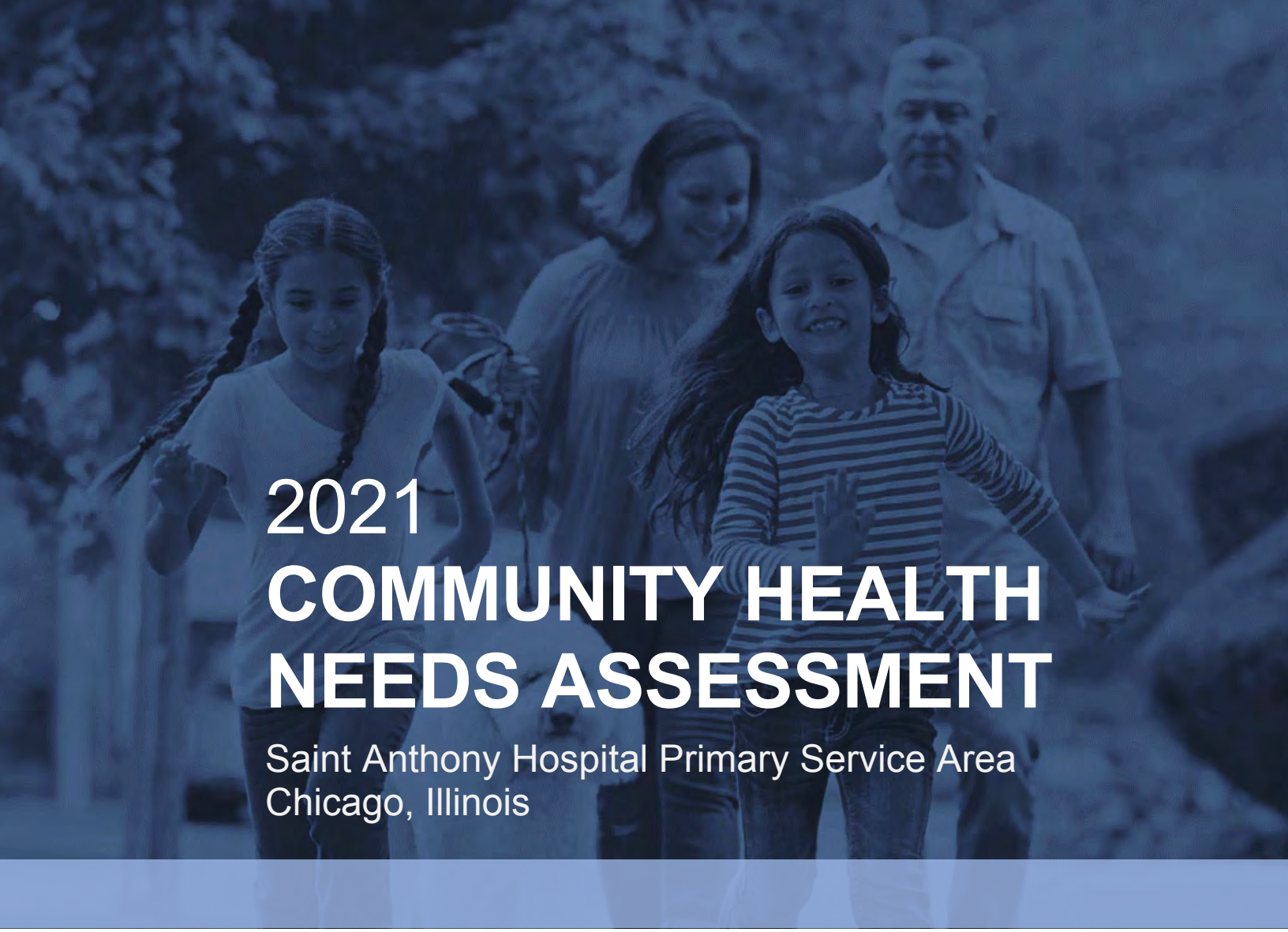

2021
COMMUNITY HEALTH NEEDS ASSESSMENT

Saint Anthony Hospital Primary Service Area
Chicago, Illinois

Sponsored by

SAINT ANTHONY HOSPITAL

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INTRODUCTION

PROJECT OVERVIEW

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2009, 2012, 2015, and 2018, 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 assessment was conducted on behalf of Saint Anthony Hospital by PRC, a nationally recognized health care 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 multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

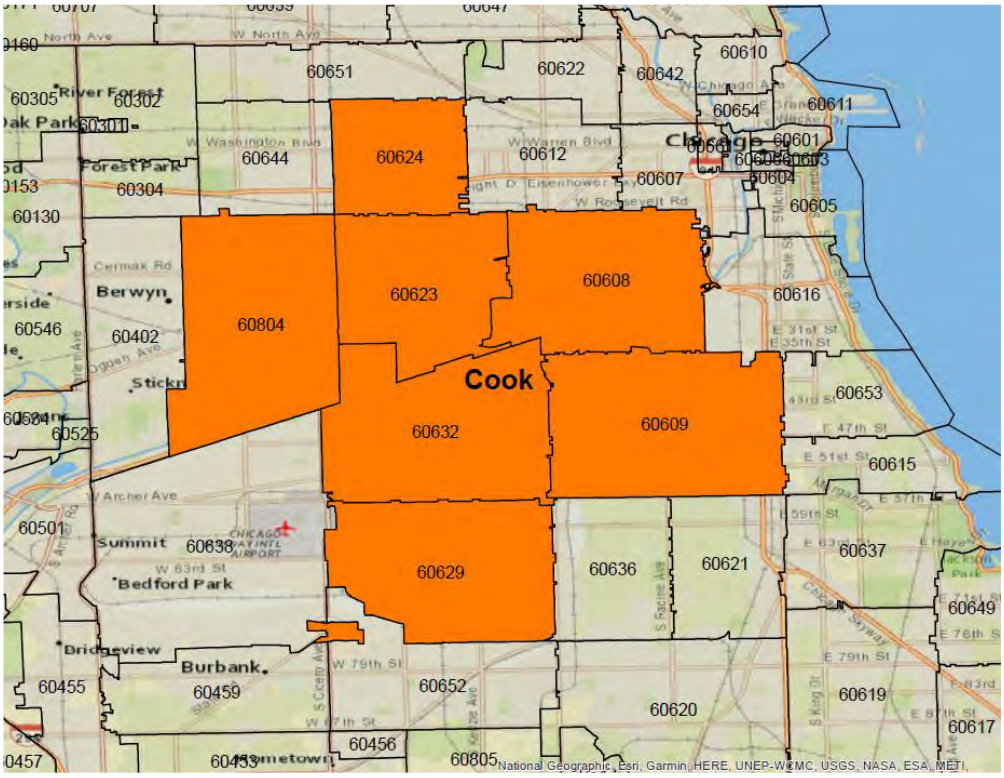
PRC Community Health Survey

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 “PSA” in this report) is defined as seven ZIP Codes (60608, 60609, 60623, 60624, 60629, 60632, and 60804). This community definition was determined because approximately 77% 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 399 individuals age 18 and older in the Primary Service Area. All administration of the surveys, data collection, and data analysis was conducted by PRC.

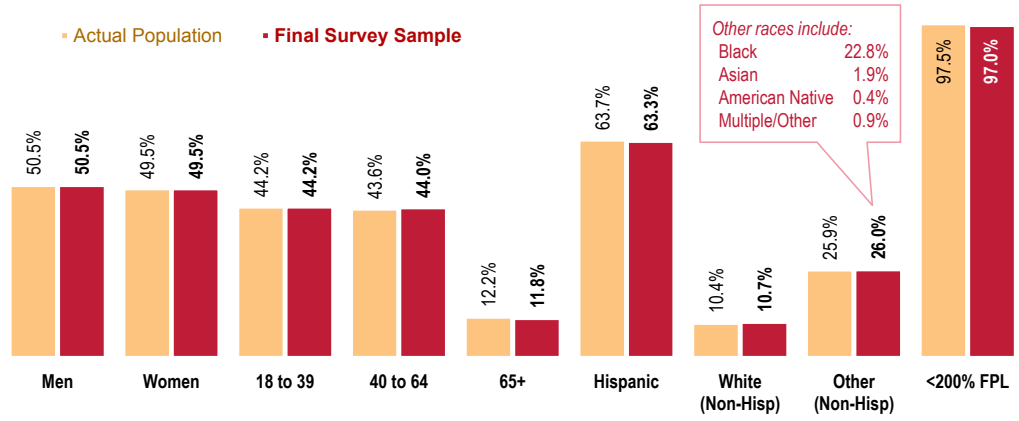
For statistical purposes, the maximum rate of error associated with a sample size of 399 respondents is ±4.9% at the 95 percent confidence level.

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.

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 children were given by proxy by the person most responsible for that child’s health care needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics
(Primary Service Area, 2021)



Sources: US Census Bureau, 2011-2015 American Community Survey.
2021 PRC Community Health Survey, PRC, Inc.
Notes: FPL is federal poverty level, based on guidelines established by the US Department of Health & Human Services.

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.

INCOME & RACE/ETHNICITY

INCOME ► 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 2020 guidelines place the poverty threshold for a family of four at $26,200 annual household income or lower). In sample segmentation: "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any other race group. Other race categories are non-Hispanic categorizations (e.g., "Black" reflects non-Hispanic Black respondents).

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, 27 community stakeholders took part in the Online Key Informant Survey, as outlined in the following table:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Public Health Representatives	1
Other Health Providers	3
Social Services Providers	10
Other Community Leaders	13

Final participation included representatives of the organizations outlined below.

- 22nd Ward Alderman
- 25th Ward
- Activist
- Alivio Medical Centers
- Archdiocese of Chicago
- A Safe Haven
- Beyond the Ball
- Carole Robertson Centers for Learning
- Chicago Department of Public Health
- Chicago Public Library
- Cristo Rey Jesuit High School
- El Valor
- Esperanza Health Centers
- Greater Chicago Food Depository
- Greater Open Door Baptist Church
- Instituto Progreso Latino
- Launch Out Into the Deep
- Lawndale Christian Development Corporation
- Lawndale Christian Health Centers
- Mujeres Latinas en Accion
- Noble Network of Charter Schools
- Resurrection Project
- Sing Tao Daily
- St. Agatha Catholic Church
- Taller de Jose
- UCAN Chicago
- Westlawn Gospel Chapel

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

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.

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 Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- 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)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- 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 secondary data reflect Cook County data.

Benchmark Data

Trending

Similar surveys were administered in the Primary Service Area in 2009, 2012, 2015, and 2018 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 *2020 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 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

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.

Public Comment

Saint Anthony Hospital made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Saint Anthony Hospital had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Saint Anthony Hospital will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

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 Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2019)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	5
Part V Section B Line 3b Demographics of the community	29
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	117
Part V Section B Line 3d How data was obtained	5
Part V Section B Line 3e The significant health needs of the community	12
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	14
Part V Section B Line 3h The process for consulting with persons representing the community's interests	7
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)	122

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. 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 HEALTH CARE SERVICES	▪ Lack of Health Insurance ▪ Insurance Instability ▪ Barriers to Access ▪ Inconvenient Office Hours – Cost of Prescriptions – Cost of Physician Visits – Appointment Availability – Finding a Physician – Lack of Transportation – Culture/Language ▪ Skipping/Stretching Prescriptions ▪ Difficulty Accessing Children's Health Care ▪ Specific Source of Ongoing Medical Care ▪ Routine Medical Care (Children) ▪ Emergency Room Utilization ▪ Ratings of Local Health Care
CANCER	▪ Leading Cause of Death ▪ Colorectal Cancer Screening [Age 50-75]
DIABETES	▪ Diabetes Prevalence ▪ Prevalence of Borderline/Pre-Diabetes ▪ Key Informants: Diabetes ranked as a top concern.
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Blood Pressure Screening ▪ High Blood Pressure Prevalence ▪ Taking Action to Control High Blood Pressure ▪ Cholesterol Screening ▪ Taking Action to Control High Blood Cholesterol ▪ Overall Cardiovascular Risk
HOUSING	▪ Housing Insecurity

—continued on the next page—

AREAS OF OPPORTUNITY (continued)	
INJURY & VIOLENCE	▪ Unintentional Injury Deaths ▪ Firearm-Related Deaths ▪ Homicide Deaths ▪ Violent Crime Rate ▪ Violent Crime Experience ▪ Intimate Partner Violence ▪ Neighborhood Safety ▪ Key Informants: Injury and violence ranked as a top concern.
KIDNEY DISEASE	▪ Kidney Disease Deaths
MENTAL HEALTH	▪ “Fair/Poor” Mental Health ▪ Stress ▪ Seeking Mental Health Services ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: Mental health ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Leisure-Time Physical Activity ▪ Meeting Physical Activity Guidelines ▪ Children’s Physical Activity ▪ Overweight & Obesity [Adults] ▪ Overweight & Obesity [Children] ▪ Professional Advice ▪ Key Informants: Nutrition, physical activity, and weight ranked as a top concern.
ORAL HEALTH	▪ Regular Dental Care [Adults] ▪ Children’s Dental Care
POTENTIALLY DISABLING CONDITIONS	▪ Activity Limitations ▪ Alzheimer’s Disease Deaths ▪ Caregiving
RESPIRATORY DISEASE	▪ Flu Vaccination [Age 65+] ▪ Asthma Prevalence [Adults] ▪ Chronic Obstructive Pulmonary Disease (COPD) Prevalence ▪ Key Informants: Coronavirus/COVID-19 ranked as a top concern.
SEXUAL HEALTH	▪ HIV/AIDS Deaths ▪ HIV Prevalence ▪ Chlamydia Incidence ▪ Gonorrhea Incidence
SUBSTANCE ABUSE	▪ Excessive Drinking ▪ Unintentional Drug-Related Deaths ▪ Key Informants: Substance abuse ranked as a top concern.
TOBACCO USE	▪ Cigarette Smoking in the Home ▪ Smokers Advised to Quit by a Health Professional

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among community stakeholders (representing a cross-section of community-based agencies and organizations) in conjunction with the administration of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Injury & Violence
2. Diabetes
3. Nutrition, Physical Activity & Weight
4. Mental Health
5. Substance Abuse
6. Access to Health Care Services
7. Potentially Disabling Conditions
8. Tobacco Use
9. Heart Disease & Stroke
10. Oral Health
11. Cancer
12. Respiratory Disease
13. Sexual Health
14. Kidney Disease

Not prioritized within the list above, is the social determinant of **Housing**, which potentially impacts outcomes for all of the above.

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, as well as trend data. These data are grouped by health topic.

Reading the Summary Tables

- In the following tables, Primary Service Area results are shown in the larger, gray column.
- 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 2030 objectives. Symbols indicate whether the Primary Service Area compares favorably (🌞), unfavorably (🌧), or comparably (🌥) to these external data.

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:
Trends for survey-derived indicators represent significant changes since 2009 (or earliest available data). Note that survey data reflect the ZIP Code-defined Primary Service Area.

OTHER (SECONDARY) DATA INDICATORS:
Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade).

Note that secondary data reflect Cook County data.

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

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

SOCIAL DETERMINANTS	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	6.9 [Cook Co. Data]	4.2	4.4		
Population in Poverty (Percent)	15.1 [Cook Co. Data]	13.1	14.1	8.0	
Children in Poverty (Percent)	21.7 [Cook Co. Data]	18.1	19.5	8.0	
No High School Diploma (Age 25+, Percent)	13.3 [Cook Co. Data]	11.1	12.3		
% Worry/Stress Over Rent/Mortgage in Past Year	60.1		32.2		41.7
		better	similar	worse	

OVERALL HEALTH	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	32.5	17.7	12.6		18.8
		better	similar	worse	

ACCESS TO HEALTH CARE	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	27.7	15.6	8.7	7.9	44.7
% [Insured] Went Without Coverage in Past Year	41.3				13.2
% Difficulty Accessing Health Care in Past Year (Composite)	53.5		35.0		44.3
% Cost Prevented Physician Visit in Past Year	27.3	13.3	12.9		21.8

ACCESS TO HEALTH CARE (continued)	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
% Cost Prevented Getting Prescription in Past Year	**22.6**		12.8		32.4
% Difficulty Getting Appointment in Past Year	**27.0**		14.5		18.0
% Inconvenient Hrs Prevented Dr Visit in Past Year	**28.4**		12.5		21.2
% Difficulty Finding Physician in Past Year	**21.3**		9.4		6.9
% Transportation Hindered Dr Visit in Past Year	**22.3**		8.9		17.8
% Language/Culture Prevented Care in Past Year	**11.4**		2.8		4.5
% Skipped Prescription Doses to Save Costs	**21.6**		12.7		17.3
% Difficulty Getting Child's Health Care in Past Year	**11.7**		8.0		4.0
Primary Care Doctors per 100,000	**93.4** [Cook Co. Data]	80.1	76.6		
% Have a Specific Source of Ongoing Care	**59.6**		74.2	84.0	57.7
% Have Had Routine Checkup in Past Year	**65.7**	76.9	70.5		67.9
% Child Has Had Checkup in Past Year	**80.0**		77.4		98.7
% Two or More ER Visits in Past Year	**15.1**		10.1		21.0
% Rate Local Health Care "Fair/Poor"	**27.2**		8.0		32.1

better similar worse

CANCER	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
Cancer (Age-Adjusted Death Rate)	**151.4** [Cook Co. Data]	154.4	149.3	122.7	177.2
Lung Cancer (Age-Adjusted Death Rate)	**32.8** [Cook Co. Data]	37.1	34.9	25.1	
Prostate Cancer (Age-Adjusted Death Rate)	**21.3** [Cook Co. Data]	19.2	18.6	16.9	
Female Breast Cancer (Age-Adjusted Death Rate)	**22.1** [Cook Co. Data]	20.6	19.7	15.3	
Colorectal Cancer (Age-Adjusted Death Rate)	**14.7** [Cook Co. Data]	14.3	13.4	8.9	
Cancer Incidence Rate (All Sites)	**448.9** [Cook Co. Data]	465.5	448.7		
Female Breast Cancer Incidence Rate	**131.7** [Cook Co. Data]	133.1	125.9		
Prostate Cancer Incidence Rate	**113.6** [Cook Co. Data]	109.1	104.5		
Lung Cancer Incidence Rate	**57.8** [Cook Co. Data]	63.7	58.3		
Colorectal Cancer Incidence Rate	**42.7** [Cook Co. Data]	42.5	38.4		
% Cancer	**3.6**	10.4	10.0		
% [Women 50-74] Mammogram in Past 2 Years	**83.6**	78.7	76.1	77.1	76.1
% [Women 21-65] Cervical Cancer Screening	**75.1**	79.3	73.8	84.3	79.6
% [Age 50-75] Colorectal Cancer Screening	**55.5**	67.0	77.4	74.4	68.5

better similar worse

DIABETES	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
Diabetes (Age-Adjusted Death Rate)	**19.0** [Cook Co. Data]	18.6	21.5		20.8
% Diabetes/High Blood Sugar	**18.4**	11.3	13.8		8.0
% Borderline/Pre-Diabetes	**18.2**		9.7		1.2
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	**46.9**		43.3		53.4
		better	similar	worse	

HEART DISEASE & STROKE	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
Diseases of the Heart (Age-Adjusted Death Rate)	**165.6** [Cook Co. Data]	163.1	163.4	127.4	188.1
% Heart Disease (Heart Attack, Angina, Coronary Disease)	**2.9**	5.7	6.1		1.6
Stroke (Age-Adjusted Death Rate)	**40.9** [Cook Co. Data]	38.3	37.2	33.4	37.3
% Stroke	**2.1**	3.0	4.3		1.2
% Blood Pressure Checked in Past 2 Years	**78.6**		85.0		91.8
% Told Have High Blood Pressure	**36.6**	32.2	36.9	27.7	18.3
% [HBP] Taking Action to Control High Blood Pressure	**76.4**		84.2		99.2
% Cholesterol Checked in Past 5 Years	**76.9**		80.7		88.8
% Told Have High Cholesterol	**28.5**		32.7		27.4

HEART DISEASE & STROKE (continued)	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
% [HBC] Taking Action to Control High Blood Cholesterol	77.4		83.2		94.7
% 1+ Cardiovascular Risk Factor	93.2		84.6		77.9

better similar worse

INFANT HEALTH & FAMILY PLANNING	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
No Prenatal Care in First Trimester (Percent)	26.1 [Cook Co. Data]	22.5			22.7
Low Birthweight Births (Percent)	9.1 [Cook Co. Data]	8.4	8.2		
Infant Death Rate	5.9 [Cook Co. Data]	5.9	5.6	5.0	7.2
Births to Adolescents Age 15 to 19 (Rate per 1,000)	24.5 [Cook Co. Data]	21.3	22.7	31.4	

better similar worse

INJURY & VIOLENCE	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
Unintentional Injury (Age-Adjusted Death Rate)	41.5 [Cook Co. Data]	44.6	48.9	43.2	25.7
Motor Vehicle Crashes (Age-Adjusted Death Rate)	6.5 [Cook Co. Data]	8.7	11.3	10.1	
[65+] Falls (Age-Adjusted Death Rate)	36.2 [Cook Co. Data]	49.9	65.1	63.4	
Firearm-Related Deaths (Age-Adjusted Death Rate)	15.0 [Cook Co. Data]	11.3	11.9	10.7	

INJURY & VIOLENCE (continued)	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
Homicide (Age-Adjusted Death Rate)	**13.8** [Cook Co. Data]	8.4	6.1	5.5	10.6
Violent Crime Rate	**627.4** [Cook Co. Data]	420.9	416.0		
% Victim of Violent Crime in Past 5 Years	**13.2**		6.2		13.8
% Victim of Intimate Partner Violence	**18.9**		13.7		18.2
% Ever Lost a Loved One to Violence	**17.9**				26.1
% Perceive Neighborhood "Slightly/Not At All Safe"	**58.3**				50.4

better similar worse

KIDNEY DISEASE	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
Kidney Disease (Age-Adjusted Death Rate)	**16.9** [Cook Co. Data]	16.7	12.9		18.4
% Kidney Disease	**5.6**	2.7	5.0		2.7

better similar worse

MENTAL HEALTH	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	**41.2**		13.4		10.6
% Typical Day Is "Extremely/Very" Stressful	**24.9**		16.1		7.0
Suicide (Age-Adjusted Death Rate)	**8.6** [Cook Co. Data]	11.1	14.0	12.8	7.5
Mental Health Providers per 100,000	**64.3** [Cook Co. Data]	31.1	42.6		
% Have Ever Sought Help for Mental Health	**19.9**		30.0		9.3
% Taking Rx/Receiving Mental Health Trtmt	**12.1**		16.8		12.6
% Unable to Get Mental Health Svcs in Past Yr	**17.5**		7.8		10.4
% Mental Health Has Gotten Worse Since Pandemic Began	**25.6**				
% Arguing With HH Members More Often Since Pandemic Began	**18.9**				
% Getting Good Sleep Less Often Since Pandemic Began	**31.8**				
% Likely to Accept Mental Health Help Due to the Pandemic	**59.0**				
		better	similar	worse	

