health was not good during the past 30 days, a higher percentage said they were not well for 1 to 7 days, although this proportion decreased in 2002 while the proportion of those whose health wasn't good for 8 to 30 days increased.

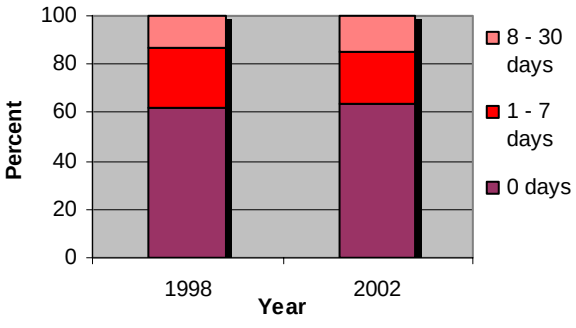
Figure 82: BRFSS Survey Question for Adults: "How is your health?"



Mental Health

The majority of adults in Chicago in 2002, 64%, reported that their mental health was good; that they had no days in the past 30 days when they experienced stress, depression, or emotional problems (Figure 83). This percentage was similar in 1998, when 63% reported no mental health problems. Twenty-five percent of the population reported mental health problems for 1 to 7 days and 13% had problems that lasted 8 to 30 days. In 2002, the percentages were similar, with 21% having mental health issues lasting 1 to 7 days and 15% having problems lasting 8 to 30 days.

Figure 83: BRFSS Survey Question for Adults: "How many days mental health not good?"



Gender and Race/Ethnicity: Changes were noted in the mental health status of some gender and racial/ethnicity populations. Males who said they had mental health problems for 8 to 30 days of the past 30 days increased from 9% of the population in 1998 to 20% in 2002. The percentage of females reporting mental health problems for the same amount of time decreased between these two years (from 15% to 11% of the population), and a higher percentage reported no mental health problems (from 58% to 65%). The percentage of individuals reporting no mental health problems also increased for the Hispanic population, from 67% to 73%.

Suicide: Through the Youth Risk Behavior Surveillance Survey (YRBSS), females reported being more at risk for suicide and depression than males. Females were more likely to attempt suicide, although there was a slight decrease, from 14% in 1997 to 13% in 2003, compared to males at 10% for both years (Figure 84). Approximately 30% of youth felt so sad or hopeless almost every day for two weeks or more during the past 12 months that they stopped doing some of their usual activities. The percentage of females reporting this status rose from 1997 to 2003 (from 33% to 36%) and was higher than males (27% and 26%) (Figure 85) .

Figure 84: YRBSS: Youth that attempted Suicide

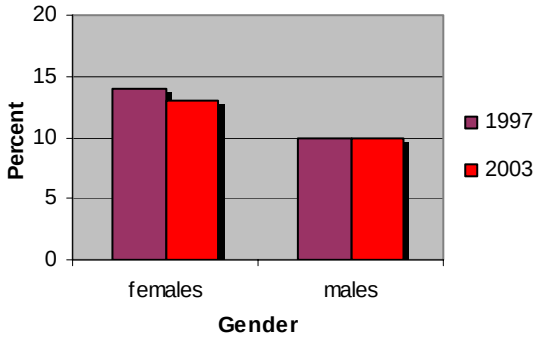
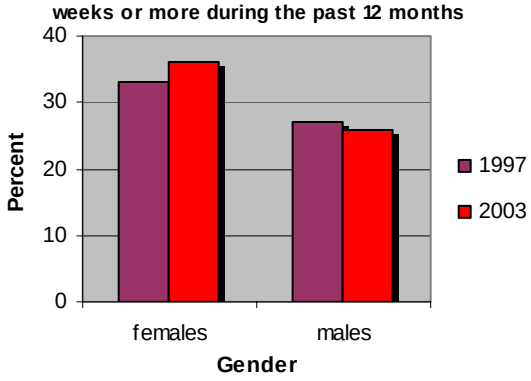


Figure 85: YRBSS: Youth that felt sad/hopeless almost every day for 2 weeks or more during the past 12 months

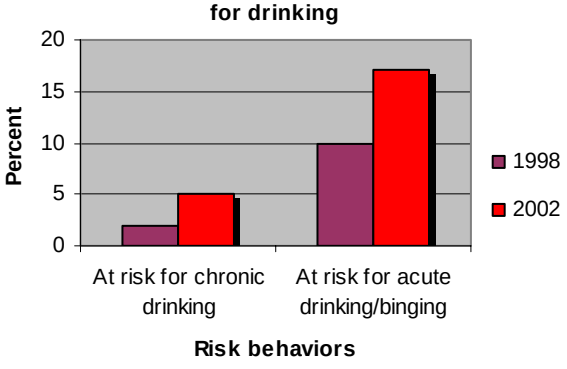


Substance Use

Alcohol

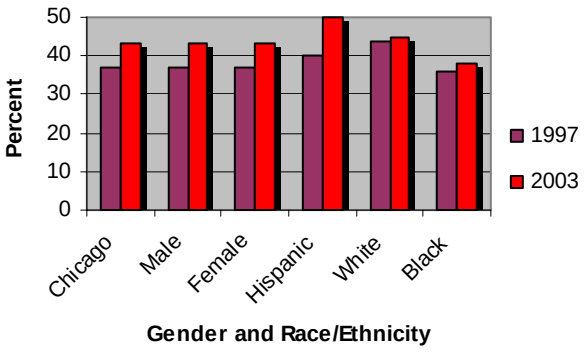
Adults: In 1998, 2% of adults surveyed on the Behavioral Risk Factor Surveillance System said they were at risk for chronic drinking. In 2002, the percentage increased slightly to 5% (Figure 86). The percentage of adults at risk for acute drinking/binge drinking also increased, from 10% in 1998 to 17% in 2002.

Figure 86: BRFSS: Adults at-risk for drinking



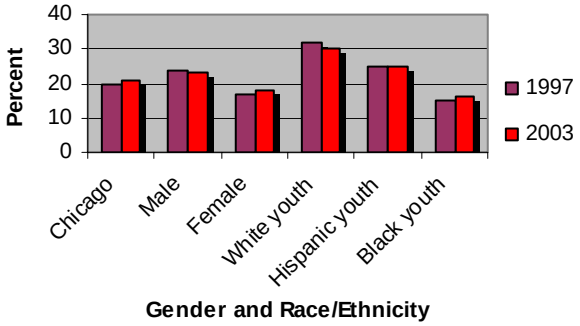
Youth: The percentage of youth who had at least one drink during the past month increased when comparing responses on the 1997 and 2003 Youth Risk Behavior Surveillance Survey, from 37% to 43% (Figure 87). Both males and females reported similar percentages. Increases were noted in all races and ethnicities, highest for Hispanic youth, which increased from 40% in 1997 to 50% in 2003. Forty-five percent of White youth reported they had at least one drink in 2003, up slightly from 44% in 1997. Black youth who drank increased slightly, from 36 to 38%.

Figure 87: YRBSS: Youth reporting having at least 1 drink during past month



The percentage of youth who had five or more drinks in a row in the past 30 days was similar when comparing 1997 and 2003, at 20% and 21% respectively (Figure 88). White youth had the highest percentage, at 30% in 2003, which was a 2% decrease compared to 1997. The second highest percentage was for Hispanics, with 25% in both years.

Figure 88: YRBSS: Youth reporting having 5 or more drinks in a row in past 30 days



The percentage of youth who drove a car when they had been drinking alcohol during the past 30 days increased by one percentage point when comparing 1997 to 2003, from 8% to 9%. The percentage of Hispanic youth increased from 9% in 1997 to 11% in 2003, and the percentage of Black youth increased from 6% to 8%. White youth were the most likely of all racial/ethnic groups to drink and drive in 1997, at 12%. This percentage decreased below other races/ethnicities in 2003, to 7%.

Marijuana

Through the YRBSS, students were surveyed about their drug use. The percent that smoked marijuana at least once in their life was 45%, the same for 1997 and 2003 (Figure 89). Use among males was higher than females, although their use decreased from 50% to 47%, while females who ever smoked marijuana increased from 41% to 44% in the corresponding years. In 2003, 50% of Black youth stated they had ever smoked

marijuana, the highest of all racial/ethnic groups. However, this percentage was 2% lower than in 1997. Hispanic youth marijuana use increased from 39% in 1997 to 44% in 2003, while White use decreased from 45% to 32%.

Almost a quarter of youth had used marijuana during the 30 days prior to the survey: 24% in 1997 and 23% 2003 (Figure 90). Thirteen percent of youth had used marijuana prior to 13 years of age for both years. Males had a higher percentage than females (16% compared to 10%) in 2003, although the male percentage had decreased while the female percentage increased from 1997 (19% for males and 7% for females). The percent of youth using marijuana on school property decreased slightly, from 10% and 8% of youth in 1997 and 2003, respectively.

Figure 89: YRBSS: Youth Reporting Ever Smoked Marijuana

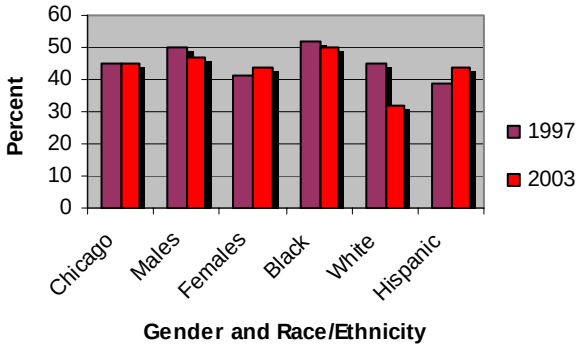
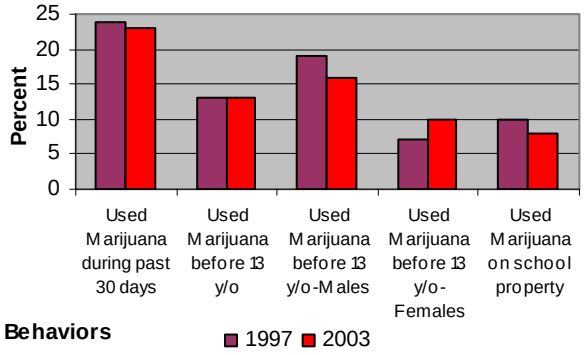


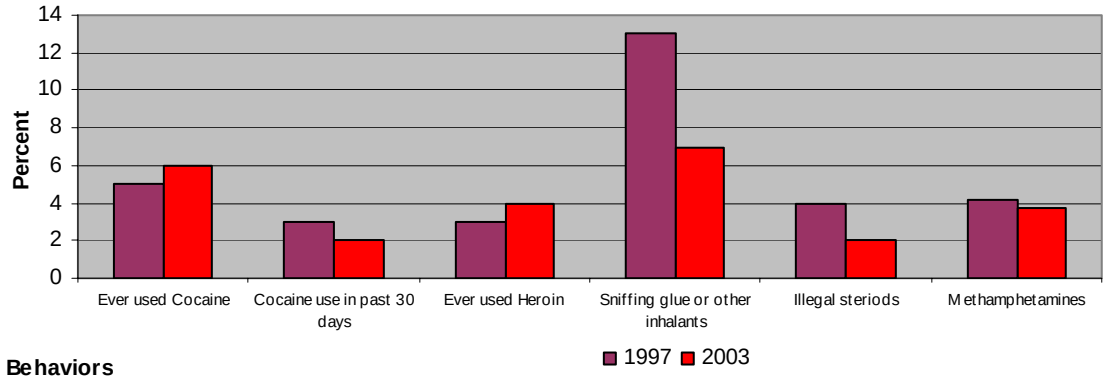
Figure 90: YRBSS: Youth Reporting Marijuana Use



Other drugs

Patterns of other drug use varied (Figure 91). While lifetime cocaine use increased (from 5% in 1997 to 6% in 2003), the percent of youth using cocaine during last 30 days decreased (3% in 1997 to 2% in 2003). Heroin use increased, from 3% in 1999 to 4% in

Figure 91: YRBSS: Youth Drug Use



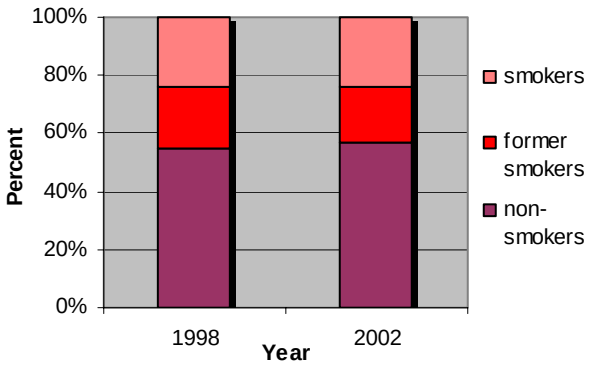
2003. In addition, the percentage of youth who were offered, sold or given illegal drugs on school property increased between 1997 and 2003, up from 28% to 38%.

Use of several drugs did decrease, including sniffing glue or other inhalants (down from 13% in 1997 to 7% in 2003), illegal steroids (4% to 2%), injected illegal drugs (from 2.4% to 1.5%), and methamphetamine use (4.2% to 3.7%). Data for 2003 indicate that 5% of youth have taken ecstasy (MDMA); 8% of male youth and 3% of female youth.

Tobacco Use

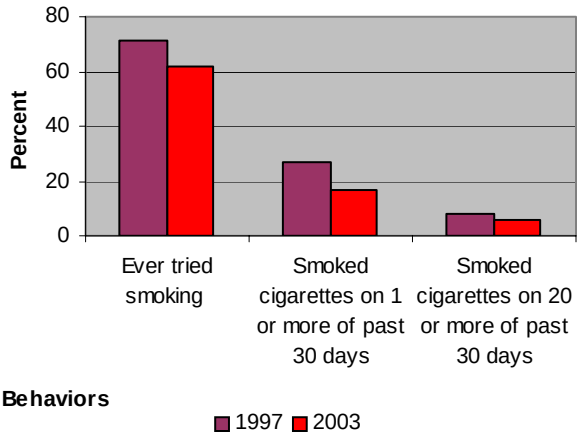
Adults: Self-reported smoking status was similar in 1998 and 2002, although the percentage of non-smokers increased slightly in 2002 (57% compared to 55%) and the percentage of former smokers was slightly lower (21% compared to 19%) (Figure 92). For 2002, the age group with the largest percent of smokers was people aged 45-64, while those aged 18-24 and 25-44 had the largest percentages of non-smokers. Twenty-nine percent of males said they smoked, compared to 18% of women.

Figure 92: BRFSS: Adult Smoking Status



Youth: Youth showed decreased tobacco use, with 62% reporting ever have tried smoking in 2003 compared to 71% in 1997 (Figure 93). Those who smoked cigarettes on one or more of the past 30 days decreased from 27% in 1997 to 17% in 2003; those who said they smoked cigarettes on 20 or more of the past 30 days decreased from 8% to 6%; and those who smoked more than 10 cigarettes a day when they smoked stayed the same at 1%. Ninth graders exhibited the largest decrease in smoking, from 30% in 1997 who had at least one cigarette in the past month to 18% in 2003.

Figure 93: YBRSS: Youth Smoking Status



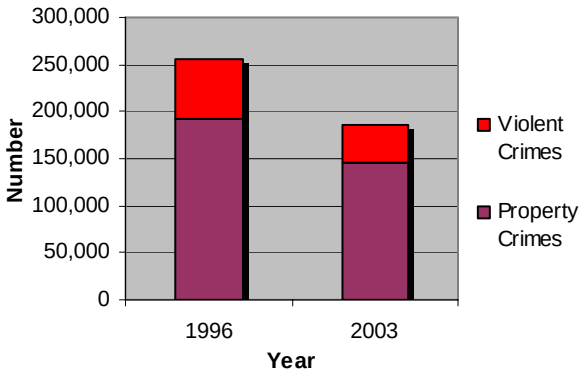
While the overall percentage of youth who smoked on 20 of the last 30 days decreased only 2%, White youth smoking decreased by 14 percentage points (from 26% to 12%). Black youth decreased from 6% to 5% and Hispanic use was 5% for both years. Accessibility of buying cigarettes decreased when looking at 2001 and 2003, with 31% of youth under 18 years of age able to purchase cigarettes at a store in 2001 compared to 23% in 2003.

Violence

Crime

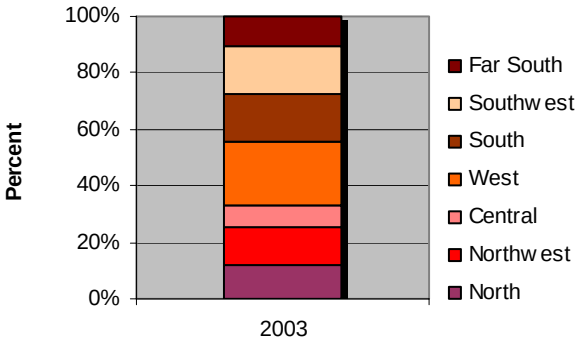
The Chicago Police Department tracks and monitors crime annually by using index crimes, which are the combination of four types of violent crimes (murder, criminal sexual assault, robbery, aggravated assault) and four types of property crimes (burglary, theft, motor vehicle theft, arson). The crime index has been steadily decreasing from 1996 through 2003, from 256,686 to 185,458, a decrease of over 71,000 crimes or 28% (Figure 94). Property crimes made up approximately three-quarters of all crime in both 1996 and 2003 and violent crimes comprised one-quarter. Theft was the most common crime, making up 67% of all property crime in 2003 and 52% of the total crime index. Aggravated assault is the most common violent crime, accounting for 50% of violent crimes and 11% of the total crime index.

Figure 94: Total Crime Index



Data were available for regional analysis for 2003, with the West Region showing the highest total crime index of all the seven regions, with 41,501 crimes, or 22% of all crimes (Figure 95). The South and Southwest regions have the next highest numbers, both with 17% of all crimes. The Central region has the lowest total crime index, with 14,209 crimes, or 8% of the total.

Figure 95: 2003 Crime Index by Region



Police also monitor other measures of the safety of the community. Calls to the police concerning domestic violence decreased by 11% between 1996 and 2003, from 239,200 to 212,400 calls. Arrests for driving under the influence (DUI) decreased 9%, from 6,558 to 5,969. Hate crimes decreased 27%, from 175 to 129 in 1996 and 2003, respectively. Motives for hate crimes changed within this time period, with race still a primary reason, but decreasing from 65% of all hate crime motives in 1996 to 44% in 2003. In contrast, more hate crimes were committed with the motives of sexual orientation and national origin.

One strategy to decrease crime is to have police and community members come together to discuss community issues and share information. The Chicago Alternative Policing Strategy (CAPS) was initiated in 1993 and continued to grow from 1996 to 2003 not only in the number of beat meetings held (up from almost 2,600 to almost 3,000), but also with the number of attendees (from 59,400 to 63,100).

Weapons

Adults*:* As reported in the Behavioral Risk Factor Surveillance Survey, 8% of adults kept firearms in or around their home in 2002. Individuals more likely to have a firearm include males (10% compared to 6% for females), Whites (9% compared to 7% for Blacks and 6% for Hispanics), college educated (10% compared to 5% for those who didn't finish high school), and people earning more than $50,000 a year (13% compared to 7% for those earning under $15,000).

Youth*:* As reported through the Youth Risk Factor Surveillance Survey, 7% of youth carried a gun in the past 30 days in both 1997 and 2003. Increases occurred in the Black population (from 8% to 10%) and the White population (from 1% to 3%). A higher percentage of males carried guns (12% and 11%), although their percentage decreased slightly while the percentage of females carrying a gun increased (from 3% to 4%).

Almost a quarter of youth in 1997 reported carrying any type of weapon (gun, knife, or club). This percentage decreased by 5 percentage points to 19% of all youth in 2003. The Black population had the highest percentage of youth carrying weapons in both 1997 and 2003, although this percentage decreased from 29% to 21%. The percentage of Hispanic youth who carry weapons increased from 18% to 19%. Both the percentage of males and females carrying weapons decreased during these time periods: males from 27% to 25% and females from 21% to 15%. The percentage of youth carrying weapons at school also decreased and was less than half of the percentage of youth who carry weapons in total 12% in 1997 and 6% in 2003.

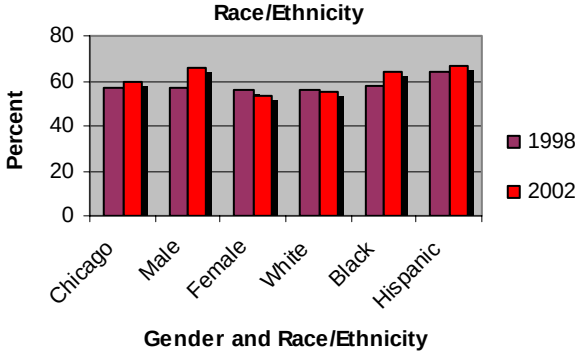
Weight Control and Exercise

Adults

Weight Control

The percentage of adults who were identified as overweight or obese through analysis of weight and height on the Behavioral Risk Factor Surveillance System survey was 57% and 60% of the population in 1998 and 2002, respectively (Figure 96).

Figure 96: BRFSS: Percent of Adults Overweight or Obese by Gender and Race/Ethnicity

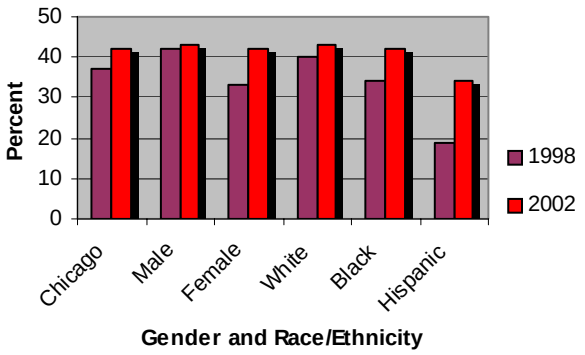


Gender and Race/Ethnicity: In 1998, males and females had similar percentages of their population that were overweight/obese. However, while this percentage decreased to 53% in 2002 for females, the percentage of males increased to 66%. Black and Hispanic adults had higher percentages of overweight/obese people than in the White adult population. In 1998, 58% of the Blacks and 64% of the Hispanics were overweight/obese, compared to 56% of Whites. Both the percentages for Blacks and Hispanic increased in 2002, to 64% and 58%, while the percentage of overweight/obese White adults decreased slightly to 55%.

