2018 Community Health Needs Assessment Report

Saint Anthony Hospital Primary Service Area
Chicago, Illinois

Prepared for:
Saint Anthony Hospital

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Introduction

Professional Research Consultants, Inc.

Project Overview

Project Goals

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2009, 2012, and 2015, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the service area of Saint Anthony Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors that historically have had a negative impact on residents' health.
- **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of Saint Anthony Hospital by Professional Research Consultants, Inc. (PRC). PRC is a nationally recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey.

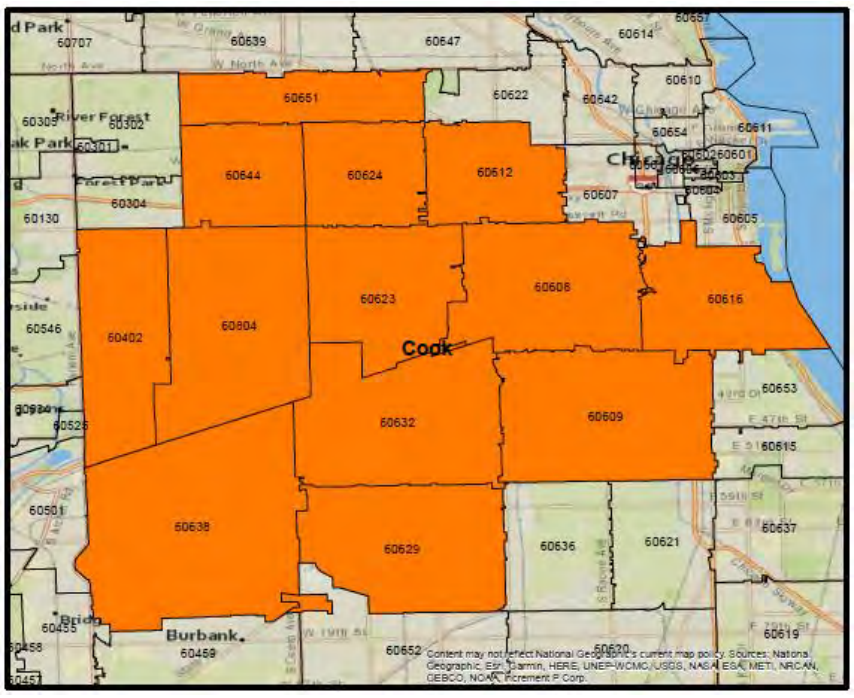
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Saint Anthony Hospital and PRC and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “Primary Service Area” or “the PSA” in this report) is defined as 13 zip codes (60651, 60644, 60624, 60612, 60402, 60804, 60623, 60608, 60616, 60638, 60632, 60609, and 60629). This community definition was determined because more than 90% of Saint Anthony Hospital's patients originate from this area. This community definition is illustrated in the following map.

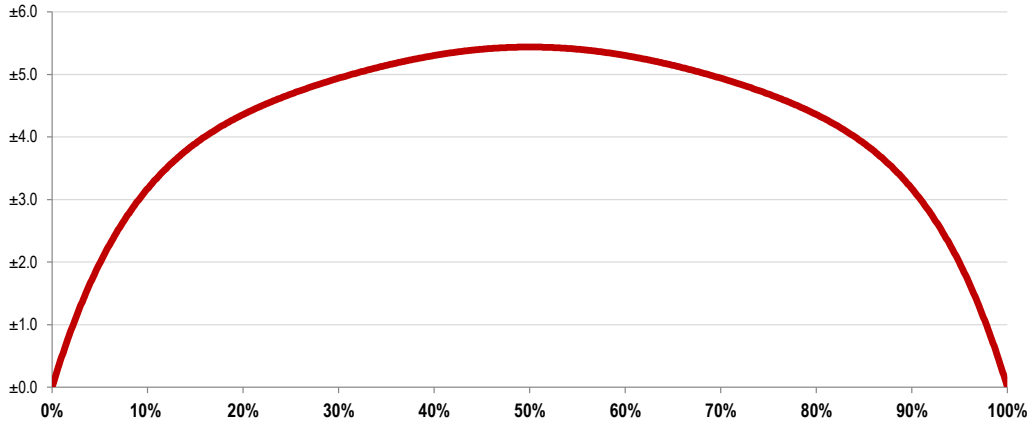


Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

The sample design used for this effort consisted of a random sample of 326 individuals age 18 and older in the Primary Service Area. All administration of the surveys, data collection and data analysis was conducted by PRC.

Expected Error Ranges for a Sample of 326 Respondents at the 95 Percent Level of Confidence



Note: The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

Examples: If 10% of the sample of 326 respondents answered a certain question with a "yes," it can be asserted that between 6.8% and 13.2% (10% 3.2%) of the total population would offer this response.

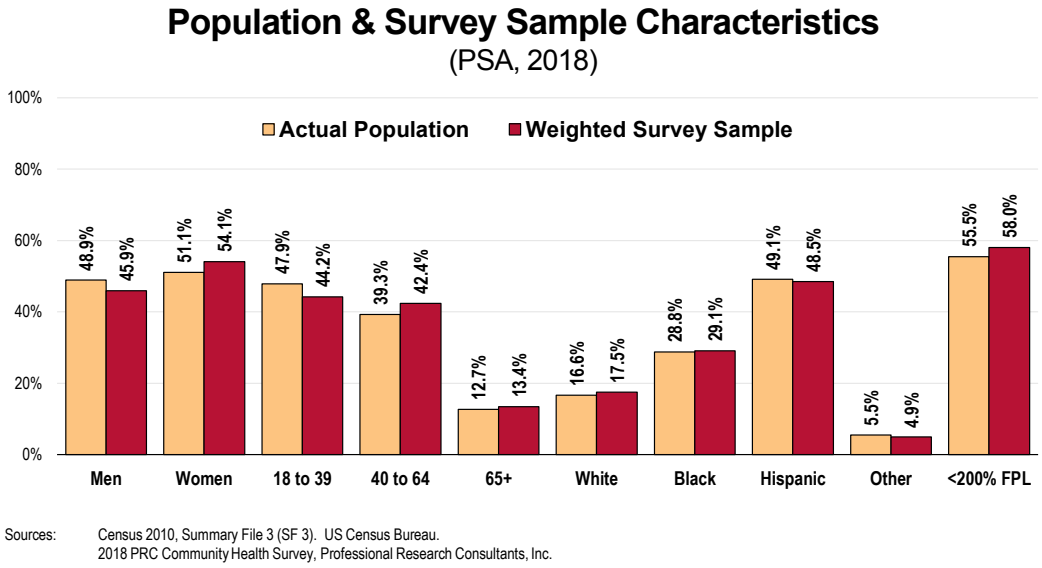
If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 44.6% and 55.4% (50% 5.4%) of the total population would respond "yes" if asked this question.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for

these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the Primary Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on



Sources: Census 2010, Summary File 3 (SF 3). US Census Bureau.
2018 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household *(e.g., the 2018 guidelines place the poverty threshold for a family of four at $25,100 annual household income or lower)*. In sample segmentation: "**very low income**" refers to community members living in a household with defined poverty status; "**low income**" refers to households with incomes just above the poverty level and earning up to twice (100%-199% of) the poverty threshold; and "**mid/high income**" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Saint Anthony Hospital; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 32 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	**Number Invited**	**Number Participating**
Physicians	18	4
Public Health Representatives	4	3
Other Health Providers	14	3
Social Services Providers	29	9
Other Community Leaders	31	13

Final participation included representatives of the organizations outlined below.

- Access Community Health Network/ Servicios Médicos La Villita
- Archdiocese of Chicago Domestic Violence Outreach
- Beyond the Ball
- Brighton Park Neighborhood Council
- Chicago Public Schools
- Chinese American Service League
- El Valor
- Enlace Chicago
- Esperanza Health Centers
- Illinois Department of Public Health
- IMAN Health Clinic
- Jesus Word Center
- John Marshall High School
- Lawndale Community Church
- New Covenant Community Development Corporation
- Rush Alzheimer's Disease Center
- St. Agatha Catholic Church
- State Farm Insurance
- The Learning Center /House of Connections
- The Peace and Education Coalition
- Universidad Popular
- University of Illinois at Chicago
- VIDA Pediatrics

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

Minority/medically underserved populations represented:

> *African-Americans, children, Chinese, disabled adults/children, family of homicide victims and perpetrators, Hispanics, homeless individuals, immigrants/refugees, LGBTQ, those with limited English, low-income residents, Middle Eastern, older adults, pregnant mothers, returning citizens, those with special needs, the undocumented, the uninsured/underinsured*

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area. Thus, these findings are not necessarily based on fact.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Primary Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Chicago Department of Public Heath, Epidemiology and Public Health Informatics
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services

- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that some secondary data reflect Cook County data, while death rates are specific to the targeted neighborhoods, as noted in charts and tables.

Benchmark Data

Trending

Similar surveys were administered in the Primary Service Area in 2009, 2012, and 2015 by PRC on behalf of Saint Anthony Hospital. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Illinois Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2017 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across communities and sectors.
- Empower individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Healthy People strives to:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.

- Provide measurable objectives and goals that are applicable at the national, State, and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data collection needs.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Form 990 Schedule H, the following table cross-references related sections.

IRS Form 990, Schedule H (2017)	See Report Page
Part V Section B Line 3a *A definition of the community served by the hospital facility*	9
Part V Section B Line 3b *Demographics of the community*	36
Part V Section B Line 3c *Existing health care facilities and resources within the community that are available to respond to the health needs of the community*	210
Part V Section B Line 3d *How data was obtained*	9
Part V Section B Line 3e *The significant health needs of the community*	17
Part V Section B Line 3f *Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups*	Addressed Throughout
Part V Section B Line 3g *The process for identifying and prioritizing community health needs and services to meet the community health needs*	19
Part V Section B Line 3h *The process for consulting with persons representing the community's interests*	11
Part V Section B Line 3i *The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)*	215

Summary of Findings

Significant Health Needs of the Community

The following "Areas of Opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in Healthy People 2020. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

Areas of Opportunity Identified Through This Assessment	

Access to Healthcare Services	• Barriers to Access
	  ○ Inconvenient Office Hours
	  ○ Finding a Physician
	  ○ Lack of Transportation
	  ○ Culture/Language
	• Specific Source of Ongoing Care
	• Routine Medical Care [Children]
	• Emergency Room Utilization
	• Low Health Literacy
	• Access to Healthcare ranked as a top concern in the Online Key Informant Survey.

Cancer	• Cancer is a leading cause of death. • Cancer Deaths ○ Including Prostate Cancer, Colorectal Cancer Deaths
Diabetes	• Diabetes Deaths • Diabetes Prevalence • Prevalence of Borderline/Pre-Diabetes • Diabetes ranked as a top concern in the Online Key Informant Survey.
Heart Disease & Stroke	• Cardiovascular disease is a leading cause of death. • Coronary Heart Disease Deaths • Heart Disease Prevalence • Stroke Prevalence • High Blood Pressure Prevalence • Overall Cardiovascular Risk

– continued on next page –

Areas of Opportunity Continued	
Injury & Violence	• Homicide Deaths • Violent Crime Rate [Cook County] • Violent Crime Experience • Neighborhood Is "Slightly/Not At All Safe" • Injury & Violence ranked as a top concern in the Online Key Informant Survey.
Kidney Disease	• Kidney Disease Deaths
Mental Health	• "Fair/Poor" Mental Health • Symptoms of Chronic Depression • Stress • Ever Sought Help for Mental Health • Adverse Childhood Experiences (ACEs) • Mental Health ranked as a top concern in the Online Key Informant Survey.
Nutrition, Physical Activity, & Weight	• Food Insecurity • Overweight & Obesity [Adults & Children] • Availability of Recreation/Fitness Facilities • Nutrition, Physical Activity, & Weight ranked as a top concern in the Online Key Informant Survey.
Potentially Disabling Conditions	• Activity Limitations • Sciatica/Chronic Back Pain Prevalence
Respiratory Diseases	• Asthma Prevalence [Adults & Children] • Chronic Obstructive Pulmonary Disease (COPD) Prevalence • Flu Vaccination [Age 65+]
Sexually Transmitted Diseases	• Gonorrhea Incidence [Cook County] • Chlamydia Incidence [Cook County] • HIV Prevalence [Cook County]
Substance Abuse	• Cirrhosis/Liver Disease Deaths • Alcohol Use • Illicit Drug Use • Substance Abuse ranked as a top concern in the Online Key Informant Survey.
Tobacco Use	• Cigarette Smoking Prevalence • Environmental Tobacco Smoke Exposure at Home ○ Including Among Households With Children

Community Feedback on Prioritization of Health Needs

On March 19, 2019, Saint Anthony Hospital convened two meetings to share the results of this assessment. The first meeting consisted of Saint Anthony Hospital leadership and staff, and the second included community stakeholders (representing a cross-section of community-based agencies and organizations). Each meeting had more than 30 attendees. The purpose of each meeting was to evaluate, discuss and prioritize health issues for the community, based on findings of this Community Health Needs Assessment (CHNA). PRC began the meetings with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above). PRC then provided participants with an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

- **Scope & Severity** — The first rating was to gauge the magnitude of the problem in consideration of the following:
    - How many people are affected?
    - How does the local community data compare to state or national levels, or Healthy People 2020 targets?
    - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

  Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

- **Ability to Impact** — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce a combined overall score representing input from both meetings. This process yielded the following prioritized list of community health needs:

1. **Diabetes**
2. **Mental Health**
3. **Access to Healthcare**
4. **Nutrition, Physical Activity & Weight**
5. **Heart Disease & Stroke**

6. **Injury & Violence**
7. **Cancer**
8. **Sexually Transmitted Diseases**
9. **Substance Abuse**
10. **Respiratory Diseases**
11. **Kidney Disease**
12. **Potentially Disabling Conditions**
13. **Tobacco Use**

Hospital Implementation Strategy

Saint Anthony Hospital will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the Primary Service Area, including comparisons with trend data. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.

Reading the Summary Tables

SURVEY DATA TREND SUMMARY
(Current vs. Baseline Data)

Trends for survey-derived indicators represent significant changes since 2009 (or the year that the indicator was first measured).

In the following charts, the Primary Service Area results are shown in the larger, blue column. For survey-derived indicators, this column represents the ZIP Code–defined hospital service area. For secondary sources, this column either represents findings specific to the targeted neighborhoods (e.g., death rates) or Cook County as a whole (e.g., cancer incidence, birth statistics). *Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.*

The columns to the right of the Primary Service Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2020 targets. Symbols indicate whether the Primary Service Area compares favorably (), unfavorably (), or comparably () to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Social Determinants	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
[Median] Linguistically Isolated Population (Percent)	36.5	4.6	4.5		
[Median] Population in Poverty (Percent)	27.0	14.0	15.1		
[Median] No High School Diploma (Age 25+, Percent)	26.7	11.7	13.0		
% Worry/Stress Over Rent/Mortgage in Past Year	41.7		30.8		
% Low Health Literacy	29.0		23.3		
% Household Mental Illness ACE*	12.0				
% Household Substance Abuse ACE*	26.2				
% Incarcerated Household Member ACE*	7.5				
% Parental Separation or Divorce ACE*	31.4				
% Intimate Partner Violence ACE*	20.3				
% Physical Abuse ACE*	20.0				
% Emotional Abuse ACE*	39.1				
% Sexual Abuse ACE*	15.2				
% High ACE* Score (4 or More)	15.9				
% Sense of Community Belonging is "Somewhat/Very" Weak	30.4				

** ACE = Adverse Childhood Experience*

better	similar	worse	

Overall Health	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
% "Fair/Poor" Overall Health	26.0	17.9	18.1		18.8
% Activity Limitations	23.1	17.7	25.0		11.0
% Caregiver to a Friend/Family Member	25.1		20.8		
		better	similar	worse	

Access to Health Services	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
% [Age 18-64] Lack Health Insurance	18.4	12.6	13.7	0.0	44.7
% Was Without Insurance Coverage in Past Year	9.7				13.2
% Difficulty Accessing Healthcare in Past Year (Composite)	45.0		43.2		44.3
% Difficulty Finding Physician in Past Year	15.1		13.4		6.9
% Difficulty Getting Appointment in Past Year	19.8		17.5		18.0
% Cost Prevented Physician Visit in Past Year	17.7		15.4		21.8
% Transportation Hindered Dr Visit in Past Year	13.7		8.3		17.8
% Inconvenient Hrs Prevented Dr Visit in Past Year	19.6		12.5		21.2
% Language/Culture Prevented Care in Past Year	4.5		1.2		
% Cost Prevented Getting Prescription in Past Year	19.1		14.9		32.4

Access to Health Services (continued)	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
% Skipped Prescription Doses to Save Costs	15.0		15.3		17.3
% Difficulty Getting Child's Healthcare in Past Year	11.1		5.6		4.0
[Cook County] Primary Care Doctors per 100,000	123.2	96.9	87.8		
% Have a Specific Source of Ongoing Care	68.0		74.1	95.0	57.7
% Have Had Routine Checkup in Past Year	79.5	70.1	68.3		67.9
% Child Has Had Checkup in Past Year	89.3		87.1		98.7
% Two or More ER Visits in Past Year	21.0		9.3		
% Rate Local Healthcare "Fair/Poor"	18.6		16.2		32.1
		better	similar	worse	

Cancer	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
Cancer (Age-Adjusted Death Rate)	179.1	184.7	176.7	161.4	
Lung Cancer (Age-Adjusted Death Rate)	54.3	51.7	49.5	45.5	
Prostate Cancer (Age-Adjusted Death Rate)	29.5	24.2	23.0	21.8	
Female Breast Cancer (Age-Adjusted Death Rate)	24.9	23.7	22.7	20.7	

Cancer (continued)	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
Colorectal Cancer (Age-Adjusted Death Rate)	21.3	18.2	16.6	14.5	
[Cook County] Female Breast Cancer Incidence Rate	129.5	130.0	123.5		
[Cook County] Prostate Cancer Incidence Rate	123.1	119.4	114.8		
[Cook County] Lung Cancer Incidence Rate	62.0	66.8	61.2		
[Cook County] Colorectal Cancer Incidence Rate	46.2	44.5	39.8		
[Cook County] Cervical Cancer Incidence Rate	8.9	7.7	7.6		
% Cancer (Other Than Skin)	3.6	6.2	7.1		3.7
% Skin Cancer	1.9	4.6	8.5		0.2
% [Women 50-74] Mammogram in Past 2 Years	80.6	78.0	77.0	81.1	76.1
% [Women 21-65] Pap Smear in Past 3 Years	75.5	83.8	73.5	93.0	79.6
% [Age 50-75] Colorectal Cancer Screening	81.6	63.5	76.4	70.5	68.5
		better	similar	worse	

Dementias, Including Alzheimer's Disease	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
Alzheimer's Disease (Age-Adjusted Death Rate)	14.5	21.4	24.5		
		better	similar	worse	

Diabetes	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
Diabetes (Age-Adjusted Death Rate)	26.9	20.9	22.0	20.5	
% Diabetes/High Blood Sugar	20.5	11.0	13.3		8.0
% Borderline/Pre-Diabetes	8.6		9.5		1.2
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	51.1		50.0		53.4
		better	similar	worse	

Heart Disease & Stroke	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
Coronary Heart Disease (Age-Adjusted Death Rate)	155.8	122.6	124.8	103.4	
Stroke (Age-Adjusted Death Rate)	47.2	42.5	41.8	34.8	
% Heart Disease (Heart Attack, Angina, Coronary Disease)	7.7		8.0		1.6
% Stroke	4.3	2.7	4.7		1.2
% Blood Pressure Checked in Past 2 Years	89.0		90.4	92.6	91.8
% Told Have High Blood Pressure (Ever)	38.3	30.8	37.0	26.9	18.3
% [HBP] Taking Action to Control High Blood Pressure	96.5		93.8		99.2
% Cholesterol Checked in Past 5 Years	86.3	86.8	85.1	82.1	88.8
% Told Have High Cholesterol (Ever)	26.6		36.2	13.5	27.4

Heart Disease & Stroke (continued)	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
% [HBC] Taking Action to Control High Blood Cholesterol	84.7		87.3		94.7
% 1+ Cardiovascular Risk Factor	90.3		87.2		77.9
		better	similar	worse	

HIV	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
[Cook County] HIV Prevalence Rate	602.0	322.9	353.2		
% [Age 18-44] HIV Test in the Past Year	37.4		24.7		33.7
		better	similar	worse	

Immunization & Infectious Diseases	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
% [Age 65+] Flu Vaccine in Past Year	56.6	54.9	76.8	70.0	72.2
% [High-Risk 18-64] Flu Vaccine in Past Year	50.1		55.7	70.0	52.0
% [Age 65+] Pneumonia Vaccine Ever	71.0	73.8	82.7	90.0	54.1
% [High-Risk 18-64] Pneumonia Vaccine Ever	44.7		39.9	60.0	49.5
		better	similar	worse	

Infant Health & Family Planning	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
[Cook County] No Prenatal Care in First Trimester (Percent)	5.6	5.4	17.3	22.1	
[Cook County] Low Birthweight Births (Percent)	9.1	8.4	8.2	7.8	
[Cook County] Infant Death Rate	7.4	6.9	6.5	6.0	
[Cook County] Births to Teenagers Under Age 20 (Percent)	42.2	35.0	36.6		
		better	similar	worse	

Injury & Violence	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
Unintentional Injury (Age-Adjusted Death Rate)	32.0	32.5	39.1	36.4	
Firearm-Related Deaths (Age-Adjusted Death Rate)	10.1	8.2	10.2	9.3	
Homicide (Age-Adjusted Death Rate)	11.6	6.7	5.8	5.5	
[Cook County] Violent Crime Rate	586.7	397.0	379.7		
% Victim of Violent Crime in Past 5 Years	7.7		3.7		13.8
% Victim of Domestic Violence (Ever)	13.7		14.2		18.2
% Perceive Neighborhood as "Slightly/Not At All Safe"	50.4		15.6		
% Lost a Loved One Due to Violence	26.1				
% [Child 5-17] Missed School for Safety Reasons/Past Year	11.2				10.1
		better	similar	worse	

Kidney Disease	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
Kidney Disease (Age-Adjusted Death Rate)	22.3	19.6	15.0		
% Kidney Disease	5.0	3.6	3.8		2.7
		better	similar	worse	

Mental Health	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
% "Fair/Poor" Mental Health	24.4		13.0		10.6
% Diagnosed Depression	20.0	17.8	21.6		15.7
% Symptoms of Chronic Depression (2+ Years)	39.1		31.4		29.9
% Typical Day Is "Extremely/Very" Stressful	16.3		13.4		7.0
Suicide (Age-Adjusted Death Rate)	4.9	8.8	11.6	10.2	
% Taking Rx/Receiving Mental Health Trtmt	12.6		13.9		
% Have Ever Sought Help for Mental Health	25.0		30.8		9.3
% [Those With Diagnosed Depression] Seeking Help	83.0		87.1		73.1
% Unable to Get Mental Health Svcs in Past Yr	10.4		6.8		
		better	similar	worse	

Nutrition, Physical Activity & Weight	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
% Food Insecure	39.5		27.9		
% "Very/Somewhat" Difficult to Buy Fresh Produce	24.6		22.1		29.4
% No Leisure-Time Physical Activity	26.7	24.0	26.2	32.6	32.2
% Meeting Physical Activity Guidelines	19.9	21.6	22.8	20.1	
[Median] Recreation/Fitness Facilities per 100,000	1.6	10.9	11.0		
% "Very/Somewhat" Difficult to Access a Place for Exercise	30.7				26.3
% Healthy Weight (BMI 18.5-24.9)	24.4	32.5	30.3	33.9	37.3
% Overweight (BMI 25+)	72.0	65.8	67.8		61.5
% Obese (BMI 30+)	40.7	31.1	32.8	30.5	30.1
% Medical Advice on Weight in Past Year	40.0		24.2		21.3
% [Overweights] Counseled About Weight in Past Year	49.2		29.0		51.5
% Child [Age 5-17] Healthy Weight	31.3		58.4		46.3
% Children [Age 5-17] Overweight (85th Percentile)	49.1		33.0		41.2
% Children [Age 5-17] Obese (95th Percentile)	34.4		20.4	14.5	22.9
% Child [Age 2-17] Physically Active 1+ Hours per Day	40.7		50.5		48.4
		better	similar	worse	

Oral Health	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
% Have Dental Insurance	69.1		59.9		42.3
% [Age 18+] Dental Visit in Past Year	56.8	65.5	59.7	49.0	57.3
% Child [Age 2-17] Dental Visit in Past Year	89.8		87.0	49.0	86.0
		better	similar	worse	

Potentially Disabling Conditions	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
% Multiple Chronic Conditions	57.3		56.8		
% [50+] Arthritis/Rheumatism	42.5		38.3		37.2
% [50+] Osteoporosis	5.5		9.4	5.3	12.5
% Sciatica/Chronic Back Pain	23.9		22.9		10.4
		better	similar	worse	

Respiratory Diseases	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
% [Adult] Currently Has Asthma	18.3	8.2	11.8		3.5
% [Child 0-17] Currently Has Asthma	16.1		9.3		3.7
% COPD (Lung Disease)	10.5	6.7	8.6		3.9
		better	similar	worse	

Sexually Transmitted Diseases	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
[Cook County] Chlamydia Incidence Rate	713.1	515.6	456.1		
[Cook County] Gonorrhea Incidence Rate	198.2	124.0	110.7		
		better	similar	worse	

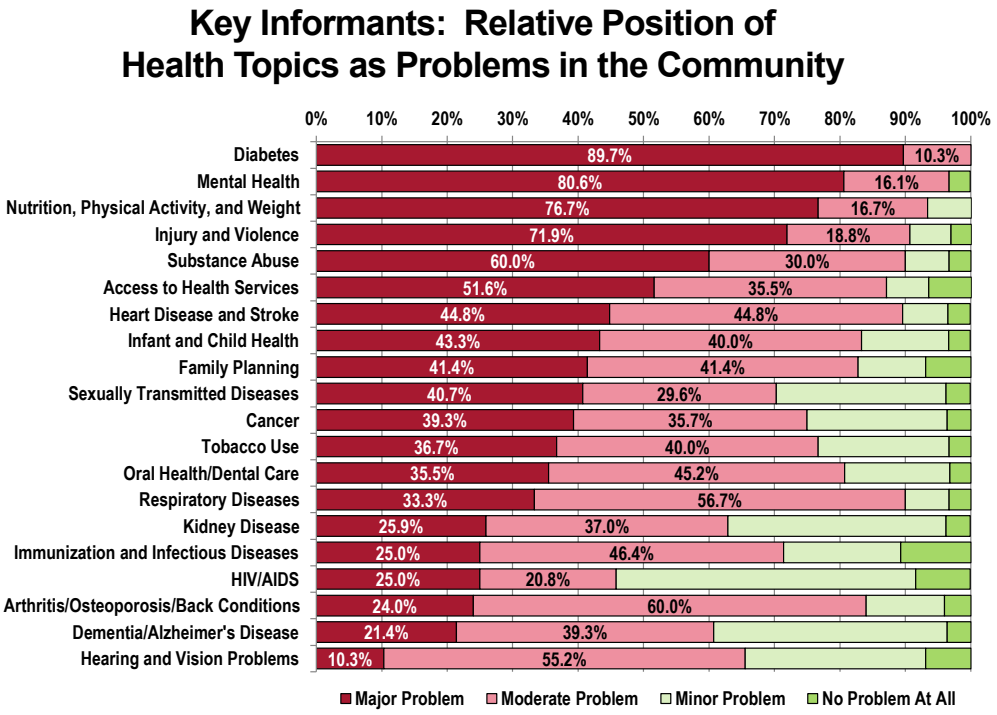
Sickle-Cell Anemia	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
% Sickle-Cell Anemia	4.1				1.9
		better	similar	worse	

Substance Abuse	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	13.3	8.2	9.1	8.2	
% Liver Disease	5.6				2.3
% Current Drinker	54.8	58.8	55.0		39.6
% Binge Drinker (Single Occasion - 5+ Drinks Men, 4+ Women)	20.6	20.3	20.0	24.4	19.6
% Excessive Drinker	22.9		22.5	25.4	22.6
% Illicit Drug Use in Past Month	6.0		2.5	7.1	3.6
% Ever Sought Help for Alcohol or Drug Problem	7.2		3.4		7.4
% Life Negatively Affected by Substance Abuse	31.9		37.3		
		better	similar	worse	

Tobacco Use	PSA	PSA vs. Benchmarks			TREND
		vs. IL	vs. US	vs. HP2020	
% Current Smoker	24.4	15.5	16.3	12.0	21.4
% Someone Smokes at Home	20.7		10.7		19.9
% [Nonsmokers] Someone Smokes in the Home	6.2		4.0		15.8
% [Household With Children] Someone Smokes in the Home	21.8		7.2		18.6
% [Smokers] Have Quit Smoking 1+ Days in Past Year	77.3			80.0	
		better	similar	worse	

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 20 health issues is a problem in their own community, using a scale of "major problem," "moderate problem," "minor problem," or "no problem at all." The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)



Community Description

Professional Research Consultants, Inc.

Population Characteristics

Total Population

Total Population
(Estimated Population, 2012-2016)

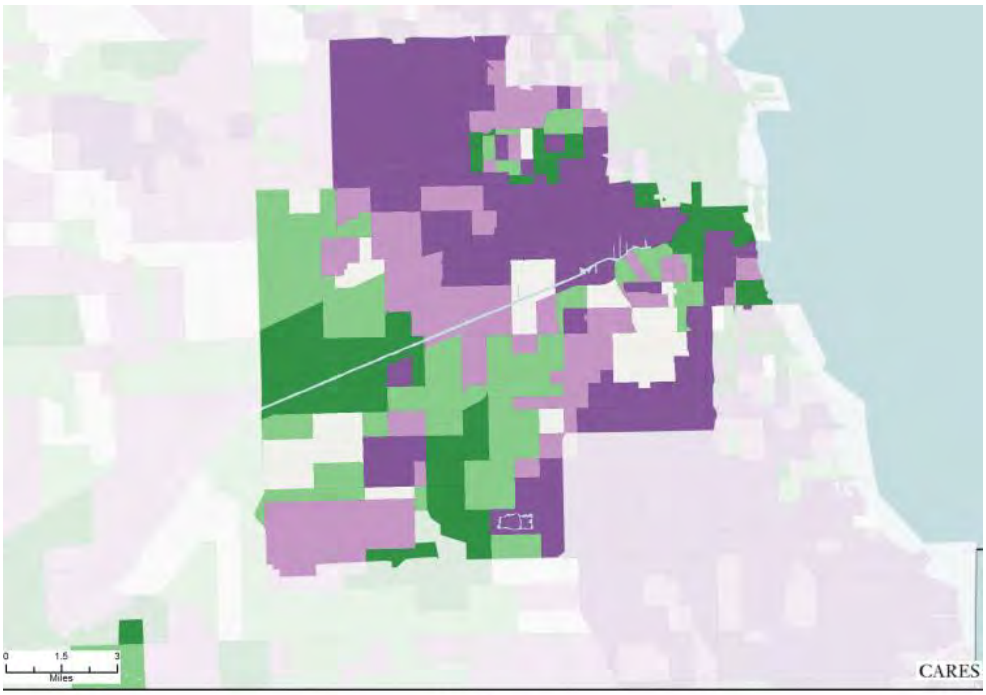
	Total Population
Primary Service Area (PSA)	635,429
Cook County	5,227,575
Illinois	12,851,684
United States	318,558,162

Population Change 2000-2010

A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

Between the 2000 and 2010 US Censuses, growth primarily occurred in the southwestern census tracts of the Primary Service Area.

- Many of the census tracts closer to downtown realized a decrease in population size.



Map Legend

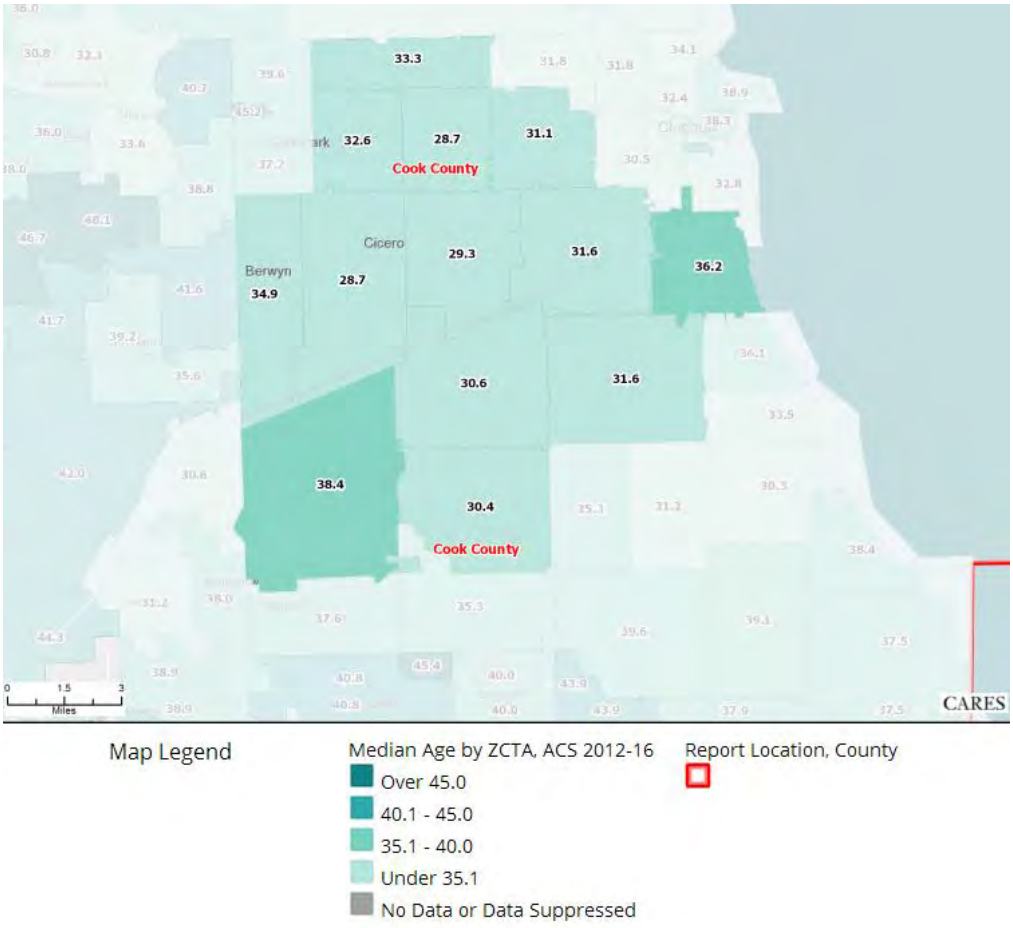
Population Change, Percent by Tract, US Census 2000 - 2010

- Over 10.0% Increase (+)
- 1.0 - 10.0% Increase (+)
- Less Than 1.0% Change (+/-)
- 1.0 - 10.0% Decrease (-)
- Over 10.0% Decrease (-)
- No Population or No Data

Median Age

The Primary Service Area is relatively "young" in that the median age in nearly every ZIP Code is lower than the median ages countywide (36.1), statewide (37.4), and nationally (37.7).

The median of these median ages among the service area ZIP Codes is 31.6 years old.



Social Determinants of Health

About Social Determinants

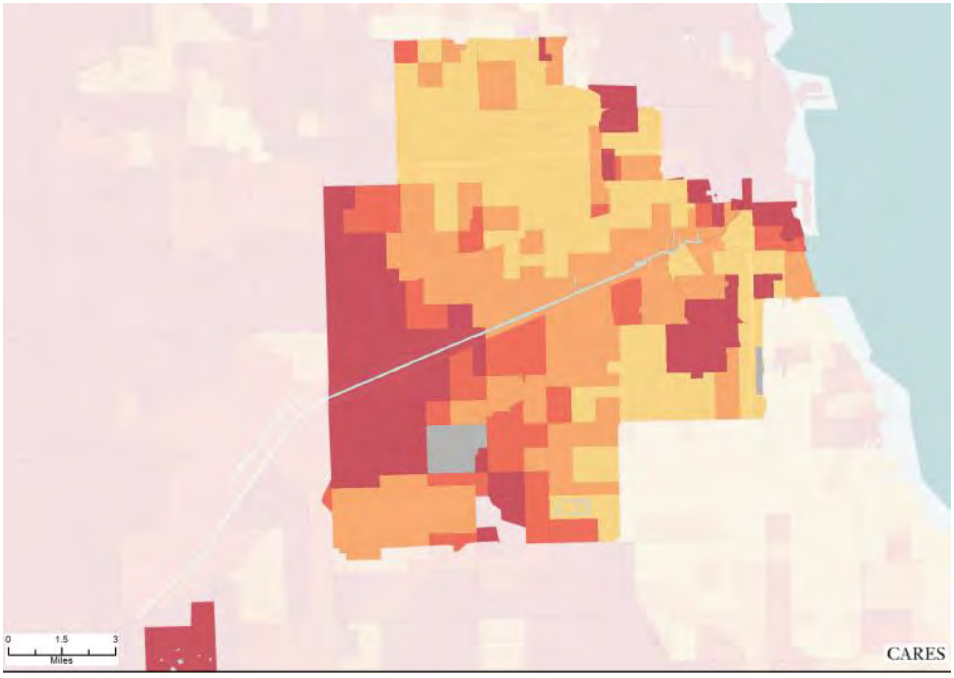
Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

— Healthy People 2020 (www.healthypeople.gov)

Income & Poverty

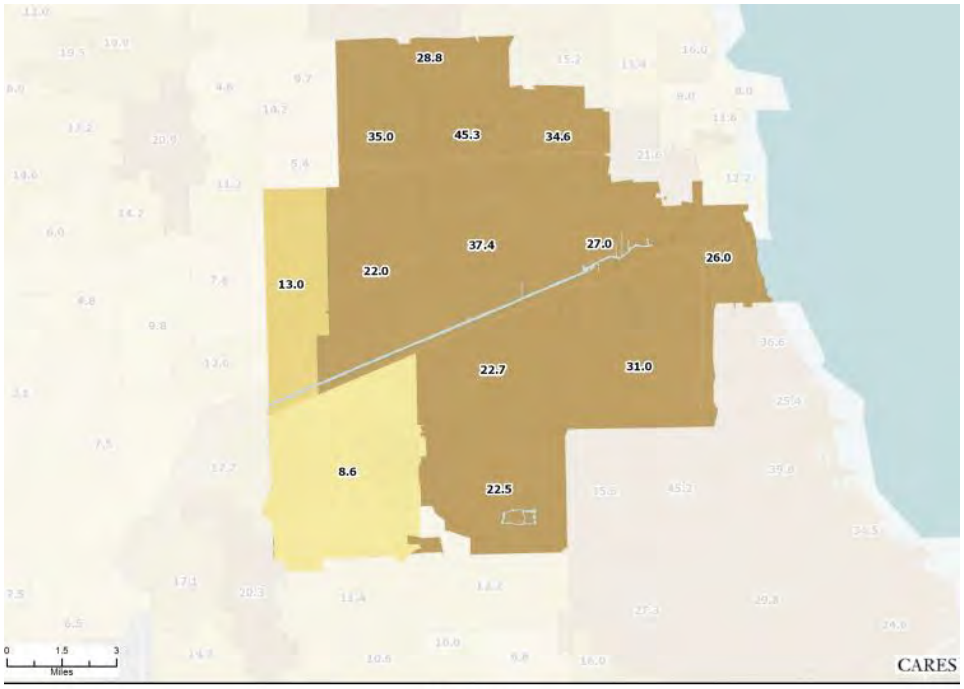
Median household incomes are well below the medians countywide ($56,902), statewide ($59,196), and nationally ($55,322).

- As noted in the following map, many census tracts in the Primary Service Area have median incomes below $35,001 per year.



The percentages of Primary Service Area residents living below the federal poverty level are much higher than found countywide (16.7%), statewide (14.0%), or nationally (15.1%).

- The median percentage among the service area ZIP Codes is 27.0% below the federal poverty level.

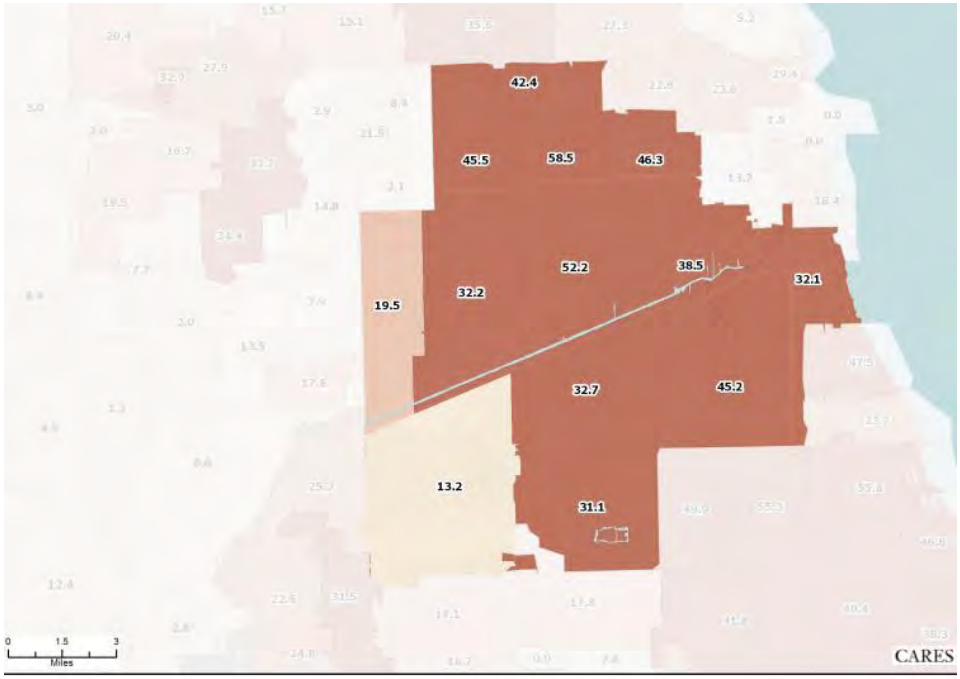


Map Legend

Population Below the Poverty Level, Percent by ZCTA, ACS 2012-16

- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed

For the child population, the proportion living below the poverty level is even higher than for adults (including a majority of children in poverty in two of the ZIP Codes of the Primary Service Area).



Map Legend

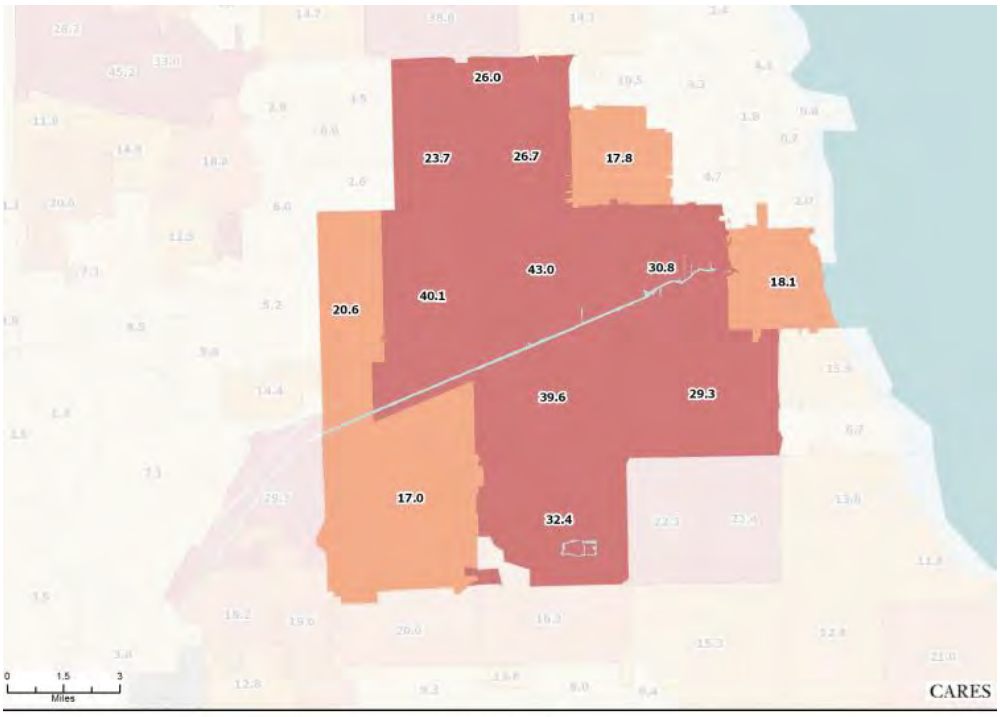
Population Below the Poverty Level, Children (Age 0-17), Percent by ZCTA, ACS 2012-16

- Over 30.0%
- 22.6 - 30.0%
- 15.1 - 22.5%
- Under 15.1%
- No Population Age 0-17 Reported
- No Data or Data Suppressed

Education

Among the Primary Service area population age 25 and older, relatively high percentages do not have a high school education.

- Among the service area ZIP Codes, a median of 26.7% of adult residents do not have a high school diploma, much higher than throughout Cook County (14.2%), Illinois (11.7%), or the US (13.0%).



Map Legend

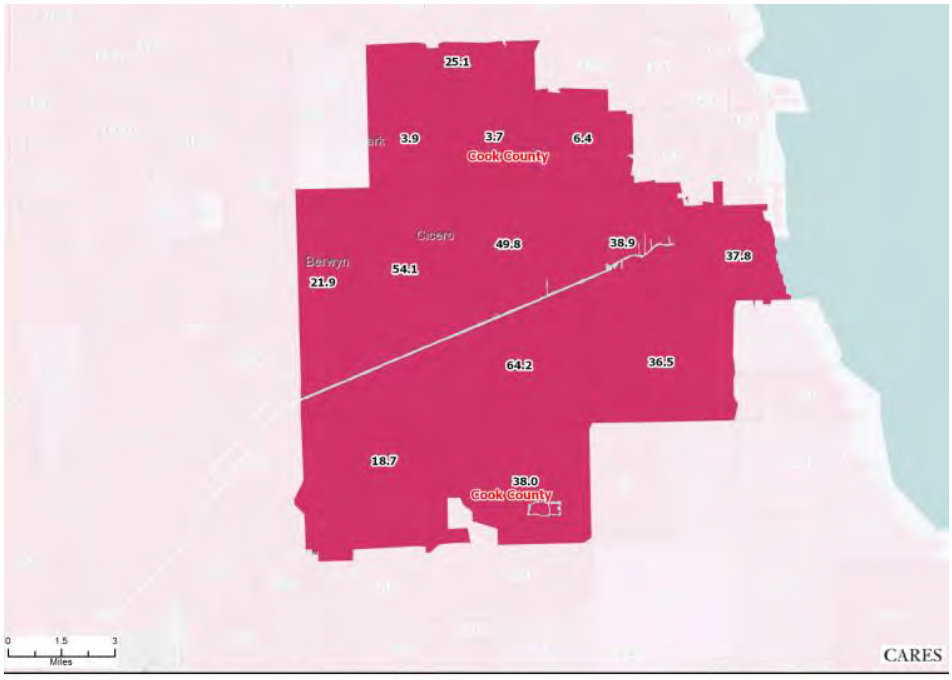
Population with No High School Diploma (Age 25+), Percent by ZCTA, ACS 2012-16

- Over 21.0%
- 16.1 - 21.0%
- 11.1 - 16.0%
- Under 11.1%
- No Data or Data Suppressed

Linguistic Isolation

In some ZIP Codes of the Primary Service area, a majority of the population age 5 and older lives in a home in which no persons age 14 or older is proficient in English (speaking only English, or speaking English "very well").

- The median percentage among the service area ZIP Codes is 36.5%. By comparison, these percentages are much lower countywide (7.5%), and especially statewide (4.6%) and nationally (4.5%).



Map Legend

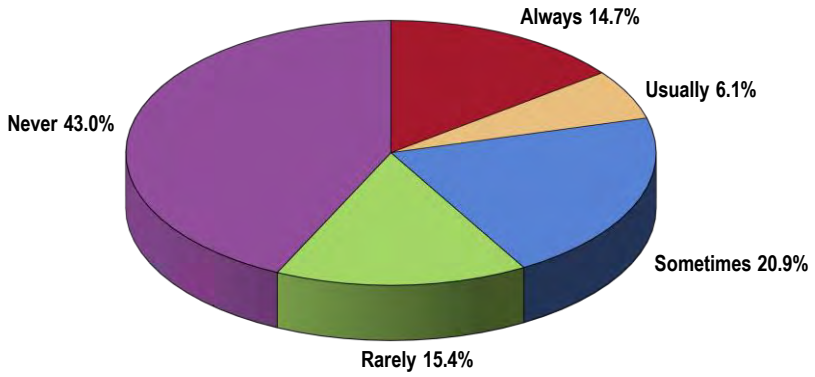
Population in Linguistically Isolated Households, Percent by ZCTA, ACS 2012-16
- Over 3.0%
- 1.1 - 3.0%
- 0.1 - 1.1%
- No Population in Linguistically Isolated Households
- No Data or Data Suppressed

Report Location, County

Housing Insecurity

While most Primary Service Area adults rarely, if ever, worry about the cost of housing, a considerable share (41.7%) reported that they were "sometimes," "usually," or "always" worried or stressed about having enough money to pay their rent or mortgage

Frequency of Worry or Stress Over Paying Rent/Mortgage in the Past Year
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 71]
Notes: Asked of all respondents.