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
Population With Low Food Access (Percent)	**7.5** [Cook Co. Data]	19.4	22.4		
% No Leisure-Time Physical Activity	**39.0**	25.6	31.3	21.2	32.2
% Meeting Physical Activity Guidelines	**22.5**	23.4	21.4	28.4	19.9
% Child [Age 2-17] Physically Active 1+ Hours per Day	**19.6**		33.0		48.4
Recreation/Fitness Facilities per 100,000	**12.2** [Cook Co. Data]	11.9	11.8		
% Healthy Weight (BMI 18.5-24.9)	**24.0**	32.6	34.5		37.3
% Overweight (BMI 25+)	**72.9**	65.7	61.0		61.5
% Obese (BMI 30+)	**43.4**	31.6	31.3	36.0	30.1
% [Overweights] Counseled About Weight in Past Year	**32.4**		24.7		51.5
% Exercising Less Often Since Pandemic Began	**29.9**				
% Eating Unhealthy/Overeating More Often Since Pandemic Began	**26.9**				
% Children [Age 5-17] Healthy Weight	**33.7**		47.6		
% Children [Age 5-17] Overweight (85th Percentile)	**51.0**		32.3		41.2
% Children [Age 5-17] Obese (95th Percentile)	**22.0**		16.0	15.5	22.9

better similar worse

ORAL HEALTH	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
% Have Dental Insurance	64.1		68.7	59.8	42.3
% [Age 18+] Dental Visit in Past Year	39.3	68.1	62.0	45.0	57.3
% Child [Age 2-17] Dental Visit in Past Year	76.0		72.1	45.0	86.0
		better	similar	worse	

POTENTIALLY DISABLING CONDITIONS	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	25.9		32.5		
% Activity Limitations	19.2		24.0		11.0
% With High-Impact Chronic Pain	10.4		14.1	7.0	
% Sickle-Cell Anemia	3.2				1.9
% [50+] Osteoporosis	5.0		10.5		12.5
Alzheimer's Disease (Age-Adjusted Death Rate)	20.4 [Cook Co. Data]	25.1	30.4		15.8
% Caregiver to a Friend/Family Member	30.8		22.6		25.1
		better	similar	worse	

RESPIRATORY DISEASE	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
CLRD (Age-Adjusted Death Rate)	26.9 [Cook Co. Data]	36.3	39.6		30.9
Pneumonia/Influenza (Age-Adjusted Death Rate)	15.0 [Cook Co. Data]	15.1	13.8		17.2
% Fully/Partially Vaccinated for COVID-19	74.8				
% [Age 65+] Flu Vaccine in Past Year	53.6	61.1	71.0		72.2
% [Adult] Asthma	8.8	8.2	12.9		3.5
% [Child 0-17] Asthma	7.9		7.8		3.7
% COPD (Lung Disease)	12.7	5.8	6.4		3.9
		better	similar	worse	

SEXUAL HEALTH	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
HIV/AIDS (Age-Adjusted Death Rate)	2.5 [Cook Co. Data]	1.4	1.9		
HIV Prevalence Rate	577.4 [Cook Co. Data]	334.5	372.8		
% [Age 18-64] Ever Tested for HIV	62.0		46.5		
% [Age 18-44] HIV Test in the Past Year	45.0		22.0		33.7
Chlamydia Incidence Rate	830.3 [Cook Co. Data]	604.0	539.9		
Gonorrhea Incidence Rate	309.3 [Cook Co. Data]	198.6	179.1		
		better	similar	worse	

SUBSTANCE ABUSE	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS			
		vs. IL	vs. US	vs. HP2030	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	**8.6** [Cook Co. Data]	9.5	11.1	10.9	8.4
% Liver Disease	**2.7**				2.3
% Excessive Drinker	**30.9**	21.6	27.2		22.6
% Using Alcohol More Often Since Pandemic Began	**8.6**				
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)	**22.4** [Cook Co. Data]	19.7	18.8		9.0
% Illicit Drug Use in Past Month	**4.3**		2.0	12.0	3.6
% Used a Prescription Opioid in Past Year	**6.3**		12.9		
% Ever Sought Help for Alcohol or Drug Problem	**7.8**		5.4		7.4
% Personally Impacted by Substance Abuse	**34.5**		35.8		31.9
		better	similar	worse	

TOBACCO USE	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. IL	vs. US	vs. HP2030	TREND
% Current Smoker	**20.1**	14.5	17.4	5.0	21.4
% Someone Smokes at Home	**21.8**		14.6		19.9
% [Household With Children] Someone Smokes in the Home	**23.4**		17.4		18.6
% [Smokers] Have Quit Smoking 1+ Days in Past Year	**65.2**	61.9	42.8	65.7	77.3
% [Smokers] Received Advice to Quit Smoking	**57.4**		59.6	66.6	92.2
% Currently Use Vaping Products	**6.9**	4.4	8.9		
% Smoking/Vaping More Often Since Pandemic Began	**5.0**				

better similar worse

DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population- based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

COMMUNITY CHARACTERISTICS

Population Characteristics

Land Area, Population Size & Density

Total Population
(Estimated Population, 2014-2018)

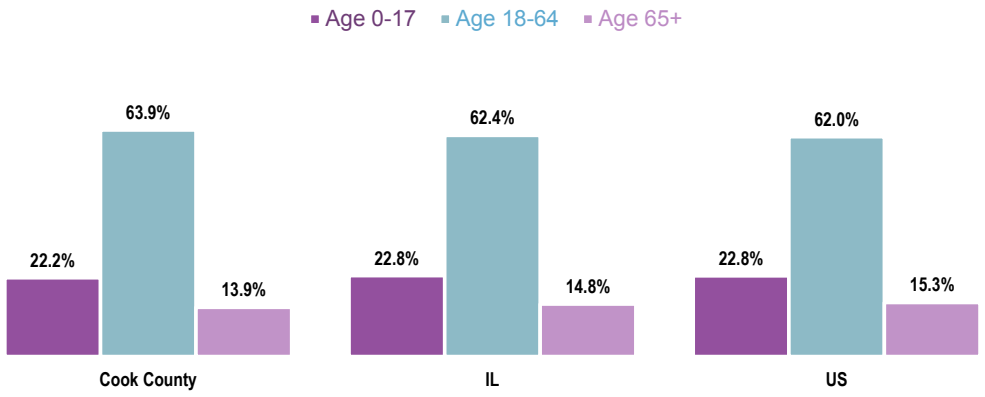
	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Cook County	5,223,719	944.94	5,528.12
Illinois	12,821,497	55,517.13	230.95
United States	322,903,030	3,532,068.58	91.42

Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).

Age

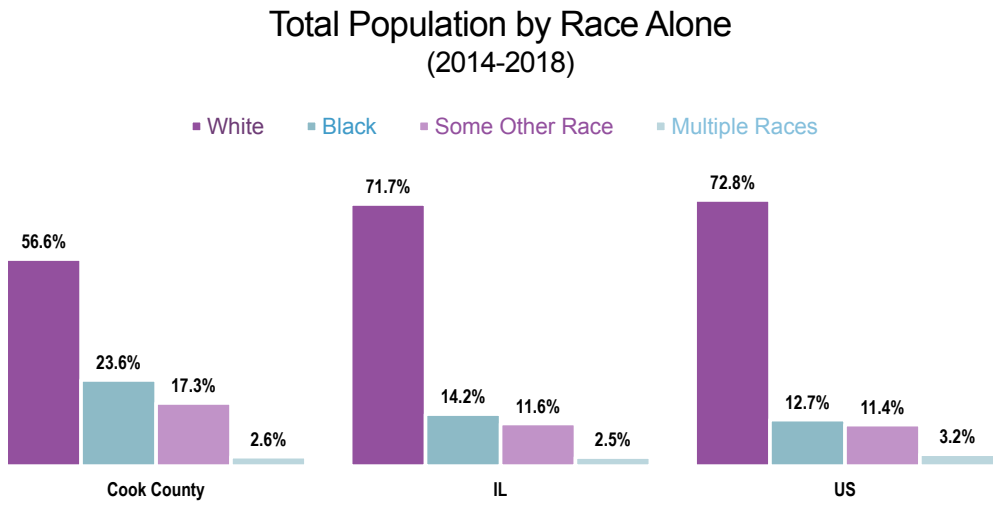
It is important to understand the age distribution of the population, as different age groups have unique

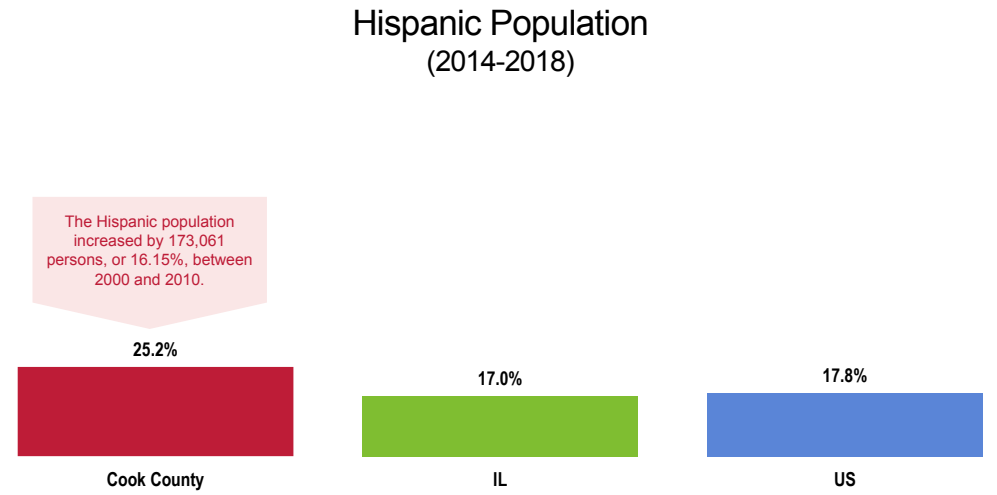
Total Population by Age Groups
(2014-2018)



Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).

Race & Ethnicity





Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).

Notes: Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Social Determinants of Health

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

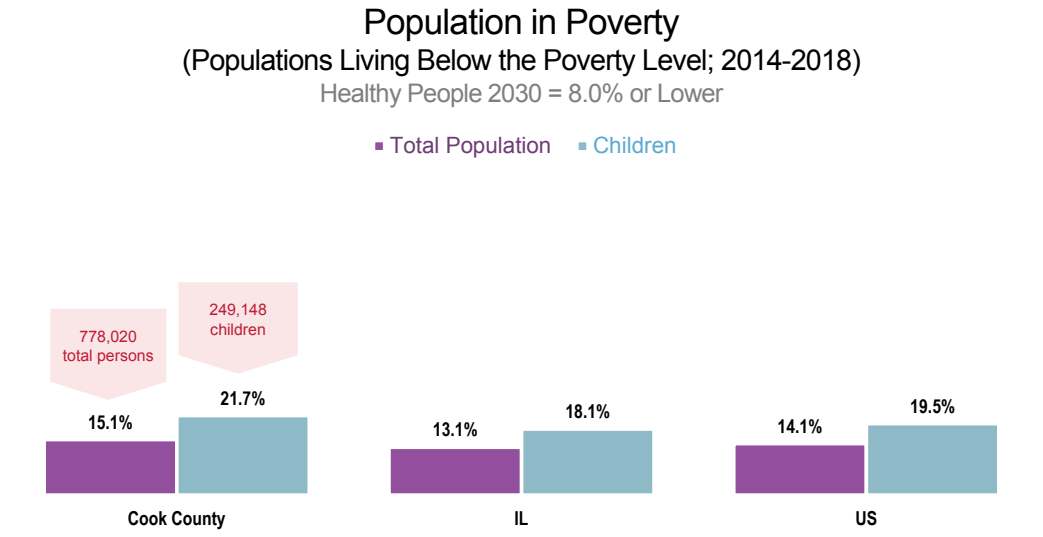
SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

- Healthy People 2030 (https://health.gov/healthypeople)

Income & Poverty

Poverty

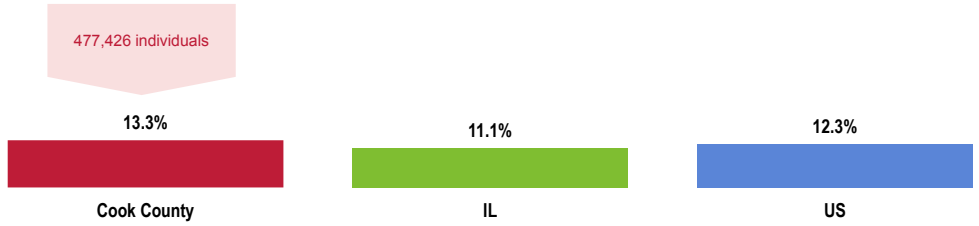


Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes: Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Education

Population With No High School Diploma
(Population Age 25+ Without a High School Diploma or Equivalent, 2014-2018)



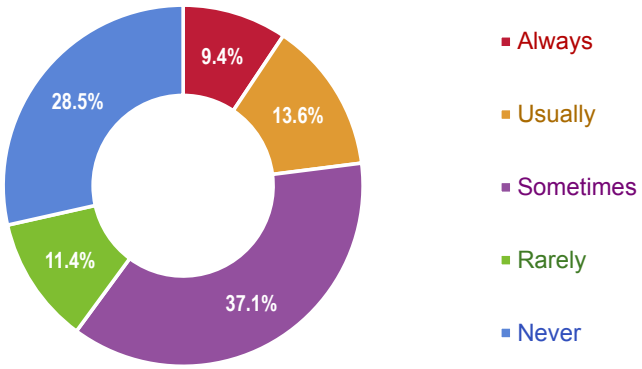
Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).
Notes: This indicator is relevant because educational attainment is linked to positive health outcomes.

Housing

Housing Insecurity

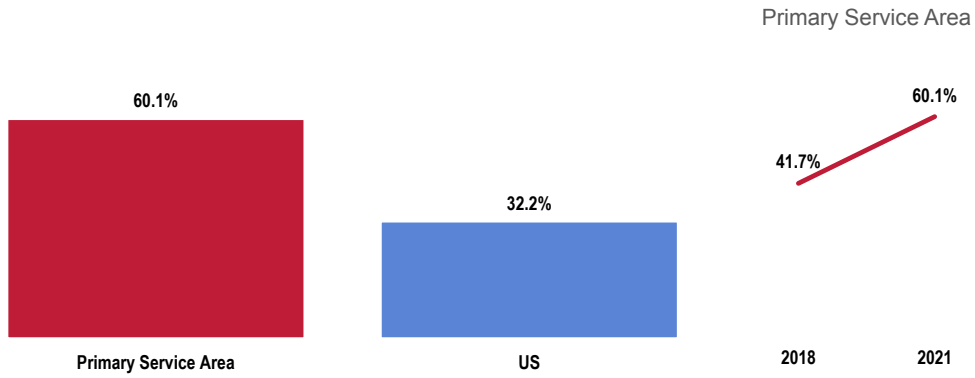
"In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually,

Frequency of Worry or Stress About Paying Rent or Mortgage in the Past Year
(Primary Service Area, 2021)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: Asked of all respondents.

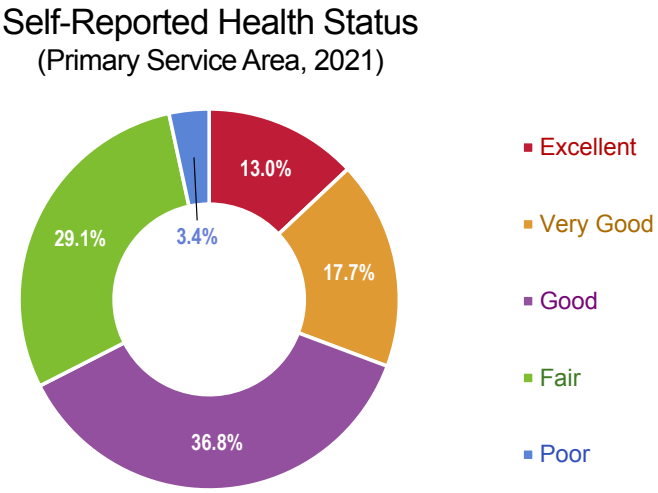
"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year
(Primary Service Area, 2021)



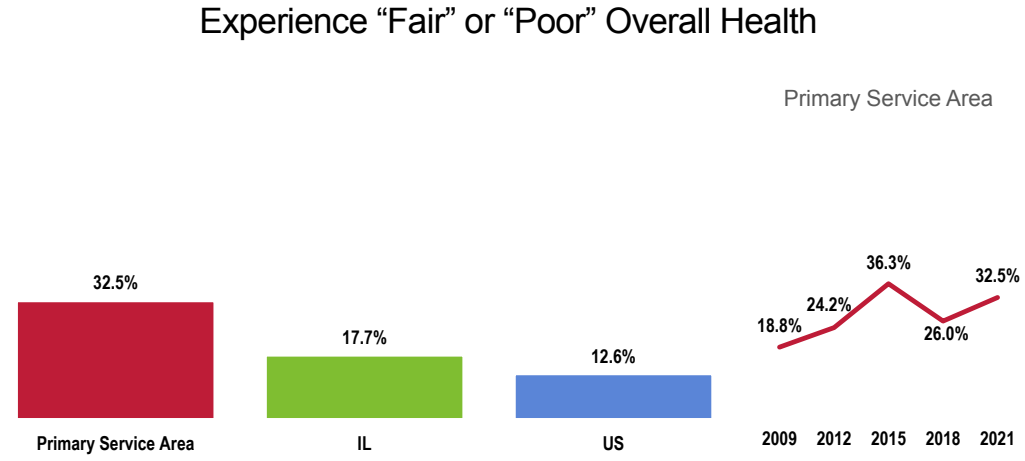
Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

HEALTH STATUS

Overall Health

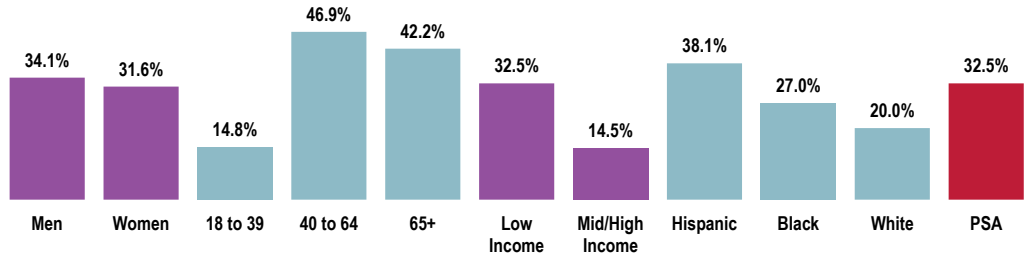


Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: Asked of all respondents.



Sources: 2021 PRC Community Health Survey, PRC, 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): 2019 Illinois data.
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Primary Service Area, 2021)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

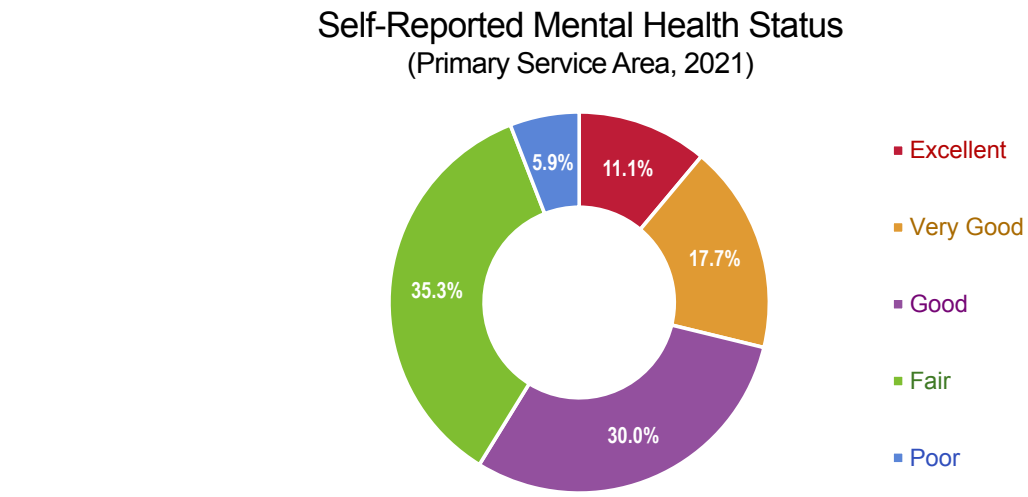
In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Status

"Now thinking about your mental health, which includes stress, depression and problems with

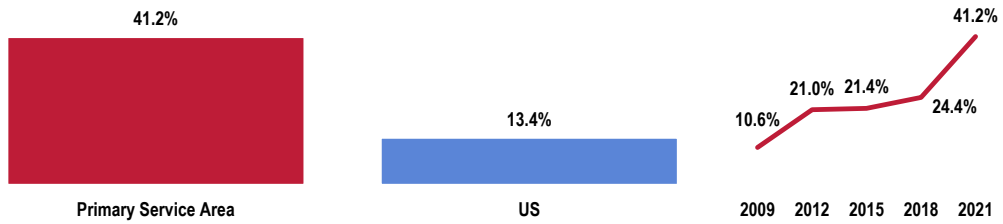
See also COVID-19 in the Respiratory Disease section of this report.



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 90]
Notes: Asked of all respondents.