Exercise

Although the percentage of adults who reported they participate in sufficient amounts of exercise or had an active lifestyle increased slightly between 1998 and 2002, still less than half of all adults exercise (Figure 97).

Figure 97: BRFSS: Adults who get sufficent exercise



Gender and Race/Ethnicity: In 2002, similar percentages of males and females exercised, which represented an increase for females (from 33% to 42%) and a slight increase for males (from 42% to 43%). A similar change occurred for exercise in racial/ethnic groups. The percentage of Blacks participating in sufficient exercise increased from 34% in 1998 to 42% in 2002. The percentage of Whites increased from 40% to 43%. While lower than other racial/ethnic groups, Hispanic participation increased 15 percentage points, from 19% in 1998 to 34% in 2002.

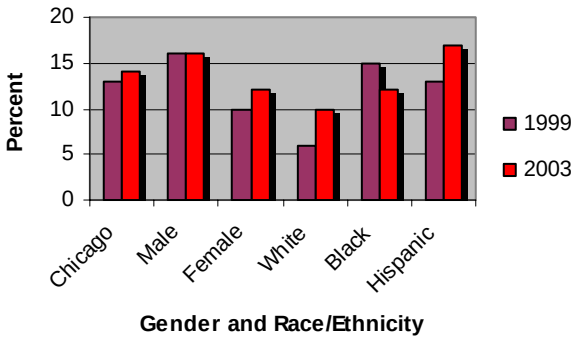
Youth

Weight Control

Through analysis of their height and weight on the 2003 Youth Risk Behavior Surveillance System (YRBSS) survey, 14% of youth were classified as being overweight. This is a slight increase from 13% in 1999 for all youth. Sixteen percent of Tenth grade students were overweight in 2003, an increase from 13% in 1999 and the highest among all grades. The largest change was seen for Twelfth graders, an increase from 9% in 1999 to 15% in 2003.

Gender and Race/Ethnicity: Data from the YRBSS showed that a higher percentage of overweight males (16% in both 1999 and 2003) compared to females (10% in 1999 and 12% in 2003) (Figure 98). In 2003, 17% of Hispanic youth were overweight, an increase from 13% in 1999. The percentage for White youth increased from 6% to 10%, while Black youth's percentage decreased from 15% to 12%.

Figure 98: YRBSS: Overweight Youth by Gender and Race/Ethnicity



When asked in a survey question to describe their weight, the results were different than when determined by a height and weight analysis. Twenty four percent of students in 1997 described themselves as overweight, as did 27% in 2003. While females were less likely than males to be overweight/obese as noted in the data above, they were more likely to perceive themselves as overweight: 29% in 1997 and 32% in 2003. Males were less likely to see themselves as overweight (18% and 23%).

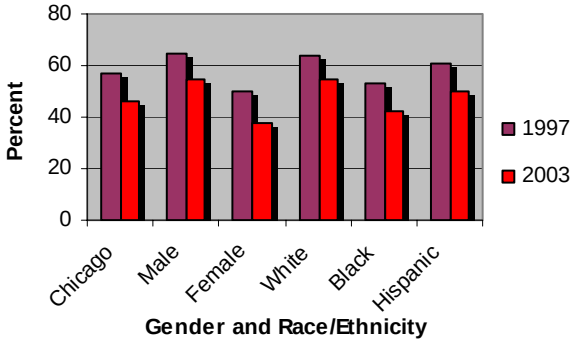
Exercise

These changes in weight correspond to the large decrease noted in students participating in vigorous physical activities at least 3 days a week. In 2003, 46% of all students participated in these types of exercises, a decrease of 11 percentage points from 1997 when 57% exercised. The largest decrease occurred for Twelfth graders, a decrease of 28 percentage points, from 66% in 1997 to 38% in 2003. Eleventh graders had the lowest percentage of exercise in 2003 (33%), which was a decrease from 57% in 1997.

Gender and Race/Ethnicity: Females participated in physical exercise at a much lower percentage than males: females at 50% in 1997 and 38% in 2003 compared to males at 65% and 55% (Figure 99). Black youth had the lowest percentage of participation in

exercise (53% in 1997 down to 42% in 2003), compared to White youth (64% in 1997 and 55% in 2003) and Hispanic youth (61% and 50%).

Figure 99: YRBSS: Youth reporting vigorous exercise 3x/week

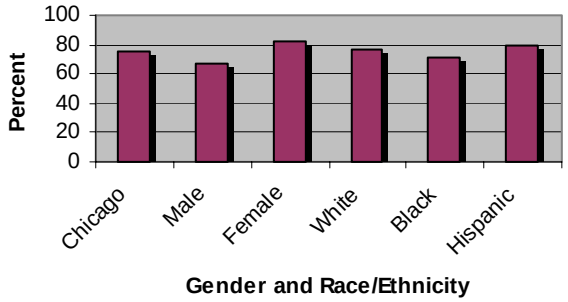


Safety and Injury Control

Seat Belt Use

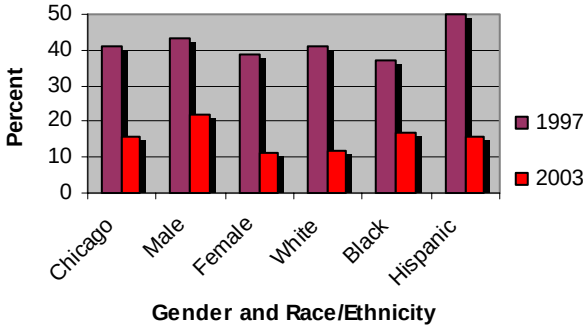
Approximately three-quarters of the adult population report that they always or nearly always wear their seatbelts: 76% in 1998 and 75% in 2002. Females were more likely to use a seat belt (82% in 2002) compared to males (67%), as were Whites (77%) and Hispanics (80%) compared to Blacks (71%) (Figure 100).

Figure 100: BRFSS 2002: Adults who report always or nearly always wearing seatbelts



The percentage of youth who state they never or rarely wear a seat belt when riding in a car driven by someone else decreased significantly when comparing 1997 and 2003 responses on the Youth Risk Behavior Surveillance System (Figure 101). The overall percentage for youth went down 25 percentage points, from 41% in 1997 to 16% in 2003. Females have a lower percentage than males of rarely wearing a seat belt: 39% in 1997and 11% in 2003 compared to 43% and 22% for males. Hispanic youth showed the largest improvement, from 50% not wearing seat belts in 1997 to 16% in 2003.

Figure 101: YRBSS: Percent of Youth who Never or Rarely Wear a Seat Belt when Riding in a Car Driven by Someone Else



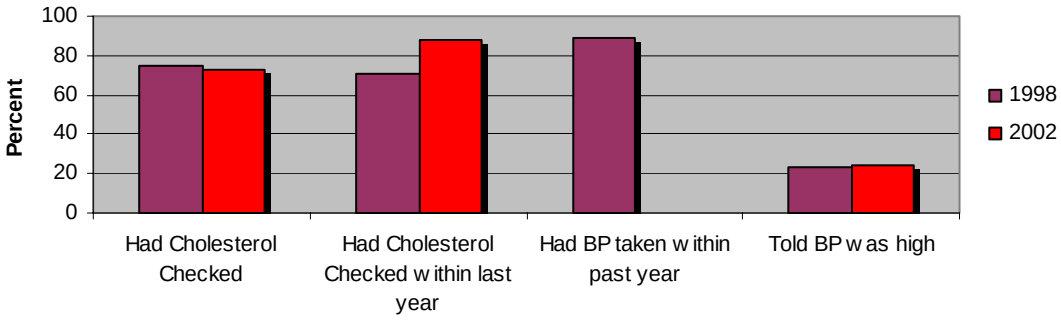
Preventive Health Screening

Cholesterol

Although the percentage of adults who reported on the Behavioral Risk Factor Surveillance Survey that they had their cholesterol checked decreased slightly in 2002 as compared to

1998 (73% in 2002 down from 75% in 1998), a higher percentage of those who had their cholesterol checked reported having had the test within the last year (71% in 1998 and 88% in 2002). A slightly lower percentage was told that they have high cholesterol levels (from 25% in 1998 to 23% in 2002) (Figure 102).

Figure 102: BRFSS: Adult Preventive Health Screenings



Hypertension

Eighty-nine percent of adults in 1998 reported having their blood pressure taken within the past year. Almost one-quarter of adults reported they had been told their blood pressure was high in both 1998 and 2002. Of this percentage in 2002, 64% of adults stated they took medication for their blood pressure.

Oral Health

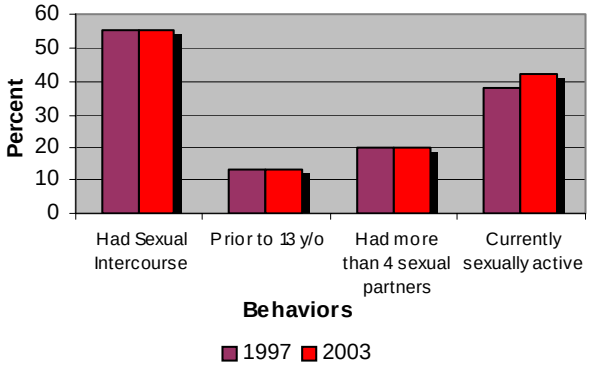
Sixty-nine percent of adults in 2002 stated they had had a dental exam within the past year. This represents a slightly higher percentage than in 1998, when 67% reported having an exam. The percentage of those having an exam between 1-2 years ago increased from 9% to 12%, while those having a dental exam more than 2 years ago/never decreased from 24% to 18%.

Sexual Activity and HIV Testing Behaviors

Youth Sexual Behaviors

Sexual behaviors in youth for the years of 1997 and 2003 were similar when comparing data from the Youth Risk Behavior Surveillance Survey (Figure 103). For both years approximately 55% reported having had sexual intercourse during their

Figure 103: YRBSS: Youth Sexual Behavior



lifetime, 13% having had sexual intercourse prior to age 13, and 20% having had four or more partners. The percentage of youth currently sexually active increased from 38% in 1997 to 42% in 2003.

Gender and Race/Ethnicity: Analysis by gender shows males more likely to be sexually active, with approximately 60% of males and 50% of females reporting having had sexual intercourse. For 1997 and 2003, 21% and 22% of males compared to 7% and 5% of females reported having sexual intercourse before age 13. Males were more likely to have had four or more partners (31% and 27%) compared to females (11% and 12%). Percentages of female youth who have had four or more partners showed a larger increase for Hispanic females (from 4% to 9%) and Black females (from 15% to 17%). In contrast, the percentage of Black male youth with four or more partners decreased from 51% to 43% and Hispanic male youth from 19% to 14%. The percentage of females that were currently sexually active increased from 35% in 1997 to 41% in 2003, with Black females having a higher percentage (43% to 53%). The percentage of male youth currently sexually active increased from 41 to 44%, with Black males having the highest percentage in both years, at 58% and 61%.

Condoms are the most common form of birth control, with 67% of youth stating they used condoms in both 1997 and 2003. Males are more likely to use condoms (76% in 1997 and 73% in 2003) than females (58% and 60%). Use of oral contraceptives increased during these years, from 5% to 9%, with females reporting higher use than males. Nine percent of youth in 2003 stated they had either been pregnant or their partner had been pregnant. This is a slight decrease from 1997, when 10% reported pregnancy. Females decreased from 11% to 10% and males from 9% to 7%.

Twenty-one percent of youth stated they used drugs or alcohol during their last sexual experience. This percentage increased slightly from 19% in 1997. Males had a higher percentage at 25% in 2003, although this percentage decreased from 26% in 1997. The percentage of females using drugs or alcohol during their last sexual experience increased, from 12% to 15%.

HIV Testing and Education

HIV Testing

In the BRFSS, 93% of adults in 2002 thought that knowing their HIV status was "very important;" however only 49% reported to have ever had a test for HIV. This percentage is slightly higher than the percentage that received an HIV test in 1998, 43%. The largest age group who had received a test for both years was 25-44 year olds, at 50% and 58%, respectively.

HIV Risk

In 1998, 8% of adults identified on the BRFSS that they had a high-medium chance of getting HIV and 3% participated in high-risk activities. In 2003, 4% of adults responded that they participated in activities that put them at high risk for HIV.

HIV Education

The percentage of all students saying they received education about HIV decreased 5 percentage points when comparing 1997 to 2003, from 86% to 81%. Large decreases in receiving HIV education were identified for both White youth (84% to 73%) and Black youth (91% to 82%). By grade, the largest decrease was for 12th graders, from 88% to 78%.

Access to Health Care

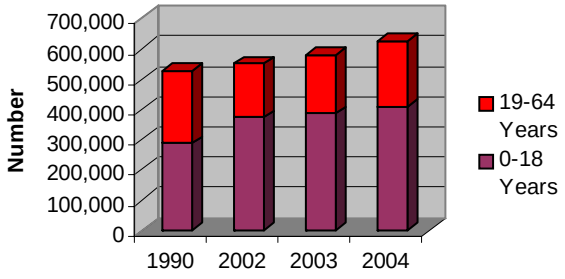
A key component of access to health care is access to health insurance. Two data sources, the Illinois Department of Healthcare and Family Services (formerly known as the Illinois Department of Public Aid) and the U.S. Census Bureau, provide some insight into the extent to which Chicago's population has either public or private health insurance

Medicaid and Medicare

Low-income persons who meet certain criteria are eligible for health care coverage under the state's Medicaid Program. The majority of Medicaid enrollees are women and children. The smallest group of enrollees by age are persons 65 years and older.

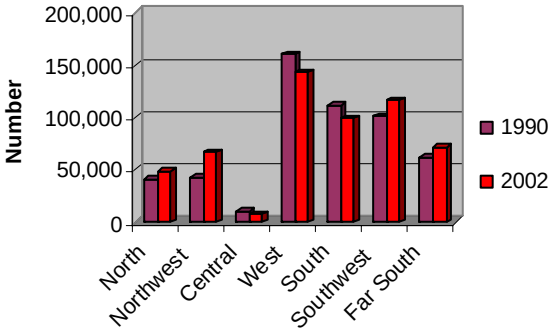
Between 1990 and 2002, the total number of Medicaid enrollees under age 65 increased by 4%. During this same period, however, the number of enrollees 18 years of age and younger increased by almost 30% (Figure 104). Children represented 54% of the 528,042 enrollees in 1990 and 67% of the 551,472 covered in 2002. This shift is not surprising given the institution of Illinois' KidCare health insurance program in the late 1990s. It is notable that despite only a minor increase between 1990 and 2002, enrollment rose nearly 14% between 2002 and 2004.

Figure 104: Chicago Medicaid Enrollees By Age



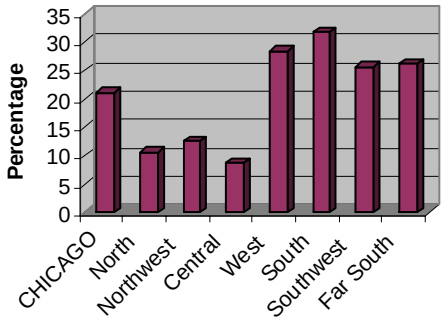
Across the city, changes in Medicaid enrollment varied greatly (Figure 105). Enrollment grew in four regions, ranging from nearly 15% in the Far South region to 56% in the Northwest region. The decreases in enrollment that occurred in three regions ranged from 11% in the South region to 21% in the Central region.

Figure 105: Medicaid Enrollees (under 65) by Region, 1990 and 2002



In 2002, 21% of Chicagoans under 65 years of age were enrolled in Medicaid. By region, the Central region had the smallest proportion of the population enrolled (9%). In four regions (West, Southwest, South and Far South) between 26% and 32% of the under-65 population were enrolled in Medicaid (Figure 106).

Figure 106: Proportion of Population Under Age 65 Enrolled in Medicaid, 2002



According to the U.S. Census Bureau's *Current Population Survey,* less than one percent of all Illinoisans ages 65 and older were uninsured and the majority receive some coverage through the Medicare program.

Uninsured

The Current Population Survey (CPS) provides estimates of insurance coverage based on an annual survey and projected population size. For 1990, 23% of Chicago's population was uninsured. In 2004, the percentage of uninsured Chicagoans increased to 26%. The Gilead Outreach & Referral Center report Real People, Real Stories analyzes CPS data for 2004 on several variables, including race/ethnicity, age, and employment status to better profile the uninsured population in Chicago. These data are presented for people under age 65, since Medicare covers the majority of this population and CPS data indicate that only one percent of people aged 65 and over are uninsured.

Race/Ethnicity: At 244,412 uninsured people, or 45% of all uninsured in Chicago in 2004, the Black population represented the largest uninsured racial/ethnic group (Figure 107). This Hispanic population had the next highest number of uninsured, at 170,812 people.

The Black population also had the largest percentage of uninsured people within its population, at 31% of all Black people in Chicago in 2004 (Figure 108). The uninsured made up similar percentages of the Hispanic population (29%) and population classified as Other/Multi-race (28%). Uninsured people comprised 16% of the White population.

Age: People aged 19-29 had the highest likelihood of all age groups of being uninsured, at 41% of their population group, or 166,347 people (Figure 109). Twenty-four percent of people aged 30-49 were uninsured and 23% of people between 50 and 64 were uninsured. Children aged 0-18 were uninsured at a rate of 19%.

Employment Status: People that are out of the work force comprise the highest number of all the uninsured people in Chicago, at 199,974 people in 2004. However, as a percentage of their population, uninsured people who are not in the work force represent 42% of this population compared to 57% of the population of people who are unemployed and looking for work (figure 110). Thirty-five percent of part time workers are uninsured and 19% of full time workers in Chicago were uninsured in 2004. Of all self-employed people, 24% are uninsured.

Figure 107: 2004 Number Uninsured by Race/Ethnicity

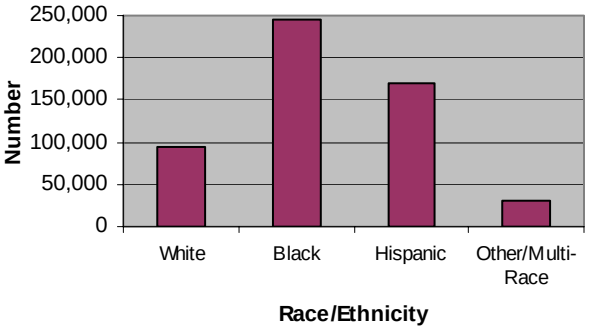


Figure 108: 2004 Percent Uninsured in Racial/Ethnic Populations

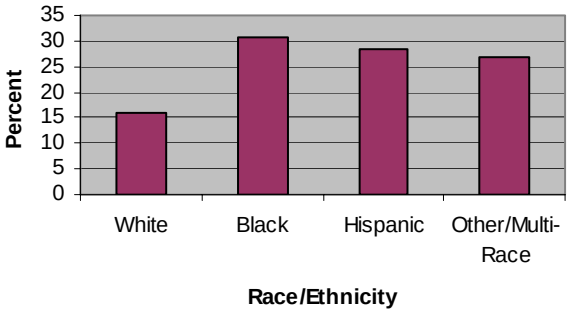


Figure 109: 2004 Percent Uninsured in Age Groups

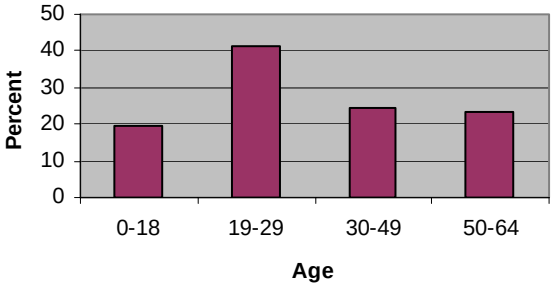
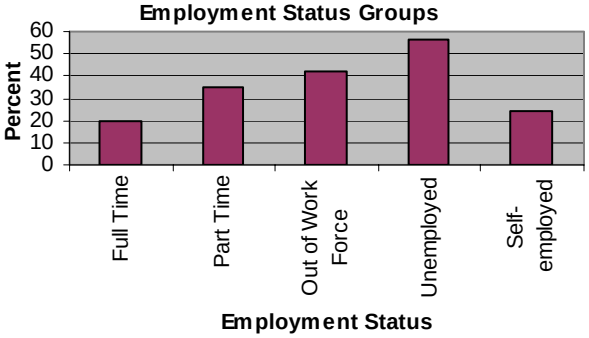
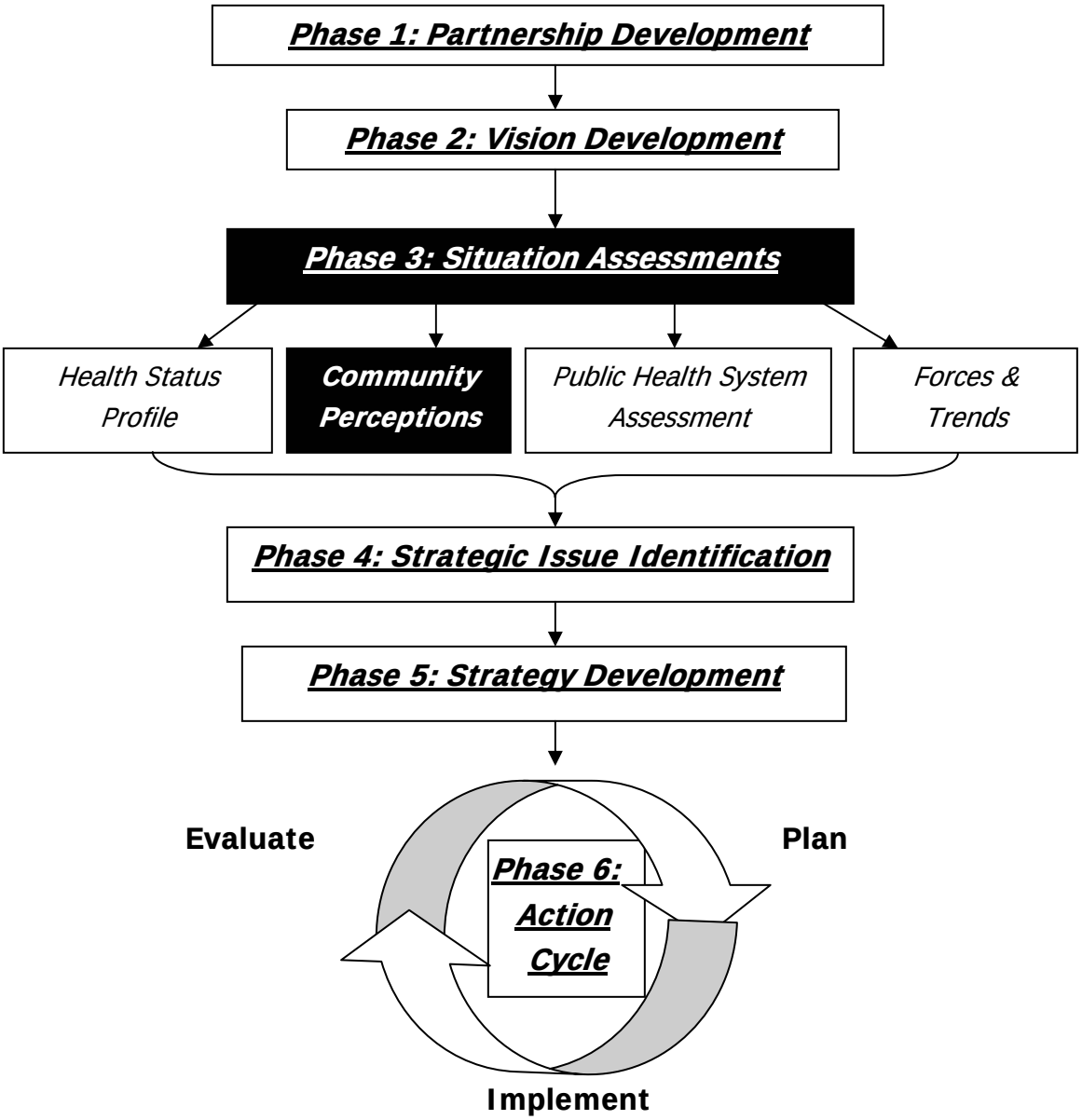


Figure 110: 2004 Percent Uninsured in Employment Status Groups



Chicago Partnership for Public Health
MAPP Process



Community Perceptions

Purpose

Community input is an important component in public health system strategic planning and made up one of the four situation assessments of the Chicago Partnership's strategic planning process. Its purpose was to gather community thoughts, opinions, and concerns to provide insight into important public health issues from the community perspective, including priority health issues, barriers to health care, and suggestions for removing those barriers.