NOTE:

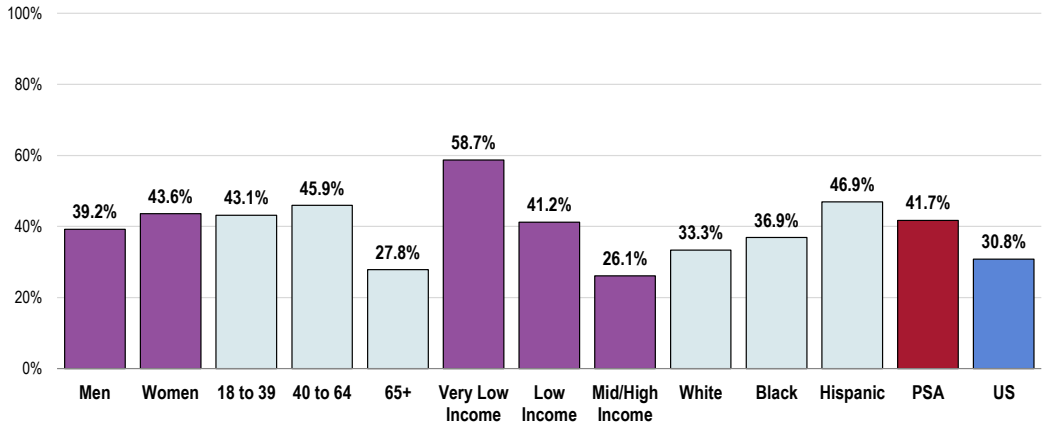
Differences noted in the text represent significant differences determined through statistical testing.

Trends are measured against baseline data – i.e., the earliest year that data are available or that is presented in this report.

Charts throughout this report (such as that here) detail survey findings among key demographic groups – namely by sex, age groupings, income (based on poverty status), and race/ethnicity.

- Compared to the US prevalence, the proportion of Primary Service Area adults who worried about paying for rent or mortgage in the past year is far less favorable.
- Adults more likely to report housing insecurity include adults under age 65 and residents living at low or very low incomes. In addition, Hispanics are more likely to worry about their rent or mortgage.
- Other differences within demographic groups, as illustrated in the following chart, are not statistically significant.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 71]
2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Food Insecurity

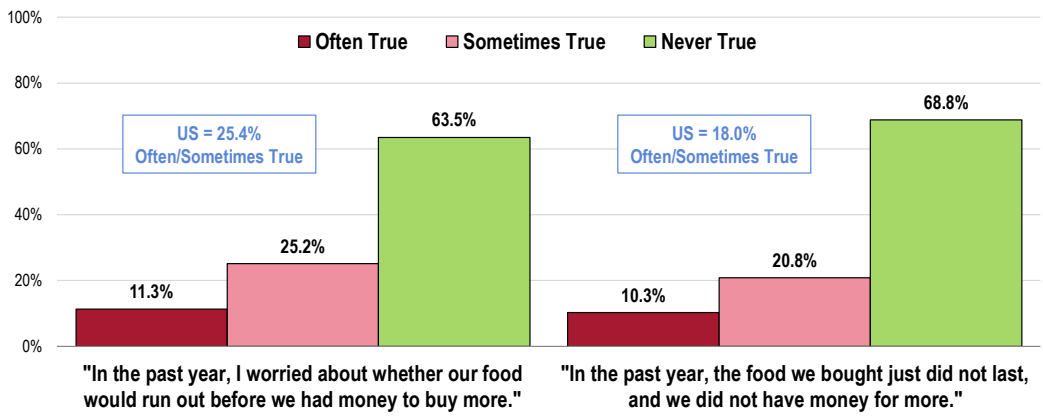
In the past year, 36.5% of Primary Service Area adults "often" or "sometimes" worried about whether their food would run out before they had money to buy more.

- Higher than seen nationally.

Another 31.1% report a time in the past year ("often" or "sometimes") when the food they bought just did not last, and they did not have money to get more.

- Also higher than found nationally.

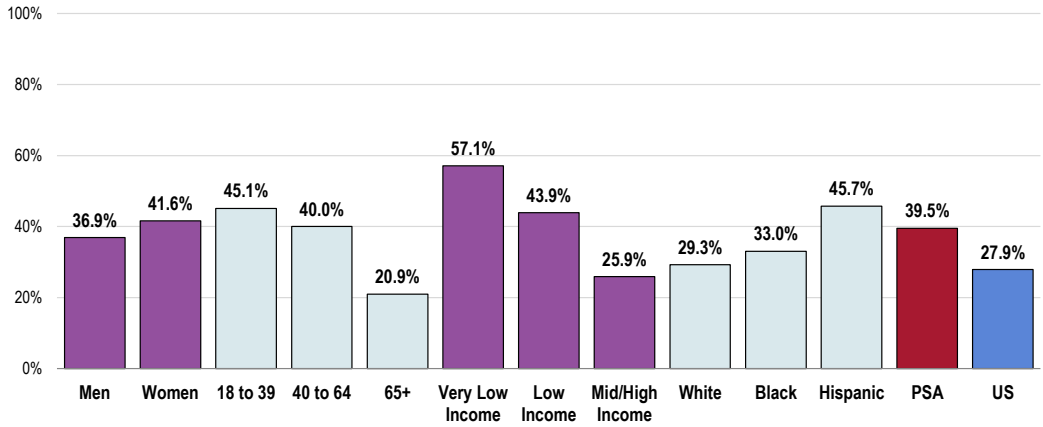
Food Insecurity
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 87-88]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Reflects the total sample of respondents.

Overall, 39.5% of community residents are determined to be "food insecure," having run out of food in the past year and/or been worried about running out of food.

Food Insecurity
(PSA, 2018)



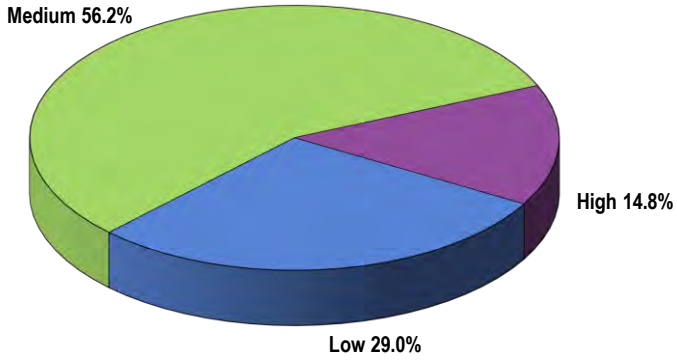
Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Health Literacy

Population With Low Health Literacy

Low health literacy is defined as those respondents who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Level of Health Literacy
(PSA, 2018)

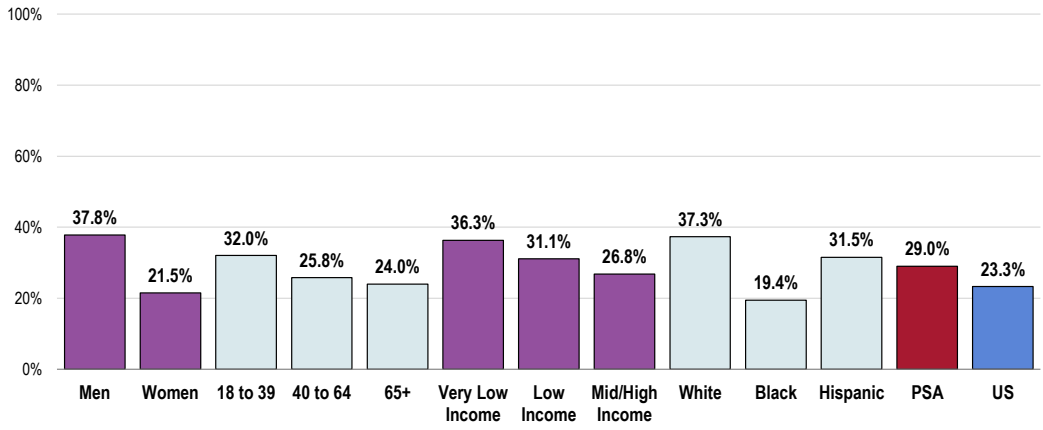


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 172]
Notes: Asked of all respondents.
Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

- Higher than national findings.
- Men, White adults and Hispanic adults are more likely to have low levels of health literacy.

Low Health Literacy

(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 172]
2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Understanding Health Information

Respondents were read:

"You can find written health information on the internet, in newspapers and magazines, on medications, at the doctor's office, in clinics, and many other places.

How often is health information **written** in a way that is easy for you to understand?

How often is health information **spoken** in a way that is easy for you to understand?"

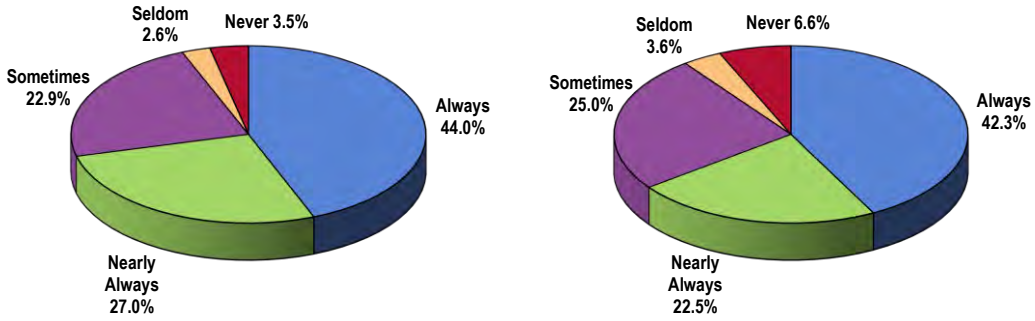
The following individual measures are used to determine the health literacy levels described above.

Written & Spoken Information

While a majority of Primary Service Area adults generally find health information to be easy to understand, 6.1% experience some difficulty with written health information and 10.2% experience considerable difficulty with spoken health information (responding "seldom" or "never" easy to understand).

Frequency With Which Health Information Is _____ in a Way That is Easy to Understand

(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 74, 76]
Notes: Asked of all respondents.

Reading Health Information & Completing Health Forms

A total of 14.6% of Primary Service Area adults "always" or "nearly always" need to have someone help them read health information.

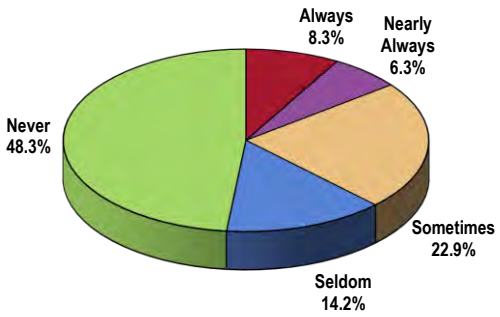
Respondents were read:

"People who might help you read health information include family members, friends, caregivers, doctors, nurses, or other health professionals. How often do you need to have someone help you read health information?"

"Health forms include insurance forms, questionnaires, doctor's office forms, and other forms related to health and health care. In general, how confident are you in your ability to fill out health forms yourself?

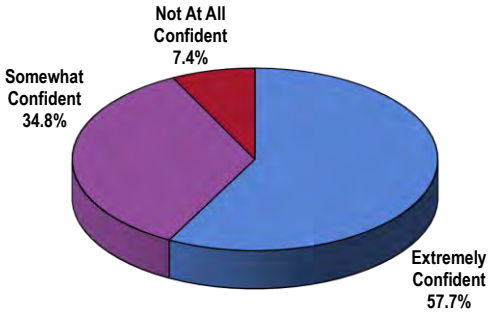
Frequency of Needing Help Reading Health Information

(PSA, 2018)



Confidence in Ability to Fill Out Health Forms

(PSA, 2018)

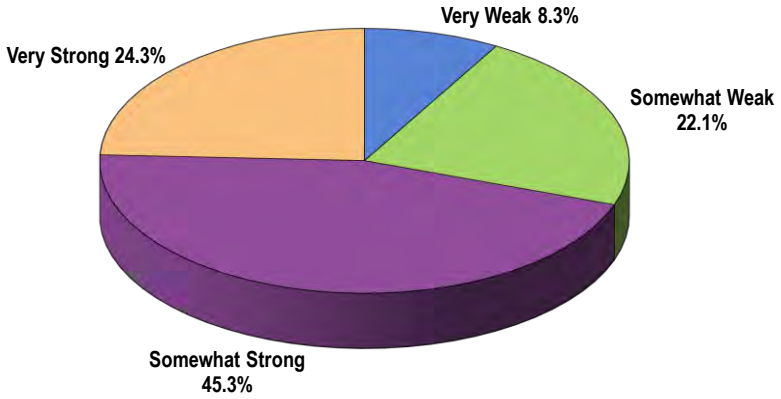


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 75, 77]
Notes: Asked of all respondents.
In this case, health forms include insurance forms, questionnaires, doctor's office forms, and other forms related to health and healthcare.

Sense of Community Belonging

While the majority of residents in the Primary Service Area report feeling a strong attachment to the community ("very strong" or "somewhat strong"), three in 10

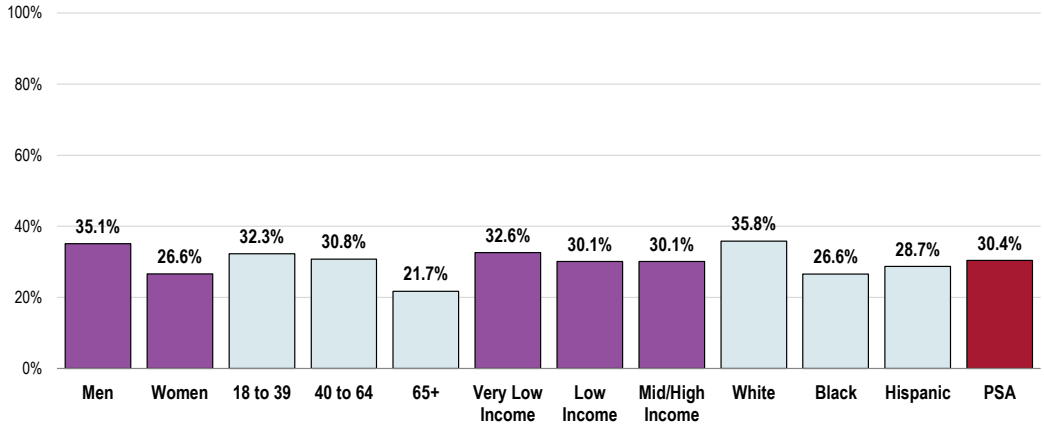
Sense of Belonging in the Community
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 324]
Notes: Asked of all respondents.

This weak sense of community belonging is statistically similar within the

Feel a "Somewhat/Very Weak" Sense of Belonging in the Community
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 324]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Adverse Childhood Experiences (ACEs)

About ACEs

Adverse Childhood Experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They are a significant risk factor for substance abuse disorders and can impact prevention efforts. ACEs include:

- Physical abuse
- Sexual Abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Intimate partner violence
- Mother treated violently
- Household substance misuse
- Household mental illness
- Parental separation/divorce
- Incarcerated household member

A series of 11 survey questions were used to identify adults' experiences of adverse childhood events prior to the age of 18 years. These 11 questions align with 8 ACEs

Adverse Childhood Experiences (ACEs)

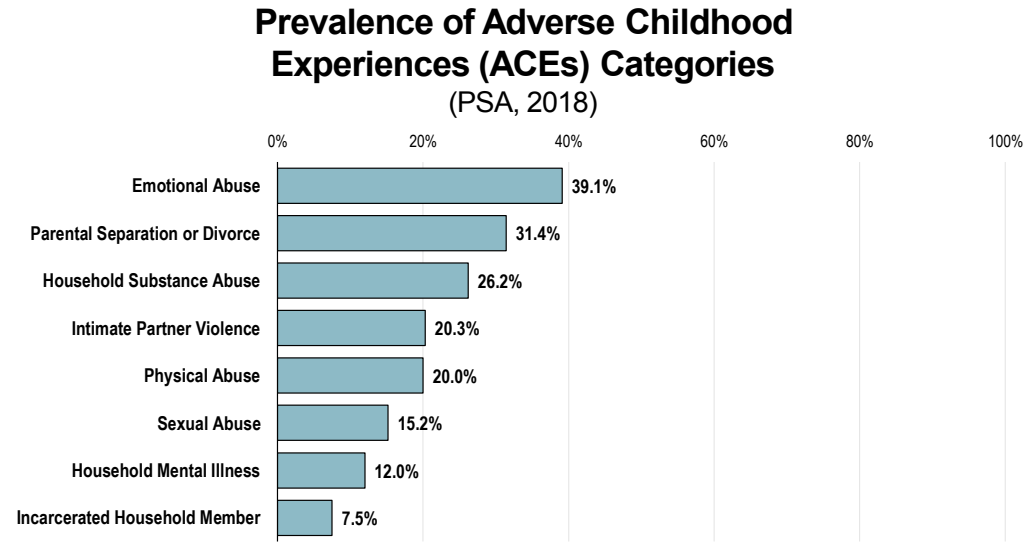
(PSA, 2018)

Category	Question
Household Mental Illness	Before you were 18 years of age, did you live with anyone who was depressed, mentally ill, or suicidal?
Household Substance Abuse	Before you were 18 years of age, did you live with anyone who was a problem drinker or alcoholic?
	Before you were 18 years of age, did you live with anyone who used illegal street drugs or who abused prescription medications?
Incarcerated Household Member	Before you were 18 years of age, did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?
Parental Separation or Divorce	Before you were 18 years of age, were your parents separated or divorced?
Intimate Partner Violence	Before age 18, how often did your parents or adults in your home slap, hit, kick, punch or beat each other up?
Physical Abuse	Before age 18, how often did a parent or adult in your home hit, beat, kick, or physically hurt you in any way? Do not include spanking.
Emotional Abuse	Before age 18, how often did a parent or adult in your home swear at you, insult you, or put you down?
Sexual Abuse	Before you were 18 years of age, how often did an adult or anyone at least 5 years older than you touch you sexually?
	Before you were 18 years of age, how often did an adult or anyone at least 5 years older than you try to make you touch them sexually?
	Before you were 18 years of age, how often did an adult or anyone at least 5 years older than you force you to have sex?

Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 312-322]
Notes: Reflects the total sample of respondents.

By category, ACEs were most prevalent in the Primary Service Area for emotional abuse (affirmed by 39.1% of respondents), followed by parental separation/divorce (31.4%) and household substance abuse (26.2%).

- Fewer residents experienced **intimate partner violence** (20.3%), **physical abuse** (20.0%), **sexual abuse** as a child (15.2%), or **mental illness** (12.0%) in the household



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 327-334]
Notes: Reflects the total sample of respondents.
ACEs are stressful or traumatic events, including abuse and neglect. They are a significant risk factor for substance abuse disorders and can impact prevention efforts.

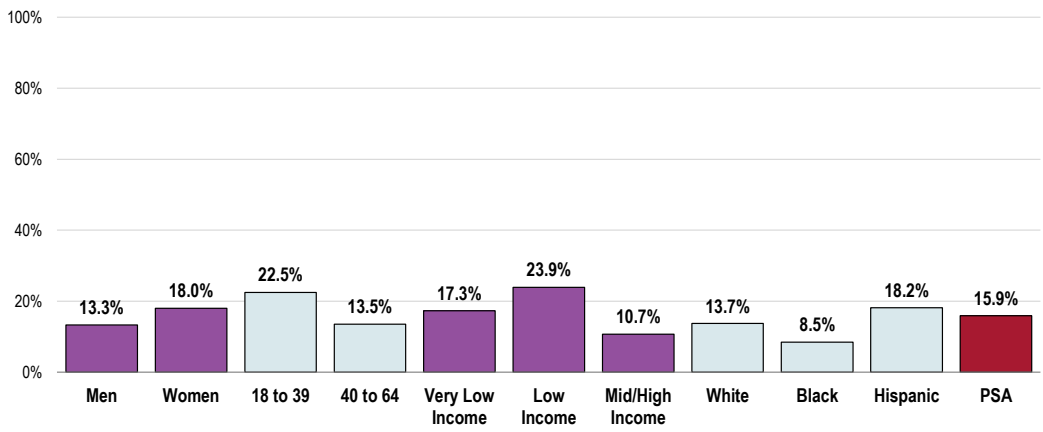
High ACE Scores

In scoring the ACE series, survey respondents receive one "point" for each of the 8 ACEs categories containing an affirmative response. A score of 4 or higher is determined to be a "high" ACE score.

In all, 15.9% of Primary Service Area residents reported 4 or more of the adverse childhood experiences tested (a high ACE score).

- Note that high ACE scores are more prevalent among low income residents (100% to 199% of the federal poverty level).

Prevalence of High ACE Scores (4 or More)
(PSA, 2018)



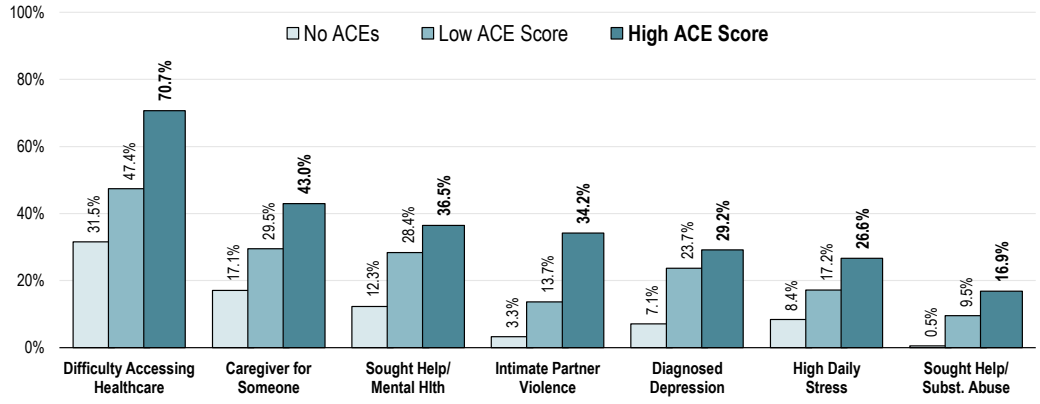
Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 335]
Notes: Asked of all respondents.
Adults who report four or more ACEs is categorized as having a high ACE score.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Relationship of ACEs with Other Health Issues

As a person's ACE score increases, so does their risk for disease, social issues, and emotional problems.

Note the following strong correlations of various health indicators in the Primary

Relationship of ACEs With Other Issues (By ACE Risk Classification; PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 47, 60, 102, 104, 101, 111, 171, 336]
Notes: Reflects the total sample of respondents.
Adults with at least one ACE are categorized as having a low score (1 to 3 ACEs) or a high score (4+ ACEs).

General Health Status

Professional Research Consultants, Inc.

Overall Health Status

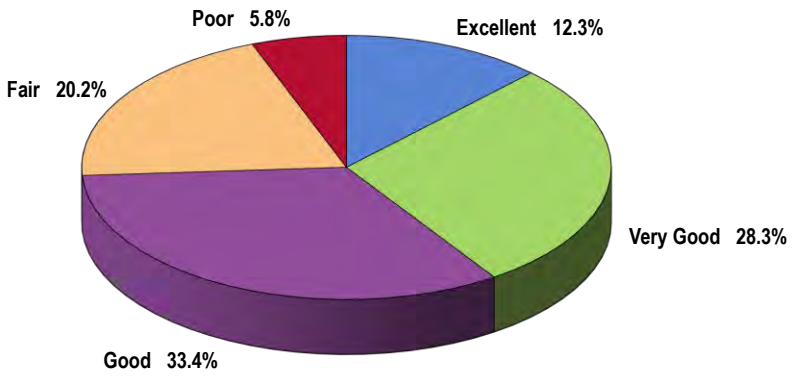
Evaluation of Health Status

The initial inquiry of the PRC Community Health Survey asked respondents the following:

"Would you say that in general your health is: excellent, very good, good, fair, or poor?"

A total of 40.6% of Primary Service Area adults rate their overall health as "excellent"

Self-Reported Health Status
(PSA, 2018)

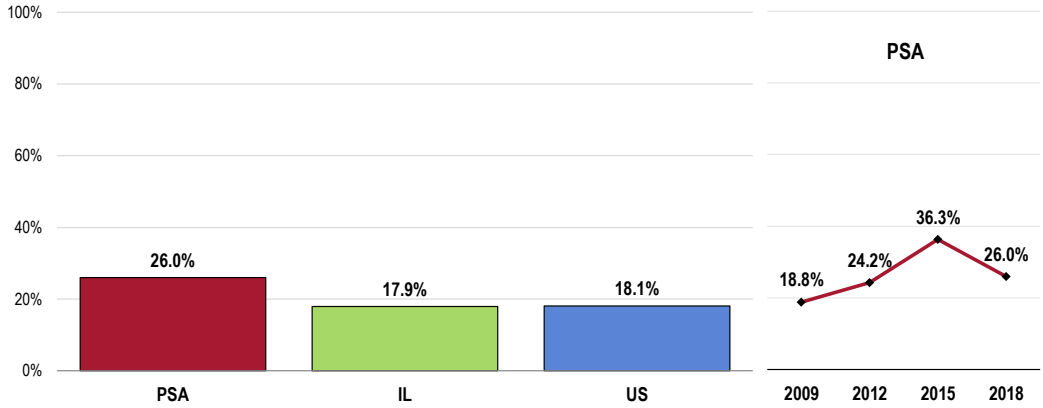


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: Asked of all respondents.

However, more than one-quarter (26.0%) of Primary Service Area adults believe that their overall health is "fair" or "poor."

- Less favorable than statewide and national findings.
- TREND: Represents a significant decrease from 2015 "fair/poor" overall health reports (statistically similar to 2009 and 2012).

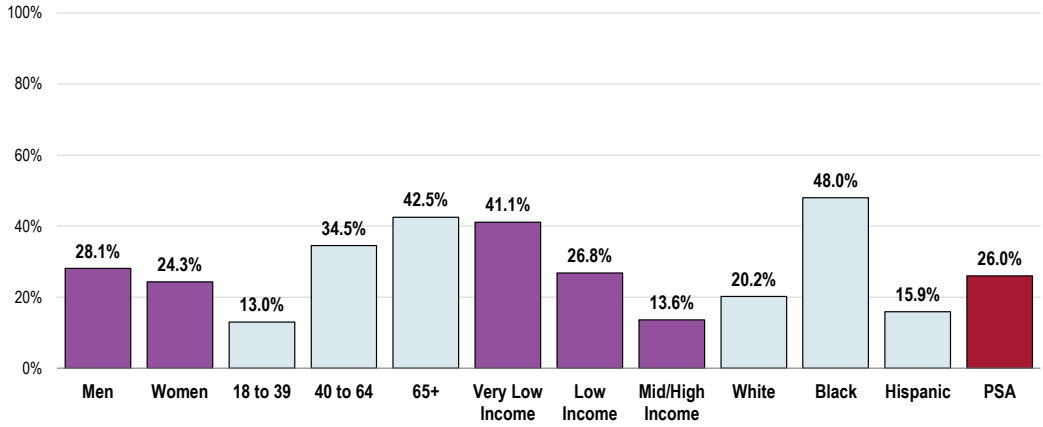
Experience "Fair" or "Poor" Overall Health



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Adults more likely to report experiencing "fair" or "poor" overall health include:

Experience "Fair" or "Poor" Overall Health
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: Asked of all respondents.
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Activity Limitations

About Disability & Health

An individual can get a disabling impairment or chronic condition at any point in life. Compared with people without disabilities, people with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need.
- Not have had an annual dental visit.
- Not have had a mammogram in past 2 years.
- Not have had a Pap test within the past 3 years.
- Not engage in fitness activities.
- Use tobacco.
- Be overweight or obese.
- Have high blood pressure.
- Experience symptoms of psychological distress.
- Receive less social-emotional support.
- Have lower employment rates.

There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO) principles of action for addressing health determinants.

- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- **Address the inequitable distribution of resources among people with disabilities and those without disabilities** by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.
- **Expand the knowledge base and raise awareness about determinants of health for people with disabilities** by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.

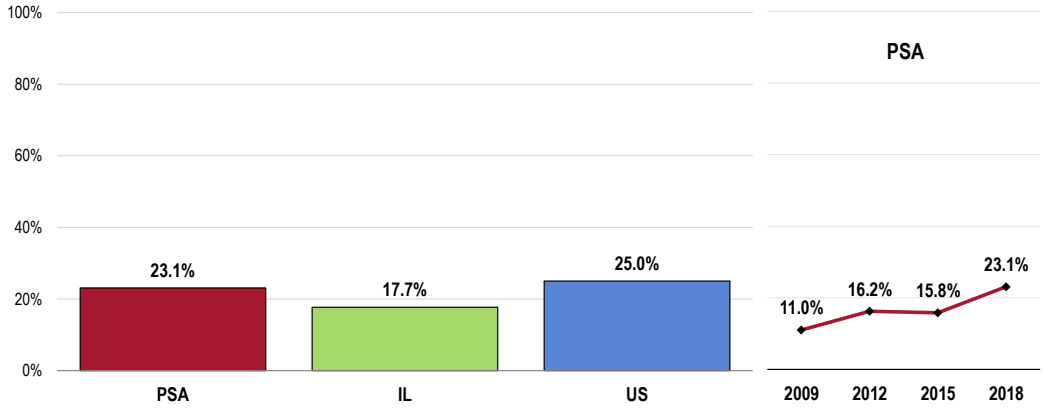
— Healthy People 2020 (www.healthypeople.gov)

A total of 23.1% of Primary Service Area adults are limited in some way in some activities, due to a physical, mental, or emotional problem.

RELATED ISSUE:
See also *Potentially Disabling Conditions* in the **Death, Disease, & Chronic Conditions** section of this report.

- Less favorable than the prevalence statewide.
- Similar to the national prevalence.
- TREND: The prevalence of activity limitations has increased since 2009.

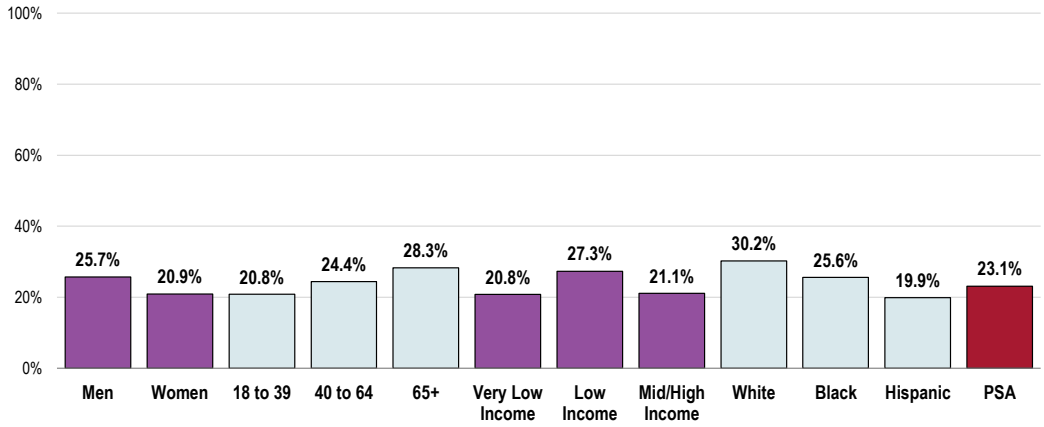
Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 109]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem

(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 109]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
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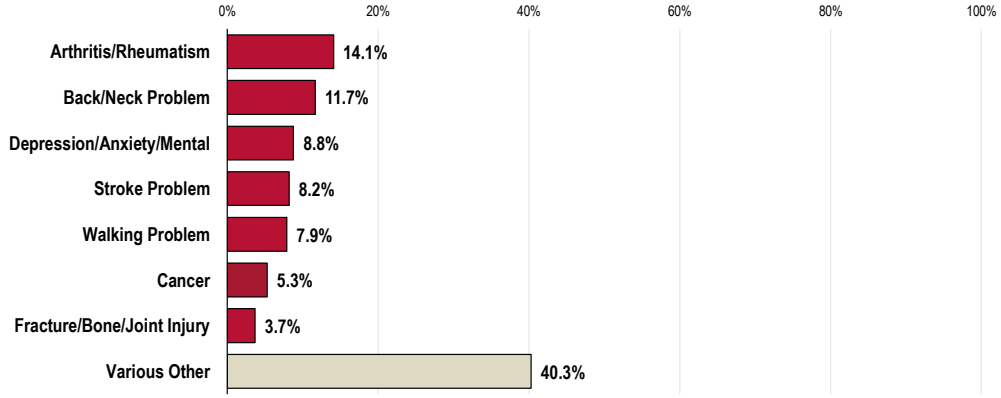
Among persons reporting activity limitations, these are most often attributed to musculo-skeletal issues, such as arthritis/rheumatism, back/neck problems, difficulty walking, or fractures or bone/joint injuries.

Type of Problem That Limits Activities
(Among Those Reporting Activity Limitations; PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 110]
Notes: Asked of those respondents reporting activity limitations.

Caregiving

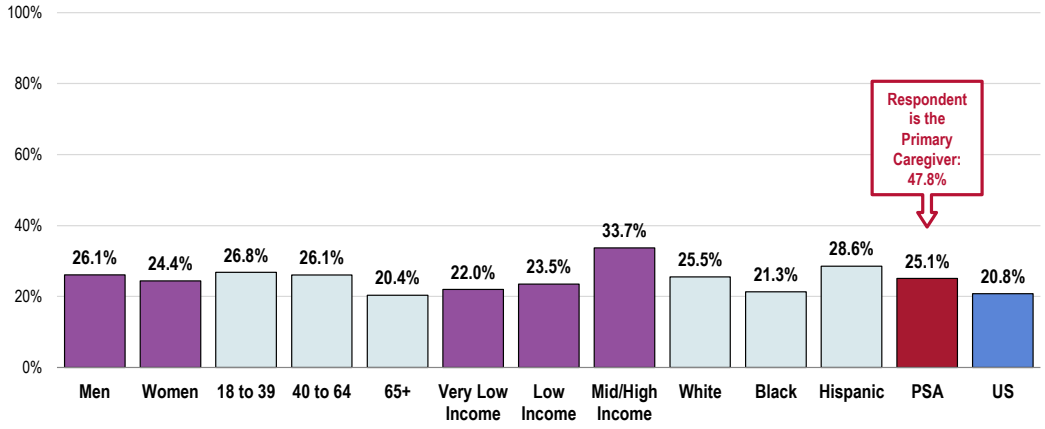
A total of 25.1% of Primary Service Area adults currently provide care or assistance to a friend or family member who has a health problem, long-term illness, or disability.

- Statistically similar to the national finding.
- Statistically similar among key demographic groups.

Of these adults, 47.8% are the ***primary*** caregiver for the individual receiving care.

Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability

(PSA, 2018)



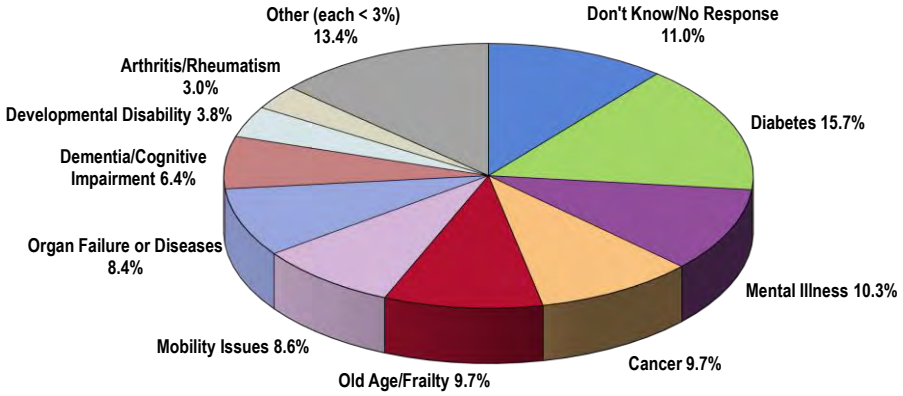
Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 111, 113]
2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

For those who provide care or assistance, the top health issues affecting those receiving their care include **diabetes** (15.7%), **mental illness** (10.3%), **cancer** (9.7%), **old age/frailty** (9.7%), **mobility issues** (8.6%), **organ failure/diseases** (8.4%), **dementia/cognitive**

Primary Health Issue of Person Receiving Care or Assistance

(Among Caregivers Providing Regular Care to a Friend/Family Member; PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 112]

Notes: Asked of those respondents reporting providing regular care or assistance to a friend or family member with a health problem, long-term illness, or disability.

Mental Health

About Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: **risk factors**, which predispose individuals to mental illness; and **protective factors**, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The major areas of progress include evidence that:

- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, and it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

— Healthy People 2020 (www.healthypeople.gov)

Evaluation of Mental Health Status

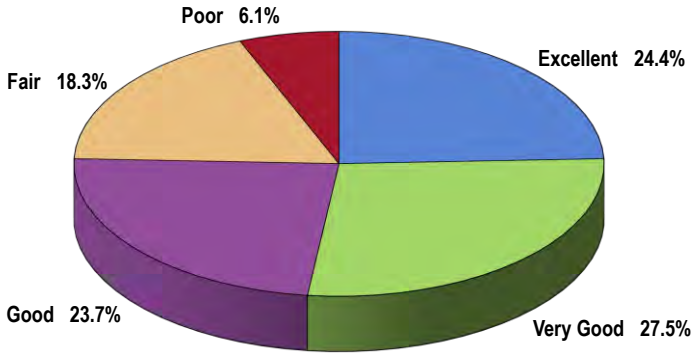
"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair or poor?"

A total of 51.9% of Primary Service Area adults rate their overall mental health as "excellent" or "very good."

- Another 23.7% gave "good" ratings of their own mental health status.

Self-Reported Mental Health Status

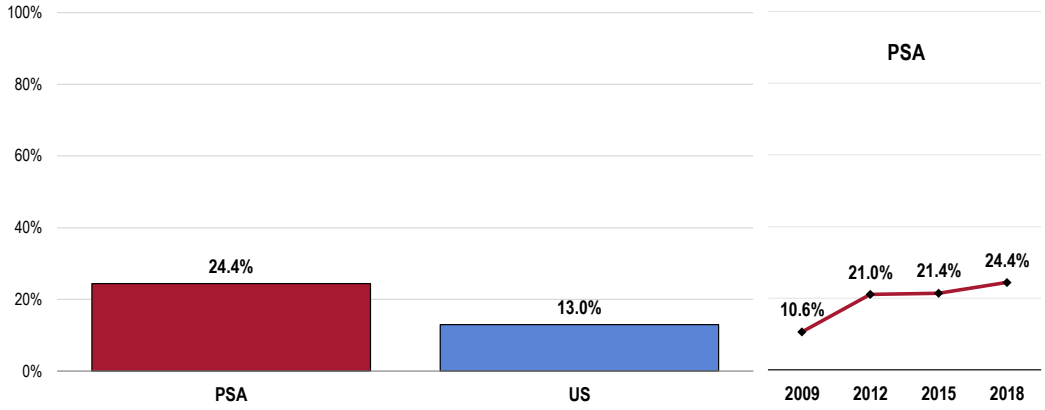
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 99]
Notes: Asked of all respondents.

A total of 24.4% of the Primary Service Area adults, however, believe that their overall mental health is "fair" or "poor."

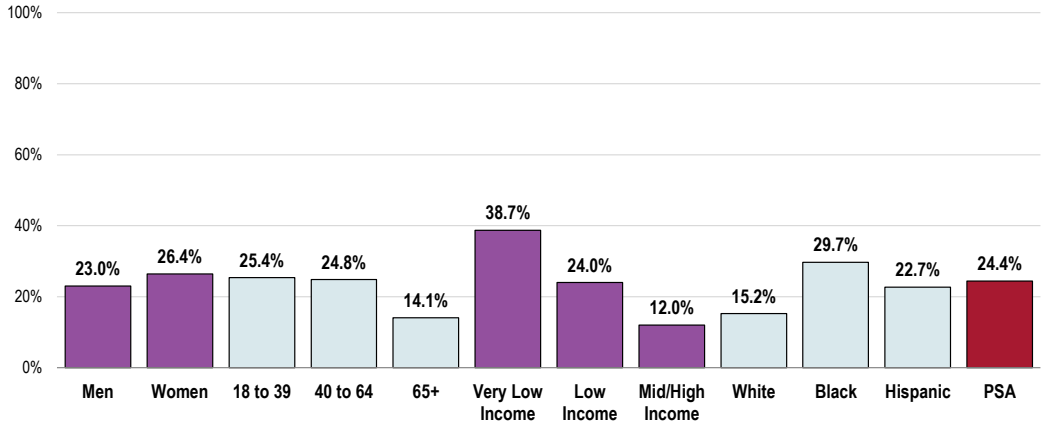
Experience "Fair" or "Poor" Mental Health



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 99]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Experience "Fair" or "Poor" Mental Health

(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 99]
Notes: Asked of all respondents.
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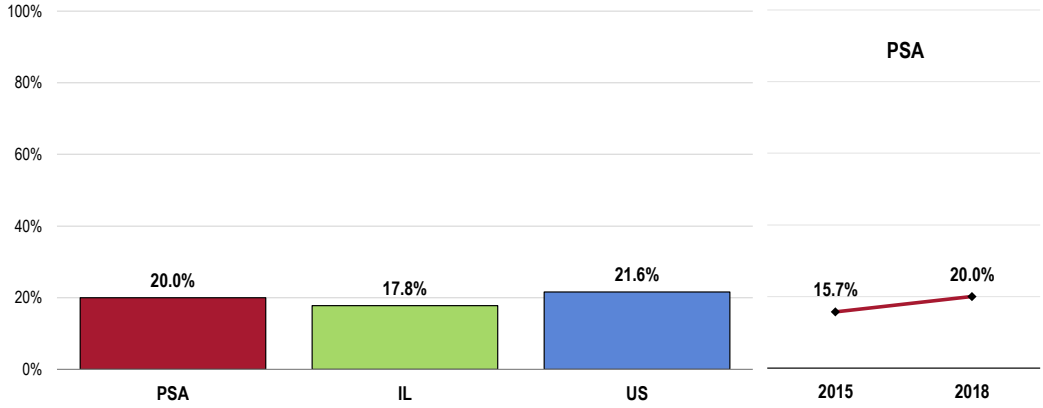
Depression

Diagnosed Depression

One-fifth (20.0%) of Primary Service Area adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

- Statistically similar to the Illinois finding.
- Similar to the national finding.
- TREND: Statistically unchanged since first measured in 2015.

Have Been Diagnosed With a Depressive Disorder

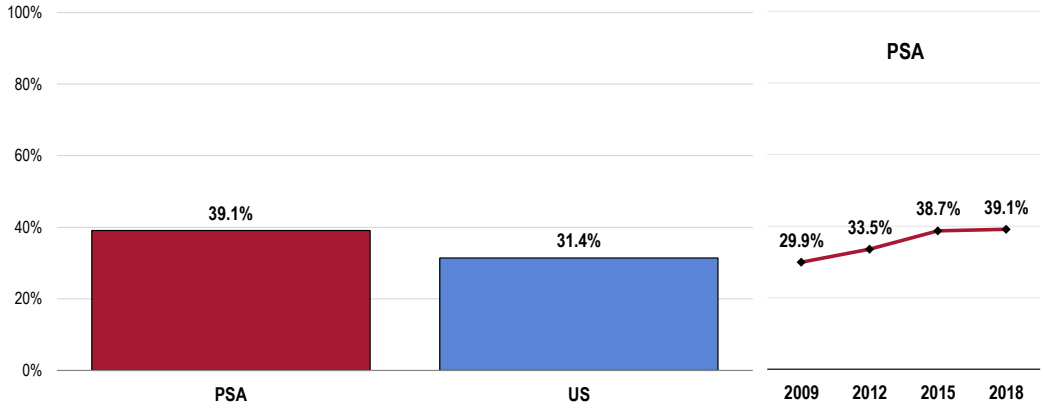


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 102]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

A total of 39.1% of Primary Service Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay

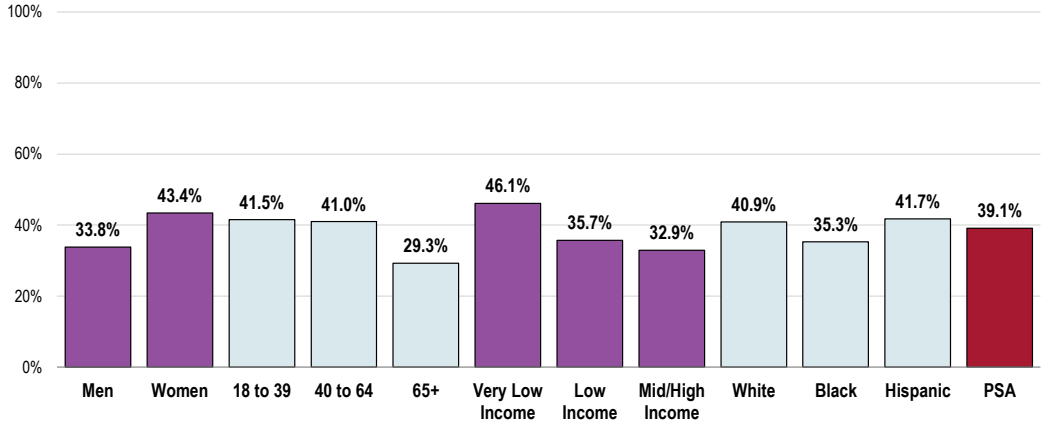
Have Experienced Symptoms of Chronic Depression



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Have Experienced Symptoms of Chronic Depression

(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]
Notes: Asked of all respondents.
Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Stress

Nearly half of Primary Service Area adults consider their typical day to be "not very stressful" (23.6%) or "not at all stressful" (24.8%).

RELATED ISSUE:

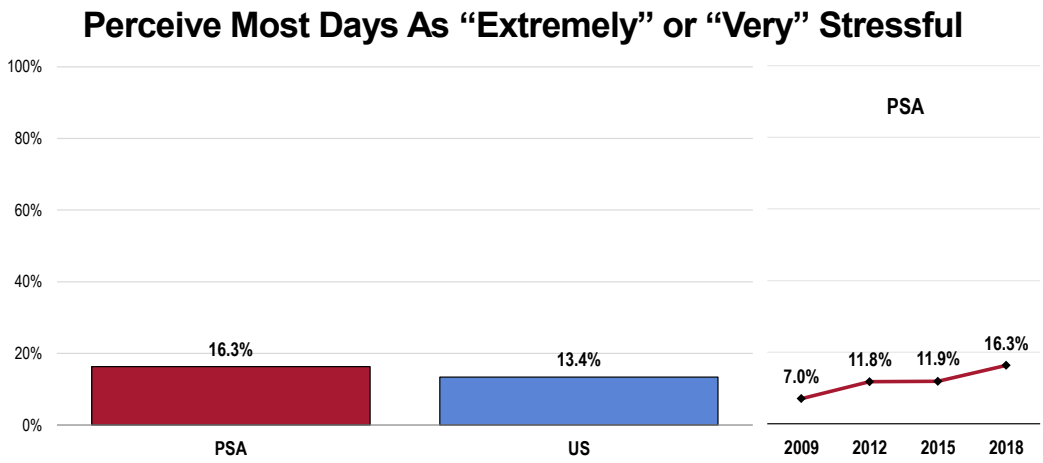
See also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Perceived Level of Stress On a Typical Day

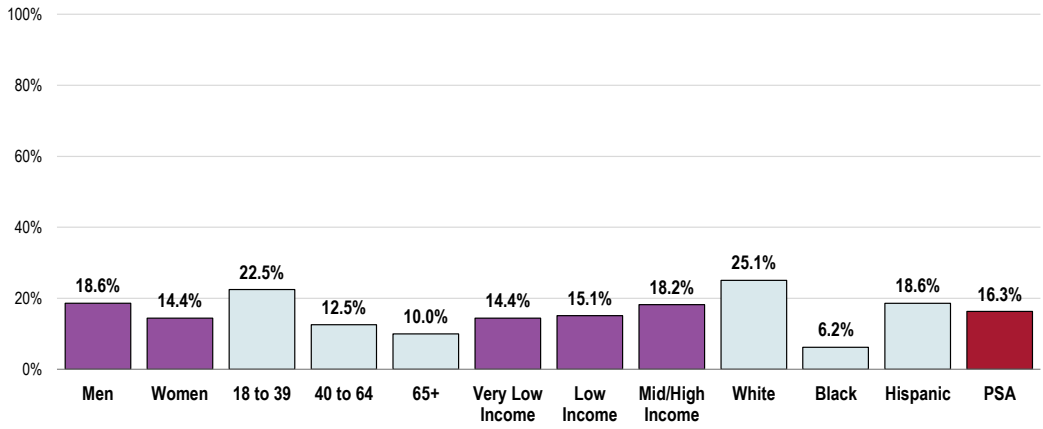
(PSA, 2018)

Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]
Notes: Asked of all respondents.

In contrast, 16.3% of Primary Service Area adults experience "very" or "extremely"



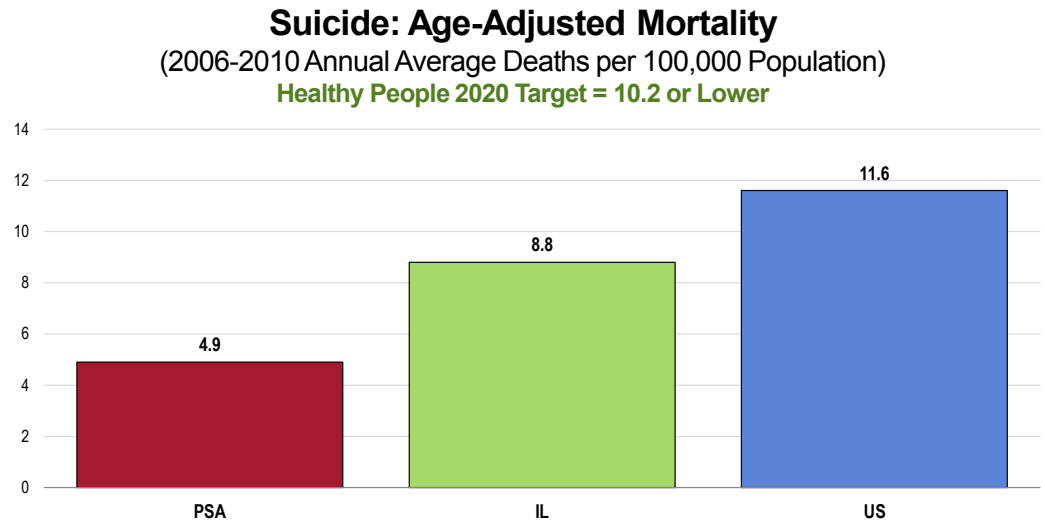
Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Suicide

Between 2006 and 2010, there was an annual average age-adjusted suicide rate of 4.9 deaths per 100,000 population in the Primary Service Area.