Experience “Fair” or “Poor” Mental Health

Primary Service Area



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 90]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

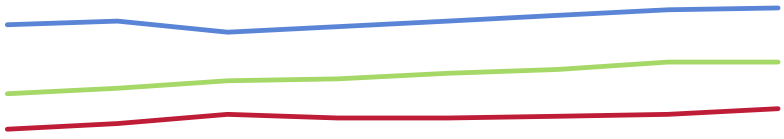
Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in Cook

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower



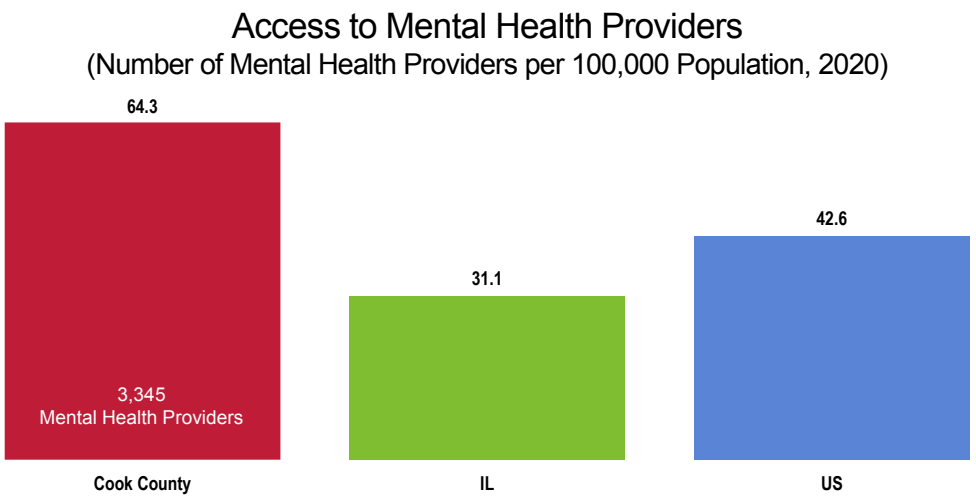
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Cook County	7.5	7.8	8.3	8.1	8.1	8.2	8.3	8.6
IL	9.4	9.7	10.1	10.2	10.5	10.7	11.1	11.1
US	13.1	13.3	12.7	13.0	13.3	13.6	13.9	14.0

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

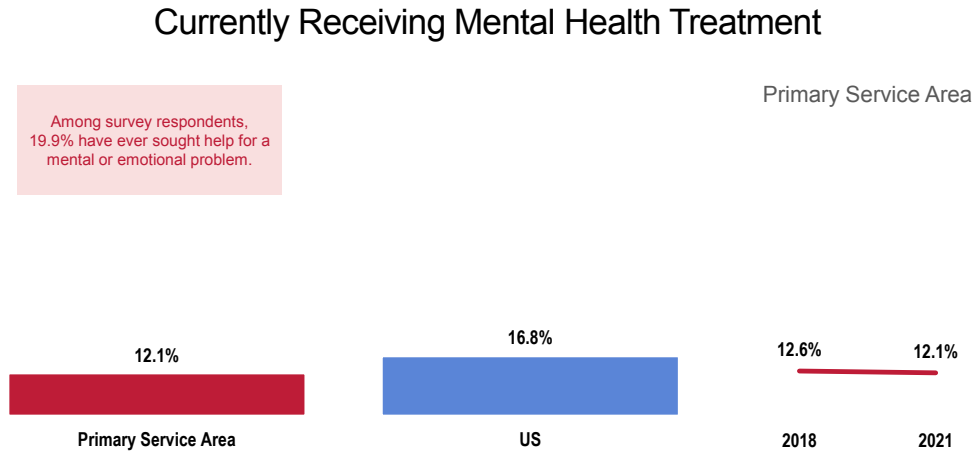
Mental Health Treatment

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in the Primary Service Area and residents in the Primary Service Area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

The following chart outlines access to mental health providers, expressed as the number of providers

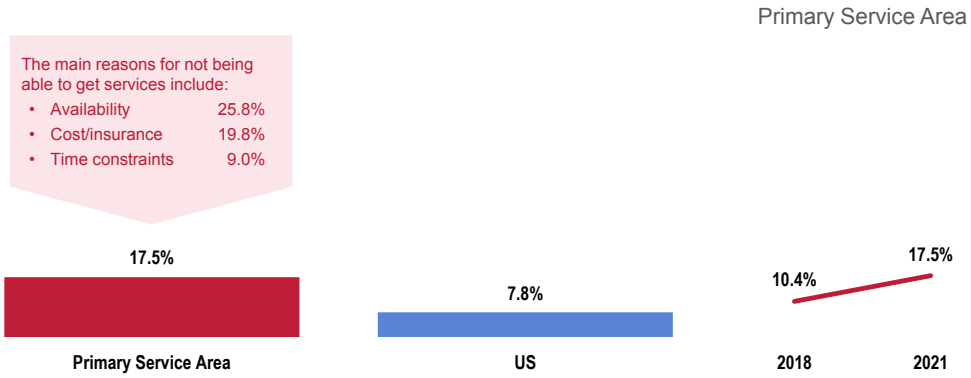


Sources: University of Wisconsin Population Health Institute, County Health Rankings.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).
Notes: This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.



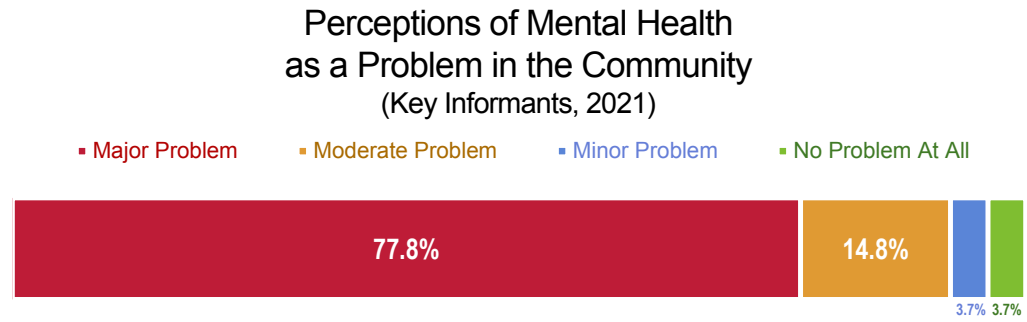
Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 94, 314]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
"Treatment" can include taking medications for mental health.

Unable to Get Mental Health Services When Needed in the Past Year
(Primary Service Area, 2021)



Unable to Get Mental Health Services When Needed in the Past Year
(Primary Service Area, 2021)

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 95]
Notes: Asked of all respondents.



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

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

Contributing Factors

> We know food insecurity is highly associated with mental health issues. Stigma, financial insecurity, housing instability, and lack of affordable/free mental health services. – Social Services Provider (Little Village)
>
> We have societal mental health issues that is embedded in our general culture and magnified in our subcultures. Culture is hard to fix. I think some of the newer techniques, like practicing mindfulness, learning to appreciate the simplicity of being is a helpful new cultural practice. Many of our societal patterns tend towards competitive tribalism, even in sports and certainly in the competition for owning "stuff" that contains a belief that owning stuff brings happiness, and these societal/cultural patterns create a sense of fear, anger, and stress. So, I'm not sure that hiring more counselors will solve these problems. People in our society will hopefully get tired of being angry and learn to embrace the joy of simply being. – Other Health Provider (North Lawndale)
>
> Stigma of accessing care and difficulty accessing low-cost services. – Public Health Representative (West Side and Southwest Side of Chicago)
>
> Homeless folks with mental health issues, such as schizophrenia, bipolar disorder, and depression, refused services. Need more funding to hire appropriate social service workers to do community outreach, be turned away by the public because of the issues. – Community Leader (Chinatown)
>
> It's difficult to find bilingual, bicultural mental health services that are both affordable, available, and accessible. Long wait lists, high costs, and distance all make this more challenging. Mental health issues were an issue prior to the pandemic and are even more prevalent now given high rates of stress and trauma. – Social Services Provider (Little Village)
>
> People of color have been devastated by the social unrest, COVID-19, and political climate. Workers are stretched and stressed. – Social Services Provider (North Lawndale)

Funding

> Lack of funding for mental health and behavioral healthcare state licensed community-based providers. Many mental health and behavioral healthcare services are funded by grants and contracts. That prove to be vulnerable to budget cuts based on administration priorities. Funding for mental health services should be tied to public and private insurers and measured for value-based outcomes and results benchmarks to qualify to be a part of a provider network. – Social Services Provider (West Side and Southwest Side of Chicago)

Gambling Addiction

> Gambling addiction. Before the pandemic, several different casinos outside the city-chartered shuttles to pick up passengers in Chinatown throughout the day, seven days a week. Part of the upcoming "The 78" project is a casino. I'm quite worried that it will turn people from social gambling to disordered gambling. Thereby, a lot of complications such as financial difficulties, domestic violence, child neglect would be present. – Community Leader (Chinatown)

Access for Medicare/Medicaid Patients

> Reimbursement from Medicaid is so low that providers can't afford to offer counseling services. – Other Health Provider (Little Village)

Access to Care/Services

> City of Chicago closed most of the clinics. – Community Leader (North Lawndale)

Violence

> The daily violence and ongoing decay of social norms. – Community Leader (North Lawndale)

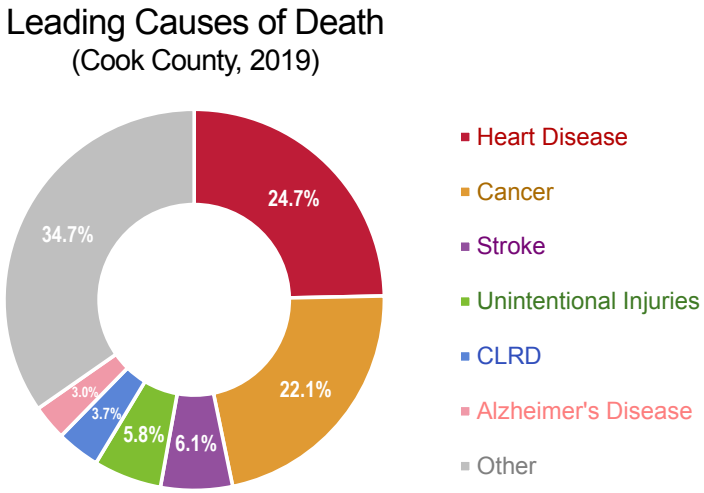
Alcohol/Drug Use

> Lots of young people and adults dependent on or addicted to drugs. – Community Leader (Little Village)

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.
Notes: Lung disease is CLRD, or chronic lower respiratory disease.

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region 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 2030 objectives.

Age-Adjusted Death Rates for Selected Causes

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in Cook County.

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

Age-Adjusted Death Rates for Selected Causes
(2017-2019 Deaths per 100,000 Population)

	Cook County	Illinois	US	HP2030
Diseases of the Heart	165.6	163.1	163.4	127.4*
Malignant Neoplasms (Cancers)	151.4	154.4	149.3	122.7
Unintentional Injuries	41.5	44.6	48.9	43.2
Cerebrovascular Disease (Stroke)	40.9	38.3	37.2	33.4
Fall-Related Deaths (65+)	36.2	49.9	65.1	63.4
Chronic Lower Respiratory Disease (CLRD)	26.9	36.3	39.6	n/a
Drug-Induced	22.4	19.7	18.8	n/a
Alzheimer's Disease	20.4	25.1	30.4	n/a
Diabetes Mellitus	19.0	18.6	21.5	n/a
Kidney Diseases	16.9	16.7	12.9	n/a
Pneumonia/Influenza	15.0	15.1	13.8	n/a
Firearm-Related	15.0	11.3	11.9	10.7
Homicide	13.8	8.4	6.1	5.5
Cirrhosis/Liver Disease	8.6	9.5	11.1	10.9
Intentional Self-Harm (Suicide)	8.6	11.1	14.0	12.8
Motor Vehicle Deaths	6.5	8.7	11.3	10.1
HIV/AIDS	2.5	1.4	1.9	n/a

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov.
Note: *The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease. The following charts outline age-

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Cook County	188.1	183.4	179.5	177.4	175.2	171.0	168.1	165.6
IL	177.5	173.9	171.1	170.7	169.0	166.8	164.3	163.1
US	191.6	188.5	169.1	168.4	167.0	166.3	164.7	163.4

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Cook County	37.3	36.8	37.0	37.7	38.8	40.2	40.5	40.9
IL	38.5	37.7	37.3	37.5	37.9	38.4	38.0	38.3
US	41.8	40.9	36.5	36.8	37.1	37.5	37.3	37.2

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Prevalence of Heart Disease & Stroke

"Has a doctor, nurse, or other health professional ever told you that you had:

- A heart attack, also called a myocardial infarction?

Prevalence of Heart Disease

Primary Service Area

18 to 39	2.0%
40 to 64	4.4%
65+*	0.2%

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 114]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Illinois data.
2020 PRC National Health Survey, PRC, Inc.

Notes: Asked of all respondents.
Includes diagnoses of heart attack, angina, or coronary heart disease.

Prevalence of Stroke

Primary Service Area

18 to 39	0.7%
40 to 64	2.6%
65+*	5.7%

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 29]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Illinois data.
2020 PRC National Health Survey, PRC, Inc.

Notes: Asked of all respondents.
*Take caution when interpreting results, as the sample size is n<50.

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

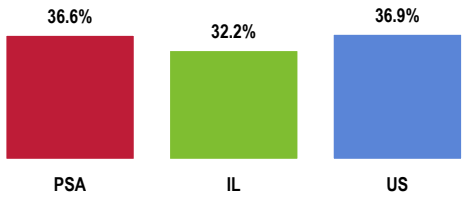
"Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

Prevalence of High Blood Pressure

Healthy People 2030 = 27.7% or Lower

Most service area adults (78.6%) have had a blood pressure screening in the past 2 years.

Of those with high blood pressure, 76.4% are taking action to control it (e.g., medication, diet, exercise).



Prevalence of High Blood Cholesterol

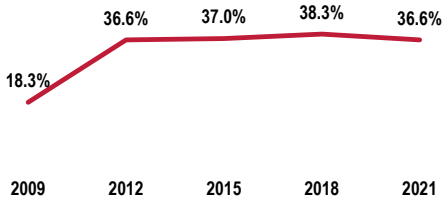
Most service area adults (76.9%) have had a blood cholesterol screening in the past 5 years.

Of those with high cholesterol, 77.4% are taking action to control it (e.g., medication, diet, exercise).

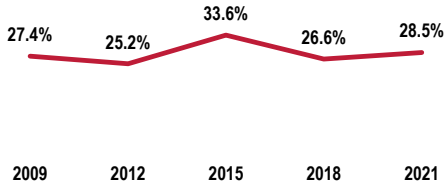
Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 35, 36, 305–308]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Illinois data.
2020 PRC National Health Survey, PRC, Inc.

Prevalence of High Blood Pressure (Primary Service Area)

Healthy People 2030 = 27.7% or Lower



Prevalence of High Blood Cholesterol (Primary Service Area)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 35–36]
US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov
Notes: Asked of all respondents.

Total Cardiovascular Risk

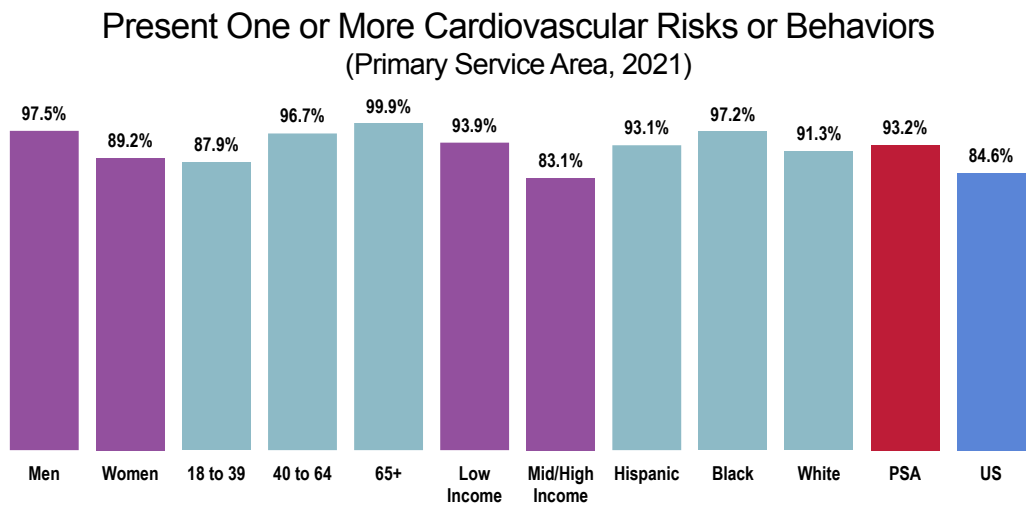
Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

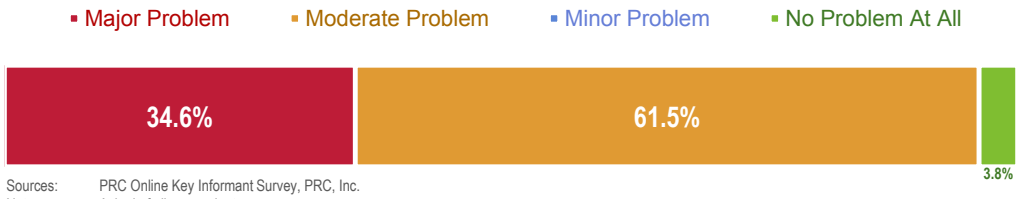
The following chart reflects the percentage of adults in the Primary Service Area who report one or more of

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



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 115]
Notes: Reflects 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) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Perceptions of Heart Disease and Stroke as a Problem in the Community
(Key Informants, 2021)



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

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

Leading Cause of Death

> Heart disease and stroke are a leading cause of death and the black-white life expectancy gap in Chicago and these communities. – Public Health Representative (West Side and Southwest Side of Chicago)

> Data points to higher mortality rates. – Community Leader (North Lawndale)

Contributing Factors

> Dietary habits and food desert designation. – Social Services Provider (West Side and Southwest Side of Chicago)

Lifestyle

> Poor diet, lack of healthy lifestyle. – Community Leader (North Lawndale)

Cancer

ABOUT CANCER

Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Cook County	177.2	174.5	172.4	170.1	167.4	162.9	156.6	151.4
IL	176.4	174.2	172.1	169.5	166.7	163.0	158.3	154.4
US	174.8	171.6	163.6	161.0	158.5	155.6	152.5	149.3

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Lung cancer is by far the leading cause of cancer deaths in Cook County.

Age-Adjusted Cancer Death Rates by Site
(2017-2019 Annual Average Deaths per 100,000 Population)

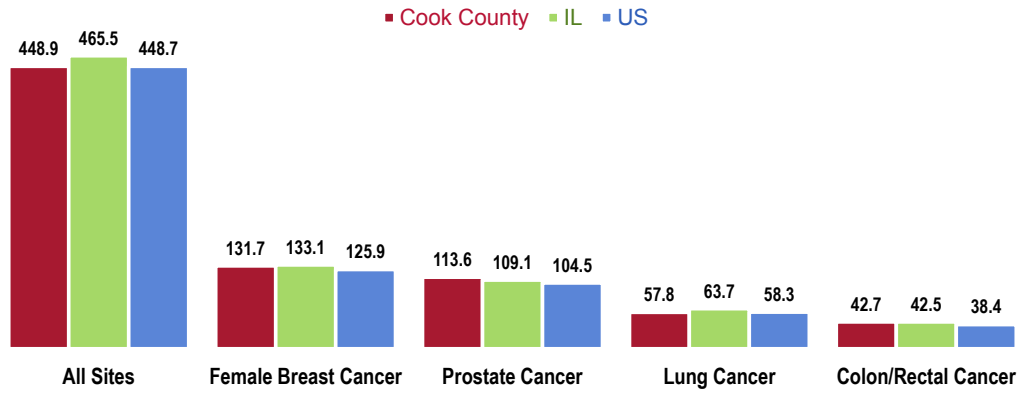
	Cook County	Illinois	US	HP2030
ALL CANCERS	151.4	154.4	149.3	122.7
Lung Cancer	32.8	37.1	34.9	25.1
Female Breast Cancer	22.1	20.6	19.7	15.3
Prostate Cancer	21.3	19.2	18.6	16.9
Colorectal Cancer	14.7	14.3	13.4	8.9

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year,

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2013-2017)

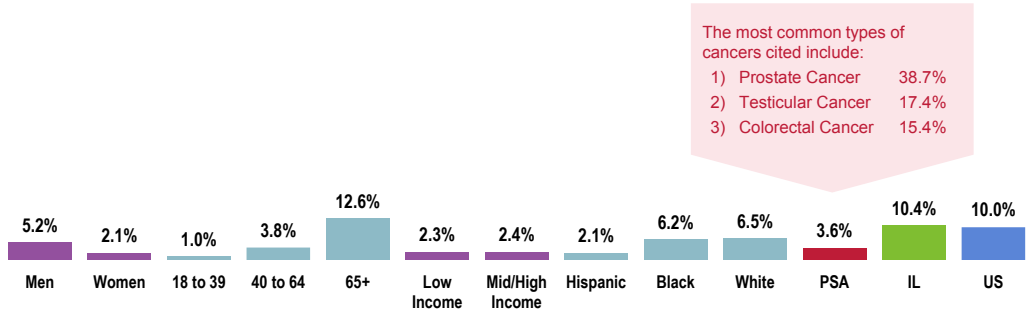


Sources: State Cancer Profiles.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).
Notes: This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 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.

Prevalence of Cancer

"Have you ever suffered from or been diagnosed with cancer?"

Prevalence of Cancer
(Primary Service Area, 2021)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 25–26]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Illinois data.
2020 PRC National Health Survey, PRC, Inc.
Notes: Reflects all respondents.

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

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

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.

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

– 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.

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).

BREAST CANCER SCREENING ► **"A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"**

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

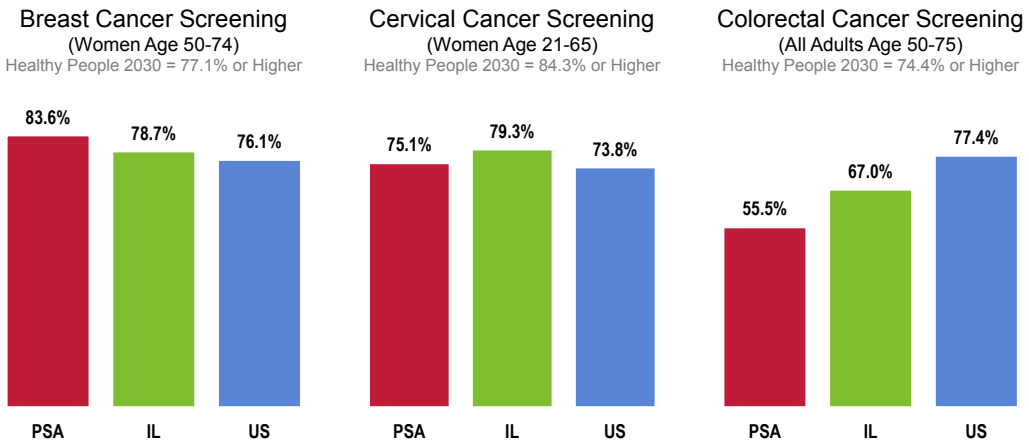
CERVICAL CANCER SCREENING ► **"A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"**

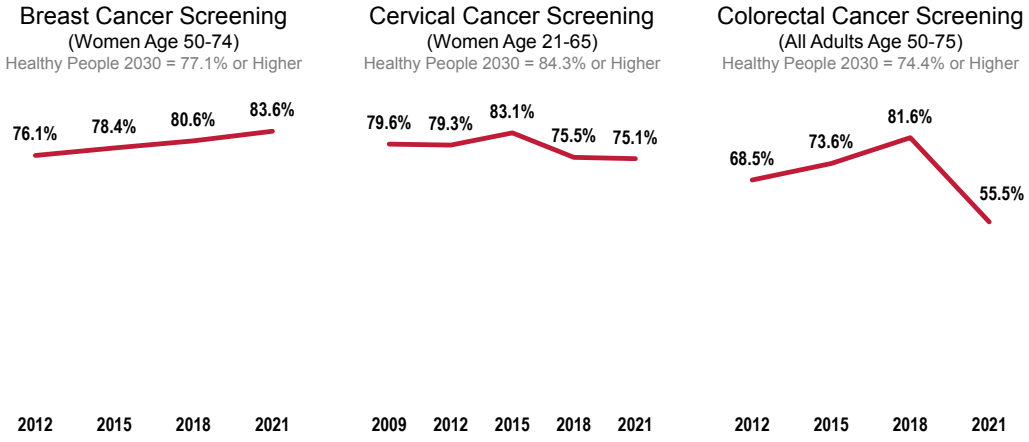
[If Pap test in the past five years] **"HPV, or the human papillomavirus, is a common infection that can cause several types of cancer. When you received your last Pap test, were you screened for HPV?"**

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

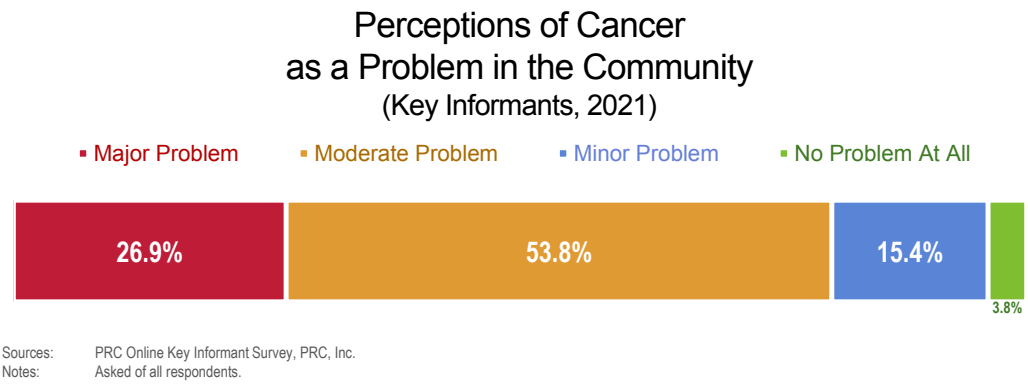
COLORECTAL CANCER SCREENING ► **"Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"**

"A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"





Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 116–118]
US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov
Notes: Each indicator is shown among the gender and/or age group specified.