Approach

Feedback from the community was obtained through focus groups conducted in 10 community areas across Chicago (Albany Park, Austin, Brighton Park, Chicago Lawn, Hermosa, Lower West Side, McKinley Park, New City, North Lawndale, and South Chicago) and in collaboration with existing partnerships and organizations (Healthy South Chicago, Healthy Hermosa, Healthy Chicago Lawn, Healthy Albany Park, Healthy Austin, and REACH 2010). These groups were held between August 2004 and April 2006.

A total of 47 focus groups were held with approximately 370 participants ranging in age from 16 to 86. Focus groups were held with youth groups, senior citizens, church groups, pregnant adolescents, English as a Second Language students, Latino participants (both English and Spanish speaking), Arabic-speaking women of Middle Eastern descent, Lithuanian men and women, Bosnian men and women, African American men and women, and White men and women. Community residents made up the majority of the focus groups, at 85%. Some focus groups involved local health care providers (12%) and business owners (3%).

Each focus group was structured around eight questions intended to result in a range of answers providing an in-depth and detailed picture of the community viewpoint:

1) What are some of the key issues in your community?
2) What do you think are the top two or three problems?
3) When you think about the health of your community, what would you say is going well?
4) When you think about the health of your community, what would you say needs improvement?
5) What barriers do you or people you know face when trying to stay healthy?
6) Who provides health care in your community?
7) Do you have any suggestions for making it easier to stay healthy?
8) What do you do to keep your neighborhood healthy?

Findings

Although the focus groups were across 10 communities and involved many different populations, responses to the eight questions were often very similar. On occasion the responses differed based on age and/or gender. Also interesting to note is that in each focus group, respondents thought of health in broad terms; when supplying answers participants did not focus only on health care or disease, but also on contributing factors to health status such as housing and employment. The responses to the questions have been grouped into four broad categories below:

Problems/Barriers: When asked about community issues and needs, responses were similar across the focus groups. Issues of community safety were frequently among those mentioned first, particularly the subjects of drugs, gangs, and violence. The topic of police-community relations was raised, but their perspective differed depending on the demographic of the respondent; youth and men generally felt police unfairly targeted them, and senior citizens felt that the police did not have a strong enough presence.

The rising costs of housing came up often, with respondents mentioning that both renters and homeowners were being pushed out of their neighborhoods due to increased rents and rising property taxes. Participants were also very savvy about the changes going on in their neighborhoods, with one participant noting that, "gentrification is a non-violent war… it is a war of money." Also frequently cited was the lack of services, including recreational facilities/programs for youth, accessible and affordable health care, and high quality education.

The topic of stress surfaced repeatedly. When asked for explanation, focus group participants talked about such issues as the high rates of unemployment, the necessity of working more than one job to make enough money for their families, and the pressures of overcrowded housing as primary contributors to stress.

When asked about specific needs, participant responses were similar across all communities. The need for additional programs, particularly for youth and for those needing mental health care, were mentioned as well as a need for more information about all existing services. There was a general feeling that there were services out there that would meet their needs, but that information about those services was scarce.

The length of waiting time for appointments, both to receive an appointment and on the actual day of the appointment, was also mentioned as a significant problem. One respondent noted, "…one has to find out how to get all the way over there, and when you arrive there are usually long lines. Sometimes it is best to do it 'Mexico style,' which is to wait the sickness out, or to find and cut some herbs that can be used to make remedies. That is what a lot of people do, but usually it doesn't work for them."

The need for affordable housing was highlighted in every community. Participants also mentioned concerns around specific health issues including HIV/AIDS, diabetes, teen pregnancy, obesity, sex education, asthma, and substance abuse. Often personal stories about relatives or friends with these conditions were shared.

When asked about barriers to receiving health care, answers varied slightly to this question depending on race/ethnicity, gender, and age. In primarily Latino communities the most commonly cited barriers to health were cultural and linguistic competency at clinics, and immigration status, which was commonly perceived to be a limiting factor in receiving health care. Cultural attitudes were also mentioned as barriers to staying healthy. Latino men spoke about not even attempting to access health care because it went against their idea of what it is to be a man. This population stated that when they do get care they don't believe the doctor and instead self-diagnose and treat: as one participant said, "if you die you die." In most communities, lack of transportation, lack of insurance, and lack of financial resources were discussed as barriers. Poor provider attitudes were mentioned as a deterrent for receiving care. For youth, gang territories were very real barriers to receiving care, as the fear of crossing gang boundaries keeps adolescents from going to certain clinics.

Positive Aspects: When asked about positive aspects of their neighborhoods, participants had a more difficult time answering. Often they commented that not much was going well and that it was much easier to identify the bad than the good. However, parks were mentioned as a valuable resource in most communities. The diversity of their neighborhoods and long-term relationships with neighbors were discussed a number of times as positive elements, with participants noting that they could rely on their neighbors to look out for them. Respondents often felt that though there were not many options for health care located nearby, the quality of the care they received from local health providers was good. There was also strong sentiment that community-based organizations in the different neighborhoods work hard and care deeply about their clients.

Focus group participants were also asked what they do to keep their neighborhoods healthy. The most common responses included belonging to block clubs, looking out for neighborhood children, going to community events, and taking care of the neighborhood by picking up garbage and growing gardens. There was a general sense that most people would like their neighborhoods to be healthier and would be willing to pitch in to community efforts if they were available or if they felt it would be worth their time.

Health Care System: Participants across all communities said that they utilized emergency rooms, publicly-operated clinics and community health centers, private doctors, and hospitals as their primary providers of health care.

Recommendations: Participants were asked for suggestions on ways to improve the health of their community and Chicago as a whole. Ideas included free and/or affordable services, including health care and housing. Respondents also expressed a desire for increased police presence, increased trust within community, community resource centers for information sharing, and higher quality education within their communities.

Often, participants felt that their concerns were not shared by those in power; "…we're not being listened to; we wanna know what will better the community for us. This is our community. We got to live here. I don't want no liquor store on every corner, I would like to have a church, restaurants, Boy's and Girl's clubs, movie theaters…" Others felt that funds were spent on low priority concerns, such as fixing potholes, rather than on high priority issues such as health care.

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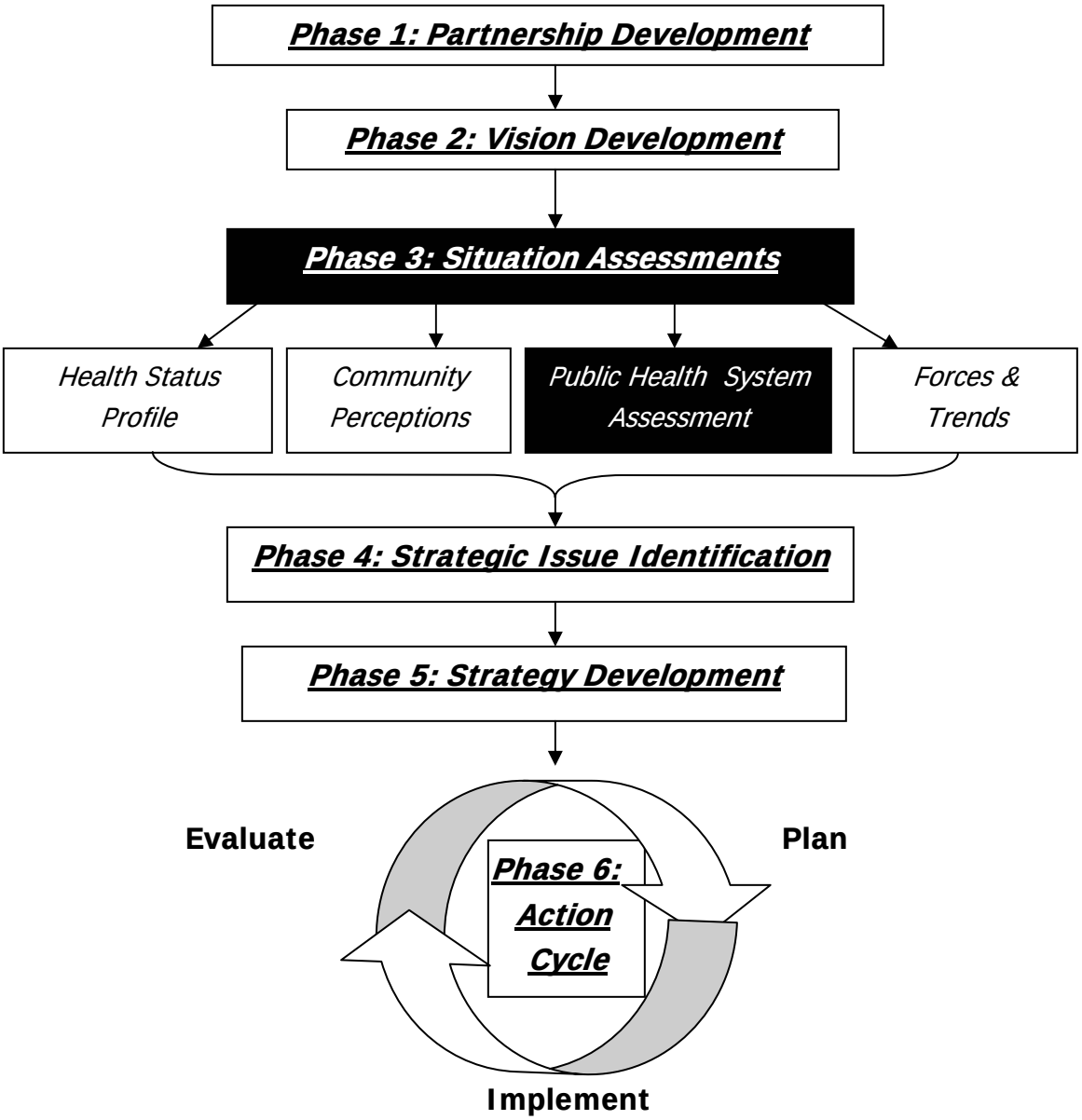


Local Public Health System Assessment

Purpose

The purpose of the local public health systems assessment is to broadly look at the local public health system to identify its components, activities, competencies and capacities. Through this information, the system will be better able to identify current infrastructure gaps, possible future systems challenges, and opportunities for collaboration.

Understanding and identifying participating agencies within the local public health system (LPHS) allows better assessment of the system. Defined by the National Association of County & City Health Officials' (NACCHO) Mobilizing for Action through Planning and Partnerships User's Handbook, the local public health system includes "…all entities that contribute to the delivery of public health services within a community…[and] includes all public, private, and voluntary entities, as well as individuals and informal associations."

Chicago is home to many governmental and non-governmental agencies serving the public's health. While some of these organizations see themselves as part of the public health system, many others do not identify with the public health system but rather view their work within a different realm. Nonetheless, all these contributors play key roles in the local public health system and were considered in this assessment.

This assessment provides an overview of how well the local public health system is meeting the ten essential public health services, which services need more focus, and which organizations are primarily involved and/or responsible for each essential service. This information provides an important base, which, together with the other situation assessments, will allow for development of realistic strategic issues and strategies to meet these identified needs.

Approach

The local public health system assessment was guided by the Local Public Health System Performance Standards, developed by the National Public Health Performance Standards Program through the National Association of County & City Public Health Officials and the Centers for Disease Control and Prevention (CDC). These LPHS performance standards use the Ten Essential Public Health Services and further develop local public health indicators describing each of the service areas.

At an extended meeting held in the beginning of 2006, the Chicago Partnership for Public Health used the LPHS performance standards to guide the discussion of the local public health system. Members identified key issues within the service areas and some

organizations that are involved in each of the ten services. This discussion is coupled with current knowledge of LPHS organizations involved in the ten essential services and key issues related to service delivery to provide the system assessment.

Assessment

Essential Service #1: Monitor Health Status to Identify Community Heath Problems

Service Components: To identify community health problems, the local public health system needs to monitor Chicago's health status. Monitoring health status is recommended to be done through the development of a population-based community health profile that identifies health risks and health service needs, with a special focus on groups at higher risks. This assessment, which should be comprehensive and conducted on a regularly scheduled timeline, should also identify available community resources that assist with the work of the local public health system.

Another component of this essential service is the transfer of information to diverse audiences. Current technologies allow for more comprehensive and analytic presentation of these data, which can be tailored to best fit the needs of the specific population. Use of geographic information systems (GIS) and use of geo-coded data help with data analysis and communication of findings.

This service also promotes the establishment, maintenance and use of population health information systems, such as disease and immunization registries. These registries are developed and maintained through LPHS member collaboration.

Activities in Chicago: Many organizations collect data on community health. The Chicago Department of Public Health (CDPH) maintains registries on cancer, communicable disease, and lead poisoning. CDPH collects information on immunizations and is working to implement a registry for these data. CDPH maintains the city's birth and death records and conducts surveillance on a range of communicable diseases and other reportable conditions.

The Illinois Department of Public Health (IDPH) gathers data on health behaviors annually through the Behavioral Risk Factor Surveillance Survey. To allow for a more in-depth picture of Chicago, CPDH worked with IDPH to obtain a larger sample for Chicago. CDPH used these data to identify level of risk of certain behaviors by community area. IDPH also collects statewide data similar to what CDPH collects locally, including communicable disease, birth, and death information. IDPH obtains data from Illinois hospitals on several indicators, including admissions, discharges, discharge diagnoses, and length of stay.

Many other governmental agencies collect community health data, including the Chicago Police Department, the Chicago Department on Aging, the Department on Children and Youth Services, the Mayor's Office for People with Disabilities, Department of Environment, Chicago Fire Department, and the Chicago Department of Human Services. Data on domestic violence are collected through the Chicago Domestic Violence Help Line. Data on youth behaviors are collected by the Centers for Disease Control and Prevention Division of Adolescent and School Health's Youth Risk Behavior Surveillance Survey and available for access online.

Other organizations collect data, including hospitals, which collect data on cancer and other hospital statistics. These data are shared with IDPH through an annual questionnaire. Community Health Centers (CHCs) collect data on health disparities and with the advent of Electronic Health Records, will soon have more data available to monitor health status. Other organizations collect data from various sources and make them more available to the community. An example of this is the Consortium to Lower Obesity in Chicago Children (CLOCC), which collects data from national, state, and local researchers on percentages of overweight children.

New technologies assist in identifying community health problems. With the use of the GIS technology, data can be mapped and graphed to help identify communities at the highest risk of health problems. Online tracking is being initiated for mortality data and being developed by CDPH for lead and communicable disease information. CDPH is developing a web-based surveillance system as part of the emergency preparedness program to improve capacity to monitor all types of data and perform geo-spatial analyses. The Internet also allows for easier and quicker access to data, including CDPH's Community Area Inventories and Community Health Profiles on ambulatory primary health care resources. Many governmental agencies post statistics online.

While advanced technologies have increased access to data for some audiences, many others benefit from more traditional communication methods. To support this, organizations continue to produce and distribute brochures and reports that provide data on health issues geared toward various populations. Computers programs allow organizations to create visually appealing brochures without high costs. In addition, the local mass media is an important outlet to distribute health status information to the general public, including newspapers, television news, radio shows, and cable television programs.

Challenges and Opportunities: Several challenges exist to monitoring health status. One of these is the significant time lag in obtaining much of the data. Organizations may obtain data from several sources, which need to be analyzed prior to release. This causes a delay

in when data are available for use. For many audiences, the lack of immediacy of data may lessen its importance and mass media outlets may not be as interested in reporting these data, especially if other changes have occurred in the meantime that are not reflected in the analysis. While real time data collection and analysis are occurring in some areas, it needs to be more widespread so the public health system can better monitor the community's health. In addition, data systems should be developed to facilitate more effective data sharing among all levels of government.

Another challenge to monitoring health status is the prescribed data groupings. Data are often reported along traditional census boundaries or by geo-political groupings that may not fully parse out the populations in need. However, with the advent of technology and GIS systems, data should become available for more specialized and individualized groupings.

While advanced technology is frequently identified as an opportunity for the LPHS, it may also present challenges, especially for smaller organizations and individuals. These entities may not have computer systems or technical staff to support GIS or geo-coded data. Some individuals or voluntary organizations may not even have access to in-house computers to obtain available data.

Essential Service #2: Diagnose and Investigate Health Problems and Health Hazards in the Community

Service Components: Another essential service of the local public health system is to diagnose and investigate health problems and health hazards. This includes epidemiological investigations of disease outbreaks and patterns of infectious and chronic diseases and injuries, environmental hazards, and other health threats. Key components of this essential service are the operation of active infectious disease epidemiology programs and having access to a public health laboratory with the capability to conduct rapid screening and handle a high volume of testing.

This service also promotes the development of a public health emergency preparedness plan that describes the roles, functions, and responsibilities of the LPHS. This plan will help to guide the investigation and response to public health emergencies to ensure that the LPHS responds rapidly and effectively.

Activities in Chicago: The Chicago Department of Public Health is the main resource for this essential public health service, through its communicable disease programs. Some of these activities include communicable disease investigations (e.g., West Nile Virus, smallpox, sexually transmitted diseases, etc.), lead poisoning screenings, and investigations of food-borne illnesses and consumer restaurant complaints. Development

of the emergency preparedness surveillance system will improve the infrastructure to identify health threats, which can then facilitate quicker responses.

Access to a public health laboratory is an important component for this essential service. The emergency preparedness program has enabled 24/7 access to a CDPH laboratory liaison to provide laboratory support to hospitals.

CDPH works with other organizations to diagnose and investigate health threats. IDPH is an important collaborator in this work, especially in investigating cancer clusters and other health threats that may pose risks beyond the city boundaries. IDPH operates a state laboratory, which has made recent operational improvements. CDPH works with local hospitals and laboratories to implement the emergency preparedness surveillance system.

The Office of Emergency Management and Communication (OEMC) lead the effort of developing an emergency preparedness plan. Many of City of Chicago's agencies were involved in its development and have identified roles and responsibilities. This plan was implemented as Chicago responded to the people displaced by Hurricane Katrina. The success of this effort was due in part to the experience the Chicago Department of Human Services developed to address the homeless population. This demonstrated how well organizations could work together.

Community coalitions, civic organizations, and individual residents often identify health and safety hazards in their community. As part of their strategic planning processes, the coalitions supported by the Chicago Center for Community Partnerships conducted block by block assessments that documented problems such as vacant lots, abandoned cars, and unsafe situations.

Challenges and Opportunities: Although work in this essential public health service has improved with the activities of the emergency preparedness surveillance system, some challenges persist. One of these is the limited relationship that CDPH has with private providers to collect data. The surveillance system will gather hospital and laboratory data, but diagnostic data from private providers may be missed. State laboratory capacity and accuracy has increased but still need improvement to be able to operate most effectively during a public health emergency.

Challenges and opportunities exist to better involve other community-based agencies serving the population in development and implementation of an emergency plan. One solution would be to develop a network of providers who would be able to offer health care, especially during health emergencies. In addition, the emergency preparedness plan needs to define the role and responsibilities of the general public and establish

communication strategies.