Sources: Epidemiology and Public Health Informatics, Chicago Department of Public Heath (CDPH). Selected underlying causes of death in Chicago, 2006-2010. Data extracted from the Chicago Data Portal at https://data.cityofchicago.org/.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

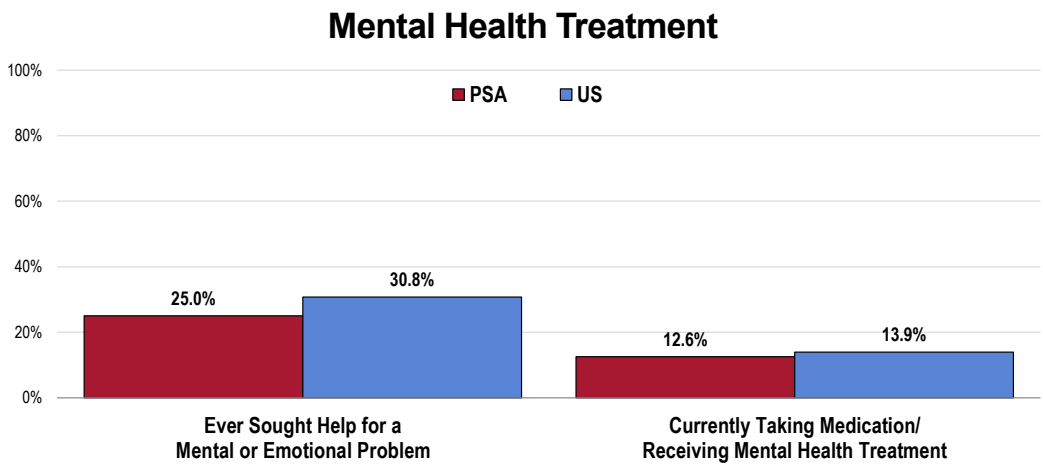
Mental Health Treatment

A total of 25.0% of Primary Service Area adults acknowledge having ever sought professional help for a mental or emotional problem.

- Similar to the nation.

A total of 12.6% are currently taking medication or receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

- Statistically comparable to national findings.

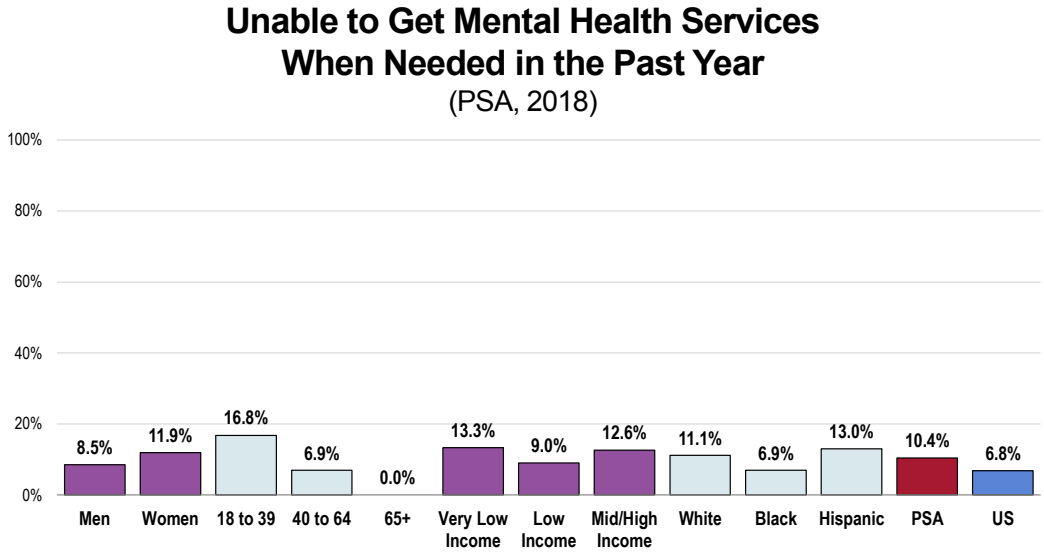


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 103-104]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Reflects the total sample of respondents.

Difficulty Accessing Mental Health Services

A total of 10.4% of Primary Service Area adults report a time in the past year when they needed mental health services, but were not able to get them.

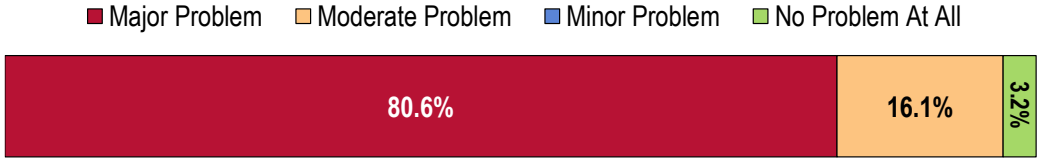
- Similar to the national finding.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 105]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among persons citing difficulties accessing mental health services in the past year, these are predominantly attributed to **cost of services** (mentioned by 16.8%) and **long waits for an appointment** (12.8%).

Perceptions of Mental Health as a Problem in the Community
(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a “major problem,” reasons related to the following:

- Bottom elements are only for presentation purposes; crop them out for the report

Access to Care/Services

The biggest challenges would be access to mental health services, gaining trust in mental health providers and counselors, identifying and accepting there is a mental health issue and removing the stigma of mental health related issues. - Social Services Provider

The biggest challenge for people with mental health in Brighton Park is that there is a lack of services. Many community members do not have medical insurance and cannot pay for mental health services. There needs to be more free mental health services in Brighton Park. - Social Services Provider

Mental health services are not as widely available as they should be, especially for kids. Adults don't have time to go to therapy. - Public Health Representative

Lack of providers to meet community demand creates a void in quality service and long waiting periods. - Community Leader

Lack of consistent mental health treatment options available. - Social Services Provider

Support groups and service having access to participating facilities. - Community Leader

Lack of resources. There are very few counselors available. - Other Health Provider

Lack of access, poverty and stress. - Physician

Limited services. - Community Leader

Prevalence/Incidence

We also see that depression is a major health issue in Brighton Park, as many youth, college students and adults suffer from depression. - Social Services Provider

Many suffer from mental illness and are not diagnosed. Taboo still exists. - Public Health Representative

Visibly homeless and people walking around talking to people who aren't there. - Social Services Provider

Affordable Care/Services

> *Access to high quality, trauma-informed, long-term services that are affordable or free. - Public Health Representative*
>
> *Cost, information, accessibility and lack of insurance. - Social Services Provider*

Language/Culture

> *Access to bilingual/bicultural clinicians, access to timely care, mental health focus on the needs of immigrants, especially those whom are undocumented. - Other Health Provider*
>
> *There is a lack of Chinese-speaking mental health professionals. - Social Services Provider*

Social Determinants of Health

> *Poverty causes chronic stress and resultant problems with behavioral health. - Physician*
>
> *Mental health is one of the biggest challenges in the community because of generational traumatic experiences that impact the mind, body and soul, which include being marginalized, ostracized, demonized, etc. Because of centuries of structural racism, certain people groups- particularly Blacks- disproportionately face lack of work, subpar education and little to no access to the basic necessities, which negatively impacts the brain and ultimately their well-being. Also, inhalation of chemical substances from the environment, dwelling and/or work spaces. And of course, lack of access to nutritious food; poor diet. Finally, there is still some stigma around getting professional help to assist in dealing with mental health challenges. - Community Leader*

Awareness/Education

> *Lack of education, awareness that they are carrying deep levels of trauma, and the stigma relating to seeking help. - Community Leader*

Death, Disease, & Chronic Conditions

Professional Research Consultants, Inc.

Leading Causes of Death

Age-Adjusted Death Rates for Selected Causes

In order to compare mortality in the community with other localities (in this case, Illinois and the United States), it is necessary to look at *rates* of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as *Healthy People 2020* targets.

The following chart outlines 2006-2010 annual average age-adjusted death rates per 100,000 population for selected causes of death in the neighborhoods best approximating the Primary

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

Age-Adjusted Death Rates for Selected Causes

(2006-2010 Deaths per 100,000 Population)

	PSA	Illinois	US	HP2020
Coronary Heart Disease	155.8	122.6	124.8	103.4
Malignant Neoplasms (Cancers)	179.1	184.7	176.7	161.4
Cerebrovascular Disease (Stroke)	47.2	42.5	41.8	34.8
Unintentional Injuries	32.0	32.5	39.1	36.4
Diabetes	26.9	20.9	22.0	20.5*
Kidney Disease	22.3	19.6	15.0	n/a
Alzheimer's Disease	14.5	21.4	24.5	n/a
Cirrhosis/Liver Disease	13.3	8.2	9.1	8.2
Homicide/Legal Intervention	11.6	6.7	5.8	5.5
Firearm-Related	10.1	8.2	10.2	9.3
Intentional Self-Harm (Suicide)	4.9	8.8	11.6	10.2

Sources: Epidemiology and Public Health Informatics, Chicago Department of Public Heath (CDPH). Selected underlying causes of death in Chicago, 2006-2010. Data extracted from the Chicago Data Portal at https://data.cityofchicago.org/.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov.

Note: Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.
*The Healthy People 2020 Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.

Cardiovascular Disease

About Heart Disease & Stroke

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than $500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Heart Disease & Stroke Deaths

Coronary Heart Disease Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

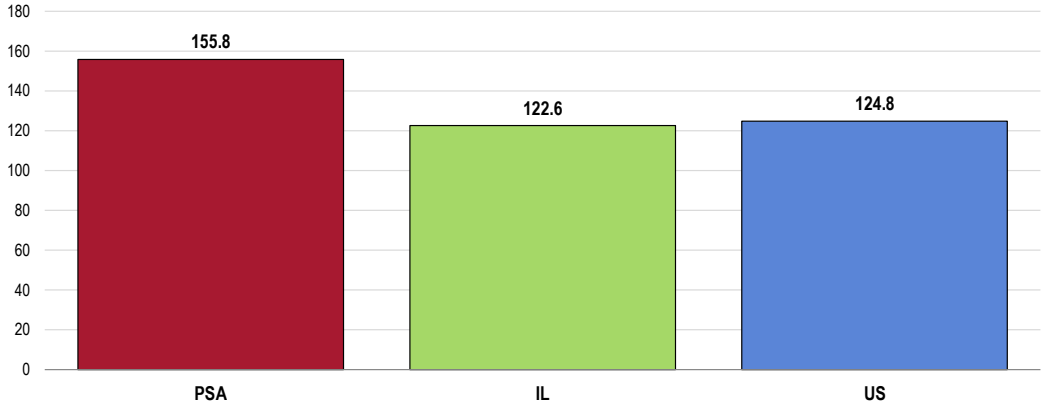
Between 2006 and 2010, there was an annual average age-adjusted coronary heart disease mortality rate of 155.8 deaths per 100,000 population in the Primary Service Area.

- Higher than the statewide and national rates.
- Far from satisfying the Healthy People 2020 target of 103.4 or lower.

Coronary Heart Disease: Age-Adjusted Mortality

(2006-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 103.4 or Lower



Sources: Epidemiology and Public Health Informatics, Chicago Department of Public Heath (CDPH). Selected underlying causes of death in Chicago, 2006-2010. Data extracted from the Chicago Data Portal at https://data.cityofchicago.org/.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

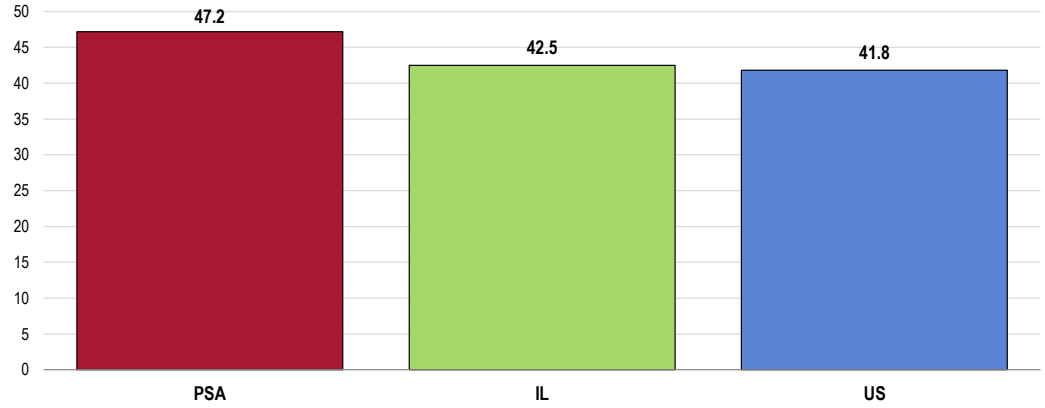
Stroke Deaths

Between 2006 and 2010, there was an annual average age-adjusted stroke mortality rate of 47.2 deaths per 100,000 population in the Primary Service Area.

Stroke: Age-Adjusted Mortality

(2006-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 34.8 or Lower



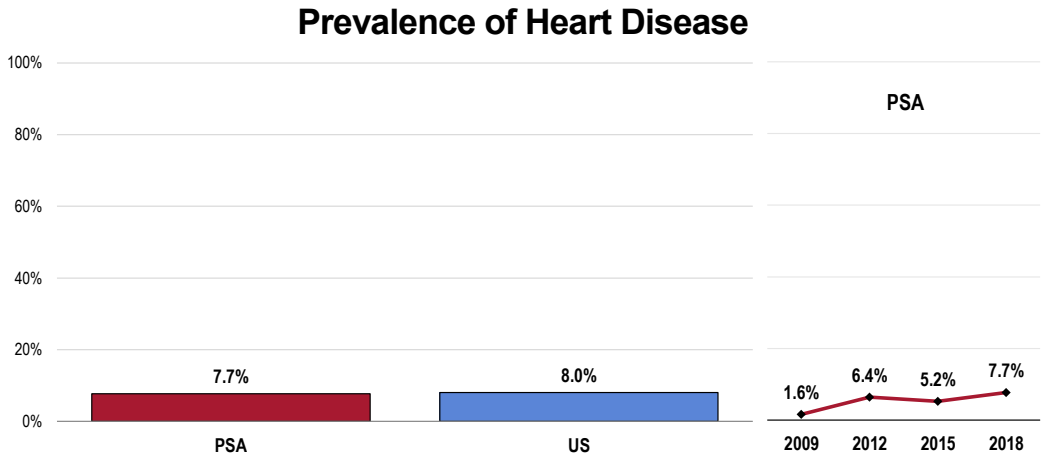
Sources: Epidemiology and Public Health Informatics, Chicago Department of Public Heath (CDPH). Selected underlying causes of death in Chicago, 2006-2010. Data extracted from the Chicago Data Portal at https://data.cityofchicago.org/.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

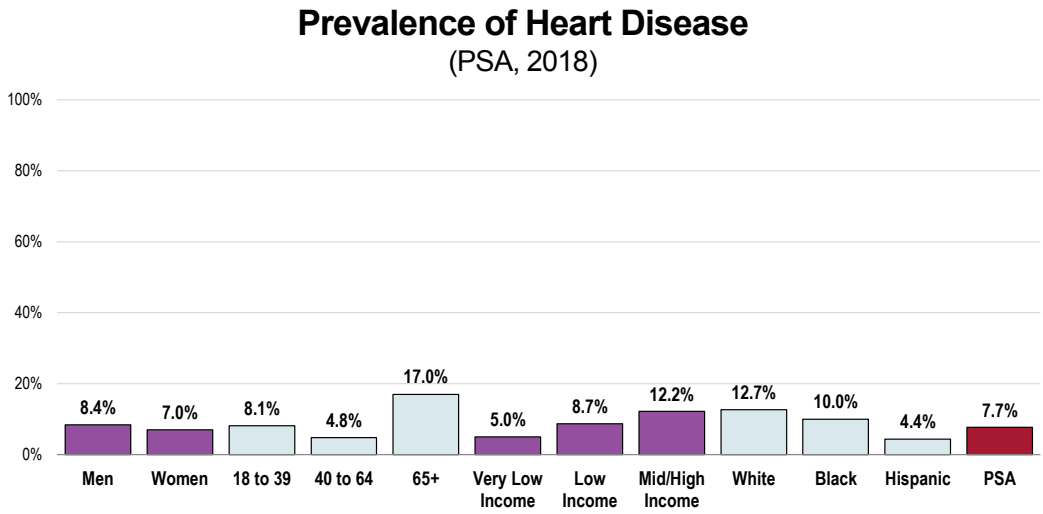
Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 7.7% of surveyed adults report that they suffer from or have been diagnosed



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Includes diagnoses of heart attack, angina, or coronary heart disease.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
Notes: Asked of all respondents.
Includes diagnoses of heart attack, angina, or coronary heart disease.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
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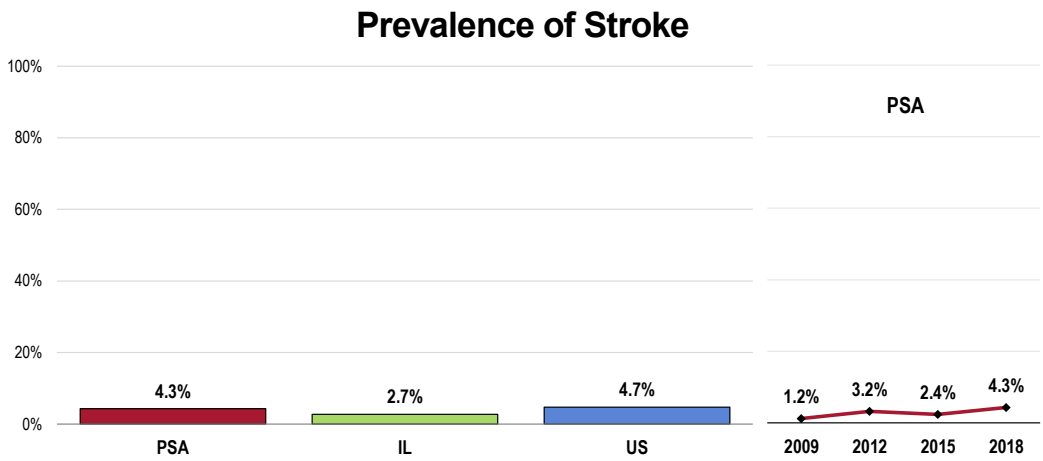
Prevalence of Stroke

A total of 4.3% of surveyed adults report that they suffer from or have been diagnosed



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Cardiovascular Risk Factors

About Cardiovascular Risk

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

— Healthy People 2020 (www.healthypeople.gov)

High Blood Pressure

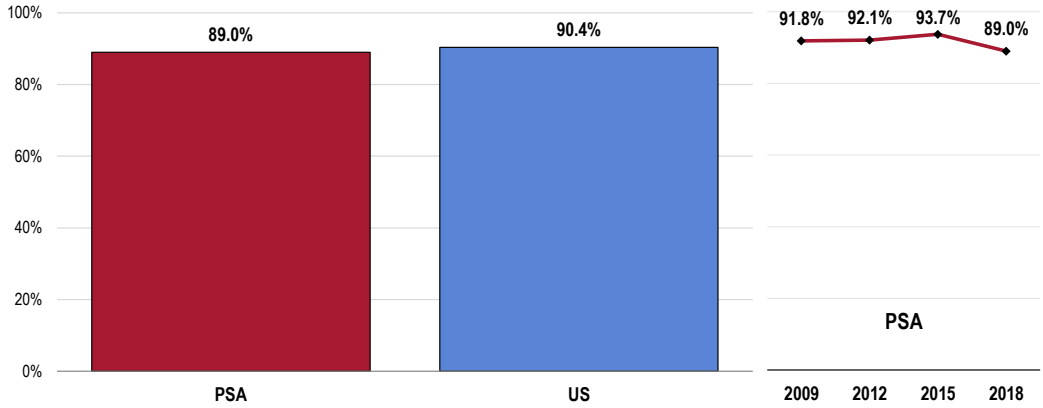
High Blood Pressure Testing

A total of 89.0% of Primary Service Area adults have had their blood pressure tested within the past two years.

- Similar to national findings.
- Fails to satisfy the Healthy People 2020 target (92.6% or higher).
- TREND: No significant change over time.

Have Had Blood Pressure Checked in the Past Two Years

Healthy People 2020 Target = 92.6% or Higher



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 42]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-4]
Notes: Asked of all respondents.

Prevalence of High Blood Pressure

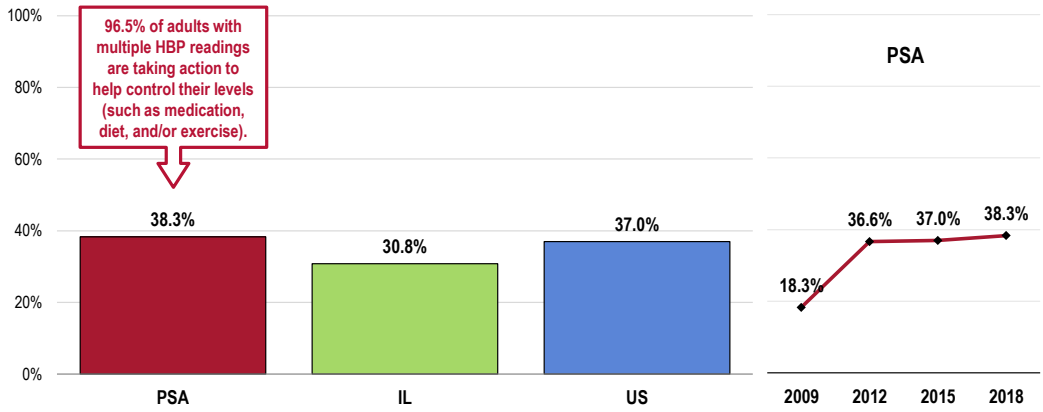
A total of 38.3% of Primary Service Area adults have been told at some point that their blood pressure was high.

- Less favorable than the Illinois prevalence.
- Statistically similar to the national prevalence.
- Far from satisfying the Healthy People 2020 target (26.9% or lower).
- TREND: Notably higher than 2009 findings (though statistically unchanged since 2012).

Among adults with multiple high blood pressure readings, 96.5% are taking action to lower their blood pressure (such as medication, change in diet, and/or exercise).

Prevalence of High Blood Pressure

Healthy People 2020 Target = 26.9% or Lower



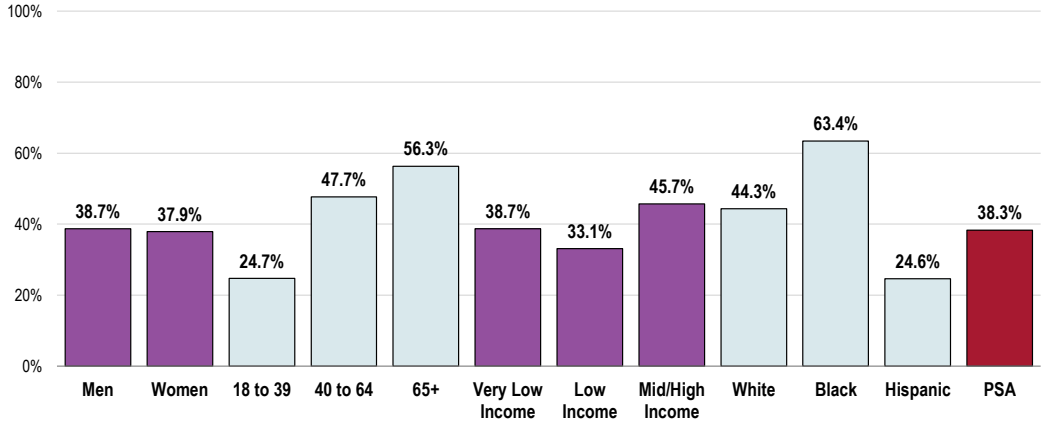
Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 41, 129]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]

Notes: Asked of all respondents.

Prevalence of High Blood Pressure

(PSA, 2018)

Healthy People 2020 Target = 26.9% or Lower



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 129]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]

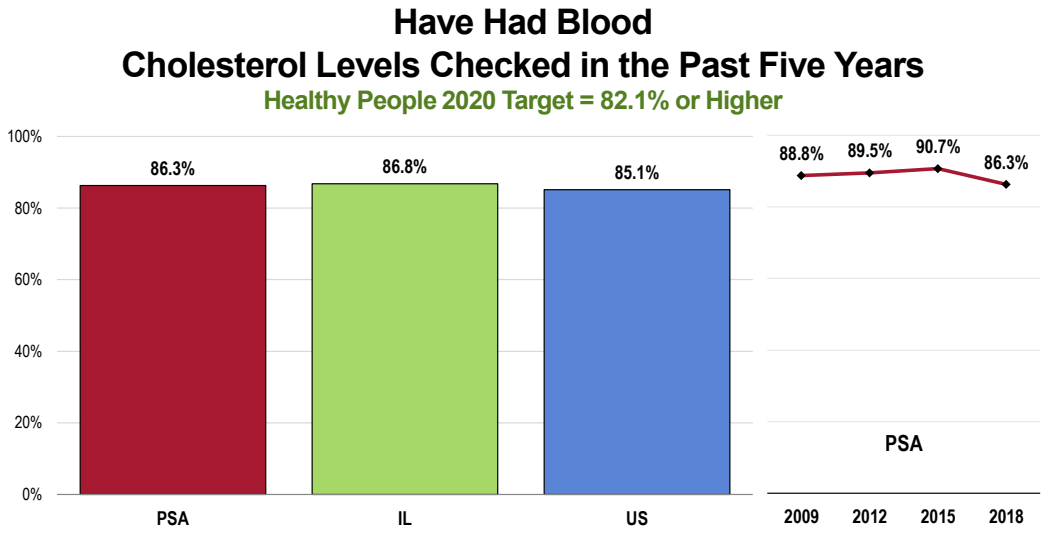
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

High Blood Cholesterol

Blood Cholesterol Testing

A total of 86.3% of Primary Service Area adults have had their blood cholesterol checked within the past five years.

- Similar to Illinois findings.
- Comparable to the national findings.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 45]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-6]
Notes: Asked of all respondents.

Prevalence of High Blood Cholesterol

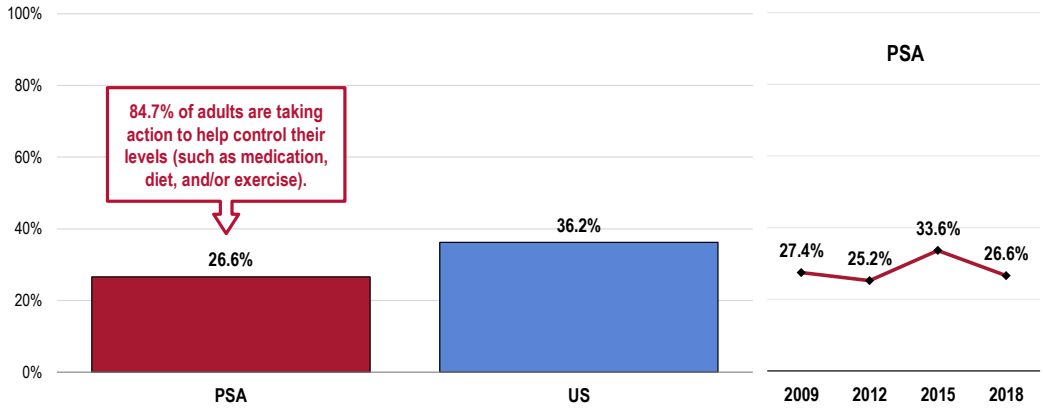
A total of 26.6% of adults have been told by a health professional that their cholesterol level was high.

- More favorable than the national prevalence.
- Nearly twice the Healthy People 2020 target (13.5% or lower).
- TREND: No clear trend is apparent.

Among adults with high blood cholesterol readings, 84.7% are taking action to lower their numbers (such as medication, change in diet, and/or exercise).

Prevalence of High Blood Cholesterol

Healthy People 2020 Target = 13.5% or Lower



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 44, 130]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]
Notes: Asked of all respondents.

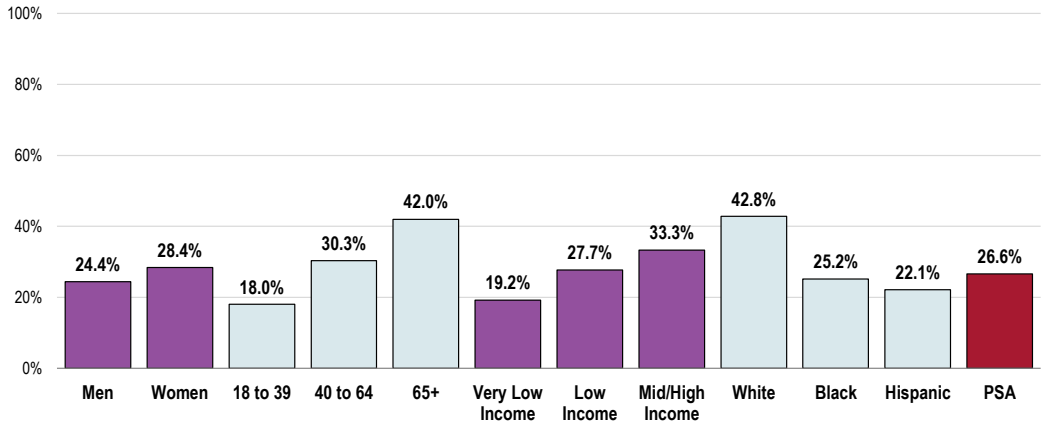
Those with higher prevalence of high blood cholesterol include:

- Adults age 40 and older.

Prevalence of High Blood Cholesterol

(PSA, 2018)

Healthy People 2020 Target = 13.5% or Lower



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 130]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

About Cardiovascular Risk

Individual level risk factors which put people at increased risk for cardiovascular diseases include:

- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes

— National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Three health-related behaviors contribute markedly to cardiovascular disease:

Poor nutrition. People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

Lack of physical activity. People who are not physically active have twice the risk for heart disease of those who are active. More than half of adults do not achieve recommended levels of physical activity.

Tobacco use. Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related. Every day, more than 3,000 young people become daily smokers in the US.

Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as appropriate, and learning the symptoms of heart attack and stroke.

— National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

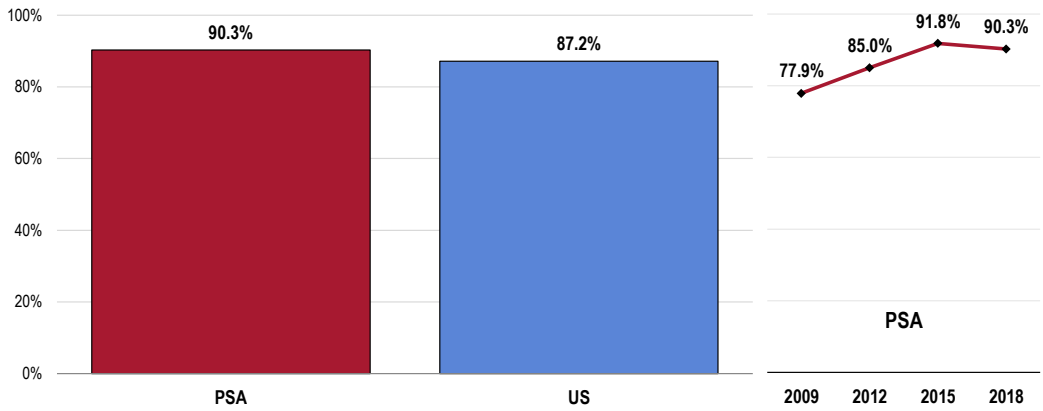
Total Cardiovascular Risk

The vast majority (90.3%) of Primary Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

- Comparable to the national findings.
- TREND: Higher than 2009 and 2012 findings (similar to 2015).

RELATED ISSUE:
See also *Nutrition*, *Physical Activity*, *Weight Status*, and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

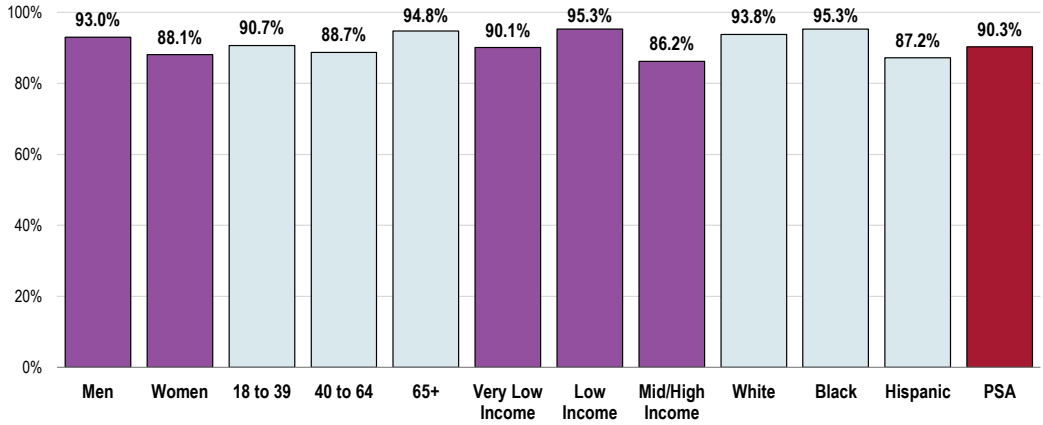
Present One or More Cardiovascular Risks or Behaviors



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 131]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.

Present One or More Cardiovascular Risks or Behaviors

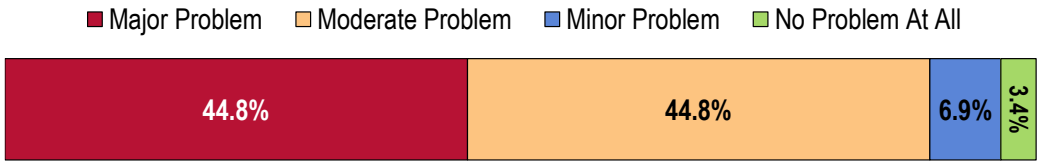
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 131]
Notes: Asked of all respondents.
Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Perceptions of Heart Disease and Stroke as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Lifestyle

Heart disease and strokes are caused in part by lack of exercise and poor eating habits. That is rampant in many underserved communities. Lack of access to healthy options, such as living in a food desert creates- or at the very least lends to- the issue of poor food choices. The community could use more options for exercise. Something as simple as "walkable" areas would be very helpful. - Community Leader

Many residents of the community face these problems because of unhealthy lifestyles, poor nutrition, lack of exercise and easy availability of fast food. - Social Services Provider

Diet and lack of healthy food resources locally. - Community Leader

Contributing Factors

Like diabetes, people cannot afford their medications. Also, lack of health literacy/education. - Other Health Provider

Early Diagnosis/Prevention

Hypertension is undiagnosed, high prevalence of overweight, low physical activity and high rates of alcohol consumption. - Other Health Provider

Stress

We believe that heart disease and stroke is a major problem in Brighton Park because many community members are living under a lot of pressure and stress due to system that we are living under, especially financial stress, and stress of deportations. Another factor is that many people in Brighton Park are overweight. - Social Services Provider

Trauma

Traumatic experiences that impact the mind, body and soul, as well as inhalation of chemical substance in dwelling or work spaces. And of course, lack of access to nutritious food, poor diet. - Community Leader

Vulnerable Populations

Major issue among minorities. Overweight is one of the factors, hereditary. - Public Health Representative

Cancer

About Cancer

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:

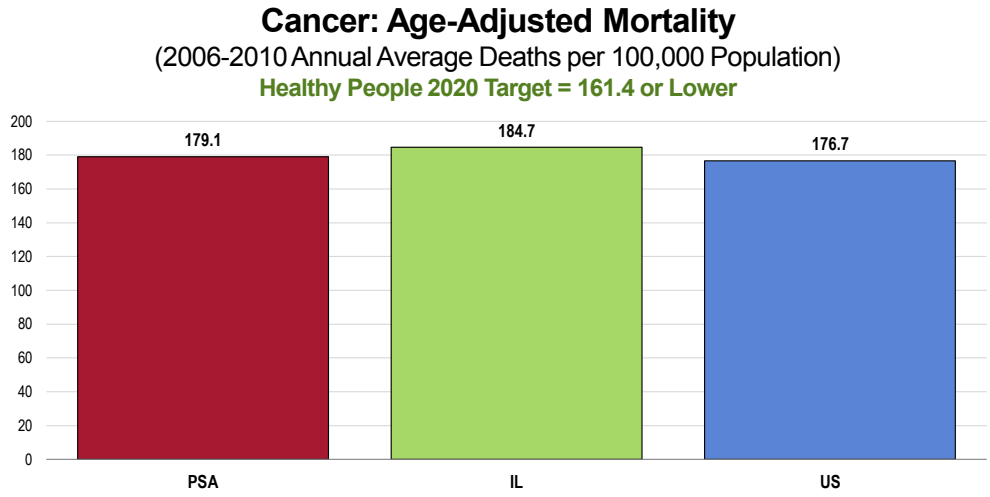
- Breast cancer (using mammography)
- Cervical cancer (using Pap tests)
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)

— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

All Cancer Deaths

Between 2006 and 2010, there was an annual average age-adjusted cancer mortality rate of 179.1 deaths per 100,000 population in the Primary Service Area.



Sources: Epidemiology and Public Health Informatics, Chicago Department of Public Heath (CDPH). Selected underlying causes of death in Chicago, 2006-2010. Data extracted from the Chicago Data Portal at https://data.cityofchicago.org/.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cancer Deaths by Site

Lung cancer is by far the leading cause of cancer deaths in the Primary Service Area.

Other leading sites include prostate cancer among men, breast cancer among women, and colorectal cancer (both sexes).

As evident in the following chart (referencing 2006-2010 annual average age-adjusted death rates):

- The Primary Service Area **lung cancer** and **female breast cancer** death rates are similar to their respective state and national rates.
- The Primary Service Area **prostate cancer** death rate is higher than both the state and national rates.
- The Primary Service Area **colorectal cancer** death rate is similar to the state rate but

Age-Adjusted Cancer Death Rates by Site

(2006-2010 Annual Average Deaths per 100,000 Population)

	Primary Service Area	Illinois	US	HP2020
ALL CANCERS	179.1	184.7	176.7	161.4
Lung Cancer	54.3	51.7	49.5	45.5
Prostate Cancer	29.5	24.2	23.0	21.8
Female Breast Cancer	24.9	23.7	22.7	20.7
Colorectal Cancer	21.3	18.2	16.6	14.5

Sources: Epidemiology and Public Health Informatics, Chicago Department of Public Heath (CDPH). Selected underlying causes of death in Chicago, 2006-2010. Data extracted from the Chicago Data Portal at https://data.cityofchicago.org/.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov

Cancer Incidence

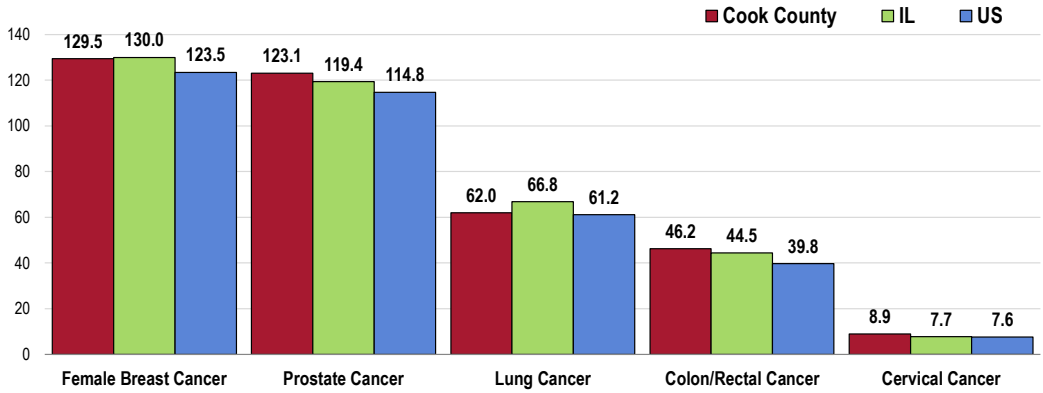
Incidence rates reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. *Note that Cook County data are used here.*

Incidence rate" or "case rate" is the number of new cases of a disease occurring during a given period of time.

It is usually expressed as cases per 100,000 population per year.

Cancer Incidence Rates by Site

(Annual Average Age-Adjusted Incidence per 100,000 Population, 2010-2014)



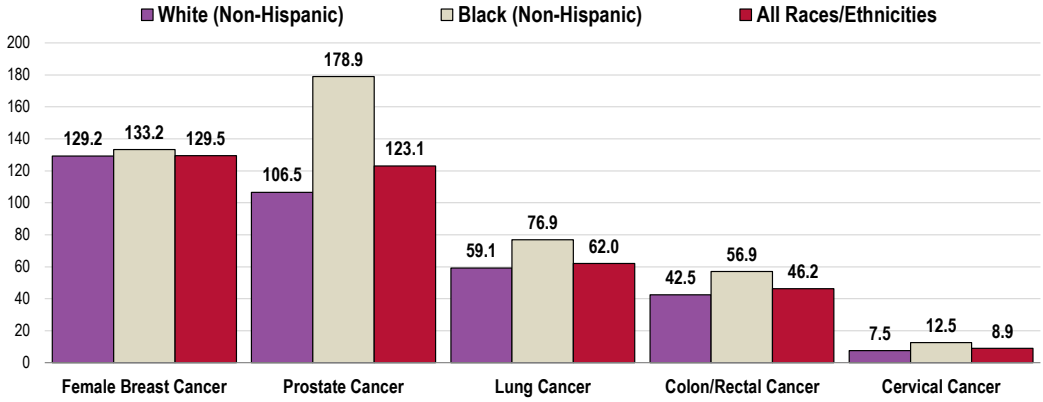
Sources: State Cancer Profiles.
Retrieved December 2018 from Community Commons at http://www.chna.org.

Notes: This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

- By available race data, Non-Hispanic Blacks experience a notably higher prostate cancer incidence than Non-Hispanic Whites in the Primary Service Area.
- Blacks also report higher lung, colorectal, and cervical cancer incidence rates (female breast cancer is similar by race).

Cancer Incidence Rates by Site and Race/Ethnicity

(Annual Average Age-Adjusted Incidence per 100,000 Population, Cook County 2010-2014)



Sources: State Cancer Profiles.
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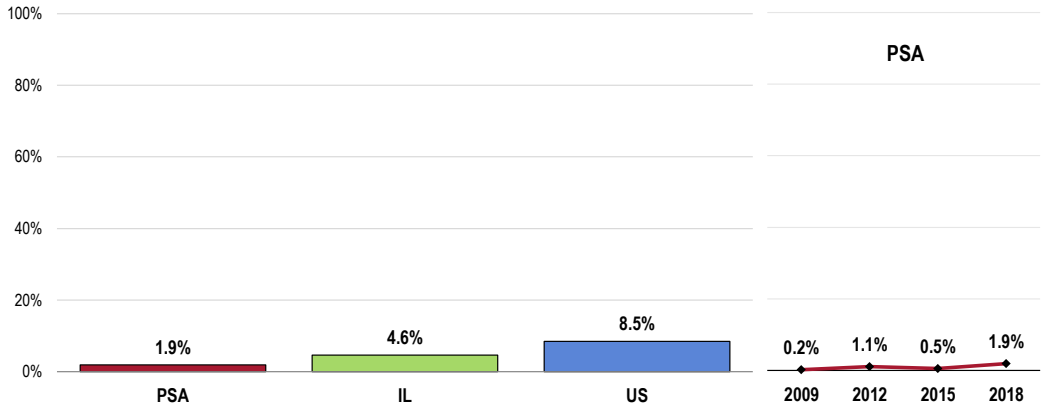
Prevalence of Cancer

Skin Cancer

A total of 1.9% of surveyed Primary Service Area adults report having been diagnosed

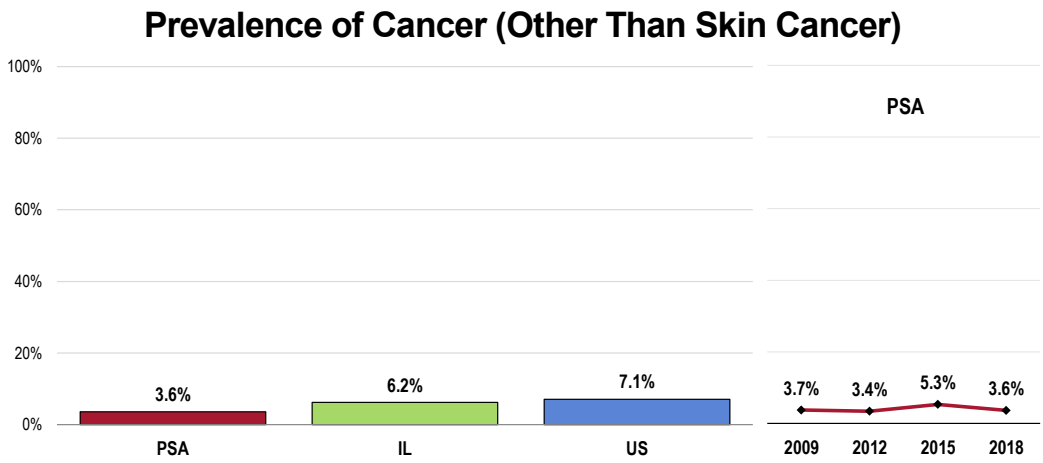
Prevalence of Skin Cancer



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 28]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents.

Other Cancer



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 27]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Cancer Risk

RELATED ISSUE:
See also *Nutrition*, *Physical Activity*, *Weight Status,* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

About Cancer Risk

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

— National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Female Breast Cancer Screening

About Screening for Breast Cancer

The US Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women age 40 and older.

Rationale: The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women age 50-69, the age group generally included in screening trials. For women age 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50.

The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. The USPSTF concluded that the evidence is also generalizable to women age 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increase along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminish from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women age 40-49.

— US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Mammography

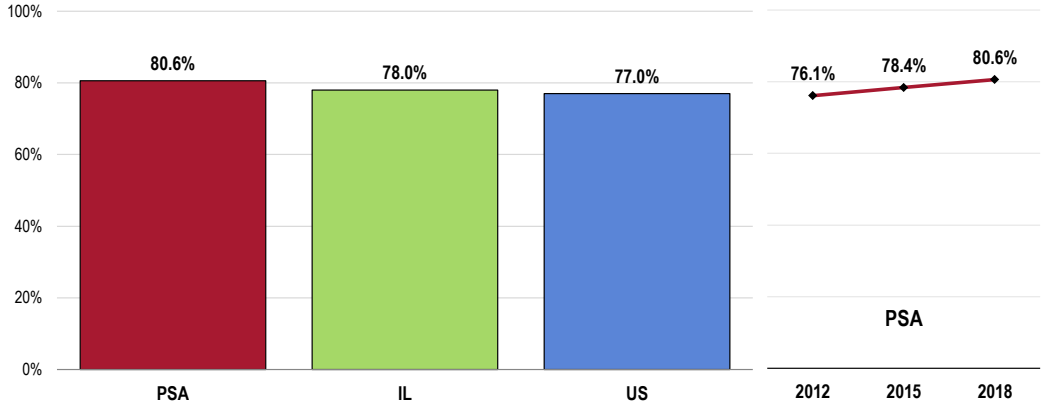
Among women age 50-74, 80.6% have had a mammogram within the past 2 years.

- Similar to statewide and national findings.
- Similar to the Healthy People 2020 target (81.1% or higher).
- TREND: Statistically unchanged since 2009.

Have Had a Mammogram in the Past Two Years

(Among Women Age 50-74)

Healthy People 2020 Target = 81.1% or Higher



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 133]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-17]

Notes: Reflects female respondents 50-74.

Cervical Cancer Screenings

About Screening for Cervical Cancer

The US Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

Rationale: The USPSTF found good evidence from multiple observational studies that screening with cervical cytology (Pap smears) reduces incidence of and mortality from cervical cancer. Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years. The USPSTF concludes that the benefits of screening substantially outweigh potential harms.

The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

Rationale: The USPSTF found limited evidence to determine the benefits of continued screening in women older than 65. The yield of screening is low in previously screened women older than 65 due to the declining incidence of high-grade cervical lesions after middle age. There is fair evidence that screening women older than 65 is associated with an increased risk for potential harms, including false-positive results and invasive procedures. The USPSTF concludes that the potential harms of screening are likely to exceed benefits among older women who have had normal results previously and who are not otherwise at high risk for cervical cancer.

The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease.

Rationale: The USPSTF found fair evidence that the yield of cytologic screening is very low in women after hysterectomy and poor evidence that screening to detect vaginal cancer improves health outcomes. The USPSTF concludes that potential harms of continued screening after hysterectomy are likely to exceed benefits.