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

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

Prevention/Screenings

> Many cancers can be addressed through preventative care with better outcomes, but folks in our community are not undergoing preventative care. – Community Leader (Little Village)
>
> Data from CHEC and the pandemic has caused the community to delay routine screenings, we are now seeing the consequences. – Other Health Provider (West Side and Southwest Side of Chicago)

Leading Cause of Death

> The data shows that while cancer rates are similar to other communities, the mortality rate for cancer and a host of other diseases is higher in our community. – Community Leader (North Lawndale)

Access to Care/Services

> Too many don't have regular primary care and only access healthcare when they have an acute issue, therefore don't get care early in the process and frequently don't get access to some place that specializes in tertiary care institutions. – Community Leader (Little Village)

Awareness/Education

> Because residents may not have accurate information and treatment in our community and lack family support. – Community Leader (North Lawndale)

Contributing Factors

> Industrial pollution, high stress levels, processed foods. – Community Leader (Little Village)

Respiratory Disease

ABOUT RESPIRATORY DISEASE

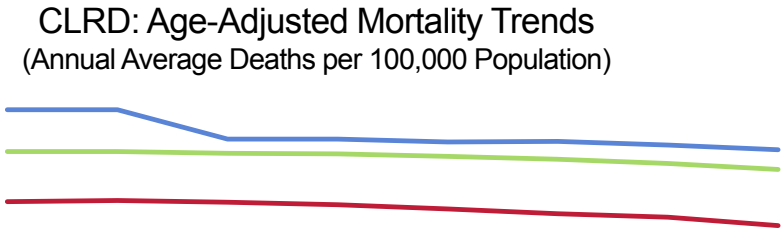
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Respiratory Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for CLRD is illustrated in the charts that follow.



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Cook County	30.9	31.1	30.8	30.4	29.7	28.9	28.3	26.9
IL	39.3	39.3	39.0	38.9	38.5	38.0	37.3	36.3
US	46.3	46.3	41.4	41.4	40.9	41.0	40.4	39.6

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.
Notes: CLRD is chronic lower respiratory disease.

Pneumonia/Influenza: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)

	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017
Cook County	17.2	17.1	16.6	16.0	15.8	15.3	15.7	15.0
IL	16.6	16.8	16.6	16.4	15.7	15.3	15.5	15.1
US	15.8	16.1	15.1	15.4	14.6	14.3	14.2	13.8

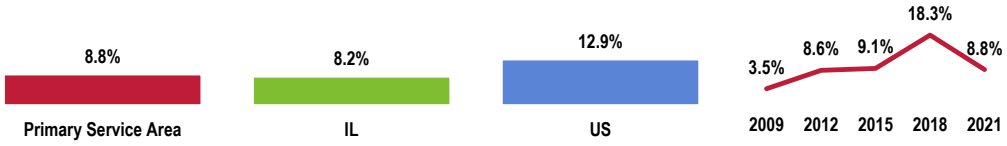
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.

Prevalence of Asthma

ADULTS ► **"Have you ever been told by a doctor, nurse, or other health professional that you had asthma?" and "Do you still have asthma?"** (Calculated here as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma.)

Prevalence of Asthma

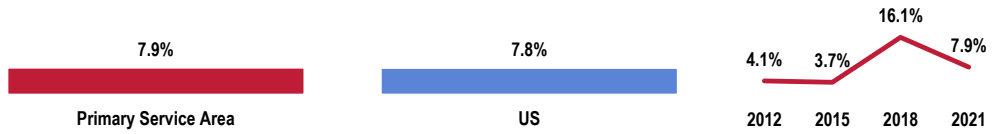
Primary Service Area



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 119]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Illinois data.
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Prevalence of Asthma in Children
(Parents of Children Age 0-17)

Primary Service Area



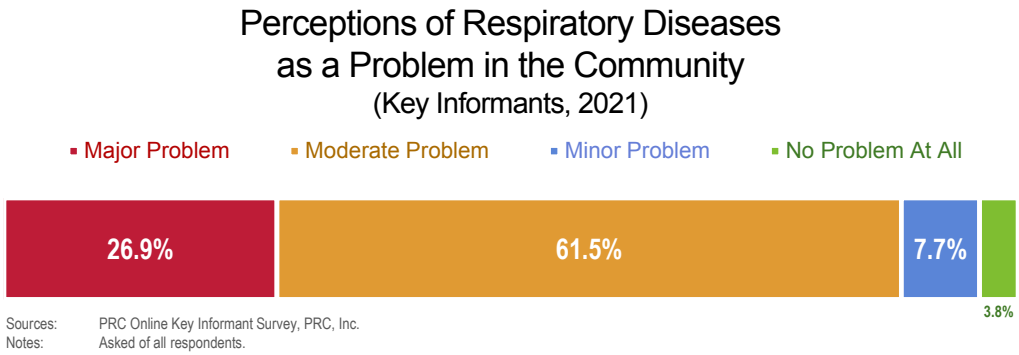
Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 120]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents with children 0 to 17 in the household.
Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

Prevalence of
Chronic Obstructive Pulmonary Disease (COPD)

Primary Service Area

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 23]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Illinois data.
2020 PRC National Health Survey, PRC, 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.
*Survey reflected the prevalence of chronic lung disease, which included bronchitis or emphysema.



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

Contributing Factors

> Poor air quality and the working conditions. – Community Leader (North Lawndale)
>
> Smoking and respiratory disease are prevalent, and the pandemic has made it much worse as the long hauler impact will continue to impact the lungs of the community that was hit the hardest by COVID-19. – Social Services Provider (West Side and Southwest Side of Chicago)

Incidence/Prevalence

> Data and mortality rates. – Community Leader (North Lawndale)

COVID-19

Impact on Health-Related Behaviors

In a series of questions, respondents were asked how certain behaviors have changed for them since the coronavirus/COVID-19 pandemic began in March 2020. As shown below, many community members reported an adverse effect.

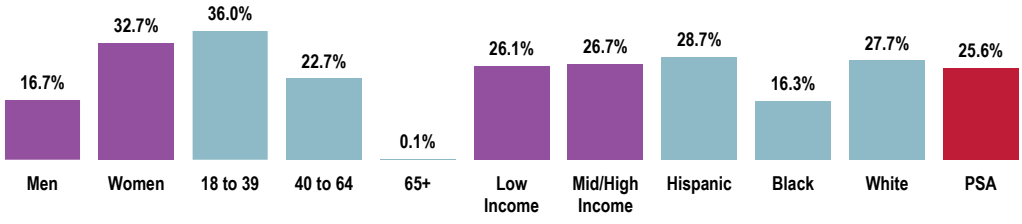
Adverse Changes in Health-Related Behaviors Since the Beginning of the Pandemic
(Primary Service Area, 2021)

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 316-321]
Notes: Asked of all respondents.

Impact on Mental Health

Mental Health Has Gotten Worse Since the Beginning of the Pandemic
(Primary Service Area, 2021)

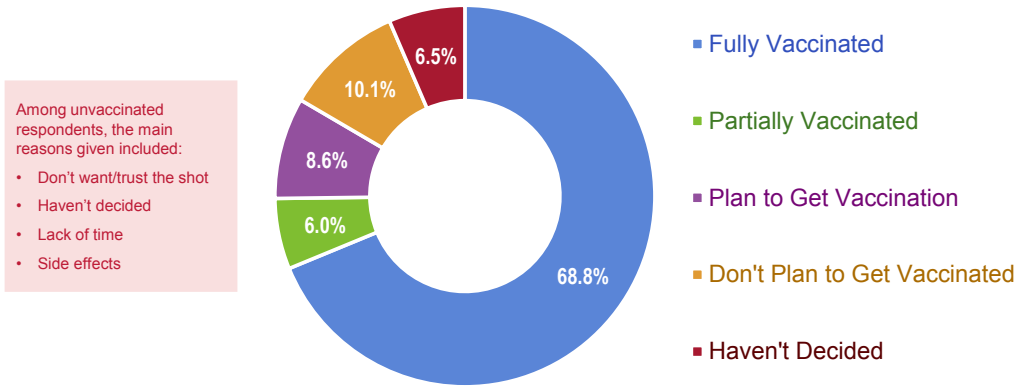
If there were no cost, 59.0% of surveyed adults say they would be (extremely, very, or somewhat) likely to talk with a mental health professional about how the pandemic has affected them.



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 322–323]
Notes: Asked of all respondents.

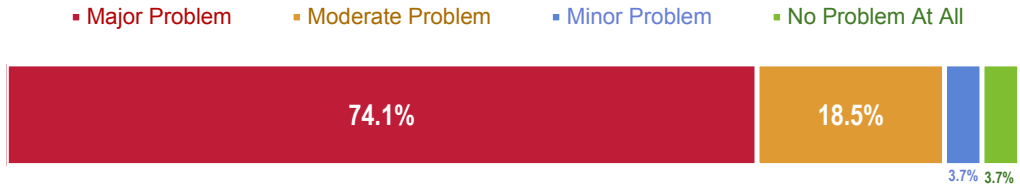
Vaccination Status

Prevalence of COVID-19 Vaccination
(Primary Service Area, 2021)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 324–325]
Notes: Asked of all respondents.

Perceptions of Coronavirus Disease/COVID-19 as a Problem in the Community
(Key Informants, 2021)



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

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

Incidence/Prevalence

> We were the community area with the highest incidence of infections in the state for a long time. We are now the fourth highest in the state. The good news is that we have done very well with vaccinations, so the problem has been abated. – Community Leader (Little Village)
>
> We were the highest impacted community for some time. – Community Leader (Little Village)
>
> Because we are at risk. – Social Services Provider (West Side and Southwest Side of Chicago)
>
> Little Village has been one of the COVID-19 hotspots in Chicago. – Social Services Provider (Little Village)
>
> It is a contagious disease killing without any regard of social or economic status. – Community Leader (North Lawndale)

> We have seen very high rates of infection in Little Villages. Many residents worked in essential jobs where they contracted the virus at work and crowded housing exacerbated the issue. We have personally seen many clients impacted by the disease. – Social Services Provider (Little Village)
>
> Because we had the highest infection rates in the state. – Other Health Provider (Little Village)
>
> Because Little Village and many communities on the Southwest Side of Chicago were ravaged by COVID-19 and the positivity rate for most of the time was higher than the city. It is now a bit lower, but the aftermath of COVID-19 and the delta variant are all too worrisome. – Social Services Provider (Little Village)

Impact on Quality of Life

> Data show ongoing infections and the resultant impacts of the pandemic, including housing and economic instability. – Public Health Representative (West Side and Southwest Side of Chicago)
>
> A Safe Haven is an anchor organization serving the homeless in one of the most poverty-stricken communities that has been hardest hit by the rate of infection, hospitalization and deaths. We are seeing firsthand how the lack of commitment, resources and a more comprehensive and integrated healthcare to community based behavioral healthcare, economic and housing system has been the directly exposed by the pandemic and wreaking havoc on the lives that depend on more efficient and outcomes based public and privately supported systems. – Social Services Provider (West Side and Southwest Side of Chicago)
>
> I defined my community to be the Latino community specifically including geographies of Pilsen and little village. COVID-19 is a major problem in the community not just in the disproportionate number of positives but in the detrimental impact to the economic stability of the family. – Social Services Provider (Pilsen)

Vaccination Challenges

> Early pandemic – insufficient testing and available vaccines. mistrust in government sponsored vaccines. political fueled issue black and brown community hard hit early on, now that vaccines are available, believe they are immune to COVID since they had it before misinformation being perpetrated on social media – vaccines are dangerous, causing aliments that are misleading. including healthcare providers from other countries who are taking advantage of immigrant population by peddling remedies that "will fight or prevent COVID" – study done by Unidos US. – Other Health Provider (West Side and Southwest Side of Chicago)

Vulnerable Populations

> There are a lot of seniors in the Chinatown community, there are also a lot of myths and rumors surrounding the virus. The myths lead to anti-Asian/Chinese hate and a possible increase of crimes in the community. – Community Leader (Chinatown)

Government/Politics

> Trust issues with the government. – Community Leader (North Lawndale)

Injury & Violence

Unintentional Injury

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

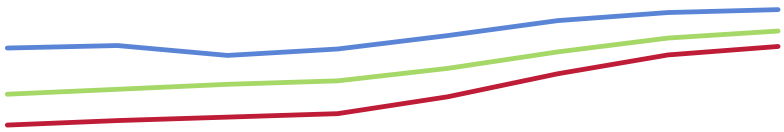
Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area. [COUNTY-

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



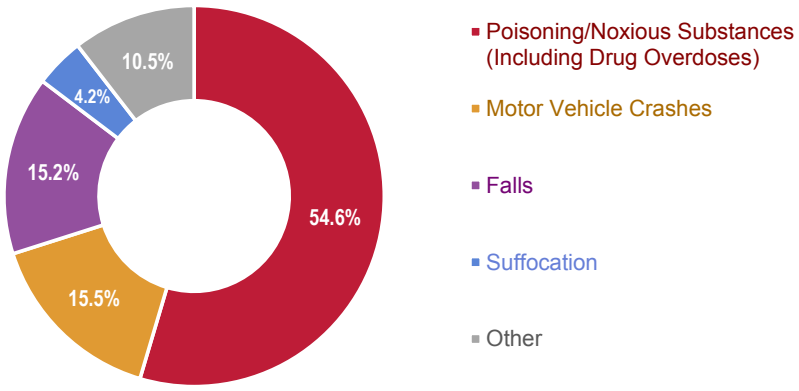
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Cook County	25.7	26.6	27.3	28.0	31.4	36.0	39.8	41.5
IL	31.9	32.9	33.9	34.6	37.1	40.4	43.2	44.6
US	41.2	41.7	39.7	41.0	43.7	46.7	48.3	48.9

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Leading Causes of Unintentional Injury Deaths

(Cook County, 2017-2019)



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.

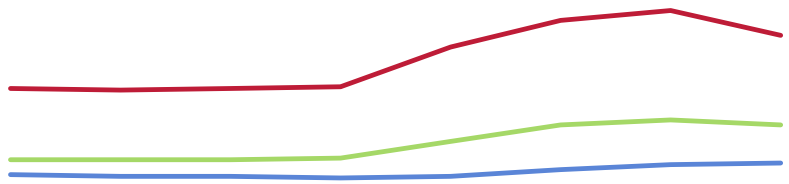
Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

Homicide: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 5.5 or Lower

Note that 17.9% of surveyed residents have lost a loved one to violence.



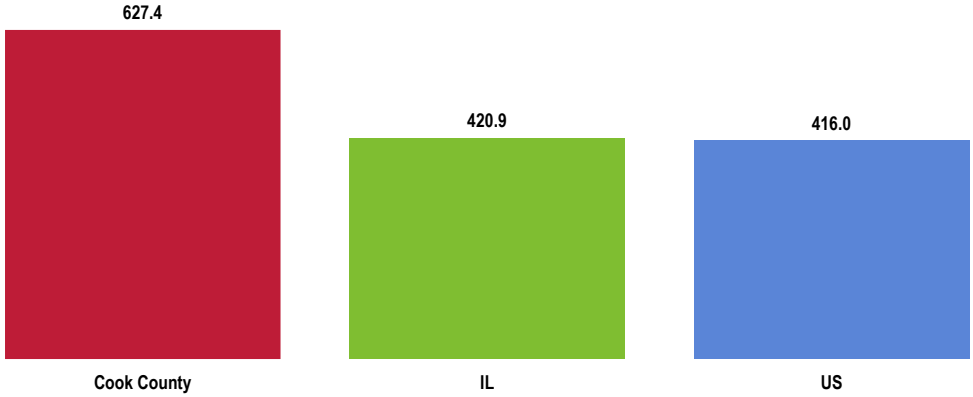
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Cook County	10.6	10.5	10.6	10.7	13.1	14.7	15.3	13.8
IL	6.3	6.3	6.3	6.4	7.4	8.4	8.7	8.4
US	5.4	5.3	5.3	5.2	5.3	5.7	6.0	6.1

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
2021 PRC Community Health Survey, PRC, Inc. [Item 310]

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter;

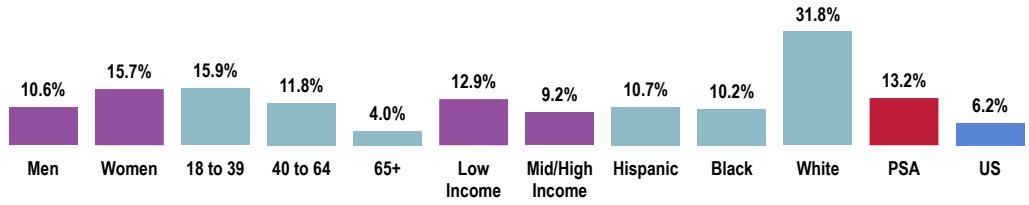
Violent Crime
(Rate per 100,000 Population, 2015-2017)



Sources: Federal Bureau of Investigation, FBI Uniform Crime Reports.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.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.

Victim of a Violent Crime in the Past Five Years
(Primary Service Area, 2021)

Note that 58.3% of service area residents perceive their neighborhoods to be "not at all safe" or only "slightly safe."

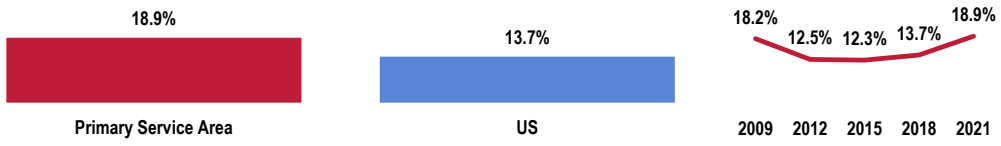


Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 38, 309]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

INTIMATE PARTNER VIOLENCE ► **"The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually**

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

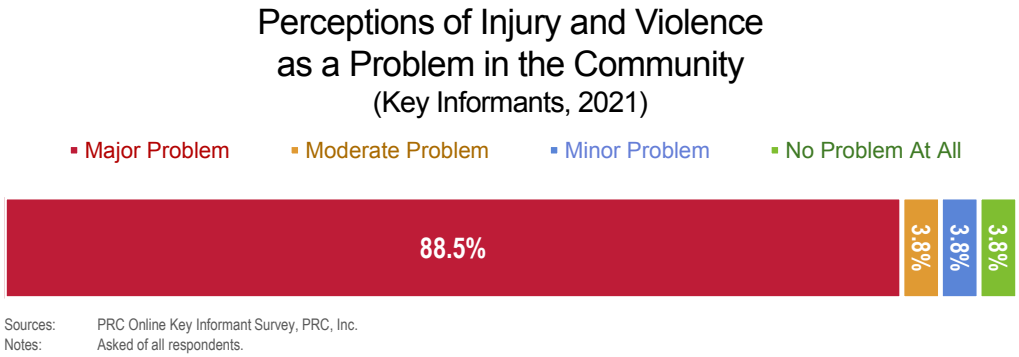
Primary Service Area



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 39]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:



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

Incidence/Prevalence

> Cases of burglary, robbery, and carjacking in the community is on the rise. – Community Leader (Chinatown)
>
> Higher rates of violence and injury in many of these communities. – Public Health Representative (West Side and Southwest Side of Chicago)
>
> This is the reason why most people leave our community and why long-time homeowners are hesitant in investing in their homes. – Social Services Provider (Little Village)
>
> Data, news reports, Ring camera. – Community Leader (North Lawndale)
>
> We live in a very violent community. People, and even children, are exposed to violence all the time, especially gun violence, but also domestic violence. – Community Leader (Little Village)
>
> The data points in that direction, as does the news and what people talk about. – Other Health Provider (North Lawndale)
>
> Gun violence, domestic violence, and gang violence are all contributing factors to injury and violence. – Social Services Provider – Back of the Yards
>
> Violence, both by community members and by police leads to significant rates of injury, death, and mental health issues. Additionally, even those who haven't personally experienced violence are impacted by it because there is a general sense of fear that impacts their mental health and limits the places in the neighborhood, they are willing to go for fear of crossing gang lines. – Social Services Provider (Little Village)
>
> Too much gun and gang violence. – Community Leader (Little Village)

Contributing Factors

> Crime and Violence occur in the North Lawndale Community on a daily basis. It is not a quick fix, and we cannot treat the symptoms and expect long-term success. More needs to be invested in proven programs that are helping to transform lives by helping to address the root causes of poverty, crime, and violence (closely correlated) and get people into a setting that can help people overcome their mental, behavioral health, employment and housing challenges and get them mainstreamed to support themselves and their families with pride and purpose restored. – Social Services Provider (West Side and Southwest Side of Chicago)
>
> Family instability. Poverty, systemic racism, guns are glamorized. – Social Services Provider (North Lawndale)
>
> Joblessness. Schools closed, creating abandoned buildings that formerly were productive, but now attract the baser elements in our neighborhood. – Community Leader (North Lawndale)
>
> Too many gang activities due to lack of quality education and job opportunities, which create hope for good futures. – Community Leader (Little Village)

Gun Violence

> The epidemic of gun violence is a major concern. There are too many guns in the community, and no one is willing to talk about banning guns. We need real policy change on guns. – Other Health Provider (Little Village)

Domestic Violence

> Domestic violence harms safety and mental health of all in the household. – Social Services Provider (Little Village)

Awareness/Education

> The lack of educational, recreational, and religious institutions providing real, honest help. – Community Leader (North Lawndale)

Diabetes

ABOUT DIABETES

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Death

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Cook County	20.8	20.6	20.3	20.4	20.3	20.4	19.6	19.0
IL	19.0	19.4	19.2	19.2	18.9	19.0	18.8	18.6
US	22	22.1	21.1	21.1	21.1	21.3	21.3	21.5

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.

Prevalence of Diabetes

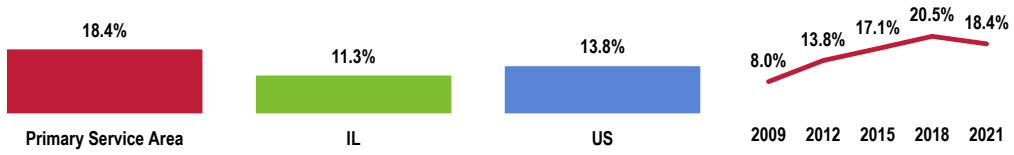
"Have you ever been told by a doctor, nurse, or other health professional that you have diabetes? (If female, add: not counting diabetes only occurring during pregnancy?)"