While community coalitions can identify neighborhood health hazards, they often can't solve the problems on their own. Many times it is not clear which agency is responsible for alleviating the problem and gaining access to the appropriate person at that agency can also be difficult. However, opportunities are available to build relationships among the communities and agencies. City agencies are encouraged to have local liaisons to interact with community residents and improve their customer relations. Local elected officials can also support the coalitions' work to improve the community by facilitating these relationships with city agencies to address health and safety problems.

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

Service Components: The LPHS provides health information, health education, and health promotion activities to reduce health risk and promote better health. With this information and training, the LPHS empowers the public to make more informed decisions regarding their health and safety.

Health education facilitates behavior change and adoption of healthier lifestyles by providing information together with skill training developed for specific populations. Health promotion also facilitates behavior change by engaging many levels of the social and physical environment that influence behavior. Community level interventions include the development of health communication plans that create media and social marketing campaigns. Policy advocacy also supports behavior change at a broad level.

Informational and educational materials help to reinforce messages received through classes or health education campaigns. This information should be available in both hard copy and web-based formats and in languages and literacy levels to reach the desired audience.

Activities in Chicago: Many organizations are involved with informing, educating and empowering the public about health issues. These types of organizations range from public health agencies, other government agencies, community health providers, hospitals, policy and advocacy groups, coalitions, educational institutions, social service agencies, philanthropic foundations, businesses, and faith-based organizations. Chicago has many medical schools, nursing schools and the School of Public Health at the University of Illinois at Chicago that are active in outreaching to populations with information about health.

Health education efforts are often conducted through ongoing programs or classes. Youth enrolled in after school activities or clubs often receive health education. Public schools provide some limited health education classes. Hospitals and community health centers

offer classes in the community for adults to quit smoking, exercise more, as well as to manage chronic health conditions such as diabetes and hypertension. Seniors can access health education through Senior Centers, and faith-based organizations also provide these programs to the community.

To increase the effectiveness of these efforts, agencies implement strategies that have shown to have the best results. For example, many youth relate better to their peers than adults when discussing sexual behaviors and risk reduction. Therefore, peer educators teach many of the youth HIV-prevention programs. Health educators that speak Spanish are important when reaching out to the Hispanic population and all programs need to be designed for their specific audience, with consideration of race/ethnicity, language, gender, and age. For the immigrant population, health messages should also include information on their right to health care to prevent discrimination and lack of access to services.

Many agencies provide health information, much of this through newsletters or brochures. Some agencies are also making health information available on their websites. Health fairs and outreach provide other outlets for health information and these provide opportunities for collaboration between agencies focusing on the same population. Recently, the Chicago Alternative Policing Strategy (CAPS) organized a meeting for the local Chambers of Commerce in Chicago where CDPH and other city agencies provided information. Throughout 2006, the Chicago Department of Human Services is sponsoring several *Chicago Works for You* Service Fairs, which will include representatives from city agencies such as CDPH, to provide information about available city services. In addition to these special events, health information can be provided at regularly scheduled meetings.

Media sources provide access to large audiences to inform and educate them about health issues. The major Chicago newspapers, as well as the smaller publications, often contain printed articles on health issues and the health care system. Local television news and cable news stations (broadcasted in many languages) are other important media outlets, along with radio shows that encourage interactive discussion about health-related topics.

Social marketing campaigns are another method of informing Chicago residents about health topics. These campaigns, often seen on subway or bus placards, reach a wide audience. For people that have not received pertinent health messages through classes or social service organizations, social marketing campaigns provide basic information and contact numbers for additional follow up. For people who have heard about these public health issues, social marketing campaigns reinforce the messages. Campaigns inform people about available programs (e.g., KidCare and All Kids programs), provide help to those in need (Domestic Violence Helpline), or teach a health education message (SIDS

guidelines). State and voluntary local agencies sponsor these campaigns, along with health associations (American Cancer Society, American Heart Association).

Challenges and Opportunities: The Chicago Public Schools (CPS), with its access to hundreds of thousands of Chicago's children, is a major access point for health education. CPS has experimented with comprehensive school health education in the recent past, but had been unable to fully integrate or support the curriculum within its schools.

Bilingual and bicultural health educators are in short supply, providing another challenge to the system to educate diverse audiences on health-related issues. These health educators are needed not only to present information, but also to create brochures, campaigns and ensure that promotions used are most effective for that specific audience. Until the number of bilingual/bicultural health educators is adequate, it will be necessary for organizations to collaborate to better reach their audiences and share resources.

Media coverage of health-related issues provides opportunities to reach a wider audience with key information. However, not all the information relayed to the public is accurate or framed in ways to help the public take the most effective action to address the problem. To improve health-related media reporting, the local public health system needs to develop stronger relationships with the media and promote local experts that can be reliable and accessible resources on health issues.

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

Service Components: Identifying and solving health problems requires a comprehensive strategy involving a wide range of organizations together with community members in a collaborative effort. This essential service recognizes the importance of mobilizing community partnerships to reach this goal. Key components to success are: (1) to identify potential stakeholders and increase their awareness of the value of public health, (2) building coalitions to draw upon the full range of potential human and material resources to improve community health, and (3) convening and facilitating partnerships among groups and associations in undertaking health improvement projects. Mobilizing partnerships builds constituencies within the public health system that at other times can be tapped to come out in support of the work of the public health agencies.

Activities in Chicago: Many organizations recognize the importance of this strategy and have facilitated the development of community partnerships. The Chicago Department of Public Health established the Chicago Center for Community Partnerships, which currently supports partnerships in seven of Chicago's community areas. The Chicago Public Schools have Local School Councils that look at community issues for the school children and also

have a role in governing school activities. Other initiatives, such as the Local Initiative Support Corporation of Chicago (LISC), bring communities together to address health problems. The Chicago Police Department holds monthly CAPS meetings where members discuss many issues related to the health and safety of their immediate community. Faith-based organizations bring congregants together on health issues and work throughout their community to address health issues. Philanthropies, both local and national, have helped to support these efforts.

Challenges and Opportunities: Bringing communities together to address issues can be a difficult and lengthy process, especially in areas of highest need where residents are focused on daily survival and/or may not identify themselves as part of the neighborhood. To entice people to get involved, partnerships often focus on broad needs of the community in addition to specific health issues. Consistent interaction between the coalition staff or leadership and the residents will also encourage people to attend meetings. However, individual community health coalitions are not necessarily needed in all of Chicago's 77 community areas as organizations and agencies can work with existing networks to provide information and support efforts that improve the health of the community.

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

Service Components: To accomplish this essential service, the local public health department needs to develop policies that protect public's health and guide the practice of public health. The local public health system is also called on to assure effective policy by facilitating community involvement in this process, reviewing policies and alerting policymakers and the public of possible problems, and advocating for prevention, especially for populations most in need. In addition, this essential function calls for a community health improvement process that includes stakeholders from many disciplines and communities and results in strategies to address identified problems. To ensure that the community health improvement plan can be realized, the LPHS must align available resources with the strategies identified in the community health improvement plan.

Activities in Chicago: CDPH, as the local governmental public health entity, is involved in leading and, at some times, participating with the local public health system in developing policies that protect the health of the public, creating a community health improvement plan, and facilitating the alignment of resources with identified needs. CDPH is accomplishing this through the Chicago Partnership for Public Health. The community partnerships connected by the Chicago Center for Community Partnerships have developed community health improvement plans and are currently implemented their strategies within their communities. The Chicago Partnership will focus on implementing

its plan at a systems level.

Many other organizations in Chicago develop policies and plans that support health efforts. These include other government agencies, community health centers, hospitals, policy and advocacy groups, coalitions, educational institutions, social service agencies, philanthropic institutions, businesses, and faith-based organizations. The Illinois Public Health Institute addresses public health issues in Illinois through partnerships and is involved with helping the State of Illinois and IDPH develop the State Health Improvement Plan. Some organizations focus on systems-level policy (KidCare, FamilyCare, etc.) and others address specific health issues (HIV/AIDS, violence, tobacco, heart disease, etc.). Through coalitions of organizations, comprehensive plans have been developed, including the HIV Prevention Plan and the Violence Prevention Plan.

Challenges and Opportunities: Undertaking a comprehensive strategic planning process and/or developing a community health improvement plan requires time and committed effort to ensure that all relevant factors are addressed. Organizations are challenged to allow themselves adequate time to fully complete the process in the midst of competing priorities, as well as the desire to focus on implementation. During this process, the individual partners should not put their own agency's activities on hold, but continue current efforts, as this will provide for better integration and institutionalization of the identified goals and strategies.

Many grant funders schedule planning time as part of their grant awards, encouraging agencies to undergo a planning process. Funders need to review these schedules to make sure the planning time is adequate for the level of complexity that the grantee will address.

Community health improvement plans address many factors that contribute to the community's health. One of the key contributing factors affecting the health of Chicago's residents is the high level of poverty. This is a huge challenge, with more than one in five residents at or below 100% of federal poverty guidelines. Illinois ranks the worst of the eight Midwest states in the areas of overall poverty rate, child poverty, rate of uninsured, housing affordability, and education. Comprehensive health plans need to address poverty and other social and political influences.

As a result of strategic planning processes, many policy issues are identified. Many organizations participate in policy advocacy, but not always in a coordinated fashion. Opportunities exist for organizations to collaborate more, following the example of the Campaign for Better Health Care, which has over 100 organizations endorsing their work to have the State of Illinois develop and implement a plan to provide health care for all people through the Health Care Justice Act.

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

Service Components: The LPHS is called upon to enforce public health laws and regulations. The LPHS also reviews and evaluates the laws, regulations, and ordinances to assure they apply the most current knowledge in how best to assure compliance and address key issues. Through these analyses, the LPHS will assist in the modification of these laws when necessary to better address the problem.

Activities in Chicago: As the legal public health authority in Chicago, CDPH is in the unique role of enforcing public health laws and regulations at many locations throughout the city, including food establishments, nursing homes, day care centers, and tanning facilities. CDPH also enforces laws that focus on specific programs, including childhood lead poisoning prevention.

CDPH communicates regularly with other city departments that have regulatory roles in areas that affect the public's health. The Chicago Department of Environment works with the CDPH Health Code Enforcement and the Lead program in regulating demolitions and controlling environmental contaminants. CDPH regularly provides technical assistance to the Chicago Park District on several environmental and occupational health and safety issues and guidance on the regulation and scientific interpretation of findings related to beaches and safety of swimming in the lake.

While not involved in the actual enforcement of public health laws or regulations, other organizations, such as hospitals and community health centers, identified that they do institute and adhere to regulations that govern their institution and may be related to public health.

Challenges and Opportunities: Enforcing laws, regulations, and ordinances related to public health are the responsibility of many city agencies in Chicago. When these responsibilities are split among agencies, it is important to coordinate activities. Improvements have occurred in some cases, such as the Mayor's Dumpster Task Force, where CDPH's Food Protection program and the Chicago Department of Streets and Sanitation developed better communication channels. In addition, city departments worked together to develop Chicago's emergency preparedness plan that identifies clear roles for each agency and promotes effective communication strategies. This model could be adapted for other situations to promote cross-agency communication.

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

Service Components: Linking people to needed services requires a relationship between the referring and receiving entity to assure that the person referred is able to obtain that

service. The LPHS supports these efforts by first clearly identifying populations in need of health care, understanding barriers to care, and recognizing specific services that need to be provided. The LPHS can then connect the person(s) to available resources and work to eliminate barriers to care.

Activities in Chicago: Most service organizations, advocacy groups, and community coalitions in Chicago provide linkages to available health care facilities through resource lists or an individual contact at the health care site. Some organizations offer access information through telephone help lines (Campaign for Better Health Care) and/or websites (CDPH, the Gilead Outreach & Referral Center). Organizations that provide ambulatory health care to populations in-need are located in many of Chicago's community areas. Growth of community health centers in the past five years has helped to increase access for the safety net population. However, many communities still lack access to these services and many sites lack sufficient capacity to provide care to the uninsured populations. Specialty, oral health, and mental health resources are even scarcer. Local governmental agencies operate health clinics to serve these safety net populations. CDPH provide primary care through seven health care centers and mental health through 12 mental health centers. The Cook County Bureau of Health Services (CCBHS) offers primary care at ten centers in Chicago and is the primary source for diagnostic and specialty care through its Fantus Health Center, the outpatient center located on the campus of Stroger Hospital.

Recent legislative changes have improved access to health care by increasing the number of people eligible for governmental health insurance. This makes linking these people to personal health care services much easier. The All Kids program augments the current Medicaid program by making health insurance available to all children through affordable premiums and co-pays. FamilyCare covers parents at up to 185% of poverty with health coverage. In addition, as a result of a 2005 court ruling (Memisovski v. Maram), the Illinois Department of Healthcare and Family Services (IDHFS) will provide families with information about preventive health services and available providers.

Many people receive periodic health care services (immunizations, blood pressure checks, etc.) at health fairs sponsored by hospitals, community coalitions, and public officials. This interaction provides an opportunity for the participant to meet providers and encourage them to identify these providers as their medical home.

Challenges and Opportunities: Due to the large number of uninsured people in Chicago (539,700 in 2004) and the limited health care resources available to them, assuring timely and comprehensive health care is difficult, especially for specialty, oral health, and mental health. Given this system, challenges exist for all organizations to ensure that their referral

resulted in the person actually received the health care services. Organizations linking people need to regularly check the accuracy of their resource lists to make sure they are providing viable sources of care. Organizations should also address barriers to care (transportation, child care, etc.). Other challenges are to (1) restore and increase Medicaid coverage and eligibility, and (2) promote the most efficient and effective use of available resources through improved linkages, especially with CCBHS and its specialty care services. Opportunities do exist to address the problem of the uninsured and limited access to care by working in collaboration with national organizations to promote universal health coverage.

The Medicare Part D Program for prescription medication was envisioned as way to assure access to medicine for Medicare beneficiaries. However, due to the confusion in design and implementation of the program, even signing up for Medicare Part D has been a challenge.

Organizations that provide health care services are challenged to serve all those in need due to limited facilities and trained staff. Developing new models of care may help increase access to care. One option is to redesign the operations to increase productivity of current providers and/or train mid-level providers to perform additional procedures. This model of training mid-level staff is being implemented to increase access to dental care.

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

Service Components: The workforce is a major part of the public and personal health care systems and their most visible representative. A competent workforce is of utmost importance in helping healthcare systems provide care and improve health status, and its assurance is seen as an essential service of the public health system. This should be done through assessment, including determining required competencies, knowledge and skills; and available training needed to attain these levels of competence. Assuring the workforce includes maintaining public health workforce standards, such as processes for licensure/credentialing of professionals and evaluation of core public health competencies. In addition, the LPHS needs to assure ongoing competence by adopting continuous quality improvement and offering life-long learning opportunities, such as access to mentors to promote public health leadership development for all levels of staff.

Activities in Chicago: Chicago is home to many institutions that train the public and personal health care workforce, including: a school of public health, medical schools, nursing schools, and a dental school. These institutions, along with the related professional associations, identify competencies needed to obtain degrees or certifications. Core pubic health competencies are also addressed by the Public Health

Practitioner Certification Board (PHPCB), which certifies public health administrators on a voluntary basis in the areas of public health practice, community health assessment, policy, advocacy and law, program development, and public health administration.

Assuring and documenting current credentials and licenses occurs within each agency hiring health professionals. Maintaining these records are important since many regulatory agencies that assess an organization's functioning refer to these documents. The Joint Commission for Accreditation of Health Care Organizations (JCAHCO) includes a section on personnel in its assessment of hospitals and community health centers. The Illinois Department of Public Health's Administrative Code requires hospitals to maintain verification of an employee's license and a record of their specialized training and experience. Community Health Centers funded by the Bureau of Primary Health Care need to undergo a Performance Review that considers staffing documentation. Mental health agencies are accredited by the Commission on Accreditation of Rehabilitation Facilities' (CARF) Behavioral Health Unit and are Medicaid-certified by the Illinois Department of Human Services Office of Mental Health.

Most agencies provide ongoing training opportunities through on-the-job training, conference attendance, and continuing education courses. Some agencies use web-based programs to provide training. For example, CDPH offers training in the core competencies for emergency preparedness online.

Another component of this essential service is leadership development. Since 1992, the Public Health Leadership Institute at the University of Illinois at Chicago School of Public Health has trained public health professionals through a yearlong leadership program.

Challenges and Opportunities: The State of Illinois recognized in their 2004 public health system assessment that not enough focus has been placed on assuring this essential service. Challenges to assuring a competent workforce include provider shortages (e.g., nursing), limited minority providers, and the inability of current programs to train enough providers to meet the expected health care needs of the population. Public health workforce competencies are also affected by low morale and substandard pay.

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

Service Components: The LPHS needs to evaluate population-based health services in terms of accessibility, quality, and effectiveness. These assessments also need to be completed for personal health services. In addition, the LPHS itself needs to be evaluated to determine if: (1) its services are comprehensive, (2) it fosters effective communication

and collaboration among agencies, and (3) it allocates resources and shapes programs effectively.

Activities in Chicago: Providers of personal and population-based health care evaluate their services through several methods. Program and patient outcome data is used to assess effectiveness of services. CDPH recently established an office to address chronic disease prevention with a strong evaluation component. Many community health centers are participants in the National Health Disparity Collaboratives through the Health Resource and Service Administration's Bureau of Primary Care, which tracks the effectiveness of clinical interventions. Use of community level data on hospital admissions for ambulatory care sensitive conditions (ACSC) gives personal health care providers information on the overall effectiveness of treatments for specific conditions. Population-based health services can also use ACSC data to track the effectiveness of their outreach and education in these areas. Population-based programs also use community level data, such as maternal and child health indicators, to look at the long-term impact of their work.

Patient and participant surveys are used to evaluate the effectiveness, accessibility, and quality of that service or intervention. Patient perspectives are often included in internal quality management programs. To maintain the ongoing focus on evaluation of services, many larger organizations designate an individual whose primary job responsibility is to run the quality management program.

Several agencies, both private and governmental, evaluate the quality of health care services. The Joint Commission of Accreditation of Health Care Organizations (JCAHO) evaluates quality and safety through an on-site review and looks at measures related to provision of care, medication management, infection control, medical and nursing staff, and improving organizational performance. The Illinois Foundation for Quality Health Care is funded by the Centers for Medicare & Medicaid Services (CMS) and works with hospitals, physician offices, nursing homes, and home health agencies on quality improvement efforts. IFQHC implements national quality improvement projects in areas including acute myocardial infarction, breast cancer, diabetes, pneumonia, and flu vaccinations. IFQHC will also conduct case reviews and determine if services are being provided based on professionally recognized standards.

On a systems level, the Chicago Department of Public Health's Chicago Health and Health Systems Project evaluates the accessibility of Chicago's ambulatory health care services. Ambulatory care resources are identified, along with provider capacity, patient utilization numbers, and data on patient characteristics. To look at gaps in care, CDPH published the report *Casting Chicago's Health Care Safety Net*, which compared data for Chicago's health care system from 1990 to 2002.

Along with assuring evaluation of personal and population health services, the LPHS needs to conduct a self-evaluation. Occurring through the Chicago Partnership for Public Health's strategic planning process. The Chicago Partnership used the local public health system performance standards to guide the analysis of the functioning of the LPHS in areas of the Ten Essential Public Health Services.

Challenges and Opportunities: Evaluating health services and systems require upfront planning and a commitment to data collection. Smaller facilities may not have adequate funding or available staff to assure follow through with these activities. New programs may want to expedite service delivery and may not spend enough time developing the evaluation component. However, management needs to commit to using the evaluation findings to improve services. Staff, especially those responsible for collecting the data, should be included in evaluation planning so they understand how this information will ultimately improve all components of their program, including effectiveness, accessibility, and quality.

As the communities surrounding Chicago grow, so do the shared health care issues. Although previous analyses of the health care system have focused solely on Chicago, organizations acknowledge the importance of a wider view of the system and are looking to address the larger metropolitan area in a collaborative systems analysis. Some of these issues affecting accessibility for residents throughout the Chicago area include limited health insurance and diminishing Medicaid coverage.

The public will have access to more information on the quality of health care with the recent passage of several pieces of legislation. One of these efforts is a "Hospital Report Card" that will be developed for each hospital in Illinois and will report on several process measures developed by national organizations, including infection prevention measures. Another report to be released is the Consumer Guide to Health Care, which will provide data for hospital comparisons on their top 30 procedures and conditions. Both these reports will be available online. Other population-based public health data could be provided to the communities through local newsletters and updates from local officials. All this information will help people make more informed decisions about their care and provide data for local coalitions as they develop plans to address concerns in their community.

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

Service Components: The LPHS should foster innovation to improve public health practice and assist with determining best practices for public health problems. This is often done through linkages with institutions of higher learning or research organizations. The system

needs to be ready to initiate or participate in research so it can respond quickly when concerns arise and have access to expertise in areas of epidemiological, health policy, and health systems research.