— US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Pap Smear Testing

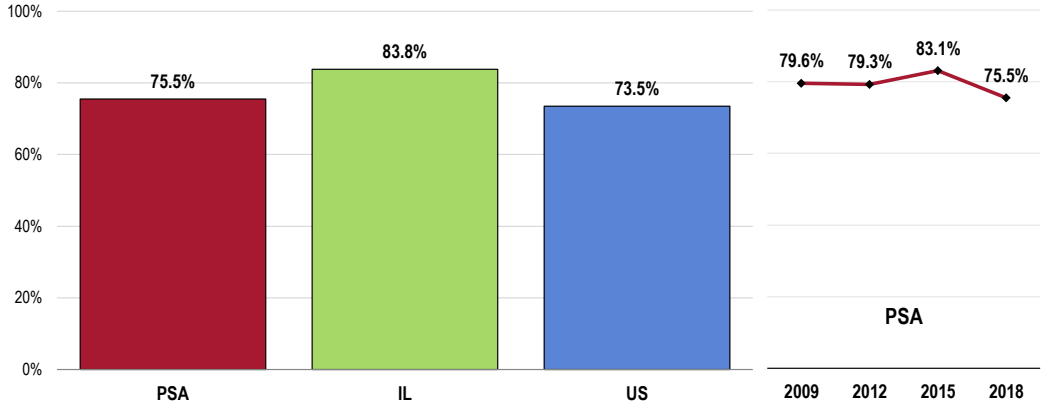
Among the Primary Service Area women age 21 to 65, three-quarters (75.5%) have had a Pap smear within the past 3 years.

- Lower than Illinois findings.
- Comparable to national findings.
- Fails to satisfy the Healthy People 2020 target (93% or higher).
- TREND: The decrease over time is not statistically significant.

Have Had a Pap Smear in the Past Three Years

(Among Women Age 21-65)

Healthy People 2020 Target = 93.0% or Higher



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 134]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-15]

Notes: Reflects female respondents age 21 to 65.

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.

The evidence is convincing that screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy detects early-stage cancer and adenomatous polyps. There is convincing evidence that screening with any of the three recommended tests (fecal occult blood testing, sigmoidoscopy, colonoscopy) reduces colorectal cancer mortality in adults age 50 to 75 years. Follow-up of positive screening test results requires colonoscopy regardless of the screening test used.

— US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Colorectal Cancer Screening

Among adults age 50-75, 81.6% have had an appropriate colorectal cancer screening.

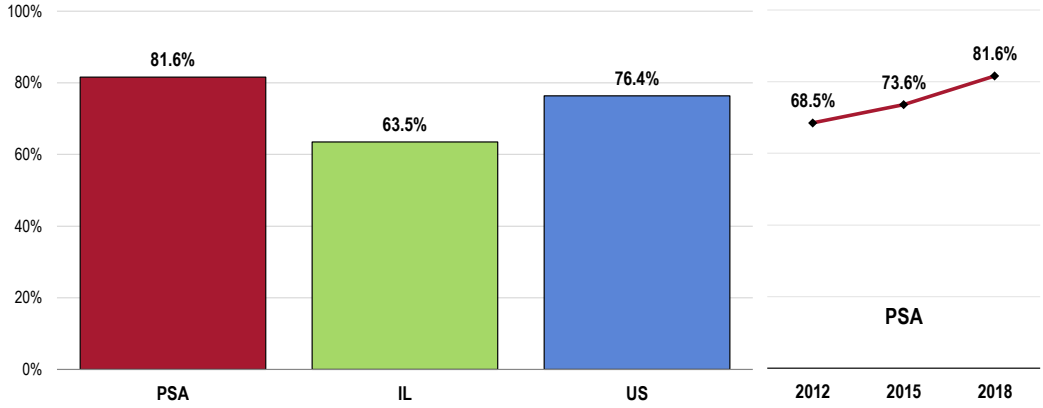
"Appropriate colorectal cancer screening" includes a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

- Higher than state findings
- Statistically similar to national findings.
- Satisfies the Healthy People 2020 target (70.5% or higher).
- TREND: Colorectal cancer screening has steadily increased since first measured in 2012.

Have Had a Colorectal Cancer Screening

(Among Adults Age 50-75)

Healthy People 2020 Target = 70.5% or Higher

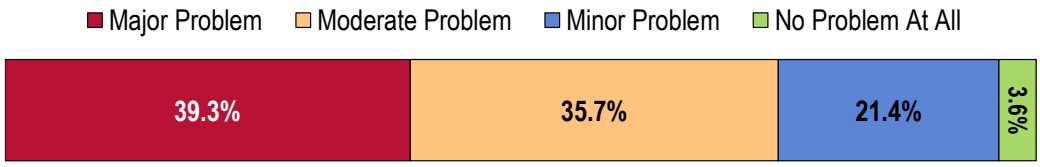


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 137]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-16]

Notes: Asked of all respondents age 50 through 75.
In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.

Perceptions of Cancer as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Screening/Prevention

We believe that cancer is a major problem in Brighton Park because people do not have access to preventative care services. There are a high number of adults who lack medical insurance (because they are not eligible for Medicaid due to immigration status). - Social Services Provider

The community does not actively engage in proactive screenings and do not go to the doctor unless something is wrong. This results in serious diseases like cancer not being caught until very late. - Social Services Provider

Low rates of routine cancer screening tests. - Other Health Provider

Prevalence/Incidence

> *Know many local families who have lost loved ones below the age of 50 to cancer. - Social Services Provider*
>
> *Too many people know of someone or is someone dealing with cancer. - Public Health Representative*

Lifestyle

> *Because of the lifestyle decisions of community members. - Community Leader*

Trauma

> *Traumatic experiences that impact the mind, body and soul, as well as lack of access to nutritious food, poor diet leads to many ailments. - Community Leader*

Respiratory Disease

About Asthma & COPD

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath. Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.

COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke). Treatment can lessen symptoms and improve quality of life for those with COPD.

The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at $20.7 billion.

Asthma. The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors.

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

— Healthy People 2020 (www.healthypeople.gov)

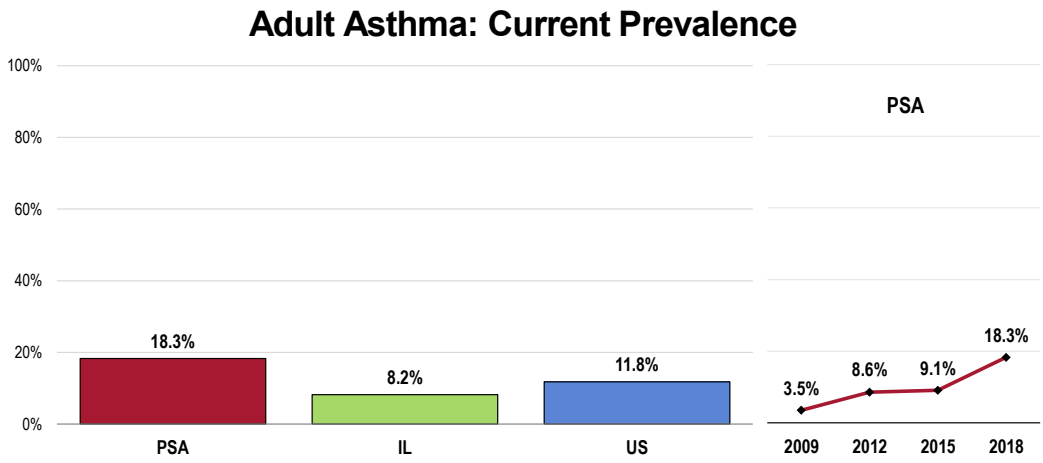
[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

Asthma

Adults

Survey respondents were asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma and COPD.

A total of 18.3% of Primary Service Area adults currently suffer from asthma.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.

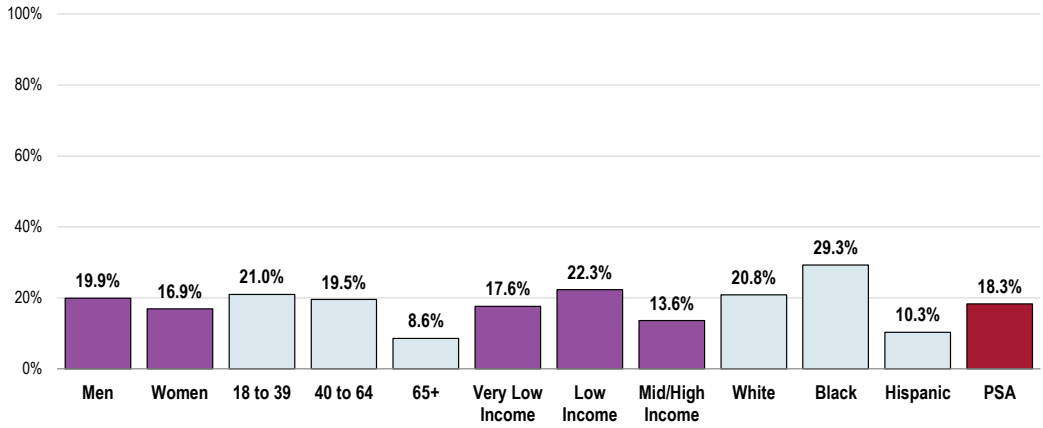
Notes: Asked of all respondents.
Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.

The following adults are more likely to suffer from asthma:

- Adults younger than 65.
- Black residents.

Currently Have Asthma

(PSA, 2018)



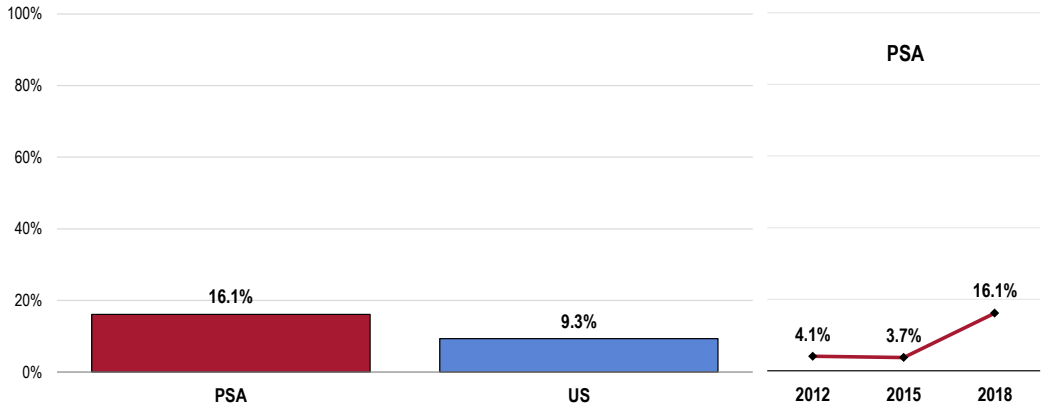
Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children

Among the Primary Service Area children under age 18, 16.1% currently have asthma

Childhood Asthma: Current Prevalence

(Among Parents of Children Age 0-17)

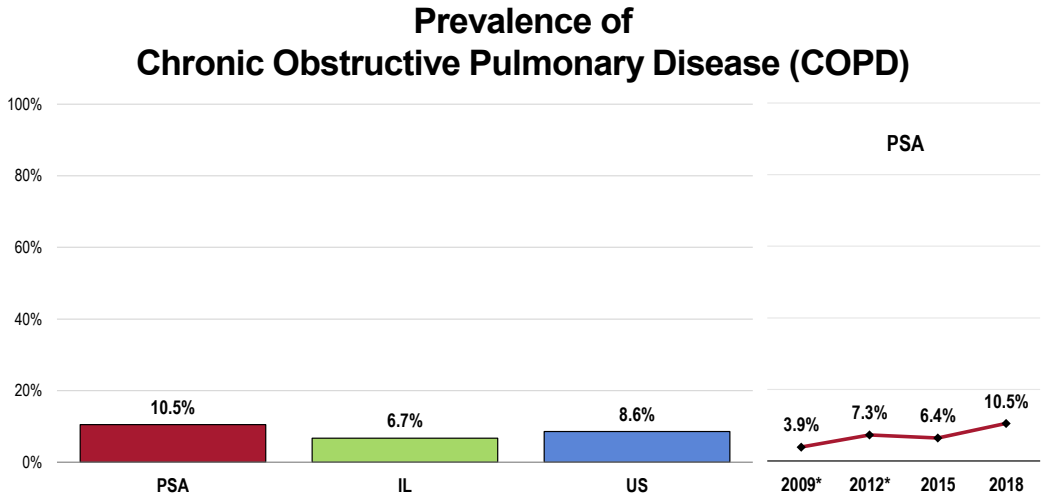


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 139]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents with children 0 to 17 in the household.
Includes children who have ever been diagnosed with asthma, and whom are reported to still have asthma.

Chronic Obstructive Pulmonary Disease (COPD)

A total of 10.5% of Primary Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

- Above the state prevalence.
- Similar to the national findings.
- TREND: Prevalence has increased significantly since 2009.
- *NOTE: In prior data, this question was asked slightly differently; respondents in 2009 and 2012 were asked if they had ever been diagnosed with "chronic lung disease, including bronchitis or emphysema," rather than "COPD or chronic obstructive*

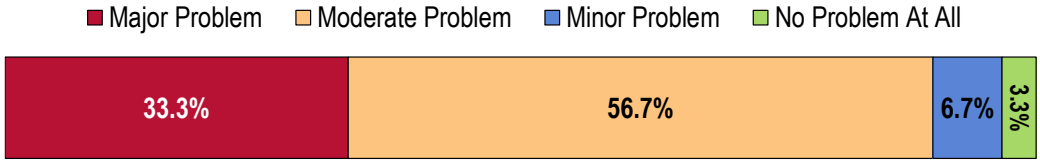


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 24]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents.
Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.
In 2009/2012 data, the term "chronic lung disease" was used, which also included bronchitis or emphysema.

Perceptions of Respiratory Diseases as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

Respiratory disease is a major problem in Brighton Park because many community members have asthma. This is probably due to environmental factors and the climate, like people live in basements, where it is very humid. - Social Services Provider

High rates of asthma and inhaler use. - Social Services Provider

Contributing Factors

Respiratory diseases are major problems in the community because of traumatic experiences that impact the mind, body and soul, which include being marginalized, ostracized, demonized, etc. Because of centuries of structural racism, certain people groups- particularly Blacks- disproportionately face lack of work, subpar education and little to no access to the basic necessities, which negatively impacts the brain and ultimately their well-being. Also, inhalation of chemical substances from the environment, dwelling and/or work spaces. And of course, lack of access to nutritious food; poor diet. - Community Leader

Injury & Violence

About Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as "accidents," "acts of fate," or as "part of life." However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

Efforts to prevent violence may focus on:

- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence

— Healthy People 2020 (www.healthypeople.gov)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

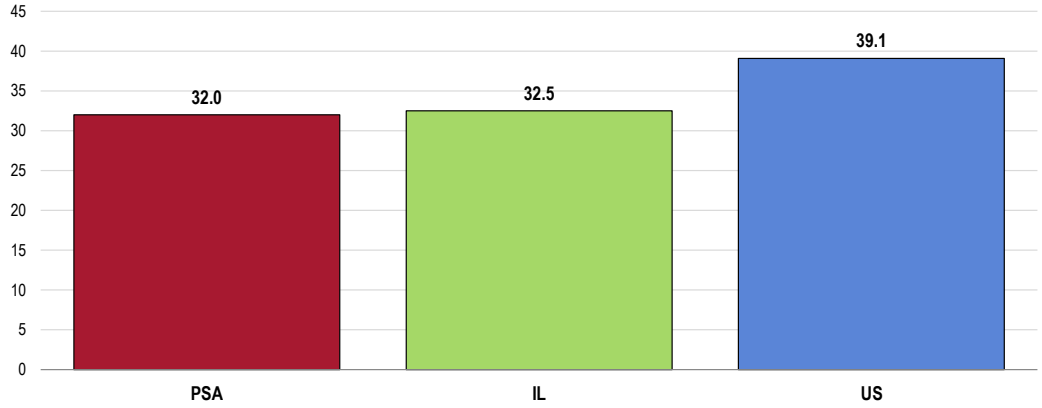
Between 2006 and 2010, there was an annual average age-adjusted unintentional injury mortality rate of 32.0 deaths per 100,000 population in the Primary Service Area.

- Almost identical to the Illinois rate.
- Lower the national rate.
- Similar to the Healthy People 2020 target (36.4 or lower).

Unintentional Injuries: Age-Adjusted Mortality

(2006-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 36.4 or Lower



Sources: Epidemiology and Public Health Informatics, Chicago Department of Public Heath (CDPH). Selected underlying causes of death in Chicago, 2006-2010. Data extracted from the Chicago Data Portal at https://data.cityofchicago.org/.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Firearm Safety

Age-Adjusted Firearm-Related Deaths

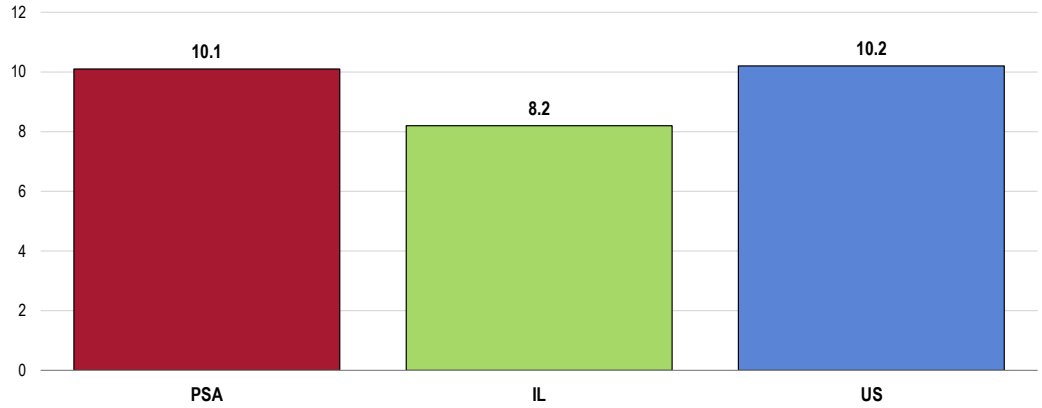
Between 2006 and 2010, firearms in the Primary Service Area contributed to an annual average age-adjusted rate of 10.1 deaths per 100,000 population.

- Higher than found statewide.

Firearms-Related Deaths: Age-Adjusted Mortality

(2006-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 9.3 or Lower



Sources: Epidemiology and Public Health Informatics, Chicago Department of Public Heath (CDPH). Selected underlying causes of death in Chicago, 2006-2010. Data extracted from the Chicago Data Portal at https://data.cityofchicago.org/.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

Between 2006 and 2010, there was an annual average age-adjusted homicide rate of 11.6 deaths per 100,000 population in the Primary Service Area.

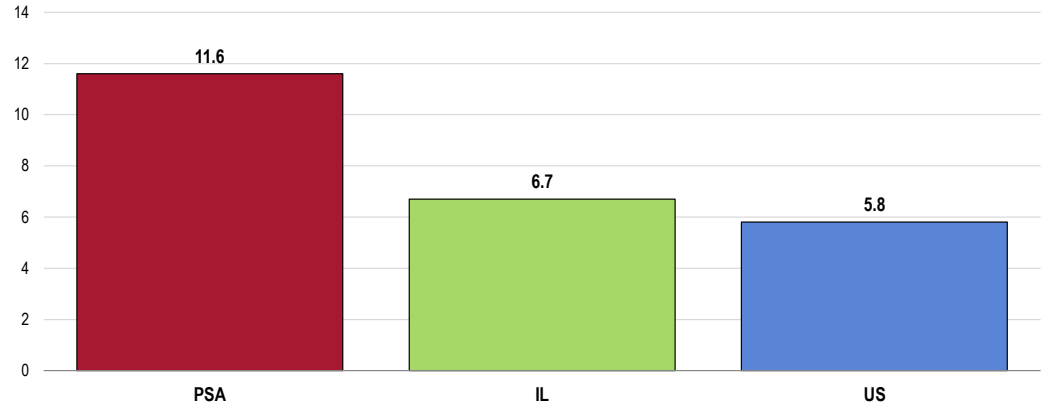
RELATED ISSUE:

See also *Mental Health*: *Suicide* in the **General Health Status** section of this report.

Homicide: Age-Adjusted Mortality

(2006-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 5.5 or Lower



Sources: Epidemiology and Public Health Informatics, Chicago Department of Public Heath (CDPH). Selected underlying causes of death in Chicago, 2006-2010. Data extracted from the Chicago Data Portal at https://data.cityofchicago.org/.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-29]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Violent Crime

Violent Crime Rates

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

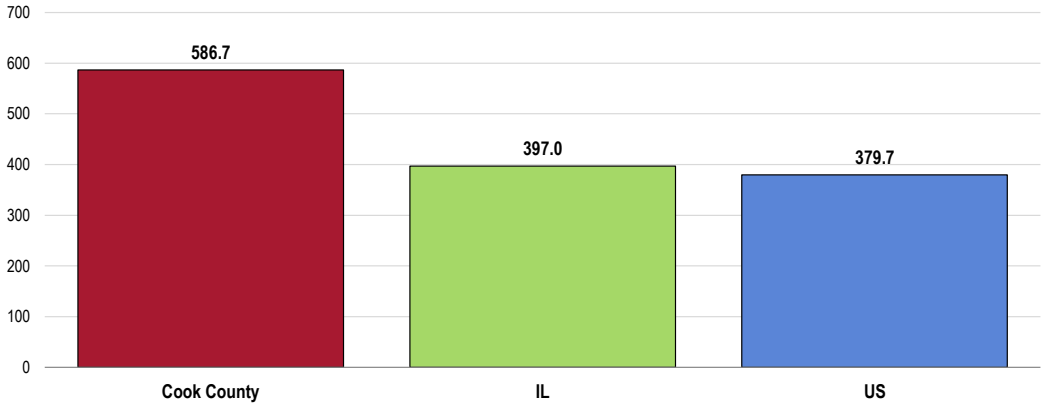
Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

In Cook County, there were a reported 586.7 violent crimes per 100,000 population between 2012 and 2014.

- Notably higher than the Illinois and US rates for the same period.

Violent Crime

(Rate per 100,000 Population, 2012-2014)



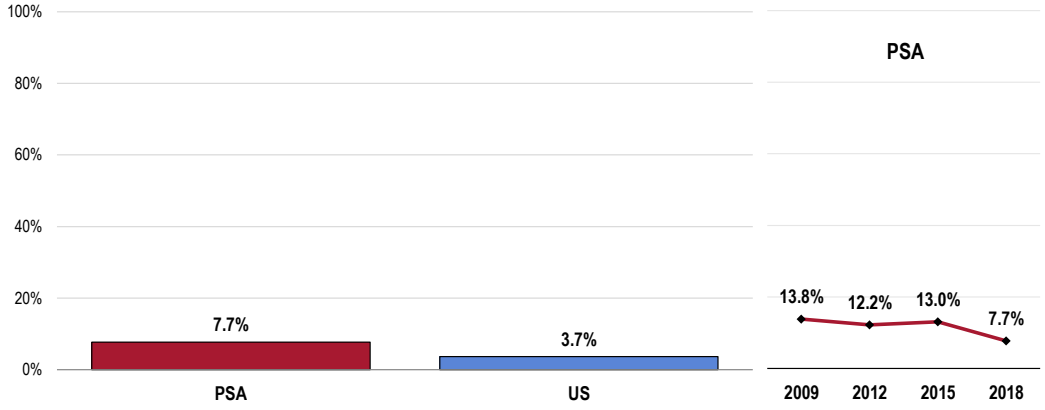
Sources: Federal Bureau of Investigation, FBI Uniform Crime Reports.
Retrieved December 2018 from Community Commons at http://www.chna.org.

Notes: This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics, but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Community Violence

A total of 7.7% of surveyed Primary Service Area adults acknowledge being the victim

Victim of a Violent Crime in the Past Five Years

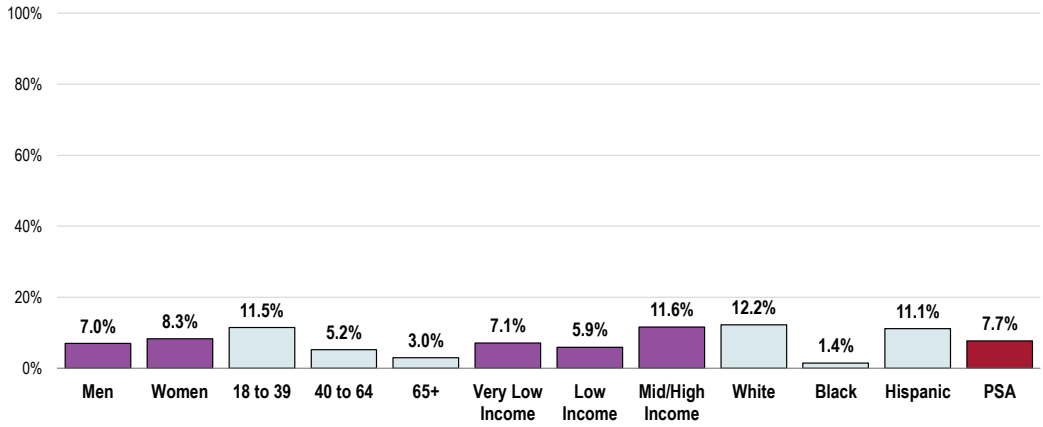


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 46]
2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents.

Victim of a Violent Crime in the Past Five Years

(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 46]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

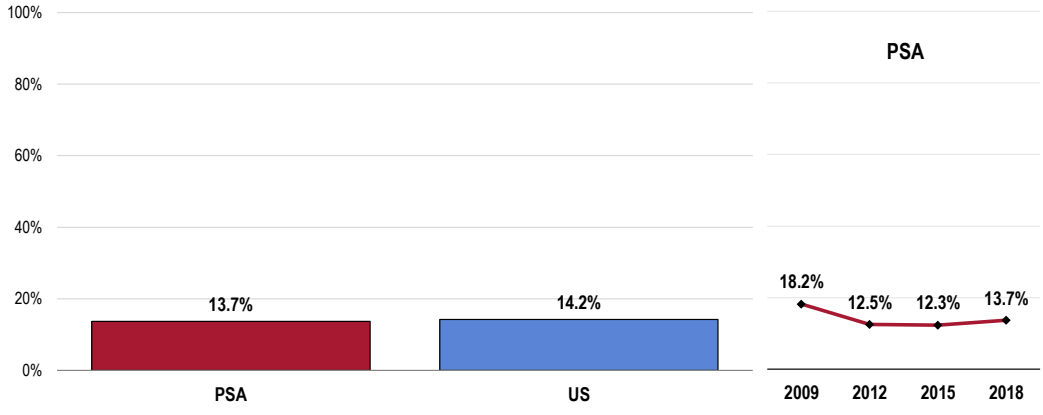
Family Violence

A total of 13.7% of Primary Service Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

Respondents were read:

"By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

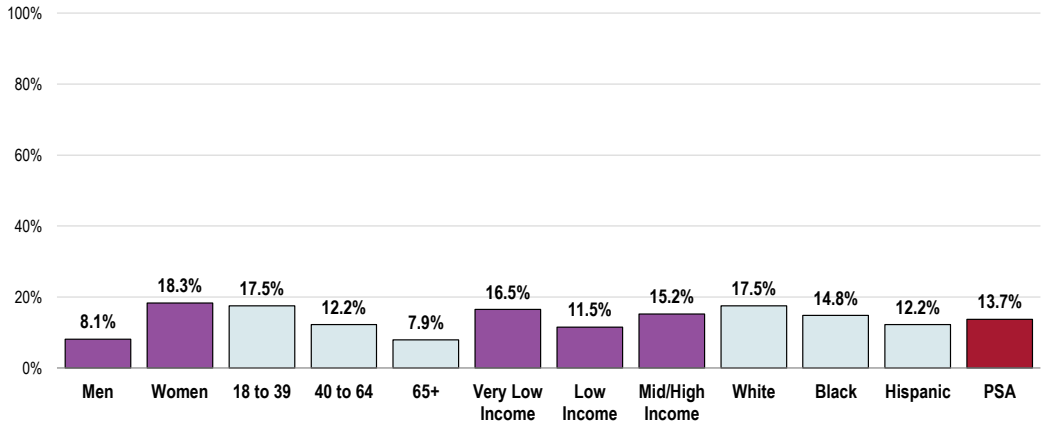
Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 47]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

(PSA, 2018)



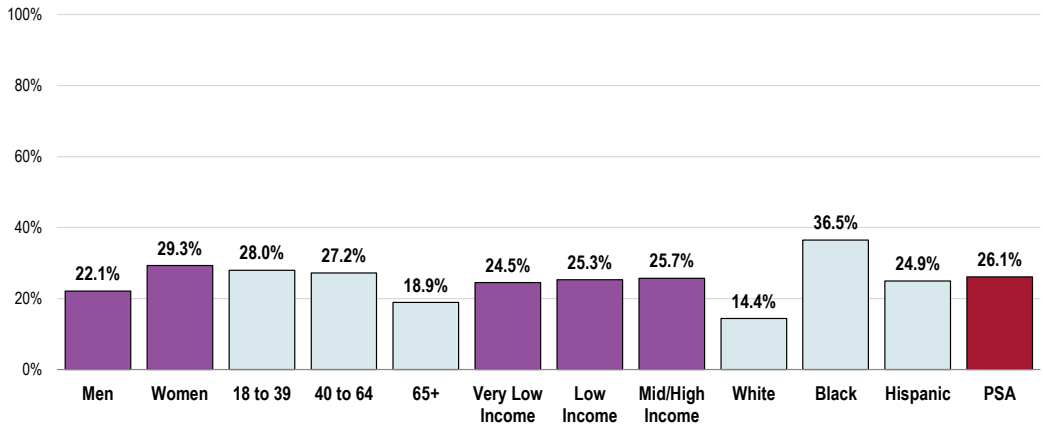
Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 47]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Loss of a Loved One Due to Violence

More than one-fourth of Primary Service Area adults (26.1%) report ever having lost a

Have Lost a Loved One Due to Violence

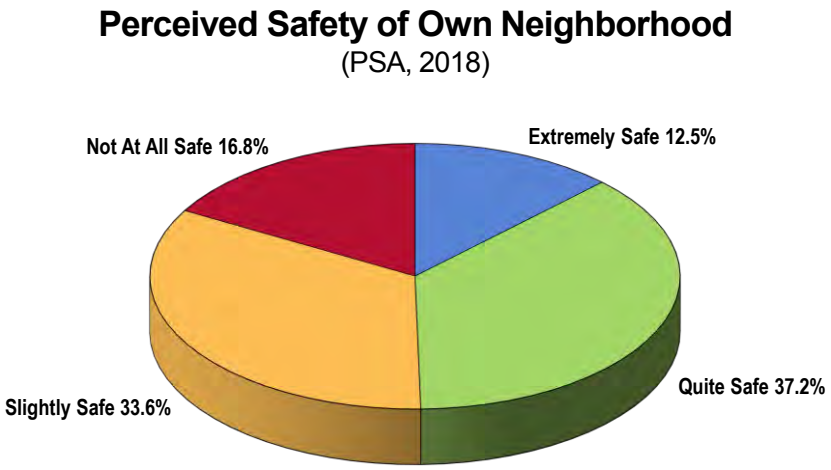
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 304]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Perceived Neighborhood Safety

While 49.7% Primary Service Area adults consider their own neighborhoods to be

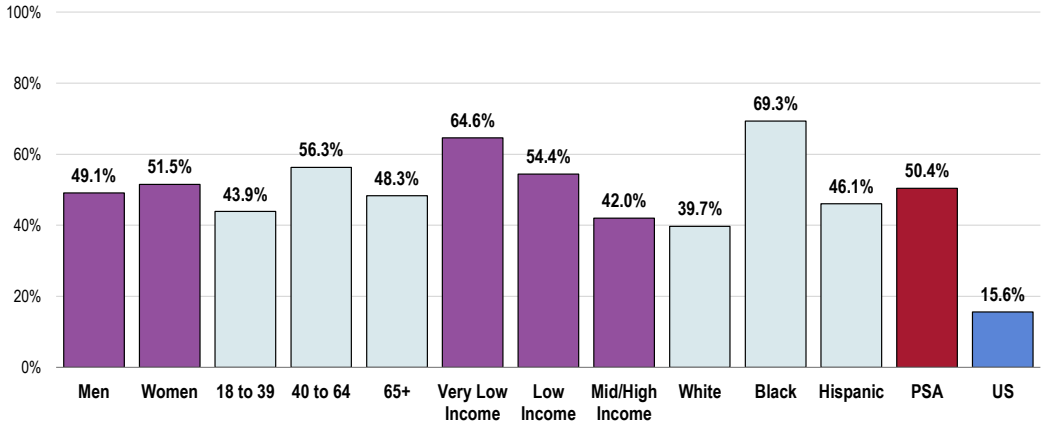


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 303]
Notes: Asked of all respondents.

- Compared with Americans overall, local adults are far more likely to consider their neighborhood to be “slightly” or “not at all” safe.
- Adults ages 40 to 64 are more likely to perceive their neighborhood as unsafe, as are (especially) lower income adults and Black residents.

Perceive Own Neighborhood as "Slightly" or "Not At All" Safe

(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 303]
2017 PRC National Health Survey, Professional Research Consultants, Inc.

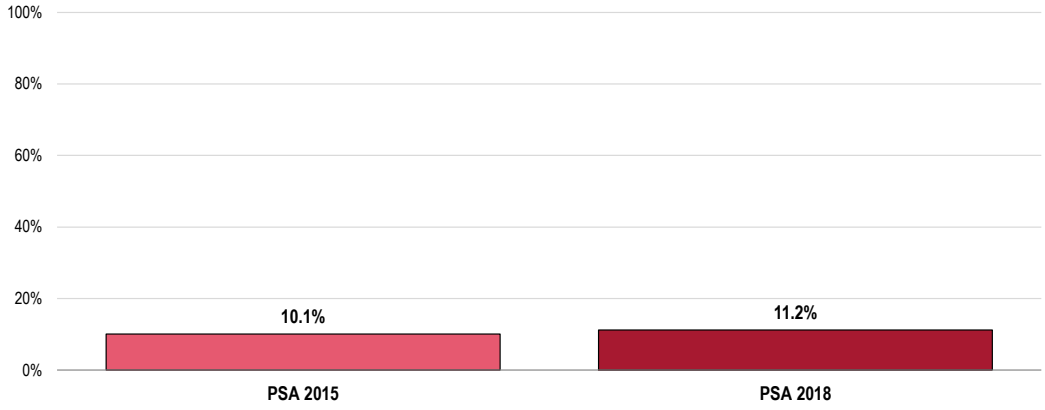
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Child Safety at School

"During the past school year, how many days did this child not go to school because he/she felt unsafe at school or on the way to or from school?"

Among service area parents of school-age children, 11.2% report that their child

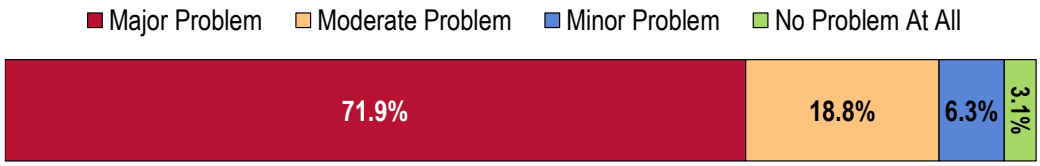
Child Missed School at Least Once in the Past Year Due to Feeling Unsafe



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 325]
Notes: Asked of those parents with school-age children.

Perceptions of Injury and Violence as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Gang Violence

Gang rivalries lead to high violence and injury in the community. Domestic abuse leads to high violence in the community. Selling and use of drugs lead to injury and violence. - Social Services Provider

Gang violence, intimate partner violence, and police actions, violence, distrust affect people of color in our community. - Other Health Provider

Gang activity, poverty, ready access to guns, violent police and violent media. - Physician

Gang violence and domestic violence are both high in the community. - Public Health Representative

High amounts of gang violence. - Social Services Provider

Prevalence/Incidence

We consider injury and violence a major problem in Brighton Park because we have seen an increase in street violence due to the cuts in social program and services that assist young people. - Social Services Provider

These communities are plagued with trauma injury and gun violence, victims of violence and unacceptable police accountability. - Community Leader

Chicago is on the news daily. Too many are out of control with guns. - Public Health Representative

Violence continues to plague the southwest side. - Public Health Representative

The high rates of gun violence, domestic violence and homicide rates in the west side. - Other Health Provider

Plethora of gun access, gangs, physical, verbal and sexual abuse, both partner and child in the home and the resulting trauma. - Community Leader

So many shootings. - Community Leader

Awareness/Education

Violence is endemic in our community. Lack of education in our kids/teens. Lack of parent involvement in the kids' education. - Physician

Need to understand trauma and healthy responses and how to de-stress, as well. - Community Leader

Trauma

> *Trauma/chronic stress disorder. People of all ages are constantly dealing with public violence- especially with guns- and there are very few resources unless you are the one that got shot. In a public shooting, anyone who experiences it or the aftermath is a victim. - Social Services Provider*
>
> *Injury and violence are major problems in the community because of traumatic experiences that impact the mind, body and soul, which include being marginalized, ostracized, demonized etc. Because of centuries of structural racism, certain people groups- particularly Blacks- disproportionately face lack of work, subpar education and little to no access to the basic necessities, which negatively impacts the brain and ultimately their well-being. Also, inhalation of chemical substances from the environment, dwelling and/or work spaces. And of course, lack of access to nutritious food; poor diet. - Community Leader*

Vulnerable Populations

> *Injuries go medically unaddressed due to the lack of insurance and financial hardship. Violence occurs for several reasons; gangs, unaddressed mental illness, latchkey kids with no adult supervision, lack of social programs, limited afterschool programs, etc. - Community Leader*
>
> *Injuries and violence are an internal part of the health disparities that take place. - Community Leader*

Diabetes

About Diabetes

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes. Effective therapy can prevent or delay diabetic complications.

Diabetes mellitus:

- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times.
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes.

Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

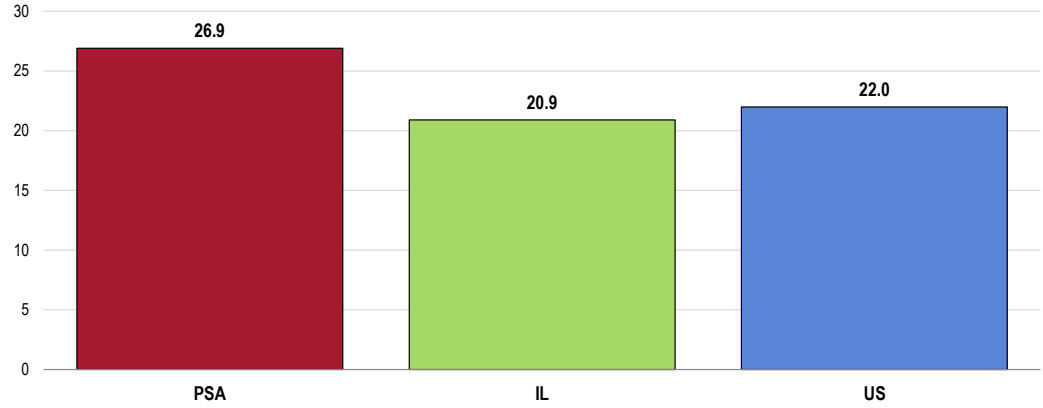
Between 2006 and 2010, there was an annual average age-adjusted diabetes mortality rate of 26.9 deaths per 100,000 population in the Primary Service Area.

- Less favorable than that found statewide or nationally.
- Fails to satisfy the Healthy People 2020 target (20.5 or lower, adjusted to account for diabetes mellitus-coded deaths).

Diabetes: Age-Adjusted Mortality

(2006-2010 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 20.5 or Lower (Adjusted)



Sources: Epidemiology and Public Health Informatics, Chicago Department of Public Heath (CDPH). Selected underlying causes of death in Chicago, 2006-2010. Data extracted from the Chicago Data Portal at https://data.cityofchicago.org/.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

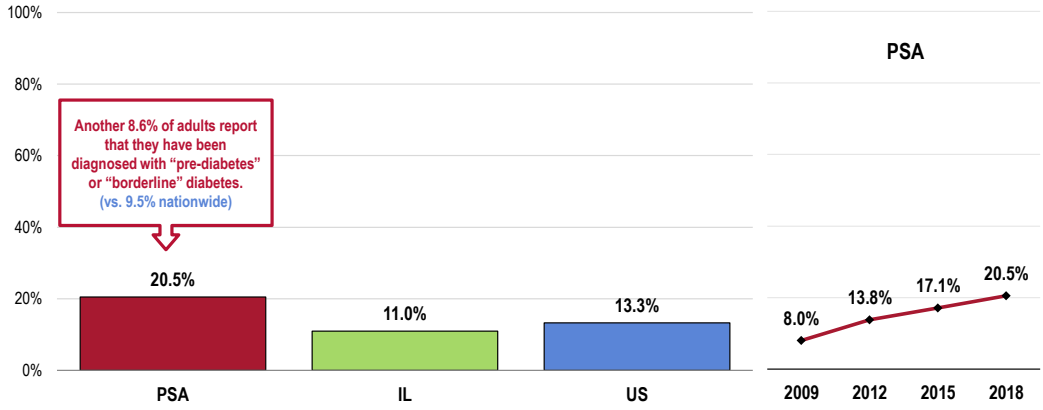
A total of 20.5% of Primary Service Area adults report having been diagnosed with diabetes.

- Notably higher than state or national proportions.
- TREND: Represents a consistent increase in diabetes prevalence over time.

In addition to the prevalence of diagnosed diabetes referenced above, another 8.6% of Primary Service Area adults report that they have "pre-diabetes" or "borderline diabetes."

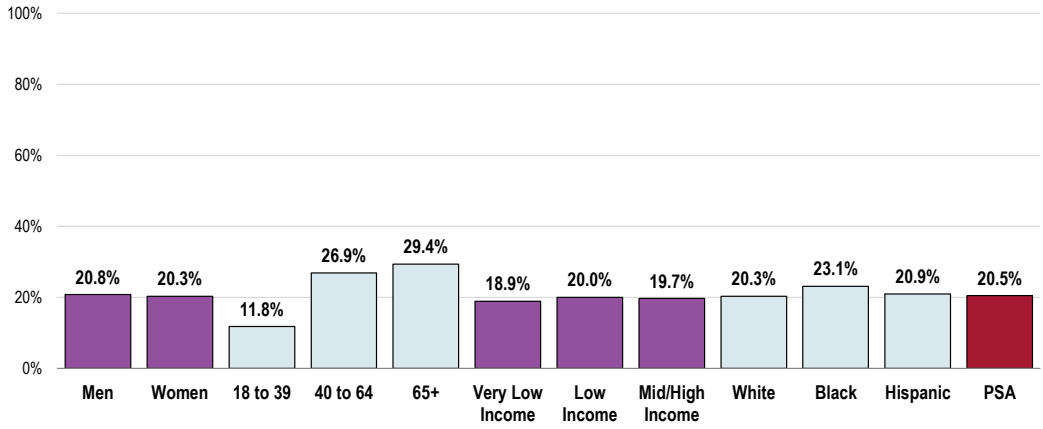
- Comparable to the US prevalence.

Prevalence of Diabetes



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 140]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.

Prevalence of Diabetes
(PSA, 2018)

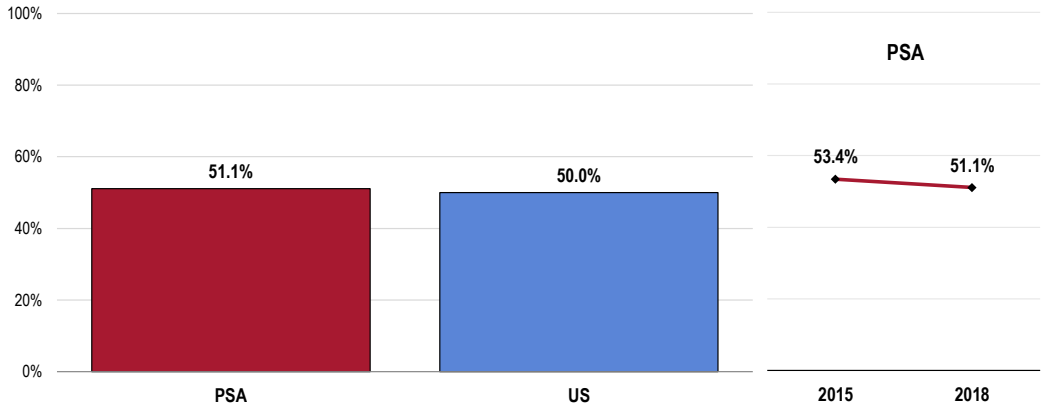


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 140]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
Excludes gestational diabetes (occurring only during pregnancy).

Diabetes Testing

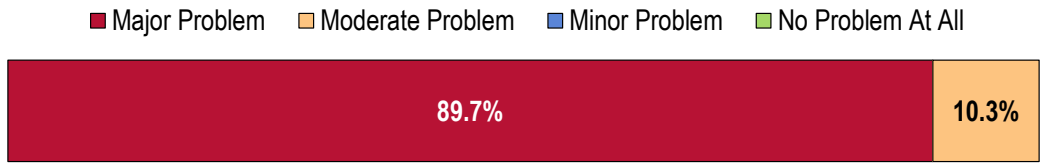
Of area adults who have <u>not</u> been diagnosed with diabetes, 51.1% report having had their blood sugar level tested within the past three years.

Have Had Blood Sugar Tested in the Past Three Years
(Among Nondiabetics)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 37]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of respondents who have not been diagnosed with diabetes.

Perceptions of Diabetes as a Problem in the Community
(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Reasons for "Major Problem" Responses:

-
-
-
-

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Awareness/Education

Some don't realize they have diabetes. Others struggle with addressing what needs to be done to minimize the impact of this disease. Exercise and healthy eating are often a challenge due to lack of options for either. - Community Leader

Education about the disease, early detection, disease management and help with changing lifestyle. - Other Health Provider

Education on how to live with or prevent diabetes. Access to medication if uninsured or underinsured. - Social Services Provider

Diabetes awareness, prevention and access to care. - Community Leader

Are unaware of how dangerous and harmful it is. - Community Leader

Not understanding how to properly prevent it or treat it. - Community Leader

Lifestyle

Diet and lack of exercise. The area is not walkable, nor is it very safe, resulting in people not being out on foot. - Social Services Provider

I think eating habits and lack of exercise may be the factors that influence the diabetes rates in our community. - Social Services Provider

Proper diet and access to information around diabetes. - Community Leader

Lifestyle changes. - Community Leader

Access to Care/Services

Lack of nutrition and weight management programs that engage the person with diabetes in a manner tailored to their needs and builds adherence to a balance lifestyle. - Community Leader

Access to supportive resources and care. Access to healthy and low-cost foods. - Public Health Representative

Access to Healthy Food

Lack of access to affordable, quality food coupled with dearth of safe public spaces where people can walk, bike or run around. - Social Services Provider

Less access to healthy food and education on how to take care of oneself. - Social Services Provider

Affordable Care/Medications

Not being able to afford diabetes supplies and medication. - Other Health Provider

Affording regular medical visits and medication. - Physician

Prevalence/Incidence

Rates of uncontrolled diabetes are very high in the community. Access to high quality specialty care for uninsured patients is limited. - Public Health Representative

Seeing high numbers of obese people and knowing lots of people who take insulin. - Social Services Provider

Disease Management

How to manage the disease. - Social Services Provider

Complicating Factors

The biggest challenges with diabetes include traumatic experiences that impact the mind, body and soul, as well as inhalation of chemical substance in dwelling or work spaces. And of course, lack of access to nutritious food, poor diet. - Community Leader

Alzheimer's Disease

About Dementia

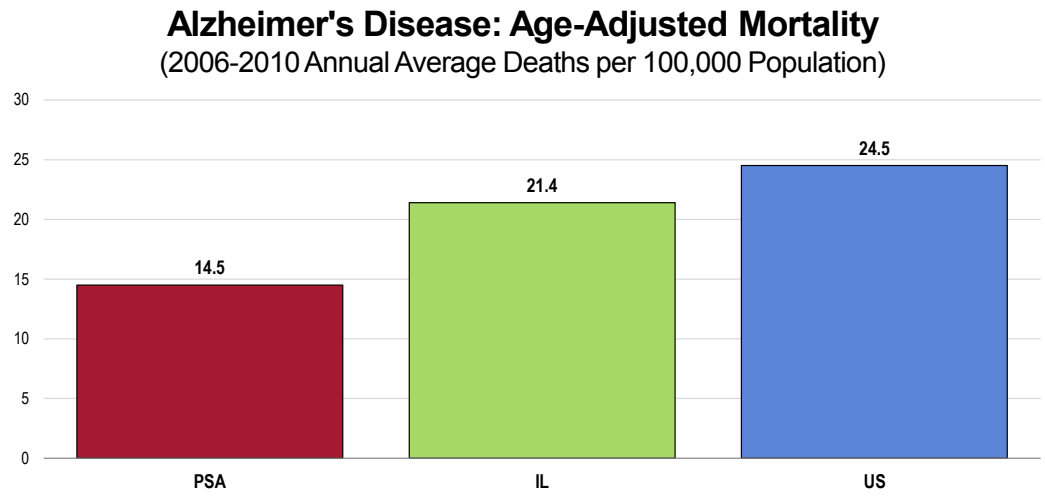
Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer's Disease Deaths

Between 2006 and 2010, there was an annual average age-adjusted Alzheimer's disease

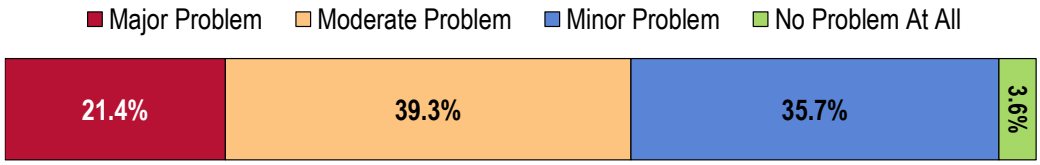


Sources: Epidemiology and Public Health Informatics, Chicago Department of Public Heath (CDPH). Selected underlying causes of death in Chicago, 2006-2010. Data extracted from the Chicago Data Portal at https://data.cityofchicago.org/.