"Have you ever been told by a doctor, nurse, or other health professional that you have pre-

Prevalence of Diabetes

Another 18.2% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

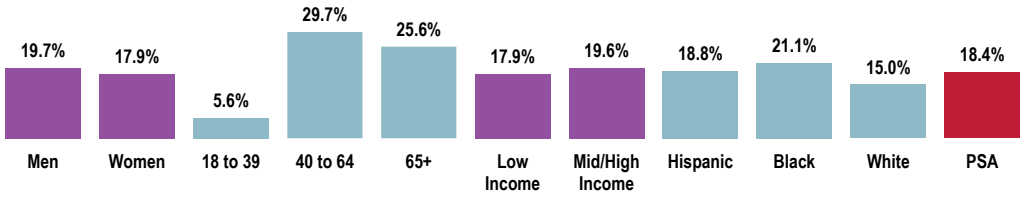
Primary Service Area



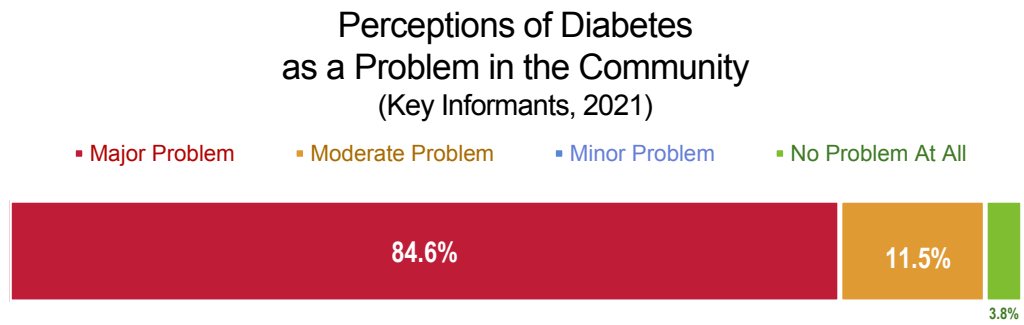
Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 121]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control

Prevalence of Diabetes
(Primary Service Area, 2021)

Note that among adults who have not been diagnosed with diabetes, 46.9% report having had their blood sugar level tested within the past three years.



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 33, 121]
Notes: Asked of all respondents.
Excludes gestational diabetes (occurring only during pregnancy).



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

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

Contributing Factors

> The need to prevent, assess, prescribe, and maintain medication and non-medically prescribed compliance. Prevent: We need more access to health food choices (North Lawndale) is considered a "Food Desert" and lacks grocery stores that provide healthy food choices. A Safe Haven offers a weekly food pantry, provides nutritious three freshly cooked meals a day to our residents, catering services with nutritious food options, and an urban garden and nutrition education program to our residents. Assess: A Safe Haven provides a nurse practitioner to assess individuals who may be at risk or diagnosed with diabetes. Prescribe: A Safe Haven ensures that all residents identified with health issues including diabetes establish a relationship with a local medical home and doctor and we enroll them in Medicaid programs. Maintain: A Safe Haven teaches our residents the importance of medication compliance, provides medication reminders and assistance, & how to keep Dr. Appts to avoid ER – Social Services Provider (West Side and Southwest Side of Chicago)
>
> Access to affordable drugs. Knowledge of healthy diet and means to eat healthy food. – Other Health Provider (Little Village)
>
> Lack of bilingual bicultural healthcare providers. Those of us who are committed to offering services in a linguistic and cultural manner and only hire bilingual providers struggle with this, lack of funding for education around nutrition, weight loss, and physical activity. – Other Health Provider (West Side and Southwest Side of Chicago)
>
> Poor diet. Neglecting symptoms and late diagnosis. – Social Services Provider (Little Village)
>
> Concerns about exercising outside (due to safety), lack of information about available treatment, language and cultural barriers in obtaining information about proper diet and ongoing care for diabetes. – Social Services Provider (Little Village)

Awareness/Education

> Lack of educational awareness and overall diet. – Social Services Provider (North Lawndale)
>
> Lack of education and resources for the dietary needs. – Community Leader (North Lawndale)
>
> Prevention and education. – Social Services Provider (Little Village)
>
> It is important that the community understand the consequences of unhealthy eating while making healthy eating assessable and economically feasible for families. – Social Services Provider (Pilsen)

Nutrition

> Nutrition. – Community Leader (North Lawndale)
>
> Diet is one of the big challenges. People do not seem to be educated as to the impact of certain foods in their diets and thus leave themselves open to diabetes. – Community Leader (Little Village)
>
> Diet and exercise. – Community Leader (North Lawndale)

Access to Care/Services

> Access to disease management services and tools. Access to diagnostic and specialty healthcare services. Community support for healthy foods and safe physical activity/exercise options. – Public Health Representative (West Side and Southwest Side of Chicago)

Cultural/Personal Beliefs

> Cultural acceptance of the problem without the belief that individuals can reduce risks for complications. – Community Leader (Little Village)

Prevention/Screenings

> Totally preventable, yet too prevalent. – Community Leader (Little Village)

Covid-19

> High-risk with the COVID-19. – Social Services Provider (West Side and Southwest Side of Chicago)

Kidney Disease

ABOUT KIDNEY DISEASE

More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

– Healthy People 2030 (https://health.gov/healthypeople)

Kidney Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Cook County	18.4	17.2	17.2	17.0	17.0	16.4	17.0	16.9
IL	17.8	17.1	17.1	17.2	17.2	17.0	16.9	16.7
US	15.9	15.2	13.2	13.3	13.2	13.2	13.0	12.9

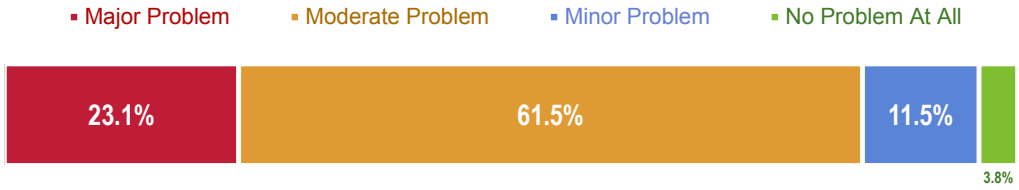
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.

Prevalence of Kidney Disease

Primary Service Area

Sources: 2021 PRC Community Health Survey, PRC, 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): 2019 Illinois data.
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

Perceptions of Kidney Disease as a Problem in the Community
(Key Informants, 2021)



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

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

Contributing Factors

> As with all undiagnosed and unaddressed health issues in poverty-stricken communities, as people may have access to healthcare, the lack of stability in all other areas of their lives tend to get neglected, including kidney disease. – Social Services Provider (West Side and Southwest Side of Chicago)

Co-Occurrences

> Too many diabetics without good follow through to reduce risks of complications. – Community Leader (Little Village)

Incidence/Prevalence

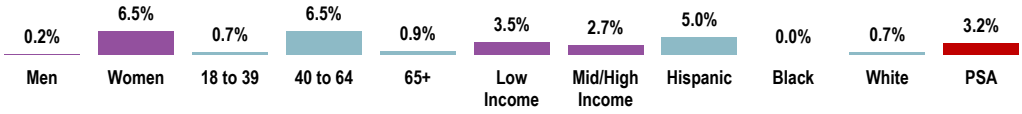
> This is due to the high incidence of diabetes in the neighborhoods. – Social Services Provider – Back of the Yards

Nutrition

> The lack of healthy diet and the educating of the population. – Community Leader (North Lawndale)

Prevalence of Sickle-Cell Anemia

Prevalence of Sickle-Cell Anemia
(Primary Service Area, 2021)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 304]
Notes: Asked of all respondents.

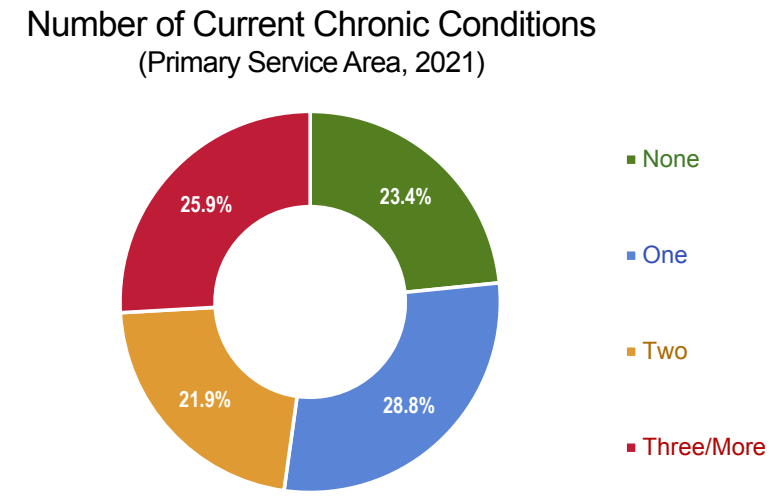
Potentially Disabling Conditions

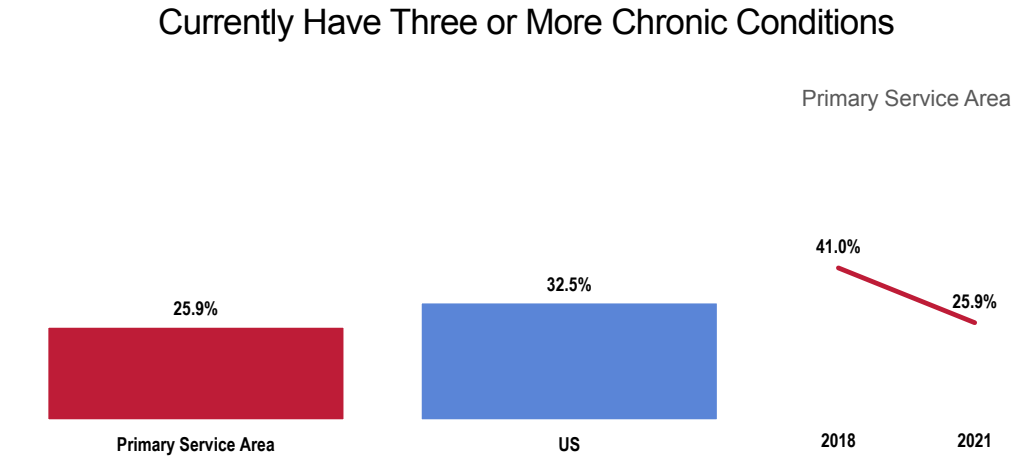
Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Osteoporosis
- Diabetes
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Kidney disease
- Liver disease
- Lung disease
- Obesity
- Sickle-cell anemia
- Stroke

Multiple chronic conditions are concurrent conditions.

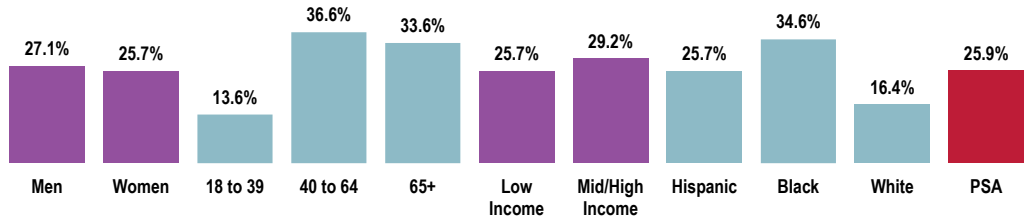




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 123]
2020 PRC National Health Survey, PRC, Inc.

Notes: Asked of all respondents.
In this case, chronic conditions include lung disease, cancer, osteoporosis, kidney disease, liver disease, sickle-cell anemia, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, and/or obesity.

Currently Have Three or More Chronic Conditions
(Primary Service Area, 2021)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 123]
Notes: Asked of all respondents.
In this case, chronic conditions include lung disease, cancer, osteoporosis, kidney disease, liver disease, sickle-cell anemia, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, and/or obesity.

Activity Limitations

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

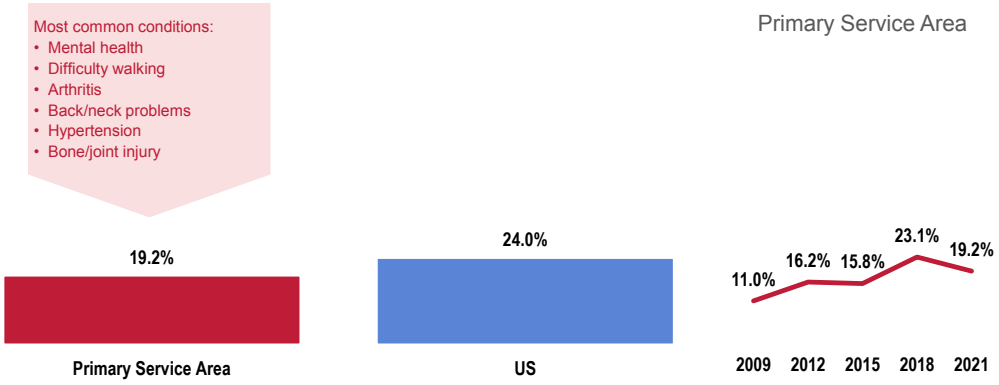
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

"Are you limited in any way in any activities because of physical, mental, or emotional problems?"

[Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**

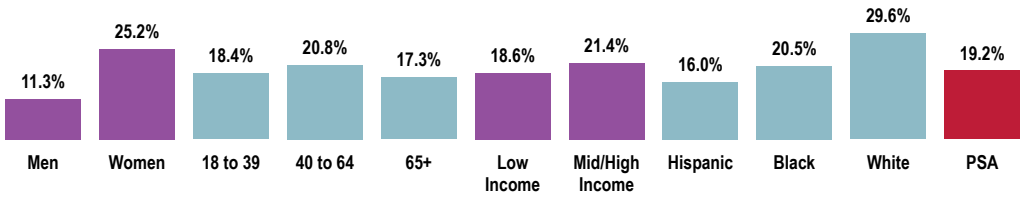
Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 96–97]

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

(Primary Service Area, 2021)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 96]
Notes: Asked of all respondents.

High-Impact Chronic Pain

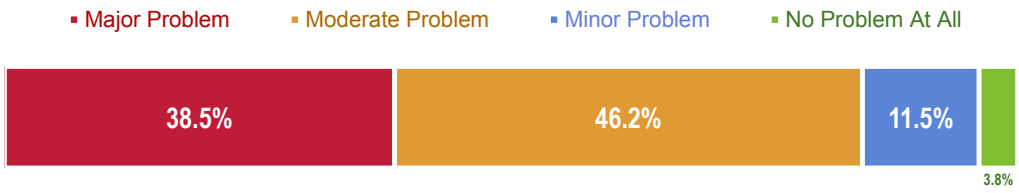
"Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?" (Reported here among those

Experience High-Impact Chronic Pain
(Primary Service Area, 2021)
Healthy People 2030 = 7.0% or Lower

Note that 2.6% of adults have been diagnosed with osteoporosis (4.6% among those age 65+*).

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 37, 302]
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov
Notes: Asked of all respondents.
High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.
*Take caution when interpreting results, as the sample size is n<50.

Perceptions of Disability & Chronic Pain as a Problem in the Community
(Key Informants, 2021)



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

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

Access to Care/Services

> Lack of care. – Community Leader (North Lawndale)

Alcohol/Drug Use

> The overuse of legal and illegal drugs. – Community Leader (North Lawndale)

Incidence/Prevalence

> The people are suffering from arteritis and osteoporosis and fibromyalgia. – Social Services Provider (West Side and Southwest Side of Chicago)

Loss of Productivity

> Chronic pain, especially low back pain, are one of the main reasons for missing work. It is difficult to get services to manage chronic pain and limits opportunities for work. – Public Health Representative (West Side and Southwest Side of Chicago)

Built Environment

> The infrastructure/facilities here are not disabled-friendly. – Community Leader (Chinatown)

Alzheimer’s Disease

ABOUT DEMENTIA

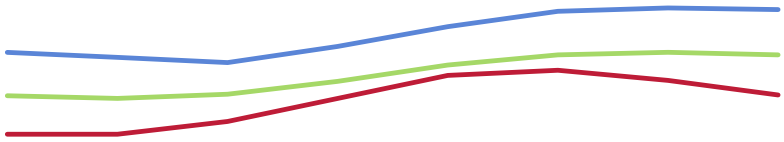
Alzheimer’s disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.1 Nearly 6 million people in the United States have Alzheimer’s, and that number will increase as the population ages.

Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there’s no cure for Alzheimer’s disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

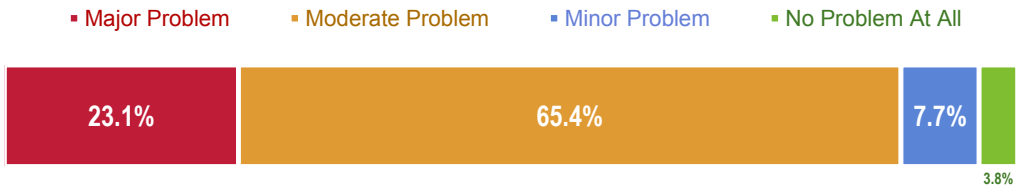
Alzheimer's Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Cook County	15.8	15.8	17.3	20.0	22.7	23.3	22.1	20.4
IL	20.3	20.0	20.5	22.0	23.9	25.1	25.4	25.1
US	25.4	24.8	24.2	26.1	28.4	30.2	30.6	30.4

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community
(Key Informants, 2021)



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

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

Incidence/Prevalence

> A lot of seniors have this disease as they get old. – Community Leader (Chinatown)
>
> Many seniors are impacted and not diagnosed. – Community Leader (North Lawndale)

Awareness/Education

> Lack of planning. – Community Leader (North Lawndale)

Denial/Stigma

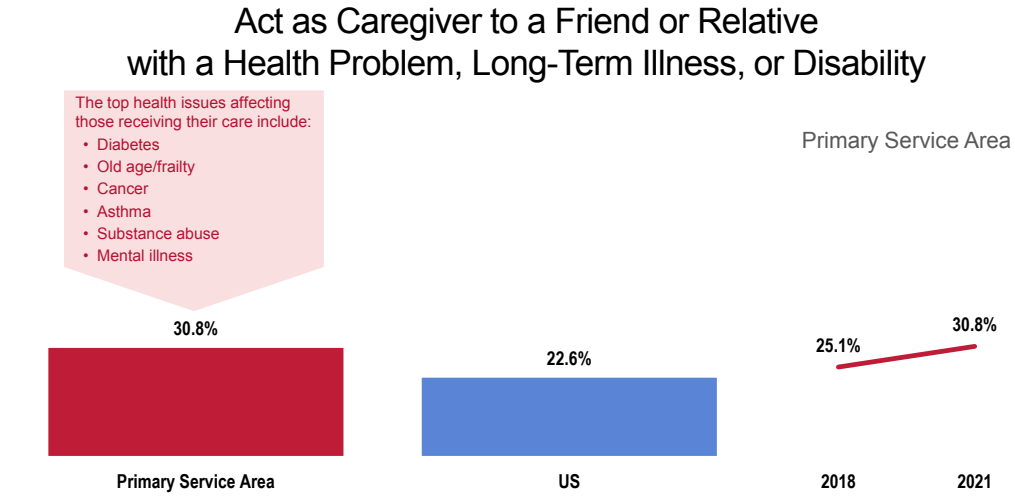
> I think that people in our community do not recognize (or want to recognize) the symptoms, and thus do nothing about it, especially early on. – Community Leader (Little Village)

Follow-Up/Support

> Because too many seniors have to fend for themselves, leaving doors open to rejection and panic. – Community Leader (North Lawndale)

Caregiving

"People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 98–99]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

BIRTHS

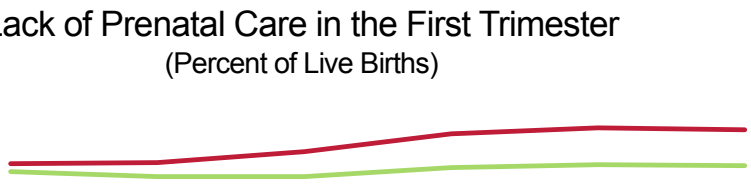
ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

– Healthy People 2030 (https://health.gov/healthypeople)

Prenatal Care



	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Cook County	22.7%	22.8%	23.9%	25.7%	26.3%	26.1%
Illinois	21.9%	21.4%	21.4%	22.3%	22.6%	22.5%

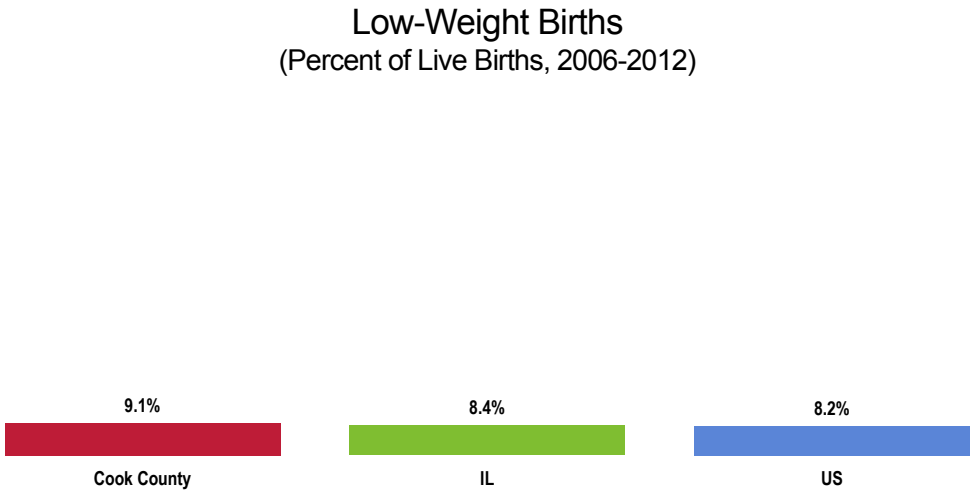
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted July 2021.

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.



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted July 2021.
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

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. These rates are outlined in the following chart. [COUNTY-LEVEL DATA]

Infant Mortality Trends

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

Healthy People 2030 = 5.0 or Lower

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Cook County	7.2	6.7	6.7	6.6	6.9	6.6	6.5	5.9
IL	6.6	6.3	6.4	6.3	6.4	6.2	6.2	5.9
US	6.1	6.0	5.9	5.9	5.9	5.8	5.7	5.6

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted July 2021.
Centers for Disease Control and Prevention, National Center for Health Statistics.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes: Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Family Planning

ABOUT FAMILY PLANNING

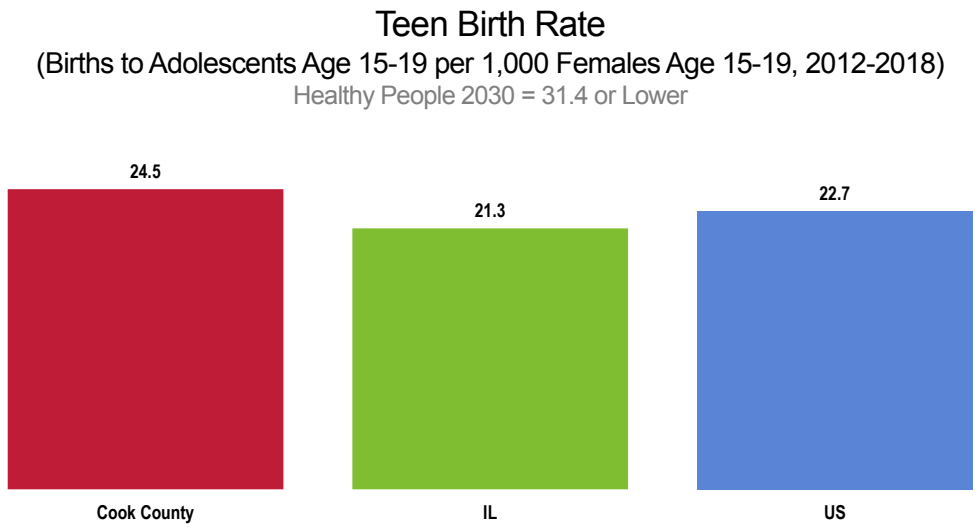
Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

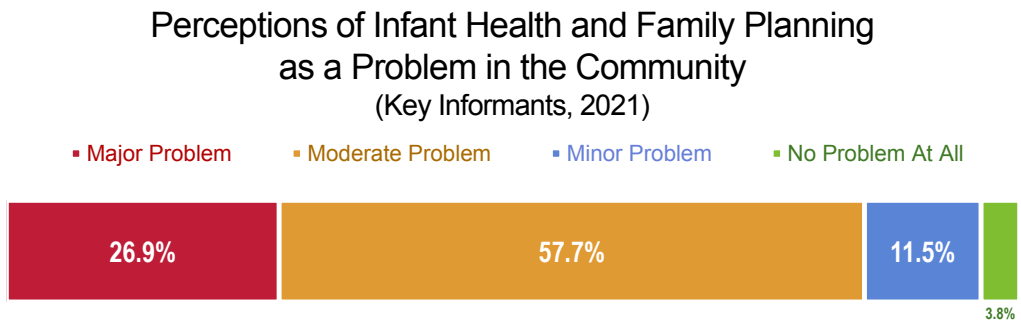
Births to Adolescent Mothers

The following chart describes births to adolescent mothers under the age of 20 years. [COUNTY-LEVEL



Sources: Centers for Disease Control and Prevention, National Vital Statistics System.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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.