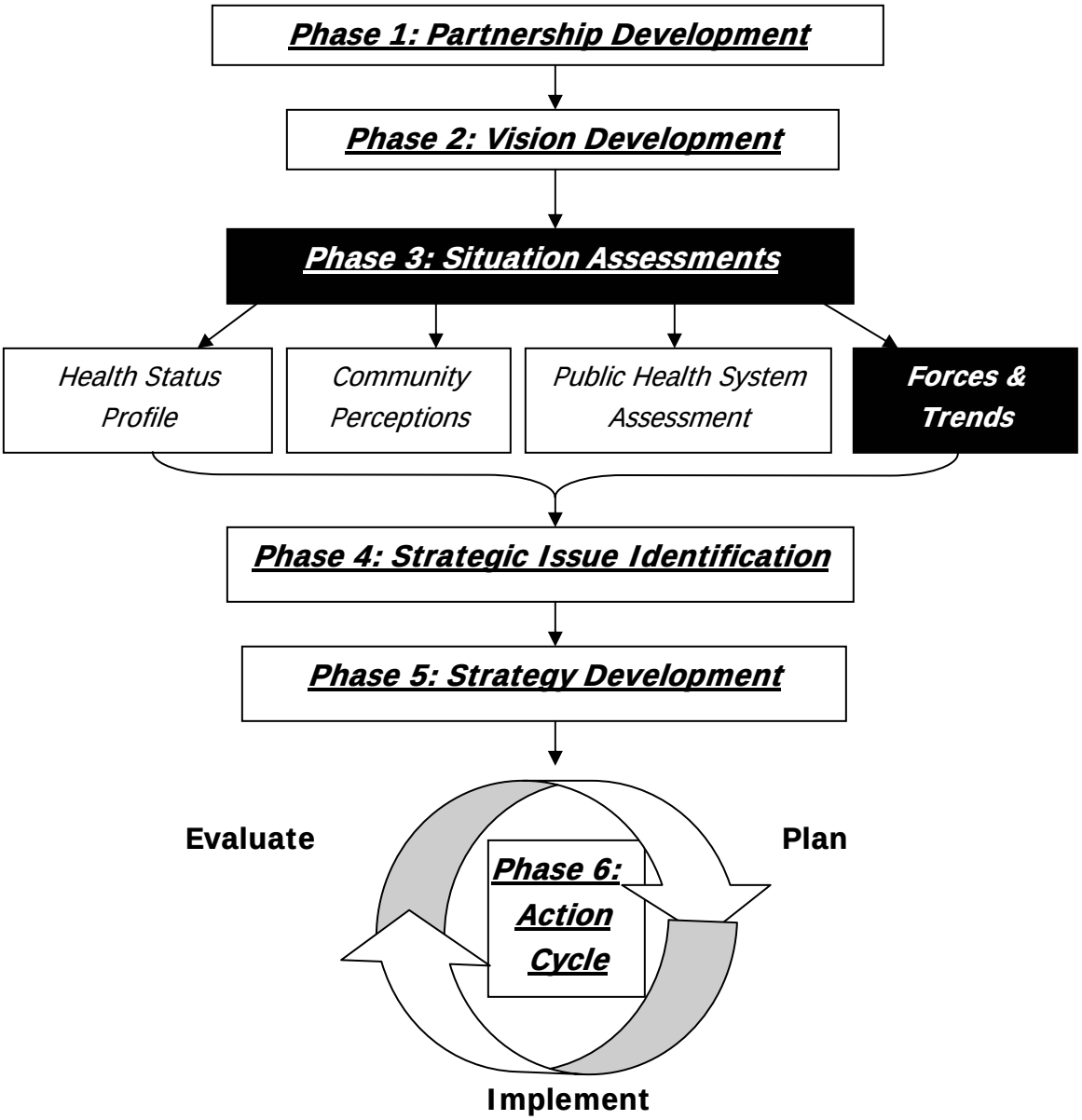
Activities in Chicago: Most organizations within the LPHS are involved in some type of public health research, although the majority participate in studies while a smaller number (primarily universities, university-based hospitals, and hospitals) actually conduct their own research projects. Hospitals and university-based hospitals use their patient base or recruit for subjects, while universities often work with community health centers, CDPH, and other community organizations. Community health centers are often involved with research projects through the Bureau of Primary Health Care or through other grantors. CDPH is involved in research studies, including several that focus on AIDS surveillance, the effect of housing on people with AIDS, and developing a strategic prevention framework to address minority substance abuse/HIV/Hepatitis. CDPH also is part of several National research efforts, including (1) the Safe Start Initiative, administered by the Office of Juvenile Justice and Delinquency Prevention and focused on developing a systemic response to the problem of children's exposure to violence, and (2) REACH 2010, an initiative of the Centers for Disease Control and Prevention to eliminate disparities in health status experienced by ethnic minority populations.

Local philanthropic foundations are involved through setting priorities and funding research studies, including the Michael Reese Health Trust and the Chicago Community Trust. Public health research addresses many areas, including health behavior and health promotion (HIV/AIDS prevention, STD prevention and treatment, substance abuse, violence prevention), chronic disease (diabetes, asthma) and women and children's health (infant mortality, pregnancy outcomes).

Facilities in Chicago have access to resources to conduct research including, databases and disease registries; GIS and mapping technologies; as well as researchers from academic institutions.

Challenges and Opportunities: Many organizations within the public health system have budget and staffing limitations. So, although they recognize the importance of research studies, some of these facilities may have to focus their attention on operations and clinical services. Organizations that do participate in research are challenged to fully implement the recommendations and evaluate their results. As a consequence, the local public health system's programs may not be using the most current approaches with their diverse populations. However, with the Internet, access to public health research is improving. Listserves also facilitate sharing of findings and communication among professionals.

Chicago Partnership for Public Health
MAPP Process



Forces and Trends Analysis

Purpose

As one of the four situation assessments, the Forces and Trends Analysis provides a forum to identify issues that affect the current and future functioning of the public health infrastructure. These issues, along with the associated intended and unintended opportunities and challenges, contribute to a more comprehensive view of the environment and allow for a more complete strategic plan.

Approach

Members completed worksheets individually to identify forces and trends and the accompanying challenges and opportunities that could arise from these issues. Staff compiled these worksheets of almost 100 key forces and trends. At two Chicago Partnership meetings in the fall of 2005, members discussed and elaborated on these issues to complete this assessment, which presents a full scope of forces and trends affecting the future of Chicago's health care system.

Forces and Trends

Demographic Changes in Chicago's Population Mix

Although Chicago's overall population only grew by 4% between 1990 and 2002, more significant changes occurred within its racial/ethnic populations. Hispanics, who made up 20% of the population in 1990, grew by almost 40% and now comprise over one-quarter of all Chicagoans. The Asian population, while smaller at 4%, grew by 27% during this same time period. Although Blacks were still the largest racial/ethnic group (at 36%), its population decreased by 2% and the White population (at 31%) decreased by 14%.

The growth in both the Hispanic and Asian populations support the importance of Chicago as a key port of entry for immigrants and as a long-term home for minorities. However, with the growth of the metropolitan area, many immigrants are moving directly to suburban areas that may be closer to available jobs. As a result of this influx of immigrant populations, some of these outlying areas may not have specialized services to meet these populations' needs. Opportunities exist to expand or relocate organizations that have experience with immigrant populations into suburban areas and/or collaborate with agencies in these communities.

Gentrification changing communities and displacing low-income populations

Gentrification, i.e., the restoration and upgrading of deteriorated urban property, is occurring throughout many of Chicago's neighborhoods. Developers are buying lands previously considered undesirable, such the Chicago Housing Authority properties, and building upscale housing projects. This change is bringing many middle and upper-middle income

residents into these areas, along with escalating property values, taxes, and rent. As a result, long-term low-income and working class residents, especially the elderly, are being priced out and can no longer stay in their neighborhoods. These residents are also vulnerable for predatory lending practices. Affordable housing may only be available in substandard buildings that have higher risk of environmental problems, such as lead paint. Many families are being displaced and have to move to communities that often have fewer resources and less access to transportation. Businesses and community organizations located in gentrified areas are also at-risk, as rents increase and their clientele are displaced.

Concerns over gentrification are tempered with positive consequences. Removal or renovation of older dilapidated housing units improves safety in the neighborhood and eliminates some of the health hazards for the residents living in these apartments. The increase in tax base will provide more funding for schools and community projects. In addition, programs serving middle-income residents can benefit residents of all income levels.

Economic and Business Changes

Analogous to many other cities, Chicago has changed from a manufacturing economy to one that is service-based, with a growing high-technology sector. Many businesses in Chicago depend upon technology for a significant portion of their operational activities. One of these is the health care system, which has forty hospitals and over 80 community health centers, as well as numerous private providers. Technology has improved patient care, permitting access to more advanced diagnostic and treatment options. Some facilities are implementing electronic health records (EHR) to better capture, organize, and present relevant clinical information and allow for easier monitoring and tracking of patient data for clinical outcome and quality management studies. Technology also improves access to real-time data and development of more advanced databases. In addition, providers, patients, and educators now have more access to diagnostic and disease prevention information.

This change to a high technology economy has created a market for highly skilled workers while those in the manufacturing fields are being laid off. These workers do not have skills to participate in this new business environment and if they are able to find a position, often have to take substantial pay cuts. As a result, the areas in Chicago that used to have large manufacturing plants are affected disproportionately by this change in the economy.

Challenges exist in building up the skills of this segment of the workforce. Funding for re-training programs are limited and people may have limited access to computers or technical support. Difficulties occur even in cases where the job doesn't require computer skills because some companies request job applicants to fill out applications online.

Medicaid and Other State Health Insurance Programs

With ongoing Federal budget concerns and competing priorities, securing adequate Federal funding for Medicaid and public health programming is a challenge. Within this environment, however, Illinois is administering several health insurance programs, including KidCare, the Medicaid program for children, and FamilyCare, a program for parents of eligible children. Illinois is also initiating the "All Kids" program, which will provide health insurance for all children, independent of income level. Enrollees pay affordable monthly premiums and co-pays. Costs for this program will come from savings generated by implementing a primary case management model for the KidCare program. While support exists for these programs, advocates are concerned that projected KidCare savings may not cover actual costs and that funding will have to be appropriated from other programs. Organizations can work with the State of Illinois to promote enrollment in these programs through health fairs and referrals. Organizations can also advocate for increasing Medicaid coverage and eligibility to provide for more people who need health care and increase providers' ability to offer these services.

Growing Number of Uninsured and Underinsured

The number of people who are uninsured and underinsured continues to grow. This happens, in part, because businesses are increasingly unable to afford to offer health care coverage. Even if a person does have insurance, the deductible is often too high to encourage preventive care and the cost of premiums may make it too expensive to extend coverage to the worker's family. Other businesses are only hiring part-time workers, who are ineligible for most company benefits, including health insurance.

Ensuring access to health care for the uninsured and underinsured is one of the goals of the Illinois Health Care Justice Act. Through this Act, the Illinois General Assembly established the Adequate Health Task Force, which will present recommendations to the General Assembly by October 2006 on how best to institute a health care plan that ensures all Illinois residents have access to the full range of preventive, acute, and long-term health care services. The Act instructs the Illinois General Assembly to enact a plan by the end of 2006 and implement it by July 2007. Opportunities exist to facilitate this process by working with the Campaign for Better Health Care, which is the key organization leading efforts to ensure that 1) the Adequate Health Task Force develops a health care access plan that considers consumer needs and 2) the Illinois General Assembly implements the plan.

Another opportunity to increase access to care is HR-676--the National Health Insurance Act, which is currently in Congress. This act proposes the establishment of a publicly-financed national health insurance program, so that all people living in the US or US territories would have access to health care, including primary care, preventive care, prescription drugs, emergency care, and mental health services.

Changes in Health System

Ambulatory Care: Over the past several years, the Federal government increased funding for federally qualified health centers, resulting in more sites and expanded medical capacity at established sites. School-based health centers also increased in number and are reaching more children and youth with affordable care. However, many people do not know about these centers and do not seek preventive care, which may result in the need for more costly services through emergency rooms. Opportunities exist to direct people to low-cost health care sites. Many organizations develop resource lists, and the Chicago Department of Public Health has this information on its website for each of the 77 community areas. The Gilead Outreach and Referral Center provides this information through a telephone referral line, and a web-based and printed resource list of health care centers.

Despite the growth in community health centers, access to care is still limited. Many of Chicago's communities do not have adequate resources of low-cost health care and specialty care is even more limited, with the overwhelming majority of the uninsured seeking advanced care through the Cook County Bureau of Health Services. Providers are also at-risk in this environment. As the number of uninsured people increases, so will the number of self-pay patients accessing services through the safety net of community health centers and publicly-operated health centers run by the City and County. These health centers will operate at a deficit if the balance of patient payor sources becomes heavily weighted toward self-pay patients, who pay only a minimal co-pay fee.

To adequately address these system problems, the public health system is called upon to develop comprehensive plans to ensure access to low-cost care. Given the changing demographics and the growth of people throughout the metropolitan area in need of low-cost services, regional solutions are essential.

Inpatient Care: Concerns about the quality of care and patient safety instigated the passage of several laws by the Illinois General Assembly. The Illinois Adverse Health Care Event Reporting Law of 2005 requires hospitals and ambulatory surgical centers to report serious adverse events to the Illinois Department of Public Health (IDPH), which will publish an annual report. The Hospital Report Card Act requires hospitals to issue reports to IDPH on staffing and patient outcomes. This information will be available through IDPH to assist consumers in making decisions on hospital care.

Another piece of legislation enacted in 2005 focused on medical malpractice reform. The cost of malpractice insurance had caused some physicians; especially in such high-risk specialties as obstetrics and gynecology, neurosurgery, and trauma, to move to other states with more affordable insurance premiums. As a result, some areas in Illinois had

limited access to these specialty providers. This bill regulates malpractice insurance companies to ensure appropriate rates to prevent excessive charges. Malpractice reform limits non-economic damages payable by a hospital (up to $1,000,000) and physician ($500,000).

The problem of medical malpractice is also being addressed through the "Sorry Works" program. When a medical error occurs, institutions implementing the Sorry Works program will issue an apology, provide complete details of the incident, and determine an up-front settlement. Through this open communication, fewer lawsuits are filed, resulting in overall savings and a higher likelihood of the patient/family continuing to seek care at that hospital. Currently two Illinois hospitals are participating in a pilot program to determine cost differences when using this approach.

Education and Outreach: Many of Chicago's residents do not understand how to access the level of health care they need. This is evidenced by the increasing number of calls to the Chicago Fire Department Emergency Medical Services for health care that does not require emergency care. Patient and family education is also needed in other areas, including Medicare Part D, the new pharmaceutical program, and end-of-life directives. These changes can be accomplished through coordinating outreach and facilitating access to comprehensive information. In addition, health care providers need advanced training to administer pain management treatments and proper care to nursing home residents.

Health Disparities (Racial, Ethnic, Other)

According to the Health Resources and Services Administration (HRSA), health disparities are "population-specific differences in the presence of disease, health outcomes, or access to health care." These populations include racial, ethnic, and other minorities. The Institute of Medicine's (IOM) 2002 Study, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health*, states that these inequalities rise out of a complex system of historical and contemporary practices and involve many participants, including the system, the providers, and the patients. These factors are also coupled with poverty, unemployment, and limited of access to care.

The IOM study also identified lack of minority providers as an important contributor to health disparities. Without adequate minority health care workers, populations may not have role models to help negotiate the health care system or better understand and follow treatment regimens. The Sullivan Commission Report in 2004, *Missing Persons: Minorities in the Health Professions* proposed three overarching principles to increase minority representation in the health professions: (1) change the culture of health professions schools to increase diversity, (2) develop new and nontraditional paths to health professions, and (3) obtain governmental and private sector commitment to making these changes.

Opportunities are available to work in collaboration with health professional groups to implement principles outlined by the Sullivan Commission Report. In addition to encouraging more minorities to join health professions, organizations should develop and provide cultural competency training so all providers can provide more appropriate care to all populations.

The Racial and Ethnic Health Disparities Action Council (REHDAC) and the Health Disparities Council of the Institute of Medicine of Chicago developed objectives to decrease health disparities. Organizations can collaborate with these entities to address eliminating health disparities. In addition, providers need to institute standard clinical treatment protocols to ensure comprehensive care for all patients and populations.

Chronic Diseases and Health Behaviors

Chronic diseases are the major cause of disability and death and people with chronic diseases consume significantly larger amounts of health care services. Despite these statistics, many communities do not have sufficient or comprehensive prevention or control initiatives. Evidence of this is seen as the percentage of overweight adults in Chicago increased from 57% in 1996 to 60% in 2002, and 14% of all youth were identified as overweight in 2002. Less than half of both adults and youth participate in sufficient exercise.

To facilitate healthier behaviors, CDPH recently established an Office of Chronic Disease to coordinate efforts and to educate and enable the public to adopt healthier behaviors. Health behaviors can also be influenced through worksite initiatives and incentives, school programs, provider involvement, and more community-based exercise and nutrition programs.

Limited Resources and Community Support

The ability of families to prosper is often related to available resources within their community. Residents rely on community organizations and local service providers to assist them in caring for their families. Increased funding for faith-based organizations has benefited some communities with additional services. However, many communities still do not have adequate resources in the areas of affordable childcare, health care, and social services for populations-in-need, including homeless individuals and families, survivors of violence, ex-offenders, and people with HIV/AIDS.

Involvement with community coalitions or neighborhood groups provides opportunities to improve access to needed resources. Not only can people learn about available resources within the community by talking to others, but a coalition can reach out to agencies to advocate for community needs. Coalitions that are a part of the Chicago Center for Community Partnerships, and therefore the Chicago Partnership for Public Health, have

access to these citywide agency contacts. In addition, coalitions work with local organizations to offer training courses to increase community skills (e.g., baby sitting courses, elder care).

Public Transportation: Another essential piece of a community's infrastructure is public transportation. Efforts are underway to improve transportation; however, these projects are lengthy and access to transportation during these changes may make it difficult to access services. In addition, the pricing structure of the Chicago Transit Authority (CTA) favors people who use the re-loadable CTA card, while those purchasing individual rides are penalized with a higher rate for both the individual ride and transfers.

Crime: The overall crime index in Chicago decreased by 11% between 1996 and 2003, although calls for emergency service increased by 47%, from 3.4 million to just over 5 million. The number of sworn police officers increased by 1% to 13,619, while the Police Department's civilian staff decreased by almost 40% to 1,576.

Many concerns with crime are related to gangs and domestic violence, which affect not only the individuals involved, but also their families and communities. Being exposed to violence is traumatic, especially for children, and issues of safety limit one's ability to access care. Individuals involved in these crimes also may not seek help, as they may feel disenfranchised from society. Families affected by domestic violence are often affected financially, as they may have higher health care costs, lost wages, and possible job loss. Employers and community-based organizations that work with families need to adhere to confidentiality laws that protect the person from further abuse.

Opportunities to counteract the effects of crime include involvement in the Chicago Alternative Policing Strategy (CAPS) program and organizing neighborhood watches. Advocates can also support those affected by domestic violence and raise awareness of these problems through outreach to employers and community residents. In addition, community-based agencies and health care providers can develop service models and alternative health programs to better reach disenfranchised youth and those affected by violence.

School System: Ongoing problems affect Chicago's public school system and the students that attend them. Overcrowding, unchallenging curricula, and limited after-school or tutoring programs all make it easy for children to get lost in the system and not get the individualized attention they may need to succeed. Lack of physical education and health education, along with limited health services, do not encourage healthy behaviors and affect obesity rates in children. Poorly performing schools are being closed; however, this may intensify the lack of available resources in some communities.

Since many people and organizations are concerned with the success of the local schools and the welfare of the students, organizing around these issues may bring in a large, vocal, and active constituency. Local community-based organizations can collaborate with the schools to sponsor after-school programs for the students. The Chicago Public Schools recently hired a new director of health services and doubled the size of the coordinated school health division, thereby expanding its commitment to school health.

Public Health and Health Care Workforce

The workforce is the key component of both public heath and health care services. However, there is a serious supply shortage of providers, especially nurses, dentists, and other allied health professionals. The shortage is expected to be more severe in the future as the population ages and is in need of more health care.

One reason for supply shortages is the lack of available training programs. Many nursing schools are not able to accept all qualified applicants because they do not have enough faculty to expand their programs. As current teaching staff retire and funding is cut from some programs, training programs will be even more challenged to educate the health care workforce. This is occurring for all levels of training, including high school, college, and advanced training programs.

A resource that could help alleviate the nursing shortage is the large number of foreign trained nurses. However, language barriers, difficulty validating credentials, and the current licensure standards prevent the full utilization of this pool of health care providers. This process improved somewhat, however, in 2005, when Illinois eliminated redundant licensure examinations.

Opportunities to strengthen the public health care workforce include promoting public health careers, supporting efforts of local nursing associations to improve licensure process, advocating for increased funding for the Nursing Reinvestment Act, and instituting recommendations previously mentioned as strategies to reduce health disparities by increasing the number of minority providers.

Emergency Preparedness Systems

With the ongoing threats of terrorism, public health and its partners are challenged to develop an emergency preparedness plan and create systems to support disaster prevention and recovery efforts. Systems also need to address natural disasters and threats from emerging diseases, such as avian influenza. The Chicago Department of Public Health received federal funding to create a comprehensive communication and surveillance system, the Chicago Health Event Surveillance System (CHESS), which will connect local government agencies, hospitals, and other first responders. In addition to gathering data on situations of concern to

emergency preparedness, CHESS will collect data related to communicable disease and other key public health programs and will facilitate better integration among CDPH programs. As a result, the system will improve ongoing public health disease surveillance activities.

Another component of emergency preparedness is informing the public. With a diverse population of over 2.8 million, the system is challenged to create communication strategies and systems to reach all populations with information and instructions of what do in an emergency and how to respond to other public health concerns.

War in Iraq

The war in Iraq impacts public health through the reallocation of domestic resources, loss of life, and increased need for services for returning military personnel.