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Not many places that can watch elders with dementia/Alzheimer's disease. Therefore, some elders have other health factors and are aggressive. Family members are mostly the caregivers. They need a break. Sometimes frustrated with the care it entails. - Public Health Representative

Aging Population

Since people are living longer, some of the seniors have developed Alzheimer's disease or related dementia disorders. It also impacts many family caregivers. Many of the families do not know about the disease and how to manage the symptoms. There is also a lack of linguistic appropriate materials for the Chinese population. - Social Services Provider

Awareness/Education

Lack of awareness about dementia and cognitive health among Latino and African American communities. Lack of experienced bilingual physicians who can conduct evaluations and provide care plan. Lack of support for Alzheimer's caregivers. - Other Health Provider

Comorbidities

Dementia/Alzheimer's disease is caused by various forms trauma not dealt with over time, diabetes (insulin instability) and consumption of prescription and street drugs. Also, inhalation of chemical substance in dwelling, work spaces, and open environment. And of course, lack of access to nutritious food; poor diet. - Community Leader

Prevalence/Incidence

A lot of people struggle with. - Community Leader

Kidney Disease

About Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

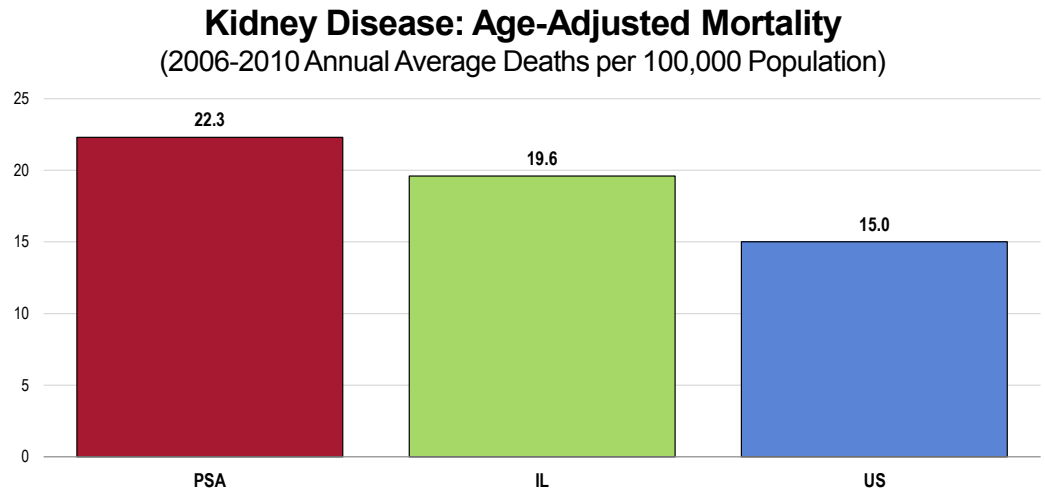
Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Between 2006 and 2010, there was an annual average age-adjusted kidney disease mortality rate of 22.3 deaths per 100,000 population in the Primary Service Area.

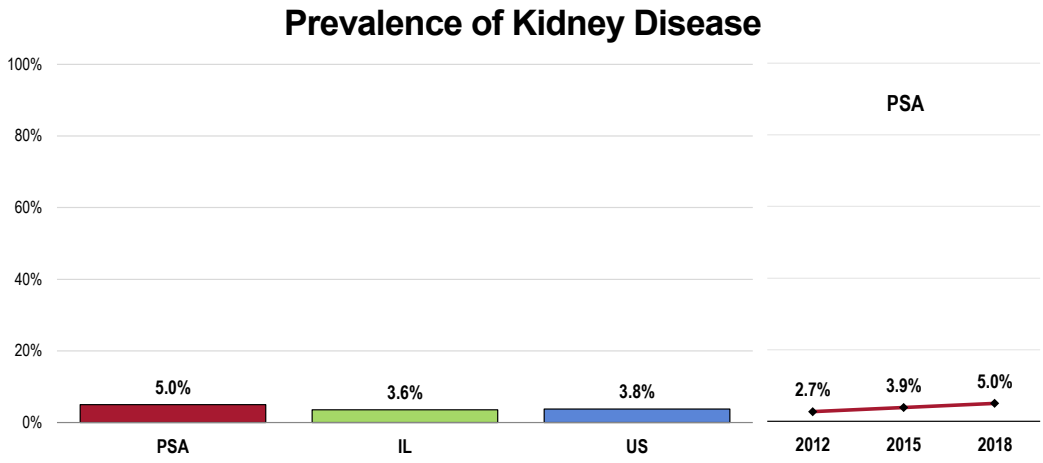


Sources: Epidemiology and Public Health Informatics, Chicago Department of Public Heath (CDPH). Selected underlying causes of death in Chicago, 2006-2010. Data extracted from the Chicago Data Portal at https://data.cityofchicago.org/.

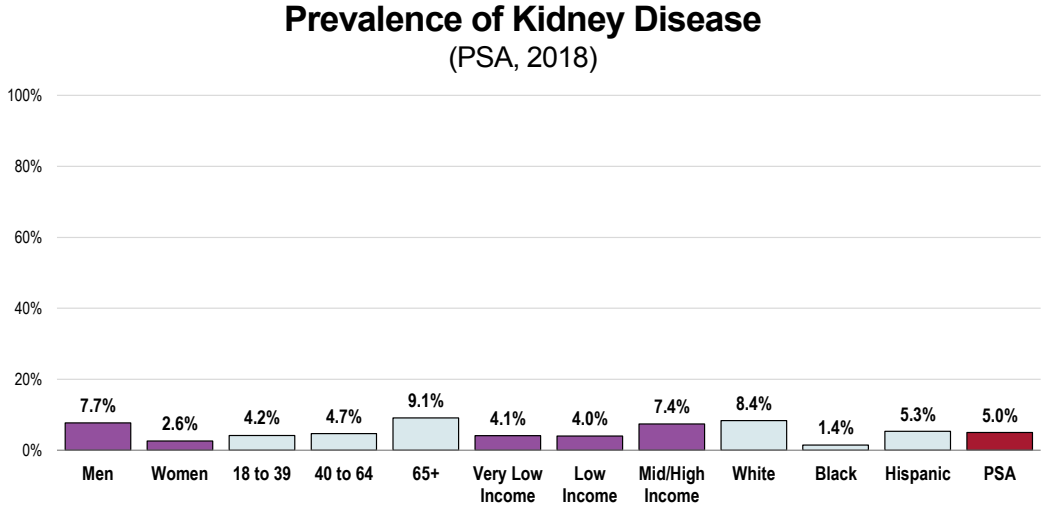
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Kidney Disease

A total of 5.0% of Primary Service Area adults report having been diagnosed with



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 30]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 30]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
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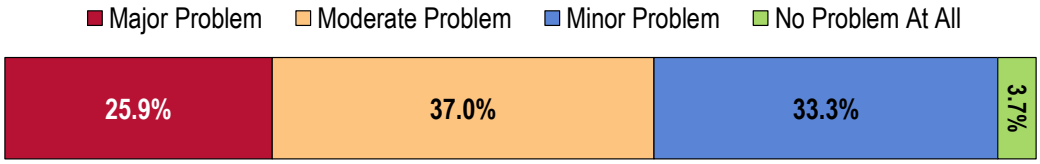
Perceptions of Kidney Disease as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Comorbidities

Kidney disease is usually linked to diabetes, and diabetes is very prevalent in our community. - Social Services Provider

If someone has diabetes, it can cause more issues to vital organs, including the kidney. - Public Health Representative

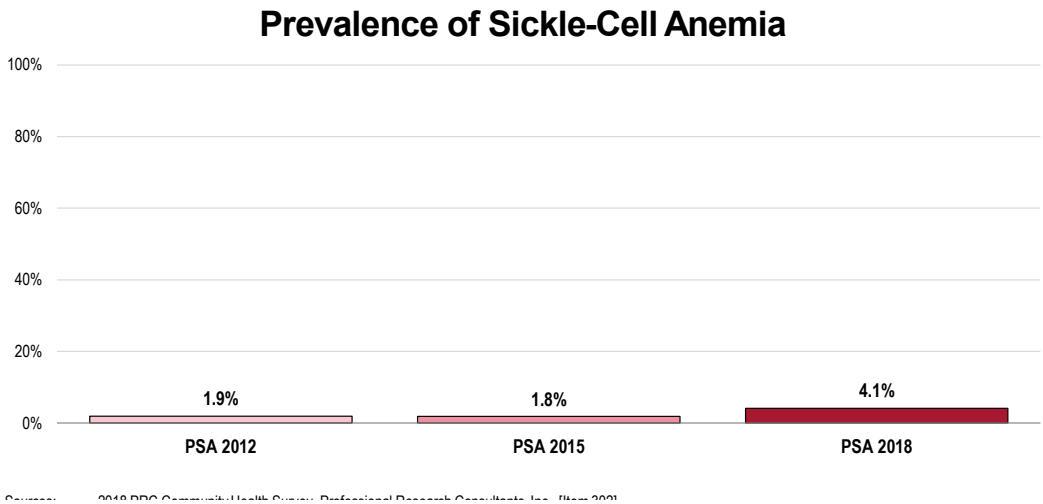
Rates of uncontrolled diabetes are very high in the community. Access to high quality specialty care for uninsured patients is limited. - Public Health Representative

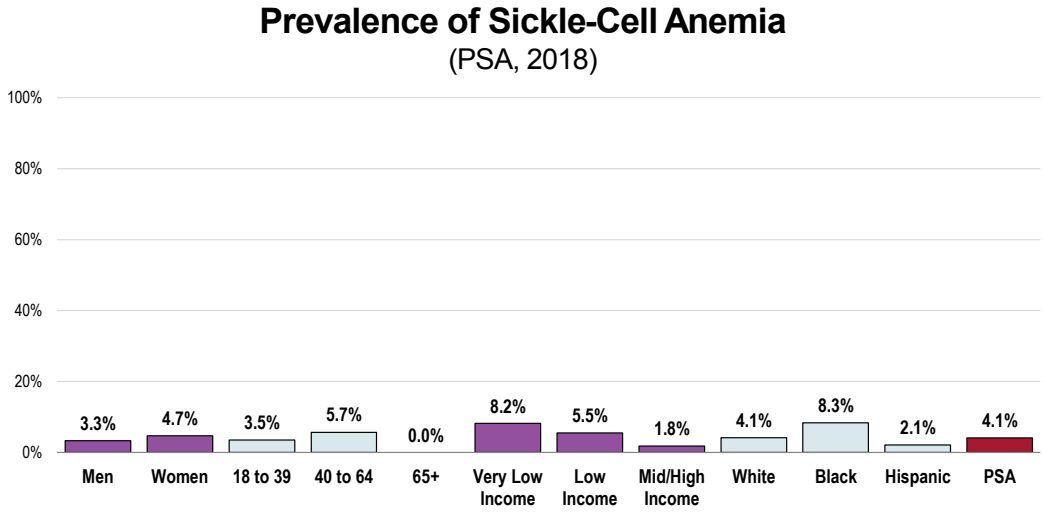
Alcohol/Drug Use

Too much consumption of prescription drugs, street drugs and unhealthy beverages, like soda, including alcohol. - Community Leader

Sickle-Cell Anemia

Prevalence of Sickle-Cell Anemia





Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 302]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Potentially Disabling Conditions

Arthritis, Osteoporosis, & Chronic Back Conditions

About Arthritis, Osteoporosis, & Chronic Back Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than $128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least $50 billion each year on low back pain. Low back pain is the:

- 2nd leading cause of lost work time (after the common cold).
- 3rd most common reason to undergo a surgical procedure.
- 5th most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

— Healthy People 2020 (www.healthypeople.gov)

More than four in 10 Primary Service Area adults age 50 and older (42.5%) report suffering from arthritis or rheumatism.

RELATED ISSUE:

See also *Overall Health Status: Activity Limitations* in the **General Health Status** section of this report.

- Similar to that found nationwide.

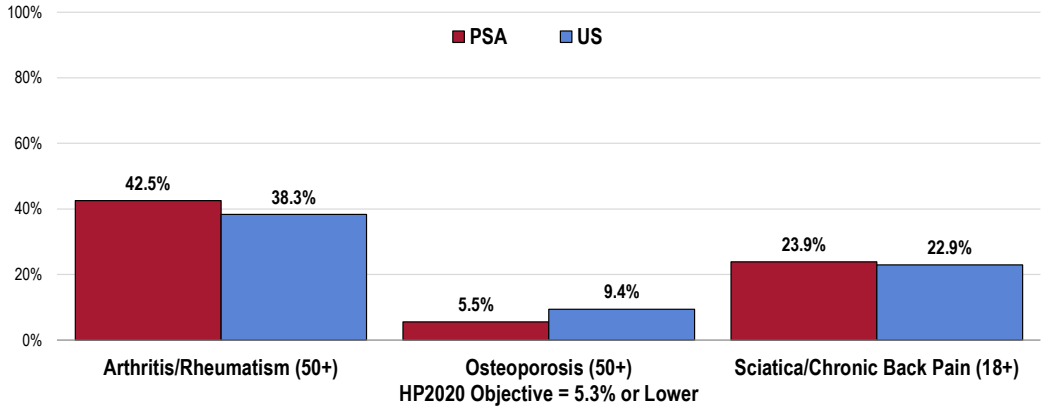
A total of 5.5% of Primary Service Area adults age 50 and older have osteoporosis.

- Similar to that found nationwide.
- Similar to the Healthy People 2020 target of 5.3% or lower.

A total of 23.9% of Primary Service Area adults (age 18 and older) suffer from chronic back pain or sciatica.

- Similar to that found nationwide.

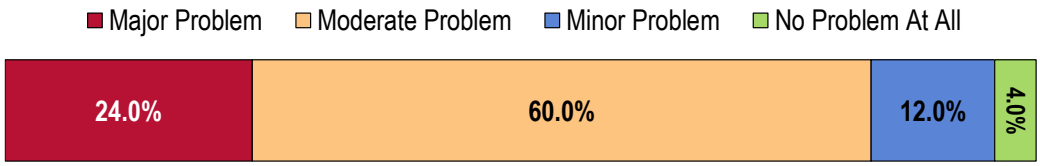
Prevalence of Potentially Disabling Conditions



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 26, 141-142]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AOCBC-10]
Notes: The sciatica indicator reflects the total sample of respondents; the arthritis and osteoporosis columns reflect adults age 50+.

Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Aging Population

> *Many seniors in the community have arthritis/osteoporosis/back pain. There is a lack of information for the seniors how to manage their pain. Because of arthritis, a lot of seniors have become inactive. It also affects their mental health because of their inactivity. - Social Services Provider*
>
> *We have a large amount of seniors in our area. - Social Services Provider*

Prevalence/Incidence

> *Many individuals suffer from these daily aches. Effects with work, life, family, etc. - Public Health Representative*
>
> *Seeing people walking around limping, hunched over, in pain on a regular basis. - Social Services Provider*

Vision & Hearing Impairment

About Vision

Vision is an essential part of everyday life, influencing how Americans of all ages learn, communicate, work, play, and interact with the world. Yet millions of Americans live with visual impairment, and many more remain at risk for eye disease and preventable eye injury.

The eyes are an important, but often overlooked, part of overall health. Despite the preventable nature of some vision impairments, many people do not receive recommended screenings and exams. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases, including diabetic retinopathy, glaucoma, cataract, and age-related macular degeneration.

These common vision problems often have no early warning signs. If a problem is detected, an eye care professional can prescribe corrective eyewear, medicine, or surgery to minimize vision loss and help a person see his or her best.

Healthy vision can help to ensure a healthy and active lifestyle well into a person's later years. Educating and engaging families, communities, and the nation is critical to ensuring that people have the information, resources, and tools needed for good eye health.

— Healthy People 2020 (www.healthypeople.gov)

About Hearing & Other Sensory or Communication Disorders

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such a social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

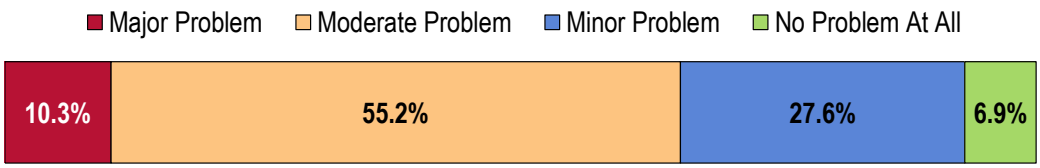
— Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: Vision & Hearing

Key informants taking part in an online survey most often characterized *Vision & Hearing* as a "moderate problem" in the community.

Perceptions of Vision and Hearing as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> *Besides having the UIC near the hospital, others need to stay home alone until someone comes to take care of them. Can fall or injure themselves. - Public Health Representative*
>
> *Eye care/eye examinations are generally covered by the schools, but for adults there is not much education or outreach. - Community Leader*

Prevalence/Incidence

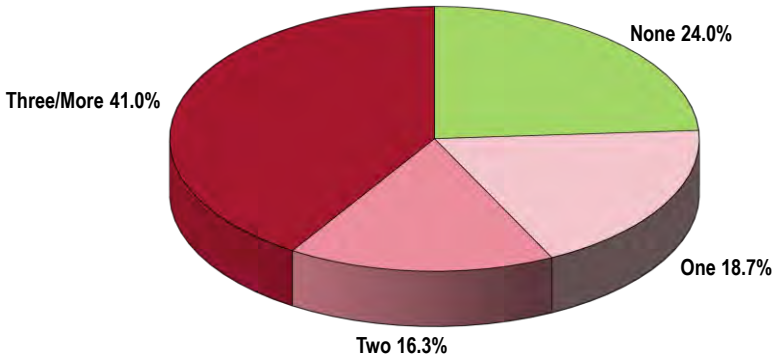
> *Lots of squinting from young people and outdated prescriptions from older people. - Social Services Provider*

Multiple Chronic Conditions

Among Primary Service Area survey respondents, most report currently having at least one chronic health condition, including 18.7% with one condition, 16.3% with two conditions, and 41.0% with three or more chronic conditions.

For the purposes of this assessment, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, hypertension, high blood cholesterol, diabetes, obesity, and/or diagnosed depression. Multiple chronic conditions are concurrent conditions.

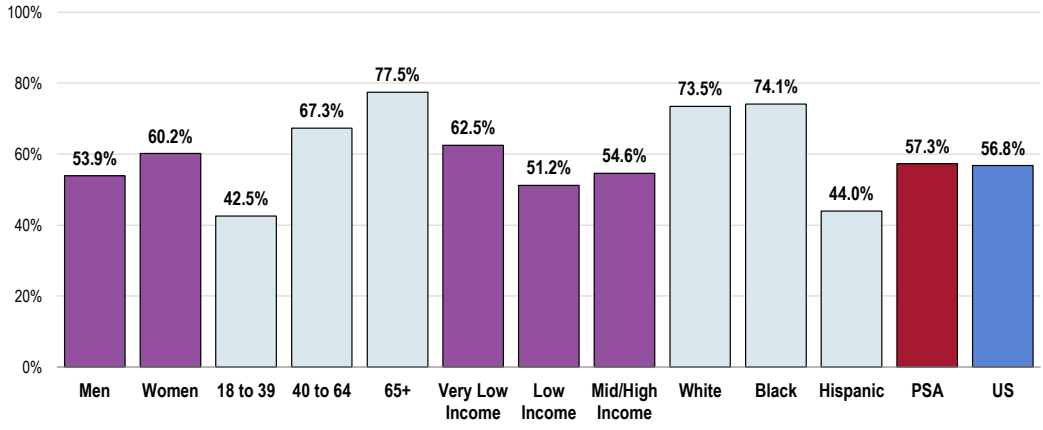
Number of Current Chronic Conditions
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 143]
Notes: Asked of all respondents.
In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, hypertension, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

- The prevalence of multiple chronic conditions (two or more) among Primary Service Area residents (57.3%) is similar to the US prevalence.

Currently Suffer From Multiple Chronic Conditions
(PSA, 2018)

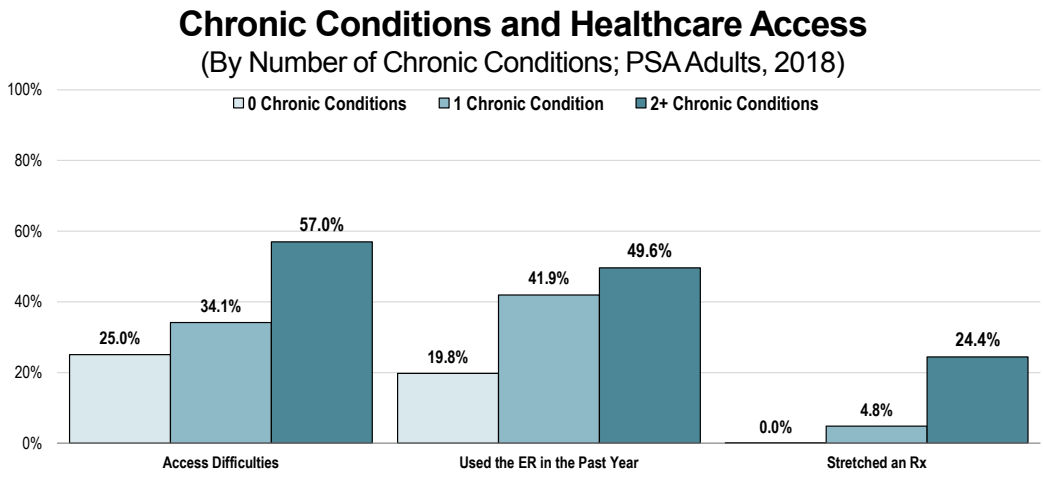


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 143]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, hypertension, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

Chronic Conditions & Healthcare Access

Adults with chronic conditions often go without needed medical care or prescription drugs due to cost, and uninsured adults with common chronic conditions suffer serious, identifiable gaps in needed medical care.

Note these strong correlations between the number of chronic conditions among the Primary Service Area adults and various healthcare access-related issues:



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 14, 22, 143, 171]
In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, hypertension, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

Infectious Disease

Professional Research Consultants, Inc.

Influenza & Pneumonia Vaccination

About Influenza & Pneumonia

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the nation, accounting for 56,000 deaths annually. Pneumonia mortality in children fell by 97% in the last century, but respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the US. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths (1,270 of which were of people younger than age 18) between April 2009 and March 2010.

— Healthy People 2020 (www.healthypeople.gov)

Flu Vaccination

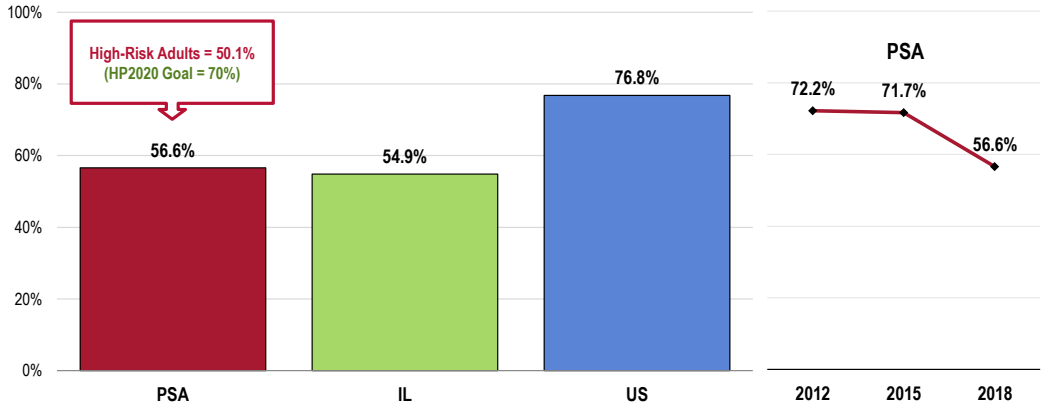
Among the Primary Service Area seniors, 56.6% received a flu shot within the past year.

- Comparable to the Illinois finding.
- Lower than the national finding.

Older Adults: Have Had a Flu Vaccination in the Past Year

(Among Adults Age 65+)

Healthy People 2020 Target = 70.0% or Higher



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 144-145]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.12]

Notes: Reflects respondents 65 and older.
"High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes, or respiratory disease.

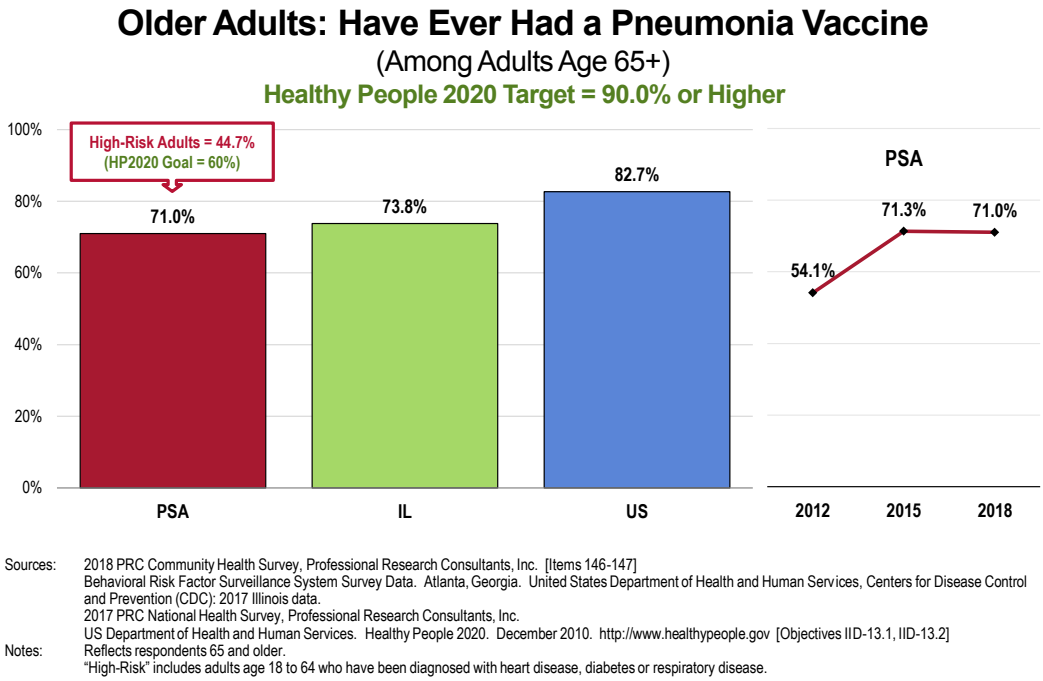
"High-risk" includes adults who report having been diagnosed with heart disease, diabetes, or respiratory disease.

A total of 50.1% of high-risk adults age 18 to 64 received a flu shot within the past year.

Pneumonia Vaccination

Among Primary Service Area adults age 65 and older, 71.0% have received a pneumonia vaccination at some point in their lives.

- Statistically comparable to Illinois and US findings.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 146-147]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives IID-13.1, IID-13.2]
Notes: Reflects respondents 65 and older.
"High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

A total of 44.7% of high-risk adults age 18 to 64 have ever received a pneumonia vaccination.

HIV

About Human Immunodeficiency Virus (HIV)

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

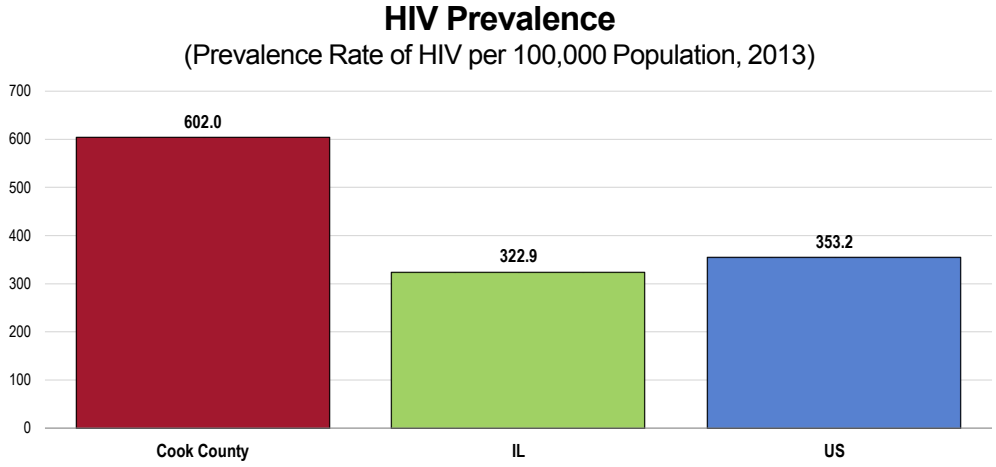
- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

— Healthy People 2020 (www.healthypeople.gov)

HIV Prevalence

In Cook County, there was a prevalence of 602.0 HIV cases per 100,000 population in

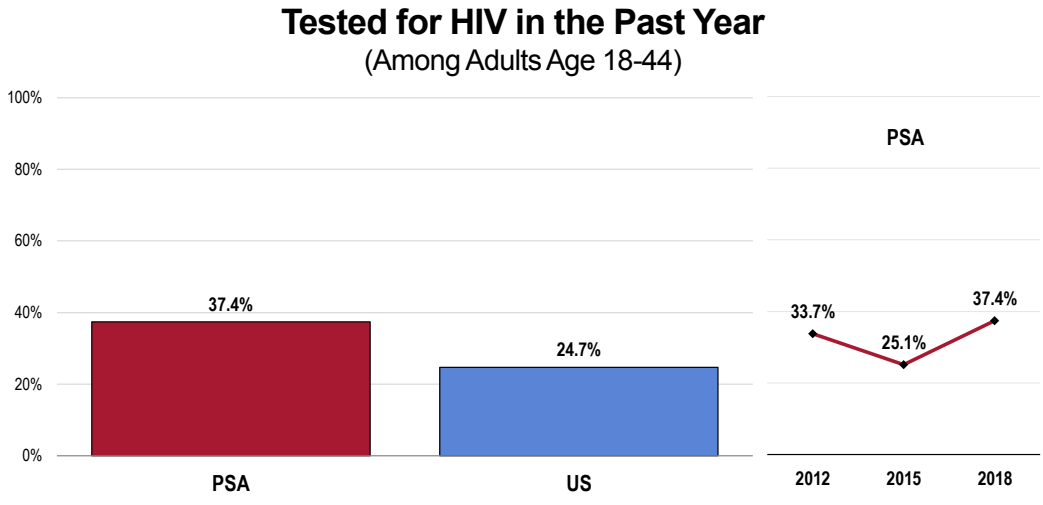


Sources: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Retrieved December 2018 from Community Commons at http://www.chna.org.

Notes: This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

HIV Testing

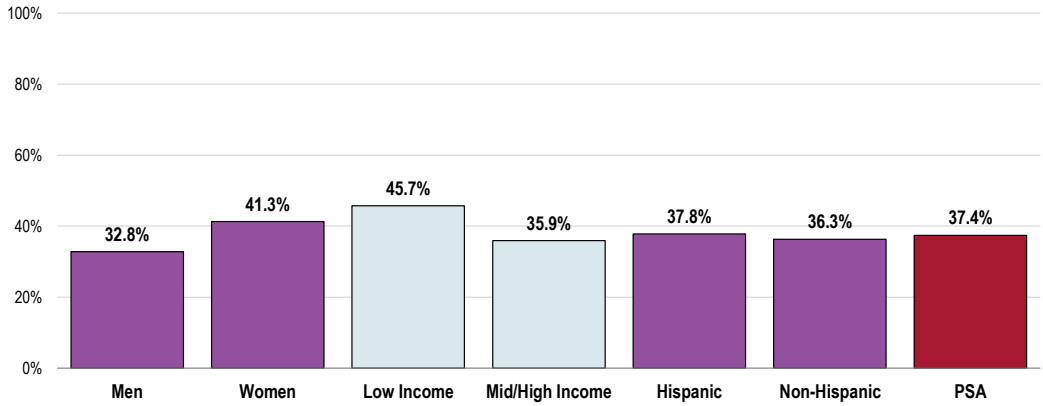
Among Primary Service Area adults age 18-44, 37.4% report that they have been tested for human immunodeficiency virus (HIV) in the past year.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 309]
2017 PRC National Health Survey, Professional Research Consultants, Inc.

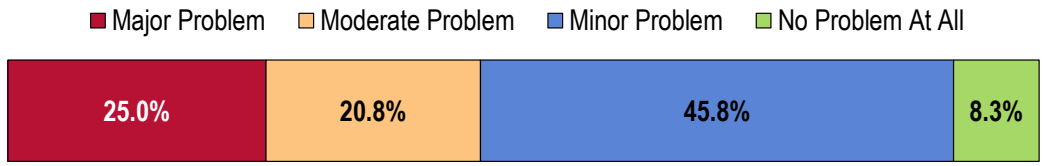
Notes: Reflects respondents age 18 to 44.

Tested for HIV in the Past Year
(Among Adults Age 18-44)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 309]
Notes: Reflects respondents age 18 to 44.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes below 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Perceptions of HIV/AIDS as a Problem in the Community
(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

Stories, word of mouth. - Social Services Provider

Risky Behaviors

Amount of drug use and sexual activity. - Community Leader

Sexually Transmitted Diseases

About Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. Several factors contribute to the spread of STDs.

Biological Factors. STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs**. The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities**. Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities**. Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications**. Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

Social, Economic, and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons “linked” by sequential or concurrent sexual partners).

— Healthy People 2020 (www.healthypeople.gov)

Chlamydia & Gonorrhea

In Cook County, the chlamydia incidence rate in 2014 was 713.1 cases per 100,000 population.

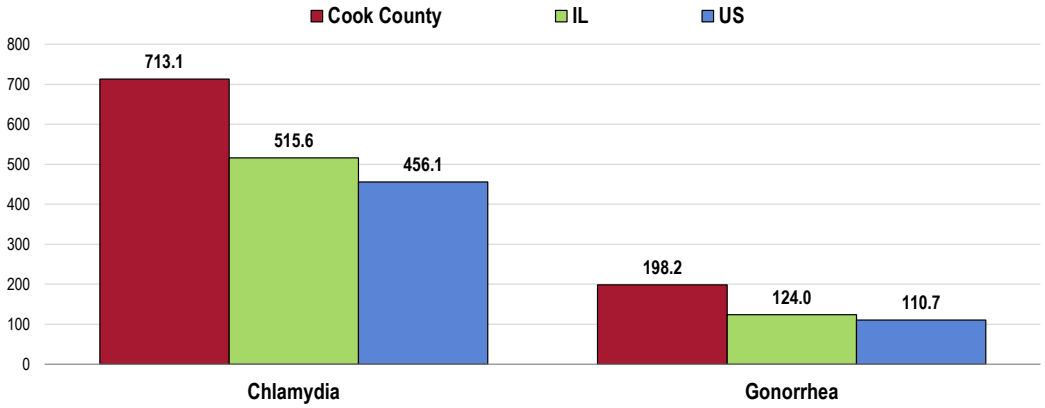
- Notably higher than the Illinois and national incidence rates.

The Cook County gonorrhea incidence rate in 2014 was 198.2 cases per 100,000 population.

- Higher than the Illinois and national incidence rates.

Chlamydia & Gonorrhea Incidence

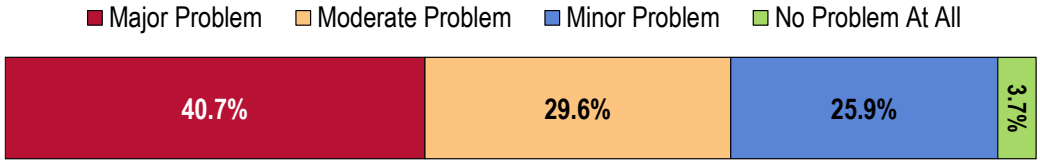
(Incidence Rate per 100,000 Population, 2014)



Sources: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Retrieved December 2018 from Community Commons at http://www.chna.org.
Notes: This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Perceptions of Sexually Transmitted Diseases as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

Lack of education, men not wanting to use condoms and lack of education on prep. - Other Health Provider

Mainly due to promiscuity and lack of education around healthy sexuality and relationship. - Community Leader

Educating is not working. Spike in diseases. There are treatments for some and feel that it is their remedy. - Public Health Representative

Social Determinants of Health

Poverty leads to low education, which leads to lack of condom use and spread of STDs. - Physician

> *Because of traumatic experiences that impact the mind, body and soul, which include being marginalized, ostracized, demonized, etc. Because of centuries of structural racism, certain people groups- particularly Blacks- disproportionately face lack of work, subpar education and little to no access to the basic necessities, which negatively impacts the brain and ultimately their well-being. Also, inhalation of chemical substances from the environment, dwelling and/or work spaces that can alter a person's thinking that result in worn actions. - Community Leader*

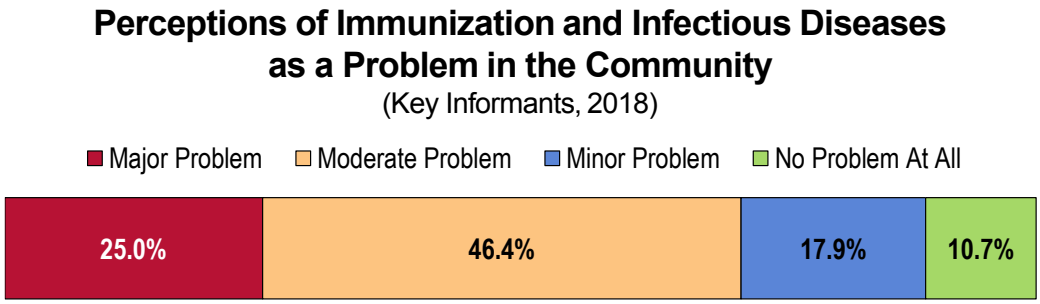
Prevalence/Incidence

> *Stories, word of mouth. - Social Services Provider*

Teenage Pregnancy

> *Pregnancy rate of teen students. Students are engaging in unprotected sex. - Community Leader*

Immunization & Infectious Diseases



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

Lack of knowledge and access to resources. - Community Leader

Lack of education. - Community Leader

Vaccinations

Some family continue to exempt their kids due to religious reasons. Causing more harm when they are around others. - Public Health Representative

Students are lacking or are behind on their immunizations. - Community Leader

Births

Professional Research Consultants, Inc.

Prenatal Care

About Infant & Child Health

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

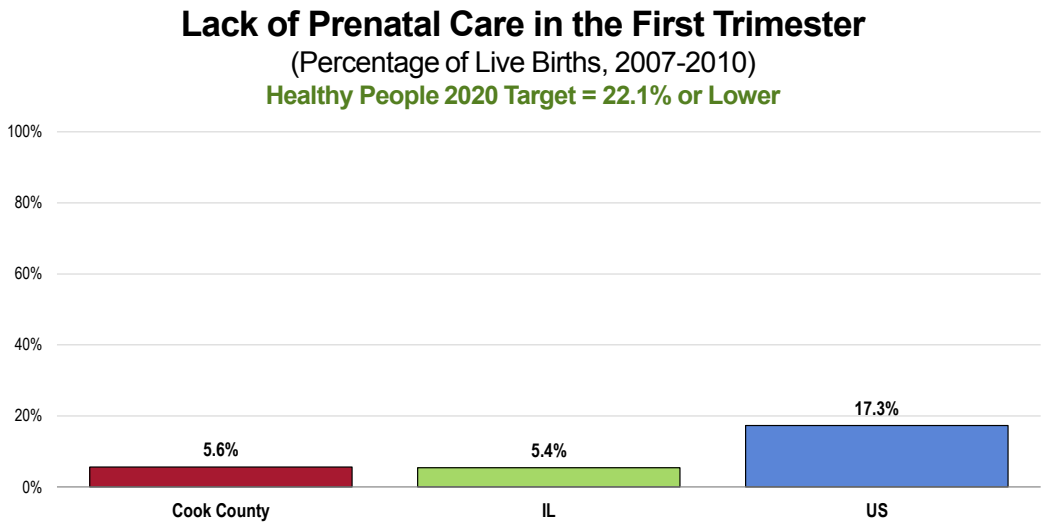
Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

— Healthy People 2020 (www.healthypeople.gov)

Early and continuous prenatal care is the best assurance of infant health.

In Cook County, 5.6% of all 2007-2010 births did not receive prenatal care in the first trimester of pregnancy.

- Similar to the Illinois proportion.



Sources: Centers for Disease Control and Prevention, National Vital Statistics System: 2007-10. Accessed using CDC WONDER. Retrieved December 2018 from Community Commons at http://www.chna.org.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-10.1]

Note: This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.

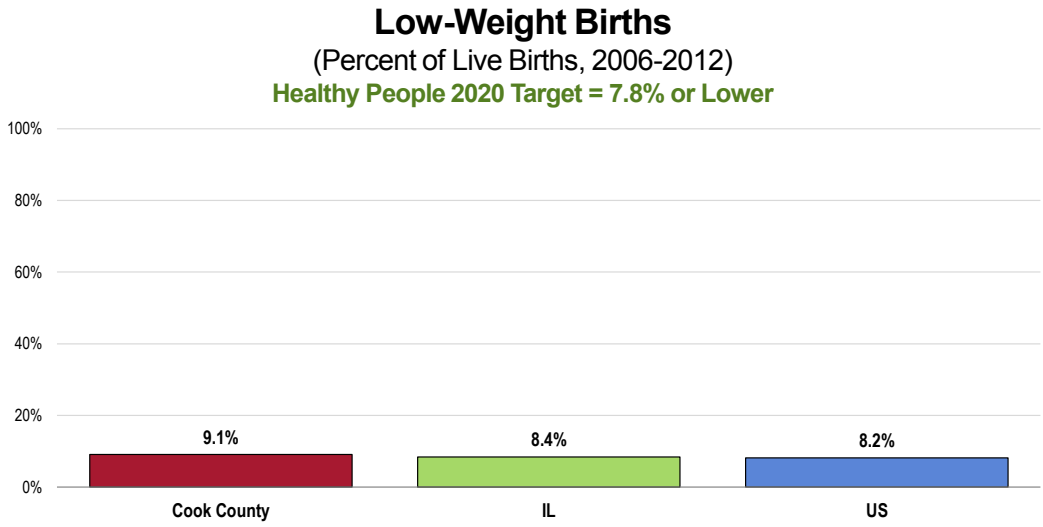
Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

A total of 9.1% of 2006-2012 Cook County births were low-weight.



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted December 2018.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note: This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

In Cook County, there was an annual average of 7.4 infant deaths per 1,000 live births between 2006 and 2010.

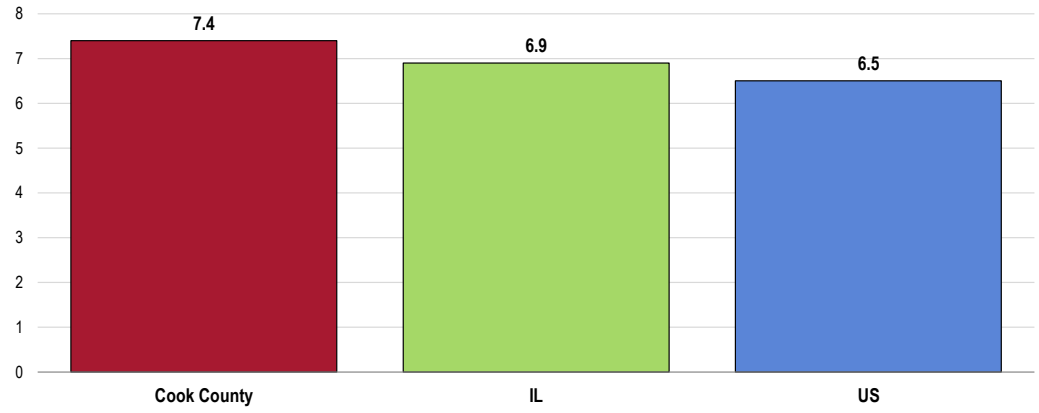
- Comparable to the Illinois and US rates.
- Fails to satisfy the Healthy People 2020 target of 6.0 per 1,000 live births or lower.

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births, 2006-2010)

Healthy People 2020 Target = 6.0 or Lower



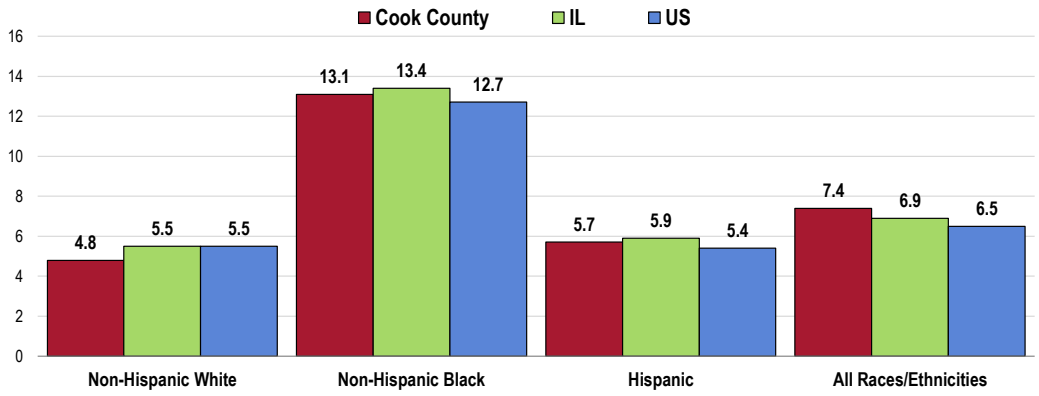
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted December 2018.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

Notes: Infant deaths include deaths of children under 1 year old.
This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Infant Mortality Rate by Race/Ethnicity

(Annual Average Infant Deaths per 1,000 Live Births, 2006-2010)

Healthy People 2020 Target = 6.0 or Lower

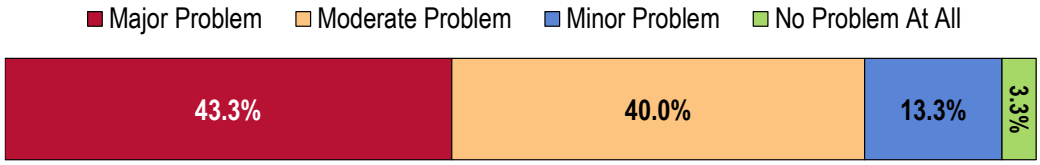


Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted December 2018.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

Notes: Infant deaths include deaths of children under 1 year old.
This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Perceptions of Infant and Child Health as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Accessing Care/Services

Parents do not seek out proper health care options and educational resources to help with common infant and child health issues. - Community Leader

Lack of regular visits to pediatricians, lack of belief in immunizations. - Physician

Many young women do not seek medical attention soon enough. - Community Leader

Parental Influence

Children are neglected physically, emotionally and mentally in unstable households, suffering major health disparities. - Community Leader

Some parents, for many reasons, are not really ready to become parents. Too poor, poor housing, just frustrated, no patience, etc. When they are sick, ignoring the signs, etc. Too many with other partners who are being introduced to the child/children, which can cause harm - Public Health Representative

Age of Population

Infant and child health is important because approximately 30% of our entire community is below 18 years of age. - Social Services Provider

Awareness/Education

Lack of healthy eating education, access to healthy foods locally and education regarding the effects of drug use, smoking and alcohol on the unborn and bon child. - Community Leader

Insurance Issues

Lack of health insurance and the cost of medical attention creates the problem. - Community Leader

Language/Culture

Information in Spanish is not readily available. No opportunities for dialog. - Community Leader

Obesity

Obesity is a major issue in our community. It has gotten to the point where being overweight is more of the norm. - Community Leader

Family Planning

Births to Teen Mothers

About Teen Births

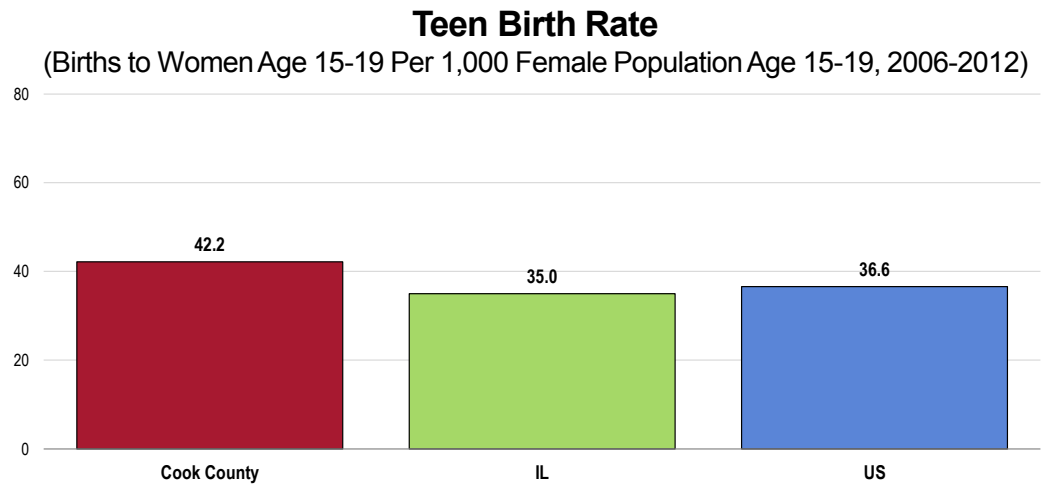
The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately $3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

— Healthy People 2020 (www.healthypeople.gov)

In Cook County, there were 42.2 births to women age 15 to 19 per 1,000 women in that age group between 2006 and 2012.