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

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

Contributing Factors

> Too many teen pregnancies. Lack of prenatal care. – Community Leader (North Lawndale)
>
> The infant mortality rate is high. No birth plans and too much focus on just having the babies. – Social Services Provider (North Lawndale)

Housing Conditions

> Homelessness and families living in unsafe and doubled up situations is a major urgent public health issue that must be included. – Social Services Provider (West Side and Southwest Side of Chicago)

Parental Influence

> Parenting skills. – Social Services Provider (West Side and Southwest Side of Chicago)

Teen Parents

> Very young childbirth age of parents. – Community Leader (Little Village)

MODIFIABLE HEALTH RISKS

Nutrition

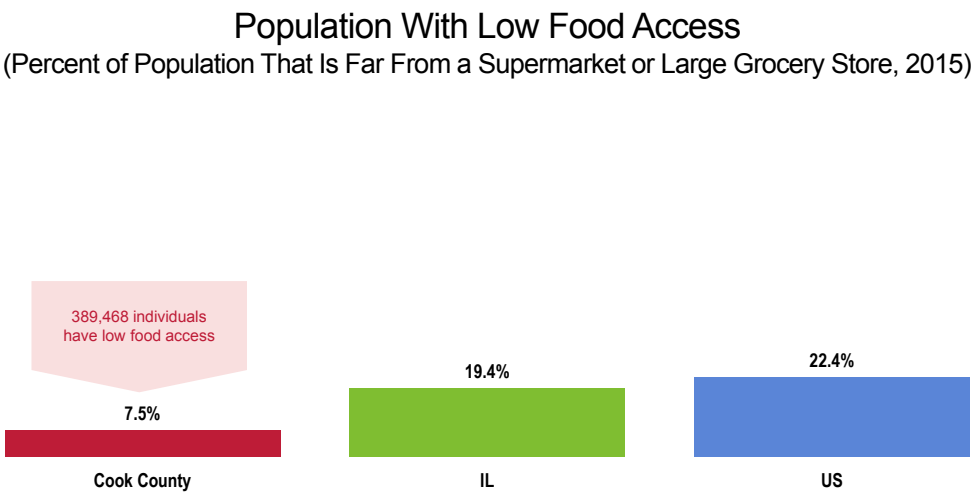
ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Fresh Produce



Sources: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).

Notes: This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Physical Activity

ABOUT PHYSICAL ACTIVITY

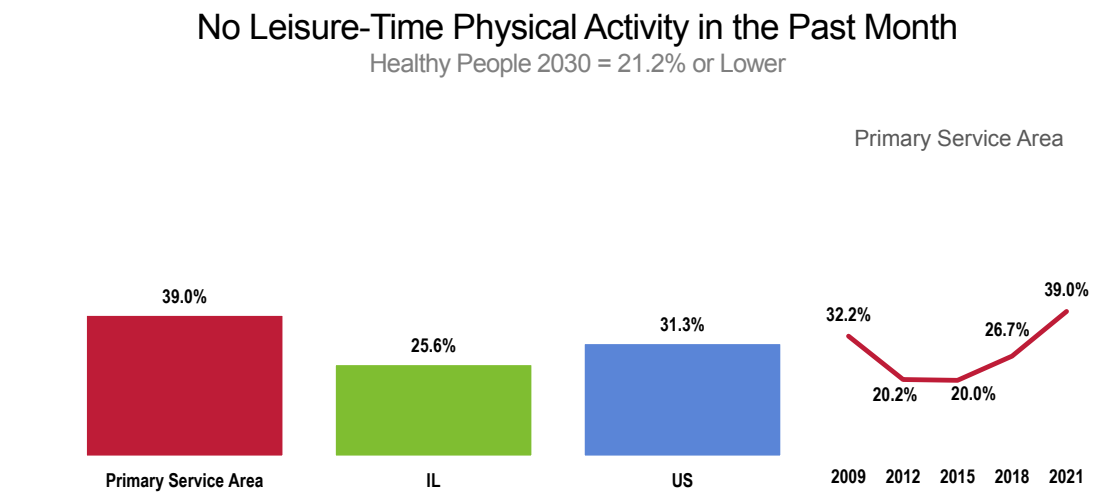
Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

"During the past month, other than your regular job, did you participate in any physical



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 82]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Illinois data.
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov
Notes: Asked of all respondents.

Meeting Physical Activity Recommendations

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

To measure physical activity frequency, duration and intensity, respondents were asked:

"During the past month, what type of physical activity or exercise did you spend the most time doing?"

"And during the past month, how many times per week or per month did you take part in this activity?"

"And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

"During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."

See also COVID-19 in the Respiratory Disease section of this report.

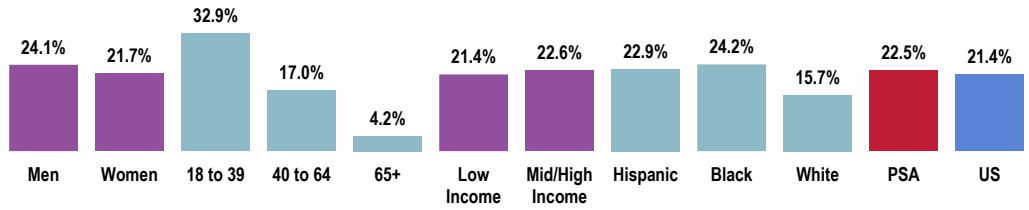
"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

- Aerobic activity is at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

Meets Physical Activity Recommendations

(Primary Service Area, 2021)

Healthy People 2030 = 28.4% or Higher



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 126]
US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

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.

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

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

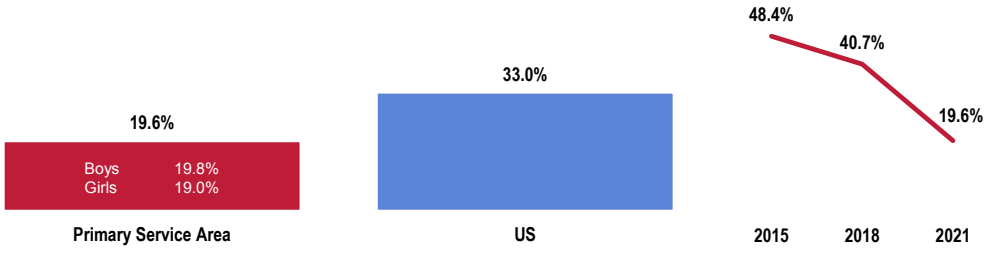
- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Children's Physical Activity

Child Is Physically Active for One or More Hours per Day

(Parents of Children Age 2-17)

Primary Service Area



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 109]
2020 PRC National Health Survey, PRC, 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.

Weight Status

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

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

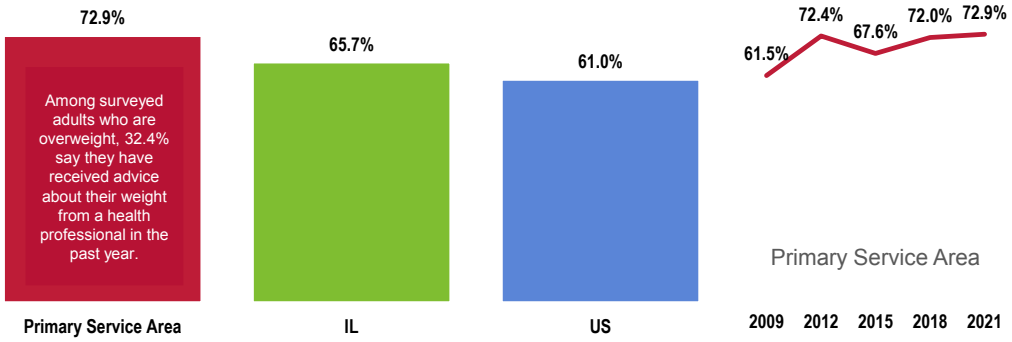
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September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

"About how much do you weigh without shoes?"

"About how tall are you without shoes?"

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

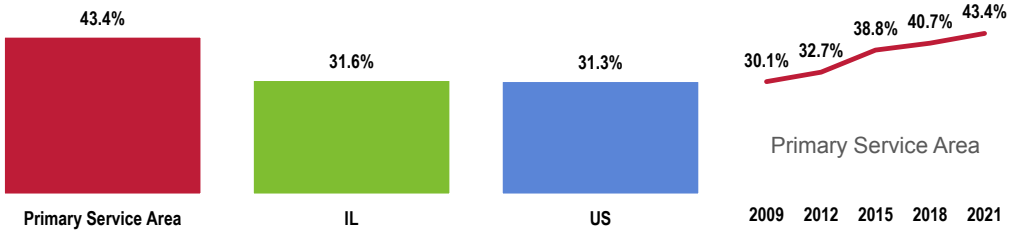
Prevalence of Total Overweight (Overweight and Obese)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 128, 313]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Illinois data

Prevalence of Obesity

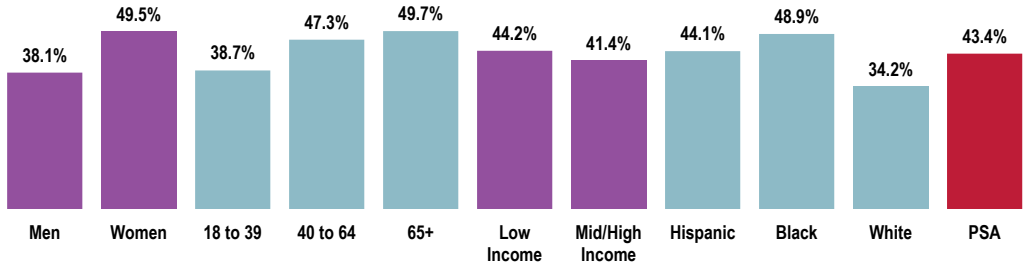
Healthy People 2030 = 36.0% or Lower



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Illinois data.
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

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
(Primary Service Area, 2021)
Healthy People 2030 = 36.0% or Lower



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov
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.

Children's Weight Status

The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

"How much does this child weigh without shoes?"

"About how tall is this child?"

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

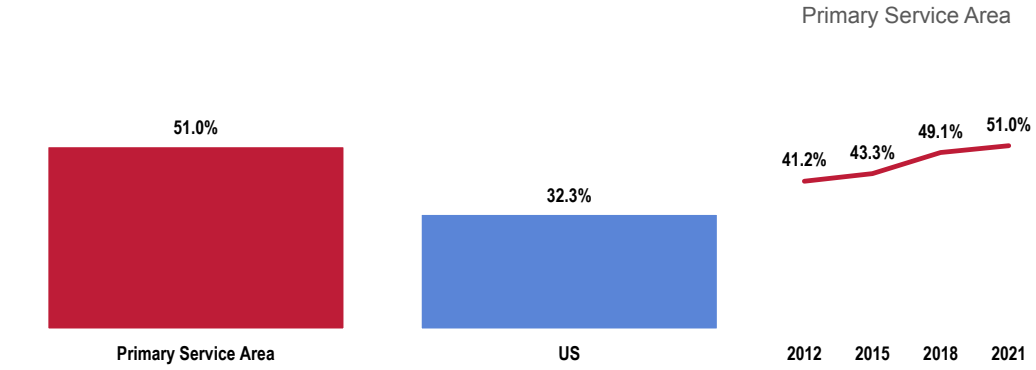
In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles 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

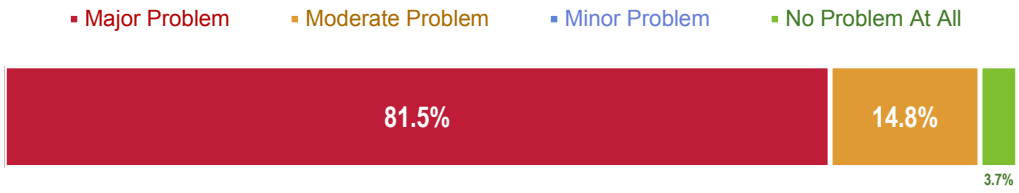
– Centers for Disease Control and Prevention

Prevalence of Overweight in Children
(Parents of Children Age 5-17)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 131]
2020 PRC National Health Survey, PRC, 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.

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community
(Key Informants, 2021)



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

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

Nutrition & Physical Activity

> Food desert, very few exercise programs other than Chicago Park District. – Community Leader (North Lawndale)
>
> Food insecurity; lack of safe and clean green space and streets. – Social Services Provider (Little Village)
>
> Folks eat poorly and get too little exercise. – Community Leader (Little Village)
>
> Access to affordable produce. Safe spaces for physical activity. – Public Health Representative (West Side and Southwest Side of Chicago)
>
> Insufficient resources for encouraging physical activities for all age groups and very little emphasis on culturally appropriate nutritional advice. – Community Leader (Little Village)

Contributing Factors

> Lack of access to fresh and nutritious food, and exercise. The fast food and processed food industry are the most available and economically available food in the community and the crime and violence keeps people indoors. – Social Services Provider (West Side and Southwest Side of Chicago)

> Lack of culturally appropriate and language accessible information. Challenges to exercising outside because of safety concerns. Chronic stress and fatigue caused by living in poverty, experiencing discrimination, etc. – Social Services Provider (Little Village)

Cultural/Personal Beliefs

> The challenges of nutrition, physical activity, and weight are cultural issues, not access issues. Our culture seems to embrace fattening foods and screen time and these two habits lead to being overweight. – Other Health Provider (North Lawndale)

Access to Fresh Produce

> The lack of any major full-service food stores with fresh produce. – Community Leader (North Lawndale)

Awareness/Education

> Going over the basics, by sharing what has worked for families in the past, for whoever is interested. – Community Leader (North Lawndale)

Childhood Obesity

> High numbers of childhood obesity. – Social Services Provider (Little Village)

Substance Abuse

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol

Age-Adjusted Cirrhosis/Liver Disease Deaths

Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The following chart outlines age-adjusted mortality for cirrhosis/liver disease in Cook County.

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 10.9 or Lower

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Cook County	8.4	8.8	9.3	9.4	9.3	9.0	8.8	8.6
IL	8.3	8.5	8.9	9.0	9.1	9.1	9.4	9.5
US	10.1	10.4	10.2	10.5	10.6	10.8	10.9	11.1

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Excessive Drinking

See also COVID-19 in the Respiratory Disease section of this report.

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKERS ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

"During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

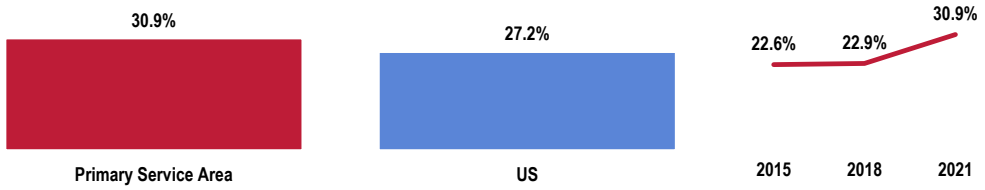
"On the day(s) when you drank, about how many drinks did you have on the average?"

"Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)**/4** (if female) **or more drinks on an occasion?"**

Excessive Drinkers

Note that 2.7% of service area adults have been diagnosed with liver disease.

Primary Service Area



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 136, 303]
2020 PRC National Health Survey, PRC, Inc.

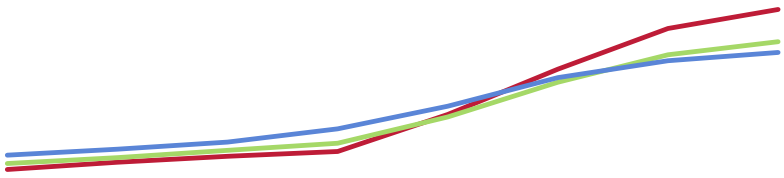
Notes: Asked of all respondents.
Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drugs

Age-Adjusted Unintentional Drug-Related Deaths

Unintentional drug-related deaths include all deaths, other than suicide, for which drugs are the underlying cause. A “drug” includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines local age-adjusted mortality for

Unintentional Drug-Related Deaths: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Cook County	9.0	9.6	10.1	10.5	13.6	17.4	20.8	22.4
IL	9.5	10.0	10.6	11.2	13.4	16.3	18.6	19.7
US	10.2	10.7	11.3	12.4	14.3	16.7	18.1	18.8

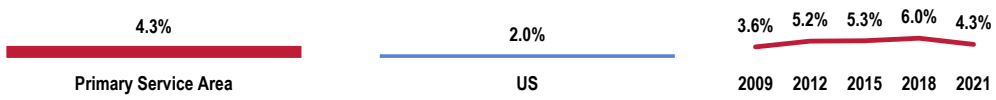
Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.

Illicit Drug Use

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.

Illicit Drug Use in the Past Month

Healthy People 2030 = 12.0% or Lower

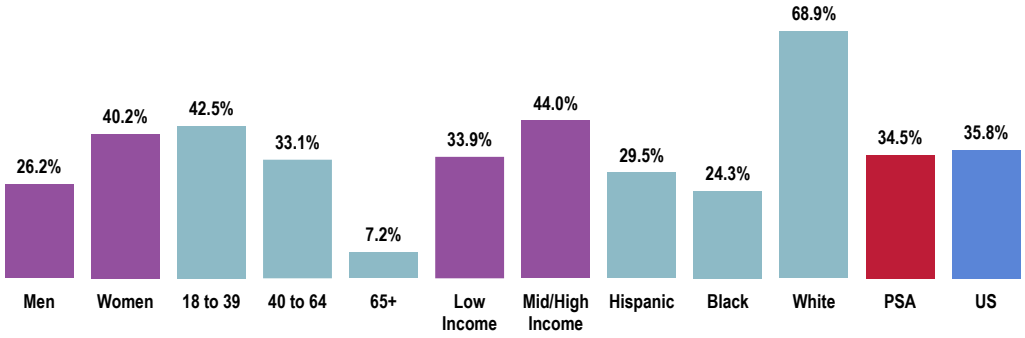


Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 49]
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov
Notes: Asked of all respondents.

Effects of Substance Abuse

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)

(Primary Service Area, 2021)

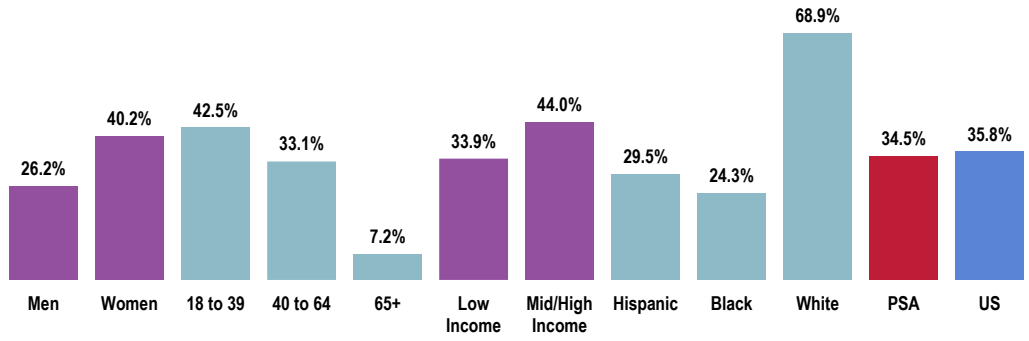


Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 52]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Includes response of "a great deal," "somewhat," and "a little."

Personal Impact From Substance Abuse

"To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs? Would you say: a

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)
(Primary Service Area, 2021)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 52]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Includes response of "a great deal," "somewhat," and "a little."

Perceptions of Substance Abuse as a Problem in the Community
(Key Informants, 2021)

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

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

Contributing Factors

> Substance abusers refused service. The substances are easy to obtain in the community (e.g. alcohol, and over-the-counter drugs). Drug dealers selling drugs can easily be found in the Chinatown community. They usually wait for the customers in cars, hence, the teens and kids in the community can get access to drugs easily. – Community Leader (Chinatown)
>
> Access to MAT treatment. Stigma. Policing that criminalize substance use problems. – Public Health Representative (West Side and Southwest Side of Chicago)
>
> Resources, stigma, facilities. – Community Leader (North Lawndale)
>
> Recognized access to care and to the emotional support that is necessary to sustain the benefits of that care. – Other Health Provider (North Lawndale)

Self-Medicating

> People are negatively impacted by various societal ills and medicate their pain. – Social Services Provider (North Lawndale)

Denial/Stigma

> Making help available without judgement. – Community Leader (North Lawndale)

Tobacco Use

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it’s more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

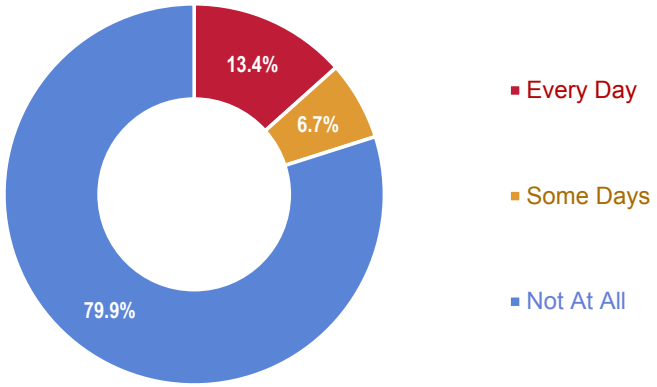
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

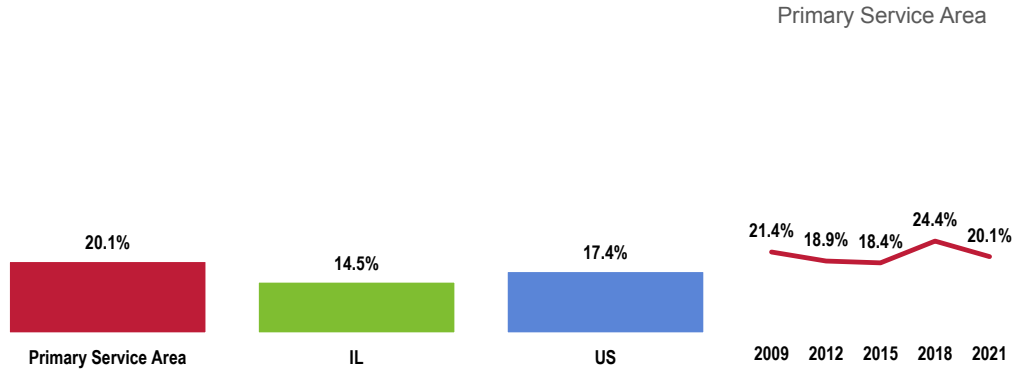
Cigarette Smoking

See also COVID-19 in the Respiratory Disease section of this report.