As noted in the book War and Public Health:

> "War has an enormous and tragic impact-both directly and indirectly-on public health. War accounts for more death and disability than many major diseases combined. It destroys families, communities, and sometimes, whole cultures. It directs scarce resources away from health and other human services, and often destroys the infrastructure for those services. It limits- and often totally eliminates-human rights...." (Source: Levy, Barry S. and Sidel, Victor W. (Eds.) 1997. War and Public Health. New York: Oxford University Press, p. Preface IX)

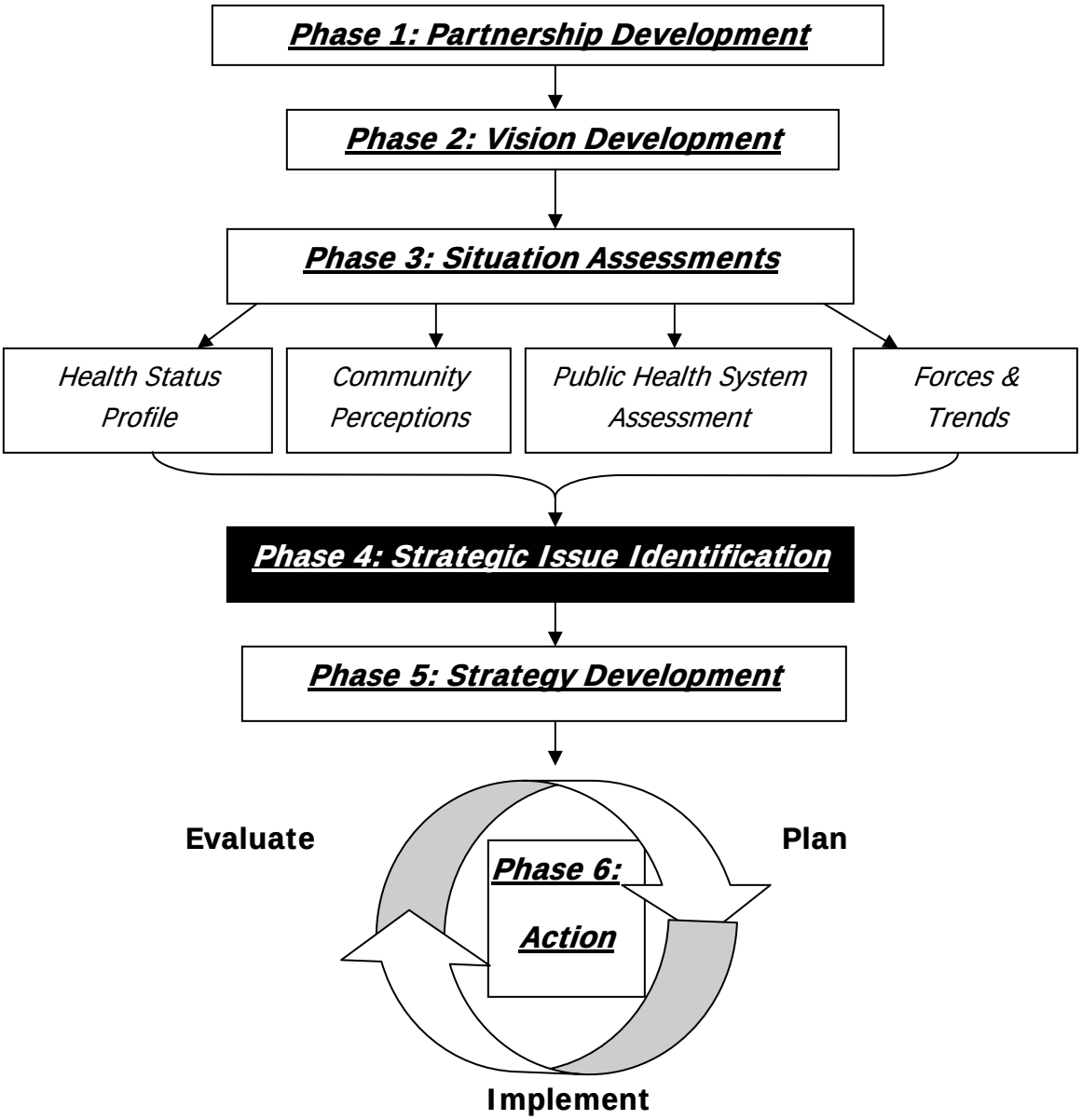
Public health advocates can work together to call for an end to the Iraqi war and the return of funds to support programs that build community infrastructure.

Public Health Accreditation Programs

National and state initiatives are strengthening government's focus on accountability and performance standards. One of the initiatives being considered is establishment of a public health accreditation program. This program, when created, would challenge the public health system to meet and exceed these set standards.

Benefits of this process would be that public health would adopt a culture of performance improvement and standards would provider markers of care for which to strive. Accreditation would also increase recognition of public health, making the public more aware of its value and more likely to support its work and advocate for adequate funding. By measuring itself against standards, each public health agency could identify areas needing improvement and focus energy on these priorities.

Chicago Partnership for Public Health
MAPP Process



Strategic Issues Affecting Chicago's Local Public Health System

Purpose

If Chicago's public health system is to achieve its vision of a responsive system that not only addresses public health challenges, but also protects and promotes the health of all its residents and visitors, particularly the most vulnerable, it must address key strategic issues that interfere with these goals. Strategic issues are those fundamental policy choices or critical challenges that represent the basis for improving the work of the public health system. As the Chicago Partnership identified strategic issues, the focus of the planning process progressed from gathering and analyzing data to determining the cross-cutting themes present among the assessment findings. This process prepared the Partnership to further develop priorities and action plans to address these concerns.

Approach

To identify strategic issues, the Chicago Partnership first reviewed its vision and findings from the four situation assessments (health status, community perceptions, public health system, and forces & trends). Members were asked to consider cross-cutting themes that emerged out of these findings and suggest issues that:

- Pose a direct threat, present an opportunity, or require significant change;
- Require action on the part of the public health system partners;
- Represent a convergence of narrow, single focus issues;
- Involve conflict or tension between current and future capacities, actual and desired conditions, past performance and expectations, and old and new roles;
- Are complex and have more than one solution; and
- Operate at the systems or policy level and involve more than a single organization or an operating unit of one organization.

Findings

Through this process, the Chicago Partnership identified five strategic issues that represent a cross-cutting of concerns brought out in the strategic planning process. This information is highlighted below, connecting each strategic issue to the vision and the findings from the situation assessments.

Issue #1: How can the local public health system best assure access to care?

Vision: Assuring access to care is a core component of the Chicago Partnership for Public Health's vision for the local public health system. The vision states that the system will protect the health and well being of all people living and working in Chicago through "…a broad focus on access to services and information." The vision also states that the local

public health system will provide comprehensive and holistic services and, as one of the Ten Essential Services, will assure the provision of health care.

Health Status: The Health Status profile highlighted disparities among populations, for which improved access to care could have lessened these differences. Need for access to care is also documented through data on hospitalizations for ambulatory care sensitive conditions (ACSC), which, if cared for properly in ambulatory primary care settings, would not require more costly acute care interventions. ACSC diagnoses include congestive heart failure, hypertension, diabetes, and asthma.

Community Perceptions: Access to care was a key issue raised by the members of the community perceptions focus groups. Participants identified a lack of available services, including mental health and services for youth, as well as a need for easily accessible and more affordable health care. Focus group members stated that not only did it take a long time to schedule an appointment at a clinic, but also they often had long waits at the clinic on the day of their appointment. When asked for suggestions on how to improve the health of their community, group participants again stressed the importance of access to care.

Public Health System: As one of the Ten Essential Public Health Services, the public health system is called upon to link people to needed health services and assure the provision of health care when otherwise unavailable. While many organizations link their constituencies to services, only a few organizations actually provide care, especially to low-income and uninsured populations. As the population of uninsured/underinsured patients continues to grow, safety net providers are challenged to continue these services.

Forces & Trends**:** Access to care is an ongoing issue that was underlies many of the external forces and trends. With the growing uninsured and underinsured populations in Chicago and limited resources, including Medicaid coverage, the local public health system is challenged to assure access. Illinois' All Kids and FamilyCare programs aim to improve access to care by increasing health coverage to these populations; however, adequate funding for these programs is not yet secure. In the midst of these concerns, advocacy efforts to achieve universal health care coverage are occurring nationally and within Illinois.

Issue #2: How can Chicago's public health system partners most effectively work to eliminate disparities in health status?

Vision: The local public health system is envisioned as one that works to eliminate disparities. While the system serves all communities, a special focus is placed on

"populations-in-need" and the "most vulnerable" Chicago residents. In addition, the system also aims to eliminate disparities by providing services that are "comprehensive and holistic," which "work to reduce the negative effects of poverty and racial/ethnic/other disparities."

Health Status: Findings from the Health Status Profile showed disparities among several populations, especially in the Black and male populations. Blacks and males had higher mortality rates than other groups and higher percentages of years of potential life lost, indicating that people in these groups died at an earlier age. Blacks and males also had higher rates of communicable diseases, including STDS, HIV/AIDS, and TB. Although generally not as severe as found in the Black population, many health indicators for the Hispanic population are higher than the indicators of the White population.

Disparities in health status were also noted geographically, with people living in the West region having the highest morbidity and mortality rates and percentages compared to the other regions.

Community Perceptions: Participants in the focus groups were concerned about barriers to health care that limit people's ability to access care. Focus groups in primarily Latino neighborhoods mentioned barriers of providers' lack of cultural and linguistic competency. All groups mentioned concerns over specific health issues that disproportionately affect minority populations, including HIV/AIDS, diabetes, teen pregnancy, and asthma.

Public Health System: Many of the Ten Essential Services form the base of work that needs to be done to eliminate health disparities. Public health's work in monitoring health status is key to identifying disparities among communities. The system's ability to track this data, however, is challenged by the lag time in obtaining data. The public health system is called upon to inform, educate, and empower people about health issues. In carrying out this service, the system must employ the most effective strategies to reach disparate communities with information to improve their health behaviors and health status. The public health system also impacts health disparities by mobilizing partnerships to identify and solve problems and by recruiting more minority providers and training people in culturally competent care. Eliminating health disparities are also part of the essential services that address the system's evaluation of effectiveness, accessibility, and quality of health services, as well as the system's responsibility to research for new insights and innovated solutions to health problems. Identifying disparities among populations and communities through evaluations in these key areas will propel the public health system to conduct research for innovative ways to solve these inequities.

Forces & Trends: Health disparities were mentioned as an important force and trend affecting the public health system. Concerns were raised about the lack of resources to provide adequate care to the minority populations. Recruiting more minority providers and training all providers in culturally competent care were identified as opportunities to counteract growing health disparities.

Disparities are also affected by one's community and living conditions. Due to problems with funding, some communities are losing access to social services and community-based programs that serve low-income families. Limited resources, coupled with housing that is more at-risk of environmental problems (i.e., lead poisoning), leads to poorer health outcomes and greater disparity among groups.

Issue #3: How can the public health system best support communities in an effort to improve neighborhood cohesion, communication, and coordination of public health care resources?

Vision: The local public health system's vision states that the system will serve all Chicago's residents and visitors, including communities, partnerships, and populations in-need. This focus coincides with the goal of this strategic issue by directing efforts in the communities to improve health and increase access to care. The vision acknowledges that the public health system will support and facilitate community empowerment and will promote networking and communication among organizations. All stakeholders, groups, and communities will be included in this process. The vision also calls upon the public health system to carry out the Ten Essential Public Health Services, which address community empowerment through information and education and mobilization of community partnerships to identify and solve health problems.

Health Status: Differences in health status were evident among the seven different regions in Chicago. While regions lack full capacity to serve all residents, most areas do have some access to health care centers, including those that serve low-income populations. This finding supports the importance of coordinating community-level activities, including communication and education on how best to use available health and social services.

Community Perceptions: Focus groups solicited members' perceptions on the health of their communities, including both the problems and the positive aspects. Along with more services, all focus groups wanted more information about existing services. Participants also identified several community-level problems, such as drugs, gangs, and violence that prevented some residents from accessing care when they needed it. To keep their neighborhood healthy, some participants got involved in their community through block

clubs or attending community events. Others worked on community gardens and watched out for neighborhood children. While members said they appreciated the diversity of their neighbors, they also acknowledged the need to build trust within the community.

Public Health System: Several of the Ten Essential Public Health Services stress the importance of community cohesion and communication to improve access to care. For example, the public health system is called upon to mobilize community partnerships to identify and solve health problems. For the partnerships to do this, they must promote communication and trust among the members. By bringing together community members and local agencies, partnerships benefit from their collective knowledge and, thus, are well suited to identify resources and disseminate information. The public health system is also required to develop plans to support individual and community health efforts. Working within the communities to develop and implement these plans necessitates cross agency communication and coordination. Another essential service calls for the public health system to inform and educate people about health issues. This is best accomplished by working through communities that can create and support outreach campaigns to reach their specific populations.

Forces & Trends: Many of Chicago's communities are going through changes that have affected their community cohesion and access to services. Limited funding has reduced available resources, making it more difficult for residents, especially low-income individuals, to maintain self-sufficiency. The racial/ethnic and income composition of communities are changing with spread of gentrification and growth of the Hispanic population. With the economy and business environment focusing more on service provision and technology rather than manufacturing, some neighborhoods have experienced a significant loss of jobs. All these forces play a part in reducing community cohesion and communication.

Issue #4: How can the public health system assure a competent and responsive workforce to meet the population's needs?

Vision: Carrying out the Ten Essential Public Health Services is an important function of the local public health system and assuring a competent public and personal health care workforce is one of these essential services. Without a workforce that is skilled and responsive to the various populations, the public health system will not be able to improve the health of Chicago's residents.

Community Perceptions: Although focus group participants felt that the local community organizations and health care providers provided good quality of care, they also mentioned that some providers lacked cultural and/or linguistic competency.

Public Health System: As mentioned as part of the Vision, assuring the workforce is one of the Ten Essential Public Health Services. Individual organizations maintain records on provider credentials as part of compliance with regulations and accreditation criteria. However, organizations are less able to verify the skills of other public health workers who are not licensed providers. In addition, the public health system is not required to maintain records on staff's cultural competency to serve their clients.

Forces & Trends**:** The health care workforce was identified as a component in several forces and trends affecting the public health system. One of these trends is the changing population mix in Chicago requiring providers to be competent in working with diverse groups. Recruiting more minority providers is an important strategy that increases trust and communication in the provider-patient relationship and promotes the provider as a role model to help patients navigate the health care system. These strategies also help address the trend of the widening gap of health disparities. The concerns over the growing uninsured and underinsured populations are impacted by current and expected workforce shortages, which limit health care facilities, including safety net sites, from expanding their capacity.

Issue #5: How can the local public health system best facilitate a paradigm shift so that preventive practices are incorporated at both the system and individual level?

Vision: The public health system envisioned by the Chicago Partnership incorporates health promotion and disease prevention through provision of comprehensive and holistic services. The system will also inform, educate and empower people about health issues. A paradigm shift for the system to focus on preventive care and for individuals to adopt healthy behaviors and participate in regular preventive care would allow the vision of the Chicago public health system to become a reality.

Health Status: The need for more preventive care is documented by the number of hospitalizations for ambulatory care sensitive conditions (ACSC), i.e., those illnesses that would not need hospitalization if managed properly through ambulatory care. ACSC comprised over one quarter of all hospitalizations in 2001.

A paradigm shift toward preventive screening would help improve the percentages of adults accessing the health care system. As reported through the 2002 Behavioral Risk Factor Surveillance Survey, 73% of adults have ever had their cholesterol checked, 88% of these in the past year. Almost 100% of all adults have ever had their blood pressure checked, however only 89% had it taken within the past year (in 1998). Adults getting dental exams comprised 82% of the population, with 69% of that group having had their

exam within the past year. These percentages vary depending upon gender and race/ ethnicity.

Data on weight and exercise from the Behavioral Risk Factor Surveillance Survey and the Youth Risk Factor Surveillance Survey support the need for the system to promote a paradigm shift. Sixty percent of adults and 14% of youth are overweight. Less than half of both these populations get sufficient exercise.

Sexual responsibility is another component of preventive practices. In 2003, 20% of youth have had 4 or more partners, 13% had sex before age 13, and 21% stated they used drugs or alcohol during their last sexual experience. Males were more likely to engage in these behaviors. Sixty-seven percent of youth report using condoms as their form of birth control.

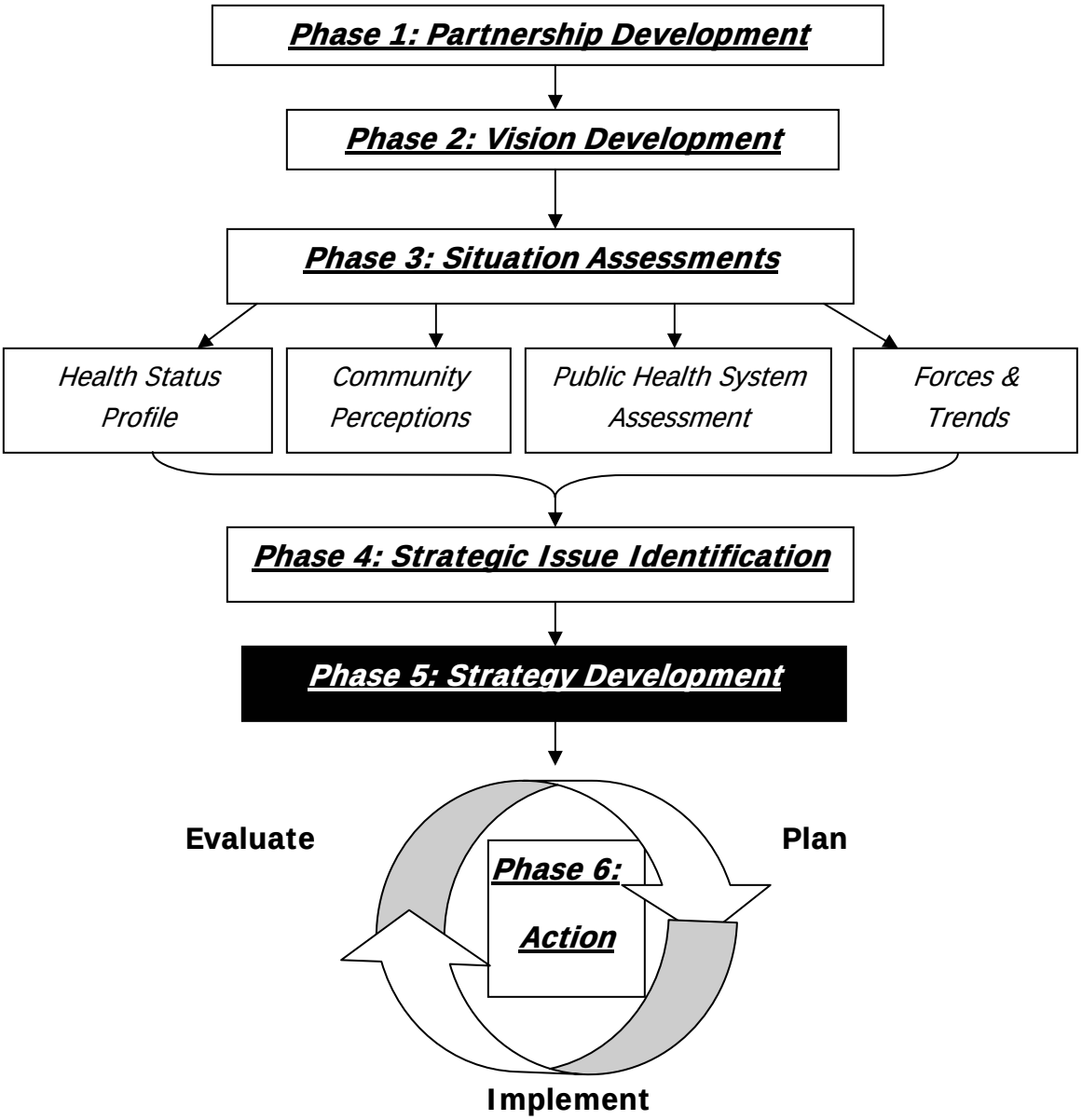
Community Perceptions: Members of the focus groups recognized that the health of their communities was not only reliant on health care services, but also depended upon available resources that promote healthier behaviors, including local parks, recreational facilities and youth programs. Focus group members also thought their community's health would be improved with access to a higher quality of education. However, when asked about barriers to health, most people primarily discussed issues related to accessing services rather than what they, as individuals or a community, could do to improve their health. These findings support the need for the public health system to more directly promote community and individual roles in prevention and health education.

Public Health System: Research, which is one of the Ten Essential Public Health Services, is crucial to identifying innovative ways to improve health status. Many foundations fund research on chronic disease and health behaviors and these findings could help guide research on how best to facilitate paradigm shifts toward prevention and healthy behaviors. Other public health essential services that support this paradigm shift are the focus on empowering people about health issues and supporting individual and community health efforts through development of plans and policies.

Forces & Trends**:** The need for a paradigm shift to a system that focuses more on prevention is substantiated by the growing gap in health disparities, as some populations do not get preventive care or practice healthy behaviors to alleviate health problems. However, this paradigm shift will be difficult for some people to adopt, including those who work several part-time jobs and don't have time to access care or exercise regularly, people who lack of health insurance to get preventive care, and individuals who live in neighborhoods without resources that support healthy behaviors and preventive care.

Chicago Partnership for Public Health

MAPP Process



Strategies for System Development

Purpose

The development of strategies moves the strategic planning process further along from assessment toward implementation. The Partnership members created the strategies listed below as methods to address the strategic issues that arose out of the vision and situation assessments. These strategies will direct the Chicago Partnership's work to improve the public health system.

Approach

Chicago Partnership members brainstormed strategies for each of the five strategic issues at one of its meetings. The Partnership used "PEARL Criteria" when developing strategies:

- *Propriety* - Is the strategy consistent with the Ten Essential Services and public health principles?
- *Economics* - Is the strategy cost-effective? Does it make financial sense?
- *Acceptability* - Will the stakeholders and the community accept the strategy?
- *Resources* - Is funding available to implement the strategy? Are organizations able to offer in-kind contributions—such as personnel, space, etc.?
- *Legality* - Do current laws allow the strategy to be implemented?

Many of the strategic issues the Partnership identified focused on closely related components of the health care system. Therefore, many of the strategies the Partnership created will impact more than one of the issues. To reflect overarching issues, all the strategies were grouped into seven cross cutting action areas. Partnership members determined the priority action areas and priority strategies within each action area by ranking them on a survey and confirming the results at the following Partnership meeting.

Findings

The Partnership identified over 40 strategies, which were then grouped into seven cross-cutting action areas. The following action areas are listed in order of Partnership priority.