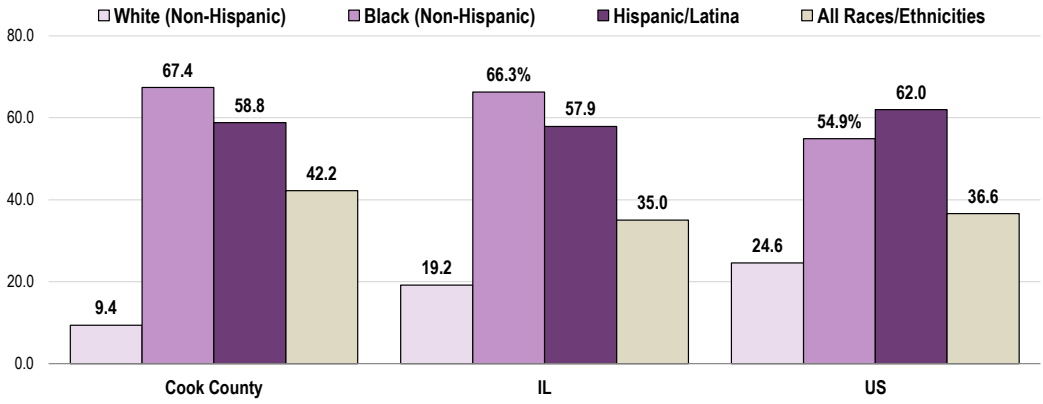


Sources: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER. Retrieved from Community Commons at http://www.chna.org.

Notes: This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Teen Birth Rate

(Births to Women Age 15-19 Per 1,000 Female Population Age 15-19; PSA by Race/Ethnicity, 2006-2012)

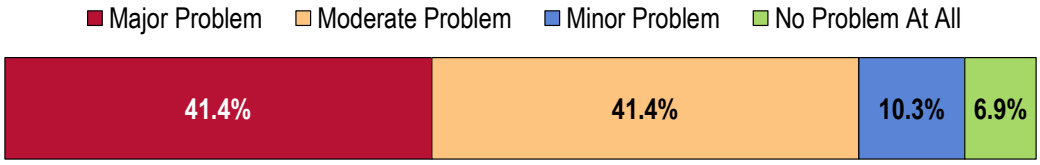


Sources: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER. Retrieved from Community Commons at http://www.chna.org.

Notes: This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Perceptions of Family Planning as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents.

Top Reasons for "Major Problem" Responses:

-
-
-
-

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Awareness/Education

> *The lack of education on family planning is a major issue. Family planning would reduce abortion rates, reduce infant mortality rates, reduce adolescent pregnancies, and prevent pregnancy-related health risks. Many teen girls, single mothers, unemployed fathers, etc., are unaware of the issues that may result from unwanted or unplanned pregnancies and later have to face major challenges to survive and take care of their children. - Social Services Provider*

> *There are few opportunities for any dialog among residents. - Community Leader*

> *Many people in the community do not know about their bodies and sexual and reproductive health. - Public Health Representative*

Cultural/Personal Beliefs

> *Families are distracted by numerous personal and community factors. Family planning is always less of a priority. - Community Leader*

> *Lack of acceptance of birth control as intervention. - Physician*

Teenage Pregnancy

> *Seeing lots of younger people having children and the children being raised by grandparents who look exhausted. - Social Services Provider*

> *Children are having children. - Community Leader*

Cost of Preventative Measures

> *Cost of birth control, idea that men will take care of it, lack of agency. - Other Health Provider*

Modifiable Health Risks

Professional Research Consultants, Inc.

Nutrition

About Healthful Diet & Healthy Weight

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

Social Determinants of Diet. Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

Physical Determinants of Diet. Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

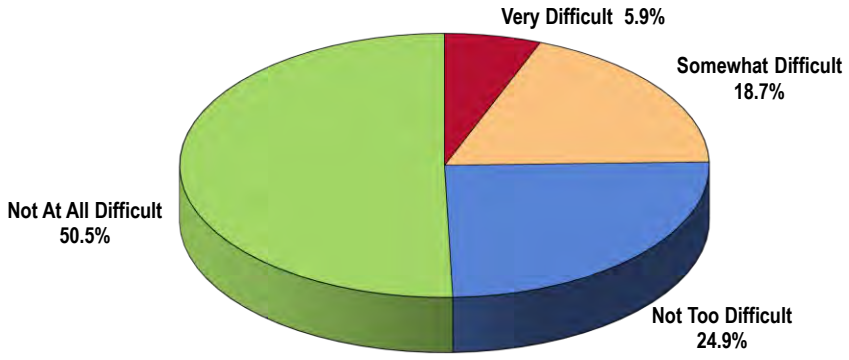
— Healthy People 2020 (www.healthypeople.gov)

Difficulty Accessing Fresh Produce

Respondents were asked:

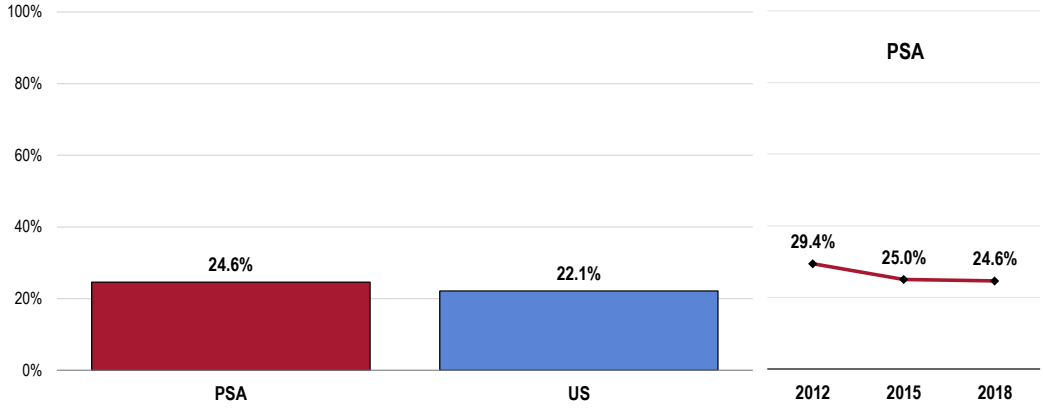
"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: Very Difficult, Somewhat Difficult, Not Too Difficult, or Not At All Difficult?"

Level of Difficulty Finding Fresh Produce at an Affordable Price
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]
Notes: Asked of all respondents.

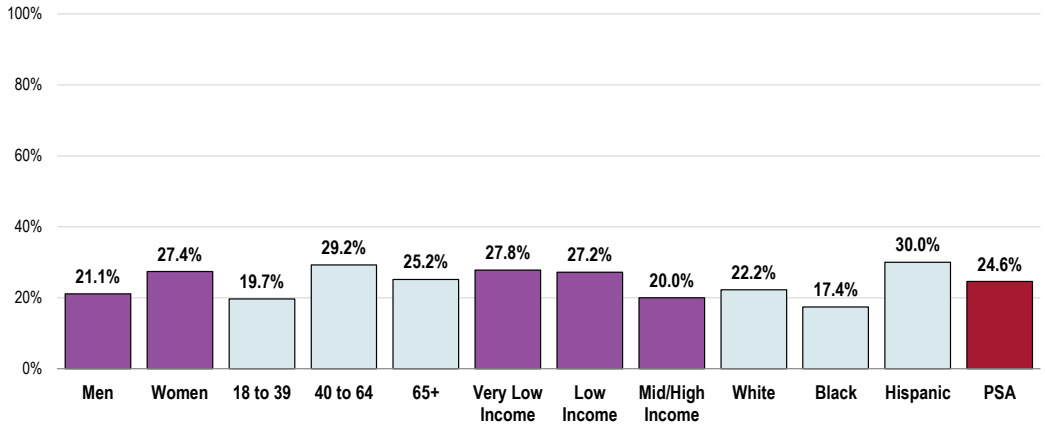
Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce

(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
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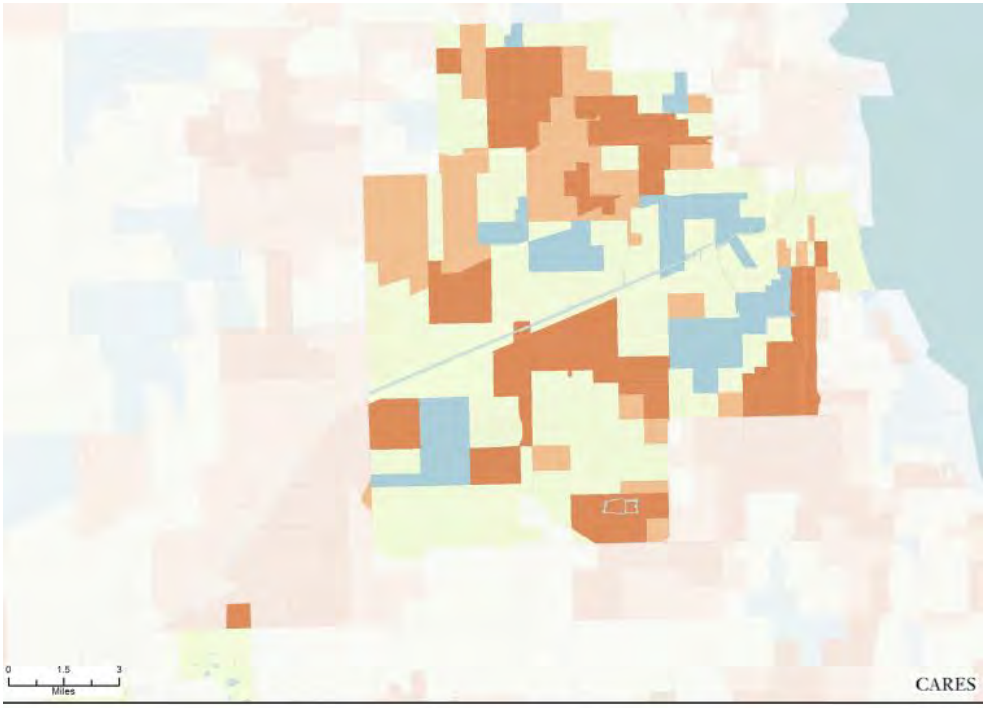
Access to Healthy Foods

Most census tracts in the Primary Service Area have an unfavorable retail food environment, with fewer food retailers that sell healthy foods and more retailers that sell unhealthy foods.

The Modified Retail Food Environmental Index (MRFEi) Score by Tract is a measure of the proportion of food retailers that typically sell healthy foods within a particular geography.

Scores can range from 0 (no food retailers that typically sell healthy food) to 100 (only food retailers that typically sell healthy food). Areas with lower mRFEI scores have more food retailers, such as fast food restaurants and convenience stores, that are less likely to sell less healthy foods and fewer food retailers, such as supermarkets, that tend to sell healthy foods, such as fresh fruits and vegetables.

In the following map, only those census tracts highlighted in blue have moderately favorable access to healthful foods.



Map Legend

Modified Retail Food Environmental Index Score by Tract, DNPAO 2011

- Index Score Over 30 (High Access)
- Index Score 15 - 30 (Moderate Access)
- Index Score 5 - 15 (Low Access)
- Index Score Under 5 (Poor Access)
- No Healthy Retail Food Outlet (No Access)
- No Retail Food Outlets Present (Food Desert)

Physical Activity

About Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity: gender (boys); belief in ability to be active (self-efficacy); and parental support.

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity: parental education; gender (boys); personal goals; physical education/school sports; belief in ability to be active (self-efficacy); and support of friends and family.

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

— Healthy People 2020 (www.healthypeople.gov)

Leisure-Time Physical Activity

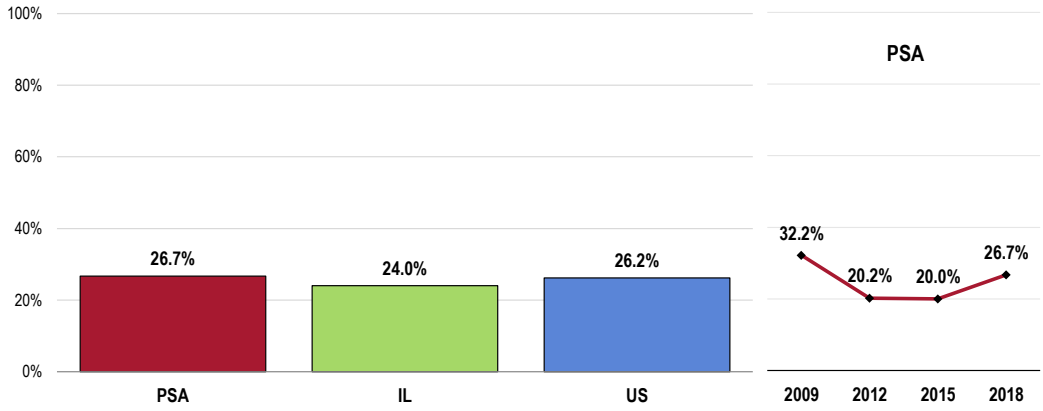
Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

More than one-quarter of Primary Service Area adults (26.7%) report no leisure-time physical activity in the past month.

- Similar to state and national findings.
- Satisfies the Healthy People 2020 target (32.6% or lower).

No Leisure-Time Physical Activity in the Past Month

Healthy People 2020 Target = 32.6% or Lower



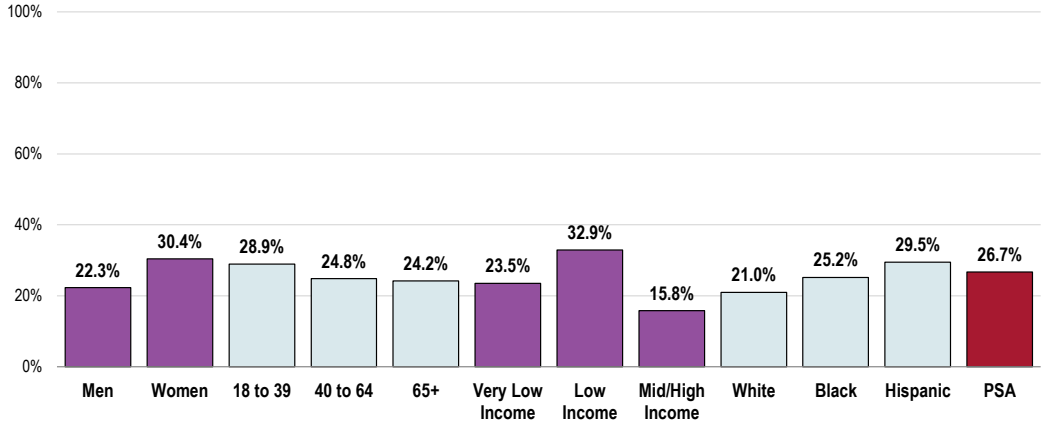
Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 89]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes: Asked of all respondents.

No Leisure-Time Physical Activity in the Past Month

(PSA, 2018)

Healthy People 2020 Target = 32.6% or Lower



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 89]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Levels

Adults

Recommended Levels of Physical Activity

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

— 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity
— Learn more about CDC's efforts to promote walking by visiting http://www.cdc.gov/vitalsigns/walking.

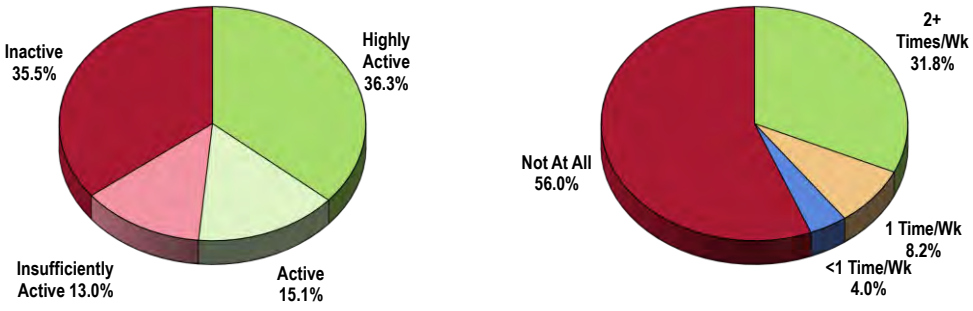
Aerobic & Strengthening Physical Activity

Survey respondents were asked about the types of physical activities they engaged in during the past month, as well as the frequency and duration of these activities.

- "Inactive" includes those reporting no aerobic physical activity in the past month.
- "Insufficiently active" includes those with the equivalent of 1-150 minutes of aerobic physical activity per week.
- "Active" includes those with 150-300 minutes of weekly aerobic physical activity.
- "Highly active" includes those with >300 minutes of weekly aerobic physical activity.

Based on reported physical activity intensity, frequency, and duration over the past month, nearly one-half (48.5%) of Primary Service Area adults are found to be "insufficiently active" or "inactive."

Participation in Physical Activities
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 96, 150]
Notes: Reflects the total sample of respondents.
In this case, "inactive" aerobic activity represents those adults participating in no aerobic activity in the past week; "insufficiently active" reflects those respondents with 1–149 minutes of aerobic activity in the past week; "active" adults are those with 150–300 minutes of aerobic activity per week; and "highly active" adults participate in 301+ minutes of aerobic activity weekly.

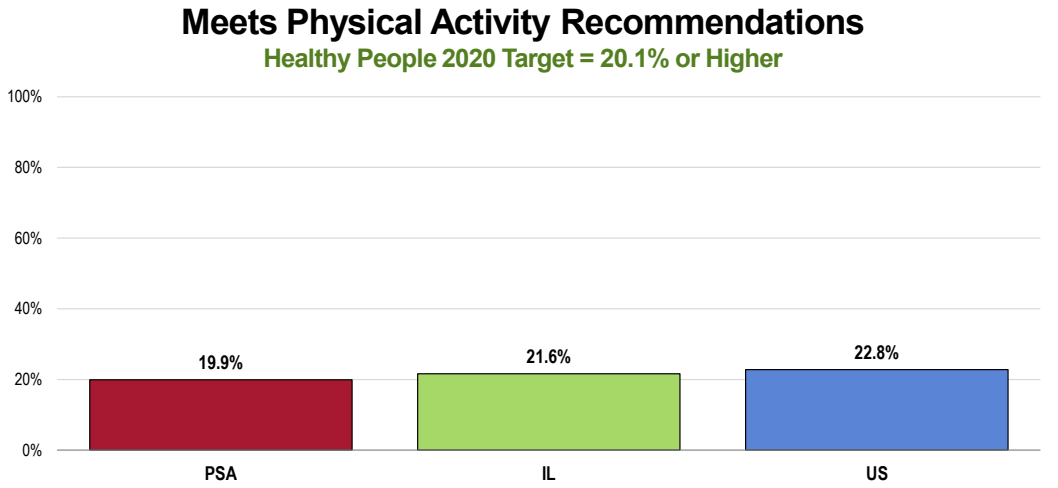
Recommended Levels of Physical Activity

A total of 19.9% of Primary Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activities:

Aerobic activity is one of the following: at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous activity, or an equivalent combination of both.

Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-2.4]

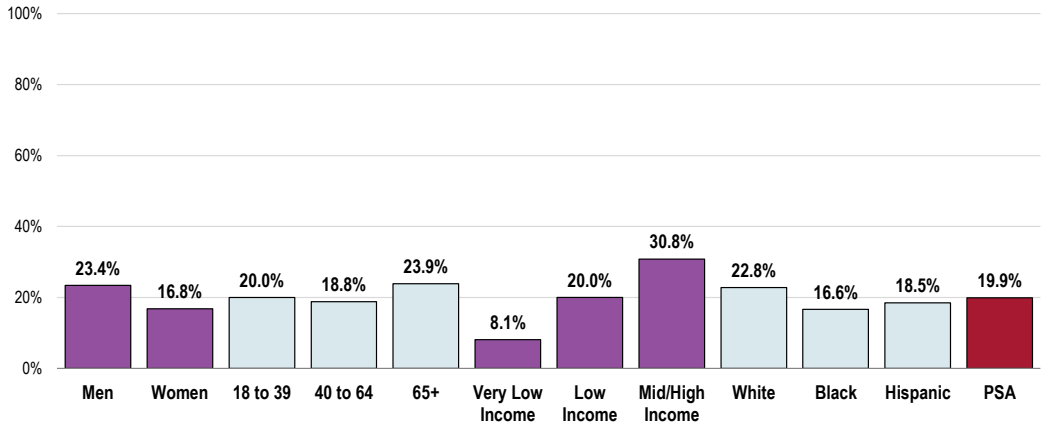
Notes: Asked of all respondents.
Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

- Residents at very low incomes are much less likely to meet physical activity requirements (note the correlation with income).

Meets Physical Activity Recommendations

(PSA, 2018)

Healthy People 2020 Target = 20.1% or Higher



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-2.4]

Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
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Children

Recommended Levels of Physical Activity

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

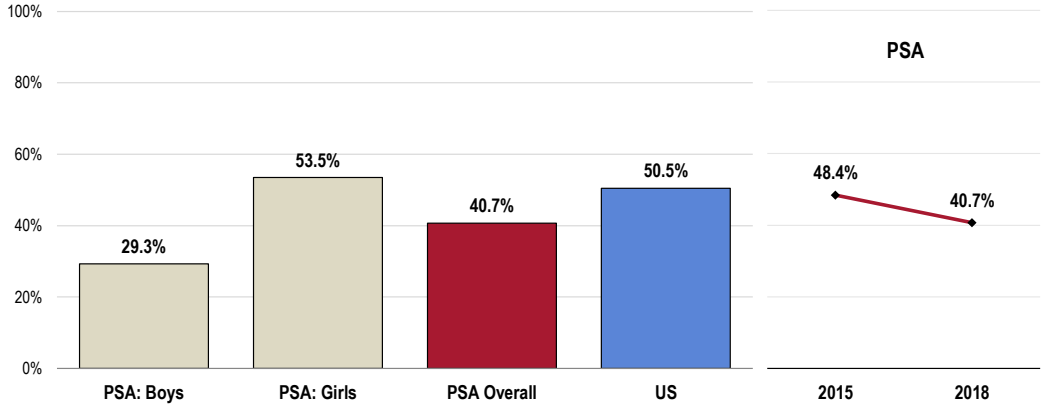
— 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Among the Primary Service Area children age 2 to 17, 40.7% are reported to have had 60 minutes of physical activity on each of the seven days preceding the interview (1+ hours per day).

- Statistically comparable to the national figure.
- By gender, boys are less likely to meet this level of activity.
- TREND: Children's physical activity is statistically unchanged since it was first measured in 2015.

Child Is Physically Active for One or More Hours per Day

(Among Children Age 2-17)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 124]
2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents with children age 2-17 at home.
Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Access to Physical Activity

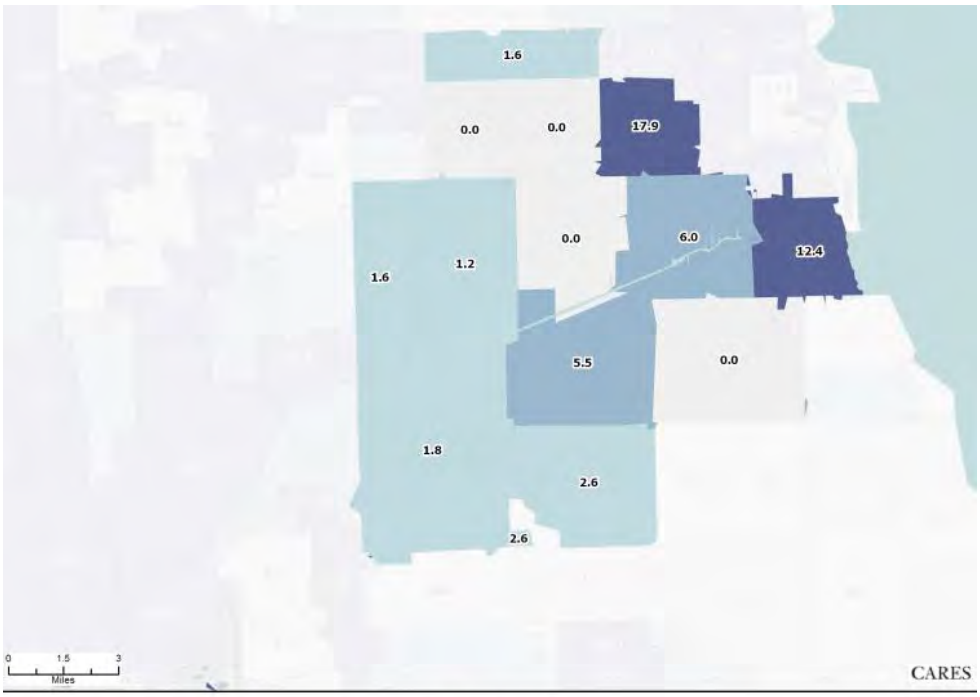
Recreation & Fitness Facilities

Residents in the Primary Service Area have relatively low access to recreation/fitness facilities. Among service area ZIP Codes, there is a median of only 1.6 such facilities for every 100,000 population.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

- This is much lower than found countywide (10.3), statewide (10.9), or nationally (11.0).



Map Legend

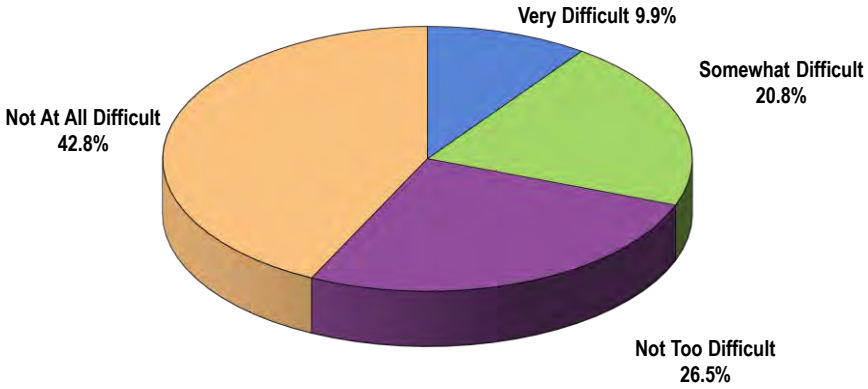
Recreation and Fitness Facilities, Rate (Per 100,000 Pop.) by ZCTA, CBP 2016

- Over 12.0
- 8.1 - 12.0
- 4.1 - 8.0
- Under 4.1
- No Fitness and Recreation Centers

Safe and Affordable Spaces

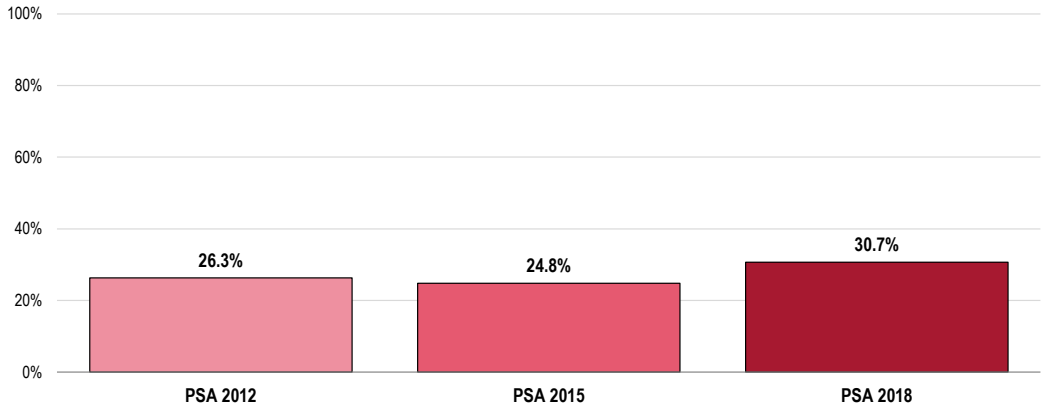
While most Primary Service Area residents find it "not too difficult" or "not at all difficult" to find safe and affordable spaces for physical activity, three in 10 residents

Degree of Difficulty in Accessing Safe and Affordable Spaces for Physical Activity
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 310]

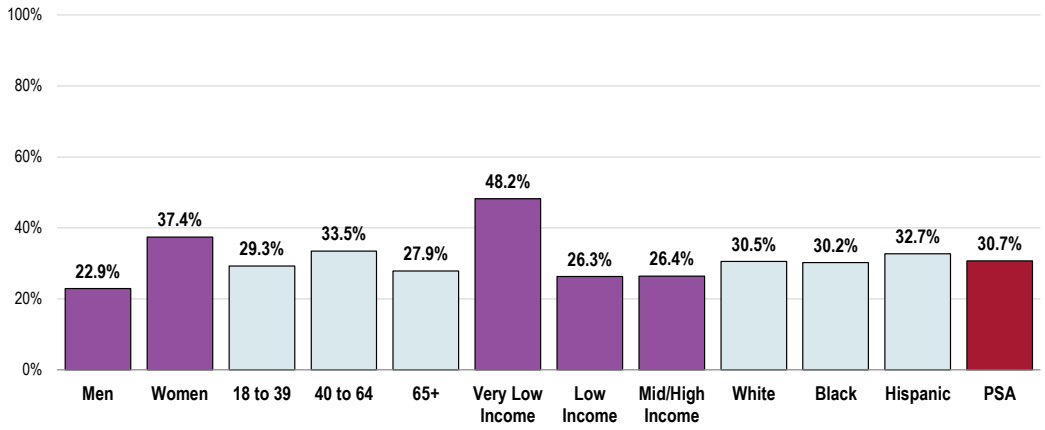
"Very/Somewhat" Difficult to Access Safe and Affordable Spaces for Physical Activity



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 310]
Notes: Asked of all respondents.

- Women and very low-income adults are most likely to report difficulty

"Very/Somewhat" Difficult to Access Safe and Affordable Spaces for Physical Activity
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 310]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
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Weight Status

About Overweight & Obesity

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

— Healthy People 2020 (www.healthypeople.gov)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

— Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

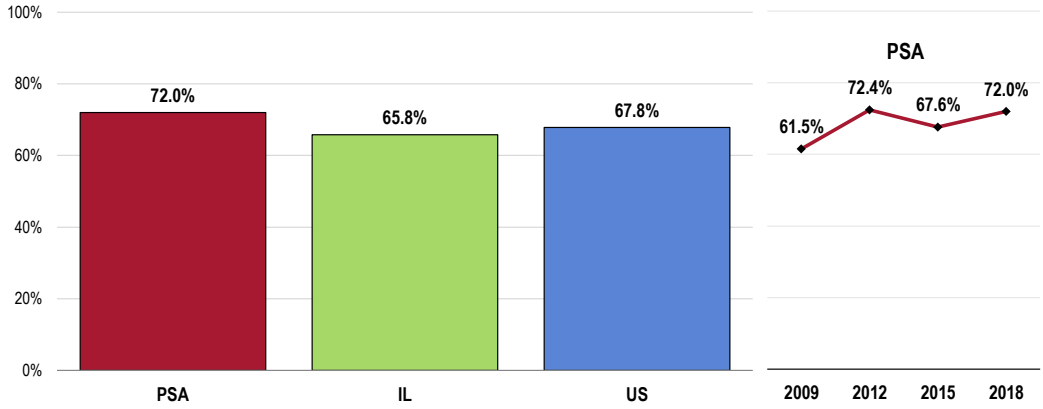
Classification of Overweight and Obesity by BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Overweight Status

Seven in 10 Primary Service Area adults (72.0%) are overweight.

Here, "overweight" includes those respondents with a BMI value ≥25.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 154]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Based on reported heights and weights, asked of all respondents.
The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Further, 40.7% of Primary Service Area adults are obese.

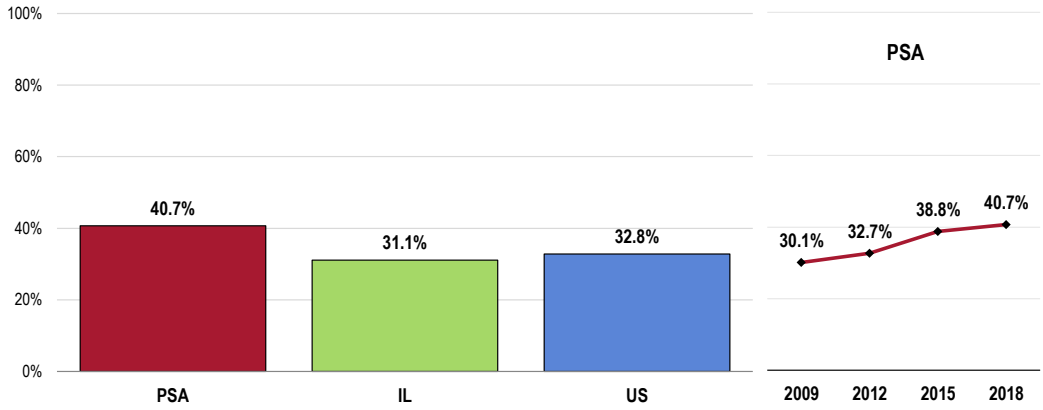
"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

- Less favorable than state and national findings.
- Fails to satisfy the Healthy People 2020 target (30.5% or lower).
- TREND: Represents a statistically significant increase over time.

Prevalence of Obesity

(Percent of Adults With a Body Mass Index of 30.0 or Higher)

Healthy People 2020 Target = 30.5% or Lower



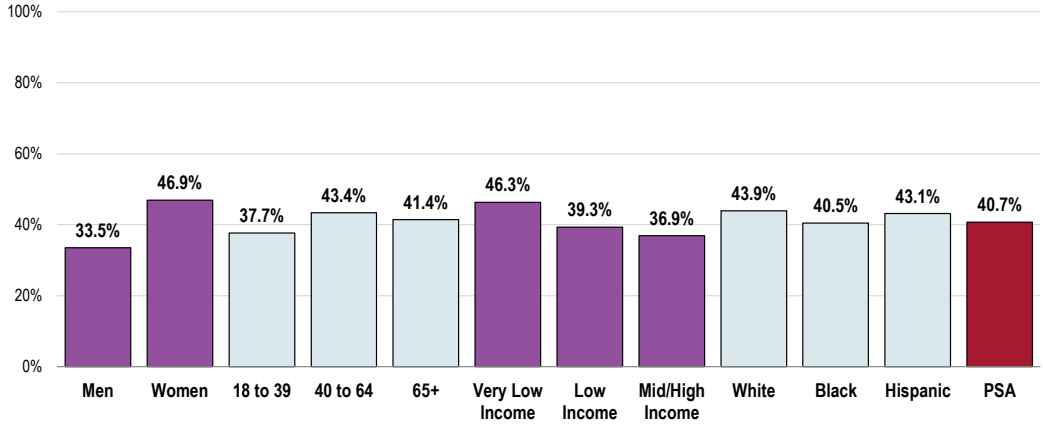
Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 154]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]

Notes: Based on reported heights and weights, asked of all respondents.
The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity

(Percent of Adults With a BMI of 30.0 or Higher; PSA, 2018)

Healthy People 2020 Target = 30.5% or Lower



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 154]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]

Notes: Based on reported heights and weights, asked of all respondents.
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The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Health Advice

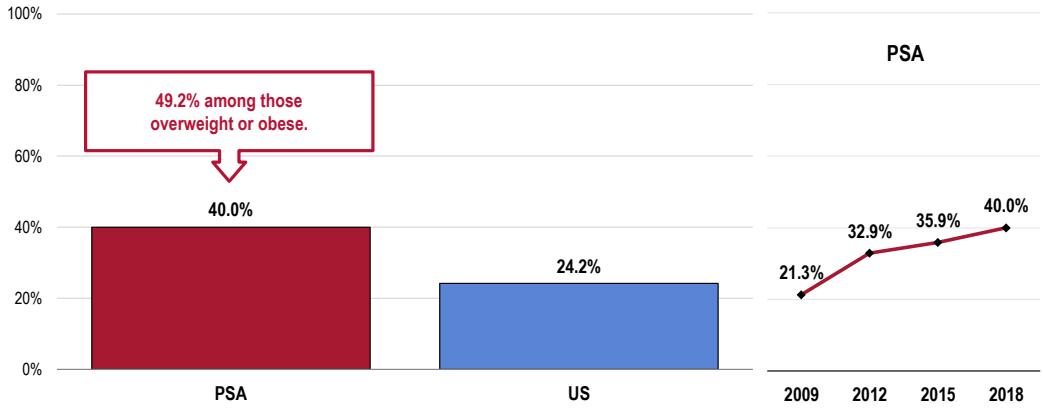
A total of 40.0% of adults have been given advice about their weight by a doctor, nurse, or other health professional in the past year.

- Far more favorable than national findings.
- TREND: This prevalence has steadily increased over time.

Note that nearly one-half (49.2%) of overweight/obese adults have been given advice about

Have Received Advice About Weight in the Past Year From a Physician, Nurse, or Other Health Professional

(By Weight Classification)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 98, 156]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

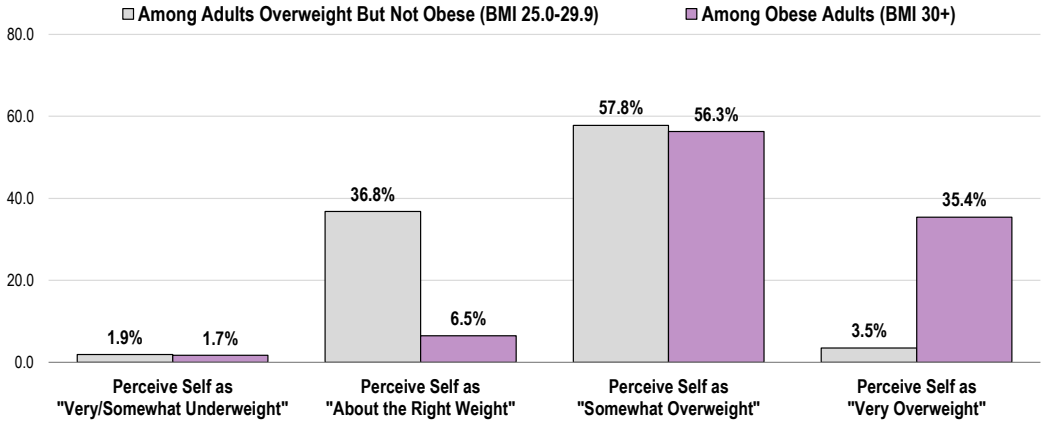
Actual vs. Perceived Body Weight

A total of 6.5% of obese adults and 36.8% of overweight (but not obese) adults feel that their current weight is "about right."

- 57.8% of overweight (but not obese) adults see themselves as "somewhat overweight."
- 35.4% of obese adults see themselves as "very overweight."

Actual vs. Perceived Weight Status

(Among Overweight/Obese Adults Based on BMI; PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 154, 311]
Notes:: BMI is based on reported heights and weights, asked of all respondents.
The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Children's Weight Status

About Weight Status in Children & Teens

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

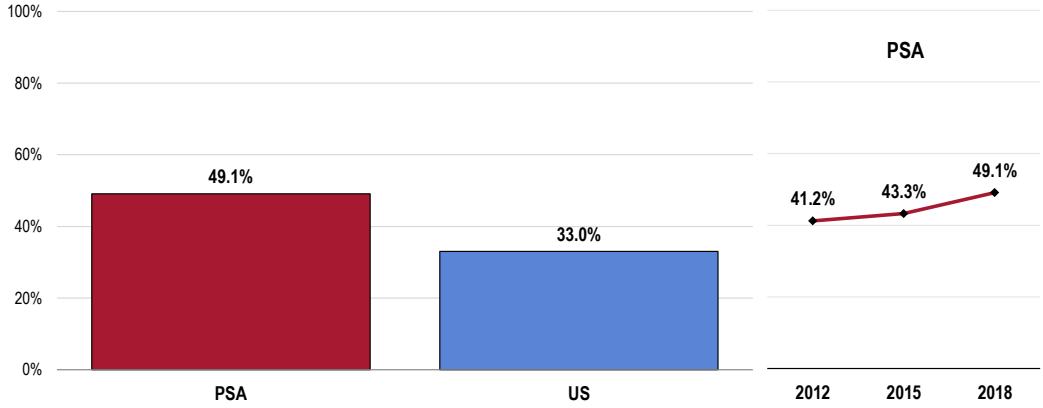
— Centers for Disease Control and Prevention

Based on the heights/weights reported by surveyed parents, 49.1% of Primary Service Area children age 5 to 17 are overweight or obese (≥85th percentile).

- Higher than found nationally.
- TREND: The increase over time is not statistically significant.

Child Total Overweight Prevalence

(Children Age 5-17 Who Are Overweight/Obese; BMI in the 85th Percentile or Higher)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents with children age 5-17 at home.
Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

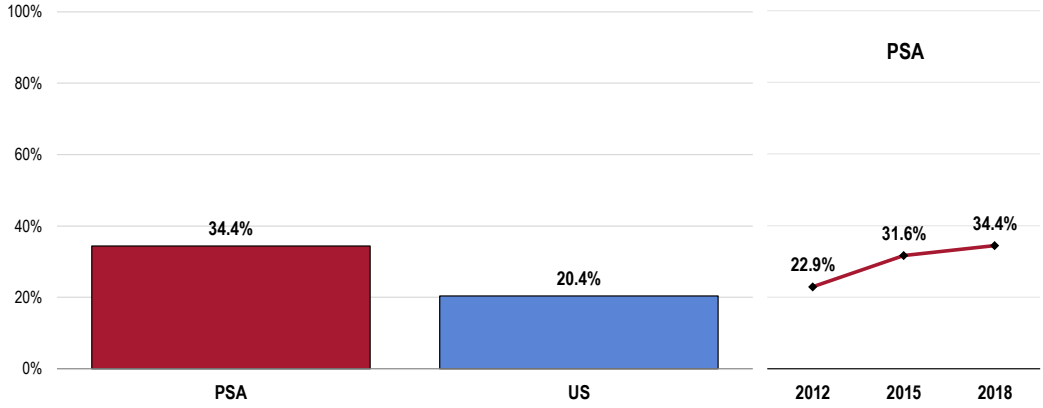
Further, 34.4% of area children age 5 to 17 are obese (≥95th percentile).

- Less favorable than the national percentage.
- Far from satisfying the Healthy People 2020 target (14.5% or lower for children age 2-19).

Child Obesity Prevalence

(Children Age 5-17 Who Are Obese; BMI in the 95th Percentile or Higher)

Healthy People 2020 Target = 14.5% or Lower

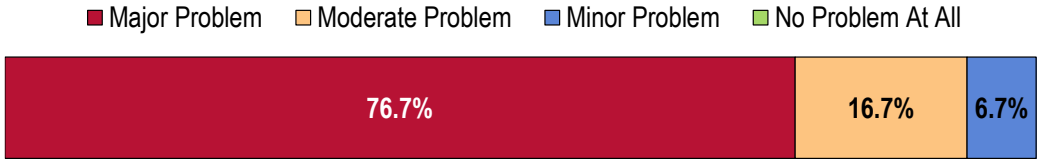


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-10.4]
Notes: Asked of all respondents with children age 5-17 at home.
Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity, & Weight

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

Limited programs that educate the community on how to eat healthy while on a budget is one of many challenges. Knowing what to look for on food labels in order to make a healthy decision. Affordable or free fitness programs could also benefit the community. - Community Leader

Families are not well-educated about nutrition, physical activity and weight. They are given mostly unhealthy options for eating in their communities. They are bombarded with unhealthy advertising and choices. - Community Leader

Lack of resources and access to the appropriate resources are a major cause. I am also concerned that our society has accepted being overweight as a new fact of life. - Community Leader

Healthy food education, availability of organic foods, abundance of fast food restaurants and affordability of fitness centers. - Social Services Provider

People do not realize how dangerous it is for getting diabetes and high blood pressure. - Community Leader

Insufficient promotion of nutrition programs carried out throughout the community. - Community Leader

Education. - Community Leader

Access to Healthy Food/Activity Options

The biggest challenges related to nutrition, physical activity, and weight are: 1) fast food is not very expensive, 2) restaurants give a large portion of food, 3) cheaper to buy a bottle of soda than water, and 4) exercise in the winter is difficult due to the weather and many people cannot afford to go to the gym (and there is no park district field house in Brighton Park). - Social Services Provider

Parks near, but unsafe. Health clubs are too expensive for some. - Public Health Representative

High-density caloric food is cheaper and easier to access than healthier options. - Physician

Increased access to unhealthy foods and lack of access to healthy choices. - Physician

Lack of access to nutritious food and limited exercise, if any, poor diet. - Community Leader

Diet and lack of safe places to exercise. - Social Services Provider

Obesity

Childhood obesity, lack of healthy food, education, a high fat, high carb diet and inability to exercise outside due to personal safety. - Other Health Provider

> *High numbers of obese people. - Social Services Provider*

Violence

> *Violence levels in the neighborhood affect how much time families are willing to spend outdoors. Lack of knowledge about nutrition, cost and other factors influence what people eat. - Social Services Provider*
>
> *Violence, lack of healthy restaurant food options and lack of green space. - Other Health Provider*

Substance Abuse

About Substance Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cirrhosis/Liver Disease Deaths

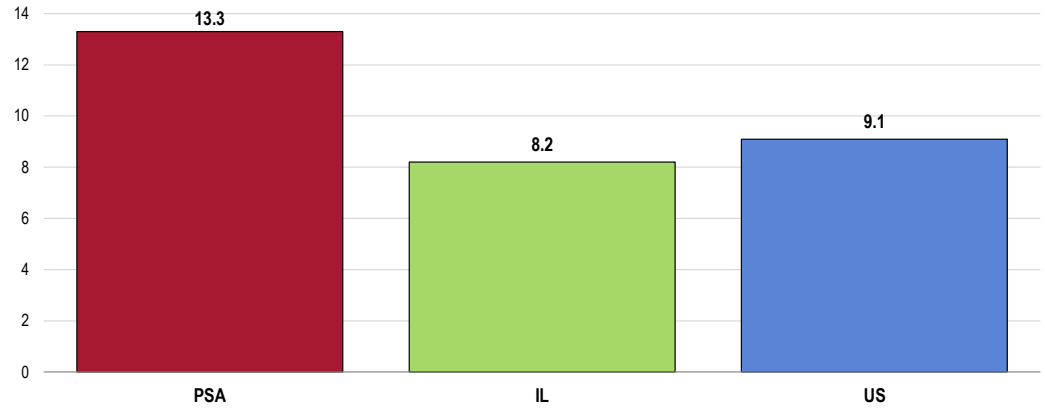
Between 2006 and 2010, the Primary Service Area reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 13.3 deaths per 100,000 population.

- Higher than the statewide and national rates.
- Fails to satisfy the Healthy People 2020 target (8.2 or lower).

Cirrhosis/Liver Disease: Age-Adjusted Mortality

(2006-2010 Annual Average Deaths per 100,000 Population)

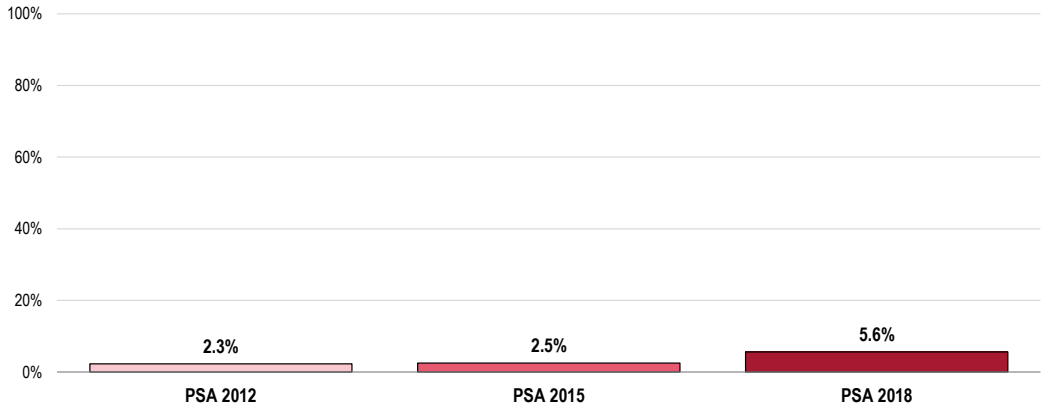
Healthy People 2020 Target = 8.2 or Lower



Sources: Epidemiology and Public Health Informatics, Chicago Department of Public Heath (CDPH). Selected underlying causes of death in Chicago, 2006-2010. Data extracted from the Chicago Data Portal at https://data.cityofchicago.org/.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Liver Disease



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 301]

Notes: Asked of all respondents.