Cigarette Smoking Prevalence
(Primary Service Area, 2021)



Current Smokers
Healthy People 2030 = 5.0% or Lower



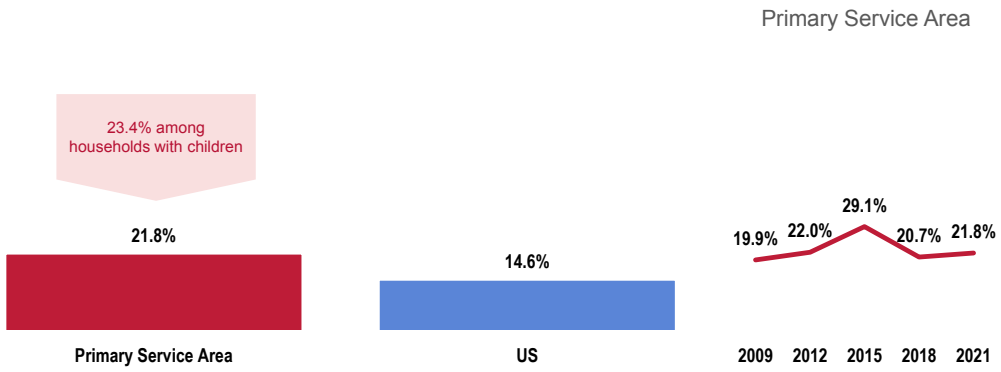
Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Illinois data.
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes: Asked of all respondents.
Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Environmental Tobacco Smoke

"In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?"

Member of Household Smokes at Home



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 43, 134]
2020 PRC National Health Survey, PRC, 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.

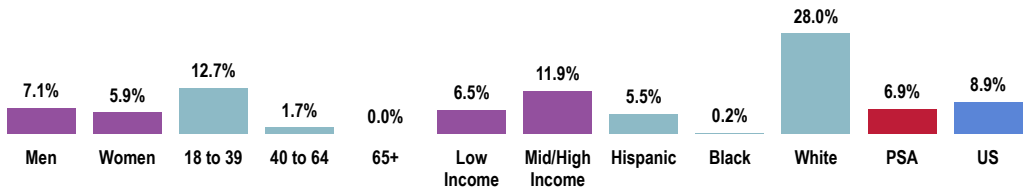
Use of Vaping Products

"The next questions are about electronic vaping products, such as electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. The cartridge or liquid "e-juice" used in these devices produces vapor and comes in a variety of flavors. Have you ever used an electronic vaping product, such as an e-cigarette, even just one time in your entire life?"

"Do you now use electronic vaping products, such as e-cigarettes, "every day," "some days," or "not at all"?"

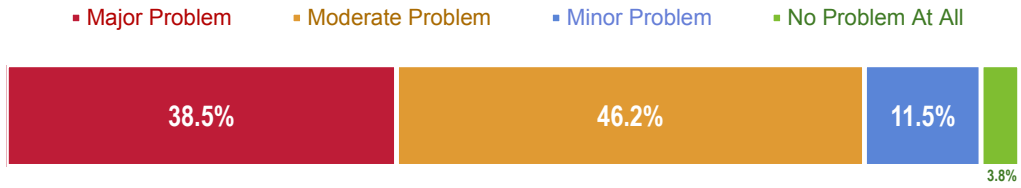
"Current use" includes use "every day" or on "some days."

Currently Use Vaping Products
(Primary Service Area, 2021)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 135]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Perceptions of Tobacco Use as a Problem in the Community
(Key Informants, 2021)



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

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

Cultural/Personal Beliefs

> Many Chinese grew up smoking tobacco when they were still in China. They use tobacco as a way to de-stress. They understand the adverse impacts brought by tobacco use, but still continue using it. – Community Leader (Chinatown)

Impact on Quality of Life

> Smoking causes many health problems. – Community Leader (North Lawndale)
>
> People don't take the affects seriously. – Community Leader (North Lawndale)
>
> It is legal but causes various health problems. – Social Services Provider (North Lawndale)

Contributing Factors

> Too many smokers and insufficient support to help people quit in appropriate language and cultural settings. – Community Leader (Little Village)

Teen/Young Adult Usage

> Too many minors using and uninformed. – Community Leader (North Lawndale)

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

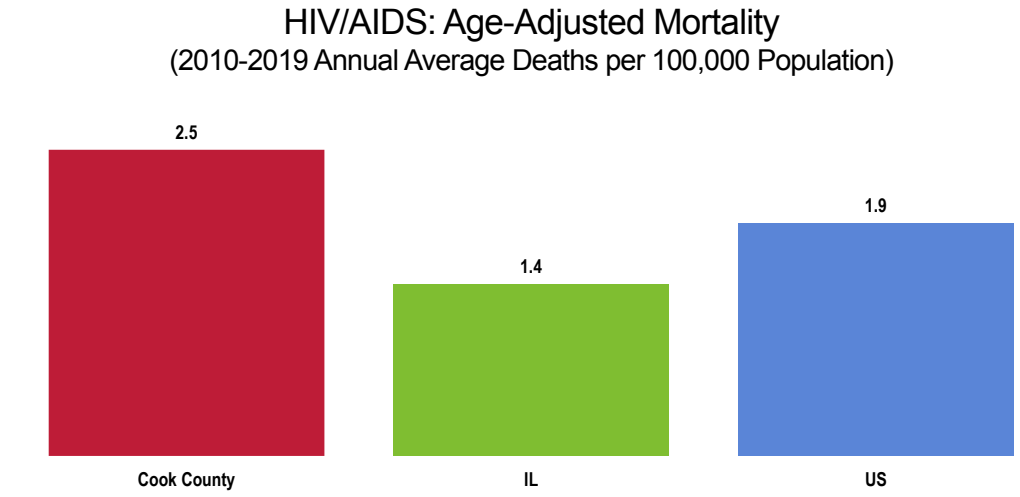
Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

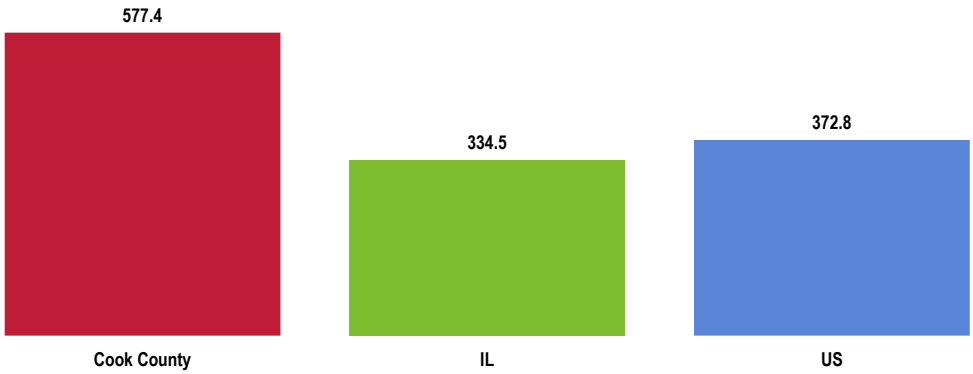
– Healthy People 2030 (https://health.gov/healthypeople)

HIV



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2021.

HIV Prevalence
(Prevalence Rate of HIV per 100,000 Population, 2018)



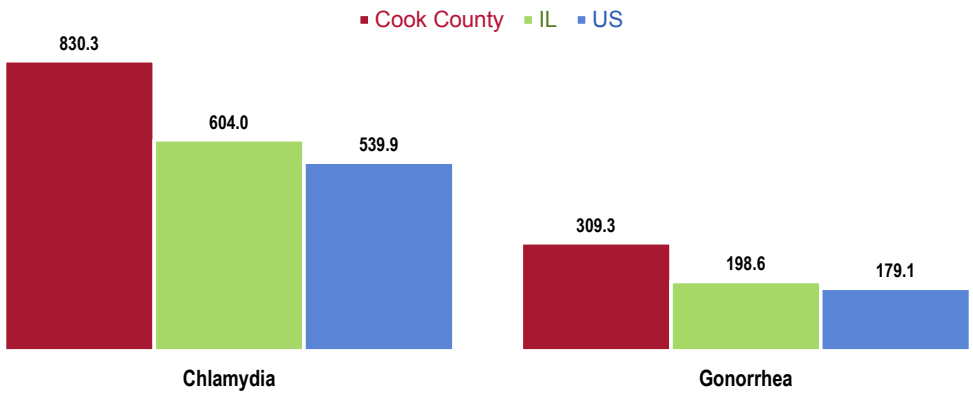
Sources: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).
Notes: This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Sexually Transmitted Infections (STIs)

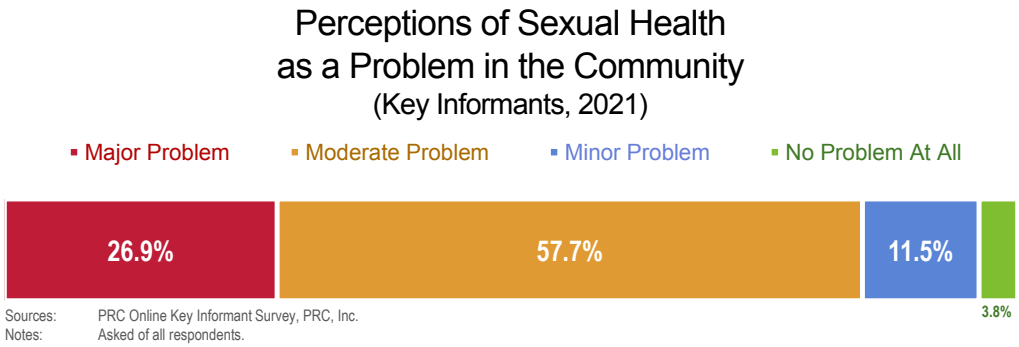
CHLAMYDIA ► Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

GONORRHEA ► Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right

Chlamydia & Gonorrhea Incidence
(Incidence Rate per 100,000 Population, 2018)



Sources: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).
Notes: This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.



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

Incidence/Prevalence

> Data. – Community Leader (North Lawndale)
>
> Young pregnancies, STDs and other sexual health issues are prevalent in the community. – Social Services Provider (West Side and Southwest Side of Chicago)

Contributing Factors

> Unprotected sex and the lack of person being proactive about their health. – Community Leader (North Lawndale)

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Lack of Health Insurance Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

"Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid (or another state-sponsored program)**, or VA/military benefits?"**

"Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?"

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).

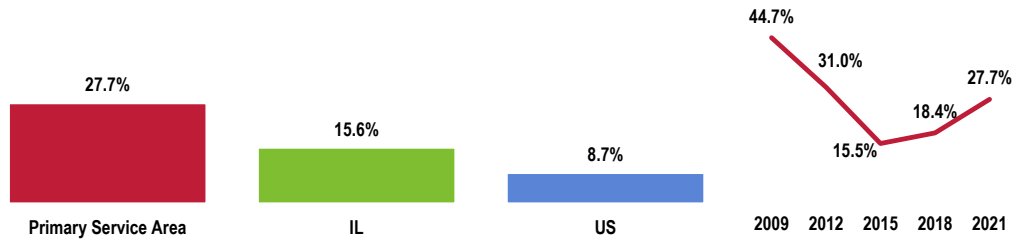
Lack of Health Care Insurance Coverage

(Adults Age 18-64)

Healthy People 2030 = 7.9% or Lower

Among those currently with insurance coverage, 41.3% say there was a time in the past year when they were uninsured.

Primary Service Area

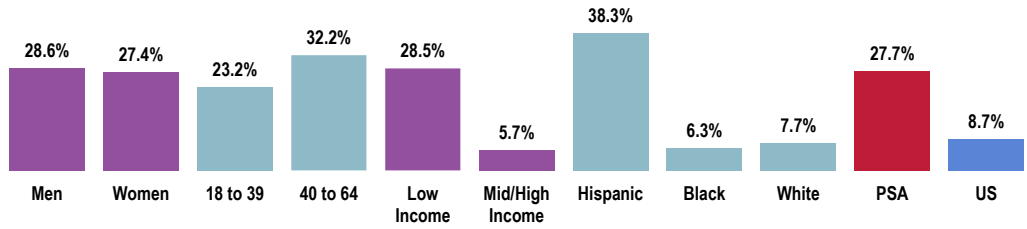


Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 137, 311]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Illinois data.

Lack of Health Care Insurance Coverage

(Adults Age 18-64; Primary Service Area, 2021)

Healthy People 2030 = 0.0% (Universal Coverage)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov [Objective AHS-1]

Notes: Asked of all respondents under the age of 65.

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

"Was there a time in the past 12 months when you needed medical care, but had difficulty finding a doctor?"

"Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

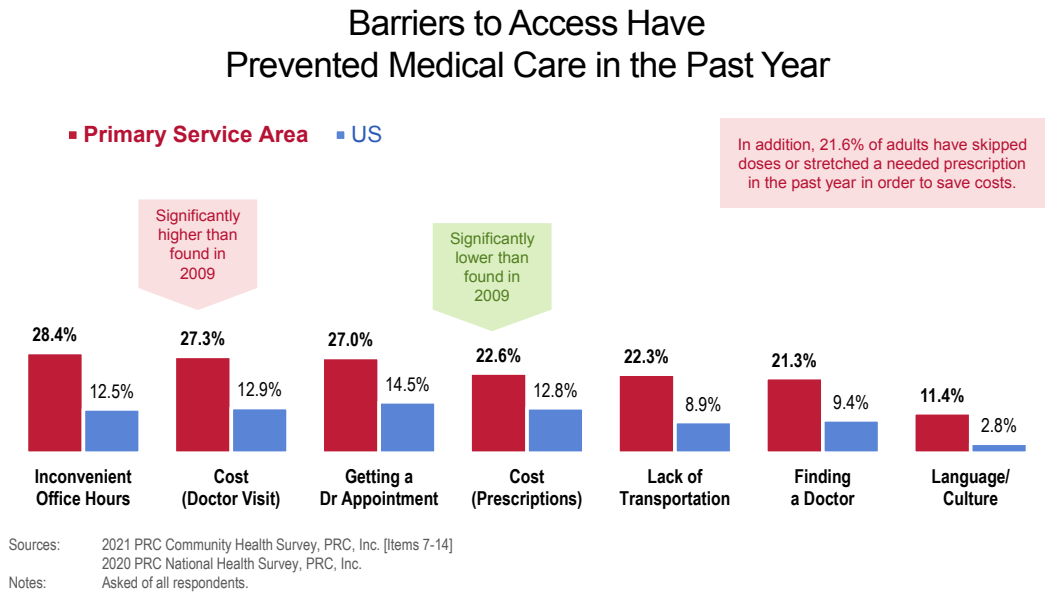
"Was there a time in the past 12 months when you needed to see a doctor, but could not because of the cost?"

"Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

"Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

"Was there a time in the past 12 months when you needed a prescription medicine, but did not get it because you could not afford it?"

"Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

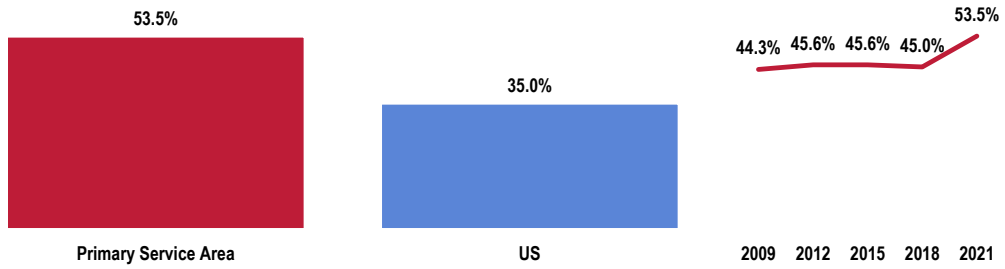


Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 7-14]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

The following charts reflect the composite percentage of the total population experiencing problems

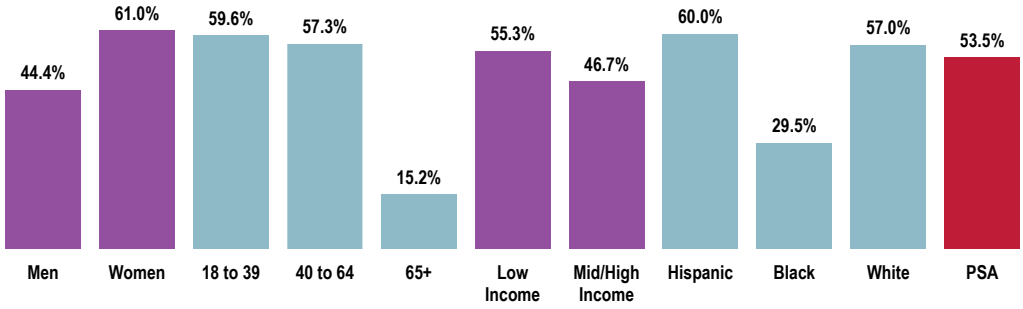
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year

Primary Service Area



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 140]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(Primary Service Area, 2021)



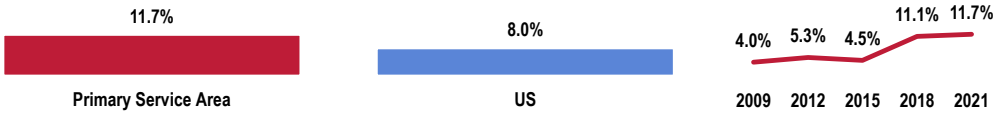
Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 140]
Notes: Asked of all respondents.
Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Accessing Health Care for Children

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.

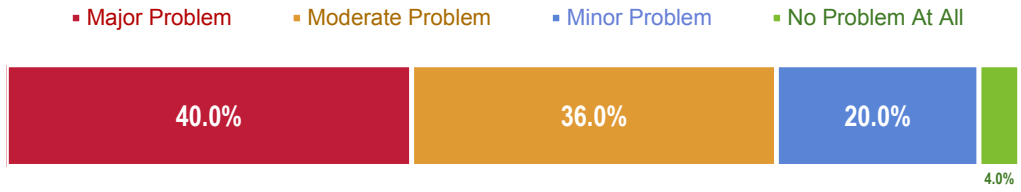
Had Trouble Obtaining Medical Care for Child in the Past Year
(Parents of Children 0-17)

Primary Service Area



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 104]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents with children 0 to 17 in the household.

Perceptions of Access to Health Care Services as a Problem in the Community
(Key Informants, 2021)



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

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

Awareness/Education

> Access to information and education about available health services. – Social Services Provider – Back of the Yards
>
> Knowledge of resources, education around preventive care, how to avoid having to go to the Emergency Room. – Community Leader (North Lawndale)
>
> Lack of health education. – Community Leader (Pilsen)

Contributing Factors

> In particular with immigrant community, distrust in institutions, lack of insurance, lack of physicians and providers that speak their language. Difficulty in referring to specialty care and inpatient services. Emergency rooms overcrowded. – Other Health Provider (West Side and Southwest Side of Chicago)
>
> Language barrier. Lack of vehicular access. Lack of internet access. Lack of support from the government. – Community Leader (Chinatown)
>
> COVID vaccination rates are number one. Historically, diabetes is a major issue. More and more people are becoming aware of respiratory issues with many trucks in our community. – Community Leader (Little Village)

Access to Care for Uninsured/Underinsured

> Accessing diagnostic and specialty care in a timely manner, especially for uninsured individuals. – Public Health Representative (West Side and Southwest Side of Chicago)

Affordable Care/Services

> Cost relating to services. Lack of insurance and transportation. – Community Leader (North Lawndale)

Mental Health

> Mental health. – Community Leader (West Side and Southwest Side of Chicago)

Primary Care Services

ABOUT PREVENTIVE CARE

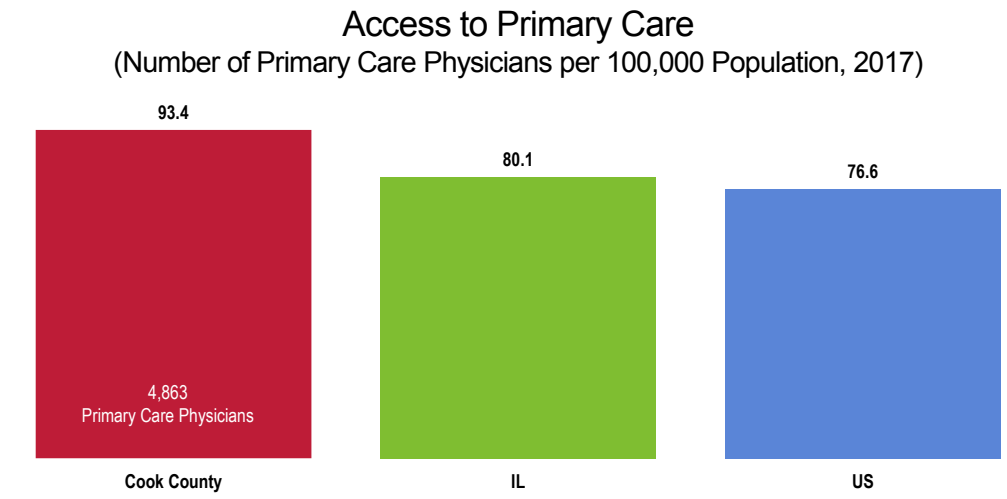
Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care



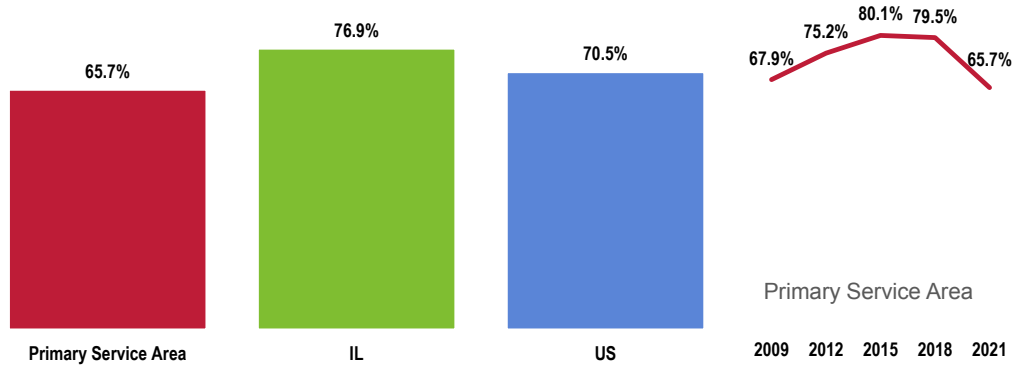
Sources: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved July 2021 via SparkMap (sparkmap.org).