1. Use data to influence resource allocation.
2. Improve processes to access to health and social services.
3. Build community structure to facilitate healthier behaviors and appropriate use of the health care system.
4. Advocate for legislative and institutional policy changes to increase access to care.
5. Conduct media campaigns to promote prevention and increase awareness of how social determinants affect health.
6. Establish non-traditional training methods to promote health care careers and increase workforce diversity.
7. Promote provider and community competencies.

Action Area #1: Use data to influence resource allocation.

Chicago Partnership members acknowledged how important data are to many aspects of the public health system: to determine population needs, monitor health status, identify trends, develop and evaluate interventions and programs, and track health system resources. Data are necessary to perform many of the Ten Essential Public Health Services, including assuring access to care. Data are necessary as the public health system works to eliminate health disparities to establish baseline status and track changes. Data that assess change are also essential, as the system works to increase preventive practices and healthy behaviors. Tracking the health system allows for coordination and communication of public health resources.

The following strategies propose methods to improve how the public health system uses data:

1.1 Collect and analyze data on access to care components from both traditional and non-traditional sources to more completely document need.
1.2 Understand data and apply to appropriately allocate resources.
1.3 Assess the availability of services in communities and leverage resources to respond to community needs.
1.4 Develop outcome measures related to data and identify as met or unmet.
1.5 Design public health service programs to best meet population needs by using current demographic trend information.
1.6 Develop a mandate for standardized data collection on racial/ethnic minorities.

Action Area #2: Improve processes to access health and social services.

State government operates several health and human services programs for high priority populations. However, because the application processes are complicated, many people who are eligible for these benefits do not receive them. Another common barrier to receiving care is inability to communicate in English. Many programs do not have adequate capacity to provide care to people with limited English proficiency and/or hearing impairments.

The Chicago Partnership believes that improving access to care and, ultimately, the population's health status, are contingent on increasing the ease with which populations enter and obtain care. The strategies identified below propose changes that would help to improve these processes. Strategic issues that overarch this action area include access to care and eliminating health disparities.

The Chicago Partnership suggested the following methods to improve current processes:

2.1 Facilitate a one-stop online application process for health and social service programs to ensure people have easy access to health and social services benefits for which they are eligible.
2.2 Employ more onsite trained interpreters at health care facilities to ensure that clients with limited English proficiency or who are hearing impaired receive the same quality of care as those patients who can communicate directly with their health care provider.
2.3 Expand use of web-based application processes for health benefits at private providers' offices.
2.4 Improve application process for available health and social service programs by use of web-based programs such as Real Benefits.

Action Area #3: Build community structure to facilitate healthier behaviors and appropriate use of the health care system.

Chicago's public health system partners recognize that community involvement is a key piece of the public health system. The Chicago Center for Community Partnerships helps to strengthen this connection with several community coalitions; however, many more communities are in need of this link to the public health system.

This action area covers many of the strategic issues the Chicago Partnership developed for the public health system: assuring access to care; eliminating disparities in health status; improving neighborhood cohesion, communication, and coordination of resources; and facilitating a paradigm shift to incorporate preventive practices. The following strategies propose methods to build the public health system's community structure:

3.1 Work with community-based organizations, both faith-based and non-sectarian, to hold local meetings, especially within areas at highest risk, to discuss preventive practices and how the community can influence health.
3.2 Encourage communities to organize on public health issues.
3.3 Educate the community on their rights within the health care system and on available resources.
3.4 Establish tax incentives for grocery stores to open in inner city neighborhoods.
3.5 Partner with other organizations and agencies (Chicago Department of Planning, Chicago Department of Transportation, Chicago Bicycle Federation, etc.) to design communities that promote healthier behaviors.
3.6 Advocate for lower insurance premiums to reward individuals that practice healthy behaviors (controlled blood pressure, healthy weight, non-smoker).
3.7 Encourage all food stores to carry healthy food items.

Action Area #4: Advocate for legislative and institutional policy changes to increase access to care.

To ensure that access to care strategies actually occur, Chicago Partnership members emphasized the importance of policy changes at both governmental and institutional levels. System changes need to be accompanied by legal mandates and change in organizational missions and procedures. Otherwise, these activities run the risk of being eliminated when funding runs out or management priorities change.

The Chicago Partnership developed strategies that promote policy changes that would increase access to care, help address health disparities, and promote a workforce that can meet the population's needs. These following strategies rely on coordinated advocacy efforts:

4.1 Support local, state, and national legislative efforts to develop and implement a national health care plan.
4.2 Change eligibility for health and social service programs to reach all people living in Chicago so that residency, not citizenship, is the eligibility requirement.
4.3 Establish school forgiveness loans or other incentive programs to encourage private providers to work in underserved areas.

Action Area #5: Conduct media campaigns to promote prevention and increase awareness of how social determinants affect health.

Media campaigns through television, radio and print are important tools to reach large audiences with public health information. Media campaigns can also serve to educate the general public on how problems in the health care system affect everyone. These campaigns can be geared to reach targeted populations, both by how the message is tailored and through the use of specific media outlets.

The media are part of Chicago's public health system because they are so influential in reaching diverse populations within the city. Therefore, the system partners need to assure that the media understand the myriad of factors that contribute to health status and affect the health system so reporting will present accurate information.

Media outreach and campaigns can educate and initiate action in several of the strategic issue areas: access to care, health disparities, and adoption of preventive practices.

Strategies that promote media connections to strengthen the public health system include:

5.1 Inform media on issues related to access to care, including how all Chicagoans are impacted by the lack of access to health care, e.g., cost (actual and social) and the security (health protection) of the city.
5.2 Media outreach to increase information on preventive practices.
5.3 Develop a broad-based public information campaign on the causes of health disparities, stressing the importance of underlying social determinants not necessarily related to health care delivery.

Action Area #6: Establish non-traditional training methods to promote health care careers and increase workforce diversity.

To facilitate better health outcomes, the public health and health care workforce needs to be better matched to the population. A more diverse workforce, both in cultural background and language ability, will allow for improved communication between the provider and client, which then facilitates improved health education and treatment compliance. However, there are not enough minority providers in Chicago.

To promote public health and health care careers to minority populations, the Chicago Partnership developed the following strategies that promote non-traditional training programs that recruit and retain qualified students. These strategies make up part of the Chicago Partnership's focus on assuring access to care, eliminating health disparities, and assuring a competent and responsive workforce. Strategies to increase workforce diversity include:

6.1 Establish "bridging programs" that support students with jobs in the health care industry while they are completing their training.
6.2 Outreach to high school and middle school students to promote careers in public health and health care.
6.3 Develop more opportunities for horizontal growth within health professions to allow people at entry-level positions to develop along a career path.
6.4 Establish more Americorps programs to promote health careers.
6.5 Advocate for strategies suggested by the Sullivan Commission's Report: Missing Persons: Minorities in Health Care (underlying principles include changing culture in health profession schools, exploring new and non-traditional paths to health professions, and obtaining commitment to change at highest levels).
6.6 Promote culture change in health professional training programs to increase diversity.

Action Area #7: Promote provider and community competencies.

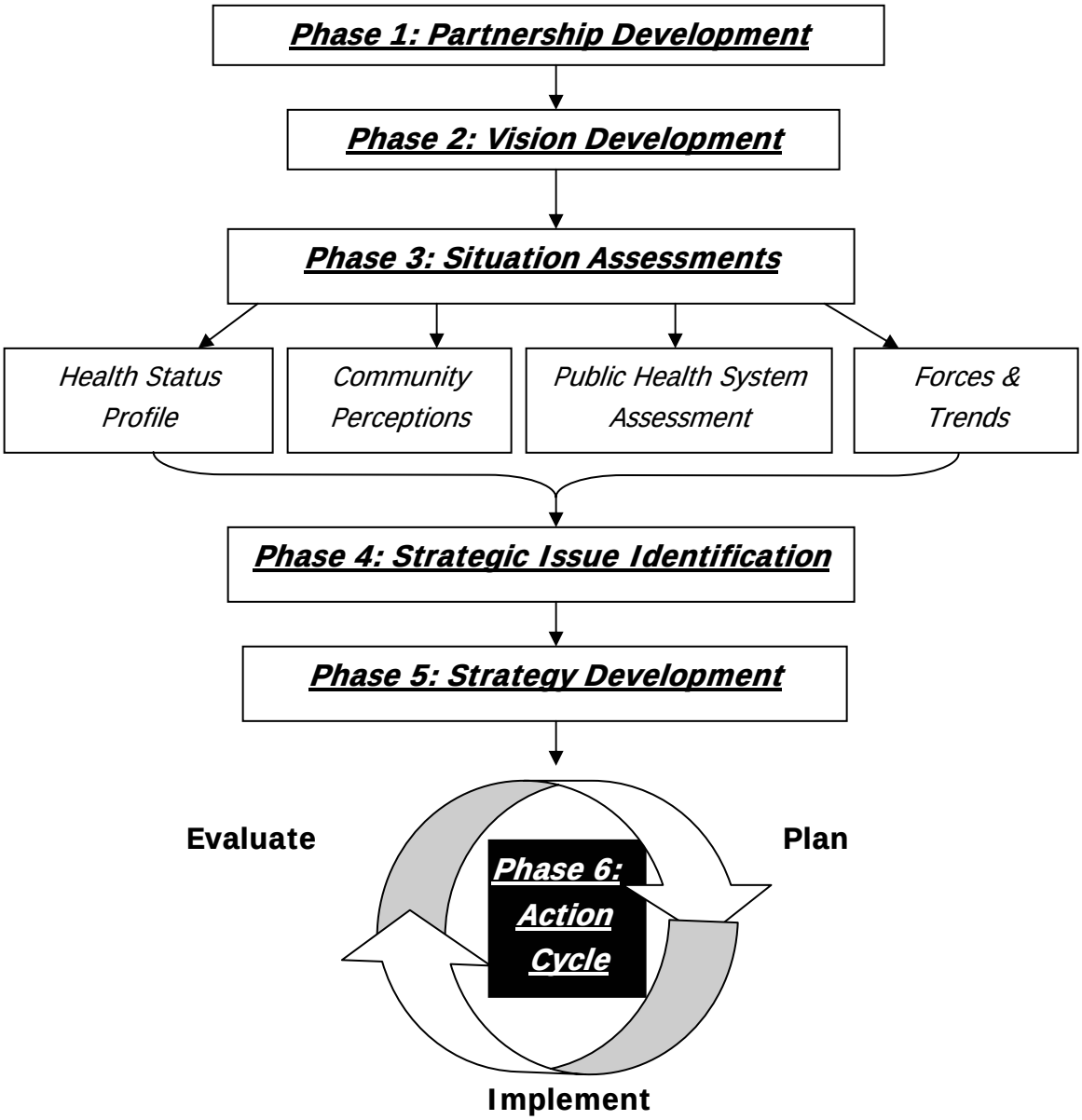
The functioning of the health system relies on the competencies of its health care providers. Not only do health care staff need to provide quality diagnostic health care services, they also need to incorporate preventive practices and encourage healthy behaviors in all their patient interactions. Providers also need to develop skills in working with the increasingly diverse patient population. This can be accomplished through cultural competency trainings and assuring capacity to serve limited English proficient patients through bilingual staff and/or interpreters. Strengthening provider capacities in these areas will increase access to care and will help decrease disparities in health.

Another part of improving the health care system and eliminating health disparities is identifying systemic problems, such as institutional racism. Health care organizations and other community institutions need to evaluate their practices to ensure all patients have equal access and receive equal treatment.

Strategies to improve provider and community competencies include:

7.1 Encourage private providers to use clinical practice models to ensure adequate focus on preventive practices.
7.2 Establish provider competencies in areas of language, cultural competence, and knowledge of racism's affect on health.
7.3 Educate health care organizations and communities about the effects of institutional racism on health status.

Chicago Partnership for Public Health
MAPP Process



Priority Action Areas, Objectives, and Implementation Plans

Purpose

To propel system change, it is essential to create specific objectives and realistic implementation plans. Therefore, the Chicago Partnership's strategic plan focuses on three action areas, with one to two objectives in each of these areas. These objectives concentrate the Partnership's efforts on improving Chicago's public health system, while at the same time, working to achieve several of the Healthy People 2010 National Health Objectives.

Approach

A survey of all Chicago Partnership members was used to set priorities among the seven action areas and among the strategies within each action area. Further discussion at a Partnership meeting determined the final three highest-ranking action areas and the top one or two strategies within these areas. Partners then worked in small groups to create objectives and implementation plans.

The implementation plans below describe the steps needed to reach the objectives, the agencies responsible for coordinating these efforts, the resources needed, and potential evaluation measures.

Action Area 1: Use data to influence resource allocation.

Outcome Objective 1.1: By December 31, 2011, state and local public health care funding will be allocated based on need, as documented by data-driven analysis.

- Impact Objective: 1.1.1: By December 31, 2008, Chicago's public health system partners will produce a comprehensive analysis of access to care needs, based on a methodology that includes data from both traditional and non-traditional sources.
- Impact Objective 1.1.2: By December 31, 2009, the Chicago Partnership for Public Health will disseminate public health funding allocation recommendations to state and local decision makers based on data-driven analyses.
- Impact Objective 1.1.3: By December 31, 2010, the Chicago Partnership for Public Health will advocate for data-driven resource allocation to state and local decision makers.

Funding for public health activities has historically been determined by many factors: effectiveness of interventions, the depth and breath of the population that is or could be affected, the seriousness of complications, national priorities, special initiatives,

recognition of core public health responsibilities, and political interest. Although this complex process has resulted in adequate funding for some programs, other public health priorities are under-funded and significant problems remain to be addressed. As an example of this disconnect between funding and epidemiologically-identified need, the Chicago Department of Public Health has been able to find and commit public grant dollars to chronic disease prevention. However, the amount available accounts for only one percent of the grant funding received by the department even though chronic diseases contribute to over 50% of all deaths in Chicago. Therefore, the Chicago Partnership for Public Health aims to influence the allocation system through use of a data-driven methodology to demonstrate need and build support for balanced advocacy efforts. This objective also reflects the thinking in two areas of the Healthy People 2010 National Health Objectives: Access to Quality Health Services and Public Health Infrastructure.

To ensure a comprehensive analysis of need, the Chicago public health system partners will design a methodology that incorporates data from both traditional (mortality, maternal and child health, infectious disease, etc.) and non-traditional (use of emergency health services, local businesses insurance coverage, etc.) sources. Information about the health care system's capacity and utilization will be obtained through the work of CDPH's Health & Health Systems Project. After analysis, the findings will be packaged and disseminated to inform and educate decision-makers about public health priorities. The Chicago Partnership for Public Health members will advocate to decision-makers to follow the data-driven recommendations when allocating funds for public health programs.

The Chicago Department of Public Health will lead this initiative, in coordination with partners from the health system, including the Metropolitan Chicago Healthcare Council, Illinois Primary Health Care Association, Chicago Fire Department, Chicagoland Chamber of Commerce, Chicago Medical Society, Illinois Department of Public Health, Illinois Hospital Association, Joint Commission for Accreditation of Health Care Organizations, Centers for Disease Control and Prevention, as well as researchers from universities and policy research groups.

Resources needed to implement this strategy include in-kind staffing for coordination and data management. Funding may be needed for university researchers to assist with developing a comprehensive methodology and analyzing the data. Funding will also be needed to develop and distribute materials to decision-makers. Evaluation of this initiative will compare spending patterns to the priorities identified through this process.

Action Area 2: Improve processes to access health and social services.

Outcome Objective 2.1: By December 31, 2011, 50% of clients who enroll in state health and social programs will use the State of Illinois' online one-stop application process. (Estimated baseline in 2006: 25%)

- Impact Objective 2.1.1: By December 31, 2007, the Chicago Partnership for Public Health will advocate to the State of Illinois to develop and promote an online one-stop application form that consolidates their online application forms.
- Impact Objective 2.1.2: By December 31, 2008, the Chicago Partnership for Public Health will advocate to the State of Illinois to make program requirements and verification processes similar for all health and social programs to increase individuals' ability to apply for benefits.

Applying for state health and social service programs can be a confusing process. Although most programs require similar information, many have different verification requirements. Program structures differ also, with some requiring recertification every six months while others recertify annually. This complex system can deter many people from obtaining all the benefits for which they are eligible. Without benefits, many people do not seek preventive care or access health care on a timely basis.

The state did combine applications for several programs; i.e., food stamps, medical assistance, and cash assistance; and provides this joint application online. However, it consists of a long form and must be printed out and delivered to the Department of Human Services office to be processed. In contrast, the online application for the All Kids health insurance program is more interactive and guides the user through the application process. Users create an account, so data can be saved and the application can be completed over multiple sessions. In addition, this information is directly downloaded to the Department of Healthcare and Family Services.

This outcome objective requires the State of Illinois to create this online application, ensure its functionality, and promote its availability so it becomes the method of choice for at least 50% of all clients applying for benefits. Because this objective aims to improve access to care, strengthen the public health infrastructure, and promote health communication, it is aligned to the objectives of Healthy People 2010. The strategy promoted by the Chicago Partnership would help to alleviate the difficulty in registering for health and social service programs by allowing an individual to apply for all state health and social service programs through a consolidated web-based online application, similar to the All Kids online application.

The Chicago Partnership for Public Health, as lead implementer for this strategy would coordinate advocacy efforts with the partners organizations of the Chicago Partnership, including the Chicago Department of Human Services, Chicago Public Schools, Heartland Alliance, Illinois Primary Health Care Association, and others. Other agencies that would be involved in this effort include the Chicago Youth Services and the Maternal and Child Health Coalition. Resources needed consist primarily of in-kind staff to coordinate advocacy efforts. Percentages of enrollees through the online site will be monitored to evaluate the progress of this objective.

Outcome Objective 2.2: By December 31, 2011, clients at Chicago Department of Public Health clinics who were served by an interpreter (both onsite and through telephone interpreting services) will report similar satisfaction levels as clients served by providers who spoke their primary language.

- Impact Objective 2.2.1: By June 30, 2007, the Chicago Partnership will participate in the CDPH Office of Multicultural Affairs Advisory Group to analyze need, devise strategies, and evaluate progress of interventions to increase access to and quality of interpreter services.

All facilities that receive federal funding (including Medicaid, Medicare, etc.), such as community health centers, are subject to the non-discrimination requirements of Title VI of the Civil Rights Act of 1964. One component of this law requires an organization to take reasonable steps to provide people with limited-English proficiency (LEP) with an opportunity to access care by offering and providing interpreters. Health care facilities are also required to ensure effective communication with clients who are hearing impaired, as legislated through the Americans with Disabilities Act. This would include access to a qualified American Sign Language (ASL) interpreter. Along with the federal requirements, health care providers recognize that clear communication between the provider and client is necessary for correct diagnosis, explanation of treatment options, health education, and obtaining informed consent.

Serving the LEP and hearing impaired population is accomplished in two ways: (1) hiring bilingual providers and/or (2) providing medical interpreters. Employing bilingual providers is the most effective and efficient solution for both the client and the health care facility because it allows clients to communicate directly to their provider and health care sites do not have to hire additional staff. Spanish is the most common language other than English spoken at health care facilities in Chicago and many health care sites recruit providers fluent in Spanish. However, there are not enough qualified Spanish-speaking providers to serve all the sites that need this competency and clients at health centers speak more

than two-dozen languages, including sign language. Therefore medical interpreters are a necessary component of serving the LEP population.

The Chicago Partnership's strategy to improve access to health care calls upon health care organizations to employ more onsite trained medical interpreters for their LEP and hearing impaired clients. The Healthy People 2010 objectives of assuring access to care, strengthening the public health infrastructure, and improving health communications relate to these objectives.

The Chicago Department of Public Health serves clients that speak over 25 languages at its five primary health care centers, two maternal and child health sites, and 14 mental health clinics. CDPH employs bilingual providers and has staff that can interpret, but has not fully assessed the adequacy of its efforts. Therefore, lead by the Office of Multicultural Affairs, CDPH will form an Advisory Group to assist with the assessment of language needs, develop interventions and sponsor trainings, and evaluate progress in serving its clients with appropriate language services. The Chicago Partnership will participate as a member of the Advisory Group to assist with this process. Resources are in-kind staff to participate on Advisory Group. Evaluation surveys will measure the change in client satisfaction with interpreter services rendered onsite or over the telephone.

Action Area 3: Build community structure to facilitate healthier behaviors and appropriate use of the health care system.

Outcome Objective 3.1: By December 31, 2011, the public health system partners will work with community organizations to involve residents in at least 30% of Chicago's community areas in discussions about use of the health care system and adoption of healthy behaviors.

- Impact Objective 3.1.1: By December 31, 2007, the Chicago Partnership, through the Chicago Center for Community Partnerships, will develop connections with community organizations throughout Chicago to facilitate dissemination of public health information.
- Impact Objective 3.1.2: By December 31, 2007, Advocate Health Care's Congregational Health Partnerships and CDPH's Team for Faith-Based Collaboratives will form a Center for Faith-Based Public Health and promote public health initiatives to faith-based organizations.
- Impact Objective 3.1.3: By December 31, 2009, CDPH and Advocate Health Care will develop educational and training models on healthier behaviors and appropriate use of health care services and promote their use to both faith-based and non-sectarian community organizations.

Reaching people within their communities with public health information is an effective way of facilitating behavior change and encouraging participation in public health efforts. Chicago is home to a wide variety of community organizations that engage residents by many different means. This objective seeks to use these existing relationships to ensure that community members have the latest public health information. The Chicago Partnership's strategy also engages residents in discussions on how the community can influence health. This objective is related to the Healthy People 2010 objectives that support interaction between the provider and client for behavior change activities (blood pressure, cholesterol, diabetes, overweight/obesity, physical activity, responsible sexual behavior, substance abuse, and tobacco use) and the functioning of the health care system (access to quality health services, health communications, and primary care).

To make this objective a success, CDPH, through the Chicago Center for Community Partnerships, will develop a comprehensive list of health and social service agencies from its myriad of connections throughout the city. CDPH will work with these agencies to disseminate public health information, as well as information on available resources.