Alcohol Use

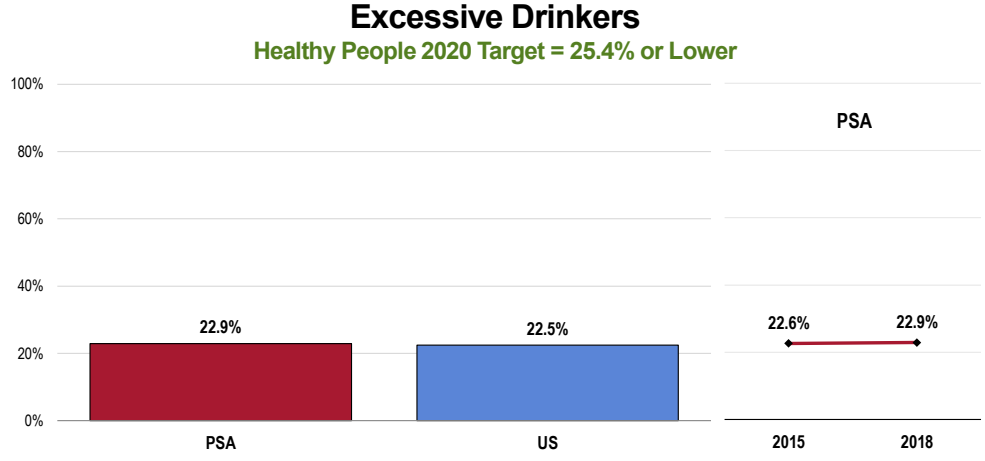
Excessive Drinking

"**Excessive drinking**" includes heavy **and/or** binge drinkers:

- **Heavy drinkers** include men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- **Binge drinkers** include men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

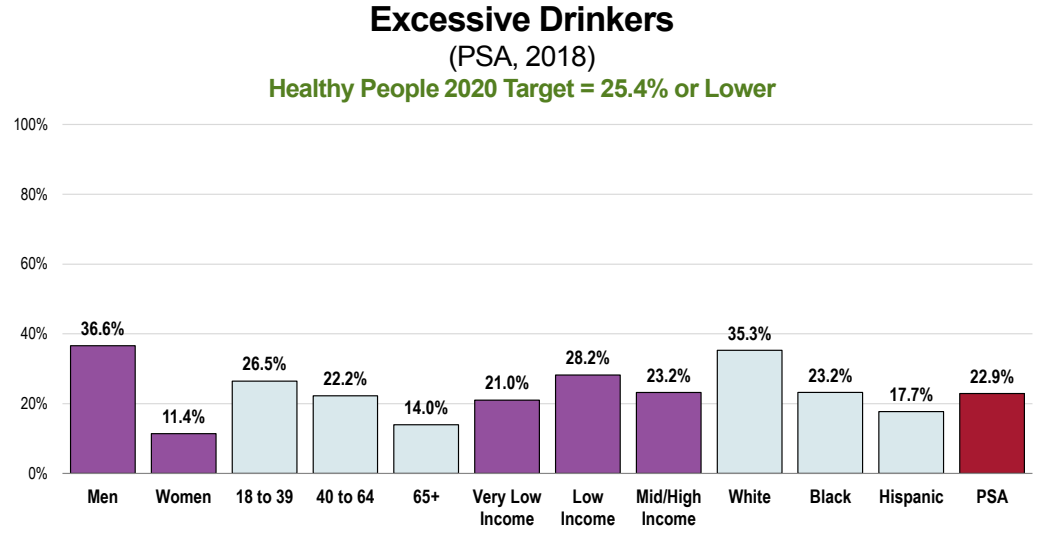
RELATED ISSUE:
See also *Mental Health: Stress* in the **General Health Status** section of this report.

A total of 22.9% of area adults are excessive drinkers (heavy and/or binge drinkers).



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]

Notes: Asked of all respondents.
Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]

Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
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Illicit Drug Use

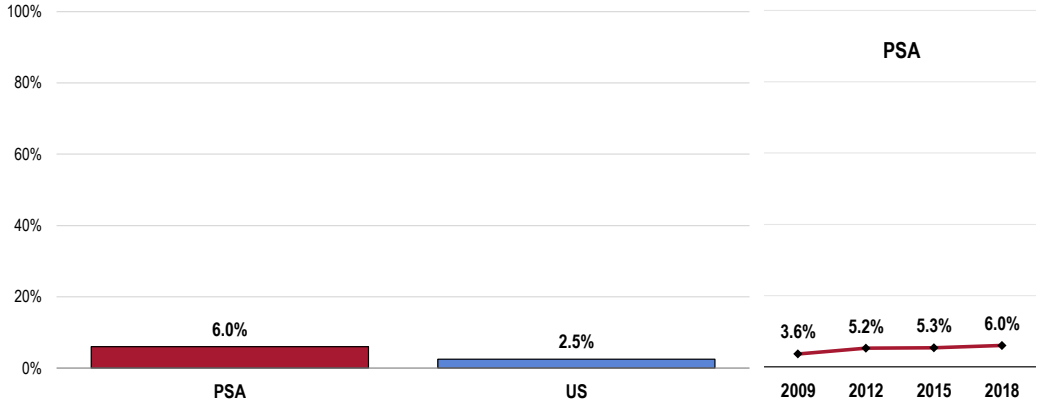
For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

A total of 6.0% of Primary Service Area adults acknowledge using an illicit drug in the past month.

Illicit Drug Use in the Past Month

Healthy People 2020 Target = 7.1% or Lower



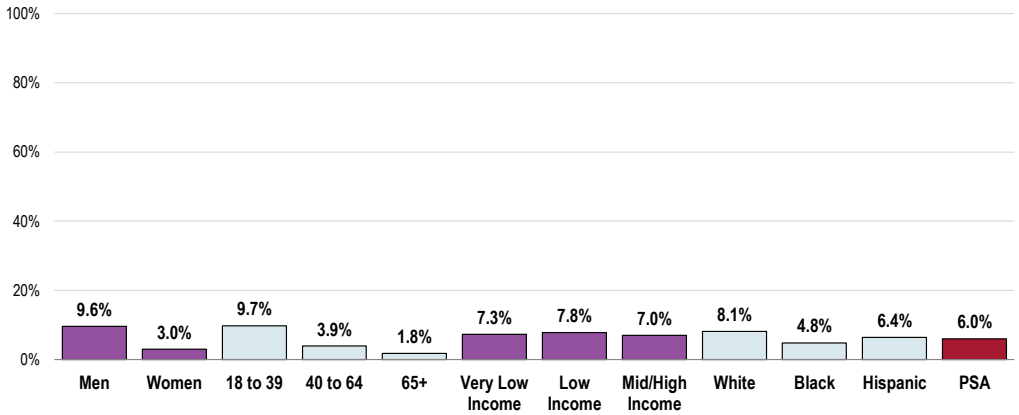
Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 59]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]

Notes: Asked of all respondents

Illicit Drug Use in the Past Month

(PSA, 2018)

Healthy People 2020 Target = 7.1% or Lower

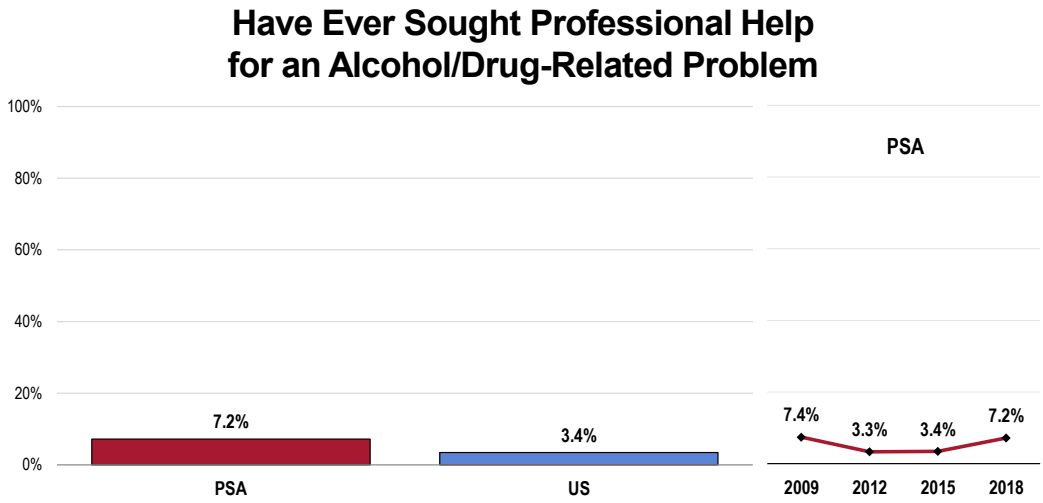


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 59]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]

Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Alcohol & Drug Treatment

A total of 7.2% of Primary Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 60]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Personal Impact from Substance Abuse

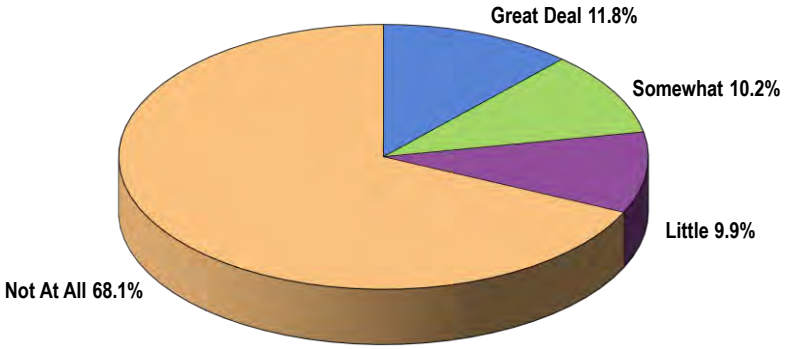
Area adults were also asked to what degree their lives have been impacted by substance abuse (whether their own abuse or that of another).

In all, most respondents have not been personally impacted (68.1% "not at all" responses).

In contrast, 31.9% of survey respondents indicate that their lives have been personally impacted by substance abuse, including 11.8% who report having been impacted "a great deal."

Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's)

(PSA, 2018)

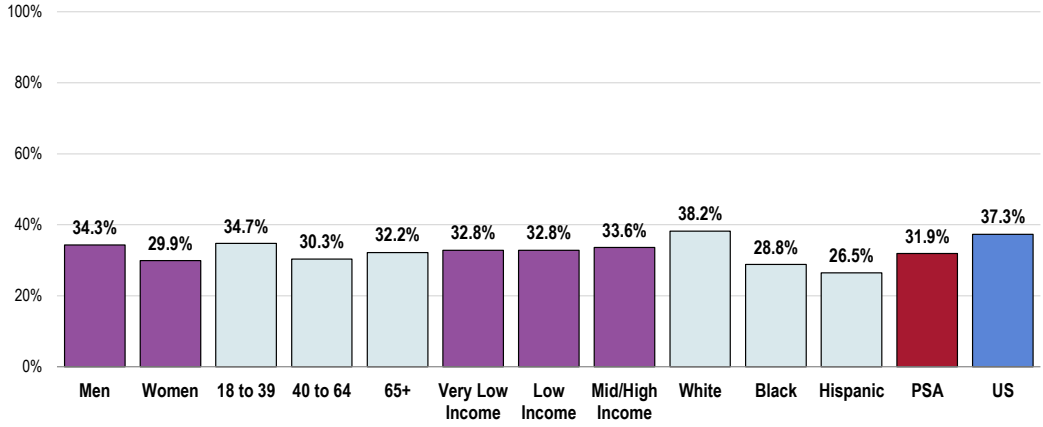


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 61]
Notes: Asked of all respondents.

- The prevalence of those personally impacted by substance abuse is similar to the US

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)

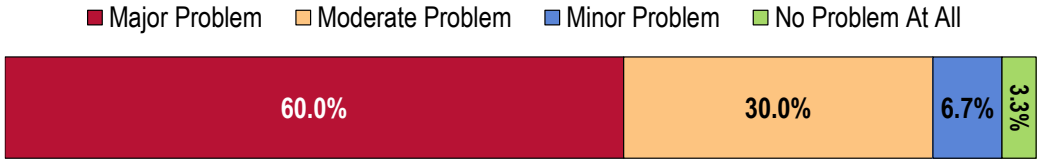
(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 61]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Includes response of "a great deal," "somewhat," and "a little."
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Perceptions of Substance Abuse as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

Drug and alcohol access had increased instances of abuse, coupled with economic hardship and stress. - Community Leader

It is all around. Drugs, alcohol, etc. You can get pulled into this behavior because of your surroundings. - Public Health Representative

People laying on the ground in public spaces/streets. The smell of weed. Addicts begging. Arrest reports from CPD website. - Social Services Provider

Drug use. - Community Leader

Access to Care/Services

Access to treatment facilities. Addressing the stigma associated with seeking treatment. Community support. - Community Leader

Lack of providers. Heroin and alcohol are cheap. - Physician

Awareness/Education

Education, acknowledgement of the problem, admitting addiction and seeking help. - Community Leader

Education and support groups. - Community Leader

Denial/Stigma

The biggest barriers to accessing needed substance abuse treatment is that people are in denial, and many think they can control their use of substances. Another barrier is that there is no substance abuse counseling offered at the neighborhood high school. - Social Services Provider

Addicted persons do not want help. - Community Leader

Social Determinants of Health

Socioeconomic status, affordability, denial and social stigmas. - Social Services Provider

Because of traumatic experiences that impact the mind, body and soul, which include being marginalized, ostracized, demonized, etc. Because of centuries of structural racism, certain people groups- particularly Blacks- disproportionately face lack of work, sub par education and little to no access to the basic necessities, which negatively impacts the brain and ultimately their well-being. Also, inhalation of chemical substances from the environment, dwelling and/or work spaces. And of course, lack of access to nutritious food; poor diet. - Community Leader

Cultural Norms

> *Normalization of alcohol abuse. - Other Health Provider*

Most Problematic Substances

Key informants (who rated this as a "major problem") clearly identified **alcohol** as the most problematic substance abused in the community, followed by **cocaine/crack** and **marijuana**.

Problematic Substances as Identified by Key Informants				
	Most Problematic	Second-Most Problematic	Third-Most Problematic	**Total Mentions**
Alcohol	71.4%	7.1%	14.3%	13
Cocaine or Crack	21.4%	14.3%	21.4%	8
Marijuana	0.0%	35.7%	21.4%	8
Heroin or Other Opioids	7.1%	21.4%	7.1%	5
Prescription Medications	0.0%	21.4%	14.3%	5
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	0.0%	0.0%	14.3%	2
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	0.0%	0.0%	7.1%	1

Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

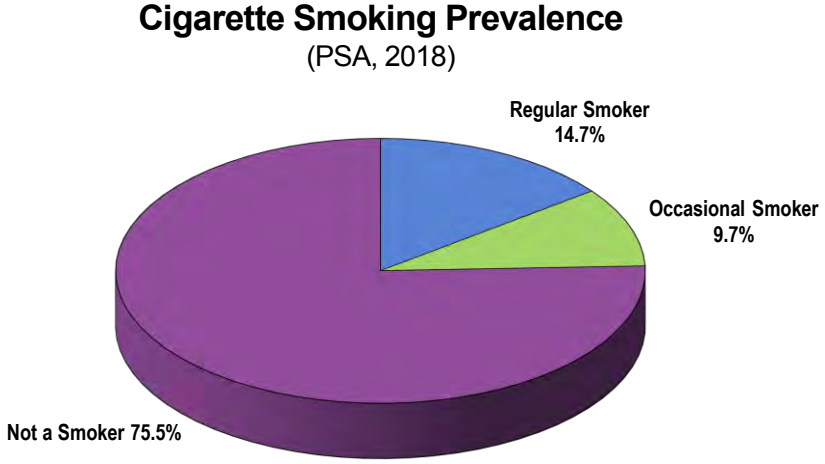
There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

— Healthy People 2020 (www.healthypeople.gov)

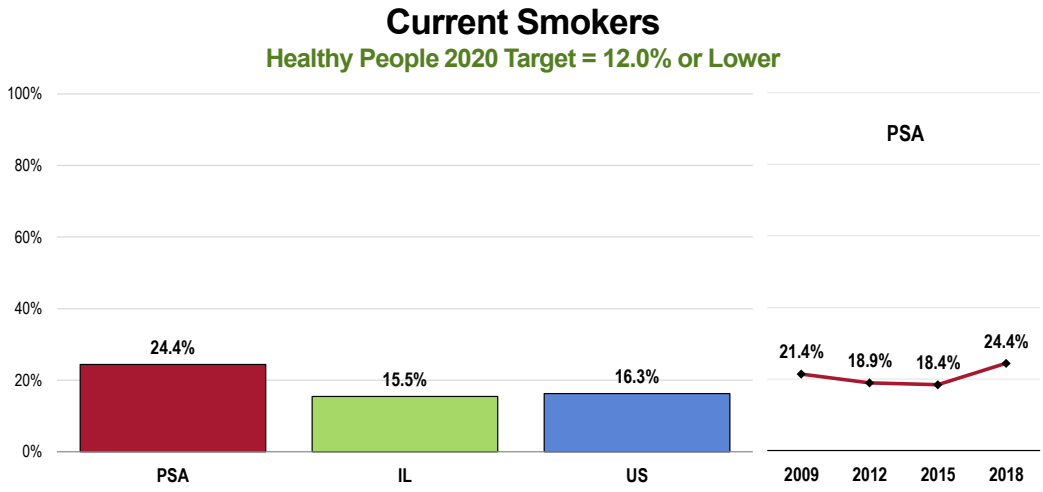
Cigarette Smoking

Cigarette Smoking Prevalence



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]
Notes: Asked of all respondents.

- Above statewide and national findings.
- Double the Healthy People 2020 target (12% or lower).

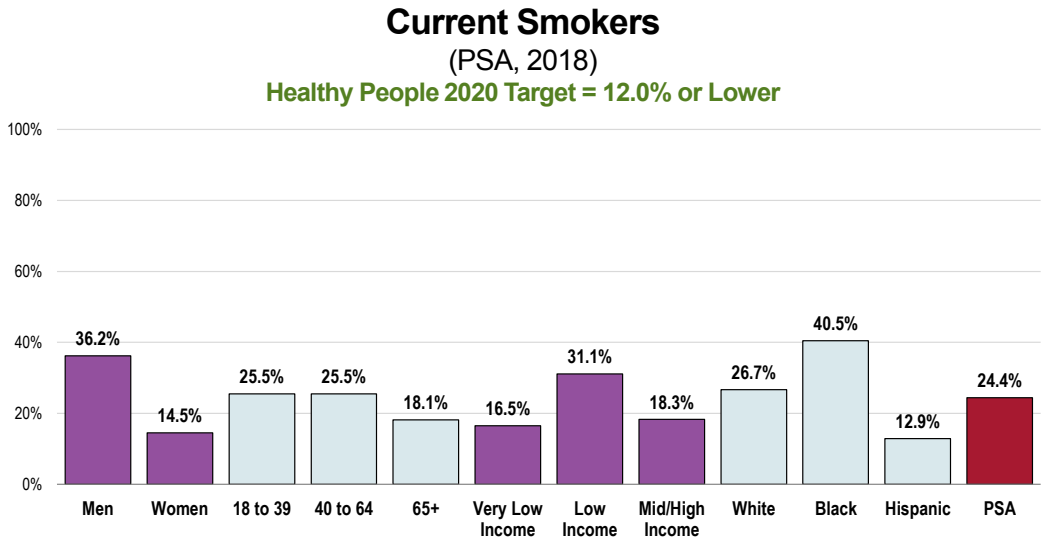


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes: Asked of all respondents.
Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Cigarette smoking is more prevalent among:

- Men.
- Adults ages 18 to 39 (as compared to seniors).



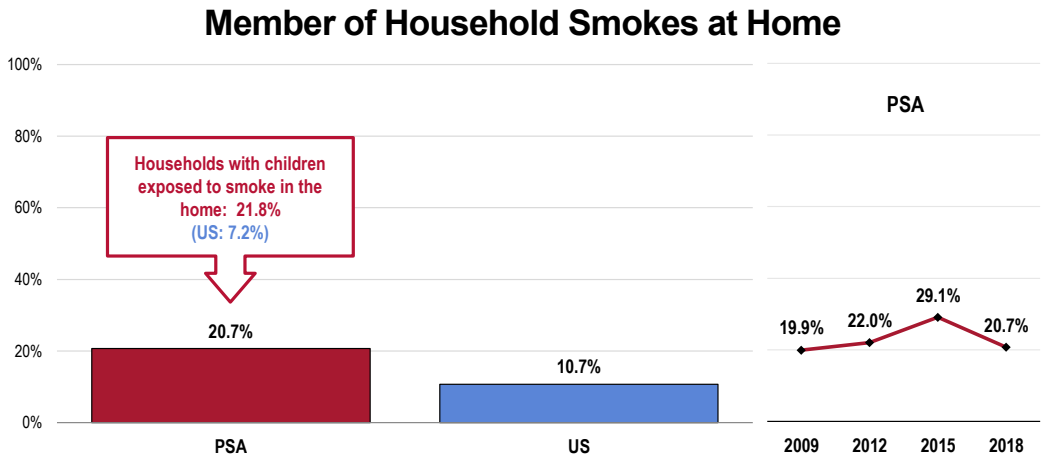
Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
Includes regular and occasion smokers (every day and some days).

Environmental Tobacco Smoke

A total of 20.7% of Primary Service Area adults (including smokers and nonsmokers) report that a member of their household has smoked cigarettes in the home an average of 4+ times per week over the past month.

- Almost double the prevalence reported nationally.
- TREND: No statistically significant change over time.

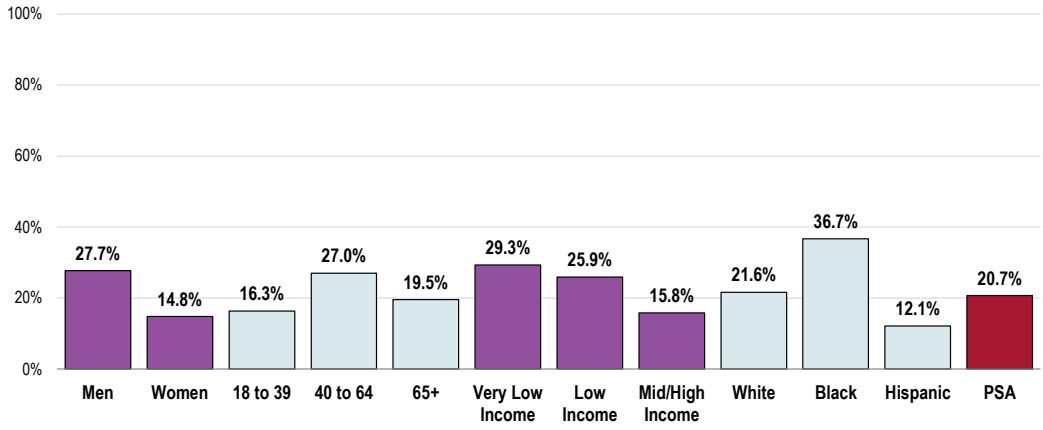


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 52, 162]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
"Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

- Notably higher among men and Black residents. Adults ages 40 to 64 and lower income residents are also more likely to have a smoker in the home.

Member of Household Smokes At Home

(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 52]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
"Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Smoking Cessation

About Reducing Tobacco Use

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

— Healthy People 2020 (www.healthypeople.gov)

Smoking Cessation Attempts

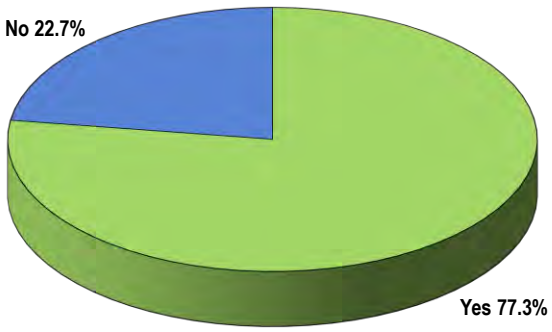
The majority of regular smokers (77.3%) went without smoking for one day or longer in the past year because they were trying to quit smoking.

- Similar to the Healthy People 2020 target (80% or higher).

Have Stopped Smoking for One Day or Longer in the Past Year in an Attempt to Quit Smoking

(Among Everyday Smokers)

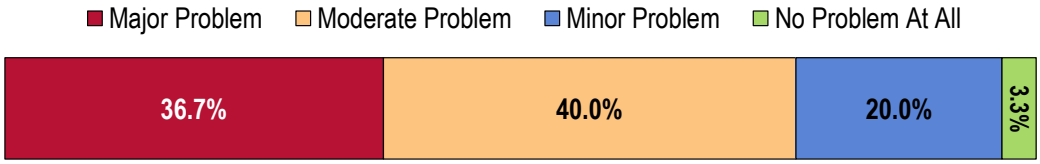
Healthy People 2020 Target = 80.0% or Higher



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 50]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-4.1]
Notes: Asked of respondents who smoke cigarettes every day.

Perceptions of Tobacco Use as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a “major problem,” reasons related to the following:

Prevalence/Incidence

I witness on an everyday basis the use of tobacco and smoking cigarettes. About 25% of our student population smokes. Several of those students have respiratory issues. - Social Services Provider

Tobacco use is a major problem in Brighton Park because many people still smoke. We see many youth smoking in Brighton Park. - Social Services Provider

Vaping continues nicotine. Tobacco in cigarettes, a trend to smoke. - Public Health Representative

A lot of smokers. - Community Leader

Trauma

> *It is a means to anesthetize residents from the pain of trauma and constant stresses of living in this community. - Community Leader*
>
> *Because of traumatic experiences that impact the mind, body and soul, which include being marginalized, ostracized, demonized, etc. Because of centuries of structural racism, certain people groups- particularly Blacks- disproportionately face lack of work, subpar education and little to no access to the basic necessities, which negatively impacts the brain and ultimately their well-being. Also, inhalation of chemical substances from the environment, dwelling and/or work spaces. And of course, lack of access to nutritious food; poor diet. - Community Leader*

Cause of Death

> *Smoking kills. - Community Leader*

Access to Health Services

Professional Research Consultants, Inc.

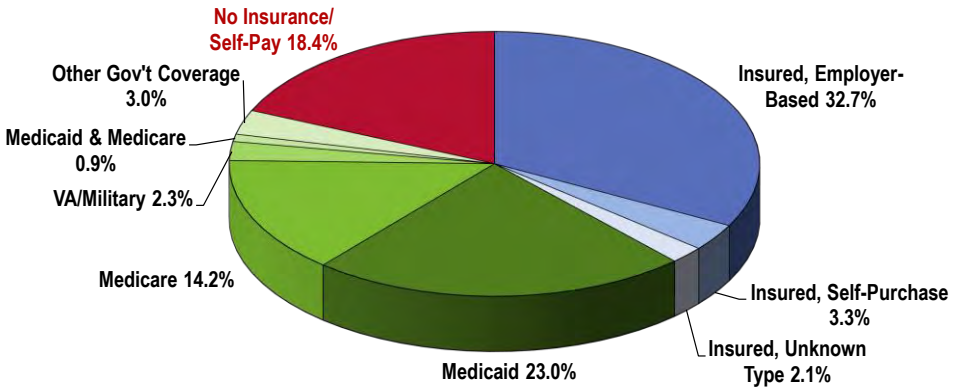
Health Insurance Coverage

Type of Healthcare Coverage

A total of 38.1% of Primary Service Area adults age 18 to 64 report having healthcare

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

Healthcare Insurance Coverage
(Among Adults Age 18-64; PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]
Notes: Reflects respondents age 18 to 64.

Lack of Health Insurance Coverage

Among adults age 18 to 64, 18.4% report having no insurance coverage for healthcare expenses.

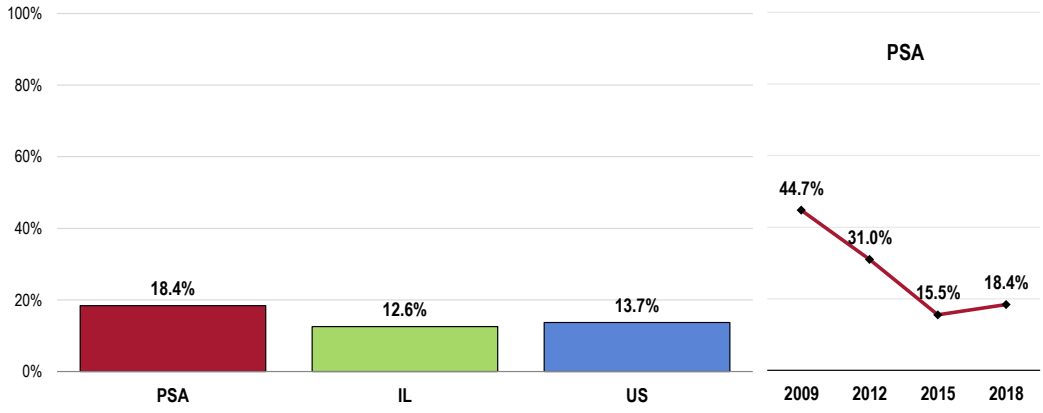
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population), who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

- Higher than the state finding.
- Statistically similar to the national finding.
- The Healthy People 2020 target is universal coverage (0% uninsured).
- TREND: Far lower than 2009 and 2012 findings. (Note that the Affordable Care Act (a.k.a. Obamacare) was introduced in 2010).

Lack of Healthcare Insurance Coverage

(Among Adults Age 18-64)

Healthy People 2020 Target = 0.0% (Universal Coverage)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

Notes: Asked of all respondents under the age of 65.

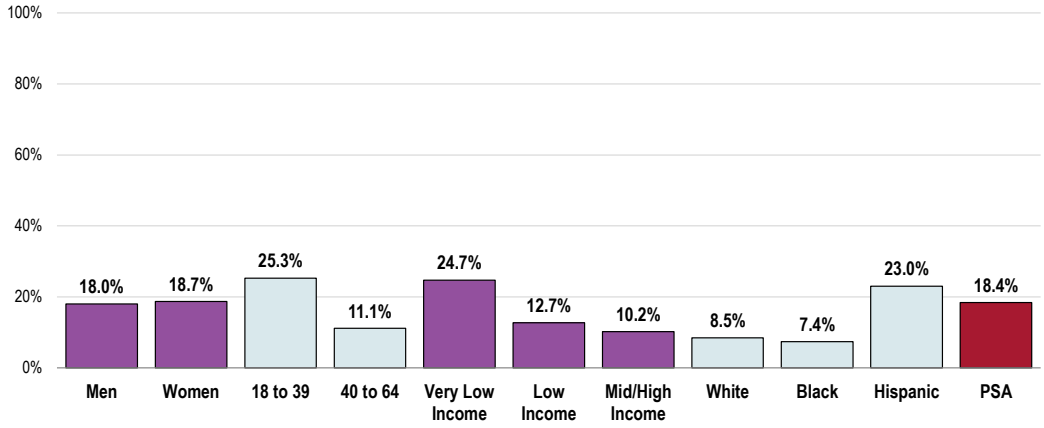
The following population segments are more likely to be without healthcare insurance coverage:

- Very low-income residents, when compared to mid/high-income residents (note the

Lack of Healthcare Insurance Coverage

(Among Adults Age 18-64; PSA, 2018)

Healthy People 2020 Target = 0.0% (Universal Coverage)

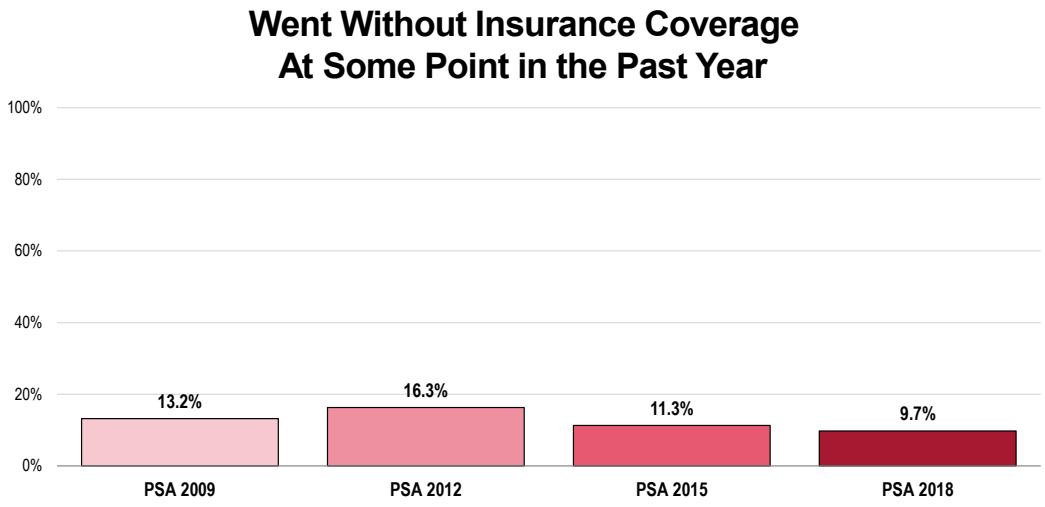


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

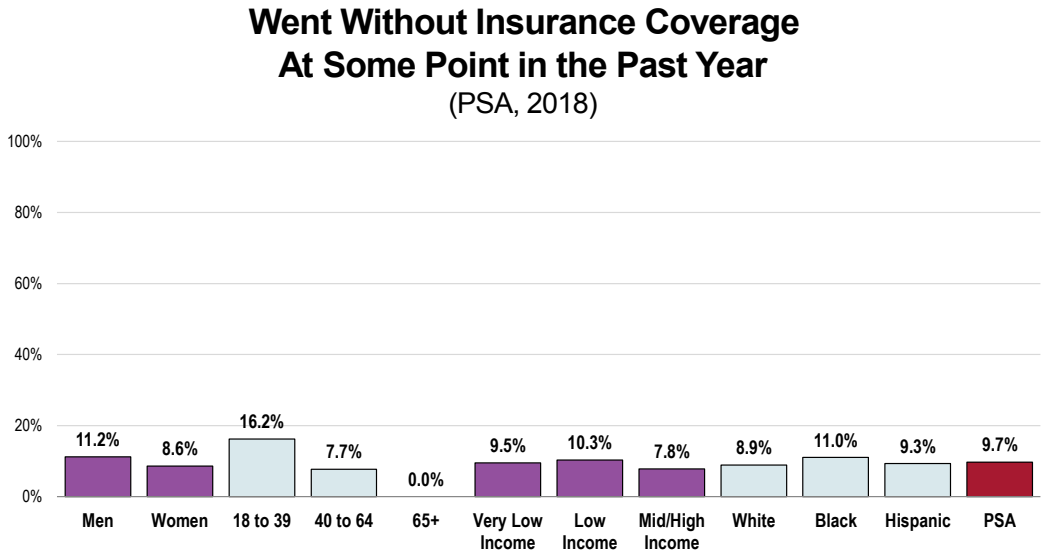
Notes: Asked of all respondents under the age of 65.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Recent Lack of Coverage

Among all Primary Service Area respondents, 9.7% report that they were without



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 308]
Notes: Reflects all respondents.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 308]
Notes: Reflects all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Difficulties Accessing Healthcare

About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

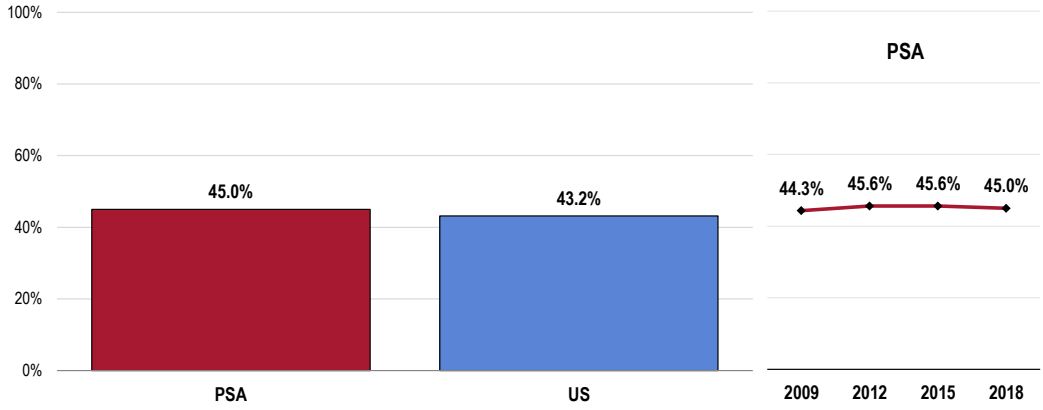
— Healthy People 2020 (www.healthypeople.gov)

Difficulties Accessing Services

This indicator reflects the percentage of the total population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care.

A total of 45.0% of Primary Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year



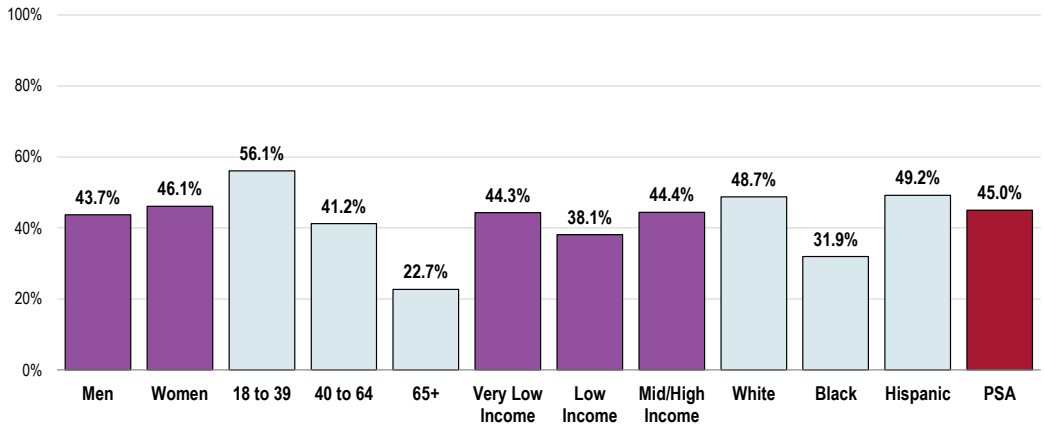
Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 171]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Note that the following demographic groups more often report difficulties accessing healthcare services:

- Adults younger than 65 (strong negative correlation with age).
- White and Hispanic residents.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 171]
Notes: Asked of all respondents.
Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Barriers to Healthcare Access

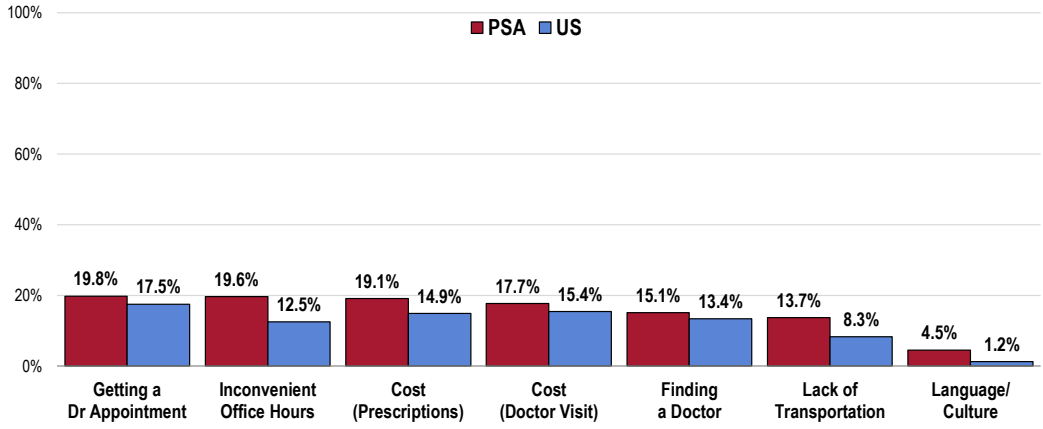
Of the tested barriers, getting an appointment to see a doctor impacted the greatest share of Primary Service Area adults (19.8% say that difficulty getting an appointment prevented them from obtaining a visit to a physician in the past year).

- The proportion of impacted Primary Service Area adults is statistically worse than that

To better understand healthcare access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

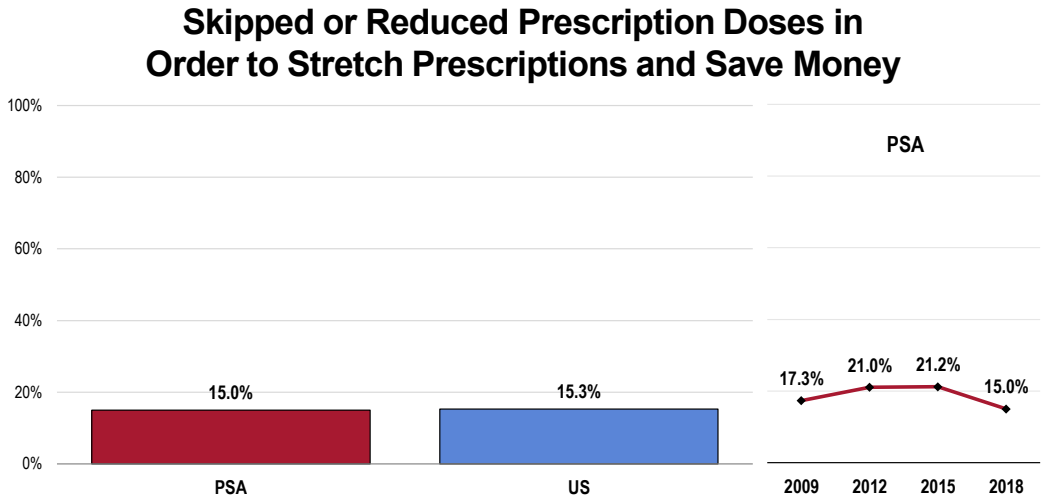
Barriers to Access Have Prevented Medical Care in the Past Year



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-13]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

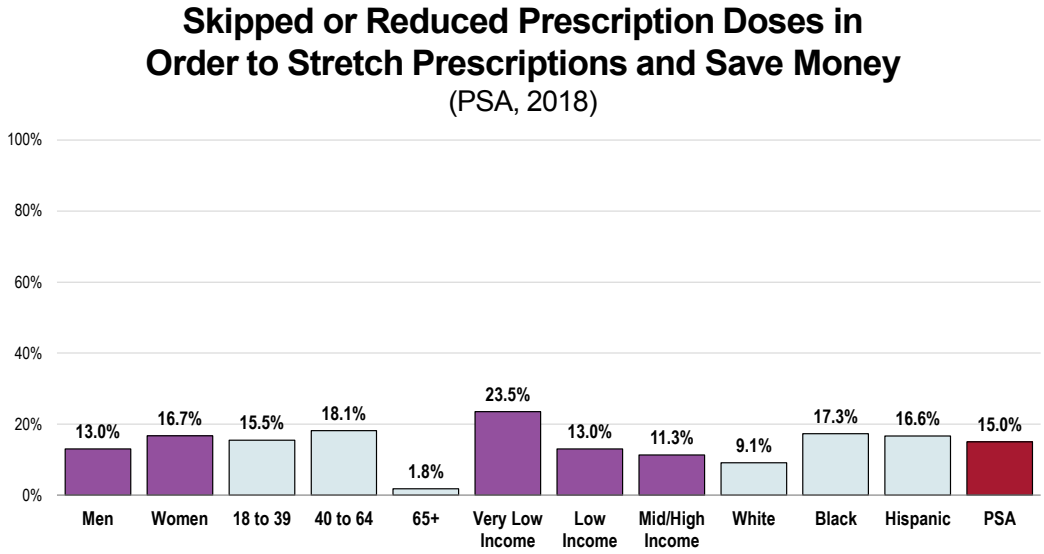
Prescriptions

Among all Primary Service Area adults, 15.0% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 14]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Adults more likely to have skipped or reduced their prescription doses include:



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 14]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Accessing Healthcare for Children

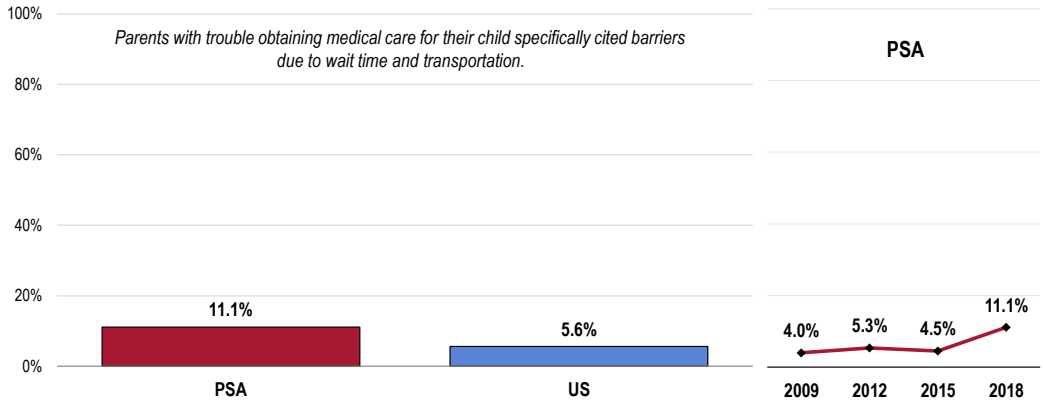
A total of 11.1% of parents say there was a time in the past year when they needed medical care for their child, but were unable to get it.

- Statistically comparable to the US figure.

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

Had Trouble Obtaining Medical Care for Child in the Past Year

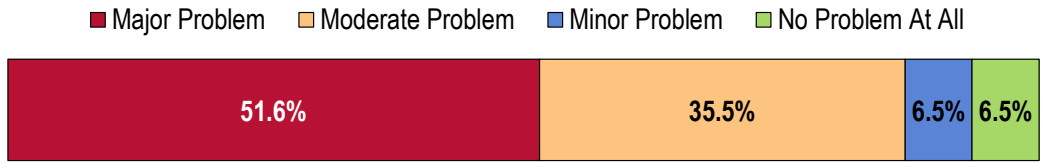
(Among Parents of Children 0-17)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 118-119]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents with children 0 to 17 in the household.

Perceptions of Access to Healthcare Services as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Reasons for "Major Problem" Responses:

-
-
-
-

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Cost/Insurance Issues

Cost is the biggest barrier. Even sliding scale fees are often too high for many individuals and families. Also, the fact that undocumented residents are not eligible for many provisions of expanded access under the Affordable Care Act means many residents are left behind. - Public Health Representative

Affordability and lack of insurance are major challenges. Lack of information regarding services offered and location. Parent work schedules preventing seeing through doctor appointments for their children's immunizations and medical needs. - Community Leader

High economic hardship coupled with lack of or no insurance eligibility add an additional burden, which in my opinion makes health care services inaccessible and expensive. Need affordable healthcare options for all residents. - Community Leader

Members of the community being uninsured due to undocumented status. Individuals lacking access to providers who accept Medicaid like dentist. Waiting is long for specialty care providers and mental and behavioral health services. - Other Health Provider

The biggest challenges are related to people being uninsured, underinsured, cost barriers, as well as disparate treatment, disrespect from healthcare service providers. - Community Leader

Undocumented immigrants are unable to have health insurance. - Physician

Affordability is the problem. - Social Services Provider

Limited Number of Clinics

Urgent care clinics, more clinics needed. This will alleviate the ER for emergent patients. - Public Health Representative

Far too few clinics in our areas. - Community Leader

Access to Providers

A big challenge is having access to professionals who can develop a relationship with the needs of the community and advise residents on how to access health care needs. - Community Leader

Lack of professional and culturally appropriate care for primary care services, and even a bigger problem for subspecialty services. - Physician

Awareness/Education

Health Education - I think it cuts across many of the specific diseases and areas listed. Many people do not have access to high-quality, accessible information about their health, whether their mental health, sexual and reproductive health, nutrition, etc. This prevents progress on many preventable conditions. - Public Health Representative

There is a lack of awareness of how to access health care services in the community. Affordability of health care services is also a challenge, especially for undocumented residents. - Social Services Provider

Language/Culture

Language of providers, as well as the waiting time to gain access to a provider. - Social Services Provider

Type of Care Most Difficult to Access

Key informants (who rated this as a "major problem") clearly identified **mental health** as the most difficult to access in the community, followed by **substance abuse treatment**, **dental care**, and **specialty care**.

Medical Care Difficult to Access as Identified by Key Informants				
	Most Difficult	Second-Most Difficult	Third-Most Difficult	**Total Mentions**
Mental Health Care	46.2%	30.8%	0.0%	**10**
Substance Abuse Treatment	15.4%	23.1%	7.7%	**6**
Dental Care	15.4%	7.7%	15.4%	**5**
Specialty Care	15.4%	15.4%	7.7%	**5**
Chronic Disease Care	0.0%	7.7%	23.1%	**4**
Elder Care	0.0%	7.7%	23.1%	**4**
Primary Care	7.7%	0.0%	15.4%	**3**
Urgent Care	0.0%	7.7%	0.0%	**1**

Primary Care Services

About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

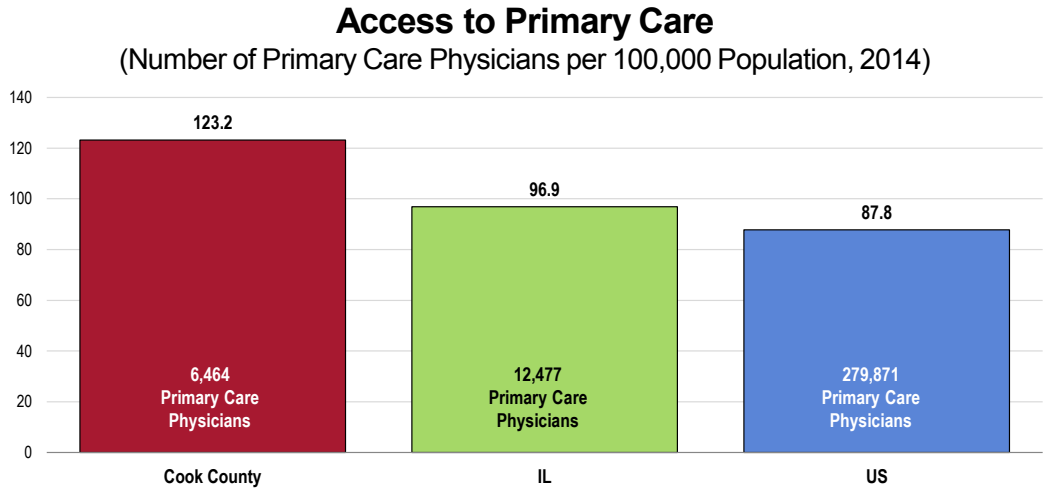
- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

— Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

In Cook County in 2014, there were 6,464 primary care physicians, translating to a rate



Sources: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. Retrieved December 2018 from Community Commons at http://www.chna.org.