Notes: Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Utilization of Primary Care Services

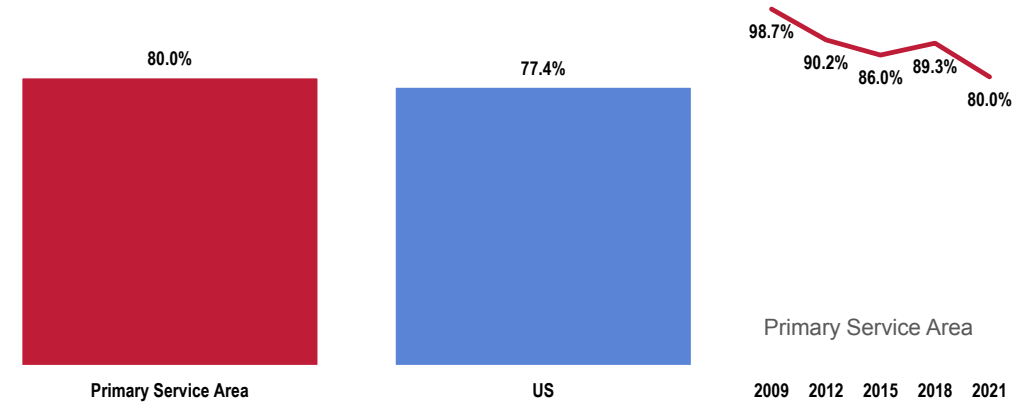
ADULTS ► **"A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?"**

Have Visited a Physician for a Checkup in the Past Year



Sources: 2021 PRC Community Health Survey, PRC, 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): 2019 Illinois data.
2020 PRC National Health Survey, PRC, Inc.

Child Has Visited a Physician for a Routine Checkup in the Past Year
(Parents of Children 0-17)



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 105]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents with children 0 to 17 in the household.

Oral Health

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

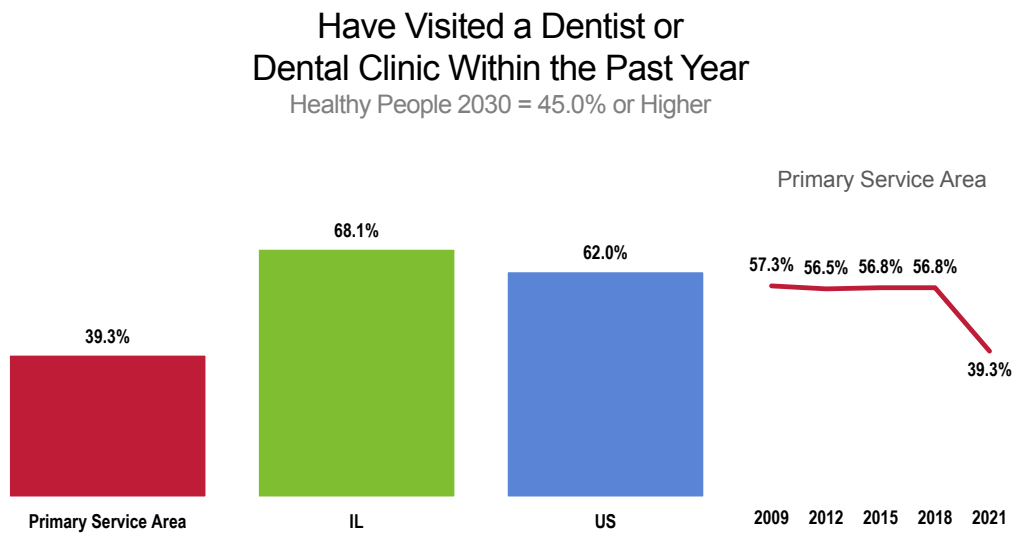
Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

ADULTS ► **"About how long has it been since you last visited a dentist or a dental clinic for any reason?"**

CHILDREN AGE 2-17 ► **"About how long has it been since this child visited a dentist or dental**

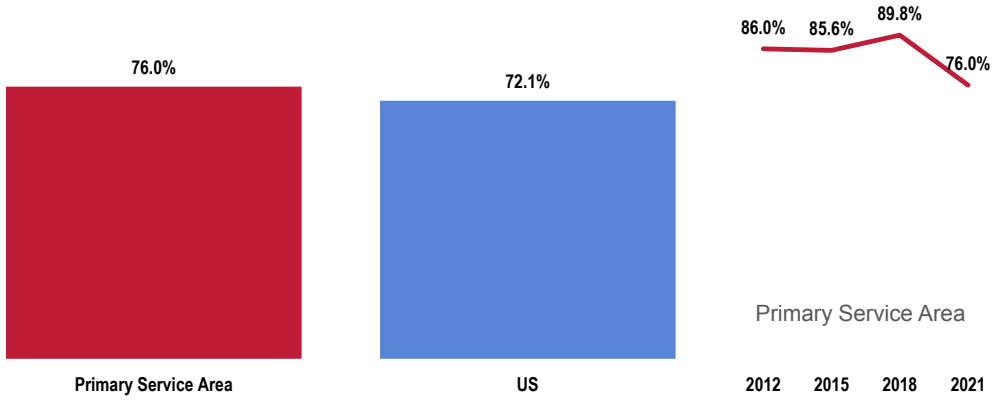


Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 20]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Illinois data.
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov
Notes: Asked of all respondents.

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Parents of Children Age 2-17)

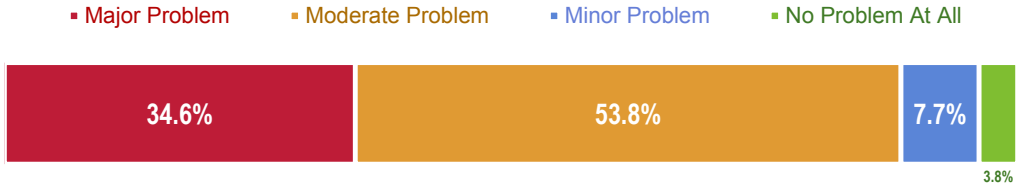
Healthy People 2030 = 45.0% or Higher



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 108]
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov
Notes: Asked of all respondents with children age 2 through 17.

Perceptions of Oral Health as a Problem in the Community

(Key Informants, 2021)



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

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

Affordable Care/Services

> Because it's expensive, this service, even with health insurance. – Social Services Provider (West Side and Southwest Side of Chicago)
>
> Oral health is expensive. Adults, whether they are uninsured, recipients of Medicaid, or beneficiaries of the Medicare program, will generally find that they need to pay out of pocket for dental services and those services are generally not affordable. – Other Health Provider (North Lawndale)

Access for Medicare/Medicaid Patients

> Limit number of dentists that are enrolled in Medicaid and/or accept self-pay for adults and pediatrics. – Public Health Representative (West Side and Southwest Side of Chicago)

Access to Care/Services

> Lack of availability in the community and cost prohibitive. – Social Services Provider (West Side and Southwest Side of Chicago)

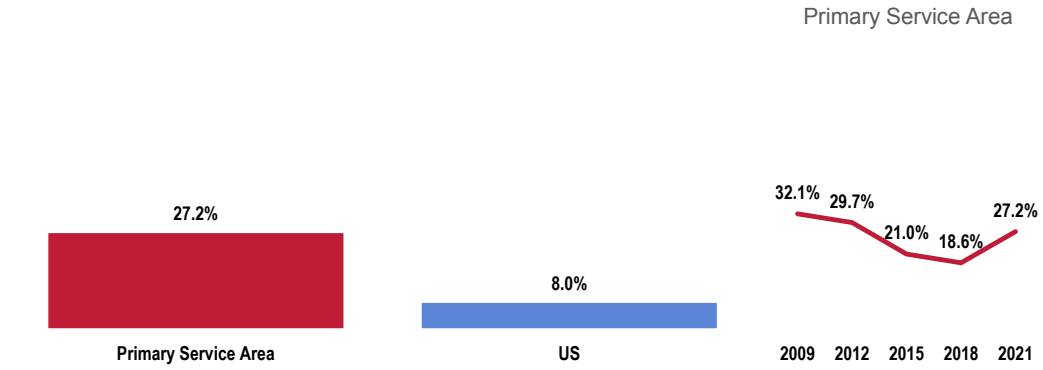
Awareness/Education

> Education and resources. – Community Leader (North Lawndale)

LOCAL RESOURCES

Perceptions of Local Health Care Services

Perceive Local Health Care Services as "Fair/Poor"



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

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 Health Care Services

- Access Community Health Network
- Alivio Health Centers
- Chinese American Service League
- Chinese Christian Union Church
- Coalition For a Better Chinese American Community
- Community Health Workers
- Cook County Health
- Enlace Chicago
- Esperanza Health Center
- Federally Qualified Health Centers
- Lawndale Christian Health Center
- Midwest Asian Health Association
- Mount Sinai Hospital
- Oak Street Health
- Prieto Family Health Center
- Pui Tak Center
- Saint Agatha Church
- Social Services
- St. Anthony Hospital

Cancer

- Access Community Health Network
- American Cancer Society
- Chicago Cancer Health Equity Collaborative
- Cook County Hospital
- Doctor's Offices
- Federally Qualified Health Centers
- Hospitals
- Jencare
- Lawndale Christian Health Center
- Mount Sinai Hospital
- Rush Hospital
- Sinai Health System
- St. Anthony Hospital

Coronavirus

- A Safe Haven
- Access Community Health Network
- Alivio Health Centers
- Amita
- Chicago Department of Public Health
- Chinese American Service League
- Chinese Christian Union Church
- City/State/County Resources Funding Community Hlth Ctrs
- Contact Tracers
- Doctor's Offices
- Enlace Chicago
- Esperanza Health Center
- Federally Qualified Health Centers
- Healthy Chicago Equity Zones Regional
- Hospitals
- Instituto
- Latinos Progresando
- Lawndale Christian Health Center
- Metropolitan Family Services Chicago
- Midwest Asian Health Association
- Mount Sinai Hospital
- Oak Street Health
- People Matter
- Pharmacies
- Prieto Family Health Center
- Project Vida
- Pui Tak Center
- Rush Hospital
- School System
- Sinai Health System
- Sinai Medical Group
- St. Anthony Hospital
- The Resurrection Project

Chronic Kidney Disease

- DaVita
- Dialysis Clinics
- Doctor's Offices
- Hospitals
- Local Healthcare Organizations
- St. Anthony's Dialysis Center

Dementia/Alzheimer's Disease

- Accountability Meetings

- Chinese American Service League
- Churches
- Cook County Hospital
- Mount Sinai Hospital
- Rush Hospital
- Sinai Medical Group
- St. Anthony Hospital

Diabetes

- Access Community Health Network
- Alivio Health Centers
- Community Clinic
- Community Education
- Community Organizations
- Cook County Hospital
- Doctor's Offices
- Enlace Chicago
- Esperanza Health Center
- Federally Qualified Health Centers
- Grocery Stores
- Health Promoters Addressing Healthy Eating
- Hospitals
- Humboldt Park Hospital
- Instituto
- Lawndale Christian Health Center
- Mount Sinai Hospital
- Olivio Medical Center
- Parks and Recreation
- Pete's Fresh Market Chicago
- Planet Fitness Gym
- Prieto Family Health Center
- Rush Hospital
- School System
- SCI
- Sinai Health System
- Sinai Medical Group
- St. Anthony Hospital
- Telpochcalli Community Education Project
- University of Chicago–Chicago Architecture Biennial Program
- Walmart
- YMCA

Disabilities

- Attorneys
- Chinese American Service League
- Cook County Health
- Doctor's Offices
- Labor Organizations
- Loyola University
- Midwest Asian Health Association
- Mount Sinai Hospital
- NAMI
- St. Anthony Hospital
- University of Illinois Chicago

Infant Health and Family Planning

- A Safe Haven
- Chinese American Service League
- Lawndale Christian Health Center
- Liam
- Mount Sinai Hospital
- St. Anthony Hospital
- UCAN Chicago

Heart Disease

- Cook County
- Federally Qualified Health Centers
- Hospitals
- Loretto Hospital
- Mount Sinai Hospital
- Rush Hospital
- St. Anthony Hospital

Injury and Violence

- 10th District Police Department
- A Safe Haven
- Beyond the Ball
- Boys and Girls Club
- Cease Fire
- Chicago Create Real Economic Destiny
- Churches
- City of Chicago, Installation of Surveillance Cameras
- Community Organizations
- Chicago Police Department
- Development of Peace Circles
- Doctor's Offices
- Enlace Chicago
- Erie Neighborhood House
- Firehouse Community Arts Center
- Hospitals
- Latinos Progresando
- Law Enforcement
- Lawndale Christian Legal Clinic
- New Life Centers
- North Lawndale Community Coordinating Council
- Parks and Recreation
- People Being on the Lookout For Each Other
- Prieto Family Health Center
- Programs to Take Guns Off the Street
- Rapid Employment and Development Initiative Chicago

- School System
- Sinai Health System
- St. Anthony Hospital
- UCAN Chicago
- Universidad Popular
- YMCA

Mental Health

- A Safe Haven
- Access Community Health Network
- Awareness Programs to Promote Importance of Mental Health
- Catholic Charities
- Chicago Department of Public Health
- Chinese American Service League
- Community Mental Health Clinics
- Community Organizations
- Cook County Health
- County Care
- Doctor's Offices
- Enlace Chicago
- Esperanza Health Center
- Federally Qualified Health Centers
- Friends/Relatives
- I Am Able
- Lawndale Christian Health Center
- Midwest Asian Health Association
- Mount Sinai Hospital
- Mount Sinai Psychiatry and Behavioral Health Clinic
- NAMI
- New Life Centers
- Pilsen Wellness Center
- Sinai Health System
- St. Anthony Community Wellness Program
- St. Anthony Hospital
- Telehealth Services

Nutrition, Physical Activity, and Weight

- A Safe Haven
- Amor De Dios UMC
- Beyond the Ball
- Boys and Girls Club
- Community Organizations
- Community Outreach
- Cook County Health
- Doctor's Offices
- Enlace Chicago
- Farm on Ogden
- Greater Chicago Food Depository
- Lawndale Christian Health Center
- Little Village Environmental Justice Organization
- New Life Centers
- Our Lady of Tepeyac
- Parks and Recreation
- Pete's Fresh Market Chicago
- Planet Fitness Gym
- School System
- Universidad Popular
- University of Illinois Extension Programs

Oral Health

- A Safe Haven
- Chicago Department of Public Health
- Cook County Health
- Federally Qualified Health Centers
- Lawndale Christian Health Center
- Oral Health Forum

Respiratory Diseases

- Lawndale Christian Health Center
- Lung Association
- Mount Sinai Hospital
- Prieto Family Health Center

Sexual Health

- Chicago Public Schools Educational System

Substance Abuse

- Drug and Alcohol Rehab Advisors
- Federally Qualified Health Centers
- Gateway
- Healthcare Alternative Systems Chicago
- Haymarket
- Habilitative Systems Inc. Chicago
- I Am Able
- Inpatient Drug Alcohol Rehab Helpline
- Lawndale Christian Health Center
- Midwest Asian Health Association
- Pui Tak Center
- School System
- Sinai Health Center
- Sinai Health System
- The Well-Funded

Tobacco Use

- A Safe Haven
- Local Stores
- Midwest Asian Health Association
- Pui Tak Center

APPENDIX

EVALUATION OF PAST ACTIVITIES

Community Benefit

Over the past three years, Saint Anthony Hospital has invested in improving the health of our community's most vulnerable populations. Our commitment to this goal is reflected in:

- Over $3,462,867 in community benefit, excluding uncompensated Medicare.
- More than $10,260,092 in charity care and other financial assistance programs.

Our work also reflects a focus on community health improvement, as described below.

Addressing Significant Health Needs

Saint Anthony Hospital conducted its last CHNA in 2018 and reviewed the health priorities identified through that assessment. Taking into account the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals, and strategic priorities — it was determined at that time that Saint Anthony Hospital would focus on developing and/or supporting strategies and initiatives to improve:

- Access to Health Care Services
- Diabetes
- Mental Health
- Heart Disease & Stroke
- Nutrition, Physical Activity, and Weight

Strategies for addressing these needs were outlined in Saint Anthony Hospital's Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by Saint Anthony Hospital to address these significant health needs in our community.

Evaluation of Impact

Priority Area: Access to Health Care Services	
Community Health Need	Increase Access to Health Care
Goal(s)	Facilitate more timely and improved healthcare by increasing patients' access to and utilization of health-related, wrap-around services. Address the local barriers for access to healthcare (i.e., language barrier, health literacy education, transportation, financial challenges, and computer literacy).

Strategy 1: Provide assistance and support to seniors, adults, and families with children enrolling in health-related government programs and public benefits	
Strategy Was Implemented?	Yes
Target Population(s)	Low-income residents
Partnering Organization(s)	A Safe Haven A Silver Lining Center Home Hispanic Elderly Chicago Suburban Westland Empowerment Network Enlace Esperanza Health Center Garfield Park Community Council Chicago Department of Public Health Illinois 7th Congressional District Illinois Hunger Coalition Instituto del Progresso Latino New City Supportive Living North Lawndale Community Coordinating Council Ombudsman Community Advisory Council Pilsen Wellness Center Prime Care Health Services Sankofa State Farm Insurance Agency (Darren Tillis) United for Better Living United Way of Metropolitan Chicago
Results/Impact	• The Health Access program provided assistance to 1410 individuals from 2019-2021 • Health access conducted 3528 sessions/appointments from 2019-2021

Strategy #2: Provide curbside transportation services as necessary	
Strategy Was Implemented?	Yes
Target Population(s)	Low income residents
Partnering Organization(s)	Internal: External:
Results/Impact	• 2,228 rides to SAH for clinical services

Strategy #4: Provide childcare for patients accessing services through the Community Wellness Program	
Strategy Was Implemented?	Yes
Target Population(s)	Low income residents
Partnering Organization(s)	Internal: External:
Results/Impact	• 661 children received childcare • Childcare provided at 287 appointments or sessions

Strategy #5: Provide charity care and need-based financial assistance to patients for medically necessary services provided through the hospital's inpatient acute, outpatient, and behavioral health care settings	
Strategy Was Implemented?	Yes
Target Population(s)	Low income residents
Partnering Organization(s)	Internal: External:
Results/Impact	• $10,260,092 spent on charity care

Priority Area: Diabetes & Nutrition, Physical Activity & Weight	
Community Health Need	Decrease
Goal(s)	• Bring diabetes education and management services to more residents in the hospital's service area. Employ best practice strategies that lead to diabetes prevention, quality diabetes outcomes, and reduction in hospital readmissions. • Maintain educational and clinical competencies endorsed by the American Diabetes Association. • Increase awareness of healthy foods and increase physical activity in the community.

Strategy #1: Provide systemic care coordination for patients in order to increase access to and availability of diabetes nutrition and management services through expanding the Center for Diabetes and implementing the Diabetes Connect Program.	
Strategy Was Implemented?	Yes
Target Population(s)	Low-income clients
Partnering Organization(s)	Internal: Saint Anthony Hospital External: Esperanza and Access
Results/Impact	• 80 clients from Esperanza, Access and SAH were provided with insulin pump services, continuous glucose monitoring services and medical nutrition therapy. • 72% of clients met nutritional goals • 74% of clients improved A1C score

Strategy #3: Provide support and education related to diabetes issues, including eating habits and lifestyle choices, to community members through Community Nurse.	
Strategy Was Implemented?	Yes
Target Population(s)	Low income residents
Partnering Organization(s)	Internal: Community Wellness Program External:
Results/Impact	• 143 clients received appointments to gestational diabetes services and/or health counseling • 277 appointments for gestational diabetes services and health counseling

Priority Area: Mental Health	
Community Health Need	Increased access to mental health services
Goal(s)	Increase awareness of associated social determinants of mental health among providers and the community, as well as increase access to mental health services for community residents.

Strategy #1: Offer free therapeutic intervention services to uninsured and underinsured individuals throughout our service areas via community wellness centers	
Strategy Was Implemented?	Yes
Target Population(s)	Low income residents
Partnering Organization(s)	Internal: External:
Results/Impact	• 640 unique individuals received free mental health therapy (group, couples, family, and individual therapy) • 9,213 therapy appointments were provided

Strategy #2: Become a source of referral to connect community residents to resources.	
Strategy Was Implemented? Yes	Yes
Target Population(s)	Low-income residents
Partnering Organization(s)	Internal: External: Behavioral Health Counseling Services Bobby E. Wright Behavioral Health Center Brighton Park Neighborhood Council Deer Rehabilitation Services Esperanza health Center Garfield Park Behavioral Hospital Healthcare Alternative Systems (H.A.S.) Chicago Department of Public Health I AM ABLE Inner-city Muslim Action Network Mount Sinai Hospital's Under the Rainbow Mujeres Latinas en Accion The Learning Center Roots to Wellness TR4IM Universidad Popular
Results/Impact	• 1,463 inbound referrals for CWP programming, including mental health • 1,958 outbound referrals to other needed services

Strategy #3: Support the development of coalitions and increase awareness of resources between providers through participation and leadership within community and healthcare coalitions.	
Strategy Was Implemented? Yes	Yes
Target Population(s)	Low-income residents
Partnering Organization(s)	Internal: External: Brighton Park Neighborhood Network
Results/Impact	• 190 coalition meetings attended • Organizations: Brighton Park Neighborhood Network, Community Quality Council, Criminal Justice Taskforce, Marshall Square Resource Network, Peace and Education Coalition, North Lawndale Community Coordinating Council, North Lawndale Reads, Rapid Employment and Development Initiative, Restorative Justice Community Courts in North Lawndale, Safety and Justice Challenge Community Engagement Council

Strategy #4: Increase mental health awareness in our community service areas and address stigma through educational presentations	
Strategy Was Implemented?	Yes
Target Population(s)	Low-income residents
Partnering Organization(s)	Internal: External: Behavioral Health Counseling Services Bobby E. Wright Behavioral Health Center Brighton Park Neighborhood Council Deer Rehabilitation Services Esperanza health Center Garfield Park Behavioral Hospital Healthcare Alternative Systems (H.A.S.) Chicago Department of Public Health I AM ABLE Inner-city Muslim Action Network Mount Sinai Hospital's Under the Rainbow Mujeres Latinas en Accion The Learning Center Roots to Wellness TR4IM Universidad Popular
Results/Impact	• 46 presentations were conducted in the community related to mental health or family support therapy, or awareness of CWP clinical services • 839 community residents attended community presentations

Strategy #5: Social work intern site placement	
Strategy Was Implemented?	Yes
Target Population(s)	Low-income residents
Partnering Organization(s)	Internal: Community Wellness Program (SAH) External: UIC and other local universities/graduate schools
Results/Impact	• Four social work interns were placed at the CWP Case Management or Mental Health Programs

Priority Area: Stroke Care and Management	
Community Health Need	Local stroke emergency services
Goal(s)	• Provide tertiary prevention for stroke • Reduce stroke mortality

Strategy #1: Establish a primary stroke center at Saint Anthony Hospital	
Strategy Was Implemented?	Yes
Target Population(s)	Low-income residents
Partnering Organization(s)	Internal: SAH External: Northwestern Memorial Hospital
Results/Impact	• In October 2020, the Joint Commission, and the American Heart Association/American Stroke Association certified SAH as a primary stroke center • Allowed emergency medical services to bring patients from the service area to care for stroke patients

Strategy #2: Provide care for stroke patients in the service area	
Strategy Was Implemented?	Yes
Target Population(s)	Low-income residents
Partnering Organization(s)	Internal: SAH External: Northwestern Memorial Hospital
Results/Impact	• 76 patients received tertiary prevention services between July 2020 and June 2021 (stabilize condition, implement treatment, provide a social worker, rehabilitation services, speech therapy, etc.)