Faith-based institutions also reach a large number of community residents. Some congregations do focus on health issues, either in committee work or through a special initiative, but many others have not yet addressed health concerns. To cultivate this resource, Advocate Health Care's Congregational Health Partnership will work with the newly-forming CDPH Team for Faith-Based Collaboratives to create a Center for Faith-Based Public Health. As with the non-sectarian organizations, faith-based groups will be encouraged to work with community residents to address local health care concerns.

CDPH and Advocate's Congregational Health Partnership will work other Chicago Partnership members to develop educational and training models geared to reach various populations with information on healthier behaviors and the health care system. CDPH and Advocate will offer trainings to assist organizations in presenting these topics to community residents. Resources needed to carry out this objective consist of in-kind staff from both CDPH and Advocate to collect and monitor organizational data, develop educational and training models, and train organizations to present this material. Translation resources will also be needed to create materials in several languages. The percentage of community areas that receive these presentations will be tracked to evaluate the success of this initiative.

Outcome Objective 3.2: By December 31, 2011, the number of known community-based public health efforts will increase by 25%. (Baseline to be determined by December 2007.)

- Impact Objective 3.2.1: By December 31, 2008, CDPH, through the Center for Community Partnerships, will provide direct technical assistance to 10 new or existing coalitions to increase their effectiveness.
- Impact Objective 3.2.2: By December 31, 2009, CDPH, through the Center for Community Partnerships, will offer 10 community-wide trainings on coalition development and strategic planning.

Coalitions enrich communities by building cohesion and strengthening relationships among neighbors as they work to address local problems. Many local efforts already focus on issues related to public health: community safety, access to services, and healthy behaviors. Coalitions are also important partners as the public health system develops its community preparedness plan. The Chicago Partnership for Public Health's strategy recognizes the importance of engaging and involving resident groups as part of the public health system. Healthy People 2010 contains objectives related to coalitions and community-based efforts, including in the focus area of substance abuse.

Six communities are currently working in public health coalitions organized through the Chicago Center for Community Partnerships. The Center for Community Partnerships was founded by CDPH in 2003 and provides technical assistance to help coalitions conduct strategic planning, implement objectives, and evaluate changes. Other communities discuss neighborhood concerns and develop interventions through groups such as the Chicago Alternative Policy Strategy (CAPS) beat meetings and Chicago Public Schools' Local School Councils. The Chicago Partnership's objective will promote more coalitions and stronger efforts by connecting communities to each other and using the Center for Community Partnership's ability to coordinate this work.

Through outreach to the communities, the Center will increase the number of community-based public health efforts by providing technical assistance to at least 10 new or existing coalitions and conducting at least 10 community-wide trainings on various aspects of operating a coalition. Resources needed to fulfill this objective include in-kind staffing for the Center and funding for administrative tasks to track and monitor public health efforts, provide individualized technical support to coalitions, and run trainings. Members of the Chicago Partnership for Public Health, especially those from agencies with community-based efforts, will assist with identifying current activities and promoting the Center for Community Partnerships. The current number of community-based efforts will be

researched and identified by December 2007. By 2011, because of the outreach of the Center, the number of community-based activities will have increased by 25% and Chicago's community structure will be stronger.

Next Steps

The next step in this strategic planning process is to organize for implementing the priority strategies. Although the Chicago Partnership has a diverse membership, the Partnership will reassess if any other organizations should to be invited to join this effort to ensure that implementation plans include all key implementers. With these organizations in place, work groups will form to further develop implantation plans for each of the objectives, complete with a detailed time line. In addition, the Chicago Partnership will further identify the resources needed for each of the objectives and initiate plans on how to obtain them.

The Chicago Partnership decided to concentrate its efforts on three priority action areas and one to two strategies within each of these areas. This was done to ensure a plan that was do-able and would also impact the system. However, the Partnership also recognized four other areas and many other important strategies that contribute to improving the public health system in Chicago. While the majority of the work will occur in the priority areas, the Chicago Partnership will be mindful of strategic opportunities to address other action areas. In addition, the Chicago Partnership may become involved with emerging issues affecting the health care system.

Appendices

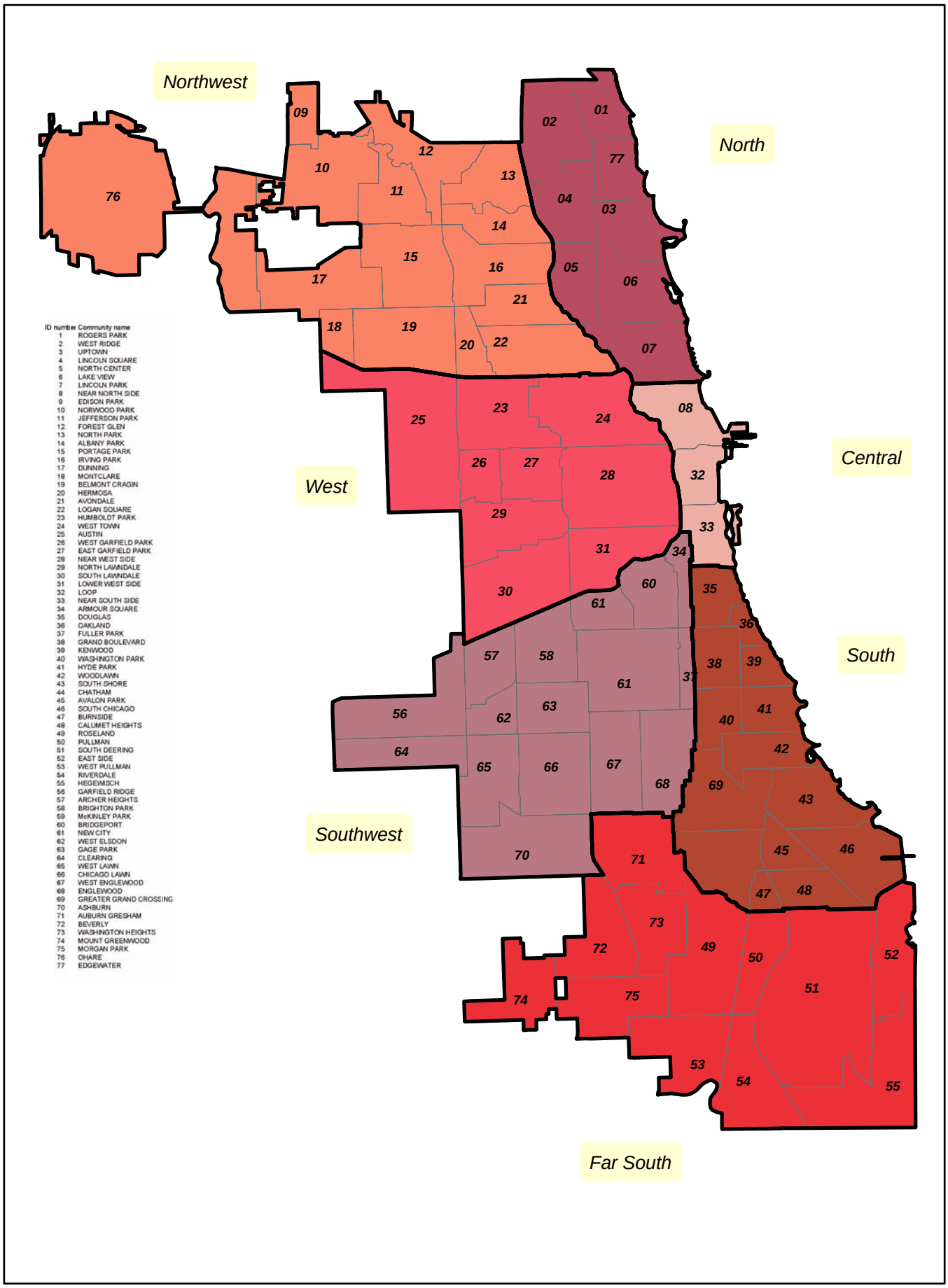
A. City of Chicago by region

B. Age-adjusted mortality rate by region (2002)

C. Age-adjusted accident mortality rate by region (2002)

D. Years of Potential Life Lost (YPLL) rate by region (2002)

City of Chicago by region



ID number	Community name
1	ROGERS PARK
2	WEST RIDGE
3	UPTOWN
4	LINCOLN SQUARE
5	NORTH CENTER
6	LAKE VIEW
7	LINCOLN PARK
8	NEAR NORTH SIDE
9	EDISON PARK
10	NORWOOD PARK
11	JEFFERSON PARK
12	FOREST GLEN
13	NORTH PARK
14	ALBANY PARK
15	PORTAGE PARK
16	IRVING PARK
17	DUNNING
18	MONTCLARE
19	BELMONT CRAGIN
20	HERMOSA
21	AVONDALE
22	LOGAN SQUARE
23	HUMBOLDT PARK
24	WEST TOWN
25	AUSTIN
26	WEST GARFIELD PARK
27	EAST GARFIELD PARK
28	NEAR WEST SIDE
29	NORTH LAWNDALE
30	SOUTH LAWNDALE
31	LOWER WEST SIDE
32	LOOP
33	NEAR SOUTH SIDE
34	ARMOUR SQUARE
35	DOUGLAS
36	OAKLAND
37	FULLER PARK
38	GRAND BOULEVARD
39	KENWOOD
40	WASHINGTON PARK
41	HYDE PARK
42	WOODLAWN
43	SOUTH SHORE
44	CHATHAM
45	AVALON PARK
46	SOUTH CHICAGO
47	BURNSIDE
48	CALUMET HEIGHTS
49	ROSELAND
50	PULLMAN
51	SOUTH DEERING
52	EAST SIDE
53	WEST PULLMAN
54	RIVERDALE
55	HEGEWISCH
56	GARFIELD RIDGE
57	ARCHER HEIGHTS
58	BRIGHTON PARK
59	MCKINLEY PARK
60	BRIDGEPORT
61	NEW CITY
62	WEST ELSDON
63	GAGE PARK
64	CLEARING
65	WEST LAWN
66	CHICAGO LAWN
67	WEST ENGLEWOOD
68	ENGLEWOOD
69	GREATER GRAND CROSSING
70	ASHBURN
71	AUBURN GRESHAM
72	BEVERLY
73	WASHINGTON HEIGHTS
74	MOUNT GREENWOOD
75	MORGAN PARK
76	OHARE
77	EDGEWATER

Chicago Department of Public Health
Planning Division

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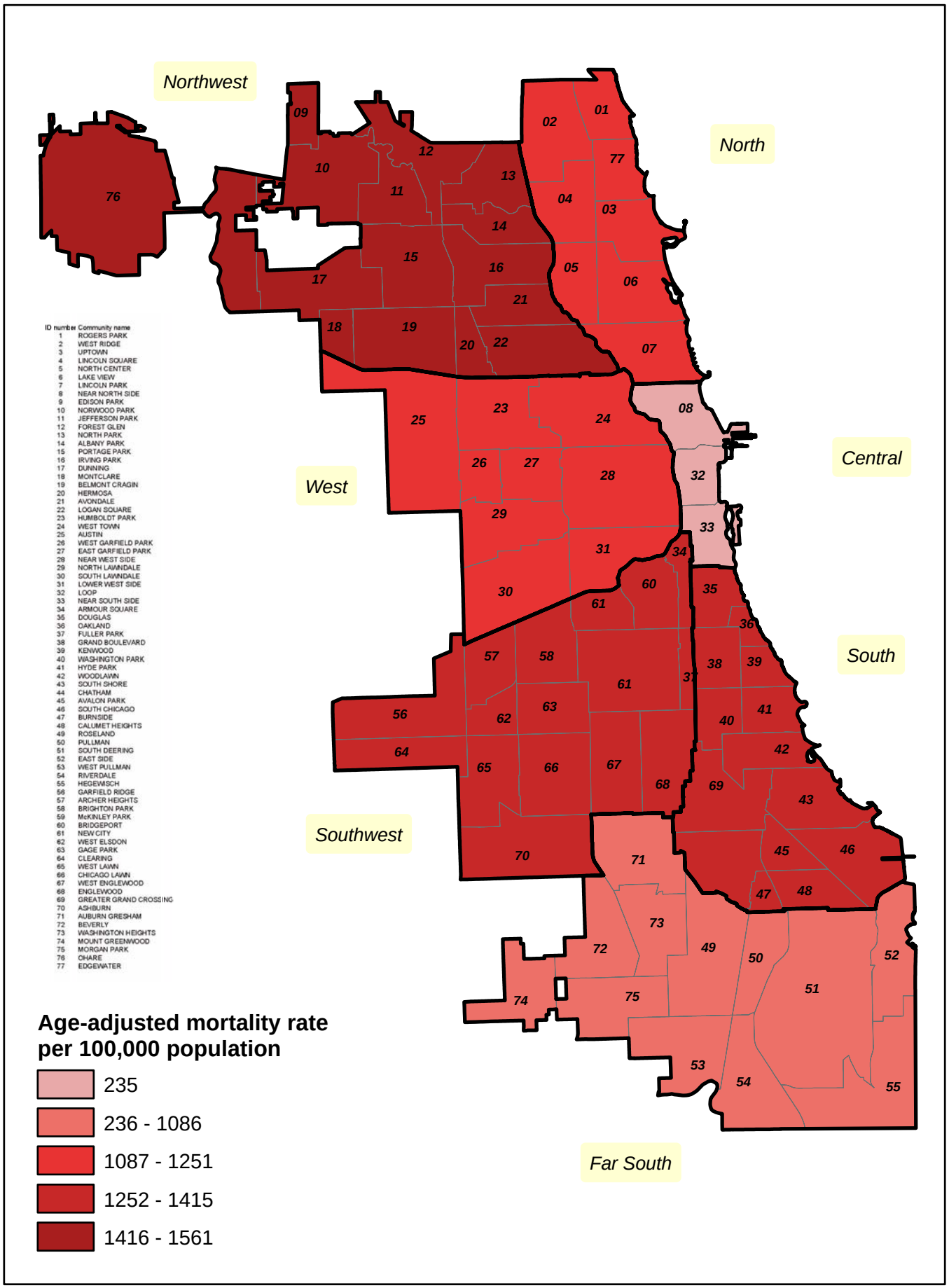
2002 Age-adjusted mortality rate by region



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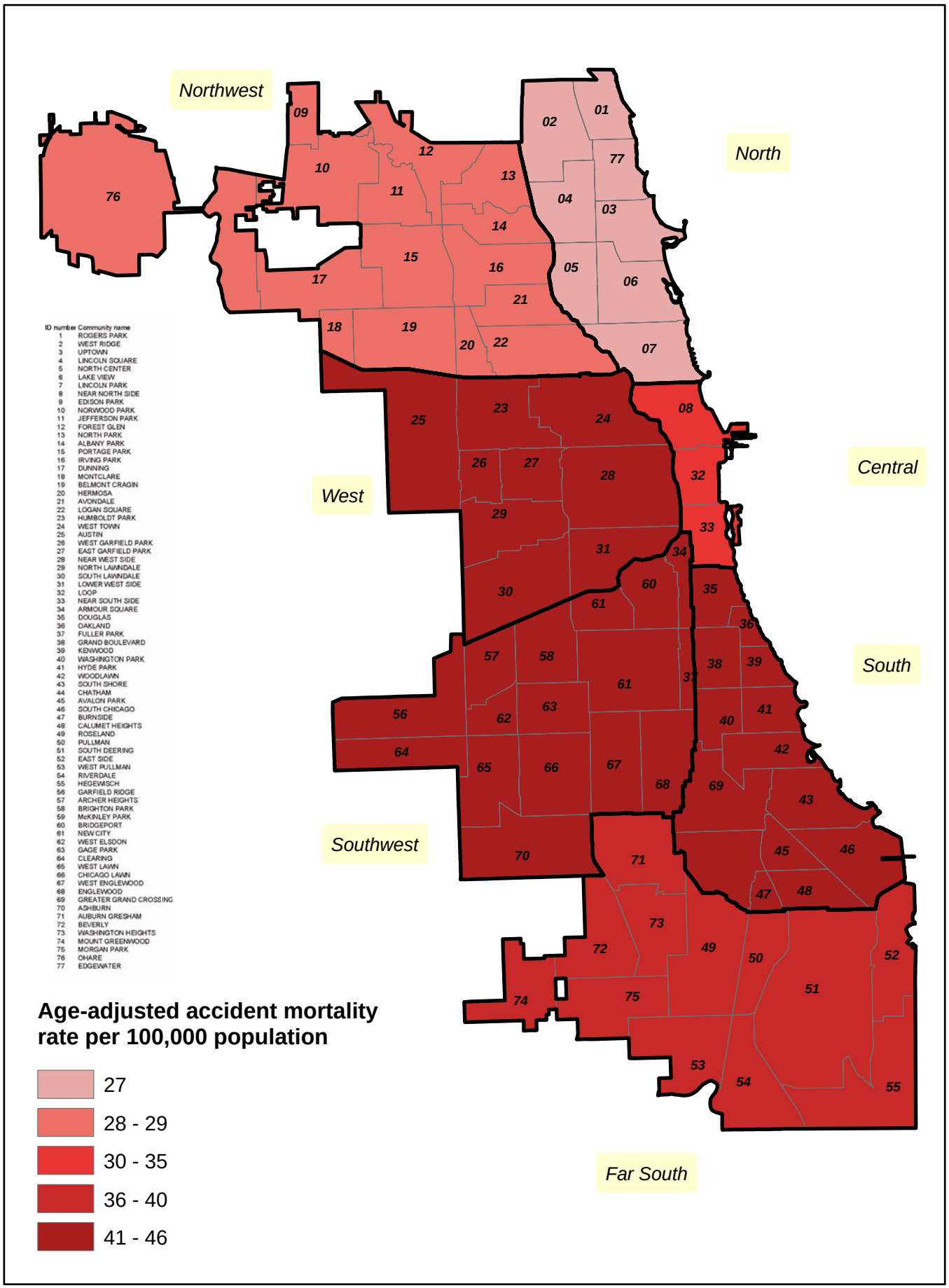
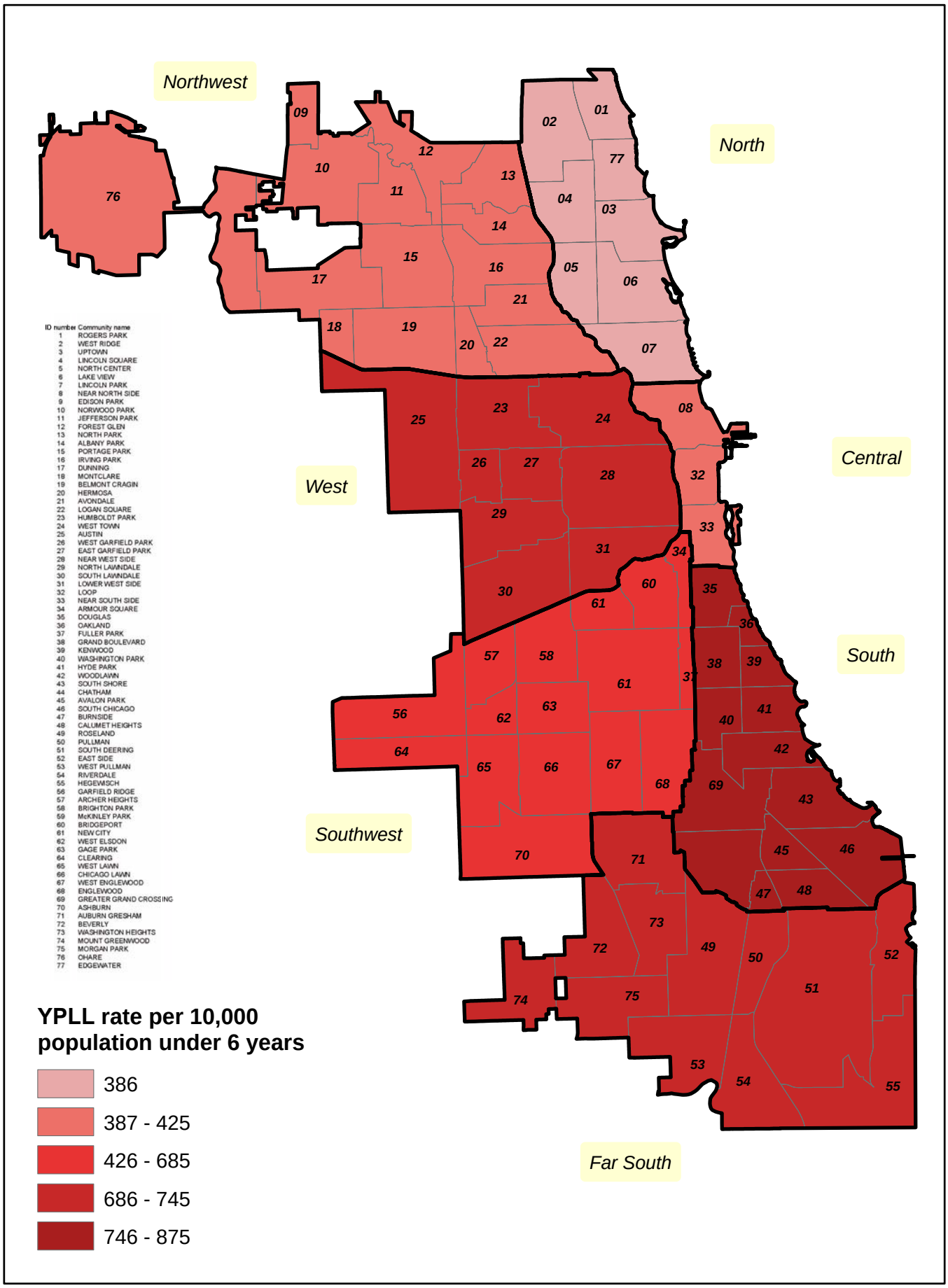
2002 Age-adjusted accident mortality rate by region



Chicago Department of Public Health
Planning Division

partnership 2002 accident mort 7-31-06.mxd
7/31/06

2002 Years of Potential Life Lost (YPLL) rate by region



Chicago Department of Public Health
Planning Division

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