Notes: This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

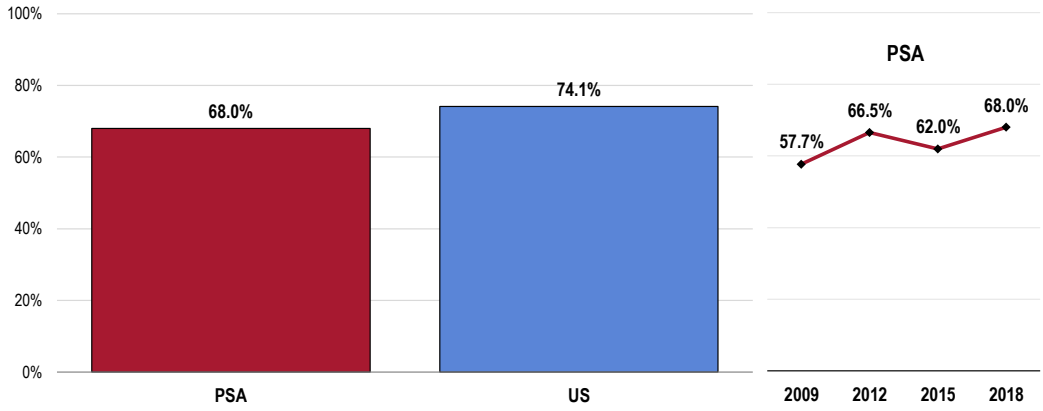
A hospital emergency room is not considered a specific source of ongoing care in this instance.

Specific Source of Ongoing Care

A total of 68.0% of Primary Service Area adults were determined to have a specific source of ongoing medical care.

Have a Specific Source of Ongoing Medical Care

Healthy People 2020 Target = 95.0% or Higher



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 170]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-5.1]
Notes: Asked of all respondents.

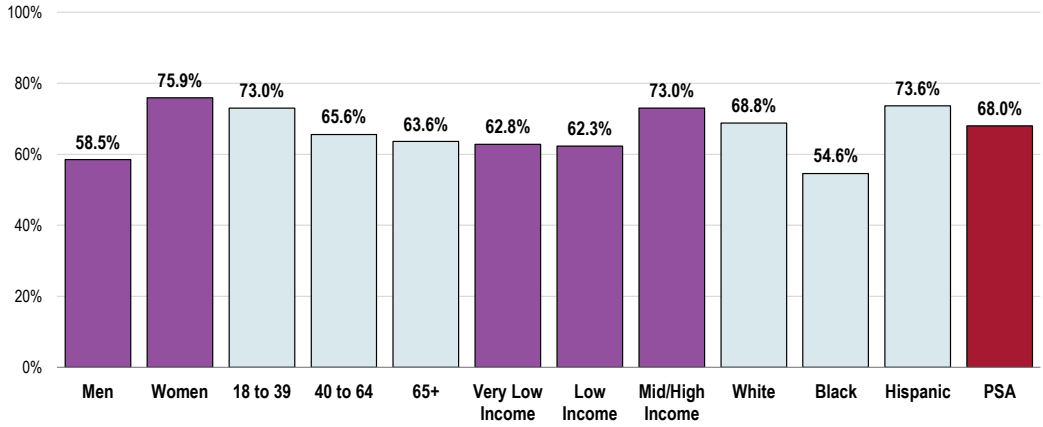
When viewed by demographic characteristics, the following population segments are less likely to have a specific source of care:

- Men.
- Adults age 40 and older.
- Black residents, when compared to Hispanic residents.

Have a Specific Source of Ongoing Medical Care

(PSA, 2018)

Healthy People 2020 Target = 95.0% or Higher



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 170]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-5.1]

Notes: Asked of all respondents.
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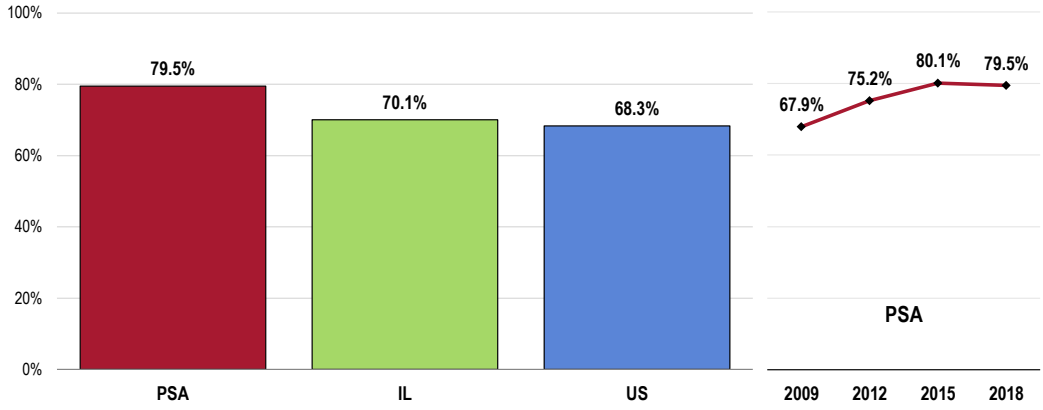
Utilization of Primary Care Services

Adults

More than three-quarters of adults (79.5%) visited a physician for a routine checkup in

Have Visited a Physician for a Checkup in the Past Year

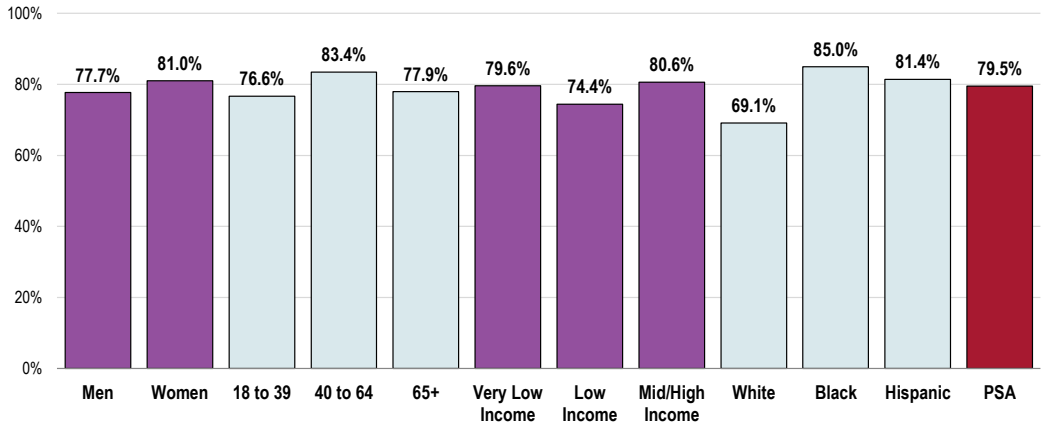


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents.

Have Visited a Physician for a Checkup in the Past Year

(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]

Notes: Asked of all respondents.

Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

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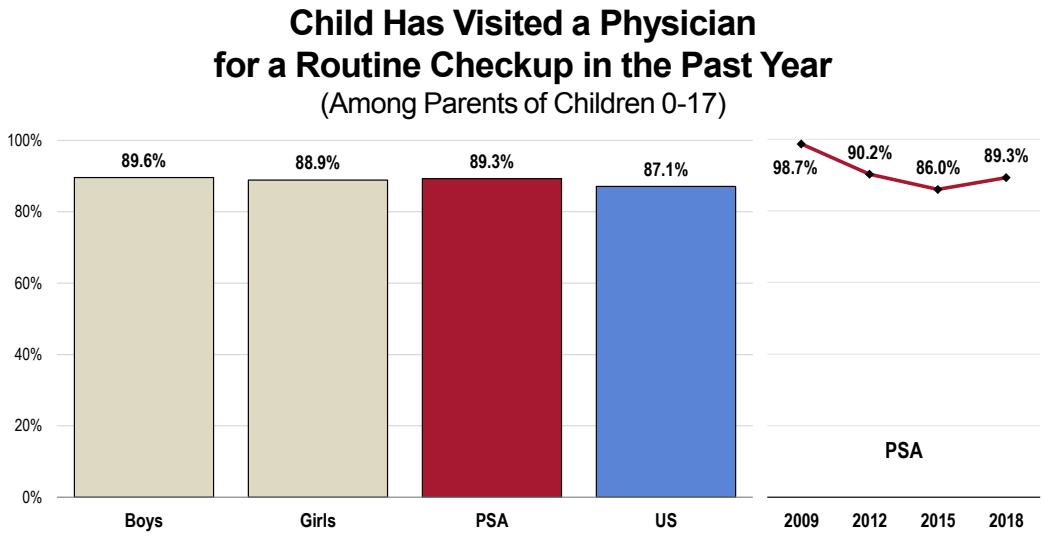
Children

Among surveyed parents, 89.3% report that their child has had a routine checkup in the past year.

- Similar to national findings.
- TREND: Marks an unfavorable decline since 2009 findings (though similar to other



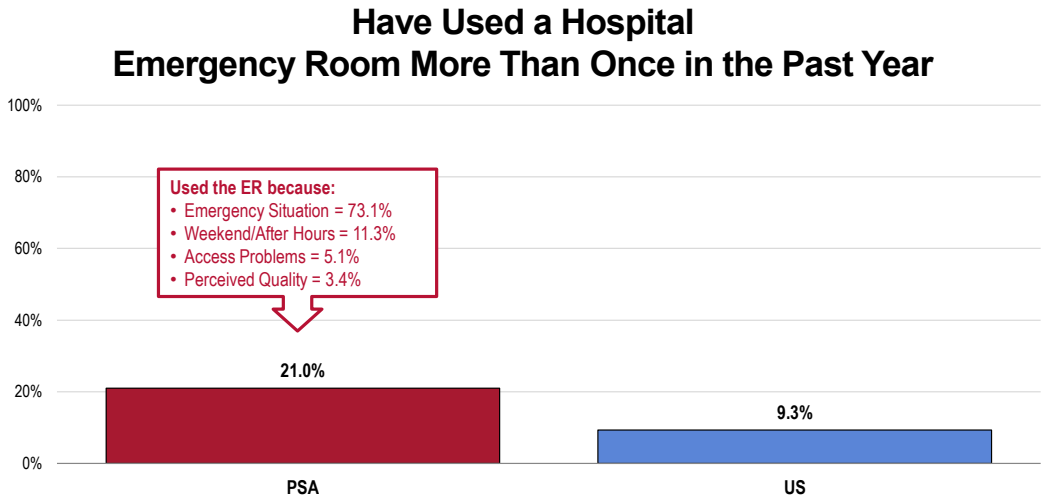
Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 120]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents with children 0 to 17 in the household.

Emergency Room Utilization

More than one-fifth of Primary Service Area adults (21.0%) have gone to a hospital emergency room more than once in the past year about their own health.

- Much higher than national findings.

Of those using a hospital ER, 73.1% say this was due to an **emergency or life-threatening situation**, while 11.3% indicated that the visit was during **after-hours or on the weekend**. A

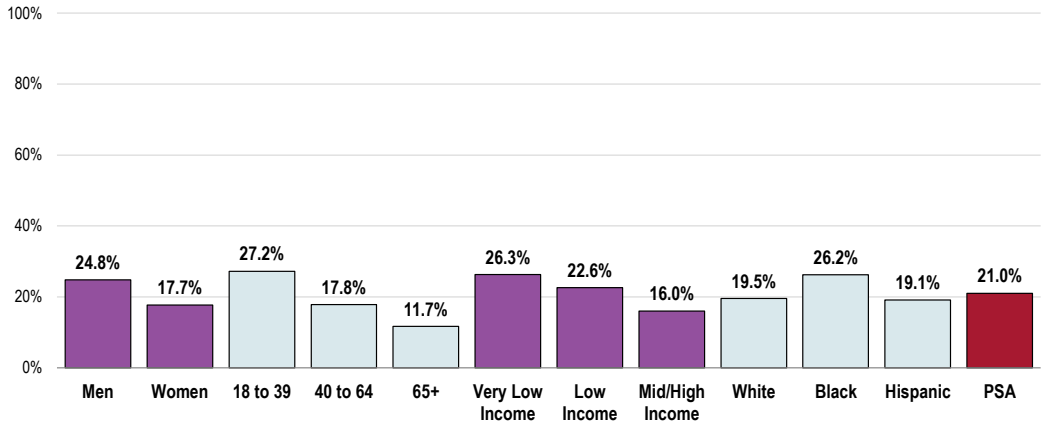


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 22-23]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

- Younger adults are more likely to have used an ER for their medical care more than once in the past year.

Have Used a Hospital Emergency Room More Than Once in the Past Year

(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
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Oral Health

About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use; excessive alcohol use;** and **poor dietary choices**.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

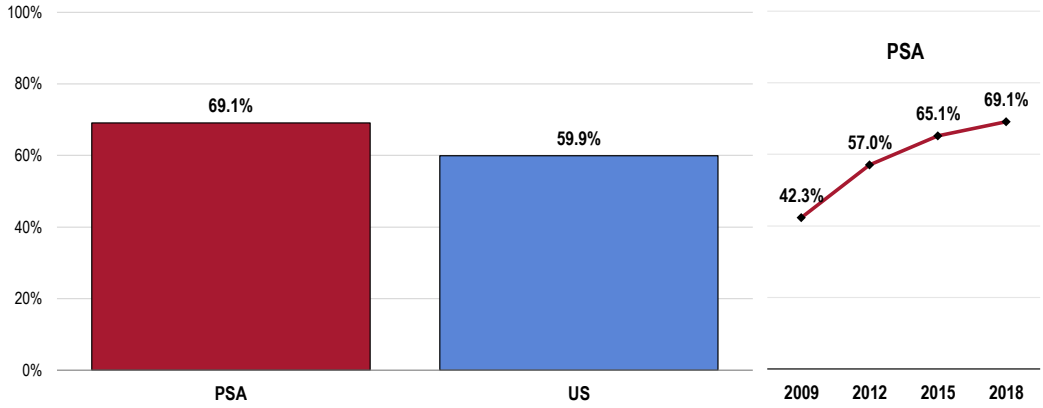
— Healthy People 2020 (www.healthypeople.gov)

Dental Insurance

Nearly seven in 10 Primary Service Area adults (69.1%) have dental insurance that covers all or part of their dental care costs.

- More favorable than the national finding.
- TREND: Marks a steady increase in coverage over time.

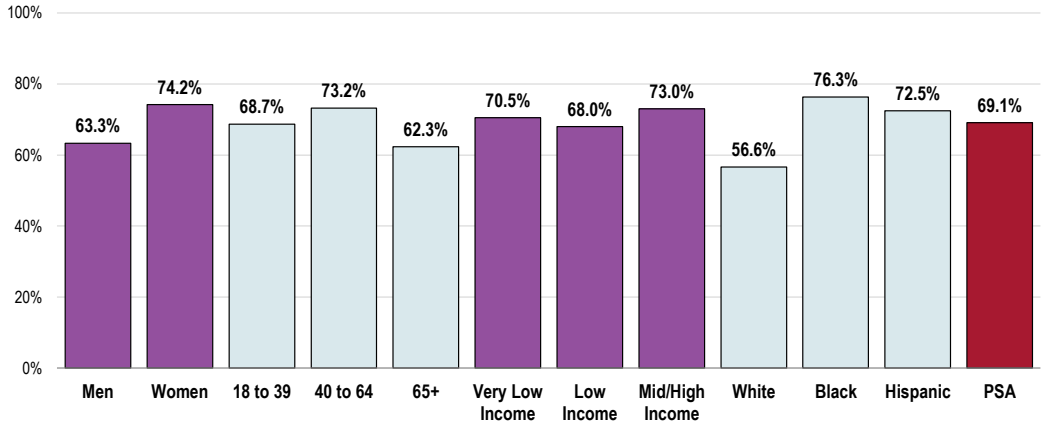
Have Insurance Coverage That Pays All or Part of Dental Care Costs



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Have Insurance Coverage That Pays All or Part of Dental Care Costs

(PSA, 2018)



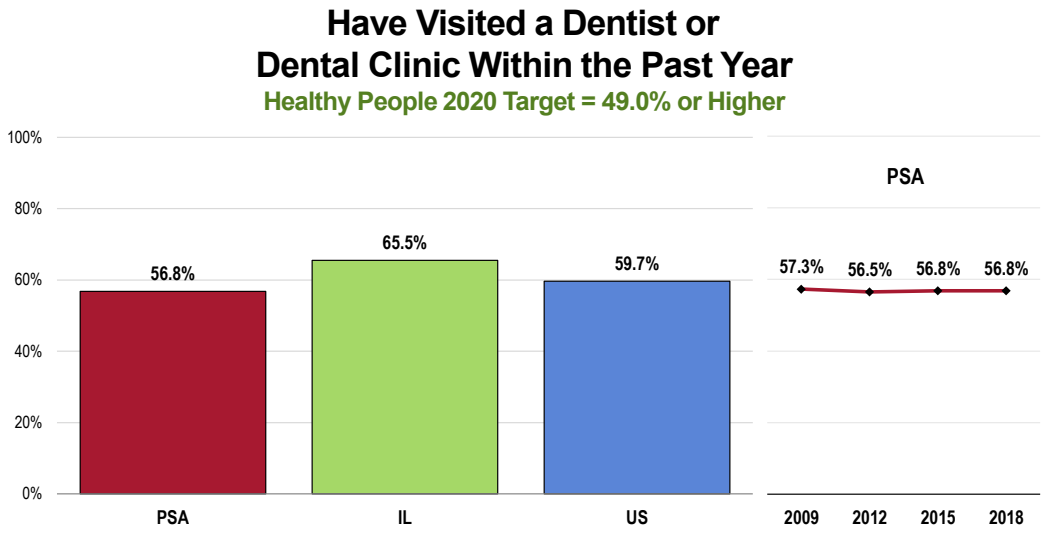
Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Dental Care

Adults

A total of 56.8% of Primary Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

- Below statewide findings.
- Comparable to national findings.



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Illinois data.
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]
Notes: Asked of all respondents.

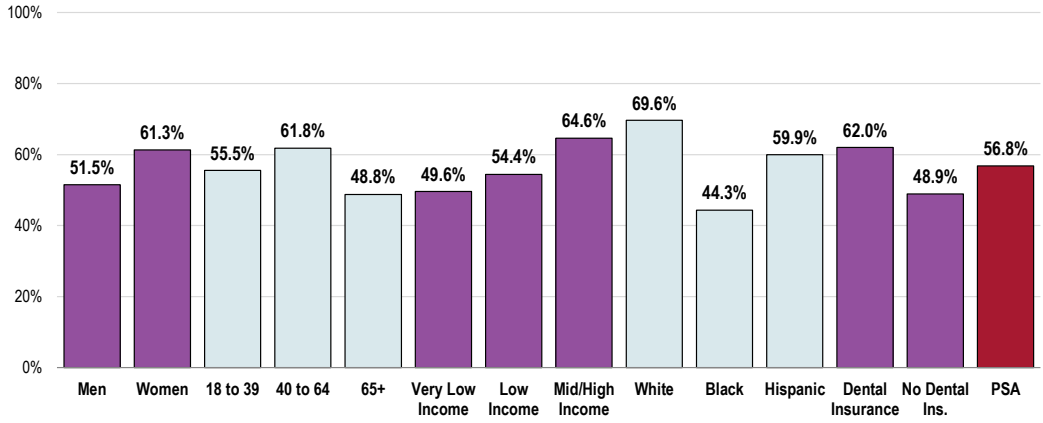
Note the following:

- Black residents are much less likely to report recent dental care.
- As might be expected, persons without dental insurance report much lower utilization of oral health services than those with dental coverage.

Have Visited a Dentist or Dental Clinic Within the Past Year

(PSA, 2018)

Healthy People 2020 Target = 49.0% or Higher



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

Notes: Asked of all respondents.
Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes below 100% of the federal poverty level; "Low Income" includes households with incomes at 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children

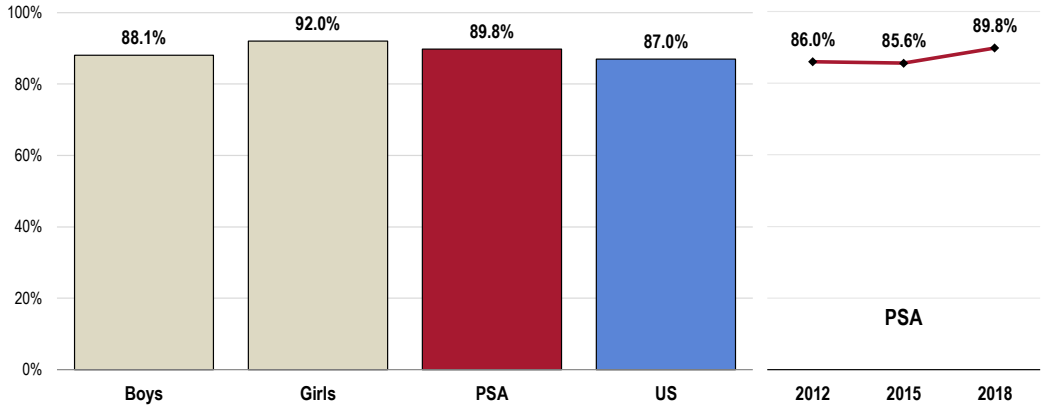
A total of 89.8% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- Similar to national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- TREND: Recent dental care for children has not changed significantly over time.
- Regular dental care is similar by child's gender.

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Among Parents of Children Age 2-17)

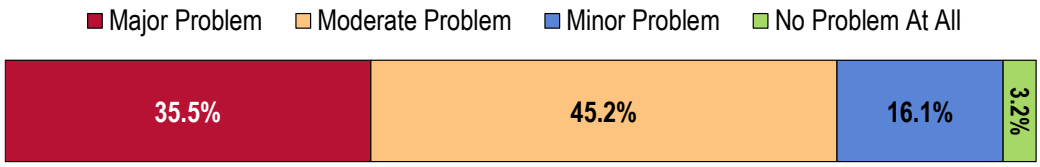
Healthy People 2020 Target = 49.0% or Higher



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 123]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]
Notes: Asked of all respondents with children age 2 through 17.

Perceptions of Oral Health as a Problem in the Community

(Key Informants, 2018)



Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Top Reasons for "Major Problem" Responses:

Among those rating this issue as a "major problem," reasons related to the following:

Affordable Care/Services

Low numbers of dentist who take Medicaid, the high cost of dental care and the lack of knowledge about the severity and graveness of not treating dental problems. - Other Health Provider

Not many dentists charging reasonably when it comes to dental treatment, and no insurance. - Public Health Representative

People cannot afford dental care. - Other Health Provider

Awareness/Education

> *Poor education about oral hygiene, lack of insurance coverage for dental care. - Physician*
>
> *Lack of understanding of the importance of dental health, which impacts overall health. - Community Leader*

Access to Care/Services

> *Access to public health care is limited. Young people with needs to have wisdom teeth extracted are often on a waiting list for months. - Community Leader*

Prevalence/Incidence

> *Kids and adults with bad or no teeth. - Social Services Provider*

Health Education

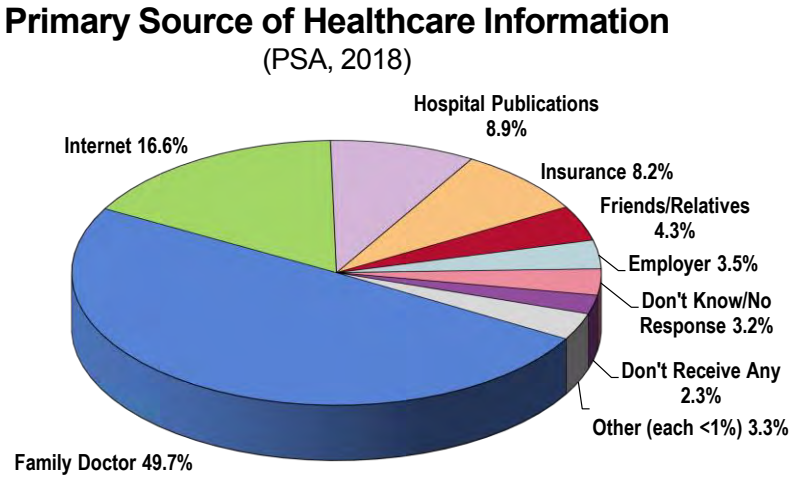
Professional Research Consultants, Inc.

Healthcare Information Sources

Family physicians and the internet are Primary Service Area residents' primary sources of healthcare information.

- 49.7% cited their family physician as their primary source of healthcare information.
- The internet received the second-highest response, with 16.6%.

Other sources mentioned include **hospital publications** (8.9%), **insurance** (8.2%), **friends/relatives** (4.3%), and an **employer** (3.5%).



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 323]
Notes: Asked of all respondents.

Local Resources

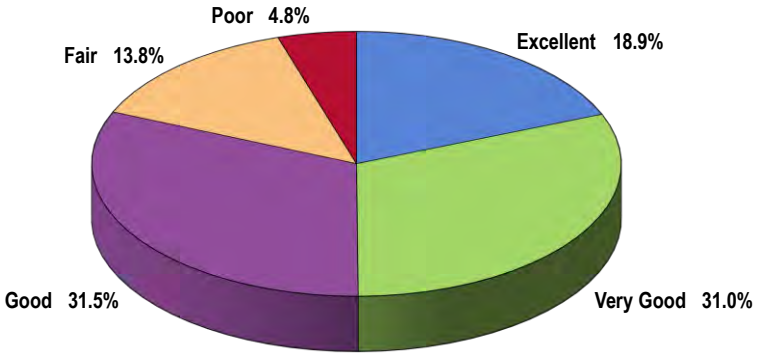
Professional Research Consultants, Inc.

Perceptions of Local Healthcare Services

Nearly one-half of Primary Service Area adults (49.9%) rate the overall healthcare services available in their community as "excellent" or "very good."

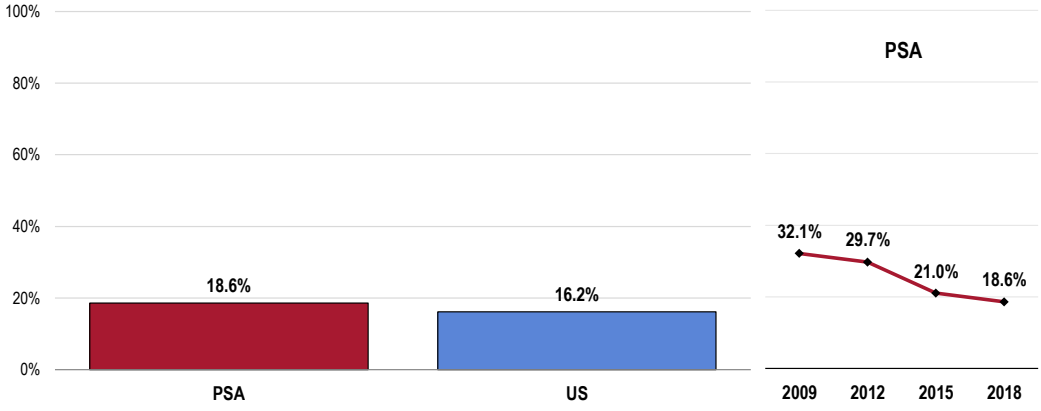
Rating of Overall Healthcare Services Available in the Community

(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: Asked of all respondents.

Perceive Local Healthcare Services as "Fair/Poor"

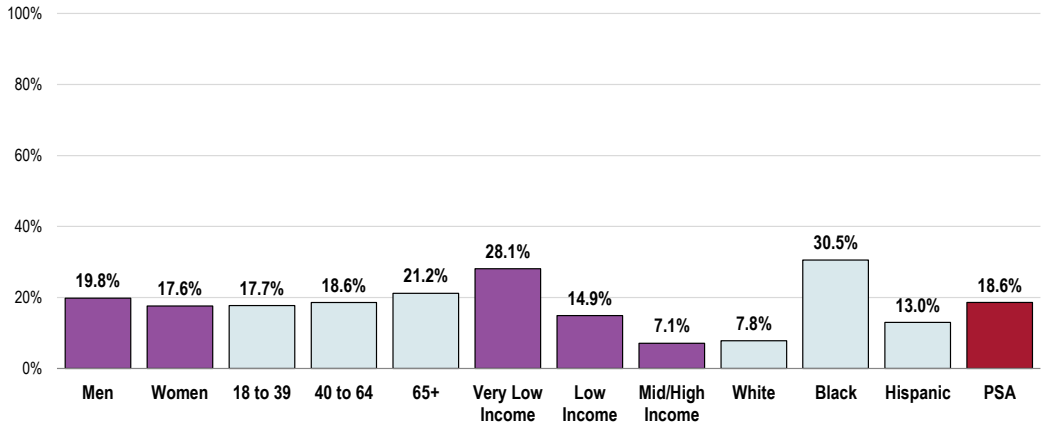


Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

The following residents are more critical of local healthcare services:

Perceive Local Healthcare Services as "Fair/Poor"

(PSA, 2018)



Sources: 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: Asked of all respondents.
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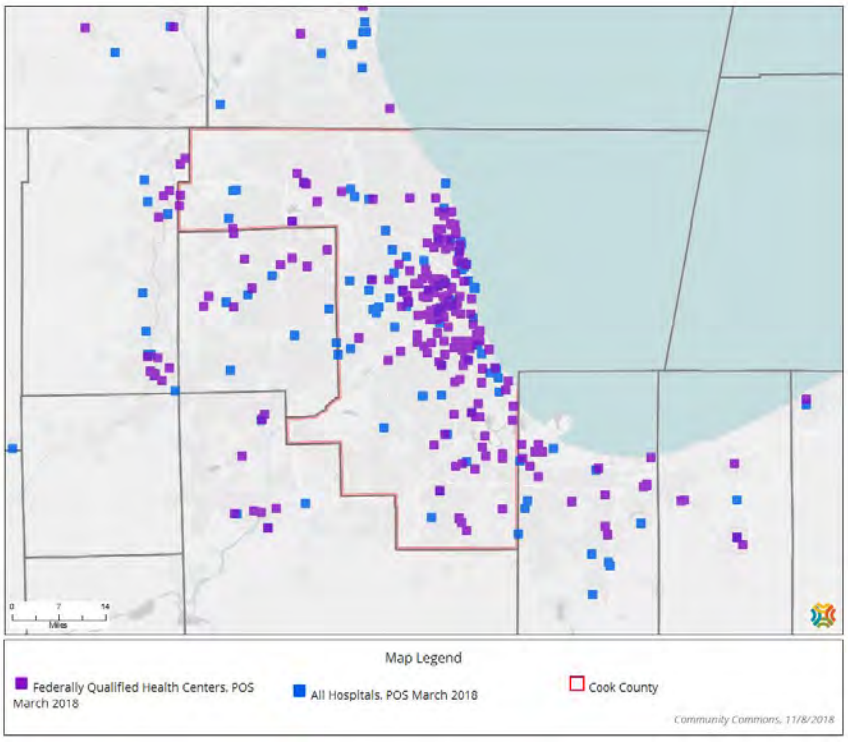
Healthcare Resources & Facilities

Hospitals & Federally Qualified Health Centers (FQHCs)

The following map details the hospitals and Federally Qualified Health Centers (FQHCs) within Cook County as of March 2018



Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Healthcare Services

- *Access Community Health Network / Servicios Médicos La Villita*
- *Alivio Medical Center*
- *Carelink*
- *Catholic Charities*
- *Charity Care*
- *Chicago Public Schools*
- *Cook County Finance Department*
- *Doctor's Offices*
- *Esperanza Health Centers*
- *Free and Federally Qualified Health Centers*
- *Habilitative Systems, Inc. (HSI)*
- *Healthcare Institutions*
- *I Am Able Family Center*
- *IMAN Health Clinic*
- *Lawndale Christian Health Centers*
- *Medication Assistance Programs*
- *Mental Health Services*
- *Mount Sinai Hospital*
- *New City Supportive Living*
- *Parks and Recreation*
- *Pilsen Wellness Center*
- *Saint Anthony Community Wellness Program*
- *Saint Anthony Hospital*
- *School System*
- *Sinai Urban Heath Institute (SUHI)*
- *SOS Children's Village*
- *Taller de Jose*

Arthritis, Osteoporosis, & Chronic Back Conditions

- *Doctor's Offices*
- *IMAN Health Clinic*
- *Lawndale Christian Health Centers*

Cancer

- *Chicago Metropolitan Breast Cancer TaskForce*
- *Community Health Clinics*
- *Community Health Fairs*
- *Community Health Promoters*
- *Cook County Health Care*
- *Cook County Hospital*
- *ELLAS Support Group With TRP*
- *Free Health Screenings*
- *Guilda's Club*
- *Health Care Clinics*
- *Mount Sinai Hospital*
- *Saint Anthony Hospital*

Dementias, Including Alzheimer's Disease

- *Casa Central - Adult Wellness Center*
- *Chinese American Service League*
- *FAMA Bilingual Caregiver Center*
- *Lambda Legal*
- *Lawndale Christian Health Centers*
- *Mount Sinai Hospital*
- *Rush Alzheimer's Disease Center*

Diabetes

- *340b Program*
- *Access Community Health Network / Servicios Médicos La Villita*
- *Alivio Medical Center*
- *Chicago Department of Public Health*
- *Chicago Literacy Coalition's Health Literacy Program*
- *Chinese American Service League*
- *Consortium to Lower Obesity in Chicago Children*
- *Cook County Hospital*
- *Education Classes*
- *Enlace*
- *Esperanza Health Centers*

Fitness Centers/Gyms
Health Care Clinics
Hospitals
IMAN Health Clinic
Jorge Prieto Clinic
Lawndale Christian Health Centers
Miles Square Health Clinic
Mount Sinai Hospital
Nutrition Services
Parks and Recreation
Rush Hospital
Saint Anthony Community Wellness Program
Saint Anthony Hospital
School System
SOS Children's Village
Tomando Control de Su Salud Workshops
Universidad Popular

Family Planning

Access Community Health Network / Servicios Médicos La Villita
Alivio Medical Center
ARCH Program
Doctor's Offices
Esperanza Health Centers
Health Centers
IMAN Health Clinic
Lawndale Christian Health Centers
Paolo Freire Center
Peace and Education Coalition
Pilsen Wellness Center
Saint Anthony Community Wellness Program
Saint Anthony Hospital

Hearing & Vision

Lawndale Christian Health Centers

Heart Disease & Stroke

340b Program
Brighton Park Neighborhood Council
Health Care Clinics
IMAN Health Clinic
Lawndale Christian Fitness Center
Lawndale Christian Health Centers
Mount Sinai Hospital
Red Cross
Saint Anthony Hospital
School System

HIV/AIDS

AIDS Pastoral Care Network
Alivio Medical Center
Lawndale Christian Health Centers
Rothstein Core Center
Saint Anthony Hospital

Immunization & Infectious Diseases

Esperanza Health Centers
IMAN Health Clinic
Lawndale Christian Health Centers
Mount Sinai Hospital

Infant & Child Health

Access Community Health Network / Servicios Médicos La Villita
Doctor's Offices
El Valor
Erikson Institute
Esperanza Health Centers
Family Literacy Programs
Gads Hill Center
Health Centers
IMAN Health Clinic
Jorge Prieto Clinic
Lawndale Christian Health Centers
Miles Square Health Clinic
Mount Sinai Hospital
Oak Street
Rush Hospital
Saint Anthony Hospital
The Port Ministries
Under the Rainbow
University of Illinois Hospital

Injury & Violence

A Safe Haven
Back of the Yards Council
BBF Family Services
Brighton Park Neighborhood Council
Cadet Explorers Program
Casa Romero/Holy Cross
Catholic Charities
CCA Academy
Ceasefire
CPS (Child Protective Services)
Domestic Violence Centers
Enlace
Esperanza Health Centers

- *Headstart Programs*
- *IMAN Health Clinic*
- *Juvenile Restorative Justice Programs*
- *La Familia Unida*
- *Latinos Progresando*
- *Little Village Youth Safety Network (LVYSN)*
- *Medical Institutions*
- *Mujeres Latinas*
- *New Life Centers*
- *New Life Urban Skills*
- *North Lawndale Community Coordinating Council*
- *North Lawndale Employment Network*
- *Nuevo Despertar, Mujeres Latinas en Accion*
- *Police*
- *Precious Blood Ministries*
- *Safe Passage Program*
- *Saint Anthony Hospital*
- *Sarah's Inn*
- *School System*
- *The Port Ministries*
- *The Violence Prevention Collaborative (VPC)*
- *UCAN*
- *Victims of Violence Programs*

Kidney Disease

- *DaVita Dialysis*
- *Esperanza Health Centers*
- *Jorge Prieto Clinic*
- *Lawndale Christian Health Centers*
- *Mount Sinai Hospital*
- *Saint Anthony Community Wellness Program*

Mental Health

- *Ada S. McKinley Community Services*
- *Asian Human Services*
- *Brighton Park Neighborhood Council*
- *Collaborative for Community Wellness*
- *Erie House*
- *Erikson Institute*
- *Esperanza Health Centers*
- *Health Centers*
- *Healthcare Institutions*
- *Heartland Alliance*
- *I Am Able Family Center*
- *IMAN Health Clinic*
- *Latinas Mujeres en Accion*
- *Literacy Programs*
- *MADO Healthcare*
- *Mental Health Services*
- *Midwest Asian Health Association*
- *Mount Sinai Hospital*
- *Padres Angeles*
- *Pilsen Little Village Community Mental Health Center*
- *Pilsen Wellness Center*
- *Saint Anthony Community Wellness Program*
- *Saint Anthony Hospital*
- *Taller de Jose*
- *The Port Ministries*
- *TR4IM/I Am Able*

Nutrition, Physical Activity, & Weight

- *Beyond the Ball*
- *Brighton Park Neighborhood Council*
- *Community Health Fairs*
- *Community Health Market*
- *CPS (Child Protective Services)*
- *Doctor's Offices*
- *Enlace*
- *Esperanza Health Centers*
- *Farm on Ogden*
- *Fitness Centers/Gyms*
- *Health Centers*
- *IMAN Health Clinic*
- *Jorge Prieto Clinic*
- *Lawndale Christian Fitness Center*
- *Lawndale Christian Health Centers*
- *Lawndale Community Garden*
- *Mount Sinai Hospital*
- *New City Supportive Living*
- *Nutrition Services*
- *Paolo Freire Center*
- *Park District*
- *Parks and Recreation*
- *Pete's Grocery Store*
- *Rush Hospital*
- *Saint Anthony Community Wellness Program*
- *Saint Anthony Hospital*
- *School System*
- *University of Illinois Hospital*
- *Viento Running Club*

Oral Health

- *Dentist's Offices*
- *Holy Cross Family Dental*
- *IMAN Health Clinic*
- *Lawndale Christian Health Centers*
- *Medicaid*

Respiratory Diseases

Brighton Park Neighborhood Council
Community Health Clinics
IMAN Health Clinic
Medical Institutions

Sexually Transmitted Diseases

Health Centers
Prep Education
School System

Substance Abuse

Brighton Park Neighborhood Council
Health Centers
Healthcare Alternative Systems
IMAN Health Clinic
La Casa Norte
Lawndale Christian Health Centers
Mount Sinai Hospital
Pilsen Wellness Center
Rush Hospital
Safe Passage Program
Saint Anthony Hospital
School System

Tobacco Use

Brighton Park Neighborhood Council
Community Members
IMAN Health Clinic

Appendix

Professional Research Consultants, Inc.

Evaluation of Past Activities

Diabetes

Saint Anthony Hospital promotes and supports diabetes self-management in an effort to decrease hospitalizations due to diabetes-related complications in the underserved community areas we serve. Project Diabetic Connect specifically focuses on patients who frequent the Emergency Department (ED) for diabetic related issues, patients with diabetic related wounds or sores, and pregnant women with diabetes or gestational diabetes. These populations were chosen because of their high risk and vulnerability.

Project Diabetic Connect staff invite and encourage patients who have visited the Saint Anthony Hospital ED more than once in the last year, patients at our Wound Center with a diabetes diagnosis, and pregnant women to visit our Certified Diabetes Center at our Community Wellness Program to get a baseline blood sugar measurement. HgbA1c is a blood test that shows how well a patient's diabetes is being controlled. The test provides an average of a patient's blood sugar control in the previous two to three months. It is used along with home blood sugar monitoring to make adjustments in diabetes medicines. HgbA1c tests are done at the three and six-month mark to monitor whether or not each patient's blood sugar level has increased, decreased or stayed the same.

In addition to testing the patients' glucose levels, patients are invited to participate in a diabetes educational workshop that is held quarterly. This two-week workshop serves as an intervention for those who have been to the ED more than once for diabetes-related hospitalizations. Patients are assessed based on their needs for resources which may include: medication management, finding a primary care practitioner, and/or applying for insurance. The workshop is based on the U.S. Diabetes Conversation Map Kit. Topics addressed during the workshop include: Diabetes Management, Diabetes and Healthy Eating, Medication Management, and Goal Setting and Trouble Shooting. Participants spend a total of eight hours in the workshop in addition to the time they spend getting their HgbA1c levels measured. This approach integrates real-time data about patients' health (patients' HgbA1c level) with education resources and discussions about how they can improve their blood sugar levels.

This approach is comprehensive in the sense that it helps patients make lifestyle changes to improve their health rather than just treatment through medication. Project Diabetic Connect served a total of 10 individuals in 2016, 16 individuals in 2017, and 12 individuals between January 1, 2018 and November 15, 2018. Lastly, in addition to the services offered through Project Diabetic Connect, Saint Anthony Hospital's Dialysis Clinic at Little Village achieved a 5-star rating from the Centers for Medicare and Medicaid Services in 2017 and 2018, putting it in the top 10% of all dialysis facilities nationally. Dialysis is a critically important service line for our patients with diabetes.

Mental Health

Saint Anthony Hospital has continued to invest in and expand its mental health programming over the past three years. Saint Anthony Hospital currently offers free, long-term, trauma-focused mental health services to uninsured and underinsured adults through its Community Wellness Program offices and satellite locations in South Lawndale, North Lawndale, Brighton Park, and Gage Park. In 2016, mental health clinicians provided 1,722 individual therapy sessions to 147 program participants; 136 couples therapy sessions to 30 program participants; and 73 group sessions to 36 program participants. Mental health clinicians also provided 1,697 individual therapy sessions to 171 program participants in 2017, as well as 85 couples therapy sessions to 21 program participants and 75 group therapy sessions to 55 program participants. Finally, from January 1, 2018 to November 14, 2018, a total of 1,459 individual therapy sessions were provided to 159 program participants; 69 couples therapy sessions were provided to 20 program participants; and 43 group sessions were provided to 25 participants.

Quantitative data indicate that program services are associated with a decrease in depression symptoms among mental health program participants. In particular, among the 59 program participants who completed the Patient Health Questionnaire (PHQ-9) upon initiating services and again upon ending services between January 1, 2016 and November 15, 2018, scores decreased by an average of 3.88 points, thus indicating a decrease in self-reported depression symptoms. Qualitative data also indicate that mental health program participants describe program services as facilitating their emotional expression, enhancing their problem-solving abilities, promoting an increased sense of self-worth, and motivating them to become involved in advocacy efforts within their community.

Nutrition, Physical Activity, and Weight

Saint Anthony Hospital addresses the priority health areas of nutrition, physical activity, and weight through its Community Wellness Program health education activities. Health education services are offered by a bilingual (English and Spanish-speaking) registered nurse who provides health promotion services to help individuals achieve healthy lifestyles and disease prevention. Services include: 1) health screenings (blood pressure, glucose, and body mass index); 2) community health workshops; 3) individual health counseling; 4) case management services, including medication assistance through the Care Link Program, discount cards, City Key Rx Program, and free clinics; 5) medical referrals and connections to medical homes; and 6) chronic disease management provided through our Certified Diabetes Center.

In the year 2016, a total of 53 individual and group sessions were provided through the Community Wellness Program's range of health education services, while 352 sessions were provided in the year 2017 and 96 sessions were provided between January 1, 2018 and November 15, 2018. In addition to these health education services provided through the Community Wellness Program, hospital dietitians also provide one-on-one counseling around

healthy diets, weight loss, and issues relating to diabetes on-site at Saint Anthony Hospital.

Access to Healthcare Services

Saint Anthony Hospital's Community Wellness Program has a Health Access Team, currently a group of four full-time employees (three of whom are bilingual English and Spanish-speaking) who provide a variety of services to patients and community residents. Services include: 1) assistance enrolling in health insurance, including CHIP benefits; 2) help identifying a primary care provider in the community, regardless of whether the provider is at Saint Anthony Hospital; 3) assistance enrolling in other community benefits, including SNAP; 4) referrals to other community resources, including food banks, free clinics, medication resources, mental health resources, housing resources, and WIC partners; 5) crisis stabilization in the form of emergency access to food; and 6) Medicare and Medicaid savings programs for eligible seniors.

All resources are available in both English and Spanish. The health access team delivered a total of 1,657 sessions in 2016; 1,468 sessions in 2017; and 1,327 sessions between January 1, 2018 and November 15, 2018. Additionally, in 2018 the Community Wellness Program created two Community Wellness Liaison positions on-site at Saint Anthony Hospital, to facilitate the identification of patients who are in need of assistance with obtaining insurance benefits and ensure that they are seamlessly connected with a member of the Health Access team.

Infant Health

In May of 2018, Saint Anthony Hospital partnered with The Baby Box Co. to provide new and expecting parents with baby boxes, making it the first hospital in Illinois to offer this program. This program was inspired by the Finnish government's practice of sending maternity packages to all expectant mothers. The aim of the baby box program is to help with the reduction of infant mortality rates, especially related to safe sleep environments, and provide better health through empowering parents with access to free products and online education. The baby boxes are certified to meet the highest level of safety standards and are intended to be used as a safe sleep space for a child's first months of life. New and expecting parents may receive baby boxes regardless of whether they deliver their child at Saint Anthony Hospital.

To qualify for a baby box, expectant and new parents just need to follow three easy steps: 1) Register online; 2) Watch a series of short videos and take a quiz; and 3) bring a certificate of completion to Saint Anthony Hospital. A Saint Anthony Hospital Patient Navigator is available to help guide new and expecting parents through this process. In the fiscal year 2018, Saint Anthony Hospital distributed a total of 120 baby boxes.

In addition to its baby box initiative, Saint Anthony Hospital also recently received its official

designation as a pediatric hospital. One of 17 hospitals in the state of Illinois to have this designation, Saint Anthony Hospital made a commitment to expand its pediatric care services at a time when a number of Chicago-area community hospitals have closed their pediatric inpatient units. In 2016, Saint Anthony Hospital formed a partnership with University of Chicago Medicine Comer Children's Hospital. As part of this partnership, Comer specialists offer services at Saint Anthony and provide consultation to Saint Anthony doctors. Comer medical residents also receive training at Saint Anthony. Saint Anthony Hospital currently has 18 pediatric beds.

Furthermore, Saint Anthony Hospital promotes healthy child development through several of its Community Wellness Program services. Through its Developmental Support Program (DSP), Saint Anthony Hospital aims to provide improved developmental care and outcomes for children birth-to-eight years of age seen by Saint Anthony Hospital's affiliated physicians. To accomplish this aim, family support staff at the Community Wellness Program provide training and technical assistance on developmentally oriented best practices to pediatricians and family practice physicians, and also provide direct support to the physicians' young patients and their families related to developmental and behavioral concerns. Family support staff link children to the local Early Intervention and Chicago Public Schools systems; to rehabilitation services, like speech therapy; to Early Head Start and Head Start programs; and to other developmental and educational programs.

In the year 2016, family support staff served a total of 144 individuals through DSP and delivered a total of 396 sessions, while they served 252 individuals and delivered a total of 836 sessions in 2017. Between January 1, 2018 and November 15, 2018, DSP has reached a total of 243 individuals through 488 sessions. In addition to DSP, the Community Wellness Program also offers interactive play groups for parents and children between 1 and 3 years of age. Known as Little Explorers, these interactive play groups are delivered in accessible community-based locations and offer semi-structured play time for children and parents, structured parent-child activities that promote the various areas of development, parent coaching to help parents become more responsive to their children's needs, modeling positive discipline strategies for inappropriate behaviors, and information sharing related to child development. The parents also benefit from having an outside speaker once a month who delivers educational workshops. One occupational and developmental therapist from Early Intervention also volunteer for the group once a week. Little Explorers groups have been offered weekly on an ongoing basis at a local church in the Little Village community since 2012, and have since expanded to include programming in community locations in North Lawndale and Back of the Yards in 2017 and 2018.

Injury and Violence

In order to address this priority health need, Saint Anthony Hospital has expanded its supportive services for individuals and families who have been impacted by violence. Since being awarded Victims of Crime Act (VOCA) grant funds in March of 2018, Saint Anthony Hospital has developed specialized programming for survivors of interpersonal and community violence across ten neighborhoods in the hospital's catchment area (Brighton Park, New City, East Garfield Park, West Garfield Park, Lower West Side, Archer Heights, North Lawndale, South Lawndale, West Elsdon, Gage Park, and McKinley Park).

Using a trauma-focused model of service delivery, VOCA staff provide mental health services and case management support to promote emotional healing and connect individuals with a range of community-based resources that address their psychosocial and material needs. Specific case management supports offered through VOCA include: accompaniment in navigating the criminal justice system; housing advocacy assistance; assistance intervening with employers, creditors, landlords, and academic institutions; interpreter services; employment and education assistance; crisis intervention; and group support. Mental health clinicians offer long-term individual, couples, and group therapy, as well as mental health assessments for immigrant survivors of crime involved in U-Visa proceedings.

In the first three quarters of its VOCA program, Saint Anthony Hospital provided mental health services to a total of 132 individuals and delivered 963 mental health therapy sessions. Furthermore, the VOCA program also offered case management support to 134 individuals and delivered a total of 291 individual counseling sessions during this same time period.